



NARRATIVE REVIEW

From Attitudes to Action, Primary Care Alzheimer's Detection: How Knowledge, Confidence, and Clinic Capacity Predict Actual Screening and Referral Behavior

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ABSTRACT

Background: Alzheimer's disease is one of the most significant and rapidly expanding public health challenges associated with global population aging. Advances in biomarker diagnostics and the development of disease-modifying therapies have increased the clinical importance of detecting cognitive impairment during the earliest stages of disease progression. Early recognition allows for timely care planning, improved management of comorbid conditions, access to emerging therapeutic interventions, and participation in clinical research. Despite these developments, substantial variability persists in Alzheimer's detection within primary care. Historically, limited physician knowledge has been considered a principal barrier to early dementia diagnosis. However, emerging research suggests that structural factors, including diagnostic confidence, clinical workflow integration, and healthcare system capacity may play a more influential role in determining whether cognitive screening and referral occur in routine practice.

Objective: This narrative review examines physician-level and system-level determinants that influence whether primary care physicians perform cognitive screening, initiate diagnostic evaluations, or refer patients for specialist assessment when Alzheimer's disease is suspected.

Results: Findings indicate that most primary care physicians possess adequate conceptual knowledge of Alzheimer's symptoms and commonly used cognitive screening tools. However, knowledge alone does not consistently predict screening behavior. Diagnostic confidence, integration of screening tools into routine workflows, electronic health record decision-support systems, and access to specialist referral networks were more consistent predictors of physician action. Time constraints and competing clinical demands remain significant barriers, although structured workflows and team-based care models substantially improve screening and referral rates.

Keywords: Alzheimer's disease, dementia diagnosis, cognitive screening, early detection, primary care physicians, clinical workflow integration, physician behavior, diagnostic.

Introduction

Alzheimer's disease represents the most common cause of dementia and is a leading contributor to disability and dependency among older adults worldwide¹. As populations age and life expectancy increases, the prevalence of Alzheimer's disease and related dementias is expected to rise dramatically. Recent global estimates indicate that more than 55 million individuals are currently living with dementia worldwide, and this number is projected to exceed 139 million by the year 2050². European nations are expected to experience particularly significant increases in dementia prevalence due to demographic aging, with projections suggesting that the number of affected individuals may double over the next three decades^{3,15}.

Alzheimer's disease is characterized by progressive neurodegeneration associated with the accumulation of amyloid-beta plaques, tau neurofibrillary tangles, synaptic dysfunction, and neuronal loss^{4,5}. These pathophysiological processes begin many years before the appearance of overt functional impairment. During the early clinical stages of the disease, individuals often experience subtle cognitive changes involving episodic memory, executive functioning, language processing, and attention¹. Because these early symptoms may be mistaken for normal age-related cognitive changes, Alzheimer's disease frequently remains undiagnosed until moderate or advanced stages of progression^{1,4}.

Early detection of Alzheimer's disease has gained increasing clinical importance in recent years due to advances in diagnostic and therapeutic technologies^{6,7}. Biomarker-based diagnostic approaches, including cerebrospinal fluid analysis and positron emission tomography imaging, have improved the accuracy of identifying Alzheimer's pathology during the early stages of disease^{5,8}. In addition, the recent development of disease-modifying therapies targeting amyloid pathology has underscored the importance of identifying eligible patients during mild cognitive impairment or early dementia stages⁶. Clinical trials of anti-amyloid therapies such as lecanemab and donanemab have demonstrated modest but meaningful slowing of cognitive decline when treatment is initiated early in the disease trajectory^{9,10}.

Primary care physicians occupy a critical position within healthcare systems for the early identification

of cognitive impairment^{7,11}. Older adults frequently interact with primary care providers through routine preventive care visits, chronic disease management appointments, and annual wellness examinations¹². These interactions present screening and opportunities for clinicians to identify cognitive concerns, initiate preliminary screening, and coordinate referrals for comprehensive diagnostic evaluation^{11,7}.

Despite this strategic role, numerous studies have demonstrated that dementia remains significantly underdiagnosed in primary care settings^{11,13}. International research suggests that between forty and sixty percent of dementia cases remain undetected during the early stages of disease^{14,13}. Delayed diagnosis may prevent individuals and families from accessing appropriate care planning, treatment options, and supportive services^{7,15}.

Historically, underdiagnosis of Alzheimer's disease in primary care has been attributed to deficiencies in physician knowledge or training¹¹. As a result, educational interventions have traditionally focused on increasing physician awareness of dementia symptoms and improving familiarity with cognitive screening instruments. Although these educational programs have enhanced knowledge levels among clinicians, evidence suggests that they have not consistently translated into increased screening rates or referral^{11,7}.

Recent research indicates that physician behavior in clinical practice is influenced by a complex interplay of factors beyond knowledge alone. Diagnostic confidence, time constraints, clinical workflow structures, availability of decision-support technologies, and accessibility of referral networks all appear to influence whether physicians initiate cognitive screening during patient encounters^{11,16,17}. In many healthcare environments, primary care clinicians operate under significant time pressure and must manage multiple chronic conditions during brief appointments^{11,16}. Under such circumstances, cognitive screening may be deprioritized unless supported by structured clinical workflows^{17,12}.

Understanding how these physician-level and system-level determinants interact is essential for improving early Alzheimer's detection within primary care. This narrative review synthesizes the current global literature examining how knowledge, diagnostic confidence, and healthcare infrastructure influence screening and referral behavior among primary care physicians.

Results

PHYSICIAN KNOWLEDGE AND AWARENESS

The reviewed literature indicates that most primary care physicians possess a foundational level of knowledge regarding Alzheimer's disease and its clinical manifestations^{11,13}. Continuing medical education programs, professional guidelines, and public health initiatives have improved physician awareness of dementia risk factors, early cognitive symptoms, and commonly used screening instruments^{1,11}.

Many clinicians' report familiarity with brief cognitive screening tools such as the Mini-Mental State Examination, the Montreal Cognitive Assessment, and the Mini-Cog. These tools are widely recommended by clinical practice guidelines as initial screening instruments for cognitive impairment in primary care settings¹⁸.

However, studies consistently demonstrate that physician knowledge alone does not reliably predict whether screening will occur in practice. Surveys of physicians across Europe, North America, and Asia reveal substantial variation in screening behavior among clinicians who report similar levels of dementia knowledge. These findings suggest that knowledge functions primarily as a prerequisite for action rather than as a direct driver of screening behavior^{11,13}.

DIAGNOSTIC CONFIDENCE

Diagnostic confidence emerges as one of the most significant predictors of Alzheimer's disease detection in primary care^{16,11}. Many physicians report uncertainty when attempting to differentiate early neurodegenerative disease from normal cognitive aging or other medical and psychiatric conditions that may produce cognitive symptoms^{11,13}.

Depression, medication side effects, sleep disorders, metabolic abnormalities, and vascular disease can all contribute to cognitive complaints that resemble early dementia. The overlap between these conditions often leads to diagnostic ambiguity during routine primary care encounters^{13,8}.

Research demonstrates that physicians who report greater confidence in their ability to recognize dementia symptoms are significantly more likely to perform cognitive screening and to initiate referrals for specialist evaluation^{16,11}. Diagnostic confidence appears to be influenced by clinical experience, mentorship relationships, and access to structured decision-support resources¹⁶.

CLINICAL WORKFLOW INTEGRATION

Clinical workflow integration represents a critical determinant of whether cognitive screening is incorporated into routine primary care practice^{11,19}. When screening tools are embedded within electronic health record systems and integrated into standardized care pathways, physicians are more likely to conduct cognitive assessments¹⁷.

Recent implementation studies have shown that automated electronic prompts reminding clinicians to conduct cognitive screening during annual wellness visits can significantly increase the rate of documented cognitive assessments and dementia diagnoses²⁰.

Structured documentation templates that guide clinicians through diagnostic evaluation steps also reduce administrative burden and improve the consistency of follow-up assessments^{19,17}.

TIME CONSTRAINTS AND COMPETING CLINICAL DEMANDS

Time limitations remain one of the most frequently cited barriers to dementia screening in primary care^{11,16}. Routine patient visits often involve the management of multiple chronic conditions, medication reconciliation, and preventive health counseling. These competing demands may leave little time for cognitive assessment^{11,13}.

However, studies demonstrate that team-based care models can mitigate this barrier⁷. In such models, nurses or medical assistants administer brief cognitive screening instruments before the physician enters the examination room. This approach allows physicians to review screening results during the encounter without significantly increasing visit duration.

REFERRAL ACCESS AND HEALTHCARE SYSTEM CAPACITY

Access to specialist referral services also influences physician screening behavior. Primary care physicians practicing in regions with limited access to neurologists or memory clinics may hesitate to initiate screening if appropriate follow-up evaluation resources are unavailable^{11,13}.

In contrast, healthcare systems that maintain well-established referral networks and interdisciplinary dementia care programs demonstrate higher rates of cognitive screening and diagnostic evaluation. These systems often incorporate coordinated care pathways involving neurologists, geriatricians, neuropsychologists, and social workers⁷.

Discussion

The findings of this narrative review highlight a persistent gap between physician awareness of Alzheimer's disease and the translation of that awareness into routine clinical action. Although most primary care physicians recognize the importance of early dementia diagnosis, multiple structural barriers frequently prevent consistent screening and referral behavior^{11,13}.

These findings align with broader research in implementation science, which demonstrates that knowledge alone rarely leads to sustained changes in clinical practice. Healthcare behaviors are shaped by a complex interaction between individual knowledge, professional confidence, organizational infrastructure, and healthcare policy environments^{7,11}.

Educational interventions that focus exclusively on increasing physician knowledge may therefore have limited impact on screening behavior. More effective strategies combine educational initiatives with structural interventions that facilitate screening within routine clinical workflows^{11,19}. For example, integrating cognitive screening prompts into electronic health records can remind physicians to assess cognitive status during preventive care visits. Similarly, team-based screening models allow cognitive assessments to be conducted efficiently without increasing physician workload^{17,19}.

Healthcare policy also plays a crucial role in shaping physician behavior. Reimbursement policies that recognize cognitive assessment and

dementia counseling services may encourage physicians to incorporate screening into routine practice. Additionally, strengthening referral networks and expanding access to specialist care can increase physician confidence in initiating diagnostic evaluations^{11,13,7}.

Policy Implications for European Health Systems

The findings of this review carry significant implications for health system planning across Europe, where demographic aging is rapidly increasing the prevalence of Alzheimer's disease and related dementias²¹. European healthcare systems are characterized by considerable variation in primary care structures, reimbursement mechanisms, and specialist referral capacity. However, across these diverse systems, primary care physicians consistently represent the first point of contact for older adults experiencing cognitive symptoms.

In recent years, several European countries have introduced national dementia strategies aimed at improving early detection and care coordination. For example, the European Union's Joint Action on Dementia and the WHO Global Action Plan on the Public Health Response to Dementia (2017-2025) emphasize strengthening primary care capacity to recognize and manage cognitive disorders^{15,22,21}. Despite these initiatives, implementation gaps remain evident in many healthcare systems.

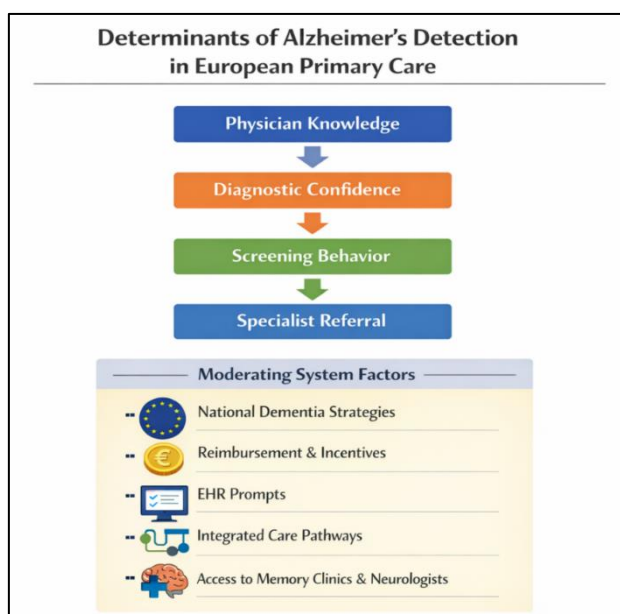


Figure 1. Determinants of Alzheimer's Detection in European Primary Care

This figure illustrates how physician knowledge influences screening and referral behavior in European primary care, moderated by structural healthcare system factors including reimbursement, workflow integration, and specialist access.

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One important policy consideration involves the integration of standardized cognitive screening protocols into routine preventive care visits. In several European countries, cognitive assessment has increasingly been incorporated into geriatric

preventive care.²¹ Evidence suggests that structured screening protocols supported by electronic health record prompts can significantly increase the identification of cognitive impairment during routine primary care encounters.

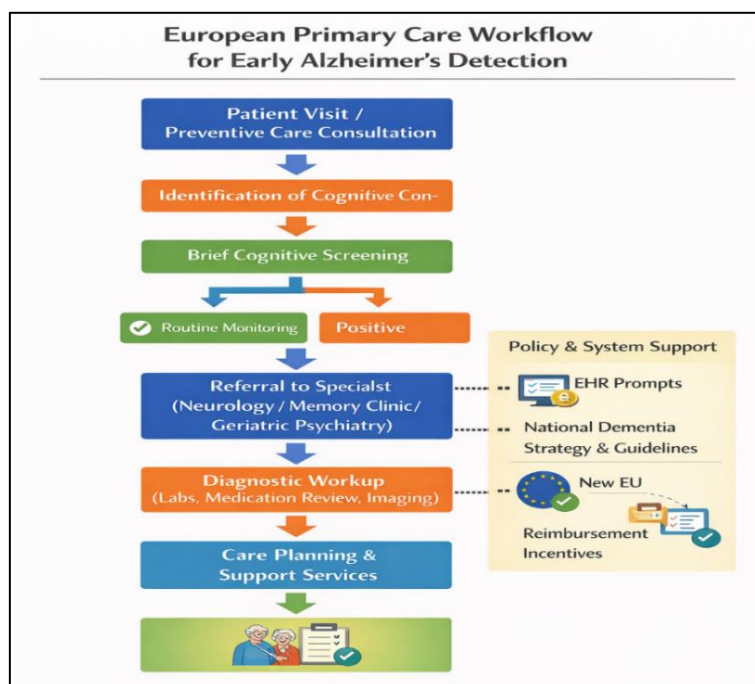


Figure 2. European Primary Care Workflow for Early Alzheimer's Detection

Proposed European primary care workflow for integrating cognitive screening, diagnostic evaluation, and specialist referral, supported by system-level policy measures.

Reimbursement policies also play a critical role in shaping physician behavior. Cognitive assessment and dementia counseling require additional clinical time and diagnostic evaluation that may not be adequately compensated within existing fee structures. Healthcare systems that provide reimbursement incentives for cognitive screening and care planning may therefore improve early detection rates^{11,7}.

Another key policy issue involves the expansion of interdisciplinary dementia care networks. Primary care physicians often report hesitancy in initiating cognitive screening when specialist referral options are limited. Expanding access to memory clinics, geriatric psychiatry services, and neuropsychological assessment can strengthen referral pathways and improve physician confidence in initiating diagnostic evaluation^{11,7,22}.

Telemedicine and digital consultation models may also help address specialist shortages, particularly in rural regions of Europe where access to neurologists and geriatric specialists may be limited. Remote consultation networks can

significantly improve dementia diagnosis rates in underserved communities⁷.

Ultimately, improving Alzheimer's detection in Europe will require coordinated policy strategies that strengthen primary care capacity, enhance specialist referral networks, and integrate dementia screening into routine healthcare delivery.

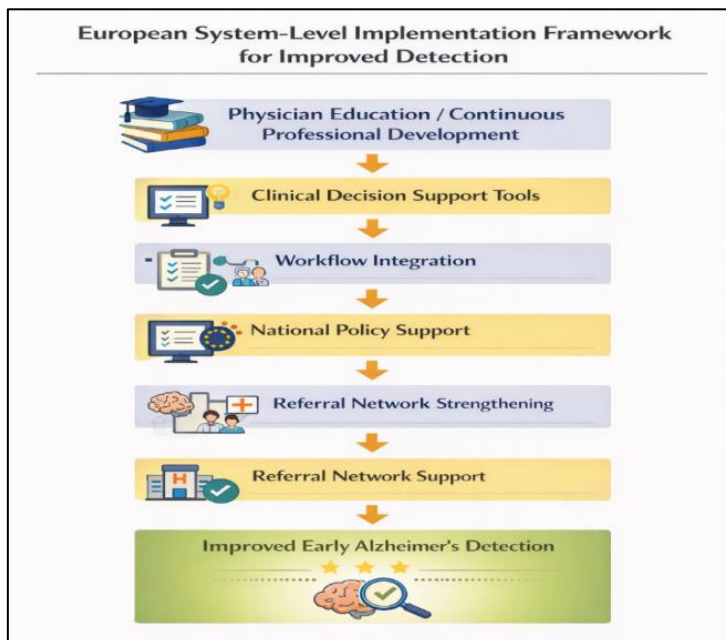


Figure 3. European System-Level Implementation Framework for Improved Detection
 Framework highlighting European health system interventions-education, workflow, digital tools, policy, and referral networks-that collectively enhance early Alzheimer's detection in primary care.

Policy Implications for American Health Systems

The findings of this narrative review have important implications for healthcare policy in the United States, where Alzheimer's disease prevalence is rapidly increasing alongside population aging¹. Primary care physicians serve as the first point of contact for older adults experiencing cognitive

changes, yet significant barriers continue to impede timely detection and referral^{11,13}. Current evidence indicates that knowledge alone is insufficient to drive consistent screening behavior; structural and system-level interventions are essential to improve early identification of Alzheimer's disease within American primary care settings^{11,7}.

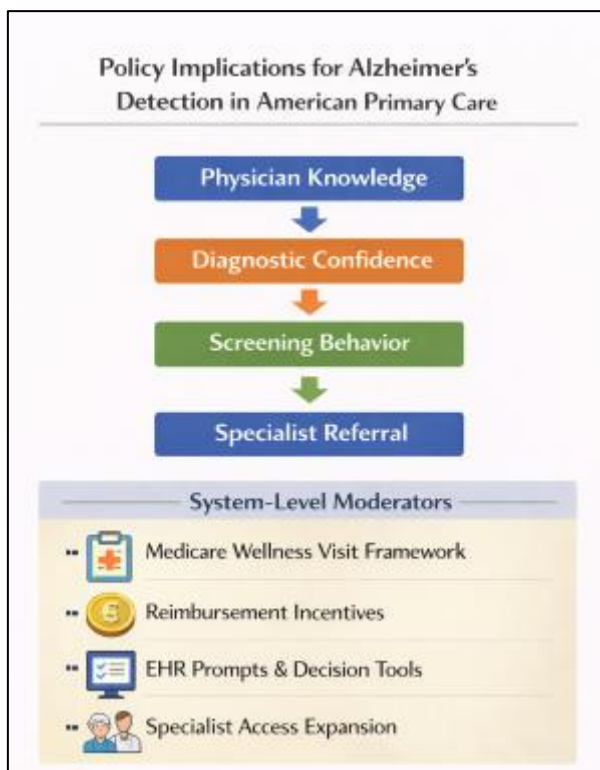


Figure 4. Policy implications for Alzheimer's detection in American primary care.
 This figure illustrates how physician knowledge influences diagnostic confidence and screening behavior, leading to specialist referral for Alzheimer's evaluation, within the context of U.S. health system factors such as Medicare wellness visits, reimbursement incentives, EHR decision-support tools, and specialist access.

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One critical policy consideration is the integration of cognitive screening into routine preventive care visits. The Medicare Annual Wellness Visit provides an opportunity for structured cognitive assessment, yet studies demonstrate that these assessments are underutilized due to time constraints, limited reimbursement incentives, and variable physician confidence^{11,17}. Policy interventions that provide enhanced reimbursement for dementia screening and counseling services may encourage primary care physicians to incorporate cognitive assessments more consistently^{11,7}.

Healthcare workforce development represents another key policy priority. Shortages of geriatricians, neurologists, and neuropsychologists in certain regions contribute to delayed or incomplete evaluation after initial cognitive screening. Expanding interdisciplinary care models that leverage nurse practitioners, physician

assistants, and care coordinators can improve access to diagnostic evaluation while supporting primary care physicians in managing cognitive health^{7,13}. Telehealth and remote consultation networks offer additional opportunities to expand access to specialist input, particularly in rural or underserved areas, and may mitigate regional disparities in Alzheimer's detection⁷.

Electronic health record (EHR) systems and decision-support tools can also be leveraged through policy-driven incentives. Incorporating structured prompts for cognitive assessment and automated referral pathways within EHRs has been shown to improve screening rates and facilitate timely specialist referral¹⁷. Federal and state policies that incentivize the adoption and meaningful use of these tools can enhance primary care capacity to identify cognitive impairment efficiently.

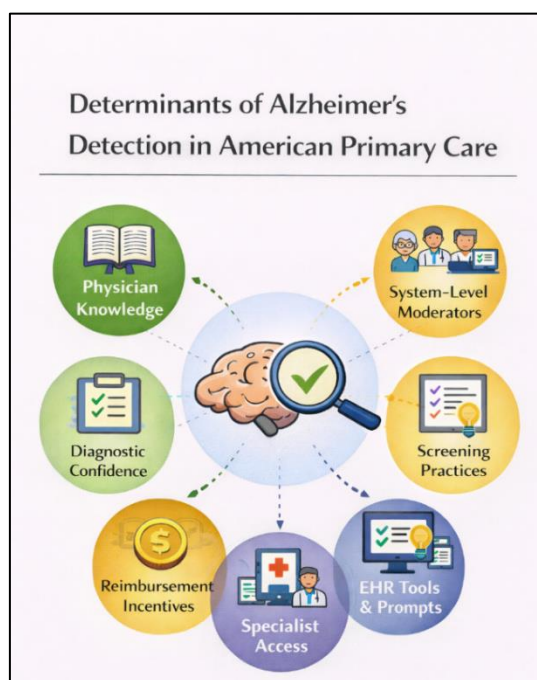


Figure 5. Determinants of Alzheimer's detection in American primary care.

This figure illustrates key factors influencing Alzheimer's disease detection in U.S. primary care, including physician knowledge, diagnostic confidence, screening practices, reimbursement incentives, electronic health record decision-support tools, specialist access, and broader system-level supports.

Finally, addressing disparities in dementia detection is an urgent policy concern. Social determinants of health, including socioeconomic status, race, ethnicity, and linguistic diversity, influence both access to care and physician diagnostic confidence. Policies that support culturally adapted screening instruments, workforce diversity, and targeted outreach programs may reduce diagnostic delays and ensure equitable access to Alzheimer's disease care for all populations^{7,1}.

In summary, enhancing early detection of Alzheimer's disease in American primary care settings will require a multipronged policy approach that combines reimbursement incentives, workforce development, digital health integration, and equity-focused interventions. By aligning physician capacity with system-level support, these policies can facilitate timely diagnosis, optimize patient outcomes, and prepare the healthcare system to meet the growing burden of Alzheimer's disease^{7,1}.

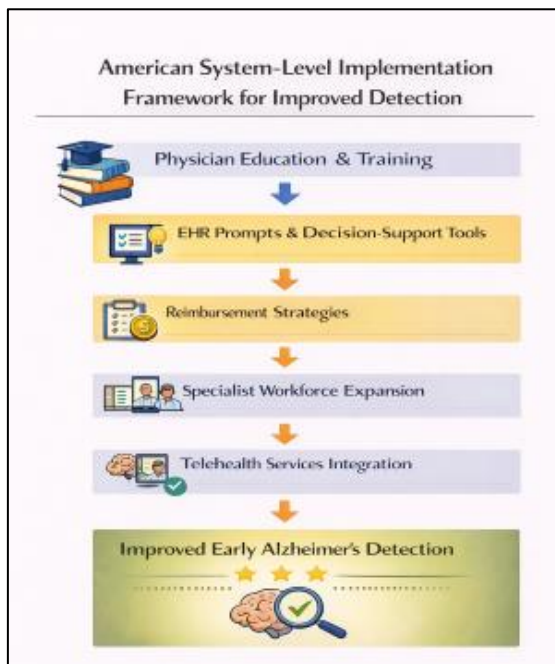


Figure 6. American system-level implementation framework for improved Alzheimer's detection.

This figure outlines key system-level strategies in the United States—including physician education, clinical decision-support tools, workflow integration, reimbursement incentives, and strengthened referral networks—that support earlier identification of Alzheimer's disease in primary care.

Limitations

Although this narrative review synthesizes a broad range of literature examining Alzheimer's detection in primary care, several limitations should be acknowledged. First, the narrative review methodology does not follow the rigid inclusion and exclusion criteria typically used in systematic reviews or meta-analyses. As a result, the synthesis may be influenced by publication bias or variations in study quality.

Second, the studies included in this review encompass diverse healthcare systems with varying primary care structures, reimbursement models, and referral infrastructures. These contextual differences may limit the generalizability of certain findings across all healthcare settings.

Third, many of the studies examining physician behavior rely on self-reported survey data, which may be subject to response bias. Physicians who participate in surveys related to dementia detection may already possess greater interest or awareness of cognitive health issues than the broader clinical population.

Fourth, although this review emphasizes recent literature published between 2022 and 2026, the rapidly evolving landscape of Alzheimer's diagnostics and therapeutics means that detection practices may continue to change in response to emerging treatments and biomarker technologies.

Finally, the review focuses primarily on physician-level and healthcare system determinants of screening behavior. Other important factors influencing dementia detection, including patient-level barriers, cultural stigma, and caregiver dynamics, were beyond the scope of this analysis but warrant further investigation.

Future Research

Future research should focus on identifying implementation strategies that effectively translate physician awareness of dementia into routine screening and referral practices. While educational interventions have improved physician knowledge, there remains limited evidence regarding which training models most effectively influence clinical behavior.

Randomized implementation trials examining integrated approaches that combine physician education, electronic decision-support tools, and team-based care models may provide valuable insight into scalable solutions for improving early Alzheimer's detection.

Additional research is also needed to evaluate the effectiveness of digital health technologies in supporting dementia detection within primary care settings. Artificial intelligence-assisted clinical decision tools and automated cognitive screening platforms are increasingly being developed and may offer opportunities to streamline diagnostic workflows¹⁷.

Another important research priority involves addressing disparities in dementia diagnosis across socioeconomically and culturally diverse populations. Studies have consistently shown that individuals with lower educational attainment, limited English proficiency, or minority ethnic backgrounds are more likely to receive delayed dementia diagnoses. Future research should examine culturally adapted screening tools and clinician training approaches that improve diagnostic accuracy across diverse populations.

Longitudinal studies examining physician behavior over time would also help clarify how diagnostic confidence evolves with experience and exposure to dementia care. Understanding these dynamics may inform the design of mentorship programs and interdisciplinary training initiatives.

Finally, health systems research examining the impact of national dementia policies and reimbursement structures on screening behavior could provide valuable guidance for policymakers seeking to improve early detection rates.

Conclusion

The early detection of Alzheimer's disease within primary care settings remains inconsistent despite increasing awareness of its clinical importance.

Evidence suggests that physician knowledge alone does not reliably predict whether cognitive screening or referral behavior will occur^{11,13}. Instead, diagnostic confidence, clinical workflow integration, and healthcare system capacity appear to represent the most influential determinants of physician action^{16,17,7}.

Improving Alzheimer's detection will therefore require a comprehensive systems-based approach that combines physician education with structural interventions designed to support screening within routine primary care workflows. Strengthening healthcare infrastructure, integrating decision-support technologies, and expanding interdisciplinary referral networks will be essential to improving early diagnosis and ensuring that individuals with Alzheimer's disease receive timely and appropriate care.

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