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Conference Abstract

10 Years experience of developing an Integrated Care Model for people with dementia in Catalonia

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Abstract

Introduction: Dementia is a chronic illness that leads to progressive disability and eventually death. During the different stages of the disease the needs of patients change, consequently the resources necessary to take care of them must also adapt. In order to provide comprehensive and integrated care to both the patient and caregivers, throughout the disease process, we created the Badalona Dementia Care Unit (B-DCU) in 2003. The unit is located in an Intermediate Care Hospital and is the reference centre of Badalona Serveis Assistencials (B.S.A), a social and health organization, for the diagnosis, monitoring and treatment of people with dementia and cognitive impairment. The area of influence is the city of Badalona and its surrounding area (north of Barcelona). Since its creation the unit was formed by professionals from different disciplines specialized in the care of people with dementia.

Objectives: To analyse the results of the activity and the resources used over the last decade in the field of integrated care for people with dementia in Badalona.

Methodology: The integrated care model is based on the development of common goals at all levels of of care. This is a care system specifically designed for people with dementia that uses quadruple integration: organizational (all the services depend on the same organization), functional (non-hierarchical leadership), clinical (patient-oriented outcomes) and services (integration of the structures of service-oriented Geriatric dementia in a single unit).

1. Creation and development of the Badalona Dementia Care Unit (B-DCU) in september-2003
Specific resources:

1.1. Outpatient diagnosis and treatment of cognitive impairment unit (DTCIU)
• A single point of access for the Badalona influence area for all cognitive disorders, dementia and psychogeriatric pathology (including behavioural problems in dementia).
• Reference population: 110,150 people.
• Consists of a multidisciplinary team with expertise in: Geriatrics, Neurology, Psychiatry, Neuropsychology, Nursing and Social Work
• Work methodology based on the evaluation of the individual / caregiver with an interdisciplinary approach, detecting problems and needs, and establishing an individualized treatment plan
• Once the diagnosis is complete, the care of the patient is shared between the unit and GPs.
• Accessibility in situations of acute crises: The nurse case manager of the B-DCU, processes the requirements of the unscheduled crises, and sets up mechanisms to resolve them.
These may be:
- Information / health education
- Adjustment of the treatment
- Programming of a medical evaluation with a preferential visit to the physician
- Admission to the preferred Psychogeriatric Short term unit
- Social Work Intervention
- Other
• Support for family and carers through:
- Nursing visit (information / health education)
- Yearly training course for the families of patients

1.2. Outpatient Assessment and Treatment Day Hospital (DH)
• Multidisciplinary team (geriatrician, nursing, neuropsychologist, social worker)
• Evaluation / crisis management
• Treatment with cognitive stimulation
• Other treatment: psychomotor, music therapy, audio-visual workshops, cooking, gardening, leisure activities, etc.

1.3. Psychogeriatric hospitalisation unit (PsGHU)
• Short term care: for patients in crisis situations, primarily psychiatric and behavioural symptoms, which are difficult to control.
• Long term care: people with a clinical situation of dependency related to a psychogeriatric condition, in need of continued long-term care.

2. Development of integrated care programs with Primary Care.
- Creation of a committee composed of B-DCU and primary care to establish local leaders from GPs.
- Training sessions for dementia and behavioural disorders.
- Development of the criteria for the integration of a primary care referral communications and records software system.
- Create a protocol for nursing case tracking.
- Proactive monitoring of the integrated tracking between B-DCU and primary care.

3. Collaboration with other resources nonspecific to dementia in order to guarantee the continuation of the care:
- Geriatric mobile team of reference hospital
- Palliative care unit

- Hospital-at-home and nursing home care geriatric (active and palliative) teams
Results:
B-DCU specific activity (01/01/2004 - 01/01/2014)

Overall results or DTCIU: In total, 4,778 patients were treated of the ten year period (4.3 cases / 1,000 inhabitants), which required 39,508 patient visits in the following categories:
Medical: 24,569
Nursing: 5,944
Neuropsychology: 6,587
Social Work: 2,408
- Requirements for unscheduled care, by telephone or face to face, over almost two years (01/01/2013 - 09/30/2014): 1,238.
- Patients treated at the Assessment and Treatment Day Hospital (01/01/2004 - 31/12/2013) 856 patients.
- Admissions to the Psychogeriatric Hospitalisation Unit in the last five and a half years (01/04/2008 -31/12/2013) for behavioural disorders: 523 patients.
- Actual status today in our area of influence:
♣ Patients living at home being tracked by the (DTCIU) and receiving integrated care: 2,033 people.
♣ Institutionalized patients being tracked by the (DTCIU) and receiving integrated care (supported by NH care geriatric teams): 97 people.

Lessons Learned:
- The process of creating a health care program that focuses on the patient and his family has developed a care model that most closely matches the real human needs.
- The collaboration of professionals from all the fields and resources involved has optimised the integration of the care process at all stages during the progression of dementia.
- A unique recognized clinical leader has been the key tool for the successful development of the project.

Summary of experience: In late 2003, the B-DCU was created with the aim of providing integrated care for people with dementia at all stages of disease: from the initial detection of cognitive impairment, diagnosis, to the more advanced stages, and finally end of life.
The system that has evolved over the last decade, started from the collaboration between Primary Care personnel and a specialized staff (from different medical departments, including Geriatric and Palliative Care) of B.S.A. organisation, to become a truly comprehensive and integrated care system for the person with dementia.

The features that made it possible were:
• Centralization of the diagnostic process in a single unit for the whole influence area, regardless of patient characteristics (age, origin ...)
• Attention focused on the priorities and wishes of the patient (patient care centred).
• Targeted support for the family from both health and social aspects.
• Proactive and integrated tracking through all the stages of the illness.
• A single point of access for all cognitive disorders and an individualized approach.

Keywords

dementia; integrated care; pathway; geriatrics; psychogeriatric

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PowerPoint presentation

http://integratedcarefoundation.org/resource/icic15-presentations