The Role of PAs in the Management of Patients with Alzheimer's Disease and Other Dementias

Challenges and Barriers

AAPA Research

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Abstract

Physician Associates/physician assistants (PAs) are increasingly involved in the care of patients with Alzheimer’s Disease and other forms of dementia. However, systemic, educational, and resource-related barriers limit their ability to provide optimal care. This brief synthesizes findings from a national survey and a focus group to identify key challenges and policy opportunities to empower PAs across the dementia care continuum.

Methodology

AAPA utilized a mixed methods study to examine the role PAs play in the screening, diagnosing, and treating patients with Azheimer’s Disease (AD) and other forms of dementia. Qualitative focus groups were used to identify the barriers to providing optimal care for their patients.

Quantitative Survey

AAPA invited PAs in family medicine, general internal medicine, geriatrics, neurology, and urgent care to participate in a survey on the screening, diagnosis, and treatment of Alzheimer’s Disease and other forms of dementia. A total of 578 PAs consented to participate. All responses received are included in this report. PAs were given an option of a $25 gift card or a $25 donation to the PA Foundation as a thank you for their survey completion.

The overall margin of error is +/- 4.1% at a 95% confidence level. Response rates and margins of error vary by section and breakout. “N” refers to the number of respondents and is generally the first column in the data tables. Totals may not equal 100% due to rounding and question type.

Summaries of open-ended questions were created using ChatGPT 4o and reviewed by the authors.

Qualitative Focus Group

An additional 12 PAs participated in a focus group to identify the barriers to providing optimal care for their patients. Selection criteria included:

- Expressed interest when registering for AAPA 2025 conference
- Encompassed a range of experience
- Were in primary care, geriatrics, obstetrics and gynecology, emergency medicine, neurology, or cardiology
- Indicated at least 10% of patients are 65+ years
- Indicated at least some of their patients have AD and/or other forms of dementias
- Available on the day of the focus group

AAPA provided each attendee with a $75 gift card at the conclusion of the focus group as a thank you for their participation.

Summaries of participant responses were created using Microsoft Co-Pilot and reviewed by the authors.

Disclosures

The Role of PAs in the Management of Patients with Alzheimer's Disease and Other Dementias: Challenges and Barriers was sponsored by Eli Lilly and Esai. AAPA had final approval for all questions within the survey. PAs were informed that Eli Lilly and Esai sponsored the survey, and Eli Lilly sponsored the focus group. Survey participant identities were not disclosed. This report is sponsored by Eli Lilly.

About PAs

Physician associates (PAs) are licensed clinicians who practice medicine in every specialty and setting. Trusted, rigorously educated and trained healthcare professionals, PAs are dedicated to expanding access to care and transforming health and wellness through patient-centered, team-based medical practice.

About AAPA

AAPA is the national membership organization for all physician associates (PAs) and PA students. PAs are licensed clinicians who practice medicine in every specialty and setting. Trusted, rigorously educated and trained healthcare professionals, PAs are dedicated to expanding access to care and transforming health and wellness through high-quality, patient-centered, team-based medical practice. Learn more about the profession at aapa.org and engage through Facebook, LinkedIn, Instagram, and X (formerly known as Twitter) using the handle @aapaorg.

How to Cite

PA's Role in, and Barriers to, Managing Patients with Alzheimer's Disease and Other Forms of Dementia. 2025. American Academy of Physician Associates. Alexandria, VA.

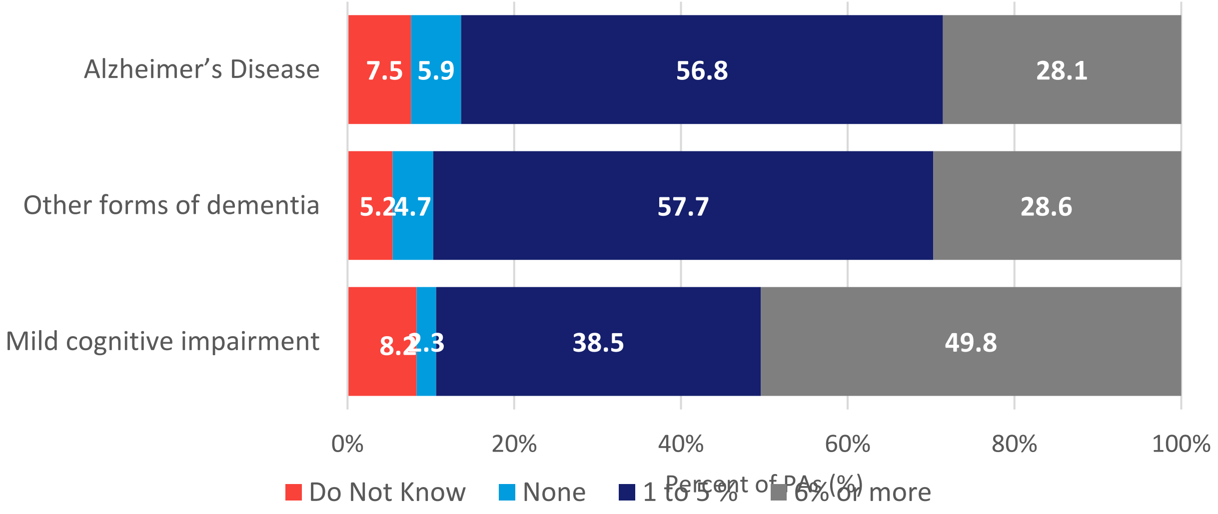
Executive Summary

This report presents the findings of a survey and focus group exploring the role of physician associates (PAs) in managing patients with Alzheimer’s disease (AD) and other forms of dementia, highlighting both their involvement and the barriers they encounter. While PAs express confidence in key areas such as collaborating with patients and families on modifiable risk factors, distinguishing between types of cognitive impairment, and knowing when to refer to specialists, there is less confidence in discussing technical details of cognitive screening tests. The frequency of engaging in specific patient care activities varies, with PAs most often identifying AD and discussing abnormal screening results, but less frequently leading lifestyle interventions or administering cognitive tests. Notably, PAs express a strong desire for greater involvement across the entire patient journey, including prevention, diagnosis, management, and ongoing support, but cite a need for more time, training, and resources to optimize the quality of care for individuals with dementia.

Findings

Most PAs have patients who are aged 50 or older and many within primary care and neurology have patients with Alzheimer’s Disease (AD), other forms of dementia, or mild cognitive impairment (Figure 1, Table 1).

Figure 1. Percentage of PAs’ Patients with Alzheimer’s Disease, Other Forms of Dementia, and Mild Cognitive Impairment



PAs Comfort in the Screening, Diagnosing and Treatment of Alzheimer's Disease and Other Forms of Dementia

PAs have varying degrees of confidence in identifying and managing patients with AD. PAs are fairly confident in their ability to collaborate with patients and families around lifestyle approaches to address modifiable risk factors for dementia (72.9% at least somewhat confident). About two in three PAs are at least somewhat confident in their abilities to distinguish between normal aging impairments and AD (67.5%) as well as differentiating between normal aging, mild cognitive impairment, and dementia (68.2%; Figure 2, Table 2).

While PAs are confident in their ability to select, administer, and interpret the appropriate cognitive screening test for their patients (70.3% at least somewhat confident), they are less confident in their ability to discuss the tests (e.g., the strengths, weaknesses, administration, and training requirements; 57.8% at least somewhat confident). Once the tests are concluded, the majority of PAs are confident in their ability to discuss abnormal screening results with patients and caregivers and addressing their concerns (74.7% at least somewhat confident). Finally, the greatest area of confidence for PAs is knowing when to refer a patient to a specialist for confirmation of AD (81.1% at least somewhat confident; Figure 2, Table 2).

A majority of PAs are at least somewhat confident in most areas of the patient journey related to Alzheimer's Disease and other forms of dementia.

PAs Are Involved Throughout the Patient Journey

Across most areas, there was great variability in the frequency PAs reported engaging in patient care activities related to the screening, diagnosing and treatment of AD and other forms of dementia. However, across all areas of the patient journey more than half rarely or never engaging in different stages. PAs are most frequently identifying patients who have AD (44.8% at least monthly), discussing abnormal screening results with patients and caregivers and addressing their concerns (43.8% at least monthly), and discussing the aspects of the different cognitive screening tests (41.7% at least monthly). Less frequently, they are collaborating with patients and families around lifestyle approaches to address modifiable risk factors for dementia (26.6% at least monthly) and selecting, administering, and interpreting an appropriate cognitive screening test (31.6% at least monthly: Figure 3, Table 3).

Figure 2. **PAs Confidence in Managing Patients with Alzheimer's Disease, Other Forms of Dementia, and Mild Cognitive Impairments**

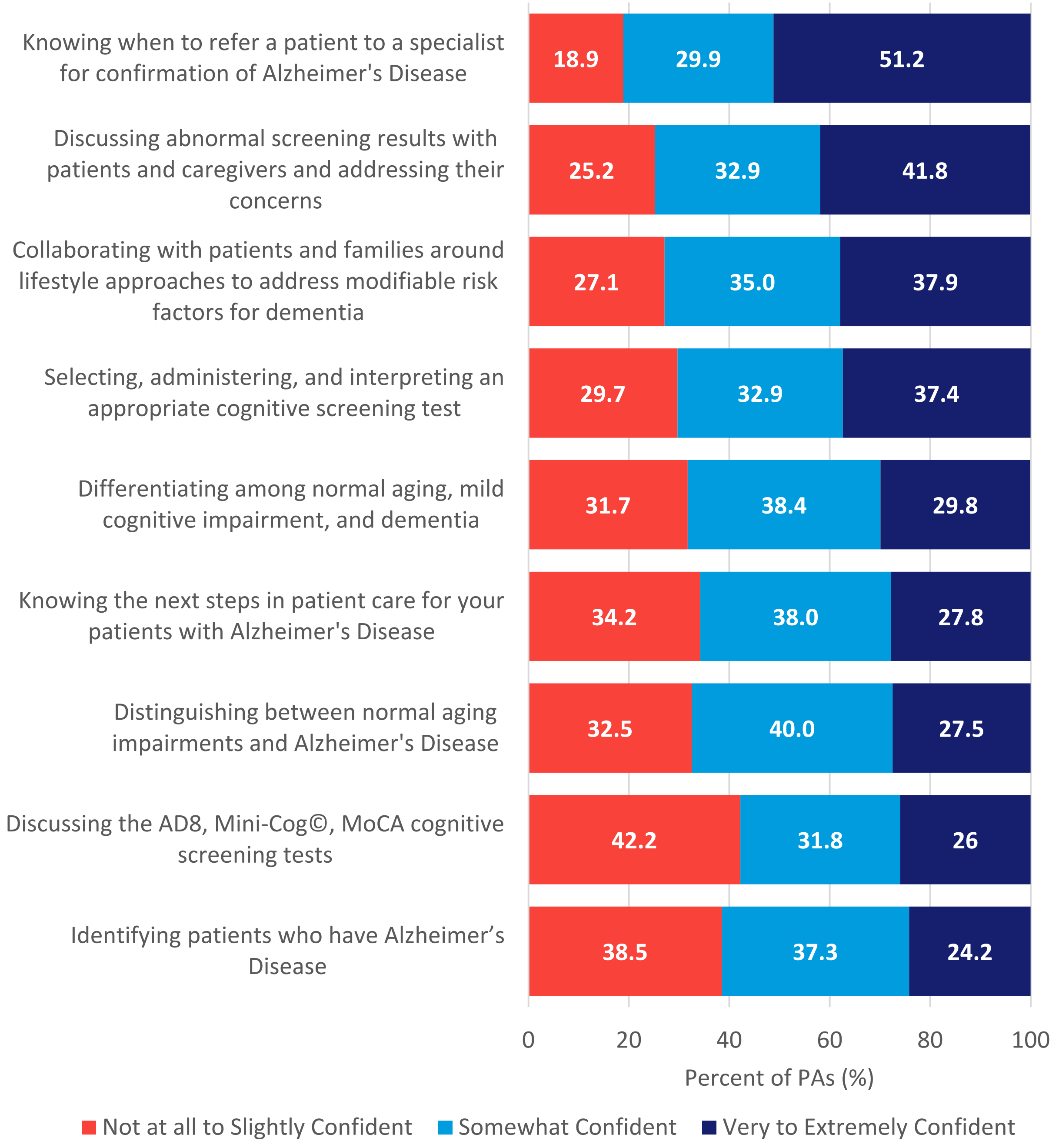
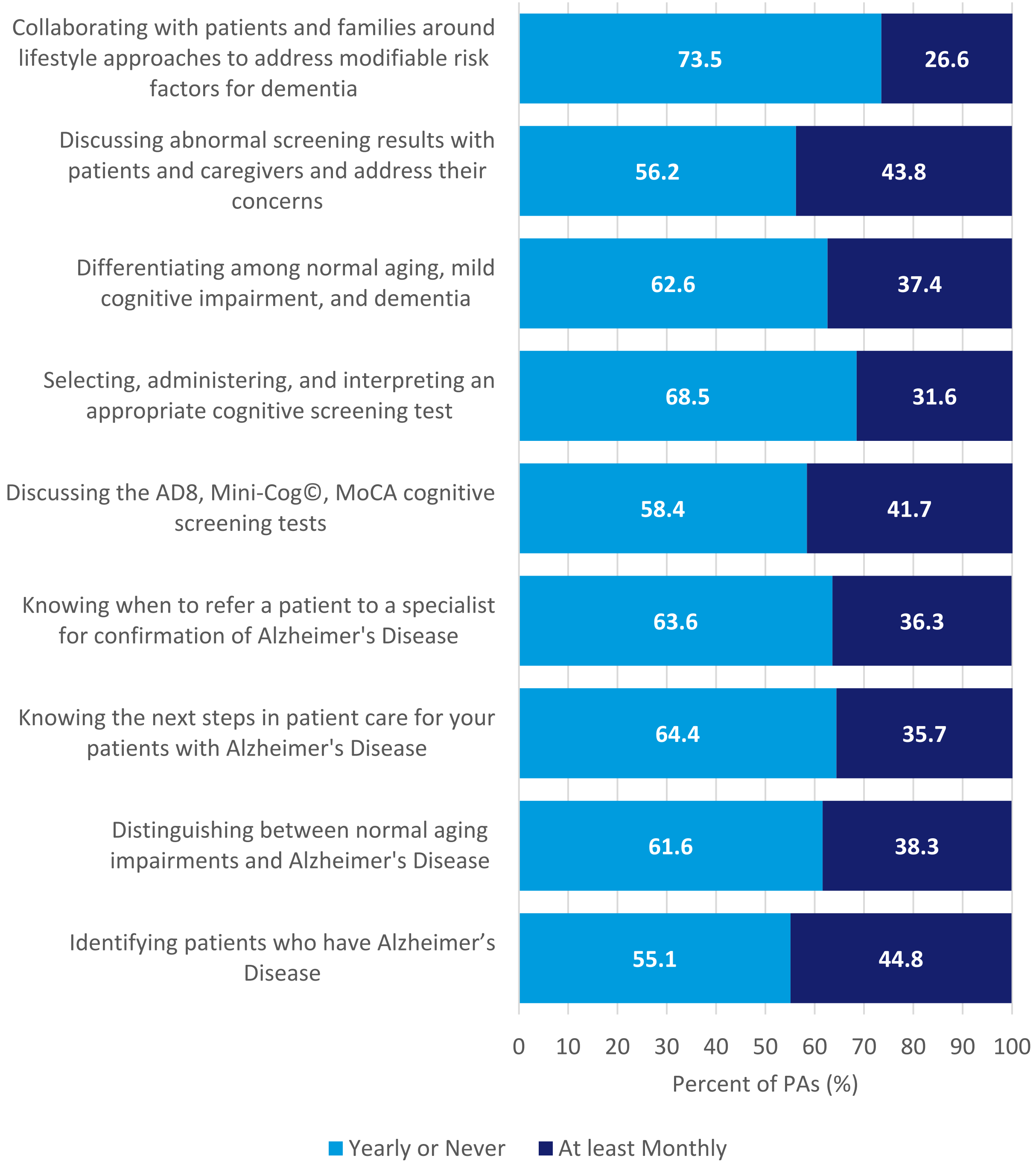


Figure 3. **Frequency of PA Patient Care Activities Related to the Screening, Diagnosing and Treatment of Alzheimer's Disease and Other Forms of Dementia.**



PAs were also asked “Where in the patient journey would you like to take a greater role in supporting patients?” They responded that they would like to be involved across the patient journey from early identification and screening through ongoing support and care coordination (Appendix B). Whether it’s prevention and screening, diagnosis and initial management, or long-term follow-up and supportive care, PAs overwhelmingly want more time, resources, and training to guide patients and families throughout every stage of Alzheimer’s Disease and other dementias.

There is an opportunity to get more PAs involved in every stage of the patient journey from ordering screen to monitoring treatment.

Barriers to Optimal Care

We focused in both the survey and the focus group on barriers to achieving the best outcomes for their patients with Alzheimer’s Disease and other dementias. Overall, the challenges stem from a combination of insufficient time, limited training, access barriers to specialists, and resource gaps. PAs often find themselves managing dementia care by default in settings with long referral wait times or specialist shortages. Despite these hurdles, many PAs express a desire for more education, structured support, and practical tools so they can confidently provide earlier detection, accurate diagnosis, and better ongoing care for patients with AD and other dementias.

Of the PAs who indicated experiencing barriers, the ones encountered the most were…

- Knowing the next steps in patient care for your patients with Alzheimer's Disease (50.3%),
- Selecting, administering, and interpreting an appropriate cognitive screening test (50.0%),
- Collaborating with patients and families around lifestyle approaches to address modifiable risk factors for dementia (46.9%),
- Discussing the AD8, Mini-Cog©, MoCA cognitive screening tests including strengths, weaknesses, administration, and training requirements for each (45.9%),
- Distinguishing between normal aging impairments and Alzheimer's Disease (45.9%), and
- Discussing abnormal screening results with patients and caregivers and addressing their concerns (44.2%).

Table 4 includes the summary data. PAs were also asked to explain more about the barriers if they indicated it was a barrier. Their responses are available in Appendix A.

More than one third of surveyed PAs indicated the following factors as having a high and somewhat high impact on their ability to achieve the best outcomes for their patients with AD and other forms of dementia:

- Access to specialists (55.3%),
- Limited time for patient education (54.3%),
- Lack of resources to deal with psychosocial issues impacting ability to adhere (49.5%),
- Large patient load (42.8%),
- Lack of resources available to manage patients with AD and other forms of dementia (39.1%),
- Coordinating care with other services/providers (38.5%),
- Treatment cost to patients (38.3%), and
- Cost of medications (36.9%).

(Table 5)

Within the focus groups PAs identified additional barriers, such as systemic barriers related to the screening tools. PAs responses also illustrate the presence of confusion and misinformation surrounding PA licensing and training related to using screening tools. As a result PAs may experience difficulty differentiating normal aging from cognitive impairment. Additionally, other interviewed PAs reported institutional restrictions placed on PAs.. Responses highlight how organization barriers and complex protocols can hinder their ability to monitor patients, limit access to specialists and treatments, and lead to patient non-compliance.

Critical barriers, such as time constraints, resource gaps, and limited access to specialists, must be overcome to allow clinicians to provide optical outcomes for patients.

Finally, there remains psychosocial and community support gaps. While many PAs rely on care coordinators and multidisciplinary teams, these important resources are not available to all PAs. Some report having no formal psychosocial support resources.

Overcoming Barriers

When reflecting on the resources that would help them to be better prepared to screen, diagnosis, and treat AD and other forms of dementia, the majority of PAs indicated:

- More time with patients (67.3%),
- Ensuring treatments are covered and/or reimbursed by health insurance (58.4%),
- Easier referral process to other specialties (54.8%),
- Regular webinars/trainings on AD and other forms of dementia (51.7%),

- Availability of more and/or newer AD diagnostic tools (51.7%), and
- Ensuring screening and diagnosis is covered and/or reimbursed by health insurance (50.4%).

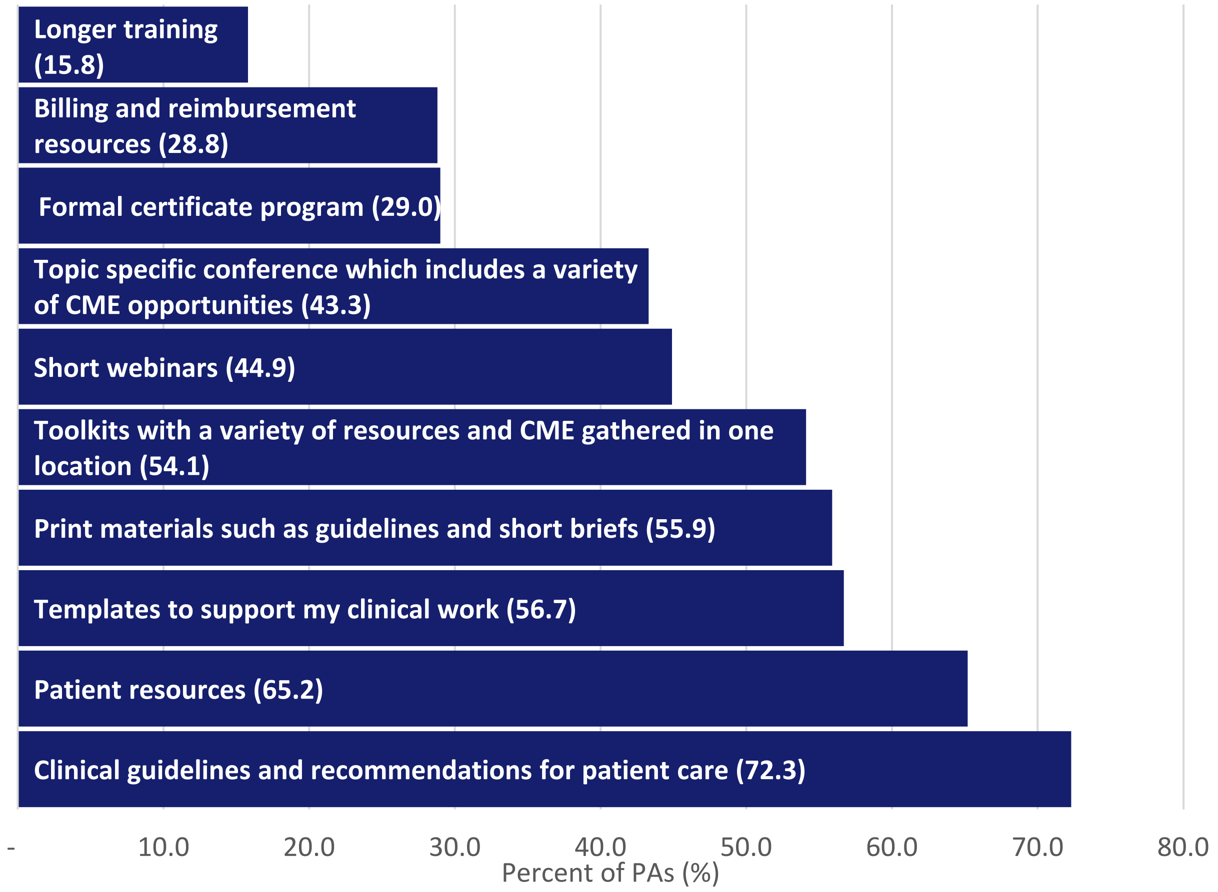
(Figure 4, Table 6)

Figure 4. **Resources to Help PAs Be Better Prepared to Screen, Diagnosis, and Treat AD and Other Forms of Dementia**

PAs were also surveyed about the types of tools and/or training specific to how to treat AD and other forms of dementias they would be interested in. Overwhelmingly, PAs are looking for clinical guidelines and recommendations for patient care (72.3%) and patient resources (65.2%). Other frequently endorsed resources include templates to support their clinical work (56.7%), print materials such as guidelines and short briefs (55.9%), and toolkits with a variety of resources and CME gathered in one location (54.1%). PAs are less interested in longer training (15.8%) or a certificate program (29.0%). Despite billing and reimbursement being a major barrier, PAs did not prioritize those resources (28.8%) either. (Table 7, Figure 5).

Patient outcomes may improve if PAs have more access to resources. Key areas of support desired by the surveyed PAs were geared towards reducing administrative barriers for screening and diagnosing, improving access to specialists and other services to coordinate patient care and condition management, and providing more information on psychological issues related to AD and other forms of dementias.

Figure 5. **Tools to Help PAs Be Better Prepared to Screen, Diagnosis, and Treat Alzheimer's Disease and Other Forms of Dementia**



Yet while billing and reimbursement resources are not frequently desired (28.8%, Table 7),PAs still want content related to billing and reimbursement for AD and other forms of dementia related treatment and services (32.9%,Table 8). More than half, however, want content related to:

- Clinical management of AD and other forms of dementia (68.5%),
- Incorporating screening and treatment tools for AD and other forms of dementia into the electronic health records (64.6%), and
- Clinical guidelines from other organizations (50.1%).

(Table 8)

Finally, PAs do see missed opportunities based on some of these barriers when it comes to patients having better clinical outcomes related to AD and other forms of dementia. More than four in 10 indicated that delays in receiving cognitive tests - which could be done the same day in the clinic on patients - and lack of clinical knowledge about blood-based biomarkers had a major to severe impacts on patient outcomes (46.4% and 43.8% respectively) (Table 9).

PAs would like resources such as toolkits, clinical guidelines, and more education to overcome barriers to providing care for their patients with AD and other forms of dementia.

Conclusion

Addressing both clinical and systemic barriers is important for improving outcomes for individuals with Alzheimer's disease and other dementias. PAs in our study report the need for additional resources related to clinical management, screening tools, and evidence-based guidelines. Currently, there are gaps in education, resources to ensure timely cognitive testing, and awareness of emerging diagnostics. Focusing on providing education to PAs, expanding access to multidisciplinary care resources related to AD and other dementias, and expanding the role of PAs in the patient journey may help the healthcare system respond more effectively to the needs of this population. Future initiatives should aim to support PAs as they work to provide timely, equitable, and effective care for patients throughout their treatment of Alzheimer's disease and related dementias.

Data Tables

Table 1. Percentage of PAs' Patients Who Have Alzheimer's Disease, Other Forms of Dementias, and Mild Cognitive Impairment

Condition	Total	Approximate Percentage of Patients					
		0%	1 to 5 %	6 to 10%	11 to 15%	More than 20%	Do Not Know
	N	Percent (%)					
Alzheimer's Disease	426	5.9	56.8	17.8	6.1	4.2	7.5
Other forms of dementia	426	4.7	57.7	18.8	7.0	2.8	5.2
Mild cognitive impairment	426	2.3	38.5	28.6	14.6	6.6	8.2

Source: Survey on PAs' Role in Screening, Diagnosis, and Treatment of Alzheimer's Disease and Other Forms of Dementia, Fielded December 2024 to January 2025
Question: Approximately what percentage of your patients have Alzheimer's Disease, other forms of dementias, and mild cognitive impairment, regardless of whether you are treating them for these conditions?

Table 2. PAs’ Confidence in Care Provided Throughout the Patient Journey with AD and Other Forms of Dementia

		Confidence		
	Total	Not at all to Slightly	Somewhat	Very to Extremely
Area of Care	**N**	**Percentage (%)**		
Identifying patients who have Alzheimer’s Disease	418	38.5	37.3	24.2
Distinguishing between normal aging impairments and Alzheimer's Disease	418	32.5	40.0	27.5
Knowing the next steps in patient care for your patients with Alzheimer's Disease	418	34.2	38.0	27.8
Knowing when to refer a patient to a specialist for confirmation of Alzheimer's Disease	412	18.9	29.9	51.2
Discussing the AD8, Mini-Cog©, MoCA cognitive screening tests including strengths, weaknesses, administration, and training requirements for each	415	42.2	31.8	26.0
Selecting, administering, and interpreting an appropriate cognitive screening test	417	29.7	32.9	37.4
Differentiating among normal aging, mild cognitive impairment, and dementia	419	31.7	38.4	29.8
Discussing abnormal screening results with patients and caregivers and addressing their concerns	416	25.2	32.9	41.8
Collaborating with patients and families around lifestyle approaches to address modifiable risk factors for dementia	417	27.1	35.0	37.9

Source: Survey on PAs’ Role in Screening, Diagnosis, and Treatment of Alzheimer’s Disease and Other Forms of Dementia, Fielded December 2024 to January 2025
Question: Please indicate your level of confidence for the following areas of your practice

Table 3. Frequency of Care Provided by PAs Throughout the Patient Journey with Alzheimer's Disease and Other Forms of Dementia

	Total	Frequency			
		Never or Less than Yearly	Yearly	Monthly	Daily to Weekly
Area of Care	N	Percentage (%)			
Identifying patients who have Alzheimer's Disease	408	20.8	34.3	28.9	15.9
Distinguishing between normal aging impairments and Alzheimer's Disease	409	30.8	30.8	24.4	13.9
Knowing the next steps in patient care for your patients with Alzheimer's Disease	409	33.3	31.1	19.6	16.1
Knowing when to refer a patient to a specialist for confirmation of Alzheimer's Disease	407	33.9	29.7	24.3	12.0
Discussing the AD8, Mini-Cog©, MoCA cognitive screening tests including strengths, weaknesses, administration, and training requirements for each	406	24.4	34.0	32.8	8.9
Selecting, administering, and interpreting an appropriate cognitive screening test	409	41.6	26.9	21.8	9.8
Differentiating among normal aging, mild cognitive impairment, and dementia	406	23.4	39.2	27.3	10.1
Discussing abnormal screening results with patients and caregivers and addressing their concerns	404	30.2	26.0	31.7	12.1
Collaborating with patients and families around lifestyle approaches to address modifiable risk factors for dementia	407	49.9	23.6	18.7	7.9

Source: Survey on PAs' Role in Screening, Diagnosis, and Treatment of Alzheimer's Disease and Other Forms of Dementia, Fielded December 2024 to January 2025
Question: How often do you do the following for your patients with Alzheimer's Disease or other forms of dementia?

Table 4. PAs' Experience of Barriers to Engaging in Patient Care Throughout the Patient Journey with Alzheimer's Disease and Other Forms of Dementia

Area of Care	Total (N=292)	Percentage for Whom It Is a Barrier (%)
Distinguishing between normal aging impairments and Alzheimer's Disease	134	45.9
Differentiating among normal aging, mild cognitive impairment, and dementia	99	33.9
Collaborating with patients and families around lifestyle approaches to address modifiable risk factors for dementia	137	46.9
Selecting, administering, and interpreting an appropriate cognitive screening test	146	50
Discussing the AD8, Mini-Cog©, MoCA cognitive screening tests including strengths, weaknesses, administration, and training requirements for each	134	45.9
Discussing abnormal screening results with patients and caregivers and addressing their concerns	129	44.2
Identifying patients who have Alzheimer's Disease	113	38.7
Knowing the next steps in patient care for your patients with Alzheimer's Disease	147	50.3
Knowing when to refer a patient to a specialist for confirmation of Alzheimer's Disease	115	39.4

Source: Survey on PAs' Role in Screening, Diagnosis, and Treatment of Alzheimer's Disease and Other Forms of Dementia, Fielded December 2024 to January 2025
Question: Are there any barriers to your engaging in any of these activities? If so, please describe your barriers. [See *Appendix A* *for summary of comments]*

Table 5. Impacts on PAs' Ability to Achieve the Best Outcomes for their Patients with Alzheimer's Disease and Other Forms of Dementia

		Degree of Impact			
	Total	None	Low to Somewhat Low	Average	Somewhat High to High
Potential Barriers	N	Percentage (%)			
Patient adherence to treatment plan	351	4.3	18.5	47.9	29.3
Access to specialists	367	4.6	18.3	21.8	55.3
Cost of medications	347	6.3	18.7	38.0	36.9
Non-medication treatment costs	339	8.3	22.7	34.8	34.2
Coordinating care with other services/providers	371	6.2	15.6	39.6	38.5
Large patient load	367	6.0	18.3	33.0	42.8
Limited time for patient education	372	3.8	14.0	28.0	54.3
Inadequate hospital or practice protocol impacts	332	10.5	26.5	34.0	28.9
Treatment cost to patients	350	5.4	17.7	38.6	38.3
Conflicting guidelines	348	12.6	39.4	34.8	13.2
Lack of resources to deal with psychosocial issues	366	5.2	13.4	32.0	49.5
Lack of resources to effectively differentiate between normal aging and Alzheimer's Disease and other forms of dementia	363	5.8	24.5	39.4	30.3
Lack of resources you have available to help identify patients with Alzheimer's Disease and other forms of dementia	358	7.0	22.6	38.5	31.8
Lack of resources you have available to manage patients with Alzheimer's Disease and other forms of dementia	363	6.6	19.8	34.4	39.1
Lack of resources needed to the start a conversations with a patient with suspected Alzheimer's Disease and other forms of dementia	360	8.1	26.9	40.0	25.0
Other impacts	120	90.0	0.8	5.0	4.2

Source: Survey on PAs' Role in Screening, Diagnosis, and Treatment of Alzheimer's Disease and Other Forms of Dementia, Fielded December 2024 to January 2025
Question: As a member of the healthcare team, please indicate to what degree each of the following impacts your ability to achieve the best outcomes for your patients with Alzheimer's Disease and other forms of dementias.

Table 6. Resources to Help PAs Be Better Prepared to Screen, Diagnosis, and Treat AD and Other Forms of Dementia

Resources Related to…	Total (N=385)	Percentage for the Resource Would Be Beneficial (%)
More time with patients	259	67.3
Ensuring treatments are covered and/or reimbursed by health insurance	225	58.4
Easier referral process to other specialties	211	54.8
Regular webinars/trainings on Alzheimer's Disease and other forms of dementia	199	51.7
Availability of more and/or newer Alzheimer's Disease diagnostic tools	199	51.7
Ensuring screening and diagnosis is covered and/or reimbursed by health insurance	194	50.4
Availability of more and/or newer diagnostic tools for other forms of dementia	186	48.3
Education on clinical outcomes of Alzheimer's Disease and other forms of dementia	177	46.0
Availability of more and/or newer Alzheimer's Disease treatments	167	43.4
Availability of more and/or newer treatments for other forms of dementia	145	37.7
Other	13	3.4
None of the above	10	2.6

Source: Survey on PAs' Role in Screening, Diagnosis, and Treatment of Alzheimer's Disease and Other Forms of Dementia, Fielded December 2024 to January 2025
Question: Which of the following resources would help you to be better prepared to screen, diagnosis, and treat Alzheimer's Disease and other forms of dementia? Select all that apply.

Table 7. Tools to Help PAs Be Better Prepared to Screen, Diagnosis, and Treat Alzheimer’s Disease and Other Forms of Dementia

Tools Related to…	Total (N=385)	Percentage for the Resource Would Be Beneficial (%)
Clinical guidelines and recommendations for patient care	274	72.3
Patient resources	247	65.2
Templates to support my clinical work	215	56.7
Print materials such as guidelines and short briefs	212	55.9
Toolkits with a variety of resources and CME gathered in one location	205	54.1
Short webinars	170	44.9
Alzheimer’s Disease and other forms of dementias specific conference which includes a variety of CME opportunities	164	43.3
Formal certificate program	110	29.0
Billing and reimbursement resources	109	28.8
Longer training	60	15.8
Another format	4	1.1
None of the above	10	2.6

Source: Survey on PAs’ Role in Screening, Diagnosis, and Treatment of Alzheimer’s Disease and Other Forms of Dementia, Fielded December 2024 to January 2025
Question: What types of tools and/or training specific to how to treat Alzheimer’s Disease and other forms of dementias would you be interested in. Select all that apply.

Table 8. Desired Content to Help PAs Learn More about How to Treat Alzheimer's Disease and Other Forms of Dementias

Content Related to…	Total (N=359)	Percentage of PAs Interested in Content (%)
Clinical management of Alzheimer's Disease and other forms of dementia	246	68.5
Incorporating screening and treatment tools for Alzheimer's Disease and other forms of dementia into the electronic health records	232	64.6
Clinical guidelines from other organizations	180	50.1
Clinical guidelines from membership organizations	169	47.1
Understanding billing and reimbursement for Alzheimer's Disease and other forms of dementia related treatment and services	118	32.9
Other	2	0.6

Source: Survey on PAs' Role in Screening, Diagnosis, and Treatment of Alzheimer's Disease and Other Forms of Dementia, Fielded December 2024 to January 2025
Question: What type(s) of content would be best to help you learn more about how to Alzheimer's Disease and other forms of dementias? Select all that apply.

Table 9. PAs' Perception of the Impact of Missed Opportunities on Patients with Alzheimer's Disease and Other Forms of Dementia and the Healthcare System

Missed Opportunity	Total	Amount of Impact		
		Insignificant to Minor	Moderate	Major to Severe
	N	Percentage (%)		
Delays in receiving cognitive tests which could be done the same day in the clinic on patients and the healthcare system	419	14.3	39.4	46.4
Lack of understanding about amyloid PET-CT scans for diagnosing Alzheimer's Disease on patients and the healthcare system	416	18.1	44.8	37.1
Lack of clinical knowledge about blood-based biomarkers on patients and the healthcare system	417	14.2	41.9	43.8

Source: Survey on PAs' Role in Screening, Diagnosis, and Treatment of Alzheimer's Disease and Other Forms of Dementia, Fielded December 2024 to January 2025
Question: There are many missed opportunities for patients to have better clinical outcomes related to Alzheimer's Disease and other forms of dementia. The list below indicates several missed opportunities. What is the impact that each of these have on patients and the healthcare system?

Appendix A. Thematic Descriptions of PAs' Responses to Perceived Barriers to Care

PAs were asked "Are there any barriers to your engaging in any of these activities? If so, please describe your barriers." The following are the themes that arose.

Summary of Challenges and Barriers to Educating Patients and Referring for Screening

Time Constraints:

- Lack of time during appointments or visits.
- Time needed for patient education, explaining diagnoses, or addressing family concerns.
- Limited time to stay updated, screen patients, and ensure proper care.
- Scheduling and appointment durations are too short for comprehensive care.

Access and Availability Issues:

- Limited access to specialists, particularly in rural areas.
- Long wait times for specialist appointments (e.g., neuropsychiatric testing, neurology).
- Insufficient local resources for screening or referral.
- Minimal availability of translators for non-English-speaking patients.

Training and Knowledge Gaps:

- Lack of training for staff to screen and educate patients effectively.
- Knowledge gaps among providers regarding diagnoses and referral protocols.

Socioeconomic and Systemic Barriers:

- Financial limitations and lack of insurance.
- Socioeconomic challenges affecting patient access to resources.
- Patients' reluctance or refusal to seek care or follow referrals.
- Insurance barriers and coverage issues for testing and specialist visits.

Cultural and Language Barriers:

- Language differences limiting communication and care quality.
- Cultural factors influencing patient or family understanding and engagement.

Rural and Resource-Limited Settings:

- Long travel distances to access care in rural areas.
- Apprehension to travel to cities for specialist appointments.
- Lack of local neurologists and other specialists in rural regions.

Patient-Specific Factors:

- Patients minimizing symptoms or lacking education about conditions like dementia.
- Difficulty in involving family or caregivers during appointments.

Systemic Delays and Structural Issues:

- Specialists booked far in advance.
- Limited resources for in-house screening and follow-up care.
- Challenges coordinating with primary care physicians or external services.

This highlights significant gaps in time, access, training, and resources that hinder the ability to provide comprehensive and timely care.

Summary of Challenges and Barriers to Ordering Screening

Time Constraints

- Insufficient time during visits to perform comprehensive assessments or screenings.
- Time required for thorough evaluations (e.g., one hour with patient and family).
- Balancing time between urgent care responsibilities and chronic care management.

Knowledge and Training Gaps

- Lack of familiarity with appropriate tests, their indications, or how to order them.
- Limited education and training on dementia screening and chronic care management.
- Nurses and staff are uncomfortable or untrained with screening tools like MoCA or Mini-Cog.

Access and Resource Limitations

- Difficulty accessing specialists, with wait times often over a year.
- Limited availability of screening resources in urgent care or inpatient settings.
- Lack of local knowledge about testing sites or resources.

Insurance and Cost Barriers

- Insurance approval and coverage issues for tests, labs, or imaging.
- High costs of testing without guaranteed reimbursement.

Patient-Specific Challenges

- Patients and families are reluctant to address cognitive issues.
- Patient population (e.g., younger occupational health patients) is not typically presenting with cognitive impairment.

Specialty and Role Limitations

- Screening tasks often deferred to primary care providers or outpatient settings.
- Specialists and consultants in hospitals consider screening inappropriate in acute settings.

Systemic Issues

- Chronic care management is not feasible in settings like urgent care or hospital admissions.
- Referrals often lead to delays due to overburdened specialists.
- Limited clinic or hospital resources for comprehensive dementia management.

There are systemic challenges in ensuring timely, effective dementia screening and chronic care management in diverse healthcare settings.

Summary of Challenges and Barriers for Administering Screening

Time Constraints

- Limited time during patient visits, often only 15–20 minutes, to address multiple comorbidities alongside screening.
- Time-consuming nature of cognitive tests and related patient education.
- Scheduling pressures in urgent care, outpatient, and primary care settings.

- Inadequate time to stay updated on best practices and screening tools.

Staff Training and Knowledge Gaps
- Lack of training for staff (e.g., RNs, medical assistants) in administering and interpreting tests.
- Limited provider familiarity with available screening tools and their appropriate use.
- Uncertainty about next steps after screening or how to act on results.
- Need for additional education to improve provider confidence and knowledge.

Resource and System Limitations
- Insufficient staff to administer tests due to shortages or competing demands.
- Limited access to advanced screening tools or materials for cognitive testing.
- Over-reliance on referrals to specialists, occupational therapists, or neuropsychology.
- Inappropriate settings, such as inpatient care or telemedicine, where screening is less feasible.

Patient-Specific Barriers
- Reluctance from patients or families to undergo screening.
- Challenges with hearing loss, language barriers, and educational disparities.
- Patient unwillingness due to previous screenings or perceived stigma.

Insurance and Financial Barriers
- Coverage limitations for screening tests, labs, or imaging.
- Denials from insurance companies, making testing inaccessible.
- High costs of tests and related follow-up procedures.

Language and Communication Challenges
- Language barriers requiring translators, which extend visit times.
- Difficulty communicating with patients who have cognitive or hearing impairments.

Policy and Specialty Limitations
- Policy restrictions requiring referrals for screening rather than in-office testing.
- Specialty providers (e.g., neurology, occupational therapy) often manage testing instead of primary care.
- Cognitive screening is seen as outside the scope of some providers, such as consultants or inpatient teams.

Environmental and Workflow Issues
- Screening is not considered appropriate in certain settings (e.g., hospital, urgent care).
- Telemedicine visits limiting the ability to perform thorough cognitive evaluations.

There are multifaceted barriers to administering cognitive screening, emphasizing the need for systemic improvements in time management, training, resources, and access.

Summary of Challenges and Barriers for Post-Screening Monitoring

Time Constraints
- Insufficient time to provide follow-up care due to packed schedules or short visit durations.
- Time demands for ongoing education and staying updated on guidelines.

Knowledge and Training Gaps

- Lack of provider training and familiarity with post-screening guidelines.
- Knowledge deficits regarding monitoring processes and interpreting follow-up results.

System and Workflow Limitations

- Inpatient and urgent care providers are not responsible for post-discharge or follow-up monitoring.
- Limited availability of appointments to accommodate timely follow-up visits.
- Fragmented care when patients see multiple providers, leading to inconsistent monitoring.

Patient Compliance and Engagement

- Difficulty ensuring patients return for follow-up appointments.
- Patient avoidance or non-compliance with recommended care plans.
- Challenges in addressing patient response to treatment or lifestyle adjustments.

Resource Limitations

- Lack of trained personnel to perform repeat evaluations.
- Limited administrative time for follow-up tasks and monitoring coordination.
- Shortages of available appointments for timely post-screening assessments.

Insurance and Socioeconomic Barriers

- Insurance coverage issues for ongoing care and monitoring.
- Socioeconomic factors affecting patient access to follow-up care.

Role-Specific Challenges

- Inpatient and hospital-based providers often do not have opportunities for post-discharge follow-up.
- Specialists and urgent care providers defer monitoring to primary care or outpatient settings.

Communication and Consistency Issues

- Inconsistent use of screening tools and scores across providers within the same practice.
- Need to involve and interview family members in follow-up care, which adds complexity and time demands.

There are multifaceted barriers to effective post-screening monitoring, emphasizing the need for better system integration, patient engagement, provider training, and resource allocation.

Summary of Challenges and Barriers to Referring for Diagnosis

Specialist Shortages

- Regional shortages of neurologists and geriatric specialists, especially in rural areas.
- Limited access to neuropsychologists, memory clinics, and other diagnostic services.

Long Wait Times

- Extended delays for appointments, often 6–9 months or more for neurology and neuropsychology evaluations.
- Backlogs in memory clinics and specialty care facilities.

Geographic and Resource Limitations

- Lack of specialists within reasonable travel distances, requiring patients to travel long distances.
- Minimal resources are available in rural areas, including geriatric or cognitive specialists.

Insurance and Socioeconomic Barriers

- Insurance coverage issues, including HMOs and policies that limit access to certain providers or diagnostic tests.
- Financial constraints for uninsured or underinsured patients.
- Language and transportation barriers further complicating access to care.

Patient Compliance and Engagement

- Reluctance or refusal by patients or families to follow through with referrals.
- Denial or minimization of symptoms by patients or caregivers.
- Mobility issues and difficulty accessing care due to patient conditions.

Provider Knowledge and Confidence

- Lack of familiarity with appropriate referral pathways or specialists.
- Limited confidence in recognizing when and how to refer for diagnosis.
- Personal education gaps regarding diagnostic options and follow-up care.

System and Workflow Barriers

- Complexity and time required to educate patients and enter referral details into EMRs.
- Urgent care and inpatient providers are not equipped to handle referrals for chronic cognitive conditions.

Specialist Capacity and Approach

- Neurology specialists often delay formal diagnoses, requiring observable cognitive decline.
- Overburdened specialists and memory clinics focusing on newer Alzheimer's treatments create additional delays.

Cost and Testing Challenges

- High costs for advanced diagnostic tests, such as MRIs or PET scans, are often not covered by insurance.
- Limited community resources to support diagnostic workups.

The barriers to referring for diagnosis stem from systemic shortages, logistical delays, patient-related factors, and provider knowledge gaps. Addressing these issues requires coordinated efforts to improve access to specialists, streamline referral processes, enhance provider education, and expand diagnostic resources in underserved areas.

Summary of Challenges and Barriers to Diagnosing

Specialist Dependency and Expertise Gaps

- Many providers defer diagnosis to specialists due to perceived lack of expertise.
- Limited confidence in distinguishing between types of cognitive impairments (e.g., mild cognitive impairment vs. early dementia).

Lack of Provider Training and Confidence

- Insufficient training in diagnostic criteria and tools.
- Limited knowledge about newer diagnostic methods and how to differentiate dementia subtypes.
- Knowledge gaps regarding diagnostic pathways and testing interpretation.
- Need for updated education or training to increase comfort and accuracy in making diagnoses.

Systemic and Workflow Challenges

- Time constraints during appointments limit the ability to perform comprehensive assessments.
- Lack of access to proper diagnostic tools, such as PET scans and detailed cognitive testing.
- Limited resources for advanced testing in primary care or inpatient settings.

Access and Resource Barriers

- Shortages of specialists especially in rural areas lead to long wait times for appointments and/or advanced diagnostic tests.
- Insurance barriers, including lack of coverage for recommended tests or imaging.
- Limited availability of diagnostic studies like MRIs and PET scans due to cost or geography.

Patient-Related Factors

- Reluctance or denial by patients or families to address memory issues.
- Cultural and educational barriers that complicate diagnosis.
- Challenges in engaging patients with language barriers or lower health literacy.

Setting-Specific Limitations

- Urgent care and inpatient settings are often inappropriate for diagnosing dementia due to lack of continuity of care.
- Providers in specialized fields (e.g., stroke or oncology) may not have the tools or focus to diagnose dementia.
- Telemedicine constraints make it difficult to assess cognitive function accurately.

Confidence and Diagnostic Reassurance

- Providers may feel uncertain or second-guess their diagnosis, preferring confirmation from specialists.
- Pressure to ensure diagnostic accuracy is given the significant impact on patients and families.

Systemic Inequities

- Resource limitations in underserved or rural areas delay or prevent timely diagnosis.
- Insurance and socioeconomic factors exacerbate inequities in accessing diagnostic care.

The barriers to diagnosing dementia highlight the need for improved training, resources, and systemic support for healthcare providers. Addressing these challenges involves enhancing access to specialists and diagnostic tools, expanding provider education, and streamlining diagnostic workflows to improve patient care.

Summary of Challenges and Barriers to Counseling Following Diagnosis

Time Constraints

- Insufficient time during appointments to provide comprehensive counseling.

- Busy schedules and limited availability of follow-up appointments.
- Counseling requires multiple visits, which are challenging to schedule and accommodate.

Training and Knowledge Gaps

- Lack of training and expertise in counseling patients and families about dementia.
- Limited education on prognosis, treatment plans, and addressing patient questions effectively.
- Providers feel unprepared to deliver counseling or explain the diagnosis comprehensively.

Systemic Barriers

- Patients referred to specialists due to policies or perceived lack of expertise in primary care.
- Lack of coordination or follow-up after referral to specialists.
- Limited availability of specialists for ongoing support.

Patient-Related Factors

- Language barriers and low health literacy hinder effective communication.
- Patient compliance and follow-through with counseling and follow-up appointments.
- Difficulty in counseling patients without family, friends, or caregivers present.

Setting Limitations

- Counseling requires continuity of care, which is lacking in some settings.

Resource and Access Issues

- Limited treatment and counseling options are available in some communities.
- Patients often face barriers such as insurance coverage, socioeconomic status, and transportation issues that impede access to counseling.
- Inadequate community resources to support post-diagnosis care and education.

Provider Confidence and Support

- Providers feel a lack of confidence in their ability to counsel patients effectively.
- Concerns about explaining complex diagnoses and their implications accurately.
- Limited continuing education and resources for providers to stay updated on best practices.

Complexity of Counseling

- Counseling requires addressing multifaceted aspects such as diagnosis, prognosis, treatment options, and patient concerns.
- Families and patients may require detailed explanations that take time and multiple visits.

Cultural and Social Challenges

- Barriers in effectively communicating the diagnosis and its implications to diverse populations.
- Challenges in ensuring patients and families understand and accept the diagnosis, particularly when cultural norms may hinder open discussions.

The challenges in counseling following a dementia diagnosis highlight the need for better time management, provider training, and systemic support. Addressing these barriers requires enhanced access to specialists, culturally sensitive resources, improved care coordination, and education for both providers and patients.

Summary of Challenges and Barriers to Referring for Treatment

Specialist Shortages & Limited Availability

- Insufficient number of neurologists, geriatricians, or memory clinics—especially acute in rural areas.
- Long wait times (often 6–12 months) for neurology or specialty appointments.
- Limited local resources, requiring patients to travel significant distances.

Insurance & Financial Barriers

- Delays or denials of coverage for specialist consultations and treatments.
- High out-of-pocket costs for patients without insurance or with limited plans.
- Prior authorization requirements and burdensome paperwork can slow down referrals.

Patient-Related Factors

- Patient reluctance or refusal to pursue further treatment (e.g., denial, fear, noncompliance).
- Mobility issues, memory limitations, and difficulty adhering to follow-up schedules.
- Reluctance to travel long distances (especially in rural settings).

Systemic & Workflow Challenges

- Overburdened specialist clinics with extensive backlogs, creating months-long delays.
- Limited appointment availability and high patient volume.
- Referral processes require significant time to complete and coordinate.

Provider Constraints

- Urgent care or hospital settings are not equipped to manage chronic dementia treatments.
- Lack of provider knowledge on where to refer or what treatment options are available.
- Time constraints hinder in-depth discussions about referral options.

Geographic & Rural Barriers

- Travel distances and limited transport options for patients in rural regions.
- Few or no local specialty clinics, leading to further delays and inconvenience for patients.

Socioeconomic & Cultural Factors

- Financial strain, language barriers, and low health literacy impacting follow-through.
- Lack of culturally or linguistically appropriate resources and support systems.

Limited Treatment Options & Evolving Therapies

- Some advanced treatments (e.g., monoclonal antibodies) are not widely offered or covered.
- Few infusion centers or imaging facilities capable of supporting novel therapies.

Overall, referring patients for specialized dementia treatment is hampered by a shortage of specialty providers, long wait times, insurance hurdles, and significant geographic and socioeconomic challenges. This underscores the need for more robust systems, improved resource allocation, and better care coordination to ensure timely access to appropriate treatment.

Summary of Challenges and Barriers to Initiating Treatment

Scope of Practice & Setting

- Many providers work in urgent care, hospital, or research settings where initiating treatment is outside their scope (e.g., inpatient focus, no follow-up).
- Referrals to neurology or memory centers are preferred/required rather than initiating treatment independently.

Knowledge & Training Gaps

- Insufficient familiarity with current treatment guidelines and medication options (beyond common oral therapies).
- Uncertainty about medication efficacy, side effects, and authorization requirements.
- Limited continuing education and lack of comfort in managing dementia treatments without specialist support.

Time & Workflow Constraints

- Short appointment times in clinical settings, limiting capacity to initiate and manage treatments.
- Competing patient priorities and other comorbidities leave insufficient time for detailed counseling on medication use or side effects.

Access to Specialists & Resource Limitations

- Lack of geriatricians, neurologists, or dedicated memory clinics, especially in rural areas.
- Long wait times for specialty appointments, delayed or nonexistent options for advanced therapies.
- Limited access to infusion centers or imaging capabilities needed for newer treatments (e.g., monoclonal antibodies).

Insurance & Financial Barriers

- Coverage denials, prior authorizations, and high out-of-pocket costs can deter initiating treatment.
- Complex or evolving reimbursement policies (e.g., for newer monoclonal antibody therapies).
- Additional burdens such as repeated insurance forms and phone calls.

Patient-Related Concerns

- Reluctance or fear of starting new or unfamiliar treatments, possibly due to side effect concerns.
- Cognitive or memory issues leading to poor compliance without a dedicated caregiver or support system.
- Cultural, linguistic, and socioeconomic factors limiting awareness and follow-through.

Confidence & Complexity

- Providers worry about correctly diagnosing and matching treatments to specific dementia subtypes.
- Potential for significant life-altering implications (e.g., side effects, high costs) makes providers hesitant to initiate therapy.
- Desire for specialist confirmation or reassurance before prescribing.

In sum, numerous interlinked factors—ranging from provider education gaps and systemic barriers to insurance obstacles and patient reluctance—impede the timely initiation of dementia treatment. Addressing these challenges requires improving provider training, expanding specialist availability, and streamlining insurance processes to better support patients.

Summary of Challenges and Barriers to Monitoring Treatment

Scope and Setting Limitations

- Providers in urgent care, inpatient, or other temporary-care settings do not typically follow patients long term.
- Some clinicians feel monitoring is outside their scope of practice and refer to specialists (neurology, PCP).

Time and Workflow Constraints

- Short or overbooked appointment slots limit thorough follow-up and monitoring.
- Providers struggle to stay updated on evolving treatment guidelines, especially for new Alzheimer's therapies.

Knowledge and Training Gaps

- Insufficient familiarity with medication management, side effects, and monitoring protocols.
- Limited education on newer treatments (e.g., monoclonal antibodies) and their monitoring requirements.

Resource and Access Issues

- Lack of local neurology services and specialists to support ongoing follow-up.
- Travel and transportation barriers for patients, especially those who need multiple appointments.
- Rural or underserved areas often have fewer referral options and limited advanced treatment facilities.

Insurance and Financial Barriers

- High costs of infusion therapies (e.g., lecanemab/Leqembi, donanemab) and associated monitoring.
- Insurance denials, changing coverage, or network restrictions can impede consistent care.
- Patients' socioeconomic constraints (e.g., transportation, time off work) reduce follow-through.

Patient Compliance and Engagement

- Patients may forget or skip follow-up appointments due to cognitive impairment or logistical challenges.
- Some patients discontinue medications or obtain new prescriptions elsewhere, complicating continuity.
- Limited caregiver support can result in poor adherence and inadequate monitoring.

Complex Monitoring Protocols

- Newer Alzheimer's treatments may require extensive follow-up (e.g., repeated imaging) to detect side effects like ARIA-H or ARIA-E.
- Coordination among multidisciplinary teams (neurology, imaging, infusion centers) is often complex.

Confidence and Comfort Level

- Providers may lack confidence in discussing treatment adjustments or side effects.
- Need for specialist input can delay or fragment ongoing monitoring.

Overall, monitoring treatment for dementia patients is hindered by a combination of setting constraints, provider knowledge gaps, resource limitations, and patient-level challenges. Overcoming these barriers requires improved education, better care coordination, and enhanced access to specialized services and support.

Summary of Challenges and Barriers to Connecting Patients with Community Resources

Limited or Nonexistent Resources

- Rural and underserved areas lack care navigators, social workers, or dementia support services.
- Scarcity of community programs or specialized services for older adults with cognitive impairments.
- Practices with small budgets or staff shortages have trouble maintaining or accessing care navigation options.

Insurance and Financial Constraints

- Lack of insurance coverage for care navigator or social work services creates financial burdens for patients.
- Confusion over insurance benefit structures can deter providers from making referrals.
- High out-of-pocket costs for resources limit patient engagement and follow-through.

Knowledge and Awareness Gaps

- Providers and clinic staff are often unaware of existing resources or how to locate them.
- Patients and families may not trust or understand telephone- or online-based navigators.
- Limited training on community support services leaves providers unsure how to refer.

Time and Workflow Pressures

- Short appointment times make it difficult to discuss or arrange referrals to community organizations.
- High-volume practices do not always have the capacity to coordinate with external agencies.
- Providers struggle to stay current with evolving community resource lists and eligibility requirements.

Language, Literacy, and Cultural Barriers

- Non-English-speaking or low-literacy patients may face difficulties connecting with navigators or social workers.
- Resources are often not available in multiple languages or adapted for diverse cultural backgrounds.
- Distrust of phone-based or remote services can impede acceptance of help.

Logistical Challenges

- Transportation issues, particularly in rural communities, prevent patients from physically reaching services.
- Difficulty with follow-up; patients may forget or struggle to keep appointments without supportive caregivers.
- Fragmented care across multiple providers can lead to confusion or duplication of referrals.

Inconsistent Funding and Sustainability

- Care navigation programs, if available, may be grant-funded or short-term, leading to instability.
- Limited government or organizational budgets can reduce the availability of social services.

Patient and Family Barriers

- Some families or patients decline nurse case management or external support.
- Fear, stigma, or denial around dementia can deter individuals from seeking community resources.

By addressing these multifaceted challenges—through improved provider education, streamlined referral workflows, and enhanced funding and resource availability—healthcare teams can better connect patients with the community support they need.

Summary of Challenges and Barriers to Discussing the AD8, Mini-Cog®, and MoCA Cognitive Screening Tests

Time Constraints

- Short appointment slots make it difficult to administer or discuss multiple screening tools.
- Competing patient needs (e.g., multiple comorbidities) limit the focus on cognitive assessments.
- Providers often prioritize urgent issues, leaving minimal time for thorough cognitive screening.

Training and Knowledge Gaps

- Many clinicians are unfamiliar with the full range of tools (e.g., AD8, MoCA) or have only trained on one (often Mini-Cog® or MMSE).
- Providers may lack education on the respective strengths, weaknesses, and proper administration of each test.
- Limited exposure to certification processes (e.g., MoCA) or uncertainty about how to access relevant training materials.

Institutional Policies and Resources

- Some clinics or health systems mandate only one or two screening tools (e.g., Mini-Cog® and SLUMS).
- Copyright issues or costs associated with certain tests (e.g., MoCA certification fees) can hinder adoption.
- Smaller practices and urgent care settings may not have the infrastructure or support staff to administer and interpret these tests.

Familiarity and Comfort Level

- Providers who rarely encounter cognitive impairment (e.g., oncology specialists, occupational health clinicians) may not feel the need to learn multiple tools.
- Fear of incomplete or inaccurate results without specialist training leads some clinicians to avoid discussing alternative tests.
- Perceived complexity of certain tests (e.g., MoCA) can discourage adoption.

Implementation Barriers

- Lack of standardized workflows within practices to incorporate screenings into routine visits.
- Uncertainty over which test best fits a patient’s language abilities, education level, or cultural background.
- Inconsistent use of screening tools across different providers within the same practice, leading to confusion.

Patient and Population Considerations

- Some patient populations (e.g., younger, occupational health) rarely present with suspected cognitive issues, so providers see little need for these tools.
- Language barriers and low health literacy can complicate test administration and interpretation.
- Patients may be uninterested or unwilling to invest time in testing if they do not perceive cognitive decline.

Cost and Administrative Hurdles

- Financial cost for MoCA certification or printed materials can deter widespread use.
- Additional staff time for administering and scoring tests increases operational costs.
- Unclear reimbursement pathways for screening may discourage providers from adopting multiple tools.

These barriers highlight the need for expanded provider education, streamlined clinic workflows, and clear institutional policies. By improving training opportunities, allocating adequate time, and clarifying the benefits and limitations of each tool, clinicians can more confidently integrate cognitive screening into patient care.

Summary of Challenges and Barriers to Selecting, Administering, and Interpreting an Appropriate Cognitive Screening Test

Time Constraints

- Short appointments (often 15 minutes) leave limited opportunity to perform thorough screenings.
- Multiple comorbidities and competing patient concerns reduce available time for cognitive testing.
- Providers prioritize urgent or acute issues over routine cognitive assessments.

Training and Knowledge Gaps

- Many clinicians have not received formal instruction on various screening tools (e.g., MoCA, Mini-Cog®, SLUMS).
- Uncertainty about which tool is most appropriate for a given patient (e.g., literacy level, language, clinical setting).
- Lack of confidence in administering, scoring, and interpreting results without specialist support.

Workflow and Setting Limitations

- Certain settings (e.g., urgent care, hospital inpatient) are not conducive to routine cognitive screening.
- Providers in specialized clinics (e.g., oncology, headache/migraine) rarely see dementia concerns and may not stay current on screening practices.
- Policies in some practices limit the use of specific screening tools or require referrals to neurology or behavioral health.

Resource and Staffing Shortages

- Insufficient staff trained to administer tests, particularly in smaller practices or rural areas.
- Limited availability of validated tools for specific patient populations (e.g., low literacy, non-English-speaking).
- Costs for certain tests (e.g., licensing, certification fees) can deter widespread adoption.

Patient-Related Factors

- Patient refusal or lack of engagement when they do not perceive cognitive concerns.

- Language barriers and low health literacy can make it challenging to administer and interpret tests accurately.
- Cognitive testing may be confounded by acute conditions (e.g., stroke, delirium) or multiple comorbidities.

Provider Preference and Variation

- Different clinicians gravitate toward the test they learned first or find easiest to use (e.g., Mini-Cog®, SLUMS).
- Inconsistent use of screening tools within the same practice can lead to confusion and inefficiency.
- Some providers defer screening test selection and interpretation to neurology or neuropsychology.

Cost and Licensing Issues

- Certain tests require fees for certification or official materials (e.g., MoCA).
- Practices with limited budgets may rely on free tools but have less flexibility in test selection.

By addressing these time, training, resource, and patient-related barriers, healthcare providers can more confidently select and administer cognitive screenings that best fit each patient's needs and clinical setting.

Summary of Challenges and Barriers to Differentiating Normal Aging, Mild Cognitive Impairment, and Dementia

Time Constraints

- Short appointment durations (often 15 minutes) make it difficult to gather a thorough history, perform detailed exams, and address confounding factors.
- Multiple comorbidities and urgent concerns often take precedence, leaving minimal time for cognitive assessments.

Knowledge and Training Gaps

- Providers express uncertainty about how to distinguish between mild cognitive impairment (MCI), normal aging, and various dementia types.
- Many clinicians seek additional education or refresher training on comprehensive evaluation methods and diagnostic criteria.
- Limited exposure during formal training (e.g., PA school) contributes to lower confidence in making definitive distinctions.

Clinical Complexity and Overlapping Presentations

- Subtle differences among normal aging, MCI, and early dementia can be nuanced and difficult to detect.
- Depression, anxiety, sleep disorders, and other confounders may mask or mimic cognitive decline.
- Emotional stakes of a dementia diagnosis increase the pressure to be accurate and to involve specialists.

Testing Limitations

- Screening tools (e.g., MMSE, MoCA) may not fully capture borderline or subtle impairments, necessitating more in-depth evaluations.

- Insurance denials or coverage limitations can prevent access to advanced imaging or neuropsychological testing.
- Some providers lack familiarity with additional diagnostic tests or how best to interpret results.

Access to Specialists and Resources

- Long travel distances to see a neurologist or geriatrician, particularly in rural areas.
- Limited specialist availability or long wait times, leading to delays in definitive diagnosis.
- Practices may not have on-site neuropsychologists or multidisciplinary teams to confirm diagnoses.

Confidence and Comfort Level

- Providers may feel uneasy initiating a life-altering diagnosis without specialist input.
- Variability in clinical experience with cognitive disorders reduces confidence in distinguishing among them.
- Need for second opinions, more detailed tests, or referral processes can slow timely decision-making.

Patient and Cultural Considerations

- Language barriers, low health literacy, or cultural factors may obscure cognitive issues or hinder accurate testing.
- Patients or families may minimize symptoms or resist diagnostic labeling, complicating assessment.

By increasing education, streamlining diagnostic workflows, and expanding access to specialists or advanced testing, providers can build the confidence and clinical insight necessary to differentiate more accurately among normal aging, mild cognitive impairment, and dementia.

Summary of Challenges and Barriers to Discussing Abnormal Screening Results

Time Constraints

- Short appointment times make it difficult to address complex questions and concerns.
- Patients and families often have extensive inquiries, requiring thorough explanations and follow-up.

Provider Training and Confidence

- Lack of formal education on how to counsel patients regarding abnormal cognitive screening results.
- Providers may feel uncomfortable or unprepared to answer detailed questions about prognosis or next steps.

Knowledge Gaps

- Limited understanding of disease progression (e.g., mild cognitive impairment versus dementia) can inhibit clear communication.
- Uncertainty about which additional tests or referrals are necessary to confirm a diagnosis.

Patient and Family Factors

- Varying levels of health literacy or language barriers can impede comprehension of results and recommended actions.
- Some patients dismiss or minimize abnormal findings, especially when unaccompanied by family or caregivers.
- Families may lack understanding of disease progression, leading to confusion, anxiety, or denial.

Language, Cultural, and Educational Barriers

- Materials may not be available in the patient's preferred language or tailored to different cultural contexts.
- Low literacy and cultural perceptions of memory loss can make discussions more challenging.

Systemic and Workflow Issues

- Specialists (e.g., neurology, geriatrics) may manage abnormal results, leaving primary providers less involved or informed.
- Urgent care or hospital-based clinicians often cannot follow patients long-term, limiting continuity of care.
- Lack of clearly defined protocols or referral pathways for abnormal results can create confusion about next steps.

Resource Limitations

- Insufficient staff support (e.g., social workers, care navigators) to help with patient education and follow-up.
- Transportation barriers hinder some patients' ability to return for counseling or additional evaluations.

Emotional and Psychological Impact

- The potential diagnosis of dementia or cognitive impairment is emotionally charged, requiring sensitive, time-intensive discussion.
- Providers may worry about the accuracy of diagnoses and the gravity of delivering concerning news to patients and caregivers.

By addressing these multifaceted barriers—through extended appointment times, enhanced provider training, improved patient education materials, and clear referral processes—clinicians can more effectively communicate abnormal cognitive screening results and offer the support patients and caregivers need.

Summary of Challenges and Barriers to Collaborating with patients and families around lifestyle approaches to address modifiable risk

Time Constraints

- Short appointment times (often 15 minutes) leave limited opportunity to discuss prevention or lifestyle modifications.
- Competing patient priorities during visits reduces the time available for in-depth conversations.
- Providers need additional time to educate, motivate, and follow up with patients and families.

Knowledge and Training Gaps

- Many clinicians feel they lack sufficient knowledge about lifestyle modifications and risk factors for cognitive decline.
- Uncertainty regarding the role of genetics, which risk factors are truly modifiable, or how to balance realistic expectations with hopeful messaging.
- Need for better education, resources, and written materials to share with patients.

Patient and Family Engagement

- Some patients and families are unwilling to change or may not believe they need additional resources.
- Limited family support or involvement, especially when family members live far away or do not attend appointments.
- Cultural differences, low health literacy, or language barriers can hinder understanding and acceptance of preventive measures.

Systemic and Practice Barriers

- Certain settings (e.g., specialized clinics, urgent care) do not provide long-term follow-up, making ongoing support difficult.
- Lack of coordination and staff training reduces the ability to address modifiable risk factors effectively.
- Providers often face misinformation or stereotypes that must be countered with clear, evidence-based guidance.

Resource Limitations

- In rural or underserved areas, resources for lifestyle interventions and community support may be scarce.
- Patients often have limited transportation or finances to access recommended programs or services.
- Families may lack knowledge about available community resources, such as home health aides or caregiver support groups.

Patient Motivation and Psychosocial Factors

- Denial, fear, or reluctance to discuss sensitive topics like driving, smoking cessation, or necessary lifestyle changes.
- Patient or family isolation and/or lack of consistent caregiver involvement reduce follow-through on recommendations.

- Cultural norms and beliefs about preventive medicine can influence receptiveness to counseling and interventions.

By addressing these time limitations, knowledge deficits, and engagement challenges, healthcare providers can more effectively counsel patients and families on the importance of lifestyle modifications, risk factor management, and available resources to support healthier outcomes.

Appendix B. Opportunities for PAs to Take a Greater Role in Supporting Patients with Alzheimer's Disease and Other Forms of Dementia

PAs were asked ""Where in the patient journey would you like to take a greater role in supporting patients?" The following are the themes that arose.

Early Identification and Screening

- **Routine Checkups**. Many feel annual wellness exams (e.g., Medicare checkups) and preventive visits are ideal times to introduce brief cognitive screenings.
- **Initial Symptom Recognition.** Providers want to be more proactive when patients or families first mention memory concerns, rather than waiting for advanced symptoms.

Diagnosis and Initial Management

- **Conducting Workups.** Some PAs wish to administer screening tools (e.g., Mini-Cog, MoCA), interpret results, and discuss possible next steps with patients.
- **Bridging Delays to Specialist Care**. Due to long wait times for neurology or neuropsychology appointments, providers want enough knowledge and resources to support patients until specialty care is available.

Counseling and Education

- **Time for Discussion**. Many emphasize a desire to spend more time explaining diagnosis, disease progression, and non-pharmacological interventions.
- **Lifestyle and Non-Medication Options**. Providers want to counsel on diet, exercise, social engagement, and other ways to potentially slow decline or maintain quality of life.

Ongoing Support and Care Coordination

- **Connecting Families to Resources**. Providers note the importance of helping families find community programs, caregiving support, and education on what to expect as dementia progresses.
- **Transitional Periods**: Some want to be more involved when patients move from home-based care to assisted living or when families need guidance managing safety concerns at home.
- **Continuous Monitoring**. Several envision a role in follow-up visits to evaluate response to treatment, address behavioral changes, and guide next steps.

Throughout the Entire Journey

- **From Prevention to End-of-Life**. Many providers see value in being there "start to finish," from discussing risk factors in younger or at-risk patients, to making an initial diagnosis, and eventually addressing palliative or hospice needs.
- **Reassuring Patients and Families.** By staying involved during every phase, providers can offer emotional support, answer ongoing questions, and help manage the disease's psychosocial impacts.