

Article

Implementation of the Memory Support System for Individuals with Mild Cognitive Impairment: A Feasibility Survey Study

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Abstract

Background/Objectives: Mild Cognitive Impairment (MCI), a condition between normal aging and dementia, is characterized by cognitive changes that do not significantly affect instrumental activities of daily living. The Memory Support System (MSS), an evidence-based behavioral intervention developed by the Mayo Clinic, has been shown to aid those living with MCI and their support partners in coping with cognitive challenges. However, the MSS has not been offered clinically within the Canadian context. Therefore, we conducted a study assessing the feasibility of the MSS from the perspectives of individuals living with MCI and their support partners. **Methods:** Participants from an institutional registry of research participants, patients, and support partners at a memory clinic, as well as members of a local Dementia Society, were approached to complete an online or paper version of a survey assessing feasibility dimensions. Responses were compared between and within groups for differences in mean scores and associations between linked binary choice response questions. **Results:** A total of 77 responses were received; 39 surveys were completed by participants with MCI, and 38 by support partners. Respondents found the MSS to be acceptable and practical. On average, participants thought it would be more difficult to train in using the MSS than support partners. Both groups expressed interest in the intervention. On average, participants with MCI and support partners preferred virtual MSS training to in-person and indicated more interest in participating in training over six weeks as compared to two weeks. **Conclusions:** Flexibility in duration and format when offering the MSS are important considerations when offering the intervention as part of a clinical program. Future research should evaluate cost-effectiveness (e.g., financial, staff resources, etc.) of the MSS approach if it were to be institutionalized in the Ontario healthcare system.

Keywords: mild cognitive impairment; cognitive rehabilitation; patient-centered care; patient preferences; behavioral intervention; memory aid; caregivers



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1. Introduction

Alzheimer's Disease (AD) continues to have a significant burden on Canadian society, with an estimated 750,000 people currently living with AD or other forms of dementia [1].

With the number of individuals living with dementia in Canada projected to exceed 1.7 million by 2050, continuing to pursue treatment possibilities for AD remains a priority for the Canadian government, as evidenced by the commitment to a national dementia strategy [2]. As with most chronic conditions, there is a progression from normal aging to AD or other dementias. Within this continuum, mild cognitive impairment (MCI) represents objective deficits in one or more cognitive domains without a significant impact on instrumental activities of daily living (IADLs) such as driving, grocery shopping, managing appointments, and cooking [3]. Additionally, individuals with MCI may face challenges in several other areas including, but not limited to, emotional state, psychological, social engagements, legal, and financial implications [4].

MCI represents a critical juncture for intervention due to the potential for delaying or preventing progression to more severe cognitive impairment, improving current cognitive function, maintaining independence, enhancing psychological well-being, and potentially reducing the overall burden of dementia care [5]. Although there are no approved pharmaceutical treatments for MCI in Canada [6], there are non-pharmacological interventions that can assist those with MCI. Particularly, cognitive interventions that are memory-focused appear effective at assisting individuals with MCI [7]. One such intervention is the Memory Support System (MSS).

A component of the HABIT Healthy Action to Benefit Independence & Thinking[®] program offered by the Mayo Clinic, the MSS is a pocket-sized calendar and note-taking system consisting of three core sections: (a) scheduled events and appointments, (b) a to-do list, and (c) a journal. The MSS training has been shown to aid individuals with MCI in terms of IADLs, self-confidence about their memory, adherence to the MSS calendar, and improving quality of life and mood of their support partners [8]. Furthermore, participants trained to use the MSS have been shown to have improved adherence, memory-based activities, and self-efficacy compared to controls [9]. Also, support partners in MSS-trained groups have demonstrated improved depression scale scores with stable anxiety scale scores compared to controls that worsened in both scales [10]. Although the MSS is currently being utilized clinically in several settings across the U.S., it has not been introduced yet in the Canadian context. Therefore, this study examines the feasibility of providing the MSS intervention in a memory clinic in Eastern Ontario.

2. Materials and Methods

2.1. Study Design

This study is part of a larger pre-post intervention project that examines the feasibility of providing the MSS for individuals with MCI and the efficacy outcomes of the MSS in a Canadian clinic setting. For this paper, we present results from a feasibility study survey completed prior to the intervention phase. As such, we designed an open-cohort, unmatched, and unpaired survey feasibility study following the feasibility study design framework proposed by Bowen et al. [11]. The feasibility framework described by Bowen et al. describes eight domains that should form the primary focus of feasibility studies aiming to investigate whether interventions should undergo further testing [11]. The framework has been widely utilized within similar fields of research or settings to that of our work; examples include a recent study of the feasibility of implementing a post-diagnosis information and support program for dementia/MCI dyads [12] or the usability of a digital diagnosis support tool in memory clinics [13]. Grounded in the dimensions considered in this framework, the surveys were designed to examine the acceptability, demand for, and practicality of the MSS. All participants provided informed consent before participating in the study. The study was approved by the Bruyère Health Research

Ethics Board as study number M16-23-024 024 and registered at clinicaltrials.gov as study ID NCT05999929.

2.2. Sample and Data Collection

To be eligible for this study, participants had to be fluent in English and had to self-declare that they were either diagnosed with MCI (referred to as “participant” henceforth) or were a support partner (i.e., family member, friend, caregiver) to a person with MCI; the former completed the participants’ version of the survey, and the latter completed the partners’ version of the survey. All respondents who provided informed consent were eligible to complete the survey.

Potential participants were approached to complete the survey in several ways. Recruitment flyers were put up in waiting areas at Bruyère Health in the Memory Clinic and Geriatric Day Hospital for patients with MCI and their support partners to access the survey following an electronic link or scanning a QR code. Electronic versions of the recruitment flyers were included in newsletters regularly sent out by The Dementia Society of Ottawa and Renfrew County. Healthcare professionals at Bruyère Health, mostly from the memory clinic, shared study flyers with potential participants and provided either a paper copy, if preferred, or an electronic link to the survey. Additionally, individuals previously enrolled in a research patient registry at Bruyère Health with a confirmed diagnosis of MCI were contacted via telephone and email. Their support partners were also invited to complete the survey through the same communication channels used for these individuals.

2.3. Survey

The electronic version of the survey was hosted by SurveyMonkey® (SurveyMonkey Inc., San Mateo, CA, USA). All responses were collected, stored, and encrypted within the SurveyMonkey platform. Paper copies were secured via a locked box only accessible to the research team located on-site at Bruyère Health. The survey went through several rounds of development, refinement, and pilot testing by field subject experts. Respondents were provided with a link to complete the survey or were able to scan a QR code on the recruitment flyers. The survey was anonymous and was active for one year. Participant consent was obtained through a mandatory survey consent question that followed a research informed consent form statement; a negative answer to this question excluded the respondent from answering further questions.

Survey questions followed best practices in survey research [14], and were designed to seek information from respondents with respect to three main areas: demographics, memory compensation/assistance tool usage, and opinions on the MSS. To seek opinions on the MSS, respondents were provided with a short description of the MSS and its training. Then, questions adapted from a framework designed to assess healthcare intervention acceptability, known as the Theoretical Framework of Acceptability (TFA) [15], and previous work on willingness to participate in clinical research [16] were posed to respondents. These guided our work as they enabled us to create questions specific to our research objectives. Furthermore, TFA-guided surveys have been utilized within populations living in similar areas to that of our study population [17] and within populations with similar cognitive challenges [18]; this also applies to the willingness to participate questions in the survey; [16]. Questions seeking opinions on the MSS used a 5-point Likert-type scale (“1 = Strongly disagree/Very unlikely” to “5 = Strongly agree/Very likely”). Questions were closed-ended and multiple-choice, with open-ended responses available only when selecting ‘other’ as a response.

2.4. Data Analysis

All statistical analyses were completed in R v3.4.4 statistical software (R Foundation for Statistical Computing, Vienna, Austria); statistical significance was reported at 5% significance level. Non-parametric statistical tests were utilized for ordinal data and non-normally distributed data determined via Shapiro–Wilk normality tests. The Wilcoxon signed-rank test (for matched pairs) or Wilcoxon rank sum test (unmatched pairs) was utilized for assessing statistical significance for within- and between-group differences in median response, respectively. Spearman rank correlation coefficient was used for assessing associations between variables of linked questions with the MSS training format (i.e., virtual or in-person) and duration (i.e., two or six weeks) within groups. Median household income (in Canadian dollars) and age were estimated via an approach that incorporates frequency distributions for grouped data [19].

3. Results

There were 86 survey responses, but not all surveys were complete. Nine surveys did not meet the inclusion criteria, as respondents indicated that they were neither diagnosed with MCI nor were they a support partner of an individual with MCI. Therefore, there were 77 usable surveys; 39 surveys were completed by individuals with MCI, and 38 surveys were completed by support partners. However, not all sections were completed by each participant which resulted in slightly varied response totals. Included surveys had responses completed for at least one of the three main areas assessed (i.e., demographics, memory compensation/assistance tool usage, and opinions on the MSS). The demographic characteristics of participants with MCI and support partners are shown in Table 1.

Table 1. Demographic characteristics of study population.

	Participants (<i>n</i> = 37, (%))	Support Partners (<i>n</i> = 34, (%))
Sex		
Male	20 (54)	10 (29)
Female	17 (46)	24 (71)
Age		
35–44	0 (0)	1 (3)
45–54	0 (0)	3 (9)
55–64	7 (19)	8 (24)
65–74	15 (41)	14 (41)
75–84	13 (35)	6 (18)
85 or older	2 (5)	2 (6)
Education		
Less than high school	3 (8)	0 (0)
High school diploma	6 (16)	7 (21)
College/CEGEP/Trade school	8 (22)	8 (24)
Bachelor's degree	7 (19)	10 (29)
Master's degree	8 (22)	4 (12)
Professional/doctorate degree	2 (5)	4 (12)
Other	3 (8)	1 (3)
Median Household Income (\$)	85,000 (<i>n</i> = 31)	110,000 (<i>n</i> = 26)

Respondents with MCI were almost evenly split in terms of sex, whereas approximately two-thirds of support partner respondents were female. Median age was estimated to be 72.7 years old and 68.6 for participants and support partners, respectively, with a range of 65–74 years. Most participants had attained post-secondary education (76%), and

a slightly higher proportion of respondents had completed (79%) post-secondary education. Median household income was estimated to be \$85,000 for participants and \$110,000 for support partners.

Table 2 shows responses on the memory aid strategies used by an individual with MCI. For both groups of respondents, the three most common techniques included making lists on paper (e.g., lists of grocery items), using a physical calendar at home, and asking someone to remind them.

Table 2. Prevalence of memory aid strategies used by individuals with MCI.

Memory Aid Strategy	Participants (n = 39, (%))	Support Partners (n = 35, (%))
Asking someone to remind you/them	24 (62)	22 (63)
Journal/personal organizer/diary to recall things you/they have done in the past or scheduled events in the future	24 (62)	13 (37)
Calendar on a wall, a refrigerator, or a table at home	26 (67)	23 (66)
Making to-do lists on paper (e.g., grocery list)	29 (74)	25 (71)
Making to-do lists electronically (e.g., on a smartphone or tablet)	13 (33)	8 (23)
Using a notebook to note down things to remember	15 (38)	7 (20)
Writing things to remember on post-it notes	18 (46)	11 (31)
Setting electronic reminders on your/their smartphone, computer, or tablet	15 (38)	8 (23)
Taking pictures of events you/they want to remember	11 (28)	3 (9)
Recording reminders on a Dictaphone or voice recorder	1 (3)	0 (0)
Setting reminders on a clock, watch, or alarm clock	13 (39)	5 (14)
Using an electronic calendar to keep track of your/their schedule (e.g., smartphone/laptop/computer calendar, Google calendar, Microsoft Outlook)	20 (51)	10 (29)
Writing on your hands	1 (3)	0 (0)
Other (e.g., Student Planner)	1 (3)	3 (9)

Table 3 presents data on home internet access and calendar use of individuals with MCI, alongside reports from their support partners regarding the individuals with MCI's habits. All but one respondent reported having home internet access. Among those with MCI, smartphones were the most-used devices for internet access, followed by desktop/laptop computers, and tablets. Support partners' reports on participants' device use showed similar trends with slightly different percentages, though they reported that desktop computers were slightly more favored than smartphones. For calendar use, electronic calendars were the most prevalent type used by participants, followed by wall calendars, notebook agendas/planners, and table calendars. Support partners' reports indicated that wall calendars were most common, followed by electronic calendars, notebook agendas/planners, and table calendars. Among those using electronic calendars, 12 of 23 participants and 8 of 15 support partners indicated use of at least one of the other types of calendars alongside electronic calendars.

Table 4 shows the perspectives of both groups on the MSS and its training across domains of acceptability, practicality, and demand. Both participants and support partners reported generally positive perceptions across most acceptability items, indicating comfort in training/assisting training, belief in cognitive improvement, confidence in training completion, and anticipation of more benefits than drawbacks. For the practicality dimensions, opinions remained moderately positive, particularly regarding committing to 12 one-hour visits. In terms of demand, virtual training and a six-week format were slightly favored over in-person and two-week formats, respectively, although mean scores remained in the moderately positive range for all demand items. Notably, support partners reported signifi-

cantly lower scores (more positive perception) than participants regarding the difficulty of training/assisting training in using the MSS.

Table 3. Internet access at home and calendar use of individuals with MCI.

	Participants (<i>n</i> = 39, (%))	Support Partners (<i>n</i> = 35, (%))
Home internet access	38 (97)	35 (100)
Electronic devices used for internet access		
Smartphone (e.g., iPhone, Samsung Galaxy)	32 (82)	25 (71)
Desktop computer or laptop	25 (64)	27 (77)
Tablet (e.g., Apple iPad, Samsung Galaxy Tab)	13 (33)	17 (49)
Other	2 (5)	0 (0)
Calendar Use		
Wall calendar	18 (46)	21 (60)
Table calendar	7 (18)	6 (17)
Notebook agenda/planner/calendar	9 (23)	8 (23)
Electronic calendar (e.g., calendar on your smartphone/laptop/computer, Microsoft Outlook, Google Calendar)	23 (59)	15 (43)

Table 4. Opinions on the acceptability, practicality, and demand for the MSS and MSS training.

Concept	Domain	Participant (<i>n</i> = 37)	Support Partners (<i>n</i> = 32)
Comfort in training/assisting training to use the MSS	A	3.70	4.03
Training/assisting training to use MSS would be difficult ‡	A	2.59	2.03 *
Training/assisting training to use MSS likely to improve cognitive issues	A	3.86	3.72
Training/assisting training to use MSS will interfere with other priorities ‡	A/P	2.11	2.16
Confident in completing (participant)/assisting with completing (support partner) MSS training	A	3.97	4.25
I would experience more benefits than drawbacks if I (participant)/the participant (partner) were to participate in MSS training	A/P	4.00	3.78
Committing to 12 one-hour visits	P	3.65	3.69
In-person MSS training	D	3.14	3.53
Virtual MSS training	D	3.51	3.72
Two-week format	D	3.16	3.06
Six-week format	D	3.32	3.59

* $p < 0.05$. ‡ indicates questions that are reverse-scored, where a higher score indicates a more negative response. A: acceptability, P: practicality, D: demand. Questions were rated on a 5-point Likert-type scale from 1 = Strongly disagree/Very unlikely to 5 = Strongly agree/Very likely.

To examine the preferences in the format (i.e., two or six weeks) and method of training (i.e., in-person or online) for the MSS, the correlation between the two choices was examined via spearman rank correlation coefficient testing. Table 5 shows a statistically significant, moderately positive correlation between preferences for two-week and six-week training durations for both participants and support partners. This suggests that participants and support partners who assigned high (or low) ratings to one duration tended to assign similarly high (or low) ratings to the other, with no evident preference between the two

durations. In contrast, no significant correlations were found for virtual versus in-person training formats, indicating that preferences for training formats (virtual vs. in-person) were unrelated for both groups.

Table 5. Testing for potential association between options for MSS training duration and format.

Duration/Format Options (P)	Participant (n = 37)	Support Partner (n = 32)
Two weeks vs. six weeks	0.492 **	0.497 **
Virtual vs. In-person	0.155	−0.265

** *p* < 0.01. *P*: Spearman correlation coefficient.

4. Discussion

This study provides initial insights into the feasibility of implementing the MSS for individuals with MCI and their support partners in a Canadian memory clinic setting. Our survey, designed to assess acceptability, practicality, and demand, reveals a generally positive attitude towards the MSS among participants and support partners. These findings are particularly relevant given the increasing prevalence of MCI and dementia in Canada [1,2], as well as the recognized need for effective, non-pharmacological strategies to support individuals with MCI in maintaining independence and quality of life [7,20].

The demographic profile of our sample largely mirrors that of typical MCI and support partner populations reported in the literature [21,22]. The balanced gender representation among individuals with MCI, despite the slightly higher risk of MCI in men [23] but a greater prevalence of dementia in women [2], likely reflects recruitment through a memory clinic setting where both genders are actively seeking support. The higher proportion of female support partners aligns with established caregiving demographics [21,24], underscoring the crucial role women play in supporting individuals with MCI. The median income [25] and education levels [26] of both groups are also consistent with contemporary Canadian trends, enhancing the generalizability of our findings to similar urban and semi-urban Canadian populations.

A key finding is the overall positive acceptability and practicality ratings of the MSS and its training by both individuals with MCI and their support partners. Mean scores consistently hovered around “Agree” for positive acceptability items, suggesting a willingness to engage with the intervention and its perceived potential benefits. Notably, support partners perceived the MSS training as significantly less difficult than for individuals with MCI. This difference warrants further exploration. It may reflect support partners’ reduced appreciation of the cognitive ability and effort required by the individual with MCI to integrate the new memory strategy. In an earlier study of the MSS, where individuals were randomized to receive training to use the MSS versus learning to use it on their own, after 6 weeks, only 17% were able to demonstrate good use of the MSS on their own, whereas nearly all trained participants (94%) demonstrated good use by the end of training [8]. Frequently, partners have not engaged in complex learning tasks with their loved one since the diagnosis of MCI and are not fully aware of how challenging such a task can now be for them. From a clinical implementation perspective, this highlights the importance of tailoring training approaches to address the specific needs and perceived challenges of both members of the dyad, ensuring that individuals with MCI feel adequately supported and empowered throughout the learning process.

The MSS intervention was developed with evidence-based principles and uses training stages from learning theory [27] to rely on procedural memory, which is generally preserved in individuals with MCI compared to more significant declarative memory impairments [28]. Although individuals with MCI who are unfamiliar with the MSS intervention may have concerns about its learning curve, the successful implementation of

MSS training at multiple U.S. sites and its favorable outcomes [8] support the ability of individuals with MCI to learn how to use it. The consistently positive practicality ratings, particularly regarding commitment to 12 one-hour visits, suggest that the time investment required for MSS training is perceived as manageable within the context of existing healthcare commitments, a crucial factor for intervention uptake in busy clinical settings.

Regarding demand, the subtle preference for virtual training over in-person sessions, while not statistically significant in between-group comparisons, aligns with broader trends in healthcare delivery and patient preferences, particularly during the post-pandemic period [29]. Virtual formats offer increased convenience, reduced travel burden, and potentially mitigate stigma associated with attending in-person clinic appointments [30]. This preference underscores the potential of telehealth modalities to enhance accessibility and reach for cognitive interventions, especially in geographically diverse regions like Eastern Ontario. The slight preference for a six-week training duration over a two-week format, coupled with the moderate positive correlation between these preferences, suggests a nuanced understanding of training intensity. While the correlation might initially suggest a lack of clear distinction between durations, the divergent views within both groups, as evidenced by the lack of strong within-group preference, point towards the importance of offering flexible training durations. This flexibility is crucial to accommodate individual learning styles, cognitive reserve, and the pace of integration of the MSS into daily routines. The absence of a definitive preference for a fixed duration reinforces the need for a patient-centered approach, allowing for individualized tailoring of training length based on ongoing assessment and progress. Data from our related pilot study that is currently ongoing will provide valuable information on whether providing the MSS training over six weeks offers similar benefits as the 2-week MSS training [8] to support the implementation of a more flexible approach. In addition, this related pilot study will provide results on measures such as program adherence, self-efficacy for memory, and others that will lend support to the implementation of the MSS in Canadian clinics.

The reported prevalence of memory aid strategies provides valuable context for MSS implementation. The widespread use of traditional paper-based methods (lists, calendars) and reliance on external reminders (asking others) aligns with established patterns of memory compensation in acquired brain injury [31]. However, the notable adoption of electronic calendars and reminders, particularly among individuals with MCI, signals a growing digital literacy and willingness to utilize technology for cognitive support, even within this older adult population. This trend is further supported by the high rates of home internet access and smartphone usage observed in our sample, exceeding national averages for older adults [32,33]. This suggests that the surveyed population may be more digitally engaged than anticipated, potentially facilitating the adoption of hybrid/virtual training for the MSS. Despite this, there remains strong current utilization of paper calendars (in the form of wall, table calendars, or agendas) within the study population as presented in Table 3. The discrepancy between individuals with MCI reporting higher electronic calendar use and support partners reporting higher wall calendar use warrants further investigation. It may reflect differing perceptions or perhaps a transition in progress, with individuals with MCI increasingly adopting electronic tools while support partners still observe and report on more traditional methods.

This study has several strengths, including its novel focus on the feasibility of MSS implementation within the Ontario healthcare context, the inclusion of both individuals with MCI and their support partners, and the use of a validated framework for assessing acceptability [11]. The anonymous survey design likely minimized social desirability bias, enhancing the authenticity of responses. However, limitations must be acknowledged. The cross-sectional survey design provides a snapshot of feasibility perceptions but does

not assess actual MSS implementation or effectiveness. Another limitation of this study is that the surveys utilized were not formally psychometrically evaluated. However, their development was guided by best practices in survey research and informed by previously administered and validated questionnaires, which helped to enhance their content relevance and clarity. The reliance on self-reported data introduces potential biases, and the sample size, while adequate for a feasibility study, limits generalizability to all Canadian MCI populations. Similarly, a slight bias towards digitally literate older adults in our recruitment strategy may have left out some of the approximately 15% of Ontario adults 65 years or older who are not internet users [34]. However, paper surveys were available as an option and were completed by 49% of participants with MCI and 39% of partners that completed surveys. The lack of dyadic data linkage prevents a direct comparison of perceptions within individual MCI–support partner pairs, which would offer richer insights into dyadic dynamics and intervention uptake. Furthermore, the study was conducted in Eastern Ontario; thus, cultural and regional variations in healthcare access and preferences may influence the generalizability to other Canadian regions. Additionally, addressing unique challenges in rural areas or areas with tighter resource constraints may also be required prior to implementation of the MSS.

Despite these limitations, our findings have significant implications for both clinical practice and future research. For clinical practice, the study supports the feasibility of offering the MSS in Canadian memory clinics. The reported acceptability, practicality, and demand, coupled with the preference for flexible training formats and durations, provide actionable guidance for implementation. Clinics should consider offering both in-person and virtual MSS training options and be prepared to tailor training duration to individual needs. Given the observed digital engagement, virtual training may be particularly appealing and should be actively promoted. Addressing the perceived difficulty of training for individuals with MCI through enhanced initial support will be important. Future qualitative research, including interviews with individuals with MCI, support partners, and clinicians, would provide deeper insights into the reasons behind training format and duration preferences, as well as to identify potential barriers and facilitators of MSS adoption in real-world clinical settings. Subsequent cost-effectiveness analyses would be essential to assess the economic viability of MSS implementation within the provincial healthcare system.

In conclusion, this feasibility survey provides initial evidence for the potential of the MSS to address the unmet needs of individuals with MCI and their support partners in Eastern Ontario. The findings indicate positive perceptions of acceptability, practicality, and demand, coupled with clear preferences for flexible training approaches, offer a foundation for the clinical implementation of this evidence-based cognitive intervention.

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Informed Consent Statement: Implied informed consent was obtained from all subjects involved in the study when they completed and returned the survey.

Data Availability Statement: The data presented in this study are available on request from the corresponding author due to privacy and ethics regulations.

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