Design and Development of a Community-Based, Interdisciplinary, Collaborative Dementia Care Program

Danielle Goldfarb, M.D., Angela M. Allen, Ph.D., Lori E. Nisson, L.C.S.W., Diana B. Petitti, M.D., M.P.H., Donald Saner, M.S., Carrie Langford, L.M.S.W., William J. Burke, M.D., Eric M. Reiman, M.D., Alireza Atri, M.D., Ph.D., Pierre N. Tariot, M.D.

ABSTRACT

Objective: To describe the design, development, and baseline characteristics of enrollees of a home-based, interdisciplinary, dyadic, pilot dementia care program. Design: Single-arm, dementia care intervention in partnership with primary care providers delivered by Health Coaches to persons with dementia and caregiver “dyads” and supervised by an interdisciplinary team. Setting: Home-and virtual-based dyad support. Participants: Persons with mild cognitive impairment or dementia diagnosis and/or who were prescribed antidementia medications; had an identified caregiver willing to participate; were under the care of a partner primary care provider; and had health insurance through the affiliated accountable care organization (Banner Health Network). Intervention: Provision of personalized dementia education and support in the home or virtually by Health Coaches supported by an interdisciplinary team. Measurements: Cognition, function, mood, and behavior of persons with dementia; caregiver stress and program satisfaction; primary care provider satisfaction. Results: Served dyads from three primary care clinics with a total of 87 dyads enrolled between December 2018 and June 2020. Conclusion: A pilot Dementia Care Partners demonstrated feasibility and suggested acceptability, and high satisfaction among primary care providers and caregivers. (Am J Geriatr Psychiatry 2021; ■■■;■■—■)

Key Words: Dementia caregivers collaborative care community-based chronic care management
Highlights

• **What is the primary question addressed by this study?**—We developed and began implementation of a community-based, interdisciplinary dementia care intervention with dyad support provided by an unlicensed work force called Health Coaches.

• **What is the main finding of this study?**—Dementia Care Partners partnered with three primary care clinics, identified eligible patients through an electronic health record algorithm, and enrolled 87 dyads from December 2018 to June 2020. We demonstrated feasibility, acceptability, and high satisfaction among primary care providers as well as dementia caregivers.

• **What is the meaning of the finding?**—Use of Health Coaches to provide dyadic dementia care services in the community and supervised by an interdisciplinary team is a promising model of adjunctive dementia care in partnership with primary care providers. Future studies assessing potential cost savings and decreased healthcare utilization are needed.

**OBJECTIVE**

A 2015 report published by the United Nations Organization for Economic Cooperation and Development Report concluded that, compared to other diseases in the developed world, persons with dementia (PWD) have the worst quality of care. Most PWD receive their medical care in primary care settings, yet primary care providers (PCPs) often lack the time, resources, and support required for quality dementia care. As well, direct and indirect dementia-related costs are profound. Family and informal caregivers living with PWD in the community are profoundly impacted, providing high intensity care involving many hours per day, requiring significant effort, and for often for years. Collaborative dementia care models in primary care, most based on case management precepts, have demonstrated that interdisciplinary services coupled with individually-tailored care plans can result in positive outcomes including appropriate use of specific anti-dementia therapies and antidepressants, greater use of community resources, reduced caregiver depression, and fewer behavioral symptoms.

Nearly 10 years ago, Banner Health, a large, non-profit community health system organization, charged Banner Alzheimer’s Institute (BAI) leadership with developing a strategic clinical initiative to improve the recognition, diagnosis, treatment and management of PWD in Banner’s primary care system.

The original program was developed via an enterprise-specific Banner process to identify, design, and implement new care processes. The goals were to identify all adult outpatients at risk of having dementia in selected primary care clinics in Banner Health in real time, to complete a comprehensive evaluation and to deliver appropriate pharmacological, psycho-social, and calibrated specialty interventions. Two pilot studies focused on identification of dementia between 2015 and 2017 yielded the following learnings: case-finding proved to be operationally challenging; the dementia workflow was too complex; identification of cases not known to patient and/or provider threatened the patient-provider relationship; family involvement was inconsistent; and healthcare providers lacked access to community resources to help manage non-medical issues.

As a result, BAI developed an innovative approach to optimize care for persons already likely to have known dementia being cared for in primary care clinics, called “Dementia Care Partners” (DCP). The program design was based on the evolving appreciation that dementia impacts not only the patient/person with dementia (PWD), but also the informal caregiver (CG), often a close family member. Both the PWD and CG, referred to as the “dyad,” were to be the unit of care. Dyads often end up in crisis and seek potentially avoidable care in acute settings. Caregivers have been called the “invisible second patients” due to high levels of burnout resulting in psychological, medical and financial issues as well as social isolation. Currently, dementia care focuses on the ‘medical’ concerns of the PWD and largely ignores...
the important web of psychosocial factors impacting CG and dyad wellness.

Importantly, the conceptualization of DCP benefited from significant expertise and guidance early on through a partnership with Dr. Malaz Boustani, based on the well-established, evidenced-based collaborative dementia care program, The Aging Brain Care (ABC) MedHome. BAI worked in close consultation with Dr. Boustani, and he continues to serve in an advisory role, with a goal of determining if the ABC MedHome model was translatable to our community-based program. DCP team members had multiple meetings and site visits with Dr. Boustani, adapted the ABC MedHome program to Banner outpatient primary care clinics, and designed HC use dyad assessment tools that were similar to ABC MedHome.

Launched in 2018, DCP is a collaborative, interdisciplinary dementia care intervention in partnership with primary care providers, dyads, and dementia specialists. The overall goals of DCP are to systematically identify and address dementia-related care needs through individualized care planning; referral and linkage to services; provision of dementia education and skill-building strategies; and care monitoring by an interdisciplinary team. The DCP team has access to Banner patient claims data for individuals enrolled in DCP, as they are required to be members of Banner Health Network (BHN), a managed Medicare program.

**METHODS**

**Teams**

The DCP team includes a dementia specialist physician acting as the Medical Director (MD), a licensed clinical social worker acting as the Clinical Director (CD) with expertise in dementia and caregiver support program development, a PhD-prepared registered nurse (RN) with expertise in program design and development, licensed master’s level social worker program manager (SWPM) and two “Health Coaches.” A Health Coach (HC) is an unlicensed dementia support provider who receives a minimum of 160 hours of dementia care and support training which includes a combination of didactic and webinar-based seminars (98 hours) on topics such as understanding dementia, communication and behaviors, elder abuse, home safety strategies, and identifying community resources and attend formal training on use of the measurement tools (6 hours). As well, HC shadow dementia outpatient clinical care providers (36 hours) and in the community (20 hours) during DCP dyad home or virtual visits. Figure 1 shows the DCP communication pathway between all team members, PCP, and patient-caregiver dyad.

A key feature of DCP is to build and evaluate a new dementia workforce, Health Coaches, who are the main points of contact for dyads and primary care providers. Their primary tasks include: 1) assessing

**FIGURE 1. DCP communication pathway.**
clinical and psychosocial needs using evidence-based tools, 2) developing personalized care plans in coordination with the MD, RN and SWPM, and 3) engaging, educating, and supporting the dyad. The HC provides in-person care in the dyad’s home and via telephone. We obtained a waiver of consent from our Institutional Review Board.

Clinics

For the pilot phase, we targeted primary care clinics in which ≥70% of the clinic’s patients age ≥ age 65 were enrolled in BHN, permitting eventual access to claims and healthcare utilization data and medication use. We provided a comprehensive overview of the program along with marketing materials to three selected clinics and all agreed to participate in the DCP pilot study. The MD and CD met with DCP primary care providers twice yearly and provided DCP program overview, reiterated the nature of services offered, discussed eligibility requirements and accrual issues.

Identification of Persons with Dementia

Figure 2 demonstrates the participant selection flow through DCP. For pre-screening, an EHR algorithm identifies individuals who were being managed in the Banner Health Network with ICD-10-CM codes for dementia (memory loss, Mild Cognitive Impairment (MCI), dementia) and/or the use of cholinesterase inhibitors and/or memantine. DCP also accept direct referrals from participating PCPs. Among patients who meet the pre-screening criteria, medical records are reviewed to assess additional eligibility criteria: ≥age 65; no active substance abuse; resides in the community and the service area; has a caregiver who has contact with the PWD at least once per week and provides the PWD assistance in daily activities; is fluent in English; and is a BHN member. Exclusion criteria include unstable psychiatric illness in the past two years or chronic psychosis.

PCPs are contacted for approval to contact eligible dyads. If approved by the PCP, a letter is mailed to the dyad describing the program and inviting participation. A DCP team member calls the dyad within two weeks to discuss program goals and services offered, describe the HC role, timing and duration of visits, assessments to be completed with the CG and patient and COVID safety measures for home visits. During the call, the DCP team member confirms eligibility, answers questions, and obtains verbal consent for enrollment for those who are interested. If there is no dyad response after four call attempts over 1 month, the dyad is removed from consideration for the program.

Description of Intervention

Table 1 shows the schedule of HC visits and assessments. The HC conducts an initial visit and visits monthly thereafter for 3 months to allow the HC to assess the dyads using tools below, ascertain their goals, and determine the appropriate care plan. Subsequent visits occur every 3 months with open-ended follow-up during the pilot phase, with the intent of optimizing a subsequent intervention duration. During the initial visit, the HC administers the Mini-Mental State Exam (MMSE) to the PWD. If the score is ≥ 17, the HC assesses depressive symptoms with the Patient Health Questionnaire - 9 (PHQ-9). The Healthy Aging Brain Care Self Report Monitor (HABC-M SR), which measures the PWD’s self-reported problems with cognition, daily function, and mood and behavior, is completed. If the MMSE score is ≤ 17, supporting a moderate or severe level of dementia, the HC does not complete the HABC-M SR or PHQ-9. We selected 17 as MMSE score threshold a priori in an effort to assure the validity of the assessments in PWD. All caregivers complete the Healthy Aging Brain Care Monitor Caregiver Report (HABC-M CG), which measures the caregiver stress level and the PWD’s CG-reported problems with cognition, daily function, mood and behavior, and psychological symptoms. The HABC-M SR and HABC-M CG are validated, clinically practical, multidimensional tools for measuring the nature and severity of cognitive, functional, and behavioral and psychological status in people with dementia and caregiver stress.

At the initial visit, the HC also reviews medical history and medications and performs a home safety assessment. The HC works with the dyad to identify two to three care plan goals. Common goals include: increasing understanding of dementia topics as relevant to the dyad, improving communication/avoiding conflict, and increasing caregiver self-care and well-being. Examples of targeted interventions include provision of written and online educational...

TABLE 1. Schedule of Assessments

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Respondent</th>
<th>Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Individual items</td>
<td>PWD and CG</td>
<td>M1</td>
</tr>
<tr>
<td>Medical history</td>
<td>EHR Review and Self-Report</td>
<td>PWD and CG</td>
<td>M1</td>
</tr>
<tr>
<td>Medications</td>
<td>Medication list</td>
<td>PWD and CG</td>
<td>M1</td>
</tr>
<tr>
<td>Cognitive Status</td>
<td>Mini-mental state exam (MMSE)</td>
<td>PWD</td>
<td>M1, Q12mo</td>
</tr>
<tr>
<td>Depression</td>
<td>Patient-Health Questionnaire-9)</td>
<td>PWD</td>
<td>M1</td>
</tr>
<tr>
<td>CG Burden</td>
<td>HABC-M CG, Stress Subscale</td>
<td>CG</td>
<td>M1, M2, M3, M4 then Q3mo, more often if indicated</td>
</tr>
<tr>
<td>PWD cognitive, function, and mood/behavior symptoms</td>
<td>HABC-M SR</td>
<td>PWD</td>
<td>M1, M2, M3, M4 then Q3mo if indicated</td>
</tr>
<tr>
<td>Home Safety</td>
<td>Informal home walk-through</td>
<td>CG</td>
<td>M1, Q3mo if indicated</td>
</tr>
<tr>
<td>Dyad Care Plan</td>
<td>Elicited Goals</td>
<td>PWD and CG</td>
<td>M1, M2, M3, M4 then Q3mo</td>
</tr>
<tr>
<td>Acute Events (ED/Hospitalizations)</td>
<td>EHR Review and Self-Report</td>
<td>CG</td>
<td>If events occurred</td>
</tr>
</tbody>
</table>

materials, information on relevant classes, events, and support groups, along with linkage to community services and resources. At subsequent dyad visits, the HC presents the care plan to the dyad along with the monitoring schedule, noting the potential to add new goals over time.

Two weeks after the initial visit, the HC calls the dyad to review progress and care plan goals and provide other support, such as educational materials and referral to community and educational programs, as needed. At subsequent visits, the HC reconciles medications and completes the HABC-M SR (if applicable) and HABC-M CG questionnaires. HCs make additional telephone calls to the dyad if there are urgent safety concerns, such as wandering or frequent falls. The MMSE is attempted annually for patients whose previous MMSE score was > 17.

The DCP interdisciplinary team meets weekly to discuss new dyad care plans and clarify goals and planned HC interventions. The HC provides updates on established dyads with recent acute events including emergency department visits and hospitalizations, or safety concerns for either the PWD or CG. If the HABC-M CG score remains at a high level or has increased after the DCP makes recommendations, the dyad is reviewed to determine whether additional interventions are needed. Following team discussion, the MD provides care recommendations to the PCP via EHR messaging if clinically indicated. Recommendations are typically provided in relationship to decisions about whether to start or increase a medication for depression or anxiety, start an anti-dementia medication, or discontinue an anticholinergic medication, and informing the PCP of an urgent or emergent medical or safety concern. The SWPM also provides quarterly dyad updates to the PCP via EHR.

The formative evaluation plan for the pilot phase of DCP includes assessing operational feasibility, program uptake by PCPs and dyads, dyad attrition, and PCP/CG satisfaction with the program. The SWPM also provides quarterly dyad updates to the PCP via EHR.

The formative evaluation plan for the pilot phase of DCP includes assessing operational feasibility, program uptake by PCP’s and dyads, dyad attrition, and PCP/C care recommendations with the program. During the pilot phase, dyads remain perpetually enrolled unless one of the following occurred: PWD/CG dies, the PWD enters long-term care, or either member of the dyad voluntarily withdraws, moves out of service area, or is lost to follow-up. PCP satisfaction assessments are completed annually, administered by a person not involved in the DCP program. Caregiver satisfaction is assessed every 6 months for active and inactive dyads, also administered by a person not involved in the DCP program.

**Modification of Electronic Health Record**

The EHR was modified to accommodate the program by embedding two new assessment tools: HABC-M SR and HABC M-CG. The EHR already incorporated the MMSE and PHQ9.

**COVID Impact**

COVID-19 led to adaptations a transition from home visits to telephonic visits in March 2020. All questionnaires and assessments were completed by phone, including administration of the telephonic MMSE in June 2020, HIPAA-compliant, high definition, synchronous audio video visits were initiated through the eVisit (www.evisit.com, Mesa, AZ) platform. Uptake of audio-video visits was hampered because dyads did not have adequate hardware and/or had difficulty accessing the platform.

**RESULTS**

Figure 2 shows participant flow. From December 2018 through June 2020, we screened 574 dyads for eligibility, of which 419 (73%) did not meet eligibility criteria. Reasons for ineligibility were as follows: 157 lacked Banner Health Network Insurance; 132 resided in a long-term care setting; 48 lacked an identifiable caregiver; 36 were deceased; 17 lived outside the service area; 15 could not be confirmed to have a diagnosis of dementia; 9 had a chronic / unstable psychiatric disorder; 5 had an unaffiliated primary care provider. This left 155 eligible dyads. Of these, PCP’s approved initial contact for 151 dyads (97.4%). Of the 151 dyads contacted, 87 (57.6%) agreed to enroll and scheduled an initial home visit. At 3, 6, 9, and 12 months, respectively, dyad retention was 77 (88.5%), 72 (82.8%), 70 (80.5%), and 68 (78.2%). The main reasons for dyad attrition were dropout, long term care placement, or death (Fig. 1).

Table 2 shows PWD and CG baseline characteristics. The mean (SD) age of PWD’s was 79.2 (12.8) years; 46 (52.8%) were female; 82 (94.2%) were Caucasian; 73 (83.9%) were married; 83 (95.4%) lived with
their CG. These demographics are similar to the patient population at the three partner Banner primary care clinics where patients are 60% female and 90% White/Caucasian, Not Hispanic or Latino. The aggregate patient age breakdown for these clinics is: age 61–70 (20%), age 71–80 (27%), and > age 80 (20%). The baseline ICD-10 codes are listed in Table 2.

Vascular Dementia. In the year prior to enrollment, 10 (11.5%) PWD had a total of 25 acute care events including emergency department visits, urgent care visits, and/or inpatient hospitalizations. The initial median MMSE score was 17.01 (7.49, 0–27), consistent with generally mild to moderate dementia severity. The mean (SD) PHQ-9 score was 6.9 (7.7), consistent with mild depressive symptoms. The HABC-M SR mean (SD) was 16.8 (16.5), completed only in patients with MMSE score ≥17 (n = 71), with this score indicating a moderate degree of cognitive and functional impairment as well as neuropsychiatric symptoms.

The CG sample was primarily a Caucasian (95.4%) one with comparable female (57.4%) and male (42.6%) gender distribution. The relationship of the CG to the PWD was spouse/partner (79.3%), adult child (18.3%), and other relationship (2%). Mean (SD) HABC-M CG scores at baseline were 34.6 (17.2), which demonstrated a high moderate degree of degree of cognitive and functional impairment as well as neuropsychiatric symptoms. The mean (SD) HABC-M CG Caregiver Burden Domain score was 3.44 (2.9), indicating a mild degree of caregiver burden approaching a moderate level.

The DCP Caregiver Satisfaction survey was offered to 30 family caregivers: 22 were completed, 3 were incomplete and 5 declined. Of the 22 complete respondents, 17 were very satisfied with the program, four somewhat satisfied and one was neutral. There were no CG responses citing any degree of dissatisfaction. Other key CG satisfaction findings of the 22 respondents included:

- Would recommend DCP to other caregivers (21)
- HC was very responsive (20);
- Education materials provided were very helpful (16);
- Provision of support from the DCP program was very helpful (14)

DCP PCP satisfaction surveys were sent to 18 participating PCPs after 1 year and 14 responded. Results included:

- Helpfulness to the PCP and patients: very helpful (7), somewhat helpful (5), neither helpful nor unhelpful (2)
- Overall program satisfaction: very satisfied (8), somewhat satisfied (3), neither satisfied nor dissatisfied (3)
- Would recommend to patients: would recommend (11), might recommend (2), not recommend (1)

When asked for comments from PCPs on how DCP may better support their patients, four PCPs noted that their patients appreciate the additional support that DCP provides, two PCPs conveyed that they did not have a clear sense of how the program was
helpful, and two requested more support for patients without identified caregivers. There were mixed comments on whether the communication was adequate.

**CONCLUSIONS**

The ultimate goal of this home-based, collaborative dementia care program is to transform how dementia care is provided, predicated on the critical assumption that this must be done in partnership with the primary care community. DCP is informed by the ABC MedHome program and capitalizes on lessons learned from earlier program iterations. Here we report on the pilot phase of DCP, which assess feasibility, and also, preliminarily, informed regarding program acceptability and satisfaction. This pilot DCP phase partnered with three primary care clinics and demonstrated feasibility, and suggested acceptability, and relatively high satisfaction with the program among PCPs and CGs. DCP attempts to fill current collaborative dementia care model gaps including identifying participants through EHR, service delivery to dyads in the home by an unlicensed dementia Health Coach, and frequent communication with PCPs. Future efforts will constrain eligibility criteria to focus on a patient sample with moderate to severe stages of dementia, bundle HC interventions by psycho-behavioral symptomatology, outline criteria for MD consultation to dyads, improve the EHR’s capability of identifying potential program participants, streamline HC documentation, and strengthen partnerships with PCPs. Finally, we plan to analyze claims data for future program design and evaluation.

There are several limitations of the DCP pilot program, which will also serve as learnings to inform the design of future phases of DCP Potential case screening via chart review was time-intensive which could decrease generalizability Our EHR algorithm was refined over time as we discovered that the initial algorithm yielded dyads who did not meet basic program criteria. Due to the COVID-19 pandemic, we halted in-home dyad visits and transitioned to telehealth visits, the majority of which have been telephonic. This adaptation may have impacted HC ability to develop rapport and complete assessments. The use of dementia support services prior to enrollment was not captured. This information would have likely influenced our understanding of dyads’ interest and enrollment in supportive care services. We did not systematically track the reasons that eligible dyads declined enrollment. We have since updated our enrollment tracking database to monitor reasons that eligible dyads opt not to enroll. These capture our prior experience approaching dyads, which include if the patient died recently or moved to a long-term care setting, dyad moved out of service area, caregiver opted not to enroll due to lack of time or feeling they did not require additional support at that time. While the DCP dyads described here represent the socio-demographics of their Banner clinics, the lack of diversity limits the generalizability of our findings. Finally, based on very anecdotal evidence, the DCP model may be potentially less beneficial in the earliest stages of disease (e.g. mild cognitive impairment and early mild dementia) due to caregiver perception being of less burden within this paradigm.

**DATA STATEMENT**

The data have not been previously presented orally or by poster at scientific meetings.

**AUTHOR CONTRIBUTIONS**

Danielle Goldfarb, MD made substantial contributions to the conception or design of the work, the acquisition, analysis and interpretation of the data, the drafting and revising of the work, and the final approval of the version to be published. She agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Angela M. Allen, PhD made substantial contributions to the conception or design of the work, the acquisition, analysis and interpretation of the data, the drafting and revising of the work, and the final approval of the version to be published. She agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.
Lori Nisson, LCSW made substantial contributions to the conception or design of the work, the acquisition, analysis and interpretation of the data, the drafting and revising of the work, and the final approval of the version to be published. She agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Diana Petitti, MD, MPH made substantial contributions to the conception or design of the work, the acquisition and interpretation of data, the revising of the work, and the final approval of the version to be published. She agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Donald Saner, MS made substantial contributions to the analysis of data for the work, the revising of the work, and the final approval for the version to be published. He agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Carrie Langford, LMSW made substantial contributions to the conception or design of the work, the acquisition, analysis and interpretation of the data, the revising of the work, and the final approval of the version to be published. She agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

William J. Burke, MD made substantial contributions to the conception or design of the work, the revising of the work, and the final approval for the version to be published. He agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Eric M. Reiman, MD, PhD made substantial contributions to the conception, design and funding of the work, the revising of the work, and the final approval for the version to be published. He agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Alireza Atri, MD, PhD made substantial contributions to the analysis and interpretation of data for the work, the revising of the work, and the final approval for the version to be published. He agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Pierre N. Tariot, MD made substantial contributions to the conception or design of the work, the acquisition, analysis and interpretation of the data, the drafting and revising of the work, and the final approval of the version to be published. He agrees to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

**DISCLOSURE**

Dr. Goldfarb received honorarium from the CME Institute. Dr. Reiman is a co-founder and shareholder in ALZ-Path and receives grant funding from NIA grant P30 AG019610, Banner Alzheimer’s Foundation, Banner Health Foundation, and the State of Arizona. Dr. Atri receives grants or contracts from the Alzheimer’s Disease Consortia, Coordinating Research Institutes or Government Funding (ACTC, ADCS, ATRI, NIH), Indiana University (observational cohort), Johns Hopkins (clinical trial), Global Alzheimer’s Platform, Athira, Alzheon, Biohaven (with ADCS), Eisai (with ATRI/ACTC), Lilly (with ACTC/NIH), Novartis, and NIH. He receives book royalty from Oxford University Press, payment or honoraria from Abbvie, Acadia, Biogen, Harvard Medical School Post-Graduate Continuing Education (HMS PGME). Dr. Atri receives Reimbursement or providing flights, transportation or lodging for advisor Eisai, Grifols, Novo Nordisk, Roche/Genentech, Harvard Medical School Post-Graduate Continuing Education (HMS PGME). He receives support for travel or lodging for advisory meetings or educational programs by Abbvie, Acadia, Alzheimer’s Association, Biogen, Eisai, Grifols, Novo Nordisk, Roche/Genentech, HMS PGME, National Institutes of Health. Dr. Atri participates on Data Safety Monitoring Board or Advisory Board for Roche/Genentech (and partner: Chugai). He has a leadership or fiduciary role in other board, society, committee or advocacy group, paid or unpaid for Alzheimer’s Association - Co-chair or member of several workgroups/
Design and Development of a Community-Based, Interdisciplinary, Collaborative Dementia Care Partners Health Coaches

organizing committees (unpaid) and Alzheimer’s Disease International (ADI) - Chair of Medical Scientific Advisory Panel and Member of Board of ADI (unpaid). Dr. Tariot receives consulting fees from Acadia, Avanir, Biogen, and Lilly, honoraria from Biogen, support for attending meetings from Novartis and Avanir, participates on advisory boards for Genentech and Abbvie, and has stock ownership in Adamas Pharmaceuticals. This work was funded by philanthropic support from Edward Fein, the Edson Family, a Cigna grant, the Banner Alzheimer’s Foundation, Banner Health Foundation, and the Sun Health Foundation. Dr. Allen, Lori Nisson, Dr. Petitti, Donald Saner, and Deborah Boyle, have no conflicts of interest to report.

The authors acknowledge the contributions of the Dementia Care Partners Health Coaches – Serena Lowery, Juliana Crouch, JennaBelle Gessel, and Clare Mueller; Research Assistants – Joshua Sipes and Anja Trncic; Information technology team – Robert Bauer III, Matthew Miller and Ashleigh Hendrickson; Program development consultant – Deborah Boyle, MSN, RN. They also express sincere gratitude to all Dementia Care Partners dyads, primary care providers and associated clinic teams.

SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found in the online version at https://doi.org/10.1016/j.jagp.2021.10.014.

REFERENCES

2. Callahan CM, Hendrie HC. Mental health services research: moving from academia to the community. Am J Geriatr Psychiatry 2010; 18(6):460–463