

National Strategy Dementia-Related 2014-2017

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Preamble

We may almost all be confronted with dementia, as either as relatives or friends of a sick person or as patients. This disease involves a complete reorganization of life and social relations. However despite difficult conditions it is possible to enable the affected people and their families to maintain a quality of life satisfactory.

To achieve this, Switzerland needs a health system that provides the best possible advice to all concerned and allows patients to be treated, accompanied and followed as required. Today, bids are already numerous and of good quality. However, considerable progress is still possible to see essential given the changing demographics. Opportunities for improvement are, firstly, on the offers at all stages of the disease. They concern, on the other hand, the quality of development, professional skills and research and the participation of those affected by dementia and awareness.

Strengthening of integrated care is one of the main objectives of the "Santé2020" strategy of the Federal Council. Integrated management of patients throughout the disease - early detection to palliative care - contributes significantly to improving the quality of life of people with a disease of dementia. By implementing the "National Dementia Strategy 2014-2017", we are making a decisive building block.

During the development of the strategy, it was clear that many actors working in the field have a very specific vision, they agree on priority actions and they are proof of unparalleled commitment. These aspects have been particularly valuable and will be critical to a successful implementation of the strategy.

The "national policy on dementia 2014-2017 Strategy" allows the Confederation, cantons, service providers, specialized or professional associations, self-help organizations and non-governmental organizations to converge their approach to dementia. It will benefit people with dementia pathology and their families, while allowing developing modern health care facilities.

We are happy to take you with the implementation of the "National Strategy on dementia 2014-2017.

1 Values and Overall Objectives

"National Dementia Strategy 2014-2017" foregrounds people with a pathology of dementia and persons accompanying them daily. Therapy, care and support are focused on maintaining the quality of life and dignity the person respecting its physical and mental integrity, autonomy and social ties. The conditions in which they live, such as occupation, civil status or immigrant background as well as special needs, for example, the existence of concomitant diseases or disabilities, are taken into account so consequent.

"National for 2014-2017 dementia strategy" promotes both a better understanding of diseases of dementia and the acceptance of those concerned. Thus, bottlenecks and stigma is reduced, allowing an open approach with dementia.

"National Dementia Strategy 2014-2017" poses the requirement that all affected persons have, at all stages of their illness, access to high quality offers, and low threshold for permanent integrated with psychosocial care levels, medical and curative.

2 Background

2.1 Parliamentary Mandate

"National Strategy for Dementia" is the result of two motions granted by the National Council that were filed in 2009 (09.3509 Steiert Jean-François and Reto Wehrli 09.3510) and presented by Parliament Federal Council on 12 March 2012.

Motion Steiert "Piloting of the material in policy pathologies i dementia. Prepare the basics required "(09.3509) 1

"In cooperation with the cantons and organizations concerned, the Confederation will develop the necessary bases a n that the costs borne by individuals and the community for pathologies of dementia can be monitored and observed over time. Thus collect regularly updated figures will be used to drive a common Swiss policy pathologies of dementia. This policy, it is imperative and urgent to de ne, will aim to fix a support mode and optimal treatment for all concerned. "

Wehrli motion "Policy Control for dementia diseases II. Common Strategy of the Confederation and the cantons "(09.3510) 2

In cooperation with the cantons and relevant organizations, the Confederation will establish the principles of a strategy pathologies of dementia. This strategy will set the priority lines of action in the following areas: the causes of dementia, prevention, development of treatment methods, improving early detection, support caregivers, planning and provision of the necessary infrastructure and clear allocation of responsibilities between stakeholders. The aim is that decisions on treatment and supervision of patients are taken in the company's interest as a whole and do not intend to respond first to a microeconomic logic and financial considerations of those who bear the costs. "

2.2 Processes to satisfy the motions

2.2.1 Insertion in the "Policy Dialogue National Health"

The political mandate is for the Confederation and the cantons. The fulfillment of this mandate and its management are integrated into the "Dialogue of the national health policy" - platform for exchanges between the Confederation and the cantons. At its meeting of 25 October 2012, it mandated the Federal Office of Public Health (FOPH) and the Swiss Conference of Cantonal Ministers of Public Health (CDS) to respond to requests within two motions developing and implementing a "national Strategy for dementia".³

If one wants to formulate a strategy close to the practical and durable, it is essential to de ne the need for priority action and, in doing so, to ensure the transfer of knowledge from practice and research to community policies. Different players have therefore actively participated in the development of the strategy: representatives of relevant organizations, experts from the professionals groups and specialized organizations, several areas service providers as well as members of staff of the federal, cantonal and of Commons.

2.2.2 Definition of the need PRIORITIES

As a first step in preparing the strategy, the FOPH and CDS mandated expertise. She had two objectives: first describe the current situation in Switzerland⁴ - by identifying gaps in knowledge - and secondly take ac- count of the knowledge of experts in Switzerland and then infer the need for priority action and issue possible recommendations.

To clarify the need for priority action, workshops following the path of a person with dementia pathology were organized. The model developed in five phases (see chap. On clinical tables). The project leaders have visited and met different people in charge of projects implemented as well as those directly involved. 66 representatives from different backgrounds: people's organizations concerned, service providers in the areas of patient care, long term and hospital, trainers and researchers, professional groups and professional associations at the national level participated in thematic workshops: "Primary prevention and early stage of the dementia pathology"/" secondary prevention, diagnosis and treatment"/" care and treatment in outpatient care (at home"/" treatment at the hospital"/" care and treatment in care long term (EMS). "representatives of organizations of persons concerned and primary care medicine were invited to all workshops. CDS has made an inventory of the implementation of the support offerings from pathologies of dementia. the aim of this survey was to take stock of the current situation in Switzerland (CDS, 2013).

The results of the expertise and state of the current situation in the townships were supplemented with further data on the need for action (see FOPH CDS, 2011; National Ethics Commission in the field of human medicine (NEK-CNE), 2011) and assembled in a comprehensive synthesis. Based on this global synthesis, proposals for the fields of action, potential targets and projects were developed and refined through a validation process in three stages.

- The first brought together members of the consultative body expanded. 5
- The second brought together as part of a hearing more than 70 experts from the suppliers of services, organizations of persons concerned, professional and specialist associations, training and research, as well as cantonal authorities.
- The third, meanwhile, takes place in the context of a broad consultation online.

3 Bases

3.1 Pathology of dementia in Switzerland

3.1.1 CLINICAL PICTURES

Dementia is a general term for various brain diseases, due to different causes:

- Degenerative changes in the brain, which to this day cannot be fully explained. Here, the most common form of dementia is Alzheimer's disease.
- Vascular dementia, which is caused by cerebral hemorrhage, by repeated cerebral infarcts (multi-infarct dementia).

A combination of several causes is possible, and even common: in many people, there is both degenerative and vascular elements.

The pathology of dementia is characterized by progressive impairment of memory combined with a disorder of at least one of the functions such as language disorders (aphasia), impaired the gestural level (difficulty in carrying out movements (apraxia) a deficit of visual and spatial recognition (agnosia), or a decline in executive function (loss of the ability to plan and act) (see Monsch et al, 2013;. Bassetti and al., 2011).

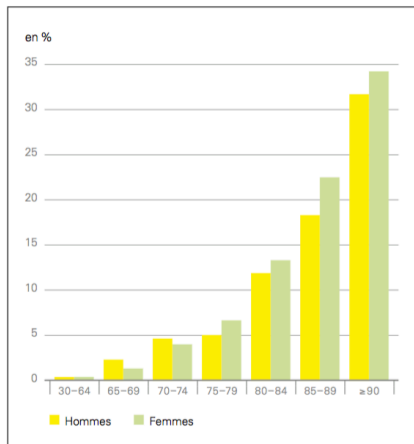
These cognitive deficits dice have the effect of reducing the autonomy of the person with dementia and make it dependent on the help of others for activities of daily living. The severity is measured in need of care (Monsch et al., 2012). A deterioration in emotional control, social behavior or motivation often accompanied, and sometimes above, disorders of cognitive function. 6

The disease occurs in several phases⁷, which can be very different and be as resources variously felt by those affected; its effect on the daily lives and quality of life also varies (see Zentrum für Gerontologie (ZfG), 2013a, 2013b, 2008; Becker et al., 2005). Specific requirements in the health system arose as the stage of the disease and should be considered (p. Ex., Offers of support for the person and caregivers or palliative care during the last phase of the disease).

3.1.2 Epidemiology

Prevalence

According to current estimates, some 110,000 people suffer from a pathology of dementia in Switzerland. The prevalence rates of dementia increase with arrow from 65 years (see Figure 1) 8: While in the group of 65 to 69 years, one out of fifty has dementia, one in eight is affected in the 80-84 age group.

Illustration 1: Prévalence de la démence 2011

Source: Taux de prévalence: Harvey et al., 1998 pour le groupe d'âge des 30-64 ans; Hofman et al., 1991 pour le groupe d'âge 65+; Office fédéral de la statistique (OFS), 2011a

People with a condition of the dice starts are mostly the very old and for two thirds of women:

- In 2011 almost two thirds of people with dementia had more than 80 years, and nearly a fifth over 90.
- A greater number of women reach a very high age, hence a higher prevalence in this population group.

However, dementia can also start earlier:

- Approximately 2,600 people are suffering from a pathology of dementia before reaching retirement age.
- In people with a deficiency intellectual, pathologies of dementia appear much earlier than in the general population. In people with Down syndrome, also called "trisomy 21", the disease occurs particularly early stage (see Deutsche Alzheimer Gesellschaft [DALzG], 2011).

As the prevalence of dementia increases sharply with age, the number of people with dementia will also increase significantly, due to the aging population. Thus, until 2030, the number of people with dementia could rise to more than 190,000 and, until 2060, that number could increase to nearly 300 000 people.

3.1.3 Groups of People Concerned

Dementia also affects the environment, which helps in everyday life (see "caregiver" glossary, p. 31) - that is to say the family members, neighbors or friends - and people who, in their professional life, regularly come into contact with people with these pathologies. This means that dementia could directly or indirectly affect nearly half a million people in Switzerland.

The "2012 Barometer of dementia" (ZfG, 2013a; 2012) highlights - a nationally representative survey - the proportion of the impact of the dice starts with the population (people with and without personal contact with people with dementia) in terms of quantity and quality:

- About 60% of respondents reported having had direct contact with people with pathology Madness. In nearly half of these cases there was a contact with someone in their family or their knowledge.
- One in four people expressed concern of one day itself with dementia. No significant difference by gender or age did not occur.

- One in six and one in five French-speaking Switzerland would not go on living with a diagnosis of Alzheimer's disease. Most are older, more respondents (both men and women) agree with this statement.

3.1.4 PRIMARY PREVENTION, EARLY DETECTION AND DIAGNOSIS

Risk Factors

The risk of developing dementia is determined mainly by three factors cannot be influenced risk, namely age, gender and genetic factors. Note that the highest prevalence of dementia in older women primarily reflect the fact...

"That women with this disease live longer than men (this is less so in the case of increased risk inherent in age)" (HOP inger et al, 2011. 64)

...It has not been conclusively established how disease risk could be reduced by impressionable risk factors. According to the Alzheimer's Disease International report (ADI) and the World Health Organization (WHO) recently released the following cardiovascular risk factors and diseases increase the risk of dementia (WHO & ADI, 2012: 2):

- Consumption of tobacco and alcohol abuse
- Hypertension, high cholesterol, the diabetes, obesity

Several studies indicate that depression may promote a form of dementia (see Saczynski et al, 2010;. Dotson et al, 2010;. Da Silva et al, 2013.).

The prevention of dementia in Switzerland

Experts nevertheless fall dice obvious deficits in the Swiss prevention strategy:

"The chance to grab is the promotion of cardiovascular health, vascular component is always more recognized as a partial cause of dementia. But there is a considerable deficit in this respect in practice for the prevention and care" (Gutzwiller & Groth, 2011: 29).

Among the measures recommended for efficient prevention strategy, ADI and WHO recommend investing in training, which strengthens the cognitive capital and executive functions. The Swiss population knows only partially the risk of developing dementia can be reduced by preventive measures. In the survey of the population for the 'dementia Barometer 2012 ', about half of respondents believe that can prevent Alzheimer's disease or another form of dementia by preventive measures, while a third party has denied this spontaneously possibilité.⁹ the people questioned in German-speaking Switzerland are more skeptical vis-à-vis the prevention of dementia than other regions.

Early detection and diagnosis

In Switzerland, it is estimated that each year, almost 25 000 new people are infected with a disease dementia (Bickel et al., 2002).

When the early signs of dementia are detected (changes related oversights, guidance, motivation, social behavior), the first step usually consists of a screening interview with the family doctor. Regarding the screening process, for experts efficient division of labor of family doctor and the specialist is required (Bassetti &

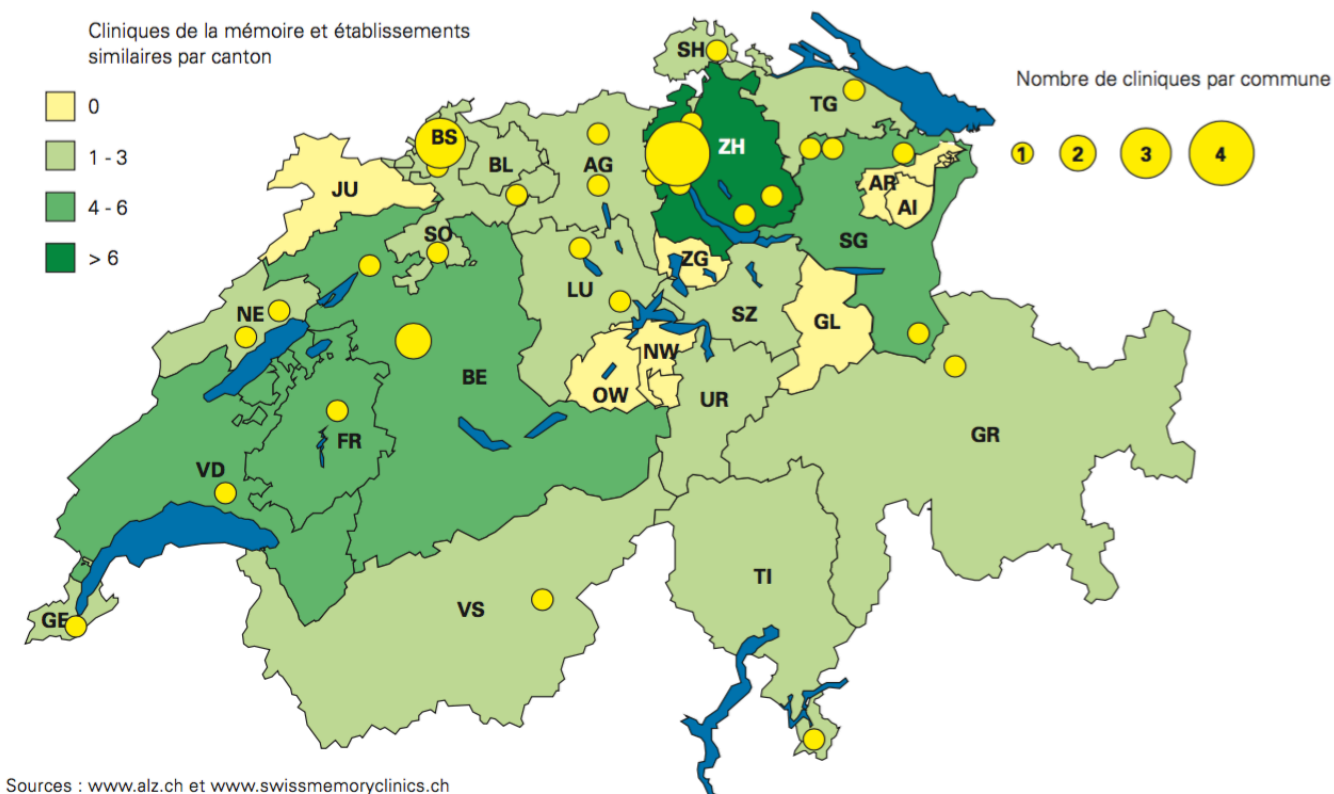
Calabrese, 2011a: 59). However, they note:

"That family physicians do recognize that some of the patients with dementia diagnostic despite recommendations that allow them to ask today with a fairly high probability diagnosis *intra vitam*. One reason is that the tools available to a diagnosis of dementia are under-used and exploited" (Bassetti & Calabrese, 2011b: 14).

The language barrier is a particular dice link when making the diagnosis (p. ex., in patients with a migration background or in people with mental disabilities (DAIzG, 2011) because of widespread testing methods fail or aids to translation must be added (See BAG; Nielsen et al., 2011). The "Consensus 2012 on the diagnosis and treatment of dementia in Switzerland" provides a list of indications for further investigation by a specialist (geriatrics, geriatric psychiatry, neurology) or an interdisciplinary assessment (see Glossary, p. 31) in a "Memory Clinic" (see glossary, page 32) (Monsch et al, 2013:.. 838).

In Switzerland, there are currently 36 memory clinics and similar institutions, in which differential diagnoses are posés¹⁰ (see illustrations 2). Af institutions linked to the Association "Swiss Memory Clinics" perform about 5,000 diagnostic investigations annually. In other words, nearly one new case of dementia in five is subject to a disciplinary investigation.

Illustration 2: Cliniques de la mémoire et établissements similaires en Suisse



According to a 2004 survey, only one third of people with dementia is diagnosed in Switzerland (gfs.berne, 2004). The Swiss Alzheimer's Association (ALZ) on the idea that less than half people with dementia received a diagnosis of a specialist. The Conference of the umbrella organizations of private aid for disabled (DOK) believes that this lack of specialized diagnostic particularly affects people living in situations of mental disability or multiple disabilities. Switzerland, missing data on the number of diagnoses by groups of people, types of dementia and disease severity. In Swiss and international professional circles, there is agreement that the lack of screening and late diagnosis of the disease are a central problem because they impede access to information, advice, support and the treatment of people with dementia (see WHO & ADI, 2012: 8; ADI, 2011: 4; Monsch et al, 2013: 838).

Support After the Diagnosis

Today, monitoring the person with a diagnosis of dementia is usually provided by the family doctor as well as a memory clinic. Referring to the survey results (written questionnaire) launched by ALZ in 2012 and distributed in nearby groups and members, about a quarter near believes not have been enough, or not at all informed enough or advised by the doctor. Among female relatives, this proportion is higher than among male relatives. The perception of the people was not recorded in this survey (Ecoplan, 2013a). In Switzerland, scientific data on the specialized support after diagnosis or the quality of maintenance of the diagnosis are lacking.

3.1.5 Drugs and Therapies

To stabilize or slow the cognitive decline in people with dementia, two classes of drugs are reimbursed by health insurance companies: the cholinesterase inhibitors (Ich) and memantine. In some countries, the cholinesterase inhibitors and memantine are combined. According to experts in Switzerland, the scientific evidence is currently insufficient to recommend this combination therapy. Moreover, the combined treatment is not reimbursed by the funds (Monsch et al., 2013). Both drugs have shown a positive effect not only on the cognitive abilities, but also on behavioral problems of dementia patients (Breil, 2010). In 2009, 130,211 packages of these drugs were sold, for a total of about 27.7 million francs (see IMS Health GmbH) .11 As people with dementia at an advanced stage - for which the administration of anti-dementia drugs is not indicated or that they are not reimbursed by the funds - only a small portion of the more than 100 000 people with this disease, it can be assumed that the people for whom medication would be indicated are by far not all processed. When sufferers appear provocative behavior during care, neuroleptics may be administered (see Lustenberger et al. 2011, c. 3.1.7). WHO and ADI advocate that prescribing practice should be reviewed to the extent that repeated dosing and too much of these products can harm the patient and threaten the safety (see WHO ADI, 2012: 64). Currently, recommendations for the pharmacological treatment and non-drug developed under the aegis of the Swiss Society of Psychiatry and Psychotherapy of the elderly (Monsch et al., 2012).

Several studies have shown that non-pharmacological therapies (p. Ex., Cognitive training, behavioral therapeutic interventions or strengthening self-esteem) have improved the functions required for the activities of daily life (cf. Olazaran et al, 2010;. Wettstein, 2004). However, there is no data on the use of these therapies in Switzerland.

3.1.6 Support and Home Care and Outpatient

A good half of people with dementia in Switzerland living at home (Romero, 2011) .12 The close survey, mentioned above des-, is not representative for the whole territory; but it shows that those who are informed solicitude tent benefits and also shows the types of deals used. In decreasing order of frequency:

- The day center services and support services and home care
- A support service at home and / or a short stay in a nursing home
- Information and specialist advice.

As interviewed relatives have a link with ALZ, we can assume that they are better informed about the discharge possibilities than the Swiss average; therefore, the family member with dementia probably uses more frequently to benefits.

The Situation of Caregivers

Relatives and entourage provide an important support function, ensuring daily accompaniment, continuous presence and care to the person with dementia. Study results show that for the 65% of people with dementia living in dominant cult, the caregiver is a partner living in the same household. About a 25% close are children that support a relative with dementia and 15% live in the same household. Approximately 30% of these relatives are men - this applies both to German Switzerland Switzerland Latin. These are 75% of spouses and 21% of ls of people with dementia. In the group of women caregivers, joint account for 60% and 30% girls.

In many cases, caregivers are already themselves in old age; more than half have exceeded 70 years. In nearly 40% of cases, the care person is sick for more than five years. The expense related to the accompaniment (see glossary, p. 31) of a person with dementia is important, as shown by the results of a participatory study of the "Zentrum für Gerontologie" (ZfG, 2010) .13

- Four partners in five living in the same household with a family member with dementia are on the go virtually 24 hours a 24. While at the beginning of the disease, they deal primarily in organizing the life everyday and care of the sick person, the practical assistance and care (see glossary, p. 31) play a more important role as and as the disease progresses.
- Many relatives are facing changes of personality in the person and a deterioration of their relationship.
- The burden assumed by the relatives can lead to a state of exhaustion and increase their risk of getting sick. Many of these caregivers suffer from depression and disorders sleep and are more exposed to physical disorders (Kesselring, 2004).

About half of caregivers surveyed as part of the Zurich study would like more support, including an aunt most important home care. The share of those who need help in the household or care is significantly lower. In the survey of ALZ, over 60% of relatives qualified very important the following issues:

- Organization of the life of every day (71%) and lack of respite exhaustion (69%)
- Behavior of the patient (63%), organization of help and support (55%) and the relationships within the family (52%)

Socio-demographic aspects such as, p. eg., sex or migration history, have not been considered in this analysis.

Support at home by aid service organizations and care

To date, there are no precise figures on the share of people with a disease of dementia among customer support services to organizations and home care in Switzerland. According to two studies, it should be in the range of 15 to 40% (see Perrig-Chiello et al, 2011; Perrig-Chiello et al, 2010; Gfs.bern, 2004). So far, there is little specific support offers for people with dementia in the offers utility assistance and home care, except for precursors project (Kopp, 2010).

Among private providers of support services and home care including nurses in independent pending, the share of people with dementia in customer might tend to be higher. Indeed, compared to public providers, they are more likely to be able to offer constant support by one person or a small team.

Support structures and day care and specialized night

In 2006 the ALZ has recorded 124 days of care facilities for people with dementia and questioned them about their organization and the number of seats. According to the survey, the number of places in these structures that covers about 12% of needs. At present, there is no overview of the discharge offers ambulatory and stationary short to enable people with dementia in Switzerland. Regarding the financing of these benefits, the same principle prevails, that the compulsory health insurance supports some of the costs of care but not those accompanying benefits (ALZ, 2010).

3.1.7 Support and stationary care

Dementia in stationary establishments of care and support long-term

Some recent studies allow us to assume that almost two thirds of the residents of nursing homes (EMS) Swiss are suffering from a dementing illness. A good 40% of these people have been diagnosed by a doctor. Added to those in which a deterioration of cognitive abilities suggests a dementia (see Bartelt, 2012; ISE 2012; FSO, 2012).

Pathologies of dementia, difficulties faced by sufferers and their relatives, carers and the professionals responsible addictive are directly related to the evolution of the disease and related abuses. The support and care of affected persons living in care facilities and long-term support are becoming more demanding than residents without dementia (Bartelt, 2012). Vast and proven professional skills are required to adequately assist these persons in difficulties they face in everyday life and manifested by a hesitant gait, agitation, apathy, debility, the aggressiveness, opposition, socially inappropriate behavior such as disinhibition, etc.

To calm the patient, it also makes use of drugs. A current survey collecting 90 EMS data in three cantons of German-speaking Switzerland showed that nearly 70% of the dementia population has received daily neuroleptics, their entry into the institution day of the last assessment (Lustenberger et al., 2011). Nevertheless, there is no detailed information concerning

the prescription (dosage and duration), and non-drug measures in place. A survey of 420 EMS in German-speaking and French-speaking Switzerland shows that in over 60% of the institutions surveyed, people with dementia live exclusively in mixed services with non-demented people. In 10% of health care institutions and support long-term, the dementia is hosted exclusively in specialist services (CURAVIVA.CH, 2013). Nearly half of the directions of the institutions surveyed considers itself well to very well prepared to deal with assistance to people with dementia, while 40% feel poorly and near 10% very badly prepared. As the biggest challenges laid in the next five years by dementia, the following three points were mentioned most often:

- Sufficient financial means to support people with 75%
- Carers and sufficient support: 72%
- Increase the individual needs of people with dementia: 67%

Among the directions of the institutions surveyed, 69% considered that current funding was insufficient. Thus, 63% found a supplement accompanying costs very important and 20% fairly important. About 40% also rated extra for accommodation costs as (rather) important.

Dementia in Hospital

Hospitalization for dementia (diagnosed main proceedings) are rare (FSO, 2011b). It nevertheless considers that every year the Swiss acute care hospitals treat nearly 50,000 people with dementia who were hospitalized for other reasons (FSO, 2011b; Harvey et al., 1998; Hofman et al., 1991).

In Swiss hospitals, dementia diseases represent a challenge for the same reasons as in other countries hospitals (see Kleina Wingenfeld & 2007; All-Party Parliamentary Group on Dementia, 2011; Gemeinnützige Gesellschaft für Soziale Projekte, 2008).

- Due to the deterioration of cognitive function, orientation disorders, com- irritating behaviors of unexpected departure, etc., treatment and care of people with dementia pathology disrupt hospital operation and require a lot of medical and nursing staff.
- The risk of complications (p. Ex., During a refusal to seek treatment or delirium) and inadequate therapeutic measures (p. Ex., Due to communication problems) is higher in patients with dementia.
- The introduction of measures requiring consent can be tricky ethical perspective when the person is no longer able to make a decision.

Researchers from the University Hospital of Lausanne and the University have shown in the field of post-acute rehabilitation, the dementia patients were, firstly, a longer length of stay in a rehabilitation facility and, secondly, require more care services such as home care services, day care facilities or nursing homes (EMS) after hospitalization (see Seematter Bagnoud et al., 2012).

3.1.8 Special challenges in later life

Dementia is now the third leading cause of death in Switzerland (OFS, 2010). It is generally not the direct cause of death. But at an advanced stage, it can induce symptoms susceptible to lead to death. The study NRP 67 "End of life", conducted by the Swiss National Science Foundation (NSF) questioned how people with severe dementia perceive the end of their life 14.

At this stage of the disease, palliative care can provide support to people and their caregivers; they will more often intend to hold and guide the person to provide the proper care. So far, there are no guidelines or quality standards generally recognized for palliative care for people with dementia (see European Association for Palliative Care, 2013; van der Stehen, 2010).

Many people with dementia do not die of dementia but with this disease. At the time of their death, most people did not arrive at the ultimate stage of the disease. They die with mild to moderate dementia, suites of another illness or accident (p. Ex., Fall). In palliative care for these people, it is important to consider the dimension of "dementia", otherwise their care needs may be underestimated (Alzheimer Europe, 2008: 24).

International studies show that at advanced stage of dementia, two thirds of people die in care homes, which are rarely specialized units Hospice (Houttekier et al, 2010;.. Mitchell et al, 2005). There are no comparable data for the Suisse.15

3.1.9 Economic Impact of Dementia

In 2009, dementia pathologies generated costs of 6.9 billion francs in Switzerland (Ecoplan, 2010). Over 95% of the total costs are attributable to the support and care. Accompanying costs and long-term care provided in institutions or by the surroundings are included. The costs of hospital stays, services of assistance and home care, visits to the family doctor, the drugs and evaluation in clinical of memory are comparatively low, because treatment options limited to date. In 2009, the direct costs of dementia totaled CHF 3.9 billion, which corresponds 6.4% of total healthcare costs for that year. The remaining costs for the care and accompanying provided free by caregivers, amounting to 3 billion francs, correspond to the estimated market value of these benefits. These indirect costs are not financed.

3.2 Evolution International

In early 2007, Alzheimer Europe 16 appealed to the European Union, WHO, the Council of Europe and national governments they are n...

"Declare Alzheimer 'public health priority' and that they develop national action programs, international and European"(Alzheimer Europe 2007: 1).

...As part of the health programs of the European Union (EU), the European Commission has set up, in 2008, the ALCOVE platform (Alzheimer cooperative Valuation in Europe). Its activities are used among others to improve the quality of life and support for caregivers in member countries. Meanwhile, 30 partner organizations in 19 EU countries there participant.17

In January 2011, the European Parliament adopted resolution on a "European initiative for dealing with Alzheimer's disease and other dementias" and, then, called on the Council "to declare dementia are for European Union a health priority "18 relying on demographic changes and the growing imbalance between the working population and retirees, the resolution stresses that dementia...

"[...] Should be in the coming decades, one of the main challenges for s sustainability of health systems and national security social systems, including informal care and long structures term "(European Parliament, 2011: paragraph D).

...In 2012, the number of people with dementia worldwide is estimated at 35.6 million. The forecasts on the assumption that this figure will triple by 2050, and that the costs for care will increase even more strongly than the prevalence.

Margaret Chan, WHO general director, considers dementia as global a health threat. The report issued jointly by WHO and ADI in 2012 called on member governments to recognize this disease as a priority global of health policy and to take corresponding measures. The report on dementia makes a substantial contribution to it: indeed, it lays the foundation for a better understanding of the disease and its effects on people, their families and society.

Different countries have specific strategies to dementia or Alzheimer's disease, legal bases and other measures, such as guidelines for better care for patients. Some of these measures had already emerged before the internationales19 initiatives while others were born in the same époque20. National dementia strategies have several things in common: preserving the quality of life of those affected, support caregivers by offering deals tailored to their needs, strengthen coordinated and multisectoral approaches, to ensure access to quality care at an affordable cost, encourage specific skills this disease and maintain social security.

3.3 Programs and related projects of the National Strategy course in dementia-related

A number of aspects of dementia and its de s health overlap with existing programs and projects already on the national, regional and cantonal. The following list shows a selection:

- The national preventive Alcohol and tobacco Food and programs and physical activity are intended to improve heart health and increase physical activity. Switzerland is involved in two of the three priorities recommended by the ADI (Alzheimer's Disease International) and WHO (World Health Organization). The continuation of these activities and increased orientation towards the target group "65+" contribute to pre- vent dementia.
- The theme "Migration and Health" is also addressed at the federal level. It aims to strengthen health skills of the migrant population and adjust the health system as needed. It is important during the implementation to integrate the topic of dementia measures in place.
- In 2011, the Federal Council took note of the pro problems faced by those providing care and assistance to their families. He created an interdepartmental working group has n to develop solutions. In this...

...framework, it was also answered questions from the postulate 13.3366 "Provide assistance allowances and discharge opportunities for people who care for a loved one." On 13 June 2013, the National Council has passed this postulate to the Federal Council.

- "Dialogue Swiss National Health Policy" adopted October 25, 2012, the pursuit of "national palliative care strategy" for the years 2013 to 2015. The second phase will focus on better integration of palliative care into the existing structures of the health system and education. In this way, all people whose life is involved will have access throughout Switzerland to palliative care for their needs.
- In April 2010, the "Dialogue of the Swiss National Health Policy" instructed the FOPH to set up and manage the platform "Future of Medical Education", which aims to deal quickly and coordinated so the current issues and propose concrete solutions. To this end, the theme of interprofessionnalité is treated intensively since 2011. The goal is to anchor interprofessional collaboration in training courses and thus achieve better coordination between the training curricula of health professions.
- Several cantons have developed and are implementing a strategy or have a cantonal policy dementia (CDS, 2013).
- In response to postulate 12.3604 "De ne a strategy for long-term care," filed June 15, 2012 by National Councillor Jacqueline Fehr line, a number of studies have been conducted in this area: a large analysis the situation, including an evaluation of concrete measures and policy options. On 28 September 2012 the National Council passed the premise to fédéral.21 Council
- National Research Programme "End of Life" (NRP 67) of the Swiss National Science Foundation (NSF): The study in this program examines how residents with severe dementia see the end of their lives in the specialized agencies of the region Zurich. 22

4 "National Strategy 2014-2017 Dementia"

Orientation Values and Overall Objectives

Starting from the idea that people with dementia and their families accompanying them daily are at the center of the "National Dementia Strategy 2014-2017", values and overall objectives defined at the beginning indicate the direction for development and implementation of this strategy. Based on the data framework conditions, we must support those affected by the disease of dementia and promote their quality of life. In doing so, it should consider systematically the individual conditions of life (p. Eg., Family situation or specific needs related to co-morbidity or disability). The persons concerned must, throughout the course of their disease, have access to a high level of support, tailored to their needs.

Limitations of the "National Strategy for 2014-2017 dementia"

The fields of action, objectives and projects identified in this strategy does not claim to cover the topic of dementia exhaustively; they reflect the most urgent needs in the crucial area of management of dementia. Nationally, many themes of *démence*²³, many interfaces are subject to analysis and further work. If all these components are included in the foundations of the national strategy, they are deliberately not defined as scope, objective or priority project. Note in this context, the themes of "cardiovascular disease prevention" or "caregiver". During the implementation of the objectives and projects mentioned in this chapitre²⁴, it is to exploit the synergies with these programs and projects while coordinating measures to avoid redundancies.

4.1 Framework conditions societal

Demographic trends (increasing the proportion of elderly and very elderly, the decline in the number and the proportion of children and youth and the increasing proportion of the migrant population also *âgée*²⁵) and changes in conditions work and lifestyles (increase of households consisting of one person, people without children or with few children or the change in the distribution of roles in family tasks and professional tasks) have an impact the demand and the requirement of quality of offers in the health system. The societal changes and economic influence not only working conditions but also the attitudes towards care in the home environment. And expectations regarding the availability and flexibility of workers increases. (Eg, support and care of family members with dementia) The reconciliation of work and family poses a growing challenge: if it could have a negative impact on the quality of life of all people concerned.

4.2 Legal Framework

Adaptation of support structures to the needs of people with dementia as well as ensuring and improving the quality of corresponding services within the constitutional jurisdiction of the cantons. These can delegate implementation of tasks to communes.²⁶ Meanwhile, the Confederation sets the framework conditions in the following areas: research, professional training and practice, funding for care and support services or the protection of adults.

4.3 Action Areas

The many topics to be treated as part of a national dementia strategy in Switzerland to improve the lives of people with this disease can be classified into four principal areas:

Action Field 1

“Skills for Health, Information, and Participation”

Action Field 2

"Tailored Offers Need"

Action Field 3

"Quality and Specific Skills"

Action Field 4

"Data and Reporting Knowledge "

Action Field 1 - “Skills for Health, Information, and Participation”

At all stages of the disease, the promotion and strengthening, or rather the consolidation of existing skills through proper information and participation of those concerned and their families are of paramount importance. These claims, however, are strongly related to the perception in society of people with dementia and how to behave with them. In the early stage of dementia, individuals often experience uncertainty and anxiety. Cognitive deficits that settle slowly, behavioral changes (also depressive) can elicit from misunderstanding entourage reproaches and prejudices. These reactions of the social environment resulting from a lack of knowledge about the early signs and symptoms of dementia as well as the benefits of early detection and accompanying measures; people with dementia then risk social isolation and loneliness. Therefore, the use of support services is frequently delayed. This is why it is important to raise awareness of the realities and needs of those affected. In doing so, it is important to consider the specific needs of certain target groups.

These awareness-raising measures mobilize resources for patients themselves, especially when they are associated with the development of information materials and the mutual assistance measures are reinforced (see self-help movements in various countries Europe and Canada). Moreover, the gaps in the information of the target groups on the symptoms of dementia as well as the benefits of early detection must be filled. Account must be taken of concomitant disease or other disabilities for people with dementia and avoid, where possible, secondary violations. If the person is still in age to engage in gainful activity, the objective is to allow him to stay as long as possible in the professional world and to support by appropriate secondary prevention measures.

Changing demographics and lifestyles and working conditions changing influence the conditions of care including care and support. All objectives and all recommendations on actions to be taken should therefore take account of these developments. Both family members and other people from the inner circle play a very important role in all stages of the disease and have a large responsibility in coaching, even at an advanced stage. For that they do not fall into exhaustion because of the accompaniment and the care and nurturing, they need to know the diversity of occupational support offers (outpatient and inpatient) and have easily access the relevant information and

consulting offers. This information should not only opportunities discharge and daily support but also questions about the benefits of different social insurance (supplementary benefits helplessness allowances, etc.). Sufferers get timely information, allowing them to share their wishes in terms of support and care taking, and thus strengthen their autonomy (see planning²⁷ advanced care, the patient's advance directives). In advanced disease, the know- ledge acquired can also facilitate the decision concerning the transfer to an institution of care and support long-term.

Objective 1

The public has a better understanding of pathologies of dementia. she born con the many facets of the reality of the daily lives of those affected. Prejudices and blockages are eliminated.

Project 1.1

Advocacy and Community Information

Harmonize the content of information taking into account the realities of daily life of the various target groups and the variety of support offerings. In addition, the information should aim to promote solidarity and integration. To play an active role to those involved.

Project 1.2

Information Materials Specific to that Branch

The daily contact with the target groups of people with dementia (p. Eg., Non-administrative employees and home economics in a hospital, co-tors in an institution for people with disabilities or as opticians, hairdressers, bank employees etc.) should be particularly aware. Personnel managers and occupational health management are another target group. They need to be educated in the context of the promotion of early diagnosis and a time to review the need for individual support when the international dementia comes in the professional life.

Objective 2

The individuals concerned and their families have easier access to detailed information at both individual and appropriate advice throughout the course of the disease.

Project 2.1

Offers Individualized Information and Social Advice for those Concerned

Develop recommendations regarding the development, promotion and coordination of a detailed and appropriate offer. In so doing, the instruments to preserve the autonomy must be taken into account (new law on the protection of adults).

Their implementation is integrated into the existing offers (p. Ex., Pro Senectute, Pro In RMIS, Switzerland Alzheimer's Association, Red Cross Switzerland). Cantonal structures AIN- if the interfaces with other projects in the field of social insurance (p. Ex., Entitled to support payments) or certain projects (reconciliation of work life and caring for relatives) are taken into account.

Action Field 2 - "Tailored Offers Need"

Currently, regarding the care of people with dementia, access to coordinated offers, flexible and easily accessible is not yet guaranteed in all of Switzerland. The establishment and extension of such offers and the promotion of access for all persons concerned must therefore advance the levels of municipalities and cantons.

At the first signs and symptoms, a screening test and a diagnosis made on time - whether in the basic medical framework (see glossary, p. 32) or a reference to the memory (clinical memory - can both soothe the anxieties of the person concerned and lack of understanding of the environment while encouraging the involvement of the person in his illness. This review offers, moreover, the important possibility of differential diagnosis since, for example, a depression can be recognized and processed.

It is important that patients with dementia and their caregivers benefit from a built-in support (see glossary, p. 32). So these people are closely accompanied and supported by professionals in all phases of the disease, taking into account different aspects of their way of life. Cooperation throughout the management chain and extending offers to relieve the daily support and care in their usual life are considered a great challenge. models such as the "case management" (see glossary, p. 31) or "personal advice" (see glossary, p. 33) (Aargau Alzheimer's Association, 2013) lend themselves well. A readily available network of support offerings based on the needs regarding the accompaniment can avoid hospitalization crisis and also protect close to overload.

The elderly live more often alone and are therefore compelled, in case of illness, external support for their desire to remain in their familiar environment is satisfied. The support services and home care, night care structures and day, short stays, the offers of information technologies and communication (such as, for example, projects in the area Atmosphere Assisted Living (AAL) 28 and the work of volunteers make a significant contribution to the accompaniment of dementia patients in their usual life. With the evolution of the disease, a place to live secure and suitable, with the presence of appropriately trained personnel, is becoming increasingly important. Indeed, the advanced stage of the disease of dementia, the entourage and volunteers reach or are still often confronted their physical and mental limits.

In acute care hospitals the management should consider the specific and special needs of people with dementia pathology by associating specialized staff with geriatric and psycho-geriatric skills. Indeed, the outcome of the practical experience shows that more and more elderly, hospitalized for a somatic health problems, dementia.

The adaptation of life forms and the development of the institutional architecture needs of dementia patients in institutions of care and long-term accompaniment should be encouraged. living spaces oriented to the needs and, in particular, supported proximity may help reduce the risk of stigmatization and encourage integration. The development of process support and care and offers long term support aims to preserve the quality of life and dignity of people with dementia, even at an advanced stage of the disease and, until they died.

The availability of such deals requires sufficient financial resources. This implies, first, that the financial burden of discharge rates and cost of living, the care (care and support) in institutions of care and long-term accompaniment is supportable by people concerned. On the other hand,

financial remuneration provided the provision of suitable investment must be guaranteed. Currently, the challenges facing both the funding of medical benefits (particularly among family physicians in acute care hospitals) than that of the support and care of people with dementia in care services of outpatient and inpatient long-term support.

Objective 3

People with dementia and their families have flexible care offerings, quality and adapted as needed throughout the chain of care.

Project 3.1

Implementation and extension of a network of regional competence centers for diagnosis

If dementia is suspected, access to diagnosis should be encouraged regardless of age, living conditions and / or diseases or existing handicaps.

Project 3.2

Promotion of coordination of benefits to cover the individual care needs

Development of recommendations on the establishment of chains of care that encourage interdisciplinary coordination and continuous networking services in primary care (especially in the areas of early detection, diagnosis, treatment, accompaniment and ambulatory care). This work networking should include crisis intervention to prevent hospitalization of the person concerned. In addition, bids are harmonized with information and offers social counseling offered outside the healthcare system.

Project 3.3

Implementation and extension of flexible regional and discharge rates for the care of day and night

Establishment and expansion of local offerings, easily accessible and affordable, to support in the usual place of living (including short stays, holiday beds, day care facilities and night services and support day and night) and oriented as required. This is to take account of potential in the field of voluntary work and involve the relevant organizations (such as Swiss Alzheimer's Association, Red Cross Switzerland, Pro Senectute, Pro Infirmis).

Project 3.4

Promotion of appropriate care to dementia in hospitals for acute care

Adaptation of existing infrastructures and processes (including treatment, care and accompaniment, spatial planning, personnel management and interfaces) to the growing number of patients with dementia hospitalized because of an (other) physical illness. Promoting consultation with experts and teams in crisis has no expertise to strengthen and ensure therapeutic quality in this area.

Project 3.5

Promotion of appropriate care to dementia in care and the steady long-term support

Adaptation of existing infrastructures (organization and operation, HR and spatial planning) and support (therapeutic process, care and support) to the demands and needs of the growing number of residents with dementia.

Objective 4

The appropriate and supportable financing services adapted for people with dementia is guaranteed.

Project 4.1

Reflection and appropriate compensation benefits

The question of analysis if funding systems (ambulatory, hospital and care and support long-term) reflect and reward appropriately the services provided to people with dementia in care tailored to their situation. This analysis also covers the possibilities of discharge and guidance by specialized bodies and care benefits provided by individuals. The results of this analysis must be integrated into the evaluation and development of existing financing systems. In this case, the following two aspects are taken into account appropriately: firstly, the effective cost of the service and, secondly, and the income and property of the persons concerned.

Action Field 3 - "Quality and Specific Skills"

For different professional groups and specialized skills at each stage dementia may have to be expanded and supplemented in order to continue to guarantee the safety and quality of care.

The new law of protection of adults, came into force in January 2013, strengthens the patient's right to self-determination. It has implications for the process of medical decision regarding patients who are no longer capable of discernment. From an ethical point of view, every human being has the right to take decisions independently and thus also the right to refuse medical interventions. Advance directives are a way to assert that right. In its considerations on the new adult protection law taking particular account of dementia, National Ethics Commission in the area of human medicine (CNE) concluded that advance directives contribute to respecting the autonomy of people with dementia. The new adult protection law allows people to have self-determination mode with regard to their future medical situations (NEK-CNE, 2011). The defense of these rights and their implementation requires in cases of dementia, on the one hand, early diagnosis so that patients can express their wishes clearly. On the other hand, it is also necessary, as part of the treatment, support and care taken to aim at the highest possible quality. The experience of the terrain showed that the systematic application of ethical guidelines can significantly contribute. For example: the treatment and care of people with dementia may be particularly demanding (aggressiveness or resistance to a therapeutic act); in these situations, these people face a higher risk of abuse (p. ex., measures restricting freedom of movement taken without the consent of the person concerned). It is possible to reduce such risks by sharing the same ethical attitude and are using as an instrument of support (p. Ex., In case studies). At all stages of dementia, but especially when the person is dependent on others for the activities and daily care as is the case under the care and guidance of

long-term, fundamentally ethical attitude in the support and care is the essential condition for the respect of the dignity and integrity of the sick. When anticipate disabilities guidelines are lacking, particularly in advanced stages of the disease, the ongoing participation of relatives is of paramount importance.

There, for the duration of the evolution of a dementing disorder, an increased need for interdisciplinary and interprofessional collaboration (see glossary, p. 31) if we want to ensure care (therapy, care and support) of impeccable quality and appropriate to the needs of patients. As part of the management of internal quality in the organization, it must promote and review the development and use of elaborate quality assurance instruments interprofessional way. These allow, for example, in the offices of primary care physicians, a review of differential diagnoses (eg, depression) and the installation of an early diagnosis of dementia as soon as the early signs of the disease appear. Overall, these instruments contribute to a comprehensive care (taking into account the biomedical dimensions, functional, environmental and ethical) and allow the maintenance of the quality of life and end of life of those affected.

The objective is the promotion of early diagnosis, treatment as well as counseling and care of people with dementia and high quality oriented as required. In this way, crisis situations, such as delirium (see glossary, p. 31) or a severe mental disorder like paranoia, can be prevented or supported in the best conditions. They place a heavy burden not only the individuals concerned but also the professional and social environment. Caregivers of a person with dementia should be integrated in this process systematically. Their competent support regarding skills and care must be recognized and strengthened.

Quality assurance and improving it throughout the care of those affected by dementia require specific knowledge about the disease and the necessary competence of action (for example, in managing case management of delirium, care processes, ethics and interdisciplinary assessments). It is appropriate to extend these to all professional groups, both social as sanitary, who could face the theme dementia.

The need for specifically trained staff for dementia is felt in all areas of care (outpatient and inpatient) but an even more acute in the care and support long term in institutions. In this case, special attention should be paid to the training of people who do not have specific degrees in counseling and care but who work in these areas (people without diplomas ad hoc) .29 In the area of caregivers and volunteering also must consider whether existing skills should be promoted and strengthened, and how. It is important to use existing modules and, if necessary, adapt them.

Goal 5

Treatment, support and care for people with dementia are based on ethical guidelines.

Project 5.1

Anchoring of ethical guidelines

Encourage the implementation of existing directives in the different management structures (ambulatory and stationary) while guaranteeing the rights of persons not, particularly the right to the protection of adults, and to avoid situations in that risk. As part of the management of institutional quality, promote the development and use of ethical guidelines in practice.

Goal 6

During the course of the disease, the quality of care for people with dementia is assured.

Project 6.1

Development of recommendations in the areas of early detection, diagnosis and treatment for basic care

Check the quality of indication criteria and examination tools for early detection of dementia and encourage their use. Ensure the quality of communication interviews (ad) diagnosis and treatment of pharmacological and non-drug.

Project 6.2

Promotion of interdisciplinary assessments

Encourage the use of interdisciplinary cooperation instruments at inter and create the appropriate framework conditions (such as standardized processes, networking). Councillor assessment instruments in the management of institutional quality.

Project 6.3

Crises management

Develop and practice recommendations and guidelines for acute care hospitals (somatic and psychiatric) and care and support long-term. Decision-making must take into account the new law of protection of the adult.

Goal 7

Professionals from all walks and corresponding health dis- pose the necessary expertise in their respective fields to diagnose or analyze the situation, treat, support and care for people with dementia. The skills relatives and volunteers will be strengthened according to need.

Project 7.1

Basic training for Enlargement, continuing education and specific to dementia development

Examine the need based on the professional field, taking into account the ethical and legal aspects as well as existing modules and develop targeted offers for professional groups.

Project 7.2

Strengthening competence for relatives and volunteers

Lighten the need to train and enhance the skills and identified the proposed training offers.

Action Field 4 - "Data and transmitting knowledge"

In Switzerland data on the structure of care offers and the use of these offers are lacking. At cantonal level, these data contribute decisively to the steering and planning cation of long-term care. However, gaps include data on care in four areas: in the services of help and home care for the treatment and support once diagnosed, for treatment in an emergency situation adapted with dementia in acute care hospitals or on the situation of people with dementia in institutions of care and long-term support. Data health statistics are an important basis to illustrate the situation of care in Switzerland. Their survey and assessment should be reviewed in view of the account taken of constant theme of dementia.

On the side of service providers (notably hospitals, EMS, ambulatory care) innovative projects to improve the supported of dementia are introduced. Their survey and assessment should be reviewed in view of the inclusion consistently the subject of dementia.

Improving the quality of care is realized in practice and is implemented by professionals working in this field. Besides deals basic training and continuing education (see above), the exchange between research and practice also allows the promotion of behavior based on evidences. To this end, the current results of important research for practice must simply be made accessible.

Goal 8

The cantons have the information on the current and future situation of people with dementia, because the data underlying the planned cation and management of medium and long-term care.

Project 8.1

Monitoring of support

The feasibility of setting up a monitoring system is to be examined. In this case, it must be examined in particular whether the topic of dementia can be better represented in the existing health statistics. If so, define and install a monitoring system and regularly update the data. Information on dementia-related prevalence and on the supply and demand for projects tailored to the needs throughout the management chain from early screening to the end of life should be postponed. Based on the results, the costs can be better quantified.

Project 8.2

Concomitant research

The new concepts of therapy, support and care launched by various service providers for people with dementia are now more fully discussed in the scientific angle, allowing to ensure and develop the quality and safety of care.

Goal 9

The transfer of research results in practice and exchange between researchers and users are supported by appropriate instruments.

Project 9.1

Networking of research and practice

Install an online platform to enter the research on dementia and make it known to the relevant services. Supporting the networking of research and practice by suitable instruments such as, p. eg., events.

Overview of Fields of Action – Objectives and Projects

Values - GLOBAL OBJECTIVES

Action Field 1: Health skills, information and participation

Objective 1

The public has a better understanding of pathologies of dementia. She knows the multifaceted reality of daily life of those affected. Prejudices and blockages are eliminated.

Project 1.1 Outreach and Community Information

Project 1.2 Equipment information specific to that branch

Objective 2

The individuals concerned and their families have easier access to detailed information at both individual and appropriate advice throughout the course of the disease.

Project 2.1 individualized offer information and social advice for those concerned

Action Field 2: Offers adapted as needed

Objective 3

People with dementia and their families have flexible care offerings, quality and adapted as needed throughout the chain of care.

Project 3.1 Implementation and extension of a network of regional competence centers for diagnosis

Project 3.2 Promotion of coordination of benefits to cover the individual care needs

Project 3.3 Implementation and extension of flexible regional and discharge rates for the care of day and night

Project 3.4 Promotion of appropriate care for dementia in hospitals for acute care

Project 3.5 Promotion of appropriate care with dementia in care and the steady long-term support

Objective 4

Adequate funding is bearable services adapted for people with dementia is guaranteed.

Project 4.1 Reflection and appropriate compensation benefits

Action Field 3: Quality and specific skills

Objective 5

The treatment, support and care for people with dementia are based on guidelines ethical.

Project 5.1 Anchoring ethical guidelines

Objective 6

During the course of the disease, the quality of care for people with dementia is assured.

Project 6.1 Development of recommendations in the areas of early detection, diagnosis and treatment for basic care

Project 6.2 Promotion of interdisciplinary assessments

Project 6.3 crises management

Objective 7

Professionals from all walks and corresponding health disciplines possess the necessary expertise in their respective fields to diagnose or analyze the situation, treat, accompany and care for people with dementia. The skills relatives and volunteers will be reinforced as needed.

Project 7.1 Basic training for Enlargement, continuing education and specific to dementia development

Project 7.2 Strengthening competence for relatives and volunteers

Action Field 4: Data and knowledge transmission

Objective 8

The cantons have the information on the current and future situation of people with dementia, because the data underlying the planning and management of medium and long-term care.

Project 8.1 Monitor support

Project 8.2 Concomitant research

Objective 9

The transfer of the results of research in practice and exchange between researchers and users are supported by appropriate instruments.

Project 9.1 Networking of research and practice

4.4 Implementation of the "Strategy national policy on dementia 2014-2017"

The Swiss health system is highly complex. This complexity is particularly expressed in the decentralization of health facilities, which piggybacks on les- a system composed of different stakeholders. During the implementation of the "National Dementia Strategy 2014-2017", it is to consider the federalist division of labor respectively borne by the Confederation, cantons and municipalities.

This national strategy is based on four action areas comprising a total of 9 goals and 18 projects, which should be given priority.

Most of the proposed projects are based on proven models of good practice in the field of dementia. The challenge now is to refine, adapt them according to the different target groups and regions, extending them where appropriate, while ensuring monitoring and coordination at the national level. During the implementation of projects, the federal, cantonal and actors among the service providers, groups and professional associations and relief organizations will be involved and each assume the leadership of a project. With this approach, the strategy will contribute significantly to improving the quality of life of people with dementia as well as the quality of offers.

Most projects will be launched and fulfilled in a decentralized manner, and those involved provide adequately for the human and financial resources. Confederation (FOPH) and the cantons (CDS) will assume responsibility for the overall strategy and in particular for the tasks related to processes and coordination (coordinating body), the quality assurance (platform "National Strategy 2014-2017 dementia"), to the anchor the objectives of the strategy in the umbrella organizations of service providers (advisory body). The Confederation and the cantons will make a specific contribution to the project "Financing", "Support the Monitoring" and "Networking of research and practice."

Coordinating Body

Composed of representatives of the Confederation (DFI / BAG) and the cantons (CDS), it performs the duties coordination and management of the consultation body and the platform "national strategy on dementia 2014-2017". In addition, he regularly reports to the principal (the National Health Policy Dialogue) of the progress of work.

Consultative Body

It consists of representatives of self-help organizations, professional associations, umbrella organizations of service providers, responsible for training and research. The advisory body is responsible for anchoring the "National Strategy for 2014-2017 dementia" within the umbrella and professional organizations.

Platform "National Strategy 2014-2017 Dementia"

This structure brings together federal and cantonal authorities as well as organizations that assume the management of projects included in the national strategy. The role of the platform is to document, evaluate and enhance the progress of implementation.

5 Glossary

Accompaniment

When coaching people with dementia, the entourage ensures a constant presence to ensure the temporal and spatial orientation, avoid isolation and / or guarantee the safety (p. Ex., Prevent injuries and falls) . This activity requires high social skills and good knowledge of the habits of the person requiring assistance. The compulsory health insurance does not support this task in private households. The support may also include support in the household (shopping, cooking) or for administrative tasks. Depending on the indication, the Association of support services and management Home-care Spitex, regulated by public law, supports the support in the household. Supplementary insurance pay part of the costs. Caregivers or assistance regulated by the Child Protection Law or adult take care of administrative tasks.

Caregiver

By analogy with the definitions of aidants³⁰ close, the caregiver is a person who, every day, devoting his time to someone in their health and independence. It ensures non-professional and regular assistance, care and presence, to support the deal with the difficulties of daily life and give a sense of security. This may be a relative, neighbor or friend. The caregiver is not within the group of organized volunteering.

Interdisciplinary and Inter-Professional Collaboration

The two terms are often used synonymously. Interdisciplinary collaboration uses the methods and concepts from different disciplines (p. Eg., Natural sciences, humanities). Interprofessional collaboration brings together the knowledge of different professions (p. Eg., Nursing, medicine, physiotherapy). The grouping of different partial aspects and skills transfer of all experts in an interprofessional group can develop new solutions strategies.

Delirium

Delirium is an acute state of disorder of mental faculties tees organic (psychosis) that is particularly accompanied by loss of the sense of orientation, hallucinations, anxiety, amnesia or disruptions heartbeat. The characteristic of delirium is the suddenness of the beginning and the changes in evolution. Division geriatric hospitals, occurs in 10 to 15% of residents and in 30 to 50% of acute somatic hospital. After an operation, delirium increases mortality postopératoire.³¹

Interdisciplinary Evaluation

An interdisciplinary evaluation involves a comprehensive analysis process and responsive involving professionals from different disciplines. Under a diagnosis of dementia, geriatric interdisciplinary assessment includes results, neuropsychological, neurological and psychopathological (Monsch et al., 2013). Additional tests of care, physiotherapy or occupational therapy are of great importance in the context of a stay ambulatory or stationary.

Case Management (Case Management)

"Case management is a specific process for managing complex matters of social welfare, health and insurance. In a systematic and collaborative process, quality services to meet individual needs are provided to achieve efficiently the objectives and agreed results. [...] The case manager is bridging function between the client / patient, his entourage, different professionals, payers and the community. [...] Case management is, firstly, to improve communication and coordination between different actors [...]. The client / patient and, if necessary, its surround

rage associated with decision making as contractual partners (participation). Case management therefore operates on the principle of accountability of the client / patient ("empowerment") and the systematic use of resources "(Case Management Net- Switzerland) .32

When accompaniment and care for people with dementia, case management (case management) assumes a "an interface between families, institutions, professionals and volunteers" (Frommelt et al, 2008: 36, trans.). The objective is to offer support and a global and individual treatment, coordinated throughout the therapeutic chain. Case management is using "one-hand" focused on the individual, while managed care ("care management" for the care structures (system)). Case management is one element, and the two concepts are integrated care concepts.

Managed Care (Care Management)

Care management is to harmonize the management of offers when similar needs (Frommelt et al, 2008: 13).

Basic Medicine

"The definition of basic medical term (German medizinische Grundversorgung) proceeds from the general public need to dispose of goods and basic medical services for curative care, rehabilitation and palliative care. Basic medical services are not provided by a single professional group, but with different professions and institutions. What is decisive for basic medical definition is that its basic services are, by experience, potentially or actually sought regularly by a large part of the population or population groups, and that this will remain the case in future. [...] The basic medicine specialists include not only those who are usually called primary care physicians or family doctors (p. Ex., Specialists in general medicine or internal medicine, pediatricians and practitioners). Other professionals, physicians (p. Ex., In the field of psychiatry, cardiology and gynecology) or not (including dentistry, pharmacy and nursing, but also, for example, assistantship in medical practice, dietetics, occupational therapy and physiotherapy medical radiology techniques or first aid), making important contributions to basic medicine "(Message for the popular initiative" Yes to the family medicine "(11,062) 16 September 2011: 6976ss) .33

"Memory Clinic"

The association "Swiss Memory Clinics" (SMC) defines a memory clinic for minimum criteria such as: "A center of excellence for the diagnosis, treatment and advice on dementia and related pathologies. The memory clinic performs at least 100 outpatient evaluations of dementia per year. The diagnosis in a memory clinic is multimodal with reference to different methods. The four basic academic disciplines: geriatrics, psychiatry of the elderly, and Neurology (neuro) psychology. (Neuro) psychology must be present. The diagnosis is established during an interdisciplinary conference. The work of memory clinics aligns with the directives and national and international recommendations. The memory clinic is a public relations and seeks the network in collaboration with other services and departments "(Swiss Memory Clinics Association, 2011).

Integrated Management

"This concept [of the Integrated Management] design the idea of an extended support to all sectors and professional groups and patient-centered, granting an important place to networking, collaboration and coordination in order to improve the quality of care "(CDS &

FOPH, 2012: 9). It therefore refers to the permeability of the support structures, interdisciplinary collaboration and professional groups in an overall consideration of the needs of those affected.

Care

Basic insurance provides a contribution for health care benefits costs when prescribed by a doctor and that their need is proven. These benefits include three groups: a) assessment, advice and coordination; b) the examination and treatment and c) basic care. These care services can be performed after an operation (by independent carers or nursing organizations and home care) or in nursing homes (EMS) .34 The Swiss association of nurses (ASI) defines nursing as follows professionals to the Swiss context with reference to the Swiss Academy of medical sciences (SAMS): "nursing contributes to the development and maintenance of health and the risk prevention for health; they support people during their treatment and help them cope with the effects of diseases and therapies related thereto, in order to achieve the best results in treatment and care, and to maintain the quality of life the best in all periods of life and to death "(ASI) .35

Personalized Follow

The custom is followed psychosocial support offered to the entourage responsible for the care and support of people with dementia. Monitoring is flexible, focused and oriented solution while integrating the skills and needs of individual people involved in the process. Personalized support includes: information (history and evolution of the disease, respite and funding opportunities, etc.), coordination of providers (therapies, discharge, care and support), individual training (action when behavior posing a challenge, treatment load, etc.), support groups and family interviews [...] [and] takes place as follows:

- Permanent accompaniment with advice as soon as possible after diagnosis and insured for the duration of the disease.
- Active making contact by advisers after diagnosis (with the consent of the families concerned).
- Counselors agree with the relevant dates of families for advice at intervals adapted to the needs and resume contact with them.
- The counselors make home visits and advise the family also including other caregivers who are associated with the support, the support and care of those affected "(Alzheimer's Association Aargau, 2012: 2, trans.).

6 Lists**ILLUSTRATIONS**

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ABBREVIATIONS

ADI: Alzheimer's Disease International

ALZ: Swiss Alzheimer's Association

CDS: Swiss Conference of Cantonal Ministers of Public Health

DOK: Conference of the umbrella organizations of private aid for disabled

WHO: World Health Organization

ZfG: Center for Gerontology at the University of Zurich

7 Literature

- All-Party Parliamentary Group on Dementia (2011): The £ 20 trillion question. An inquiry into Improving Lives through cost-effective dementia services. London.
- Alzheimer's Disease International (ADI 2011): World Alzheimer Report 2011. The benefits of early diagnosis and surgery. London.
- Alzheimer Europe (2008): Alzheimer Europe Report. End-of-life care for people with dementia. 2/2008
- Alzheimer Europe (2007): Paris Declaration: political priorities of the Alzheimer movement in Europe.
- Aargau Alzheimer Association (2013): Fact Sheet "Case Management" und "Custom Tracking" with people with dementia. Developed on behalf of the BAG.
- Aargau Alzheimer Association (2012): Pilot-Projekt "Zugehende Beratung". 1. Zwischenbericht. Brugg.
- Swiss Alzheimer's Association (2010): Financial Assumptions in dementia. Yverdon-les-Bains.
- Bartelt G. (2012): Auswertung von RAI-Daten im Auftrag der Schweizerischen Alzheimervereinigung. Technischer Bericht. St. Gallen.
- C. L. Bassetti, Calabrese P. & F. Gutzwiller (2011): Dementia. Etiologies, evolution and treatment options. The situation in Switzerland. Stuttgart.
- Bassetti C. Calabrese L. & P. (2011a): Diagnosis of dementia and assessing its evolution. In: L. Bassetti C. et al. (Ed.): Dementia. Etiologies, evolution and treatment options. The situation in Switzerland. Stuttgart.
- Bassetti C. Calabrese L. & P. (2011b): Concepts, definitions and classification. In: L. Bassetti C. et al. (Ed.): Dementia. Etiologies, evolution and treatment options. The situation in Switzerland. Stuttgart.
- S. Becker, Kruse, A, Schröder J. Seidl & U. (2005): Das Heidelberger Instrument zur Erfassung bei der Lebensqualität Demenz (H.I.L.DE.) Dimensionen von und deren Lebensqualität Operationalisierung. In: Zeitschrift für und Gerontology Geriatrics, 38: 1-14.
- Bickel, H. et al. (2002): Stand der Epidemiology. In: J. Hallauer F. & A. Kurz (Hrsg.): Weissbuch Demenz. Stuttgart, p. 10-15.
- Breil D. (2010): Irrungen Wirrungen und im Alter - eine medikamentöse Gratwanderung. Delirium or behavioral and psychological symptoms of dementia in the elderly patient: Diagnosis and treatment. In: Praxis, 99 (18): 1079-1088.
- National Ethics Commission in the field of human medicine (NEK-CNE) (2011): Advance directives. Ethical considerations on the new law of the adult protection, taking particular account dementia. Berne.
- Swiss Conference of Cantonal Ministers of Health (CDS) (2013): Inventory of development and implementation in the cantons of support deals pathologies of dementia. Report on the results of the 2013 survey of cantons (January-April 2013). Berne.

Swiss Conference of Principals of Health and Federal Office of Public Health (2012): New models of care for primary care medicine. Report of the Working Group "New models of care for primary care medicine" CDS and the BAG. Berne.

CURAVIVA.CH (Ed.) (2013): Support for people with dementia in the medico-social institutions for the elderly in German-speaking and French-speaking. A national survey of nursing homes. evaluation report of the results. Study mandate by developing QUALIS assessment and Berner Fachhochschule (BFH). Zurich.

Da Silva J. et al. (2013) Affective disorders and Risk of Developing Dementia: Systematic review. In: The British Journal of Psychiatry, 202: 177-186.

Deutsche Alzheimer Gesellschaft (DAzG) (2011): Demenz bei geistiger Behinderung. <http://www.deutschealzheimer.de/fileadmin/alz/pdf/factsheets/FactSheet16-2011.pdf>

Dotson V. M. et al. (2010): Recurrent depressive symptoms and the incidence of dementia and mild cognitive impairment. In: Neurology, 75: 27-34.

Ecoplan (2013a): Menschen mit Demenz, die zu Hause leben, und ihre pflegenden Angehörigen. Ergebnisse einer der schriftlichen Befragung Angehörigen. Studie der zuhause Schweizerischen Alzheimervereinigung.

Bern. Unpublished. [For this study, 1284 relatives were interviewed.]

Ecoplan (2013b): Principles underlying the development of a national dementia strategy. Dementia in Switzerland stock of the current situation. To the attention of the Federal Office of Public Health (BAG) and the Conference of Cantonal Health Directors (CDS). Berne.

Ecoplan (2010): Kosten der Demenz in der Schweiz. Schlussbericht im Auftrag der Schweizerischen Alzheimervereinigung. Bern.

EuroCoDe (2009): Report of WP July 2006 Prevalence of Dementia in Europe. Final Report 17.07.2009. http://ec.europa.eu/health/archive/ph_information/dissemiation/diseases/docs/eurocode.pdf

European Association for Palliative Care (2013): White Paper Defining optimal palliative care in older people with dementia: A Delphi study and recommendations from the European Association for Palliative Care.

<http://www.eapcnet.eu/LinkClick.aspx?fileticket=PrBuOaKGih4%3d&tabid=1616>

Frommelt, M. et al. (2008): Pflegeberatung, Pflegestützpunkte und das Case Management. Die Aufgaben personen und Unterstützung bei familienbezogener Pflegebedürftigkeit und ihre Realisierung in der Reform der Pflegeversicherung. Freiburg im Br.

Gemeinnützige Gesellschaft für Soziale Projekte (2008): Projekt Blickwechsel - Nebendiagnose Demenz. Warum sich mit dem Thema Krankenhäuser Demenz beschäftigen sollten und was sie zur Verbesserung der Versorgung demenzkranker Patienten tun können - Sieben Gründe und sieben Empfehlungen. Wuppertal.

gfs.bern (2004): erhebliche Unterversorgung. Verbreitung und Versorgung in der Schweiz Demenzkranker. Studie im Auftrag der Schweizerischen Alzheimervereinigung. Bern.

Gutzwiller F. & H. Groth (2011): Dementia, a challenge for society and health systems: overview of the Swiss point of view. In: L. Bassetti C. et al. (Ed.): Dementia. Etiologies, evolution and treatment options. The situation in Switzerland. Stuttgart

- Harvey R. et al. (1998): Young onset dementia: epidemiology, clinical symptoms, family burden, medium and outcome. Dementia Research Group. Imperial College of Science, Technology and Medicine. London.
- Höpflinger F. Bayer-Oglesby Zumbrunn L. & A. (2011): The dependence of the elderly and long-term care. Updated scenarios for Switzerland. Cahiers Swiss Health Observatory. Berne.
- Hofman A. et al. (1991): The Prevalence of Dementia in Europe: A Collaborative Study of 1980-1990 Findings. Eurodem Prevalence Research Group. In: International Journal of Epidemiology, 20: 736-748.
- Houttekier D. et al. (2010): Place of death of older persons with dementia. A study in five European countries. In: Journal of the American Geriatrics Society, 58: 751-756.
- Health Institute and ISE economy (2012): Analysis of Alzheimer type dementia in PLASIR Database May 2012. Cantons of Geneva, Jura, Neuchâtel and Vaud. Report to the Swiss Alzheimer's Association. Lausanne.
- Kesselring A. (2004): Angehörige zu Hause pflegen. Anatomie einer Arbeit. In: Schweizerische Ärztezeitung, 85 (10): 504-506.
- . Kleina Th & Wingenfeld K. (2007): Die Versorgung demenzkranker älterer Menschen im Krankenhaus. Veröffentlichungsreihe Institutes für Pflegewissenschaft an der Universität Bielefeld. Bielefeld.
- Kopp M. (2010): Demenz neu denken. Was bedeutet die Menschen für die Zunahme demenzkranker Spitex? In: NOVAcura 6/10: 50-51.
- Lustenberger I. et al. (2011): Psychotropic medication use in Swiss nursing homes. In: Swiss Medical Weekly, 141: w13254.
- Mitchell S. L. et al. (2005): A national study of the rental of death for older persons with dementia. In: Journal of the American Geriatrics Society, 53: 299-305.
- Monsch AU, Bula C., Hermelink M., Kressig RW, Martensson B., Mosimann U., Müri R. Vögeli S. & A. von Gunten (2013): Consensus 2012 on the diagnosis and treatment of people with dementia in Switzerland. In: Swiss Medical Review, 9: 838-847.
- Nielsen T. R et al. (2011): Assessment of dementia patients in ethnic minority in Europe.
- Federal Office of Public Health (BAG): Community Interpreting.
<http://www.bag.admin.ch/themen/gesundheitspolitik/07685/12532/13702/index.html?lang=fr>
- Federal Office of Public Health (BAG) & Federal Office of Professional Education and Technology (OPET) (2012): national concept "Palliative care and training." Strategy Paper (recommendations). Berne.
- Federal Office of Public Health (BAG) & Swiss Conference of Cantonal Ministers of Health (CDS) (2011): Conference Act "Dementia - a challenge for social policy and health."
<http://www.bag.admin.ch/themen/gesundheitspolitik/13916/index.html?lang=de>
- Federal Statistical Office (FSO) (2012): Health of older people living in medical-social establishment (2008/09). Neuchâtel.

- Federal Statistical Office (FSO) (2011a): STATPOP. Statistics of the population and households. Neuchâtel.
- Federal Statistical Office (FSO) (2011b): Medical Statistics hospitals 2011. Neuchâtel.
- Federal Statistical Office (FSO) (2010): Statistics of Causes of Death 2010. Neuchâtel.
- Olazaran J. et al. (2010): nonpharmacological therapies in Alzheimer's disease: A systematic review of efficacy. In: *Dementia and Geriatric Cognitive Disorders*, 30: 161-178.
- Perrig-Chiello P. Hutchison Höpflinger S. & F. (2011): Support for older people by carers in western Switzerland and Italy. AgeCare-SuisseLatine. term research project of the Association of assistance and home care Spitex.
- Perrig-Chiello P., F. & Höpflinger Schnegg B. (2010): Pflegende Angehörige älteren von Menschen in der Schweiz. SwissAgeCare-2010. Forschungsprojekt im Auftrag of Spitex Verband Schweiz.
- Romero B. (2011): Support relatives. In: L. Bassetti C. et al. (Ed.): *Dementia. Etiologies, evolution and treatment options. The situation in Switzerland*. Stuttgart.
- Saczynski J. S. et al. (2010) Depressive symptoms and risk of dementia: the Framingham Heart Study. In: *Neurology*, 75, 1: 35-41.
- Seematter Bagnoud L. Martin E. & Bula Ch J. (2012). Health services utilization associated with cognitive impairment and dementia in older patients Undergoing post-acute rehabilitation. In: *JAMDA*, 13: 692-697.
- Swiss Memory Clinics (2011): Minimum criteria for defining a memory clinic. Adopted and implemented in the General Assembly of the Association "Swiss Memory Clinics" May 5 .2011. Basel.
- Van der Steen J. T. (2010): Dying with Dementia: What we know after-more than a decade of research. In: *Journal of Alzheimer's Disease*, 22: 37-55.
- Wettstein A. (2004): Nicht-pharmakologische Therapie der Demenz. *Schweiz Med Forum*, 2004, 4: 632-635.
- World Health Organization (WHO) & Alzheimer's Disease International (ADI) (2012): *Dementia: a public health priority*. Geneva.
- Zentrum für Gerontology, University of Zurich (2013a): *Alzheimer Barometer 2012. Knowledge, attitudes and experiences in Switzerland. Summary (Management Summary)*. Zurich.
- Zentrum für Gerontologie (2013b): *Fact Sheet "Quality of life of people with a disease of dementia*. University of Zurich. Developed on behalf of the BAG.
- Zentrum für Gerontology (2012): *Demenzbarometer 2012*. Universität Zürich. Bericht der zuhanden Schweizerischen Alzheimervereinigung. Zürich.
- Zentrum für Gerontology (2010) *Menschen mit einer Demenz zuhause begleiten*. Universität Zürich.
- Zentrum für Gerontology (2008): (Bd. 5) *Lebensqualität bei Demenz*. Universität Zürich.

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