

General Practice Dementia Projects

funded under the
NSW Action Plan
on Dementia
1996-2001

Summary Report
September 2003

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Foreword

In 2001, around 55,000 people were living with dementia in NSW and this number is expected to increase to approximately 91,000 by 2020. It is crucial that key health professionals such as General Practitioners (GPs) are able to respond appropriately to the needs of people with dementia.

GPs are often the first point of contact for people with memory loss or for family members concerned on another person's behalf. GPs can play a central role in diagnosis and ongoing management of people with dementia, frequently providing care and support throughout the course of the disease. However, there is considerable variation in GPs' access to appropriate information to assist them in this role, their skills in diagnosis, assessment and management, their involvement of carers and attention to their needs, and their linkages with Aged Care Assessment Teams (ACATs) and other key services.

Under two successive NSW dementia strategies, NSW Health has funded a range of initiatives to assist GPs in providing good primary health care to people with dementia and in collaboration with families and carers and in partnership with other health, aged and community support services.

In developing these initiatives, we have been guided by the GP Dementia Working Group - a committed expert working group comprising GPs, specialist clinicians and researchers with expertise in dementia, consumer/carer representatives and government policy-makers. This working group is chaired by Professor Dimity Pond, Discipline of General Practice, School of Medical Practice and Population Health, University of Newcastle.

Six projects specifically targeting GPs were funded under the *NSW Action Plan on Dementia 1996-2001*. These projects are outlined in this summary document. They have produced a number of useful resources for GPs and have facilitated improved care for patients with dementia. They are also instructive for further planning and service development around the management of people with dementia in the general practice setting.

This document is intended for government policy-makers, Area Health Service planners and Divisions of General Practice. It aims to:

- disseminate information about the purpose, elements and outcomes of the GP-related projects funded under the NSW Action Plan on Dementia 1996-2001
- foster partnerships and shared care approaches to the management of people with dementia and their carers
- inform planning, service development and decision-making regarding strategies to involve and support GPs in dementia care.

This publication is one of a number of strategies being pursued by NSW Health in partnership with the Department of Ageing, Disability and Home Care under the current NSW dementia strategy – *Future Directions for Dementia Care and Support in NSW 2001-2006*.



Robyn Kruk
Director-General
NSW Health

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Executive summary

This report highlights the methods and findings of six dementia projects funded by NSW Health under the *NSW Action Plan on Dementia 1996-2001*. The projects targeted various aspects of dementia care and management by General Practitioners (GPs) in community and residential aged care settings. Key components of the projects include the development of shared care processes between GPs and other key service providers, the development of evidence-based resources on dementia assessment and management for GPs, and the implementation of education sessions to increase the knowledge, skill and confidence of GPs in caring for patients with dementia.

The project evaluations focussed on process assessment and self-reporting by GPs on the impact of the initiative on their overall management of the care and support needs of patients with dementia. Some key findings were as follows:

- Shared care meetings were found to improve communication between service providers and carers, and were considered to improve the management of people with dementia by the majority of GPs. However, the processes surrounding shared care need to be clearly defined and to take into account traditional work practices and the expectations of all practitioners regarding the partnership.
- The introduction of assessment tools with concurrent educational activities resulted in reported increases in knowledge, skills and confidence in assessment tool use, overall dementia management and a stated willingness by GPs to use the tools in the future.
- GPs and Aged Care Assessment Teams (ACATs) were found to have a preference for verbal communication/discussions compared to written (faxed) communication. Preferences were found to depend upon individual clinicians' expectations concerning the purpose of the shared care arrangement.
- Educational activities were shown to perform a critical role in promoting the uptake of evidence-based practices.

Two key resources for GPs have been produced as a result of these projects:

- An NESB dementia assessment tool (the Rowland Universal Dementia Assessment Scale or RUDAS) which has been shown to be a valid, reliable and user-friendly tool for use by GPs in assessing cognitive impairment in elderly people from culturally and linguistically diverse backgrounds.
- *Guidelines for the Care of Patients with Dementia in General Practice* which are based on the consensus of clinicians and are endorsed by the Royal Australian College of General Practitioners.

The dementia pilot projects raise a number of issues for future service planning and delivery. Further service development and longer-term evaluations focussing on the integration of shared care processes into the routine practices of GPs and other clinicians are required. Promotion of appropriate assessment tools with concurrent dementia education activities appears to be an effective way of upskilling GPs in dementia assessment and management. However, further work is required to better understand how to effectively promote evidence-based practice amongst GPs. This work would contribute to further improvements in dementia care and management and the satisfaction and commitment of service providers.

I. Rationale and scope

This document provides a qualitative analysis of the key elements, methods and outcomes of the six general practice dementia projects funded by NSW Health as part of the *NSW Action Plan on Dementia 1996-2001*.

The purpose of the document is to provide practical information to government policy makers, area health service planners and Divisions of General Practice for future planning and service development in the area of dementia care and management.

The information presented here has been extracted from the final reports of the individual projects and has been reviewed by the original project managers. It should be remembered that most of these initiatives were not designed or implemented as research projects, but were intended to improve service delivery in the area of dementia care. While this report reviews and compares the projects it has not sought to critically appraise their methods or the outcomes they achieved.

The six pilot projects were :

1. NESB Dementia Assessment Model Project (South Western Sydney Area Health Service)
2. General Practice Dementia Management Guidelines Project (Royal Australian College of General Practitioners [RACGP] NSW Projects, Research and Development Unit)
3. GP Dementia Skills Enhancement Project (Alzheimer's Association NSW)
4. GP-Aged Care Facility: Shared Care Project (St Vincent's Mental Health Service and Presbyterian Village)
5. Integrated Dementia Care Model Project (Wagga Wagga Division of General Practice [WWDGP] and Greater Murray Area Health Service [GMAHS])
6. Integrated Primary Dementia Care Model Project (Western Sydney Area Health Service [WSAHS] and Western Sydney Division of General Practice [WSDGP])

2. Dementia projects in summary

NESB Dementia Assessment Model Project¹

Project methods

The project team collaborated with health professionals and people from diverse cultural and linguistic backgrounds to develop and pilot items. The items that were the best predictors of cognitive status were operationalised into a multicultural mini-mental state examination named RUDAS (Rowland Universal Dementia Assessment Scale). The RUDAS was validated with a sample of elderly people from diverse cultural and linguistic backgrounds living in the community and trialed with the Liverpool/Fairfield ACAT and GPs.

Findings

RUDAS is acceptable to patients and practitioners and is a better method for detecting cognitive impairment in elderly people from culturally and linguistically diverse backgrounds. Many GPs indicated they would be likely to use RUDAS in their practice.¹

Implications

RUDAS provides GPs with a valid, reliable, user-friendly tool to assist them in assessing patients with dementia from culturally and linguistically diverse backgrounds in a community setting

General Practice Dementia Management Guidelines Project²

Project methods

The project team developed guidelines for GPs for managing patients with dementia in the community. They were based on existing guidelines, and were modified in the light of a literature search and input from a multidisciplinary advisory committee and GP focus groups. The Guidelines were then field tested by GPs to examine their relevance and their benefits for GPs and their patients.

Findings

GPs rated the Guidelines overall as ‘very helpful’ for at least one aspect of care for 50% of patients. Twelve aspects of the Guidelines were individually rated. The guidelines were rated by more than one GP as being helpful in: highlighting the importance of family involvement; highlighting cultural issues; managing a patient with a disinterested family; detecting co-morbid depression; understanding benefits of a geriatric team referral, and difficulties of failure of insight or denial by carers.²

In most cases, GPs were not aware of how the family or carer of most of their patients was coping and there was room for improvement in detecting the presence and extent of depression in families or carers.

Implications

GPs may find the Guidelines helpful in various aspects of their diagnosis, assessment and management of patients with dementia.

1. Research findings to be published in *International Psychogeriatrics*, March 2004.

2. Research findings published in *Australian Family Physician*, 32 (4), 283-5, April 2003.

2. Dementia projects in summary

GP Dementia Skills Enhancement Project³

Project methods

This project provided an education and skills enhancement session based on the concept of a 'Dementia Tool Kit' to help GPs better manage patients with dementia and support and resource their carers. Nine Dementia Tool Kit courses were conducted in rural and metropolitan NSW, in conjunction with Divisions of General Practice, and presented by a multidisciplinary team including a geriatrician and psychogeriatrician. Sessions were flexible in length based on the needs of the local Division. Content was consistent but depth and skills development were related to available time. Pre and post course evaluation was undertaken.

Findings

Following the Dementia Tool Kit courses, GPs reported a general increase in knowledge concerning diagnosis and assessment of patients with dementia, as well as a greater use of formal dementia screening tools (Mini-Mental State Examination [MMSE] and Geriatric Depression Scale [GDS]) and increased confidence in the support/care of dementia patients and their families/carers. In addition, all GPs could identify appropriate management strategies and service supports. There was an increase in the number of GPs reporting use of the MMSE.

Implications

A tailored education program can enhance dementia care practice amongst GPs, including knowledge of service supports, familiarity with and use of assessment tools such as the MMSE.

GP-Aged Care Facility Shared Dementia Care Project⁴

Project methods

This project undertook a profile analysis of a hostel facility to review communication processes, medication usage patterns, personal interests of the residents and the milieu of the facility. At the same time, the project developed a 'Model of Care Manual' (key elements and guidelines) and implemented a series of workshops for GPs concerned with trends in psychopharmacology, differentiation of early dementia and depression and behavioural management of residents. Pre and post evaluation was implemented.

Findings

Overall, the evaluation found a significant increase in GPs' knowledge, confidence and skill in the assessment of depression/dementia, managing difficult behaviour, reviewing psychotropic medication and mobilising services outside the facility. In addition, GPs and facility staff were more aware of the milieu of the facility and adopted a more holistic approach to care. Staff members were significantly more knowledgeable, skilled and confident about note-taking procedures and legal issues. The majority of GPs indicated a willingness to use MMSE and GDS.

Implications

Targeted education sessions, in combination with supporting material (guidelines) and processes, can support better communication, procedures and practice by GPs and staff in dementia care and management within a residential aged care setting.

2. Dementia projects in summary

Integrated Dementia Care Model Project⁵

Project methods

This project developed a 'Protocol and Guideline Package' for GPs, ACATs and other service providers to utilise in conducting shared care meetings. The package contained four generic forms related to the Enhanced Primary Care MBS Items for Health Assessment, Case Conferencing and Care Planning (referral, consent, individual management plan & feedback). After a patient had been referred to the project by an ACAT clinician, the project officer would fax forms to all the relevant service providers and schedule (three to four weeks in advance) a shared-care meeting at the participating GP's practice. At the conclusion of the meeting, a copy of the documentation was placed in the patient's notes and distributed to the case conference participants. Education sessions were held for participating GPs. These focused on the use of screening tools, dementia/depression diagnosis and management in the elderly.

Findings

Overall, communication improved between GPs and ACAT clinicians, GPs and other service providers, and GPs and patients/carers. All participants agreed that the management of people with dementia had been improved by shared-care.

Implications

Shared-care processes can improve the care of people with dementia and communication between service providers and patient/carers.

Integrated Primary Dementia Care Model Project⁶

Project methods

This project developed a computerised care plan to coordinate care between GPs and ACAT clinicians. Once a patient had been referred to the project by an ACAT clinician, the ACAT/other service providers completed the care plan and faxed it to the patient's GP for additions and further comments. The GP then returned the altered/signed care plan to ACAT. During the course of the project the process was modified to remove the 'GP fax back' component. Participating GPs also received additional information to support their dementia care, including published evidence-based guidelines for the primary care management of dementia and information on the MMSE and Dementia with Lewy Bodies (DLB). Two separate types of education sessions were conducted. GPs were offered individual education sessions at their practice to support the use of the guidelines, and a Dementia Interest Group offered general dementia education sessions.

Findings

The majority of GPs and ACAT clinicians reported being satisfied with the use of a fax as a means of communication and the care plan as a good or excellent aid to communication. However both GPs and ACAT clinicians reported that the project made little difference to GP involvement in the patient's care plan. 60% of GPs reported referring to the guidelines for an actual patient. There was a high ACAT default rate with the fax process.

Implications

Although participants were satisfied with the fax process and care plan as a means of communication, these do not necessarily flow into increased GP involvement in dementia management, and may not be easily integrated into routine practices of ACAT clinicians.

3. Project approaches – Integrated Care Models and Good Practice Models of Dementia Care

The dementia projects can be grouped into two distinct categories: those concerned with integrating care between different providers and those concerned with achieving better practice models of care by enhancing the skills of GPs and other service providers.

Integrated Care Models

Two of the projects focussed on the development of an integrated care model:

- The Integrated Dementia Care Model Project (WWDGP and GMAHS).
- The Integrated Primary Dementia Care Model Project (WSAHS and WSDGP).

Table 1. Comparison of goals, aims and desired outcomes of the integrated care model projects

	Integrated Dementia Care Model Project	Integrated Primary Dementia Care Model Project
Goal	Optimise the quality of life of people with dementia and their carers in the GMAHS.	Optimise the quality of life of patients with dementia and their carers in the WSAHS.
Aims	<ul style="list-style-type: none"> ● Increase the knowledge and expertise of GPs in detection, assessment & care of people with dementia. ● By utilising existing services, increase GPs' participation and role in the management of patients with dementia. ● Develop effective communication networks. 	<ul style="list-style-type: none"> ● Enhance communication between GPs, geriatricians and ACAT members. ● Enhance the role of the GP as the primary care giver and legitimate medical case manager. ● Promote management of dementia in the primary care setting that is evidence based.
Desired outcomes	<ul style="list-style-type: none"> ● Development of an integrated approach to the planning and delivery of effective services for people with dementia and their carers. ● Improvement in the diagnosis, assessment and management for people with dementia. ● GPs considered the primary care provider in dementia management. ● Increased knowledge and understanding of dementia through the provision of education programs. ● Establishment of a sustainable integrated service model working in partnership with all stakeholders. 	<ul style="list-style-type: none"> ● Client/carer satisfaction. ● Optimisation of client/carer autonomy and independence. ● Better client/carer outcomes. ● Reduction in carer stress and improved carer support. ● GP and ACAT reported satisfaction with the shared care process and outcomes. ● GP satisfaction with the guidelines. ● GP reported use of the guidelines.

3. Project approaches

Comparable project components

Both projects were community-based and had the same goal of ‘optimising the quality of life of people with dementia and their carers’. Both projects focused on enhancing communication between service providers, increasing the role of GPs in patient management and promoting evidence-based dementia management by GPs (Table 1).

The key difference between the projects lay in the focus of the integrated care process. One project utilised shared care case conferences (Integrated Dementia Care Model Project); the other utilised a computer generated care plan (Integrated Primary Dementia Care Model Project). They also differed in the way they recruited GPs and referred patients to the project, in the content and focus of education sessions and the way they were evaluated (Table 2).

Table 2. Comparison of key elements of the integrated care model projects

	Integrated Dementia Care Model Project	Integrated Primary Dementia Care Model Project
Focus of integrated care	Shared care meetings.	Computer generated care plan.
Recruitment of GPs	Visited by project officer.	ACAT.
Patient referral	ACAT and Riverina Dementia Services.	ACAT and GPs.
Content of education sessions	<ul style="list-style-type: none"> ● Use of screening tools. ● Dementia diagnosis and management. ● Depression in the elderly. 	<ul style="list-style-type: none"> ● Concurrent education to support guideline.
Evaluation focus	<p>Process</p> <ul style="list-style-type: none"> ● GP attendance at education sessions. ● GP attendance at shared-care meetings. ● No. patients involved. ● No. service providers involved. <p>Impact</p> <ul style="list-style-type: none"> ● Pre and post consumer attitude. ● Pre and post GP attitude & involvement. ● Pre and post ACAT & other services attitude and involvement. 	<p>Process</p> <ul style="list-style-type: none"> ● GP satisfaction. ● ACAT satisfaction. ● Carer/patient satisfaction. ● Audit care plan. ● No. GPs involved. ● No. GPs default care plan. ● Guideline use by GPs. ● GP satisfaction with guideline.

Aspects of dementia care influenced by the Integrated Care Models

Communication between service providers

Both projects improved communication between service providers. Shared care meetings were found to enhance communication between service providers and carers. The majority of GPs and ACAT clinicians rated the care plan as a ‘good or excellent’ aid to communication and reported being satisfied with the use of a fax as a means of cross communication. Despite being satisfied with the fax as a means of communicating, the ACAT clinicians had a high default rate associated with the fax process and this element of the integrated care was modified during the project.

Impact on dementia management

The majority of GPs, ACATs and other service providers and carers thought that shared care meetings improved the management of people with dementia. The majority of carers ‘agreed or strongly agreed’ that the patient (and themselves) had more support as a result of the ACAT assessment and care plan process.

Increasing GP involvement in dementia management

The method of developing a care plan and faxing it to the GP for inclusions or comments was not found to increase GP involvement in joint care plan formulation with the ACAT clinicians.

3. Project approaches

Evaluation of the shared care meeting process did not review impact on GP involvement in dementia management.

Promotion of evidence-based management

GPs reported varying levels of use of guideline in the Integrated Primary Dementia Care Model Project. Approximately half of the GPs reported referring to the Guidelines ‘once or twice’, 27% found the Guidelines ‘of little use’, 36% ‘somewhat useful’ and 11% ‘very useful’. They were more likely to use the guidelines when they were provided in the context of treating an actual patient enrolled in the project than in their ongoing care of existing patients.

Good practice models and skill enhancement of service providers

Four of the projects were concerned with good practice and skills enhancement for dementia care:

- General Practice Dementia Management Guidelines (RACGP)
- NESB Dementia Assessment Model Project (SWSAHS)
- GP Dementia Skills Enhancement Project (Alzheimer’s Association NSW)
- GP-Aged Care Facility Shared Care Project (St Vincent’s Hospital Mental Health Service and Presbyterian Village).

Table 3. Comparison goals, aims and desired outcomes of the best practice projects

	General Practice Dementia Management Guidelines Project	NESB Dementia Assessment Model Project	GP Dementia Skills Enhancement Project	GP – Aged Care Facility Shared Care Project
Aims	<ul style="list-style-type: none"> ● Address the neglected issue of the quality of care of patients with dementia in the community. ● Address the issue of support for family and friends of patients with dementia in the community. 	<ul style="list-style-type: none"> ● Address the identified shortcomings of current assessment tools in relation to appropriate assessment of people from Non-English Speaking Backgrounds (NESB). ● Enhance the capacity of ACATs, GPs and other primary health care professionals in administering the tool. 	<ul style="list-style-type: none"> ● Enhance GPs’ skills in dementia assessment and management. ● Improve the quality of life of individuals who have dementia. ● Ensure carers are recognised, supported and consulted throughout the course of the disorder. 	<ul style="list-style-type: none"> ● Enhance GPs’ role as case managers in dementia care. ● Evaluate the changes to the system of care within an aged care facility.
Desired outcomes	<ul style="list-style-type: none"> ● Development of guidelines for diagnosis and ongoing management of people with dementia in partnership with carers, families and relevant services. ● Conduct of a field test of the guidelines in General Practice. 	<ul style="list-style-type: none"> ● Development of a multi-cultural dementia assessment tool. ● Piloting of the tool with Aged Care Assessment Teams (ACAT) and GPs. ● Development a video-based user guide to support primary health care professionals in administering the tool. 	<ul style="list-style-type: none"> ● Increased GP understanding of dementia, differential diagnosis and latest diagnostic/assessment methods. ● GP identification of appropriate strategies for patient care. ● Recognition of the role of the family/carer in patient management by GPs. ● Increased GP knowledge on how they can effectively support people with dementia and their carers. 	<ul style="list-style-type: none"> ● Increased GP and hostel staff knowledge of medication usage and behavioural approaches to problems associated with ageing. ● Enhanced communication processes between GPs and other health care providers. ● Improvement in the milieu of the facility.

Comparable project components

Most of the projects were concerned with community-based dementia care, with only one project being conducted in a residential care setting. Common elements across the good practice projects were: a focus on the diagnosis and assessment of dementia (including use of formal tools such as the MMSE, GDS or Guidelines) and an emphasis on consultation with and support of family members or carers (Table 3).

The projects reflected varying approaches to skills enhancement, including production of management guidelines and an assessment tool (RUDAS), strategies focusing on the GP as the case manager, and the implementation of education sessions. These differences were reflected in the focus of the evaluation undertaken and the overall content of the education sessions (Table 4).

Aspects of dementia care influenced by the Best Practice Models

Impact on dementia assessment

The introduction of assessment tools with concurrent education sessions resulted in a reported increase in GP's knowledge, skills and confidence in dementia assessment, with practitioners saying they would use the tools in future practice. The RUDAS tool provides a culturally sensitive tool to assist practitioners working with patients from diverse NESB backgrounds.

Individual GPs had different views on how useful the Dementia Management Guidelines were for undertaking functional or cognitive assessment or differential diagnosis of patients with dementia. GPs found the Guidelines overall to be 'very helpful' for at least one aspect of care for 50% of patients.

Impact on dementia management

Participants reported that components of the individual projects had a beneficial impact on the management of patients with dementia, with education sessions improving GPs' knowledge and skills in understanding the benefits of early intervention, behaviour management strategies and areas of dementia support and care.

Many of the projects highlighted the role of the patient's family/carers in patient management, and increased GPs' confidence in supporting them.

Promotion of evidence-based management

All of the projects have promoted the use of evidence-based tools in dementia management. The projects have resulted in an increase in the number of GPs reporting familiarity with assessment tools such as the MMSE and RUDAS and willingness to use the tools in the future.

In general, GPs reported the Dementia Management Guidelines helpful for most patients and would be likely to refer to them for some aspects of care in the future.

3. Project approaches

Table 4. Comparison of the key elements within the best practice projects

	General Practice Dementia Management Guidelines	NESB Dementia Assessment Model	GP Dementia Skills Enhancement Project	GP-Aged Care Facility Shared Care Project
Project focus	Guideline development.	Multi-cultural Mini-Mental State Exam.	GP education sessions.	GP as case manager.
Best practice focus	<ul style="list-style-type: none"> ● Diagnosis and ongoing management. ● Use of guidelines. 	<ul style="list-style-type: none"> ● Diagnosis and assessment. ● Use of assessment tool. 	<ul style="list-style-type: none"> ● Diagnosis and assessment. ● Strategies for patient care. ● Role of family/carers. ● Support role of GP. 	<ul style="list-style-type: none"> ● Medication usage. ● Behavioural strategies. ● Communication between service providers and family/carers.
GP recruitment	Sample of GPs interested in dementia care.	GP Division.	GP Division.	Invitation to local GPs and hostel GPs.
Education sessions		<ul style="list-style-type: none"> ● Individual GP RUDAS training. ● Training video and booklet. 	<ul style="list-style-type: none"> ● Assessment methods. ● Strategies for patient care. ● Role of family/carers. ● Support role of GP. 	<ul style="list-style-type: none"> ● Depression and dementia. ● Managing difficult behaviour.
Evaluation	<p>Field Test of Guidelines. GPs were asked to rate 12 aspects of the Guidelines via a three point scale: 'Not at all helpful'; 'A bit helpful'; 'Very helpful'.</p> <p>12 aspects of the Guidelines rated were:</p> <ul style="list-style-type: none"> ● Functional assessment. ● Forming an action plan. ● Cognitive assessment. ● Differential diagnosis. ● Investigations. ● History taking. ● Telling patients/ families about dementia. ● Management of behavioural difficulties. ● Use of medications. ● Social support. ● Health promotion. ● Referral. 	<p>Pilot with the Liverpool/Fairfield ACAT and GPs. Written feedback form re:</p> <ul style="list-style-type: none"> ● GP satisfaction with RUDAS. ● GP response rate. ● Test-retest reliability data for patients. ● Calculation of RUDAS scores for GP patients. 	<p>GP self-administered survey and focus groups.</p> <p>Process:</p> <ul style="list-style-type: none"> ● GP satisfaction with education sessions. ● GP identification of most useful information in education sessions. <p>Impact</p> <ul style="list-style-type: none"> ● Pre and post GP knowledge dementia diagnosis/assessment. ● Pre and post GP confidence dementia diagnosis/assessment. ● Pre and post GP knowledge/attitude early intervention. ● Pre and post GP diagnostic/screening practices. ● Pre and post GP confidence in dementia support/ care. ● Pre and post GP knowledge of MMSE. ● Pre and post no. Of patients diagnosed by GP with dementia. ● Pre and post GP referral patterns. ● Pre and post GP identification of management strategies. 	<p>Resident assessment, GP and other staff self administered survey, resident file audit.</p> <p>Process:</p> <ul style="list-style-type: none"> ● No. residents with cognitive dysfunction. ● Resident profiles. ● Resident satisfaction with music therapy sessions. <p>Impact:</p> <ul style="list-style-type: none"> ● Pre and post Hostel Atmosphere Profile (Milieu Measure). ● Pre and post information recorded in resident file. ● Pre and post medication usage. ● Pre and post GP knowledge, confidence, skill in detecting difference between depression and dementia. ● Pre and post GP knowledge, confidence, skill in managing difficult behaviour. ● Pre and post hostel staff knowledge, confidence, skill in resident file documentation. ● Pre and post hostel staff knowledge, confidence, skill concerning legality issues. ● Pre and post GP usage of MMSE and GDS.

Similarities in design and implementation of the dementia projects

The projects were similar in design and implementation in six main areas:

1. Advisory/Steering/Management Committee.
2. Use of evidence in project design.
3. Focus on community-based versus institutionalised care.
4. Education sessions.
5. Contact with family/carers.
6. Promotion of project information and participation.

Advisory/Steering/Management Committee

All projects involved an Advisory/Steering/Management Committee that oversaw the development and implementation of the project. Committees were typically multidisciplinary and represented a variety of stakeholders, the most common being Divisions of General Practice (Executive Director, Aged Care Program Manager, Program Director) and individual GPs, geriatricians and a representative from the Alzheimer's Association. (One project included GP representatives from both rural and metropolitan areas and two projects involved family/carers/community representatives.)

Other stakeholders represented on the Advisory/Steering/Management Committees included: clinicians (eg psycho-geriatrician, ACAT Medical Officer, nurses), researchers/academics, Area Health Service area and program managers, and residential and community aged care service providers.

All of the projects employed a project officer (usually part time).

Use of evidence in project design

All projects drew on current evidence to varying degrees. Most commonly projects reported undertaking literature reviews or utilisation of existing reviews (such as the *Beach Report*), utilising Australian statistics on dementia and care of people with dementia, or modifying previous projects undertaken as a framework to conduct the present projects.

The development of General Practice Dementia Management Guidelines by Bridges-Webb et al, focused purely on modifying existing and/or previously published guidelines to suit the Australian context. The project undertaken by Rowland et al (2002) was notably scientific in its methods and employed rigorous techniques in tool design and undertook extensive reliability and validity studies.

The projects made use of established assessment/management tools or best practice guidelines in the area of dementia or primary health care. These included the Geriatric Depression Scale (GDS), Mini-Mental State Examination (MMSE), Ward Atmosphere Scale (adapted version), and evidence-based guidelines previously published in the United Kingdom.

Other methods employed in project design included consultation with local GPs, Advisory/Steering/Management Committee and liaison with relevant practitioners in related disciplines. The GP-Aged Care Facility Shared Care Project used existing software for pharmacological investigations.

Education sessions for GPs/other staff were delivered by experienced educators or clinicians and drew on evidence-based material (including assessment tools).

Community-based versus institutionalised care

The majority of projects were concerned with enhancing partnerships, skills and practice in community-based dementia care. The exception to this was the GP-Residential Aged Care Facility Shared Care Project.

3. Project approaches

Contact with family/carers

Many of the projects included an overall goal of increasing support and understanding of the role of family/carers in the management of dementia. The GP Dementia Skills Enhancement Project had an explicit aim of 'ensuring carers are recognised, supported and consulted throughout the course of the disorder'. Two projects promoted carer involvement by including a carer representative on the project steering/management committee.^{3,4} The Integrated Primary Dementia Care Model Project had usual clinical contact with patients/carers, as well as undertaking a post telephone survey with carers concerned with their perceptions of how the project had impacted on themselves and the patients.

Promotion of project information and participation

GPs were most commonly recruited to the project through Divisions of General Practice, and project information and feedback was generally disseminated via the local Division of GPs monthly newsletter. Other methods of project information dissemination included: specific project 'flyers', media outlets, weekly GP fax, and liaison by project officer with GPs or other service providers.

3. Bridges-Webb C, Wolk J, Britt H, Pond D. *The Management of Dementia in General Practice: a Field Test of Guidelines*. Final Report. RACGP NSW Projects, Research and Development Unit, Sydney. Pages: 1-6.

4. Anderson L. *GP Dementia Skills Enhancement Project*. Final Report October 2000. Alzheimer's Association NSW, Sydney. Pages: 1-22.

4. What did we learn?

The projects demonstrated the importance of partnerships and good communication between care providers in dementia care including family/carers and highlighted the benefits (and challenges) of supporting GPs in evidence-based practice.

Developing partnerships and effective communication

Many of the projects relied on forming multidisciplinary and inter-organisational partnerships. These most commonly involved Area Health Services, Divisions of General Practice and ACATs. Other organisations included the Royal Australian College of General Practitioners, community service providers (including community nursing), mental health services, pharmaceutical companies and staff of an aged care facility.

The projects highlighted four main factors in the development of successful partnerships and effective communication between services involved in dementia care:

1. All partners should have an understanding of other partners' core business and defined roles and responsibilities in the partnership.
2. Partners should clearly define their expectations concerning the desired outcomes associated with the partnership or shared care arrangements.
3. Project planning should consider the preferred mode of communication between service providers for different project tasks.
4. Divisions of General Practice can play a pivotal role in the implementation of projects.

The projects also demonstrated the importance of acknowledging and including the carer/family in the shared care planning process and care team.

Defining partnerships/shared care

The projects showed the importance of practitioners/services having clearly defined roles and responsibilities in the partnership and an overall understanding of each other's core business.

The culture of services and attitude of individual clinicians was shown to be critically important for effective interaction between service providers. The dementia projects highlight the need for project partners to get to know the work culture and practices of the other organisations or groups in the project development phase. Strategies could then be developed and implemented to promote inter-service understanding, clearly defined roles and responsibilities and ways in which the services may work effectively together.

Defining desired outcomes from shared care

The majority of clinicians reported favourably on the benefits of shared care both for individual practitioners and for patients with dementia. However, in some cases service providers appeared to mis-understand the aims of the project, leading to individual dissatisfaction with the process of sharing care and the overall impacts on service delivery. This highlights the need to educate all participants on the aims and expected outcomes of the program and to understand their individual needs and expectations. This means involving clinicians in the design and planning of the program and also fine-tuning the way the program works to meet their needs.

4. What did we learn?

General comments on partnership/shared care

- The shared care processes are valuable, enabling the sharing of ideas regarding the care of patients with dementia and developing a better understanding of the services and resources required (Integrated Dementia Care Model Project).
- Regular attendance by the GP at the hostel ensures staff support... lessening the number of surgery interruptions by hostel staff (GP-Aged Care Facility Shared Care Project).

Preferred mode of communication

The projects showed that clinicians prefer verbal communication (by telephone or face-to-face) to written (faxed) communication. This was particularly so for complex case management. There were however, a number of comments about the difficulties of contacting some GPs by telephone.

Comments supporting face-to-face discussions or meetings

- GPs commented on the benefits of meeting local aged care representatives and the value of networking with local geriatricians, aged care service providers and representatives of the Alzheimer's Association (GP Dementia Skills Enhancement Project).
- The share care process enables the sharing of ideas regarding the care of patients with dementia and developing a better understanding of the services and resources required (Integrated Dementia Care Model Project).
- Case conferencing with relatives, staff, GPs and specialists optimises patient care (GP – Aged Care Facility Shared Care Project).

Written communication was found useful for sharing clinical information between service providers but did not increase individual clinicians' (particularly GPs') participation in the joint management of patients with dementia. Overall, different methods of communication suited different tasks: for example, for sharing ideas and providing information on resources versus increasing involvement or active management of patients by the service providers.

Comments regarding a computerised/fax care plan

Comments supporting a computerised/fax care plan:

- The chief use of the care plan is the sharing of clinical information (Integrated Primary Dementia Care Model Project).

Comments against using a computerised care plan/fax system:

- One third of ACAT clinicians surveyed stated a preference for verbal communication with GPs and found written communication 'tedious and difficult when you are busy' (Integrated Primary Dementia Care Model Project)
- One GP thought more discussion was needed in complex cases (Integrated Primary Dementia Model Project)
- One GP thought phone discussions were more helpful (Integrated Primary Dementia Care Model Project).

Individual work practices, clinicians' flexibility and their ability to incorporate new communication methods into their existing ways of working were important factors in the success of new systems of communication. Other factors, which influenced the success of communication, included time, how much the individual needed the information, whether they had timely access to any technology that was required, and their understanding of the way the project operated.

4. What did we learn?

Several GPs commented on barriers associated with the use of the fax system and computerised care plans. Comments included:

- ‘fax machine problems’
- ‘fax back instructions should be made clearer’
- ‘the care plan was too straightforward to require any further comment’
- ‘the care plan was too complex, with too much information for a busy GP to read’.

Possible reasons cited for the high default rate of ACAT clinicians faxing the care plan to GPs included:

- lack of time
- clinician preference to share information with the GP more directly via the telephone
- lack of immediate access to a computer when ready to draw up the plan
- clinician resistance to changes in work practices
- lack of confidence of individual clinicians to summarise complex patients on behalf of all disciplines making up the multidisciplinary team.

Pivotal role of Divisions of General Practice

Involving Divisions of General Practice in the design and implementation of the projects was shown to be important. Divisions of General Practice assisted many of the projects in recruiting GPs, promoting projects, organising education sessions/supporting CME activities and assisting in data collation for evaluation purposes.

Comments concerning the role of Divisions of General Practice

- The only effective way of presenting the Dementia Tool Kit to local GPs was to develop a close partnership with Divisions (GP Dementia Skills Enhancement Project).

Supporting Evidence-Based Practice

Projects highlighted two key issues in supporting evidence-based practice in dementia care:

- the role/importance of assessment tools and management guidelines
- the role/importance of education sessions.

Role/importance of assessment tools and management guidelines

All of the projects had a focus on promoting evidence-based practice, through developing guidelines/assessment tools or utilising guidelines/assessment tools within project implementation.

Comments in support of assessment tools

- Familiarisation with assessment tools (MMSE and GDS) improves confidence in diagnosing and differentiating between dementia and depression (GP-Aged Care Facility Shared Care Project).
- Use of MMSE and GDS will provide a clearer assessment of residents cognitive function and depression and better inform care management (GP-Aged Care Facility Shared Care Project).
- GPs responded positively to the RUDAS with many requesting copies of the test for routine use in their practices (NESB Dementia Assessment Model Project).

Overall, the projects found the assessment tools, and to a lesser extent the Guidelines, were valuable in enhancing the skills and confidence of GPs in diagnosing, assessing and managing patients with dementia. In most cases, GPs intended to continue using the tools or guidelines. The NESB Dementia Assessment Model Project reported that some GPs who expressed a preference for the RUDAS tool over the MMSE.

4. What did we learn?

Comments in support of guidelines

- Results indicate the value of the provision of guidelines [North of England evidence-based guidelines] in the context of an actual patient (Integrated Primary Dementia Care Model Project).
- GPs found the Guidelines (developed in this project) helpful, at least to some extent, for most patients (General Practice Dementia Management Guidelines Project).
- The most useful aspects of the Guidelines were those dealing with functional and cognitive assessment of the patient, differential diagnosis and forming an action plan (General Practice Dementia Management Guidelines Project).

GPs had varying levels of familiarity with the principles of evidence-based medicine and using evidence-based guidelines or assessment tools. Key factors in the GPs propensity to use the guidelines were:

- The provision of the guidelines in the context of an actual patient.
- The number of dementia patients being diagnosed and cared for in their practice.
- How user-friendly the format of the guidelines was.

In the Integrated Primary Dementia Care Model Project, GPs were polarised in their opinions of the evidence-based guidelines that were provided - some thought them excellent, some thought too complicated. This suggests that clinical guidelines provided to GPs may be better utilised if they are structured in such a way as to cater to GPs' needs for different levels of detail in the information they are seeking.

Barriers to the use of evidence-based practice reported by GPs included:

- Being overwhelmed by other trials, new policies and procedures that they were expected to implement at the same time.
- Expectation from some that they would be remunerated for their participation in the project.
- Lack of patients with dementia for some.
- Not having time to trial the guidelines.

The role/importance of education sessions

Many of the projects held education sessions/workshops for participating GPs and other interested service providers and staff. Typically the education sessions were delivered by a multidisciplinary group of presenters. Presentations by a geriatrician and psycho-geriatrician were common in the Integrated Dementia Care Model Project conducted by WWDGP and GMAHS and central to the GP Dementia Skills Enhancement Project conducted by the Alzheimer's Association.

Such education sessions developed a focus on dementia care within the Divisions' Continuing Medical Education programs and promoted the uptake of evidence-based practices.

The projects demonstrated the importance of flexibility and tailoring of education to meet the needs of each Division of General Practice. A wide range of formats was requested in terms of length, day and time of delivery (evenings often preferred) and lead time for ensuring maximum attendance. A vital component of each session was the inclusion of an interactive, facilitated question and answer time with experts to enable GPs to address their own individual learning needs.

In some instances, the education sessions were used to formally introduce GPs to assessment tools and their application for the first time. GPs reported greater knowledge and confidence in assessing or managing patients with dementia and supporting their carers. Project evaluations found that such activities increased GPs' skills and interest in dementia care, their knowledge of alternative and complementary strategies to pharmacotherapy in dementia care, and their familiarity with other key local dementia care and support services.

4. What did we learn?

Comments concerning GP education sessions

- Need to ensure education sessions address and reflect local conditions, eg Aboriginal and NESB needs and specific areas of disadvantage, particularly in rural and remote areas (GP Dementia Skills Enhancement Project).
- Education evenings for GPs and staff resulted in shared knowledge and discussion, and increased interest from GPs not initially involved in the project GP – Aged Care Facility Shared Care Project).
- Workshops increased GPs' knowledge, confidence and skills in assessment and management of aged residents (GP – Aged Care Facility Shared Care Project).
- Workshops were useful for GPs and staff in considering alternative strategies to medication usage (GP – Aged Care Facility Shared Care Project).

Content of the education sessions was specific to each project, and included:

- understanding differential diagnosis
- diagnosis of dementia
- dementia management
- depression in the elderly
- understanding diagnostic/assessment methods/tools
- use of screening tools
- recognising the role of the family/carer
- Support for family/carer.
- Information on local service providers.

5. What did we produce?

The outputs of the projects can be placed into three broad categories:

1. Dementia care and management methods.
2. Dementia education packages and models.
3. Information for service planning.

Dementia care and management methods

The dementia projects collated existing assessment tools such as the MMSE and GDS and developed new tools such as RUDAS and guidelines for the detection and management of dementia. In addition the projects have developed models of communication between service providers including a format for conducting case conferences and a computerised care plan.

Table 5. Outputs from the dementia projects associated with care and management methods

Dementia care and management methods	Project	Outputs
	GP-Aged Care Facility Shared Care Project	<i>Model of Care Manual</i>
	General Practice Dementia Management Guidelines Project	<i>Guidelines for the Management of Dementia in General Practice</i>
	NESB Dementia Assessment Model Project	<i>RUDAS Training Video and Guide</i>
	Integrated Dementia Care Model Project	Case Conference Model
	Integrated Primary Dementia Care Model Project	Computerised Care Plan

Details about how to access these resources are outlined at Appendix 1.

Dementia education packages and models

The projects used several different methods of conducting education sessions ranging from formal presentations to individual practitioner training. The projects provide a range of content appropriate for education sessions and other resources available to supplement the sessions.

Sessions went tailored to the logistical needs of Divisions, with flexibility and interaction with experts being critical to success. Further evaluation of the different education approaches is warranted to develop dementia care education models that could be used in future projects or programs.

Table 6. Outputs from the dementia projects concerned with dementia education

	Project	Dementia Education Program and Model
Outputs	GP Dementia Skills Enhancement Project	Dementia Tool Kit Model

5. What did we produce?

Information for service planning

The analysis conducted within some of these projects provides useful information for service planners and government policy makers,

highlighting some of the training needs of GPs in relation to dementia care, and some of the primary health care needs of hostel residents with dementia.

Table 7. Outputs from the dementia projects concerned with information for service planning

Information for service planning	Project	Outputs
	GP Dementia Skills Enhancement Project	GP Profile
	GP-Aged Care Facility Shared Care Project	Hostel Resident Profile

6. Implications for planning and service development

Collectively, these projects provide lessons for future planning or service development in two areas:

1. Promotion of evidence-based practice.
2. Future research and development.

Promotion of evidence-based practice

Current assessment tools such as the MMSE and GDS are applicable for use in general practice and participating GPs have shown themselves willing to use them. In addition, RUDAS is an effective tool for use by practitioners and NESB patients. Given the widespread lack of familiarity with these assessment tools, there may be merit in a broad strategy to disseminate the tools in combination with interactive education programs to support their use. This is likely to develop GPs' interest and skills in dementia care.

Dementia management guidelines proved to be less immediately applicable than assessment tools at present in general practice. Appropriate formats for such guidelines and ways of promoting their use will be needed if they are to be integrated into the routine practices of GPs.

Verbal communication processes such as case conferencing (face-to-face or over the telephone) are likely to be more successful than processes relying on written communication if the aim of the program is to increase GP involvement in patient management.

Future research and development

Future development of programs in the area of dementia care and management should streamline the processes developed in the six pilot projects and focus particularly on integrating shared care processes into the routine practices of all clinicians, taking into account constraints of existing workloads and traditional methods of operation.

Future programs should cover the importance of incorporating all shared care into the routine activities of clinicians, individual clinician roles and functions, the ways in which key partners will work together, and the expected outcomes from the partnerships in the planning phase.

Education programs should cover general dementia management and care, use of assessment tools and management guidelines, behavioural management strategies and support to the family/carer. Program development and evaluation should address the issues of how knowledge can be integrated into practice, and how the provision of assessment tools is best integrated with educational activities to support appropriate skills development amongst GPs.

Existing models of dementia care and management involving GPs could be subjected to further piloting with larger sample sizes of GPs and other clinicians. Future evaluation of such projects should particularly focus on achievement of the aims of the project through emphasis on impact and longer-term outcome evaluations.

Development of a good working relationships with Divisions of General Practice will be important in undertaking future programs.

Postscript

The management of dementia is becoming an increasingly important aspect of General Practice. Its importance will increase sharply as the Australian population continues to age into the 21st Century. This report provides an overview of six important projects funded under the *NSW Action Plan on Dementia 1996-2001* in the area of General Practice and dementia care.

The projects funded included a number that provide General Practitioners with useful aids to assist in the management of dementia: the RUDAS instrument to assist in the assessment of dementia in patients from culturally and linguistically diverse backgrounds and Dementia Management Guidelines for the assessment and management of dementia. A number of the other projects did not focus mainly on the development of tools, but nevertheless produced very useful aids to assessment and management, such as the Model of Care manual produced for a shared care project in a residential facility.

A key feature of a number of the projects was GP education in assessment and management of dementia. The project evaluations showed that GPs responded well to these initiatives, reporting improvements in knowledge, skills and confidence, as well as increased familiarity with some of the tools described above.

Many of the projects also focused on improved communication between GPs and other parts of the health care system. The communication was improved through shared care meetings, faxes and care plans. Most of the evaluations were positive, and some included carers' comments that they also felt care had been improved.

General Practitioners already provide much in the way of holistic care to their patients. This is important to elderly people in particular, many of whom have had the same General Practitioner for many years. These projects point the way forwards for dementia management in General Practice. As we move into the 21st Century, there clearly needs to be communication between the GP and the multidisciplinary team, there need to be accessible aids for the GP to assist in the diagnosis and management of dementia, and information about the latest advances in diagnosis and management needs to be communicated to GPs in an accessible manner. These projects make a start on all those processes.

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Chair

General Practitioner Dementia Working Group

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5. Wagga Wagga Division of General Practice and the Greater Murray Area Health Service. *Integrated Care Model for People with Dementia Project*. Final Report August 2000. Wagga Wagga Division of General Practice, Wagga. Pages: 1-12.
6. Rees L, Elliot B, Heart B, Price M. *The Primary Care Management of Dementia An Integrated Care Model for General Practitioners*. Evaluation Report 1999-2000. Western Sydney Area Health Service and Western Sydney Division of General Practice, Sydney. Pages: 1-18.

Appendix I

How to access project resources and materials

Project	Resources	Contact details
GP-Aged Care Facility Shared Care Project	<i>Model of Care Manual</i>	To be available on the NSW Health website shortly – www.health.nsw.gov.au
General Practice Dementia Management Guidelines Project	<i>Guidelines for the Management of Dementia in General Practice</i>	Available on the following websites: NSW Health – www.health.nsw.gov.au RACGP – www.racgp.org.au Available to GPs in hard copy and CD Rom format, on request, from local Divisions of General Practice in NSW.
NESB Dementia Assessment Model Project	<i>RUDAS Training Video and Guide</i>	Available in limited numbers from SWSAHS. E-mail postal details to – ivana.colala@swsahs.nsw.gov.au RUDAS test also available.
Integrated Primary Dementia Care Model Project	Computerised Care Plan	Available on request by return e-mail from – Michael_Price@wsahs.nsw.gov.au To be available on the NSW Health website shortly – www.health.nsw.gov.au

