WELCOME
to the

Primary Care for People Living with Dementia ECHO

Funding Statement

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Series Learning Objectives

- Describe the role of Primary Care in dementia assessment and care planning for people living with dementia
- Discuss common challenges experience by people living with dementia and their caregivers, including strategies to address those challenges

Series Sessions

Date	Session Title
9/18/2025	Diagnosis
10/16/2025	Chronic Disease and Dementia
11/20/2025	Driving
12/18/2025	Depression and Dementia
1/15/2026	Long Term Care Options
2/29/2026	Care Partner Support

Assessment of Dementia in Primary Care

Ken Dolkart MD FACP

Section of Geriatrics DHMC

September 18, 2025

Learning Objectives

Review rationale for early dx, definitions & clinical features

Outline the diagnostic process & explore clinical tools for assessing cognitive impairment in the Primary Care Office

Case-illustration of Primary Care work-up for common scenarios

Explore the plethora of recent diagnostic advances

Assessment Begins with Recognition

- **Dementia often undiagnosed:** 53% of seniors whose families recognize serious memory issues do NOT receive an evaluation by their primary care clinician
- Ave. time to diagnosis for AD is 3.5 years, 4.5 years for LBD
- Delay in dx common in younger pts, those w FTD w atypical sx & in those who live alone
- Even after dx, presence of dementia **often undocumented in notes** when that dx that would:

Kusoro O, Roche M et al. Time to Diagnosis in Dementia: A Systematic Review With Meta-Analysis. Int J Geriatr Psychiatry. 2025 Jul;40(7):
Davis KAS et al, What gets recorded, counts: dementia recording in pc compared with a specialist database. Age Ageing. 2021 Nov 10;50(6)
Arsenault-Lapierre G, et al. Rural & urban differences in quality of dementia care:a systematic review. BMC Health Serv Res. 2023 Jan 31;23(1)

Timely Dx & Documentation **Informs Care**

- prompts evaluation for correctable contributing factors (deleterious meds, MDD, OSA, vit. deficiency, etoh…)
- initiates assistance w adherence w medication & follow-up visits
- may reduce pt & societal risk of injury a/w MVA, fire, guns, unsafe behavior
- w early dementia, enables **pt participation** in advanced directives, financial trusts, estate planning & choices for future living arrangements
- mitigate risk for scams, financial exploitation & abuse
- reduce caregiver stress via education, training & assistance
- allows intervention w meds & non-pharm. Rx for maintaining memory & mood

Definition – Dementia

(“Major Neurocognitive Disorder” in DSM- V)

A. Chronic, gradual acquired decline in one or more cognitive domains sufficient to affect daily life **AND**

B. The cognitive deficits interfere with **independence in everyday activities.**

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).

In Contrast to Mild Cognitive Impairment

("Mild Neurocognitive Disorder" in DSM- V)

"Modest" reduction in at least 1 cognitive domain compared to age-matched controls but **no interference w independence** in activities

However, daily activities may require more time, effort or compensatory strategies

30% - 50% of pts w MCI convert to AD dementia over a 5- to 10-year period w amnestic impairment most consistently predictive of such progression

Distinguish from Delirium:

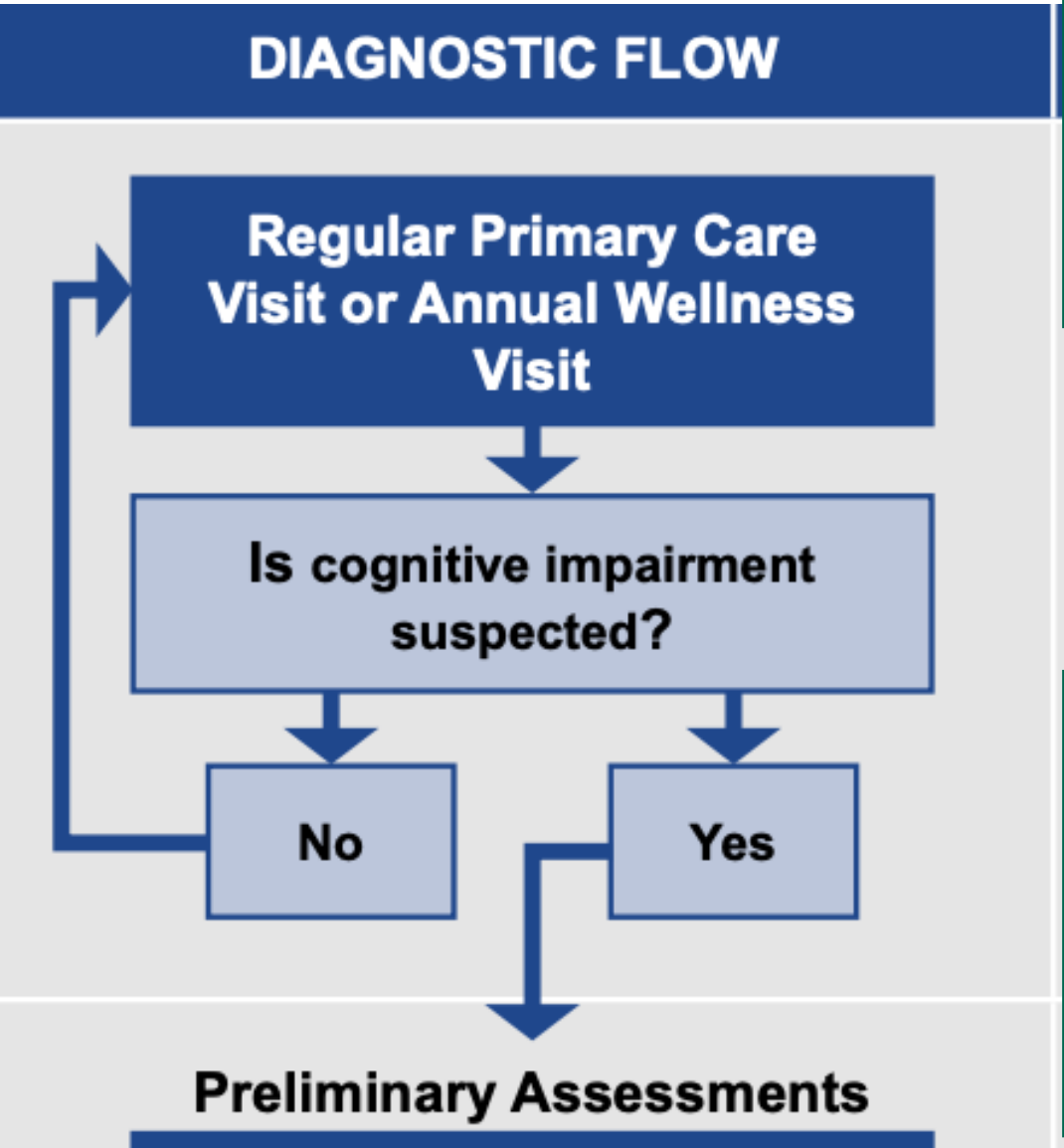
Acute decline of cognition & attention, related to physiological stress of a general medical or surgical disorder

Alzheimer's disease	Dementia with Lewy bodies
Gradual decline in global cognition and day to day ability Memory for recent conversations and events most prominent symptom	Fluctuations in cognition and alertness Visual hallucinations Movement symptoms of Parkinson's disease Vivid dreams/moving in sleep Falls Symptoms of anxiety/depression
Vascular dementia	**Frontotemporal dementia**
History of stroke History of vascular risk factors Patchy cognitive impairment (some areas of cognition preserved in unusual pattern) "Stepwise decline" often quoted but less often seen	Disinhibition Impulsivity Loss of empathy Change in food preferences (often sweet foods) Change in eating habits Lack of insight Language symptoms

Dartmouth Health

Project ECHO

Diagnostic Process



Higher vigilance for older age (incidence doubles every 5 yrs after age 65), poorly controlled HTN, CV risk factors, low education, MDD, isolation, etoh

CLINICAL ASSESSMENT

- Patient report
- Caregiver report
- Clinical observation during visits

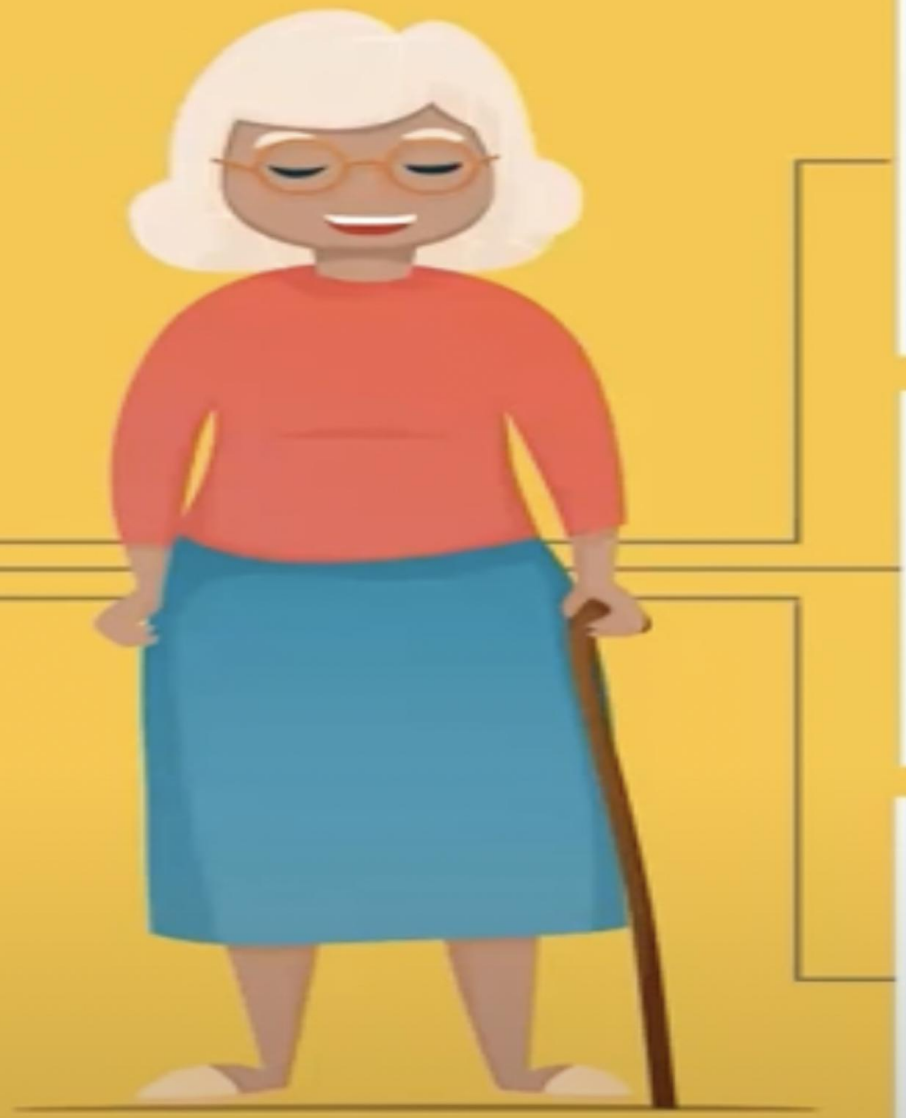
Red flags: Unexpectedly missing appointments, Vagueness in recall of prior instructions or conversations
Suspected non-adherence, vagueness in describing medication taking & difficulty filling meds

SIGNS OF DEMENTIA

Difficulty with every day tasks.

Becoming lost in familiar places.

Forgetful of recent events, people & their names.



Difficulty with communication and language.

Becoming unaware of the time and place.

Changes in mood and behaviour.

Informant Hx via Validated "AD8"

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. **Daily** problems with thinking and/or memory			
TOTAL AD8 SCORE			

Adapted from Galvin JE et al, The AD8, a brief informant interview to detect dementia, Neurology 2005:65:559-564

Score of ≥2 suggests *possible* cognitive impairment, which warrants further assessment

score = 3-4 sens. 82-.91 spec. 0.76-94)

Ascertain History of Functional Decline

Instrumental Activities of Daily Living

Enables Independence in Community:

-Driving, Arranging Transportation
-Managing Finances, Checkbook
-Managing Medications
-Shopping
-Preparing Food, Cooking
-Cleaning, housekeeping
-Laundry
-Leisure Activities, travel
-Use of Telephone

Complex, multi-step tasks

Activities of Daily Living

Enables staying in home with support

-Bathing
-Dressing
-Personal Hygiene
-Toileting, continence
-Ambulation, stairs
-Transfering OOB & to chair
-Feeding

Less complex tasks

Katz ADL Scale/Lawton IADL scale

Clinical Hx & *Correctable Factors

Onset & Tempo:

Age of onset, insidious vs. abrupt or stepwise

Progressing over years vs months

Use of **anticholinergics, *sedating meds, drugs & alcohol

Mood - *depression common in early AD, often not fully explanatory of cognitive impairment

H/o sleep disorder (*OSA, h/o RSBD)

Staring spells a/w *seizures, fluctuating LOC a/w LBD

Behavioral changes, **Personality** Changes - early in FTD

Hallucinations - early feature of LBD

PMHx in Evaluating Dementia

-hx HTN, DM, HLD, CAD/vascular dz predisposing to microvasc CNS dz

-hx abrupt onset, staggering step-wise decline, focal neuro sx, suggests Multi-infact dementia

-recent hx of serious systemic illness w current sequelae of delirium

-h/o possible liver disease that might be a/w encephalopathy

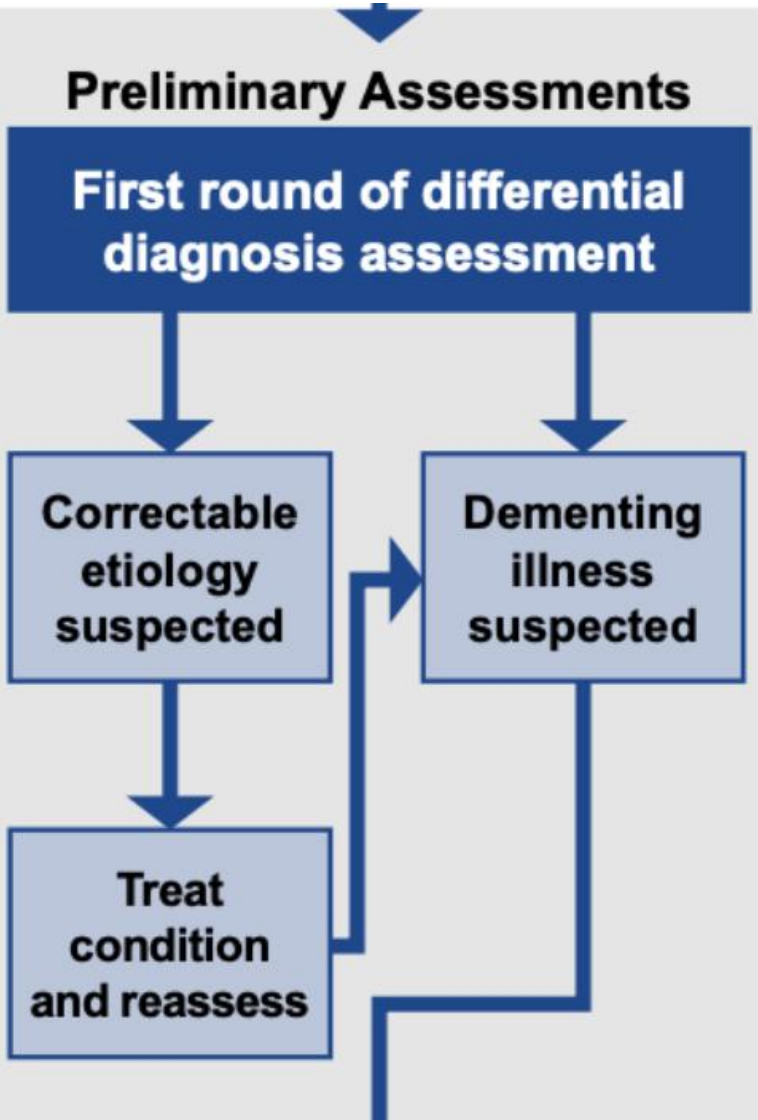
-hx CP arrest, concussions, SDH, encephalitis, neurosurgery

-hx heavy alcohol use w possible Wernicke Encephalopathy —> Korsakoff Syndrome

-Risk factors or other sx suggesting HIV/syphillis/untreated lyme

-Occupational-environmental risks for heavy metal exposures

Assessment Requires Hx from both Patient & Informant (family, friend,caregiver)



BASIC DIAGNOSTIC ASSESSMENTS

- Obtain expanded history focused on cognitive abilities to include onset of complaint (recent or chronic; abrupt or gradual), pace of decline and nature of cognitive loss:
  - Short-term memory
  - Instrumental ADLs (balancing checkbook, cooking, driving, manipulation of electronics)
- Conduct neurologic physical examination
- Assess risk factors for cognitive decline (e.g. cerebrovascular risk factors) and medications (e.g. anticholinergics or sedative hypnotics)
- Assess for psychiatric conditions
- Diagnostic
  - Request general labs including thyroid function tests, vitamin B12, homocysteine, complete blood count with differential, complete metabolic panel (including calcium, magnesium and liver function tests), erythrocyte sedimentation rate and C-reactive protein

Early Dx frequently **requires** diagnostic tools

Brief. Validated. Effective Diagnostic Tools:

Table 3a. Cognitive assessment tools		
Tool	**Benefits**	**Limitations**
Mini-Cog[1] dementia.americangeriatrics.org/#tools	Short time to administer.	Positive score triggers further testing with one of the other screening tools.
Mini-Mental State Examination (MMSE) www4.parinc.com/products/Product.aspx?ProductID=MMSE[2]	One of the most widely used tests; high specificity.	Low sensitivity.
Montreal Cognitive Assessment (MoCA) www.mocatest.org/	Most comprehensive test; high sensitivity.	Longer administration time; low specificity.

Case #1 Jane Thomas

78 yo former administrator w h/o well-controlled HTN, insomnia & osteoarthritis, here after ER visit out-of-state for wrist injury.

-She had missed the previous AWV 2 months ago due to having her car in the shop. She lives alone, but states she is managing adequately at home w her wrist cast. Her daughter drove her to office, but she requested she wait in lobby.

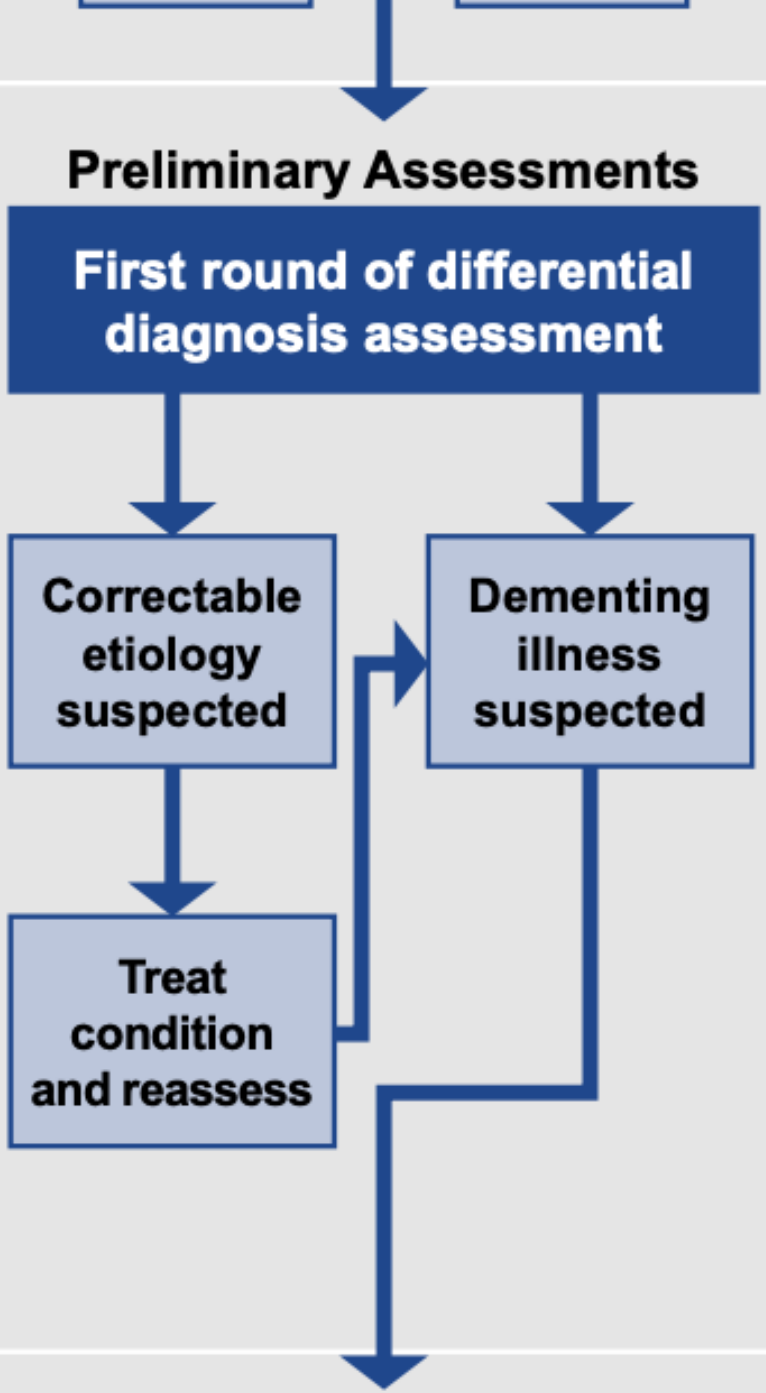
Jane is her usual delightful self, jokes about her clumsiness, but is a little vague about recent ER details, otherwise feels well & reports no difficulty w memory, mood or function.

-BP is 165/102 L arm in short-cast

What further steps are prompted by this scenario?

Mrs H is seen in office 2 days after ER visit for fx wrist– meds include lasix, amlodipine and trazodone. The problem list indicates hypertension, cataracts, osteoarthritis, and insomnia. You are scheduled for a 30 minute visit.

You ask Mrs. H to recount "the story of her fall" and she reports that she didn't lose consciousness but thinks she may have tripped on the mat outside the bathroom, when hurrying to the bathroom in the early morning after taking her pills. She did not strike her head. She had just resumed amlodipine (the prescription had run out last month), and was feeling "dizzy" in the mornings since then. She also admits that she has been taking OTC tylenol PM (diphenhydramine) at bedtime. She has been groggy in the AM with a sense of balance being off



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- Conduct neurologic physical examination
- Assess risk factors for cognitive decline (e.g. cerebrovascular risk factors) and medications (e.g. anticholinergics or sedative hypnotics)
- Assess for psychiatric conditions
- Diagnostic
  - Request general labs including thyroid function tests, vitamin B12, homocysteine, complete blood count with differential, complete metabolic panel (including calcium, magnesium and liver function tests), erythrocyte sedimentation rate and C-reactive protein
  - Structural brain imaging with MRI (head CT if MRI contraindicated)

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Primary Care for People Living with Dementia ECHO

Session 2,Chronic Disease and Dementia
October 16, 2025

Dementia and Chronic Disease: 10 Pearls

1. Remember Goals of Care

IF I GET SICK:

- Do everything to save my life (ICU, Vent, Dialysis, CPR, Major Surgeries.)
- Do non-heroic things to save my life (IV meds, simple surgeries)
- Do gentle things to save my life (oral medications, outpatient procedures)
- Don't do anything to save my life, just keep me comfortable.

2. Your Mantra: “How will it change management?”

3. Prioritize health problems

- Discontinue visits to low priority providers
- Discontinue low priority medications

BEFORE

- Diabetes
- Congestive Heart Failure
- Breast Cancer s/p lumpectomy 2019

NOW

- Dementia
- Frequent Falls
- Recurrent Delirium
- Depression
- Congestive Heart Failure
- Diabetes

5. Never Forget about Delirium

- Sleep
- Pain
- Hydration
- Routine
- Familiar Faces
- Bowels
- Avoid the ED

4. Never Forget about Falls

6. Caregivers come to **every** visit

7. Take Care of the Caregiver

8. A few words about Medications

- Beers!
- No Sliding Scale Insulin
- No tight control of pretty much anything (DM, HTN, HF)
- No Sliding Scale Diuretics – Use a Target Weight
- No warfarin unless absolutely necessary
- Whenever possible: Once Daily, all in the morning
- Worry less about rare adverse effects
- Worry less about a little kidney failure
- Pill Box!

9. Write down instructions(in simple 3-8 word sentences)

- "Increase Sertraline to 200 mg (2 pills)every morning."
- "Don't drive any more."
- "Walk to the mailbox every day."
- "Cancel the appointment with Dr. Smith."
- "Be nicer to your daughter."

Be the Captain of the Ship.

Thank-you!

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Primary Care for People Living with Dementia ECHO

Session 3,Driving and Dementia
November 20, 2025

Dementia and Driving

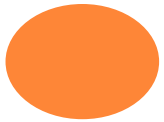
Daniel Stadler, MD – November 20, 2025

What the data supports

- Driving skills deteriorate with increasing dementia
- Elderly individuals have the highest risk of MVA per mile driven.
- 15% of all traffic deaths are caused by an elderly driver.
- Limited driving among older adults is associated with social isolation, depression.
- ~75% of individuals with dementia can pass a road test.
- A patients self rating of “safe” is un-useful for determining risk.

What the data suggests

- A Caregiver's rating of marginal or unsafe is probably useful in identifying unsafe drivers.
- Caregivers tend to overrate performance in nearly every category of driving safety.
- The following likely predicts unsafe driving and accidents:
  - A recent history of a crash or citation
  - A MMSE of ≤ 24
  - Self reported reduced mileage/avoidance
  - Aggressive or impulsive characteristics
  - Specific comorbidities



Can we just refer to the DMV?

- No standardization between states or departments
- ORDT effectiveness is questionable
- Can damage patient/physician relationship
- Can results in costs to the patient

GOALS

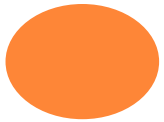
1 – Protect the safety of the patient, his/her family and the community

2 – Maximize the patient's independence and quality of life

3 – Preserve the relationship between the patient and caregiver

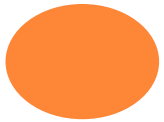
4 – Preserve the relationship between the patient and clinician

5 – Minimize chance of litigation toward clinician



RISK STRATIFY

- Low – can probably drive, perhaps with limits
  - MCI or very mild dementia/High function
- Medium – maybe can drive (but not for long)
  - Mild dementia/Some mild functional impairment
- High – should not drive
  - Moderate – Severe dementia/Significant functional impairment
  - Mild dementia with “alarm signs”



Low Risk Patients

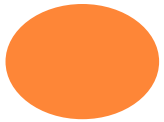
- Counsel patients and families to anticipate changes and plan accordingly.
- Encourage
  - Moving to population dense areas
  - Limiting driving
  - Using public transportation
  - Engaging family in driving
- Consider Occupational Therapy
- Reassess every six months

Medium Risk Patients

- Consider Clinical Dementia Rating scale (might move the patient up or down)
- Consider OT assessment
- Consider driving restrictions
- Consider written, vision and road test
- Reassess every 6 months

High Risk Patients

- 1)Cajole/Engage the patient to stop driving.
  - Emphasize:
    - Risk to self
    - Risk to others
    - Financial/Legal liability
- Engage the family
  - Suggest:
    - Taking away the keys or car
    - Family reporting to the DMV
    - Providing alternative travel arrangements
- "Order" no driving until further eval:
  - "Driving specialist"
  - Road, written and vision test by DMV.
- If all else fails, report to the DMV as unsafe to drive.



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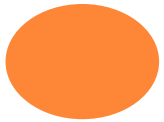

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Primary Care for People Living with Dementia ECHO

Session 4, Depression and Dementia
December 18, 2025

Diagnosing and Managing Depression in Dementia

Why Depression in Dementia Is Different

- Depression is common across all dementia subtypes
- Symptoms present atypically
- Standard diagnostic criteria perform poorly
- Treatment response is modest but meaningful

What is “Depression”

Common	Less common
• Apathy or withdrawal • Irritability rather than sadness • Loss of initiative • Somatic preoccupation • Reduced emotional reactivity	• Sustained guilt • Ruminative self blame • Verbalized hopelessness

Screening Tool: Cornell Scale for Depression in Dementia (CSDD)

Scoring System: a = unable to evaluate
0 = absent
1 = mild or intermittent
2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview. No score should be given if symptoms result from physical disability or illness.

A. Mood-Related Signs

1. Anxiety anxious expression, ruminations, worrying	a	0	1	2
2. Sadness sad expression, sad voice, tearfulness	a	0	1	2
3. Lack of reactivity to pleasant events	a	0	1	2
4. Irritability easily annoyed, short-tempered	a	0	1	2

B. Behavioral Disturbance

1. Agitation restlessness, handwringing, hairpulling	a	0	1	2
2. Retardation slow movements, slow speech, slow reactions	a	0	1	2
3. Multiple physical complaints (score 0 if GI symptoms only)	a	0	1	2
4. Loss of interest less involved in usual activities (score only if change occurred acutely, i.e., in less than 1 month)	a	0	1	2

C. Physical Signs

1. Appetite loss eating less than usual	a	0	1	2
2. Weight loss score 2 if greater than 5 lb. in one month	a	0	1	2
3. Lack of energy fatigues easily, unable to sustain activities (score only if change occurred acutely, i.e., in less than 1 month)	a	0	1	2

D. Cyclic Functions

1. Diurnal variation of mood symptoms worse in the morning	a	0	1	2
2. Difficulty falling asleep later than usual for this individual	a	0	1	2
3. Multiple awakenings during sleep	a	0	1	2
4. Early-morning awakening earlier than usual for this individual	a	0	1	2

E. Ideational Disturbance

1. Suicide feels life is not worth living, has suicidal wishes or makes suicide attempt	a	0	1	2
2. Poor self-esteem self-blame, self-deprecation, feelings of failure	a	0	1	2
3. Pessimism anticipation of the worst	a	0	1	2
4. Mood-congruent delusions delusions of poverty, illness or loss	a	0	1	2

Scoring:

A score >10 probably major depressive episode
A score >18 definite major depressive episode

D. Cyclic Functions

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3. Pessimism anticipation of the worst	a	0	1	2
4. Mood-congruent delusions delusions of poverty, illness or loss	a	0	1	2

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A score >18 definite major depressive episode

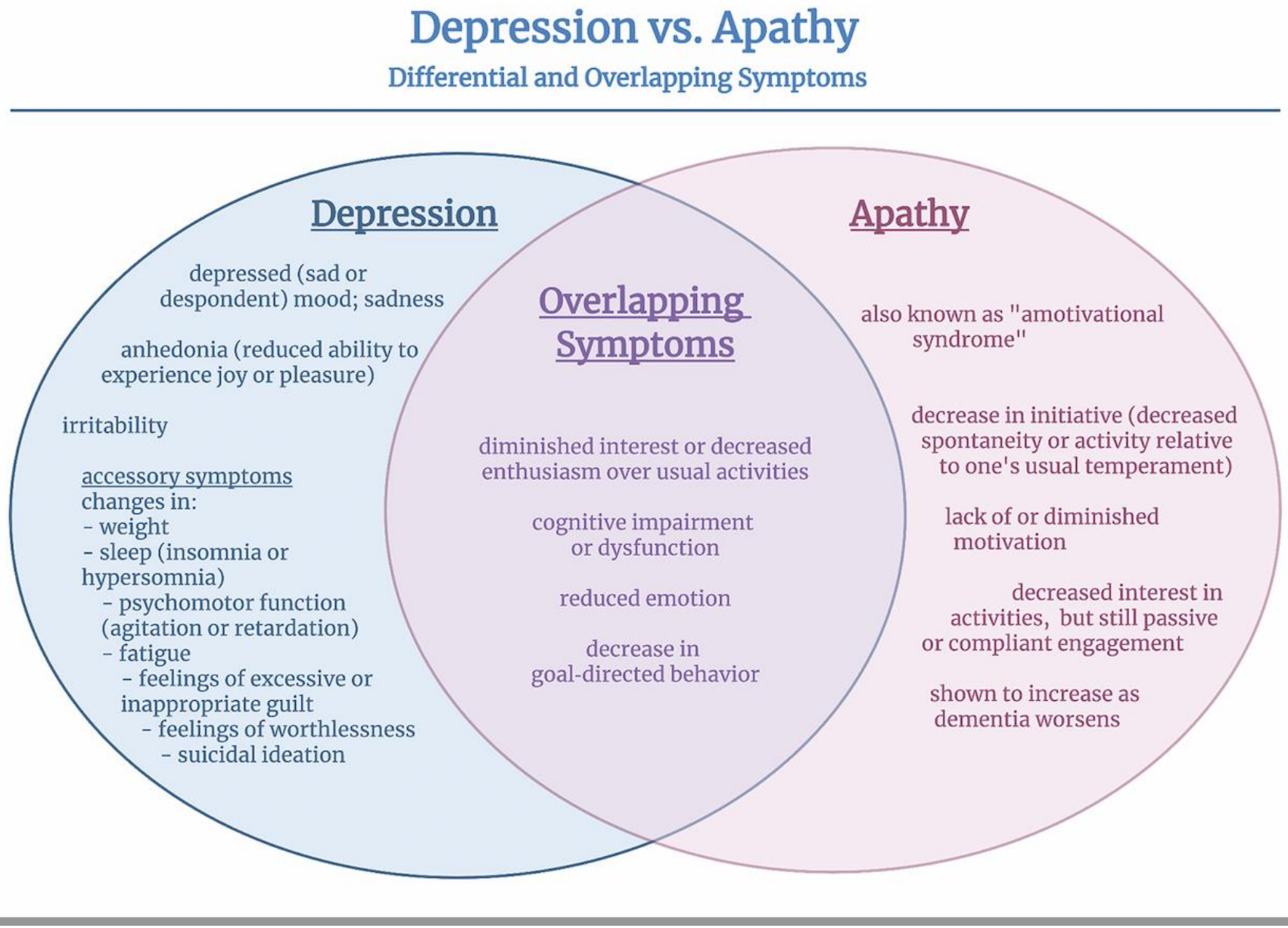
Commonly Confused

Depression

- Subjective distress when accessible
- Emotional pain
- Reactivity may still be present
- May respond to antidepressants

Apathy

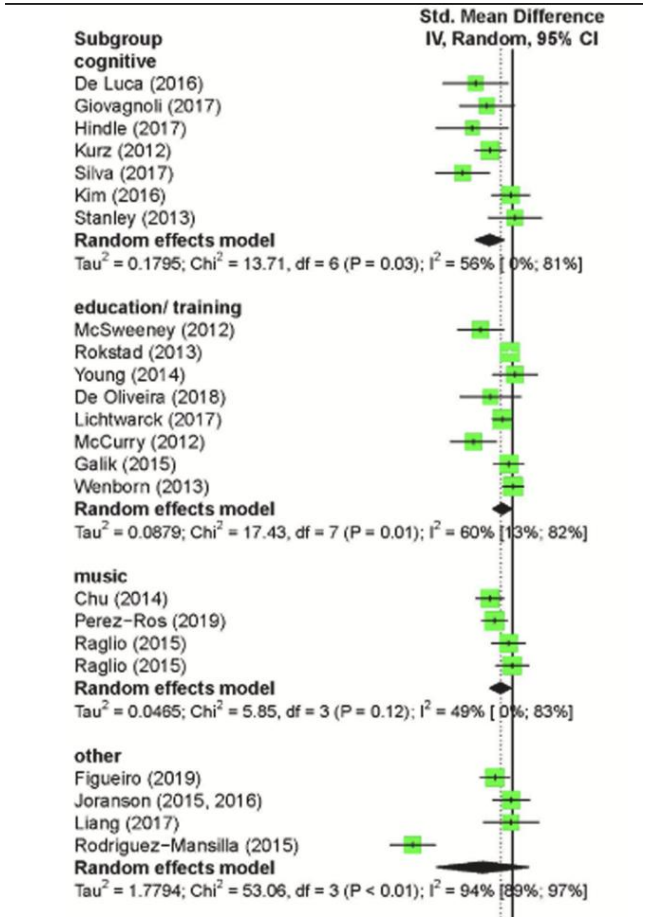
- Reduced motivation without distress
- Emotional blunting
- Minimal response to antidepressants
- Often neurodegenerative

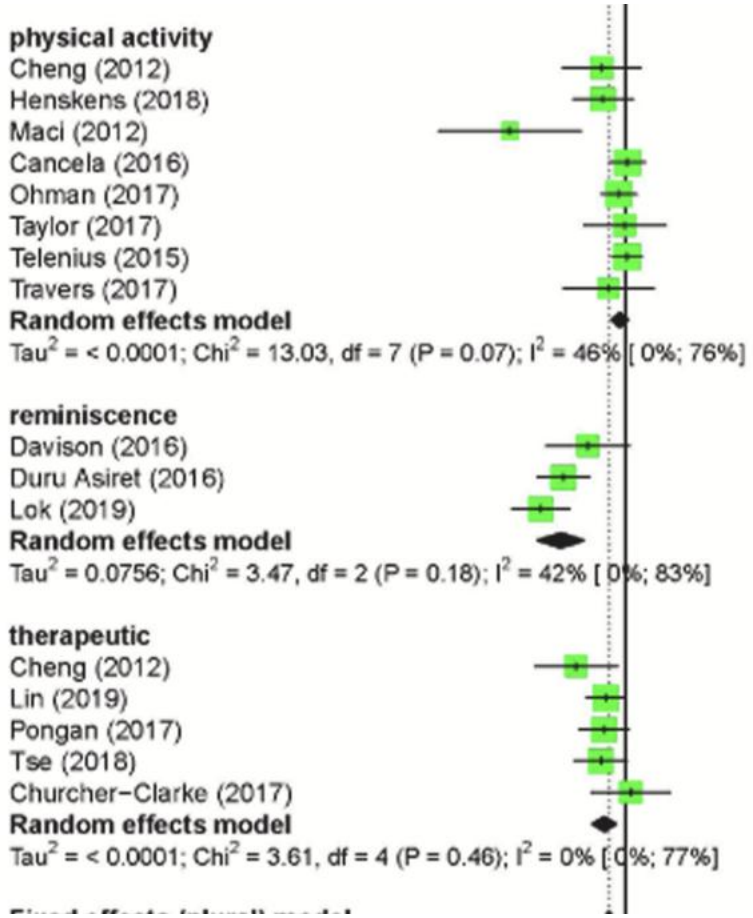


Maguire K, Cranley M, Grossberg GT: Managing symptoms of depression, apathy, psychosis, and agitation in people living with Alzheimer disease. Practical Neurology (US). 2025;24(6):7-12.

Treatment Principles

- **Nonpharmacologic**
  - Structured daily activity
  - Exercise and social engagement
  - Caregiver education and support
  - Therapy (reminiscence, CBT, ACT, supportive)





Burley CV, Burns K, Lam BCP, Brodaty H. Nonpharmacological approaches reduce symptoms of depression in dementia: A systematic review and meta-analysis. Ageing Res Rev. 2022 Aug;79:101669. doi: 10.1016/j.arr.2022.101669. Epub 2022 Jun 14. PMID: 35714853.

Treatment Principles

- **Pharmacologic**
  - Expect small effect sizes
  - SSRIs first line
  - Avoid reflexive antipsychotic use
  - Treat pain, sleep, and anxiety and other identified co-morbidities

Take Home

- Depression in dementia looks and feels different
- Apathy is not depression
- Diagnosis is longitudinal and collateral driven
- Treatment aims for function, not remission
- Reassess over time

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Session 5, Long Term Care Options
January 15, 2025

When your patient needs more care:
Options and considerations

Catherine Amarante, BSN, RN
GWEP Consultant
Dartmouth Centers for Health and Aging

Learning Objectives

- Understand Long Term Care and payment options.
- Explore the importance of anticipatory guidance regarding long term care plans for your patients living with dementia.

Martha & Ray

- 80-year-old female diagnosed with Alzheimer's type dementia approximately 9 years ago.
- Lives with her husband of 58 years, Ray (primary caregiver)
- Cognitive and functional decline over past 6 months; husband calling office more frequently reporting:

  Lots of arguments.

  Refusing medications and help with care.

  He finds her wandering around the house at night.

"I'm not sure I can do this"

What additional information do we need?

- What is their support system?
- What are their financial resources?
- What are their goals of care?
- What is his readiness for help?

Is it time for more help?

Red flags:

- Safety concerns (wandering, leaving stove on, med mismanagement, etc)
- Actual or threat of physical harm.
- Caregiver's own health is declining.
- Caregiver burnout/frustration.
- Care needs are not being met.

There is no universal “right” or “wrong” choice

This is a complex, personal decision based on many factors including specific care needs of the individual

There are options with pros and cons for each.

Option# 1:
Stay at home with increased support

- Hire private caregivers (hourly or live-in)
- Elicit help of family and friends
- Cameras/monitors/door alarms
- Adult Day program (private pay and some LTC Medicaid/other insurance)

Considerations for staying at home

Positives:

- Patient stays in familiar environment
- 1:1 personalized care
- Might save money depending on care needs and support system

Possible Challenges:

- Finding/managing/scheduling and paying for private caregivers
- May need to invest in home modifications for safety
- Will need a back up plan for emergency changes.

Option #2: Make a Move

Long Term Care Facility options:

- Nursing Home (Skilled Nursing Facility)
- Assisted Living Home
- Residential Care Home

Considerations of “placement”

- Who will pay?
- Care needs/behavioral concerns (will they accept her? do they know how to take care of her? will she have to move again?)
- Grief/Promises/Guilt
- Living in community/sharing a room.

Who pays for long term care?

- Private pay
- Long term care insurance
- Long Term Care Medicaid (vs Medicare – NOPE!)
- VA benefit

Talking to family members about accepting help.

There are trained professional caregivers who love their work.

There are many positive ways to facilitate a transition.

You can go back to being a spouse/daughter/son instead of a caregiver.

You might BOTH be happier.

How to make the move

- Have a transition plan based on individual needs.
- Assemble a team: Family, medical team (?medication), facility staff, friends
- Have the new room/apartment set up before. (less is more)
- Consider NOT involving the patient in all the details or packing.

Other ideas that might help:

- What to bring: LESS IS MORE. What means "home?"
- A few days/week in advance of move try an outing to have a meal or attend an event at the new home so it feels familiar.
- Share with staff his/her story and routine.
- Give him/her some time without you there.

Anticipatory Guidance

"I promise I will never put you in a facility"

Investigate values, goals of care, options and resources BEFORE it's a crisis.

Hints:

- Financial planning
- LTC Medicaid application (start early!)
- Pick out facilities you might like. Get on wait lists.
- Investigate private duty agencies or individuals.

Questions/Comments?