

# Evaluation of Academic Detailing for Primary Care Physician Dementia Education

American Journal of Alzheimer's Disease & Other Dementias®  
25(4) 333-339  
© The Author(s) 2010  
Reprints and permission:  
sagepub.com/journalsPermissions.nav  
DOI: 10.1177/1533317510363469  
http://ajadd.sagepub.com



Marcia J. Cameron, MA<sup>1</sup>, Micki Horst, MA<sup>2</sup>,  
Larry W. Lawhorne, MD<sup>3</sup>, and  
Peter A. Lichtenberg, PhD, ABPP<sup>4,5,6</sup>

## Abstract

The objective of this evaluation study was to assess the effect of academic detailing (AcD) as a strategy to increase early detection of dementia in primary care practice and to improve support and management of Alzheimer's disease and other dementia disorders by increasing communication and referrals to local community agencies. As designed for dementia education, AcD consisted of 15-minute educational sessions delivered in primary care practice offices. Twenty-nine visits were conducted by trained teams comprised of a physician and representatives of the Alzheimer's Association (AA) and Area Agency on Aging (AAA). A key outcome of the visits was increased knowledge of the specific programs and services available. In all, 77.4% rated the visit very effective, and follow-up evaluation suggests visits led to an increase in referral to these agencies (55%) and potentially enhanced early detection of dementia by physicians as measured by 35% making changes in the way they identify at-risk patients.

## Keywords

dementia, academic detailing, physician education, older adults

## Introduction

Currently, people aged 65 and older account for 30% to 40% of primary care physician visits.<sup>1</sup> One in 8 persons aged 65 and older (13%) have Alzheimer's disease or other dementia disorders.<sup>2</sup> Of persons aged 85 and older, the percentage is close to half. The number of Americans with Alzheimer's and other dementia disorders is increasing every year because of the steady growth in the older population.

Older adults and their family members often rely on their primary care physicians to evaluate symptoms of memory loss and to provide health information and referrals. Studies of family caregiver interactions with physicians have identified 4 primary concerns: (1) obtaining a diagnosis, (2) learning how to manage current or expected symptoms, (3) locating and using community support services, and (4) receiving emotional support. One study found physician linkage to support services received the lowest rating among these domains of concern.<sup>3</sup> Physician surveys show that many physicians lack sufficient knowledge in diagnosis, treatment, and community resources for dementia.<sup>4</sup> Physicians reported in another study that unfamiliarity with community services was the most significant barrier to ongoing management of people with dementia, more than lack of time and reimbursement.<sup>5</sup>

Studies have consistently shown that active medical management of Alzheimer's and other dementias can significantly improve quality of life through all stages of the disease for

diagnosed individuals and their caregivers, according to the Alzheimer's Association's (AA) 2009 Alzheimer's Disease Facts and Figures. Active management includes appropriate use of available treatment options, effective integration of coexisting conditions into the treatment plan, and use of supportive services. One study found that care consultation delivered in a partnership between a managed health care system and AA chapter reduced use of physician and emergency department visits and reduced likelihood of a hospital admission by people in the intervention group.<sup>6</sup>

A needs assessment conducted by the Michigan Dementia Coalition (MDC) in 2002 to develop a statewide dementia plan confirmed that family caregivers, especially, viewed dementia

<sup>1</sup> Mental Health & Substance Abuse Administration, Michigan Department of Community Health, Lansing, MI, USA

<sup>2</sup> Michigan Public Health Institute, Okemos, MI, USA

<sup>3</sup> Department of Geriatrics, Boonshoft School of Medicine, Wright State University, Dayton, OH, USA

<sup>4</sup> Institute of Gerontology, Wayne State University, Detroit, MI, USA

<sup>5</sup> Merrill Palmer Skillman Institute, Wayne State University, Detroit, MI, USA

<sup>6</sup> Psychology, Psychiatry and PM&R, Wayne State University, Detroit, MI, USA

## Corresponding Author:

Marcia J. Cameron, Mental Health & Substance Abuse Administration, Michigan Department of Community Health, Lewis Cass Bldg, 5th floor, 320 S Walnut St, Lansing MI 48913, USA  
Email: cameronm@michigan.gov

education for primary care physicians as a top priority. The MDC is a grassroots statewide organization of consumers and representatives of community groups, universities, and state government. The coalition embarked on a primary care initiative to develop strategies for promoting dementia competency among primary care physicians, disseminating information about effective disease management practices, and linking physicians with resources for diagnostic consultation and non-medical community services. A focus group, conducted with 30 physicians, identified barriers to effective dementia care practice, developed recommendations for possible solutions, and enlisted workgroup members to address these concerns. Interested primary care and specialty physicians subsequently formed the Michigan Primary Care Dementia Network (PCDN), with a current membership of approximately 80 physicians. The network developed strategies to address the following goal within the 2003 Michigan Dementia Plan, "Promote a public health, disease management approach to dementia care in primary care practices that makes full use of best dementia practices." One of the strategies identified was the development of a community resource model that offers procedures that physicians can use to link individuals and their families with community services.<sup>7</sup> This model uses community resources in developing educational outreach and also emphasizes use of community resources in ongoing patient management.

## Methods

Although no single method of physician education is known to be superior to others,<sup>8</sup> a peer-to-peer outreach model was identified as promising. The PCDN established a Community Resources Workgroup to develop a community resource model and related materials to provide structured educational outreach visits, also known as academic detailing (AcD), to individual primary care clinics. Academic detailing serves as a brief, personal, in-office dialogue that focuses intensely on a single topic of interest. Pharmaceutical companies have successfully used AcD to provide drug information to physicians to influence their prescribing behaviors.<sup>9</sup>

A key feature of the method is a face-to-face visit with the physician by a peer. In fact, 1 of 3 factors cited by physicians through questionnaires as most discouraging the use of AcD was having continuing medical education provided by a non-physician (along with spending office time and scheduling time). Another factor physicians found useful was providing comprehensive as well as concise handout material.<sup>10</sup>

As designed in Michigan for dementia education, AcD consisted of 15-minute educational sessions delivered to physicians and their staff. Visits were conducted by trained teams composed of a physician, an AA representative, and an Area Agency on Aging (AAA) representative. (There are 2 AA chapters in the state of Michigan: Michigan Great Lakes chapter and Greater Michigan chapter.) Key message points and practical examples were highlighted. A packet of materials, including triggers for identifying potential dementia and

contact information of local organizations, served as the basis of the visit.

The general script for visits covered: (1) identifying each office staff member's biggest concern about addressing dementia; (2) providing brief educational sessions tailored to specific domains of concern; (3) discussing different management strategies, including the role local community organizations can play in providing services to older adults with dementia and to family members; (4) promoting increased communication and collaboration among the primary care practices and these local agencies; and (5) ending with a strong message that early detection is important, that primary care practices do not have to provide information and resources alone, and that community resources and supports are available.

The overarching goal and primary objective of the evaluation of the 2005-2008 model project was to assess the merit of AcD as a strategy for achieving PCDN objectives to

- increase early detection and diagnosis of dementia in primary care practice and
- improve support and management of Alzheimer's and other dementias by increasing communication, referrals, and coordination of services with the AA and other local community agencies and resources.

A secondary objective was to obtain feedback to improve the educational content, materials, and delivery. Feedback gathered in 2005 and 2006 was used to make changes prior to the 2007 visits. A third objective, added in 2007, was to attempt to gather data to help determine the cost and cost-effectiveness of providing AcD visits.

The evaluation consisted of 3 components:

To help evaluate content, delivery, and overall effectiveness of the visits:

(Component 1) Team member feedback (completed immediately following each visit);

(Component 2) Participant feedback (physicians and staff; completed immediately following the visit);

To assess the extent to which the visit may have influenced early detection practices and referral practices:

(Component 3) Follow-up survey completed by visited physician, conducted 3 to 6 months following visit. This survey was mailed with an addressed, stamped envelope to each physician who had participated. For most visits, further follow-up attempts were made by fax or phone until at least one of the physician participants responded or numerous attempts had been made.

Most PCDN Steering Committee members conducted at least 1 detailing visit and contributed to informal discussion on the challenges and benefits of AcD as a method of outreach and education with other primary care physicians.

Four of the AcD visits in the first year (2005) were made to PCDN members. The remaining 25 visits were made to physicians who were not PCDN members at the time of the visit. The

**Table 1.** Participant Feedback (Component 2) Summary (Range: 1 = Not Very Helpful to 5 = Very Helpful)

	No of Responses	1	2	3	4	5
How much visit would help practice identify patients with dementia early?	209	0	0	8 (4%)	47 (22%)	154 (74%)
How helpful it is to patients and their families to identify patients with dementia early?	208	0	1 (<1%)	8 (4%)	38 (18%)	161 (77%)
Effectiveness of visit in increasing or refreshing knowledge about importance of addressing dementia	207	1 (<1%)	3 (<1%)	22 (11%)	70 (34%)	117 (57%)
Effectiveness of visit in providing information about 1 or more concerns participant had about addressing dementia in the practice	208	0	1 (<1%)	31 (15%)	71 (34%)	110 (53%)
Overall helpfulness of the visit	191	0	2 (1%)	12 (6%)	49 (26%)	128 (67%)
Effectiveness of the visit in providing information about community resources to assist families	208	0	1 (<1%)	4 (2%)	42 (20%)	161 (77%)
Effectiveness of the visit in helping participant identify specific community resources that will work with the practice to assist patients with dementia and their families	209	2 (1%)	0	8 (4%)	51 (24%)	148 (71%)

former yielded constructive feedback on materials and approach, along with feedback on early detection and community resources. The latter yielded helpful information on ways to gain access and inform practices, along with changes in physician behavior.

## Results

Twenty-nine AcD visits were conducted July 2005 through August 2008. Participants included 104 physicians and 248 office/clinic staff. The average number of physician participants in the visits was 3.6. Five visits had 6 or more physician participants.

Visits were conducted in all regions of the state, in 16 different communities in 11 counties, including urban and rural areas. At least 20% of the visits were conducted in rural and underserved areas of the state.

Fifty-three team member feedback forms (component 1) were completed for every visit. Some variations in procedures occurred as some teams completed 1 form together by reaching consensus on perceptions or reactions of the visit, and other teams had each member complete forms individually.

Two hundred sixteen participant feedback forms (component 2) were completed. Of participants who designated their status, 50 designated themselves as physicians and 99 designated themselves as nonphysicians. The status of the remaining 67 participants is unknown. Forms collected in the first year (30) did not have a section for designating status. On the subsequent version of the form that did have the status designation section, 37 respondents did not indicate their status.

Thirty physician follow-up survey forms (component 3) were completed, representing 68% of the detailing visits conducted. The follow-up survey questioned activity in the 3 to 6 months since the visit, including use of materials provided, use of triggers to identify patients who may need to be screened for dementia, changes in the way the practice identified patients with dementia, and referrals to community resources.

Results obtained from the follow-up survey of physician participants (component 3) provide an indication of the effectiveness of the AcD visits in altering physician behavior. Results obtained from the team feedback forms and the participant feedback forms supplement these findings and provide an indication of the effectiveness of the visits in increasing participant knowledge and awareness. In addition, the results of the 2005 and 2006 team and participant feedback were used to make modifications in the educational materials and the evaluation forms and process.

### Effectiveness in Providing Information

Of the 344 physician and nonphysician participants in the visits, 216 (63%) completed immediate postvisit evaluation forms (component 2). The forms asked participants to rate the helpfulness or effectiveness of the visits on a Likert-type scale. The vast majority of participants gave high ratings on all items. Table 1 shows the number and percentage of respondents in each category on 7 items.

Two of the key measures on the participant feedback form were (1) the effectiveness of the educational team's visit in increasing or refreshing participants' knowledge about why to address dementia and (2) the effectiveness of the visit in providing information about concerns in addressing dementia. The first of these key measures shows that nonphysician ratings were more variable than physician ratings: nonphysicians more frequently gave a 5 rating (58% compared to 50% by physicians). Nonphysicians also more frequently gave a 3 rating (12% compared to 8% by physicians). Table 2 shows the distribution (number and percentage) of responses between physician and nonphysician participants. On the second key measure, nonphysician ratings continued to be more positive than physicians. The highest rating of 5 was given by 54% of nonphysicians compared to 46% of physicians. The mid-point rating of 3 was given by 12% of nonphysicians compared to 18% of physicians. Table 3 shows the distribution (number

**Table 2.** How Effective Was the Educational Team's Visit in Increasing or Refreshing Your Knowledge About Why to Address Dementia in Your Practice? (Range: 1 = Not Very Effective to 5 = Very Effective)

	1	2	3	4	5
Physicians (50)	1 (2.0%)	1 (2%)	4 (8%)	19 (38%)	25 (50%)
Nonphysicians (99)	0	1 (1%)	12 (12%)	27 (27%)	57 (58%)
Unknown (67)	0	1 (2%)	6 (9%)	24 (36%)	35 (53%)
All combined (216)	1 (0.5%)	3 (1%)	22 (10%)	70 (33%)	117 (55%)

**Table 3.** How Effective Was the Visit in Providing You With Information About 1 or More of the Concerns You Have Had About Addressing Dementia in Your Practice? (Range: 1 = Not Very Effective to 5 = Very Effective)

	1	2	3	4	5
Physicians (50)	0	0	9 (18%)	17 (34%)	23 (46%)
Nonphysicians (99)	0	1 (1%)	12 (12%)	31 (31%)	54 (54%)
Unknown (67)	0	0	10 (15%)	23 (35%)	33 (50%)
All combined (216)	0	1 (0.5%)	31 (15%)	71 (33%)	110 (52%)

and percentage) of responses between physician and nonphysician participants.

**Increasing early detection.** Findings from the participant feedback (component 2) show physicians and staff believe early detection is helpful (see Table 1). Asked how helpful it is to patients and their families to identify patients with dementia early, 77.4% responded *very helpful* (point 5 on 5-point scale), which is tied for the highest percentage among the seven items rated. Asked how much the visit would help the practice to identify patients with dementia early, 73.7% of respondents indicated the highest rating of 5 and 22.5% indicated a rating of 4.

To assess AcD effectiveness in increasing early detection, the follow-up survey directed to physicians (component 3) asked (No/Yes), "Since the visit, has your practice made any changes in the way it identifies dementia?" Most (65%) of the physicians indicated they had not made changes in the way they identify patients with dementia but slightly more than a third (35%) said they had. All of the PCDN members (4 respondents) said they had not changed the way they identify patients with dementia compared to 62% of the non-PCDN physicians (25 respondents). If they responded yes, they were asked, "Please note the specific way." Open-ended responses included (each response was made only once)

- involve family members more in visits;
- use Mini-Mental State Examination (MMSE) form more routinely;
- ask about activities of daily living (ADLs);
- ask more questions of families and caregivers;
- more aware of possibilities;
- more in tune with warning signs;
- increased attention to early diagnosis; and
- follow red flags.

A related item asked whether the physician had used or made plans to use the triggers to identify patients who may need to

be screened for dementia. Nearly half (48%) said they had. Of the remainder, 40% said they had not but intended to and 12% said they already had a way of identifying patients.

**Increasing knowledge of and referral to community resources.** Results of the participant feedback form (component 2) indicate the AcD visits helped increase participant knowledge of available community resources. Many physicians and staff members who participated in the AcD visits were already aware that AA chapters and AAAs provide services. The AcD visits increased their knowledge of the specific programs and services available. Asked how effective the visit was in providing information about community resources to assist families, this item tied for the highest percentage, 77.4%, of respondents indicating *very effective* (5). A similar item, asking about the effectiveness of the visit in helping participants identify specific community resources that will work with the practice to assist patients with dementia and their families, received a 5 rating from 70.8% of respondents. Team member feedback supports these findings.

According to participant feedback responses (component 2) and consistent with the information shared during the visit, the community resources used most often are the AAA (20%) and the AA (7%). Other resources were quite varied and were cited by fewer than 4% of all participants. Physicians were more likely to say they currently use the AAA (14% of physicians) than to say they currently use AA (2% of physicians). Table 4 shows the number of participants citing the AAA or AA and the percentage in each category of participant status (physician, nonphysician, or unknown). Others named were specific neurologists or social workers, community mental health, senior housing agencies, and home care agencies.

Participants were also asked which (if any) community resources discussed during the visit they were "now more likely to use for referrals." Again, the most frequent responses were the AAA (25%) and the AA (25%). The most dramatic difference is seen in the physician responses. Although only 2% of physicians said they currently use the AA for referrals,

**Table 4.** Which Community Resources Do You Currently Use for Referrals?

	AAA	AA
Physicians (50)	7 (14%)	1 (2%)
Nonphysicians (99)	15 (15%)	8 (8%)
Unknown (67)	21 (30%)	6 (9%)
Total (216)	43 (20%)	15 (7%)

40% said they were now more likely to do so. Table 5 shows the number of participants citing the AAA or AA and the percentage in each category of participant status (physician, nonphysician, or unknown). Taken together, these findings suggest that prior to the AcD visit, physicians and nonphysicians were using AAA services more than AA services, and the AcD visits significantly increased awareness of AA services, particularly among physicians.

The significance of knowing about community resources was also a key finding in the team member feedback (component 1). Team feedback indicated that the concerns most often voiced by providers were knowing about resources available and getting families to comply with recommendations or follow through. Of 53 feedback forms, the percentage indicating these concerns and others were

- 28% knowing about resources—where and how to access, identifying services;
- 21% getting patients/families involved, patient/family follow-up;
- 13% managing behaviors;
- 13% medications, treatment, treatment effectiveness; and
- 11% lack of time to spend with patients.

Results of the evaluation suggest the AcD visits were effective in increasing physician and staff referral to community resources available for patients with dementia and their caregivers. Of the physicians who responded to the follow-up question (component 3) asking whether their practice had increased referrals to community resources, 55% said they had, 24% said they were already making satisfactory referrals prior to the visit, and the remaining 21% said they had not increased referrals but intend to. Comparison of the responses of the 4 PCDN member physicians to responses of the non-PCDN members showed a very slight difference, with 50% of PCDN members saying yes compared to 52% of non-PCDN physicians saying yes.

A related item asked physicians how important community resources are in helping meet the needs of patients with dementia and their caregivers. Although 31% did not answer this question, of those who did, 80% indicated a 5- and 20% indicated a 4- (on a 5-point Likert-type scale with 1 for *not very important* and 5 *very important*).

**Cost estimate.** The cost estimate component added to the evaluation in 2007 asked the 2 Michigan AA chapters to estimate

**Table 5.** Which (if any) Community Resources Discussed During the Visit Are You Now More Likely to Use for Referrals?

	AAA	AA
Physicians (50)	10 (20%)	20 (40%)
Nonphysicians (99)	25 (26%)	24 (25%)
Unknown (67)	18 (26%)	9 (13%)
Total (216)	53 (25%)	53 (25%)

- number of hours the chapter spent arranging and preparing for visits, including training time;
- salary costs for chapter time spent;
- miles traveled by chapter personnel; and
- cost of materials.

Chapters were also asked to obtain and report, if possible, estimates of the time spent and miles traveled by physicians and AAA representatives. Only 1 visit cost estimate included these figures. Wide variations in data (staff time, salary, travel) and low number of visits with cost estimates resulted in lack of reliable information regarding costs of visits.

## Discussion

Findings from the formal evaluation of the project suggest the AcD visits were effective in

1. increasing physician awareness of the importance of early detection;
2. increasing physician awareness of the importance of referral to community resources; and
3. increasing referrals to community resources.

These findings were substantiated in informal discussion and feedback from physician presenters. Because these results indicate AcD visits are a promising strategy for increasing early detection and referral, an important question is whether it is a cost-effective strategy.

Consideration needs to be given to the circumstances that may have played a role in the amount of time spent on each visit. Over the 4 years of the project, changes in staff occurred at every level. It is possible that the amount of time required per visit could be substantially decreased with more stable staffing. In addition, higher level and higher wage personnel were sometimes called upon to conduct scheduling and visits when consistent coordinating staff was not available.

To assess the usefulness of AcD as a strategy for dementia education, it is important to consider the context of primary care physician education generally. A vast number of educational topics compete for their attention. A study of dementia assessment in primary care suggests the perception that dementia assessment is not warranted, because little can be done to improve Alzheimer's disease and other progressive dementias.<sup>11</sup>

Informal feedback from team members over the course of the project suggests that obtaining assent from a physician to host or receive an AcD visit is the most challenging aspect of the AcD model. In the first year of the project, the physicians visited were typically members of the PCDN (4 of the 29 project total visits) and therefore predisposed to host a visit. In the second year, it became more challenging to identify practices receptive to a visit (all non-PCDN members). It was not uncommon for the project coordinator and chapter personnel to be told by a physician or practice that they were not interested in having a visit. Many indicated they already had expertise with dementia. Anecdotally, those who accepted a visit also often said in advance that they were already knowledgeable on the topic but afterward offered that they had learned more than they had expected to learn. Overall, the inclusion of a respected, local physician to lead the team—effectively saying to fellow physicians, “This is important. Here are resources available to you”—was indicated by team members as the most crucial factor in gaining access to physicians.

In addition, many physicians may resist the visits as part of a broader increasing resistance to AcD in its traditional form (delivered by drug companies). A *Newsweek* article, “Thanks, But No Thanks” asserted that increasingly doctors are saying no to drug company promotions.<sup>12</sup>

The project implemented 2 strategies to help address the problem of resistance. One was to have the physicians who had agreed to serve as presenters speak directly to their colleagues. This strategy, while effective, also required chapter coordinators and the project coordinator to spend time following up with the physician presenters to contact colleagues. Often the physician presenters simply did not have time to contact potential recipient colleagues.

The second strategy adapted to address the problem of resistance was to partner with drug company representatives, with visits framed in a purely educational format. Although some physicians and practices may reject visits from drug company representatives, others were more receptive to a visit if it included a complimentary luncheon that was an expectation of company representatives. Some drug company representatives can open doors, but the effectiveness varied according to individual company representatives and the characteristics of the practice. Because drug company representatives, when present, did not present information at the AcD visits, their cosponsorship was not noted on evaluation forms, though informal feedback indicates increasing numbers further into the project to help with gaining access to clinics.

With regard to the design and delivery of the dementia AcD, the evaluation findings suggest overall that the materials and content were well designed but that substantial variation occurred in the implementation or delivery. Primary Care Dementia Network physician presenters with experience and commitment to dementia education often offered their own particular focus. It is not clear whether the variation enhanced or detracted from the effectiveness of the visits.

Another question raised by the findings pertains to the size and composition of the participant group. The original design was intended for small groups of physicians and staff. Because

of the existence of large clinics, some of the visit groups were considerably larger (30 in 1 group). In addition, some groups consisted primarily of physicians while other groups consisted primarily of nonphysician staff.

Finally, implementation of AcD takes a great deal of time and persistence and should include adequate lead time. The estimate of number of hours spent by AA chapter staff per visit indicates considerable time spent to secure a visit (averaging close to 10 hours).

Following the grant period, primary care practices have expressed interest in the AcD model or visits. The model and lessons learned have been incorporated as an elective for the Geriatric Education Center of Michigan (GECM) Community Teams to use for their outreach curriculum to local interdisciplinary health professionals. New agency collaborations have been developed and continue to grow as a result of this process. In final reports on AcD, the PCDN and both Michigan AA chapters plan to continue outreach to primary care practices, including offering and scheduling AcD meetings. One chapter stated, “There is still demand for this type of programming and community education. It has also been found to be a successful marketing technique for the Alzheimer’s Association and the local Area Agencies on Aging to increase visibility in the community and awareness of programs and services.”

## Conclusion

The evaluation of PCDN AcD indicates that a key outcome of the AcD visits was increasing primary care practice physician and staff knowledge of the community resources available for persons with dementia and their caregivers. Many physicians and staff who participated in the dementia AcD visits were already aware that the AA chapters and AAAs provide services. The visits increased their knowledge of the specific programs and services available and follow-up evaluation suggests visits led to an increase in referral of patients and caregivers to these agencies. Results also indicate that AcD was successful in helping increase early detection of dementia by physicians. This evaluation was not sufficient to establish the cost-effectiveness of dementia AcD. More evaluation studies are needed to compare AcD cost-effectiveness to other physician education strategies.

Given the enormity of the challenge of effecting any change in primary care practice, any tool or strategy that contributes to improvements needs to be considered. A recent Cochrane Review indicated that AcD can lead to modest improvement in behavioral aspects of physician performance, such as use of screening tests, implementation of guidelines, or management of problems encountered in general practice.<sup>13</sup> Presented as a peer-to-peer encounter, AcD can be used as an educational tool to stimulate knowledge of and referral to community resources. Although it is not clear that dementia AcD by itself brings about significant, sustainable changes, the strategy does appear to have a positive effect. The findings from this evaluation suggest that dementia AcD can help increase awareness of the importance of early detection and diagnosis and the importance and availability of community resources.

## Authors' Note

All authors have read the final manuscript draft and approved it for submission. Micki Horst, MA, is currently retired (Akron, Ohio). Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Point of view or opinions do not, therefore, necessarily represent official Administration on Aging policy. The original final evaluation report was written by Micki Horst, Senior Community Health Consultant, Dementia Program, Michigan Public Health Institute. The Community Resource Committee of the PCDN developed the dementia detailing packet of materials and provided training to teams from across the state. The Committee consisted of representatives of Alzheimer's Association-Greater Michigan Chapter, Alzheimer's Association-Michigan Great Lakes Chapter, Geriatric Education Center of Michigan, Michigan Public Health Institute, Office of Services to the Aging of Michigan Department of Community Health (MDCH), Mental Health & Substance Abuse Administration of MDCH, Primary Care Dementia Network, and Michigan Alzheimer's Disease Research Center (MADRC) of the School of Public Health, University of Michigan. An evaluator affiliated with Michigan State University worked with the Community Resource Committee to develop the evaluation component. The Area Agencies on Aging represented in AcD visits include Region 2, Northwest Michigan, Region 1-B, Region 7, Region 9, and Tri-County Office on Aging. The following PCDN physicians conducted AcD visits: Iris Boettcher, MD, Gwendolyn Dansby, MD, Alan Dengiz, MD, Kevin Denlinger, DO, Mark Ensberg, MD, Marvin Fields, MD, Kevin Foley, MD, William Kerr, MD, Larry Lawhorne, MD, Richard Knecht, MD, Karen Ogle, MD, Kelly O'Sullivan, MD, Roman Politi, MD, Rhonna Shatz, DO, and Danny Yarger, MD.

## Declaration of Conflicting Interests

The authors declared no conflicts of interest with respect to the authorship and/or publication of this article.

## Funding

This project was funded in part by grants to Michigan Public Health Institute from the GECM in 2004/05 and from the Michigan Department of Community Health 2006 through 2008. The GECM provided support for the GECM Initiative to Improve Dementia Care in Michigan grant it received from the Bureau of Health Professions of the Health Resources and Services Administration as authorized through Section 777(a), Title VII of the U.S. Public Health Service Act, as amended (CFDA #93.969; Michigan State University IRB approved). The Michigan Department of Community Health provided support from the Alzheimer's Disease Demonstration Grants to States provided by the Administration on Aging, Department of Health and Human Services, Washington, DC 20201 (CFDA #93-051).

## References

- Adams WL, McIlvain HE, Lacy NL, et al. Primary care for elderly people: why do doctors find it so hard? *Gerontologist*. 2002;42(6):835-842. [Cites 3 sources: Schappert S. Ambulatory care visits to physicians offices, hospital outpatient departments, and emergency departments: United States. *Vital Health Stat*. 1997;13(143):1-39. Stafford R, Saglam D, Causino N, et al. Trends in adult visits to primary care physicians in the United States. *Arch Fam Med*. 1999;8(1):26-32. U.S. Bureau of the Census. *Current Population Reports, Special Studies, P23-190, 65+ in the United States. Curr Popul Rep*. Washington, DC: U.S. Government Printing Office; 1996.]
- Herbert LE, Scherr PA, Bienias JL, Bennett DA, Evans DA. Alzheimer's disease in the U.S. population: prevalence estimates using the 2000 census. *Arch Neurol*. 2003;60(8):1119-1122; [Cited in 2009 Alzheimer's disease facts & figures. *Alzheimers Dement*. 2009;5(3):234-270.]
- Fortinsky RH. Health care triads and dementia care: Integrative framework and future direction. *Aging Ment Health*. 2001;5(suppl 1):S35-S48.
- Hinton L, Franz C, Reddy G, Flores Y, Kravitz R, Barker J. Practice constraints, behavioral problems, and dementia care: primary care physicians' perspectives. *J Gen Intern Med*. 2007;22(11):1487-1492. [Cites the following sources: Turner S, Iliffe S, Downs MG, et al. General practitioner's knowledge, confidence and attitudes in the diagnosis and management of dementia. *Age Ageing*. 2004;33(5):461-467. Barrett JJ, Haley WE, Harrell LE. Knowledge about Alzheimer disease among primary care physicians, psychologists, nurses, and social workers. *Alzheimer Dis Assoc Disord*. 1997; 11(2):99-106.]
- Fortinsky RH. How linked are physicians to community support services for their patients with dementia? *J Appl Gerontol*. 1998;17(4):480-498.
- Clark PA, Bass DM, Looman WJ, McCarthy CA, Eckert S. Outcomes for patients with dementia from the Cleveland Alzheimer's Managed Care Demonstration. *Aging Ment Health*. 2004;8(1):40-51.
- Michigan Dementia Coalition and Michigan Department of Community Health. Michigan dementia plan: reducing the burden of dementia in Michigan. 2003;4:1-22.
- Hartig JR, Allison J. Physician performance improvement: an overview of methodologies. *Clin Exp Rheumatol*. 2007;25(suppl.47):S50-S54.
- Soumerai SB, Avorn J. Principles of educational outreach ('academic detailing') to improve clinical decision making. *JAMA*. 1990;263(4):549-556.
- Allen M, Ferrier S, O'Connor N, Fleming I. Family physicians' perceptions of academic detailing: a quantitative and qualitative study. *BMC Med Educ*. 2007;7:36.
- Boise L, Neal M, Kay J. Dementia assessment in primary care: Results from a study in three managed care systems. *J Gerontol A Biol Sci Med Sci*. 2004;59A(6):621-626. [Cites prior qualitative research by primary author in this article in Boise L, Camicioli R, Morgan D, et al. Diagnosing dementia: perspectives of primary care physicians. *Gerontologist*. 1999;39(4): 457-464.]
- Underwood A. Thanks, but no thanks: Why more doctors, medical schools and hospitals are just saying no to drug-company promotions. *Newsweek*. October 29, 2007:49.
- O'Brien MA, Rogers S, Jamtvedt G, et al. Educational outreach visits: effects on professional practice and health care outcomes. *The Cochrane Collaboration*. 2009;3(3).