

Special Topic Section on Optimizing Care Coordination. Moving Care Forward in Alzheimer's Disease: Opportunities and Challenges

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Today many global and national public policy health plans express a mandate for improved quality of care for individuals with chronic brain disorders such as Alzheimer's, related dementias and other conditions that impair memory, movement and mood. While these are important goals, the design, the funding and the implementation of these plans remain exceedingly complex endeavors. Managing the perspectives of various stakeholders including the patient, their caregiver, their health care providers, their health care payers and their society presents a critical challenge.

Increasing human longevity is the most important factor underlying the problem of many chronic brain diseases, particularly Alzheimer's. The global age wave is now recognized as a public health super-crisis that comprises ever-increasing costs for diagnosis, assessment and treatment monitoring. In addition, this super-crisis also impacts an ever-increasing demand for acute- and long-term care services. Many countries recognize the central problem of chronic brain disorders are the inadequacies and inefficiencies of existing care and services delivery programs.

Alzheimer's disease (AD) is perhaps the most important chronic brain disorder and represents a global health concern, and its management differs considerably worldwide. Providing both care and support is difficult because of the variation in the symptoms each person faces. Moreover, a vast majority of patients have other co-occurring health conditions. Although reimbursement for diagnostics and treatment varies across countries, generally most national policies place a high priority on the importance of managing these costs associated with AD. Yet, there still remains an urgent need for effective and equitable access to care. More importantly, there is an even larger need for greater research support to develop, test and implement better and more efficient care service-interventions.

Given the complexity of AD care, coordination remains the key to overcoming numerous challenges. Like other chronic conditions, AD

care requires well-integrated medical and social services in order to have the best management. This is accomplished through a carefully constructed care plan. The primary objective is the achievement of the best health outcomes and prevent unnecessary acute care visits while insuring these services provide this in an efficient and cost-effective way. Further, it is also an imperative to recognize the impact that AD has on caregivers.

Supporting primary health care professionals, particularly general practitioners (GPs) to deliver timely diagnosis, effective referral and ongoing care, is a sustainable and cost-effective way of improving the care for people with AD and their caregivers. But there is a need to ensure that care planning is reliably undertaken and to guarantee both the most effective care service intervention for a given patient, at a given stage, is easily accessible and adaptable.

The first step is to build a personalized care and support plan (PCP) in order to agree with goals, develop and implement action plans, and monitor disease progress. The PCP is a planned and continuous process. It encourages professionals and patients, as well as their careers, to work together to clarify what is important to the patient and to caregivers. The major question is to find the best way to ensure that these principles are actually applied.

One clear example is the advent of multicomponent practice-change interventions. The advanced practice registered nurses (APRN) who is skilled at the co-management for chronic conditions, represents a key advance for the delivery of quality care in AD. The APRN has usually both geriatric and dementia-content expertise and can provide continuity in the management of PCP and implement secondary and tertiary prevention avoiding or delaying complications. These nurses are able to manage behavioral and psychological symptoms of dementia, to help provide non-pharmacological interventions and to bring support in order to improve the level of information that patients have on research objectives and access to clinical

research processes. APRNs can communicate with acute-care physicians for goals-of-care discussions and insure transitions of care, always in close collaboration with GPs.

There are several other important examples. Education and skill-training for formal and informal caregivers of people living with dementia and other chronic brain disorders should aim to establish customizable learning formats (e.g., individual or group sessions, or online training and support). The application of new technologies (e.g., wearable sensors, home-based monitoring, telepresence) have the potential to monitor disease progression, home environment/safety quality, nutrition as well as assessment of therapeutic responses. Although data acquired from these technologies offer the promise of greater accuracy over traditional methods, questions remain on the reliability, validity, and implementation of new health technologies into real life situations encountered by patients, caregivers and their health care service providers.

For 2019, Care Weekly will advance these topics as a key priority for publication, known as a Special Topic Section. Special Topic Section will serve as ongoing virtual special issue where the Journal publishes manuscripts on a given topic area. Once a sufficient number of papers are published, an e-book collection of all published papers from a given Special Topic Section may be produced in the future to help showcase the content similar to a typical journal special issue.

The Journal recognizes that personalized/precision medicine, person-centered health and wellbeing continue to be important themes for effective, efficient, and value-based healthcare. Yet, there is an ongoing need to translate health care services research to better inform those audiences that implement new ideas on the practice and delivery of care to the general population. To help this process, the Journal's Special Topic Section on Optimizing Care Coordination actively encourages the submission

of manuscripts to establish conceptual linkages between various domains of knowledge.

This Special Topic Section seeks research papers, reviews or perspective papers that assimilate and explore what is known, what is newly found and what remains unknown. Author should evaluate how new/amended ideas or care-service models might translate from the research setting to community/population level. In addition, this Special Topic Section seeks to foster discussions that cover not only research findings, but also goes further into the evaluation of the research methods, the necessary next research steps, and the implications for a robust and efficient newly developed care service intervention. In addition, prospective authors may describe novel new approaches to data collection, modeling and hypothesis generation with the caveat that any such presented methods include sufficient detail such that replication and/or reproducibility could be conducted.

An overarching objective for published articles will be to communicate knowledge so that all members of the care continuum (i.e. policy makers, elderly, formal and informal care givers, public sector, entrepreneurs, etc.) may share outcomes and new ideas that lead to innovative and cost-effective population-based interventions. The Journal looks forward to your submissions, especially those that improve the value of care for both patients and their caregiver.

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