VIEWPOINT

AGING AND HEALTH

# Importance of Function for Alzheimer Diagnosis and Management—More Than Memory

Nathaniel A. Chin, MD; Claire M. Erickson, PhD, MPA; Eric Widera, MD

The Food and Drug Administration approval of 2 blood tests to detect amyloid plaques marks a breakthrough moment for Alzheimer disease.[1] Compared with diagnostics based on cerebrospinal fluid or positron emission tomography imaging, blood biomarkers are much more accessible and provide a more streamlined path to potential treatments and clinical trials. Yet, the growing enthusiasm for biomarkers risks obscuring a fundamental truth: biomarkers only reflect disease pathology. They cannot assess cognition or illuminate the functional changes that transform memory concerns into meaningful impairment. If we rush to adopt blood biomarkers as a frontline solution in primary care, we risk neglecting what should remain the unique and irreplaceable role of primary care: assessing cognitive concerns through a clinically grounded approach that begins with and depends on a functional assessment.

Primary care practitioners (PCPs) are often the first to hear about cognitive changes and are best positioned to assess function due to the long-standing and trusting relationships they hold with patients. These relationships allow PCPs not only to detect subtle deviations from a patient's functional baseline but also to create the safe space needed for patients and families to share vulnerable or emerging issues. Yet PCPs typically have just 18 minutes to address concerns, manage chronic conditions, provide preventive care, and maintain rapport.[2] In this time-pressured reality, evaluations of cognitive symptoms must be efficient and productive. Blood biomarkers may appear to offer a convenient solution, but they only provide a piece of the diagnostic puzzle—the likelihood an individual has amyloid pathology in the brain. They cannot distinguish normal aging from mild cognitive impairment (MCI), nor MCI from dementia.[3] Functional assessments, on the other hand, can establish disease severity, identify safety risks, and capture the daily disabilities that make cognitive change consequential: missed medications, unpaid bills, disorientation while driving, difficulty managing appointments, or declining meal preparation.

A careful, systematic initial evaluation of function gives PCPs a window into the capabilities that define daily life. Function is the lived expression of cognition. It stages cognitive syndromes in ways cognitive screening tests and biomarkers cannot.[4] A patient with memory complaints who remains independent suggests normal aging or MCI; a patient struggling with instrumental activities of daily living (IADLs), such as paying bills or keeping appointments, likely has dementia. Disabilities in activities of daily living (ADLs) mark a profound shift with implications for autonomy, safety, and quality of life. They also serve as markers for the syndromic diagnosis of MCI or dementia, which anchors all subsequent decisions, guides treatments, and directs future referrals.

Understanding the degree and cause of functional decline enables clinicians to identify reversible contributors, recommend lifestyle interventions, and support patients and their caregivers through emotional and logistical challenges. Functional changes also raise critical safety issues—such as medication errors, unsafe driving, or vulnerability to exploitation—and guide counseling about autonomy, home safety, and future planning. As dementia progresses, measured by changes in IADLs and ADLs, care becomes increasingly palliative, focused on symptom relief and caregiver support, with conversations that evolve as caregiving demands intensify. Above all, functional history resonates with what matters most to patients and families: preserving independence and identity in daily life. Prioritizing function grounds evaluation in lived experience, allowing patients to share their struggles and families to voice observations that validate previously unspoken concerns. As function erodes, it marks both clinical thresholds and emotional turning points—moments when help is needed, roles shift, and futures must be reimagined.

Functional assessment can be supported with workflows for collecting information that fit into busy schedules. Documentation templates in the electronic health record can prompt and streamline assessments; trained staff can collect functional details during the rooming process; and validated questionnaires, such as the Functional Assessment Questionnaire or Lawton Instrumental Activities of Daily Living Scale, can offer efficient, semistructured formats. A simple table of IADL and ADL abilities completed in the waiting room or while vitals are taken can capture meaningful data and serve as a starting point for open-ended conversations. Alternatively, functional questionnaires can be mailed or sent electronically in advance of a visit, allowing patients and collateral historians to report changes before the appointment. When functional assessment is routinely conducted, follow-up appointments can reduce redundancy by focusing on any changes since the prior visit. These strategies make functional assessment more feasible and consistent within the constraints of real-world primary care practice.

A good functional history, just like a good medical history, can never be reduced to only yes-or-no questions. Clinicians must go beyond checklists to uncover deeper insights. For example, a patient who responds "doing fine" to a closed-ended question about managing finances may reveal, when asked "what's it like for you to pay bills now?" that a spouse has taken over financial responsibilities. Similarly, a patient may deny getting lost while driving, but a caregiver might note that the car hasn't been driven in months when asked, "what's driving been like lately?" Although open-ended questions may prompt longer responses, they can

more efficiently uncover both what patients are doing and how they manage daily tasks. These nuanced details carry substantial diagnostic value, including distinguishing cognitive-driven functional decline from limitations caused by mobility issues, pain, or depression.

Medical education often emphasizes cognitive screening tests but rarely teaches how to uncover the patient's daily realities, particularly in a time-constrained visit. Improved training during medical school, residency, and continuing education could help clinicians gain comfort with inquiry and response to disclosure of functional impairments. The ability to conduct a thorough functional history—from structured questionnaires to open-ended questions—is a teachable skill. It involves knowing which daily activities to explore, asking questions that elicit meaningful details, and incorporating observations from family members or caregivers. In time-limited encounters, clinicians may start by focusing on IADLs—where early impairment typically emerges—and move to basic ADLs if all instrumental functions are affected. As clinicians refine these techniques, they become more adept at identifying responses that warrant further investigation, ultimately improving the efficiency and accuracy of functional assessments.

Supporting primary care means enabling clinicians to do what they do best: build on long-standing relationships to collect meaningful histories, diagnose syndromes, stage disease, and partner with patients and families in care planning. Functional assessment is a clinical framework, rooted in patient-centered care and adaptable to time-constrained systems. When PCPs are given the resources to use this framework effectively, they can lead not only in identifying MCI and dementia but in managing these conditions over time.

Alzheimer care is increasingly complex, requiring more specialized knowledge, enhanced training in pretest and posttest counseling, and nuanced interpretation of diagnostic tools—expectations that can easily overburden already stretched primary care practices.[5] Recent progress in the field can add value once a syndrome and stage are established, but diagnostic advances and emerging therapies cannot replace the preceding foundational evaluation.[4] The shortage of specialists is not a reason to bypass this process; rather, it is a call to strengthen primary care's ability to lead in diagnosis, staging, and management. Technology will continue to advance, but the evaluation of cognitive symptoms still begins where it always has—not with a vial of blood, but with the story of functional change and the compassion to listen.

## ARTICLE INFORMATION

**Author Affiliations:** Division of Geriatrics & Gerontology, Department of Medicine, University of Wisconsin School of Medicine and Public Health, Madison (Chin); Banner Alzheimer's Institute, Phoenix, Arizona (Erickson); Division of Geriatric Medicine, Department of Medicine, University of California, San Francisco, San Francisco (Widera); San Francisco Veterans Affairs Healthcare System, San Francisco, California (Widera).

**Corresponding Author:** Nathaniel A. Chin, MD, Division of Geriatrics & Gerontology, Department of Medicine, University of Wisconsin School of Medicine and Public Health, 600 Highland Ave, K6/434, Madison, WI 53792 (nachin@wisc.edu).

**Published Online:** February 9, 2026. doi:10.1001/jamainternmed.2025.7621

**Conflict of Interest Disclosures:** Dr Chin reported receiving personal fees for serving on a New Amsterdam Pharma Consulting advisory board on cholesterol medication and phase 3 clinical trial development and personal fees from Eli Lilly for serving on an advisory board on health care needs for a time when preclinical Alzheimer disease may be addressable, outside the submitted work. No other disclosures were reported.

## REFERENCES

1. Hu S, Yu H, Gao J. The pTau217/$A\beta_{1-42}$ plasma ratio: the first FDA-cleared blood biomarker test for diagnosis of Alzheimer's disease. *Drug Discov Ther*. 2025;19(3):208-209. doi:10.5582/ddt.2025.01055

2. Neprash HT, Everhart A, McAlpine D, Smith LB, Sheridan B, Cross DA. Measuring primary care exam length using electronic health record data. *Med Care*. 2021;59(1):62-66. doi:10.1097/MLR.0000000000001450

3. Widera E, Covinsky K. The limited role of Alzheimer disease blood-based biomarkers in primary care. *JAMA Intern Med*. 2025;185(7):755-757. doi:10.1001/jamainternmed.2025.0976

4. Jack CR Jr, Andrews JS, Beach TG, et al. Revised criteria for diagnosis and staging of Alzheimer's disease: Alzheimer's Association Workgroup. *Alzheimers Dement*. 2024;20(8):5143-5169. doi:10.1002/alz.13859

5. Erickson CM, Largent EA, O'Brien KS. Paving the way for Alzheimer's disease blood-based biomarkers in primary care. *Alzheimers Dement*. 2025;21(1):e14203. doi:10.1002/alz.14203