

2026 National Plan to Address Alzheimer's Disease Listening Sessions

Executive Summary

INTRODUCTION

Dementia is an increasingly urgent public health crisis in the United States, affecting millions of people and their families. Alzheimer's disease is the most common cause of dementia, but dementia can result from a range of diseases and conditions, including frontotemporal, vascular, and Lewy body dementias. The term Alzheimer's disease and related dementias (ADRD) is commonly used to describe these conditions. The National Plan to Address Alzheimer's Disease (National Plan), updated annually by the U.S. Department of Health and Human Services (HHS), guides the federal response to ADRD, and outlines key priorities and investments to support people living with ADRD and their caregivers. This project will inform the 2026 update to the National Plan based on feedback from listening sessions with people living with ADRD; caregivers; healthcare providers; researchers; advocates; private-sector partners; state, Tribal, and local officials; and other community members.

KEY FINDINGS

Listening sessions revealed ongoing challenges and opportunities to improve ADRD risk reduction; research and therapeutic development; clinical care, detection, and diagnosis; services and supports; and workforce.

- **Risk reduction.** Barriers to practicing healthy brain habits include limited access to nutritious foods and safe places to exercise. Participants suggested public outreach and action on these drivers of health.
- **Research and therapeutic development.** Clinical trials do not adequately include those disproportionately impacted by ADRD. Participants suggested exploring strategies to increase participation.
- **Clinical care, detection, and diagnosis.** Challenges included delays in diagnosis, limited access to ADRD testing and therapies, and stigma. Participants suggested expanding provider education on diagnosis and treatment, expanding coverage for testing and therapies, and addressing stigma in communities disproportionately impacted by ADRD.
- **Services and supports.** Challenges included lack of support for caregivers and people living with young-onset dementia. Participants suggested improving care coordination and case management, offering financial supports, and increasing access to affordable respite care.
- **Workforce.** Participants identified shortages of neurologists, limited primary care capacity, and a lack of dementia-trained health professionals, particularly in rural areas. They suggested increasing pay and

benefits for long-term care staff, offering more incentives for pursuing careers in geriatrics, compensation for ADRD training, and increasing the use of telehealth in rural areas.

Key considerations for the 2026 National Plan

To promote risk reduction:

- Amplify the work of [Building Our Largest Dementia \(BOLD\) Centers of Excellence](#) grantees by identifying best practices for communicating about ADRD and considering opportunities to expand and scale effective strategies.
- Consider how addressing drivers of health, such as nutrition and living environments, can help reduce the risk of ADRD.
- Build on efforts to reach Tribal and urban Indian communities with information about ADRD, along with other communities disproportionately impacted by ADRD such as Black and Hispanic Americans.

To improve research and therapeutic development:

- Explore tailored recruitment and transportation to increase participation in clinical trials among populations disproportionately impacted by ADRD.

To improve clinical care, detection, and diagnosis:

- Consider identifying and implementing best practices for disseminating research to clinicians (for example, through communities of practice or other educational approaches).
- Build on the 2025 National Plan accomplishments by pilot-testing programs to incentivize cognitive testing as part of annual physicals in primary care settings or community health centers.
- Continue exploring barriers to ADRD testing and treatment and consider strategies such as expanding Medicare and Medicaid coverage for blood-based biomarker testing and genetic counseling; covering testing at younger ages; and covering music, speech, or cognitive therapies.

To strengthen services and supports:

- Consider expanding eligibility for the [Guiding an Improved Dementia Experience \(GUIDE\) Model](#) to cover Medicare Advantage plan members or people living in memory care units.
- Consider ways to alleviate financial burden and support financial planning for caregivers and people living with ADRD, including for people living with young-onset dementia transitioning out of careers.
- Continue to fund innovations that increase the availability of and access to respite care, including efforts to evaluate and scale public-private partnership models.
- Consider referring to ADRD as “Alzheimer’s disease and other dementias” in the National Plan to better reflect its focus on dementias other than Alzheimer’s disease.

To enhance the workforce:

- Build on the success of the [Geriatrics Workforce Enhancement Program](#) and [Geriatrics Academic Career Award](#) program, to continue improving workforce capacity and addressing shortages.
- Consider incentivizing or requiring dementia care education for practicing certified nursing assistants, primary care providers, and assisted living facility staff, and leverage tools like [Project Extension for Community Healthcare Outcomes \(ECHO\)](#) to train providers in rural areas.

2026 National Plan to Address Alzheimer's Disease Listening Sessions: Summary Report

I. INTRODUCTION

A. Background

Dementia is an increasingly urgent public health crisis. The population of older adults is expected to double over the next 30 years, and the number of Americans living with Alzheimer's disease is predicted to reach 13 million by 2060.¹ Alzheimer's disease is the most common cause of dementia, but dementia can result from a range of diseases and conditions, including frontotemporal, vascular, and Lewy body dementias. The term Alzheimer's disease and related dementias (ADRD) is commonly used to describe these conditions.¹

To address the challenges of people living with ADRD and their caregivers and to establish a federal response to ADRD, the federal government enacted the National Alzheimer's Project Act (NAPA) (Public Law 111-375) in 2011. This act required the U.S. Department of Health and Human Services (HHS) to establish a National Plan to Address Alzheimer's Disease, which guides federal priorities and investments in addressing ADRD. The first National Plan was published in 2012, and it has since been updated annually.¹

To inform the 2026 update to the National Plan and planning through 2035, HHS conducted a series of listening sessions to gather perspectives from people living with ADRD, their caregivers, and professionals. This report summarizes findings from the listening sessions and offers considerations for the National Plan.

B. Listening sessions

HHS held five Zoom listening sessions between July 13 and July 17, 2026. The listening sessions focused on understanding current challenges and opportunities related to ADRD risk reduction, research and therapeutic development, detection and diagnosis, services and supports, and the workforce.

Sessions were organized into two distinct audience groups. Three listening sessions engaged healthcare providers; researchers; advocates; private-sector partners; and state, local, and Tribal officials. Two listening sessions engaged individuals living with ADRD and their caregivers. These two sessions were smaller, dedicated forums to elevate the perspectives of people with lived experience. Each session included structured discussion questions on priority topics and open time for participants to raise additional issues and perspectives. In total, 194 people participated in the listening sessions. Table 3 outlines the number and types of listening session participants.

¹ US Department of Health and Human Services. National Plan to Address Alzheimer's Disease: 2025 update. Office of the Assistant Secretary for Planning and Evaluation; 2025. Accessed August 21, 2026.
<https://aspe.hhs.gov/sites/default/files/documents/b285be4a31850170c2bcad19eb80ebe4/FINAL%20FINAL%202025%20National%20Plan%20to%20Address%20Alzheimers%20Disease%20%281%29.pdf>

Table 3. Number and types of listening session participants

Participant type	Number of participants (n, %) ¹
Advocate	49 (26%)
Caregiver to a person living with ADRD	44 (24%)
Researcher/academic	28 (15%)
State government representative	22 (12%)
Healthcare provider ²	13 (7%)
Other ³	13 (7%)
Person living with ADRD	12 (6%)
Private-sector partner	5 (3%)

ADRD = Alzheimer's disease and related dementias.

(1) Participant type was based on a survey participants completed with online meeting registration. Participants who joined by phone were not identified by name and could not be linked to their surveys. 8 participants are therefore missing from this count.

(2) Healthcare providers included clinicians as well as social workers and care navigators.

(3) The 'Other' category includes professionals such as public health staff, Tribal public health professionals, and consultants.

II. FINDINGS

Key findings are organized into five sections: risk reduction; research and therapeutic development; clinical care, detection and diagnosis; services and supports; and workforce. Participant quotes and examples of effective programs that support people living with ADRD and their caregivers are included in call-out boxes.

A. Risk reduction

Participants described a need for public outreach initiatives connecting brain health to holistic health across the lifespan. They advocated for a national media campaign focusing on how well-known chronic disease risk factors including poor nutrition, and limited physical activity also increase ADRD risk. Participants offered suggestions for the campaign:

- Highlight the [Alzheimer's Association's 10 Brain Healthy Habits](#) or research from [The Lancet](#).
- Make messaging simple and clear.
- Coordinate with federal programs like [the Special Supplemental Nutrition Program for Women, Infants, and Children](#) (WIC) and [Head Start](#), or partner with schools on dissemination.
- Tailor messaging to different cultures and age groups and offer materials in multiple languages.

“ On a national level, we're talking about a campaign for brain health. Maybe it's really more of just connecting that increased risk to these diseases that...we already have all this education and promotion out there about. Because people tend to maybe not care as much about their diabetes being uncontrolled, but they will care about their cognition later in life, so maybe making that connection for people would be helpful. ”

— Healthcare provider



EFFECTIVE PROGRAM SPOTLIGHT

Alzheimer's Association Building Brain-Healthy Habits Program

The [Building Brain-Healthy Habits Program](#) is a free, volunteer-led educational workshop that focuses on ways to protect memory and reduce the risk of cognitive decline. It is a preventive program available across local communities that teaches participants how to build a personalized action plan for brain-healthy habits.

Participants said there is a need to address the structural factors contributing to increased risk of ADRD. They highlighted connections between ADRD risk and drivers of health that can make healthy living difficult. Lack of access to nutritious foods, limited transportation to grocery stores or healthcare, lack of housing, limited access to safe spaces for exercise, and economic stress are barriers to practicing healthy brain habits. Policies and supports could address these factors and encourage healthy aging.

B. Research and therapeutic development

Participants highlighted that groups disproportionately impacted by ADRD are not well represented in clinical trials. These groups include people living with Down syndrome and other intellectual disabilities, women, American Indian, Black, and Hispanic communities, and people living in medically underserved and rural areas. They suggested strategies to increase representation, including federal grants to cover transportation to clinical trials and tailored recruitment strategies developed in partnership with community-based organizations. Participants also noted that delays in diagnosis hamper research efforts because many clinical trials are designed for people in the early stages of ADRD. Medical providers should be equipped and incentivized to refer patients to clinical trials as soon as they receive a diagnosis.

C. Clinical care, detection, and diagnosis

Participants said it took too long to receive an ADRD diagnosis. They stressed the importance of early diagnosis for effective treatment, planning, and care, but several shared stories of waiting months or years for a diagnosis. Providers often dismissed ADRD symptoms as mental illness, especially in cases of young-onset dementia, or as normal signs of aging. Many participants said they visited multiple providers before receiving an accurate diagnosis.

Several participants suggested expanding training and education on ADRD diagnosis, testing, and treatment, particularly for primary care providers (PCPs). Participants noted that training PCPs could help address challenges in receiving a diagnosis. It could also enable providers to interpret dementia screening results without a specialist, which would be optimal given the shortage of neurologists in many areas (see Section III.D). They shared the following suggestions for training:

- Add training on ADRD to medical school curricula.
- Make training easier to access, particularly for providers in rural areas.

“My husband's a veteran and we already have the data that says that this is an illness that impacts our veterans twice as much. He's also African American. He's been seeing a doctor for 20-plus years with significant sleep issues, so there were a lot of things that put him at high risk, and yet it took me going into the doctor's office 5 times over a course of 18 months to even convince him to even run an MMSC [Mini-Mental State Examination].”

— Caregiver

- Focus education on understanding the types of dementias. Many participants were diagnosed with “dementia,” but received no additional information on the type of dementia or related care.
- Train providers on ADRD risk factors and predictors, risk reduction strategies, and early treatment options. When appropriate, encourage providers to pair diagnosis with risk-reduction counseling.

Participants suggested incorporating dementia screening and treatment pathways into standard care. They said systems-level changes to standard care could improve detection and diagnosis, especially for young-onset dementia. Although Medicare covers cognitive testing at annual wellness visits, some participants noted that providers do not reliably implement it. They suggested incentivizing providers to use validated screening tools, such as the Montreal Cognitive Assessment and Mini-Mental State Examination, at annual visits and conducting a baseline test to better detect cognitive changes over time. Participants thought cognitive screenings as early as age 30 could identify more cases of young-onset dementia faster. One participant also suggested adding flags in electronic health record systems to recommend screening for people at risk for dementia, similar to electronic health record protocols that flag heart disease risk based on elevated cholesterol levels.

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Participants cited a need to expand access to and coverage of blood-based biomarker (BBM) and genetic testing for ADRD. Participants were excited about recent advances in BBM tests, particularly their ability to support accurate Alzheimer’s diagnoses before symptoms appear. They said these tests are also critical for younger or asymptomatic people, those at high risk, and people with limited access to specialists. Participants encouraged Medicare coverage of BBM tests, which are not yet part of standardized primary care and remain unaffordable for many. They also recommended prioritizing research on biomarkers that can detect dementias other than Alzheimer’s disease, and expanding access to genetic counseling, especially for assessing frontotemporal dementia risk.

Participants voiced a need for wider access to positron emission tomography (PET) scans to aid in diagnosis. They repeatedly reported having no access to PET scans. One participant suggested using mobile imaging vehicles, like those used for mammography, to expand access. Instead of investing in new brick-and-mortar PET imaging facilities, participants suggested equipping rural health clinics, small hospitals, and Federally Qualified Health Centers to provide PET scans, and leveraging infrastructure at existing imaging centers.

Participants described gaps in access to and coverage of cognitive, physical, occupational, and speech therapy. In addition to pharmaceutical treatment, participants said other therapies could improve quality of life for people living with ADRD. For example, a few caregivers shared how doll and music therapy improved well-being for their family members living with ADRD and advocated for insurance coverage of



EFFECTIVE PROGRAM SPOTLIGHT

Effective Program Spotlight: Project Extension for Community Healthcare Outcomes (ECHO)

[Project ECHO](#) is a model that uses videoconferencing technology to train and advise primary care providers through discussions and collaboration with peers. Participants suggested using this for ADRD training, similar to the Alzheimer’s Association’s [Alzheimer’s and Dementia Care ECHO](#), which connects experts in dementia care with healthcare workers, long-term care staff, and public health professionals.

these interventions. Other participants advocated for coverage of speech and physical therapy to help people living with ADRD stay physically active and socially engaged.

Participants shared that stigma is a key barrier to diagnosis, treatment, and care. They noted that stigma often prevents people from seeking an ADRD diagnosis, acknowledging their risk based on family history, or learning about signs and symptoms. To combat stigma, participants suggested public awareness initiatives that emphasize available ADRD treatments and the benefits of early diagnosis. Across several listening sessions, participants emphasized the need to address stigma within communities disproportionately affected by ADRD, including American Indian, Black, and Hispanic communities. They stressed the importance of training providers and offering tailored and linguistically appropriate approaches to diagnosis, treatment, education, and care. They also discussed partnering with community- or faith-based institutions to build trust and help people feel comfortable seeking information, diagnosis, treatment and care for ADRD.

“ A huge gap really is with our urban American Indian and Alaska Native folk, where there's a lack of cultural awareness in not only the...recognition of symptoms, but also in the treatment, and diagnosis processes, where a lot of the cultural background to our people and historical trauma is not as taken into consideration...And so, it's something that we have been seeing a lot and have heard a lot from, especially our elders, that their concerns are not taken seriously, in a primary care or emergency or even specialist setting.”

— Public health professional

Participants advocated for passing the Accelerating Access to Dementia and Alzheimer's Provider Training (AADAPT) and Alzheimer's Screening and Prevention (ASAP) Acts to support provider education and ADRD diagnosis. The AADAPT Act would provide grants to PCPs participating in virtual ADRD education programs, helping them improve their knowledge of ADRD and capacity to address it. The ASAP Act would allow Medicare coverage for FDA-approved BBM tests, making early detection routine. As one participant put it, these actions will help ensure the “medicine's keeping up with the science.”

D. Services and supports

Participants cited a need for warm handoffs to community services and increased case management. Many shared stories of receiving a diagnosis without any follow-up, forcing them to navigate resources, information, and care systems on their own. They advocated for increased care management and referrals to community support services. According to participants, better care coordination could help people evaluate their legal and financial situations and determine the care path that aligns with their needs. Several participants highlighted the Center for Medicare and Medicaid Innovation's [Guiding an Improved Dementia Experience \(GUIDE\) Model](#) as an example of a program that helped fill care coordination gaps and support navigation for people living with ADRD and their caregivers. However, they suggested expanding this model to a broader group, including people in memory care and those with Medicare Advantage plans.² Participants also suggested that state-specific or regional databases of ADRD support services could give caregivers a starting point. As one caregiver noted, “A resource a caregiver can't find is a resource that doesn't exist.”

² The GUIDE model only accepts Original Medicare and excludes Medicare Advantage plans.

Participants highlighted the need for increased financial support for people living with ADRD and their caregivers. Across multiple listening sessions, caregivers shared financial challenges resulting from caregiving. These included leaving the workforce, losing employer-sponsored insurance, experiencing food insecurity, facing home foreclosure, and waiting extended periods for Social Security Disability Insurance. Participants living with young-onset dementia also described losing employer-sponsored insurance, and in some cases, challenges qualifying for Medicaid. Participants suggested a caregiver tax credit or other federal financial supports.

“ I was a high performer at work, and I was in a 31-year career. And when the diagnosis came down, I tried to put a plan...together, and proposal to my work organization at the time. Obviously, having a cognitive issue is typically not something that they can really accommodate. It was night and day. One day I had a job, one day I did not... We're also having more individuals experience a situation like I am, a sudden loss of income. It does take time to apply for Social Security...There needs to be some type of transitional support, or even some type of transitional funding to help individuals. ”

— Person living with ADRD

Participants said respite care is insufficient, and often unaffordable, making caregiving relentless and unsustainable. Caregivers identified the lack of affordable respite care as a major financial strain, especially for those who quit their jobs to take care of loved ones at home. They emphasized the need to increase the number of respite programs and offer financial assistance or insurance coverage for respite care. They provided the following suggestions:

- Subsidize in-home adult day programs and short-term in-facility respite services (such as overnight stays), with eligibility for middle-class caregivers.
- Use paid leave policies as an avenue for expanding respite care.
- Provide respite services in multiple languages.
- Remove age requirements from programs that exclude people living with young-onset dementia.
- Provide federal support for public-private partnerships that increase access to respite care (for example, encourage cities to rent underutilized real estate to non-profit adult day care centers for free or at low rates).

E. Workforce

Participants highlighted widespread shortages of neurologists, long-term care staff, certified nursing assistants (CNAs), and other healthcare workers. Several participants waited months to see neurologists, with some having to cross state lines to receive an ADRD diagnosis. Participants also described high staff turnover rates in both hospital settings and long-term care facilities, resulting in inconsistent care. They said burnout from mandated overtime hours, low pay, and limited benefits were factors contributing to turnover, and suggested making geriatrics and dementia care more attractive career paths. One participant suggested a federal analysis of the market mechanisms influencing medical students' decision to pursue neurology. Others suggested structural changes, including increased benefits, higher pay scales, full-time employment, and increased reimbursement rates, especially for community health workers and CNAs.

Participants also described a lack of knowledge about ADRD and its associated behavioral issues among PCPs and frontline staff. Several encountered healthcare providers and staff who did not understand the behavioral issues and care needs of people living with ADRD—in some cases leading to harmful transfers to psychiatric hospitals. Participants suggested federally mandated training at adult nursing home facilities to ensure dementia-capable and dementia-competent care, along with opportunities for continuing education. A few participants also suggested increased compensation and higher reimbursement rates tied to training, which could improve retention rates and quality care.

“ One of my biggest challenges over the 12-year period that I took care of my mom was that she had behavioral changes with her dementia, and very few caregivers in residential settings, even in hospitals had the training or experience to deal with someone who had those disruptive behaviors. When we would run into that, where the healthcare workers lacked the experience or training or knowledge to deal with it, it resulted in my mom either being shipped off to an inpatient psych facility, who would just basically drug her beyond recognition, or she would be transferred out to a local hospital where she’d end up in restraint. ”

— Caregiver



EFFECTIVE PROGRAM SPOTLIGHT

Michigan’s Geriatric Workforce Enhancement Program

Michigan’s [Geriatric Workforce Enhancement Program](#) developed a [Geriatric Specialist Training Certificate](#), which creates a career ladder for community health workers and direct care providers. The 48-hour training program shares evidence-based practices and builds practical skills for effectively and safely supporting older adults in elder care settings.

Workforce shortages and the resulting lack of available dementia care were particularly challenging in rural areas.

Several participants mentioned difficulties accessing dementia care in rural areas due to workforce shortages, long distances to healthcare facilities, and in some cases, limited access to transportation. To address these issues, participants suggested leveraging community health workers to conduct nonclinical assessments for ADRD and support initial diagnosis. Others suggested offering transportation to appointments or telehealth access to specialists. However, some noted that resources and care should also be available in non-electronic formats to reach people with limited technology access and literacy.

III. CONSIDERATIONS FOR THE NATIONAL PLAN

Listening sessions highlighted opportunities to build on the progress made through the National Plan to date and illuminated considerations for the 2026 update. Recommendations are organized by key topics addressed during the listening sessions.

A. Risk reduction

Amplify the work of Building Our Largest Dementia (BOLD) Centers of Excellence grantees, and continue efforts to increase public awareness of ADRD risk reduction strategies. For the 2026 update to the National Plan, HHS could build on this work by gathering information on best practices for disseminating information to the public, and considering opportunities to expand or scale effective strategies.

Consider how addressing drivers of health, such as nutrition and living environments, can help reduce the risk of ADRD. In 2025, research highlighted in the National Plan, including the [U.S. Protect Brain Health Through Lifestyle Intervention to Reduce Risk \(POINTER\)](#) study, provided further evidence that addressing modifiable risk factors can support brain health. HHS could consider incorporating drivers of health across the lifespan into its approach to ADRD risk reduction and scaling effective approaches.

Continue efforts to reach Tribal and urban Indian communities and other communities disproportionately impacted by ADRD such as Black and Hispanic Americans. HHS has initiatives focused on improving dementia care and increasing awareness about ADRD supports in Tribal and urban Indian communities. HHS could consider developing similar initiatives focused on engaging Black and Hispanic communities—for example by partnering with trusted organizations that serve these communities, and by offering resources in multiple languages. The [NIH Mind Your Risk campaign](#) is an example of this type of initiative.

B. Research and therapeutic development

Consider increasing participation in clinical trials among groups disproportionately impacted by ADRD. HHS could consider opportunities to improve how information about clinical trials reaches groups such as American Indian, Black, and Hispanic communities. To build trust with these groups, HHS might also consider encouraging researchers to partner with community-based organizations on outreach strategies, and to develop mechanisms for sharing key findings from trials with participants.

C. Clinical care, detection, and diagnosis

Consider new approaches to disseminating information on and expanding access to the latest advancements in diagnosing and treating ADRD. As part of its ongoing work to enhance the research infrastructure through the National Plan, HHS could consider partnering with translational science researchers to identify and implement best practices for disseminating research to clinicians (for example, through communities of practice or other educational approaches). HHS could also consider strategies to address barriers to accessing testing and treatment, such as expanding Medicare and Medicaid coverage for BBM testing and genetic counseling or covering testing at younger ages.

Build on the 2025 National Plan accomplishments to incentivize cognitive assessment. HHS could build on successful 2025 efforts to increase cognitive screening, such as the [Age-Friendly attestation in the Hospital Inpatient Quality Reporting \(IQR\) Program](#), and the [Indian Health Services pilot tests of Mini-Cog screenings](#) by community health representatives. For example, HHS could consider conducting similar pilot programs to incentivize cognitive testing as part of annual physical exams in primary care or community health settings.

D. Services and supports

Consider expanding eligibility for the GUIDE Model. In 2026, HHS intends to expand Medicare beneficiary enrollment in the GUIDE Model. HHS could consider further expanding eligibility to cover Medicare Advantage plan members or people living in memory care units, in 2026 or in future iterations of the National Plan.

Consider how to improve financial support for caregivers and people living with ADRD. HHS could prioritize evaluating and implementing policies, strategies, or resources to alleviate financial burden and promote financial planning. This could include partnering with employers to evaluate and implement benefits, policies, or other supports that help people living with young-onset dementia, who may be transitioning out of full-time careers and/or applying for Social Security Disability Insurance payments.

Continue prioritizing dementia-specific respite care. In 2025, through the [Center for Dementia Respite Innovation](#), HHS increased access to programs delivering dementia-specific respite care. HHS could consider continuing to fund innovations that increase availability of and access to respite care. HHS could consider continuing to fund innovations that increase the availability of and access to respite care, including efforts to evaluate and scale public-private partnership models described by participants (see Section II.D).

Consider updating the language in the National Plan to highlight the focus on dementias other than Alzheimer’s disease. Although the National Plan clearly recognizes the importance of addressing other dementias, HHS could consider whether the plan’s title and language adequately reflect this focus. For example, HHS could consider using “Alzheimer’s disease and other dementias” rather than “Alzheimer’s disease” or “Alzheimer’s disease and related dementias.”

E. Workforce

Build on the successes of the [Geriatrics Workforce Enhancement Program](#) and [Geriatrics Academic Career Award](#) program to improve workforce capacity and address shortages. HHS could consider strategies to incentivize or require dementia care education for practicing CNAs, PCPs, and staff at assisted living facilities, and use tools like [Project ECHO](#) to train providers in rural areas.

IV. CONCLUSION

By convening participants with professional and lived experience with ADRD, listening sessions generated valuable insights on progress, ongoing challenges and gaps in addressing ADRD. The sessions highlighted significant advancements in understanding ADRD diagnosis, treatment, care, and risk reduction. They also illuminated opportunities to improve dissemination of research; expand coverage for ADRD diagnosis, treatment, and care; increase financial and respite support for caregivers; educate the primary care and nursing workforce; and inform the public about the connection between holistic health and brain health. By incorporating feedback from listening sessions, recommendations from the Advisory Council on Alzheimer’s Research, Care, and Services, and public comment, HHS can craft a 2026 National Plan that is responsive to the public’s needs, concentrates on high-priority gaps, and leverages partnerships across sectors to continue progress toward systemwide change.

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