



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

January 26, 2012

Helen Lamont, Ph.D.  
HHS Office of the Assistant Secretary for Planning and Evaluation  
Room 424E, Humphrey Building  
200 Independence Avenue, SW  
Washington DC, 20201

Dear Dr. Lamont:

On behalf of the American Psychological Association, I would like to commend the Department of Health and Human Services and its federal partners, the Interagency Group on Alzheimer's Disease and Related Dementias, and the Advisory Council on Alzheimer's Research, Care, and Services for your efforts to develop the National Plan to Address Alzheimer's Disease.

The American Psychological Association (APA) is a scientific and professional organization that represents psychology in the United States. With more than 154,000 members, APA is the largest association of psychologists worldwide. The mission of the APA is to advance the creation, communication and application of psychological knowledge to benefit society and improve people's lives.

APA would also like to submit the following comments for your consideration as you refine the Plan Framework.

We stand ready to assist by recommending content experts (including researchers, clinicians, educators, specialists in multicultural practice and neuropsychological assessment), publicizing the Advisory Council's efforts, and reviewing and disseminating its work. APA remains committed to partnering with other organizations to prevent and reduce the burdens of this devastating disease. We very much appreciate your consideration of these comments.

Please direct any questions, comments or concerns to Deborah DiGilio, MPH, Director of our Office on Aging who can be reached at (202) 336-6135 or [ddigilio@apa.org](mailto:ddigilio@apa.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Norman B. Anderson".

Norman B. Anderson, Ph.D.  
Chief Executive Officer

Enclosure

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Norman B. Anderson, Ph.D.  
Chief Executive Officer

## **APA Comments on the *Draft Framework for the National Plan to Address Alzheimer's Disease***

The science and practice of psychology are integral to efforts to prevent this disease and slow its progression, to assess, diagnose, treat, and support those with AD, and to lighten the burdens of the families and institutions that care for them.

Psychologists:

- conduct basic and translational research
- develop and implement neuropsychological tests for assessment and diagnosis
- develop evidence based behavioral interventions to address age-related cognitive decline and the known behavioral risk factors for AD, to reduce caregiver stress and burden, and to manage the challenging behaviors often associated with the disease, a
- assess decision making capacity
- use psychotherapeutic approaches to help individuals with AD and their caregivers cope with the illness and its associated consequences

Independently, and as a part of interdisciplinary teams, psychologists have been at the forefront of research and treatment of AD.

***Given the important efforts by psychologists to understand and address AD, it is surprising that there is no mention of the role of psychology in the Draft Framework: not in the sections on research or its translation into practice, nor in the list of professions that provide high quality health care, nor in the discussion of timely AD diagnosis, nor in the framework's discussion of education and support of patients and families. Most notably, neuropsychological evaluation, a component of the original and current gold standard for AD diagnosis, is not mentioned.***

APA offers its support to your efforts to refine and finalize the Draft Framework. Below, please find our feedback, organized in response to the strategies listed.

### ***Strategy 1.A: Identify Research Priorities and Milestones***

APA is eager to participate in the development of a strategic Alzheimer's research agenda proposed by the Framework, and in the May 2012 research summit to be convened by the National Institute on Aging (NIA). We encourage NIA to invite scientists who understand not only current gaps in AD research but who also have a broad understanding of such integral topics as normative aging, cognition, clinical care, or caregiving. We also hope there will be an opportunity for scientists who didn't participate in the meeting to comment on the research agenda before it is finalized.

While a focus on biomarkers is propelling the AD field forward, how biomarkers cause or relate to the dementia syndrome (with which we are ultimately concerned) is still poorly understood. Therefore, we

believe the participation of scientists who are working in interdisciplinary teams and who understand biomarkers AND behavior would be especially important. We say more on this issue in 1.C.

***Strategy 1.B: Enhance Scientific Research Aimed at Preventing and Treating Alzheimer's Disease***

While the draft plan emphasizes the need to expand research on molecular and cellular mechanisms and genetic research to identify risk and protective factors, a research agenda that neglects the critical behavioral and social aspects of AD would be unsuccessful and insufficient.

The research agenda for the National Action Plan should prioritize research that underlies each section of the plan, e.g., research to enhance communication between caregivers and health care providers, to better tailor interactions with the health care system to the special needs of persons with AD, to enhance communication among interdisciplinary care teams, to develop and disseminate 'best practices' for caregivers and to provide support for the caregivers themselves. Significant health risks to caregivers are well documented. To that end, APA would support the convening of additional summits to focus on clinical care research and caregiving.

In the domain of prevention, research focused on enhancing cognitive function may demonstrate pathways to prevention. Two promising areas include research on lifestyle, particularly connections between cognition and exercise (Anderson-Hanley, et al., in press; Colcombe, et al., 2003; Head, et al., in press) and research on cognitive training (Ball, et al., 2002; Basak, et al., 2008; Smith, et al., 2009).

More research needs to be focused on understanding how AD interacts with "other" diseases to cause dementia, and other vulnerabilities caused by normal aging (e.g. vascular changes, inflammation, and immune system changes). Most community based studies indicate that multiple pathologies play a role in the clinical syndrome and *all* autopsy series would suggest that multiple pathologies *must* be present in order for a person to have the disease clinically.

Because the first draft of the Framework dealt so cursorily with the issue, we want to emphasize again the importance of expanding research to understand how biomarkers relate to AD symptoms. It is perhaps the single most important area of focus for the research agenda, and is discussed more fully in our response to Section 1C.

We also request that the term "non-pharmacologic" be replaced with "behavioral." Behavioral describes a wide variety of interventions that NIA and other NIH institutes have funded and supported, and that may be extremely valuable for prevention and intervention. For example, for the management of behavioral disturbances in dementia, most reviews of this field suggest that behavioral interventions are preferred, due to their effectiveness, and because they help to avoid the serious side effects that are common with pharmacological approaches to dementia management (American Geriatrics Society, 2011; Camp & Nassar, 2003; Cohen-Mansfield, et al, 2007; Salzman, 2008; Sink et al., 2005).

***Strategy 1.C: Accelerate Efforts to Identify Early and Presymptomatic Stages of Alzheimer's Disease***

While the increased ability for scientists to monitor changes in biomarkers is certainly promising, psychologists and others are concerned that there is considerable heterogeneity in how pathogenic factors in AD are related to the symptoms of the disease. There is strong evidence that some neuropsychological measures can more sensitively predict conversion to Alzheimer's than most biomarkers (Gomar et al, 2011; Heister, et al., 2011; Landau, et al., 2010).

Research to understand and chart the earliest course of the disease should support biomarker development in tandem with neuropsychological research, not to the exclusion of it. More psychological/neuropsychological research needs to be supported to understand the behavioral manifestations of the putative biology. The use of biomarkers to monitor the effects of treatment only provides information on how the treatment affects *that biomarker*, which may or may not lead to improvement in the clinical syndrome associated with the disease. We need better psychological and behavioral markers that are sensitive to disease progression over shorter periods to understand whether treatments improve the symptoms of the disease rather than simply the putative biological features. Right now, treatment trials use neuropsychological outcomes that are specific to diagnosis but may not detect disease progression with high sensitivity. More sensitive neuropsychological markers for diagnosis also need to be developed given that the biology of the disease starts years before evidence of the clinical syndrome. We believe the expertise of psychology in defining relationships between the biology and behavior is critical, and is not acknowledged in this draft of the Framework.

We want to emphasize that the first sentence in the draft Framework's Strategy 1.C is the subject of much disagreement. It is not currently possible to track the progression of AD through tracking biomarkers. And it is only possible to monitor the effect of such treatment as may be targeted specifically to a biomarker, not to a larger clinical syndrome.

#### ***Strategy 1.E: Facilitate Translation of Findings into Medical Practice and Public Health Programs***

It is important for research findings to be translated into a universe much larger than medical practice. Because of the complex needs often presented by individuals with AD and their families and caregivers, the provision of care by an interdisciplinary health care team is generally needed. Thus, useful findings must be translated into the practices of *many* health care providers and in a *variety* of settings. Individuals with AD and their caregivers are found in multiple settings, not only traditional, medical settings, including long term care, community, and home care. We recommend the terms "medical" practice and "medical" practitioners be replaced by "health care" practice and "health care" providers to capture this inclusive model of care. Finally, individuals with AD and their caregivers should be explicitly mentioned as recipients of information regarding effective interventions.

#### ***Strategy 2.A: Build a Workforce with the Skills to Provide High-Quality Care***

We urge you to include psychologists among your list of specialists that care for people with AD and their families. The major initiatives to expand geriatric training opportunities at the Department of Veterans Affairs and the Health Resources and Services Administration cited in this section both include psychology as one of the disciplines targeted.

Psychologists are integral members of the geriatric and dementia care workforce. They include highly trained professionals with unique skills in assessment, research and evaluation, behavioral health, geriatric and neuropsychological practice, evidence-based behavioral treatment and behavioral medicine practice, group dynamics, and systems that are of critical importance in addressing the health care needs of individuals with AD, their families, and caregivers.

Care provided by interdisciplinary health care teams ensures optimal assessment, diagnosis, treatment planning and implementation, and outcome evaluation that is responsive to the physical, behavioral, mental health, and social needs of patients and their families (APA, 2007). Caregivers of individuals with AD, and the individuals with AD themselves when possible, should be included as members of the team.

In addition, given the pressures faced by physicians, counseling efforts proven most effective in educating family members about how to handle the problems of AD are impossible to complete during the time allotted to a brief office visit.

Finally, Medicare reimbursement policies act as a deterrent to building the health workforce necessary to provide high quality care to individuals with AD and their caregivers. For example, Medicare will not pay for CPT codes 90846 (family psychotherapy without the patient present), or for 96155 (health and behavior intervention for the family without the patient present). Nor will Medicare pay for a physician service such as an office visit with a patient's family if the patient is not present. For patients with cognitive impairment, there must be options for reimbursement when working with families and caregivers without the patient present. In terms of integrated care teamwork, there are Medicare CPT codes (e.g., 99366 and 99368 initiated in 2008) that allow team conferences that involve interdisciplinary professionals from at least three disciplines to assess a patient's care plan and progress, however these codes are very poorly reimbursed. Reimbursement of behavioral interventions, other than psychotherapy, which would allow psychologists and other mental health professionals to intervene on behalf of people who cannot benefit from traditional therapy because of their cognitive deficits, e.g., behavior management interventions, is also critical.

### ***Strategy 2.B: Ensure Timely and Accurate Diagnosis***

We would like to emphasize that the current gold standard for AD diagnosis involves a neuropsychological evaluation - - the integration of objective measures of cognitive performance with historical, neurological, and other diagnostic information. Psychologists, with specific competency in evaluation of cognition and expertise in the integration of cognitive data with other psychodiagnostic approaches, clearly need to be represented as primary practitioners involved with enhancing AD care quality and efficiency through timely and accurate diagnosis. The *APA Guidelines for the Assessment of Dementia and Age-Related Cognitive Change* (APA, 2012) note that neuropsychological evaluation and cognitive testing remain among the most effective differential diagnostic methods in discriminating pathophysiological dementia from age-related cognitive decline, cognitive difficulties that are depression-related, and other related disorders. Even as biomarker identification and analysis improve, neuropsychological evaluation and cognitive testing will still be necessary to determine the onset of dementia, the functional expression of the disease process, the rate of decline, the functional capacities of the individual, and, hopefully, response to therapies.

The citation for this sentence: "Research has helped identified some assessment tools that can be used to rapidly assess patients showing signs and symptoms of AD and to help health care providers make a diagnosis or refer for further evaluation" focuses almost exclusively on biological markers. However, behavioral (neuropsychological) markers remain the gold standard against which biological markers are validated (Blacker, et al., 2007; Gomar, et al., 2011; Jacobs, et al., 1995; Tabert, et al., 2006). Neuropsychological assessment tools are non-invasive, highly accessible, and reasonable for the assessment of AD either in isolation or with other markers of disease. We request that the literature documenting the usefulness of behavioral markers be included in this section of the framework.

### ***Strategy 2.C: Educate and Support Patients and Families Upon Diagnosis***

Multiple health care providers, including psychologists, are involved in assessment and planning of advance care counseling for individuals with AD. Assuming that these tasks are the sole purview of the physician is incorrect. Thus the term “physician(s)” should be replaced with “health care provider(s).”

The APA Guidelines for the Evaluation of Dementia and Age-related Cognitive Change (2011) state, “Individuals concerned about cognitive and behavioral changes associated with aging, generally come to the evaluation process seeking information as well as emotional support. This often is a severely distressing situation for the individual, who may or may not have been the key individual in making the decision to have an assessment conducted (American Bar Association & American Psychological Association, 2008; American Psychological Association, 1998). .... Providing feedback, education, and support to persons significant to the individual, with the individual’s informed consent, are also important aspects of evaluations and enhance their value and applicability. Knowledge regarding levels of impairment, the expected course, and expected outcomes can help these significant others to make adequate preparations. Working with the individual’s support network in this way can provide them with effective means of responding to the challenges posed by behavior changes stemming from a diagnosis of dementia. Healthy older adults who have had concerns about their cognitive functions can benefit from reassurance based on results of testing and from suggestions as to how they may enhance their everyday cognitive function.”

Unfortunately, research on advance care planning for persons with cognitive impairment shows that even when physicians and social workers in a Memory Disorders Clinic encourage advance care planning only about 40% of clients do so (Garand, 2011). It appears that the most effective way to foster the development of advance care plans is to involve multiple face-to-face educational sessions (Bravo, 2008). Thus, support for more intensive interventions is necessary if we are to increase advance care planning.

We would also like to note that at this time, the evidence does not indicate that early detection will lead to improved treatment, or actually help people to plan for their future care. There is a risk to early detection (as noted in recent guidelines for cancer screening) – large numbers of individuals being identified as patients, or at risk. This can create needless psychological distress because there are so few current treatment options, and those few options are often inappropriate. This may lead to discouragement on the part of families whose support and partnership with care providers is critical to the person with AD.

### ***Strategy 2.D: Identify and Implement High-Quality Dementia Care Guidelines and Measures Across Care Settings***

Identification and implementation of high-quality dementia care guidelines should include both those that focus on pharmacological and behavioral intervention and take the whole person into account, including behavioral and mental health considerations along with physical care. Interdisciplinary consensus development processes, such as the Consensus Statement on Improving the Quality of Mental Health Care in U.S. Nursing Homes: Management of Depression and Behavioral Symptoms Associated with Dementia (American Geriatrics Society, 2003) in which 15 health provider organizations participated is one effective model for developing high-quality dementia care guidelines. APA has developed Guidelines for the Evaluation of Dementia and Age-related Cognitive Change

(<http://www.apa.org/pi/aging/resources/dementia-guidelines.pdf>) and is interested in working with other organizations to develop additional dementia care guidelines.

***Strategy 2.F: Advance Coordinated and Integrated Health and Long-Term Care Services and Supports for Individuals Living with Alzheimer's Disease***

Mental and behavioral health services must be included in the wide array of health services available to individuals with AD. Psychologists and other mental and behavioral health providers should be represented on interdisciplinary health care teams that work with individuals with AD and their families and caregivers in primary care, long-term care and community and home-based settings. Cognitive impairment alone does not preclude the ability to benefit from various forms of psychotherapy. Behavioral interventions are effective in addressing dysphoria, agitation, anxiety, and apathy in persons with dementia (Teri et al., 2005). Behavioral interventions are an especially important tool as medication treatment of behavioral disturbances in dementia is of limited efficacy and should be used only after environmental and behavioral techniques have been implemented (American Geriatrics Society, 2011; Sink, et al., 2005). At more advanced stages of dementia, use of sensory stimulation often assists in addressing issues related to agitation or anxiety (Lin et al., 2009). At all stages of dementia, apathy is the most common behavioral challenge facing caregivers. Therefore, provision of optimal stimulation and ensuring positive engagement are critical features of interventions to improve the quality of life of both persons with dementia and their caregivers (APA, 2012).

A major challenge arising from the anticipated rapid growth in the population of those suffering from AD is provision of support, both to the individuals with AD and to their caregivers. It may not be feasible to construct the number of nursing homes, assisted living facilities, and Continuing Care Retirement Communities (CCRCs) required to provide a continuum of care for individuals with dementia in the coming decades. Even if it proves possible, the cost of maintaining people in such facilities may be prohibitive without a rapid enrollment of people into long-term care insurance programs. In addition, home and community-based care is often preferred by patients and their families. Finding ways to support those with AD and other dementias in their homes is going to be critical to effective coordination of care.

Randomized control trials, such as REACH and REACH II, have shown that innovative health care tools, such as remote delivery of services through telemedicine with the support of integrated health care teams, can relieve caregiver burden, particularly depression, for those caring for people with AD (Eisdorfer et al., 2003; Czaja & Rubert, 2002; Finkel et al., 2007). Such interventions can be structured to provide effective, culturally-sensitive support (e.g., Belle et al., 2006).

***Strategy 2.G: Improve Care for Populations Disproportionally Affected by Alzheimer's Disease***

APA concurs that improved care is necessary for populations disproportionately affected by AD. Health care providers must understand and competently manage the cultural differences in these populations. In many ethnic minority groups, familial support extends beyond the immediate family system. Thus it is important that providers be as inclusive of the extended family system as possible.

***Strategy 3.A: Ensure Receipt of Culturally Sensitive Education, Training, and Support Materials***

We concur that ensuring the development and receipt of culturally sensitive education, training and support materials by family caregivers is crucial as there is evidence that the problems experienced by

caregivers differ in occurrence and intensity across racial and ethnic lines (Dilworth-Anderson, Williams, & Gibson, 2002; Janevic & Connell, 2001; Piquart & Sörenson, 2005). Replication and dissemination of model interventions such as REACH II (Belle et al, 2006; Burgio, 2009; Elliott et al., 2010) that are proven to be effective with diverse populations, is encouraged.

The strengths and coping mechanisms of culturally diverse groups should not be overlooked. For example, in a study of caregivers of patients with AD, Morano and King (2005) found that caregivers with higher levels of religiosity reported significantly lower levels of depression. Inter-ethnic comparisons showed that, African American caregivers reported the highest level of religiosity and the lowest levels of depression.

When considering issues of diversity and the effective provision of culturally sensitive education, the special needs of individuals with intellectual disabilities who develop AD should be considered. In addition, culturally sensitive education should include efforts directed to lesbian, gay, bisexual and transgender communities. In these communities, “familial support” includes “families of choice,” a term which is often used in lieu of family of origin for many LGBT adults.

Psychologists have a long history of involvement in the development of culturally competent health care interventions (e.g., many of the lead investigators on the REACH and REACH II projects were psychologists) and could provide additional direction in the development of this strategy.

### ***Strategy 3.B: Enable Family Caregivers to Continue to Provide Care While Maintaining Their Own Health and Well-Being***

Rather than beginning the description of this strategy with a sentence about the eventuality of nursing home placement, it would be more useful to begin with the second sentence that speaks to supports for families and caregivers. This is an area in which we *do* have evidence-based interventions to assist caregivers in maintaining their own health and well-being. Research on the effectiveness of behavioral interventions for caregivers of individuals with dementia has been quite prolific (APA, 2011). For example, The New York University Caregiver Intervention (NYUCI) benefits the caregiver’s mental and physical health and delays institutional placement of the care recipient (Mittleman et al., 2006). This intervention provides dementia caregivers with 6 sessions of individual and family counseling, support group participation, and additional on-call telephone consultations in a flexible counseling approach that is tailored to each caregiving family. The STAR-C intervention (Teri, et al, 2005) produces benefits for both the caregiver and care recipient, improving caregiver depression, reducing burden, improving sleep, lessening subjective ratings of burden, improving caregiver reaction to behavioral problems, improving care recipient quality of life and memory-related behavioral problems. The STAR-C program has been successfully taught to community consultants, providing evidence that it can be disseminated into diverse community settings. In this intervention, caregivers are taught to monitor problems, identify possible environmental or interpersonal triggering events, and develop more effective responses in order to improve patients’ environment, maximize their abilities, and minimize their impairments. Psychologists have been involved in the development and evaluation of each of these interventions and have trained masters level professionals and aging and community service workers to implement them in community settings.

It should be noted, however, that the use of the term “supports” is a bit misleading in this strategy’s description. The meta analysis cited (Sorensen, 2002) shows that interventions that *only* offer supports are much less effective than interventions that offer caregivers information and skills training – that is,



psychoeducational interventions with an “active” component. Cognitive behavioral therapy was found to be the most effective intervention in decreasing caregiver depression in this meta analysis.

***Strategy 3.C: Assist Families in Planning for Future Long-Term Care Needs***

Assistance is critical for family members who must prepare to transition from care partners to caregivers (Aneshensel, et al., 1995). Families need not only education but skills training and the availability of counseling services as they take on multiple roles and responsibilities (Zarit, 2009). As noted elsewhere in this document, Individuals with AD should also be included in planning for their future needs.

Unfortunately, the resources for planning and meeting long-term care needs are woefully inadequate. Many families and caregivers of individuals with AD perceive themselves as not ‘fitting’ many of the support options communities may have to offer. Often the individual with AD does not qualify for services because they do not have IADL limitations.

***Strategy 3.D: Maintain the Dignity, Safety, and Rights of People with Alzheimer’s Disease***

Psychological interventions stress the importance of personhood and preserving the individuals’ dignity in AD and person-centered planning during MCI and mild AD. Enabling family members to accept, support, and engage the person with dementia as he or she is now is an important challenge to address. It is also critically important that therapeutic goals be discussed directly with the individual who has dementia. This not only provides the respect and dignity that should be given any individual, but also provides highly relevant information regarding the individual’s understanding and attitude about the goal, his or her motivation in achieving the goal, and his or her willingness to expend time and energy working toward the goal (APA, 2012).

Regarding safety, although physical neglect and abuse tend to occur most of the time during the more severe stages of the AD, it is also important to recognize that older adults during the stages of MCI and mild AD are vulnerable to neglect and abuse in other domains. This is particularly true for financial abuse as there is evidence that diminished financial capacity or decision making is one of the early signs of cognitive decline (Marson et al., 2000). Individuals who are living independently are at high risk. It is not enough to say that we have APS or the Ombudsman program in place – we must be much more proactive to prevent abuse before it happens. Psychologists play a key role with regard to assessment of capacity (e.g., capacity for medical consent, financial capacity, testamentary capacity, capacity for independent living).

APA and the ABA Commission on Law and Aging have jointly published a series cost-free handbooks on the Assessment of Older Adults with Diminished Capacity for psychologists, lawyers and judges <http://www.apa.org/pi/aging/programs/assessment/index.aspx>. The handbooks have proved useful to a variety of health and aging professionals.

***Strategy 4.A: Educate the Public about Alzheimer’s Disease***

The public health initiative described focuses on enhancing public awareness about AD, including misconceptions about diagnosis and treatment. We believe the main focus of a public education campaign should be on modifiable risk factors for AD – including diabetes, midlife hypertension, midlife obesity, smoking, depression, cognitive inactivity or low educational attainment, and physical inactivity - and actions individuals can take now to reduce their risks. We know enough about these modifiable risk

factors to institute a public health/awareness campaign, even if the risk factors are not related to the putative pathology. A recent study (Barnes, et al, 2011), notes that up to half of AD cases worldwide are attributable to seven potentially modifiable risk factors — and that a 10—25% reduction in all seven risk factors could potentially prevent as many as 1.1—3.0 million AD cases worldwide.

In addition, the educational effort should not be alarmist, rather clearly state that the *majority* of older adults before the age of 80, which is currently about the average life expectancy for U.S. citizens, do not develop AD. AD is not a normal part of cognitive aging. Findings from longitudinal studies of intellectual development, such as the Seattle Longitudinal Study (Schaie, 2005), suggest that individuals who develop dementia after the age of 60 need to show multiple risk factors, including both genetic and behavioral risk factors. To be specific, estimates of the prevalence rates of dementia (i.e., most of the time estimates of dementia of the Alzheimer’s type) for different age groups vary across study and range from about 5% to 13% for individuals age 65 and older to over 40% for adults age 85 and older (Hebert et al., 2003; Plassman et al., 2007). Thus, it is well established that the prevalence rate increases disproportionately with age and that individuals who are at greatest risk for showing signs of dementia are not individuals in the young-old age range, but individuals in the old-old and very-old age range (i.e., 80 years and older). This information should inform the public education campaign.

There are also pronounced racial differences in the prevalence rate of dementia and that this should be taken into account when raising public awareness and discussing the needs of this segment of the population. Gurland et al. (1999), for example showed that while the prevalence rate for white Americans was 2.9%, 10.9%, and 30.2% for the age groups of 65-74, 75-84, and 85+, respectively, the rates for the same age groups for African-Americans were 9.1%, 19.9%, and 58.6%, respectively. The pattern of prevalence rates for Hispanics was even higher in the age groups of 75-84 and 85+ (i.e., 27.9% and 62.9%), respectively.

***Goal 5: Improve Data to Track Practice***

APA concurs with the importance of this goal and its corresponding strategies.

We offer the additional reference links to the following relevant APA publications: [Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change](#); [Assessment of Older Adults with Diminished Capacity \(A Handbook for Psychologists\)](#) and [Assessment of Older Adults with Diminished Capacity \(A Handbook for Lawyers\)](#). References to articles and other publications cited in our comments appear below.

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