QUESTIONNAIRE: YOUR COMMENTS ON PROPOSED STRATEGIES FOR DEMENTIA CARE AND SUPPORT IN VICTORIA 2005 AND BEYOND

The input of individuals and organisations is sought on suggestions to build on dementia policy and practice in Victoria, as outlined above. Organisations may wish to agenda this document for discussion at a regular or extraordinary meeting.

Please return your questionnaire before Friday 25 February 2005.

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You may not be able or wish to provide feedback on every question. Please answer those questions you wish to.

General Comments from GPDV

There are a number of general comments on the *Dementia Framework for Victoria, 2005 and Beyond* that GPDV would like to contribute. These comments focus on aged care policies at Commonwealth and State level and include practical recommendations intended to define the role of both divisions and general practice in the diagnosis and care of patients with dementia.

GPDV suggests that both the Departments of Human Services (DHS) and Health and Ageing (DoHA) support the role of the GP along the pathway of dementia - from prevention, to diagnosis and management of dementia through:

a) the establishment of a Joint Working Party, comprising State, Commonwealth and NGO representatives, to co-ordinate efforts in dementia care;

b) the provision of public information about dementia and services through co-ordinated State and Territory health campaigns;

c) the provision of information about dementia and State services, such as Memory Clinics, to GPs through the Divisions of General Practice;

d) the provision of evidence-based guidelines to support the role of general practice in the early detection and management of dementia;

e) scoping the role of GPs in SRSs and creating opportunities for ensuring residents of SRSs have appropriate access to medical care;

f) targeted GP training in the diagnosis and management of dementia, and other forms of support for GPs. The Southcity GP Services *Getting Across Dementia* workshops and resources developed in 2000/2001 would be an example of appropriate GP training in this area;

g) encouraging the systematic use of Annual Health Assessments for over 75s to specifically screen for early signs of dementia and address patient concerns;

h) the identification and promotion of a sensitive dementia screening test that can be applied by a general practice nurse for patients where recommended by the GP;

i) the introduction of an MBS item, similar to the Annual Health Assessment item for over 75s, that includes screening for dementia, cardiovascular disease, and other conditions associated with ageing for patients in their early 60s and over;

j) the introduction of an MBS item to facilitate home visits by GPs for patients in the later stages of dementia who are being cared for at home;

k) ensuring GP EPC Plans, with particular reference to new EPC plans forthcoming in the May Schedule, are employed to co-ordinate care for patients with dementia;

l) ensuring that utilisation of the Allied Health items, following an EPC Care Plan, for referral to a psychologist or mental health worker, or other appropriate referrals to mental health providers (potentially under the *Better Outcomes in Mental Health Care* initiative, is part of the co-ordinated care for patients with dementia *and* their carers and families.

m) Promotion at the community level of awareness of the early stages of dementia and available supports to increase family recognition of dementia. This should include educating the community regarding the differences between dementia, delirium and depression and the value of advance care planning.

GPDV would also like to emphasise that in rural areas, GPs face significant difficulties in the lack of available state services for care of the elderly. Hence, it is important that CDAMs and other services are accessible to patients across Victoria, not just in metropolitan areas. Second, GPs in rural areas also encounter difficulties when trying to co-ordinate care for patients in residential facilities. These difficulties can be exacerbated when the progress of dementia is rapid, and access to support is limited.

Question A - Preventing and reducing the risks of dementia - healthy and active living

i) What comments do you have on the possible strategies in this consultation paper for preventing and reducing the risks of dementia, the impact of healthy and active living, and how to implement these strategies? (See pages 18 - 20).

ii) What other strategies could be added for preventing and reducing the risks of dementia, including the impact of healthy and active living?

iii) What examples of good practice can you identify of awareness raising activities about preventing and reducing the risks of dementia, and the impact of healthy and active living?

iv) What strategies can you suggest to ensure that the interests of special needs groups are met in preventing and reducing the risks of dementia, and the impact of healthy and active living? (Special needs groups include Indigenous people, people of cultural and linguistic diversity, homeless people, people with Down syndrome, and people with younger onset dementia).

v) For your organisation or sector to address the issues raised, what:
- do you currently do?
- could you do?

In 2002-03, 71 of Australia's 120 divisions ran projects that were specifically targeted at older people. These focused primarily on immunisation and diabetes. With Commonwealth and State incentives, there is scope to improve the divisional emphasis on dementia using the key population health strategies which are known to be effective:

- evidence-based guidelines for prevention and early diagnosis;
- practice systems to support assessment and care for the target group, such as recall and reminder systems;
- effective links to appropriate local services to ensure support and to promote health;
- data collection for baseline assessment of population needs and GP/practice progress on implementing guidelines.

With appropriate funding, divisions are well placed to support GPs' care for patients across all stages of the dementia pathway described in this document.

There are no known ways of preventing dementia, except for good general primary medical care .

Question B – Early stages on the dementia pathway

i) What comments do you have on the possible strategies in this consultation paper for the early stages on the dementia pathway, and how to implement them? (See pages 21 - 27).

GPDV would specifically support the first part of Point 10a) on page 24 of the document. *(See end of this document for relevant extract)* With incentives and support, it is appropriate that early detection, planning and support for people with dementia and their families and carers is undertaken in general practice. Support for individuals and their carers/families should be included in the management plan. Please see recommendations for GP training above.

A further suggestion—that GPs undertake specialist clinical diagnosis of dementia instead of CDAMS (Cognitive Dementia and Memory Services) —is not supported. GPs are able to screen for, and conduct initial investigation of, dementia (in particular, looking for underlying and/or treatable causes. The service currently provided by CDAMS goes much further than this, identifying specific cognitive deficits and tailoring a multidisciplinary response. This is beyond the scope of general practice.

An alternative strategy may be to fund a GP training program whereby GPs could undertake clinical attachments with CDAMS in order to build their competence to undertake appropriate early detection as well as to build linkages and increase understanding of the role of CDAMS.

In addition to clinical attachments we support the provision of support to GPs in the practice as detailed in 10 (b). *(See end of this document for relevant extract)* Further exploration of appropriate models of care is warranted.

With regard to points 20-22 under *Respite and Residential Services* on page 26, *(See end of this document)* it is the view of GPDV that this is an area requiring more detailed consideration to ensure increased capacity for GPs to offer quality care for patients. GPDV recommends that collaboration between both levels of government is needed to address the structural and policy issues relevant to SRSs and residential services for patients with dementia. These issues should be addressed by a joint Commonwealth/State Working Party with appropriate representation from government, NGOs, and carer and consumer organisations.

It is further suggested that DHS should consult widely with divisions of general practice to identify the achievable strategies to resource general practice in the prevention and management in dementia. GPDV (if funded) could assist with this consultation.

ii) What other strategies could be added in the early stages of the dementia pathway?

Early education and support of carers would ensure a better transition to dementia support in the home, preferable provided by a co-ordinated allied health team working with the GP. Early education for carers and families should include safety issues around the home.

iii) What examples of good practice can you identify in the early stages of the dementia pathway?

There are a number of strategies to support care in the early stages of dementia. These include:

- incentives to GPs to co-ordinate care, possibly similar to those for the management of diabetes; possibly through modifications to the EPC requirements for patients with dementia.
- strategies to ensure a GP or other professional is identified to co-ordinate care for all patients in the early stages of dementia
- encouraging GPs to ensure that any person with suspected early memory loss or dementia is recommended for a home medicines review as good medication management may delay hospital admission, reduce overdoses and be cost saving
- Increasing the uptake of home medicine reviews through raising awareness amongst GPs and pharmacists about the relevance of this for patients with dementia

iv) What strategies can you suggest to ensure that the interests of special needs groups are met in the early stages of the dementia pathway? (Special needs groups include Indigenous people, people of cultural and linguistic diversity, homeless people, people with Down syndrome, and people with younger onset dementia).

- Ensure an appropriate GP is identified for these patients.
- Explore the incidence of dementia in different community groups to identify particular community needs.
- Where relevant, provide extra resources/supports to residential care settings
- Increase support for carers very early in the process
- Provide early diversional therapy/other interventions where these are known to be effective.
- Ensure information about dementia and available supports and services is available in community languages for workers, patients and families from CALD community groups
- Ensure that workers with people from CALD community groups have cultural awareness training to alert them to special needs of patients with dementia from those communities (ie: patients may wish to have things done according to cultural traditions).

v) For your organisation or sector to address the issues raised, what:
- do you currently do?
- could you do?

In view of GPDV's statewide role, it is recommended that

- GPDV regularly receives information from DHS on dementia services and projects;
- is represented on relevant State and joint State/Commonwealth co-ordinating committees; and
- is funded to co-ordinate statewide division activities and training in dementia care through general practice.

Question C – Middle stages on the dementia pathway

i) What comments do you have on the possible strategies in this consultation paper for the middle stages of the dementia pathway, and how to implement them? (See pages 27 – 31).

It is suggested that the recommendation on page 28 *(See extract at end of this document)* includes identifying which provider is responsible for ensuring families undertake forward planning when a family member has been diagnosed with dementia. We recommend that where the provider is not the GP that appropriate information is provided to the GP with the patient's permission.

Little is known and documented about services provided by GPs to residents of SRSs. It is our general observation that care of patients in SRSs is particularly problematic for GPs as the care and quality of services provided by SRSs vary. We also understand that there is little knowledge amongst GPs about the regulations that exist in regard to SRSs.

In 2002 the Victorian Joint State & Commonwealth Advisory Committee on General Practice (VACGP) established a sub-committee to look at the GP/Residential Aged Care interface. The report produced by the committee has provided a comprehensive overview of the issues for GPs and Aged Care Homes in relation to the care provided to residents. SRSs were not included in this study and warrant similar investigation.

It is also problematic that incentives and opportunities available for the role of GPs in Commonwealth-funded Residential Aged Care facilities (RACFs) are not available in SRSs. This distinction has caused some confusion and disadvantages residents of SRSs. For example, since July 1st 2004, a Comprehensive Medical Assessment item, rebatable under Medicare, has become available in RACFs. This service is available to all new and existing residents of aged care homes regardless of age. However, residents of SRSs are not entitled to access this service from their GP. The Home Health Assessment item is available only to residents who are 75 years and over. In addition, the recent Commonwealth-funded GP Panels Initiative provides an opportunity for divisions of general practice to undertake developmental work to improve access to medical care for residents of aged care homes. The GP Panels Initiative is not available to SRSs.

GPDV recommends the provision of funding for training for staff of SRSs in the care of people with dementia, and opportunities for developmental work by divisions in scoping and improving the GP/SRS interface mirroring the GP Panels Initiative in Commonwealth-funded aged care homes.

It is further recommended that SRSs:

- have performance indicators for care of patients with dementia at all stages of the pathway;
- receive incentives to ensure co-ordination of care for patients with dementia
- are evaluated; and that
- information about SRSs is distributed to GPs.

ii) What other strategies could be added for the middle stages of the dementia pathway?

In view of the important role of carers of people with dementia, and the risk of neglecting their own emotional and physical needs, it is emphasised that:

- support services including carer supports are promoted to carers through many avenues, including the GP;
- a new MBS item number to enable GPs to 'case conference' with carers or family members without the need for a second health professional is strongly considered;
- packages of in-home community support need to be developed and made accessible to patients and carers.

iii) What examples of good practice can you identify in the middle stages of the dementia pathway?

The GP role in the middle stages of the dementia pathway would be greatly enhanced by increased support for GPs to provide care coordination and home based consultations. This might be achieved through incentives for home visits for patients with dementia, as well as modifications to EPC items to facilitate increased care planning for this group.

iv) What strategies can you suggest to ensure that the interests of special needs groups are met in the middle stages of the dementia pathway? (Special needs groups include Indigenous people, people of cultural and linguistic diversity, homeless people, people with Down syndrome, and people with younger onset dementia).

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v) For your organisation or sector to address the issues raised, what:
- do you currently do?
- could you do?

Question D – Late stages on the dementia pathway

i) What comments do you have on the possible strategies in this consultation paper for the late stages of the dementia pathway, and how to implement them? (See pages 31 - 35).

GPDV particularly supports points 12 and 13 on page 34. *(See end of this document)*

It is suggested that divisions be encouraged to develop systems for GPs to support families to access respite by arranging temporary GP care for patients when care is provided by an Aged Care Home out of the usual family GP's area.

Overall, it is suggested that this section of the document clarify the transitions of care for the patient with dementia in the later stages of the dementia pathway, and which health providers are responsible for coordinating care at these points.

ii) What other strategies could be added for the late stages of the dementia pathway?

It is suggested that DHS support/monitor the uptake of Comprehensive Medical Assessments (MBS) for residents of RACFs by GPs as a key means of addressing other health issues.

iii) What examples of good practice can you identify in the late stages of the dementia pathway?

iv) What strategies can you suggest to ensure that the interests of special needs groups are met in the late stages of the dementia pathway? (Special needs groups include Indigenous people, people of cultural and linguistic diversity, homeless people, people with Down syndrome, and people with younger onset dementia).

- adequate access to medical care
- supported accommodation in an environment appropriate to their capabilities with good access to family and community supports.

v) For your organisation or sector to address the issues raised, what:
- do you currently do?
- could you do?

GPDV will consult with our Aged Care Panels Reference Group to identify further strategies to support GP care of patients with dementia.

Question E - Other comments

Extracts from the Draft Framework referred to GPDV's response paper.

From p.24

10 Promote and where appropriate enhance GP services, for example:

a) Facilitate appropriate training and support to GPs in: early identification of possible memory and thinking issues/ cognitive impairment, and more developed cases of dementia; making appropriate referrals; and facilitating appropriate early planning and support for people with dementia and their families and carers. There may be opportunities for CDAMS to train GPs in screening for dementia, or in some cases distribution of CDAMS clinical diagnosis workloads to diagnose dementia. Seek to further engage the Commonwealth Government in assisting GPs with diagnosis, management and care of people with dementia

b) Out-post community practitioners, for example AAV counsellors, Royal District Nursing Service (RDNS) staff, ACAS workers, or other community care workers with expertise in dementia, to support GPs in their work with people with dementia. Facilitate the use of Practice Nurses in GPs, or a case manager in GPs – for example the Hospital Admission Risk Program (HARP) model, which boosts community capacity to keep people out of hospital, Enhanced Primary Care (EPC) and pharmaceutical reviews. Existing models utilising practice nurses could be extended to other disciplines with expertise in dementia, to provide holistic care through general practices.

From p.26 Respite and residential accommodation

20. Assist service providers to provide early responsive respite that meets needs, for example providing low key responsive respite early, rather than in crisis situations alone, and providing where appropriate culture and language specific respite.

21. Promote appropriate policy and practice in Supported Residential Services (SRSs) for residents with a diagnosis of dementia and their families, and other health care providers. Seek opportunities to provide support to SRS operators, for example through the provision of training opportunities, advice and written resources.

22. Continue approaches to the Commonwealth Government regarding subsidy rates and low admission rates of people with dementia who are recommended for residential care. Seek opportunities to provide support to residential care facilities, for example through the provision of training opportunities, advice and written resources, to encourage a better understanding of caring for people with dementia.

From p.28:

Forward planning

1. As appropriate, support the work of the Public Advocate to increase awareness in the community about the benefits of planning for the future, taking out powers of attorney, and organising advanced care directives.

From p.34:

Respite and residential accommodation

12. Continue to seek change in negotiations with the Commonwealth Government on systemic issues that form barriers to flexible respite in the residential care system.

13. Promote appropriate policy and practice in Supported Residential Services (SRSs) for residents with a diagnosis of dementia and their families, and other health care providers. Seek opportunities to provide support to SRS operators, for example through the provision of training opportunities,

advice and written resources. Facilitate transfer to more appropriate, specialised, supported accommodation.