Hawai‘i Health Partners Webinar:
Dementia Care

Wednesday, August 13, 2025

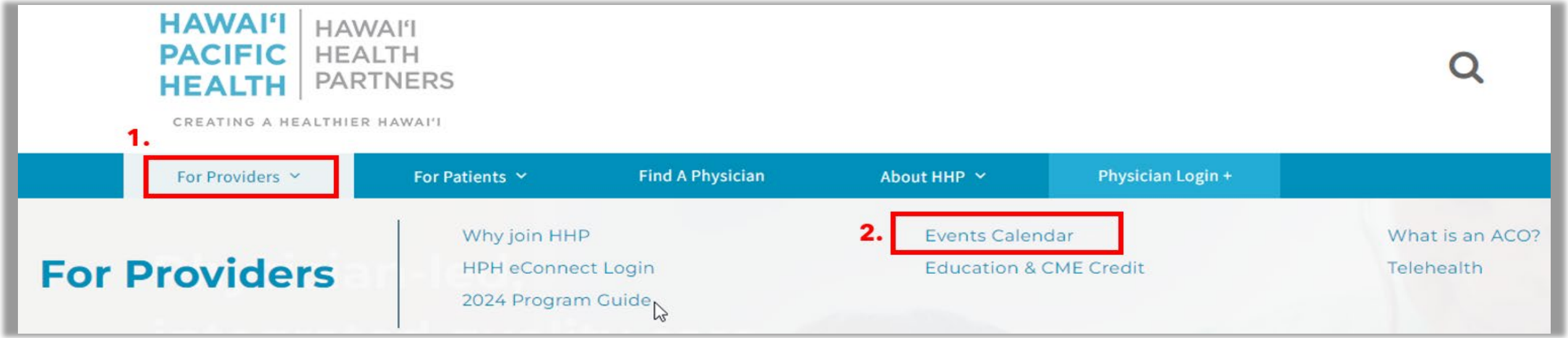
5:30pm—6:30pm via Zoom

HAWAI‘I PACIFIC HEALTH | HAWAI‘I HEALTH PARTNERS

Next HHP Webinar: (for HQIP Credit)

Thursday, September 11 from 5:30-6:30p
"The Importance of Peer Support: Resilience in Stressful Events"
By Visiting Professor Dr. Albert Wu

To view upcoming HHP webinars and future events, please visit our Hawai'i Health Partners website for the "**Events Calendar**" from the "For Providers" dropdown.



For Specialists Only: Annual Assessment of Chronic Conditions (for HQIP Credit)

Presentation #2 coming end of October via email from Info@HawaiiHealthPartners.org

This measure is separate from HHP Network Engagement – Webinars

GENERAL OBJECTIVES:

This offering is intended for Physicians, Nurses and other health care professionals.

By the end of the course, the participants will be able to:

1. Define the diagnosis of dementia.
2. Describe the elements of cognitive health screening.
3. Discuss the evaluation of a patient with dementia.
4. Explain the "GUIDE" program to eligible patients.

CONTINUING EDUCATION:

In support of improving patient care, Hawai'i Pacific Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Hawai'i Pacific Health designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credits™* for physicians. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Hawai'i Pacific Health designates this live activity for 1.0 contact hours for nurses. Nurses should only claim credit commensurate with the extent of their participation in the activity.

TO CLAIM CE:

Please note that in order to receive continuing education credits for this offering, you must:

- Be registered for this activity and Sign in.
- Claim credit commensurate with the extent of your participation in the activity.
  Speakers cannot claim credit for their own presentations.
- Complete and submit the evaluation survey that will be emailed to you within one week of the offering.
- Your CE certificate will be immediately available to you upon completion of your evaluation.

DISCLOSURE INFORMATION:

Per CE requirements, a disclosure report is included below listing any relationships that faculty, planners and others in control of educational content may have with an ineligible company. An Ineligible Company, as defined by the ACCME, is a company whose primary business is producing, marketing, selling, re-selling or distributing healthcare products used by or on patients.

The following Faculty, Planners, and Others in control of educational content have reported no relationships with any ineligible company as defined by the ACCME new "Standards for Integrity and Independence in Accredited Continuing Education":

Faculty	**Relationship**
Susan Price, MD	None
Huidy Shu, MD	None
Planning Team Members	
Jennifer Lo, MD	None
Walter Schroeder, PharmD	None
Matthew Sasaki	None
Rachelle Meza, RN, BSN	None

Webinar Information

- You have been automatically muted
  - You cannot unmute yourself

- You will be able to submit questions via the Q&A section

- This webinar counts for HQIP credit for the measure HHP Network Engagement - Webinars

DEMENTIA CARE

Susan Price, MD
Geriatrics

Hawai‘i Pacific Health Medical Group

Huidy Shu, MD
Neurology

Hawai‘i Pacific Health Medical Group

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Overview

- What is dementia?
- Prevalence and impact
- Screening for cognitive impairment
- Evaluation
- Treatment
  - Medical
  - Supportive

What is dementia?

- Dementia is an acquired decline in memory and/or other areas of cognition or behavior, of sufficient magnitude to cause impairment of social or occupational functioning.

- DSM-5: Major Neurocognitive Disorder (MNCD)
  - Cognitive deficits in one or more areas of cognition, such as memory, language, visuospatial abilities, (apraxia, aphasia, agnosia), or executive function
  - Cognitive deficits must impair social or occupational functioning
  - Gradual onset and progressive cognitive decline
  - Not due to another CNS cause of dementia, substance abuse, or systemic conditions that can cause dementia
  - Not due to delirium
  - Not accounted for by another Axis 1 disorder.

DSM-V

What is Mild Cognitive Impairment (MCI)?

- Cognitive impairment with minimal impairment of instrumental activities of daily living (IADL)
- Minor Neurocognitive Disorder
- May lead to dementia

Types of dementia

- Alzheimer's Disease
- Vascular Dementia
- Dementia with Lewy Body Disease or Parkinson’s Disease
- Frontotemporal Dementia
- Others

Dementia Statistics

- ~7 million Americans are living with dementia*
  - Expected to double by 2060
- ~6 million Americans have MCI due to Alzheimer's pathology
- >20 million Americans have preclinical (asymptomatic) Alzheimer's pathology
- ~10% of people over 65 have dementia
  - 5% of 65-74 yo, 13% 75-84 yo, 33% 85y+
  - 42% lifetime risk after age 55
- 1/3 of older adults die with dementia
- 2/3 of people with dementia are women

Alzheimer's Association

Local dementia statistics

- ~30,000 people in Hawai'i have dementia

- HPHMG
  - 122,611 unique primary care visits (2 year look back)
  - 36% of these primary care patients were 65+
    - ~1000 of these were identified to have memory/cognitive/dementia issue
    - ~4500 (10%) of our primary care patients 65+ would be predicted to have dementia

Impacts of dementia

- Health care costs
  - 2025: $384 billion (US)
  - 2050: $1 trillion

- Morbidity
  - 7th leading cause of death in US
    - Alzheimer's disease kills more people than breast cancer and prostate cancer combined
  - Increased risk for falls, accidents, medication errors, pneumonia

- Caregivers
  - ~12 million Americans provide unpaid care to a person living with dementia
  - Caregivers have an increased risk of death compared to non-caregivers

Alzheimer's Association

Screening for cognitive impairment

- Cognitive impairment and dementia are underdiagnosed in older adults

- Benefits of early detection
  - Identify treatable or reversible factors (vascular, sleep, medications)
  - Assist with planning for the future
    - Advance Care Planning
    - Financial planning
  - Opportunities for early therapy (e.g. anti-amyloid)

Cognitive Health Assessment

When to screen

- Warning signs noted by patient/family
- Problems with medication adherence and missed appointments
- Annually for patients 65 and over

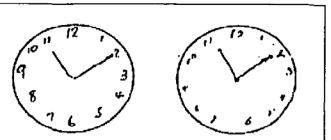
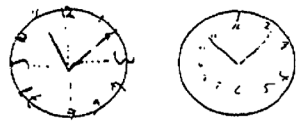
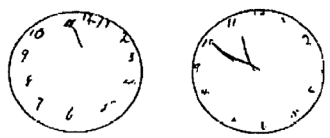
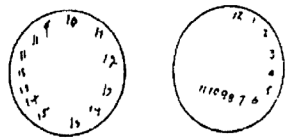
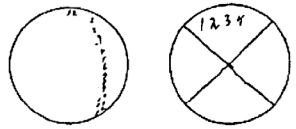
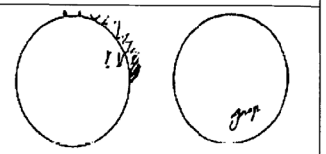
Components of Cognitive Health Assessment

- Cognitive screen
- Functional screen
- Inclusion of care partner/informant

Cognitive Screening Instruments

- Mini-Cog
  - Takes ~3 minutes to administer
  - Components
    - 3 item recall (3 points)
    - Clock drawing (2 points)
  - Total possible score 5/5
    - Scores of 0-2 should be investigated further

Clocks

1. Perfect	
2. Minor visuospatial errors *Examples* - Mildly impaired spacing of times - Draws times outside circle - Turns page while writing numbers so that some numbers appear upside down - Draws in lines (spokes) to orient spacing	
3. Inaccurate representation of 10 after 11 when visuospatial organization is perfect or shows only minor deviations. *Examples* - Minute hand points to 10 - Writes '10 after 11' - Unable to make any denotation of time	
4. Moderate visuospatial disorganization of times such that accurate denotation of 10 after 11 is impossible. *Example* - Moderately poor spacing - Omits numbers - Perseveration – repeats circle or continues on past 12 to 13, 14, 15 etc. - Right-left reversal – numbers drawn counter clockwise - Dysgraphia – unable to write numbers accurately	
5. Severe level of disorganization as described in 4.	
6. No reasonable representation of a clock Exclude severe depression or other psychotic states. *Examples* - No attempt at all - No semblance of a clock at all - Writes a word or name	

Other screening tools

- MMSE
- SLUMS
- MoCA
- Short Blessed Test

Functional Assessment

- Activities of Daily Living (ADL)
- Instrumental Activities of Daily Living (IADL)

Activities of Daily Living

- Bathing
- Dressing
- Toileting
- Transferring
- Continence
- Feeding

Instrumental Activities of Daily Living (IADL)

- Using telephone
- Shopping
- Food preparation
- Housekeeping
- Laundry
- Transportation
- Taking medications
- Handling finances

Care Partner/Informant

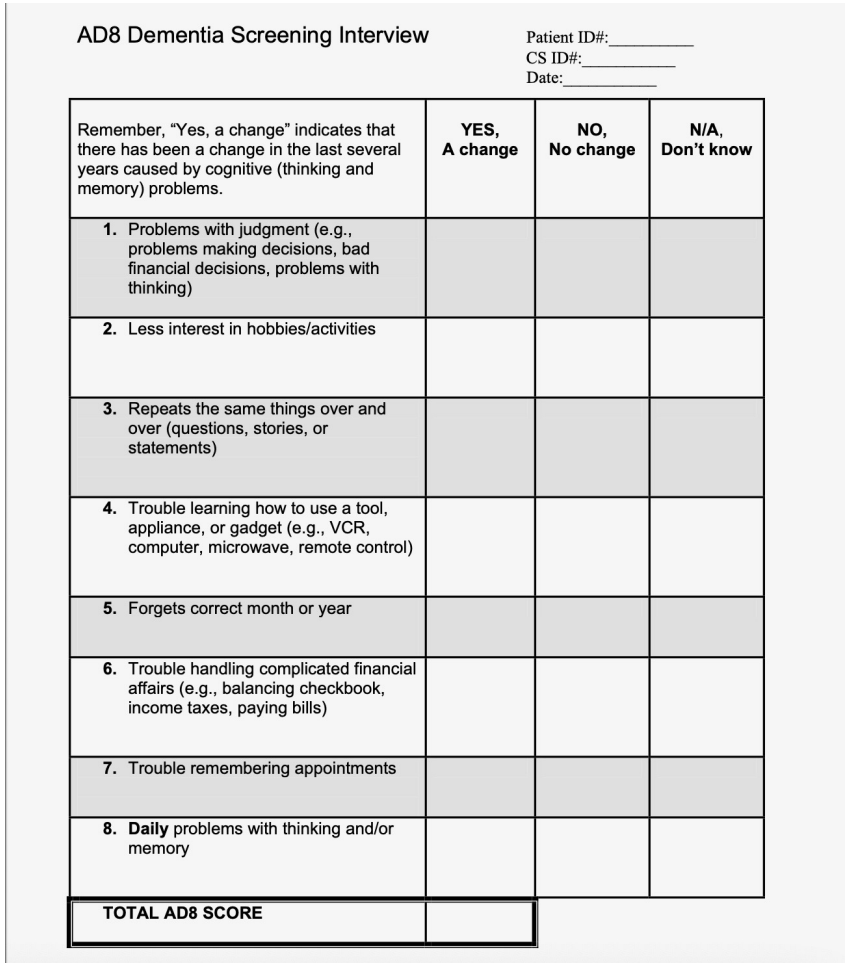
Cognitive Screen Instruments

- AD8

Functional Screen Instruments

- Functional Activities Questionnaire (FAQ)

AD8



AD8 Dementia Screening Interview

Patient ID#:_____
CS ID#:_____
Date:_____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	**YES, A change**	**NO, No change**	**N/A, Don't know**
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			

Cognitive Health Plan

- Lifestyle changes for brain health
  - Diet (MIND, Mediterranean)
  - Exercise
  - Mental activity
  - Socializing
- Advance Care Planning
  - Advance Health Care Directive
  - General Power of Attorney
- Further evaluation of positive screening

Evaluation of cognitive impairment and dementia

"I'm concerned about his memory. He keeps asking, 'Who's a good boy? Who's a good boy?'"

Clinical Syndromes of Dementia

- Memory Disorders (Short-Term Memory Loss)
  - Alzheimer's Disease, Limbic-associated Age-related TDP43 Encephalopathy (LATE)
- Speech and Language Disorders (Primary Progressive Aphasia)
  - Frontotemporal Dementia (FTD), CBD, PSP, Alzheimer's Disease
- Behavioral / Executive Syndrome (Disinhibition, Difficulty Organizing and Planning)
  - Frontotemporal Dementia, Huntington's Disease, Alzheimer's Disease, Vascular Dementia
- Posterior Cortical Atrophy Syndrome (Visuospatial Dysfunction)
  - Alzheimer's Disease, Dementia with Lewy Bodies, Creutzfeldt-Jakob Disease
- Movement Disorders (Tremors and Gait Abnormality)
  - Parkinson's Disease, Dementia with Lewy Bodies, PSP, CBD, NPH, Vascular Dementia
- REM Sleep Disorder (Acting Out Dreams)
  - Parkinson's Disease, Dementia with Lewy Bodies, Multiple System Atrophy
- Rapidly Progressive Dementia (No Symptoms to Severe in < 1 year)
  - Creutzfeldt-Jakob Disease, Autoimmune Encephalopathy

Differential Diagnosis

- Neurodegenerative
  - **Alzheimer's disease (AD)**
  - **Dementia with Lewy bodies (DLB)**
  - **Parkinson's disease (PD)**
  - Frontotemporal dementia (FTD)
  - Progressive supranuclear palsy (PSP)
  - Corticobasal degeneration (CBD)
  - Multiple systems atrophy (MSA)
  - Huntington's disease (HD)
  - Limbic-associated age-related TDP43 Encephalopathy (LATE)
  - Neuronal intranuclear inclusion disease (NIID)
- Vascular
  - **Stroke,** CADASIL, **mixed dementia**
- Autoimmune
  - Autoimmune encephalopathy, Lupus cerebritis, Hashimoto's, CNS vasculitis
- Cancer
  - CNS metastases, lymphoma, paraneoplastic
- Infectious
  - Syphilis, HIV, SSPE, chronic CNS infection
- Metabolic/ Nutritional Deficiency
  - B12, thiamine, niacin, porphyria
- Toxic
  - **Sedatives, anticholinergics, alcohol,** bismuth, heavy metals, domoic acid
- Other
  - Normal pressure hydrocephalus (NPH), Prions/ Creutzfeldt Jakob Disease (CJD), pseudodementia

Diagnostic Evaluation

- History and Physical (with Neurological Exam)
  - Insidious onset is typical; watch out for “Rapidly Progressive Dementia”
  - Evaluate medication list carefully for CNS active meds (esp. sedatives, anticholinergics)
  - Thoroughly evaluate patient for depression, anxiety, and hallucinations
- Brief Cognitive Testing (MMSE, MOCA, SLUMS)
  - Provides an objective baseline to follow over months to years
- Routine Laboratory Testing to Rule Out:
  - *Metabolic Disorders*- Hyponatremia, Thyroid, Liver, Kidney Dysfunction (CBC, CMP, TSH)
  - *Nutritional Disorders*- B12 and Thiamine Deficiency (B12, sometimes whole-blood thiamine)
  - *Infectious Causes*- Neurosyphilis (RPR)
- Neuropsychological Testing
  - Can be helpful in high functioning patients and those who have depression
- Biomarkers of Neurodegenerative Disease

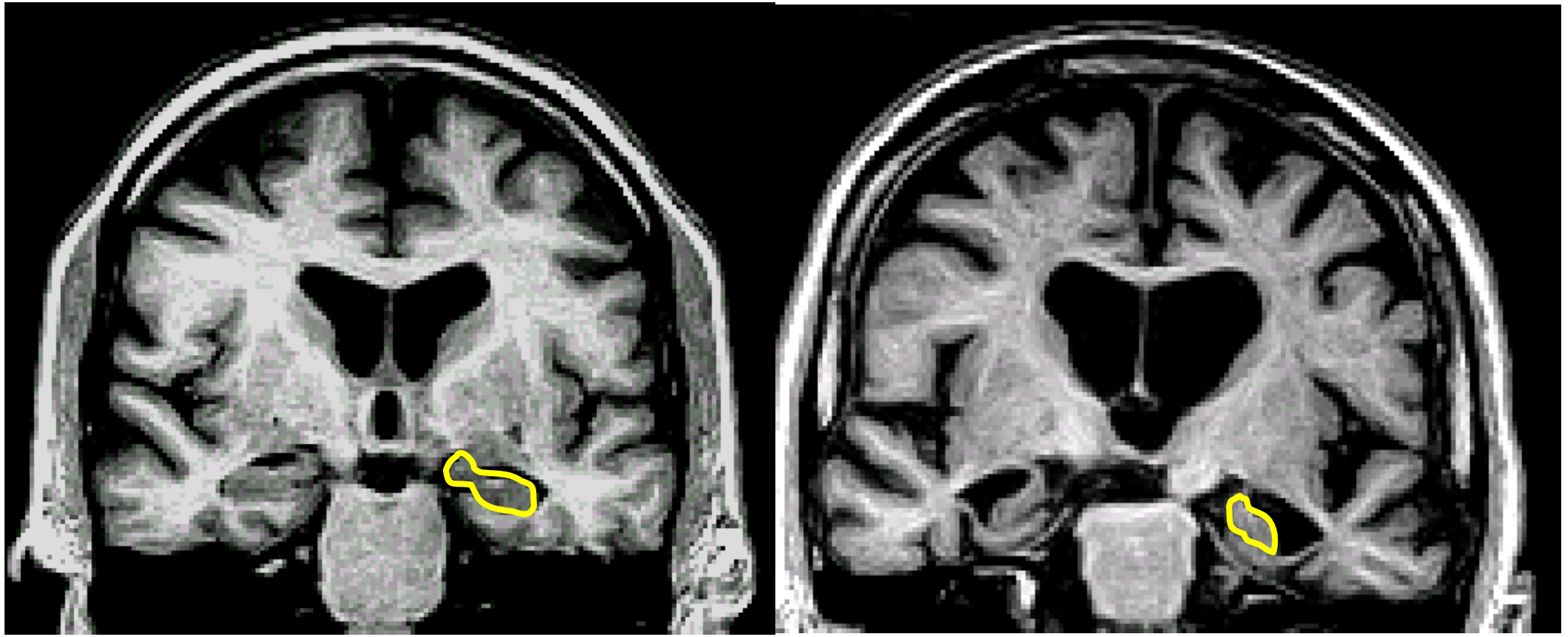
Biomarkers of Neurodegenerative Disease

- Imaging
  - *Structural*
    - **Magnetic Resonance Imaging (MRI)** is significantly better than CT scans
    - No contrast necessary unless you are concerned for tumors / metastases
  - *Functional*
    - Amyloid Positron Emission Tomography (Amyloid PET) for patients interested in Anti-Amyloid therapy
- Cerebrospinal Fluid (CSF) for Alzheimer's Disease
- Blood-based Biomarkers (BBM) for Alzheimer's Disease

Brain Magnetic Resonance Imaging (MRI)

- The most important general test for finding other causes of cognitive impairment
  - e.g. strokes/infarcts, tumors, blood, edema
- Brain atrophy is seen late in Alzheimer's Disease and other degenerative conditions
  - Patterns of brain atrophy are typically unique to different diseases
  - Alzheimer's Disease typically causes parietal lobe and hippocampal atrophy
- MRI does NOT detect the molecular hallmarks of Alzheimer's disease
  - Aβ protein
  - Tau protein

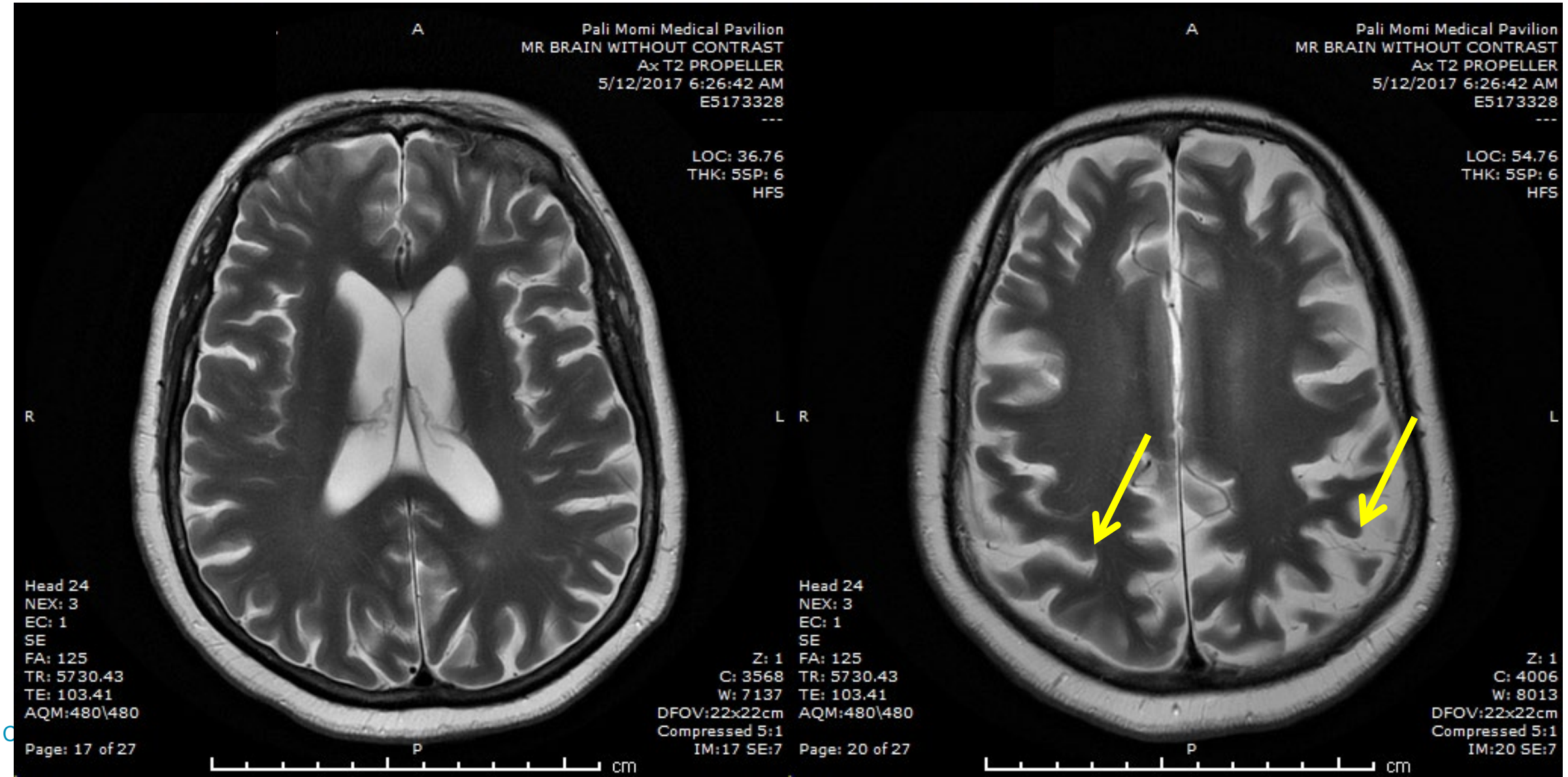
Hippocampal Atrophy In Alzheimer's Disease



Normal Elderly

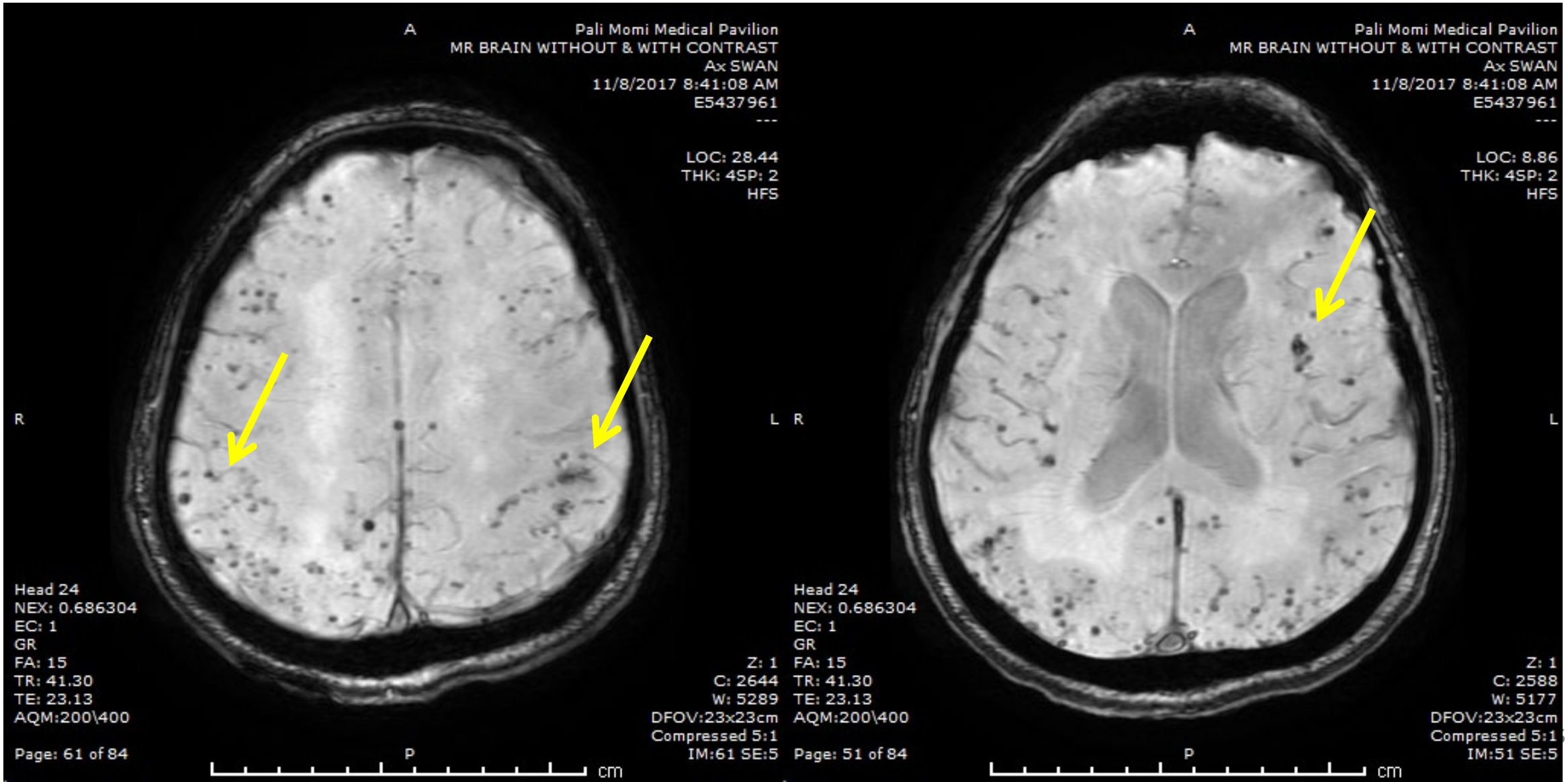
Alzheimer's Disease

Parietal Lobe Atrophy In Alzheimer's Disease

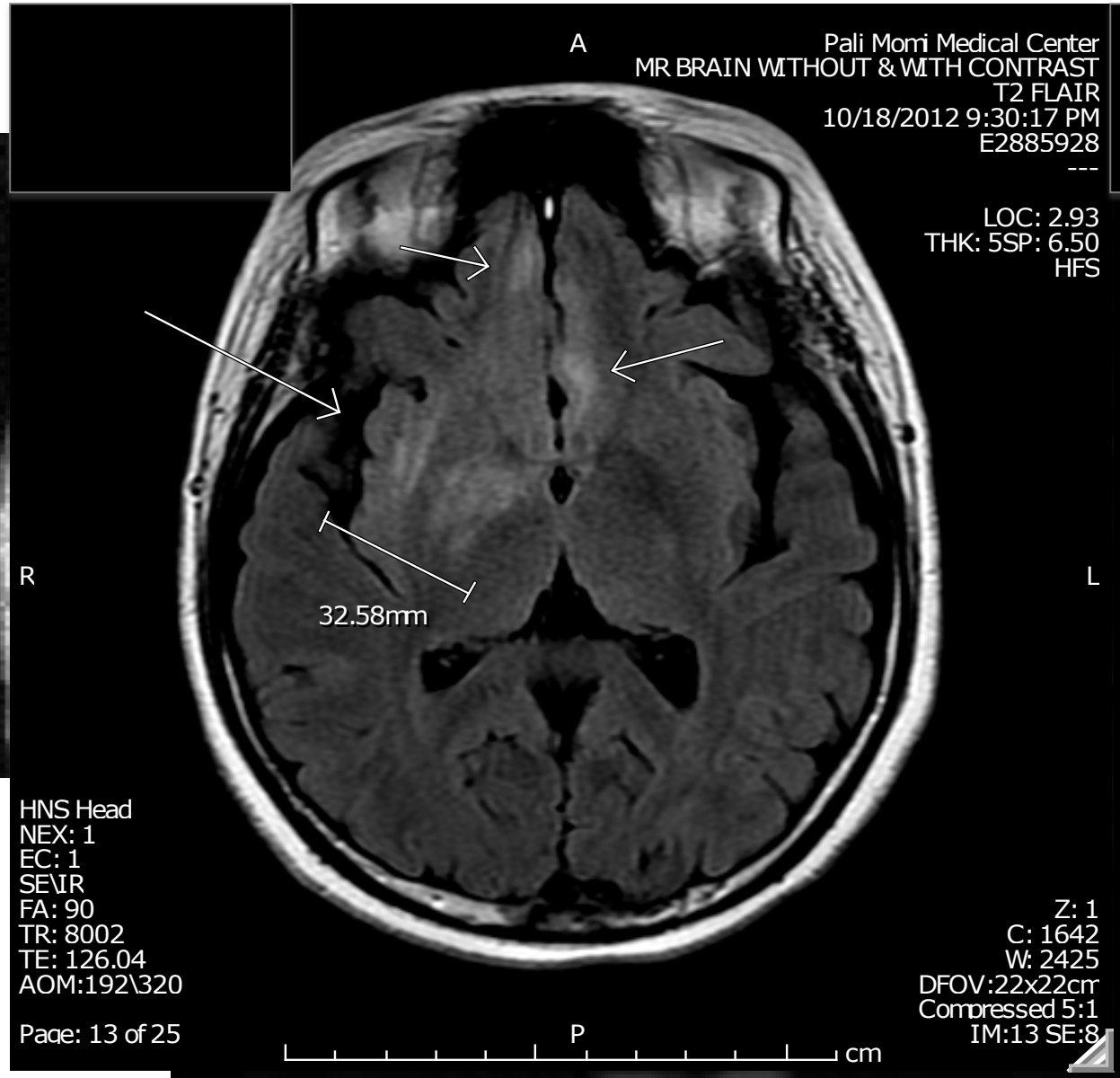


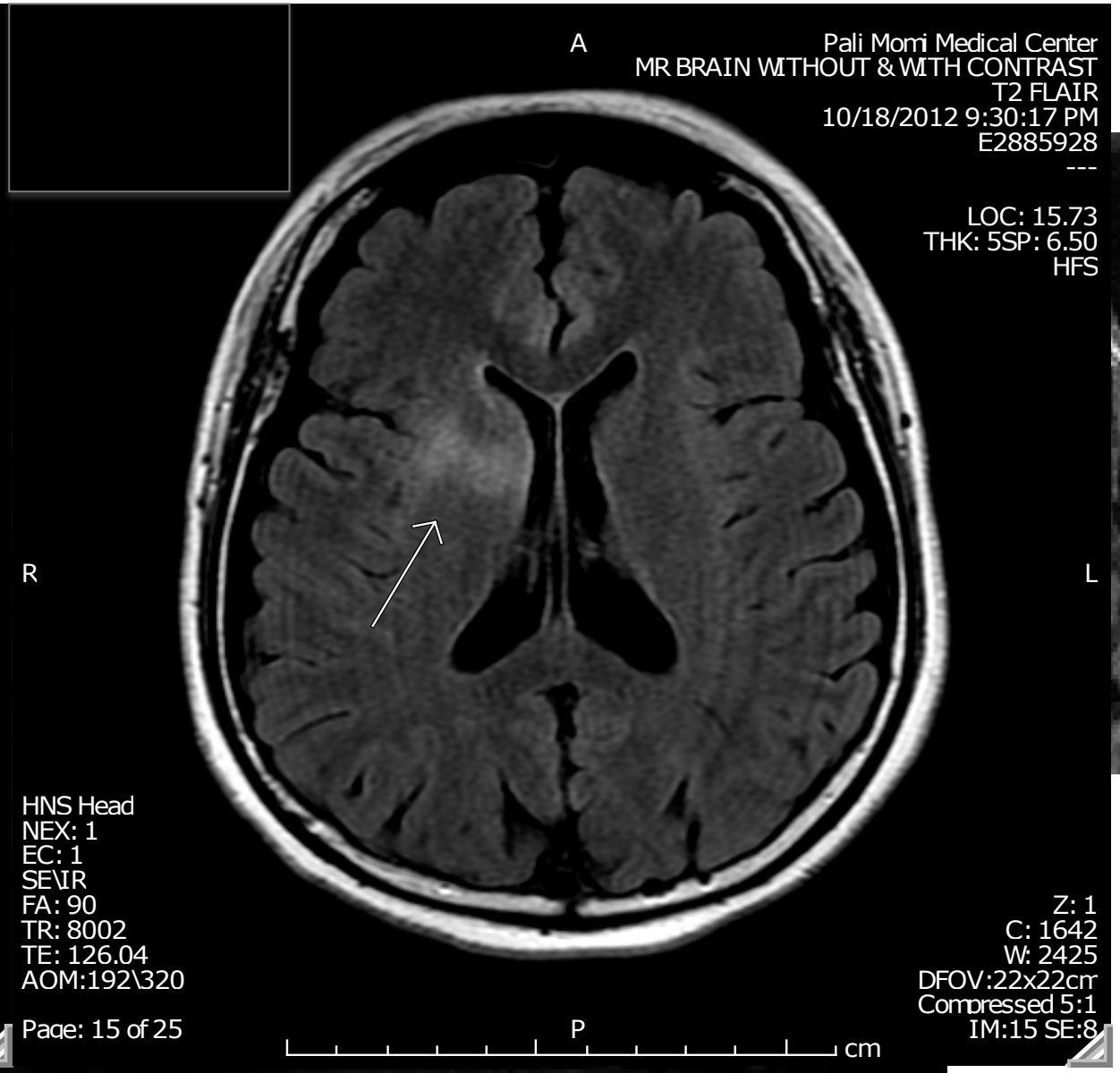
Microhemorrhages (Cerebral Amyloid Angiopathy)

- Associated with Alzheimer's Disease

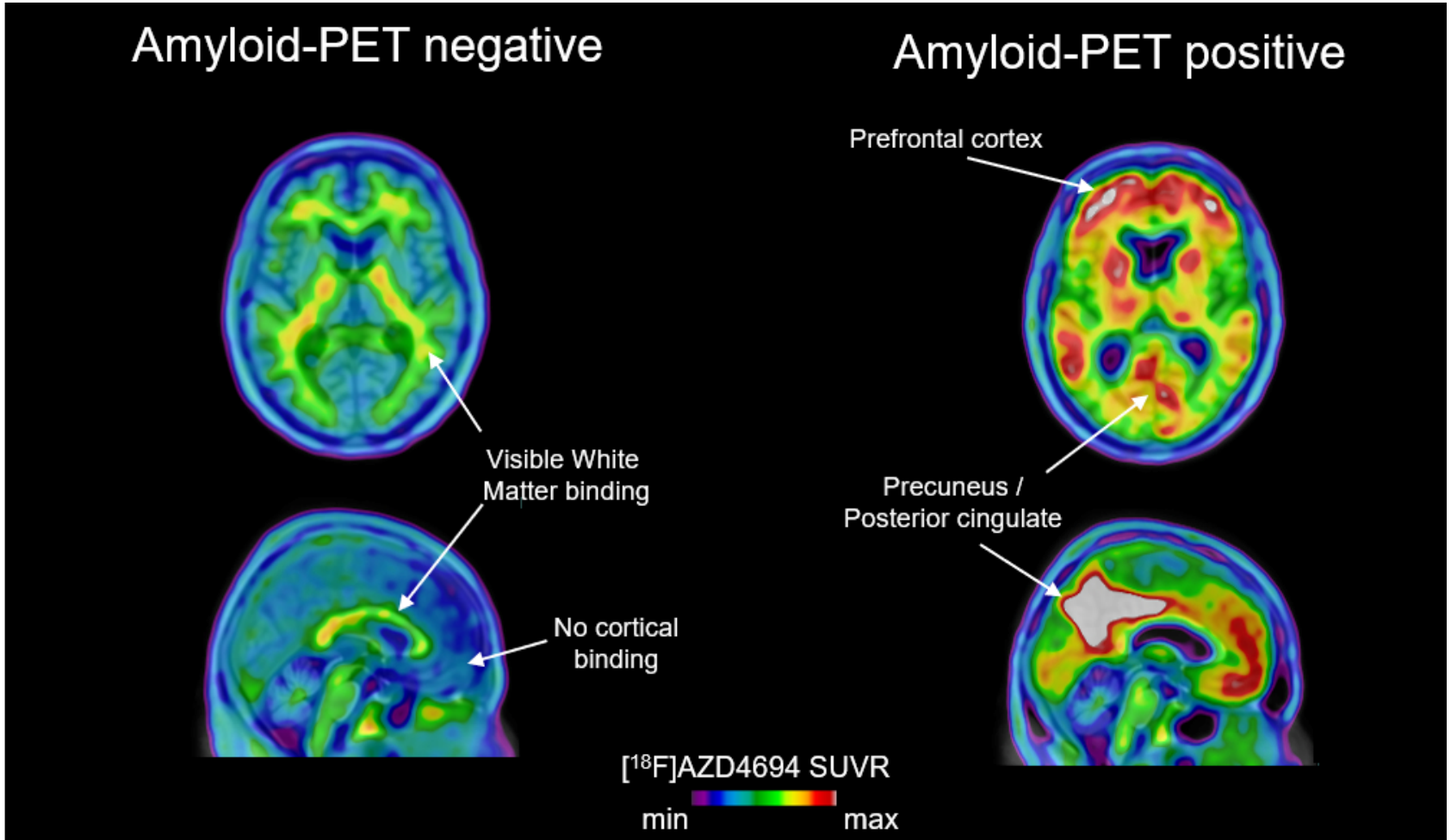


MRI Findings in Non-Alzheimer Dementias

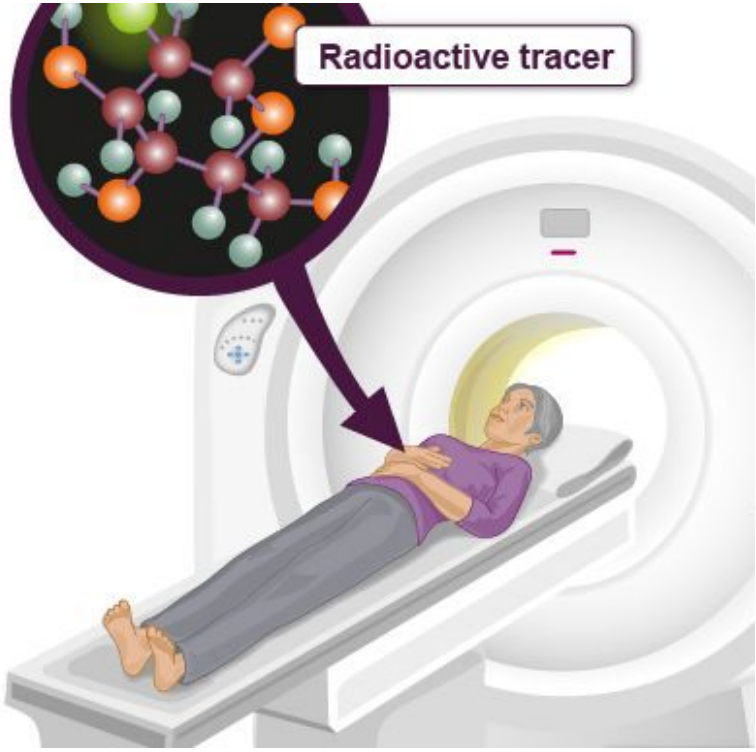




Amyloid Positron Emission Tomography (PET)



PET=positron emission tomography
Representative scans acquired from the Translational Research in Aging and Dementia cohort study, Canada.
This figure is developed by Joseph Therriault, Ph.D.



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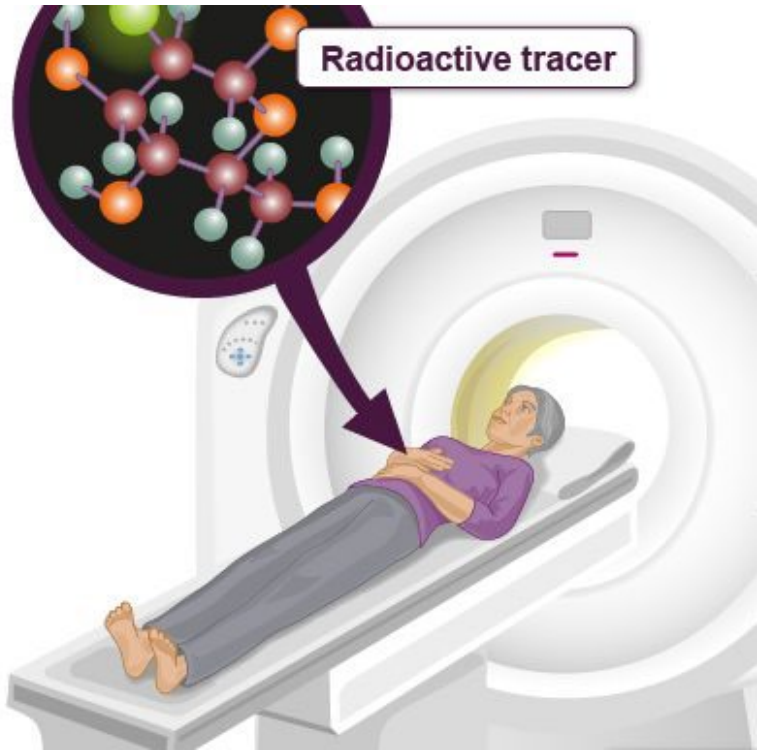
Amyloid Positron Emission Tomography (PET)

- Current gold standard for Alzheimer's Disease diagnosis in living patients
- 96% Sensitive and 100% Specific for detecting amyloid plaques on autopsy
- Currently unavailable in Hawaii, but in development at both HPH and QMC with target availability in 2026



Lancet Neurology. 2012; 11:669-678.

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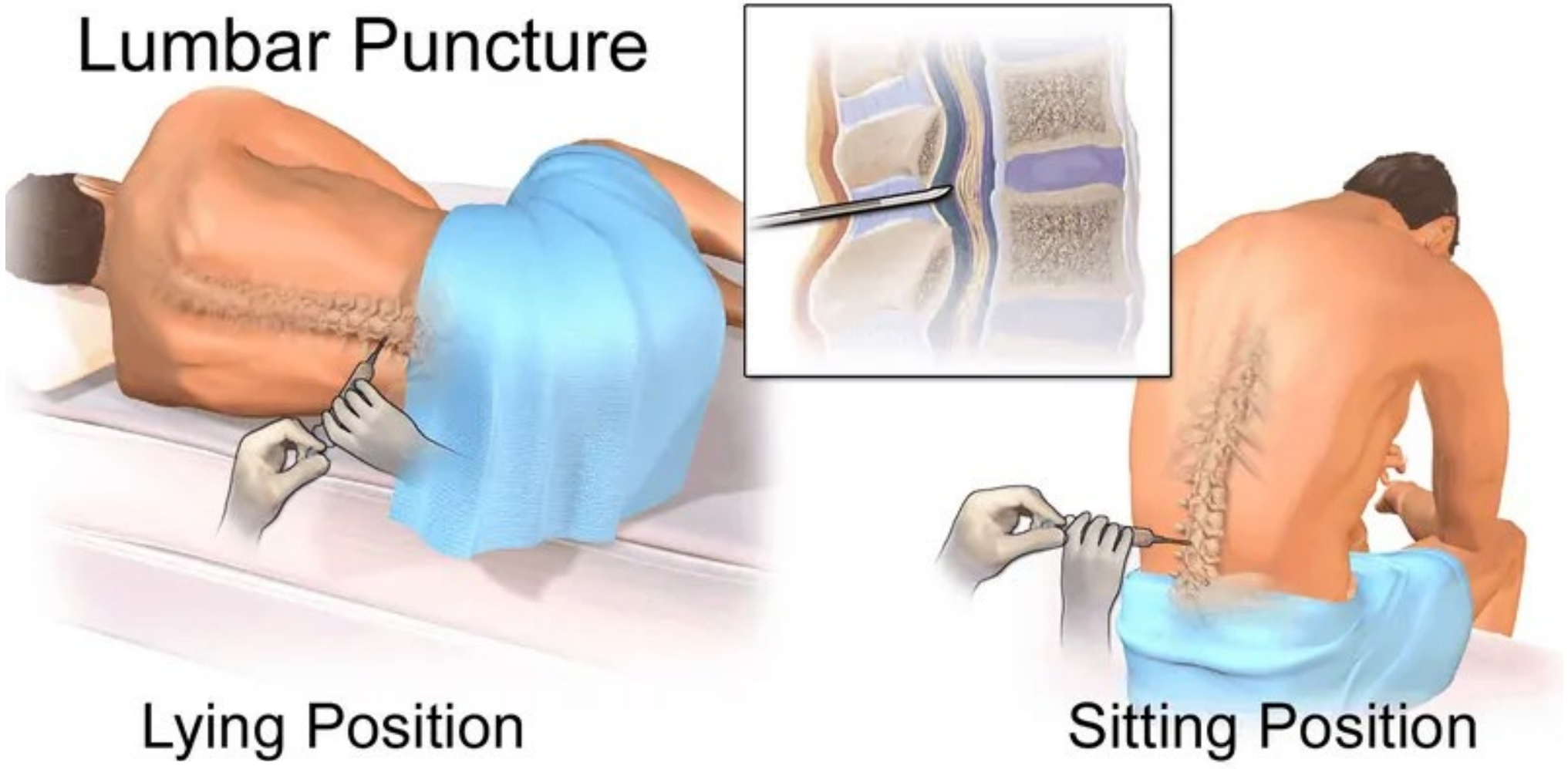
Cerebrospinal Fluid (CSF) Analysis



Cerebrospinal Fluid (CSF) Analysis

- Currently our local Hawaii standard for Alzheimer's Disease diagnosis
  - Aβ42 levels decrease in CSF
  - Phosphorylated and total Tau (P-Tau / T-Tau) increase in CSF

- 85-88% sensitive and 93-94% specific for positive Amyloid PET

- BUT, there are many drawbacks including:
  - Patients don't like spinal taps
  - High accuracy amyloid testing in CSF requires special tubes and handling

Adminisration UFaD. Evaluation of automatic class III designation for Lumipulse G Beta-amyloid ratio (1-42/1-40) Decision Summary. In: FDA, ed. 2023
Administration UFAD. Elecsys Beta-Amyloid CSF II, Elecsys Phospho-Tau (181P CSF) Decision Summary. In FDA, ed. 2023.
Administration UFaD. FAD Permits Marketing for new test to Improve Diagnosis of Alzheimer's Disease. In: Administration USFaD, ed. 2022.

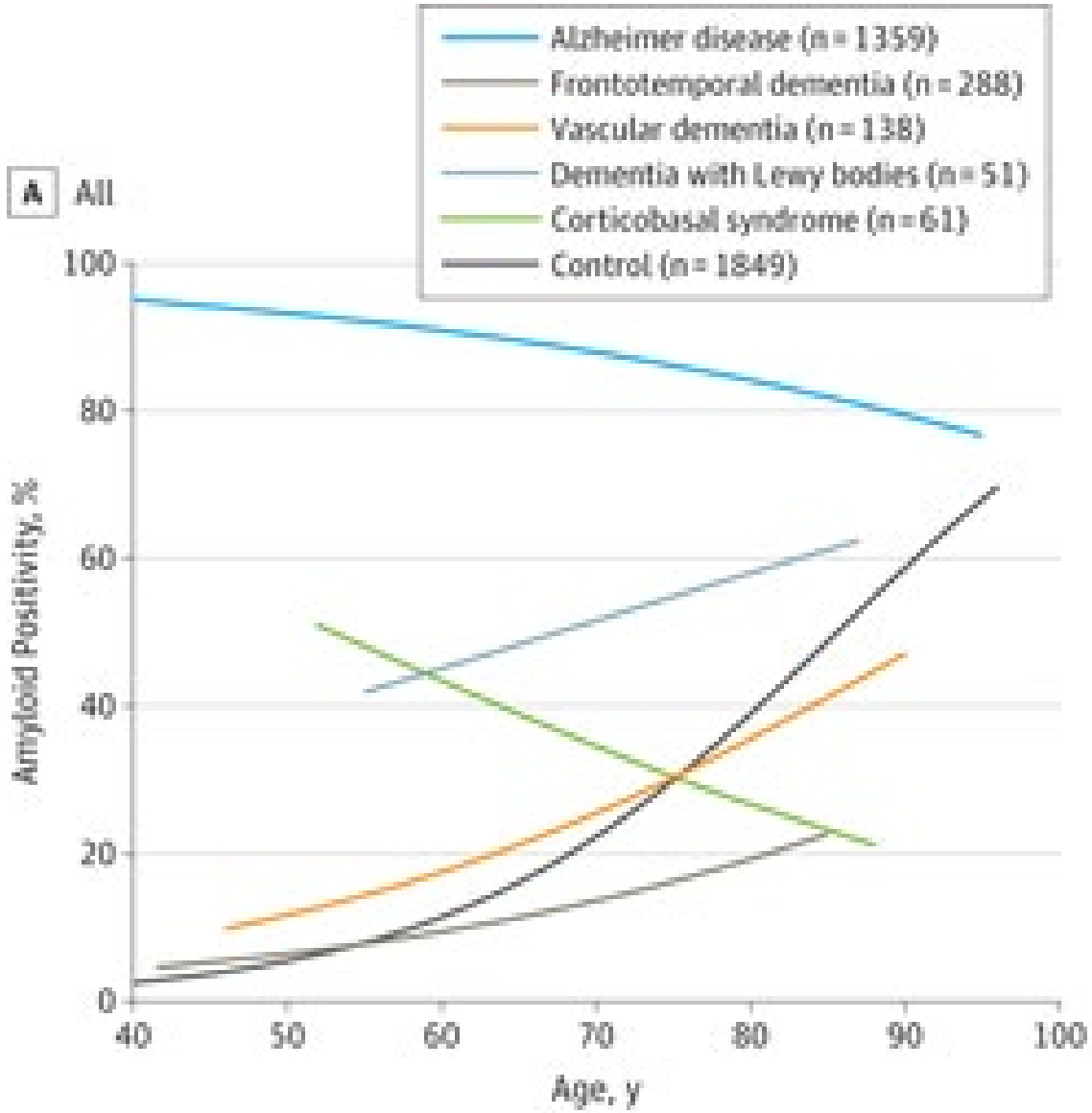
Blood-Based Biomarkers (BBMs) for Alzheimer's Disease

- Plasma "pTau217" Testing Is Transforming Alzheimer's Diagnosis
  - pTau217 levels increase in blood as plaques and tangles form within the brain
  - Plasma Mass Spectrometry / Chemiluminescent Immunoassays ➔ PPV and NPV 89-90%
  - There are several Laboratory Developed Tests (LDTs) on the market:
    - Mayo Labs, Labcorp, Quest Diagnostics, C2N Diagnostics
  - NONE of these tests are covered by Medicare or other insurance yet
  - FDA recently "cleared" Fujirebio's "LUMIPULSE G pTau217/β-Amyloid 1-42 Plasma Ratio" to be marketed for "*in vitro* diagnostic use" on May 16, 2025
  - This will lead to more widespread availability of accurate blood tests for Alzheimer's Disease at laboratories using Fujirebio's LUMIPULSE G1200 analyzer technology

Nature Medicine. 2024; 30:1085-1095.

Biomarker Testing Currently Requires Expert Interpretation

- Alzheimer's disease pathology is often "mixed" with other causes of dementia, making interpretation of biomarker tests complex
- Accurate diagnosis will depend on many factors, including:
  - Clinical syndrome / presentation
  - Brain MRI Interpretation
  - Biomarker interpretation
    - Amyloid, p-Tau, α-Synuclein, etc.
- Clinical practice guidelines for use of BBMs were recently released at AAIC meeting in late July 2025

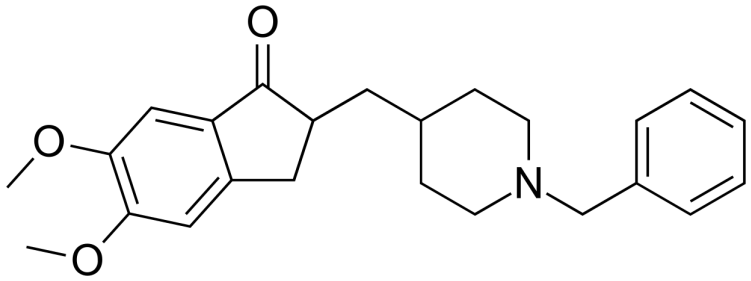


JAMA. 2015;313(19):1939-1950.

FDA-Approved Treatments for Alzheimer's Disease

- Acetylcholinesterase Inhibitors (AChEI)
  - Donepezil
  - Rivastigmine
  - Galantamine
- NMDA-Receptor Antagonists
  - Memantine
- Combination Therapy
  - Donepezil/Memantine
- Anti-Amyloid Monoclonal Antibodies
  - Aducanumab **(Discontinued in 2024)**
  - Lecanemab
  - Donanemab

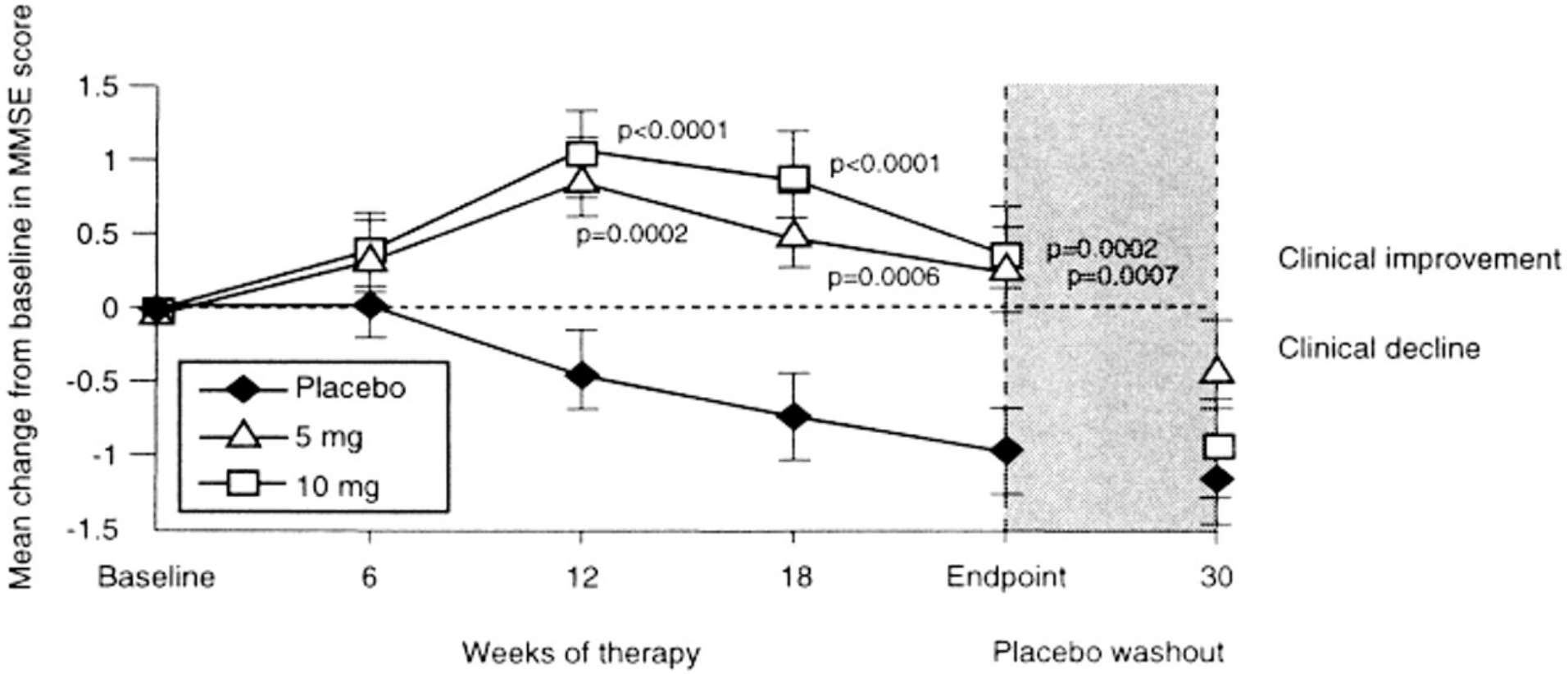
Donepezil (“Aricept”)



- Approved 1996, Eisei
- Increases acetylcholine signaling at cholinergic synapses, that selectively degenerate in **Alzheimer’s Disease** and **Dementia with Lewy bodies**
- FDA approved for mild, moderate, or severe stages of Alzheimer’s Disease
- 100% Oral Bioavailability
- Elimination half-life 70 hours, 57% urine and 15% fecal
- Conventional, extended release, and oral disintegrating tablets; all dosed daily
- **5 mg, 10 mg tablets** and ODT and 23 mg ER tablets

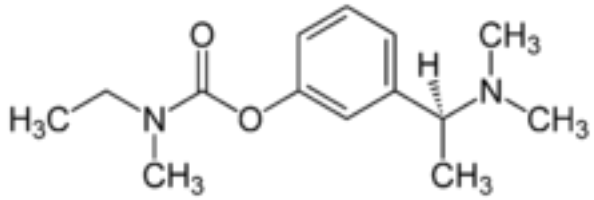
MicroMedex

Donepezil Improves MMSE Performance in Alzheimer's Disease at 24 weeks



Rogers, et al. Neurology. 1998 50(1) 136-145.

Rivastigmine ("Exelon")

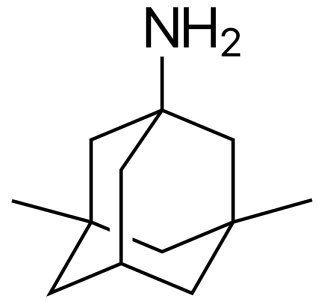


- Approved 2000, Novartis
- Increases acetylcholine signaling at cholinergic synapses, that selectively degenerate in **Alzheimer Disease** and **Dementia with Lewy bodies**
- FDA approved for mild or moderate **Alzheimer Disease**, cognitive symptoms of **Parkinson's Disease**
- 36-40% Oral Bioavailability
- Elimination half-life 1.5 hours, 97% urine
- 1.5, 3, 4.5, and 6 mg capsules (BID dosing)
- **4.6 mg/24 hour, 9.5 mg/24 hour, and 13.3 mg/24 hour patches** (Daily dosing)

AChE Inhibitors Adverse Effects

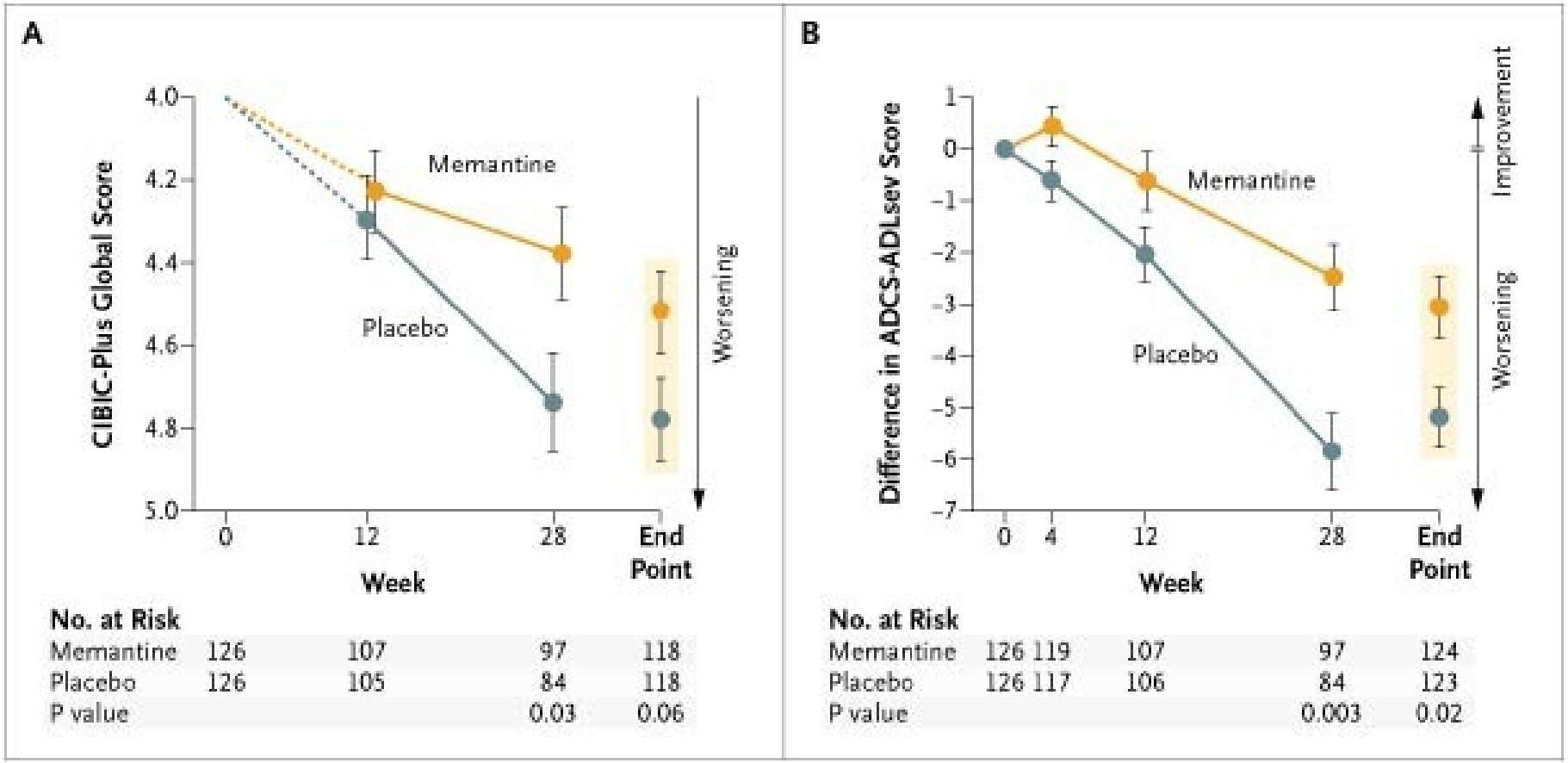
- Common
  - **Nausea**, vomiting, **decreased appetite**, **diarrhea**, muscle cramps, vivid dreaming, insomnia, fatigue, urinary frequency, **skin irritation** (Rivastigmine patch)
- Serious
  - **Bradycardia**, heart block, seizures

Memantine ("Namenda")



- Approved 2003, Allergan, now made by Forest
- Blocks excitotoxicity from NMDA receptor overactivity
- FDA approved for *moderate to severe stages* of **Alzheimer's Disease**
- Oral Bioavailability ~100%
- Elimination half-life 60-80 hours, 57-82% urine
- Conventional (BID dosing) and Extended-release tablets (Daily dosing), Oral solution (BID dosing)
- 5 mg and 10 mg tablets; **7 mg**, 14 mg, 21 mg and **28 mg** extended-release capsules; 2 mg per mL solution

Memantine Improves Function in Moderate to Severe Alzheimer Disease at 28 weeks



Reisberg et al. N Engl J Med 2003: 348: 1333-1341.

Memantine Adverse Effects

- Common
  - Dizziness, confusion, headache, constipation
- Serious
  - Stevens Johnson Syndrome

- Placebo group had more adverse events than Memantine group

MicroMedex

Every Supplement Studied for Dementia Treatment To Date Has Proven Ineffective

- Gingko Biloba
- Huperzine A
- Coenzyme Q10
- Resveratrol
- Curcumin or Turmeric
- Vitamin E
- Fish Oil
- Vinpocetine
- Acetyl-L-Carnitine
- Coconut Oil- Not studied yet but raises LDL significantly

Behavioral and Psychiatric Symptoms of Dementia (FDA-Approved and OFF LABEL)

- Depression/ Anxiety/ Irritability
- Insomnia
- Hallucinations/Delusions
- Agitation and Aggression

Depression/ Anxiety/ Irritability

- Mood disorders are exceedingly common in patients with dementia
- Daily exercise is helpful for mood
- Talking therapy is less helpful in dementia
- Avoid benzodiazepines and tricyclic antidepressants due to cognitive side effects
- SSRI- Citalopram, Escitalopram, Sertraline
  - Proven benefit for mood disorders in dementia
- SNRI- Venlafaxine, Duloxetine
  - Often helpful if patient has chronic neuropathic pain or failed SSRI
  - Sometimes causes hypertension as AE

Insomnia

- Non-pharmacologic methods are first line
  - Avoid daytime naps
  - Avoid excessive stimulation before bedtime
  - Have a bedtime routine
- Melatonin- start 3-5 mg nightly, titrate up to 15 mg nightly as needed
  - Especially helpful for REM behavior disorder in PD and DLB
  - Few cognitive side effects and overall well tolerated
- Trazodone- start 25 mg nightly, titrate up to 150 mg nightly as needed
  - Most people have few cognitive side effects
  - Recent studies have shown similar fall frequency as benzodiazepines
- **Avoid benzodiazepines and Zolpidem**
  - Frequent cognitive side effects and increased falls

J Am Geriatr Soc. 2018 Oct: 66(10):1963-1971.

Hallucinations and Delusions

- Most frequently seen in: Dementia with Lewy Bodies, Alzheimer's Disease, and Parkinson's Disease on high doses of Sinemet
- **Treat with Acetylcholinesterase Inhibitors**
  - Donepezil, Rivastigmine, Galantamine all work
  - Sometimes poorly tolerated due to irritability and mood changes
- Atypical antipsychotics, only in rare situations that are extremely distressing or dangerous:
  - Aripiprazole, Quetiapine
- Avoid typical antipsychotics (like haloperidol) if at all possible as DLB patients can have extreme reactions to these meds

Agitation and Aggression

- Check for underlying pain or infection/illness that acutely triggers these symptoms
  - Physical examination
  - CBC, Chem panel, Urinalysis, Chest Xray
- Long term treatment with SSRI or SNRI
  - Citalopram 10 mg daily or Venlafaxine ER 37.5 mg daily
  - Trazodone 25-50 mg, 1 tab BID PRN agitation
- Short-term use of an Atypical Antipsychotic
  - Aripiprazole 2 mg daily or Brexipiprazole 0.5 mg daily (FDA approved in AD agitation)
  - Quetiapine 12.5 to 25 mg nightly to start (Sedation)
  - All antipsychotic medicines (Typical and Atypical) have increased mortality when used in dementia patients in this clinical scenario, with increased rates of infection, cardiovascular events, and death. Therefore, I recommend having a direct discussion with caregivers or POAs regarding the risks and benefits before beginning.

Lecanemab (“Leqembi”)

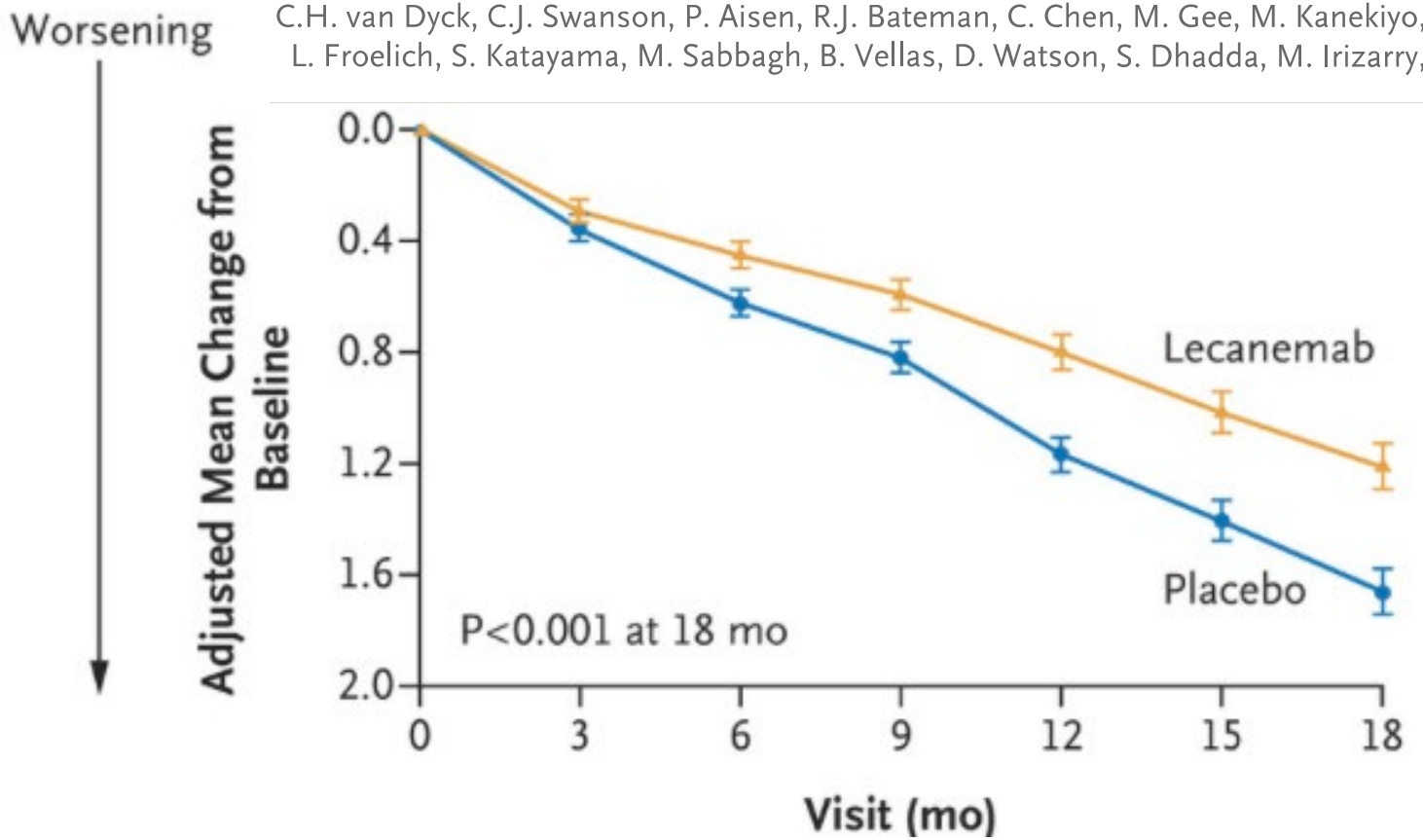
- Approved 2023, Eisei
- Dr. Lars Lannfelt and the “Arctic” Mutation
- Human monoclonal antibody that binds large soluble Aβ protofibrils and reduces beta amyloid plaques in the brain
- IV infusion every 2 weeks for 78 weeks
- FDA approved for treatment of Alzheimer’s Disease with Mild Cognitive Impairment or mild dementia

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JANUARY 5, 2023 VOL. 388 NO. 1

Lecanemab in Early Alzheimer's Disease

C.H. van Dyck, C.J. Swanson, P. Aisen, R.J. Bateman, C. Chen, M. Gee, M. Kanekiyo, D. Li, L. Reyderman, S. Cohen, L. Froelich, S. Katayama, M. Sabbagh, B. Vellas, D. Watson, S. Dhadda, M. Irizarry, L.D. Kramer, and T. Iwatsubo



27% Reduced Decline
(P < 0.001)

N Engl J Med 2023; 388:9-21

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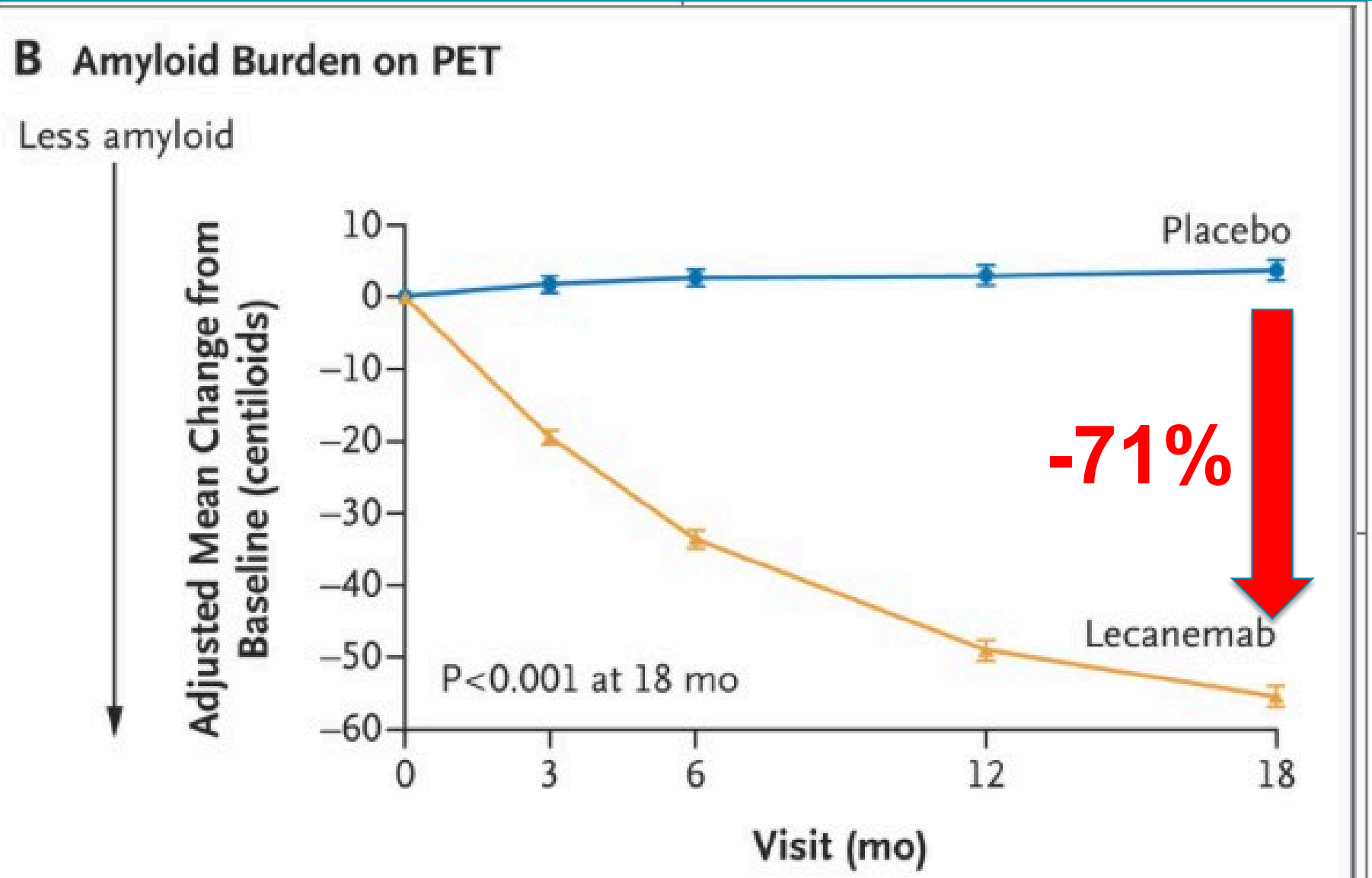
Lecanemab Secondary Analysis



No. of Participants

Lecanemab	354	296	275	276	210
Placebo	344	303	286	259	205

N Engl J Med 2023; 388:9-21

Additional Testing Required Before Treatment

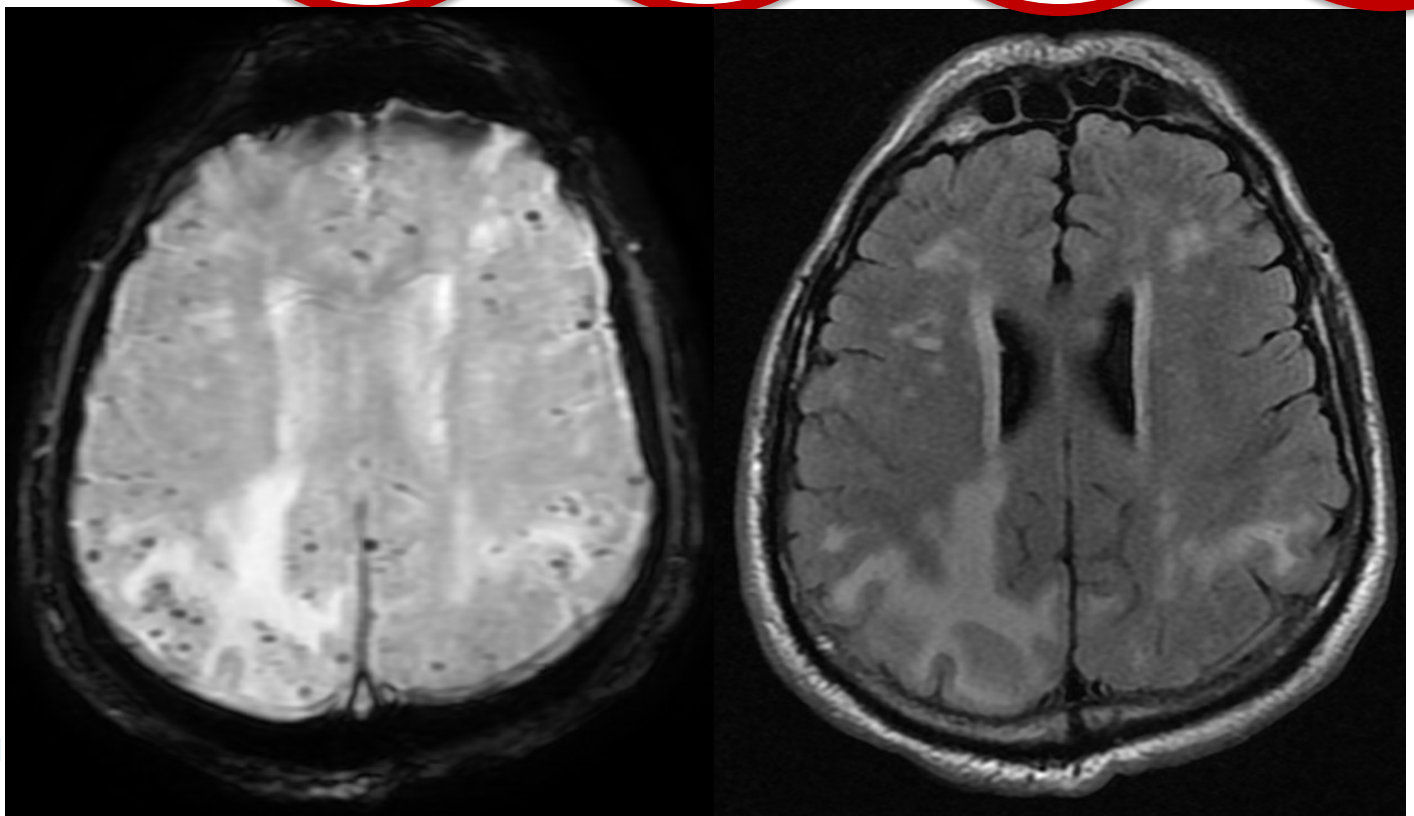
- MRI brain within 12 months prior to treatment initiation
- Lumbar puncture for CSF amyloid testing (or Amyloid PET Scan)
- Genetic testing for ApoE4
  - ApoE4 homozygotes have high rates of ARIA side effects

J Prev Alzhemer Disease 10, 362-377 (2023)

Amyloid Related Imaging Abnormalities (ARIA)

	All Lecanemab	Symptomatic Lecanemab	All Placebo	Symptomatic Placebo
ARIA-E	12.6%	2.8%	1.7%	0%
ARIA-H	17.3%	0.7%	9.0%	0.2%

ARIA-H



ARIA-E

N Engl J Med 2023; 388:9-21

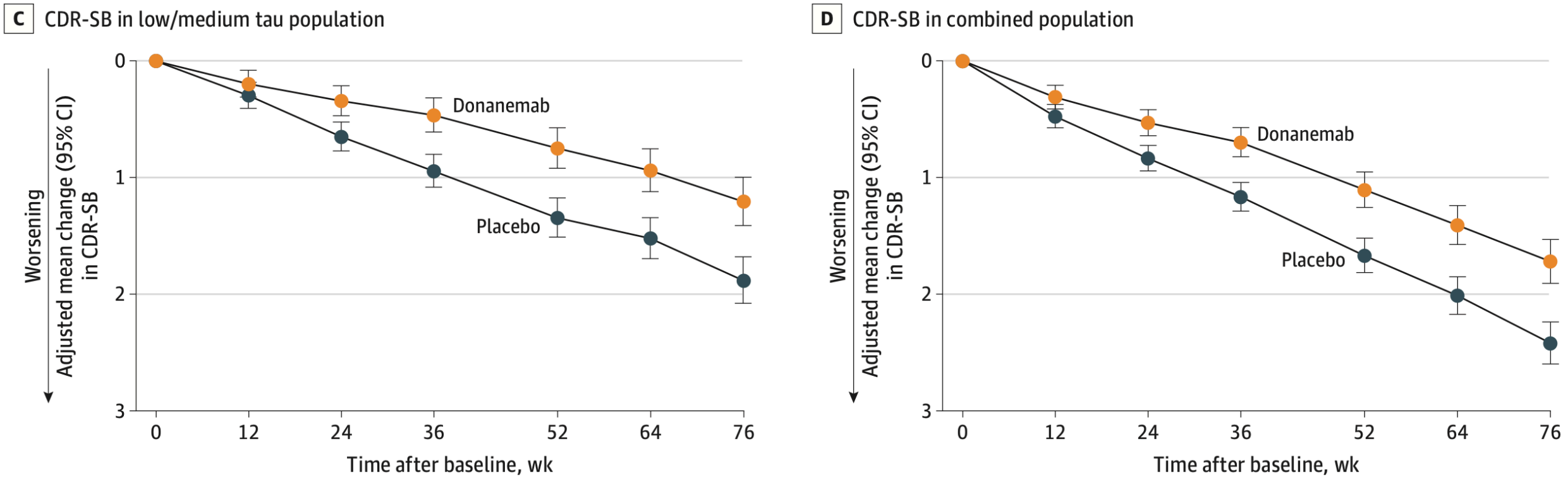
Donanemab ("Kisunla")

- Approved 2024, Lilly
- Human monoclonal antibody that binds Aβ (P3-42), a pyroglutamate form of Aβ found specifically in Amyloid plaques
- IV infusion every 4 weeks for 72 weeks
- FDA approved for treatment of Alzheimer's Disease with Mild Cognitive Impairment or mild dementia
- Recommend Amyloid PET monitoring every 6 mos to evaluate for Amyloid depletion which ends treatment early when achieved

JAMA 330:512-527 (2023)

N Engl J Med 2023; 388:9-21

Donanemab in Early Symptomatic Alzheimer Disease
The TRAILBLAZER-ALZ 2 Randomized Clinical Trial



28.9% Reduced Decline (or 36% in Early Cases)

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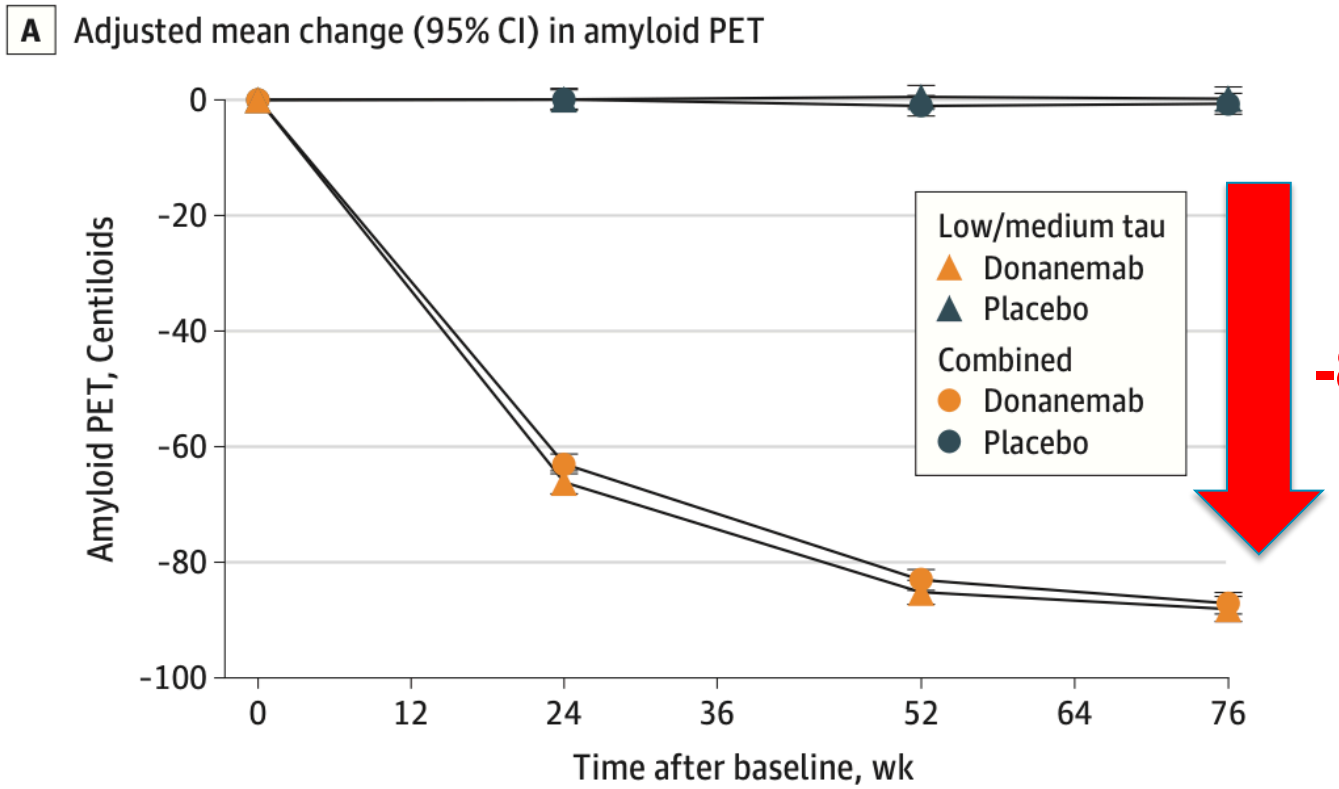
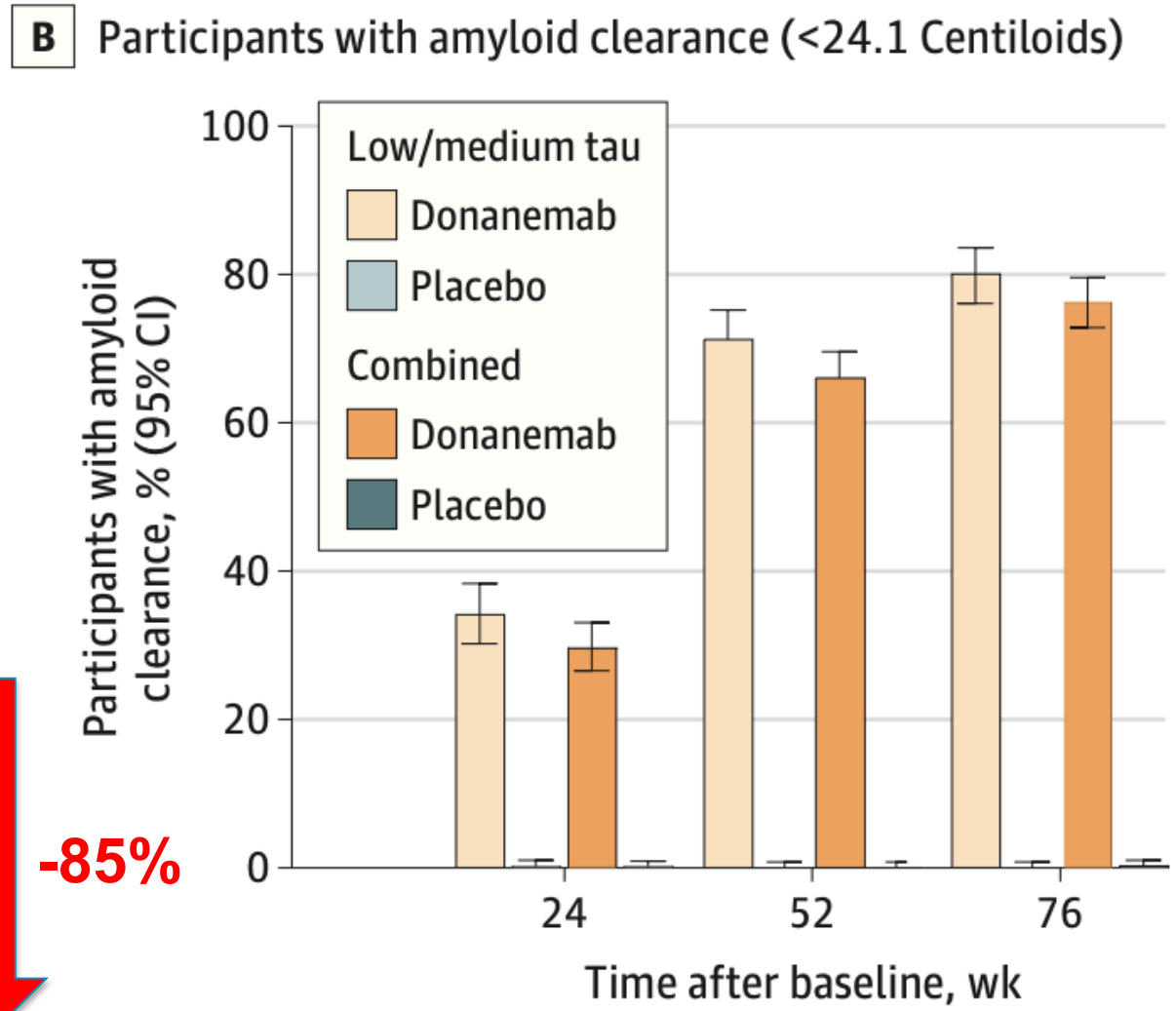
Donanemab Removes Amyloid More Effectively Than Lecanemab



-85%



N Engl J Med 2023; 388:9-21

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Supportive Dementia Care

- Caregiver education and support
- Connection to community resources
- Frequent follow up

Straub Benioff GUIDE Program

What is GUIDE?

- "Guiding an Improved Dementia Experience"

- CMS-funded, 8-year study of a new model of care delivery for persons living with dementia
  - Goal is to identify ideal ways to provide dementia care

- Straub Benioff has the only GUIDE program in Hawai'i
  - We started enrolling patients 7/1/25

Who is eligible for GUIDE?

- Medicare beneficiaries with a diagnosis of dementia
  - Medicare is primary insurance
  - Medicare Advantage plans are not eligible

- Eligible patients will be identified by CMS

- We will be prioritizing our current Geriatrics and Neurology Clinic patients, followed by other HPH/HHP patients, then external patients

GUIDE Components

- Standardized Comprehensive Assessment
- Care Navigation with regular follow up
- Availability of 24/7 advice line
- Annual stipend for respite care
- New payment methodology

Comprehensive Assessment

- Cognitive testing
- Functional assessment
- Medication review
- Caregiver burden inventory (Zarit Burden Assessment)
- Quality of life measure (PROMIS-10)
- Socioeconomic assessment (PRAPARE)
- Dementia severity rating (FAST, CDR)
- Assignment to one of 5 tiers based on severity and presence of caregiver

GUIDE Tiers

- Low complexity dyad tier
- Moderate complexity dyad
- High complexity dyad
- Low complexity individual tier
- High complexity individual

Care Navigation

- Patients are assigned to a Care Navigator
  - Social Worker, Community Health Worker, RN
- Home visit within 60 days of enrollment
- Care plan creation
- Regular follow up
  - Monthly for higher risk tiers
  - Quarterly for lower risk tiers

24/7 Advice Line

- Business hours: advice provided by Geriatrics Clinic Staff

- After hours: On-call provider renders advice and notifies GUIDE team the next day

Respite Care

- GUIDE patients in higher tiers are allotted ~$2700 per year to pay for respite care

- Respite care is delivered by Partner Organizations
  - Home Care
  - Day Care
  - Inpatient Respite

- Payments are made from CMS via SBMC to the Partner

Follow-up Assessments

- Patients are assessed on an annual basis and if there is a clinical change
- Patients may move from one tier to another during the study
- GUIDE program continues until 2032 (8 years from initial start date)

How to refer a patient to GUIDE

- Confirm eligibility: Dementia + Medicare A&B (no Advantage plans)
- Place a Geriatrics Consult and indicate that this is for GUIDE
- Current and new Geriatrics Clinic patients will automatically be considered for GUIDE program enrollment

Questions about GUIDE

- CMS link:
  - https://www.cms.gov/priorities/innovation/innovation-models/guide

- Email: susan.price@hphmg.org

Thank you for joining us!

- A recording of the meeting will be available afterwards
- Unanswered question?
  - Contact us at Info@HawaiiHealthPartners.org

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