B.C. Dementia Education Strategy, 2010-2012

FINAL REPORT

Submitted by:

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Submitted to:

BC Ministry of Health, Pharmaceutical Services Division, Alzheimer Drug Therapy Initiative (ADTI)

Date:

March 31, 2013
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We would like to acknowledge the financial support of the BC Ministry of Health, Pharmaceutical Services Division, Alzheimer Drug Therapy Initiative (ADTI), as well as the input and advice from the ADTI project team, the ADTI Project Advisory Committee, the ADTI Educational Working Group (EWG), as well as the Dementia Education Strategy Planning Committee members.

The Planning Committee has been involved with the Dementia Education Strategy and the ADTI’s Educational Working Group since 2007 and we would like to thank them for their extensive support and input over the past five years.

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About UBC CPD

The Dementia Education Strategy was designed and delivered by the UBC Division of Continuing Professional Development (UBC CPD).

Within the UBC Faculty of Medicine and as a major CME/CPD provider in BC, UBC CPD brings together a unique combination of expertise and quality in innovation, research, education and training, as well as event planning and management in support of Continuing Medical Education/Continuing Professional Development (CME/CPD) and better patient care. The Division has a wealth of experience developing and evaluating educational content focused on supporting optimal physician knowledge uptake and innovation in the delivery of clinical care.

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## Glossary

### 1 GLOSSARY & ABBREVIATIONS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADTI</td>
<td>BC Ministry of Health Services, Pharmaceutical Services Division, Alzheimer’s Drug Therapy Initiative</td>
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<tr>
<td>AD</td>
<td>Alzheimer’s Disease</td>
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<tr>
<td>ASBC</td>
<td>Alzheimer’s Society of British Columbia</td>
</tr>
<tr>
<td>BC</td>
<td>British Columbia</td>
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<tr>
<td>BCMA</td>
<td>British Columbia Medical Association</td>
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<tr>
<td>BCMoH</td>
<td>British Columbia Ministry of Health</td>
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<tr>
<td>CCCDTD3</td>
<td>Third Canadian Consensus Conference on Diagnosis and Treatment of Dementia</td>
</tr>
<tr>
<td>CFPC</td>
<td>College of Family Physicians of Canada</td>
</tr>
<tr>
<td>ChEI</td>
<td>Cholinesterase Inhibitors</td>
</tr>
<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>DES1</td>
<td>Dementia Education Strategy 2007-2010</td>
</tr>
<tr>
<td>DES2</td>
<td>Dementia Education Strategy 2010-2012</td>
</tr>
<tr>
<td>FP</td>
<td>Family Physician</td>
</tr>
<tr>
<td>GDS</td>
<td>Global Deterioration Scale</td>
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<tr>
<td>GPAC</td>
<td>Guidelines and Protocols Advisory Committee</td>
</tr>
<tr>
<td>IP</td>
<td>Interprofessional</td>
</tr>
<tr>
<td>LHA</td>
<td>Local Health Authority</td>
</tr>
<tr>
<td>MoCA</td>
<td>Montreal Cognitive Assessment</td>
</tr>
<tr>
<td>RCPSC</td>
<td>Royal College of Physicians and Surgeons of Canada</td>
</tr>
<tr>
<td>SA</td>
<td>Special Authority Form</td>
</tr>
<tr>
<td>SGP</td>
<td>Society of General Practitioners of British Columbia</td>
</tr>
<tr>
<td>SMMSE</td>
<td>Standardized Mini-Mental State Examination</td>
</tr>
<tr>
<td>SRPC</td>
<td>Society of Rural Physicians of Canada</td>
</tr>
<tr>
<td>UBC</td>
<td>University of British Columbia</td>
</tr>
<tr>
<td>UBC CPD</td>
<td>University of British Columbia Faculty of Medicine, Division of Continuing Professional Development</td>
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</table>
1. Executive Summary

The Dementia Education Strategy, 2010-2012 (DES2) was a multi-modal educational strategy designed primarily to support family physicians who provide care to patients with dementia. Each Continuing Medical Education (CME) program that was developed as part of this initiative incorporated aspects of the Guidelines and Protocols Advisory Committee (GPAC) provincial guidelines, promoting best practices in dementia care provision.

The strategy aimed to increase the educational reach of the CME by engaging a larger and more diverse participant pool via interprofessional programming. Opportunities for dementia education were provided along the learning continuum from beginner (creating awareness), to intermediate (encouraging adoption), to expert (supporting adherence). This was the second iteration of the DES2, and it reached over 600 health care professionals in British Columbia and beyond, including family physicians, specialists, nurses, pharmacists. DES2 built on the educational offerings from the first iteration of the Dementia Education Strategy (DES1), which took place between 2007 and 2010 and reached more than 1,000 BC health providers.

DES2 consisted of five main deliverables: (1) webinars, (2) conference breakout sessions, (3) province-wide case-based workshops (three types: general community workshops, culturally specific workshops, and online workshops), (4) a formal mentoring program, and (5) an advanced learning seminar with a follow-up teleconference.

All of the programs within the educational portfolio met accreditation requirements from both Canadian medical colleges: the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada. Several of the educational programs were accredited for pharmacists through UBC Continuing Pharmacy Professional Development using the Canadian Council for Continuing Education in Medicine.
Pharmacy (CCCEP) accreditation guidelines. This allowed participants to receive credits towards the maintenance of their medical and professional licenses.

Additionally, several of the educational programs doubled as research studies (e.g. the workshops and mentoring program) and underwent formal ethical review from the University of British Columbia’s (UBC) ethics board. Furthermore, evaluations were built in to each educational program, ensuring standardization and quality of programming as well as to enable measurements, based upon participant self-report, of whether clinical practice changes occurred.

Program evaluation data to date confirms that dementia workshops, webinars, and mentoring programs offered through UBC CPD continue to influence physician enrolment in the ADTI and prescribing patterns. Furthermore, data reveals that to help practitioners identify their gaps in knowledge relating to dementia and Alzheimer Disease (AD), they must be supported in an ongoing way with continuing medical education opportunities. As the major CME provider in the province with a five year history with the Dementia Education Strategy, the UBC CPD was well-positioned to take on this educational initiative.

DES2, similar to the first iteration of the strategy, showed that a small group interactive learning format provides an enhanced learning experience. Participants in DES2 had varied baseline comprehension of dementia issues, and did not necessarily have a strong background in this area. Findings confirm that physicians appreciated a variety of educational formats including community-based programs, online education, in-depth programs with integrated practice tools, and mentoring. The strategy shows an improvement in collaborative practices and relationships between family physicians, pharmacists, and specialists.

Although there was no funding provided to formally evaluate the impact of the DES2 program, the program’s educational interventions were evaluated via participant self-report and self-assessment data. The results indicate that, like the first iteration of the strategy from 2007-2010, CME programs within this strategy supported adoption and adherence to the GPAC provincial guidelines by physicians and resulted in improvements in the provision of dementia care throughout British Columbia.

Results of the Dementia Education Strategy, that is, DES1 and DES2 show that education around dementia care and management continues to be an ongoing need for BC physicians, pharmacists, and other health care practitioners. The successes of the Dementia Education Strategy over the past five years, as outlined in this final report, have resulted in an extensively engaged and more informed network of primary care providers in British Columbia around optimal care and prescribing for patients with dementia.

2. Introduction

Based upon the successes of the UBC CPD DES1 from 2007-2010, the BC Ministry of Health (BCMoH) awarded funding to implement and expand the strategy for a second iteration, which took place between 2010 and 2012.
The overarching goal of the educational strategy remained unchanged from the first strategy: to provide CME to healthcare practitioners, primarily family physicians (FPs) and pharmacists, to create awareness of BCMoH and the BC Medical Association (BCMA) GPAC provincial best practice guidelines; to support adoption of the guidelines in medical practice and; to reinforce adherence to best practices in prescribing and disease management when providing dementia care.

During DES1, UBC CPD partnered with the BCMoH, to show that physicians who participated in educational components of the strategy (community case-based workshops) incorporated GPAC best practice guidelines into their medical practices, resulting in significant clinical changes: physicians were more likely to perform the Standardized Mini-Mental State Examination (SMMSE) and the Global Deterioration Scale (GDS) cognitive tests following the workshop than when compared to their pre-workshop scores and to other community matched family physicians.

By expanding upon the types of educational programs offered as well as the modes of program delivery, the aim for the DES2 was to encourage practitioner engagement by providing different levels of education to accommodate learners’ motivations and expertise relating to the provision of dementia care in British Columbia.

This final program report is an opportunity for UBC CPD to share what the DES2 entailed. Within this report, there will be a description of the educational programs offered and delivered by UBC CPD over the duration of the strategy from 2010-2012. Each program is broken down into these sections:

- Rationale for the intervention;
- Description of the educational delivery and content; and
- Highlights from the evaluation findings, which include:
  - Discussion of significant findings; and
  - Discussion of the impact each program had on participants’ clinical practice.

Also included within this report will be a description of the use of DES web-based resources, the dissemination of DES knowledge, a comparison of DES1 to DES2, and reflections and/or lessons learned about which educational interventions were most successful.
3. Educational Interventions

The DES2 was built on effective CME principles, frameworks, and engagement strategies to optimize performance improvement for health care providers. It was also based on a collaborative and interprofessional approach. This novel approach was based on lessons learned from the first iteration of the strategy in 2007-2010, and was designed to foster improved patient care outcomes and cost savings for PharmaCare. The components of this program included education development, implementation of interactive team-based learning, quality improvement processes, and robust evaluation – all of which were designed to make high quality education on dementia in British Columbia (BC) more accessible and impactful to physicians, pharmacists, and other health care professionals.

Each of the sections below provides a rationale, description, and highlights from the multi-modal educational interventions that were designed and delivered as part of the DES2 program.

3.1 Dementia Webinars

Rationale

Webinars were used as a tool to increase awareness about several broad topics related to the provision of dementia care (Davis and Davis, 2010). The aim of using this convenient online platform was to reach a large interprofessional audience by including a panel or having interprofessional speakers present on a given topic. Audience engagement was encouraged via real-time Q&A opportunities with the speaker, live polling, and downloadable resources. By using an online platform, learners were able to participate from anywhere, anytime—as long as they had an internet connection. This allowed UBC CPD to extend the reach of CME to rural or remote healthcare professionals who may have limited access to other CME opportunities.

The flexibility of the webinar platform allowed for the presentation topics to be selected a few months prior to the webinar. This created an opportunity for the timely incorporation of new developments and emerging topics in dementia care and treatment.

Description

The Dementia Education Webinar Series consisted of six webinars delivered 2-3 months apart over the course of one year: June 2011 to June 2012. Webinars were designed to support an interdisciplinary audience of FPs, nurses, specialists, and other allied health care providers who provide dementia care. There was no cost associated with registering for webinars and anyone could participate so long as they registered for the event.
The webinar series consisted of the following presentations:

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Speaker</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-Jun-2011</td>
<td>Caring for Your Patients with Dementia</td>
<td>Dr. Joanie Sims Gould &amp; Ms. Jan Robson</td>
<td>32</td>
</tr>
<tr>
<td>21-Sep-2011</td>
<td>A Practical Approach to Dementia-Related Behaviours</td>
<td>Dr. Elizabeth Drance &amp; Dr. Michael Wilkins-Ho</td>
<td>67</td>
</tr>
<tr>
<td>7-Dec-2011</td>
<td>Planning Ahead: Advance Care Planning in Dementia Care</td>
<td>Dr. Doris Barwich &amp; Ms. Pat Porterfield</td>
<td>41</td>
</tr>
<tr>
<td>22-Feb-2012</td>
<td>Effectiveness and Use of Cholinesterase Inhibitors in Dementia</td>
<td>Dr. Donna Buna &amp; Dr. Dean Foti</td>
<td>87</td>
</tr>
<tr>
<td>25-Apr-2012</td>
<td>Pain Management in Dementia: Recent Issues with Narcotics</td>
<td>Dr. Romayne Gallagher</td>
<td>77</td>
</tr>
<tr>
<td>13-Jun-2012</td>
<td>Mild Cognitive Impairment: The Transition Zone Between Normal Aging and Dementia</td>
<td>Dr. Doug Drummond</td>
<td>72</td>
</tr>
</tbody>
</table>

**Total number of participants: 376**

Webinars were 60 minutes in duration and were presented in the evening to accommodate a larger webinar audience. Webinar presentations were 45 minutes in duration, allowing for a 15-minute Q&A session at the end of the presentation. Webinar presenters consisted of FPs, specialists, nurses and pharmacists. In total there were 376 participants in this webinar series. Each participant earned CME credits for their participation.

Webinars were evaluated on quality improvement, learning experience, and presentation metrics. At the end of each webinar, participants were given a link to complete an attendance form. Completion of this form was required for participants to earn CME credits. Participants were also given a link to complete an online webinar evaluation. The evaluation took approximately 5 minutes to complete and asked participants to rate the speaker’s presentation, state whether the learning objectives were achieved, and what they learned or planned to do differently as a result of attending the webinar.

Please see Appendix A for a list of webinar learning objectives.

**Highlights from Evaluation Feedback**

The majority of webinar participants were FPs (65%). The number of participants from other medical specialties differed depending on the webinar topic. Overall, the Dementia Education Webinar Series was able to engage a large number of medical professionals from all over BC (and other areas of Canada). On average, most participants lived and practiced medicine in urban settings (78%). Interestingly, over half the webinar participants (58%) had been practicing medicine for more than 20 years.

Each of the six webinars had pre-defined learning objectives on a specific dementia related topic. The aim of the learning objectives was to promote awareness and facilitate adoption of key clinical aspects
of dementia care. Collapsing the data across the six webinars, 90% of participants agreed or strongly agreed that the webinar learning objectives were achieved.

Below are some of the remarks made by webinar participants when asked about what they plan to do differently as a result of attending a webinar:

**Effectiveness and Use of Cholinesterase Inhibitors in Dementia, Feb 22, 2012**
- “I will now try to discuss some medication expectations with patients and discuss probability of benefit/harm.”
- "Regular follow up and monitoring, counsel patients regarding the expectation of treatment.”
- “I will be better able to make good recommendations for dementia patients when dealing with the need to switch drugs, and/or deal with side effect management.”

**Caring for Your Patients with Dementia, June 21, 2011**
- “Increased use of Alzheimer’s Society of BC’s resources.”
- “Refer to support services earlier.”

**A Practical Approach to Dementia-Related Behaviours, Sept 21, 2011**
- “I will adopt the assessment tools that I have learned about in this webinar, and place much greater emphasis on nonpharmacologic management of dementia-related behaviours.”
- “I will give some suggestions to the doctors if they would like to try Memantine for our clients with dementia.”
- “After changes of behavior have been addressed review of patient’s behavior and treatment in 6 weeks”
- “Will use more loxapine vs. haldol for acute agitation/aggression in delirium.”

**Planning Ahead: Advance Care Planning in Dementia Care, Dec 7, 2011**
- “More emphasis on conversations to clarify and reinforce patients on their understanding of their prognosis and treatment complications.”
- “I will have the updated provincial forms available in clinic, with increased organization in approaching the topic of advance planning on patient visits for other routine issues.”
- “Use the resources more readily and discuss ACP earlier and more openly in dementia and other chronic illnesses.”

**Pain Management in Dementia: Recent Issues with Narcotics, April 25, 2012**
- “Consider opioids without active metabolites such as hydromorph[one], oxycodone, fentanyl”
- “I will focus on pain management in patients who may be exhibiting behaviours and are unable to express this.”
- “If elderly patients drowsy, decrease dose of neuroleptic before pain meds.”
- “Better able to make clear recommendations for dosing to nursing and physicians for changing from oral opioids to fentanyl patch, be able to give good options for topical analgesics.”

**Mild Cognitive Impairment, June 13, 2012**
- “1) Follow-up every 6 months
  2) Recognize risk factors for progression to AD.”
• “Explain MCI better to my patients. Dr Drummond’s example of how to broach the subject (‘Today you do not have dementia, but you are in this category ... in the meantime, do brain healthy things, etc’) will be something I use regularly.”

• “Obtain MOCA test from website.”

Further, the webinar sessions provided an interactive opportunity to present on most recent issues that arise throughout dementia care rather than following pre-determined topics:

• “The Dementia webinar series is excellent, and gives practical advice to FPs that is not otherwise readily available.”

Overall the Dementia Education Webinar Series was able to engage a large number of medical professionals from all over BC (and other areas of Canada). Each webinar was rated highly in meeting learning objectives and provided an opportunity to present on recent issues that arose throughout the course of the program rather than following pre-described topics.

3.2 Dementia Community-Based Workshops (Interprofessional)

Rationale

Building upon the webinars, which primarily functioned as a mode for increasing physician awareness about specific dementia-related topics, workshops enabled education delivery to transcend awareness and move to participant agreement and adoption of the behaviours and best practices outlined in the workshops. Workshops encouraged moving beyond the awareness stage by providing the opportunity for a small group of participants to focus and have in-depth conversations about specific content with an expert facilitator. During 2007-2010, the DES1 delivered 40 case-based workshops in communities around BC, reaching over 500 participants. These workshops provided health care professionals from communities across BC with an up-to-date review of the fundamentals of dementia diagnosis and management using a case-based approach.

The DES2 continued to provide the community-based workshops based upon the ongoing need for educational support in the area of dementia care. The workshop content and delivery for the second iteration of workshops was updated and modified based upon recommendations from DES1 workshop evaluations. Twenty workshops were offered as part of DES2 (for a full list of workshops, see table on page 14).

The DES2 workshops were designed to be interprofessional (IP), including both FPs and pharmacists. The rationale behind making these workshops interprofessional reflected the reality that dementia care is not provided by one health care group in isolation. Rather, it requires collaboration among a variety of health professionals. Reeves (2009) states the importance of having healthcare providers understand and respect the roles of other healthcare professions and that there was an opportunity for this type of collaboration to come from CME. The planning committee thought that offering IP education would be an opportunity to breakdown professional silos between these two healthcare groups, both of whom are invested in the provision of dementia care. The workshops were thus designed to improve the
understanding of care roles between these two professions and ultimately lead to better dementia care within each workshop community.

In addition, the DES2 workshop content was updated from the first iteration of the community case-based workshops. Unlike DES1 workshops, which required participants to work through four cases on specific aspects of dementia care, DES2 workshops had participants discuss one global dementia case that covered the entire dementia journey from diagnosis to end of life care. This change was made based on evaluation data received at the end of DES1 that indicated that not all of the course content was discussed due to time constraints. The planning committee thought that offering one case instead of four would allow for more content to be discussed in the same period of time.

Description

Between October 2011 and March 2012, twenty small-group, interprofessional workshops were offered in communities throughout BC. Workshops were held in communities in five BC Health Authorities: Fraser Health (FHA), Interior Health (IHA), Vancouver Coastal Health (VCH), Vancouver Island Health (VIHA), and Northern Health (NHA). Community selection was based upon the availability of local workshop facilitators, community interest, and whether a DES1 workshop was held in that community. The aim of DES2 workshops was to broaden the reach of the initiative and to limit revisiting communities where DES1 had already delivered education.

<table>
<thead>
<tr>
<th>Community</th>
<th>Health Authority</th>
<th>Date</th>
<th>Workshop Facilitator</th>
<th>No. of Attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cranbrook</td>
<td>IHA</td>
<td>Oct 19, 2011</td>
<td>Dr. Hubertus van der Lugt</td>
<td>12</td>
</tr>
<tr>
<td>2. Vernon</td>
<td>IHA</td>
<td>Oct 19, 2011</td>
<td>Dr. Mahmoud Abdel-Kader</td>
<td>5</td>
</tr>
<tr>
<td>3. Comox</td>
<td>VIHA</td>
<td>Oct 26, 2011</td>
<td>Dr. Natasha Frolic</td>
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<tr>
<td>4. Sechelt</td>
<td>VCH</td>
<td>Oct 27, 2011</td>
<td>Dr. Anthony Barale</td>
<td>4</td>
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<tr>
<td>5. Trail</td>
<td>IHA</td>
<td>Nov 8, 2011</td>
<td>Dr. Bruce Fawcett</td>
<td>8</td>
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<tr>
<td>7. Dawson Creek</td>
<td>NHA</td>
<td>Nov 15, 2011</td>
<td>Dr. Andrew Hellyar</td>
<td>3</td>
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<tr>
<td>8. Victoria</td>
<td>VIHA</td>
<td>Nov 15, 2011</td>
<td>Dr. Michael Cooper</td>
<td>5</td>
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<tr>
<td>9. Smithers</td>
<td>NHA</td>
<td>Nov 23, 2011</td>
<td>Dr. Karin Blouw</td>
<td>6</td>
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<tr>
<td>10. White Rock</td>
<td>FHA</td>
<td>Nov 24, 2011</td>
<td>Dr. Pamela Thornton</td>
<td>7</td>
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<tr>
<td>11. Campbell River</td>
<td>VIHA</td>
<td>Nov 29, 2011</td>
<td>Dr. Natasha Frolic</td>
<td>7</td>
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<tr>
<td>12. Parksville</td>
<td>VIHA</td>
<td>Dec 1, 2011</td>
<td>Dr. Pawal Juralowisc</td>
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<td>13. Vancouver</td>
<td>VCH</td>
<td>Dec 1, 2011</td>
<td>Dr. Kathy Bell</td>
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<td>14. Oliver</td>
<td>IHA</td>
<td>Dec 7, 2011</td>
<td>Dr. Dave Shaw</td>
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<td>15. New Westminster</td>
<td>VCH</td>
<td>Feb 28, 2012</td>
<td>Dr. Doug Drummond</td>
<td>10</td>
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<tr>
<td>16. Courtenay</td>
<td>VIHA</td>
<td>Feb 29, 2012</td>
<td>Dr. Natasha Frolic</td>
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<td>17. Langley</td>
<td>FHA</td>
<td>Mar 6, 2012</td>
<td>Dr. Paul Fluit</td>
<td>12</td>
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<tr>
<td>18. New Westminster</td>
<td>VCH</td>
<td>Mar 13, 2012</td>
<td>Dr. Doug Drummond</td>
<td>12</td>
</tr>
<tr>
<td>20. Vancouver</td>
<td>VCH</td>
<td>Mar 29, 2012</td>
<td>Dr. Kathy Bell</td>
<td>9</td>
</tr>
</tbody>
</table>

Total number of workshop participants: 169
The Dementia Planning Committee identified workshop facilitators (geriatric experts) practicing medicine in the communities selected for workshop delivery. Once workshop facilitators were identified and accepted the request to facilitate a workshop, they were invited to attend a train-the-trainer session. Each twenty-minute session was led by one of the case authors and included training on the workshop case content and best practices on facilitating group discussion. Each workshop followed a similar structure and standardized procedure.

The interprofessional workshops were two hours in duration and were held in a local hospital board rooms or other convenient locations. Workshops were open to both FPs and to pharmacists, who paid $25 to cover the cost of dinner and the workshop syllabus.

There were two versions of the workshop syllabus 1) facilitator version and 2) participant version. The difference between the versions was that the facilitator syllabus included discussion topics, additional questions and responses. Additional resources were included in the syllabi, which included the GPAC best practices for dementia care, cognitive tests (e.g., SMMSE) and corresponding instructions and information from the Alzheimer Society. (See Appendix B for the syllabus Table of Contents).

For the final six workshops delivered in 2012, a representative from the Alzheimer Society was invited to give a brief presentation to workshop participants that focused on community and patient-based services offered by the Alzheimer Society, including the FirstLink and the Safely Home programs.

Prior to the workshop, participants were asked to read several journal articles, which were considered valuable resources that would help add to workshop discussions. (See Appendix C for a list of pre-readings). During the workshops participants discussed a global dementia case (a patient case that covered the entire dementia journey from diagnosis to end of life care) over an informal dinner.

Learning objectives for the workshops:

- Review the clinical criteria for diagnosing Mild Cognitive Impairment (MCI)
- Assess the role of medications for MCI management
- Discuss pharmacotherapy & Cholinesterase Inhibitors
- Evaluate appropriate treatment for behavioral & psychological symptoms of dementia
- Consider aspects of end of life care

Workshop participants included both FPs (96) and pharmacists (73). Both professional groups earned continuing professional education credits from their respective colleges for participation in the workshops. (These credits go toward maintaining their licensure.)

Workshop participants were invited to complete three surveys that evaluated participants’ content learning and gauged whether any clinical changes had occurred as a result of attending the workshop. The pre-workshop survey was completed by participants online prior to the workshop. At the end of the workshop, participants were asked to complete the onsite evaluation. Two-months after the workshop, participants were invited to complete the post-workshop survey.
Highlights from Evaluation Feedback

Between October 2011 and March 2012, of the 169 workshop participants, 96 registered as a physician (67%) and 73 registered as a pharmacist/other health care professionals (43%).

The on-site workshop evaluations provide first-hand information around the value of the workshops in promoting an increase in participant learning. These questions were directed to all workshop participants, including pharmacists, physicians, and other healthcare professionals:

Participants’ self-reported increase in knowledge after vs. before the workshops:

- 57% increase in knowledge re: clinical criteria for diagnosing MCI
- 50% increase in knowledge re: the role of medications in MCI and dementia management
- 55% increase in knowledge re: initiating switching, or discontinuing cholinesterase inhibitors appropriately
- 42% increase in knowledge re: providing end of life care to patients with dementia

Physician participants reported an overall increase in adherence to the clinical Guidelines on Cognitive Impairment.

Pre-workshop:
- 58% of physician participants reported that they found some major barriers to adhering to clinical guidelines. The most common barriers described were a lack of the following: (1) familiarity and experience using the guidelines; (2) time to implement the guidelines; (3) additional external barriers including access to collateral health professional services, (4) lack of readily accessible guidelines when needed, and (5) no specific EMR template for memory loss. Physicians’ perspectives reflected their learning gaps and potential further support needs that we can provide.

Post workshop:
- Pre- and post-workshop surveys were compared, 42% more physicians reported that they were adhering to the clinical guidelines on cognitive impairment frequently (post- vs. pre-workshop, 71% vs. 29%).

Physician workshop participants reported increased use of the Global Deterioration Scale (GDS) as a result of attending one of the workshops. See Chart below. Compared to pre-workshop findings, 12% more physicians used GDS in patient initial assessment and 16% more physicians used it in patient re-assessment. Thirty-one percent of physicians agreed that, as a result of attending the workshop, they had more expertise in diagnosing dementia using the GDS. These positive increases in GDS use supports the efforts made by the ADTI, as GDS scores are required fields in the initiation and renewal/switching ADTI forms.
In the post-workshop survey, participants stated that since attending the workshop, they have made some specific changes in their practice relating to dementia care:

- “(1) No longer referring routinely for diagnosis. (2) Considering doing fewer CT head exams as per guidelines. (3) Started to use the MoCA instead of the MMSE in high-scoring MMSE patients.”
- “Enhanced counseling of patients/caregivers regarding what to expect from the medication in terms of side effects and outcomes.”
- “I am trying to make more emphasis in using assessment tools to make proper therapeutic recommendations.”
- “Utilizing the MoCA and talking to patients about mild cognitive impairment.”

Overall, those who participated in the workshop found it a positive experience and stated that they were performing more cognitive tests and reviewing the guidelines more following the workshop, which are important steps for early diagnosis and better management practices for dementia.

3.3 Dementia Case-Based Online Workshops

Rationale

The planning committee recognized that not all physicians who wanted to attend community workshops were able to do so because of where they lived. To reduce geographical barriers, the committee decided to pilot an online version of the community-case based workshop. The goal of the online workshops was to engage FPs who were unable to attend one of the community workshops due to a variety of factors including time, location, professional responsibilities (e.g. on-call duties, lack of locum coverage, etc.), or other factors.

To offer a similar level of interaction and dialogue, online workshops used an online platform—a user-friendly webinar technology called Adobe Connect, and a teleconference line. In addition, the number of workshop participants was deliberately kept low in order to improve the learning experience. Having
multiple participants on the same teleconference, for example, can be challenging when trying to have in-depth discussions.

**Description**

Two online case-based dementia workshops were delivered to participants throughout BC in May and June 2012. Seven family physicians participated in these online pilot workshops. The majority of participants were from rural communities where no in-person community workshop was offered: Crofton, Kitimat, Powell River, Salmon Arm, Sparwood, and Vancouver.

<table>
<thead>
<tr>
<th>Participant Communities</th>
<th>Date</th>
<th>Workshop Facilitator</th>
<th># of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kitimat, Powell River,</td>
<td>May 23, 2012</td>
<td>Dr. Doug Drummond</td>
<td>3</td>
</tr>
<tr>
<td>Vancouver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crofton, Salmon Arm (2),</td>
<td>June 6, 2012</td>
<td>Dr. Doug Drummond</td>
<td>4</td>
</tr>
<tr>
<td>Sparwood</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total number of participants: 7

The Dementia Planning Committee identified and invited a previous community workshop facilitator to facilitate the online workshops. The workshop facilitator was invited to attend a train-the-trainer session, which included training on the workshop case content, best practices on facilitating group discussion, technical training for using the online platform, and strategies for facilitating group discussion using a teleconference line. Both online workshops followed a structure and format that was similar to the in-person community workshops.

The online workshops used an adapted version of the global case used in the community workshops. The case was shortened to 90 minutes (reduced from 120 minutes for the in-person workshops). The online workshops, like the community workshops, were held in the evening and cost $25, which covered a portion of the facilitator fee and the cost of mailing the course syllabus to participants prior to the event.

The same workshop package that was provided during the community case-based workshops was also used for online workshops. Similarly, prior to the online workshop, participants were asked to read several journal articles which were considered valuable resources that would enhance workshop discussions. See Appendix C for a list of pre-readings.

However, unlike the community case-based workshops, the online workshops were only offered to FPs. As this was a pilot program, the planning committee thought it best to only offer the workshop to FPs rather than making the workshop an interprofessional event.

Registration for the online workshops was limited to a 5:1 ratio (5 FPs to 1 facilitator). The reason for such a small group size was to provide all of the participants an opportunity to participate in the discussions while also reducing the number of interruptions which can frequently occur while using a teleconference line.

The online workshop presented a modified version of the case that was used for the community case-based workshops. To ensure participant engagement throughout the workshop, a teleconference line was provided as well as a hard copy of the PowerPoint presentation of the case. An electronic copy of the presentation was available, as well as intermittent real-time interactive online polling questions via
the Adobe Connect webinar platform.

The learning objectives were the same as those from the community case-based workshops:

- Review the clinical criteria for diagnosing Mild Cognitive Impairment (MCI)
- Assess the role of medications for MCI management
- Discuss pharmacotherapy & Cholinesterase Inhibitors
- Evaluate appropriate treatment for behavioral & psychological symptoms of dementia
- Consider aspects of end of life care

Online workshop participants earned CME credits from their respective colleges for participation in the workshops.

Participants were invited to complete three surveys that evaluated their understanding of the content and gauged whether any clinical changes had occurred as a result of attending the workshop. The pre-workshop survey was completed by participants prior to the workshop. At the end of the workshop, participants were asked to complete a workshop evaluation form. Two months following the workshop, participants were invited to complete a post-workshop survey.

**Highlights from Evaluation Feedback**

Similar to the community case-based workshops, online workshop participants were all experienced physicians (having been in practice 15 years or more). Participants reported that they attended the online workshop because of its convenience.

Participants’ self-reported **increase in knowledge** after vs. before the workshops in:

- 50% increase in knowledge re: clinical criteria for diagnosing MCI
- 33% increase in knowledge re: the role of medications in MCI and dementia management
- 67% increase in knowledge re: initiating switching, or discontinuing cholinesterase inhibitors appropriately
- 33% increase in knowledge re: providing end of life care to dementia patients
Below is a comment from one of the online workshop participants:

- “I will screen more patient for cognitive impairment, regular follow up/assessment of patients who are diagnosed with dementia/AD.”

The online workshop evaluations were consistent with the community case-based workshops. Participants reported a similar increase in knowledge and confidence, as well as what they planned to do differently following the workshop.

### 3.4 Culturally-Specific Dementia Community-Based Workshops

#### Rationale

The culturally-specific community case-based workshops were designed to highlight cultural differences and realities of dementia care among three distinct ethnic groups: South Asian, Chinese and Iranian. Within BC’s Lower Mainland there are communities with high densities of residents who belong to these ethnic groups. Patients from certain ethnic groups such as South Asian, Chinese, and Iranian tend to delay reporting dementia until its later stages due to cultural beliefs about aging and cognitive impairments. This delay in diagnosis can lead to undue medical crises; further burdening the health care system and families caring for loved ones who suffer from dementia.

The culturally specific community case-based workshops were created to better equip family physicians to make earlier diagnoses and improve overall dementia care for these patients. The workshop cases were adapted to highlight unique aspects of specific ethnicities and emphasize culturally sensitive treatment approaches.

#### Description

Five culturally-specific workshops were delivered: four in September 2011 and one in March 2012. All workshops followed a similar structure. The Dementia Planning Committee identified workshop case
authors. Each case author was considered an expert in dementia care and had a large patient base from one of the three identified cultural groups: South Asian, Chinese and Iranian. Most of the case authors went on to facilitate the workshop(s) in specific communities with high populations of a particular cultural group, that is, South Asian (Surrey and Abbotsford), Chinese (Richmond and Vancouver) and Iranian (North Vancouver). Workshop facilitators were invited to attend a train-the-trainer session offered by a member of the planning committee. The training sessions included strategies and tips on how to facilitate group discussions and covered GPAC guidelines for best practices in providing dementia care. Each workshop followed a similar structure and standardized procedure.

<table>
<thead>
<tr>
<th>Community</th>
<th>Health Authority</th>
<th>Cultural Community</th>
<th>Date</th>
<th>Workshop Facilitator</th>
<th>No. of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surrey</td>
<td>FHA</td>
<td>South Asian</td>
<td>Sept 14, 2011</td>
<td>Dr. Hetesh Ranchod</td>
<td>7</td>
</tr>
<tr>
<td>2. Vancouver</td>
<td>VCH</td>
<td>Chinese</td>
<td>Sept 14, 2011</td>
<td>Dr. Janet Kushner-Kow</td>
<td>10</td>
</tr>
<tr>
<td>3. Richmond</td>
<td>VCH</td>
<td>Chinese</td>
<td>Sept 22, 2011</td>
<td>Dr. Janet Kushner-Kow</td>
<td>10</td>
</tr>
<tr>
<td>4. Abbotsford</td>
<td>FHA</td>
<td>South Asian</td>
<td>Sept 27, 2011</td>
<td>Dr. Hetesh Ranchod</td>
<td>6</td>
</tr>
<tr>
<td>5. North Vancouver</td>
<td>VCH</td>
<td>Iranian</td>
<td>Oct 6, 2011</td>
<td>Dr. Hetesh Ranchod</td>
<td>9</td>
</tr>
</tbody>
</table>

Total number of participants: 42

The culturally-specific workshops were two hours in length and were held in a local hospital boardroom or other convenient location. Workshops were open to all family physicians with a high volume of patients from one of the three ethnic groups. Workshop registration cost $25 and included the cost of dinner and the workshop syllabus.

There were two versions of the workshop syllabus: a facilitator version and a participant version. The difference between the versions was that the facilitator syllabus included discussion topics, additional questions, and responses. Additional resources were included in the workshop syllabus, including the GPAC guidelines for dementia care, cognitive tests (e.g., SMMSE) and corresponding instructions in both English and the language of that particular ethnic group (e.g. Mandarin SMMSE for the Chinese workshop). Other information that was included in the syllabus was from the Alzheimer Society and other groups offering dementia programs for specific ethnic groups. See Appendix D for the workshops Table of Contents.

Prior to the workshop, participants were asked to read several journal articles, which were considered valuable resources that would help add to workshop discussions. See Appendix E for a list of pre-readings.

During the culturally-specific workshops, participants discussed a global dementia case (a patient case that covered the entire dementia journey from diagnosis to end of life care) over an informal dinner.
Learning objectives for the culturally-specific workshops:

- Discuss pharmacotherapy & Cholinesterase Inhibitors
- Review the clinical criteria for diagnosing Mild Cognitive Impairment (MCI)
- Assess the role of medications for MCI management
- Appropriate treatment for behavioural & psychological symptoms of dementia
- Evaluate appropriate treatment for behavioral & psychological symptoms of dementia
- Consider aspects of end of life care

Workshop participants were FPs (N = 42) who had a high proportion of patients belonging to one of the three cultural groups. Similar to the community case-based workshops, participants received CME credits for the maintenance of their medical license.

Workshop participants were invited to complete three surveys that evaluated their content learning and gauged whether any clinical changes had occurred as a result of attending the workshop. The pre-workshop survey was completed by participants online prior to the workshop. At the end of the workshop, participants were asked to complete an onsite evaluation. Two-months after the workshop participants were invited to complete a post-workshop survey.

**Highlights from Evaluation Feedback**

A large proportion of workshop participants had been practicing medicine for more than 20 years, implying that these experienced practitioners were more likely to be aware of the culturally specific challenges related with patient ethnicity in dementia care.

Workshop participants (60%) described in the pre-workshop survey that major barriers to adhering to the clinical guidelines on cognitive impairment were: familiarity with the guidelines, time to implement guidelines, access to resources for patients from different cultures and language and cultural barriers.

Onsite workshop evaluations asked participants to state whether the workshop had helped address some of the barriers to adherence, these are a few comments that were made:

- “Yes...resources in Chinese language are very helpful”
- “Yes. The workshop described differences in dosage of medications prescribed to Asian patients. I didn’t know that their metabolism in relation to drugs was slower.”
- “Better understanding of the cultural barriers set up by Chinese family in the denial of mental disasters.”

Participants’ self-reported **increase in knowledge** after vs. before the workshops in:

- 44% increase in knowledge re: clinical criteria for diagnosing MCI
- 46% increase in knowledge re: the role of medications in MCI and dementia management
- 59% increase in knowledge re: initiating switching, or discontinuing cholinesterase inhibitors appropriately
- 26% increase in knowledge re: providing end of life care to dementia patients
Results of the two month post-workshop follow-up survey indicated that a significant proportion of participants were adhering to the guidelines more frequently (13% increase) than prior to the workshop. Comparisons of pre- and post-workshop surveys also revealed that physicians were more strongly in agreement that their skills in diagnosing dementia using the Standardized Mini Mental State Examination (SMMSE) were excellent, following the workshop (33% increase).

While physicians agreement (agree and strongly agree) diagnosing dementia using the Global Deterioration Scale (GDS) increased by 52% (pre - 28%; post - 80%). Physicians indicated that they were using the GDS more frequently in both their patients’ initial assessments (20% increase) and in re-assessments (23% increase). The most significant changes were seen when comparing percentages of physicians who indicated that they never performed the GDS either at initial assessment (pre - 44%; post - 10%) or during re-assessment (pre - 48%; post - 10%). These significant increases in GDS use were consistent with the learning that was reported in community-based workshops in section 3.1 of this report.

![Graph showing changes in GDS use](image)

In the post-workshop follow-up survey, participants reported specific clinical changes that they have made in regards to their dementia care as a result of attending the workshop. Here are a few examples of these changes:

- “Correct scoring on the SMMSE”
- “Use of rating scale I did not use previously.”
- “Better use of standardized forms to assess dementia, more appropriate use of medications and more aware of patient resources available.”

Collectively, participants’ self-reported awareness concerning differences in care and treatment for specific ethnic groups as well as an increase in knowledge regarding the GPAC clinical guidelines for best practices in dementia care.

BC Dementia Education Strategy, 2010-2012, Final Report
3.5 Dementia Case-Based Conference Workshops

Rationale

The planning committee recognized that many physicians attend conferences as a primary means of obtaining CME credits. To broaden the reach of the DES2, the planning committee decided to deliver workshops as conference breakout sessions. The purpose was to reach a multidisciplinary audience and increase physician awareness about GPAC guidelines and best practices in dementia care.

The community case-based workshop was adapted so that it would be more suitable for a self-contained one-hour breakout session at a major conference. The community workshop case was selected to be adapted for the conference because of its global nature and because it covered many key points in the provision of dementia care.

Description

During the “Hot Topics in Mental Health” Conference in January 2012, two breakout sessions were held. Dr. Martha Donnelly, a geriatric specialist and a member of the planning committee led both of the conference breakout sessions which followed a similar structure. As Dr. Donnelly is familiar with facilitating group discussion and was one of the co-authors of the presentation content, there was no train-the-trainer session. Dr. Doug Drummond was also at the breakout sessions and helped guide the session.

The breakout session registration was open to all who were registered for the conference and both breakout sessions were fully subscribed.

During the conference registration, breakout session registrants received a course syllabus. The syllabus provided was the same one used for the community case-based workshops. During the breakout sessions, Dr. Donnelly touched upon key aspects of dementia care, pulling specific information from the workshop case. The interactive sessions involved Dr. Donnelly rephrasing several of the workshop questions to fit a larger group format. PowerPoint slides and flip-boards were used to illustrate key points and clinical best practices in providing dementia care.

The learning objectives of the breakout sessions included:

- Reviewing the clinical criteria to make an initial diagnosis;
- Identifying management approaches for dementia; and
- Discussing palliative and end-of-life care options.

Of the 55 health professionals who registered for the breakout sessions before the workshop, 60% were family physicians, 25% were specialists, and 15% did not indicate their profession. The combined total of breakout session participants was 62. Both professional groups earned continuing professional education credits from their respective colleges for participation in the workshops.

At the end of each breakout session, participants were invited to complete a session evaluation form.
The conference session participants were well experienced physicians. From the on-site evaluation, participants reported similar learning and increase of confidence as other education programs of DES2. The interactive sessions provide an excellent medium for educating physicians on a larger scale.

Participants were given the opportunity to describe what they planned to do differently following the conference session. One participant said:

- “Use tools more effectively, review meds/alternate traditional meds that could be interfering.”

In summary, the evaluation data indicated that participants enjoyed the interactive nature of the breakout sessions and thought that it was an effective mode of delivering dementia education. Participants noted that they enjoyed Dr. Donnelly’s skills as a facilitator.

### 3.6 Dementia Advanced Learning Program

#### Rationale

The DES2 Planning Committee recognized that there was a gap in the educational opportunities provided in DES1 and sought to address it with the Dementia Advanced Learning Program. The Committee wanted DES2 to offer educational initiatives that covered the entire Pathman-PRECEED model for knowledge translation (Davis, Evans, Jadad, et al., 2003; Pathman, Konrad, Freed, et al., 1996). Whereas the webinars provided physicians with an opportunity to become aware of issues related to providing dementia care and the workshops supported physician agreement and adoption to GPAC Guidelines for clinical best practices in providing dementia care, there were no educational programs offered that went beyond that. That is, they did not offer ongoing support for physician adoption of and adherence to the GPAC Guidelines.
The planning committee also noted that there was a gap in the provision of on-going education, which has been found to improve educational outcomes such as increases in participant knowledge, skill, clinical and practice behaviour outcomes (Marinopoulos, Dorman, Ratanawongsa, et al, 2007). Therefore, the planning committee thought that one way to address these gaps in educational programming would be to adapt the standard PDSA (“Plan-Do-Study-Act”) cycle, a highly effective educational format, to better suit the continuum of care that is provided for patients with dementia, offering family physicians a more advanced educational opportunity that was on-going and would meet the criteria for adoption and adherence.

The Dementia Advanced Learning Program (DALP) included several components of the community case-based workshop such as the small group format, facilitated discussion, the inclusion of a course syllabi and having participants within the same community. The DALP also built on the workshops by offering participants with the opportunity to focus on high-level aspects of dementia care, clinical self-assessments, links with community resource programs, dementia tools and on-going support. The program also built in a reflection component, which the planning committee thought was important to encourage physician practice change and is supported by work done Eva and Regehr (2005). The DALP included two reflection periods, the first after the seminar and the second after the teleconference. The idea was that by encouraging reflection throughout the learning process would result in lasting physician change.

**Description**

Between September and November 2013, a Dementia Advanced Learning pilot program was developed and delivered to a select group of office-based family physicians who practice medicine in Vancouver, BC. The Dementia Advanced Learning Program was held in Vancouver, primarily because of the location of the program’s two facilitators, a geriatric specialist and a family physician expert in dementia care. Both facilitators were on the planning committee and helped to develop the program and the program tools.

The three month program consisted of a four-hour evening seminar held in September at the UBC CPD office and a one-hour teleconference held in late October, approximately six weeks later.

The Dementa Advanced Learning Program was selective in who could participate in the program and had specific criteria that the participants’ needed to have met.
The following is the list of criteria for program participants:

- Family physician;
- Practices medicine in an office-based setting;
- Practices medicine in the Lower Mainland;
- Has 5+ patients with dementia, the majority of whom do not live in a long-term care facility;
- Would attend the seminar and participate in the follow-up teleconference; and
- Would complete a needs assessment, two chart audits, and a reflective exercise.

The cost to participate in the Dementia Advanced Learning Program was $50 and included dinner, refreshments, and the course syllabus.

The course syllabus included a blank copy of the chart audit exercise, a completed version of the chart exercise that also included rational for each component, a copy of the program’s patient flow-sheet and other resources including cognitive tests, billing codes and community programs. See Appendix F for the syllabus’s Table of Contents.

Workshop participants also received a web link that gave them access to download electronic PDF fillable forms for both the chart audit exercise and the patient flow-sheet. The purpose of providing these electronic resources was to encourage participants to incorporate the use of the tools in their clinical practice (i.e., integrate the forms into their EMR systems.)

Prior to the seminar, participants were asked to select two of their patients who had dementia and perform the chart audit exercise for each patient. Participants were asked to bring in their completed chart audits as their audits would be discussed during the seminar.

During the seminar, and over the course of dinner and light refreshments, both the geriatric specialist and the family physician facilitators worked through the chart audit exercise answering participant questions and providing clinical tips and suggestions following the GPAC Guidelines for Best Practices for dementia care. Once the chart audits had been reviewed, the patient flow chart was introduced. Seminar participants had the opportunity to discuss the various fields on the flow chart and make comments and suggestions for additional fields and formats for the chart. Following the flow-chart presentation, two representatives from two community groups came to present information on their organizations programs. (See Appendix G for the seminar agenda).

The first representative was from the VCH Caregiver Support program and the second representative was from the Alzheimer’s Society of BC. Both representatives gave an overview of the programs their organization offered, described the referral process and gave information handouts for both the family physicians and their patients.

Learning objectives for the seminar:

- Identify and assess individual gaps in providing care to patients with dementia by using an audit tool;
• Plan and implement a process for monitoring and managing patients with dementia using a chronic disease management framework; and
• Decide how to integrate the use of a patient flow sheet into clinical practices to more effectively track and manage patients with dementia over time.

Six-weeks after the seminar, participants were asked to complete an exercise that would prepare them for the hour-long teleconference. Two teleconferences were delivered, which kept the group size small (roughly 5:1 participant to facilitator ratio) allowing for easier discussion.

The learning objectives for the teleconference included:

• Reflecting upon completed chart audits and how that exercise impacted clinical practice;
• Critiquing the patient flow sheet; and
• Describing any practice improvements and/or subsequent changes that have been made, possibly referring to the statements of commitment to change.

There were 11 participants in the pilot session of the Dementia Advanced Learning Program. Unlike the webinars or workshops, the Dementia Advanced Learning Program was accredited for a higher value of professional credits: Mainpro C. Which in effect is worth twice as much for the same amount of time spent attending a webinar or a workshop. Subsequently, participants also had several additional requirements to fulfill to earn their credits: completion of a chart-audit, commitment to practice change exercise and a reflective exercise.

In addition to the Mainpro C requirements, the Dementia Advanced Learning Program participants were invited to complete a needs-assessment, seminar evaluation, and a teleconference preparation form.

**Highlights from Evaluation Feedback**

Participants in the Dementia Advanced Learning Program were experienced physicians (on average they had been practicing for more than 16 years). The results of the program evaluation form confirmed that all the learning objectives of the program had been met, that the audit tool was clear and easy to use, and that they found the review of available tools helpful.

Participants discussed their self-audit exercise and found it to be straightforward in the sense that care gaps were easily identifiable. They also shared the experiences of using the flowchart and integrating it into their clinical consults and electronic medical record (EMR) system.

Participants described that after participating in the program, they were “more comfortable referring to community resources. It’s easier now because I know what the Alzheimer’s Society does. The flow chart also allows me to go through things more systematically and therefore I have a more organized approach.”

In the two-month post course reflection, participants said:
• “I am screening more elderly patients for dementia, offering resources to those with established dementia and supporting families in their journey.”
• “I started a dementia registry.”
• “I recalled patients with dementia on a regular basis and addressed the patient's and family's concerns.”
• “I also provided ongoing support and referrals to community resources as needed.”

In summary, participants reported that performing the chart audit exercise was beneficial in identifying their individual gaps in care. While the integration of a patient flow chart was helpful during patient consults – especially when consults are spaced several months apart. The results of this pilot program indicate that this program met its intended learning objectives and provided physicians with practical resources that could be used in their clinical practice.

3.7 Dementia Mentorship Program

Rationale

The DES2 Planning Committee recognized that there were very few formal mentoring programs that existed for physicians in Canada and those that did exist were typically for new medical graduates or residents. Additionally, they conceded that that one of the gaps in the educational opportunities provided in DES1 was a lack of ongoing educational support offered to those who participated in the programs. The planning committee thought that a structured eight month mentoring program would provide physicians with a unique opportunity to work on personal goals related to dementia care.

The dementia mentoring program was a pilot program as well as a research study. The program matched well-established family physicians with geriatric experts. Similar to the Thorndyke, Gusic, & Milner (2008) functional mentoring model, the mentoring program matched mentees to mentors with expertise in providing dementia care. Mentees would identify their personal learning goals over the course of the program and work with their mentor to address them.

Description

The Dementia Mentorship Program was delivered from March to October 2012 as an eight month formal program. The planning committee identified potential mentors (geriatric experts) and invitations were sent out in early January. Ten mentors from across BC accepted the invitation to participate in the program.

The program was launched with a Faculty Development Session for the program’s mentors on February 22, 2012. The session was presented in Vancouver via videoconference to three other videoconference sites across BC. The program’s mentors attended either in person or by video conference. The session included presentations from the UBC research team, Dr. Gisèle Bourgeois-Law, UBC CPD Associate Dean, Dr. Jeff Plant, UBC CPD Medical Director and Dementia Planning Committee member Dr. Doug
Drummond. There were presentations on best practices for mentorship and how to give effective feedback, as well as a discussion of program details.

A week after the Faculty Development Session, an Information Webinar for the program’s mentees was held. Of the 24 mentees who registered for the program, 12 attended the session while the other 12 were sent a recording of the presentation. Feedback from the webinar was positive with many mentees expressing a better understanding of how the program worked and what was expected of them throughout the duration of the program.

Due to scheduling and program logistics, 8 mentor groups were formed. One mentor was matched to three mentees (8 mentors and 24 mentees). Mentors were geriatric experts while mentees were family physicians. The mentor-mentee groups were formed based on the mentees’ location, clinical practice and areas of need/interest and the Planning Committee supported UBC CPD’s research team in the matching process.

At the beginning of March 2012, program participants received comprehensive Resource Binders which were tailored for each participant to ensure that community-specific resources relating to dementia care were included.

Mentors were supposed to meet with each of their three mentees individually six times over the course of the 8-month program. Mentors were also supposed to meet small group meetings with each of their three mentees four times throughout the program. During the meetings, participants worked toward achieving their individual learning goals with the support of their mentor and their peer group.

The ultimate goal of the Dementia Mentorship Program was to develop relationships between practitioners, create peer-support networks, and create local experts in dementia care in rural communities. Unfortunately, not all of the groups met as frequently as they were supposed to due to scheduling issues.

Over the duration of the program, participants were asked to complete various forms and evaluations that were designed to support individuals achieve their personal goals and to evaluate the program at various time points. Prior to the start of the mentorship program, mentees completed a Needs Assessment which assisted with the mentor-mentee matching process. During the first individual meeting, mentees completed an Individual Development Plan (IDP) outlining their goals for the program and any foreseeable barriers to achieving their goals. At the end of each month both the mentors and the mentees were asked to complete a monthly log depicting the individuals activities in the program (i.e., did you meet with your mentor, did you work on any of your goals, etc.) At the end of the program, in October 2012, participants completed a program evaluation. Two-months after this, they were asked to complete a reflective exercise which was designed to show any clinical changes that the mentee had completed over the eight month program.

Mentee participation in the mentoring program was dependent on signing consent and learning contracts and the completion of a needs assessment survey. The cost to participate in the mentoring program for mentees was $250, which included a comprehensive resource binder, which was tailored to
the mentee and the community in which he or she practiced. See Appendix H for the Resource Binder Table of Contents.

Mentors were invited by the planning committee and by members of the UBC CPD research team to participate. Mentors received an honorarium of $2500 for their participation in the program. Mentors also received a comprehensive resource binder that was tailored to the mentor and the communities in which their mentees practiced medicine.

Overall learning objectives for the Dementia Mentoring Program:

- Identify individual long-term and short-term goals of dementia care;
- Develop close supportive relationships with the mentors in addressing clinical challenges of dementia care;
- Grow collaborative peer-support networks with other mentees in developing practice skills and exploring clinical resources; and
- Increase confidence in providing dementia care, and become local experts in dementia care in their communities.

Mentoring participants included mentees who were all family physicians (24) and mentors, who were both family physicians (3) and specialists (5) with expertise in providing geriatric care. Both professional groups earned continuing professional education credits from their respective colleges for participation in the workshops. Similar to the Dementia Advanced Learning Program, Dementia Mentoring Program participants earned Mainpro C credits for their participation in the program. As the mentoring program was both an educational program and a research study, mentoring participants had to complete the evaluation components of the study or were removed from the program. The mentoring program had participants complete the following evaluation tools:

- Needs assessment survey
- Individual Development Plan
- Monthly Log (for both mentors and mentees; ongoing over the eight month program)
- Program Evaluation (for both mentors and mentees)
- Reflective Exercise (for both mentors and mentees; two months post-program)

Highlights from Evaluation Feedback

More than half of the mentees who participated in the Dementia Mentorship Program were experienced family physicians practicing who had been in practice for more than 20 years. Mentees described several factors that motivated them to sign up for the program:

- “It seems like a good way to get to know geriatricians in my area to whom I could refer in future; I do have a lot of older patients!”
- “Customize the learning need that is applicable to my practice.”
- “I can ask questions that are specific to my patients, and "pick an expert's brain".
Program mentees highly rated the following areas as their top learning needs:

- Determining dementia subtype.
- Setting up an individualized care plan and setting goals of care for patients with dementia.
- Managing BPSD with medications.

The program mentees refined their personal learning goals throughout the eight months, discussing patient cases with their mentors and updating the learning goals once progress has been made. The mentees highly valued the mentoring program:

- “I am grateful that this program existed. I enjoyed the format. Our mentor was excellent and was key to making the program worthwhile. I enjoyed the small group discussions and the opportunity to connect with other physicians in my community. The timeframe of the program seemed about right.”
- “[The program] allows for continuity and follow up, direct case based learning will benefit my patient, I would like to think that relationships developed with the mentor and other mentees [will] continue well after the program ends.”
- “The model works well for physicians like me who are working in rural areas.”
- On the other hand, the mentors also reflected on their experiences during the program:
  - “We used consults as our primary learning environment. These ‘live fire’ experiences are the best way to learn.”
  - “The least skilled mentee in my group came a long way in ability to assess and manage dementia; all 3 clearly developed more confidence.”
  - “I ended up with a much clearer idea of what a family physician is dealing with particularly in less urban settings. I gained more admiration than I had previously (and I had quite a bit) for the
work of the family physician, and the benefit of perhaps developing a RACE (Rapid Access Communication Line for Geriatric psychiatry) line to be able to support them more in real time.”

- “[I learned that ] 1) Community family physicians need and benefit from case based support and supervision; 2) The most advanced mentee in my group presented challenging cases. I did need to access expert advice twice during the program and this was a good learning experience for me”

- “Overall I felt that the program was very innovative and likely to produce more lasting practice change in its participants than other forms of CME.”

Collectively, the results from the mentoring program have been very positive. The program’s mentees reported that most of their individual learning goals were achieved. Additionally, both mentees and mentors noted that mentees confidence in treating their patients with dementia increased over the duration of the program.
Knowledge Dissemination

The Dementia Education Strategy (2010-2012) evaluation process confirmed an increase in physician and other health care provider knowledge and practice improvement relating to dementia care. There were numerous knowledge dissemination activities included as a component of the strategy, including the development of the Dementia Education Strategy website [http://www.ubccpd.ca/programs/bc-dementia-education-project/](http://www.ubccpd.ca/programs/bc-dementia-education-project/), numerous print and online marketing campaigns for various activities, regular quarterly reports, newsletters for program participants, and DES2 representation/presentations at numerous conferences throughout Canada, including the Canadian Conference on Medical Education, CME Congress, the Tapestry Foundation for Health Care Conference, and the Centre for Health Education Scholarship Conference (CHES). Please find a full list of conference presentations and other communication activities related to this project in Appendix I.

Furthermore, UBC CPD plans on submitting several abstracts to peer reviewed journals in the upcoming year relating to two DES2 educational interventions that were also approved as research studies: the case-based workshops and the formal mentorship program. The research findings from these projects are of interest to medical educators, healthcare providers who are involved in the provision of care for dementia patients, advocacy and community groups, and other stakeholders.

Some of the most notable findings are the effectiveness of integrated practice tools, tailored community-based resources, integration of technology, and ongoing support and feedback from mentors in the area of dementia care. The rigor of the study/program design within DES2 and the outcomes of these educational interventions can be extrapolated to other clinical education activities and are adaptable strategies to other health conditions and chronic conditions.
Conclusion

Overall, the purposed of the Dementia Education Strategy was to help BC physicians and other healthcare professionals achieve optimal care for patients suffering from dementia. The educational deliverables within this program incorporated clinical practice guidelines on cognitive impairment and were designed to assist healthcare professionals by giving them the tools and knowledge that they need to better manage patients with dementia.

In all, the five year strategy, including both DES1 and DES2, reached 1,643 family physicians, specialists, pharmacists, nurses, and other primary health care providers in British Columbia.

As evidenced by this report, the Dementia Education Strategy (2010-2012) allowed UBC CPD and the ADTI to show continued provincial and national leadership in educational outreach and community engagement in support of proper dementia diagnosis, ongoing management, prescribing patterns, billing, and caregiver decisions in order to improve patient care.

DES1 built upon the most impactful elements of the first iteration of the Dementia Education Strategy from 2007-2010, enhanced awareness of the ADTI, and encouraged participation from clinicians and pharmacists in helping to evaluate the rationale and appropriate use of Cholinesterase Inhibitors.

Evaluation findings show that two of the most effective programs in DES2 were the formal Mentorship Program and the Dementia Advanced Learning Program. The Dementia Mentorship Program was the first of its kind in British Columbia, and paired family physicians with geriatric specialists and other dementia expert physicians over an eight month period. By working with mentors and peers, participants developed and refined their learning objectives and were given ongoing support to address these objectives in their practices. The Dementia Advanced Learning Program offered novel methods for office-based family physicians to manage their patients with dementia as they would for other chronic diseases. A variety of practice tools were provided, including a dementia patient chart self-audit tool and a dementia flow sheet which some participants integrated into their Electronic Medical Record (EMR) systems to track dementia patients over time.

Over the past five years and two iterations of this strategy, UBC CPD built a successful outreach model for dementia education that allowed for increased accessibility and higher engagement. The activities outlined in this report show that continuous quality improvement methods, interprofessional resource sharing, advanced case-based small group and online activities, and mentorship, are effective methods for improved care of patients with dementia.
References


https://www.bcma.org/files/PhysicianWorkforce_paper_WEB.pdf


## Appendix A: Webinar Learning Objectives

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| 11-June-11 | Caring for Your Patients with Dementia             | 1. Understand the impact of the diagnosis on patients, family members, and caregivers  
2. Understand the key elements of “success” in care communication using a strengths-based perspective  
3. Apply strategies that promote better communication between physicians, patients, and caregivers around dementia care  
4. Become aware of caregiver needs and know how to access available community resources that supports families throughout the progression of the disease  
5. Become aware of and how to access community resources that can support family physicians in caring for patients and their families | Dr. Joanie Sims Gould & Ms. Jan Robson                     |
| 21-Sep-11  | A Practical Approach to Dementia-Related Behaviours | 1. Assess factors that may contribute to Dementia-related behaviour;  
2. Describe key non-pharmacological approaches to coping with Dementia-related behaviour;  
3. Use pharmacological approaches to managing Dementia-related behaviours with more confidence. | Dr. Elizabeth Drance & Dr. Michael Wilkins-Ho |
| 7-Dec-11   | Planning Ahead: Advance Care Planning in Dementia Care | 1. Identifying practice supports for advance care planning  
2. Understanding substitute decision-making and advance directives in the new legislation  
3. Identifying opportunities for advance care planning within the person's dementia journey | Dr. Doris Barwich & Pat Porterfield              |
| 22-Feb-12  | Effectiveness and Use of Cholinesterase Inhibitors in Dementia | 1. Determine the role of medications in the management of MCI and dementia.  
2. Understand when initiation, discontinuation, or switching of cholinesterase inhibitors is appropriate.  
3. Discuss the risk benefit ratio of typical and atypical antipsychotic use in the management of dementia. | Dr. Donna Buna & Dr. Dean Foti                  |
| 25-Apr-12  | Pain Management in Dementia: Recent Issues with Narcotics | 1. Manage pain in patients with dementia  
2. Support patients with dementia through end of life and palliative care issues  
3. Determine alternative and appropriate narcotics to prescribe as a result of recent changes.  
4. Evaluate the ethics of prescribing narcotics to | Dr. Romayne Gallagher                          |
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Appendix C: Community Case-Based Workshop Pre-Reading List

   Available from: [http://goo.gl/X30E2](http://goo.gl/X30E2)

   Available from: [http://goo.gl/Jy2ZN](http://goo.gl/Jy2ZN)

   *UBC eLink: [http://goo.gl/ldD2M](http://goo.gl/ldD2M)
   *CPSBC Link: [http://goo.gl/s84KY](http://goo.gl/s84KY)
   *UBC eLink: [http://goo.gl/rC2SO](http://goo.gl/rC2SO)
   *Links will first lead to a login page on the CPSBC or UBC website and then on to the article itself. Access is limited to CPSBC registered physicians or UBC staff/students.

Appendix D: Culturally-Specific Community Case-Based Workshop Syllabi Table of Contents
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SECTION 2: Guidelines

- Full 2008 GPAC Guidelines
- Third Canadian Consensus Conference on Diagnosis and Treatment of Dementia (2007)
- MMSE, with instructions
- MOCA, with instructions
- Global Deterioration Scale
- Katz Basic Activities of Daily Living (ADL) Scale & Lawton – Brody Instrumental Activities of Daily Living Scale (IADL)

SECTION 3: CMAJ article series, Diagnosis and treatment of dementia


SECTION 4: Diagnosis and Disclosure

- Diagnosing and Treating Alzheimer’s Disease, by Doug Drummond.
- Information Sheet: Cognitive Impairment, Alzheimer’s Disease, & Dementia, prepared by Dr. Drummond
- Dementia CDM Tracking Flowchart; prepared by Dr. Drummond

SECTION 5: Alzheimer Society

- Alzheimer Society of BC: Brochure, Program Overview
- Alzheimer Society of BC: Dementia Education Program Descriptions
- Alzheimer Society of BC: First Link Locations, brochure, referral form (specific for each community) & Program Description
- Alzheimer Society of BC: Safely Home brochure & Registration Form
- Alzheimer Society of BC: Minds in Motion Information Page & Locations
SECTION 6: Special Authority and Fees

- ADTI Billing Overview
- ADTI Research Compensation Algorithm Billing Flow Chart
- ADTI – Reference Guide to Prescribing Cholinesterase Inhibitors (Table/Flowchart)
- ADTI Forms – Copies of the online fill-able forms physicians complete: Initial Coverage, Renewal/Switching Coverage, Switching for Tolerability
- Dementia Care – Potential Service scenario for GP’s

SECTION 7: Driving

- CMA Driver’s Guide: Appendix D Driving and Dementia Toolkit
- Cognitive Impairment Suspected or Diagnosed, Flowchart of steps to be taken in regards to scores on specific driving tests
- Form: Report of a condition affecting fitness and ability to drive
- Driver Fitness BC: Determination of Driver Fitness in BC (brief description of driving tests)
- SIMARD MD
- DriveABLE Information Sheet
- DriveABLE article: Research-Based Assessments for Medically At-Risk Drivers
- (Suggested alternatives: Access Victoria (only for Victoria, Vancouver Translink: HandyDART)

SECTION 8: Incapacity Planning

Advanced Care Planning

- Federal/Provincial/Territorial Ministers Responsible for Seniors: What every older Canadian should know about: Planning for possible Loss of Independence
- Fraser Health Information Booklet for Advance Care Planning: Planning for Future Healthcare Choices

Legal Matters

- Public Guardian and Trustee of British Columbia: Consent to Health Care and the role of the public guardian and trustee
- Nidus Personal Planning Resource Centre and Registry: Enduring Power of Attorney, Planning for Financial and Legal Affairs
- Ministry of Health BC: Health Care Providers’ Guide to Consent to Health Care

Abuse, Neglect and Self-Neglect

- B.C.’s Adult Guardianship Laws – Protecting adults from abuse, neglect and self-neglect
- World Elder Abuse Awareness Day – Abuse of Older Adults: Signs and Effects
- Public Guardian and Trustee of British Columbia: Services to adults assessment and investigation services
- Alzheimer Society: Living Alone

Housing, Assisted Living, Care Facilities
• BC Housing for Seniors
• Seniors Services Society: Seniors Housing Option Grid
• Questions and Answers on Client Rates for Publicly Subsidized Residential Care Services, Feb 2012
• Vancouver Island Health Authority: Assisted Living Handbook
• BC Government Community Care Facilities: Choosing a Care Facility or Home

SECTION 9: Home & Community Care

• Home & Community Care Offices in BC - Contact List
• Caregiver Supports in BC – Contact List
• Specific Community Resources
• BC Ministry of Health: Health & Seniors Information Line

SECTION 10: Coaching Program Meeting Resources

• How to Use Doodle to schedule meetings
• DEP1 Workshop Case: Global Dementia Case and Progressive Care
• DEP1 Workshop Case: Driving with Dementia
• DEP1 Workshop Case: Living at Risk
• DEP1 Workshop Case: Nursing Care

Mentee Related Article:

• Zerzan, J., Hess, R., Schur, E., Phillips, R., and Rigotii, N. (). Making the most of mentors: A guide for mentees. Academic Medicine, 84, 140-144.

Patient Advocacy

• Alzheimer Society: Principles for a Dignified Diagnosis
• Vancouver Coastal Health: Dorothy’s Story – Seniors, Families and Professionals Partners in Care

Appendix I: List of Conference Presentations & Other Communications Activities

Conference Presentations:

2011
2012

June 2012 Webinar Flyer
Culturally-Specific Community Case-Based Workshop Flyer

UBC CPD Case Based Dementia Workshops:
For Family Physicians Providing Medical Care to Chinese, Iranian, or South Asian Patients & Their Caregivers

- Registration open now for individual workshops (max. 12 per workshop)
- Cost: $250 includes dinner & course materials

2011 WORKSHOP SCHEDULE 1:00-5:00pm
Date Location Faculty Community
December 15 Tegh Lee Family Dr. Jana Annand North Vancouver

The workshop hour covers the following topics:
- Clinical criteria for diagnosing mild cognitive impairment
- Role of non-pharmacological treatment for cognitive impairment
- Appropriate treatments for behavioral and psychological symptoms of dementia
- Pharmacotherapy & Cholinesterase Inhibitors
- End of Life care

www.ubcpd.ca/programs/DementiaEducation

Dementia Advanced Learning Program Brochure

Is your practice aging faster than you are? We can help.

UBC Dementia Learning Seminar for Family Physicians

Monday, September 10th, 2012, 1:00-9:00pm

A free MUNPRO educator program
Earn up to 85 MUNPRO credits

Before the seminar:
- Review two patient charts using a chart audit tool we will provide

At the seminar:
- Bring your completed chart audit to the seminar
- Two expert facilitators will introduce the group to new tools and resources for screening and managing patients with dementia
- Learn practical solutions for improving how you track patients over the course of their dementia journey
- Dinner-reservations will be provided

After the seminar:
- Participate in 3hr follow-up telephone call 6-8 weeks later

www.ubcpd.ca/programs

Would you like to...

☐ Improve how you monitor and manage your patients with dementia

Do you have...

☐ A high rate of dementia patients who are being managed by long-term care facilities?

Are you...

☐ An Office-Based Family Physician
- Working in the Lower Mainland
- Available to attend both a seminar & telephone follow-up

Interested?

Dr. Kathy Ball, MD, RCPC: Geriatric and Internal Medicine
Dr. Douglas Drummond, MD, CCFP
Clinical Associate Professor, UBC Department of Family Medicine

Seminar Agenda
Early September, 2012:
- Review two patient charts prior to the seminar
- Lunch seminar
- Location: 855 West 13th Ave, Free Parking Available
1630: Light Refreshments & Registration
1700: Introduction
1730: Chart Audit Review
1900: Dinner
2030: Participant Follow Up
1945: Presentations from Community Organizations
2045: Commitment to Practice Change
2100: Seminar Ends

Mid-October, 2012
- Follow-up telephone call

BC Dementia Education Strategy, 2010-2012, Final Report
Mentoring Program Mentee Invitation Letter

Dear Colleagues,

BE: IMPROVING YOUR DEMENTIA CARE THROUGH A MENTORING PROGRAM

If you are interested in improving your management of the growing number of patients in your practice with Alzheimer’s disease and other dementias, you may want to consider this unique program from UBC CPD.

IN A NUTSHELL:

- Each participating family physician will pair with a mentor/coach and two other "mentees".
- Mentees are specialists in dementia care, e.g., geriatricians, geriatric psychiatrists, or family physicians with advanced knowledge of dementia.
- Each pair will have 4 hours of face-to-face interaction and 45 minutes of phone calls with the mentor/coach each month.
- Participants will set their own learning goals and work with their mentors and group mates to achieve those goals.

Some unique advantages to this mentoring approach:

- Participants get direct and informal access to dementia specialists.
- Feasibility in scheduling may allow for little or no time loss from practice.
- Subsidy from the Ministry of Health results in very low tuition.
- Program qualifies for up to 10 Mainpro-C credits (convertible to 5 Mainpro-M credits)

HOW TO REGISTER:

- See 1124.04.15-1501 or 1124.04.15-1601 (or email mainpro@ubc.ca) for the signed General Consent Form and Learning Contract.
- Register through UBC CPD.
- Tuition fee $250.
- You will be assigned a mentor/coach based on your learning objectives and geography.
- Meet with your mentor and write an Individual Development Plan (your learning objectives).
- About every 5 weeks there will be a 1-hour meeting with your mentor and a small group meeting with your mentor and the other family physicians.

The Mentor:

- To qualify for Mainpro-C credits, there has to be a mentee-mentor reflective exercise (an online form).
- Must complete a monthly log of your goals and progress toward them (online form).
- Final evaluation form (online) at the end of the 6 meetings.

For more information, please contact mainpro@ubc.ca or call 604-875-9756.
Improving the Dementia Education Program: Assessing Diversified Learning Needs of Participants

Gurveen Grewal, BA, Chloe Wu, MSc, MEd, Tanuja Barker, MSc, Andrea Keesey, MA, Brenna Lynn, PhD
UBC Continuing Professional Development (UBC CPD)

Background

Literature and evaluation findings from the UBC CPD Dementia Education Strategy (2007-2010) identified the following areas for ongoing CMG program improvement:
1. Increase interprofessional education.
2. Adjust length of workshops to allow broader and more roundtable discussions.
3. Address challenges faced by family physicians improving dementia care to BC’s multi-ethnic population that need to be addressed at the understanding of aging and delayed dementia management.
4. Offer training to newly-trained health care professionals who serve this population.

May dementia patients are cared for at the primary health care levels. The CMG interventions to improve the quality of care provided by CP are widely recognized.

Methods

Based on these findings, UBC CPD has developed a unique approach to the workshop component of the current Dementia Education Program that effectively addresses the needs. See Figure 1.

Workshop evaluations are comprised of two components:
1. Secondary evaluation of the evaluation measures used in the current dementia education program.
2. Facilitated participant feedback:
   a) Pre-workshop survey
   b) Workshop completion survey
   c) Post-workshop survey
   d) 6 month post workshop survey
   e) Post workshop interviews & focus groups

Results

Figure 1: UBC CPD’s multi-pitched approach to dementia workshops.

Lessons Learned

- Evaluation results will reveal how multi-pitched workshops can effectively address the learning needs and personal goals of the workshop.
- Participants will be reminded that interactive, multi-faceted interventions are necessary in removing barriers to learning.
- To improve learning and practice change.

Current literature on education and practice change training for dementia care and management is limited.

References


Acknowledgements

The Dementia Workshops were authored by Martha Donnelly, Yvonne Drummond, and Elizabeth MacNeil. Funding for this project was provided by the British Columbia Ministry of Health, Pharmaceutical Services Division.

Feedback & Questions

Further information

More information on the CMG work and related projects can be obtained at: www.dementiaeducation.ubc.ca

Post of poster: http://jga.to/CQg8
BC Dementia Education Strategy

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Context

Education around dementia care and management continues to be an ongoing need for BC health care practitioners. Since 2007, UBC CPO has delivered a series of Dementia Education Programs throughout BC. at the beginning of 2010-2012 a new iteration of the strategy was implemented. The aim of the strategy was to improve the quality of dementia care provided by healthcare professionals in BC.

Educational Intervention

The multi-modal educational strategy aimed to address gaps in dementia care, reinforce best practices, and maximize learner engagement to meet the needs of clinicians at different stages of learning. Five educational activities were designed. (Table 1)

Table 1. 2010-2012 Dementia Education Programs

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conference Break-out Sessions</td>
<td>2 one-hour sessions</td>
</tr>
<tr>
<td>Webinars</td>
<td>2 one-hour presentations</td>
</tr>
<tr>
<td>Case-based Workshops</td>
<td>2-3 hour small-group workshops</td>
</tr>
<tr>
<td>Coaching Program</td>
<td>8 month formal mentoring program</td>
</tr>
<tr>
<td>Advanced Learning Program</td>
<td>3 month program for family physicians</td>
</tr>
</tbody>
</table>

Observations

The 2010-2012 Dementia Strategy has engaged over 700 healthcare providers—including family physicians, specialists, residents, nurses, social workers, and pharmacists—and have been reached in 55 communities across the province. (Table 2)

Ligorous program evaluations are built into the educational programming allowing for quality control and insight into course improvement/expansion.

Participants described the program(s) as a valuable learning experience that aligned with their clinical realities as well as best practices in providing dementia care.

“Customized learning needs; applicable to my practice and ongoing interactions with mentor to deal with the challenges.”

— Coaching Program Participant

“It was great to share experiences and be more aware of different practices (MD/pharmacists)”

— Workshop Participant

“Ongoing. We will learn as we go, rather than a ‘one-shot’ approach”

— Coaching Program Participant

“It allows me to audit my own dementia assessment and management strategies.”

— Dementia Advanced Learning Program Participant

“The Dementia webinar series is excellent, and gives practical advice to FPs that is not otherwise readily available”

— Workshop Participant

Discussion

The multi-faceted Dementia Education Program extended its reach by offering CME in various formats, supporting physicians and other health care professionals by equipping them with the knowledge and tools that they need to better manage their patients with dementia.

Through small-group community-based learning, online learning and, assisted self-directed learning the UBC CPD Dementia Education Program has:

- Addressed clinical knowledge gaps
- Improved diagnostic skills and prescribing patterns
- Increased confidence (leading to a reduction in unnecessary referrals and delayed decision-making)
- Improved relationship between family physicians and dementia care experts

The quality of care patients with dementia experience when their primary health care teams are given the appropriate tools and skills cannot be underestimated, and the Dementia Education Program has made tremendous inroads in this area of need.

Acknowledgements:

Program content was developed by members of the UBC CPD Dementia Educational Committee, Dr. Karen Bell, Dr. Martha Donovan, Dr. Doug Drummond and Dr. Denise Macdonald. Funding for the project was provided by the British Columbia Ministry of Health, Pharmaceutical Services Division.