

Session 1: Implementation Strategy

1. “When implementing a plan, which approach is preferable: Having a first phase with implementation projects to develop lessons for improvement and scaling-up, then generalize, or go straight into generalization? Why?
 - a. With the first approach, how do we ensure the initial implementation projects are not «diluted» in the generalization phase (how do we keep up the level of support, inspiration and management, training activities, updated protocols etc.)
2. What is the role of the provincial ministry and regional jurisdictions in inspiring change, ensuring training programs, change management, keeping up to date with latest evidence, further pathway and protocol development etc.?
3. What are key barriers and facilitators to implementing within the GMF/FHTs etc.?
 - a. Which of these are key elements for scaling up and generalisation?
 - b. What resources are needed to support treating family medicine teams? What kind of support do they need?
4. Implementation in non-GMF/FHT general practices; how does it differ and how should it be approached?”

Generally, having a pilot to implementation was seen a positive and necessary element. Firstly, pilot projects came together with the identification of champions and leaders who were passionate about the issue. Both family doctors and nurses within the family medicine groups were needed as champions, in order to draw in the support of the entire clinical team. As happens often in projects with limited funds, it was passion driving involvement, and not financial incentives. While this worked for pilot projects, it is harder for scaling-up initiatives, since most of the very enthusiastic parties are already on board.

No matter the system in place, (family medicine groups, solo practice or mobile memory clinics), the need for champions and at the local and regional levels remained critical for scaling up. In New Brunswick for example, the mobile memory clinics still require a champion and support network of social workers, pharmacists and nurses.

Reflecting this challenge of scaling-up, pilot projects were also seen as providing evidence that the implementation could work, was suited for the primary care setting, and that it had positive results for patients. Some sites found that documenting the impact of the pilot project, or being involved with research projects, were a good way to ‘sell’ future iterations of implementation. It also helped identify further elements needed for success, or ways to improve iterations.

For example, one element identified was the need to scale up links and network sharing with community and homecare organizations in tandem with building the capacity in primary care, otherwise there is the threat of bottlenecks in transferring care from the clinic to the home. Additional administrative support was also needed to deal with the organizational issues, and the division of responsibilities between the different management levels, as well as within the healthcare teams, was unclear.

Despite the shift to primary care, partnerships with specialists and memory clinics were still critical for consultation and support as ‘experts’. Further training for entire health teams was

needed, but the additional training was not outside the scope of primary care. Refresher courses provided by memory clinic experts were given each year, and in Quebec there was a program for training nurses, who were then able to go and train other practitioners in the family health groups and in homecare. In the future, the College of family physicians of Canada will need to update their curriculum to include these topics so new physicians are prepared to deal with dementia in the primary care setting.

Another positive element to the use of pilot projects was the ability for them to be locally driven and very context-specific. If Quebec's Alzheimer plan was implemented generally across the province, that flexibility would be impossible to achieve. Champions were able to learn about their regions and use an iterative process to come up with the best solutions for their practices. Coordinating committees from the family health groups were able to work in partnership with the CIUSS, instead of given specific instructions for implementation they could not adapt.

Lastly, it was noted that the term 'pilot' project itself came with some wariness, especially surrounding funding. Groups either felt that there would be no money available to pilot projects, or that there would be money and enthusiasm for the pilot phase, but that momentum would be lost when it came to generalization to the rest of the province.

Session 2: Interdisciplinary care (within primary care), and the role of specialty care (memory clinics)

1. What are the roles and responsibilities of social workers, nurses, physicians, and how do you go about organizing the interdisciplinary approach?
 - a. What are barriers and facilitators to interdisciplinary care?
 - b. What are lessons from the experience working with interdisciplinary teams in QC and ON?
2. The Canadian plans are anchored in primary care, compared to the British and French plans that are anchored in specialist care; what are they key differences, benefits and pitfalls?
 - a. What does it mean to be anchored in primary care?
 - b. What is the role of specialist memory clinics?
 - c. The role of a Family medicine memory clinic within the GMF/FHT?
 - i. What is the role of a family physician resource person in the GMF/FHT?

There was a group consensus that in order for an interdisciplinary team to work, there needed to be mutual respect and confidence in the quality of care. It was noted that physician familiarity with the expertise and capacity offered by nurse practitioners, led to increased confidence in their abilities, and more readily set up a health team. For example, in Quebec, the nurses who had previous experience working in diabetes teams were more accepted into dementia care. This experience with interdisciplinary health teams in general, both past and present, made a strong case for using health teams in dementia care. Again, in Quebec the experience using health teams for diabetes worked very well, and the improved patient care while reducing physician workload really sold the idea of health teams to other doctors.

Nurses were seen as being especially valuable in this shift to interdisciplinary care. Due to their involvement in other chronic disease matters, often the patient-base for dementia was similar, giving them familiarity with the patients. They were also able to play the role of ‘point of contact’ where applicable for the patients and their families, and coordinate follow-up and concerns.

Interdisciplinary care can take many different forms, adapting to the geographical constraints of each region. Teleconferences were especially interesting for teams that worked across many different sites. Roles, responsibilities and the extent of the collaboration with physicians varied across the regions and sites, and over time. Both Ontario and Quebec had experiences with successful teams where each member was able to fully play their role with the patient depending on their personal expertise. This variation is often dictated by the needs of the patient – with someone who has more need of social support, the social worker may take charge of the management and follow-up of their file.

The experience of treating dementia has evolved from being the doctor alone, seeing his patients every three months, to working with nurse practitioners who took over education and did joint follow-up, allowing the doctor to see the patient less often. In dementia care, nurses can do the cognitive tests, education, support for caregivers, and thanks to the collective agreement, can prescribe blood tests and imaging, as well as medication (due to the medication protocols). Now

we have the addition of the social workers, that are familiar with the local networks and communities. Their arrival changed the access to homecare services, because they speak the same language as the social workers from these networks.

Defining the roles in interdisciplinary care too precisely, or being strict about who can do what turns out to be a barrier to team care. When the INESS delineated which professionals could conduct a function test, it hampered the ability of teams to adapt and change according to the needs of the patient. On the other hand, training different health professionals together creates a sense of teamwork, and often improves collaboration.

There are still challenges to overcome when it comes to interdisciplinary care. Different health professionals are regulated by different professional orders, and they do not always agree. In Ontario, not every profession received the same training, or is subject to the same regulations about what they can communicate to the caregivers – especially those who do not have legal authority to make decisions for the patient. Physiotherapists are ahead in this regard, but young doctors aren't as aware of their rights and responsibilities when it comes to caregivers of patients with neurocognitive disorders. In Quebec, the role of nurses is currently being redefined, which will bring adjustments for everyone on the team.

Another challenge is how different training backgrounds and perspectives can affect communication between team members. The addition of pharmacists to the mix will only add to this potential for communication. Additionally, roles of different health professionals are constantly evolving, and being redrawn.

For many patients still, the absence of a single reference point of care can be confusing, as well as the communication of information from many different sources, some which may be redundant or contradictory. For home-care workers, there is also ambiguity when they don't receive the results of the function-tests, or to know what are the latest instructions from the care team in the case of acute care.

Session 3: Coordination with community organizations, caregivers and homecare services

1. What is the role and place of Alzheimer Societies and other community organizations in the identification and management of patients?
 - a. Is this role evolving with the increasing interdisciplinary intervention within FHTs and GMFs?
2. What are the roles and responsibilities for home care?
 - a. How do the GMFs/FHTs coordinate with home care and other community organizations?
 - b. As the disease progresses in a patient, how do you maintain clinical involvement and responsibilities of the GMF/FHTs and their engagement with homecare and community services?
3. For patients with and without family or social support, do their care protocols change?
 - a. How does the presence of the caregiver affect patient care pathways?

It is better for the system for patients to stay in their homes for as long as possible. Financially there are less costs to the system, and better outcomes for the patient. Unfortunately, many patients end up institutionalized due to caregiver burnout, so there is a clear need to support caregivers and provide them with respite and resources. The Alzheimer societies have many of these resources and program available – the issue then becomes defining what their needs are, then outreach and building better links between the clinics and the community.

A challenge to this is that many caregivers do not think of themselves in that role, and rather just see themselves as a spouse or family member. They are also part of a population that does not usually reach out to services, or ask for help. There needs to be proactive methods of linking with these families. It is also important to link early, before a crisis occurs. The Alzheimer Society First Link program is funded in every province except Quebec. While in Quebec they have an agreement with the CIUSS, it is not generally supported across the province.

Some solutions include having a central contact, depending on each team and patient, where they can go for information. Online resources need to be better organized and made more accessible to patients and caregivers. Involving other community organizations, such as YMCAs or bowling alleys may also help in destigmatizing the idea of ‘day programs’ or other terms that may alienate some patients. There is a tax credit available for having a memory-friendly piece to your community organization (ex bowling alley, bingo parlor), so encouraging other community organizations to be involved that may not have previously been aware of what they can do. There has also been a move in Quebec towards the family medicine groups, so there needs to be increased communication and coordination with homecare services.