Bree Collaborative | Alzheimer's and Other Dementias Revision
April 20th 2026| 2:30-4PM PST
Hybrid

MEMBERS PRESENT

Katina Rue, DO, FAAFP, FACOFP, Team Health
Carla Ainsworth, MD, KP
Allyson Schrier
Laura Cepoi, MA, Olympic AAA
LuPita Guitierrez-Parker
Lynne Korte, MPH, DSHS
Nancy Isenberg, MD, MPH, Swedish
Maureen Schmitter-Edgecombe, PhD, WSU
Michelle Graham, MD, MME, FAAFP, UHC
Nina Sanderson, Midwest QIN-QIO
Barak Gaster, MD, UW
Carroll Haymon, MD, Providence Swedish
LuPita Guitierrez-Parker
Vicki McNeally, PhD, MN, RN, WHCA

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Kelly Williams, Midwest QIN-QIO

INTRODUCTIONS

Beth welcomed everyone to the meeting and reviewed the agenda. A quorum was not obtained at the beginning of the meeting, so March minutes were approved later in the meeting. Beth provided brief updates to the workplan, including asynchronous literature gathering, uploading to our SharePoint website, (password BreeDementia2026) and guideline review.

Action: Motion to approve the March minutes
Outcome: March minutes approved

PRESENT & DISCUSS: COGNITION IN PRIMARY CARE – DR BARAK GASTER

Dr. Gaster presented an overview of the Cognition in Primary Care program, highlighting its development, implementation, and the major barriers to effective cognitive impairment diagnosis in primary care.

- Cognition in Primary Care adapts the KAER toolkit for large health systems, integrates training and EHR tools, and has been rolled out across UW medicine and other health systems across Washington.
- Making a diagnosis is the key to improving care, enabling better communication, involving family members and facilitating concrete action plans
- Main barriers in primary care include PCP's lack of confidence, time constraints, insufficient tools and resources to make a diagnosis, and the challenge of fitting comprehensive cognitive testing into standard office visits
- New proposed workflow: abnormal brief screen or concern -> dedicated brain health visit -> visit for cognitive function testing by trained medical assistant (CPT 96138) -> follow-up visit for disclosure of diagnosis

- Discussion

- Dementia has an HCC code with a risk adjustment factor, while MCI doesn't – can influence health system finances under value-based contracts; mention of clinicians tendency to under-diagnose dementia due to lack of efficient assessment tools.
- Blood based biomarkers are only appropriate after diagnosis of cognitive impairment
- There are limitations to using hard numerical score cut offs when diagnosing dementia versus MCI – the diagnosis should be made on clinical judgment and functional assessment, not score on any assessment tool on its own

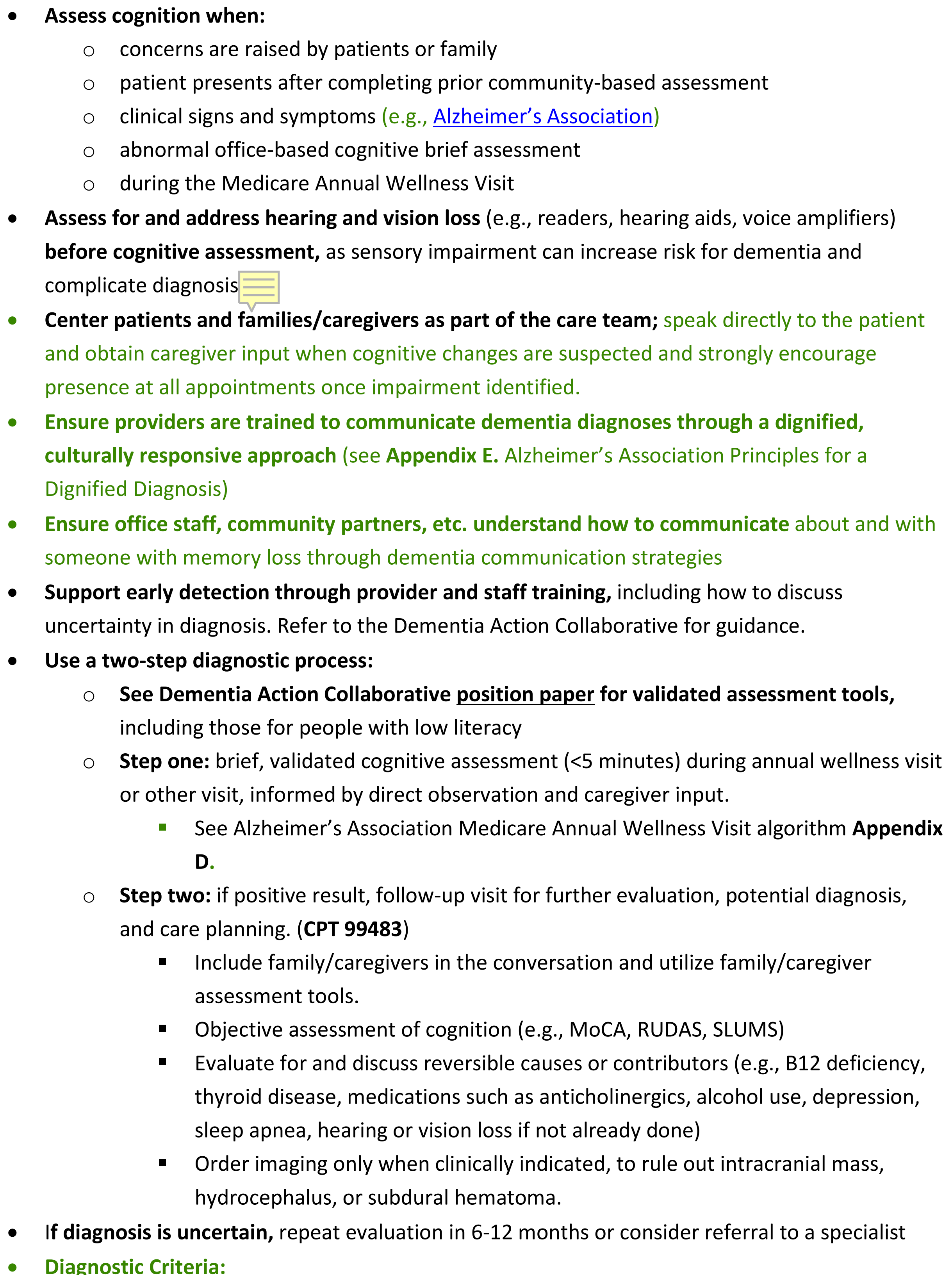
PRESENT& DISCUSS: DETECTION & DIAGNOSIS GUIDELINES

Barak transitioned the meeting to review the draft edits to the detection and diagnosis guidelines. The following changes were made to guidelines:

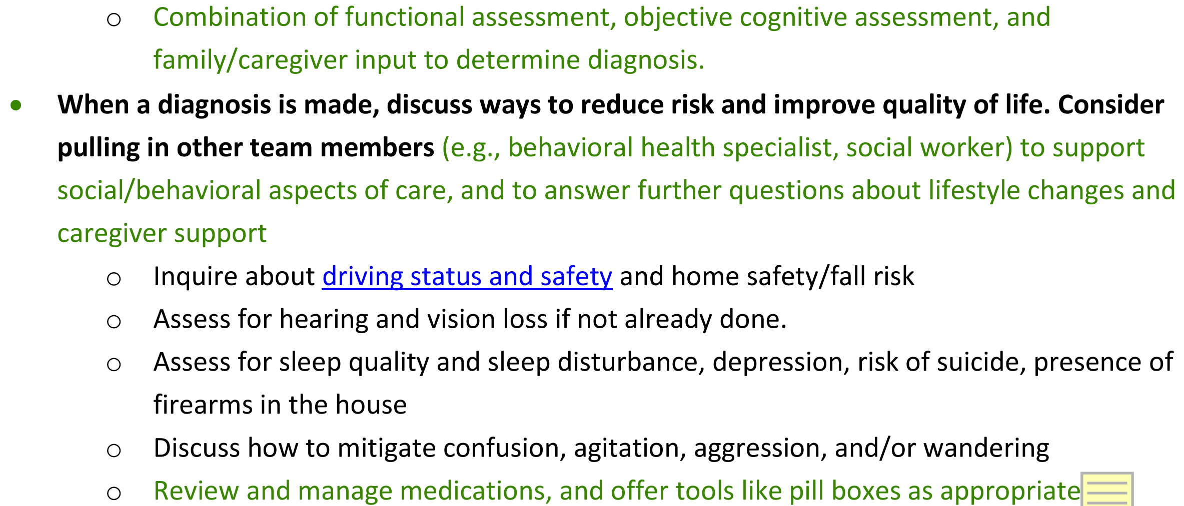
Persons Living with Cognitive Impairment and Families/Caregivers

- **Talk to your health care providers early about any concerns you might have about memory or thinking ability.** Your care team should ask you some questions about this and should set up a follow-up appointment. If you have concerns, speak up or ask.
- It is normal for our brains to change as we age – however, signs of dementia including loss of memory, language, and thinking abilities, are not normal aspects of aging. Dementia is a neurological condition that interferes with daily functioning. You can keep your brain healthy in many ways – see more here
- Some cognitive changes happen as you get older, but…
- **If you've taken an online memory or cognitive test or had a memory assessment with a community based provider, discuss your results with your healthcare team.**
- **Talk to your health care providers about any concerns you have about being able to hear or see.** If you do have difficulty hearing, talk about hearing aids or an assisted listening device (e.g., pocket talker). If you have changes in vision, it's important to get this evaluated and corrected.
  - How to identify hearing loss
  - How to communicate with someone who has hearing loss
- ~~**Make sure you can identify your primary care provider or family doctor.**~~
- **Review the resources developed by the Washington State Dementia Action Collaborative, especially the Dementia Road Map: A Guide for Family and Care Partners.**
  - This tool guides people living with memory loss and caregivers through action steps and questions.
- ~~During diagnosis we recommend that your health care provider follow the **principles outlined in the Alzheimer's Association's Principles for a Dignified Diagnosis**. You can see these principles that have been developed by people living with memory loss here and also listed in **Appendix E**.~~
- **Ask your care team about local resources**. Connect to others in your community who may be going through the same process. Some resources include are available ~~here~~.

Primary Care Clinics



- **Assess cognition when:**
    - concerns are raised by patients or family
    - patient presents after completing prior community-based assessment
    - clinical signs and symptoms (e.g., Alzheimer's Association)
    - abnormal office-based cognitive brief assessment
    - during the Medicare Annual Wellness Visit
- **Assess for and address hearing and vision loss** (e.g., readers, hearing aids, voice amplifiers) **before cognitive assessment,** as sensory impairment can increase risk for dementia and complicate diagnosis
- **Center patients and families/caregivers as part of the care team;** speak directly to the patient and obtain caregiver input when cognitive changes are suspected and strongly encourage presence at all appointments once impairment identified.
- **Ensure providers are trained to communicate dementia diagnoses through a dignified, culturally responsive approach** (see **Appendix E.** Alzheimer's Association Principles for a Dignified Diagnosis)
- **Ensure office staff, community partners, etc. understand how to communicate** about and with someone with memory loss through dementia communication strategies
- **Support early detection through provider and staff training,** including how to discuss uncertainty in diagnosis. Refer to the Dementia Action Collaborative for guidance.
- **Use a two-step diagnostic process:**
    - **See Dementia Action Collaborative** position paper **for validated assessment tools,** including those for people with low literacy
    - **Step one:** brief, validated cognitive assessment (<5 minutes) during annual wellness visit or other visit, informed by direct observation and caregiver input.
        - See Alzheimer's Association Medicare Annual Wellness Visit algorithm **Appendix D.**
    - **Step two:** if positive result, follow-up visit for further evaluation, potential diagnosis, and care planning. (**CPT 99483**)
        - Include family/caregivers in the conversation and utilize family/caregiver assessment tools.
        - Objective assessment of cognition (e.g., MoCA, RUDAS, SLUMS)
        - Evaluate for and discuss reversible causes or contributors (e.g., B12 deficiency, thyroid disease, medications such as anticholinergics, alcohol use, depression, sleep apnea, hearing or vision loss if not already done)
        - Order imaging only when clinically indicated, to rule out intracranial mass, hydrocephalus, or subdural hematoma.
- I**f diagnosis is uncertain,** repeat evaluation in 6-12 months or consider referral to a specialist
- **Diagnostic Criteria:**



- Combination of functional assessment, objective cognitive assessment, and family/caregiver input to determine diagnosis.

- **When a diagnosis is made, discuss ways to reduce risk and improve quality of life. Consider pulling in other team members** (e.g., behavioral health specialist, social worker) to support social/behavioral aspects of care, and to answer further questions about lifestyle changes and caregiver support
  - Inquire about driving status and safety and home safety/fall risk
  - Assess for hearing and vision loss if not already done.
  - Assess for sleep quality and sleep disturbance, depression, risk of suicide, presence of firearms in the house
  - Discuss how to mitigate confusion, agitation, aggression, and/or wandering
  - Review and manage medications, and offer tools like pill boxes as appropriate

Discussion

- Discussion about the desire of family caregivers to have alone time with the provider to share concerns, but often providers will speak directly to caregivers without speaking to the person with cognitive impairment about their own health
- More and more younger people are beginning to have cognitive impairment concerns – want to call attention to that

PUBLIC COMMENT AND GOOD OF THE ORDER

Barak invited final comments or public comments, then thanked all for attending. We will continue the conversation on detection & diagnosis in May. The workgroup's next meeting will be on Wednesday, May 11th from 2:30-4PM.