BOLD
PUBLIC HEALTH CENTER OF EXCELLENCE
EARLY DETECTION OF DEMENTIA

Early Detection of Dementia: A Resource Guide for Departments of Health

TABLE OF CONTENTS

Early Detection
DOH Role, Agency Structure, and Data
Detection, Screening, and Linkages
Workforce Development
Dissemination and Outreach

EARLY DETECTION

Early Detection

DOH Role, Agency Structure, and Data

Detection, Screening, and Linkages

Workforce Development

Dissemination and Outreach

WHO WE ARE – BOLD CENTER

The BOLD Public Health Center of Excellence on Early Detection of Dementia (PHCOE EDD) is led by a team of faculty from the Division of Geriatric Medicine and Palliative Care and the Department of Population Health at NYU Langone and the Department of Family Medicine at Keck School of Medicine at USC.

To partner with us on an early detection of dementia initiative, email us here: nyuboldcenter@nyulangone.org.

If you have used or are using this resource guide, please get in touch with us so that we can learn more about what actions you are taking and how we can best support your efforts.

Suggested citation: BOLD Public Health Center of Excellence on Early Detection of Dementia. (2025). Early Detection of Dementia: A Resource Guide for Departments of Health.

UNDERSTANDING DEMENTIA

Dementia is a word used to describe a group of adult-onset medical disorders that cause impairment of brain function. The defining symptoms are cognitive – such as problems with memory, thinking, planning, judgment, language, and awareness of one's own functioning. Sometimes the first noticeable signs are changes in social or behavioral functioning, such as misreading others' body language or intentions, becoming paranoid, or becoming agitated when frustrated.

Dementia results from damage to the brain, most often by disease processes like Alzheimer's disease and related disorders, exposure to certain toxins, or – as recently highlighted by studies of athletes playing contact sports and survivors of war – by major or repeated brain injury.[1]

Asking about a cognitive concern can be an effective first step in identifying people who may have dementia.

People living with dementia are usually aware of some changes in their memory or other mental abilities. They may underestimate the extent of the change and its effect on their everyday lives. Even if they do recognize a problem, they may forget – or not want – to mention it to their primary care physician or other clinicians, but may be willing to talk with a trusted member of their community.

Dementia is not the only form of cognitive change. "Mild cognitive impairment" (MCI) is a change in cognition that has minimal effects on everyday function or independence. It may represent an early stage in the development of dementia, or may result from a treatable condition and improve with appropriate care. "Subjective Cognitive Decline" (SCD), refers to symptoms experienced by an individual who does not have cognitive impairment on testing. It can be an early warning sign[2] of dementia risk but it's not the same as dementia or MCI. SCD can be caused by many different conditions, some of which are reversible. It is much more common than dementia.[3] However, when a person senses a change in mental function – becoming more forgetful or distractible, or having more trouble paying attention or planning complex activities or other symptoms related to memory or thinking – it's an important indicator of need for further evaluation. It shouldn't be ignored or discounted.

WHY EARLY DETECTION MATTERS

Early detection, when coupled with appropriate assessment of needs and proactive care planning, helps individuals, their families, and the communities around them learn how to live well with dementia. Seeing dementia as a manageable chronic condition fosters care that can prevent or reduce crises and improve overall quality of life.

Prevalence. The prevalence of dementia and its strong relationship to aging have become well known, thanks to the wide dissemination of information through national organizations (e.g., Alzheimer's Association), public health, research, and media channels over the past two decades. Of the approximately 7 million affected today, over 95% are 65 or older, and over 10,000 Americans turn 65 every day.[4, 5] As the proportion of older adults in the United States increases over the next few decades, many more people will develop dementia and require care. Although advances in public health and medicine have made survival into advanced age possible for many individuals and populations, persisting gaps in physical/mental health and social care leave many affected individuals, their families, and their communities at risk for potentially preventable crises.

Association of dementia with crisis. Dementia is often associated with several types of crises that can result from changes in emotions, behaviors, and relationships that can occur as part of the disease process. These may even include preventable medical crises such as new or worsening medical conditions or injuries that require urgent medical or surgical care. These too often disrupt care at home, with effects that are felt in our emergency departments, hospitals, and public spaces. Acute crises in dementia are not only highly stressful for individuals and families, they often disrupt patterns of care or established routines – and they can accelerate the course of dementia. Social and economic disadvantages magnify the effects of dementia and can also lead to acute disruptions to care.

Unmet needs for support services, health care, and preventive interventions are often at the root of crisis in dementia, regardless of what form it takes.

Crisis reduction and mitigation are possible. Preventive interventions may avert many dementia-related crises, but only if planned for and with timely implementation.[6]

Opportunities to consider new care pathways and medical treatments. Research has clearly established the value of care management for people with dementia and their care partners, and spurred new Medicare benefits to help pay for this care. At the same time, approval of new biomedical therapeutics for early and mild stages of cognitive decline (when due specifically to Alzheimer's disease) promotes hope – even though new anti-amyloid antibody treatments (e.g., lecanemab, donanemab) aren't for everyone. Dozens of new treatments are in development, while long-available other pharmaceuticals (e.g., donepezil, memantine) continue to have value in patient care.

DETECTION VS. DIAGNOSIS: WHAT'S THE DIFFERENCE?

While *diagnosis* of dementia is a medical activity, *detection* of dementia can occur anywhere. Detection of dementia means recognizing that an individual is experiencing limitations in functioning as a result of cognitive impairment that began or significantly worsened in adulthood – this distinguishes dementia from stable, lifelong cognitive limitations caused by developmental disabilities.

Diagnosis of dementia is a medical judgment based on relevant clinical evaluation. A formal diagnosis of dementia is not always required to qualify an individual for community support services, which typically requires evidence of functional disability (e.g., a person who cannot prepare their own meals due to cognitive impairment can qualify for Meals on Wheels without having a formal dementia diagnosis by a clinician). In some settings, however, including the Veterans Administration medical centers, a physician's diagnosis is required to support an application for additional services.

In general, detection of cognitive impairment in any setting should be followed by a medical evaluation to explain why cognitive functioning has changed, identify appropriate preventive and therapeutic interventions, and organize comprehensive whole-person care.

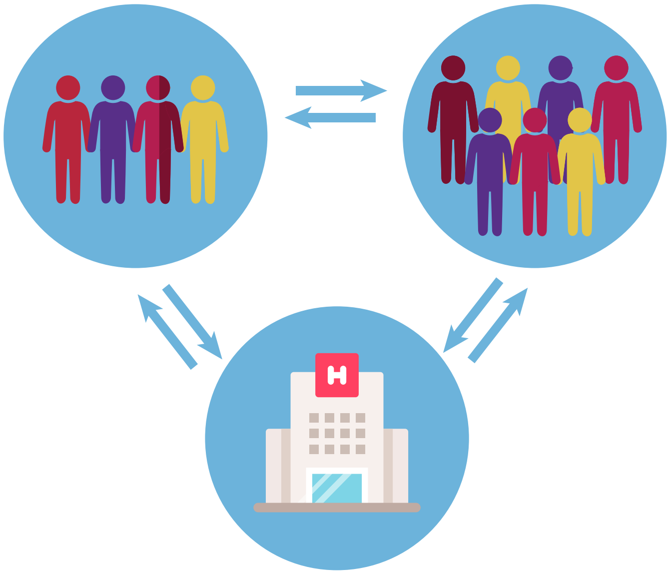
Refer to Appendix A for more information on a dementia diagnosis and mild cognitive impairment

ECOLOGICAL MODEL

Dementia is a manageable chronic condition when Departments of Health (DOHs), clinical / health systems, and community-based initiatives come together. Effective programs improve awareness and education about brain health; capacity for early detection and timely linkage to dementia evaluation and care; and support services.

Our Center uses an ecological model as a framework for dementia detection that includes 1) public health, 2) healthcare delivery, and 3) community-based services. This model is based on the idea that behaviors and outcomes are influenced by interconnecting factors and systems across levels (biological, psychological, social, cultural, organizational, community, physical and built environments, and policy), and that this work should not and can not be siloed.

Within this model, we believe dementia can be detected wherever people living with it are found – at home, in the supermarket, at the bank, on the bus, at the park, at the food bank, in the senior center, at your local pharmacy, and at local health fairs.



The table below covers the roles that the three sectors – health systems; health departments; communities, individuals, families, and friends – can play in dementia detection.

Person, Group, or Organization	Role
Departments of Health	Departments of Health can serve as both bridge and glue between health systems and communities, by supporting education and encouraging coordination between health and community services. Departments of Health can also help develop and disseminate common language and key messaging for public education, stigma-reduction, and other campaigns for equitable detection across all communities. Public health agencies that provide clinical services are an important stop gap for preventive measures by delivering vaccines, disease management, and health promotion.”
Individuals, families, and friends	People with symptoms of cognitive decline and their family or friends who notice signs of cognitive decline should bring those concerns and observations to a professional equipped to evaluate the situation.
Health systems	Clinicians—usually physicians, nurse practitioners, or physician assistants—are charged with diagnosing dementia in their patients, but this process is smoother when initiated by a question or concern from a patient or family member. Some doctors have adopted routine screening approaches, using, for example, the Medicare Annual Wellness Visit (AWV)[7] as a vehicle. The AWV requires screening for cognitive impairment, but the clinician or health care system determines how to implement it. The simplest method is first to ask about symptoms (see “Pre-screening Conversations” in our health system provider toolkit and the KAER resource guide), and then use a screening tool with the patient or family member. There is not yet a consensus about whether to use screening tools with patients who don’t report symptoms, although doing so can increase recognition of dementia.

Communities and community-based organizations

We do not expect strangers in our communities who observe possible signs of dementia to report them to anyone, and it could be considered invasive or overly paternalistic to do so in the absence of an obvious danger. However, there are exceptions. Workers in community-based aging and service organizations are often in an excellent position to observe signs of dementia and promote early detection through each of the roles they collectively play in the landscape of services for older people. The process of individual needs assessment, a core CBO activity, often uncovers dementia through its effects on functional independence – assessing change in functional status is one evidence-based form of "screening" for dementia.

Some organizations, including many Area Agencies on Aging (AAAs) and Title VI programs have developed training programs for staff to recognize possible dementia. What is missing in most settings is a standardized way to make that information actionable – for example, to help coordinate and navigate a focused visit to a clinician. AAAs are located in every state and can be found in most communities. To find the AAA nearest you, use the Elder Care Locator.

WHY AN EARLY DETECTION RESOURCE GUIDE FOR DEPARTMENTS OF HEALTH?

We know that cognitive impairment, whether unrecognized or formally diagnosed, often underlies older adults' need for support services, yet initiation of support services for people living with dementia or their care partners is too often triggered by a crisis – an injury, acute medical event or hospitalization, threatened loss of housing or employment, or a breakdown in care of the person at home. Some of these crises can be prevented, at widespread/

population-level scale, and across all communities, by comprehensively recognizing, integrating, and supporting proactive detection and care planning as a public health priority for all departments of health. Our goal is to equip DOHs nationally with key understandings and strategies to promote widespread early detection and care as a key public health action that can *prevent* crises from happening across the communities they serve. To do this, departments of health need proactive early detection strategies and messaging to make their resources more effective – we all do better when we plan ahead.

This resource guide focuses specifically on the role of departments of health in early detection of dementia and complements our healthcare system toolkit and community-based organization resource guide. We provide practical approaches and resources to help public health professionals initiate or enhance existing Alzheimer's Disease and Related Dementias (ADRD) services or detection into their existing infrastructure.

This resource guide is also designed for use by anyone who wants to learn about how DOHs can incorporate ADRD awareness, comprehensive care planning, and access to care in departments of health, programs, and other services. You may be someone who wants to know how to screen for or detect dementia. You may be a public health professional wanting to expand your department's existing programs to include dementia or dementia detection. You may be a community service worker advising clients at risk for dementia, or a public health worker wondering how to better connect community members to a medical care provider. You might also be a person with current concerns or future worries about your own or a loved one's memory.

DOH ROLE, AGENCY STRUCTURE, AND DATA

ROLE OF DEPARTMENTS OF HEALTH IN EARLY DETECTION OF DEMENTIA

Public health professionals working across a range of department of health settings – federal, state, tribal, local, and territorial departments of health and agencies – can leverage data and local resources to ensure that the dementia detection needs of the communities they serve are met by establishing and managing comprehensive early detection programs, fostering and sustaining linkages to clinical and social care for all communities, and ensuring healthcare and social services are available and accessible to all.[8] In these ways and more, departments of health and public health agencies can play a key role in reaching and impacting people living with dementia and their caregivers in all communities.

Resources

Please click on each link to visit these resources

- Early Detection and Diagnosis – Alzheimer's Association
- Why get checked? – Alzheimer's Association | (Spanish version)
  - Medical benefits
  - Emotional and social benefits
  - More time to plan for the future
  - Cost savings

Figure 1. THE 10 ESSENTIAL PUBLIC HEALTH SERVICES
To protect and promote the health of all people in all communities

Image source: Centers for Disease Control and Prevention. (2024). 10 Essential Public Health Services. Centers for Disease Control and Prevention. https://www.cdc.gov/public-health-gateway/php/about/index.html

For example, in looking at the CDC’s 10 Essential Public Health Services, see figure 1 above,[9] concrete applications to prioritizing and driving action to advance early detection of dementia across all DOHs can be made. These include, but are not limited to the examples below in **table 1**.

Based on varying capacity, resources, leadership buy-in, partnerships, and integration of dementia and early detection into agency priorities, some of these activities may appear differently for each agency, however, fundamentally there are opportunities for all to contribute.

TABLE 1. 10 ESSENTIAL PUBLIC HEALTH ACTIONS TO PROMOTE EARLY DETECTION OF DEMENTIA

Actions to Promote Early Detection of Dementia

Essential Public Health Service	Example Action
Assess and monitor cognitive decline, dementia diagnoses, and dementia care coordination population-wide and across communities	Use all available data sources that capture cognitive symptoms, diagnoses, and care delivery
Investigate and address gaps in dementia detection efforts	Identify best available data sources to help assess population-level detection inequities
Communicate effectively to inform and educate the public on the importance of early detection, and to de-stigmatize dementia and screening	Develop educational materials tailored to reach communities with messaging on dementia as a biological process with social impact
Strengthen, support, and mobilize communities and partnerships to advance early and equitable dementia detection	Engage health care systems and community-based organizations to explain benefits of early detection and promote collective action
Create, champion, and implement policies, plans, and laws that promote early detection of dementia	Develop and promote policies that provide sustained funding for early detection across sectors

Utilize legal and regulatory actions to encourage early detection of dementia	Promote benchmarking of Annual Wellness Visit (AWV) implementation; require documentation of how cognitive impairment is identified in AWV
Enable equitable access to early detection	Identify and promote dementia detection tools validated for the intended population; partner with community-based organizations (CBOs) to promote uptake; facilitate state certification of dementia-capable community health workers (CHWs)
Build a diverse and skilled dementia-capable workforce that understands the importance and value of early detection	Define team roles and training targets to increase capacity for early detection + transitions to diagnosis and care
Improve and innovate public health action to advance early detection of dementia through evaluation, research, and quality improvement	Spotlight state and local early detection initiatives + their evaluation metrics
Build and sustain strong agency infrastructure that recognizes dementia detection as relevant to all public health priorities	Embed brain health and dementia awareness in all department of health sectors, from child health (e.g., grandparents caring for grandchildren) to chronic disease education and monitoring, healthy life habits training, emergency preparedness, and injury prevention (e.g., transportation safety, fall prevention).

To begin, it is important to concretely identify and understand your agency's current landscape (e.g., whether dementia and early detection are even recognized as a public health issue) and what key barriers and facilitators exist to meaningfully recognizing and addressing dementia and early detection as a priority across existing divisions, bureaus, programs, and initiatives.

Federal public health agencies manage health policies and provide program evaluation and assessment. They handle developing and maintaining data repositories to inform health policies and the distribution of and guidance on using resources.[10]

State departments of health are responsible for carrying out national mandates and developing state policies to improve public health. They conduct environmental scans to understand and address their local population's needs and inform their state policies and programs.[11] This can include coordinating data on caregiver health and wellbeing (e.g., from Behavioral Risk Factor Surveillance System (BRFSS) modules) to prioritize earlier detection, diagnosis, and care planning. Some key opportunities for state agencies to integrate data and action items related to early detection of dementia, include ensuring that early detection is explicitly mentioned in the following examples:

- State Planning and Priority Setting
- State Health Assessments (SHAs), State Health Improvement Plans (SHIPs), State Department of Health Strategic Plans, and other plans that are required for accreditation
- State Plans on Aging, State Alzheimer's Disease and Dementia Plans, Public Health and Healthcare Workforce Plans, Multi-sector Plans for Aging, and other related plans

Local departments of health, or local health departments (LHDs) ensure the delivery of services, education, and resources to their community. The size and capacity of local departments of health vary. Some local departments of health may be responsible for setting local public health policies and implementing programs.[7, 12]

- Clinical services provided directly by LHDs may include immunizations, screening for diseases/conditions, treatment for communicable diseases, maternal and child health services, or other services (e.g., oral, home health, substance abuse, behavioral/mental health, comprehensive primary care).

- Population-based programs and services provided directly by LHDs may include population-based primary prevention; regulation, inspection and/or licensing; environmental health services.

Several key recommendations include:

- Focus on normalizing healthy aging and early detection of dementia as cross-cutting public health priorities that affect all branches and programs at your agency. For example: engage key opinion leaders; widely communicate the work of BOLD-funded public health programs; share success stories and lessons learned from what public health dementia and detection programs are able to accomplish and sustain across settings.
- Emphasize that healthy aging is an essential dimension of public health across the life course. Start with programs that are clearly aligned (e.g., for partners in Injury Prevention, connect dementia to falls prevention and traumatic brain injuries, and the bi-directional relationship between these), and then expand to showcase how healthy aging, brain health, dementia, and early detection can fit into and strengthen the existing priorities and goals of every area of public health activity (e.g., for partners in Emergency Preparedness and in Climate/Environmental Health, the need to consider people living with dementia, their caregivers, and medication access across efforts).

Additional considerations include:

- **In chronic disease:** Consider incorporating brain health resources in existing chronic disease management programs, such as diabetes, heart disease, or hypertension management programs. People with type II diabetes are more likely to develop dementia; Hypertension control as a modifiable risk factor and heart disease are factors in poor brain health.[13, 14, 15, 1]
- **In child health:** Older family members (e.g., grandparents) taking care of children often need support in order to do that well – consider collaborating with partners from Child Health and Motor Vehicles to show that early detection is a key step in the shared goals of injury prevention. Caregivers of any age experiencing memory issues may encounter difficulties remembering to use or how to use car seats and seatbelts. Explore potential partnerships with Child Occupant Safety Project, or similar program, and the network of inroads for their established program. This is an opportunity to provide resources for them and the child.

- **School health programs** can also educate learners in all grades, so they hear about dementia and detection from an early age and onwards. School nurses can do presentations on what dementia is, what screening looks like, and how to have conversations with loved ones around these issues.

a. **Example: Call for Caring** offers education for young givers of care at schools combined with community 5k's to fund and weave intergenerational approaches that combat stigma and empower communities

b. **Example: The Boston Public Health Commission (BPHC)** partnered with the Boston Area Health Education Center (BAHEC),a youth initiative of BPHC's Child, Adolescent, and Family Health Bureau, to educate high school age students in Boston Public Schools about ADRD and brain health topics

c. **Example: Wisconsin Department of Public Instruction Brain Health Curriculum.** The Wisconsin Department of Public Instruction approved mini-unit was developed for use in middle and high schools and includes information on brain health, dementia, and caregiving. Health Education | Wisconsin Department of Public Instruction Advocating for Brain Health Skills Based Unit.

- Opportunities to customize dementia messaging for your population.
  - Assessment for data monitoring:
    - Understand what data your dept of human services has access to
    - What training or certifications are offered in your department/bureau?
    - What are common sources for monitoring dementia?
    - What are common tools for assessing dementia?
    - What models of engaging and mobilizing community partners do we recommend?
      - Engage people living with dementia, care partners, and people providing direct care in assessment and planning

- What are some implementation strategies that we recommend? Do you have a state plan for dementia?
- How to best provide equitable care/services?
- How do you incorporate evidence-informed research into your program evaluations?

Case example: The Tennessee Department of Health's 2025 State Health Plan Update provides additional considerations for incorporating Healthy Aging activities within various divisions, programs, services, and initiatives.

LOCATION OF ADRD PROGRAMS WITHIN DOH STRUCTURES

To begin optimizing and sustaining new, as well as established programs at DOHs focused on early detection of dementia, requires a clear understanding of where healthy aging, AD/ADRD, and other related programs and efforts are currently situated throughout your agency and jurisdiction. It is important to have a clear understanding of your organizational contexts to better understand and leverage your current: structure, capacity, partnerships, processes, and goals.

For example, at some departments of health, dementia-focused programs are housed in a larger division, bureau, or office of Chronic Disease, Behavioral Health, or Healthy Aging. Where the work is situated in the overall agency structure can impact what is feasible for your early detection program to focus on, and to what extent it can be connected to other relevant issues and programs.

If you are situated at a local or tribal department of health, it is important to identify if the state department of health is prioritizing dementia and/or healthy aging.

And if you are situated at a state department of health, it is important to identify localized efforts, as well as identify where else in your state public health system dementia is being addressed.

State	Agency Name	Structural/Organizational Location(s) of Dementia and Healthy Aging projects and teams
Georgia	Georgia Department of Public Health	Division of health protection, injury prevention program houses 55+ driver safety, fall prevention, and BOLD efforts. We collaborate with Opioid program (also within Health protection), Chronic Disease (housed in Medical/Clinical Services), Office of Nursing (in Division of Health promotion)
Minnesota	Minnesota Department of Health	Health Improvement Bureau, Health Promotion and Chronic Disease Division, Center for Health Promotion, and Healthy Communities Unit
Mississippi	Mississippi State Department of Health	Office of Community Health Improvement Health Aging Bureau
Vermont	Human Services	Alzheimer's Disease and Healthy Aging Program of the Health Promotion and Disease Prevention Division of the Vermont Department of Health.
Wisconsin	Wisconsin Department of Health Services	Within DHS is the Division of Public Health, within that is the Bureau of Aging and Disability Resources, and within that is the State Office on Aging

Each have benefits from tapping into and enhancing existing programs to be dementia-friendly. For example:

- When situated in **Healthy Aging** – Memory loss and cognitive decline are not a normal part of aging[17]; work with clinicians to engage their patients in conversations around brain health and to monitor and detect signs of cognitive impairment.
- When situated in **Chronic Disease** – Most people living with dementia have multiple other chronic conditions. Bringing dementia and other comorbidity data together in a chronic disease framework could strengthen efforts to manage both. Sources of funding and location at the agency may determine which chronic conditions to prioritize (e.g., situated in cardiovascular vs. diabetes management). In the aging model, resources may be more readily available to address stigma around dementia diagnosis, caregiver support, and healthy brain aging programs, such as through ACL. In chronic disease departments which are separate from aging services, it is vital to build a strong relationship with the aging services partner, such as ACL, who administers these funds. A key opportunity to find alignment and common ground between your chronic disease and aging services teams is to start with recognizing that "more than 95% of PLWD (persons living with dementia) have one or more other chronic conditions."[16]

Example: The Boston Public Health Commission's (BPHC) Chronic Disease Division plays an important advisory role within the Boston BOLD Coalition, supporting our efforts to reduce risk factors for Alzheimer's Disease and Related Dementias (ADRD). As part of this partnership, we are collaborating to integrate ADRD risk reduction messaging into the Division's ongoing programs and communications. In addition, we are working jointly with BPHC to update its food procurement policy. The goal is to establish and implement healthy nutrition standards for all food and beverages served within BPHC facilities, as well as those offered by community partners receiving BPHC funding.

Case examples of the benefits of cross-sector collaborations.

MINNESOTA

The Minnesota Department of Health established the MN Healthy Brain Partnership, which is a group of cross-sector partners that come together to address statewide dementia related efforts. This group strengthened relationships and worked together to create a MN Dementia Strategic Plan that was refined by a group of diverse older age members of the community. Since its inception, these Healthy Brain partners have collaborated on several initiatives, events, presentations, advocacy efforts, trainings, communications activities, and resource sharing. The group is organized around multi-sector collective action, rather than having a formal or fixed membership structure. **Partners on the MN Healthy Brain Partnership** include but are not limited to: *Alzheimer's Association Minnesota-North Dakota Chapter, University of Minnesota (UMN) Center for Healthy Aging and Innovation, UMN Geriatric Workforce Enhancement Program (GWEP), Act on Alzheimer's/Dementia Friends MN, Arrowhead Area Agency on Aging, Memory Keepers Medical Discovery Team, MN Dept of Human Services and MN Board on Aging, MN Leadership Council on Aging, Central MN Dementia Community Action Network*

MISSISSIPPI

The BOLD Program is housed within the Office of Community Health Improvement, Health Aging Bureau. Alzheimer's disease and related dementias efforts are integrated within public health programs utilizing a life course approach. Cross-sector collaboration is illustrated through several strategies: 1) Alzheimer's coalition led by four key stakeholder organizations: University of Mississippi Medical Center (UMMC) the Memory Impairment and Neurodegenerative Dementia (MIND) Center, the Mississippi State Department of Health, the Mississippi Department of Mental Health, and the Alzheimer's Association. The Coalition's Goal Group Leaders and Members is represented by seventy-plus volunteers representing government, academia, community-based organizations, non-profit, and faith-based communities. Early detection efforts include training and education for primary care providers, specifically Federally Qualified

Health Centers (FQHCs), to assess for cognitive impairment during annual wellness visits. Multi-sector partnerships are also demonstrated through the advancement of Mississippi's Age-Friendly Ecosystem. For example, AARP's "Better Together" approach is being implemented to increase age-friendly and dementia friendly communities, aiming to create places where older adults and people with dementia can stay active and independent in their communities for as long as possible. Serving as the backbone organization for the Ecosystem, the Age-Friendly Public Health System is integrating age-friendly and dementia-friendly best practices within workplaces, businesses, health systems, and universities. Increasing awareness of and coordinating access to early detection screenings is an essential prevention strategy for the Mississippi BOLD program.

What is the impact on types of ADRD goals and initiatives that are possible depending on your location within your agency?

Case example: The Boston Public Health Commission successfully advocated and secured a full-time "Healthy Aging Director" position in an effort to sustain ADRD initiatives beyond grant funding.

Case example: The Georgia Department of Public Health's 55+ Driver Safety Program focuses on the impact that aging has on safe driving. This includes not only older drivers but on caretakers who are aging themselves. The Program focuses on education and outreach to this "club sandwich generation," sandwiched between aging parents, adult children, and grandchildren. As caregivers for multiple generations, the 55+ age group will need to navigate the driving cessation talk with their older parents. In addition to the effects of aging beginning at this stage, the stress of caregiving can lead to poorer health outcomes, increased risk of distracted driving & unrecognized personal physical decline. These factors lead to increased risks of crashes with serious health outcomes due to increased fragility (likelihood of injury) & frailty (difficulty recovering from injuries).

This program sits within the Injury Prevention Program along with the BOLD program and existed prior to the BOLD program inception. Subject matter experts in the 55+ program identified the connection of the programs from a safety and injury prevention perspective. Both programs now share resources among partners, provide educational presentations at their respective standing meetings, and identify new connection opportunities in the injury prevention space.

Communications and messaging example

Case example: The Minnesota Department of Health (MDH) Aging and Healthy Communities Unit in the Health Promotion and Chronic Disease Division collaborates with the MDH Health Care Homes Unit in the Health Policy Division to promote early detection resources and trainings for primary care teams.

Minnesota's Age Friendly Council drafted a statewide Multi-Sector Blue Print on Aging. The Minnesota Board on Aging leads this effort and the department of health has historically had a minimal role in statewide aging efforts. By building strong relationships and aligning MDH dementia related goals with Age-Friendly goals, MDH successfully advocated for dementia as a priority area in the plan.

Some **guiding questions** to encourage you to have a more complete understanding of where your potential or established program on early detection is positioned and how to best integrate and align with other priorities and programs at your agency:

Where does your team sit within your agency? (i.e., What division, bureau, or office?)

How connected is your team to other teams/bureaus/divisions at your agency?

Where does your team sit within your agency?

- If yes, briefly describe what other staff/teams at your agency are also working on issues related to health aging + brain health:
- If no, how do DOH staff advocate for work in this area? I think we should try to answer this question vs. just ask it here.

To what extent are healthy aging/brain/health/dementia currently priorities for leadership at your agency?

Additional considerations to help you find common ground with other key priorities and programs at your agency can be drawn from DC Health's Social Determinants of Health and Dementia framework (Figure 2), which highlights that many disease programs share common drivers *and* goals for improving the health and wellbeing of communities.

FIGURE 2.
DC HEALTH'S SOCIAL DETERMINANTS OF HEALTH AND DEMENTIA

Economic Stability

- People who are employed have better health, and individuals and families supported by stable employment are better positioned to use preventative services and consistently practice healthy behaviors.
- The increased health risks of unemployment are linked to loss of health insurance, depression and increases in unhealthy coping behaviors.

Education Access and Quality

- Studies show an association between a higher level of education and better brain health.
- In DC, among adults aged 45 years or older, the proportion experiencing subjective cognitive decline was lowest for college graduates.
- The proportion of residents experiencing subjective cognitive decline is nearly three times greater for those without a high school diploma.

Neighborhood and Built Environment

- Spending time in a natural and outdoor environment has been shown to have positive physical and cognitive health outcomes.
- A healthy community design improves opportunities for exercise, access to services, transportation and community supports.

Health Care Access and Quality

- Access to health care has a variety of consequences on a person's physical and cognitive well-being.
- Consistent access to health care services gives people the opportunity for regular preventive health services and early diagnosis of many health conditions, such as diabetes, heart disease, and dementia.
- Access to care can lead to successful chronic disease management. As a result, reducing the risk for cognitive decline.

Social and Community Context

- People's relationships and interactions with family, friends, co-workers, and community members can have a major impact on their health and well-being.
- Maintaining strong social connections and keeping mentally active as we age may lower the risk of cognitive decline and dementia.
- Although it's hard to precisely measure social isolation and loneliness, there is strong evidence that many adults aged 50 and older are socially isolated or lonely in ways that put their health at risk.

Image source: Government of the District of Columbia. (n.d.). Social Determinants of health and dementia. DC Health. https://brainhealth.dc.gov/page/social-determinants-health-and-dementia

Importance of local population mapping

Case example: The Minnesota Department of Health (MDH) partners with the Volunteers of America (VOA) Culturally Responsive Caregiver Support and Dementia Services team. Using a mobile clinic funded through a previous grant, the VOA team has been able to leverage funds through MDH to reach older African American adults and their caregivers with dementia screening, referrals, and chronic condition management. With support from MDH, the VOA team also established a Brain Health component to their regular caregiver support programming, recognizing the need to increase awareness of the connection between brain health and heart health in their community. Through the evolving partnership between MDH and VOA, the VOA team engaged barbers and hair stylists in conversations about dementia including what they see and need in their roles as trusted community messengers. VOA has since initiated a project to provide training to barbers and hair stylists to support dementia friendly communities and accurate information about dementia in the community.

PUBLIC HEALTH SURVEILLANCE AND DATA-DRIVEN PROGRAMMING

The first of the Centers for Disease Control and Prevention's 10 Essential Public Health Services, that we highlight in Figure 1 and Table 1, speak to how essential it is to have relevant and sufficient data to meaningfully drive public health action to advance early and equitable detection.

- Assess and monitor cognitive decline, dementia diagnoses, and dementia care coordination population-wide and across communities
- Investigate and address gaps in dementia risk reduction, early detection, and caregiving

For routine data collection and surveillance: you must be able to prove that you are collecting data and document that you were/are meeting your mission

First, what data does your organization currently require you to collect?

Second, it is essential to understand what data sources are routinely collected and available in your setting. Data sources to consider include: Behavioral Risk Factor Surveillance System (BRFSS), Medicare and Medicaid payment data, hospital discharge data systems, or all payer claims databases.

- If you pull the latest surveillance data on comorbidities, chronic disease divisions may be interested in collaborating on addressing areas with limited data and engaging community-based organizations and clinicians to help contextualize the surveillance data (e.g., do these data reflect your experiences and what you have been seeing on the ground and in communities?).
    - Addressing areas with limited data
    - Use of surveillance data in engaging community-based organizations (CBOs) and clinicians – individually and together?

Case example: Minnesota Department of Health has used BRFSS data is to tell the story of dementia caregivers in Minnesota, including highlighting the higher rates of chronic disease, smoking and depression among caregivers, promoting dementia caregiving as a social determinant of health, and advocating for increased support for dementia caregivers. This includes earlier detection and diagnosis for people living with dementia to avoid stress and crisis for the caregiver.

Third, it is important to align efforts with other data-driven initiatives in your setting, such as those developing a master plan for aging (e.g., New York State Aging Master Plan[23]).

All three sectors – health systems, departments of health, and community-based organizations – must be accountable for data on what they are doing, services they deliver, and what their outcomes are. Developing data-sharing mechanisms across sectors can strengthen both individual and collective efforts.

- A comprehensive multi-sector approach is important to data-driven programming (see description of our Center's 3-sector approach above on page 9).
    - Each sector's data collection and data-driven decision making is better if they're all contributing to each other's data.
        - DOH cannot access clinical data unless an explicit data-sharing agreement is in place
            - Guide for detection, screening, and linkage accessing and utilizing surveillance data for resource allocation, intervention, planning; challenges (e.g., after the referral), and ethical considerations related to data sharing agreements that facilitate those productive conversations on the topic.

Case example: Georgia State Alzheimer's Registry was one of the first recommendations from the Georgia Alzheimer's and Dementia Collaborative in 2014. As Georgia developed their state plan for dementia and created a collaborative to implement the plan's goals, the collaborative understood the need to develop a state dementia registry to inform services and programs, identify trends, and better understand the burden.

There are several data sources for the state registry:

- **Clinical data:** The registry collects data from various healthcare providers who see people with suspected cognitive impairment, not just those diagnosed with ADRD. This data collection is driven by State Law.
    - Data are currently submitted on a monthly basis from 5 clinics that are part of the Georgia MemoryNet. These 5 clinics were chosen due to their hands-on training. There was no standardized definition of what is Alzheimer's and how to diagnose it. The goal is accuracy rather than numbers, using ICD codes and physician notes, which required reformatting data from physicians' notes from different clinics.
    - Scaling the registry will require additional staff to increase capacity, provide training, clean/analyze the data, and provide technical assistance through a quality assurance/quality improvement lens.
- **Medicare data:** As a department of health, they are able to access and link identifiers and participation Part A and Part B, etc., to other datasets on hospitalization or emergency room utilization. They also receive all claims related to Alzheimer's disease, regardless of age.
    - These data are critical to provide descriptive analysis and, where counts are sufficient, visualizations that show geographic distribution of burden. These analyses are used to frame and focus efforts across the state.
    - **Behavioral Risk Factor Surveillance System (BRFSS).** Georgia collects data on perceived cognitive impairment (PCI) and dementia caregiving in alternating years. Georgia combines the datasets to create prevalence estimates. Georgia works with the

CDC on BRFSS sampling frame to collect minimum 200 respondents for each district.

- Phone numbers of county residents
- Screened for eligibility (active phone numbers, household not business)
- Sampling on a monthly basis
- Landline lists as well as cell phone lists
- Cell phone bucket is not by county, but based on what cell tower they use
- As accurate as they have cell towers in Georgia but some counties have no cell towers
- Easily analyzed at the district level
- Ability to combine several years
- Re-weigh the data and produce prevalence by county

Case example: The Minnesota Department of Health (MDH) using available data to educate partners and guide implementation:

- **Developing a Shared Data Dashboard:** The Minnesota Department of Health engaged a dynamic workgroup of multi-sector partners to identify and refine population health indicators for a dementia data dashboard.
    - Identification of dementia dashboard risk reduction indicators was supported by the Data to Action Workgroup we convened in February 2024. A total of 15 members representing different sectors were oriented to the dashboard project. Over the course of 4 additional monthly meetings ending June 2024, the group 1) led other Minnesota Healthy Brain Partnership (MHBP) groups in developing a vision statement for the Minnesota Dementia Strategic Plan (MDSP), 2)identified key populations of focus or a population-level indicator dashboard, and 3) agreed to use a Results-Based Accountability framing of process level measures of to support program evaluation. The group explored the evidence-base for dementia risk reduction and identified concepts and populations

that should be covered by the indicators. Our program epidemiologist continued to lead a group of 5 workgroup members to refine indicators and explore the landscape of available data, including through meetings with data holders. As of February 2025, most indicators and data sources are identified.

- **Developing a Call to Action for Early Detection and Diagnosis of Dementia**
    - The MDH team developed a mixed methods report using BRFSS from Community listening sessions and the MN Dementia Partner Survey, which made plain that community has a role in screening and referral for early detection. The drafted report led with the fact that only 4 in 10 people experiencing cognitive impairment spoke with a provider. There is a need to address stigma, fear, and other barriers to screening and to emphasize the essential role that trusted messengers including community organizations, have in this work. It is clear in sharing these concepts with stakeholders that a well-communicated early detection framework for MN is needed to guide collective action in this area. We look forward to engaging key MHBP partners passionate about community-based early detection to help us polish the report and use it along with the PHCOE-EDD toolkits and resource guides to support increased screening in community settings.

DETECTION, SCREENING, AND LINKAGES

GUIDE FOR DETECTION, SCREENING, AND LINKAGE FOR DOH

In general, a good strategy for detecting cognitive impairment starts with a conversation – in the community or a clinical setting. This approach creates an opportunity to talk about brain health, elicit any concerns that might be neglected in a routine visit for some other problem and offer support. It allows for normalizing the discussion of brain health as an important part of overall health. It sets the stage for introducing options for assessing cognition, identifying possible cognitive impairment, and making collaborative decisions about next steps.

It is important to know your community before you can address what care is needed but not provided. You may conduct a basic service-needs assessment to identify what may benefit people living with dementia and the people around them.

Key questions to assess options and move into next steps:

- Can I provide this service, or does somebody else need to provide it? (e.g., does your DOH already provide direct services?)
- If not your agency, who else can provide the service?
- How would I connect this person to that service?
- Consider being an origination/physical site for telehealth efforts

Be systematic in your approach
Our Center has developed an interactive decision support tool for implementation of an early detection approach. You can use this tool to assess yourself, plan your next steps, and evaluate your progress as you go.

Refer to Appendix B for a preview of the decision tree, or visit our website to explore the interactive tool.

Choosing a Cognitive Assessment Tool:

The "best" tool is the one that works best in your setting and meets your needs. The tools listed in our website and HSP resource guide are promoted by the American Geriatrics Society (AGS), the Gerontological Society of America (GSA), and/or United States Preventive Services Task Force (USPSTF). They have been tested and validated across various communities and settings (e.g., Clinics, community settings).

No single screening or assessment tool is perfect for all uses. You may start by using one and later add or change to another as needs evolve. Please refer to the resources linked in this section for an overview of brief tools. In the overview, you can see details about language availability for each tool, as well as information related to overall complexity of the screener (e.g., time required, who is suited to administer) that can help identify which tools might meet the literacy and other needs of the communities you serve.

Linking persons living with dementia and their families to resources

Departments of health are also uniquely positioned to foster coordinated approaches for partners across all sectors and settings to develop and disseminate common language and key messaging for public education, stigma-reduction, and detection promoting campaign materials. Crucially, departments of health also have the capacity and resources to ensure that materials are meaningfully culturally adapted (not just literal translation) and disseminated using the preferred channels for reaching historically marginalized and minoritized communities within the public at large, to ensure equitable reach and impact.

Phases of hand-offs and examples: Building systems for people living with dementia, whether for referral from detection to screening or from screening to healthcare.

- Community ADRD education (phase 0 – general population)
    - DOHs may provide rack cards, to address different questions on brain health, recognizing signs of dementia in yourself or others, and how to talk to your doctor about concerns, materials that encourage self-advocacy (GA *Think About It* include CPT codes for annual wellness visit and Georgians are taking them to primary care wanting assessments)
- Referral handoff (phase I)
    - Alzheimer's Association pioneered the referral by secure fax to link their community to medical resources
- Warm handoff (phase II)
    - Person-to-person spoken/written contact between professionals in service of patient
- Contracting Department of Health and Health System relationships (phase III)
    - How to overcome cultural gaps between sectors and agree on a funding structure with money changing hands

Case example: The Minnesota Department of Health used federal BOLD Grant funds to establish the MN Healthy Brain Community Grant Program. Healthy Brain Community Grantees create, improve, or amplify brain health messages and strategies that reduce dementia risk, detect and diagnose dementia earlier, and support people living with dementia and their care partners. The focus is on engaging communities disproportionately impacted by underdiagnosis and misdiagnosis. These communities include Black, Indigenous, People of Color (BIPOC); Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+); American Indian; people living with disabilities; and communities in Greater Minnesota.

Resources

Please click on each link to visit these resources

Introduction to Alzheimer's and Dementia

- Overview of 7 Memory Screeners – BOLD Public Health Center of Excellence on Early Detection of Dementia
- How is Alzheimer's Disease Diagnosed? – Alzheimer's Association
- Medical tests for Diagnosing Alzheimer's – Alzheimer's Association
- Visiting You Doctor (when seeking a diagnosis) – Alzheimer's Association

How to Begin and Sustain a Program of Early Detection

Establishing and sustaining initiatives that support brain health, encourage conversations about cognitive decline, and promote early detection starts by evaluating your available resources. As part of your program development, evaluation, and implementation consider: internal or external partnerships, current initiatives and programs, and funding to identify readiness or needs to successfully launch or expand a program.

Understand your state or local capabilities, allowances, and funding models within the DOH framework.

Wisconsin BOLD Case example: Current project partnering with the Hispanic Health Resource Center that is part of the ProHealthcare system in southeast Wisconsin. They provide outreach and connection to the Spanish speaking communities living there to link them to dementia information and care.

As part of your process evaluation, identify:[18, 19]

1. Identify effective program implementation strategies within/across your department
    - Is there one uniform implementation strategy across your jurisdiction? What works?
2. Identify weak points that would benefit from clarification
3. Identify your goals, and how you will measure your goals and progress.
4. Align data collection to your program goals, evaluation, and assessment. See below “Goal Setting, Metrics, and Indicators or Progress” section.

Wisconsin Case example: The Memory Screening in the Community program in Wisconsin utilizes county-based resource centers to provide a simple cognitive screening program consisting of the Animal Naming Screen and the Mini-cog. These tools facilitate a conversation regarding concerns around cognition for someone interested for themselves or a family member or friend. These conversations result in the appropriate referral to a primary care practitioner for evaluation and connections to education and other resources that may be beneficial for both the individual and the family.

Yang KL, Kelble L, Felten K, Carlsson CM, Clark LR. Memory screening in the community: Facilitating earlier dementia diagnosis and care—Preliminary data. *J Am Geriatr Soc. 2024; 1-10. doi:***10.1111/jgs.19302**

Catalog and Build Relationships with Known Community and Clinical Supports and Services

Identify and partner with state-approved or -identified providers or services that offer “best practice” approaches to ADRD diagnosis and care.

Consider building a statewide and even regional or eventually national model that supports those living with ADRD.

Engaging with resources and establishing feedback loops are essential for effective health program development. This involves utilizing resources efficiently, addressing service gaps, and providing departments of health with templates and tools to catalog and evaluate available community and clinical resources. Additionally, it is crucial to increase awareness of the local population’s needs, particularly for people living with dementia and their care partners, using inclusive messaging. This includes ensuring relevant language translations and accessibility for individuals with visual or hearing impairments.

Once you have identified existing programs or services in your community, share what you have found with your internal and external partners, this can foster your cross-sector relationships and enhance your and your partners’ programs.

Case example: Georgia’s state unit on aging (Division of Aging Services) team and academic partners met with other states’ Dementia Care Specialists (DCS) programs to learn how they define a DCS and how they build their responsibilities.Georgia’s state unit on aging is a close partner to the BOLD team. They also led the creation of the state plan for dementia. This agency partners closely with all groups working on aging and dementia in Georgia through their facilitation of the Georgia Alzheimer’s Disease and Related Dementia (GARD) collaborative. It is through the collaborative that the state plan for dementia is implemented. Prior to being funded for BOLD, Georgia Department of Public Health provided recommendations to the Georgia Division of Aging Services as they created the state plan for dementia, and later the newly funded DCS program. The Georgia BOLD team has encouraged and mentored the new Dementia Care Specialists to partner with local health departments, DPH chronic disease prevention managers, and to be active within workgroups of the Georgia Alzheimer's and Dementia Collaborative (GARD). They bring their local and regional knowledge to help in updating the state plan and operationalizing the implementation plan within communities across the state.

WORKFORCE DEVELOPMENT

WORKFORCE DEVELOPMENT

A critical component for starting, growing, and sustaining robust DOH action on dementia services or detection programs is the ability to hire, train, mentor, and maintain teams of public health professionals who understand healthy aging and brain health.

Some criteria to consider for example, are whether staff are comfortable speaking in public and can do some comfortably about issues like dementia and brain health, whether they have demonstrated skills in writing, creating presentations, and doing literature reviews. For the Georgia BOLD program, for example, their job candidates must do either a) a writing prompt or b) construct a brief PowerPoint presentation that they will then present during an interview.

This section will guide you through some key considerations for building and sustaining a dementia-capable public health workforce. These considerations include guidance and examples for:

- Team Composition and Roles
- Hiring and Job Postings
- Training Structure and Content
- Mentoring and Career Development
- Peer Networks, Affinity Groups, and Learning Collaboratives

Team Composition and Roles

- Consider what does your ideal team look like to do this work and to do it well?

Georgia BOLD program has a gerontologist, a public health professional with CHES certification as well as local public health and chronic disease experience, a consultant who specializes in rural health, and a team member who is well-connected to other partners in the state and has in-depth knowledge of state processes.

Consider the workforce composition of full-time equivalent (FTE) department of health (DOH) staff who may already be at your agency. This may include direct service providers, nutritionists, registered nurses, community health workers (CHWs), health educators, among others who may be instrumental in helping your team achieve your early detection goals. To help plan your team's composition and identify who else to engage at your agency, review the National Association of County and City Health Officials (NACCHO)'s 2019 Profile of Local Health Departments (Table 2 and Figure 3).

Table 2.

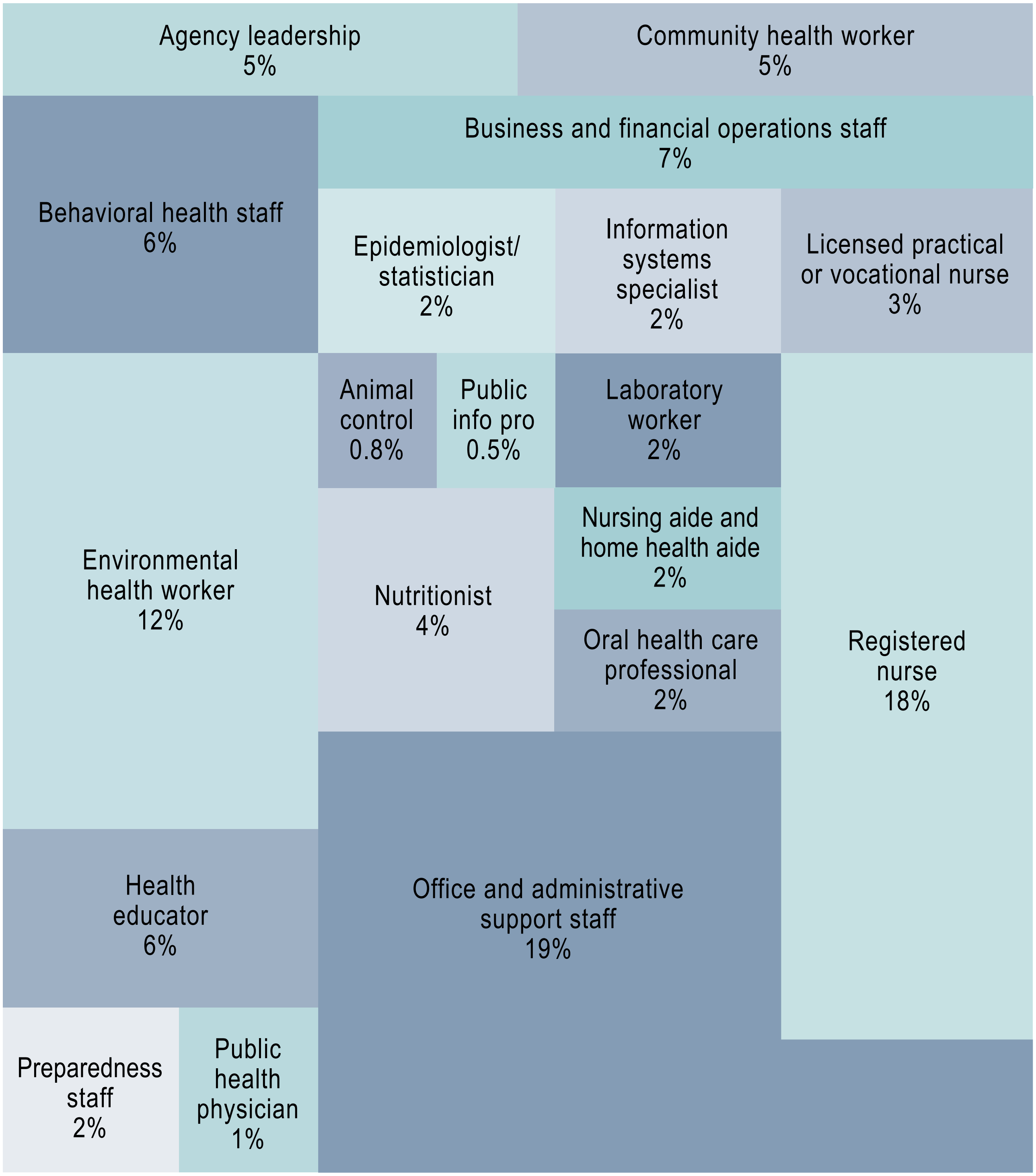
NACCHO's 2019 LHD Estimated number of Full-Time Equivalents (FTEs) in select occupations

Occupation	Number of FTEs	95% Confidence intervals	
Agency leadership	5,800	5,500	6,100
Animal control worker	1,000	800	1,200
Behavioral health staff	6,700	4,500	8,900
Business and financial operations staff	8,900	5,900	11,900
Community health worker	5,600	4,800	6,300
Environmental health worker	14,500	12,500	16,500
Epidemiologist/statistician	2,900	2,000	3,800
Health educator	7,500	5,100	9,900
Information systems specialist	2,200	1,300	3,100
Laboratory worker	2,100	1,500	2,700
Licensed practical or vocational nurse	3,600	1,900	5,400
Nursing aide and home health aide	2,200	1,800	2,600
Nutritionist	5,100	4,700	5,500
Office and administrative support staff	23,100	20,800	25,500
Oral healthcare professional	2,200	1,900	2,500
Preparedness staff	2,300	2,100	2,400
Public health physician	1,300	900	1,600
Public information professional	600	550	700
Registered nurse	21,200	18,800	23,700

n=1, 110-1, 129

Image source: National Association of County and City Health Officials. 2019 National Profile of Local Health Departments. (2019). https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf

Figure 3.
NACCHO's 2019 LHD Workforce Composition



n=1, 110-1, 129

Image source: National Association of County and City Health Officials. 2019 National Profile of Local Health Departments. (2019). https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf

Also consider how roles are defined and integrated throughout the team you have composed, as well as their integration into the larger bureau/division/agency overall. For example, consider the importance of integrating specialty community-connected workers such as community health workers (CHWs) and dementia care specialists into referral loops, as well as into planning and evaluation. Make sure to identify required core competencies for all DOH staff working on programs related to brain health and dementia. Further, make sure to outline exactly who in your setting can and will conduct screenings for dementia, and also concretely identify care and care planning pathways (who will diagnose + what happens next). Understanding the comprehensive care pathways available in your local settings should be one of the key requirements for all staff that are working on dementia or early detection programs.

Case example: The Dementia Care Specialist (DCS) program in Wisconsin is a county-based community program available as part of the Aging and Disability Resource Center statewide network and Tribal Nations. As part of their role, DCS provide training and support to Center staff in working with individuals and families living with dementia, including how to provide the community-based memory screening program. Screening is offered in a variety of settings from multiple staff members. Community-based services and supports are offered as the individual and family are supported on their journey to obtain a diagnosis.

Hiring and Job Postings

As you plan to hire and develop job descriptions for your teams, some important considerations include:

- What does it mean when you find motivated public health professionals, but they don't necessarily have prior training or experience in brain health, healthy aging?
- How can you best prioritize identifying individuals who are motivated to do this work (i.e., have lived experience), and have a meaningful understanding of communities and their needs?
- Are there opportunities to hire from within your agency – to bring someone onto your team who understands the agency well but maybe not the content?

Minnesota BOLD: while their team does not have experience in dementia prior to joining their BOLD team, their team members' expertise in community engagement, communications, and data strategy has been invaluable to their BOLD initiatives. They have brought on a medical student intern through the UMN Robert L Kane program. The intern is providing clinical expertise to their program. The intern is working to support Minnesota specific issue briefs targeted at providers on dementia risk factors like untreated hearing loss and hypertension and implications for primary care teams and other providers, and reaching out to GUIDE model participants in Minnesota to learn about their approaches and opportunities for collaboration.

Wisconsin BOLD: In Wisconsin, the DHS provides their DCS's with a 20-hour training and education on dementia. While their DCSs may not start with prior dementia experience, their community experience has been critical to their success:

- One team member has been incredibly successful in her DCS role, not because she was a dementia expert, but because of her prior role within the Tribe she served. She was an established and trusted individual within the community.
- Another DCS for their Hispanic Health Resource Center has been a public health educator for the Spanish speaking community for 15 years. Her experience in the community has established her as a trusted and respected member which has supported her dementia-related work in the community.

Georgia BOLD: Internships are integral to their workplan. The Georgia BOLD team hosts at least two interns every year. To support these early career professionals for success, interns support various projects including educational outreach, community event planning, and create visualizations using hospitalizationand ED visit data. For professional develop, interns receive one-on-one mentoring throughout their program and are expected to facilitate at least one meeting. As part of the on-boarding process, mentors model language and nomenclature to set up these interns for success in the field. Past undergraduate interns have transitioned into part-time employees, with others transitioning to and growing into full-time employees within the department.

Training Structure and Content

As you focus on training and onboarding for new team members, as well as professional development opportunities for existing team members, it is important to consider:

- What is on your wish list and what are the baseline pre-requisites for your staff to know about brain health or early detection in order to be capable of addressing these issues and doing this work?
- What kinds of training do they need to do this work comprehensively and compassionately?
- What do you hope to bring into the staff training so that they can do this work well?
- What cost and budget limitations may constrain training opportunities to enhance the skills of your team members? And what opportunities are there to cross-train with other departments or agencies to help reduce training costs?
    - What free trainings and resources can be identified to build staff capacity and competency? (e.g., the Alzheimer’s Association provides a free, online, interactive curriculum – A Public Health Approach to Dementia – that includes videos and knowledge checks for public health students and professionals)

- What existing training structures in the field can you leverage (e.g., how are staff in other chronic disease programs currently trained and what opportunities are there to cross-train staff from across your program and those programs)? And what champions on your team can you prepare to take on providing teaching, mentorship, and guidance to other staff as they become more dementia capable?
- State-funded Memory Clinics should be required to offer, and fill, internships, practicum in cognitive impairment/dementia for students in public health, medicine, and social work/gerontology. Ideally students from all 3 sectors would train together, forming a cross-trained annual cohort prepared to enter careers in aging brain fields. Students get invested early on, becoming champions for change later on. Identify people that see themselves as change agents.

Mentoring and Career Development

- Not just training a large group of people, but identifying and supporting others who see themselves as change agents that magnifies the opportunities for development.

Case example: Wisconsin Department of Health Services (DHS) provides several opportunities for the county-based and Tribal Dementia Care Specialist (DCS) to participate in training and peer-learning opportunities.

- DHS convenes monthly virtual meetings for local program staff and local supervisors to allow for educational speakers, the sharing of program-wide information and opportunities and to hear about and address programmatic concerns.
- DHS has also provided a venue for the DCS staff to meet on their own and create their own agenda for discussion in four regions of the state. In each region, an experienced DCS volunteered to be the lead to

organize and convene quarterly regional meetings of the DCS staff to discuss regional challenges and share successful strategies in reaching the different parts of the state they serve. DHS also facilitates a monthly Tribal DCS meeting just for tribal DCS to share and learn from each other about successful strategies and discuss the challenges unique to tribes.

- DHS also partners with the Wisconsin Alzheimer's Disease Research Center and the Wisconsin Alzheimer's Institute to provide an annual in-person conference for DCS staff. The two-day conference includes Collaboration Day and Research Day. Collaboration Day is an opportunity for the DCS to talk with each other as a unique peer group and discuss the issues that arise and are always unique to the role of the program across the state. The ability to connect face to face with colleagues from across the state has been valuable in sharing ideas and best practices.

Research Day is presented at the Alzheimer's Disease Research Center and provides the DCS with access to the researchers and other experts in our state. The DCS learn about the latest research findings and the clinical implications for the future. Research day provides the DCS with the ability to address concerns raised when working with families who have misunderstandings or questions about research or the latest treatments for dementia.

Peer Networks and Learning Collaboratives

Leveraging peer networks and establishing formal learning collaboratives within and across agencies in your jurisdiction, as well as with peer agencies in other locales, can facilitate better understandings of addressing early detection of dementia as a complex public health issue.

Guidance on creating successful public health learning collaboratives based on lessons learned and research include:

- Focus on building strong relationships
- Balance breadth and depth
- Consider whether centralization could help
- Prioritize trust building
- Monitor and evaluate network structures
- Manage resource contributions
- Set clear goals and outcomes
- Continuously learn and adapt
- Remember: There is no right way to build a collaborative

Please visit the Visible Network Labs' Guidance on Navigating a Public Health Collaborative.

These types of workforce opportunities for connectedness eliminate opportunities for professional workforce isolation and can strengthen connections for more comprehensive public health action.

One strategy and key opportunity for workforce convening could be leveraging existing professional consortiums – for example, convening home health aids at a local, regional, or national home health aid conference and have them share their best practice recommendations and challenges faced in working in dementia care.

DISSEMINATION AND OUTREACH

60 **Public Messaging and Media Campaigns to Communicate Effectively, Inform, and Educate**

PUBLIC MESSAGING AND MEDIA CAMPAIGNS TO COMMUNICATE EFFECTIVELY, INFORM, AND EDUCATE

Georgia BOLD Case Study: With support from Georgia Chapter of the Alzheimer's Association, GA DPH Communications created the Think About It campaign. We have metrics available for the campaign that can be easily shared. The audience was adults, families, and care partners. Materials were distributed via pharmacies, earned media in ball fields, on public transportation, etc. The materials are still used today by multi-sector partners, in conjunction with federal resources to educate the public about lowering risk of developing dementia and when to talk to their doctor to advocate for assessment.

Washington, D.C. Health Case Study: In 2023, DC Health launched a multi-media campaign to increase public awareness of brain health, Alzheimer's disease and related dementias. In their campaign, they highlighted their website, brainhealth.dc.gov, that provides resources on supporting brain health and dementia risk reduction.

The District of Columbia State Plan on Alzheimer's Disease and Related Dementias 2024-2028.

Identify the group you want to reach and ways to bring them together. Then start the conversation.

Normalize conversations on brain health as part of overall health.
In most communities there is some stigma associated with dementia, cognitive impairment, and changes in brain health. DOHs can start the conversation on brain health, which might be holding discussions about risk factors that can be controlled and ways community members can protect their aging brain.

Community education around brain health normalizes conversations, raises awareness of brain health issues, and may open the door for conversations on early detection. Leverage existing resources and build the necessary partnerships to promote and normalize conversations about brain health and early detection:

- BOLD and Healthy Brain Initiative (HBI) resources
- Links to adoptable educational programs including costs if any
- Partnerships with ADRD organizations and community-based organizations (CBOs) for assistance
- Public education of benefits of early detection of dementia
- ADRD and other organization resources including culturally-adapted resources

Case example: The Boston Public Health Commission is partnering with our local public housing authority and other affordable rental housing providers to support the Boston BOLD Project objective to educate members of the public (including populations of high burden) about ADRD topics. The goal is to increase awareness and understanding of brain health, Alzheimer’s and dementia, and supports available to unpaid family caregivers of people living with dementia within the community of affordable housing residents and staff.

SUMMARY

This BOLD Early Detection of Dementia Resource Guide for Departments of Health provides resources to guide you in building and customizing dementia detection efforts into your existing services, needs, and setting. This resource guide supports a comprehensive approach to early detection of dementia and to becoming more "dementia-capable" at the individual and community level: assessing needs, reaching out as brain health and dementia educators, forging alliances between community and dementia-specific organizations, and amplifying your impact through creative partnerships.

While screening tools are an important resource for detection, the conversations before and after testing form an essential foundation for ongoing planning and helping individuals and families realize the full benefits of early diagnosis.

We appreciate all the members of our Department of Health Sector Workgroup from state, regional, and local health departments who contributed to this resource guide, either through contributing ideas and case examples, or by helping us to review the content. This resource guide would not have been possible without their willingness to participate.

Workgroup Co-Leads:
Kristen Felten, MSW, APSW (Wisconsin Department of Health Services)
Patricia Takawira, MPH (Minnesota Department of Health).

Workgroup Members:
Chandra Wilson, MSW (Northwest Portland Area Indian Health Board)
Edwin DeMott, MS (Vermont Department of Health)
Elizabeth Head, MPH (Georgia Department of Public Health)
Eugene Barros (Boston Public Health Commission)
Kina White, DrPH (Mississippi State Department of Health)
Lynnley Stern, DrPH California Department of Public Health)
Tony Kuo, MD (Los Angeles County Department of Public Health)

ACKNOWLEDGMENT /DISCLOSURE

This resource was supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award (NU58DP006911) totaling $2,652,318 with 100 percent funded by CDC/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by, CDC/HHS, or the U.S. Government.

DIAGNOSIS OF DEMENTIA AND MILD COGNITIVE IMPAIRMENT

While *diagnosis* of dementia is the responsibility of medical professionals, dementia can be *detected* anywhere. Detection of dementia means recognizing that an individual is experiencing changes in everyday functional abilities because of new or worsening cognitive impairment. Diagnosis of dementia is a medical judgment based on relevant clinical evaluation. A medical diagnosis is not necessarily required to qualify an individual for community support services, though it can help support individualized, whole-person care planning and service coordination.

How is a diagnosis made? Diagnosis of dementia is based on a history of decline in cognitive functioning (usually memory, problem solving, and planning ahead, among others), objective demonstration of cognitive decline, and impaired everyday functioning that is at least partly explained by cognitive changes. Once dementia is detected, a medical diagnostic evaluation should follow. This usually includes a general physical and neurological examinations, blood tests, and, often, brain imaging studies. Recently, blood tests able to identify markers specific for Alzheimer’s disease have become available, and similar tests for other types of diseases are in development. Different causes of dementia can produce different patterns of cognitive impairment and biomarker results. Alzheimer’s disease is best known for its early impact on short-term memory, but it causes many other cognitive deficits too. Alzheimer’s disease is the most common single cause of dementia, but often occurs with other types of brain pathology. Other degenerative dementias are diagnosed based on patterns of change in a wide range of domains, including cognition, behavior, social relationships, sleep, or neurological function (e.g., inappropriate social judgement in frontotemporal degeneration, tremor, and rigidity in Parkinson disease, acting out dreams in dementia with Lewy bodies).

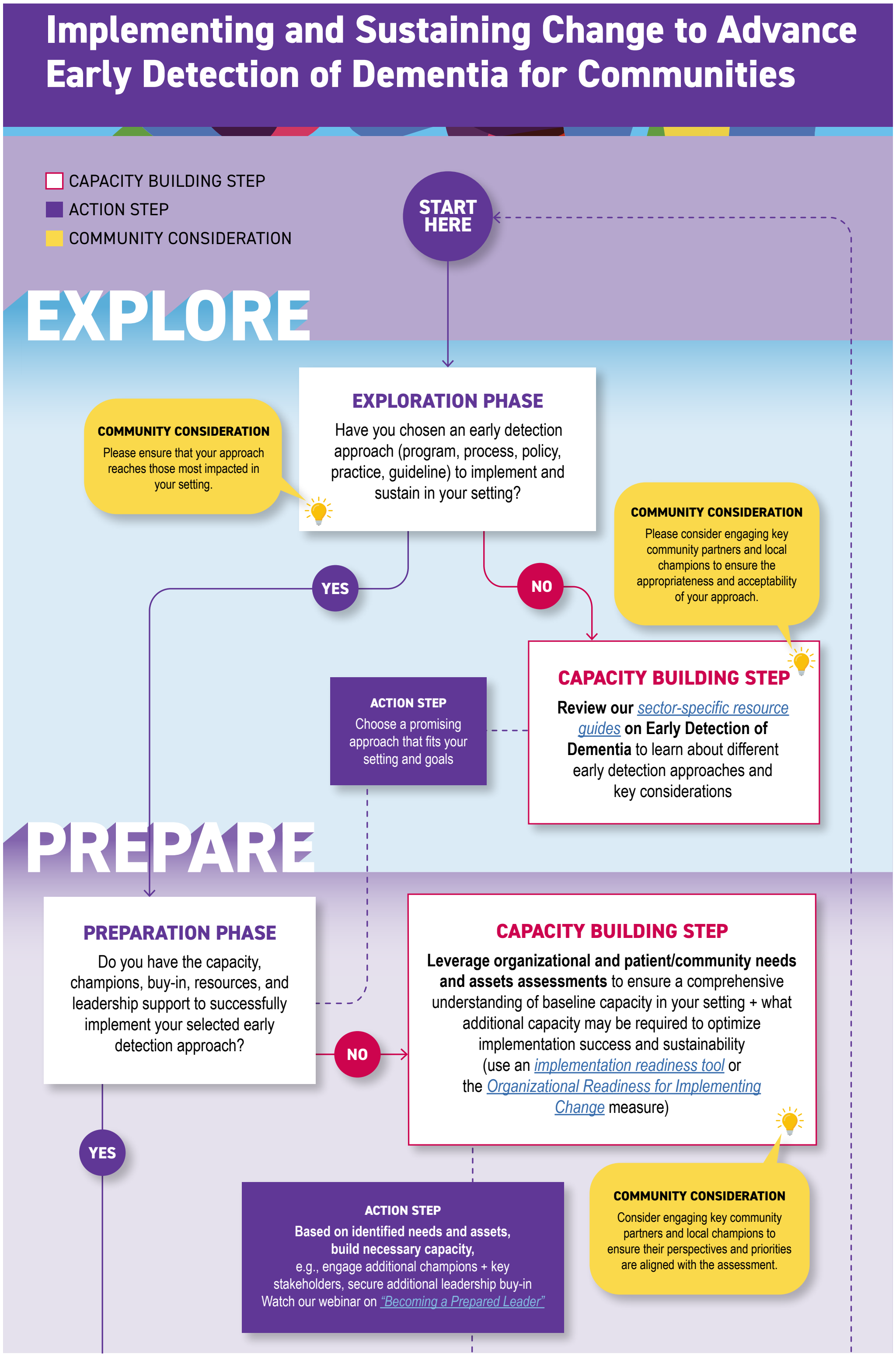
What about Mild Cognitive Impairment (MCI)? This term refers to detectable cognitive impairment that doesn’t severely affect everyday functioning. Mild functional and behavioral changes do occur in people experiencing MCI, but many affected individuals are able to live independently. MCI may progress to dementia (more severe cognitive impairment and functional limitations) but can remain stable or even improve in some cases. The presence of MCI increases the likelihood of future dementia, but many people with MCI will never develop dementia during their lifetimes. There is increasing interest in using blood biomarkers to identify possible Alzheimer's disease in people with MCI, as some may be eligible for newer therapeutic approaches to delay progression, and many may benefit from individualized health behavior changes.

Much research has gone into identifying just where the boundaries are that distinguish normal age-related cognitive changes from MCI, and MCI from dementia. The importance of MCI has been elevated by the recognition that most dementias – notably (but not limited to) Alzheimer's disease – have a long "silent" phase before they cause dementia – that is, disability due to cognitive decline. Current expectations are that early-stage diagnosis can identify people who might benefit from risk-reduction interventions to slow or stop disease progression. This resource guide focuses on opportunities for CBOs to improve detection of *dementia* – but future scientific and public health advances may justify extending this to detection of cognitive impairment at earlier stages and at the community level.

Appendix B (Decision Tree)

EARLY DETECTION OF DEMENTIA IMPLEMENTATION AND SUSTAINMENT DECISION TREE

Visit our website to explore the interactive tool.



Implementing and Sustaining Change to Advance Early Detection of Dementia for Communities

☐ CAPACITY BUILDING STEP
🟪 ACTION STEP
🟨 COMMUNITY CONSIDERATION

START HERE

EXPLORE

EXPLORATION PHASE

Have you chosen an early detection approach (program, process, policy, practice, guideline) to implement and sustain in your setting?

COMMUNITY CONSIDERATION

Please ensure that your approach reaches those most impacted in your setting.

YES

NO

COMMUNITY CONSIDERATION

Please consider engaging key community partners and local champions to ensure the appropriateness and acceptability of your approach.

CAPACITY BUILDING STEP

Review our sector-specific resource guides **on Early Detection of Dementia** to learn about different early detection approaches and key considerations

ACTION STEP

Choose a promising approach that fits your setting and goals

PREPARE

PREPARATION PHASE

Do you have the capacity, champions, buy-in, resources, and leadership support to successfully implement your selected early detection approach?

NO

CAPACITY BUILDING STEP

Leverage organizational and patient/community needs and assets assessments to ensure a comprehensive understanding of baseline capacity in your setting + what additional capacity may be required to optimize implementation success and sustainability (use an implementation readiness tool or the Organizational Readiness for Implementing Change measure)

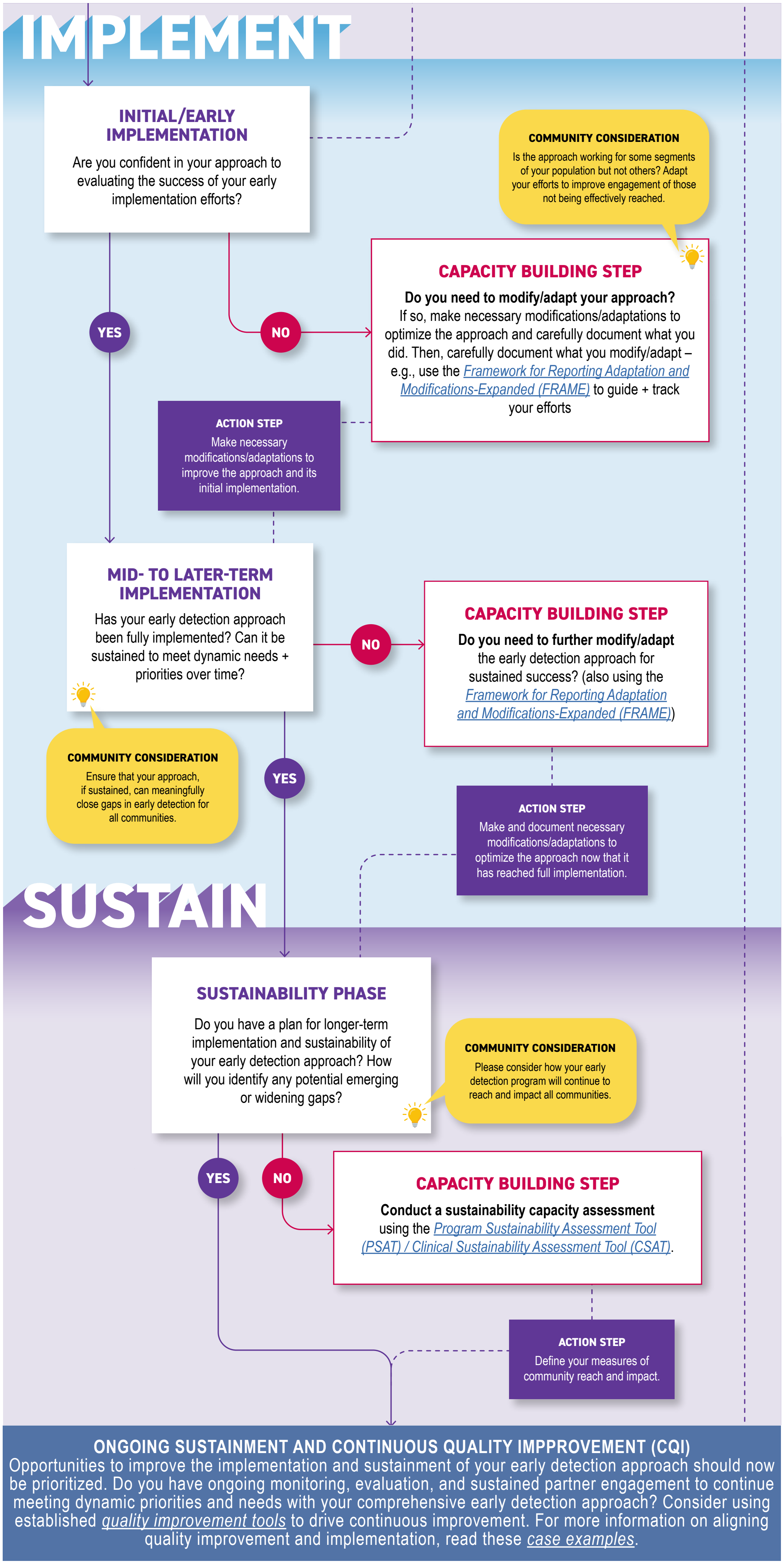
YES

COMMUNITY CONSIDERATION

Consider engaging key community partners and local champions to ensure their perspectives and priorities are aligned with the assessment.

ACTION STEP

Based on identified needs and assets, build necessary capacity,
e.g., engage additional champions + key stakeholders, secure additional leadership buy-in
Watch our webinar on *"Becoming a Prepared Leader"*



IMPLEMENT

INITIAL/EARLY IMPLEMENTATION

Are you confident in your approach to evaluating the success of your early implementation efforts?

YES

NO

COMMUNITY CONSIDERATION

Is the approach working for some segments of your population but not others? Adapt your efforts to improve engagement of those not being effectively reached.

CAPACITY BUILDING STEP

Do you need to modify/adapt your approach? If so, make necessary modifications/adaptations to optimize the approach and carefully document what you did. Then, carefully document what you modify/adapt – e.g., use the *Framework for Reporting Adaptation and Modifications-Expanded (FRAME)* to guide + track your efforts

ACTION STEP

Make necessary modifications/adaptations to improve the approach and its initial implementation.

MID- TO LATER-TERM IMPLEMENTATION

Has your early detection approach been fully implemented? Can it be sustained to meet dynamic needs + priorities over time?

NO

CAPACITY BUILDING STEP

Do you need to further modify/adapt the early detection approach for sustained success? (also using the *Framework for Reporting Adaptation and Modifications-Expanded (FRAME)*)

COMMUNITY CONSIDERATION

Ensure that your approach, if sustained, can meaningfully close gaps in early detection for all communities.

YES

ACTION STEP

Make and document necessary modifications/adaptations to optimize the approach now that it has reached full implementation.

SUSTAIN

SUSTAINABILITY PHASE

Do you have a plan for longer-term implementation and sustainability of your early detection approach? How will you identify any potential emerging or widening gaps?

COMMUNITY CONSIDERATION

Please consider how your early detection program will continue to reach and impact all communities.

YES

NO

CAPACITY BUILDING STEP

Conduct a sustainability capacity assessment using the *Program Sustainability Assessment Tool (PSAT) / Clinical Sustainability Assessment Tool (CSAT)*.

ACTION STEP

Define your measures of community reach and impact.

ONGOING SUSTAINMENT AND CONTINUOUS QUALITY IMPPROVEMENT (CQI)

Opportunities to improve the implementation and sustainment of your early detection approach should now be prioritized. Do you have ongoing monitoring, evaluation, and sustained partner engagement to continue meeting dynamic priorities and needs with your comprehensive early detection approach? Consider using established *quality improvement tools* to drive continuous improvement. For more information on aligning quality improvement and implementation, read these *case examples*.

REFERENCES

[1] Gardner, R. C., & Yaffe, K. (2015). Epidemiology of mild traumatic brain injury and neurodegenerative disease. Molecular and Cellular Neuroscience, 66, 75–80. https://doi.org/10.1016/j.mcn.2015.03.001

[2] van Harten AC, Mielke MM, Swenson-Dravis DM, Hagen CE, Edwards KK, Roberts RO, Geda YE, Knopman DS, Petersen RC. (2018). Subjective cognitive decline and risk of MCI: The Mayo Clinic Study of Aging. Neurology, 91, e300-e312. https://doi.org/10.1212/WNL.0000000000005863

[3] Jessen F, Amariglio RE, Buckley RF, van der Flier WM, Han Y, Molinuevo JL, Rabin L, Rentz DM, Rodriguez-Gomez O, Saykin AJ, Sikkes SAM, Smart CM, Wolfsgruber S, Wagner M. (2020). The characterisation of subjective cognitive decline. Lancet Neurol, 19, 271-278. https://doi.org/10.1016/S1474-4422(19)30368-0

[4] Alzheimer's Association. 2025 Alzheimer's Disease Facts and Figures. (2025). Alzheimers Dement 21. https://www.alz.org/alzheimers-dementia/facts-figures

[5] Department of Health and Human Services. (2022, April 27). Aging. HHS.gov. https://www.hhs.gov/aging/index.html

[6] von Kutzleben M, Schmid W, Halek M, Holle B, Bartholomeyczik S. (2012). Community-dwelling persons with dementia: What do they need? What do they demand? What do they do? A systematic review on the subjective experiences of persons with dementia. Aging Ment Health, 16. 378-90. https://doi.org/10.1080/13607863.2011.614594

[7] Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN). (n.d.). Medicare wellness visits back to MLN print November 2024 updates. MLN6775421 – Medicare Wellness Visits. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

[8] American College of Education. (2024). What is the Difference Between Public Health and Clinical Medicine? https://ace.edu/blog/what-is-the-difference-between-public-health-and-clinical-medicine/

[9] Centers for Disease Control and Prevention. (2024, May 16). 10 Essential Public Health Services. https://www.cdc.gov/public-health-gateway/php/about/

[10] Assistant Secretary for Planning and Evaluation (ASPE). (2025, January 3). Strategic Plan FY 2022 – 2026. HHS.gov. https://www.hhs.gov/about/strategic-plan/2022-2026/index.html

[11] Public Health Law Center. (2015). State & Local Public Health: An Overview of Regulatory Authority. https://publichealthlawcenter.org/sites/default/files/resources/phlc-fs-state-local-reg-authority-publichealth-2015_0.pdf

[12] National Association of County and City Health Officials. (2019). National Profile of Local Departments of health. https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf

[13] Alzheimer's Association. (n.d.) Chronic Diseases and Dementia. https://www.alz.org/professionals/public-health/public-health-topics/chronic-diseases

[14] Gotanda H, Nuckols T, Mori K, Tsugawa Y. (2021). Comparison of the Quality of Chronic Disease Management Between Adults With and Without Dementia. JAMA Netw Open, 4, e219622. https://doi.org/10.1001/jamanetworkopen.2021.9622

[15] Snowden MB, Steinman LE, Bryant LL, Cherrier MM, Greenlund KJ, Leith KH, Levy C, Logsdon RG, Copeland C, Vogel M, Anderson LA, Atkins DC, Bell JF, Fitzpatrick AL. (2017). Dementia and co-occurring chronic conditions: a systematic literature review to identify what is known and where are the gaps in the evidence? Int J Geriatr Psychiatry, 32, 357-371. https://doi.org/10.1002/gps.4652

[16] Alzheimer's Association. (2022, March). March 2022 Factsheet: Alzheimer's and Multiple Chronic Conditions." https://www.alz.org/getmedia/4102d0c5-51a8-4de0-8771-a044b715690e/alzheimers-and-multiple-chronic-conditions.pdf

[17] Association of State and Territorial Health Offices. (2022, May 31). Public Health Frameworks to Advance Healthy Aging. https://www.astho.org/topic/brief/public-health-frameworks-to-advance-healthy-aging/

[18] Centers for Disease Control and Prevention. (2024, August 18). CDC Approach to Program Evaluation. https://www.cdc.gov/evaluation/php/about/index.html

[19] PACE MySPH. (2012). CDC Evaluation Framework. YouTube. https://www.youtube.com/watch?v=tOjieBh1ce0