平成 26 年度　老人保健事業推進費等補助金

老人保健健康推進等事業

諸外国の認知症施策に関する調査研究事業

平成 27（2015）年 3 月

独立行政法人国立長寿医療研究センター

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Ⅰ．　研究の概要

１．研究の目的

平成２５年１２月のG8認知症サミット宣言において、我が国主導で行うこととされた後継イベントの実施を通じて、国際社会との分野横断的なパートナーシップとイノベーションを構築し、これを通じて得られた調査研究結果により、我が国における研究と実践の向上に資する。

シンポジウムの計画は有識者で構成される委員会の了承を得ながら進めるとともに、イギリス・カナダで開催される関連イベントについての情報収集を行う。国際シンポジウム実施を受けて、その後の進展状況を追跡し2015年2月に米国で開催される会合において報告する。

２．事業実施の概要

認知症高齢者の増加は世界共通の課題であり、主要８カ国（G8）「認知症サミット」の後継イベントのテーマである「新しいケアと予防」に関して、国内での取組を調査・検討するとともに、G8各国やOECD各国の施策や取組をふまえての検討も行う。

G8宣言に基づいて行われる英国及び仏･加主導による同様のイベントの状況も踏まえつつ、平成26年11月に東京都内において、実務的分科会及びシンポジウムを開催することを通じて、高齢化の先進国である日本の研究や施策の現状を国際的にアピールするとともに、内外の状況についての調査研究を行う。

シンポジウム等には閣僚級を含むG8各国の代表及び内外の専門家を招請する。

結果は、2015年2月に米国で開催されるレビューイベントにおいて報告し、その進展について審査されることとされている。

あわせて、我が国における今後の認知症施策を国際的文脈の中でさらに強化していくための基礎資料とする。

Ⅱ．　諸外国の認知症施策に関する実態調査

II. 諸外国の認知症施策に関する実態調査

１．目的

世界的な課題である認知症に対して、ケアと予防という点に着目し、世界の現状を概観し、先進事例を紹介する。 地域を作る各々の主体となる者（本人・介護者、住民、事業者、民間企業など）の、積極的な参画と情報発信により、日本が目指す地域包括ケアシステムを紹介する。 ICT 等の新たな技術、手法について紹介するとともに、その可能性を検討する。「新たなケアと予防のモデル」について討議、結果を報告するとともに、可能であれば将来的な提言を行う。

２．実施内容（対象と方法）

１）G8 認知症サミットの概要

平成 25 年（2013 年）12 月 11 日、ロンドン（英国）で「G8 認知症サミット」が開催された。日本からは土屋品子厚生労働副大臣が出席し、英国のデイビット・キャメロン首相、ジェレミー・ハント保健大臣等 G8 各国の政府代表のほか、欧州委員会、WHO、OECD の代表が出席した。また、各国の認知症専門家や製薬会社代表等も参集し、世界的な共通課題である認知症について、各国の施策や認知症研究、社会的な取組み等幅広い観点からその現状や取組みを紹介するとともに、熱心な意見交換が行われた。土屋厚生労働副大臣は、日本の高齢化と認知症の現状、認知症施策推進 5 カ年計画（オレンジプラン）等について説明を行った。会議の成果として、G8 各国代表者の間で、認知症問題に共に取り組むための努力事項を定めた「宣言（Declaration）」及び「共同声明（Communique）」に合意した。

２）G8 認知症サミット宣言の主な内容

2025 年までに認知症の治療又は病態修飾療法を同定し、その目的を達成するために、認知症に関する研究資金を共同で大幅に増やすという目標を掲げる。 認知症関連の調査研究に従事する人々の数を増やす。 国際的な専門知識を結集することでイノベーションを促進し、また、認知症イノベーションを世界規模で支える民間・慈善基金を立ち上げる可能性の模索を含む、新たな資金源を獲得するための国際的な取り組みを調整するグローバルな「認知症イノベーション特使（Dementia Innovation Envoy）」を任命するとの英国の決断を歓迎する。 我々が資金提供する研究に関する情報を共有し、ビッグデータ構想の共有を含む連携と協力が可能な戦略的優先領域を同定する。

認知症研究に対するオープンアクセスを奨励し、研究データと研究結果を更なる研究のためにできるだけ速やかに利用できるようにする。 2014 年、OECD、WHO、欧州委員会、神経変性疾患に関する EU の共同プログラム（JPND）及び市民社会との連携の下、一連のハイレベルフォーラムを開催し、次のことに焦点を当てた分野横断的なパートナーシップとイノベーションを構築する。

社会的影響への投資（Social impact investment）―英国主導
新しいケアと予防のモデル（New care and prevention models）―日本主導
学術界と産業界のパートナーシップ（Academia–industry partnership）
―カナダとフランスの共同主導

３）後継イベントについて

（１）テーマ
新しいケアと予防のモデル　New care and prevention models

（２） 実施対象
各国代表者、国内研究者、厚労省関係者、マスコミ

（３）会議への参加者
約 300 名を超える G7 各国の専門家等が討議するために参加された。
また、会議の模様は、一般に向けてインターネットにより動画配信した。

実施方法
主にパワーポイントを用いたプレンゼンテーションと意見交換

（４）日程
平成 26 年（2014 年）11 月 5 日から 7 日の 3 日間
第 1 日目　専門分科会
第 2 日目　後継イベント本体
第 3 日目　視察旅行（東京、愛知、京都）
平成 26 年 10 月 6 日公表のプログラム（別添資料）

主催・運営：厚生労働省
国立長寿医療研究センター
認知症介護研究・研修東京センター

11 月 5 日～7 日にかけて、六本木アカデミーヒルズにおいてイベントが開催された。世界 12 か国から、401 人の参加があり、「新しいケアと予防のモデル」をテーマに活発な議論が交わされた。具体的には発言者は 81 名、参加者 232 名、当日参加者 2 名、展示関係者は 86 名であり、合計 401 名となった。さらにマスコミ関係者が 128 名であった。国別ではカナダ、中国、フランス、ドイツ、イタリア、日本、オランダ、韓国、台湾、タイ、英国、米国の計 12 カ国であった。その他 WHO,EU,WDC,CEO の参加者もあった。

（The Global Dementia Legacy Event Japan was held at Roppongi Academy Hills from November 5th to 7th. Over 300 attendees from more than ten countries gathered and productive discussion on “New Care and Prevention Models” was made.）

３．結果と考察

会議日程は計画通り実施、安倍総理大臣の出席があり、認知症を国家戦略とする宣言がなされ、その後新オレンジプランとして認知症の国家戦略が実施されることとなった。

すなわち認知症サミット後継イベントの開催が認知症対策の充実につながることとなった。また国家間での共通理解を深め、良い政策の共通化がはかられる方向となっている。またまとめでは地域での認知症対策の実施、人材育成、認知症の予防や適切なケアの提供が必要であるとの集約がなされた。

【新オレンジプラン】
以下、厚生労働省 HP より引用 : http://www.mhlw.go.jp/stf/houdou/0000072246.html

認知症施策推進総合戦略（新オレンジプラン）　資料２

～認知症高齢者等にやさしい地域づくりに向けて～

平成２７年１月２７日

我が国における認知症の人の数は２０１２（平成２４）年で約４６２万人、６５歳以上高齢者の約７人に１人と推計されている。正常と認知症との中間の状態の軽度認知障害(MCI: Mild Cognitive Impairment)と推計される約４００万人と合わせると、６５歳以上高齢者の約４人に１人が認知症の人又はその予備群とも言われている。

また、この数は高齢化の進展に伴いさらに増加が見込まれており、今般、現在利用可能なデータに基づき新たな推計を行ったところ、２０２５（平成３７）年には認知症の人は約７００万人前後になり、６５歳以上高齢者に対する割合は、現状の約７人に１人から約５人に１人に上昇する見込みとの結果が明らかとなった。認知症の人を単に支えられる側と考えるのではなく、認知症の人に寄り添いながら、認知症の人が認知症とともによりよく生きていくことができるよう、環境整備を行っていくことが求められている。

一方、高齢化に伴う認知症の人の増加への対応は今や世界共通の課題となっている中、世界でもっとも早いスピードで高齢化が進んできた我が国が、全国的な公的介護保険制度の下、重度な要介護状態となっても住み慣れた地域で自分らしい暮らしを人生の最期まで続けることができるよう、医療・介護・介護予防・住まい・生活支援が包括的に確保される地域包括ケアシステムの実現を目指す中で、社会を挙げた取組のモデルを示していかなければならない。

このため、いわゆる団塊の世代が７５歳以上となる２０２５（平成３７）年を目指し、認知症の人の意思が尊重され、できる限り住み慣れた地域のよい環境で自分らしく暮らし続けることができる社会を実現すべく、今般、「認知症施策推進５か年計画」（オレンジプラン）（２０１２（平成２４）年９月厚生労働省公表）を改め、新たに「認知症施策推進総合戦略～認知症高齢者等にやさしい地域づくりに向けて～」（新オレンジプラン）を策定した。

本戦略の策定に当たっては、認知症の人やその家族をはじめとした様々な関係者から幅広く意見を聞き、認知症の人やその家族の視点に立って、施策を整理した。また、本戦略は、厚生労働省が、内閣官房、内閣府、警察庁、金融庁、消費者庁、総務省、法務省、文部科学省、農林水産省、経済産業省及び国土交通省と共同して策定したものであり、今後、関係府省庁が連携して認知症高齢者等の日常生活全体を支えるよう

取り組んでいく。

基本的考え方

認知症高齢者等にやさしい地域づくりを推進していくため、認知症の人が住み慣れた地域のよい環境で自分らしく暮らし続けるために必要としていることに的確に応えていくことを旨としつつ、以下の７つの柱に沿って、施策を総合的に推進していく。本戦略の対象期間は２０２５（平成３７）年までであるが、施策ごとに具体的な数値目標を定めるに当たっては、介護保険が３年を一つの事業計画期間として運営されていることを踏まえ、その動向と緊密に連携しながら施策を推進していく観点から、２０１７（平成２９）年度末等を当面の目標設定年度としている。

①　認知症への理解を深めるための普及・啓発の推進

社会全体で認知症の人を支える基盤として、認知症の人の視点に立って認知症への社会の理解を深めるキャンペーンや認知症サポーターの養成、学校教育における認知症の人を含む高齢者への理解の推進など、認知症への理解を深めるための普及・啓発の推進を図る。

②　認知症の容態に応じた適時・適切な医療・介護等の提供

本人主体の医療・介護等を基本に据えて医療・介護等が有機的に連携し、認知症の容態の変化に応じて適時・適切に切れ目なく提供されることで、認知症の人が住み慣れた地域のよい環境で自分らしく暮らし続けることができるようにする。このため、早期診断・早期対応を軸とし、行動・心理症状（BPSD:Behavioral and Psychological Symptoms of Dementia）や身体合併症等が見られた場合にも、医療機関・介護施設等での対応が固定化されないように、退院・退所後もそのときの容態にもっともふさわしい場所で適切なサービスが提供される循環型の仕組みを構築する。

③　若年性認知症施策の強化

若年性認知症の人については、就労や生活費、子どもの教育費等の経済的な問題が大きい、主介護者が配偶者となる場合が多く、時に本人や配偶者の親等の介護と重なって複数介護になる等の特徴があることから、居場所づくり、就労・社会参加支援等の様々な分野にわたる支援を総合的に講じていく。

④　認知症の人の介護者への支援

高齢化の進展に伴って認知症の人が増えていくことが見込まれる中、認知症の人の介護者への支援を行うことが認知症の人の生活の質の改善にも繋がるとの観点に立って、介護者の精神的身体的負担を軽減する観点からの支援や介護者の生活と介護の両立を支援する取組を推進する。

⑤　認知症の人を含む高齢者にやさしい地域づくりの推進

６５歳以上高齢者の約４人に１ 人が認知症の人又はその予備群と言われる中、高齢

者全体にとって暮らしやすい環境を整備することが、認知症の人が暮らしやすい地域づくりに繋がると考えられ、生活支援（ソフト面）、生活しやすい環境の整備（ハード面）、就労・社会参加支援及び安全確保の観点から、認知症の人を含む高齢者にやさしい地域づくりの推進に取り組む。

⑥　認知症の予防法、診断法、治療法、リハビリテーションモデル、介護モデル等の研究　開発及びその成果の普及の推進

認知症をきたす疾患それぞれの病態解明や行動・心理症状（ＢＰＳＤ）を起こすメカニズムの解明を通じて、認知症の予防法、診断法、治療法、リハビリテーションモデル、介護モデル等の研究開発の推進を図る。また、研究開発により効果が確認されたものについては、速やかに普及に向けた取組を行う。なお、認知症に係る研究開発及びその成果の普及の推進に当たっては、「健康・医療戦略」（平成２６年７月２２日閣議決定）及び「医療分野研究開発推進計画」（平成２６年７月２２日健康・医療戦略推進本部決定）に基づき
取り組む。

⑦　認知症の人やその家族の視点の重視

これまでの認知症施策は、ともすれば、認知症の人を支える側の視点に偏りがちであったとの観点から、認知症の人の視点に立って認知症への社会の理解を深めるキャンペーン（再掲）のほか、初期段階の認知症の人のニーズ把握や生きがい支援、認知症施策の企画・立案や評価への認知症の人やその家族の参画など、認知症の人やその家族の視点を重視した取組を進めていく。

Global action against dementia

認知症サミット日本後継イベント

- 新たなケアと予防のモデル-

11月5日（水）　専門分科会
　　日本政府主催レセプション
11月6日（木）　国際会議
11月7日（金）　視　察

会場：六本木アカデミーヒルズ（東京都港区）

厚生労働省

独立行政法人
国立長寿医療
研究センター

社会福祉法人浴風会
認知症介護研究・研修
東京センター

第1日（11月5日（水））　専門分科会日程概要

Global action against dementia

9:30～

イントロダクション　（オーディトリウム。※スカイスタジオに配信）

10:00～

G７各国の認知症の予防とケアの現状報告　（オーディトリウム　※スカイスタジオに配信）

G7各国の認知症の人、ケアと予防に関する施策・システムの概要についての報告を行い、各国の政策の動向についての共通理解を図る。

OECD「医療の質のレビュー公表イベント」　（コラボレーションルーム１・２）

OECDが日本について行った「医療の質のレビュー」の調査結果の報告を受け、日本の医療政策の現状、課題及び今後の方向性に関して議論を深める。

11:30～

交流のためのランチミーティング　（六本木ヒルズクラブ）

13:00～

Ⅰ．認知症予防とケアー適時適切な支援の提供　（オーディトリアム）

予防・ケアの新たなモデルについて、認知症の時間的経過に即した観点から検討することを目的とする。
早期の診断から初期対応、予防、診断後の支援からターミナルケアに至る各段階における介入・支援の形態と各主体の連携方策についての新たなモデルを見出す。

Ⅱ．認知症予防とケアの科学的側面　（スカイスタジオ）

従来、経験に多くを依存していた認知症の予防やケアの分野において、客観性を確保するための取組みが進められている。
認知症の予防やケアに関し、各地で進められている実証的研究から、科学的な根拠に関する現在の知見を共有し、今後の施策への活用の可能性や、今後進むべき研究の方向についての示唆を得る。

15:30～

Ⅲ．認知症の人が地域で暮らす　（オーディトリアム）

認知症の人々は、診断を受けた後も継続して自らの生活を営めることが重要であり、このための新たな取組みが進められている。
これらの取組みについての現在の知見を共有し、今後の施策への活用の可能性や、今後の方向についての示唆を得る。

Ⅳ．認知症に関する理解の促進や教育の推進　（スカイスタジオ）

認知症に関するスティグマを防止するため、啓発活動が重要であるが、啓発を実際の行動変容につなげるための様々な新たな取組が行われており、その可能性を探る。
認知症に関する診断、予防、ケアの知識・技術については、保健医療介護関係者に広く浸透することが重要であり、一部の専門家からより広範な関係者への知識の共有が必要である。また、すでに高齢化に直面している国から今後認知症問題へ直面する国々への知識・経験の共有が重要である。

カンファレンスルームにおいてポスター等の交流展示を実施

※プログラムは今後変更がありうる。

第2日（11月6日（木））　国際会議　（タワーホール）

プログラムは今後変更がありうる

9:00～	開　会
9:30～	OECD挨拶、調査発表：「各国の認知症に関する分析」 OECDに対し調査を依頼した各国における認知症のケアと予防について、とりまとめの発表を行う
10:00～	トピック１：地域における認知症予防とケア～認知症の状態に応じた適切な予防とケア 前日の最初のセッションの各国の現状報告、OECDの報告から、現状に対し共通の認識をしたうえで、前日のセッションⅠで話し合われた地域における適時適切な予防とケアについても各スピーカーから話をしてもらう
11:30～	トピック２：　認知症予防とケアへの科学的アプローチ 前日のセッションⅡでまとめられた認知症予防とケアの科学的側面について各学会や研究者から、研究の最前線の話を各演者から話をしてもらう
12:45～	昼　　食　　（六本木ヒルズクラブ）
14:15～	トピック３：認知症にやさしいコミュニティとITの活用 前日のセッションⅢでまとめられた、認知症の人と、地域社会の在り方について概観し、認知症にやさしいコミュニティに関して話をしてもらう。そのような社会実現のために、IT等の新たなテクノロジーは何ができるか、についても、関連省庁や企業代表などから話をしてもらう
15:45～	トピック４：将来に向けた課題 認知症予防･ケアの新たなモデルに関して今後の展開等について検討する
17:00～	閉　会

○認知症に関連する最新のロボット等の展示を実施（スカイスタジオ）
○ポスター等の交流展示を実施（カンファレンスルーム7）

日本政府主催レセプション：
11月5日（水）１８：００～　六本木ヒルズクラブ

海外からの参加者の現地視察：11月7日（金）
東京：認知症介護研究・研修東京センター、**愛知**：国立長寿医療研究センター、**京都**：宇治市

Global action against dementia

Ⅲ.　資料

Global action
against dementia

Global Dementia Legacy Event Japan

-New Care and Prevention Models-

Wednesday 5 Nov. Subspecialty Meeting, Reception
Thursday 6 Nov. Main Conference
Friday 7 Nov. Excursion

Roppongi Academyhills ; Minato-ku, Tokyo

厚生労働省

Ministry of Health
Labour & Welfare

National Center for
Geriatrics and Gerontology

Tokyo Dementia Care
Research and Training Center

Global action
against dementia

Free WiFi access is available on the 49th floor.

Global action against dementia

Day 1: Wednesday, 5 November, Subspecialty meeting

9:30 | 10:00 — *Welcome Addresses* (Auditorium)

Koji Miura (Director General, Health and Welfare Bureau for the Elderly, Ministry of Health, Labour and Welfare)

Kenji Toba (President, National Center for Geriatrics and Gerontology, Japan)

Kiyoshi Kurokawa (World Dementia Council)

Yoshitake Yokokura (President, Japan Medical Association)

Shekhar Saxena (Director, Department of Mental Health and Substance Abuse, World Health Organization)

Tomofumi Yamamoto (Journalist, Shukan Asahi Weekly Magazine)

10:00 | 11:30 — *Session-0 The Challenges of Dementia : From Participating Countries* (Auditorium)

(10:00~11:30)

Overview the policies and systems for persons with dementia related to care and prevention in participating countries, to nurture a common ground of understanding among participants.

【Chairperson】 **Kenji Toba**
(National Center for Geriatrics and Gerontology, Japan)

【Chairperson】 **Christian Berringer**
(Federal Ministry of Health, Germany)

Charles Alessi (Public Health England, UK)

Yves Joanette
(Institute of Aging, CIHR & University of Montreal, Canada)

Etienne Hirsch
(French Institute Neurosciences, Cognitive sciences, Neurology and Psychiatry, France)

Kenneth Earhart
(US Department of Health and Human Services, USA)

Teresa Di Fiandra (Ministry of Health, Italy)

Jürgen Scheftlein (European Commission)

Tadayuki Mizutani
(Ministry of Health, Labour and Welfare, Japan)

11:30 | 13:00

11:30～13:00
Lunch meeting for networking
(Roppongi Hills Club 51F)

12:15～13:00
Free Discussion at Booth and Poster Exhibition
(Conference Room 7)

10:00 | 11:45 — *OECD : "Reviews of Health Care Quality: JAPAN"* (Collaboration Room 1+2)

(10:00~11:45)

The OECD is conducting a series of reviews of health care quality and related policies in a dozen of OECD countries, including Japan. Following a presentation of key findings by the OECD, panelists will discuss the current situation and the future challenges of the Japanese health care system. The full OECD Review of Health Care Quality of Japan will be published in the coming months.

【Welcome】 **Mitsuhiro Ushio**
(Ministry of Health, Labour and Welfare, Japan)

【Introduction】 **Mark Pearson** (OECD)

【Presentation】 **Francesca Colombo** (OECD)

【Moderator】 **Toshiro Kumakawa**
(National Institute of Public Health, Japan)

Satoshi Imamura (Japan Medical Association)

Tsuguya Fukui
(President, St. Luke's International Hospital)

Shinya Matsuda
(Professor, University of Occupational and Environmental Health)

Yuichi Imanaka
(Professor, Kyoto University Graduate School of Medicine)

ToshihikoTakeda
(Ministry of Health, Labour and Welfare, Japan)

Yasumasa Fukushima
(Ministry of Health, Labour and Welfare, Japan)

【Closing】 **Tomoyuki Ozuru**
(Ministry of Health, Labour and Welfare, Japan)

Day 1: Wednesday, 5 November, Subspecialty meeting

	Session-1 Dementia Prevention and Care: Providing Timely and Appropriate Support (13:00~15:00) Auditorium Explore new models of prevention and care throughout the course of the illness —from early diagnosis to initial response and prevention, and from post-diagnostic support to end of life care—to provide optimized, better coordinated intervention and support.	Session-2 Scientific Aspects of Dementia Prevention and Care (13:00~15:00) Sky Studio Advance initiatives to ensure objectivity in the field of dementia prevention and care, which has traditionally relied heavily on experience Share the latest scientific knowledge culled from empirical studies on dementia prevention and care around the world; gather suggestions for possible policy activities and directions for future research.
13:00 | 15:00	【Chairperson】**Kazuo Hasegawa** (Tokyo Dementia Care Research and Training Center, Japan)	【Chairperson】**Takao Suzuki** (National Center for Geriatrics and Gerontology)
	【Chairperson】**Yves Joanette** (Institute of Aging, CIHR & University of Montreal, Canada)	【Chairperson】**Martin Prince** (King's College London)
	Haruyasu Yamaguchi （Gunma University, Japan）	**Vladimir Hachinski** (University of Western Ontario)
	Jiro Okochi (Japan Association of Geriatric Health Services Facilities, Japan)	**Piu Chan** (Xuanwu Hospital of Capital Medical University)
	Manabu Ikeda （Kumamoto University, Japan）	**Katsuhiko Yanagisawa** (National Center for Geriatrics and Gerontology)
	Charles Alessi (Public Health England, UK)	**Liang-Kung Chen** (Taipei Veterans General Hospital)
	Howard Bergman (McGill University, Canada)	**Hiroyuki Shimada** (National Center for Geriatrics and Gerontology)
	Florence Pasquier (University of Lille and Centre Hospitalier Universitaire de Lille, France)	**Dawn Brooker** (University of Worcester)
	Peter Whitehouse (Case Western Reserve University and University of Toronto, USA)	**Graham Stokes** (Bupa)
	Francesca Colombo (OECD)	**Hiroaki Kazui** (Osaka University)
15:00 | 15:30	*Break Time*	

Global action against dementia

Day 1: Wednesday, 5 November, Subspecialty meeting

	Session-3 Living Well with Dementia in the Community	Session-4 Enhance Awareness and Education in the Society
	(15:30~17:30) **Auditorium** Share information of progressive approaches from across the globe, designed to enable persons with dementia to continue living in the community. Seek for the possibility to reflect the fruits of those inspiring efforts to the specific and effective measures.	(15:30~17:30) **Sky Studio** Investigate the possibilities of a variety of initiatives to change public attitude through public awareness. Public awareness campaigns are necessary to prevent stigmas against dementia. Knowledge of and technology for the diagnosis, prevention, and care of dementia must be well understood by nursing and health care officials. Knowledge shared by a small group of experts should be shared with a broader range of interested parties. Moreover, nations that are dealing with aging societies need to share their knowledge and experience with those nations that will be facing issues concerning dementia.
15:30 | 17:30	【Chairperson】**Koichi Kozaki** (Kyorin University, Japan)	【Chairperson】**Akira Homma** (Tokyo Dementia Care Research and Training Center, Japan)
	【Chairperson】**Cyndy Cordell** (Alzheimer's Association, USA)	【Chairperson】**Marc Wortmann** (Alzheimer's Disease International)
	Jean Georges (Alzheimer Europe)	**Gillian Ayling** (Department of Health, UK)
	Shuichi Awata (Tokyo Metropolitan Institute of Gerontology, Japan)	**Sabine Jansen** (German Alzheimer Association)
	Annette Pauly (Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, Germany)	**Michael Splaine** (ADI. / Splaine Consulting and Cognitive Solutions, LLC)
	Jeremy Hughes (Alzheimer's Society, UK)	**Tasanee Tantirittisak** (Prasat Neurological Institute,Thailand)
	Kunio Takami (Alzheimer's Association Japan)	**Kunio Nitta** (Medical Corporation Tsukushikai, Japan)
	Ki Woong Kim (National Institute of Dementia, S.Korea)	**Noriko Saito** (Japanese Nursing Association)
	Kumiko Utsumi (Sunagawa Medical Center, Japan)	**Kumiko Nagata** (Tokyo Dementia Care Research and Training Center, Japan)
	Rumiko Otani (Omuta-city Dementia Care Society, Japan)	**Hidetoshi Endo** (National Center for Geriatrics and Gerontology, Japan)

Day 1: 5th November (Wednesday) Reception hosted by the Government of Japan

18:00 | 20:00	*Roppongi Hills Club (51F)* *Welcome Speech* *Yasuhisa Shiozaki , Minister of Health, Labour and Welfare, Japan.*

Day 1: Wednesday, 5 November, Booth and Poster Exhibition at Conference Room 7			
		Booths	***Posters***
9:30 | 17:30	**1**	▶ Alzheimer's Disease International	▶ Alzheimer's Association Japan (Association of Family Caring for Demented Eldery Japan)
	2	▶ Center for Global Communications, International University of Japan ▶ Dementia Friendly JAPAN Initiative	▶ Dementia Care Research and Training Centers (Tokyo, Obu, Sendai)
	3	▶ Japan Psychiatric Hospitals Association	▶ Japan Association of Geriatric Health Services Facilities
	4	▶ Japanese Psychogeriatric Society ▶ The Japanese Society for Dementia Care	▶ Japan Group-Home Association for People with Dementia
	5	▶ National Center for Geriatrics and Gerontology, Japan	▶ National Center for Geriatrics and Gerontology Biobank, Japan
	6	▶ National Center of Neurology and Psychiatry, Japan	▶ Steering Committee of Advanced Dementia Care Japan
	7	▶ NINCHISHO(DEMENTIA) FORUM.COM, Japan	
	8	▶ OECD	
	9	▶ Specified Non-profit Corporation Heart Ring Movement, Japan	
	10	The Joint Council of the Japanese Rehabilitation Professionals ▶ Japanese Association of Occupational Therapists ▶ Japanese Physical Therapy Association ▶ Japanese Association of Speech-Language-Hearing Therapists	

※ ***Free Discussion from 12:15 to 13:00***

Global action against dementia

Day 2: Thursday, 6 November, Main Conference (Tower Hall)

9:00 | 9:30	***Opening Presentation***
	Yasuhisa Shiozaki (Minister of Health, Labour and Welfare, Japan)
	Kiyoshi Kurokawa (World Dementia Council)
	Dennis Gillings (World Dementia Envoy)
	Mark Walport (Chief Scientific Adviser to HM Government and Head of the Government Office for Science, UK)
	Shekhar Saxena (Director, Department of Mental Health and Substance Abuse, World Health Organization)
	Shigenobu Nakamura (Councelor, Alzheimer's Association, Japan)
	Kazuko Fujita (Co-Chair, Japan Dementia Working Group)
	*Other speakers to be confirmed
9:30 | 10:00	***Keynote address: "Dignity in Dementia: How policy can improve the lives of people with dementia"***
	Mark Pearson (Deputy Director of Employment, Labour and Social Affairs, OECD)
	Shekhar Saxena (Director, Department of Mental Health and Substance Abuse, World Health Organization)
10:00 | 11:15	***Topic1***
	Dementia in the Community : Timely and appropriate prevention and care
	Reach a shared awareness of the status of various nations based on national status reports presented during Session-0 on Day1 and OECD reports. Expanding on discussions held during Session-1 on Day 1, speakers will present on timely and appropriate prevention and care in their communities.
	Kenji Toba (National Center for Geriatrics and Gerontology, Japan)
	Christian Berringer (Federal Ministry of Health, Germany)
	Yves Joanette (Institute of Aging, CIHR & University of Montreal, Canada)
	Kazuo Hasegawa (Tokyo Dementia Care Research and Training Center, Japan)
	Jacqueline Hoogendam (Ministry of Health, Welfare and Sport, Netherlands)
	Jeremy Hughes (Alzheimer's Society, UK)
	Geoff Huggins (Health and Social Care Integration, Scotland)
	Etienne Hirsch (French Institute Neurosciences, Cognitive sciences, Neurology and Psychiatry, France)
	Jeff Huber (Home Instead, Inc., USA)
11:15 | 11:30	*Break & Slide Show* *Yasuhiro Kunimori*
11:30 | 12:45	***Topic2***
	Scientific Approach toward Dementia Prevention and Care
	Presentation by each society representative and researcher on the scientific aspects of dementia prevention and care summarized during Session-2 on Day 1. Each presenter will discuss current research on the topic.
	Takao Suzuki (National Center for Geriatrics and Gerontology, Japan)
	Martin Prince (King's College London, UK)
	Yuko Harayama (Council for Science, Technology and Innovation, Cabinet Office, Japan)
	Hiroshi Mori (Japan Society for Dementia Research)

Day 2: Thursday, 6 November, Main Conference （Tower Hall）

11:30 | 12:45	**Philippe Amouyel** (Fondation Plan Alzheimer, France)	
	Yves Joanette (Institute of Aging, CIHR & University of Montreal, Canada)	
	Yasuyoshi Ouchi (Japan Geriatric Society)	
12:45 | 14:15	*Lunch meeting for networking* *(Roppongi Hills Club 51F)*	*Slide Show (Tower Hall)* ・*Yasuhiro Kunimori* ・*Cathy Greenblat* *Demonstration at ICT&Robot Exhibition (Sky Studio)*
14:15 | 15:30	***Topic3*** ***Dementia-friendly Community and ICT*** Overview of characteristics of persons with dementia and ways to support community living, as summarized during Session-3 on Day 1. Discussion featuring representatives from related government ministries and company representatives on the potential of ICT and other new technologies to help realize dementia-friendly communities.	
	Shuichi Awata (Tokyo Metropolitan Institute of Gerontology, Japan)	
	Koichi Kozaki (Kyorin University, Japan)	
	Sadao Katayama (Alzheimer's Association Japan)	
	Couichi Oku (NPO Machidashi Connection a Society, Japan)	
	Marc Wortmann (Alzheimer's Disease International)	
	Kiyokuni Goshima (The Association for Technical Aids, Japan)	
	Takenobu Inoue (National Rehabilitation Center for Persons with Disabilities, Japan)	
	Yoshiki Niimi (Ministry of Health, Labour and Welfare, Japan)	
	Peter Whitehouse (Case Western Reserve University and University of Toronto, USA)	
15:30 | 15:45	*Break & Slide Show* *Cathy Greenblat*	
15:45 | 17:00	***Topic4*** ***Future Initiatives*** Examine the horizontal spread of new models of dementia prevention and care and investigate issues associated with the new forms of care and prevention.	
	Akira Homma (Tokyo Dementia Care Research and Training Center, Japan)	
	Marc Wortmann (Alzheimer's Disease International)	
	Tom Wright (Age UK)	
	Toshiharu Ninomiya (Kyushu University, Japan)	
	Mark Pearson (OECD)	
	Hiroko Sugawara (Community-Care Policy Network, Japan)	
	Jean Georges (Alzheimer Europe)	
	Jürgen Scheftlein (European Commission)	
	Jon Rouse (Department of Health, UK)	
	Shekhar Saxena (World Health Organization)	

Global action against dementia

Day 2: Thursday, 6 November, Main Conference (Tower Hall)

17:00 | 17:30	***Closing Addresses***
	Kenneth Earhart (US Health Attache for China, US Department of Health and Human Services)
	Koji Miura (Director General, Health and Welfare Bureau for the Elderly, Ministry of Health, Labour and Welfare, Japan)
	Kiyoshi Kurokawa (World Dementia Council)
	Yasuhisa Shiozaki (Minister of Health, Labour and Welfare, Japan)
	*Other speakers to be confirmed

Day 2: Thursday, 6 November, Booth and Poster Exhibition at Conference Room 7

		Booths	***Posters***
9:30 | 17:00	1	▶ Alzheimer's Disease International	▶ Alzheimer's Association Japan (Association of Family Caring for Demented Eldery Japan)
	2	▶ Center for Global Communications, International University of Japan ▶ Dementia Friendly JAPAN Initiative	▶ Dementia Care Research and Training Centers (Tokyo, Obu, Sendai)
	3	▶ Japan Psychiatric Hospitals Association	▶ Japan Association of Geriatric Health Services Facilities
	4	▶ Japanese Psychogeriatric Society ▶ The Japanese Society for Dementia Care	▶ Japan Group-Home Association for People with Dementia
	5	▶ National Center for Geriatrics and Gerontology, Japan	▶ National Center for Geriatrics and Gerontology Biobank
	6	▶ National Center of Neurology and Psychiatry, Japan	▶ Steering Committee of Advanced Dementia Care Japan
	7	▶ NINCHISHO(DEMENTIA) FORUM.COM, Japan	
	8	▶ OECD	
	9	▶ Specified Non-profit Corporation Heart Ring Movement, Japan	
	10	The Joint Council of the Japanese Rehabilitation Professionals ▶ Japanese Association of Occupational Therapists ▶ Japanese Physical Therapy Association ▶ Japanese Association of Speech- Language-Hearing Therapists	

Day 2: Thursday, 6 November, ICT&Robot Exhibition at SkyStudio

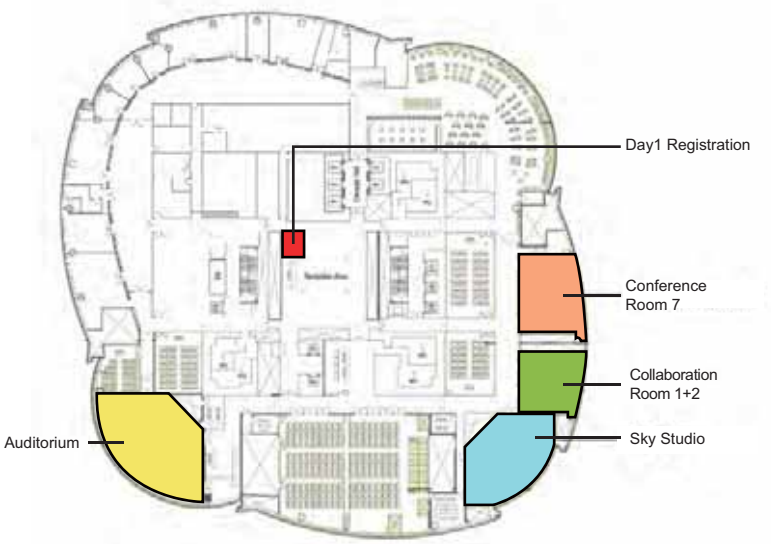
9:30 | 17:00	・ Humanoid Robot - Pepper for Seniors (Softbank Robotics corp.)
	・ Communication Partner Robot (Toyota Motor Corporation Partner Robot Division)
	・ Neurological Therapeutic Seal Robot - PARO (National Institute of Advanced Industrial Science and Technology)
	・ Development of an information support system for the elderly with cognitive decline by the communication robot (National Rehabilitation Center for Persons with Disabilities)
	・ Communication Robot PALRO® (FUJISOFT INCORPORATED)

※ ***Demonstration time for Exhibition From 13:15 to 14:15***

Global action against dementia

Day 1: Wednesday 5, November , Floor Information

	49F				51F
Time	Auditorium	Sky Studio	Collaboration Room 1+2	Conference Room 7	Roppongi Hills Club
9 a.m.	Registration				
	9:30 Introduction 10:00	9:30 Live coverage from Auditorium 11:30		9:30 Booth and Poster Exhibition 12:15	
10 a.m.	10:00 Session 0 11:30		10:00 OECD event 11:45		
11 a.m.	11:30 Lunch / Break Time 13:00				11:30 Lunch Meeting for Networking 13:00
12 a.m.				12:15 Free Discussion 13:00	
1 p.m.	13:00 Session 1 15:00	13:00 Session 2 15:00		13:00 Booth and Poster Exhibition 17:30	
2 p.m.					
3 p.m.	15:00 Break Time 15:30				
4 p.m.	15:30 Session 3 17:30	15:30 Session 4 17:30			
5 p.m.					
6 p.m.					18:00 Reception hosted by the Government of Japan 20:00
7 p.m.					



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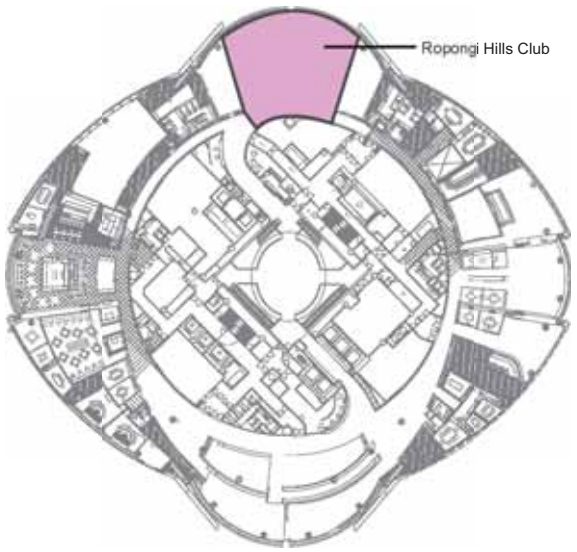

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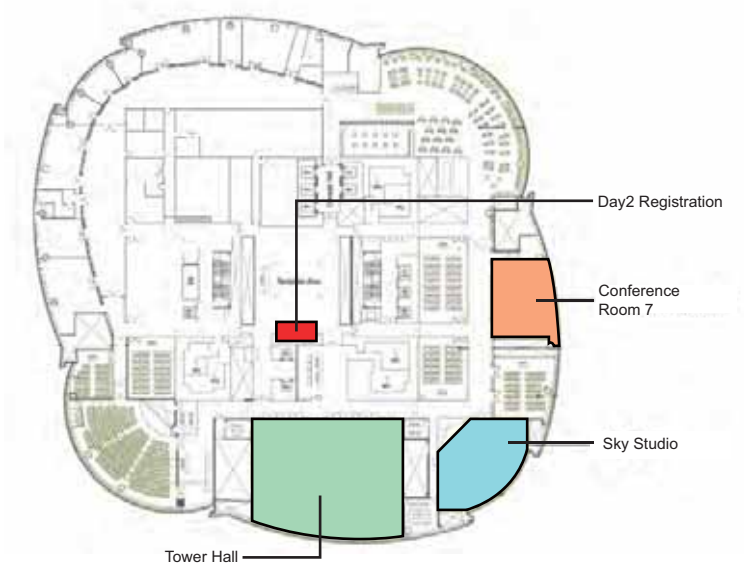
Global action against dementia

Day 2: Thursday, 6 November, Floor Information

	49F			51F
Time	Tower Hall	Sky Studio	Conference Room 7	Roppongi Hills Club
8 a.m.				
	Registration			
9 a.m.	9:00 Opening 9:30			
	9:00 Keynote Address 10:00	9:30 ICT&Robot Exhibition	9:30 Booth and Poster Exhibition	
10 a.m.	10:00 Topic 1 11:15			
11 a.m.	11:15 Break Time 11:30			
	11:30 Topic 2 12:45			
12 a.m.	12:45 Lunch / Break Time 14:15			12:45 Lunch Meeting for Networking 14:15
1 p.m.		13:15 Demonstration 14:15		
2 p.m.	14:15 Topic 3 15:30			
3 p.m.	15:30 Break Time 15:45	ICT&Robot Exhibition 17:00	17:00	
	15:45 Topic 4 17:00			
4 p.m.				
5 p.m.	17:00 Closing Addresses 17:30			



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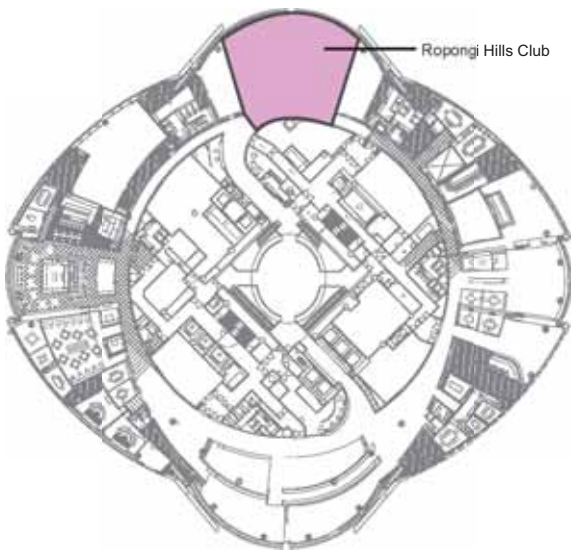

51F

Global action
against dementia

Global Dementia Legacy Event Japan
-New Care and Prevention Models-

Global action against dementia

DAY 1

Wednesday, 5 November

Sectional meeting

Speaker Biographies

Koji Miura

MD, MPH, PhD

Director General
Health and Welfare Bureau for the Elderly
Ministry of Health Labour and Welfare, Japan

Biography

He started his carrier at the Ministry of Health and Welfare in 1983. His carrier at Ministry includes Director of the Health for the Elderly Division of the Health and Welfare Bureau for the Elderly, Director of the Health Sciences Division of the Minister's Secretariat, and the Director - General for the Technical Affairs of the Minister's Secretariat.
Since July 2014, he has been in the current position

Kenji Toba

MD, PhD

President
National Center for Geriatrics and Gerontology, Japan

Biography

Postgraduate Career:

1978	Diploma of University of Tokyo, Faculty of Medicine
1996-2000	Associate Professor, Department of Geriatrics, Tokyo University
2000-2010	Professor and Chairman, Department of Geriatric Medicine, Kyorin University, School of Medicine
2006-2010	Director, the Center for comprehensive care on memory disorders(Kyorin)
2010-2013	Director, Hospital of National Center for Geriatrics and Gerontology Director at the Center for comprehensive care and research on memory disorders
2011-2013	Director, the Bio-bank of National Center for Geriatrics and Gerontology
2013-	President, National Center for Geriatrics and Gerontology

Membership of Academic Society:

The Japan Geriatrics Society (Vice Chairman)
The Japan Gerontological Society (Director)
Japan Atherosclerosis Society (Councilor)
Japan Osteoporosis Society (Councilor)
Japan Dementia Society (Director)

Award:

1994, 2000	Most Excellent Research Paper Award The Japan Geriatrics Society
2001	Award of Japan Osteoporosis Society

Kiyoshi Kurokawa

MD, MACP, FRCP (London)

World Dementia Council
Professor Emeritus of the University of Tokyo

Biography

Dr. Kurokawa, Professor Emeritus of the University of Tokyo, is Professor of National Graduate Institute for Policy Studies (2007-); Chairman, Health and Global Policy Institute (2005-); Commissioner on the WHO Commission for Social Determinants of Health (2005-2008); Chair, Global Health Innovative Technology Fund (2013-); Council Member of the World Dementia Council (2014.4.30-).

He received a MD degree from the University of Tokyo. Following clinical training in internal medicine and nephrology at the Department of Medicine of the University of Tokyo, Faculty of Medicine, he spent 15 years in USA (1969-84); professor of medicine, Department of Medicine, UCLA School of Medicine, University of Tokyo, Faculty of Medicine (1989-96), Dean and Professor of Tokai University School of Medicine and Director of the Institute of Medical Sciences (1996-2002) of Tokai University.

He has served as president and/or executive officer to many prestigious national and international professional societies in medicine, nephrology, science academies and science policy organizations. He is also an elected member of professional societies including Science Council of Japan (President, 2003-06), Institute of Medicine of the National Academies of the USA. He was/is Board Member of Bioblioth eca Alexandria, Egypt, Khalifa University of Science and Technology of Abu Dhabi, Okinawa Institute of Science Technology Graduate University and Advisory Board to the Prime Minister of Malaysia.

Dr. Kurokawa, Special Advisor to the Cabinet (2006-08), has served many committees of the Ministries and Cabinet Office of Japan, eg, Chairperson of the Hideyo Noguchi Africa Prize Committee.
He chaired the Fukushima Nuclear Accident Independent Investigation Commission by the National Diet of Japan (2011.12-2012.7) for which he recognized as ‘Scientific Freedom and Responsibility Award’ of AAAS (2012) and of ‘100 Top Global Thinkers 2012’ of Foreign Policy.
His website: <http://www.kiyoshikurokawa.com/en>

Yoshitake Yokokura

MD, PhD

President
Japan Medical Association

Biography

Dr. Yoshitake Yokokura graduated from Kurume University School of Medicine in March, 1969, and worked for the surgery department of the University as an assistant. After that he worked for the surgery department of the Detmold Hospital in West Germany for two years. He has served as president of Yokokura Hospital since 1990.
He took office as President of the Fukuoka Prefecture Medical Association in 2006. He was elected as President of the Japan Medical Association in April 2012. He is also serving Council Member of the World Medical Association (WMA) and Councilor of the Confederation of Medical Associations in Asia and Oceania (CMAAO).

Interests: Surgery

Professional Experience

2012-Present	President, Japan Medical Association
2010- 2012	Vice-President, Japan Medical Association
2006- 2010	President, Fukuoka Prefecture Medical Association
2002- 2010	Delegate, House of Delegates, Japan Medical Association
2002- 2006	Vice-President, Fukuoka Prefecture Medical Association
1998- 2002	Executive Director, Fukuoka Prefecture Medical Association
1990-1998	Executive Board Member, Fukuoka Prefecture Medical Association
1990-Present	President, Yokokura Hospital
1980-1983	Master, Kurume University School of Medicine
1977-1979	The Department of Surgery, Detmold Hospital
1969-1977	Assistant, the Department of Surgery, Kurume University School of Medicine

Education:

1969	Graduated from Kurume University School of Medicine

Shekhar Saxena

MD

Director
Department of Mental Health and Substance Abuse
World Health Organization

Biography

Dr Saxena is a psychiatrist by training, working at World Health Organization since 1998 and the Director of the Department since 2010. He is responsible for all work at WHO related to mental, developmental, neurological and substance use disorders and suicide prevention.

His responsibilities include evaluating evidence on effective public health measures and providing advice and technical assistance to ministries of health on prevention and management of mental, developmental, neurological and substance use disorders. His work also involves establishing partnerships with academic centres and civil society organizations and global advocacy for mental health. Dr Saxena initiated WHO's work on the Mental Health Atlas that has led to a global monitoring of mental health resources over the last 14 years. He also led the project on mental health Gap Action Programme (mhGAP), to scale up services, currently being implemented in more than 60 countries.

Dr Saxena is currently leading WHO's work to implement the Comprehensive Mental Health Action Plan adopted by the World Health Assembly in May 2013. He is also responsible for assisting countries on Assembly directed work on Developmental disorders including Autism and work related to public health action on dementia. His responsibilities also include leading activities on strategies to reduce harmful use of alcohol and illicit drugs. He is also responsible for revision of mental, behavioural and neurological disorders for ICD-11 to be published by WHO in 2017.

Dr Saxena has edited or authored more than 30 books including WHO publications and has authored more than 250 scientific papers in indexed journals.

Tomofumi Yamamoto

Journalist
Shukan Asahi Weekly Magazine

Biography

Tomofumi Yamamoto graduated from Waseda University, and began his career as a Journalist on 1975 at one of the most famous newspaper in Japan, Mainichi Shimbun.
He moved to Asahi Shimbun on 1983, which is famous as well, and then Shukan Asahi Weelky Magazine on 1986.
Still continuing to work actively after diagnosed as MCI on early 2014, he wrote his personal experience on his serial article" Honshi Kisha 62 sai. Bokete Tamaruka ! (Our writer 62y.o. No way I'll go senile !)", which gained high reputation among Japanese readers.

Christian Berringer

MD, PhD

Head of unit “Definition and Assessment of Need of Care; Quality Assurance; General Matters of Care Provision”
Federal Ministry of Health, Germany

Biography

Dr Christian Berringer is head of the unit “Definition and Assessment of Need of Care; Quality Assurance; General Matters of Care Provision” in Germany's Federal Ministry of Health.
He studied at the Universities of Munich and London and received a PhD in history in 1996.

After working as assistant to members of the European Parliament (Brussels) and the German Bundestag, he joined the staff of the German Federal Government Commissioner for Matters relating to Disabled Persons in 1998 and became head of staff in 2002.
In 2005 he moved to his current position.

Charles Alessi

MD

Senior Advisor on Dementia
Public Health England, UK

Biography

Dr Charles Alessi
Senior Advisor and Lead on Dementia for Public Health England Co-Chair of National Association of Primary Care

Dr Charles Alessi is a GP in South West London.
In January 2013, he was appointed as Senior Advisor to Public Health England and was appointed lead for preventable dementia in January 2014.
Dr Alessi has extensive experience of the NHS in a variety of senior positions in both primary and secondary care as well as PCTs and Health Authorities. Dr Alessi assumed the role of Chairman of NAPC in January 2012. In September 2014 he assumed the role of Co-Chair of NAPC. He is also Chairman of NHS Clinical Commissioners.
In July 2012, he was appointed Adjunct Research Professor at the Ivey School of Business, University of Western Ontario, Canada for the MBA in Health Innovation and in July 2013 was also appointed Adjunct Research Professor in Clinical Neurosciences at the Schulich school of Medicine and Dentistry at the University of Western Ontario, Canada.
He also sits on the mental health Advisory Board of one of the largest Academic Health Networks, University College London Academic Health Partnership.
He has extensive experience of working at senior levels both nationally and internationally, in Europe and the Americas. As Chair of the NAPC, which represents the out of hospital sector in the NHS Confederation, he is very active in the development of policy in healthcare and internationally he has been active in advising both Governments and international organisations. He also has experience of military medicine until recently acting as Director of Medicine and Clinical Governance for the British Armed Forces in Germany.
In September 2014, Dr Alessi was appointed Visiting Professor of Psychology & Language Sciences Clinical Educational and Health Psychology at UCL.
and internationally he has been active in advising both Governments and international organisations. He also has experience of military medicine until recently acting as Director of Medicine and Clinical Governance for the British Armed Forces in Germany.
In September 2014, Dr Alessi was appointed Visiting Professor of Psychology & Language Sciences Clinical Educational and Health Psychology at UCL.

Yves Joanette

MD, PhD

ScientificDirector
CIHR-InstituteofAging
Professor
Cognitive Neurosciences and Aging at the Faculty of Medicine of the Universitéde Montréal, Canada

Biography

Yves Joanette is Professor of Cognitive Neurosciences and Aging at the Faculty of Medicine of the Université de Montréal. He is currently the Scientific Director of the Institute of Aging of the Canadian Institutes of Health Research (CIHR) and the Executive Director of the CIHR International Collaborative Research Strategy on Alzheimer's Disease.
He previously served as Director of the Centre de recherche de l'Institut universitaire de gériatrie de Montréal as well as President & CEO, as well as the Chair of the Board, of the Fonds de la recherche en santé du Québec (FRQ-S).
Yves Joanette has been a Scholar and then Scientist of the Canadian Medical Research Council (now CIHR) and has received many distinctions, including the André-Dupont Award from the Club de recherches cliniques du Québec, in 1990, and the Eve-Kassier Award, in 1995, for exceptional professional accomplishment. Yves Joanette is a Fellow of the Canadian Academy of Health Science. In 2007, the Université Lumière de Lyon in France presented him with an Honorary Doctorate.

Etienne C Hirsch

MD, PhD

Director
French Institute Neurosciences, Cognitive sciences, Neurology and Psychiatry, France

Biography

Etienne Hirsch is a neurobiologist involved in research on Parkinson's disease and related disorders. He obtained his PhD in 1988 from the University of Paris VI (Pierre et Marie Curie). He is currently the director of the Insitute for Neurosciences, Cognitive sciences, Neurology and Psychiatry at INSERM and the French alliance for life and health science Aviesan, the associate director of the research center of the Institute of Brain and spinal cord (ICM), head of “Experimental therapeutics of Parkinson disease” at the ICM at Pitié-Salpêtrière hospital in Paris and councilor for Neuroscience, Neurology and Psychiatry at the department for research and innovation at French Ministry for higher education and research. His work is aimed at understanding the cause of neuronal degeneration in Parkinson's disease and is focused on the role of the glial cells, the inflammatory cytokines and apoptosis but also on the consequences of neuronal degeneration in the circuitries downstream to the lesions. He is member of several advisory boards including, French Society for Neuroscience (past-President), Scientific Advisory board at INSERM. He obtained several prizes including Tourette Syndrome Association Award in1986, Young researcher Award, European Society for Neurochemistry in 1990, Grand Prix de l' Académie de Sciences, Prix de la Fondation pour la recherche biomédicale « Prix François Lhermitte » in 1999, Chevalier de l'ordre des palmes académiques in 2009, Prix Raymond et Aimée Mande of the French National academy of Medicine in 2011, Member of the French National Academy of Pharmacy in 2011. He is author of more than 200 peer reviewed articles.

Teresa Di Fiandra

Chief Psychologist
Ministry of Health, Italy

Biography

Chief Psychologist of the National Health Service, presently working at the Ministry of Health, General Directorate for Health Prevention.
Officially appointed as

1. Responsible for planning at national level in the areas of: mental health, dementia, health in prison
2. Italian National Counterpart for WHO Europe in the field of Mental health (from 2001 to 2003 and from 2004 up to now);
3. Member of the OECD Mental Health Care Quality Indicators;
4. Italian representative in the Mental Health Group of the Council of Europe;
5. Governmental expert for Italy to the European commission in all matters concerning mental health (in particular the consultation process on the EU Green Paper and for all matters related to the European Pact for Mental Health and its implementation)
6. Coordinator of the Associated partner unit (MINSAL) of the ALCOVE Joint Action on Dementia
7. Coordinator of the Collaborating partner unit (MINSAL) of the Joint Action on mental health and well-being
8. Scientific Coordinator of National Research Projects on Mental health, Ageing, Dementia, Drug Dependence
9. Representative of the Ministry of health in the national Committees on Health in prison and on closure of forensic hospitals

Specific experience as:
Director of a Drug abuse services in Valle d' Aosta (1988/1991);
Director of the City Health District in Trieste (1996/1998);
Coordinator of the network of Italian Regions in the health and social area (2003/2004);
Scientific Director of several research teams, at National and International level; Trainer of personnel in local health units, and particularly in mental health services;
Coordinator of activities for the construction of the national information systems for mental health and for addiction;
Responsible for the coordination of interregional technical working groups in the field of health and social activities

Jürgen Scheftlein

Policy Officer
European Commission's Directorate-General
for Health and Consumers

Biography

Jürgen Scheftlein is policy officer in the European Commission's Directorate-General for Health and Consumers. His fields of responsibility are mental health / mental disorders and dementia.

Jürgen is a historian by academic qualification. After his studies of history, German language and literature and political Science in Cologne, he worked for the Federal German Ministry of Development Cooperation. In 1997 he took up a position as a civil servant in the European Commission services. After several years in the Directorate-General for Enterprise, he changed in 2004 to the Directorate-General for Health and Consumers.

Tadayuki Mizutani

Director
Office for Dementia and Elder Abuse Prevention
Health and Welfare Bureau for the Elderly
Ministry of Health, Labour and Welfare, Japan

Biography

Graduated from the University of Tokyo majoring in law, he started his carrier at the Ministry of Health, Labour and Welfare (MHLW) in 1997. While experiencing various positions in MHLW, in Health Policy Bureau, Policy Planning and Evaluation Division, and Health and Welfare Bureau for the Elderly among others, he was dispatched to the EBRI (Employee Benefit Research Institute) in Washington, DC as a visiting researcher from 2000 to 2001. As a Deputy Director, he worked for Medical Economics Division of Health Insurance Bureau, Welfare Promotion Division of Social Welfare and War Victims' Bureau, and Pharmaceutical and Food Safety Bureau. From 2008 to 2011, he again moved to the U.S. serving as First Secretary (Health and Welfare) at the Embassy of Japan in Washington, DC. After coming back from the U.S., he worked as Deputy Director of Department of Health and Welfare for Persons with Disabilities and Office of Counsellor for Social Security. Since July 2014, he has been in the current position

Kazuo Hasegawa

MD, PhD

Director Emeritus
Tokyo Dementia Care Research and Training Center, Japan

Biography

1953 Graduated Tokyo Jikeikai University school. School of Medicine. 1956 Residency in Psychiatry, St. Elizabeths Hospital In Washington, D.C., U.S.A. 1958 Research Fellow, Dept. of Neurosurgery, Johns Hopkins Hospital, Baltimore, U.S.A. 1973 Professor & Chairman, Dept. of Psychiatry, St. Marianna University School of Medicine. 1993 Dean of the School, St. Marianna U. school of Med. 1996 President, St. Marianna U. school of Med. 2000 Director. Center for Research and Education of Dementia Care in Tokyo.

Advice and supervision for the research activities and enlightening in the community.
Emeritus Professor of psychiatry, St. Marianna University School of Medicine.

Haruyasu Yamaguchi

MD, PhD

Professor
Gunma University Graduate School of Health Sciences, Japan

Biography

Education

1970-1976: MD course, Gunma University School of Medicine, Maebashi

1976-1980: Postgraduate PhD course, Pathology (Neuropathology), Gunma University School of Medicine, Maebashi
PhD degree (Gunma University, March 1980)

License and Certification:

1994: Diploma of Rehabilitation Medicine,

2010: Diploma of Dementia Medicine

Academic Appointments:

1986.4.1-: Associate Professor of Physical Therapy, College of Medical Care and Technology, Gunma University

1993.3.1-: Professor of Physical Therapy, College of Medical Care and Technology, Gunma University

1996.10.1-: Professor of Basic Physical Therapy School of Health Sciences, Gunma University

2011.4.1-: Professor of Rehabilitation Sciences Graduate School of Health Sciences, Gunma University

Major Research Fields:

1. Pathology of the cerebral 1 amyloid deposition
2. Clinical study on Alzheimer’ s disease
3. Prevention of mental decline in elderly people

Jiro Okochi

MD, PhD

Director of Research and Development Executive Committee
Japan Association of Geriatric Health Services Facilities

Biography

Jiro Okochi is a Director of the Tatsumanosato Geriatric Health Services facility in Osaka, Japan, and the Director of Research and Development at the Japanese Association of Geriatric Health Services Facilities. He received his M.D. from Tsukuba Medical School in 1990, and obtained a PhD in Medicine from the University of Occupational and Environmental Health (UOEH) in 2004.
Jiro was an associate at UOEH from 2001 to 2005, and was an associate professor at Kyushu University from 2005 to 2006. He is also a board-approved Neurologist and Internal Medicine since 1995, and has worked as a clinician at Tsukuba University Hospital, Tokyo Metropolitan General Hospital and Kyushu University Hospital.
Jiro joined the Ministry of Health for development of a case-mix classification for long-term nursing care insurance in Japan. He has been a PCSI Executive Committee member since 2006 and WHO FIC member since 2010. He loves music and sports, especially cycling.

Manabu Ikeda

MD, PhD

Professor & Chairman
Department of Neuropsychiatry,
Faculty of Life Sciences, Kumamoto University, Japan

Biography

Manabu Ikeda trained in medicine, neuropsychiatry, neuropsychology, and neuropathology in Osaka and Tokyo before gravitating old age psychiatry. In 1994, he was appointed a Research fellow, Division of Clinical Neurosciences in Hyogo Institute for Aging Brain and Cognitive Disorders. A sabbatical in Cambridge in 2000-2001 with Prof. John Hodges rekindled research for dementia and neuropsychology. In 2001, he was appointed an associate professor, department of neuropsychiatry in Ehime University and in 2007 become professor of neuropsychiatry in Kumamoto University. He directs the department of neuropsychiatry (general psychiatry) and busy Kumamoto Prefecture Dementia-related Disease Medical Center (Core center) where patients in the Kumamoto prefecture receive comprehensive clinical evaluations. He was the principal investigator of the Japanese government-sponsored grants such as “Driving and human rights in dementia”，“Educational program for general practitioners about differential diagnosis and disease specific treatment of dementia”，“Early onset dementia care in Asia”，and so on. He has written more than 90 papers in English on aspects of neuropsychology and dementia, epidemiology and elderly depression.

Howard Bergman

MD, FCFP, FRCPC, FCAHS

Chair,
Department of Family Medicine
McGill University, Canada

Biography

HOWARD BERGMAN MD, FCFP, FRCPC, FCAHS
Howard Bergman MD, FCFP, FRCPC is Chair of the Department of Family Medicine, Professor of Family Medicine, Medicine, and Oncology and the first Dr. Joseph Kaufmann Professor of Geriatric Medicine at McGill University.

From 2009 to 2011, Dr. Bergman served as Vice-President, Scientific Affairs of the Fonds de la recherche en Santé du Québec (FRSQ), Quebec's health research funding agency.
From 1993-2009, He was Director of the Division of Geriatric Medicine at McGill University.

Dr. Bergman is a fellow of the College of Family Physicians of Canada and of the Royal College of Physicians and Surgeons of Canada. He is a Fellow of the Canadian Academy of Health Sciences (CAHS). He is a past President of the Canadian Geriatrics Society.

The main thrust of his work in health services research and policy has been on aging, chronic disease, frailty and primary care. He is internationally recognized for his work with over 160 publications as well as numerous reports and book chapters.

In the area of Alzheimer's disease, Dr. Bergman was co-founder and co director of the Jewish General Hospital/McGill University Memory Clinic. He is a past president of the Consortium of Canadian Centres for Clinical Cognitive Research and was a member of the Steering Committee of the second (1999) and third (2006) Canadian Consensus Conference on the Diagnosis and Treatment of Dementia.

Appointed by the Quebec Minister of Health in 2007, Dr. Bergman tabled in 2009 a proposal for the Quebec Alzheimer Plan from prevention to end of life care, including research. He is now working with the Quebec Ministry of Health in the implementation of the plan. He also leads the Canadian Team for Healthcare Services/System Improvement in Dementia Care bringing together researchers, decision-makers, managers, clinicians and patients/caregivers. He serves as an advisor to many governments in Canada and international.

Florence Pasquier

MD, PhD

Professor of Neurology
Head of the national reference center for Patients with early onset Alzheimer's disease and related disorders.
University of Lille and Centre Hospitalier Universitaire de Lille, France

Biography

Florence Pasquier MD, PhD in cognitive psychology, is professor of neurology, and head of the Memory Research and Resources clinic at the University Hospital of Lille, France, which is also the Reference center for patients with early onset dementia.
She graduated from the University of Nantes school of medicine and completed her specialisation in Neurology in Lille, doing internships in Paris Salpêtrière, and Boston Massachusetts General Hospital.

She leads a network of memory clinics in the North of France, and the Regional Network for Care of Demented Patients, which aims to coordinate public and private medical, social, and psychological resources for patients with dementia. She was advisor for the Government programmes on Alzheimer's disease and member of the steering committee of the 3rd French Alzheimer plan (2008-2012), running measure 18 (accommodations for young demented patients).

Her main domains of interest are 1) early and differential diagnosis of dementia with a special concern about non-Alzheimer diseases [vascular dementia, frontotemporal dementia, focal atrophy, dementia with Lewy bodies, …] especially frequent in young patients 2) links between vascular and degenerative diseases, since the vascular risk factors can be controlled, and 3) natural history of dementia, with the aim of improving the clinical management of these diseases.

She is involved in clinical research on cognitive and behavioural changes in Alzheimer's disease and related disorders. She uses a multidisciplinary approach thanks to clinical and basic research collaborations in neurology, neuropsychology, behaviour, biology, genetics, and brain imaging.
Her group is a member of the European Alzheimer's disease consortium, and of the Laboratory of Excellence DISTALZ (development of innovative strategies for a trans-disciplinary approach to Alzheimer's disease.)

Peter J. Whitehouse

Professor
Case Western Reserve University and University of Toronto

Biography

Peter J. Whitehouse, MD, PhD is Professor of Neurology as well as current or former Professor of Cognitive Science, Psychiatry, Neuroscience, Psychology, Nursing, Organizational Behavior, Bioethics and History. He is also currently a strategic advisor in innovation and Visiting Scholar at Baycrest and Professor of Medicine at the University of Toronto. He received his undergraduate degree from Brown University and MD-PhD (Psychology) from The Johns Hopkins University (with field work at Harvard and Boston Universities), followed by a Fellowship in Neuroscience and Psychiatry and a faculty appointment at Hopkins. With colleagues he discovered fundamental aspects of the cholinergic pathology in Alzheimer's and related dementias, which lead to the development of our current generation drugs to treat these conditions. In 1986 he moved to Case Western Reserve University to develop the University Alzheimer Center (now University Brain health and Memory Center). He continued his own life-long learning with a Masters Degree in Bioethics and Fellowship in Organizational Behavior at Case. In 1999 he founded with his wife, Catherine, The Intergenerational School, a successful, public, multiage, community school (www.tisonline.org). He is currently President of Intergenerational Schools International. His current information technology and transmedia arts based project is called The Intergenerativity Project.

He works clinically in various capacities in Cleveland. He developing an integrative health practice focused on the healing power of storytelling in a school-based health education program called InterWell.

His research interests include the neurobiology of what he used to refer to as Alzheimer's disease and related conditions, the development of more effective treatments for individuals with cognitive impairment, ethical issues in the medical profession and integrative health care systems. He is the author (with Danny George) of a provocative book entitled “The Myth of Alzheimer's: what you aren't being told about today's most dreaded diagnosis.” (www.themythofalzheimers.com)

Francesca Colombo

Head of OECD Health Division

Biography

As Head of the OECD Health Division, Francesca Colombo oversees OECD work on health, which aims at providing internationally comparable data on health systems and applying economic analysis to health policies, advising policy makers, stakeholders and citizens on how to respond to demands for more and better health care. She has led projects on the performance of health systems in OECD countries, covering a wide range of topics, including quality of health care policies, health financing and the impact of private health insurance on health systems, health workforce and the international migration of doctors and nurses.

She has been responsible for OECD Asian Social and Health activities with non-member countries, working with the OECD/Korea Policy Centre. Mrs Colombo is a leading international expert on health and care issues for elderly populations and also held responsibilities for co-ordinating OECD involvement at high-level meetings such as on diabetes and dementia. Prior to joining OECD in 1999, she was seconded to the Ministry of Health and Labour of Guyana as Acting Head of the Planning Unit, where she was instrumental to the implementation of financing and governance reforms of the health system, and also worked at UNCTAD. Over her career, she has travelled extensively in Europe, South America and Asia, advising governments on health system policies and reforms. Mrs Colombo holds a MSc Development Studies from the London School of Economics and Political Science (United Kingdom) and BSc in Economics and Management from Bocconi School of Economics (Italy).

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Takao Suzuki

MD, PhD

Research Institute Director
National Center for Geriatrics and Gerontology, Japan

Biography

Dr. Takao Suzuki is currently the director of the Research Institute, National Center for Geriatrics and Gerontology, Obu City, Aichi Prefecture.
He has published more than 200 peer reviewed international papers and served as editorial members of several domestic and international journals. He has been the chairs of some national committees related the Long-Term Care Insurance in Japan, particularly effective strategy for the prevention of long-term care state in the elderly living in the community.
He has also attempted for many years to accumulate the evidence-based effective measures for the prevention of geriatric syndrome such as falls, incontinence, foot and walking trouble, undernutrition relating to the insufficiency of serum vitamin D, sarcopenia and mild cognitive impairments (MCI) as an early stage of dementia, all of which have negative influence on the health status and quality of life among the elderly people.

Martin Prince

MD

Professor
King's College London Institute of Psychiatry, Psychology & Neuroscience, UK

Biography

Martin Prince is Professor of Epidemiological Psychiatry, Head of Department of the Health Service and Population Research department, and joint-Director of the Centre for Global Mental Health which is a joint King's Health Partner and London School of Hygiene centre. He trained in Psychiatry at the Maudsley Hospital and in Epidemiology at the London School of Hygiene and Tropical Medicine.

His work is oriented to the salience of mental and neurological disorders to health and social policy in low and middle income countries (LMIC), with a focus on ageing and dementia. He has coordinated, since 1998 the 10/66 Dementia Research Group, a network of researchers, mainly from LMIC working together to promote more good research into dementia in those regions. The group has published 100 papers covering dementia prevalence, incidence, aetiology and impact and contributed to knowledge of public health aspects of ageing and chronic disease in LMIC.

He was co-author of the Dementia UK report that informed the UK Government's National Dementia Strategy. He lead the development of the widely reported ADI World Alzheimer Reports for 2009 (prevalence and numbers), 2010 (societal cost) and 2011 (early intervention) and was a leading contributor to the WHO World Dementia Report 2012. He was one of three editors for the 2007 Lancet Series on Global Mental Health, and is committed to further research and advocacy to support the call for action for improved coverage of evidence-based community treatments. He coordinated the development of the WHO Mental Health Gap Action Plan (mhGAP) clinical guidelines for dementia care by non-specialists in LMIC.

Vladimir Hachinski

CM, MD, FRCPC, DSc

Professor
University of Western Ontario, Canada

Biography

Vladimir Hachinski, CM, MD, FRCPC, DSc, Distinguished University Professor of Neurology at Western University, London, Canada, graduated with an MD from the University of Toronto and trained in neurology and research in Montreal, Toronto, London, U.K. and Copenhagen.

Dr. Hachinski pioneered with Dr. John Norris the world's first successful acute stroke unit and discovered the key role of the insula of the brain sudden death.

With Shawn Whitehead and David Cechetto he discovered an ischemia, amyloid, inflammation link between Alzheimer disease and stroke paving the way for novel therapeutic approaches.

He has authored, co-authored or co-edited 17 books and over 600 scientific and scholarly publications whose impact is reflected in over 28,000 citations and a Hirsh index of 79. He was Editor-in-Chief of the journal STROKE, the leading publication of this field from 2000-2010. In 2011 he received the International BIAL Merit Award in Medical Sciences for a monograph on “The Long Fuse: Silent Strokes and Insidious Alzheimer Disease” . Dr. Hachinski is past President of the World Federation of Neurology and Chair, Working Group, World Brain Alliance. He was the Allan & Maria Myers International Visiting Fellow for 2014 at the Florey Neurosciences Institute, Melbourne, Australia and the 2014 Brain Visiting Scholar at Oxford, Cambridge and London Universities. He has been awarded the 2014 Karolinska Stroke Award.

Piu Chan

MD, PhD

Professor, Director
Department of Geriatrics and Neurology,
Xuanwu Hospital of Capital Medical University, China

Biography

Professor Piu Chan, MD PhD, is Professor and Director of the Beijing Institute of Geriatrics, Departments of Neurobiology, Neurology and Geriatrics of Xuanwu Hospital of Capital Medical University, and Chairman of Faculty of Geriatrics and Deputy Chairman of Neurology of Capital Medical University.

He acts as the deputy director of the Key Laboratory of Ministry of Education for Neurodegenerative Diseases, the director of Parkinson's Disease Center of Beijing Institute of Brain Disorders, and the Director of the National Center of GCP Trials for Neurodegenerative Disorders.
He is an ad hoc consultant for the State Food and Drug Administration of China. Professor Chan is the Vice President of the Chinese Society of Gerontology and Geriatrics, council member of the International Association of Gerontology and Geriatrics (IAGG), and the past Secretary of the IAGG Asia-Oceania Region.

Professor Chan is well known for his translational research on neurodegenerative disorders and other age-related disorders. He has been working on developing models for CNS diseases including non-human primate models of Parkinson’ s disease and dyskinesia. He has been studying familial and susceptibility genes and a variety of biomarkers for Parkinson's and Alzheimer's diseases in a few unique cohorts in China aimed for prediction and prevention of neurodegenerative diseases. He has initiated projects investigating the role of polyphenols (funded by M. J. Fox foundation) and Traditional Chinese Medicine in two multi-center trials.

Dr. Chan has published more than 250 peer-reviewed papers and served as editorial members of more than 15 international and Chinese journals.

Katsuhiko Yanagisawa

MD, PhD

Vice Director of Research Institute
National Center for Geriatrics and Gerontology, Japan

Biography

Present Position
Director, Center for Development of Advanced Medicine for Dementia (CAMD) and Vice-Director, Research Institute, National Center for Geriatrics and Gerontology (NCGG)

Education

1974-1980	Faculty of Medicine, Niigata University
1981-1983	Resident, Department of Neurology, Brain Research Institute, Niigata University
1984-1986	Research Fellow, NINCDS, NIH
1991	Degree of Medical Doctor (Niigata University)

Past and Current Appointments

1990-1991	Assistant Professor, Department of Neurology, Brain Research Institute, Niigata University
1992-1993	Assistant Professor, Department of Neurology, Tokyo Medicaland Dental University
1994-1995	Assistant Professor, Department of Neuropathology, University of Tokyo
1995-2004	Head, Department of Dementia Research National Institute for Longevity Sciences
2005-present	Vice-Director, Research Institute, NCGG
2010-present	Director, Center for Development of Advanced Medicine for Dementia (CAMD), NCGG

Membership
Japanese Society for Dementia Research (Member of Board Directors)
American Society for Biochemistry and Molecular Biology
Asian and Pacific Society for Neurochemistry (Member of Board Directors until 2010)
International Society for Neurochemistry

Award
The 48th Erwin von Baelz Prize (First Prize)
“Molecular Mechanism Underlying Initiation of Amyloidogenesis and Its Application to Development of Disease-Modifying Drugs for Alzheimer Disease” (2011)

Editorial Activity
Lead Guest Editor for Special Issue on Aß Behavior on Neuronal Membranes (International Journal of Alzheimer's Disease)

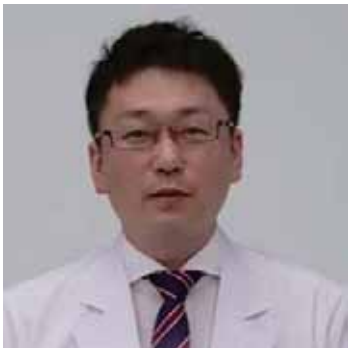
Research Interest
Molecular pathology of Alzheimer's disease

Liang-Kung Chen

Professor, Director
Center for Geriatrics and Gerontology, Taipei Veterans General Hospital Aging and Health Research Center, National Yang Ming University, Taiwan

Biography

Professor Liang-Kung Chen is Professor and Director of Aging and Health Research Center of National Yang Ming University, Taiwan, as well as the Director of Center for Geriatrics and Gerontology of Taipei Veterans General Hospital, Taiwan. Prof Chen's main research interests include prevention and care for frailty, sarcopenia and dementia, as well as age-friendly healthcare system. He has published more than 150 SCI-indexed papers in the past 10 years and led Asian Working Group for Sarcopenia, and also the Asia Pacific Working Group for Herpes Zoster. He is currently the editor-in-chief of Journal of Clinical Gerontology and Geriatrics, associate editor of Journal of Nutrition, Health and Aging, BMC Geriatrics, Journal of Frailty and Aging, and Frontiers in Geriatric Medicine.
Professor Chen led an interdisciplinary research team in Taiwan covering researches in aging Biology, a series of omics studies, clinical researches, and policy researches. Aging and Health Research Center of National Yang Ming University affiliated with the National Health Research Institute of Taiwan to start the Integrated Center of Aging and Health, which aims to promote active collaborations with domestic and international aging researchers in the future.



Hiroyuki Shimada

PhD

Head of Center for Gerontology and Social Science
National Center for Geriatrics and Gerontology, Japan

Biography

Present Position

Head, Department of Functioning Activation, Center for Gerontology and Social Science (CGSS), National Center for Geriatrics and Gerontology (NCGG)

Education

1990-1993	Faculty of Physical Therapy, Junior College of Saitama Medical School
1994-1998	Faculty of Education, Meisei University
1998-2003	Graduate School of Kitasato University

Past and Current Appointments

2003-2010	Researcher, Department of Prevention for Long-Term Care, Tokyo Metropolitan Institute of Gerontology
2010-2012	Chief, Section for Health Promotion, Department of Health and Medical Care, Center for Development of Advanced Medicine for Dementia, NCGG
2012-2014	Chief, Section for Health Promotion, Department for Research and Development to Support Independent Life of Elderly, CGSS, NCGG
2014-present	Head, Department of Functioning Activation, CGSS, NCGG
2014-present	Visiting associate professor, Department of Center of Innovation Program, Nagoya University

Membership

Japanese Association of Physical Therapy Fundamentals (Member of Board Directors)
Japanese Association of Physical Therapy for Prevention (Member of Board Directors)
The Society of Physical Therapy Science (Councilor)
The Japanese Society for Fall Prevention (Councilor)

Award

2003	10th Japan Geriatrics Society Award
2010	Journal of Japanese Physical Therapy Association Best Article Award
2010	Geriatrics and Gerontology International Best Article Award Excellent
2011	Paper Award, Journal of Physical Therapy Science

Editorial Activity

2006-2008	Editorial Board, Journal of Geriatric Physical Therapy
2013- present	Editorial Board, BioMed Research International 2013-

present Associate Editor, BMC Geriatrics

Research Interest

Prevention of cognitive decline and frailty using non-pharmacological intervention.

Dawn Brooker

Professor
Director of the Association for Dementia Studies
University of Worcester, Association for Dementia Studies, UK

Biography

Professor Brooker qualified as a clinical psychologist in 1984. Her academic career is grounded in practice experience gained from a variety of clinical and leadership roles in health services for older people. She was influenced by the late Professor Tom Kitwood particularly his work on personhood and dementia. Following Kitwood's death in 1997 she was invited to take his work on Dementia Care Mapping forwards at the Bradford Dementia Group, where she led the DCM International Implementation Group. In 2005 she was awarded a personal chair in recognition of her scholarship. In 2009 she took up her current post as the Director of the newly established Association for Dementia Studies (ADS Research Centre) at the University of Worcester. ADS consists of 30 researchers, educationalists and PhD students dedicated to developing evidence-based practical ways to help people live well with dementia. Professor Brooker and her team work as part of the Prime Minister's Challenge on Dementia and in the National Dementia Action Alliance.

Professor Brooker has published across the spectrum of research papers, practice papers, chapters and books on dementia care. She is invited to speak at many international conferences and has provided practitioner workshops world-wide. Recent research includes developing practice in person-centred approaches for people living with dementia at home, in care homes, hospitals and housing; Care fit for VIPS and Stand by me toolkits; understanding the role of care culture and how to impact change; providing alternatives to anti-psychotic medications; the Enriched Opportunities Programme; early intervention and dementia friendly communities. She recently completed work funded by an EU Joint Action on developing evidence based recommendations on timely diagnosis as part of the ALCOVE programme. She is just commencing as the UK lead on a JPND funded programme to implementation and evaluate the Dutch Meeting Centres for people with dementia and their carers across Europe.

Graham Stokes

PhD

Global Director of Dementia Care
Bupa

Biography

Professor Graham Stokes is Global Director of Dementia Care at Bupa, a leading international healthcare group offering health insurance and medical subscription products, and running care homes, retirement villages, hospitals, primary care centres and dental clinics. Bupa also provide workplace health services, home healthcare, health assessments and long-term condition management services.

Bupa is the largest international provider of specialist dementia care.

Prior to his appointment Professor Stokes was a senior consultant clinical psychologist in the National Health Service where he was Head of Psychology Services for Older Adults and Adults with Neurodegenerative Diseases in Staffordshire and Shropshire NHS Foundation Trust.

He is Visiting Professor of Person-Centred Dementia Care at Bradford University and holds other honorary academic appointments at the Universities of Manchester, Birmingham and Staffordshire. He is Co-Chairman of the Dementia Action Alliance in England and a Member of the International Advisory Board, Alzheimer's Disease International.

His interests embrace the spectrum of dementia care from diagnosis to the care of people with advanced dementia and the understanding and resolution of behaviour that challenges. He has been instrumental in the development of person-centred approaches to care.

He has written many books, academic papers, articles and book chapters on dementia, behavior that challenges and person-centred care.

His current position as Global Director of Dementia Care at Bupa means he has strategic overview of the care provided to 24,000 people with complex health and social care needs living in Bupa's dementia care homes and retirement villages in the United Kingdom, Spain, Australia, New Zealand, and as from next year Poland.

Hiroaki Kazui

MD, PhD

Associate Professor
Department of Psychiatry,
Osaka University Graduate School of Medicine, Japan

Biography

EDUCATION

1983-1989	Tottori University Medical School, M.D.
1991-1995	Graduate School of Medicine, Osaka University (Neuropsychiatry) Ph.D.

POSITIONS

1989-1990	resident, Department of Psychiatry, Osaka University Medical Hospital
1990-1991	resident, emergency and critical care center, Hyogo College of Medicine
1997-2002	Head of Geriatric Psychiatry, Department of Clinical Neurosciences, Hyogo Institute for Aging Brain and Cognitive Disorders
2002-2006	Assistant Professor, Department of Psychiatry, Osaka University Graduate School of Medicine
2006-present	Associate Professor, Department of Psychiatry, Osaka University Graduate School of Medicine

ACADEMIC SOCIETIES serving as BOARD of DIRECTORS

Japanese society of neuropsychology
Japanese society of normal pressure hydrocephalus

ORGANIZED ACADEMIC CONFERENCE

Feb 2014, President, The 15st Meeting of Japanese society of normal pressure hydrocephalus

BIOSKETCH

Dr. Kazui, MD, PhD, is the head of laboratory of neuropsychology in the Department of Psychiatry, Osaka University Graduate School of Medicine since 2006. He has been engaged with neuropsychological and neuroimaging research in dementia and other neuropsychiatric disorders in Hyogo Institute for Aging Brain and Cognitive Disorders and Osaka University. His recent research interest covers idiopathic normal pressure hydrocephalus (iNPH), which is a treatable dementia. He has been a steering committee member of two multicenter prospective studies conducted in Japan for iNPH patients (SINPHONI and SINPHONI-2). He was also a member to develop Japanese clinical guidelines for management of iNPH. His recent research interest also covers health service for dementia patients. He developed a regional cooperative system for dementia patients at home with a collaboration notebook and put this system into practice in one city in Japan.

Koichi Kozaki

MD, PhD

Professor
Department of Geriatric Medicine
Kyorin University School of Medicine, Japan

Biography

Work Place: Department of Geriatric Medicine, Kyorin University School of Medicine

Career:

1986:	Graduated from University of Tokyo, School of medicine
1995-2004:	Assistant Professor and Lecturer at the Department of Geriatric Medicine, University of Tokyo Graduate School of Medicine
2005-:	Associate Professor at the Department of Geriatric Medicine, Kyorin University School of Medicine
2010-:	Professor at the Department of Geriatric Medicine, Kyorin University School of Medicine

Main Membership of Academic Society:

The Japanese Society of Internal Medicine
The Japan Geriatrics Society (Board certified member)
Japan Atherosclerosis Society (Board certified member)
Japan Society for Dementia Research (Board certified member)

Research of interest:

geriatric medicine, cognitive disorder, frailty/fall

Cyndy Cordell

Director
Alzheimer's Association, USA

Biography

Cyndy Cordell is the Director of Healthcare Professional Services for the Alzheimer's Association. She is responsible for the Association's outreach to practicing healthcare professionals as well as management of their nationally supported dementia care training programs. In conjunction with the Association's Policy Office, she also seeks beneficial policies for people with dementia with the U.S. Centers for Medicare and Medicaid Services (CMS), the National Institutes of Health, and the Administration on Aging. She served on the Alzheimer's Association Medicare Annual Wellness Visit task force and was instrumental in the publication of the workgroup recommendations. She has over 20 years experience in healthcare communications with a focus on working with thought leaders to develop clinical guidelines, disease state education, and peer-to-peer medical education programs. She has a B.S. degree in Medical Technology and an M.B.A degree, and has completed advanced studies in health administration.

Jean Georges

Executive Director
Alzheimer Europe

Biography

Before joining Alzheimer Europe as its first Executive Director in 1996, Jean Georges had worked as a journalist for the European and International department of the Luxembourg newspaper “Tageblatt” and as a parliamentary assistant for Members of the Luxembourg and European Parliament.
As Executive Director of Alzheimer Europe, Jean was in charge of the various projects of the organisation including the three-year European Commission financed “European Collaboration on Dementia-EuroCoDe” (2006-2008) project which brought together over 30 dementia experts from 20 European countries. He also represents the organisation in IMI and FP7 projects, such as Pharma Cog, DECIDE or EMIF.
He has been liaising with various other European organisations and held a number of elected positions, such as Secretary General of the European Federation of Neurological Associations (2002-2004) or Vice-Chairperson of the European Patients’ Forum (2007-2008). In 2005, he was appointed by the Council of Ministers and the European Parliament as one of two patient representatives to the Management Board of the European Medicines Agency (2005-2008).

Shuichi Awata

MD, PhD

Team Leader
Research Team for Promoting Independence of the Elderly
Tokyo Metropolitan Institute of Gerontology, Japan

Biography

Shuichi Awata was born in Tokyo, Japan, in 1959; graduated from School of Medicine, the University of Yamagata, in 1984; received training for a medical doctor and a clinical psychiatrist from Tohoku University Hospital during 1984-1991; received M.D. and Ph.D. degree from Tohoku University

Graduate School of Medicine in 1997. He worked as an Assistant Professor and a Lecturer on Department of Neuropsychiatry, Tohoku University Hospital, during 1991-2001; an Associate Professor on Division of Neuropsychiatry, Tohoku University Graduate School of Medicine, during 2001-2005; a Director on Division of Psychiatry and Medical Center for Dementia, Sendai City Hospital, during 2005-2009. He was appointed as a Team Leader of Research Team for Promoting Independence of the Elderly at Tokyo Metropolitan Institute of Gerontology in 2009; a Director of Medical Center for Dementia at Tokyo Metropolitan Hospital of Geriatrics in 2012; a member of the board of trustees in the Japanese Psychogeriatric Society in 2014. He has been clinically active in the field of geriatric psychiatry and studied on the establishment of prevention, early diagnosis and intervention system for dementia and other neuropsychiatric disorders in late life.

Currently, his studies focus on the establishment of a community-based integrated care system supporting the lives of people with dementia and family caregivers, to create the society where people with dementia can live safely, peacefully, with dignity and respect, in accordance with each local characteristics, in collaboration with national and local government, medical and long-term care service providers, some citizens' groups and non-profit organizations, including the group founded by people with dementia themselves.

Annette Pauly

Deputy head of unit
Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, Germany

Biography

Annette Pauly is a lawyer. She worked in German administration in different fields of work on federal level. 2000 she joined the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth. Since 2008 she has been working in the department for Demographic Change, the Elderly, Welfare Work. Social Reporting on the elderly, the German Ageing Survey and Images of Ageing are among her current tasks.

Jeremy Hughes

Chief Executive Officer
Alzheimer's Society, UK

Biography

Jeremy Hughes joined Alzheimer's Society in November 2010. He is leading the charity in its five year strategy 'Delivering on Dementia 2012-17' and in 2013-14 the Society's income exceeded £80m for the first time. Jeremy co-chairs the Dementia Friendly Communities Champions Group for the UK Prime Minister, David Cameron.

Jeremy was previously Chief Executive of Breakthrough Breast Cancer where he was instrumental in providing visionary leadership, galvanising the charity's research platform and its authority on campaigning and policy. Before that Jeremy was Head of External Affairs at the International Federation of Red Cross and Red Crescent Societies.

His career in health and social care charities includes leadership posts at the British Red Cross, Leonard Cheshire, Muscular Dystrophy and NCH Action for Children.

Jeremy was the chair of National Voices 2009-14. He is currently the Co-chair of the UK Dementia Action Alliance and chair of the Global Alzheimers and Dementias Action Alliance

Kunio Takami

President
Alzheimer's Association Japan

Biography

Born in 1943
Served in Kyoto's prefectural local government for 42 years
Cared for his mother with dementia for eight years while working In 1980, he participated in the establishment of AAJ Represented AAJ from its establishment to the present for 35 years.

Worked to build up a dementia friendly society for people with dementia, their caregivers, and 11,000 members in 47 branches throughout the 47 prefectures of Japan

Ki Woong Kim

MD, PhD

Director of National Institute of Dementia of S. Korea
Professor of Seoul National University Bundang Hospital
Associate Dean of Seoul National University College of Medicine, South Korea

Biography

Dr. Kim is professor of the Department of Psychiatry, Seoul National University College of Medicine and the Department of Brain and Cognitive Science, Seoul National University College of Natural Sciences. Currently he is serving for the Korean National Institute of Dementia as a director, the Dementia and Geriatric Cognitive Disorders Center of Seoul National University Bundang Hospital as a head, and the Korean College of Geriatric Psychoneuropharmacology as a president. His major field of practice and research is cognitive disorders and late life depression.
He is currently leading the Korean Longitudinal Study on Health and Aging (KLoSHA), the Korean Longitudinal Study on Cognitive Aging and Dementia (KLOSCAD), and the Nationwide Surveys on Dementia Epidemiology of Korea. He published more than 200 papers in peer-reviewed scientific journals and wrote 12books on dementia and geriatric psychiatry.

Kumiko Utsumi

MD, PhD

Director of Dementia disease medical center
Sunagawa Medical Center, Japan

Biography

1988/3	Graduated from Sapporo Medical College, medical department
1996/10	Sunagawa Medical Center
1996/12	Received PhD in medicine
2010/4	Appointed as Director of Dementia disease medical center

My research theme is disability for conversion of visual space representation in the patients with Alzheimer's disease.
I organize a local network to support the elderly with dementia and caregiver in the community. In 2006, we launched the outpatient clinic specialized in dementia in cooperation with the department of psychiatry, neurology and brain surgery. In the same year, we have established NPO “Dementia support team in Nakasorachi” for education of general practitioners and formal carers, awareness raising, family education and volunteer training.

Rumiko Otani

Chairwoman
Omuta-city Dementia Care Society, Japan

Biography

1990 Qualified as Registered Nurse
1990 Appointed as Head Nurse at Medical Cooperation Toushoukai
1996 Invited as a visiting researcher of social welfare in Denmark (until present)
2001 Appointed as Chief of Familie, Group-home for people with dementia Appointed as Chairwoman of Omuta City Dementia Care Society
2001 I established Omuta City Dementia Care Society with the purpose of promoting the measures against dementia steadily, step by step.
2002 We have implemented “Omuta City Dementia Care Community Promotion” in order to achieve the society where all the people including persons with dementia can coexist with dignity in cooperation with the municipality of Omuta City.
2003 We have implemented education course of the dementia coordinator, the leader of community support members for people with dementia; 95 persons have completed the course within 12 years.
2004 We wrote a picture-book “Their hearts are always living” for awareness raising of dementia. Since then, 6,000 elementary and junior high school students have learned the significance of support for people with dementia in community. We also made a residents’ network, “Hayame-Minami Humanity Network for Everyone in Neighborhood Including People with Dementia and Their Families” in school district of Hayame-minami. This network is well-established as safety to search for the persons with dementia who have wondered off in cooperation with police stations, fire departments, municipalities, and community dwellers. This network conducts simulation training for effective implementation regularly. This unique activity is now widespread across Japan, and is recognized as one of the effective models of dementia measures.
2006 We have been promoting early detection and prevention for people with dementia in cooperation with medical specialists and the comprehensive support centers.
2009 We implemented “Dementia Local Support Team” to collaborate with the specialists in dementia and dementia coordinators, e.g., keeping a network of people with young-onset dementia, and family gatherings in Omuta City.
Now we are promoting all the projects above.

AKIRA HOMMA

MD, PhD

Director
Tokyo Dementia Care Research and Training Center, Japan

Biography

Graduated from a medical school in Japan in 1973. After studying as a visiting associate in the Institute of Demography and Cytogenetic in Aarhus State Hospital, Denmark, and a lecturer of Department of Psychiatry, St. Marianna University School of Medicine.
I worked in Tokyo Metropolitan Institute of Gerontology, Tokyo, Japan as the department Director. Since 2009.
I am working as the director, Center for Dementia Care Research and Education in Tokyo. I am a geriatric psychiatrist and currently working with the development of the educational program on the management of dementia for GPs. In addition, I have been involved in the development of anti-dementia drugs in Japan. I am currently serving as a board member of Japan Society for Geriatric Psychiatry and as the president for Japan Society for Dementia Care.

Marc Wortmann

Executive Director
Alzheimer's Disease International

Biography

Marc Wortmann is Executive Director of Alzheimer's Disease International (ADI). Marc studied Law and Art in the city of Utrecht in the Netherlands and was an entrepreneur in retail for 15 years. During this time Marc was a member of the Parliament of the Province of Utrecht and worked closely with various charities and voluntary organisations. He became Executive Director of Alzheimer Nederland in 2000. From 2002 to 2005 he chaired the Dutch Fundraising Association and was Vice-President of the European Fundraising Association from 2004 to 2007. Marc joined ADI in 2006 and is responsible for external contacts, public policy and fundraising. He is a speaker at multiple events and conferences on these topics and has published a number of articles and papers on dementia awareness and public policy.

Gillian Ayling

Deputy Director
Social Care, Local Government and Care Partnerships Directorate
Department of Health, UK

Biography

Gill is a senior civil servant whose service spans over 25 years with experience in central government policy and operations work in both the Department of Work and Pensions and the Department of Health. She has an excellent track-record of delivering results in the context of strategic policy development and implementation. Gill also has senior level knowledge and experience of working with Ministers, and successful cross-sector working across Whitehall, with the wider public sector, independent and third sector partners as well as a range of professional groups. She currently works in the Social Care, Local Government and Care Partnerships Directorate within the Department of Health and until recently led on the Prime Minister's Challenge on Dementia, but is now head of the Global Action Against Dementia team.

Sabine Jansen

Executive Director
German Alzheimer Association

Biography

Mrs Sabine Jansen is executive director of Deutsche Alzheimer Gesellschaft in Berlin, Germany. Deutsche Alzheimer Gesellschaft is the umbrella organisation of 137 regional and local Alzheimer associations in Germany.

Mrs. Sabine Jansen did studies in social work and economics. She worked in a nursing home, in different ambulant services and in a university hospital responsible for the Geriatric ward. In 1995 she started her work for the Alzheimer Association, first for the branch in Berlin, since 1997 for the umbrella organisation German Alzheimer Association. Since 2000 she is the executive director of the national association.

Michael Splaine

Policy Adviser, ADI
Splaine Consulting and Cognitive Solutions, LL

Biography

Michael Splaine is owner and principal in Splaine Consulting, a small advocacy and government affairs consulting firm based in Washington, D.C. Immediately prior to starting this company, Mike was Director of State Government Affairs in the Public Policy Division of the Alzheimer's Association, leading its grassroots network to accomplish state policy priorities, including comprehensive state Alzheimer Plans. While at the Association Mike was a staff team member for the Association's Early Stage Initiative (a program working to promote inclusion and programs for persons with Alzheimer's.) and provided leadership in the Association on the government affairs aspects of the Healthy Brain Initiative, a cooperative agreement with CDC, and continues this work as a consultant to the Association.

Well known as an advocacy trainer and grassroots organizer, Mike has also been faculty for Alzheimer's Disease International Alzheimer University Public Policy and was coordinator of the last three. He is active with ADI's World Health Organization strategy group and is now advancing its policy agenda with UN based opportunities in New York and Geneva. He was a contributor to the landmark Dementia: A Global Health Priority 2011 WHO report and has tracked global developments in dementia friendly communities for ADI.

Mike is also CEO of a new company called Cognitive Solutions, LLC, a specialized consultancy to hospitals on their care of persons with dementia and other cognitive impairment.

He makes his home in Columbia, Maryland with his amazing wife Sandy, enjoying occasional inspirational visits from his three daughters and granddaughter

Tasanee Tantirittisak

MD

Head of neurological department

Prasat Neurological Institute, Thailand

Biography

Office address

DIVISION OF NEUROLOGY, PRASAT NEUROLOGICAL INSTITUTE
RAJVITHEE RD., RAJTHEVI, BANGKOK, THAILAND.

Degree and certificates

-MD. (Mahidol University) 1992
- THAI BOARD OF NEUROLOGY, FRCPCT. (Mahidol University) 1995
-ASN certified in Neurosonology. 1999
Certificated in sub board of stroke

Other position

- Secretariat of Thai neurological society
- Vice president of Thai stroke society
- Treasurer of Thai society of dementia and Alzheimer disease

Publications

1.Tantirittisak T, Boongird P, Witoonpanich R. VITAMIN B12 DEFICIECY IN A VEGETARIAN PATIENT. Ramathibodi medical Journal. 1994; 17(4): 408-414.

2.Tantirittisak T, Phuapradit P. Colchicin induce neuromyopathy: a case report. Ramathibodi Medical journal.

3.Tantirittisak T. Association of carotid stenosis and type of ischemic stroke. The journal of Prasat neurological institute 2001; 3(2): 27-33

4.Jirathampinyo W, Tantirittisak T. Cerebral venous thrombosis: A review of 38 cases in Prasat Neurological Institute. The Journal of Prasat neurological institute 2003; 5(2): 57-67.

5.Tantirittisak T, Kuntiranont R, Boonyakajanakorn R, Junyawattiwong S, Srisubat K. Measurement of carotid stenosis in ischemic stroke by carotid duplex ultrasound and magnetic resonance imaging. Bull Dept Med Serv 2005; 30: 241-8.

6.Ruamradeekul T, Tantirittisak T. The clinical presentation, electrophysiology Study and factors associated of carpal tunnel syndrome in Prasat Neurological Institute. The Journal of Prasat neurological institute 2005; 7(1): 1-12.

7.Tantirittisak T, Sura t, Moleerergpoom W, Hanchaipiboonkul S. Plasma Homocysteine and Ischemic Stroke Patients in Thailand. J Med Assoc Thai 2007; 90: 1183-7.

8.Poungvarin N, Prayoonwiwat N, Ratanakorn D, Towanabut, Tantirittisak T, Suwanwela N, Phantumjinda K, atc. Thai Venous Stroke Prognostic Score: TV-SPSS. J Med Assoc Thai 2009; 92: 1413-22.

Kunio Nitta

MD

Chairman
Medical Corporation Tsukushikai, Japan

Biography

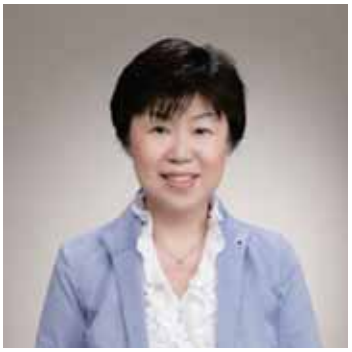
April 1963 I graduated from Waseda University with a B.A. to March 1967 degree in Faculty of Commerce Same as above

April 1973 I graduated from Teikyo University with a B.A. to March 1979 degree in Faculty of Medicine Same as above

WORK EXPERIENCE

April 1990 Nitta Clinic the opening of a hospital

Director, Nitta Clinic
Chairman, Kita-Tama Medical Association



Noriko Saito

Executive Officer
Japanese Nursing Association

Biography

Educational History:
1998 graduated from Rikkyo University
2001 completed master's course in College of Nursing Art and Science, University of Hyogo

Career
1982- Asahikawa Medical University Hospital
1994- Juntendo University Hospital
2001- Japanese Nursing Association
2009- present Executive Officer of Japanese Nursing Association

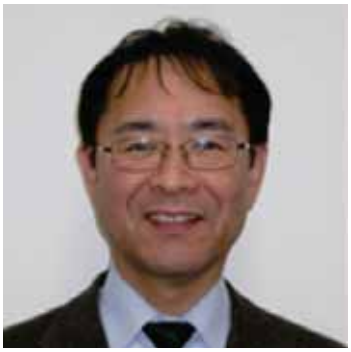
Kumiko Nagata

Research director
Tokyo Dementia Care Research and Training Center, Japan

Biography

2000-Present Dementia Care Research and Training Center ,Tokyo

- Research into experience and needs of people living with dementia
- Development and the spread of the care management system for people living with dementia
- Development and the spread of the system of the personnel training of the dementia care
- Development and the spread of the community-based system which supports people living with dementia
- Support of Japan Dementia Working Group(JDWG)



Hidetoshi Endo

MD, PhD

Head of Training and Innovation Center
National Center for Geriatrics and Gerontology, Japan

Biography

Dr. Endo is a Geriatrician, the title is Head of Training and Innovation Center working in NCGG in Japan and the board of directors at Japan Society of Dementia Research, Society of Gerontology, Japan Society of Care Management, and Japan Academy for the Prevention of Elder Abuse. Research fields are reminiscence therapy, spiritual care for dementia, and NIRS study in early detection for MCI and dementia. I have worked for long term care insurance at the stage of implementations as a medical adviser for government. I am in charge of training for the dementia support doctors, nurses, and hospital staffs in all of Japan collaborating with Japanese government. In hospital training, 87,000 staffs of all hospitals in Japan will be taken lessons about communication and care for dementia in next 3 three years supported by Japanese health policies, which are so-called “Orange plan” . I am also educating for medical aspects and care of dementia for dementia families, care works and people in the community. Finally I am so interested in care system and education for doctors and care workers, especially in Asian Area because of rapid increase of elderly people in near future.

Mark Pearson

Deputy Director for the Directorate on Employment, Labour and Social affairs, OECD

Biography

Mark Pearson is Deputy-Director for Employment, Labour and Social Affairs at the Organisation for Economic Co-operation and Development (OECD). Mr. Pearson works with the Director to provide leadership in the co-ordination and management of the activities of DELSA and ensure that it is at the forefront of the international social and employment agenda.

Mr. Pearson joined the Organisation in 1992, initially working in DAF on tax issues. After working on the OECD Jobs Study, he moved to ELS where he headed work on employment-oriented social policies, including developing the concept of 'Making Work Pay' and starting the publication 'Society at a Glance' . He became head of the Social Policy Division from 2000-2008, during which time he initiated work on 'Babies and Bosses' , 'Pensions at a Glance' , led the first cross-directorate work on gender, and work on income inequality in OECD countries.

In 2009 he became Head of the Health Division where the central focus of work has been on how to deliver health care with greater efficiency, including putting much more effort into prevention of obesity and harmful use of alcohol.

He gave evidence to the US Senate on 'Obamacare' , and has been on a panel advising the Chinese government on its health reforms. Prior to joining the OECD, Mr. Pearson worked for the Institute for Fiscal Studies in London, and also as a consultant for the World Bank, the IMF and the European Commission.

Mr. Pearson is British, and has a degree in Politics, Philosophy and Economics from Oxford, and an MSc in Economics and Econometrics from Birkbeck, University of London.

Toshiro Kumakawa

MD, MBA, PhD

Director
Department of Health and Welfare Services.
National Institute of Public Health, Japan

Biography

Education
Graduate School of Business Sciences, University of Tsukuba, MBA , 2003
The University of Tokyo, PhD(Hematology), 1992
Showa University School of Medicine, Doctor of Medicine(M.D.), 1982

Experience

2011-Present	Director, Department of Health and Welfare Services, National Institute of Public Health (NIPH) , Japan.
2006-2011	Director, Department of Management Sciences, National Institute of Public Health (NIPH), Japan.
1996-2006	Director, Department of Blood transfusion, Tokyo Metropolitan Geriatric Hospital.
1988-1996	Senior staff, Department of Hematology, Tokyo Metropolitan Geriatric Hospital.
1986-1988	Researcher, Department of Internal Medicine, University of Texas, Galveston, Texas, USA.
1982-1986	Staff, Department of Internal Medicine, The Institute of Medical Science, The University of Tokyo.

Research
The concern of his research is in an evidence based policy and strategic management on various systems within the field of health and welfare services, as well as human resource development. Recently he has been interested strongly in Big Data in healthcare system, Non Communicable Diseases in the Aged Society and Universal Health Coverage post MDGs. He is a member of Bureau of OECD HCQI experts Group.

Satoshi Imamura

MD

Vice-President
Japan Medical Association

Biography

Dr. Satoshi Imamura graduated the Akita University Faculty of Medicine in 1977. His specialty is anesthesiology. He has been working as Director of Imamura Clinic since 1991. He was serving as a Board Member of the Tokyo Medical Association in 2004 to 2006. He was also serving as an Executive Board Member of the Japan Medical Association (JMA) in 2006 to 2012. He has been working as Vice-President of the JMA since 2012. He is mainly in charge of general affairs, health policy, finance, member's welfare, pension, taxation policy and public health.

Tsuguya Fukui

MD

President
Chairman of the Board of Trustees
St. Luke's International University
St. Luke's International Hospital, Japan

Biography

Dr. Tsuguya Fukui is the Chairman of the Board of Trustees and the President of St. Luke's International Hospital, one of the most prestigious hospitals in Japan. St. Luke's International Hospital has been playing pivotal roles in improving medical care through the development and introduction of innovative clinical, administrative, and other systems and practical postgraduate training of doctors and allied health professionals.
Dr. Fukui's background is in general internal medicine, cardiology, clinical epidemiology and public health. He was previously Professor of Medicine and Clinical Epidemiology as well as founding Dean of the School of Public Health at Kyoto University Graduate School of Medicine. He took initiatives in establishing the fields of general internal medicine and clinical epidemiology and introducing the concept of evidence-based medicine in Japan, and has been instrumental in an overhaul of the medical education in the country.
Dr. Fukui is currently President of The Japan Medical Library Association and is a board member of various organizations including the National Hospital Organization, Japan Hospital Association and Yokohama Municipal Medical College. He has also been serving as a member of various committees of the Ministry of Health, Labour and Welfare and the Ministry of Education, Culture, Sports, Science and Technology.

Shinya Matsuda

MD, PhD

Professor
University of Occupational and Environmental Health, Japan

Biography

1985	Graduated form University of Occupational and Environmental Health, Japan (Sangyo Ika Daigaku)
1992	Graduated from National School of Public Health, France
1993	PhD degree from Kyoto University
1999	Professor, University of Occupational and Environmental Health, Japan

Research
Health system and Health policy

2001-2009	Chief researcher of National Casemix Project (DPC project: MHLW)
2011-	Chief researcher of Regional Health Plan (MHLW)

Yuichi Imanaka

MD, DrMedSci, MPH, PhD

Professor

Kyoto University Graduate School of Medicine, Japan

Biography

Professor and Head, Department of Healthcare Economics and Quality Management
Graduate School of Medicine, Kyoto University
e-mail: imanaka-y@unim.net http://med-econ.umin.ac.jp/

Education & Work Experience
MD & DrMedSci (University of Tokyo)
MPH & PhD (University of Michigan)
Board-Certification in Internal Medicine
National Certification for Autopsy Practice (Pathology)
Current Position since 2000, through clinical experience as an internist, and research/education experience in medical schools
Main theme is to visualize and design the health care system and its future.

Professional affiliations
International Journal of Quality in Health Care (Editorial Committee Member)
International Society for Quality in Health Care (Executive Board Member, 1997-2003)
Japan Council for Quality Health Care (Executive Board, in charge of Planning and International Affairs)
Japanese Society for Health Administration (Board Member, Education Committee Chair), Japanese Society for Public Health (Board Member, Education & Professional Certification Committee Chair), Health Economics Association (Board Member, 10th Conference Chair)

Projects
(Japan)
Wide-Region Integrative Database for Health & Long-term Care System and Policy
Quality Indicator/Improvement Project (Principal Investigator) (about 400 hospitals from all over Japan)
Healthcare Costing Project, Visualization of Organizational Culture and Patient Experience
Human Resource Development for Effective Healthcare Management

(International)
IHF & WHO/ WPRO Expert Group. Hospitals within healthcare systems: Their capacity to meet the needs of populations - Western Pacific Region. WHO, August 2001.
International Hospital Federation (IHF) and World Health Organization (WHO). The performance of hospitals under changing socioeconomic conditions: A global study on hospital sector reform. WHO, 2007. (as the principal investigator for the Western Pacific Region)
OECD Ageing-Related Diseases Projects (Ischaemic Heart Disease: OECD Health Working Papers NO.3,2003, Stroke: OECD Health Working Papers NO.5, 2003)
OECD & WHO Consultation on the Health Care Quality Improvement Network (2012, 2013)

Toshihiko Takeda

Assistant Minister for Health Insurance
Minister's Secretariat
Ministry of Health, Labour, and Welfare, Japan

Biography

He started his carrier at the Ministry of Health and Welfare in 1983. His carrier at Ministry includes Director of the Economic Affairs Division of the Health Policy Bureau, Director of the National Health Insurance Division of the Health Insurance Bureau, Counselor of the Director-General for Policy Planning and Evaluation.
Since July 2014, he has been in the current position.

Yasumasa Fukushima

MD, MPH, PhD

Minister's Secretariat, the Ministry of Health, Labour, and Welfare
Assistant Minister for Health Policy, Japan

Biography

He started his carrier at the Ministry of Health and Welfare in 1984. His carrier at Ministry includes Director of the Tuberculosis and Infectious Diseases Control Division of the Health Service Bureau, Director of the Health Sciences Division of the Minister's Secretariat.
Since July 2014, he has been in the current position.

Dementia Care and Prevention in Germany: Challenges and Fields of Action

Global Action against Dementia
Legacy Event Japan –
New Care & Prevention Models

Tokyo, 5th / 6th November 2014

Dr. Christian Berringer
Head of Unit -
Definition and Assessment of Need of Care; Quality Assurance;
General Matters of Care Provision
Federal Ministry of Health, D-11055 Berlin, Germany

Long Term Care Insurance

- Compulsory system for entire population based on contributions
- More than 2.5 persons receiving benefits (cash or kind); but: covering only a share of total costs
- Reform Acts 2012 /2014 aimed at
  - improving and enhancing level of benefits for people with dementia
  - offering more flexible support to people with dementia and families
- Accessibility: current definition and assessment of need of care based on physical problems / needs

The Challenge

Consequences of a changing population

- low birth rate: 1,4 children/woman, increasing life expectancy
- Population: 81 mio. today ➔ 65-70 mio. in 2060
- Increasing number and share of elderly people: 21 % (today) ➔ 29% (2013) ➔ 34 % (2060)
- Increasing number of people in need of care: 2,4 mio. (today) ➔ 3,2 mio. (2030) ➔ 4,2 mio. (2060)
- Increasing number of people with dementia: 1,4-1,5 mio. (today) ➔ 2,2 mio. (2030) ➔ 3 mio. (2060)

Families and Neighbourhoods

- Home Care (1.74 Mio. persons): family care / informal caregivers: 80% 12300 care services: 20%
- Individual approaches, based on e.g:
  - Counselling
  - relief measures for family carers
  - volunteer work
  - new forms of accommodation
- Local Alliances for people with dementia

Concepts and Tasks

- Supporting and coordinating research efforts in diagnosis, therapy and preventive measures
- Improving the Long-Term Care Insurance scheme, focussing on people with dementia
- Developing and supporting instruments and therapies not based on drugs
- Focussing on care at home
- National alliance for people with dementia

Joining Forces – Alliance for people with dementia

- „**Joining forces for people with dementia**“
- Agenda signed on Sept. 15th, 2014 by ministers and stakeholders
- Four fields of action / ca. 150 measures:
  - Science and Research
  - Social responsibility
  - Support for people with dementia and their families
  - Structuring the support and health care system
- Progress report in 2016

Dementia risk reduction in England: a public health priority

Dr Charles Alessi
Senior Advisor on Dementia, Public Health England

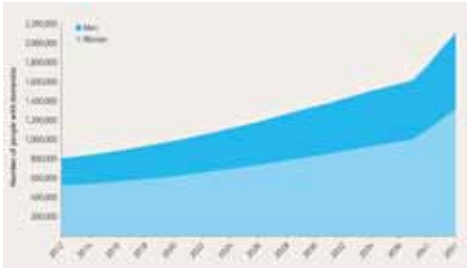
Risk factors

Risk factors for dementia are common with many other conditions, and include:

Source:

Why is dementia a public health priority?

- 800,000 people with dementia in the UK
- Expected to climb to more than 1 million by 2021 and more than 2 million by 2051.
- 21 million of the UK population have a close friend or family member with dementia.
- Overall economic impact estimated to be £26 billion a year (ca. $42 billion)



Projected increases in the number of people with dementia in the UK (2012–2051)

Source: Dementia UK: Second edition - Alzheimer's Society / King's College London / London School of Economics

Why dementia risk reduction?

- In the absence of a cure, ***risk reduction is the only way we can reduce the numbers of people getting dementia, postpone the onset and/or mitigate the impact of dementia***
- The ground-breaking Blackfriars Consensus statement, signed by 60 leading figures and organisations from across the dementia and public health community, stated that: the scientific evidence is sufficient to justify action on dementia prevention and risk reduction"

- The evidence suggests that effective public health policies to tackle the major chronic disease risk factors of smoking, physical inactivity, alcohol and poor diet across the population will help reduce the risk of dementia in later life.

What is PHE doing on dementia risk reduction?

- We have made dementia risk reduction ***one of our 7 key priorities for the next five years***
- We are particularly focussing on reducing the number of people getting dementia within ten years of retirement age, so that more people can enjoy a healthy and independent life for longer
- We want to ***"transform a generation's risk of dementia"***

Our programme of work for the first 18 months covers:

- Public understanding and personalised tools
- Support for people at higher risk
- Professional understanding and action
- Evidence and research

What is PHE doing on dementia risk reduction?

Public understanding and personalised tools

- Major new healthy living ***marketing campaign*** aimed at getting 40 to 60-year-olds to "reassess" their health and make changes to help them live healthily in older age
- ***Personalised diagnostic tools*** to help people understand and manage their risk of developing dementia e.g. the brain age tool being developed by University College London

Support for people at higher risk

- Build dementia risk reduction into ***care and support for pre-disposing conditions*** and raise awareness of inequalities in dementia, supporting people to receive a timely diagnosis and the care and support they need
- Incorporate dementia risk reduction as a ***key outcome in health improvement programmes***, such as the NHS Health Check

What is PHE doing on dementia risk reduction?

Professional understanding and action

- Work with our partners e.g. Health Education England, the Royal Colleges and others to ***increase professionals' understanding*** of dementia risk reduction and enable them to support people in taking action to reduce risk
- For example incorporate dementia risk reduction into ***training materials and curricula***

Evidence and research

- Work with academics and other partners to develop ***measures for modelling of dementia incidence and prevalence***
- Support continued development the ***evidence base*** for dementia risk reduction and its implementation

The brain age tool prototype

- As part of our work on public awareness and understanding of dementia risk reduction, we want to give people access to personalised diagnostic tools which can help them to understand their risk level and what they can do to reduce it
- Public Health England is working with University College London on development of an online tool which will calculate an individual's 'brain age' based on information such as their blood pressure and cholesterol levels
- We currently have an early prototype and are about to start testing it with users so that we can develop the functionality and messaging
- Video clip demonstrating prototype:
  Brain age video.mpeg
  Brain age video.MOV

The brain age tool prototype – screenshot 1

The brain age tool prototype – screenshot 2

Global action against dementia
Action mondiale contre la démence

The Challenges of Dementia : The French experience

Etienne C Hirsch

Director of the Insitute for Neurosciences, Neurology and Psychiatry

Inserm

aviesan

Local care system for AD

Services at home

- Physical therapist, home-maker, home-cleaner, occupational therapist
- Specific team for AD including physical therapist, occupational therapist, nurse and psychologist who reorganize the home and teach how to behave
- Nurse care at home
- Day care structures with transportation from and to home
- Personalized financial help

More complex service

- Specialized case manager (often a specialized nurse)
- Center for autonomy and integration of AD patients : single window approach

Alzheimer PLAN 2008 > 2012 L'ENGAGEMENT DE TOUS

Plan Maladies Neuro-Dégénératives

2015-2019

Local institutions

Medicalized institution for eldery

- Often with a coordinator who is a GP with a specialization in geriatry and/or in AD
- 1/3 paid by social security, 1/3 paid by the French national funding agency for the elderly and handicapped and 1/3 by the families

Hospital

- *Cognitive and behavior units for agited patients or patients with behavior disorders*
- Long term care unit for AD patients in public hospitals

The 3 levels organization of care for AD In France

Level 1: the GP

- identification and screening of patients with simple tools;
- orientation to level 2 for a more complete investigation;
- follow-up of patients in connection with the local network of professionals.

Level 2: the Memory Clinic or the Specialist (N,G,P)

- confirmation of the diagnosis based on a specialized neuropsychological investigation and neuro-imaging ;
- therapeutic initiation.

Recommendations for a timely diagnosis for AD

December 2000

Level 1: the GP

- identification and screening of patients with simple tools
- orientation to level 2 for a more complete investigation
- follow-up of patients in connection with the local network of professionals.

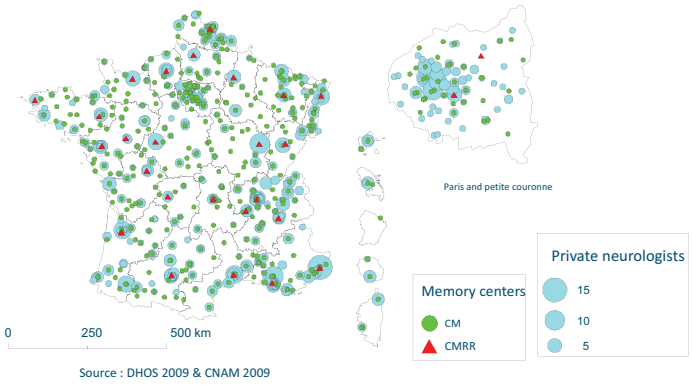
Level 2: the Memory Clinic or the Specialist (N,G,P)

- confirmation of the diagnosis based on a specialized neuropsychological investigation and neuro-imaging
- therapeutic initiation

Level 3: Regional Expert Centre (platform of resources)

- for complex diagnosis and Young-onset AD patients
- for clinical research
- for clinical trials mainly on disease modifier treatments

The 3-level organization in France



Source : DHOS 2009 & CNAM 2009

7 7

National reference centre for young Alzheimer 's patients

Local correspondants

In September 2012 :
-Nb of young patients followed by national center : 10 000
- Nb of patients in epidemiological cohort of youg patients : 207

8

The 3 level organization of care for AD in France

Allows a local care of the patients suffering from dementia
Allows the patients to stay at home as long as possible
Addresses the different stages of the disease
Allows a cost efficient treatment

But

The number of patients will increase in the coming years
GP needs to be better trained
The system needs to be adapted for other neurodegenerative disorders

Dementia in the United States and the National Alzheimer's Project Act

Kenneth C. Earhart, MD, FACP
Health Attache, China
US Department of Health and Human Services

ASPE.hhs.gov

Alzheimer's Disease/Related Dementias in the U.S.

- Estimated 5 million people in the U.S. with Alzheimer's disease and related dementias
  - The U.S. population over age 85 is growing; thus, experts expect there will be a large increase in this number.
- Estimated annual costs to health and long-term care systems for people with Alzheimer's disease and related dementias: $109 billion, most of which is long-term care
- Estimated costs of care by family and friends
  - Foregone wages: $50 billion
  - In the private market, this care would cost over $106 billion

Source: Hurd et al. N Engl J Med 2013;368:1326-34.

Major Challenges Presented by Alzheimer's Disease and Related Dementias

- Currently there is no way to prevent, treat or cure Alzheimer's disease and related dementias.
- Better quality of care measures and staff training are needed.
- Family members and other caregivers need support.
- Stigmas and misconceptions are widespread.
- Public and private progress should be coordinated and tracked.

Investments and Resources prior to National Alzheimer's Project Act

- Research
  - $502 million on research in 2010
  - Vast majority ($457 million) funded by the National Institutes of Health (NIH)
- Clinical care
  - Detection and diagnosis
  - Treatment and care coordination
  - Training
- Long-Term Care
  - Nursing home entitlement from the government for people who meet need criteria
  - Smaller programs to support national network of aging services providers

President Obama's Investment

- Designed to take immediate action on Alzheimer's disease.
- Increased Alzheimer's disease research funding.
  - The National Institutes of Health (NIH) immediately dedicated an additional $50 million in 2012.
- In 2013 NIH Director, Dr. Francis Collins, provided $40 million from the Director's Fund to support new Alzheimer's research.
- Support for people with Alzheimer's disease and their families and educating the public and providers.

Key Features of the National Alzheimer's Project Act (NAPA)

Signed January 4, 2011, required the Secretary of the U.S. Department of Health and Human Services (HHS) to establish the National Alzheimer's Project to:

- Create and maintain an integrated national plan to overcome Alzheimer's and related dementias
- Coordinate research and services across all federal agencies
- Accelerate the development of treatments that would prevent, halt, or reverse the disease
- Improve early diagnosis and coordination of care and treatment of the disease
- Improve outcomes for ethnic and racial minority populations at higher risk
- Coordinate with international bodies to fight Alzheimer's globally.
- Create an Advisory Council to review and comment on the national plan and its implementation

Early Activities

- Formation of Federal Interagency Workgroup & Advisory Council
- Formation of Research, Clinical Care and Long-term Services and Supports subcommittees
- Quarterly formal meetings of the Advisory Council and ad hoc meetings of federal workgroups and subcommittees
- Work to date addresses current programs serving those with Alzheimer's and related dementias and their caregivers, possible improvements to programs, and new initiatives.

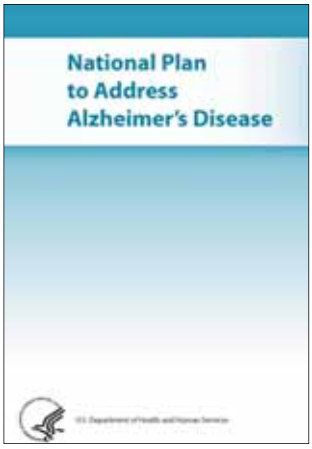
National Plan

- Balance work on treatments with care needed by people with the disease and their families now
- National Plan, not just a federal plan: requires engagement of public and private sector stakeholders
- Long-term goals, strategies to achieve those goals, and immediate actions, which are reviewed annually
- Transparent reporting on progress:
  - Implementation timeline is appendix
  - Bi-annual reporting on progress to Advisory Council
- Final Plan released May 2012:
  http://aspe.hhs.gov/daltcp/napa/NatlPlan.shtml

Most recently, the 2014 Update was released April 2014
http://aspe.hhs.gov/daltcp/napa/NatlPlan2014.shtml

Goals

1. Prevent and Effectively Treat Alzheimer's Disease by 2025
2. Optimize Care Quality and Efficiency
3. Expand Supports for People with Alzheimer's Disease and Their Families
4. Enhance Public Awareness and Engagement
5. Track Progress and Drive Improvement



Progress to Date

- Developed recommendations on how best to advance research: Alzheimer's Disease Research Summit 2012: Path to Treatment and Prevention
- Created an appendix to the National Plan with a list of milestones to reach 2025 goals: http://aspe.hhs.gov/daltcp/napa/NatlPlan2014.shtml#append2
- Provided resources to train more than 10,000 health care providers on topics from dementia diagnosis to effective behavior management
- Brain Health Resource made available online, which presents information about risk factors associated with brain health for the public: http://www.acl.gov/Get_Help/BrainHealth/Index.aspx
- NIH research summit on other related dementias (May 2013)
- Began work on a National Cognitive Health Awareness Campaign (September 2014)

Resources: Additional Information

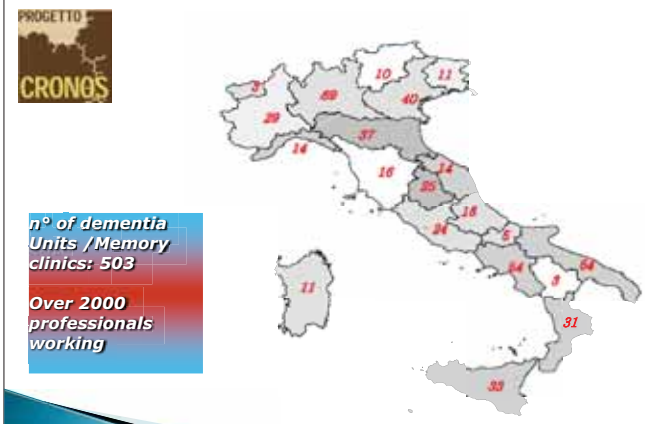
- NAPA website:
  http://aspe.hhs.gov/daltcp/napa/
- http://www.alzheimers.gov
- National Institute on Aging:
  http://www.nia.nih.gov/alzheimers
- National Family Caregiver Support Program:
  http://www.aoa.gov/AoA_programs/HCLTC/Caregiver/index.aspx

Report on dementia prevention and care in Italy

Teresa Di Fiandra
Ministry of Health, Italy

Tokyo, 5 November 2014

Services for dementia in Italy (survey 2006)



Italy at a glance

Area: **301,340** sq km

Population: 60 million

% urban population **68.36**

Life expectancy at birth (2011): **82**

Male: **79.4**

Female: **84.5**

Total fertility rate (2011): **1.39**

Source: ISTAT
WHO European health for all database

Services for dementia: survey 2014

- A new survey is undergoing to update information on the global offer of services in the Country, taking into account the differences among the 20 Italian Regions
- Data will be the basis for monitoring the application of the new National strategy (2014)
- Local and regional needs are crucial for organizing services, in the framework of National Laws and assuring essential levels of quality care

Italy and dementia

- **1.000.000 people with dementia** (estimate)
- 3.000.000 estimated family carers

- **In 2000** the so-called **«Project CRONOS»,** starting from an observational study on drugs, established a new approach to dementia which multiplied the number of **health services** all over Italy (**from 50 to 500 Units, regionally based**)

The National Plan on dementia

The plan has been developed by the Ministry of health in cooperation with the Regions, the National Institute of health and the major National patients/carers Associations

The strategy addresses:

- Prevention
- *Network of services*
- Integrated care
- *Research*
- Ethics and empowerment of patients/carers

The National Plan on dementia

The actions listed aim at:

- Integrating disciplines and professionals
- Integrating health and social approach and functions
- Training specialists, also in common settings with GPs and carers
- Developing/adjourning Guidelines and Consensus documents

The National Plan on dementia

- Assuring quality of care through continuous monitoring
- Promoting empowerment of people with dementia
- Fighting stigma and promoting social inclusion
- Offering support to carers and involving them in every phase of disgnosis/treatment

European Union-level activities on new forms of care and prevention in dementia

Global Action Against Dementia Legacy Event,
Tokyo,
05 November 2014

Jürgen Scheftlein
Unit "Health Programme and Diseases"
Health and Consumers Directorate General
European Commission

Joint Action Alzheimer COoperative Valuation in Europe (ALCOVE)

Has estimated epidemiological data for the EU:

- Prevalence rate: 7.23% in 65 years or higher aged population (2011, EU-27 Member States) corresponding to 6.37 million cases.

Has formulated recommendations and developed toolkits. These address, with regard to care:

- Timely diagnosis of dementia;
- Support systems for Behavioural ad Psychological Symptoms in Dementia;
- Antipsychotics limitation in Dementia.

Dementia on the EU-agenda

Strategy „European Initiative on Alzheimer's Disease and other forms of Dementias" (2009). Four priorities:

- Early (timely) diagnosis of dementia and promoting well-being with age;
- Better understanding dementia, epidemiological knowledge and coordination of research;
- Best practices in care for people with dementia;
- Respecting the rights of people with dementia.

An Implementation report was published on 16.10.2014

European Innovation Partnership Active and Healthy Ageing

- This EU-flagship initiative was launched in 2011. It is mobilising one thousand European regions and municipalities, involving 3000 partners and 300 leading organisations.
- All relevant actors involved in ageing are involved: industry, research, healthcare providers, NGOs,...
- The objective is to increase the average healthy life years of EU-citizens by two years by 2020 by identifying European good practices and scaling them up;
- The Partnership includes two actvity strands relevant for dementia: one on **„prevention of frailty and cognitive decline"** and a further one on **„innovation for age-friendly environments**".

Implementation of dementia strategy – key activities

- Joint Action Alzheimer COoperative Valuation in Europe (ALCOVE), 2011-2013, 19 Member States, lead: France
- European Innovation Partnership Active and Healthy Ageing, launched in 2011;
- 7th EU Research Framework Programme 2007-2013 and Horizon 2020 (2014-2020)

EU-research and eHealth-policies

- An investment of more than 355 million Euros into reserach on Alzheimer's disease between 2007 and 2013 (7th Framework Programme Research) and further research is funded from the new Horizon 2020-Programme.
- eHealth is ssen as having a great potential for improving prevention and care for people with dementia. So far, three projects have been completed, further ones are being implemented.

Respecting the rights of people with dementia Empowering NGOs

- The NGO Alzheimer Europe receives financial support from the EU Health Programme. This support is used to cover its operating costs and organise annual conferences.

EU-approach to dementia

The implementation of the EU-dementia strategy combines a variety of instruments:

- Promotion of cooperation between Member States (Joint Action);
- Mobilising actors from various backgrounds in regions (EIP);
- Using own EU-financial instruments (Research and Health Programmes);
- Supporting NGOs.

Next step: Second Joint Action on Dementia (2015-2018), to be led by United Kingdom (Scotland).

Dementia Prevention and Care in Japan

November 5th, 2014

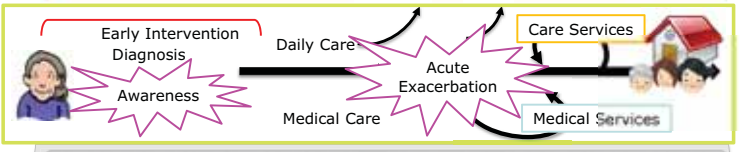
Tadayuki MIZUTANI

Director, Office for Dementia and Elder Abuse Prevention
Health and Welfare Bureau for the Elderly
Ministry of Health, Labour and Welfare (MHLW) in Japan

Orange Plan

Five-Year Plan for Promotion of Dementia Measures (2013-2017)

1. Development of Standard Dementia Care Pathway
2. Earlier Diagnosis & Intervention
3. Improved Health Care Services to support Living in Community
4. Improved LTC Services to support Living in Community



5. Better Support for Daily Living and Family Caregivers
6. Reinforcement of Measures for Younger Onset Dementia
7. Training of Personnel Engaged in Care Services

3

In 2004,
the Japanese Government
modified the Japanese
terminology for "Dementia"

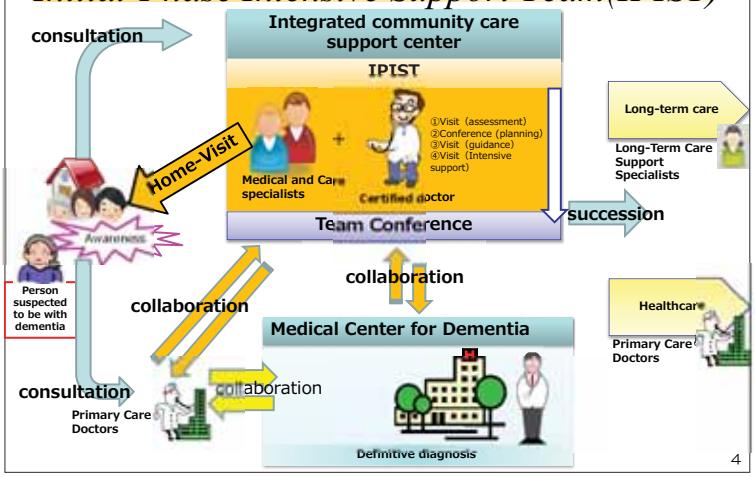
痴呆 (Chihō) — Idiocy, Stupidity

認知症 (Ninchishō) — Cognition Disorder

1

Earlier Diagnosis & Intervention

Initial-Phase Intensive Support Team(IPIST)



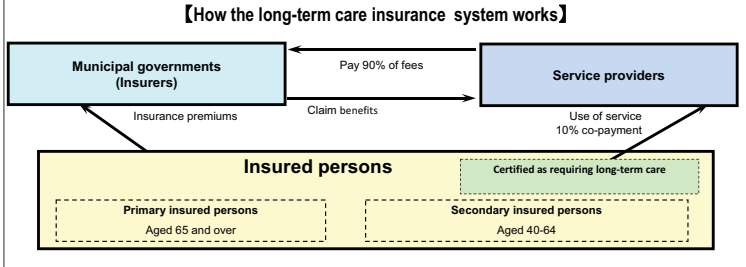
4

Aging Society and Dementia in Japan

- Proportion of the elderly in Japan is the highest in the world.
- Prevalence rate of **dementia** is estimated to be **15%** (12-17%, 95% CI), higher than any previous reports in Japan.
- Prevalence rate of **MCI** is estimated to be **13%** (10-16%, 95% CI).

2

Structure of the Long-Term Care Insurance System



【Examples of the long-term care services】

- Home-visit long-term care
  ※Provided by Home Helpers
- Home-visit nursing
  ※Medical care is provided by nurses
- Outpatient day long-term care
  ※By visiting Day Service Centers
- Short-stay services
  ※ Short-term admission to facilities
- Group home for persons with dementia
- Facility services

5

Integrated Community Care System

To live in community in a pleasant and familiar environment

"Dementia Supporters" Training Program

5.5 million Participants

as of Sep, 2014

-people of every generation, every occupation are becoming **"Dementia Supporters"**

Early detection of dementia and the “Initial-phase intensive support team” for preventing BPSD.

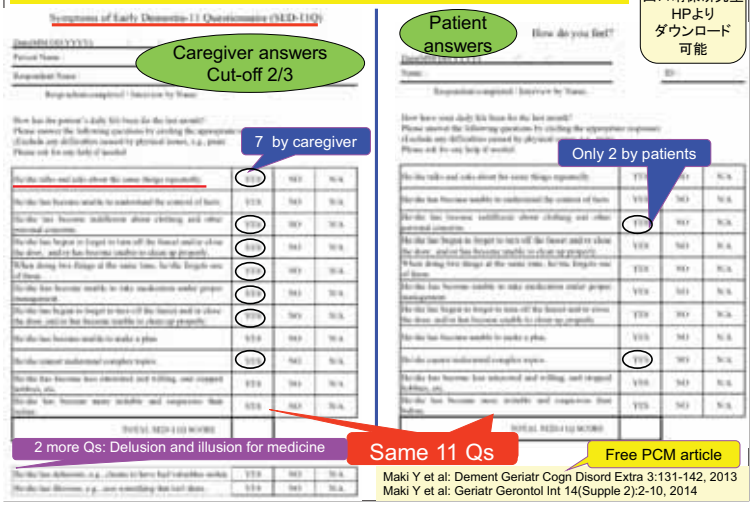
Haruyasu Yamaguchi, MD
Gunma University
Graduate School of Health Sciences

Japanese cat is now doing weight training.
To prevent dementia ??
Exercise is the best way.
But exercise prolongs one’s life, enhancing occurrence of dementia.
Prevention is to postpone.

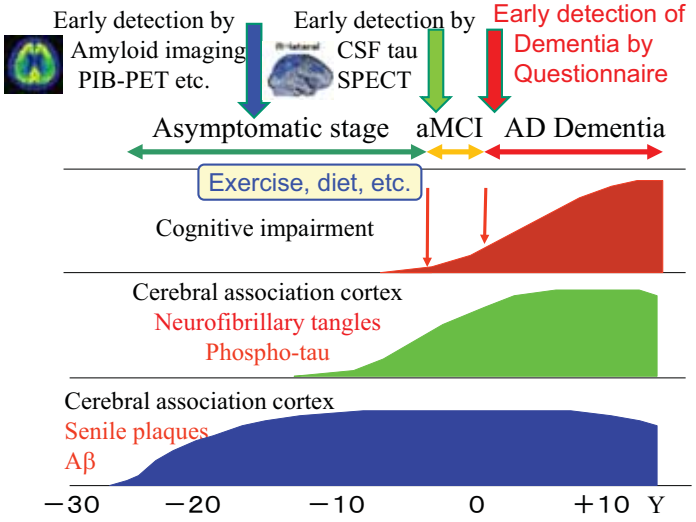
I found it at a souvenir shop in Takayama.

Early detection of dementia by SED-11Q, and assessment of anosognosia

日本語版の質問票は山口晴保研究室HPよりダウンロード可能



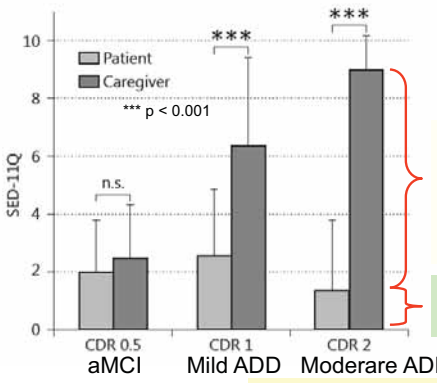
Maki Y et al: Dement Geriatr Cogn Disord Extra 3:131-142, 2013
Maki Y et al: Geriatr Gerontol Int 14(Supple 2):2-10, 2014



Anosognosia evaluated by SED-11Q

Symptoms of Early Dementia-11 Questionnaire

Subjects: 13 in aMCI (CDR 0.5); 73 in Mild ADD (CDR 1); 21 in Moderare ADD (CDR 2)



To prevent BPSD, caregiver should understand the “Anosognosia”, and be careful not to warn

Discrepancy shows the degree of “Anosognosia”
→Caregiver tend to give attention & warning
“Be careful not to fail!”

Patients score shows “Awareness of illness”

Maki Y et al: Dement Geriatr Cogn Disord Extra 3:351-359, 2013

Advantages and Disadvantages of early detection of dementia

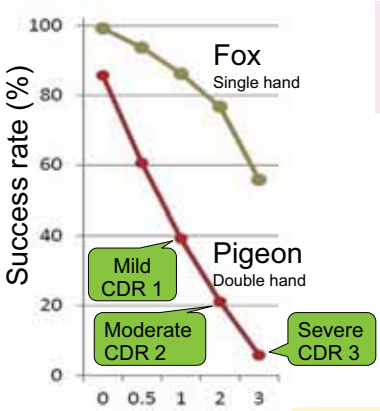
	Advantages	Disadvantages
Patients	Receiving pharmacological and non-pharmacological therapies Access to appropriate agencies and support networks Prevention of BPSD	Psychological damages of anxiety and depression Risk of withdrawal, isolation, stigma and social exclusion Risk of false positive diagnosis
Families and caregivers	Mental preparation for disease progression Access to appropriate agencies and support networks	Stigma and exclusion Care burden from early stages
Social services	Net cost reduction effects including delay of institutionalized care	Shortage of social resources, including human resources

Maki Y et al: Geriatr Gerontol Int 14(Supple 2):2-10, 2014

Easy, quick detection of dementia by the Yamaguchi fox-pigeon imitation test

Yamaguchi fox-pigeon imitation test (YFPIT); 20 secs.

Subjects: 1,219 aged people; 387 normal; 497 ADD; 98 DLB; etc.



About 70% of demented subjects failed the imitation of pigeon.

Palms Outside

ADD patients showed difficulty in taking the 3rd person's viewpoint.
(Perspective taking)
→Self-monitoring↓
Anosognosia

Yamaguchi H : Dement Geriatr Cogn Disord 2:254-258, 2010
Yamaguchi H : Psychogeriatrics 11:221-226, 2011

Stream of the task
Meeting→Assessment →Meeting→Support→ Connecting→Monitoring

Family of demented people | Neighbors | Welfare volunteer commissioner
Hospitals & Clinics | Consultation Requests | Medical centers for dementia
11 Community general support centers
Care manager (Long-Term Care Support Specialists)
Primary doctor
Asking provision of information
Medical information 38/44
Report of assessment/results
46 subjects
IPIST Visiting staffs
IPIST Team meeting +Doctors +City officers
Subjects Family
Assessment
Support
Connecting/Passing
Follow up monitoring
Maebashi city
3 hundred thousand people
Orange Plan
Family care Guidebook

視線を落とす→落ち目
Looking down causes being out of luck.
うつむく→うつの気分
Neck flexion causes depressive feeling.

He was given a diagnosis of dementia just now.
He said,
"Early diagnosis" thrown me into "Early despair".

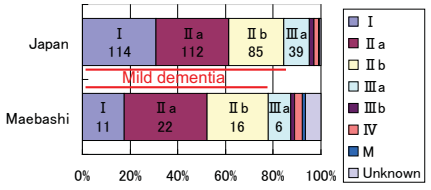
早期診断＝早期絶望

Early diagnosis should be associated with early support to reduce psychological damages of anxiety and depression.

IPIST in Maebashi city

Orange Plan

- Subjects: 63 persons
(Visited : 58 persons; Not visited 5 persons)
- Number of visit : 2.5±1.9 times First visit 101min.
- Disease : Dementia? 51; Psychiatric? 3; Alcoholic 5
- Problem in caregiver rather than in subjects 8
- Family doctor (GP) : Having 46; Not having 17
→ Response form GP : 38/44 informed
- Diagnosis of dementia : Already 11; Not yet 31



Independence degree of daily living for the demented elderly

Initial-phase Intensive Support Team(IPIST)

【purpose】to organize supporting system for early detection and early diagnosis. To enable elderly people to live in their community in a pleasant and familiar environment throughout their life, even if they come to require advanced-level care.

【What is IPIST?】

IPIST visit people with dementia (and their households).
IPIST support includes:
assessments of patient s state,
supports for family
in initial-phase (<6-months) etc.

Community general support center

Members of IPIST
Medical and Care specialists
(public health nurse, nurse, occupational therapist, social worker, LTC public aid worker)

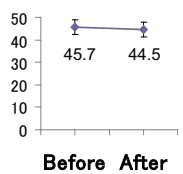
【People supported by IPIST】

- People with or suspected to be with dementia (40 years old and over)
- People live in home
- Person with one of (a) to (d)
(a) without proper diagnosis.
(b) without continual medical services.
(c) without proper welfare services
(d) with proper diagnosis and discontinuous services
- Person with severe BPSD

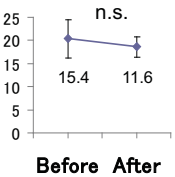
Five-year Plan for Promotion of Dementia Measures (2013-2017)
"Earlier diagnosis and Intervention" < Orange Plan >

Initial-phase intensive support team in Maebashi city: 1 year achievment from Sep 2013 to Sep 2014

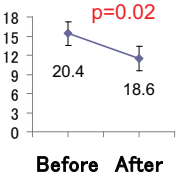
Dementia severity
DASC 21 n=22
n.s.



BPSD
DBD 13 n=20
n.s.



Care burden
J-ZBI_8 n=20
p=0.02



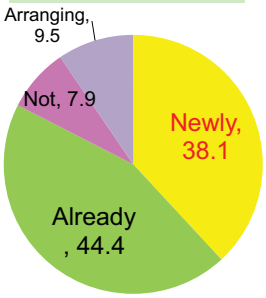
Dementia severity, assessed by DASC21, did not changed.
Behavioral disturbance, assessed by DBD13, tended to improve.
Care burden, assessed by Zarit 8, improved significantly.

DASC21 is a Dementia Assessment Sheet in Community-based Integrated Care System, which consisted of 21-items questionnaire asking living functions

Initial-phase intensive support team in Maebashi city: 1 year achievment from Sep 2013 to Sep 2014

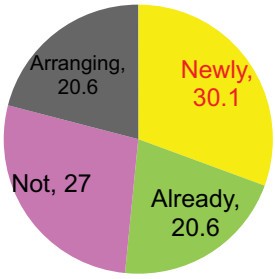
Total 63 Subjects ; Visits 2.5 +/- 1.9 times (n=46)

Connected to Medical treatment



Most were connected to medical treatment

Connected to Welfare service



More than half were connected to welfare service

Thank you for your attention. Oshino-Hakkai 忍野八海 2006.5.4

Initial-phase intensive support team for dementia in 2013 in Japan <Orange plan>

Model project Half year: 2013.9 to 2014.3

Orange Plan

14 areas (city, town, village, ward)

Cases: Total 636 cases, 45.4 cases/area (mean)
50% of cases have difficulty in support
<anosognosia (refusal), neglect, alcohol, etc>

Visits: Total 2,106 visits, 3.14 visits/case (mean)
First visit 77 min. (mean); Third visit 55 min.

Team staff meeting: Total 316 times, 22.6/area (=1/w)
Taking 89 min. ; 20 min./case (mean)

Now going on in 108 areas (2014.9)

Take Home Message

Early detection & Initial-phase intensive support team (IPIST)

Questionnaire (SED-11Q) and the Yamaguchi fox-pigeon imitation test (taking 30 sec.) contribute to early detection of dementia as a screening.

Furthermore, SED-11Q evaluates "anosognosia" that is difficulty in self-awareness, and is useful to prevent BPSD through caregiver education.

Tool

Family care Guidebook

As an early support system, IPIST in the orange plan connects demented subjects to medical and social supports to reduce care burden, and to prevent BPSD.

We hope the subjects continue to live at-home with dignity.

Five-year Plan for Promotion of Dementia Measures (2013-2017)
"Earlier diagnosis and Intervention" < Orange Plan >

Effectiveness of Rehabilitation and Health Promotion Activities in Japanese Intermediate Facilities (Roken)

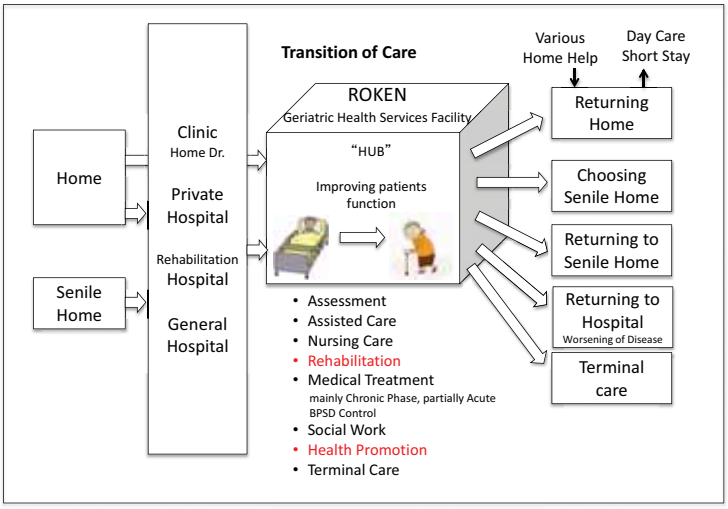
Jiro Okochi[1-3], Kentaro Higashi[1]

1. Japan Association of Geriatric Health Services Facilities, Tokyo, Japan
2. Tatsumanosato Geriatric Health Service Facility, Tatsuma, Daitou, Osaka, Japan
3. Department of Health Services Researches, Faculty of Medicine, Tsukuba

Health Promotion activities (Kaigo-Yobo Salon)

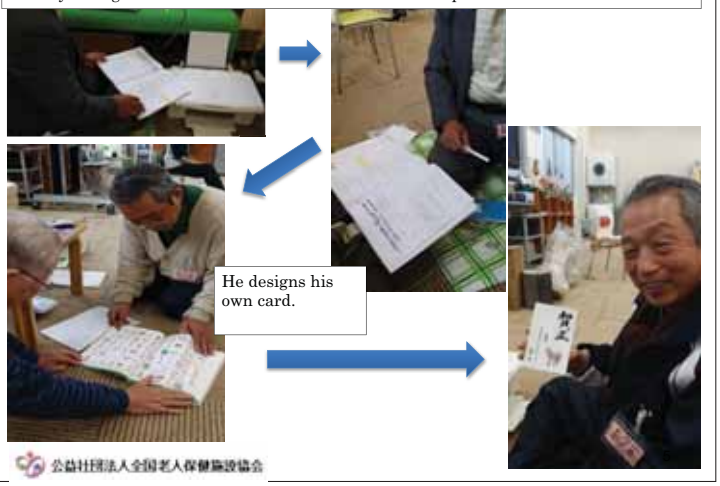
- Aimed at Prevention of Frailty of the elderly people living in the community
- Roken provides the facility space
- Participants take initiative on deciding the activities in a group discussion.
- Staffs and therapists provide help as needed.

Patient flow of Roken



Making an Original New Years Greeting Card

Facility staff gives an instruction on how to use a PC and printer while he takes a note.



Two recent services by specialists team at Roken facilities

- Intensive Rehabilitation for Dementia patients
  - For elderly inpatients eligible for public long-term care insurance (LTCI) services
- Health Promotion activities (Kaigo-Yobo Salon)
  - For elderly persons in the community not eligible for LTCI, but with risks of developing disabilities, including cognitive deteriorations

Intensive rehabilitation for dementia patients

- The rehabilitation program was designed in a tailor-made manner to meet individual needs
- The personal sessions were carried out three times a week for three months by physical, occupational or speech therapists

Toba et al. GGI 2014 Jan;14(1):206-11
Please see the poster session for detail

Example of rehabilitation program


Learning session


Training with memory card


Music therapy


handicrafts session

Effectiveness of Roken stay

- As a result of rehabilitation, treatment and care at Roken, the functions of elderly persons improve during the stay
- When they go home…
  - functional deterioration is gradual
  - Social participation continue to improve

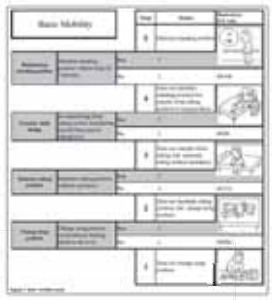
Outcome of intensive cognitive rehabilitation

Table 2 Outcome of intensive cognitive rehabilitation

		Intervention group(n=158)					Control group(n=54)				
		Before		After			Before		After		
	test item	mean	SD	mean	SD	P value	mean	SD	mean	SD	P value
Short term memory	HDS-R	16.9	5.7	17.9	6.5	<.001	17	5.9	16.7	6.3	0.48
Activity of daily living related scales	N-Memory scale	30.4	9.1	32.1	9.5	P<0.001	31.4	9.8	30.7	10.9	0.38
	Barthel Index	16.4	7.1	17.3	7.1	<.001	15.7	7	15.9	6.9	0.621
	Social activity scale	8.6	3.3	8.8	3.4	0.026	8.5	3.1	8.6	3.2	0.972
Vitality and Depression	Vitality Index	8	1.7	8.2	1.6	0.004	8.1	1.8	8.2	1.8	0.864
	Geriatric Depression scale	2.5	1.8	2.4	1.9	0.042	2.3	1.5	2.4	1.5	0.634
Behavior Disturbance	Dementia Behavior Disturbance scale	4.5	5.2	4	4.1	0.004	4.5	4.2	4.8	4.7	0.413

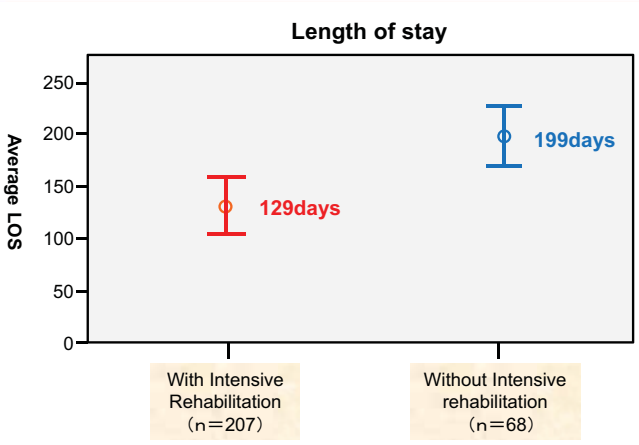
Toba K et al GGI. 2014 Jan;14(1):206-11.
Higashi K. Monthly book medical rehabilitation (164), 66-71, 2013-11

ICF staging and Five summary scales

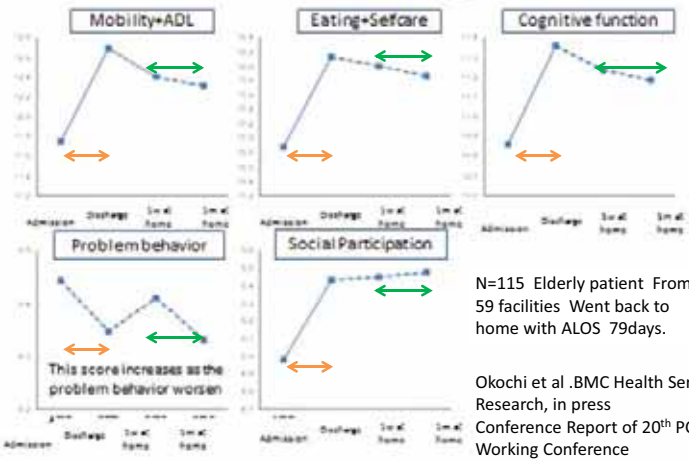


Mobility	Basic mobility, Walking	
ADL	Toileting, Bathing	
Eating	Eating maneuver, Swallowing	2
Self care	Personal care, Dressing, Oral hygiene,	
Cognition	Orientation, Communication, mental activity	3
Behavior	Behavior problems	4
Participation	Leisure activity, Social communication	5

Dementia Rehabilitation -Effectiveness on Length of Stay



Change of functional status during Roken stay and after discharge



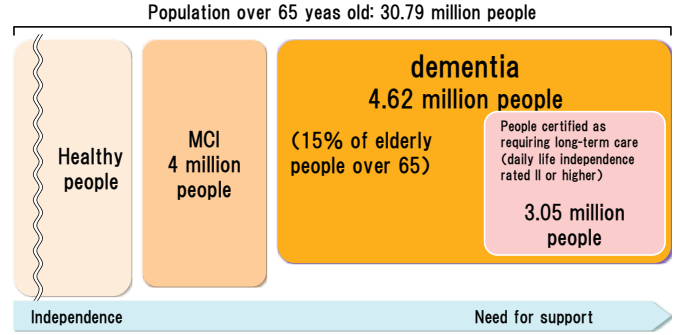
N=115 Elderly patient From 59 facilities Went back to home with ALOS 79days.

Okochi et al .BMC Health Service Research, in press
Conference Report of 20th PCSI Working Conference

Conclusion

- Roken stay contributes to functional improvement, cognitive and physical
- Roken stay enhances Elderly person's dignity and promote their social participation

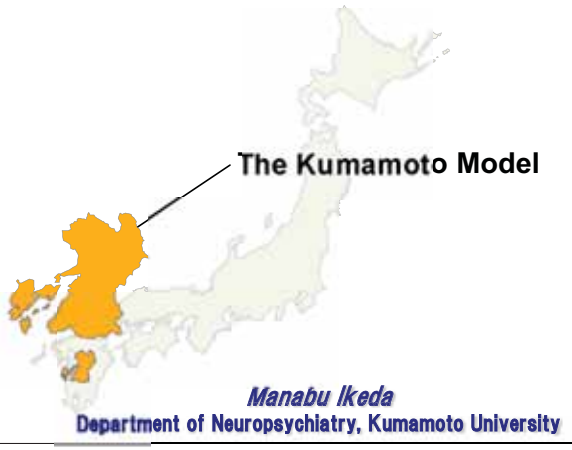
Number of people with dementia in Japan



Survey method: Specialist dementia doctors carried out interview surveys nationwide. The data used in this survey comes from the 5,386 people interviewed in the 8 regions which had the highest rates of response in the interview surveys.

Data materials: Health and Labour Sciences Research Grant, (General Strategies for Dementia), General Research Report: "Responses to the prevalence of dementia in urban areas and lifestyle dysfunction" by Professor Takashi Asada of Tsukuba University and others (2013), "Elderly people with dementia whose daily life independence level is rated II or higher" (2012) by the Ministry of Health, Labour and Welfare, and "Population Statistics" (2013) by the Ministry of Internal Affairs and Communications.

Medical service network with cultivating human resources for dementia in Japan



Manabu Ikeda
Department of Neuropsychiatry, Kumamoto University

Specialists for dementia

The Japanese Psychogeriatric Society

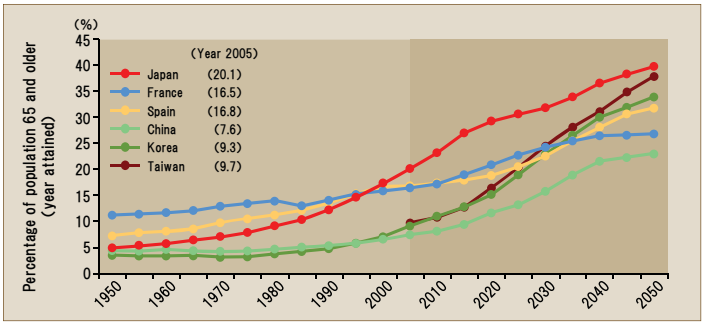
- Years of foundation : 1986
- Number of members : 2,598
- Number of psychogeriatric specialist : 1,497

Japan Society for Dementia Research

- Years of foundation : 1982
- Number of members : 3,150
- Number of dementia specialist : 890

Specialists for Dementia : Patients with dementia = 1 : 2000

International comparison of aging



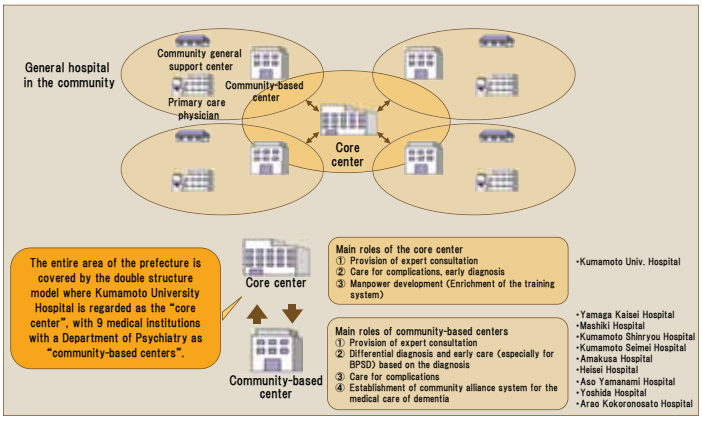
Source: UN, World Population Prospects: The 2008 Revision
However, the data for Japan are estimated from the "Population Census" by the Ministry of Internal Affairs and Communications up to 2005 and the data on assumed median births and median deaths in the "Projected Population of Japan (estimated in December 2006)" (National Institute of Population and Social Security Research) since 2010.
(Note) The advanced regions consist of North America, Japan, Europe, Australia and New Zealand.
The developing regions consist of Africa, Asia (except for Japan), Central and South America, Melanesia, Micronesia and Polynesia.
2011 White Paper on Aging Society by Cabinet Office, Japan.
http://www8.cao.go.jp/kourei/whitepaper/w-2011/zenbun/23pdf_index.html

Challenges faced by dementia treatment

Establishment of medical centers for dementia care

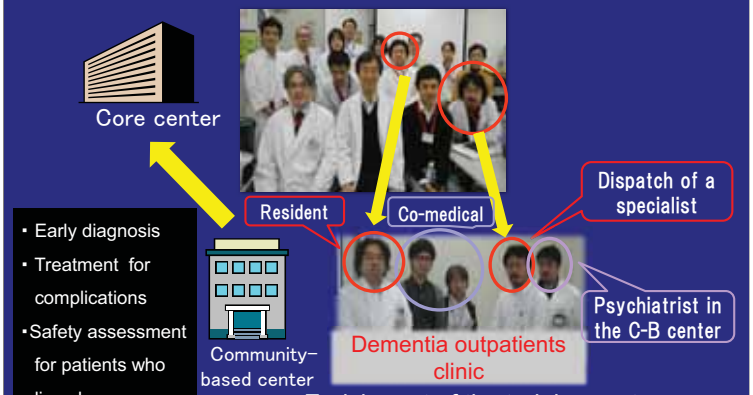
1. Early diagnosis (differential diagnosis)
2. Provision of specialized medical care
3. Treatment for BPSD
4. Management of concomitant physical symptoms
5. Regional cooperation (Education for GP, care stuffs, and caregivers)
   - Widespread use of a standardized treatment for dementia
   - Coordination with long-term care
6. Manpower development (Enrichment of the training system)
7. Prefecture-wide distribution of specialized medical care

Example of the Dementia-related Medical Center operation project（Kumamoto Model）



Textbook for Dementia (edited by Japan Society for Dementia Research, Chugaigakusha), p208.

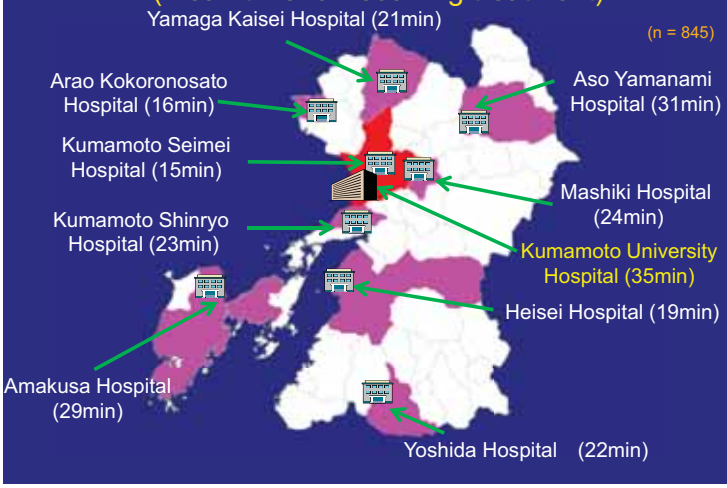
Core center: Manpower development for community-based centers



- Early diagnosis
- Treatment for complications
- Safety assessment for patients who live alone

Enrichment of the training system for stuffs in the community-based center

10 Dementia-related Medical Centers in Kumamoto (mean time for receiving treatment)



Case conferences prepared by the core center

Difficult case-study conferences are held by the core center. The aim of this conference is to improve multi-disciplinary stuffs' skill. 33 conferences are held by now (6 times per year).

Multi-disciplinary participants : Dr, Ns, PSW, CP, OT, local government stuffs
（Stuffs of call center & Community general support centers as observers ）

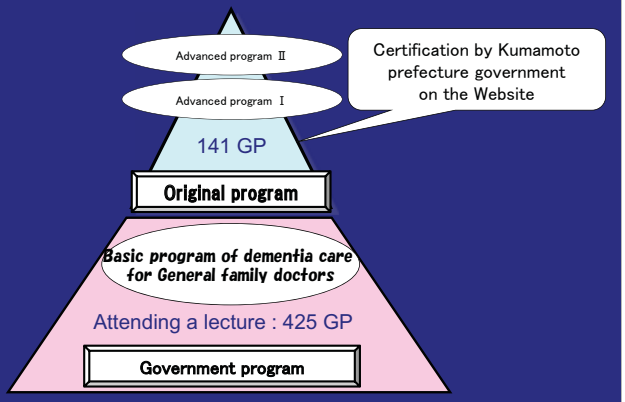
Multi-disciplinary participants

Provision of specialized medical care for dementia

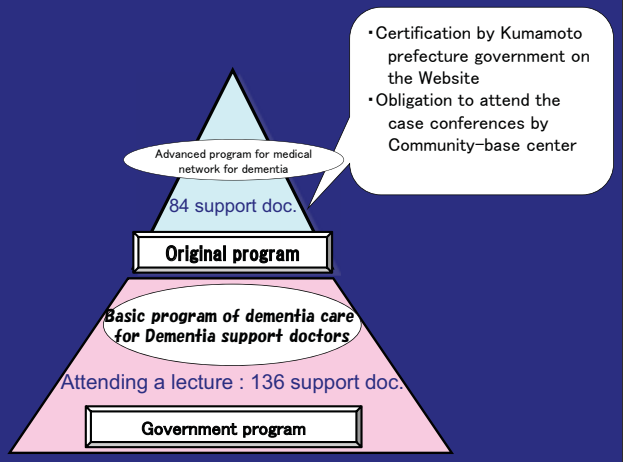
	2009.12	2010.12	2011.12	2012.12	2013.12
Consultation (No. of times)	143	471	571	578	647
New outpatients (n)	106	203	223	194	229
Total outpatients (n)	2,777	3,200	3,876	3,982	4,245
No. of Medical care centers	8	8	10	10	10

◆Monthly average of ten centers in 2013
Consultation cases: 621　New outpatients: 221
Total outpatients: 2,679　Hospitalized patients: 52

Training programs for General family doctors



Training programs for dementia support doctors



Case Mrs. K

78yr Female DLB
MMSE 22/30
Living alone in the apartment care lank 1
Visiting with her care manager and daughter

Check points
☆Handrail in the bathroom
☆Chair in the bathroom
☆Her movements when taking a bath

Preparation for safety life

☆Install handrail
(lengthwise direction)
☆Purchase a chair for bathroom
☆training for taking a bath

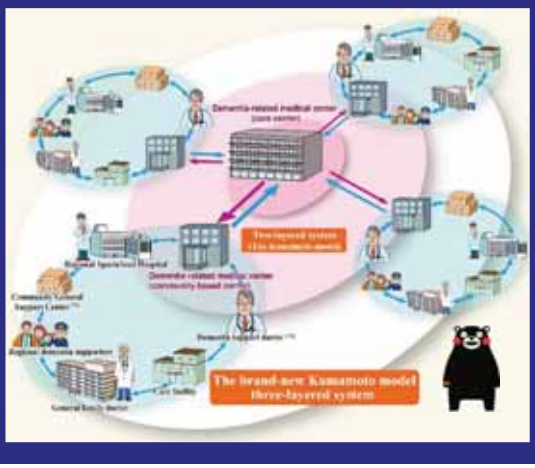
Case conferences prepared by the community-based centers

Difficult-case-study conferences are held by the community-based center.
The aim of this conference is to support the care for difficult dementia cases in the community.
30-40 conferences are held per year.

Multi-disciplinary participants ：Dr (specialist, GP, & dementia support doctor), Ns, PSW, OT, PT, ST, CP, care worker, home helper, care manager, local nurse, policeman, and so on
from community-based centers, community general support centers, clinics, general hospitals, psychiatric hospitals, group homes, nursing homes, police station, and so on
(Stuffs of local government & the core center as observers)

The brand-new Kumamoto model

Three-layered system with GP, care stuffs, & dementia supporters



Outreach services for dementia before discharge from the core center

Aim ：Guarantee safety and high QOL life after discharge from the university hospital

•Visiting patient's home between April 2012 and September 2014

•Subjects：40 patients (M/F 13/27)
（patients living alone 17 (M/F 1/16名）

•Multi-disciplinary visiting team ：OT, PSW, Ns, ST, CP, Dr

Public Health England

Dementia in England

Dr Charles Alessi
Senior Advisor on Dementia, Public Health England

The dementia challenge

- Currently more than 800,000 people with dementia in the UK – projected to increase to over 1m by 2021 and over 2m by 2051
- Overall economic impact estimated to be £26 billion a year (ca. $42 billion)
- Four-fifths of people over 50 fear they will develop dementia
- Prime Minister recognised "One of the greatest challenges of our time" and created the Dementia Challenge. In December 2013 the UK made the fight global by hosting the first G7 summit

The health and care system in England

National Health Service (NHS)	World's largest publicly funded health service (and 4th biggest employer in the world). Current budget of ca £110bn ($177.5bn). Funded through taxation and provided free at the point of use.
Public health	System of national, regional and local organisations, including Public Health England, the NHS and local government, with responsibilities for protecting, promoting and improving the health and wellbeing of the population and reducing health inequalities
Adult social care	Care and support in addition to healthcare e.g. to help older people or people with disabilities to live their lives. Unlike healthcare, social care is means-tested. Local government is responsible for ensuring social care is commissioned and provided for those who qualify as eligible in their area and that those who are not eligible for free care have the information they need to buy their own care.

Areas of focus: risk reduction and early identification

Risk reduction

- ***Blackfriars Consensus***: ground-breaking agreement that concerted action is needed to reduce dementia risk
- A ***key priority for Public Health England.***.We want to "transform a generation's risk of dementia"

Dementia risk reduction work programme covers:

- Public understanding and personalised tools
- Support for people at higher risk
- Professional understanding and action
- Evidence and research

Early identification

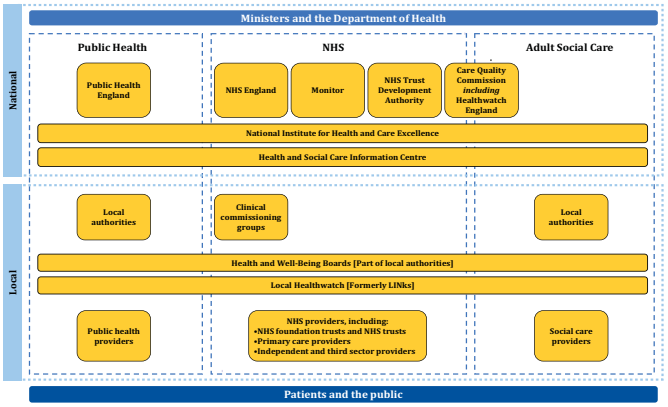
Primary Care

- Innovation in detection of dementia in primary care
- NHS Health Check
- Case finding in primary care for at risk groups

Memory Clinics

- National Network
- Four-fold increase in activity in two years; half of people seen in early stages
- 75% of clinics asking about research

Overview of the system



Areas of focus: diagnosis and post-diagnostic support

Diagnosis and post-diagnostic support

- On average, in England, ***53%*** of people with dementia receive a diagnosis
- ***Significant variation*** across the country in diagnosis rates and post-diagnostic care

- ***National ambition:*** by March 2015 two thirds of people with dementia should receive a diagnosis and appropriate post-diagnostic support
- We want everyone to get a ***timely assessment***. People with suspected dementia are referred to and assessed by a memory clinic within an average of six weeks in ¾ of England. We are working with the areas with the longest waits..

- ***Improving post-diagnostic support*** is a key part of the Dementia Challenge, e.g. by
  - improving access to dementia advisors
  - investing in better care environments
  - reducing use of anti-psychotics
  - building staff understanding
  - integrating care better

Areas of focus: society & communities and equity

Society and communities

- ***Dementia Friends Campaign**:* more than 500,000 Friends so far
- ***Dementia Friendly Communities*** and ***Dementia Action Alliances*** to help support people living with dementia and enable them to be active in their communities

Equity

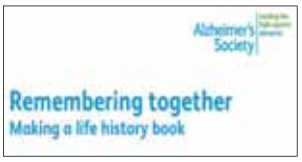
- Developing ***briefings*** to help commissioners address the equality issues associated with dementia services.

1. Impact of different characteristics on dementia
2. How to build a local data profile
3. Simple local actions that make a difference
4. Case studies of good practice
5. Library of links, resources etc

Areas of focus: carers and knowledge & intelligence

Support for carers

- ***Quality of post diagnostic support*** is key e.g. life story work
- Evaluation of dementia advisers published in 2013
- "***The Dementia Guide***" - over 100,000 copies distributed



Knowledge and intelligence

- ***Dementia Intelligence Network*** to provide authoritative intelligence, research and evidenced best practice for commissioners, local decision makers and other health professionals

Innovation in health system improvement in dementia care

The Canadian perspective

Example of the Quebec Alzheimer Plan

Howard Bergman, MD, FCFP, FRCPC
Chair, Department of Family Medicine
Professor of Family Medicine, Medicine and Oncology
The Dr. Joseph Kaufmann Chair of Geriatric Medicine
McGill University

Isabelle Vedel, MD, PhD
Assistant Professor, Department of Family Medicine
And Division of geriatric medicine
McGill University

Tokyo 3.11.14

An approach focused on the individual, humanism and excellence

- Respect the dignity and choices of people with Alzheimer's and their families
- Draw on emerging solutions validated by:
  - Evidence-based knowledge and research findings
  - Canadian and international experience
  - In the context of the Quebec health care system
- Promote an organizational culture characterized by:
  - Empowering people
  - Evaluating practices
  - Continuously improving quality and accessibility
  - Ensuring accountability
- Recognize and mobilize all sectors concerned by Alzheimer's disease and foster synergies among them.

Meeting the Challenge of Alzheimer's Disease and Related Disorders

A Vision Focused on the Individual, Humanism, and Excellence

REPORT OF THE COMMITTEE OF EXPERTS FOR THE DEVELOPMENT OF AN ACTION PLAN ON ALZHEIMER'S DISEASE AND RELATED DISORDERS
HOWARD BERGMAN, M.D., CHAIR

May 2009

Québec

Priority Action 1

Raise awareness/prevention

- Incorporate Alzheimer's disease into Quebec's public health plan
  - Hypertension, hyperlipidemia, diabetes
  - Promote education
  - Prevent head injuries
  - Encourage physical, social and intellectual activities, good eating habits, no-smoking, drinking in moderation

Seven priority actions
24 recommendations

1. Raise awareness, inform and mobilize/prevention
2. ***Provide access to personalized, coordinated assessment and treatment services for people with Alzheimer's and their family/informal caregivers.***
3. In the advanced stages of Alzheimer's, promote quality of life and provide access to home-support services and a choice of high-quality alternative living facilities.
4. Promote high-quality, therapeutically appropriate end-of-life care that respects people's wishes, dignity and comfort.
5. Treat family/informal caregivers as partners who need support.
6. Develop and support training programs.
7. Mobilize all members of the university, public and private sectors, for an unprecedented research effort.

Access to personalized, coordinated evaluation and treatment
The Challenge

- Poor access to:
  - Diagnosis, treatment (including behavioral issues), support for patients and their caregivers
  - Integrated management through the stages of the disease
    - Including in crises
- Memory clinics cannot handle the volume nor assure comprehensive continuity of care
  - Resulting in very long waiting lists, delayed diagnosis and late intervention
- Primary care generally not prepared to deal with patients with ADR

Why primary care is seen as the way forward

- Canadian Consensus conferences recommendations since 1989
- First contact, has longitudinal experience with patient and family; best trained and equipped to deal with older persons with multi-morbidity in the community
- Will never be enough specialists interested and trained in ADR
  - Enormous costs
- Preparing for the advent of bio-markers and disease-modifying medications

Provide access to personalized, coordinated services

- **Fast, easy, flexible access to specialized resources as necessary**
  - Memory Clinics
    - Secondary and tertiary care
  - Behavior and Psychological Systems of Dementia teams
  - Psychosocial resources
    - Alzheimer's Support Centres (ASC)
  - Home care programs
  - Optimal hospital stay and transitions

The Way Forward

- Important primary care reform: Medical Home (Groupes de médecine de famille (GMF) in Qc, Family Health teams (FHT) in ON:
  - group practice, team based, interdisciplinary (nurse clinician/practitioners, other healthcare professionals) and inter-specialty practice
- Quebec Alzheimer Plan (Bergman Report) (2009) emphasized the central role of primary care.
- In Ontario: Bottom up development: 60 FHT'S have already implemented innovative interventions-rural and urban
- Progress in other provinces

Implementation in Quebec

- Ministerial decision with budget after ministerial study of the Qc AD plan recommendations
- Priority: enable/empower primary care clinicians (mainly MD-Nurse team) to detect, Dx, Tx, follow vast majority of AD
- Funded Implementation projects in 40 GMF's to then scale-up
- Produced an interdisciplinary, proactive trajectory of care with practice guidelines and training strategy for MDs, nurses, other clinicians
- Evaluation for scaling up

Quebec AD Plan
Provide access to personalized coordinated services

Collaborative care model

- Approach based on the chronic-care model and the collaborative-practice model, introduced gradually, starting in Family Medicine Groups (GMFs)
- The primary care physician and the nurse clinician in partnership with patient and family in assessment, diagnosis, treatment, monitoring, and follow-up
  - The nurse clinician plays the role of Alzheimer's pivotal nurse.

Callahan JAMA 2006

Canadian Consortium on Neurodegenerative Diseases of Aging(CCNA)
PI Howard Chertkow-47co-PI's $35 million budget (CIHR and other partners)

	Theme 1: PREVENTION	Theme 2: TREATMENT	Theme 3: QUALITY OF LIFE
CROSS-CUTTING PROGRAMS	1. Genetics of NDD 2. Inflammation & Growth Factors 3. Protein Misfolding 4. Synapses & Metabolomics 5. Lipids & Lipid Metabolism 6. Nutrition, Lifestyle, & Prevention of AD	7. Vascular Aspects of NDD 8. Lewy Body Dementia 9. Biomarkers 10. Cognitive Intervention and Brain Plasticity 11.Prevention and Treatment of Neuropsychiatric Symptoms 12. Mobility, Exercise, and Cognition 13. Frontotemporal Dementia	14. How Multi-Morbidity Modifies the Risk of Dementia and the Patterns of Disease Expression 15. Gerontechnology & Dementia 16. Driving & Dementia 17. Interventions at the Sensory and Cognitive Interface 18. Effectiveness of Caregiver Intervention 19. Integrating Dementia Patient Care into the Health Care System 20. Issues in dementia care for rural and indigenous populations
TRAINING & CAPACITY BUILDING			
KNOWLEDGE TRANSFER			
ELSI			
WOMEN & DEMENTIA			

Eight Platforms to Support the Teams

1. Clinical Cohorts
2. The Normative Comparison Group
3. Imaging/Database/Information Technology
4. Blood, Saliva & CSF Biosamples
5. DNA Sequencing
6. Brain Banking
7. Transgenic Colonies
8. Academic Clinical Trials

From practice to research to policy

The Canadian Team for Healthcare Services/System Improvement in Dementia Care

- Evaluate the Quebec and Ontario (other provinces) interventions with rapid, pertinent and actionable results for key partners in order to refine the interventions
- Identify key components and key contextual factors linked with an optimal impact
- Facilitate rapid dissemination and scale up successful and sustainable collaborative care models across Canada

the Canadian perspective for innovation in health system improvement in dementia care

- Implementation projects with the perspective of scaling up by identifying key elements for rapid health system change
- Based in primary medical care closely linked and supported by to specialty care; interdisciplinary clinical leadership
- Paradigm for management of multiple chronic disease
- Training for students, residents and grad students
- True partnership: researchers, decision-makers, managers, clinicians, patient-caregiver
- Basis for ongoing Canadian and international research and policy network

An Innovative Transformative Approach

Integration of research and knowledge transfer and exchange (KTE)

- *Participatory research*: stakeholders involved in defining outcome measures/feedback to sites, drawing conclusions
- *Developmental evaluation*: rapid-***as the study unfolds***- impact on health system improvement and practice
  - Rapid dissemination of innovation/best practices
  - Primarily through the ON and Qc experience (possibly others) with early input/dissemination to other Canadian provinces

For a copy of the Quebec AD report

En Français

- http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2009/09-829-01W.pdf

In English

- http://www.medicine.mcgill.ca/geriatrics/QuebecAlzheimerPlanEnglish.pdf

Partners

- Researcher team actively engaged with 4 involved stakeholder groups:
  - Decision-makers (e.g. Ministries of health)
  - Patients/family (e.g. Alzheimer society)
  - Administrators Clinicians Industry
- Canadian Partners Council
- International advisory committee (PAHO/WHO, 4 high income, 2 middle income countries)

French organization of care for patients with Young Onset Dementia to meet their specific needs

Florence Pasquier, M.D., Ph.D.

Epidemiology

- **Prevalence of YOD : 50-80** [CI95: 39-98] **per 100,000 inhab.** < 65 y. Incidence : **10-15 new cases per 100,000 inhab. /y;** As many men as women
- **Extrapolation of number of YOD patients in UK** for a population of 59 millions inhabitants: **18,319** [CI 95%: 15,296 – 21,758]

Alzheimer's disease	6,000 [4,254-7,989] 550 new cases/y
Vascular dementia	3,000 [1,832-4,526]
Frontotemporal dementia	2,500 [1,502-4,008] 460 new cases/y
Alcoholic dementia	2,200 [1,290-3,654]

Mercy et al Neurology 2008; Ikejima et al, Stroke 2009; Ratnavalli et al, Neurology 2012; Harvey et al, JNNP 2003; Vieira et al, Clin Pract Epidemiol Ment Helath 2013; Sanchez-Abraham et al, Neurologia 2014 Lambert et al, Eur J Neurol 2014; Ikejima et al, Psychiatr Clin Neurosci 2014

Disclosures

- Participation in many pharmaceutical trials and academic studies in dementia
- Occasional participation in scientific advisory boards
- No specific disclosure for the present communication

Progression and survival of patients with YOD

- Shorter survival in some old studies
- Actually more rapid decline in young than in old demented patients although no difference in MMSE score at first visit (because of delayed diagnosis and cognitive reserve?) but longer survival.
- Longer survival (except for genetic cases) **but higher impact of the disease on mortality in young patients**

Koedam et al, Dement Geriatr Cog Disord 2008; Van der Vlies Psychol Med 2009; Rountree et al, Alz Res Ther 2012, Go et al, Dement Geritr Cogn Disord 2013

Introduction

- **Early** or **Young Onset dementia** = usually **onset before 65**.
  - For some authors "**Early Onset**" means **diagnosed** before 65
  - Early dementia ≠ early onset dementia
  - "**Young Onset**" sometimes means **< 60** or even **45**

Prevalence and incidence doubles every 5 years from 35 years

Numbers depend on settings and data collection, size of the studied population; inclusion/exclusion of causes (alcohol, stroke, TBI, HD, psychosis, mental disabilities, AIDS, MS …), age < 65 years at onset, at diagnosis **or** at entry

Woodburn & Johnstone, Health Bull (Edinb) 1999, Kelley et al Arch Neurol 2008; Harvey et al JNNP 2003

Distinctive features of YOD

Delay in establishing a proper diagnosis

- Time between 1st symptoms and diagnosis 5 years versus 3 years (personal data)
- Illness often considered by the general public –and many professionals - as a disease of the elderly
- Many differential diagnosis
- Atypical features

→ difficult diagnosis → expertise mandatory

Alzheimer's Australia report 2007; Masellis et al, Alzheimers Res Ther 3013

A number of different causes of dementia

- **Degenerative** : **AD**, **FTLD**, DLB (including Parkinson), Huntington's disease…
- **Vascular** (including genetic like CADASIL)
- Autoimmune of inflammatory (MS…)
- Traumatic
- Toxic (alcohol)
- Infectious (including AIDS)
- Metabolic (including inborn errors of metabolism)
- Other

Harvey et al, JNNP 2003; Panegyre & Frencham, Am J Alz Dis Other Dement 2007; Shinagawa et al, Dement Geriatrc Cogn Disord 2007; Fujihara et al, Arq Neuropsiquiatr 2004; McMutray et al, Int J Geriatr Psychiatry 2006; Kelley et al., Arch Neurol 2008

Atypical clinical features in YO-AD:

- **Predominant instrumental cognitive deficits :** visuospatial functions, language, praxis… disconcerting if amnesia does not seem severely impaired
- **Focal atrophies** (Primary Progressive Aphasia, Posterior Cortical Atrophy…) Rarer with ApoE4
- **Less anosognosia**
- **Genetic forms** of AD (10% vs 2%), with possible neurological symptoms e.g. spastic paraparesia, Lobar haemorrhages, extra-pyramidal symptoms

→ contribute to misleading

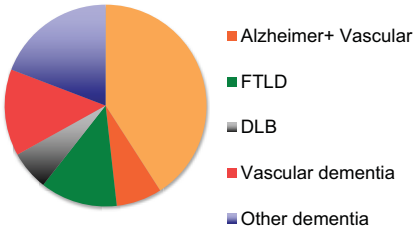
Imamura et al, Neuropsychologia 1998;
Rossor MN et al, Lancet Neurology 2010;9: 793-806;
van der Flier et al, Lancet Neurol 2011
Mendez et al, Am J Alz Dis & Other Dement 2012

Diagnostic distribution in the Memory clinics

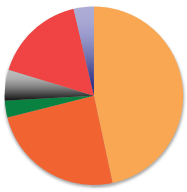
Nord – Pas-de-Calais 2013 (4 millions inhabitants)
New patients with onset before 65 y =1756 out of 6497 (27%)

Higher proportion of related/associated disorders in young patients

New patients < 65 y
With dementia n=396 (23%)
11% of all dementias



All new patients
With dementia n=3443 (53%)



Imaging

Structural imaging :

Global atrophy may be severe, but **hippocampal atrophy may be relatively less severe in young patients** compared to older patients (should not exclude the diagnosis of AD)

Frisoni et al, Brain 2007, Shibuya et al, Int J Geriatr Psychiatry 2013

Importance of psychiatric symptoms

- Frequent history of depression
- Apathy, Delusion, hallucinations, aggression
- **Frontal lobe syndrome** (FTLD and some EOAD)
- In addition to atypical age, and awareness of cognitive problems

→ Psychiatric misdiagnoses (depression +++ and psychosis) → diagnostic delay if no denial

Harvey et al., 1998 www.dementia.ion.ac.uk; Alzheimer's Australia report 2007; Garre-Olmo et al, Neurology 2010; van Vliet et al, Dement Geriatr Cogn Disord 2012

However : Molecular Imaging

- FDG-PET and HmPA0- SPECT : differences according to age : more diffuse and severe hypometabolism in YOD, especially in posterior regions, posterior cingulate
- PIB-PET : no difference according to age or higher PIB retention, similar burden in posterior cortical atrophy and diffuse Alzheimer's disease

Rabinovici et al, Brain 2010; Choo et al, Am J Geriatr Psychiatry 2011; de Souza et al, Brain 2011

Cerebrospinal Fluid (CSF)

- **No difference according to age** *:*

  ↘ Aβ Total, ↗Tau and Phospho-Tau

  even more discriminant in young patients

- No difference according to clinical features : instrumental predominance and focal atrophy or amnestic and spread

→ Young patients should be referred to tertiary centres

Bouwman et al, Neurobiol Aging 2009; Dumurgier et al, Neurobiol Dis 2013; Van de Flier et al, Lancet Neurol 2011; Moore et al, Can Fam Physician 2014

Caregivers of Young patients

- Main complaints:
  - **Behavioural changes** : excessive spending, addiction, impulsivity, apathy → professional, financial, social difficulties, dangerous driving, sometimes violence against spouse or children.
  - **Difficult communication.**
- Expressed needs :
  - **Early recognition and referral**
  - **Dedicated** day-care, temporary respite care or long term care facilities, and **financial support.**

Thomas et al, Int J Geriatr Psychiatr 2005; Arail et al Int J Geriatr Psy 2007 Alzheimer's Australia report 2007; Bakker et al, Am J Alz Dis & Other Dement 2010 Aramari et al AmJAlzDis & OtherDement 2012

Medico-social characteristics of YOD

Alzheimer PLAN 2008 › 2012 L'ENGAGEMENT DE TOUS

- Two measures of the French Alzheimer plan 2008-2012 dedicated to YOD (<60)
  - Measure 19: Setting a reference center for YOD
  - Measure 18: Accommodations for YOD

Caregivers of Young patients

- Observation:
  - Stunned by an unexpected diagnosis, often denied
  - « Sandwich generation »: caregivers sometimes responsible not only for their ill-spouse but also for their children, and their parents (or parents in law).
  - Often suffer from health problems
  - Exhausted, depressive, often under antidepressants and/or hypnotics
  - Have few respite
  - Anxious about heredity of the disease and end of life

Thomas et al, Int J Geriatr Psychiatr 2005; Wojtas et al, Can J Neurol Sci 2013

Measure 19: Multisite Reference Centre

Call for proposal, independent international committee

- Complementarities
  - LILLE-BAILLEUL: Coordinator

    Clinic, Management, Biology (CSF, plasma): ePLM network
  - ROUEN : Genetics of monogenic forms of AD: AD network
    - National coordinator for DIAN
  - PARIS-SALPETRIERE: Imaging, rare dementias, and national FTD network
- Linked with the 26 Memory Resources and Research Centres (follow-up of patients both by MRRCs and GP ± local specialists)

AIMS: care, management / public health, research, int. collaborat.

I - CARE

- **Raising awareness in professionals & general public**
  - Conferences, media, communications, reviews…
  - www.centre-alzheimer-jeunes.fr, http://www.alzheimer-genetique.fr
- **Improvement of diagnosis and genetic testing**
  - Identification of a **referent specialist** (neurologist) for YOD in each MRRC (n=26)
  - Continuous training, educational publications, ethics meetings (EREMA = Ethics in AD)
  - **Implementation of procedures in genetics** → 150 AD families and FTD families → DIAN GENFI, new mutations
  - In **CSF** sampling, in **imaging**
  - And in **neuropathology** AD-PATH

AIMS : II - Management

- **Accommodations for YOD: Course of actions**
  - **Documentary** filmed in places spotted by the survey as having an experiment in managing patient with YOD (support for raising awareness, discussion and training)
  - **Questioning:** Does the number of beds occupied by YOD patients meet the needs? Difficulties to enter such services? Inadequate offer?
    - Questionnaires analyses, visits and meetings on site (nurses, directors and practitioners), survey of services allowing dispensations, longitudinal survey of 110 YOD patients /caregivers
    - 2-day seminar with professionals experimented in caring YOD
    - 1 day meeting with YOD patients able to express their needs in public and who whished to be "actors of their life"
    - Literature analysis, other countries experience

→ Synthesis of the needs for YOD patients presented at a national meeting

II - Management

- **Identification of a referent** in each MRRC, social worker, psychologist, or nurse
- **Training of professionals** (with France Alzheimer)
  Publications for professionals, www.centre-alzheimer-jeunes.fr, http://www.alzheimer-genetique.fr
- **Support for caregivers**
  - Support groups, thematic day cares, specific programs, Week-ends for YOD patients and caregivers (UTB foundation), Web site, Brochure on YOD, Photographic work to de-stigmatize YOD and point out the specificity of different causes of dementia: "I still exist",
- **Procedures:** Mobiqual, Parcours, Long Visit (for GPs), Welcome in facilities
- **Measure 18**: Accommodations and facilities for YOD

Accommodations for YOD

- **Observations and synthesis of the needs**
  - YOD specificities disconcert and worry relatives as well as professionals
  - YOD patients are scarce and dispersed in nursing homes
  - Difficult relationship between the young patient(s) and the staff (distress, painful projection). **Need for training and support +++**
  - Before 60 y: very few patients, many with frontal lobe syndrome or severe behavioural disorders

II - Management

- **Measure 18: Accommodations for YOD**
  - To evaluate quantitative and qualitative needs – if specificities have been detected for accommodations for young patients (< 60 years)
    To synthesize propositions

Course of actions :

- **Epidemiological context**
- **National survey:** questionnaire sent to all collective accommodations possibly receiving individuals with YOD (including nursing home for people aged > 60 allowing special dispensation for younger patients) and psychiatric yards (n > 10,000)
  - Out of 2,400 young patients (<60 y) living in collective accommodations at that time, 220 suffered from ADAD

Lettre de l'observatoire n° 21 Sept2011 fondation-mederic-Alzheimer.org

Accommodations for YOD

- **Observations and synthesis of the needs**
  - 3 situations needing an entry in a collective setting:
    - 1) Loss of autonomy (socially isolated or whish to protect the family) ; New needs, a lot of expectations
    - 2) "Behavioural crisis" whatever the cause (depression, delirium, inappropriate behaviour/ exhaustion of the family, social issues…) need for medical and social services, revised care plan
    - 3) Long term accommodation for severe behavioural troubles or somatic problems (difficulties with swallowing…), and too many interventions impossible at home
  - Many services already appropriate, however age was often the cause of supplementary distress
  - Limitations: focused on Alzheimer's disease and related disorders
  - Specific situation of patients with mental retardation i.e. Down syndrome

Accommodations for YOD

- **Orientations**
  - Help and support for life at home
  - Conciliate specialisation and proximity
  - Remove barriers at entry in close existing facilities willing to welcome a young patient
  - Spread care practices to all teams facing this unusual situation : role for the reference centre: running an expert network of duos (doctor + nurse) and social workers
  - A few specific accommodations for a small number of very specific patients (resource centre as well as place for training professionals from other teams) – + a few experimentations
  - Identification of facilities welcoming YOD patients: a list is available on www.centre-alzheimer-jeunes.fr and regularly updated
  - Participative training meetings, sharing of practices, regional and national once a year (project of an internet forum)

IV – International collaborations

- **DIAN** Dominant Inherited Alzheimer's disease Network
- **GENFI-2 :** Genetic FTD Initiative
- **EADC** European Alzheimer's Disease Consortium
  - European Early-Onset Dementia consortium
- **ANR/FRSQ** programme**: AMAJ** Aide aux Malades Alzheimer jeunes
- **JPND** Joint Programing on Neurodegenerative Diseases
  - CSF, PPI (Patient Public Involvement)
- Task Force of the IPA (international Psychogeriatic Association)

Accommodations for YOD

- **5 points to be given priority in nursing homes that welcome young patients:**
  - Need for a precise diagnosis (collaboration with tertiary memory clinics)
  - How to accompany a young patient with a frontal lobe syndrome?
  - Activities to be offered to young patients in a nursing home
  - Support to families and relatives of young patients in nursing homes
  - End of life of young patients in nursing homes

Conclusions

- Long delay between 1st symptoms and diagnosis made at a more severe stage
- Socio-professional, family and financial impact
- Lack of specific facilities (nursing home, respite care) and trained professionals
- Genetic concerns:10% in EOAD (vs < 2% in LOAD) ; ≈ 40% in FTLD
- Important research challenge
  - Target of disease-modifying treatments, wilful population to participate in research
- **The needs of young patients of today are those of older patients in the future**

III - Research

- **Cohorts : COMAJ** (n= 270)
  - and G-MAJ, Parcours, IMAP+, AMABIO3
- **Identification of new genes, ANR on imaging**
- **Identification of risk factors**
- **Participation in studies in Social and Human Sciences** including an economic survey with Médéric Alzheimer Foundation*www.fondation-mederic-alzheimer.org/content/download/18759/83735/file/RAPPORT%20ESEMAJ%20FINAL.pdf*

Florence Lebert

Adeline Rollin-Sillaire

Dominique Campion Didier Hannequin David Wallon

Bruno Dubois Isabelle Le Ber

French organization of care for patients with Young Onset Dementia

florence.pasquier@chru-lille.fr

- Autosomal dominant forms of AD are a great model to develop disease-modifying drugs (cf. DIAN, GENFI), but:
  - Is the physiopathology the same whatever the mutations and similar to sporadic multifactorial cases?
  - Ethical issues
- Monogenic mutations account for 10% of EOAD (< 2% of LOAD) and 20-40% of FTD
- Important to understand why sporadic cases have a large range of onset. It would lead to strategies to delay the disease(s).
- Important not to miss atypical phenotypes
- Need for research in Human and Social Sciences

Advocacy for research in YOD (and not only familial YOD)

Difficult diagnosis ?

- Biological and imaging studies give confidence in the diagnosis of AD, even when clinical features and age at onset (before 60) are not typical
- Young patients (and families) often in favour of autopsy to confirm diagnosis and to help research → helpful to validate biomarkers.
- Neuropathology does not differ in EOAD and LOAD
  - vascular burden higher in LOAD and genetic burden higher in EOAD

Young patients usually:

- Have no other disease, co-morbidities, other medications
  - Especially have no (or less) vascular disorders, and cerebrovascular lesions
- Are willing to participate in research programmes, as well as their family, mainly spouse, often pro-active, well organised
  - YOD patients are actually are overrepresented in patients participating in clinical research
- Can be a lobby, because they are still in active life (even if they have ceased working)
- Are not afraid of new examinations, or technologies
- Move, are not reluctant to travelling (e.g. to go to an expert centre)
- Are not resigned, are not accepting the disease
- Are less at risk of attrition in longitudinal studies (do not give up)

and so far are excluded from clinical and pharmaceutical studies because of their young age!

Role of young patients

- The (relatively rare) young patients of today are representative of what will be the much more numerous 'old' patients of tomorrow in terms of habits, likes and dislikes, abilities and skills (e.g. transportation mastering, information technology, communication, electronic devices…).
- In studying this population we could anticipate the future needs the society will have to face.
- International collaborations mandatory!

From labels to legacy: deepening our understanding and caring for dementia

Peter J. Whitehouse MD-PhD
Professor, Case Western Reserve University and University of Toronto
President, Intergenerational Schools International

Dementia is a changing label

Japan and Asia from Chiho to Ninchisho

American psychiatry Major Neurocognitive Disorder

Thanks to the Alzheimer Society of Canada

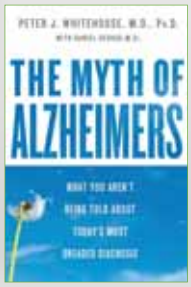
Labels –"timely" diagnosis of what and for what purpose?

- Dementia
- Alzheimer's
- Mild Cognitive Impairment
  - Pre
  - Early
  - Late
- Preclinical or symptomatic Alzheimer's
- Subjective Cognitive Impairment
- **Aging Associated Cognitive Challenges**

Alzheimer's is an outmoded concept, maybe even a cognitively challenged one

G7 process is ending ("curing") Alzheimer's disease as a label by rightfully focusing on broader concept of dementia

What is the Myth of Alzheimer's?



- Alzheimer's is heterogeneous i.e. not a single disease
- Alzheimer's is related to severe brain aging – perhaps the same processes

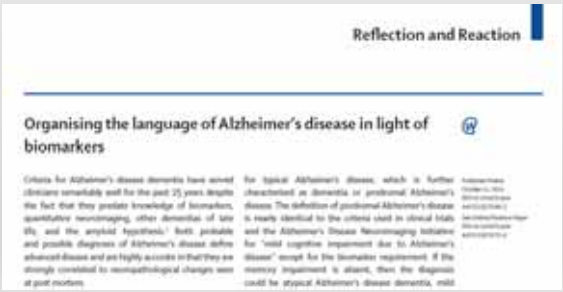
Implications

- Cure or cures will be perhaps impossible, especially practically
- Care, community, prevention and public health will be key

www.themythofalzheimers.com

Neuropathology – not definite but "disengaged" –Brad Hyman but "it's aging"

Alzheimer's Language Games
Is it "just" aging?

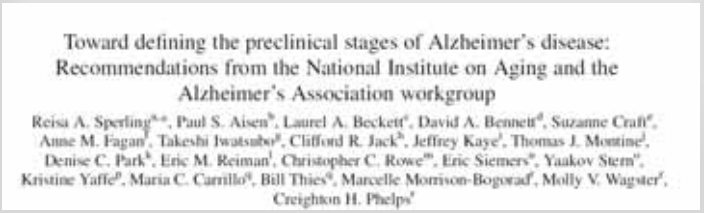


Reflection and Reaction

Organising the language of Alzheimer's disease in light of biomarkers

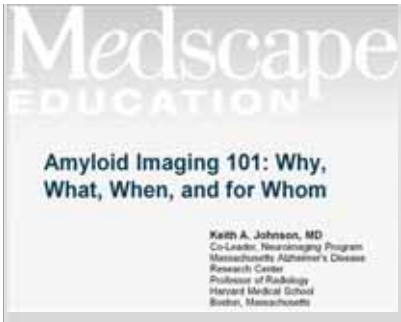
Biomarkers are unproven in many ways but being promoted

Asymptomatic Alzheimer's disease – Reisa Sperling (but "its aging")



Toward defining the preclinical stages of Alzheimer's disease: Recommendations from the National Institute on Aging and the Alzheimer's Association workgroup

Reisa A. Sperling[a,*], Paul S. Aisen[b], Laurel A. Beckett[c], David A. Bennett[d], Suzanne Craft[e], Anne M. Fagan[f], Takeshi Iwatsubo[g], Clifford R. Jack[h], Jeffrey Kaye[i], Thomas J. Montine[j], Denise C. Park[k], Eric M. Reiman[l], Christopher C. Rowe[m], Eric Siemers[n], Yaakov Stern[o], Kristine Yaffe[p], Maria C. Carrillo[q], Bill Thies[q], Marcelle Morrison-Bogorad[r], Molly V. Wagster[r], Creighton H. Phelps[r]



Basic science is Alzheimer's/dementia is in trouble –scientifically and morally

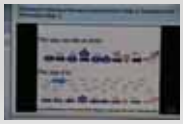
Mice get Mouseheimer's disease, not Alzheimer's disease

Problems of replicability

Problems of fame and fortune

Age and dementia-friendly communities movements

Alzheimer's Disease Research Summits NIH May 2012 and Duke November 6, 2014 Cure or even effective treatment by 2020?



Nov. 6 conference at Duke will allow both national experts and concerned laypeople to catch up on the use of stem cells in Alzheimer's research, a direction that is showing promise.

Japan -Omuta City

Care is not something we only do while waiting for a cure

Only politicians and those trying to raise money talk about cure as realistic in any time span but especially short…

And what would "cure" look like, back to "normal"?

Germany - Arnsberg

Person (with dementia and otherwise) -friendly communities are what we need

Schools are essential to community and human flourishing

Intergenerational relationship and story-based learning is the most powerful

Literacy and especially ecoliteracy is essential to human survival

Qualitative results

Quality of life:

Main themes	Sub themes
Perceived health benefits	Reduced stress and depression Youthful energy Cognitive stimulation
Sense of purpose and sense of usefulness	Role continuation Reminiscence Joy of teaching children
Relationships	Physical touch Proxy grandchildren Racial reconciliation Acceptance Reciprocity

The Intergenerational School

Grew from 30 to 240 K-8 Students
95% African American
65% Poverty rate

Last year served 330+ adult learners

Consistently one of the top performing charter schools in Ohio

Internationally and nationally recognized for intergenerational programs and student success

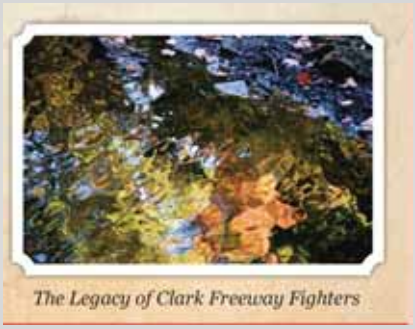
www.tisonline.org

"Concert offers different take on Alzheimer's disease" Cleveland Plain Dealer
Enhancing the role of art, music, and dance

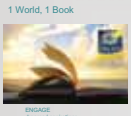
Intervention

Legacy Projects

Freeway Fighters
1960's environmental activists



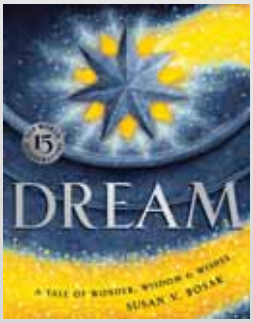
Legacy Center Toronto



YOU 177

YOU 177 is a r/evolution in the way we think and solve problems that strategically empowers and connects youth, adults, and elders of all ages and abilities for inspired lives, stronger communities, and a sustainable world. 1 World, 7 Generations, 7 Billion People and YOU.

www.legacyproject.org



World Dementia Council lead by
World Dementia Envoy –what will the **legacy** of the G7 be?

"Think like a mountain" – a powerful metaphor to rethink dementia

- What is **aging** (in community) about?
- How can **science** contribute to **life**?
- How central is the **brain** to thinking and valuing?
- What does it mean to be a mortal **human being**?

Global prevalence of dementia and prevention strategy

Martin Prince

Centre for Global Mental Health
King's College London
1066drg@iop.kcl.ac.uk

Why is risk reduction important?

Alzheimer's Disease International
The global voice on dementia

World Alzheimer Report 2014

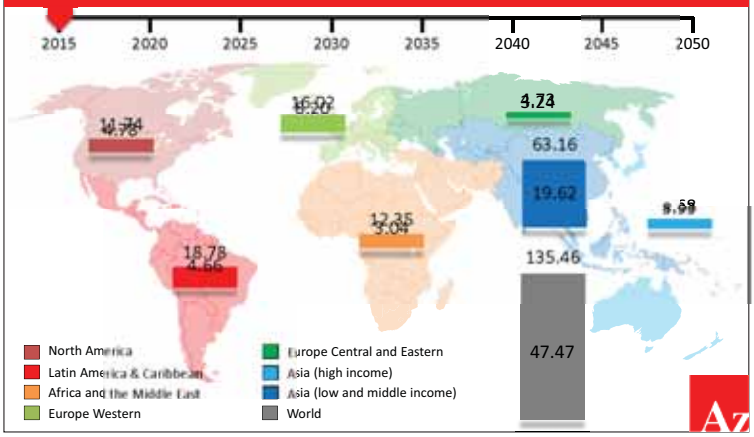
Dementia and Risk Reduction

AN ANALYSIS OF PROTECTIVE AND MODIFIABLE FACTORS

Global Observatory for Ageing and Dementia Care

Martin Prince
Emiliano Albanese
Maelenn Guerchet
Matthew Prina

Numbers of people with dementia by world region (2015-2050)

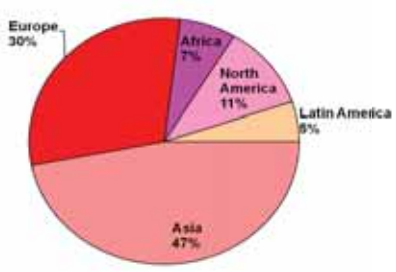


KING'S College LONDON

Global Observatory for Ageing and Dementia Care

Alzheimer's Disease International

Global Distribution of Incident Dementia (7.7 million new cases per year)

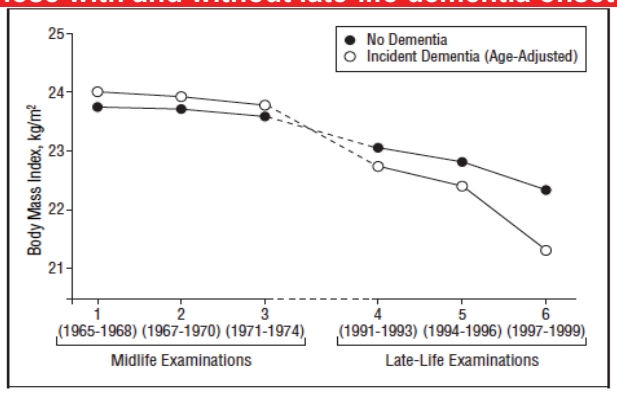


One new case every 4 seconds!

WHO Report 2012 – Dementia a Public Health Priority

Background – concept and methods

Changes in body mass index from mid to late-life for those with and without late-life dementia onset



Stewart et al. *Arch Neurol.* 2005

Risk factors and causes

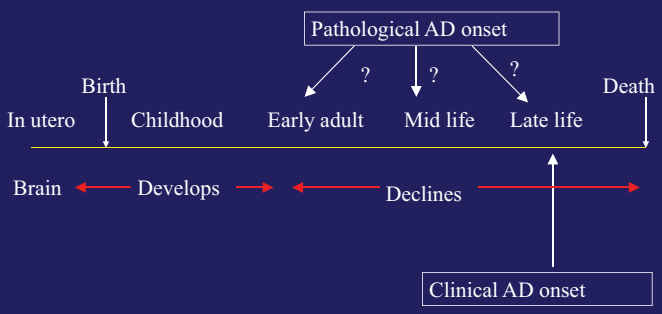
- If A is associated with B, this does not demonstrate that A causes B
  - Chance
  - Bias
  - Confounding
  - Reverse causality
- Sources of evidence
  - Longitudinal cohort studies (bias and reverse causality)
  - Randomised controlled trials (confounding)
  - Systematic reviews and meta-analyses (consistency)
  - Biological studies (mechanisms)

What did we do?

- Determined the scope
- Appointed review groups

- Identified reviews
- Read all the papers
- Updated the search
- Critically appraised the evidence
- Considered need for new systematic review/ meta-analysis
- Summarised the evidence – consistency/ strength

A lifecourse perspective



Domains (lifecourse)

- Developmental and early-life factors
- Psychological factors
- Lifestyle
- Cardiovascular risk factors

Key findings

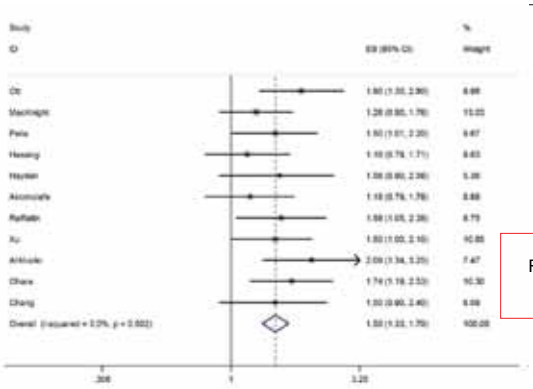


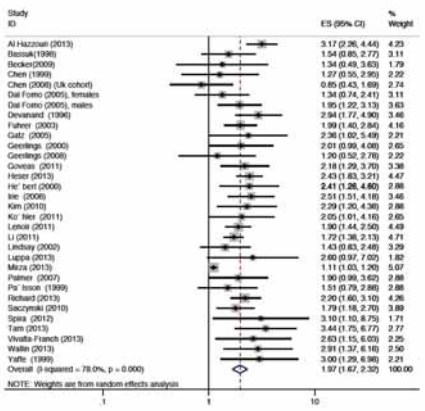
Figure 5.1

Forest plot for the association of diabetes in late-life with the incidence of any dementia (AnyDem)

RR 1.50 (1.33-1.70)
Heterogeneity 0%

Figure 3.1

Meta analysis for the unadjusted effect of depression on the risk of incident dementia



RR 1.97 (1.67-2.32)
Heterogeneity 78%

Robust findings

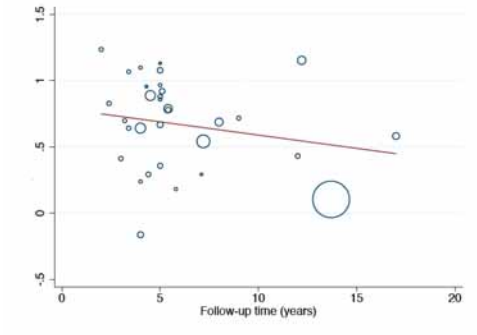
Exposure	Period
Education	**Early life**
Hypertension	**Midlife**
Diabetes	**Mid- to late-life**
Smoking	**Mid- to late-life**

Reverse causality?

(Bigger effect of depression with shorter follow-up periods)

Figure 3.2

Meta regression exploring the effect of length of follow-up on the risk of incident dementia



Mechanisms

- Cognitive/ brain reserve (education)
- Vascular disease (hypertension, smoking, diabetes)
  - Additive effect in combination with AD pathology?
  - Interactive effect promoting AD pathology?
  - Other (non-vascular) effects on AD pathology?

What have we achieved?

- We started with a long list of potential risk factors
- We have reduced these to just four where the evidence is strongest
- This does not mean that other factors may not also be modifiable risk factors
  - Less consistent evidence
  - Insufficiently studied
  - No/ few long-term cohort studies (reverse causality)
  - Confounding or bias likely explanations
  - Need for RCTs where feasible

Future Research

- Dementia as an outcome
- Systematic reviews and meta-analyses
  - More collaboration using primary data
  - Standardisation (harmonisation)
  - Quality control (!)
  - Open source documentation
- RCTs in late-life
  - Diabetes (glycemic) control
  - Physical activity
  - Cognitive stimulation
  - Micronutrient deficiency
  - Complex interventions for at risk groups (www.edpi.org)
- Monitoring the course of the epidemic

The greatest obstacle to discovery is not ignorance – it is the illusion of knowledge

Daniel J. Boorstin

PREVENTING DEMENTIA: CAN WE DO BETTER?

Vladimir Hachinski, CM, MD, FRCPC, DSc
Department of Clinical Neurological Sciences
University of Western Ontario, London, Ontario

THE EFFECT OF DIFFERENT DIAGNOSTIC CRITERIA ON THE PREVALENCE OF DEMENTIA

Canadian Study of Health and Ageing (n=1879)	
DSM-111	29.1%
DSM-III-R	17.3%
DSM-IV	13.7%
ICD-9	5.0%
ICD-10	3.1%

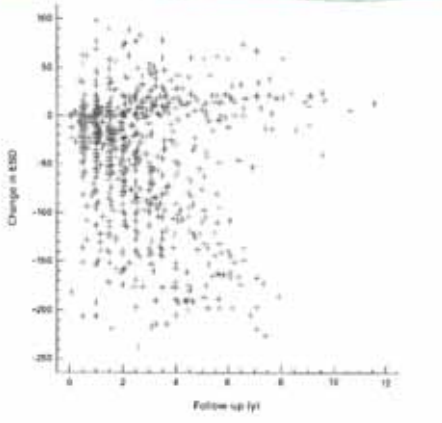
Erkinjuntti T et al. N Engl J Med 1997;337:1667-74

PREVENTING DEMENTIA: CAN WE DO BETTER?

I ACKNOWLEDGING REALITY

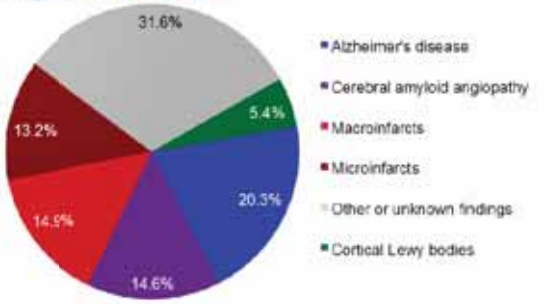
II FOCUSING ON THE TREATABLE, VASCULAR COMPONENT

III TRYING NEW, MULTIMODAL INTEGRATED APPROACHES



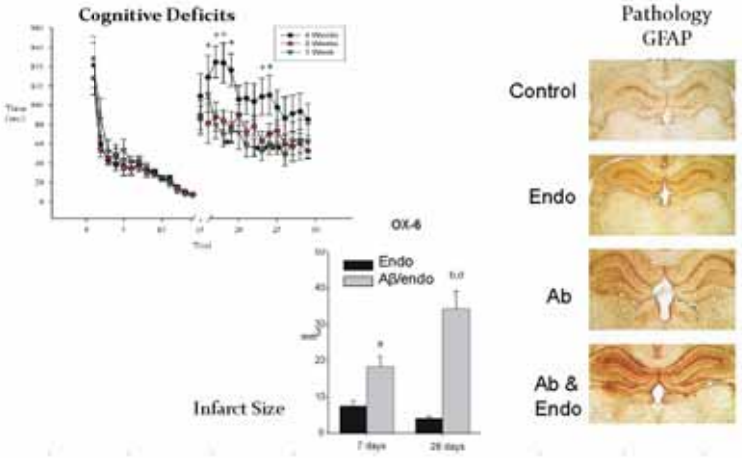
Follow-up of patients initially diagnosed as having Alzheimer disease clinically, but neuropsychic testing and brain imaging

Percent Population Attributable Risk of Dementia of Vascular and Non-Vascular Pathological Findings



Hachinski & Sposato (unpublished)

Preliminary Data and Survivability



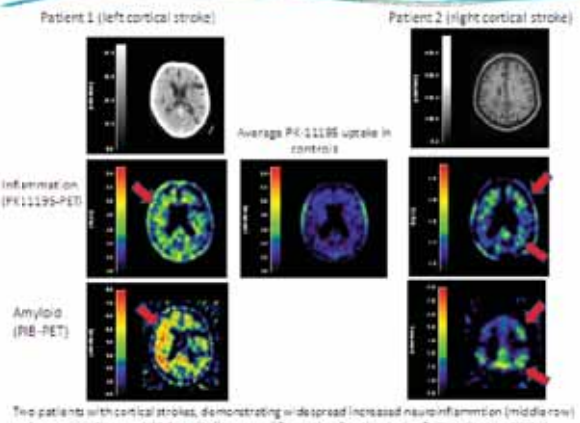
Original Contributions

National Institute of Neurological Disorders and Stroke-Canadian Stroke Network Vascular Cognitive Impairment Harmonization Standards

Vladimir Hachinski, MD, DSc; Costantino Iadecola, MD; Ron C. Petersen, MD, PhD; Monique M. Breteler, MD, PhD; David L. Nyenhuis, PhD; Sandra E. Black, MD; William J. Powers, MD; Charles DeCarli, MD; Jose G. Merino, MD; Raj N. Kalaria, PhD, FRCP; Harry V. Vinters, MD; David M. Holtzman, MD; Gary A. Rosenberg, MD; Martin Dichgans, MD; John R. Marler, MD; Gabrielle G. Leblanc, PhD

Background and Purpose—One in 3 individuals will experience a stroke, dementia or both. Moreover, twice as many individuals will have cognitive impairment short of dementia as either stroke or dementia. The commonly used stroke scales do not measure cognition, while dementia criteria focus on the late stages of cognitive impairment, and are heavily biased toward the diagnosis of Alzheimer disease. No commonly agreed standards exist for identifying and describing individuals with cognitive impairment, particularly in the early stages, and especially with cognitive impairment related to vascular factors, or vascular cognitive impairment.

Stroke. 2006;37:2220-2241



Two patients with cortical strokes, demonstrating widespread increased neuroinflammation (middle row) and corresponding amyloid deposits (lower row) 3 months after the stroke. Both patients exhibited lasting post-stroke cognitive impairment.

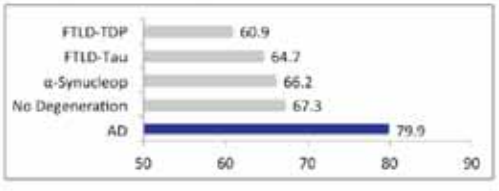
Thiel A. et al. 2013 (unpublished)

Contribution of Cerebrovascular Disease in Autopsy Confirmed Neurodegenerative Disease Cases

National Alzheimer's Coordinating Centre Database 6 205 autopsy cases

Prevalence of Vascular Pathology (%)

Vascular findings reaching or not a threshold sufficient enough to contribute to clinical status



Toledo JB, Arnold SE, et al. Brain 2013;135:2697-2706

PREVENTING DEMENTIA: CAN WE DO BETTER?

I ACKNOWLEDGING REALITY

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Main Proposed Risk & Protective Factors Common for Stroke & Dementia

Non-modifiable	Modifiable	
Risk Factors	**Risk Factors**	**Protective Factors**
Advanced age	Cerebrovascular disease/stroke	High education
Genetic factors (Apo E4)	Cardiovascular diseases	Physical activity
Family history	Hypertension	Active lifestyle
	Hypercholesterolemia	Alcohol consumption
	Obesity	Antioxidants
	Diabetes	Fish oils
	Smoking	Antihypertensives
	Homocysteine	Statins
	Pyschosocial stress/depression	
	Atrial fibrillation **(added)**	Anticoagulation **(added)**

Kivipelto and Solomon. Eur Neurol 2008

3 STEPS IN PREVENTION

RISK ⇆ **MOTIVATION**
Personality
Decision stage

⇆ **ENABLEMENT**
School/Work
Communities
Harnessing technologies and social media
Environment

….no RCT's that investigated overall blood pressure control, weight reduction, smoking cessation or other interventions related to reduction of vascular risk factors that may…….reduce cognitive decline

Naqvi R. et al. CMAJ 2013;185:881-885

PREVENTING DEMENTIA: CAN WE DO BETTER?

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PARTNERS

A Canadian Multi-Center, Randomized, Controlled, Open-Labeled, Blinded Adjudication Clinical Trial

Current Status of Dementia and Challenges in China

Piu Chan, MD PhD
Xuanwu Hospital
Capital Medical University
Beijing, China

Arch Neurol. 2005;62(3):447-453. doi:10.1001/archneur.62.3.447

3.5% (3.0%-3.9%) or 4.8% (after post hoc correction for negative screening errors) for older than 65

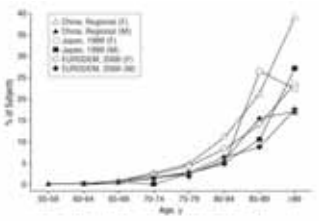
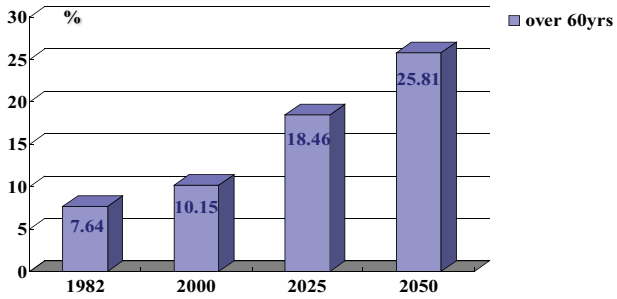


Figure Legend:

Age- and sex-specific prevalence of Alzheimer disease in China (present study) compared with east Asian (Japan, 1999) and Western (European Community Concerted Action on the Epidemiology and Prevention of Dementia Group [EURODEM], 2000) studies.

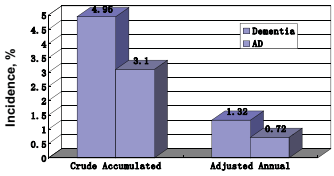
Population Ageing in China:

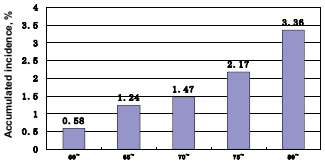
past, present and future



The Fifth National Population Survey, 2002

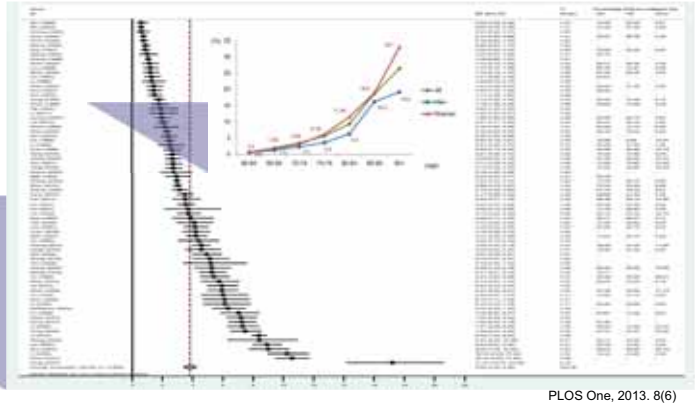
Incidence of Dementia and Alzheimer's Disease (1997-2000)





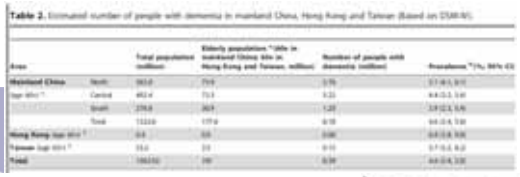
Beijing Longitudinal Study on Aging I (BLSA-I)

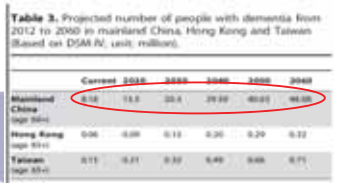
Dementia Prevalence in Chinese



PLOS One, 2013. 8(6)

Estimated Number of Dementia Patients



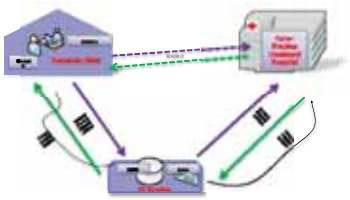


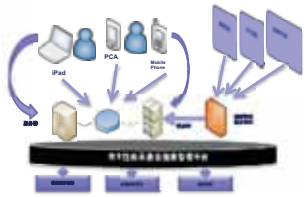
PLOS One, 2013. 8(6)

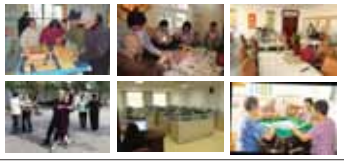
Challenges China is Facing

- China is facing a new epidemic of unprecedented increase of population ageing and burden associated with dementia
- Societal costs will rise inexorably, driven by the increasing need for long term care
- Limited number of specialized dementia clinics
- Limited number of family doctors and GPs, & lack of specialized training on caring dementia patients
- Limited beds and nursing homes and experienced care takers
- Lack of specialized dementia nursing homes
- Change of family structure with 4:2:1 and even 8:4:2:1 families

Building Integrated Model for Care & Prevention





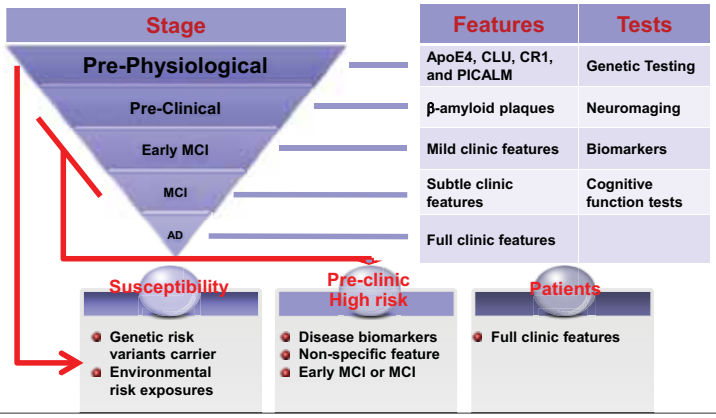


Time for Action

- Clinical care
  - ✓ Promoting awareness of dementia in the community
  - ✓ Establishing more dementia clinics & guideline
  - ✓ Increased coverage of drugs & included in special schemes of insurance
  - ✓ Building more specialized dementia nursing homes
  - ✓ Establishing the integrated "Care and Nursing Combined Community Hospitals"
  - ✓ Programs to train more GPs and care takers
- Social policy
  - ✓ National Day on Dementia
  - ✓ Enforcing laws on responsibility of caring elderly
  - ✓ Promoting commercial insurance and increased investment on research and care
- Prevention
  - ✓ Promoting research for early diagnosis and intervention
  - ✓ Comprehensive programs including community health and rehab centers, and community activities

Thanks!

Screening Programs and Dementia Clinic



Detection of preclinical Alzheimer's diseas for the preemptive therapy

National Center for Geriatrics and Gerontology
Center for Development of Advanced Medicine for Dementia
Katsuhiko Yanagisawa

A tangled web of targets

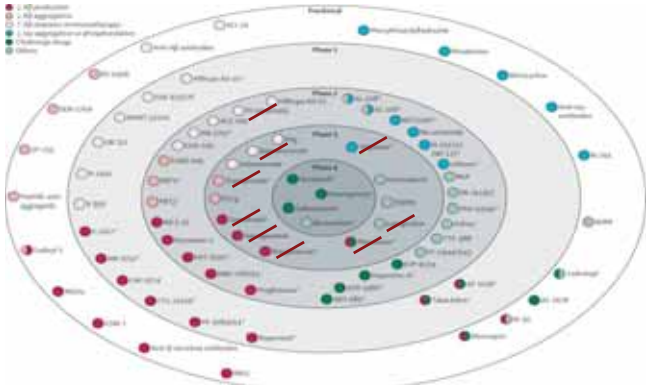
Drugs in development for Alzheimer's disease take aim at a variety of neural mechanisms. But despite a wealth of possibilities, there have been few successes. *Lauren Gravitz*

Illustration by Gracia Lam *Nature 475, S9, 2011*

Stop Alzheimer Disease Before It Starts !

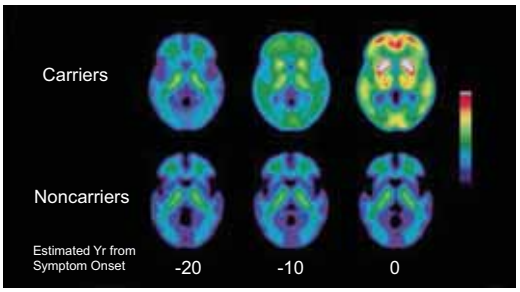
Greg Miller, Science 337, 790-792, 2012

too late for therapeutic intervention

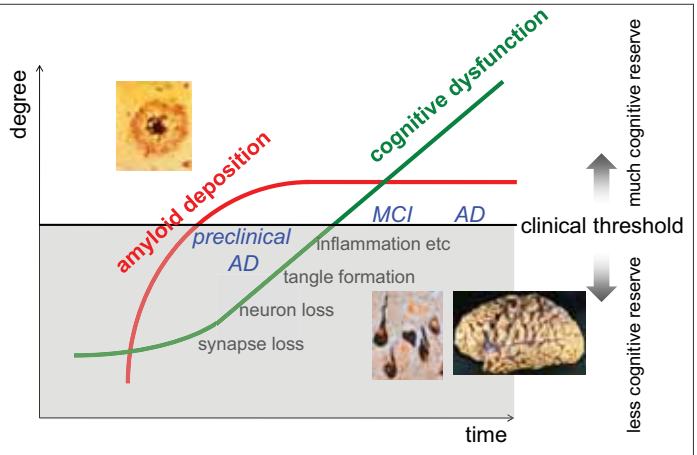


Mangialasche et al., Lancet Neurology, 9:702-716, 2010

PiB-amyloid imaging on PET
- Study on familial Alzheimer disease -

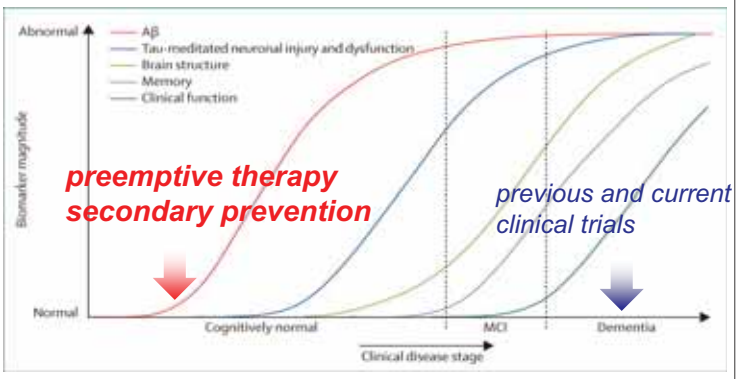


Bateman et al, New Engl J Med, 367: 795-804, 2012



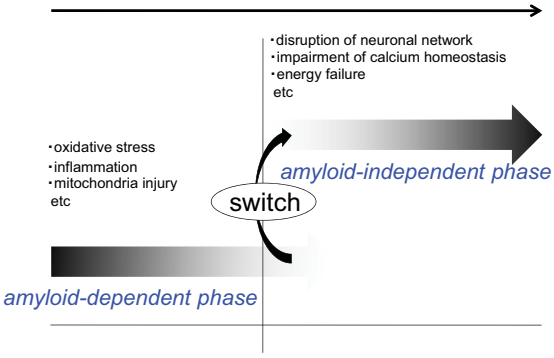
Yanagisawa, Cognition and Dementia, 2012

Pathological stage of Alzheimer Disease



Modified Jack et al. The Lancet Neurology, 2010

Alzheimer Disease

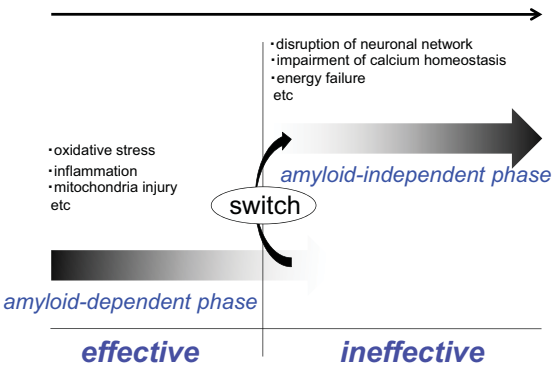


modified from Yanagisawa. Igaku-no-Ayumi 239: 379-382, 2011

Alzheimer Disease

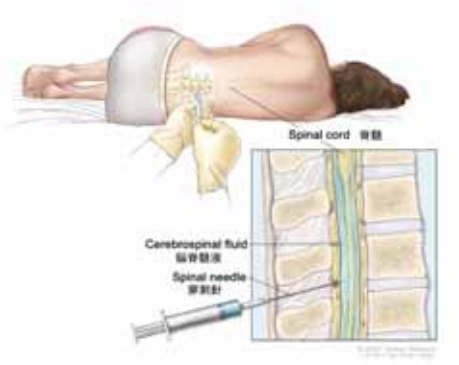
How should you know the pathological change before clinical onset?

Alzheimer Disease



anti-amyloid therapy

Cerebrospinal fluid examination

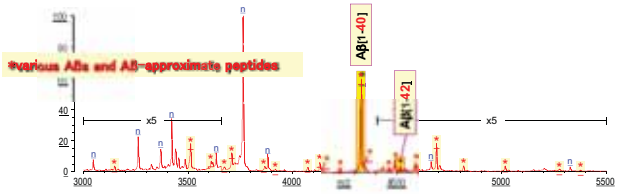


(Yahoo Japanより取得)

Amyloid imaging on PET

Novel procedure to detect Aß from plasma using mass spectrometry

Kaneko et al., Proc. Jpn. Acad. Ser. B, 104-117, 2014

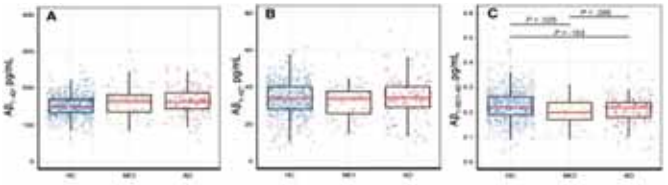


Plasma!

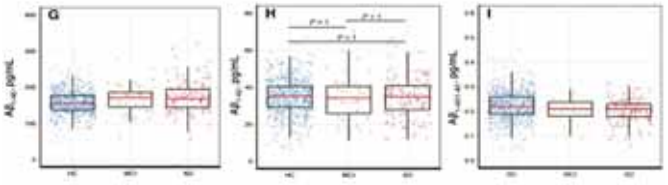
obtained from Yahoo Japan

Plasma amyloid ß-proteins

Baseline



18-months later



Rembach A et al., Alzheimer's and Dementia,10: 53-61, 2014

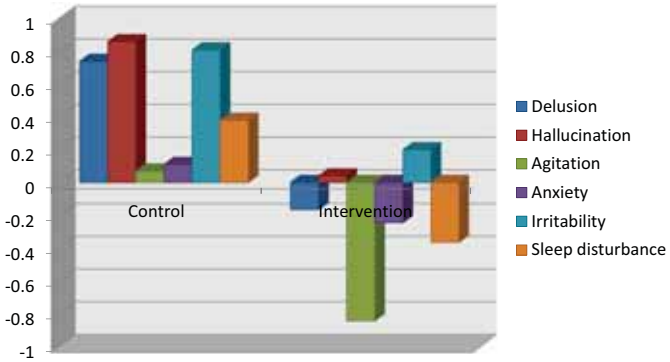
Dementia Prevention Study and Policy in Taiwan

Liang-Kung Chen, MD, PhD
Professor and Director, Aging and Health Research Center, National Yang Ming University;
Director, Center for Geriatrics and Gerontology, Taipei Veterans General Hospital

Non-pharmacological treatment reducing not only behavioral symptoms, but also psychotic symptoms of older adults with dementia: A prospective cohort study in Taiwan

Rue-Chuan Chen,[1,2] Chien-Liang Liu,[3] Ming-Hsien Lin,[1,2] Li-Ning Peng,[1,2] Liang-Yu Chen,[1,2] Li-Kuo Liu[1,2] and Liang-Kung Chen[1,2]

[1]Aging and Health Research Center, National Yang Ming University, [2]Department of Family Medicine, Taipei City Hospital Zhongxiao Branch, and [3]Center for Geriatrics and Gerontology, Taipei Veterans General Hospital, Taipei, Taiwan



Chen RC., Geriatr Gerontol Int 2014;14:440-6

Identifying residents at greater risk for cognitive decline by Minimum Data Set in long-term care settings

Liang-Yu Chen, MD [a, b, c], Li-Kuo Liu, MD [a, c, d], Li-Ning Peng, MD [a, b, c], Ming-Hsien Lin, MD [a, c], Liang-Kung Chen, MD, PhD [a, b, c, *], Chung-Fu Lan, MD, PhD [e], Po-Lun Chang, MD, PhD [d]

[a] Aging and Health Research Center, National Yang-Ming University, Taipei, Taiwan
[b] Institute of Public Health, National Yang-Ming University, Taipei, Taiwan
[c] Center for Geriatrics and Gerontology, Taipei Veterans General Hospital, Taipei, Taiwan
[d] Institute of Biomedical Informatics, National Yang-Ming University, Taipei, Taiwan
[e] Institute of Health and Welfare Policy, National Yang-Ming University, Taipei, Taiwan

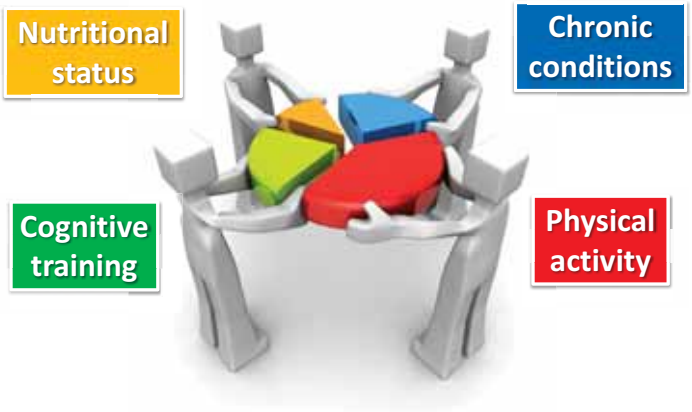
Table 2
Factors associated with cognitive decline by multivariate analysis.[a,b]

Variables	Decline		
	Odds ratio	95% confidence interval	*p*
Age (y)	1.061	1.008–1.115	0.023*
Cancer	1.613	0.304–8.547	0.574
Chronic lung disease	1.018	0.448–2.309	0.966
RUG-III ADL	1.111	1.008–1.225	0.034*
RAP trigger for cognitive loss/dementia	3.774	1.825–7.813	<0.001*
Sum of RAP triggers	1.188	1.046–1.349	0.008*

Physical function is a good predictor for cognitive decline

Chen LY, et al., J Clin Gerontol Geriatr (in press)

Integrated approach is needed



LATE-LIFE METABOLIC SYNDROME PREVENTS COGNITIVE DECLINE AMONG OLDER MEN AGED 75 YEARS AND OVER: ONE-YEAR PROSPECTIVE COHORT STUDY

C.-L. LIU[1,2], M.-H. LIN[1,2], L.-N. PENG[1,2], L.-K. CHEN[1,2], C.-T. SU[3,4], L.-K. LIU[1,2], L.-Y. CHEN[1,2]

1. Aging and Health Research Center, National Yang Ming University, Taipei, Taiwan; 2. Center for Geriatrics and Gerontology, Taipei Veterans General Hospital, Taipei, Taiwan; 3. Department of Family Medicine, Taipei Medical University Hospital; 4. School of Public Health, College of Public Health and Nutrition, Taipei Medical University, Taipei, Taiwan.
Corresponding author: Dr. Liang-Kung Chen, Center for Geriatrics and Gerontology, Taipei Veterans General Hospital, No. 201, Sec. 2, Shih-Pai Road, Taipei, Taiwan 11217.
TEL: +886-2-28757830; FAX: +886-2-28757715; Email: lkchen2@vghtpe.gov.tw

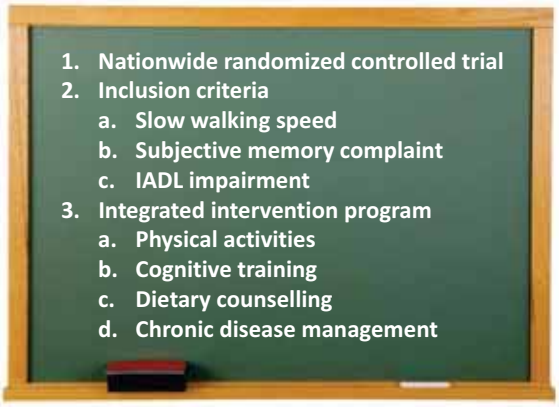
Table 2
Comparisons of cardiometabolic risk factors between subjects with and without cognitive decline (Cog-D)

	Cog-D (+) (N=43)	Cog-D (-) (N=186)	P-value
Age (yr)	83.8±4.2	82.1±4.2	0.020*
Current smoking (%)	10(23.3)	49(26.3)	0.330
Hypertension (%)	30(69.8)	107(57.5)	0.168
Diabetes mellitus (%)	12(27.9)	40(21.5)	0.419
ATP III-defined Metabolic syndrome (%)	7(16.3)	44(23.7)	0.299
IDF-defined Metabolic syndrome (%)	7(16.3)	34(18.3)	0.775
Body mass index (kg/m²)	23.6±3.2	23.8±3.3	0.673
Waist circumference (cm)	86.9±7.9	85.6±9.3	0.430
Systolic blood pressure (mmHg)	135.8±20.8	138.4±22.1	0.479
Diastolic blood pressure (mmHg)	66.7±12.7	71.5±13.9	0.040*
Fasting plasma glucose (mg/dL)	110.1±29.4	105.8±34.5	0.446
Serum total cholesterol (mg/dL)	167.6±29.2	182.8±36.5	0.011*
Serum triglyceride (mg/dL)	114.7±59.0	128.6±67.2	0.215
Serum HDL-C (mg/dL)	55.5±13.2	60.0±15.0	0.072

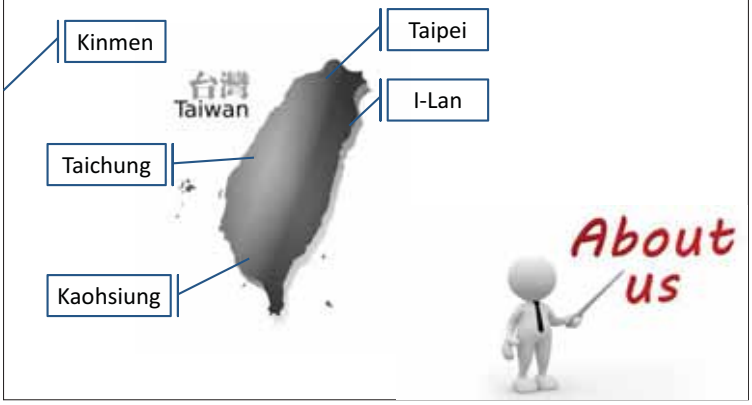
Good nutrition is protective

Liu CL, et al., J Nutr Health Aging 2013;17:523-6

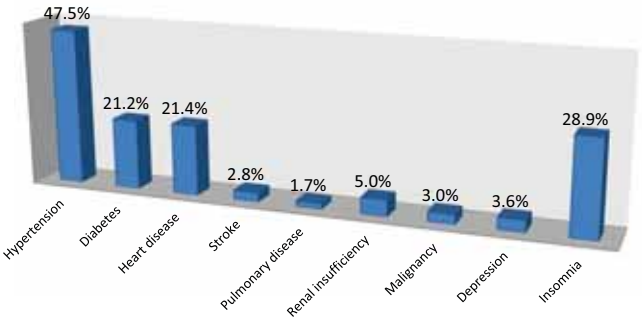
Taiwan Health Intervention Study on Community-dwelling Elders (THISCE)



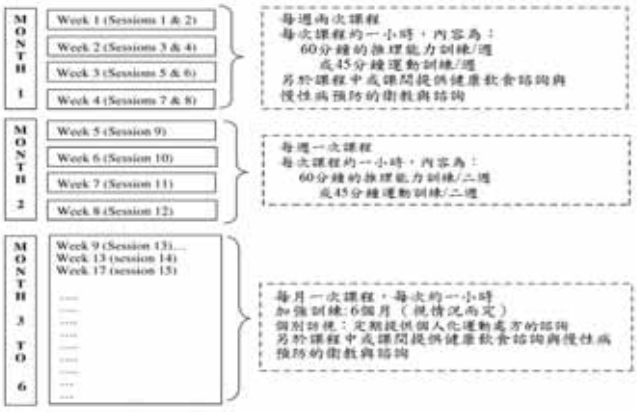
Taiwan Health Intervention Study on Community-dwelling Elders (THISCE)



Chronic conditions



Study flowchart



Cognitive training

1. Memory training + Deductive function training
2. Group-based and person-based
3. Frequency
   a. Twice a week, 8 courses in the 1st month
   b. Once a week, 4 courses in the 2nd month
   c. Once a month up to 6th month
   d. Education for home maintenance training

Baseline demography

- 1191 community-dwelling older people participated
  - Female dominant (63.6%)
  - Age: 75.1 ± 8.0 years
  - Formal education year: 2.1 ± 1.6 years
  - IADL score: 7.1 ± 1.4
  - MNA-SF: 13.2 ± 1.2
  - TGDS-5: 0.4 ± 0.9
  - 6m walking speed: 0.92 ± 0.34 m/s
  - Grip strength: 28.7 ± 8.4 Kg for men; 17.4 ± 4.9 Kg for women
  - MoCA: 19.9 ± 5.9 adjusted for education

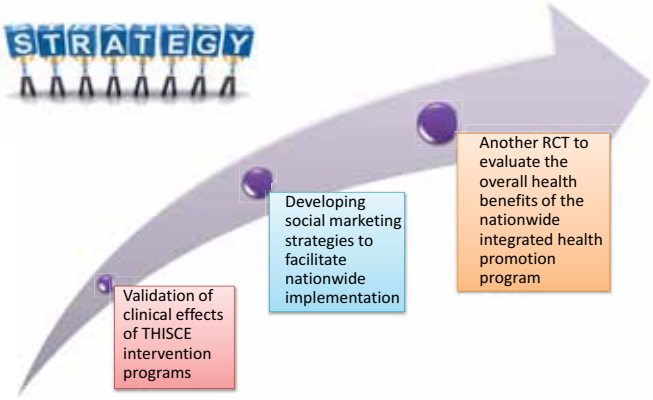
Old old people with low education and some cognitive impairment and certain degree of physical frailty

Exercise training

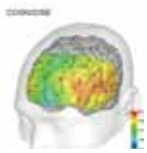
1. Resistance exercise-based program
2. Accumulated dose: 150 minutes per week
3. Frequency
   a. Twice a week, 8 courses in the 1st month
   b. Once a week, 4 courses in the 2nd month
   c. Once a month up to 6th month
   d. Education for home maintenance training

Diet and chronic conditions

National implementation strategy



Liang-Kung Chen, MD, PhD
Professor and Director, Aging and Health Research Center, National Yang Ming University, TAIPEI, TAIWAN
Director, Center for Geriatrics and Gerontology, Taipei Veterans General Hospital, TAIPEI, TAIWAN
Email: lkchen2@vghtpe.gov.tw



A Scheme for Preventing Cognitive Decline in the Community

National Center for Geriatrics & Gerontology

Hiroyuki Shimada

Schema for Preventing Cognitive Decline in the Community

National Center for Geriatrics and Gerontology

Examinations for identifying risks of functional decline

Participation in physical and cognitive activities In the community

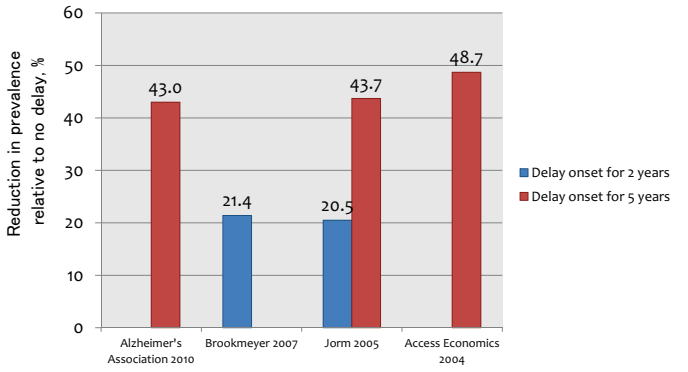
Questionnaire

Physical Assessments

Cognitive Assessments

Blood Exam

Changes in Prevalence in 2050 Associated with Delaying Onset of Dementia by Up to 5 Years



A report for Alzheimer's Australia: Paper 30, 2012

Programs for Preventing Dementia Using Community resources

Activity is the best medicine

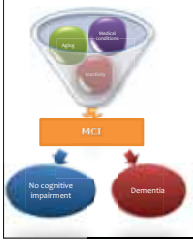
Deweerdt S, *Nature* 2011

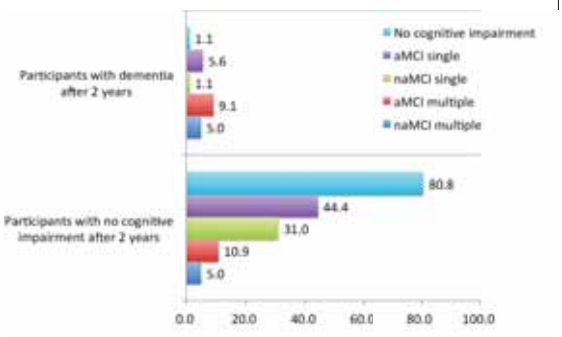
Recovery to No Cognitive Impairment from MCI

The Sydney Memory and Ageing Study (N=837)

Participants: community-dwelling adults aged 70 to 90 years

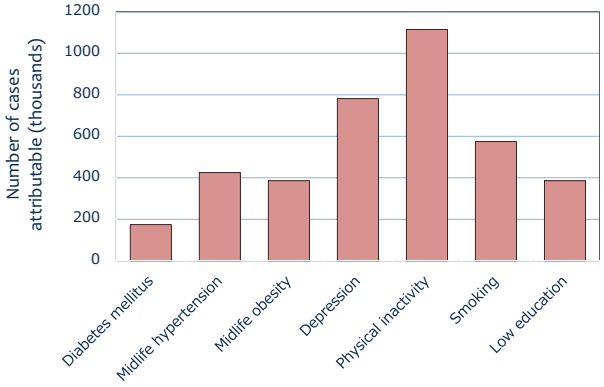
Design: 2 years follow-up observational study





Brodaty H, *Alzheimer's & Dementia* 2013

Alzheimer's disease cases attributable to potentially modifiable risk factors in the USA



Barnes D, *Lancet Neurol* 2011

Potential Mechanisms of Exercise

Cardiovascular Health
- Improves body composition
- Improves the lipid profile
- Aid in the prevention and control of hypertension
- Peak and prevents hyperglycemia and decreases insulin resistance
- Decreases the levels of inflammatory markers
- Increased capillarization
- Decreased cerebral hypoperfusion
- Consequent increase in brain oxygenation levels

Neurotrophic factors
- Improve protective neurotrophines (such as BDNF and IGF-1)
- Production of endorphins and serotonin
- Increased neurogenesis
- Facilitate synaptogenesis

Brain Health
- Reduce disorder protein deposition
- Increases brain volume
- Stimulates neurogenesis and synaptogenesis
- Decreases neuronal death

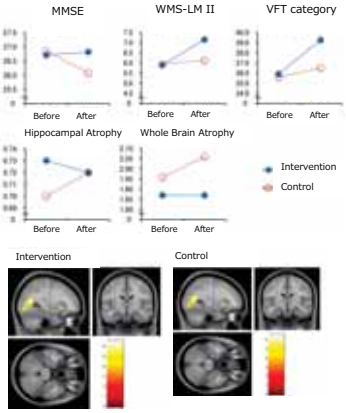
Physical Health
- Improves aerobic resistance
- Increases muscular mass
- Increases bone density
- Decreases body fat
- Improve coordination and balance
- Decrease the risk of falls

Kirk-Sanchez, N. J., & McGough, E. L. (2014). Physical exercise and cognitive performance in the elderly: current perspectives. Clinical interventions in aging,9, 51.

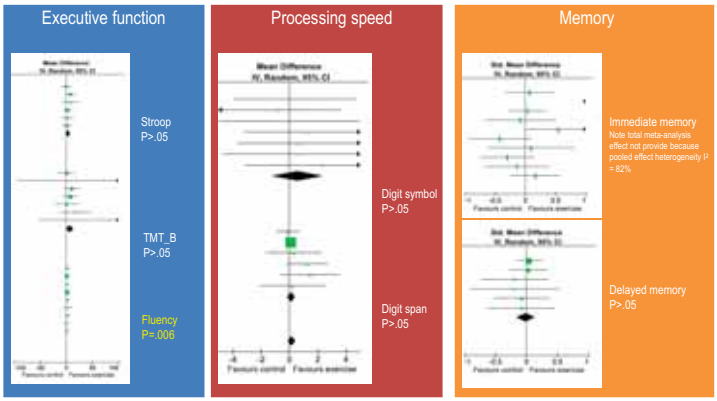
Effects of COGNICISE on Cognitive Performances

Subjects: 308 older adults with MCI
Design: RCT
Setting: Community
Intervention:
Multicomponent exercise program
10 months, weekly, 90 min/session

RESULTS:
1. Mini-mental state examination, $p < .01$
2. Wechsler Memory Scale-logical memory II, $p < .01$
3. Verbal Fluency Test, $p < .01$
4. Hippocampal atrophy, $p < .05$
5. Whole brain atrophy, $p < .01$



The Effect of Exercise Training on Cognitive Function in Older Adults with Mild Cognitive Impairment: A Meta-analysis of Randomized Controlled Trials



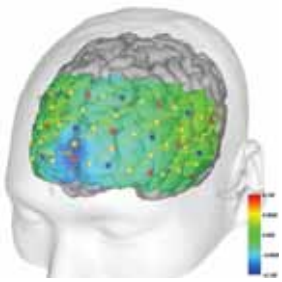
Gates N. *Am J Geriatr Psychiatry* 2013.

Conclusion

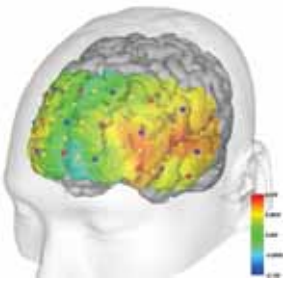
1. To prevent dementia, early detection of MCI in the community is a critical issue
2. Exercise, especially COGNICISE, may useful to maintain cognitive functions in MCI subjects

New Exercise Program for Improving Cognitive Performances

Aerobic Exercise



COGNICISE

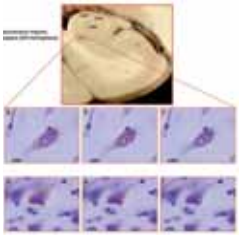


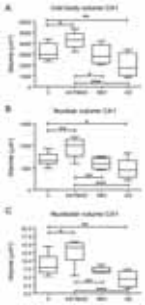
Thank You!

Exercise Your Brain

Hippocampus hypertrophy and asymptomatic AD

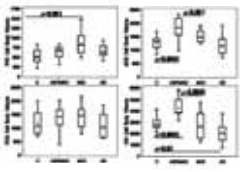
The Nun Study





Iacono D. Neurology. 2009

BLSA: Baltimore Longitudinal Study of Aging



Iacono D. J Neuropathol Exp Neurol. 2008

Person-Centred Dementia Care Research

Global Action on Dementia
Tokyo November 2014

Professor Dawn Brooker
Association for Dementia Studies
University of Worcester UK

Hoping to cover

- What we mean by Person-Centred Care
- Overview of RCT's in the area
- The FITS into Practice Implementation study
- A case study from the Enriched Opportunities Programme

Thanks to….

- G7 Legacy Events Team
- The Japanese Society for Person-centred care
- The Alzheimer's Society
- Alzheimer's Europe
- Alzheimer's Disease International
- The ExtraCare Charitable Trust UK
- InterDem
- The Association for Dementia Studies Team

Theory of Person centred dementia care Professor Tom Kitwood

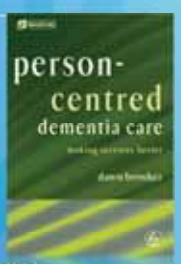
- Person centred approaches to dementia care; 1989-1997 drawing on Martin Buber and Carl Rogers
- The enriched model of dementia
- Supporting personhood through the eradication of malignant social psychology
- Dementia Care Mapping

Kitwood, T. (1997). *Dementia Reconsidered: the person comes first*. Buckingham: Open University Press.

The Association for Dementia Studies at Worcester University

We provide research, education and scholarship to deliver evidence-based practical ways of working with people living with dementia and their families that enables them to live well.
http://www.worc.ac.uk/discover/association-for-dementia-studies.html

Person centred care fit for VIPS

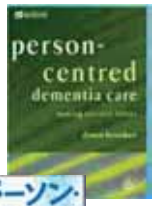


V = *Values* people
I = *Individuals* needs
P = *Perspective* of service user
S = *Supportive* social psychology

Brooker, D. (2004) What is Person Centred Care for people with dementia? *Reviews in Clinical Gerontology* 13 (3): 215-222.
Brooker, D. (2007) *Person Centred Dementia Care: Making services better* London, Jessica Kingsley Publications
http://www.nice.org.uk/guidance/cg42/resources/guidance-dementia-pdf

VIPSに即した パーソン・センタード・ケア

V = 人々の価値を認める
I = 個人の独自性を尊重する
P = サービス利用者の視点に立つ
S = 相互に支え合う社会的環境



Person centred RCTs for people and families living at home

- Brooker D., Argyle, E., Clancy, D. & Scally A. (2011) Enriched Opportunities Programme: A cluster randomised controlled trial of a new approach to living with dementia and other mental health issues in ExtraCare housing schemes and villages. *Aging and Mental Health*. 15 (8); 1008-1017
- Graff, M.J., Vernooij-Dassen, M.J., Thijssen, M., Dekker, J., Hoefnagels, W.H. & Rikkert, M.G. (2006). Community based occupational therapy for patients with dementia and their care givers: Randomised control trial. *British Medical Journal, 333*, 1196
- Logsdon, R., Pike, K., McCurry, S.., Hunter, P, Mather, J., Snyder, L., & Teri, L. (2010). Early stage memory loss support groups: Outcomes from a randomised controlled clinical trial. *Journal of Gerontology B; Psychological Sciences and Social Sciences, 65B,* 691-697
- Mittleman, M., Brodaty, H., Wallen, A. and Burns, A. (2008). A three-country randomized controlled trial of a psychosocial intervention for caregivers combined with pharmacological treatment for patients with Alzheimer disease: effects on caregiver depression. *American Journal of Geriatric Psychiatry*, 16 (11), 893-904.

INTERDEM

- Emerging research from InterDem members

http://www.interdem.org:8085

The research evidence?

- Person centred care provides a set of guiding principles to apply across service settings and countries.
- In itself it is not a single intervention
- The challenge is to enable practitioners, professionals and services that can provide interventions in a person centred manner.
- Cluster randomised controlled trials evidence shows this is possible…..

Person centred care in care homes: cluster-randomised controlled trials

- Chenoweth, L., King, M.T., Jeon, Y-H., Brodaty, H., Stein-Parbury, J., Norman, R., Haas, M. and Luscombe, G. (2009). Caring for Aged Dementia Care Resident Study (CADRES) of person-centred care, dementia-care mapping, and usual care in dementia: a cluster-randomised trial. *The Lancet/ Neurology*. 8, 317-325.
- Cohen-Mansfield, J., Libin, A. and Marx, M.S. (2007). Nonpharmacological treatment of agitation: a controlled trial of systematic individualized intervention. *Journal of Gerontology Series A: Biological Sciences Medical Sciences,* 62 (8), 908-916.
- Fossey, J., Ballard, C., Juszczak, E., James, I., Alder, N., Jacoby, R. and Howard, R. (2006). Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: cluster randomised trial. *British Medical Journal*, 332, 756-761.
- Mork Rokstad, A.M., Røsvik, J., Kirkevold, O., Selbaek, G., Saltyte Benth, J and Engedal, K. (2013). The Effect of Person-Centred Dementia Care to Prevent Agitation and Other Neuropsychiatric Symptoms and Enhance Quality of Life in Nursing Home Patients: A 10-Month Randomized Controlled Trial. *Dementia and Geriatric Cognitive Disorders,* 36:340–353

This is a complex intervention

- UK MRC (Medical Research Council) framework for complex interventions
- www.mrc.ac.uk/complexinterventionsguidanc

1. Theory, proof of concept
2. Exploratory pilots
3. Definitive multicentre RCTs
4. Implementation studies

Alzheimer's Society

University of Worcester
Association for Dementia Studies

FITS into Practice

Focused Intervention Training and Support

Oxford Health NHS
NHS Foundation Trust

UNIVERSITY OF OXFORD

Newcastle University

KING'S College LONDON

The Original FITS Project

Objective: to reduce the use of antipsychotic medication in residents with dementia in a care home through the use of person centred care and supportive interventions in 12 care homes.

Fossey, J., Ballard, C., Juszczak, E., James, I., Alder, N., Jacoby, R. & Howard, R. (2006). Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: a cluster randomised trial. *British Medical Journal* 332. 756-58

FITS into Practice: an implementation study of the RCT

The original FITS programme was a high cost and intensive intervention, using an in-house 'FITS therapist' to support person-centred care and medication review in each care home.

The real challenge was how to translate the model into an approach that could be effective across a large number of care homes.

The Association for Dementia Studies (ADS) and the Alzheimer's Society worked together to design, implement and evaluate a programme to implement FITS into Practice across 100 care homes

Acknowledgements

- *The FITS into Practice programme was a research project led by the Association for Dementia Studies, University of Worcester and funded by the Alzheimer's Society. It followed on from an original randomised controlled trial of the FITS programme which produced significant results in terms of antipsychotic reduction (Fossey et al, 2006. FITS into Practice is based on this original research conducted at King's College London, in association with Oxford University, University of Newcastle and Oxford Health NHS Trust. Copyright of the original FITS manual is held by Dr Jane Fossey (Oxford Health NHS Trust) and Dr Ian James (University of Newcastle).*

Thanks to

- The Association for Dementia Studies at the University of Worcester: Prof Dawn Brooker, Isabelle Latham, Dr Simon Evans, Nicola Jacobson, Wendy Perry (report authors) also to Jen Bray, Michael Watts, Jenny La Fontaine and David Moore.
- The Alzheimer's Society: Professor Clive Ballard, Dr James Pickett, Anne Corbett, Nicola Hart, Keara O'Connor, Barbara Woodward-Carlton.
- The steering group: Dr Jane Fossey (chair), Nia Golding (HC1), Professor Robin Jacoby, Dr Claire Surr, Paula Windmill, Karen Culshaw, Barbara Woodward-Carlton.
- All the Dementia Care Coaches & care homes who took part for the many examples of good practice, dedication, creative thinking, compassion and hard work implementing learning in their homes and making a difference to the lives of people with dementia in their care.

The FITS into Practice programme

- Two **Dementia Practice Development Coaches** were employed and supported by the Association for Dementia Studies
- They delivered training and supervision to **Dementia Care Coaches** – nominated staff from 100 care homes
- Dementia Care Coaches attended a 10 day training programme over 3 months (meeting fortnightly in 2-day blocks)
- Following training, Dementia Care Coaches attended monthly supervision sessions for 6 months, whilst they implemented FITS in their home.
- Dementia Care Coaches implemented their learning, supported by the Dementia Practice Development Coaches

Results Fossey et al 2006

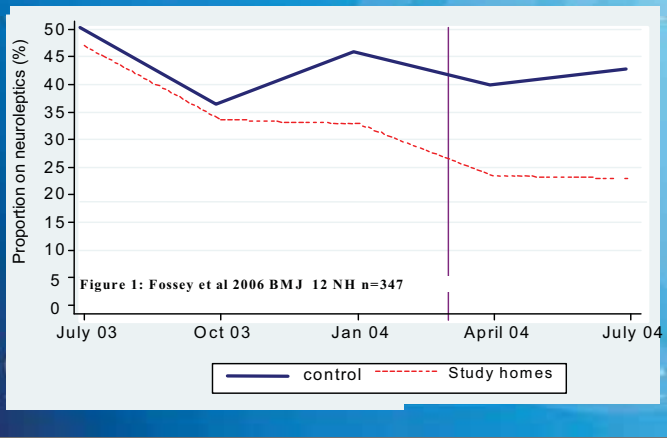


Figure 1: Fossey et al 2006 BMJ 12 NH n=347

Results of the FITS into Practice Project

- 106 homes were initially recruited. Care homes ranged in size, owning organisation and geographical location. 67 completed the programme.
- DCCs evaluated the intervention (training & supervision) highly; pre-post questionnaires demonstrated increased knowledge of dementia, increased confidence and improved attitude to dementia.
- 30.5% reduction in anti-psychotic medication with dose reductions being reported for additional residents.

Results

- Increased activity and better staff-resident relationships
- Crucial for FITS into Practice to succeed was the allocation and protection of time for the DCC to attend training and carry out implementation tasks in addition to their existing job role. Evaluation data showed that this was a substantial barrier to implementation in a number of homes.

University of Worcester

"all needs, no mobility, not eating"

6 days after admission to a care home.....

Mrs May Williams , Lady Forester Home

University of Worcester

1998-2009 Enriched Opportunities Programme

1998- 2000

Between group comparison of nursing home residents participating in an activity challenge holiday and a matched control group.

2001-2003

The development of the EOP programme using qualitative enquiry and within group quantitative evaluation in four study sites

2005- 2009

Random cluster controlled trial in ten extra care housing schemes

University of Worcester

THE EXTRACARE CHARITABLE TRUST

University of Worcester Association for Dementia Studies

"all needs, no mobility, not eating"

1 month later – baking

Mrs May Williams , Lady Forester Home

University of Worcester

Enriched Opportunities published outputs

Brooker D., Argyle, E., Clancy, D. & Scally A. (2011) Enriched Opportunities Programme: A cluster randomised controlled trial of a new approach to living with dementia and other mental health issues in ExtraCare housing schemes and villages. *Aging and Mental Health*. 15 (8); 1008-1017

May, H., Edwards, P. and Brooker, D. (2009). *Enriched Care Planning for People with Dementia: A Good Practice Guide to Delivering Person-Centred Care.* London, Jessica Kingsley Publications

Brooker D., Argyle, E. & Clancy, D. (2009) Mental Health Needs of people living in extra care housing. *Journal of Care Services Management*, Vol 3.3 March/April

Brooker, D. & Woolley, R. (2007) Enriching Opportunities for People living with Dementia: The Development of a Blueprint for a Sustainable Activity-Based Model of Care. *Aging and Mental Health*, 11(4): 371-383

Brooker, D., Woolley, R. & Lee, D. (2007) Enriching Opportunities for People living with Dementia in Nursing Homes: An evaluation of a multi-level activity-based model of care. *Aging and Mental Health* 11(4): 361-370

Brooker, D. (2001) Enriching Lives: evaluation of the ExtraCare Activity Challenge. *Journal of Dementia Care.* (Research Focus) 9 (3), 33-37.

University of Worcester

University of Worcester Association for Dementia Studies

"all needs, no mobility, not eating"

1 month later – baking

Mrs May Williams , Lady Forester Home

University of Worcester

"all needs, no mobility, not eating"

6 weeks later – Italian meal .....

"all needs, no mobility, not eating"

2 months later – old skills returning.....

"all needs, no mobility, not eating"

6 weeks later tea and teddy

"all needs, no mobility, not eating"

2 months later – silk scarves.....

ing"

2 months later – head massage .

"all needs, no mobility, not eating"

3 months later – dancing to music....

"all needs, no mobility, not eating"

3 months later Mexican celebration

Thank you for listening!

Professor Dawn Brooker
University of Worcester
Association for Dementia Studies
d.brooker@worc.ac.uk

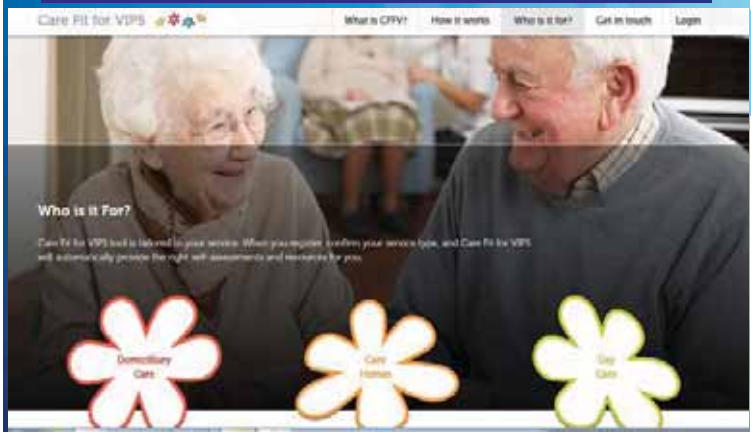
http://www.worc.ac.uk/discover/association-for-dementia-studies.html

Photographs of people living with dementia taking part in The Enriched Opportunities Programme

Interventions to improve quality of life for May Williams?

- **Interventions:** Person centred animal therapy, baking, good food, special occasions, eating, knitting, teddy, dressing up, silk scarves, head massage, dancing
- **Outcomes:** Alive, weight gain, happy, active, having fun, no BPSD, no sedation

www.carefitforvips.co.uk



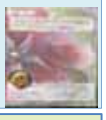
Take home messages

- Person-centred care transforms lives.
- If we put person centred principles into practice globally we would save millions of people from misery. We do not need to wait until 2025 to have an impact.
- Prioritise robust implementation studies across the journey with dementia and in low and middle income countries
- Develop strong international networks for sharing data on what works, InterDem, Dementia-NET, International Person-Centred Values Network; ADI;.....

パーソン・センタード・ケア関連情報Dawn Brooker 著書/講演他

D.ブルッカー「VIPSですすめるパーソン・センタード・ケア」
水野裕監修
村田康子他訳、2010
クリエイツかもがわ
TEL：075-661-5741

「パーソン・センタード・ケアを 実践する ー ドーン・ブルッカー講演よりー」（日本語吹替）
水野裕監修
中川経子他訳、2012
シルバーチャンネル
TEL：048-711-7762



「パーソン・センタード・ケアとDCM研修会」基礎コース年4回開催
問合せ先：
認知症介護研究研修大府センター
http://dcnet.gr.jp TEL：0562-44-5551

NPOシルバー総合研究所
http://silver-soken.com/

NPOその人を中心とした認知症ケアを考える会 ーパーソン・センタード・ケアに関する学習会
問合せ先：http://www.pcdc.or.jp
E-mail：office@pcdc.or.jp
TEL：080-2025-7416

Useful websites

Association for Dementia Studies, University of Worcester

- http://www.worc.ac.uk/discover/association-for-dementia-studies.html

Interdem: European Early & Timely Interventions in dementia research network

- http://www.interdem.org/

Care fit for VIPS

http://www.carefitforvips.co.uk

Lifestory network

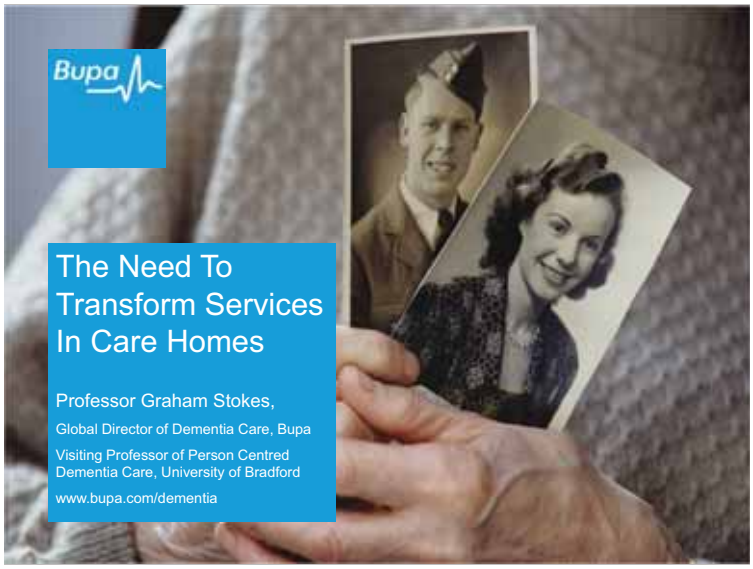
- http://www.lifestorynetwork.org.uk/

Memory Bridge:

www.memorybridge.org

Social Care Institute for Excellence: Dementia Gateway

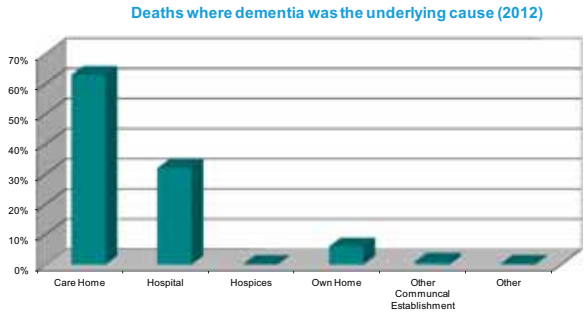
- www.scie.org.uk/publications/dementia



The Need To Transform Services In Care Homes

Professor Graham Stokes,
Global Director of Dementia Care, Bupa
Visiting Professor of Person Centred Dementia Care, University of Bradford
www.bupa.com/dementia

Where people with dementia die in the UK



Using the UK as an example: Care homes and dementia care

- 432,000 people in care homes in the UK.
- In England Alzheimer's Society (2013) now estimate **80% of people in care homes have dementia or significant memory problems.**
- More than 300,000 people with dementia live in care homes most with high dependency, challenging and end-of-life care needs
- 40% of all people with dementia in the UK

Low expectations, Alzheimer Society 2013, http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=1024

People's expectations of care are low

Low Expectations (Alzheimer's Society 2013)
http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=1024

- 68% of residents' relatives said quality of care was good.
- Less than half of relatives (**41%**) said the person with dementia had a good quality of life

But what do we mean when we talk about dementia care?

It is caring for people whose brains are so damaged by disease their **dementia renders them incapable of taking responsibility for their hygiene, personal care and daily lives**. It is **caring for people whose judgement is so diminished** they cannot take responsibility for their actions and who as a result engage in unacceptable risks

...Except it is not...

It's caring for people who do not know they need to be cared for.

When people with dementia know they need us, they need us least;

when they need us most, they know they do not need us at all.

So we need to rethink how we care for people living with dementia

The Key Message

There is a distinction between quality of care and quality of life

It is not one and the same thing

Good care contributes to a person's quality of life and to think otherwise sets the bar far too low

The need to identify and prioritise unanswered questions

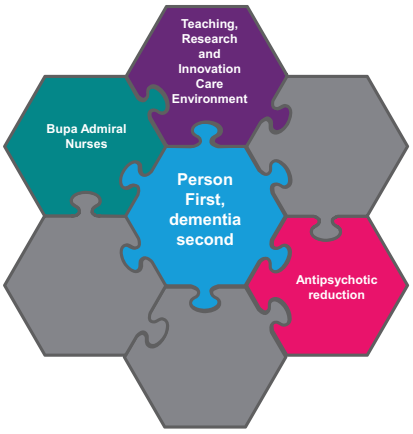
Dementia Priority Setting Partnership with the James Lind Alliance: Using patient and public involvement and the evidence base to inform the research agenda.

Sarah Kelly, Louise Lafortune et al. (on behalf of the Dementia Priority Setting Partnership steering group)

http://alzheimers.org.uk/site/scripts/download_info.php?downloadID=1427

- The JLA Dementia Priority Setting Partnership was an evidence-based project to identify and prioritise unanswered questions ('uncertainties') about the prevention, diagnosis, treatment, and care relating to dementia.
- The PSP process was conducted between April 2012 and June 2013
- Uncertainties were collected via a survey disseminated to a wide range of stakeholders.
- Thematic analysis was developed to manage and generate research questions.
- Each question was checked against an extensive evidence base of high quality systematic reviews to verify they were true uncertainties
- The top ten list of dementia research priorities provide a focus for researchers, funders and commissioners

Bupa - raising standards of dementia care in the UK



Dementia Priority Setting Partnership top 10 priorities - the five with direct relevance to care homes

We know that we need to transform care homes, these questions will help us think how to design new services:

What are the most effective components of care that keep a person with dementia as independent as they can be at all stages of the disease **in all care settings?**

What non-pharmacological and/or pharmacological (drug) interventions **are most effective for managing challenging behaviour** in people with dementia?"

"What is **the best way to care for people with advanced dementia** (with or without other illnesses) at the end of life?"

What are the **most effective design features** for producing dementia friendly environments at both the housing and neighbourhood levels?

When is the optimal time to move a person with dementia into a care home setting and **how can the standard of care be improved?**

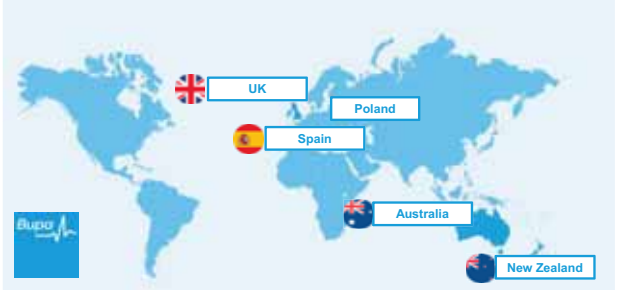
Sarah Kelly, Louise Lafortune et al. (on behalf of the Dementia Priority Setting Partnership steering group)

http://alzheimers.org.uk/site/scripts/download_info.php?downloadID=1427

Antipsychotic reduction programme, 2009 - 2014

- 2009 - **35.0%** residents with dementia prescribed antipsychotics
- 2013 - **19.5%** residents with dementia prescribed antipsychotics

Four national care home businesses providing dementia care



- **Bupa cares for approximately 24,000 residents** with dementia across the world, most with advanced Alzheimer's disease, complex behaviours and/or multiple morbidities
- We are **the only global provider of dementia care** (and in 2015 services will expand into Poland)
- **In the UK** 171 care homes provide specialist dementia care, caring for 7.000 residents
- Another 7,000 people with dementia are living on frail elderly units because they have multiple co-morbidities and/or end of life care needs

www.bupa.com

Antipsychotic reduction programme: New ways of working

- **Person First, dementia second staff training programme. Launched 2010**
- **Behavioural analysis** (Stokes G, 2000. Challenging Behaviour in Dementia: A Person-centred Approach, Winslow Press)
- **Functional analysis** (Moniz-Cook E, Stokes G and Agar S. Difficult behaviour and dementia in nursing homes. Clinical Psychology and Psychotherapy, 2003, 10: 197-208)

Appreciative Enquiry

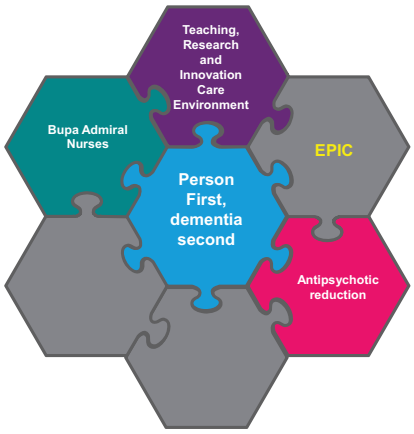
Admiral Nursing in the UK

What is an admiral nurse: Dementia Care Specialist Nurses

Bupa Admiral Nurses

- Appointed in 2013
- 6 currently in post across in England
- **6 more to be appointed in 2015 in England and Scotland**
- An external layer of extraordinary capability currently supporting 40 dementia care homes

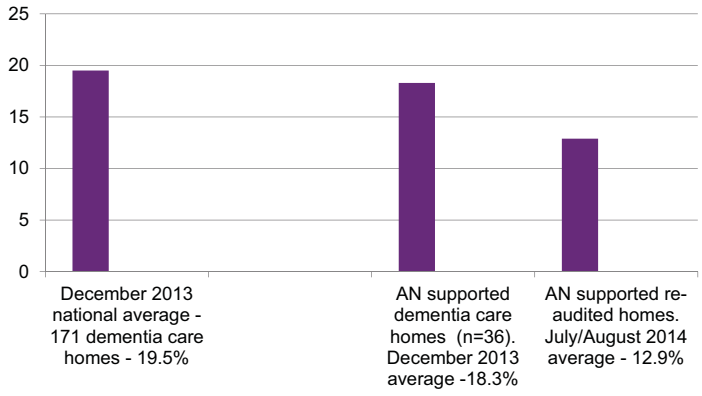
There are still pieces of the puzzle missing...



Evaluating the effectiveness and cost effectiveness of Dementia Care Mapping (DCM) to Enable Person Centred Care Training (PCCT) for people with dementia and staff: A UK cluster randomised controlled trial In Care homes (DCM EPIC trial). Lead applicant, Dr Claire Surr (University of Bradford Dementia Group).

16

Admiral Nurses are delivering great results in reduction of prescribed antipsychotics



14

A Proposed **Teaching, Research and Innovation Care Environment**

Bupa + UNIVERSITY of BRADFORD

The environment will be a research-rich, scholarly environment testing design principles, clinical practice and care innovation. Hosted in the United Kingdom, led and delivered by outstanding dementia care practitioners, academics and researchers from the Bradford Dementia Group, it will be a global exemplar, using research-informed training and practice development.

Effect of a regional cooperative system for dementia patients with a collaboration notebook

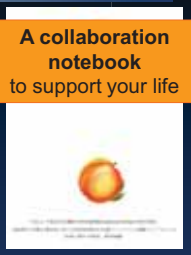
Hiroaki Kazui

Department of Psychiatry
Osaka University Graduate School of Medicine

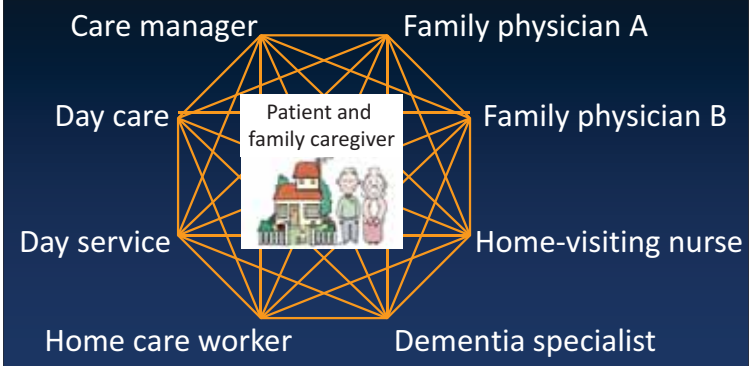
Disclosure: Our activities were supported in part by research grants for Research on Dementia from the Ministry of Health, Labour and Welfare of Japan, the Sugiura Foundation for the Development of Community Care, and the Nippon Life Insurance Foundation for Aging Society.

The collaboration notebook to support patient life at home

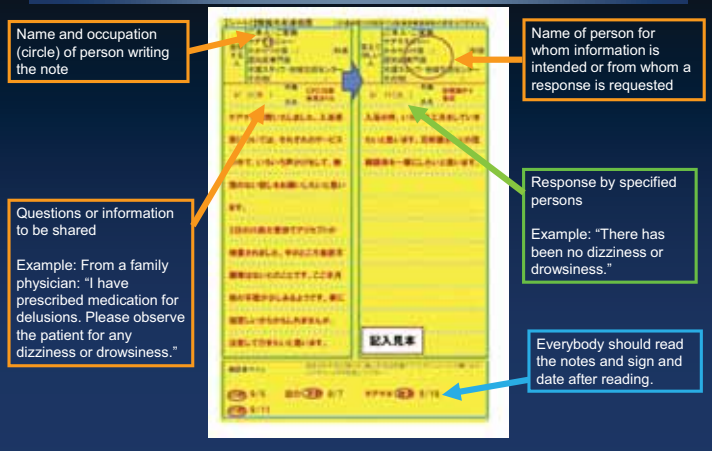
- Provided for the patient when diagnosed with dementia
- Brought by a caregiver whenever a patient attends a healthcare provider
- Consists of two parts:
  - First part: patient's clinical information
  - Second part: information for sharing



Need for collaboration among the many people caring for dementia patients living at home

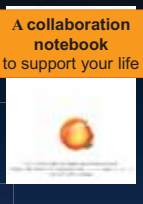


Yellow page for information sharing



Our system for dementia patients consists of:

- Collaboration notebook
- Disease- and severity-specific care guidebooks
- Collaborative meetings



Disease- and severity-specific care guidebooks

- 10 kinds:
  - Overview
  - Alzheimer's disease: early ・ middle ・ late stage
  - Dementia with Lewy bodies: early ・ middle ・ late stage
  - Frontotemporal lobar degeneration: early/middle ・ late stage
  - Vascular dementia
- contains a small number of pages and focuses on
  - the common types of Behavioral and Psychological symptoms of Dementia (BPSD)
  - how to cope with the BPSD in a specific stage of a particular disease.
- Prompt and appropriate measures to be taken by a nearby people if patient has mild BPSD in order to prevent worsening of BPSD.

Trial implementation of regional cooperative system

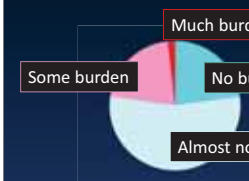
Collaborative meeting

Feb 2011 - Jul 2011
- 59 Dementia patients (& caregivers)
- 75 Family physicians
- 48 Care managers
- 84 Care facilities

Burden of using notes and their usefulness

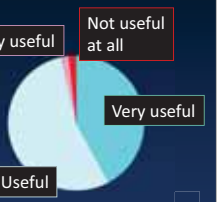
Family caregivers

Burden of writing notes



Burden of carrying the notebooks

Usefulness

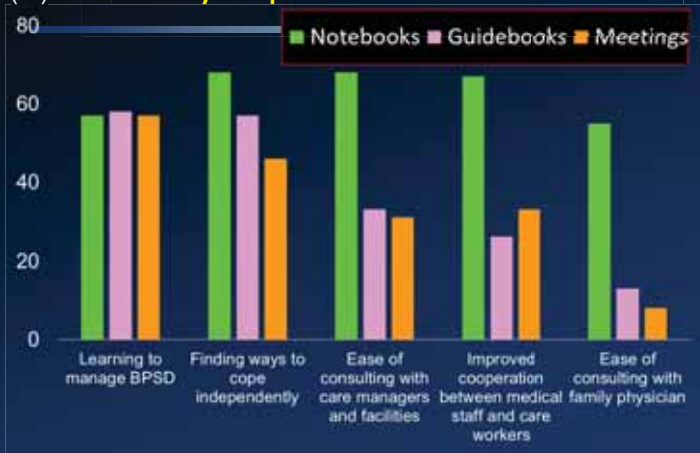


Family physicians

Burden of writing notes

Usefulness

Results: Family impressions and comments



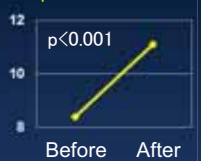
Kawanishi City collaboration notebook (tsunagari note) system

- Introduction of our regional cooperative system
  - Starting in 2013
  - Kawanishi City, Hyogo Prefecture
    - Population: 160,000; 25% elderly
- Creation of Kawanishi City collaboration notebooks (tsunagari note)

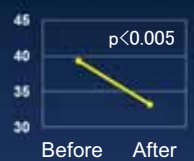
Benefits of regional cooperative system

Family knowledge about dementia and caregiving

Family physician's understanding of patient condition



Family caregiver burden (ZBI)



(Kazui H, Sugiyama H, Takeda M. Jpn J of Clin Psychiatry 2012;41(12):1731-40)

(https://www.e-rapport.jp/team/clinicalpath/sample/sample22/01.html)

Kawanishi City collaboration notebook (tsunagari note) program

Criteria for candidate selection:
- Residents of Kawanishi City
- Support Required level of severity 2 or more in the Japanese Long-term Care Insurance system

3073 persons extracted from city government database

Feb 1, 2013: Use of notes begins
- April 18, 2013: 463 users

Collaborative meetings: Held 4 times a month at start of project
- Mini-lectures by dementia specialists
- Discussion by all participants on how to use notes more effectively.

Promotion of continuous educational activities

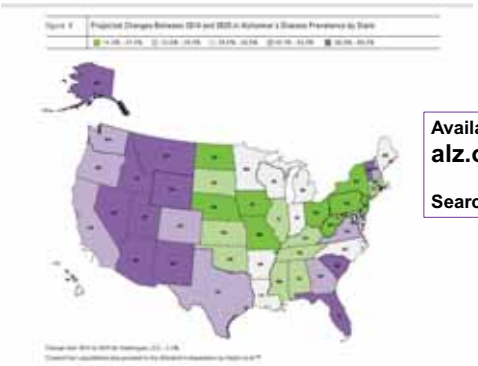
- a series of lectures with a dementia care guidebook
- e-learning program

dementia care guidebook

http://www.handaichiikirenkei.com/movie/

- continually searching for ways and means to more effectively use the notes and to support dementia patients living at home

Projected Changes Between 2014 and 2025 in AD Prevalence



Available at our website:
alz.org

Search: Facts Figures

36 States have State Plans (7 more and Puerto Rico are in process)

STATE ALZHEIMER'S DISEASE PLANS

Table of Contents

Available at our website:
alz.org

Search: State Plans

Dementia-friendly communities: Linking up with WHO and EIP AHA initiatives

Tokyo, Japan
5 November 2014

Outline

1. Some European initiatives on dementia-friendly communities
2. WHO and EU initiatives on age-friendly environments
3. Linking up age- and dementia-friendly environments

Key objectives

- Identify the key partners, services, activities and businesses within any given community to develop a local map of the people and the place
- Engage with the key stakeholders by increasing their knowledge and understanding of dementia to ensure that it becomes part of the local agenda
- Challenge the stigma, myths and misconceptions around dementia by opening the channels of communication and removing the barriers to change
- Work with local services and businesses to make the community a dynamic and friendly place for people with dementia, their carers, families and friends to live and work in
- Work together to increase the opportunity for people with dementia and their carers to remain engaged in their chosen activities of life for as long as they wish to

Stakeholders

- People with dementia are central to creating Dementia Friendly Communities
- Neighbours, friends, supporters and families
- Local businesses that exist in every community such as banks, post office, coffee shop owners
- Local statutory service providers that would be likely to have interactions with people with dementia and their families: emergency services, police, local authority personnel, councillors, town planners,
- Local mainstream community service - youth clubs, church groups, older people's groups, community projects, arts based and theatre groups,
- Specialist support service providers such as The Alzheimer Society of Ireland

Ireland

Dementia Aware Donegal

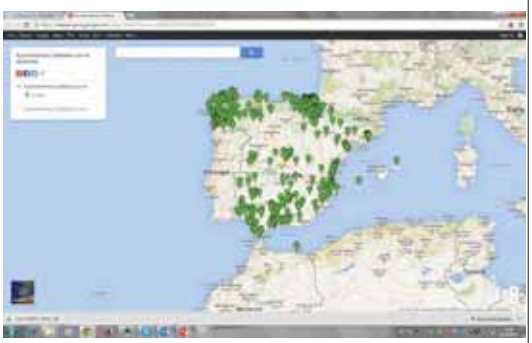
Memory Matters
Kilkenny Age Friendly

Community Action on Dementia in Galway City

WICKLOW DEMENTIA FRIENDLY

Spain

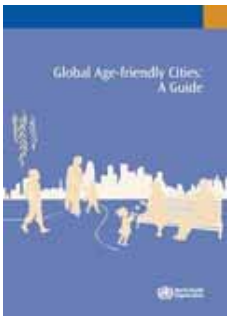
SOLIDARIO CON EL ALZHEIMER



WHO – Age-friendly cities

"An age-friendly city is an inclusive and accessible urban environment that promotes active ageing"

WHO Global Network of Age-friendly Cities©



Action Group Innovation for age-friendly buildings, cities and environments 2012-2015

- Adapting Environments to the challenge of ageing populations
- Understanding how ICT and Service innovations can help shape supportive environments ;
- Running pilots to analyse integrated approaches to urban design, housing, health and social services, age-friendly workplaces, ICT and smart environments;
- Setting up mechanisms to engage the older person and ensure their participation in society;
- Exploring new ways to promote active and healthy ageing with age friendly environments.

Domains influencing health and quality of life of older people

- Outdoor spaces and buildings
- Transportation
- Housing
- Social participation
- Respect and social inclusion
- Civil participation and employment
- Communication and information
- Community support and health services

Good Practices Age friendly-environments 2013

62 good practices- 32 regions, 12 Member States

Cluster Living environments - 31 good practices: Ambient Assisted Living, Housing and Urban Environment.

Cluster Active Ageing in the community - 16 good practices: Age-friendly businesses, Voice of Older People, Transportation

Cluster Active & Healthy Lifestyles - 10 good practices, physical activity and tourism

Cluster Dementia Supportive Environments -5 good practices community support and solutions

Link: https://webgate.ec.europa.eu/eipaha/library/index/show/filter/actiongroups/id/729

European Innovation Partnership on Active and Healthy Ageing

- Triple win:
  - Improving health status and quality of life of older people
  - Improving efficiency and sustainability of health systems
  - Fostering the competitiveness of EU industry working in innovative age and health related products and services
- D4 Specific Action on "Innovation for age-friendly buildings, cities and environment"
- 800 partners, 27 Member States, 30 European cities and 360 regions and municipalities

AFE-INNOVNET TOWARDS AN AGE-FRIENDLY EUROPE

AFE-INNOVNET (Aims)

- Support the European Innovation Partnership on Active and Healthy ageing through setting up a large EU wide community of local and regional authorities and other relevant stakeholders who want to work together to find smart and innovative evidence based solutions to support active and healthy ageing and develop age-friendly environments.

This project is funded under the ICT Policy Support Programme (ICT PSP), grant agreement n° 620978

AFE-INNOVNET (Network)

- **29 stakeholders**
  - 16 Member States (BE, DK, EE, ES, FR, IE, IT, LU, LV, NL, PL, PT, SE, SF, SI, UK)
  - 13 cities (Brussels, Celje, Fredericia, Groningen, Krakow, Kuldiga, Ljubljana, Manchester, Porto, Stockholm, Tallinn, Tampere, Warsaw)
  - 6 regions (Flanders, Franche-Comte, Friuli-Venezia-Giulia, Louth County, Puglia, Wales)
  - 5 EU networks (AGE, Alzheimer Europe, CEMR, ESN, Eurohealthnet)
  - 4 research centers/consultancy (DKIT/Netwell Centre, Inova+,TNO, UVEG)
  - 1 Communication Agency (PAU)
  - WHO Europe and EUROFOUND, in advisory capacity
- **Open to additional partners: www.afeinnovnet.eu**

This project is funded under the ICT Policy Support Programme (ICT PSP), grant agreement n° 620978

Conclusions

- **Develop dementia-friendly communities in collaboration with age-friendly environments rather than in isolation**
- **Ensure age-friendly initiatives pay specific attention to needs of and involve people with dementia**
- **Develop/link up repositories/databases to allow exchange of good and best practices**
- **Develop evidence-based tool kits for the creation and implementation of age/dementia-friendly communities**

Thanks

- **Eibhilin Manning, European Commission**
- **Julia Wadoux, Ophélie Durand, AGE Platform Europe**

- www.alzheimer-europe.org
- www.afeinnovnet.eu
- http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=home

Towards Creating a Society Where People Can Live Well with Dementia with Hope and Dignity

Tokyo Metropolitan Institute of Gerontology
Shuichi Awata, M.D., Ph.D.

"Five-Year Plan for Promotion of Dementia Measures"

Orange Plan 2013-2017

(published by MHLW in 2012)

Basic Objective:

To realize a society where one's will shall be respected, and one can live in pleasant and familiar surroundings as long as possible and practicable, even after they suffer dementia

Seven Fundamental Policy Directions:

1. Development of Standard Dementia Care Pathway
2. Earlier Diagnosis and Intervention
3. Improved Health Care Services to Support Living in Community
4. Improved LTC Services to Support Living in Community
5. Better Support for Daily Living and Family Caregivers
6. Reinforcement of Measures of Younger Onset Dementia
7. Acceleration of Human Resources Development

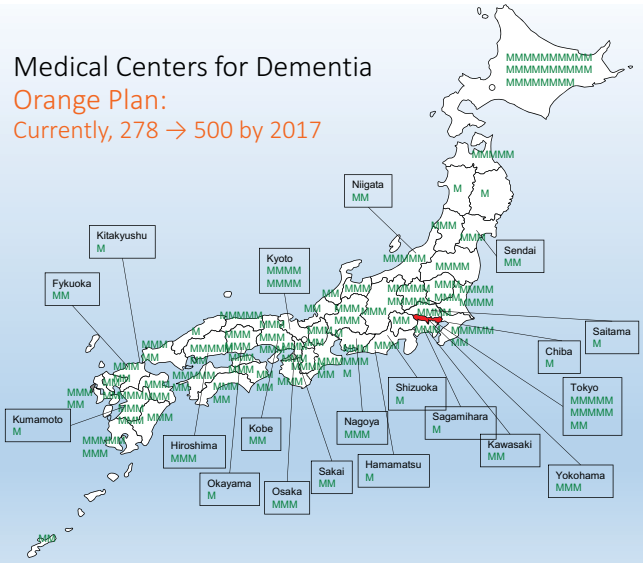
Changes in Percentage of People aged 65+ by Country (1980 – 2060)

UN World Population Prospects: The 2012 Revision

Medical Centers for Dementia

Orange Plan:

Currently, 278 → 500 by 2017



History of National Dementia Policy

- 1984 Dementia Care Training Program
- 1989 Dementia Center for the Elderly (DCE)
- 1992 Day-Service Center for Dementia
- 1997 Group Home for Dementia
- 2000 Long-term Care Insurance Act (LTCI act)
- 2004 Changes of the Japanese terminology for "Dementia"
- 2005 Training Program for Dementia Support Doctors
- 2005 Nationwide Program to Train One Million Dementia Supporters
- 2006 Training Program for PCDs to upskill Dementia Practice
- 2006 Community General Support Center (CGSC)
- 2008 Medical Center for Dementia (MCD, Revision of DCE)
- 2012 Five-Year Plan for promotion of Dementia Measures ("Orange Plan")

For the creation of dementia friendly towns, hopes and wishes of people with dementia, community-initiated-efforts, and government-initiated policies must be harmonized.

Thank you

Federal Ministry for Family Affairs, Senior Citizens, Women an Youth

Joining Forces for People with Dementia

Global Action against Dementia
Legacy Event Japan - New Care & Prevention Models
Tokyo , 5th and 6th of November 2014

Annette Pauly

Federal Ministry for Family Affairs, Senior Citizens, Women and Youth

Local Alliances for persons with Dementia in Germany

- **Background:**
  People suffering from dementia in Germany
  2014 up to 1,5 million => 2050 up to 3 million
- **Framework:**
  Alliance for People with Dementia on national level as part of the Demographic Strategy in Germany
- **Programme:**
  Local Alliances for Persons with Dementia

Conceptual Approach:

- contest for pilot projects in multi-generational centres (23)
- call for proposals to a wide range of organisations
- 10.000 Euro over a period of two years
- selecting participants in close cooperation with the federal Laender:
  => 292 alliances as of today => up to 500 alliances by 2016
- associated scientific evaluation

Objectives in general:

- spreading & expanding knowledge of the disease
- improving care of affected persons
- making society & individuals aware of the needs of persons with dementia
- furnishing support for affected persons and also their families
- inclusion

Specific objectives:

- fostering self-determination and participation
- cultivating and stabilizing contacts & personal networks
- tapping resources without asking too much
- helping to stay in the familiar living environment
- getting society to better appreciate the value of care giving relatives

Experiences so far:

- very strong demand to participate
- multitude of different thematic approaches
- regional differences

Next steps:

- concentrating on selected focus areas in order to align activities, e.g. municipal networking, intergenerational approaches, migrants and dementia
- convening local alliances with similar focus areas once a year in conferences on federal level
- launching a website & developing e-learning modules in order to achieve sustainable networking
- joint campaigning and shared PR

Federal Ministry for Family Affairs, Senior Citizens, Women an Youth

Lokale Allianz für Menschen mit Demenz

Good practice: 2 out of 292

(1) County of Herford, North Rhine-Westfalia, Germany

- joining forces and building networks around the Alzheimer information centre Enger :
- involving all municipalities within the county (so far 4/9)
- cooperating with social services, municipalities, Alzheimer society Minden, Protestant and Catholic Church parishes and many others
- activities, e.g. concerts, sports, 3rd International Conference on Intercommunal networking: How to build a humane community

Federal Ministry for Family Affairs, Senior Citizens, Women an Youth

Lokale Allianz für Menschen mit Demenz

Good Practice: 2 out of 292

(2) City of Emden (Lower Saxony, Germany)

- Cooperation of Alzheimer Society Emden and Kunsthalle Emden (Museum of Modern Arts Emden)
- “Studio für People with Dementia”
- Participation via creative work – guided by an art therapist

http://www.lokale-allianzen.de/

The contribution of corporations to enabling people with dementia to live well in the community.

Jeremy Hughes
Chief Executive

Creating a dementia friendly society 1.

- National companies

National Dementia Declaration

- I have personal choice and control or influence over decision about me
- I know that services are designed around me and my needs
- I have support that helps me live my life
- I have knowledge and know-how to get what I need
- I live in an enabling and supportive environment where I feel valued and understood
- I have a sense of belonging and of being a valued part of my family, community and civic life
- I know there is research going on which delivers a better life for me now and hope for future

Small changes help make a dementia friendly community

Lloyds Bank training video

Creating a dementia friendly society 2.

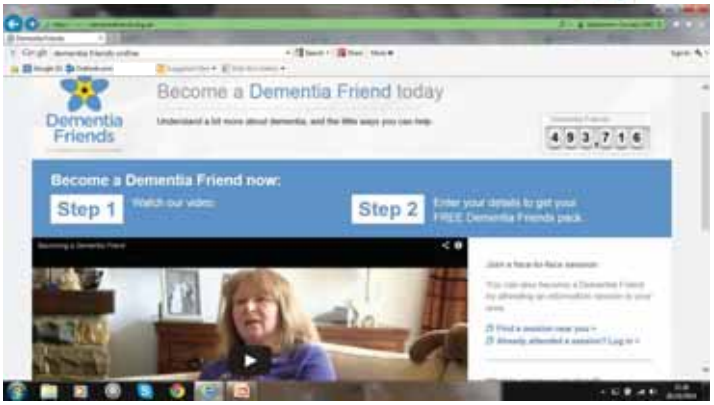
• Local communities

Creating a dementia friendly society 3.

• Enabling individual employees

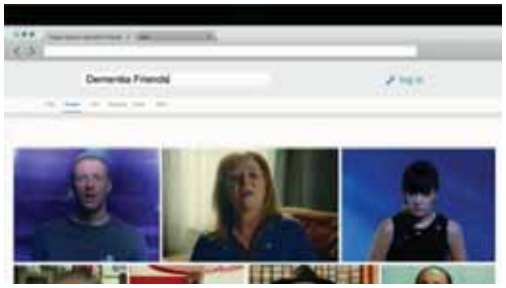
Example: Dementia Friendly Crawley

- 1 in 5 people in the town will have a form of dementia during their lifetime
- Diagnosis rates have gone up 16% since 2011
- There are now over 100 members of the Crawley Dementia Action Alliance



Example: First Bus

30 second Dementia Friends TVC



Thank you

Jeremy Hughes
Chief Executive, Alzheimer's Society
jeremy.hughes@alzheimers.org.uk

www.alzheimers.org.uk

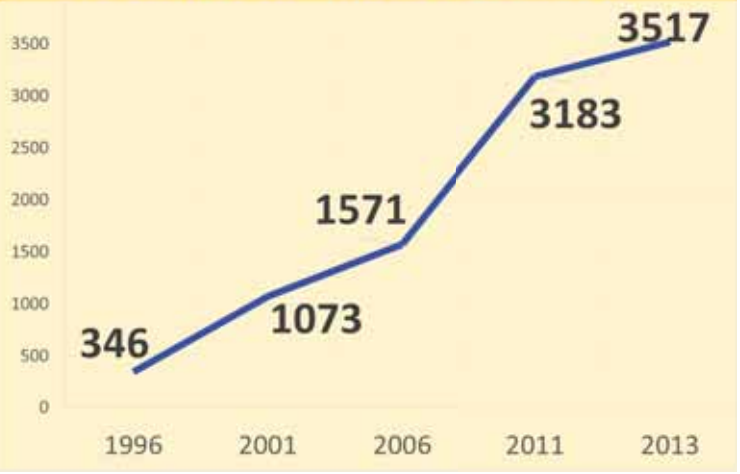
TSUDOI

- Crystallization of Autonomy and Creativity-

Kunio Takami

President of Alzheimer's Association Japan

Number of TSUDOI



What is TSUDOI?

The name of the meeting held for people with dementia and their carers run by AAJ branches.

Equal Standing

Voluntary basis

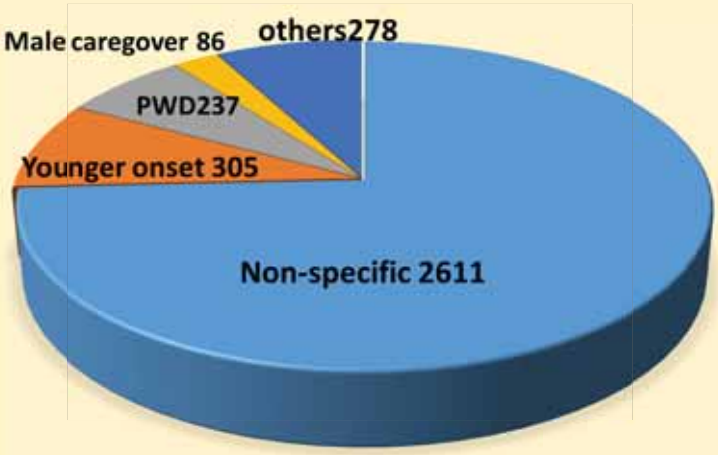
Caregivers

PWD

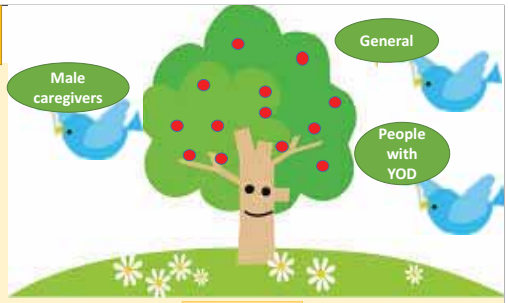
Professionals

Open minded discussion

Breakdown of the TSUDOI

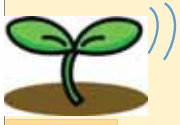


TSUDOI History



In 2013

3,517 times with 44,118 people all over Japan



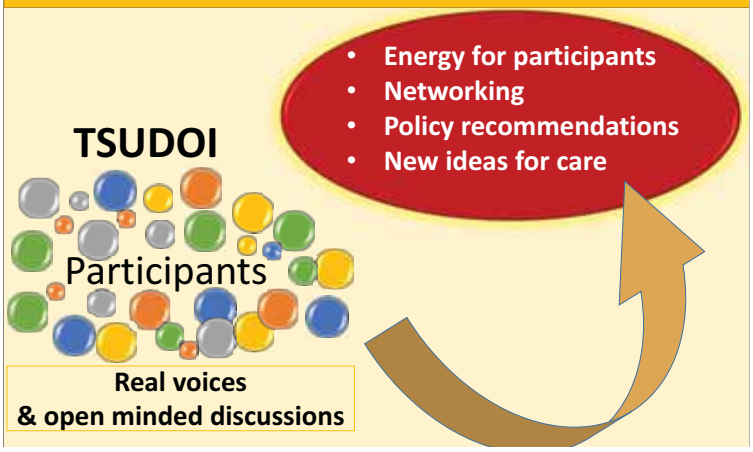
In 1979 A small group of caregivers conversation

In 1980 Established AAJ by 90 family caregivers

The characteristics of TSUDOI Autonomy

- **Started in the age without social services and developed as an autonomous group**
- **Continues as an independent, grassroots project**
- **All participants are autonomous & self-motivated and interacting on an equal basis**

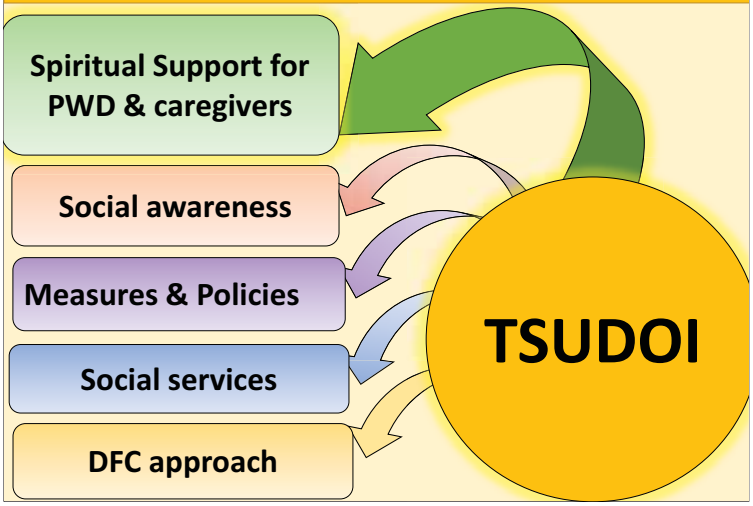
Characteristics of TSUDOI Generated Creativity



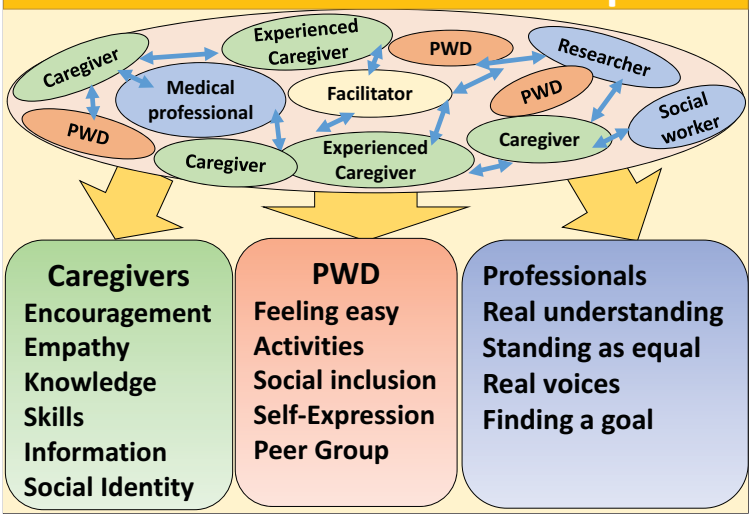
How we conduct TSUDOI?

Funding	Small entry fee Subsidy from local government
Frequency	Depending on group needs
Location	Branch offices, Community halls, Cafés, etc.
Sharing	Documented in each branch's newsletter

Needs for living well with dementia in the community



Concrete Benefits for Participants



How we conduct TSUDOI?

Organizer	AAJ branch members
Participants	PWD, Family Caregivers, Medical & Care professionals , Researchers, Students
Categories	General, male caregivers, people with younger onset dementia

Feedback from participants

Strengths

★Well-rounded and continuous effect on PWD, caregivers, and society

★Simplicity and economic cost value

Our Challenge

More sites and higher frequency
with easy access for PWD & Caregivers
Autonomy with collaboration
for further development and growth

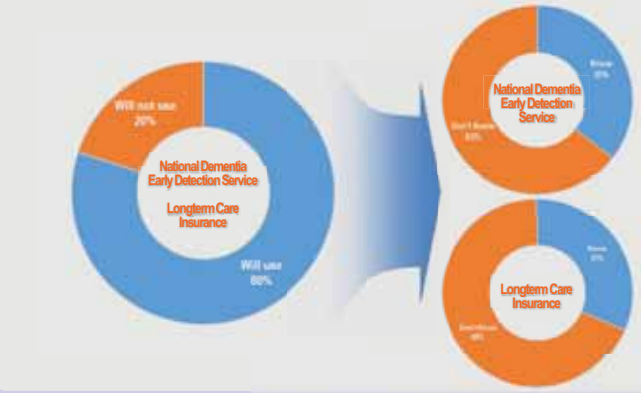
How to enhance family caregivers' accessibility to information and services for dementia

5 Nov 2014

Ki Woong Kim, M.D., Ph.D.

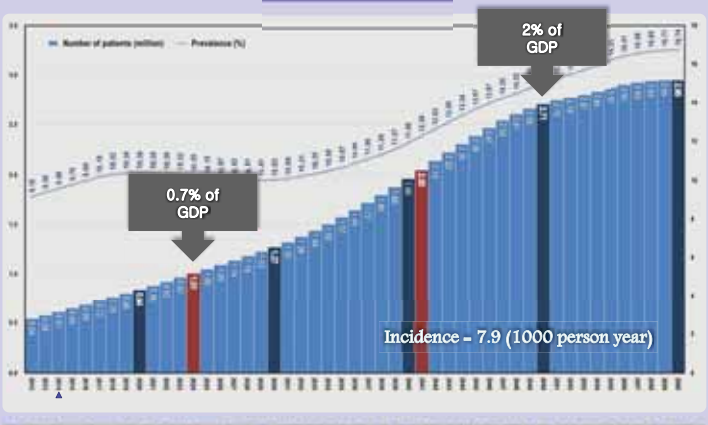
Director, National Institute of Dementia / Professor, Seoul National University

Limited Accessibility to Information

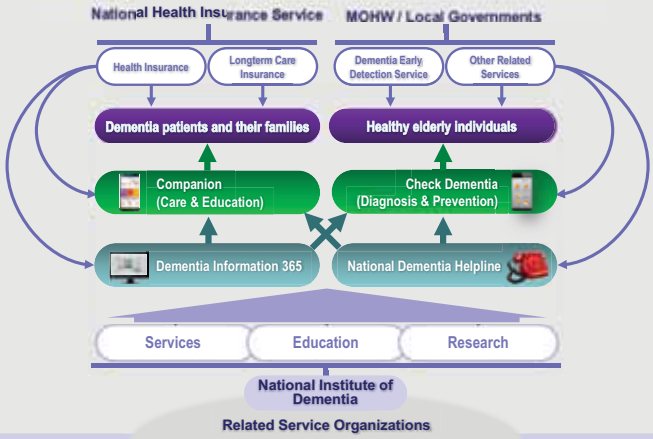


Korean National Institute of Dementia. Nationwide Survey on Dementia Awareness (2014)

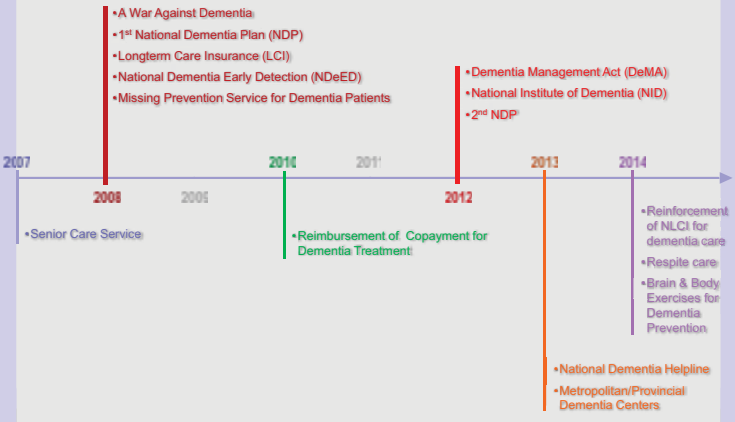
Dementia Epidemic



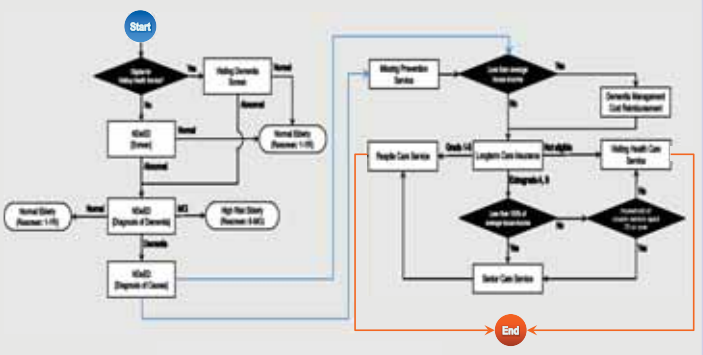
Unification of Information-Delivering Channel



Services for Dementia Management



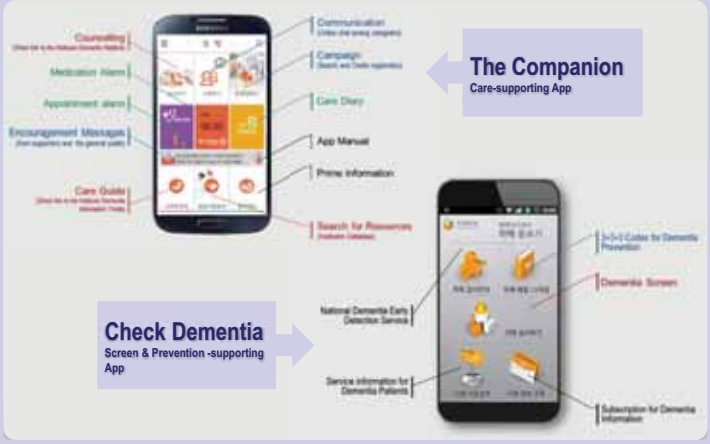
Abstraction, Integration and Organization of Information



Dementia Service Navigator: Basic Package

Korean National Institute of Dementia. Ministry of Health and Welfare (2014)

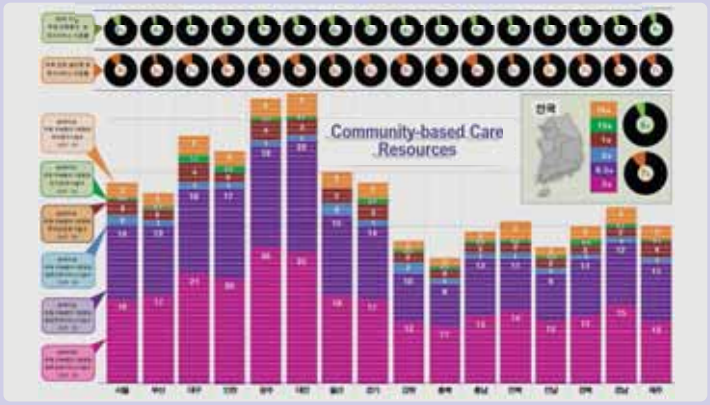
Active Delivery of Tailored Information



National Daily Exercise for Dementia Prevention

Korean National Institute of Dementia. Ministry of Health and Welfare (2014)

Limited Financial and Physical Accessibility to Services



Korean National Institute of Dementia (2014)

THANK YOU

Newspaper-based Daily Cognitive Training

Kim et al. Korean National Institute of Dementia (2014)

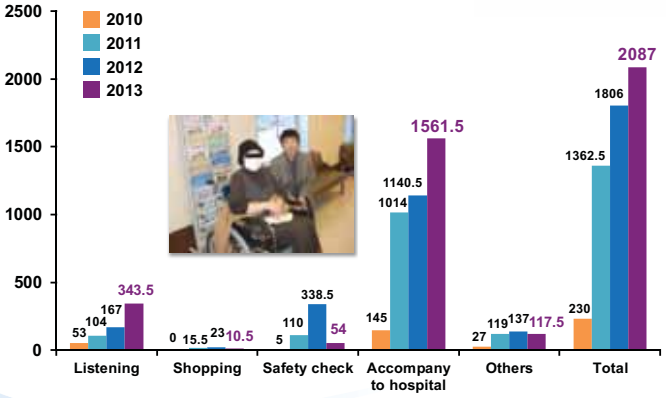
Support Activities System of Sunagawa Medical Center for Dementia

Kumiko Utsumi
Medical Center for Dementia, Sunagawa City Medical Center

G7 Dementia Summit - November 5, 2014

Hours Spent on "Pokke" Activities

Fee-based volunteering: 600 yen per hour (350 yen for a volunteer)



Nakasorachi Community Support Group for Dementia

(Launched in April 2004, incorporated as an NPO in January 2009)

Objectives: To promote and raise the awareness of dementia in the community through the involvement of professionals in various occupations such as doctors, health nurses, care managers, social workers and family members of individuals with dementia, as well as citizens

<Support for families>

(1) Lecture presentations for public enlightenment
(2) Information provision to the community
(3) Lecture for family members

- Banish the stigma of dementia
- Early detection
- Motivating citizens to volunteer

<Support for nursing care professionals>

(4) Organizing lecture presentations and workshops for specialists
(5) Visits to care facilities by doctors and psychiatric social workers to have round-table talks with the staff

<Support for primary care doctors>

(6) Dementia trainings for primary care doctors

Activity Episode

- **A son who is in charge of chief mourner asked us to take care of his mother with dementia all night for keeping vigil.**
- **A woman who became alone after her son's death feels scared by seeing her son's ghost every night. She asked us to stay with her overnight even for just a short period until admission to a nursing home.**
- **Elderly caregiver himself had to go to hospital urgently, then asked for caring service.**

Support "Right Now"!!

Volunteer Training Course
(a series of 5 sessions)

October 2009:
Participated by 38 persons (Sunagawa)
(Held every year since at different locations)

Dementia Support Volunteer Organization "Pokke" launched (2010)

Sunagawa City Ordinance on Support for Active Living of Elderly (2013)

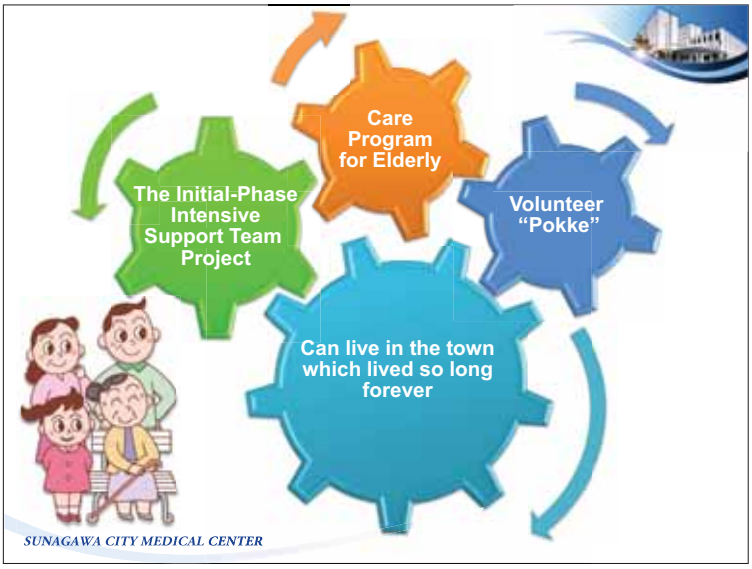
To promote activities to support active living for elderly people and assist them with their daily living, this ordinance aims to clarify the basic principle of those activities and roles of the city, citizens and business entities, while stipulating the obligations and responsibilities associated with the provision and handling of information concerning elderly people, so that it can contribute to building a community where each member can comfortably lead an active, spiritually rich lifestyle throughout his/her life. (The rest is omitted.)

Community Care Program for Elderly (2013)

Based on the registry for householders aged 65 or older, elderly person living alone or elderly person-only households, who are considered potentially at risk, are selected and visited by a nurse specializing in comprehensive care and a staff member of the Senior Citizens' Welfare Division to assess their needs for supportive services.

The results are discussed among the regional comprehensive support center, neighborhood association, welfare commissioners and public administration to provide necessary support from the neighborhood association and welfare commissioners, along with appropriate medical and welfare services.

SUNAGAWA CITY MEDICAL CENTER



SUNAGAWA CITY MEDICAL CENTER

Population aged 65 or older in Sunagawa City
6,187 people (H26.3)

Enrollment of "Information system for elderly people aged 65 or older"
5,964 people (H26.3)

Neighborhood association etc. which completed their discussion to comprehend elderly people in need of care 83 out of 90 neighborhood association etc.

Elderly people living alone
About 950 people

Elderly people who was visited actually
About 760 people

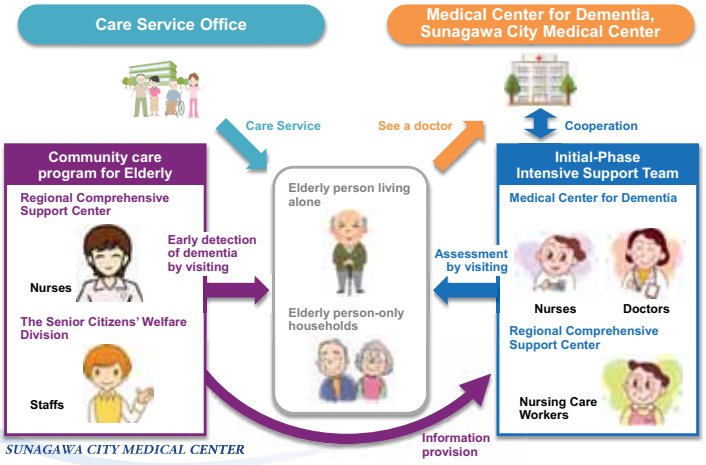
Elderly people who provided their information with their consent
About 600 people

Elderly people with suspected dementia
4-5 people

As of August 29, 2014

SUNAGAWA CITY MEDICAL CENTER

Cooperation of Care Program for Elderly and Initial-Phase Intensive Support Team



SUNAGAWA CITY MEDICAL CENTER

Global Dementia Legacy Event Japan session3

"Omuta city Dementia Care Community Promotion"- to build society where all the people can live together with dignity even suffering dementia

Key words :

intergenerational exchange and SOS network

Rumiko Otani

Omuta-city Dementia Care Community promotion

2001～2002	2003～2005	2006～2013
■Dementia care society start Member: nurse ,caregiver of Care service institution and Medical institution Long-Term Care Insurance Division ■ **Omuta city Dementia Care Community Promotions start** ・responsible organization ⇒Omuta city ・superintendence ⇒Dementia care society **All household Actual condition survey , citizen's opinion is reflected in measures**	■**Dementia Coordinator education** ・Person-centered care ・improvement of the care ・promotor of regional construction ⇒95persons completion ■**Picture book classroom of Elementary and Junior high school** ・Enlightenment ・Supporters training ■Hayame-minami Ninzyou Network strat **Wandering simulated training**	■Dementia screening and Prevention activity ■consultation and support for citizen about dementia ■Association for young dementia person ■Association for family ■**Local dementia support team** ・Dementia specialist ・Dementia coordinator ■**Omuta–city Hotto Anshin(wandering)network** **wandering simulated training in overall city**
The cooperation of the administrative and professional	Human resource development that you share the mission	The improvement of local dementia support system

Hayame-minami Ninjyou Network

The cooperation of local residents, Younger generation and Long-term Care service institution

To watch, and support each other

An Overview of Omuta City, Fukuoka Prefecture in Japan

Miyahara coal mine
(An Important Cultural Property)

Omuta, once a city of coal mines (Miike coal mine was closed in 1997), is now evolving into a people-oriented community.

- Total Population of Omuta City
  From approx. 210,000 (in 1960)
  approx. 121,098 (October, 2014)
- Aged Population 39,811
  Percentage of Aged Population: 32.9 % (October, 2014)
  Percentage of Population Aged 75+: 17.6 %
- People with Certification of Needed Long-Term Care 7,820
  Certificate rate: 19.4% *aged 65+ (August, 2014)
- Total Households: 57,347 (October, 2014)
  Household with aged population: 29,550 (51.5%)
  Household of an aged single-person: 13,406 (23.4%)
  Household in public housing: 4,832 (8.4%)
- Percentage of population belonging to a community center
  32.4% (2014)

Omuta city "Hotto Anshin"(wandering)Network

Wandering simulated training since 2004

"wandering"is OK!

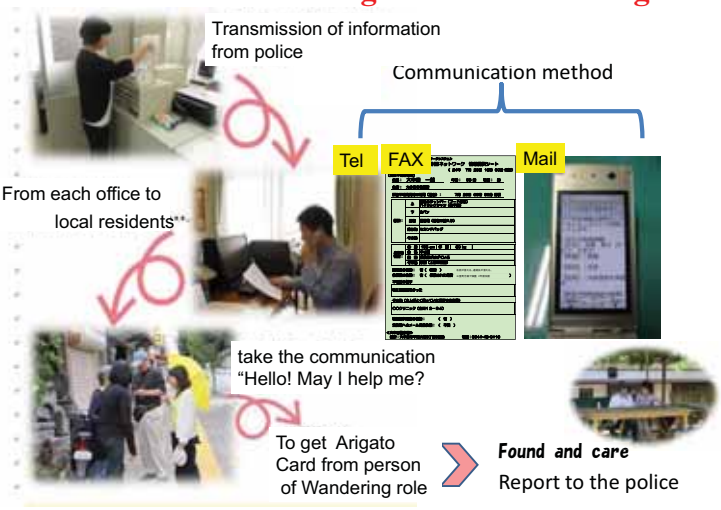
Regional Development of Society in which everyone can wandering in easy and safety even dementia

Spread understanding of dementia in the whole area and usually watch them and raise awareness to support them.

Make safety net having high effect at the time of the disappearance outbreak

2014 : 11th wandering simulated training
3000 citizens participated

<Flow of Wandering simulated training>



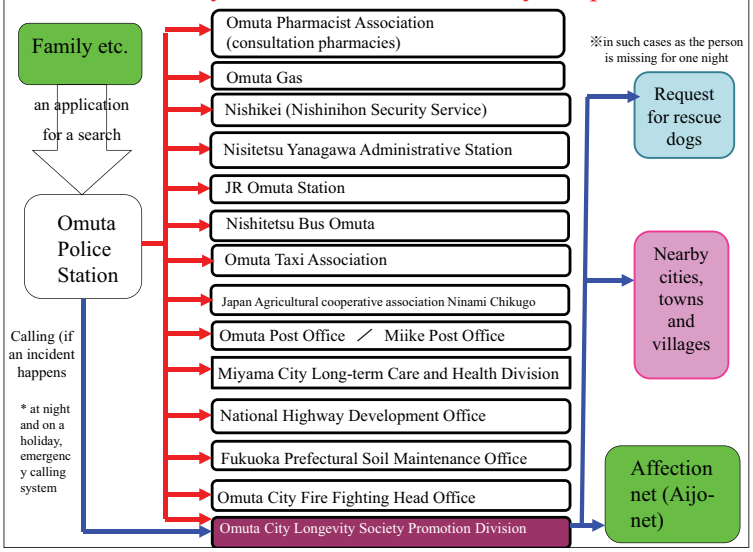
Omuta City SOS Network for Elderly People
（Sample by Omuta police station ）

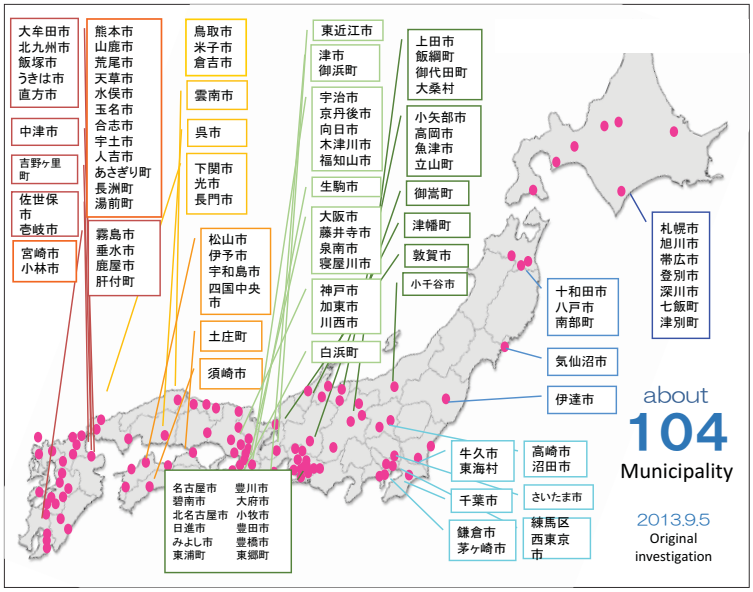
year	2007	2008	2009	2010	2011	2012	2013
Number of the missing person reports	129	134	132	143	106	123	156
The number of use of SOS network	30	20	14	16	20	24	23

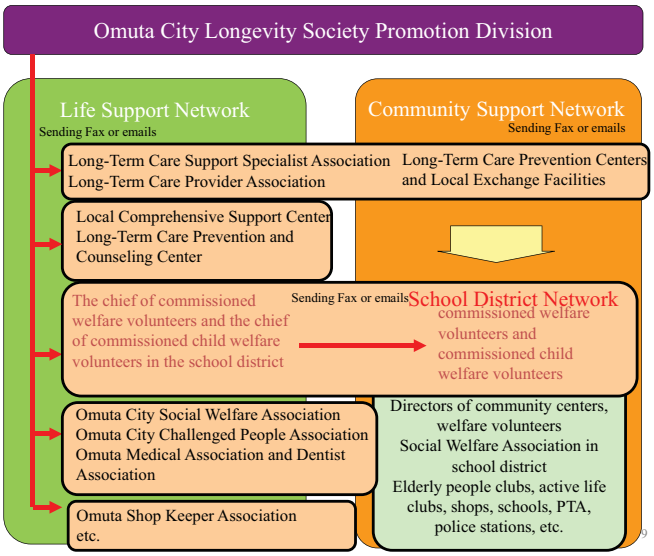
※**Exclusion**: Missing persons from the wide area

year	2010	2011	2012	2013
Number of the missing person reports	143	106	123	156
dementia ⇒	16	24	24	24
Number of protected of persons with dementia	112	121	169	138

Omuta City SOS Network for Elderly People







Picture-book classroom in Elementary and Junior high school 2004~2014

■The number of students who attended ： 7492
(without '04, '14)

■Elementary school which have it everyear ： 9 / 21 school

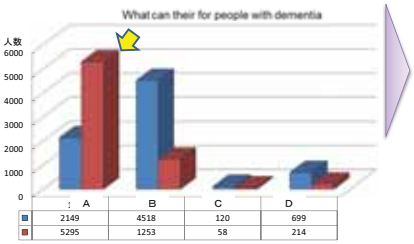
■Junior high school which have it every year ： 9 / 11 school

Intergenerational exchange
Participation in community development

Changes in the perception of elementary and junior high school students for dementia and the elderly(after classroom)

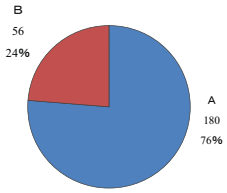
Q. Do you think that you can support something to people with dementia by yourself?

A : Yes, I know what to do.
B : Yes , but I don't know what to do
C : No, I don't think so
D : I don't understand



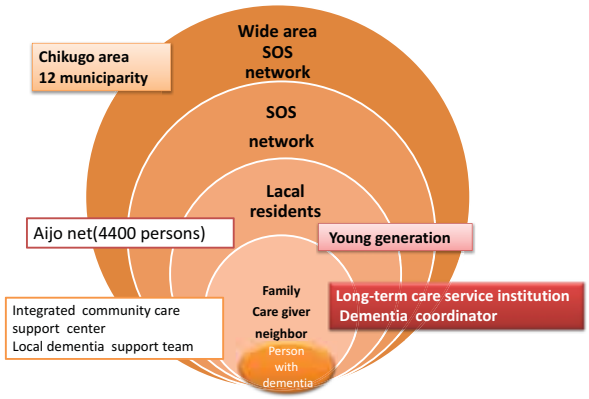
The Students who understand the support for people with dementia specifically has increased ,after picture classroom.

Q. Did you support for people with dementia by yourself in rural community?



As a result of having followed all students of Yoneo junior high school after learning in 1-2 half a year '07, 76% students performed the community activities.

Regional Development of Society in which everyone can wandering in easy and safety even dementia



Basic policy : Person-centard care and life support

Department of Health

Global action against dementia

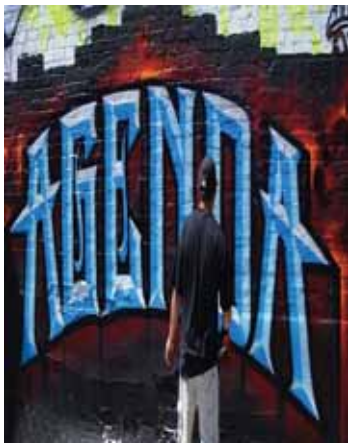
Enhance Awareness & Education in the Society

Gill Ayling
Head of Global Action Against Dementia
Department of Health, UK

5th November 2014

The Dementia Journey – The PM's Challenge

- National Dementia Strategy Feb 2009
- Prime Minister's Challenge March 2012
  - Increase diagnosis rates
  - Raise awareness & understanding
  - Double funding for research by 2015
- G8 Summit December 2013
  - Cure or disease modifying therapy by 2025
  - Support improvements in care and services
  - Through civil society, reduce stigma, exclusion and fear
- Global Action Against Dementia 2014 onwards
- We need to champion, pioneer & innovate in order to defeat dementia, not just in our own countries but all over the world in order to galvanise a truly long term, global response.



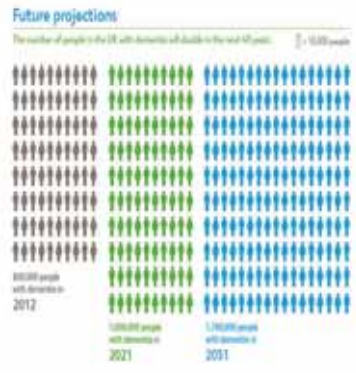
- Key Facts & Figures
- Prime Minister's Challenge
- Importance of Education
- Public awareness to reduce stigma
- Practical Action
- New Models

Importance of Education

- The best possible care is not a replacement for a treatment, but through innovative care we can really change the experience of people with dementia & their carers over the next 10 years.
- Therefore, as we await a cure, education & training is key to improving the way we:
  1. think about dementia
  2. reduce stigma
  3. increase our awareness & understanding &
  4. Most importantly improve care & outcomes
- The nature of dementia means that managing the condition can pose unique and sometimes difficult issues for staff in hospitals and in the community and also for carers.
- Care for people with dementia needs to start in education to create dementia-aware workforce & communities.

5

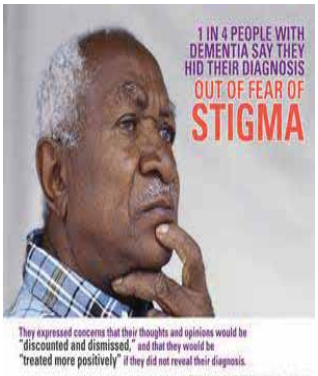
Key Facts & Figures



- Dementia is one of the biggest **global** challenges we face today & is one that we as a society simply cant afford to ignore.
- Globally there are **44 M** people living with dementia, set to double by 2030 and triple by 2050 & estimated costs of **$604 billion,** rise to **$1 trillion by 2030**.
- In the UK there are **800,000** people who have dementia, this number will double in the next 30 years.
- Among the over 55s, dementia is feared more than any other illness.
- **550,00** carers of people with dementia.
- Costs an estimated **£19 billion** a year – higher than the costs of cancer, heart disease or stroke.
- Huge variation in services.

3

Public Awareness to Reduce Stigma



- While public awareness of the existence of dementia has increased, that has **NOT,** as yet, led to a greater acceptance of individuals who are coping with dementia.
- Nearly 1 in 4 people with dementia **(24%)** hide or conceal their diagnosis citing stigma as the main reason.
- **40%** of people with dementia report not being included in everyday life & **three quarters** don't feel society is geared up to dealing with people with dementia.
- People living with dementia commonly experience loneliness, isolation, anxiety & depression.
- **"I am afraid to tell others that I have dementia. Therefore, other people are always impatient toward me, and sometimes make fun of me"**
- If there was no stigma, we might recognise people with dementia as being different, but still make every effort to include them as members of society.

6

Change Attitudes and Raise Awareness

From

Lonely, isolated, people in care homes

To

Engaged & alive individuals actively involved in life

Harnessing People Power

Practical Action

House of Memories

- **Dementia Friends Campaign** Social movement aimed at raising awareness, improving understanding & attitudes – **over 500,000**.
- **Dementia Friendly Communities - 70 DFC's** working to break down stigma across towns & cities.
- **Health Check** – helping to raise awareness, understanding and improve timely diagnosis – **400,000 leaflets, 48% received a dementia health check**
- **House of Memories** –promotes the need & value for compassion, respect and dignity in care & support – **5,000 people trained** www.liverpoolmuseums.org.uk/memoryap
- **National Dementia Training** – promoting education & awareness , improving timely diagnosis, & providing support throughout the dementia journey – **358,000 by March 2015**

The Power of the Crowd

COMMUNITIES | FAMILIES | PARTNER ORGANISATIONS | BUSINESS | 3rd SECTOR | CITIZENS

New Models

- Global Action Against Dementia is becoming a reality, with countries working together to change lives.
- We need to make sure that the very best care & treatment is available to all no matter what their circumstances or background.
- We need to make sure that the very best ideas, models & techniques are shared globally so that best practice is available around the world
- Based on the practical actions I have highlighted, some of the models we could use in order to improve education, reduce stigma and raise awareness include:
  - Harnessing people power
  - The power of the crowd
  - Partnerships
  - Universal Advocacy

Partnerships

Universal Advocacy

Out of the shadows – campaigning and educating in Germany

Global Action against Dementia
Legacy Event Japan –
New Care & Prevention Models

Tokyo, 5th/6th November 2014

Sabine Jansen

Deutsche Alzheimer Gesellschaft e.V.
Selbsthilfe Demenz

„Alzheimer and you“

- Competition für young people
- Education materials for teachers
- Interactive Website

Different target groups

- People with dementia
- Caregivers
- Volunteers
- Health care professionals
- Children and young people „Alzheimer and you“
- Other groups like policemen, fireworkers, bank officers, salespersons,….
- General public

People with dementia – part of the community

Different materials and methods

- Empowerment to people with dementia through meetings and support groups
- Education programs for caregivers (also E-Learning course)
- Attractive advanced training to find volunteers
- Brochures, leaflets, DVDs,….
- TV-spots, Posters in the public
- …..

„Greetings from the sea“

- Campaigning through desorientation:

„It can happen to be confused about the place where you are but to loose orientation completly is bad. There are 1,5 Mio. people with dementia in Germany. Do not forget them!

„Demenz – jede/r kann etwas tun“
www.deutsche-alzheimer.de

The case for increased awareness and concern

Global Dementia Legacy Event
Minato-ku, Tokyo, Japan
November 5, 2014

Splaine Consulting

Overview

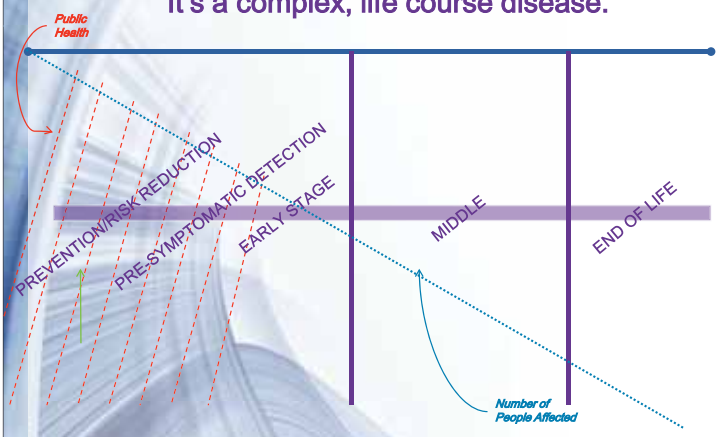
- The state of Alzheimer's and dementia
- What makes dementia different?
- Domains of dementia friendly communities

Disclsoures

Consulting Agreements as of 10/1/2014

- Alzheimer's Disease International
- Consumer Voice (aka NCCNHR)
- Eli Lilly
- Bayer A.G. (non-U.S.)
- Alzheimer's Association (US) Healthy Brain Initiative
- Elder Justice ACTion, Elder Justice ACTion SC
- Alzheimer's Association GA/GA Dept Aging
- National Center on Elder Abuse (US)
- Also: Splaine is CEO and principal member, Cognitive Solutions LLC

A Comprehensive Approach to Alzheimer's:
It's a complex, life course disease.



Conflict of Interest

- None of the views represented here are those of my clients nor have they had any control or input into this presentation.

What makes ADRD Different?

- **Families are the caregivers.**
- **Gap between prevalence and diagnosis**
- Diagnosis late in disease process
- **Co-morbid chronic diseases**
  - Lack of attention to population health/risk
  - ***Siloed budgets and systems***
- Stigma, nihilism, ageism plus capacity
- Duration of disease process, care
- Special pops: complicated lives

Goals for national plans

- NOT Ageing, but health and public health
- Increase awareness, reduce stigma
- Implement to the limit of the evidence available
- Inclusion of persons with the disease
- Not necessarily new spending, better spending

Domains of Dementia Friendliness

- Public awareness and access to information
- Inclusive planning processes
- Access and consideration for dementia in local businesses or public services
- Creation of activities such as memory café led by persons with dementia
- Community based innovation in services
- Access to transportation

Contact information

- www.splaineconsulting.com
- www.cognitivesol.com
- mikesplaine@verizon.net

Care and prevention of dementia in Thailand

Tasanee Tantirittisak MD.
Prasat Neurological Institute
DMS, MOPH
Thailand

Organization of care

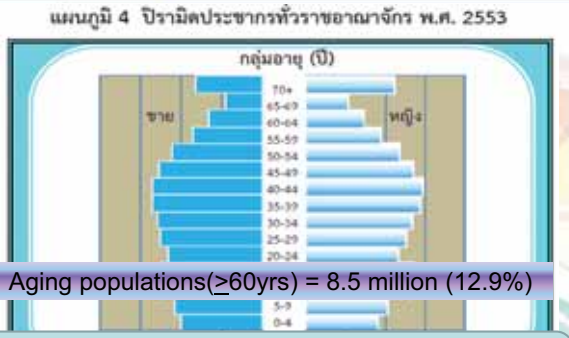
Cognitive impairment patients → 1° doctor → Specialist doctors
1. Gerontologists
2. Neurologists
3. Psychiatrists



1.The dementia association of Thailand.
2.Alzheimer and related disorder association (ARDA)
3.Foundation of Alzheimer's disease
4.Gerontology and geriatric medicine association.

Tertiary cares
Special hospitals
University hospital
Private hospital

Thailand Aging populations in 2010



Aging populations(≥60yrs) = 8.5 million (12.9%)

In 2012, Thailand may have 542,300 demented people.

Awareness Activities

- World Alzheimer's day events.
- Short movies
- Educations:
  - talk
  - News letter
  - events (world AD month)
  - website (azthai.org), (Thai memory test.com)
- Capacity building for medical personals (nurse, doctors), caregivers (informal=family)
- Healthy elderly clubs.

Organization of care

Government section
1. Hospitals under ministry of public health
2. University hospitals
3. Local administrative hospitals
4. Hospital under Ministry of defense
5. Hospital under authorities

Private section
1. Private hospitals
2. Medical clinics
3. Long term care and respite care centers
4. Elderly clubs or groups

3 helath funds
- Welfare for civil servants
- Social security
- Universal coverage

Prevention projects

1.Use the brain or lose it

2.Old people play young (OPPY)

3. Active social engagement

4.Healthy aging clubs

5.Cognitive training program for MCI

Acknowledgement

Dr. Sirithron Chansirikarn MD. ,
President of Thai Alzheimer Association
www.thaialzheimer.org

World Alzheimer's day events

Check BP, BMI and blood test

Food demonstration

Cognitive screening

Brain exercise

Treatments

CPG for diagnosis and management

Memory clinic

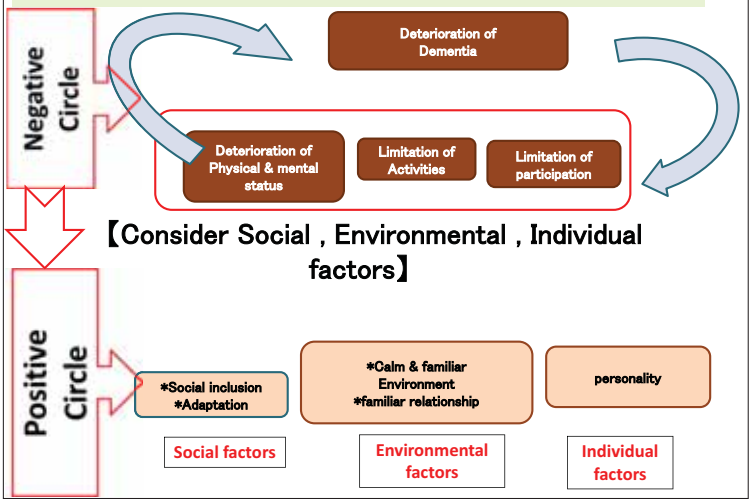
Day care

Drugs

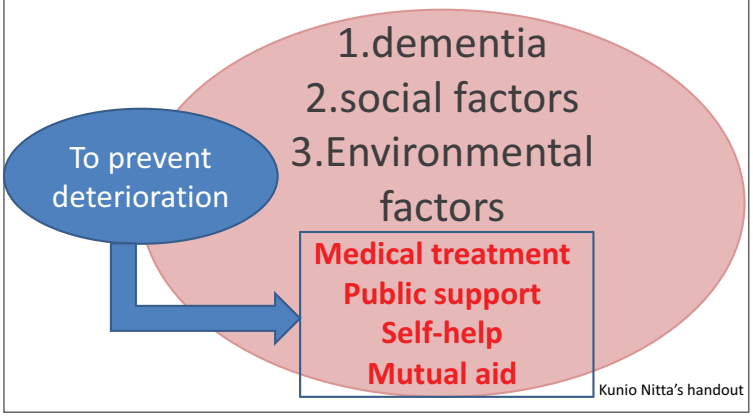
Aim at the ideal town in which the person with dementia can live.

Kunio Nitta, MD
Medical Corporation Tsukushikai

ICF ; Positive Circle of Dementia

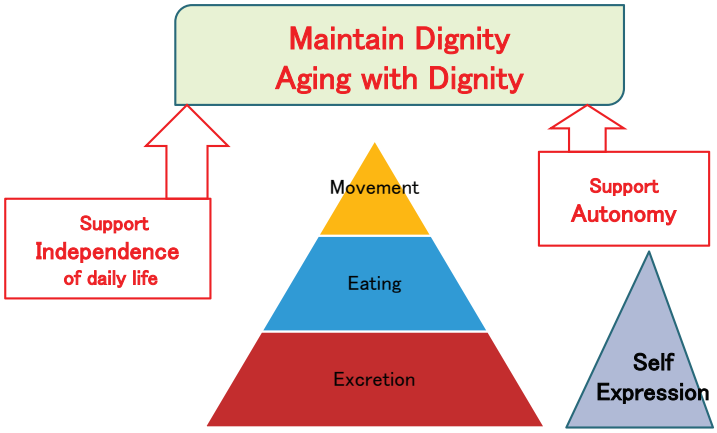


Factors which affect Dementia condition



Kunio Nitta's handout

To maintain Dignity of the person with Dementia – to live as a whole person –

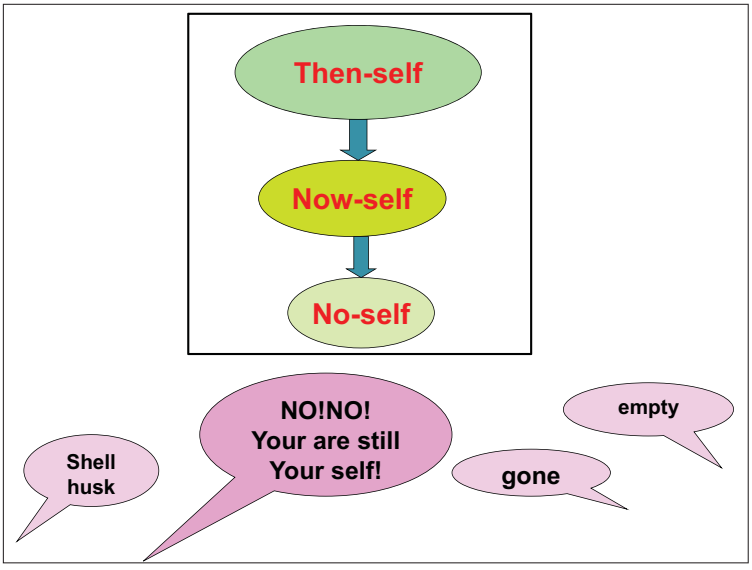


Kunio Nitta's handout

The structure of the dementia condition

$$D = P \times B \times H \times NI \times SP$$

D ; Dementia
P ; Personality
B ; Biography
H ; Physical-health
NI ; Neurological Impairment
SP ; Social Psychology



Kunitachi City

area approximately 8.15 ㎢

Population of elderly people

01/04/2014	total	%
total	74,303	—
Over 65	15,716	21.15%
Over 75	7,703	10.3%

Number of elderly certified who need nursing care

01/04/2014	人
total	2,994
40～64	92
65～74歳	350
Over 75	2,552

01/2013
【over 75 who need home care】 7,282
- not certified 5,140
- certified 2,142

- dementia (−) 1,087
- dementia with family 767
- dementia , alone 288

* the dementia on this map means that the degree of independence in one's everyday life is over Ⅱa
*refering residence registration

7

Management for wandering elderly with dementia

◆Analysis of 13 wandering person with dementia

(There is reasons for going out & wandering)

- **Desire**
  「to go working to the office」
  「to do exercise」
  「to eat breakfast」
- **Lose one's way**
  「can't return from the post office」
- **Delirium**
- **Other reasons**

(ex.)
- go out with his business bag
- feel hungry & go shopping for breakfast
- go out by bicycle for exercise

(Management)

Using GPS
(in one's bag)

Watching
(inhabitants, shopkeepers, police, care managers, etc.)

Food delivery service
(to supply daily food)

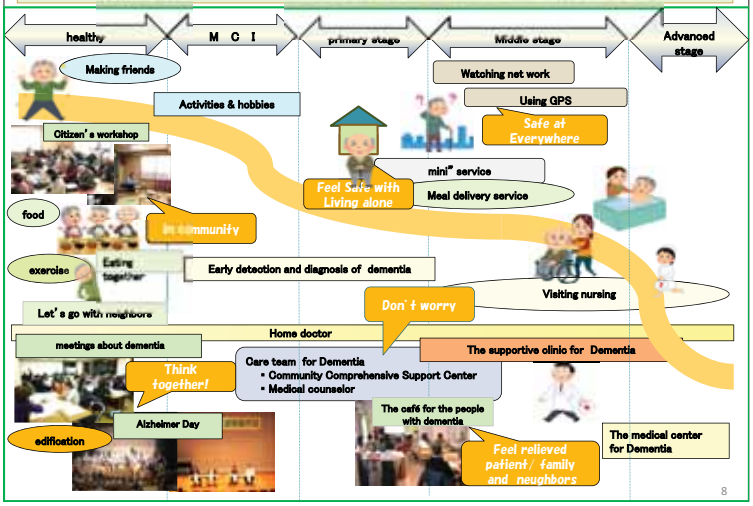
Daytime Care
(place to stay)

Working with
Offices of Care giving
Local government

Aiming at Community
where person with Dementia can go out & wandering safely

10

Approach of Dementia Care in Kunitachi City



8

The 56 visiting care cases of dementia patients who are living alone

【findings in this study】

①Cooperation with medical care
*inform the doctors of accurate patient status
* the need of medical care on dementia

②Family support
*mitigate care burden
*resolve conflicts among family members

③Recognize the changes of patient status
*who should notice them,
and to whom convey the information

④Need of community support
*person with dementia can't live alone with the help of present social support (sometimes it is not enough)

(Improvement in Care management)

★Regular exchange of information with Care manager
Recognize the change of the status

★Level up the technique of dementia care
Specialist (Dr.) for dementia care
Case management meeting

★Cooperation among the Community
for continuous support
(inhabitants/medical staff/ care staff /local government)

9

Japanese Nursing Association

G8 dementia summit
the Global Dementia Legacy Event Japan
November 5, 2014

Toward the achievement of the dementia friendly society

Noriko Saito
Executive Officer
Japanese Nursing Association

Missions of the Japanese Nursing Association

We aim to realize a society where patients with dementia and their families can continue living in their own town until their last minutes, while maintaining their human dignity.

Business development

- Education/Training
- Publicity/Public relations
- Policy proposals

This will be discussed today

Society to aim at

- Patients can receive continuous medical/nursing/long-term care services of high quality from the early to the terminal phases of illness, and there are least burdens on the patients and their families.
- Patients and their families can continue living in their own town and home as members of their community.
- There is no prejudice against dementia, and patients' wishes and rights are respected, and their dignity is maintained.
- Residents, healthcare and long-term care professionals, and government administrations collaborate for realizing dementia friendly society.

Education and training currently implemented by the Japanese Nursing Association

1. Intensive education on dementia among nursing staff

Contents of education and training

Training of practitioners
- Fundamental knowledge of dementia
- Understanding of and looking after patients with dementia
- Collaboration at a community level to protect the lifestyle that suits each individual

Training of managerial staff
- Care and a care system
- Support of families and a support system
- Staff education/staff support
- Task management
- Development and implementation of a collaboration system

*Implemented as of fiscal year 2014

Number of participants

24,920 members (total)

Outcome

- Understanding of the fundamental knowledge, clinical practice, etc. of dementia have been enhanced.
- Challenges concerning nursing care for dementia has become clearer, so that awareness, such as the need for leadership, etc. has been promoted.

System to support patients with dementia to "live life"

Education and training currently implemented by the Japanese Nursing Association

2. Preparation of specialists in dementia care among nursing staff

Contents of cultivation of professionals

Certified Nurse in Dementia Nursing
Education for more than 6 months/615 hours (Educational institutions: 8 institutions in Japan)

Certified Nurse Specialist in Gerontological Nursing
Postgraduate education (26 units)
(Educational institutions: 33 institutions in Japan)

Number of certified members

Certified Nurse in Dementia Nursing
- 480 members (as of October 2014)

(working at hospitals, clinics, care facilities, home-visit nursing stations, etc.)

Certified Nurse Specialist in Gerontological Nursing
- 66 members (as of October 2014)

(working at hospitals, care facilities, home-visit nursing stations, etc.)

Contents of activities and outcomes

Certified Nurse in Dementia Nursing
- Expansion of the life functions of people with dementia, prevention and alleviation of BPSD
- Enhancement of understanding, and quality of care for, dementia by providing education and training opportunities to local medical practitioners and other relevant workers
- Awareness campaign aimed at local residents

Certified Nurse Specialist in Gerontological Nursing
- Same as above
- Ethical coordination ➡ Enhancement of QOL of elderly people with complicated health problems
- Education, research

The Multilayered Human Resource Development System to Support People Living with Dementia

Tokyo Dementia Care Research and Training Center, Japan

Kumiko Nagata

Challenges of Human Resource Development in Dementia Care

[in Quantity]

- **The amount of human resources developed are unable to keep up** with the rapid increase of people with dementia.
- **Many care staffs leave their workplace** after development training.
- **Local government cannot identify the number of people trained** as the trainings are done by various different organizations.

[in Quality]

- **Not- enough works have been done together on shared value** "for people with dementia to continue living with hope and respect in their communities,"
- There are,
  - **Gaps between what has been learned and what to practice**
  - **Lacks of continues learning opportunities** to acquire the most updated, various knowledge

Disparities among local governments widen In human resource development & reservation

Shifts of Targets in Dementia Care and Human Resource Development in Japan

2000 → 2010 → 2014

Institutional Care	Individual Care	Individual Care in Local Community	Community Integrated Care

- Care Staffs
- Senior Leaders, Leaders & Care Staffs in all Japan
- Dementia Supporters
- Dementia Support Doctors and Primary Care Doctors
- Promoters of Community Dementia Care in municipalities

→ Various human resources

Keys to Tackle the Challenges
-Learning from Our Trials of the Decade-

Grow human resource who think and practice from the eyes of people living with dementia In each municipalities

Enhance network of various human resources

- Dementia supporters
- Dementia care professionals
- Leaders of dementia care
- Promoters of community dementia care
- Local government officer

Share Experiences living well with Dementia In a community

The Construction of Multilayered Human Resource Development System for people with dementia and the community

Attained Targets of Dementia Care

Increase of varieties in dementia care professionals
- Doctors, nurses, pharmacists
- Care workers, Care managers
- Welfare workers

Increase of varieties in dementia supporters
- Local residents, families
- Stores, Banks, Transportations
- Police, Fire authorities etc.

Increase of promoters at municipalities
- Dementia Support Doctors
- Promoters of Community Dementia Care
- Leaders of Dementia Care

Multilayered Human Resource Development System for People Living with Dementia and The Community

Municipalities

People with Dementia to continue living well in community

Dementia supporter ＋ Dementia care professionals

Promoters ＋ Leaders

Municipality officials

Systematic develop human resource

Prefectures

Prefectural officials

Backup and monitor of municipalities

The nation wide : Tokyo Dementia Research & Training Center
- Help develop officials at municipalities and prefectures
- Training promoter & senior leader
- Collect cases, provide information

What Will be Important in Human Resource Development - Based on Our Trails -

1. Share the values and objectives thoroughly at each layer of dementia care.

   "People with dementia will live in their communities with hope, dignity."

2. Examine every case of practice after training for evaluation. Also, establish the ways to share what are found.

3. Build a human resource development system that evolves with people living with dementia.


Person with dementia as a lecturer on "Medicine, Care & Support That We Need"


Evaluation taken place with people with dementia



Pursue possibility of living well together

Thank you for your kind attention

G8 dementia summit
the Global Dementia Legacy Event Japan
November 5, 2014

Trends and Future of Enhance Awareness and Education in Japan

National Center for Geriatrics and Gerontology,
Center of Training and Innovation for Gerontology
Hidetoshi Endo, MD

Target of education and training dementia
~Leadership by government and local government~

- People with dementia(at hospital or clinics)
- Families(schools for families in clinics or hospital)
- Health care professionals(lecture, group-work and e-learning and others)
  (Doctors, Nurses, Care staffs)
- Shop keepers, policeman and others(Dementia supporters)
- Students (Dementia supporters)
- Volunteers

History of health policy for dementia training

- 1984 Training for care staffs to people with dementia
- 2000 Implementation of Long term care insurance
- 2004 Dementia → Ninchi-sho (=Neurocognitive disorder)
- 2005 「10 years strategy for dementia campaign」
  to know about dementia and to support for dementia
  Dementia Support doctors (~3,400)
  Dementia Supporters (~4,600,000)
- 2006 Training for primary care doctors by dementia support doctors
- 2008 Medical Center of dementia (~300 , 「Urgent Projects for improvement of medical aspect and QOL of person with dementia」
- 2012 「5 year plan of dementia health policy」 (Orange plan)

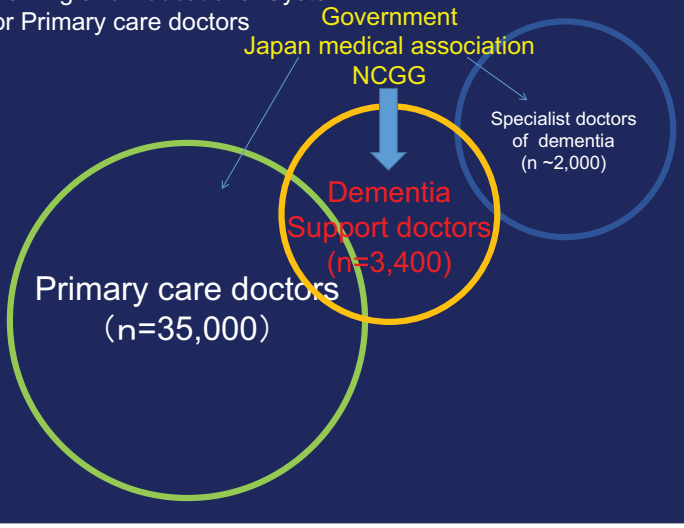
Tools of education to dementia
~For enhance awareness~

- Lecture(using textbooks, DVD) for Doctors, and professionals by government
- Group work(conference)
- TV programs(NHK and others)
- Books(many books related dementia)
- Movies(Everyday is Alzheimer's et al.)
- Internet(ninchisyo-forum.com et al.)
- NCGG Information services http://monowasure.org/ninchi/

Aim of education and training for dementia

- To stop the stigma for dementia
- To enhance awareness to public for dementia
- To educate families to understand dementia and BPSD for reducing care burden
- To educate medical and care staffs for improvement of care
- To make an early diagnosis for AD bucause of future treatment

Training and Educational System for Primary care doctors



Activities of dementia support doctors

- Lecture for 35,000 GPs
- Consultant for GPs "Dementia support doctor"
- Leader for network in the community
- A member of support team for Initial-Phase Intensive Support Team in every city
- Collaboration with certified doctors and 300 Dementia Medical Centers

National Center for Geriatrics and Gerontology (NCGG), Japan

Frameworks of training and education

Target	Leaders of Education and training	Mass-communication
Doctor	◎ 3400 support doctors (35000 primary care doctors)	○
Professionals (Care manager, OT, nurse)	◎ 460 Certified nurses	○
Families	◎ School in clinic	◎ Association
Person with dementia	○ support system IC, advocacy	○ Group, dementia café
Community residence, student shop staff, policeman&+	○ Caravan Mate 4600000	◎ Supporters

Future aspects of education related dementia

- More and continuous education and training for care staffs and families, the innovative care principle "Person centered care" is very important, one of example is DCM to reduce care burden from BPSD and to improve BPSD
- Mutual Understanding the importance of good practice and framework of education and training in Integrated Community care system
- Necessity of Worldwide Support system for education and training system in developing countries, by WHO or others.

Global action against dementia

DAY 2

Thursday, 6 November

Main Conference

Speaker Biographies

Yasuhisa Shiozaki

Minister of Health, Labour and Welfare, Japan

Biography

Date of Birth: November 7, 1950
Place of Birth: Ehime Prefecture
Constituency: Ehime 1st district (elected 6 times)

Education

Jun.	1982	Graduated from Harvard Kennedy School
Mar.	1975	Graduated from Faculty of Arts and Sciences, Tokyo University

Career

2014 Sep.		Minister of Health, Labour and Welfare (reshuffled 2nd Abe cabinet)
Oct.	2013	Director, Committee on Budget, House of Representatives (HR)
Dec.	2012	Re-elected to the HR (46th general election)
Sep.	2010	Director, Committee on Budget, HR
Aug.	2009	Re-elected to the HR (45th general election)
Sep.	2006	Chief Cabinet Secretary, Minister in charge of the Abduction Issue
Nov.	2005	State Minister for Foreign Affairs
Sep.	2005	Chairperson, Committee on Judicial Affairs, HR
Sep.	2005	Re-elected to the HR (44th general election)
Oct.	2004	Chairperson, Committee on Judicial Affairs, HR
Nov.	2003	Re-elected to the HR (43rd general election)
Oct.	2002	Director, Treasury and Finance Division, Policy Research Council,Liberal Democratic Party (LDP)
Jan.	2001	Acting Director, Health, Labor and Welfare Division, Policy
Jul.	2000	Research Council, LDP Director, Foreign Affairs Division, Policy Research Council, LDP
Jun.	2000	Re-elected to the HR (42nd general election)
Oct.	1999	Director, Judicial Affairs Division, Policy Research Council, LDP
Sep.	1997	Parliamentary Vice-Minister of Finance
Jan.	1996	Director, Committee on Budget, House of Councillors (HC)
Jul.	1995	Elected to the HC for the first time (17th general election)
Jul.	1993	Elected to the HR for the first time (40th general election)
Apr.	1975	Joined Bank of Japan

Kiyoshi Kurokawa

MD, MACP, FRCP (London)

World Dementia Council
Professor Emeritus of the University of Tokyo

Biography

Dr. Kurokawa, Professor Emeritus of the University of Tokyo, is Professor of National Graduate Institute for Policy Studies (2007-); Chairman, Health and Global Policy Institute (2005-); Commissioner on the WHO Commission for Social Determinants of Health (2005-2008); Chair, Global Health Innovative Technology Fund (2013-); Council Member of the World Dementia Council (2014.4.30-).

He received a MD degree from the University of Tokyo. Following clinical training in internal medicine and nephrology at the Department of Medicine of the University of Tokyo, Faculty of Medicine, he spent 15 years in USA (1969-84); professor of medicine, Department of Medicine, UCLA School of Medicine, University of Tokyo, Faculty of Medicine (1989-96), Dean and Professor of Tokai University School of Medicine and Director of the Institute of Medical Sciences (1996-2002) of Tokai University.

He has served as president and/or executive officer to many prestigious national and international professional societies in medicine, nephrology, science academies and science policy organizations. He is also an elected member of professional societies including Science Council of Japan (President, 2003-06), Institute of Medicine of the National Academies of the USA. He was/is Board Member of Biobliotheca Alexandria, Egypt, Khalifa University of Science and Technology of Abu Dhabi, Okinawa Institute of Science Technology Graduate University and Advisory Board to the Prime Minister of Malaysia.

Dr. Kurokawa, Special Advisor to the Cabinet (2006-08), has served many committees of the Ministries and Cabinet Office of Japan, eg, Chairperson of the Hideyo Noguchi Africa Prize Committee.
He chaired the Fukushima Nuclear Accident Independent Investigation Commission by the National Diet of Japan (2011.12-2012.7) for which he recognized as ‘Scientific Freedom and Responsibility Award’ of AAAS (2012) and of ‘100 Top Global Thinkers 2012’ of Foreign Policy.
His website: <http://www.kiyoshikurokawa.com/en>

Dennis Gillings

PhD, CBE

World Dementia Envoy

Biography

Dr Dennis Gillings was appointed as the World Dementia Envoy in February 2014. As the founder and executive chairman of Quintiles, the world's largest provider of biopharmaceutical development and commercial outsourcing services, Dr Gillings has more than 30 years' experience. He has worked with numerous biopharmaceutical companies and with many health organisations. Prior to this Dr Gillings spent some time in academia as Professor of Biostatistics at the University of North Carolina.

Dr Gillings also has personal experience of dementia, as his mother lived with the condition for 18 years until her death in 2013. Having seen first-hand the devastating effects of the condition and lack of effective treatment, he is passionate about harnessing innovation in care; bringing together ideas from around the world to try to prevent the condition and improve the lives of those living with dementia. Other key priorities of the World Dementia Council are to reduce barriers to investment in research and speeding up drug development, with the ultimate goal of finding a cure or disease modifying therapy by 2025.

Dr Gillings, who was born and educated in the UK, was awarded a CBE in 2004 for services to the pharmaceutical industry.

Sir Mark Walport

FRS FMedSci

HM Government
Head of the Government Office for Science,UK

Biography

Sir Mark is the Chief Scientific Adviser to HM Government and Head of the Government Office for Science.

Previously, Sir Mark was Director of the Wellcome Trust, which is a global charitable foundation dedicated to achieving extraordinary improvements in human and animal health by supporting the brightest minds. Before joining the Trust he was Professor of Medicine and Head of the Division of Medicine at Imperial College London.

He has been a member of the Prime Minister's Council for Science and Technology since 2004. He has also been a member of the India UK CEO Forum, the UK India Round Table and the advisory board of Infrastructure UK and a non-executive member of the Office for Strategic Coordination of Health Research. He is a member of a number of international advisory bodies.

He has undertaken independent reviews for the UK Government on the use and sharing of personal information in the public and private sectors: ‘Data Sharing Review’ (2009); and secondary education: ‘Science and Mathematics: Secondary Education for the 21st Century’ (2010).

He received a knighthood in the 2009 New Year Honours List for services to medical research and was elected as Fellow of The Royal Society in 2011.

Shekhar Saxena

MD

Director
Department of Mental Health and Substance Abuse
World Health Organization

Biography

Dr Saxena is a psychiatrist by training, working at World Health Organization since 1998 and the Director of the Department since 2010. He is responsible for all work at WHO related to mental, developmental, neurological and substance use disorders and suicide prevention.

His responsibilities include evaluating evidence on effective public health measures and providing advice and technical assistance to ministries of health on prevention and management of mental, developmental, neurological and substance use disorders. His work also involves establishing partnerships with academic centres and civil society organizations and global advocacy for mental health. Dr Saxena initiated WHO's work on the Mental Health Atlas that has led to a global monitoring of mental health resources over the last 14 years. He also led the project on mental health Gap Action Programme (mhGAP), to scale up services, currently being implemented in more than 60 countries.

Dr Saxena is currently leading WHO's work to implement the Comprehensive Mental Health Action Plan adopted by the World Health Assembly in May 2013. He is also responsible for assisting countries on Assembly directed work on Developmental disorders including Autism and work related to public health action on dementia. His responsibilities also include leading activities on strategies to reduce harmful use of alcohol and illicit drugs. He is also responsible for revision of mental, behavioural and neurological disorders for ICD-11 to be published by WHO in 2017.

Dr Saxena has edited or authored more than 30 books including WHO publications and has authored more than 250 scientific papers in indexed journals.

Shigenobu Nakamura

MD

Counselor

Alzheimer's Association Japan

Biography

In 1979	President of 8th Annual Meeting of Japan Society for Dementia Research
In 1990-2012	Professor of Internal Medicine, Hiroshima University
2012-Present	Emeritus Professor of Hiroshima University
2012-Present	Director of Rakuwa-kai Kyoto Clinical Trial Center
2015-Present	Counselor of Alzheimer Association Japan

My subjects

Through my daily care and pharmaceutical therapy or clinical trial for people with dementia, I try to introduce new clues of dementia care and to develop methods to prevent Alzheimer's disease.

Kazuko Fujita

Co-Chair of the Japan Dementia Working Group

Biography

Kazuko was born in 1961. She worked for 7 years as a nurse at Tottori Red Cross Hospital. After 9 years of caring her mother-in-law with dementia, she again worked for a local hospital as a nurse for 8 years.

In June 2007, she was diagnosed as Eaily-onset Alzheime's.

In November 2010, she set up a group named “Clover, the group dealing with young onset dementia,” and became its representative. In September 2014, Clover became a nonprofit organization and Kazuko is now working as a deputy vice-president.

Besides that, she has made a speech at meetings held by the Ministry of Health, Labour and Welfare and a study group of persons with Dementia. And from 2011 to 2013, Kazuko was selected as a member of the Committee to Create the Society without any Discrimination in Tottori City. Also, she has worked to set up the new group, the Dementia Working Group in Japan.

Mark Pearson

Deputy Director for the Directorate on Employment, Labour and Social affairs, OECD

Biography

Mark Pearson is Deputy-Director for Employment, Labour and Social Affairs at the Organisation for Economic Co-operation and Development (OECD). Mr. Pearson works with the Director to provide leadership in the co-ordination and management of the activities of DELSA and ensure that it is at the forefront of the international social and employment agenda.

Mr. Pearson joined the Organisation in 1992, initially working in DAF on tax issues. After working on the OECD Jobs Study, he moved to ELS where he headed work on employment-oriented social policies, including developing the concept of 'Making Work Pay' and starting the publication 'Society at a Glance' . He became head of the Social Policy Division from 2000-2008, during which time he initiated work on 'Babies and Bosses' , 'Pensions at a Glance' , led the first cross-directorate work on gender, and work on income inequality in OECD countries.

In 2009 he became Head of the Health Division where the central focus of work has been on how to deliver health care with greater efficiency, including putting much more effort into prevention of obesity and harmful use of alcohol.

He gave evidence to the US Senate on 'Obamacare' , and has been on a panel advising the Chinese government on its health reforms. Prior to joining the OECD, Mr. Pearson worked for the Institute for Fiscal Studies in London, and also as a consultant for the World Bank, the IMF and the European Commission.

Mr. Pearson is British, and has a degree in Politics, Philosophy and Economics from Oxford, and an MSc in Economics and Econometrics from Birkbeck, University of London.

Kenji Toba

MD, PhD

President
National Center for Geriatrics and Gerontology, Japan

Biography

Postgraduate Career:

1978	Diploma of University of Tokyo, Faculty of Medicine
1996-2000	Associate Professor, Department of Geriatrics, Tokyo University
2000-2010	Professor and Chairman, Department of Geriatric Medicine, Kyorin University, School of Medicine
2006-2010	Director, the Center for comprehensive care on memory disorders(Kyorin)
2010-2013	Director, Hospital of National Center for Geriatrics and Gerontology Director at the Center for comprehensive care and research on memory disorders
2011-2013	Director, the Bio-bank of National Center for Geriatrics and Gerontology
2013-	President, National Center for Geriatrics and Gerontology

Membership of Academic Society:

The Japan Geriatrics Society (Vice Chairman)
The Japan Gerontological Society (Director)
Japan Atherosclerosis Society (Councilor)
Japan Osteoporosis Society (Councilor)
Japan Dementia Society (Director)

Award:

1994, 2000	Most Excellent Research Paper Award The Japan Geriatrics Society
2001	Award of Japan Osteoporosis Society

Christian Berringer

MD, PhD

Head of unit “Definition and Assessment of Need of Care; Quality Assurance; General Matters of Care Provision”

Federal Ministry of Health, Germany

Biography

Dr Christian Berringer is head of the unit “Definition and Assessment of Need of Care; Quality Assurance; General Matters of Care Provision” in Germany's Federal Ministry of Health.
He studied at the Universities of Munich and London and received a PhD in history in 1996.

After working as assistant to members of the European Parliament (Brussels) and the German Bundestag, he joined the staff of the German Federal Government Commissioner for Matters relating to Disabled Persons in 1998 and became head of staff in 2002.
In 2005 he moved to his current position.

Yves Joanette

MD, PhD

ScientificDirector
CIHR-InstituteofAging
Professor
Cognitive Neurosciences and Aging at the Faculty of Medicine of the Universitéde Montréal, Canada

Biography

Yves Joanette is Professor of Cognitive Neurosciences and Aging at the Faculty of Medicine of the Université de Montréal. He is currently the Scientific Director of the Institute of Aging of the Canadian Institutes of Health Research (CIHR) and the Executive Director of the CIHR International Collaborative Research Strategy on Alzheimer's Disease.

He previously served as Director of the Centre de recherche de l'Institut universitaire de gériatrie de Montréal as well as President & CEO, as well as the Chair of the Board, of the Fonds de la recherche en santé du Québec (FRQ-S).

Yves Joanette has been a Scholar and then Scientist of the Canadian Medical Research Council (now CIHR) and has received many distinctions, including the André-Dupont Award from the Club de recherches cliniques du Québec, in 1990, and the Eve-Kassier Award, in 1995, for exceptional professional accomplishment. Yves Joanette is a Fellow of the Canadian Academy of Health Science. In 2007, the Université Lumière de Lyon in France presented him with an Honorary Doctorate.

Kazuo Hasegawa

MD, PhD

Director Emeritus
Tokyo Dementia Care Research and Training Center, Japan

Biography

1953 Graduated Tokyo Jikeikai University school. School of Medicine. 1956 Residency in Psychiatry, St. Elizabeths Hospital In Washington, D.C., U.S.A. 1958 Research Fellow, Dept. of Neurosurgery, Johns Hopkins Hospital, Baltimore, U.S.A. 1973 Professor & Chairman, Dept. of Psychiatry, St. Marianna University School of Medicine. 1993 Dean of the School, St. Marianna U. school of Med. 1996 President, St. Marianna U. school of Med. 2000 Director. Center for Research and Education of Dementia Care in Tokyo.

Advice and supervision for the research activities and enlightening in the community.
Emeritus Professor of psychiatry, St. Marianna University School of Medicine.

Jacqueline Hoogendam

Ministerial advisor on dementia
Ministry of Health, Welfare and Sport, Netherlands

Biography

Jacqueline Hoogendam started her professional career as a lawyer in the private sector. In 1994 she switched to the Dutch government, the Ministry of Justice, with special responsability on crime prevention and business ethics. After developing a chronic disease herself, she was offered a position at the Ministry of Health, Welfare and Sport. At the Department of Long Term Care she became responsible for dementia care. In the past eight years she extended this position to resposibility for all aspects of dementia on a national and international level. As a part of this job, Jacqueline represents the Dutch government in the Management Board of the EU Joint Programme - Neurodegenerative Disease Reseach (JPND).

Jeremy Hughes

Chief Executive Officer
Alzheimer's Society, UK

Biography

Jeremy Hughes joined Alzheimer's Society in November 2010. He is leading the charity in its five year strategy 'Delivering on Dementia 2012-17' and in 2013-14 the Society's income exceeded £80m for the first time. Jeremy co-chairs the Dementia Friendly Communities Champions Group for the UK Prime Minister, David Cameron.

Jeremy was previously Chief Executive of Breakthrough Breast Cancer where he was instrumental in providing visionary leadership, galvanising the charity's research platform and its authority on campaigning and policy. Before that Jeremy was Head of External Affairs at the International Federation of Red Cross and Red Crescent Societies.

His career in health and social care charities includes leadership posts at the British Red Cross, Leonard Cheshire, Muscular Dystrophy and NCH Action for Children.

Jeremy was the chair of National Voices 2009-14. He is currently the Co-chair of the UK Dementia Action Alliance and chair of the Global Alzheimers and Dementias Action Alliance

Geoff Huggins

Acting Director of Health and Social Care Integration
Scottish Goverment, UK

Biography

Geoff Huggins is Acting Director for Health and Social Care Integration at the Scottish Government. He is responsible for the major public service reform programme to integrate health and social care in Scotland, for primary care services, for mental health, including dementia, and for social care policy. He has led work in Scotland on dementia since 2004 and was responsible for the work to set and achieve the dementia diagnosis target, the work to establish and implement a commitment on post-diagnostic support for people with dementia and their families, for the establishment of standards for dementia care in all settings and the creation of a framework for workforce development. He was strategic lead for the engagement process and the preparation of each of Scotland's two dementia strategies. He will be strategic lead for the European Union Joint Action on dementia.
He has previously worked on housing and education policy in Scotland and from 1991 to 1998 worked in Northern Ireland on counter terrorism and the political process.

Etienne C Hirsch

MD, PhD

Director
French Institute Neurosciences, Cognitive sciences, Neurology and Psychiatry, France

Biography

Etienne Hirsch is a neurobiologist involved in research on Parkinson's disease and related disorders. He obtained his PhD in 1988 from the University of Paris VI (Pierre et Marie Curie). He is currently the director of the Insitute for Neurosciences, Cognitive sciences, Neurology and Psychiatry at INSERM and the French alliance for life and health science Aviesan, the associate director of the research center of the Institute of Brain and spinal cord (ICM), head of “Experimental therapeutics of Parkinson disease” at the ICM at Pitié-Salpêtrière hospital in Paris and councilor for Neuroscience, Neurology and Psychiatry at the department for research and innovation at French Ministry for higher education and research. His work is aimed at understanding the cause of neuronal degeneration in Parkinson's disease and is focused on the role of the glial cells, the inflammatory cytokines and apoptosis but also on the consequences of neuronal degeneration in the circuitries downstream to the lesions. He is member of several advisory boards including, French Society for Neuroscience (past-President), Scientific Advisory board at INSERM. He obtained several prizes including Tourette Syndrome Association Award in1986, Young researcher Award, European Society for Neurochemistry in 1990, Grand Prix de l' Académie de Sciences, Prix de la Fondation pour la recherche biomédicale « Prix François Lhermitte » in 1999, Chevalier de l'ordre des palmes académiques in 2009, Prix Raymond et Aimée Mande of the French National academy of Medicine in 2011, Member of the French National Academy of Pharmacy in 2011. He is author of more than 200 peer reviewed articles.

Jeff Huber

President
Home Instead, Inc., USA

Biography

As president of Home Instead, Inc., Jeff Huber oversees strategic planning and advocacy for the Home Instead Senior Care network; provides leadership on key initiatives; and manages the day-to-day operations of the Global Headquarters. The Global Headquarters has been named one of Omaha's "Best Places to Work" in Omaha for the past nine years.

Jeff joined Home Instead, Inc. in 1998 as franchise development manager when the company had just 125 franchise offices. Today, the Home Instead Senior Care network includes more than 1,000 franchises in 17 global markets. He previously served as Chief Administrative Officer, Chief Development Officer and Vice President of Franchise Development before assuming his current role as president.

Jeff graduated magna cum laude from the Creighton University School of Law and summa cum laude from Creighton University. Jeff practiced law for four years, including two years as a law clerk for a United States District Court judge.

"It is an honor to be associated with an organization that not only enhances the lives of individuals, but also steps up to the challenges of a global aging society," he says. "Home Instead Senior Care is the right company to identify solutions to the sociological challenges that lie ahead, and I am proud to be a part of it."

Takao Suzuki

MD, PhD

Research Institute Director
National Center for Geriatrics and Gerontology, Japan

Biography

Dr. Takao Suzuki is currently the director of the Research Institute, National Center for Geriatrics and Gerontology, Obu City, Aichi Prefecture.
He has published more than 200 peer reviewed international papers and served as editorial members of several domestic and international journals. He has been the chairs of some national committees related the Long-Term Care Insurance in Japan, particularly effective strategy for the prevention of long-term care state in the elderly living in the community.
He has also attempted for many years to accumulate the evidence-based effective measures for the prevention of geriatric syndrome such as falls, incontinence, foot and walking trouble, undernutrition relating to the insufficiency of serum vitamin D, sarcopenia and mild cognitive impairments (MCI) as an early stage of dementia, all of which have negative influence on the health status and quality of life among the elderly people.

Martin Prince

MD

Professor
King's College London Institute of Psychiatry, Psychology & Neuroscience, UK

Biography

Martin Prince is Professor of Epidemiological Psychiatry, Head of Department of the Health Service and Population Research department, and joint-Director of the Centre for Global Mental Health which is a joint King's Health Partner and London School of Hygiene centre. He trained in Psychiatry at the Maudsley Hospital and in Epidemiology at the London School of Hygiene and Tropical Medicine.

His work is oriented to the salience of mental and neurological disorders to health and social policy in low and middle income countries (LMIC), with a focus on ageing and dementia. He has coordinated, since 1998 the 10/66 Dementia Research Group, a network of researchers, mainly from LMIC working together to promote more good research into dementia in those regions. The group has published 100 papers covering dementia prevalence, incidence, aetiology and impact and contributed to knowledge of public health aspects of ageing and chronic disease in LMIC.

He was co-author of the Dementia UK report that informed the UK Government's National Dementia Strategy. He lead the development of the widely reported ADI World Alzheimer Reports for 2009 (prevalence and numbers), 2010 (societal cost) and 2011 (early intervention) and was a leading contributor to the WHO World Dementia Report 2012. He was one of three editors for the 2007 Lancet Series on Global Mental Health, and is committed to further research and advocacy to support the call for action for improved coverage of evidence-based community treatments. He coordinated the development of the WHO Mental Health Gap Action Plan (mhGAP) clinical guidelines for dementia care by non-specialists in LMIC.

Yuko Harayama

PhD

Executive Member
Council for Science, Technology and Innovation
Cabinet Office, Japan

Biography

Yuko Harayama is an Executive Member of the Council for Science, Technology and Innovation (CSTI) at the Cabinet Office. Prior to joining the CSTI, she spent two years at the OECD as the Deputy Director of the Directorate for Science, Technology and Industry (STI), and ten years at the Graduate School of Engineering of Tohoku University as a professor of Science and Technology Policy.

In Japan, she served as a member of different commissions related to Science, Technology and Innovation at Cabinet Office and Ministerial levels.

Her experience prior to Tohoku University includes being a Fellow at the Research Institute of Economy, Trade and Industry in Japan and an Assistant Professor in the Department of Political Economy at the University of Geneva. Ms. Harayama holds a Ph.D. in Education Sciences and a Ph.D. in Economics both from the University of Geneva.

She has received Chevalier de la Légion d'honneur in 2011.

Hiroshi Mori

Professor
Osaka City University Medical School
President
Japan Society for Dementia Research, Japan

Biography

Academic Career:
1974 Osaka Univ, Faculty of Science
1979 Univ of Tokyo, Grad School of Science

Appointment;
1988 Harvard Medical School, Research Associate
1991 Univ of Tokyo, Med Sch, Associate Professor
1992 Tokyo Institute of Psychiatry, Dept Head
1998 Osaka City University Med Schl, Professor

Philippe Amouyel

MD, PhD,

General Director
Fondation Plan Alzheimer, France

Biography

Trained as hospital medical resident in Neurology, Philippe Amouyel, MD, PhD, is Professor of Epidemiology and Public Health at the University Hospital of Lille. Since 1998, he heads a research unit of 50 persons dedicated to the public health and the molecular epidemiology of age-related diseases. Part of its work is devoted to cardiovascular diseases and to the understanding of their multiple determinants. The other part of his research focuses on the study of the determinants, mainly genetic, of neurodegenerative diseases associated with cognitive decline and Alzheimer's disease in particular. Since 2012 he obtained an excellence laboratory from the government, named Distalz that brings together seven of the very best French research teams whose objective is the development of innovative strategies for transdisciplinary approach to Alzheimer's disease. He published more than 600 articles and participated in the discovery of 20 confirmed genetic locus predisposing to sporadic Alzheimer's disease.

He headed from 2002 to 2011 the Pasteur Institute of Lille, a non-profit foundation dedicated to the improvement of the health of man and his environment. Since 2008, he heads the National Foundation for Scientific Cooperation on Alzheimer's disease and related disorders that participated to the implementation of the research measures of the French Alzheimer Plan 2008-2102. This non-profit foundation dedicated to Alzheimer's disease and related disorders research, thanks to several partnerships, funds and supports research programs from basic research to social and health care research, including clinical and translational research.

At the European level, Philippe Amouyel chairs the European Joint Programming Initiative on research on neurodegenerative diseases and Alzheimer's in particular (JPND) that groups 28 countries including Canada and whose main objective is to combine the strengths of European and global research to tackle more efficiently these diseases.

Shuichi Awata

MD, PhD

Team Leader
Research Team for Promoting Independence of the Elderly
Tokyo Metropolitan Institute of Gerontology, Japan

Biography

Shuichi Awata was born in Tokyo, Japan, in 1959; graduated from School of Medicine, the University of Yamagata, in 1984; received training for a medical doctor and a clinical psychiatrist from Tohoku University Hospital during 1984-1991; received M.D. and Ph.D. degree from Tohoku University

Graduate School of Medicine in 1997. He worked as an Assistant Professor and a Lecturer on Department of Neuropsychiatry, Tohoku University Hospital, during 1991-2001; an Associate Professor on Division of Neuropsychiatry, Tohoku University Graduate School of Medicine, during 2001-2005; a Director on Division of Psychiatry and Medical Center for Dementia, Sendai City Hospital, during 2005-2009. He was appointed as a Team Leader of Research Team for Promoting Independence of the Elderly at Tokyo Metropolitan Institute of Gerontology in 2009; a Director of Medical Center for Dementia at Tokyo Metropolitan Hospital of Geriatrics in 2012; a member of the board of trustees in the Japanese Psychogeriatric Society in 2014. He has been clinically active in the field of geriatric psychiatry and studied on the establishment of prevention, early diagnosis and intervention system for dementia and other neuropsychiatric disorders in late life.

Currently, his studies focus on the establishment of a community-based integrated care system supporting the lives of people with dementia and family caregivers, to create the society where people with dementia can live safely, peacefully, with dignity and respect, in accordance with each local characteristics, in collaboration with national and local government, medical and long-term care service providers, some citizens' groups and non-profit organizations, including the group founded by people with dementia themselves.

Koichi Kozaki

MD, PhD

Professor
Department of Geriatric Medicine
Kyorin University School of Medicine, Japan

Biography

Work Place: Department of Geriatric Medicine, Kyorin University School of Medicine

Career:

1986:	Graduated from University of Tokyo, School of medicine
1995-2004:	Assistant Professor and Lecturer at the Department of Geriatric Medicine, University of Tokyo Graduate School of Medicine
2005-:	Associate Professor at the Department of Geriatric Medicine, Kyorin University School of Medicine
2010-:	Professor at the Department of Geriatric Medicine, Kyorin University School of Medicine

Main Membership of Academic Society:

The Japanese Society of Internal Medicine
The Japan Geriatrics Society (Board certified member)
Japan Atherosclerosis Society (Board certified member)
Japan Society for Dementia Research (Board certified member)

Research of interest:

geriatric medicine, cognitive disorder, frailty/fall

Couichi Oku

Non-profit Organization
Machida-city Tsunagari-no-Kai

Biography

Mr. Oku was a corporate worker for 40 years (worked at the sales and planning devision).
At the age of 60, he started to run his own business on the next day of his retirement from the company.

However, his business was bunkrupt and closed his office when he was 62.
At the same time, he suffered from deep depression.
At the sage of 68, he was diagnosed as fronto-temporal dementia.
He thinks that his disease might have developed gradually at the age of 64~65.

Marc Wortmann

Executive Director
Alzheimer's Disease International

Biography

Marc Wortmann is Executive Director of Alzheimer's Disease International (ADI). Marc studied Law and Art in the city of Utrecht in the Netherlands and was an entrepreneur in retail for 15 years. During this time Marc was a member of the Parliament of the Province of Utrecht and worked closely with various charities and voluntary organisations. He became Executive Director of Alzheimer Nederland in 2000. From 2002 to 2005 he chaired the Dutch Fundraising Association and was Vice-President of the European Fundraising Association from 2004 to 2007. Marc joined ADI in 2006 and is responsible for external contacts, public policy and fundraising. He is a speaker at multiple events and conferences on these topics and has published a number of articles and papers on dementia awareness and public policy.

Kiyokuni Goshima

Planning Department Manager
The Association for Technical Aids, Japan

Biography

The Association for Technical Aids, a public interest incorporated foundation, is responsible for promoting safe and effective use of assistive products to improve QOL of elderly persons and persons with disability. Our mission in this field includes promotion of R&D,compilation and dissemination of information, and clinical assesment, of assistive products and training of related professionals. We are also in charge of the national examination for prosthetists and orthotists.

April 2014, Planning Department Posting
Welfare equipment and nursing care robot
Responsible for development and support research, provide information

Yoshiki Niimi

MD, PhD

Senior Specialist for Dementia
Office for Dementia and Elder Abuse Prevention
Health and Welfare Bureau for the Elderly
Ministry of Health, Labour and Welfare, Japan

Biography

Is a Senior Specialist for Dementia from Office for Dementia and Elder Abuse Prevention, Health and Welfare Bureau for the Elderly, Ministry of Health, Labour and Welfare Japan.
He received a M.D. from NAGOYA University in 1998. He worked at Municipal Hospital as a neurologist until 2008 when he entered Nagoya University, Graduate School of Medicine. After graduated from Nagoya University in 2011, he started to work as a Research Associate at Department of Neurology of Fujita Health University, School of Medicine. He joined Ministry of Health, Labour and Welfare Japan and took the current position in 2013.

Peter J. Whitehouse

Professor
Case Western Reserve University and University of Toronto

Biography

Peter J. Whitehouse, MD, PhD is Professor of Neurology as well as current or former Professor of Cognitive Science, Psychiatry, Neuroscience, Psychology, Nursing, Organizational Behavior, Bioethics and History. He is also currently a strategic advisor in innovation and Visiting Scholar at Baycrest and Professor of Medicine at the University of Toronto. He received his undergraduate degree from Brown University and MD-PhD (Psychology) from The Johns Hopkins University (with field work at Harvard and Boston Universities), followed by a Fellowship in Neuroscience and Psychiatry and a faculty appointment at Hopkins. With colleagues he discovered fundamental aspects of the cholinergic pathology in Alzheimer's and related dementias, which lead to the development of our current generation drugs to treat these conditions. In 1986 he moved to Case Western Reserve University to develop the University Alzheimer Center (now University Brain health and Memory Center). He continued his own life-long learning with a Masters Degree in Bioethics and Fellowship in Organizational Behavior at Case. In 1999 he founded with his wife, Catherine, The Intergenerational School, a successful, public, multiage, community school (www.tisonline.org). He is currently President of Intergenerational Schools International. His current information technology and transmedia arts based project is called The Intergenerativity Project.

He works clinically in various capacities in Cleveland. He developing an integrative health practice focused on the healing power of storytelling in a school-based health education program called InterWell.

His research interests include the neurobiology of what he used to refer to as Alzheimer's disease and related conditions, the development of more effective treatments for individuals with cognitive impairment, ethical issues in the medical profession and integrative health care systems. He is the author (with Danny George) of a provocative book entitled “The Myth of Alzheimer's: what you aren't being told about today's most dreaded diagnosis.” (www.themythofalzheimers.com)

Tom Wright

CBE

CEO
Age UK
Chief Executive
Age International

Biography

Tom Wright is Group Chief Executive of Age UK and Age International. Age UK is the largest charity and social enterprise in the UK for older people reaching over 5 million people every year with charitable services and providing health and care services to 0.5 million older people, and financial services to a further 1.3 million. Age UK has also been pioneering new integrated care models aimed at older people with dementia and co-morbidities, and is a leading research organisation into age related conditions including dementia and cognitive impairments. Tom also sits on the Dementia Programme Board.

Age International is part of the Help Age global network working in low to middle income territories and has been developing global toolkits with the WHO for NCDs (non-communicable diseases). Tom also sits on the Disasters Emergency Committee (DEC) and is a Non-Executive Director of a large NHS community and mental health Foundation Trust.

Tom is a founder Trustee of GO ON UK; Chair of STAR; a Trustee of The Imperial War Museum Development Trust; and of the Royal Green Jackets Museum; and a Director of Leeds Castle Enterprises Limited. Tom's previous roles include CEO of VisitBritain and Managing Director of Saga Holidays

Toshiharu Ninomiya

Prof.

Professor
Center for Cohort Studies, Graduate School of Medical Sciences,
Kyushu University

Biography

CURRENT APPOINTMENTS:

2014-Present: Professor in Center for Cohort Studies, Graduate School of Medical Sciences, Kyushu University, Japan,

PREVIOUS POSITIONS:

2003-2006: Research Fellow in the Department of Medicine and Clinical Science, Graduate School of Medical Sciences, Kyushu University, Japan

2006-2009: Visiting Research Fellow in the Renal & Metabolic Division, The George Institute for International Health, Australia

2009-2013: Clinical Fellow (2009-2011) and Assistant Professor (2011-2013) in the Department of Nephrology, Hypertension and Stroke, Kyushu University Hospital, Japan

2013-2014: Senior Research Fellow in the Renal & Metabolic Division, The George Institute for Global Health, Australia

ACADEMIC QUALIFICATIONS:

2000: Ph.D. (Dr. of Medical Science) Faculty of Medicine, Kyushu University, Japan

1993: M.D. Faculty of Medicine, Kyushu University, Japan

MAJOR RESEARCH INTERESTS:

1. Epidemiological research on the development of dementia
2. Epidemiological and clinical research on the development cardiovascular and kidney disease
3. Meta-analysis with regard to risk factors for cardiovascular disease and kidney disease

PUBLICATIONS (in English) :

Original investigation, 170 publications; Case reports: 3 publications; Review article 6 publications; Book chapters, 2 publications

AWARDS AND HONORS:

2010: Young Investigator Imura Award 2010

2010: Young Investigator Award 2010 for ISN Nexus Symposium Kyoto 2010.

2008: ISH Visiting Postdoctoral Award 2007-2008 sponsored by Foundation for High Blood Pressure Research.

2007: ISH Visiting Postdoctoral Award 2007 sponsored by Foundation for High Blood Pressure Research.

2006: Banyu Fellowship Program sponsored by Banyu Life Science Foundation International.

2004: Over sea presentation course of Japan society of nephrology and Baxter Joint Scholarship Program

MEMBERSHIPS:

Japanese Society of Nephrology, Japanese Society of Dialysis and Transplantation, Japanese Society of Internal Medicine, Japanese Society of Hypertension, Japanese Society of Public Health, Japan Epidemiological Association, High Blood Pressure Research Council of Australia, International Society of Hypertension and American Society of Nephrology

Hiroko Sugawara

Secretary General
Community-Care Policy Network

Biography

1997- Secretary General, Association of Local Government for Citizens' Welfare
2001- Secretary General, Community-Care Policy Network

Jean Georges

Executive Director
Alzheimer Europe

Biography

Before joining Alzheimer Europe as its first Executive Director in 1996, Jean Georges had worked as a journalist for the European and International department of the Luxembourg newspaper “Tageblatt” and as a parliamentary assistant for Members of the Luxembourg and European Parliament.
As Executive Director of Alzheimer Europe, Jean was in charge of the various projects of the organisation including the three-year European Commission financed “European Collaboration on Dementia-EuroCoDe” (2006-2008) project which brought together over 30 dementia experts from 20 European countries. He also represents the organisation in IMI and FP7 projects, such as Pharma Cog, DECIDE or EMIF.
He has been liaising with various other European organisations and held a number of elected positions, such as Secretary General of the European Federation of Neurological Associations (2002-2004) or Vice-Chairperson of the European Patients’ Forum (2007-2008). In 2005, he was appointed by the Council of Ministers and the European Parliament as one of two patient representatives to the Management Board of the European Medicines Agency (2005-2008).

Jürgen Scheftlein

Policy Officer
European Commission's Directorate-General
for Health and Consumers

Biography

Jürgen Scheftlein is policy officer in the European Commission's Directorate-General for Health and Consumers. His fields of responsibility are mental health / mental disorders and dementia.

Jürgen is a historian by academic qualification. After his studies of history, German language and literature and political Science in Cologne, he worked for the Federal German Ministry of Development Cooperation. In 1997 he took up a position as a civil servant in the European Commission services. After several years in the Directorate-General for Enterprise, he changed in 2004 to the Directorate-General for Health and Consumers.

Jon Rouse

Director General for Social Care,
Local Government and Care Partnerships
Department for Health, UK Government

Biography

Jon Rouse was appointed Director General, Social Care, Local Government and Care Partnerships in March 2013.
Before joining the department, he was Chief Executive of the London Borough of Croydon.
Other previous roles include:
Chief Executive, Housing Corporation
Chief Executive, Commission for Architecture and the Built Environment
He has also held a wide range of non-executive positions with organisations including English Partnerships and Homelessness International, and was a non-executive director on the Department of Health's board until 2010.
As Director General, Social Care, Local Government and Care Partnerships, Jon is part of the Department of Health senior team and an executive member of its board. The Director General, Social Care, Local Government and Care Partnerships is responsible for:

- policies on care and support for adults, and health services for children
- the department' s relationship with local government across all of health and care
- mental health disability
- health equalities

Yasuyoshi Ouchi

President
Federation of National public Service Personnel Mutual Aid Associations Toranomon Hospital, Japan

Biography

Current appointments: President, Federation of National Public Service Personnel Mutual Aid Associations Toranomon Hospital, Professor Emeritus, University of Tokyo

CV

1973 September	M.D. Degree, University of Tokyo
1984 July	Assistant Professor, The 3rd Department of Medicine, University of Tokyo
1985 January	Visiting Assistant Professor, Department of Physiology & Biophysics, University of Tennessee
1995 August	Professor & Chairman, Department of Geriatric Medicine, Graduate School of Medicine, University of Tokyo
2013 April	Current appointments

Main academic activities: Chair, IAGG Asia/Oceania Region (2005-2009), Chair, The Japan Gerontological Society (2008-2013), Chair, The Japan Geriatrics Society (2005-present), Adjunctive member, The Science Council of Japan

Abstract of presentation

The Japan Geriatrics Society (JGS) is only one scientific society in Japan which organize the research in the field of geriatric medicine. Clinical and basic research of dementia is a main interest for JGS. JGS considers that the role of geriatricians in dementia clinic is the management of life style and life style-related diseases including hypertension, diabetes, and dyslipidemia which possibly accelerates the development of not only vascular dementia but also Alzheimer's disease (AD).

Evidence has accumulated suggesting that life style affects the occurrence and prognosis of AD. Some epidemiological studies have indicated that the diet containing fish, vegetable, vitamin C and E, regular exercise of adequate intensity and some intellectual performances are negative risk factors against AD. Moreover, life style-related diseases are risk factors of AD, and both life style modification and treatment of life style-related diseases have been reported to reduce the occurrence of AD and to maintain cognitive function, although it is still controversial. In this brief report, I would like to review the recent research regarding the relationship between life style or life style-related diseases and dementia. The research for elucidating underlying mechanism may provide a new preventive and therapeutic approach for AD.

Sadao Katayama

MD, PhD

Chairman
International Exchange Committee, Association of Patients with Dementia and their Families (Alzheimer's Association Japan)

Biography

Name: Sadao Katayama, M.D., Ph.D.

1985 Bachelor of Medicine, Medical Department of Hiroshima University.

1988 Doctor of Medicine majored in study of Alzheimer's disease.
Research Associate of the third department of Internal Medicine at Medical Department of Hiroshima University.

2003 Assistant Professor of the third department of Internal Medicine at Medical Department of Hiroshima University.
Participate in Hiroshima Branch of Japan Alzheimer's Association along with the association of people with dementia on their early on-set in order to support them and their family.

April, 2005
Chief Doctor of Neurology at Yanai Hospital of National Hospital Organization.

April, 2007
General Manager of Clinical Research, Department and Chief Doctor of faculty of cognitive disorders at Hiroshima-Nishi Medical Center of National Hospital Organization.

April, 2012
Associate Professor with Special Assignment, Division of Neurology, Department of Medicine, Deputy Director, Medical Center for Dementia and Related Disorders, Kawasaki Medical School

Director board Member, Chairman of International Exchange Committee, Association of Patients with Dementia and their Families (Alzheimer's Association Japan (AAJ))

Fellow and Board Certified Senior Member of the Japanese Neurology.

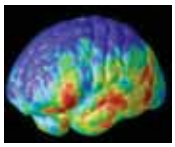
Takenobu Inoue

Director of Department of Assistive Technology
The National Rehabilitation Center for Persons
with Disabilities, Japan

Biography

Mr. Inoue aims at research on assistive technology that helps people, based on a broad view encompassing people who use assistive technology and the environments and situations in which it is used. He has been researching assistive technology at the Research Institute, National Rehabilitation Center for Persons with Disabilities, since 1989. His major research themes have included development of a head-controlled electric powered wheelchair, the psychological effects of assistive technology, the economy of assistive technologis and development of technology to assist patients with dementia. From 1996 to 1997, he received a Science and Technology Agency long-term fellowship abroad to the University of Toronto.

2015 Research Summit Update



- *Alzheimer's Disease Research Summit 2015: Path to Treatment and Prevention*
- February 9th-10th, 2015
- Convened by the National Institute on Aging at NIH and the U.S. Department of Health and Human Services, with private support through the Foundation for the NIH
- Summit registration now open

http://www.nia.nih.gov/about/events/2014/alzheimers-disease-research-summit-2015

- The meeting will also be made available via a live videocast (see registration page for information)

Summit Research Topics

- NAPA Research Milestones
- Socioeconomic Burden of Alzheimer's disease
- The Etiology of Alzheimer's disease
- Alzheimer's Therapy Development
- Prevention
- Disease monitoring, assessment and care
- Empowering Patients, Engaging Citizens
- Partnerships

G8 UK
United Kingdom 2013

Global action against dementia

G7/8 Summit Legacy Meetings 2014-2015

- Social impact investment – United Kingdom
- New care and prevention models – Japan
- Academia-industry partnerships – Canada and France
- ***International research coordination – USA***
  - **Small research-oriented meeting**
  - **To include an exchange of research accomplishments, and a discussion of information sharing, planned research initiatives, and potential collaborations**
  - **February 11th, 2015, on the NIH Campus in Bethesda, MD**
- G7 Wrap-up meeting in Geneva – March 2015

Global Dementia Legacy Event Japan

認知症サミット日本後継イベント

New care and prevention models

新たなケアと予防のモデル

November 5-7 2014
平成26年11月5-7日

Koji Miura,
Director General, Health and Welfare Bureau for the Elderly, MHLW
厚生労働省　老健局長　三浦公嗣

Topic1 : Dementia In the Community ～timely and appropriate prevention and care
トピック１：地域における認知症予防とケア ～認知症の状態に応じた適切な予防とケア～

- Realize a society where people with dementia live well

  認知症の人がより良く生きていける社会の実現

- Appropriate and seamless coordination of medical and long-term care, rehabilitation and social inclusion according to its stage.

  医療・介護・リハビリ・社会包摂等が、認知症の各ステージに応じて、適切かつ切れ目なく連携

- Early diagnosis and intervention

  早期診断・早期対応

Topic1 : Dementia In the Community ～timely and appropriate prevention and care
トピック１：地域における認知症予防とケア ～認知症の状態に応じた適切な予防とケア～

- Willingness to receive early diagnosis

  早期の診断を望む多くの人の存在

- Early support following early detection

  早期診断後の早期支援

- Education to professionals

  医療・介護従事者への教育・研修

- Sufficient support for care givers

  介護者に対する十分な支援

Topic1 : Dementia In the Community ～timely and appropriate prevention and care
トピック１：地域における認知症予防とケア ～認知症の状態に応じた適切な予防とケア～

- Considering cost effectiveness

  費用対効果を考慮

- Respecting perspective of people with dementia

  認知症御本人の視点の尊重

- Person-centered and Relation-based care

  本人中心で社会的関係性を重視したケア

Topic2:Scientific Approach toward Dementia prevention and care
トピック２：認知症予防とケアへの科学的アプローチ

- Dementia as a preventable condition

  認知症は予防が可能

- Establishing of proper biomarker, standardization of data collection and sharing the data

  適切な生体指標、データ収集方法等の標準化、得られたデータの共有化

- Collecting and sharing research results and good practices for promoting international collaboration

  国際協調の促進のため、研究成果・好事例の集約・共有

Topic2:Scientific Approach toward Dementia prevention and care
トピック２：認知症予防とケアへの科学的アプローチ

- Comprehensive approach concerning risk and protective factors

  様々な危険因子・防御因子に対する総合的なアプローチ

- Modification of life style such as diet, smoking and exercise

  食事、禁煙や運動など生活習慣の改善

- Possible development for preclinical therapeutic intervention

  発症前段階における先制治療の可能性

Topic3:Dementia Friendly Community and ICT
トピック３：認知症にやさしいコミュニティとICTの活用

- Realize a society where people with dementia live well

  認知症の人がより良く生きていける社会の実現

- Collaboration among private companies, administrative institutions, educational institutions and above all, people living in a community in creating DFC（Dementia Friendly Community）

  「認知症の人に優しい社会」の実現のため、企業、行政機関、教育機関、住民が協働

Topic3:Dementia Friendly Community and ICT
トピック３：認知症にやさしいコミュニティとICTの活用

- Innovation of robotic technology in reducing care burden

  介護者の負担軽減のためのロボット技術の発展

- Gathering huge amount of data through ICT technology for new research methodology

  今後の認知症研究に関する新たな方法論を提供するためのICTによる膨大な情報の蓄積

Topic4:For the Future
トピック４：将来に向けた課題

- Establishing new care and prevention model for creating DFC

  「認知症の人に優しい社会」の構築のため、新たなケアと予防のモデルの確立

- Collaboration of many local stakeholders, public-private partnership and an industry-academia collaboration

  地域の様々な関係者の連携と官民産学等の様々な主体の協働

- Promoting and sharing good care and effective prevention internationally

  研究成果・好事例の情報共有や共同研究を国際的に促進

Topic4:For the Future
トピック４：将来に向けた課題

- Education to the practitioners of dementia care and prevention

  ケアや予防を担う人材への教育

- Cohort study in collaboration with other countries to elucidate pathology of dementia

  認知症の病態解明を進め、予防や治療の研究開発に繋げるための国際連携も視野に入れたコホート研究

- Spreading educational program such as “Dementia Supporters” over the globe in order to raise public awareness

  認知症への理解を促進するため、世界規模で、認知症サポーターのような普及啓発

G7 dementia legacy event
Japan
6th November 2014

DIGNITY IN DEMENTIA

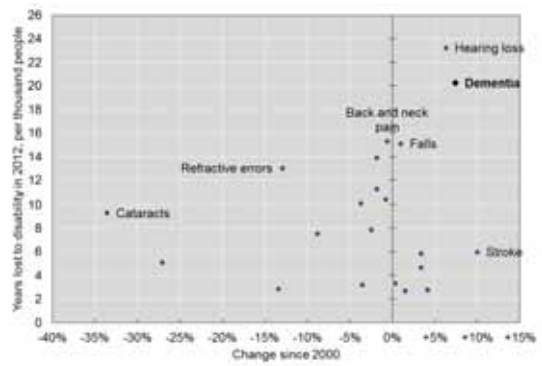
How better policy can improve the lives of people with dementia

Mark Pearson
Deputy Director
Directorate for Employment, Labour and Social Affairs

OECD

…and is already the second biggest cause of disability for the over-70s

Years lost due to disability from major* causes, over-70s

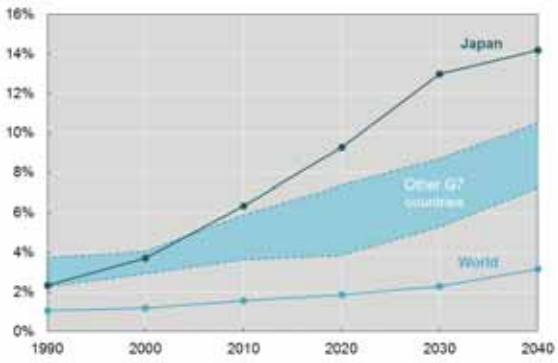


Source: WHO Global Health estimates 2014
** "Major" means causes contributing more than 1% of the total global burden of disability for over-70s*

THE CASE FOR POLICY ACTION

The increase in burden of disease is due to ageing populations…

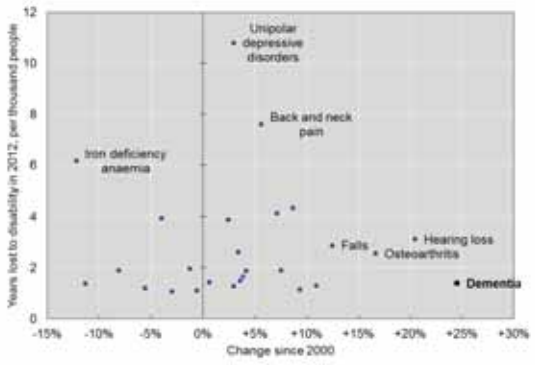
Proportion of the population over 80



Source: UN World Population Prospects, 2012 revision

Dementia is the fastest growing major cause of disability in the world today…

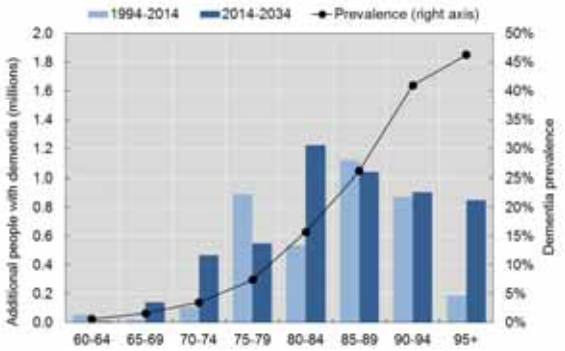
Years lost due to disability from major* causes, all ages



Source: WHO Global Health estimates 2014
** "Major" means causes contributing more than 1% of the total global burden of disability*

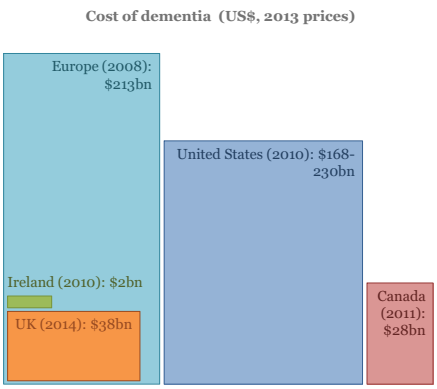
…and the fact that dementia prevalence is strongly linked to age.

Dementia prevalence in Europe by age and the additional number of people with dementia as a result of ageing in the last 20 and next 20 years



Source: OECD analysis of data from Alzheimer's Europe and the United Nations

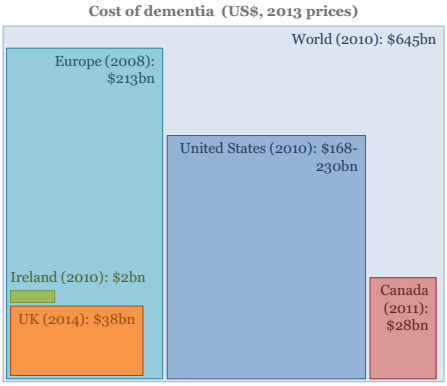
The financial cost of dementia is a major issue globally



Sources: Wimo, A. et al. (2013); Wimo, A. et al. (2011); Connolly, S. et al. (2014); Prince, M., Knapp, M. et al. (2014); Hurd et al. (2013); Canadian Institutes of Health Research

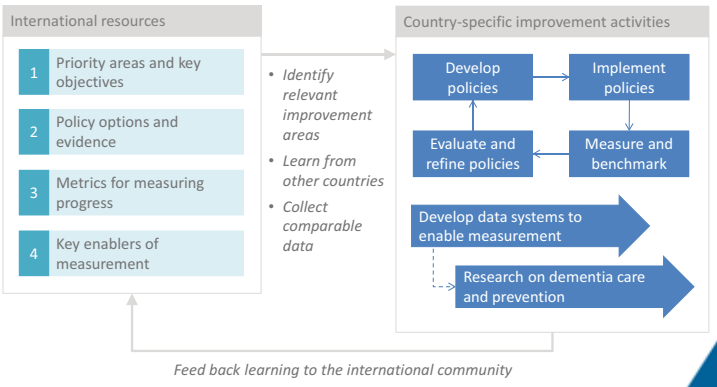
HOW CAN DEMENTIA POLICY BE IMPROVED?

The financial cost of dementia is a major issue globally



Sources: Wimo, A. et al. (2013); Wimo, A. et al. (2011); Connolly, S. et al. (2014); Prince, M., Knapp, M. et al. (2014); Hurd et al. (2013); Canadian Institutes of Health Research

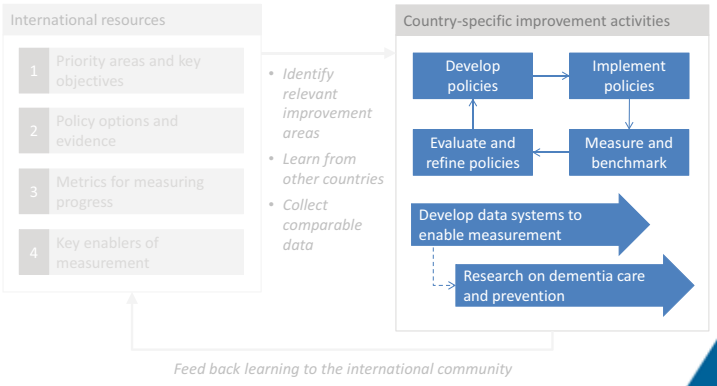
Country strategies should be supported by international collaboration



These three facts mean that dementia should be a global policy priority

1. Dementia has a large human cost
2. Dementia has a large financial cost
3. Both of these costs are growing

Countries need to focus on evaluating and improving policies



There are four key ways international collaboration can support countries

International resources

1. Priority areas and key objectives
2. Policy options and evidence
3. Metrics for measuring progress
4. Key enablers of measurement

- *Identify relevant improvement areas*
- *Learn from other countries*
- *Collect comparable data*

Country-specific improvement activities

Develop policies → Implement policies → Measure and benchmark → Evaluate and refine policies

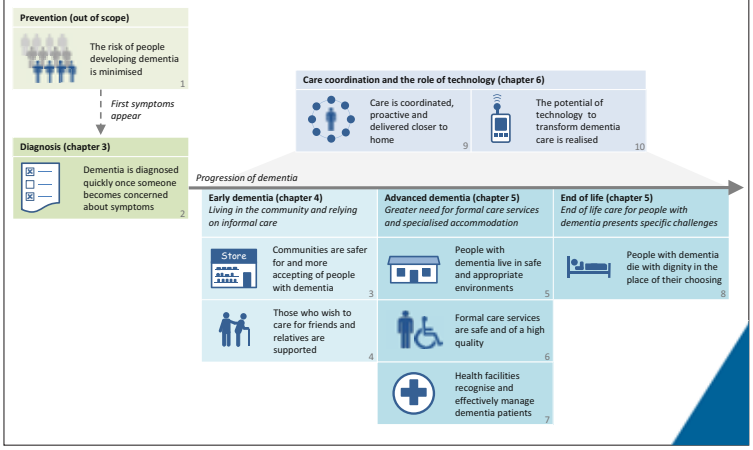
Develop data systems to enable measurement

Research on dementia care and prevention

Feed back learning to the international community

TIMELY DIAGNOSIS

We have identified ten key objectives for dementia policy in OECD countries

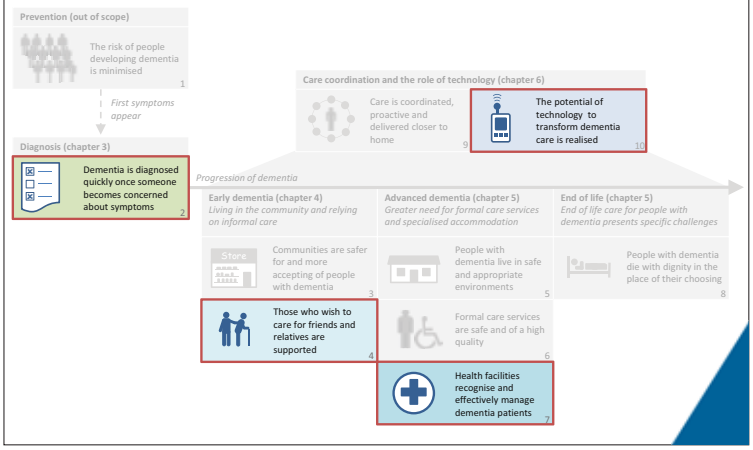


Diagnosis should be available to those who are concerned about symptoms

Benefits and disbenefits to people with dementia of diagnosis at different stages

Pre-symptomatic stage	Mild symptoms	Advanced dementia
− Distress	+ Can reduce anxiety if someone is concerned about symptoms	+ Access to services
− Social stigma	+ Able to plan	+ Management of risks (e.g. in hospital)
− Risk of over-diagnosis	− Distress or social stigma	+ Able to plan (incl. end-of-life care)
	− Risk of over-diagnosis	
Currently no case for pre-symptomatic screening	Those concerned about symptoms should be diagnosed	All cases of advanced dementia should be diagnosed

This presentation will focus on four areas where progress is needed



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A number of countries are focusing on increasing diagnosis rates

Diagnosis rates are low:

England: fewer than half of all people with dementia have a diagnosis

Germany: 44.5% of care home residents with dementia have no diagnosis

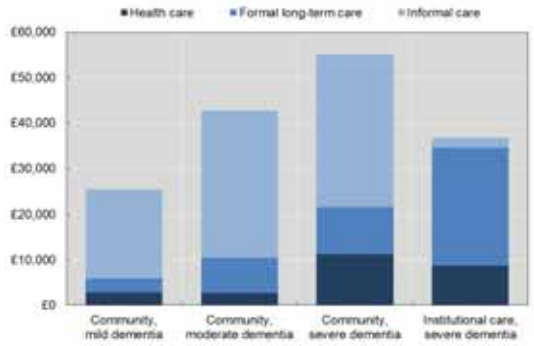
Different strategies for increasing rates:

Scotland
- Supporting local health systems to make improvements
- Diagnosis rates increased from 40% in 2008 to 67% now

England
- Aiming to achieve a similar improvement
- Using financial incentives for GPs

…but this puts a significant burden on informal carers.

Estimated value of formal and informal services for people with dementia in the United Kingdom in 2015 (2012 prices)



Source: Dementia UK – second edition, Alzheimer's Society (2014)

SUPPORTING INFORMAL CARERS

So policies to support carers are more important than ever

Respite care
- At home, day care centres or temporary institutional care
- Available but underused?
- **Netherlands:** farms provide day care for people with dementia

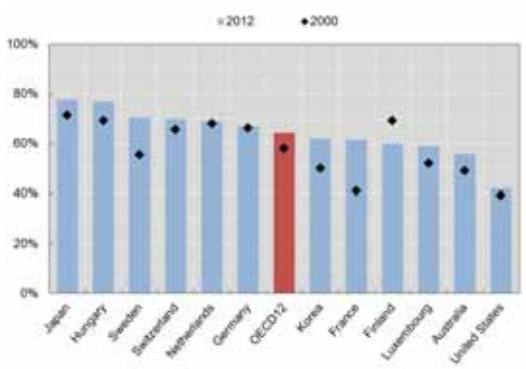
Counselling and support
- Can be effective at relieving stress
- Include peer support, e.g.
  - dementia cafés in **Japan**
  - NHS Dementia Carers' Support Service in **England**

Information and training
- Provide skills to care effectively and minimise negative impacts
- e.g. **France**: carers entitled to two days of training per year.
- Phone advice services, such as "Dementia Link" in **Canada**

Help with employment
- **Germany**: "family caring time" law helps carers reduce hours temporarily
- **Canada**: bringing together employers to explore how to help carers to keep working

Most OECD countries are moving towards more community care…

Proportion of LTC users living in the community



Source: OECD Health Statistics 2014

MANAGING DEMENTIA IN HOSPITALS

Outcomes for people with dementia in hospital are often very poor

People with dementia are 2-3 times as likely to be admitted to hospital...

HOSPITAL

...they stay on average twice as long as other people...

With dementia

Other

...cost nearly three times as much...

...15-30% develop delirium...

...a third lose functional ability...

...and are more likely to be readmitted.

...and one in five of them still have symptoms six months later.

...and half of them never recover these abilities.

Source: studies from various OECD countries

Despite promising examples, dementia care technology is not widely used

Promoting social interaction

- e.g. Paro robot in **Japan**
- Randomised clinical trial planned in the Netherlands

Managing medical needs

- Automated dispensers to reduce medication error (e.g. **Germany**)
- *Telehomecare nurses* in **Canada** provide remote support

Mechanical lifting devices

- Reduce manual lifting and the risk of injury
- **British Columbia (Canada)** aims to eliminate manual lifting

Monitoring systems

- *ComfortZone* in the **United States** provides tracking devices
- The *Independent Project* in **Europe** is piloting alarms, fall detectors and gas detectors.

Better identification and management of dementia in hospitals is needed

Identifying dementia	Providing appropriate care
Half of dementia patients not identified in some countries *No systems for sharing diagnoses between departments in many hospitals*	*Managing risks such as delirium, distress and pressure ulcers*
Information sharing can identify existing diagnoses **Consistent recording of diagnoses** across health and care system is also essential	**Consultation and liaison services** can reduce the risk of depression. **Specialist wards** can lead to shorter stays, better outcomes and better experiences.

There are examples of good practice, but all OECD countries should aim to implement these measures in all hospitals.

We must address three key barriers to the development of care technologies

1 User-focused development

- Some technologies do not currently address the priorities of people with dementia
- Developers need to work closely with users

2 Robust, independent evaluation

- Too few robust trials of current technologies
- Essential to give care systems the confidence to implement new technologies

3 Clear reimbursement criteria

- Most care systems have not set out criteria.
- Would give manufacturers the confidence to invest in development

Care technology assessment processes, mirroring the the health technology assessments that already exist in many countries, could address points 2 and 3

THE ROLE OF TECHNOLOGY

MEASURING PERFORMANCE

Improving the measurement of dementia should be a priority

- There are currently few internationally comparable measures of dementia outcomes and the impact of policy.
- Changing this should be a priority for countries and the international community.
- This event provides an opportunity to start a conversation about measurement.

Key enablers of measurement:

Improving diagnosis rates and recording

Consistent identification and coding of dementia in health facilities

Linking data across health and care systems using EHRs or registries

Possible measures:

- Initial suggestions in our paper
- More work needed to refine the list and build consensus

Thank you

Contact: mark.pearson@oecd.org

Read more about our work

Follow us on Twitter: @OECD_Social

OECD SOCIAL

Website: www.oecd.org/health

CONCLUSIONS

Conclusions

- Need an international framework for understanding performance and holding each other to account for improvements.
- Supported by four elements:
  1. Objectives of dementia policy
  2. Evidence on policy approaches
  3. Metrics for measuring performance
  4. Enablers of measurement
- More work is needed to develop the framework and build international consensus.
- We need to start a conversation about measurement – both what we want to measure and how we can do it.

Shared Points

1) Dementia challenges
2) Establishing Care System
3) Education of professionals (including GP)
4) Dementia at home
5) Dementia friendly community
6) Co-ordination of efforts
7) Co-lab internationally

認知症の人ができるだけ地域で暮らすことは、
各国の認知症対策の基本的理念
Aging in place is essential for people with dementia. To achieve this,

認知症は進行性の疾患であり、その対応には
ステージに応じた適切な、医療、ケア、リハビリ等が必要
Adequate medical, rehabilitational as well as
social services should be provided

予防は1次、2次それぞれに適切な時期に適切な場での対応が必要
Primary as well as secondary preventive approach
to dementia are key challenges.

このような取り組みを推進するためには、地域においてシームレスに
ケアと予防が提供されること、地域住民の積極的な関与が必要
The well balanced trails from MCI to advanced stage of dementia
need Co-operation of people indwelling community.

メモリークリニック、初期集中支援チームなど
早期診断・早期対応は重要
Easy access to memory clinic and /or care service is essential
for aging in place.
Out reach intervention is considered to be
beneficial for smoothing the access to services.

ケアについて、ケア従事者への支援が不可欠である
To ease caregivers' burden should be more seriously considered.

行政レベルだけではなく、民間の力も必要
Integrated services of public sector and private sector are preferable
for increased demand of service and for high quality of care.

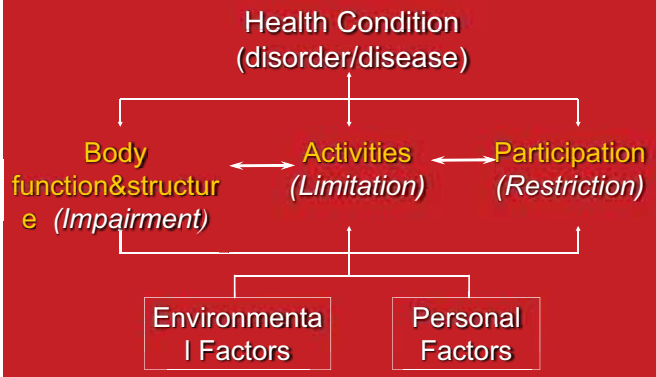
Session 1

Dementia Prevention and Care:
Providing Timely and Appropriate Support

Global Dementia Legacy Event Japan
-New Care and Prevention Models-

ICF

Interaction of Concepts ICF 2001



Prevention

- Promotion of preventative measures
- Included in most dementia plans and referred to as crucial component

- Different levels of prevention
  - Preventing the ND to occur
  - Preventing the ND to induce dementia
  - Preventing dementia to interfere with social participation

Early & Timely Diagnostic

- Advantage and disadvantage of early detection while questioning the cocnpet of ≪ timely ≫
- Necessity of early support following early detection
- ROKEN facilities to support and provide intesive tailored rehabilitation
- Tools to support GPs such as calculator and risk-evaluation infromation

ICF

Human Functioning not disability alone

- **Body functions** *vs* impairments
- **Body Structures** → Neurodegenerative Disease
- **Activities** *vs* activity limitation
  1980 disability → Dementia
- **Participation** *vs* handicap → Social Participation

Models of Care

- Specific to dementia vs integrated in the community-based system vs hybrid model
  - Education of health professionals
  - Availability of specialists
  - Necessity of including co-morbidity management
  - Specific needs of special populations, such as YOD
- Orange Plan, Kumamoto model, UK Hybrid approach, Specialized-center-based model

Balanced Approach

- Balance between efforts to cure/delay/modifiy course and offering social inclusion and adaptation
  - Importance of reaching the young elelents of societty
  - Advantages of inter-generational inititaives

Session 1

Dementia Prevention and Care:
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Unique Opprotunities

- Coordination
  - At all the levels health/social, long/short term, information dissemination, inter-disciplines
- Measures
  - Measure the impact, associated conditions, falls, etc.
- Evaluation
  - Necessity to evaluate all the innovative initiatives, including the technology
  - Notion of participatory evaluation
- Patient-centered care
  - With emphasis on the trajectory

Some Points Discussed

- Costs
- Costs
- Costs
- Costs
  - Financial/Social/Quality of Life

Ministry of Health, Welfare and Sport

Reform in Dutch Long Term Care

The Positive Effect on Dementia Care

Jacqueline Hoogendam

Ministry of Health, Welfare and Sport
The Netherlands

Creation of a sustainable long term care system

- no decrease of long term care
- increase quality of care
- increase quality of life for patients
- increase social involvement of all residents

Development of long term care in the past

- disproportionate increase in costs of ltc
- growing number of elderly people
- decreasing number of working people
- dementia most expensive illness in ltc

Dementia Care as a Model for LTC

- 2008: second national dementia programme
- aims:
  - to offer coordinated care for people with dementia in accordance with their needs and wishes
  - to improve guidance and support for people with dementia and their relatives
  - to measure the quality of this care annually

Results

- 2011:
  - 86 (sub)regions offer coordinated care (95% of the Netherlands)
  - all regions offer case management
  - some regions have projects to involve the general public in dementia care
- 2013:
  - steady increase of quality of care and patient satisfaction
  - cost effective
  - Dementia Care Standard

Reform in Long Term Care

- three main parts:
  1. more tasks for municipalities, focus on welfare and participation in society, public funding
  2. home nursing part of private health insurance
  3. care in nursing homes, public insurance
- effective from January 1st, 2015

Expected Positive Effect on Dementia Care

- legal foundation for important parts of coordinated dementia care
- more attention to social involvement of all residents, with focus on a dementia friendly society
- less burden on informal carers
- more tailor-made care → more patient satisfaction and better quality of life

Expected Reform Results

- sustainable ltc system
- increase in quality of care through:
  - more coordinated care
  - care organised closer to home
  - more involvement of informal carers/volunteers
  - tailor-made solutions
- increase in quality of life for all people dependent on ltc, especially those with dementia and their relatives

THANK YOU FOR YOUR ATTENTION

Diagnosis and Support

Jeremy Hughes
Chief Executive

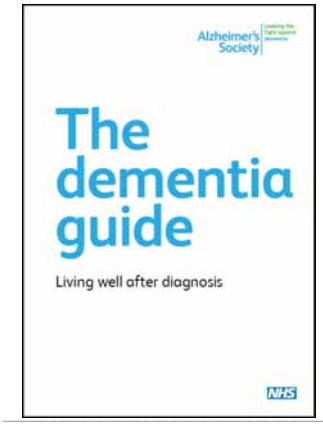
Working with primary care

- Family doctors
- Health centres
- Specialists

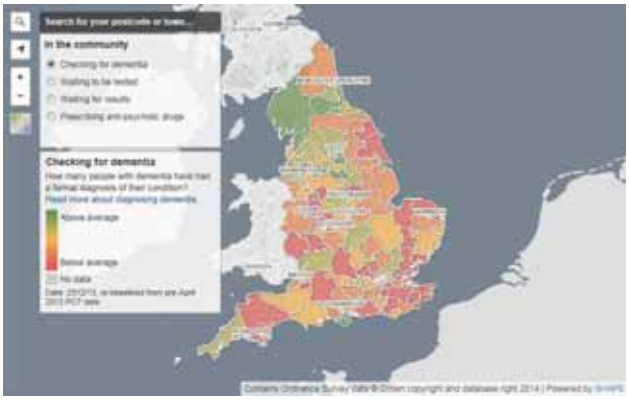
National Dementia Declaration

- I have personal choice and control or influence over decision about me
- I know that services are designed around me and my needs
- I have support that helps me live my life
- I have knowledge and know-how to get what I need
- I live in an enabling and supportive environment where I feel valued and understood
- I have a sense of belonging and of being a valued part of my family, community and civic life
- I know there is research going on which delivers a better life for me now and hope for future

Post Diagnostic Support



Diagnosis rates in the UK



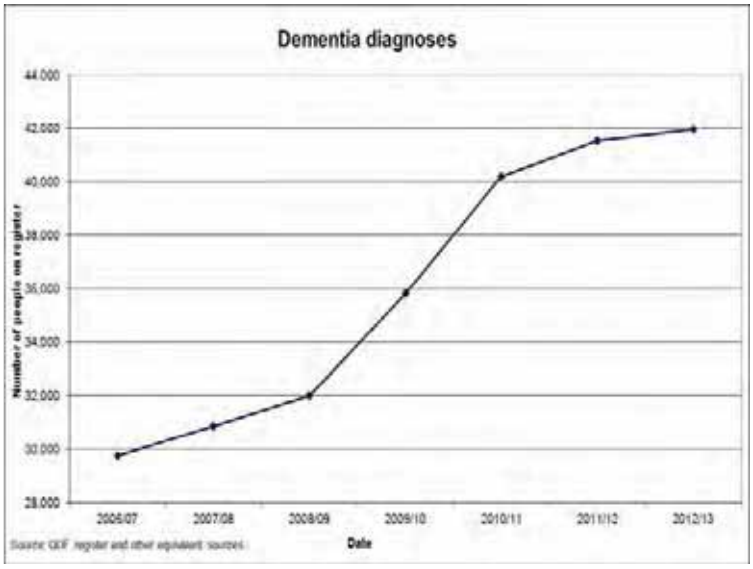
Thank you

Jeremy Hughes
Chief Executive, Alzheimer's Society
jeremy.hughes@alzheimers.org.uk

www.alzheimers.org.uk

Quality of Care for People Living with Dementia

Geoff Huggins



Thank You

Not going to tell you what we did

National Priority since 2007

Sorry

Design Principles to Improve Quality of Care

Post diagnostic support
=
One year + named worker +
quality measures

@worlddementia
@oecd
@who
@eu

Quality Principle

Care and support must be truly person centred, and should understand care and support from the perspective of people living with dementia, not the perspective of service managers or clinicians

Humanity Principle

Care and support is offered to people with dementia and their families and carers in a way which promotes their wellbeing and quality of life, protects their rights and respects their humanity

Nothing about us without us

Effectiveness Principle

Care and support services must be redesigned to deliver integrated care to ensure that we deliver services effectively and efficiently

Care and support for people caring for people with dementia

=

Care and support for people with dementia

Person to person care

Humanity Principle

Quality Principle

Effectiveness Principle

What do you think?

Global action against dementia
Action mondiale contre la démence

Timely and appropriate prevention and care
The French experience

Etienne C Hirsch

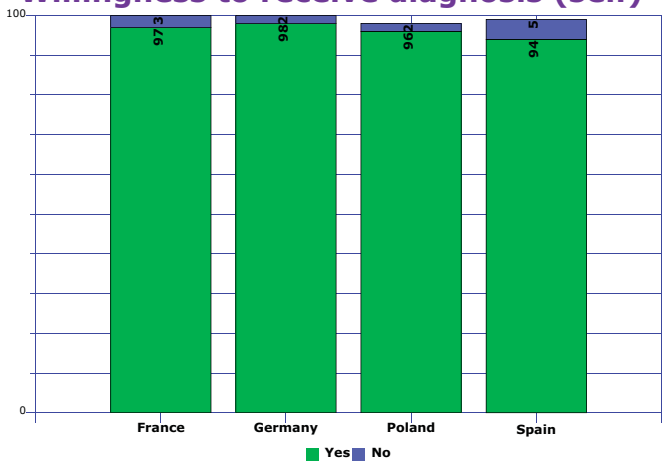
Director of the Insitute for Neurosciences, Neurology and Psychiatry

Inserm

aviesan

~~No desire to know?~~

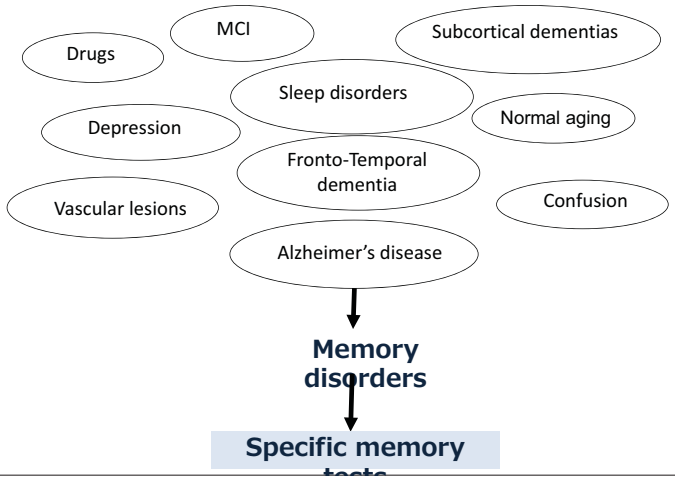
Willingness to receive diagnosis (self)



Today in France older subjects are anxious about their memory

- memory complaints: almost the rule
- complaints not correlated with objective memory performance
- in most of the cases, complaints are related to attention disorders:
  - depressive mood
  - anxiety and professional stress
  - drugs
  - sleep disorders and sleep apneas
  - normal ageing

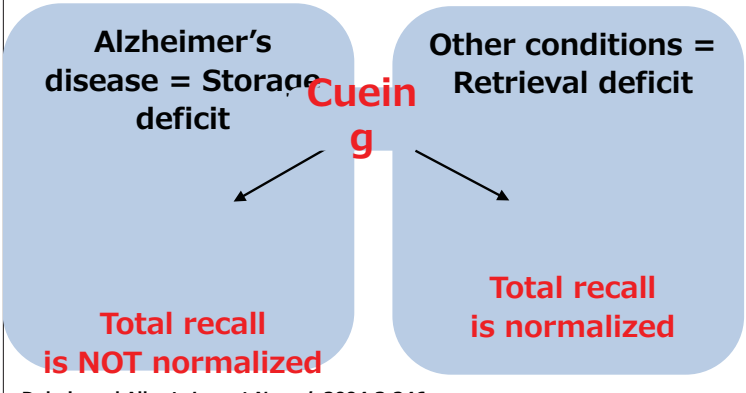
No certainty of diagnosis: Early diagnosis is difficult



The 4 arguments put forward against an early diagnosis for AD

1) No desire to know
2) No certainty of diagnosis
3) Nothing to do for the patient
4) Risk of catastrophic reactions

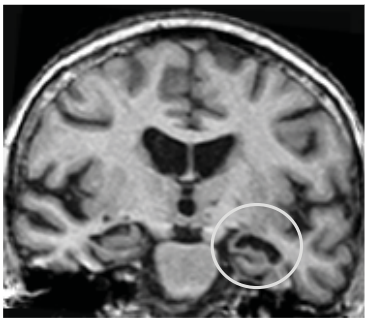
The specific pattern of AD memory disorders can be identified with cueing



Dubois and Albert. *Lancet Neurol.* 2004;3:246-248.

MRI is useful at the prodromal stage

- MRI excludes other causes (vascular, tumor, hydrocephalus…)
- MRI shows a precocious atrophy of the hippocampus



The diagnosis is more difficult at an early stage

Lehericy et al. Eur Radiol 2007

Recommendations for a timely diagnosis for AD

December 2000

Level 1: the GP

- identification and screening of patients with simple tools;
- orientation to level 2 for a more complete investigation;
- follow-up of patients in connection with the local network of professionnals.

Level 2: the Memory Clinic or the Specialist (N,G,P)

- confirmation of the diagnosis based on a specialized neuropsychologic investigation and neuro-imaging ;
- therapeutic initiation.

Level 3: Regional Expert Centre (platform of resources)

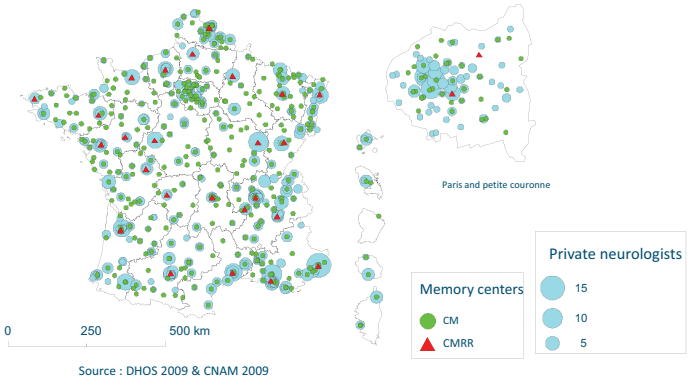
- for complex diagnosis and Young-onset AD patients;
- for clinical research;
- for clinical trials mainly on disease modifier treatments.

'There is nothing to do'

Current available Non Pharmacological Treatment

- Cognitive stimulation is as effective on cognition as symptomatic drugs
- Cognitive rehabilitation
- Behavioral therapy applied by informal carers as co-therapists
- Support groups for informal carers improve quality of life
- Physical activity
- Multicomponent caregiver interventions
- Less evidence, still good: arts and musical therapy

The 3-level device in France



Source : DHOS 2009 & CNAM 2009

10

Risk of catastrophic reactions

Disclosure of the diagnosis enables the patient to:

Alzheimer PLAN 2008 › 2012 L'ENGAGEMENT DE TOUS

Plan Maladies Neuro-Dégénératives

2015-2019

Relationship-based Care and Positive Outcomes for People with Alzheimer's and Their Families

Global Dementia Legacy Event Japan
6 November 2014
Tokyo

Jeff Huber
President, Home Instead Senior Care
Member, Global Coalition on Aging

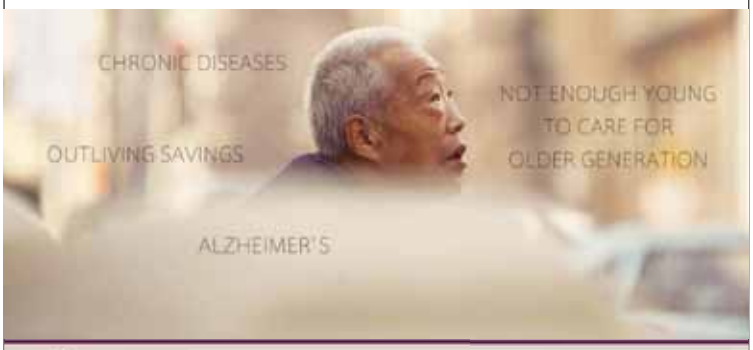
How we provide care

Person-Centered and Relationship-Based	Specific Focus on Alzheimer's and Other Dementias	Care for the Family Caregiver
• 90% of seniors prefer to live at home as they age • Focus on relationships, not tasks • Personalized care solutions, including care coordination	• Alzheimer's training for our professional CAREGivers • Free Alzheimer's training for the public • 5,000+ in-person trainings completed and 30,000+ [illegible]-learning course	• Free resources for family caregivers • Focus on family caregiver wellness • Alleviates physical and emotional burdens, provides peace of mind

OUR CARE OBJECTIVES

Active & Healthy Living ⟷ Extended Life With Quality

The aging movement is becoming a powerful social and political global force



Home Instead Services

Companion and Home Helper
- Meal preparation
- Medication reminders
- Accompany to doctor visits
- Grocery shopping and errands
- Laundry and linens
- Socializing
- Light housekeeping

Personal Services
- Bathing
- Dressing
- Incontinence care/toileting
- Mobility assistance

Alzheimer's or Other Dementias Care
- Managing behaviors
- Encouraging engagement
- Assisting with ADLs
- Keeping seniors safe

Transitional Care Services
- Transportation/prescription pick-up
- Discharge assistance
- Hospital readmissions

Care for Serious Conditions
- Observe how conditions affect seniors
- Recognize changes that may occur
- Report and record information relevant to care

Hospice Support
- Supplemental support services
- Respite for family caregivers

Serving Seniors Across the Globe

1,022 total franchises worldwide

65,000 CAREGivers • 30 million hours of care annually

Year Started	Country
1994	United States
2000	Japan
2001	Canada
2003	Portugal
2004	Australia
2005	Ireland New Zealand United Kingdom
2006	Taiwan
2007	Switzerland Germany
2008	Finland Austria
2010	Italy
2011	Netherlands
2012	Mexico
2013	China
2014	Quebec

Home care supplements traditional senior care and supports a new and more efficient care model

Non-medical home care can be applied at any interval across the care continuum

Independence → Family → Intermediate → Facility → Hospice

Home Instead Is Improving Quality of Life for Seniors with Alzheimer's

2x Double the Care Time

AOD patients with paid home care received 97.1 hours per week, compared to 51.7 for those without.

Nearly 50% Fewer Doctor Visits

AOD seniors with home care averaged 10.2 doctor visits per year versus 19.2 for those without home care.

Fewer Hospital Admissions

AOD seniors receiving home care had a 58% rate of in-patient hospital admissions, compared to 65% for those without.

Overall Better Quality of Care

73% of caregivers using professional home care rated the overall quality of care for their family members with AOD as "very good" or "excellent," compared with 62% of non-users.

SOURCES: "The Value of Caregiving at Home" – Conducted by the Boomer Project on behalf of Home Instead, Inc., with advisor of the Home Instead Senior Care network, this major national study surveyed more than 1,600 family caregivers across the U.S. Results described here refer to the "more serious" AOD group evaluated.

Home Instead SENIOR CARE *To us, it's personal.*

Global Coalition on Aging

Relationship-based Care and Positive Outcomes for People with Alzheimer's and Their Families

Global Dementia Legacy Event Japan
6 November 2014
Tokyo

Jeff Huber
President, Home Instead Senior Care
Member, Global Coalition on Aging

Day 1 Session-2

Scientific Aspects of Dementia Prevention and Care

National Center for Geriatrics & Gerontology

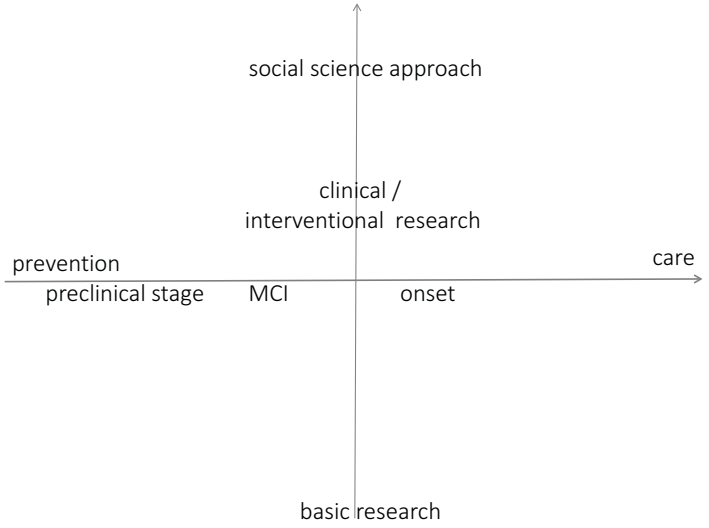
Takao Suzuki

Dr. Prince: Proposal for the future research

- analysis of global prevalence of dementia
- Identification of modifiable factors & pharmacological / non-pharmacological intervention for risk reduction

education	in early life
hyper tension	in midlife
diabetes	in mid-to-late life
smoking	in mid-to-late life

- We have to continue our efforts to establish other robust risk factors for prevention of cognitive decline and dementia



Dr. Hachinski

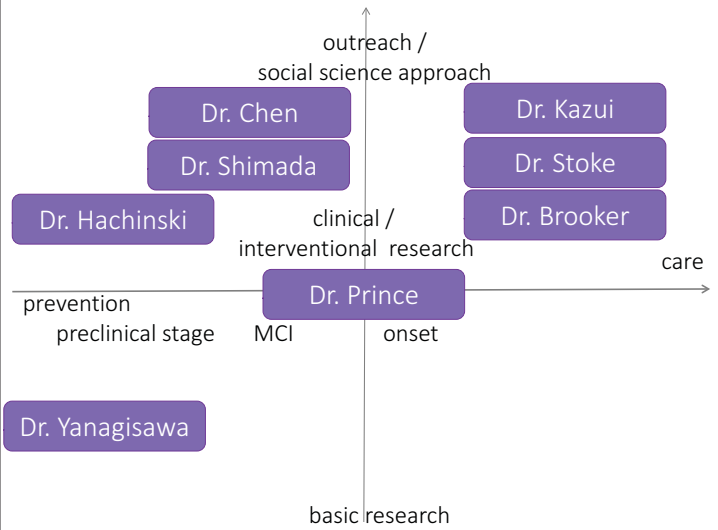
prevention
preclinical stage

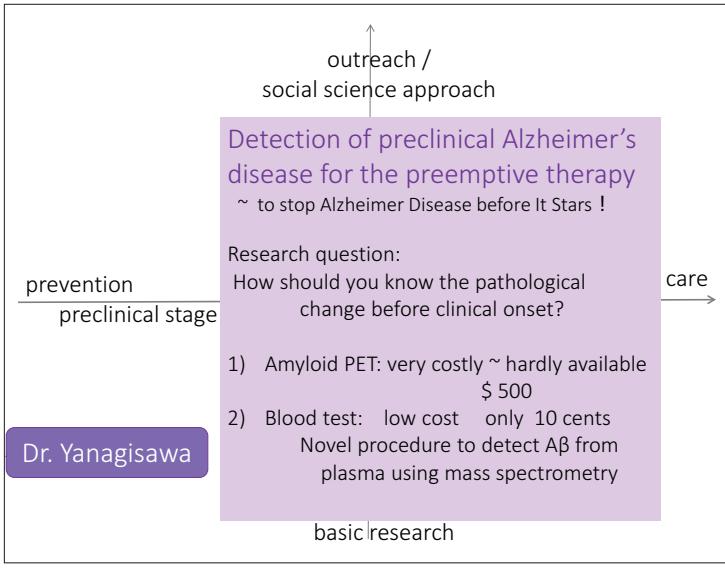
Preventing Dementia: Can We Do Better?

Focusing on the treatable Vascular Component
Trying new multimodal integrated approaches

Vascular risk factors may be related to cognitive decline
e.g., blood pressure control, weight reduction, smoking cessation, etc.

Interventions of 3 steps
1) identification of risk factors
2) enhancing motivation
3) enablement in the society
e.g., education in school/work, supported by IT technologies social media environment, etc.





A Scheme for Preventing Cognitive Decline in the Community

Dr. Shimada

prevention
preclinical stage

Aim: Delay the onset of dementia
Target population: MCI
Early detection by population screening

Intervention
~ New method of preventive intervention of dementia
COGNICISE = Cognitive training + Exercise

Results: cognitive improvement
reduction of brain atrophy
~ hippocampus + whole brain

Conclusion
1. Early detection of MCI in the community is critical for prevention of dementia
2. Exercise, especially COGNICISE, may useful to maintain cognitive functions in MCI subjects

The Need To Transform Services In Care Homes

Dr. Stoke

care

<implementation of person-centered care in care homes>
1) 2009-2014 ~ Antipsychotic reduction program
"Person First, dementia second staff training program"
Results
2009 - 35.0%
2013 - 19.5% residents with dementia prescribed antipsychotics

basic research

Dementia Prevention Study and Policy in Taiwan

Dr. LK Chen

prevention
preclinical stage

Taiwan Health Intervention Study on Community-dwelling Elders (THISCE)

1 Nationwide randomized controlled trial to validate clinical effects of THISCE integrated intervention program
Physical activities
Cognitive training
Dietary counselling
Chronic disease management

2 Developing social marketing strategies to facilitate nationwide implementation

Dr. Piu Chan

presented the Current Status of Dementia and Challenges in China

Effect of a regional cooperative system for dementia patients with a collaboration notebook

Dr. Kazui

care

Needs for collaboration among the many people caring for dementia patients living at home
↑
The collaboration notebook
to support patient life at home
1) patient's clinical information
2) information for sharing among stakeholders

<use of the notebook>
inter-professional collaborative meeting
education for healthcare professionals & caregivers

Person-Centred Dementia Care Research

Dr. Brooker

care

The gist of person-centered care
V = Values people
I = Individuals needs
P = Perspective of service user
S = Supportive social psychology

Intervention Results
Qualitative results QOL improvement
reduction in anti-psychotic medication

basic research

Messaging the message

(who?, what?, where?, when?, why?)

Martin Prince

Centre for Global Mental Health
King's College London
1066drg@iop.kcl.ac.uk

Messaging the message

- **Dementia is a preventable condition**
- **Myth-busting**
  - It's an inevitable, normal part of ageing
  - There is nothing that we can do
- **Dementia is everybody's business**
  - never too early… (brain health promotion)
  - never too late… (dementia prevention)

Alzheimer's Disease International
The global voice on dementia

World Alzheimer Report 2014

Dementia and Risk Reduction

AN ANALYSIS OF PROTECTIVE AND MODIFIABLE FACTORS

Global Observatory for Ageing and Dementia Care

Martin Prince
Emiliano Albanese
Maelenn Guerchet
Matthew Prina

Dementia is a preventable condition

- Not widely understood or accepted
- Needs to be integrated and mainstreamed within emerging global health NCD prevention agendas e.g '25 by 25'
  - Tobacco control, salt, alcohol, inactivity, CVRF management
  - Current focus is on 'premature' mortality
  - Older people marginalised
  - Actual societal benefit may be much wider and greater
  - Global societal cost of dementia = $600bn

The message (modifiable risk factors for dementia)

Exposure	Period
Education	Early life
Hypertension	Midlife
Diabetes	Mid- to late-life
Smoking	Mid- to late-life

It's never too early…. (brain health promotion)

- Education
  - As a source of cognitive/ brain reserve
  - As 'education for life'
  - Benefits with every additional level from primary > tertiary (and beyond?)
- Upstream determinants of adult cardiovascular risk
  - Poverty, inequality
  - Foetal nutrition/ childhood obesity
  - 'Habits of a lifetime'
    - Diet
    - Exercise
    - Smoking initiation

It's never too late…. (dementia prevention)

- Evidence on smoking, diabetes
- There may be additional benefits from multicomponent interventions for high CVD risk groups
  - FINGER trial
  - Polypill?
- Older people not prioritised in NCD prevention…

…despite equivalent or greater health benefits

- Concerns about dementia may be a powerful motivator for behavioural change
- NB - social learning theory – older people as authoritative communicators

Monitoring progress

- Cardiovascular health is improving in many developed countries
  - Less smoking, declining BP and cholesterol
  - Increased physical activity
  - Prevalence of obesity and diabetes is increasing
  - Falling incidence of heart disease and stroke
- Better education

- Natural experiment
  - Track change in risk factor profile
  - Predicted vs. observed change in dementia incidence
  - Attribute change in incidence to individual risk factors

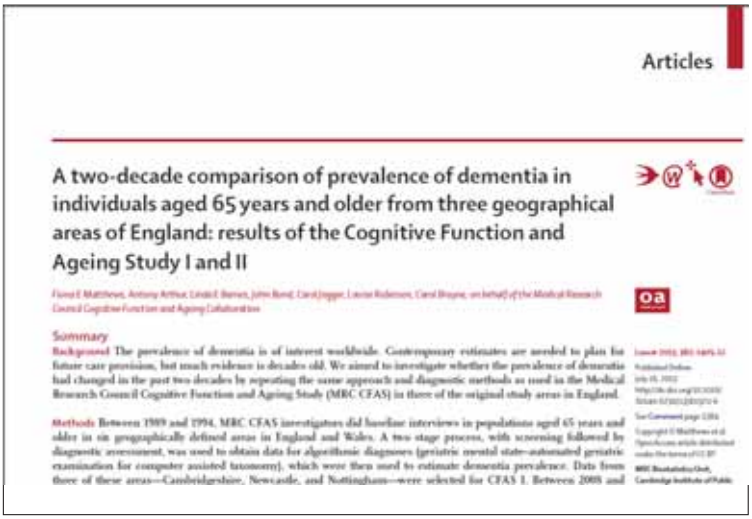
Can prevention help to reduce the burden of dementia?

Exposure	Meta-analysed RR - association with AD	Population attributable risk fraction (PARF%)
Diabetes	1.46 (1.20-1.77)	2.9%
Midlife hypertension	1.61 (1.16-2.24)	5.1%
Midlife obesity	1.60 (1.34-1.92)	2.0%
Physical inactivity	1.82 (1.19-2.78)	12.7%
Smoking	1.59 (1.15-2.20)	13.9%
Depression	1.65 (1.42-1.92)	7.6%
Low education	1.59 (1.35-1.86)	19.1%
COMBINED TOTAL		28.2%

(Norton et al 2014)

10% reduction in risk exposure – (8.3% reduction)

25% reduction in risk exposure – (15.3% reduction



Articles

A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II

Summary

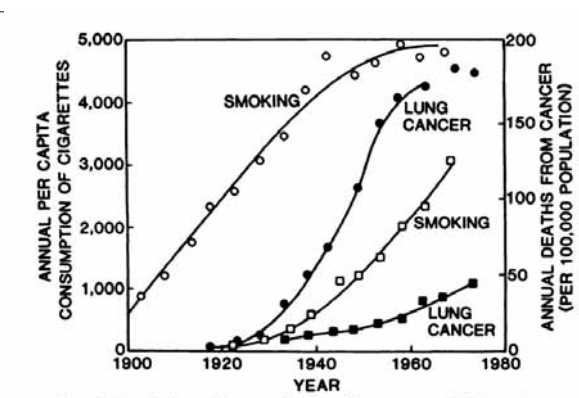
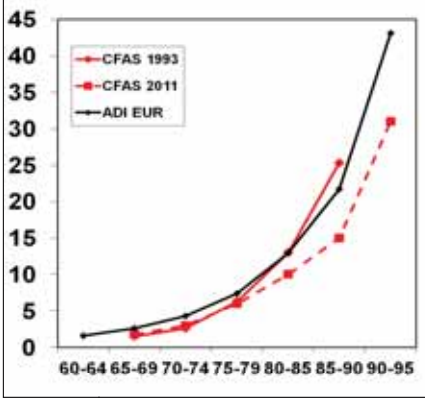


Chart 4. Trends in smoking prevalence and lung cancer, British males and females. The data for this chart are for England and Wales. In men, smoking (○) began to increase at the beginning of the 20th century, but the corresponding trend in deaths from lung cancer (●) did not begin until after 1920. In women, smoking (□) began later, and the increase in lung cancer deaths in women (■) has only appeared recently. Redrawn with permission from the paper of Cairns (4).

Prevalence may already be falling in HIC… e.g MRC CFAS (England) 1993-2011



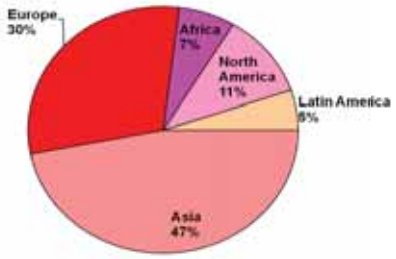
Standardised prevalence
1993 - 8.3%
2011 - 6.5%

Prevalence of dementia nearly **one third lower** in 2011 compared with 1993

OR 0.7 (0.6-0.9)

Matthews et al, Lancet 2013

Global Distribution of Incident Dementia (7.7 million new cases per year)



One new case every 4 seconds!

WHO Report 2012 – Dementia a Public Health Priority

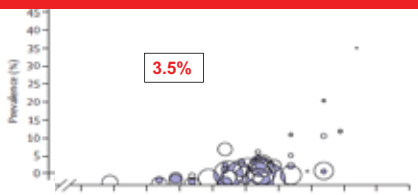
An index of the quality of public healthcare – detection and control of hypertension

	Detection	Control	Detected and controlled
Good			
Peru (rural)	97%	93%	90%
Peru (urban)	93%	78%	73%
Puerto Rico	91%	65%	58%
Moderate			
Mexico (urban)	80%	55%	44%
Venezuela	83%	50%	42%
DR	82%	48%	39%
Mexico (rural)	73%	52%	38%
China (urban)	79%	45%	36%
Poor			
S Africa	82%	32%	24%
Cuba	70%	34%	24%
India (rural)	43%	43%	18%
India (urban)	44%	37%	16%
China (rural)	51%	5%	3%

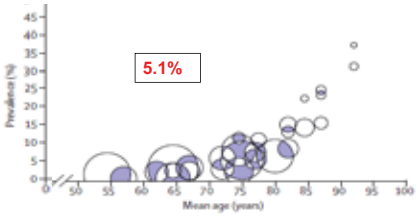
Prince et al, Journal of Hypertension, 2011

Increasing prevalence of dementia in China?

1990

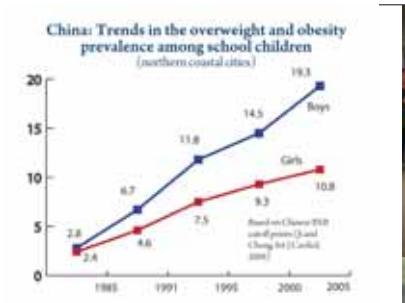


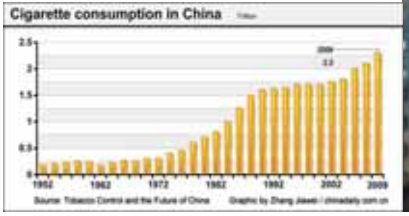
2010



The prevalence of dementia in China 1990-2010
Chen et al, Lancet 2013

46% increase 1990-2010



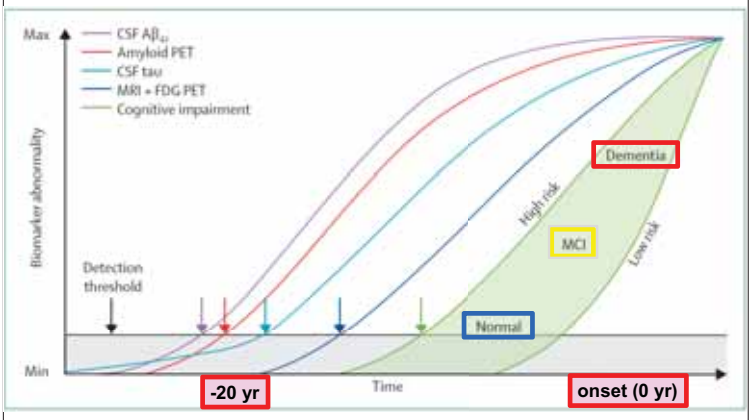


TOPICS-2: Scientific approach to the dementia prevention and care

Efficient prevention of dementia based on medical evidence and an financial view

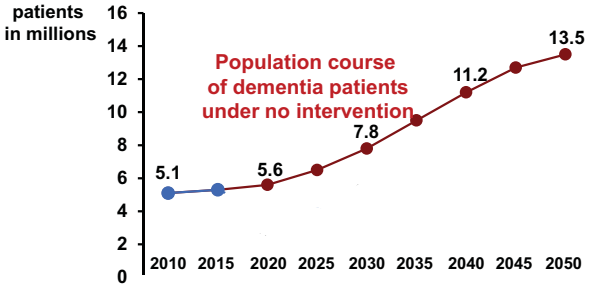
Predident, Japan Society of Dementia Research
Professor, Osaka City University, Medical School
Hiroshi Mori

Revised model from ADNI & DIAN studies



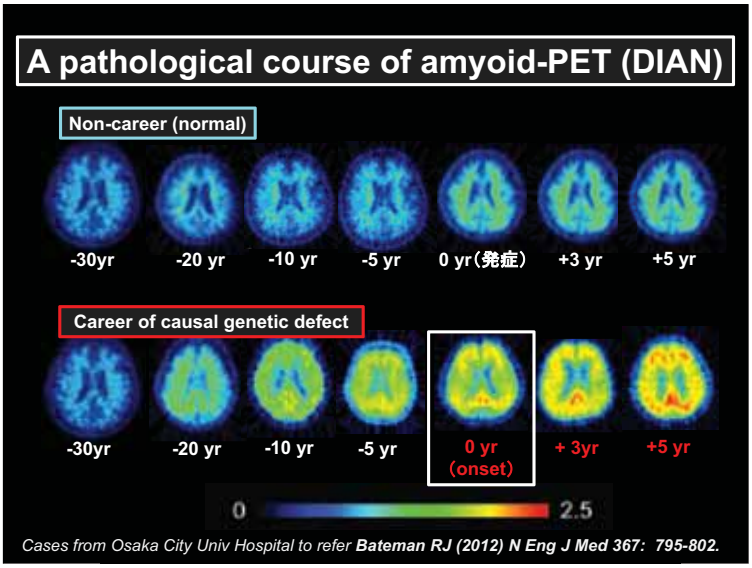
Petersen RC (2010) Lancet neurol 9: 4-5.;
Juck Jr, C. et al (2013) Lancet neurol 12: 207–16.
Bateman RJ (2012) N Eng J Med 367: 795-802.

A 5-yr delay of disease onset result in a big reduction of AD patients.



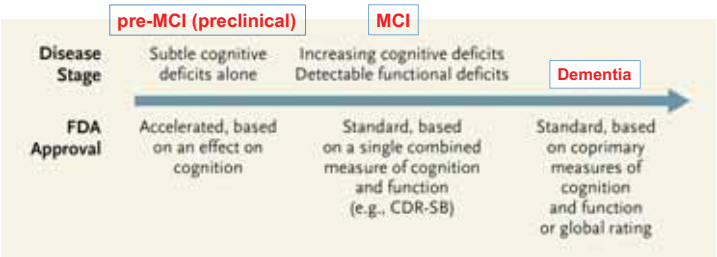
Reported by Alzheimer's Association, 2010

A pathological course of amyoid-PET (DIAN)



Cases from Osaka City Univ Hospital to refer ***Bateman RJ (2012) N Eng J Med 367: 795-802.***

From cure to prevention of dementia



The US-FDA has developed guidance for the design and execution of clinical trials involving patients who do not present with dementia.

from Kozauer N and Katz R., New Engl J Med 2013; 368: 1169.

Clinical challenges

Clinical trials	participants	Drugs (new concepts)	Target to challenge	Budgets million US$
① ADNI project (Weiner M)	200 healthy, 400 MCI, 200 AD Also, Japan running	Observation	① Cognitive state ②biomarker	67
② Anti-Amyloid Treatment of Asymptomatic Alzheimer's (A4) (Sperling R)	1,500 amyloid-PET positive	Solanezmab	① Cognitive state ②biomarker	36
④ Dominantly Inherited Alzheimer Network (DIAN, DIAN-TTU) (Morris J, Bateman R)	240 familial AD in US, UK, Germany, Australia Also, Japan just joining	Observation + Solanezmab Gantenezmab One more?	① Cognitive state ②biomarker	6
⑤ Banner project (Reiman E, Tariot P)	1,300 healthy subjects in 60-75yr ApoEε4/4	BACE-I CAD106	Disease onset & more?	45 + more
③ Alzheimer's Prevention Initiative (API) (Reiman E, Lopera F)	300 familial AD in Colombia, Presenilin-1 E280A	Crenezmab	① Cognitive state ②biomarker	116

from Underwood BY, Science Insider, Science 2013

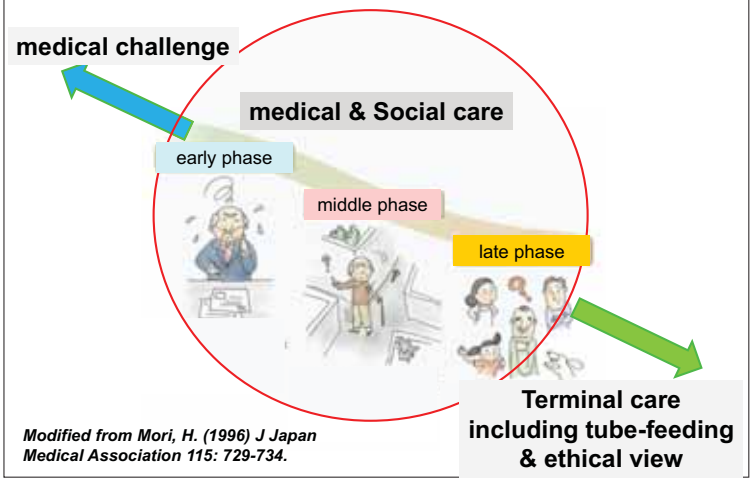
Current situation of dementia in Japan

Dementia : 4,620,000 patients

general practitioner : 100,000 doctors
(dementia supporter educated : 3,000 doctors)

Specialists to see dementia authorized by two academic societies (Japan Society of Dementia Research & Japanese Psychogeriatric Society) : 1,800 doctors

Perspective for dementia science



Modified from Mori, H. (1996) J Japan Medical Association 115: 729-734.

Thanks a lot for your attention

Global action against dementia

New Care and Prevention Models
3rd Global Dementia Legacy meeting

JPND research

Joint Programming in Neurodegenerative Disease Research (JPND)

Coordinating approaches to research across Europe

Prof. Philippe Amouyel, MD, PhD
JPND Chair
Tokyo, November6th, 2014

The JPND goals

To tackle the challenge of Alzheimer's and other neurodegenerative diseases, the goals of the JPND Research Strategy are:

- **To develop new treatments and preventive strategies**
- **To improve health and social care approaches**
- **To raise awareness and de-stigmatise neurodegenerative disorders**
- **To alleviate the economic and social burden of these diseases**

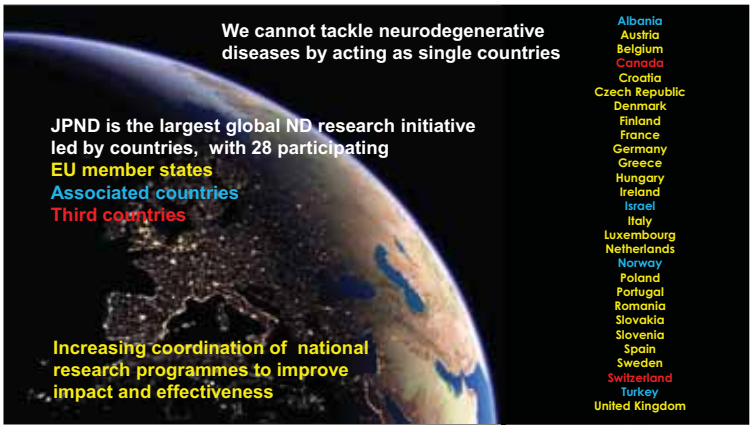
What is Joint Programming in Research?

Three pillars

- **A shared vision :** countries **engaging voluntarily and on a variable geometry** basis to tackle a major societal challenge
- **A management structure :** to address as efficiently as possible this societal challenge
- **A common strategic research agenda** : to be defined, developed and implemented

JPND brings together

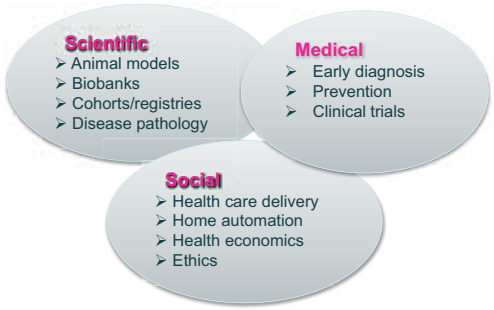
- Researchers (Basic, Clinical, Healthcare/Social)
- National Funding Bodies
- National Research Strategies and Investments



Neurodegenerative Diseases?

- **The neurodegenerative diseases that JPND focuses on are:**
  - **Alzheimer's disease (AD) and other dementias**
  - Parkinson's disease (PD) and PD-related disorders
  - Prion disease
  - Motor neurone diseases (MND)
  - Huntington's Disease (HD)
  - Spinocerebellar ataxia (SCA)
  - Spinal muscular atrophy (SMA)

Scope of JPND, Research



SRA Implementation (2012-2014)

Annual Calls for Proposals

Year	Total fund available	Research Area	No. of Projects
2011 (pilot)	€16M	Optimization of biomarkers + harmonization of their use	4
2012	€18M	Risk and Protective Factors	5
2012	€11M	Evaluation of Healthcare	6
2013	€12M	Cross-Disease Analysis	10
2013	€11M	Preventive Strategies	5

Centres of Excellence in Neurodegeneration (CoEN)

2011	€6M	Phase I : common resources and methodological approaches	8
2012-13	€8M	Phase II : "Pathfinder" projects	5

Defragmentation – what JPND is all about…

STRATEGIC RESEARCH AGENDA

ALIGNMENT OF COUNTRIES ON COMMON RESEARCH GOALS

Call statistics

Year	Call area of interest	No. of proposals submitted	Budget requested (million €)	No. of proposals recommended for funding	No. of proposals supported	Budget supported (million €)	Success rate (%)
2011	Harmonization of Biomarkers	14	€31	5	4	€14	29%
2012	Risk and Protective Factors	52	€97	18	5	€17	10%
2012	Healthcare Evaluation	22	€29	9	6	€9	27%
2013	Cross-Disease Analysis	90*	€112	23	10	€12.5	11%
2013	Preventive Strategies	35*	€36	5	5	€7	14%
Total		**213**	**€157m**	**60**	**30**	**€59.5m**	**18%**

*** pre-proposals**

JPND Research Strategy (SRA)

- **Agreed by all JPND Member States + Assoc. Countries**
  - Officially Launched Feb 7th 2012
- **Thematic priorities for future research:**
  - The origins of neurodegenerative disease
  - Disease mechanisms and models
  - Disease definitions and diagnosis
  - **Developing therapies, preventive strategies and interventions**
  - **Healthcare and social care**

JPND-supported projects in Preventive Strategies

- **EURO-SCD:**
  Subjective cognitive decline in preclinical Alzheimer's Disease: European initiative on harmonization and on a lifestyle-based prevention strategy (Coordinator: Frank Jessen, Germany)
- **MIND-AD:**
  Multimodal preventive trials for Alzheimer's Disease: towards multinational strategies (Coordinator: Mia Kivipelto, Finland)
- **NEUROEXERCISE:**
  The effects of an extensive exercise program on the progression of mild cognitive impairment (MCI) (Coordinator: Stefan Schneider, Germany)
- **ONWebDUALS:**
  ONTology-based Web Database for Understanding Amyotrophic Lateral Sclerosis (Coordinator: Mamede de Carvalho, Portugal)
- **PreFrontAIs:**
  Searching for therapeutic interventions in frontotemporal dementia with C9ORF72 repeat expansions in the presymptomatic stage (Coordinator: John C van Swieten, The Netherlands)

Encouraging deeper levels of collaboration for research groups

JPND Online Partnering Tool

Assisted Living Technologies

Innovation For Our Future

30 focused in dementia out of 150 AAL funded projects

JPND Alignment Actions

- **JPND Action Groups for:**

Palliative and End-of-life care for ND

- Distinct from cancer palliative care
- Advanced care planning
- Family involvement
- Cognition
- Difficult prognostication
- Important challenges:
  - how to shape palliative care through:
    - the stages of disease
    - the place of care
    - the key transitions more generally
  - optimizing care delivery through appropriate timing + integration of expertise
    - e.g. expertise in palliative, psychiatric, geriatric, dementia care, social and medical care

Participants at the JPND workshop, Amsterdam, June 25th, 2014

Action Group Recommendations

Partnership with the EC

- Establish programme of co-investment to leverage the value of investments and resources at both national and EC level, to the benefit of Europe
- **Synergy between JPND actions and H2020 programme**
- First call of Horizon 2020 (Dec. 2013)
- ERA-NET cofund: Implementing a transnational call with EU co-funding
- **Three Call Topics in preparation for the end 2014/beginning 2015:**
- Identification of genetic, epigenetic and environmental risk + protective factors
- Longitudinal cohorts in ND research
- Advanced experimental models of ND

From G7 to JPND, a shared vision

	G7	JPND
United Kingdom	YES	YES
France	YES	YES
Germany	YES	YES
Italy	YES	YES
Canada	YES	YES
United States of America	YES	-
Japan	YES	-
European Commission	YES	YES

Keep up to date

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  - http://www.jpnd.eu
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- **E-mail us**: secretariat@jpnd.eu
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@JPNDEurope

Providing Evidence for the Prevention and Care of Dementia in Canada and Globally

Yves Joanette, PhD, FCAHS
Scientific Director, CIHR Institute of Aging
Executive Director, ICRSAD

Japan Legacy Event
Tokyo, November 2014

www.cihr-irsc.gc.ca

Canada

CCNA

Canadian Consortium on Neurodegeneration in Aging

Collaborating with Asia
China NSFC

Strengthening Canadian Research on Neurodegenerative Diseases Affecting Cognition
CCNA

Collaborating with EU
COEN – JPND

Collaborating with USA
ADNI 2

Canada

Dementia – A Global Health Issue

Table 1 Updated estimates of the number of people with dementia living in G8, G20, OECD, LMIC and HIC countries, and as a percentage of world total

	People with dementia millions (% of world total)			Proportionate increase (%)	
Region	2013	2030	2050	2013-2030	2013-2050
G8	14.02 (32%)	20.38 (27%)	28.91 (21%)	45	106
G20	33.93 (77%)	56.40 (75%)	96.61 (71%)	66	185
OECD	18.08 (41%)	27.98 (37%)	43.65 (32%)	55	142
High income	17.00 (38%)	25.86 (34%)	39.19 (29%)	52	131
Low and middle income	27.84 (62%)	49.76 (66%)	96.27 (71%)	79	246
World	44.35	75.62	135.46	71	205

2

Supporting Prevention and Care Integrated Research

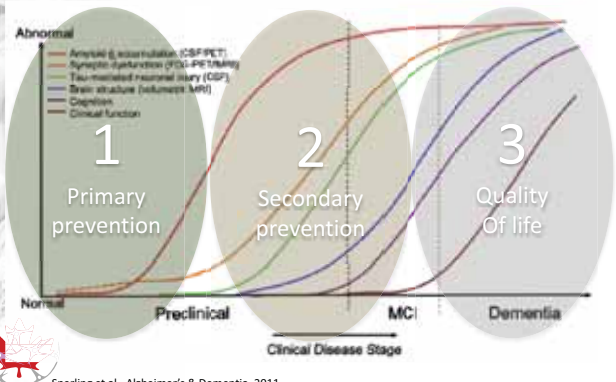
	Theme 1: PREVENTION	Theme 2: TREATMENT	Theme 3: QUALITY OF LIFE
CROSS-CUTTING PROGRAMS	1. Genetics of NDD 2. Inflammation & Growth Factors 3. Protein Misfolding 4. Synapses & Metabolomics 5. Lipids & Lipid Metabolism 6. Nutrition, Lifestyle, & Prevention of AD	7. Vascular Aspects of NDD 8. Lewy Body Dementia 9. Biomarkers 10. Cognitive Intervention and Brain Plasticity 11.Prevention and Treatment of Neuropsychiatric Symptoms 12. Mobility, Exercise, and Cognition 13. Frontotemporal Dementia	14. How Multi-Morbidity Modifies the Risk and the Patterns of Disease 15. Gerontechnology & Dementia 16. Driving & Dementia 17. Interventions at the Sensory and Cognitive Interface 18. Effectiveness of Caregiver Intervention 19. Integrating Dementia Patient Care into the Health Care System 20. Issues in dementia care for rural and indigenous populations
TRAINING & CAPACITY BUILDING			
KNOWLEDGE TRANSFER			
ELSI			
WOMEN & DEMENTIA			

Eight Platforms to Support the Teams

1. Clinical Cohorts
2. The Normative Comparison Group
3. Imaging/Database/Information Technology
4. Blood, Saliva & CSF Biosamples
5. DNA Sequencing
6. Brain Banking
7. Transgenic Colonies
8. Academic Clinical Trials

Canada

From Prevention to Care



Sperling et al., Alzheimer's & Dementia, 2011
Adapted from Jack et al., Lancet Neurol., 2010

Canada

The Canadian Dementia Research Strategy

Collaborating with Asia
China NSFC

Strengthening Canadian Research on Neurodegenerative Diseases Affecting Cognition

Collaborating with EU
COEN – JPND

Collaborating with USA
ADNI 2

Canada

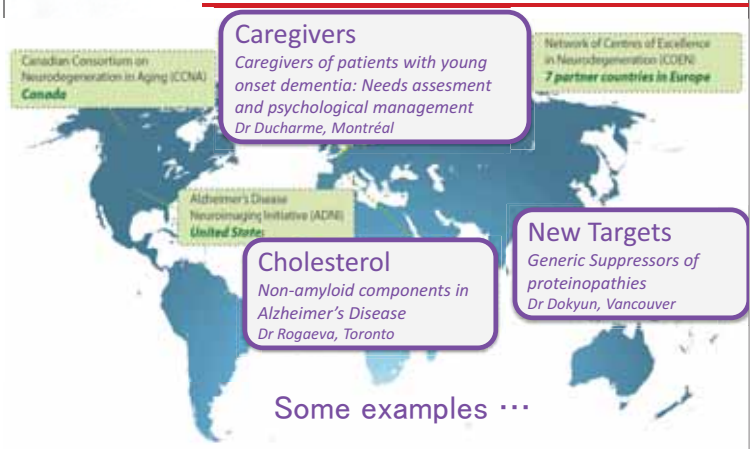
International Initiatives

Canada

A Unique Collaborative Ecosystem to Face the Global Challenge of Dementia

Canada

International Initiatives



Caregivers
Caregivers of patients with young onset dementia: Needs assesment and psychological management
Dr Ducharme, Montréal

Cholesterol
Non-amyloid components in Alzheimer's Disease
Dr Rogaeva, Toronto

New Targets
Generic Suppressors of proteinopathies
Dr Dokyun, Vancouver

Some examples …

Canada

CIHR IRSC

Providing Evidence for the Prevention and Care of Dementia in Canada and Globally

http://www.cihr-irsc.gc.ca/e/46475.html

yves.joanette@umontreal.ca

www.cihr-irsc.gc.ca

Canada

CDKTN

CDKTN has three research themes at sites across Canada. You can explore these themes below.

Education and Training

This theme focuses on development of training programs and opportunities for researchers and health practitioners in knowledge translation and exchange (KT&E), funding opportunities and research projects for the study of KT in dementia research. The heads for this theme are Dr. Judy Illes and Dr. Lynn Beattie (National Core for Neuroethics and Division of Geriatric Medicine, University of British Columbia)

Knowledge Exchange

Website for teens living with fronto-temporal dementia in the family:

Tweens and teens who have a parent or grandparent with dementia now have a website designed specifically for them. When Dementia is in the House was developed to educate caregiving for children living with someone who has dementia, with a focus on frontotemporal dementia (FTD).

Global Dementia Legacy Event Japan

Roppongi Hills, Tokyo 2014.11.6

The role of geriatricians in management of dementia

- from the viewpoint of life style modification -

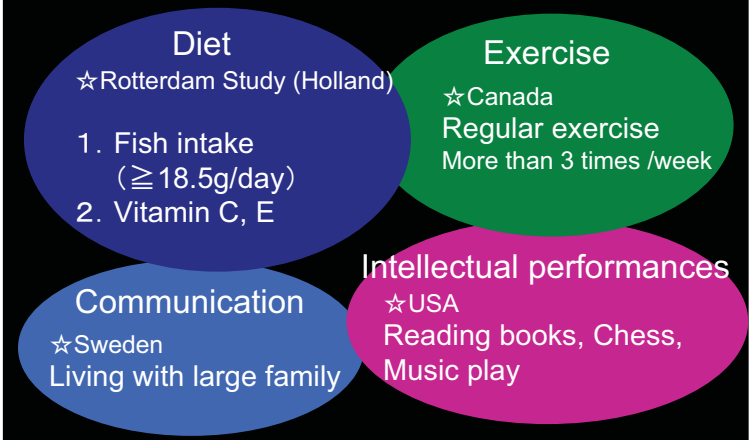
President, Federation of National Public Service Personnel Mutual Aid Associations Toranomon Hospital

Professor Emeritus, University of Tokyo

Chair, The Japan Geriatrics Society

Yasuyoshi Ouchi, MD., Ph.D.

What life-style is good for preventing Alzheimer's disease?



Some about The Japan Geriatrics Society

- The Japan Geriatrics Society (JGS), established in 1959, is only one scientific society in Japan which organizes the research in the field of geriatric medicine, focusing mainly on the research of the diagnosis & treatment of geriatric diseases including dementia, osteoporosis, atherosclerosis, infectious diseases, and geriatric syndrome such as frailty.
- JGS also aims at conducting research toward the construction of better long-term care for the elderly.
- JGS has 6,486 members, mainly medical practitioners and investigators.
- JGS organizes an annual scientific meeting and many educational seminars for practitioners and medical students.
- JGS publishes official scientific journals, Japanese journal and English journal named *Geriatrics and Gerontology International* (2012 IF 2.167).
- JGS approves board-certified geriatricians (1,537 all over Japan at present).
- JGS is a member society of The Japan Gerontological Society.

- JGS considers that the role of geriatricians in dementia practice is the management of life style and life style-related diseases including hypertension, diabetes, and dyslipidemia which possibly accelerates the development of not only vascular dementia but also Alzheimer's disease.

The content of daily foods in AD (Case-control study)

Food	AD n=64	Control n=80	P value
Rice	261.9 ± 105.8	231.9 ± 94.1	NS
Potate	16.7 ± 12.2	22.6 ± 16.7	NS
Sugar	6.1 ± 15.1	5.4 ± 3.8	NS
Snack	16.1 ± 16.0	16.5 ± 13.4	NS
Beans	119.5 ± 86.9	127.8 ± 69.2	NS
Fish	40.5 ± 24.4	58.3 ± 28.2	0.0001
Meat	25.1 ± 15.4	21.0 ± 16.3	0.13
Egg	16.0 ± 15.4	13.5 ± 11.0	NS
Milk	77.2 ± 77.8	117.5 ± 99.9	0.01
Green vegetable	45.7 ± 31.7	68.9 ± 59.8	0.01
Vegetable	55.9 ± 32.2	70.6 ± 46.4	0.03
Fruits	78.9 ± 60.1	89.4 ± 54.2	NS
Fungi	4.4 ± 4.4	7.6 ± 7.7	0.004
See weeds	6.3 ± 7.3	10.7 ± 8.3	0.001
Alcohol	65.1 ± 164.4	75.5 ± 177.2	NS
Soft drink	399.7 ± 320.0	559.8 ± 381.5	NS
Spice	18.9 ± 23.1	39.4 ± 47.3	NS

Risk factors for Alzheimer's Disease

① Unpreventable risk factors
- 1) Aging
- 2) Menopause
- 3) Family history
- 4) Genetic factors
  - APP gene
  - Presenilin gene1,2
  - Apo E

② Medical risk factors
- Depression
- Head trauma
- hypothyroidism

Life style-related diseases
- hypertension
- DM
- dyslipidemia ….

③ Life style

⇒Diet, Smoking, Excess intake of alcohol, exercise deficiency …..

Dietary intervention to AD

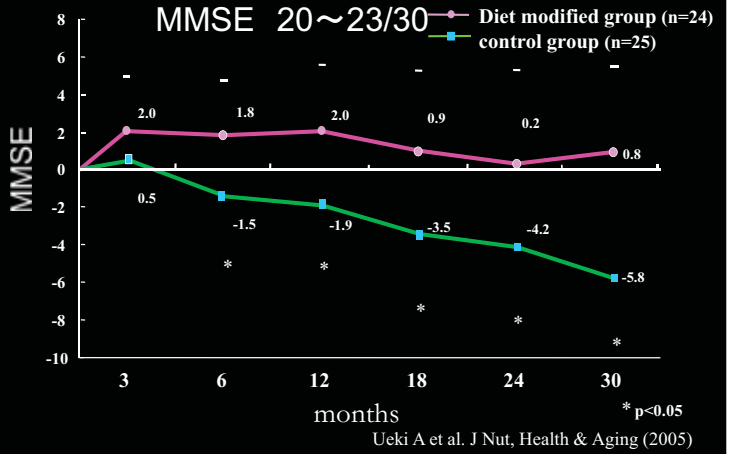
Adequate calorie intake

Sufficient vitamin & mineral intake

Fatty acids : n-6/n-3 = 3.0

Fish	60～90g/day
Vegetable	100g/day
Fruits	at least once a day

The effect of dietary modification on MMSE in mild to moderate AD



Ueki A et al. J Nut, Health & Aging (2005)

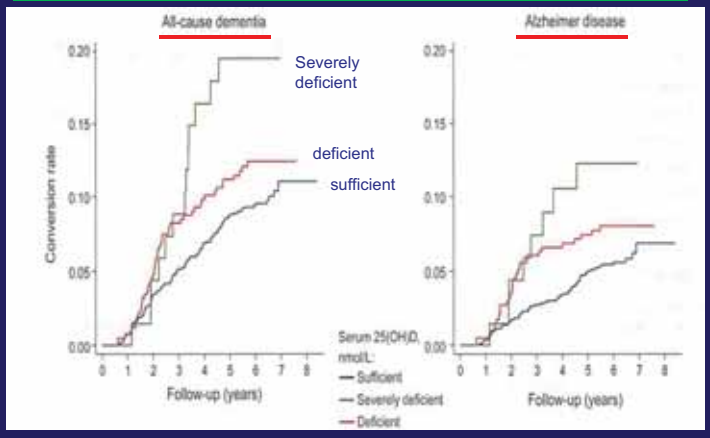
Smoking and Smoking cessation vs. the risk of dementia

Smoking Status	Non-smoker	Ex-smoker	Current Smoker	< 20 /day	> 20 /day
<Total dementia>					
Age-,sex-, survey year-matched OR	1.0	1.4 (0.6-2.8)	2.2 (1.1-4.4)	2.1 (1.1-4.3)	2.6 (0.9-7.3)
Multivariable OR	1.0	1.5 (0.7-3.3)	2.3 (1.1-4.7)	2.2 (1.1-4.7)	2.7 (0.9-8.2)
<Dementia with history of stroke>					
Age-,sex-, survey year-matched OR	1.0	1.4 (0.4-4.5)	2.4 (0.8-7.1)	2.4 (0.8-7.2)	2.5 (0.5-11.9)
Multivariable OR	1.0	1.7 (0.5-5.9)	2.4 (0.8-7.7)	2.4 (0.7-7.9)	2.5 (0.4-14.4)
<Dementia without history of stroke>					
Age-,sex-, survey year-matched OR	1.0	1.3 (0.5-3.5)	2.0 (0.8-5.0)	2.0 (0.8-4.9)	2.6 (0.6-11.1)
Multivariable OR	1.0	1.5 (0.6-4.3)	2.3 (0.9-6.0)	2.2 (0.8-5.9)	3.0 (0.7-13.8)

(Adjusted for body mass index, alcohol use, serum total cholesterol, systolic blood pressure, use of antihypertensive medication, diabetes mellitus, atrial fibrillation and ST-T abnormality)

(Ikeda A, et al.: Cerebrovascular Diseases 2008)

Cumulative occurrence of all-cause dementia and Alzheimer's disease when subjects were classified by serum 25(OH)D concentration



(Littlejohns TJ, et al. Neurology 2014)

AD and life style-related diseases

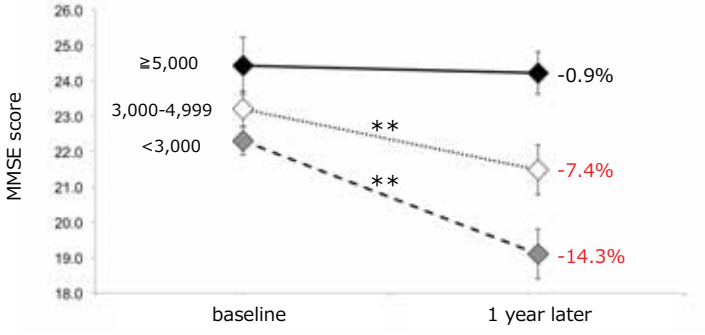
Well-known risk factors for atherosclerosis・・・

Hypertension
Diabetes
Dyslipidemia
Obesity
Smoking

have been reported to be risk factors also for AD

Also, treatment of life style-related diseases has been reported to decrease the incidence of AD.

The daily steps and cognitive function decline in mild to moderate AD patients

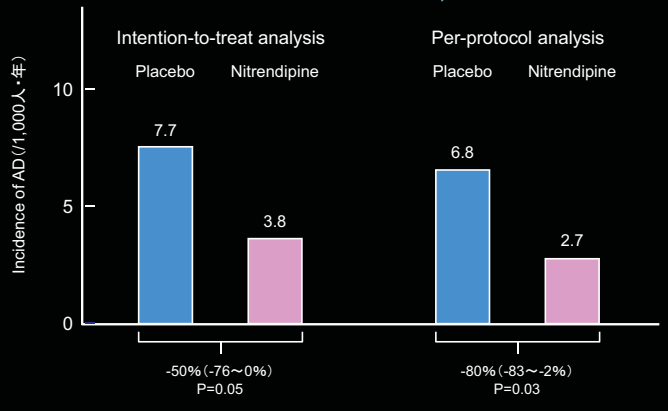


Cognitive function was preserved in AD patients who walk ≧5,000 steps/day.

(Yamada A, Arai H, Kyoto University, unpublished data)

The incidence of AD in Syst-Eur Trial

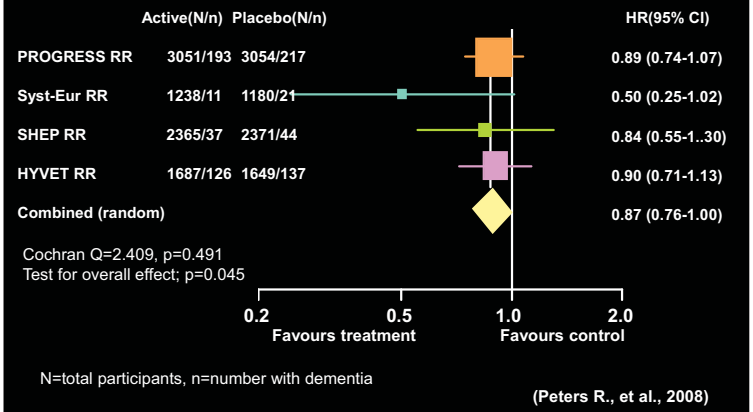
Possibility : Treatment of life style-related disease reduces the risk of AD　Diabetes, HT.....



(Staessen JA, et al., 1997

The effect of anti-hypertensive treatment on the occurrence of dementia

−Meta-analysis−

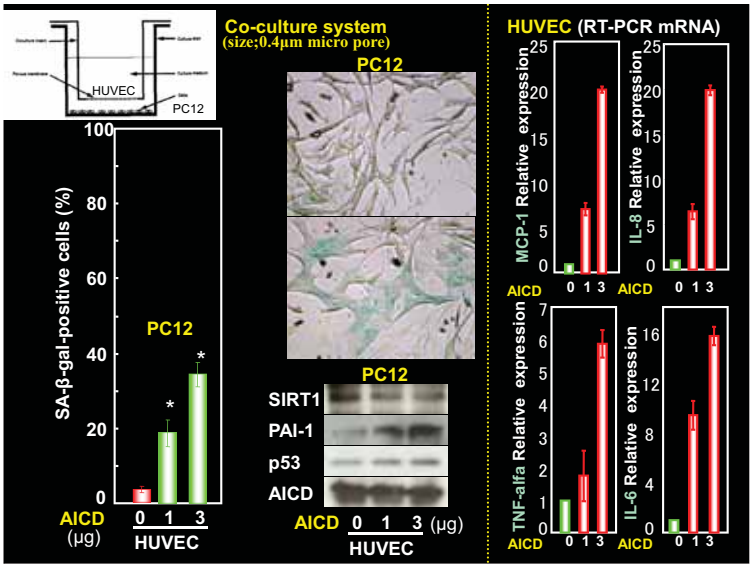


N=total participants, n=number with dementia

(Peters R., et al., 2008)

Messages from JGS

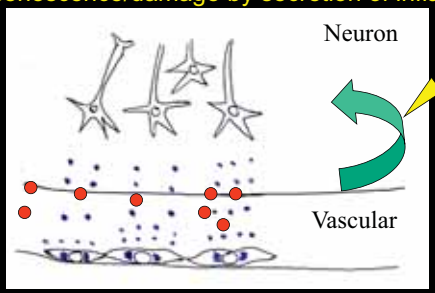
- Life style modification is important for the prevention of both vascular and Alzheimer's types of dementia.
- Although evidence is not concrete, life style-related diseases, especially diabetes and hypertension, should be well treated for the prevention of both types of dementia.
- The basic research on the mechanism underlying the effect of life style modification or treatment of life style-related diseases may provide a new preventive and therapeutic approach for AD.



The perspective of dementia practice from the geriatric point of view

1. Seamless coordination:
   - Prevention→diagnosis & treatment at early stage→care
2. Insight from whole body to brain
   - Control of vascular risk factors
3. Insight from brain to whole body
   - Treatment and care for geriatric syndrome including aspiration pneumonia, osteoporosis and frailty
   - Treatment and care of complicated diseases in demented patients
4. Coordination: Geriatricians – Neurologists - Psychiatrists
5. Coordination: Medical - Care & Social welfare

Hypothesis: Vascular senescence/damage promotes neuronal senescence/damage by secretion of inflammatory cytokines



Longevity gene SIRT1

IL-6,IL-1α,IL-1β,IL-24
IL-8,GROα,β,γCXCL20,CCL3
MMP3,MMP14
BMP2,PAI-1,PAI-2 et al

SASP (Senesence-associated secretory phenotype)

1.Progression or inhibition of tumor
2.Induction of inflammation
3.Progression of Cellular Senescence

Thank you very much for your attention

Kunio Takami, Alzheimer's association, Japan

"TSUDOI—Crystallization of Autonomy and Creativity-"

He introduced the promotion for 35 years of "TSUDOI" meaning getting together of people with dementia and carers. In 2013, they conducted "Tsudoi" 3,517 times with 44,118 participants. "Tsudoi" provides a good opportunity of sharing experiences and feelings, mutual encouragement, social inclusion, and networking. "Tsudoi" is an attractive initiative, which is very simple and low cost.

Ki Woong Kim, National Institute of Dementia, S Korea

How to enhance family caregiver's accessibility to information and services for dementia

In order to provide the citizens with up-to-date and credible information about dementia, they have been creating various IT tools, such as web-based information portal, an application assisting diagnosis and prevention of dementia, a newspaper-based cognitive training program.

Jean Georges, Alzheimer Europe Germany

Dementia-friendly communities: Linking up with WHO and European Innovation Partnership on Active and Healthy Ageing initiatives

He introduced the idea of the iEU-based nitiatives on dementia-friendly communities, such as AFE-INNOVENT (network), which is to be realized with the collaboration of WHO and European Innovation Partnership on Active and Healthy Ageing initiatives.

Shuichi Awata, Tokyo Metropolitan Institute of Gerontology

Towards creating a society where people can live well with dementia with hope and dignity

He introduced the Japanese national "Five-Year Plan for Promotion of Dementia Measures" (Orange Plan 2013-2017), an example of Dementia Support Team Meeting in a small island since the Great East Japan Earthquake in 2011. For the creation of dementia friendly community, community-initiated-efforts, and government-initiated policies must be harmonized.

Kumiko Utsumi, Sunagawa City Medical Center Japan

Support Activities System of Sunagawa Medical Center for Dementia

To realize the society where all the people with dementia can live with a sense of security, collaboration of three measures are necessary: volunteers, good care program, and multidisciplinary collaborative team of first-aid to the suspected persons.

Rumiko Otani, Omuta-city Dementia Care Society Japan

Omuta city Dementia Care Community Promotion
- intergenerational exchange and SOS network -

She introduced the development of the regional dementia care community initiatives in Omuta city. Especially, the project of "wandering-watch program" and education of 8,000 elementary and junior high school students with picture books. Now they have grown to help the person with dementia, e.g who have lost their way.

Annette Pauly, Federal Ministry for Family Affairs, Senior Citizens, Women and Youth, Germany

Joining forces for people with dementia

She introduced a program of local alliances for people with dementia. So far, 292 alliances were develped. Strong demand to participate, multitude of different thematic approaches, regional differences were found. Two good practices are highlighted; County of Herford and City of Emden.

Jeremy Hughes, Alzheimer's Society UK

The contribution of corporations to enabling people with dementia to live well in the community

He showed an example of how corporations can contribute to create a dementia-friendly-society by showing VTR, e.g. in a bus, in a supermarket, in a bank

Global Dementia Legacy Event Japan

New care and prevention models

Topic3 : Information and Communication Technology

Expectations of ICT to support the TSUDOI

06/Nov/2014 14:15～

Roppongi Academyhills, Roppongi Hills Mori Tower 49F

Director board Member,
Association of Persons living with dementia and their Families
(Alzheimer's Association Japan (AAJ))

Sadao Katayama MD, PhD

Organizer: Ministry of Health, Labour and Welfare

TSUDOI（meeting）

TSUDOI is a place for when you feel lost and don't know what to do
To feel and understand how one with dementia feels.
To feel and understand how one who is assisting feels.
One starts to understand how it feels to not remember, and how to live with someone who is loosing their memory.
What is expected: To be able to go back to the family one was
Family consultation: Peer counseling
Conversation between patience: Ability to talk about dreams and hopes.

A place where the patient and the family of the patient can be at ease, a place with knowledge (medical, welfare, and life information) and experience.

A place where the patient and family of the patient can remember what it is to be a family, and build/re-build the trust and family ties.

To be able to share and smile with ones partner

Cognitive Impairment and Hardships in Life

- Depending on the core cause of Cognitive impairment, the disease can move from phase (1) through phase (3)
- Depending of the level of necessary medication, the physical condition, level of understanding of the surrounding, the level of hardships that one faces in life change.

（1）During the initial phase of the disease, the level of hardships that one will face will vary from case to case.
Some may see an immediate impact on life, some may not see an impact at first
Some may not be able to perform if they feel that the expectation on them is high. If they do not feel the expectation to perform, it can often be easier to do so. Often people confuse the disease with "a fact of life due to old age".

（2）The phase in where all affected feel the full impact of the disease.
Not able to remember who one is, not being able to understand, feeling frustration due to not being able to do what one once could. Not being able to ask for help.
Condition will worsen without risk management, especially for large changes in life such as being hospitalized, going on a trip, moving home, being swindled, a change of medication, etc.

ICT, support TSUDOI

1）To supplement the loss of recognition
The type of cognitive function: What functions remain? What functions are being used?
2）The goal is to get the peace of mind: Supplement the loss of cognitive function in order to attain the peace of mind.
3）It is important give the family comfort and ease of mind

The use of IT in case distance is a barrier to connenct.

Forgetfulness
Forgetting the meeting days Can a reminder be posted on the TV?
Reminders for medication and/or hospital days by writing or visits/calls
Not being confident that the clothes are coordinated correctly.
To have someone give feedback To have family members give positive feedback while looking in the mirror.
Not knowing where to go Navigation to the site by family from afar (via technology?)

Not remembering how to get home once one leaves the meeting
One may forget why one is there the moment he/she leaves the building
Have a sensor devise notify once one leaves a building.

Dementia: The need for peace of mind

(3) The phase in where one cannot see beyond ones self.
When one looses their role in life/when one starts being "monitored"
Without family and friends in where one can depend upon and smile with, one will start to get bottled up, and wont be able to see beyond ones self.
One begins to stop thanking, or caring about others.

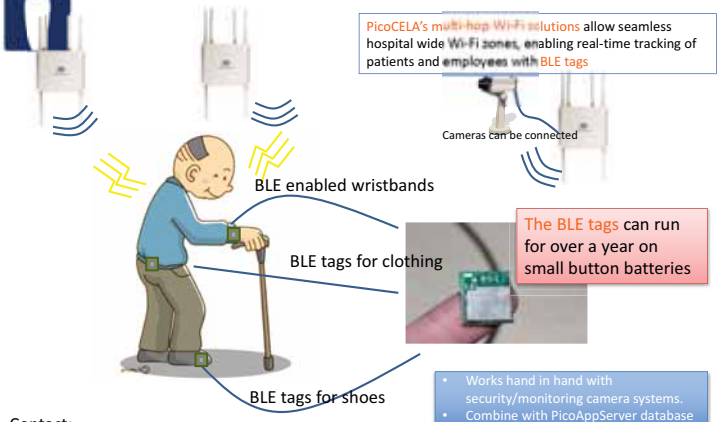
To "own" ones life, it means that one has a role in society and in family, is trusted, is confident, lives ones life in peace, and has time that one considers fun.

The complete requirement is to "know", the acceptable requirement is to have the peace of mind. Knowledge (information), is a requirement for gaining the peace of mind.

Basic information for when signs start showing.
Loss of confidence, uncertainness
If misunderstood, can lead to a loss of trust in others
If unable to control this feeling, this leads to a decline in function

When one does not know how to react to a sitiuation, or cannot react in a way that is thoughtful of others….: The stress level of those with cognitive impairment will heighten, along with the feeling of uncertainness and lack of trust.
In turn, this raises the stress level and uncertainness of those around the patient.

BLE tracking solutions for Tsudoi(meeting)



Contact:
www.kpnetworks.jp
h.shannon@kpnetworks.jp

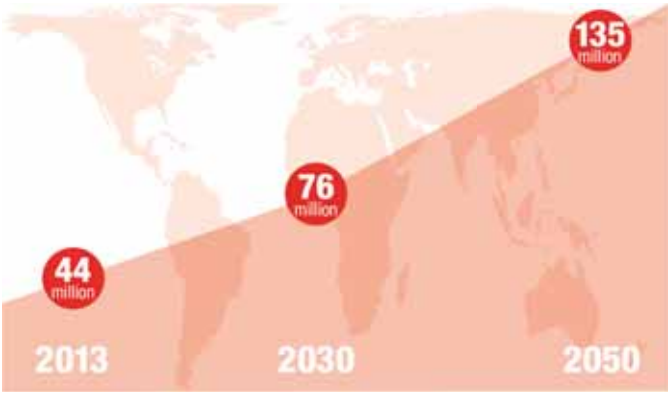
To participate, not only monitor a meeting

＃1. Even with ICT, progressive dementia means that the current functions may not remain functional.

＃2. The need for financial aid to gain access to necessary hardware and software
＃3. In the case of Japan, the need to be able to use ICT via rental depending on necessary functions, while these costs being covered by Public nursing care insurance

It is also important to support and give encouragement to the “non family members” who give and show support.
To support the functions and give mental care for the patient and his/her family is also of grave importance.

Global prevalence of dementia



www.alz.co.uk/statistics

Dementia Friendly Communities (DFC)

- **Two-tiered approach:**
  - The "invisible" network of businesses, healthcare workers, emergency services personnel and other civic employees .
  - The grassroots, "bottom-up" network comprised by persons with dementia engaging socially in their community.

In planning, building and developing DFCs, there is a need to recognise both tiers.

Global prevalence of dementia

www.alz.co.uk/statistics

Examples

- **Little understanding that dementia is a disease of the brain; huge impact on families**
- **South Korea since 2008 training of 120,000 volunteers to support families**
- **Japan developed 90-minute course on dementia (caravan); over 5 million attended**
- **Other clever solutions (factsheet)**
- **UK Dementia Friends programme + Canada**
- **Several countries created Alzheimer Cafe of Memory Cafe**

Dementia Friendly Communities (DFC)

- **Aim to create an environment with a good level of public awareness, where people with dementia can participate in society as long as possible**
- **Tackles social exclusion and supports caregivers**
- **Makes longer independent living more likely**
- **6 key domains:**
  - **Public awareness**
  - **Planning processes**
  - **Physical environment**
  - **Access to business and public services**
  - **Community-based innovation**
  - **Transportation**

Learning points

- **Involve people living with dementia, family carers and experts (in that order)**
- **A bottom-up process is helpful to increase understanding**
- **Mobilise local resources**
- **Lots of innovation**
- **Ideally part of overall dementia strategy**

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認知症サミット日本後続イベント
ー新たなケアと予防のモデルー

福祉用具・介護ロボットの開発及び普及に関する取り組み

平成26年11月6日（木） トピック3

公益財団法人テクノエイド協会
企画部　五島清国

ロボット介護機器の開発・導入促進体制

現状・課題

要介護者について

- 要介護高齢者の増加
- ニーズの多様化・複雑化
- 認知症高齢者の増加
- 高齢者世帯や高齢者独居の増加
- ＡＤＬやＱＯＬの維持・向上　など

介護分野の人材について

- 介護人材の確保
- 職員の腰痛
- 働きやすい職場環境の構築　など

福祉用具・介護ロボットの実用化支援
（厚生労働省）

1．相談窓口の設置
- 開発者側と使用者側双方からの相談受付

2．モニター環境の整備
- モニター調査協力可能な施設等のＤＢ化

3．モニター調査の支援協力
- 現場との意見交換やモニター計画書の作成支援

4．普及・啓発
- 展示、研修、貸出などの実施

5．高齢者ニーズの把握・実態調査

日本再興戦略

ロボット介護機器開発５ヵ年計画

- 高齢者や障害者の自立支援の促進
- 介護者の負担軽減

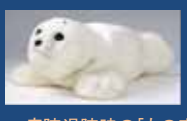
実用性の高いロボット介護機器の開発を加速化させる開発５ヵ年計画を実施する

開発されたロボット介護機器を積極的に活用することで、自立支援の促進と質の高いケアの提供が期待される

認知症ケア関連機器に関するモニター調査事例

コミュニケーション支援

特別養護老人ホーム
導入前後の比較
・コミュニケーションの変化
・運動機会の変化
・自発性の変化
・不穏行動の変化
・生活リズムの変化
(2013-1014)



病院退院時の「もの忘れ外来」で認知症と診断された方
スクリーリング
・セラピー効果
・介護負担の変化
(2013)

有料老人ホーム
入居している利用者とその家族を結び、当該機器を使用したコミュニケーションによって、どのような効果が期待できるか調査
(2014)

見守り支援

瞳点のみ撮影

三次元に再構成

安全
要確認
危険
判定

演算装置

タブレット

危険を通知

特別養護老人ホーム・有料老人ホーム(2013-2014)
複数の入所者と同時に検知する機器
危険に繋がる可能性のある状態とパターンマッチングし異常検知・通知する
プライバーを配慮しながら状態の確認、危険状態の防止、見守り回数の減少

ロボット介護推進プロジェクト
（経済産業省）

事業概要

ロボット介護機器の量産化への道筋をつけることを目的として、ロボット介護機器を実際に介護現場で活用しながら、大規模な効果検証等を行う。

さらに、検証結果に基づく効果のＰＲ、普及啓発、教育活動を通じて、ロボット介護機器導入の土壌を醸成する。

移乗介助
装着

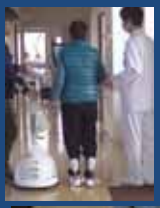
移乗介助
非装着

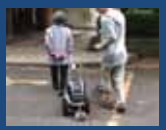
移動支援

排泄支援

見守り

その他のモニター調査事例





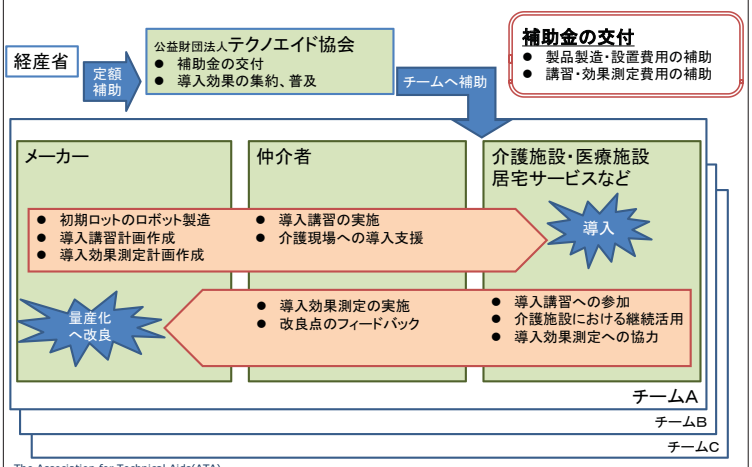
移乗支援機器

歩行訓練用のツール

追従型酸素機器搬送移動車両

トイレでの姿勢保持

ロボット介護推進プロジェクト　事業スキーム



その他のモニター調査事例

上肢支持機能付き免荷型のリフト

補聴耳カバーシステム

離床アシストベッド

個人の体型に合った上肢運動機能補助装具

多機能車いす
施設での散髪や口腔ケア

腰部の負担軽減スーツ

補助対象となるロボット介護機器一例

重点分野	件数
移乗介助（装着）	1
移乗介助（非装着）	6
移動支援	2
排泄支援	4
見守り支援	１３
合　　計	２６

移乗介助（装着）

移乗介助（非装着）

移動支援

排泄支援

見守り支援

利用効果の検証

○性能評価
　工学的試験
　安全性

◎ユーザービリティー評価
　使い勝手
　実践を通じた製品の製品安全の確認

利用者のADLやQOLの維持・向上
介護負担の軽減
サービスの改善・効率性、経済性

自立支援、介護負担の軽減

○介護を受ける側への効果
- 利用前後におけるＡＤＬやＱＯＬの変化（維持・向上）
- 機器利用の満足度、安心感、快適性、操作など理解のしやすさ
- 心理的負担感の変化　など

○介護者する側への効果
- 利用前後における腰痛等の発生頻度、精神的負担の変化、
- 作業負担の軽減、見守り負担の軽減、新たな業務負担の有無　など

○機器の使い勝手による効果
- 訓練時間、使用（装着）時間、準備や手間、メンテのしやすさ
- 臨床場面での操作機能性・安全性、表示、禁忌事項　など

○介護サービスのプロセスに関する効果
- 移乗介助の時間変化、排泄支援の時間変化、見守りの時間変化
- 介護手法の変化、経済的変化、人員（配置）の変化　など

ご静聴ありがとうございました

公益財団法人テクノエイド協会　企画部　五島清国
〒162-0823　東京都新宿区神楽河岸１－１
セントラルプラザ4階
電話　03－3266－6883

goshima@techno-aids.or.jp

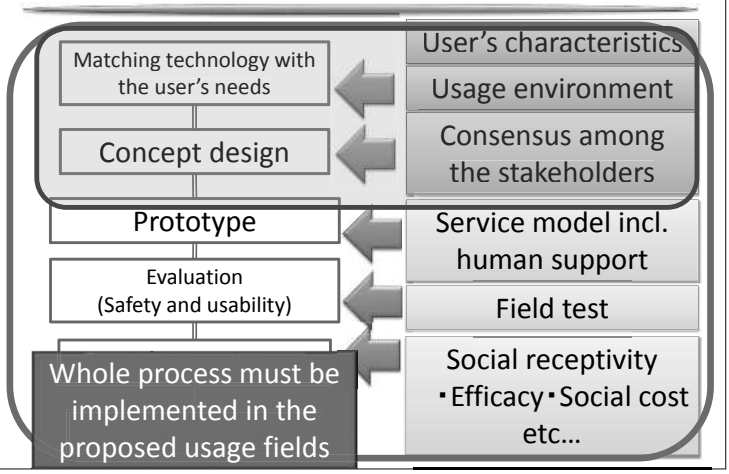
Global action against dementia

Communication Robot for Persons with Dementia - Based on Field-based Innovation

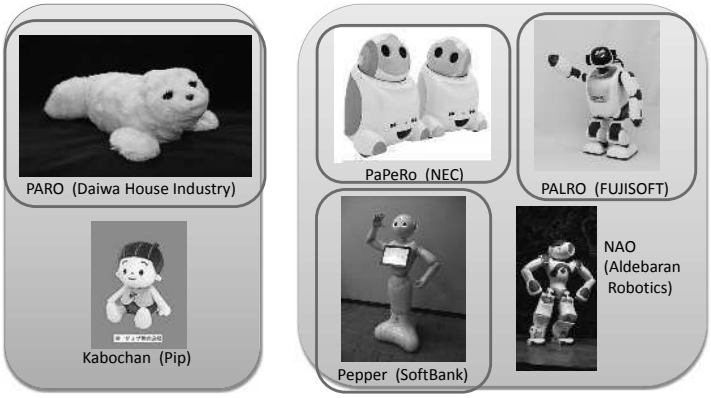
Takenobu Inoue

Director of Department of Assistive Technology,
Research Institute of The National Rehabilitation Center for Persons with Disabilities

Field-based Innovation



Communication Robots (ICT & Robot Exibition @ Sky Studio)



Development of an information support robot for the elderly with cognitive disabilities

Takenobu Inoue[1], Shinichi Ohnaka[2], Yumiko Oosawa[3], Kouichi Watabe[3], Yousuke Shimizu[3], Ayumi Harada[3], Hiromi Hamada[4], Ikuko Mamiya[1], Yuko Nishiura[1], Atsushi Kobayashi[1], Minoru Kamata[5], Misato Nihei[5], Hiroaki Kojima[6], Ken Sadohara[6],

1:The National Rehabilitation Center for Persons with Disabilities, 2:NEC Corporation, 3:Seikatsu Kagaku Un-Ei Co., Ltd., 4:France Bed Co., Ltd., 5:The University of Tokyo, 6:National Institute of Advanced Industrial Science and Technology

Communication Robots (ICT & Robot Exibition : Sky Studio)

There is no answer on the desk nor in the laboratory.

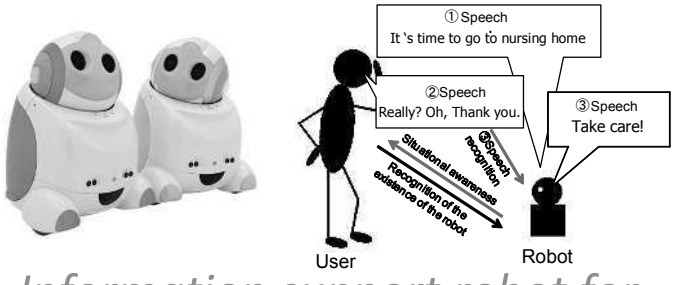
Why do we use these robots for

Answers must be in the use field.

with dementia want ?

Field-based innovation.

How to develop useful technologies for the elderly ?



Information support robot for persons with dementia ???

Decision process of the system concept based on field-based innovation

①Matching technology to users at the living environment

Participant observation
Mock-up evaluation
User experiment

- Possibility of information support using the robot
- Suitable method according to the cognitive function of the elderly
- Information acquisition >90%
- Suitable environment
- Suitable synthesized speech
- Speech recognition 78.9%

②Making system concept in the community (Izu city)

Group interview
(124 older people)
(40 professionals)
Interview(9families)
Workshop(2families and related professionals)

172 needs from the elderly

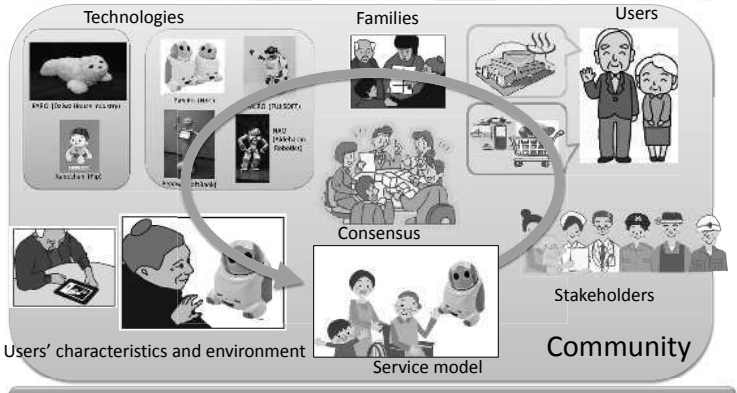
36 support scenarios

③Business model

- Target users :
  >Home-bound elderly with forgetfulness; incl. MCI and Mild dementia
- Services :
  >Medication adherence
  >Schedule indication
- Provision form :
  >Rental provision
- Related professionals:
  >Home cares
  >Area comprehensive support center

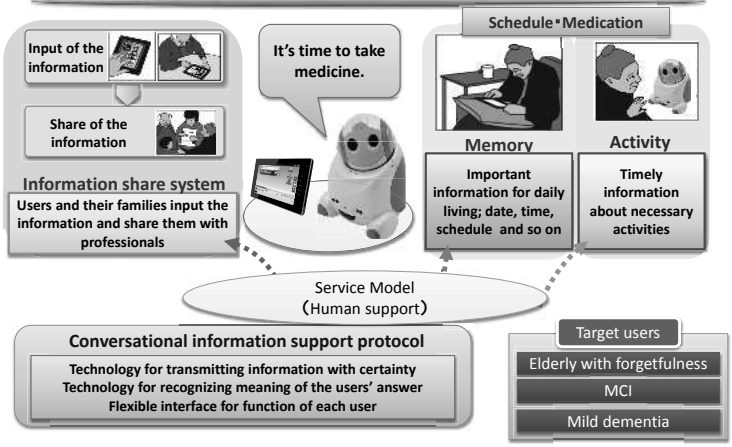
System concept

Conclusions



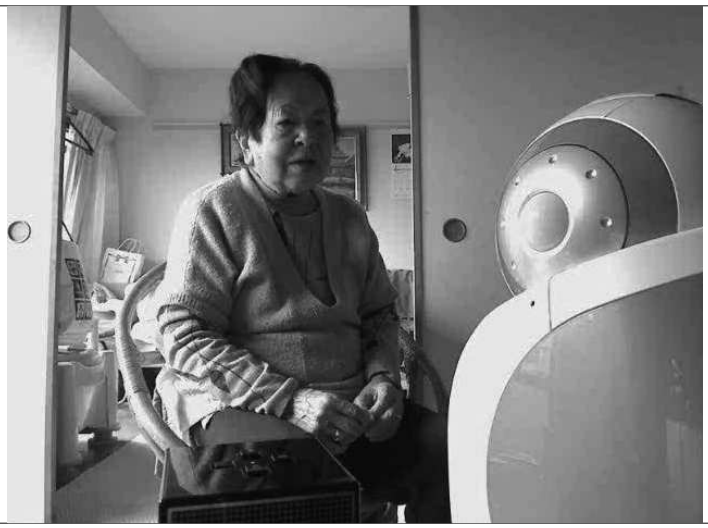
Community and use field create innovation.

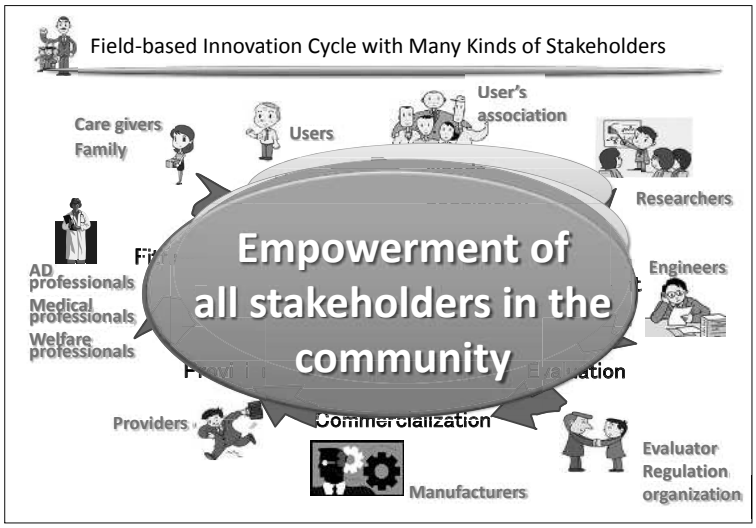
System concept



Acknowledgement

- This research was partially supported by the Japan Foundation for Aging and Health, KAKENHI (21300213) and Japan Science and Japan Science and Technology Agency, JST, under Strategic Promotion of Innovative Research and Development Program.




Field-based Innovation Cycle with Many Kinds of Stakeholders
Care givers
Family
Users
User's association
Researchers
Engineers
AD professionals
Medical professionals
Welfare professionals
Empowerment of all stakeholders in the community
Providers
Commercialization
Manufacturers
Evaluator
Regulation organization

Global Dementia Legacy Event Japan

New care and prevention models

Topic 3 Day 2

Dementia-friendly community and ICT

Yoshiki Niimi, MD
Senior Specialist for Dementia
Office for Dementia and Elder Abuse Prevention Health and Welfare Bureau for the Elderly
Ministry of Health, Labour and Welfare, Government of Japan

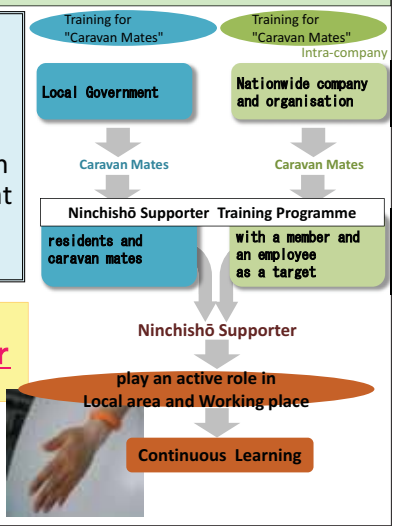
November 6th 2014

"Ninchishō Supporters (Dementia Friends)" (2005～)

What are "Ninchishō Supporters"?

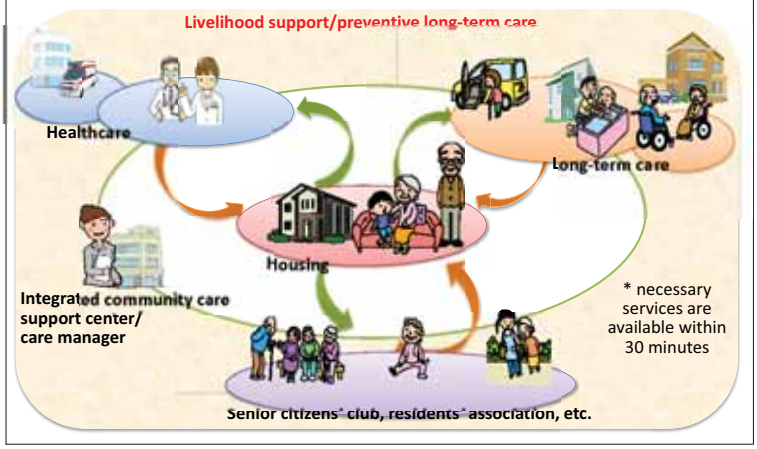
- With good knowledge and understanding of dementia, they support the elderly with dementia and their families at regional/professional levels, to the extent possible

※ Totlal Number 5,445,162(as ofSeptember 30th 2014)



Integrated Community Care System

To live in community in a pleasant and familiar environment



Supporting Development of Care Robot

民間企業・研究機関等	機器の開発	介護現場	介護現場での実証等
○日本の高度な水準の工学技術を活用し、高齢者や介護現場の具体的なニーズを踏まえた機器の開発支援 【METI】		○開発の早い段階から、現場のニーズの伝達や試作機器について介護現場での実証(モニター調査・評価) 【MHLW】	

exchange of opinions of both side

(priority areas)

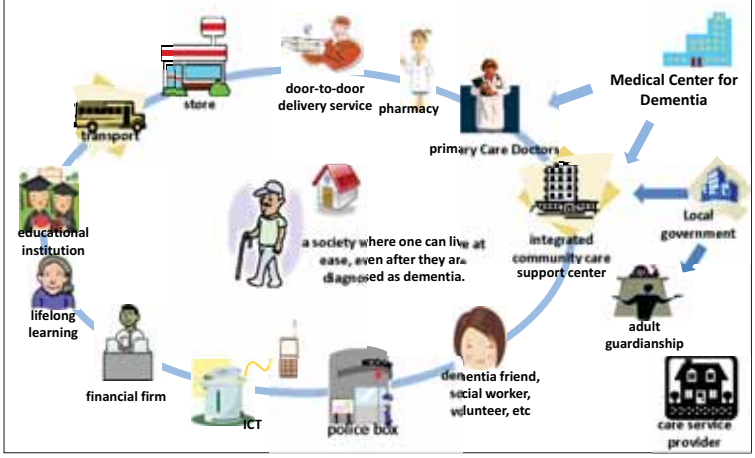
- ○Lifting Assistance(1)
- ○Lifting Assistance(2)
- ○Transferring Assistance(1)
- ○Transferring Assistance(2)
  - ・高齢者等の屋内移動や立ち座りをサポートし、特にトイレへの往復やトイレ内での姿勢保持を支援するロボット技術を用いた歩行支援機器
- ○Excertion Assistance
- ○Watching for PWD (1)
  - ・介護施設において使用する、センサーや外部通信機能を備えたロボット技術を用いた機器のプラットフォーム
- ○Watching for PWD
  - ・在宅介護において使用する、転倒検知センサーや外部通信機能を備えたロボット技術を用いた機器のプラットフォーム
- ○Bathing Assistance
  - ・ロボット技術を用いて浴槽に出入りする際の一連の動作を支援する機器

※点線枠は平成26年2月に新たに追加した項目。平成26年度より開発支援の対象。
※開発支援するロボットは、要介護者の自立支援促進と 介護従事者の負担軽減に資することが前提。

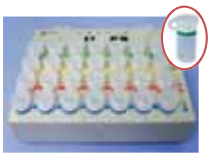
5

self and mutal aid network

cross-ministerial collaboration to support measures of each area



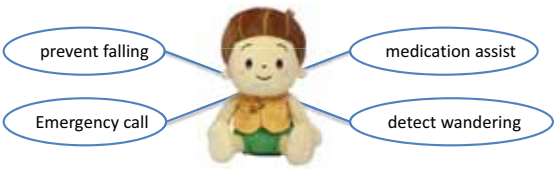
What can technology do for person with dementia?



Assistance of medication

With potable device
Gain the data about
・sleep
・sitting on bed
・leaving bed
,etc

Watching around the bed



Watch comprehensively through robot

On-going trial about robotics

HAL（robot suites）

PAPERO
（communication robot）

Walk-assist robot

Smart suits
（robot suit）

PARO（mental commit robot）

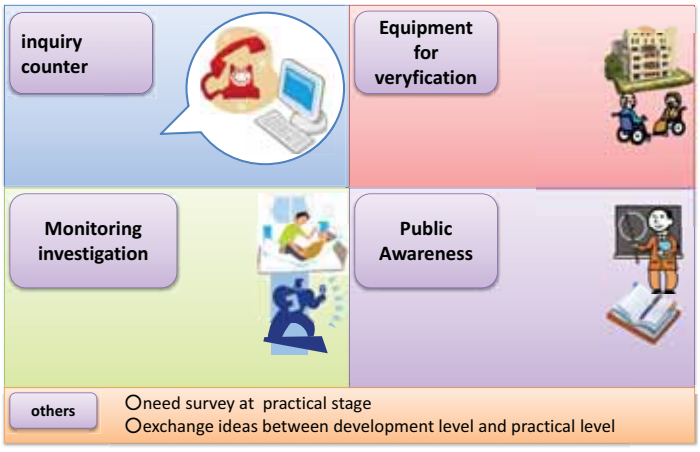
PALRO（communication robot）

SASUKE（Lift assist robot）

MHLW; Health and Labour Sciences Research Grants for Research on Dementia.

Support practical application of robots for care and welfare

【Specifically】



7． Project for Psychiatric and Neurological Disorders

- Aiming for the realization of a society where healthy brains can be developed, protected and restored -

Project to overcome brain diseases by cooperation between MEXT, MHLW and METI

Establish innovative methods for the diagnosis, prevention and medical treatment of mental disorders and disabilities by strong promotion of R&D and infrastructure development for research on brain neural circuits and functions related to their etiology.

Goals and objectives by FY 2015

- Establish diagnostic technologies and criteria of very early stage brain degeneration by novel molecular imaging methods.
- Discover candidate biomarkers with clinical utility for the early diagnosis and treatment of brain diseases.

Goals and objectives by FY 2020

- Initiate pre-clinical and clinical trial studies of candidate drugs of Japanese origin for treatment of brain diseases including depression.
- Establish objective diagnosis methods and criteria for brain diseases.
- Complete a whole brain map including neural circuits and functions.

Joint Promotion Committee
For promoting effective cooperation within the project

MEXT; Ministry of Education, Culture, Sports, Science and Technology
METI; Ministry of Economy, Trade and Industry
MHLW; Ministry of Health, Labour and Welfare

Develop Innovative Technologies for Diagnosis
METI; Super-earlier Diagnosis of Alzheimer's Disease by Analyzing Brain Images and Clinical Information
MEXT; Japan Advanced Molecular Imaging Program
MHLW; Health and Labour Sciences Research Grants for Comprehensive Research on Disability Health and Welfare
Development of biomarkers and image diagnostics for depression, schizophrenia and other mental diseases

Understand Clinical Disease Landscape
MHLW; Health and Labour Sciences Research Grants for Research on Dementia.
※ J-ADNI2 preclinical AD research
※ Longitudinal preclinical study for familial Alzheimer's disease

Develop methods of diagnosis, prevention and medical treatment

Support for Clinical Trials and Research (promotion of networking among major institutions)
National Center for Geriatrics and Gerontology (NCGG)
National Center for Neurology and Psychiatry (NCNP), etc.

Development of Technologies for Understanding Higher-order Mental Functions of the Human Brain
(e.g. generate disease model animals)

Support for clinical trial studies

Comprehensive Analysis of Structure and Activities of Whole Brain Neural Circuits at the Macro Level
MEXT;
•Strategic Research Program for Brain Sciences
•Network Mapping Project for Understanding Brain Function (Tentative)

Global Understanding of Brain Circuits at the Neuronal Level Critical for Mental Activity

Reveal mechanisms of psychiatric diseases

Overcome brain diseases including psychiatric and degenerative disorders

Reference: trends in other countries

BRAIN Initiative / USA

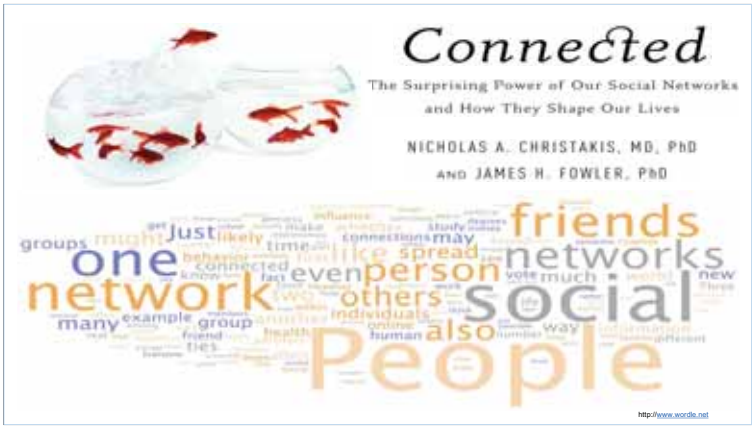
- In April 2013, President Obama announced the "BRAIN Initiative: Brain Research through Advancing Innovative Neurotechnologies", a ten-year project that aims to develop transformative technologies for recording and observing brain cell signals at large scale and high precision, in order to understand and cure mental diseases and disabilities.

Human Brain Project / EU

- In January 2013, The Human Brain Project was adopted as a EU Flagship Project, together with the Graphene Project, as a ten-year project to understand brain by means of computer simulation for robotics and ICT consisting of five sub-projects: ICT integrated infrastructural research platform as the core, data acquisition, theory, applied computing, and ethics.

Information technology and dementia: from brain fitness to collective wisdom

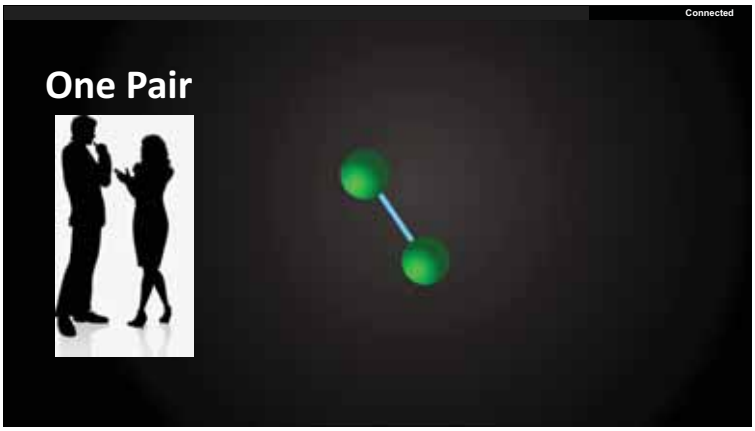
Peter J. Whitehouse MD-PhD
Professor, Case Western Reserve University and University of Toronto
President, Intergenerational Schools International



What about the non-G7 world? What will our legacy be?

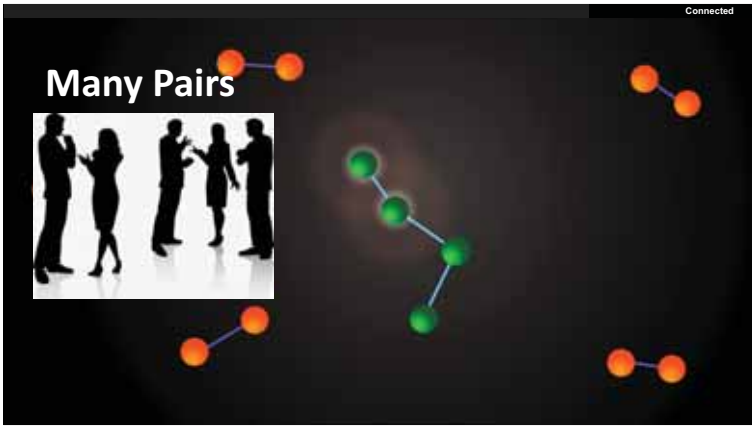
Income inequity and associated global climate change are the greatest threats to persons with dementia, not to mention human civilization, if not existence

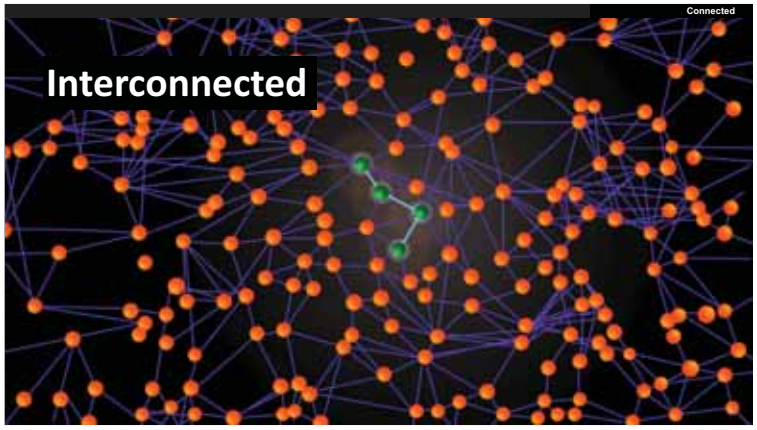
ASK THEM and LISTEN

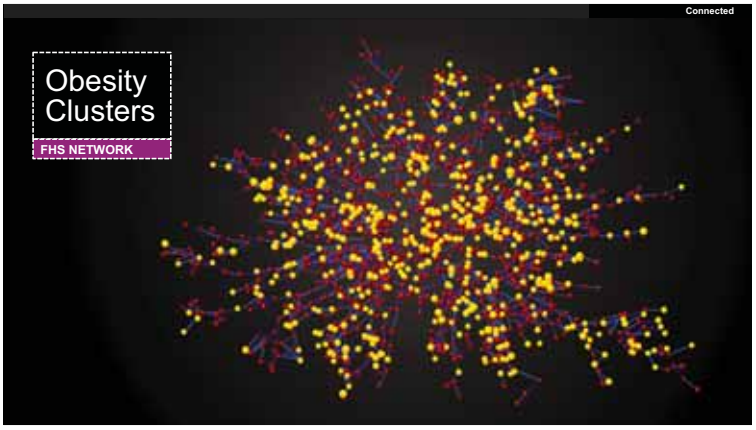


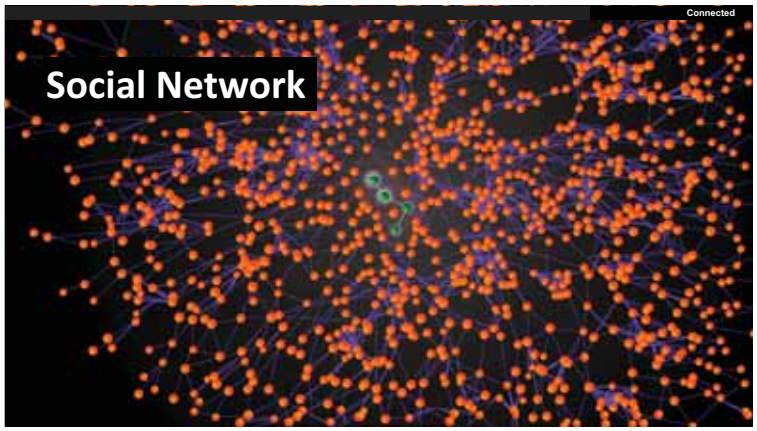
Social (and nature) connectivity across space and time

World Wide Web eHealth and teleHealth
Mobile mHealth
Virtual Reality vrHealth







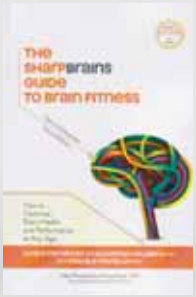


OneCommunity and the Internet of Things
Gigabit Broadband

Connected Health Telepresence Project

Brain health coaching

From Brain fitness to brain health



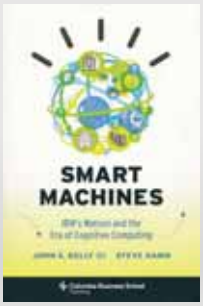
Social networks across time and in nature

Effects of IG exercise of adult cognition using Kinect

Robots – from Paro and beyond

"Scientists striving to cure Alzheimer's disease and other brain disorders are turning to a powerful new tool they hope will light the way to effective treatments: big data."

"Cognitive Expansion" including skepticism



Virtual reality – helping reality virtually through powerful narrative

Era of Cognitive Computing

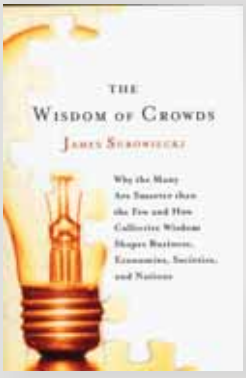
- Big Data Techniques
  - Stochastic optimization –e.g. incentives and power grid management
  - Contextual analytics –e.g. identifying casino violators
    - NORA – Nonobvious Relationship Awareness
- Augmenting our senses through embedded sensors
- Redesigning computers
  - Using quantum mechanics
  - Using DNA
  - Using neural nets
- Imagining the Cognitive City – alliance of human and machine

Eco Wise and friends
Digital Story Telling
Transmedia

Saving the Forest Video Game




Modelling nature in virtual reality



Open, disruptive, intergenerative innovation
with youth and Nadia and Kay both with dementia

Add some younger people and elders to the World Dementia Council (and perhaps a PWD) but not from the US

Intergenerativity: going “between” to go “beyond”
learning to “think like a mountain”
Thank you Japan!

Global Alzheimer's and Dementia Action Alliance

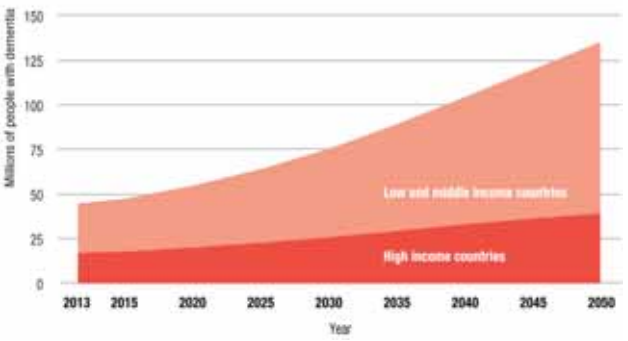
Mission: To transform the lives of people with dementia and those that care for them through building commitment and actions at a national and international level and through the sharing of best practice and learning.

The G8 Dementia Summit Declaration: "Enhance global efforts to reduce stigma, exclusion and fear" and reduce the burden and impact of dementia on individuals, families and society.

The Alliance: Global organizations committed to using their existing information channels to raise awareness about dementia, to increase the understanding of dementia as a disease and to reduce the stigma surrounding it.

Steering group members: Alzheimer's Disease International, the UK Department of Health on behalf of G7, Int Fed of Red Cross and Red Crescences, the NCD Alliance, Worldwide Hospice Palliative Care Alliance and HelpAge International.

Numbers of People with Dementia (Millions)



www.alz.co.uk

Global Alzheimer's and Dementia Action Alliance

Main activities so far

- Invitations sent to 20 international non-governmental organizations, 10 have now accepted
- Shared public information on risk reduction for dementia during World Alzheimer's Month – September 2014
- Develop general toolkit how civil society organizations can raise awareness and make communities more dementia friendly including links this to the global health agenda
- Plan for newsletter and website
- Prepare for each member organization to develop an internal dementia action plan in 2015

Global Alzheimer's and Dementia Action Alliance

How you can help: There is no fee to participate for International NGOs, although we do kindly ask for a voluntary contribution; we ask that we execute a simple agreement and that you sign the dementia rights charter and that you identify the key contacts in your organization for implementation issues.

We also hope to reach out to governmental development aid agencies of G7 governments and beyond, to be able to reach out to all parts of the world, including lower and middle-income countries that will face the main burden of dementia in the future

It's the little things that make all the difference.

Through increasing understanding of dementia we can make the world a better place for people living with the disease, both now in the future.

Contact us:
Twitter: @GADAAlliance
Email: gadaa@alz.co.uk

Tom Wright, CBE

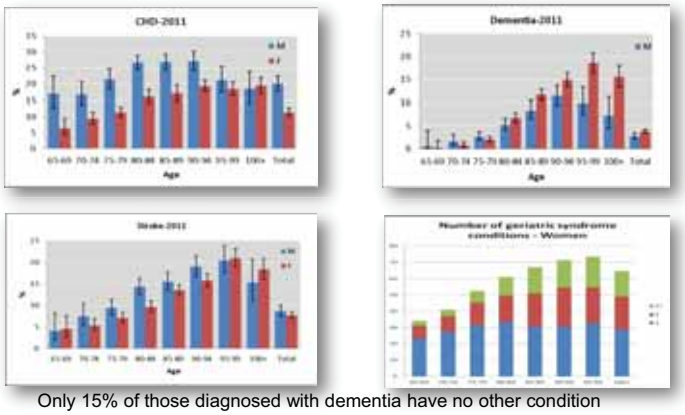
Group Chief Executive, Age UK and Age International

New models of healthcare for dementia and co-morbidities

- The Age UK approach – life long cognitive ageing
- Dementia and co-morbidity
- New models of integrated care – including technology

Dementia and co-morbidity

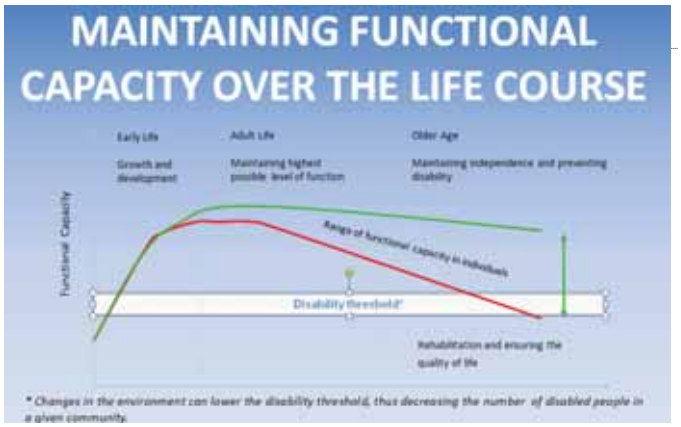
(Diagnoses in primary care, UK 2011)



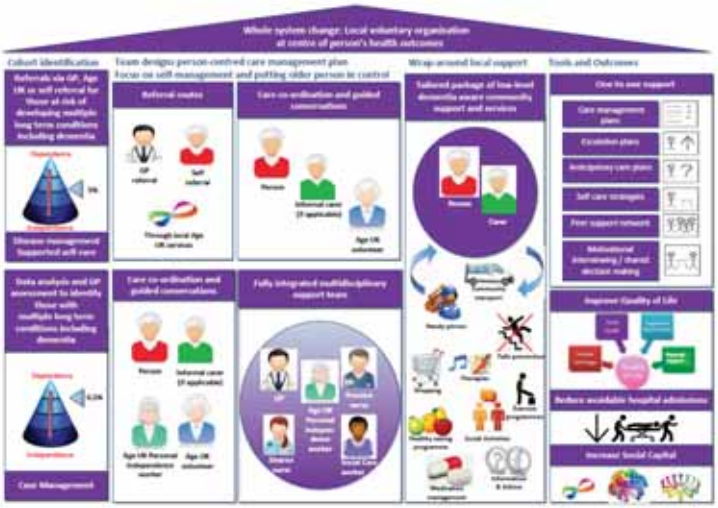
Only 15% of those diagnosed with dementia have no other condition

Melzer et al, Age & Ageing 2014, and related data (Exeter University, UK)

The Age UK approach – life long health and wellbeing



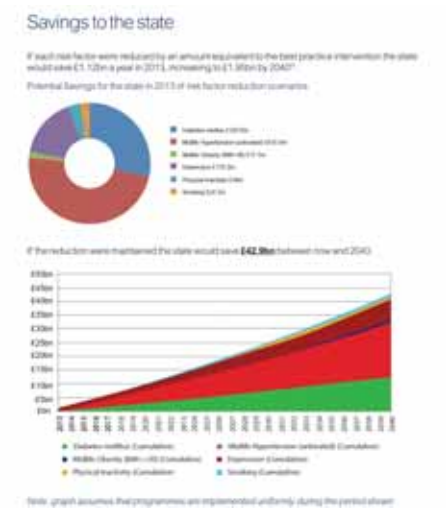
Age UK Model of Integrated Care



The Disconnected Mind

- Longitudinal cohort study on cognitive ageing
- Location: University of Edinburgh
- Aim: Determine factors and mechanisms that influence cognitive ageing during the life-course *and* during ageing itself
- Unique study using cohort of 1,000 people in their 70's
  - access to validated IQ data age 11
  - assessments at age 70, 73 and 76
  - World's most advanced brain imaging protocols

- Global importance: "….one of the most important scientific projects in the world at the present time." Professor Timothy Salthouse, Brown - Forman Professor of Psychology, University of Virginia
- Prestigious publications: Science 346, 6209, 568-571 (2014); Nature 482, 7384, 212-215



(Source: ILC, London, 2014)

Thank you for listening

Tom Wright, CBE

Group Chief Executive, Age UK and Age International

Tom.wright@ageuk.org.uk

Global Dementia Legacy Event Japan

Secular trends in dementia and its risk factors in a Japanese Community: the Hisayama Study

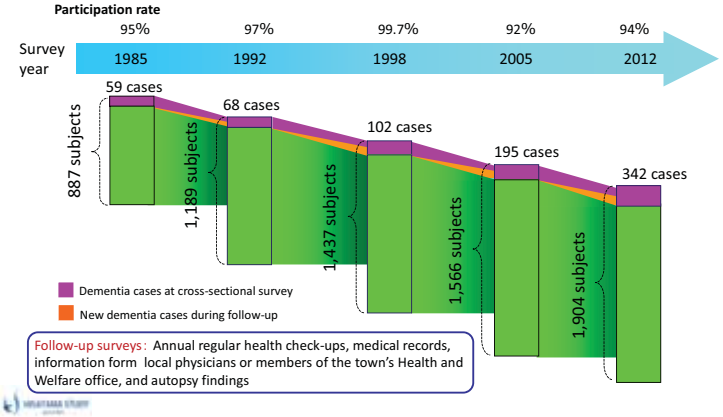
Toshiharu Ninomiya[a)], Yutaka Kiyohara[b)]

a) Center for Cohort Studies, Graduate School of Medical Sciences, Kyushu University
b) Department of Environmental Medicine, Graduate School of Medical Sciences, Kyushu University

Nov 6, 2014
Academy Hills
Roppongi, Tokyo

Cross-sectional and follow-up surveys of dementia in the Hisayama Study

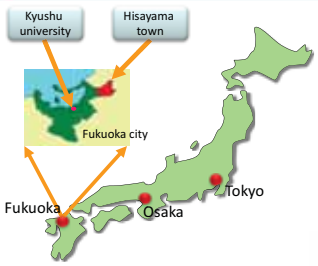
Hisayama residents, aged ≥65 years



Follow-up surveys: Annual regular health check-ups, medical records, information form local physicians or members of the town's Health and Welfare office, and autopsy findings

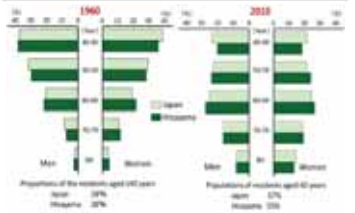
Population of Hisayama town

Location of Hisayama town



Year	1960	2010
Hisayama town	6,500	8,400
Japan	93 million	128 million

Age-distribution
Japan vs. Hisayama town, in 1960 and 2010

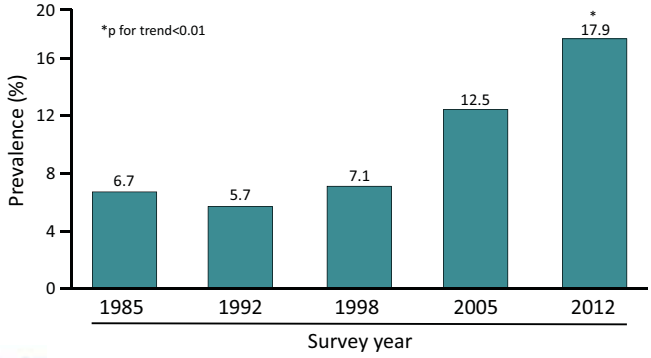


Proportions of labor population by industry
Japan vs. Hisayama town, in 2010

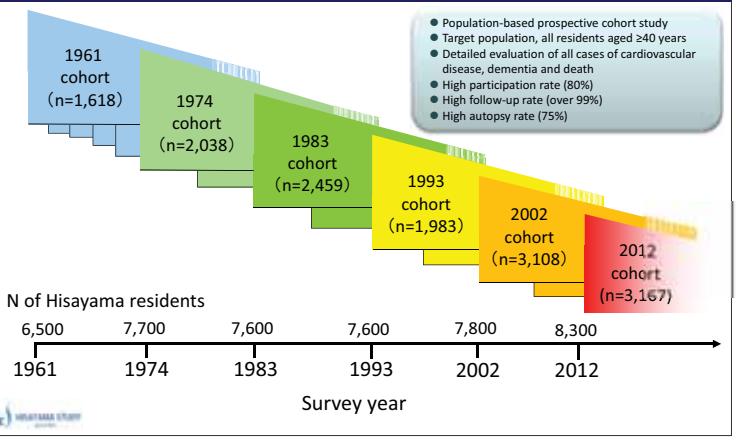
Trend in prevalence of total dementia

Hisayama residents, aged ≥65 years, unadjusted

Prevalence of total dementia increased with time.



The Hisayama Study

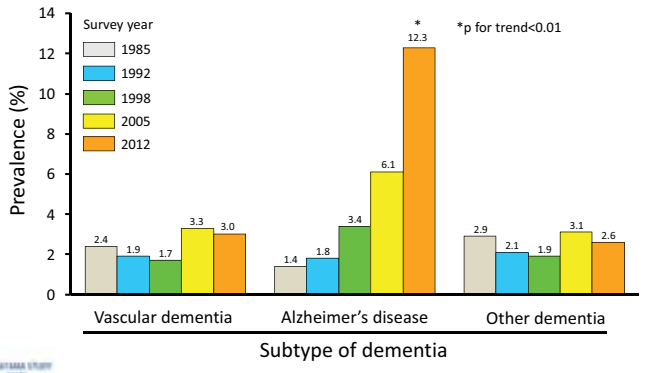


- Population-based prospective cohort study
- Target population, all residents aged ≥40 years
- Detailed evaluation of all cases of cardiovascular disease, dementia and death
- High participation rate (80%)
- High follow-up rate (over 99%)
- High autopsy rate (75%)

Trends in prevalence of dementia subtypes

Hisayama residents, aged ≥65 years, unadjusted

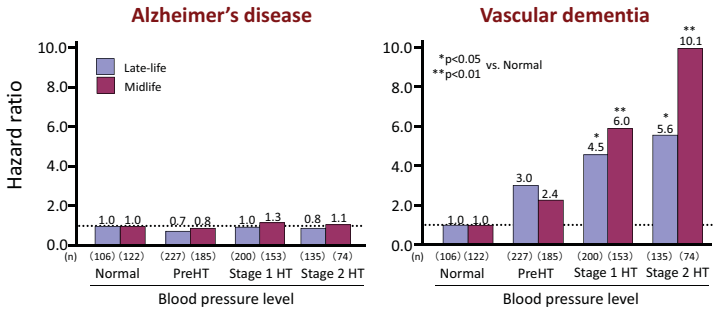
Prevalence of Alzheimer's disease increased with time.



Risks of dementia subtypes in people with late-life or midlife hypertension

Hisayama 668 residents aged 65-79years (1988-2005) and 534 residents aged 50-64 years (1973-2005), multivariable-adjusted

Hypertension, especially from midlife, is a risk factor for vascular dementia.

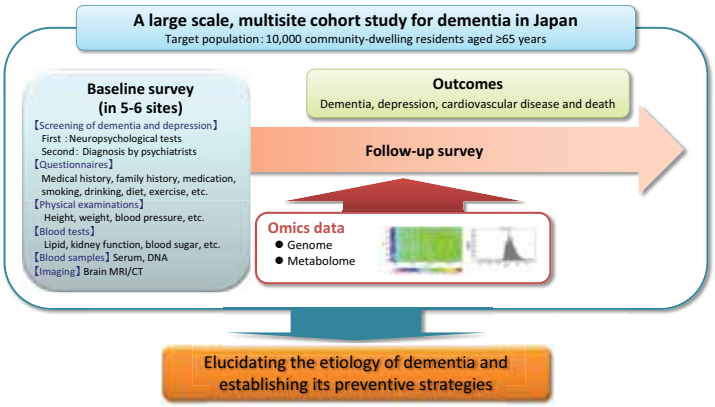


PreHT: prehypertension, HT: hypertension

Adjusted for age, sex, education level, antihypertensive agent use, diabetes, chronic kidney disease, serum total cholesterol, body mass index, history of stroke, smoking habits, and alcohol intake

Ninomiya T, et. al. Hypertension 58: 22, 2011

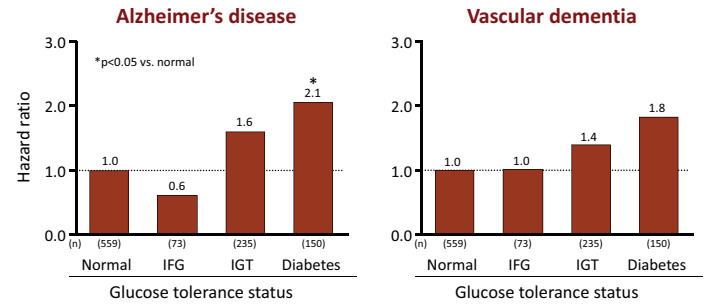
Establishing a large scale, multisite cohort study for dementia in Japan



Risks of dementia subtypes in people with diabetes

Hisayama 1,017 residents aged ≥60 years (1988-2003), multivariable-adjusted

Diabetes is a risk factor for Alzheimer's disease.



IFG: impaired fasting glycemia, IGT: impaired glucose tolerance

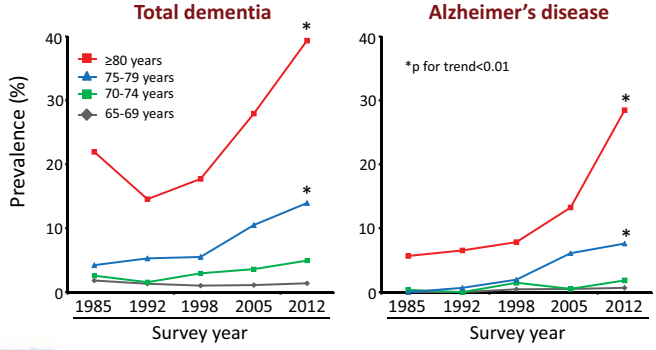
Adjusted for age, sex, education level, hypertension, total cholesterol, body mass index, waist to hip ratio, electrocardiogram abnormalities, history of stroke, smoking habits, alcohol intakes, and physical activity

Ohara T, et. al. Neurology 77:1126, 2011

Trends in age-specific prevalence of total dementia and Alzheimer's disease

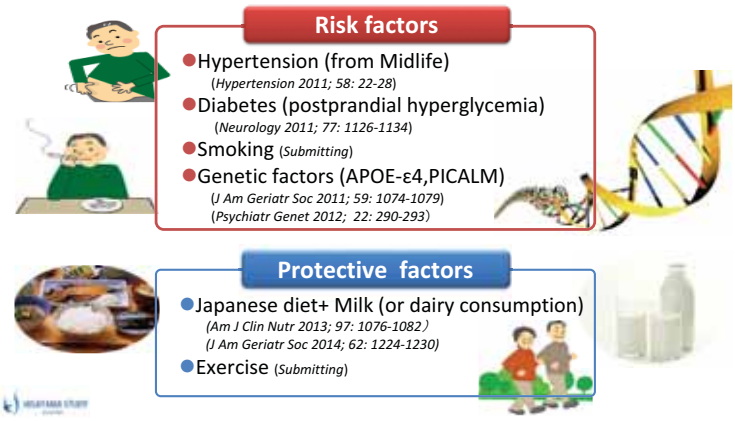
Hisayama residents, aged ≥65 years, unadjusted

Age-specific prevalence of Alzheimer's disease increased with time in individuals aged 75-79 years and 80 years or older.



Risk factors and protective factors for dementia

Summaries of the results from the Hisayama Study



"Ninchisho（Dementia) Supporter Caravan" Supporter Training in Communities

National Caravan-Mate Coordinating Committee
Hiroko Sugawara

2. Dementia Awareness Campaign and Support Structure

Knowledge Transfer and Multi-Tiered Support Infrastructure Using Unified Learning Resource

1st Tier — 1) Medical professionals specializing in dementia trains 2) Caravan-Mates
- Diagnosis/ Treatment/ Consultation
- Knowledge transfer
- • Dementia specialists
  Doctors at Dementia Medical Center, medical school professors

2nd Tier — 2) Caravan-Mate (100,147) Train Ninchisho Supporter
- Nursing care/ consultation
- Knowledge transfer
- • Multi-role Caravan-Mates
  e.g. care managers, nursing staff, public health nurses, nurses, doctors, nursing consultants, children's public welfare leaders, administrative, volunteer leaders, academics (professors, teachers), companies (CSR, training), etc.

3rd Tier — 3) 5.5 million Ninchisho Supporters in Practice
- Support by Watching
- Knowledge transfer
- • e.g. local residents, police officers, firefighters, vehicle drivers, transportation operators, shopkeepers, clerks, bankers, students(elementary, junior-high, high school), elderly club members, family clubs, children's committee, caretakers, couriers, postmen, mechanic, etc.

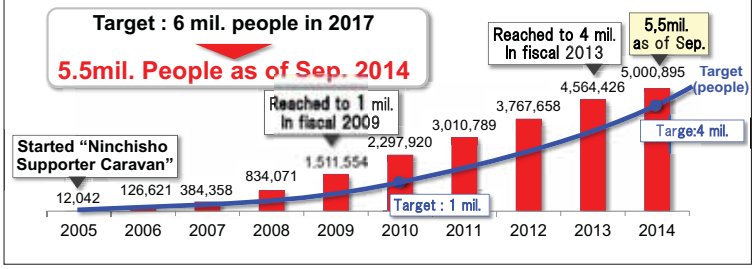
Support structure → **People with dementia and their families**

"Ninchisho Supporter Caravan" = Dementia Edification

Campaign to encourage early detection and treatment while reducing prejudice and gaining awareness

Ninchisho(Dementia) Supporter is... **not a special someone**
With proper knowledge of dementia, they aid, support, and watch over the people and their families

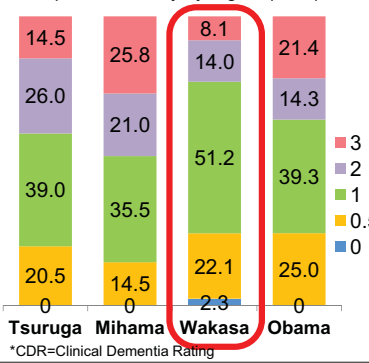
Caravan-Mate is... Trainer for the Ninchisho Supporters



3. Effect of "Ninchisho Supporter Caravan" (1) Early Detection and Treatment

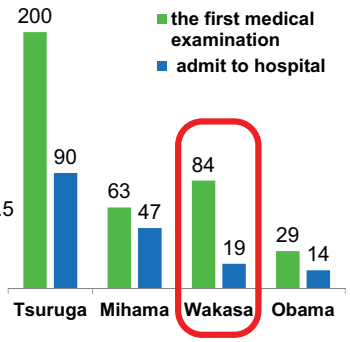
Number of patients hospitalized, and severity upon their initial visit
Towns with 2 Ninchisho supporters per elderly over age 65

2012 comparison of 4 Reinan towns in Fukui prefecture
New patient severity by region (CDR): %



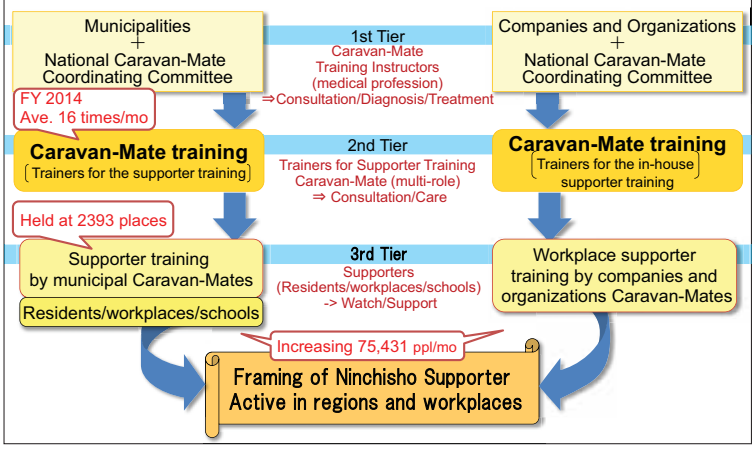
*CDR=Clinical Dementia Rating

2012 New patient and inpatient comparison: people



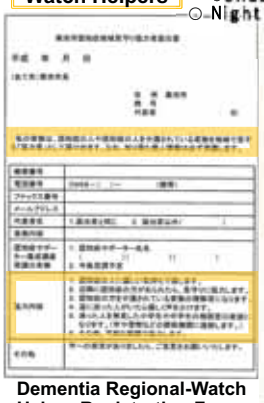
1. "Ninchisho Supporter Caravan" System

[Able to keep living in the familiar environment with multi-tiered support for dementia]

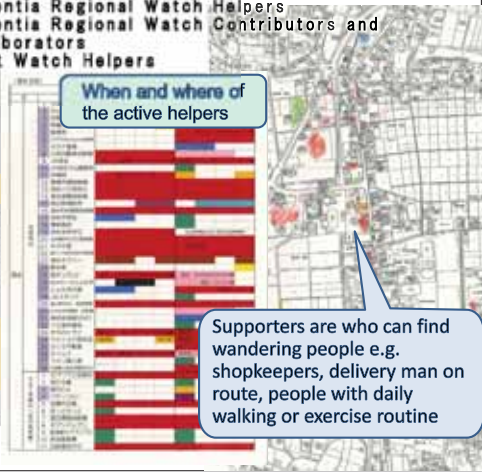


3. Effect of "Ninchisho Supporter Caravan"
(2)Supporter activities: Zero Wandering-Missing
(Kikuchi-shi, Kumamoto prefecture)

Regional-Watch Helpers
- ○ Dementia Regional Watch Helpers
- ○ Dementia Regional Watch Contributors and Collaborators
- ○ Night Watch Helpers



Dementia Regional-Watch Helper Registration Form

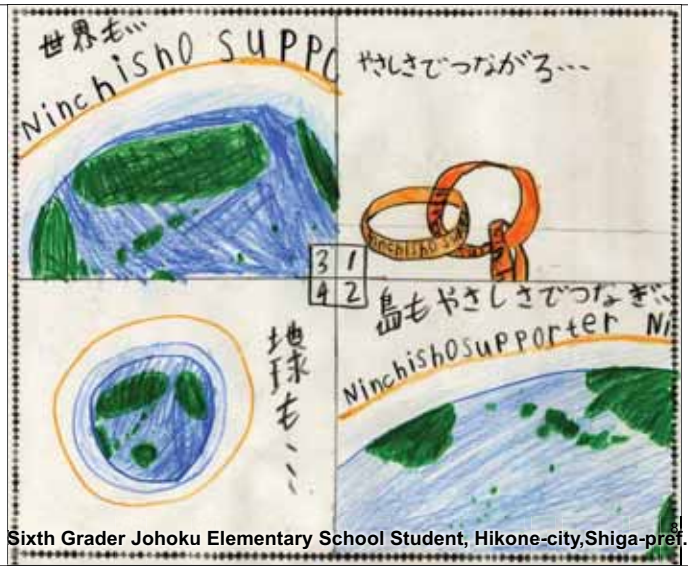


4. "Ninchisho Supporter Caravan" for overseas

New York(U.S.A.) 【The Japanese American Association of New York」		
Aug., 2010 : Caravan-Mate Training	Caravan-Mate	56
	Supporter	148
Toronto(Canada)【Toronto Japanese Social Services】		
Oct., 2013 : Caravan-Mate Training	Caravan-Mate	52
	Supporter	7
Vancouver(Canada)【Nikkei Seniors Health Care & Housing Society】		
Sep., 2014 : Caravan-Mate Training	Caravan-Mate	56
Dusseldorf(Germany)【Deutsch-Japanischer Verein für kultursensible Pflege】		
Oct., 2014 : Caravan-Mate Training	Caravan-Mate	51
"Ninchisho Supporters Training Course"	Supporter	124

* Supporter Training planned in Netherlands, Denmark, and Switzerland at Japanese societies

- Planned in Thailand (Embassy in Thailand) Caravan-Mate Training
- "Ninchisho Supporters Training Course by Chinese" for the Chinese Returnees (on July 25, 2014) at China Returnees Support and Exchange Center



Sixth Grader Johoku Elementary School Student, Hikone-city,Shiga-pref.

Future initiatives - the EU-level perspective

Global Action Against Dementia Legacy Event,
Tokyo,
06 November 2014

Jürgen Scheftlein
Unit "Health Programme and Diseases"
Health and Consumers Directorate General
European Commission

European Initiative on Alzheimer's disease and other dementias (2009)

Developed under French EU-Presidency to launch European collaboration on dementia.

Implementation report published on 16 October 2014.

Some key implementation activities:

- Joint Action ALCOVE (2011 – 2013);
- European Innovation Partnership Active and Healthy Ageing (2011);
- EU Reseach Framework Programmes and eHealth Action Plans

Dementia: a challenge for EU-Member States

All 28 Member States are concerned:

- 6.37 million people were living with dementia in the EU in 2011 (JA ALCOVE-report, 2013)
- Economic costs of € 105 M in 2011 (J. Olesen et al., 2012)
- A diversity of situations and of health and social welfare systems.

Joint Action ALCOVE (2011-2013)

- Led by France and involving 19 Member States;
- Funded by Member States and EU-Health Programmes.

Developed recommendations and toolkits on:

- Timely diagnosis of dementia;
- Epidemiology of dementia;
- Support systems for Behavioural and Psychological Symptoms in Dementia (BPSD);
- Advance Declarations of Will;
- Limitation of antipsychotics use.

European Initiative on Alzheimer's disease and other dementias (2009)

Developed under French EU-Presidency to launch European collaboration on dementia.

Priorities:

- Early (timely) diagnosis of dementia and promoting well-being with age;
- Better understanding dementia, epidemiological knowledge and coordination of research;
- Best practices in care for people with dementia;
- Respecting the rights of people with dementia.

Implementation report published on 16 October 2014.

ALCOVE Toolkit Timely Diagnosis of Dementia

Second EU- Joint Action on dementia (2015-2018)

- To be led by United Kingdom (Scotland);
- Good interest among Member States in participation.

Proposed focus themes:

Postdiagnostic support, improvement of care pathways, use of medicinal products and psychotropic substances, care for family carers, workforce skills, quality of residential care.

Reaching Scale

Second EU- Joint Action on dementia (2015-2018)

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- Good interest in participation.

Proposed focus themes:

Postdiagnostic support, improvement of care pathways, use of medicinal products and psychotropic substances, care for family carers, workforce skills, quality of residential care.

One example of good practice on prevention of cognitive decline (21 identified)

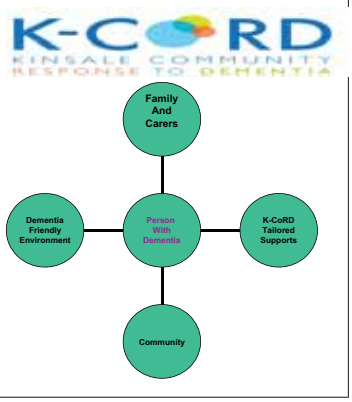
Create a Circle of Care around the person with dementia

Collaborating with, enhancing and Coordinating existing services

Delivering to the clients a package tailored to their individualised needs

Introducing the benefits of Assisted Technology

Develop Kinsale as a Dementia Friendly Environment



European Innovation Partnership Active and Healthy Ageing

- This EU-flagship initiative was launched in 2011. It is mobilising one thousand European regions and municipalities, involving 3000 partners and 300 leading organisations.
- All relevant actors involved in ageing are involved: industry, research, healthcare providers, NGOs,...
- The objective is to increase the average healthy life years of EU-citizens by two years by 2020 by identifying European good practices and scaling them up;
- The Partnership includes two actvity strands relevant for dementia: one on **„prevention of frailty and cognitive decline“** and a further one on **„innovation for age-friendly environments**“.

Good practice „Age-friendly environment“ Cumbria County Council Investment in Residential Care (2010)

Activties:

Simple changes such as different colours on walls and door frames, plain carpets that are similar in colour and texture and clear signage on rooms and cupboards help reduce stress and anxiety levels of people with dementia, and provide a safer environment by reducing the risk of slips, trips and falls.

Outcome:

A reduction in slips ,trips and falls (reduction from 22 in a 4 month period to 0 in the 4 months after refurbishment) . Evidence of a reduction in antipsychotic medication, improved food intake (half a pound additional intake per person per day).

The first scheme at Elmhurst, Ulverston was awarded the University of Stirling Gold Standard for dementia design.

Completed eHealth projects (further ones ongoing)

PredictAD
Aimed to identity a biomarkger and develop a software allowing the GP to assess the risk of dementia

SOCIABLE
Personalized cognitive training interventions for senior citizens including cognitive intact elderly, older adults with Mild Cognitive Impairment, as well as patients suffering from mild Alzheimer's disease.

VERVE
Games modelling everyday scenarios and instances where anxieties might occur.

Does EU-action make a difference?

We believe, it does:

- It supports the collaboration between large EU-countries;
- It enables smaller countries with more limited resources and infrastructure to liaise with work in other countries and to contribute to these.

Evidence of change:

2009: only one EU-country had a National Action Plan on Dementia (France);

2016: 16 EU-Member States have a National Dementia Action Plan or are working on it.

Dissemination

- Implementation report on the Commission Communication on a European Initiative on Alzheimer's Disease and other Dementias (16.10.2014);
- Dissemination activities as part of the programmes and projects including the new EU-Joint Action on Dementia;
- Italian EU-Presidency conference „Dementia in Europe: A challenge for our common future", Rome, 14 November 2014;
- Group of Governmental Experts on Dementia (second meeting: Rome, 13 November 2014).

Conclusions

Building on the activities and achievemtns since 2009, the Commission has launched action to:

- Maintain its coordinating role in the development of EU-policy on dementia and in supporting Member States in their actions;
- Launch the second Joint Action;
- Provide further opportunities to support research under the 'Horizon 2020'-EU Research Framework Programme;
- Stimulate the development and use of e-Health solutions in the field of dementia;
- Continue playing a global role and collaborating with international stakeholders, in particularly in the context of the initiative „Global Action Against Dementia".

Department of Health

Global action against dementia

Japan Legacy Event: Care & Prevention

Jon Rouse,
Director General - Social Care, Local Government and Care Partnerships
Department of Health

Global Action Against Dementia

- Co-ordinating activity across the G7
  - G8 Dementia summit (December 2013)

    Declaration with 12 supporting commitments

    Identify a cure or disease modifying therapy by 2025
- Collaborative working

Academia	Industry	Civil Society
HIROs	NGOs	G7

Care whilst seeking a cure

Affordability & timeliness

Current workstreams

- Integrated Development
  Availability of drugs and treatments
- Finance
  Increase levels of dementia research
- Open Science and data
  sharing knowledge and data to reduce duplication
- Care
  Role of technology and links with other workstreams

Innovation in care

Global

- Global Alzheimer's and Dementia Action Alliance (GADAA) (launched May 2014)
- Reviewing the cost / benefit case for technology in care
- Social Outcomes Innovation Fund
- Global Dementia Care Framework

UK

- Timely diagnosis – accessing the right level of care at the right time
- Improving care environment
  - Domestic wards
  - Butterfly scheme
- Dementia friendly communities

Care models support personalisation

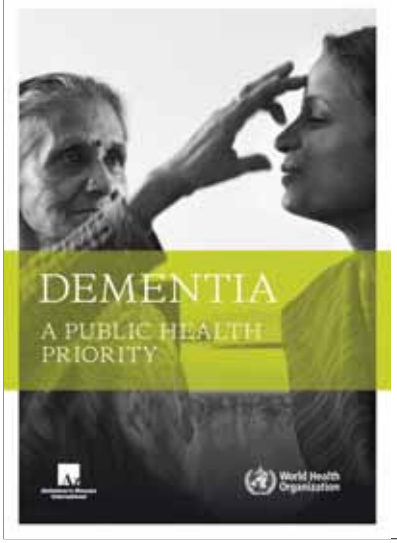
Technology allows us to take the next step in care improvements

Going forwards

- Learn from, align with and build upon existing mechanisms
  - Learn – Genetics and HIV
  - Align - Critical role of HIROs
  - Build - WHA Resolutions (Non-Communicable Disease & Mental Health)
- Sustainable medium term platform
- Inclusive global collaboration
  - Respect and nurture cultural, political and organisational differences
  - Enriched activity through engagement
- International reference and advocacy

Continuing innovations in dementia

- Stakeholders – working across traditional boundaries
- Collaboration – embrace don't fear
- Sharing – central to improving experiences
- Civil Society – adapt messages promoting culturally acceptable activity
- Champions – varying backgrounds with advocacy across boundaries



World Health Organization

Future Initiatives on Dementia

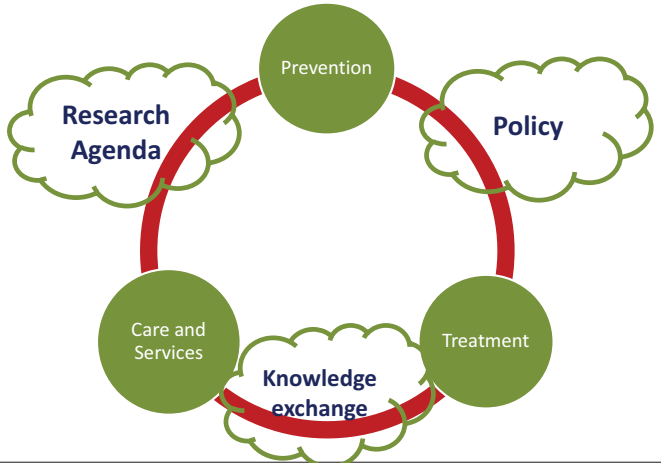
CARE TODAY, CURE TOMORROW!

WHO DG: Dr Margaret Chan

December 2013

I can think of no other condition that has such a profound effect on loss of function, loss of independence, and the need for care. I can think of no other condition that places such a heavy burden on society, families, communities, and economies. I can think of no other condition where innovation, including breakthrough discoveries, is so badly needed.

World Health Organization and Dementia Initiatives



Global Impact, Global Solutions

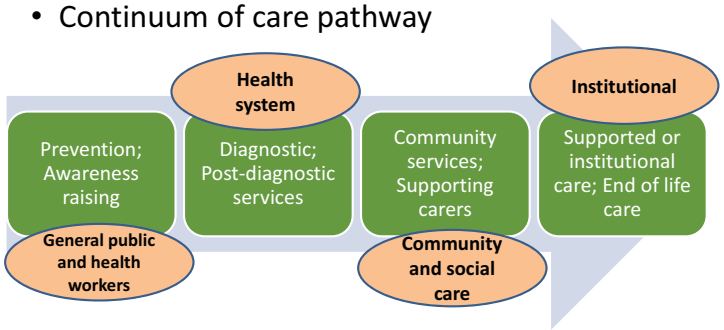
1. Setting agenda for dementia research

- Core role of WHO in shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge
- Will enable strategic investments, improved coordination and reduce duplication in dementia research
- Ultimately maximise reduction in disease burden in an equitable and cost-effective way

- **Dementia research portfolio analysis**
  - To map the current funding and type of research landscape
- **Dementia research prioritization exercise**
  - Through consultation with wide range of stakeholders
  - Following a systematic and transparent methodology

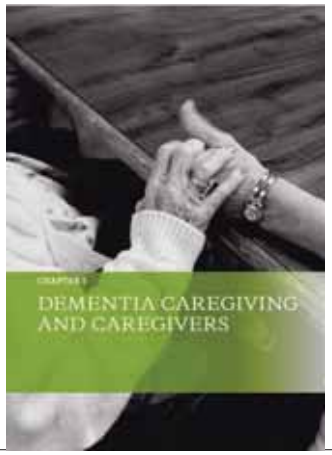
2. Dementia care and prevention: Policy action

- Continuum of care pathway



- Supporting countries for developing and implementing dementia friendly policies

5. Information and Communication Technology for Dementia Care



ICT for caregivers: *iSupport*

- Most care for people with dementia is provided by family caregivers
- Dementia is overwhelming for the caregivers – physically, emotionally and economically
- Support is required from the health, social, financial and legal systems

3. Monitoring the response: Global Dementia Observatory

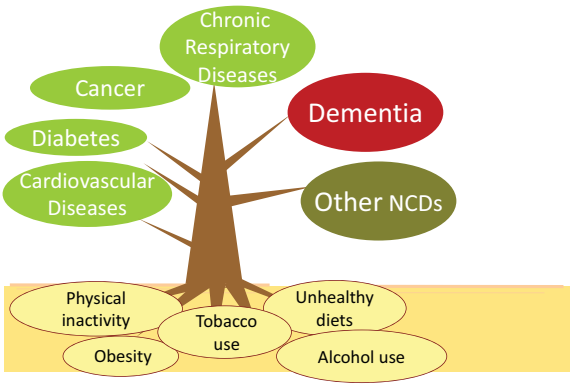
- Observatory will provide data and analyses highlights on dementia burden and response
  - Global epidemiological trends
  - Policy formulation and adoption
  - Country implementation through health and social care system
  - Partnerships

First Ministerial Conference on Global Action Against Dementia

- **3-4 March 2015**
- Supported by DoH, UK and OECD
- Main objective : to widen the prioritization of dementia as a global issue.
- **First day: technical event around "dementia care today and cure tomorrow"**
- **Second day: "moving forward with action"**

Look forward to seeing you in Geneva…….

NCDs and Dementia share common risk factors



Combined efforts to develop an integrated approach – at policy and programme level