The Memory Team

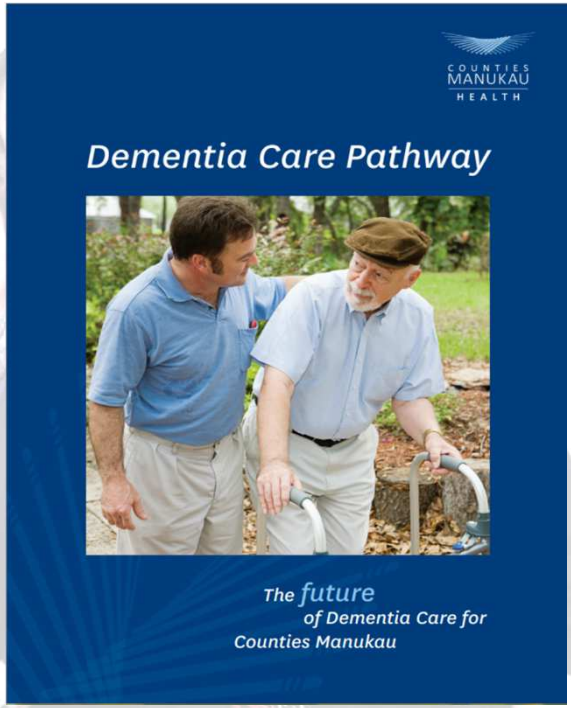
Counties Manukau Dementia service

Northern Regional Alliance Ltd

COUNTIES MANUKAU HEALTH

The Counties Manukau Memory Team

1. Where we started
2. Memory Team Pilot
3. Twelve Months later…
4. Future Changes



Dementia Care: Where we started

General Hospital

- High number of cases in some services
- Frequently not diagnosed

Referrals to Secondary Care for Dementia

- Geriatrics outpatients
  - 700 referrals per year
- Mental Health Service for Older People
  - 500 referrals per year

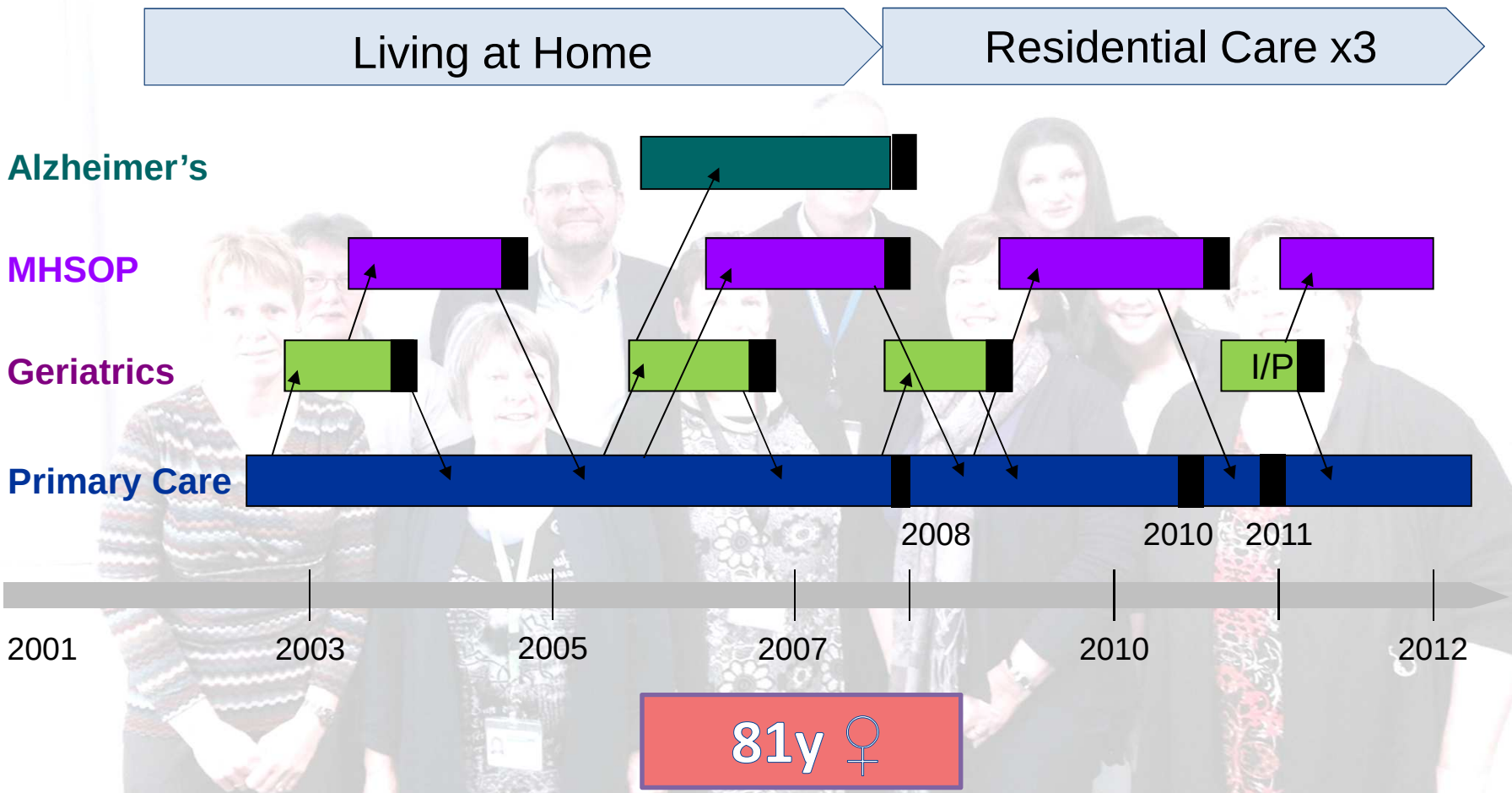
Primary Care

- Unknown

Alzheimer's Association

- Unclear

Dementia Care: Where we started

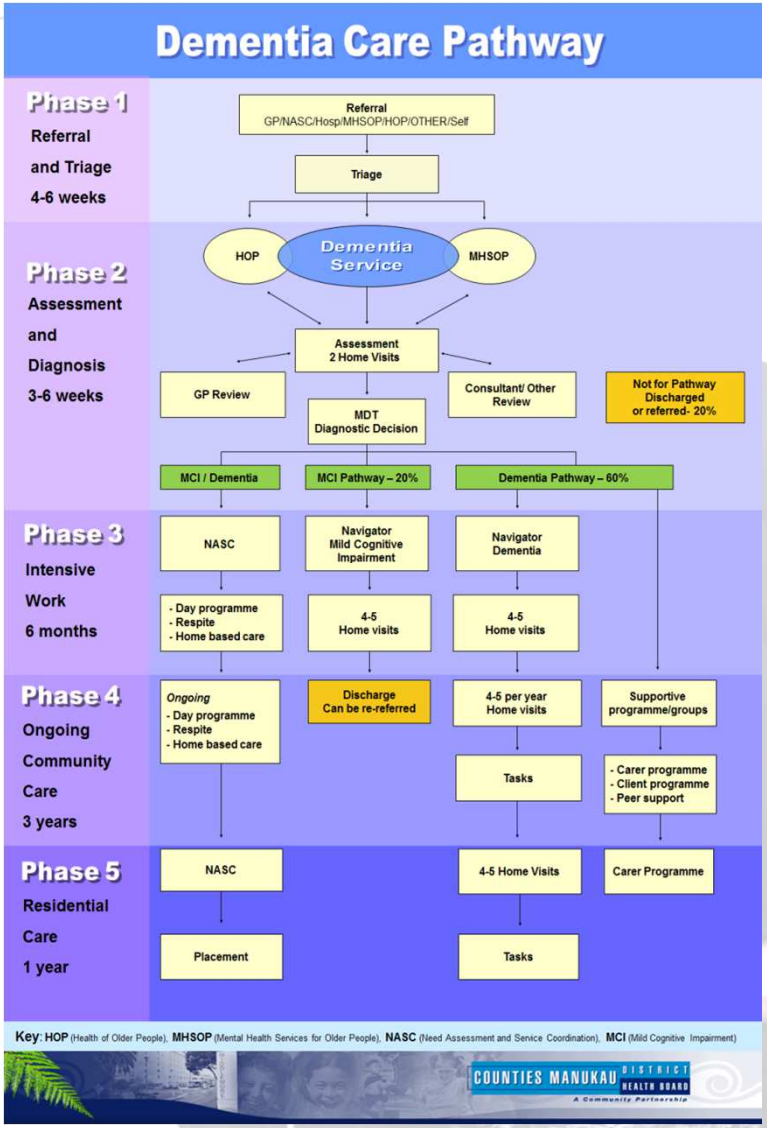


Where we started

What was being done poorly?

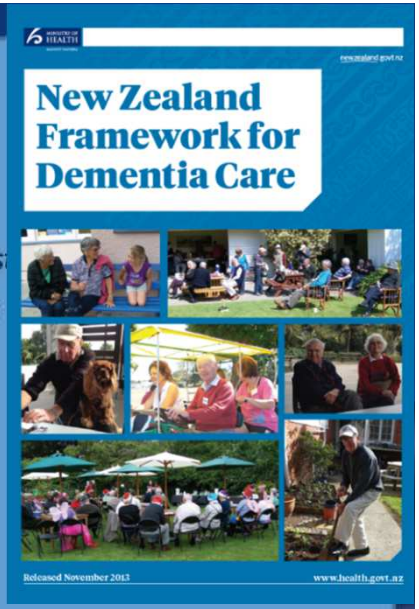
- Diagnosis – Primary and Secondary
- Dementia Medications under-used
- Driving
- Legal issues
- Family and carers
- Delirium in Hospital
- End of Life Care
- Attending Alzheimer's

The CMH Pathway



- **Fix secondary care pathway**
- Follow-up for whole of journey
- Provide more support to carers
- Mental and Physical Health
- Increase efficiency - MDT
- Tidy up “Loose Ends”
- Strengthen links Primary care
- Strengthen links with Alzheimer’s

New Zealand Dementia Care Framework



Vision:

People with dementia, their family and whānau are valued partners in an integrated health and support syst supported throughout their journey with dementia, to enable them to maintain and maximise their abilities, well-being and have control over their circumstances.

Principles:

- Person-centred and people-directed approach
- Accessible and Proactive services
- Integrated services
- Highest possible standard of care

Key Elements:

Awareness and Risk Reduction → Assessment, Diagnosis, Early Intervention and On-going Support → Living Well with Dementia → Addressing challenges to Maximise Well-being → End of Life

Overarching aspects:

- Rights of the person with dementia
- Education and training for people with dementia, their family and whānau
- Workforce education and training
- Information resources
- Governance
- Carer support
- Funding streams
- Monitoring and evaluation
- Advocacy

New Zealand Dementia Care Framework

Vision:

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The Memory Team

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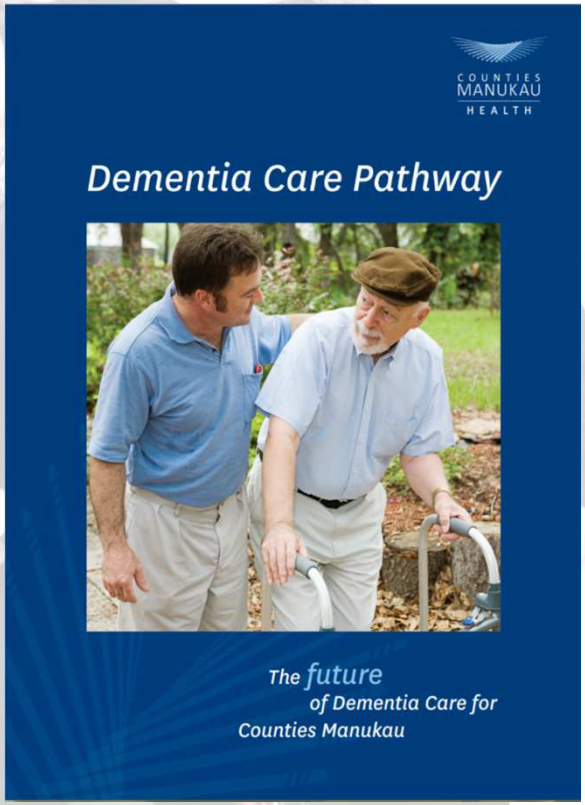
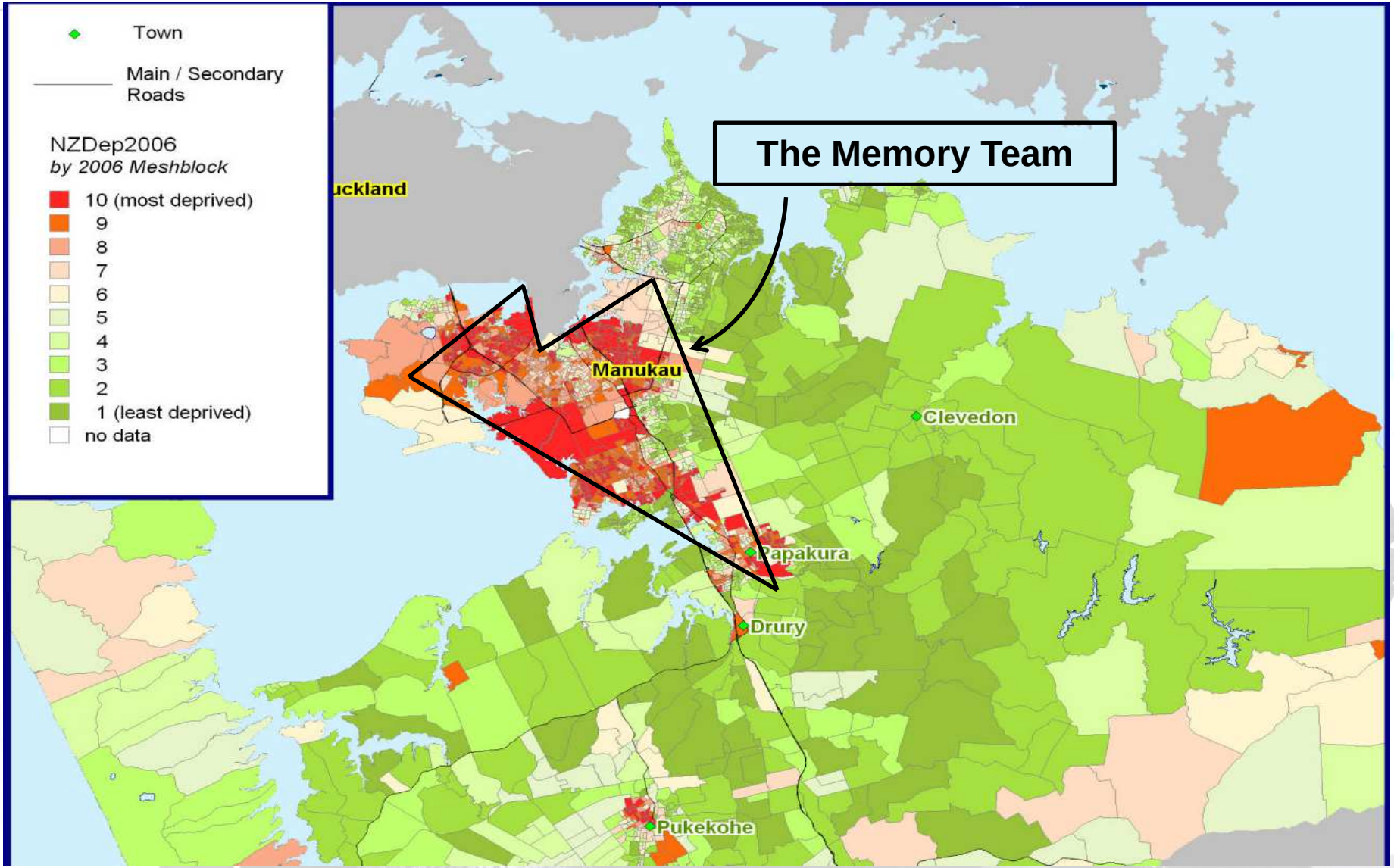
Memory Team Pilot 2013 / 2014

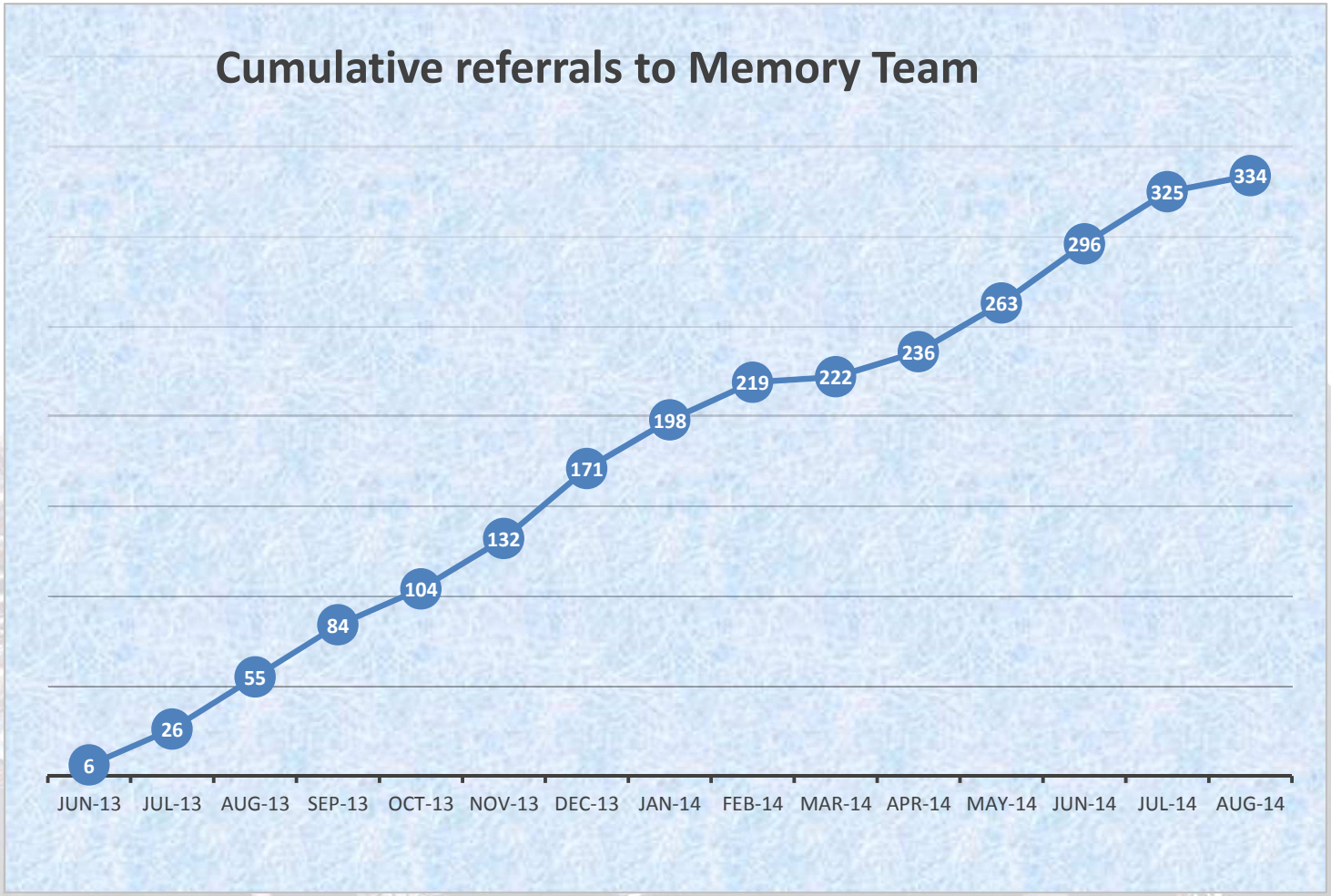
- Funding secured
- Started July 2013
- 40% Counties Manukau area
- 4 Clinical FTE
  - 2 psychologists, 1 nurse, 1 OT
  - 0.5 FTE Project Manager
  - “Borrowed” Specialist SMO input
  - Health of Older People service



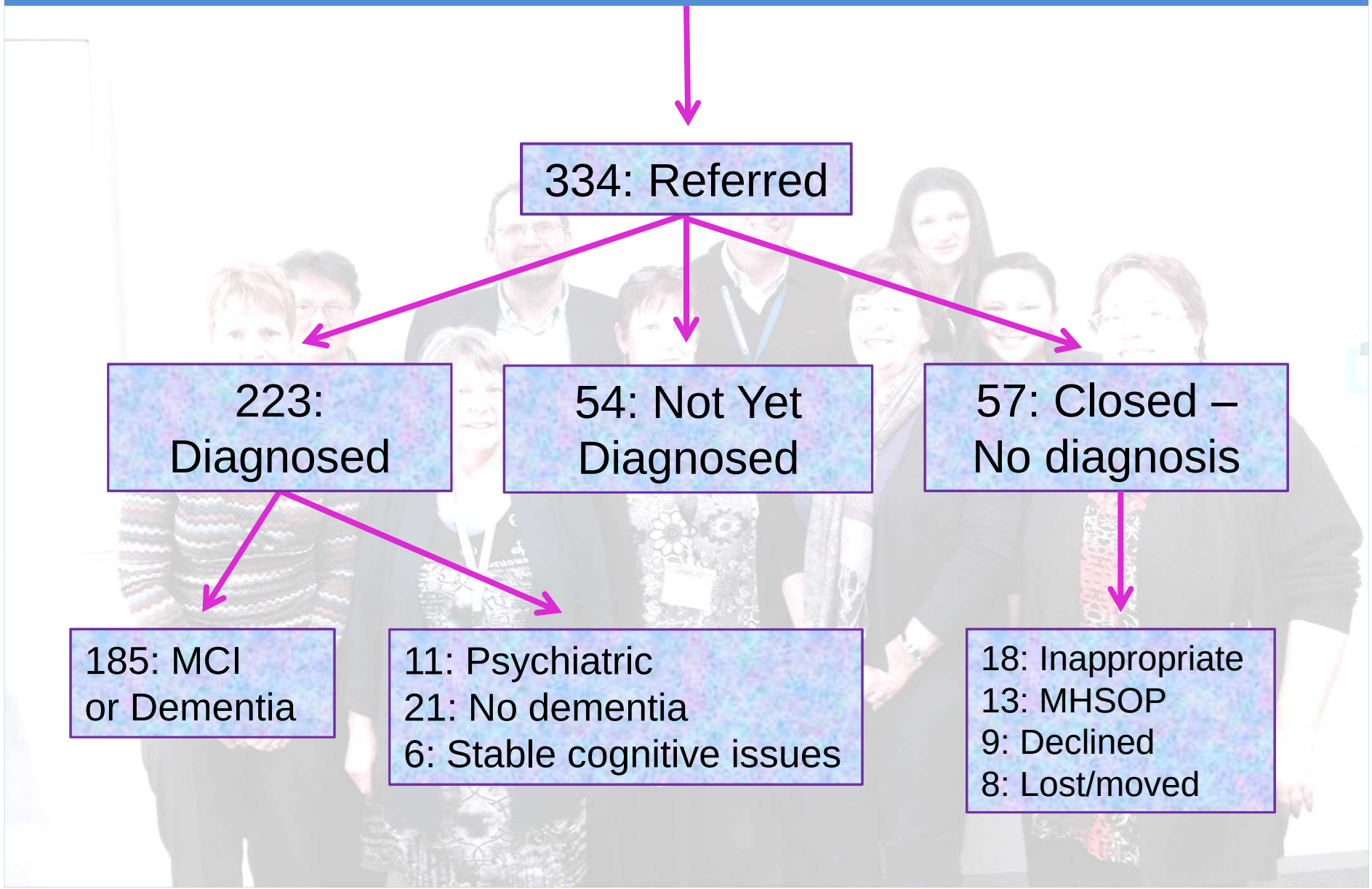
The Memory Team: Pilot Area



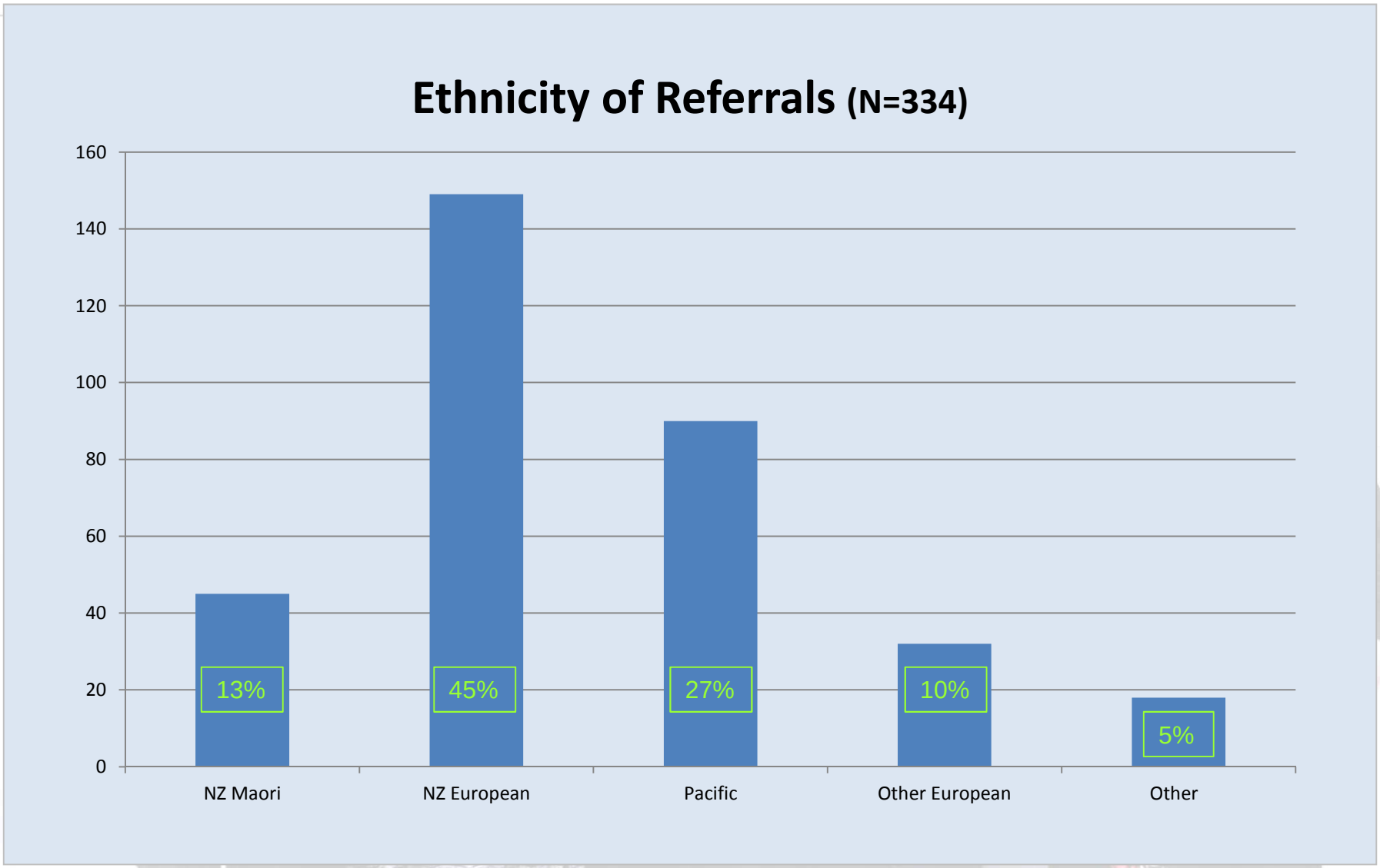
Twelve Months Later….



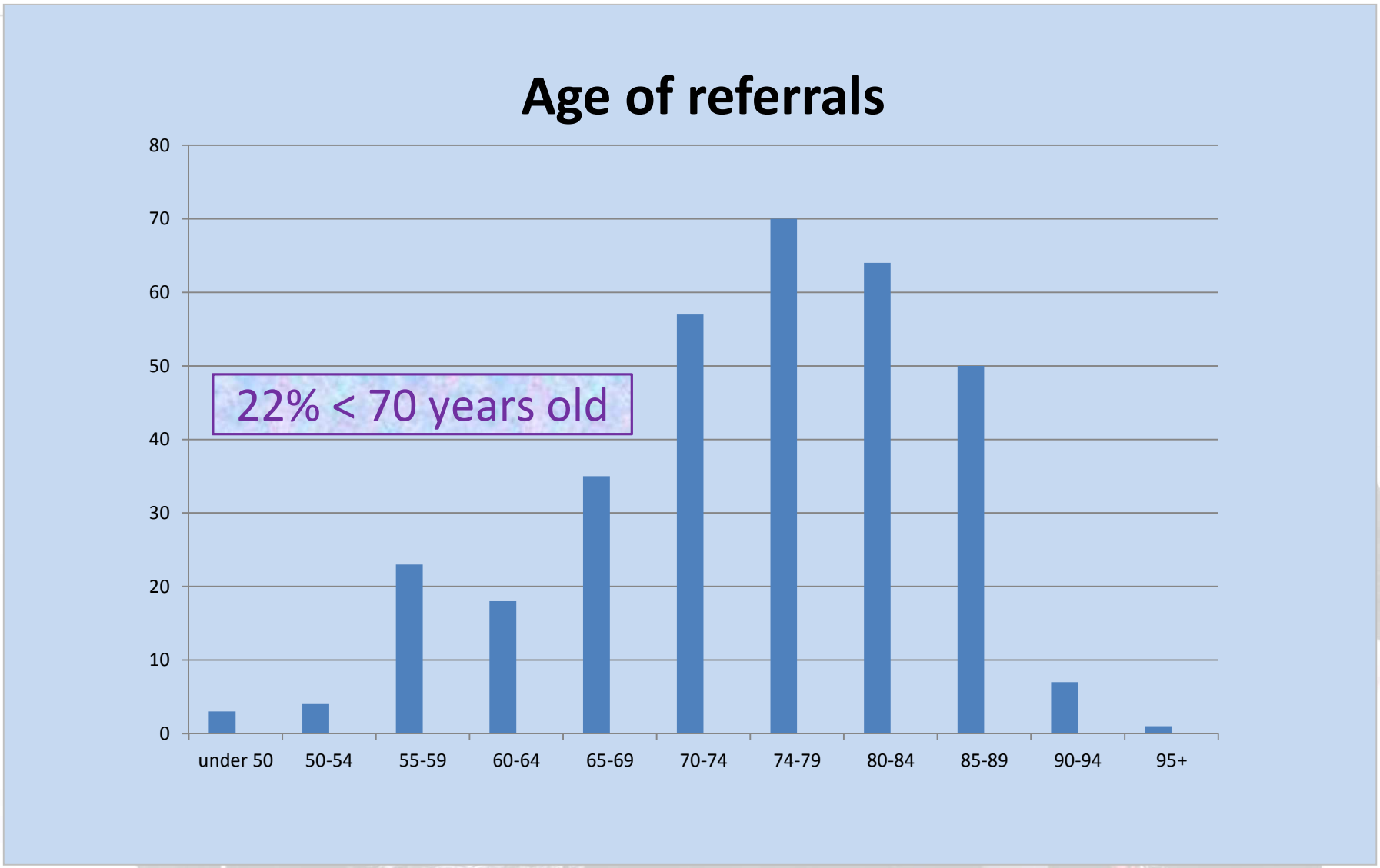
Referrals: (80% Primary Care)



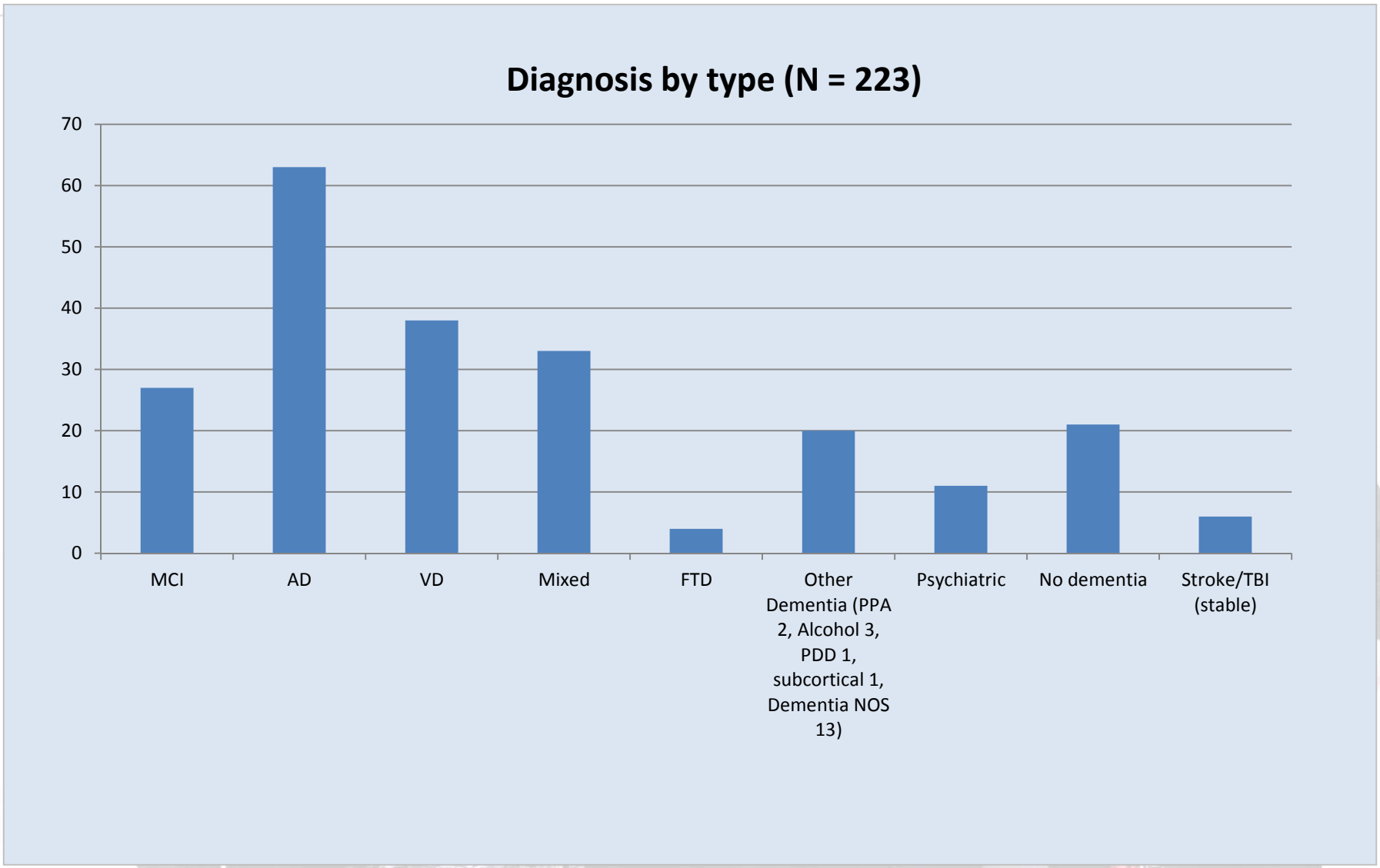
Ethnicity


Ethnicity of Referrals (N=334)
160
140
120
100
80
60
40
20
0
13%
45%
27%
10%
5%
NZ Maori
NZ European
Pacific
Other European
Other

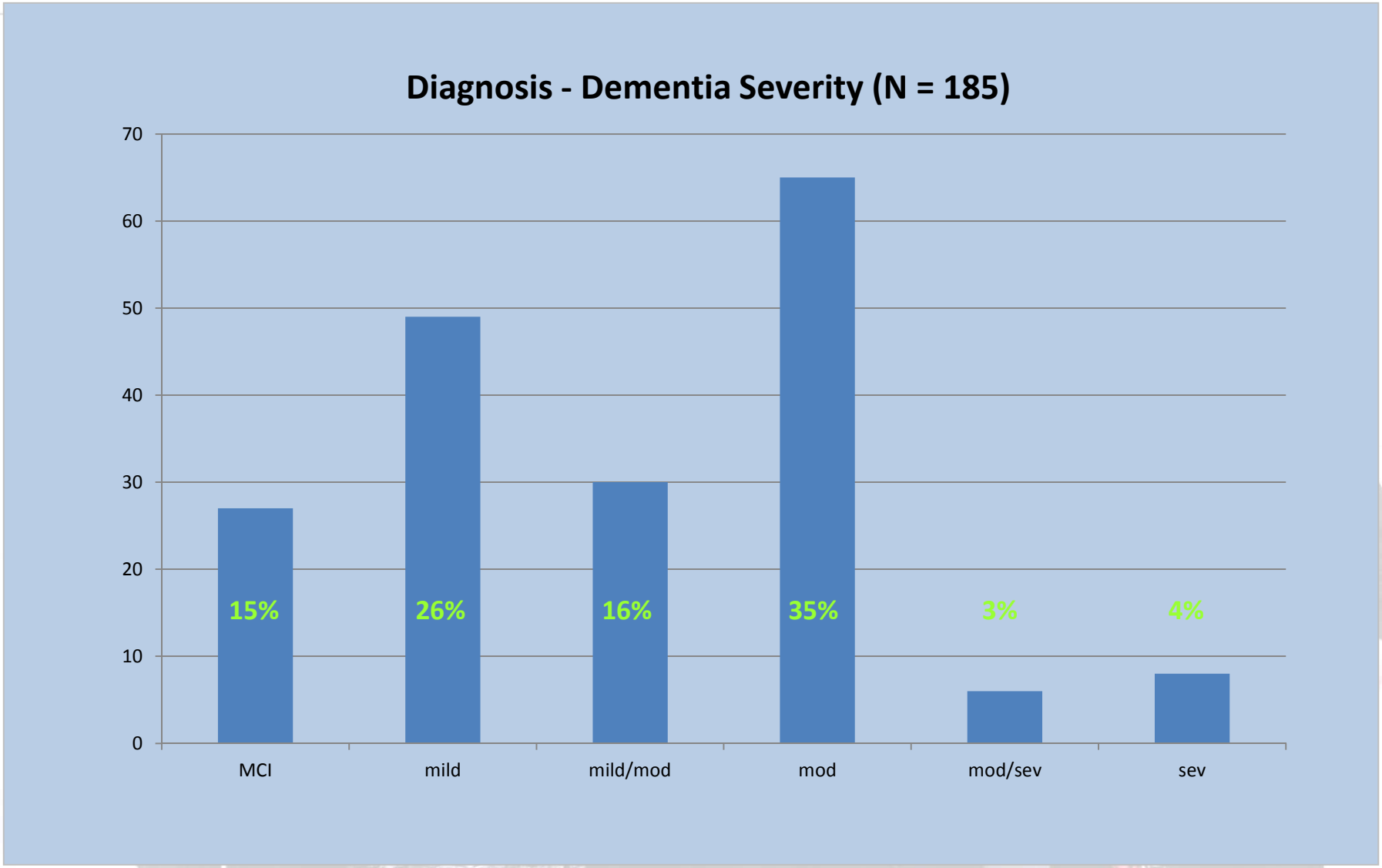
Referrals: age range



Diagnoses made



Dementia Severity



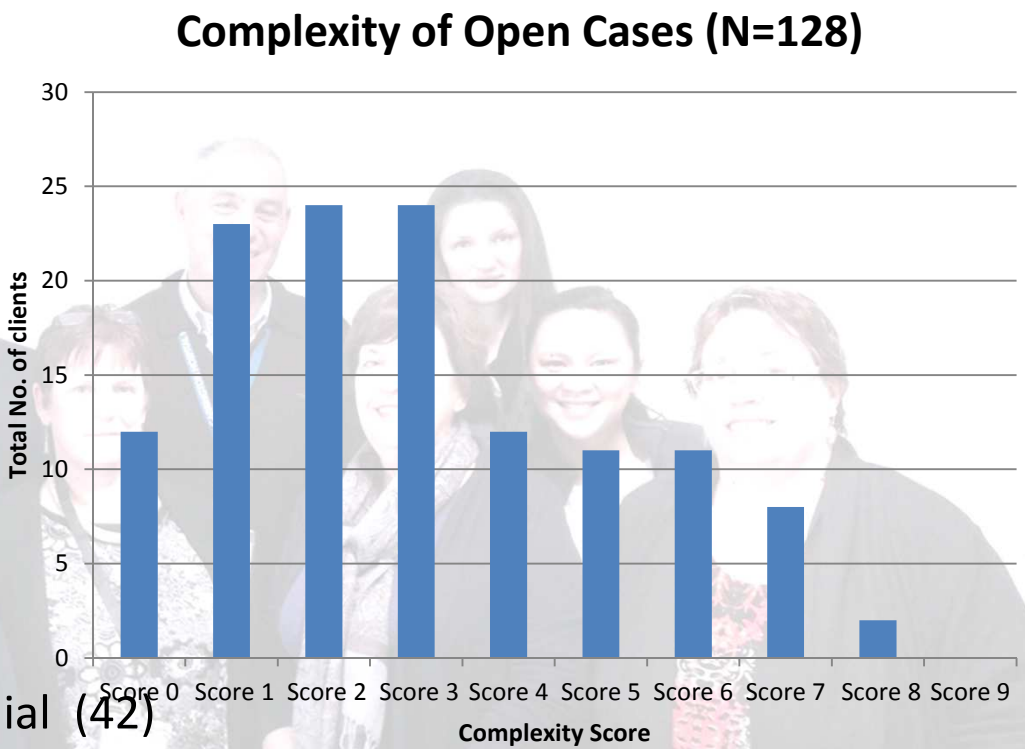
Experience: the first twelve months

- Well received
  - Patients and Carers
  - Primary Care
- Short waiting times
- Triage messy
- Difficult / complex cases
- “Driving” a major battleground
- Younger patients
- Specialist visits limited – MDT model
- Link with Alzheimer’s successful

“Complex” cases

- Complexity List

1. Lives alone (24)
2. Multiple co-morbidities (62)
3. Poor insight / awareness (86)
4. Complex family situation (43)
5. Alcohol / Drug abuse (15)
6. Driving issues (39)
7. Carer limited knowledge / in denial (42)
8. Carer stress levels high (55)
9. Needs interpreter (17)



“One third of cases had four or more complexities”

Future Changes

- Capacity
  - Team increased to 6FTE
  - Enlarged Pilot area (Half CMH area)
  - Shifting cases to Alzheimer's / Primary Care
  - e-Shared Care link-up
- Primary Care computerised pathways
  - Cognitive Impairment Pathway
  - At Risk Individuals Pathway (CMH)