ALZHEIMER'S ASSOCIATION | ALZPro

Implementing Early Dementia Diagnosis in Clinical Practice: Practical Guidance from the DETeCD-ADRD Framework

With more than 7 million Americans currently living with Alzheimer's dementia, and that number projected to reach 13.8 million by 2060, early and accurate detection is crucial for effective management and support, especially as new disease-modifying therapies continue to emerge. Primary care providers play a vital role in the early detection of cognitive impairment and referral for specialized assessment and treatment. To support this effort, the Alzheimer's Association convened an expert workgroup to develop the Diagnostic Evaluation, Testing, Counseling and Disclosure of Suspected Alzheimer's Disease and Related Disorders (DETeCD-ADRD) guidance. This guidance offers a practical, patient-centered approach to evaluating cognitive and behavioral symptoms suggestive of Alzheimer's disease (AD) or Alzheimer's disease and related dementias (ADRD).

DETeCD-ADRD empowers clinicians in a variety of clinical settings to develop a three-step diagnostic formulation, which may lead to a diagnosis, inform prevention and brain health strategies, or identify and treat comorbid medical conditions.

The **full guidance** is published in *Alzheimer's & Dementia: The Journal of the Alzheimer's Association*.

Diagnostic Formulation

The DETeCD-ADRD evaluation process aims to achieve a three-step diagnostic formulation:

Cognitive Functional Status

Determine the patient's overall level of cognitive impairment (cognitively unimpaired, subjective cognitive decline, mild cognitive impairment or dementia). This crucial first step clarifies the severity of the impairment and guides subsequent assessment and management decisions.

Cognitive-Behavioral Syndrome

Characterize the specific profile of the patient's cognitive and behavioral symptoms (e.g., amnestic, language, visuospatial, dysexecutive). Identifying the dominant syndrome helps pinpoint the likely underlying cause(s) and informs targeted interventions to address the patient's most prominent challenges.

Etiological Diagnosis

Establish the most likely underlying brain disease or condition causing the clinical syndrome (e.g., AD, Lewy body dementia [LBD], frontotemporal lobar degeneration [FTLD], vascular contributions to cognitive impairment and dementia [VCID]). Pinpointing the etiology is essential for appropriate treatment selection, prognosis discussion, and connection to relevant resources and support services.

About the Workgroup & Methodology

The Alzheimer's Association convened the Diagnostic Evaluation, Testing, Counseling, and Disclosure Clinical Practice Guideline (DETeCD-ADRD CPG) Workgroup to develop guidance to help primary care clinicians and other providers to systematically evaluate, diagnose, and disclose information to patients with suspected AD or ADRD and their care partners. The workgroup involved 10 voting members representing primary care, specialty and subspecialty care, long-term and palliative care, health economics and bioethics.

About the Alzheimer's Association

The Alzheimer's Association is a worldwide voluntary health organization dedicated to Alzheimer's care, support and research. Our mission is to lead the way to end Alzheimer's and all other dementia — by accelerating global research, driving risk reduction and early detection, and maximizing quality care and support. Our vision is a world without Alzheimer's and all other dementia®. Visit alz.org or call 800.272.3900.

Achieving the Three-Step Formulation: Key Actions for Providers

STEP 1: Initial Assessment & Evaluation Planning

Initiate the evaluation for *any* patient with reported cognitive, behavioral or functional changes. The multi-tiered evaluation process will use levels of assessments and tests based on individual presentation, risk factors and patient profile to establish the three-part diagnostic formulation.

Establish shared goals for the evaluation with the patient and care partner, and assess their capacity to engage in the goal-setting process. Involve a care partner early, especially if capacity is a concern.

Consider referral to a specialist if the patient presents with early-onset cognitive decline (<65 years old) or other atypical features.

STEP 2: Gather Clinical Information

Obtain a detailed history from the patient and a care partner, focusing on changes in:

- Cognition
- Activities of daily living
- Mood and neuropsychiatric symptoms
- Sensory and motor function

Assess individualized risk factors, including medical conditions (e.g., vascular risk factors, hearing loss, sleep apnea), lifestyle factors and family history.

Conduct a mental status exam, including a cognitive assessment using a validated brief cognitive test and a dementia-focused neurologic exam.

Consider referral for comprehensive neuropsychological testing if brief cognitive tests are insufficient, the clinical picture is complex or there are significant confounding factors.

STEP 3: Diagnostic Testing and Formulation

Obtain routine Tier 1 laboratory tests and structural brain imaging (MRI preferred, CT if MRI is contraindicated or unavailable).

Based on the information gathered in Steps 1 and 2, and the results of diagnostic testing, determine the patient's:

- Cognitive Functional Status
- Cognitive-Behavioral Syndrome
- Provisional Etiological Diagnosis

STEP 4: Disclosure & Care Planning

Ask the patient (and document) "May I speak frankly about what I think is going on with your memory and thinking problems?" permits the patient to retain autonomy with disclosure.

Honestly and compassionately inform the patient and care partner of the provisional diagnostic formulation. Discuss the likely diagnosis, prognosis, initial treatment options, potential safety concerns and available resources (medical, psychosocial and community).

Develop an initial shared care plan incorporating the patient and care partner's goals and preferences.

STEP 5: Referral/Further Evaluation

Expedite referral to a specialist (e.g., neurologist, psychiatrist, geriatrician or dementia specialist) for:

- Diagnostic uncertainty
- Consideration of disease-modifying therapies and/or biomarker testing
- Management of complex cases or those with concerning indicators (e.g., atypical presentation, early-onset dementia, rapidly progressive dementia, or other features not typical of AD)
- The presence of severe neuropsychiatric symptoms such as severe agitation, aggression or disturbing psychosis (hallucinations or delusions)

Further evaluation conducted by a specialist after referral may include:

- Comprehensive neurological and neuropsychiatric evaluation
- Neuropsychological testing
- Advanced laboratory testing (i.e., Tier 2-4)
- Advanced imaging and biomarkers (e.g., CSF analysis, amyloid PET)
- Genetic testing with counseling

Continuously assess patient and care partner understanding throughout the evaluation process and tailor communication to support individual needs. Ensure patients and care partners feel heard, understood and supported.

Conclusion

The DETeCD-ADRD guidance empowers providers to improve early detection of AD/ADRD. Dementia diagnosis and treatment is an evolving field, and the Alzheimer's Association® will update this guidance as new evidence emerges.

ALZHEIMER'S ASSOCIATION | ALZPro

For additional information and professional resources, visit **alz.org/ALZPro**.