

UsAgainstAlzheimer's

October 7, 2019

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Chairperson
U.S. Preventive Services Task Force
USPSTF Program Office
5600 Fishers Lane
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RE: *Draft Recommendation Statement and Draft Evidence Review: Screening for Cognitive Impairment in Older Adults*

by electronic delivery to <https://www.uspreventiveservicestaskforce.org>

Dear Chairman Owens:

UsAgainstAlzheimers (UsA2) and the undersigned partners and friends appreciate the opportunity to comment on the U.S. Preventive Services Task Force (USPSTF) [Draft Recommendation Statement and Draft Evidence Review: Screening for Cognitive Impairment in Older Adults](#) (USPSTF Draft).

We write today on behalf of millions of Americans and their families who are facing Alzheimer's disease and other forms of dementia. These include the many people who overcame enormous obstacles to receive their diagnosis, those who remain undiagnosed, and the tens of millions of people whose cognitive health may be at risk.

The USPSTF Draft as written concludes that current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment in older adults. **Respectfully, we disagree and urge USPSTF to revise its recommendation to Grade B, encouraging providers to screen persons 65 and older for cognitive impairment**, and to further specify that:

- Screening should be conducted in health care settings by staff who are appropriately trained to use the screening test(s) and with procedures in place for follow-up.
- Screening should be followed by an evaluation to diagnose the cause of any detected cognitive impairment, treatments to reduce modifiable causes, and ongoing efforts to reduce the impact of diagnosed dementia and support people with dementia and their caregivers.

We believe that the USPSTF Evidence Review is narrowly constructed from a disease-centric perspective that undervalues and overlooks the body of evidence demonstrating the health benefits of screening. It

appears the USPTF failed to adequately consider that 1) screening has the potential to improve overall health outcomes; 2) interventions for asymptomatic older adults and those with mild cognitive impairment (MCI) can delay onset or slow progression of dementia; and 3) dementia is a significant health disparity that may be fueled in part by disparities in early detection and diagnosis, which this recommendation will only serve to perpetuate.

As a result, the USPSTF draft risks reinforcing the discredited notion that physicians only need to or ought to diagnose that which they are able to treat or cure. This view did catastrophic damage during the early years of the HIV/AIDS epidemic— before effective biomedical treatments became available – by impeding efforts to account for the full scope of the public health burden, raise awareness and reduce stigma, and generate data for bench and social science researchers. Still today, more than six in 10 medical providers believe the scientific falsehood that dementia is part of normal aging. (ADI, 2019) The “I” (insufficient) in the draft, if allowed to stand, would inadvertently equate to, and reinforce, “indifference” toward the many issues related to detection of cognitive impairment and dementia and the ability and desire of individuals to take steps, when armed with this information, to reduce the risk and impact of this condition.

Leading non-governmental organizations and federal agencies alike have updated their guidelines and practice in response to evidence of the net benefit of screening. Case in point, the American Academy of Neurology (AAN) recently updated its practice guidelines on cognitive impairment stating that:

In the United States, the Medicare Annual Wellness Visit requires an assessment to detect cognitive impairment. Subjective cognitive complaints alone can result in both over- and underdiagnosis of MCI [mild cognitive impairment] and thus are insufficient to screen for MCI. Clinicians assessing for cognitive impairment should use a brief, validated cognitive assessment instrument in addition to eliciting patient and informant history regarding cognitive concerns. (Peterson et al, 2018)

AAN joins organizations representing providers and patients that have called for increased screening, including Alzheimer’s Disease International (2019), American Diabetes Association (ADA, 2018), the American Heart Association (Gorelick, 2018), the Alzheimer’s Association (Cordell et al, 2013) the Endocrine Society (LeRoith et al., 2019), National Academy of Neuropsychology (Perry et al., 2018) , the Alzheimer’s Foundation of America (Borson et al, 2013), the Heart Failure Society of America (Lindenfield et al., 2010) and the Usa2 Brain Health Partnership (Tumlinson 2019).

Cognitive health screening for MCI and dementia in older adults is warranted for several important reasons:

- Validated screening instruments are currently and widely available. (Draft Evidence Review, 2019)
- Waiting for subjective cognitive complaints alone can result in both over- and underdiagnosis of MCI and thus are insufficient to screen for MCI. A brief, validated cognitive assessment instrument is needed. (Foster et al, 2019)

- Cognitive impairment is a dominant comorbidity influencing not only what care is recommended for that problem, but also how care for all other illnesses should be provided. Consequently, knowing the cognitive health status of high-risk patients, especially older patients has inherent clinical relevance. (Foster et al, 2019)
- Evidence shows that promoting cognitive health by addressing key risk factors (treatment of hypertension, exercise, social engagement, smoking, and hearing loss, depression, diabetes, and obesity) may slow or prevent the progression of cognitive decline, and screening offers an opportunity to employ counseling interventions for the lifestyle interventions recommended to address these key risk-factors as supported by USPSTF’s own recommendations. (Livingston et al, 2017; Ngandu et al, 2015; World Health Organization, 2019)
- Screening can identify cognitive impairment that is caused by treatable conditions that are not dementia (including nutritional deficiencies, subdural hematoma, normal pressure hydrocephalus, and medication side effects) but may result in dementia-like symptoms. (Chari et al, 2015)
- Screening can prompt health care professionals and others to counsel people with cognitive impairment or dementia and their families about important safety risks including falls, motor vehicle accidents, gun accidents, and vulnerability to financial exploitation. (Hsieh et al., 2015; Levy-Storms et al., 2017; O’Connor et al., 2019)
- Cognitive impairment screening is a measure of brain health. If providers make screening more routine and systematic, changes in cognitive status can be detected earlier. This is important because indications of treatable cognitive decline begin well before the symptoms of full-blown dementia occur. (Tarawneh and Holtzman, 2012)
- Cognitive impairment screening can improve access to and utilization of available therapies and effective services and supports for people with cognitive impairment or dementia and their families and other caregivers.

We believe the USPSTF Draft runs contrary to existing federal government policies and programs – and emerging efforts by state and local government agencies and private sector organizations – thereby slowing progress toward earlier diagnosis of dementia, improved care and services, and better outcomes for people with dementia and their families. Recognizing the importance of detection of cognitive impairment, earlier diagnosis of dementia, and improved care and services for people with dementia and their caregivers, the federal government has taken decisive steps to advance detection, diagnosis, medical care, residential and home and community-based services, family caregiver support, and research participation. Recent steps by agencies of the U.S. Department of Health and Human Services include:

- Healthy People 2020 and proposed 2030 Public Health Objectives aiming to increase provider-patient discussions of subjective memory impairment (SMI) (specifically Objectives DIA-2030-01, DIA-2030-02, and DIA-2030-03) (HHS, ODPHP, 2019)
- CMS updates to the Medicare Physician Fee Schedule that encourage dementia diagnosis and care planning (HCPCS 99483)

- CMS' new Medicare Advantage (MA) rules that increase benefits for Alzheimer's and dementia care, along with risk score adjustments for MA Plans caring for people with dementia (Pyenson, B.S. and Steffens, 2019)
- CDC's 2018-2023 Brain Health Roadmap and implementation planning for the 2018 BOLD Infrastructure for Alzheimer's Act (Alzheimer's Association, 2018)
- The 2017 NIH National Research Summit on Care, Services, Supports for Persons with Dementia and Their Caregivers which will now be conducted in 3-year cycle with NIH's Alzheimer's Disease Summit and its Alzheimer's Disease-Related Dementias Summit (ASPE, 2018)
- CMS' 2017 Behavioral Health Payment and Care Delivery Innovation Summit (CMS, 2017)
- The Administration on Community Living (ACL) Alzheimer's Disease Programs Initiative (ADPI) that provides grants to support and promote the development and expansion of dementia-capable home and community-based service (HCBS) systems in both states and communities (ACL, 2018).
- HRSA's GWEP program and online training materials for physicians and other health care professionals (HRSA, 2019)
- The 2018 NIH National Strategy for Recruitment and Participation in Alzheimer's and Related Dementias Clinical Research (NIA, 2018) (which has a special emphasis on health disparities), and
- The FDA's 2018 updated "Early Alzheimer's Disease: Developing Drugs for Treatment, Guidance for Industry." (FDA, 2018)

Furthermore, the USPSTF draft recommendation on detection of cognitive impairment diverges from patient and healthcare provider preferences. In 2018, surveys of 1,000 primary care physicians and almost 2,000 people age 65 conducted for the Alzheimer's Association showed that "although nearly all primary care physicians and four of five older adults think brief cognitive assessments are beneficial, only 16 percent of the older adults surveyed are receiving regular brief cognitive assessments" (Alzheimer's Association, Special Report, 2019). About one third of the older adults surveyed were aware that the Annual Wellness Visit includes detection of cognitive impairment, and only 32 percent recalled a health care provider asking them about memory or thinking problems during an Annual Wellness Visit. Support for better cognitive assessments extends to caregivers themselves who strongly recommend providers receive adequate training on the prognosis and disease course of different types of dementia, effective pharmacological and non-pharmacological interventions and caregiving resources. (Griffin et al, 2019) Despite this strong support, estimates based on national surveys and clinical studies continue to indicate that only about half of older people who have dementia have had a diagnostic evaluation (Lang et al 2017). Should the Task Force fail to change its recommendation, those numbers are unlikely to change, and a rapidly increasing number of older adults will have undiagnosed cognitive impairment.

The USPSTF draft recommendation on detection of cognitive impairment is therefore inconsistent with government, non-governmental organizations and patient and provider preferences in the United States and across the globe.

We urge USPSTF to broaden its consideration to include benefits of cognitive impairment screening to address:

- 1. Identification of modifiable causes of cognitive impairment**
- 2. Risk-reduction and progression of MCI**
- 3. Care for co-occurring chronic conditions**
- 4. Access and utilization of available therapies and support services**
- 5. Identification of safety risks and available information and programs to address the risks**
- 6. Development of a baseline for improved care and better research**
- 7. Value of currently available screening tools**

Addressing modifiable causes of cognitive impairment

Cognitive impairment in older adults takes many different forms and can lead to a variety of health problems, reduce health outcomes, and significantly increase unnecessary utilization of our health care system. The Task Force's current analysis, which states "[O]ne potential harm [of screening] is labeling a person with an illness that is typically progressive and for which treatment appears to have limited effectiveness," assumes that the only cause of cognitive impairment is a progressive neurodegenerative disease. Such an assumption will lead to missed opportunities to determine the cause of cognitive impairment being experienced by a large number of older adults, obtain a differential diagnosis, and implement a treatment and planning protocol appropriate to that diagnosis.

Use of cognitive screening tests and follow-up evaluation can identify cognitive impairment that is caused by treatable conditions that are not dementia but may result in dementia-like symptoms. Such treatable conditions (Mayo Foundation, 2019) include:

- Infections and immune disorders. Fever or other side effects of the body's attempt to fight off an infection can cause cognitive impairment; multiple sclerosis and other conditions in which the body's immune system attacks nerve cells also can cause cognitive impairment.
- Metabolic problems and endocrine abnormalities. Thyroid problems, low blood sugar, too little or too much sodium or calcium, or problems absorbing vitamin B-12 can cause cognitive impairment.
- Nutritional deficiencies. Not drinking enough liquids (dehydration); not getting enough thiamin (vitamin B-1), which is common in people with chronic alcoholism; not getting enough vitamins B-6 and B-12, and copper and vitamin E deficiencies can cause cognitive impairment.
- Medication side effects. Side effects of medications, a reaction to a medication or an interaction of several medications can cause cognitive impairment.
- Subdural hematomas. Bleeding between the surface of the brain and the covering over the brain, which is common in the elderly after a fall, can cause symptoms similar to those of dementia.
- Poisoning. Exposure to heavy metals, such as lead, and other poisons, such as pesticides, as well as recreational drug or heavy alcohol use can lead to cognitive impairment.

- Anoxia. This condition occurs when organ tissues aren't getting enough oxygen; Anoxia can be caused by severe sleep apneas, asthma, heart attack, carbon monoxide poisoning.
- Normal-pressure hydrocephalus. This condition is caused by enlarged ventricles in the brain.

Although these treatable conditions may be identified by other screening and medical tests, a low score on a cognitive screening test is one way that health care professionals become aware of them and begin treatment.

Addressing risk-reduction and progression of MCI

Recent research findings about the impact of programs to reduce potentially modifiable risk factors for dementia suggest that, for as much as one-third of the population, it may be possible to prevent dementia and perhaps also slow the progression of mild cognitive impairment (MCI) to dementia. (Livingston et al, 2017) The results from the comprehensive FINGER study -- excluded from USPSTF consideration -- indicate that lifestyle modifications, including dietary guidance, physical activity, cognitive training, social activities, and monitoring and management of metabolic vascular risk factors, can improve or maintain cognitive functioning in older adults. (Ngandu et al. 2015)

The SPRINT MIND study found that people with hypertension who received intensive treatment to lower systolic blood pressure were less likely to develop memory problems that often progress to dementia than those who were receiving standard blood pressure treatment. The findings showed that keeping tight control of blood pressure can reduce the risk of developing mild cognitive impairment by 19 percent. In fact, the evidence indicates that more than a third of dementia cases are potentially preventable by addressing nine factors accounting for 35 percent of the population dementia risk including, for those over 65, treatment of hypertension, exercise, social engagement, smoking, and hearing loss, depression, diabetes, and obesity. (Williamson et al. 2018)

Brief, inexpensive cognitive training methods have been shown to increase functional independence, maintain accident-free driving, improve mood and enhance cognitive functions for as long as 10 years post training, and may even significantly reduce dementia risk after 10 years. Systematic reviews confirm the effectiveness of cognitive training on everyday function and dementia risk in older people. (citation?)

The USPSTF has already made recommendations related to several of these risk factors for cognitive impairment, including pharmacotherapy and counseling for tobacco cessation; screening and counseling to reduce unhealthy alcohol use; counseling to promote healthy diet and physical activity; statins to reduce cardiovascular disease risk; and screening for hypertension; abnormal blood glucose, and depression, therefore providing primary care providers with ample guidance around preventive interventions indicated for pre-clinical MCI or dementia.

In fact, leading government agencies and advisory groups are aligned in the position that promoting brain health can strengthen the brain's resistance to brain conditions later in life and reduce the risk of dementia.

- The World Health Organization's 2019 Guidelines state "the existence of potentially modifiable risk factors means that prevention of dementia is possible through a public health approach, including the implementation of key interventions that delay or slow cognitive decline or dementia."
- The 2015 Institute of Medicine report on cognitive aging recommends that health and payer systems "promote cognitive health in regular medical and wellness visits among people of all ages."
- The Lancet Commission urged that the "prevention or delay of dementia onset is a public health priority with potential to reduce not only the disability of individuals but also the associated societal and economic burden."
- The American Academy of Neurology, in its latest recommendation calling for annual cognitive assessments, recognized that "early diagnosis can help identify forms of mild cognitive impairment that may be reversible, including those caused by sleep problems, depression or medications, and lead to treatments that can improve a person's quality of life such as correcting hearing loss and avoiding social isolation."
- The American Heart Association noted in its Presidential Advisory that "advances in our understanding of the role of cardiovascular risks have shown them to be closely associated with cognitive impairment and dementia. Because many cardiovascular risks are modifiable, it may be possible to maintain brain health and prevent dementia in later life."
- The Centers for Disease Control and Prevention's Healthy Brain Initiative leads with "(w)hile a person with mild cognitive impairment is at greater risk of developing dementia, this is not inevitable. There is growing scientific evidence that healthy behaviors, which have been shown to prevent cancer, diabetes, and cardiovascular disease, also may reduce risk for cognitive decline and possibly dementia."

The USPSTF, by restricting the evidence assessment to adults who have been screen-detected with cognitive impairment and those with mild to moderate dementia or MCI, considerably underestimates the impact of risk reduction for not only dementia but also for related risk factors such as hypertension, diabetes, and depression. A brain health perspective eschews such binary diagnostic classifications and instead assesses a range of cognitive strengths and weaknesses with a view to recommending appropriate strategies for building brain health. This approach has more in common with a family doctor's periodic assessment of vital signs which might lead her to recommend life style changes such as losing weight, increasing physical activity, engaging in relaxation exercises etc.

By excluding primary prevention trials in which treatment was aimed at preventing or delaying the onset of cognitive impairment in older adults without known cognitive impairment, the USPSTF undermines the central purpose of Task Force recommendations - to evaluate the evidence of preventive interventions for people with no signs or symptoms of the specific disease or condition.

When providers detect the earliest manifestations of mild cognitive impairment or decline, they can prioritize managing interconnected diseases and direct patients to interventions that slow progression. Depending on underlying disease, physicians can potentially help patients reverse mild cognitive impairment, or prevent or delay progression to dementia.

Addressing care for co-occurring chronic conditions

The American Academy of Neurology (AAN) recently released a cognitive impairment quality measure stating that:

“Cognitive impairment is a dominant comorbidity influencing not only what care is recommended for that problem, but also how care for all other illnesses should be provided. Consequently, knowing the cognitive health status of high-risk patients, especially older patients has inherent clinical relevance.” (Foster et al, 2019)

The majority of people with cognitive impairment are living with one or more chronic conditions. (Nelis et al, 2019) While 26 percent of Medicare beneficiaries age 65 and older with Alzheimer’s or other dementias have five or more chronic conditions (including Alzheimer’s or other dementias), only 4 percent of Medicare beneficiaries without Alzheimer’s or other dementias have five or more chronic conditions. (Alzheimer’s Association, 2019)

A systematic review of studies about dementia and co-existing medical conditions found that people with multiple chronic conditions plus dementia had more impairments in functioning than people with multiple chronic conditions and no dementia (Snowden et al., 2018). An analysis of the prevalence and mean costs of care for 15 co-existing medical conditions in people with and without dementia -- including congestive heart failure, chronic renal failure, chronic obstructive pulmonary disease (COPD), diabetes, heart attack and stroke -- found that prevalence and costs were higher for each condition in people with dementia than in those who did not have dementia (Salber et al., 2018). Another review of studies from around the world about care for people with various co-existing medical conditions and cognitive impairment or dementia also found high prevalence of co-existing conditions and some evidence of reduced access to and quality of treatment for those co-existing conditions (Bunn et al., 2014).

People with cognitive impairment or dementia often have difficulty recognizing and reporting symptoms and/or side effects, adhering to medication, and complying with treatment and follow-up recommendations because of deficits in memory, language, judgment, and reasoning ability (McGuire et al., 2006; Boustani et al., 2007; Arlt et al., 2008; Punthakee et al., 2012; El-Saifi, et al, 2018) These deficits can have negative effects on treatment of co-existing medical conditions. For example:

- A study of older adults with heart failure found that those who had cognitive impairment had poorer medication adherence than those without cognitive impairment (Dolansky et al., 2016)

- A systematic review of the impact of cognitive impairment on self-care by people with heart failure concluded that screening for cognitive impairment is essential for effective management of heart failure (Cameron et al., 2017)
- A study of older people with COPD found that those with cognitive impairment or dementia had reduced COPD treatment adherence and effective self-management, including inability to use an inhaler effectively (Baird et al., 2017).

Policies and procedures that improve surveillance among those with significant cognitive impairment may encourage timely diagnosis and treatment that with sufficient support can reduce severity and promote improved health. (Snowden et al.,2018)

Addressing safety risks in older people with cognitive impairment or dementia

Use of cognitive screening tests can prompt health care professionals and others to counsel people with the cognitive impairment or dementia and their families about important safety risks including falls, motor vehicle accidents, gun accidents, and vulnerability to financial exploitation. **Effective resources to identify and address safety risks for people with cognitive impairment or dementia and their caregivers have been developed (Hsieh et al., 2015; Levy-Storms et al., 2017; O’Connor et al., 2019), but are unlikely to be used if cognitive impairment has not been detected.**

- Falls in older people are a significant public health concern, and awareness of the association between fall risk and cognitive impairment and dementia is growing. (Muir, et al. 2012, Montero-Odasso, et al 2017). Early recognition of cognitive impairment can allow for home modifications, exercise programs and other care interventions that may reduce fall risk (Booth V, et al. 2016).
- Cognitive impairment is associated with driving difficulties and increased risk of motor vehicle accidents in older people with cognitive impairment (Fraade-Blanar, et al., 2018., Huisingh et al., 2018; Oh and Rabins, 2019).
- People with dementia may experience delusions, hallucinations, and aggressive behaviors, and a recent study found that approximately 17percent of people with dementia had access to a gun, and nearly half of those people also experienced delusions and behavioral disturbances (49 percent and 44 percent respectively) (Hsieh et al., 2015)
- Older people with cognitive impairment and dementia are at risk of poor financial decision making, including susceptibility to scams and other forms of financial exploitation (Han et al., 2015) One study found that older people may experience poor financial decision making even before their cognitive impairment is diagnosable (Boyle et al., 2012)

Development of a baseline for improved care and better research

Cognitive impairment screening is a measure of brain health. If providers make a screening more routine and systematic, healthcare systems can more quickly detect a change in cognitive status and introduce lifestyle and other risk-reduction strategies. Research shows that indications of treatable cognitive

decline begin well before the symptoms of full-blown dementia occur. The pathology of Alzheimer's dementia may begin as many as 20 years before dementia symptoms surface. (Perl, 2010; Bateman et al., 2012) For this reason, the Alzheimer's Association recommends seniors undergo cognitive impairment screening and evaluation to establish a baseline for comparison, and then have regular follow-up assessments in subsequent years.

The Agency for Healthcare Research and Quality's own commissioned evidence review recognized that the baseline status of study participants needs to be better measured and documented. Medicare, which already provides and recommends a cognitive assessment as part of its Annual Wellness Visit has the opportunity to create such a baseline for improved study using formal guidelines such as those from the NIA and the Alzheimer's Association, yet the Task Force recommends against using them citing lack of said baseline.

Disturbingly, the draft USPSTF Statement omits the fact that dementia is a health disparity and lacks important context for considering how cognitive screening can impact those at greatest risk for dementia. Specifically, Latina/o and other racial/ethnic minority populations (e.g., African Americans) are at significantly increased risk for Alzheimer's disease and related dementias (ADRDs) compared with non-Hispanic white adults. (Chin et al, 2011). Although the causes of these ADRD disparities are likely multifactorial, delayed detection and late diagnosis may be a prime culprit. It is important to note that a potential barrier to early diagnosis is the lack of culturally and linguistically appropriate cognitive screeners and the lack effective screening instruments is limited for special populations, particularly those with intellectual disabilities such as Down syndrome.

Harms associated with misinterpretation of screening results (false positives and negatives) highlighted in the USPSTF's evidence review could be mitigated by appropriate healthcare provider training and routine practices in place to follow up with further evaluation of people whose screening test indicate a problem— as we expect for medical tests more generally. Failure of healthcare systems to implement routine practices for diagnosing and managing patients with screen-detected cognitive impairment or dementia should not be attributed to screening as such.

Five studies of screening for cognitive impairment in older adults that were conducted in the United States show some encouraging results. Four of the studies show an increase in diagnosis of MCI or dementia and increased prescriptions for cognition enhancing medications in older adults with screening-detected cognitive impairment (Boise et al., 2010; Borson et al., 2006; McCarten et al., 2012; Rosenbloom et al., 2015). It is important to note, however, that the four studies also show that many of the older adults with screening-detected cognitive impairment did not receive a follow-up evaluation for MCI or dementia or a desirable change in medications. One additional study conducted in a large community hospital (Boustani et al., 2012) found no significant changes in physician follow-up of patients with screening-detected cognitive impairment. Researchers who conducted these studies noted that "additional efforts are needed to help primary care physicians follow up appropriately on information suggesting cognitive impairment in older patients" (Borson et al., 2006) The researchers

also recommended that “at the very least, a recommendation similar to what the Task Force recommendation on depression screening concluded – that screening is warranted provided systems are in place to follow up with suitable diagnosis and treatment – is warranted with respect to dementia.” (Borson et al, 2007)

Recent studies showed that cognitive impairment goes unrecognized in more than 50 percent of cases among patients aged 70 years or older seen in primary care settings. (Kotagal V, et al 2015) Among older Latinx adults, approximately 40 percent have undiagnosed cognitive symptoms for three years or more. (Novak K et al 2004) Failure to recognize cognitive impairment delays diagnosis, appropriate treatment, and information to improve patients’ and caregivers’ quality of life. (Espino DV 2001) This issue has been raised by the National Task Group on Intellectual Disabilities and Dementia Practice and should be noted in the USPSTF Draft. Naturally, there is value in continuing to develop improved screening tools. The USPSTF Draft could have the unintended consequence of diminishing the perceived and actual return on investment for research focused on developing new screening tools that could provide improved sensitivity, specificity and overall efficacy.

Beyond ensuring that those with the earliest signs of cognitive impairment receive the appropriate interventions, early assessment also plays an important role in improving recruitment for Alzheimer’s clinical research. The majority of interventional studies seek participants with prodromal or early Alzheimer’s – overall, at least 70,000 volunteers are needed to participate in more than 150 active clinical trials and studies designed to better understand, diagnose, treat, and prevent Alzheimer’s disease. Participation in a clinical trial is a very personal and individualized decision that can empower patients facing any life-threatening or life-limiting disease at any stage of life. Without meaningful cognitive impairment detection to enable early diagnosis, individuals with cognitive impairment more often than not lose the opportunity to make that very important and highly personal decision. Failing to encourage screening for cognitive impairment risks similar damage and threatens to have a chilling effect on development of improved screening and diagnostic tools, delay diagnosis of people with MCI and undermine efforts to recruit clinical trial participants for research aimed at earlier and more effective interventions to improve functional and clinical outcomes.

At a time when we have within our grasp opportunities for profound advances in public attitudes and scientific research regarding cognitive impairment and dementia, it is vitally important that USPSTF include in its final Recommendation Statement a Grade B. Such a decision would be evidence-based, in clear alignment with other federal agencies and established national policy. It also would be an ethical step forward in solidarity with people searching for answers about undetected and unexplained emergent cognitive decline.

Thank you for considering our comments. For any questions or additional information, please contact Kelly O’Brien, Executive Director of the Brain Health Partnership at UsAgainstAlzheimer’s at 312-532-4881 or kobrien@usagainstalzheimer’s.org.

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Alzheimer's Drug Discovery Foundation
Alzheimer's Mississippi
Alzheimer's Texas
Alzheimer's Orange County
American Association on Health and Disability
American Medical Women's Association (AMWA)
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Flawless Foundation
Global Coalition on Youth Mental Health
Guadalupe Centers
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The Global Alzheimer's Platform Foundation
The Global CEO Initiative on Alzheimer's (CEOi)
The Kennedy Forum
The Milken Institute Center for the Future of Aging
University of Pennsylvania, School of Nursing
UsAgainstAlzheimer's
Women Against Alzheimer's
YMCA of the USA

*representing individual

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About UsAgainstAlzheimer’s

UsA2 is an innovative non-profit organization committed to driving the change needed to halt the devastating burden of Alzheimer’s Disease by 2025. Powered by our personal experience and the suffering of millions of families, we press for greater urgency from government, industry, and the scientific community in the quest to end Alzheimer’s-- through effective leadership, collaboration, advocacy, and strategic investments.