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Testing for Alzheimer Disease Biomarkers and Disclosing Results Across the Disease Continuum

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Abstract

Three pathological processes define or are characteristic of Alzheimer's disease (AD): amyloid- β , hyperphosphorylated tau, and neurodegeneration. Our understanding of AD is undergoing a transformation due to our ability to measure biomarkers of these processes across different stages of cognitive impairment. There is growing interest in using AD biomarker tests in care and research and, with this, a growing need for guidance on how to return these sensitive results to patients and participants. Here, we propose a five-step approach informed by: clinical

and research experience designing and implementing AD biomarker disclosure processes; extant evidence describing how individuals react to AD biomarker information; ethics; and the literature on breaking bad news. The clinician should (1) determine the appropriateness of AD biomarker testing and return of results for the particular patient or research participant. If testing is appropriate, the next steps are to: (2) provide pre-test education and seek consent for testing to the individual and their support person; (3) administer testing; (4) return the results to the individual and their support person; and (5) follow up to promote the recipient's wellbeing and to learn from their experience. We conclude by identifying open questions to guide future studies of biomarker disclosure.

Introduction

Until quite recently, many clinicians refrained from disclosing diagnoses of dementia to patients. This reflected a desire to protect patients from adverse psychological effects, such as “depressive illness, suicide or catastrophic reaction.”¹ Yet, studies did not support this practice. Most patients wished to be fully informed and, if they were informed, learning their dementia diagnosis generally did not cause the harms feared.² These data, together with the ability to prescribe treatments such as acetylcholinesterase inhibitors and long term care services and supports led to a change in practice. Patients ought to be told a diagnosis of dementia, and disclosure protocols have since been developed.

There are parallels between the history of dementia disclosure and the current state of Alzheimer's disease (AD) biomarker disclosure. Questions about the appropriateness of biomarker disclosure are giving way to a recognition that disclosure is generally safe and that many individuals want to know their results. Disease-modifying treatments will soon be available, making biomarker information more medically actionable and also spurring widespread availability of biomarker testing. All this has resulted in growing interest in disclosing AD biomarkers in both clinical and research contexts and while also highlighting the need for guidance on how to disclose them with due scientific and ethical care.

This article outlines a five-step disclosure process: assessing the appropriateness of testing for a particular individual and, if it is appropriate, delivering pre-test education and seeking consent, administering testing, returning results, and providing for follow-up. In developing this disclosure process, we have drawn upon our own experience designing and implementing AD biomarker disclosure processes, as well as others' disclosure recommendations; available evidence describing how individuals react to learning AD biomarker results; legal and ethical considerations salient to AD biomarkers; and insights from the literature on breaking bad news to patients.

Overview of AD Biomarkers

Three pathological processes define AD: deposition of amyloid- β fibrillar plaques, accumulation of hyperphosphorylated tau-based neurofibrillary tangles, and neuronal and synaptic degeneration or neurodegeneration.³ Biomarkers for these three processes can be measured using various modalities, including positron emission tomography (PET), cerebrospinal fluid (CSF) assays, and magnetic resonance imaging (MRI). These modalities differ in important ways. Measures of molecular pathology can indicate the pathology's presence or absence or its regional distributions and overall load. Biomarkers of neurodegeneration are not specific to AD, though their regional distribution can suggest AD.

AD biomarkers can be applied across different stages of cognitive impairment. They can explain whether AD is the likely cause of a person's dementia or Mild Cognitive Impairment (MCI). Biomarkers can also provide risk stratification: their presence increases the likelihood of progression from MCI to dementia. Because AD neuropathology can be present years or even decades before the onset of measurable cognitive impairment, biomarkers can be measured in people who have cognitive complaints but continue to perform normally on cognitive testing—that is, those with subjective cognitive impairment—as well as in those who are unimpaired and asymptomatic. For these persons, biomarker tests inform their risk of future cognitive impairment caused by AD; presently, however, we lack a precise understanding of what AD biomarkers mean for the individual.

To date, access to AD biomarker testing has, outside of research, been limited. The confluence of reasons for this includes: the burdens of testing for individuals; the specialized resources needed to conduct testing or the expertise needed to interpret results; and the substantial expense coupled with a lack of insurance coverage.¹/25/2023 5:31:00 PM Recent advances in blood-based biomarker tests will likely overcome many of these barriers. Some blood-based tests are already commercially available, though there are ongoing discussions about appropriate use.⁴ When disease-modifying therapies for AD become widely available, biomarker testing will likely be used to inform identification of individuals for whom therapy is indicated and so will be covered by insurers. Lowered barriers to testing and increased medical actionability of results will speed uptake of AD biomarker testing, including in clinical settings beyond specialized memory centers.

Overview of AD Biomarker Disclosure

The prospect of widespread AD biomarker testing—and, with it, widespread disclosure of results—lends importance to the project of understanding disclosure's effects and of developing best-practices.

AD biomarker results, typically amyloid- β PET scan results, have been disclosed in research settings—both in clinical trials where their presence is an eligibility criterion and in longitudinal cohort studies.⁵ Researchers have developed protocols for disclosing amyloid- β PET scan results to either cognitively unimpaired or cognitively impaired individuals.^{6–8} These protocols

consistently incorporate practices intended to: ensure participant understanding, communicate results effectively, and promote participant safety.

Trials and studies incorporating AD biomarker disclosure have offered opportunities to discover disclosure's effects on older adults and their family members.^{9–11} A limitation of this research is that participants in studies of disclosure—like participants in AD research more broadly—are not representative. There is an urgent need to study disclosure in broader populations.

Studies have addressed several concerns that loomed over disclosure.^{12–16} With adequate pre- and post-test education, individuals generally recall and understand the import of their AD biomarker results.^{17,18} Further, education and psychological screening allow for safe delivery of these results. Individuals who learn they have “elevated” amyloid- β , indicative of AD neuropathology, are no more likely than those receiving a “not elevated” result to experience clinically significant anxiety, depression, or suicidality.^{10,19}

Learning AD biomarker results does, however, have an emotional impact. Cognitively unimpaired persons who learn they have “elevated” amyloid- β have increased scores on the Impact of Events Scale (IES), a measure of distress caused by traumatic events.¹⁰ By comparison, cognitively unimpaired individuals who learn a “not elevated” result almost uniformly express relief.^{9,20} Some cognitively impaired individuals experience emotional distress after learning they have “elevated” amyloid- β , as reflected in increased IES scores.¹⁹ Persons with subjective cognitive impairment or MCI who receive “not elevated” results may express frustration because they lack an explanation for their cognitive complaints; others experience relief, given the reduced likelihood of symptom progression.⁹

Cognitively unimpaired adults use biomarker results to shape future plans and may adopt new behaviors to promote brain health.⁶ Individuals with MCI or mild-to-moderate dementia may benefit from a conclusion of their diagnostic odyssey. AD biomarker testing may avert delayed and missed diagnoses as well as imprecise medical management. Even at the dementia stage, etiological misdiagnosis is common.²¹ AD biomarker results can thus provide valuable diagnostic and prognostic information and assist cognitively impaired adults and their families in future planning.²²

Family members' emotional reactions to AD biomarker results typically parallel the reactions of the older adult who undergoes testing, and family members use the results to inform their own future plans.^{11,20} For instance, some anticipate and prepare for caregiving responsibilities.¹¹ Clinicians use biomarkers to more confidently deliver diagnoses, reduce additional or unnecessary testing, change diagnoses when AD biomarkers conflict with initial clinical impressions, and instruct treatment choices.^{23–25}

Commonalities across published disclosure protocols and empirical insights into the effects of AD biomarker disclosure, as well as recognition of ethical and legal challenges with particular salience to AD biomarkers, informed the development of our 5-step AD biomarker disclosure process, which we turn to next.

AD Biomarker Disclosure Process

Several preconditions and assumptions frame this process, which is summarized in Figure 1. First, a knowledgeable clinician will disclose AD biomarker results. At minimum, this clinician should have facility discussing cognitive impairment, disease staging, and AD biomarkers, and also confidence interpreting and contextualizing biomarker test results.²⁶

Second, AD biomarker disclosure is just one aspect of an individual's participation in research or receipt of care. This process therefore assumes that cognitive testing—and any necessary clinical assessment—has already been completed when a clinician contemplates biomarker testing. Adjustments to the disclosure process are warranted to account for an individual's cognitive stage.

A closely related consideration is whether the individual has decision-making capacity.²⁷ Capacity is not the same as cognition; however, the presence of cognitive impairment suggests capacity may also be impaired and should prompt a capacity assessment. If the clinician determines that the individual lacks decision-making capacity, a surrogate decision maker should be prospectively identified and included throughout the disclosure process.

Finally, the clinician should recommend that a family member, close friend, or other member of an individual's support network (hereafter, “support person”) be included in the AD biomarker disclosure process.²⁸ A support person's inclusion is likely to enhance the diagnostic process, support decision making, and facilitate the steps following disclosure. Nevertheless, some individuals, particularly those who are cognitively unimpaired or have MCI, may decline because they fear stigma or a loss of privacy.²⁹

Step 1: Determine Appropriateness of AD Biomarker Testing and Return of Results for This Individual

The ordering clinician must determine whether it is appropriate to offer AD biomarker testing to any given individual. Determination of appropriateness inherently has a ‘case-by-case’ quality, as features of the specific test, the clinical or research context, and the individual's circumstances will vary and merit consideration.

Cognitively Unimpaired, with or without Cognitive Complaints

Biomarker testing is not indicated in the clinical care of cognitively unimpaired individuals.³⁰ This position will evolve with the approval of a disease-modifying therapy that makes a diagnosis of preclinical AD—that is, when AD biomarkers are present in individuals who have no measurable cognitive impairment—medically actionable and with greater understanding of the implications of these results for individuals.

For now, disclosure of AD biomarkers to cognitively unimpaired individuals should be limited to research, the design of which allows for discoveries about the impact of learning the result. In interventional studies that assign treatment to persons who are biomarker positive, disclosure of biomarker results allows for an efficient study. It also protects biomarker negative individuals from the risks of study participation and contributes to knowledge about the experience of being biomarker positive.¹⁵ In longitudinal cohort studies, such as those tracking the progression of disease using biomarkers, disclosures should be accompanied by assessments of the effects on individuals and their support persons.

Cognitively Impaired: MCI or Dementia

For individuals with MCI or dementia who desire to know their AD biomarker results, disclosure can permissibly be offered in both clinical and research contexts. Even when biomarker disclosure is undertaken as a clinical activity to inform diagnosis or care, there may be value in conducting research to understand how individuals react to and use their results or in referring them to other relevant research opportunities.

After considering the individual's cognitive stage and the potential utility of AD biomarker testing and before recommending the test, the clinician should assess the individual's psychological readiness to receive the result. This assessment includes an evaluation of the individual's (and, as appropriate, their support person's) current thinking around their condition. The clinician should consider depression, suicidality, and presence of recent or ongoing significant life stressors.⁶ Individuals may be candidates for AD biomarker testing even if they are experiencing depression or anxiety. In fact, they may be particularly good candidates if these psychiatric symptoms are judged to be the consequence of a neurodegenerative disease.³¹ If serious psychiatric symptoms are identified, the clinician should offer care as necessary and exercise clinical judgment as to whether to delay or abandon testing.

Step 2: Provide Pre-Test Education and Seek Informed Consent

The aim of pre-test education is to ensure individuals understand the strengths and limitations of the proposed AD biomarker test: what it can and—as important—what it cannot do. For example, can it offer prognostic information about the timing or rate of decline? The discussion of strengths and limitations will differ depending upon which AD biomarkers are being tested and the testing modality. Education should address possible results and their implications for care or research.

Further, education should address the results' implications for the individual's life, broadly construed. These include their utility for future planning but also their potential, if shared, to precipitate stigma or discrimination. Individuals, particularly cognitively unimpaired individuals, ought to be told about and understand the risks—such as the possibility for discrimination by

insurers, employers, or continuing care communities—and the gaps in existing legal protections for AD biomarker results.^{32,33} Prospective research participants should understand whether these results will be part of their medical record (or kept in a research record) and the consequences of a loss of confidentiality.³⁴

Table 1 provides exemplary prompts for introducing these topics and for assessing individuals' understanding (their knowledge of facts) and appreciation (how they apply these facts to themselves).

The pre-test education process culminates in the clinician seeking the individual's voluntary informed consent—or informed refusal—for biomarker testing. If the individual lacks capacity, the clinician must identify their surrogate decision maker; seek that surrogate's permission; and, if appropriate, seek the individual's assent or dissent.³⁵

In select instances, an individual may previously have consented to and undergone AD biomarker testing in the course of research—for example, as part of a longitudinal cohort study—but their result went unreturned.³⁰ The clinician-investigator may now be contemplating return of results. *Step 1* and *Step 2* should still be followed before proceeding to *Step 4*. In such cases, it is important to frame the result as “a snapshot in time” and note it may have since changed.

Step 3: Administer the AD Biomarker Test

It may be desirable to perform the test on a different day than the pre-test education and consent. This grants individuals time to reflect and, potentially, change their mind.²³ A pause may be more beneficial for some individuals than others and so, like the appropriateness of testing, should be determined case-by-case. For example, an individual with MCI—given the prognostic implications and, perhaps, greater emotional significance of biomarker results—may have more need for a pause than an individual with dementia.

Individuals should know when to expect their result. It may be useful to schedule a return-of-results visit at the time of testing. In the United States, the 21st Century Cures Act requires, among other things, that clinical test results rapidly be made available to patients.³⁶ Clinicians should be aware that individuals who undergo biomarker testing in a clinical context might have access to AD biomarker results via their electronic medical record *before* the return-of-results visit. If this is a possibility, the clinician ought to discuss with the individual and support person at the time of testing how they want to first learn the result (i.e., self-mediated via the electronic medical record or clinician-mediated in a visit).

Step 4: Return the AD Biomarker Results

The time between testing and the return of AD biomarker results allows for additional reflection. Therefore, before returning results, it is important for the clinician to ascertain the individual's continued desire to learn them.

After sharing the ‘headline,’ the clinician should explain the result’s meaning and discuss next steps with the individual and their support person. Table 2 includes prompts for returning AD biomarker results, which may feel familiar to clinicians who have experience disclosing other sensitive health information.

Some AD biomarker results will be perceived by individuals and support persons as “bad news.” How bad news is discussed can affect an individual’s comprehension, satisfaction, and their subsequent psychological adjustment.³⁷ Therefore, the prompts reflect established methods for breaking bad news. One such method is the SPIKES protocol; SPIKES stands for Setting, Perception, Invitation for information, Knowledge, Empathy, Summarize and strategize.³⁷ Baile et al, who developed the SPIKES protocol, describe four essential goals of disclosing bad news: (1) gather information from the patient; (2) provide information in accordance with the patient’s needs and desires; (3) support the patient; and (4) form a treatment plan with the patient’s input and cooperation.³⁷

As noted above, some individuals may have seen their AD biomarker result before the return-of-results visit via their electronic medical record. (Or, they may have learned the result in a different context and are now seeking the clinician’s opinion.³⁸) If the individual has previously learned their result, the clinician can ask the individual to relay it in their own words; what they say will inform the subsequent dialogue.

Cognitively Unimpaired, with or without Cognitive Complaints

Individuals who are cognitively unimpaired or who have subjective cognitive complaints will be interested in learning their risk for developing cognitive impairment caused by AD. The AD field is still developing risk prediction tools and does not have any widely accepted tools akin to what is available, for example, for heart disease or hip fracture. Nevertheless, studies offer some risk-prediction data. Clinicians should identify the studies most relevant to their participant population and be prepared to discuss them. Emphasizing uncertainty—for instance, that AD biomarkers cannot speak to onset, rate of progression, or prognosis—is important when returning results to cognitively unimpaired individuals.

Because AD biomarker testing for this population should only occur in a research context, the discussion should also address how, if at all, the result affects their participation in research—for example, their eligibility to participate in a clinical trial.

Cognitively Impaired: MCI or Dementia

Whether AD biomarker disclosure occurs in the course of care or research, it is important to discuss the result’s implications for clinical care with cognitively impaired individuals.

If the biomarker results—consistent with the broader clinical picture—suggest impairment is likely caused by AD, there should be a discussion of what additional changes in cognition and

function might be expected moving forward, as well as a timeline for these changes. A diagnosis of definite AD should also address the potential for additional pathologies to be present in the brain and contribute to cognitive symptoms. This is a time to discuss medical interventions and caregiving needs; these conversations will, of course, be shaped by the availability of disease-modifying drugs.

For other individuals, the results may indicate that their cognitive impairment is likely *not* caused by AD. In such cases, the clinician can provide information about other potential etiologies and discuss next steps in diagnosis or care.

If the individual is not already enrolled in a study or trial, the clinician might share information about clinical trials or longitudinal cohort studies for which the individual's biomarker profile makes them eligible.

For biomarker positive individuals, two additional topics are relevant regardless of the individual's cognitive stage. First, clinicians might highlight the importance of life planning—such as identifying people to provide assistance in making decisions, drafting advance directives or wills, and reviewing plans for paying for long term care services and supports. Clinicians can refer individuals and their support persons to a social worker, if available; alternatively, they might encourage individuals to seek out reputable resources and professional advice. Second, clinicians should discuss pursuing a healthy lifestyle and avoiding unproven treatments. AD is deeply feared, and desperation can render persons with AD biomarkers vulnerable to trying interventions that lack evidence of efficacy or that are potentially harmful.³⁹

Step 5: Check-In and Provide for Follow-Up

Individuals and their support persons may need additional time to reflect on the information they have received. Therefore, following the disclosure of AD biomarker results, it is desirable that the clinician check-in with the individual, their support person, or both to confirm their understanding of the results, ascertain how they are feeling, and ask if they have any questions. This is an opportunity to clarify or provide further information and to address any concerns. The necessity of this check-in will depend on the result and how the disclosure process unfolded in terms of the individual's or support person's understanding and emotions. For instance, biomarker positive persons who are cognitively unimpaired but now understand themselves to be at heightened risk for impairment may benefit from a check-in call or visit. In contrast, persons with well-characterized dementia who expected and accepted their result may simply need an invitation to reach out with questions.

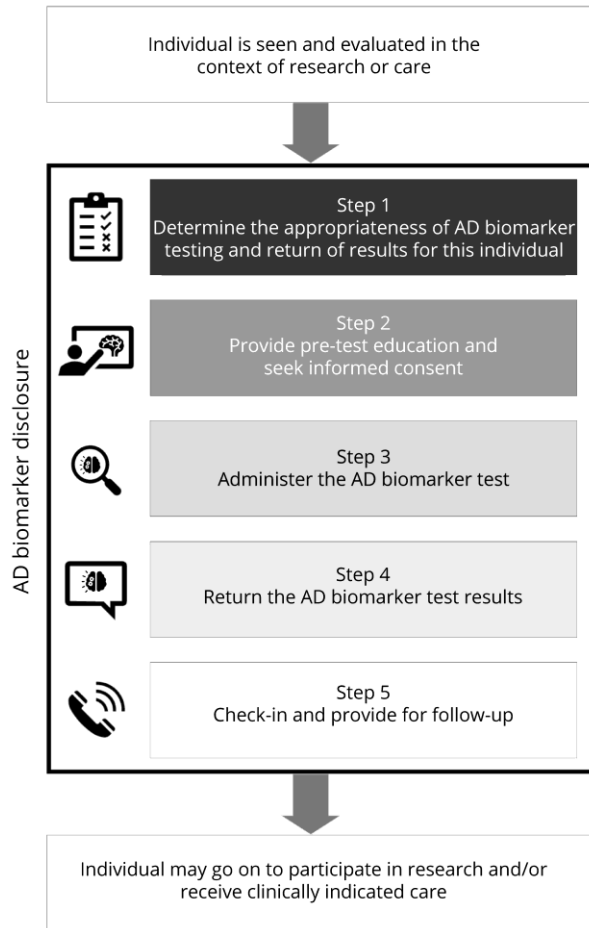
Additionally, as the disclosure process concludes, there ought to be a clear plan for post-disclosure follow-up. The precise nature of follow-up, and whether that includes research or care, will depend on the individual's AD biomarker result, cognitive stage, and preferences. For cognitively impaired individuals, follow-up might include the provision of medical care and

identification of community-based services and supports to address unmet needs.⁴⁰ For cognitively unimpaired individuals, it might include participation in an interventional study or a study of disclosure's effects. Follow-up may be handled by the disclosing clinician, by other members of the care team, or by additional professionals as appropriate.

Conclusion

Over time, diagnostic disclosure practices change, often reflecting a move away from paternalism and withholding toward respecting autonomy through truth-telling. Although an MCI or dementia diagnosis can be highly emotionally charged, practice has evolved, and individuals are now understood to have a right to know these diagnoses. As AD biomarkers become more clinically valuable, individuals will understandably want and reasonably expect to receive these results, too, despite their emotional charge. Guidance is needed to ensure that AD biomarker information is delivered in a manner that is scientifically and ethically informed. To that end, we have proposed a five-step process that can be used in research or care and that seeks to ensure individuals understand the test, their results, and the implications for their lives. We anticipate that, as the care and research contexts evolve, so too will this process.

Figure 1. The five-step Alzheimer’s disease (AD) biomarker disclosure process. This disclosure process is to be led by a knowledgeable clinician and embedded within the individual’s ongoing participation in research or receipt of care, which is understood to include cognitive testing and capacity assessment.



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TABLE 1. PRE-TEST EDUCATION

GET READY

- Ensure appropriate conditions for pre-test education (e.g., private place, adequate time for discussion).
 - Make sure you have the right people in the room – ideally, the individual and their support person, such as a family member or close friend.
 - If the individual is reluctant to have someone join them: *“I recommend having someone join you. There are several reasons I recommend this. Someone you know and trust can provide emotional support, help you make sense of the results, and, going forward, assist you. By assistance, I mean keeping an eye on how you are doing and helping out, if you need it. The choice of whether to bring someone into this is yours, of course.”*
 - If the individual has identified someone to join them: *“I’m glad that [your friend] is here with you. Having someone you know and trust can provide emotional support, help you make sense of the results, and, going forward, assist you. By assistance, I mean keeping an eye on how you are doing and helping out if you need it.”*
 - Have any information you need on hand (e.g., results of cognitive testing and functional assessment); this pre-test education guide assumes that you have already discussed any cognitive testing results with the individual.
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ASSESS WHAT THE INDIVIDUAL KNOWS ALREADY

- Consider social and cultural context, including stigma and perceptions related to inevitability or addressability.
 - Individuals may have misperceptions, and these should be addressed.
 - *“Tell me about what you learned from our discussion of your cognitive testing?”*
 - *“What, if anything, have you learned about Alzheimer’s disease biomarkers or biomarker testing?”*
-

EDUCATE THE INDIVIDUAL ABOUT COGNITION, ALZHEIMER’S DISEASE, AND BIOMARKERS

- Break the education up into manageable blocks of information.
 - Topics to cover:
 - What is an Alzheimer’s disease biomarker? How is an Alzheimer’s disease biomarker result different from a diagnosis of cognitive impairment such as dementia or MCI?
 - If the individual is cognitively unimpaired: *“Cognitive impairment describes problems with memory and thinking. Right now, our tests suggests that you aren’t cognitively impaired, although I realize that you have some concerns. Biomarkers help us understand if there are changes in your brain that might place you at increased risk of developing cognitive impairment in the future.”*
 - If the individual is cognitively impaired: *“Cognitive impairment describes problems with memory and thinking. As we discussed before, you have [Mild Cognitive Impairment/dementia]. Cognitive impairment can have many causes; one common cause is Alzheimer’s disease. Biomarker tests can help us understand whether your cognitive impairment is likely caused by Alzheimer’s disease, but these tests do not identify other diseases that cause cognitive impairment.”*
 - What is the nature of the specific AD biomarker test(s) being proposed? Address which biomarker(s) will be tested, the modality, and limitations of the test.
 - *“Alzheimer’s disease can be measured using various biomarkers. One of them is called [amyloid]. We can test for biomarkers in various ways, the test I am recommending that you undergo is a [PET scan]. The PET scan takes pictures of your brain and allows us to measure amyloid.”*
 - If the individual is cognitively unimpaired: *“A positive scan means that you’re at greater risk of developing cognitive impairment caused by Alzheimer’s disease in the future. A negative scan usually means you’re at lower risk for developing Alzheimer’s disease in 10 or more years; usually amyloid is present at least a decade before symptoms become apparent .”*
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- If the individual is cognitively impaired: “A positive scan may mean your symptoms are likely due to Alzheimer’s disease, although it is still possible other conditions could be primary drivers or contributing to your symptoms. A negative scan almost always means Alzheimer’s disease is not the cause of your symptoms.”
- What are the benefits or upsides of learning an AD biomarker result?
 - If the individual is cognitively unimpaired and screening for or participating in a research study:
 - “You’re being screened for a study. In order to determine if you are eligible for the study, we need to test for Alzheimer’s disease biomarkers.” or “As part of this long-term study of brain health, we test participants for Alzheimer’s disease biomarkers.”
 - “When people who are cognitively unimpaired learn biomarker results, they might be motivated to adopt new health habits, such as changing their diet or exercising more often.”
 - “Some people use their results to plan for the future; for example, they might update their finances or living arrangements. Some people share their results with others—like family members or close friends—so that they can make a plan for how they would get help if they were to develop cognitive impairment.”
 - If the individual is cognitively impaired:
 - “Some people learn their results so that they have a better understanding of the cause of their cognitive impairment and how their memory might change going forward.”
 - “The results might inform what medications may be appropriate for you.”
 - “Some people use their results to plan for the future; for example, they might develop a plan for who will care for them in the future.”
- What are the risks or downsides of learning an Alzheimer’s disease biomarker result?
 - If the individual is cognitively unimpaired:
 - Tell the individual directly if their research results will or will not be included in their medical record.
 - Be prepared to discuss the implications of biomarker testing for long-term care insurance and the lack of legal protections for biomarker information.
 - “So, if you want to purchase long-term care insurance, you might want to do that before you would undergo the test.”
 - “Some people who learn they have a positive test may feel differently about their memory.”
 - “Some people worry that they will be treated differently by others if they share the result.”
 - If the individual is cognitively impaired:
 - “Some people do not share their results with other people. They are concerned about being treated differently by others.”
- After each topic, a general approach to assess understanding by asking, “Do you have any questions?” followed by “Can you tell me in your own words what we’ve just been over?”

ASSESS APPRECIATION

- Points to explore:
 - “Some people feel differently about themselves and their abilities after they learn their results. Some people do not. How might you feel?”
 - “Some people feel differently about their future after they learn their results. Some people do not. How might you feel?”
 - “Some people, after they learn their results, worry that other people will treat them differently. Some people do not experience this. How might you feel?”
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- If the individual is cognitively unimpaired:
 - *“What would a biomarker result suggestive of increased risk for developing cognitive impairment due to Alzheimer’s disease in the future mean for you? What might you do with this result?”*
 - *“What would a biomarker result that is not suggestive of increased risk for developing cognitive impairment due to Alzheimer’s disease in the future mean for you? What might you do with this result? How would knowing this change things?”*
 - If the individual is cognitively impaired:
 - *“What would a biomarker result consistent with a diagnosis of Alzheimer’s disease mean for you? What might you do with this result?”*
 - *“What would a biomarker result that is not consistent with a diagnosis of Alzheimer’s disease mean for you? What might you do with this result? How would knowing this change things?”*
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SEEK CONSENT

- If capacity has not already been assessed, use the individual’s answers to the educational session to determine if the individual has capacity to consent to biomarker testing.
 - If the individual does not have capacity, determine who serves as their legally authorized representative or surrogate; get the surrogate’s permission for testing and ask for the individual’s assent. Ideally, the surrogate was present at the education session.
 - *“Is this something you want to know or do not want to know?”*
 - If yes: *“If you’d like to move ahead with this, let’s talk about next steps.”*
 - If no: *“Not everyone wants to know if they have Alzheimer’s disease biomarkers, and that’s okay. We can revisit the idea again in the future if you like.”*
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PREPARE FOR NEXT STEPS

- *“I want you to be prepared for what happens next. May I explain how the testing will occur?”*
 - *“Results are typically ready within [2 weeks]. We will discuss the results at your next visit, but you may receive your results through your electronic medical record before this visit.”*
 - Send the individual or support person home with written materials describing the test (e.g., <https://www.agreedementia.org> or <https://www.nia.nih.gov/health/how-biomarkers-help-diagnose-dementia>).
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TABLE 2. RETURN OF RESULTS

GET READY	<ul style="list-style-type: none">• Revisit clinical information, including assessment of mood.• Ensure appropriate conditions for disclosure (e.g., private place, adequate time for discussion).• Make sure you have the right people in the room – ideally, the individual and their support person, such as a family member or close friend.• Have any information you need on hand (e.g., about opportunities to participate in research, community resources and supports).
ASSESS WHAT THE INDIVIDUAL KNOWS	<ul style="list-style-type: none">• Consider the individual’s current thinking about their condition based on previously obtained information. For example, does the individual expect “bad news”?• Determine whether the individual had access to their result via their electronic medical record prior to the return-of-results visit. They may volunteer this spontaneously, or you may need to ask.<ul style="list-style-type: none">○ <i>“Did you see your result? In your own words, what was it?”</i>• <i>“What is your understanding of the reasons we did the [biomarker test]?”</i>• <i>“What thoughts have you had since you completed the test?”</i>• <i>“Do you have any questions or concerns about learning your biomarker test result?”</i>
CONFIRM THE INDIVIDUAL WANTS TO KNOW THEIR BIOMARKER RESULT	<ul style="list-style-type: none">• <i>“How are you feeling about learning the result of your biomarker test today?”</i>• <i>“You had a biomarker test, but that doesn’t mean you have to learn the results. Is this still something you want to know?”</i><ul style="list-style-type: none">○ If the individual prefers not to know, determine why they changed their mind, address any misunderstandings, and note that it’s possible to revisit the question if they ever change their mind.
RETURN THE RESULT	<ul style="list-style-type: none">• Use nontechnical words and meet the individual’s level of vocabulary and comprehension.• Use repetition and pauses to allow the individual time to deal with facts and the accompanying emotions.• Give information in small chunks and periodically assess understanding.<ul style="list-style-type: none">○ Start with the headline. <i>“Your result is”</i>○ If the individual is <u>cognitively unimpaired</u>:<ul style="list-style-type: none">▪ If biomarker (+): <i>“You are at increased risk for developing Mild Cognitive Impairment or dementia caused by Alzheimer’s disease in the future, but it’s not a guarantee. Just like high cholesterol doesn’t mean you’ll have a heart attack, elevated amyloid doesn’t mean you’ll develop cognitive impairment.”</i><ul style="list-style-type: none">• Be prepared to offer an evidence-based assessment of prognosis using the studies you find most useful.▪ If biomarker (-): <i>“This is reassuring. You can think of the biomarker result as a snapshot in time. You might develop Alzheimer’s disease biomarkers in the future.”</i>○ If the individual is <u>cognitively impaired</u>:<ul style="list-style-type: none">▪ Explain what this result means for diagnosis clearly and to the point:<ul style="list-style-type: none">• If biomarker (+): <i>“Alzheimer’s disease is likely contributing to your cognitive impairment.”</i>• If biomarker (?): <i>“The results are not conclusive.”</i>

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- If biomarker (-): *“Alzheimer’s disease is not contributing to your cognitive impairment.”* Discuss other possible etiologies and next steps for diagnosis.
 - Explain what this result means for prognosis—how long and how well—clearly and to the point:
 - If biomarker (+): *“Your cognitive impairment is likely to worsen with time.”*
 - Be prepared to offer an evidence-based assessment of prognosis.
 - If biomarker (-): *“There is a reduced likelihood that your cognitive impairment will worsen with time because of changes due to Alzheimer’s disease. However, we do not currently have biomarkers for other causes of mild cognitive impairment and dementia, which could also cause cognitive decline over time.”*
 - Be prepared to offer an evidence-based assessment of prognosis.
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ACKNOWLEDGE EMOTION

- Expect the individual’s (and their support person’s) first response to be emotion.
 - Acknowledge the emotion explicitly, show empathy.
 - If biomarker (+): *“I can see that this is not the news that you were hoping for.”*
 - If biomarker (+): *“Many people derive a sense of relief from having a greater understanding of their condition.”*
 - If biomarker (-): *“You seem relieved.”*
 - If biomarker (-): *“You may have been hoping to get a more definitive answer about what is causing your cognitive impairment.”*
 - If an individual is not expressing their emotions clearly, ask exploratory questions before making an empathetic response.
 - *“How are you feeling?”*
 - *“What’s going through your mind?”*
 - *“Could you explain what you meant when you said ... ?”*
-

ENSURE COMPREHENSION OF THE RESULT

- *“Can you tell me in your own words what the biomarker test showed?”*
 - If the individual does not understand their result clearly, re-educate.
 - *“What does this result mean to you?”*
 - *“What questions do you have about the biomarker result?”*
-

PREPARE FOR NEXT STEPS

- Don’t dismiss the individual’s concerns or say things will be fine.
 - Discuss next steps; those may be related to care, research, or both. Presenting options to individuals and sharing responsibility for decision making will make them feel that their wishes are prioritized.
 - Send the individual and their support person home with written materials describing the test results.
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