Dementia Care
QUALITY IMPROVEMENT PROGRAM

Enhancing **dementia care** in primary care

phn NORTHERN SYDNEY
An Australian Government Initiative

SYDNEY NORTH Health Network

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A note about the cover image: The forget-me-not is a small blue flower that represents remembrance and has long been associated with dementia.

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INTRODUCTION

Welcome

Sydney North Health Network (SNHN) is delighted that your practice has decided to participate in the Dementia Quality Improvement Program (DQIP).

The aim of the DQIP is to encourage and support general practices within the Sydney North region to improve practice processes, resulting in better health outcomes for patients and provide sustainable quality improvement for General Practice.

This will be achieved by reviewing current clinical coding, incorporating cognitive testing, reviewing ongoing dementia management processes and prevention strategies within your practice setting. Suggested indicators and quality improvement ideas are detailed later in this guide.

The program will provide support to you and your team to analyse current dementia care management and develop individualised plans to deliver improvements in the quality of services you provide to your patients with dementia and other health care needs.

Training and support will be provided alongside this guide. The ideas included in this handbook are those that we currently know will have the greatest impact on achieving improvements. We acknowledge, however, that you may have practical approaches and examples that can improve on these ideas, and we welcome and hope you will share your experiences.

We hope you find this handbook to be a practical resource in supporting the work of you and your team, and we look forward to your contribution to future editions of this work.

The Primary Care Advancement team at SNHN welcomes your practice to the Dementia Quality Improvement Program.

The role of the GP and the general practice team

Dementia is the ninth National Health Priority Area due to the increased burden of disease and the rising prevalence of dementia in Australia, but diagnosing dementia can be difficult because of its insidious nature.

In the absence of a cure there is increasing focus on risk reduction, timely diagnosis, early intervention and ongoing management.

Dementia has a profound life-changing impact – not only on the person with dementia, but their carers, family members and friends.

The Department of Health National Framework for Action on Dementia 2015-2019 states:
"A person's main healthcare provider, their General Practitioner has an important role in recognising, assessing, diagnosing and providing support".

Australian Institute of Health and Welfare (AIHW) data indicates people with dementia living in the community had twice as many GP consultations (average of 14 per year) than those without dementia (average of 7 per year).*

Early intervention can reduce the impact of dementia and improve quality of life. This program aims to build capacity within general practice to enhance timely assessment, diagnosis and management.

**AIHW Dementia in Australia web report, updated 2023*

Getting started

It is useful to have a clear idea of your practice demographics, especially older people, and also the number of patients currently coded with a diagnosis of dementia or Mild Cognitive Impairment (MCI).

This can often be lower than anticipated, and there are many reasons for this, including:

- stigma of dementia which can make this a difficult topic to discuss, for patient and GP
- delay in presentation by patients (it takes approximately 3 years from symptoms to present to GP)
- lack of regular cognitive testing, e.g. in health assessment to pick up mild changes.

An analysis of current practice processes for assessing, recording, managing and supporting patients with mild impairment through to dementia can provide insights and quality improvement ideas.

DEMENTIA QUALITY IMPROVEMENT

The "Thinking" Part

THREE FUNDAMENTAL QUESTIONS WHEN UNDERTAKING QUALITY IMPROVEMENT

QUESTION 1
WHAT ARE WE TRYING TO ACCOMPLISH?

By answering this question you will develop your goal

QUESTION 2
HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?

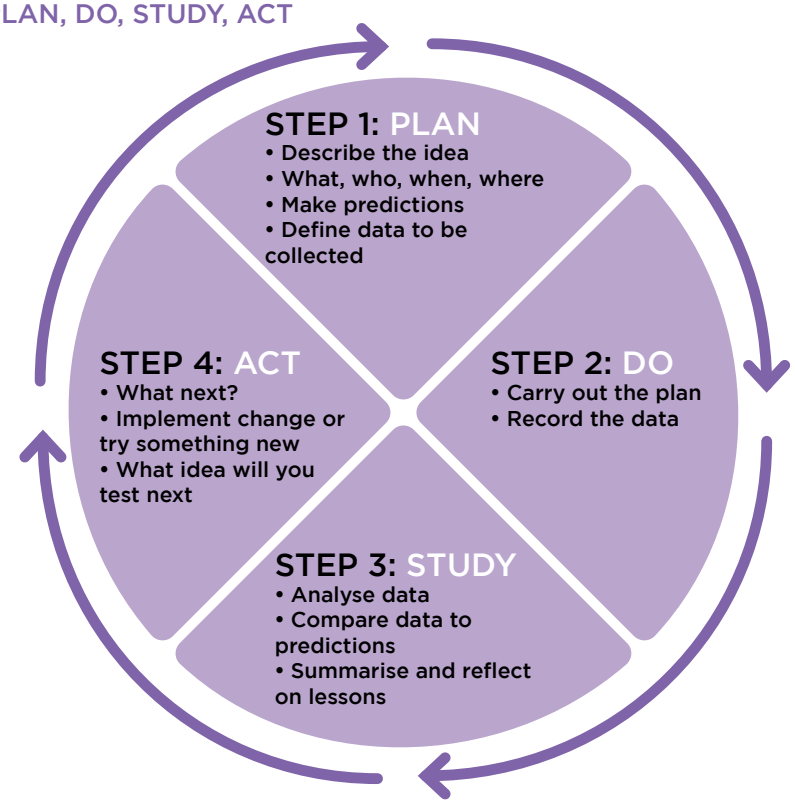
By answering this question you will develop measures for tracking your goal

QUESTION 3
WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN IMPROVEMENT?

By answering this question you will develop ideas for change

The "Doing" Part

PLAN, DO, STUDY, ACT



You will find through PDSA cycles that some changes lead to improvements. If so, these improvements can be implemented on a wider scale. You may also find that some improvement ideas are not successful. Analyse why they didn't work and learn from this. By carrying out small tests in PDSA cycles, you have avoided implementing unsuccessful change on a wider scale.

SUGGESTED INDICATORS

- Establish a Dementia Register (patients with a diagnosis of dementia, including all subtypes)
- Review 75+ Health Assessments (and include cognitive testing)
- Reducing cardiovascular disease risk (as a form of dementia prevention)
- MyHealth record currency (health summary uploaded)
- Carer identified (person most responsible and support provided, with contact details recorded)
- Domiciliary Medication Management Review (including anticholinergic load and use of anti-psychotic medication, and assessment of the person's ability to take medication – consider Webster pack)
- High risk of dementia (identify patients and consider diabetes, cardiovascular disease, age, diagnosis of mild cognitive impairment)

HELPFUL TIPS

- No PDSA cycle is too small; keep it simple.
- You may complete a series of PDSA cycles to achieve your goal. Results will be achieved through building on previous cycles.
- Set aside protected time to complete the agreed upon tasks.
- Document your PDSA cycles and present findings at team meetings.
- Improvement is a team effort.
- Other examples can be found via the Primary Sense reports.

QI IDEAS

The PDSA cycles are used to test an idea which may need refining as your team uncovers quality improvement methods. Further examples of PDSA cycles:

- Establish a consistent diagnosis coding for dementia, to be used by all GPs.
- Utilise free text or a medication search to check and convert to coded diagnosis if appropriate. The following medications are available on PBS for confirmed diagnosis of dementia – onezepil, Rivastigmine, Galantamine, Memantine.
- Review cognitive function test options and incorporate in all health assessments, or for those who have indicators of memory problems (see resources for test options).
- Increase GPMPs and TCA for patients on dementia register (dementia is a chronic disease).
- Ensure recalls and reminders are added to review GPMP and TCA for people with dementia.
- Consider DMMR for all patients on the dementia register taking 5 or more medications. This should include a request to identify anticholinergic medications for people with dementia.
- Improve vaccination rates for people with dementia (influenza and COVID). They may forget to book for these.
- Review information sheets/handouts and other support options for patients newly diagnosed or in early stages. Provide Dementia Australia referral pads, hotline phone number and resources.
- Review social and support needs for patients with dementia eg support groups, dementia cafes, social clubs. Consider creating a directory for your local area.
- Consider patients with lower health literacy or language barriers and make available specific, clear information in relevant languages and access to Translating & Interpreting Services (131 450).
- Check that carer/support person is identified in patient record, for those with a diagnosis of dementia, with contact phone number.
- Identify and screen patients identified as high risk for dementia – e.g. patients with high risk of CVD; those with diabetes, high cholesterol and BP; smokers; people with depression.
- Review (and introduce) BrainTrack app to patients with high risk of dementia or older patients. The app helps patients and GP to monitor changes in cognition over time.
- Take steps to promote a dementia-friendly practice – encourage staff to become a Dementia Friend, review waiting area and signage, advertise local dementia cafes and other support networks.
- Agree on a time frame to archive patients, 2-3 years.

Example 1

THINKING PART

Your general practice decides to focus on creating a dementia register

What are we trying to accomplish?	To create a register of patients with known dementia and those newly diagnosed, and use the register to review management
How will we know that a change is an improvement?	We will measure through Clinical Software such as BP/MD: • The number of patients with a coded diagnosis of dementia and cognitive impairment • Use free text search in software and convert to coded diagnosis • Review patients identified through searches • Review recall and reminder process in practice
What changes can we make that will result in improvement?	• Use free text search in software and convert to coded diagnosis • Review patients identified through clinical software searches • Review recall and reminder process in practice

DOING PART

Review patients identified through clinical software searches

Plan	What: Use clinical software such as BP/MD to extract data Who: Practice Manager When: Wednesday 3 November 2023 Where: General Practice Data to be collected: Extract or record the number of patients with coded diagnoses of dementia and cognitive impairment Prediction: Expect 5% of population to have a diagnosis of dementia
Do	Practice Manager extracted data as planned using clinical software to ensure correct data was extracted.
Study	Percentage of patients with dementia was significantly lower than expected.
Act	Data presented to practice team to discuss how to identify people with dementia.

Example 2

THINKING PART

Improve 75+ Health Assessment uptake rates

What are we trying to accomplish?	To improve number of 75+ patients who have a Health Assessment, and to identify those with any cognitive impairment.
How will we know that a change is an improvement?	We will measure through Primary Sense and clinical software: • the number of health assessments conducted each quarter (Health Assessment Report in Primary Sense) • the number of cognitive impairment diagnoses (BP/MD search)
What changes can we make that will result in improvement?	• Identify eligible patients and invite for health assessment • Follow up with phone call reminder

DOING PART

Identify eligible patients and invite for health assessment

Plan	Use Primary Sense to extract data and send invitation for health assessment by text and phone
Do	Practice Manager extracted data as planned. Invitations sent to this cohort.
Study	Percentage of patients eligible for health assessment was higher than predicted (15%). Number of health assessments booked is 5%.
Act	• Continue the process and incorporate follow up reminders • Encourage GPs to promote health assessment to appropriate patients

GENERAL PRACTICE QUALITY IMPROVEMENT READINESS

General Practice Quality Improvement Readiness Tool

EXAMPLES/IDEAS

Area: General Practice Systems	Yes/No	Action/Comment (what, when and who)
1. Have you inactivated your inactive patients as per RACGP guidelines – 3 visits in 2 years?		
2. Does your practice request consent for de-identified patient information to be used for research purposes?		
3. Does the new patient form ask if the person identifies as Aboriginal or Torres Strait Islander?		
4. Regular data cleansing activities are undertaken to establish up to date lists (registers) of patients eligible for screening.		
5. Practice software is utilised for actions/ prompts for the GP/Nurse to ask about routine screening, immunisation status or chronic illness.		
6. There are policies and procedures in place that include reminders and recalls.		
7. The practice sends targeted reminders to patients (e.g. letters, SMS, email or phone calls).		
8. Have you developed a work-flow to manage and monitor CDM and recalling patients for review?		
9. Does your practice have a formalised team approach to quality improvement?		
10. Clinicians access HealthPathways.		
Areas for Action (Here you can use the PDSA template)		
1.		
2.		
3.		

Change ideas to consider

The following ideas are suggestions only, with the concept adaptable across all areas of quality improvement.

IDEA:

Encourage person centred care by encouraging patients to discuss screening with their GP.

- Display Health Assessment promotional material in the waiting room.
- Have the reception team mention the Health Assessment to eligible patients.
- Incorporate cognitive testing, frailty screen and depression test in 75+ Health Assessment.

IDEA:

Engaging the General Practice Team - Develop and maintain an effective recall and reminder system: staff education.

There is often a lot of work that needs to be done to improve how practices use software to maintain effective recall and reminder systems. Staff education is the first step towards improvement. Ask the PHN for information on how to improve your recall and reminder systems.

IDEA:

Appoint a staff member who is responsible for creating and maintaining Chronic Disease registers, and add this role to their job description.

Providing professional development opportunities to this staff member will assist with rewarding and recognising this person's contribution to the team.

IDEA:

Have a team meeting to brainstorm how recall and reminder systems could improve income generation and patient care (e.g. by linking multiple recalls such as Cancer screening recall, Immunisations, GP Management Plans, Health Assessments, etc together).

IDEA:

Work towards becoming a Dementia Friendly Practice.

Encourage staff to undertake a short training to Become a Dementia Friend. Create a directory of local social and support services, including dementia cafes, local groups and day centres, and respite care.

IDEA:

Send reminder letter to eligible patients for review of GPMP or TCA.

Following the establishment of your dementia patient register, identify patients due for GPMP/TCA and invite them to see the GP. Schedule regular reviews for these patients. Consider a medication review if appropriate.

Measuring success

Choosing an activity/idea to explore will have its own measure of success. It is important to identify in each activity what you are wanting to change and how you will know WHEN the change has occurred. This is identified in Question 2.

Applying a SMART (Specific, Measurable, Achievable, Realistic and Time-framed) goal-setting process will assist you.

S **Specific:** Goals that are too vague and general are hard to achieve, for example 'be a better parent'. Goals that work include specifics such as 'who, where, when, why and what'.

M **Measurable:** Ideally goals should include a quantity of 'how much' or 'how many' for example drinking 2 litres of water per day. This makes it easy to know when you have reached the goal.

A **Achievable:** Goals should be challenging, but achievable. Goals work best when they are neither too easy or too difficult. In many cases setting harder goals can lead to better outcomes, but only as long as the person has the ability to achieve it. Setting goals which are too difficult can be discouraging and lead to giving up altogether.

R **Relevant:** The goal should seem important and beneficial to the person who is assigned the goal.

T **Time-framed:** 'You don't need more time, you just need a deadline'. Deadlines can motivate efforts and prioritise the task above other distractions.

Reflecting on the Health Assessment Screening Activity identified earlier, where you have undertaken a data analysis utilising Primary Sense. This has shown the percentage of active patients that have had a 75+ Health Assessment in the last 12 months. The report can also provide data on the number of health assessments completed each quarter. This forms your baseline measure.

The next step is to decide on an activity and set a goal. For the example above, you may like to set a goal to increase health assessments by 5% each quarter. When this has been implemented, within a set time frame, you can then repeat the data analysis to see if the goal has been achieved.

INFORMATION AND EDUCATION

Sydney North Health Network

Health Pathways Cognitive Impairment and Dementia

Memory Problems Booklet Information for people with Dementia and their carers

A Care Guide for General Practice

Forwardwithdementia.au

- Answers after diagnosis: For healthcare professionals, carers, people with dementia
- Cognitive Decline Partnership Centre
- Clinical Guidelines for Dementia
- Care Guide for General Practice
- Consumer Companion Guide

BrainTrack App

Dementia QI PDSA Template (Excel Spreadsheet)

University of Tasmania Wicking Dementia Research and Education Centre

Dementia Training Australia

Dementia In Practice Podcast Series

Become a Dementia Friend

SUPPORT AND SERVICES

National Dementia Helpline Free 24 hour telephone service providing information and advice to people with dementia and their friends and family and health and aged care workers. They can also connect to Dementia Australia and community support services and program and discuss government support, including My Aged Care, NDIS, Carer Gateway and DBMAS.

Phone 1800 100500. Webchat: dementia.org.au/helpline/webchat. Mon – Fri 8am-8pm.
Use the referral form for all Dementia Australia services including:

- Post diagnostic support program 6 sessions over 12 months to enhance understanding, plan support, and plan and prepare for changes
- Individual and family-based Counselling support face to face, on the phone, or via videoconferencing

Living with Dementia group program Interactive program provides an overview of dementia and how to proceed after a diagnosis. It covers coping with change, relationships and communication, planning for the future and staying healthy.

- Online Referral form. NSW Referrals: NSW.Referrals@dementia.org.au

Dementia Behaviour Management Advisory Service (DBMAS) 24 hour over the phone advice when there are complex behaviours that are stressful for a Carer to manage. They can help the carer work out strategies and access appropriate medical care. Phone 1800 699 799.

Proveda Northern Sydney Dementia Advisory Service provides advice and assistance to people with dementia and their families and can link them with other people with dementia and their carers. Phone 1300 002 262.

Dementia Support Australia (DSA) Free dementia behaviour support programs for carers of people living with dementia where behaviour impacts their care, at home, in community respite settings, residential or acute care settings. Anyone can refer, providing there is a diagnosis of dementia (or suspected dementia); behaviours relate to dementia (including apathy, and depression), and that the person with dementia or their substitute decision maker consents to the referral. Other options include Specialist Dementia Care Programs and the Staying at Home program for carers and people living with dementia who are recently diagnosed with dementia. Phone 1800 699 799.

GP Advice Service - DSA – email service for GPs

My Aged Care and dementia

Social Work Service provides patients with chronic or complex health care conditions with appropriate service access to nutritional, social, and welfare support.

Hornsby, Ku-ring-gai, and Ryde: PCCS GP Social Work Connect Program: Phone 9477 8700. Referral form.

Hunters Hill, Willoughby, Lane Cove, Mosman, North Sydney, Northern Beaches: CCNB Health at Home Program. Phone 1300 002 262.

Geriatrician Outreach to Primary Care This service aims to increase Geriatrician input into GP-led patient planning and care in the community while building relationships and facilitating two-way learning opportunities. It seeks to work collaboratively with GPs to manage complex patients and prevent conditions that may be at potential risk of deterioration.

Northern Sydney Carer Support Provides information, guidance and support that is practical and local to help carers find the right services for their needs. Phone 02 9462 9488.

Carers Australia Phone 1800 242 636.

Carer Gateway

THE IMPACT OF DEMENTIA IN AUSTRALIA

Dementia is the second leading cause of death in Australia.[1]

It is the leading cause of death of Australian women, surpassing heart disease. Females account for 64.5% of all dementia-related deaths.

It is the single greatest cause of disability in older Australians (65 years and older)

In 2024, it is estimated that more than 421,000 Australians live with dementia. Without a medical breakthrough, the number of people with dementia is expected to increase to more than 812,500 by 2054.

It is estimated that more than 1.6 million people in Australia are involved in the care of someone living with dementia.[2]

People with dementia account for 52% of all residents in aged care facilities.[2]

In Northern Sydney, 58.2% of people using permanent residential care (on 30th June 2022) had a diagnosis of dementia (https://www.gen-agedcaredata.gov.au/My-aged-care-region).

In 2024, it is estimated there are almost 29,000 people living with younger onset dementia, expected to rise to almost 41,000 people by 2054. This can include people in their 30s, 40s and 50s.[1]

2 in 3 people with dementia are thought to be living in the community.[1]

From 2024-2054 it is estimated that there will be an increase of at least 75% in the number of people living with all forms of dementia in the Northern Sydney region.

Here's a summary by LGA:

LGA	*Increase in prevalence*
Hornsby	84%
Hunters Hill	91%
Ku-ring-gai	86%
Lane Cove	81%
Mosman	83%
North Sydney	76%
Northern Beaches	83%
Ryde	85%
Willoughby	84%

[1] Australian Institute of Health and Welfare (2022) Dementia in Australia, AIHW, Australian Government, accessed 20 January 2023.

[2] Dementia Australia (2024) Dementia Facts and Figures, accessed 3rd June 2024. https://www.dementia.org.au/about-dementia/dementia-facts-and-figures