



IMPROVING EARLY DETECTION OF COGNITIVE IMPAIRMENT IN PRIMARY CARE:

RECOMMENDATIONS INFORMED BY THE DAVOS ALZHEIMER'S COLLABORATIVE

TIMOTHY FARRELL, MD, AGSF, CPAFH
PROFESSOR OF MEDICINE & PRESIDENTIAL ENDOWED CHAIR IN THE DIVISION OF GERIATRICS
GERIATRICS DIVISION ASSOCIATE CHIEF FOR AGE-FRIENDLY CARE
SPENCER FOX ECCLES SCHOOL OF MEDICINE AT THE UNIVERSITY OF UTAH
ACTING ASSOCIATE DIRECTOR FOR CLINICAL INNOVATIONS, VA SALT LAKE CITY GRECC

ADVISORY COUNCIL ON ALZHEIMER'S RESEARCH, CARE, & SERVICES

OCTOBER 19, 2026



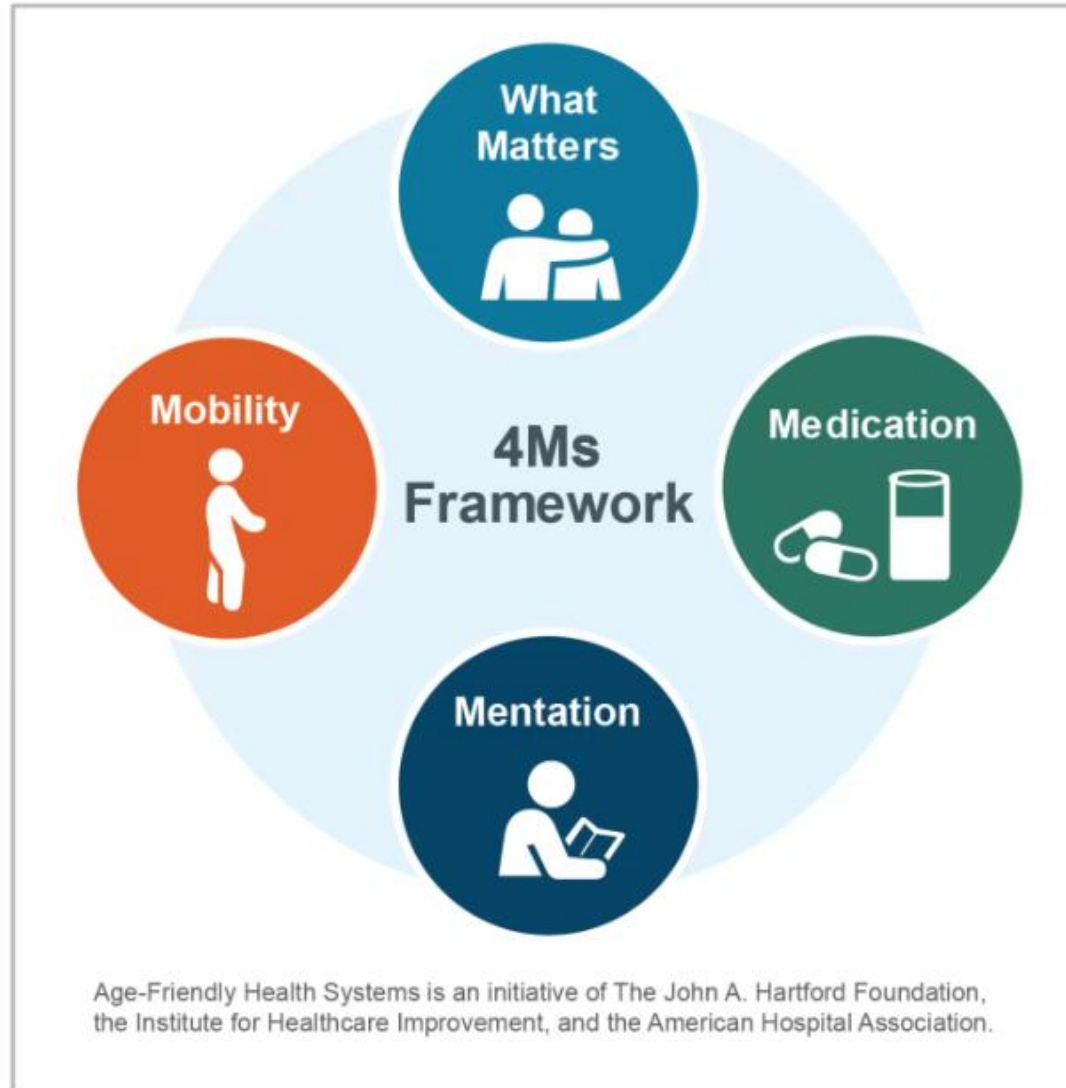
DISCLOSURES

- The opinions expressed here are my own and not necessarily the same as the University of Utah or University of Utah Health.
- The views expressed are my own and do not represent formal policy of the Veterans Administration.
- I receive salary support as Project Director for the University of Utah's participation in the Davos Alzheimer's Collaborative US Fellowship Expansion Program.

OBJECTIVES

- Review the evidence for the current state of cognitive assessment in US primary care
- Describe the Davos Alzheimer's Collaborative approach to improve early detection of cognitive impairment in primary care
- Recommend structural changes to improve the Nation's capacity to address Mentation in primary care

4Ms Framework of an Age-Friendly Health System



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences, including day-to-day needs as well as end-of-life planning, and across settings of care.

Medication

If medication is necessary, use age-friendly medications that do not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

GOING BEYOND THE USPSTF “I” RECOMMENDATION: BENEFITS OF EARLY DETECTION OF COGNITIVE IMPAIRMENT IN PRIMARY CARE

- Render an accurate diagnosis
 - Identify potentially reversible causes of cognitive impairment
 - Avoid delays in diagnosis
- Identify factors (e.g. blood pressure control, lifestyle changes, deprescribing or starting medications) that can slow progression of cognitive impairment
- Assess eligibility for caregiver and respite support (e.g. CMS GUIDE Model)
- Identify safety concerns (e.g. medications, home safety, driving, firearms, elder abuse)
- Conduct advance care planning to ensure patient wishes are captured before a crisis occurs

REALITIES OF DEMENTIA CARE IN PRIMARY CARE



Original Investigation | Geriatrics

Primary Care Practitioner Perspectives on the Role of Primary Care in Dementia Diagnosis and Care

Alissa Bernstein Sideman, PhD, MPH, MA; Melissa Ma, BA; Alma Hernandez de Jesus, BA; Cecilia Alagappan, RN; Na'amah Razon, MD, PhD; Daniel Dohan, PhD; Anna Chodos, MD, MPH; Tala Al-Rousan, MD, MPH; Loren I. Alving, MD; Freddi Segal-Gidan, PA, PhD; Howie Rosen, MD; Katherine P. Rankin, PhD; Katherine L. Possin, PhD; Soo Borson, MD

Philosophically, I think who else is better suited to [provide dementia care]? And then at the same time, we definitely don't have the resources, the culture societally, or the systems and structures in place with reimbursement and funding to do it well.

PCP16

LOW PCP CONFIDENCE IN COGNITIVE ASSESSMENT

- A survey of 100 PCPs and 50 neurologists caring for older adults found that 20% of PCPs had high confidence in interpreting cognitive test results (vs. 68% for neurologists)¹
 - 14% of PCPs had high confidence in interpreting brain imaging (vs. 70% for specialists)¹
- A survey of 1000 PCPs caring for older adults found that 39% are “never or sometimes comfortable” diagnosing ADRD²
 - 27% of PCPs are “never or sometimes comfortable” answering patient questions about ADRD²

¹Bernstein et al. BMC Health Services Research 2019.

²[Primary Care Physicians on the Front Lines of Diagnosing and Providing Alzheimer's and Dementia Care: Half Say Medical Profession Not Prepared to Meet Expected Increase in Demands](#) (Alzheimer's Association)

INADEQUATE PCP TRAINING IN DEMENTIA CARE

- A systematic review of PCP views on barriers to dementia care identified lack of training as a key factor¹
- 22% of PCPs caring for older adults had no residency training in dementia care²
 - Of the 78% receiving training, 65% reported the training was “too little”²

¹Mansfield et al. *The Gerontologist*, 2019.

²[Primary Care Physicians on the Front Lines of Diagnosing and Providing Alzheimer's and Dementia Care: Half Say Medical Profession Not Prepared to Meet Expected Increase in Demands](#)

UNIVERSITY OF UTAH HEALTH RATES OF DEMENTIA SCREENING IN PRIMARY CARE

- Between June 2024 – June 2025:
 - Only 46.5% of older adults were screened for dementia in Geriatrics
 - Only 42.1% of older adults were screened for dementia in Primary Care
- Anecdotally, U of Utah PCPs express lack of comfort with cognitive assessment, and cite challenges of workflow integration and reimbursement related to cognitive assessment
- How might these challenges be addressed?

DAC-SP Key Programs



Early Detection Flagship

What Is It?

- Global initiative launched in 2021 to implement early detection of cognitive impairment in primary care settings
- Two-pronged approach: Flagship program (7 sites) + Grant program (12 sites)

Key Elements

- Testing digital cognitive assessments and blood biomarkers
- Identifying real-world implementation barriers and the acceptability and feasibility of tools in real world settings
- Developing scalable solutions across different healthcare systems

Major Output

- Early Detection Blueprint: practical implementation guide
- Academic publications, media coverage, conference presentations



US Early Detection Program

What Is It?

- Launched H2 2024
- Provides technical assistance and seed funding to healthcare organizations to implement the early detection Blueprint 1.0 in primary care settings
- Increase Patient Access to Early Detection at 10 US sites

Key Elements

- Blueprint implementation support
- Community of practice participation
- Collaborative barrier identification
- Data-driven evaluation of Blueprint effectiveness

Current Status

- 10 US sites have implemented the BP 1.0 and are in various stages of completing their plans/developing report.



US Brain Health Navigator Program

What Is It?

- Brain Health Navigator program launched Q3 2024
- Complementary to US Early Detection
- Develop training materials for pre-diagnosis and post-diagnostic processes with emphasis on pre-diagnosis
- Six sites participating in co-design and pilot implementation

Key Elements

- Training material development
- Pilot implementation at selected sites
- Material refinement based on pilot results
- Dissemination through DAC channels and events, congress presentations, and train-the-trainer events



Accurate Diagnosis

What Is It?

- Real-world implementation study launched 2024
- Focuses on accurate diagnosis of MCI due to AD vs. other dementias
- Implementation across 8 global sites (4 US, 1 Japan, 1 UK, 2 EU)
- Testing blood-based biomarkers and a confirmatory diagnostic (CSF or PET)

Key Elements

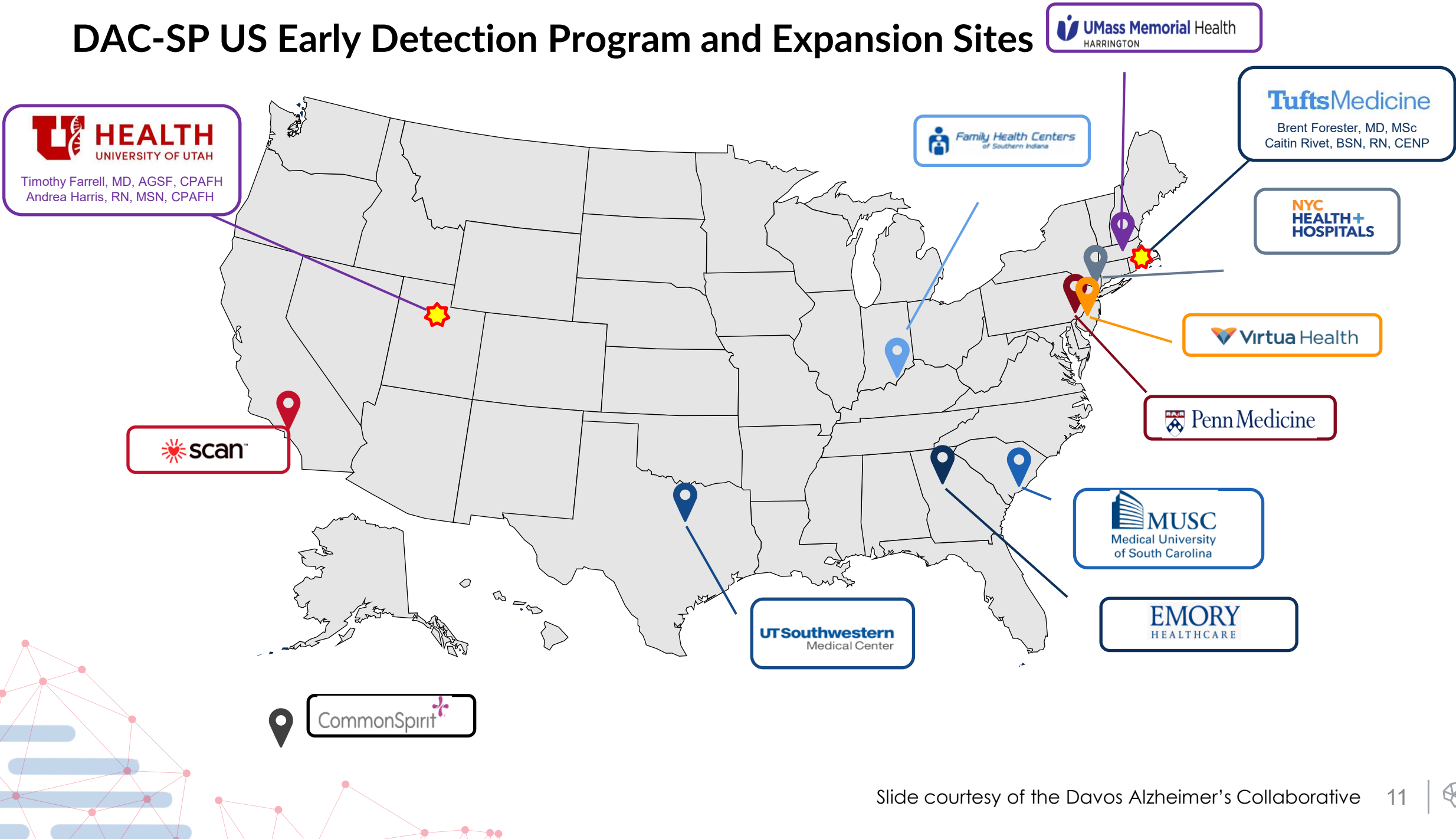
- Documenting workflow
- Understanding changes to clinical management and resource use, barriers and facilitators to implementation and key implementation outcomes
- Expansion through IHI AD-RIDDLE program (6 additional EU sites)

Current Status

- Sites are actively onboarding clinics and enrolling patients



DAC-SP US Early Detection Program and Expansion Sites



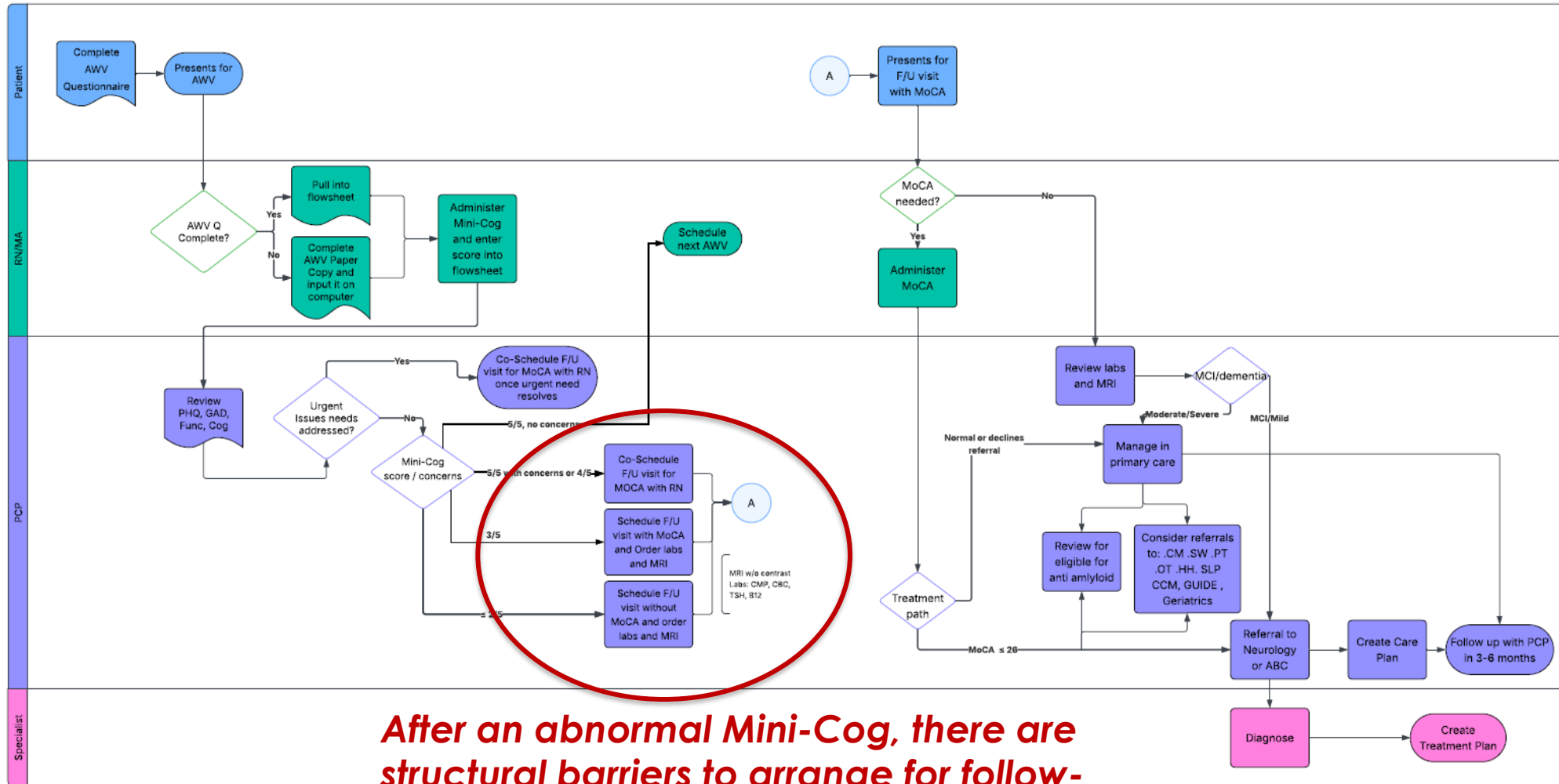
PAIN POINTS IN COGNITIVE ASSESSMENT IN PRIMARY CARE: THE UTAH EXPERIENCE

- **Need for additional training in cognitive assessment**
 - Consistent with national studies of PCPs, U Health PCP site leads generally feel uncomfortable with cognitive assessment
 - They have received little or no training on appropriate use of biomarkers (e.g. importance of avoiding biomarker use for patients without objective evidence of cognitive impairment)
 - They generally have little time for lectures/modules but instead prefer to embed learning at the point of care

PAIN POINTS IN COGNITIVE ASSESSMENT IN PRIMARY CARE: THE UTAH EXPERIENCE

- **Structural issues (billing and workflow) impede cognitive assessment**
 - 20 to 30-minute appointment slots are generally inadequate for cognitive assessment
 - It is difficult to pair a follow-up MoCA with a clinician visit using existing scheduling templates
 - Utah PCP site leads cannot satisfy 99483 billing requirements in a 30-minute visit
 - 2 consecutive 99214 visits reimburse as much or more than a single 99483 visit

COGNITIVE ASSESSMENT WORKFLOW EXAMPLE



After an abnormal Mini-Cog, there are structural barriers to arrange for follow-up testing (labs, imaging, MoCA) in primary care.

RESOLVING PAIN POINTS IN COGNITIVE ASSESSMENT AT U OF UTAH HEALTH

Problem	Approach
Clinician discomfort	• 1-page educational handout at point of care • “Micro-CMEs” embedded in EHR workflows
Low screening rates	• Prioritize Medicare Annual Wellness Visit scheduling • Educate medical assistants in cognitive screening (Mini-Cog, MoCA)
Workflow integration	• Schedule MoCA administration adjacent to an office visit
Inadequate time to bill 99483	• Divide the cognitive assessment into 2 separate appointments each billed with 99214

U OF UTAH TRAININGS IMPLEMENTED IN 2026

- **Virtual lectures from cognitive neurology** to family medicine, internal medicine and geriatrics provider meetings
- **Standardized Mini-Cog and MoCA training materials** for medical assistants administering these tests
- **HCC coding seminar for PCPs treating neurological conditions** including ADRD
- **1-page clinician education handout** for PCPs at 5 pilot sites

1-PAGE CLINICIAN EDUCATION HANDOUT

COGNITIVE IMPAIRMENT DETECTION and MANAGEMENT WORKFLOW for PRIMARY CARE

Primary Care Clinical Reference

Version 1
September 2026

Core Diagnostic Rule: Dementia diagnosis requires functional deficits (ADL/IADL). Mild Cognitive Impairment (MCI) involves objective cognitive decline without significant functional loss. Both dementia and MCI require cognitive decline from baseline. Always obtain history from **both patient and informant/caregiver**. Ensure sensory deficits such as vision and hearing are addressed before cognitive testing.

1. HISTORY & DIFFERENTIAL DIAGNOSIS

RED FLAGS (Urgent Action):

- Rapidly Progressive (weeks-months):** Rule out CJD or autoimmune encephalitis. Consider immediate Neurology admission for expedited workup.
- Young Onset (<60 yrs) OR Parkinsonism:** Suggests early-onset Alzheimer's Disease, Lewy body dementia, or frontotemporal dementia. Refer to Neurology.

Reversible & Contributing Factors (Rule Out First):

- Acute Decline / Delirium:** Waxing/waning baseline → work up acute medical triggers (infection, metabolic, hypoxia).
- Meds & Substances:** Ask about anticholinergics (e.g., Tylenol PM), sedatives, alcohol/substance use.
- NPH:** Unexplained gait disturbance + hydrocephalus → Refer to Dr. Clatt Brown (Neurology) and if prior neurology records and images were done externally, request these records and images.
- Medical/Psych:** Screen/treat depression, anxiety, insomnia, sleep apnea, serious mental illness (e.g. schizoaffective disorder, bipolar disorder.)

2. COGNITIVE & FUNCTIONAL ASSESSMENT

Functional Spectrum (ADL and IADL)	
Stage	Functional Spectrum
Mild Cognitive Impairment	No functional decline or subtle IADL impairment only.
Mild Dementia	Some IADL deficits; basic ADL completely intact.
Moderate Dementia	Most IADL impaired; some basic ADL deficits present.
Severe Dementia	All basic ADL significantly impaired.

Step 1: Mini-Cog Screening (~3 min)

Score	Interpretation & Action
5/5 (Without cognitive concerns)	Negative screen. Repeat Mini-Cog in 1 year.
4/5 or 5/5 (With cognitive concerns)	Negative screen BUT: Consider MoCA and additional workup since Mini-Cog is less sensitive for MCI than MoCA.
≤ 3/5	Positive screen. Administer MoCA & initiate diagnostic workup.

Step 2: MoCA Evaluation (~10-15 min)

Score	Clinical Action & Care Pathway
≥ 26	Normal. If high clinical suspicion remains, order formal neuropsychological testing.
11 – 25	Abnormal. Complete functional evaluation & lab/imaging workup. Evaluate for appropriateness of Amyloid-Targeting Therapy (ATT). Schedule close follow up. - MoCA < 17 & Driving: Refer to Sugar House OT for driving eval. - Imminent safety threat: Report to Utah Driver License Division
≤ 11	Abnormal. Complete workup; consider Geriatrics consultation for complex cases (e.g. multiple geriatric syndromes) & GUIDE program. Refer to ABC/Neurology if atypical presentation and desire for further workup.

3. DIAGNOSTIC WORKUP & BIOMARKERS

Standard Laboratory & Imaging Workup

- Neuroimaging:** MRI Brain W/O contrast (CT Head W/O contrast only if MRI contraindicated).
- Routine Serology:** CBC, CMP, TSH, Vitamin B12
- Targeted testing** (if risk factors): HIV, RPR, Vitamin B1 (Thiamine).

Plasma Biomarker: pTau217
A positive ptau217 test strongly suggests amyloid pathology (17% indeterminate rate, negative=AD unlikely)

Result	Clinical Interpretation & Next Steps
pTau217 (+)	Likely Amyloid Pathology: - If typical presentation & non-ATT candidate: Manage in Primary Care. - If ATT candidate: Refer to ABC / Neurology.
pTau217 (-) / Indeterminate	AD Unlikely / Uncertain: Refer to Aging Brain Care (ABC) / Neurology for complex diagnostic evaluation.

4. TREATMENT & DISEASE MANAGEMENT

Mild Cognitive Impairment (MCI)

- Non-Pharmacologic:** Cognitive/intellectual engagement, social activity, regular aerobic exercise, BP control.
- Meds:** Standard AChEs (e.g., donepezil) are NOT indicated. Evaluate for ATT eligibility.

Alzheimer's Disease (AD) Pharmacotherapy

- Donepezil (Aricept):** Indicated for Mild, Moderate, & Severe AD*
- Dosing:** Start 5 mg qHS x 4-6 wks → Titrate to 10 mg qHS (minimizes GI side effects).
- Caution:** Watch for bradycardia / syncope; avoid in severe cardiac conduction defects.

- Memantine (Namenda):** Indicated for Moderate to Severe AD* (monotherapy or add-on to donepezil).
- Dosing:** Start 5 mg OD → Titrate weekly by 5 mg to target 10 mg BID. A once daily extended release formulation is available but is expensive
- Caution:** Adjust dosage in severe renal impairment (max 5 mg BID).

*Especially in severe dementia, the benefits of pharmacotherapy may be limited. Consider deprescribing donepezil and/or memantine if consistent with the goals of care.

5. AMYLOID TARGETING THERAPY (ATT)

ATT Candidate Checklist (Refer to Cognitive Neurology or ABC Program at Madsen Geriatrics):

✓ High clinical suspicion for AD	✓ MoCa score MoCa Score ≥ 16
✓ MCI or Mild Dementia stage	✓ No Pacemaker (MRI required)
✓ NO Anticoagulation therapy	✓ MRI without severe microvascular disease/microhemorrhages

Note: ATT slows but does not reverse disease progression. It is expensive and patients must commit to serial brain MRIs to monitor for ARIA (Amyloid-Related Imaging Abnormalities: edema and microhemorrhages). A conversation about risk and benefits in the context of What Matters to the patient is strongly suggested before considering ATT.

6. CARE MANAGEMENT & LOCAL RESOURCES

- Advance Care Planning:** Verify/complete Utah Advance Directive, and if relevant, OLST form.
- GUIDE Program (Guiding an Improved Dementia Experience):** Refer to Geriatrics or ABC for consultation and enrollment. Eligibility: Dementia dx + Traditional Medicare A&B (non-MA) + Salt Lake County resident + non-LTC/hospice.
- Geriatric Psychiatry:** Refer to Geriatrics or Cognitive Neurology for severe behavioral or psychiatric symptoms of dementia.
- Occupational Therapy:** Sugar House OT Clinic for driving safety assessments (especially if MoCA ≤ 17).
- Follow-Up Intervals:** Suggest minimum primary care follow-up interval of 6 months for all patients with MCI and dementia.



Age-Friendly
Health Systems

Excellence in
System-wide Spread

2026-2029



HEALTH
UNIVERSITY OF UTAH

Created by the University of Utah Early Detection of Cognitive Impairment Workgroup
(801 213-4156)

U OF UTAH LESSONS LEARNED IN INCREASING EARLY DETECTION OF COGNITIVE IMPAIRMENT*

- PCPs generally prefer educational content embedded in their workflows (e.g. 1-page handout, EHR prompts) over separate resources such as training modules or lectures
- Increasing Medicare Annual Wellness Visits appears to be an effective way to increase cognitive screening of older adults
- Billing remains misaligned with the work of cognitive assessment in primary care

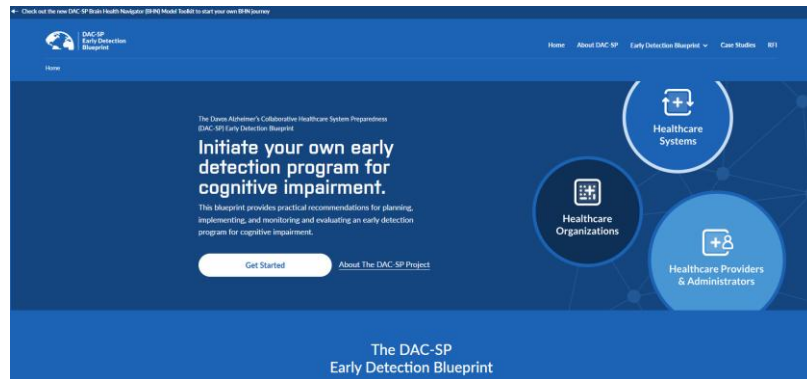
**Data collection is underway and should be completed by mid to late 2027.*

Blueprint is Central to the Early Detection Programs' Curriculum

Provides practical recommendations for planning, implementing, and monitoring and evaluating an early detection program for cognitive impairment

Blueprint 1.0

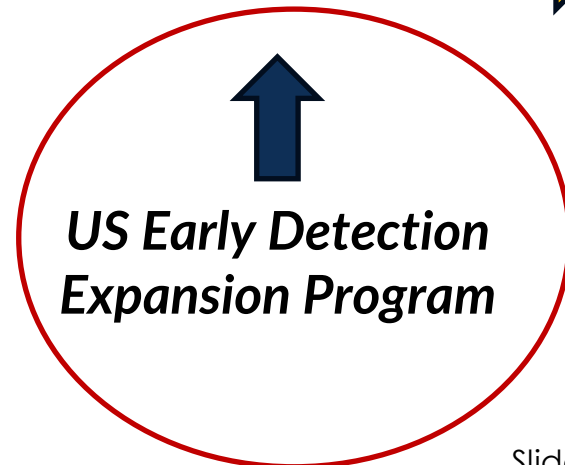
- *Informed by DAC-SP Flagship Program*
- *BP 1.0 guided program development and implementation for current cohort*



www.dacblueprint.org

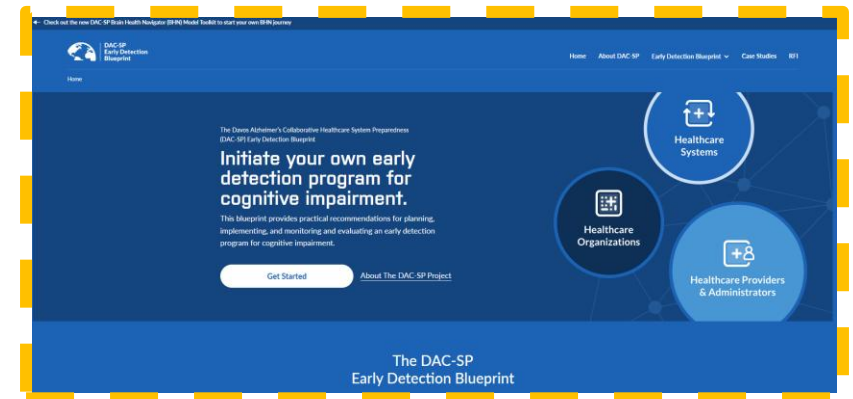
Blueprint 1.5

- *Revised, streamlined content based on current program's feedback*



Blueprint 2.0 (2027)

- *Informed by extensive interim program data, CoP insights, site feedback*
- *Consolidate & streamline content*



RECOMMENDATIONS TO THE NAPA ADVISORY COUNCIL: PCP TRAINING

Problem #1: Inadequate PCP training in cognitive assessment

Recommendations:

1. Ensure that all medical students, internal medicine residents, and family medicine residents acquire proficiency in the **Minimum Geriatrics Competencies**^{1,2} – including assessment and management of cognitive concerns.
2. Embed best practices & guidelines for cognitive assessment within EHR workflows as “**micro-CMEs**,” including education on appropriate use of biomarkers.

1. [Geriatrics Competencies for Medical Students | ADGAP - Association of Directors of Geriatrics Academic Programs](#)
2. [Minimum Competencies in Geriatrics for IM/FM Residents | ADGAP - Association of Directors of Geriatrics Academic Programs](#)

RECOMMENDATIONS TO THE NAPA ADVISORY COUNCIL: FINANCIAL INCENTIVES

Problem #2: Inadequate financial incentives for cognitive assessment in primary care

Recommendations:

1. **Create a modifier*** for both new and established patient billing codes that would increase primary care reimbursement for conducting additional cognitive evaluation (labs, imaging, MoCA) when there is an abnormal cognitive screen such as an abnormal Mini-Cog.*
2. **Create a new billing code** (similar to Transitional Care Management codes) that would provide increased primary care reimbursement for cognitive assessment and management over a defined time period (e.g. 6 months).
3. **Incorporate metrics to incentivize “acting on” a cognitive screen** including driving safety evaluation, completed CMS GUIDE referral, completed cognitive neurology referral, and discussion of pharmacotherapy options in appropriate patients (for an abnormal screen), or a plan to reassess cognition in 1 year (for a normal cognitive screen).

*This modifier would be in addition to the G2211 add-on code.



THANK YOU!

timothy.farrell@hsc.utah.edu