The Quebec Alzheimer Plan: Impact on Dementia Care Management in Family Medicine Groups

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Meeting the Challenge of Alzheimer’s Disease and Related Disorders

A Vision Focused on the Individual, Humanism, and Excellence

Report from 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
Collaborative primary care model

Patient - Caregiver

Case finding – diagnosis
Treatment – follow-up

Family Medicine Group (FMG)

Family Physician
Nurse / Social worker

Support/Complex cases
Specialized services – Memory Clinic

Coordination - transition
Home-based services, community pharmacy, hospital, Alzheimer society
Implementation

• Ministerial decision
• Priority: Primary care (Family Medicine Groups - FMGs)
• Implementation projects in 40 FMG’s since in 2012
  • $250,000 per project
  • Support: Project managers, guidelines, training
• Now in scaling up phase
Two interrelated cross-fertilizing studies

- To identify the impact of the QC Alzheimer plan on detection, diagnosis, referral patterns, and quality of follow-up

  OBSERVATIONAL (Quantitative) Study:
  Isabelle Vedel MD, PhD

- To examine the implementation strategies used in order to identify key factors for successful development and large-scale up-take across Canada

  IMPLEMENTATION (Qualitative) Study
  Yves Couturier, PhD

Participatory research approach.
Continuous KTE with stakeholders: decision-makers, managers, clinicians and patients and caregivers representatives.
Provincial, Canadian and International Councils
## Data collection

### Observational Study (Quantitative)
- Pre-Post Chart review
  - 13 FMGs
  - 1,919 charts (Patients 75+ with and without cognitive impairment)
- Questionnaires
  - MDs - response rate 84%
  - Nurses - response rate 66%

### Implementation study (qualitative)
- Interviews
  - Family caregivers (n=9)
  - Clinicians and managers (n=45)
- 16 focus groups (n=100 clinicians)
- Observations of meetings
- Analysis of documentation
RESULTS
### In Patients 75+

|                                | PRE          | POST         | OR (95% CI) |
|                                | N = 944      | N = 975      |             |
| Note regarding cognitive status| 351 (37.2 %) | 440 (45.1 %) | 1.46 (1.18-1.81) |
| Documented diagnosis/condition | 208 (22.0 %) | 255 (26.2 %) | 1.25 (0.98-1.60) |
| Dementia                        | 127 (13.5 %) | 141 (14.5 %) | -           |
| MCI                             | 41 (4.3 %)   | 52 (5.3 %)   | -           |
| Unspecified cognitive impairment| 40 (4.2 %)   | 62 (3.4 %)   | -           |
| None                            | 736 (78.0 %) | 720 (73.8 %) | -           |
| Cognitive testing               | 137 (14.6 %) | 166 (17.1 %) | 1.21 (0.92-1.60) |
| Referred to memory clinic       | 22 (2.5 %)   | 19 (2.1 %)   | 0.84 (0.42-1.68) |
| Pertinent references            | 14 (63.6 %)  | 16 (84.2 %)  | -           |
| Impertinent references          | 6 (27.3 %)   | 3 (15.8 %)   | -           |
| Other/unknown                   | 2 (9.1 %)    | 0 (0.0 %)    | -           |
In Patients 75+ with cognitive impairment

<table>
<thead>
<tr>
<th></th>
<th>PRE N = 455</th>
<th>POST N = 490</th>
<th>OR / adjusted Mean difference (95% CI)</th>
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</thead>
<tbody>
<tr>
<td>Number of contacts with the FMG, mean (SD)</td>
<td>7.9 (10.2)</td>
<td>9.9 (9.7)</td>
<td>1.57 (0.30-2.84)</td>
</tr>
<tr>
<td>Quality of follow-up score, mean (SD)</td>
<td>44.1 (19.7)</td>
<td>52.0 (18.8)</td>
<td>8.06 (5.40-10.72)</td>
</tr>
<tr>
<td>Use of antipsychotics</td>
<td>162 (35.6 %)</td>
<td>175 (35.7 %)</td>
<td>0.89 (0.65-1.23)</td>
</tr>
<tr>
<td>Prescription of Memantine and cholinesterase inhibitors by FMG</td>
<td>27 (71.1 %)</td>
<td>26 (72.2 %)</td>
<td>0.81 (0.23-2.81)</td>
</tr>
</tbody>
</table>
Change in quality of dementia care among patients 75+ with cognitive impairment

<table>
<thead>
<tr>
<th>Weight</th>
<th>Function</th>
<th>BPSD</th>
<th>Driving</th>
<th>Home Care</th>
<th>Alz Soc</th>
<th>Caregiver</th>
<th>Alz Med</th>
<th>Cog Test</th>
<th>Antichol Med</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td>58.2</td>
<td>69.7</td>
<td>69.9</td>
<td>11.4</td>
<td>52.1</td>
<td>1.8</td>
<td>23.5</td>
<td>20.7</td>
<td>49.7</td>
</tr>
<tr>
<td>Post</td>
<td>70.6</td>
<td>81.0</td>
<td>81.2</td>
<td>20.0</td>
<td>60.0</td>
<td>6.7</td>
<td>27.1</td>
<td>21.4</td>
<td>48.8</td>
</tr>
</tbody>
</table>
HOW TO EXPLAIN THESE RESULTS?
Positive knowledge, attitudes and practices of FMGs’ clinicians

- Clinicians have good clinical knowledge and perceive themselves as being competent
- Good attitude towards dementia
- Agreement with the principles and objectives of the plan
  - But not enough training and mentoring

Legend:
- Disagree
- Somewhat disagree
- Somewhat agree
- Agree
Facilitators/barriers

- Presence of a support strategy
  - Project managers
  - High satisfaction with developed tools
    - Sometimes implemented too late
  - Challenges to the maintenance of leadership in the FMGs vs. health agencies
- Identification of a FMG champion
  - Supported by project managers, tools and specialists-trained family physicians
  - Challenges to involve non-champion physicians
- The role of FMGs’ nurses is key
  - Good collaboration with physicians
    - But poor participation in the detection of patients
    - Challenge to the integration of new clinicians (eg. social workers)
    - Disclosure of diagnosis: not always done
Conclusion

• It is feasible to anchor national Alzheimer Plans in primary care
  • More awareness in FMGs’ clinicians without an associated increase in referrals in older patients
  • Improved intensity and quality of care for patients with cognitive impairments
  • Primary care clinicians are interested, feel competent and can manage patients with dementia
• Still some room for improvement
• Limitations: pre-post design
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