Supplemental file 1. Main clinical, organizational and change management components of collaborative care models

| **Main clinical components of the collCM** |
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| - Early detection of cognitive decline and assessment by the FMG/FHT clinicians |
| - Early diagnosis of Alzheimer's disease and related disorders for typical cases; complicated cases to be referred to a specialist physicians |
| - Explanation of the diagnosis to the patient and caregiver by the FMG/FHT physician followed by the nurse to assure that the information is well understood |
| - Initiation of pharmacological treatment by the FMG/FHT physician (for typical case) and follow-up by the FMG/FHT nurse, social worker, or pharmacist |
| - Identification of patient and caregiver's needs, preferences and expectations by the FMGs' clinicians |
| - A dedicated FMG/FHT nurse case manager for each patient and caregiver dyad |
| - Interdisciplinary care among FMG/FHT physicians, nurses, and other disciplines (e.g. social workers, pharmacists, etc.) |
| - Development of individualized care plans, promotion of self-care, management of multiple chronic diseases |
| - Early involvement of community-based resources for patients and family caregivers (e.g. Alzheimer Society) |
| - Deliberate and pro-active systematic follow up |
| - Care coordination among health and social services, community organizations and patient/family caregiver support groups |
| **Main organizational components of the collCM to support clinical processes** |
| - A strong training program for primary health care professionals |
| - Collaborative chronic disease management based on a holistic approach to these complex patients and their caregivers, treating them as whole individuals within a socio-cultural context |
| - A strong partnership between FMG/FHT physicians and nurses with patients and their caregiver |
| - Agreements to support collaboration between primary health care, secondary/tertiary clinicians and community-based health and social cared professionals, to offer support in a timely sensitive fashion |
| - Timely access to specialists for Behavioral and Psychological Symptom of Dementia |
| - The use of standardized clinical tools and evidence-based protocols based on the Canadian Consensus Conference on Alzheimer Disease and Related Disorders (e.g. decisional algorithms, toolkits, guidelines, and clinical assessment tools) |
| - Shared care between FMG/FHT physicians and specialists for complex cases, such as the involvement of visiting specialists' clinicians |
| - Coordination of patients transitions between the hospital and FMG/FHT (transitional care) to avoid re-hospitalization and emergency department visits |
| - Ongoing information exchange between professionals and settings (e.g. information technologies, interoperable electronic medical records) |
| - Hiring of nurses and social worker in FMG/FHT as case manager |

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| - Use of case discussion at interdisciplinary meetings, with the support of specialists if needed |
| **Main change management components of the collCM** |
| - Identification of a champion |
| - Creation of users' committee, such as caregivers and patients |

FMG/FHT: Family Medicine Group and/or Family Health Teams. collCM: collaborative care models