



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	<u>Diagnosis</u>
10/16/2025	<u>Chronic Disease and Dementia</u>
11/20/2025	<u>Driving</u>
12/18/2025	<u>Depression and Dementia</u>
1/15/2026	<u>Long Term Care Options</u>
2/19/2026	<u>Care Partner Support</u>

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:

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 amnesic 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

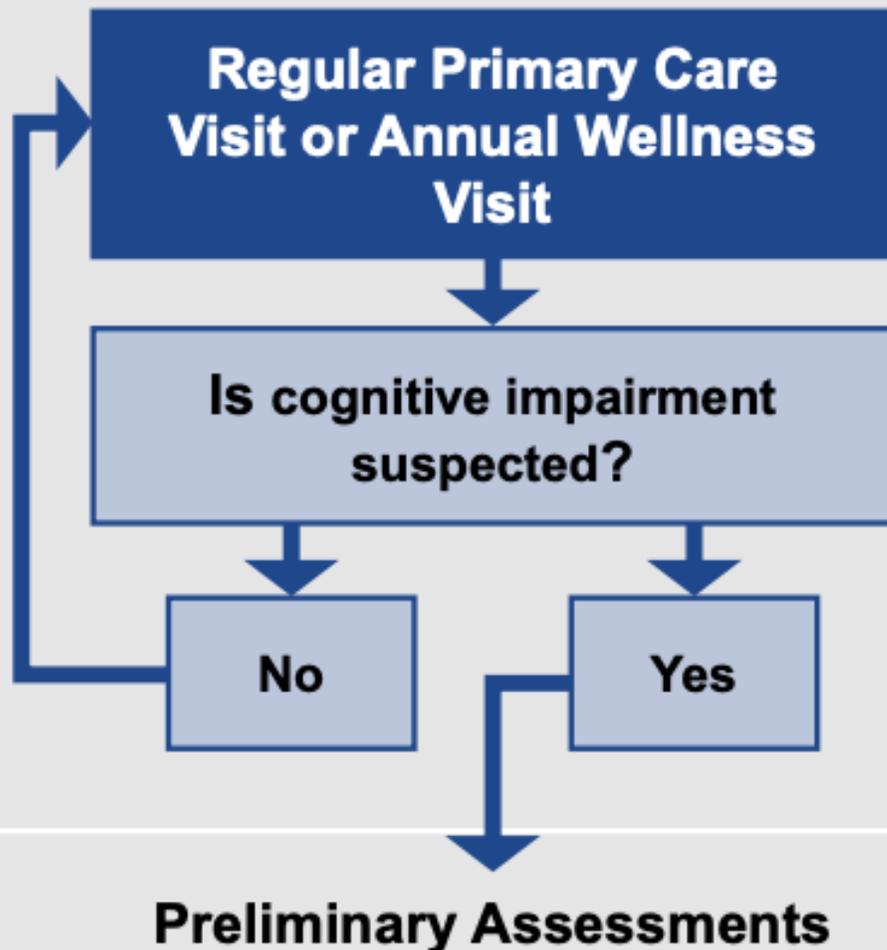
Alzheimer's disease	Dementia with Lewy bodies
<p>Gradual decline in global cognition and day to day ability</p> <p>Memory for recent conversations and events most prominent symptom</p>	<p>Fluctuations in cognition and alertness</p> <p>Visual hallucinations</p> <p>Movement symptoms of Parkinson's disease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



Early Detection & Diagnosis

Diagnostic Process

DIAGNOSTIC FLOW



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.



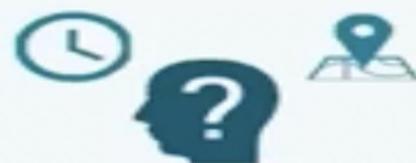
Becoming lost in familiar places.



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”

Score of ≥ 2 suggests
possible cognitive
impairment, which
warrants further
assessment
score = 3-4 sens. 82-
.91 spec. 0.76-94)

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			

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
- Transferring OOB & to chair
- Feeding

Less complex tasks

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 RSD)

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-infarct 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/syphilis/untreated Lyme
- Occupational-environmental risks for heavy metal exposures

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

Preliminary Assessments

First round of differential diagnosis assessment

Correctable etiology suspected

Treat condition and reassess

Dementing illness suspected

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
 - Structural brain imaging with MRI (head CT if MRI contraindicated)

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



Preliminary Assessments

First round of differential diagnosis assessment

Correctable etiology suspected

Treat condition and reassess

Dementing illness suspected

Follow up Assessments

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
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 - Structural brain imaging with MRI (head CT if MRI contraindicated)



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*Primary Care for People Living
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*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!





WELCOME
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*Primary Care for People Living
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*Session 3, Driving and Dementia
November 20, 2025*



Dementia and Driving

Daniel Stadler, MD – November 20, 2025

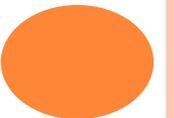
WHAT THE DATA SUPPORTS

- 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 result 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



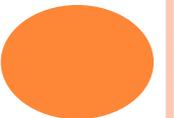
RISK STRATIFY

- 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”



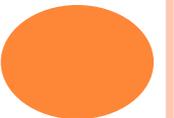
LOW RISK PATIENTS

- 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

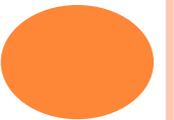


HIGH RISK PATIENTS

- 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.



THANK YOU.





WELCOME
to the

*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

- Apathy or withdrawal
- Irritability rather than sadness
- Loss of initiative
- Somatic preoccupation
- Reduced emotional reactivity

Less common

- 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

1. Diurnal variation of mood symptoms worse in the morning	a	0	1	2
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Scoring:

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Commonly Confused

Depression

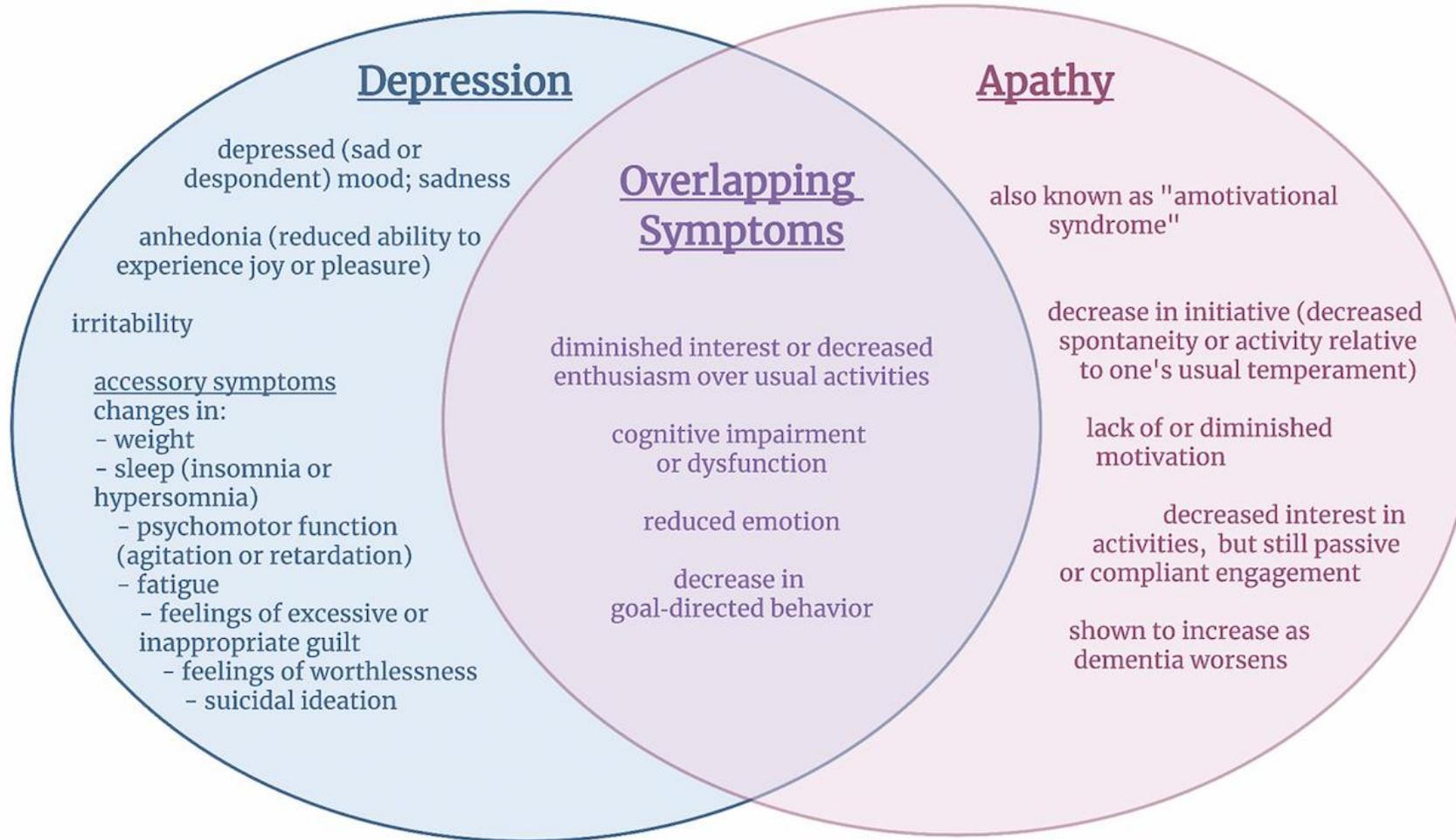
- Subjective distress when accessible
- Emotional pain
- Reactivity may still be present
- May respond to antidepressants

Apathy

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

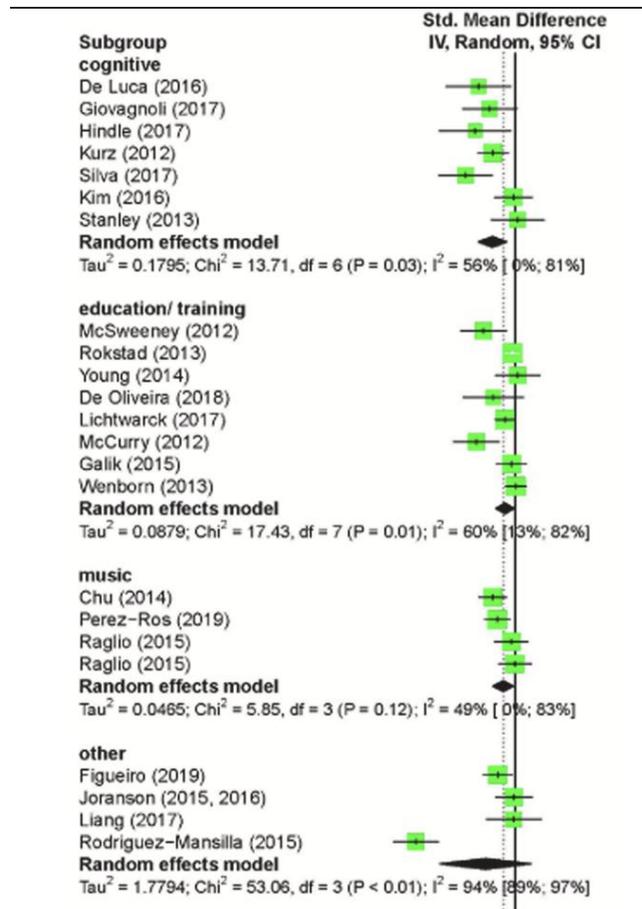
Depression vs. Apathy

Differential and Overlapping Symptoms

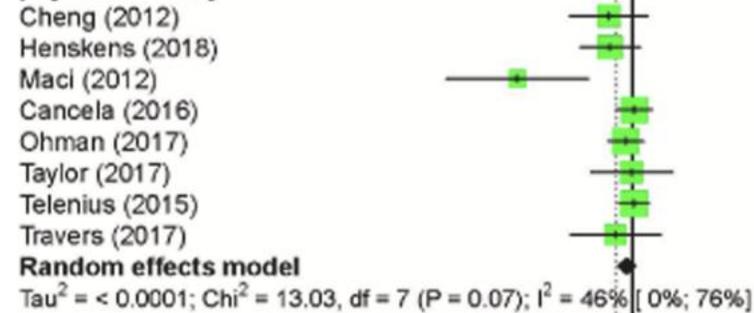


Treatment Principles

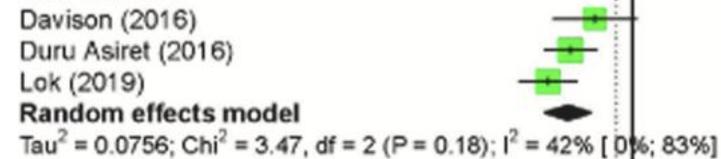
- **Nonpharmacologic**
 - Structured daily activity
 - Exercise and social engagement
 - Caregiver education and support
 - Therapy (reminiscence, CBT, ACT, supportive)



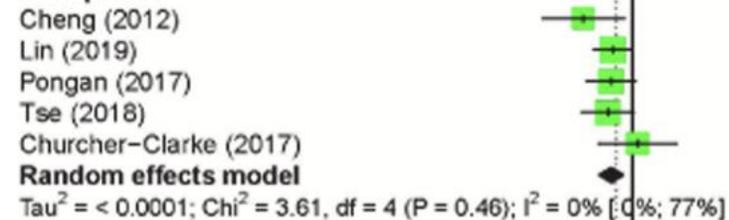
physical activity



reminiscence



therapeutic



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



WELCOME
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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?





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*Session 6, Care Partner Support
February 19, 2025*



Supporting Carepartners

Meredith Kolodze, DSW, LICSW

NAMI NH



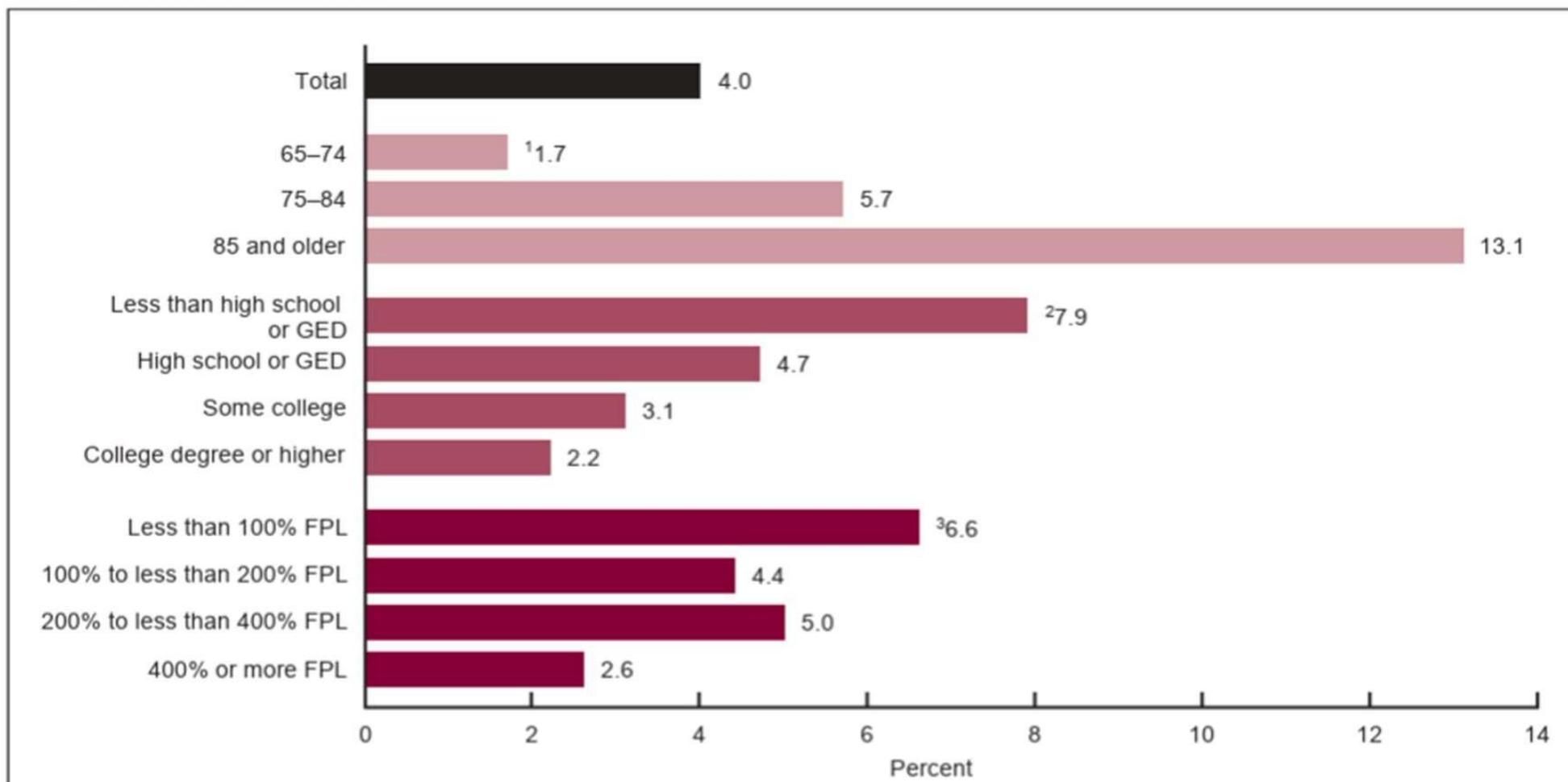


7 million people in the US live with Alzheimer's (Alzheimer's Association, 2025)

26,000 people in NH live with Alzheimer's (Alzheimer's Association, 2024)



Figure. Percentage of adults age 65 and older with diagnosed dementia, by age group, education level, and family income: United States, 2022





NEARLY
12
MILLION

Americans provide
unpaid care for people
with Alzheimer's or
other dementias

These caregivers
provided more than
19 billion hours
valued at nearly

\$413
BILLION



For more information, visit alz.org/facts

- About 30% of caregivers are age 65 or older.
- Approximately two-thirds of caregivers are women; more specifically, over one-third of dementia caregivers are daughters.
- Most caregivers (66%) live with the person with dementia in the community.
- Approximately one-quarter of dementia caregivers are "sandwich generation" caregivers — meaning that they care not only for an aging parent but also for at least one child.

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25% of caregivers report providing 40+ hours of CG per week



Disparities

- 50% of caregivers experienced financial strain. This is worse for younger, lower-income, Black, Latinx, and LGBTQ+ communities.
- 20% caregivers report being in fair or poor health themselves.
- 25% struggle to care for their own health needs
- 25% of caregivers feel isolated.

Caregiving in the US, AARP, 2025



Caregiver Struggles

- Grief
- Fatigue
- Resource difficulties
- Family dynamics
- Trauma
- Navigating family or work priorities
- Needs of self vs needs of PLWD



Positive Aspects of Caregiving



- A sense of purpose and being needed
- Giving back
- Strong community connection
- Helping other people earlier on in the journey
- Self-growth



“I often find that the medical community tends to be focused a lot on, understandably and that it’s important, the person being cared for...Like even my family doctor, it’s not like, “Well how’s it going?” And I think it’s important that they ask that sometimes because sometimes it does get very difficult, especially when I was working and trying to cope with everything that was going on.”



Meng et al., 2025

The 3 Stages of Caregiver Burnout

1. Caregiver Stress

- Becoming easily irritated or angry
- Feeling overwhelmed or constantly worried
- Experiencing periods of high blood pressure
- Grinding your teeth at night
- Having difficulty sleeping
- Being forgetful/trouble concentrating
- Feeling heart palpitations



2. Caregiver Burnout

- Being late for work/Procrastinating
- Having trouble relaxing
- Experiencing a decreased sexual desire
- Loss of energy
- Withdrawing socially
- Thinking cynically/resentfully
- Drinking, smoking, or eating more
- Experiencing apathy

3. Compassion Fatigue

- Feeling hopelessness and meaninglessness
- Having chronic stomach or bowel problems
- Feeling overwhelmed, exhausted, and drained
- Having chronic headaches
- Desiring to "drop out" of society
- Avoiding friends/work/family
- Thinking of suicide as a means of escape



What do Carepartners need?

- Support
- Connection
- Education
- Practical tools
- Resources





Dartmouth
Health

Aging Resource Center



Resources

- Alzheimer's Association www.alz.org
- Lorenzo's House <https://www.lorenzoshouse.org/>
- Family Caregiver Alliance www.caregiver.org
- Teepa Snow's Positive Approach to Caregiving www.teepasnow.org
- Caregiver Action Network <https://www.caregiveraction.org>
- Memory Café Directory <https://dfamerica.org/memory-cafe-directory/>
- The Dice Approach www.diceapproach.com