

Implementing Brief Cognitive Assessments in Adults Aged 55 and Older

A Guide for Primary Care Providers

Early recognition of cognitive change is central to high-quality Alzheimer's disease (AD) and dementia care. Primary care providers (PCPs) play a vital role in the early detection of mild cognitive impairment (MCI) and dementia, yet time constraints in busy practices can make thorough evaluations challenging.

Brief validated cognitive assessments are essential tools that bridge this gap. They support earlier, more consistent detection and allow patients and care partners to proactively plan, address safety and consider therapies when appropriate.

To aid PCPs in implementing these evaluations, the Alzheimer's Association developed this practical, at-a-glance workflow. It serves as an advance companion to the forthcoming *Clinical Practice Guideline on Cognitive Assessments for the Early Detection of Cognitive Impairment in Adults within Primary Care Settings*. Once finalized, the full guideline will be published in *Alzheimer's & Dementia®: The Journal of the Alzheimer's Association*.

The Annual Brain Health Conversation

Primary care providers (PCPs) should use routine visits, especially Medicare Annual Wellness Visits (AWVs), as opportunities to have a conversation about cognitive and brain health with **all patients aged 55 years and older**.*

During this conversation, or any time a patient raises concerns about their memory, PCPs should:

- **Ask** patients about memory loss or changes in their thinking.
- **Document** risk factors, cognitive, behavioral and functional changes (e.g., difficulties with activities of daily living) and family history.
- **Involve** a care partner early and use shared decision-making to set patient-centered goals.

When to Administer a Brief Cognitive Assessment

While all patients 55 years and older should engage in a brain health conversation, PCPs should consider administering a brief validated cognitive assessment if the patient meets any of the following criteria:

- **Aged 65 years and older**, presenting for a Medicare AWV.
- **Presents with specific cognitive or functional concerns** (e.g., missing medications or appointments), whether self-reported, reported by a family member or care partner, or raised during the annual brain health conversation.
- **Aged 55 years and older with history of serious vascular conditions** (e.g., prior stroke, transient ischemic attack [TIA], coronary artery disease [CAD]) **or family history of Alzheimer's disease and related dementias (ADRD)**.
- **Demonstrates signs of cognitive impairment** as observed by the clinician during any visit.

*While Medicare AWVs begin at age 65, the Alzheimer's Association recommends initiating brain health conversations at age 55, or any time a patient raises concerns about their memory. This earlier baseline addresses a growing number of adults in this age group expressing cognitive concerns. As always, a patient's clinical presentation and individual concerns should guide clinical reasoning.

Clinical Workflow for Primary Care Settings

If a patient has met any of the above criteria, PCPs should consider administering a brief cognitive assessment using the following workflow:

STEP 1: Administer the Assessment

Use **validated and sensitive tools** whenever possible. Successful implementation depends on clinician training, workflow integration and patient population characteristics. *View brief validated cognitive tests [here](#).*

IF YOU CURRENTLY USE A VALIDATED TEST:

Ensure it works well for your team and prompts actionable next steps (e.g., monitoring, conducting further evaluation, implementing care planning). If it does, continue its use.

IF YOU DO NOT HAVE A STANDARD PROCESS:

Implement a brief validated cognitive assessment that fits into your clinical workflow and patient demographics.

STEP 2: Interpret Results and Determine Next Steps

NORMAL RESULT:

Continue routine monitoring and universal brain health conversations at least annually; document findings.

POSSIBLE IMPAIRMENT:

Consider further evaluation or repeat testing (in 6 months or at the next AWW) to assess changes over time.

CLEAR IMPAIRMENT:

Initiate holistic care planning, including appropriate referrals to support formal diagnosis, ongoing support and care partner involvement.

Rule out other causes or contributing factors of abnormal test scores (see the [Quick Reference Guide: Differential Diagnosis and Mimics of Mild Cognitive Impairment and Dementia](#)) through general and metabolic panels, nutritional and thyroid screenings, infection screenings, careful medication review and mental health evaluation.

Note: Identification of these factors does not necessarily preclude an underlying diagnosis of dementia.

STEP 3: Disclose Results and Initiate Care Planning

A

SHARE RESULTS:

Discuss test findings with the patient and care partner. Emphasize that a positive score on an initial brief assessment does **not** equal a diagnosis, and further work-up and evaluation are necessary.

B

CARE PLANNING:

Develop a plan using resources that align with the patient's and care partner's values and care goals.

C

PROVIDE EDUCATION:

Activate strategies to improve **brain health** and optimize safety, especially if the patient is waiting for a specialist referral.

STEP 4: Refer and Conduct Further Clinical Evaluation

Refer the patient to a specialist (e.g., behavioral neurologist, geriatric or neuropsychiatrist, neuropsychologist) when you need help. High-priority triggers for specialist referral:

Diagnostic uncertainty

Younger onset (symptom onset <65 years of age)

Complex or atypical clinical presentation

Rapidly progressive dementia

Severe neuropsychiatric symptoms



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

Good Practice Statement

In primary care and appropriate ambulatory care settings, all patients 55 years and older should have their full medical history, including a discussion on brain health, taken annually.

Consider giving those with cognitive or functional concerns a brief cognitive assessment to begin their evaluation. Although there is limited evidence on the diagnostic test accuracy of clinically relevant tests designed to detect cognitive impairment in primary care settings, the workflow above reflects the best available data and aims to support appropriate and timely referral/diagnosis of patients with cognitive concerns, including MCI and dementia.

Intellectual Disabilities

Cognitive testing is important for individuals with intellectual disabilities; however, this workflow was not specifically developed for these populations and may require adaptation.

Adapted tools and clinical judgment should be used, and published resources provide guidance on appropriate, tailored approaches.^{1,2}

References:

1. Global Down Syndrome Foundation. *GLOBAL Medical Care Guidelines for Adults with Down Syndrome*. Global Down Syndrome Foundation. Accessed October 15, 2025. <https://www.globaldownsyndrome.org/medical-care-guidelines-for-adults/>
2. Moran JA, Rafii MS, Keller SM, Singh BK, Janicki MP. *The National Task Group on Intellectual Disabilities and Dementia Practices consensus recommendations for the evaluation and management of dementia in adults with intellectual disabilities*. *Mayo Clin Proc*. 2013;88(8):831-840. [https://www.mayoclinicproceedings.org/article/S0025-6196\(13\)00371-6/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(13)00371-6/fulltext).

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.