



Colorado Alzheimer's Disease and Related Dementias State Plan

June 2022



COLORADO
Department of Public
Health & Environment



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Helpful Terms for the Plan:

ADRD: Alzheimer’s Disease and related dementias are conditions that impair memory, thought processes, and functioning, primarily among older adults.

Priority Populations: This plan prioritizes populations that have been disproportionately impacted by ADRD including:

- *American Indian/Alaskan Native*
- *Black/African American*
- *Latinx/o/a/Hispanic/Chicano/a*

Note: Other gaps have been identified and outlined in the plan, such as populations in rural communities that experience lack of access to resources.

Care Partners: Care partners are informal, unpaid caregivers, usually friends or family members that partner with the person living with ADRD to provide support, resources, and care.





Welcome

Alzheimer's Disease and related dementias (ADRD) affect millions of Americans and tens of thousands of Coloradans. ADRD are degenerative brain diseases which destroy brain function, leading to cognitive decline, behavioral disorders and decreased functional abilities.

The Colorado Department of Public Health and Environment (CDPHE) recognizes the devastating impact of Alzheimer's Disease and related dementias on Coloradans. As such, CDPHE supported a community-informed process to co-create the Colorado Alzheimer's Disease and Related Dementias (ADRD) State Plan with an ADRD Advisory Committee.

This plan sets an overarching direction for the next five years and outlines actions to advance risk reduction and early diagnosis, and improve outcomes for all people living with ADRD and their care partners who live, work, and play in Colorado.

Source: Alzheimer's Association Risk Reduction, Retrieved May 31, 2022 from [website](#).

Addressing Risk Factors with a Public Health Approach

Alzheimer's Disease is one of the top ten causes of death in Colorado. While as of today it cannot be prevented and there is no cure yet, risk factors for ADRD can and should be addressed. Risk factors may be modifiable or non-modifiable.

Evidence suggests that the link between cognitive health and dementia, and certain behaviors/ conditions is growing stronger. The healthy behaviors that can have the biggest impact on reducing risk for dementia and cognitive decline are, being physically active, quitting or not starting smoking, and being heart healthy- including managing blood pressure and diabetes risk factors.





Fighting Alzheimer's Disease and Related Dementias Together

Alzheimer's is the most common cause of dementia. Dementia is not a specific disease. It is an overall term that describes a particular group of symptoms.

ADRD not only significantly affects the life of the person living with dementia, but also significantly impacts family members and friends, especially those who serve as care partners.

A review of recent data by the Alzheimer's Association and Centers for Disease Control and Prevention reveals rapidly increasing trends in the number of people with dementia and associated healthcare costs.

Accompanying these trends is the growing challenge to family and friends who are caring for others over extended periods of time.

ADRD is one of the costliest conditions in America:

- Total costs of ADRD in 2022, not including informal caregiving, were estimated at \$321 billion.
- By 2050, addressing dementias is estimated to cost \$1.1 trillion.



Data Regarding Dementias

Alzheimer's accounts for for 60–80% of dementia cases. The remaining 20-40% include vascular dementia, dementia with Lewy bodies, frontotemporal dementia, and others. Most data available is related to Alzheimer's and is summarized for Colorado on the next page. Additional data regarding dementias will be considered as the plan is implemented.

Sources: Alzheimer's Association and Centers for Disease Control and Prevention. Healthy Brain Initiative, State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map. Chicago, IL: Alzheimer's Association; 2018.

2022 Alzheimer's Disease Facts and Figures Report.



Colorado

Alzheimer's Statistics



Prevalence

NUMBER OF PEOPLE
AGED 65 AND OLDER
WITH ALZHEIMER'S

Year	TOTAL
2020	76,000
2025	92,000

ESTIMATED % CHANGE

21.1%



Workforce

96

of geriatricians

201.0%

% increase needed to meet
the demand in 2050

38,930

of home health and
personal care aides

48.9%

% increase needed to meet
demand in 2028



Caregiving (2021)

159,000

Number of Caregivers

\$3,711,000,000

Total Value of Unpaid Care

23.2%

% of caregivers
with depression

184,000,000

Total Hours of Unpaid Care

73.1%

% of caregivers
with chronic
health conditions

14.0%

% of caregivers
in poor physical
health



Health Care

HOSPICE (2017)

3,254

of people in hospice
with a primary diagnosis
of dementia

15%

% in hospice with a primary
diagnosis of dementia

HOSPITALS (2018)

1,425

of emergency department
visits per 1,000 people
with dementia

18.6%

dementia patient hospital
readmission rate

MEDICAID

\$635M

Medicaid costs of caring
for people with Alzheimer's
(2020)

24.1%

projected change in costs
from 2020 to 2025

MEDICARE

\$24,751

per capita Medicare spending on people
with dementia (in 2021 dollars)



Mortality

OF DEATHS FROM ALZHEIMER'S DISEASE (2019)

1,909

168.1% increase in
Alzheimer's deaths since 2000

More than **6 million Americans** are living with Alzheimer's, and over **11 million** provide their unpaid care. The cost of caring for those with Alzheimer's and other dementias is estimated to total **\$321 billion** in 2022, increasing to nearly **\$1 trillion** (in today's dollars) by mid-century.

For more information, view the **2022 Alzheimer's Disease Facts and Figures** report at alz.org/facts.
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Addressing Risk Reduction for ADRD

Research shows that brain changes that lead to dementia begin 20 years before the symptoms appear. This provides ample opportunity for risk reduction.

While there are risk factors that cannot be changed, such as age, genetics, and family history, there are **several modifiable risk factors for cognitive decline and dementia.** The prevalence of several modifiable risk factors is also **higher among our priority populations than other racial and ethnic groups***.

These risk factors include physical activity, diet, sleep, smoking, cardiovascular health, traumatic brain injuries, and hearing loss. **Evidence suggests that addressing modifiable risk factors might prevent or delay up to 40% of dementias.**

Those **aged 45 and over with cognitive decline were more likely to report more risk factors than those without cognitive decline.** This further highlights the importance of implementing risk reduction strategies to reduce risk of ADRD.



**Priority populations include: American Indian/Alaskan Native Black/African American, Latinx/o/a/Hispanic/Chicano/a populations.*

When it comes to sharing data regarding priority populations and health disparities, it is important not to misinterpret or create unintended consequences like perpetuating negative stereotypes and victim-blaming. Many of the differences between populations are the result of long-standing systemic injustices, creating conditions that negatively affect certain communities, particularly black, indigenous, and people of color (BIPOC) communities.

Sources: Alzheimer's Association and Centers for Disease Control and Prevention. *Healthy Brain Initiative, State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map*. Chicago, IL: Alzheimer's Association; 2018.

Omura JD, McGuire LC, Patel R, et al. *Modifiable Risk Factors for Alzheimer Disease and Related Dementias Among Adults Aged ≥45 Years — United States, 2019*. *MMWR Morb Mortal Wkly Rep* 2022;71:680–685. DOI: <http://dx.doi.org/10.15585/mmwr.mm7120a2external icon>.

2022 Alzheimer's Disease Facts and Figures Report.



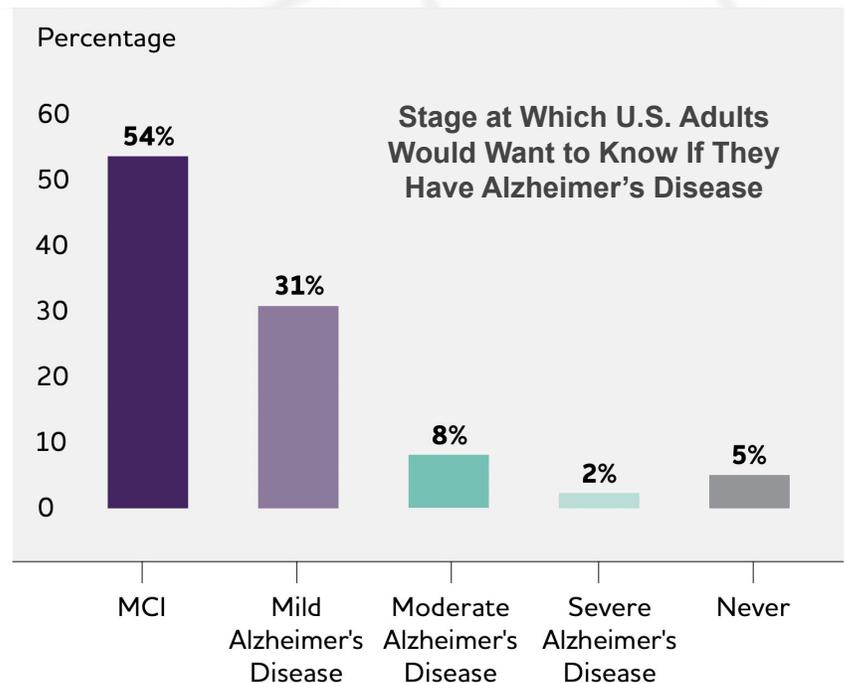
Early Detection and Diagnosis of ADRD

While there is currently no cure for dementia, **early detection and diagnosis of ADRD are still important**. A formal diagnosis allows people and their families to access all available treatments and interventions, including treatments that can delay the progression of dementia and participate in clinical trials.

Early detection and diagnosis also **allow individuals and their care partners to build a care team, participate in support services, prepare for future financial needs, make end of life choices, and be part of their care planning decisions**.

Adults with ADRD are more likely than other older adults to have multiple chronic health conditions, and early detection of ADRD allows people and their care partners to put systems in place for properly managing their chronic health conditions.

While diagnosis rates are currently low, the majority of adults (85%) report they would want to know if they had Alzheimer's disease early, including Mild Cognitive Impairment (MCI) and Mild Alzheimer's Disease.



Sources: Livingston G, Huntley J, Sommerlad A, Ames D, Ballard C, Banerjee S, et al. Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *Lancet* 2020;396(10248):413-46.

Alzheimer's Association and Centers for Disease Control and Prevention. *Healthy Brain Initiative, State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map*. Chicago, IL: Alzheimer's Association; 2018.

2022 Alzheimer's Disease Facts and Figures Report.



Background

The Colorado ADRD State Plan **incorporates a public health perspective to address upstream factors that may be modified and the systems and environments that can impact Alzheimer’s Disease and related dementia risk factors.**

The actions selected for Colorado’s ADRD State Plan were identified based on the [2018-2023 Healthy Brain Initiative Road Map](#). The Road Map, developed by the Centers for Disease Control and Prevention and the Alzheimer’s Association, outlines effective public health actions to address ADRD within the following four domains of Public Health:



E = Educate and Empower: Public health informs, educates, and empowers people about health issues.



P = Develop Policies and Mobilize Partnerships: Public health develops policies and plans that support people and community health efforts. It also mobilizes community partnerships and action to identify and solve health problems.



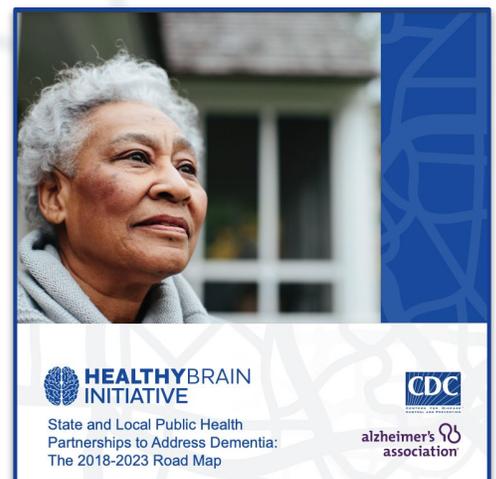
W = Assure a Competent Workforce: Public health assures that public and personal healthcare workforce have essential competencies.



M = Monitor and Evaluate: Public health monitors health status to identify and solve community health problems and evaluates effectiveness, accessibility, and quality of personal and population-based services.

In order to reduce health disparities, the Colorado ADRD State Plan will have an intentional focus on priority populations including: **American Indian/Alaskan Native, Black/African American, and Latinx/o/a/Hispanic/Chicano/a populations.**

The plan will allow partners to act quickly and strategically by stimulating changes in policies, systems, and environments while ensuring health equity; collaborating across multiple sectors; and highlighting the need to leverage resources for sustained effect.





Process Overview

From April 2021 to June 2022, the ADRD planning process was guided with the strategic engagement of a multi-sectoral, diverse advisory committee, the **Alzheimer's Disease and Related Dementias Advisory Committee (ADRDAC)**, to collaboratively develop the Colorado ADRD State Plan.

The ADRDAC included 16 organizations (*outlined in the Appendix*) within public health, government, healthcare, nonprofit and community perspectives including those with lived experiences.

The ADRDAC met monthly to accomplish the following vision and mission.



Vision: Address the special needs of Coloradans living with Alzheimer's Disease, related dementias, and their care partners, through a Colorado State Plan that is evidence based, promotes risk reduction and early diagnosis, and provides an intentional focus on highly impacted populations of **American Indian/Alaskan Natives, Black/African Americans, Latinx/o/a/Hispanic/Chicano/a**, and their care partners.

Mission: Come together as interested parties to address the issues affecting people living with Alzheimer's Disease and related dementias and their care partners, and to address the racial and ethnic disparities in all aspects of dementia risk reduction, diagnosis and care.

The ADRDAC will collaborate to combine their expertise in ADRD, caregiving, risk reduction, and priority populations, with research presented by CDPHE, to prioritize the Healthy Brain Initiative Road Map actions into a plan that addresses the needs of Coloradans across the continuum of the person's dementia journey.



Process Overview

The planning process included the following phases:

1. Convened a diverse and multi-sectoral advisory committee with representation from priority populations.
2. Conducted a partner assessment to determine resources and data available.
3. Conducted key informant interviews to further inform priorities Colorado should address in the ADRD State Plan based on opportunities, needs and gaps identified in the ADRD Partner Assessment and relevant research and data.
4. Conducted Community Engagement Sessions by engaging and amplifying voices of community members representing each priority population as they outlined health equity needs, considerations related to ADRD, and strategies that are inclusive and individualized for each priority population.
5. Contracted with [Colorado Health Institute](#) to conduct a literature review, data analysis and key informant interviews to inform policy recommendations.
6. Narrowed and prioritized actions and activities of the Colorado ADRD State Plan with input from ADRDAC and community members.

Along with CDPHE staff, [Advancing Dynamic Solutions](#) provided facilitation and consultative support to develop the Colorado ADRD State Plan.

This plan serves as a call to action for those working to impact ADRD through collaboration.

Only by working together, and intentionally engaging priority populations, can the actions and activities outlined in the plan be realized.



Inequities Impact Priority Populations

The priority populations identified in the mission statement for the ADRD State Plan experience disproportionate impacts of dementia. These populations include: *American Indian/Alaskan Native, Black/African American, and Latinx/o/a/Hispanic/Chicano/a.*

These priority populations will see the largest increases in Alzheimer’s Disease and related dementias between 2015 and 2060.

Systemic and structural racism have caused priority populations to experience inequitable access to education, healthcare, higher rates of poverty, and greater exposure to adversity and discrimination, which may also increase risk of Alzheimer’s Disease. Understanding the disparities and inequities in ADRD is the first step toward developing risk reduction strategies and co-leading efforts to support those most at risk for developing the disease.

Assuring to Support Priority Populations

The Colorado ADRD State Plan will focus on priority populations by outlining overarching actions and activities that include efforts co-led or supported by priority populations, also referred to as Black, Indigenous, and People of Color (BIPOC) populations in the plan activities.

During the planning phase, CDPHE and partners conducted Community Engagement Sessions to learn what aspects of implementation are the most important to assure across Colorado. Those [findings are outlined here](#) and are included throughout the plan.





Inequities Impact Priority Populations

Priority populations may face discrimination when seeking healthcare for ADRD and experience racial disparities in ADRD diagnosis. Findings from two national surveys conducted by the Alzheimer's Association in 2021 show that priority populations reported higher rates of discrimination when seeking healthcare.

Populations reporting discrimination in ADRD care:

- 50% of Black/African Americans
- 42% of American Indian/Alaskan Natives
- 33% of Latinx/o/a/Hispanic/Chicano/a
- 9% of Whites (Non-Hispanic)

A report from the National Institute on Aging also found that Black participants in Alzheimer's Disease research studies were **35% less likely to be diagnosed** with ADRD than white participants, despite national statistics that indicate that **Black Americans are overall about twice as likely to develop dementias than whites**.

Similarly, **older Latinos are one and a half times more likely to develop ADRD than older whites**. By 2030, 40% of people with ADRD will be either Latino or Black. It is also estimated that by 2060, the number of American Indians and Alaskan Natives aged 65 and older living with dementia will grow over five times.

With the projected increases in Alzheimer's Disease among priority populations, it is vital to address these inequities now.



Sources: Alzheimer's Association. 2021 Alzheimer's Disease Facts and Figures. *Alzheimers Dementia* 2021;17(3), [Special Report: Race, Ethnicity and Alzheimer's in America pdf icon \[PDF-787 KB\] external icon.](#)

Lennon, et al. [Black and white individuals differ in dementia prevalence, risk factors, and symptomatic presentation.](#) *Alzheimer's and Dementia*. 2021; <https://doi.org/10.1002/alz.12509>.

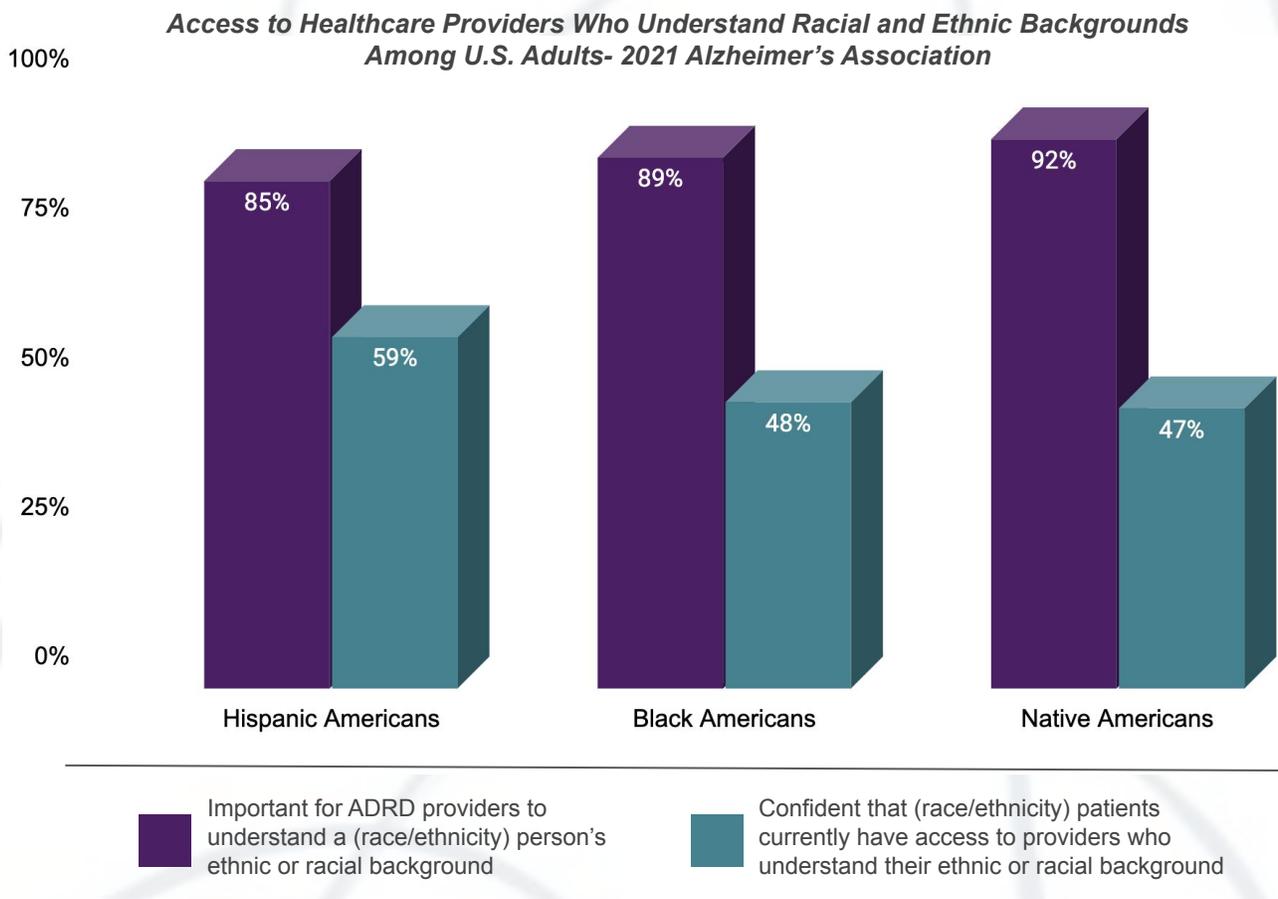
Alzheimer's Association and Centers for Disease Control and Prevention. *Healthy Brain Initiative, Road Map for Indian Country.* Chicago, IL: Alzheimer's Association; 2019.



Inequities Impact Priority Populations

Based on the experience of discrimination, as well as **systems of oppression that have caused higher rates of disease and poorer health outcomes**, priority populations called for ADRD healthcare providers to be more focused and understanding of their ethnic and racial background as well as acknowledge how historical factors impact their trust with providers and the healthcare system.

From the 2021 Alzheimer's Association Special Report, most priority populations say they want dementia healthcare providers who understand their ethnic background, **yet fewer have confidence they currently have access to them.**



With the help of community members representing priority populations, these needs as well as others have been integrated throughout the Colorado ADRD State Plan.



Measures and Goals for the Plan

The Colorado ADRD State Plan outlines overarching actions and activities that will be implemented over the next five years (2022-2027). Each year, an implementation plan will be developed and updated with collaborating organizations.

This will include evaluation activities, documentation and tracking of action steps, along with reviewing and analyzing available outcome data on ADRD.

Over the next five years, CDPHE will track SMARTIE Goals for plan implementation. *SMARTIE stands for **Specific, Measurable, Ambitious, Realistic, Time-bound, Inclusive, and Equitable.***

Goal 1: Over the next five years, CDPHE will convene collaborators, ensuring to represent all priority populations, at least 4 times per year as part of an ADRD State Coalition to deliver upon the annual implementation plans, based on the Colorado ADRD State Plan.

Goal 2: Over the next five years, CDPHE and the ADRD State Coalition will engage priority populations in all meetings and efforts to co-lead and support implementation of the ADRD State Plan.





E= Empower and Engage

**OUTCOME: INFORMED PUBLIC AND INFORMED PEOPLE
WITH DEMENTIA AND THEIR CARE PARTNERS**



E= Empower and Engage

Action 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.1.1 | Develop an evidence-based, culturally sensitive, and bilingual ADRD public awareness campaign to reduce stigma and increase understanding of the early warning signs of ADRD and the value of early detection and diagnosis. |
| E.1.2 | Promote and expand ADRD education across the state that prepares people for living with ADRD or caring for someone with ADRD, promotes risk reduction, and that is culturally sensitive, bilingual, and free of cost. |
| E.1.3 | Support public-facing organizations to deliver cohesive ADRD messaging to the populations they serve. |
| E.1.4 | Identify and pursue best practices to deliver ADRD education, evaluations, and care planning to rural communities. |
| E.1.5 | Develop messaging specifically for care partners that addresses changes to be expected as ADRD progresses, challenges, safety considerations, and accessible resources, and identify best avenues for delivering messaging to care partners. |
| E.1.6 | Partner with priority population representatives to develop and test ADRD messaging and materials for their respective communities, and to develop relationships with community based organizations who can partner to disseminate messaging to their members. |

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Partner with community health representatives, tribal leaders, tribal elders, and community members for dissemination of materials and ensure all aspects are available in the appropriate tribal language (if requested) and reflect specific tribal communities.
- Ensure content acknowledges that many tribal beliefs of those with ADRD have a special connection to the spiritual realm and to others who have crossed over. There is a core belief that elders are revered and precious.

Black / African American:

- Partner with trusted organizations/community leaders to develop culturally appropriate messages.
- Utilize community hubs; spaces outside of healthcare to share materials (e.g., churches).

Latinx/o/a / Hispanic / Chicano/a:

- Partner with community leaders to develop culturally appropriate messages.
- Ensure language (both written and spoken) is accessible.

All Priority Populations:

- Include images of BIPOC, including medical providers, in all materials.
- Ensure content of communication materials:
 - Continue to reduce the stigma around ADRD and aging in general.
 - Promote preventative approaches for ADRD.
 - Share real life stories from care partners and those with ADRD; the stories must be told.
 - Consider differing cultural needs based on origin country, heritage, and immigration status.
- Disseminate through social media, churches, community centers.



E= Empower and Engage

Action 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 lifespan.

E.2.1	Identify opportunities to promote evidence about brain health and cognitive decline within health promotion and chronic condition management across social services agencies.
E.2.2	Incorporate ADRD, brain health, and healthy cognitive aging messaging into other Colorado state plans and existing public health campaigns.
E.2.3	Tailor public health communications with ADRD messaging to be culturally sensitive, accessible and impactful, particularly for communities with high burden or who are at highest risk.
E.2.4	Partner with priority population representatives to participate in cognitive health and ADRD message integration efforts.

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Ensure communications recognize and address that people feel healthcare providers are not valuing or understanding cultural and spiritual beliefs and that there may be historical mistrust.
- Ensure content addresses support and respect for aging overall; respect and dignity for elders is very important.

Black / African American:

- Ensure communications recognize and address that people have challenges with and are often skeptical of healthcare providers.
- Ensure content addresses that there are significant differences in health outcomes for Black/African Americans versus non-Hispanic Whites and this population is more likely to die at early ages from all causes of death.

Latinx/o/a / Hispanic / Chicano/a:

- Utilize intergenerational programming, education, and resources.
- Ensure communications consider:
 - Healthcare providers and educators are generally considered trusted resources for messaging.
 - Public health can be considered as more of a "white organization."

All Priority Populations:

- Update existing communication resources to be reflective of BIPOC.
- Include images of BIPOC in all materials, ensure appropriate use.
- Expand knowledge of ADRD and prepare younger populations.
- Disseminate materials through a local resource, a local community or senior center, and build local recognition and awareness of ADRD at town councils/municipal level about needs and gaps.



E= Empower and Engage

Action E-7 Improve access to and use of evidence-informed interventions, services, and supports for people with dementia and their care partners to enhance their health, well-being, and independence.

- | | |
|--------------|--|
| E.7.1 | Facilitate access to a public, centralized platform that includes evidence-based services and supports for people living with ADRD and their care partners. |
| E.7.2 | Create an evidence-informed Dementia Guide for each priority population that outlines basic dementia information, healthy brain aging, and risk reduction. |
| E.7.3 | Identify and take steps to mitigate barriers to access to home and community-based services, including adult day care and respite services, so those with ADRD have access to these services regardless of age or financial status. |
| E.7.4 | Convene priority population representatives to identify ways to improve access to and use of evidence-informed interventions, services, and supports. |

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Promote increased use of services that consider family and friends are key in providing care and information sharing.
- Improve access to and use of services by partnering with providers that represent the community.
- Build relationships and address the reluctance (whether it may be pride, mistrust, or any other personal reason) to not accept help.

Black / African American:

- Promote increased use of services that consider that a primary source of information are churches (primarily black churches) and health ministry.
- Improve access to and use of services by addressing the challenges/skepticism felt with healthcare providers.
- Create more population specific resources and partner with providers that represent the community.

Latinx/o/a / Hispanic / Chicano/a:

- Promote increased use of services through Spanish-speaking providers, conectores/promotoras, educators, clergy, and churches, as these sources are trusted advisors.
- Improve access to and use of services by ensuring all services and materials (written and spoken) have accessible language.
- Address reluctance to talk about highly personal things, shame and guilt associated with the disease and asking for help, and tendency to delay or not seek treatment.

All Priority Populations:

- Address gaps with transportation, housing, food access, reliable access to Internet, pay differences, health insurance, support groups, care partner services, etc.
- Consider differing cultural needs based on origin country, heritage, and immigration status.
- Expand messaging through legitimate websites.
- Utilize social media to share messaging.
- Create ongoing communication streams through trusted community centers or local organizations.



P= Develop Policies and Mobilize Partnerships

**OUTCOMES: SCIENCE TRANSLATED INTO PRACTICE
AND POLICIES; SUPPORTIVE COMMUNITIES
AND WORKPLACES**



P= Develop Policies and Mobilize Partnerships

Action P-1 Promote the use of effective interventions and best practices to protect brain health, address cognitive impairment, and help meet the needs of care partners for people with dementia.

P.1.1	Promote best practices, evidence-informed interventions, services and supports for people living with dementia, and care partners, including interventions, services, and supports that are tailored to priority populations.
P.1.2	Promote the integration of effective ADRD interventions and evidence-based approaches into practice.
P.1.3	Identify opportunities to incentivize and create career pathways for BIPOC to pursue healthcare workforce education and training to adequately support aging priority populations and ADRD in priority populations.
P.1.4	Develop and advance a policy platform that includes ADRD advocacy and engages communities in the policy process to increase access to services.
P.1.5	Identify barriers to accessing behavioral health services for those with ADRD and their care partners, and prioritize solutions to pursue with healthcare providers.
P.1.6	Identify and promote an existing database with latest medical advances on ADRD to increase utilization among healthcare providers and partners.
P.1.7	Partner with priority population representatives in efforts that identify and tailor best practices, interventions, and services for their respective communities, and in planning efforts to incentivize BIPOC to pursue healthcare workforce education.

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Acknowledge feedback that society has something to learn from Indigenous knowledge, philosophy and beliefs and the way Native people respect and value their elders.

Black / African American:

- Acknowledge feedback that there is mental and physical strain with caregiving; acknowledge the shame and guilt associated with ADRD and the loss of a loved one who is “no longer the same”.

Latinx/o/a / Hispanic / Chicano/a:

- Address mental health support and resources for care partners.

All Priority Populations:

- Ensure outreach utilizes images, messages, and language that resonates and is supported by priority populations.
- Consider the "Three A's" (Awareness, Availability, Accessibility) in identifying supports that best address each population's special requirements and needs.
- Ensure language (both written and spoken) is accessible.
- Expand knowledge of ADRD and prepare younger populations.
- Provide help with knowing what is legitimate and trusted information.



P= Develop Policies and Mobilize Partnerships

Action P-3 Support better informed decisions by educating policymakers on the basics of cognitive health and impairment, the impact of dementia on care partners and communities, and the role of public health in addressing this priority problem.

P.3.1

Educate policymakers on ADRD including basic ADRD education, the role of chronic disease prevention and management in reducing risk, data, personal stories, disproportionate impact on priority populations, the importance of care partners, and policy actions that align with the Colorado ADRD State Plan.

P.3.2

Advocate for sustained state support of ADRD risk reduction and management, and coordination and implementation of the Colorado ADRD State Plan.

P.3.3

Integrate ADRD topics and policy platform into efforts of the Colorado Health Equity Commission to address social determinants of health, including unfair and inequitable risk factors for ADRD.

P.3.4

Engage priority population representatives to participate in message development and share lived experiences with policymakers.

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Incorporate messages to address feedback from American Indian/Alaskan Native populations:
 - Policy discussions on aging should be less about the financial aspect and more about treating human beings as precious, not a budget line item.
 - Ensure policymakers understand and value the experiences, needs, and history of the American Indian/Alaskan Native population.

Black / African American:

- Incorporate messages to address feedback from Black/African American populations:
 - Policymakers should know how expensive ADRD is, both financially and emotionally.

Latinx/o/a / Hispanic / Chicano/a:

- Incorporate messages to address feedback from Latinx/o/a/Hispanic/Chicano/a populations:
 - Policy discussions should address lack of financial resources for care partners to continue employment and care for a loved one with ADRD.
 - Do not limit resources for being undocumented.

All Priority Populations:

- Ensure policymakers are informed on:
 - Not addressing issues of aging in isolation and looking at overall needs of the aging population, including comorbidities, especially for priority populations, as limits on medical coverage impact other important medical issues.
 - Barriers occurring with housing, medical coverage, transportation, distance to care, lack of affordable care facilities, etc.
 - Impacts of staffing shortages, low pay, and benefits for workers and care partners.
 - Extreme financial impacts on families and communities.



P= Develop Policies and Mobilize Partnerships

Action 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.4.1	Identify statewide ADRD quality metric tools and establish a baseline for possible inclusion of clinical metrics in the future.
P.4.2	Partner with other state agencies, health insurance providers, and healthcare providers, to review and refine ADRD-related quality measures and ADRD-related value-based payments and identify opportunities for integration.
P.4.3	Promote the existing federal law, HOPE for Alzheimer's Act, that allows eligible providers to be reimbursed for care planning following a dementia diagnosis.
P.4.4	Ensure access to care planning services for people recently diagnosed with ADRD, including support through medical-legal partnerships: <ul style="list-style-type: none">• Ensure access to care planning services for priority populations.• Mitigate unintended negative consequences for any specific populations or sub-groups, such as limiting the rights of people with disabilities.
P.4.5	Engage priority population representatives in processes to co-develop and utilize quality measures and assessments for ADRD.

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Ensure any quality measures and assessments are reviewed by tribal leaders and tribal community members for cultural aspects and sensitivity.

Black / African American:

- Ensure any quality measures and assessments are reviewed by community leaders for cultural aspects and sensitivity.

Latinx/o/a / Hispanic / Chicano/a:

- Ensure any quality measures and assessments are reviewed by community leaders for cultural aspects and sensitivity.

All Priority Populations:

- Consider the "Three A's" (Awareness, Availability, Accessibility) in identifying quality measures and assessments that best address each population's special requirements and needs.
- Ensure language (both written and spoken) is accessible.
- Ensure communications recognize and address that people have challenges with and are often skeptical of healthcare providers.



P= Develop Policies and Mobilize Partnerships

Action 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 care partners.

P.5.1	Establish a Dementia Friendly State Initiative to support communities and businesses interested in becoming dementia friendly.
P.5.2	Engage health systems and community-based organizations to identify opportunities for communication and collaboration that can enhance support for people with ADRD and their care partners.
P.5.3	Establish statewide coordination of ADRD and care partner resources, an online repository of resources, and promotion of this centralized resource.
P.5.4	Support local funding for community-driven dementia actions, particularly for areas with high burden of ADRD or risk factors for ADRD.
P.5.5	Provide technical assistance to health systems interested in achieving Institute for Healthcare Improvement's Age Friendly Health Systems recognition for mobilizing their local communities, and to understand priorities, including the Mentation* component.
P.5.6	Engage priority population representatives to co-develop criteria and in planning efforts to establish policies that promote supportive communities and workplaces for people with dementia and their care partners.

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Ensure tribal leaders and tribal community members have been engaged to incorporate cultural aspects, sensitivity, and relevancy in the identification and planning of efforts.

Black / African American:

- Ensure community leaders have been engaged to incorporate cultural aspects, sensitivity, and relevancy in the identification and planning of efforts.

Latinx/o/a / Hispanic / Chicano/a:

- Ensure community leaders have been engaged to incorporate cultural aspects, sensitivity, and relevancy in the identification and planning of efforts.

All Priority Populations:

- Consider the "Three A's" (Awareness, Availability, Accessibility) in identifying opportunities and gaps that best address each population's special requirements and needs.
- Ensure language (both written and spoken) is accessible.
- Build relationships and listen to assess needs, gaps, and culturally relevant solutions.
- Create ongoing communication streams through trusted community centers or local organizations to build awareness and support.

**Mentation refers to one of the 4 M components of an Age-Friendly Health System and refers to "prevent, identify, treat, and manage dementia, depression, and delusion across settings of care."*



W= Assure Competent Workforce

**OUTCOMES: IMPROVED PRACTICE IN PROMOTING
HEALTH AND REDUCING RISK; IMPROVED EARLY
DETECTION AND DIAGNOSIS; IMPROVED COMPETENCIES
OF PROFESSIONALS WHO DELIVER CARE AND SERVICES**



W= Assure Competent Workforce

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

W.2.1

Collaborate with programs that train healthcare professionals to incorporate training about care partners of people with ADRD that addresses differences among racial and ethnic populations and explore a certification for undergoing training.

W.2.2

Incorporate brain health messaging into existing chronic disease messaging for healthcare providers that highlights dementia risk reduction practices, and underscores the importance of engaging care partners, and the impact of ADRD on care partners.

W.2.3

Invite priority population representatives to participate in a work group that develops messaging about care partners in each priority population for inclusion within health promotion and chronic disease interventions.

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Ensure training materials have been assessed for cultural relevance and engaged tribal leaders.
- Show respect for the medicines and spiritual practices that are used; don't shame person living with dementias or care partners for their beliefs.

Black / African American:

- Ensure training materials have been assessed for cultural relevance and engaged community leaders.
- Show respect by taking time to understand the Black/African American culture, including faith-based involvement.

Latinx/o/a / Hispanic / Chicano/a:

- Ensure training materials have been assessed for cultural relevance and engaged community leaders.
- Listen to the family and value their expertise and cultural traditions (i.e., onus to care for elder family members).
- Ensure language (both written and spoken) is accessible.

All Priority Populations:

- Consider the "Three A's" (Awareness, Availability, Accessibility) in designing training content and messaging that best addresses each population's special requirements and needs.
- Ensure messaging for healthcare providers includes practices such as:
 - Build relationships and show you care by listening to needs and getting to know both the person living with dementia and the care partner personally.
 - Ensure to address and value cultural differences.
 - Understand, educate and refer to available ADRD community resources.
 - Acknowledge there is mental and physical strain with caregiving.
 - Be direct and help care partners prepare.
 - Understand and acknowledge stigma and fear. Be humble if an answer is unknown.
 - Consider health literacy when communicating, respecting the care partner and person living with dementia.



W= Assure Competent Workforce

Action 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.3.1

Partner with higher education public health programs to integrate ADRD education into their curricula and create a certificate program that includes ADRD education.

W.3.2

Convene a statewide ADRD coalition that brings together public health, clinical practitioners, people living with ADRD, and care partners to share best practices.

W.3.3

Identify opportunities to provide statewide dementia training to existing public health staff.

W.3.4

Incorporate brain health and risk reduction messaging that includes specific information about ADRD into existing health-professional facing chronic disease messaging.

W.3.5

Engage priority population representatives to participate in efforts to tailor existing curriculum or to develop new public health education to include a cultural sensitivity component.

Assurance for Priority Populations:

All Priority Populations:

- Consider the "Three A's" (Awareness, Availability, Accessibility) in designing training content that best addresses each population's special requirements and needs.
- Ensure that any materials or awareness campaigns have been assessed for cultural relevance and engaged community/tribal leaders.
- Consider health literacy when developing communication, respecting the care partner and person living with dementia.
- Ensure language (both written and spoken) is accessible.
- Be aware of and share local resources and services.
- Utilize data to understand why priority populations are disproportionately impacted by ADRD.
- Ensure training content helps public health professionals to:
 - Build relationships with the community to decrease fear and mistrust.
 - Understand, educate and refer to available ADRD community resources.
 - Increase the value, understanding and support for cultural differences.



W= Assure Competent Workforce

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 care partners, as appropriate, in care management.

W.4.1	Integrate education about the evidence and importance of a Cognitive Assessment at all Annual Wellness Visits within continuing education for primary care providers and through existing healthcare provider communication channels.
W.4.2	Partner with organizations that train healthcare professionals to prepare healthcare professionals to initiate conversations about brain health, incorporate practices that support early diagnoses and disclosure of dementia, and apply cultural sensitivity in those conversations.
W.4.3	Partner with organizations that provide continuing education to integrate education about ADRD counseling, care planning, referrals, and engaging care partners after a diagnosis.
W.4.4	Engage priority population representatives to participate in efforts to tailor existing training modules or develop new provider education to include a cultural sensitivity component.

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Ensure training materials have been assessed for cultural relevance and engaged tribal leaders and tribal community members.
- Show respect for the medicines and spiritual practices that are used; don't shame person living with dementias or care partners for their beliefs.

Black / African American:

- Ensure training materials have been assessed for cultural relevance and engaged community leaders.
- Show respect by taking time to understand the Black/African American culture, including faith-based involvement.

Latinx/o/a / Hispanic / Chicano/a:

- Ensure training materials have been assessed for cultural relevance and engaged community leaders.
- Listen to the family and value their expertise and cultural traditions (i.e., onus to care for elder family members).
- Ensure language (both written and spoken) is accessible.

All Priority Populations:

- Ensure training content helps healthcare professionals to:
 - Build relationships with the community to decrease fear and mistrust.
 - Understand, educate and refer to available ADRD community resources.
 - Increase the value, understanding and support for cultural differences.
 - Communicate effectively with care partners and people living with dementia, and utilize more active listening and relationship building skills.



W= Assure Competent Workforce

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

W.5.1	Offer competency-based ADRD training for all direct service, administrative, supervisory, and other staff who are involved in the delivery of care to those with ADRD in licensed long-term care facilities, the home, and adult day settings.
W.5.2	Offer ADRD trainings to professionals who offer services to people with ADRD, including first responders and adult protective services staff.
W.5.3	Identify facilities that serve a high number of individuals who belong to priority populations to prioritize offering available trainings.
W.5.4	Engage priority population representatives to participate in efforts to develop ADRD trainings for care facilities, and professionals who offer services to people with ADRD including first responders and adult protective services staff to include a cultural sensitivity component.

Assurance for Priority Populations:

American Indian / Alaskan Native:

- Ensure training materials have been assessed for cultural relevance and engaged tribal leaders and tribal community members.
- Show respect for the medicines and spiritual practices that are used; don't shame person living with dementias or care partners for their beliefs.

Black / African American:

- Ensure training materials have been assessed for cultural relevance and engaged community leaders.
- Show respect by taking time to understand the Black/African American culture, including faith-based involvement.

Latinx/o/a / Hispanic / Chicano/a:

- Ensure training materials have been assessed for cultural relevance and engaged community leaders.
- Listen to the family and value their expertise and cultural traditions (i.e., onus to care for elder family members).
- Ensure language (both written and spoken) is accessible.

All Priority Populations:

- Consider the "Three A's" (Awareness, Availability, Accessibility) in designing training content that best addresses the population's special requirements and needs.
- Ensure training content helps professionals to:
 - Build relationships with the community to decrease fear and mistrust.
 - Understand, educate and refer to available ADRD community resources.
 - Increase the value, understanding and support for cultural differences.
 - Communicate effectively with care partners and people living with dementia, and utilize more active listening and relationship building skills.



M= Monitor and Evaluate

**OUTCOME: IMPROVED DECISION MAKING
USING STATE AND LOCAL DATA**



M= Monitor and Evaluate

Action 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.3.1	Maintain a list of available surveillance systems and data sources for ADRD indicators.
M.3.2	Convene a data sub-committee that includes partners that manage relevant data sources and priority population representatives, to identify gaps, and expand measures related to the activities in the Colorado ADRD State Plan.
M.3.3	Review available quantitative and qualitative data to inform ongoing implementation and evaluation plans for the Colorado ADRD State Plan, with input from priority populations.
M.3.4	Utilize available data, and leverage qualitative data to include barriers and opportunities for priority populations, to create fact sheets and other resources for awareness campaigns, policy initiatives, and other related plan activities.

Assurances for Priority Populations:

American Indian / Alaskan Native:

- Gather feedback from American Indian and Alaskan Native populations on data that is collected and shared to ensure it is culturally responsive and addresses the needs of the population.

Black / African American:

- Gather feedback from Black and African American populations on data that is collected and shared to ensure it is culturally responsive and addresses the needs of the population.

Latinx/o/a / Hispanic / Chicano/a:

- Gather feedback from Latinx/o/a / Hispanic / Chicano/a populations on data that is collected and shared to ensure it is culturally responsive and addresses the needs of the population.

All Priority Populations:

- Support expanding representation from priority populations across data collection and surveillance systems, including oversampling to get reliable and accurate data, gathering input on questions with priority populations, and co-developing or sharing reports and information about priority populations to ensure they accurately represent these groups.
- Ensure to include equity and justice statements when presenting data to prevent stereotyping and blaming. Example statements:
 - *Long-standing **systemic injustice** has created conditions that negatively affect certain communities, particularly BIPOC.*
 - *When it comes to presenting and interpreting data and health disparities regarding race/ethnicity, sexual orientation and gender identity, it's important not to misinterpret or create unintended consequences like perpetuating negative stereotypes and victim-blaming.*
 - *Not enough data are collected with some priority populations in Colorado to present that data. This means that many inequities and disparities are not accurately represented in the data collected and shared.*



Next Steps

The Colorado ADRD State Plan outlines overarching actions and activities that will be implemented over the next five years (2022-2027).

The priorities identified in the Colorado ADRD State Plan cannot be achieved in isolation. As the work proceeds over the next five years, a vital part of the process includes **implementation teams**. Partners must work productively together through a continuum of collaboration; from actively supporting implementation of the plan to networking with others addressing similar efforts to continually engaging the community.

Implementation efforts will support exchanging information, leveraging existing efforts, building relationships with priority populations, sharing resources, and **enhancing each other's capacity to achieve a common purpose**. If done right, duplication of work and miscommunication is reduced while systems change can be realized.

An implementation plan will be developed each year to outline the specific steps, partners, and timelines for each domain.



CDPHE will continue to work with community members, private, nonprofit, and governmental partners at the state and local level to make Alzheimer's Disease and Related Dementias the next public health success story.

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Health & Environment



Appendix

Thank you to the dedicated members of the Alzheimer's Disease and Related Dementias Advisory Committee (ADRDAC) who supported development of this plan!

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Dementia Friendly Denver	JJ Jordan
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Compassion Works, LLC	Kay Adams
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Colorado Cross-Disability Coalition	Shannon Secrest
VIVE Wellness	Yoli Casas

Thank you to the CDPHE staff, consultants, facilitators and community members who also informed the plan.

Additional Resources and ADRD Products:

- [CDC Healthy Brain Roadmap](#)
- [Community Engagement Session Report](#)
- [Colorado Health Institute Key Informant Interviews](#)
- [Colorado Health Institute Memorandum on ADRD and Comorbidities Data in CO](#)
- [Colorado Health Institute Memorandum on ADRD Literature Findings](#)
- [Colorado Alzheimer's Association](#)