PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Assessing care models implemented in primary health care for persons with dementia : a mixed methods study protocol
AUTHORS	Vedel, Isabelle; McAiney, Carrie; Couturier, Yves; Pakzad, Sarah; Arsenault-Lapierre, Genevieve; Godard-Sebillotte, Claire; Sourial, Nadia; Simmons, Rachel; Bergman, Howard

VERSION 1 – REVIEW

REVIEWER	Amanda Leggett University of Michigan, United States of America
REVIEW RETURNED	03-Feb-2020

GENERAL COMMENTS	This proposed protocol is a huge undertaking and laudable effort by a clearly strong team. It will be a helpful protocol for other groups undertaking similar efforts. My main suggestions for revision/improvement involve increasing the clarity of wording in some places. In abstract and elsewhere the phrase “good quality of dementia care” is used but it reads as very non-specific. Could a concise operational definition be provided? The strengths and bullets may come at the end of text, but as presented they were upfront and as such I found the second bullet to be unclear and also the “collCM” acronym had yet to be defined. The first sentence of the introduction is a very non-specific opening- I think the second sentence is a better start and dementia can defined there. Page 5 line 31- should it read health promotion? Page 5 line 34- is primary healthcare the same as a primary care team/outpatient medical providers? Page 6- there is some weird spacing in the top paragraph of this page Page 6 line 15- the FMG acronym has previously been defined but the FHT has not- please define. Page 6 line 30- should it read dementia “care” strategies? Site selection- it sounds like quote sampling? Are the chosen sites representative of all types of collCM and levels of implementation? Why was 75 years and older the chosen age cut-point? It might help in Table 1 notes or column heading to list the supplementary table where items are described for each type of variable or provide a couple of sample questions. Page 18 line 15- reads “Physicians will identify patients who are capable to participate”- are they selecting only early stage dementia patients or how is this determination made? The authors might provide some short definitions of some of the qualitative terminology that all readers may not be familiar with (e.g. triangulation). The authors describe a very specific protocol for what themes they

	will be looking for within the data, but I wondered if the researchers would let any themes emerge from the qualitative data? Sometimes interesting findings can come from qualitative data that were not anticipated.

REVIEWER	Jill Manthorpe NIHR Policy Research Unit on Health and Social Care Workforce Policy Institute at King's King's College London UK The reviewer is a co-applicant on the UK Alzheimer's Society funded Pri-Dem study
REVIEW RETURNED	29-Feb-2020

GENERAL COMMENTS	Thank you for explaining your interesting study which I am sure will develop new knowledge for Canada and internationally. It is addressing timely questions about service re-design and professional practice. You may wish to add more to the key words, eg collaborative care. And the date of the study could be included in the Abstract and reinforced in the text. Under PPI you refer to 'heavily' engagnng them - that might be better expressed as 'substantial'. It was interesting to read of your cut off of patients by age, 75 years and over and some explanation of this might be helpful and reflection on what this might mean to the data. Reference is made on page 13 to the intention to mail the organisations' and the clinicians' questionnaires in 2017-18 - presumably this has been done? I was not clear of the dates of the implementation study and its stages, as I see on page 17 that interviews will be conducted in 2017 and 2019 - have these been done? Part of the Ethics section on page 19 seems a repeat - this could be checked. Reference is made on page 21 to 'different jurisdictons' - does this mean the jursidictions of Canada or more widely? Finally in Supplemental File number 2, the example of questions in the organisational questionnaire are helpful - but could say if they are being completed by pre-selected options or free text. Thanks for the opportunity to read about your ongoing study.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1
Reviewer Name: Amanda Leggett
Institution and Country: University of Michigan, United States of America Please state any competing interests or state ‘None declared’: None declared

This proposed protocol is a huge undertaking and laudable effort by a clearly strong team. It will be a helpful protocol for other groups undertaking similar efforts. My main suggestions for revision/improvement involve increasing the clarity of wording in some places.

> We thank the reviewers for this very positive encouragement! We have reviewed your comments below and are now confident that your concerns have been addressed and that our manuscript is now improved. Below, we have answered your comments and suggestions and we have indicated where in the manuscript our answers have been addressed.

1. In abstract and elsewhere the phrase “good quality of dementia care” is used but it reads as very non-specific. Could a concise operational definition be provided?

Thank you for this opportunity clarify our definition of good quality of care for dementia. We developed a score to measure the quality of dementia care, which is based on recommendations and guidelines by organizations such as the Canadian Consensus Conference for the Diagnosis and Treatment of Dementia and Assessing Care for Vulnerable Elders (ACOVE) project. The good quality of dementia care is a measurement of the application of these guidelines in practice. We have made this more explicit throughout the manuscript.

2. The strengths and bullets may come at the end of text, but as presented they were upfront and as such I found the second bullet to be unclear and also the “collCM” acronym had yet to be defined.

   The “strengths and limitations” section is instructed to come after the abstract, thus unless the editors agree with the reviewer we will leave this section where it is. However, we have made sure to clarify what collaborative care model (collCM) means in this section (p. 3 line 57).

3. The first sentence of the introduction is a very non-specific opening- I think the second sentence is a better start and dementia can defined there.

   We have made the suggested changes in our introduction (p4, line 79-81).

4. Page 5 line 31- should it read health promotion?

   Thank you for pointing out this issue. We have revised our manuscript (p. 4, line 92; p. 5, line 109-110).

5. Page 5 line 34- is primary healthcare the same as a primary care team/outpatient medical providers?

   Indeed, we meant to say primary healthcare team. We have corrected this sentence in the manuscript (p. 5, line 114).

6. Page 6- there is some weird spacing in the top paragraph of this page Page 6 line 15- the FMG acronym has previously been defined but the FHT has not- please define.

   Indeed, we have now spelt out the acronym in the manuscript (p. 5 line 113).

7. Page 6 line 30- should it read dementia “care” strategies?

   Thank you for pointing out this confusion. Collaborative care models were implemented at different levels of jurisdictions in Canada, including the Dementia Strategy in Quebec. However, collaborative care models are not necessarily Dementia Strategies, so we have clarified what we mean by collaborative care model in the introduction (p. 5, lines 101-102; Supplemental File 1).

8. Site selection- it sounds like quote sampling? Are the chosen sites representative of all types of collCM and levels of implementation?

   While it was not possible to choose sites that were representative of all collCM, we used a purposive sampling strategy aimed at increasing the diversity of collCM seen in Canada. We also made sure to select sites at all levels of implementation, with some collCM that have been implemented for several years and others that have just begun their implementation. We have modified our methods section to reflect this (p. 8, line 160).

9. Why was 75 years and older the chosen age cut-point?

   We chose to select patients 75+ as opposed to a younger population (e.g. 65+) given the higher prevalence of dementia among 75-84 (44%) versus 65 to 74 (18%) (Canadian Study of Health and Aging Working Group, 1994 CMAJ). This ensured that a greater number of eligible charts of older patients with dementia would be identified to assess detection, diagnosis and management of dementia. We have clarified this in the methods (p. 8, lines 172-173).

10. It might help in Table 1 notes or column heading to list the supplementary table where items are described for each type of variable or provide a couple of sample questions.

    We now have cited these resources in the table, where the full questionnaires can be accessed. We also added the names of the domains in each of the questionnaires (Table 1).

11. Page 18 line 15- reads “Physicians will identify patients who are capable to participate”- are they selecting only early stage dementia patients or how is this determination made?

    We did not specify that patients needed to be in the early stage because we believe that patients, where capable, should be provided with opportunities to participate in research if they would like to. That said, it is likely that physicians identified patients in the earlier stages of dementia. The determination of who was able to participate was done based on the physician’s clinical expertise and knowledge of the patient. A primary concern for us was not doing harm or adding burden to a patient and/or their caregiver. Thus, we asked physicians to identify patients for whom participation in the study would not be determinantal (e.g., it would not be stressful or anxiety provoking for them to participate). We have revised the manuscript to clarify this (p. 19, lines 338-341).

12. The authors might provide some short definitions of some of the qualitative terminology that all readers may not be familiar with (e.g. triangulation).

    We have revised the manuscript to explain triangulation and how it is being used in this study (p. 21, lines 381-385).

13. The authors describe a very specific protocol for what themes they will be looking for within the data, but I wondered if the researchers would let any themes emerge from the qualitative data? Sometimes interesting findings can come from qualitative data that were not anticipated.

    Thank you for this comment. While there are specific things we are interested in learning from the qualitative data, we are also open to new themes that might emerge as we undertake the analysis.

Reviewer: 2
Reviewer Name: Jill Manthorpe
Institution and Country: NIHR Policy Research Unit on Health and Social Care Workforce, Policy Institute at King's, King's College London, UK

Thank you for explaining your interesting study which I am sure will develop new knowledge for Canada and internationally. It is addressing timely questions about service re-design and professional practice.

We want to thank the reviewer to take the time to give us their comments. We are confident that our manuscript is now improved. Please see our answers to your comments below. We have indicated where these modifications are reflected in the manuscript.

1. You may wish to add more to the key words, eg collaborative care.

Thank you for this helpful comment. See our answer to Reviewer 1 comment 2. In addition, we have included a new additional file which describes the elements of a collaborative care model (Supplemental file 1).

2. And the date of the study could be included in the Abstract and reinforced in the text.

We have specified the date of data collection in our abstract and also clarified this information in the text and in table 1. We also added a table to describe the timeline of data collection (table 2).

3. Under PPI you refer to 'heavily' engagnng them - that might be better expressed as 'substantial'.

We thank the reviewer for this suggestion. See the answer to your comment 7.

4. It was interesting to read of your cut off of patients by age, 75 years and over and some explanation of this might be helpful and reflection on what this might mean to the data.

Please refer to our answer to Reviewer 1's question 9 above.

5. Reference is made on page 13 to the intention to mail the organisations' and the clinicians' questionnaires in 2017-18 - presumably this has been done?

We thank the reviewer for this comment. We have reviewed our entire manuscript and corrected tenses where appropriate.

6. I was not clear of the dates of the implementation study and its stages, as I see on page 17 that interviews will be conducted in 2017 and 2019 - have these been done?

We agree that this was confusing, so we have corrected the abstract and the text. We have also added a table to clarify the timeline. Please see our response to your comment 2.

7. Part of the Ethics section on page 19 seems a repeat - this could be checked.

This has been corrected in the main document (p. 7, lines 148-50).

8. Reference is made on page 21 to 'different jurisdictons' - does this mean the jursidictions of Canada or more widely?

Indeed, we meant Canadian jurisdictions. We have clarified this throughout our manuscript.

9. Finally in Supplemental File number 2, the example of questions in the organisational questionnaire are helpful - but could say if they are being completed by pre-selected options or free text.

All our questionnaires are now published or accepted. We have removed the appendices and put references in the manuscript where appropriate.

VERSION 2 – REVIEW

REVIEWER	Amanda Legget University of Michigan, United States of America
REVIEW RETURNED	08-Apr-2020

GENERAL COMMENTS	I think this paper will make a strong contribution to the field. I have just two very minor editorial type comments: 1. Page 13 line 231-232: Should questionnaires be possessive here as in questionnaires' four domain scores 2. Page 14 line 237 might state "described in a published report" or something like that.