Agents of Change: Empowering Clinicians to Disrupt the Status Quo in Dementia Care

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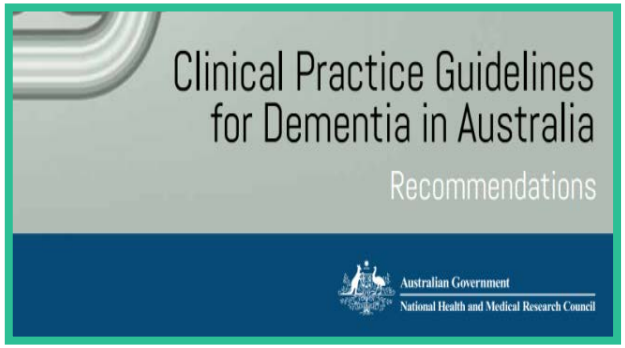
Dementia care in Australia

- Fractured and dependent on the health care professional (and patient demographic factors)
- 2016 *Clinical Practice Guidelines for Dementia in Australia*
- Dissemination of guidelines not enough to create real change in clinical practice



Agents of Change

AIM: Implement and sustain improvements in post-diagnosis care for people with dementia and their supporters by increasing adherence to three key recommendations from the *Clinical Practice Guidelines for Dementia in Australia:*

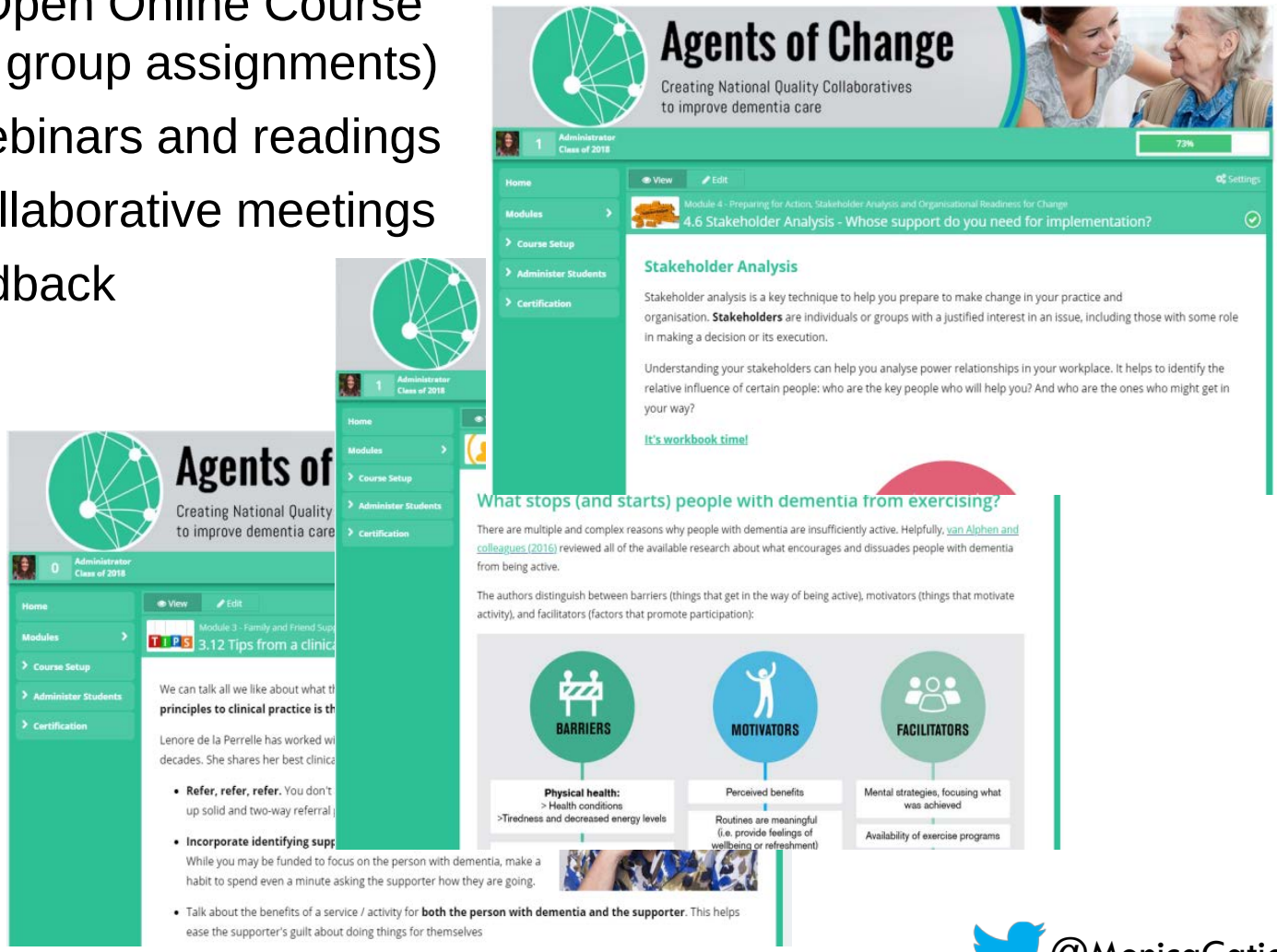
People with dementia living in the community should be offered evidence-based occupational therapy	Why?	Occupational therapists spend the majority of their time with people with dementia on assessment (at the expense of intervention)
People with dementia should be strongly encouraged to exercise	Why?	People with dementia are not routinely encouraged to exercise or involved in exercise programs
Carers and family of people with dementia have access to programs to support and optimise their ability to provide care for the person with dementia, including respite	Why?	Carers report they need more respite, education, help to problem solve, and skills in managing symptoms

Quality Improvement Collaboratives

"Assessing one's own progress and benchmarking with other professionals facilitates faster and wider implementation of quality improvement practices" – Shaw et al., 2012

Training package

- Start up meeting
- ‘Massive’ Open Online Course (with small group assignments)
- Regular webinars and readings
- Regular collaborative meetings
- Expert feedback



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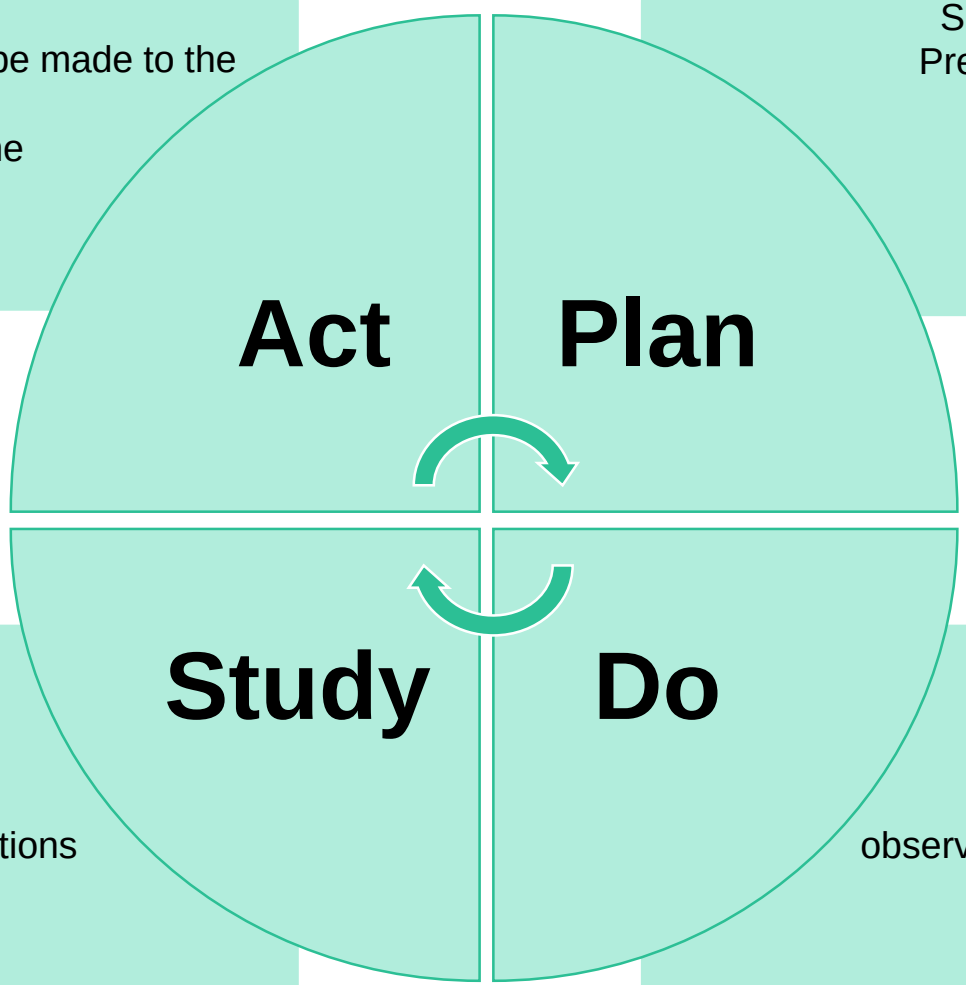
Implementation plans

Clinicians identify their own service- and practice-specific:

- Areas for improvement
- Opportunities to improve
- Barriers and facilitators to change
- Organisational readiness to change (and strategies to address)

Site-specific implementation plan

Specific, iterative strategies to provide service / care consistent with clinical guidelines



What changes need to be made to the next cycle?
If no changes, roll out the improvement

Set improvement goals
Predict what will happen
Plan the cycle (who, where, what, how)
Decide what data to gather

Fully analyse the data
Compare data to predictions
Examine learning

Carry out the plan
Document any observations and problems encountered
Gather data

An example - Karen

- Senior OT working in a hospital avoidance program
- Role is both OT specific (home safety assessment and equipment) and case management (referral to My Aged Care). She usually sees clients 2-3 times at home + follow-up paperwork in office.

Reflects on her own practice:

- Doing environmental assessment and modification + technology prescription well (though she is more focused on falls prevention than dementia)
- Not providing any intervention to promote independence
- Not providing any education and skills training for carers

An example - Karen

- Upskilled on key principles of best practice OT – how to adapt?
- Conducted stakeholder analysis
- Identified barriers to change
- Thought about how to assess outcomes

Implementation plan:

- Regular inservice
- Developing referral pathways
- Incorporation of dementia-specific assessment
- Demonstration and practicing skills with carer
- ‘Library’ of resources
- Plan-Do-Study-Act cycles

Research questions

1. Impact on guideline adherence
2. Clients with dementia and supporters – satisfaction with care, quality of life
3. Process outcomes - uptake, sustainability, acceptability, fidelity, penetration, safety
4. Return on investment
5. Involvement of people with dementia and supporters

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Implementation Science

STUDY PROTOCOL Open Access

Agents of change: establishing quality improvement collaboratives to improve adherence to Australian clinical guidelines for dementia care

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Method

Primary outcome: Guideline adherence

→ Interrupted time-series design, powered to detect

Scores	
1	Full adherence
0	Partial adherence Unclear Insufficient detail
-1	No adherence Unsatisfactory adherence

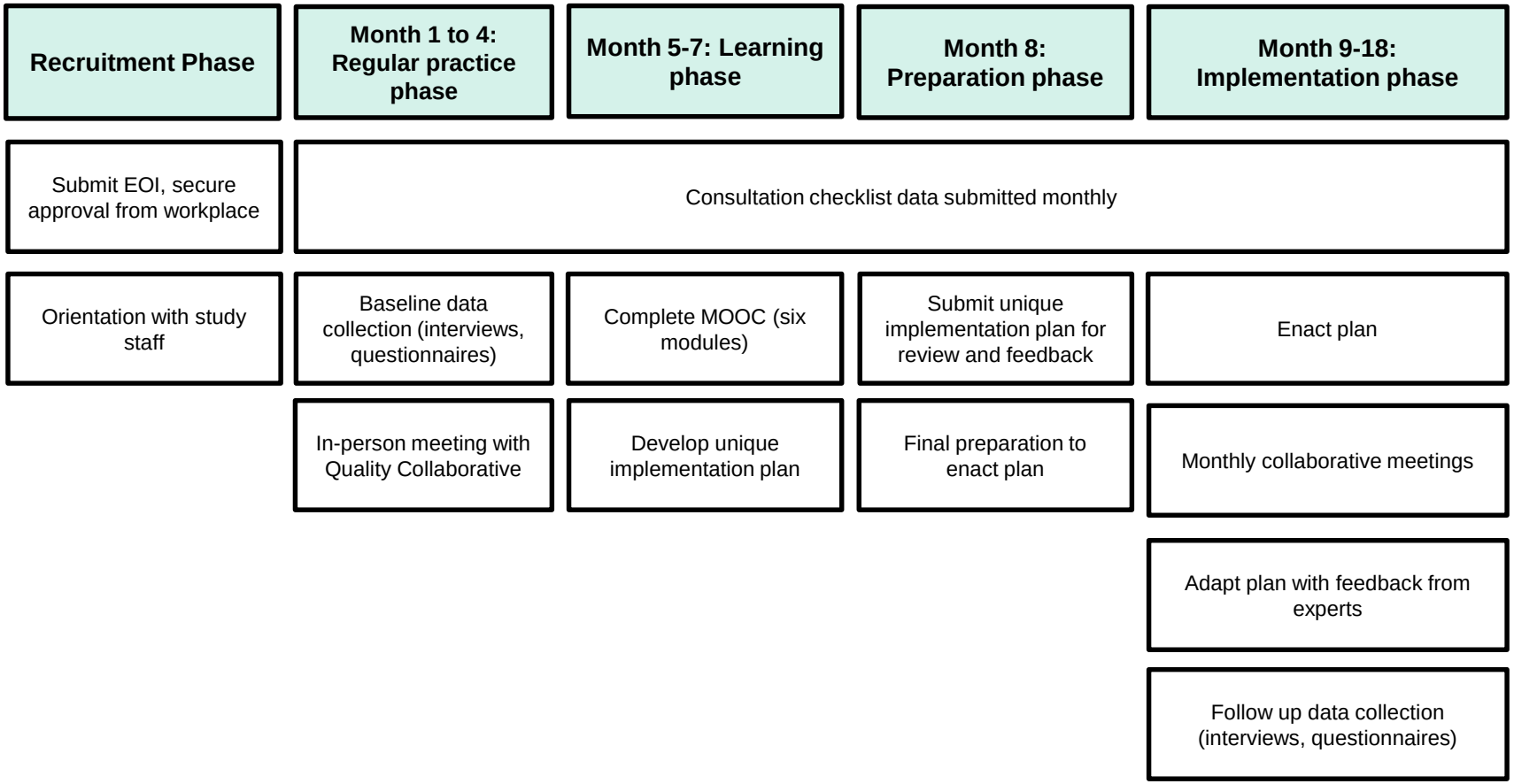
Guideline adherence	
Exercise guideline adherence	Full adherence when: a) Clinician checklist explicitly references a discussion about current physical activity levels, and; b) Specific needs and barriers to physical activity are identified, and; c) Treatments/strategies recommended are clinical indicated based on needs/barriers, and; d) A written treatment plan for physical activity or exercise is provided to the person with dementia
Occupational therapy guideline adherence	Full adherence when: a) Home environment assessment has occurred (where applicable), and; b) Clinician checklist explicitly references identification of primary concern/s of person with dementia and carer, and; c) A written treatment plan to address needs of person with dementia and carer or give specific advice about suitable activities (that are tailored, of interest, and match capabilities) is provided
Carer support guideline adherence	Full adherence when: a) Clinician checklist explicitly references that the needs of the carer have been discussed during the consultation, and; b) Clinician checklist explicitly references clinically indicated provision of information about programs providing respite for the carer and/or other carer support services, and; c) A written treatment plan detailing key carer concerns and strategies to manage these is provided

Method

Secondary outcomes:

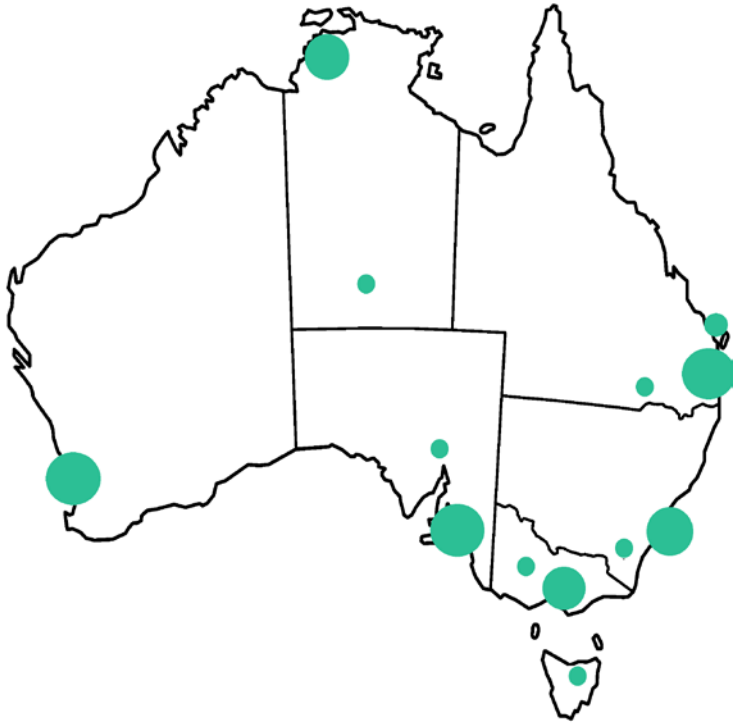
- Implementation → Process evaluation
  - Clinician interviews
  - Management interviews
  - NoMAD, QIKAT (repeated)
  - Field notes
- Client satisfaction with care, quality of life (Zarit, DEMQOL)
- Return on investment → Clinician willingness to pay

Pathway


Recruitment Phase
Month 1 to 4: Regular practice phase
Month 5-7: Learning phase
Month 8: Preparation phase
Month 9-18: Implementation phase
Submit EOI, secure approval from workplace
Consultation checklist data submitted monthly
Orientation with study staff
Baseline data collection (interviews, questionnaires)
Complete MOOC (six modules)
Submit unique implementation plan for review and feedback
Enact plan
In-person meeting with Quality Collaborative
Develop unique implementation plan
Final preparation to enact plan
Monthly collaborative meetings
Adapt plan with feedback from experts
Follow up data collection (interviews, questionnaires)

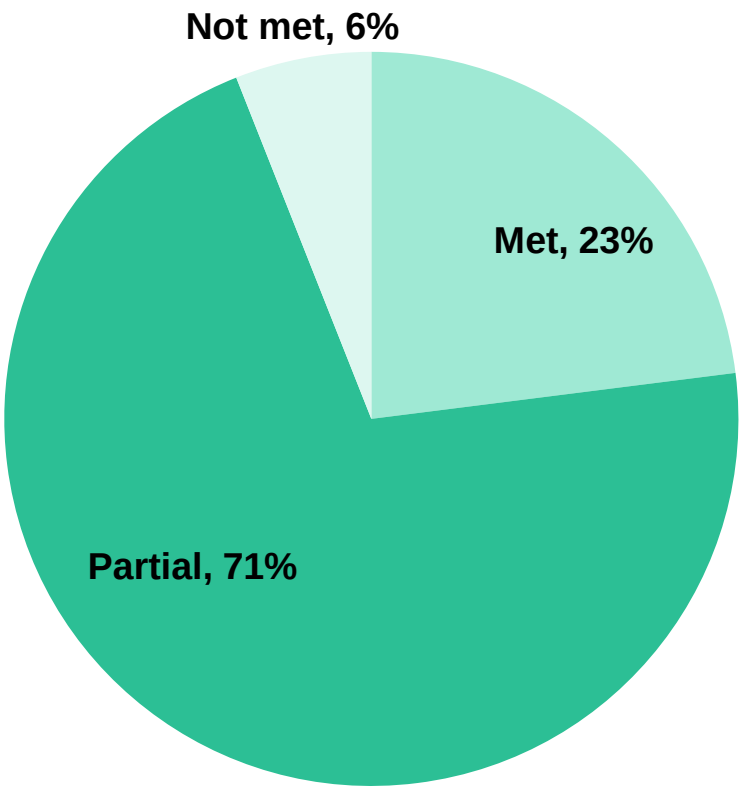
Progress

- 40 clinicians recruited (32 sites)
- All states represented
- 20% regional or rural
- Physicians, occupational therapists, physiotherapists, nurses, dieticians, social workers, social workers, YOD NDIS providers



Progress – guideline adherence

- 4 months of consultation checklists submitted to date (537 checklists; 301 included here) – all pre-intervention



Key areas for improvement:

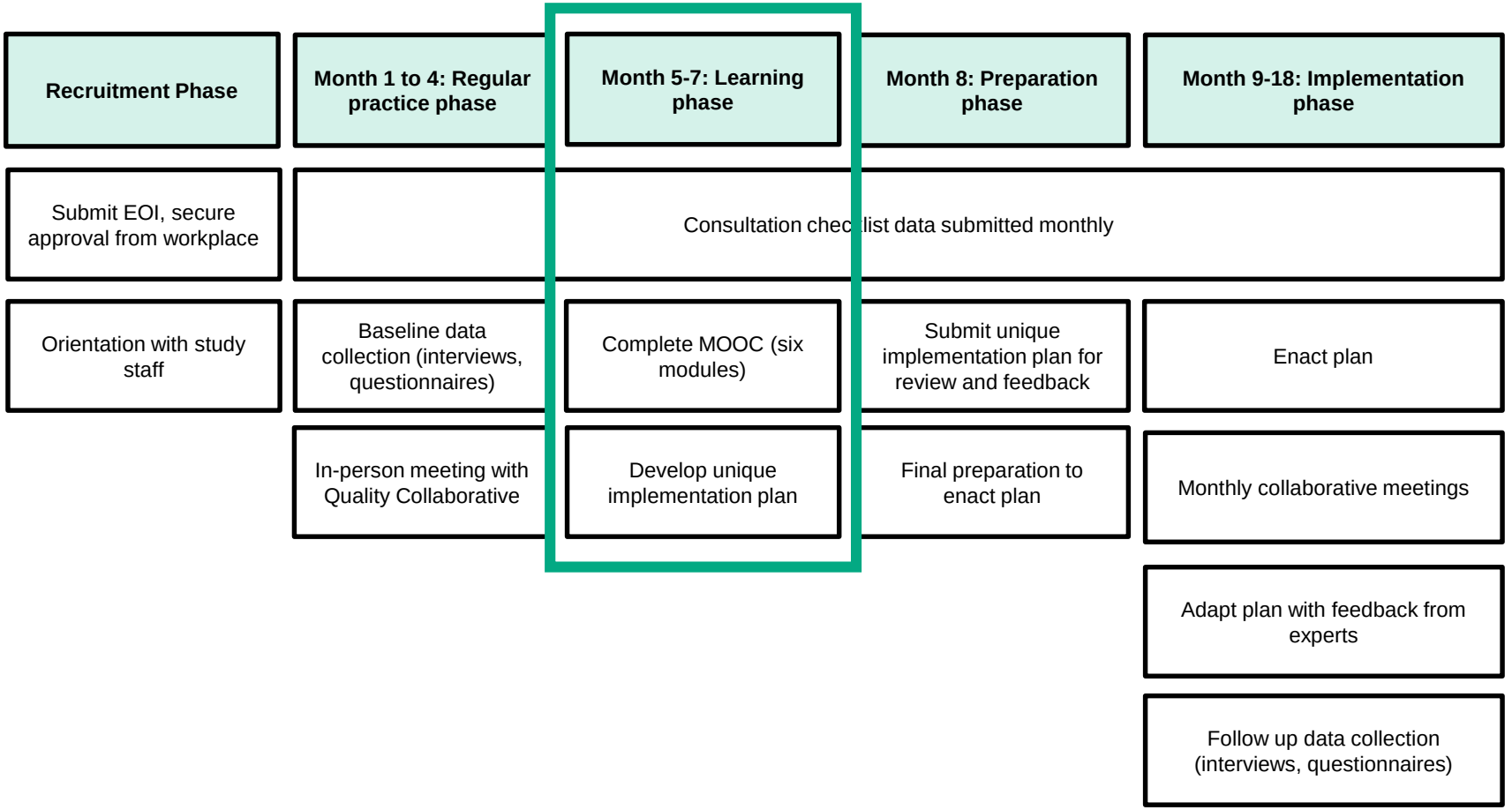
- Provision of written information
- **Exercise**: Lack of assessment of specific needs and barriers; overwhelmed by barriers to between-session adherence
- **OT**: Reliance on assessment at the expense of intervention
- **Carers**: Finding time to assess / address carer needs within funding model

Progress – process evaluation

Qualitative interviews

- Highly motivated group overall, very keen for collaboration with each other
- Low awareness of guidelines, clients unaware of treatment options
- Most feel that innovation is encouraged (by workplace and funders) – but not all
- Stricter funding criteria (especially residential care), less autonomy = less optimism about success
- Funding focussed on person with dementia – when / how do we focus on the carer?
- Scepticism about client adherence to recommendations

Where to from here?



The Agents of Change team

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COGNITIVE DECLINE PARTNERSHIP CENTRE

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Thank you

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