Managing Dementia: The primary care perspective

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Learning objectives

- Introduce dementia types, incidence and risk factors
- Identify reversable causes of dementia
- Discuss the primary care approach to cognitive decline: work up and screening
- Review high risk medications and established treatment options
- Review management of behaviors associated with dementia
- Discuss various initiatives to improve screening and provide care giver support

U.S. prevalence rises sharply with age

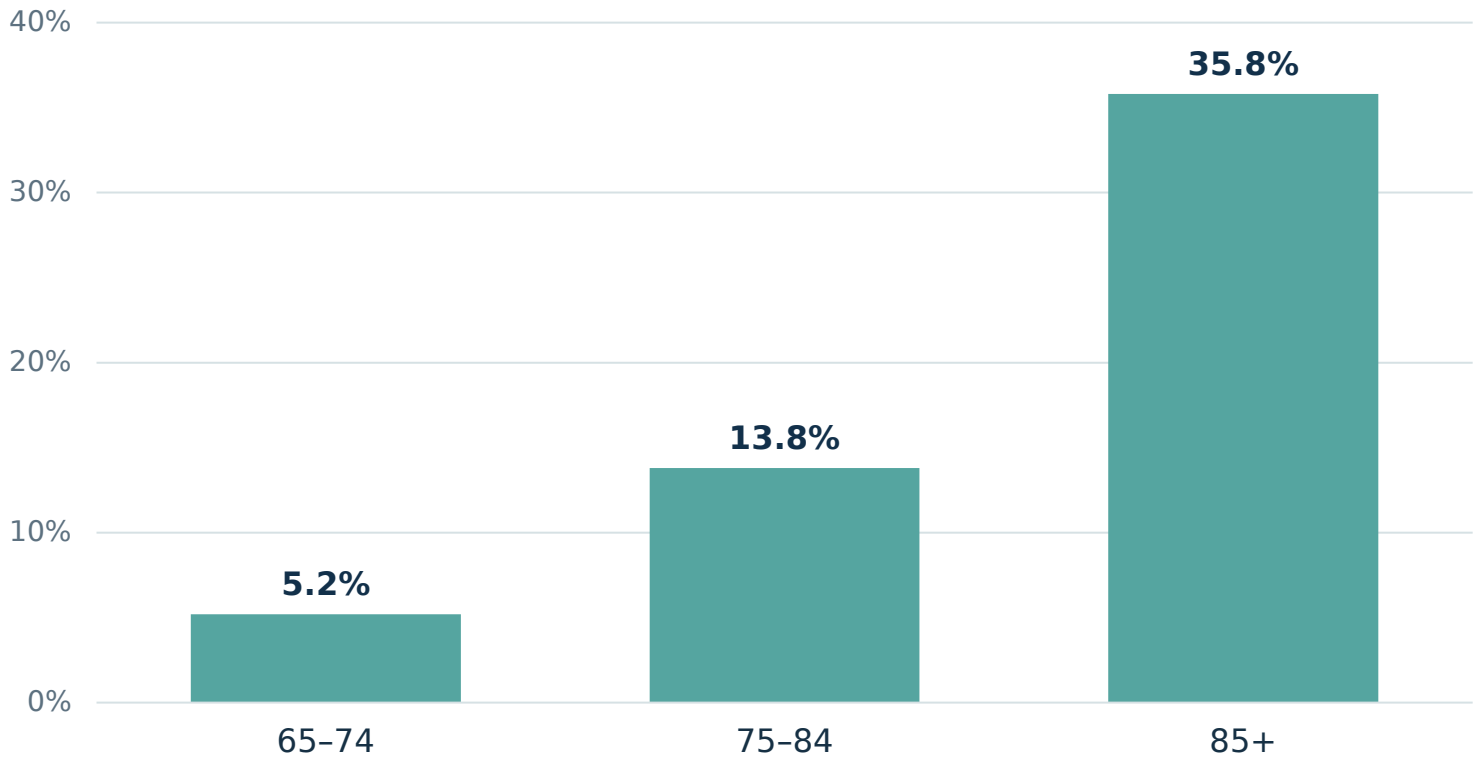
Clinical Alzheimer’s dementia among adults age 65 and older, 2026

7.4

million

Americans age 65+

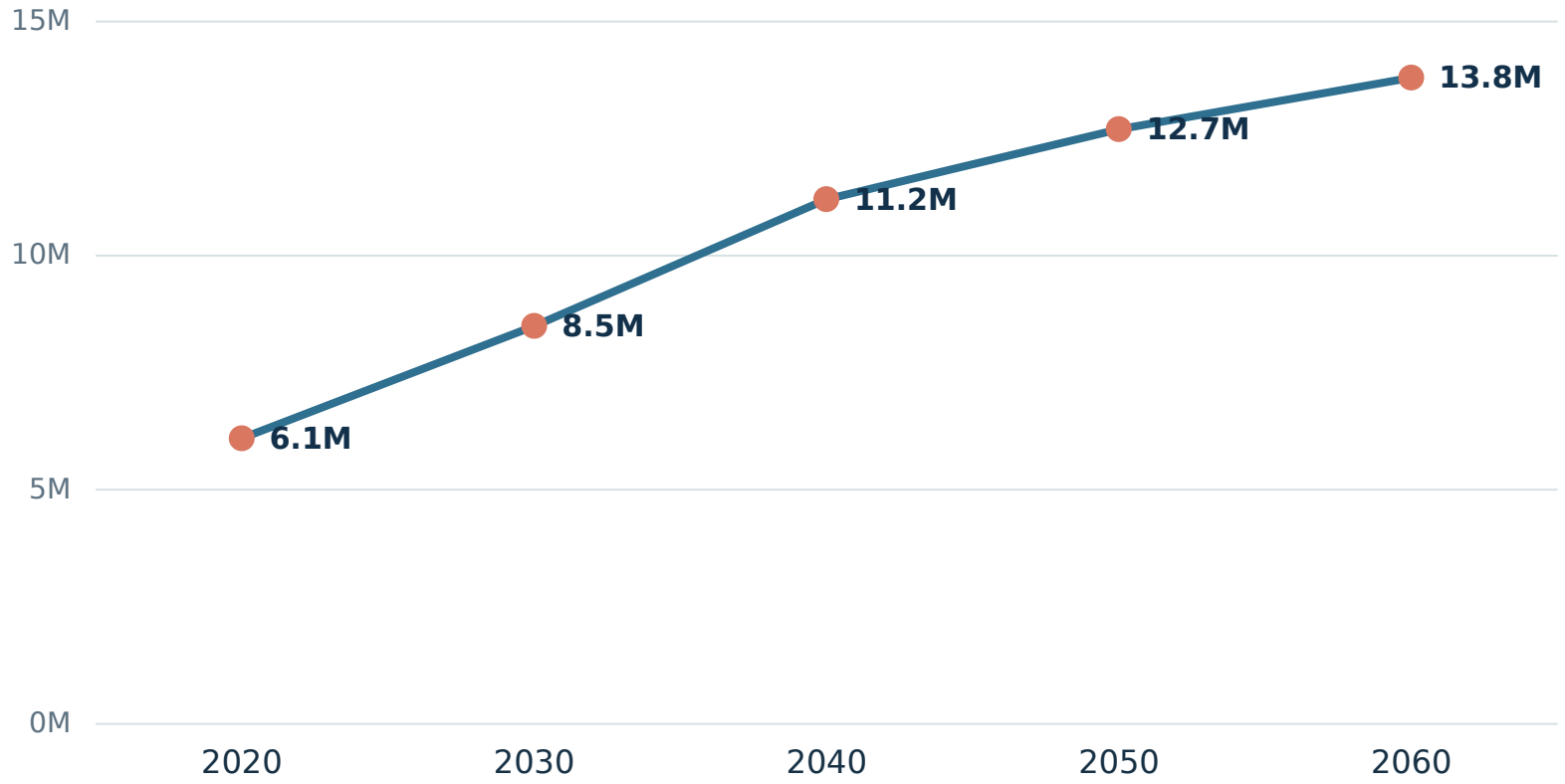
About 1 in 9



Source: Alzheimer’s Association, 2026 Alzheimer’s Disease Facts and Figures

The number of affected older adults will continue to grow

Projection assumes no major breakthrough that prevents or cures Alzheimer’s disease



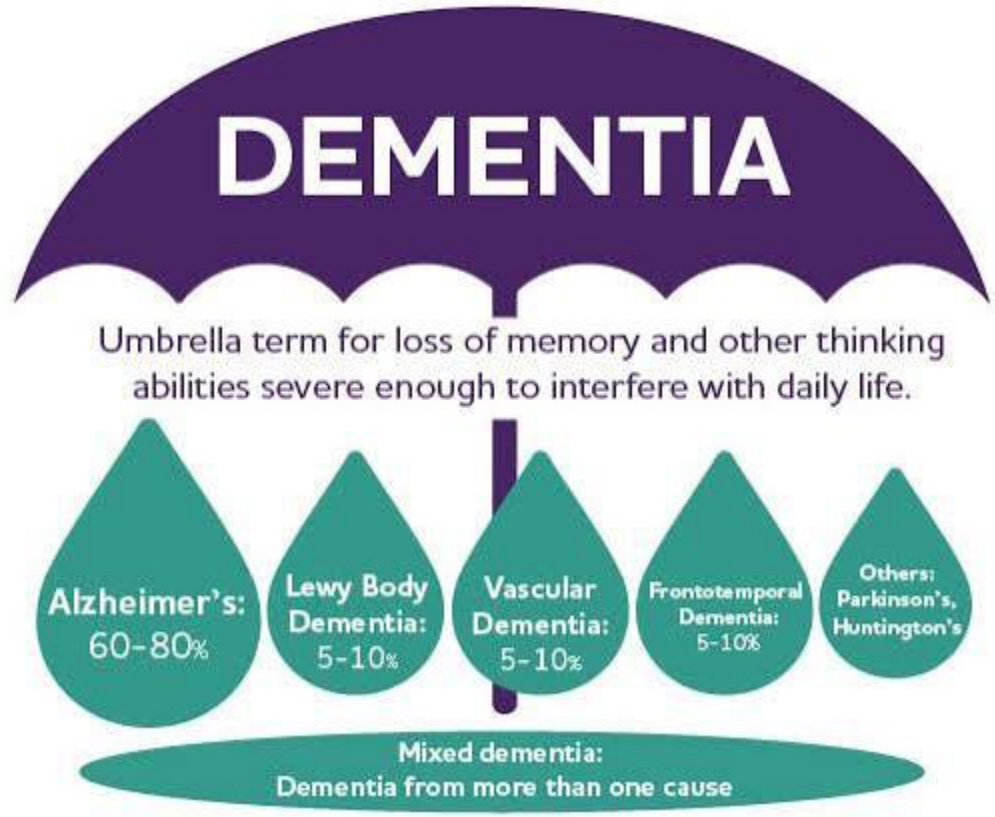
13.8M

projected by 2060

Nearly half are expected to be age 85+

Source: Alzheimer’s Association, 2026 Alzheimer’s Disease Facts and Figures




DEMENTIA
Umbrella term for loss of memory and other thinking abilities severe enough to interfere with daily life.
Alzheimer's: 60-80%
Lewy Body Dementia: 5-10%
Vascular Dementia: 5-10%
Frontotemporal Dementia: 5-10%
Others: Parkinson's, Huntington's
Mixed dementia: Dementia from more than one cause

Risk factors that cannot be changed

Risk factors increase probability, but they do not determine an individual outcome

Age

The strongest known risk factor. Most people with Alzheimer’s develop symptoms after age 65, and prevalence increases steeply in the oldest age groups.

Genes and family history

APOE variants can change risk but do not predict an individual’s future with certainty. Rare variants in APP, PSEN1 and PSEN2 can cause familial early-onset disease.

Sex and biology

Women represent almost two-thirds of Americans living with Alzheimer’s. Longevity explains part, but not all, of the difference.

Sources: NIA, Alzheimer’s causes and risk factors; Alzheimer’s Association 2026 Facts and Figures

Risk reduction and reversible contributors

Long-term risk factors and treatable causes of cognitive change require different clinical responses

POTENTIALLY MODIFIABLE RISK FACTORS

Risk accumulates across the life course

Cardiovascular and metabolic

High blood pressure
Diabetes
Obesity
High LDL cholesterol
Smoking
Physical inactivity

Sensory and neurologic

Hearing loss
Untreated vision loss
Traumatic brain injury
Excessive alcohol use
Sleep problems

Cognitive, social and environmental

Less education early in life
Depression
Social isolation
Air pollution
Limited access to care

REVERSIBLE CONTRIBUTORS

Evaluate when cognition changes

- **M** Metabolic disturbance
- **E** Endocrine
- **I** Infection
- **A** Alcohol, drugs or medications
- **+** Other medical conditions
- **S** Sleep disorders
- **D** Depression or anxiety
- **P** Other psychiatric diagnoses

Clinical evaluation can identify causes that may improve with treatment.

Sources: Lancet Commission 2024; CDC MMWR 2022; National Institute on Aging resources

Workup and treatment of memory loss

A practical pathway from first complaint to follow-up care

1 INITIAL WORKUP

History and exam

Onset and course
Daily function
Medications
Family and social history
Mental status and physical exam

Laboratory tests

Metabolic panel and CBC
Thyroid and vitamin testing
HIV or syphilis testing when indicated

Imaging

CT or MRI for stroke, structural change, or atrophy
Consider PET when Alzheimer disease versus FTD remains uncertain

2 CLASSIFY FINDINGS

Normal age-related change

Reassure

Encourage physical, cognitive, and social activity

Monitor over time

Mild cognitive impairment

Treat coexisting conditions

Encourage ongoing activity

Monitor cognition and function

Dementia / major NCD

Treat coexisting conditions and encourage activity

Consider a cholinesterase inhibitor or NMDA receptor antagonist

Monitor cognition, function, and safety

3 PLAN ONGOING CARE

Nonpharmacologic support

Reduce triggers, support personal care and activity, adapt the environment, and address safety.

Symptom treatment

Use medication for mood or behavioral symptoms only when clinically indicated.

Care planning

Address caregiver stress, living environment, advance care planning, driving, and safety.

DON'T MISS

Potentially reversible causes

Metabolic or endocrine disorders
Infection
Alcohol, drugs, or medications
Sleep disorders
Depression, anxiety, or other psychiatric illness
Other medical causes

Consider neurology referral

Early onset
Unusual or atypical findings
Focal neurologic concerns
Atypical neurologic exam

Common dementia types

Alzheimer disease
Lewy body / Parkinson disease
Vascular dementia
Frontotemporal dementia

Adapted from Steven Tam, MD

Screening Exams

- Mini-mental status exam (MMSE)
    - Early dementia: score ≤ 24
    - Mild dementia: score 20-24
    - Moderate dementia: score 13-20
    - Severe dementia: score < 12
- Montreal Cognitive Assessment (MoCA) (20 minutes)
    - MCI: score 19-25
    - Alzheimer's dementia: 11-21
- Mini-Cog (3 minutes)
    - Reall of 3 words 1 pt each: 3 pts
    - Clock drawing 2 pts
    - Scores of 0-2 likely cognitive impairment

https://www.alz.org/media/documents/mini-cog.pdf
https://www.parkinsons.va.gov/resources/MOCA-Test-English.pd
http://www.heartinstitutehd.com/Misc/Forms/MMSE.1276128605.pdf



Folstein MMSE

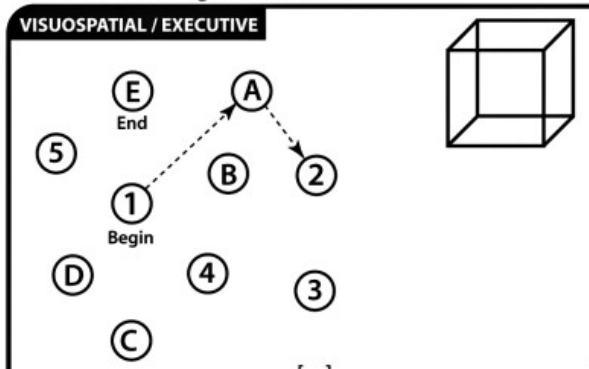
Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day? Month?"
5		"Where are we now? State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then the instructor asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible.
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, …) Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

MoCA

MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.1 Original Version

NAME :
Education : Date of birth :
Sex : DATE :

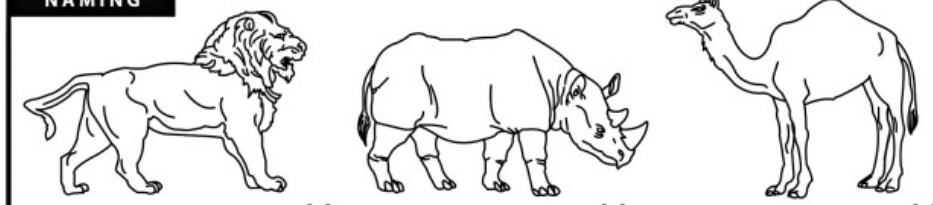
VISUOSPATIAL / EXECUTIVE — POINTS



Copy cube [ ] [ ]

Draw CLOCK (Ten past eleven) (3 points) [ ] Contour [ ] Numbers [ ] Hands __/5

NAMING __/3



[ ] [ ] [ ]

MEMORY Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes. No points

	FACE	VELVET	CHURCH	DAISY	RED
1st trial					
2nd trial					

ATTENTION Read list of digits (1 digit/ sec.). __/2
Subject has to repeat them in the forward order [ ] 2 1 8 5 4
Subject has to repeat them in the backward order [ ] 7 4 2

Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors __/1
[ ] F B A C M N A A J K L B A F A K D E A A A J A M O F A A B

Serial 7 subtraction starting at 100 [ ] 93 [ ] 86 [ ] 79 [ ] 72 [ ] 65 __/3
4 or 5 correct subtractions: **3 pts**, 2 or 3 correct: **2 pts**, 1 correct: **1 pt**, 0 correct: **0 pt**

LANGUAGE Repeat : I only know that John is the one to help today. [ ] __/2
The cat always hid under the couch when dogs were in the room. [ ]

Fluency / Name maximum number of words in one minute that begin with the letter F [ ] _____ (N ≥ 11 words) __/1

ABSTRACTION Similarity between e.g. banana - orange = fruit [ ] train – bicycle [ ] watch - ruler __/2

DELAYED RECALL __/5

	Has to recall words **WITH NO CUE**	FACE [ ]	VELVET [ ]	CHURCH [ ]	DAISY [ ]	RED [ ]	Points for UNCUED recall only
Optional	Category cue						
	Multiple choice cue						

ORIENTATION [ ] Date [ ] Month [ ] Year [ ] Day [ ] Place [ ] City __/6

© Z.Nasreddine MD www.mocatest.org Normal ≥ 26 / 30

TOTAL __/30
Add 1 point if ≤ 12 yr edu

Administered by: _____

Looking for polypharmacy and medication related cognitive decline

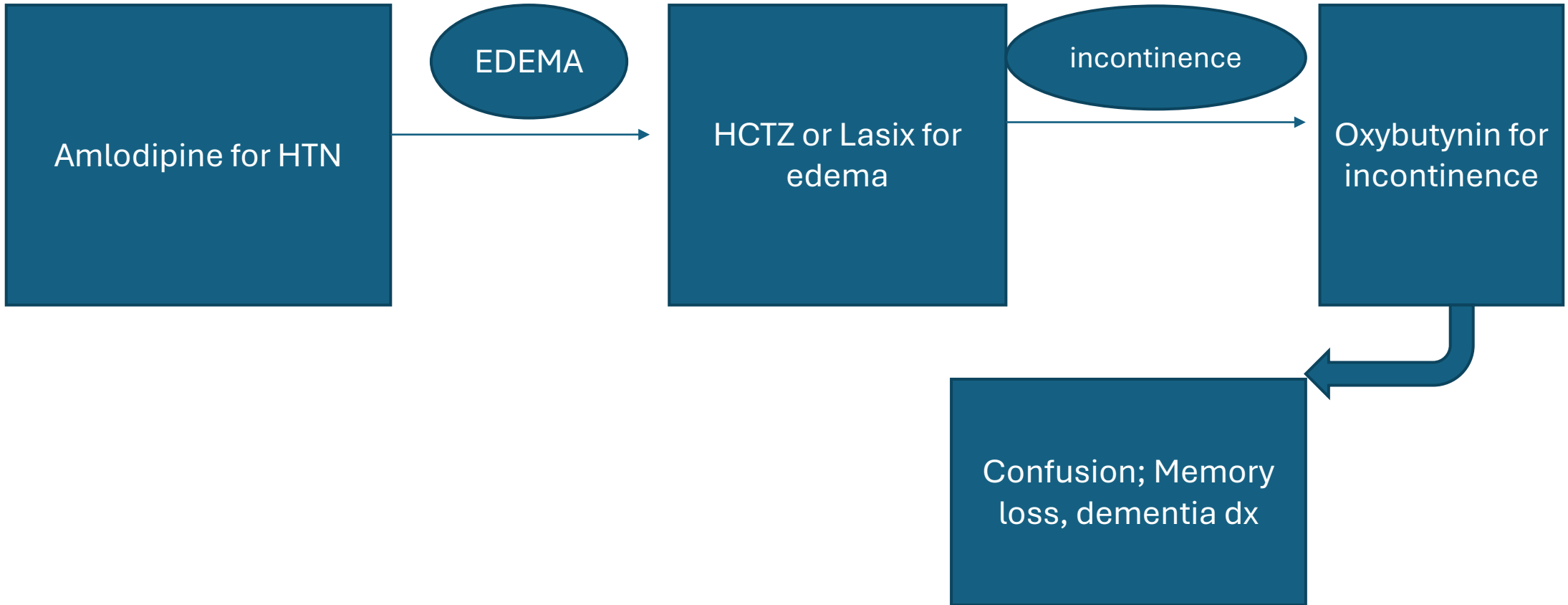
- 5 or more meds is a risk factor
- Medication with no apparent indication
- Use of duplicative medications
- Adverse CNS effect can be cumulative
- Reviewing supplements and OTC meds for hidden ingredients
- OH and Cannabis
- Focus on high- risk meds
- Non-high risk meds which have a CNS component
- Ensuring other medical problems are dealt with appropriately
- Inappropriate doses: START LOW GO SLOW BUT DO GO



	Common Sleep Aids	Allergy Medicines	Motion Sickness Medicines
Ingredients to Avoid	diphenhydramine or doxylamine	chlorpheniramine	dimenhyrinate or meclazine
Example Drugs			

Belladonna	Valerian Root	Marijuana	Alcohol
			

A Medication Cascade Leading to a Dementia



Common medications that can impair cognition

Older adults are more susceptible to sedation, confusion, slowed thinking and delirium

Strong anticholinergics

OTC + Rx

Diphenhydramine, doxylamine, hydroxyzine, oxybutynin, tolterodine, amitriptyline, paroxetine

Memory problems, confusion, dry mouth, constipation

Benzodiazepines

Anxiety / sleep

Alprazolam, lorazepam, diazepam, clonazepam, temazepam

Sedation, slowed processing, amnesia, delirium

Nonbenzodiazepine sleep drugs

Sleep

Zolpidem, eszopiclone, zaleplon

Next-day impairment, confusion, falls, delirium

Opioids

Pain

Oxycodone, hydrocodone, morphine, tramadol

Sedation, inattention, confusion, delirium

Antiseizure and neuropathic-pain drugs

Neurologic / pain

Gabapentin, pregabalin, topiramate

Drowsiness, dizziness, slowed thinking or word-finding difficulty

Sedating muscle relaxants

Muscle spasm

Cyclobenzaprine, methocarbamol, carisoprodol, baclofen

Sedation, confusion and reduced attention

Medication review: consider total anticholinergic and sedative burden, recent dose changes, kidney function and drug interactions. Avoid abrupt discontinuation.

Sources: 2023 AGS Beers Criteria; National Institute on Aging guidance for cognitive impairment

Medications used to stabilize cognitive decline



Medications used to manage Alzheimer's Disease



Cholinesterase inhibitors

Increase the amount of acetylcholine in the brain, which can improve neuronal communication



NMDA blockers

Prevent the impact of glutamate dysregulation which occurs in AD



Monoclonal Antibodies

Remove Amyloid Beta plaques and Tau proteins which are the hall mark of AD pathology

Medicines for memory symptoms

Donepezil, rivastigmine and galantamine

These medicines may offer modest help with memory or everyday activities. They do not cure dementia, and benefits vary from person to person.

Donepezil

Usually taken once a day

Rivastigmine

Available as a pill or skin patch

Galantamine

Available in regular or extended-release forms

WHAT TO EXPECT

Benefits are usually small

Some people notice steadier thinking or greater independence

The care team will review whether the medicine is helping

SIDE EFFECTS TO WATCH

Stomach upset, diarrhea or vomiting
Loss of appetite or weight
Dizziness, fainting or a slow heartbeat
Sleep changes or vivid dreams
More frequent urination

Talk with the prescriber about fainting, a very slow pulse, ongoing vomiting or weight loss. Review medicines that have anticholinergic effects. Do not stop treatment without guidance.

Sources: Lexicomp 2023; Geriatric Dosage Handbook, 12th edition

Memantine (Namenda): what to know

A medicine used for moderate to severe Alzheimer’s disease

Memantine may modestly slow the loss of everyday function. It does not cure Alzheimer’s disease, and the benefit varies.

WHAT IT MAY DO

May help a person maintain daily activities for longer

May be used alone or with donepezil, rivastigmine or galantamine

The care team will check whether it is helping

HOW IT IS TAKEN

The prescriber usually starts with a low dose and increases it slowly

Regular and extended-release forms are available

People with serious kidney problems may need a lower dose

COMMON SIDE EFFECTS

- **Dizziness**
- **Headache**
- **Confusion**
- **GI side effects**

Better tolerated than Cholinesterase inhibitors.

Tell the prescriber about kidney problems, new confusion or severe dizziness. Follow the prescribed schedule and do not change the dose without guidance.

Sources: Current FDA labeling via DailyMed; Geriatric Dosage Handbook, 12th edition

A practical care plan for cognitive decline

Look for treatable contributors, reduce risk and support the person and caregiver

1 Review every medicine and substance

Include prescriptions, over-the-counter products, vitamins, herbal products and cannabis. Look for medicines that may worsen thinking or create a prescribing cascade.

2 Address other health concerns

Treat sleep problems, depression or anxiety, thyroid disease and vitamin deficiencies. Manage blood pressure, cholesterol and other heart-health risks.

3 Consider treatment and track changes

Discuss whether a dementia medicine is appropriate. Monitor memory, daily function, behavior and safety over time.

4 Support the person and caregiver

Explain what to expect, share practical caregiving strategies and revisit the plan as needs change.

A sudden change in thinking or behavior needs prompt medical evaluation.

Responding to challenging behaviors

Behavior often communicates discomfort, fear, frustration or an unmet need

ID — Identify the behavior

Describe exactly what happens. Note when it occurs, what happened just before it and who was present.

E — Educate yourself

Look for possible causes and consider what the behavior may mean to the person.

A — Adapt the response

Try a different approach. Pay attention to feelings and remain gentle, calm and reassuring.

Helpful non-drug responses

- **Approach calmly** — Avoid startling the person.
- **Do not argue** — Acknowledge feelings instead of correcting every statement.
- **Redirect attention** — Offer a familiar activity, snack, music or a change of setting.
- **Make the area safer** — Reduce clutter and remove hazards.
- **Use one-step directions** — Speak slowly and give time to respond.

Source: Alzheimer's Los Angeles IDEA! Strategy caregiver tip sheet

Management of Behavioral Symptoms - Agitation

- Black Box Warning
  - Increased risk of Stroke or Death when used in demented elderly patients
- Identify specific problem behaviors
  - Danger to self or others
  - Refusing care/Endangering the caregiver
- Monitor for efficacy
- Doses are low and particular for this indication

EPS: Dystonia /Pseudo PD / Akathisia

Antipsychotic	Considerations
Olanzapine Zyprexa 2.5mg-5mg daily	Low EPS High sedation Mod Orthostatic Hypotension. High Anticholinergic profile (Beers) Metabolic SE most likely
Risperidone Risperdal 0.25-2mg daily	Low EPS, but higher with increasing dose Low sedation High Orthostatic Hypotension
Quetiapine Seroquel 12.5-100mg daily	Low EPS Moderate sedation Mod Orthostatic Hypotension
Aripiprazole Abilify 1-5mg daily	Low EPS Low sedation Low Orthostatic Hypotension
Pimavanserin Nuplazid 17-34mg daily	5HT2a and 5HT2c receptor modulator Minimal effect of DA, Ach, and H1 Side effects: HA, QT prolongation, UTI, Constipation
Brexipiprazole Rexulti 2-3mg daily	1st FDA approved drug for agitation in Dementia. Expedited review. Modest benefit. Strict Exclusion criteria. Adverse events noted. Some orthostatic hypotention

Beers Criteria 2023;
FDA News Release. Food and Drug Administration Web site. https://www.fda.gov/news-events/press-announcements/fda-approves-first-drug-treat-agitation-symptoms-associated-dementia-due-alzheimers-disease.
Rexulti® (brexpiprazole) [package insert]. Rockville, MD: Otsuka America Pharmaceutical, Inc. May 2023. https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/205422s009lbl.pdf

Initiatives to help with diagnosis and management

Dementia Care Aware

- **Leadership & Funding:** Led by the University of California, San Francisco (UCSF) in partnership with state entities, originally supported by the California Department of Health Care Services (DHCS) and the West Health Institute.
- **Cognitive Health Assessment (CHA):** A quick 5-to-10-minute annual screening tool for adults aged 65 and older, covering cognitive, functional, and care partner evaluations.
- **Medi-Cal Benefit & Billing:** Medi-Cal covers an annual dementia screening for older members. Practitioners who complete the interactive online training can utilize specific billing codes upon completing the CHA.
- **Free Training & CE Credits:** Offers free, self-paced online courses and live virtual events offering continuing education (CE/CME/MOC) credits for clinicians.

Medicare Guide Program

- **Dedicated Care Navigation:** A personal care navigator coordinates medical appointments, connects families with community resources, and manages care transitions.
- **24/7 Support Line:** Round-the-clock access to clinical support for urgent questions and crisis management.
- **Caregiver Training and Education:** Free education programs, skills training, support groups, and ad-hoc one-on-one sessions for family and unpaid caregivers.
- **Respite Services:** Up to $2,500 annually to cover temporary relief care for eligible patients.
- **No Out-of-Pocket Cost:** Covered 100% by Original Medicare (Parts A and B) with no cost-sharing for enrolled services.


OH NO!
I FORGOT ...
SOMETHING ..
... BUT WHAT

