IHS DEMENTIA CARE PATHWAY

Primary Care

This pathway is intended to provide guidance to clinicians as they care for American Indian and Alaska Native people who may be experiencing cognitive impairment.

DETECT

Recognize possible cognitive impairment

- Patient & Caregiver
- Community Staff
- Primary Care Team

EVALUATE

Assess cognition and perform targeted history, physical and diagnostics

- Patient & Caregiver
- Primary Care Team
- Neurology or Geriatrics Specialists (optional)

DIAGNOSE AND DISCUSS

Integrate findings and communicate to patient and care partners

- Patient & Caregiver
- Primary Care Team
- Neurology, Geriatrics, or Neuropsychology Specialists (optional)

Content derived from expert opinions of Indian Health Service, tribal, and urban Indian health providers and based on most recent clinical evidence as of June 2025.

DETECT

Community-Based Staff | **Patient or Family** | **Clinician**

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Identifies concern for cognitive impairment through:
- Signs or symptoms (Table A)
- Positive screening tool (e.g. Mini-Cog, AD-8)
- Annual Wellness Visit (AWV)

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Primary Care Triage

Table A: Potential Signs of Cognitive Impairment

- Memory loss (e.g. forgetting new information, repeating questions) that disrupts daily life
- Trouble planning or solving problems
- Confusion with time and location
- Difficulty completing familiar tasks
- Trouble with vision and spatial relationships
- Difficulty with speech and writing
- Misplacing things and unable to find them
- Decreased or poor judgement
- Mood or personality changes
- Withdrawal from social activities

EVALUATE

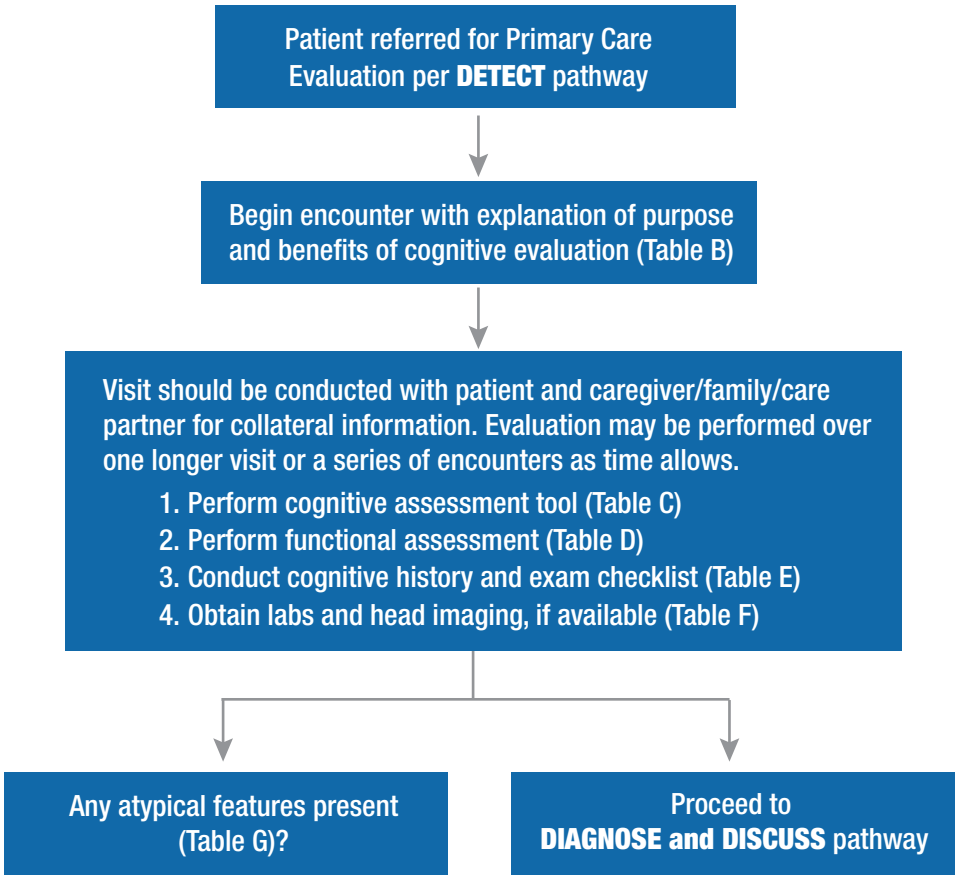

Table B: The "Why" of Cognitive Evaluation

Discussion of cognitive concerns can be difficult for many patients and their care partners. It is helpful to explain the purpose of a cognitive evaluation to build trust and validate the following benefits:

- Assess risks
- Guide treatment options, such as symptomatic and disease-modifying therapeutics (as they become more available)
- Plan for care needs
- Guide care coordination
- Increase access to services and resources

Table C: Cognitive Assessment Tool Examples

- MoCA
- SLUMS
- RUDAS (easy to use with translator)

NOTE: Published score cut-offs may not be reflective of cognitive function and should be interpreted within a patient's context.

EVALUATE (CONTINUED)

Table D: Activities of Daily Living

ADLs

- ☐ Bathing
- ☐ Dressing
- ☐ Toileting
- ☐ Transfers
- ☐ Continence
- ☐ Feeding

IADLs

- ☐ Telephone
- ☐ Shopping
- ☐ Cooking
- ☐ Housekeeping
- ☐ Laundry
- ☐ Transportation
- ☐ Managing Medications
- ☐ Managing Money

Table E: Cognitive History and Exam Checklist

- ☐ Cognitive concerns and behavioral symptoms (e.g. memory loss, concentration difficulties, personality changes, mood symptoms, sleep disturbance, hallucinations; can use AD-8 for structured interview), sensorimotor symptoms (e.g. abnormal gait, tremor)
- ☐ Medical History: Risk factors for cerebrovascular disease, hearing/vision loss, TBI, sleep apnea, substance use, and environmental exposures
- ☐ Medications: Psychoactive medications, including OTCs
- ☐ Family history of cognitive disorders
- ☐ Physical exam and brief neuro exam
- ☐ Anxiety and depression screen (PHQ/GDS, GAD)

Table F: Diagnostics

Labs

- ☐ CBC
- ☐ CMP
- ☐ A1C
- ☐ TSH
- ☐ B12
- ☐ RPR
- ☐ HIV

Head Imaging*

- ☐ Non-contrast CT head
- ☐ Non-contrast MRI brain

* NOTE: Imaging is used to rule out other causes of cognitive changes, such as a mass or significant infarct. **It is not essential in the diagnosis of dementia.**

Table G: Atypical Symptoms

RARELY, there are findings that may suggest a diagnosis other than a typical dementia process.

If any of the following are present, you may consider a discussion with a neurologist, if available, about additional evaluation:

- Unusual Onset
  - Age <65
  - Rapid progression of symptoms
- Unusual Presenting Symptoms
  - Primary language dysfunction
  - Psychosis
  - Severe social disinhibition
- Unusual Features
  - Upper motor neuron signs (upgoing toes, hyperreflexia, myoclonus)
  - Well-formed visual hallucinations
  - Parkinsonism (tremor, slow movement, impaired speech, stiffness, orthostasis)
  - Focal neurologic deficit
  - Seizures

DIAGNOSE AND DISCUSS

Synthesize findings from evaluation to determine cognitive functional status and diagnosis. Does patient have:

1. Objective cognitive changes present?
   - Subacute / Chronic?
   - Progressive?
2. Impairment in daily function due to cognitive changes?
3. No other clear etiology?

All Criteria Met
DEMENTIA is DIAGNOSED

If pattern of symptoms can be identified to determine etiology, the dementia subtype can be classified (Table H). This is not necessary to diagnosis, however, and rarely changes management.

- Discuss diagnosis and answer questions
- Assess for immediate needs and risk to safety
- Referral to resources for information and support
- Brain health discussion
- Schedule close follow up for more complete discussion and care plan development

One Criteria Met
UNCERTAINTY in DIAGNOSIS

Either objective evidence of cognitive impairment OR functional decline due to cognitive changes are present, but there is uncertainty in the diagnosis of dementia.

- Discuss concern for cognitive impairment but exact diagnosis is unclear at this time (e.g., mild cognitive impairment (MCI) vs. early dementia vs. another process)
- Address immediate needs/safety risk
- Brain health discussion
- Schedule follow up with repeat evaluation in 6 months to assess for progression
- If no progression > annual reassessment
- Consider neuropsychology referral (Table I)

No Criteria Met
NO EVIDENCE of DEMENTIA

No objective cognitive changes AND no functional impairment due to cognitive changes are present.

- Reassurance with commitment to follow up and monitoring
- Brain health discussion
- Continue screening at follow up for:
  - Depression/anxiety
  - Substance use
  - Hearing loss

Table H: Features of Most Common Dementia Subtypes

- **Alzheimer's:** Most prevalent in adults >65; presents with difficulty with short-term memory and difficulty with complex tasks, social cognition is often intact early on**
- **Vascular:** History of stroke, TIA, or significant vascular risk factors; often occurs concurrently with Alzheimer's (mixed dementia)
- **Frontotemporal:** Most present between 56-65; behavioral variant with severe social disinhibition; language variant with significant difficulty with speech production and comprehension
- **Lewy Body:** Visual hallucinations, REM sleep disorder, Parkinsonism
- **Mixed Dementia:** Majority of dementia occurs from more than one etiology

**NOTE: Biomarker testing is becoming more available for Alzheimer's; it is not currently recommended as part of initial diagnosis in primary care at this time.

Table I: Neuropsychological Testing

If available, expanded neuropsychological testing can be used to:

- Help detect more MCI not found using a standard cognitive exam
- Provide diagnostic clarity if initial evaluation is unclear
- Help classify a subtype of dementia

However, it is not necessary for diagnosis of dementia and rarely changes management.