FINDINGS FROM KEY STAKEHOLDERS IN DEVELOPING A DEMENTIA CARE MANAGEMENT PROGRAM

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Introduction

- Significant gaps exist in the care continuum for **persons with dementia (PWD)**
- PWD are more susceptible to gaps in the system
- Overall, there is a lack of systems based solutions
- Patient centered care for PWD and their caregivers requires linkage between healthcare systems and community resources
- Geriatricians are positioned to develop patient centered care programs

Purpose

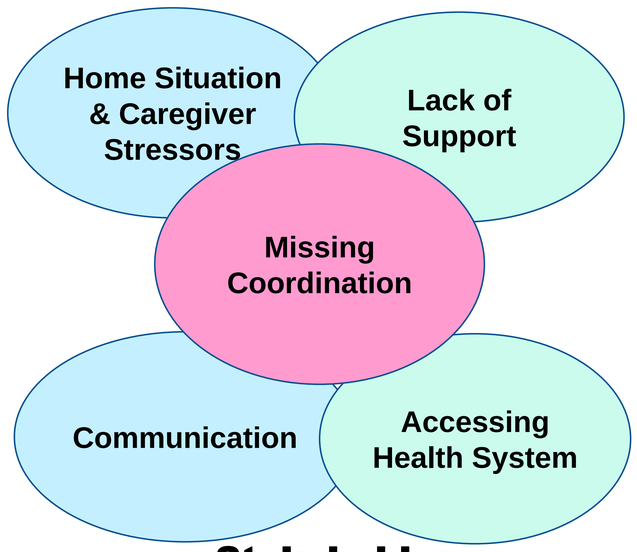
- To identify key issues and barriers to the development of a comprehensive dementia care management program, focusing on intervention and successful implementation from the perspectives of key stakeholders

Methods

- Focus groups were held with the different stakeholders from within an academic institution (UC Irvine) and a community resource (Alzheimer's Orange County).
- The discussion centered on barriers and enablers to providing care, recommendations on improving care, improving quality of life for both patients and caregiver and implementation of such a program.
- Recordings were made of the focus groups, transcribed, and key themes were analyzed.

Common Themes

Barriers to Comprehensive Dementia Care



Stakeholder Recommendations

PWD & Caregiver
- Improve patient education
- Improve resource awareness
- Support for caregivers

- Health navigator
- Community resource link
- Improve clinician training
- Improved communication protocols

- Home evaluation
- EMR improvement
- Centralized care

Clinicians & Social Workers

Results of Focus Groups

- Focus groups were held with geriatricians (n=7), neurologists (n=5), social workers (n=5), PWD and their caregivers (n=48).
- **Barriers:**
  - PWD and their caregivers lacking support and information to cope with the condition.
  - Clinicians felt they needed a better understanding of community resources
  - Lack of communication between the PWD, and caregiver throughout the health system.
  - Difficulty easily accessing services.
  - Lack of coordinated care
- **Recommendations:**
  - Reliable communication/referral system between healthcare and community resources
  - Ongoing education and training
  - A health navigator role to fill gaps in the care continuum by providing direct support to PWD and their caregivers, link to community resources and relay crucial, and often undocumented, social information to healthcare teams

Conclusion

- Key stakeholder focus groups provided data for a framework of a patient-centered, physician and social worker relevant, dementia care program that utilizes community health navigators to serve the needs of PWD and caregivers

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