Appendix 2

Table 1 - Reported citations concerning the themes and subthemes approached

APÊNDICE

A. Facilitators	
A.1. Individual level	
A.1.2. *Literacy*	"We have elderly people in their 70s, (...) who already have completely different computer literacy, who search for health resources much more quickly. We are able to work with these people in a much easier way (…). Family Health teams must also feel this difference according to geographic areas (...)." (*P1, primary care professional*)
A.1.3. *Awareness of cognitive decline*	"(…) because people are more aware and seek help, (...). (...)There are also more and more younger people who are aware of some warning signs and who are looking for this help." *(P8, primary care professional)*
A.2. Provider level	
A.2.1. *Behaviors and attitudes of healthcare professionals*	
A.2.1.1. Concerning the assistance of patients with cognitive complaints	"(...) we [General and Family Medicine Doctors] know the patient, we follow their life, (...) and we can see if there is a degradation in their cognitive state." (*P4, primary care professional*)
A.2.1.2. Concerning the use of referral criteria	"I think it is fundamental to timely identify the clinical cases of mild cognitive impairment. It is a priority. It will optimize the person's autonomy and functionality in their context, in their home, in their family, perpetuating the roles they play, (...)." *(P3, primary care professional)*
A.3. System level	
A.3.1. *Organizational context*	
A.3.1.1. At primary and secondary healthcare services	"(…) So, the real strong point is the communication that already exists and the coordination between the two levels of care." (*P7, primary care professional)*
A.3.2. *Research on cognitive decline*	"The local health cluster is committed to and has been developing and supporting projects in the field of dementia." (*P9, primary care professional*)
B. Barriers	
B.1. Individual level	
B.1.1. *Sociodemographic context*	"The doctor in the hospital does not know the patient's reality. We [Nurses] go home, know and come across situations, sometimes very complicated, in which all we have to solve are, essentially, social issues and very little on the neurological side (…). The patient does not have money for medication, nor to eat (...)." *(P2, primary care professional)*
B.1.2. *Literacy*	"(...) Around 98% of the patients I have in the group would not be able to use a computer. (...)They have no literacy, they are people with low education, some only have third grade. They have never had a computer at home, (...)." *(P5, secondary care professional)*
B.2. Provider level	
B.2.1. *Behaviors and attitudes of healthcare professionals*	
B.2.1.1. Concerning the assistance of patients with cognitive complaints	"Other difficulties that we can think of are the way we have to evaluate these people with possible mild cognitive impairment, the tools we have, and then refer to the appointment, whether they are suitable or not suitable (…)." *(P10, primary care professional)*
B.2.1.2. Concerning the use of referral criteria	"Although we [General and Family Medicine Doctors] know that referral criteria exist, we do not always consult them or ensure that they are met for referral. (…) at an early stage, I think it [the referral] does not always end up happening, (...). (...) we have to (...) do a whole study

	first which, if there is an initial suspicion, will not immediately be something to refer to Neurology in particular." *(P10, primary care professional)*
B.3. System level	
B.3.1. *Organizational context*	
B.3.1.1. At primary and secondary healthcare services	"(…) the number of professionals, given the number of patients, is not enough." (*P8, primary care professional)* "We have a lot of people registered who are not residents. We have tried to communicate with teams from other units and received no feedback." *(P2, primary care professional)*
B.3.1.2. At primary healthcare service	"We are talking about appointments that last 15 minutes. This is surreal! This is how long it takes for a patient who has mobility difficulties to sit and say: "Hello, good morning."" *(P11, secondary care professional)*
B.3.1.3. At secondary healthcare service	"(…) we have an average waiting time for an appointment [of Neurology] of one and a half years." *(P11, secondary care professional)*
B.3.2. *Research on cognitive decline*	"The local health cluster is committed to and has been developing and supporting projects in the field of dementia, but support has limits and resources are very limited." *(P9, primary care professional)*
C. Solutions	
C.2. Provider level	
C.2.1. *Behaviors and attitudes of healthcare professionals*	
C.2.1.1. Concerning the assistance of patients with cognitive complaints	"In my field of work, I add this issue of differential diagnosis and valuing patients´ cognitive complaints. Often, it is a condition of mental health, depression, anxiety, (...), with prolonged symptoms. Often, these complaints are not valued and, perhaps, if they are identified it may allow for a differentiated intervention." *(P6, secondary care professional)* "I think that having greater proximity between Neurologists and Primary Care Clinicians can be a differentiator, (...): the Primary Care Clinician has doubts and asks for a consultation for the Neurology department." *(P1, primary care professional)* "I think more training needs to be done (...), not only to Primary Care Clinicians and Family Nurses about the early detection of cognitive impairment, but also about the services that the local health cluster provides to follow the patients. (...) The healthcare teams need to forward immediately the patients to the services that can provide the support needed." *(P1, primary care professional)* "I think it is important, when making the referral, to include information about the caregiver. (...) If there is the inclusion of a reference person, a child, a neighbor, who can follow the patient, it will be much better. The truth is that at an early stage the person goes alone to the appointment. Much of the information is lost." *(P3, primary care professional)* "Having time to be with a colleague is important, to discuss a clinical case, which is not always easy by email. This type of personal coordination between professionals would add value and avoid many subsequent difficulties." *(P5, secondary care professional)*

C.2.1.2. Concerning the use of referral criteria	"I think that, when Primary Care Clinicians make the referral request, they must accurately justify the referral. (…) They have to make referrals assertively." *(P8, primary care professional)* "We have to decide what to do with the altered Mini Mental. Sending everyone to Neurology will not be the solution." *(P11, secondary care professional)*
C.2.2. *General performance of primary and secondary healthcare teams*	
C.2.2.1. Concerning prevention of cognitive decline due to dementia	"(…) implementation of a methodology, with the support of other elements, that could monitor the cognitive health of patients in general, from 65 years old onwards. I think this is what would allow us to diagnose mild cognitive impairment that was not in the appointment yet, or dementia that needed the appointment, or between mild cognitive impairment and mild dementia." *(P11, secondary care professional)*
C.2.2.2. Concerning prioritization of early diagnosis of cognitive decline due to dementia	"(…) The truth is that at an early stage the person goes to the appointment alone. Much of the information is lost. (...) I think there could be a strategy to maximize the adherence of people and try to include the caregiver, because it is a very important link." *(P3, primary care professional)* "It is essential to intervene appropriately, through cognitive stimulation strategies, training, strategies for the family and the patient, which can only be done at an early stage. If dementia is already present or more advanced, the benefits will not be the same. This has already been reported in several studies. Hence the importance of early detection, especially changes in executive function, that are most indicative of a decline to dementia or a mild deficit to dementia." *(P5, secondary care professional)*
C.3. System level	
C.3.1. *Organizational context*	
C.3.1.1. At primary and secondary healthcare services	"Maybe it would be necessary to screen the referrals and really understand which ones are urgent, because there are already many priorities and not even these can be seen in a timely manner." (*P9, primary care professional*) "We need, (...) more integrated care between primary care and secondary care, (...)." (*P1, primary care professional*) "I have more tools to offer a patient from here than to a patient from (...) [another geographic region] and this creates a lot of inequality in health. So I think that something in the future could also be trying to gather local providers to external ones." (*P11, secondary care professional*)
C.3.1.2. At primary healthcare service	"There are very few human resources in these social services. (...) I think it is one of the fields most in need and that it is really bad in terms of human resources." *(P1, primary care professional)*
C.3.1.3. At secondary healthcare service	"I work at the hospital. I can say that, at the moment, if I want to make further appointments, I do not have an office. (…)" *(P11, secondary care professional)*
C.3.2. *Research on cognitive decline*	"I think (...) management would have to promote this, too: organize programs and competitions to support those who want to carry out

	projects. (...) It could be a way for us to get more things done." *(P11, secondary care professional)*
C.3.3. *Referral system*	"(...) What I'm seeing happening at the moment is that there are many Primary Care Clinicians who are making referrals as if they were all priorities, because they know they have a year and a half of waiting. So, this will delay the true priorities, which is already happening. So, I think there also has to be criteria for forwarding what is very priority, priority and normal." *(P11, secondary care professional)*