ROSA
Research on Organization of Healthcare Services for Alzheimers
Canadian Team for Healthcare Services/System Improvement in Dementia Care

THE QUÉBEC ALZHEIMER PLAN

Sharing the experience of its implementation to strengthen primary care

Policy brief (short)

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June 2021

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Highlights

- It is possible to meet the **primary care** needs of people living with dementia and their families:
  - through collaboration between professionals (physicians, nurses, and social workers);
  - by implementing an approach focused on the person rather than the disease;
  - by limiting the inappropriate use of specialized care.
- The **winning conditions** are:
  - the presence of effective innovators who have both policy and clinical credibility;
  - the introduction of a partnership-based governance system and a vast change support mechanism by the ministry;
  - the mobilization of primary care clinicians in family medicine groups, and the development of professional and organizational capacities;
  - the ongoing evaluation of the implementation by a team of independent researchers.

Context

- The accessibility and quality of the care provided to people living with dementia and their families represents a major challenge for health and social services systems due to the complexity of the disease, the growing number of people affected, and the advent of new therapies requiring the use of biomarkers.
- Under the Québec Alzheimer Plan, primary care clinicians are responsible for detecting, assessing, and following people living with dementia in family medicine groups (the user's attending clinicians). Specialized care, such as memory clinics, is reserved for more complex clinical situations.
- The choice to focus on primary care is in line with the Canadian Consensus Conferences on the Diagnosis and Treatment of Dementia.

Implementation of the Québec Alzheimer Plan

Phase I :
local implementation
2013-2016

Phase II :
general implementation
2016-2019

Phase III :
consolidation and expansion
2020 - ongoing

- Phase I gave rise to 19 innovative projects in 38 family medicine groups in various regions of Québec. These projects were developed by and for the primary care sector. Phase I provided lessons on the conditions that support the implementation of the Plan.
- Phase II focused on the general implementation of the changes in all family medicine groups.
- Phase III aims to consolidate the changes in family medicine groups (detection, assessment, and follow-up). The plan is also to perform a post-COVID follow-up of new realities, to improve care transitions, and to strengthen practices for behavioural and psychological symptoms.

Evaluation of the Québec Alzheimer Plan

- At the beginning of Phase I, a call for applications was issued to select an independent evaluation team tasked with studying the implementation processes and outcomes. Our team was chosen.
- This developmental evaluation is both quantitative and qualitative.
- To promote knowledge transfer, our team works closely with the people in charge of implementation and participates in the main implementation committees. However, we do not have decision-making powers.

Outcomes

- An evaluation of Phase I shows an **increase in the quality of follow-up** in family medicine groups:
  - The average number of annual contacts between patients and clinicians increased from 7,9 to 9,9.
  - Referrals to a memory clinic after a diagnosis decreased from 12 % to 9 %.
  - The proportion of unjustified referrals to a memory clinic dropped from 20 % to 7 %.
- The **change management** strategy played a major role. Four regional project managers supported the family medicine groups. Their presence helped to manage the tensions between the necessary local adaptations and compliance with the fundamental principles of change targeted by the Québec Alzheimer Plan.
- The support system was generally maintained during Phase II, although the significant increase in the number of family medicine groups affected by the change resulted in a **dilution of the support resources**.
- **Leadership has sometimes been inconsistent from one region to the next**. As a result, the degree of progress in implementing the change varies by region.
- Family medicine groups are **all different** and are marked by **a high degree of autonomy of the medical professionals** who work there.
- The innovative projects (Phase I) have helped to: create a better understanding of the **implementation conditions**, **mobilize** the clinicians, show them that change is **feasible**, and encourage their **buy-in** for the process. The presence of a **physician champion** within the family medicine group is an important condition for mobilizing other physicians.
- The **pandemic has undermined some of the progress made**; a consolidation strategy will be needed.

Lessons to be learned from the Québec Alzheimer Plan

- It is possible to strengthen the capacities of family medicine groups (detection, assessment, and follow-up) and for these organizations to provide good quality care. Consequently, specialized care, which by nature is expensive and difficult to access, can focus on people with complex clinical situations.
- The development of professional capacities and the introduction of a vast change support mechanism are drivers for the implementation and generalization of the plan.
- A multi-phase implementation strategy is essential to fully understand the changes, engage the clinicians in family medicine groups, learn more about the implementation conditions, and generalize and consolidate the change.
- However, the transition from a local implementation phase to a generalization phase is a critical moment that requires an increase in support resources.

Learn more...

Three complementary tools

Posters
3 pages

Webinar
30 minutes

Policy brief (long)
27 pages

HealthcareExcellence.ca/QuebecAlzheimerPlan

Contact us

Discussion and possible support

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Additional resources are available online

Government resources

Bergman H. (2009). *Meeting the Challenge of Alzheimer's Disease and Related Disorders: A Vision Focused on the Individual, Humanism and Excellence (Bergman Report).* Available online: www.mcgill.ca/geriatrics/files/geriatrics/qap_english.pdf

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Scientific resources

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Arsenault-Lapierre G, Henein M, Rojas-Rozo L, Bergman H, Couturier Y, Vedel I. Primary care clinicians' attitudes, knowledge and practice toward dementia: they are willing and need training! *Canadian Family Physician journal – commentary* (accepted 2021).

Guillette M, Couturier Y, Lanneville D, Tannouche-Bennani S, Thiam Y, Belzile L, Vedel I, Bergman, H. (2018). *Literature Review: Alzheimer's Disease Policies in OECD Countries*. Available online: www.savoirs.usherbrooke.ca/handle/11143/14189

Healthcare Excellence Canada is an independent, not-for-profit charity funded primarily by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.