

Connecticut State Plan

to Address Alzheimer's Disease and Related Dementias
2023 - 2028



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Department of Public Health

Acknowledgements

Public health staff and consultants who coordinated the Alzheimer's Disease and Related Dementias (ADRD) Coalition and prepared this plan:

Amy Mirizzi, MPH, CPH	Connecticut Department of Public Health
Elizabeth J. Conklin, MPH	Connecticut Department of Public Health
Justin Peng, MPH	Connecticut Department of Public Health
Jennifer Behuniak	Connecticut Department of Public Health
Teresa McDowell, EdD	Partners in Social Research

Connecticut Alzheimer's Disease and Related Dementias (ADRD) Coalition Members:

Early Diagnosis & Treatment Workgroup

Carolyn DeRocco	Alzheimer's Association Connecticut Chapter
Linda Kaufman	Alzheimer's Association Connecticut Chapter
Amanda Marin-Chollom	Central Connecticut State University
Sheila Molony, PhD (Chair)	Quinnipiac University
Amy Sanders, MD (Chair)	Hartford Healthcare Ayer Neuroscience Institute Memory Care Center
Robin Tousey-Ayers	Connecticut Department of Public Health, Injury Prevention
Gigi Weiss, MSPT, CDP	RVNAhealth

Educate & Empower Workgroup

Karen Blank, MD	Institute of Living
Angela Christie	Hartford Health Care
Patrick Coll, MD	University of Connecticut Center on Aging
Carolyn DeRocco (Chair)	Alzheimer's Association Connecticut Chapter
Donna Fedus (Chair)	Gerontologist/Founder Borrow My Glasses, LLC
Maureen McIntyre	Connecticut Association of Area Agencies on Aging
Lisa Sabatini	CCARC, Inc.

Support Caregivers & Family Members Workgroup

Karina Berg, MD	University of Connecticut Center on Aging
Andrei Brel	Connecticut Association of Adult Day Centers
Claire Cote	Connecticut Department of Aging and Disability Services
Nancy Creel-Gross	Family Member
Breno Diniz, MD	University of Connecticut Center on Aging
Anna Doroghazi	American Association of Retired Persons Connecticut
Shannon Jordan	Home Instead
Christy Kovel	Alzheimer's Association Connecticut Chapter
Robin Roscillo (Chair)	Alzheimer's Association Connecticut Chapter, Volunteer
Maria Tomasetti	Alzheimer's Association Connecticut Chapter

Statewide Coordination & Policy Workgroup

Adelaide Conaway	Student Intern, CWCSEO
Brian Cournoyer	Connecticut Hospital Association

Ginny Hanbridge
Mary-Kay Harrity
Christy Kovel (Chair)
Mag Morelli
Alyssa Norwood
Patty O'Brian, CDP
Deb Polun
Sheldon Toubman, JD
Michael Werner (Chair)
Tracy Wodatch
Kristina Zdanys, MD

Alzheimer's Association Connecticut Chapter
Alzheimer's Association Connecticut Chapter
Alzheimer's Association Connecticut Chapter
LeadingAge Connecticut
Connecticut Age Well Collaborative
Hartford Healthcare Center for Healthy Aging
Connecticut Association for Community Action
Disability Rights Connecticut
Commission on Women, Children, Seniors Equity & Opportunity
Connecticut Association for Homecare
University of Connecticut Center on Aging

Data & Evaluation Workgroup

Nancy Creel-Gross
Celeste Jorge, MPH
Iva Kosutic, PhD
Justin Peng, MPH (Chair)
Xi Zheng, MPH

Family Member
Connecticut Department of Public Health, BRFSS
Partners in Social Research
Connecticut Department of Public Health, Chronic Diseases
Connecticut Department of Public Health, BRFSS

Additional Coalition Members

Christopher Carter, MPA
Jennifer Cavallaro
Erica DeFrancesco
Heidi Gil
Robyn Harper-Gulley
David Hunter
Dawn Lambert
Nancy V. Leonard, LCSW, MBA
Katie Luce
Yazeed Maghaydah, MD
Richard Marottoli, MD, MPH
Teresa McDowell, EdD
Alyssa Norwood, JD, MPH
Chioma Ogazi, DVM, MS, RN
Sherry Ostrout
Maireed Painter
Milagrosa Seguinot
Andrew Yim, APRN, MPH

Connecticut Assisted Living Association
Connecticut Department of Social Services
LiveWell
LiveWell
North Central Area Agency on Aging
Mary Wade Home
Connecticut Department of Social Services
Master's in Homecare
LiveWell
University of Connecticut Center on Aging
Yale School of Medicine, Department Internal Medicine/Geriatrics
Partners in Social Research
Connecticut Age Well Collaborative
Connecticut Department of Public Health, Chronic Diseases
Connecticut Healthy Living Collective
Connecticut State Long Term Care Ombudsman Program
Community Health Workers Association of Connecticut
Community Health Center, Inc.

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Acronyms

ADRD	Alzheimer's Disease and Related Dementias
BRFSS	Behavioral Risk Factor Surveillance System
BOLD	Building our Largest Dementia (BOLD) Infrastructure for Alzheimer Act
CDC	Centers for Disease Control and Prevention
COE	Centers of Excellence
CT	Connecticut
DPH	Department of Public Health
EHR	Electronic Health Records
FDA	Food and Drug Administration
MCI	Mild Cognitive Impairment
PCP	Primary Care Physician
SCD	Subjective Cognitive Decline
RM	Healthy Brain Initiative 2018-2023 Road Map

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Executive Summary

Dementia is an overall term referring to loss of memory, language, problem-solving, and other thinking ability, severe enough to interfere with everyday life. Alzheimer's disease is the most common type of dementia, accounting for 60-80% of all dementia cases. A recent annual report released by the Alzheimer's Association estimated 80,000 people in Connecticut age 65 and over had Alzheimer's in 2020, and this number is projected to grow to 91,000 by 2025.¹

As of this writing, the Centers for Disease Control and Prevention (CDC) has two Healthy Brain Initiative Road Maps (HBI RMs): [State and Local Public Health Partnership to Address Dementia 2018-2023 Road Map](#) and Healthy Brain Initiative Road Map for Indian Country. HBI RMs outline actionable steps to promote brain health, address cognitive impairment, and address caregiver needs.

Nationally, the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act was passed into law in 2018 (P.L. 115-406) and amends the Public Health Service Act (Section 398A; 42 U.S.C. 280c-3-4). This Act focused on creating a uniform national public health infrastructure and supports efforts related to the HBI Road Maps (RM), including increasing early detection and diagnosis, risk reduction, prevention of avoidable hospitalizations, and supporting dementia caregiving.

With support from US Department of Health and Human Services Centers for Disease Control and Prevention, Grant # NU58DP006942 BOLD Core Capacity Award, the Connecticut State Plan to Address Alzheimer's Disease and Related Dementias (CT ADRD State Plan) was developed as a strategic plan that engaged a wide variety of stakeholders and community partners in determining a common vision for meeting urgent needs and priority actions related to those in Connecticut with ADRD and their care partners. The CT ADRD Plan was informed by the HBI RM and includes many of the 25 actions under six main goals:

- 1) **IMPROVE COORDINATION STATEWIDE ACROSS THE CONTINUUM OF CARE**
- 2) **INCREASE PUBLIC KNOWLEDGE AND AWARENESS**
- 3) **WORKFORCE DEVELOPMENT**
- 4) **BEST PRACTICES FOR EARLY DIAGNOSIS AND TREATMENT**
- 5) **COMMUNITY SUPPORT FOR THOSE WITH ADRD & THEIR CARE PARTNERS**
- 6) **DATA AND SURVEILLANCE**

The CT ADRD State Plan is designed to be reviewed and revised annually by the CT ADRD Coalition and other stakeholders. The plan is also designed to identify funding and action priorities. As the plan develops and funding is secured, strategies will be amended, and specific timelines will be added.

The Connecticut Department of Public Health is committed to applying a public health approach through collaboration with key partners to inform policy, systems, and environmental changes to decrease the burden of Alzheimer's disease and related dementias (ADRD) in the state over the next five-years.

Background

What is Alzheimer's Disease/Dementia?

Dementia is an overall term referring to loss of memory, language, problem-solving and other thinking ability severe enough to interfere with everyday life. Dementia develops when brain cells are damaged and cannot communicate with each other normally. When that happens, a person's ability to think, behave, and feel can be affected.² There are many types of dementia, including Alzheimer's disease, Vascular dementia, Lewy body dementia, Parkinson's disease, Frontotemporal dementia, Huntington's disease, Creutzfeldt-Jakob disease, Normal pressure hydrocephalus, and Wernicke-Korsakoff syndrome.³ Mixed dementia refers to someone having two or more types of dementia.

Alzheimer's is the most common type of dementia, accounting for 60-80% of all dementia cases.⁴ The causes of Alzheimer's disease are not fully understood by scientists. People with Alzheimer's disease have plaques and tangles in their brains that result in loss of neurons and their connections.⁵ Plaques are formed by clumps of amyloid proteins that damage brain cells, and tangles are fibrous tangles made up of tau proteins that prevent brain cells from communicating.⁶

Alzheimer's is a progressive disease with worsening symptoms over time. Mild cognitive impairment (MCI) with visible signs of hallmark changes in the brain can be seen as an early stage of the Alzheimer's disease, but not everyone with MCI will develop dementia. The stages of Alzheimer's disease are categorized as early-stage (mild), middle-stage (moderate), and late-stage (severe).⁷ Individuals with mild Alzheimer's may function independently, but experience having memory lapses, such as not remembering familiar words or the location of everyday objects. Other signs of mild symptoms include wandering and getting lost, repeating the same questions, and getting upset and

angry more easily. In the moderate stage of Alzheimer's, the dementia symptoms become more noticeable. Memory loss and confusion get worse, and those in the moderate stage start having problems recognizing their friends and family. Learning new things, dressing, and coping with new situations become increasingly difficult. They may begin to hallucinate, have delusions, become paranoid, and/or act impulsively. At this stage, it is often too difficult to perform routine tasks without assistance.⁷ People in the severe stage of Alzheimer's need extensive care as their brain tissue



shrinks and memory and cognitive skills deteriorate significantly. They need around-the-clock care and require help with basic activities of everyday living, such as eating, bathing, dressing, and using the bathroom. They become unable to control their movement, and their ability to communicate with others may be lost. Alzheimer's disease is ultimately fatal.^{7,8}

Risk Factors

Alzheimer's disease and related dementias (ADRD) includes all disorders that cause dementia. Risk factors for developing ADRD are categorized as modifiable and non-modifiable. Age is non-modifiable and the most important risk factor for ADRD. In fact, ADRD incidence and prevalence doubles every 5 years after 65 years of age.⁹ However, dementia is not a normal part of aging, and young people can develop ADRD. Other non-modifiable risk factors that put people at greater risk of developing ADRD are having a family history of dementia or having Down syndrome.¹⁰ Researchers have also found that people with *apolipoprotein E* gene called *APOE4* may be at increased risk of developing ADRD due to altering brain cells' lipid metabolism.¹¹

Modifiable risk factors are behaviors or health conditions people can change or improve to reduce the risk of developing ADRD. For example, regular exercise may increase blood and oxygen supply to the brain, which benefit the brain cells and lower the risk of ADRD. There is also evidence that suggests certain heart-healthy diets, such as the Dietary Approaches to Stop Hypertension (DASH) diet and Mediterranean diet, may help protect the brain and lower the risk of ADRD. Heart-healthy diets generally emphasize eating fruits, vegetables, whole grains, fish, seeds, and nuts and avoiding red meats, salt, sweets, and sugary drinks. Excessive alcohol use can cause brain changes, and smoking can damage blood vessels, increasing the risk of developing ADRD. Addressing hypertension, high cholesterol, and obesity; reducing depression and social isolation; and managing diabetes are other modifiable risk factors that can reduce the risk of

developing ADRD. Furthermore, some studies indicate there is a strong link between traumatic brain injury and future risk of cognitive decline, and efforts to prevent head traumas (eg, wearing seat belt, using a helmet when playing sports, and fall-proofing homes) can reduce the risk developing ADRD.^{6,10}

Treatments

Currently there is no cure for ADRD. At the time of this writing, the US Food and Drug Administration (FDA) has approved two treatments that address the underlying biology. Other medications may temporarily relieve Alzheimer's symptoms, such as memory loss and confusion.

More recent medications have been researched and developed, and people with Alzheimer's and their care partners are encouraged to discuss the appropriateness and potential benefits and side effects of the pharmacologic treatments with their healthcare providers. Non-drug treatments aimed at reducing the modifiable risk factors for ADRD are often used to maintain or improve cognitive function and quality of life. Active management of ADRD can improve the quality of life for people with ADRD and their care partners. This includes appropriately using available treatment choices, managing coexisting conditions, coordinating care, effectively training care partners, participating in meaningful activity, connecting with others living with dementia, becoming educated about the disease, and planning for the future.^{1,12}

Prevalence

Over 6 million people in the United States age 65 and over, or about 1 in 9 people, are estimated to have Alzheimer's disease, and the number is projected to grow to 14 million by 2060 as more



Americans are surviving into their 80s, 90s, and beyond. About three-quarters of people with Alzheimer's disease are age 75 or older.^{13–15} A recent annual report estimated 80,000 people in Connecticut age 65 and over had Alzheimer's in 2020, and this number is projected to grow to 91,000 by 2025.¹

Subjective Cognitive Decline

Subjective cognitive decline (SCD) is a self-reported experience of more frequent confusion or worsening memory loss within the past year. This is one of the earliest symptoms of ADRD. One mechanism of estimating prevalence of SCD is through the Behavioral Risk Factor Surveillance System (BRFSS), which is a state-based telephone survey of adults aged 18 years and older in all 50 states, the District of Columbia, and several U.S. territories.¹⁶ In 2019, Connecticut included the Cognitive Decline module in the BRFSS, providing a snapshot of SCD issues reported by residents aged 45 years and older. The data showed 7.3% or about 102,000 people aged 45 years and older reported experiencing SCD. As expected, SCD prevalence

was significantly higher in older adults, with an estimated 10.3% of people aged 75 and older who experienced/have SCD compared with 6.8% of people between 45 and 74 years of age. Residents with a household income of less than \$25,000 reported significantly higher prevalence of SCD when compared to those with a household income of \$75,000 or more (13.4% vs. 4.6%). People with a high school education or less reported significantly higher prevalence of SCD when compared to those with more than a high school education (9.8% vs. 6.0%). SCD prevalence did not vary significantly by sex or race/ethnicity.¹⁷

Among people with SCD, 33.7% reported having to give up day-to-day household activities or chores, such as cooking, cleaning, taking medications, driving, or paying bills. As a result of having SCD, 26.0% reported needing assistance with these day-to-day activities. Among those needing assistance, 3 in 4 (76.8%) were able to get the help they needed. Besides having difficulty with day-to-day activities, 28.5% of people with SCD reported it interfered with their ability to work, volunteer, or engage in social activities outside the home. When examining for limitations in household or social activities, about 2 in 5 people (42.1%) with SCD reported having at least one type of limitation. Despite experiencing worsening confusion or memory loss, only half (49.9%) have discussed their symptoms with a healthcare provider.¹⁷ Additionally, 4 in 5 people (81%) with SCD have at least one chronic condition (i.e., risk factors for ADRD), which further highlights the importance of discussing their SCD symptoms with a healthcare provider.¹⁸

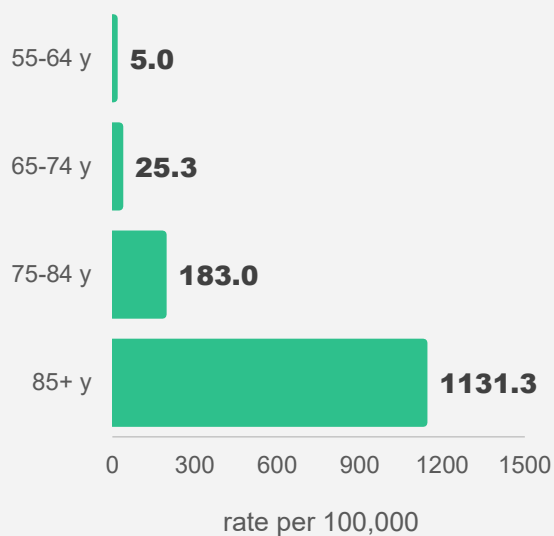
Mortality

Alzheimer's disease was the sixth or seventh leading cause of death in the United States in 2019, 2020, and 2021. The age-adjusted death rate for ADRD was 28.0 per 100,000 population in 2021.

Age is the most important risk factor for ADRD, with the death rate increasing to 183.0 per 100,000 population among those aged 75-84 years and 1,131.3 per 100,000 population among those 85 years old and older. The 2021 ADRD death rates were also higher among female and non-Hispanic White populations. Note that people with ADRD who died due to acute conditions such as pneumonia may not have ADRD listed as the primary cause of death, even though ADRD may well have caused the acute condition listed on death certificate. Looking at deaths that listed ADRD as either an underlying or contributing cause of death may show a clearer impact of ADRD on deaths. In 2021, 1862 Connecticut residents died with ADRD listed as underlying or contributing cause of death, with an age-adjusted death rate of 34.5 per 100,000 population.¹⁹ Figures 1-3 show the provisional 2021 data on the rates for ADRD as the underlying cause of death by age group, race/ethnicity, and sex.

FIGURE 1

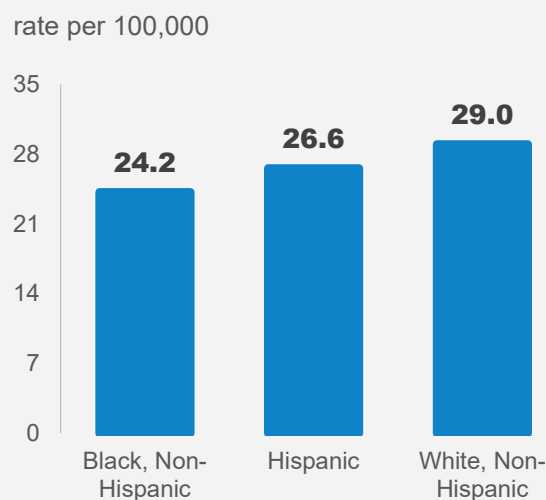
Rate for ADRD as the underlying cause of death by age group, Connecticut, 2021



Note: See Appendix B, Table 2 for technical data.

FIGURE 2

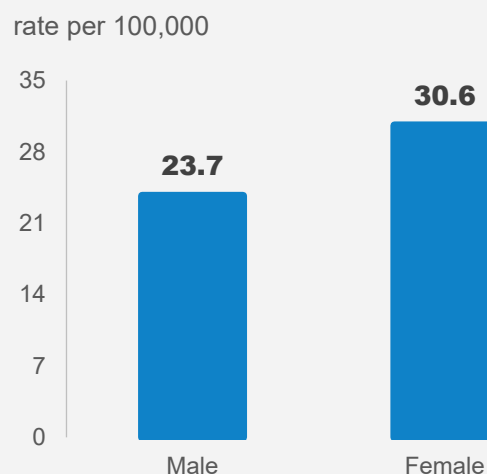
Age-adjusted rate for ADRD as the underlying cause of death by race, Connecticut, 2021



Note: See Appendix B, Table 2 for technical data.

FIGURE 3

Age-adjusted rate for ADRD as the underlying cause of death by sex, Connecticut, 2021



Note: See Appendix B, Table 2 for technical data.

Hospitalization and Emergency Department Visits

ADRD can result in disability and poor health that require hospitalization or emergency department (ED) visits. To examine ADRD morbidities, both hospitalizations and ED visits that listed ADRD in any of the diagnosis codes as reason for visit (ie, ADRD-related) were included for analysis. In 2021, there were 23,874 ADRD-related hospitalizations (467.3 per 100,000 population) and 13,359 ADRD-related ED visits (260.7 per 100,000 population)

among Connecticut residents. Like mortality, rates for ADRD-related hospitalization and ED visit are much higher among older adults (Figure 4). Non-Hispanic Black and Hispanic residents also experienced disproportionately high rates of ADRD-related hospitalization and ED visit when compared to non-Hispanic White residents (Figure 5). About 94% of ADRD-related hospitalizations and ED visits were paid for by public insurance.²⁰ Figures 4-6 show the provisional 2021 data on the number and rates of ADRD-related hospitalization and ED visit by age group, race/ ethnicity, and sex.



FIGURE 4

Rate for ADRD hospitalizations and emergency department visits as any diagnosis by age group, Connecticut, 2021

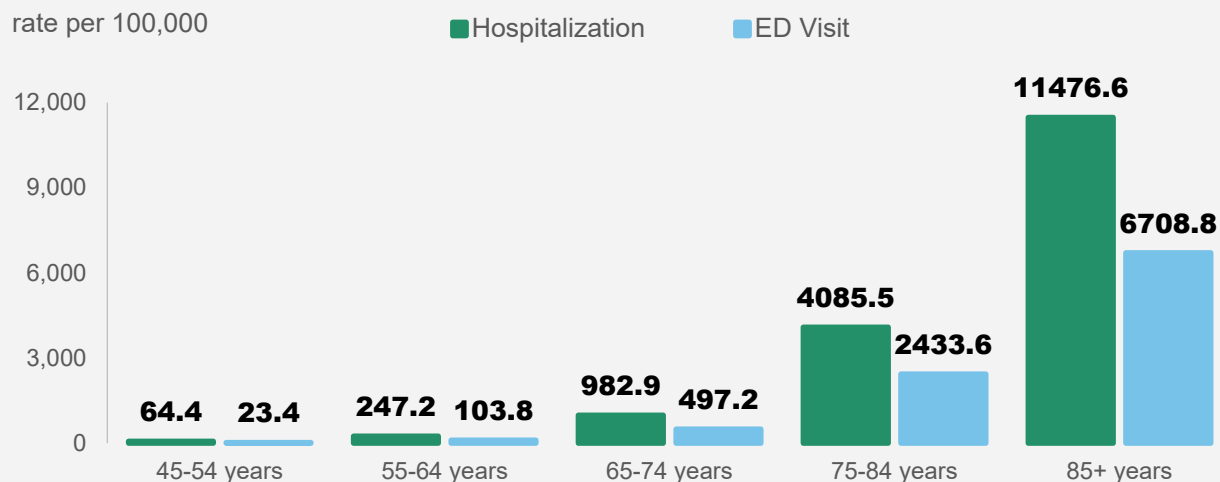
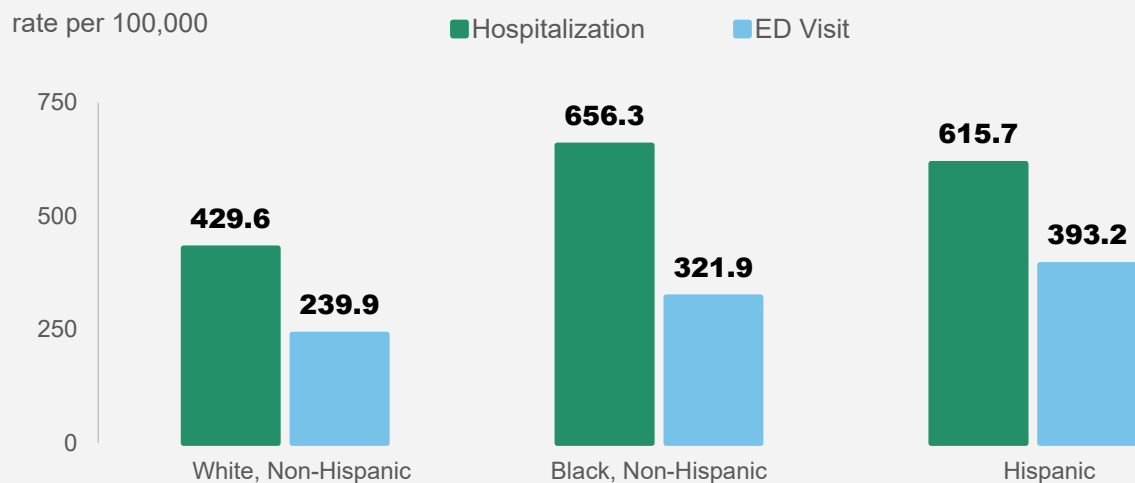


FIGURE 5

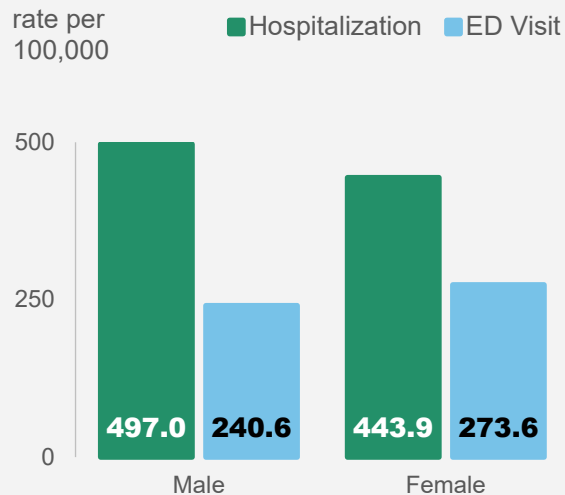
Age-adjusted rate for ADRD hospitalizations and emergency department visits as any diagnosis by race/ethnicity, Connecticut, 2021



Note: See Appendix B, Table 3 for technical data.

FIGURE 6

Age-adjusted rate for ADRD hospitalizations and emergency department visits as any diagnosis by sex, Connecticut, 2021



Note: See Appendix B, Table 3 for technical data.

Caregiving

Caregiving refers to providing regular care or assistance with one or more activities of daily living to someone who has a health problem or disability. In 2021, Connecticut included the Caregiver module in the BRFSS, providing insights into the caregiving needs among Connecticut adults 18 years and older. The data showed 1 in 5 adults (20.3%) are caregivers in Connecticut. Among caregivers 22.2% are providing care for someone with ADRD who has a major or secondary health problem. Among caregivers of those with ADRD, 72.1% are female, 29.2% are 65 years old or older, and 47.0% are caring for a parent or parent-in-law.

Caregiving for people with ADRD can be lengthy, with 63.3% having provided care for at least two years, including 35.3% for at least five years. Caregiving for people with ADRD can also be

intense, with 42.4% having provided care for at least 20 hours per week, including 25.8% providing care for at least 40 hours per week. In terms of type of care or assistance provided to people with ADRD, 85.2% manage household tasks (eg, cleaning, managing money, preparing meals) and 65.3% assist with personal care (eg, giving medications, feeding, dressing, bathing). As our population grows older, more people will be expected to provide care for their friends or family members. Among adults who are not current caregivers, 17.7% reported anticipating the need to provide care within the next two years for someone who has any kind of health problem or disability.²¹

Workforce

About 1 in 6 Connecticut residents are age 65 and over, and the number of people aged 65 and over is estimated to reach 633,000 by 2040, with more than half being age 75 and over.²² As our older population and prevalence of ADRD increase, so does the need for a workforce who can diagnose, treat, and care for those living with the disease. The workforce includes physicians, nurses, physical therapists, and social workers with specialized training in geriatrics and care of people with ADRD. The workforce also includes home health aides and personal care aides who assist with activities of daily living or household task.

The report released by the Alzheimer's Association in 2022 indicated a shortage of geriatricians in Connecticut, with 91 geriatricians in 2021.¹ To serve 10% of those 65 years old and older by 2050, the estimated number of geriatricians that would be needed is 166. That number grows to 497 if Connecticut needs to serve 30% of those 65 years old and older.

Connecticut is not alone in having a shortage of workforce capable of serving people with ADRD. It is a national and global issue that requires a major commitment and resources to build our workforce and adequately address the needs of people with ADRD.

Healthy Brain Initiative & BOLD Infrastructure

The Healthy Brain Initiative (HBI) acknowledges brain health as an important part of public health practice. According to the CDC, the Healthy Brain Initiative “creates and supports partnerships, collects and reports data, increases awareness of brain health, [and] supports populations with a high burden of Alzheimer’s disease and related dementias.”²³

Nationally, the Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer’s Act was passed into law in 2018 (PL 115-406) and amends the Public Health Service Act (Section 398A; 42 USC 280c-3-4). The Act focused on creating a uniform national public health infrastructure. This act supports efforts related to the HBI Road Maps (RM), including increasing early detection and diagnosis, risk reduction, prevention of avoidable hospitalizations, and supporting dementia caregiving.

Currently there are two Healthy Brain Initiative Road Maps (HBI RMs): State and Local Public Health Partnership to Address Dementia 2018-2023 Road Map, and Healthy Brain Initiative Road Map for Indian Country. HBI RMs outline actionable steps to promote brain health, address cognitive impairment, and address caregiver needs. Following is the HBI 2018-2023 RM agenda of 25 actions for state and local public health agencies and their partners to accomplish.







The CT ADRD Plan was informed by the HBI RM and includes many of the 25 actions; those most clearly targeted in the CT Plan are noted by the small icon (») placed next to action items in the following list of descriptions.



The Healthy Brain Initiative's (HBI) State and Local Public Health Partnerships to Address Dementia, The 2018-2023 Road Map: Action Agenda



EDUCATE & EMPOWER





-  **E-1** Educate the public about brain health and cognitive aging, changes that should be discussed with a health professional, and benefits of early detection and diagnosis.
-  **E-2** Integrate the best available evidence about brain health and cognitive decline risk factors into existing health communications that promote health and chronic condition management for people across the life span.
-  **E-3** Increase messaging that emphasizes both the important role of caregivers in supporting people with dementia and the importance of maintaining caregivers' health and well-being.
-  **E-4** Promote prevention of abuse, neglect, and exploitation of people with dementia.
-  **E-5** Provide information and tools to help people with dementia and caregivers anticipate, avert, and respond to challenges that typically arise during the course of dementia.
-  **E-6** Strengthen knowledge about, and greater use of, care planning and related tools for people with all stages of dementia.
- E-7** Improve access to and use of evidence-informed interventions, services, and supports for people with dementia and their caregivers to enhance their health, well-being, and independence.



Denotes inclusion in the Plan.



DEVELOP POLICIES & MOBILIZE PARTNERSHIPS

- P-1** Promote the use of effective interventions and best practices to protect brain health, address cognitive impairment, and help meet the needs of caregivers for people with dementia.
-  **P-2** Assure academic programs, professional associations, and accreditation and certification entities incorporate the best available science about brain health, cognitive impairment, and dementia caregiving into training for the current and future public health workforces.
- P-3** Support better informed decisions by educating policy-makers on the basics of cognitive health and impairment, the impact of dementia on caregivers and communities, and the role of public health in addressing this priority problem.
-  **P-4** Improve inclusion of healthcare quality measures that address cognitive assessments, the delivery of care planning to people with diagnosed dementia, and improved outcomes.
-  **P-5** Engage public and private partners in ongoing planning efforts to establish services and policies that promote supportive communities and workplaces for people with dementia and their caregivers.
-  **P-6** Assure public health plans that guide emergency preparedness and emergency response address the special needs of people with dementia and their caregivers, support access to critical health information during crises, and prepare emergency professionals for situations involving people with dementia.



ASSURE A COMPETENT WORKFORCE

W-1 Educate public health and healthcare professionals on sources of reliable information about brain health and ways to use the information to inform those they serve.

W-2 Ensure that health promotion and chronic disease interventions include messaging for healthcare providers that underscores the essential role of caregivers and the importance of maintaining their health and well-being.

W-3 Educate public health professionals about the best available evidence on dementia (including detection) and dementia caregiving, the role of public health, and sources of information, tools, and assistance to support public health action.

W-4 Foster continuing education to improve healthcare professionals' ability and willingness to support early diagnoses and disclosure of dementia, provide effective care planning at all stages of dementia, offer counseling and referral, and engage caregivers, as appropriate, in care management.

W-5 Strengthen the competencies of professionals who deliver healthcare and other care services to people with dementia through interprofessional training and other strategies.

W-6 Educate healthcare professionals about the importance of treating co-morbidities, addressing injury risks, and attending to behavioral health needs among people at all stages of dementia.

W-7 Educate healthcare professionals to be mindful of the health risks for caregivers, encourage caregivers' use of available information and tools, and make referrals to supportive programs and services.



MONITOR & EVALUATE

M-1 Implement the Behavioral Risk Factor Surveillance System (BRFSS) optional module for Cognitive Decline in 2019 or 2020, and the BRFSS optional module for Caregiving in 2021 or 2022.

M-2 Support national data collection on dementia and caregiving.

M-3 Use data gleaned through available surveillance strategies and other sources to inform the public health program and policy response to cognitive health, impairment, and caregiving.

M-4 Embed evaluation into training and caregiving support programs to determine program accessibility, effectiveness, and impact.

M-5 Estimate the gap between workforce capacity and anticipated demand for services to support people with dementia and their caregivers. cdc.gov/agingalz.org/publichealth.

Connecticut State Plan to Address ADRD

Plan Development

A task force established in 2013 studied the care and services provided to persons diagnosed with Alzheimer's disease and dementia in Connecticut. Based on the need to develop a state strategy to address and prepare for the escalating public health crisis, the findings and recommendations focused on strategies to increase public awareness, improve early detection and diagnosis of the disease, and address gaps in quality of care by building a capable workforce through dementia specific training. The recommendations provided a guide to improve the quality of life for those affected by ADRD and minimize the associated public and private costs through better case management. In 2019, under Public Act 19-115, a Working Group was established in CT to review and prioritize the 2013 report recommendations, and their recommendations were submitted in 2020.

In 2021, the CT Department of Public Health (DPH) entered a Cooperative Agreement with the Centers for Disease Control and Prevention (CDC) to develop a state plan for ADRD using the HBI Road Map series. DPH worked in partnership with the Alzheimer's Association CT Chapter to convene a CT ADRD Coalition to assist with the statewide strategic planning process under the CDC grant award. The Coalition is ongoing and includes over 50 representatives from approximately 40 organizations, including those that were involved in previous ADRD planning efforts, long-term care advisory body members, other state agencies, and health care, non-profit, and community-based organizations.

The kickoff meeting of the CT ADRD Coalition took place in February of 2022. During that meeting, workgroups were formed to address specific areas of the strategic plan. The work group focus areas included the following:

1. Statewide Coordination and Policy,

2. Early Diagnosis and Treatment,
3. Educate and Empower,
4. Support Caregivers and Family Members, and
5. Data Monitoring and Evaluation.

All workgroups were charged with integrating health equity and inclusion into their work.

DPH project staff met with workgroup co-chairs monthly to check on progress, receive feedback, and provide direction and support. Co-chairs were provided with extensive materials to share with workgroup members including the existing CT ADRD recommendations, the HBI 2018-2023 Road Maps, the Alzheimer's Association Strategic Plan, the Connecticut State Plan on Aging 2020-2023, and related research and literature. Co-chairs facilitated workgroup meetings every other month with administrative support from DPH staff. These meetings occurred between bi-monthly meetings of the full CT ADRD Coalition.

The full coalition meetings were designed to leverage ideas and expertise across workgroups, update all members on the progress of each workgroup, and provide the structure and guidance required to complete the strategic planning process. The last two full coalition meetings in 2022 were devoted to securing member endorsement for the strategic plan goals and objectives and working across workgroups to enhance the focus on health equity and inclusion throughout the strategic plan. DPH project staff continued to work on the plan during December of 2022 and January of 2023 to: 1) prepare for public review and comment and 2) begin using the Plan to guide ADRD efforts in Connecticut.

The CT ADRD Coalition has been established as an ongoing advisory and action group that will continue to share information, announce ADRD related efforts by various constituencies, provide expertise on ADRD related initiatives, identify gaps in ADRD care and care partner needs, and review the CT ADRD State Plan. The group is open and there is an ongoing effort to recruit new members.

CT ADRD State Plan Goals and Objectives

The Connecticut ADRD State Plan was developed as a strategic plan that engaged a wide variety of stakeholders in determining a common vision for meeting urgent needs and priority actions related to those in Connecticut with ADRD and their care partners.

Strategic plans are living documents based on a common vision that provide agreed-upon goals and objectives, proposed strategies to meet goals, and measurable expected outcomes. As such they support processes of continuous improvement when used to identify needs, create goals and strategies to meet needs, find resources necessary to act, complete strategies, evaluate the effectiveness of actions, and revise plans accordingly. Surveillance

data is used throughout the process to identify prevalence, gaps in services, areas of need, and outcomes of interventions.

The CT ADRD State Plan is designed to be reviewed and revised annually by the CT ADRD Coalition and other stakeholders. The plan is also designed to identify funding and action priorities. As the plan develops and funding is secured, strategies will be amended, and specific timelines will be added.

Following is a snapshot of the CT ADRD State Plan goals and objectives. The intention for creating this “at a glance, user-friendly” version is to ensure ease in understanding and commenting on the plan.

The full strategic plan includes six primary goals with associated objectives, strategies, and outcomes. The full plan can be found in Appendix A.



GOALS & OBJECTIVES

GOAL 1: IMPROVE COORDINATION STATEWIDE ACROSS THE CONTINUUM OF CARE



Acquire funding to address ADRD needs across Connecticut.



Expand statewide network of ADRD partnerships & activities across the state.



Explore opportunities to create and maintain Neurocognitive disorder *Centers for Excellence*.



Create & continue to build a statewide website to encompass all related information & resources for ADRD.



Identify and engage State ADRD Champions.

GOAL 2: INCREASE PUBLIC KNOWLEDGE AND AWARENESS



Promote public awareness of brain health, including knowledge regarding brain diseases, risk, and protective factors.



Promote public awareness of diagnosis, support, and resources related to brain disease and neurocognitive disorders.



Continue to expand and update public awareness efforts.

GOAL 3: WORKFORCE DEVELOPMENT



Expand initial & continuing education on ADRD for healthcare and related professions.



Build workforce capacity to identify and support those with ADRD.



Promote ADRD education for public safety and emergency personnel.

GOAL 4: BEST PRACTICES FOR EARLY DIAGNOSIS AND TREATMENT



Standardize the routine inclusion of cognitive assessments in health checks.



Improve collaborative and interdisciplinary team care.



Streamline care documents to reduce duplication and improve patient and provider access.

GOAL 5: COMMUNITY SUPPORT FOR THOSE WITH ADRD & THEIR CARE PARTNERS



Identify and assess gaps in support and services for those with ADRD and their families and care partners at the community-level



Identify, create, and disseminate resources to support the wellbeing of those with ADRD and their families and care partners



Promote Inclusive and Dementia Friendly Communities across the state

GOAL 6: DATA AND SURVEILLANCE



Maintain access to existing DPH data sources available for ADRD surveillance.



Secure a minimum of one new data source that will enhance description of ADRD burden.



Analyze and publish all available ADRD data through summary statistics and fact sheets annually.



Establish and maintain an ADRD surveillance webpage that serves as the main access point for all ADRD data in Connecticut.

NEXT STEPS



The CT State ADRD Plan will be used by the CT DPH to seek funding for and put the plan into action

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Appendix A: CT ADRD State Plan

Connecticut Alzheimer's Disease and Related Dementias (ADRD) State Plan, 2023-2028

The Connecticut State ADRD Strategic Plan was developed by engaging a wide variety of partners to develop a common vision and set of goals for meeting urgent needs and priority actions related to those in Connecticut with ADRD, their families, and care partners. The plan was open for public comment between March and May, 2023. As a strategic plan, this is a living document, meant to be used, reviewed, and updated on at least a yearly basis (eg, the next plan will be for 2024-2029 and include progress made in 2023). Timelines will be added in relationship to strategies and outcomes when funding becomes available for objectives under each goal.

GOAL 1: IMPROVE COORDINATION STATEWIDE ACROSS THE CONTINUUM OF CARE FOR THOSE WITH ADRD (P-4, P-5)*			
Objectives	Strategies	3/5-Year Outcome / Metrics	
1.1 Acquire funding to address ADRD needs across Connecticut	1.1.1 Identify state and federal funding opportunities for ADRD efforts 1.1.2 Develop Connecticut ADRD State Plan with review and feedback provided by: a. Local partners b. General Public c. Stakeholders d. State agency leadership e. Governor's Office	<ul style="list-style-type: none">Grant funding securedFinal Connecticut ADRD State Plan (to be Reviewed and Revised Annually)Improved implementation of state ADRD goals that are comprehensive across public health domains, ADRD topics, and prevention levels	
1.2 Expand statewide network of ADRD partnerships & activities across the state	1.2.1 Establish a State Dementia Coordinator position housed within state government. 1.2.2 Establish a permanent ADRD Coalition & Infrastructure 1.2.3 Assess Coalition based on attendance numbers, sector, equity, and inclusion. 1.2.4 Review and revise ADRD State Plan on an annual basis with ADRD Coalition. 1.2.5 Create and disseminate annual brief of state plan efforts, including relevant data.	<ul style="list-style-type: none">Permanent Coordinator in place to oversee state plan executionQuarterly meetings conducted and documentedIncreased engagement & diversity among Coalition membersADRD State Plan continues to reflect the needs across the State. Updates documentedAnnual brief distributed broadly	

*Healthy Brain Initiative Road Map references listed on page 25.

Objectives	Strategies	3/5-Year Outcome / Metrics
1.3 Explore opportunities to create and maintain Neurocognitive disorder Centers for Excellence (COEs)	1.3.1 Study the feasibility and financial impact of developing ADRD Centers for Excellence (COEs) or geriatric assessment units (GAU) (in- and outpatient) or Diagnostic Centers at CT hospitals 1.3.2 Assess health care infrastructure across the state for ADRD COEs 1.3.3 Research other state models	<ul style="list-style-type: none"> Documentation of the feasibility and financial impact of developing ADRD COEs or GAU or diagnostic Centers at CT hospitals Documentation of patient access to COEs Final summary report shared with funder(s), ADRD coalition, & stakeholders. SWOT analysis conducted and used to evaluate possibilities for adapting other state COE models in CT
1.4 Create & continue to build a statewide website to encompass all related information & resources for ADRD	1.4.1 Include culturally and linguistically appropriate resources related to public awareness campaigns, primary & secondary prevention resources, workforce development, early diagnosis & treatment resources, care partners, data & surveillance 1.4.2 Promote website broadly to reach all populations across the state and monitor traffic data. 1.4.3 Add continuous improvement efforts to website including new resources and necessary additions.	<ul style="list-style-type: none"> Comprehensive public facing website launched and built upon over time Online ADRD resources are reaching the public as evidenced by web traffic metrics
1.5 Identify and Engage State ADRD Champion(s)	1.5.1 Recruit State Champion(s) with clinical ADRD expertise to: <ul style="list-style-type: none"> Identify best means of information dissemination for clinical workforce Develop public speaking capacity on ADRD Work with Dementia Coordinator for recruitment & retention of ADRD referral network & state coalition (Goal 4.2) 1.5.2 Leverage State Champion(s) to create expert panel to develop best practices (referenced Goal 4.1)	<ul style="list-style-type: none"> A Clinical State Champion committed and working with State Dementia Coordinator & ADRD Coalition Expert panel created and met regularly Structure created to disseminate information to clinical workforce. Used as appropriate State Champion(s) utilized in media activities & campaign to promote ADRD information & ADRD State Plan

*Healthy Brain Initiative Road Map references listed on page 25.

GOAL 2: INCREASE PUBLIC KNOWLEDGE AND AWARENESS (E-1, E-2, E-3)*



Objectives	Strategies	3/5-Year Outcome / Metrics
2.1 Promote public awareness of brain health, including knowledge regarding brain diseases, risk, and protective factors (primary prevention).	<p>2.1.1 Carry out a statewide public awareness campaign on brain health that:</p> <ul style="list-style-type: none"> a. Includes information on disease v normal aging b. Includes when and where to go for cognitive assessments c. Includes changes that should be discussed with a health professional d. Ensures socio-culturally attuned, equity-based, multi-language approach, and diverse dissemination <p>2.1.2 Maintain active campaign information on statewide website</p> <p>2.1.3 Integrate ADRD information into DPH chronic disease programs as part of a comprehensive mind body wellness promotion effort, including memory screening</p>	<ul style="list-style-type: none"> ▪ Increased awareness among residents of CT of healthy lifestyle choices to promote brain health and reduce the risks of neurocognitive disorders ▪ State website maintained and updated as needed to align with media campaign ▪ ADRD information integrated into DPH chronic disease programs ▪ Increased awareness and understanding of ADRD topics among the public
2.2 Promote public awareness of diagnosis, support, and resources related to brain disease and neurocognitive disorders (secondary prevention).	<p>2.2.1 Carry out a statewide public awareness campaign on ADRD that:</p> <ul style="list-style-type: none"> a. Includes information on disease v normal aging b. Includes when and where to go for cognitive assessments c. Includes information on the role of care partners d. Includes care partners and those living with neurocognitive disorders in message development e. Ensures sociocultural attuned, multi-language approach; diverse dissemination, equity based <p>2.2.2 Maintain active campaign information on statewide website</p>	<ul style="list-style-type: none"> ▪ Increased awareness among those in CT who are diagnosed with neurocognitive disorders, their care partners, and family members to educate & support informed decision-making and access to resources ▪ Increased public awareness of why and where to go for cognitive assessment ▪ Increased public awareness and use of statewide website to learn about ADRD resources
2.3 Continue to expand and update public awareness efforts	<p>2.3.1 Respond to gaps</p> <p>2.3.2 Leverage Champions to grow partnerships</p> <p>2.3.3 Develop and expand partnerships to increase reach of public awareness efforts</p> <p>2.3.4 Gain input on efforts from ADRD Coalition, care partners, and those living with dementia</p>	<ul style="list-style-type: none"> ▪ Campaign efforts updated to reflect identified gaps ▪ Increased partnerships for sharing public ADRD awareness ▪ Feedback from ADRD Coalition documented and used in campaigns as necessary ▪ Increased use of information, tools, resources, and training on ADRD topics among the public and health professionals

*Healthy Brain Initiative Road Map references listed on page 25.

GOAL 3: WORKFORCE DEVELOPMENT (P-2, P-6, W-4, W-5, M-5)*



Objectives	Strategies	3/5-Year Outcome / Metrics
3.1 Expand initial & continuing education on ADRD for healthcare and related professions	<p>3.1.1 Integrate ADRD content and end of life care into existing initial trainings and refresher courses for healthcare and related professionals including oral health care providers. Offer online, on-demand trainings that cover best practices for care for those with ADRD</p> <p>3.1.2 Use coaching model for best practice education</p> <p>3.1.3 Create incentives for health professional and healthcare agencies to attend training on ADRD</p> <p>3.1.4 Develop ADRD curricula that can be delivered/modified for delivery across contexts; include social/cultural awareness, sociocultural attunement, and health equity/social determinants of health (SDOH) throughout ADRD curricula</p> <p>3.1.5 Develop a Connecticut standard for non-medical homemakers to provide ADRD care and incorporate recommendations from the CT Homemaker Companion Task Force</p>	<ul style="list-style-type: none"> Increased ability of primary care and other clinicians to apply best practices in support of detecting ADRD in high-risk populations and to make referrals to ADRD specific services Increased availability of resources for ADRD care managers Increased availability of educational resources to support non-medical homemakers/care partners in providing ADRD care Increased sociocultural attunement among all whose work impacts those with ADRD, their families, and care partners Increased awareness and understanding of ADRD topics among health professionals
3.2 Build workforce capacity to identify and support those with ADRD	<p>3.2.1 Build relationship and partner with CT Office of Workforce Strategy to create awareness of careers & direct toward training opportunities, include messaging about job satisfaction and rewards of working with those with ADRD</p> <p>3.2.2 Build relationships and partnerships with CT educational institutions, training schools, and other relevant career tracks to explore integration of ADRD in curriculum</p> <p>3.2.3 Explore incentive programs to strengthen the ADRD care workforce (eg, career pathways/pipeline, loan repayment, job placement, and agency incentives for career training)</p> <p>3.2.4 Address reimbursement issues, particularly challenges among Medicaid waiver clients or clients with managed Medicare plans</p> <p>3.2.5 Explore community health worker model as a best practice for ADRD care</p>	<ul style="list-style-type: none"> Increased interest in the care field of memory care Successful recruitment and retention of a more robust, diverse, and socioculturally attuned brain health/ADRD workforce ADRD workforce reflects the racial and ethnic makeup of CT residents
3.3 Promote ADRD education for public safety and emergency personnel (eg, law enforcement, first responders, EMS/ EMTs, municipal employees)	<p>3.3.1 Offer municipal trainings for public safety and emergency personnel</p> <p>3.3.2 Expand the categories of health care professionals required to have ADRD training hours</p>	<ul style="list-style-type: none"> Increased ADRD knowledge, awareness, and sensitivity among public safety and emergency personnel (eg, law enforcement, first responders, EMS/EMTs, municipal employees, 211 staff).

*Healthy Brain Initiative Road Map references listed on page 25.

GOAL 4: BEST PRACTICES FOR EARLY DIAGNOSIS AND TREATMENT (E-6, P-4)*



Objectives	Strategies	3/5-Year Outcome / Metrics
4.1 Standardize the routine inclusion of cognitive assessments in health checks	<p>4.1.1 Create collaborative expert panel to develop best practices to include:</p> <ul style="list-style-type: none"> a. Comprehensive memory screening b. Diagnosis & disclosure c. Treatment options / FDA-approved medications d. Care for those with ADRD e. Collaboration with care partners f. Equity-based and socioculturally attuned care for patients <p>4.1.2 Explore options for patient care bundles by engaging providers and stakeholders throughout the process</p> <p>4.1.3 Educate PCPs on Medicaid and Medicare coverage of memory screening (e.g, Medicare Annual Wellness visits)</p> <p>4.1.4 Embed memory screening tools within Emergency Department visit protocols</p>	<ul style="list-style-type: none"> ▪ Increased number of routine cognitive assessments completed ▪ Increased proportion of older adults with subjective cognitive decline who have discussed their symptoms with a health professional ▪ Increased proportion of older adults with dementia, or their care partners, who are aware of the diagnosis
4.2 Improve collaborative & interdisciplinary team care	<p>4.2.1 Develop additional physician referral networks and programs (road maps for screening through diagnosis, referral, and long-term care options), including guidance on communicating about signs of cognitive impairment</p> <p>4.2.2 Establish workgroup of providers and stakeholders to explore best use of technology to capture cognitive assessments, e.g, electronic health record (EHR) templates that include cognitive assessment</p> <p>4.2.3 Explore options to increase screening capacity among expanded care team members</p> <p>4.2.4 Improve health and mental health facilities' discharge policies to ensure safety and optimum care</p>	<ul style="list-style-type: none"> ▪ Increased communication across disciplines and professions about cognitive assessment findings ▪ Increased number of community clinical linkages among health care systems and existing services, public health agencies, and community-based organizations
4.3 Streamline care documents to reduce duplication and improve patient and provider access	<p>4.3.1 Review of required provider and support services forms and documents to reduce duplication</p> <p>4.3.2 Leverage expert panel to develop care planning tools for those with ADRD and care partners</p>	<ul style="list-style-type: none"> ▪ Uniform care planning tools in place and being used

*Healthy Brain Initiative Road Map references listed on page 25.

GOAL 5: COMMUNITY SUPPORT FOR THOSE WITH ADRD & THEIR CARE PARTNERS (E-4, E-5, E-6, P-5, P-6)*



Objectives	Strategies	3/5-Year Outcome / Metrics
5.1 Identify and assess gaps in support and services for those with ADRD and their families and care partners at the community-level	5.1.1 Assess current resources and identify gaps 5.1.2 Engage local health Departments, municipal Leaders, ADRD care partners and those living with dementia to work collaboratively to perform an environmental scan of their community using community forums, surveys, and review of existing resources	<ul style="list-style-type: none"> Increased implementation of goals and activities that lead to sustainable ADRD program activities Increased number of ADRD projects and initiatives that are created and influenced by available data Increased sustainability of program activities
5.2 Identify, create, and disseminate resources to support the wellbeing of those with ADRD and their families and care partners	5.2.1 Ensure all resources are inclusive of the linguistic and cultural identity of Connecticut residents 5.2.2 Share interventions and resources broadly across the state, eg, Veterans Administration, Medicaid, Social Security/Disability insurance 5.2.3 Promote access to safety measures for those with ADRD and their families and care partners <ul style="list-style-type: none"> a. Develop relationships with legal organizations to expand access and broaden state reach in legal assistance and financial safety b. Promote financial literacy and fraud protection among individuals with ADRD and their families and care partners c. Develop resources to support safety planning among individuals with ADRD, their families, and care partners 5.2.4 Increase availability of community resources and supports for care managers, non-medical homemakers and community health workers 5.2.5 Assess and promote care partners' access to respite care and support. Areas of focus include: <ul style="list-style-type: none"> a. Care partner support groups, including use of evidence-based methods when available and appropriate b. Access to non-medical homemakers c. Adult daycare centers 5.2.6 Collate existing documents to create and disseminate a discharge planning toolkit	<ul style="list-style-type: none"> Improved peer support for ADRD care partners Increased access to safety measures for those with ADRD and their families and care partners Increased awareness of signs of abuse and neglect of older and vulnerable adults and available supports Increased access to legal support for those with ADRD, eg, advanced directives, consumer protection Increased safety and protection for those with ADRD and their families and care partners Increased awareness of respite support available in the state
5.3 Promote Inclusive and Dementia Friendly Communities across the state	5.3.1 Reduce stigma and increase community inclusivity by increasing ADRD knowledge and awareness: <ul style="list-style-type: none"> a. Provide training and educational resources for those who deliver services across communities eg, librarians, restaurant servers, home renovation contractors, grocery store staff, public transportation staff b. Increase awareness of ADRD among community organizations, eg, faith-based organizations, community centers 	<ul style="list-style-type: none"> All resources available on state supported website and broadly shared Increased availability of information, tools, resources, and trainings on ADRD topics ADRD Coalition apprised of local resources and needs on a regular basis Increased awareness and understanding of ADRD among the public, community members, and professionals

Objectives	Strategies	3/5-Year Outcome / Metrics
	<p>5.3.2 Engage local communities to become age friendly communities:</p> <ul style="list-style-type: none"> a. Collaborate with municipal services, senior & community centers, Community Health Worker (CHW) Association of CT, Care partners, those living with dementia, etc. b. Promote systematic structural support for inclusive communities eg, buildings, culture, transportation, strong municipal support, state policy and funding sources. c. Meet transportation needs of people with dementia and their care partners by considering walkability, fostering complete streets implementation, improvements for transportation design access d. Enhance local municipal services and activities, including memory cafes e. Improve public facilities and outdoor spaces in coordination with aging and disability-inclusive efforts f. Include focus on ADRD in public safety, disaster planning and emergency response <p>5.3.3 Identify and develop local/ area Champion(s) who:</p> <ul style="list-style-type: none"> a. Continually update and share local resource with community members & state partners b. Inform DPH staff and partners when gaps in support or resources are identified c. Provide advocacy tools for community members d. Support care partner needs in community <p>5.3.4 Include people with dementia and their care partners in municipal planning (eg, affordable housing plans, plans of conservation and development, disaster planning, etc); value contributions of all generations, abilities, and community sectors</p> <p>5.3.5 Increase the diversity of affordable housing and expand access to quality home modification and repair services that improve accessibility and meet changing needs</p>	<ul style="list-style-type: none"> ■ Increased integration of care partners into processes and systems impacting individuals with ADRD ■ Improved quality of life for those living with ADRD within a community

*Healthy Brain Initiative Road Map references listed on page 25.

GOAL 6: DATA AND SURVEILLANCE (M-1, M-3)*



Objectives	Strategies	3/5-Year Outcome / Metrics
6.1 Maintain access to existing Department of Public health (DPH) data sources available for ADRD surveillance	6.1.1 Collect and obtain Behavioral Risk Factor Surveillance System (BRFSS) Cognitive Decline module data biennially on odd-numbered years 6.1.2 Collect and obtain BRFSS Care partner module data biennially on even-numbered years 6.1.3 Obtain inpatient and emergency department visit discharge data annually 6.1.4 Obtain vital records mortality data annually	<ul style="list-style-type: none"> ▪ Cognitive Decline data collected for 2023 and 2025 BRFSS and obtained six-nine months post-data collection ▪ Care partner data collected for 2024 and 2026 BRFSS and obtained 6-9 months post-data collection ▪ Inpatient and emergency department visit discharge data obtained 6-9 months post- calendar year ▪ Mortality data obtained 9-12 months post-calendar year
6.2 Secure a minimum of one new data source that will enhance description of ADRD burden.	6.2.1 Investigate the feasibility and usefulness for accessing DPH Syndromic data for ADRD surveillance 6.2.2 Investigate the availability of DPH licensing or other data sources on healthcare medical professional continuing education or training on ADRD 6.2.3 Investigate the feasibility and pursue data sharing agreement with Department of Social Services for Medicaid/Medicare data 6.2.4 Investigate the feasibility and pursue data sharing agreement with Office of Health Strategy for All Payer Claims Database 6.2.5 Identify and obtain relevant data maintained by the Alzheimer's Association 6.2.6 Identify and obtain relevant data (eg, Connecticut Statewide Respite Care Program) maintained by the Department of Aging and Disability Services 6.2.7 Explore alternative methods for obtaining data from care partners and healthcare medical professionals	<ul style="list-style-type: none"> ▪ Obtained and using at least one new data source by the end of the 3-year period
6.3 Analyze and publish all available ADRD data through summary statistics and fact sheets annually	6.3.1 Analyze BRFSS, inpatient, emergency department visit, mortality, or other available data annually 6.3.2 Produce or update summary statistics in tabular format annually that describe ADRD high-risk populations, disparities, and trends 6.3.3 Produce or update fact sheet on ADRD burden annually with BRFSS, inpatient, emergency department visit, mortality, or other available data	<ul style="list-style-type: none"> ▪ All available ADRD data analyzed when data is available ▪ Summary statistics updated annually ▪ ADRD burden fact sheet updated and distributed annually ▪ ADRD surveillance webpage established and regularly updated when new data is available ▪ Increased number of ADRD projects and initiatives that created and influenced by available data. ▪ Increased availability and use of data to inform, monitor, and improve ADRD goals implementation and supporting activities
6.4 Establish and maintain an ADRD surveillance webpage that serves as the main access point for all ADRD data in Connecticut	6.4.1 Publish all available summary statistics from DPH that describe ADRD high-risk populations, disparities, and trends on the webpage 6.4.2 Publish all available Cognitive Decline, Care partner, and ADRD burden factsheets from DPH on the webpage 6.4.3 Identify all other available ADRD data and publications from non-DPH sources and provide links on the webpage	

*Healthy Brain Initiative Road Map references listed on page 25.

Definitions:

The term *patient care bundles*, as used here, refers only to a structured way of improving the processes of care and patient outcomes: a small, straightforward set of evidence-based practices—generally three to five—that, when performed collectively and reliably, have been proven to improve patient outcomes, as discussed by the Institute for Healthcare Improvement.²⁴

The term *sociocultural attunement* refers not only to awareness of societal systems, culture and power, but to a willingness to pay close attention and be responsive to the experience of others.²⁵

References to the Healthy Brain Initiative Road Map:

- E-1** Educate the public about brain health and cognitive aging, changes that should be discussed with a health professional, and benefits of early detection and diagnosis.
- E-2** Integrate the best available evidence about brain health and cognitive decline risk factors into existing health communications that promote health and chronic condition management for people across the life span.
- E-3** Increase messaging that emphasizes both the important role of caregivers in supporting people with dementia and the importance of maintaining caregivers' health and well-being.
- E-4** Promote prevention of abuse, neglect, and exploitation of people with dementia.
- E-5** Provide information and tools to help people with dementia and caregivers anticipate, avert, and respond to challenges that typically arise during the course of dementia.
- E-6** Strengthen knowledge about, and greater use of, care planning and related tools for people with all stages of dementia.
- P-2** Assure academic programs, professional associations, and accreditation and certification entities incorporate the best available science about brain health, cognitive impairment, and dementia caregiving into training for the current and future public health workforces.
- P-4** Improve inclusion of healthcare quality measures that address cognitive assessments, the delivery of care planning to people with diagnosed dementia, and improved outcomes.
- P-5** Engage public and private partners in ongoing planning efforts to establish services and policies that promote supportive communities and workplaces for people with dementia and their caregivers.
- P-6** Assure public health plans that guide emergency preparedness and emergency response address the special needs of people with dementia and their caregivers, support access to critical health information during crises, and prepare emergency professionals for situations involving people with dementia.
- W-4** Foster continuing education to improve healthcare professionals' ability and willingness to support early diagnoses and disclosure of dementia, provide effective care planning at all stages of dementia, offer counseling and referral, and engage caregivers, as appropriate, in care management.
- W-5** Strengthen the competencies of professionals who deliver healthcare and other care services to people with dementia through interprofessional training and other strategies.
- M-1** Implement the Behavioral Risk Factor Surveillance System (BRFSS) optional module for Cognitive Decline in 2019 or 2020, and the BRFSS optional module for Caregiving in 2021 or 2022
- M-3** Use data gleaned through available surveillance strategies and other sources to inform the public health program and policy response to cognitive health, impairment, and caregiving.
- M-5** Estimate the gap between workforce capacity and anticipated demand for services to support people with dementia and their caregivers. cdc.gov/aging alz.org/publichealth.

Appendix B: Supplemental Tables

TABLE B-1

Percent of adults 45 years and older who experienced/have subjective cognitive decline by age group, sex, race/ethnicity, household income, and educational attainment, Connecticut, 2019¹

	Percent (%)	95% Confidence Interval
Overall	7.3	6.5 – 8.1
Age Group		
45-74 years	6.8	5.9 – 7.7
75+ years	10.3	8.1 – 12.5
Sex		
Male	7.6	6.3 – 8.9
Female	7.0	6.0 – 8.1
Race / Ethnicity		
White, Non-Hispanic	6.9	6.0 – 7.7
All other race/ethnicity	9.3	6.8 – 11.7
Household Income		
Less than \$25,000	13.4	10.6 – 16.3
\$25,000 - \$49,999	11.1	8.5 – 13.7
\$50,000 - \$74,999	5.2 [†]	3.5 – 6.9
\$75,000+	4.6	3.4 – 5.8
Educational Attainment		
High school graduate or less	9.8	8.0 – 11.6
More than high school education	6.0	5.1 – 6.8

¹ From Behavioral Risk Factor Surveillance System, subjective cognitive decline is defined as adults 45 years or older who answered yes to having experienced confusion or memory loss that is happening more often or is getting worse during the past 12 months.

[†] Estimates may be of limited validity due to a high coefficient of variation (CV), 15.0% < CV < 20.0%.

TABLE B-2

Number and rates for Alzheimer's disease and related dementia deaths¹ as the underlying cause of death by age group, sex, and race/ethnicity, Connecticut, 2021 (provisional data)²

	N	Rate ³
Total	1,509	28.0
Age Group		
55-64 years	26	5.0
65-74 years	93	25.3
75-84 years	354	183.0
85+ years	1,034	1,131.3
Sex		
Male	478	23.7
Female	1,031	30.6
Race / Ethnicity		
White, Non-Hispanic	1,341	29.0
Black, Non-Hispanic	75	24.2
Hispanic	77	26.6

¹ Alzheimer's disease and related dementia were identified using underlying cause of death *International Classification of Disease, Tenth Revision* codes F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, G13.8, F05, F06.1, F06.8, G30.0, G30.1, G30.8, G30.9, G31.1, G31.2, G31.01, G31.09, G31.83, G94, R41.81, and R54.

² 2021 death number and rates are considered provisional.

³ For total, sex, and race/ethnicity: age-adjusted death rates per 100,000 population were standardized to the 2000 projected U.S. standard population. For age group: unadjusted death rates per 100,000 population.

TABLE B-3

Number and rates for Alzheimer's disease and related dementia hospitalizations and emergency department visits¹ as any diagnosis by age group, sex, and race/ethnicity, Connecticut, 2021 (provisional data)²

	Hospitalization		Emergency Department Visit	
	N	Rate ³	N	Rate ³
Total	23,874	467.3	13,359	260.7
Age Group				
45-54 years	300	64.4	109	23.4
55-64 years	1,281	247.2	538	103.8
65-74 years	3,610	982.9	1,826	497.2
75-84 years	7,902	4,085.5	4,707	2,433.6
85+ years	10,490	11,476.6	6,132	6,708.8
Sex				
Male	10,222	497.0	4,923	240.6
Female	13,652	443.9	8,436	273.6
Race / Ethnicity				
White, Non-Hispanic	18,542	429.6	10,463	239.9
Black, Non-Hispanic	2,189	656.3	1,052	321.9
Hispanic	1,978	615.7	1,217	393.2

¹ Alzheimer's disease and related dementia were identified using any diagnosis with International Classification of Disease, Tenth Revision codes F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F04, G13.8, F05, F06.1, F06.8, G30.0, G30.1, G30.8, G30.9, G31.1, G31.2, G31.01, G31.09, G31.83, G94, R41.81, and R54.

² 2021 hospitalization and emergency department visit rates are considered provisional.

³ For total, sex, and race/ethnicity: age-adjusted rates per 100,000 population were standardized to the 2000 projected U.S. standard population. For age group: unadjusted rates per 100,000 population.