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The Honorable Robert F. Kennedy, Jr.
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Kennedy,

Thank you for the opportunity to provide input on the Request for Information (RFI) pertaining to the update to the National Plan to Address Alzheimer's Disease ([HHS-ASPE-2026-0298](https://www.fda.gov/oc/foia/HHS-ASPE-2026-0298)). We are writing on behalf of the LEAD Coalition¹ to highlight the progress that has been made in the fight to defeat Alzheimer's disease and related disorders (AD/ADRD) and outline recommendations for how the National Plan update can close gaps and propel the field closer to prevention, diagnosis, treatment, and care for all people at risk for and affected by AD/ADRD.

Since the enactment of the National Alzheimer's Project Act (NAPA) and the first National Plan in 2012, great progress has been made in addressing AD/ADRD. The U.S. Department of Health and Human Services (HHS) has played a key role in these efforts by establishing and overseeing a coordinated federal strategy that aims to improve outcomes for people at risk for or living with AD/ADRD, their care partners, and families. More progress is on the horizon, and greater coordination across the federal government will be necessary to bring the nation closer to a future where AD/ADRD are prevented, effectively treated, and ultimately overcome with cures.

The LEAD Coalition believes firmly that the updated National Plan must be ambitious, measurable, and adequately resourced, with a focus on ensuring **equitable, timely, accurate, compassionate, and actionable** prevention, diagnosis, treatment, and care. The National Plan must further advance research and translate innovations effectively into clinical practice, elevate

¹ Leaders Engaged on Alzheimer's Disease ([LEAD Coalition](https://www.leadcoalition.org/)) is a diverse and growing national policy coalition committed to overcoming Alzheimer's disease and related disorders (AD/ADRD), including vascular contributions to cognitive impairment and dementia, Lewy body dementia, and frontotemporal degeneration. The Coalition serves as the uniting voice of more than 260 member and allied organizations and over 500 researchers to focus the nation's attention on accelerating transformational progress to reduce risk, enhance detection and diagnosis, improve care and support, and develop increasingly effective treatments and eventual cures.

evidence-based risk reduction strategies, and strengthen infrastructure to deliver effective diagnostics, care, treatments, services, and supports to individuals and care partners in need. Success relies upon strategic coordination across federal agencies and the entire ecosystem, including state and local governments, non-governmental organizations, industry, payers, healthcare delivery systems, and more. The National Plan update must explicitly recognize and serve the full community affected by AD/ADRD, including people living with Alzheimer's disease, Lewy body dementia (LBD), frontotemporal degeneration (FTD), and vascular contributions to cognitive impairment and dementia (VCID), as well as individuals with Down syndrome, who face a substantially elevated risk of Alzheimer's disease. We respond to each of the RFI's eight questions in detail below.

1. What opportunities or challenges exist in advancing research and development of interventions to prevent or treat AD/ADRD, including translating scientific progress into effective and scalable treatments and care?

Over the past decade, unprecedented Congressional investments in AD/ADRD research and development have transformed the scientific landscape, with the National Institutes of Health (NIH) playing a central leadership role in driving discovery and innovation. These sustained investments have led to pivotal breakthroughs, including two Food and Drug Administration (FDA)-approved drugs to treat early-stage AD and two FDA-approved blood tests to aid in the diagnosis of AD, with many more advances in the pipeline. Strategic NIH research investments have also established critical research infrastructure throughout the AD/ADRD ecosystem, supporting basic, translational, and clinical research. NIH initiatives and grants are attracting newly-trained investigators and encouraging well-established scientists to pivot to AD/ADRD from other areas of research while also aiding in de-risking the private sector by funding critical foundational science to identify promising therapeutic targets. These investments and the leadership of NIH's expert career staff have generated a robust NIH research portfolio reflecting a balanced mix of basic neuroscience work, clinical research, the behavioral and social sciences, and care and delivery research, among other research areas.

The field is now at a vital inflection point. Sustained and predictably growing investment in the full AD/ADRD research enterprise, along with indispensable expert career staff, will be critical to building on these breakthroughs and ensuring that scientific advances continue to translate into meaningful improvements in AD/ADRD risk reduction, diagnosis, treatment, and care.

To ensure AD/ADRD research continues to advance, the National Plan must:

- Continue to support aggressive Congressional appropriations increases to NIH. Funding increases must continue on pace with past investments and consistent with needs outlined in the annual NIH Professional Judgement Budget. The Fiscal Year (FY) 2027 budget estimate – \$187 million in new funding – illustrates that critical research needs in the field are not yet adequately addressed.
- Prioritize the study of disease complexity and heterogeneity of AD/ADRD. The National Plan is designed to address Alzheimer's disease as well as related disorders, including

FTD, LBD, VCID, and mixed etiology dementia. The overlap among the biological contributors to these diseases makes diagnosis difficult, even with the advent of new and less invasive or resource-intensive biomarkers, and many individuals exhibit a blend of brain pathology. The study of this biological heterogeneity is critical to understanding how to identify drug targets relevant to the biology of each disease, to tailor risk reduction and prevention strategies, and to develop appropriate care interventions for people with AD/ABRD and support systems for care partners. Without further knowledge in this area, we have little hope of making highly-specific diagnoses and developing the person-centered interventions that will be critical to applying true precision medicine in the future.

- Continue to support and elevate the work of the Department of Defense's Congressionally Directed Medical Research Programs (CDMRP) Alzheimer's Research Program (AZRP). This program complements the NIH research portfolio by supporting innovative, solution-oriented AD/ABRD research with a particular focus on the needs of service members, veterans, and their families. The program is uniquely positioned to address questions that are especially relevant to military and veteran populations, including the long-term consequences of traumatic brain injury (TBI), the relationship between TBI and subsequent dementia risk, and approaches to reducing the burden of AD/ABRD on affected individuals and their caregivers.
- Elevate a precision medicine model. The promise of precision medicine depends on understanding how disease risk and treatment response vary across individuals. To achieve this, research must account for biological variables and upstream drivers of health that influence disease onset, progression, and treatment response. For example, nearly two-thirds of people living with Alzheimer's disease are women, and sex-based differences in cardiovascular, immune, endocrine, and other biological systems are increasingly being recognized as important contributors to this disease. HHS must implement new policies and more strongly enforce existing policies (such as [Consideration of Sex as a Biological Variable in NIH Research](#)) to ensure discoveries translate into safe, effective, and personalized interventions for all populations. Understanding for which patients (and under what circumstances) interventions work is vital to health system efficiency.
- Invest in cutting-edge resources and tools. Opportunities to advance AD/ABRD research increasingly lie in developing new tools to deliver more precise and efficient diagnosis, treatment, and care. Continued investment in prognostic biomarkers, predictive algorithms, and related technologies could improve the identification of therapeutic targets, enabling more efficient clinical trial enrollment, and support shared decision-making between clinicians and patients as treatment options expand. Emerging approaches, including AI and advanced computational methods, also have the potential to accelerate discovery by identifying opportunities for risk stratification, drug repurposing, optimizing combination therapies, improving analysis of longitudinal data, informing innovative trial designs, and strengthening post-market evidence generation. At the same time, these technologies should be developed and deployed responsibly, with appropriate ethical guardrails, legal protections, validation, transparency, and

oversight to ensure they complement rigorous scientific investigation and produce findings that are reliable, equitable, and clinically meaningful to all intended users.

- Strengthen and harmonize longitudinal cohort infrastructure. Longitudinal cohort studies are among the most valuable research assets for understanding brain aging and AD/ADRD over time. HHS and NIH should continue to invest in and strategically align these cohorts by promoting harmonized data collection, common data elements, interoperable platforms, and coordinated planning across federally funded studies. Successful models, such as the Uniform Data Set (UDS) used across the Alzheimer's Disease Research Centers (ADRCs), demonstrate the value of standardized data collection and should inform broader efforts to integrate data across AD/ADRD and brain health studies. Better harmonization will maximize the return on existing federal investments, facilitate data sharing, strengthen opportunities for AI and other advanced analytic approaches, and accelerate discovery.
- Prioritize and adequately fund recruitment and engagement efforts for clinical trials. Hundreds of NIH-funded AD/ADRD clinical trials are currently underway, but clinical trial recruitment remains a challenge across populations. It is imperative that all Americans, including those in disadvantaged and rural areas of the country, have opportunities to participate in clinical trials. NIH should incentivize partnerships between the NIH-funded Alzheimer's Disease Clinical Trial Consortium (ACTC) and other existing research infrastructure that has deep relationships with local communities (i.e., the ADRCs). Additionally, clinical trials must be insulated from the overall destabilization of the federal research funding. Participants should not be afraid to join at the risk of a trial being defunded midway through the research.
- Continue to build sustainable mentorship and career development programs for new and early-career researchers. Instability of such resources and initiatives weakens both NIH intramural and extramural AD/ADRD research along with undermining the likelihood of downstream private sector investments.
- Ensure evidence-based decision-making at NIH, Department of Defense (DoD), Department of Veterans Affairs (VA), and other federal agencies responsible for AD/ADRD research funding. Research planning within the government must support a balanced portfolio that spans the full continuum of AD/ADRD research and should not become overly focused on a single scientific area or stage of research. Specifically at NIH, the AD/ADRD Research Summit series, the development of research implementation milestones, and the preparation of the NIH Professional Judgment Budget should reflect expertise and input from all relevant NIH Institutes, Centers, and programmatic portfolios. This comprehensive approach should also extend to the strategic investments in research infrastructure that serve as foundational resources to support discovery across the field. Destabilizing the current framework risks undermining existing investments before their full benefits can be realized and jeopardizing essential systems that support individuals living with AD/ADRD and those who care for them.
- Implement and strengthen enforcement of policies that ensure adequate representativeness in research and clinical trials. The NIH must commit to monitoring and enforcing clinical trial recruitment goals in NIH-funded research. NIH – and specifically NIA – has made important progress by modernizing recruitment tracking

through the [Clinical Research Operations & Management System \(CROMS\)](#), but these efforts must be maintained and strengthened. Continued investment is needed both in systems that monitor recruitment and enrollment and in the programmatic staff needed to use these data to ensure investigators meet recruitment goals and that NIH-funded trials generate evidence that is representative of the populations most affected by AD/ADRD. Similarly, the FDA requires trial sponsors to submit a Diversity Action Plan (DAP) for most Phase 3 and pivotal clinical studies of drugs, biologics, and medical devices. Mandated by the Food and Drug Omnibus Reform Act (FDORA), these plans must outline enrollment goals and strategies to include historically underrepresented demographic populations. FDA needs both expert staff and sufficient resources to ensure compliance with FDORA's requirements.

In order to translate current and future AD/ADRD research advances into clinical practice, the National Plan must:

- Prepare the U.S. healthcare system to deliver tailored AD/ADRD care. Translation requires that an adequate workforce of healthcare professionals exists, has the patient capacity and geographic distribution to meet the needs of all populations, and possesses a sufficient understanding of the complexities of the emerging science along with the infrastructure to detect, diagnose, and treat AD/ADRD at any stage of disease. It also requires that a system for adequate reimbursement exists. Significant gaps remain across each of these areas, limiting the nation's ability to translate research advances into improved care.
- Rebuild public health research infrastructure. NIH, FDA, DoD, VA, the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and other federal agencies require sufficient scientific and programmatic staff to ensure timely grant administration, rigorous peer review, effective oversight of research investments, and efficient translation of discoveries into practice. Current workforce shortages and instability within federal agencies delays research, undermines collection of epidemiologic data, stagnates efforts to promote risk reduction interventions, and generally reduces the return on Congressional investments. HHS and the NAPA Advisory Council have an opportunity to ensure a structure is present where AD/ADRD-related activities are adequately and reliably supported and where these activities are well-coordinated. As scientific advances move from discovery to clinical practice and public health, agencies and NAPA can aid in ensuring that evidence is translated effectively into care and community practice, rather than being slowed or fragmented by the differing statutory responsibilities of individual agencies.

2. What opportunities or challenges exist in improving risk reduction and promoting brain health across the lifespan?

Evidence continues to grow that addressing modifiable risk factors can help reduce the risk of cognitive decline and dementia ([Livingston et al., 2024](#), [Baker et al., 2025](#)), potentially slow progression and mitigate the emergence and intensity of some symptoms (e.g., use of hearing

aids may reduce social isolation and depression while increasing opportunities for intellectual stimulation). However, several barriers limit the successful implementation and uptake of brain health and AD/ADRD risk reduction strategies by the general public. Public awareness of activities that can protect brain health remains low, and educational efforts are either lacking or not culturally and linguistically tailored to reach the communities they are intended to serve. Healthcare providers also need supplemental training and resources to know how to effectively communicate evidence-based risk reduction and adherence strategies to heterogeneous patients. Additionally, providers need adequate coverage and reimbursement policies to afford time in their caseload to deliver effective and sustainable support for such risk-reduction and adherence strategies.

Furthermore, public health messaging around brain health has become increasingly difficult in an environment of declining trust in science and public health institutions. The public health infrastructure needed to advance brain health has been dangerously and precipitously weakened in recent years. Reduced capacity at the CDC has downstream effects on state and local health departments (many of which also have faced resource reductions), limiting their ability to implement brain health initiatives, disseminate evidence-based information, and partner with community organizations to reach populations at greatest risk.

Research gaps also remain. More evidence is needed to understand how risk differs across populations, including the influence of environmental exposures, nutrition, routine vaccination (e.g., flu and shingles), delirium, traumatic brain injury, geography (e.g., rural populations are at higher risk for cognitive impairment), and other factors. While individual interventions have demonstrated strong promise, additional research is needed to further evaluate programs alone and in combination (including pharmacological and non-pharmacological combination).

[Age-Friendly Health Systems](#) address AD/ADRD risk reduction and brain health across the lifespan by systematically embedding preventative care into their core operating framework, known as the "4Ms" (What Matters, Medication, Mentation, and Mobility). By aligning clinical workflows with the 4Ms, Age-Friendly Health Systems shift the medical focus from late-stage crisis management to proactive, lifespan-oriented cognitive optimization. The Mentation pillar in particular directly targets brain health by screening for early cognitive changes and aggressively managing psychological and sensory factors. The LEAD Coalition was pleased with the FY2025 CMS Inpatient Prospective Payment Systems final rule inclusion of a new Age Friendly Hospital Measure. Hospitals that participate in Medicare's Hospital Inpatient Quality Reporting (IQR) Program are now required to report on whether they have protocols in place to: 1) elicit patient health care goals, 2) responsibly manage medications, 3) implement frailty screening and intervention (including for cognition and mobility), 4) assess social vulnerability (e.g., social isolation, caregiver stress, elder abuse) and 5) designate age-friendly leadership. Hospitals that choose not to participate in the IQR program face a significant reduction in their annual Medicare payment update.

To address these challenges, the National Plan must:

- Restore and strengthen CDC's capacity by restaffing the Healthy Aging Branch, ensuring federal employees are subject-matter experts who can oversee and manage the AD/ADRD public health portfolio, including BOLD Act activities ([Public Law 118-142](#)). This restaffing is essential to ensuring adequate support for the state and local public health agencies implementing brain health and AD/ADRD risk reduction initiatives. HHS also should work directly with state and local governments to encourage expansion of their AD/ADRD public health capacity.
- Strengthen and coordinate a public-private national brain health education strategy that promotes clear, evidence-based, and culturally-responsive messaging for both the general public and healthcare professionals.
 - The NAPA Advisory Council should identify and prioritize risk factors based on the strength of the scientific evidence, readiness for public health action, and potential for meaningful impact. In setting these priorities, HHS should also consider the needs of at-risk communities and the potential benefits that targeted action could provide to those communities and individuals.
 - Caregiving responsibilities contribute to adverse health outcomes – including sleep deprivation, depression, high blood pressure, and elevated stress – AD/ADRD care partners may face an increased risk of dementia and should be considered a priority population for risk-reduction efforts. The NAPA Advisory Council, in consultation with CDC and other public health experts, should identify opportunities to promote action to address and help mitigate AD/ADRD risk factors among care partners specifically.
- Continue to prioritize research that advances precision approaches to AD/ADRD risk reduction, including epidemiological research that identifies differential risk and protective factors across heterogeneous populations. These include, but are not limited to, continuing to support research on sex as a biological variable, environmental exposures (exposome), nutrition, vaccination, delirium prevention, and traumatic brain injury. This research should complement the clinical research to develop and test scalable interventions that can be implemented in real-world settings.
- Work to improve equitable access to preventive services and community-based supports through Medicare and Medicaid and other federal programs so that all individuals have the opportunity to benefit from advances in brain health and AD/ADRD prevention.
- Continue to work through CMS and other relevant agencies to encourage broader adoption and implementation of Age-Friendly Health Systems principles with special emphasis on the Mentation pillar for promoting brain health and reducing AD/ADRD risk.

3. What barriers or challenges affect early detection and timely diagnosis of AD/ADRD?

The science of AD/ADRD detection is advancing rapidly, but the U.S. healthcare system is not prepared to translate these advances into **equitable, timely, accurate, compassionate, and actionable** detection and diagnosis at scale. The challenge is twofold: The field needs

continued research to develop and validate better tools – including prognostic tools – and the health system infrastructure, workforce, clinical pathways, coverage and reimbursement policies, ethical frameworks, legal protections, and public health capacity must be in place in order to deploy these tools effectively. Such infrastructure becomes even more essential as the field moves from diagnosing people who already have symptoms to identifying disease before symptoms, including through emerging blood-based biomarkers.

To address these challenges, the National Plan must:

- Prioritize efforts to identify and diagnose individuals who present with cognitive concerns. Today, routine cognitive assessment using validated instruments is uncommon in primary care and inconsistent in some specialty care settings – far too many clinicians rely on observation, subjective assessment, or unvalidated assessment instruments to determine whether an individual is cognitively impaired.
 - CMS must require the use of validated screening instruments in Welcome to Medicare and Annual Wellness visits for the Medicare population. Legislative efforts such as the CHANGE Act ([H.R.3501/S.1799](#)) recognize the importance of strengthening cognitive assessment in primary care and ensuring that detection is connected to appropriate follow-up.
 - AHRQ and the USPSTF must continue its [stalled review of evidence for cognitive impairment screening in older adults \(65+\)](#) and consider evidence for risk-stratification* and testing at earlier ages as well. Establishing a validated cognitive baseline and repeating assessments over time will help clinicians identify meaningful changes in cognition in individuals.
 - **Rather than viewing early detection solely through the lens of universal population-based screening, evidence-based approaches to risk stratification could be applied, considering factors associated with AD/ADRD risk and progression, such as age, genetic predisposition and family history, hypertension, diabetes, traumatic brain injury, social isolation, and other biological and social factors.*
 - The NAPA Advisory Council should consider opportunities for expanding the use of digital cognitive assessments (DCAs) to aid in moving beyond subjective observation in primary care. DCAs can also potentially detect more subtle changes, track change over time, and increase access/scalability (e.g., positioning in pharmacies, faith communities, community centers). DCAs also can be useful in triaging before potential utilization of more expensive and less accessible testing (e.g., PET imaging).
 - The NAPA Advisory Council should consider other steps necessary to develop a healthcare delivery system capable of surfacing cognitive concerns early, staging them accurately, and matching individuals to appropriate interventions. For example, the Advisory Council should consult and collaborate with ongoing efforts to improve diagnosis, treatment, and care in healthcare systems throughout the U.S. (e.g., [NEWDIGS's early Alzheimer's disease work](#), a pre-competitive initiative to develop a clear roadmap and model for health

systems to diagnose and treat early AD by 2030 and beyond; [Davos Alzheimer's Collaborative](#), a global partnership focused on piloting innovative approaches to AD/ADRD care in diverse, real-world settings).

- Address significant shortages of neurologists, geriatricians, and other dementia specialists while also expanding the AD/ADRD capability of primary care and other health professionals.
 - The NAPA Advisory Council should explore opportunities to expand incentives (e.g., loan repayment and scholarship programs) for clinicians and practices who commit to geriatrics, neurology, psychiatry, and practice in Tribal, rural, and other underserved communities.
 - The NAPA Advisory Council should ensure stable support for the Health Resources and Services Administration (HRSA) Geriatric Workforce Education Program (GWEP) and Geriatric Academic Career Awards (GACAs) to train healthcare professionals, family caregivers, and academic faculty to provide age-friendly and dementia-friendly care for older adults
- Prepare a capable healthcare delivery system for advances in blood-based biomarkers to detect AD/ADRD pathology prior to symptom onset (i.e., in the “asymptomatic” or “pre-clinical” population). FDA-approved blood-based screening tools will create an opportunity to move beyond symptom-based detection and identify AD pathology much earlier in the disease course, allowing for the potential of early intervention (emerging lifestyle modifications and future pharmacologic treatments) to significantly slow or halt the disease course before symptoms appear. The bipartisan congressional support for the Alzheimer’s Screening and Prevention Act (ASAP Act; [H.R.6130/ S.3267](#)) reflects growing interest in ensuring Medicare coverage for FDA-approved blood-based biomarker screening tests for AD/ADRD, when they become available. However, deploying these tools responsibly will require more than simply making tests available. The healthcare system will need clear clinical pathways for determining who should be tested, how results should be interpreted and conveyed, when confirmatory testing or specialist evaluation is appropriate, and what treatment and care options should follow.
 - The NAPA Advisory Council should encourage relevant federal agencies to collaborate with legal experts, medical societies, patient advocacy organizations, and other interested parties to assess any gaps in legal protections for biomarker-positive asymptomatic individuals and develop consensus recommendations for any necessary agency or congressional actions to close any such gaps.
- Address stigma, trust, and public awareness. Many individuals and families are currently reluctant to seek evaluation and some providers are reluctant to raise the possibility of AD/ADRD to their patients. Stigma, concerns about loss of independence, employment and insurance implications, and uncertainty about what a diagnosis means can all discourage detection. These concerns become even more important as detection moves into earlier and potentially asymptomatic stages, where existing legal and policy protections may not fully address emerging issues. Public education and community engagement—developed with people with lived experience and tailored to different

communities—will be essential for building trust and communicating the value of earlier detection and diagnosis.

4. What are the most significant gaps in dementia care, services, and supports for people living with AD/DRD and their families, caregivers and care partners, including caregiver well-being?

Over the past two decades, the NIH (through both funding and strategic thought-leadership) has helped build a substantial evidence base demonstrating that comprehensive, person-centered care can improve outcomes for people living with AD/DRD and their care partners. This body of work has shifted the field beyond documenting unmet needs toward identifying interventions that improve quality of life, reduce caregiver burden, and enable people living with MCI and dementia to receive care that reflects their goals, preferences, and strengths. The [2017 National Research Summit on Care, Services, and Supports for Persons with Dementia and Their Caregivers](#) marked an important turning point for the field. The summit identified research priorities for understanding unmet care needs, developing new interventions, and exploring pathways for implementing evidence-based dementia care effectively across the continuum of real-world settings. Subsequent NIH AD/DRD care research summits – in 2020, 2023, and 2026 – have identified additional “Gaps and Opportunities” for the field and are shaping the next generation of AD/DRD care research.

Although progress has been made, especially in developing the evidence base, gaps and challenges persist in ensuring that individuals living with AD/DRD and their care partners receive the care, services, and supports they need. Workforce shortages across the AD/DRD care continuum – including direct care workers, home- and community-based services (HCBS), long-term services and supports (LTSS), and medical professionals – substantially limit access to care particularly in rural and other underserved communities but also in high-resource communities. These challenges are compounded by immigration-related barriers imposed by the current administration, affecting key segments of the healthcare and direct care workforce. Heightened immigration enforcement has contributed to enormous instability among workers and employers, especially in HCBS and LTSS settings. Increased visa restrictions and delays in processing have reduced opportunities for international students to train in the U.S. and for U.S.-trained professionals to remain working in the U.S. and fill urgently needed healthcare roles. These workforce shortages have direct impacts on the AD/DRD community, including (but not limited to) reduced access to services, longer wait times, and greater reliance on unpaid family care partners. It also is essential to recognize that immigration enforcement actions can have the unintended but catastrophic consequence of separating people living with AD/DRD from family care partners.

Furthermore, many AD/DRD care partners experience substantial physical, psychological, and financial burdens while simultaneously managing their own health needs. Care partners face serious unmet needs, in part because there is a lack of understanding of the caregiver experience due to limited data collection on caregiver health and well-being. These challenges are particularly pronounced among women, who disproportionately provide unpaid care and

may experience devastating impacts on their physical and mental health, social connections, employment, and retirement security.

Care delivery also remains highly fragmented, creating substantial burdens for individuals living with AD/ADRD and their families as they navigate multiple providers, service systems, and payers. Existing care models have largely been designed around typical late-onset Alzheimer's disease and may not adequately address the needs of people living with DSAD, FTD, LBD, VCID, or mixed etiology dementia, especially those with younger-onset forms. Significant gaps also remain in advance care planning, palliative care, and end-of-life decision-making. Families frequently encounter confusion regarding hospice eligibility and access to palliative care services, resulting in delayed support and avoidable pain and distress during moderate and advanced stages of illness.

Stigma and overt discrimination surrounding AD/ADRD continues to delay diagnosis, discourage individuals and families from seeking care, and contribute to social isolation for both individuals living with cognitive impairment and their care partners. Continued investment in public education and community initiatives, including [Dementia Friendly America](#) and its locally driven, cross-sector approach, can help create more inclusive communities while equipping organizations across healthcare, business, faith communities, transportation, emergency response, and other sectors to better support people living with AD/ADRD. A greater use of technology (e.g., telehealth, remote monitoring, digital care coordination tools, and technologies that promote safety, independence, and connection to resources) could offer opportunities to improve quality of life for individuals living with cognitive impairment and reduce care partner burden.

To address these gaps, the National Plan must:

- Expand investments in the AD/ADRD care workforce education. Strengthening the workforce requires both expanding its size and improving AD/ADRD-specific education across disciplines. Calling for the passage of the Accelerating Access to Dementia and Alzheimer's Provider Training (AADAPT) Act ([H.R.3747/S.4036](#)), which expands and reauthorizes the Project ECHO grant program to provide primary care clinicians with virtual training and mentoring in AD/ADRD care, is one step toward creating a more dementia-capable workforce.
 - The NAPA Advisory Council should also work with relevant federal agencies, Congress, the AD/ADRD community, healthcare and HCBS/LTSS providers, and other stakeholders to craft pathways to continued legal residence and attainment of citizenship for immigrants (and their families) who work in healthcare and HCBS/LTSS. The Administration also should reexamine its immigration enforcement policies to minimize the risk that people with AD/ADRD and their family care partners will be separated, even for short periods of time, by detention or by deportation of either party. Detainment or deportation of individuals living with cognitive impairment should not occur except in the exceptionally rare case of imminent threat to public safety.

- Improve national data collection on family care partners by expanding the collection of measures of caregiver health, well-being, financial impact, workforce participation, and service needs. These efforts can inform policies that address caregiver health, reduce disparities, and better support populations with unique needs, including women and care partners from underserved communities.
- Ensure tailored AD/ADRD services and supports are available to individuals across the country. Services should be tailored to different disease pathologies and stages, age of onset, culture and linguistic background, individual goals, degree of family care partner availability and burden, etc.
- Continue to invest in public awareness and AD/ADRD-capable communities by supporting initiatives such as Dementia Friendly America, expanding dissemination of resources that reduce stigma and discrimination, and improve community capacity to support people living with AD/ADRD and their families.
- Accelerate the equitable adoption of technology and telehealth solutions that improve assessment, care coordination, monitoring, independence and quality of life, and access to services for people living with AD/ADRD and their care partners.
- Support the passage of the Palliative Care and Hospice Education and Training Act (PCHETA; [H.R. 4425/S.2287](#)).

5. What models, programs, or practices are currently working well in supporting people living with AD/ADRD and their families, caregivers, and care partners, and what factors contribute to their success (e.g., effectiveness, scalability, or applicability across settings)?

The research “Gaps & Opportunities” identified during the 2017 NIH Dementia Care Research Summit led to NIH’s engagement with AHRQ and the National Academies of Sciences, Engineering, and Medicine (NASEM) to conduct a systematic evidence review and convene a consensus panel. The resulting report, [Meeting the Challenge of Caring for Persons Living with Dementia and Their Care Partners and Caregivers: A Way Forward](#), found that there exists demonstrated evidence to support collaborative dementia care models and multicomponent caregiver interventions; it also called for broader implementation, standardized outcomes, greater inclusion of diverse populations, and continued investment in implementation science. Building on both NASEM’s findings and groundwork laid over the years, the community was pleased that CMS – through the CMMI program – launched the eight-year demonstration project of the [GUIDE Model](#) in 2024, to translate these evidence-based approaches into a nationwide Medicare payment and care delivery model for individuals living with AD/ADRD and their care partners. Evaluation is ongoing to determine whether the model improves individual Medicare beneficiary and care partner outcomes, reduces avoidable hospitalizations and emergency department visits, delays long-term nursing home placement when appropriate, and lowers overall Medicare spending, and we await periodic updates on the evaluation findings. Other clinical care interventions showing promise include:

- Geriatric emergency departments are an important opportunity to integrate AD/ADRD-informed practices into acute care settings, improving care transitions,

reducing avoidable hospitalizations, and better addressing the unique needs of older adults living with cognitive impairment.

- The Geriatric Emergency Care Applied Research Network 2.0 – Advancing Dementia Care ([GEAR 2.0 ADC](#)) is a NIH-funded program to advance the science supporting emergency care for people with dementia.
- The [ACEP Geriatric Emergency Department Accreditation \(GEDA\) program](#) is a national initiative designed to improve and standardize emergency care for older adults.
- Hospital-at-home programs have been effective for some families, with studies demonstrating a link between these programs and fewer health complications, lower readmissions, and reduced overall healthcare costs.

Numerous community-based resources and programs also effectively support individuals living with AD/ADRD as well as their care partners and families. Examples include:

- Adult Day Services provide structured daytime supervision, therapeutic activities, meals, and social engagement for people living with AD/ADRD while offering care partners scheduled respite.
- Local Area Agencies on Aging (AAAs), funded by the Older Americans Act through the Administration for Community Living (ACL), provide care partners with vital education and counseling, connect them to respite care, transportation, adult day services, home-delivered meals, elder law services, and local caregiver support programs.
- REACH II is an evidence-based caregiver intervention that provides individualized coaching, problem-solving strategies, stress management, and skills training to reduce caregiver burden. Indicative of its value, REACH II has been adapted successfully by the VA as the [REACH VA](#) Program to serve both veterans and their families.
- Faith-based programs such as [Alter Dementia](#) showcase how person-centered approaches can be adapted to meet the spiritual, social, and emotional needs of people living with cognitive impairment and their care partners. At its April 2026 meeting, the NAPA Advisory Council highlighted a similar program called [Respite For All](#).
- “Strengths-based approach” programs (such as [Opening Minds through Art](#) (OMA), [Arts & Minds](#), the [Giving Voice Chorus](#), [Eldergrow](#) and [The Eden Alternative](#)) emphasize maintaining cognitive and physical function, preserving dignity and autonomy, supporting meaningful relationships, and enabling people to live lives of purpose and well-being despite cognitive impairment.

Other programs can be found described within Benjamin Rose Institute’s [Best Programs for Caregiving](#) website, a free online, searchable database of evidence-based dementia support programs for family caregivers, providing detailed information for both professionals and the public to learn about the availability of these proven-effective programs.

Importantly, as more care, services, and support programs are developed and tested across the AD/ADRD community, an important challenge remains: defining what constitutes sufficient evidence to support broad implementation. Within HHS, NIH and ACL contribute complementary perspectives on what constitutes evidence for improving AD/ADRD care. NIH’s

mission emphasizes generating rigorous, generalizable scientific evidence through clinical trials, observational studies, and systematic evidence reviews to determine whether interventions are effective, for whom they work, and under what conditions. ACL builds on this evidence while also valuing practice-based evidence generated through community programs, service delivery, program evaluation, quality improvement, and the lived experiences of people living with AD/ADRD, care partners, and service providers to assess whether interventions are feasible in real-world settings. While these perspectives are complementary, the absence of a shared framework for determining when an intervention has accumulated sufficient evidence to move from research to broad implementation can slow dissemination and implementation, creating uncertainty for researchers, health systems, community organizations, and policymakers. Developing a common HHS framework for evidentiary readiness in the AD/ADRD space – one that recognizes the value of both scientific rigor and real-world implementation – would help establish clear pathways for translating effective AD/ADRD care interventions into routine practice while ensuring that scaling decisions remain grounded in robust evidence.

To ensure continued success of these programs, the National Plan must:

- *If early evidence shows GUIDE Model promise, encourage CMMI to consider expansion of the program – where resources and capacity allow – so that more individuals living with AD/ADRD and their care partners can benefit from comprehensive, coordinated care. Particularly, we implore HHS to explore opportunities to extend the model to individuals with mild cognitive impairment (MCI). While the impairment in MCI is mild in comparison to dementia, it is not mild to the individual and those who support them. GUIDE Model services – particularly education and care coordination – would be highly valuable to people even in this early stage of cognitive impairment and better prepare them for the clinical course ahead. In some cases, the GUIDE Model’s respite benefit and other services also may be valuable in helping family members transition into a care role and better support quality of life for the individual with MCI.*
- Elevate and improve acute and emergency care for individuals living with AD/ADRD. We encourage the NAPA Advisory Council to ensure sustained funding for NIH research programs like GEAR aimed at advancing the science, and to raise awareness and encourage implementation of the GEDA accreditation program and hospital at-home programs. Ensuring individuals and families have options for AD/ADRD-capable acute and emergency care is critical to ensuring the safety and appropriate support for individuals living with cognitive impairment.
- Strengthen the integration of community-based AD/ADRD supports into the broader health care and social services system by promoting partnerships among health care providers, AAAs, community organizations, and other service providers, while ensuring sustained funding and broader implementation of evidence-based programs.
- Ensure coordinated efforts across HHS by aligning the work of key agencies involved in AD/ADRD research, care delivery, implementation, and community support. NIH, AHRQ, CMS, ACL, CDC, and Indian Health Service (IHS) must continue working collaboratively – through complementary efforts in evidence generation, dissemination and implementation of evidence-based practices, sustainable payment models, and

community-based supports – to ensure that comprehensive, evidence-based AD/ADRD care reaches more individuals living with cognitive impairment and their families. Developing a common HHS framework for evidentiary readiness in the AD/ADRD space is a key collaborative opportunity, particularly between NIH and ACL.

- Encourage coordination, where feasible, with other federal departments and agencies, state and local governments, private entities, and community-based organizations to advance shared goals.
 - The NAPA Advisory Council should consider ways to encourage federal agencies such as the U.S. Department of Transportation and U.S. the National Parks Service, state and local governments, Amtrak, U.S. airlines and other transportation services, and the retail sector, to become more accessible to people living with AD/ADRD and their care partners. For example, some airlines and airports along with a growing number of businesses participate in the [Sunflower Hidden Disability](#) program, a global initiative that allows individuals with non-visible disabilities to discreetly signal that they may need extra assistance, patience, or time.

6. What health outcomes and care goals are most meaningful to people living with AD/ADRD and their families, caregivers, and care partners, and how should these be measured and incorporated into care over time?

AD/ADRD research advances include growing recognition that individuals living with AD/ADRD, their care partners, and families must help shape – from the initial design stage – research, care, and treatment development. Their voices have become particularly important as drug development and, though to a lesser extent, care and services development have shifted toward the earliest stages of disease, where outcomes that matter most to individuals living with disease may not be adequately captured by traditional clinical measures alone.

The Alzheimer's Disease Patient and Caregiver Engagement ([AD PACE](#)) Initiative has demonstrated the value of applying rigorous scientific approaches to systematically identifying and measuring the outcomes and care goals that matter most to people living with AD/ADRD and, separately, to their care partners. The What Matters Most (WMM) Research Program of AD PACE (see: [sample of peer-reviewed publications and posters](#)) has conducted an observational survey-based study including 640 people with lived experience across five stages of AD progression to improve understanding and measurement of these outcomes. Results make clear that there are important variations in what symptoms and treatment outcomes matter most to people in different stages of AD, between people with AD and their care partners, and between people of different backgrounds. The person-centered data focus of AD PACE complements the [FDA's Patient-Focused Drug Development Guidance Series](#) and has become increasingly important not only for clinical trial design, but also for evaluating treatment value and informing coverage and reimbursement decisions. The next stage of this research is ongoing, and adds in the much-needed focus on aiding communication between clinicians and their patients about the disease and potential outcomes. These efforts will contribute to ensuring ongoing care is appropriately informed by the outcomes and care goals found to be most meaningful – literally “What Matters Most” - to those affected.

AD PACE focuses on individuals living with Alzheimer's disease, and it is imperative that the research and clinical community has a firm understanding of what matters most to individuals living with LBD, FTD, VCID, and other forms of dementia, their care partners, and families. The FDA's Patient-Focused Drug Development (PFDD) initiative provides an important framework for incorporating lived experience into medical product development and regulatory decision-making. Findings from recent externally-led PFDD meetings on Dementia with Lewy Bodies (2024) and Down Syndrome-associated Alzheimer's Disease (2026) and other patient listening sessions are a significant step toward ensuring that clinical trial endpoints and risk-benefit assessments reflect the outcomes most meaningful to these individuals and families.

This work is imperative as it extends beyond traditional measures of cognition and function to capture broader concepts of well-being, participation in meaningful activities, communication, autonomy, and overall quality of life – and recognize that supporting individuals in living well with AD/ADRD is a fundamental goal of care, alongside slowing disease progression.

Federal agencies participating in the NAPA Advisory Council already embrace a strengths-based approach to Alzheimer's disease and related disorders care and support, which incorporates significant focus on what individuals living with cognitive impairment still can do rather than exclusively focusing on what capabilities they have lost. By shifting away from a traditional, deficit-centered medical model, this person-centered philosophy uses an individual's remaining cognitive, emotional, and social assets to promote well-being, preserve dignity, and prevent excess disability. For example, the CMMI's GUIDE Model emphasizes supportive, holistic, and strength-based approaches focusing on remaining functional abilities, care coordination, and caregiver empowerment. Similarly, the VA Dementia Care Coordination Program utilizes specialized social workers and nurses at VA facilities to build custom care plans centered around the unique residual functional capabilities and daily living goals of the individual living with cognitive impairment. Additionally, ACL hosts specialized national webinars through its National Alzheimer's and Dementia Resource Center ([NADRC](#)) to promote person-centered, strength-based community engagement models like "[Respite for All](#)" (which was presented at the April 2026 NAPA Advisory Council meeting). Concurrently, the CDC funds the [Healthy Brain Initiative](#) to help local public health departments build dementia-capable communities that support the independence and existing assets of individuals living with cognitive decline. These and other federal agency actions support private sector initiatives including Dementia Friendly America and the work of hundreds of participating community-based DFA programs nationwide.

To ensure these outcomes are appropriately measured and incorporated into care over time, the National Plan must:

- Prioritize sustained investment in longitudinal person- and caregiver-centered data collection and better integration of these data with existing federally-funded research efforts.

- Prioritize person-centered outcome measurements for FTD, LBD, VCID, DSAD, and other forms of AD/ADRD cognitive impairment. AD PACE provides a model for meaningfully incorporating lived experience across the disease spectrum, and this approach can be expanded and adapted for all forms of AD/ADRD.
- Ensure FDA continues to support opportunities for PFDD meetings and patient listening sessions, and utilize evidence gathered to inform future activities and initiatives associated with the National Plan.
- Continue to encourage federal agencies to prioritize funding and policies that support strength-based AD/ADRD initiatives. Grants should target community programs that offer arts, music, peer mentoring, and physical activities tailored to individual strengths.
- Ensure federal guidelines and training programs encourage health and social service providers to shift from an exclusively medical model of pure deficit management to a holistic, person-centered framework.

7. What barriers exist to accessing timely, high-quality, person-centered care across different community settings and stages of disease progression?

Significant barriers exist that limit access to timely, high-quality, person-centered AD/ADRD care and support across the disease continuum. Under-diagnosis, delayed diagnosis, misdiagnosis, and under-reporting of diagnosis to the affected individuals all remain among the primary challenges inhibiting person-centered care. Many individuals and families experience prolonged periods of uncertainty before being able to access a diagnostic work-up and then receiving an accurate diagnosis due to limited awareness of early symptoms, variability in presentation, stigma associated with cognitive decline, limited access to specialists, and gaps in clinical capacity to conduct comprehensive cognitive evaluations. Earlier and more accurate differential diagnosis is essential to improving access to care as it informs personalized treatment decisions, care planning, and connection to appropriate resources and services (*specific barriers to achieving timely, differential diagnosis are described in more depth in response to Question 3*), including clinical trial participation. As innovative clinical and non-clinical prevention and treatment options continue to emerge, differential diagnosis will also increase in importance for its value in providing a clear family history to blood relatives. There is also persistent confusion between dementia and delirium, underscoring the need for greater clinician education and broader adoption of personalized, evidence-based approaches to ensure accurate diagnosis and care.

Beyond diagnosis, many existing programs and services continue to rely on a one-size-fits-all approach that does not adequately address the heterogeneous needs of people living with AD/ADRD. Cognitive impairment is not a single or static condition. Individuals experience different symptoms and intensity of symptoms, rates of progression, and functional changes based on disease pathology and their lived experiences; and care and support needs differ based on underlying disease process, age of onset, co-occurring conditions, and personal circumstances. For example, services must differ for individuals with Down syndrome-associated Alzheimer's disease (DSAD) vs. younger-onset AD vs. individuals with co-occurring intellectual, developmental, or other disabilities. Similarly, a person with

frontotemporal degeneration or Lewy body dementia would benefit more from tailored services than from services designed around an AD model. Additionally, services for people with mild cognitive impairment (MCI) should be distinct from those for people who have progressed to dementia stages of impairment.

Access to quality care is further hindered by workforce shortages across all disciplines from direct care workers through clinical specialists, fragmented care delivery, and inadequate coordination across primary care, specialty care, hospitals, home- and community-based services, and long-term care settings. Many individuals living with MCI and dementia are also living with other chronic conditions and require care from multiple providers, yet the current U.S. healthcare system often lacks incentives for care coordination, resulting in fragmented care that can increase avoidable healthcare utilization and overlook the important role of care partners. Furthermore, stigma and the non-disclosure by health providers of cognitive concerns or an AD/ADRD diagnosis can also limit participation in support services and reduce opportunities for advance care planning.

To address these barriers, the National Plan must:

- Expand access to comprehensive cognitive assessment and reduce barriers to early and differential diagnosis
- Address workforce shortages by expanding AD/ADRD workforce education training and supporting interdisciplinary care teams (*see also response to Question 4*)
- Increase clinician education of differential diagnosis, including distinguishing dementia from delirium, and disease staging.
- Ensure tailored AD/ADRD services and supports are available to individuals across the country. Services should be tailored to different disease pathologies and stages, age of onset, culture and linguistic background, individual goals, degree of family care partner availability and burden, etc. (*see also response to Question 4*)
- Increase public awareness of cognitive impairment to encourage earlier evaluation, diagnosis disclosure, reduced stigma, advance care planning, and engagement with available services.
- Support legislation that aims to improve early care coordination and recognize the role of the care partner. For example, enactment of the BRIDGE Act ([H.R.6799](#)) would aid in reducing fragmentation for individuals diagnosed with AD before the traditional age of Medicare eligibility. The enactment of the Essential Caregivers Act ([H.R.6766](#)/ [S.3492](#)) would help ensure that care partners can continue providing critical support during hospitalizations and other care transitions (including during public health emergencies).

8. What workforce or infrastructure challenges most affect:

a. AD/ADRD research and intervention development

- **Research workforce.** Recent federal funding changes have weakened the research workforce. Grant cancellations continue to disrupt ongoing studies and reduce support for research programs, while early-career investigators have

been disproportionately affected, threatening the pipeline of future AD/ADRD researchers and limiting opportunities for mentorship and career development.

- **Clinical trial recruitment infrastructure.** Substantial cost and specialized expertise are required to conduct effective outreach and sustained engagement with individuals and communities most impacted by AD/ADRD. Building and maintaining trust with these communities requires long-term investment in community partnerships, evidence-based recruitment strategies, and retention efforts – and also requires hiring and training skilled individuals to lead outreach and engagement activities. Evidence submitted to the FDA and CMS must reflect the safety, efficacy, and clinical benefit data for all intended user populations, and infrastructure and resources must be supported to ensure that representative data is generated to meet these important scientific and regulatory expectations.

b. risk reduction activities

- **Public health infrastructure.** Sustained investment in public education and community-based risk reduction programs is needed to increase awareness of modifiable risk factors and support healthy aging across the lifespan. Recent reductions in federal public health capacity, including the disbandment of the CDC Healthy Aging Branch and budget cuts affecting chronic disease programs, threaten the ability to coordinate and implement evidence-based initiatives. Conflicting public health messages from the federal government also creates new challenges for the community (e.g., reduced adherence to recommended vaccinations despite evidence that flu and shingles vaccines may lower one's risk of cognitive impairment and are important in reducing morbidity and mortality among people with AD/ADRD who typically are more medically fragile and vulnerable than their peers who are not cognitively impaired).
- **Access to preventive services.** Many individuals and communities face persistent challenges to adopting healthy lifestyle behaviors and/or significant barriers to preventative healthcare related to cost, transportation, and limited availability of services. For example, Tribal and other rural communities may have more difficulty accessing both primary and specialty health care, healthy food options, and smoking cessation and physical activity programs, which make it far more difficult to adopt and sustain risk reduction behaviors.

c. public health AD/ADRD initiatives

- **Public health workforce capacity and sustained infrastructure.** Federal, state, local, and Tribal public health departments/agencies require sufficient staffing, funding, and other resources to implement and sustain AD/ADRD initiatives. Reductions in federal public health personnel, technical assistance, and funding opportunities limit the capacity to support surveillance, workforce training, implementation of evidence-based programs, and partnerships with healthcare systems and community organizations across the country. Limited capacity and a lack of sustained infrastructure can make it difficult to translate

evidence into practice consistently across communities and to sustain successful programs over time.

d. delivery of healthcare and long-term care

- **Healthcare workforce shortages.** Persistent shortages of healthcare professionals with expertise in AD/ADRD – including geriatricians, neurologists, geriatric psychiatrists, geriatric advanced practice nurses, neuropsychologists, and direct care workers – limit timely diagnosis, comprehensive care, ongoing disease management, and provision of even basic health and safety care services (let alone the sort of strengths-based approaches described in response to Question 6). Workforce shortages are particularly acute in Tribal, rural, and other underserved communities and for people with atypical forms of cognitive impairment such as young-onset AD, DSAD, FTD, and LBD
- **Diagnostic infrastructure.** As screening, diagnostic, and prognostic blood-based biomarkers become available, healthcare systems need the infrastructure to support their appropriate use. This includes laboratory capacity, standardized clinical workflows, provider training (including for disclosure best practices), reimbursement pathways, and equitable access to testing. Continued investment in this infrastructure will be essential to ensure biomarkers can be effectively integrated into clinical care.
- **Disease management and care delivery infrastructure.** Health systems often lack the infrastructure needed to deliver coordinated, team-based AD/ADRD treatment and care across settings. Fragmented care delivery, limited care coordination, and inadequate integration of medical, behavioral, and long-term services contribute to inefficiencies and place additional burdens on people living with cognitive impairment and their families.

e. support for families, caregivers, and care partners?

- **Fragmented care and support systems.** Families and care partners frequently navigate disconnected healthcare, long-term services and supports, and community-based systems with limited coordination. This fragmentation makes it difficult to identify, access, and utilize appropriate services throughout the course of the disease. In all too many cases, families are left to figure it out on their own, sometimes with informal or sporadic support from friends, community volunteers, or generalized tips from patient-advocacy organizations.
- **Access to tailored support.** Many communities have limited access to culturally- and linguistically-appropriate education, support services, and dementia-capable programs. For rural and underserved areas, geographic barriers, transportation challenges, and shortages of home- and community-based services (HCBS) further limit access to the resources most families and care partners desperately need. A lack of programs tailored for individuals living with DSAD, FTD, LBD, or VCID, among other forms of cognitive impairment, also remains a substantial barrier to families and care partners seeking adequate support and care.

Conclusion

As HHS looks ahead to the next phase of the National Plan, there is an opportunity to build on the progress of the past decade and address the current gaps that exist in translating these advances to individuals, care partners, families, and communities. The next iteration of the National Plan must be grounded in a clear commitment to ensuring that every person affected by AD/ADRD has access to **equitable, timely, accurate, compassionate, and actionable** prevention, diagnosis, treatment, and care. Achieving this vision will require sustained investment in research that advances our understanding of AD/ADRD, produces rigorous evidence, and moves the field closer to a precision medicine model in which prevention, diagnosis, treatment, and care can be increasingly tailored to individuals and their needs. At the same time, the nation must begin to translate what is already known into action – raising awareness and adoption of modifiable risk factors, expanding access to treatment and care, and ensuring that individuals and families have the information and support they need.

A successful National Plan must also recognize that scientific progress will only improve outcomes if the healthcare systems and communities are prepared to deliver it. Steps must be taken to strategically strengthen the AD/ADRD workforce through training and education, preparing healthcare systems to adopt emerging advances, and building the infrastructure, policies, and partnerships necessary to bring innovation into real-world clinical settings. Equally important is addressing the stigma and mistrust that can prevent people from seeking care or participating in research; investing in dementia-capable communities that can support individuals and care partners throughout the disease journey is imperative. Ultimately, the next National Plan must commit to ensuring that advances translate into meaningful improvements in people's lives — and those improvements are tailored to reach all communities.

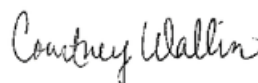
Thank you for the opportunity to provide input and for your continued commitment to the AD/ADRD community. Please consider the LEAD Coalition as a partner for federal agencies and Congress in advancing the work of the National Plan.

For any questions or additional information, please contact Ian Kremer, executive director of LEAD Coalition, ikremer@leadcoalition.org, or Courtney Wallin, federal policy director of the LEAD Coalition, cwallin@leadcoalition.org.

Sincerely,



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