

Educational interventions for dementia care in Primary Care: What works?

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A TRADITION OF INDEPENDENT THINKING
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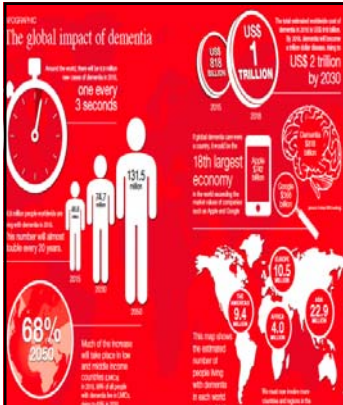
This Morning's Discussion

- Dementia Impact & Policy Response
- Challenges in Primary Care
- Dementia Educational Interventions in Primary Care
- PREPARED
(Primary Care Education, Pathways & Research of Dementia)

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Dementia Impact & Policy Response

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The Importance of Dementia Care

Prevalence
Increasing from 47,000 to 140,000 by 2041

Cost
DALY
> Stroke, CVS Disease and Cancer

Impact
Currently €1.69 Billion/Annium in Ireland
> 1% of World's GDP

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Policy Context: Kyoto Declaration 2004

Minimum actions required for the care of people with dementia

- Provide **treatment in primary care**
- Make appropriate treatments available
- Give **care in the community**
- Educate the public
- **Involve communities**, families and consumers
- Establish national policies, programs and legislation
- Develop human resources
- Link with other sectors
- Monitor **community health**
- Support more research

<http://www.alz.co.uk/ad/pdf/kyotodeclaration.pdf>

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Policy, Plans & Strategies



■ Countries with a National Dementia Plan
■ Countries without a National Dementia Plan


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Challenges in Primary Care



The Context in Irish General Practice

- Average list approx. 2,000 patients
- 2-4 new patients with dementia/yr/GP
- 12-15 patients with dementia/GP
- Increasing Chronic Disease Management in General Practice
- No Chronic Disease Management Structures
- The 10 Minute Consultation



Challenges in Primary Care


Systematic review

Irish context


- Diagnosis
- Disclosure
- Lack of support services
- Time
- Financial constraints
- Stigma
- Lack of knowledge about care pathway

- 90% no dementia-specific training
- 83% keen for training
- 69% regularly diagnosed dementia
- 4 new cases/year
- Diagnostic uncertainty/confidence
- Concern re' impact on patient
- Low disclosure rates
- GP Training needed



KOON T. *et al.* *Global prevalence of dementia: the diagnosis and systematic review.* *BMJ Family Practice.* 2010; 11: 527
Cahill S *et al.* *Dementia in primary care: the first survey of Irish General Practitioners.* 2008; Age 21(6): 319-24



Dementia Educational Interventions in Primary Care




Dementia Education We've tried...


Dementia Care Conference
 "Learning together to work together"
 Form for 4.30pm Wednesday
 November 23rd 2011, Acton's Hotel, Kinsale

Dr. Elizabeth O'Brien, M.D.
 General Practitioner, Kinsale Health Centre, Kinsale
 Dr. Robert Murray, M.D.
 General Practitioner, Kinsale Health Centre, Kinsale

9:00 - 9:15 Registration
9:15 - 9:30 Welcome
9:30 - 9:40 Opening together to work together
9:40 - 10:15 *Walden's Theme: The Role of a Psychiatrist*
Dr. Walden's Theme: The Role of a Psychiatrist



The Kirkpatrick Model: Evaluation of Training




Results
To what degree targeted outcomes occur, as a result of the learning event(s) and subsequent reinforcement.

Behavior
To what degree participants apply what they learned during training when they are back on the job

Learning
To what degree participants acquire the intended knowledge, skills and attitudes based on their participation in the learning event

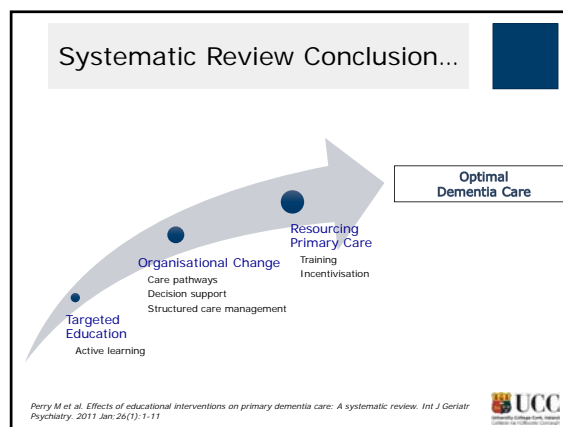
Reaction
To what degree participants react favorably to the learning event

Source: Donald Kirkpatrick



RCTs of educational interventions

| Author | Intervention | Outcome Measure | Result |
|-------------------------------|---|--|--|
| Waldorf et al. 2003; Denmark | 1. Four seminars 2. Outreach visits | Adherence to guidelines Bloods, cognitive testing & referrals to specialists | No improvement in the adherence to a guideline for diagnosing dementia |
| Downs et al. 2006; UK | 1. Small group workshop 2. DSS 3. Electronic Tutorial on CD-RFCM | Dementia detection rates & Concordance with guidelines | Significant increase in the detection of dementia in arms 1 & 2 No improvement in adherence to guidelines |
| Vickrey et al. 2006; USA | 1. Installation of dementia care managers 2. Training primary care providers: 5 X 90 min standardized interactive seminars | Primary outcome: Adherence to guidelines Secondary outcomes: Use of cholinesterase inhibitors, patient CoQ, caregivers' knowledge, CoQ, social support and confidence | GP care more adherent to guidelines. Patients received more community services & were prescribed more cholinesterase inhibitors Caregivers were more confident |
| Rondeau. 2008; France | 1. 2hr educational group meeting 2. Group educational meeting and training in use of neuropsychological tests | Primary outcome: Suspicion of dementia by GP Secondary outcome: Diagnosis of dementia by GP GP Knowledge | No difference in diagnosis of dementia in intervention group Education ineffective |
| Vollmar. 2010; Germany | 1. Online learning plus structured case discussion (blended learning) 2. Lecture plus structured case discussion | GP Knowledge | Both groups showed a significant gain in knowledge |
| Whitlock et al. 2013; England | Workplace based tailored educational intervention | Primary outcome: 2 dementia-specific reviews/year Secondary outcome: Case identification | No change in reviews or in cases identified Education alone not enough |



However, current GP education...

| The Requirements | Weaknesses |
|--|--|
| <ul style="list-style-type: none"> Mandatory CPD¹ 50 hrs (points/year) External (lectures/small group CME) Internal (practice based) Audit | <ul style="list-style-type: none"> CPD not based on needs of GP Not focused on needs of patient Not multidisciplinary No organisational change |

ICGP Professional competence scheme framework. Available at http://www.icgp.ie/go/pcs/scheme_framework

PREPARED

(Primary Care Education, Pathways & Research of Dementia)

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(Primary care education, pathways and research of dementia)

PREPARED Actions

- Educational Needs Analysis
- Intervention
- Evaluation

<https://www.ucc.ie/en/gp/research/prepared/project/>

1. Educational Needs Analysis (& Unknown Unknowns)

There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know.

(Donald Rumsfeld)

izquotes.com

1. Triangulated & Qualitative

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Designing the Intervention

Activities should demonstrate to the learner where he or she would benefit in their jobs.

Adults are motivated to learn by both extrinsic and intrinsic motivators.

Focus activities on "doing" something with the information rather than simply "knowing" it.

Adults enter into a learning experience with a task-centered (or life-centered) orientation.

Adults become ready to learn when they experience "a need to know".

Adult Learning Principles

Adults have a need to know why they should learn something.

Adults have a deep need to be self-directing.

Adults have a greater volume and different quality of experience than youth.

Activities should be based around real work experiences.

Present training with as many options for learning as possible.

Design activities that reflect the actual work learners perform.

Don't do an information dump.

www.caracorp.com

2. The Intervention

- a) Practice Level:
 - o Peer-facilitated workshops, problem-based scenario
 - o Decision support – web-resource/pathway & e-referrals
 - o Audits – e.g. diagnosis/coding/referral/antipsychotic prescribing
- a) Nationally for GPs and PCT Members:
 - o CME
 - o Interdisciplinary Workshops
 - o PCT Meetings
 - o E-learning
 - o Guidelines
 - o Decision support - web resource

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Problem-based Scenario: An Untimely Diagnosis

- 77yr old lady, Brid, retired book-keeper, spinster, lives alone
- Missed appointment – usually religiously attended every 3/12
- Uncharacteristic argument with receptionist
- Chemist says not collecting scripts

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Case History - 1 Work-up

- History – 'not quite right'
- Collateral – nephew a doctor in USA
- Exam – nil focal
- MMSE 27/30 (DLROW mistakes)
- Bloods

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Case History - 1 Management

- Watchful waiting
- Home Help - reluctantly
- Weight loss - Meals-on-wheels
- Repeat MMSE @ 3/12 – 26/30
- Missed appointments
- **What's the next step in care? Why?**




Case History – 1 Progression

- Falls
- Midnight Phone-calls
- House-call - Glass of wine
- Aricept (Donepezil)
- Referral to Memory Clinic – 4/12
- ? Dementia – await Scan – 6/12
- **Any other management options?**




Case History – 1 Outcome

- Fall with Fractured Femur and Deep Laceration
- Ortho admission
- Delirium
- Long-term nursing home care
- Advancing Dementia
- Doesn't retain capacity, No Will, No EPA
- **What are the lessons?**




Lessons Learned

- MMSE Fallibility – Link to GPCOG - <http://gpcog.com.au>
- Value of Timely vs Early Diagnosis
 - Early interventions – OT assessment, PHN, PCT support
 - Will
 - EPA
 - ASI
- Need for Integrated Dementia Care Pathway



3. Evaluation

- Practice Level - before & after measures
- National Level
- Meaningful Outcome Measures
- GP & PCT Members
- Collaboration with DCU



Summary

- Education alone is not enough
- Need combine relevant, interactive, problem-based learning with practice-based organisational change
- Integrated care pathway
- Multidisciplinary approach
- PREPARED

