

RaDAR Rural Primary Health Care Memory Clinics

Debra Morgan, PhD, FCAHS
Professor and Chair, Rural Health Delivery
Department of Medicine
Canadian Centre for Health & Safety in Agriculture
University of Saskatchewan

ASC/CCNA/BrainXchange Webinar
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UNIVERSITY OF
SASKATCHEWAN

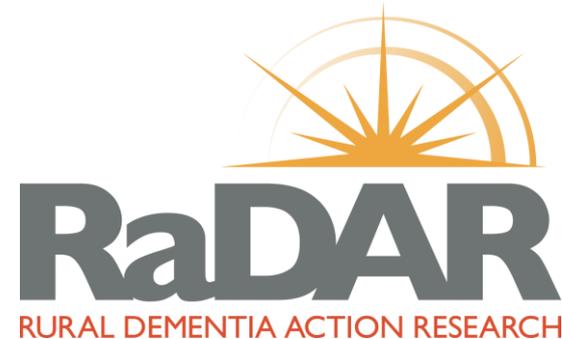


We acknowledge that we are on Treaty 6 territory and Homeland of the Métis



Objectives of this presentation

- Describe the history of the Rural Dementia Action Research (RaDAR) research program
- Describe development and implementation of the RaDAR Rural Primary Health Care Memory Clinics
- Report on evaluation of the clinics



Community-Based Participatory Research (CBPR)

CBPR Principle *	Example
Partners in full research process	Partnership levels <ul style="list-style-type: none">• Health region• Full PHC team• Smaller PHC team workgroup
2-way capacity building	RaDAR → SHA (decision support tools, specialist support) SHA → RaDAR (regional processes, EMR system)
2-way knowledge exchange	Regional steering group meetings, frequent consultation with PHC team, RaDAR newsletters
Action-oriented	Focused on improvement in dementia care across health region and in PHC teams
Sustainability	Focused on sustainability at the outset - by adapting model to PHC team, addressing team priorities (e.g., education), incorporating team processes

* Morgan et al. 2014, Israel et al. 1998, Shalowitz et al. 2009, Cabassa et al. 2011



Annual Summit of the Knowledge Network in Rural and Remote Dementia Care

- First Summit in 2008; started as strategy to guide a CIHR Applied Chair in Health Services & Policy grant
- Evolved to include sharing information about dementia research and programs in SK, Canada, and internationally
- 2-day event
 - Evening poster session + Summit Day
- Venue is Western Development Museum in Saskatoon but online last 3 years b/c Covid



Summit 2018

Top: Evening poster session
Middle: Small Group discussion
Bottom: Presentations

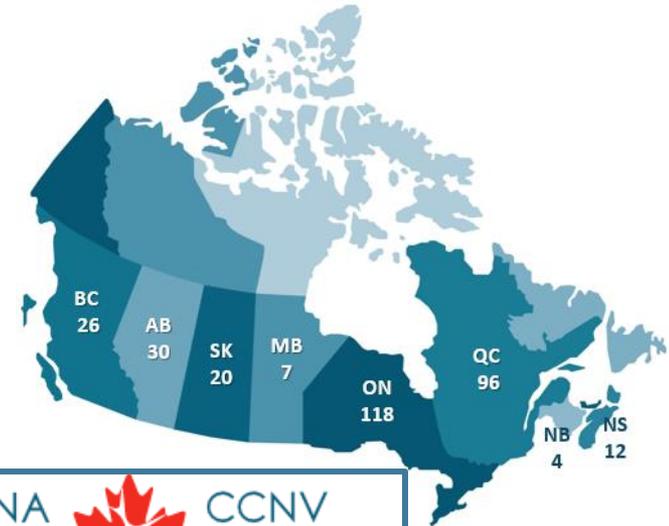
RaDAR Team Funding

Canadian Consortium on Neurodegeneration in Aging (CCNA)

- Created in 2014
- Includes 310+ researchers in 19 teams across 3 themes (prevention, treatment, quality of life)

RaDAR = CCNA Team 15 “Issues in Rural Dementia Care”

- *Phase 1 (2014-2019)*
led by Debra Morgan
- *Phase 2 (2019-2024)*
led by Megan O’Connell and Debra Morgan
- Collaborations with other CCNA Teams



RaDAR Team Funding

CIHR Foundation Grant

- PI Debra Morgan
- 2016-2023
- “Design and evaluation of integrated primary health care practices for dementia in rural and remote settings”
 - Stream 1 – Support interdisciplinary PHC teams
 - Stream 2 – Provide remote specialist-to-provider dementia support and education
 - Stream 3 – Embed point-of-care decision support tools in EMR (for PHC teams)



Specialist Rural and Remote Memory Clinic



Dr. Debra
Morgan
Administrative
Director



Dr. Megan
O'Connell
Neuropsychologist
& Clinical Director



Dr. Andrew
Kirk
Neurologist

- Established 2004, U of S campus
- Funded by SK government
- **Diagnose and manage complex and atypical cases of suspected dementia**
 - Interprofessional clinical interview with patient, family, and team
 - End of day team conference after individual assessments
 - Follow-up by telehealth videoconferencing and in-person
- Virtual
 - Remote interventions and diagnostic support
- Supports interdisciplinary research and training

RaDAR Website www.ruraldementiacare.usask.ca

Rural & Remote Memory Clinic

A cornerstone project of the RaDAR Team is the Rural and Remote Memory Clinic (RRMC), housed in the Health Sciences E Wing building at the University of Saskatchewan.

Due to COVID-19 concerns and proactive closure of facilities at the University, the *in-person services* of Rural and Remote Memory Clinic (RRMC) in Saskatoon are cancelled until further notice.

HOWEVER we are providing RRMC services virtually. Learn more at www.remotememoryclinic.ca
On the [Healthcare Providers providers page](#) under Diagnostic Support you will find the [referral form](#) and processes for referring to the RRMC specialist clinic.

Concerns about current patients can be directed to Dr. Kirk's office directly.

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2009 video about RRMC

The Rural and Remote Memory Clinic was originally implemented and evaluated through a Canadian Institutes of Health Research NET (New Emerging Team) Grant funded research program. Today the Rural and Remote Memory Clinic receives funding from the Saskatchewan Ministry of Health to provide clinical services to Saskatchewan residents.

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RRMC Development

Morgan, D., Crossley, M., Stewart, N., Kirk, A., Forbes, D., D'Arcy, C., Dal Bello-Haas, V., McBain, L., O'Connell, M. E., Bracken, J., Kosteniuk, J., & Cammer, A.* (2014). Evolution of a community-based participatory approach in a Rural and Remote Dementia Care Research Program. *Progress in Community Health Partnerships: Research, Education, and Action*, 8(3), 337-345. [doi:10.1353/cpr.2014.0040](https://doi.org/10.1353/cpr.2014.0040)

Morgan, D., O'Connell, M. E., Bracken, J., & Tandon, D. (Podcast participants) *Beyond the Manuscript*. (Fall 2014). A podcast interview hosted by Project Muse to share the researchers' perspective on the behind-the-scenes work that went into the preparation of the 2014 manuscript Evolution of a Community-Based Participatory Approach in a rural and remote dementia care research program as published in the journal *Progress in Community Health Partnerships: Research, Education, and Action*. A transcript of the podcast is available [doi:10.1353/cpr.2014.0043](https://doi.org/10.1353/cpr.2014.0043)

Morgan, D., Crossley, M., Kirk, A., D'Arcy, C., Stewart, N., Biem, J., Forbes, D., Harder, S., Basran, J., Dal Bello-Haas, V., & McBain, L. (2009). Improving Access to Dementia Care: Development and Evaluation of a Rural and Remote Memory Clinic. *Aging & Mental Health*, 13(1), 17-30. [doi:10.1080/13607860802154432](https://doi.org/10.1080/13607860802154432)

Crossley, M., Morgan, D., Lanting, S.* Dal Bello-Haas, V., & Kirk, A. (2008). Interdisciplinary research and interprofessional collaborative care in a memory clinic for rural and northern residents of Western Canada: A unique training ground for clinical psychology graduate students. *Australian Psychologist*, 43(4), 231-238. [doi:10.1080/00050060802492564](https://doi.org/10.1080/00050060802492564)

Morgan, D., Stewart, N., Crossley, M., D'Arcy, C., Biem, J., Kirk, A., & Forbes, D. (2005a). Dementia care in rural and remote areas: The first year of a CIHR New Emerging Team. *Canadian Journal of Nursing Research*, 37(1), 177-182

Telehealth & Technology

Scerbe, A.*, O'Connell, M. E., Astell, A., Morgan, D., Kosteniuk, J., & DesRoches, A. (2019). Digital tools for delivery of dementia education for healthcare providers: A systematic review. *Educational Gerontology*, 45(11), 681-699. [doi:10.1080/03601277.2019.1687149](https://doi.org/10.1080/03601277.2019.1687149)

[PDF](#) Blackberry, I., Wilding, C., Perkins, D., Greenhill, J., Farmer, J., Bauer, M., Winbolt, M., Morley, C., O'Connell, M.E., Morgan, D. (December 2018/January 2019). Virtual dementia-friendly rural communities. *Australian Journal of Dementia Care*, 7(6), 11-13.

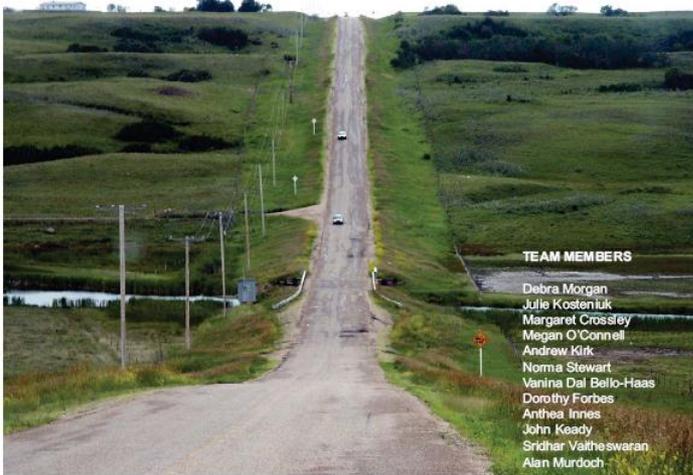
The pdf link provide on this page is a pre-publication version of the article. The final version was published in the journal *Australian Journal of Dementia Care*.

Provincial Consultation on Rural Primary Healthcare

Planning for the Rising Tide: New Models of Rural Primary Healthcare for Persons with Dementia

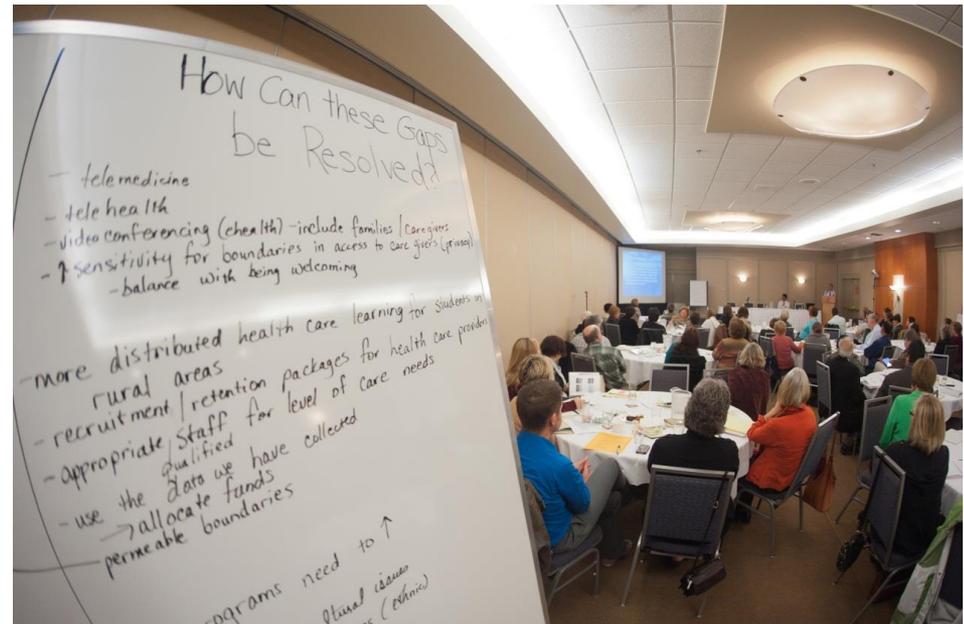
Community-Based Primary Healthcare Team Grant
Planning Session, October 17, 2011

REPORT



TEAM MEMBERS

Debra Morgan
Julie Kosteniuk
Margaret Crossley
Megan O'Connell
Andrew Kirk
Norma Stewart
Vanina Dal Bello-Haas
Dorothy Forbes
Anthea Innes
John Keady
Sridhar Valtheswaran
Alan Murdoch



Partnership with (former) Sun Country Health Region



GOAL: To work with rural PHC teams to develop a **model for dementia care** that was:

- based on research evidence,
- is effective, feasible, sustainable,
- adaptable to diverse rural contexts.



Partnership with (former) Sun Country Health Region

CCNA Phase 1 Objectives (2014-2019)

- Develop/adapt, implement, and evaluate a **Rural Primary Health Care (PHC) Model for Dementia Care**
- Implement the model in **1 PHC team at a time, 4 teams in total**

Sun Country Health Region

- Former health region in southeast SK
- 33,239 km²
- 16% aged 65+ (vs. 15% provincially)
- **58% rural \leq 10,000 pop.**
- **60,124 regional pop.**
 - 29% towns
 - 29% villages, reserves, others
 - 42% Weyburn and Esteva



Established Steering Group in former Sun Country HR in 2013

Meet every 3 months since 2013

Members

- Directors and managers connected with their local Memory Clinics
 - *PHC, Long-term Care, Mental Health*
- Alzheimer Society staff
- RaDAR team

Purpose

- Share initiatives in dementia care
- Sustain and spread RaDAR memory clinics



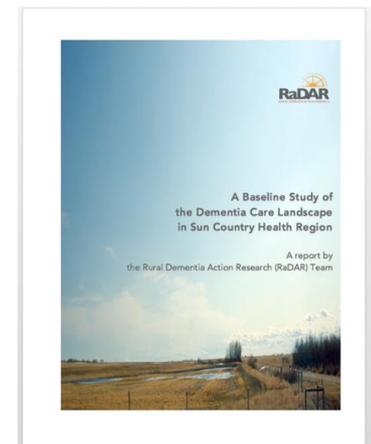
Needs Assessment (Challenges)

Sun Country Health Region

Team-based dementia care “There is no two-way communication, unless I try to reach out to them. I talk to the GP, then I talk to the family members, there’s no way to communicate at the same place. So that makes it harder to provide accurate assessment.” (PHC Team member 1)

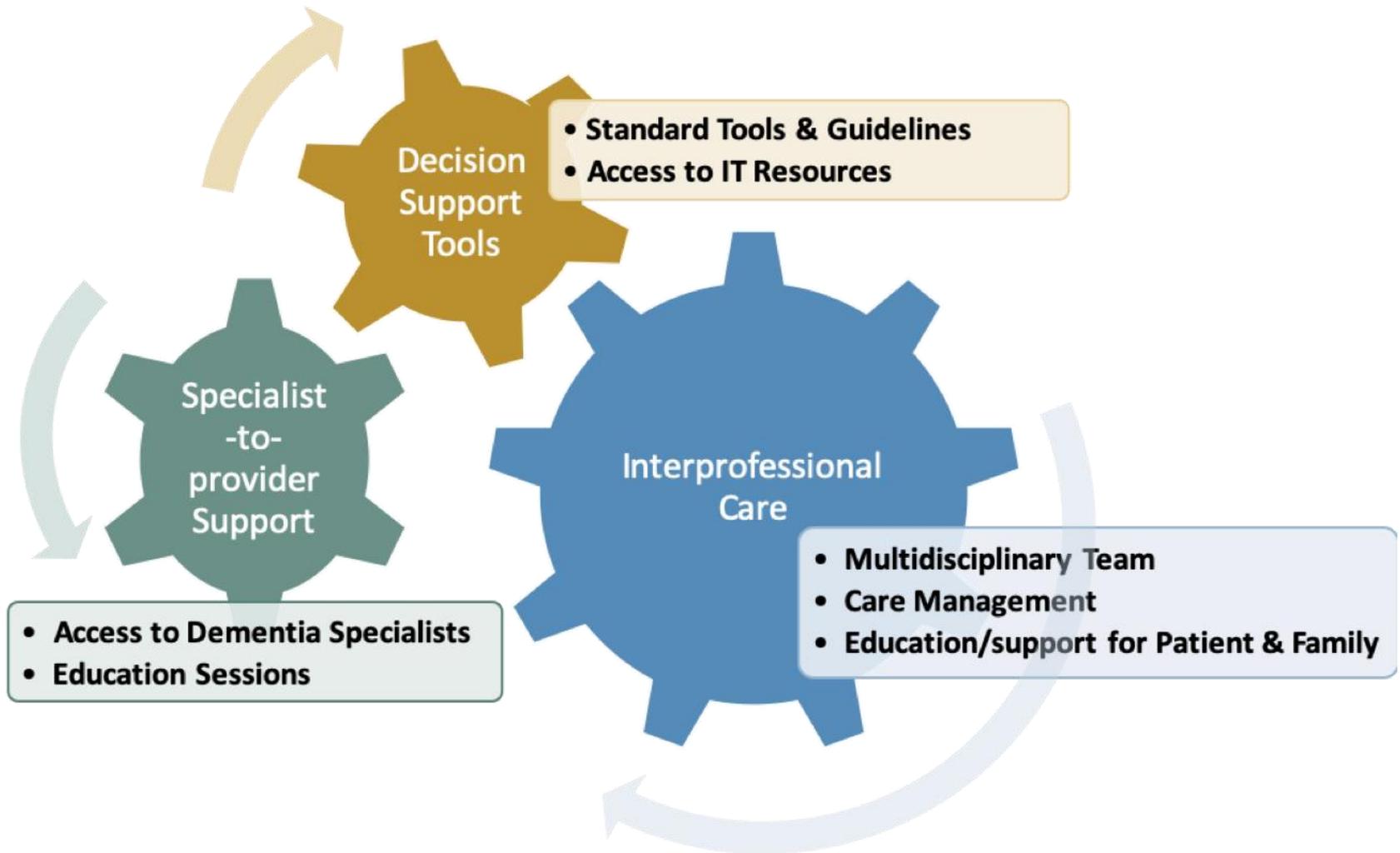
Early recognition and diagnosis “I would say we need to early diagnose so that the family is aware and they can start to take steps for safety for that person as they deteriorate, so us to be able to early diagnose them. It’s not that it’s going to get much better just because we diagnose them, but then we can have things in place for them to help with their safety, etc. etc.” (PHC Team member 5)

Access to decision support tools “What I mean is there is no standard, how do I say it, standard care or like standard template that everybody has to follow when it comes to dementia, so people will look for information and try to adjust or adapt it to their teams on the way to work for it.” (Decision-maker 1)



Rural PHC Model for Dementia

Best practices based on review by Aminzadeh et al. (2012)



Interprofessional Care

Interprofessional Care

Multidisciplinary Team

- Family Physician or Nurse Practitioner
- Home Care Nurse
- Social Worker
- Occupational Therapist
- Physical Therapist
- Dietitian, Pharmacist
- Alzheimer Society First Link Coordinator
- PHC Facilitator
- Office staff

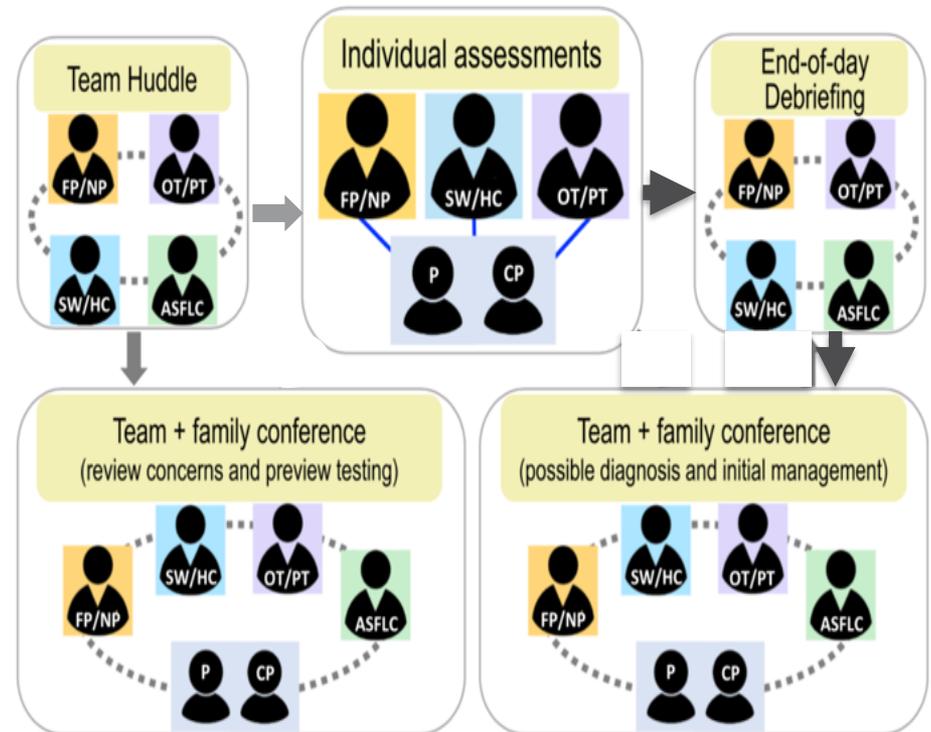
Coordinated Care Management

- Clinic day assessments
- Shared EMR flowsheets and decisions
- Team conference with patient and family
- Shared care plan

Education/support for Patient & Family

- Alzheimer Society services
- Community services

1-day Memory Clinic (Initial Evaluation)



FP/NP = Family Physician/Nurse Practitioner; OT/PT = Occupational Therapist/Physical Therapist;
SW/HC = Social Worker/Home Care Nurse; ASFLC = Alzheimer Society First Link Coordinator;
P = Patient; CP = Care Partner



Interprofessional Care

Rural PHC Memory Clinic Video (short)

<https://www.youtube.com/watch?v=Tzr1MVu7Mpc>

Rural PHC Memory Clinic Video (long)

[https://www.youtube.com/watch?v=9o- JCKDc-c&t=](https://www.youtube.com/watch?v=9o-JCKDc-c&t=)

Decision Support Tools

PC-DATA™

Primary Care Dementia
Assessment and Treatment
Algorithm

- based on Canadian guidelines
 - Visit flow sheets
 - Algorithms
 - Education manual
 - Education sessions

Developed by Dr. Dallas Seitz
Geriatric Psychiatrist
University of Calgary

www.dementiahub.net



A screenshot of a web-based educational platform. At the top, there is a banner image of a doctor and an elderly woman, with a text box on the right that reads "CONTINUING MEDICAL EDUCATION FOR Alzheimer's Disease and Related Dementias". Below the banner is a "Brief Program Description" section containing text about the PC-DATA tool and its development. At the bottom, there are two module cards: "MODULE 1: Assessment of Cognition & Diagnosis of Dementia" and "MODULE 2: Initial Management of Dementia". Each card lists key topics and has a "Start Course" button.

Decision Support: EMR PC-DATA Flowsheets

Physician/NP

Initial Evaluation PC DATA, Dementia Visit Flowsheet

PC DATA [Substrate](#)
PC DATA [Education Manual](#)
PC DATA [Algorithm](#)

Physician/NP Section

Date patient seen:

1. Demographic Data

Living Environment:

Living Situation:

Main Caregiver/Relationship:

Name/POA (Physician):

POA (Personal Care):

Educational Achievement:

Primary Language:

2. Family History

Family History: Anorexia
 Depression
 Neurological conditions
 Endometriosis/Polycystic Ovary Syndrome
 Alzheimer's Disease

history of Alzheimer's Disease give specifics:

3. Past Psychiatric History

Past Psychiatric History: Anxiety
 Depression
 Psychosis
 Alcohol Use/dependence
 Other substance use/abuse (specify):

history of drug or alcohol abuse give specifics:

4. Presenting Complaint

Source of information regarding change:

Presenting Symptoms: Depression or Anxiety
 Functional decline
 High risk population (individuals over age 75, new onset depression, history of delirium, stroke or TIA)
 Memory impairment
 Personality change
 Psychosis or Schizophrenia

Home Care/Social Work

11. History of Cognitive Changes

Duration of Complaint(years):

Onset:

Progression:

Cognitive Symptoms

Memory: Difficult recalling recent events
 Forgetting appointments
 Forgetting conversations
 Forgetting instructions
 Misplacing objects

Language: Difficulty understanding conversations
 Dysarthria/aphasia fluent or paraphasic
 Word finding difficulties
 Word substitutions

Visuospatial: Difficulty navigating in unfamiliar environments
 Getting lost while driving
 Wandering out of home

Apraxia: Failure to recognize familiar locations
 Difficulty using tools/appliances

Complex Attention: Difficulties with walking
 Difficulties following multi-step sequences with intact language

Executive Functioning: Difficulties multitasking
 Difficulty organizing activities
 Difficulty planning
 Difficulty sequencing actions
 Loss of abstract thinking

Associated Symptoms

Behavioural/Personality Changes: Abnormal motor activity
 Agitation/aggression
 Anxiety
 Apathy/lack of interest
 Appetite/weight changes
 Depression/delirium
 Disinhibition
 Elation/euphoria
 Hallucinations
 Irritability
 Sleep disturbances
 Socially inappropriate behaviour
 Suspiciousness/paranoia

Team + family conference

End of Occupational Therapy/Physical Therapy Section
Dementia Case Conference Diagnosis and Initial Management

17. Impression

Impression: Normal Aging - no cognitive complaints, testing normal for age, doesn't meet criteria for dementia
 Subjective Cognitive Impairment - cognitive complaints, worried about cognition, but testing is normal for age and no significant functional impairment
 Mild Cognitive Impairment - Amnesic - evidence of objective memory problems/cognitive complaints, abnormal cognitive testing, no significant impairment in other areas of cognition or behaviour/cognitive o
 Mild Cognitive Impairment- Non-amnesic- no objective memory problems, problems in other areas of cognition or behaviour/cognitive o
 Dementia - abnormal cognitive testing, significant cognitive decline in 2 areas of cognition/memory, language, perceptual motor, complex
 Uncertain

18. Determine Type of Dementia

Alzheimer's Disease: Onset Insidious
 Slow Progression
 Initial Symptoms often deficits in short term memory

Vascular Dementia: History(stroke)
 Neuroimaging
 Physical Exam

Mixed Alzheimer's and Vascular:

Dementia with Lewy Bodies: Major criteria: Parkinsonism within 1 year of onset of cognitive symptoms
 Major criteria: visual hallucinations early in course
 Major criteria: fluctuations in cognition or level of consciousness
 Minor criteria: antipsychotic sensitivity
 Minor criteria: falls
 Minor criteria: other psychotic symptoms
 Minor criteria: REM sleep disorder

Physical Therapist

Physical Therapy Assessment

16. Living Arrangement:

Stairs/Railings: Outside:

Stairs/Railings: Inside:

Equipment: Cane
 Crutches
 Standard Walker
 2wheeler
 4wheeler
 Wheelchair

Home Oxygen:

Other:

Mobility:

Falls in the last year?

Comments:

4 Meter Walk Test:

Occupational Therapist

15. Functional and Cognitive Abilities

Assessment Tools

CLOX:

Trails A:

Trails B:

TUGS Score:

Others:

Task Oriented Assessment: Coin Sort
 Medication Management
 Cooking
 Paying Bills
 Telephone
 Menu Planning
 Categorization

Comments:

EMR flow sheets are based on **PC-DATA™** developed by Dr. Dallas Seitz, University of Calgary

Decision Support: RaDAR Handbook

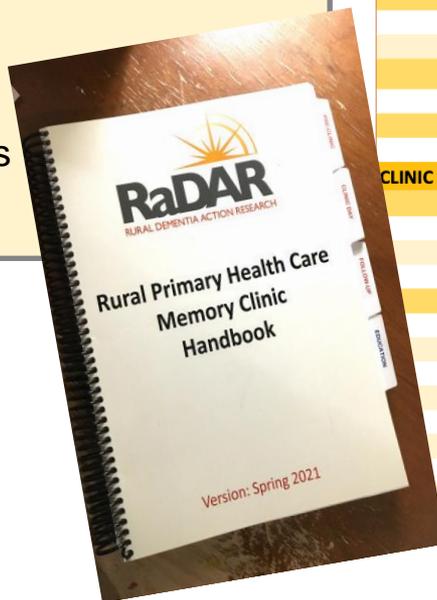
Decision Support Tools

Standard Tools & Guidelines

- PC-DATA™ tools and education manual
- Work standards for memory clinics
- Scripts (e.g., booking appointments, topic of driving)
- Patient letters for appointment confirmation and recommendations

Access to IT Resources

- RaDAR Handbook contains all tools
- EMR visit flowsheets



Citation: Elliot, V., Morgan, D., Kosteniuk, J., Seitz, D., Cameron, C., Minish, D. & Rural PHC Memory Clinic Team Members. (2021). *RaDAR Rural Primary Health Care Memory Clinic Handbook*. Version: Spring 2021. Saskatoon, Saskatchewan: University of Saskatchewan. (XXX pages, distributed as print and electronic versions).

RaDAR Handbook – Rural Primary Health Care Memory Clinics

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Specialist to Provider support

PC-DATA education

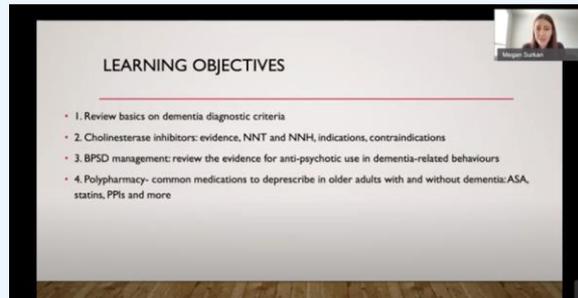


*Education session with Dr. Dallas Seitz
June 2019*

Education webinars 3-4 times/yr

Past topics

- Differential diagnosis
- Medications
- Capacity and competency
- Driving assessment
- Behavioural symptoms
- End-of-life care



*Education webinar with geriatrician
Megan Surkan, April 2021*

RRMC Clinic in Saskatoon provides remote support to rural PHC memory clinics:

1. Rural primary health-care memory clinic patients can be referred to **RRMC specialist clinic (Drs. Kirk and O'Connell and interdisciplinary team)**
2. RRMC can conduct **telephone-administered neuropsychological battery** and family interview (Pilot Study, Dr. Megan O'Connell)
3. **Remotely-delivered interventions** from RRMC (eg, sleep, cognitive rehab)

ALSO: Telephone consult with 2 Saskatoon geriatricians (falls or medications)

Memory Clinic Teams



Kipling (pop. 1140)



Weyburn (pop. 10,900)



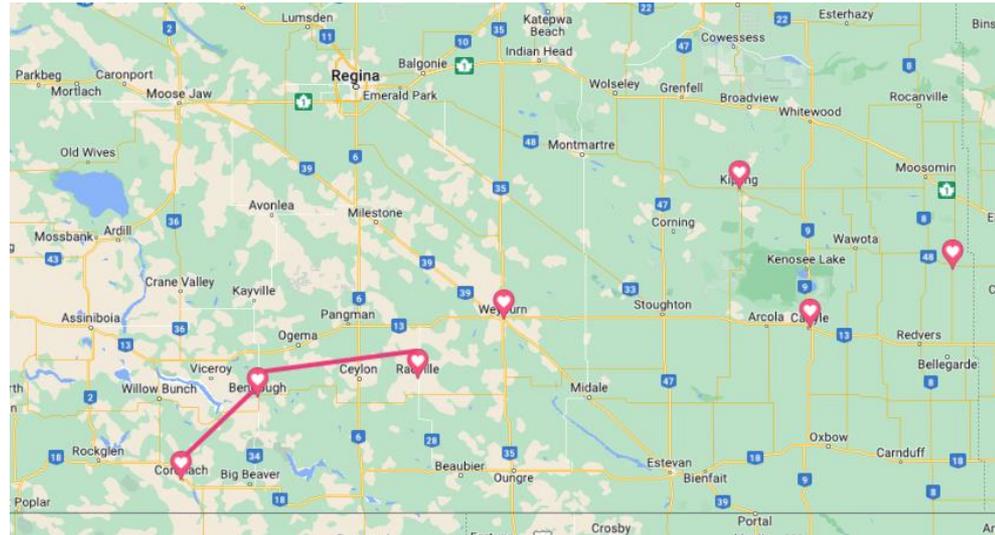
Rural West
(3 communities pop. 332-807)



Carlyle (pop. 1500)



Maryfield (pop. 348)



Local RaDAR Team members
support sustaining and spreading

RaDAR's Role in Launching & Sustaining the Clinics



- Helping adapt clinic to new setting, new teams
- Regular workgroup meetings with teams
- Monthly check-in meetings with the teams' regional PHC facilitators and managers
- Provide access to PC-DATA flow sheets and RaDAR handbook, newsletters with updates
- Provide resources (e.g., laptop, conference phone, MOCA training)
- NP (Jean D) provides leadership and clinical mentorship
- Former facilitator (Chelsie C) provides operational support and research data collection
- Targeted education sessions



Publications on RaDAR Memory Clinics

Morgan et al. *BMC Health Services Research* (2019) 19:709
https://doi.org/10.1186/s12913-019-4548-5

BMC Health Services Research

RESEARCH ARTICLE Open Access

Barriers and facilitators to development and implementation of a rural primary health care intervention for dementia: a process evaluation

Check for updates

Debra Morgan^{1*},
Melanie Bayly¹,
Amanda
Deb Kennett-Russell¹

Abstract

Background: We explored barriers and facilitators to the development and implementation of a rural primary health care intervention for dementia in rural settings. The role of facilitators and barriers to the sustainability of a rural primary health care intervention was explored. We collaborated with a rural primary health care team to develop and implement a rural primary health care intervention for dementia in a rural setting, involving individual stakeholders, small group discussions, and a deductive approach.

Primary Health Care
Research & Development

cambridge.org/phc

Development

Cite this article: Morgan D, Kosteniuk J, Seitz D, O'Connell ME, Kirk A, Stewart NJ, Holroyd-Leduc J, Daku J, Hack T, Hoiu M, Kennett-Russell D, Sauter K. (2019). A five-step approach for developing and implementing a Rural Primary Health Care Model for Dementia: a community-academic partnership. *Primary Health Care Research & Development* 20(e25): 1–11. doi: 10.1017/S1463423618000968

Received: 29 January 2018
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Key words:

community-based participatory research; dementia; implementation; primary health care; rural

Author for correspondence:

Debra Morgan, Professor and Chair of Rural Health Delivery, Canadian Centre for Health & Safety in Agriculture, University of Saskatchewan, 104 Clinic Place, Saskatoon, SK, Canada S7N 2Z4. E-mail: debra.morgan@usask.ca

A five-step approach for developing and implementing a Rural Primary Health Care Model for Dementia: a community-academic partnership

Debra Morgan¹, Julie Kosteniuk², Dallas Seitz³, Megan E. O'Connell⁴, Andrew Kirk⁵, Norma J. Stewart⁶, Jayna Holroyd-Leduc⁷, Jean Daku⁸, Tracy Hack⁹, Faye Hoiu¹⁰, Deb Kennett-Russell¹¹ and Kristen Sauter¹²

¹Professor and Chair of Rural Health Delivery, Canadian Centre for Health & Safety in Agriculture, University of Saskatchewan, Saskatoon, SK, Canada, ²Professional Research Associate, Canadian Centre for Health & Safety in Agriculture, University of Saskatchewan, Saskatoon, SK, Canada, ³Associate Professor, Department of Psychiatry, Queen's University, Providence Care - Mental Health Services, Kingston, ON, Canada, ⁴Associate Professor, Department of Psychology, University of Saskatchewan, Saskatoon, SK, Canada, ⁵Professor, Department of Medicine, Head of Neurology, University of Saskatchewan, Saskatoon, SK, Canada, ⁶Professor Emerita, College of Nursing, University of Saskatchewan, Saskatoon, SK, Canada, ⁷Section Chief, BSF Chair in Geriatric Medicine and Professor, Section of Geriatrics, Departments of Medicine and Community Health Sciences, University of Calgary, Alberta, Canada, ⁸Nurse Practitioner, Sun Country Health Region Kipling, Saskatchewan, Canada, ⁹Home Care Nurse, Sun Country Health Region, Kipling, Saskatchewan, Canada, ¹⁰Business Manager, Primary Health Care, Sun Country Health Region, Kipling, Saskatchewan, Canada, ¹¹Occupational Therapist, Regional Manager of Therapies, Sun Country Health Region, Kipling, Saskatchewan, Canada and ¹²Facilitator, Primary Health Care, Sun Country Health Region, Kipling, Saskatchewan, Canada

Abstract

Aim: This study is aimed at developing a Rural Primary Health Care (PHC) Model for delivering comprehensive PHC for dementia in rural settings and addressing the gap in knowledge about disseminating and implementing evidence-based dementia care in a rural PHC context. **Background:** Limited access to specialists and services in rural areas leads to increased responsibility for dementia diagnosis and management in PHC, yet a gap exists in evidence-based best practices for rural dementia care. **Methods:** Elements of the Rural PHC Model for Dementia were based on seven principles of effective PHC for dementia identified from published research and organized into three domains: team-based care, decision support, and specialist-to-provider support. Since 2013 the researchers have collaborated with a rural PHC team in a community of 1000 people in the Canadian province of Saskatchewan to operationalize these elements in ways that were feasible in the local context. The five-step approach included: building relationships; conducting a problem analysis/needs assessment; identifying core and adaptable elements of a decision support tool embedded in the model and

Morgan et al. *BMC Health Services Research* (2022) 22:148
https://doi.org/10.1186/s12913-022-07550-0

BMC Health Services Research

RESEARCH Open Access

Factors influencing sustainability and scale-up of rural primary healthcare memory clinics: perspectives of clinic team members

Check for updates

Debra Morgan^{1*}, Julie Kosteniuk¹, Megan E. O'Connell², Dallas Seitz³, Valerie Elliot¹, Melanie Bayly¹, Amanda Froehlich Chow⁴ and Chelsie Cameron¹

Abstract

Background: The aging of rural populations contributes to growing numbers of people with dementia in rural areas. Despite the key role of primary healthcare in rural settings there is limited research on effective models for dementia care, or evidence on sustaining and scaling them. The purpose of this study was to identify factors influencing sustainability and scale-up of rural primary care based memory clinics from the perspective of healthcare providers involved in their design and delivery.

Methods: Participants were members of four interdisciplinary rural memory clinic teams in the Canadian province of Saskatchewan. A qualitative cross-sectional and retrospective study design was conducted. Data were collected via 6 focus groups ($n = 40$) and 16 workgroup meetings held with teams over 1 year post-implementation ($n = 100$). An inductive thematic analysis was used to identify themes.

Results: Eleven themes were identified (five that influenced both sustainability and scale-up, three related to sustainability, and three related to scale-up), encompassing team, organizational, and intervention-based factors. Factors that influenced both sustainability and scale-up were positive outcomes for patients and families, access to well-developed clinic processes and tools, a confident clinic leader-champion, facilitation by local facilitators and the researchers, and organizational and leadership support. Study findings revealed the importance of particular factors in the rural context, including facilitation to support team activities, a proven ready-to-use model, continuity of team members, and mentoring.

Conclusions: Interdisciplinary models of dementia care are feasible in rural settings if the right conditions and supports are maintained. Team-based factors were key to sustaining and scaling the innovation.

Keywords: Sustainability, Spread, Scaling up, Primary healthcare, Memory clinic, Rural, Dementia

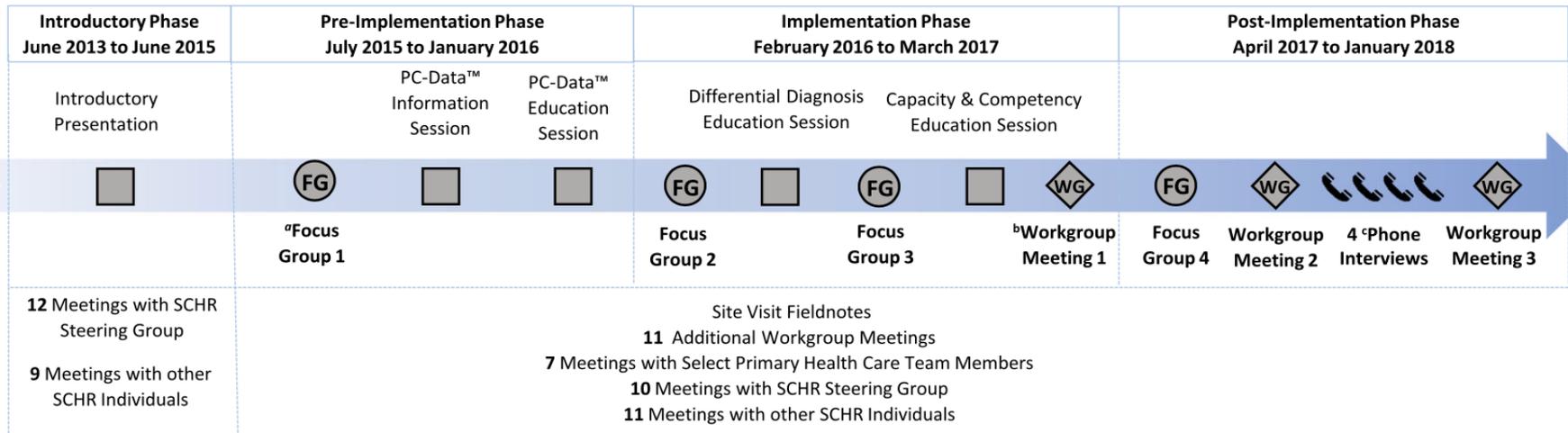
Introduction

The expanding field of implementation science reflects increasing awareness that many innovative pilot programs have failed to have a significant impact because of challenges in sustainability and scaling up [1]. Early efforts to address this research-to-practice gap focused on understanding factors influencing suc-

Barriers and Facilitators to Memory Clinic Development and Implementation

Methods

- Qualitative longitudinal process evaluation (2015 to 2018)
- Data collection and analysis guided by the Consolidated Framework for Implementation
- Focus groups, workgroup meetings, interviews, fieldnotes



Note. SCHR = Sun Country Health Region, PC-DATA™ = Primary Care – Dementia Assessment and Treatment Algorithm

^aFocus Groups (4). Participants included primary health care (PHC) team (nurse practitioner, three family physicians, occupational therapist, home care nurse), Alzheimer Society First Link Coordinator, regional electronic medical record (EMR) manager, regional managers of PHC, community health services, home care, and chronic disease care. Four focus groups were conducted (mean duration = 70 minutes, range = 40-120 minutes; number of participants: range 7-16).

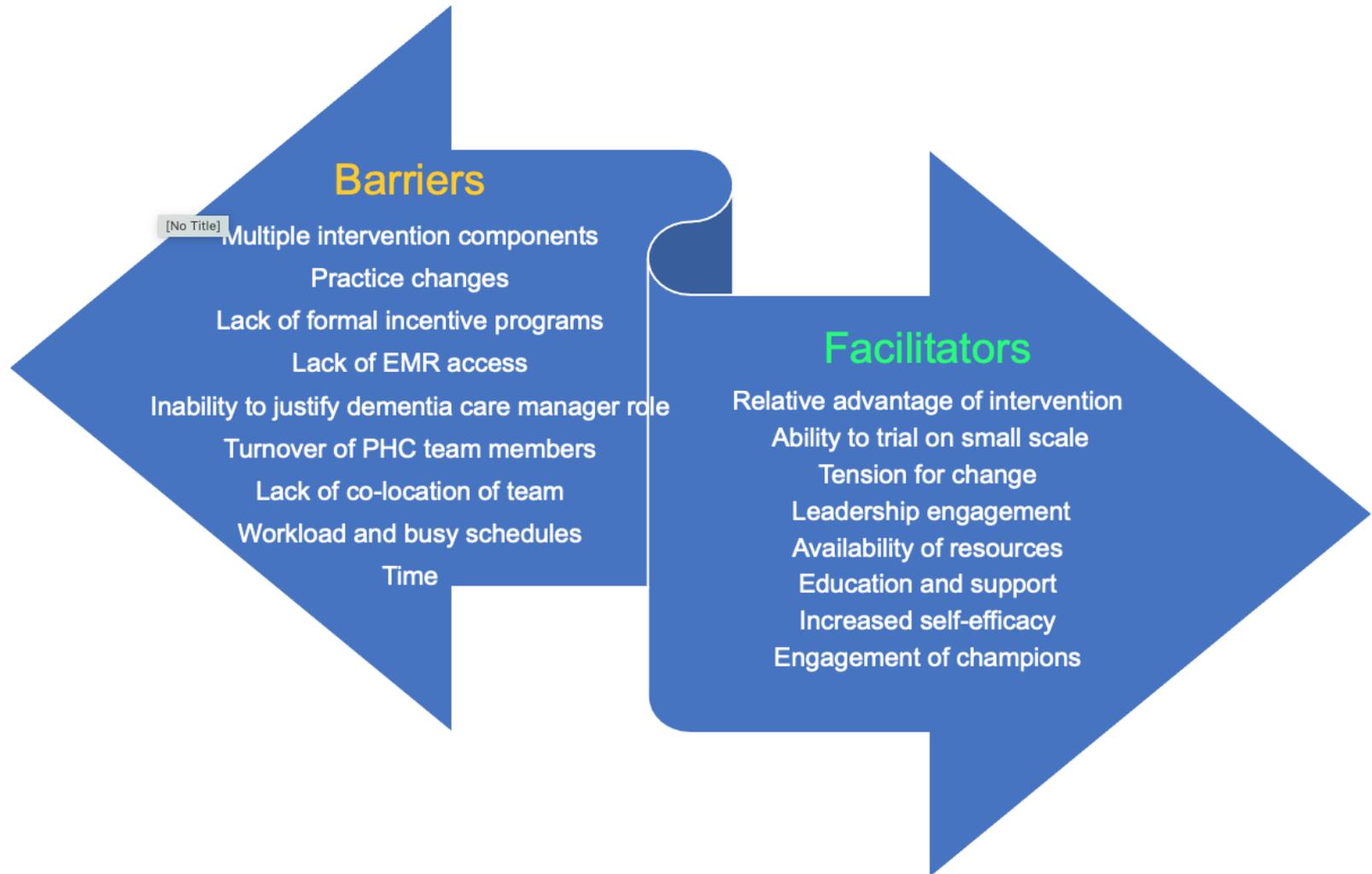
^bWorkgroups (3). Self-selected participants included PHC team health care providers (nurse practitioner, occupational therapist, home care nurse), PHC team facilitator, regional EMR manager, First Link Coordinator. Three Workgroup meetings were recorded and transcribed (mean duration = 73 minutes, range = 52-110 minutes; number of participants: range 7-8).

^cIndividual telephone interviews (4) were conducted with Workgroup members.

Fig. 3 Data Collection Timeline

Barriers and Facilitators to Memory Clinic Development and Implementation

Results



Source: Morgan et al. 2019. Barriers and facilitators to implementation of a rural primary health care intervention for dementia. 2019. *BMC Health Services Research*, October; 19: 709.



Factors influencing sustainability and scale-up of primary healthcare memory clinics: Perspectives of clinic team members

Sustain and spread

- Positive outcomes for patients & families
- Well-developed clinic processes/tools
- Clinic champion/engaged confident leader
- Facilitation & problem-solving support
- Organizational & leadership support

Sustain

- Team passionate and engaged
- Continuity of team members
- Positive outcomes for team members

Spread

- Sustained, successful pilot clinic
- Teams with interest, capacity, resources
- Shadowing & mentoring opportunities

Current rural memory clinic research

Sustaining Sustaining existing primary health care memory clinics

Spreading Spreading/ scaling up to other sites in Saskatchewan

Measuring Measuring impact of the clinics for patients, families, and team members



RaDAR Projects

Evaluating strategies to sustain & spread**

Patient and family experiences

Care partner service needs

Patient quality of life and service needs

Team perceptions of RaDAR education sessions**

Evaluation of Kipling Active Living Program

Environmental scan of community programs

ASOS First Link Coordinator role



**Published



Patient and Family experiences

- Rural-based local clinic is important for comfort and convenience
- Feel heard, supported, and at ease
- Appreciate team expertise, interprofessional format, professionalism, sensitivity, and understanding
- Informative about patient's condition, supports/services, and planning



Dr. Melanie Bayly
Lead

“Because of the distance that my parents need to travel to their physician, it also made it convenient, right, that we could just do all of that at once. And I would think folks in similar situations might feel the same way ... to be able to have all of those touchpoints at the same time, was very positive.” (Care partner)



Team member perspectives



“...these patients know us so they’re **comfortable** being ([team members]). They know all the people that are sitting around **helping them make decisions**. I think it’s less intimidating for them...At least we’re not sitting here trying to figure out what to do with our family, right? And the **travel** – the travel is huge. You know, they’re in their own small town, relatively, close to the town.” *(Team member)*



“The main thing that I’ve noticed ... was the **caregiver’s relief, gratitude, appreciation**. Feeling like they’re not alone, that now they’ve got team members, they’ve got people to go to...Just **relieving that kind of feeling of isolation** and – they come in feeling very overwhelmed and very concerned, not knowing what to do. And then **leave with something and with people to call.**” *(Team member)*



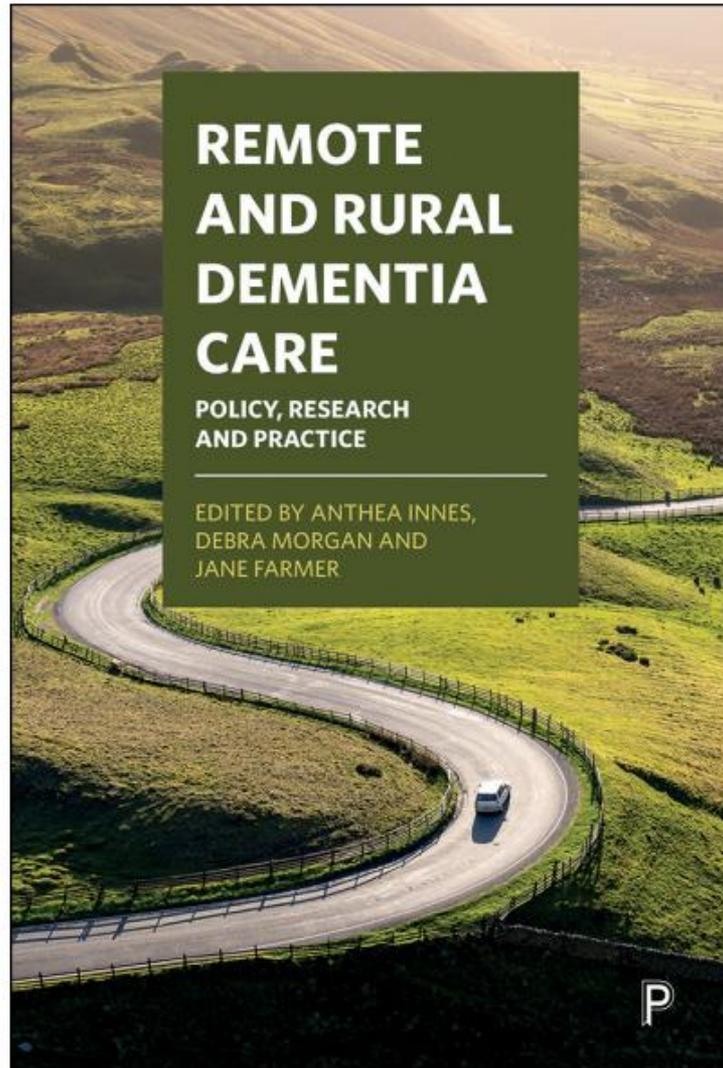
Perceptions and outcomes of an embedded Alzheimer Society First Link Coordinator in rural primary healthcare memory clinics

Themes: First Link Coordinator (FLC) Interviews

- **Benefits to patients and families of FLC involvement**
 - Meeting face-to-face establishes bond/relationship:
 - makes follow-up contacts more comfortable
 - opens the door to further support; family knows FLC is there to support them
- **Benefits to memory clinic and team members**
 - FLC fills a gap in providing emotional support, directing to services, etc
 - Other team members can focus on their unique contributions
 - Involvement allows team to see FLC role and benefits
- **Benefits to ASOS and First Link Program, and First Link Coordinators**
 - Relationships with team means FLC can refer other patients or contact team members about clinic pts
 - FLC involvement validates, raises awareness of role
 - Mutual learning among team members from different disciplines is rewarding

Analysis of E-Tapestry data (ASOS database)

- 127 clients referred to ASOS from Dec 2017 – Dec 2021 (42% spouses, 33% children, 17% PLWD, 8% other).
- Clients 62% female, 38% male; sex missing for 40%
- We compared memory clinic (n = 49), self (n = 25), and direct referrals from primary care professionals in the same area as the memory clinics (n = 53).
- **Statistically significant ($p < 0.05$) differences between memory clinic clients and self/direct referrals included:**
 - Memory clinic clients **contacted sooner after referral** than direct referrals (75% same day or within 3 days)
 - **Longer duration of first contact** for memory clinic clients (76% had 3-4 hour contact vs. 15-90 minutes)
 - **More in-person contacts** for memory clinic clients (85% vs. 15% for self-referral, 6% for direct referral)



- Co-editors: Anthea Innes, Jane Farmer, Debra Morgan (RaDAR Lead)
- Sections
 - Policy Drivers
 - Research Evidence
 - Practice Challenges
 - Living with Dementia
- The chapter “Rural Dementia Research in Canada” features the RaDAR program, including specialist RRMC and rural primary health-care memory clinics.



debra.morgan@usask.ca



RaDAR website:

www.ruraldementiacare.usask.ca

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