Advisory Council on Alzheimer's Research, Care, and Services

Recommendations for 2026

Research Subcommittee Recommendations

RECOMMENDATION 1: Ensure research directions are determined by scientific experts using evidence-based decision making and input from people living with Alzheimer's disease and related dementias (ADRD) and their caregivers.

- **Recommendation 1 to Congress: Increase federal research funding and investments to meet NAPA goals of preventing and treating Alzheimer's disease and related dementias.**

Research progress depends on scientific rigor that has driven breakthroughs in diagnostics and treatments. The scientific approach is the only proven way to meet NAPA goals and improve human health outcomes. Critical decisions about Alzheimer's disease and Alzheimer's disease–related dementias (AD/ADRD) research priorities and funding must be made by scientific experts utilizing evidence-based research informed by people living with AD/ADRD and their caregivers.

  - **Why is this so critical now?** *Scientific advances in medicine are made based on high-quality experimental evidence with guidance from experts (dedicated and trained scientists in the field). With the first disease-modifying treatments and highly accurate diagnostics approved and in use, and ongoing prevention trials underway, expert guidance is crucial to evaluate and advance numerous high-priority research areas from understanding disease basics to implementing care models. Federally funded AD/ADRD research has delivered transformative breakthroughs including blood tests for early detection and the first treatments that slow disease progression.* **We are at an unprecedented moment where decades of investments are paying off, and reducing this momentum and failing to capitalize on these advances would forfeit our best chances to prevent and treat AD/ADRD.** We are facing a critical juncture where existing high-impact programs must be protected and continued. Equally critical is funding innovative new projects that can capitalize on recent discoveries and yield the next breakthroughs. The scientific workforce and research infrastructure supporting everything from understanding disease causes, to testing treatments in communities, represents decades of investment and will cause permanent damage if dismantled.

Deliverables:

Implementation milestones:

- 1 year: Continuation and completion of ongoing studies that are delivering continued breakthroughs in highly accurate tests, treatment development, and dementia prevention.
- 3 years: Expanded and optimized research portfolio based on scientific evidence will lead to new breakthroughs; successful translation of discoveries to patient care.
- 5 years: National Alzheimer's Project Act (NAPA) goals of accurate diagnosis, prevention, and treatment will be met through strategic, science-driven investments, preventing millions of people from getting AD/ADRD, preventing dependency, patient and caregiver burden and suffering, and enormous financial costs to our public and private healthcare systems and families.

Funding milestones:

- 1 year: Support research on different mechanisms giving multiple shots on goal to advance next-generation treatments; continue ongoing prevention trials; maintain critical long-term study cohorts; fund innovative projects; continue efficiency of existing infrastructure to accelerate translation of discoveries to patients and families.
- 1-3 years: Prevention trial results from ongoing trials; expanded diagnostic tools in primary care; new treatment targets identified through novel research approaches.
- 5 years: Translation of scientific discoveries to the general public; evidence-based prevention strategies; multiple treatment options for different disease stages; novel, disease-specific biomarkers and personalized medicine approaches; breakthrough discoveries from innovative research.

Consequences if no implementation or funding:

- Waste of years of progress and billions of dollars in investments by disrupting ongoing research that shows extraordinary promise.
- Misallocation of resources away from high-impact studies or limiting advances due to non-scientific reasons.
- Certainty of AD/ADRD profoundly affecting millions of lives, including physical, emotional, and financial hardships (costing immeasurable human suffering and hundreds of billions of dollars in the United States alone).
- Failure to capitalize on prior investments, reducing positive impacts on human health: halts decades of progress and ongoing research for breakthrough diagnostics and disease-modifying therapies.
- Suspension of pharmacological and non-pharmacological prevention trials: halts critical research in early-intervention strategies that industry sponsors are unlikely to finance independently.
- Permanent loss of irreplaceable longitudinal study cohorts: erases 20+ years of continuous, irreplaceable patient data, severely undermining future research and progress.
- Loss of U.S.-based scientific expertise and innovation forfeits the United States' historic position as the global leader in AD/ADRD research and care.

- Substantial setback in meeting NAPA's goals.

RECOMMENDATION 2: Sustain current trials and fund new long-term prevention and early intervention trials for AD/ADRD.

- **Recommendation 2 to Congress and the U.S. Department of Health and Human Services (HHS): Sustain current trials and fund new long-term prevention and early intervention trials for AD/ADRD Prevention of AD/ADRD**. This will have far greater impact than treatment alone after symptom onset and brain damage have occurred. Current treatments work best in very early disease, and early detection followed by prevention intervention is critical.
    - ***Why is this so critical now? We've learned that Alzheimer's disease begins 15-20 years before symptoms appear, giving us a crucial window to prevent the disease entirely - but only if we complete the long-term studies already underway and launch new prevention trials targeting newly discovered mechanisms.*** *Prevention strategies targeting at-risk individuals before any symptoms emerge, including both pharmacologic and non-pharmacologic trials designed to lower risk and prevalence of AD/ADRD, represent the most efficient and cost-effective approach to reducing dementia burden. These multi-year prevention trials require sustained federal commitment as industry and philanthropic funding alone cannot support 10–20-year studies.*

Deliverables if funded:

- 1 year: Maintain ongoing prevention study cohorts addressing fundamental prevention strategies; evaluate multiple pathways being tested in parallel (multiple shots on goal) to improve rates of success; initiate combination prevention approaches targeting multiple risk factors; readout of ongoing non-pharmacologic prevention trials.
- 3 years: Interim results showing which prevention strategies are working; refined risk prediction tools; readout of the first pharmacologic prevention trials.
- 5 years: Definitive results from ongoing prevention trials guiding clinical practice and population-level interventions.

Consequences if not implemented:

- Failure to capitalize on prior investments, decades of progress, and ongoing research for breakthrough disease-modifying therapies (e.g., prevention trials showing 50% reduction in onset and progression of autosomal dominant Alzheimer’s disease).
- Inability to substantially reduce overall dementia incidence fails to intercept disease onset and progression with prevention and treatment, resulting in unmitigated, irreversible neurological damage across populations.
- Continued reliance on costly late-stage treatments with limited effectiveness.

- The critical 15- to 20- year presymptomatic disease window will not be studied, degrading the capacity to identify, test, and validate early prevention strategies before cognitive decline begins.
- Public health impact: by 2050 in the US, projected doubling of AD dementia cases to 12.7 million and increased healthcare and long-term care costs projected to reach $1 trillion annually without treatment and prevention breakthroughs.

RECOMMENDATION 3: Invest in the application of artificial intelligence (AI) and big data to transform discoveries in AD/ADRD mechanisms, diagnosis, treatments, and management.

- **Recommendation 3 to Congress HHS: Through the revised National Plan to Address Alzheimer's Disease, Congress and HHS should invest in the application of AI and big data to transform discoveries in AD/ADRD mechanisms, diagnosis, treatments, and management.**

AI and big data analytics offer transformative potential to accelerate every stage of AD/ADRD research, from understanding the biological underpinnings of disease to improving how clinical trials are designed and conducted. Decades of AD/ADRD research have generated massive, underutilized repositories of electronic health records, genomic and other omics data, neuroimaging, biomarkers, and longitudinal cohort studies. Traditional approaches cannot fully digest the scale and multi-dimensional complexity of AD/ADRD. To break through, the field must intentionally pivot from siloed, incremental research to AI-driven approaches that can detect patterns across these large, multidimensional datasets that would be impossible to identify through traditional methods.

  - ***Why is this so critical now?*** *We are witnessing a convergence of four unprecedented forces: highly accurate Alzheimer's diagnostics, massive longitudinal datasets and cohorts, breakthrough techniques in biomolecular spatial mapping, and revolutionary generative AI/machine learning capabilities. With deliberate, coordinated federal funding to incentivize disruptive approaches and cross-disciplinary collaborations, the field can accelerate high-impact discoveries and avoid relying on outdated methodologies that slow progress and clinical impact.*

Deliverables if funded:

- 1 year: Federal investment directed to AI and big data applications across AD/ADRD research; AI-enabled cross-disciplinary approaches piloted within existing trial networks and research programs; AI systems launched to discover novel mechanisms and targets to accelerate treatments and preventions.
- 3 years: AI-enhanced tools reaching clinical and research settings; measurable acceleration in the speed and efficiency of discovery and trial conduct by 50-200%, discovery of additional causes and mechanisms of AD/ADRD, early-stage testing of novel preventions and treatments.

- 5 years: AI-accelerated discovery pipeline producing a new generation of therapeutic candidates and informing population-level prevention strategies.

Consequences if not implemented:

- The AD/ADRD field forfeits the benefits that other disease areas, particularly oncology, gain in leveraging AI to accelerate drug discovery and trial efficiency.
- Opportunities to identify novel therapeutic targets and reduce the high failure rate of AD/ADRD drug development go unrealized.
- Trial costs and timelines remain high, limiting the number of candidates that can be tested and reducing overall shots on goal.

RECOMMENDATION 4: Leverage the revised National Plan to Address Alzheimer's Disease to establish a coordinated national AD/ADRD clinical research infrastructure.

- **Recommendation 4 to HHS and Congress: Through the revised National Plan to Address Alzheimer's Disease, establish a coordinated national AD/ADRD clinical research infrastructure that is modeled on the highly successful National Cancer Institute (NCI) system.**

Modeled on the highly successful NCI system, this proposed infrastructure will greatly accelerate the development of prevention, diagnosis, monitoring, and treatment approaches and expand patient access to clinical trials nationally. This recommendation aims to achieve two interrelated goals: 1) expand patient access to clinical care for state-of-the-art diagnosis and treatment (something that is sorely lacking now), and 2) incorporate clinical trials into the care model, so that patients have the opportunity to participate in trials and the entire clinical trials ecosystem is accelerated.

Background: The AD/ADRD research field has achieved transformative scientific breakthroughs, but lacks the national infrastructure to effectively and efficiently deliver these advances to patients. Despite a growing pipeline of 192 active AD drug trials globally, these trials are designed to enroll only approximately 55,000 participants in total, representing *less than 1%* of the approximately 7 million Americans currently living with AD dementia or mild cognitive impairment. This is in contrast to the NCI, which estimates *over 20%* of cancer patients participate in cancer trials at NCI-designated cancer centers. The NCI built its national clinical trials system over decades through sustained federal investment, dedicated infrastructure funding, and a community-based research network that brings trials to patients regardless of where they live. Cancer outcomes have been improving as a result, leading to breakthroughs and additional years of life, with cures for many cancers now being delivered to patients. A parallel comprehensive system for AD/ADRD does not yet exist at the necessary scale.

  - ***Why is this so critical now?*** *The field now faces a formative opportunity: with the approval of first-generation disease-modifying treatments, the emergence of highly accurate diagnostic blood tests, and a robust pipeline of prevention and combination therapy trials, sustained federal investment in infrastructure will yield the highest possible return on investment.*

Treating patients at the earliest stage of cognitive decline yields the greatest clinical benefits, promising to extend years of independent living, accelerate novel therapies, and avert the impending public health crisis of AD/ADRD.

Developing infrastructure with proven model:

- Independently funded Centers of Excellence that integrate prevention, clinical care, clinical trials, translational research, and biorepositories, with infrastructure funding separate from individual trial grants.
- A community-based clinical research network analogous to the NCI Community Oncology Research Program (NCORP), with dedicated sites serving rural, minority, and underserved populations and structured accrual expectations.
- Formalized master protocol and platform trial frameworks that enable simultaneous evaluation of multiple therapeutic targets under shared operational infrastructure.
- Centralized data and biospecimen repositories accessible across trials and longitudinal cohorts.
- Training for physicians, including primary care providers, in accurate diagnosis and treatment.
- Coordinated direction of funds to the National Institutes of Health (NIH), Advanced Research Projects Agency for Health (ARPA-H), and other relevant agencies with clear cross-agency accountability to NAPA.

Deliverables if funded:

- 1-3 years: Federal funding appropriated to launch the establishment of AD/ADRD Centers of Excellence and a community-based clinical research network.
- 3-5 years: Increased interventional trial readouts from multiple parallel trials targeting distinct mechanisms, and trial participation available to a substantially larger share of eligible patients, with a goal of offering access to 10 to 50 times more patients seen in clinical settings.
- 5-10 years: Prevention trial readouts and a fully operational data and biospecimen commons supporting biomarker-guided trial design across the network.

Consequences if not implemented:

- Clinical trial access will remain concentrated in a small number of medical centers; a low percentage of patients treated with disease-modifying treatments; AD/ADRD, dementia disability, and dependence continue to grow, straining and breaking medical systems.
- Only a few treatments tried per year in interventional and prevention trials; low probability of success leading to very few new effective preventions and treatments.
- Inefficiency in trial infrastructure limits the number of candidates that can be tested, slowing the overall pace of discovery.

Clinical Care Subcommittee Recommendations

RECOMMENDATION 1: Advance best practices across the AD/ADRD care continuum.

- **Recommendation 1 to HHS: Develop a framework for continuous improvement and implementation of best practices for screening, diagnosis, delivery of care, treatment pathways, and care navigation for people living with AD/ADRD and their caregivers. Provide training across all clinical roles.**

Support and incentivize role-specific AD/ADRD care training for clinical and community-based care teams, ensuring proficiency in screening, diagnostic evaluation, caregiver engagement, referral management, and care coordination.

Promote innovative, technology-enabled learning models, including Project ECHO (Extension for Community Healthcare Outcomes). Federal incentives should be aligned with demonstrated competencies and effective closed-loop care processes rather than training completion alone.

- **Recommendation 1 to Congress: Prioritize funding for an improved, consistent national AD/ADRD care continuum.** To advance the goals of the National Alzheimer's Plan, Congress should prioritize funding for the following recommendations, with a focus on improving outcomes, expanding access, and strengthening the nation's dementia care infrastructure.

1. **Standardize Alzheimer's disease and related dementias screening through Annual Wellness Visits (AWVs):** Tie funding to increased screening rates and equitable access.
2. **Expand workforce training:** Invest in scalable models (e.g., Project ECHO, continuing medical education [CME], and nursing curricula).
3. **Strengthening care pathways:** Incentivize clinical practitioners to utilize best practices. Ensure coordination, education, implementation, and training become standardized across all clinical roles.
4. **Support prevention research:** Include vaccines, vascular health, and delirium prevention; explore the Alzheimer's Screening and Prevention (ASAP) Act with broader committee group while acknowledging concerns about biomarker/blood-test implementation.
5. **Tie funding to measurable outcomes:** Ensure metrics are realistic and actionable. Avoid over-specifying metrics prematurely.
6. **Address access gaps:** Prioritize underserved communities in screening, diagnosis, and care.
7. **Dedicate funding:** To support national brain health initiatives, including prevention, public awareness, and evidence-based interventions that promote long-term cognitive well-being.

RECOMMENDATION 2: Improve screening and diagnosis by standardizing AD/ADRD screening.

- **Recommendation 2 to HHS: Direct the Centers for Medicare & Medicaid Services (CMS) to include in their AWVs, standardized AD/ADRD screening.** CMS should require an AD/ADRD screening as part of AWVs, as well as ensure prevention guidance is updated continuously as evidence evolves.
    - There should also be a national public health campaign launched by HHS (or CMS) that focuses on nutrition, risk-reduction strategies, and early intervention across the lifespan.

- **Recommendation 2 to Congress: Congress should provide dedicated funding and incentive structures to support education, prevention programs, screening initiatives, and community-based interventions that improve long-term cognitive health outcomes, including a national Alzheimer's and Brain Health Awareness Campaign.** The Clinical Care Subcommittee reiterates the importance of prioritizing this campaign as detailed in the Risk Reduction's Recommendations.

RECOMMENDATION 3: Create a Current Procedural Terminology (CPT) Code Education Campaign for providers and health systems and use this education campaign to underscore the value and consistent use of CPT Codes related to AD/ADRD.

- **Recommendation 3 to HHS:** Direct CMS to create a CPT Code Education Campaign that targets and trains care providers and health systems. This would prioritize **CPT code 99483**, and include education on relevant ICD-10-CM diagnostic codes, including the following:

Diagnostic Codes:

G31.84 - Mild cognitive impairment
G30.0 - Alzheimer's disease with early onset
G30.1- Alzheimer's disease with late onset
G30.9 - Other Alzheimer's disease
G30.9 - Alzheimer's disease unspecified
F03.90 - Unspecified dementia without behavioral disturbances
F03.91 - Unspecified dementia with behavioral disturbances
F01.50 - Vascular dementia without behavioral disturbances
F01.51 - Vascular dementia with behavioral disturbances
G31.83 - Dementia with Lewy bodies
G31.09 - Frontotemporal dementia
R41.81 - Age-related cognitive decline

Diagnostic Codes for Dementia with Behavioral Health Settings (ICD-10):
G31.83 - Dementia with Lewy bodies
G31.09 - Frontotemporal dementia
F03.91 - Unspecified dementia with behavioral disturbances
F01.51 - Vascular dementia with behavioral disturbances
F02.80 - Dementia in other diseases classified elsewhere without behavioral disturbances
F02.81 - Dementia in other diseases classified elsewhere with behavioral disturbances

Key Considerations:

- 1/2 of people living with dementia do not have a diagnosis.
- Highest risk factor for dementia is age (65+).
- An estimated 11% of people 65+ and 32% 85+ are living with dementia.
- 2/3 of people living with dementia are women.
- Psychological symptoms and behavioral abnormalities in dementia are common such as depression, anxiety, psychosis, agitation, aggression, disinhibition, and sleep disturbances.
- Approximately 30% to 90% of patients living with dementia suffer from behavioral symptoms.
- Nearly all community-dwelling elderly individuals living with dementia will develop psychiatric symptoms within five years.

Background:

NAPA Clinical Care Subcommittee - Consolidated Summary:

The Clinical Care Subcommittee's first two meetings identified consistent gaps, strategic priorities, and opportunities for improvement across AD/ADRD prevention, screening, diagnosis, care delivery, and workforce preparedness. This summary outlines the key challenges, recurring themes, and policy recommendations intended to inform updates to the National Plan to Address Alzheimer's Disease and guide Congressional funding priorities.

Key Gaps in Care:

- **Patient-care gaps:** Inconsistent diagnostics, unclear care pathways, limited care coordination, and delayed access to resources.
- **Lack of standardization:** Wide variation in provider behavior, screening practices, and clinical expectations; few clinicians trained in care navigation.
- **Missing mandates:** AWVs underutilized for cognitive screening; no required AD/ADRD-specific screening or counseling.
- **Limited prevention/intervention infrastructure:** Prevention science is evolving quickly; clinicians and caregivers lack timely updates.
- **Access inequities:** Underserved populations face the greatest barriers to screening, diagnosis, and long-term support.
- **Training consistency:** Training must clarify expectations for all clinical practitioners. PCPs, nurses, allied health professionals, community screeners, and specialists.

Possible care pathways and ideas to be considered:

- Patients need a navigable, consistent pathway from screening → diagnosis → care planning → long-term support.
- Project ECHO-style models can scale training and ensure clinicians stay current.
- Caregivers need digestible, timely updates as science changes.
- Patients need primary care providers (first point of contact) to be educated and aware of screening, CPT codes, etc. and be able to make confident referrals.

Common Themes:

- Science is evolving rapidly; clinicians and caregivers need continuous education.
- Provider inconsistency remains a major barrier.
- Early detection is only valuable when paired with clear pathways.
- Metrics matter but must be practical.
- Strategic clarity is essential for actionable NAPA recommendations.

Long-Term Services and Supports Subcommittee Recommendations

Recommended No-Cost / Existing Resource Recommendations

RECOMMENDATION 1: Strengthen dementia care navigation leveraging federal resources.

Recommendation 1 to HHS: Improve coordination and visibility of existing federal navigation resources, including the Eldercare Locator, Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), CMS resources, and state Alzheimer's programs - through consistent cross-referrals, provider education, and standardized public messaging.

RECOMMENDATION 2: Increase utilization of existing Medicare dementia care planning benefits.

- Recommendation to HHS: To direct that CMS expand education and outreach to physicians, health systems, and clinicians on appropriate use of existing Medicare dementia care planning services, including **CPT 99483**, to improve early care planning, caregiver engagement, and referrals to community-based supports.

***Special Note**: Additional context on the implementation and use of CPT code 99483 is included in the Clinical Care Subcommittee's recommendations.*

RECOMMENDATION 3: Promote trusted community and technology-based navigation.

- **Recommendation 3 to HHS:** To direct the Administration for Community Living, CMS, and other federal partners to encourage development and use of evidence-based digital navigation tools - including AI-enabled platforms - that direct caregivers to verified local dementia resources through existing community infrastructure, while promoting common quality standards to ensure accurate, reliable, and person-centered referrals.

***Special Note:** These recommendations leverage existing federal programs, Medicare benefits, and community networks rather than requiring new statutory authority or significant new appropriations, making them well suited for inclusion in the National Plan to Address Alzheimer's Disease 2026 update.*

Risk Reduction Subcommittee Recommendations

RECOMMENDATION 1: Prioritize Early Detection and Early Diagnosis

- **Recommendation 1 to HHS: Standardize and Require the Use of Validated Cognitive Assessments During Medicare Visits.**

We recommend that HHS direct CMS to standardize and require the use of validated cognitive assessments during the Welcome to Medicare Visit and Annual Wellness Visit. Establishing a consistent national standard would improve early detection and diagnosis of Alzheimer's Disease and Related Dementias (AD/ADRD), giving individuals and families the opportunity to make lifestyle changes, access treatment and support services, receive education, and plan for the future during the stages of the disease when interventions can have the greatest impact. This recommendation would also build on existing Medicare processes rather than create new ones. Alzheimer's care should follow the same standardized, evidence-based approach that Medicare already uses for other major health conditions, including cancer and heart disease.

- **Recommendation 1 to Congress: Pass Two Key Bipartisan Bills to Advance Early Detection.**

We recommend that Congress pass two bipartisan bills to ensure Medicare keeps pace with scientific advances in AD/ADRD.
First, Congress should pass the Alzheimer's Screening and Prevention (ASAP) Act (S. 3267 / H.R. 6130). This legislation would authorize Medicare to cover Food and Drug Administration (FDA)-cleared blood-based screening tests for AD/ADRD, using CMS's existing evidence-based process to determine coverage. It would also allow eligible beneficiaries to access screening before symptoms develop, creating opportunities for earlier detection and intervention.

Special Note: Congress has authorized Medicare coverage for routine screening tests for diseases such as cancer. Until Congress provides similar authority for AD/ADRD, Medicare cannot cover FDA-cleared Alzheimer's screening tests.

Second, Congress should pass the Concentrating on High-Value Alzheimer's Needs to Get to an End (CHANGE) Act. Introduced in 2025 with bipartisan, bicameral support, this legislation directs CMS to identify and promote evidence-based cognitive impairment detection tools for use during Medicare's Annual Wellness Visit. Using tools vetted by the National Institute on Aging (NIA), primary care providers would be able to screen for mild cognitive impairment and early Alzheimer's disease and refer patients for diagnostic evaluation, treatment, community-based support services, and clinical trials when cognitive decline is detected.

Together, these bills would help clinicians identify Alzheimer's disease earlier, when interventions can have the greatest impact; connect patients and families to timely diagnosis, treatment, and support; and reduce long-term healthcare costs. Research

suggests that delaying the onset of Alzheimer's disease by just five years could reduce Alzheimer's-related spending by more than 40 percent.

RECOMMENDATION 2: Launch of National Alzheimer's Education and Awareness Campaign with a multi-sector, multi-agency approach.

- **Recommendation 2 to HHS:** We recommend that HHS, through the National Institutes of Health, National Institute on Aging, Centers for Disease Control and Prevention (CDC), and CMS, launch a coordinated national education and awareness campaign to promote early detection, risk reduction, and healthy brain aging. The campaign should include tailored messaging for the public, primary care providers, federal and state agencies, and the broader healthcare community.

- **The campaign should:**
    - Promote the importance of obtaining an early Alzheimer's diagnosis, emphasizing that Alzheimer's disease should be approached like other serious chronic diseases, such as cancer and heart disease, where early detection leads to better outcomes**.** The campaign should communicate why early diagnosis matters now: individuals can adopt evidence-based lifestyle interventions, access newly available treatments, participate in clinical trials, preserve cognitive function for longer, maintain quality of life, and gain valuable time to plan for their future and support their families.
    - Educate primary care providers on the importance of baseline cognitive assessments, early detection, and timely referral for diagnostic evaluation, treatment, care planning, community support services, and clinical trials. The campaign should also increase provider awareness of existing CMS reimbursement opportunities, including Medicare-covered services and billing codes for cognitive assessment, care planning, care consultation, diagnosis, and ongoing dementia care management.
    - Provide updated CMS guidance on evidence-based cognitive assessment and care pathways.
    - Increase public awareness of baseline cognitive screening, Alzheimer's risk factors, and opportunities for early intervention.
    - Promote evidence-based lifestyle interventions informed by the U.S. Study to Protect Brain Health Through Lifestyle Intervention to Reduce Risk (U.S. POINTER), demonstrating that a multidomain approach - including regular physical activity, healthy nutrition, cognitive and social engagement, and management of cardiovascular and other health conditions - can help protect cognitive function from normal age-related decline.
    - Increase awareness of available treatment options and expand patient access to appropriate clinical trials.

- **Recommendation 2 to Congress:** We recommend that Congress provide funding for a national multi-sector, multi-agency Alzheimer’s Concern and Awareness Campaign in the amount of $7,000,000 (as described above).

RECOMMENDATION 3: Direct FDA to continue fast tracking more AD/ADRD trials that include pharmaceuticals and non-pharmaceutical approaches, while expanding the FDA's Accelerated Approval Program and convene the U.S. Preventive Services Task Force (USPSTF).

- **Recommendation 3 to HHS**: We recommend that HHS establish a Coordinated Pathway to Accelerate Innovation and Expand Access to Alzheimer's Treatments and Interventions and direct the FDA to continue fast tracking more AD/ADRD trials, while also convening the USPSTF.

We recommend that HHS establish a coordinated AD/ADRD innovation pathway across FDA, CMS, and other relevant agencies to identify and reduce regulatory and implementation barriers, accelerate review and coverage processes, and ensure patients have timely access to safe and effective treatments and interventions. This pathway should support the development, adoption, and dissemination of emerging therapies, including FDA-designated fast-track treatments, non-pharmacological interventions, lifestyle interventions, neuroceuticals, and other evidence-based approaches.

HHS should also convene the USPSTF to evaluate the growing evidence base for early detection and intervention and help establish clear, evidence-based guidance that supports timely access to screening, diagnosis, and available treatment options.

HHS should direct NIH, NIA, CDC, and CMS to launch a coordinated national education initiative that provides the public, primary care providers, neurologists, and other healthcare professionals with current, evidence-based information on AD/ADRD treatments, interventions, clinical trials, and available care resources.

The goal of this coordinated strategy should be to ensure that individuals and families have access to every available evidence-based opportunity during the critical early diagnosis window when interventions may have the greatest impact. Earlier access to diagnosis, treatments, lifestyle interventions, clinical trials, and support services can help preserve cognition, maintain independence, improve quality of life, and provide more time for informed care planning and decision-making.