We Screen for Blood Pressure, Why Not Brain Health?

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At nearly every clinic, community health fair, or hospital visit, a clinician wraps a blood pressure cuff around a patient's arm. Screening for hypertension has become an essential part of preventive care. Yet we often overlook another vital measure of health, especially in underserved communities: cognitive health.

As a medical student and Chicago Area Schweitzer Fellow working with underserved populations, I have seen how cognitive changes frequently go unnoticed until they significantly interfere with a person's daily life. By the time many patients receive a cognitive evaluation, we have already missed opportunities for early intervention, planning and support. This delay is not because cognitive decline appears suddenly, but because we have failed to make brain health screening a routine and equitable part of care.

Early cognitive changes are often subtle, including word-finding difficulty, memory challenges or trouble managing medications. When identified early, these symptoms help patients and families access resources, manage underlying risk factors and plan for the future. Yet cognitive screening is rarely standardized in primary care, and it is even less common in settings serving low-income and marginalized communities. The result is a system in which those already facing barriers to care are diagnosed later and experience worse outcomes.

This gap illustrates a broader issue. Structural inequities drive cognitive health disparities. Communities with limited access to consistent primary care, fewer preventive services and higher burdens of chronic disease are at increased risk for delayed diagnosis. When screening depends on time-intensive clinic visits and specialist referrals, many patients are left out.

But the solution cannot rest solely within exam rooms. Clinics face real constraints, including short appointment times, limited staffing and insufficient resources for follow-up care. Expecting clinicians to close the cognitive health gap on their own is unrealistic. If we are serious about equity, we must expand where and how we think about brain health.

Cognitive health is shaped by education, social connection, physical activity and access to trusted information. Community spaces such as senior centers, libraries, faith-based organizations and neighborhood nonprofits are uniquely positioned to support early awareness and engagement. These settings are often more accessible and more trusted than traditional healthcare institutions, particularly in communities that have historically been marginalized by the medical system.

Investing in community-based cognitive health initiatives is not a substitute for medical care. It is a necessary extension of it. Partnerships between healthcare systems and community organizations can promote education about early warning signs, reduce stigma and create pathways for screening and referral that meet people where they are. Programs that are culturally responsive and locally rooted are more likely to reach those most at risk.

We already understand the power of prevention. We do not wait for a stroke to treat high blood pressure, nor do we delay diabetes care until complications arise. Brain health deserves the same proactive approach. Treating cognitive decline as an inevitable consequence of aging, rather than a condition influenced by social and structural factors, perpetuates disparities and limits our response.

Chicago has an opportunity to lead. By investing in community-based cognitive health programs and integrating routine screening into primary care, especially in underserved neighborhoods, we can shift from late diagnosis to early support. This requires commitment from health systems, funders and policymakers.

Screening for brain health should be as routine as checking blood pressure, and support should extend beyond clinic walls. The question is not whether we can afford to invest in cognitive health equity, but whether we can afford not to.