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## Letters to the Editor

## Delaying Transition Into Long-Term Care for Persons Living With Dementia: Multispecialty Interprofessional Team Memory Clinics

*To the Editor:*

With COVID-19 highlighting the substantive risks to older adults living in congregated settings, an emphasis should be on supporting persons with dementia to live in the community safely for as long as possible. Primary care-based interventions such as Multispecialty Interprofessional Team (MINT) memory clinics (previously referred to as Primary Care Collaborative Clinics) provide a significant opportunity to support community-dwelling older adults to live at home, delay long-term care placement, and address systemic challenges that impede the delivery of quality dementia care.<sup>1</sup> Although primary care is well positioned to manage chronic disease, family physicians lack the knowledge and confidence to adequately assess and manage dementia and, as a result, the condition often goes undiagnosed and unmanaged with resulting deleterious consequences for patients and families.<sup>2</sup> Moreover, the structure of family practice does not allow enough time to manage the complex issues associated with this condition and many family practices lack the resources needed to optimally manage dementia.<sup>3</sup> Support for community-dwelling persons with dementia is further hampered by a lack of integration and coordination between health services and providers, and poor information sharing and transitions between health sectors.<sup>4</sup>

MINT memory clinics aim to build primary care capacity for comprehensive dementia assessment and management, increase efficiency of referrals to specialists, extend reach of their expertise to rural and remote communities through collaboration with MINT clinics, and increase equitability of access to timely, necessary dementia care.<sup>1,5</sup> The MINT memory clinic care model is characterized by 4 major components, as presented in [Supplementary Figure 1](#).

MINT memory clinics are family physician-led and include nurses, social workers, pharmacists, occupational therapists, and other disciplines. Inclusion of representatives from various community agencies and services as available provides timely and ongoing access to community supports. Each team is supported by a triad of specialists in geriatric medicine, geriatric psychiatry, and cognitive neurology, who provide consultation support to team members for more complex cases using virtual technologies and, when needed, direct patient consultation. Assessments include standardized, evidence-informed assessments of cognition, mood,

functional ability, caregiver burden, and medications; assessments include both patients and their caregiver.<sup>1</sup> Comprehensive care plans are customized to preferences, goals, and needs of each patient-caregiver dyad. These care plans, along with support from the interprofessional team, serve to enhance the capacity of referring family physicians to provide better dementia care within this shared care approach. Continuing care is provided over the course of the illness with pro-active, rather than reactive, assessment and management of safety risks, aiming to avert crises that lead to hospital admissions and early institutionalization.<sup>6</sup> As most clinics operate in the patient's own primary care setting, care is accessible close to home and delivered by familiar care providers. MINT clinics are established following a standardized, evidence-informed, and nationally accredited training program that is completed by all team members.<sup>7</sup> Annual Booster Days provide ongoing knowledge and skill development and serve to facilitate development of regional and provincial Communities of Practice.

Multiple evaluative studies have demonstrated that the memory clinic training program and the MINT memory clinics have increased capacity for high quality dementia care in primary care.<sup>5,7</sup> Typically, the clinics refer approximately 10% of patients for specialist care, enabling the majority of care to be provided in primary care.<sup>1,5</sup> Wait time for MINT memory clinic assessment is typically 1.5 months<sup>1,5</sup> compared with the typical 6- to 12-month wait for assessment by some specialists.<sup>8</sup> These findings have been supported by the results of an independent third party evaluation commissioned by the Ontario government, which found that MINT clinics are associated with significant cost savings for Ontario's healthcare system with lower emergency department and hospitalization costs, delayed admissions to long-term care by nearly 6 months, and substantive reduction in referrals to specialists compared with usual care.<sup>9</sup> Several studies have also demonstrated positive patient, caregiver, and referring physician experience with the care provided by the clinics, as well as increased access to community and home care services to further support community living.<sup>1,10</sup>

The MINT memory clinic team approach to care provides continuing, comprehensive person-centered care, with an efficient, collaborative care process and training and skills-building opportunities for team members. With increased capacity for high quality dementia care in primary care and efficient collaboration and integration with specialist care, persons with dementia are enabled to live at home as long as possible, thereby delaying transition into long-term care. Moreover, potential exists for significant health system cost savings and reducing current pressures on hospitals and long-term care.

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## Care Is Needed to Apply Hypertension Guidelines to Community-Living Older Adults Aged 60 Years and Over



### To the Editor:

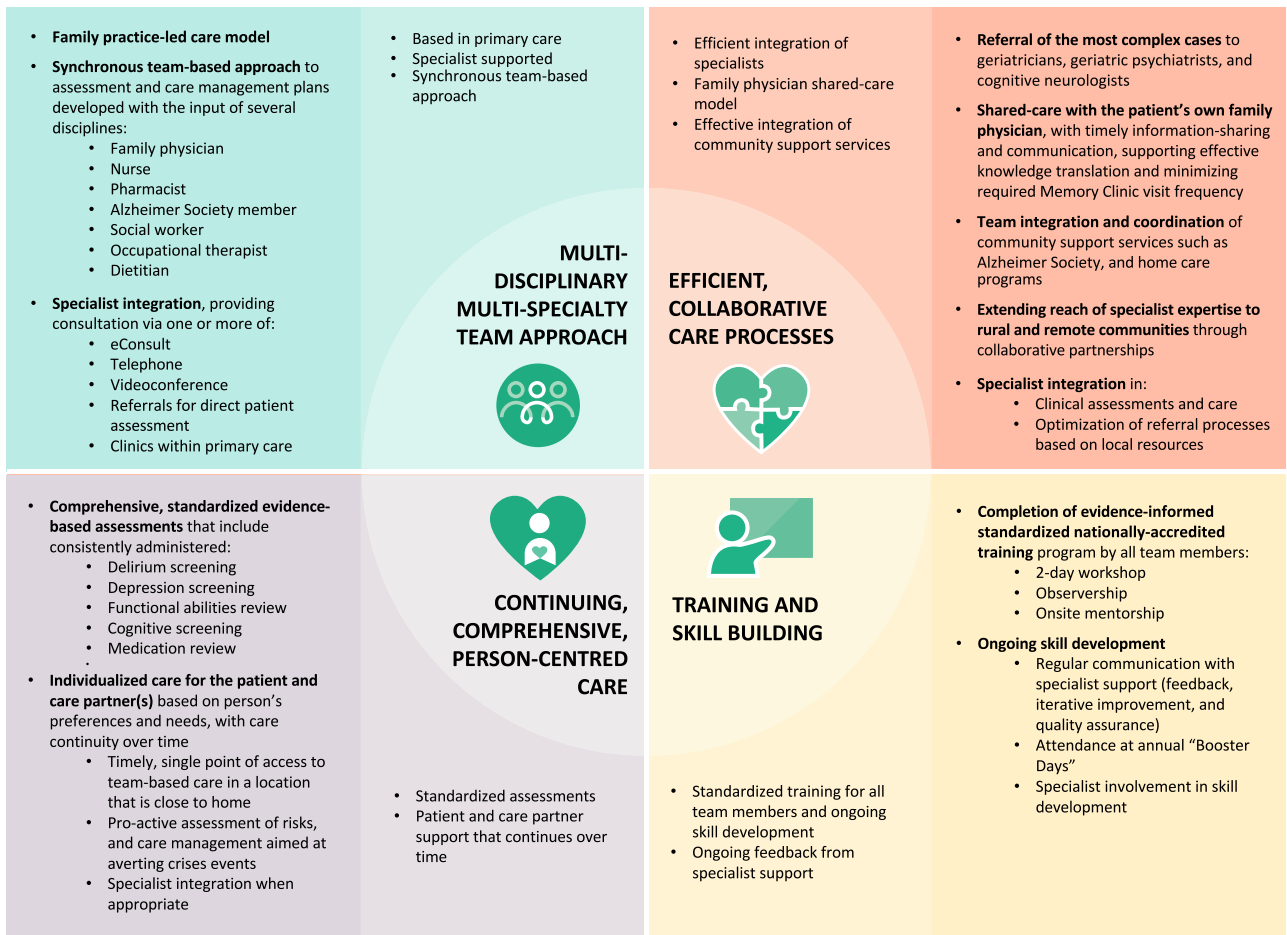
Guidelines for blood pressure (BP) treatment initiation and targets have been developed based on evidence from randomized controlled trials (RCTs). A definition of 140/90 for older adults is generally adopted.<sup>1</sup> Recent reviews suggested a target of 130/80 based on RCTs.<sup>2</sup> Optimal control of BP reduces risk of cardiovascular disease morbidity and mortality;<sup>3</sup> however, few RCTs include older adults that are representative of those living in the community with multimorbidity, frailty, cognitive impairment, or varying degrees of dependency in the long-term care setting.

In a community-wide health screening of older women aged 60 years and older based in 80 community centers all over Hong Kong, we examined whether frailty affects the relationship between systolic BP (SBP) and 12-month hospitalization episodes, to attempt to determine the SBP value associated with optimal outcomes in terms of hospitalization. The latter was used as a surrogate of incident cardiovascular events that usually results in hospital admissions, although self-reported episodes were not as accurate as hospital-linked admission data.

The program consisted of BP measurement 2 to 3 times per week, over a 1-year period, using a commercial automated blood pressure machine supplied by Hong Kong Telecom or Smartone where data are uploaded on to a cloud platform for monitoring, and a brief screening questionnaire covering impairments, activities of daily living, memory impairments, sarcopenia, frailty, and self-reported comorbidities.<sup>4,5</sup> Frailty was assessed using the 5-item FRAIL scale developed by Morley et al.<sup>6</sup> We excluded all participants who had been admitted to hospital in the previous 12 months, and documented the number of self-reported hospital admissions during the 1-year period of follow-up. Those lost to follow-up after 1 year, and those who attended for less than 9 months were excluded. Associations of SBP and diastolic BP (DBP) level at baseline with incident hospitalization at 1 year were analyzed using binary logistic regressions, according to frailty groups (robust, prefrail, and frail). The study has been approved by the Clinical Research Ethics Committee.

The risk of incident hospitalization at 1 year using SBP (SBP <120, and 120–139 mm Hg) for different frailty groups is shown in [Table 1](#). Among those who were classified as robust or frail, no increase in hospitalization at 1 year was seen for any BP categories without or with adjustment for age, education, and comorbidity. In particular, there was no difference in incident hospital admissions for those with SBP <140 or ≥140. However for the prefrail group, SBP ≥140 increased the risk compared with those with SBP <120 [odds ratio (OR) 2.65, 95% confidence interval (CI) 1.05–6.70], and those with SBP ≥160 had a more than double increased risk (OR 5.81, 95% CI 1.90–17.74). Using SBP 120–139 as the reference group, only a significant risk was observed for those with SBP ≥160 (OR 3.18, 95% CI 1.46–6.95). No significant association between DBP categories and incident

**MINT MEMORY CLINICS: CORE COMPONENTS & IMPLEMENTATION DETAILS**



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**Supplementary Fig. 1.** Mint memory clinics: Core components and implementation details.