

# **Developing and implementing provincial Alzheimer Strategies**

## **Lessons learned from the Quebec Alzheimer Plan**

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# Context

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- ◆ A complex, chronic disease
  - Most important cause of disability in older persons
  - Major human, social, societal, healthcare system impact
  
- ◆ Rapidly aging population, in particular in:
  - Old-old
  - One baby boomer in five will develop Alzheimer's Disease in his or her lifetime
    - Although evidence that incidence may be declining.
  
- ◆ Preparing for the advent of bio-markers and disease-modifying medications



# International Plans

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- ◆ AD plans in France, England, Scotland, Australia, and New Zealand
- ◆ European Union (2008) asked member countries to develop and implement national Alzheimer's strategies and action plans.
- ◆ Discussions in middle-income countries-Mexico, China

# Mandate from the Quebec Minister of Health

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- ◆ Propose to the Minister of Health the Quebec Alzheimer Plan
  - From prevention to end of life care, including the research agenda





Meeting the Challenge of  
Alzheimer's Disease and  
Related Disorders

A Vision Focused on the  
Individual, Humanism, and  
Excellence

REPORT OF THE COMMITTEE OF EXPERTS FOR  
THE DEVELOPMENT OF AN ACTION PLAN ON  
ALZHEIMER'S DISEASE AND RELATED  
DISORDERS  
HOWARD BERGMAN, M.D., CHAIR

Québec 

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# Practice to Research to Policy In Preparing the Qc AD plan

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- ◆ An approach based on emerging solutions and best evidence
  - Quebec emerging solutions
  - Evidence-based knowledge and research findings
  - Canadian and international experience
  - *In the context of the Quebec health care system*
    - ◆ *Not a parallel AD system of care*
  - 79 references: peer-reviewed papers, reports, etc
- ◆ Composition of the committee
  - Researchers with practice, policy and KT experience; managers; clinicians; patient representatives
  - Engagement more widely with stakeholder groups and with decision makers

# Seven priority actions 24 recommendations

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1. Raise awareness, inform and mobilize.
2. ***Provide access to personalized, coordinated assessment and treatment services for people with Alzheimer's and their family/informal caregivers.***
3. In the advanced stages of Alzheimer's, promote quality of life and provide access to home-support services and a choice of high-quality alternative living facilities.
4. Promote high-quality, therapeutically appropriate end-of-life care that respects people's wishes, dignity and comfort.
5. Treat family/informal caregivers as partners who need support.
6. Develop and support training programs.
7. Mobilize all members of the university, public and private sectors, for an unprecedented research effort.



# Access to personalized, coordinated evaluation and treatment

## *The Challenge*

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- ◆ Complex disease requiring:
  - Many interactions both inside and outside the health care system
  - Complex medical and multiprofessional follow-up, associated with frequent comorbidities in older persons
- ◆ Not considered to be a chronic disease:
  - Few dedicated resources
  - Lack of integrated clinical approach
- ◆ Inadequate:
  - Training and use of clinical guidelines in primary care, limiting recognition and management of the disease
- ◆ Shortage of specialized services
  - Cognition clinics, geriatric psychiatry services.



# Access to personalized, coordinated evaluation and treatment

## *The Challenge*

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### ◆ Poor access to:

- Diagnosis, treatment (including behavioral issues), support for patients and their caregivers
- Integrated management through the stages of the disease
  - ◆ Including in crises

### ◆ Memory clinics cannot handle the volume nor assure comprehensive continuity of care

- Resulting in very long waiting lists, delayed diagnosis and late intervention

### ◆ Primary care generally not prepared to deal with patients with ADR

# Provide access to personalized, coordinated services: Objectives

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- ◆ Ensure rapid access to assessment and management of the disease following a comprehensive process
  - Pharmacological, psychological, social and environmental approaches
- ◆ Innovative ways to negotiate services; faster and easier access to a varied and flexible range of services in community and specialized services
  - Develop a lasting relationship of trust between the person with Alzheimer's/family and a professional assigned to the patient as soon as the diagnosis is made



# Why primary care is seen as the way forward

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- ◆ Canadian Consensus Conferences recommendations since 1989
- ◆ Primary care
  - First contact;
  - >90% of patient-MD contacts occur in 1e care;
  - longitudinal experience with patient and family;
  - best trained and equipped to deal with older persons with multi-morbidity in the community
- ◆ Memory clinics may not be more effective—Meeuwssen et al BMJ,2012;  
Le Couteur et al BMJ 2013
- ◆ Will never be enough specialists interested and trained in ADR
  - Enormous costs



# Des interventions prometteuses en première ligne

Dimensions		Effets Positifs	Effets Neutre
<b>Processus de soins</b>	<b>Identification patients</b>	Borson 2007 Rondeau 2008 Jedenius 2008	
	<b>Pertinence référence au spécialiste</b>	<u>Lee 2010</u> Borson 2007 Rubenstein 2007	
	<b>Prescription médicaments</b>	Borson 2007 Callahan 2006	
	<b>Qualité des soins globale</b>	Vickrey 2006	
	<b>Suivi - coordination</b>	Idem clinique mémoire (Meeuwssen BMJ 2012)	
<b>Impacts Patients</b>	État cognitif – Sévérité des TCV		Callahan 2006
	<b>SCPD</b>	Callahan 2006 Clark 2004	
	État fonctionnel		Callahan 2006 Rubenstein 2007 Rondeau 2008
	Mortalité		Callahan 2006 Phelan 2007
	<b>Qualité de vie</b>	Vickrey 2006	
	<b>Satisfaction</b>	Clark 2004 <u>Lee 2010</u>	
<b>Impacts Aidants</b>	Détresse, fardeau, qualité de vie	Callahan 2006	Vickrey 2006
<b>Utilisation et coûts</b>	Hospitalisations	Clark 2004	Callahan 2006
	Placement en hébergement	Fischer 2003	Callahan 2006 Fortinski 2009
	Coûts		Jedenius 2008

# Primary Care Reform across Canada

## Family Medicine Groups (GMF) in Quebec

A key integrating factor in a complex healthcare system

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- ◆ Group practice, team based, interdisciplinary (nurse clinician/practitioners, other healthcare professionals) and inter-specialty practice
- ◆ Patient-centred, patient-active, patient/community engaged
- ◆ Pro active care, continuity of care
- ◆ Population and community responsibility through rostered population
- ◆ Integrating public health: health promotion and prevention
- ◆ Evolving remuneration
- ◆ Electronic Medical Records



# Collaborative care model

Provide access to personalized  
coordinated services

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- ◆ Approach based on the chronic-care model and the collaborative-practice model, introduced gradually, starting in Family Medicine Groups (GMFs) and CR (Cliniques Réseaux)
- ◆ **The primary care physician and the nurse clinician responsible for continuity of patient care**
  - partnership with patient and family in assessment, diagnosis, treatment, monitoring, and follow-up
  - The nurse clinician plays the role of Alzheimer's nurse care navigator.

Callahan JAMA 2006



# Vital support elements for the GMF

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- ◆ Training for physicians, nurses, and other members of the team
- ◆ Clinical guidelines and standardized tools for decision making and follow-up
- ◆ Additional human resources as required, including psychosocial professionals
- ◆ Revised and specific medical remuneration structure
- ◆ Easy user friendly access to the required technical platforms; information technology
- ◆ Elimination of the exceptional drug status for Alzheimer's medications

# Provide access to personalized, coordinated services

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## ◆ Fast, easy, flexible access to specific, specialized resources as the disease progresses

- Memory Clinics
  - ◆ Secondary and tertiary care
- Behavior and Psychological Systems of Dementia teams
- Psychosocial resources
  - ◆ Alzheimer's Support Centres (ASC)
- Home care programs
- Optimal hospital stay and transitions



# Implementation

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- ◆ Ministerial decision with budget after ministerial study of the Qc AD plan recommendations
  - Strategic ministerial team for implementation
    - ◆ Included HB, author of the Plan as advisor
  - Mobilisation/consultation of clinical milieu
- ◆ Priority: Primary care
  - Implementation projects (\$250,000/year/project) in GMF's to then scale-up
  - Objectives: enable/empower primary care clinicians (mainly MD-Nurse team) to detect, Dx, Tx, follow vast majority of AD

# Quick and dirty study at ministry request

Vedel et al

## ◆ What is out there

- The good, the bad and the ugly
- What are the emerging solutions

## ◆ 11 GMF's in diverse regions

- Qualitative
- Interviews with clinicians
- Review of documentation

## ◆ Results

- key elements necessary for the optimal organisation of services for patients and caregivers
- strategic elements for successful implementation
- potential barriers

# Already implemented in certain GMF's

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- ◆ Detection of patients with memory problems
- ◆ Cognitive and functional assessment by nurse with MD
- ◆ Diagnosis of typical dementia
- ◆ Communication of diagnosis
- ◆ Initiation of treatment by MD and joint proactive management/follow-up by MD and nurse
- ◆ Training, utilisation of standardized instruments
- ◆ Links with
  - memory clinics
  - Community based services
  - AD society



# Implementation

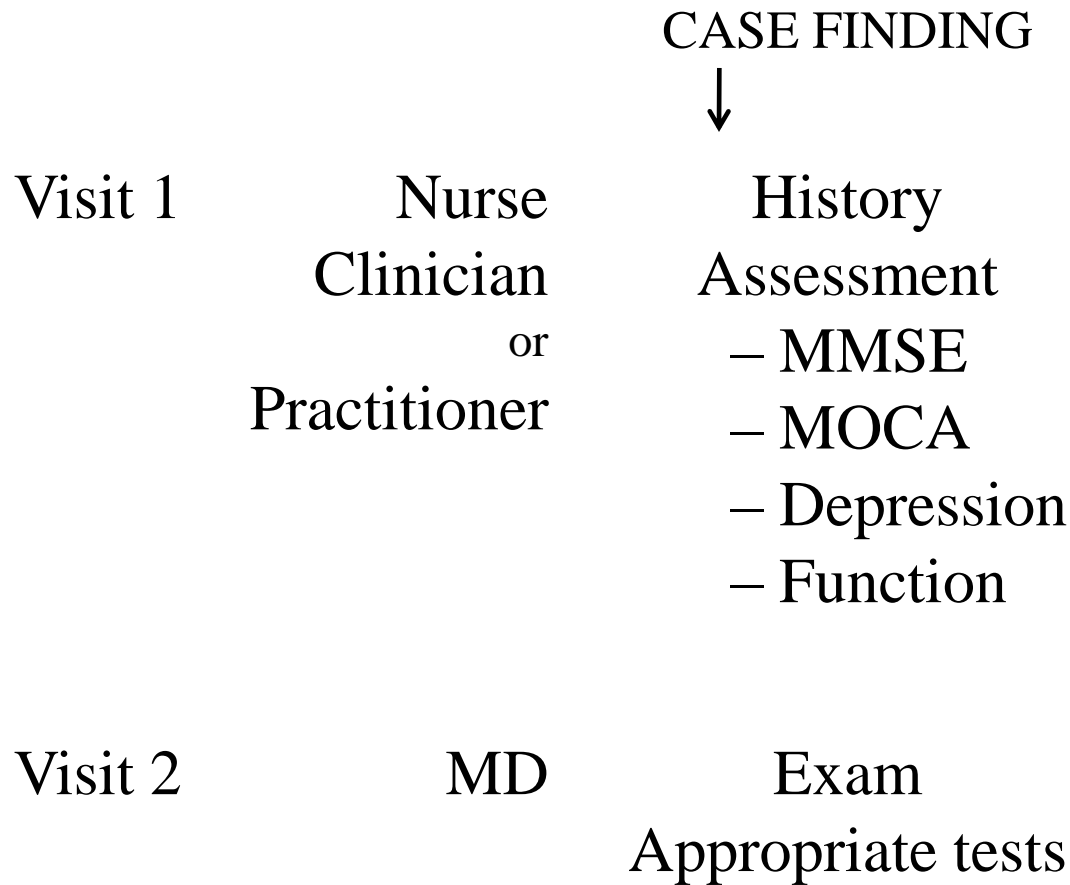
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- ◆ Call and selection of 19 implementation projects based in 38 GMF's and in partnership with specialty and community based-care
  - Diverse regions (urban/rural), populations
  - Diverse approaches
- ◆ Support for sites
  - An interdisciplinary, proactive trajectory of care
  - A training strategy for MDs, nurses, other clinicians
  - Utilisation of guidelines



# First 6 Month PATIENT TRAJECTORY IN PRIMARY CARE

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# PATIENT TRAJECTORY IN PRIMARY CARE

## First 6 Months

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Visit 3	MD and Nurse	Explanation/Discussion DX and TX plan	Referral as necessary • Memory Clinic; psychoger team • AD Society; community services
Visit 4 (2 weeks)	Nurse	Telephone call	
Visit 5 (3 months)	Nurse	Review assessment	
Visit 6 (6 months)	MD and Nurse	Review Assessment	



# Evaluation of the Implementation

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- ◆ Having made the policy decision, what lessons can be learned from the initial implementation projects in order to better understand the essential elements for improvement and scaling-up
  - Peer-reviewed FRQS/Pfizer grant
  - Qc wide team led by Isabelle Vedel under the umbrella of the Quebec Primary Care Research Network
- ◆ Integration of research and knowledge transfer
  - Early rapid feedback for early rapid improvement through participatory research and developmental evaluation



# The Canadian Experience

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- ◆ In ON, AD plan (1999 and 2004) mainly focused on increasing awareness and training of physicians
  - Development of important «bottom-up» initiatives (Lee, Moore, etc)
  - 14 Local Health Integration Networks (LHIN) introduced programming for seniors with cognitive impairment
  - 12 FHT have already implemented innovative interventions
    - ◆ Diverse approaches including family medicine memory consultation in FHTs
    - ◆ Urban/rural
  
- ◆ Initiatives in other provinces eg NB





# Canadian Team for Healthcare services/system Improvement in Dementia Care

A major sustainable Canadian research team

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- ◆ Interdisciplinary team including researchers and stakeholders (patients-caregivers-citizens, decision makers, managers and clinicians)
- ◆ Basis for an ongoing Canadian and international research and policy network bringing together decision-makers (ministry), managers, clinicians, patients and caregivers and researchers

# Partners

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- ◆ Researcher team actively engaged with stakeholder groups:
  - Decision-makers (e.g. Ministries of health)
  - Patients/family (e.g. Alzheimer society)
  - Administrators (local/regional)
  - Clinicians (PCP, NP, pharmacists)
  - Industry
- ◆ Canadian Partners Council
- ◆ International advisory committee (PAHO/WHO, 4 high income, 2 middle income countries)
- ◆ INSPQ (Institut national de santé publique du Québec) in Qc and ICES (The Institute for Clinical Evaluative Sciences in ON)

# Research Program Objectives

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## ◆ Overall objective:

- Understand, refine, improve and facilitate rapid dissemination and scale up successful and sustainable collaborative care models in Qc, ON, and across Canada

## ◆ Specific objectives:

- Evaluate the Qc/ON (and possibly NB) interventions with rapid, pertinent and actionable results for key partners in order to refine the interventions
- Identify key components and key contextual factors that are linked with an optimal impact and scaling-up

# 2 interrelated studies will cross-fertilize each other

- ◆ Study 1: Evaluate impact of the intervention (Quantitative study)
  - Accessibility, continuity, coordination
  - Quality of care; patient/caregiver outcomes
  - Utilization of healthcare services
  - Longitudinal quasi-experimental study (implementation sites vs. control sites)
  - Chart review with admin database linkage
  
- ◆ Study 2: Implementation dynamics (Qualitative study)
  - Understand the change process occurring in the GMFs and FHTs and experience of the partners involved
  - Mainly interviews with clinicians, decision makers-managers, family caregivers, patients and patient groups
  
- ◆ Gender based analyses, rural/urban, immigrant, multi-ethnic, aboriginal

# An Innovative Transformative Approach

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## Integration of research and knowledge transfer and exchange (KTE)

- ◆ *Participatory research*: stakeholders involved in defining outcome measures/feedback to sites, drawing conclusions
- ◆ *Developmental evaluation*: rapid-**as the study unfolds**- impact on health system improvement and practice
  - Rapid dissemination of innovation/best practices
  - Primarily through the ON and Qc experience (possibly others) with early input/dissemination to other Canadian provinces

# Conclusion

## a Canadian perspective for innovation for health system improvement in dementia care

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- ◆ Implementation projects with the perspective of scaling up
  - Evaluation for site improvement and to rapidly facilitate adaptation and dissemination
- ◆ Based in primary medical care closely linked and supported by to specialty care; interdisciplinary clinical leadership
- ◆ Paradigm for management of multiple chronic disease
- ◆ Training for students, residents and grad students
- ◆ True partnership: researchers, decision-makers, managers, clinicians, patient-caregiver
- ◆ Basis for ongoing Canadian and international research and policy

# For a copy of the QC AD report

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## French

- <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2009/09-829-01W.pdf>

## English

- <http://www.medicine.mcgill.ca/geriatrics/QuebecAlzheimerPlanEnglish.pdf>

For Vedel report

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