Case 2: Mr. L.T.C Dementia – in Berlin, Germany

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SETTING		**At Home, Informal Care**	**At Home, Informal + Professional Care**	**Hospital**	**Short Term/ Part Time Institutional Care**	**Nursing Home, Assisted Living/ Sheltered Housing**
PATHWAY		**Diagnosis + Early Support**	**Care Delivery in the Community**	**Crisis Intervention**	**Crisis Intervention Short-Term Admission**	**Long Term Institutional Care**
WHO IS INVOLVED (selection of typically involved actors)	**Family/ Friends/ Neighbours…**	…initiate contact to GP	…do informal case management …complement formal care	…engagement is often crucial for pathway decisions after acute crisis	…can get support from respite services (day care, etc.)	…are often crucial for organising medical and social care (GP and specialists visits, voluntary services, etc.)
	GP…	…does dementia assessment …refers to specialist for diagnosis	…is responsible for medical follow up, home visits, therapeutic devices	… is recipient of discharge information after hospital stay, organises follow-up	…is responsible for medical care also during inpatient care (visits at institution)	…is responsible for medical care
	Medical Specialists…	…refine diagnosis and therapy, geriatric assessment in specialist practice (outpatient/ inpatient)	…offer outpatient services (e.g. memory clinic) for follow up	…are responsible for geriatric assessment and treatment (psychiatric, neurological) in case of acute deterioration	…are responsible for medical care (visits at institution)	…are responsible for medical care
	Alzheimer Society…	…involved for knowledge transfer, counselling for patient and family	…offers knowledge transfer and support services for informal carers	…offers counselling and knowledge transfer for patient and family		…offers additional community services within nursing home (palliative care, voluntary social care)
	Community Care Services (Health + Social Care)…		…deliver home care according to needs assessment …apply preventive/rehabilitative concepts of activating care	…are recipients of discharge information after hospital stay	…often do case management by ensuring continuity and information exchange between residential and community care	
PROBLEMS		**Area-wide preventive activities not available (e.g. preventive visits for elderly)** **GPs: not always well trained (dementia remains under diagnosed, not sufficient referrals to specialists)** **Alzheimer Society: not involved systematically**	**Clear task sharing/case management for dementia pathway lacking (GP is weak as gatekeeper and case manager)** **Scarce home visits by GPs (disincentives)** **Discrimination of dementia patients in needs assessment criteria** **Private co-payment for adequate community care** **Financial scarcity in community care challenges quality (e.g. lack of time, unskilled staff)**	**Geriatric/specialised rehabilitation units not available everywhere (lack of resources)** ***Discharge Management:*** **Decisions about appropriateness of home care dominated by hospital staff** **Informal carers, Alzheimer Society, information centre for LTC not systematically involved** **Gaps in information transfer (e.g. medication)**	**Intermediate services not well-established and not comprehensively available** **Preventive/rehabilitative concepts underdeveloped** **Private co-payment required** **Access often depends on family's engagement** **Access to medical care difficult**	**Undersupply of medical care (GP and specialist home visits)** **Specialised care (e.g. palliative services) not systematically involved** **Nursing home staff not always properly trained for dementia care** **Not enough specialised care units** **Quality assurance insufficient (especially for innovative assisted living/ sheltered housing projects)** **Lack of private financial resources restricts choice of nursing home**