Developing and implementing provincial Alzheimer Strategies
Lessons learned from the Quebec Alzheimer Plan

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Context

◆ 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
Mandate from the Quebec Minister of Health

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

May 2009
An approach focused on the individual, humanism and excellence

- Respect the dignity and choices of people with Alzheimer’s and their families
- Draw on emerging solutions validated by:
  - Evidence-based knowledge and research findings
  - Canadian and international experience
  - In the context of the Quebec health care system
- Promote an organizational culture characterized by:
  - Empowering people
  - Evaluating practices
  - Continuously improving quality and accessibility
  - Ensuring accountability
- Recognize and mobilize all sectors concerned by Alzheimer's disease and foster synergies among them.
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<th>Normal cognition</th>
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<td>Detection/diagnosis and investigation/treatment</td>
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**Progression of the disease**

- Society
- Public health
- Regional health and social services (ASSSs) and local health and social services (CSSSs)
- Primary medical

*Primary medical supported by specialized services*

**Ethical Issues**

- Families
- Informal caregivers

**Research and Innovation**

- Alternative living arrangements

**Behavioral and Psychological Symptoms of Dementia**

- Families/informal caregivers

* Depending on needs and stages: specialized memory clinics, psychiatry, geriatrics, urology*
Seven priority actions
24 recommendations

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

◆ 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

◆ 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

◆ 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
Contrary to most, if not all national Alzheimer Plans, The Quebec AD Plan, and in fact the Canadian approach, is grounded in primary care with the support of secondary and tertiary care.
Primary care as the way forward

◆ Canadian Consensus Conferences recommendations since 1989

◆ Primary care
  • First contact;
  • >90% of patient-MD contacts occur in primary care;
  • longitudinal experience with patient and family;
  • best trained and equipped to deal with older persons with multimorbidity in the community

◆ Memory clinics may not be more effective—Meeuwsen et al BMJ, 2012; Le Couteur et al BMJ 2013

◆ Will never be enough specialists interested and trained in ADR
  – Enormous costs
Primary Care Reform across Canada
Family Medicine Groups (GMF) in Quebec
A key integrating factor in a complex healthcare system

◆ 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

◆ Approach based on the chronic-care model and the collaborative-practice model, introduced gradually, starting in Family Medicine Groups (GMFs)

◆ 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

◆ 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

◆ 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

◆ Ministerial decision with budget after ministerial study of the Qc AD plan recommendations
  • Strategic ministerial team for implementation
  • Mobilisation/consultation of clinical milieu
  • Quick study in primary care: the good, the bad and the ugly

◆ 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
Implementation

◆ Call and selection of 19 implementation projects based in 40 GMF’s and in partnership with specialty and community based-care
  • Diverse regions (urban/rural), populations
  • Diverse approaches

◆ Evaluation for scaling up: What does the government want to know
  • Does it work or not Or rather 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

◆ Support for sites
  • An interdisciplinary, proactive trajectory of care linked to guidelines
  • A training strategy for MDs, nurses, other clinicians
1. REPÉRAGE

A. Personnes de ≥ 75 ans qui renouvellent leur permis de conduire (formulaire M28 de la SAAQ)
B. Personnes de ≥ 65 ans à grand risque
   a. ACV (Accident cérébral-vasculaire)
   b. ICT (Ischémie cérébrale transitoire)
   c. Délirium récent
   d. 1ère dépression après 65 ans
   e. Parkinson
C. Cas suspects (plaintes de la personne, des proches ou suspicion clinique)
   a. Oubli médication / rendez-vous
   b. Se tourne vers l’accompagnant pour répondre aux questions
   c. Changements de comportement (apparence, humeur...)
   d. Retrait social
   e. Difficultés d’expression

Décision par médecin ou infirmière d’enclencher une évaluation

2. VISITE D’ÉVALUATION ET COLLECTE DE DONNÉES PAR L’INFIRMIÈRE CLINICIENNE OU PRATICIENNE (OU AUTRE CLINICIEN DÉSIGNÉ) DU GMF — en présence de l’aidant si le patient est d’accord

A. Histoire familiale, antécédents personnels, soutien social et familial, contexte psycho-social...
B. MMSE (Mini Mental State Examination-Folstein)
C. MOCA (Montreal Cognitive Assessment) qui inclut le test de l’horloge
D. GDS-15 ou GDS-5 (Geriatric Depression Scale)
E. Évaluation fonctionnelle

Informations transmises au médecin

TESTS

Mini-COG
OU
DRD (dépistage rapide de la déméncie)

Si positif
Revoir dans 6 à 12 mois
Si négatif
3. VISITE D’ÉVALUATION MÉDICALE – à partir des informations transmises et à partir d’un examen physique et neurologique s’il y a lieu
   A. Décision si investigations supplémentaires, par exemple : prises de sang, imagerie, ...
   B. Décision sur demande de consultation complémentaire : clinique de mémoire, équipe SCPD, clinique de gériatrie (voir les guides pratiques en annexe)
   C. Si l’investigation est complète et qu’il n’y a pas de consultations complémentaire à demander, l’annonce du diagnostic pourrait être faite au terme de cette visite.

4. VISITE D’ANNONCE DU DIAGNOSTIC PAR LE MÉDECIN - en présence de l’infirmière si possible
   A. Annonce du diagnostic
   B. Présentation du plan traitement et discussion (s’il y a lieu)
   C. Demande RAMQ (avec formulaire de remboursement complet)

5. VISITE AVEC L’INFSIRMIÈRE POUR PARLER DU DIAGNOSTIC ET DU SUIVI À VENIR – cet échange peut se faire à la suite de l’annonce par le médecin ou dans les jours qui suivent
   A. Établir une relation de confiance avec la personne atteinte et ses proches
   B. Donner ses coordonnées directes pour que le patient ou le proche aidant puissent contacter l’infirmière si besoin
   C. Échanger sur le diagnostic et le plan de traitement
   D. Évaluer les besoins et l’état psychologique du patient et de l’aidant
   E. Éducation et explications sur la maladie
      a. Discussion du besoin évaluation de la conduite automobile
      b. Évaluation des risques prise de médication
      c. Évaluation des risques financiers
   F. Références s’il y a lieu
      a. Services communautaires appropriés (Société d’Alzheimer ou Appui)
      b. CLSC
      c. Popote roulante
      d. Aide dans la communauté

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The Challenge of Implementation

“Hey, no problem!”
The challenge of implementation re accessibility

◆ Implementation projects clearly anchored in primary medical care-Family Health Teams
  ▪ With clear mandate, expectations, deliverables, accountability
  ▪ Convince/mobilise clinicians in transformative change
  ▪ Role models, early success, MD/nurse
  ▪ Support planned before and early on in implementation
    • Guidelines, training, mentorship and coaching
  ▪ Easy user friendly access to memory clinics and other specialty care and community care
  ▪ Rethink AD clinical research paradigm

◆ Success closely linked to the capacity of primary care to manage chronic disease and multi morbidity in older persons
  ▪ Inseparable from primary care reform and chronic disease management

◆ Plan/Establish evaluation at the same time as implementation

◆ Overcome healthcare system inertia
The Canadian Experience

◆ 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
Practice to Research to Policy

The Canadian Team for healthcare services/system improvement in dementia care (CCNA)

A collaborative care model in primary health care for persons with Alzheimer’s disease/related disorders and with other chronic diseases

◆ Produce rapid and pertinent results for stakeholders (patients-caregivers-citizens, decision makers, managers and clinicians), in order to refine the collCM for persons with ADR+ CD, maximizing its effectiveness and its efficacy;
  • Refine essential structures and processes necessary for maximizing impact of the collCM
  • Identify key strategies for implementation and dissemination necessary for uptake and sustainability of the collCM

◆ Systematically evaluate the impact of the refined collCM;

◆ Facilitate knowledge exchange and effective linkages to facilitate the adaptation, dissemination and sustainability of the collCM in the two provinces and in Canada.
Conclusion
a Canadian perspective for innovation for health system improvement in dementia care

◆ 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

French

English

For Vedel report

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