

RISK REDUCTION GOAL UPDATES

LISA C. MCGUIRE, PHD



Risk Reduction Goal

Objective

To develop a national goal to reduce the burden of risk factors in order to prevent or delay onset of Alzheimer's Disease and related dementias (ADRD)

Rationale

- Advances in science of risk factors: Science continues to evolve in the prevention, identification, treatment, and management of Alzheimer's disease and related dementias (ADRD). The most current scientific information will be utilized to drive the development of this goal.
- Preclinical stages of the disease: The preclinical states of ADRD are ripe for primary prevention. Intervening during this portion of the life course will not only reduce or delay the onset on ADRD but also will help to maintain the health, well-being, and independence of older adults by improving the health of the nation.
- Heterogeneity of pathologies that cause dementias: Dementia symptomology is caused by multiple pathologies and combinations of pathologies. The intervention of risk factors known to prevent or delay onset of ADRD, regardless of pathology, is the key.

Steering Committee



Matthew Baumgart

Vice President of Health Policy at Alzheimer's Association



Lisa C. McGuire, Ph.D.

Lead, [Alzheimer's Disease Program](#)

National Center for Chronic Disease Prevention and Health Promotion
Division of Population Health



Kelly O'Brien

Executive Director of the Brain Health Ecosystem project at [UsAgainstAlzheimer's](#)

Timeline

March

- Framing Meeting
- Identify & Invite Workgroup Members

April

- Workgroup Meetings

May

- Workgroup Meetings
- Update to NAPA Advisory Council

June

- Outputs Meeting (SUBC present findings & suggestions)
- Solicit External Reviews

★ **July**

- External Reviews
- Present recommendations to NAPA Advisory Council

August

- Submit final recommendations to HHS

Subcommittee & Workgroup Members



Jewel Mullen
Dell Medical School



Joshua Chodosh
New York University
Langone Health

Group A: Joshua Chodosh and Jewel Mullen

Obesity, Diet, Sleep, Traumatic Brain Injury

Jeannette Beasley

Jennifer Martin

Temitayo Oyegbile-Chidi

Kristine Yaffe

Alice Lichtenstein

Subcommittee & Workgroup Members

Group B: Laurie Whitsel and Caraline Coats

Physical Activity, Tobacco Use, Alcohol

Ross Arena Aruni Bhatnagar

Cedric Bryant Jordan Endicott

Hadiya Green Gerraro James Galloway

Mark Stoutenberg Monica Rivera-Mindt

Amy Bantham Melinda Kelley

Monica Cornelius Alison Moore

John Omura Kathy Watson



Laurie Whitsel
American Heart Association,
American Stroke Association



Caraline Coats
Humana

Subcommittee & Workgroup Members

Group C: Marilyn Albert and Joe Chung

Social Isolation, Depression, Hearing Loss and Cognitive Activity

Carla Perissinotto

Ipsit Vahia

Meryl Butters

Frank Lin

Michael Marsiske



Joe Chung
Kinto Care,
Redstar Ventures



Marilyn Albert
Johns Hopkins
Medicine

Subcommittee & Workgroup Members

Group D: Rebecca Gottesman and Karthik Sivashanker

Hypertension, Hyperlipidimia, Diabetes

Hugo Aparicio

Heather Hodge

Walter Kernan

David Hoffman

Ann Marie Navar

Laura Baker

Denard Cummings

Judy Hannan



Karthik Sivashanker
American Medical
Association



Rebecca Gottesman
Johns Hopkins
University

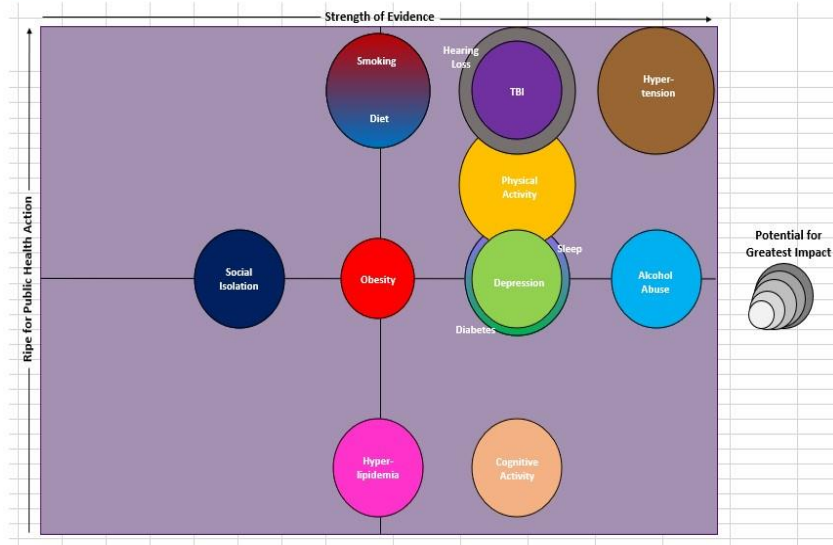
Framing Questions

1. To what extent does the potential dementia risk and protective factor have *strong evidence from a population-based perspective*?
2. To what extent is the potential dementia risk and protective factor *ripe for public health action* (i.e., Does it have promising [strong evidence-based] community-level interventions)?
3. To what extent would the potential dementia risk and protective factor, if addressed by the public health community, have *strong public health impact* (including in diverse communities)?
4. Does the potential dementia risk and protective factor have interventions or actions that *individual health care providers/teams can recommend to their patients*?

Outputs Meeting

Agenda Item	Lead
Welcome and Thank You	Lisa McGuire
Objective and Approach	Kelly O'Brien
Report out & Discussion Group A Obesity, Diet, Sleep, TBI	Josh Chodosh & Jewel Mullen
Report out & Discussion Group B Physical Activity, Tobacco/Smoking, Alcohol	Laurie Whitsel & Caraline Coats
Report out & Discussion Group C Social Isolation, Depression, Hearing Loss, Cognitive Activity	Marilyn Albert & Joe Chung
Report out & Discussion Group D Hypertension, Hyperlipidemia, Diabetes	Rebecca Gottesman & Karthik Sivashanker
Combined Scores and Summary	Matthew Baumgart
Building a Plan for Dementia Risk Reduction: Next Steps	Kelly O'Brien
Thank you and Close	NAPA Co-Chair, Katie Brandt

Outputs Meeting



Review Process

1. Recommendations and strategies sent to external reviewers
 - NAPA Advisory Council Members and Co-Chairs
 - Subcommittee co-chairs
 - Workgroup members
 - Researchers, NGOs, and other professionals
 - Tribal expertise
 - Volunteers
2. Comments incorporated
3. Present recommendations to NAPA Advisory Council
4. Submit final recommendations and strategies

THANK YOU

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Centers for Disease Control and Prevention

National Center for Chronic Disease Prevention and Health Promotion

Division of Population Health
The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.



Recommendations for a Goal and the Focus of Effort

Matthew Baumgart
Vice President, Health Policy
Alzheimer's Impact Movement
Alzheimer's Association



Developing a Recommendation



Recommendation: Goal

Add a **sixth goal** to the National Plan:



1. Prevent and Effectively Treat Alzheimer's Disease and Related Dementia by 2025
2. Enhance Care Quality and Efficiency
3. Expand Supports for People with Alzheimer's and Related Dementias and Their Families
4. Enhance Public Awareness and Engagement
5. Improve Data to Track Progress
- 6. Reduce the Burden of Risk Factors for Alzheimer's Disease and Related Dementias**



Recommendation: Focus of Effort

- From the Outputs Meeting, we identified 10 potential risk factors to recommend as the focus of the National Plan's efforts
- Selection based on:
 - Strength of scientific evidence
 - Ripeness for public health action
 - Potential for impact
- To achieve the goal, reduce the prevalence of these potential risk factors **by 15% by 2030**



Recommendation: Focus of Effort

Unhealthy Alcohol Abuse	Physical Inactivity
Depression	Poor Diet Quality/Obesity
Diabetes	Poor Sleep Quality/Sleep Disorders
Hearing Loss	Tobacco Use
Mid-life Hypertension	Traumatic Brain Injury

- 66.8% of American adults have at least one of these potential risk factors¹
- An aggressive 15% per decade reduction in the prevalence of these risk factors could result in **as many as 1.2 million fewer people** with Alzheimer's dementia in 2050²



¹Based on data from 2019 BRFSS

²Assumes causal link and no other changes to current prevalence projections

Thank You.

Matthew Baumgart
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Risk Reduction
Subcommittee

STRATEGIES



Under this goal for risk reduction, mirroring the National Plan's approach and guided by suggestions from subcommittee and workgroup members, the following strategies and preliminary action steps are recommended.

- A Identify priorities and milestones
- B Accelerate public health action
- C Reduce risk & intervene early in
- D clinical care

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More research

STRATEGY A



STRATEGY A



IDENTIFY PRIORITIES + MILESTONES

Identify priorities and specific milestones that would make progress toward goal. These should be established utilizing a health equity framework for public health, clinical and community-based interventions, and research.

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STRATEGY A

01

FORMALIZE COMMITTEE



The Risk Reduction Subcommittee should be formalized within the Advisory Council. Communities at greatest risk for ADRD should be represented.

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STRATEGY A



02

CONVENE SUMMIT

HHS should convene a bi-annual ADRD summit on risk reduction, with CDC as the lead agency.

- Meetings should establish and update priorities and milestones for addressing dementia risk factors.
- Meetings should address specific barriers/challenges and strategies to effect measureable change for marginalized communities.
- Meetings should engage diverse stakeholders including historically marginalized voices and communities, other federal agencies, state and local public health departments, health providers, educators and payers, community based organizations, and private sector partners. Specific time-bound actions by public and private entities that advance the milestones should be identified. This includes private and public partners outside the traditional ADRD community who focus on the targeted risk factors including depression, diabetes, hearing loss, mid-life hypertension, physical inactivity, poor diet quality and obesity, poor sleep quality and sleep disorders, tobacco use, traumatic brain injury and unhealthy alcohol use.

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STRATEGY A



03

ANNUAL PROGRESS REPORT

HHS and all relevant federal agencies should identify, coordinate and implement strategies within their current authorities and annually report on progress within the national plan.

In their reports, relevant agencies should:

- Identify gaps and note where additional legislative authority is needed.
- Monitor progress toward the goal, with reporting and updating annually, considering new science, emerging challenges, and opportunities.
- In their internal budget process, annually estimate the federal funding that is needed to successfully reach the milestones, and the Administration's annual budget request to Congress should publicly identify the amounts proposed for addressing dementia risk reduction across all relevant federal agencies.
- Highlight significant actions and progress at the state, local and tribal level.

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STRATEGY B



STRATEGY B



PUBLIC HEALTH

Accelerate **public health** action on addressing the **risk factors with the strongest evidence of beneficial impact on dementia prevalence, particularly for communities at greatest risk**. Specifically, the federal government, in partnership with state, local, and tribal governments, community based organizations, and relevant private sector entities should:

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STRATEGY B



01

Public health infrastructure

Sustain and strengthen the public health infrastructure - federal, state, local, community and tribal - for ADRD to support robust efforts to address prevention of dementia risk factors.

02

Address social determinants of health

Address social determinants of health that affect risk and health outcomes.

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STRATEGY B



03

Target communities

Develop strategies and interventions to target communities with both the highest prevalence of priority risk factors, low longevity rates, and the highest prevalence of ADRD with explicit attention to the social determinants of health and strategies and interventions for historically marginalized communities.

04

Collaborate

Identify opportunities for collaboration with existing public and private initiatives and campaigns designed to reduce the prevalence of diseases, conditions, and other factors that are associated with risk of dementia, such as the Million Hearts initiative and the Diabetes Prevention Program. Increase access of these programs for marginalized communities that are at high risk for dementia.

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STRATEGY B



05

Align actions with CDC's Healthy Brain Initiative

Align actions with those identified in CDC's Healthy Brain Initiative State and Local Public Health Partnerships to Address Dementia: The 2018–2023 Road Map (S&L) and Road Map for Indian Country (RMIC).

The Road Map series charts a course for state and local public health agencies and their partners to act quickly and strategically to prepare all communities to address AD/DRD by stimulating changes in policies, systems, and environments. Effectively addressing the rising number of people with Alzheimer's and other dementias will require diligent attention to three fundamental principles in planning and implementing Road Map actions. These principles—eliminate health disparities, collaborate across multiple sectors, and leverage resources for sustained impact—are central to public health and have been noted by many other seminal reports. Relevant actions from the Road Map series and Healthy People 2030 (HP2030) objectives include:

- 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 (S&L E-1, RMIC 1, & HP2030 DIA-3).
- Integrate the best available evidence about brain health and cognitive decline risk factors into existing health and communications that promote health and chronic condition management for people across the life span (S&L E-2, RMIC 2, HP2030 DIA-2).
- 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 (S&L P-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 (S&L W-1).
- 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 (S&L M-3, RMIC 5).

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STRATEGY C



STRATEGY C



Clinical care

Identify and accelerate efforts to reduce risk and intervene early in clinical care

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STRATEGY C

01

COMPREHENSIVE APPROACH



CMS, HRSA, the VA, IHS, state Medicaid programs, and other public and private payers should identify a comprehensive set of actions to assess and reduce dementia risk, delay the onset of dementia, and improve early intervention, ensuring equitable reach and impact of interventions for historically marginalized populations.

This should include:

- **Identifying opportunities to reduce the risk of MCI and dementia by addressing known risk factors and support early intervention for Alzheimer's disease and related dementias**, including but not limited to beneficiary education; requiring use of specific evidence-based cognitive screening tools in the Medicare Annual Wellness Visit; offering reimbursement incentives; providing payments for prevention and care delivery models; and implementing quality measures.
- **Identifying existing benefits related to factors that can potentially help reduce dementia risk, as well as coverage gaps and inequities that, if addressed, could potentially reduce known risk factors associated with ADRD**. Examples include: nutrition support; physical activity prescriptions; diabetes management and treatment; audiology assessments and screenings, hearing rehabilitation, appropriate hearing technology; and screening and treatment for depression and unhealthy alcohol use.

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STRATEGY C



02

Improve access to care

HHS should identify and accelerate strategies to improve access to primary care, team-based care, home and community based care and preventive care, including better utilization of existing benefits such as the Annual Wellness Visit.

03

Pilots

CMMI should pilot ADRD risk reduction interventions. For example CMMI could pilot a “Dementia Prevention Program” modeled on the Diabetes Prevention Program, with special attention on optimal implementation including payment, training, delivery, and uptake.

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STRATEGY C



04

WORKFORCE Training

HRSA should develop and broadly implement training curriculum for the primary and community care workforce to improve MCI and dementia risk reduction and early detection.

05

Address coverage gaps

Congress should address coverage gaps in Medicare, Medicaid and the VA that would improve interventions for identified ADRD risk factors: for example, Medicare Audiologist Access and Services Act to increase Medicare coverage for hearing and rehabilitation services; and improvements in Medicare’s coverage of substance use disorder and mental health services to align with evidence-based practices, current service-delivery models, and standards that apply to other major health care financing programs.

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STRATEGY D



STRATEGY D



Research

Initiate and fund research to strengthen the strategies for addressing the potential risk factors for dementia, including translation and implementation scalability.



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STRATEGY D



01

MORE RISK REDUCTION RESEARCH

HHS, including NIH, CDC, AHRQ, and other agencies should:

- Adopt an equity and inclusion framework when developing and supporting research on factors for dementia risk reduction to address biases in eligibility criteria, proportional representation, oversampling, data stratification, systemic racism, historical context, and structural factors that disproportionately impact the health of marginalized and minoritized populations.
- Support specific research to identify linkages to the causal pathway for dementia, including:
 - Risk factors that have promising research to date and/or currently lack strong evidence-based public health, community health and/or clinical interventions (e.g., loneliness, cognitive training, and hyperlipidemia).
 - Pinpointing the specificity of successful interventions (such as the duration, frequency, and intensity of physical activity).
 - The interconnectedness of risk factors and multivariate interventions to address risk factors.
 - Social determinants of health that may elevate the risk of developing dementia.
 - Demonstrated impacts of risk reduction across the life course and the value of implementing risk reduction interventions before the pre-clinical stage of Alzheimer's disease.
 - Mitigating effects of lifelong disability on risk factors.

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STRATEGY D



02

ONGOING CDC UPDATES

CDC should periodically update the list of key risk factors that are the focus of efforts to achieve this goal, based on the strength of scientific evidence, ripeness for public health action, and potential for impact and taking into account the needs of and potential benefits to at-risk communities.

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