Appendix 1 (as supplied by the authors): Summary of the CSHA and NACC database characteristics

	CSHA	NACC
Eligibility criteria	- Representative sample of people aged 65 and over - Those in the community (9,008 subjects) were chosen randomly from medicare lists in nine provinces or from the Enumeration Composite Record in Ontario - People in institutions (1,255) were randomly selected from residents in stratified random samples of institutions in each region	- Subjects with a range of cognitive status – normal cognition, mild cognitive impairment, and dementia - Subjects are enrolled through clinician referral, self-referral by patients or family members, active recruitment through community organizations, and volunteers who wish to contribute to research - Most centers also enroll volunteers with normal cognition (these tend to be highly educated)
Evaluations	At each visit: - The Modified Mini-Mental State (3MS) Examination to identify cognitive impairment - Tests for hearing and vision - Vital signs, height, weight and medication use - Subject's cognitive and family history from a relative, using section H of the Cambridge Mental Disorders of the Elderly Examination - A psychometrician blind to the 3MS score administered a battery of neuropsychological tests to subjects with a score of 50 – 77 - Clinical examination of all those in institutions, those in the community with a 3MS score of less than 78 and a sample of those in the community with a 3MS score of 78 or more to diagnose dementia - A neuropsychologist evaluated the test results in conjunction with the results of the CAMDEX and the 3MS - A physician reviewed the information collected by the nurse and examined the patient, performing a mental status assessment as well as physical and neurologic examinations	- Standardized evaluation - Written informed consent is obtained from all participants and informants - Diagnosis is made by either a consensus team or a single physician (the one who conducted the examination)

Appendix to: Bernier PJ, Gourdeau C, Carmichael P-H, et al. Validation and diagnostic accuracy of predictive curves for age-associated longitudinal cognitive decline in older adults. *CMAJ* 2017. doi: 10.1503/cmaj.160792.

	- Physician then made a preliminary diagnosis before seeing the neuropsychologist's evaluation - Subjects suspected of having dementia or delirium were sent for hematologic and biochemical tests - A case conference was then held to arrive at a consensus diagnosis in one of the following categories: no cognitive loss, cognitive loss but no dementia (eight subcategories were specified), AD (probable or possible, divided into four subcategories), vascular dementia (four subcategories), other specific dementia (six subcategories) or unclassifiable dementia	
Follow up	- Study span: 1991 – 2002 - At 5 years' interval (i.e. Visit 1: Year 0, Visit 2: Year 5, and Visit 3: Year 10)	- Started in 2005, ongoing - Annual follow-up for a maximum of ten years (as long as the subject is able to participate)
Abbreviations: CSHA: Canadian Study of Health and Aging[1]; MMSE: Mini-Mental State Examination; NACC's UDS: National Alzheimer's Coordinating Center's Uniform Data Set([2]).		

References

1. The Canadian Study of Health and Aging: risk factors for Alzheimer's disease in Canada. *Neurology*. 1994;44:2073-80.
2. National Alzheimer's Coordinating Center. For researchers using NACC data: Information and resources University of Washington School of Public Health. 2016. Available: https://www.alz.washington.edu/WEB/researcher_home.html (accessed June 15, 2015).