Key components	**Reinforce Family Medicine Group (FMG) capacity and competency**	**Management of patients living with dementia in FMG** Collaboration family physician-case manager			**Pertinent referrals to memory clinics, BPSD team, homecare services, caregivers support**
		Identification of patients	**Treatment**	**Follow-up**	
Bergman report's recommendations	Training in FMG Additional resources and role definition of case manager (pivot nurse) – resources utilisation Adapted clinical tools and practice guides to the FMG context	Identification and evaluation of cognitive disorders by family physician or case manager Dementia diagnosis Explanation of diagnosis to patient and caregiver	Prescription of dementia medications when appropriate Evaluation of patients and caregivers needs Education and implication of patients and caregivers	Proactive follow-up of patients and caregivers Easy access to a clinician for patients and caregiver Regular assessments by the family physician or case manager of cognition, functional status, behavioral and psychological symptoms of dementia (BPSD), driving, dementia medication, weight, and homecare services and community services' needs No anticholinergic prescriptions Assessment of caregiver needs Coordination of services by case manager	Agreement between FMG and other services Collaboration between all health services Use of criteria for referrals Shared Clinical Information System Shared information Homecare services – caregiver support: rapid referrals of patients and sufficient resources Memory clinic – BPSD team: appropriate referrals and evaluation within 3 months (1 month for BPSD team) Access to laboratory tests, CT scans within 1 month Improve transition between home and long term care
Outputs	*Not evaluated* • *Training received* • *Knowledge, attitude and practice of FMG clinicians* • *Elaboration and systematic use of practice guides and clinical tools in FMG* • *Allocated time by additional resources in FMG versus other populations*	• Number of diagnosed patients and type of dementia or cognitive impairment *Not evaluated* • *Number of identified patients* • *Number of patients evaluated* • *Patients and caregivers' education and information*	*Not evaluated:* • *Number of patients for whom the FMG initiated the treatment* • *Evaluation of patients' needs* • *Experience of patients and caregivers*	• Quality of Follow-up *Not evaluated* • *Number of contacts or visits between patients or their family and the family physician or case manager* • *Role of the case manage in care coordination*	*Not evaluated:* • *Number of referrals, motives and content* • *Time between referral and evaluation by homecare services* • *Time between referral and evaluation by memory clinic (<3 months)* • *Time between referral and evaluation by BPSD team (<1 month)* • *Report sent back to FMG* • *Number of patients admitted to long term care*

Short term results

Improve identification and diagnosis of patient with cognitive impairment by the FMG
Improve the quality of the management by FMG
Not evaluated:
Improve knowledge, attitude and practice of all FMG clinicians
Decrease delays for memory clinic, BPSD teams, home-based services, CT scans
Decrease non pertinent referrals and increase pertinent referrals to memory clinic
Increase clinicians' satisfaction
Increase patients and caregivers' satisfaction and experience
Unexpected results: overcrowding of home-based services and memory clinic; decrease access to programs for other diseases

Long term results

Not evaluated:
Maintain patients' functional status and quality of life
Decrease burden and improve the quality of life of caregivers
Decrease inappropriate service uses and costs
Maintain patients at home