



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 (long)



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INTRODUCTION

This policy brief (long) is part of a larger set of tools aimed at sharing the experience of the Québec Alzheimer Plan; it is the most detailed tool of the set. It aims to provide an in-depth portrait of the Québec Alzheimer Plan, by exploring its development, main orientations, implementation conditions, outcomes, and potential areas of development. Readers who are pressed for time are advised to review the summarized knowledge transfer tools for the key elements.

Policy brief (short) 3 pages	Posters 3 pages	Webinar 30 minutes
		
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This policy brief (long) is divided into eight main sections; the first presents the key messages and the following seven, in the form of sheets on specific topics, provide more detail about the contents. It is designed to allow the reader to choose the sheet they wish to read, based on their needs and interests.

Feel free to contact us if you would like more information about these tools. We would be pleased to discuss them with you and to offer you personalized support.

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Care



ROSA

Recherche en organisation des
services sur l'Alzheimer

Équipe canadienne de services de
santé/amélioration du système de soins de
la démence

KEY MESSAGES



This section briefly outlines the key messages, which will be discussed in more detail in the following seven sheets.

ABOUT THE QUÉBEC ALZHEIMER PLAN

- The international and national context is conducive to putting the needs of people living with dementia on the public policy agenda.
- A precursor to the ministerial plan, the Bergman Report (2009), was written with the intention of inspiring decision makers.
- The Québec Alzheimer Plan focuses on primary care and on the person rather than the disease.
 - Its primary goal is to mobilize the doctor-nurse duo (the user's attending clinicians).
 - These clinicians are responsible for detection, diagnosis, and follow-up (comprehensive response to users' needs).
- The Québec Alzheimer Plan incorporates:
 - Partnership-based governance and an ambitious change management strategy.
 - Capacity building strategies (training, clinical tools, etc.).
 - An independent and collaborative evaluation.

KEY MESSAGES ABOUT ITS IMPLEMENTATION

- The ongoing presence of a national innovator with acumen in three areas (clinical, scientific, and political) is conducive to tabling the matter, to mobilizing stakeholders, and to ensuring the coherence of actions over time.
- A pre-implementation study and consultations with geriatricians aided in designing the model that was put forward.
- The incorporation of an implementation plan into the ministerial guidelines helped with implementation.
- The mobilization of clinical champions (from primary and specialized care) was instrumental in developing clinical tools, training, and the model that was put forward.
- A strategy for training and the dissemination of clinical tools is needed.

- Change management supported by resources is needed:
 - Confirmation from the ministry that the Québec Alzheimer Plan is a priority.
 - The ministère de la Santé et des Services sociaux (MSSS) assumes the role of promoting (stimulating) the change, through partnership-based governance.
 - An opportunity to adapt the changes to the local population and organizational realities, while remaining focused on the basic objectives of the change (*one size does not fit all*).
 - A commitment by university partners.
 - The presence of four regional project managers to manage tensions between the emergence of innovations adapted to local realities and compliance with the fundamental principles of change covered by the Québec Alzheimer Plan.
 - Substantial, stable financial support for change management.
- Partnership-based governance and the joint efforts of many stakeholders led to the development of new organizational and professional capacities. Ultimately, these approaches also led to the development of a common vision and the buy-in of various stakeholder groups.
- A sequential roll-out, in three phases, proved to be effective.
 - The first phase of the implementation led to the emergence of innovative projects, the mobilization of clinicians, and helpful lessons on which to base the generalization (phases II and III).
- The plan was supported by an independent and collaborative developmental evaluation, meant to inform decision makers throughout the implementation.

KEY MESSAGES ABOUT THE SCALE-UP

- From the very start, in planning for its generalization, the plan was conceptualized in several phases.
- The integrated implementation strategy provided for continuity of the key support elements needed to achieve generalization (e.g., regional project managers, partnership-based governance, clinical tools, financial support) during the three phases.
- Several mechanisms allowed for learning during the scale-up (developmental evaluation, project managers, reporting, and partnership-based governance).
- The transition from a local implementation phase to a generalization phase is a critical moment that requires an increase in support resources.
- The transition in leadership of the change management process from the family medicine groups to the integrated health and social services centres (called integrated centres in this report) between phases I and II is:
 - Necessary to ensure dissemination throughout Québec.
 - Difficult because of the limited capacity of these organizations (integrated centres) to effectively support the family medicine groups.
- The pandemic has undermined some of the progress made; a consolidation strategy will be needed.

KEY MESSAGES ABOUT THE IMPACTS

- The Québec Alzheimer Plan resulted in:
 - Clarification of the trajectories within primary care and between primary care and specialized care.
 - Increased detection and diagnosis of dementia in primary care.
 - An improvement in the quantity and quality of follow-ups (e.g., assessment of functional condition, and behavioural and psychological symptoms of dementia; management of medications for people with dementia).
 - An increase in the quality of referrals to memory clinics and a decrease in the proportion of people referred.
 - An increased sense of competence among primary care professionals.
 - An increase in positive attitudes toward people living with dementia.
 - An emerging sense of confidence in interprofessional teamwork.
 - An increased appreciation of the nursing role.
- The Québec Alzheimer Plan is still facing challenges:
 - Improperly coordinated intra-ministerial inconsistencies between innovations parallel to the plan.
 - A partial change in the care culture.
 - Significant variations from one context to the next.
 - Dilution of support resources during Phase II (generalization).
 - Sometimes inconsistent leadership in managing change in the integrated centres.
 - The complex nature of the change in primary care due to the organization of the medical field and staff instability.
 - Except for the champions, persistent difficulty mobilizing and training physicians.
 - Persistent challenges with certain aspects of care quality in the family medicine groups (e.g., assessment of caregiver status, ability to drive, need for community services, integration of social workers).
 - Difficulty monitoring the internal performance of family medicine groups.

The Québec Alzheimer Plan, which sets out the Québec government's major orientations in dementia, was developed in several stages. At the request of the Québec government, a group of experts made recommendations on dementia (see Bergman, 2009). The ministère de la Santé et des Services sociaux (MSSS) subsequently developed a ministerial action plan for implementing the priority recommendations. The following subsections describe the circumstances in which the Québec Alzheimer Plan emerged and the process of transforming the Bergman Report into the ministerial action plan.

EMERGENCE OF THE QUÉBEC ALZHEIMER PLAN

- The 1990s saw an increase in concern about dementia in Canada and, in part because of increased knowledge that these diseases are not the product of normal aging, but rather disorders for which aging is the main risk factor. This period was characterized by the adoption of the first provincial plan (Ontario, 1999) and by the Canadian Consensus Conferences on the Diagnosis and Treatment of Dementia (1991, 1999, 2006, 2012).
- In Québec, clinical champions were developing local initiatives aimed at strengthening primary care, which were occasionally funded by pharmaceutical companies (2000-2015).
- The adoption of new policies on dementia accelerated in the 2000s. A political window of opportunity opened up for the creation of an Alzheimer's action plan, leading to the production of the Bergman Report.

BERGMAN REPORT

- At the request of the Québec government, Dr. Howard Bergman was asked in 2007 to chair a working group on dementia made up of managers, researchers, and clinicians.
 - The committee was chaired by a clinical, policy, and scientific innovator who helped usher in a modern, integrated vision.
 - The work is based on scientific knowledge and on the Canadian Consensus Conferences on the Diagnosis and Treatment of Dementia.
 - The Bergman Report puts forth 24 recommendations divided into seven priority actions.
 - It guides reflections by decision makers and inspires clinician champions.
 - It proposes an approach centred on the person rather than the disease.
 - It was adopted in 2009.

1 Priority action 1: An awareness and prevention strategy that proposes dismantling false beliefs and informing the public about risk and protection factors (prevention).

2 Priority action 2: A rapid response to overall primary care needs that promotes fast, high-quality access to assessments and post-diagnostic follow-ups. Intervention must be focused on primary care, via inter-professional teams. Specialized services play a supporting role to primary care in complex cases.

3 Priority action 3: An improvement in care and services at the advanced stages of dementia by increasing care and services provided at home and in residential settings. The report proposes creating teams whose role is to support families and professionals when the person is exhibiting behavioural and psychological symptoms of dementia.

4 Priority action 4: Personalized support for family caregivers. The report proposes encouraging their involvement in decisions related to the care and services provided to their loved ones and supporting them from the onset of the person's disease until the end of their life.

5 Priority action 5: Adaptation of end-of-life care and services in all types of institutions, which requires more support for families, while respecting everyone's wishes.

6 Priority action 6: Ongoing training for stakeholders and development of tools to improve the abilities of managers, stakeholders, and caregivers to meet the needs of users. It is also important to develop and make available to clinicians standardized tools for the assessment, diagnosis, and treatment process.

7 Priority action 7: Research that supports leading-edge interventions. The development of research capacity across all dimensions concerned by these diseases, including treatment and social aspects, is necessary for the transformation of practices.



MINISTERIAL ACTION PLAN

The Bergman Report was well received by the ministry. Subsequently, the ministère de la Santé et des Services sociaux prioritized the recommendations of the Bergman Report, focusing primarily on the report's second priority action, namely a global response to primary care needs. A certain amount of influence was exerted to maintain the focus on primary care rather than specialized care. During the years between the Bergman Report and the ministerial plan, innovators mobilized to maintain the interest of decision makers, in particular in the wake of a change of government.

Six priority targets were identified by the ministry:

- 1 *Improve access to primary care health and social services, namely through the implementation of support measures by second- and third-line services.*
- 2 *Develop and make accessible standardized, evidence-based practice guides and tools covering all steps in the intervention process, at the various stages of the disease.*
- 3 *Develop and implement training programs on aging and, more specifically, on the evolving needs of people with Alzheimer's disease and their families.*
- 4 *Develop communication tools for third parties containing relevant information on the proper management of problems associated with Alzheimer's disease.*
- 5 *Improve the care conditions and subsequent transition during an acute care hospital stay.*
- 6 *Gradually implement a range of services for family caregivers adapted to their needs, in conjunction with community organizations involved in this activity sector.*

OBSERVATIONS ON THE TRANSFORMATION OF THE BERGMAN REPORT INTO THE MINISTERIAL PLAN

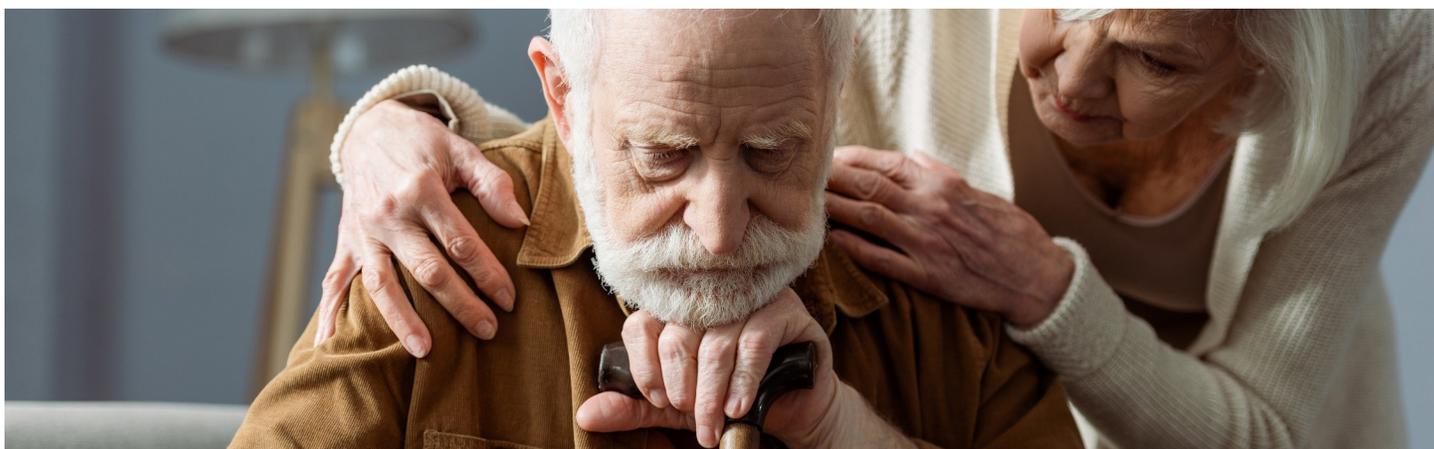
- A ministerial committee was formed to prioritize and implement the recommendations of the Bergman Report. The report contained a wide range of recommendations from prevention to improved care and services at all stages of dementia, including enhanced research efforts. The ministerial action plan focused on the dissemination of best practices and implementing a support strategy for innovative projects in family medicine groups.

- The ministerial targets cover all stages of dementia. However, the actions focused mainly on
- the early stages, detection and diagnosis, as vectors for a change in professional and organizational culture.

- Some of the recommendations in the Bergman Report were not addressed in the ministerial
- action plan (e.g., private seniors' residences, organization of long-term care, end-of-life care, etc.), although were sometimes the subject of ministerial interventions not included in the plan.

CANADIAN AND INTERNATIONAL POSITIONING OF THE QUÉBEC ALZHEIMER PLAN

- The main orientations of the Québec Alzheimer Plan are consistent with those adopted in other jurisdictions.
- However, internationally, most jurisdictions simply prioritize the detection of dementia in primary care, and then refer users to specialized resources for diagnosis and follow-up. The Québec Alzheimer Plan is therefore unique in proposing a focus on primary care throughout the entire intervention (detection, assessment, and follow-up), and in only referring patients to specialized resources in more complex cases. Three other Canadian provinces, Alberta, Manitoba, and Saskatchewan, take the same approach.
- Although not very common on the international scene, this focus on primary care is consistent with the Canadian Consensus Conferences on the Diagnosis and Treatment of Dementia.
- The ministerial action plan is also unique in that it emphasizes the presence of social workers on the interprofessional teams.



SHEET 2 EMERGENCE OF AN IMPLEMENTATION STRATEGY

To date, the Québec Alzheimer Plan has been implemented in three main phases:

Phase I (2013- 2016)

Phase I focused on the local implementation of innovative projects in volunteer family medicine groups.

Phase II (2016-2019)

Phase II focused on the generalization of the change to all family medicine groups in Québec.

Phase III (2020 - ongoing)

Phase III aims to continue generalizing and consolidating (detection, assessment, and follow-up) the change in family medicine groups. It also aims to improve clinical and organizational practices for behavioural and psychological symptoms of dementia, and to adapt the plan to the impacts of the COVID-19 pandemic.

Family medicine groups

In Québec, most family physicians work in family medicine groups. These primary care clinics (private, public, or mixed) were created in 2002, to encourage doctors to work together and improve collaboration with public services. They were initially made up of doctors and nurses. Partially inspired by the Alzheimer Plan, new professional resources arrived at these clinics starting in 2016 (social workers, pharmacists, etc.).

Prior to the launch of Phase I, the partnership-based development of an integrated implementation strategy had a significant impact on the implementation itself. The relative stability of this strategy throughout the three phases has proven useful. The following subsections describe the emergence of the integrated implementation strategy and attributes of the innovators who achieved it.

ORIGINS OF THE IMPLEMENTATION STRATEGY (AROUND 2010)

- The design of the implementation strategy by the ministry stakeholders made it possible to integrate, from the start.
 - Partnership-based governance comprised of representatives from the ministry, various community organizations (e.g., Alzheimer Society), researchers, regional project managers, representatives of professional orders, clinicians, the INESSS, clinical experts, and close partners (Phase III).
 - An independent evaluation carried out by a team of researchers chosen following a competition led by the Fonds de recherche en santé du Québec.

- In addition to evaluating the plan, the research team conducted various studies on this topic, which continuously fed the reflection on its implementation and development.
- Three partnership committees of clinicians and specialists were formed:

1) Memory clinics

2) Clinical process

3) Training

- A change management strategy and research efforts focused on change management as an object of knowledge.
- This implementation strategy attests to the ministry team’s leadership in bringing to life the vision of the Bergman Report, as well as mobilizing and coordinating stakeholders.
- There is a strong emphasis on knowledge brokering to ensure that scientific knowledge can be mobilized in order to design the implementation strategy and clinical tools.
- Partnership-based governance and the joint efforts of many stakeholders led to the development of new organizational and professional capacities. Ultimately, these approaches also led to the development of a common vision and promoted the buy-in of various stakeholder groups.

ATTRIBUTES OF THE INNOVATORS THAT MAKE UP THE STRATEGY

- An internationally renowned innovator with recognized clinical, scientific, and policy expertise.
- A ministry representative transformed the Bergman Report into policies/administrative processes for the ministère de la Santé et des Services sociaux. He received support from senior ministry officials to implement the orientations, coordinated the groundwork for the implementation, and was given a budget to introduce the change. He formed committees to spearhead the change, and inspired a shared vision among the various stakeholders.
- The author of the report was involved throughout the implementation processes, providing support to the ministry representative.
- These two stakeholders created some leeway for action and chose the right moment to make sure that the vision constructed by the partnership-based governance was incorporated into policy and operational decisions.

In designing the strategy, I drew on work I had already done in the past. This resulted in a much broader and deeper strategy, in terms of regional project managers, research, and everything else. It allowed us to go further. And we had the leeway to do that, even though I had to get my decisions approved and make sure the authorities were comfortable with them.

Ministry representative who initiated the implementation strategy

(Translated from original statement in French)

SHEET 3 DESCRIPTION OF THE THREE PHASES

The Québec Alzheimer Plan was implemented in three phases. This was a decision by the implementation strategy's designers to take a sequential approach, making it possible to test-drive the change, learn from the transition to a real-life situation, and adapt the implementation to the realities of the professionals, institutions, and regions concerned.

Usually, the ministry would come up with orientations, send them to the entire network, then tell everyone to implement them and report back in a year. That's how it normally works. But, with the Alzheimer Plan, we said, "No, that's not what we want to do." We stated what we needed, and validated and implemented things gradually, all the while thinking about the best place to start, where things would have the maximum effect, and where we could take things a step further. And we were able to adapt the plan according to the needs of each territory.

Ministry representative who initiated the implementation strategy

(Translated from original statement in French)

PHASE I (2013-2016): SUPPORTING THE INNOVATIONS

- A pre-implementation study was done (Vedel et al., 2018), showed the importance of designing an interprofessional clinical process and better training of the professionals in the family medicine groups.
- The roll-out of the ministerial action plan for the emergence of implementation projects in primary care. A general project framework and a structural requirements booklet were disseminated (see MSSS 2014a and MSSS 2014b).
- Innovative projects focused on better understanding the implementation conditions, mobilizing the clinicians, demonstrating the feasibility of the change, and encouraging their buy-in.
 - The presence of a physician champion in a primary care organization is an important condition for mobilizing the other doctors.
 - The regional project managers (n=4) play a key role in supporting the change.
- The initiative generated a variety of projects and project proponents.
 - It helped achieve a balance between the needs of primary care and those of specialized resources.
- Mobilization of clinical champions around capacity building (training and tools), in particular by using a knowledge brokering strategy.
- Selection of 19 promising implementation projects (out of 34 proposals) in the various regions, involving 38 family medicine groups.

PHASE II (2016-2019): GENERALIZATION

- Development of an organizational model based on the promising practices identified in the 19 implementation projects (see MSSS, 2019a).
- Dissemination and support for the implementation of this model across the province.
 - The integrated centres are given the leadership role in this process and are expected to disseminate the model to each family medicine group on their territory.
 - They lead steering committees on their territory.
 - They appoint and oversee the work of territorial resources, which are tasked with training and supporting the professionals in the family medicine groups .
- Maintenance of change management resources (four regional project managers) and financial resources were dedicated to the ministerial plan and to research, but with expanded responsibility to all of Québec.
 - This is conducive to resorting back to a more traditional reporting strategy.

Integrated health and social services centres

Created in 2015, the integrated centres group together several public health and social services organizations (e.g., hospitals, long-term care centres, home care, rehabilitation) located throughout vast territories. The 22 integrated centres are responsible for ensuring that the needs of the population in their territory are met.

PHASE III (2020 - ONGOING): STRENGTHENING TRANSITIONS

- Fifth Canadian Consensus Conferences on the Diagnosis and Treatment of Dementia (2020).
- COVID-19 delayed the roll-out of Phase III and caused disruptions at the integrated centres and in the family medicine groups. Nevertheless, the ministry and the regional project managers continued to focus their efforts during the pandemic.
- Phase III was launched in December 2020.
 - Continued focus on strengthening primary care, while continuing to focus more on care transitions, behavioural and psychological symptoms of dementia, services for family caregivers, and preservation of cognitive resources.
 - First-time participation by a patient-partner in the plan's governance structure.
- Support for change.
 - Maintenance of the regional project managers.
 - Maintenance of the leadership role assigned to the integrated centres and regional resources.
 - Maintenance of the financial resources allocated to the plan.
 - Increase in resources for research.
- Winter 2021: Planning for a post-COVID follow-up strategy.

SIMILARITIES AND DIFFERENCES BETWEEN THE THREE IMPLEMENTATION PHASES

- A recurring, indexed, annual budget of \$5 million dedicated to the implementation of the Québec Alzheimer Plan.
- A portion of this amount is earmarked for the regional project managers' salaries and implementation of the change.
 - In Phase I, each local implementation project received an annual amount of \$250,000.
 - In Phases II and III, each CIUSSS received an annual amount of \$225,000.
- This financial support is stable over time. However, the magnitude of the change increased in Phase II (generalization) and the budget remained the same. It is therefore possible to observe a relative decrease in the financial resources available to implement the change, as well as a dilution of the capacity to sustain the transformations.
- At the beginning of Phase II, this dilution of resources appeared to support a return to a more traditional reporting strategy, to the detriment of personalized support for adapting the changes to the realities of the local stakeholders.
- The ministère de la Santé et des Services sociaux is responsible for promoting the change (stimulating, encouraging, and supporting it), through a partnership-based governance involving the main stakeholders.
- The main targets of the change are generally the same across all phases, although the change becomes much larger in scale starting in Phase II (from 38 to approximately 300 family medicine groups). This sequential approach reflects the concern by ministry officials to adequately plan for the scale-up of the change.
- During Phase I, the family medicine groups are directly involved in designing and spearheading the change, within the guidelines put forward by the ministry. Starting in Phase II, the responsibility for change management is shifted to the integrated centres.
- Since 2018, \$10 million has been invested in research into dementia.



	PHASE I (2013-2016)	PHASE II (2016-2019)	PHASE III (2020-ONGOING)
BUDGET	\$5 million	\$5 million	\$5 million
KEY TARGETS OF THE CHANGE	<p>Expand the role of family medicine groups to detect, diagnose, and follow-up on people living with dementia.</p> <p>Create a local implementation strategy that will lead to learning in anticipation of a scale-up.</p> <p>Clarify the care trajectory (detection, diagnosis, and follow-up in primary care, supported by specialized care).</p> <p>Improve services for people with behavioural and psychological symptoms of dementia.</p>	<p>Expand the role of family medicine groups to diagnose and follow-up on people living with dementia.</p> <p>Generalize the most promising practices.</p> <p>Consolidate services for people with behavioural and psychological symptoms of dementia.</p>	<p>Expand the role of family medicine groups to diagnose and follow-up on people living with dementia.</p> <p>Consolidate the most promising practices.</p> <p>Place more emphasis on care transitions.</p> <p>Preserve cognitive resources.</p> <p>Review the clinical and organizational parameters for behavioural and psychological symptoms of dementia.</p>
SCOPE OF THE CHANGES	38 family medicine groups involved in 19 local innovations.	All family medicine groups across Québec (approximately 300).	All family medicine groups across Québec (approximately 300).
INNOVATION AND CHANGE MANAGEMENT PROCESSES	<p>The training and tools are defined by the ministry and made available to clinicians.</p> <p>The family medicine groups are the centre of the change design and management process. The clinicians develop a local innovation, according to the plan guidelines.</p> <p>Create a local implementation monitoring committee.</p>	<p>The integrated centres are responsible for spearheading the change, training the clinicians, and transmitting the tools to the family medicine groups.</p>	<p>The integrated centres are responsible for spearheading the change, training the clinicians, and transmitting the tools to the family medicine groups.</p> <p>Create a working committee dedicated to reviewing the clinical and organizational parameters for behavioural and psychological symptoms of dementia.</p>

SHEET 4 IMPLEMENTATION SUPPORT

A vast mechanism was rolled out to support the implementation of the change. It includes awareness and training strategies, as well as clinical support strategies.

AWARENESS AND TRAINING STRATEGIES

- Once a year, a Québec-wide meeting (phase launch or symposium) brings together decision makers, researchers, partners, local proponents of the ministerial action plan, and clinicians.
- Training for clinicians initially focused on detecting and assessing dementia in primary care.

CLINICAL SUPPORT STRATEGIES

- In Phase I, clinical discussions with expert practitioners aimed mainly to identify the cases that require a specialized assessment.
- In Phase I, each physician in charge of one of the family medicine groups selected was asked to decide on the initial and ongoing training to be completed by doctors and nurses during the project.
- The regional project managers disseminated the tools and training.
- Communities of practice emerged.

TOOLS

Development of tools

- Before and at the start of Phase I, tools were locally developed, some of which were disseminated after the launch of Phase I.
- Sometimes inspired by local practices, the partnership-based working committees developed tools:
 - Organizational parameters for the teams dedicated to behavioural and psychological symptoms of dementia (MSSS, 2014c).
 - Clinical process for treating behavioural and psychological symptoms of dementia (see MSSS, 2015).
 - Interdisciplinary clinical process in the family medicine groups (see MSSS, 2019b).

- At the request of the ministry, the Institut national d'excellence en santé et services sociaux produced a guide on detecting, diagnosing, announcing, and following up on dementia (INESSS, 2015).
- In Phase I, each local implementation project used the protocols, practice guides, forms, and assessment tools provided by the ministry. However, most of the projects adapted them to their reality. Other tools were developed to promote interventions for the optimal treatment of people living with dementia, including processes for:
 - Assessing the cognitive condition.
 - Performing a more extensive cognitive assessment in order to establish a diagnosis.
 - Explaining the diagnosis to the person affected or their family (for the doctor and nurse).
 - Making decisions about whether or not to prescribe treatments.
 - Systematically and proactively following the user.
- The ministry and its partners developed indicators for following patients using a structured tool (e.g., user referrals, wait times, number of cases assessed, number of users waiting to be assessed, proportion of cases referred to specialized services).
- Some memory clinics played the role of expert trainer through teaching activities with future graduates. They also provided support to the primary care doctors and teams in terms of diagnoses and treatments.
- Third-line specialists provided support for highly complex cases, especially diagnoses. They also participated in the creation and presentation of training activities.
- Development and implementation of the interdisciplinary clinical process in primary care, in two parts (diagnosis and follow-up). This tool facilitates the detection, diagnosis, and follow-up of people with potential dementia through the use of a simple clinical process based on interprofessional collaboration. This tool outlines how to refer patients to key partners and how to improve the support offered to caregivers.
- Some of these tools have been revised:
 - In 2019, the ministry formed a committee to update the Processus clinique interdisciplinaire en soins primaires (interdisciplinary clinical process in primary care) (see MSSS, 2019b). The committee's mandate was to take stock of the evidence on the subject, identify required changes to be made to the document, and adjust its content.
 - In 2020, revision of the ministry's orientations on dementia for institutions, in preparation for Phase III.
 - In 2021, review of the clinical and organizational parameters for creating intervention teams in Phase I dedicated to behavioural and psychological symptoms of dementia (ongoing).

Dissemination of tools

- Seminars and phase rollouts.
- National, regional, and local training.
- Regional project managers and territorial resources use them to support the change in practice.
- Via the ministry's website: <https://www.msss.gouv.qc.ca/professionnels/maladies-chroniques/alzheimer-et-autres-troubles-neurocognitifs-majeurs>

CHANGE SUPPORT STRATEGIES

Local

- Appointment of a person in charge of implementation in the family medicine group (Phase I).
- Some sites hired a local project manager (Phase I).
- Identification of physician and nurse champions (Phase II), but engagement varies widely.

Québec-wide

- Partnership-based governance under the leadership of two ministry branches (Direction des services aux aînés et aux proches aidants and Direction des services de proximité en santé physique).
- A ministry representative ensures that processes are implemented and reports are submitted.

Regional

- Appointment of a person in charge of implementation at each integrated centre (Phase II). Because this person is often a manager in the Direction des services aux personnes en perte d'autonomie (services for people experiencing a loss of autonomy), who is sometimes supported by one or two people, as opposed to a primary care manager, this has had a negative impact on the relationship with the family medicine groups.
- For these individuals, the ministerial plan is a concrete way to strengthen ties with the family medicine groups on the integrated centre's territory.
- Presence of territorial resources hired by the integrated centres to support the implementation of the clinical practices proposed in the plan, to promote the use of clinical tools, and to provide clinical support to the professionals.
- Four regional project managers who cover all of Québec.

We were doing a lot more mobilizing than reporting. The regional project managers were our eyes and ears on the ground, and we had a sense of what direction the change was taking. The idea was to know where we were at, what we needed to improve, and what we could do better. This was our usual way of doing things, as opposed to formal reporting, which is part for the course at the ministry. Reporting needs to reflect the progress of the implementation and the achievements made.

Ministry representative who initiated the implementation strategy

(Translated from original statement in French)

ATTRIBUTES AND ROLES OF REGIONAL PROJECT MANAGERS

- The regional project managers do not report to the ministry, but rather to the integrated university health and social services networks (*réseaux universitaires intégrés de santé et de services sociaux*). One of the mandates of these organizations is to bring together universities and institutions with a health-social services vocation. To facilitate dissemination to stakeholders from other jurisdictions, we use the term “regional project managers”.
- They possess change management skills, without necessarily being experts in the field, or clinicians specialized in Alzheimer’s disease.
- Above all, they have an in-depth knowledge of the health system, but are less familiar with family medicine groups.
- They were hired to help structure the change process and to act as facilitators in the field.
- They support change at the level of the family medicine groups (Phase I) and the integrated centres (Phase II), often targeting the sites where a change in practice is more difficult.
- They embody the ministry’s orientations in the internal development of the various activities of the ministerial action plan (change management, reporting, development of tools, etc.).
- They were responsible for striking a balance between adapting the ministerial action plan at the local level and maintaining the principles promoted by the plan. They were therefore important drivers of support and an important reference for the champions in the field.
- They relay information from the field (formally, through reports, and informally, through their participation in governance).

The ministry couldn’t oversee everything. There needed to be regional project managers on the ground, capable of leading at the local level and making adjustments based on the needs of each territory. We knew we’d be able to coordinate things with them, and that they’d coordinate at the local level.

The regional project managers were our go-to people. When we wanted to make adjustments or figure out how the plan would impact operations or the issues we were dealing with, we had four contact people. We set up a system where we met regularly, sharing our achievements, failures, and strategies for translating the change to other sites. They played a crucial role in the end results.

Ministry representative who initiated the implementation strategy

(Translated from original statement in French)

ATTRIBUTES, PROFILES, AND ROLES OF THE EVALUATION TEAM

- The evaluation was developmental, meaning that it continuously informed the innovation—namely, the Plan—so as to adjust it to real-life circumstances.
- The researchers have clinical knowledge about dementia and the organization of health services. One part of the team specializes in quantitative methods, while the other has extensive experience in qualitative methods.
- The evaluation team’s roles included:
 - Studying the effects.
 - Understanding the implementation process.
 - Contributing to the key presentation activities of the ministerial action plan.
 - Participating in the main implementation committees to contribute to the transfer of knowledge (without having decision-making powers).
 - Applying the knowledge obtained from other research studies.



SHEET 5 PLAN OUTCOMES

The evaluation team helped document the various outcomes of the implementation projects. These are briefly described in the following subsections. For more information, the scientific sources on which this section is based are presented in the document entitled *Additional references*.

OUTCOMES OF PHASE I (2013-2016)

In family medicine groups

- Measurements taken before and after implementation of the ministerial plan revealed an increase in the quality of follow-up in the family medicine groups participating in the study:
 - The average score of 10 quality-of-care indicators rose from 48 % to 54,6 %.
 - The number of annual contacts (in person or by telephone) between patients and clinicians increased from 7,9 to 9,9.
 - The prescription of medications initiated in the family medicine groups increased from 71% to 72%.
 - Referrals to a memory clinic following diagnosis decreased from 12 % to 9 %.
- Primary care clinicians gave themselves an average score of 75 % for their competency in and knowledge of dementia.
- Doctors scored an average of 90,8 % for their attitudes about working with other clinicians.
- Useful clinical tools, relevant training.
- Increased recognition for the nursing role.
- Knowledge of what works and what doesn't, numerous local innovations and adaptations, a proven change management strategy.
- Mobilization of physician champions.

At memory clinics (specialized care)

- Consolidation in some settings that lack specialized resources.
- The proportion of unjustified referrals dropped from 20 % to 7 %.
- More effective communication and referral methods.

At integrated health and social services centres

- Opportunity for a few institutions to showcase their efforts in terms of dementia and collaboration with the family medicine groups.
- Consolidation or creation of teams dedicated to behavioural and psychological symptoms of dementia.

At the ministère de la Santé et des Services sociaux

- The creation of the plan allows the MSSS to monitor its performance in terms of dementia.
- The plan gives the MSSS an internal argument to address ministerial priorities.
- The MSSS's capacity for operational change management enables it to better understand the field and continuously adjust its actions on this issue.

OUTCOMES OF PHASE II (2016-2019)

Phase II maintains the orientations of Phase I and identifies priority strategies. Using the same resources as Phase 1, the plan is required to be implemented in all family medicine groups, not just the ones that volunteer. The integrated centres are required to support this dissemination throughout their territory.

In family medicine groups

- In general, the outcomes are maintained, although some sites slid back into their previous practices due to a dilution of resources at the local level, a transfer of responsibility for spearheading the change from the family medicine groups to the integrated centres, and the pandemic.
- Nurses are exposed to the tools and training included in the plan.
- Loss of specialized nursing skills due to a loss of the financial capacity needed to retain the nurse specialized in dementia who was hired in Phase I.

At memory clinics (specialized care)

- Maintenance of Phase 1 outcomes.

At integrated health and social services centres

- The plan allows them to move toward a key strategic target, which is to establish a close collaboration with the family medicine groups, which are historically independent organizations.

At the ministère de la Santé et des Services sociaux

- Maintenance of Phase 1 outcomes.

SHEET 6 DETERMINANTS THAT EXPLAIN THE RESULTS

Despite the successes and difficulties identified here, there is significant local variability, and progress remains tenuous, often being dependent on the engagement of staff, who are frequently champions or near-champions. In the following subsections, we present the determinants that are specific to implementing the plan. The usual determinants of the success of health innovations during a real-world implementation are mostly present.

FACILITATING FACTORS

Québec-wide

- Development of an implementation plan and its integration with the ministerial orientations.
- The quality of the leadership and of the partnership-based governance promotes buy-in by the various stakeholder groups.
- The integrated nature of the change management strategy, including the capacity-building strategies, the presence of the regional project managers, and the existence of communities of practice.
- The mobilization of experts.
- The sequential approach to disseminating the innovation and the ongoing change management efforts.

If there's one thing to remember, I'd say that we need proactive change management. We need to be able to take action, analyze, react, take steps, evaluate, and re-position. We need to be proactive. We did this by developing new things on demand, by asking questions, by getting answers, by adapting and correcting. And we had the people to do it.

Ministry representative who initiated the implementation strategy

(Translated from original statement in French)

At the regional level

- Use of the ministerial action plan by the integrated centres in an effort to collaborate with the family medicine groups on the territory.

At the local level

- Participation in local innovations prior to Phase 1.
- Participation in Phase 1.
- Presence of a clinical champion.
- Well-trained nurses.

BARRIERS

Québec-wide

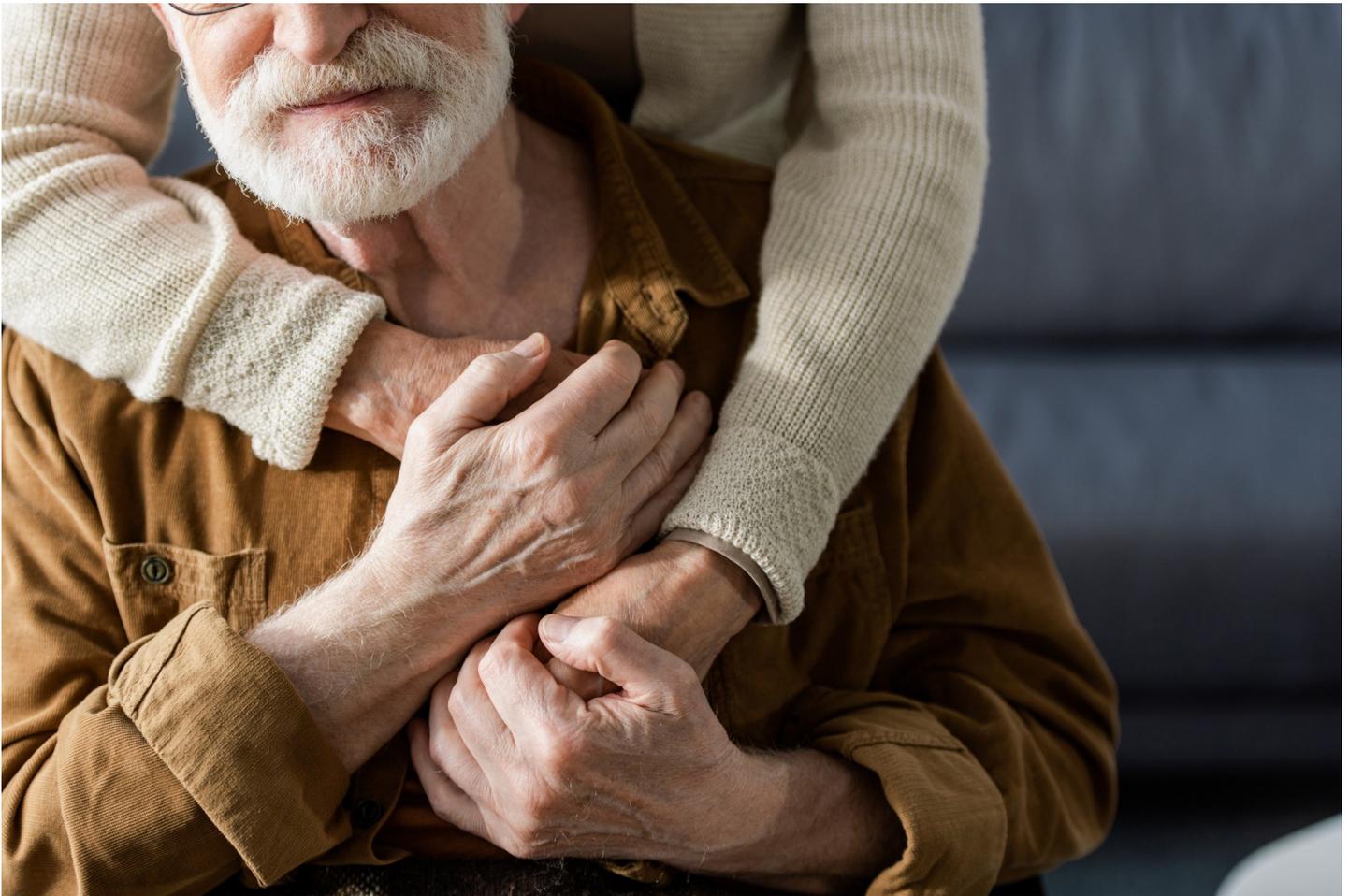
- The scope of the targeted change.
- Dilution of support resources during the transition to Phase II.
- Insufficiently coordinated intra-ministerial inconsistencies between innovations parallel to the plan (e.g., introduction of social workers in family medicine groups in 2016, but minimal ties to the Québec Alzheimer Plan).
- A return to a more traditional reporting strategy at the start of Phase II (fluctuation in the ministry's operational engagement).
- The complexity of the change in primary care due to the organization of the medical field.
- The inability to measure the progress of the change within the organizations on a large scale, due to an inability to access clinical data in many family medicine groups.
- The pandemic jeopardizing the gains made in Phase II.

At the regional level

- It is difficult for the ministry to know how budget amounts allocated to the integrated centres are used.
- Their leadership may lead to disengagement, or even a refusal to cooperate, among some doctors in the family medicine groups, especially those who did not participate in Phase I.
- Their overall knowledge of the family medicine groups is poor.
- Competing organizational change mandates among proponents of the ministerial action plan at the integrated centres; sometimes, the Québec Alzheimer Plan is just one file among many.
- In remote areas, there may be a lack of resources due to distance, for example.
- In urban areas, the complex nature of the service offering requires broader action.

📍 At the local level

- Absence of physician champions.
- Limited management capabilities of the family medicine groups.
- Physicians and other clinicians are overwhelmed by the large number of innovations proposed to them.
- Difficulties monitoring the internal performance of family medicine groups, let alone setting up a reflective practice based on the learning health system model.
- Staff instability.
- Poor integration of social workers.
- Lack of interest by some clinics in care trajectories or even in people living with dementia.
- After Phase I, scarcity of nurses specialized in dementia in the family medicine groups.



SHEET 7 CHALLENGES AND AREAS FOR DEVELOPMENT

Despite considerable progress, several challenges still require close attention. Albeit understandable, the ministry has not been able to address all the recommendations in the Bergman Report. For this reason, there are several possible areas for development.

PERSISTENT CHALLENGES

- Some specialists are less happy with the focus on primary care and would have preferred the responsibility fall to the memory clinics (specialized care), especially given the impending arrival of new therapies.
- In general, the outcomes are maintained, although some sites slid back into their previous practices during Phase II due to a dilution of resources at the local level, transfer of responsibility for spearheading the change from the family medicine groups to the integrated centres, and the pandemic.
- Staff instability.
- Difficulty engaging non-physician champions, who receive little training.
- The extent and scope of clinical follow-up (the focus is often solely on detection and assessment).
- Interprofessional collaboration beyond the doctor-nurse duo is limited.
- Persistent difficulty intervening with patients with dementia, in order to prevent a loss of autonomy or to maintain their autonomy before the situation deteriorates (e.g., avoiding preventable hospitalizations).
- Coordination of services, including the transition to home care, remains difficult.
- Some ministry initiatives could be better integrated with the Québec Alzheimer Plan (e.g., OPUS-AP, a program to optimize the use of antipsychotics in long-term care residents with behavioural and psychological symptoms of dementia could be extended to home care; the transfer of social workers to family medicine groups; policy on support for family caregivers).

SUSTAINABILITY CHALLENGES

- Implementing a complex innovation such as the Québec Alzheimer Plan requires ongoing, long-term support because of the intricate nature of primary care.
 - An innovation is never completely sustainable.
 - Due to the constantly evolving nature of primary care, training and awareness efforts need to be ongoing.
 - The plan itself is constantly evolving, with numerous ongoing developments.
- The pandemic has undermined some of the progress made; a consolidation strategy will be needed.

AREAS FOR DEVELOPMENT

- Conduct a post-COVID implementation follow-up that takes the new realities into account.
- Anticipate how the arrival of biomarkers and new therapies will impact the organization of services.
- Pursue the change in the family medicine groups, in particular at the follow-up stage.
- Strengthen the integrated centres' capacity to manage projects and provide support to the clinics.
- Expand certain segments of the service trajectory (e.g., to private seniors' residences).
- Smooth transitions between the family medicine groups and home care services.
- Engage the home care staff.
- Promote the optimal use of medications in the community.
- Develop intervention capacities for clients with co-morbidities (e.g., mental health issues).
- Better document the outcomes from the patient's perspective (appreciation of care and services, wait times, access to specialized care, etc.).