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Ellen Kelsay
That's Joanne Pike, president and CEO of the Alzheimer's Association, whose recent research is delivering breakthrough insights in the fight against Alzheimer's and dementia.

I'm Ellen Kelsay, and this is the Business Group on Health podcast, conversations with experts in the most relevant health and well-being issues facing employers.

Today, we're diving into the groundbreaking U.S. Poynter study, a major research initiative by the Alzheimer's Association to uncover how lifestyle changes can protect brain health. Joanne joins us today to discuss what drove this research, what makes it unique, and the key findings that could change the way we approach cognitive health.

Joanne, welcome, thrilled to have you back on the podcast.

Joanne Pike
Thank you. It's great to be back.

Ellen Kelsay
Yes, we spoke about a year ago and you shared a lot about what your association's up to in the field of Alzheimer's research, and you were just in our office early this afternoon meeting with some of our committee members, and so we're delighted to have you back on the podcast to talk about one of your more recent studies, and that's the U.S. POINTER study. So let's start with, what's that study all about and what led the Alzheimer's Association to embark on it?

Joanne Pike
Thank you. The U.S. POINTER study is a great example of the progress that we're making right now in Alzheimer's and the other dementias. The U.S. POINTER study is really focused in on building the knowledge around risk reduction and how we can, as individuals, use lifestyle as a protective factor. We built the U.S. POINTER study based off of a research study done in Finland that showed that you could have a lifestyle intervention that reduced cognitive decline over time. We wanted to be able to replicate that here in the U.S., to really see in a diverse U.S. that has different lifestyle factors, including the foods we eat, how we exercise, how we get our health care, can we create an intervention that does protect against cognitive decline and ultimately Alzheimer's or another form of dementia. A couple years ago, we started that research study. We enrolled over 2,000 individuals. We randomized them to a self-help, a self-guided group or a structured intervention. In both of those groups, we really focused in on four factors. Nutrition that focused in on the MIND diet, physical activity and maintaining a high level of physical activity, social and cognitive intervention, and then also health monitoring. At the heart of that was heart health and blood pressure control. The structured group had significantly more in-person events. They had a higher accountability structure. What we found over that two-year intervention is that structured group was able to protect cognitive decline at a higher rate than the self-guided group. Now both groups did improve, but that structured intervention had what amounts to about a one- to two-year cognitive protective factor for individuals. So we were able to show that if you control for all of these lifestyle interventions, you increase individuals' physical activity and the quality of their nutrition, then you can protect brain health.

Ellen Kelsay
You did this in five different locations in the U.S. over a two-year period and you were looking for a dispersion in terms of not only geography, but also population demographics. Can you speak a little bit more about the demographics of the participants of the studies?

Joanne Pike
Yes, absolutely. The demographics were between the ages of 60 and 80. We looked for both men and women. We had a higher percentage of women who were in the study than men, about 65 to 35% women. Then we also wanted to look at ethnicity and race because we really wanted to target a diverse population. We were able to enroll greater than 30% non-white, which we were really proud of for the outreach that we did at the community level, the engagement strategy on that front, and also for risk factors. We know that African-Americans and Hispanic Latinos carry a much higher risk of developing cognitive decline or a type of dementia. So we wanted to make sure that we could build an intervention that worked for those who are at greatest risk.

Ellen Kelsay
So there were four areas that you were focused on in the study, two different cohorts. Let's dive into those four areas more specifically. In nutrition, in diet and exercise, and the others, what were some of the things that the participants were doing in the more controlled group that were more substantial than maybe what you saw in the self-controlled group?

Joanne Pike
Just to start off with, the self-guided group received the same type of information. It was just delivered to them in a way where they received it in self-education and they received touch points with a navigator or a coach three times a year. Now, the structured group, on the other hand, received that information and they had 38 touch points over the two-year intervention time period. That is a lot of time that we spent with those individuals to make sure that they were doing all of the things that we were asking of them to do. On the nutrition standpoint, we really looked at teaching them and coaching them on how to eat a MIND diet, which is a combination of a Mediterranean and a DASH diet. So high protein, high vegetable, fruit consumption and lower on the saturated fats. We also looked at physical activity. We tracked them using Fitbits and monitoring their physical activity engagement. We had classes for them on that front. Another key piece to this was the social and cognitive engagement. They had to participate in a cognitive online training program and that training program got harder over time as they progressed through the intervention. Then the other key piece was this was all done in coordination with health systems in these five locations. So they were also required to control for blood pressure and any other health monitoring that they needed to do. I think one of the things to keep in mind about this is these were not healthy individuals to begin with. They were at risk. They were not exercising. They were not eating well. They scored low on the MIND diet rating. They were the couch potatoes. Not only that, but they also had a family history for the most part of cognitive decline or Alzheimer's or another dementia. About 75 percent of them had some family history. So we knew they were at high risk based on their behaviors and we knew they were at high risk based on family history as well.

Ellen Kelsay
What I imagine too, as we were talking about in the meeting that you just presented at with our smaller group here, many of these things, whether it be lifestyle, nutrition, brain health, social interaction, those are just good for general well-being and for the treatment of other conditions. I would imagine that the structured group, as well as the self-guided group, saw improvements in other areas of their health as well.

Joanne Pike
We did a couple, actually, ancillary studies that were funded by the National Institute on Aging, and we were able to show just that. We looked at sleep because we know sleep is an important factor within cognition and health generally. We also looked at blood pressure and the impact that maintaining healthy blood pressure has on cognitive resilience. We also did an imaging study to look at if we do these things, does it change the actual biomarkers within the brain and the resiliency that happens as a result of that. Some very interesting stuff, but you're absolutely right. Does a structured intervention that focuses on these core areas not only improve cognition, it improves other areas as well. And blood pressure, sleep and cognitive resilience are a big part of that.

Ellen Kelsay
Yes and you said you're going to track these participants now for how much longer into the future?

Joanne Pike
We've made a commitment that we're going to track them for another four years.

Ellen Kelsay
And are they enrolled in the program? Are they still meeting with the clinician?

Joanne Pike
They are not. The structured intervention is over. Now it's a matter of are they going to maintain it themselves. Have they built that infrastructure within their lives to do that? So we're going to track them over the next four years and see what happens with both the self-guided and the structured intervention group and see what changes for them. We consider it almost like our little mini Framingham study to track their outcomes. But not only that, we know that if we've learned this about the U.S. POINTER study, it's valuable information. If we can keep people sharper and in the community longer, then we need to be replicating that in other ways. We've also looked at implementation grants in communities where we're working with other health systems, with departments of public health, with physicians groups to tailor the intervention and go from a very controlled clinical trial setting to a real world setting, and can you see those changes within that landscape also.

Ellen Kelsay
And the age group, you said, remind me again for the participants.

Joanne Pike
60 to 80.

Ellen Kelsay
Okay, can you think about an application? Many of our listeners are employers with people who are working for them that are very well north of 60, but also well south of 60 in terms of age range. How could employers think about adopting some of these principles or the outcomes from the study and apply them to their benefits, their programs, how they think about the well-being of their workforce?

Joanne Pike
Yes, I think this is a great question because we know that the benefits that we saw with those who are 60 to 65, let's just say Medicare age, are implied within this. But we know that if you go younger, that the same types of implications exist out there. I think there's a few ways that

employers can think about it, optimizing their health plan to align with some of these interventions within the POINTER study, thinking about wellness offerings and how do those wellness offerings align to POINTER and how do you incentivize the use of both of those things at the individual level and not just assuming that because it's there that people are going to use it. Then increasing efforts to ensure employees know about their benefits, know about their coverage that they have and the access they have to that. Then one of my favorite things is data and what can we learn from data. And of course, requiring, if you're going to do all these things, require your health plans to report that data back to you.

Ellen Kelsay
I was fascinated when we were speaking earlier, talking about some blood testing that is available and ruling in and ruling out of Alzheimer's. Can you elaborate on that for the audience? What is out there today? What might be coming and also in the vein of what should or how should employers be thinking about applicability within their programs?

Joanne Pike
Well, I think the blood tests and the progress that we've been making with diagnostics is another great example of the movement that we're seeing in research and everything that is coming out of the pipeline that is not just on the treatment landscape, but on the accurate diagnosis landscape and how can we really get an earlier and accurate diagnosis for Alzheimer's disease and the implications for other cognitive impairments or other dementias out there. In 2025, we really had a breakthrough from the standpoint of FDA cleared blood tests that can be used to diagnose Alzheimer's disease, but that can also be used to rule out Alzheimer's disease. So we have two FDA cleared blood tests, one that can be used in a specialty setting. So if someone presents in a specialty office, a neurologist, a gerontologist, and they are showing cognitive changes, there is a blood test now that's called the Lumipulse created by Fujirebio to rule in, it can diagnose Alzheimer's disease through P-tau 217, the presence of P-tau 217 within blood. Then on the other side, there's a rule out test that was more recently approved. It can be used in the primary care setting. So if someone goes into primary care, they have some cognitive concerns, this test can be used to rule out Alzheimer's disease. If it doesn't rule out Alzheimer's disease, then the primary care physician knows they need to refer them to a specialist. But if it does rule out Alzheimer's disease, then the primary care physician knows that they can investigate other areas of concern. Maybe that's sleep. Maybe that's a vitamin deficiency. Maybe it is another form of dementia or cognitive impairment besides Alzheimer's disease.

Ellen Kelsay
You also referenced, well, actually, before I ask you that question, applicability for employers on these blood tests.

Joanne Pike
Yes, I think that's truly important because these are blood tests that are approved for on the rule in application, it's approved for the 50 plus population in a specialist setting. In the rule out in the primary care setting, that is approved for 55 and up. These are two tests that should be covered within payers and the health plan setting. So this is an opportunity for employers to ensure that their health plan and what they are providing for their employee base has these two tests available to them. Access is incredibly important. But then also understand what those coverage opportunities are so if someone does test positive in these blood tests for Alzheimer's disease, there are disease modifying treatments available and really understanding what is available within your health plan to offer those disease modifying treatments.

Ellen Kelsay
There's so much research that you and your organization are pursuing. You mentioned a meeting earlier this week where there were findings from one study related to GLP-1s that I thought might be interesting for you to share with the audience. We all are hearing about, you know, every day almost it sounds as though there's a new potential area of health care that GLP-1s could be useful for and you were curious about that and you explored it related to cognitive decline in Alzheimer's. So what did you see in that study?

Joanne Pike
At the Clinical Trials for Alzheimer's Disease Conference, one of the biggest highlights that we were all anticipating was the report out from Novo Nordisk around their GLP-1 semaglutide and whether it could be used to treat early-stage Alzheimer's disease. We were all disappointed to see a negative outcome on cognitive scores for individuals who are enrolled in that for Alzheimer's disease. But there were changes in the biomarkers associated with Alzheimer's disease. So we know there's something there. It will be interesting to see what happens with the GLP-1 landscape. We know that there is another GLP-1 that just finished up a phase two trial and that was positive. There are still things out there that while this one clinical trial, actually two, EVOKE and EVOKE Plus, were negative, there are lessons to be learned from that. I don't think that story is over yet. I think the data is going to tell us a lot more. But I'm really hopeful about what's in the pipeline right now and the Clinical Trials for Alzheimer's Disease Conference was a great example of that. Right now, there are over 180 clinical trials going on with over 130 novel drugs in various stages of the pipeline. I think in the next 12 to 18 months to 5 years, we're going to see a significant amount of breakthroughs and innovation happen within the landscape. I think that's also as we get better at diagnosing, as we get better at having conversations, as stigma is reduced, we're going to see the population start to talk about brain health and cognitive decline at a younger age.

Ellen Kelsay
I think it's so amazing when you talk about 180 studies right now going on and potentially that many plus more therapeutics available, coupled with the U.S. POINTER study on lifestyle, it does not all have to be pharmacological intervention and treatment, although they are amazing and wonderful, that is not the only answer. So that's what I found so profound about the POINTER study that you all did as well.

Joanne Pike
Yes, absolutely. I think what we're on the cusp of is while we have a couple of FDA approved treatments right now, there's going to be more in the pipeline. We're going to get to combination therapy and then you combine combination therapy with what we know from a personalized standpoint on lifestyle. We're on the cusp of personalized medicine to treat Alzheimer's. As soon as we can do that, it builds more knowledge so that we can work on the other dimensions as well. We know we all need to do better by our lifestyle and this is proof that we have the knowledge to change our cognitive health long into the future. Going from clinical trial to community, I think making that jump is critically important and thinking about where we do that and how we do that. I'm a big believer that we have to create the environment for individuals to be successful. That means multiple places, whether that's in the workplace or whether that's in a health system or whether it's through local policy and the benefits that our states and federal government can provide. But we got to start with individuals. We've been really working on what individuals can do to learn more about their brain health, to change some of their habits. Then we're also looking at systems that support individuals, health care systems. How can we intervene with health care systems? How can we think about where benefits are provided, whether that's in the workplace or through another payer model? Then also, what is our role and the work that we need to do

with our departments of health, both at the state and CDC or other federal agencies, to ensure that those investments are being made into people and places.

Ellen Kelsay
No shortage of things to continue to focus on and it's great. Of all the wonderful things you've talked about on a topic that can be a little bit dark and gloomy, there are so many lights of optimism and things to be hopeful about. If you could pull one or two things forward that give you most hope for the future in this field, what would you say?

Joanne Pike
I would say progress. Progress and people. We're at this pivotal moment when it comes to the way we treat Alzheimer's, the way we diagnose Alzheimer's and the innovations that we see coming out of the pipeline. But that's all made possible by advocates and it's made possible by people who are willing to share their story, who are willing to participate in clinical trials. There is no shortage of individuals who are impacted by this disease in some way, shape or form. Those two lights to me are kind of North Stars, right? We're going to change the way this disease and the other dementias look in the next five years.

Ellen Kelsay
Well, we all know somebody who has been impacted, whether it be directly within our immediate families or elsewhere. Many of us in our lifetime probably will be directly impacted if we haven't been already, so the more upstream we can get with the education, the knowledge and all the wonderful work you all are doing is certainly helpful to that end. So appreciate you joining us today, sharing the results of the study with the audience and your second time on the podcast. Maybe we'll have you back a third time when the next study comes out. Thanks again for joining us, Joanne.

Joanne Pike
Thank you.

Ellen Kelsay
I've been speaking with Joanne Pike, president and CEO of the Alzheimer's Association, about their work to spread awareness that lifestyle changes like staying active, eating well and engaging with your community can truly make a difference in brain health. To learn more, visit their website at https://www.alz.org/us-pointer.

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