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Meaningful Lives As We Age

August 15, 2026

Maria-Theresa Okafor, Ph.D., MCG
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Department of Health and Human Services
Submitted electronically via regulations.gov

Re: HHS Request for Comment on the Update to the National Plan To Address Alzheimer's Disease
Docket ID: HHS-ASPE-2026-0298

Dear Dr. Okafor and Respected Colleagues:

The Gerontological Society of America (GSA) appreciates the opportunity to provide comments to inform the comprehensive update to the National Plan to Address Alzheimer's Disease. HHS has stated that this update will guide federal efforts through 2035 and seeks input on AD/ADRD research, risk reduction, early detection and diagnosis, care, services and supports, caregiver needs, workforce, infrastructure, and coordination across federal, state, Tribal, local, private sector, and community partners (U.S. Department of Health and Human Services [HHS], 2026).

GSA's mission is to foster excellence, innovation, and collaboration to advance aging research, education, practice, and policy. We envision meaningful lives as we age. GSA's 6,000 members include gerontologists, health professionals, behavioral and social scientists, biologists, demographers, economists, and many other disciplines. These experts study all facets of aging with a life-course orientation. The multidisciplinary nature of the GSA membership is a valued strength, enabling the Society to provide a rich perspective on the issues facing our population as we age.

GSA's comments are informed by its multidisciplinary membership; peer-reviewed scientific and educational work; public resources including the GSA KAER Toolkit for Brain Health; the National Center to Reframe Aging; GSA's policy work on workforce, care delivery, and access; and recent member input gathered through GSA convenings focused on brain health, dementia detection, caregiver support, workforce, public health, and person-centered dementia care. As a member of the Leaders Engaged on Alzheimer's Disease (LEAD) Coalition, GSA is also pleased to support the coalition's comments.

Priority Recommendations
GSA urges HHS to sustain a healthy AD/ADRD research ecosystem and strengthen translation, implementation, workforce, care delivery, public health, and caregiver support. The Plan can connect discovery to practice while continuing to support the research infrastructure that makes discovery possible.

- **Sustain a robust AD/ADRD and aging research ecosystem.** The Plan should support basic, translational, clinical, behavioral, social, health services, implementation, and policy research, including research training and career pathways for investigators across disciplines.
- **Strengthen primary care capacity for brain health, early detection, diagnosis, and referral.** The GSA KAER Toolkit for Brain Health equips primary care teams to Kickstart brain health conversations, Assess for

cognitive impairment, Evaluate for dementia, and Refer individuals and families to community resources (Gerontological Society of America [GSA], n.d.).

- **Advance AD/ADRD research, care, and caregiver support recognizing the impact of sex differences.** GSA-published work points to the importance of recognizing sex differences in aging research, memory performance, dementia risk, and dementia caregiving (Anderson et al., 2023; Arbel et al., 2019; Bohn et al., 2024; Eastman et al., 2022).
- **Promote brain health and dementia risk reduction across the lifespan.** The U.S. POINTER randomized clinical trial found that both structured and self-guided multidomain lifestyle interventions improved cognition, with greater benefit in the structured intervention group (Baker et al., 2025).
- **Address stigma and communication barriers directly.** The Plan should include actionable strategies to reduce barriers to timely conversations, help-seeking, diagnosis, referral, and follow-up. Dementia-related stigma can affect recognition, help-seeking, clinical interactions, and care quality (Herrmann et al., 2018; Warren & Wynia, 2025).
- **Strengthen public health infrastructure and federal subject-matter capacity.** The Plan should ensure sustained CDC and public health capacity for dementia risk reduction, early detection and diagnosis, caregiving, data, health communication, and state, local, Tribal, and community implementation, building on the Healthy Brain Initiative Road Map and BOLD infrastructure (Centers for Disease Control and Prevention [CDC], 2024a, 2024b).
- **Support a dementia-capable workforce across the full continuum.** The Plan should support the research workforce, primary care, geriatrics, nursing, social work, pharmacy, direct care, care navigation, public health, community health, and aging services workforces. HRSA's GWEP and GACA programs, GSA education resources, and aging-sector coalitions provide infrastructure the Plan can build on (American Geriatrics Society, n.d.; Eldercare Workforce Alliance, n.d.; Health Resources and Services Administration [HRSA], 2023a, 2023b).
- **Support caregivers and community-based services as core infrastructure.** The Plan should recognize caregivers as essential partners in care, measure caregiver outcomes, support respite and care navigation, and strengthen linkages between clinical systems and community-based aging services.

Responses to RFI Questions

Question 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?

The updated National Plan should strengthen the AD/ADRD research ecosystem while building the infrastructure needed to translate discoveries into practice. GSA recommends that HHS support the full continuum of research, including basic biology of aging, geroscience, clinical research, behavioral and social research, health services research, implementation science, and policy research. Sustaining this ecosystem is essential to the Plan's long-term success through 2035.

GSA also recommends that the Plan make translation a funded and measurable priority. Research investments should support the work required to integrate evidence into primary care workflows, community-based services, long-term care, caregiver supports, reimbursement models, data systems, and team-based care. GSA's brain health resources for primary care, including Insights & Implications and the KAER Toolkit, are examples of how

research can be curated and translated for clinicians who need actionable guidance in practice (GSA, 2025a, 2025b, n.d.).

Sex differences should be treated as core scientific variables across AD/ADRD research and translation. GSA has previously urged NIA to elevate age-and-sex interactions in aging research (GSA, 2024). GSA's Public Policy & Aging Report issue on sex differences in aging research, health care, and policy underscores that biological sex has too often been overlooked in disease etiology, manifestation, treatment, and care (Anderson et al., 2023; Public Policy & Aging Report, 2023).

GSA-published research further illustrates why the Plan should move beyond simple demographic reporting. Innovation in Aging has shown that selected contextual factors may mediate observed sex differences in memory performance among cognitively normal older adults (Bohn et al., 2024). The Gerontologist has synthesized sex differences among dementia spousal caregivers, including differences in depression, burden, physical health, and informal supports (Arbel et al., 2019). The Journals of Gerontology: Series A has published evidence on sex differences in dementia risk among older Veterans (Eastman et al., 2022).

The updated Plan should require more consistent measurement and reporting of sex differences in AD/ADRD research, support studies that distinguish biological sex from social and life-course exposures, and ensure that findings are translated into detection, diagnosis, treatment, care planning, caregiver support, and outcome measurement.

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

The updated Plan should treat brain health as a lifespan public health priority. The GSA KAER Toolkit for Brain Health states that many strategies can help preserve brain health and that early conversations and planning should begin as part of routine health care (GSA, n.d.). This approach aligns with GSA's life-course orientation and with the need to normalize brain health before a crisis occurs.

U.S. POINTER provides important evidence for multidomain lifestyle approaches to brain health. In the randomized clinical trial, Baker and colleagues found that both structured and self-guided multidomain lifestyle interventions improved cognition in older adults at risk for cognitive decline, with greater cognitive benefit in the structured intervention group (Baker et al., 2025).

The Plan should also invest in communication strategies that avoid fatalistic or decline-only assumptions about aging. The National Center to Reframe Aging, led by GSA, advances tested communication strategies to frame aging more effectively and counter age-related tropes that drive unproductive thinking about age (National Center to Reframe Aging, n.d.). Public-facing brain health messages should emphasize that aging is a life-long process shaped by biology, environments, policies, opportunities, and supports.

GSA recommends that HHS align risk-reduction goals with CDC's Healthy Brain Initiative and BOLD infrastructure while ensuring sustained public health subject-matter expertise and capacity. The Healthy Brain Initiative Road Map provides a framework for public health action on brain health, caregiving, partnerships, data, workforce, and public education (CDC, 2024a). The BOLD Infrastructure for Alzheimer's Act directs CDC to strengthen public health infrastructure for risk reduction, early detection and diagnosis, prevention of avoidable hospitalizations, and dementia caregiving (CDC, 2024b).

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

Barriers to timely detection and diagnosis include limited appointment time, uneven access to dementia-capable evaluation, geography, lack of standardized workflows, limited referral capacity, and stigma. Geography matters because rural and other communities with limited access may have fewer dementia-capable clinicians, longer travel distances, and fewer referral options for evaluation and follow-up.

Stigma should be addressed directly because it can delay help-seeking, reduce willingness to raise concerns, affect clinician-patient communication, and limit access to timely care. A 2025 scoping review of dementia-related stigma among physicians found that stigma remains a barrier to early recognition and effective care and that interventions such as education, skill-building, and person-centered approaches can improve clinical confidence, reduce negative stereotypes, and enhance care quality (Warren & Wynia, 2025). A systematic review of dementia-related stigma research found that stigma impedes help-seeking and treatment and can vary by knowledge, contact with people living with dementia, and cultural context (Herrmann et al., 2018).

The Plan should therefore include actionable strategies to reduce stigma and improve timely diagnosis: normalize brain health conversations during routine preventive care; support language that frames cognitive assessment as establishing a baseline and planning for health; train care teams to communicate clearly about what screening can and cannot determine; ensure referral pathways after a positive screen; and support clear communication for individuals, families, and communities.

The GSA KAER Toolkit for Brain Health offers a practical model. KAER supports primary care teams in initiating brain health conversations, assessing cognitive impairment, evaluating for dementia, and referring individuals and families to community resources (GSA, n.d.). HHS should support broader implementation of KAER-like approaches through training, workflow redesign, reimbursement supports, referral infrastructure, and partnerships with community-based aging services.

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

A persistent gap is what happens after diagnosis. A dementia diagnosis should be treated as the beginning of an ongoing care journey, not the end of a clinical encounter. The updated Plan should support systems that ensure people living with dementia and care partners receive timely follow-up, care planning, referral support, caregiver education, respite options, and connection to community resources.

GSA recommends that the Plan make referral completion and follow-through explicit quality expectations. A referral should not be considered successful simply because it was made. Systems should help confirm that individuals and caregivers reached recommended services, that barriers were addressed, and that primary care stays connected to the person's evolving needs.

The GUIDE Model should be referenced as an implementation opportunity. HHS should use GUIDE's experience to identify which care-navigation, caregiver-support, respite, payment, and community-linkage components improve outcomes and should be evaluated, refined, sustained, and scaled (Centers for Medicare & Medicaid Services [CMS], n.d., 2024).

Caregiver support should be informed by the best available evidence regarding factors that influence caregiver well-being and outcomes. GSA-published research in The Gerontologist has found that sex and gender differences among dementia spousal caregivers have been documented across domains including depression, burden, physical health, and informal supports, and that this evidence can inform more effective caregiver practices and policies (Arbel et al., 2019). The Plan should require caregiver identification, caregiver needs

assessment, caregiver education, respite access, and caregiver-reported outcomes. It should also encourage caregiver support strategies that are responsive to the circumstances and needs of individual caregivers and families.

Question 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?

GSA recommends that the Plan identify models not only by whether they are promising, but by what makes them scalable and measurable. Successful models should be adaptable across settings, grounded in evidence, usable by interprofessional teams, linked to community resources, inclusive of caregivers, and attentive to quality of life.

GSA's KAER Toolkit for Brain Health is a directly relevant model because it gives primary care teams a practical structure for brain health conversations, detection, evaluation, and referral (GSA, n.d.). GSA's Insights & Implications brain health reports are also relevant because they translate emerging evidence on biomarkers, disease-modifying therapies, detection, risk factors, and care gaps for primary care audiences (GSA, 2025a, 2025b).

GSA-published policy scholarship should also inform the Plan. The 2025 Public Policy & Aging Report issue on Dementia Policy and Practice includes articles on the AD/ADRD policy landscape, cognitive care planning, people living alone with dementia, early detection in primary care, and quality-of-life outcome measures in dementia interventions (Public Policy & Aging Report, 2025). These topics map directly to NAPA's questions about care models, meaningful outcomes, access, and person-centered care.

GUIDE and dementia-friendly community models should be referenced as implementation examples, but the policy recommendation should be clear: HHS should evaluate which components work, for whom, in what settings, and under what payment and workforce conditions; disseminate lessons learned; and align federal models with the aging services network and community-based organizations. Dementia Friendly America offers tools for communities to build awareness, adapt environments, and strengthen support across everyday settings (Dementia Friendly America, n.d.).

Question 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?

The Plan should incorporate outcomes that matter to people living with dementia and to caregivers, not only outcomes that matter to systems. Meaningful outcomes include quality of life, autonomy, social connection, ability to remain engaged in community, caregiver well-being, reduced avoidable crises, timely access to services, and alignment of care with the person's values and goals.

Shared decision-making should be a core dementia care principle. AHRQ defines shared decision-making as a collaborative process in which patients and clinicians make health care decisions informed by evidence, care-team expertise, and the patient's values, goals, preferences, and circumstances. AHRQ also notes that family members and caregivers play an important role in shared decision-making and that shared decision-making supports person-centered care (Agency for Healthcare Research and Quality [AHRQ], 2023).

Outcome measures should be collected over time because dementia is progressive and goals, needs, preferences, and caregiver capacity can change. Because caregiving experiences and outcomes may differ by sex, outcome measurement should be designed to detect and respond to these differences rather than assume a uniform caregiving experience (Arbel et al., 2019).

The Plan should also avoid defining success only by delay of decline. GSA's National Center to Reframe Aging emphasizes more complete and accurate framing of aging and the importance of avoiding narratives that reduce aging to inevitable decline (National Center to Reframe Aging, n.d.).

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

Barriers include geography, workforce shortages, fragmented care, stigma, inadequate referral follow-through, underfunded community infrastructure, and limited access to dementia-capable services. The Plan should address these barriers across the full continuum, from first concern to diagnosis, treatment, caregiving, long-term services and supports, and end-of-life care.

GSA recommends that HHS incorporate stigma reduction, clear communication, and public education into the Plan's access strategy. This should be framed as a concrete care-access issue: people and families are more likely to benefit from emerging diagnostics, treatments, care planning, and supports if they can raise concerns early and receive trustworthy information and follow-up.

Person-centered care should also be aligned with age-friendly care principles. The Age-Friendly Health Systems 4Ms framework emphasizes What Matters, Medication, Mentation, and Mobility (Institute for Healthcare Improvement, n.d.). These principles are especially relevant to dementia care because they connect cognition with the individual's goals, medications, function, mobility, and family context.

The Plan should recognize that dementia care occurs across communities, not only in clinical settings. Dementia Friendly America offers resources for community sectors to build awareness, adapt environments, and strengthen support (Dementia Friendly America, n.d.). HHS should support implementation strategies that help communities become more dementia-capable and dementia-friendly while strengthening referral links between health care and the aging services network.

Question 8. What workforce or infrastructure challenges most affect AD/ADRD research, risk reduction activities, public health initiatives, delivery of healthcare and long-term care, and support for families, caregivers, and care partners?

Workforce and infrastructure challenges cut across every domain of the National Plan. HHS should treat workforce development as a central implementation requirement for research, care, public health, community-based services, and caregiver support.

Research and intervention development. The Plan should sustain the research workforce through training, mentorship, interdisciplinary collaboration, and support for early-career investigators. AD/ADRD research requires investigators across biological, clinical, behavioral, social, health services, implementation, and policy sciences. A healthy research ecosystem also requires conference, career-development, and training mechanisms that allow ideas, methods, and investigators to move across disciplines.

Risk reduction activities. Public health, primary care, and community-based professionals need training and infrastructure to promote brain health across the lifespan. Evidence from U.S. POINTER supports multidomain risk-reduction approaches, but community implementation requires workforce, financing, and delivery capacity (Baker et al., 2025).

Public health AD/ADRD initiatives. The Plan should ensure sustained federal public health subject-matter expertise and capacity for dementia risk reduction, early detection and diagnosis, caregiving, data, and

community implementation. CDC's Healthy Brain Initiative Road Map and BOLD infrastructure provide starting points, but the long-term Plan should make this capacity durable (CDC, 2024a, 2024b).

Healthcare and long-term care delivery. The dementia-capable workforce must include primary care, geriatrics, neurology, nursing, social work, pharmacy, direct care, care navigation, community health, public health, and aging services professionals. HRSA's GWEP is designed to educate and train the health care and supportive care workforces to care for older adults in collaboration with community partners, while GACA supports clinician educators who train the next generation of geriatrics professionals (American Geriatrics Society, n.d.; HRSA, 2023a, 2023b). The Eldercare Workforce Alliance emphasizes GWEP and GACA as Title VII geriatrics workforce programs that train in geriatrics principles, engage family caregivers, promote interprofessional team-based care, improve care for older adults including those with AD/ADRD, and reach underserved and rural communities (Eldercare Workforce Alliance, n.d.).

Support for families, caregivers, and care partners. Caregivers need formal recognition, education, respite, inclusion in care planning, and connections to community support. GSA recommends that the Plan align caregiver goals with caregiving research, aging services infrastructure, and coalition expertise. GSA works with many organizations and coalitions across the aging, caregiving, dementia, and health policy communities and recommends that HHS continue to draw on that broad expertise while keeping the Plan focused on measurable supports for people living with dementia and care partners.

Closing

GSA urges HHS to ensure that the updated National Plan connects research, public health, clinical practice, community services, caregiver support, and workforce development. The next phase of national AD/ADRD policy should sustain the scientific ecosystem needed for discovery while strengthening implementation, access, person-centered care, and measurable support for people living with dementia and their families.

GSA stands ready to support HHS by contributing interdisciplinary expertise, evidence from gerontology and geriatrics, tools such as the KAER framework, workforce and education resources, and member-informed recommendations to advance a National Plan that improves brain health, dementia care, caregiver support, and quality of life across the lifespan.

If you have any additional questions or would like additional information, please contact Patricia D'Antonio, Vice President, Policy & Professional Affairs, at pdantonio@geron.org.

Thank you for your consideration.

Respectfully submitted,

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Chief Executive Officer

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