
Primary Care physicians & Dementia: Screening, Diagnosis, Disclosure & Management

**A Collection of Over 300 Relevant Published
Manuscripts
(2000-2011)**

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January 2012
Available at www.rgpeo.com



1. Koehn, S., McCleary, L., Garcia, L., Spence, M., Jarvis, P., & Drummond, N. (2012). **Understanding chinese-canadian pathways to a diagnosis of dementia through a critical-constructionist lens.** *Journal of Aging Studies, 26*(1), 44-54. Efforts to understand pathways to a diagnosis of Alzheimer's Disease and Related Dementias (ADRD) are important in light of the benefits of early diagnosis to both patients and families, but very little is known about the ways in which persons with dementia and their family caregivers experience this pathway from the point of initial symptom recognition by family or friends to formal diagnosis seeking, particularly for immigrant older adults. Our team employed qualitative methods and a critical constructionist and intersectional framework to understand this experience from the perspectives of ten Chinese-Canadian dyads of persons with dementia and their caregivers. Situating the decisions made by these dyads relative to their intersecting identities and the power structures that inhibit them steered us away from essentializing attributions of their experiences to their 'culture' or ethnicity. Early signs of dementia were recognized as such in hindsight. There was no evidence of a strong link between culture and symptom appraisal. Knowledge about dementia, which may be influenced by culture, age, income, knowledge of English, and other determinants of health, played a role in symptom appraisal and help seeking. The role of family caregivers in care-seeking was more highly influenced by structural factors than by traditional Chinese cultural norms about family responsibilities and filial piety. Once caregivers realized that the symptoms and behaviors were 'problematic,' they quickly sought out additional information, usually from a family physician. At 1.5 years, the time zbetween symptom onset and diagnosis is comparable to or shorter than that reported in research with other cultural groups. Gender-based power imbalance between female family caregivers and male Chinese-Canadian physicians appear to have contributed to delayed investigations and diagnosis. Sensitivity to such imbalances is important when working with older adults and those from more hierarchical cultures. Essentialized portraits of traditional family structures and cultural beliefs may not accurately reflect the variety of lived experiences of the dementia care-seeking by older Chinese immigrants in Canada. (PsycINFO Database Record (c) 2011 APA, all rights reserved) (journal abstract)

2. Adler, G., & Rottunda, S. J. (2011). **The driver with dementia: A survey of physician attitudes, knowledge, and practice.** *American Journal of Alzheimer's Disease & Other Dementias, 26*(1), 58-64. Background: One of the most difficult issues physicians must address when caring for persons with dementia is fitness to drive. The purpose of this project was to investigate the attitudes, knowledge, and practices of physicians toward drivers with dementia. Methods: A questionnaire that obtained perspectives about and experiences with drivers' with dementia was mailed to physicians from North Carolina and South Carolina. Results: The sample was comprised of 239 physicians who worked with persons with dementia. Respondents who were aware of the Physician's Guide to Assessing and Counseling Older Drivers, had a strong perceived role regarding driving, were older, and believed it was important to address driving were more likely to engage in driving discussions. Conclusions: Concerns associated with the driver with dementia have implications for not

only patient care but also public safety. We recommend that all physicians be encouraged to address the issue and utilize existing educational materials.

3. Apesoa-Varano, E., Carolina, Barker, J., C., & Hinton, L. (2011). **Curing and caring: The work of primary care physicians with dementia patients.** *Qualitative Health Research*, 21(11), 1469-1483. doi:10.1177/1049732311412788

4. Barth, A., Riedel, O., & Wittchen, H. -. (2011). **The psychopathological burden of outpatients with alzheimer's dementia and their caregivers - the idea-study (improving alzheimer's dementia treatment: Epidemiological assessment of patients', caregivers' and doctors' unmet needs and barriers).** *Neurodegenerative Diseases. 10th International Conference Alzheimer's and Parkinson's Diseases: Advances, Concepts and New Challenges. Barcelona, Spain. Conference Start: 20110309 Conference End: 02110313*, 8 doi:<http://dx.doi.org/10.1159/000327701>

Little is known about the impact of neuropsychiatric symptoms in Alzheimer's Dementia (AD) patients and the associated psychopathological burden for their caregivers (CG) in familial care. Aims: 1) Describing the familial care situation of patients with mild/moderate AD. 2) Exploring the impact of neuropsychiatric symptoms in patients with AD on caregiver burden. Nationwide random sample of N=500 AD-outpatients and their CG. Patients were assessed by their office-based physicians. CG filled out a questionnaire and subsequently were interviewed by the research team (N=221). Patients' neuropsychiatric symptoms were assessed by a standardized clinical appraisal (physician). The caregiver interview included the Neuropsychiatric Inventory, Depression Screening Questionnaire and Anxiety Screening Questionnaire. According to the physicians 91.6% and according to CG 95.7% of patients revealed clinically significant neuropsychiatric symptoms. CGs rated a higher mean number of syndromes (4,5 vs. 3,2 (physicians); p71 vs. <=55 years, OR=0.3). Patients' apathy and depression were associated with CGs' depressive symptoms; patients' apathy and irritability with GAD symptoms in CG. Findings underline an exceedingly high burden of depressive spectrum symptoms in early stages, which seem to significantly increase family care burden and contribute to increased psychopathology burden in CG.

5. Callahan, C. M., Boustani, M. A., Weiner, M., Beck, R. A., Livin, L. R., Kellams, J. J., . . . Hendrie, H. C. (2011). **Implementing dementia care models in primary care settings: The aging brain care medical home.** *Aging & Mental Health*, 15(1), 5-12. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20945236>

OBJECTIVES: The purpose of this article is to describe our experience in implementing a primary care-based dementia and depression care program focused on providing collaborative care for dementia and late-life depression. **METHODS:** Capitalizing on the substantial interest in the US on the patient-centered medical home concept, the Aging Brain Care Medical Home targets older adults with dementia and/or late-life depression in the primary care setting. We describe a structured set of activities that laid the foundation for a new partnership with the primary care practice and the lessons learned in implementing this new care model. We also provide a description of the core components

of this innovative memory care program. **RESULTS:** Findings from three recent randomized clinical trials provided the rationale and basic components for implementing the new memory care program. We used the reflective adaptive process as a relationship building framework that recognizes primary care practices as complex adaptive systems. This framework allows for local adaptation of the protocols and procedures developed in the clinical trials. Tailored care for individual patients is facilitated through a care manager working in collaboration with a primary care physician and supported by specialists in a memory care clinic as well as by information technology resources. **CONCLUSIONS:** We have successfully overcome many system-level barriers in implementing a collaborative care program for dementia and depression in primary care. Spontaneous adoption of new models of care is unlikely without specific attention to the complexities and resource constraints of health care systems.

6. Cheng, S. -, Lam, L. C. W., Chan, L. C. K., Law, A. C. B., Fung, A. W. T., Chan, W. -, . . . Chan, W. -. (2011). **The effects of exposure to scenarios about dementia on stigma and attitudes toward dementia care in a chinese community.** *International Psychogeriatrics*, 23(9), 1433-1441. doi:<http://dx.doi.org/10.1017/S1041610211000834>
Background: This study investigated whether brief exposure to information has any effect on stigmatizing attitudes towards older people with dementia, and how people responded to this medical diagnosis. Methods: 494 adults were randomly assigned to three groups differentiated by experimental conditions. Group A (control) responded to questions on stigma directly. Group B (symptom) read two vignettes that described the symptoms of two fictitious individuals with dementia, before answering questions on stigma. Group C (label) read the same vignettes which ended with a statement that the person was recently diagnosed with dementia by a physician. Data were analyzed with ANOVA, together with other pre-existing between-subjects factors. Results: Brief exposure to information about dementia led to a statistically significant reduction in stigma (Groups B, C < A), regardless of whether the diagnostic label of "dementia" was included or not. Moreover, lower stigma was reported by persons who knew a relative or friend with dementia, who were younger and more educated, and who thought dementia was treatable. Conclusions: As stigmatizing attitudes toward dementia are still a hindrance to early help-seeking in Asian communities, the findings suggest that community education may play a useful role in alleviating this barrier to early detection and intervention. Copyright 2011 International Psychogeriatric Association.

7. Chesney, T. R., Alvarado, B. E., & Garcia, A. (2011). **A mild dementia knowledge transfer program to improve knowledge and confidence in primary care.** *Journal of the American Geriatrics Society*, 59(5), 942-944. Early detection of mild dementia facilitates optimal care, which provides social, economic, and medical benefits. A Mild Dementia Knowledge Transfer (MDKT) pilot program incorporating contemporary knowledge translation concepts, practice opportunities with feedback, and collaboration between specialty and primary care, was developed to increase the knowledge and confidence of primary care professionals in addressing mild dementia. Community primary care professionals were recruited within the referral area of the Queen's University memory clinics. Recipients completed the pre-program questionnaire and received the MDKT toolkit developed for the program, and

the Montreal Cognitive Assessment (MoCA). Forty nine patients were assessed, with program exposure determined according to clinics' needs and availability, allowing the program to fit within usual care processes. Recipients showed significantly better scores after the program than before. However, time limitation was a perceived barrier for the integration of program information into practice. (PsycINFO Database Record (c) 2011 APA, all rights reserved)

8. Connolly, A., Gaehl, E., Martin, H., Morris, J., Iliffe, S., Drake, R., . . . Purandare, N. (2011). **Quality of care for dementia in primary care.** *Alzheimer's and Dementia.Conference: Alzheimer's Association International Conference, AAIC 11 Paris France.Conference Start: 20110716 Conference End: 20110721.Conference Publication: (Var.Pagings), 7(4 SUPPL. 1), S631.* doi:<http://dx.doi.org/10.1016/j.jalz.2011.05.1805>
Background: Primary care services are often the main health care service for patients with dementia (PWD), hence good quality of care at this level is important. For example, treatment of non-cognitive symptoms with antipsychotic medication is associated with a greater risk of stroke with associated negative outcomes in PWD.We investigated patient- and practice-level predictors of quality of dementia care in primary care. Methods: 994 PWD were identified from dementia registers of 52 general practices, randomly selected and stratified according to list size, population over 65, patients on dementia register and number of GPs. Information was obtained from medical records, including: demographics, dementia subtype and other medical diagnoses, pharmacological management of cognitive and noncognitive symptoms, last dementia review and its contents (discussion with carers, and medication, mental health and social care reviews) for those diagnosed with dementia more than 15 months previously (n=745). Multilevel ordinal regression was used to determine patient and practice predictors of dementia review quality, determined by presence of review and its contents. Results: 80% (599 / 745) patients had an annual dementia review, but just 51% (305 / 599) had social care review, and 61% (367 / 599) discussion of carers included in this. 86% (364 / 422) patients with Alzheimer's disease (AD) were checked for cognitive enhancing medication eligibility. Despite high prevalence of vascular disease, 26 %(262/994) were currently prescribed antipsychotics; 57 %(148/262) of these had record of medication reviewed in the previous 6 months, and 77 %(203/262) in the previous 15 months. Type of dementia was the only significant predictor of dementia review quality, with AD significantly associated with receiving better quality. Conclusions: Though the number of PWD with a record of an annual dementia review is high, its quality is sub-optimal. Further research needs to investigate whether the better quality of care for AD patients relates to the availability of cognitive enhancers and national guidelines' requirements for monitoring. Research should also focus on reducing the use of antipsychotics, which continue to be overused, without a regular review, in PWD. Addressing these deficiencies in dementia care is important to maintaining the quality of life for PWD, especially as disease modifying strategies are not yet available.

9. Connolly, A., Gaehl, E., Martin, H., Morris, J., Iliffe, S., Drake, R., . . . Purandare, N. (2011). **Under-provision of medical care for people with dementia in primary care.** *Alzheimer's and Dementia.Conference: Alzheimer's Association International Conference, AAIC 11 Paris France.Conference Start: 20110716 Conference End:*

20110721.Conference Publication: (Var.Pagings), 7(4 SUPPL. 1), S631.
doi:<http://dx.doi.org/10.1016/j.jalz.2011.05.1804>

Background: Vascular diseases are important in predicting progression of dementia, including AD. To get a true reflection of the overall quality of care provided to patients with dementia (PWD) in primary care we need to investigate, and combine, the quality of care across multiple domains. We examined the quality of medical care for vascular diseases and risk factors provided to PWD in primary care, and the patient and practice characteristics that may influence it. Methods: Primary care medical records of 994 PWD, from a random sample of 52 general practices stratified according to list size, population over 65, patients on dementia register and number of GPs, were reviewed. Care for PWD on 30 quality indicators for Hypertension, Coronary heart disease (CHD), Stroke/TIA, Diabetes Mellitus, Atrial Fibrillation, Heart Failure, and smoking was analysed, and compared to achievement levels for patients without dementia (obtained from online governmental databases). Total quality of vascular care was calculated as the proportion of quality indicators met out of all those for which each PWD was eligible, and multilevel linear regression used to determine associated patient (demographic and clinical characteristics) and practice factors (socioeconomic deprivation, over 65s population, run by single vs. multiple GPs). Results: Care was (significantly) poorer for PWD compared to those without dementia on 22/30 (73%) indicators. Peripheral pulses check, neuropathy testing, retinal screening, and BMI monitoring for diabetes; cholesterol records for Stroke and CHD patients; and smoking cessation advice received the lowest provision of care. The median proportion of indicators met for each PWD was 67% (IQR = 45 - 89). After multivariate adjustment, better quality of vascular care was found for males ($b = 11.0$, 95%CI[4.7,16.4], $p < .001$), those living in the community rather than care homes ($b=7.6$, 95%CI[1.6,13.6], $p=.013$), and those with more comorbid physical conditions ($b= 5.0$, 95%CI[2.9, 7.1], $p < .001$) and medications ($b=0.3$, 95%CI[0.1,0.5], $p=.013$). Conclusions: Overall, the quality of medical care provided to PWD with regard to vascular disease is not concordant with the national guidelines. Research to improve access to high quality care is needed as a tertiary prevention to slow progression in dementia.

10. Connolly, A., Gaehl, E., Martin, H., Morris, J., & Purandare, N. (2011). **Underdiagnosis of dementia in primary care: Variations in the observed prevalence and comparisons to the expected prevalence.** *Aging & Mental Health*, 15(8), 978-984. doi:10.1080/13607863.2011.596805

OBJECTIVES: Dementia is a major and growing health problem. Diagnosis is an important step in the access to care, but many dementia patients remain undiagnosed. This study investigated the magnitude and variation in the difference between 'observed' and 'estimated' prevalence of dementia in general practices. We also explored practice characteristics associated with observed prevalence rates. METHOD: Six Primary Care Trusts (PCTs) provided data on all general practices (N = 351) in their area in terms of number of doctors, patient list size, number of patients over 65 years of age, socio-economic deprivation status of practices and number of patients on dementia registers. RESULTS: The average observed prevalence overall of dementia amongst patients 65 years and over was 3.0% [95CI 2.8, 3.2]. The observed prevalence was 54.5% [95CI 49.2, 58.9] lower than the prevalence observed in the epidemiological studies in the UK. For an

average size general practice (list size of 5269 patients) approximately 27 [95CI 22, 32] patients with dementia may remain undiagnosed. Statistically significant differences in prevalence rates were found between the different PCTs (Wald chi-square = 103.8 $p < 0.001$). The observed prevalence of dementia was significantly lower among practices run by one GP compared to multiple GPs ($p = 0.003$), and in more affluent areas ($p < 0.001$). CONCLUSION: Just under a half of the expected numbers of patients with dementia are recognised in GP dementia registers. The underdiagnosis of dementia varies with practice characteristics, socio-economic deprivation and between PCTs, which has implications for the local implementation of the National Dementia Strategy.

11. Fowler, N., Gao, S., Frame, A., Perkins, A., Monahan, P., & Boustani, M. (2011). **Who refuses diagnostic assessment for dementia?**. *Alzheimer's and Dementia. Conference: Alzheimer's Association International Conference, AAIC 11 Paris France. Conference Start: 20110716 Conference End: 20110721. Conference Publication: (Var. Pagings), 7(4 SUPPL. 1), S451-S452.* doi:<http://dx.doi.org/10.1016/j.jalz.2011.05.1305>

Background: Dementia is a chronic, progressive and eventually fatal disorder characterized by cognitive decline in memory and at least one other cognitive domain such as language, visuo-spatial, or executive function. Presently, dementia is under recognized in the primary care of older adults. Screening for dementia in primary care increases recognition and treatment of reversible causes of memory loss and may delay of disease progression. In addition, earlier identification of dementia through screening may improve the diagnostic process and provide opportunities for physicians to discuss prognosis, learn about patient's goals, and tailor prevention and disease management targets and may improve patient and family outcomes such as knowledge about dementia, preparedness for future medical decisions, and confidence in medical decision-making. Once patients screen positive, they may delay or decline a diagnostic assessment for dementia due to concerns about having others know about their cognitive status, the belief that dementia cannot be treated or a general negative attitude toward medical assessment. In addition, previous studies have found that despite a caregiver recognizing more benefits from diagnostic assessment, 70.3% had a hard time accepting their family member's cognitive decline and 67.7% were concerned with how the diagnosis would impact their own life. In an effort to design patient-centered interventions to increase screening and diagnostic assessments, it is important to understand and enumerate the behaviors regarding diagnostic assessment. The purpose of this cross-sectional survey study is to determine the characteristics and perceptions of patients who completed (Table presented) the Perceptions Regarding Investigational Screening for Memory in Primary Care (PRISM-PC) Questionnaire and screened positive for dementia but subsequently refused further diagnostic assessment for dementia compared to those who screened positive and agreed to a diagnostic assessment. Methods: Cross-sectional survey of 554 primary care patients 65 years old and older without a diagnosis of dementia attending urban primary care clinics in Indianapolis, Indiana, in 2008-2009. Perceptions of dementia screening were measured with the Perceptions Regarding Investigational Screening for Memory in Primary Care (PRISM-PC) instrument. The PRISM-PC includes scales for benefits, stigma, independence, and suffering which are scored from 0 (strongly disagree on all items) to 100 (strongly agree on all items) with 50

as a neutral score. Refusing diagnostic assessment for dementia was determined by the percentage of patients who screened positive on at least one of two written screening instruments (MMSE or CSI-D) but subsequently refused a diagnostic assessment at a specialty clinic. Associations were assessed between scores on the PRISM-PC questionnaire, screening performance, and behavior regarding diagnostic assessment for those with a positive screen. Results: 497 individuals completed the PRISM-PC and agreed to dementia screening. Of those who agreed to screening, 63 (12.6%) screened positive. Among the 63 participants who screened positive, 21 (33.3%) accepted diagnostic assessment and 42 (66.6%) refused diagnostic assessment. Those who accepted diagnostic assessment did not differ in age, race, sex, education or income compared to those who refused diagnostic assessment. Individuals who refused diagnostic assessment following a positive screening test were more likely to live alone ($p = 0.008$). A bivariate comparison of the mean PRISM-PC scores of participants who accepted a diagnostic assessment and participants who refused it (Table 1) showed that there was a significant difference in the domain score for stigma of dementia screening (35.2 vs. 42.0; $P = .045$) but not in the domain scores for the benefits of dementia screening, the negative impact of dementia screening on independence, and the suffering related to dementia screening. There were also significant differences regarding the individual item that asked about agreement to be tested for Alzheimer's disease with a short questionnaire (3.9 vs. 3.5; $P = .023$). Conclusions: In order to improve acceptance of diagnostic assessments for dementia, development of a decision aid that describes the components of what a diagnostic assessment entails as well as emphasizing potential benefits of early identification and acknowledgment of the perceived stigmata of having a dementia diagnosis may reduce patient reluctance to undergo a diagnostic assessment for dementia. (Table presented).

12. Galvin, J. E., Morris, J., & Meuser, T. (2011). **Improving physician awareness of alzheimer's disease and enhancing recruitment: The clinician partners program.** *Alzheimer's and Dementia. Conference: Alzheimer's Association International Conference, AAIC 11 Paris France. Conference Start: 20110716 Conference End: 20110721. Conference Publication: (Var. Pagings), 7(4 SUPPL. 1), S160.* doi:<http://dx.doi.org/10.1016/j.jalz.2011.05.432>

Background: Primary care providers routinely evaluate older adults and are thus in a position to first detect symptoms and signs of Alzheimer's disease. In urban areas, diagnostic or management difficulties may be referred to specialists; however, in rural areas, specialists may not be available. The Clinician Partners Program (CPP) was initiated to enhance rural health providers' ability in dementia diagnosis and care, and to increase research recruitment into dementia research studies of participants from rural communities. Methods: The CPP is a 3-day "mini-residency" of didactic, observational and skill-based teaching techniques. Participants completed pre- and post-tests evaluating dementia knowledge, confidence in providing care, and practice behaviors. Between May 2000 and January 2009, 146 individuals (48% physicians, 25% advance practice nurses and physician assistants, 23% psychologists, social workers, and other health professionals, 4% other) graduated from the CPP. Results: Between 2000-2009, 146 healthcare professionals with a mean age of 45.7+10.8y attended the CPP; 79.2% were Caucasian, 58.2% were female, and 58% of participants had been in practice for more

than 10y. Post-tests showed improvements in knowledge and confidence to diagnose and treat and increased use of dementia screening tools. Rural research participation in an urban Alzheimer Disease Research Center increased 52% over the pre-CPP period. Conclusions: Primary goals were accomplished: increased knowledge and confidence, changed practice habits, and enhanced research recruitment. Educational programs such as the CPP may be beneficial for increasing access to accurate diagnoses and appropriate treatment of Alzheimer's disease while also enhancing research participation.

13. Gauthier, S., Patterson, C., Gordon, M., Soucy, J. -, Schubert, F., & Leuzy, A. (2011). **Commentary on "recommendations from the national institute on aging-alzheimer's association workgroups on diagnostic guidelines for alzheimer's disease." A canadian perspective.** *Alzheimer's and Dementia*, 7(3), 330-332. doi:<http://dx.doi.org/10.1016/j.jalz.2011.03.006>

The criteria for mild cognitive impairment due to Alzheimer's disease (AD) and preclinical AD, while offering great hope of fostering research on primary and secondary prevention for AD, are currently unsuitable for use in general clinical practice and must be used with great caution in specialized memory clinics. 2011 The Alzheimer's Association. All rights reserved.

14. Hollingworth, S. A., & Byrne, G. J. (2011). **Prescribing trends in cognition enhancing drugs in australia.** *International Psychogeriatrics*, 23(2), 238-245. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20670461>

BACKGROUND: This study sought to examine the trends in the prescribing of subsidized and unsubsidized cognition enhancing drugs (CEDs) in Australia over five years from 2002 to 2007. Subsidized cholinesterase inhibitor medication could be prescribed to people with mild to moderate Alzheimer's disease (AD) once a specialist physician had confirmed this diagnosis. Memantine was available for use in moderately severe AD but not subsidized. **METHODS:** We analyzed the Medicare Australia and Drug Utilisation Sub-Committee databases for CED prescription data, 2002-2007, by gender, age and prescriber class. Aggregated prescription data for each medication were converted to defined daily doses (DDD) per 1000 persons per day using national census data. **RESULTS:** There were 1,583,667 CED prescriptions dispensed during the study period. CED use increased 58% from 0.91 to 1.56 DDD/1000 persons/day between 2002 and 2007. Peak use was in those aged 85-89 years. Age-adjusted utilization was slightly higher in females than males. Donepezil was the most widely used CED (66%), followed by galantamine (27%) then memantine (4%). General practitioners prescribed the majority of CEDs. Geriatricians exhibited a greater preference for galantamine than other prescribers. CED dispensing peaked towards the end of each calendar year, reflecting stockpiling by patients under the influence of a federal safety net subsidy. **CONCLUSIONS:** Despite subsidized access to CEDs in Australia, only a minority of people with AD was prescribed these drugs during the period of the study. It is likely that the combination of complex prescribing rules and negative perceptions about efficacy or cost-effectiveness might have contributed to these findings.

15. Koch, T., & Iliffe, S. (2011). **Dementia diagnosis and management: A narrative review of changing practice.** *The British Journal of General Practice : The Journal of the Royal College of General Practitioners*, 61(589), e513-525. Early detection and management of dementia in primary care are difficult problems for practitioners. England's National Dementia Strategy 2009 seeks to improve these areas but there is limited evidence on how to achieve this most effectively. This review aims to identify and appraise empirical studies of interventions designed to improve the performance of primary care practitioners in these areas. A narrative review of primary-care based studies. Publications up to February 2010 were identified by searching the electronic databases MEDLINE, Embase, and PsycINFO, and bibliographies. The criterion for inclusion was that studies had to be of interventions aimed at improving detection or management of dementia in primary care. Exclusion criteria included studies in non-English publications, pharmacological interventions, and screening instrument studies. Quality was assessed using the PEDro (Physiotherapy Evidence Database) scale. Fifteen studies were identified, of which 11 were randomised controlled trials. Eight reported educational interventions, and seven trialled service redesign, either by changing the service pathway or by introducing case management. Educationally, only facilitated sessions and decision-support software improved GPs' diagnosis of dementia, as did trials of service-pathway modification. Some of the case-management trials showed improved stakeholder satisfaction, decreased symptoms, and care that was more concordant with guidelines. The quality of the studies varied considerably. Educational interventions are effective when learners are able to set their own educational agenda. Although modifying the service pathway and using case management can assist in several aspects of dementia care, these would require the provision of extra resources, and their value is yet to be tested in different health systems.

16. Lee, L., Kasperski, M. J., & Weston, W. W. (2011). **Building capacity for dementia care: Training program to develop primary care memory clinics.** *Canadian Family Physician*, 57(7), e249-e252. Problem being addressed: Currently, dementia care provided by family physicians is suboptimal and access to specialist resources is limited. With the aging population, there is a need for system-wide, programmatic interventions to improve the diagnosis and management of patients with memory difficulties. The development of primary care memory clinics addresses this need. Objective: The Memory Clinic Training Program aims to develop highly functioning interprofessional memory clinics that assist family physicians in providing improved care for patients with dementia and other forms of cognitive impairment. Program description: The interprofessional training program consists of a 2-day case-based workshop, 1 day of observership and clinical training at the Centre for Family Medicine Memory Clinic, and 2 days of on-site mentorship at each newly formed memory clinic. Conclusion: The Memory Clinic Training Program is an accredited, comprehensive program designed to assist family practice groups with developing primary care memory clinics. These clinics aim to transform the current limited practice capability of individual family physicians into a systematic, comprehensive, interprofessional health care service that improves capacity and quality of primary care for patients with cognitive impairment and dementia.

17. Lee, S. M., Lin, X., Haralambous, B., Dow, B., Vrantsidis, F., Tinney, J., . . . Giudice, D. L. (2011). **Factors impacting on early detection of dementia in older people of asian background in primary healthcare.** *Asia-Pacific Psychiatry*, 3(3), 120-127. doi:<http://dx.doi.org/10.1111/j.1758-5872.2011.00130.x>

Introduction: The prevalence of dementia in people from Culturally and Linguistically Diverse (CALD) backgrounds is predicted to increase. By 2026, Chinese and Vietnamese languages are projected to be the first and fourth most prevalent languages spoken by older people from CALD backgrounds living in Australia. Varying expressions of dementia literacy within these groups sometimes result in presentation to health services at a later stage of the disease. Methods: This paper aims to present a literature review on factors impacting on the early diagnosis of dementia in primary care. Cultural factors pertaining to older people of Chinese and Vietnamese backgrounds are identified and described. Results: The review found that despite the benefits and emphasis on early diagnosis of dementia, GPs' uncertainty, insufficient training, ambivalent attitude and therapeutic nihilism have contributed to delayed diagnosis of dementia in CALD populations in primary care. Other factors included time pressures, poor remuneration and lack of CALD appropriate diagnostic tools and services. From the older Chinese and Vietnamese people and their families' perspective, living arrangements, level of dementia literacy, symptom interpretation, stigma associated with dementia and their concept of morality significantly impacted on health-seeking behaviour, contributing to delayed presentation to GPs. Language barriers and lack of bilingual GPs were also found to be deterring factors. Discussion: There is a need to remove barriers impacting on the timely diagnosis of dementia in primary healthcare for older people from CALD backgrounds. Increasing CALD-appropriate services, workforce training, public awareness and removing stigma may assist. 2011 Blackwell Publishing Asia Pty Ltd.

18. Leung, K. -, & Chen, C. -. (2011). **A quick dementia screening tool for primary care physicians.** *Archives of Gerontology and Geriatrics*, 53(1), 100-103. doi:<http://dx.doi.org/10.1016/j.archger.2010.06.008>

The accuracy and consuming-time of screening methods are important factors in the early diagnosis of dementia. In this study, we aimed to know whether the eight-item test (including three-item recall, attention and calculation, subtracted from the mini-mental state examination (MMSE), clock drawing test (CDT), and instrumental activities of daily living (IADL) impairment or any combination of the above tests can be used as a quick and effective dementia screening tool. A total of 188 seniors aged over 60 years were enrolled at a geriatric clinic. The result revealed that a cutoff score of 6/7 in an eight-item scale had a sensitivity of 94.9% and a specificity of 59.1% in the detection of dementia. In terms of sensitivity and specificity, the eight-item scale performed better than a score of two in three-item recall (51.3%/87.3%), a score of one in three-item recall (83.3%/53.6%), CDT (39.0%/96.9%), mini-cognitive assessment instrument (Mini-Cog) test (53.7%/95.5%), a score of less than three in attention/calculation test (74.7%/77.3%), impairment of transportation or medication in IADL (67.2%/90.6%), and any impairment in IADL (77.2%/67.9%). In subgroup analysis, a cutoff score of 5/6 were adjusted for the low-education group. We conclude that an eight-item test is a sufficient and simple tool for the screening of early dementia in primary-care clinics focused on older people care. 2010 Elsevier Ireland Ltd.

19. Menon, R., & Lerner, A. J. (2011). **Use of cognitive screening instruments in primary care: The impact of national dementia directives (NICE/SCIE, national dementia strategy).** *Family Practice*, 28(3), 272-276. doi:<http://dx.doi.org/10.1093/fampra/cmq100>

Background: Publication of national dementia directives, namely the National Institute for Health and Clinical Excellence/Social Care Institute for Excellence (NICE/SCIE) guidelines (2006) and the National Dementia Strategy (NDS; 2009), has aimed to improve dementia awareness, diagnosis and management in all sectors of the health service. Aim: To measure the frequency of cognitive screening instrument use reported in referrals from primary care to a dedicated secondary care Cognitive Function Clinic (CFC) over the period encompassing the launch of NICE/SCIE guidance and NDS, in comparison with cohorts seen before these directives were issued. The design of study is prospective. The setting of the study is CFC, Regional Neuroscience Centre. Method: Over a 2 year period (February 2008 to February 2010), referral letters for patients referred from primary care to CFC (n = 306) were examined for mention of cognitive screening instrument use. Patients were evaluated in CFC with standard clinical, neuropsychological and neuroimaging methods and diagnoses were made following widely accepted diagnostic criteria for dementia and dementia subtypes. Results: There was an increase in the number of GP referrals over the study period compared to a prior cohort but the proportion of dementia diagnoses fell and the frequency of cognitive screening instrument use was unchanged. Conclusions: Increased numbers of referrals would be consistent with an awareness raising effect of NICE/SCIE and NDS and a willingness among GPs to refer cases. But the falling proportion of dementia diagnoses suggests that these are 'worried well' individuals. There is no evidence for closure of the dementia 'diagnosis gap'. The Author 2010. Published by Oxford University Press. All rights reserved.

20. Millard, F. B., Kennedy, R. L., & Baune, B. T. (2011). **Dementia: Opportunities for risk reduction and early detection in general practice.** *Australian Journal of Primary Health*, 17(1), 89-94. doi:<http://dx.doi.org/10.1071/PY10037>

This project aimed to measure general practitioner (GP), practice nurse and patient health literacy about memory problems, dementia and its risk factors. Data were collected from general practices across Australia and a smaller sample in England. Questionnaires explored sources and adequacy of dementia knowledge and a randomised controlled trial tested the intervention of a dementia risk reduction pamphlet on patient knowledge of dementia risk reduction strategies. Data were analysed using SPSS software. The results of 621 questionnaires from patients aged over 30 years showed 37% had memory concerns, 6% recalled having a memory test, 52% would like a memory test and 15% had heard about dementia from their GP. Patients receiving the intervention were significantly more likely to be aware of dementia risk reduction strategies (P=0.05). The frequency of documentation of Mini-Mental State Examination and dementia diagnosis in computerised medical records of patients over 75 years was less than 0.01. These results demonstrate that many adult patients attending GPs have memory concerns, associate dementia with memory loss, and are receptive to information about dementia risk reduction. Most general practitioners and their nurses rate their dementia knowledge as

inadequate with few testing for memory problems or discussing dementia with their patients. 2011 La Trobe University.

21. Mitchell, A. J., Meader, N., & Pentzek, M. (2011). **Clinical recognition of dementia and cognitive impairment in primary care: A meta-analysis of physician accuracy.** *Acta Psychiatrica Scandinavica*, 124(3), 165-183. doi:<http://dx.doi.org/10.1111/j.1600-0447.2011.01730.x>

Objective: We aimed to examine the ability of the general practitioners (GPs) to recognize a spectrum of cognitive impairment from mild cognitive impairment (MCI) to severe dementia in routine practice using their own clinical judgment. Method: Using PRISMA criteria, a meta-analysis of studies testing clinical judgment and clinical documentation was conducted against semi-structured interviews (for dementia) and cognitive tests (for cognitive impairment). We located 15 studies reporting on dementia, seven studies that examined recognition of broadly defined cognitive impairment, and eight regarding MCI. Results: By clinical judgment, clinicians were able to identify 73.4% of people with dementia and 75.5% of those without dementia but they made correct annotations in medical records in only 37.9% of cases (and 90.5% of non-cases). For cognitive impairment, detection sensitivity was 62.8% by clinician judgment but 33.1% according to medical records. Specificity was 92.6% for those without cognitive impairment by clinical judgment. Regarding MCI, GPs recognized 44.7% of people with MCI, although this was recorded in medical notes only 10.9% of the time. Their ability to identify healthy individuals without MCI was between 87.3% and 95.5% (detection specificity). Conclusion: GPs have considerable difficulty identifying those with MCI and those with mild dementia and are generally poor at recording such diagnoses in medical records. 2011 John Wiley & Sons A/S.

22. Morgan, D., Innes, A., & Kosteniuk, J. (2011). **Dementia care in rural and remote settings: A systematic review of formal or paid care.** *Maturitas*, 68(1), 17-33. doi:<http://dx.doi.org/10.1016/j.maturitas.2010.09.008>

Objectives: The purpose of this review is to critically evaluate the available evidence from the published scientific literature on dementia care and service provision in rural and remote settings from the perspective of formal/paid caregiving, in order to assess the current state of knowledge, identify policy and practice implications, and make recommendations for future research. Methods: A systematic review of the literature indexed in ISI Web of Knowledge, PsychInfo, Medline, Healthstar, CINAHL, EMBASE, and Sociological Abstracts was conducted. Data were extracted from papers meeting inclusion criteria: peer-reviewed papers that focused on dementia or Alzheimer's disease (AD), examined care or service provision in relation to persons with AD or dementia, and relevant to rural or remote care or services. Results: The search identified 872 articles for review, reduced to 72 after removing duplicates and articles not meeting criteria. Of the 72 remaining, 46 are included in this current review focusing on formal or paid care. A future review will focus on the 26 studies on informal/unpaid care. Six themes that correspond to the current state of knowledge in rural dementia care in the 46 included studies were: diagnostic processes, service provision, service models and programs, staff education and support needs, use of technology, and long-term care. Conclusions: Despite the growing body of evidence over the 20 years covered by this review, much of

the research is descriptive and/or based on small sample sizes, and distributed across the care continuum. Hence the body of evidence on which to base policy and program decisions remains limited. More research is needed that would support the development of comprehensive rural dementia care models. 2010 Elsevier Ireland Ltd. All rights reserved.

23. Mutasingwa, D. R., Ge, H., & Upshur, R. E. G. (2011). **How applicable are clinical practice guidelines to elderly patients with comorbidities?**. *Canadian Family Physician*, 57(7), e253-e262.

Objective: To examine the applicability of 10 common clinical practice guidelines (CPGs) to elderly patients with multiple comorbidities. Design: Content analysis of published Canadian CPGs for the following chronic diseases: diabetes, dyslipidemia, dementia, congestive heart failure, depression, osteoporosis, hypertension, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and osteoarthritis. Main outcome measures: Presence or absence of 4 key indicators of applicability of CPGs to elderly patients with multiple comorbidities. These indicators include any mention of older adults or people with comorbidities, time needed to treat to benefit in the context of life expectancy, and barriers to implementation of the CPG. Results: Out of the 10 CPGs reviewed, 7 mentioned treatment of the elderly, 8 mentioned people with comorbidities, 4 indicated the time needed to treat to benefit in the context of life expectancy, 5 discussed barriers to implementation, and 7 discussed the quality of evidence. Conclusion: This study shows that although most CPGs discuss the elderly population, only a handful of them adequately address issues related to elderly patients with comorbidities. In order to make CPGs more patient centred rather than disease driven, guideline developers should include information on elderly patients with comorbidities.

24. Noel, M. (2011). **Memorycare: A community based dementia care model.** *Alzheimer's and Dementia. Conference: Alzheimer's Association International Conference, AAIC 11 Paris France. Conference Start: 20110716 Conference End: 20110721. Conference Publication: (Var.Pagings), 7(4 SUPPL. 1), S635. doi:<http://dx.doi.org/10.1016/j.jalz.2011.05.1817>*

Background: MemoryCare was founded as a community based non-profit charitable organization in 2000 to offer families an alternative to the traditional medical approach to dementia care. In a holistic, multi-disciplinary team approach, we incorporate caregiver education, counseling, and support into the evaluation and medical management of the patient. MemoryCare is designed to address the most common concerns of caregivers who interface with the medical system as advocates for a memory impaired loved one: the lack of recognition that a memory disorder is present and the lack of communication between medical provider and caregiver on how to best assist their loved one. With seventeen percent of our region's population over 65 years of age, we are ahead of much of the nation in the prevalence of individuals with memory disorders. Nationwide, 70% of those with memory impairment are cared for in their homes; at MemoryCare 85% of patients are cared for in the home setting by family members who need support and education in order to continue this care. Our goal is to enhance basic community services with a program that helps older adults and their families have the best possible quality of life in the face of a progressive memory disorder. With our physician and care manager

teams, we provide excellent medical care for the individual with memory impairment and support and education services to their caregivers. The teams coordinate diagnostic work-up, disease management planning, caregiver training, counseling and support for each enrolled family. They also provide guidance and medical assistance in managing difficult behaviors. Our staff help coordinate available community resources, assist low income elderly in applying for medical assistance, and counsel families regarding end of life decision making. After the initial evaluation families receive a carefully written care plan that is amended over time as their loved one's disease progresses. They have full access to our resource library, workshops, and staff for educational materials. MemoryCare staff is devoted to providing community education on dementia, care giving, and aging related health issues. We teach professional health care providers on these topics as well. Methods: This presentation is descriptive of our program and based on an observational gathering of data on client characteristics, outcomes and satisfaction surveys from our program in 2010. Results: In 2010, MemoryCare provided comprehensive services to 915 patients and 2673 caregivers. Our rural satellite clinic extends our outreach and our home visitation program includes over 120 families. Eighty-five percent of our patients are cared for in the home setting; one third are dependent in two or more basic activities of daily living. Our minority low income community screening program offered screenings at several community-based sites to 68 individuals. We provided dementia related education through our "Caregiver College" and other workshops to over 2500 health care professionals and community members. We maintain a peer education network of caregivers who provide support and mentoring for each other both in person and through electronic means of communication. MemoryCare's model of care has received prestigious awards from the public sector and high praise from its clientele. In our 2010 caregiver outcome survey, 95% of caregivers said their knowledge of memory disorders improved, 93% said their ability to manage their loved ones behavior improved, 70% reported a reduction in stress, 89% said they had benefitted from assistance accessing community resources, and 83% of those still living in a home setting said that MemoryCare services helped them remain at home longer thus saving themselves and the government the cost of placement. Conclusions: MemoryCare's model successfully addresses the common complaints regarding dementia care in the U.S.: rushed practitioners not following established practice guidelines,(Table presented).

25. Pentzek, M., Fuchs, A., Abholz, H. -, & Wollny, A. (2011). **Awareness of local dementia services among general practitioners with academic affiliation.** *Aging - Clinical and Experimental Research*, 23(3), 241-243. doi:<http://dx.doi.org/10.3275/7105> Background and aims: Cooperation with specialized services is one important resource for general practitioners (GPs) in managing dementia patients and caregivers. Methods: In a questionnaire study among GPs involved in university teaching (n=137) we asked if GPs knew of four types of local dementia services. A linear regression analysis was conducted to find associations with GPs' awareness. Results: Day care services could be named by over two-thirds of GPs, patient support groups by nearly half, carer support groups and memory clinics by only 40%. Greater awareness of services was associated with better theoretical knowledge of dementia and GP practices in urban areas. Conclusions: In the light of the specificity of our GP sample, our results display remarkably poor awareness of institutions caring for demented patients and their relatives.

A more active approach in acquainting GPs with dementia services, especially in rural areas, may enhance awareness and cooperation. 2011, Editrice Kurtis.

26. Perry, M. (2011). **Training family physicians and primary care nurses improves diagnostic assessment of dementia: Results of a randomized controlled trial.** *Alzheimer's and Dementia. Conference: Alzheimer's Association International Conference, AAIC 11 Paris France. Conference Start: 20110716 Conference End: 20110721. Conference Publication: (Var.Pagings), 7(4 SUPPL. 1), S498.* doi:<http://dx.doi.org/10.1016/j.jalz.2011.05.2393>

Background: Early diagnosis of dementia is important. Primary care can be considered as an excellent setting for dementia detection, for it is usually the first place for patients or caregivers to present symptoms of cognitive decline. However, primary health caregivers experience several barriers to dementia detection. This study aims to investigate the effects of a multi-faceted EASYcare-based Dementia Training Programme (DTP) for dyads of family physicians (FPs) and primary care nurses (PCNs) aimed at stimulating collaboration on the quality of dementia care. Methods: The DTP is a complex educational intervention that consists of two workshops, individual coaching, access to an internet forum, and a computerized decision support system. Its content was based on three Dutch dementia guidelines. Participants were dyads of FPs and PCNs. The effects of the DTP were studied in a cluster-randomised controlled trial. Primary outcomes were the number of cognitive assessments and dementia diagnoses in a period of 9 months following workshop participation. Secondary outcomes were adherence to guidelines and FPs' and nurses' attitude and knowledge regarding dementia. Data were collected from FPs' electronic medical records and by questionnaires. Results: 105 FP-PCN dyads participated; 74 in the intervention group and 31 in the control group. They recruited respectively 283 and 145 patients. In all patients without dementia diagnosis at baseline (265/ 135), cognitive assessments were performed in 92% of the intervention group patients and in 32% of the control group patients. 49.1% of the patients in the intervention group were diagnosed with dementia, against 14.8% in the control group (both $p < .001$). Intervention group dyads showed better adherence to diagnostic guideline recommendations (73.5%) than control group dyads (42.3%) ($p < .001$). Furthermore, intervention group participants showed a bigger change towards a positive attitude and a larger increase in knowledge on dementia. Conclusions: This Dementia Training Programme increases the number of cognitive assessments and dementia diagnoses performed in primary care, and improves adherence to diagnostic guidelines. We advocate the focus on training dyads of FPs and PCNs in multifaceted dementia training programmes to overcome current under-detection of dementia in primary care.

27. Perry, M., Draskovic, I., Lucassen, P., VernooijDassen, M., van Achterberg, T., & Rikkert, M. O. (2011). **Effects of educational interventions on primary dementia care: A systematic review.** *International Journal of Geriatric Psychiatry, 26(1), 1-11.* Objective: To determine the effects of educational interventions about dementia, directed at primary care providers (PCPs). Design: We searched Medline, Embase, PsycInfo, Cinahl and the Cochrane library for relevant articles. Two researchers independently assessed the citations identified against the following inclusion criteria: educational

intervention on dementia directed at PCPs and study designs being randomized controlled trials (RCTs), controlled clinical trials (CCTs), controlled before and after studies (CBAs) or interrupted time series (ITS) analyses. Outcomes of interest were PCPs' knowledge and attitude on dementia, and quality of dementia care at PCP and patient level. Results: Of 3953 citations identified, six articles representing five studies (four cluster RCTs and one CBA) were eligible, describing educational interventions directed at 1904 PCPs. Compliance to the interventions varied from 18 to 100%. Systematic review of the studies showed moderate positive results. Five articles reported at least some effects of the interventions. A small group workshop and a decision support system (DSS) increased dementia detection rates. An interactive 2-h seminar raised GPs' suspicion of dementia. Adherence to dementia guidelines only improved when an educational intervention was combined with the appointment of dementia care managers. This combined intervention also improved patients' and caregivers' quality of life. Effects on knowledge and attitudes were minor. Conclusion: Educational interventions for PCPs that require active participation improve detection of dementia. Educational interventions alone do not seem to increase adherence to dementia guidelines. To effectively change professionals' performance in primary dementia care, education probably needs to be combined with adequate reimbursement or other organizational incentives. (PsycINFO Database Record (c) 2011 APA, all rights reserved) (journal abstract)

28. Pond, C. D., Brodaty, H., Stocks, N., Paterson, N., Magin, P., Gunn, J., . . . Marley, J. (2011). **The attitudes of Australian general practitioners to breaking the news of dementia: A qualitative and quantitative exploration.** *Alzheimer's and Dementia.Conference: Alzheimer's Association International Conference, AAIC 11 Paris France.Conference Start: 20110716 Conference End: 20110721.Conference Publication: (Var.Pagings), 7(4 SUPPL. 1), S164.* doi:<http://dx.doi.org/10.1016/j.jalz.2011.05.443> Background: The international literature identifies that many general practitioners (GPs) fail to meet guideline recommendations for early diagnosis and management of dementia. As one aspect of the gap between guideline recommendations and practice, there is some limited evidence that GPs do not always communicate the diagnosis, once made, to the patient or carer. This report focuses on the issue of communicating the diagnosis from the Australian GPs' perspective. Methods: A-5 site cluster randomised controlled trial of an educational intervention to improve GPs' identification and management of dementia reached over 170 GPs and over 2000 patients. One hundred GPs in the intervention group received two detailing visits from a peer educator and screened all their participating patients for dementia. At the second (12 month) detailing visit they were told which of these patients had dementia based on detailed research interviews including the CAMCOG. The issue of communicating the diagnosis was discussed and these qualitative data collected using a semi-structured interview. Interviews were tape recorded and transcribed verbatim. Thematic analysis was conducted on 23 interviews, using a constant comparative process. Related codes were grouped into major and sub-themes and negative cases identified. The researchers met and reviewed the coding process and the dominant themes. This enabled agreement or differences in researcher perspectives to enrich the analysis and overall interpretation of the data. At a subsequent 24 month data collection, approximately seventy GPs were audited as to whether they had communicated the diagnosis of dementia to the patient and/or the carer, and what

term they used. In this presentation, these data will be triangulated with the qualitative data to provide a fuller picture of what the intervention GPs did in the area of communicating the diagnosis and why this might be. Results: GPs reported reluctance to discuss the diagnosis explicitly with patients and their carers. A number of words other than dementia were used, including "memory loss" and "cognitive impairment", which would be unlikely to have carried the full implications of the diagnosis to the patient or carer. Reasons for this include concerns about the certainty of the diagnosis, lack of explicit diagnosis from the memory clinic, unpredictability of the course of the disease, patients' and carers' responses to the stigma of the diagnosis and limitations of treatments and access to services. Approximately 70 GP audits are available providing a range of GP approaches to breaking the news of the diagnosis, including quantitative evidence that the diagnosis is not always communicated or not communicated explicitly, and a variety of terms used instead of the word "dementia". Data will be presented as to how many GPs broke the news to the patient, how many to the carer or carer alone, and what terms were used. Conclusions: Health planners and educators concerned to align GP management with guidelines should address issues which prevent GPs from conveying the diagnosis to patients and their carers.

29. SegalGidan, F., Cherry, D., Jones, R., Williams, B., Hewett, L., Chodosh, J., & California Workgroup on Guidelines for Alzheimer's Disease Management. (2011). **Alzheimer's disease management guideline: Update 2008.** *Alzheimer's & Dementia*, 7(3), e51-e59.

Background: Frequent review and update of guidelines are necessary for them to remain current and useful for clinical practices. This second revision of the postdiagnostic management of Alzheimer's disease (AD) guideline by the California Workgroup was prompted by significant advances in knowledge about appropriate care management, including pharmacologic and nonpharmacologic approaches to treatment of the disease, accompanying behavioral problems, and functional decline. The focus remains explicitly on primary care, where the majority of it occurs for those with AD and other dementias. Methods: In all, 40 experts in dementia care were recruited from a variety of disciplines across California. Four workgroups were created that reviewed recent research findings from a total of 569 publications since 2002. The revised Guideline incorporates 305 new references, including 11 state and federal laws, in addition to 78 references from the previous version. Results: The Guideline is divided into four sections that address postdiagnostic management: (1) assessment, (2) treatment, (3) patient and family education and support, and (4) legal considerations associated with AD. Significant revisions and changes in each area and the underlying research to support the recommendations are presented in this article. New topics related to early stage and end-of-life were identified and recommendations were developed for these specific populations. Conclusions: The Guideline recommendations provide a framework to inform and improve medical care for AD by primary health care providers. (PsycINFO Database Record (c) 2011 APA, all rights reserved) (journal abstract)

30. Shankle, W., Dick-Muehlke, C., Brant-Zawadzki, M., Hara, J., Fortier, D., Holnagel, D., . . . Capell, S. (2011). **Orange county vital aging program: A community-based approach to reduce impact of alzheimer's disease on health care**

resources. *Alzheimer's and Dementia.Conference: Alzheimer's Association International Conference, AAIC 11 Paris France.Conference Start: 20110716 Conference End: 20110721.Conference Publication: (Var.Pagings), 7(4 SUPPL. 1), S617. doi:<http://dx.doi.org/10.1016/j.jalz.2011.05.1758>*

Background: In 2007, the Leon Thal Symposium convened an international panel of experts to develop a roadmap to Prevent AD by 2020. The roadmap envisioned a broad coordination of national and local resources focused on managing risk factors, monitoring cognition and function, and enabling early diagnosis and treatment. The panel recognized that both the public and the physician community need education about the benefits of proactive risk management, early detection, and timely diagnosis and treatment. The Orange County Vital Aging Program (OCVAP: www.OCVitalAging.org) was established in line with the roadmap as a community-based educational effort including the necessary tools to allow both the public and physicians to assess risk factors, functional capacity, cognition and affect. This effort has evolved into a coordinated community program that is reaching the at-risk population, physicians, and relevant healthcare organizations. Methods: The OCVAP has implemented 7 key program components: 1) public relations and educational campaign; 2) educational web site with self-assessment tools for the public; 3) community cognitive screening services; 4) objective cognitive assessment tools for physicians; 5) network of community physicians trained to deliver proper ADRD healthcare; 6) expert physician panel to guide the broad physician community; and 7) outcome analyses. Results: Within the first 6 months (as of 12/31/2010), 13 educational activities have been attended by both the public and physician community (total 515 attendees). The website and self-assessments tools have been well used (1026 unique visitors). The community screening services have attracted 248 participants and found 23% prevalence of mild cognitive impairment (consistent with national estimates). Coordinated follow-up of impaired participants is a key challenge being addressed by the OCVAP participating physician network. In response to emerging needs, we have created clinical guidelines for community physicians and links to physician support services and resources. Conclusions: Changing public and physician behavior to achieve a more proactive approach to ADRD healthcare is a substantial, yet achievable challenge that requires a well-coordinated effort among a variety of medical and non-medical professionals, institutions, community-based organizations, and public advocates. Successful implementation of the OCVAP may provide a replicable model for other communities.

31. Thyrian, J. R., & Hoffmann, W. (2011). **Dementia care in family practices in germany: Primary data on figures and attitudes.** *Alzheimer's and Dementia.Conference: Alzheimer's Association International Conference, AAIC 11 Paris France.Conference Start: 20110716 Conference End: 20110721.Conference Publication: (Var.Pagings), 7(4 SUPPL. 1), S636. doi:<http://dx.doi.org/10.1016/j.jalz.2011.05.1820>*

Background: The relatives and the general physicians play a key part in providing appropriate care for people with dementia. There is a need for primary data about perceived numbers of people with dementia and the attitudes towards dementia and treatment of dementia in the primary care setting. Methods: All n = 1109 general physicians (GP) in residency were contacted and asked to participate in a written survey in the whole federal state of Mecklenburg - West Pomerania, the response rate was 31%

(n = 335). The survey included data about (a) the GP (age, sex, education.), (b) the practice (number of patients per quarter, number of people with dementia), (c) the treatment (guidelines, screening, diagnostics) (d) knowledge, attitudes and competences regarding dementia and (e) the GP giving recommendations to improve health care for people with dementia. Results: Preliminary results show that the average number of patients per quarter was 1085; the average of patients with dementia living at home the GP cares for was 17. More than 50% of the responding GP answered that they were treating their patients very individually and/ or based the treatment on clinical experience. Approximately 30% treated their patients according to dementia treatment guidelines. 50-80% used systematic screening instruments. Conclusions: The results of a GP survey provide a first impression about prevalent attitudes about the care for people with dementia in primary care in Germany. Dementia care is a challenge which is perceived by nearly all of the GP. The GP feel confident in treating dementia and put a special emphasis on the inclusion of the relatives and caregivers into the treatment. They also emphasize the need for participation of people with dementia in social activity and in the society. The results also indicate that dementia is just one area of illnesses inside the GP practice and is usually combined with other chronic diseases and disabilities. This large variability needs to be taken into account, when concepts for dementia care are to be implemented in the primary care setting.

32. Adams, A. J. (2010). **Should family physicians assess fitness to drive?: Yes.** *Canadian Family Physician*, 56(12), 1264-1266. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=21375059>

33. Ahmad, S., Orrell, M., Iliffe, S., & Gracie, A. (2010). **GPs' attitudes, awareness, and practice regarding early diagnosis of dementia.** *British Journal of General Practice*, 60(578), e360-5. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20849686>

BACKGROUND: In primary care, the diagnosis of dementia is often delayed and the 2007 National Audit Office Report concluded action was needed to improve patient care and value for money. **AIM:** To investigate the attitudes, awareness, and practice of GPs in England regarding early diagnosis and management of patients with dementia, and perceptions of local specialist services, to identify training or support needs. **DESIGN OF STUDY:** Secondary analysis of survey data that capture the above attitudes, awareness, and practice. **SETTING:** Online survey, targeting GP members of medeConnect. **METHOD:** Survey data were obtained using an anonymised online self-completion questionnaire, and then analysed using standard data-analysis software. **RESULTS:** A total of 1011 GPs across the eight English regions responded. Older GPs were more confident in diagnosing and giving advice about dementia, but less likely to feel that early diagnosis was beneficial, and more likely to feel that patients with dementia can be a drain on resources with little positive outcome. Younger GPs were more positive and felt that much could be done to improve quality of life. Attitudes had no correlation with sex. GPs in general felt they had not had sufficient basic and post-qualifying training in dementia, and overall knowledge about dementia was low. **CONCLUSION:** Much could

be done to improve GPs' knowledge of dementia, and the confidence of older GPs could be an educational resource. However, greater experience may create scepticism about early diagnosis because of the perceived poor quality of specialist services.

34. Baloch, S., Moss, S. B., Nair, R., & Tingle, L. (2010). **Practice patterns in the evaluation and management of dementia by primary care residents, primary care physicians, and geriatricians.** *Baylor University Medical Center Proceedings*, 23(2), 121-125.

With the aim of determining if specialty type or the amount of geriatric training during primary care residencies correlated with the rate of and comfort with dementia identification and management in patients 65 years and older, physician practice patterns were compared through a web-based survey. The survey was sent to family medicine, internal medicine, and geriatric physicians in Dallas County and the Health Texas Provider Network as well as third-year family medicine and internal medicine residents in Texas. Chi-square analyses revealed no relationship between the quantity of geriatric training and either dementia screening rates or comfort with dementia diagnosis. However, there was a significant difference in these areas based on specialty: more geriatricians reported asking senior patients about memory problems and being very comfortable in making a diagnosis of dementia, while fewer family medicine and internal medicine physicians reported being very comfortable in making the dementia diagnosis. Most physicians surveyed supported instituting routine screening and evaluation of senior patients during residency training. Further research is needed to determine if brief screening modalities, enhanced training, and institution of national guidelines would result in earlier identification and management of dementia in primary care.

35. Boise, L., Eckstrom, E., Fagnan, L., King, A., Goubaud, M., Buckley, D. I., & Morris, C. (2010). **The rural older adult memory (ROAM) study: A practice-based intervention to improve dementia screening and diagnosis.** *Journal of the American Board of Family Medicine*, 23(4), 486-498. doi:<http://dx.doi.org/10.3122/jabfm.2010.04.090225>

Introduction: The aim of the Rural Older Adult Memory (ROAM) pilot study was to evaluate the feasibility of screening and diagnosing dementia in patients aged 75 years or older in 6 rural primary care practices in a practice-based research network. Methods: Clinicians and medical assistants were trained in dementia screening using the ROAM protocol via distance learning methods. Medical assistants screened patients aged 75 years of age and older. For patients who screened positive, the clinician was alerted to the need for a dementia work-up. Outcomes included change in the proportion of patients who were screened and diagnosed with dementia or mild cognitive impairment, clinician confidence in diagnosing and managing dementia, and response to the intervention. Results: Results included a substantial increase in screening for dementia, a modest increase in the proportion of patients who were diagnosed with dementia or mild cognitive impairment, and improved clinician confidence in diagnosing dementia. Although clinicians and medical assistants found the ROAM protocol easy to implement, there was substantial variability in adherence to the protocol among the 6 practices. Conclusion: This study demonstrated the complex issues that must be addressed in implementing a dementia screening process in rural primary care. Further study is needed

to develop effective strategies for overcoming the factors that impeded the full uptake of the protocol, including the logistic challenges in implementing practice change and clinicians' attitudes toward dementia screening and diagnosis.

36. Bond, J., Graham, N., Padovani, A., MacKell, J., Knox, S., & Atkinson, J. (2010). **Screening for cognitive impairment, alzheimer's disease and other dementias: Opinions of european caregivers, payors, physicians and the general public.** *Journal of Nutrition, Health and Aging*, 14(7), 558-562. doi:<http://dx.doi.org/10.1007/s12603-010-0268-6>

The IMPACT survey queried physicians, caregivers, payors and members of the general public from 5 European countries (France, Germany, Italy, Spain and the United Kingdom) regarding their opinions towards screening for Alzheimer's disease (AD) as part of a 30-minute Web-based questionnaire conducted between April and May 2009. A larger proportion of caregivers (84%) and members of the general public (80%) than of physicians (56%) or payors (40%) viewed routine screening for AD as extremely or very important ($P < 0.001$ for caregivers or general public vs physicians or payors). When asked if everyone should be routinely screened for AD at age 65, a smaller proportion of physicians (42%) and payors (44%) than members of the general public (81%) or caregivers (80%) agreed ($P < 0.001$ for caregivers or general public vs physicians or payors). These opinions were generally consistent across the 5 countries for each respondent group. A notable exception was physician respondents from Italy, where most generalists and specialists actually favoured screening. Overall, generalists had a more positive attitude towards screening than specialists. The most frequently cited reason given by those who did not favour routine screening at age 65 was screening inaccuracy. This article discusses these results in relation to what screening is, when to screen and the barriers to screening. Despite the majority of IMPACT respondents being in favour of screening for AD, the evidence to support the introduction of population screening for cognitive impairment is not available; however, the importance of optimal identification of AD and other dementias in primary care should be a priority for community health professionals and payors. In order to do this effectively, further work is required to identify good assessment guidelines for use during opportunistic screening for cognitive impairment in primary care. 2010 Serdi and Springer Verlag France.

37. Cameron, M. J., Horst, M., Lawhorne, L. W., & Lichtenberg, P. A. (2010). **Evaluation of academic detailing for primary care physician dementia education.** *American Journal of Alzheimer's Disease & Other Dementias*, 25(4), 333-339. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20228361>

The objective of this evaluation study was to assess the effect of academic detailing (AcD) as a strategy to increase early detection of dementia in primary care practice and to improve support and management of Alzheimer's disease and other dementia disorders by increasing communication and referrals to local community agencies. As designed for dementia education, AcD consisted of 15-minute educational sessions delivered in primary care practice offices. Twenty-nine visits were conducted by trained teams comprised of a physician and representatives of the Alzheimer's Association (AA) and

Area Agency on Aging (AAA). A key outcome of the visits was increased knowledge of the specific programs and services available. In all, 77.4% rated the visit very effective, and follow-up evaluation suggests visits led to an increase in referral to these agencies (55%) and potentially enhanced early detection of dementia by physicians as measured by 35% making changes in the way they identify at-risk patients.

38. Donath, C., Grassel, E., Grossfeld-Schmitz, M., Menn, P., Lauterberg, J., Wunder, S., . . . Holle, R. (2010). **Effects of general practitioner training and family support services on the care of home-dwelling dementia patients--results of a controlled cluster-randomized study.** *BMC Health Services Research*, 10, 314. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=21087474>

BACKGROUND: More than 90% of dementia patients are cared for by their general practitioners, who are decisively involved in the diagnosis, therapy and recommendation of support services. Objective: To test whether special training of general practitioners alters the care of dementia patients through their systematic recommendation of caregiver counseling and support groups. METHOD: 129 general practitioners enrolled 390 dementia patients and their informal caregivers in a prospective, three-arm cluster-randomized 2-year study. Arm A constituted usual care, in Arm B and C support groups and caregiver counseling (in Arm B one year after baseline, in Arm C at baseline) were recommended by the general practitioners. The general practitioners received arm-specific training. Diagnostic and therapeutic behavior of physicians was recorded at baseline. Informal caregivers were questioned in follow-up after 2 years about the utilization of support services. RESULTS: The diagnostic behavior of the general practitioners conforms to relevant guidelines. The procedure in newly-diagnosed patients does not differ from previously diagnosed patients with the exception of the rate of referral to a specialist. About one-third of the newly-diagnosed dementia patients are given an anti-dementia drug. The utilization of support groups and counseling increased five- and fourfold, respectively. Utilization of other support services remained low (< 10%), with the exception of home nursing and institutional short-term nursing. CONCLUSION: Trained general practitioners usually act in conformity with guidelines with respect to diagnosing dementia, and partly in conformity with the guidelines with respect to recommended drug therapy. Recommendations of support services for informal caregivers by the general practitioner are successful. They result in a marked increase in the utilization rate for the recommended services compared to offers which are not recommended by the general practitioner. TRIAL REGISTRATION: ISRCTN68329593.

39. Eisele, M., van den Bussche, H., Koller, D., Wiese, B., Kaduszkiewicz, H., Maier, W., . . . Schon, G. (2010). **Utilization patterns of ambulatory medical care before and after the diagnosis of dementia in germany--results of a case-control study.** *Dementia & Geriatric Cognitive Disorders*, 29(6), 475-483. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20523045>

AIMS: To analyze how the diagnosis of dementia changes the utilization of the ambulatory medical care services in the German statutory health insurance. METHODS:

In this case-control study, claims data of 1,848 insurants aged ≥ 65 years with incident dementia and 7,392 matched controls were compared regarding their utilization of ambulatory medical care services. RESULTS: We found an increase in the utilization of ambulatory medical care services by demented patients of 50% in the year before and of 40% in the year after the incidence, predominantly in primary care and neurology/psychiatry settings. A negative interaction effect of age and gender ($p \leq 0.000$) was found regarding the number of visited physicians. CONCLUSION: Service utilization by demented patients increases already within the year before the first diagnosis and stays on a relatively high level within the year after. Especially (female) patients aged 80 years and older at dementia onset ought to be observed to prevent a possible undersupply. Copyright 2010 S. Karger AG, Basel.

40. England, E. (2010). **Survival after diagnosis of dementia in primary care.** *BMJ*, 341, 3530. Retrieved from <http://dx.doi.org/10.1136/bmj.c3530>; <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20688839>

41. Fearn, S., & Lerner, A. J. (2010). **Have quality and outcomes framework depression indicators changed referrals from primary care to a dedicated memory clinic?** *Mental Health in Family Medicine*, 6(3), 129-132. The proportion of patients referred from primary care to dedicated dementia clinics who receive a final diagnosis of dementia is low. Many of these non-demented patients may have depressive disorders, since depression is the most common differential diagnosis of dementia. The UK general practitioner (GP) General Medical Services contract, introduced in April 2006, included a Quality and Outcomes Framework (QOF) with indicators related to depression. We investigated whether introduction of the QOF Depression Indicators changed the pattern of referrals from primary care to a dedicated dementia clinic. The results indicated that the null hypothesis could not be rejected. 2009 Radcliffe Publishing.

42. Fortinsky, R. H., Zlateva, I., Delaney, C., & Kleppinger, A. (2010). **Primary care physicians' dementia care practices: Evidence of geographic variation.** *Gerontologist*, 50(2), 179-191. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19597058>

PURPOSE: This article explores primary care physicians' (PCPs) self-reported approaches and barriers to management of patients with dementia, with a focus on comparisons in dementia care practices between PCPs in 2 states. DESIGN AND METHODS: In this cross-sectional study, questionnaires were mailed to 600 randomly selected licensed PCPs in Connecticut and to all 1,017 licensed PCPs in Maine. RESULTS: A total of 422 eligible PCPs responded. Nearly 90% of PCPs prescribed donepezil in the previous year for their dementia patients. Connecticut PCPs were more likely to prescribe several other therapeutics than their Maine counterparts. Connecticut PCPs were more likely to refer dementia patients to adult day care (85% vs. 59%) but less likely to refer to Area Agencies on Aging (21% vs. 44%; both $ps < .05$); referral rates to Alzheimer's Association chapters were low in both states (30%). A greater proportion

of Connecticut PCPs reported barriers to optimal dementia care, including time constraints (54% vs. 31% of Maine PCPs), unfamiliarity with community resources (46% vs. 30%), and reimbursement constraints (45% vs. 23%; all $p \leq .05$). Two thirds of PCPs were "very" or "somewhat" interested in using information technology to assist with dementia diagnosis and management; controlling for other variables, youngest PCPs were more than twice as likely as oldest to profess such interest (adjusted odds ratio = 2.04; 95% confidence interval [CI] = 1.02-4.08). IMPLICATIONS: Geographic variations are evident in PCP medication prescription patterns, community resource referral patterns, and reported barriers to optimal dementia care. Younger PCPs are more likely to adopt information technology to assist in dementia diagnosis and management.

43. Franz, C. E., Barker, J. C., Kim, K., Flores, Y., Jenkins, C., Kravitz, R. L., & Hinton, L. (2010). **When help becomes a hindrance: Mental health referral systems as barriers to care for primary care physicians treating patients with alzheimer's disease.** *American Journal of Geriatric Psychiatry, 18*(7), 576-585. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20593538>

OBJECTIVES: To describe structural barriers to mental health specialists and consequences of these barriers to care for patients with dementia and neuropsychological symptoms and their primary care physicians (PCPs). DESIGN: Cross-sectional qualitative interview study of PCPs. SETTING: Physicians' offices, primarily managed care. PARTICIPANTS: Forty PCPs in Northern California. MEASUREMENTS: Open-ended interviews lasted 30-60 minutes. The interview guide covered clinician background, practice setting, clinical care of a particular patient, and general approach to managing patients with Alzheimer disease or related dementias. Interviews were transcribed and themes reflecting referrals identified. RESULTS: Ninety-three percentage of the PCPs described problematic access to and communication with mental health specialists (in particular psychiatrists and neuropsychologists) as impediments to effective care for dementia patients. Thematic analysis identified structural barriers to mental health referrals ranging from problems with managed care and reimbursement policies to lack of trained providers and poor geographic distribution of specialists. Structural barriers compromised care for patients with dementia because the barriers limited PCP treatment options, and resources, impacted office staff and time with other patients, impeded and delayed care, and fostered poor communication and lack of coordinated care. Negative consequences for PCPs included increased frustration, conflict, and burnout. CONCLUSION: PCPs viewed problems created by onerous referral systems, such as mental health carve outs, as particularly burdensome for elderly patients with comorbid dementia and neuropsychiatric problems. These problems were cited by PCPs across different types of practice settings. PCPs managed treatment of neurobehavioral symptoms as best they could despite lack of specialist support.

44. Greaves, I., & Jolley, D. (2010). **National dementia strategy: Well intentioned - but how well founded and how well directed?.** *British Journal of General Practice, 60*(572), 193-196. doi:<http://dx.doi.org/10.3399/bjgp10X483553>
The National Dementia Strategy was published in February 2009. It was eagerly anticipated and has generated a good deal of sustained media interest, widened awareness,

and heightened expectation of better help for people with dementia. The three ambitions of the strategy - to raise awareness, facilitate assessment, and improve services - are unquestionably correct; but the assumptions, emphases, and economic predictions are questionable. Encouraging reliance on referral to secondary care centres, and exaggerated claims for the effectiveness of interventions to achieve clinical improvement and cost savings, may lead to disappointment and frustration. The infrastructure of care and treatment of people throughout the course of dementia will be better informed and delivered by a collaborative model which respects the knowledge and commitment contained within families and primary care. Better services will require substantial redirection of resources. *British Journal of General Practice*.

45. Hunsaker, A. E., Schmidt, K., & Lingler, J. H. (2010). **Discussing dementia-related behaviors during medical visits for people with alzheimer's disease.** *American Journal of Alzheimer's Disease & Other Dementias*, 25(3), 248-254. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20147601>

Research suggests that caregivers appreciate support from primary care physicians (PCPs) regarding dementia care; however, there remains a need for studies examining the role that PCPs play in behavior management. The purpose of this study was to quantitatively characterize the discussion on dementia-related behaviors (DRBs) during PCP visits and compare findings to an independently administered assessment of DRBs exhibited within a period of 4 weeks prior to the PCP visit. Twenty-five PCP visits of persons with dementia, in which caregivers coattended the visit, were audio-recorded and analyzed for occurrence of DRB discussion. Disruptive behaviors were reported by 80% of caregivers via independent assessment, yet discussed in 23% of medical visits. Dementia-related behavior discussion occurred in visits where caregivers independently reported significantly higher behavior frequency and behavior-related burden. Implications of findings for ways PCPs can assist the caregiver in behavior management are discussed.

46. Iliffe, S., Wilcock, J., Griffin, M., Jain, P., Thune-Boyle, I., Koch, T., & Lefford, F. (2010). **Evidence-based interventions in dementia: A pragmatic cluster-randomised trial of an educational intervention to promote earlier recognition and response to dementia in primary care (EVIDEM-ED).** *Trials*, 11, 13. doi:<http://dx.doi.org/10.1186/1745-6215-11-13>

BACKGROUND: The National Dementia Strategy seeks to enhance general practitioners' diagnostic and management skills in dementia. Early diagnosis in dementia within primary care is important as this allows those with dementia and their family care networks to engage with support services and plan for the future. There is, however, evidence that dementia remains under-detected and sub-optimally managed in general practice. An earlier unblinded, cluster randomised controlled study tested the effectiveness of educational interventions in improving detection rates and management of dementia in primary care. In this original trial, a computer decision support system and practice-based educational workshops were effective in improving rates of detecting dementia although not in changing clinical management. The challenge therefore is to find methods of changing clinical management. Our aim in this new trial is to test a

customised educational intervention developed for general practice, promoting both earlier diagnosis and concordance with management guidelines. DESIGN/METHOD: The customised educational intervention combines practice-based workshops and electronic support material. Its effectiveness will be tested in an unblinded cluster randomised controlled trial with a pre-post intervention design, with two arms; normal care versus the educational intervention. Twenty primary care practices have been recruited with the aim of gaining 200 patient participants. We will examine whether the intervention is effective, pragmatic and feasible within the primary care setting. Our primary outcome measure is an increase in the proportion of patients with dementia who receive at least two dementia-specific management reviews per year. We will also examine important secondary outcomes such as practice concordance with management guidelines and benefits to patients and carers in terms of quality of life and carer strain. DISCUSSION: The EVIDEM-ED trial builds on the earlier study but the intervention is different in that it is specifically customised to the educational needs of each practice. If this trial is successful it could have implications for the implementation of the National Dementia Strategy. TRIAL REGISTRATION: NCT00866099.

47. Iracleous, P., Nie, J. X., Tracy, C. S., Moineddin, R., Ismail, Z., Shulman, K. I., & Upshur, R. E. (2010). **Primary care physicians' attitudes towards cognitive screening: Findings from a national postal survey.** *International Journal of Geriatric Psychiatry*, 25(1), 23-29. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19513985>

OBJECTIVE: The objectives of this paper are: (a) to determine Canadian family physicians' attitudes towards cognitive screening, (b) to identify what cognitive screening tools are being used, (c) to investigate how they rate these tools' effectiveness and (d) to identify the attributes of an ideal cognitive screening tool for the primary care setting. METHOD: Postal survey questionnaire of a random sample of 249 practicing members of the College of Family Physicians of Canada. RESULTS: Response rate was 52%. The majority of physicians 'Agreed' or 'Strongly Agreed' that cognitive impairment assessment is important in primary care (89%), and 'Disagreed' or 'Strongly Disagreed' that it should be left to specialists (92%). However, 35% were undecided when asked if assessment in primary care would lead to better outcomes. The most frequently used assessment tools were Mini-Mental Status Exam (MMSE), Clock Drawing, Delayed Word Recall, Standardized MMSE and Alternating Sequences, but were mainly rated as only 'Good' in terms of perceived effectiveness. Validity/accuracy was identified as the top attribute of an ideal screening tool. Female physicians were more likely to have a positive attitude towards cognitive assessment. Younger physicians, those in group practices, or those with either $\leq 20\%$ or 61-80% of elderly patients in their practice indicated a shorter ideal time to administer a cognitive screening tool. CONCLUSION: Despite general agreement that primary care physicians have an important role in cognitive screening, there is less agreement that it leads to better outcomes. The development of a superior screening tool to be used in the primary care setting is needed. (c) 2009 John Wiley & Sons, Ltd.

48. Jedenius, E., Wimo, A., Strömquist, J., Jönsson, L., & Andreasen, N. (2010). **The cost of diagnosing dementia in a community setting.** *International Journal of Geriatric Psychiatry*, 25(5), 476-482.

Objectives In order to cope with the increasing number of individuals with dementia, it is crucial to develop the diagnostic capacity in primary care in cooperation with dementia specialists. Further, in order to establish prerequisites for care and planning it is important to identify the cost of dementia diagnosis. This study aims to evaluate the cost of establishing a dementia diagnosis. Methods This is a prospective, time- and resource utilization study for the identification of the total cost associated with diagnosing dementia (from start of the diagnostic process to time for established or rejected dementia diagnosis) both at the specialist and primary care level. Results Dementia evaluation in primary care took between 2 weeks and 2 months before reaching diagnosis. The average cost for all patients evaluated at the primary care level was 477 Euro (€), whereas evaluations done on a specialist level reached a cost of 1115 €. Thus, the costs per true diagnosed case consist of the cost for all dementia investigations divided by the number of finalized diagnoses. Conclusions In this study the cost for diagnosing dementia per true diagnosed patient is 849 € at the primary care level and 1334 € at the specialist level. Based on this result we estimated that the cost of establishing a dementia diagnosis is 1% of the total cost of dementia. Copyright © 2009 John Wiley & Sons, Ltd. ABSTRACT FROM AUTHOR (Copyright of International Journal of Geriatric Psychiatry is the property of John Wiley & Sons Ltd. 1996 and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract.)

49. Koch, T., Iliffe, S., & Evidem, P. (2010). **The role of primary care in the recognition of and response to dementia.** *Journal of Nutrition, Health & Aging*, 14(2), 107-109. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20126958>

50. Koch, T., Iliffe, S., & EVIDEM-ED, p. (2010). **Rapid appraisal of barriers to the diagnosis and management of patients with dementia in primary care: A systematic review.** *BMC Family Practice*, 11, 52. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20594302>

BACKGROUND: The diagnosis of dementia in primary care is perceived as a problem across countries and systems, resulting in delayed recognition and adverse outcomes for patients and their carers. Improving its early detection is an area identified for development in the English National Dementia Strategy 2009; there are thought to be multiple benefits to the patient, family, and resources by doing this. The aim of this review was to carry out a rapid appraisal in order to inform the implementation of this policy. METHOD: Publications in English up to August 2009 relating to barriers to the recognition of dementia, were identified by a broad search strategy, using electronic databases MEDLINE, EMBASE, and psycINFO. Exclusion criteria included non-English

language, studies about pharmacological interventions or screening instruments, and settings without primary care. RESULTS: Eleven empirical studies were found: 3 quantitative, 6 qualitative, and 2 with mixed methodologies. The main themes from the qualitative studies were found to be lack of support, time constraints, financial constraints, stigma, diagnostic uncertainty, and disclosing the diagnosis. Quantitative studies yielded diverse results about knowledge, service support, time constraints, and confidence. The factors identified in qualitative and quantitative studies were grouped into 3 categories: patient factors, GP factors and system characteristics. CONCLUSION: Much can still be done in the way of service development and provision, GP training and education, and the eradication of stigma attached to dementia, to improve the early detection and management of dementia. Implementation of dementia strategies should include attention to all three categories of barriers. Further research should focus on their interaction, using different methods from studies to date. [References: 45]

51. Kurz, A. F., & Lautenschlager, N. T. (2010). **The concept of dementia: Retain, reframe, rename or replace?** *International Psychogeriatrics*, 22(1), 37-42. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19814839>

From antiquity the term "dementia" has denoted a state of severe acquired intellectual deterioration which significantly interferes with the fulfillment of personal, social or occupational roles, and makes the individual dependent on care and supervision by others. The medical concept of dementia refers to a pattern of cognitive and behavioral symptoms which typically arises from chronic and often progressive brain diseases. The quantitative expression of this pattern shows broad variability, and some patients fall within the boundaries of the concept whose intellectual and functional abilities are only mildly impaired. On the other hand, the concept currently has an unduly narrow qualitative bandwidth, because it is modeled after the subtype which occurs in Alzheimer's disease but does not represent a good fit for other important subtypes. In the authors' view, the concept of dementia should be retained despite its limitations, since it has an important role in directing the physician's attention to a certain group of underlying pathologies. This diagnostic role of the concept will remain important in primary care even if biological indicators for one or several etiologies will become part of the diagnostic routine in research units in the future. The medical construct has further value since it entitles patients to medical treatment, social assistance and legal protection. Although in our opinion the concept of dementia does not need to be replaced, upcoming revisions of the psychiatric classification systems will have to reframe it by emphasizing the heterogeneity of the psychopathological symptom pattern. In view of the increasing importance of early diagnosis and treatment, however, the term "dementia", which literally means "absence of mind", is no longer an appropriate and timely designation for the broad range of cognitive and behavioral limitations covered by the concept. It should be renamed, using a terminology which accommodates scientific advance and meets the requirements of medical communication while preserving the benefits for patients and their families. [References: 42]

52. Lands, R. (2010). **The man with the angry face.** *Journal of the American Geriatrics Society*, 58(1), 178. A personal narrative is presented which explores the author's experiences as a physician with his patients with dementia.

53. Laycock, K. M. (2010). **Should family physicians assess fitness to drive?: No.** *Canadian Family Physician*, 56(12), 1265-1267. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=21156886>

54. Lee, L., Hillier, L. M., Stolee, P., Heckman, G., Gagnon, M., McAiney, C. A., & Harvey, D. (2010). **Enhancing dementia care: A primary care-based memory clinic.** *Journal of the American Geriatrics Society*, 58(11), 2197-2204. Retrieved from <http://dx.doi.org/10.1111/j.1532-5415.2010.03130.x>; <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20977435>

Memory clinics have been promoted as opportunities for improving dementia diagnosis and care. This article describes the implementation of an interdisciplinary memory clinic within primary care in Ontario, Canada, that aims to provide timely access to comprehensive assessment and care and to improve referring physicians' knowledge of the management of dementia through collaborative care and practice-based mentorship. Between July 2006 and September 2009, 246 initial and follow-up assessments were conducted with 151 patients, a high proportion of whom received a new diagnosis of mild cognitive impairment (44.4%) or dementia (19.2%). A trial of cholinesterase inhibitors was recommended for almost all patients newly diagnosed with dementia. Management interventions and recommendations included social worker outreach, long-term care planning, home safety or driving assessments, referral to community resources, and periodic follow-up and monitoring. A small proportion of patients (7.8%) were referred to a specialist. Surveyed patients and caregivers were very satisfied with their visit to the clinic. A chart audit conducted by two independent geriatricians indicated agreement with diagnosis and intervention, particularly related to use of specialists. The results indicate that memory clinics within primary care settings can support capacity building to ensure quality assessment and management of dementia at a primary care level. Copyright 2010, Copyright the Authors. Journal compilation Copyright 2010, The American Geriatrics Society.

55. Lehmann, S. W., Black, B. S., Shore, A., Kasper, J., & Rabins, P. V. (2010). **Living alone with dementia: Lack of awareness adds to functional and cognitive vulnerabilities.** *International Psychogeriatrics*, 22(5), 778-784. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20478092>

BACKGROUND: Approximately 25% of individuals with dementia live alone, yet little is known about the cognitive and functional factors that impact detection of impairment. **METHODS:** Subjects with dementia (n = 349) from a community study of dementia management were administered the Mini-mental State Examination (MMSE) and were asked to rate their cognitive status. Each participant's knowledgeable informant (KI) was

interviewed to provide information about the subject's mental health and levels of cognitive and functional impairment. Subjects with dementia living alone (n = 97, 27.8%) were compared to subjects living with others (n = 252, 72.2%) regarding functional impairment, psychiatric symptoms, cognitive functioning, and dementia recognition. RESULTS: While subjects with dementia living alone had significantly fewer ADL impairments ($p < 0.0001$) and less cognitive impairment ($p < 0.0001$) than subjects with dementia who were living with others, nearly half of subjects living alone had two or more IADL impairments. Both knowledgeable informants ($p < 0.001$) and primary care physicians ($p < 0.009$) were less likely to detect dementia in subjects living alone, while 77.3% of subjects with dementia living alone rated their cognitive abilities as "good" or "a little worse". Subjects with dementia living alone and those living with others had similar rates of psychosis ($p = 0.2792$) and depressive symptoms ($p = 0.2076$). CONCLUSIONS: Lack of awareness of cognitive impairment by individuals with dementia living alone as well as their knowledgeable informants and physicians, combined with frequent functional impairment and psychiatric symptoms, heightens risk for adverse outcomes. These findings underscore the need for increased targeted screening for dementia and functional impairment among older persons living alone.

56. Luconi, F. (2010). *Exploring rural family physicians' learning from a web-based continuing medical education program on alzheimer's disease: A pilot study*. . (Dissertation Abstract: 2010-99110-276). Physicians online learning has been gaining attention in the continuing medical education (CME) literature. This descriptive multiple case study investigated rural family physicians's (RFPs) learning about early Alzheimer's disease (AD) from an online continuing medical education (OCME) program. To overcome common criticisms of lecture-based OCME programs, a problem-based collaborative approach was implemented. Eight RFPs, working in pairs and plenaries, completed the AD Program which lasted 9 months. A family physician with expertise in AD moderated the online discussions; an educator coordinated logistics and took the dual role of designer and researcher. The effectiveness of the program in supporting participants' learning about Alzheimer's disease and transfer to practice was evaluated at various levels: participation, satisfaction, learning, competence and performance. Data analysis included within- and cross-case analyses. Member checks, data triangulation, long-term observation and thick description were used to verify the quality of the study. Regarding learning, objective measures demonstrated a significant increase in declarative AD knowledge and improved problem solving of clinical cases focused on AD treatment. Self-reported measures provided evidence that the AD Program had an impact on the RFPs' reports of their clinical practice. Regarding the effectiveness of the Program, participants were uniformly satisfied, and would recommend it to their peers and to accreditation bodies mainly for its innovative design, interactivity and convenience of access. They said the most effective features were the educator's scaffolding, opportunities to practice, and collaborative plenary discussions. The least effective features were an unfriendly platform (i.e., WebCT), paired activities and, limited facilitation during online discussions. Variables that may have influenced learning and reports of transfer to practice were: (a) levels of computer literacy and ease with technology; (b) program platform; (c) readiness for self-directed learning; (d) readiness to learn and change; (e) level of expertise in AD practice;

(f) level of engagement and (g) an open, safe learning environment with effective scaffolding. This study demonstrates that online learning is a viable option for continuing medical education. Program design and evaluation should be theory driven; the framework developed for this study provides some initial steps in this direction. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

57. Massoud, F., Lysy, P., & Bergman, H. (2010). **Care of dementia in Canada: A collaborative care approach with a central role for the primary care physician.** *Journal of Nutrition, Health & Aging, 14*(2), 105-106. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20126957>

58. Mitchell, A. J., & Malladi, S. (2010). **Screening and case finding tools for the detection of dementia. part I: Evidence-based meta-analysis of multidomain tests.** *American Journal of Geriatric Psychiatry, 18*(9), 759-782. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20808118>

AIM: To evaluate the diagnostic accuracy of all brief multidomain alternatives to the Mini-Mental State Examination (MMSE) in the detection of dementia. METHODS: A literature search, critical appraisal, and meta-analysis were conducted of robust diagnostic validity studies involving cognitive batteries. Twenty-nine distinct brief batteries were tested in 44 large-scale analyses. Twenty studies took place in specialist settings (11 in memory clinics and 9 in secondary care), ten studies were conducted in primary care, and 14 in the community. RESULTS: In community settings with a low prevalence of dementia, short screening methods of no more than 10 minutes had an overall sensitivity of 72.0% (95% confidence interval [CI] = 60.4%-82.3%) and a specificity of 88.2% (95% CI = 83.0%-92.5%). The optimal individual tests were the Telephonic interview based on MSQ, Category fluency/Memory impairment screen-Telephonic interview and 6 item Cognitive Impairment Test (6-CIT), but data were limited by the absence of multiple independent confirmation for any individual test. In primary care where the prevalence of dementia is usually modest, the optimal individual tools were the Abbreviated mental test score/Mental status questionnaire (MSQ), and Prueba cognitive de leganes (PCL). Furthermore, the Abbreviated mental test score (AMTS) was superior to the MMSE for case finding, but for screening the MMSE was optimal. If length is not a major consideration, the MMSE may remain the best tool for primary care clinicians who want to rule in and rule out a diagnosis. In specialist settings where the prevalence of dementia is often high, the optimal individual tools were the DEMTECT, Montreal cognitive assessment (MOCA), Memory Alteration test, and MINI-COG. Two tools were potentially superior to the MMSE for rule in and rule out, namely the 6-CIT and MINI-COG. Only four analyses looked specifically at accuracy in early-stage dementia, and each showed at least equivalent diagnostic accuracy, suggesting these methods might be applicable to early identification. CONCLUSION: A large number of alternatives to the MMSE have now been validated in large samples with favorable rule-in and rule-out accuracy. Evidence to date suggests for those wishing to use brief battery tests then the original MMSE or the AMTS should be considered in primary care and either the 6-CIT or the MINI-COG should be considered in specialist settings.

59. Mitchell, A. J., & Malladi, S. (2010). **Screening and case-finding tools for the detection of dementia. part II: Evidence-based meta-analysis of single-domain tests.** *American Journal of Geriatric Psychiatry*, 18(9), 783-800. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20808094>

AIM: To evaluate the diagnostic validity of single-domain cognitive tests for detecting dementia. These methods were defined as those that focus mainly on one domain of cognitive function such as orientation, memory, or executive function. METHODS: A meta-analysis of robust studies was conducted. There were 15 categories of single-domain methods assessed in 45 analyses, including 27 performed head-to-head against the Mini-Mental State Examination (MMSE). Thirteen studies took place in community settings, 9 in primary care, and 23 in specialist settings. RESULTS: In community settings, single-domain cognitive tests helped detect 64.2% of all dementias. In this setting, specificity (Sp) was 84.9%, positive predictive value (PPV) was 57.1%, and negative predictive value (NPV) was 88.3%. This was significantly less accurate than the MMSE itself. The optimal individual method was the memory impairment screen (MIS). In primary care, the sensitivity (Se) and specificity of single-domain tests were 69.5% and 82.5%, respectively. The PPV and NPV were 36.5% and 95.8%. Considered together, these methods were less specific but equally sensitive as the MMSE when applied in primary care. Here, the most successful methods were the selective reminding test (SRT) and clock drawing test, the latter having data from independent samples. In specialist settings, single-domain methods had a Se of 76.6%, a Sp of 81.9%, a PPV 80.8%, and a NPV 74.9%. This represented almost equivalent accuracy to the MMSE. The optimal method for specialist settings (based on accuracy alone) was the memory alteration test. CONCLUSION: Brief single-domain methods offer diagnostic performance for detection of dementia that is surprisingly close to that offered by cognitive batteries such as the MMSE. As a method of screening or as part of a diagnostic algorithm, brief single-domain tests may be an efficient first step in identifying cognitive impairment.

60. Muther, J., Abholz, H. H., Wiese, B., Fuchs, A., Wollny, A., & Pentzek, M. (2010). **Are patients with dementia treated as well as patients without dementia for hypertension, diabetes, and hyperlipidaemia?.** *British Journal of General Practice*, 60(578), 671-674. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20849694>

BACKGROUND: Patients suffering from dementia are at risk of being treated differently by GPs from patients without it. Explanations for this could be stigmatisation, treatment with a palliative approach, and the result of the disease process. AIM: To ascertain whether patients with dementia are treated differently, the index diseases of hypertension, diabetes, and hyperlipidaemia were used to measure care. DESIGN OF STUDY: Retrospective matched control study. SETTING: German general practice. METHOD: Sixteen GP practices recruited all their patients with dementia and at least one of the index diseases. Patients without dementia but only the index diseases were matched for age, sex, index disease, and practice, resulting in 216 pairs of patients with and without dementia. From the files, blood pressure, blood sugar/glycated haemoglobin, cholesterol, the dates of measurement, the number of doctor-patient contacts, and the prescribed

medication to treat the three conditions under scrutiny were documented. For analysis, t-tests and (2)-tests were used. **RESULTS:** No differences were found in treatment outcomes between the two patients groups, except one significant difference: one of the two documented systolic blood pressure values is lower in the dementia group. Furthermore, patients with dementia more often do not receive any medication or are treated with low-priced medications for hypertension (nearly significant). **CONCLUSION:** GPs do not seem to treat patients with dementia differently. The use of lower-priced antihypertensive medication could be the only indication for some kind of difference in approach.

61. Perry, M., Draskovic, I., van Achterberg, T., van Eijken, M., Lucassen, P., Vernooij-Dassen, M., & Olde Rikkert, M. (2010). **Development and validation of quality indicators for dementia diagnosis and management in a primary care setting.** *Journal of the American Geriatrics Society*, 58(3), 557-563. doi:10.1111/j.1532-5415.2010.02726.x

OBJECTIVES: To construct a set of quality indicators (QIs) for dementia diagnosis and management in a primary care setting. **DESIGN:** RAND modified Delphi method, including a postal survey, a stakeholders consensus meeting, a scientific expert consensus meeting, and a demonstration project. **SETTING:** Primary care. **PARTICIPANTS:** General practitioners (GPs), primary care nurses (PCNs), and informal caregivers (ICs) in postal survey and stakeholders consensus meeting. Eight national dementia experts in scientific consensus meeting. Thirteen GPs in the demonstration project. **MEASUREMENTS:** Mean face validity and feasibility scores. Compliance rates using GPs' electronic medical record data. **RESULTS:** The initial set consisted of 31 QIs. Most indicators showed moderate or good face validity and feasibility scores. Consensus panels reduced the preliminary set used in the demonstration project to 24 QIs. The overall compliance to the QIs was 45.3%. Discriminative validity of the set was good; significant differences in adherence were found between GPs with high and low levels of patients aged 65 and older in their practice, with and without PCNs, and with positive and negative attitudes toward dementia (all $P < .05$). Based on the demonstration project, one QI was excluded. The final set consisted of 23 QIs; 15 QIs contained innovative quality criteria on collaboration between GPs and PCNs, referral criteria, and assessment of caregivers' needs. **CONCLUSION:** This new set of dementia QIs is feasible, reliable, and valid and can be used to improve primary dementia care. Because of the innovative quality criteria, the set is complementary to the existing dementia QIs.

62. Rait, G., Walters, K., Bottomley, C., Petersen, I., Iliffe, S., & Nazareth, I. (2010). **Survival of people with clinical diagnosis of dementia in primary care: Cohort study.** *BMJ: British Medical Journal*, 341(7768), No Pagnaton Sefe.

Objectives: To estimate survival after a diagnosis of dementia in primary care, compared with people without dementia, and to determine incidence of dementia. **Design:** Cohort study using data from The Health Improvement Network (THIN), a primary care database. **Setting:** 353 general practices in the United Kingdom providing data to THIN. **Participants:** All adults aged 60 years or over with a first ever code for dementia from 1990 to 2007 (n=22 529); random sample of five participants without dementia for every participant with dementia matched on practice and time period (n=112 645). **Main**

outcome measures: Median survival by age and sex; mortality rates; incidence of dementia by age, sex, and deprivation. Results: The median survival of people with dementia diagnosed at age 60-69 was 6.7 (interquartile range 3.1-10.8) years, falling to 1.9 (0.7-3.6) years for those diagnosed at age 90 or over. Adjusted mortality rates were highest in the first year after diagnosis (relative risk 3.68, 95% confidence interval 3.44 to 3.94). This dropped to 2.49 (2.29 to 2.71) in the second year. The incidence of recorded dementia remained stable over time (3-4/1000 person years at risk). The incidence was higher in women and in younger age groups (60-79 years) living in deprived areas. Conclusions: Median survival was much lower than in screened populations. These clinically relevant estimates can assist patients and carers, clinicians, and policy makers when planning support for this population. The high risk of death in the first year after diagnosis may reflect diagnoses made at times of crisis or late in the disease trajectory. Late recording of diagnoses of dementia in primary care may result in missed opportunities for potential early interventions. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

63. Reuben, D. B., Roth, C. P., Frank, J. C., Hirsch, S. H., Katz, D., McCreath, H., . . . Wenger, N. S. (2010). **Assessing care of vulnerable elders--alzheimer's disease: A pilot study of a practice redesign intervention to improve the quality of dementia care.** *Journal of the American Geriatrics Society*, 58(2), 324-329. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20374405>

OBJECTIVES: To determine whether a practice redesign intervention coupled with referral to local Alzheimer's Association chapters can improve the quality of dementia care. **DESIGN:** Pre-post intervention. **SETTING:** Two community-based physician practices. **PARTICIPANTS:** Five physicians in each practice and their patients aged 75 and older with dementia. **INTERVENTION:** Adaptation of the Assessing Care of Vulnerable Elders (ACOVE)-2 intervention (screening, efficient collection of clinical data, medical record prompts, patient education and empowerment materials, and physician decision support and education). In addition, physicians faxed referral forms to local Alzheimer's Association chapters, which assessed patients, provided counseling and education, and faxed information back to the physicians. **MEASUREMENTS:** Audits of pre- (5 per physician) and postintervention (10 per physician) medical records using ACOVE-3 quality indicators for dementia to measure the quality of care provided. **RESULTS:** Based on 47 pre- and 90 postintervention audits, the percentage of quality indicators satisfied rose from 38% to 46%, with significant differences on quality indicators measuring the assessment of functional status (20% vs 51%), discussion of risks and benefits of antipsychotics (32% vs 100%), and counseling caregivers (2% vs 30%). Referral of patients to Alzheimer's Association chapters increased from 0% to 17%. Referred patients had higher quality scores (65% vs 41%) and better counseling about driving (50% vs 14%), caregiver counseling (100% vs 15%), and surrogate decision-maker specification (75% vs 44%). Some quality indicators related to cognitive assessment and examination did not improve. **CONCLUSION:** This pilot study suggests that a practice-based intervention can increase referral to Alzheimer's Association chapters and improve quality of dementia care.

64. Robinson, L., Vellas, B., Knox, S., & Lins, K. (2010). **Clinical practice patterns of generalists and specialists in alzheimer's disease: What are the differences, and what difference do they make?.** *Journal of Nutrition, Health & Aging*, 14(7), 545-552. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20818469>

Optimising the roles played by both generalists and specialists in the diagnosis and treatment of Alzheimer's disease (AD) could have a major impact on the quality and cost of patient care. Therefore, one aim of the IMPACT survey was to characterise the similarities and differences between these 2 categories of physicians, in 5 different European countries, across a number of domains relevant to the medical care of people at risk for AD and those with the disease. Physician respondents comprised 250 generalists and 250 specialists from 5 European countries--France, Germany, Italy, Spain, and the United Kingdom. A substantial majority of generalists were either general practitioners or family physicians; the majority of specialists were neurologists. In April and May 2009, physician respondents completed a 30-minute, Web-based questionnaire during which they were presented with a number of multiple-choice-type questions concerning their knowledge of AD, approach to diagnosis and treatment of AD and experience of providing care for people with dementia. Generalists reported that 45% of their AD patients had mild symptoms at the initial visit compared with 60% for specialists ($P < 0.001$). Specialists claimed that they diagnose patients with AD themselves in 65% of cases versus 33% for generalists ($P < 0.001$). The main prescription treatment options employed were AD-specific medication (90%) and medication for mood or behaviour (78%). A similar percentage of generalists and specialists (77% and 75%) initiate drug treatment within 1 month of diagnosis. Overall, there were more similarities than differences between specialists and generalists regarding a broad spectrum of issues relating to AD; differences between countries appear to be greater than differences between physician groups.

65. Robinson, L., Iliffe, S., Brayne, C., Goodman, C., Rait, G., Manthorpe, J., . . . Moniz-Cook, E. (2010). **Primary care and dementia: 2. long-term care at home: Psychosocial interventions, information provision, carer support and case management.** *International Journal of Geriatric Psychiatry*, 25(7), 657-664. Objective To write a narrative review of the role of primary care physicians in the long-term care of people with dementia living at home, with a focus on psychosocial interventions, the provision of information and carer support, behavioural and psychological symptoms and case management. Methods The systematic review carried out for the NICE/SCIE Guidelines was updated from January 2006, Cochrane Reviews were identified and other publications found by consultations with experts. Results In primary care, the long-term care of people with dementia living at home can be structured around several key themes: reframing dementia with a focus on a social model of disability; active use of information sources; supporting carers (caregivers); the management of behavioural and psychological symptoms and a structured case management approach. Conclusions Caring for people with dementia in primary care demands the same systematic approach as the management of other long-term conditions. The systematic follow-up of both people with dementia and their carers should be

integrated into primary care. Reframing dementia, with an emphasis on abilities retained may allow people with dementia and their families to develop more effective coping strategies; an increase in skill mix within primary care is required to deliver this and may also improve the management of behavioural problems. The potential benefits of person-centred interventions, like advance care planning, and alternative models of service delivery, such as a structured, collaborative care approach which promotes integrated case management within primary care, require further evaluation. Copyright © 2009 John Wiley & Sons, Ltd. ABSTRACT FROM AUTHOR (Copyright of International Journal of Geriatric Psychiatry is the property of John Wiley & Sons, Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract.)

66. Rockwood, K., & Keren, R. (2010). **Dementia services in Canada.** *International Journal of Geriatric Psychiatry*, 25(9), 876-880. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20803711>

Canadians with dementia have access to Medicare, a universal, single payer healthcare program. Implementation of Medicare is through the provinces and territories, giving variation in the level of care available. At present, there is no national strategy for dementia, although a recent report from the Alzheimer Society of Canada is expected to catalyze one. Most dementia care is provided by primary care practitioners, with three specialties (geriatric psychiatry, geriatric medicine and neurology) providing consultant expertise. Primary care reforms are aimed at developing a more coordinated approach to the complex needs of people with dementia, and have especially emphasized education of providers. Any national strategy is expected to underscore prevention and research, the latter building on Canada's strong contribution to this international undertaking. (c) 2010 John Wiley & Sons, Ltd.

67. Thomas, H. (2010). **Attitudes of primary care team to diagnosing dementia.** *Nursing Older People*, 22(3), 23-27. Healthcare professionals in primary care are gatekeepers to specialist services and are important in terms of ensuring access to community support and appropriate referral for the sizable number of older people with mental health problems. This literature review explores the role of primary care professionals, particularly GPs and practice nurses, in diagnosing and managing patients with dementia. It recommends that education and training are required to raise awareness of the importance of accurate diagnosis and management in primary care. [References: 57]

68. Thomas, H. (2010). **Monitoring referrals to mental health services.** *Nursing Older People*, 22(1), 16-22. The referral of patients with dementia from primary care professionals to specialist mental health services can fluctuate markedly. This article examines referrals to a mental health service for older people and the role of an education facilitator in primary care.

Evaluation and analysis of the data collected from a single point of referral highlight possible delays in referrals by primary care professionals, failure to recognise mental health needs in older people or a tendency to refer initially to medical services instead of specialist mental health services. The education facilitator provides information about specialist services, identifies delays in referral and improves diagnostic accuracy.

69. Tsolaki, M., Papaliagkas, V., Anogianakis, G., Bernabei, R., Emre, M., Frolich, L., . . . Winblad, B. (2010). **Consensus statement on dementia education and training in europe.** *Journal of Nutrition, Health and Aging*, 14(2), 131-135. Objectives: The aim of the current statement is to agree on: (1) what is the current situation with education and training on dementia in Europe; (2) what are the minimum educational requirements for professionals (neurologists, psychiatrists, primary care providers, nurses, biologists, neuroradiologists, etc.) regarding Alzheimer's disease and dementia, and (3) how to start a course of action for the future. Design: In 2005, a simple questionnaire was sent to members of the European Alzheimer's Disease Consortium (EADC) concerning the education and training on dementia in their countries. Fourteen universities of the respective countries responded to this simple questionnaire. The answers varied, and the conclusion of this effort was that little was done concerning the training of students and health professionals on dementia. In 2008, another more structured and specified questionnaire was sent to professors in different universities of the same countries. Results: The answers obtained were different from those of the previous questionnaire and demonstrated that it is very difficult to know about training and education in the field of dementia in every European country. Conclusion: From the data collected, it seems that although in the recent past little had been done concerning training on dementia, nowadays training has been developed in most European countries, and relevant educational projects exist both for medical students and doctors during their specialty training. Our main purpose is to develop training material or develop specific courses to improve the professional knowledge about dementia so that best medical and non-medical practice is implemented.

70. Villars, H., Oustric, S., Andrieu, S., Baeyens, J. P., Bernabei, R., Brodaty, H., . . . Vellas, B. (2010). **The primary care physician and alzheimer's disease: An international position paper.** *Journal of Nutrition, Health & Aging*, 14(2), 110-120. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20126959>

This paper aims to define the role of the primary care physician (PCP) in the management of Alzheimer's disease (AD) and to propose a model for a work plan. The proposals in this position paper stem from a collaborative work of experts involved in the care of AD patients. It combines evidence from a literature review and expert's opinions who met in Paris, France, on July 2009 during the International Association of Geriatrics and Gerontology (IAGG) World Congress. The PCP's intervention appears essential at many levels: detection of the onset of dementia, diagnostic management, treatment and follow-up. The key role of the PCP in the management of AD, as care providers and care planners, is consolidated by the family caregiver's confidence in their skills. In primary care practice the first step is to identify dementia. The group proposes a "case finding"

strategy, in target situations in which dementia should be detected to allow, secondarily, a diagnosis of AD, in certain cases. We propose that the PCP identifies 'typical' cases. In typical cases, among older subjects, the diagnosis of "probable AD" can be done by the PCP and then confirm by the specialist. While under-diagnosis of AD exists, so does under-disclosure. Disclosure to patient and family should be done by both specialist and PCP. Then, the PCP has a central role in management of the disease with the general objectives to detect, prevent and treat, when possible, the complications of the disease (falls, malnutrition, behavioural and psychological symptoms of dementia). The PCP needs to give basic information to the caregiver on respite care and home support services in order to prevent crisis situations such as unplanned institutionalisation and "emergency" hospital admission. Finally, therapeutic research must be integrated in the daily practice of PCP. It is a matter of patients' right to benefit from access to innovation and clinical research whatever his age or diseases, while of course fully respecting the rules and protective measures that are in force. [References: 120]

71. Warshaw, G. A., Modawal, A., Kues, J., Moore, I., Margolin, G., Sehgal, M., . . . Cluxton, R. (2010). **Community physician education in geriatrics: Applying the assessing care of vulnerable elders model with a multisite primary care group.** *Journal of the American Geriatrics Society*, 58(9), 1780-1785. doi:10.1111/j.1532-5415.2010.03029.x

Providing practicing physicians with effective education that leads to better patient outcomes remains challenging. In 2003, the University of Cincinnati College of Medicine developed a comprehensive program to enhance practicing physician geriatric medicine education based on the Assessing the Care of Vulnerable Elders model. The program was implemented with a large, multisite primary care group based in the greater Cincinnati area and was designed to increase physicians' clinical skills and assist them in implementing new office and system strategies that could improve the quality of care for their older patients. Four topic areas were chosen: medication management, falls and mobility, urinary incontinence, and dementia. A multifaceted physician education program was developed for each topic area, with lunch-time, in-office, geriatrician-led presentations as the primary intervention. Over a 4-year period (2004-2007), more than 60 physicians in 16 primary care practices attended 107 teaching sessions. The value of the presentation content, quality of the presentations, and perception of meeting the primary care physicians' (PCPs') educational needs were each rated at 3.8 or above (4=excellent). Between 80% and 92% of the PCPs planned to make a change in their practice behavior as a result of the training, but only two offices initiated formal quality improvement projects. During the teaching sessions, the PCPs were provided with screening tools to identify "at risk" patients, assessment chart templates, and community resource and patient education materials. The application of a modified version of the ACOVE model to reach a large group of primary care physicians is possible and may be one strategy to improve the assessment and management of geriatric syndromes.

72. Wise, J. (2010). **Government must enthruse GPs to improve early diagnosis of dementia.** *BMJ*, 341, 6793. Retrieved from <http://dx.doi.org/10.1136/bmj.c6793>; <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=21109574>

73. Workman, B., Dickson, F., & Green, S. (2010). **Early dementia - optimal management in general practice.** *Australian Family Physician*, 39(10), 722-726. **BACKGROUND:** The assessment and management of dementia is complex. General practitioners are often the first point of contact for people with dementia, and their families. General practitioners have a key role in providing quality primary care in terms of the identification, assessment, provision of information, referral and ongoing management. **OBJECTIVE:** This article discusses the role of the GP in the diagnosis and management of people with dementia. **DISCUSSION:** It is important GPs are aware of the importance of early detection of dementia. Dementia is a complex condition. It develops slowly and early signs of dementia are very subtle. Difficulty in detecting the transition between normal aging and the onset of dementia and the lack of a definitive diagnostic tool often precludes early diagnosis. Evidence based recommendations are available to assist GPs in the diagnosis and ongoing management of people with dementia.

74. Assal, F., & van der Meulen, M. (2009). **Pharmacological interventions in primary care: Hopes and illusions.** *Frontiers of Neurology & Neuroscience*, 24, 54-65. Alzheimer's disease is a neurodegenerative disease characterized by senile plaques, neurofibrillary tangles, synaptic loss, neuronal death and cholinergic deficits, causing cognitive, behavioral and psychological deficits, as well as a functional impairment that results in serious caregiver distress and a great economic burden worldwide. High hopes rose with the development of symptomatic treatments, resulting from randomized controlled trials using cholinergic enhancers or cholinesterase inhibitors, such as donepezil, galantamine and rivastigmine. When memantine, an NMDA antagonist, was approved and the first phase III anti-amyloid immunization was launched, many clinicians eagerly anticipated the first disease-modifying drugs in their daily practice. For the treatment of behavioral and psychological symptoms of dementia (BPSD), atypical antipsychotics and new-generation antidepressants also seemed to offer great promises, mainly because of their good tolerance and side effect profiles. Hopes, however, were followed by disillusion: subsequent studies demonstrated that cholinesterase inhibitors and memantine had only modest and short-lived effects on cognition and BPSD, and the effect of antipsychotics on BPSD appeared questionable. Disease-modifying drugs such as anti-amyloid immunization or amyloid clearance medication had to be abandoned for safety reasons or absence of efficacy. Although the early treatment of vascular risk factors is increasingly recognized in Alzheimer's disease prevention because of their implication in the amyloid cascade, randomized controlled trials have yielded largely negative results. Therefore, pharmacological as well as fundamental research that better underpins the complex pathophysiology of this devastating disease constitutes one of the biggest challenges of the 21st century. Copyright (c) 2009 S. Karger AG, Basel. [References: 45]

75. Aziz, N. A., Leelavathi, M., Tohid, H., & Hamzah, M. S. (2009). **Challenges in managing dementia in a primary health care setting: A case report.** *South African Family Practice*, 51(6), 519-520. Dementia is a condition that is frequently associated with ageing. However, many fail to recognise that dementia is a treatable condition if detected early. This case report

illustrates a 64-year-old man who was initially presented in a primary health care (PHC) centre in Kuala Lumpur Malaysia, with gradual changes in his behaviour. Initial assessment concluded that he suffered from depression and he was treated accordingly. However, over time his condition deteriorated and the diagnosis was re-evaluated from depression to dementia when he developed poor cognitive and memory function. The patient defaulted on his follow-up appointments due to poor understanding of the illness and poor family support. Medpharm.

76. Bradford, A., Kunik, M. E., Schulz, P., Williams, S. P., & Singh, H. (2009). **Missed and delayed diagnosis of dementia in primary care: Prevalence and contributing factors.** *Alzheimer Disease & Associated Disorders*, 23(4), 306-314. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19568149>

Dementia is a growing public health problem for which early detection may be beneficial. Currently, the diagnosis of dementia in primary care is dependent mostly on clinical suspicion on the basis of patient symptoms or caregivers' concerns and is prone to be missed or delayed. We conducted a systematic review of the literature to ascertain the prevalence and contributing factors for missed and delayed dementia diagnoses in primary care. Prevalence of missed and delayed diagnosis was estimated by abstracting quantitative data from studies of diagnostic sensitivity among primary care providers. Possible predictors and contributory factors were determined from the text of quantitative and qualitative studies of patient, caregiver, provider, and system-related barriers. Overall estimates of diagnostic sensitivity varied among studies and seemed to be in part a function of dementia severity, degree of patient impairment, dementia subtype, and frequency of patient-provider contact. Major contributory factors included problems with attitudes and patient-provider communication, educational deficits, and system resource constraints. The true prevalence of missed and delayed diagnoses of dementia is unknown but seems to be high. Until the case for dementia screening becomes more compelling, efforts to promote timely detection should focus on removing barriers to diagnosis. [References: 76]

77. Callahan, C. M., Boustani, M., Sachs, G. A., & Hendrie, H. C. (2009). **Integrating care for older adults with cognitive impairment.** *Current Alzheimer Research*, 6(4), 368-374. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19689236>

The number of older adults with Alzheimer's disease and related disorders is expected to triple over the next 50 years. While we may be on the cusp of important therapeutic advances, such advances will not alter the disease course for millions of persons already affected. Hoping for technology to spare the health care system from the need to care for older adults with dementia is no longer tenable. Most older adults with dementia will receive their medical care in the primary care setting and this setting is not prepared to provide for the complex care needs of these vulnerable elders. With an increasing emphasis on earlier diagnosis of dementia, primary care in particular will come under increasing strain from this new care responsibility. While primary care may remain the

hub of care for older adults, it cannot and should not be the whole of care. We need to design and test new models of care that integrate the larger health care system including medical care as well as community and family resources. The purpose of this paper to describe the current health care infrastructure with an emphasis on the role of primary care in providing care for older adults with dementia. We summarize recent innovative models of care seeking to provide an integrated and coordinated system of care for older adults with dementia. We present the case for a more aggressive agenda to improving our system of care for older adults with dementia through greater training, integration, and collaboration of care providers. This requires investments in the design and testing of an improved infrastructure for care that matches our national investment in the search for cure. [References: 91]

78. Cherry, D. L., Hahn, C., & Vickrey, B. G. (2009). **Educating primary care physicians in the management of alzheimer's disease: Using practice guidelines to set quality benchmarks.** *International Psychogeriatrics*, 21(Suppl 1), S44-52. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19288963>

This paper presents a strategy for training primary care physicians in the identification, diagnosis and management of Alzheimer's disease and related disorders. The strategy uses evidence-based practice guidelines to establish quality benchmarks and then provides training and other interventions to improve the quality of care received by these patients. The three projects described in this paper assumed that training of primary care physicians alone would not be sufficient to achieve the quality benchmarks derived from guidelines. The projects used creative training strategies supplemented by provider "tool kits", provider checklists, educational detailing, and endorsement from organizational leadership to reinforce what the primary care providers learned in educational sessions. Each project also implemented a system of dementia care management to "wrap around" traditional primary care to ensure that quality benchmarks would be achieved. Outcomes of two completed studies support the premise that it is possible to improve quality of dementia care through physician education that occurs in association with a coordinated system of dementia care management and in collaboration with community agencies to access guideline-recommended social services.

79. Degryse, J., Lepeleire, J., Southgate, L., VernooijDassen, M., Gay, B., & Heyrman, J. (2009). **An evaluation of a computer based education program for the diagnosis and management of dementia in primary care. an international study of the transcultural adaptations necessary for european dissemination.** *Medical Teacher*, 31(5), 397-402.

Objectives: The aim of this study is to make an inventory of the changes that are needed to make an interactive computer based training program (ICBT) with a specific educational content, acceptable to professional communities with different linguistic, cultural and health care backgrounds in different European countries. Methods: Existing educational software, written in two languages was reviewed by GPs and primary care professionals in three different countries. Reviewers worked through the program using a structured critical reading grid. Results: A 'simple' translation of the program is not

sufficient. Minor changes are needed to take account of linguistic differences and medical semantics. Major changes are needed in respect of the existing clinical guidelines in every country related to differences in the existing health care systems. Conclusions: ICTB programs cannot easily be used in different countries and cultures. The development of a structured educational program needs collaboration between educationalists, domain experts, information technology advisers and software engineers. Simple validation of the content by local expert groups will not guarantee the program's exportability. It is essential to involve different national expert groups at every phase of the development process in order to disseminate it in other countries. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

80. Feldman, S. (2009). **The referral dance: Improving the interface between primary care practitioners and specialists caring for patients with dementia.** *American Journal of Alzheimer's Disease and Other Dementias*, 23(6), 513-515. This issues related to referrals of patients with dementia from primary care practitioners (PCPs) to neurologists. Prior to referral, patients had received a number of investigations, including laboratory investigations (49%) and imaging with computed tomography and magnetic resonance (CT and MR; 55%) though, disturbingly, only 13% had received basic standardized cognitive testing with Mini-Mental State Examination (MMSE) or other instruments. Neurologists, not surprisingly, performed objective mental status testing and functional assessment of instrumental activities of daily living in the vast majority of referrals and formulated a diagnosis in 99% of patients after 1 visit. Caring for patients with cognitive impairment is one of the great challenges in primary care. This appears to be an almost universal phenomenon. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

81. Fortinsky, R. H., Kulldorff, M., Kleppinger, A., & Kenyon-Pesce, L. (2009). **Dementia care consultation for family caregivers: Collaborative model linking an alzheimer's association chapter with primary care physicians.** *Aging & Mental Health*, 13(2), 162-170. OBJECTIVE: The primary objective is to report on the efficacy of an individualized dementia care consultation intervention for family caregivers of patients with diagnosed dementia living in the community. The secondary objective is to present evidence on the intervention process to inform the feasibility and sustainability of the model featuring collaboration between primary care physicians and a voluntary sector organization. METHOD: Randomization was based on primary care physician practice site. In the intervention group, dementia care consultants located at an Alzheimer's association chapter provided individualized counseling and support over a 12-month period, and sent copies of care plans developed with family caregivers to referring primary care physicians. In the control group, family caregivers received educational and community resource information but no care consultation. Nursing home admission of patients during the 12-month study period was the primary outcome; secondary outcomes included measures of caregiver self-efficacy for managing dementia, caregiver depressive symptoms, and caregiver burden. RESULTS: A total of 84 family caregivers participated. After adjusting for baseline characteristics, patients whose family caregivers were in the intervention group were less likely than their control group counterparts to be admitted to

a nursing home (Adjusted odds ratio = 0.40; 95% C.I. = 0.14-1.18; p = 0.10). No other outcomes were significantly different between treatment groups; however, intervention group caregivers reporting greater satisfaction with the intervention showed improved self-efficacy for managing dementia compared to their less satisfied counterparts. Medical record reviews found that care plans were found in most patient records, but that only 27% of intervention group caregivers reported discussing these care plans with physicians. Three different individuals occupied the dementia care consultant position during the study period, and this turnover led to family caregiver dissatisfaction. CONCLUSION: The dementia care consultation intervention showed favorable effects on nursing home admission and on caregiver outcomes among intervention group caregivers more satisfied with the intervention, but there are important barriers to sustaining this collaboration between primary care physicians and a voluntary sector organization such as an Alzheimer's association chapter.

82. Froelich, L., Andreasen, N., Tsolaki, M., Foucher, A., Kavanagh, S., Baelen, B. V., & Schwalen, S. (2009). **Long-term treatment of patients with alzheimer's disease in primary and secondary care: Results from an international survey.** *Current Medical Research & Opinion*, 25(12), 3059-3068. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19852697>

OBJECTIVE: The International Outcomes Survey in Dementia (IOSID) was initiated to observe the effects of current standard of care for Alzheimer's disease (AD) on patient outcomes and caregiver burden in a real-life setting. RESEARCH DESIGN AND METHODS: This 2-year, international, prospective, longitudinal and observational cohort survey involved patients with mild-to-moderate AD (Mini-Mental State Examination [MMSE] scores of 10-26 points) living in an ordinary household at baseline. There was no intervention with regard to patient management. Primary informal caregivers were also included in the survey. MAIN OUTCOME MEASURES: Patient parameters assessed included the MMSE, Disability Assessment for Dementia (DAD), Neuropsychiatric Inventory (NPI), and Clinical Global Impression (CGI). Caregiver burden was evaluated with the Zarit Burden Interview and caregiver distress was assessed as part of the NPI. Adverse events (AEs) were monitored. RESULTS: Of 2288 patients recruited, 1382 (60.4%) completed the survey. At baseline, the majority (79.3%) of patients were receiving treatment with acetylcholinesterase inhibitors (AChEIs) or/and memantine. MMSE, DAD, NPI and CGI scores all showed that patients experienced deterioration of AD symptoms during the survey. MMSE scores declined less steeply than might have been expected based on historical data. Scores on the four outcome scales were significantly correlated at all time points. Mean caregivers' feeling of strain and caregiver distress increased during the survey. AEs occurring in more than 2% of patients were nausea (3.0%), injury (2.6%), fall (2.4%), depression (2.2%) and urinary tract infection (2.2%). CONCLUSIONS: Community patients with AD experience progressive and interconnected decline in cognition, behaviour and functioning over time, placing increased burden on caregivers. However, improved care in recent years, including AChEI use, might be reflected in slower rates of patient decline than were evident in the past. Overall, relatively low rates of AEs were apparent during the survey. Limitations of this survey included a smaller than anticipated number of recruited

patients confounding the possibility of performing comprehensive subgroup analyses, and the lack of randomisation inherent in the survey methodology.

83. Greening, L., Greaves, I., Greaves, N., & Jolley, D. (2009). **Positive thinking on dementia in primary care: Gnosall memory clinic.** *Community Practitioner*, 82(5), 20-23.

Memory problems are a common phenomenon in later life, and are sometimes symptomatic of dementia or other serious illness. A memory clinic established two years ago within primary care is facilitated by a practice health visitor. The clinic has focused on patients with newly identified symptoms in association with vascular disorders. Many patients presented with complex problems including physical, social and psychological dimensions. The clinic has attracted a referral rate three times that reported from hospital-based memory clinics, and has been able to meet the needs of patients and families with little use of other specialist services. Providing expertise within a practice is recommended as a preferred mode of service for people with memory problems. Health visitors are well placed to co-ordinate care for family members of all ages, including the elderly.

84. Greenway-Crombie, A. M., Davis, S., Disler, P., Pond, D., & Swain, J. (2009). **Does the management of people with dementia differ in rural general practice compared to urban general practice?** [Does the management of people with dementia differ in rural general practice compared to urban general practice?.] *Alzheimer's and Dementia. Conference: Alzheimer's Association International Conference on Alzheimer's Disease Vienna Austria. Conference Start: 20090711 Conference End: 20090716. Conference Publication: (Var.Pagings), 5(4 SUPPL. 1), 235.* doi:<http://dx.doi.org/10.1016/j.jalz.2009.04.205>

Background: The substantial ageing of the Australian population has provoked a 'dementia epidemic' which has far-reaching consequences for people with dementia, their carers and for the health system in meeting increasing demand for services. The health status of the rural elderly is poorer than that of their urban counterparts. A study is currently being undertaken in Australia examining the detection and management of dementia in general practice. This presentation will explore some of the differences in the management of people with dementia in rural compared to urban general practice. Methods: General Practitioners (GPs) participating in the study were asked to complete an audit form for patients whom they had diagnosed with definite, probable or possible dementia. The audit form asks GPs to indicate what pathology, radiology or pencil and paper tests they ordered in relation to memory problems and whether they have referred the patient to any services in relation to the memory problems. GPs from four urban centres in three different Australian States and one regional centre (that includes three rural towns) are participating in the study. Results: Results from the preliminary analysis of the audit data will highlight differences in tests and referrals for patients with dementia by rural and urban GPs. Conclusions: The relevance of results will be discussed in relation to Australian evidence based management guidelines for dementia. The discussion will consider these issues from a rural versus urban perspective.

85. Harris, D. P., Chodosh, J., Vassar, S. D., Vickrey, B. G., & Shapiro, M. F. (2009). **Primary care providers' views of challenges and rewards of dementia care relative to other conditions.** *Journal of the American Geriatrics Society*, 57(12), 2209-2216. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19943831>

OBJECTIVES: To compare primary care providers' (PCPs') perceptions about dementia and its care within their healthcare organization with perceptions of other common chronic conditions and to explore factors associated with differences. **DESIGN:** Cross-sectional survey. **SETTING:** Three California healthcare organizations. **PARTICIPANTS:** One hundred sixty-four PCPs. **MEASUREMENTS:** PCPs' views about primary care for dementia were analyzed and compared with views about care for heart disease, diabetes mellitus, and selected other conditions. Differences in views about conditions according to PCP type (internists, family physicians) were assessed. Multivariate analysis examined relationships between provider and practice characteristics and views about dementia care. **RESULTS:** More PCPs strongly agreed that older patients with dementia are difficult to manage (23.8%) than for heart disease (5.0%) or diabetes mellitus (6.3%); PCPs can improve quality of life for heart disease (58.9%) and diabetes mellitus (61.6%) than for dementia (30.9%); older patients should be routinely screened for heart disease (63.8%) and diabetes mellitus (67.7%) than dementia (55.5%); and their organizations have expertise/referral resources to manage diabetes mellitus (49.4%) and heart disease (51.8%) than dementia (21.1%). More PCPs reported almost effortless organizational care coordination for heart disease (13.0%) or diabetes mellitus (13.7%) than for dementia (5.6%), and a great deal or many opportunities for improvement in their ability to manage dementia (50.6%) than incontinence, depression, or hypertension (7.4-34.0%; all $P < .05$). Internists' views regarding dementia care were less optimistic than those of family physicians, but PCP type was unrelated to views on diabetes mellitus or heart disease. **CONCLUSION:** Improving primary care management of dementia should directly address PCP concerns about expertise and referral resources, difficulty of care provision, and PCP views about prospects for patient improvement.

86. Holle, R., Grassel, E., Ruckdaschel, S., Wunder, S., Mehlig, H., Marx, P., . . . Lauterberg, J. (2009). **Dementia care initiative in primary practice: Study protocol of a cluster randomized trial on dementia management in a general practice setting.** *BMC Health Services Research*, 9, 91. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19500383>

BACKGROUND: Current guidelines for dementia care recommend the combination of drug therapy with non-pharmaceutical measures like counselling and social support. However, the scientific evidence concerning non-pharmaceutical interventions for dementia patients and their informal caregivers remains inconclusive. Targets of modern comprehensive dementia care are to enable patients to live at home as long and as independent as possible and to reduce the burden of caregivers. The objective of the study is to compare a complex intervention including caregiver support groups and counselling against usual care in terms of time to nursing home placement. In this paper the study protocol is described. **METHODS/DESIGN:** The IDA (Initiative

Demenzversorgung in der Allgemeinmedizin) project is designed as a three armed cluster-randomized trial where dementia patients and their informal caregivers are recruited by general practitioners. Patients in the study region of Middle Franconia, Germany, are included if they have mild or moderate dementia, are at least 65 years old, and are members of the German AOK (Allgemeine Ortskrankenkasse) sickness fund. In the control group patients receive regular treatment, whereas in the two intervention groups general practitioners participate in a training course in evidence based dementia treatment, recommend support groups and offer counseling to the family caregivers either beginning at baseline or after the 1-year follow-up. The study recruitment and follow-up took place from July 2005 to January 2009. 303 general practitioners were randomized of which 129 recruited a total of 390 patients. Time to nursing home admission within the two year intervention and follow-up period is the primary endpoint. Secondary endpoints are cognitive status, activities of daily living, burden of care giving as well as healthcare costs. For an economic analysis from the societal perspective, data are collected from caregivers as well as by the use of routine data from statutory health insurance and long-term care insurance. **DISCUSSION:** From a public health perspective, the IDA trial is expected to lead to evidence based results on the community effectiveness of non-pharmaceutical support measures for dementia patients and their caregivers in the primary care sector. For health policy makers it is necessary to make their decisions about financing new services based on strong knowledge about the acceptance of measures in the population and their cost-effectiveness. **TRIAL REGISTRATION:** ISRCTN68329593.

87. Iliffe, S., Jain, P., Wong, G., Lefford, F., Warner, A., Gupta, S., . . . Kennedy, H. (2009). **Dementia diagnosis in primary care: Thinking outside the educational box.** *Aging Health*, 5(1), 51-59. doi:<http://dx.doi.org/10.2217/1745509X.5.1.51> Dementia syndromes are common, increasing in prevalence and are the largest cause of disability in industrialized societies. The costs of care for people with dementia in the UK are greater than the annual expenditure on heart disease, stroke and cancer, combined. Delayed recognition of dementia is common in community settings, but its causes are poorly understood. Specialists tend to identify lack of diagnostic skills amongst primary care physicians as the main cause, and attempt to remedy these limitations with training and the use of brief instruments for assessing cognition. This approach appears to have had little impact over the last decade. There are fundamental misunderstandings regarding how the diagnostic characteristics of dementia syndromes diverge from the cognitive changes of normal aging, and how dementia emerges through the personality of the individual. This paper discusses the factors/ processes involved in these changes in cognitive function, behavior and personality and why recognition of dementia in primary care is problematic, especially at an early stage. The important and tractable factors impeding earlier recognition of dementia in primary care include deficits in management (rather than diagnostic) skills amongst primary care practitioners and lack of adequate specialist support (including psychology and social work expertise) over the long term. Nevertheless, we believe that the diagnosis and early clinical management of dementia can be achieved in the setting of primary care. The pattern of interweaving psychological, social and economic factors relevant to the needs of individual patients and their carers can be taken into account and met in the community, providing sufficient expert

resources are available and systematically organized. This paper explores the different dimensions of relevant management skills and systems and makes proposals regarding changes in primary and secondary care that will increase earlier diagnosis in the community. 2009 Future Medicine Ltd.

88. Iliffe, S., Robinson, L., Brayne, C., Goodman, C., Rait, G., Manthorpe, J., & Ashley, P. (2009). **Primary care and dementia: 1. diagnosis, screening and disclosure.** *International Journal of Geriatric Psychiatry*, 24(9), 895-901.

OBJECTIVES: To write a narrative review of the roles of primary care practitioners in caring for people with dementia in the community. **METHODS:** The systematic review carried out for the NICE/SCIE Guidelines was updated from January 2006, Cochrane Reviews were identified, and other publications found by consultation with experts. **RESULTS:** The insidious and very variable development of dementia syndromes makes recognition of the syndrome problematic in primary care. Dementia is probably under-diagnosed and under treated with an estimated 50% of primary care patients over 65 not diagnosed by their primary care physicians. This problem of under-diagnosis is probably not due to lack of diagnostic skills, but rather to the interaction of case-complexity, pressure on time and the negative effects of reimbursement systems. Primary care physicians often over-estimate the prevalence of dementia syndromes, but in some countries may also overestimate the prevalence of vascular dementia compared with Alzheimer's disease. Diagnosis is a step-wise process which can be aided by use of a cognitive function test, of which there are a number suitable for primary care use. Evidence based practice protocols can enhance detection rates in primary care, and there is growing evidence that communication skills in talking to people with dementia about dementia can be improved. Nevertheless there are multiple obstacles to bringing recognition forward in time, both in public awareness and professional understanding of the early changes in dementia. **CONCLUSIONS:** There is insufficient evidence of benefit to justify population screening in primary care but earlier recognition of people with dementia syndrome is possible within primary care. The diagnosis of dementia is a shared responsibility between generalist and specialist disciplines. Primary care physicians should explore patients' ideas and concerns around their symptoms prior to referral and tentatively discuss possible diagnoses. Once the diagnosis has been confirmed, the primary care physician should provide both practical and emotional support to allow the patient and their family to come to terms with living with dementia, and refer them for additional psychosocial support if required.

89. Justiss, M. D., Boustani, M., Fox, C., Katona, C., Perkins, A. J., Healey, P. J., . . . Scott, E. (2009). **Patients' attitudes of dementia screening across the atlantic.** *International Journal of Geriatric Psychiatry*, 24(6), 632-637. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19115255>

BACKGROUND: Dementia is a common and growing global public health problem. It leads to a high burden of suffering for society with an annual cost of \$100 billion in the US and \$10 billion in the UK. New strategies for both treatment and prevention of dementia are currently being developed. Implementation of these strategies will depend on the presence of a viable community or primary care based dementia screening and

diagnosis program and patient acceptance of such a program. OBJECTIVE: To compare the acceptance, perceived harms and perceived benefits of dementia screening among older adults receiving their care in two different primary health care systems in two countries. DESIGN: A Cross-sectional study. SETTING: Primary care clinics in Indianapolis, USA and Kent, UK. PARTICIPANTS: A convenience sample of 245 older adults (Indianapolis, n = 125; Kent, n = 120). OUTCOMES: Acceptance of dementia screening and its perceived harms and benefits as determined by a 52-item questionnaire (PRISM-PC questionnaire). RESULTS: Four of the five domains were significantly different across the two samples. The UK sample had significantly higher dementia screening acceptance scores ($p < 0.05$); higher perceived stigma scores ($p < 0.05$); higher perceived loss of independence scores ($p < 0.01$); and higher perceived suffering scores ($p < 0.01$) than the US sample. Both groups perceived dementia screening as beneficial ($p = 0.218$). After controlling for prior experience with dementia, acceptance and stigma were marginalized. CONCLUSIONS: Older adults attending primary care clinics across the Atlantic value dementia screening but have significant concerns about dementia screening although these concerns differed between the two countries. Low acceptance rates and high rates of perceived harms might be a significant barrier for the introduction of treatment or preventive methods for dementia in the future. (c) 2008 John Wiley & Sons, Ltd.

90. Kennedy, G. J., George, C., & Lui, Y. W. (2009). **Dementia or depression? diagnostic bias in geriatric practice.** *Primary Psychiatry*, 16(10), 15-18. The distinction between dementia and depression in the care of older adults is a common challenge made more difficult when other illnesses and medications confound the task. Practitioners are subject to biases resulting from the frequency with which they encounter clinical syndromes as well as pride in "making the diagnosis," particularly when the disease is rare. The following is a case in which one diagnosis was accurately rejected but the correct diagnosis was missed. This affords an opportunity to examine a common clinical problem with an uncommon cause in geriatric practice. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

91. Koch, T., & Iliffe, S. (2009). **Implementing the NDS: Case studies from primary care.** *Journal of Dementia Care*, 17(6), 26-29. Tamar Koch and Steve Iliffe share the innovative work of several general practitioners working to better identify and support people with dementia in their practices.

92. Leifer, B. P. (2009). **Alzheimer's disease: Seeing the signs early.** *Journal of the American Academy of Nurse Practitioners*, 21(11), 588-595. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19900220>

PURPOSE: Many patients with early symptoms of Alzheimer's disease (AD) first seek help from their primary care providers (PCPs). PCPs must therefore be watchful for signs and symptoms of AD, and should screen elderly patients who complain of memory and cognitive problems for dementia. DATA SOURCES: Published literature on case detection, diagnosis, and treatment of AD. CONCLUSIONS: There are a number of simple, accurate, and fast tools to facilitate case detection, including the Mini-Mental

State Examination. Once a diagnosis has been made, healthcare providers, patients, and caregivers can evaluate treatment options. Several medications are available for symptomatic treatment of AD, including the cholinesterase inhibitors donepezil, galantamine, and rivastigmine, and for later stage disease, the N-methyl D-aspartate (NMDA) receptor antagonist, memantine. **IMPLICATIONS FOR PRACTICE:** Early intervention is critical because a delay in treatment is associated with nonreversible symptom progression. Realistic treatment expectations include reduction in symptom severity and slowed decline in cognition, function, and behavior. Treatment may allow patients to retain independence longer and reduce the burden that advanced AD places on caregivers.

93. Meeuwssen, E. J., German, P., Melis, R. J., Adang, E. M., Goluke-Willemse, G. A., Krabbe, P. F., . . . Rikkert, M. G. (2009). **Cost-effectiveness of post-diagnosis treatment in dementia coordinated by multidisciplinary memory clinics in comparison to treatment coordinated by general practitioners: An example of a pragmatic trial.** *Journal of Nutrition, Health & Aging, 13*(3), 242-248. **BACKGROUND:** With the rising number of dementia patients with associated costs and the recognition that there is room for improvement in the provision of dementia care, the question arises on how to efficiently provide high quality dementia care. **OBJECTIVE:** To describe the design of a study to determine multidisciplinary memory clinics' (MMC) effectiveness and cost-effectiveness in post-diagnosis treatment and care-coordination of dementia patients and their caregivers compared to the post-diagnosis treatment and care-coordination by general practitioners (GP). Next, this article provides the theoretical background of pragmatic trials, often needed in complex interventions, with the AD-Euro study as an example of such a pragmatic approach in a clinical trial. **METHOD:** The study is a pragmatic multicentre, randomised clinical trial with an economic evaluation alongside, which aims to recruit 220 independently living patients with a new dementia diagnosis and their informal caregivers. After baseline measurements, patient and caregiver are allocated to the treatment arm MMC or GP and are visited for follow up measurements at 6 and 12 months. Primary outcome measures are Health Related Quality of Life of the patient as rated by the caregiver using the Quality of Life in Alzheimer's Disease instrument (QoL-AD) and self-perceived caregiving burden of the informal caregiver measured using the Sense of Competence Questionnaire (SCQ). To establish cost-effectiveness a cost-utility analysis using utilities generated by the EuroQol instrument (EQ-5D) will be conducted from a societal perspective. Analyses will be done in an intention-to-treat fashion. **RESULTS:** The inclusion period started in January 2008 and will commence until at least December 2008. After finalising follow up the results of the study are expected to be available halfway through 2010. **DISCUSSION:** The study will provide an answer to whether follow-up of dementia patients can best be done in specialised outpatient memory clinics or in primary care settings with regard to quality and costs. It will enable decision making on how to provide good and efficient health care services in dementia. **TRIAL REGISTRATION:** ClinicalTrials.gov Identifier NCT00554047.

94. Millard, F., & Baune, B. (2009). **Dementia - who cares? A comparison of community needs and primary care services.** *Australian Family Physician, 38*(8), 642-

649.

BACKGROUND: Health professionals have varying levels of knowledge about, and interest in, providing dementia services. This article compares patient experiences in dealing with dementia with the perceived role of health care providers in providing dementia care. **METHOD:** Qualitative data from interviews of patients with dementia and their carers was compared with quantitative data from health professional surveys, where health professionals described their knowledge of dementia and their attitudes toward, and roles in, management. **RESULTS:** Patients often notice dementia symptoms before their general practitioner and seek diagnosis and support. Not all GPs wish to provide dementia services and many are unaware of the benefits of early diagnosis and dementia care guidelines. Dementia forums attract older health professionals, suggesting younger members are less engaged in dementia care. Older patients tend to consult with older GPs, but older GPs are less aware of dementia diagnosis and management guidelines. **DISCUSSION:** Patients turn to their GP for help with dementia but may find most benefit from the assistance and advice of people who have already negotiated the pathways to care. Health professionals who fail to investigate patients presenting with dementia symptoms can delay diagnosis, denying patients and carers early intervention that could improve quality of life for both patient and carer.

95. Nies, H., Meerveld, J., & Denis, R. (2009). **Dementia care: Linear links and networks.** *Healthcarepapers*, 10(1), 34-43.

The consequences of dementia, for both patients and primary caregivers, are formidable. Primary caregivers are often overburdened or are significantly at risk for becoming overburdened. How do we meet this substantial and complex social challenge, which is as yet insufficiently recognized? We must start looking for new forms of care and support, for more goal-oriented care while maintaining humane values. The problem of dementia demands that we follow more leads: new treatments and interventional care, greater use of technology, new divisions of labour among professionals and more empowerment of primary care. At issue is the organization of physical and social environments for patients with dementia that closely meet their needs. The road toward this goal is long and complicated, but a start has been made in the Netherlands.

96. Pentzek, M., Abholz, H. H., Ostapczuk, M., Altiner, A., Wollny, A., & Fuchs, A. (2009). **Dementia knowledge among general practitioners: First results and psychometric properties of a new instrument.** *International Psychogeriatrics*, 21(6), 1105-1115.

BACKGROUND: General practitioners (GPs) play an important role in dementia care. Sufficient knowledge is one of the prerequisites for adequate dementia management, and educational activities do include knowledge transfer. There is no up-to-date measure of GPs' knowledge of dementia, resulting in the use of unreliable ad hoc questionnaires in recent studies, thus increasing the risk of biased results. **METHODS:** In a cross-sectional, observational questionnaire study, 292 German GPs answered 37 questions regarding factual dementia knowledge. For the purpose of cross-validation, the psychometric properties of the test and its associations with GP characteristics were analyzed in independent samples with item and regression analyses. **RESULTS:** Twenty questions constituted a reliable questionnaire (Cohen's alpha = 0.733) with a normal distribution of

test scores. Linear regression analysis revealed significant associations of the knowledge test score with the GPs' age and their attitudes towards dementia. CONCLUSIONS: The newly developed dementia-knowledge test for GPs can be used in observational studies, in which a rough and easy to use instrument is required.

97. Pentzek, M., Fuchs, A., Wiese, B., Cvetanovska-Pllashniku, G., Haller, F., Maier, W., . . . AgeCoDe study, g. (2009). **General practitioners' judgment of their elderly patients' cognitive status.** *Journal of General Internal Medicine*, 24(12), 1314-1317. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19844763>

BACKGROUND: General practitioners (GP) play an important role in detecting cognitive impairment among their patients. OBJECTIVES: To explore factors associated with GPs' judgment of their elderly patients' cognitive status. DESIGN: Cross-sectional data from an observational cohort study (AgeCoDe study); General practice surgeries in six German metropolitan study centers; home visits by interviewers. PARTICIPANTS: 138 GPs, 3,181 patients (80.13 +/- 3.61 years, 65.23% female). MEASUREMENTS: General practitioner questionnaire for each patient: familiarity with the patient, patient morbidity, judgment of cognitive status. Home visits by trained interviewers: sociodemographic and clinical data, psychometric test performance. Multivariate regression analysis was used to identify independent associations with the GPs' judgment of "cognitively impaired" vs. "cognitively unimpaired." RESULTS: Less familiar patients (adjusted odds ratio [aOR] 2.42, 95% CI 1.35-4.32, for poor vs. very high familiarity), less mobile patients (aOR 1.29, 95% CI 1.13-1.46), patients with impaired hearing (aOR 5.46, 95% CI 2.35-12.67 for serious vs. no problems), and patients with greater comorbidity (aOR 1.15, 95% CI 1.08-1.22) were more likely to be rated as "cognitively impaired" by their GPs. CONCLUSIONS: The associations between GPs' assessments of cognitive impairment and their familiarity with their patients and patients' mobility, hearing, and morbidity provide important insights into how GPs make their judgments.

98. Pentzek, M., Wollny, A., Wiese, B., Jessen, F., Haller, F., Maier, W., . . . AgeCoDe Study, G. (2009). **Apart from nihilism and stigma: What influences general practitioners' accuracy in identifying incident dementia?.** *American Journal of Geriatric Psychiatry*, 17(11), 965-975. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=20104054>

OBJECTIVES: To assess the accuracy of the General Practitioner's (GP) judgment in the recognition of incident dementia cases and to explore factors associated with recognition. DESIGN: Prospective observational cohort study, two follow-up assessments (FU 1 and FU 2) within 3 years after baseline. SETTING: One hundred thirty-eight general practice surgeries in the six study centers of a prospective German study. PARTICIPANTS: Participants were between 75 and 89 years of age at baseline and were recruited from the GPs' patient lists. In FU 1, 2,402 patients and in FU 2, 2,177 patients were analyzed. MEASUREMENTS: GPs' judgments on their patients' cognitive status as index test; at-home patient interviews and tests, consensus diagnosis as reference; validity of the GP judgment; associations between patient factors and GPs' dementia recognition.

RESULTS: One hundred eleven incident dementia cases with complete data were identified in FU 1 and FU 2. Overall sensitivity of the GP judgment was 51.4%, specificity 95.9%, positive predictive value 23.6%, and negative predictive value 98.8%. GPs missed dementia more frequently in patients living alone. GPs overrated the presence of dementia more frequently in patients with problems in mobility or hearing, in patients with memory complaints, and in patients with a GP-documented depression. CONCLUSION: GPs miss nearly half of incident dementia cases. They should be alert not to miss dementia in patients living alone. Without seeking additional information, a positive GP judgment seems not sufficient for case finding. GPs should be aware of their tendency to overestimate dementia in depressed and frail patients.

99. Pimlott, N. J., Persaud, M., Drummond, N., Cohen, C. A., Silvius, J. L., Seigel, K., . . . Dalziel, W. B. (2009). **Family physicians and dementia in canada: Part 2. understanding the challenges of dementia care.** *Canadian Family Physician*, 55(5), 508-9.e1-7. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19439708>

OBJECTIVE: To explore the challenges Canadian family physicians face in providing dementia care. DESIGN: Qualitative study using focus groups. SETTING: Academic family practice clinics in Calgary, Alta, Ottawa, Ont, and Toronto, Ont. PARTICIPANTS: Eighteen family physicians. METHODS: We conducted 4 qualitative focus groups of 4 to 6 family physicians whose practices we had audited in a previous study. Focus group transcripts were analyzed using the principles of thematic analysis. MAIN FINDINGS: Five major themes related to the provision of dementia care by family physicians emerged: 1) diagnostic uncertainty; 2) the complexity of dementia; 3) time as a paradox in the provision of dementia care; 4) the importance of patients' families; 5) and familiarity with patients. Participants expressed uncertainty about diagnosing dementia and a strong need for expert verification of diagnoses owing to the complexity of dementia. Time, patients' family members, and familiarity with patients were seen as both barriers and enablers in the provision of dementia care. CONCLUSION: Family physicians face many challenges in providing dementia care. The results of this study and the views of family physicians should be considered in the development and dissemination of future dementia guidelines, as well as by specialist colleagues, policy makers, and those involved in developing continuing physician education about dementia.

100. Pimlott, N. J., Persaud, M., Drummond, N., Cohen, C. A., Silvius, J. L., Seigel, K., . . . Dalziel, W. B. (2009). **Family physicians and dementia in canada: Part 1. clinical practice guidelines: Awareness, attitudes, and opinions.** *Canadian Family Physician*, 55(5), 506-7.e1-5. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19439707>

OBJECTIVE: To assess Canadian family physicians' awareness of, attitudes toward, and use of the 1999 Canadian Consensus Conference on Dementia (CCCD) clinical practice guidelines (CPGs); to explore the barriers and enablers to implementing dementia CPGs in clinical practice; and to identify more effective strategies for future dementia guideline development and dissemination. DESIGN: Qualitative study using focus groups.

SETTING: Academic family practice clinics in Calgary, Alta, Ottawa, Ont, and Toronto, Ont. PARTICIPANTS: Eighteen family physicians. METHODS: Using a semistructured interview guide, we conducted 4 qualitative focus groups of 4 to 6 family physicians whose practices we had audited in a previous study. Transcripts were coded using an inductive data analytic strategy, and categories and themes were identified and described using the principles of thematic analysis. MAIN FINDINGS: Four major themes emerged from the focus group discussions. Family physicians 1) were minimally aware of the existence and the detailed contents of the CCCD guidelines; 2) had strong views about the purposes of guidelines in general; 3) expressed strong concerns about the role of the pharmaceutical industry in the development of such guidelines; and 4) had many ideas to improve future dementia guidelines and CPGs in general. CONCLUSION: Family physicians were minimally aware of the 1999 CCCD CPGs. They acknowledged, however, the potential of future CPGs to assist them in patient care and offered many strategies to improve the development and dissemination of future dementia guidelines. Future guidelines should more accurately reflect the day-to-day practice experiences and challenges of family physicians, and guideline developers should also be cognizant of family physicians' perceptions that pharmaceutical companies' funding of CPGs undermines the objectivity and credibility of those guidelines.

101. Reuben, D., Levin, J., Frank, J., Hirsch, S., McCreath, H., Roth, C., & Wenger, N. (2009). **Closing the dementia care gap: Can referral to alzheimer's association chapters help?** *Alzheimer's & Dementia*, 5(6), 498-502. The quality of care provided by primary-care physicians for patients with dementia remains poor, in part because physicians do not provide counseling and education. Local Alzheimer's Association chapters have the potential to improve the quality of care provided for dementia, but are hampered by a lack of referrals from primary-care physicians. Many physicians remain unaware of the services available through Alzheimer's Association chapters, but recognize the need to provide support to families, ensure patient safety, and manage behavioral problems. At present, systems to promote referrals and communication with local chapters are lacking. Practice redesign may facilitate linkages between practices and Alzheimer's Association chapters. However, if these linkages are to be adopted and sustained, they must demonstrate a relative advantage to physicians beyond the care they currently provide, and must be compatible with how care is currently delivered in their practices. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

102. Robinson, A., Emden, C., Lea, E., Elder, J., Turner, P., & Vickers, J. (2009). **Information issues for providers of services to people with dementia living in the community in australia: Breaking the cycle of frustration.** *Health & Social Care in the Community*, 17(2), 141-150. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18800981>

The rising prevalence of dementia and concomitant demands upon dementia services are global issues. In Australia, dementia has attained national health priority status and governments at all levels have implemented service strategies to help manage the complex lives of people with dementia. Despite recognition that information is pivotal to

effective dementia service delivery, little is known about the information needs of individual providers and the processes used to transfer information between providers. This qualitative study scoped information issues for key service providers for people with dementia living in the community in southern Tasmania, Australia, including information needs, availability, and transfer. Eleven focus groups were held with general practitioners, residential aged care facility staff, home carers, community health nurses, and aged care-assessment team members. Findings revealed that provider groups shared common, albeit unbeknown to them, information needs (e.g. diagnosis, behaviours, and services) and information concerns (e.g. untrustworthy information and poor information transfer) leading to poor service coordination. General practitioners emerged as a stand-out group with markedly fewer needs and concerns than other providers, a finding of special interest given their pivotal role in dementia diagnosis and referral. Participants were adamant in their view that electronic data bases and single points of entry to dementia services would improve service provision and should be developed. The research highlights complexities and associated frustrations of information transferability, accessibility, and trustworthiness for dementia service providers in the community. Increased understanding of providers' diverse yet interdependent roles could, we believe, play an important part in breaking the cycle of frustration experienced by all participants and thus contribute to system reform.

103. Sakurai, T., Taniguchi, H., Nambu, S., Tokuda, M., Makibayashi, T., Yokono, K., & Endo, H. (2009). **Education of lifestyle risk factors associated with dementia likely to help primary care physicians to improve consultation for elderly people with dementia.** *Journal of the American Geriatrics Society*, 57(12), 2358-2361. doi:10.1111/j.1532-5415.2009.02576.x

104. Schmidt, K. L., Lingler, J. H., & Schulz, R. (2009). **Verbal communication among alzheimer's disease patients, their caregivers, and primary care physicians during primary care office visits.** *Patient Education & Counseling*, 77(2), 197-201. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19395224>

OBJECTIVE: Primary care visits of patients with Alzheimer's disease (AD) often involve communication among patients, family caregivers, and primary care physicians (PCPs). The objective of this study was to understand the nature of each individual's verbal participation in these triadic interactions. **METHODS:** To define the verbal communication dynamics of AD care triads, we compared verbal participation (percent of total visit speech) by each participant in patient/caregiver/PCP triads. Twenty-three triads were audio taped during a routine primary care visit. Rates of verbal participation were described and effects of patient cognitive status (MMSE score, verbal fluency) on verbal participation were assessed. **RESULTS:** PCP verbal participation was highest at 53% of total visit speech, followed by caregivers (31%) and patients (16%). Patient cognitive measures were related to patient and caregiver verbal participation, but not to PCP participation. Caregiver satisfaction with interpersonal treatment by PCP was positively related to caregiver's own verbal participation. **CONCLUSION:** Caregivers of AD patients and PCPs maintain active, coordinated verbal participation in primary care visits

while patients participate less. PRACTICE IMPLICATIONS: Encouraging verbal participation by AD patients and their caregivers may increase the AD patient's active role and caregiver satisfaction with primary care visits.

105. Schoenmakers, B., Buntinx, F., & Delepeleire, J. (2009). **What is the role of the general practitioner towards the family caregiver of a community-dwelling demented relative? A systematic literature review.** *Scandinavian Journal of Primary Health Care*, 27(1), 31-40. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19040191>

OBJECTIVE: To identify the attitudes and perspectives of the family physician towards the caregivers of demented relatives and to describe the caregivers' satisfaction. DESIGN: Systematic review. SUBJECTS: The studied population consisted of dementia family and their general practitioners. MAIN OUTCOME MEASURES: Outcome measures were the generic tasks and skills of the general practitioner to improve home care from the perspective of the family caregiver. Caregivers were assessed on satisfaction regarding the care provided by their general practitioner. RESULTS: The general practitioner is aware of his/her skills and limits in all aspects of dementia care and his/her role towards the family caregiver. They also acknowledged the importance of an adequate diagnostic process, but they felt uncomfortable disclosing the diagnosis to both the patient and the caregiver. They reported having more confidence in treatment matters than in diagnostic stages. Caregivers' reports on the attitude of their general practitioner in the diagnostic process were rated from helpful to poorly empathized. General practitioners found themselves to be highly involved in dementia home care, but caregivers rated their involvement to be insufficient. The lack of appropriate communication skills of general practitioners was also not appreciated by the caregivers. A lack of time and reward was considered by the general practitioner to be a major obstacle in dementia care. CONCLUSION: The key role of general practitioners as care providers and care planners is consolidated by the family caregivers' confidence in their skills. Clear guidelines from early diagnosis to adequate referrals should improve the ability of the general practitioner to support these time and energy-consuming home-care situations. Intervention studies addressing the gaps in the skills of the general practitioners in dementia home care management could be helpful in supporting the family caregiver. [References: 42]

106. Travers, C., Martin-Khan, M., & Lie, D. (2009). **Barriers and enablers of health promotion, prevention and early intervention in primary care: Evidence to inform the Australian national dementia strategy.** *Australasian Journal on Ageing*, 28(2), 51-57. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19566797>

A comprehensive literature review was undertaken to: (i) identify and summarise the research evidence regarding barriers and enablers of health promotion, prevention and early intervention (PPEI) in primary care to reduce the risk of chronic disease in the older population; and (ii) use this evidence to make recommendations to inform the Australian national dementia prevention strategy around the translation of evidence-based care into practice. PPEI activities in primary care have the potential to not only reduce the

prevalence and impact of a number of chronic diseases, but may also prevent or slow the onset of dementia given the apparent overlap in risk factors. While sizeable gaps exist regarding the most effective ways to promote the adoption of these activities, limited evidence suggests that, to be effective, PPEI activities should be quick and easy to administer, have a sound rationale and be readily incorporated into existing work processes. [References: 30]

107. Tsolaki, M., Paraskevi, S., Degleris, N., & Karamavrou, S. (2009). **Attitudes and perceptions regarding alzheimer's disease in greece.** *American Journal of Alzheimer's Disease & Other Dementias*, 24(1), 21-26. The Facing Dementia Survey was conducted across Europe to assess awareness and behaviors regarding Alzheimer's disease. A similar survey was undertaken in Greece. Interviews were conducted with the general public, primary caretakers, and physicians involved with Alzheimer's disease patients. Results indicated that the general public is not able to recognize the early symptoms of the disease and seek help resulting in a delay in the diagnosis. The principal cause was attributing the symptoms as part of the normal ageing process and ignorance regarding the disease. In addition, the survey indicated that only a small proportion of the physicians and the primary caretakers believed that there is an effective treatment for Alzheimer's disease but agreed on the goals of treatment. In addition there was a consensus among all respondents that the government should take a more active role as far as informing the public, supporting the caregivers, and treating the patients.

108. Waldorff, F. B., Siersma, V., Nielsen, B., Steenstrup, A. P., & Bro, F. (2009). **The effect of reminder letters on the uptake of an e-learning programme on dementia: A randomized trial in general practice.** *Family Practice*, 26(6), 466-471. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19858123>

BACKGROUND AND AIMS: The aim of the present study was to evaluate whether three reminder letters mailed to GPs after dissemination of a Dementia Guideline increased the GPs' use of the corresponding e-learning programme (ELP). METHODS: Single-blinded randomized trial among all GPs in Copenhagen Municipality from 1 November 2006 to 1 May 2007. RESULTS: A total of 15 of 320 GPs (4.7%) had a web-based logon during the study period. The intervention group had a significantly increased frequency of web-based logons ($P = 0.0192$) equivalent to a hazard ratio of 8.0 (95% CI: 1.03-66.1; $P = 0.047$). NNT was calculated to 22.2. We could not detect any significant differences in any of the secondary outcomes. CONCLUSIONS: Three reminder letters added to a nation-wide dissemination increased the probability for a GP logon in the ELP by a Factor 8. However, in total, only a small proportion used the ELP. Thus, further research is needed in order to consider future implementation strategies for Internet-based Continuous Medical Education activities among not primed GPs.

109. Wijeratne, C., & Harris, P. (2009). **Late life depression and dementia: A mental health literacy survey of australian general practitioners.** *International Psychogeriatrics*, 21(2), 330-337.

BACKGROUND: Whilst previous surveys of mental health literacy of general practitioners (GPs) have shown high rates of recognition of common mental disorders, few studies have been carried out into GPs' understanding of presentations in late life. This study aims to determine GPs' recognition of mental disorders in older people, their intentions regarding investigation, specialist referral and treatment, and their beliefs about prognosis. **METHODS:** Australian GPs who attended an educational seminar were administered questions based on clinical vignettes describing older people with depression, dementia and coronary heart disease. **RESULTS:** There was a high rate of recognition of all disorders amongst the 436 respondents. GPs demonstrated a high level of consistency about screening questionnaires, investigations and specialist referral in the dementia vignette. In contrast, less than half of GPs endorsed using a screening questionnaire or neuroimaging, and considered referral to a variety of medical specialties in the depression vignette. For both the depression and dementia vignettes, self-help treatments like walking, dietary advice or alcohol reduction were endorsed more frequently than an antidepressant or cholinesterase inhibitor respectively. Dementia tended to be viewed as having a poor prognosis, and late-life depression a moderate prognosis. **CONCLUSIONS:** Actual or intended rates of diagnostic recognition, specialist referral and benzodiazepine prescription found in this study may not translate into clinical practice for a number of reasons. Non-specific treatments without a clear evidence base were considered as often as those with a stronger evidence base. There is a need to improve the knowledge of GPs with regard to screening and investigating late life depression and managing dementia.

110. Wilcock, J., Iliffe, S., Turner, S., Bryans, M., O'Carroll, R., Keady, J., . . . Downs, M. (2009). **Concordance with clinical practice guidelines for dementia in general practice.** *Aging & Mental Health, 13*(2), 155-161. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19347682>

BACKGROUND: Dementia is said to be under-recognized and sub-optimally managed in primary care, but there is little information about actual processes of diagnosis and clinical care. **AIM:** To determine general practitioners' concordance with clinical guidelines on the diagnosis and management of patients with dementia. **Design:** Unblinded, cluster randomized pre-test-post-test controlled trial involving 35 practices in the UK. **METHODS:** Patients with a diagnosis of probable or confirmed dementia were identified in practices, and permission sought from the older person and/or their carer to study the medical records of these patients. Medical records were reviewed using a data extraction tool designed for the study and based on published guidelines, and unweighted scores for diagnostic concordance and management concordance were calculated. **RESULTS:** We reviewed 450 records of patients aged 75 and over with a diagnosis of dementia and found that: only 4% of cases were identified first in secondary care; two-thirds of those identified in primary care were referred immediately; about one-third identified had informant history and blood tests documented at the Index consultation and one-fifth underwent cognitive function testing. **DISCUSSION:** The records analysed in this study came from a period before the Quality Outcomes Framework and show that the documentation in primary care of the diagnostic process in dementia syndromes is good,

although there were significant gaps, particularly around depression case-finding. Information about management processes were less evident in the records.

111. **Overcoming barriers to early dementia diagnosis.** (2008). *Lancet*, 371(9628), 1888. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18539203>

112. Alexander, C., & Fraser, J. (2008). **General practitioners' management of patients with mental health conditions: The views of general practitioners working in rural northwestern new south wales.** *The Australian Journal of Rural Health*, 16(6), 363-369.

Objective: To identify the needs of the region's general practitioners concerning diagnosing, treating and referring patients with mental health disorders and major barriers to the general practitioners' management of these patients. Design: Cross-sectional survey. Subjects: All general practitioners working in rural north-western New South Wales. Measurements: Self-assessed levels of confidence (5- point Likert scale) in diagnosing and treating patients with a mental health condition. Practice data relating to presentation of such patients as well as issues affecting treatment and referral. Results: The three most commonly diagnosed and treated mental health conditions are depression, anxiety and dementia. General practitioners assessed themselves as being confident in diagnosing and treating these three mental health conditions and in diagnosing and treating adults and the elderly. The only form of treatment intervention that the general practitioners self-assessed as being confident in relates to medication. Referrals to mental health specialists were due mostly to patients needing mental health counselling, the general practitioners seeking clarification of diagnosis as well as having insufficient skills to provide the best possible care. Barriers to being able to refer relate mainly to specialist services not being available and/or accessible as well as patients being reluctant to accept such a referral. Conclusion: Our results indicate that other than for depression, anxiety and dementia, efforts to improve the general practitioners' diagnostic and treatment skills and to diagnose and treat adolescents and children are warranted. Up-skilling the general practitioners' ability to confidently use treatment options other than medication are worth considering. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

113. Andersen, A., Silvius, J., Slaughter, S., Dalziel, W., & Drummond, N. (2008). **Lay and professional expectations of cholinesterase inhibitor treatment in the early stage of alzheimer's disease.** *Dementia*, 7(4), 545-558. Identified, compared, and contrasted the expectations of key stakeholders regarding cholinesterase inhibitor (CI) treatments prescribed to people with Alzheimer's disease (AD) in Canada. Four older women diagnosed with early stage AD, their lay caregivers, their professional health care providers, and pharmacists and policy makers participated in semi-structured interviews designed to elicit accounts of expectations of CI in relation to diagnosis and treatment for AD. Although the policy makers and physicians harbored more skeptical or negative expectations, the majority of stakeholders expected that people diagnosed with AD would reap beneficial effects through the use of CI. Findings indicate

there is still controversy about the use of CI, particularly in terms of their cost-effectiveness. A clear and ethical argument exists in support of attempts to both modify unrealistic patient expectations where they exist, and to enhance the knowledge base of prescribers. Greater concordance between physicians', patients', and caregivers' treatment goals, and appropriate prescription of these agents in line with available research, will require more complete patient and caregiver information on the one hand, and potentially a shift in emphasis to more individualized, clinically focused outcomes on the other. (LC) (AgeLine Database, copyright 2008 EBSCO Publishing, Inc., all rights reserved)

114. Arlt, S., Hornung, J., Eichenlaub, M., Jahn, H., Bullinger, M., & Petersen, C. (2008). **Patient with dementia, the caregiver and the doctor: Cognition, depression and quality of life from three perspectives.** *International Journal of Geriatric Psychiatry*, 23(6), 604-610. Examined how the ratings of patients with dementia, their caregivers, and their clinicians related to each other regarding the patients' cognitive impairment, depression, and health-related quality of life (HRQoL). Participants were 100 outpatients aged 48-92 (mean age 70.49) in Germany with mild to moderate dementia or mild cognitive impairment (MCI) and their family caregivers. Depression and cognitive impairment were examined with self- and proxy ratings (Geriatric Depression Scale, communication and memory subscales of the Stroke Impact Scale) as well as with the MMSE; HRQoL was assessed with the SF-12 Health Survey and the EUROHIS quality of life index. High correspondence was found between caregivers' assessments of cognitive function and MMSE scores, while patients' self-ratings did not correlate with MMSE scores. HRQoL was underestimated by caregivers compared with self ratings. Concerning depression, the patients' assessments were in good accordance with the clinicians' evaluations. The results suggest that patients with mild to moderate dementia or MCI are important informants of their HRQoL and depressive symptoms, but they underestimate their cognitive deficits. (KM) (AgeLine Database, copyright 2008 EBSCO Publishing, Inc., all rights reserved)

115. Cahill, S., Clark, M., O'Connell, H., Lawlor, B., Coen, R. F., & Walsh, C. (2008). **The attitudes and practices of general practitioners regarding dementia diagnosis in ireland.** *International Journal of Geriatric Psychiatry*, 23(7), 663-669. BACKGROUND: The diagnosis of dementia poses difficulties for general practitioners (GPs) particularly when access to specialist diagnostic services is delayed. Ireland is soon to witness an increase in numbers of people presenting with dementia, yet little is known about the service needs of GPs when attempting to diagnose dementia. OBJECTIVES: To detail the service needs of GPs, especially their training needs, access to diagnostic resources such as CT and MRI brain scans and access to specialist services such as Old Age Psychiatry (OAP), Geriatric Medicine (GM) and Neuropsychology (NP). METHODS: The paper is based on survey data collected from a sample of GPs (n = 300) registered with the Irish College of General Practitioners (ICGP) and on qualitative data collected from a Focus Group (n = 7). RESULTS: GPs were more likely to blame themselves than either the health care system, their patients or family members for the late presentation of dementia in primary care. Stigma was a major obstacle preventing GPs from being more proactive in this area. Rural GPs felt geographically disadvantaged

accessing diagnostic services and both rural and urban GPs experienced considerable time delays accessing specialist diagnostic services. **CONCLUSIONS:** Findings provide compelling evidence that training and access to diagnostic services are only two of several different structural and ideological obstacles that GPs encounter when attempting to diagnose dementia. Future educational supports for GPs need to be developed which concentrate on these areas.

116. Chotirmall, S. H., Lee, G., Cosgrave, M., & Moore, A. (2008). **Optimisation of dementia management in irish primary care.** *International Journal of Geriatric Psychiatry*, 23(8), 880. Comment on an article by Cahill et al. (see record 2008-10365-001). We read with great interest the recent article by Cahill et al. that studied the attitudes and practices of general practitioners regarding a diagnosis of dementia in Ireland. Training and access to diagnostic services were highlighted correctly as major factors limiting the formulation of an earlier diagnosis in an excellent study. We believe through institutional experience that Irish General Practitioners (GPs) perform an equivalent assessment to hospital physicians but often remain reluctant to make and disclose a formal diagnosis of dementia. In conclusion, development of a rapid access memory clinic would be welcomed by Irish GPs. Interestingly, although Irish GPs appear armed with sound knowledge in the use of anti-dementia medications, few would commence them but nearly all would titrate their dosages confidently. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

117. Chow, T. W., Binder, C., Smyth, S., Cohen, S., & Robillard, A. (2008). **100 years after alzheimer: Contemporary neurology practice assessment of referrals for dementia.** *American Journal of Alzheimer's Disease & Other Dementias*, 23(6), 516-527. **BACKGROUND:** The prevalence of dementia is placing an increased burden on specialists. **METHODS:** Canadian neurologists responded to a structured questionnaire to assess reasons for referral and services provided as well as to compare the neurologists' perceptions of their practice characteristics against cases seen over a 3-month period. **RESULTS:** The audit confirmed the participants' perception that family practitioners are the main referral source (358/453, 79%). Sixty-two percent of patients had undergone clinical investigation for dementia prior to being seen by the neurologist; 39% (177/453) were on pharmacotherapy at the time of referral, 68% were initiated on pharmacotherapy by the neurologist. A fifth of the referrals did not meet clinical criteria for dementia, which may be directly related to the prevalence of prior workup that did not include mental status testing. **CONCLUSIONS:** Neurologists currently treat patients referred for dementia who may already have been adequately evaluated and treated by primary care providers.

118. Coley, N., Ousset, P. J., Andrieu, S., Matheix Fortunet, H., & Vellas, B. (2008). **Memory complaints to the general practitioner: Data from the GuidAge study.** *Journal of Nutrition, Health & Aging*, 12(1), 66S-72S. Memory complaints are relatively common in elderly people, although they are not always reported to the general practitioner (GP). These subjective complaints do not necessarily correlate with objective measures of memory impairment or cognitive

performance, but they may be an early indication of impairment at a state that is undetectable by standard testing instruments. Memory complaints may also predict future cognitive decline. The GuidAge study is a secondary prevention trial for Alzheimer's disease involving non-demented individuals aged 70 years or older having spontaneously complained of memory problems to their GP. More than half of participants had a Clinical Dementia Rating score of 0.5 at baseline. The percentage of participants reporting problems on the McNair and Kahn scale varied from 6.2% to 78.6% per item. Certain specific memory complaints may be more related than others to the beginning of the neurodegenerative process, and could predict future cognitive decline. The importance of memory complaints should not be underestimated in clinical practice.

119. Culverwell, A., Milne, A., Guss, R., & Tuppen, J. (2008). **Screening for dementia in primary care: How is it measuring up?** *Quality in Ageing*, 9(3), 39-44. Despite evidence that early identification of dementia is of growing policy and practice significance in the UK, limited work has been done on evaluating screening measures for use in primary care. The aim of this paper is to offer a clinically informed synthesis of research and practice-based evidence on the utility, efficacy and quality of dementia screening measures. The study has three elements: a review of research literature; a small-scale survey of measures employed in three primary care trusts; and a systematic clinical evaluation of the most commonly used screening instruments. The authors integrated data from research and clinical sources. The General Practitioner Assessment of Cognition (GPCOG), Memory Impairment Screen (MIS) and Mini-Cognitive Assessment Instrument (Mini-Cog) were found to be: brief; easy to administer; clinically acceptable; effective; minimally affected by education, gender, and ethnicity; and to have psychometric properties similar to the Mini Mental State Examination (MMSE). Although the MMSE is widely used in the UK, this project identifies the GPCOG, MIS and Mini-Cog as more appropriate for routine use in primary care. A coherent review of evidence coupled with an in-depth evaluation of screening instruments has the potential to enhance ability and commitment to early intervention in primary care and, as part of a wider educational strategy, improve the quality and consistency of dementia screening.

120. De Lepeleire, J., Wind, A. W., Iliffe, S., MonizCook, E. D., Wilcock, J., Gonzalez, V. M., . . . Interdem Group. (2008). **The primary care diagnosis of dementia in europe: An analysis using multidisciplinary, multinational expert groups.** *Aging & Mental Health*, 12(5), 568-576. Objectives: To explore the extent of variation in the detection of dementia in primary care across Europe, and the potential for the development of European guidelines. Method: A mixture of focus group and adapted nominal group methods involving 23 experts of different disciplines and from eight European countries. Results: The diagnosis of dementia should be 'timely' rather than 'early'. Timeliness has an impact on the patient, on the caregiver, on healthcare professionals, and on society. Ethical and moral issues may interfere with the aim of timely diagnosis. Guidelines may be important for facilitating a timely diagnosis of dementia, but were infrequently used and not even available in three of the eight countries. Referral pathways often depended on health care system characteristics, differing throughout the eight European countries, whilst diagnostic strategies differed due to varied cultural influences. There was consensus that national

variations can be reduced and timely diagnosis enhanced by combining simple tests using a systematic stepwise case-finding strategy, in conjunction with a strong infrastructure of multidisciplinary collaboration. Conclusions: This study identified three key themes that should be considered in harmonizing European approaches to the diagnosis of dementia in primary care: (1) a focus on timely diagnosis, (2) the need for the development and implementation of guidelines, and (3) the identification of appropriate referral pathways and diagnostic strategies including multi-professional collaboration. The content of guidelines may be determined by the perspectives of the guideline developers. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

121. Feldman, S. (2008). **The referral dance: Improving the interface between primary care practitioners and specialists.** *American Journal of Alzheimer's Disease & Other Dementias*, 23(6), 513-515.

122. Gonzalez-Moneo, M., Simo, M., Pie, M., & Rivero, D. (2008). **Preferences of general practitioners and carers of alzheimer patients regarding the use of neuroleptics for behavioural disorders in alzheimer's disease.** *International Journal of Geriatric Psychiatry*, 23(10), 1095-1097. Examined the preferences of general practitioners (GPs) and caregivers of persons with Alzheimer's disease (AD) regarding the use of neuroleptics for behavioral disorders. Two focus groups--1 with 8 physicians, the other with 8 caregivers--were held in 2 urban health centers in Barcelona, Spain. The doctors varied in gender (7 women), age, experience with dementia patients and their families, clinical shifts, and research interests. Five caregivers were women, 5 were spouses, and 3 were daughters. The semistructured interview involved emotional impact of the problem, feelings generated, management strategies, perceptions about management skills, and training needs. Results show that some nonclinical elements influence the prescription of neuroleptics, such as the feelings the symptoms provoke in both physicians and caregivers. Quality of life and negative feelings were the main areas related to behavioral disorders and the use of neuroleptics. Both groups consider the risk of treatment with neuroleptics acceptable because of the poor quality of life the behavioral disorders cause in the patient and, for the physicians, in the caregivers. (SW) (AgeLine Database, copyright 2008 EBSCO Publishing, Inc., all rights reserved)

123. Hansen, E. C., Hughes, C., Routley, G., & Robinson, A. L. (2008). **General practitioners' experiences and understandings of diagnosing dementia: Factors impacting on early diagnosis.** *Social Science & Medicine*, 67(11), 1776-1783. This article reports findings from three linked qualitative research projects that explored how Australian general practitioners (GPs) spoke about their experiences in diagnosing dementia and their views on early diagnosis and barriers towards early diagnosis. The authors conducted this research with the aim of elucidating the GP perspective and using this to better understand the process of diagnosing dementia and delays in diagnosing dementia. Twenty-four GPs based in Australia participated in the study (eleven females and thirteen males). Six of these GPs worked in rural practices, eight in a large town and the remainder in urban practices in a capital city. The major themes in GPs' accounts of the diagnosis of dementia could be grouped under the headings of 'recognizing dementia',

'holistic viewpoint', 'family members and patients' and 'medication'. Key findings are that dementia is a complex condition that takes time to diagnose. Diagnosis may involve conflict between GPs, family members/carers and the person with dementia (PWD). GPs did not consider that diagnosing dementia early was particularly important and may in fact be harmful to some patients. They are skeptical about the advantages of dementia medications. GPs assess the need for a formal diagnosis of dementia within the broader context of their older patients' lives. They are more likely to pursue a formal diagnosis in situations where they see it leading to benefits for their patient such as accessing dementia specific services. Increasing the availability of support services for PWD and educating GPs about the benefits of a formal diagnosis of dementia for stakeholders other than PWD, for example family members and carers may increase the likelihood that they will diagnose dementia early.

124. Helmer, C., Peres, K., Pariente, A., Pasquier, F., Auriacombe, S., Poncet, M., . . . Dartigues, J. -. (2008). **Primary and secondary care consultations in elderly demented individuals in france: Results from the three-city study.** *Dementia and Geriatric Cognitive Disorders*, 26(5), 407-415. doi:<http://dx.doi.org/10.1159/000164692>
Background/Aims: Our purpose was to analyze consultations with primary- and secondary-care physicians by demented people and identify factors that hamper or facilitate consultation. Methods: In total, 498 demented subjects were evaluated within the Three-City Study, a population-based cohort of individuals aged ≥ 65 years. Primary- and secondary-care consultations (consultation with a specialist and/or treatment with anti-dementia drugs) were assessed by a neurologist or geriatrician. Results: Thirty-five percent of the demented subjects did not seek advice for their cognitive problems and only 31% consulted a specialist. Consultation for primary care was principally dependent on the subjects' own awareness of the cognitive disorder and on their age. Factors associated with consultation for secondary care were younger age, higher education level, higher instrumental activities of daily living disability and awareness of the cognitive disorder by the subject, all of which predicted more frequent consultation. The level of cognitive performance had only a slight influence on primary care and none on secondary care. Conclusion: The failure to see a physician due to dementia, especially secondary-care practitioners, is frequent in the community, particularly in the oldest subjects. Copyright 2008 S. Karger AG.

125. Jedenius, E., Wimo, A., Stromqvist, J., & Andreasen, N. (2008). **A swedish programme for dementia diagnostics in primary healthcare.** *Scandinavian Journal of Primary Health Care*, 26(4), 235-240. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18788054>

OBJECTIVE: To meet diagnostic needs of dementia, a new care programme was implemented in the county of Kalmar, Sweden. The objective of the study was to analyse whether the programme could identify and diagnose the estimated number of new cases. METHODS: A long-term follow up study on all new patients referred to primary and specialist care between 1999 and 2005 for dementia evaluation. RESULTS; Based on epidemiological data, 153 new cases per year were expected. Using the programme, an average of 127 cases was identified in primary healthcare and 22 at specialist level.

Although the number of false-negative cases is not known, it may be concluded that most of the new cases with dementia were identified. The proportion of cases identified doubled after implementing the programme. The programme was implemented within an unchanged budget. CONCLUSION: The programme may be of value for diagnosis and management of demented patients in primary healthcare.

126. Kada, S., Nygaard, H. A., Kada, R., Laura, T., Billsback, U., & Geitung, J. T. (2008). **Quality and general practitioner satisfaction with reply letters for dementia patients.** *Quality in Primary Care, 16(3), 165-170.* Objective: The exchange of information between specialists and general practitioners (GPs) is an important aspect of the referral process at the stage of diagnosis. Comprehensive and satisfactory information from specialists guides GPs in choosing the best possible management. The objective of this study was to assess the quality of information in reply letters with regard to the GPs' problem as presented, and the level of GP satisfaction, and to determine if there is any relation between the quality of the referrals and the reply letters. Design: A retrospective review of reply letters from the Department of Geriatric Medicine to primary health care. A data sheet was developed using the existing literature. Three GPs assessed the quality of the reply letters and GP satisfaction. Setting: Patient records in the geriatric department were collected, registered and examined according to pre-defined criteria. Subjects: A total of 135 first-time replies from January 2002 to December 2002 were evaluated. All patients and relatives were informed that participation was voluntary and anonymity was guaranteed. Main outcomes: Assessment of the quality of replies and GP satisfaction. Results: The mean age of all referred patients was 78.7 years (standard deviation (SD) 7.3, range: 42 to 90 years) and 61.5% were female. Multi-rater agreement analysis showed that 86% of the replies were classified as very good/good quality, 10% as fair, and 4% as poor quality. The mean agreement was 85% ([kappa] 0.37; 95% confidence interval (CI) 0.29-0.45; $P < 0.0001$); 89% of the replies were classified as very satisfactory/satisfactory, 9% as less satisfactory and 2% as unsatisfactory. The mean agreement was 86% ([kappa] 0.34; 95% CI 0.25-0.42; $P < 0.0001$). Conclusion: The reply letters were overall of good quality and GPs were generally satisfied with the reply letters. No association between the quality of referral and reply letters was found.

127. Kaduszkiewicz, H., Bachmann, C., & H. (2008). **Telling "the truth" in dementia-do attitude and approach of general practitioners and specialists differ?** *Patient Education & Counseling, 70(2), 220-226.* OBJECTIVE: The prevailing opinion in the literature that disclosing the diagnosis of dementia to patients is important is not always put into practice. The purpose of this study was to investigate differences between GPs and specialists (neurologists and psychiatrists) in the German ambulatory care system concerning the disclosure of the diagnosis of dementia. METHODS: Thirty in depth interviews with randomly selected GPs were conducted. On this basis a standardised questionnaire was developed and sent to 389 GPs and 239 neurologists and psychiatrists. RESULTS: The postal survey revealed only minor differences between GPs and specialists, both groups being equally in favour of a timely disclosure. For example, 70% of the GPs and 77% of the specialists strongly agreed that "patients with dementia should be informed early because of the possibility to

plan their lives". This positive attitude is pronounced among younger physicians, but is somewhat contradicted by difficulties in the communication with patients expressed in the interviews. In the interviews, what may be described as a "double taboo" emerges, in that GPs describe taboo topic areas related to dementia for them and for their patients. **CONCLUSION:** The postal survey shows the two professional groups to be very much in favour of a timely disclosure-an attitude that is pronounced among younger physicians. These findings can be interpreted as a recent change of attitudes regarding the disclosure of the diagnosis of dementia in the medical profession. **PRACTICE IMPLICATIONS:** Training opportunities are needed in order to overcome communication obstacles in the doctor-patient-communication about dementia.

128. Kaduszkiewicz, H., Wiese, B., & van den Bussche, H. (2008). **Self-reported competence, attitude and approach of physicians towards patients with dementia in ambulatory care: Results of a postal survey.** *BMC Health Services Research*, 8, 54. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18321394>

BACKGROUND: Caring for patients with dementia is a demanding task. Little is known as to whether physicians feel competent enough to perform this task or whether a lack of self-perceived competence influences attitudes and professional approach. Even less is known with respect to potential differences between general practitioners (GPs) and specialists. The purpose of this study was to investigate the interrelationship between the self-perceived competence, attitude and professional approach of physicians in ambulatory care in Germany. A further aim was to compare GPs and specialists with regard to differences in these areas. **METHODS:** A standardised postal survey was sent to 389 GPs and 239 neurologists and psychiatrists in six metropolitan areas in Germany. The 49-item questionnaire consisted of attitudinal statements to be rated on a Likert-type scale. Return rates were 54 percent for GPs and 40 percent for specialists. Statistical methods used to analyze data included correlation analysis, cluster analysis and ordinal regression analysis. **RESULTS:** No differences were found between GPs and specialists with regard to their general attitude towards caring for patients with dementia. Approximately 15 percent of both disciplines showed a clearly negative attitude. Self-reported competence was strongly associated with general attitude. In particular among GPs, and less so among specialists, a strong positive association was found between self-reported competence, general attitude and professional approach (e.g. early detection, active case finding and cooperation with caregivers). Differences between GPs and specialists were smaller than expected and appear to predominantly reflect task differences within the German health care system. **CONCLUSION:** Training opportunities which enable in particular GPs to enhance not only their competence but also their general attitude towards dementia care would appear to be beneficial and might carry positive consequences for patients and their caregivers.

129. Maeck, L., Haak, S., Knoblauch, A., & Stoppe, G. (2008). **Primary care physicians' attitudes related to cognition enhancers in early dementia: A representative eight-year follow-up study in lower saxony, germany.** *International Journal of Geriatric Psychiatry*, 23(4), 415-421.

OBJECTIVE: By means of a representative follow-up survey, we investigated changes in family physicians' (FPs) attitudes towards cognition enhancers in early dementia during 1993 and 2001. **METHODS:** One hundred and twenty-two FPs (response rate 71.8%) in Lower Saxony, Germany, were randomly assigned to one of two written case samples presenting a patient with cognitive decline suggestive of early Alzheimer's disease (DAT; case A: female patient vs case B: male patient). Using a structured face-to-face interview, they were asked to suggest their potential drug treatment. The results were compared to corresponding data from our previous survey in 1993. **RESULTS:** FPs' readiness to start antedementia drug treatment decreased from 70.4% in 1993 to 43.4% at follow-up, although underlying DAT was significantly more frequently suggested (11.0% vs 26.2%, $p < 0.05$). Substances with questionable efficacy such as Piracetame were prescribed less frequently in 2001 whereas evidence-based medication like cholinesterase inhibitors (ChEIs) failed to compensate for this drop. Compared to 1993, when 55.2% of FPs expected no therapeutic impact, at follow-up, 75.4% expected slowdown of disease progression, stabilisation or improvement of symptoms ($p < 0.05$). **CONCLUSIONS:** Our results demonstrate a significant decrease of therapeutic nihilism in primary care within eight years. However, in patients with suspicion of DAT, this is not reflected accordingly in potential treatment.

130. Maeck, L., Haak, S., Knoblauch, A., & Stoppe, G. (2008). **Dementia diagnostics in primary care: A representative 8-year follow-up study in lower saxony, germany.** *Dementia & Geriatric Cognitive Disorders*, 25(2), 127-134. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18087153>

AIM: To investigate whether primary-care physicians' competency regarding dementia diagnostics improved from 1993 to 2001. **METHODS:** In a representative follow-up survey 122 out of 170 (71.8%) family physicians (FPs) were randomly assigned to 2 written case samples presenting patients with slight memory impairment (case 1a: female vs. case 1b: male) and moderate dementia [vascular type (case 2a) vs. Alzheimer's disease (case 2b)]. Potential diagnostic workup was inquired by a structured face-to-face interview. **RESULTS:** 'Basic' diagnostics like history taking or laboratory investigations were considered in the first place. In case 1, neuropsychological screening was significantly more frequently considered at follow-up (19.3% in 1993 vs. 31.1% in 2001); it still would have been applied rarely in case 2 (2a: 14.1 vs. 14.8%; 2b: 23.5 vs. 24.6%). Neuroimaging remained not to be considered as a standard procedure, and only a minority of FPs would have performed a screening for depression (2001: 1a: 6.7%; 1b: 11.3%; 2a: 0.0%; 2b: 1.6%). **CONCLUSIONS:** With regard to dementia diagnostics in primary care, guideline adherence remained low at follow-up. Structured training efforts aiming at FPs appear to be necessary.

131. McAiney, C. A., Harvey, D., & Schulz, M. E. (2008). **First link: Strengthening primary care partnerships for dementia support.** *Canadian Journal of Community Mental Health*, 27(2), 117-127. While primary care faces many challenges, including an increasing prevalence of older individuals, emerging knowledge about the potential benefits of collaborative

partnerships has encouraged the development of new means of providing and supporting primary care. First Link™ is an innovative program involving collaborations among primary care providers, Alzheimer Societies, and other health professionals. The program aims to support persons with Alzheimer's and related diseases after the diagnosis is made and to link them with support services earlier in the disease course. This paper describes the First Link program, provides an overview of a study currently underway to evaluate it, and identifies some of the benefits and challenges associated with this partnership. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

132. Millard, F. (2008). **GP management of dementia--a consumer perspective.** *Australian Family Physician*, 37(1-2), 89-92. As the population ages, the general practitioner is likely to have an increasingly important role in diagnosing and managing dementia. Many people in the community dealing with dementia have little help until a diagnosis is made, and their experiences produce a profile of their met and unmet needs. A nondirected interview technique elicits a wide range of themes from individual life phenomena, with each person attributing their own meaning to events and experiences. Open ended discussion can produce unexpected information that is outside the experience of the researcher but relevant to the people being studied, reflecting the unique nature of each person's experience with dementia. Patients expect their GP to know about dementia and look to their GP for help with the disease, but these expectations may not always be matched by the doctor's knowledge about dementia or their perceived role in dementia care.

133. Millard, F. B., Thistlethwaite, J., Spagnolo, C., Kennedy, R. L., & Baune, B. T. (2008). **Dementia diagnosis: A pilot randomised controlled trial of education and IT audit to assess change in GP dementia documentation.** *Australian Journal of Primary Health*, 14(3), 141-149. This trial aimed to test whether education and audit can change documentation of dementia by general practitioners (GPs). We measured the number of new dementia diagnoses documented and Mini Mental State Examinations (MMSEs) performed following the interventions of education and audit, using electronic data for audit and outcomes. GPs in Mackay were randomly assigned to the interventions of either an educational workshop or education combined with audit of their documented dementia diagnoses and MMSE performed in electronic medical records. The results were compared with a control group of GPs in Townsville. Together with education, audit significantly improved documentation of dementia compared with education alone and a control group. We developed a data extraction tool for Medical Director (MD) software producing a report of dementia diagnoses, MSSE tests and practice population at risk of dementia. General practitioners participating in this project were likely to be motivated to learn about dementia. Education using Royal Australian College of General Practitioners' (RACGP) guidelines and audit using an IT extraction tool can improve computer documentation of dementia. Differences in practice software and past adverse experiences with new software were barriers to using our data extraction software for audit purposes.

134. Milne, A., Culverwell, A., Guss, R., Tuppen, J., & Whelton, R. (2008). **Screening for dementia in primary care: A review of the use, efficacy and quality of measures.** *International Psychogeriatrics*, 20(5), 911-926. Background: Despite evidence that early identification of dementia is of growing policy and practice significance in the U.K., limited work has been done on evaluating screening measures for use in primary care. The aim of this paper is to offer a clinically informed synthesis of research and practice-based evidence on the utility, efficacy and quality of dementia screening measures. Method: The study has three elements: a review of research literature, a small-scale survey of measures employed in three primary care trusts, and a systematic clinical evaluation of the most commonly used screening instruments. The study integrates data from research and clinical sources. Results: The General Practitioner Assessment of Cognition (GPCOG), the Memory Impairment Screen (MIS), and the Mini-Cognitive Assessment Instrument (Mini-Cog) were found to be brief, easy to administer, clinically acceptable, effective, and minimally affected by education, gender, and ethnicity. All three have psychometric properties similar to the Mini-mental State Examination (MMSE). Conclusions: Although the MMSE is widely used in the U.K., this project identifies the GPCOG, MIS and Mini-Cog as clinically and psychometrically robust and more appropriate for routine use in primary care. A coherent review of evidence coupled with an indepth evaluation of screening instruments has the potential to enhance ability and commitment to early intervention in primary care and, as part of a wider educational strategy, improve the quality and consistency of dementia screening. ABSTRACT FROM AUTHOR (Copyright of International Psychogeriatrics is the property of Cambridge University Press and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract.)

135. Perry, M., Draskovic, I., van Achterberg, T., Borm, G. F., van Eijken, M. I., Lucassen, P., . . . Olde Rikkert, M. G. (2008). **Can an EASYcare based dementia training programme improve diagnostic assessment and management of dementia by general practitioners and primary care nurses? the design of a randomised controlled trial.** *BMC Health Services Research*, 8, 71. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18384675>

BACKGROUND: Early diagnosis of dementia benefits both patient and caregiver. Nevertheless, dementia in primary care is currently under-diagnosed. Some educational interventions developed to improve dementia diagnosis and management were successful in increasing the number of dementia diagnoses and in changing attitudes and knowledge of health care staff. However, none of these interventions focussed on collaboration between GPs and nurses in dementia care. We developed an EASYcare-based Dementia Training Program (DTP) aimed at stimulating collaboration in dementia primary care. We expect this program to increase the number of cognitive assessments and dementia diagnoses and to improve attitudes and knowledge of GPs and nurses. METHODS: The DTP is a complex educational intervention that consists of two workshops, a coaching program, access to an internet forum, and a Computerized Clinical Decision Support

System on dementia diagnostics. One hundred duos of GPs and nurses will be recruited, from which 2/3 will be allocated to the intervention group and 1/3 to the control group. The effects of implementation of the DTP will be studied in a cluster-randomised controlled trial. Primary outcomes will be the number of cognitive assessments and dementia diagnoses in a period of 9 months following workshop participation. Secondary outcomes are measured on GP and nurse level: adherence to national guidelines for dementia, attitude, confidence and knowledge regarding dementia diagnosis and management; on patient level: number of emergency calls, visits and consultations and patient satisfaction; and on caregiver level: informal caregiver burden and satisfaction. Data will be collected from GPs' electronic medical records, self-registration forms and questionnaires. Statistical analysis will be performed using the MANOVA-method. Also, exploratory analyses will be performed, in order to gain insight into barriers and facilitators for implementation and the possible causal relations between the rate of success of the intervention components and the outcomes. **DISCUSSION:** We developed multifaceted dementia training programme. Novelty in this programme are the training in fixed collaborative duos and the inclusion of an individual coaching program. The intervention is designed according to international guidelines and educational standards. Exploratory analysis will reveal its successful elements. Selection bias and contamination may be threats to the reliability of future results of this trial. Nevertheless, the results of this trial may provide useful information for policy makers and developers of continuing medical education. **TRIAL REGISTRATION:** ClinicalTrials.gov ID NCT00459784.

136. Perry, M., Melis, R. J. F., Teerenstra, S., Draskovic, I., van Achterberg, T., van Eijken, M. I. J., . . . Rikkert, M. G. M. O. (2008). **In-home geriatric programme for vulnerable community-dwelling older people improves the detection of dementia in primary care.** *International Journal of Geriatric Psychiatry*, 23(12), 1312-1319. Investigated whether an in-home geriatric assessment and management program could improve the identification of dementia in vulnerable community-dwelling older adults. This secondary analysis used data from a randomized controlled trial in the Netherlands that studied the effects of the Dutch Geriatric Intervention Programme (DGIP) on functional ability and mental well-being compared with usual care. General practitioners (GPs) referred 151 vulnerable patients aged 70 and older with problems in cognition, nutrition, behavior, mood, or mobility to the DGIP. A geriatric nurse specialist administered the DGIP at baseline during a visit to the 85 patients (mean age 81.7) in the intervention group and made up to 6 follow-up visits during a maximum of 3 months; in addition, the nurse, GP, and a geriatrician had frequent consultations. The 66 patients (mean age 82.8) in the control group received usual care. The effect of the program on the dementia detection rate was determined by comparing the number of new dementia diagnoses in both study arms at 6-month follow-up. Of the 151 participants, 38 (25%) had a registered dementia diagnosis at baseline. During follow-up, 23 of 113 patients without a dementia diagnosis at baseline were diagnosed with dementia. The difference between the numbers of new dementia diagnoses in the intervention group (19 of 66 patients) and the control group (4 of 47 patients) was significant. The results demonstrated that the DGIP was successful in detecting dementia in a primary care population of vulnerable older adults in the Netherlands. (SW) (AgeLine Database, copyright 2008 EBSCO Publishing, Inc., all rights reserved)

137. Pezzotti, P., Scalmana, S., Mastromattei, A., Di Lallo, D., & Progetto Alzheimer Working, G. (2008). **The accuracy of the MMSE in detecting cognitive impairment when administered by general practitioners: A prospective observational study.** *BMC Family Practice*, 9, 29. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18477390>

BACKGROUND: The Mini-Mental State Examination (MMSE) has contributed to detecting cognitive impairment, yet few studies have evaluated its accuracy when used by general practitioners (GP) in an actual public-health setting. **OBJECTIVES:** We evaluated the accuracy of MMSE scores obtained by GPs by comparing them to scores obtained by Alzheimer's Evaluation Units (UVA). **METHODS:** The study was observational in design and involved 59 voluntary GPs who, after having undergone training, administered the MMSE to patients with symptoms of cognitive disturbances. Individuals who scored ≤ 24 (adjusted by age and educational level) were referred to Alzheimer's Evaluation Units (UVA) for diagnosis (including the MMSE). UVAs were unblinded to the MMSE score of the GP. To measure interrater agreement, the weighted Kappa statistic was calculated. To evaluate factors associated with the magnitude of the difference between paired scores, a linear regression model was applied. To quantify the accuracy in discriminating no cognitive impairment from any cognitive impairment and from Alzheimer's disease (AD), the ROC curves (AUC) were calculated. **RESULTS:** For the 317 patients, the mean score obtained by GPs was significantly lower (15.8 vs. 17.4 for the UVAs; $p < 0.01$). However, overall concordance was good (Kappa = 0.86). Only the diagnosis made by the UVA was associated with the difference between paired scores: the adjusted mean difference was 3.1 for no cognitive impairment and 3.8 for mild cognitive impairment. The AUC of the scores for GPs was 0.80 (95%CI: 0.75-0.86) for discriminating between no impairment and any impairment and 0.89 (95%CI: 0.84-0.94) for distinguishing patients with AD, though the UVA scores discriminated better. **CONCLUSION:** In a public-health setting involving patients with symptoms of cognitive disturbances, the MMSE used by the GPs was sufficiently accurate to detect patients with cognitive impairment, particularly those with dementia.

138. Qaseem A. Snow V. Cross JT Jr. Forciea MA. Hopkins R Jr. Shekelle P. Adelman A. Mehr D. Schellhase K. Campos-Outcalt D. Santaguida P. Owens DK. American College of Physicians/American Academy of Family Physicians Panel on Dementia. (2008). **Current pharmacologic treatment of dementia: A clinical practice guideline from the american college of physicians and the american academy of family physicians.** *Annals of Internal Medicine*, 148(5), 370-378. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18316755>

DESCRIPTION: The American College of Physicians and American Academy of Family Physicians developed this guideline to present the available evidence on current pharmacologic treatment of dementia. **METHODS:** The targeted literature search included evidence related to the effectiveness of 5 U.S. Food and Drug Administration-approved pharmacologic therapies for dementia for outcomes in the domains of cognition, global function, behavior/mood, and quality of life/activities of daily living. **RECOMMENDATION 1:** Clinicians should base the decision to initiate a trial of therapy

with a cholinesterase inhibitor or memantine on individualized assessment. (Grade: weak recommendation, moderate-quality evidence.) RECOMMENDATION 2: Clinicians should base the choice of pharmacologic agents on tolerability, adverse effect profile, ease of use, and cost of medication. The evidence is insufficient to compare the effectiveness of different pharmacologic agents for the treatment of dementia. (Grade: weak recommendation, low-quality evidence.) RECOMMENDATION 3: There is an urgent need for further research on the clinical effectiveness of pharmacologic management of dementia.

139. Robinson, A. L., Emden, C. G., Elder, J. A., Lea, E. J., Vickers, J. C., & Turner, P. A. (2008). **Multiple views reveal the complexity of dementia diagnosis.** *Australasian Journal on Ageing*, 27(4), 183-188. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=19032619>

OBJECTIVE: To reveal views about dementia diagnosis derived from a larger study of information needs of carers of people with dementia in Tasmania, Australia. **METHODS:** Over 100 participants, including family carers, health professionals and dementia service personnel, met as discrete focus groups. Data pertinent to dementia diagnosis were segregated and subjected to across-group comparative analysis. **RESULTS:** The term dementia held connotations of stigma and futility, despite stated benefits of having a diagnosis. General practitioners were regarded as pivotal but having inadequate diagnostic and treatment options. While most health professionals advocated a longitudinal diagnostic process, this created considerable stress for family carers who sought a speedy process. Without a diagnosis, some dementia-specific services were undeliverable. **CONCLUSION:** Dementia diagnosis is steeped in deep-rooted difficulties and stressful implications, compounded by carers' differing needs and interests. Better understanding between care providers of their conflicting and consistent views could contribute to better dementia care.

140. Rondeau, V., Allain, H., Bakchine, S., Bonet, P., Brudon, F., Chauplannaz, G., . . . Dartigues, J. F. (2008). **General practice-based intervention for suspecting and detecting dementia in france: A cluster randomized trial.** *Dementia (14713012)*, 7(4), 433-450.

The study evaluated the impact of a general practice-based intervention on 3021 patients in France aged 75 years and above with spontaneous memory complaints. The objective was to identify evocative signs of Alzheimer's disease through a cluster randomized controlled trial. The study involved 681 general practitioners (GPs), randomly selected and assigned to an intervention (n = 352) or a control group (n = 329), and 214 specialists. The intervention group participated in training sessions relating to dementia diagnosis and the use of brief neuropsychological tests suited to general practice. The control group dispensed usual general practitioner care. The primary outcome was suspicion of dementia by GPs. The secondary outcome was accurate detection of dementia by the GPs. Most patients (96%) were already followed by the GPs (mean follow-up duration 10.8 years, similar in both groups). Suspicion of dementia was two-fold higher for GPs in the intervention group (adjusted OR = 1.99, p < 0.0001). Probability of suspected dementia increased with patient age and decreased with educational level. However the positive

predictive value was not significantly different between the two groups (60.9% vs. 64.4%, $p = 0.41$). GPs from the intervention group also had a higher probability (adjusted OR = 2.24, $p = 0.01$) of correctly detecting demented patients (intervention did not increase the number of diagnosed cases of dementia, but increased the number of suspected cases that were later confirmed by specialists). The study showed that information on dementia and application of simple psychometric tests could improve the precision of a GP's diagnosis without changing the efficacy of detection of dementia.

141. Speechly, C. M., Bridges-Webb, C., & Passmore, E. (2008). **The pathway to dementia diagnosis.** *Medical Journal of Australia*, 189(9), 487-489. Objective: To describe the steps taken by health professionals to diagnose dementia and the timeframes for these steps, as reported by carers. Design, setting and participants: A cross-sectional, anonymous survey was mailed or distributed by Alzheimer's Australia New South Wales, six Sydney residential aged care facilities and 13 Sydney general practitioners to 415 carers or family members of patients with dementia between May and August 2007. Main outcome measures: First symptoms noticed and actions taken; time to first health professional consultation and diagnosis; reported actions of first health professional; satisfaction with first consultation; and use of dementia and chronic illness resources. Results: 209 surveys were returned. Family members noticed the first symptoms of dementia at a mean of 1.9 years before the first health professional consultation about dementia, and 3.1 years before a firm diagnosis. Resource use first occurred 2.8 years after the first symptoms. Most carers (72%) were satisfied with the first consultation, which was usually with a GP (84%). Two-thirds of carers (64%) reported that the first health professional had performed a memory test. Conclusions: Delays in presentation, diagnosis and resource use may have clinical and social implications for people with dementia and their families, in addition to the challenges of the process of obtaining a firm diagnosis.

142. Werner, P., & Giveon, S. M. (2008). **Discriminatory behavior of family physicians toward a person with alzheimer's disease.** *International Psychogeriatrics*, 20(4), 824-839. BACKGROUND: It has been anecdotally suggested that health care professionals have stigmatic beliefs about persons with Alzheimer's disease (AD). However, the nature and prevalence of those beliefs have yet to be elucidated. The aim of the present study is to examine stigma towards a person with AD among primary care physicians. METHODS: A nationally representative sample of 501 family physicians (54.1% female, mean age = 49, mean years in the profession = 21) were interviewed using a computer-assisted telephone interview and a structured questionnaire based on an expanded version of attribution theory. RESULTS: The findings showed that physicians' discriminatory behavior was especially high in the dimension of avoidance and coercion, but low in the dimension of segregation. Two central emotions (anger-fear and pity) were found to affect participants' tendency to discriminate, as were attributions of dangerousness. CONCLUSIONS: Addressing these factors may require targeted education of health professionals as well as the enforcement of anti-discrimination policies.

143. Wilson, L. R., & Kirby, N. H. (2008). **Individual differences in south australian general practitioners' knowledge, procedures and opinions of the assessment of older drivers.** *Australasian Journal on Ageing*, 27(3), 121-125. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18713171>

OBJECTIVE: Investigate individual differences in general practitioners' (GP) knowledge, procedures and opinions of older driver assessments. **METHODS:** Ninety-nine South Australian GPs completed a survey on their knowledge, procedures and opinions concerning fitness to drive assessments in older people. **RESULTS:** Most GPs were well informed about older driver legislation and used appropriate medical assessments when considering fitness to drive. However, there was much less consistency in the assessment of relevant cognitive abilities. Most GPs believed that there was a need for more transport and support services for older drivers when they ceased driving. Demographic and qualitative information helped explain some differences in both GPs' practice and opinions concerning the assessment of older drivers. **CONCLUSIONS:** Measures should ensure that GPs have accurate knowledge of legislation concerning older drivers; appropriate tests of driving-related cognitive abilities are available; and transport and support options for those older individuals who are no longer fit to drive are considered.

144. Yaffe, M. J., Orzeck, P., & Barylak, L. (2008). **Family physicians' perspectives on care of dementia patients and family caregivers.** *Canadian Family Physician*, 54(7), 1008-1015. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=18625826>

OBJECTIVE: To identify factors that facilitate or impede family physicians in ambulatory care of patients with dementia and the family caregivers of such patients. **DESIGN:** Explanatory qualitative analyses of focus group discussions. **SETTING:** Large, medium, and small urban; suburban; and rural family practices from various regions of the province of Quebec. **PARTICIPANTS:** Twenty-five family doctors whose practices had at least 75% ambulatory patients; of these patients, an estimated minimum of 20% were 65 years old or older and at least 2% suffered from dementia. **METHOD:** Physicians were recruited by telephone to be paid participants in their regions in focus groups studying aspects of dementia care in ambulatory settings. Grounded theory and constant comparative methods were used to explore data from 3 French-speaking focus groups and 1 English-speaking focus group. **MAIN FINDINGS:** Physicians were 72% male, had a mean of 21.3 years in practice, and spent about 87% of their professional time in office practice. An estimated 38.7% of their patients were 65 years old or older, and 5.6% of these patients had Alzheimer disease or related dementias. Physicians were comfortable caring for these patients and their family caregivers but thought much of this care should come from support services offered elsewhere. Physicians admitted they had little knowledge of these services and had little interest in acquiring information about them. Government-run, community-based health and social service centres were the "black boxes" to which they referred patients and their caregivers for any form of help. Inconsistencies in the services offered by these centres were noted. **CONCLUSION:** While family doctors are seeking a more seamless form of interdisciplinary dementia care,

a large amount of that care comes from support services about which physicians are not well informed and are not interested in learning.

145. Bamford, C., Eccles, M., Steen, N., & Robinson, L. (2007). **Can primary care record review facilitate earlier diagnosis of dementia?** *Family Practice*, 24(2), 108-116.

Background: There is concern over delayed diagnosis of dementia in primary care. Objective: To determine whether primary care record review can facilitate earlier diagnosis of dementia. Methods: Retrospective notes-based case--control study. Older people with dementia (cases) were identified through older age psychiatrists in the north-east of England. Age- and sex-matched controls were identified in primary care. Frequency and place of consultations, symptoms, presentation, tests and investigations, management, referrals and selected prescription data during the 5 years prior to the diagnosis of dementia were recorded. Results: Relevant symptoms, involvement of family members, unpredictable consulting patterns and problems with management were more likely to be recorded in the notes of cases than controls. Key variables predicting subsequent diagnosis of dementia included the absence of nurse and outpatient consultations and the presence of cognitive symptoms, consultations with primary care physicians and referral for clarification of diagnosis or management. Regression models were better at predicting cases (sensitivity = 80.2%) than controls (specificity = 69.8%). Applying the models to a typical primary care physician's list would result in the identification of 93 false positives in order to identify two new cases 18 months earlier than currently occurs. Conclusions: Differences in consultation patterns can be observed up to 4 years prior to formal diagnosis of dementia, indicating that primary care physicians are attending to possible signs of early dementia. However, it is not practicable to use the systematic review of primary care records to facilitate earlier diagnosis without identifying large numbers of false positives requiring investigation. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

146. Banerjee, S., Willis, R., Matthews, D., Contell, F., Chan, J., & Murray, J. (2007). **Improving the quality of care for mild to moderate dementia: An evaluation of the Croydon memory service model.** *International Journal of Geriatric Psychiatry*, 22(8), 782-788.

BACKGROUND: The large majority of people with dementia receive nothing in the way of specialist assessment and care at any stage of their illness. There is a particular lack of services focussed on early identification and intervention in dementia where there is the possibility of long-term harm reduction for people with dementia and their family carers. We have developed a model of care that is complementary to local systems of health and social care (The Croydon Memory Service Model [CMSM]). This is a low-cost, high-throughput, generic service to enable early identification and intervention in dementia. It is a multi-agency approach with joint ownership by health services, social services and the voluntary sector with embedded specifically-tailored approaches to primary care and minority ethnic communities. METHOD: We completed a service evaluation of the introduction of the CMSM in a single borough in South London. Six predefined service goals were set: high acceptability; high appropriate referral rate; successful engagement with people from minority ethnic groups; successful engagement with people with young

onset dementia; focus on engagement with mild cases to enable early intervention; and an increase in the overall number of new cases of dementia seen. Mixed qualitative and quantitative methodologies were used including a description and 6-month follow-up of a cohort of 290 consecutive referrals. **RESULTS:** All key predefined service goals were met: 95% acceptability; 94% appropriate referrals; successful engagement with minority ethnic groups (two-fold greater number compared with that expected from general population demographic data); 17% of referrals under 65 years of age; 68% referrals with mild or minimal dementia severity; and an estimated 63% increase in the number of new cases of dementia seen in Croydon. At 6-month follow up, those referred to the service had decreased behavioural disturbance and increased quality of life compared with baseline. **CONCLUSIONS:** Specific services for early dementia, which deliver diagnosis and care, can be established. These services can increase the numbers of people with early dementia identified and provided with care. Those receiving such services appear to improve in terms of quality of life and behavioural and psychological symptoms of dementia. Next steps should include the establishment of such services in other representative areas and evaluation of their effectiveness in comparison with other models of care.

147. Borson, S., Scanlan, J., Hummel, J., Gibbs, K., Lessig, M., & Zuhr, E. (2007). **Implementing routine cognitive screening of older adults in primary care: Process and impact on physician behavior.** *Journal of General Internal Medicine*, 22(6), 811-817. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=17447100>

BACKGROUND: Early detection of cognitive impairment is a goal of high-quality geriatric medical care, but new approaches are needed to reduce rates of missed cases. **OBJECTIVE:** To evaluate whether adding routine cognitive screening to primary care visits for older adults increases rates of dementia diagnosis, specialist referral, or prescribing of antidementia medications. **SETTING:** Four primary care clinics in a university-affiliated primary care network. **DESIGN:** A quality improvement screening project and quasiexperimental comparison of 2 intervention clinics and 2 control clinics. The Mini-Cog was administered by medical assistants to intervention clinic patients aged 65+ years. Rates of dementia diagnoses, referrals, and medication prescribing were tracked over time using computerized administrative data. **RESULTS:** Twenty-six medical assistants successfully screened 70% (n = 524) of all eligible patients who made at least 1 clinic visit during the intervention period; 18% screened positive. There were no complaints about workflow interruption. Relative to baseline rates and control clinics, Mini-Cog screening was associated with increased dementia diagnoses, specialist referrals, and prescribing of cognitive enhancing medications. Patients without previous dementia indicators who had a positive Mini-Cog were more likely than all other patients to receive a new dementia diagnosis, specialty referral, or cognitive enhancing medication. However, relevant physician action occurred in only 17% of screen-positive patients. Responses were most related to the lowest Mini-Cog score level (0/5) and advanced age. **CONCLUSION:** Mini-Cog screening by office staff is feasible in primary care practice and has measurable effects on physician behavior. However, new physician action relevant to dementia was likely to occur only when impairment was severe, and

additional efforts are needed to help primary care physicians follow up appropriately on information suggesting cognitive impairment in older patients.

148. Boustani, M., Sachs, G., & Callahan, C. M. (2007). **Can primary care meet the biopsychosocial needs of older adults with dementia?**. *Journal of General Internal Medicine*, 22(11), 1625-1627. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=17882498>

149. Boustani, M., Schubert, C., & Sennour, Y. (2007). **The challenge of supporting care for dementia in primary care.** *Clinical Interventions in Aging*, 2(4), 631-636.

Most patients with dementia receive care within primary care systems and have challenging medical and psychiatric issues. Their dementia related symptoms are often not recognized by the primary care system; they suffer from multiple chronic medical conditions; receive numerous psychotropic medications including anticholinergics; and display clinically relevant behavioral and psychological symptoms. Improving the care for such vulnerable patients demands supporting the primary care system with various resources, including dementia care managers, access to and coordination with interdisciplinary dementia specialists, and a feasible dementia screening and diagnosis process. Understanding primary care clinics as a complex adaptive system may enhance our capacity to deliver a flexible supportive process using the above crucial resources to adequately assess and effectively manage patients with dementia. Such a complex adaptive system process would have the best probability of surviving the unknowable future challenges that will face the primary care system. [References: 19]

150. Chodosh, J., Mittman, B. S., Connor, K. I., Vassar, S. D., Lee, M. L., DeMonte, R. W., . . . Vickrey, B. G. (2007). **Caring for patients with dementia: How good is the quality of care? results from three health systems.** *Journal of the American Geriatrics Society*, 55(8), 1260-1268. doi:<http://dx.doi.org/10.1111/j.1532-5415.2007.01249.x>
OBJECTIVES: To describe the quality of dementia care within one U.S. metropolitan area and to investigate associations between variations in quality and patient, caregiver, and health system characteristics. DESIGN: Observational, cross-sectional. SETTING AND PARTICIPANTS: Three hundred eighty-seven patient-caregiver pairs from three healthcare organizations MEASUREMENTS: Using caregiver surveys and medical record abstraction to assess 18 dementia care processes drawn from existing guidelines, the proportion adherent to each care process was calculated, as well as mean percentages of adherence aggregated within four care dimensions: assessment (6 processes), treatment (6 processes), education and support (3 processes), and safety (3 processes). For each dimension, associations between adherence and patient, caregiver, and health system characteristics were investigated using multivariable models. RESULTS: Adherence ranged from 9% to 79% for the 18 individual care processes; 11 processes had less than 40% adherence. Mean percentage adherence across the four care dimensions was 37% for assessment, 33% for treatment, 52% for education and support, and 21% for safety. Higher comorbidity was associated with greater adherence across all four dimensions, whereas greater caregiver knowledge (in particular, one item) was associated with higher

care quality in three of four care dimensions. For selected dimensions, greater adherence was also associated with greater dementia severity and with more geriatrics or neurologist visits. **CONCLUSION:** In general, dementia care quality has considerable room for improvement. Although greater comorbidity and dementia severity were associated with better quality, caregiver knowledge was the most consistent caregiver characteristic associated with better adherence. These findings offer opportunities for targeting low quality and suggest potential focused interventions. 2007, The American Geriatrics Society.

151. Dalsgaard, T., Kallerup, H., & Rosendal, M. (2007). **Outreach visits to improve dementia care in general practice: A qualitative study.** *International Journal for Quality in Health Care*, 19(5), 267-273. **BACKGROUND:** Outreach visits reflect newer developments in adult learning theory, where the learner is actively involved in the session. Previous studies have indicated a positive effect of outreach visits on GPs' behaviour. However, the empirical role of the facilitator in the visits is poorly described. **OBJECTIVE:** To explore general practitioners' perception of the outcome of a facilitator programme about dementia, in relation to central aspects of the facilitator's communicative role during the visits. **METHOD:** Observational studies, and focus group discussions with participating general practitioners (3 groups, 19 participants) as well as with facilitators (4 participants) in Vejle County, Denmark. **RESULTS:** Facilitators drew both on a 'factual' knowledge of dementia and a more 'experience-based' knowledge when conveying programme messages. They described themselves as 'carriers of experience'. All general practitioners described an outcome of the programme, and all wished to receive a future visit by a facilitator on new topics. The outcome was described not as ground-breaking medical news, but as practical effects in terms of knowledge of dementia, motivation for working with dementia, structured assessment and management of dementia and critical reflection of established practices regarding dementia. Some general practitioners remained critical as to whether this outcome justified the resources used in the programme. The experience-based dialogue was described as central to the outcome as it linked factual knowledge to clinical practice. **CONCLUSION:** This study confirms that outreach visits contribute to the integration of factual knowledge in clinical practice, but it also underscores the importance of addressing tacit communicative practices during facilitator visits and their implications for the outcome of the programme.

152. Fisher, C. A., & Lerner, A. J. (2007). **Frequency and diagnostic utility of cognitive test instrument use by GPs prior to memory clinic referral.** *Family Practice*, 24(5), 495-497. **BACKGROUND:** Previous studies have indicated not only that cases of dementia are missed in primary care but also that many non-demented patients are referred for evaluation to secondary care. **OBJECTIVES:** To measure frequency of cognitive test instrument use in primary care prior to patient referral to secondary care and to assess the relationship between instrument use and ultimate diagnosis. **METHODS:** This was a prospective study conducted in a Cognitive Function Clinic, Regional Neuroscience Centre setting. The referral letters for all patients seen in the clinic over a 2-year period (n = 231) were examined for mention of cognitive test instrument use. Patients were

evaluated by standard clinical, neuropsychological and neuroimaging methods and diagnoses were made according to widely accepted diagnostic criteria for dementia and dementia subtype. Primary care cognitive test use and final diagnosis were then compared. RESULTS: Evidence of cognitive test use in primary care was found in 20% of referrals. Patients evaluated with cognitive test instruments in primary care were more likely to receive a diagnosis of dementia, whereas those not tested were more likely to receive a diagnosis of 'not demented'. CONCLUSIONS: Use of simple cognitive test instruments in primary care may improve dementia diagnosis and reduce the rate of referral of non-demented patients.

153. Fortinsky, R. H. (2007). **Physicians' views on dementia care and prospects for improved clinical practice.** *Aging-Clinical & Experimental Research*, 19(5), 341-343.

154. Franz, C. E., Barker, J. C., Kravitz, R. L., Flores, Y., Krishnan, S., & Hinton, L. (2007). **Nonmedical influences on the use of cholinesterase inhibitors in dementia care.** *Alzheimer Disease and Associated Disorders*, 21(3), 241-248. Examined the attitudes of primary care physicians (PCPs) toward cholinesterase inhibitors (ChEIs) to better understand nonmedical factors influencing prescribing decisions in dementia care. A total of 40 PCPs aged 25-80 participated in interviews concerning their general approach to managing patients with dementia and their care for a particular dementia case. Physicians were predominantly ambivalent (51%) or negative (31%) about prescribing ChEIs for their patients with dementia; of the remaining physicians, 5% were positive and 13% expressed no opinion. The groups were not significantly different in any demographic except that all 5 female PCPs were rated as ambivalent. All physicians had at least some patients taking ChEIs. Nonmedical factors affecting prescribing included lack of knowledge, dependence on specialists, influence of family wishes and involvement, and physicians' values. PCPs reported that lack of knowledge and experience made prescribing decisions for ChEIs challenging. Some PCPs expressed lack of confidence, usually tied to lack of education or experience, in providing care for dementia patients. Physicians reported feeling pressured by families to prescribe ChEIs, and some physicians prescribed medications simply to be able to offer "something" to patients. (LC) (AgeLine Database, copyright 2008 EBSCO Publishing, Inc., all rights reserved)

155. Frisoni, G. B., Canu, E., Geroldi, C., Brignoli, B., Anglani, L., Galluzzi, S., . . . Zanetti, O. (2007). **Prescription patterns and efficacy of drugs for patients with dementia: Physicians' perspective in Italy.** *Aging-Clinical & Experimental Research*, 19(5), 349-355.

BACKGROUND AND AIMS: The aim of this study was to assess the prescription practices and judgment of efficacy of physicians of drugs used for the cognitive and non-cognitive symptoms of dementia. METHODS: Physicians from 88 Italian Alzheimer Evaluation Units were surveyed by means of a structured questionnaire assessing the proportion of patients with four different types of dementia prescribed with drugs for cognitive and non-cognitive symptoms, and physicians' perceived efficacy of cholinesterase inhibitors. The Units prescribed cholinesterase inhibitors for 73 patients

per year on average. RESULTS: Cholinesterase inhibitors are prescribed to 90% of patients with Alzheimer's disease (AD), 80% with with Lewy body dementia (LBD), and 35-45% with vascular dementia (VD) and frontotemporal lobar degeneration (FTLD). Selective serotonin uptake inhibitors (SSRIs) are prescribed for 28-45% of patients with all dementias except LBD (16%). Atypical neuroleptics were prescribed for 23-31% of patients, with no difference across types of dementia. Other drugs, such as ginkgo and nootropics, were prescribed less frequently, except in VD (20%). The perceived efficacy on cognitive and non-cognitive symptoms, assessed on a 0-to-10 ordinal scale, was highest in AD (4.3-6.1), intermediate in LBD (3.5-5.3) and VD (3.3- 4.7), and lowest in FTLD (2.0-2.7). CONCLUSIONS: The data indicate that, in specialized Italian centers, cholinesterase inhibitors and atypical neuroleptics are largely used in patients with AD and LBD, but the former are prescribed off-label to a remarkable proportion of patients with VD and FTLD. The efficacy of cholinesterase inhibitors is perceived to be highest in AD and poorest in FTLD. Perceived efficacy is affected more by whom is treated than by what is used.

156. George, S. M. (2007). *Physicians' reported beliefs about their role in the diagnosis and management of dementia of the alzheimer's type* UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI. This study investigated physicians' perceptions of their communication skills when managing patients with dementia. Ten physicians specializing in areas associated with family practice, gerontology, and neurology were interviewed, and their responses recorded auditorily, regarding various aspects of their interaction with persons with dementia and caregivers. Data from the interviews was transcribed verbatim by the author using conventions associated with clinical discourse analysis, and analyzed drawing on methods associated with both discursive psychology and clinical discourse analysis. Results indicated the physicians, while using different discursive styles to report their beliefs, showed similar viewpoints in their responses to questions about lack of communications training, difficulty in communication of bad news, awareness of the problems for caregivers of persons with dementia, difficulty in separating professional and personal identities in clinical interactions, and awareness that understanding and compassion needs to be used in the diagnosis and prognosis of dementia. (Author Abstract, used by permission) (AgeLine Database, copyright 2008 EBSCO Publishing, Inc., all rights reserved)

157. Gladman, J. R. F., Jones, R. G., Radford, K., Walker, E., & Rothera, I. (2007). **Person-centred dementia services are feasible, but can they be sustained?** *Age and Ageing*, 36(2), 171-176. doi:<http://dx.doi.org/10.1093/ageing/afl161> Background: We evaluated a specialist community-based dementia service to establish whether high quality care was being delivered and the conditions for doing so. The service was in an urban part of Rushcliffe Primary Care Trust, Nottinghamshire, United Kingdom. The service comprised an assessment team of an occupational therapist, a community psychiatric nurse and a community care officer, supported by 235 h per week of care delivered by a team of specially trained community care workers. Methods: A qualitative study was performed using non-participant observation, semi-structured interviews and focus groups, and analysed using a thematic framework approach. There

were 2 focus groups involving staff, 11 interviews of staff and stakeholders, and interviews of 15 carers of people with dementia. Results: The care provided was appreciated by carers, and the service was approved by staff and stakeholders. Care was delivered using a rehabilitative style that aimed to maintain personhood, rather than to promote independence. Clients were usually referred with the object of preventing unwanted admission to institutional care but, over time, moving into an institution ceased to be a uniformly undesirable outcome. The service's resources were reduced during the evaluation period, in part to meet mental health needs in intermediate care services. Conclusions: An appropriately resourced and constructed specialist service using an adaptive rehabilitation approach aimed at maintaining personhood can deliver good individualised care to people with dementia, but specific and appropriate commissioning for these services is needed to nurture them. 2007 Oxford University Press.

158. Hinton, L., Franz, C. E., Reddy, G., Flores, Y., Kravitz, R. L., & Barker, J. C. (2007). **Practice constraints, behavioral problems, and dementia care: Primary care physicians' perspectives.** *Journal of General Internal Medicine*, 22(11), 1487-1492. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=17823840>

OBJECTIVES: To examine how practice constraints contribute to barriers in the health care of persons with dementia and their families, particularly with respect to behavioral aspects of care. **DESIGN:** Cross-sectional qualitative interview study of primary care physicians. **SETTING:** Physicians' offices. **PARTICIPANTS:** Forty primary care physicians in Northern California. **MEASUREMENTS:** Open-ended interviews lasted 30-60 minutes and were structured by an interview guide covering clinician background and practice setting, clinical care of a particular patient, and general approach to managing patients with AD or dementia. Interviews were transcribed and themes reflecting constraints of practice were identified through a systematic coding process. **RESULTS:** Recurring themes (i.e., those present in > or = 25% of physician interviews) included insufficient time, difficulty in accessing and communicating with specialists, low reimbursement, poor connections with community social service agencies, and lack of interdisciplinary teams. Physician narratives suggest that these constraints may lead to delayed detection of behavior problems, "reactive" as opposed to proactive management of dementia, and increased reliance on pharmacological rather than psychosocial approaches. **CONCLUSION:** Physicians often feel challenged in caring for dementia patients, particularly those who are more behaviorally complex, because of time and reimbursement constraints as well as other perceived barriers. Our results suggest that more effective educational interventions (for families and physicians) and broader structural changes are needed to better meet the needs of the elderly with dementia and their families now and in the future. Without these changes, dementia care is likely to continue to fall short.

159. Holsinger, T., Deveau, J., Boustani, M., & Williams, J. W., Jr. (2007). **Does this patient have dementia?** *JAMA*, 297(21), 2391-2404. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=17551132>

CONTEXT: While as many as 5 million individuals in the United States have dementia, many others have memory complaints. Brief tests to screen for cognitive impairment could help guide dementia diagnosis. OBJECTIVE: To review the literature concerning the practicality and accuracy of brief cognitive screening instruments in primary care. DATA SOURCES: A search of MEDLINE (including data from AIDSLINE, BioethicsLine, and HealthSTAR) and psycINFO was conducted from January 2000 through April 2006 to update previous reviews. STUDY SELECTION: Studies of patients aged 60 years and older and use of an acceptable criterion standard to diagnose dementia were considered. DATA EXTRACTION: Studies were assessed by 2 independent reviewers for eligibility and quality. A third independent reviewer adjudicated disagreements. Data for likelihood ratios (LRs) were extracted. DATA SYNTHESIS: Twenty-nine studies using 25 different screening instruments met inclusion criteria; some studies evaluated several different instruments, thus, information could be examined for 38 unique instrument/study combinations. RESULTS: For the commonly used Mini-Mental State Examination, the median LR for a positive result was 6.3 (95% confidence interval [CI], 3.4-47.0) and the median LR for a negative result was 0.19 (95%CI, 0.06-0.37). Briefer approaches are available but have not been studied as frequently. Reports from an informant that the patient has memory loss yields an LR of 6.5 (95% CI, 4.4-9.6) for dementia. The Memory Impairment Screen takes 4 minutes to ask 4 items and has an LR for a positive result of 33 (95% CI, 15.0-72.0) and an LR for a negative result is 0.08 (95% CI, 0.02-0.3). Clock drawings are helpful in 1- to 3-minute forms, but must be scored appropriately and sensitivity to mild forms of impairment can be low. CONCLUSIONS: Clinicians should select 1 primary tool based on (1) the population receiving care; (2) an awareness of the effects of educational level, race, and age on scoring; and (3) consideration of adding 1 or 2 other tools for special situations as needed. [References: 132]

160. Jaglal, S., Cockerill, R., Lemieux-Charles, L., Chambers, L. W., Brazil, K., & Cohen, C. (2007). **Perceptions of the process of care among caregivers and care recipients in dementia care networks.** *American Journal of Alzheimer's Disease and Other Dementias*, 22(2), 103-111. Examined perceptions of the process of care among caregivers and care recipients in dementia care networks in Ontario, Canada. Data were obtained from 4 community-based, not-for-profit dementia care networks in regard to 267 caregiver-care recipient dyads (caregiver mean age 61.6, care recipient mean age 80.7), focusing on sociodemographic and health characteristics, type of support network, and amount of service use among care recipients and caregivers. The process-of-care constructs were: family physicians' awareness of services, experiences with health care workers, and assessment and placement activities. It was found that family physicians' understanding of dementia and their ability to work with the dyad to become aware of and accept services was an important component in the dyad's satisfaction. If caregivers received home support and the care recipients received emotional support from their social support network, they were more likely to be satisfied with their experiences with health care workers. The results suggest that increased awareness and provision of services were associated with more positive perceptions of network effectiveness. (MM) (AgeLine Database, copyright 2007 EBSCO Publishing, Inc., all rights reserved)

161. Jansen, A. P. D., van Hout, H. P. J., Nijpels, G., van Marwijk, H. W. J., de Vet, H. C. W., & Stalman, W. A. B. (2007). **Yield of a new method to detect cognitive impairment in general practice.** *International Journal of Geriatric Psychiatry*, 22(6), 590-597.

Compared 2 methods of identifying dementia: usual identification by general practitioners (GPs) and a 2-stage screening to identify patients with cognitive impairment (CI) who needed further examination. Both methods were implemented with the same 2,101 community-dwelling general practice patients aged 75 and older and 44 GPs in the Netherlands. The 2-stage method involved a postal questionnaire that included the short Informant Questionnaire on Cognitive Decline, followed by targeted cognitive assessments among high-risk persons. The 2-stage screening yielded 117 patients (5.6%) with CI who needed further examination; in most cases (82 people, 70.1%) their GP was unaware of the symptoms. Among patients identified by the screening, GPs' awareness was associated with comorbidity of chronic diseases (odds ratio [OR] 3.19), depressive symptoms (OR 0.41), and cognitive functioning (per point on the MMSE, OR 0.88). It is concluded that a 2-stage screening and increased alertness for CI and dementia among patients with depressive symptoms may improve the detection rate of dementia in general practice. (SW) (AgeLine Database, copyright 2007 EBSCO Publishing, Inc., all rights reserved)

162. Kada, S., Nygaard, H. A., Geitung, J. T., Mukesh, B. N., Naik, M., Wold, G., & Soevik, D. H. (2007). **Quality and appropriateness of referrals for dementia patients.** *Quality in Primary Care*, 15(1), 53-57.

Objective: To evaluate the quality and appropriateness of referrals from general practitioners (GPs) to geriatricians of patients with suspected dementia. Design: A retrospective review of referrals from primary health care to a department of geriatric medicine. A data sheet was developed from a review of previous literature. Two GPs and two geriatricians assessed the quality and appropriateness of the referrals. Setting: Patient records in the geriatric department were collected, registered and scrutinised. Subjects: A total of 135 first-time referrals from January 2002 to December 2002 were evaluated. All patients and relatives were informed that participation was voluntary and anonymity was guaranteed. Main outcomes: Assessment of the appropriateness of referrals. Results: The mean age of all referred patients was 78.7 years (standard deviation (SD) 7.3; range 42-90 years) and 61.5% were female; 81 (60.0%) referrals were initiated by GPs, 33 (24.4%) by family members, three (2.2%) by community nurses, nine (6.7%) by the patients themselves and referral initiation was not specified for nine (6.7%). The agreement on appropriateness of referrals between the geriatricians was 83.7% (kappa 0.67; 95% confidence interval (CI) 0.55-0.79; $P = 0.03$) and the GPs was 71.1% (kappa 0.21; 95% CI 0.07-35.3; $P < 0.001$). After consensus, the agreement between the geriatricians and GPs was 57.8% (kappa 0.08; 95% CI 0-0.23). This difference was statistically significant ($P < 0.001$). Conclusion: There was disagreement between geriatricians and GPs regarding the appropriateness of referrals. It was found that time-consuming tests were infrequently performed or reported, and key medical information was absent from the referral letters. 2007 Radcliffe Publishing.

163. Karnieli-Miller, O., Werner, P., Aharon-Peretz, J., & Eidelman, S. (2007). **Dilemmas in the (un)veiling of the diagnosis of alzheimer's disease: Walking an ethical and professional tight rope.** *Patient Education & Counseling*, 67(3), 307-314. OBJECTIVE: To enhance the understanding and effect of physician's difficulties, attitudes and communication styles on the disclosure of the diagnosis of AD in practice. METHODS: Qualitative, phenomenological study, combining pre-encounter interviews with physicians, observations of actual encounters of diagnosis disclosure of AD, and post-encounter interviews. RESULTS: There were various ways or tactics to (un)veil the bad news that may be perceived as different ways of dulling the impact and avoiding full and therefore problematic statements. In the actual encounters this was accomplished by keeping encounters short, avoiding elaboration, confirmation of comprehension and explicit terminology and using fractured sentences. CONCLUSION: The present study's findings highlight the difficulties encountered in breaking the news about AD, in the way it is actually done, and the problems that may arise from this way of un/veiling the news. The main problem is that the reluctance to make a candid disclosure of the diagnosis as was demonstrated in this study may violate basic moral and legal rights and may also deprive patients and caregivers of some of the benefits of early disclosure of diagnosis. PRACTICE IMPLICATIONS: There is a need for assisting physicians to cope with their personal difficulties, problems and pitfalls in breaking the news.

164. Kissel, E. C., & Carpenter, B. D. (2007). **It's all in the details: Physician variability in disclosing a dementia diagnosis.** *Aging & Mental Health*, 11(3), 273-280. This study explored physician opinion about how to disclose a dementia diagnosis. Qualitative analysis was used to examine group and individual variability regarding the philosophy about and pragmatics of disclosure in a sample of physicians experienced with dementia. While all clinicians believed they should disclose a dementia diagnosis, there was wide variability in what 'disclosure' meant to them. Even individual physicians said their disclosure strategy differs from patient to patient depending on the specifics of each case. Variability was seen in attitudes about when and to whom they disclose a dementia diagnosis, who should deliver the news, what language is used, and what topics are covered. Each physician seemed to apply an idiosyncratic and complex algorithm to make decisions about these process features of the conversation. They weigh shifting perceptions of the utility of disclosure in conjunction with a desire to facilitate care planning, an awareness of family dynamics, a responsibility to acknowledge preferences, and an obligation to communicate clear information, all within the time constraints of a medical consultation. Further empirical research is needed to establish best practices that promote psychological adjustment and successful disease management in patients and caregivers who receive a dementia diagnosis.

165. Lavery, L. L., Lu, S. Y., Chang, C. C., Saxton, J., & Ganguli, M. (2007). **Cognitive assessment of older primary care patients with and without memory complaints.** *Journal of General Internal Medicine*, 22(7), 949-954. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=17453265>

BACKGROUND: Dementia screening is currently recommended only for symptomatic patients. OBJECTIVE: To evaluate memory complaints, a mental status test, and several

cognitive tests as dementia screens in primary care. DESIGN: Cross-sectional clinical epidemiologic study. PARTICIPANTS: Three hundred thirty-nine comprehensively assessed, primary care patients aged $>$ or $=$ 65 years. MEASUREMENTS: Memory complaints were abstracted from chart review. Scores on Mini-Mental State Examination (MMSE) and domain-specific cognitive testing were compared to a dementia diagnosis based on Clinical Dementia Rating score $>$ or $=$ 1, and areas under the receiver operating characteristic curves (AUC) were calculated. Classification and regression tree analyses were performed on memory complaints and tests with the highest AUCs. RESULTS: Of 33 patients with dementia, only 5 had documented memory complaints. In 25 patients with documented memory complaints, no cognitive tests further improved identification of the 5 with dementia. In 28 patients with dementia but without memory complaints, an MMSE score or $=$ 22. CONCLUSIONS: In older primary care patients with memory complaints, cognitive screening does not help identify those who require further examination for dementia. Most patients with dementia do not report memory complaints. In these asymptomatic individuals, general mental status testing, supplemented by a memory test when the mental status score is equivocal, will identify lower-scoring patients who need dementia assessment. However, high-scoring asymptomatic dementia cases will remain undetected.

166. Maeck, L., Haak, S., Knoblauch, A., & Stoppe, G. (2007). **Early diagnosis of dementia in primary care: A representative eight-year follow-up study in lower saxony, germany.** *International Journal of Geriatric Psychiatry*, 22(1), 23-31. OBJECTIVE: To investigate whether primary care competency in early diagnosis of dementia might have changed during 1993 and 2001. METHOD: By means of a representative follow-up survey 122 out of 170 (71.8%) family physicians (FPs) in Lower Saxony, Germany, were randomly assigned to two written case samples presenting a patient with mild cognitive impairment (case 1a vs. 1b: female vs. male patient) and moderate dementia (case 2a vs 2b: vascular type (VD) vs Alzheimer's disease (DAT)), respectively. By means of a structured face-to-face interview, they were asked for their diagnostic considerations. RESULTS: In comparison to 1993, dementia was significantly more frequently considered. However, there was a striking tendency in overestimating vascular aetiology and under-diagnosing probable DAT (case 1a/1b: DAT: 11.0% in 1993 vs 26.2% in 2001; VD: 2.1% in 1993 vs 17.2% in 2001). As a possible contributor to a dementia syndrome, concomitant medication was considered only exceptionally (case 2a/2b: 4.4% in 1993 vs 2.5% in 2001). Physicians above 50 years of age showed a significantly lower early diagnostic awareness. At follow-up, the presumed interest in geriatric (psychiatric) topics dramatically faded from 66.9% to 35.2%. CONCLUSIONS: Our results demonstrate a persistent need of training efforts aiming at the early recognition of dementia, especially of DAT, in primary care. Copyright 2006 John Wiley & Sons, Ltd.

167. Oremus, M., Wolfson, C., Bergman, H., & Vandal, A. C. (2007). **Physicians' efficacy requirements for prescribing medications to persons with alzheimer's disease.** *Canadian Journal on Aging*, 26(2), 139-148. Investigated clinically relevant efficacy measures in Alzheimer's disease (AD) and their impact on physicians' prescribing practices. A total of 233 physicians (geriatricians,

neurologists, psychogeriatricians, and general practitioners) in Quebec, Canada, completed a postal survey asking them to consider 2 scenarios: a new medication for AD could prolong the time in months that a patient would remain in a mild or moderate disease state, after which cognitive decline would recommence, or a new medication could permanently halt or even reverse a patient's condition. As efficacy measures, physicians were asked to specify the minimum number of months of prolongation or the minimum effect (levels of modification to cognition, behavior, mood, and basic activities of daily living performance) that they would require of the medication before prescribing. Analyses revealed that physicians would prescribe the first hypothetical medication if it would allow patients to remain in their current disease state for 15 months in cases of mild AD or for 11 months in moderate AD. Most physicians required a permanent halt to, or some reversal of, AD progression as a prerequisite for prescribing the second drug; a few required substantial reversal. It is concluded that physicians with stringent efficacy requirements for outcomes that concerned the prolongation of time are less likely to prescribe cholinesterase inhibitors for the treatment of mild to moderate AD. However, physicians' efficacy requirements were more modest for outcomes that involved permanently halting or reversing the course of AD. (BN) (AgeLine Database, copyright 2007 EBSCO Publishing, Inc., all rights reserved)

168. Ramakers, I. H., Visser, P. J., Aalten, P., Boesten, J. H., Metsemakers, J. F., Jolles, J., & Verhey, F. R. (2007). **Symptoms of preclinical dementia in general practice up to five years before dementia diagnosis.** *Dementia & Geriatric Cognitive Disorders*, 24(4), 300-306.
OBJECTIVES: To investigate which symptoms are indicative of preclinical dementia in general practice and whether subjects with preclinical dementia have an increased contact frequency with their general practitioner (GP). METHODS: Individuals with preclinical dementia (n = 75) and non-demented controls (n = 125) were selected from the Dutch GP registration network (RNH). Number of visits and odds ratio for the risk of subsequent dementia of various symptoms were analysed. Analyses were done separately for each 12-month period, in the 5 years prior to the diagnosis of dementia. RESULTS: In the 5 years prior to diagnosis, subjects with preclinical dementia visited their GP more often than controls. Gait disturbances were the earliest predictor. Cognitive complaints were predictive for dementia in the 3 years before diagnosis. All other symptoms, except vascular symptoms, were predictive in the year prior to diagnosis. Sensitivity was highest for cognitive symptoms (0.58) and gait disturbances (0.47) in the year before diagnosis. CONCLUSION: Preclinical dementia is associated with an increased contact frequency between patient and GP at least 5 years prior to the diagnosis of dementia. Gait disturbances and cognitive complaints are the earliest symptoms of preclinical dementia.

169. Rubenstein, L. Z., Alessi, C. A., Josephson, K. R., Trinidad Hoyl, M., Harker, J. O., & Pietruszka, F. M. (2007). **A randomized trial of a screening, case finding, and referral system for older veterans in primary care.** *Journal of the American Geriatrics Society*, 55(2), 166-174.
OBJECTIVES: To test whether a system of screening, assessment, referral, and follow-up provided within primary care for high-risk older outpatients improves recognition of geriatric conditions and healthcare outcomes. DESIGN: Controlled clinical trial with 3-

year follow-up; intervention versus control group allocation based on practice group assignment. SETTING: Department of Veterans Affairs (VA) ambulatory care center. PARTICIPANTS: Seven hundred ninety-two community-dwelling patients aged 65 and older identified by postal screening survey. INTERVENTION: The intervention combined a structured telephone geriatric assessment by a physician assistant, individualized referrals and recommendations, selected referral to outpatient geriatric assessment, and ongoing telephone case management. MEASUREMENTS: Main outcomes were VA medical record evidence of recognition and evaluation of target geriatric conditions (depression, cognitive impairment, urinary incontinence, falls, functional impairment), functional status (Functional Status Questionnaire, FSQ), and hospitalization (VA databases and self-reported non-VA usage). RESULTS: Intervention participants were more likely to have target conditions recognized, evaluated, and referred to specialized services within 12 months of enrollment, although there were no significant differences in FSQ scores or acute hospitalization between intervention and control groups at 1, 2, or 3 years follow-up. Subgroup analyses suggested improvements in depression symptoms and functional impairment at 1-year follow-up in intervention participants with these problems at baseline, but these findings were not evident at later follow-up. CONCLUSION: The intervention increased recognition and evaluation of target geriatric conditions but did not improve functional status or decrease hospitalization. Innovative screening methods can identify older people in need of geriatric services, but achieving measurable improvement in functional status or hospitalization rates will likely require a more-intensive intervention than a program involving primarily unsolicited referrals and short-term consultations.

170. Shah, A. (2007). **Can the recognition of clinical features of mental illness at clinical presentation in ethnic elders be improved?** *International Journal of Geriatric Psychiatry*, 22(4), 277-282. Calculation from the 2001 census data for England and Wales indicated that the proportion of ethnic minority individuals over the age of 65 years has increased from 3% in 1991 to 8.2%. The two most common mental disorders in old age are dementia and depression. The prevalence of dementia and depression among elders from several different ethnic minority groups in the UK is generally similar to or higher than amongst indigenous elders. Thus, with the increase in the ethnic minority elderly population, the absolute number of cases of dementia and depression is likely to increase among ethnic minority elders. Despite this increase in psychiatric morbidity and high awareness and utility of general practice services among ethnic minority elders, they are poorly represented in old age psychiatry services (OAPSs). There are several possible explanations for this discrepancy. Each of these issues is systematically considered utilising observations from ethnic minority elderly populations in the UK and from cross-national populations. However, observations from the country of origin of ethnic minority elders may not reflect the true picture in the UK. This is because complex migration histories and the degree of assimilation and acculturation with the host culture may also influence the types and nature of signs and symptoms of mental illness at the time of clinical presentation. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

171. Spiegel, W. (2007). **Should family physicians screen for cognitive impairment and/or dementia.** *American Journal of Geriatric Psychiatry*, 15(8), 726-727.

172. Stoppe, G., & Maeck, L. (2007). **Early diagnosis of dementia in primary care.** *International Journal of Geriatric Psychiatry*, 22(5), 498.

173. van Hout, H. P., Vernooij-Dassen, M. J., & Stalman, W. A. (2007). **Diagnosing dementia with confidence by GPs.** *Family Practice*, 24(6), 616-621. **BACKGROUND:** Earlier reports suggest limited clinical reasoning and substantial uncertainty of GPs in assessing patients suspected of dementia. **OBJECTIVE:** To explore the predictors of GPs to decide on the presence and absence of dementia as well as the predictors of diagnostic confidence of GPs. **DESIGN:** An observational study was set up among 107 patients of 64 GPs. The GPs were instructed to use the Dutch national dementia guideline on consecutive patients newly suspected of dementia and to register their assessment on a detailed form. The predictors of the presence and absence of dementia according to the GPs and their diagnostic confidence were explored by logistic regression analyses. **MAIN OUTCOME MEASURES:** Dependent variables: (i) presence and absence of dementia according to GPs and (ii) diagnostic confidence. Independent variables: clinical (cognitive, behavioural, somatic, functional), applications of recommendations, patient related and GP related. **RESULTS:** Dementia was diagnosed in 67% of the suspected patients. The presence of dementia according to the GPs was positively associated with observed impairment of the higher cognitive functions, absence of depression and female gender of patients. The GPs expressed diagnostic confidence in 58% of the cases. This was positively associated with application of recommendations, ADL dependency, longer duration, informant availability, restless behaviour and a patient's female gender. Use of the Mini Mental Status Examination was not associated with confidence. **CONCLUSIONS:** GPs seem to base the diagnosis of dementia on rational grounds. Application of the dementia guideline's recommendations may contribute to more diagnostic confidence.

174. Vollmar, H. C., Butzlaff, M. E., Lefering, R., & Rieger, M. A. (2007). **Knowledge translation on dementia: A cluster randomized trial to compare a blended learning approach with a "classical" advanced training in GP quality circles.** *BMC Health Services Research*, 7, 92. doi:<http://dx.doi.org/10.1186/1472-6963-7-92>

BACKGROUND: Thus far important findings regarding the dementia syndrome have been implemented into patients' medical care only inadequately. A professional training accounting for both, general practitioners' (GP) needs and learning preferences as well as care-relevant aspects could be a major step towards improving medical care. In the WIDA-study, entitled "Knowledge translation on dementia in general practice" two different training concepts are developed, implemented and evaluated. Both concepts are building on an evidence-based, GP-related dementia guideline and communicate the guideline's essential insights. **METHODS/DESIGN:** Both development and implementation emphasize a procedure that is well-accepted in practice and, thus, can achieve a high degree of external validity. This is particularly guaranteed through the

preparation of training material and the fact that general practitioners' quality circles (QC) are addressed. The evaluation of the two training concepts is carried out by comparing two groups of GPs to which several quality circles have been randomly assigned. The primary outcome is the GPs' knowledge gain. Secondary outcomes are designed to indicate the training's potential effects on the GPs' practical actions. In the first training concept (study arm A) GPs participate in a structured case discussion prepared for by internet-based learning material ("blended-learning" approach). The second training concept (study arm B) relies on frontal medical training in the form of a slide presentation and follow-up discussion ("classical" approach). **DISCUSSION:** This paper presents the outline of a cluster-randomized trial which has been peer reviewed and support by a national funding organization--Federal Ministry of Education and Research (BMBF)--and is approved by an ethics commission. The data collection has started in August 2006 and the results will be published independently of the study's outcome. **TRIAL REGISTRATION:** Current Controlled Trials [ISRCTN36550981].

175. Waldemar, G., Phung, K. T., Burns, A., Georges, J., Hansen, F. R., Iliffe, S., . . . Sartorius, N. (2007). **Access to diagnostic evaluation and treatment for dementia in europe.** *International Journal of Geriatric Psychiatry*, 22(1), 47-54. This paper reviews and discusses existing barriers to diagnosis and treatment for patients with dementia in Europe as well as approaches to overcome these barriers. The barriers to care are manifold, being present at all levels in each society and between countries in Europe. Multilevel and multifaceted strategies are needed to improve diagnosis and treatments for all patients with cognitive complaints. A multidisciplinary approach based on close collaboration between GPs and specialised memory clinics may be the ideal model for early accurate diagnosis and subsequently early pharmacological and psychosocial interventions. For all healthcare professionals, there should be specialised training in dementia and frequently updated practice guidelines to provide the framework for standards of care. Culture-sensitive strategies to promote public knowledge and destigmatize dementia are essential. Policy makers and authorities should be made aware of the benefits of early access to diagnosis and treatment. Copyright 2006 John Wiley & Sons, Ltd. [References: 60]

176. Werner, P. (2007). **Family physicians' recommendations for help-seeking for a person with alzheimer's disease.** *Aging-Clinical & Experimental Research*, 19(5), 356-363.

BACKGROUND AND AIMS: To assess family physicians' recommendations for help-seeking for a person with Alzheimer's disease, and their relation to knowledge about symptoms of the disease. **METHOD:** An experimental vignette method was used, with a nationally representative sample of 395 Israeli family physicians. Intentions to seek help from professional and non-professional sources and knowledge about 11 warning signs of Alzheimer's disease (AD) and 4 non-AD symptoms was assessed. **RESULTS:** With the exception of the spouse and children, family physicians were more likely to recommend seeking help from professional than from non-professional sources. The main professional sources recommended concerned primary care. Participants were very knowledgeable about the symptoms of AD, and more knowledge about cognitive symptoms was associated with recommendations to seek help from specialists and

primary care sources. CONCLUSIONS: The findings of this study emphasize the complexity of recommendations for help-seeking in the management of dementia, and stress the importance of improving physicians' knowledge about symptoms of the disease and about guidelines suggesting collaboration with specialists and community professionals.

177. Werner, P. (2007). **Family physicians' perceptions and predictors regarding the competence of a person with alzheimer's disease.** *International Journal of Geriatric Psychiatry*, 22(4), 320-326.

OBJECTIVE: The aim of the present study was to assess family physicians' perceptions about the competence of a person with AD. METHODS: Telephone interviews were conducted with a representative sample of 395 family physicians using an experimental vignette methodology, varying in the severity of the disease. Participants were requested to rate the competence of the person described in the vignette in the areas of driving, health-decision making, financial decisions, and the performance of instrumental activities of daily living. RESULTS: Results of the study showed that family physicians perceived the person described in the vignette to be highly incompetent in items involving safety issues. Only a small variety of factors were associated with these perceptions. The main factors were the severity of the disease as reflected in the vignette, participants' perceptions regarding the dangerousness and responsibility of the person with AD, and the percentage of patients aged 65 + with cognitive deterioration in the physician's practice. CONCLUSION: The assessment of competence in persons with AD is a subtle and complex process. Future research is urgently needed to further explore the factors affecting the process, such as stigmatic views.

178. Wilkins, C. H., Wilkins, K. L., Meisel, M., Depke, M., Williams, J., & Edwards, D. F. (2007). **Dementia undiagnosed in poor older adults with functional impairment.** *Journal of the American Geriatrics Society*, 55(11), 1771-1776. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=medl&AN=17916120>

OBJECTIVES: To identify variables associated with diagnosing dementia in poor older adults by comparing older people with dementia who were diagnosed by their primary care physicians (PCPs) with those not diagnosed by their PCP. DESIGN: Observational study. SETTING: Community-based, in-home cognitive assessment program. PARTICIPANTS: Four hundred eleven adults aged 55 and older with cognitive impairment. MEASUREMENTS: Instrumental activities of daily living (IADLs), activities of daily living (ADLs), Mini-Mental State Examination, Short Blessed Memory Orientation and Concentration Test, and Clinical Dementia Rating. RESULTS: Alzheimer's disease was the most common diagnosis in this group of primarily African-American (73%) older people. Of the 411 participants, 232 (56%) were not diagnosed by their PCP. Participants without a previous diagnosis were older (mean age 81.7 vs 78.7, $P=.01$), more independent in IADLs ($P<.001$), and more likely to live alone ($P=.001$) than persons diagnosed by their PCP. Of the 201 who lived alone, 66% were not diagnosed with dementia by their PCP. Variables associated with PCP diagnosis were more severe cognitive impairment ($P<.001$), spouse caregiver ($P=.009$), younger age ($P=.02$) and care from a university-based PCP ($P=.04$). CONCLUSION: Persons with dementia who were

older and lived alone were less likely to be diagnosed by their PCP. Although persons not diagnosed by their PCP had less cognitive impairment, they had substantial impairment in activities, including handling finances, cooking, and managing medications.

179. Wolfs, C. A. G., Verhey, F. R. J., Kessels, A., Winkens, R. A. G., Severens, J. L., & Dirksen, C. D. (2007). **GP concordance with advice for treatment following a multidisciplinary psychogeriatric assessment.** *International Journal of Geriatric Psychiatry*, 22(3), 233-240. Evaluated the concordance of general practitioners (GPs) with advice for treatment after a multidisciplinary psychogeriatric assessment by the Diagnostic Observation Centre for PsychoGeriatric patients (DOC-PG) in the Netherlands. Analysis is based on 137 patients aged 55-93 (mean age 78.3) referred by 49 GPs for psychogeriatric assessment. Concordance checklists, listing the recommendations from the multidisciplinary team, were sent to the GPs in order to establish GP concordance. Regression models were used to study the associations between various patient and GP characteristics and level of concordance. Based on 530 recommendations, the overall GP concordance rate amounted to 71%. The most common types of advice pertained to medication, GP follow-up/advice, and referral. GP concordance with advice regarding admissions was the highest, followed by advice concerning the arrangement of daycare, home care, and the adaptation of medication. GP concordance was lowest for referral recommendations to other specialties and recommendations regarding psychoeducation. Concordance was higher for patients who lived alone, for patients with fewer cognitive problems, when the number of recommendations did not exceed 6, and in group practices. Concordance was dependent on the type of advice. GP satisfaction with DOC-PG did not correlate with the level of concordance. (MM) (AgeLine Database, copyright 2007 EBSCO Publishing, Inc., all rights reserved)

180. Ariss, S. M. B., Grant, E., Downs, M., Fernandez, B., Gallagher, R., Cherry, D., & Barclay, M. (2006). **Piloting a consumer-directed intervention to improve primary care for dementia in the UK.** *Dementia*, 5(3), 456-462. Investigated the potential for introducing into the United Kingdom a consumer-directed education innovation from the United States designed to improve user and caregiver involvement in primary care services for dementia. This pilot study used an action research methodology to test the potential for applying the Partnering with your Doctor (PWYD) program developed by the Alzheimer's Association in California for use in the United Kingdom. Fifteen people with dementia and their family caregivers met in opportunity groups for consultation on the usefulness of the program, and interviews were held with primary care doctors from 3 practices. Preliminary results suggest 4 areas that need further consideration prior to any application of the PWYD program in the United Kingdom: availability of consultation time with general practitioners, appropriateness of the patient taking responsibility for determining the pattern of consultations, clarification as to who is in the partnership, and representation in the patient-caregiver partnership. It is concluded that the PWYD program has potential for enhancing user involvement but it will need adapting and evaluating for the U.K. context. (SW) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

181. Austrom, M. G., Hartwell, C., Moore, P., Perkins, A. J., Damush, T., Unverzagt, F. W., . . . Callahan, C. M. (2006). **Integrated model of comprehensive care for people with alzheimer's disease and their caregivers in a primary care setting.** *Dementia*, 5(3), 339-352.

Describes an integrated model of Alzheimer's disease (AD) care in a primary care setting serving a predominantly African American, medically indigent population. The model, used at a university-affiliated primary care setting in Indiana, includes a comprehensive screening and diagnosis process, a multidisciplinary team approach to care that is coordinated by a geriatric advanced practice nurse (GAPN), and a proactive, longitudinal tracking system. The psychosocial intervention included specific responses to the treatment and management of behavioral and psychological symptoms of dementia, including caregiver-directed interventions and pharmacological treatment if needed. Results suggest that this type of model can be implemented in primary care, particularly with the involvement of GAPNs who can effectively manage the complex nature of AD. (SW) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

182. Boise, L. (2006). **Improving dementia through physician education: Some challenges.** *Clinical Gerontologist*, 29(2), 3-10.

Most of the estimated 4.5 million Americans who currently suffer from Alzheimer's disease are cared for by primary care physicians rather than geriatric or other specialists. Although clinical practice guidelines provide evidence-based recommendations for diagnosing and managing dementia, a number of barriers prevent their implementation in the primary care setting. These barriers include the nature of dementing illness which make its symptoms difficult to recognize and respond to, time and other constraints in the primary care setting, and physician attitudes. As well as presenting sound evidence-based knowledge, effective medical education programs must use effective educational approaches and must seek strategies to overcome these barriers.

183. Borson, S., Scanlan, J. M., Watanabe, J., Tu, S. P., & Lessig, M. (2006). **Improving identification of cognitive impairment in primary care.** *International Journal of Geriatric Psychiatry*, 21(4), 349-355.

OBJECTIVES: To compare the relative level and predictors of accuracy of a brief cognitive screen, the Mini-Cog, with spontaneous detection of cognitive impairment by subjects' primary care physicians. **PARTICIPANTS:** A heterogeneous community sample (n=371) of predominantly ethnic minority elderly assessed by standardized research protocol, 231 of whom met criteria for dementia or mild cognitive impairment (MCI). **RESULTS:** The Mini-Cog detected cognitively impaired subjects much more effectively than did subject's own physicians ($p < 0.0001$), correctly classifying 83% of the sample and 84% of cognitively impaired subjects. Physicians correctly classified 59% of all subjects but identified only 41% of cognitively impaired subjects. The Mini-Cog's advantage over physicians was greatest when impairment was mildest (screen vs physician recognition at CDR 0.5, 58% vs 6%; at CDR 1, 92% vs 41%). Additional subject variables associated with missed detection by physicians were non-Alzheimer type dementia and low education, low literacy, and non-English speaking, factors that had little or no effect on the performance of the Mini-Cog. Ethnic differences, also observed for physician recognition, were not significant in final regression equations. The

number and recency of primary care visits, and duration of the primary care relationship, were not associated with physicians' recognition of cognitive impairment. CONCLUSION: This study demonstrates that recognition of cognitive impairment by primary care physicians is adversely influenced by important patient and disease characteristics. Results also show that use of the Mini-Cog would improve recognition of cognitive impairment in primary care, particularly in milder stages and in older adults subject to disparities in health care quality due to sociodemographic factors. Copyright (c) 2006 John Wiley & Sons, Ltd.

184. Boustani, M., Perkins, A. J., Fox, C., Unverzagt, F., Austrom, M. G., Fultz, B., . . . Hendrie, H. C. (2006). **Who refuses the diagnostic assessment for dementia in primary care?**. *International Journal of Geriatric Psychiatry*, 21(6), 556-563. OBJECTIVE: Early screening and detection of dementia in primary care remains controversial. At least half of the patients identified as cognitively impaired by screening instruments do not meet criteria for dementia and some patients refuse further evaluation following a positive screen. The aim of this study was to identify the characteristics of patients who refuse a clinical diagnostic assessment for dementia after screening. DESIGN: Cross sectional study. SETTING: Seven primary care practice centers in Indianapolis. PARTICIPANTS: Four hundred and thirty-four individuals aged 65 and older who screened positive for dementia with a mean age of 74.6, 67% women, and 68% African-American. MAIN OUTCOME MEASURE: Patients' acceptance of undergoing a dementia diagnostic assessment that included neuropsychological testing, caregiver interview, and medical chart review. RESULTS: Among patients with positive screening results for dementia, approximately half (47.7%) refused further assessment to confirm their screening results. In a bivariate analysis, possible factors associated with a higher probability of refusing dementia assessment were older age and better screening score. In a multiple logistic regression model, performing well on the temporal orientation of the screening instrument was associated with a higher probability of refusing diagnostic assessment for dementia (OR = 1.37; $p = 0.001$). Also, African-American patients aged 80 and older were more likely to refuse the diagnostic assessment than African-Americans less than 80 years of age (OR = 3.1, $p < 0.001$), while there was no significant age association for white patients (OR = 0.9, $p = 0.728$). CONCLUSIONS: Older primary care patients who perceived themselves as having no cognitive symptoms refused dementia diagnostic assessment despite their positive screening results. We must improve our understanding of the decision-making process driving patients' beliefs and behaviors about the benefits and risks of dementia screening and diagnosis before implementing any broad-based screening initiatives for dementia.

185. Bridges-Webb, C., Giles, B., Speechly, C., Zurynski, Y., & Hiranmanek, N. (2006). **Patients with dementia and their carers in general practice.** *Australian Family Physician*, 35(11), 923-924. In 2004, 6.5% of Australians over 65 years of age were estimated to have dementia and the prevalence of dementia is rising as a result of our aging population. There is evidence to show that carer wellbeing is important for the wellbeing of the patient. Increasing burden of care may lead to depression, anxiety, and more frequent physical illness in the carer, and earlier institutionalisation of patients. The general practitioner's role includes

recognising early dementia, undertaking assessments to confirm the diagnosis, managing the disease, health promotion and support for both patient and carer, and follow up. We initiated a project to explore the extent to which GPs currently fulfill this role for patients with dementia still living in the community (rather than in hostels or nursing homes).

186. Brodaty, H., Low, L. F., Gibson, L., & Burns, K. (2006). **What is the best dementia screening instrument for general practitioners to use?** *American Journal of Geriatric Psychiatry*, 14(5), 391-400. OBJECTIVE: The objective of this study was to review existing dementia screening tools with a view to informing and recommending suitable instruments to general practitioners (GPs) based on their performance and practicability for general practice. METHOD: A systematic search of pre-MEDLINE, MEDLINE, PsycINFO, and the Cochrane Library Database was undertaken. Only available full-text articles about dementia screening instruments written in English or with an English version were included. Articles using a translation of an English language instrument were excluded unless validated in a general practice, community, or population sample. RESULTS: The General Practitioner Assessment of Cognition (GPCOG), Mini-Cog, and Memory Impairment Screen (MIS) were chosen as most suitable for routine dementia screening in general practice. The GPCOG, Mini-Cog, and MIS were all validated in community, population, or general practice samples, are easy to administer, and have administration times of 5 minutes or less. They also have negative predictive validity and misclassification rates, which do not differ significantly from those of the Mini-Mental Status Examination. CONCLUSIONS: It is recommended that GPs consider using the GPCOG, Mini-Cog, or MIS when screening for cognitive impairment or for case detection. [References: 69]

187. Burns, A., O'Brien, J., BAP Dementia Consensus, g., Auriacombe, S., Ballard, C., Broich, K., . . . British Association for, P. (2006). **Clinical practice with anti-dementia drugs: A consensus statement from british association for psychopharmacology.** *Journal of Psychopharmacology*, 20(6), 732-755. The British Association for Psychopharmacology (BAP) coordinated a meeting of experts to review the evidence on the drug treatment for dementia. The level of evidence (types) was rated using a standard system: Types 1a and 1b (evidence from meta-analysis of randomised controlled trials or at least one controlled trial respectively); types 2a and 2b (one well-designed study or one other type of quasi experimental study respectively); type 3 (non-experimental descriptive studies); and type 4 (expert opinion). There is type 1a evidence for cholinesterase inhibitors (donepezil, rivastigmine and galantamine) for mild to moderate Alzheimer's disease; memantine for moderate to severe Alzheimer's disease; and for the use of bright light therapy and aromatherapy. There is type 1a evidence of no effect of anti inflammatory drugs or statins. There is conflicting evidence regarding oestrogens, with type 2a evidence of a protective effect of oestrogens but 1b evidence of a harmful effect. Type 1a evidence for any effect of B12 and folate will be forthcoming when current trials report. There is type 1b evidence for ginkgo biloba in producing a modest benefit of cognitive function; cholinesterase inhibitors for the treatment of people with Lewy body disease (particularly neuropsychiatric symptoms); cholinesterase inhibitors and memantine in treatment cognitive impairment associated with vascular dementia; and the effect of metal collating agents (although these should

not be prescribed until more data on safety and efficacy are available). There is type 1b evidence to show that neither cholinesterase inhibitors nor vitamin E reduce the risk of developing Alzheimer's disease in people with mild cognitive impairment; and there is no evidence that there is any intervention that can prevent the onset of dementia. There is type 1b evidence for the beneficial effects of adding memantine to cholinesterase inhibitors, and type 2b evidence of positive switching outcomes from one cholinesterase inhibitor to another. There is type 2a evidence for a positive effect of reminiscence therapy, and type 2a evidence that cognitive training does not work. There is type 3 evidence to support the use of psychological interventions in dementia. There is type 2 evidence that a clinical diagnosis of dementia can be made accurately and that brain imaging increases that accuracy. Although the consensus statement dealt largely with medication, the role of dementia care in secondary services (geriatric medicine and old age psychiatry) and primary care, along with health economics, was discussed. There is ample evidence that there are effective treatments for people with dementia, and Alzheimer's disease in particular. Patients, their carers, and clinicians deserve to be optimistic in a field which often attracts therapeutic nihilism. [References: 165]

188. Cahill, S., Clark, M., Walsh, C., O'Connell, H., & Lawlor, B. (2006). **Dementia in primary care: The first survey of irish general practitioners.** *International Journal of Geriatric Psychiatry*, 21(4), 319-324. OBJECTIVE: To investigate General Practitioners' (GPs) attitudes and practices in relation to screening, diagnosing, and disclosing a dementia diagnosis to patients. DESIGN: National postal survey. PARTICIPANTS: A random sample of 600 GPs from a national database of 2,400. RESULTS: Of the 600 GPs surveyed, 60% returned questionnaires of which 50% (300) were useable. GPs reported diagnosing on average four new cases of dementia annually. A multivariate analysis revealed that females diagnosed significantly fewer cases annually ($t=5.532$, $df=289$, $p<0.001$). A large majority of GPs reported performing thyroid function tests (77%), B(12) (75%) and Folic acid tests (75%) to out rule reversible causes of cognitive impairment. The most reliable signs and symptoms of dementia identified were memory problems (58%). Main barriers to diagnosis were difficulty differentiating normal ageing from symptoms of dementia (31%), lack of confidence (30%) and the impact of the diagnosis on the patient (28%). GPs' age ($\chi^2=14.592$, $df=3$, $p<0.005$) and gender ($\chi^2=11.436$, $df=3$, $p<0.01$) were significantly associated with barriers to diagnosis. Only 19% claimed they often or always disclosed a diagnosis to a patient. Over one-third of GPs (38%) reported that the key factor influencing their disclosure patterns was their perceptions of the patient's level of comprehension. Most GPs (90%) had never undergone any dementia specific training and most (83%) expressed a desire for this. CONCLUSIONS: GPs experience difficulty diagnosing and disclosing a diagnosis of dementia to patients. To improve dementia care in Ireland, there is an urgent need to develop an active and more systematic approach to GP training in dementia care.

189. Callahan, C. M., Boustani, M. A., Unverzagt, F. W., Austrom, M. G., Damush, T. M., Perkins, A. J., . . . Hendrie, H. C. (2006). **Effectiveness of collaborative care for older adults with alzheimer disease in primary care: A randomized controlled trial.** *JAMA*, 295(18), 2148-2157. Retrieved from

<http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med4&AN=16684985>

CONTEXT: Most older adults with dementia will be cared for by primary care physicians, but the primary care practice environment presents important challenges to providing quality care. OBJECTIVE: To test the effectiveness of a collaborative care model to improve the quality of care for patients with Alzheimer disease. DESIGN, SETTING, AND PATIENTS: Controlled clinical trial of 153 older adults with Alzheimer disease and their caregivers who were randomized by physician to receive collaborative care management (n = 84) or augmented usual care (n = 69) at primary care practices within 2 US university-affiliated health care systems from January 2002 through August 2004. Eligible patients (identified via screening or medical record) met diagnostic criteria for Alzheimer disease and had a self-identified caregiver. INTERVENTION: Intervention patients received 1 year of care management by an interdisciplinary team led by an advanced practice nurse working with the patient's family caregiver and integrated within primary care. The team used standard protocols to initiate treatment and identify, monitor, and treat behavioral and psychological symptoms of dementia, stressing nonpharmacological management. MAIN OUTCOME MEASURES: Neuropsychiatric Inventory (NPI) administered at baseline and at 6, 12, and 18 months. Secondary outcomes included the Cornell Scale for Depression in Dementia (CSDD), cognition, activities of daily living, resource use, and caregiver's depression severity. RESULTS: Initiated by caregivers' reports, 89% of intervention patients triggered at least 1 protocol for behavioral and psychological symptoms of dementia with a mean of 4 per patient from a total of 8 possible protocols. Intervention patients were more likely to receive cholinesterase inhibitors (79.8% vs 55.1%; P = .002) and antidepressants (45.2% vs 27.5%; P = .03). Intervention patients had significantly fewer behavioral and psychological symptoms of dementia as measured by the total NPI score at 12 months (mean difference, -5.6; P = .01) and at 18 months (mean difference, -5.4; P = .01). Intervention caregivers also reported significant improvements in distress as measured by the caregiver NPI at 12 months; at 18 months, caregivers showed improvement in depression as measured by the Patient Health Questionnaire-9. No group differences were found on the CSDD, cognition, activities of daily living, or on rates of hospitalization, nursing home placement, or death. CONCLUSIONS: Collaborative care for the treatment of Alzheimer disease resulted in significant improvement in the quality of care and in behavioral and psychological symptoms of dementia among primary care patients and their caregivers. These improvements were achieved without significantly increasing the use of antipsychotics or sedative-hypnotics. TRIAL REGISTRATION: clinicaltrials.gov Identifier: NCT00246896.

190. Cantegreil-Kallen, I., Turbelin, C., Angel, P., Flahault, A., & Rigaud, A. (2006). **Dementia management in france: Health care and support services in the community.** *Dementia*, 5(3), 317-326. Investigated health care and support service interventions prescribed by general practitioners (GPs) in France for community-dwelling adults with Alzheimer's disease (AD) as well as barriers to arranging these interventions. A total of 631 GPs aged 31-78 (mean age 50) completed postal questionnaires on clinical practice and perceived barriers to dementia management. Prescribed community care and support were divided into

rehabilitation therapy, home help support services, nursing care, psychological interventions, and respite care. On average, GPs reported having 4 patients with AD, of which 1 was included in the questionnaire study. The patients were primarily female (67%), and mean age was 80. Findings reveal that support services used by patients with AD were home help (63%), nursing care (48%), and physiotherapy (35%). Although GPs acknowledged caregivers' need for emotional support, only minimal levels of other interventions such as day care (12%) and psychotherapeutic interventions (12%) were prescribed. Reasons for underuse included nonavailability and caregivers' reluctance to undergo psychotherapy. Lack of integrated community care services, insufficient information on services, lack of collaboration between health professionals, and the frequent absence of a reliable caregiver were considered the most important barriers to the effective support of people with dementia in primary care settings. (SW) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

191. Chodosh, J., Berry, E., Lee, M., Connor, K., DeMonte, R., Ganiats, T., . . . Vickrey, B. (2006). **Effect of a dementia care management intervention on primary care provider knowledge, attitudes, and perceptions of quality of care.** *Journal of the American Geriatrics Society*, 54(2), 311-317. OBJECTIVES: To evaluate the effect of a multicomponent dementia care management program on primary care provider knowledge, attitudes, and perceptions of quality of dementia care. DESIGN: A clinic-level randomized, controlled trial of a comprehensive care management program for patients with dementia and their nonprofessional caregivers. The program included provider education and protocols for care managers to communicate with patients' medical providers. SETTING: Eighteen clinics (nine intervention, nine [corrected] usual care) in three healthcare systems in San Diego, California. PARTICIPANTS: Two hundred thirty-two medical providers; 129 from nine [corrected] intervention clinics; 103 from nine [corrected] usual-care clinics. MEASUREMENTS: Providers were surveyed 9 months after intervention onset on knowledge (five items on four topics), attitudes about dementia (three items), and perception of quality of dementia care in their practice setting (three items). Multivariable linear and logistic regression models were used to evaluate the differences between intervention and usual-care providers, adjusting for covariate effects across groups and clustering by clinic. RESULTS: One hundred sixty-six of 232 (72%) providers responded. Intervention providers had better knowledge about assessing decision-making capacity than usual-care providers (adjusted difference in percentage correct = 12%; adjusted odds ratio = 2.4, 95% confidence interval = 1.2-4.8). Intervention providers viewed dementia patients as more difficult to manage in primary care than usual-care providers (P = .03). There were no other differences in knowledge, attitudes, or care quality perceptions across intervention and usual-care providers. CONCLUSION: A comprehensive dementia care management model resulted in few differences in provider knowledge or attitudes favorable to dementia care, suggesting that this care model's effects on quality were primarily mediated through other components of the care management program.

192. Crane, M. K., Bogner, H. R., Rabins, P. V., & Gallo, J. J. (2006). **Brief report: Patient cognitive status and the identification and management of depression by primary care physicians.** *Journal of General Internal Medicine*, 21(10), 1042-1044.

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<http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med4&AN=16836621>

OBJECTIVES: No known study has examined the role of patients' cognitive impairment in the identification and management of depression by primary care physicians. **DESIGN:** A cross-sectional survey conducted between 2001 and 2003. **PARTICIPANTS:** A sample of 330 adults aged 65 and older from Maryland primary care practices with complete information on cognitive and psychological status, and physician assessments. **MEASUREMENTS:** Primary care physicians were asked to rate cognition and depression on a Likert scale, as well as report management of depression within 6 months of the index visit. Patient interviews included standardized measures of psychological and cognitive status. **RESULTS:** Older adults identified as depressed by their physician were more likely to be identified as cognitively impaired (unadjusted odds ratio [OR] = 3.71, [95% confidence interval] [CI] [1.93, 7.16]). Older adults identified as cognitively impaired had a tendency to be managed for depression (unadjusted OR = 2.62, 95% CI [0.96, 7.19]). In adjusted multivariate models, these associations remained unchanged. **CONCLUSIONS:** When physicians identified a patient as cognitively impaired, they were more likely to identify the patient as depressed and to report treatment of the depression. An understanding of how physicians think about depression in the context of cognitive impairment is important for designing depression interventions for older adults.

193. Downs, M., Ariss, S., Grant, E., Keady, J., Turner, S., Bryans, M., . . . Iliffe, S. (2006). **Family carers' accounts of general practice contacts for their relatives with early signs of dementia.** *Dementia* (14713012), 5(3), 353-373. The role of families in supporting people with dementia is widely acknowledged in literature and UK government policy. The role of general practice in ensuring early and effective support for people living with mental health problems including dementia is also enshrined in UK policy. As part of a larger study, a total of 122 carers were asked to rate predefined aspects of the primary care response. For some responses they were also asked to provide a reason for their rating. The purpose of this study was to examine carers' accounts of contacts with general practitioners (GPs) and general practice teams when they were first approached with concerns about their relative. Findings suggest that, on average, carers rate the service as being at least 'good'. However, their accounts describe a wide variety of experiences and demonstrate that expressed satisfaction does not necessarily reflect a satisfactory service. Both practitioner-related and carer-related issues were cited as reasons for their ratings. Implications for practice and research are discussed.

194. Downs, M., Turner, S., Bryans, M., Wilcock, J., Keady, J., Levin, E., . . . Iliffe, S. (2006). **Effectiveness of educational interventions in improving detection and management of dementia in primary care: Cluster randomised controlled study.** *BMJ*, 332(7543), 692-696. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med4&AN=16565124>

OBJECTIVE: To test the effectiveness of educational interventions in improving detection rates and management of dementia in primary care. **DESIGN:** Unblinded,

cluster randomised, before and after controlled study. SETTING: General practices in the United Kingdom (central Scotland and London) between 1999 and 2002. INTERVENTIONS: Three educational interventions: an electronic tutorial carried on a CD Rom; decision support software built into the electronic medical record; and practice based workshops. PARTICIPANTS: 36 practices participated in the study. Eight practices were randomly assigned to the electronic tutorial; eight to decision support software; 10 to practice based workshops; and 10 to control. Electronic and manual searches yielded 450 valid and usable medical records. MAIN OUTCOME MEASURES: Rates of detection of dementia and the extent to which medical records showed evidence of improved concordance with guidelines regarding diagnosis and management. RESULTS: Decision support software ($P = 0.01$) and practice based workshops ($P = 0.01$) both significantly improved rates of detection compared with control. There were no significant differences by intervention in the measures of concordance with guidelines. CONCLUSIONS: Decision support systems and practice based workshops are effective educational approaches in improving detection rates in dementia.

195. Ganguli, M., Du, Y., Rodriguez, E. G., Mulsant, B. H., McMichael, K. A., Bilt, J. V., . . . Dodge, H. H. (2006). **Discrepancies in information provided to primary care physicians by patients with and without dementia: The steel valley seniors survey.** *The American Journal of Geriatric Psychiatry*, *14*(5), 446-455. Objective: The objective of this study was to examine associations between discrepancies in health information provided to primary care providers and severity of impairment in older patients with and without dementia. Methods: This study included brief assessment and medical record review of 1,107 patients with a mean (standard deviation) age of 76.3 (6.6) years (range: 65-100 years) in seven small-town primary care practices. In 358 patients, detailed in-home assessment included demographics; dementia by Clinical Dementia Rating (CDR) scale; and frequencies of memory complaints, falls, and inadvertent medication nonadherence determined from medical records and standardized in-home research assessments. Main outcome variables were trends in discrepancies between chart reviews and research assessments. Main explanatory variable was CDR box total scores. Results: Proportions of patients reporting memory complaints and falls, and evidence of inadvertent nonadherence, in the charts and by research assessment increased with CDR. Discrepancies between medical record and research assessment, were also associated with CDR, showing linear trends for memory complaints and inadvertent nonadherence and a quadratic trend for falls. Conclusion: Memory complaints, falls, and inadvertent medication nonadherence increase with dementia severity. The levels of discrepancy between information patients provided to their physicians and information they provided in response to detailed, standardized assessments, also varied with dementia severity. Physicians should be alert to the possibility of receiving unreliable health information from even mildly demented patients, whether or not dementia has been detected. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

196. Harvan, J. R., & Cotter, V. (2006). **An evaluation of dementia screening in the primary care setting.** *Journal of the American Academy of Nurse Practitioners*, *18*(8), 351-360.

PURPOSE: To evaluate current screening methods for dementia to determine the most accurate and efficient tools for use in primary care. **DATA SOURCES:** Search included the following: Medline, CINAHL, BIOSIS, PsycINFO, ISI Web of Science, and Health & Psychosocial Instruments (1840-2005). The following search terms were used: screen, screening, tools, Mini Mental, MMSE, clock drawing, subjective memory, assessment, diagnosis, primary care, outpatient, community based, ambulatory care, dementia, cognitive impairment, and memory impairment. There was no limit to publication year. Articles excluded were those not published in English and those which used screening tools as part of diagnostic evaluation. The search revealed 581 relevant articles, which were narrowed to 20. **CONCLUSIONS:** The Mini Mental State Examination (MMSE) has high sensitivity and specificity in outpatients older than 65 years when age- and education-specific cutoffs are used. The clock drawing test has lower sensitivity and specificity when used alone; however, in combination with the MMSE, its sensitivity is higher than that of the MMSE while specificity is slightly lower. Subjective memory complaints contribute diagnostic information; however, objective memory performance is a stronger predictor of future dementia. All measures are subject to influence by age, education, and other physical factors. The body of evidence regarding dementia screening methods has increased in recent years. The studies have been well conducted, of large sample size, in various geographic locations and populations, and by numerous investigators. **IMPLICATIONS FOR PRACTICE:** Dementing illnesses will become a common presentation in primary care. Currently, routine screening is not conducted although acceptable instruments, such as the MMSE, are available. Additional research on routine screening in primary care to bolster the current evidence, use of nurses as evaluators of cognition, and utilization of specialists is needed. [References: 47]

197. Harvey, R. M., Horvath, K. J., Levine, S. A., & Volicer, L. (2006). **Models of physician education for alzheimer's disease and dementia: Practical application in an integrated network.** *Clinical Gerontologist*, 29(2), 11-23. Two models were used to provide ongoing education about Alzheimer's disease for primary care physicians in a Veterans Health Administration (VHA) network including 8 facilities. The train the trainer model developed by the John A. Hartford Foundation and the American Geriatrics Society was used to prepare physician leaders to conduct Memory Loss Tool Kit sessions for colleagues in their VHA settings. Videoconference techniques were used to present case-based Grand Rounds about best practices around particular patient situations. Methods and evaluation of both programs are discussed. Successful follow through by physician leaders requires ongoing incentives and support. The Videoconference Grand Rounds Program requires skill to initiate and maintain effective technology. Both programs demonstrate successful outcomes.

198. Hillmer, M., Krahn, M., Hillmer, M., Pariser, P., & Naglie, G. (2006). **Prescribing patterns for alzheimer disease: Survey of canadian family physicians.** *Canadian Family Physician*, 52, 208-209. **OBJECTIVE:** To describe Canadian family physicians' prescribing practices with regard to Alzheimer disease (AD). **DESIGN:** Cross-sectional survey administered by facsimile. **SETTING:** Four regions in Canada (British Columbia, the Prairie Provinces, Ontario, and the Atlantic Provinces). **PARTICIPANTS:** A stratified random sample of 1000 Canadian

family physicians (250 per region) chosen from the Canadian Medical Directory; 81 of whom were excluded as ineligible. MAIN OUTCOME MEASURES: Prescribing practices regarding cholinesterase inhibitors (ChIs) for patients with AD. RESULTS: Response rate was 36.3%. About 27% of respondents reported that ChIs were prescribed for less than 10% of their AD patients, while 12.5% reported that ChIs were prescribed for more than 90% of their AD patients. More physicians prescribed ChIs in the two regions with provincial formulary coverage (Prairie Provinces and Ontario) than in the two regions without coverage (British Columbia and Atlantic Provinces). Factors that significantly predicted lower prescribing rates included female sex, perception of ChIs' effectiveness, and self-reported knowledge of ChIs. CONCLUSION: Canadian physicians' prescribing patterns for ChIs vary; the optimal prescribing rate is unclear. Provincial coverage of these drugs along with physicians' sex, knowledge of ChIs, and perception of the effectiveness of ChIs appear to influence prescribing rates.

199. Iliffe, S., Wilcock, J., & Haworth, D. (2006). **Obstacles to shared care for patients with dementia: A qualitative study.** *Family Practice*, 23(3), 353-362. BACKGROUND: All Primary Care Trusts in England were meant to have shared care protocols for antedementia medication use in place by 1 April 2004. Shared care of medical treatment in dementia depends upon early diagnosis, but under-recognition of and under-response to dementia appear widespread in general practice. AIM: To investigate the perceptions of specialists and generalists about the potential for shared care of people with dementia. DESIGN OF STUDY: Qualitative study with semistructured interviews. SETTING: Three inner-city and two rural areas. METHODS: Semistructured interviews were arranged at the participants' convenience and were tape-recorded and transcribed. Thematic analysis of the anonymized transcripts was undertaken and a case and cross-case analysis was performed. RESULTS: Thirty-nine GPs and 30 specialists were interviewed. Broad themes were reduced to following four key categories which appear to be layered over each other: therapeutic nihilism; risk reduction or avoidance; concerns about competency; and resources for shared care. CONCLUSION: Roles for primary and secondary care professionals are inappropriately distributed and require clearer definition. Resistance to shared care mostly comes from within general practice and reflects concerns about staffing, time constraints, lack of experience and confidence in making and disclosing a diagnosis. Developers of shared care protocols must dissect layered obstacles, addressing the issues of therapeutic nihilism, risk management and clinical competence.

200. Iliffe, S., Wilcock, J., & Haworth, D. (2006). **Delivering psychosocial interventions for people with dementia in primary care: Jobs or skills?** *Dementia* (14713012), 5(3), 327-338. Psychosocial interventions are emerging as potentially important therapies for primary care, partly to fill a therapy "vacuum" and partly because the evidence base for their effectiveness is growing. They can be labour-intensive and their effectiveness depends on the skills of those working with people with dementia. This creates an immediate problem, since the workforce necessary to extend psychosocial interventions beyond innovative schemes does not exist. The existing workforce in health and social care in the UK is already too small to implement all of the changes required by the National Service

Framework for Older People and National Service Framework for Mental Health. This has clear implications for the labour-intensive work of dementia care. If the job categories cannot expand as fast as is needed, the tasks of dementia care will have to be redistributed, suggesting that skills will have to be shared and transferred between different disciplines. The question for service commissioners and providers is: how can smarter working be achieved? This article attempts to answer this question with a qualitative study in general practice settings and with specialist informants. A triangulation approach to data collection was used, involving nominal groups, individual interviews and participant observation. We identified five skills that appear key in primary care: pattern recognition; deductive synthesis to reduce uncertainty; dialogue and disclosure; disability perspectives; and case management with shared care. The paucity of understanding of psychosocial interventions across disciplines who offer dementia care in the community is, we suggest, a major problem for those attempting to deploy such interventions in primary care settings. The pervasive tendency to frame the tasks of dementia care in terms of a medical management model brings responses that can undermine the view that people with dementia may in fact have a tractable disability. We use our findings to suggest solutions to this problem.

201. Nazerali, N. (2006). **Maximizing available time: Family doctors' challenges with dementia.** *Canadian Family Physician*, 52, 157-159.

202. Pimlott, N. J., Siegel, K., Persaud, M., Slaughter, S., Cohen, C., Hollingworth, G., . . . Eliasziw, T. (2006). **Management of dementia by family physicians in academic settings.** *Canadian Family Physician*, 52(9), 1108-1109. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med4&AN=17279222>

OBJECTIVE: To determine what proportion of patients with dementia seen by family physicians are assessed and managed according to the recommendations of the Canadian Consensus Conference on Dementia (CCCD). **DESIGN:** Retrospective medical record review. **SETTING:** Outpatient services in university-affiliated family practice clinics in Calgary, Alta; Ottawa, Ont; and Toronto, Ont. **PARTICIPANTS:** One hundred sixty patients who were diagnosed with dementia between January 1, 2000, and June 1, 2004. **MAIN OUTCOME MEASURES:** Use of the Mini-Mental State Examination (MMSE); collateral history; physical examination maneuvers; initial laboratory tests; diagnostic imaging; caregiver identification, assessment, and referral; driving assessment; specialist referral patterns; and other recommendations of the CCCD. **RESULTS:** The average age of patients assessed was 83 years; most patients (66.3%) were female. More than half (54.1%) were diagnosed with Alzheimer disease or vascular dementia. More than 25% of patients were not given a specific diagnosis: 13.1% were labeled as "dementia," and 12.5% as "not yet diagnosed." For most patients (69.6%) a collateral history was obtained and a primary caregiver identified (79.4%). Few physicians, however, assessed caregiver stress (33.1%) or referred caregivers for support (12.5%). Most patients (80.6%) seen by their family physicians for cognitive changes underwent at least one MMSE. The average score on the first MMSE was 23.5 (of 30) points. Most physicians ordered appropriate "basic" blood tests as part of their assessment. Forty percent of patients had computed tomographic examinations within 3 months of reporting symptoms of cognitive

difficulties to their family physicians. Of these, 25% met the criteria for computed tomographic scan as recommended by the guidelines. Only 36.5% were asked about driving status or safety concerns and had this inquiry documented. Of those, 15.5% were referred for driving evaluations and 12.5% were reported to the Ministry of Transportation. **CONCLUSION:** There is fair to good compliance with recommendations of the 1999 CCCD guidelines. There is, however, little assessment of caregiver coping and referral of caregivers for support. Similarly, there is little assessment of driver safety and referral for formal driving evaluations. Computed tomographic imaging as part of the evaluation of dementia is overused.

203. Schubert, C. C., Boustani, M., Callahan, C. M., Perkins, A. J., Carney, C. P., Fox, C., . . . Hendrie, H. C. (2006). **Comorbidity profile of dementia patients in primary care: Are they sicker?**. *Journal of the American Geriatrics Society*, 54(1), 104-109.

OBJECTIVES: To compare the medical comorbidity of older patients with and without dementia in primary care. **DESIGN:** Cross-sectional study. **SETTING:** Wishard Health Services, which includes a university-affiliated, urban public hospital and seven community-based primary care practice centers in Indianapolis. **PARTICIPANTS:** Three thousand thirteen patients aged 65 and older attending seven primary care centers in Indianapolis, Indiana. **MEASUREMENTS:** An expert panel diagnosed dementia using International Classification of Diseases, 10th Revision, criteria. Comorbidity was assessed using 10 physician-diagnosed chronic comorbid conditions and the Chronic Disease Score (CDS). **RESULTS:** Patients with dementia attending primary care have on average 2.4 chronic conditions and receive 5.1 medications. Approximately 50% of dementia patients in this setting are exposed to at least one anticholinergic medication, and 20% are prescribed at least one psychotropic medication. After adjusting for patients' age, race, and sex, patients with and without dementia have a similar level of comorbidity (mean number of chronic medical conditions, 2.4 vs 2.3, $P=.66$; average CDS, 5.8 vs 6.2, $P=.83$). **CONCLUSION:** Multiple medical comorbid conditions are common in older adults with and without dementia in primary care. Despite their cholinergic deficit, a substantial proportion of patients with dementia are exposed to anticholinergic medications. Models of care that incorporate this medical complexity are needed to improve the treatment of dementia in primary care.

204. Werner, P. (2006). **Family physicians' recommendations for the treatment of alzheimer's disease.** *American Journal of Alzheimer's Disease & Other Dementias*, 21(6), 403-410.

The aim of this study was to examine family physicians' recommendations for various pharmacological and nonpharmacological treatments for Alzheimer's disease (AD) and its correlates. A phone survey was conducted with 395 family physicians using an experimental vignette methodology, varying in the severity of the disease. Information regarding participants' recommendations about 10 interventions for the person described in the vignette was elicited. Sociodemographic and professional correlates were examined. Engagement in social activities and participation in support groups were the interventions most recommended by the physicians. Isolation and physical restraints were the least recommended. Recommendations about AD treatments were associated with the

severity of the disease and the extent to which the person described in the vignette was perceived as dangerous. Physicians' recommendations were very similar to those of the lay public, a fact that might contribute to the efficiency of the treatment plan.

205. Adams, W. L., McIlvain, H. E., Geske, J. A., & Porter, J. L. (2005). **Physicians' perspectives on caring for cognitively impaired elders.** *Gerontologist*, 45(2), 231-239.

PURPOSE: This study aims to develop an in-depth understanding of the issues important to primary care physicians in providing care to cognitively impaired elders. **DESIGN AND METHODS:** In-depth interviews were conducted with 20 primary care physicians. Text coded as "cognitive impairment" was retrieved and analyzed by use of grounded theory analysis techniques. **RESULTS:** A patient's impaired ability to provide an accurate history and to participate in self-care hindered the usual process of care, often resulting in greater medical uncertainty and feelings of inadequacy and frustration for the physician. Shifting the goal of care from "curing" the patient's illness to "caring" for the patient's quality of life was also problematic. The doctor-patient relationship changed dramatically as others became involved in care, often with attendant ethical dilemmas related to patient autonomy and the locus of decision making. Many physicians described a deep sense of loss and grief as the personhood of patients faded. The increased complexity and prominent social and emotional issues were difficult to manage in the context of the current model of practice. **IMPLICATIONS:** Profound changes occur in the process of care with cognitively impaired patients. The increased complexity mandates an expanded model of care that addresses the prominent psychosocial and ethical aspects of care as well as the medical ones.

206. Allen, M., Ferrier, S., Sargeant, J., Loney, E., Bethune, G., & Murphy, G. (2005). **Alzheimer's disease and other dementias: An organizational approach to identifying and addressing practices and learning needs of family physicians.** *Educational Gerontology*, 31(7), 521-539.

Examined the practices and learning needs of family physicians caring for older adults with Alzheimer's disease (AD). A total of 116 family physicians in Nova Scotia, Canada, completed a mail survey on their assessment and management practices, barriers to providing optimal care, and learning needs and resources. Focus groups and individual interviews were also conducted with family physicians, psychiatrists, geriatricians, long term care staff, home care professionals, and patients with mild dementia and their caregivers. About 40-50% of questionnaire respondents indicated that they routinely take a history from more than one person or inquire about behavioral and psychiatric aspects of dementia. Family physicians in focus groups reported difficulty in making the diagnosis of dementia and differentiating the different types of dementia, and indicated varying comfort levels with communicating the diagnosis. Diagnosing the cause of dementia was the highest rated learning need on the questionnaire by family physicians, while the most highly rated barrier to care was inadequate provincial insurance coverage for medications. The results suggest that family physicians may not be performing certain assessment and management practices as frequently as they ideally should. (MM) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)

207. Andrade, M. C. M. d. (2005). *Understanding physician caring behaviors in the physician-patient-family caregiver relationship* UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI. Physician caring behaviors, the medical management of patients with dementia, and the triadic relationship have been broadly discussed in the literature, but research on dementia care and caring has been limited. This dissertation carried out three qualitative interview studies and a cross-sectional mail survey to investigate physician caring and noncaring behaviors toward patients with dementia and family caregivers during medical visits in the medical office in the context of the triadic relationship, the most important physician caring behaviors, perceptions of feelings, some aspects of the medical care, and predictors of the frequency of physician caring behaviors. Twenty physicians, 15 family caregivers, and 9 patients with dementia participated in the qualitative studies and 71 family caregivers participated in the survey. Kendall's tau b rank correlation, Wilcoxon rank sum test, baseline-category, adjacent-category and binary logistic analyses were used. The level of statistical significance was set at p less than .10. The categories of physician caring behaviors identified in the content analysis were connecting, showing respect and integrity, knowing, and providing for the needs. Physician noncaring behaviors were mostly related to not attending to the needs, disrespect, and disconnection of the physician. Descriptions of good feelings were associated with positive perceptions about the triadic relationship. Descriptions of negative feelings were mostly associated with disrespect of the physician. Listening was the most frequently identified as the most important physician caring behavior. The majority of patients had had the first evaluation for memory problems two or more years prior to this study, had two or more physicians over the course of the illness, had seen current physicians for two or more years, and had family caregivers who were always present in the medical visits. Positive associations between satisfaction with the medical care and perceptions of physician caring behaviors were identified. Findings suggest that family caregivers who were women, less educated, younger, religious, and whose relatives had seen fewer physicians over the course of the illness and had longer relationships with current physicians were more likely to perceive physician behaviors as more frequently caring. Implications for research, professional practice, education, and policy are discussed. (Author Abstract, used by permission) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

208. Austrom, M. G., Hartwell, C., Moore, P. S., Boustani, M., Hendrie, H. C., & Callahan, C. M. (2005). **Care management model for enhancing physician practice for alzheimer disease in primary care.** *Clinical Gerontologist*, 29(2), 35-43. Describes a collaborative care management program for the treatment and management of dementia in primary care. The PREVENT (Providing Resources Early to Vulnerable Elders Needing Treatment for Memory Loss) study is administered in a university-affiliated primary care practice serving a medically indigent population aged 65 and older. The program's essential components are a comprehensive screening and diagnosis protocol for cognitive impairment, a multidisciplinary team approach coordinated by a geriatric advance practice nurse, and a proactive longitudinal tracking system. The key role of the geriatric nurse practitioner is emphasized. While the clinical trial is still ongoing, the intervention has been well received by primary care physicians, patients,

and their families. (SW) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

209. Boise, L. (2005). **Improving dementia care through physician education: Some challenges.** *Clinical Gerontologist*, 29(2), 3-10. Discusses challenges in providing good dementia care from the perspectives of families and primary care physicians, as well as implications for physician education. Most of the estimated 4.5 million Americans who suffer from Alzheimer's disease are cared for by primary care physicians rather than geriatric or other specialists. Although clinical practice guidelines provide evidence-based recommendations for diagnosing and managing dementia, a number of barriers prevent their implementation in the primary care setting. These barriers include the nature of dementing illness, which makes its symptoms difficult to recognize and respond to; time and other constraints in the primary care setting; and physician attitudes. As well as presenting sound evidence-based knowledge, effective medical education programs must use effective educational approaches and must seek strategies to overcome these barriers. (SW) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

210. Boise, L., & Connell, C. M. (2005). **Diagnosing dementia--what to tell the patient and family.** *Geriatrics and Aging*, 8(5), 48-51. Reviews research on physician practices and perspectives as well as older patients' and family members' preferences in disclosing the diagnosis of dementia. Research suggests that, in general, patients and families want an accurate and clearly explained diagnosis, and they desire guidance from the physician in understanding the course of the illness over time as well as resources that will help them to cope with the disease. Yet available research suggests that no more than 50% of clinicians regularly disclose the diagnosis to patients with dementia. Suggestions for disclosing the diagnosis of dementia to the family include providing the most clinically accurate diagnosis possible, erring on the side of disclosing rather than withholding a dementia diagnosis, and balancing a discussion of the patients' cognitive deficits with their strengths and abilities. Ideally, clinicians should seek to understand their patients' and families' preferences before undertaking a clinical evaluation so that the resulting diagnosis can be disclosed in a way that is most beneficial. (SW) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)

211. Bond, J., Stave, C., Sganga, A., O'Connell, B., & Stanley, R. L. (2005). **Inequalities in dementia care across europe: Key findings of the facing dementia survey.** *International Journal of Clinical Practice (Supplement)*, 59, 8-14. The Facing Dementia Survey was undertaken to assess the awareness of and behaviours surrounding Alzheimer's dis-ease (AD) and dementia among all key stakeholders in Europe. Interviews were conducted with more than 2500 persons, including caregivers, members of the general population, physicians, persons with AD and influencers of health care policy. Four key messages emerged from the results. First, AD often remains undiagnosed until symptoms become moderate or severe. This delay may be because of the difficulty of recognising the symptoms of early AD and the attribution of symptoms to so-called normal ageing, the fear of AD common among older people, inadequate screening tools for use by physicians and/or a delay in the confirmation of the diagnosis

once suspicion is raised. Second, a majority of respondents perceive their governments as indifferent to the economic, social and treatment burdens associated with AD. Third, a substantial majority of caregivers, physicians and the general population appreciate the wide-ranging impact that AD can have on the quality of life of people who suffer from it and their informal caregivers. While most caregivers reported life-changing negative effects, a few also noted some positive aspects to their experience. Finally, survey results revealed that most caregivers and members of the general public do not have sufficient information about the benefits of treatment and care. The findings of the Facing Dementia Survey support the development of an agenda for change in dementia care across Europe.

212. Boustani, M., Callahan, C. M., Unverzagt, F. W., Austrom, M. G., Perkins, A. J., Fultz, B. A., . . . Hendrie, H. C. (2005). **Implementing a screening and diagnosis program for dementia in primary care.** *Journal of General Internal Medicine*, 20(7), 572-577. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med4&AN=16050849>

BACKGROUND: Primary care physicians are positioned to provide early recognition and treatment of dementia. We evaluated the feasibility and utility of a comprehensive screening and diagnosis program for dementia in primary care. **METHODS:** We screened individuals aged 65 and older attending 7 urban and racially diverse primary care practices in Indianapolis. Dementia was diagnosed according to International Classification of Diseases (ICD)-10 criteria by an expert panel using the results of neuropsychologic testing and information collected from patients, caregivers, and medical records. **RESULTS:** Among 3,340 patients screened, 434 scored positive but only 227 would agree to a formal diagnostic assessment. Among those who completed the diagnostic assessment, 47% were diagnosed with dementia, 33% had cognitive impairment-no dementia (CIND), and 20% were considered to have no cognitive deficit. The overall estimated prevalence of dementia was 6.0% (95% confidence interval (CI) 5.5% to 6.6%) and the overall estimate of the program cost was \$128 per patient screened for dementia and \$3,983 per patient diagnosed with dementia. Only 19% of patients with confirmed dementia diagnosis had documentation of dementia in their medical record. **CONCLUSIONS:** Dementia is common and undiagnosed in primary care. Screening instruments alone have insufficient specificity to establish a valid diagnosis of dementia when used in a comprehensive screening program; these results may not be generalized to older adults presenting with cognitive complaints. Multiple health system and patient-level factors present barriers to this formal assessment and thus render the current standard of care for dementia diagnosis impractical in primary care settings.

213. Cantegreil-Kallen, I., Turbelin, C., Olaya, E., Blanchon, T., Moulin, F., Rigaud, A., & Flahault, A. (2005). **Disclosure of diagnosis of alzheimer's disease in french general practice.** *American Journal of Alzheimer's Disease & Other Dementias*, 20(4), 228-232.

Most practitioners find disclosing the diagnosis of Alzheimer s disease (AD) to an individual with dementia very difficult. Literature results show a wide variability in attitudes and clinicalpractice, and diagnosis seems to be more often disclosed to

caregivers than to patients. The objective of this study was to examine whether and how diagnosis of AD is disclosed in French general practice and which issues are addressed with the patient. A questionnaire was sent via mail to 1,629 general practitioners (GPs), 1,105 belonging to the Sentinel's network and 524 specially recruited doctors practicing in the Rhone-Alpes region. A total of 631 questionnaires were returned (response rate, 39 percent), of which 616 were eligible for analysis. Twenty-eight percent of GPs reported having disclosed diagnosis to the patient (25 percent mentioned "Alzheimer's disease"), whereas 88 percent considered it their role to announce the diagnosis to the patient. Regarding the type of information provided to the patient, only 25 percent discussed the nature of the illness, 23 percent behavioral problems, and 47 percent depression, mainly for psychological reasons (63 percent). Stress was discussed with 79 percent of the caregivers. We concluded that GPs do not discuss the consequences of AD and symptoms (e.g., behavioral disorders) with patients, mainly for psychological reasons, whereas they have a less-reluctant attitude toward caregivers. As the GP has the weighty task of providing appropriate community care and psychological support to the patient, it is of utmost importance to reflect on how disclosure of diagnosis can be facilitated.

214. Crofton, J. E. (2005). *Dementia diagnosis practices of primary care physicians in british columbia: Who knows?* UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI. Three hundred and twelve primary care physicians, working in British Columbia, responded to a survey describing their practices with dementia patients and their families. The decision of whether or not to disclose a dementia diagnosis and to whom, factors influencing a physician's practice, confidence in diagnosis, and the impact of medical training was queried. The questionnaire was designed in cooperation with the British Columbia Medical Association (BCMA) and geriatric specialists. Univariate (t-test, chi-square) and Anova calculations were used to identify significant results. Almost 60% of primary care physicians are disclosing a dementia diagnosis in over 75% of their cases. Significance was observed noting a difference between the influences of various factors on physicians' dementia diagnosis practices. Physicians reported feeling unequally confident in their skills relating to dementia disclosure, and consider some factors as more important than others in how they influence their practice of disclosure. (Author Abstract, used by permission) (AgeLine Database, copyright 2007 EBSCO Publishing, Inc., all rights reserved)

215. Hansen, E., Robinson, A., Mudge, P., & Crack, G. (2005). **Barriers to the provision of care for people with dementia and their carers in a rural community.** *Australian Journal of Primary Health*, 11(1), 72-79. This article describes results from a community initiated qualitative research project investigating barriers to the provision of care for people with dementia (PWD) and their carers. The study was conducted in a rural remote Tasmanian community ("Cape Coastal"). Focus group discussions were held with family member carers of PWD, members of the Aged Care Assessment Team (ACAT), nurses employed in the local hospital and a local nursing home, community health nurses and local general practitioners. In addition, two semi-structured interviews were conducted with a dementia support worker allocated to service the region and a single family member carer. Barriers

to the effective provision of care for PWD and their carers were identified. These were: distance and isolation; perceptions of geographic and professional boundaries including issues of medical dominance; and gaps in health care provider and carers' knowledge about dementia and dementia services. These results demonstrate that while Cape Coastal has many points in common with other rural and remote communities in Australia and in Canada and the United States (Australian Institute of Health and Welfare [AIHW], 2002), it is important to recognise local context when planning and providing services for PWD and other chronic diseases.

216. Harvey, R. M., Horvath, K. J., Levine, S. A., & Volicer, L. (2005). **Models of physician education for alzheimer's disease and dementia: Practical application in an integrated network.** *Clinical Gerontologist*, 29(2), 11-23. Describes 2 models of physician education for Alzheimer's disease (AD) and dementia for primary care physicians in a Veterans Health Administration (VHA) network including 8 facilities in New England. The Train the Trainer model developed by the John A. Hartford Foundation and the American Geriatrics Society uses a Memory Loss Tool Kit, which contains professional resources and patient education materials including a review of AD, a clinical process guide for managing memory loss, case studies, resources for education and service, and numerous tools for assessment and evaluation. The second program is a bimonthly interdisciplinary videoconference series called Case Studies in Dementia in which case-based grand rounds about best practices around particular patient situations are presented. Methods and evaluation of both programs are discussed. Successful follow-through by physician leaders required ongoing incentives and support. The videoconference grand rounds required skill to initiate and maintain effective technology. Both programs demonstrated successful outcomes. (SW) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

217. Holmes, S. B., & Adler, D. (2005). **Dementia care: Critical interactions among primary care physicians, patients and caregivers.** *Primary Care; Clinics in Office Practice*, 32(3), 671-682. Enormous progress has been made in understanding and treating Alzheimer's disease (AD) and other dementing illnesses, and developing home and community-based support services to assist patients and their families. This article reviews the range of interactions and barriers physicians, patients who have dementia, and their families face over the course of the disease. In addition, strategies are presented which enhance referral of patients and families to appropriate community support services. [References: 22]

218. Iliffe, S., de Lepeleire, J., van Hout, H., Kenny, G., Lewis, A., & Vernooij-Dassen, M. (2005). **Understanding obstacles to the recognition of and response to dementia in different european countries: A modified focus group approach using multinational, multi-disciplinary expert groups.** *Aging and Mental Health*, 9(1), 1-6. Explored obstacles to recognition of and response to dementia in general practice in different European countries, using a modified focus group approach with multinational, multidisciplinary expert groups. Focus groups of experts from 8 European countries (Belgium, France, the Netherlands, Ireland, Italy, Portugal, Spain, and the United Kingdom) met in 2003 over a 2-day period, with 5 sessions lasting more than an hour

each. An adapted nominal group method was used to record themes arising from the group discussion, and these themes were used in a grounded theory approach to generate explanations for delayed recognition of and response to dementia. The main theme that arose from the focus groups was movement, which had 3 different expressions: population movement and its consequences for localities, services, and professional experience; the journey of the person with dementia along the disease process; and the referral pathway to access services and support. Change is the core issue in dementia care, with multiple pathways of change that need to be understood at clinical and organizational levels. Practitioners and people with dementia are engaged in managing emotional, social, and physical risks, making explicit risk management a potentially important component of dementia care. The boundary between generalist and specialist services is a particular problem with great potential for dysfunctionality. Stigma and ageism are variably distributed phenomena both within and between European countries. (SW) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)

219. Iliffe, S., & Wilcock, J. (2005). **The identification of barriers to the recognition of, and response to, dementia in primary care using a modified focus group approach.** *Dementia: The International Journal of Social Research and Practice*, 4(1), 73-85.

This study reports upon the identification of barriers to the recognition of and response to dementia in primary care as perceived by general practitioners and highlights areas of information and training need. The study took a qualitative approach involving group work with 144 general practitioners in three purposively selected settings using adapted nominal group data collection methods. Six key themes were identified that explain the complexity of dementia diagnosis and management: (1) the pre-eminence of problem-solving over differential diagnosis as a working style; (2) the existence of gaps in support services; (3) problems of confidentiality; (4) the importance of 'red flags'; (5) rules governing disclosure of diagnoses; and (6) heuristics for distinguishing dementia from normal ageing or other pathologies. In addition the practitioners identified principles governing medication use, issues around carers' needs and implications for professional education. The National Service Framework for Older People emphasizes the need for early detection and diagnosis of dementia in primary care. This study identified barriers to be overcome by targeted educational interventions and through service provision. There is an uneven geographical distribution of support and diagnostic services and a lack of awareness of how to access these, and this needs addressing. A stepwise educational method is recommended as opposed to promotion of a formal syllabus. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

220. Kumar, S. (2005). **Dementia in the community: Evaluation of diagnosis and management issues.** *North and West London Journal of General Practice*, 11(1), 11-22.

Objectives: To investigate how dementia in the elderly are diagnosed in primary care before referral to secondary care, and to assess the availability of care to sufferers in the community. Design/Method: A survey into how accurately dementia is diagnosed, expecting a prevalence of 5% in patients over 65 years and about 20% in patients over 80 years. The second aim was to identify whether carers of those with dementia were identified. Setting: General practice surgery in Reading, England, United Kingdom.

Results: It was found that only 28 patients were diagnosed as suffering from dementia, were as it was expected that about 152 out of 1523 patients over 65 years old would have dementia. About 82% of cases were referred to secondary care where dementia was suspected. Varying levels of care were received by patients suffering from dementia. These include institutional, family and home carers. Discussion & Conclusion: This survey indicates that there are under-diagnosis of dementia in the practice. Identification of the need for more facilities in dementia care by increasing the number of diagnoses made by the GP will hopefully create a demand that would be difficult to ignore. There is a poor record of caregivers in the practice. This can be improved by flagging carers in patient records, as awareness of patient circumstances aids consultation. Kingscos Medical Publishers.

221. Lampley-Dallas, V. T., Mold, J. W., & Flori, D. E. (2005). **African-american caregivers' expectations of physicians: Gaining insights into the key issues of caregivers' concerns.** *Journal of National Black Nurses Association*, 16(1), 18-23. This qualitative study was done to determine what expectations, if any, African-American caregivers' have of physicians; what were the various causes of caregivers' distress, and what were the participants' perceived level of satisfaction or lack of satisfaction with the physician-patient-caregiver relationship. The participants in this current study were either providing or had provided assistance in the activities of daily living of elders diagnosed with Alzheimer's or dementia. Focus group methodology was used and participants were recruited from Oklahoma County, Oklahoma. A total of 13 participants, whose mean age was 53.8 years of age and whose education was at least that of high school graduate, participated in the study. The majority of the caregivers were children who were caring for parents. The participants were asked three basic questions relating to their experiences or frustrations and the questions were followed by a 45-minute discussion to allow for further elaboration. The Geriatric Depression Scale (GDS), and the Zarit Burden Interview, combined with a demographic information form, was used to define the characteristics of the caregivers (Sheik, et al., 1986; Zarit, Reeve & Bach-Peterson, 1980; Vitaliano, Russo, Yung, Becker, & Maiuro, 1991; National Center for Cost Containment, 1993). Findings from this study suggest that of the 13 participants only 2 could be classified as depressed. However, the caregivers expected information, referral for services and assistance in recognizing disease progression. These elements were sometimes lacking as well as not always having effective caregiver-physician interaction. Greater attention by physicians to the needs, stressors, and expectations of African-American caregivers may improve the caregiver-physician interaction and may reduce caregiver stress. Further studies in this area can add to the sparsely available information.

222. Loh, P. P. K., Maher, S., Goldswain, P., Flicker, L., Ramesh, P., & Saligari, J. (2005). **Diagnostic accuracy of telehealth community dementia assessments.** *Journal of the American Geriatrics Society*, 53(11), 2043-2044. Compared the sensitivity and specificity of telehealth Alzheimer's disease (AD) assessments with that of face-to-face assessments within the 40-site telehealth network of rural Western Australia. Twenty community-dwelling adults aged 67-89 (mean age 78.8) referred by their general practitioners for suspected cognitive impairment were assessed

directly by a visiting geriatrician and remotely by a geriatrician at Royal Perth Hospital. Clinicians using both methods of assessment followed a protocol that included the MMSE, Geriatric Depression Scale, activity of daily living (ADL) and instrumental ADL assessments, and the Informant Questionnaire for Cognitive Decline in the Elderly. Direct assessment resulted in 10 patients diagnosed with AD, whereas remote assessment resulted in 9 patients diagnosed with AD. The sensitivity and specificity for remote assessments were 90% and 100%, respectively. Findings demonstrate that it is feasible to diagnose AD by telehealth videoconferencing. (AY) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)

223. Milne, A. J., Hamilton-West, K., & Hatzidimitriadou, E. (2005). **GP attitudes to early diagnosis of dementia: Evidence of improvement.** *Aging & Mental Health*, 9(5), 449-455. This paper offers a comparative analysis of GPs attitudes towards early diagnosis of dementia in 1997 and 2001. It draws on data from two studies conducted in the same area using the same research instrument. Overall, findings reveal a significantly greater commitment to early diagnosis at Time 2 than at Time 1. More GPs hold positive attitudes and consider early diagnosis to facilitate a number of practical and therapeutic benefits for users and carers. Further, fewer GPs regard early diagnosis as having negative consequences. Findings also support existing evidence about attitudes being underpinned by drivers and barriers. Those GPs who are committed regard it as an opportunity to offer preventive treatment and plan for the future; barriers include limited treatment options. Primary reasons for the attitudinal shift are greater accessibility of psychiatric colleagues, additional investment in support services, and enhanced policy and clinical emphasis on the value of early diagnosis.

224. Monnot, M., Brosey, M., & Ross, E. (2005). **Screening for dementia: Family caregiver questionnaires reliably predict dementia.** *Journal of the American Board of Family Practice*, 18(4), 240-256. INTRODUCTION: Because of increasing numbers of patients with diseases that cause dementia, primary care physicians must use efficient assessment procedures in their clinics. Important advantages of screening for dementia include determination of the patient's cognitive capacity to participate competently in his/her own medical care and early diagnosis, which enables administration of medications that preserve some cognitive functions. METHODS: A study was conducted to determine whether questionnaires completed by a family caregiver about a patient could differentiate between those with dementia and those with other neurological disorders that do not cause dementia. Clinical and demographic information gleaned from more than 330 consecutive multidisciplinary outpatient dementia clinic assessments were entered into an Institutional Review Board-approved database and analyzed post hoc to answer several research questions. RESULTS: Three questionnaires completed by family caregivers about patients were able to differentiate reliably between patients with dementia with a variety of degenerative disorders and patients without dementia with other neurological disorders that often are mistaken for dementia. When these questionnaires are combined with a patient test (Mini-Mental State Examination), an accurate prediction of which patients suffer from a true degenerative disease that causes dementia was robust (effect

size of $R^2 = 0.81$, $P < .0001$ for the multiple logistic regression analysis). **DISCUSSION:** These instruments assist the primary care physician to determine which patients seem to suffer from a disease that causes dementia and need further assessment by the physician or at a specialized dementia clinic. The ultimate goal is to assure that patients receive appropriate medical management as early in the disease process as possible.

225. Oremus, M. (2005). *Use of medications in the alzheimer's disease population: Physician and caregiver perspectives* UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI. Introduction. Research into medications for Alzheimer's disease (AD) is primarily conducted in drug trials, where efficacy is assessed by changes in score on established outcome measurement scales. However, physicians' and caregivers' perspectives on efficacy, along with their perspectives on other factors that may influence prescribing (e.g., adverse effects), remain largely unexplored. The objective of this thesis is to examine these perspectives to gain a broader understanding of the factors that can influence the use of medications in AD. Two studies were conducted. The first involved all of the Province of Quebec's geriatricians, neurologists, and psychogeriatricians, as well as a random sample of Quebec's 8,115 general practitioners. The second study involved 375 caregivers who attended AD-related support groups. Questionnaires were used to collect data on the proportion of patients prescribed cholinesterase inhibitors (ChEIs), efficacy requirements for prescribing new medications, acceptance of adverse effects, physician-caregivers discussions about medications, and caregiver pressure on physicians to prescribe medications. Response rates were 35.4% (physicians) and 64.4% (caregivers). More stringent efficacy requirements on the part of physicians were negatively associated with prescribing ChEIs, although effect sizes were small and associations were not always statistically significant. More stringent efficacy requirements on the part of caregivers were negatively associated with prescribing in some instances (e.g., required improvements to patients' ability to eat, $OR=0.74$, 95% $CI=0.61$ to 0.89), but not in others (e.g., required improvements to patients' speech, $OR=1.02$, 95% $CI=0.81$ to 1.19). Caregivers' willingness to accept adverse effects was positively associated with prescribing ChEIs (odds ratios for 11 adverse effects ranged from 1.83 to 8.30); however, prescribing was not associated with physicians being the first to discuss the use of medications to treat AD ($OR=2.37$; 95% $CI=0.90$ to 6.24), nor was it associated with caregiver pressure on physicians to prescribe ($OR=1.33$; 95% $CI=0.49$ to 3.58). This research is the first to show how physician and caregiver perspectives on issues such as efficacy and safety can affect the use of medications in AD. (Author Abstract, used by permission) (AgeLine Database, copyright 2008 EBSCO Publishing, Inc., all rights reserved)

226. Solomon, P. R., & Murphy, C. A. (2005). **Should we screen for alzheimer's disease? A review of the evidence for and against screening alzheimer's disease in primary care practice.** *Geriatrics*, 60(11), 26-31. Fewer than one-half of all Alzheimer's disease (AD) patients are currently diagnosed; approximately 25% are treated with antidementia compounds. Screening has been proposed to help combat underdiagnosis of AD. An emerging consensus suggests that the three keys to the successful treatment of Alzheimer's disease are early detection, use of

currently approved medications to provide symptomatic treatment, and development of medications to slow and eventually halt disease progression. If early detection of Alzheimer's disease is the first step, screening would seem to be an important strategy. We review the arguments for and against screening and suggest several strategies and instruments that may be helpful in the context of screening for Alzheimer's disease in primary care practice. [References: 29]

227. Vernooij-Dassen, M., Moniz-Cook, E., Woods, R. T., De Lepeleire, J., Leuschner, A., Zanetti, O., . . . Iliffe, S. (2005). **Factors affecting timely recognition and diagnosis of dementia across europe: From awareness to stigma.** *International Journal of Geriatric Psychiatry*, 20(4), 377-386. **BACKGROUND:** Timely recognition and diagnosis of dementia is the pre-condition for improving dementia care, but diagnosis often occurs late in the disease process. **OBJECTIVE:** To compare facilitators and obstacles to the timely recognition of dementia across eight European Union states, in order to implement established policies for earlier diagnosis. **METHODS:** A modified focus group technique, including a pre and posterior procedure. **RESULTS:** Twenty-three participants from different disciplines, purposively sampled for professional expertise in dementia research and innovative practice, attended two focus groups. Stigma in ageing and dementia, accompanied by a sense that there is little to offer until later on in the disease, underpinned the widespread reluctance of GPs to recognise dementia at an early stage and were major obstacles to the timely diagnosis of dementia across all eight countries. Dementia care services varied widely across Europe. Countries with the greatest development of dementia health care services were characterised by national guidelines, GPs fulfilling a gatekeeper function, multi-disciplinary memory clinics and innovative programmes that stimulated practice and new services. Dementia-related stigma was perceived as being less prominent in these countries. **CONCLUSIONS:** Overcome of delays in the timely diagnosis of dementia needs more than specialist services. They should address the processes associated with stigma, age and dementia, especially where these relate to physician practice and diagnostic disclosure. Stigma is perceived as variable across European States, with a promising finding that its impact is relatively small in countries with the widest range of dementia care services. Copyright 2005 John Wiley & Sons, Ltd.

228. Vickrey, B. G. (2005). **Effective strategies for changing physicians' behavior: Insights from research on diffusion of innovations.** *Clinical Gerontologist*, 29(2), 25-34.

Discusses insights from research on diffusion of innovations in both health and nonhealth settings and applies them to an understanding of how to effect changes in physician behavior and health care organizational practices around care for dementia. At the individual physician level, strategies should be interactive and employ social influence-based methods, such as using opinion leaders, academic detailing, and study groups. It is likely that for a complex and chronic condition like dementia, much of the emphasis on improving care should target creation, testing, and replication of effective models for delivering care within different health care organizations. Support is strongly needed for continued expansion of the knowledge base about effective quality interventions, policy research addressing reimbursement and other financial barriers to care management, and

advocacy to support replication and dissemination of interventions found to be effective. (SW) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

229. Waldorff, F. B., Rishoj, S., & Waldemar, G. (2005). **Identification and diagnostic evaluation of possible dementia in general practice. A prospective study.** *Scandinavian Journal of Primary Health Care*, 23(4), 221-226. **OBJECTIVE:** To investigate the rate of diagnostic evaluation of dementia for patients in whom a suspicion of dementia was raised, and to investigate reasons why a diagnostic evaluation was not always being performed. **DESIGN:** A prospective study among elderly patients aged 65+, and a follow-up study. **SETTING:** In all, 17 general practices in Copenhagen with 40 865 patients on their lists of whom 2934 were aged 65+. **SUBJECTS:** A total of 793 patients consulting their GP regardless of reason of encounter, in October and November 2002. **MAIN OUTCOME MEASURES:** MMSE score < or = 23, GP clinical impression of dementia, laboratory-screening tests prescribed by the GPs and referral status after 6 months, and follow-up questionnaire. **RESULTS:** Of 793 patients a total of 138 patients were identified with possible dementia. Among the identified patients 26 (20%) were referred for further evaluation within 6 months, and 4 (3%) were treated for depression or referred for another condition. A total of 6 patients were lost to follow-up. In the remaining 102 undiagnosed patients the main reasons for not performing a diagnostic evaluation of dementia were patient/relative hesitation (34%), the GP thought that it would not have any consequences for the patient, or the GP estimated that the patient was too fragile (21%). **CONCLUSION:** In 17% of elderly patients in general practice a suspicion of dementia could be raised based on the clinical impression of the GP or MMSE score. However, only 23% of this group were evaluated by their GP or referred to a memory clinic within a subsequent period of 6 months.

230. Wilkinson, D., Sganga, A., Stave, C., & O'Connell, B. (2005). **Implications of the facing dementia survey for health care professionals across europe.** *International Journal of Clinical Practice (Supplement)*, 59, 27-31. Approximately 600 general practitioners, primary care physicians and specialists in six European nations (France, Germany, Italy, Poland, Spain and UK) who treat patients with Alzheimer's disease (AD) were interviewed during the Facing Dementia Survey. Compared with generalists, specialists displayed the most optimism regarding the effects of age, believing that health and memory do not inevitably deteriorate as one grows older. Most physician respondents agreed that the diagnosis of AD is too often delayed. A primary reason cited for this delay was the difficulty experienced by both physicians and the general public in identifying early signs of AD. Many physicians believed treatments are available that can slow the disease course. The vast majority surveyed in each nation believed that early treatment of AD can delay disease progression [mean, 87%; range, 68% (United Kingdom) to 96% (Poland)]. More than half of physicians who initiate treatment in France (66%), Germany (59%), Italy (82%), Poland (82%) and Spain (69%) said they institute treatment for AD immediately after diagnosis. The exception was the United Kingdom, where 48% initiated treatment immediately, whereas more than half waited at least a month to start therapy. To a large extent, physicians saw the governments of their countries as a hindrance rather than a help in caring for persons with AD.

231. Adelman, R. D., Greene, M. G., & Friedmann, E. (2004). **Discussions about cognitive impairment in first medical visits: Older patients' perceptions and preferences.** *American Journal of Alzheimer's Disease & Other Dementias*, 19(4), 233-238.

Primary care physicians are the first medical contact for most patients with early-stage dementia. However, little is known about older patients' desire for discussions about cognitive problems or the frequency of discussions about cognitive status during primary care visits. To investigate this question, older patients and accompanying individuals were interviewed separately following the first visit with a primary care physician in an outpatient geriatric medical practice. Patients indicated that memory was discussed in 62 percent of visits. When memory was not discussed, almost one-third of patients stated that they would have wanted to discuss it. Physicians were more likely than patients to initiate discussions about memory. Patient factors, including age, gender, the presence of an accompanying individual, number of diagnoses, and the patient's statement that cognitive function was a main goal of the visit, were examined as predictors of the likelihood of discussion of memory during the first visit. Patients who identified discussing cognitive function as a goal of the visit were more likely to have a discussion about memory than those who did not.

232. Austrom, M. G., Damush, T. M., Hartwell, C. W., Perkins, T., Unverzagt, F., Boustani, M., . . . Callahan, C. M. (2004). **Development and implementation of nonpharmacologic protocols for the management of patients with Alzheimer's disease and their families in a multiracial primary care setting.** *The Gerontologist*, 44(4), 548-553.

Purpose: Most patients and families with dementia are cared for in primary care clinics. These clinics are seldom designed to provide the necessary comprehensive care. The purpose of this article is to describe nonpharmacologic protocols for the management of patients with Alzheimer's disease and their families that are administered as part of a multifaceted care-management intervention program in a multiracial primary care clinic. Design & Methods: The nonpharmacologic component for the integrated program of collaborative care was developed based on a literature review and previous clinical experience. The care is coordinated by a geriatric nurse practitioner who meets with patients, families, and the primary care physicians. The nonpharmacologic protocols included general educational guidelines about Alzheimer's disease. Specific protocols to treat the common behavioral disturbances associated with Alzheimer's disease also were developed. A major component of the intervention is a monthly psycho-educational support group for caregivers. Results: The intervention has been well accepted by patients, families, and physicians. Approximately one-half of the treatment group has participated in the support group regularly. Implications: The integration of behavioral interventions and team care within the primary care environment has been successful. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

233. Boise, L., Neal, M. B., & Kaye, J. (2004). **Dementia assessment in primary care: Results from a study in three managed care systems.** *Journals of Gerontology: Series A: Biological Sciences and Medical Sciences*, 59A(6), 621-626. Studied the dementia assessment practices of primary care physicians working in

managed care environments. A cross-sectional cohort study design was used to screen 553 patients aged 75-100 (mean age 81) for dementia in 3 managed health care systems in Portland, Oregon. For participants determined to be cognitively impaired, their medical charts were reviewed to determine if they had experienced adverse events, had been clinically evaluated for possible dementia, had received a diagnosis of dementia, or had been offered treatment. Nearly 43% of the participants were identified as cognitively impaired: 29.7% were classified as mildly cognitively impaired (MI), and 13.7% as moderately to severely cognitively impaired (MSI). Eighteen percent of the MI group and 34.8% of the MSI group had evidence in their medical chart of having been clinically evaluated for dementia. None of the MI group and only 4.3% of the MSI group had been offered a cholinesterase inhibitor. Nearly two-thirds (61.6%) of the MI and 75.4% of the MSI participants had experienced 1 or more adverse events. Of those who had experienced adverse events, 23.7% in the MI group and 44.2% in the MSI group had received a clinical evaluation for dementia. It is suggested that primary care physicians give greater attention to the cognitive functioning of their older patients, especially patients who experience adverse events that may be indicators of dementia. (KM) (AgeLine Database, copyright 2004 EBSCO Publishing, Inc., all rights reserved)

234. Cherry, D. L., Vickrey, B. G., Schwankovsky, L., Heck, E., Plauchm, M., & Yep, R. (2004). **Interventions to improve quality of care: The kaiser permanente-alzheimer's association dementia care project.** *American Journal of Managed Care*, 10(8), 553-560.

OBJECTIVE: To improve quality of dementia care in a Kaiser Permanente service area through rigorous dissemination of practice guidelines and social worker support for physicians and patients. **STUDY DESIGN:** Pre-post design with practice behavior change assessed by medical record review, and provider and caregiver satisfaction with care assessed by surveys. **METHODS:** A diagnostic guideline and later a management guideline were adopted for use by Kaiser Permanente physicians in metropolitan Los Angeles. Physicians received training based on the guidelines, and social workers provided ancillary support. Eighty-three community-dwelling dementia patients and their caregivers were referred to the project by primary care physicians and then were assessed and followed by social workers. Data were abstracted from medical records to determine whether these interventions led to improved quality of care as indicated by adherence to key care processes derived from the adopted dementia guidelines. Chi-square and t tests were applied to compare guideline adherence and satisfaction rates before and after the interventions. **RESULTS:** Compared with baseline, higher rates of provider and caregiver satisfaction with Kaiser's system of dementia care were found at the postintervention follow-up. There also were significantly higher rates of adherence to several practice guideline-based quality measures: assessment of cognitive status; referrals to the Alzheimer's Association; and assessments of activities of daily living, decision-making capacity, depression, and wandering risk. **CONCLUSION:** Quality of primary care for people with dementia can be improved through guideline implementation with care management support by social workers.

235. Connell, C. M., Boise, L., Stuckey, J. C., Holmes, S. B., & Hudson, M. L. (2004). **Attitudes toward the diagnosis and disclosure of dementia among family**

caregivers and primary care physicians. *Gerontologist*, 44(4), 500-507. **PURPOSE:** This study examined attitudes of caregivers and physicians toward assessing and diagnosing dementia, with an emphasis on how a diagnosis is disclosed. **DESIGN AND METHODS:** Seventeen focus group interviews were conducted with caregivers or physicians from three sites; 52 caregivers participated in nine interviews (three each at the three sites), and 39 physicians participated in eight interviews (three each at two sites; two at one site). Structured interview protocols were used to assess diagnostic disclosure, first reactions, and suggestions for improving the diagnostic process. **RESULTS:** Caregivers recounted a highly negative emotional response to the disclosure, whereas many physicians reported that families handled the information well. Caregivers expressed a range of preferences for how the diagnosis should have been disclosed, from a direct approach to having the physician ease them into the results. **IMPLICATIONS:** Whenever possible, physicians should consult with the patient and family at the outset of the diagnostic process to better understand their preferences for diagnostic disclosure. Addressing diagnostic disclosure as part of physician education programs on dementia is recommended.

236. De Lepeleire, J., Aertgeerts, B., Umbach, I., Pattyn, P., Tamsin, F., Nestor, L., & Krekelbergh, F. (2004). **The diagnostic value of IADL evaluation in the detection of dementia in general practice.** *Aging & Mental Health*, 8(1), 52-57. It is assumed that general practitioners can make an important contribution to the diagnosis of dementia. One of the used strategies comprises an evaluation of the Instrumental Activities of Daily Living (IADL). There are contradictory data on the value of this strategy. During one month, 21 Flemish general practitioners evaluated the IADL capacities of all subjects older than 65 years with whom they had contact. Subjects with dementia and/or living in a residential home for the elderly were excluded. Housing and living conditions, medication use and IADL were registered. The general practitioner formulated a clinical evaluation. All subjects with an IADL score $>$ or $=$ 1 and a random sample from the group IADL = 0 underwent a Mini Mental State Examination. Subjects with an IADL score = 4 were referred for neuropsychological and specialist examination. The average age of the 1003 registered subjects was 75.1 years (SD = 6.8). A large majority of them (85%) were totally independent. There was a large discrepancy between the family's and the patient's judgment on the presence of memory problems. There was an inverse correlation between the IADL and MMSE: when the IADL score increased, the MMSE score fell. The diagnostic value of the IADL for the diagnosis of dementia with Camdex-N as a reference standard could not be evaluated because the number of tested subjects was too small. Against the MMSE, sensitivity was 0.81 (SE = 0.03), and specificity was 0.48 (SE = 0.05). The evaluation of the IADL activities had some drawbacks as a detection method for dementia but the use of IADL data may still be clinically valuable in general practice. The correlation between the general practitioner's judgment and that of the specialist was very good. This study showed that the use of the IADL score might change the general practitioner's diagnostic judgment. Furthermore this study confirms the existence of a major threshold for the referral to a specialist of patients with suspected dementia by general practitioners.

237. De Lepeleire, J., Buntinx, F., & Aertgeerts, B. (2004). **Disclosing the diagnosis of dementia: The performance of Flemish general practitioners.** *International Psychogeriatrics*, 16(4), 421-428. Explored the performance in clinical practice of Flemish general practitioners (GPs) in Belgium regarding disclosing the diagnosis of dementia to patients. A mail questionnaire was sent to a random sample of 1,000 Dutch-speaking GPs in May 2002; 647 questionnaires were returned, and 521 were eligible for analysis. Thirty-seven percent of these 521 GPs said that they always or usually disclosed the diagnosis of dementia to their patients, while 37% said that they rarely or never did. Disclosure was mostly affected by the insight of the patient (75%), the patient's personality (59%), and the certainty of diagnosis (54%), as well as by the wishes of relatives not to inform the patient (41%). When they did not disclose the diagnosis, respondents were most concerned about destroying hope for the patient (56%), causing psychological distress (36%), precipitating depressive illness (27%), and prompting catastrophic reactions (22%). Most respondents (75%) saw benefits in disclosure, particularly in regard to planning care, providing treatment, and encouraging a good doctor-patient relationship. Only 61% of respondents presented an appropriate differential diagnosis. The results are similar to those from other studies. (MM) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)

238. Ganguli, M., Rodriguez, E., Mulsant, B., Richards, S., Pandav, R., Vander Bilt, J., . . . Morycz, R. K. (2004). **Detection and management of cognitive impairment in primary care: The steel valley seniors survey.** *Journal of the American Geriatrics Society*, 52(10), 1668-1675. Identified characteristics of older primary care patients who were cognitively impaired and who underwent mental status testing by their physicians. Participants in the Steel Valley Seniors Survey, a small-town epidemiological study in Pennsylvania, were aged 65-100 (mean age 76.3) and were patients of one of 15 primary care physicians in 7 office practices in the area. The 1,107 patients provided demographic data and underwent an MMSE screening; a nurse reviewed patient medical records for the previous 5 years in the physician's office. Two sets of comparisons were made: between participants with an MMSE score less than 25 (cognitively impaired) and those with an MMSE score of 25 or greater (unimpaired), and between participants whose charts showed documentation of mental status testing by physicians and those without such documentation. Overall, the mean MMSE score was 25.5 (median 26). A total of 343 (31%) of the sample scored in the impaired range on the MMSE; this group had a mean age of 79.4 and was significantly older than the unimpaired group (mean age 74.9). Of the 31% with MMSE scores indicating impairment, physicians documented memory loss in only 23% of patients, dementia in 12.2%, and impairment in activities of daily living in 6.7%. Physicians documented having performed mental status testing in roughly similar proportions of the impaired and unimpaired. (SW) (AgeLine Database, copyright 2004 EBSCO Publishing, Inc., all rights reserved)

239. Gardner, I. L., Foreman, P., & Davis, S. (2004). **Cognitive dementia and memory service clinics: Opinions of general practitioners.** *American Journal of Alzheimer's Disease & Other Dementias*, 19(2), 105-110.

This study examined general practitioners' (GPs) satisfaction with services provided by memory clinics and the extent to which the clinics were seen as assisting with the management of their patients with dementia. Thirty-five GPs, who had recently referred patients to the Cognitive Dementia and Memory Service (CDAMS) in Victoria, Australia, were interviewed about their experiences. Overall, most were satisfied with the service the clinic provided. They were most positive about the completeness and utility of the assessment and diagnostic information provided, but relatively less satisfied with advice regarding the family's coping and community support services for the patient. It was concluded that the CDAMS is enhancing the capacity of GPs to provide ongoing care to people with dementia. However, the establishment of firmer communication and collaborative protocols between the clinics and GPs would improve their usefulness.

240. Hinton, L., Franz, C., & Friend, J. (2004). **Pathways to dementia diagnosis: Evidence for cross-ethnic differences.** *Alzheimer Disease and Associated Disorders*, 18(3), 134-144.

Summary: The diagnosis of dementia often occurs well after the onset of the disease. Studies of help-seeking behavior may help illuminate why delays occur. Specific Aims: (1) To describe pathways to diagnosis from the perspective of family caregivers and (2) to compare help-seeking patterns and experiences across three ethnic groups. Methods: Semi-structured qualitative interviews were conducted with 39 ethnically diverse family dementia caregivers. Interviews were coded for help-seeking events (initial help-seeking, referrals to secondary helpers, and site of final diagnosis), pathway types, and adverse experiences within the healthcare system along pathways to diagnosis. Results: Help-seeking was most often initiated by family members or formal care providers (ie, healthcare providers or social workers), usually in outpatient primary care settings but also elsewhere (eg, social service agencies, hospitals). "Secondary" formal helpers were often involved, usually through self-referral by families rather than by healthcare providers. While most families reported receiving a "final" diagnosis, a small minority of predominantly Chinese-American families did not. Four distinct pathways to diagnosis were identified and found to vary significantly ($p < 0.03$) across the three ethnic groups, which we label as smooth pathways, crisis events pathways, fragmented pathways, and dead-end pathways. Adverse experiences in the healthcare system were common and included unsatisfactory diagnosis disclosure and explanation, inadequate workup, uncaring or insensitive attitude, language barriers, and discrimination. Conclusions: Cross-ethnic differences were found in both pathway types and in adverse experiences. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

241. Iliffe, S., Wilcock, J., & Haworth, D. (2004). **A toolbox of skills to share across dementia care.** *Journal of Dementia Care*, 12(4), 16-17. Following from their article in the last issue, on a 'shared care' approach of collaboration between GPs and hospital specialists in dementia care, Steve Iliffe, Jane Wilcock and Deborah Haworth here identify twelve competencies needed by professionals along the dementia care pathway. A third article (next issue) will discuss how to make use of the current positive environment of change.

242. Iliffe, S., Wilcock, J., & Haworth, D. (2004). **A 'shared care' model for people with dementia.** *Journal of Dementia Care*, 12(3), 16-18. Recent legislation obliges Primary Care Trusts to implement 'shared care' protocols -- collaboration between GPs and hospital specialists -- for people with dementia. Steve Iliffe, Jane Wilcock and Deborah Haworth explain 'shared care' and suggest how PCTs should proceed.

243. Meuser, T. M., Boise, L., & Morris, J. C. (2004). **Clinician beliefs and practices in dementia care: Implications for health educators.** *Educational Gerontology*, 30(6), 491-516. Examined clinician beliefs and practices regarding the care of individuals with dementia, with an emphasis on the implications for health educators. A 2-page survey was mailed to a sample of 5,000 Missouri clinicians likely to be involved in dementia care, including primary care physicians and specialist physicians in geriatrics, neurology, and psychiatry; advance practice nurses in family, adult, and geriatric practice; and physician's assistants. A total of 834 completed surveys were returned. The survey focused on knowledge related to Alzheimer's disease (AD), confidence and attitudes toward dementia care, and continuing education (CE) preferences. Specialist physicians had the highest scores in regard to knowledge and confidence; specialists also demonstrated higher scores on items related to dementia care practices and motivation for learning. Specialist physicians reported attending dementia-specific CE programs to a greater degree than other groups, though a substantial proportion of all groups responded positively. Overall, respondents reported a greater preference for live, in-person programming than for technology-driven offerings, such as CD/DVD, satellite, and Internet CE programs. (MM) (AgeLine Database, copyright 2004 EBSCO Publishing, Inc., all rights reserved)

244. Mok, W., Chow, T. W., Zheng, L., Mack, W. J., & Miller, C. (2004). **Clinicopathological concordance of dementia diagnoses by community versus tertiary care clinicians.** *American Journal of Alzheimer's Disease & Other Dementias*, 19(3), 161-165. Subjects enrolled in the Autopsy Program at the University of Southern California Alzheimer's Disease Research Center may receive clinical diagnoses from primary care providers in the community or from specialists in neurology. We reviewed the autopsy concordance rates for 463 subjects for diagnoses made by both groups of clinicians. Seventy-seven percent of the sample met neuropathological criteria for Alzheimer's disease (AD). The overall diagnostic accuracy for this sample was 81 percent. Neurologists assessed 200 of the subjects (43 percent). The diagnostic accuracy for any clinical diagnosis among the non-neurologists was 84 percent, and 78 percent ($p = 0.07$) among neurologists. For AD, non-neurologists had a diagnostic concordance rate of 91 percent and neurologists 87 percent. Where neuropathological AD was missed, non-neurologists had failed to detect any cognitive impairment; neurologists had diagnosed Parkinson's disease (PD) and amyotrophic lateral sclerosis (ALS). Erroneous clinical diagnoses of AD missed dementia with Lewy bodies (DLB) or AD concurrent with Parkinson's disease (PD). Our findings identify specific foci for improving clinical diagnosis of dementia among all physicians managing dementia.

245. Musicco, M., Sorbi, S., Bonavita, V., Caltagirone, C., & Study Group on Validation of the Guidelines for the Diagnosis of Dementia and Alzheimer's Disease of the Italian Neurological Society. (2004). **Validation of the guidelines for the diagnosis of dementia and alzheimer's disease of the italian neurological society. study in 72 italian neurological centres and 1549 patients.** *Neurological Sciences*, 25(5), 289-295. The objective of this study was to verify the adherence of Italian family physicians and neurologists to the Guidelines on Diagnosis of Dementia of the Italian Society of Neurology. A multicentre survey was carried out, in 72 neurological centres. The centres included at least 15 consecutive subjects suspected of having a dementia. The adherence of family physicians to the guidelines was poor. Neurologists performed a complete neuropsychological evaluation in a minority of the cases. Patients who had a decrease of Mini Mental Status Examination scores after six months higher than or equal to 4 were more represented among those patients for whom one or more recommendations were not respected. In Italy the adherence to the Guidelines on Diagnosis of Dementia and Alzheimer Validation study's Disease of the Italian Society of Neurology is very poor for family physicians (GPs) and satisfactory, albeit improvable, on the part of neurologists. Respect for the guidelines might improve the outcome of patients with dementia.

246. Phelan, E. A., Williams, B., LaCroix, A. Z., Grothaus, L., LoGerfo, J. P., & Wagner, E. H. (2004). **Effects of provider practice on functional independence in older adults.** *Journal of the American Geriatrics Society*, 52(8), 1233-1239. Objectives: To examine provider determinants of new-onset disability in basic activities of daily living (ADLs) in community-dwelling elderly. DESIGN: Observational study. Setting: King County, Washington. Participants: A random sample of 800 health maintenance organization (HMO) enrollees aged 65 and older participating in a prospective longitudinal cohort study of dementia and normal aging and their 56 primary care providers formed the study population. Measurements: Incident ADL disability, defined as any new onset of difficulty performing any of the basic ADLs at follow-up assessments, was examined in relation to provider characteristics and practice style using logistic regression and adjusting for case-mix, patient and provider factors associated with ADL disability, and clustering by provider. Results: Neither provider experience taking care of large numbers of elderly patients nor having a certificate of added qualifications in geriatrics was associated with patient ADL disability at 2 or 4 years of follow-up (adjusted odds ratio (AOR) for experience = 1.29, 95% confidence interval (CI) = 0.81-2.05; AOR for added qualifications = 0.72, 95% CI = 0.38-1.39; results at 4 years analogous). A practice style embodying traditional geriatric principles of care was not associated with a reduced likelihood of ADL disability over 4 years of follow-up (AOR for prescribing no high-risk medications = 0.56, 95% CI = 0.16-1.94; AOR for managing geriatric syndromes = 0.94, 95% CI = 0.40-2.19; AOR for a team care approach = 1.35, 95% CI = 0.66-2.75). Conclusion: Taking care of a large number of elderly patients, obtaining a certificate of added qualifications in geriatrics, and practicing with a traditional geriatric orientation do not appear to influence the development of ADL disability in elder, community dwelling HMO enrollees. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

247. Pond, D., & Brodaty, H. (2004). **Diagnosis and management of dementia in general practice.** *Australian Family Physician*, 33(10), 789. **BACKGROUND:** The assessment and management of dementia has changed in the past 5 years with the introduction of new drugs to combat dementia. In addition, services available for patients with dementia and the means of accessing these services is constantly changing. **OBJECTIVE:** This article discusses the assessment and management of dementia using two case studies. The case studies raise issues about screening and accessing the new drugs for a patient with early dementia, care planning, and the involvement of the carer for a patient with more advanced disease. **DISCUSSION:** As the population ages, dementia is an increasingly important part of general practice. It is important general practitioners are aware of early detection issues, and understand basic screening as well as the possibility of accessing new treatments and community management for patients with dementia.

248. Pucci, E., Angeleri, F., Borsetti, G., Brizioli, E., Cartechini, E., Giuliani, G., & Solari, A. (2004). **General practitioners facing dementia: Are they fully prepared?.** *Neurological Sciences*, 24(6), 384-389. We assessed knowledge about Alzheimer's disease (AD) in a sample of Italian general practitioners (GPs). We first carried out a propedeutic study to verify the ability of an Italian version of the University of Alabama at Birmingham's AD Knowledge Test for Health Professionals to distinguish between 20 AD specialists and 20 non-specialists and to gain reference values. We then administered the test, together with a short questionnaire, to 139 GPs attending an educational programme in November 2000. The cut-off score for discriminating specialists from non-specialists was ≥ 9 . Among the 95 GPs who performed the AD Knowledge Test (68.3% response rate), 21% had a total score ≥ 9 . Our findings suggest that particular focus should be given to dementia in continuing medical education (CME) programmes for GPs.

249. Sexson, K. E. (2004). *Alzheimer disease: Practice patterns of primary care providers in Alaska* UMI Dissertation Services, ProQuest Information and Learning, Ann Arbor, MI. Alzheimer disease (AD) may be the most severe of all the incurable diseases as individuals lose control over both their minds and their bodies. The prevalence of AD in Alaska is projected to increase 226% by 2025 (Alaska Commission on Aging, 2001). A survey was used in this non-experimental, cross sectional study to examine the practice patterns of primary care providers in Alaska. It was also structured to identify potential barriers to implementation of the early detection guidelines. Results indicated adherence to early detection assessment strategies, with the exception of neuropsychologic batteries, and low adherence to patient education strategies. Providers who personally knew someone with AD were more likely to practice to current guidelines. This study is significant to practice and society as the results reflect opportunities to improve the quality of life for patients and caregivers through onset delay, early symptom management, deferral of institutionalization, and cost reduction. (Author Abstract, used by permission) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)

250. Teel, C. S. (2004). **Rural practitioners' experiences in dementia diagnosis and treatment.** *Aging and Mental Health*, 8(5), 422-429. Investigated the experiences of primary care providers in nonmetropolitan settings in diagnosing and treating dementia. Nineteen primary care providers aged 31-67 (mean age 50.5) in mostly rural areas of a Midwestern state were interviewed about their experiences in diagnosis and treatment of dementia. Participants estimated that the time from symptom onset to diagnosis ranged from several months to 1 year, largely dependent on family recognition. Limitations in access to consultants and limited or nonexistent community support and education resources were major impediments to diagnosis and treatment, respectively. Denial among family members, or families who were absent or uncooperative, created additional challenges for providers in making and communicating diagnoses and in supporting home-based or institutional care. Conversely, supportive and motivated families played a central role in positive patient care experiences. The providers agreed that support and education services were important for family caregivers, but they generally had few resources to offer the families, which constrained their ability to provide optimal care. (SW) (AgeLine Database, copyright 2004 EBSCO Publishing, Inc., all rights reserved)

251. Turner, S., Iliffe, S., Downs, M., Wilcock, J., Bryans, M., Levin, E., . . . O'Carroll, R. (2004). **General practitioners' knowledge, confidence and attitudes in the diagnosis and management of dementia.** *Age & Ageing*, 33(5), 461-467. OBJECTIVE: To measure general practitioners' knowledge of, confidence with and attitudes to the diagnosis and management of dementia in primary care. SETTING: 20 general practices of varying size and prior research experience in Central Scotland, and 16 similarly varied practices in north London. Participants: 127 general practitioners who had volunteered to join a randomised controlled trial of educational interventions about dementia diagnosis and management. METHODS: Self-completion questionnaires covering knowledge, confidence and attitudes were retrieved from practitioners prior to the educational interventions. RESULTS: General practitioners' knowledge of dementia diagnosis and management is good, but poor awareness of its epidemiology leads to an over-estimate of caseload. Knowledge of local diagnostic and support services is less good, and one third of general practitioners expressed limited confidence in their diagnostic skills, whilst two-thirds lacked confidence in management of behaviour and other problems in dementia. The main difficulties identified by general practitioners were talking with patients about the diagnosis, responding to behaviour problems and coordinating support services. General practitioners perceived lack of time and lack of social services support as the major obstacles to good quality care more often than they identified their own unfamiliarity with current management or with local resources. Attitudes to the disclosure of the diagnosis, and to the potential for improving the quality of life of patients and carers varied, but a third of general practitioners believed that dementia care is within a specialist's domain, not that of general practice. More experienced and male general practitioners were more pessimistic about dementia care, as were general practitioners with lower knowledge about dementia. Those reporting greater difficulty with dementia diagnosis and management and those with lower knowledge scores were also less likely to express attitudes endorsing open communication with patient and carer. CONCLUSION: Educational support for general practitioners should

concentrate on epidemiological knowledge, disclosure of the diagnosis and management of behaviour problems in dementia. The availability and profile of support services, particularly social care, need to be enhanced, if earlier diagnosis is to be pursued as a policy objective in primary care.

252. Werner, P., Gafni, A., & Kitai, E. (2004). **Examining physician-patient-caregiver encounters: The case of alzheimer's disease patients and family physicians in israel.** *Aging and Mental Health*, 8(6), 498-504. Examined the characteristics of physician-patient-caregiver encounters in the presence of dementia and how sociodemographic and professional characteristics of family physicians in Israel and severity of symptoms in their patients with dementia affected these encounters. Data were collected from telephone interviews with 141 Israeli-Jewish family physicians (mean age 48.6). Physicians were presented with 1 of 2 vignettes describing a 76-year-old woman with dementia, one in which the woman sits quietly and cooperates during the examination and the other where she is agitated and uncooperative. They were then asked to what extent they would ask questions to inform and involve the patient and caregiver, respectively. Findings suggested that physicians would address the caregiver more than the patient, with respect to questions, information, and involvement. It was also found that older physicians who had a higher number of years in the profession would address the caregiver to a higher degree than younger and less experienced physicians. (DA) (AgeLine Database, copyright 2005 EBSCO Publishing, Inc., all rights reserved)

253. Wilkinson, D., Stave, C., Keohane, D., & Vincenzino, O. (2004). **The role of general practitioners in the diagnosis and treatment of alzheimer's disease: A multinational survey.** *Journal of International Medical Research*, 32(2), 149-159. Alzheimer's disease (AD) is a growing healthcare problem. Early diagnosis and effective treatment would benefit patients and caregivers, as well as having economic implications. We conducted a survey of 741 caregivers of patients with AD in Australia, France, Italy, Spain and the UK to assess the current situation regarding the diagnosis and treatment of AD in routine clinical practice. The average time from when symptoms were first noticed by the caregiver to making the first doctor's appointment was 4 months, but 22% of caregivers waited more than 1 year before consulting a doctor. Although the majority of patients (74%) consulted their general practitioner first, the diagnosis was more likely to be made by a specialist; on average, there was a 1-year delay from when symptoms were first noticed by the caregiver to diagnosis. Access to AD care is restricted by many national healthcare systems. The delay in diagnosis imposed by such restrictions impacts on access to early and effective treatment.

254. Aupperle, P. M., MacPhee, E. R., Coyne, A. C., Blume, J., & Sanchez, B. (2003). **Health service utilization by alzheimer's disease patients: A 2-year follow-up of primary versus subspecialty care.** *Journal of Geriatric Psychiatry & Neurology*, 16(1), 15-17. All dementia patients and their caregivers who had received a university-based comprehensive evaluation and a diagnosis of Alzheimer's disease during 1997 (N = 80) were identified. Of the original cohort, 48.8% (n = 39) were able to be contacted

approximately 2 years after their initial assessment, and the caregivers were the informants for this follow-up. Two subgroups were defined: 22 patients were being seen only by their primary care physicians (MED), while 17 patients were also being treated by a geriatric psychiatry faculty member (GERO). There were statistically significant differences between the 2 groups (MED versus GERO, respectively) at follow-up in terms of (1) institutionalization (30.0% versus 4.6%, $P < .05$), (2) CDR (2.3 versus 1.5, $P < .005$), and (3) prescription of donepezil at follow-up (45.5% versus 76.5%, $P = .05$). These differences are being assessed in a larger scale prospective study.

255. Boustani, M., Peterson, B., Hanson, L., Harris, R., Lohr, K. N., U.S. & Preventive Services Task, F. (2003). **Screening for dementia in primary care: A summary of the evidence for the U.S. preventive services task force.** *Annals of Internal Medicine*, 138(11), 927-937. Retrieved from <http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=med4&AN=12779304>

BACKGROUND: Dementia is a large and growing problem but is often not diagnosed in its earlier stages. Screening and earlier treatment could reduce the burden of suffering of this syndrome. **PURPOSE:** To review the evidence of benefits and harms of screening for and earlier treatment of dementia. **DATA SOURCES:** MEDLINE, PsycINFO, EMBASE, the Cochrane Library, experts, and bibliographies of reviews. **STUDY SELECTION:** The authors developed eight key questions representing a logical chain between screening and improved health outcomes, along with eligibility criteria for admissible evidence for each question. Admissible evidence was obtained by searching the data sources. **DATA EXTRACTION:** Two reviewers abstracted relevant information using standardized abstraction forms and graded article quality according to U.S. Preventive Services Task Force criteria. **DATA SYNTHESIS:** No randomized, controlled trial of screening for dementia has been completed. Brief screening tools can detect some persons with early dementia (positive predictive value $<$ or $=50\%$). Six to 12 months of treatment with cholinesterase inhibitors modestly slows the decline of cognitive and global clinical change scores in some patients with mild to moderate Alzheimer disease. Function is minimally affected, and fewer than 20% of patients stop taking cholinesterase inhibitors because of side effects. Only limited evidence indicates that any other pharmacologic or nonpharmacologic intervention slows decline in persons with early dementia. Although intensive multicomponent caregiver interventions may delay nursing home placement of patients who have caregivers, the relevance of this finding for persons who do not yet have caregivers is uncertain. Other potential benefits and harms of screening have not been studied. **CONCLUSIONS:** Screening tests can detect undiagnosed dementia. In persons with mild to moderate clinically detected Alzheimer disease, cholinesterase inhibitors are somewhat effective in slowing cognitive decline. The effect of cholinesterase inhibitors or other treatments on persons with dementia detected by screening is uncertain. [References: 119]

256. Bridges-Webb, C., Wolk, J., Britt, H., & Pond, D. (2003). **The management of dementia in general practice. A field test of guidelines.** *Australian Family Physician*, 32(4), 283-285. **INTRODUCTION:** Guidelines for the management of dementia in non-institutionalized

patients living in the community were developed by a broadly representative group. We assessed their usefulness. **METHOD:** The draft guidelines included emphasis on psychosocial issues. They were field tested by 17 general practitioners with 119 dementia patients. **RESULTS:** There was a high prevalence of comorbidity in the patients and frequent psychosocial issues in their management that were often not addressed. The guidelines were rated as very helpful for at least one aspect of care for 50% of the patients. **DISCUSSION:** The guidelines were found to be useful to GPs.

257. Byszewski, A. M., Graham, I. D., Amos, S., Man-Son-Hing, M., Dalziel, W. B., Marshall, S., . . . Guzman, D. (2003). **A continuing medical education initiative for canadian primary care physicians: The driving and dementia toolkit: A pre- and postevaluation of knowledge, confidence gained, and satisfaction.** *Journal of the American Geriatrics Society*, 51(10), 1484-1489. This study examined the effect of the Driving and Dementia Toolkit on physician knowledge and confidence gained and the anticipated change in patient assessment and evaluated the extent to which physicians found the material to be useful. Before receiving the driving toolkit, 301 randomly selected primary care physicians received a copy of the pretest questionnaire; 145 responded and met the eligibility criteria. This group was then sent the toolkit, a satisfaction a survey, and a posttest questionnaire. Physicians were faxed the questionnaires (with up to three reminders) and telephoned if necessary. Changes in pre- and posttest results were analyzed using the McNemar test and Wilcoxon signed rank test nonparametric procedures included in SPSS, Version 10.0, and paired-samples t test. Pre- and posttest data were available and could be matched for 86 physicians (59.3%) response. Knowledge and confidence increased significantly ($P \leq .05$) for most of the toolkit content questions. There was also a clear intent on the part of study participants to begin including additional pertinent questions in the patient/caregivers interview when assessing a patient's fitness to drive. On a scale from 1 (low) to 10 (high), overall satisfaction with the toolkit rated an average of 8.4. Use of the toolkit resulted in a clear improvement in physicians' reported knowledge of and confidence in dealing with dementia and driving. Future applications of similar innovative continuing education models can be used for other areas such as disclosure of dementia diagnosis, capacity assessments, or end-of life issues.

258. Finkel, S. I. (2003). **Cognitive screening in the primary care setting. the role of physicians at the first point of entry.** *Geriatrics*, 58(6), 43-44. There are many reasons why it is important to conduct the cognitive assessment and arrive at a preliminary diagnosis within the primary care setting. In addition to starting the patient on anti-cholinesterase medications, the physician must discuss with the family (and often the patient) issues related to financial matters and self-care. Alzheimer's patients who live alone may be targets for financial and personal exploitation, and are at risk for self-neglect. Community support or provision might be needed to assist with medication compliance, provide nutritional services by shopping for prepared foods or through Meals on Wheels, housekeeping to maintain cleanliness, adult day services to provide social and recreational activities, live-in companions, and assistance with other instrumental activities of daily living. Sometimes more structured or institutional living is necessary. Generally, the primary care practice is not set up to coordinate these additional

services, as well as to provide ongoing care. We will discuss potential solutions to providing ongoing care in next month's column.

259. Finkel, S. I. (2003). **Dementia patients in primary care.** *Geriatrics*, 58(8), 42. Presents a case study of a community-dwelling 91-year-old man presenting to his primary care physician with cognitive impairment, medication noncompliance, medical problems, and social isolation. Discusses the role and value of a care manager who can conduct in-home assessments of the patient's safety, suggest referrals for transportation and other services, and determine whether the patient needs personal care services. Argues that a critical aspect of primary medical care for patients with mild-to-moderate dementia is determining their nonmedical needs, and suggests that public policy planners must look at care management in primary care settings as an important clinical provision of care. (SW) (AgeLine Database, copyright 2003 EBSCO Publishing, Inc., all rights reserved)

260. Iliffe, S., Manthorpe, J., & Eden, A. (2003). **Sooner or later? issues in the early diagnosis of dementia in general practice: A qualitative study.** *Family Practice*, 20(4), 376-381. OBJECTIVE: The aim of this study was to explore the perspectives of primary care practitioners on the early diagnosis of dementia. METHODS: A total of 247 GPs, 146 community nurses, 36 practice nurses, 79 community mental health nurses and others working in a range of hospital, residential and community settings attended 24 one-day workshops in 21 cities and towns in the UK. A nominal group approach was used relating to the early diagnosis of dementia in the community. RESULTS: Groups agreed on the benefits and risks of early diagnosis of dementia; disagreed about screening for dementia, and about professional resistance to making the diagnosis; constructed comprehensive guidelines on diagnosis, but without much reference to resource implications; yet described actual local resource limitations in detail; and avoided dilemmas about dementia care by framing it as a specialist activity. CONCLUSION: Practitioners situate dementia in a family context but do not yet use a disablement model of dementia which might reduce tensions about early diagnosis and the disclosure of the diagnosis. The term diagnosis could usefully be replaced by recognition, to aid this shift in model. Service gaps may emerge or widen if earlier diagnosis of dementia is pursued as a policy objective.

261. Lawrence, J. M., Davidoff, D. A., KattLloyd, D., Connell, A., Berlow, Y. A., & Savoie, J. A. (2003). **Is large-scale community memory screening feasible? experience from a regional memory-screening day.** *Journal of the American Geriatrics Society*, 51(8), 1072-1078. The objective was to investigate whether a large-scale memory-screening program for community-dwelling elders would be successful in identifying individuals with a high probability of dementia in need of further assessment that would result in the earlier diagnosis of dementia. A descriptive study of experience with a volunteer sample. Ten sites throughout New England on October 29, 1999. Trained volunteer clinicians evaluated 497 community-dwelling individuals on the screening day. An additional 162 subjects who could not be accommodated on that day were subsequently screened at local sites by appointment during the following month. Subjects participated in a standardized

format consisting of an educational lecture, followed by individual screenings with the 7-minute screen (7MS) with locally trained staff. Subjects were informed immediately of test results and counseled regarding follow-up options. A survey was conducted with these subjects and their primary care physicians over the following year. One hundred ten individuals received high/retest scores on the 7MS. A follow-up survey of participants and their physicians supported the conclusion that a community memory-screening program might detect individuals who were previously unknown to have cognitive problems. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

262. Leifer, B. P. (2003). **Early diagnosis of alzheimer's disease: Clinical and economic benefits.** *Journal of the American Geriatrics Society*, 51(5 Suppl Dementia), S281-8.

An estimated four million individuals in the United States have Alzheimer's disease (AD). This number is expected to more than triple by mid-century. Primary care physicians have a key role in evaluating older patients for early signs of dementia and in initiating treatment that can significantly retard its progression over the maximum period of time. That role and its challenges will inevitably grow along with the expected increase in the population aged 65 and older. The tendency for physicians to dismiss memory complaints as normal aging must be replaced by awareness of the need to assess and possibly intervene. Early intervention is the optimal strategy, not only because the patient's level of function will be preserved for a longer period, but also because community-dwelling patients with AD incur less societal cost than those who require long-term institutional placement. Institutionalization contributes heavily to the annual cost of care for AD in the United States, which is estimated to be 100 billion dollars annually. [References: 63]

263. Lopponen, M., Raiha, I., Isoaho, R., Vahlberg, T., & Kivela, S. L. (2003). **Diagnosing cognitive impairment and dementia in primary health care -- a more active approach is needed.** *Age & Ageing*, 32(6), 606-612. OBJECTIVE: to determine the documentation rate of dementia in primary health care, the clinical characteristics of patients with documented and undocumented dementia, and the diagnostic evaluations made in cognitive impairment. DESIGN: cross-sectional population-based study with a retrospective review of medical history. SETTING: primary health care in the municipality of Lieto, Southwestern Finland. SUBJECTS: all the inhabitants aged 64 and over in Lieto. Participation rate 82%, numbers = 1260. MEASUREMENTS: assessment of dementia according to DSM-IV criteria, and severity according to Clinical Dementia Rating. Possible documentation of dementia and evaluations done were reviewed from primary health care medical records. RESULTS: 112 patients with dementia were found. The sensitivity of the general practitioners' judgment of dementia was 48.2% and the specificity 99.6%. The documentation rate of dementia was 73% in severe, 46% in moderate and 33% in mild dementia. A greater proportion of the patients with undocumented dementia were male ($P = 0.003$), lived at home ($P = 0.003$), coped better with the instrumental activities of daily living ($P = 0.006$), had more depression ($P = 0.029$) and milder dementia ($P = 0.005$) than patients with documented dementia. Thyroid stimulating hormone was measured in 51% of the patients with suspected memory impairment or dementia, B12 vitamin in 20%, and serum calcium in 18%. Twenty-eight per cent of the patients had been tested for cognitive function, 68%

for depressive symptoms, and 88% for social abilities. Forty-two per cent of patients were referred to a specialist, 32% of patients who were over 75 years. **CONCLUSIONS:** less than half of the patients with dementia had their diagnosis documented in primary care medical records. Documentation increased in more advanced dementia. The diagnostic evaluations for reversible causes of dementia were insufficient in primary care, and they were done at a late phase of cognitive impairment.

264. Manthorpe, J., Iliffe, S., & Eden, A. (2003). **The implications of the early recognition of dementia for multiprofessional teamworking: Conflicts and contradictions in practitioner perspectives.** *Dementia (14713012)*, 2(2), 163-179. In health and social care in the UK there is increasing emphasis on the need to recognize mental health problems as early as possible, particularly among older people. Both research and policy have identified the difficulties caused by delayed or late awareness of dementia and depression, and the potential benefits of their recognition at earlier stages. This article draws on the output from a series of multidisciplinary dementia workshops to explore the implications of such a shift in practice for interprofessional working. At a time when core specialist mental health teams have been identified as a way forward for dementia care in the UK, this discussion sets out four key bipolar categories derived from the workshops which may be useful in planning, implementing and reviewing the development of services and the drawing of professional responsibilities. These categories are opportunistic recognition versus population screening; referral and responsibility; key working and team working; generalist versus specialist roles. From this discussion we note a further four determinants which in our view need to be addressed in order to promote positive developments in dementia services: learning processes, resource implications, professional capacity and confidence and the impact of new teams on broader systems.

265. Manthorpe, J., Iliffe, S., & Eden, A. (2003). **Testing twigg and atkin's typology of caring: A study of primary care professionals' perceptions of dementia care using a modified focus group method.** *Health and Social Care in the Community*, 11(6), 477-485. Examined primary care professionals' perceptions of dementia care using a modified focus group methodology. Data were obtained from over 1,000 general practitioners, community psychiatric nurses, practice and community nurses, social workers, and nursing home staff who took part in 24 one-day multidisciplinary workshops convened in 21 cities in the United Kingdom over a 3-month period. Four focus groups with primary care professionals were held as part of each workshop and concentrated on primary care and the design of dementia care services. Analysis is based on Twigg and Atkin's (1995) typology of caring. It was found that primary care professionals' understanding of caregivers' needs and circumstances fit best with Twigg and Atkins' models of caregivers as resources and coworkers, but showed limited awareness of caregivers responses and attitudes toward caregiving. It is argued that professional assumptions about family members' roles when dementia is recently recognized among older people expand definitions of caregivers, but still confirm their instrumental role. (MM) (AgeLine Database, copyright 2006 EBSCO Publishing, Inc., all rights reserved)

266. Reuben, D. B., Roth, C., Kamberg, C., & Wenger, N. S. (2003). **Restructuring primary care practices to manage geriatric syndromes: The ACOVE-2 intervention.** *Journal of the American Geriatrics Society*, 51(12), 1787-1793. Despite evidence suggesting that primary care physicians do not address geriatric conditions adequately in practice, most efforts to change physicians' practice behaviors have been ineffective or too expensive to implement and sustain. In its second phase, the Assessing Care of the Vulnerable Elders (ACOVE-2) project has developed an intervention aimed at improving the care that primary care physicians provide for three geriatric conditions-falls, urinary incontinence, and cognitive impairment/dementia. The intervention addresses specific processes of care identified in the first phase of the ACOVE project (ACOVE-1) as important to the care of community-dwelling older persons. Beginning with case finding, the intervention uses a standardized multicomponent practice-change effort. The condition-specific intervention employs four methods of changing medical practice: efficient collection of condition-specific clinical data, medical record prompts to encourage performance of essential care processes, patient education materials and activation of the patient's role in follow-up, and physician decision support and physician education. Moreover, the costs of the intervention are low. The effectiveness of the intervention in improving the processes of care for these conditions and clinical outcomes will need to be evaluated in controlled trials.

267. Turner, S., Iliffe, S., Downs, M., Bryans, M., Wilcock, J., & Austin, T. (2003). **Decision support software for dementia diagnosis and management in primary care: Relevance and potential.** *Aging and Mental Health*, 7(1), 28-33. Investigated the potential usefulness and constraints of a Computer Decision Support System (CDSS) to assist practitioners in diagnosing and managing dementia. The CDSS covers 5 separate but related consultations: dementia diagnosis, diagnostic review, dementia management, caregiver needs assessment, and dementia problems. Questionnaire information was obtained from 97 primary-care practitioners (53 physicians and 44 nurses) regarding their current practice and views on dementia care, priority given to training, and familiarity with computer use. The results suggest that although the CDSS is relevant and well-targeted, there may be potential constraints that limit its efficacy, such as the location of patient contacts and limited familiarity with the practice electronic patient record system. The frequency of patient and caregiver contact in settings other than the surgery may limit the usefulness of software designed to assist in live consultations in the surgery. In addition, time constraints already limit the extent to which patients with dementia and their carers can be supported. Any intervention that increases pressure on time within the surgery consultation or home visit may therefore meet considerable resistance. (AS) (AgeLine Database, copyright 2003 EBSCO Publishing, Inc., all rights reserved)

268. Waldorff, F. B., Almind, G., Makela, M., Moller, S., & Waldemar, G. (2003). **Implementation of a clinical dementia guideline: A controlled study on the effect of a multifaceted strategy.** *Scandinavian Journal of Primary Health Care*, 21(3), 142-147. The aim of the study is to assess the impact of a multifaceted implementation strategy aiming to improve GP adherence to a clinical guideline on dementia. Controlled before and after study using data records from regional laboratories. The guideline was mailed to

all general practitioners (GPs). The multifaceted implementation strategy was planned with local GPs, and consisted of seminars, outreach visits, reminders and continuing medical education (CME) small group training. 535 GP practices with 727 physicians in Denmark were selected as the subjects. The diffusion and use of the guideline was measured by a mailed survey. Adherence to guideline recommendations was monitored by data on laboratory tests from general practice in patient's ≥ 65 years: thyroid stimulating hormone requested with vitamin B12 or methylmalonate. The use of these tests as part of a diagnostic evaluation of dementia was subsequently verified by a questionnaire to the practices. Of the GPs who read the guideline, 88% found it applicable in primary care. Although GPs regarded the guideline applicable in primary care, no change in practice adherence to guideline recommendations was detected after a multifaceted implementation. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

269. Wilkinson, H., & Milne, A. J. (2003). **Sharing a diagnosis of dementia--learning from the patient perspective.** *Aging and Mental Health*, 7(4), 300-307. Reviews research evidence from the general practitioner (GP) and patient perspectives on giving and receiving a diagnosis of dementia. Data is drawn from 2 of the authors' own research projects--a survey of GPs in Kent, England, investigating attitudes toward early diagnosis (Milne and colleagues, 2000) and a project exploring patient experiences of receiving a diagnosis (Pratt and Wilkinson, 2001)--as well as wider research. Evidence indicates that in order for practitioners to disclose a diagnosis, they need to believe that it can help the practical and therapeutic outcomes for patients and their families. Most people with dementia want to be told their diagnosis and feel that the diagnostic window offers a number of positive opportunities, and that diagnosis should be a normal component of treatment. GPs need to recognize that people have a right to know their dementia diagnosis and that not sharing a diagnosis can cause distress. The adoption of a person-centered approach underpins good practice and supports the development of an approach that aims to counter the impact of neuronal losses in a realistic, accepting way. This approach requires time, a commitment to early diagnosis and treatment, and preparedness to be honest, however challenging or painful. (AR) (AgeLine Database, copyright 2003 EBSCO Publishing, Inc., all rights reserved)

270. Blunden, P., & Long, L. (2002). **Dementia and GP referrals to CPNs.** *Mental Health Nursing*, 22(4), 8-12. It has long been noted by community psychiatric nurses (CPNs) in Buckinghamshire, that some general practitioners (GPs) frequently refer patients with dementia to the CPN, while others, often within the same practice, rarely do so. This research by Phil Blunden and Richard Long attempts to discover the reasons for this and identify GP's perceptions of the CPN role, with regards to patients suffering from dementia. One hundred and seventy five GPs were mailed or hand delivered a questionnaire with a covering letter. A sufficient number of responses (55 per cent) managed to give the researchers an increased understanding of what GPs expect from a CPN with regards to dementia care.

271. Bridges-Webb, C. (2002). **Dementia care in general practice: What can the BEACH survey tell us?** *Australian Family Physician*, 31(4), 381-383.

BACKGROUND: Only a small amount of rather selective information about dementia care in general practice in Australia is available. **AIM:** To obtain a broader understanding of the prevalence and management of dementia in general practice. **METHOD:** An analysis of data from the Bettering the Evaluation And Care of Health (BEACH) study of general practice in 1998-2000 was undertaken. **RESULTS:** Only 21% of GPs reported any encounter with a patient at which dementia was treated within their reported 100 patient encounters. These encounters comprised only 0.43% of all encounters; 39% of these encounters were in a nursing home and 28% occurred in the GP's consulting rooms. For 7% of patients the diagnosis of dementia was new. Most patients with dementia were aged over 75 years, but dementia was treated in only 3% of all patients of this age. It was treated in 19% of patients seen in nursing homes. Nearly all patients (96%) with dementia had other conditions managed at the encounter. Medication was infrequently prescribed for dementia. **DISCUSSION:** More information is needed about dementia and its care in the community--its stage, extent of impairment and disability, social functioning, use of services, carers and their health, and progression over time.

272. Brodaty, H., & Green, A. (2002). **Who cares for the carer? the often forgotten patient.** *Australian Family Physician*, 31(9), 833-836. **BACKGROUND:** Dementia not only affects the patient but also those nearest the patient most notably the carer. It is known that caring for a patient with dementia can adversely affect one's psychological, physical, social and financial health. **OBJECTIVE:** To highlight the needs of the carer of a patient with dementia and suggest means by which general practitioners may provide the necessary support for these carers. **DISCUSSION:** The GP has a key role in providing support to the carer of the patient with dementia. General practitioners and carers can work as partners in the long term management of dementia thereby reducing the adverse health effects on the carer. [References: 35]

273. Bruce, D. G., Paley, G. A., Underwood, P. J., Roberts, D., & Steed, D. (2002). **Communication problems between dementia carers and general practitioners: Effect on access to community support services.** *Medical Journal of Australia*, 177(4), 186-188. **OBJECTIVES:** To investigate the circumstances that led general practitioners to refer dementia sufferers and their carers to community support services. **DESIGN:** Qualitative study using semi-structured interviews, carried out between 1 September 1999 and 30 April 2000. **SETTING AND PARTICIPANTS:** 21 live-in carers of patients with dementia referred for the first time to a Western Australian metropolitan Aged Care Assessment Team, and 19 of their referring general practitioners. **RESULTS:** Most referrals occurred after the carers had been experiencing carer stress, and were precipitated by crisis situations. Carers failed to discuss their difficulties with the referring GP for a variety of reasons, including the belief that they should cope because it was their duty. The doctors found it difficult to know how the carers were coping or when to intervene, and some carers tended to resist their attempts to help. Time constraints were a significant problem for both groups. **CONCLUSION:** Attitudinal barriers in both carers of patients with dementia and GPs, combined with time constraints, often lead to inadequate assessment of carer problems. While it is important that strategies to improve communication between carers and GPs are developed, it would be

sensible for GPs to assume that dementia carers are at risk of carer stress and should be encouraged to use community care services.

274. Cavalieri, T. A., Latif, W., Ciesielski, J., Ciervo, C. A., Jr, & Forman, L. J. (2002). **How physicians approach advance care planning in patients with mild to moderate alzheimer's disease.** *Journal of the American Osteopathic Association*, 102(10), 541-544.

Decision-making ability regarding end-of-life issues is often compromised by dementia in patients with Alzheimer's disease. This study assessed physicians' discussions of advance care planning with patients with mild to moderate Alzheimer's disease. Data were collected by a survey of full-time faculty in the departments of Medicine and Family Medicine and the Center for Aging at the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine, as well as physicians in private practice affiliated with the Kennedy Health System. Data consisted of questions that assessed whether advance care planning was provided, what specific topics were discussed, and what actions were taken if advance care planning was not offered. Of the 271 physicians to whom the survey was sent, 63 responded, for a return rate of 23%. Of those responding, 81% indicated that they counseled their patients regarding advance care planning issues, while 19% did not. Of those who provided advance care planning for their patients (N = 51), 88% discussed living wills; 53%, the durable power of attorney for healthcare; 47%, end-of-life care; and 35%, financial planning issues. Thirty-seven percent recommended an elder law attorney, and 31% made a referral to the Alzheimer's Association. Of those who provided advance care planning for their patients' caregivers (N = 51), 86% discussed living wills; 78%, nursing home care; 69%, driving issues; and 47%, end-of-life care. Twenty-five percent referred their patients to an elder law attorney. Results indicate that physicians need to be more knowledgeable and proactive in their approaches to advance care planning for patients with mild to moderate Alzheimer's disease.

275. Cody, M., Beck, C., Shue, V. M., & Pope, S. (2002). **Reported practices of primary care physicians in the diagnosis and management of dementia.** *Aging and Mental Health*, 6(1), 72-76.

Examined the practices of primary care physicians (PCPs) in regard to the diagnosis and management of dementia in their patients. A convenience sample of 142 PCPs (mean age 46) in Arkansas completed a questionnaire that focused on dementia diagnostic, referral, and management practices, based on the Scottish General Practitioner Survey. Most of the PCPs (54%) reported difficulty establishing a diagnosis of dementia, and they had more difficulty telling patients about the diagnosis. PCPs were less likely to tell the patient if they suspected dementia (73%) than if they were sure the patient had dementia (88%). In both cases, they were more likely to tell the family (92% and 100%, respectively). The PCPs discussed disease progression and driving risks with patients and families, but few referred them to social workers or community agencies. Findings support training PCPs in the diagnosis and management of dementia and providing tools to improve care, particularly in light of the shortage of geriatric specialists. (MM) (AgeLine Database, copyright 2002 EBSCO Publishing, Inc., all rights reserved)

276. Cummings, J. L., Frank, J. C., Cherry, D., Kohatsu, N. D., Kemp, B., Hewett, L., & Mittman, B. (2002). **Guidelines for managing alzheimer's disease: Part II. treatment.** *American Family Physician*, 65(12), 2525-2534. Once the clinical diagnosis of Alzheimer's disease has been made, a treatment plan must be developed. This plan should include cholinesterase inhibitor therapy to temporarily improve cognition or slow the rate of cognitive decline, management of comorbid conditions, treatment of behavioral symptoms and mood disorders, provision of support and resources for patient and caregiver, and compliance with state-mandated reporting requirements for driving impairment and elder abuse. The primary caregiver can be a valuable ally in communication, management of care, and implementation of the care plan. Patient symptoms and care needs change as Alzheimer's disease progresses. In the early stage of the disease, the family physician should discuss realistic expectations for drug therapy, solicit patient and family preferences on future care choices, and assist with advance planning for future care challenges. In the middle stage, the patient may exhibit behavioral symptoms that upset the caregiver and are difficult to manage. When the patient is in the advanced stage of Alzheimer's disease, the caregiver may need support to provide for activities of daily living, help in making a difficult placement decision, and guidance in considering terminal care options. Throughout the course of the disease, routine use of community resources allows care to be provided by a network of professionals, many of whom will be specialists in Alzheimer's disease. [References: 23]

277. Cummings, J. L., Frank, J. C., Cherry, D., Kohatsu, N. D., Kemp, B., Hewett, L., & Mittman, B. (2002). **Guidelines for managing alzheimer's disease: Part I. assessment.** *American Family Physician*, 65(11), 2263-2272. Family physicians play a key role in assessing and managing patients with Alzheimer's disease and in linking the families of these patients to supportive services within the community. As part of comprehensive management, the family physician may be responsible for coordinating assessments of patient function, cognition, comorbid medical conditions, disorders of mood and emotion, and caregiver status. Suggestions for easily administered and scored assessment tools are provided, and practical tips are given for supporting primary caregivers, thereby increasing efficiency and quality of care for patients with Alzheimer's disease. [References: 22]

278. Downs, M., Clibbens, R., Rae, C., Cook, A., & Woods, R. (2002). **What do general practitioners tell people with dementia and their families about the condition? A survey of experiences in scotland.** *Dementia (14713012)*, 1(1), 47-58. There has been growing discussion in the literature about the merits and demerits of disclosing a diagnosis to a person with dementia. There is growing empirical evidence that general practitioners (GPs) are reluctant to share the diagnosis with people with dementia. To date little research has examined what GPs tell their patients and their families. The purpose of the reported study was to examine what GPs tell people with dementia and their families about the condition. The study relied on data gathered from an opportunistic sample of 114 GPs who were attending a training course in care of people with dementia. Findings reveal a disparity between what GPs tell the family and the person. People with dementia tend to be given information about the symptoms and the cause is described predominantly as part of ageing. Family members are given

information about symptoms, cause, prognosis and available supports. Best practice regarding diagnosis disclosure to people with dementia needs to be established. This includes what people with dementia are told, how they are told and what supports are made available to those who have been told.

279. Fortinsky, R. H., Unson, C. G., & Garcia, R. I. (2002). **Helping family caregivers by linking primary care physicians with community-based dementia care services: The alzheimer's service coordination program.** *Dementia (14713012)*, 1(2), 227-240.

The Alzheimer's Service Coordination Program (ASCP) was developed based on the rationale that family caregivers of people with dementia could benefit in measurable ways from a care partnership arrangement linking primary care physicians with a community organization that specializes in dementia education and support. In metropolitan Cleveland, Ohio, USA, 29 physicians referred 62 family caregivers to a Service Coordinator (SC), who provided individualized consultation to family caregivers and capable patients with dementia regarding all non-medical aspects of dementia care and available resources in the community. Over a six-month intervention period, 44 caregivers with complete follow-up data reported statistically significant increases in self-efficacy for managing dementia symptoms, and self-efficacy for using community support services. Caregivers and participating physicians reported satisfaction with the ASCP. Despite relatively small numbers of participants, the service coordination and individualized consultation model featured in the ASCP has been adapted for two larger randomized trials in the USA.

280. Goodwin, J. S. (2002). **Language and medicine: Thinking and talking about alzheimer's disease.** *Gerontologist*, 42(3), 293-296.

Discusses the ways in which confusion about language hinders the practice of medicine, focusing on miscommunications between physicians and patients, miscommunications among physicians, and distortion of medical thinking. Many terms in medicine, such as "arthritis," communicate different things to doctors and patients: doctors think in terms of a technical diagnosis, while patients think of a malign force within the body, a crippling disease that can strike anywhere. It may be more appropriate for doctors to talk about "bad knees" or "bad shoulders" when talking with patients, in that these less precise terms come much closer to communicating what is going on inside the body. Physicians themselves are often confused by the highly technical language of the field. The language used to describe a condition or disease may influence the medical thinking about it. While "Alzheimer's disease" is a progressive, incurable, and fatal condition with much stigma attached to it, it might be better to tell patients over 80 that they have a late-life learning disability. Most of these individuals will die of other causes before severe dementia occurs, without the loss of personhood and status associated with a diagnosis of Alzheimer's disease. (MM) (AgeLine Database, copyright 2002 EBSCO Publishing, Inc., all rights reserved)

281. Iliffe, S., Austin, T., Wilcock, J., Bryans, M., Turner, S., & Downs, M. (2002). **Design and implementation of a computer decision support system for the diagnosis and management of dementia syndromes in primary care.** *Methods of Information in*

Medicine, 41(2), 98-104.

Background: Diagnosis and management of dementia is a complex process and primary care physicians are under-equipped to deal with uncertainties in the provision of optimal care for the patient. Objective: To develop a computer decision support system (CDSS) which could assist physicians with diagnosis and management and improve patient care. Methods: A design group including general practitioners derived logic pathways for diagnosis and management of dementia and validated them with a multiprofessional expert group. Logic pathways were used to construct a comprehensive CDSS rendered as a series of expert consultations. The CDSS was inserted into commercially available GP systems and bench and field-tested. Results: The complexity of dementia diagnosis and management can be captured in logic pathways which can be expressed as decision trees within existing electronic patient records. The resulting CDSS appears useable in routine practice. Conclusion: The impact of this CDSS will be evaluated in a randomised controlled trial of educational interventions in primary care.

282. Iliffe, S., & Manthorpe, J. (2002). **Dementia in the community: Challenges for primary care development.** *Reviews in Clinical Gerontology*, 12(3), 243-252. The paper reviews issues related to caring for older people with dementia from a primary care perspective. It focuses on the problematic nature of dementia for general practitioners and community nurses, the issues around patient and carer experience that must be understood if the quality of care is to be improved, and the division of labour between specialists and generalists that needs to be achieved to optimize service delivery. The article concludes that shared-care approaches to dementia care, with a clear division of labour between specialist and generalist medical and nursing care, are needed. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

283. Iliffe, S., Wilcock, J., Austin, T., Walters, K., Rait, G., Turner, S., . . . Downs, M. (2002). **Dementia diagnosis and management in primary care: Developing and testing educational models.** *Dementia: The International Journal of Social Research and Practice*, 1(1), 11-23. Dementia presents a challenge for primary care and the advent of new therapeutic options has highlighted the need to improve its detection so that early decisions about medication use can be made. Efforts at earlier diagnosis should be targeted at primary care as the gateway to specialist health and social services. There is, however, evidence that dementia remains under-detected and sub-optimally managed in general practice throughout the world. This article reviews the obstacles to early recognition of dementia and the factors causing sub-optimal management in the community, and discusses educational approaches to enhancing professional skills in the recognition of and response to dementia. Three educational interventions with different characteristics and methods of delivery are described. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

284. Kemp, N. M., Brodaty, H., Pond, D., & Luscombe, G. (2002). **Diagnosing dementia in primary care: The accuracy of informant reports.** *Alzheimer Disease and Associated Disorders*, 16(3), 171-176. Investigated the accuracy of informant reports of cognitive status against psychometric

tests for diagnosing dementia. Four areas of patient cognitive ability were examined: memory of recent events, ability to remember a short list of items after a delay, language/naming abilities, and working memory. A convenience sample of 67 primary care practitioners in Australia recruited 242 community-dwelling patients aged 75 or older regardless of cognitive status or aged 50-74 with suspected memory complaints; patients were aged 56-94 (mean age 79.6), and 58.3% were women. A total of 242 friends or relatives aged 20-90 (modal age 70-79 years) acted as informants. The Cambridge Examination for Mental Disorders in the Elderly (CAMDEX) was administered to patients at home, and the CAMDEX informant interview and the scale of instrumental activities of daily living were administered to informants in person or by telephone. More than half of the informants (60%) gave responses consistent with psychometric testing. Informants who underreported patient difficulties tended to report on patients who were diagnosed as having subclinical dementia, were less educated, and had poorer remote memory. Informants who overreported difficulties were more likely to report on those diagnosed with dementia. While informant accounts are critical for assessing dementia, in 40% of cases these reports may be inaccurate, particularly when the patient has low education and poor remote memory or when overall cognitive difficulties are mild. (SW) (AgeLine Database, copyright 2002 EBSCO Publishing, Inc., all rights reserved)

285. Lipski, P. S. (2002). **Survey of general practitioners' attitudes to older drivers on the new south wales central coast.** *Australasian Journal on Ageing*, 21(2), 98-100.

Investigated the attitudes of general practitioners (GPs) to older drivers in the central coast area of New South Wales, Australia. A 26-item questionnaire was mailed to 275 GPs; 175 (63%) completed the questionnaire. Responses indicated the following: 98% perform medical driver assessments for older drivers, 91% are aware that they are indemnified by law to report unfit or unsafe drivers to the Roads and Traffic Authority (RTA), 61% allow older drivers with very mild Alzheimer's disease to still drive a motor vehicle, 9% allow older drivers with moderate Alzheimer's disease to continue to drive, 23% allow an older person with Alzheimer's disease to drive the vehicle locally only (restricted license), and 21% allow older drivers they deem medically unfit to drive to still drive locally if there is no public transportation nearby. Only 41% of GPs thought they had enough training to make an appropriate medical driver assessment, only 29% routinely asked about driving habits and medical fitness to drive in their older patients, and 55% think that another medical body should oversee all medical driver assessments rather than the GP. The results suggest that some GPs are allowing medically unfit drivers to continue to drive, are concerned about the consequences of canceling an older driver's license, and are unhappy in dealing with these issues. (SW) (AgeLine Database, copyright 2002 EBSCO Publishing, Inc., all rights reserved)

286. Pinner, G., & Bouman, W. P. (2002). **To tell or not to tell: On disclosing the diagnosis of dementia.** *International Psychogeriatrics*, 14(2), 127-137. Discusses how health care providers should disclose a diagnosis of dementia to the patient. Research suggests that there has been a cultural change in the disclosure of such diagnoses. However, health care providers show great variation in the practice, with only

around 50% of clinicians regularly telling patients with dementia their diagnosis. The majority of caregivers also appear to prefer the diagnosis to be withheld from the patient with dementia. However, research indicates that most practitioners and caregivers would wish to know themselves if they had the illness. Factors influencing the decision to disclose diagnosis include the degree of certainty of the diagnosis of dementia, the degree of insight of the patient, and the severity of the dementia. The advantages and disadvantages of disclosure are examined, along with the ethical issues involved in deciding whether and how to disclose the diagnosis. (MM) (AgeLine Database, copyright 2002 EBSCO Publishing, Inc., all rights reserved)

287. Podgorski, C. A., Lanning, B. D., Casaceli, C. J., Nardi, A. L., & Cox, C. (2002). **Dementia consults: Predictors of compliance by primary care physicians.** *American Journal of Alzheimer's Disease & Other Dementias*, 17(1), 44-50. This study was designed to determine rates of primary care physician compliance with recommendations made by physician-consultants at an Alzheimer's disease center. A mail survey was sent to primary care physicians, who were asked to indicate which recommendations had been implemented and to select reasons for lack of adherence. The response rate was 53 percent (49/92). Some 83 percent of recommendations were implemented. Compliance with medical recommendations was higher (87 percent) than with social or behavioral issues (69 percent). Reasons for noncompliance indicated that patient or family barriers were responsible in 48 percent of cases, while physicians were responsible in 24 percent. These findings validate the development of two educational programs: curricula that support the primary care physician in conveying the value of these interventions and guidelines to assist specialists in communicating treatment recommendations.

288. Powell, A. L. (2002). **On issues pertinent to alzheimer disease and cultural diversity.** *Alzheimer Disease & Associated Disorders*, 16(Suppl 2), S43-5. Issues that are important in defining the expression of Alzheimer disease in diverse patient groups are critiqued. Topics are partitioned into generic factors that apply to any patient and specific factors for diverse racial and ethnic populations. The range of issues discussed includes the need to better disseminate research data to properly educate primary care physicians about recent insights into the disorder. This critique also considers the need to determine actual diagnostic practices, the distribution of patients and dementia specialists, the lack of standard, valid neuropsychology test panels and the need to define how the disease expression is modified in diverse populations.

289. Ruof, J., Mittendorf, T., Pirk, O., & von der Schulenburg, J. M. (2002). **Diffusion of innovations: Treatment of alzheimer's disease in germany.** *Health Policy*, 60(1), 59-66. Systematic barriers seem to slow down the market penetration of innovative acetylcholinesterase (AChE) inhibitors in Alzheimer's disease. The goal of our study was to examine the diffusion of AChE inhibitors into the German market in more detail. On the basis of using the ongoing surveillance panel of the Institute of Medical Statistic (IMS) Health, the prescription patterns of 100 physicians (72 general practitioners, 28 neurologists) were examined. In addition, structured telephone interviews with the same

100 physicians were conducted. The interview included the assessment of a hypothetical treatment situation (i.e. physicians were asked what they would prescribe if a close relative of theirs had Alzheimer's disease) as well as qualitative items examining the physicians' attitudes towards AChE inhibitors and the perceived impact on drug budgets. As a major result, the analysis revealed that neurologists prescribed AChE inhibitors to 44.6% of their patients, while general practitioners only treated 9.0% of their patients with AChE inhibitors. The analysis of the qualitative items revealed positive attitudes regarding the safety and efficacy of AChE inhibitors, but negative attitudes regarding the budgetary limitations to prescribing these drugs. A correlation of $r=0.21$ ($P<0.05$) was found between the perceived impact on drug budgets and the adoption of AChE inhibitors and a correlation of $r=0.32$ ($P<0.002$) was seen between the physician's specialty and the adoption of AChE inhibitors. These data show that, while the AChE inhibitor adoption process has passed the early stages, various barriers slow down the final stages of AChE inhibitor adoption. The drug budget in particular seems to inhibit the adoption of the innovation by the majority of general practitioners. This leads to a more short-term cost control strategy instead of long-term disease management and cost saving approaches.

290. Sibley, A., MacKnight, C., Rockwood, K., Fisk, J., Gauthier, S., Guzman, D. A., . . . Consortium to Investigate Vascular Impairment of Cognition. (2002). **The effect of the living situation on the severity of dementia at diagnosis.** *Dementia & Geriatric Cognitive Disorders*, 13(1), 40-45.

INTRODUCTION: Previous studies have shown that social determinants not directly involved in the disease process may be implicated in the timing of dementia diagnosis. This study explores the relationship between a patient's living situation and the severity of dementia at diagnosis. METHODS: Data were collected from the baseline interviews of 1,325 patients with cognitive decline enrolled in the Consortium for the Investigation of Vascular Impairment of Cognition study. Data collected included: age, sex, living situation and scores on the Mini-Mental State Examination (MMSE), Global Deterioration Scale (GDS), the Functional Rating Scale (FRS), the Disability Assessment for Dementia (DAD) scale and the Cumulative Illness Rating Scale (CIRS). Living situation was grouped as: (1) lives alone, (2) lives with spouse, (3) lives with child, relative or other and (4) lives in a nursing home. A general linear model univariate analysis was used to compare patients by their respective living situations for differences in mean scores on each of the 4 measures of dementia severity. RESULTS: Statistical analysis of both unadjusted data and data adjusted for age, sex and CIRS scores showed significant differences among the groups. Those who lived alone were diagnosed at an earlier stage (mean scores: MMSE 21.4, GDS 3.6, FRS 20.0, DAD 29.8) followed by those who lived with a spouse (mean scores: MMSE 20.5, GDS 3.7, FRS 20.4, DAD 28.0), those who lived with a child or other (mean scores: MMSE 19.3, GDS 3.9, FRS 22.5, DAD 24.9) and finally those who lived in a nursing home (mean scores: MMSE 15.2, GDS 4.8, FRS 27.5, DAD 16.9). CONCLUSION: Living situation is related to the severity of dementia at diagnosis. Primary care providers should have a low threshold for case-finding in older adults who live with family or friends. Copyright 2002 S. Karger AG, Basel

291. Snellgrove, C. A., & Hecker, J. R. (2002). **Driving and dementia: General practitioner attitudes, knowledge and self-reported clinical practices in south australia.** *Australasian Journal on Ageing*, 21(4), 210-212. Objective: To investigate the attitudes, knowledge, and self-reported clinical practices of general practitioners (GPs) in South Australia (SA) regarding driving and dementia. Method: Information from GPs was gathered via a postal questionnaire. Results: Respondent GPs shared concern about the safety of patients with dementia who drive. Familiarity with the current SA legislation relevant to driving and dementia was modest. A variety of clinical practices are employed by GPs in relation to the assessment and management of the safe driving practices of patients with dementia. Conclusions: Recommendations are made to guide SA GPs in their judgements regarding the driving safety of patients with dementia.

292. van Hout, H. P., Vernooij-Dassen, M. J., Hoefnagels, W. H., Kuin, Y., Stalman, W. A., Moons, K. G., & Grol, R. P. (2002). **Dementia: Predictors of diagnostic accuracy and the contribution of diagnostic recommendations.** *Journal of Family Practice*, 51(8), 693-699. OBJECTIVES: To explore and quantify the relative contribution of guideline recommendations and other determinants in the family physician's diagnostic work-up of patients suspected of dementia. STUDY DESIGN: We prospectively studied 64 family physicians in an Eastern district in the Netherlands who diagnosed dementia according to the national Dutch guidelines in primary care. Their diagnoses were compared with the reference standard embodied by the memory clinic team of the University Medical Center Nijmegen. POPULATION: The physicians evaluated 107 patients older than 55 years suspected of having dementia. OUTCOMES MEASURED: Predictive values of various clinical and demographic parameters were measured in both univariate and multivariate logistic regression analyses. RESULTS: Activities of daily living (ADL) dependency (odds ratio [OR] = 5.3, P = .03), years since symptoms first started (OR = 1.84, P = .03), and the presence of somatic comorbidity (OR = 0.48, P = .02) independently contributed to the prediction of the presence or absence of dementia. The area under the receiver-operating characteristic (ROC) curve for these 3 variables together was 0.79. The ROC area of the family physician's diagnosis to determine the final diagnosis was 0.74. The number of recommendations applied did not additionally contribute to the assessment of the final diagnosis. CONCLUSIONS: The diagnostic accuracy of the family physician was reasonable. For family physicians, ADL dependency is a better predictor of dementia than cognitive impairment. Family physicians should be aware of diagnostic difficulties in patients with somatic comorbidity. We were unable to confirm the diagnostic value of many of the recommendations of dementia guidelines.

293. White, N., Scott, A., Woods, R. T., Wenger, G. C., Keady, J. D., & Devakumar, M. (2002). **The limited utility of the mini-mental state examination in screening people over the age of 75 years for dementia in primary care.** *British Journal of General Practice*, 52(485), 1002-1003. The Mini-Mental State Examination (MMSE) is used worldwide to assess cognitive status and it has been recommended for use in primary care to detect dementia. In this

study, the MMSE was administered during annual health checks for patients over 75 years of age in nine practices by a member of the primary care team. The mean age was 80 years. Of the 709 patients screened, 286 scored at or below the cut-off point, which was set at 26/30 on the MMSE, and they were invited to be assessed further by a researcher, using the well-validated GMS-AGECAT diagnostic system. Eighty-four of these patients refused, 173 were identified as not having dementia, and 29 (14%) were identified as having dementia. These results, with an 86% false-positive rate, raise concerns regarding the utility of the MMSE as a screening instrument for dementia in primary care.

294. Wilcock, J., Iliffe, S., Walters, K., Rait, G., Austin, T., Turner, S., . . . Keady, J. (2002). **Development of an evidence-based curriculum for dementia care training in general practice.** *Education and Ageing*, 17(2-3), 217-236. Developed an educational curriculum for improving dementia diagnosis and management in general practice in the United Kingdom. The project advisory team incorporated members from primary care, experienced general practitioner tutors, psychology, nursing, and the lay population. A modified Delphi approach was used as a method of laboratory testing to establish the content of the core curriculum. The curriculum is built around 5 cases drawn from practitioner experience and organized into a hierarchy of complexity and competence. It incorporates a logic path for dementia diagnosis, beginning with a clinical problem: "Could this patient have dementia?" The flow path with feedback loops allows the whole curriculum to be represented as an electronic tutorial with hypertext links between cases and modules of information, and the case-based approach lends itself to decision support driven by the problems expressed by each case, meeting the need for a curriculum to be adaptable to different settings. The curriculum is currently being tested in a randomized controlled trial of different educational methods in general practices in London and Stirling. (AY) (AgeLine Database, copyright 2004 EBSCO Publishing, Inc., all rights reserved)

295. Cohen, C. A., Pringle, D., & LeDuc, L. (2001). **Dementia caregiving: The role of the primary care physician.** *Canadian Journal of Neurological Sciences*, 28(Suppl 1), S72-6.

BACKGROUND: Family and friends play an important role in caring for individuals with dementia living in the community. In preparation for the Canadian Consensus Conference on Dementia held in Montreal, Canada in February 1998, the subject of dementia caregiving was reviewed in order to provide primary care physicians with some guidelines for their practice. The review was updated in June 2000 in preparation for this article. **METHOD:** Pertinent English-language publications and resources from the Alzheimer Society of Canada were reviewed from 1985 onwards. Findings related to the consequences of caregiving, services for caregivers and recommendations regarding the role of the primary care physician were reviewed. **FINDINGS:** Dementia caregivers experience many positive and negative consequences of caregiving. Some comprehensive services for caregivers have been shown to delay institutionalization and reduce negative consequences of caregiving. The primary care physician has a role to play in working with families and should address the following issues: 1) education about dementia; 2) psychological support for caregivers; 3) assistance mobilizing caregiver social support

networks. CONCLUSION: Primary care physicians have an important role to play in acknowledging and supporting the caregiving provided by family and friends to individuals with dementia. [References: 30]

296. Fortinsky, R. H. (2001). **Health care triads and dementia care: Integrative framework and future directions.** *Aging & Mental Health*, 5(Suppl1), S35-S48. Provides a synopsis of research findings and knowledge gaps regarding interactions among participants in the health care triad--primary care physicians, family caregivers, and persons with dementia. Research traditions that inform knowledge about health care triads and dementia care include: older patient-physician relationships; the stress-coping social-support health model that dominates family caregiver research; the social learning-self-efficacy model; and literature on the quality of medical care. An integrative framework is presented to illustrate how the quality of interaction in dementia care encounters may be influenced by specific characteristics of members of the health care triad. Domains of dementia care interaction include symptom diagnosis, symptom management, medication management, support service linkage, and emotional support. This integrative framework also links the quality of interaction in these domains with health-related outcomes relevant to each of the health care triad members. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

297. Foster, N. L. (2001). **Barriers to treatment: The unique challenges for physicians providing dementia care.** *Journal of Geriatric Psychiatry and Neurology*, 14(4), 188-198. Evaluating and treating dementia is intellectually demanding and enormously satisfying. However, physicians providing dementia care also confront unique challenges that cause discomfort and overwhelming frustration unless they are recognized and overcome. Physicians must care for individuals who do not adopt the "sick role." They must establish and maintain rapport with patients while also approaching collateral sources to obtain a complete history. They must develop a complex alliance with the patient, caregivers, community agencies, and other health professionals to provide effective treatment. Physicians must relate "bad news" to several people at once who are unequally prepared for it, while dealing with their own diagnostic uncertainty. Furthermore, physicians must honor patient autonomy and balance it with the needs of caregivers. Since the demands of providing dementia care are not typical of most medical practice, the special attributes needed are often not taught to students or adequately reimbursed by health insurance. The quality of dementia care will improve when strategies that address these aspects of care for patients with dementia are widely adopted.

298. Freyne, A. (2001). **Screening for dementia in primary care--a viable proposition?** *Irish Journal of Psychological Medicine*, 18(2), 75-77. Discusses issues that require consideration in implementing a primary care (PC) screening program for dementia, with a focus on Ireland. While there is no evidence in support of mass screening of older adults in the general population, it is acknowledged that opportunistic case finding and screening of certain groups can be useful. Practical difficulties faced by PC practitioners include lack of training in the detection and management of dementia, lack of awareness, varying capacity and commitment to

identifying people with dementia, and reluctance to test because of labeling. Those best placed to carry out a screening program are those in PC, ideally the general practitioner, practice nurse, or public health nurse. One model is that of the memory clinic, dedicated to the assessment and management of those with cognitive impairment and early stage dementia, with a focus on early diagnosis and treatment and that maintains close links with PC and community care services. There is no consensus yet regarding which tests to use. Strengthening links between primary and secondary care and developing pilot studies addressing these questions would be an initial step in identifying barriers to and difficulties with screening. This would enable future expansion of screening to develop in a planned, coordinated manner. (AR) (AgeLine Database, copyright 2003 EBSCO Publishing, Inc., all rights reserved)

299. Iliffe, S., & Drennan, V. (2001). **Primary care and dementia.** (2001). *Primary Care and Dementia*. 155 Pp. London, England: Jessica Kingsley Publishers; England, (from the cover) This practice and training guide is written with the needs of health and social care professionals working with people with dementia in mind. Drawing together theoretical considerations and examples of good practice, Steve Iliffe and Vari Drennan look at the different stages of dementia and explain how to: (a) make the initial diagnosis--including guidelines for distinguishing dementia from depression; (b) convey the diagnosis to the person with dementia and their family--outlining the use of cognitive tests and the role of anti-dementia drugs; (c) support the client through lifestyle adjustments; and (d) care for people with dementia as it progresses--both in their own homes and in care home settings. The book is illustrated with case studies and includes a chapter on understanding and responding to the needs of the caregiver--such as access to information and support - and the effect on their own health. Outlining the shared knowledge base required by health and social care practitioners, this useful and accessible work book will also facilitate inter-disciplinary and inter-agency working. (PsycINFO Database Record (c) 2010 APA, all rights reserved); List of figures List of tables List of boxes Foreword Preface The clinical features of dementia Confirming and conveying the diagnosis The pathway of dementia Carers of people with dementia Caring for people as the dementia progresses Good practice and service development References Subject index Name index

300. Lionis, C., Vlachonikolis, J., Chatziarsenis, M., Faresjo, T., Kristjansson, I., Tzagournissakis, M., . . . Trell, E. (2001). **Managing alzheimer's disease in primary care in crete, greece: Room for improvement.** *Quality Management in Health Care*, 9(2), 16-21.

As Greece moves during the last two decades toward a national health care system, which gives emphasis to the development of a primary care system, many worry how to ensure that the quality of care is assessed. This is more apparent in the rural populations, in which health care is served to a large extent by physicians without formal training in general practice. This article explores the level of knowledge of primary care physicians in relation to Alzheimer's disease in geographically defined areas of Crete, Greece, in comparison with that of general practitioners in Ostergotland, Sweden, and in Iceland. It emphasizes the need for better education and training for primary care physicians in Crete in both the early diagnosis and management of Alzheimer's disease.

301. O'Brien, J., Robinson, L., & Fairbairn, A. (2001). **Proposed shared care protocol between primary and secondary care for the ongoing management of those on anti-dementia medication.** *Primary Care Psychiatry*, 7(3), 111-113. Notes that cholinesterase inhibitors have been made available for the management of those with mild to moderate Alzheimer's disease. The National Institute for Clinical Excellence has limited initial assessment and prescribing to secondary care, but recommended that shared care protocols with primary care need to be developed for ongoing management. The authors describe a protocol which may be useful as a model for this purpose. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

302. Olafsdottir, M., Foldevi, M., & Marcusson, J. (2001). **Dementia in primary care: Why the low detection rate?.** *Scandinavian Journal of Primary Health Care*, 19(3), 194-198. OBJECTIVE: The aim of the present study was to find reasons for the low detection rate of dementia in primary care. Another aim was to investigate the attitudes and knowledge on dementia among Swedish general practitioners (GPs). DESIGN: Two-hundred-and-twenty-eight postal questionnaires were distributed to GPs in the county of Ostergotland. SETTING: Primary care in Sweden. MAIN OUTCOME MEASURES: The opinions of GPs on dementia management in primary care. RESULTS: The response rate was 67%. GPs showed a good knowledge of dementia diseases but underestimated the occurrence of dementia. They presented a positive attitude towards managing patients with dementia and considered that existing drug therapy justified an active search for patients with dementia in primary care, but they believed the efficacy of the drugs to be limited. Assessing the social environment of patients and organising social support were regarded as the most difficult tasks in the management of demented patients. CONCLUSION: The study indicates that the main obstacles are a lack of resources and a sceptical attitude to the benefits of drug treatment. Co-operation between the community services, specialist clinics and the primary care team should be improved.

303. Patterson, C., Gauthier, S., Bergman, H., Cohen, C., Feightner, J. W., Feldman, H., . . . Hogan, D. B. (2001). **The recognition, assessment and management of dementing disorders: Conclusions from the canadian consensus conference on dementia.** *Canadian Journal of Neurological Sciences*, 28(Suppl 1), S3-16. OBJECTIVE: i) To develop evidence based consensus statements on which to build clinical practice guidelines for primary care physicians towards the recognition, assessment and management of dementing disorders; ii) to disseminate and evaluate the impact of these statements and guidelines built on these statements. OPTIONS: Structured approach to assessment, including recommended laboratory tests, choices for neuroimaging and referral; management of complications (especially behaviour problems and depression) and use of cognitive enhancing agents. POTENTIAL OUTCOMES: Consistent and improved clinical care of persons with dementia; cost containment by more selective use of laboratory investigations, neuroimaging and referrals; appropriate use of cognitive enhancing agents. EVIDENCE: Authors of each background paper were entrusted to: perform a literature search, discover additional relevant material including references cited in retrieved articles; consult with other experts in the field and then synthesize information. Standard rules of evidence were applied. Based upon this

evidence, consensus statements were developed by a group of experts, guided by a steering committee of eight individuals from the areas of Neurology, Geriatric Medicine, Psychiatry, Family Medicine, Preventive Health Care and Health Care Systems. VALUES: Recommendations have been developed with particular attention to the context of primary care and are intended to support family physicians in their ongoing assessment and care of patients with dementia. BENEFITS, HARMS AND COSTS: Potential for improved clinical care of individuals with dementia. A dissemination and evaluation strategy will attempt to measure the impact of the recommendations. RECOMMENDATIONS: See text. VALIDATION: Four other sets of consensus statements and/or guidelines have been published recently. These recommendations are generally congruent with our own consensus statements. The consensus statements have been endorsed by relevant bodies in Canada. [References: 118]

304. Patterson, C. J., & Gass, D. A. (2001). **Screening for cognitive impairment and dementia in the elderly.** *Canadian Journal of Neurological Sciences*, 28(Suppl 1), S42-51.

OBJECTIVE: To review the evidence available to support or refute the recommendation to screen for cognitive impairment (cognitive deficits which do not affect daily function) and dementia in primary care. DATA SOURCES: Medline search using terms listed at the end of this article; consultation with experts in the field; review of other published recommendations. STUDY SELECTION: There were no articles which described a randomized controlled trial of screening versus no screening. Studies were therefore chosen which aided in the definition; natural history; interventions and outcomes including possible negative effects. DATA SYNTHESIS: No systematic synthesis was performed. Background papers were circulated to a panel of experts prior to the Canadian Consensus Conference on Dementia and conclusions endorsed by consensus. CONCLUSIONS: 1. There is insufficient evidence to recommend for or against screening for cognitive impairment or dementia. (C); 2. Memory complaints should be evaluated and the individual followed to assess progression. (B); 3. When caregivers or informants describe cognitive decline in an individual, these observations should be taken very seriously; cognitive assessment and careful follow-up are indicated. (A) (See Appendix). [References: 94]

305. Renshaw, J., Scurfield, P., Cloke, L., & Orrell, M. (2001). **General practitioners' views on the early diagnosis of dementia.** *British Journal of General Practice*, 51(462), 37-38.

This study investigated the views on the early diagnosis of dementia from over 1000 general practitioners (GPs) from 12 Health Authority areas in England and Wales. Almost half of the GPs did not believe it was beneficial to make an early diagnosis, yet most admitted they needed more training in the area. In areas where there had been specific efforts to contact and educate local GPs, the GPs were far more likely to believe in the value of early diagnosis.

306. Robinson, B. E., Barry, P. P., Renick, N., Bergen, M. R., & Stratos, G. A. (2001). **Physician confidence and interest in learning more about common geriatric topics: A needs assessment.** *Journal of the American Geriatrics Society*, 49(7), 963-967.

OBJECTIVE: To assess physicians' confidence in and interest in learning more about 18 specific geriatric topics. **DESIGN:** Written survey. **SETTING:** Annual meetings of the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP). **PARTICIPANTS:** Seven hundred and fifty-eight physicians (547 ACP members, 211 AAFP members). **MEASUREMENTS:** For each topic, participants rated their confidence in performance, their peers' need for education, and their interest in learning more, using a five-point Likert scale. **RESULTS:** Survey participants were on average 16 years out of medical school and 61% were in a community primary care practice that included many geriatric patients on a primarily fee-for-service basis. High levels of interest in learning more about dementia, functional assessment, urinary incontinence, and sensory impairment were found. A substantial correlation ($r = .44$, $P < .0001$) between the proportion of seniors reported in the physicians' practice and confidence in performance in the areas surveyed was identified. **CONCLUSIONS:** These findings provide useful information on the physician-learner's perception of needs, which is important in the design of effective continuing education efforts in geriatrics.

307. Santacruz, K. S., & Swagerty, D. (2001). **Early diagnosis of dementia.** *American Family Physician*, 63(4), 703-713, 717-718. Until recently, the most significant issue facing a family physician regarding the diagnosis and treatment of dementia was ruling out delirium and potentially treatable etiologies. However, as more treatment options become available, it will become increasingly important to diagnose dementia early. Dementia may be suspected if memory deficits are exhibited during the medical history and physical examination. Information from the patient's family members, friends and caregivers may also point to signs of dementia. Distinguishing among age-related cognitive decline, mild cognitive impairment and Alzheimer's disease may be difficult and requires evaluation of cognitive and functional status. Careful medical evaluation to exclude treatable causes of cognitive impairment is important. Patients with early dementia may benefit from formal neuropsychologic testing to aid in medical and social decision-making. Follow-up by the patient's family physician is appropriate in most patients. However, a subspecialist may be helpful in the diagnosis and management of patients with dementia with an unusual presentation or following an atypical course.

308. van Hout, H., Vernooij-Dassen, M., Poels, P., Hoefnagels, W., & Grol, R. (2001). **Applicability of diagnostic recommendations on dementia in family practice.** *International Journal for Quality in Health Care*, 13(2), 127-133. doi:<http://dx.doi.org/10.1093/intqhc/13.2.127>

Objective. To evaluate the applicability of the Dutch dementia guideline's recommendations, including the diagnostic criteria used by family practitioners, and to explore characteristics in both patients and family practitioners which are associated with the use of these recommendations. **Design.** An observational study was set up with a sample of 64 family practitioners who were instructed to use the Dutch national dementia guideline on incident-suspected dementia patients. The applicability was expressed as the percentage of recommendations applied. The use of diagnostic criteria was checked by comparing the family practitioners diagnoses with the diagnoses received by integrating the registered symptoms according to the DSM-III-R criteria. Associations between the

number of recommendations applied, and demographic and clinical features were explored. Main outcome measures. (i) guideline applicability (ii) integrated use of DSM-III-R criteria. Results. 107 patients were included. The average application rate of the guideline's 31 diagnostic key recommendations was 86% or 24.8 (SD 3.6). The family practitioners diagnoses were consistent with the expected DSM-III-R diagnoses in 26% of the cases ($\kappa=0.1$). A greater number of patients in a practice was positively associated with the use of recommendations. A need for referral by the family practitioners, and patients' denial of dementia were negatively associated with the use of recommendations. The presence of dementia and a patient's age were negatively associated with the use of the DSM-III-R criteria. Conclusions. The applicability of the diagnostic recommendations of the national Dutch dementia guideline in a representative sample of family practitioners was promising. Nevertheless, the diagnostic criteria of the DSM-III-R, which were part of the dementia guideline, provided little or no guidance to the family practitioners in their diagnostic decision-making. Clinical and demographic variables explained some of the variation in the use of recommendations.

309. van Hout, H. P. J., Vernooij-Dassen, M., Hoefnagels, W. H. L., & Grol, R. P. T. M. (2001). **Measuring the opinions of memory clinic users: Patients, relatives and general practitioners.** *International Journal of Geriatric Psychiatry, 16*(9), 846-851. Measured the quality of care of a memory clinic in the Netherlands as perceived by its users: the patients, their relatives, and the general practitioners (GPs). An observational study was set up to measure the opinions of the users of an outpatient memory clinic at a university medical center. From January 1996 until January 1998, 105 consecutively referred patients completed assessments. In total, 31 opinions of patients (mean age 73), 81 opinions of relatives (mean age 60), and 101 opinions of 60 different GPs (mean age 47) were derived. Positive opinions were recorded on the way assessment results were communicated, the usefulness of the assessment, and the attitude of the clinicians. In contrast to GPs and relatives, patients were less positive about the clarity of the diagnostic information received. Both relatives and GPs were negative on information and advice to relatives. Results suggest that quality improvement could focus on the clarity of the diagnostic information for patients and on better advice to relatives. (AR) (AgeLine Database, copyright 2001 EBSCO Publishing, Inc., all rights reserved)

310. Venohr, I., Fine, R., Saunders, V., Tenney, E., Vahan, V., & Williams, M. (2001). **Improving dementia care through community linkages: A multi-site demonstration project.** *Home Health Care Services Quarterly, 19*(4), 51-63. The purpose of the multi-site project was to develop and implement a model for dementia care which improved linkages of caregivers to community services. Key components of the model included a single point of informational contact, provider education, case-finding, caregiver education and support, internal linkages, and linkages with community services. The model was implemented at six medical centers. Outcome measures included caregiver, provider, and community agency satisfaction. Caregivers reported high satisfaction with information provided to them about community resources. Primary care providers reported that dementia services had improved from one year earlier. Community agencies reported high satisfaction with the dementia program initiatives.

311. Waldorff, F. B., Bulow, L. B., Malterud, K., & Waldemar, G. (2001). **Management of dementia in primary health care: The experiences of collaboration between the GP and the district nurse.** *Family Practice*, 18(5), 549-552. OBJECTIVE: The objective of this study was to explore the context and experiences of collaboration between the GP and the district nurse (DN) in diagnosing dementia, in order to identify possible procedures to improve care. METHODS: Two group interviews were conducted with four DNs and five GPs, respectively, working in the municipality of Copenhagen. RESULTS: The group interviews revealed that the suboptimized collaboration could be due to different inter-professional diagnostic strategies and a lack of understanding of the importance of early, shared, decision making. This could create conflicts between the groups. CONCLUSIONS: This study indicates a possibility for improved collaboration between the two professional groups in diagnosing dementia. Possible approaches for improved care should focus on an inter-professional understanding of the importance of early, shared, decision making, emphasizing early identification and care of diagnosed demented patients. Establishing a shared collaboration model including out-patient memory clinics, GPs and DNs could be a first step. This model should also take into account an evaluation of possible consequences for the diagnosed demented patients in terms of treatment and care and consider the indication for referrals to a comprehensive diagnostic evaluation. We are at present planning a study to address these aspects.

312. Waldorff, F. B., & Moller, S. (2001). **Diagnostic evaluation of dementia in general practice in denmark: A national survey.** *Scandinavian Journal of Primary Health Care*, 19(2), 117-121. doi:<http://dx.doi.org/10.1080/028134301750235367> Objective - To examine GPs' self-reported basic diagnostic evaluation of dementia according to the recommendations in multidisciplinary consensus guidelines and to analyse explanatory factors for GP performance. Design - Postal questionnaire study, spring 1998. Setting - General practice in Denmark. Subjects - All 3379 GPs in Denmark. Results - The questionnaire was completed by 75.1%. According to our Diagnostic Evaluation Index, 47.2% of the GPs were classified as conducting a good basic diagnostic evaluation of dementia, and tended to have the following characteristics: they conducted regular follow-up consultations with demented patients (odds ratio (OR) 2.4), they were inclined to state that all patients with possible dementia should undergo diagnostic evaluation (OR 2.0), they considered that the GP should play the major role in diagnostic evaluation (OR 1.7) and they believed their methods were adequate to identify dementia (OR 1.7). Gender, attitude to development of clinical guidelines and being able to refer patients to specialists were not influential. Conclusion - We conclude that the previously reported reluctant attitude of GPs is now more positive.

313. Aupperle, P. M., & Coyne, A. C. (2000). **Primary vs. subspecialty care: A structured follow-up of dementia patients and their caregivers.** *American Journal of Geriatric Psychiatry*, 8(2), 167-170. doi:<http://dx.doi.org/10.1176/appi.ajgp.8.2.167> All dementia patients and their caregivers who had received a University-based comprehensive evaluation and a diagnosis of Alzheimer's disease during 1997 (N = 80) were surveyed 1 year after their initial assessment. Of the original cohort, 72.5% were contacted, and two subgroups were defined: 31 patients were being seen only by their

primary care physicians (MED), and 27 patients were being treated in addition by a geriatric psychiatry faculty member (GERO). There were statistically significant differences between the two groups (MED vs. GERO, respectively) at follow-up in terms of: 1) hospitalization (39% vs. 15%; $P < 0.05$) ; 2) cognitive status ($P < 0.05$) ; and 3) prescription of donepezil at follow-up (35% vs. 64%; $P < 0.005$). These differences need to be assessed in a larger- scale prospective study.

314. Bruce, D. G., & Paterson, A. (2000). **Barriers to community support for the dementia carer: A qualitative study.** *International Journal of Geriatric Psychiatry*, 15(5), 451-457.

OBJECTIVES: To understand how carers of dementia sufferers gain access to community support and to determine potential barriers for carers. **DESIGN:** Qualitative study using semi-structured interviews of carers after an Aged Care Assessment Team intervention. **SETTING:** Australian metropolitan Aged Care Assessment Team. **SUBJECTS:** 24 live-in carers of dementia sufferers. **MAIN OUTCOME MEASURES:** Carers' subjective experience of sources of stress in their care of the dementia sufferer focusing on interactions with the general practitioner and formal community support agencies. **RESULTS:** Most carers suffered high levels of stress, mainly due to behaviour disturbances and care needs of the dementia sufferers. Problems with health care agencies were also reported by a majority of the carers to be contributors to their distress. General practitioners were perceived to have referred dementia sufferers late for community care, despite the carer having experienced difficulties for a considerable time period. Carers also complained that too little information was provided about the diagnosis of dementia, how to deal with problem behaviours and how to access support services before and after the assessment procedure. **CONCLUSIONS:** Problems with the interaction between the carer and the general practitioner appear to be important in delaying access to appropriate support and information. Earlier recognition of carers' problems, the provision of better education and earlier access to support services may lessen the degree of stress experienced by carers. Copyright 2000 John Wiley & Sons, Ltd.

315. Cable, G., Reisner, M., Gerges, S., & Thirumavalavan, V. (2000). **Knowledge, attitudes, and practices of geriatricians regarding patients with dementia who are potentially dangerous automobile drivers: A national survey.** *Journal of the American Geriatrics Society*, 48(1), 14-17.

Surveyed geriatricians on their knowledge, attitudes, and practices regarding patients with dementia who are potentially dangerous drivers. A total 467 geriatricians from across the country responded to a survey containing three items: a question addressing knowledge of the steps to take to report patients with dementia who drive and may be a danger to others, a 5-item scale measuring physicians' perception of their responsibility to report patients with dementia who drive and may be a danger to others, and a question assessing whether the geriatrician would recommend to the "appropriate authority" that the driving privileges be revoked and whether the geriatrician would do so despite the objections of the patient or the patient's family. More than 28 percent of all respondents did not know how to report patients with dementia who are potentially dangerous drivers. In California, where legislation requires physicians to report drivers with dementia to the local health department, only 9.8 percent did not know the steps to take to report patients,

compared with 31.8 percent of geriatricians in all other states. More than 86 percent of all respondents would contact state authorities despite the objections of the patient, and 72.9 percent would contact authorities despite the objections of the patient's family. (WD) (AgeLine Database, copyright 2000 EBSCO Publishing, Inc., all rights reserved)

316. Camicioli, R., Willert, P., Lear, J., Grossmann, S., Kaye, J., & Butterfield, P. (2000). **Dementia in rural primary care practices in lake county, oregon.** *Journal of Geriatric Psychiatry and Neurology*, 13(2), 87-92. Procedures used in assessing patients with dementia in rural settings are little studied. Among all patients aged 65 years and older in the four primary care practices in Lake County, Oregon, dementia cases were identified from computerized office databases using preselected International Classification of Diseases, Ninth Edition, codes. A semi-structured chart review determined (1) a dementia diagnosis, (2) cognitive and functional domains assessed, and (3) diagnostic studies performed. Of 1540 available records, 30 had dementia. Nineteen of them met National Institute of Neurological and Communicative Diseases and Stroke-Alzheimer's Disease and Related Disorders Association criteria for Alzheimer's disease (AD). Cognitive impairment was documented in 73% of the 51 identified charts and all with AD. Laboratory studies were recorded in 33% overall and in 42% with AD. Neuroimaging was documented in 18% overall and in 16% with AD. The prevalence of documented dementia in these rural practices may be low, possibly because cases of mild dementia may not be labeled as such. Laboratory studies were performed in a minority of cases of dementia.

317. Cohen, C. A. (2000). **Caregivers for people with dementia. what is the family physician's role?.** *Canadian Family Physician Medecin De Famille Canadien*, 46, 376-380.

OBJECTIVE: To examine the role of family physicians in providing support and care to caregivers for people with dementia. **QUALITY OF EVIDENCE:** Data were obtained from Alzheimer Society guidelines, published consensus statements, and guidelines for family physicians caring for people with dementia and their caregivers. Most of the reported findings and recommendations are based on information from expert consensus statements and opinion. **MAIN MESSAGE:** Caring for people with dementia causes substantial psychological and physical morbidity. Services developed for caregivers (in-home respite and individual psychological interventions) and comprehensive support programs are helpful in relieving caregiver distress. There is a role for family physicians in following caregivers longitudinally to assess their physical and emotional health and coping skills, to provide information and assistance in dealing with problems as they arise, to assist caregivers in mobilizing family and friends, and to facilitate referrals to appropriate services and resources. **CONCLUSIONS:** Family physicians have an important role in identifying caregiver problems and providing direct and ongoing support to caregivers in their day-to-day role.

318. Coleman, W. H. (2000). **Importance of behavioral and psychological symptoms of dementia in primary care.** *International Psychogeriatrics*, 12, 67-72. Examines the importance of behavioral and psychological symptoms of dementia (BPSDs) in primary care. Effective early diagnosis and cost-effective management of

BPSDs must be centered on the primary care setting and based on the primary care physician-patient-family relationship. Achievement of the most successful result requires extensive use of a neurocognitive screening tool in primary care and an educational effort designed for primary care physicians and nurses. The main themes of any educational activity should be the importance of early diagnosis of AD, current diagnostic and treatment techniques, and the impact of AD on primary care practices. Primary care physicians should be encouraged and aided in developing local collaborative models that maximize available professional and agency resources. Four scenarios are presented that illustrate the impact of AD and other dementias on primary care. (MM) (AgeLine Database, copyright 2000 EBSCO Publishing, Inc., all rights reserved)

319. Downs, M., Cook, A., Rae, C., & Collins, K. E. (2000). **Caring for patients with dementia: The GP perspective.** *Aging & Mental Health, 4*(4), 301-304. While general practitioners (GPs) have a central role to play in the effective primary care response to people with dementia and their families, concern has been raised as to the adequacy with which they fulfil this role. The purpose of this study was to assess GPs' views and practices regarding dementia diagnosis and management. A secondary goal was to determine whether practitioner characteristics were associated with these views and practices. A self-administered questionnaire was given to 278 GPs at the outset of a 2-hr training seminar on dementia. Results suggest that GPs perceive considerable difficulties with some aspects of their care for their patients with dementia. In general, their self-reported approach to diagnosis and management of dementia was not consistent with recommended practice. Practitioner characteristics failed to distinguish those GPs whose practice was more in line with recommended practice. GPs endorsed a range of interventions that would assist them in better meeting the needs of people with dementia. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

320. Duthie, A., & Mountjoy, C. Q. (2000). **The management of the alzheimer's patient by the general practitioner: A UK perspective.** *Primary Care Psychiatry, 6*(2), 49-55.

This review article outlines current knowledge about Alzheimer's disease and the general practitioner's (GP) role, taking into consideration the current evidence base and best practice. It also addresses the core issue of how GPs could be empowered to take on this demanding role. Medline since 1996 and the Cochrane database were searched. An informal survey of specialist services available to GPs in 6 areas in England was also conducted. The omens for a GP attempting to manage Alzheimer's disease initially might not look good. Alzheimer's disease has been 'specialized' by the structure of the services in place, the poor education and support for GPs and limiting the the use of new treatments. However, there is room for optimism; Alzheimer's disease id gaining a much higher profile both medically and in the media. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

321. Geldmacher, D. S. (2000). **Conflicting priorities in alzheimer's care, primary care, and managed care: Who pays the price?** *American Journal of Managed Care, 6*(22), S1161-S1164.

This conference paper offers a commentary on the presentations and roundtable

discussions contained in this special journal issue on the diagnosis and management of Alzheimer's disease (AD). It summarizes issues underlying conflicting demands in caring for Alzheimer's disease patients in a managed care (MC) setting and explores possibilities for reconciling them. The author suggests that ideal AD care is interdisciplinary care, a departure from medicine's traditional focus on the treatment of disease in an individual. Primary care providers are an important link in successful AD care, but conflicting demands often limit their effectiveness. Patients and their families pay the price of ineffective AD diagnosis and management. Informal surveys show that even Medicare-risk MC organizations generally have neither AD nor dementia care recommendations in place. Currently the MC community has little incentive to revise its current diagnostic and pharmaceutical approaches to dementia. The author suggests that for the next decade or more, we will be addressing sometimes conflicting problems: the needs of patients with AD, pressures on primary care providers, and the financial realities of paying for direct medical care. (KM) (AgeLine Database, copyright 2001 EBSCO Publishing, Inc., all rights reserved)

322. Iliffe, S., Walters, K., & Rait, G. (2000). **Shortcomings in the diagnosis and management of dementia in primary care: Towards an educational strategy.** *Aging and Mental Health*, 4(4), 286-291. Dementia is under-diagnosed and sub-optimally managed in primary care, and general practitioners (GPs) appear to have a limited conceptual framework for the dementias. This review identifies barriers to early diagnosis and optimal management, and proposes educational methods for overcoming them that have been developed and tested for applicability and acceptability. Field testing of these approaches, ideally in randomized controlled trials, will show if they change practitioner behaviour and improve the quality of dementia care.

323. Milne, A. J., Woolford, H. H., Mason, J., & Hatzidimitriadou, E. (2000). **Early diagnosis of dementia by GPs: An exploratory study of attitudes.** *Aging & Mental Health*, 4(4), 292-300. The capacity of early diagnosis of dementia to facilitate effective treatment and care is well established. The pivotal role of the GP has also been identified by research, although accuracy in detecting and diagnosing dementia at an early stage varies considerably. Despite the likely influence of attitude on practice, little is known about GP attitudes towards early diagnosis. This study collected attitudinal data, and supplementary commentary, from 182 GPs in 1 health authority. The research suggests consistency between belief in the value of early diagnosis and reported practice. Specifically, results reveal that 3 variables significantly predict practice: a belief there are benefits to patients from early diagnosis, a belief that negative outcomes may result from a failure to diagnose early and the accessibility of local support services. Overall, the study found that 40% of GPs hold positive views and 20% hold negative views towards early diagnosis. The study concludes that if GPs are to extend their commitment to early diagnosis, development work needs to focus on investing in the training and resources, which facilitate practice, and challenging attitudinal barriers, which undermine it. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

324. Olafsdottir, M., Skoog, I., & Marcusson, J. (2000). **Detection of dementia in primary care: The linköping study.** *Dementia & Geriatric Cognitive Disorders*, 11(4), 223-229.

We examined to what extent dementia and cognitive impairment are detected in a primary health care centre. A systematic sample of patients aged 70 years and above, who attended a primary health care centre for a doctor's consultation (n = 350) were examined with a neuropsychiatric examination and an interview with a close informant. Dementia was diagnosed according to DSM-III-R. Medical records from the health centre were examined for entries on cognitive decline or dementia, other diagnoses and prescribed drugs. The prevalence of dementia was 16.3% and a further 3.1% had questionable dementia. Cognitive disturbances or dementia were noted in case records in 15 out of 57 (26%) demented cases, and in 1 out of 11 (9%) questionable dementias. Compared to non-demented patients, the demented had more diagnoses and a higher number of prescribed drugs. Severity and duration of dementia were associated with an increased detection. Copyright 2000 S. Karger AG, Basel.

325. Solomon, P. R., Brush, M., Calvo, V., Adams, F., DeVeaux, R. D., Pendlebury, W. W., & Sullivan, D. M. (2000). **Identifying dementia in the primary care practice.** *International Psychogeriatrics*, 12(4), 483-493.

BACKGROUND: The purpose of this study was to evaluate the utility (i.e., positive and negative predictive value) of the 7 Minute Screen in identifying patients with probable Alzheimer's disease (AD) in a primary care practice. A second objective was to estimate the number of undiagnosed AD patients in a typical primary care practice. **METHODS:** One hundred thirty-seven successive admissions (96%) of patients over the age of 60 to a primary care practice over a 53-day period who completed informed consent documents were administered the 7 Minute Screen. All patients who screened positive (n = 13) and a random sample of those who screened negative (n = 26) returned for full diagnostic evaluation. Positive predictive value (PPV) and negative predictive value (NPV) of the 7 Minute Screen were determined using the criterion standard of clinical diagnosis established by examination, history, and laboratory studies. Test-retest reliability and time for administration were also determined. **RESULTS:** Of the 137 patients evaluated, 13 screened positive and 124 screened negative. Eleven of the 13 patients who screened positive were willing to return to the primary care practice for follow-up evaluation. A random sample of 26 patients who screened negative all agreed to return for follow-up evaluation. Of the 11 patients who screened positive and who returned for evaluation, 10 were subsequently diagnosed with probable AD. The remaining patient was diagnosed with mixed dementia. The caregivers of the two patients who refused to return were contacted and both indicated that the patients were having significant cognitive problems as verified by an activities of daily living scale. Of the 26 patients who screened negative, 25 were judged to be cognitively normal and the 26th was judged to have mild cognitive impairment. **DISCUSSION:** In successive admissions of patients over the age of 60 in a primary care practice, the 7 Minute Screen showed a PPV of 91% and an NPV of 96% in identifying patients who were subsequently identified with AD or other dementing disorder. These data suggest that this may be a useful instrument in identifying patients who should undergo diagnostic evaluation for AD and other dementing disorders. Additionally, extrapolation from the data in this practice suggests that there may be

between 75 and 100 AD patients in the typical primary care practice, many of whom may not be diagnosed.

326. Valcour, V. G., Masaki, K. H., Curb, J. D., & Blanchette, P. L. (2000). **The detection of dementia in the primary care setting.** *Archives of Internal Medicine*, 160(19), 2964-2968.

BACKGROUND: Recognition and medical record documentation of dementia in the primary care setting are thought to be poor. To our knowledge, previous studies have not examined these issues in private practice office settings within the United States. **OBJECTIVE:** To determine the rate of unrecognized and undocumented dementia in a primary care internal medicine private practice. **METHODS:** This was a cross-sectional study of 297 ambulatory persons aged 65 years and older attending an internal medicine private group practice within an Asian American community of Honolulu, Hawaii. Of the subjects, 95% had been with their current primary care physician for at least 1 year. Each subject's primary care physician noted the presence or absence of dementia by questionnaire at the time of an office visit. An investigating physician (V.G.V.) subsequently assessed cognitive function using the Cognitive Abilities Screening Instrument, and confirmed the presence of dementia and its severity, if present, using Benson and Cummings' criteria and the Clinical Dementia Rating Scale, respectively. A trained research assistant completed telephone interviews to proxy informants for collateral information concerning cognition, behavior, and occupational or social function. Subjects' outpatient medical records were reviewed for documentation of problems with cognition. **RESULTS:** Twenty-six cases of dementia were identified. Of these 26, 17 (65%) (95% confidence interval, 44.3-82.8) were not documented in outpatient medical records; of 18 patients, 12 (67%) (95% confidence interval, 40.9-86.7) were not thought to have dementia by their physicians at the time of the office visit. Recognition and documentation rates increased with advancing stage of disease. **CONCLUSION:** Dementia is often unrecognized and undocumented in private practice settings. *Arch Intern Med.* 2000;160:2964-2968

327. van Hout, H., Vernooij-Dassen, M., Poels, P., Hoefnagels, W., & Grol, R. (2000). **Are general practitioners able to accurately diagnose dementia and identify alzheimer's disease? A comparison with an outpatient memory clinic.** *British Journal of General Practice*, 50(453), 311-312.

Since the introduction of agents for the treatment of Alzheimer's disease, and in order to increase understanding of a patient's changed behaviour, it has become particularly important that dementia is both diagnosed at an early stage and differentiated into its subtypes. This study aims to ascertain whether GPs were able to diagnose dementia and identify the type of dementia accurately and confidently. GPs were well able to assess the firmness of their own dementia diagnoses, which supposes that they are able to make appropriate selection for referral. Diagnostic support from a specialised team can particularly contribute to identifying the type of dementia.

328. van Hout, H., Vernooij-Dassen, M., Bakker, K., Blom, M., & Grol, R. (2000). **General practitioners on dementia: Tasks, practices, and obstacles.** *Patient Education and Counseling*, 39(2-3), 219-225.

Examined how general practitioners (GPs) in the Netherlands perceive their tasks, their practice, and the obstacles they face related to the diagnosis and management of dementia. A sample of 28 GPs participated in focus-group interviews and completed a questionnaire. Results showed that the GPs perceived their tasks to be to diagnose, inform, and manage patients with dementia and their relatives preferably from an early stage on and in such a way that patients are able to stay at home as long as possible. Nevertheless, the GPs usually make the diagnosis at a later stage of the illness. The GPs mentioned the following as main reasons for this delay: diagnostic uncertainty during the early stages, embarrassment to conduct a cognitive examination and communicate the diagnosis, nonconsulting patients, and a lack of time. Other reasons given include feelings of having little to offer patients with dementia, the idea that telling a diagnosis does more harm than good, and the difficulty of coordinating services. Several instruments, such as a caregiver-based cognitive screening instrument and a test to assess family caregivers' burden, were noted as scales that may be helpful in improving dementia care in general practice. (AS) (AgeLine Database, copyright 2000 EBSCO Publishing, Inc., all rights reserved)

329. Williams, I. (2000). **What help do GPs want from specialist services in managing patients with dementia?**. *International Journal of Geriatric Psychiatry*, 15(8), 758-761.

The views of GPs about psychiatric services for dementia were obtained by questionnaire survey. Provision of adequate long term care, together with support for both family carers and healthcare workers were strongly stated needs. Other needs were rapid access to care, clear diagnosis, special needs of young patients with Alzheimer's disease, joint guidelines, and an increased role for CPNs. GPs valued the role of voluntary organisations and help given to them by Consultant Psycho-geriatricians.