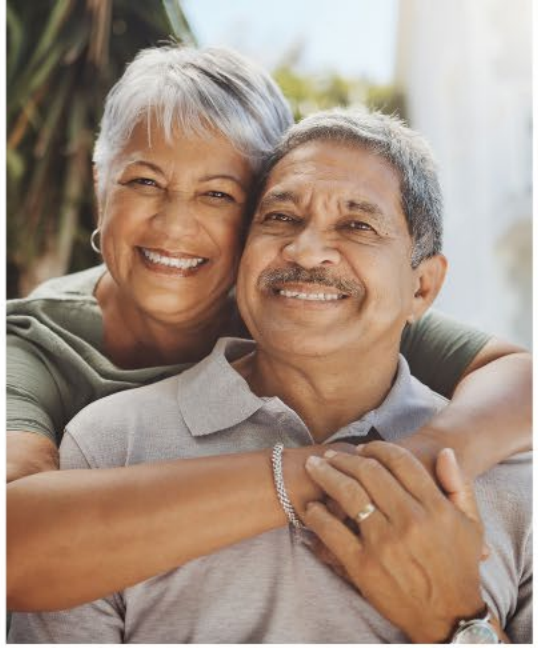


Alzheimer's Disease and Related Conditions Advisory Committee (ADRCAC)

August 6, 2026 | 10:00 a.m. – 1:00 p.m.

CalHHS
California Health & Human Services Agency

CALIFORNIA ALL

Welcome & Meeting Operations

Carroll De Andreis

Manager, Master Plan for Aging (MPA), Stakeholder Engagement
California Department of Aging (CDA)

Meeting Operations

- **Join by smart phone, tablet, or computer:**
  https://aging-ca-gov.zoom.us/j/86928406112

  Join by phone (audio only):
  Tel: (888) 788-0099 | Meeting ID: 869 2840 6112

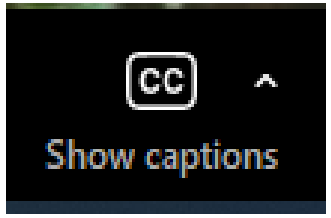
- **Meeting slides and recording** will be posted to the CalHHS Alzheimer's Disease & Related Conditions Advisory Committee webpage

Accessibility

American Sign Language (ASL) interpretation is provided.

Closed Captioning is available during this meeting.

To initiate Closed Captioning (CC):



1. Click the CC icon on the Zoom toolbar
2. Click “Show captions” to display spoken meeting content as text
3. Click “View full transcript” to review previous caption text

If the CC icon does not appear on your toolbar select “More” then select “Captions” and begin at Step 1 above.

Safety and Evacuation for In-Person Meeting Attendees

- In the event of an evacuation order, evacuate the building immediately and remain with a CDA staff member.
- Proceed to the nearest stairwell/main stairway.
- Proceed to the primary relocation site – in front of 2890 Gateway Oaks (building located southwest of the meeting building).
- If the primary relocation is compromised, you will be directed secondary relocation site.
- A CDA staff member is available to support individuals needing evacuation assistance.

Virtual Meeting Operations

- The chat function is enabled for Committee Members, California Department of Aging and other state staff, and invited guests to share meeting-related resources and information. The public will be able to view content in the chat during the meeting.
- We invite the public to provide comments. Please hold comments until the designated Public Comment period(s).
- Additional public comments and questions can be posted in Zoom using the Question & Answer feature or sent via email to Engage@aging.ca.gov.

Public Comment

Time is reserved on the meeting agenda for public comment.

- **In-Person Comments**: Raise your hand or let the designated CDA staff member know you want to make a public comment.
- **Verbal Comments**: “Raise your hand” in the Reactions feature of Zoom or press *9 on your phone dial pad to enter the line for a verbal comment. The moderator will unmute your line and announce your name or the last 4 digits of your phone number.
- **Written Comments**: You may submit comments throughout the meeting using the Zoom Q&A or email Engage@aging.ca.gov.

Note: Public commentors will each have 2 minutes.

Welcome, Introductions & Meeting Minutes

Dr. Wynnelena Canlas Canio

Committee Chair

Behavioral Health Representative

Meeting Agenda

10:00 a.m. | Welcome and Meeting Operations
10:05 a.m. | Call to Order: Welcome, Introductions, & May 2026 Minutes
10:15 a.m. | Opening Remarks from CDA Director
10:20 a.m. | Early Detection and Better Outcomes
11:30 a.m. | 2026 Alzheimer's Disease Facts and Figures Report
11:50 a.m. | Break
12:05 p.m. | California Department of Public Health Update
12:15 p.m. | Legislative Updates
12:30 p.m. | Public Comment
12:40 p.m. | Finalize Recommendations for CalHHS Agency Secretary
12:55 p.m. | Closing Comments, Upcoming Meeting Dates, & Next Steps
1:00 p.m. | Adjourn

ADRCAC Member Introductions

Committee Chairs

- **Dr. Wynnelena Canlas Canio**, *Kaiser Permanente, Behavioral Health Rep. (Chair)*
- **Carlos Olivas III**, *Family Member Rep. (Vice Chair)*

Committee Members

- **Senator Jesse Arreguín Rep.**, *Senate Rules Committee Appointee*
- **Sally Bergman**, *Elder Law Rep.*
- **Claire Day**, *Alzheimer's Association, Consumer Organization Rep.*

ADRCAC Member Introductions (cont.)

- **Dr. Sarah Tomaszewski Farias**, *Alzheimer's Disease Diagnostic & Treatment Centers Rep.*
- **Tony Gonzales,** Advocate, *Persons Living with Alzheimer's or Related Conditions Rep.*
- **Dr. Jerry Jew,** *North-East Medical Services, Organization Providing Services to Persons Living with Alzheimer's or Related Conditions Rep.*
- **Barbra McLendon**, *Alzheimer's Los Angeles, Service Provider Rep.*
- **Dr. Jeanine Lynn Walter-Misirli**, *Kaiser Permanente, Family of Persons Directly Affected by Alzheimer's Disease or Related Conditions Rep.*

ADRCAC Member Introductions (cont.)

- **Dr. William Mobley**, *UC San Diego, Academic Medical Research Rep.*
- **Munir Moon**, *CEO, Persons Living with Alzheimer's or Related Conditions Rep.*
- **Stephanie Navarette**, *Organization providing services to persons living with Alzheimer's or Related Conditions Rep.*
- **Assemblymember Gail Pellerin,** *Speaker of the Assembly Appointee*

ADRCAC Member Introductions (cont.)

- **Celine Regalia**, *Providence Community Health Napa Valley, Alzheimer's Day Care Resource Center Rep.*
- **Kate Schulenberg**, *San Joaquin Commission on Aging, Family of Persons Directly Affected by Alzheimer's Disease or Related Conditions Rep.*
- **Julie Souliere**, *California Health & Human Services Agency Rep.*
- **Dr. Dolores Gallagher Thompson**, *Stanford University, Social Research Rep.*
- **Dr. Lindsey Yourman,** *California Commission on Aging Rep.*

ADRCAC Member Recruitment Update

California Health and Human Services Agency is seeking to fill vacancies including:

- Individuals and organizations that represent first responders (emergency medical technicians (EMTs), paramedics, law enforcement, and firefighters).

- Online Application for ADRCAC Member

Committee Question & Answer, and Discussion

Opening Remarks

Susan DeMarois

Director

California Department of Aging (CDA)

Early Detection & Better Outcomes
Part I: Dementia Care Aware

Danielle Taylor, MBA

Director of Program Operations, Dementia Care Aware,
University of California San Francisco (UCSF)

Josette Rivera, MD

Professor of Medicine/Clinician Educator

UCSF Division of Geriatrics

DEMENTIA Care Aware

Early detection. Better care.

Advancing Brain Health Through Better Care

Presenters:
Danielle Taylor, MBA
Director of Program Operations, Dementia Care Aware

Josette Rivera, MD
Professor of Medicine, UCSF Division of Geriatrics

UCSF westhealth

The Challenge for Early Detection

Screening is not currently routine: Many people with cognitive decline go undetected until later stages, limiting treatment options

Provider constraints: Overloaded visits make it hard to add anything new to routine care

Limited dementia training: Primary care teams under diagnose
due to lack of confidence, practical training, and clear workflows

Specialist shortages: Long wait times and unequal access to specialty dementia care, especially in rural and underserved areas

Delayed diagnosis: Leads to higher costs, greater caregiver strain,
and **crisis-driven care** (ED visits, etc.)

DEMENTIA Care Aware westhealth UCSF

Dementia Care Aware (DCA) Vision and Mission

VISION

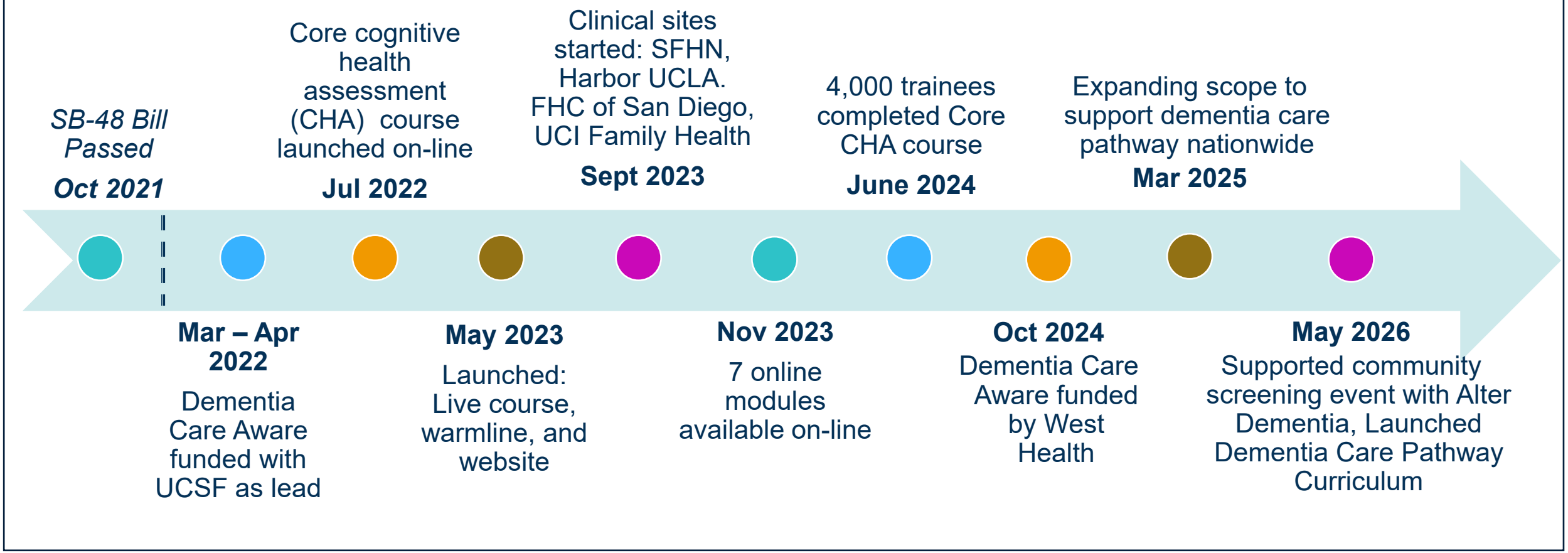
Every older adult who goes to primary care has a health care team that is confident in preventing, detecting, diagnosing, and treating dementia.

MISSION

Provide the tools, support, and education needed to transform dementia care.

Dementia Care Aware

Program Timeline



DEMENTIA Care Aware westhealth UCSF

What Dementia Care Aware Offers

Available resources for all primary care teams

EDUCATION AND TRAINING

- Live training
- Online modules
- Webinars & Podcasts

WARMLINE CONSULTATION

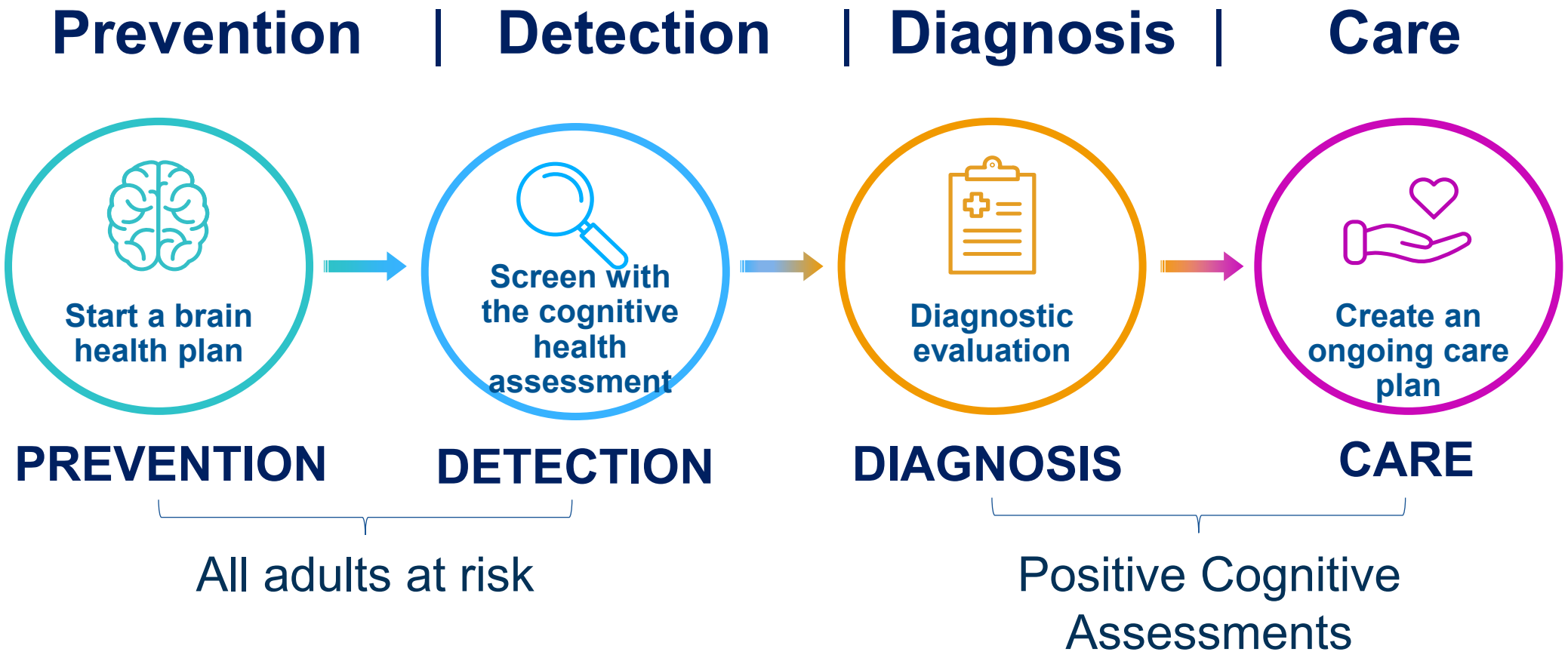
1-800-933-1789

Primary Care support and consultation service staffed by dementia experts

IMPLEMENTATION SUPPORT

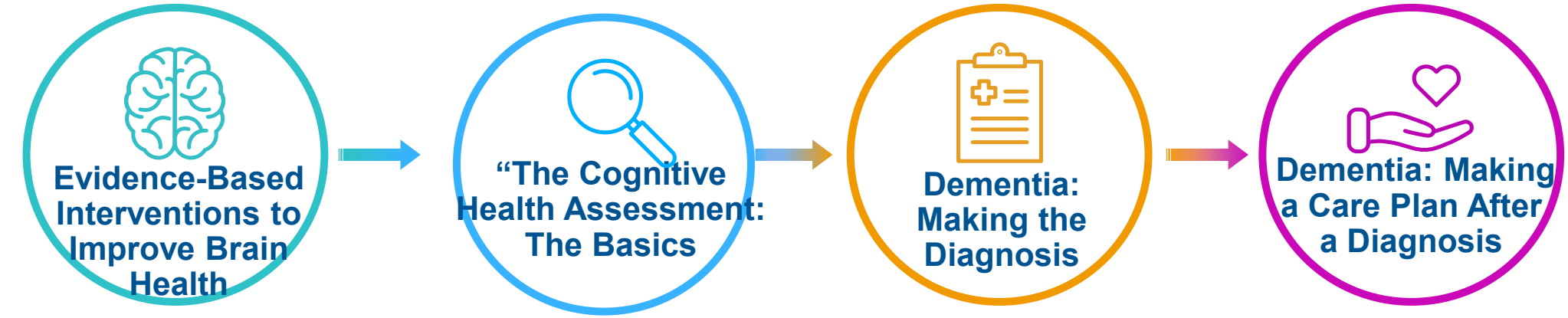
- Tailored training
- Implementation support
- Impact analysis

The Dementia Care Aware Clinical Pathway



The Dementia Care Aware Clinical Pathway: Courses

Prevention | Detection | Diagnosis | Care



All adults at risk

Positive Cognitive Assessments

DCA Trained Primary Care Teams Across CA

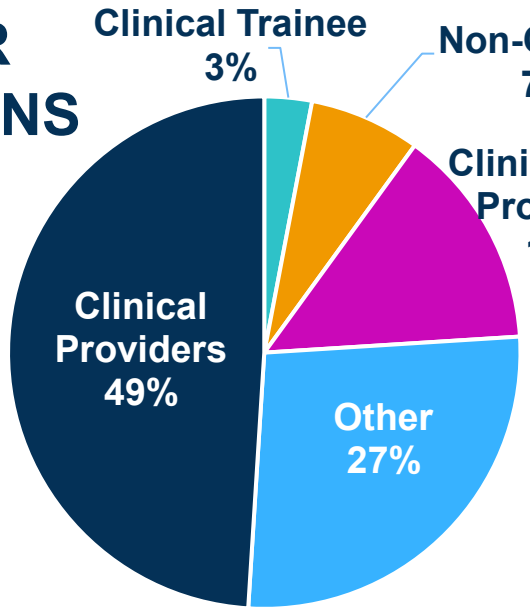
"The Cognitive Health Assessment: The Basics" Remains Our Core Course

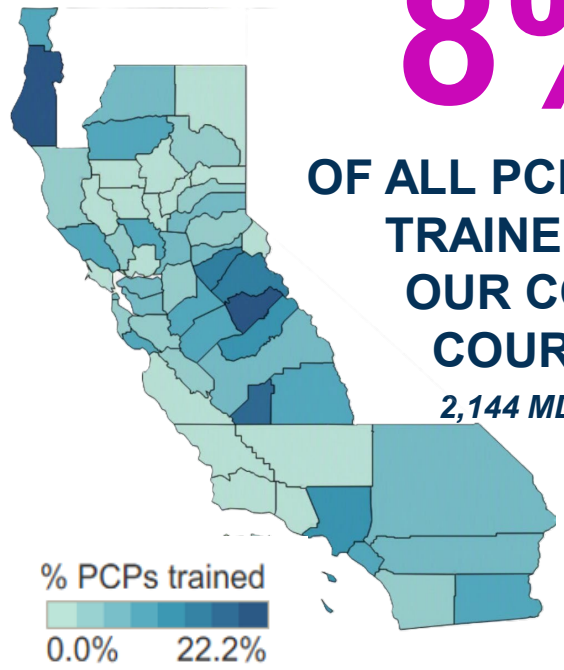
8,684

INDIVIDUALS TRAINED IN CALIFORNIA

90% of which completed our core course on screening

LEARNER OCCUPATIONS





8%

OF ALL PCPS IN CA TRAINED ON OUR CORE COURSE

2,144 MDs, 1,461 NPs, and 222 PAs

Data from July 2022 – June 2026

Our Training Increased Knowledge in Learners

Results from Our Learner Evaluations for our “The Cognitive Health Assessment: The Basics” Course

INCREASED KNOWLEDGE

91%

of respondents

Reported that the training increased their knowledge about dementia care

RELEVANT TO CLINICAL PRACTICE

87%

respondents

Reported that the training was relevant to their practice

INCREASED CONFIDENCE TO CHANGE PRACTICE

74%

of respondents

of learners intend to change their practice and apply what they learned to patient care

Training evaluation responses from July 2022 – June 2026
N= 2,593 (for the main group surveyed)

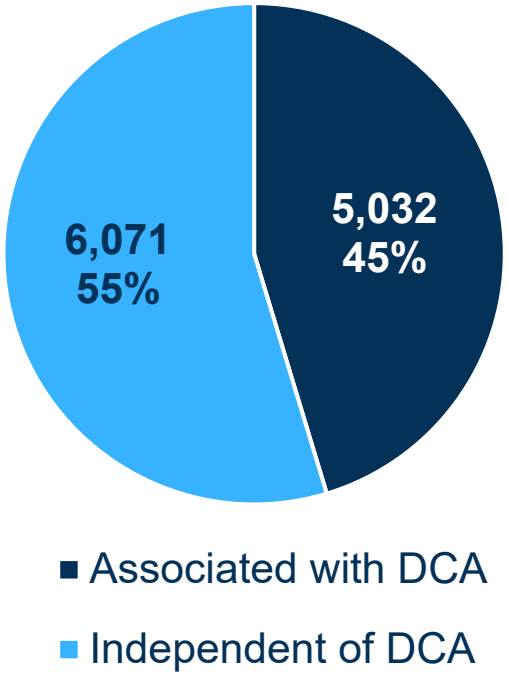
Cognitive Health Assessments are Taking Hold

As seen by billing activity, the associated 1494F Medi-Cal code

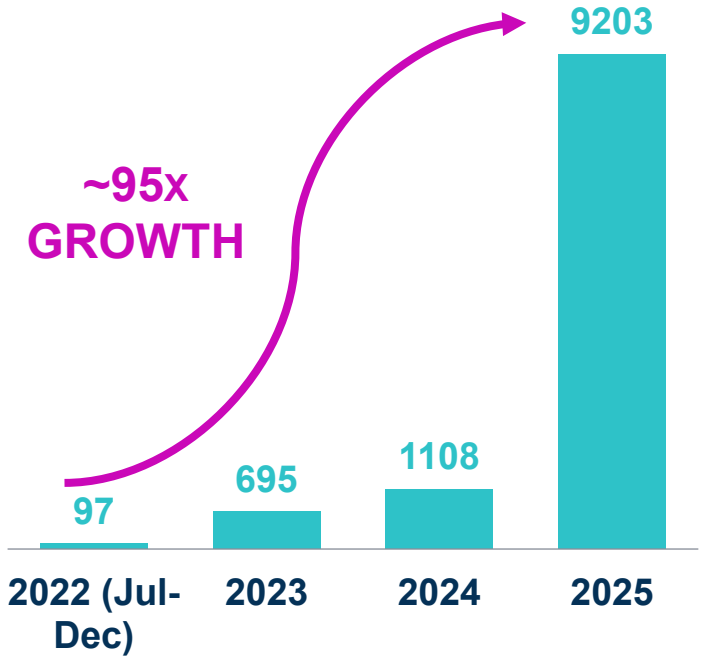
CHA'S COMPLETED WITH 1494F CODE

11,100

1494F CHA SCREENS



BILLING CODE USAGE PER YEAR

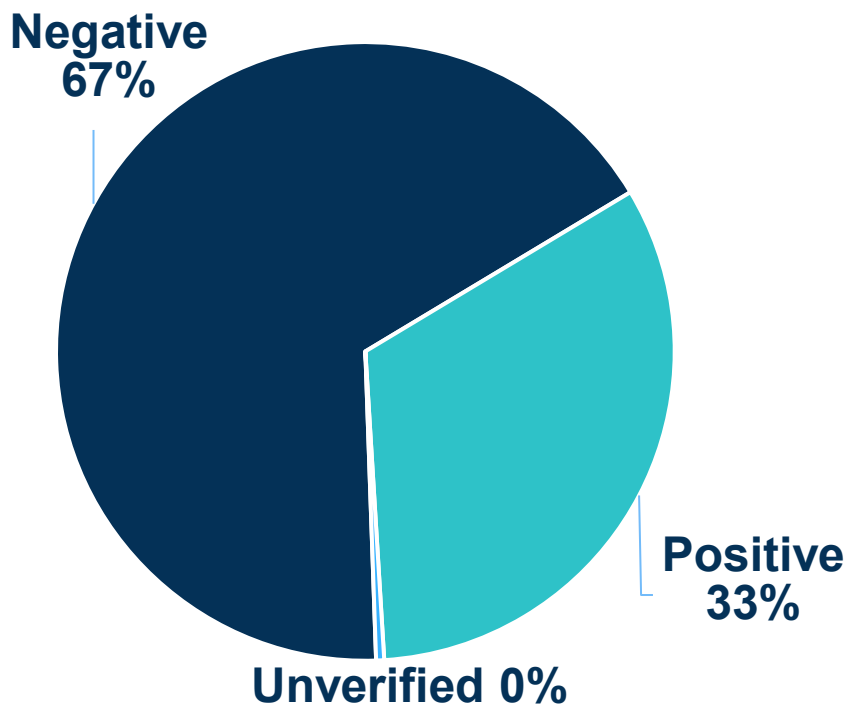


1494F billing records from July 2022 – December 2025

DEMENTIA Care Aware · westhealth · UCSF

Case Study: Implementing the CHA at LA DHS
Results and Impact

- **800+ CHA screens completed** (May 2023 - March 2024).
- **16% of eligible patients screened** at pilot sites.
- Able to more effectively report on screens and outcomes, going from no reportable data to robust reports.
- These reports identified more positive patients than originally expected, underscoring the need for a screening program
- Patients who screened positive saw benefits like additional workups, timely diagnoses, and the opportunity to do advanced care planning.
- Following the pilot, the team was able to make a case for integrating CHA training into system-wide training protocols, and create a Cerner tool to standardize data collection.



The Next Phase of DCA

- DCA is a part of HCAI's Rural Health Transformation Initiative, providing training, webinars, ECHOs, warmline, implementation support to rural CA practices

CALIFORNIA RURAL HEALTH TRANSFORMATION

- Continue implementation support focused on California FQHCs to maximize policy momentum at the state level.
- Training extends nationally as a standard model for education across the US

Thank you!

For more information please contact:

Danielle.Taylor2@ucsf.edu

DEMENTIA Care Aware

westhealth

Part II: National Task Group on Intellectual Disabilities and Dementia Practices (NTG) Screening for Dementia in Adults with Intellectual and Developmental Disabilities (I/DD)

Lucille Esralew, PhD

Senior Psychologist Supervisor at California Department of Developmental Services (DDS)

Early Screening For Dementia And IDD

Presenter:
Lucille Esralew, PhD
Senior Supervising Psychologist

August 6, 2026

DDS Department of Developmental Services

Photo by Chona Kasinger, from Disabled and Here

Agenda

- Introduce the use of the ***NTG-EDSD*** as a tool to aid team decision-making

- Provide considerations for the use of findings from the ***EDSD*** to advance conversation about planning services, supports and seeking healthcare for individuals served with suspected dementia

Early Detection of Dementia

Why Do We Need A Different Screen For Early Detection of Dementia?

- Professionals may have expertise in the evaluation of neurocognitive disorders
    - However, family members and staff who know the individual are in the best position to notice important changes
- Standard screens for dementia are not useful for individuals with IDD
- Individuals with intellectual disability need to be assessed by recognizing significant change from their own baseline functioning

Importance Of Baseline

- When we measure “baseline,” we are identifying someone’s usual or typical behaviors or functioning.
- This helps us recognize when a person may be changing in their usual, typical behaviors and skill sets.
- By identifying what is changing and what remains the same, we have a better idea of how to tailor services, care, and support.

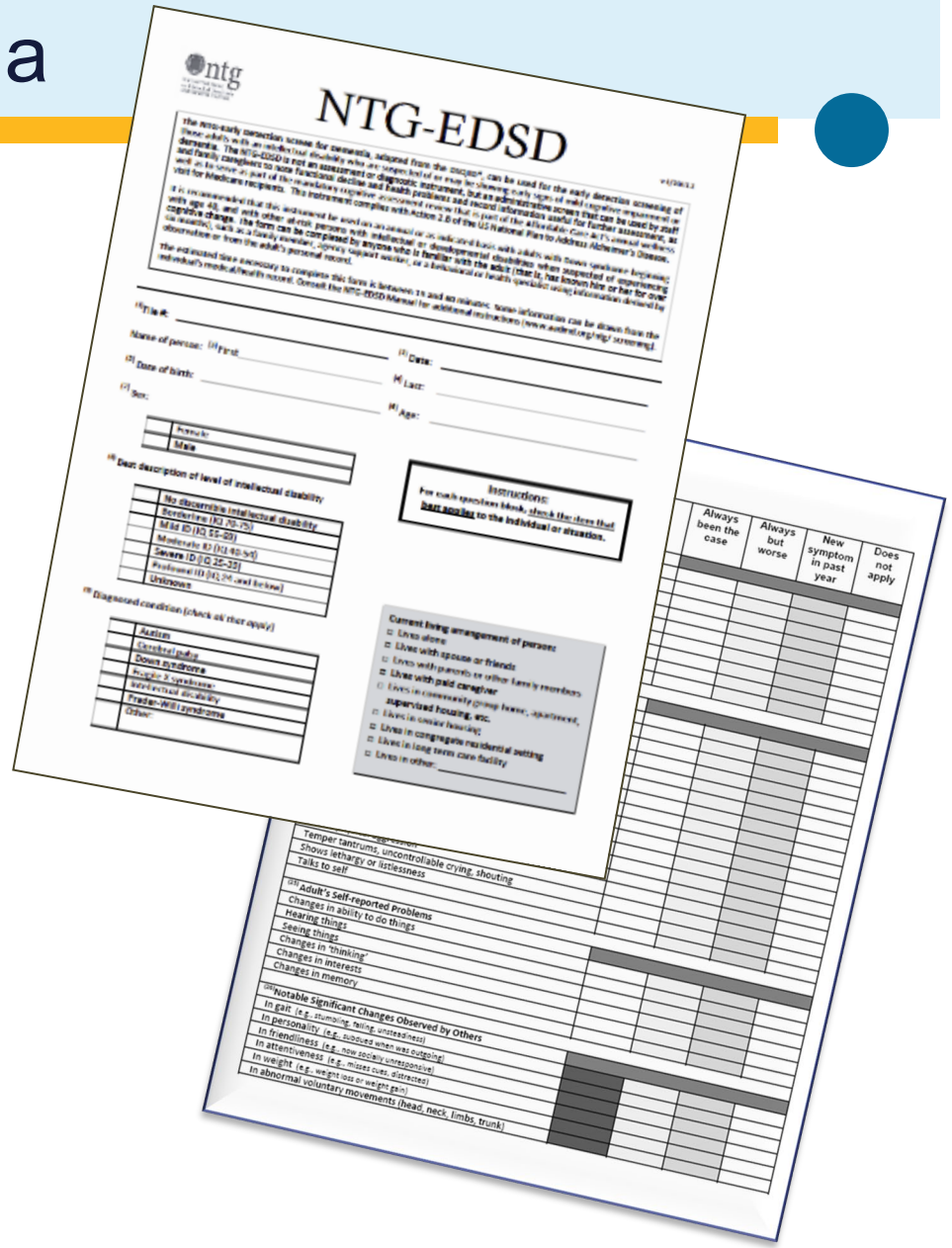
What Might We Observe…

- When we consider someone's baseline, we are talking about what is ***typical*** or ***usual*** for the person in terms of memory, thinking, behavior and ADLs
- David ***usually*** remembers staff names and is good about following up on his work routines and is independent in his ADLs
- If David cannot learn the names of new staff members and refers to them by names of staff who have long-ago left the workplace, has difficulty completing previously mastered skills, and now needs support in showering and toileting, we would say he is displaying a ***departure or change from baseline***

Early Detection Screen For Dementia

National Task Group on Intellectual Disabilities and Dementia Practices Early Detection Screen for Dementia (NTG EDSD)

- Completed by support staff, family and others to note the presence of key behaviors and signs associated with dementia
- Picks up on health status, ADLs, behavior and function, memory, self-reported concerns
- Available in multiple languages



www.the-ntg.org

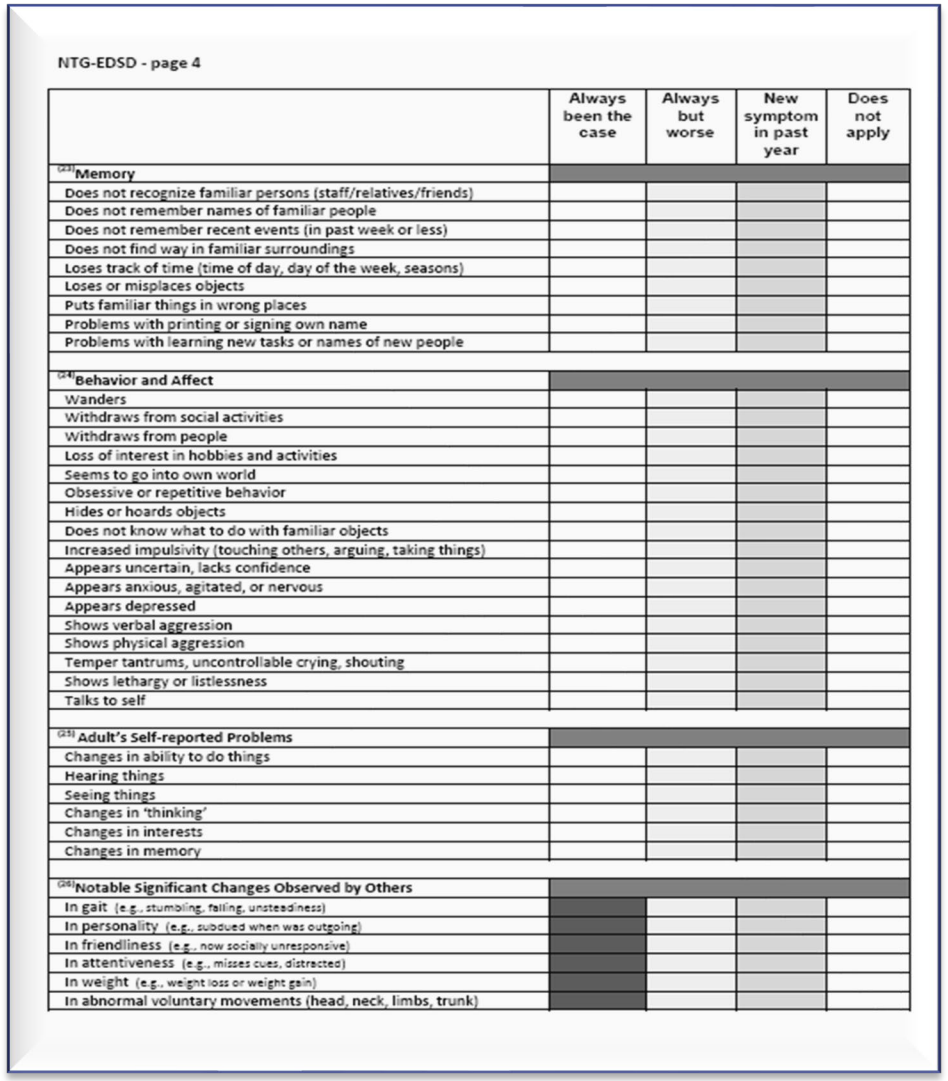
Completing The NTG-EDSD – Tips for Raters

Who: Should be completed by someone who is familiar with the individual. This is an *administrative tool* and not a clinical screen. It is best completed by whomever has everyday knowledge of the individual whose functioning is being rated

Where: If the individual attends day program, it may be helpful for the staff at day program to complete a separate record form or the day program's staff can be included in the completion of one rating instrument by providing input to family or residential support staff completing a form

What: Gather medical and other chart materials to fill out some of the questions pertinent to medical and mental health status changes

Tips For Completing The NTG-EDSD



NTG-EDSD - page 4

	Always been the case	Always but worse	New symptom in past year	Does not apply
[22] **Memory**				
Does not recognize familiar persons (staff/relatives/friends)				
Does not remember names of familiar people				
Does not remember recent events (in past week or less)				
Does not find way in familiar surroundings				
Loses track of time (time of day, day of the week, seasons)				
Loses or misplaces objects				
Puts familiar things in wrong places				
Problems with printing or signing own name				
Problems with learning new tasks or names of new people				
[24] **Behavior and Affect**				
Wanders				
Withdraws from social activities				
Withdraws from people				
Loss of interest in hobbies and activities				
Seems to go into own world				
Obsessive or repetitive behavior				
Hides or hoards objects				
Does not know what to do with familiar objects				
Increased impulsivity (touching others, arguing, taking things)				
Appears uncertain, lacks confidence				
Appears anxious, agitated, or nervous				
Appears depressed				
Shows verbal aggression				
Shows physical aggression				
Temper tantrums, uncontrollable crying, shouting				
Shows lethargy or listlessness				
Talks to self				
[23] **Adult's Self-reported Problems**				
Changes in ability to do things				
Hearing things				
Seeing things				
Changes in 'thinking'				
Changes in interests				
Changes in memory				
[26] **Notable Significant Changes Observed by Others**				
In gait (e.g., stumbling, falling, unsteadiness)				
In personality (e.g., subdued when was outgoing)				
In friendliness (e.g., now socially unresponsive)				
In attentiveness (e.g., misses cues, distracted)				
In weight (e.g., weight loss or weight gain)				
In abnormal voluntary movements (head, neck, limbs, trunk)				

NTG-EDSD

- If possible, have the same rater fill out the EDSD every year or quarterly, if necessary, until a diagnosis is confirmed
- Mark/highlight items about which you are unsure to check in with other members of the team
- Share the ratings with your supervisor or designated staff for team review
- Summarize findings for the individual's health care provider

Capturing Observations Of Change

- The assessment of dementia depends upon **observation**
- For older adults without IDD, there are tests that can yield information about change (particularly decline) from age-relevant behaviors and thinking skills which may signal dementia
- There are very few assessments that provide similar **information about change** pertinent to detection of dementia for individuals with IDD, and little consensus about use of those tests that do exist
- Health care practitioners depend upon collateral information from family members and staff who know the individual and can recognize changes from **baseline functioning**

What Changes Might We Observe In Adaptive Skills?

Changes in ADLs: Activities that supports daily living

- Incontinence
- Balance and gait problems
- Apraxia- dressing, feeding, speaking
- Increased dependence upon assistance for bathing and grooming

Changes in IADLs: Activities that support independent living

- Difficulty handling money (if this was previously a skill)
- Difficulty maintaining one's own space
- Difficulty shopping or cleaning (if these have been skills within the person's repertoire)
- Difficulty using the phone or other devices

What Changes Might We Observe In Behavior?

- Increased impulsivity: hoarding, verbal and physical aggression
- Increased reactivity to others
- Social behavior not matched to social situation
- Increased restlessness and agitation

What Changes Might We Observe In Cognition?

- Memory changes that interfere with productivity at work or chores at home
- Problems maintaining focused attention, highly distractible
- Difficulty adapting to change (learning new information)
- Difficulty in everyday problem solving
- Language skills may become impoverished

Always Been The Case…

Pages 3-4

What do we mean by "*always been the case*"?

Kenan has always needed help bathing

It has always been the case that he does not initiate conversations

He always sleeps excessive amounts

By choosing "always been the case," you are indicating this is usual for the person and there has been no change

Always The Case But Worse…

Pages 3-4

What do we mean by “always the case but worse”?

Rose has previously needed verbal prompts to complete showering and now she needs hand-over-hand assistance

Rose has mobility support needs; she previously used a walker, and now needs a wheelchair for anything further than short distances

She previously needed her food cut up for her, but now she can only eat finger food

***By choosing “always been the case but worse” you are indicating the person has lost more skills and is less independent with an activity of daily living for which she has needed support, the situation has gotten worse*.**

New Symptom

Pages 3-4

What do we mean by choosing “new symptom”?

Walt has episodes of incontinence which began 3 months ago.

Walt has become lost while walking home from his program twice within the past 6 months

He cannot remember the name of his new staff and began calling the new staff by the name of a worker who has not been at the home for several years.

By choosing “new symptom” you are indicating that this was not a concern observed during last assessment but is a concern now and is a new sign of change

Does Not Apply

Pages 3-4

What do we mean when we choose the rating “does not apply”?

- Joy does not need assistance in showering
- She does not need assistance in dressing
- Joy may have episodes of mild forgetfulness, but this does not interfere with her work or daily activities

By choosing “does not apply” we are indicating that this is an area in which Joy does not have a concern

Page 5-Chronic Health Conditions

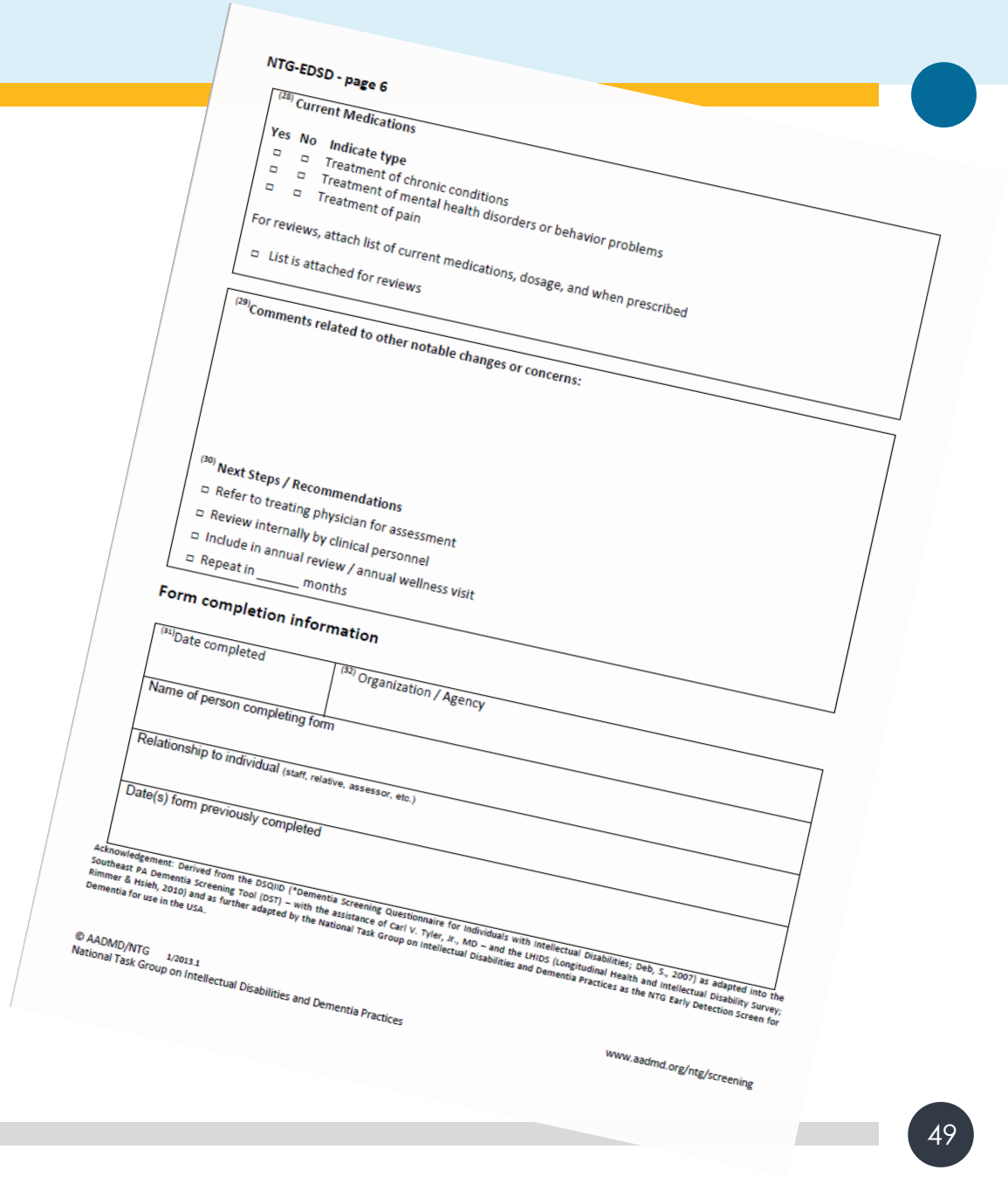
On Page 5, you will see a list of health conditions

You are asked to indicate the following for each:

- Recent condition (past year)
- Condition diagnosed in the last 5 years
- Lifelong condition
- Condition not present

Page 6

- Gather information regarding the person's current medication, dosage, and when prescribed
- Background information
- Other changes observed but not covered in the rating form? This is your opportunity to share what you have observed.
- Next Steps



NTG-EDSD - page 6

(28) Current Medications

Yes No Indicate type
- ☐ ☐ Treatment of chronic conditions
- ☐ ☐ Treatment of mental health disorders or behavior problems
- ☐ ☐ Treatment of pain

For reviews, attach list of current medications, dosage, and when prescribed

☐ List is attached for reviews

(29) Comments related to other notable changes or concerns:

(30) Next Steps / Recommendations
- ☐ Refer to treating physician for assessment
- ☐ Review internally by clinical personnel
- ☐ Include in annual review / annual wellness visit
- ☐ Repeat in _____ months

Form completion information

(31) Date completed | (32) Organization / Agency

Name of person completing form

Relationship to individual (staff, relative, assessor, etc.)

Date(s) form previously completed

Acknowledgement: Derived from the DSQIID (*Dementia Screening Questionnaire for Individuals with Intellectual Disabilities; Deb, S., 2007) as adapted into the Southeast PA Dementia Screening Tool (DST) – with the assistance of Carl V. Tyler, Jr., MD – and the LHIDS (Longitudinal Health and Intellectual Disability Survey; Rimmer & Hsieh, 2010) and as further adapted by the National Task Group on Intellectual Disabilities and Dementia Practices as the NTG Early Detection Screen for Dementia for use in the USA.

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National Task Group on Intellectual Disabilities and Dementia Practices

www.aadmd.org/ntg/screening

Sharing Findings With Members Of The IDT

- Discuss observations captured through ***EDSD*** ratings within the IDT/MDT
- Reconcile any discrepancies across settings
- Request additional information, if necessary
- Brainstorm possible approaches
- Operationalize a plan of action
- Is it time to refer to the HealthCare Provider or other professionals?
- Evaluate the effectiveness of the plan

Use The Tool To Detect Patterns

- Look for patterns
- What are areas in which change has been noted?
- What is the extent of change?
- Is something being done to currently address identified issues?

Considerations For Using The *NTG-EDSD*

- This tool is not used for the diagnosis of dementia
- This is an administrative and not a clinical rating instrument
- The diagnosis of a neurocognitive disorder involves medical exam and direct cognitive and adaptive testing of the individual in question
- If the individual is already known to have a neurocognitive disorder, you can still use the rating form to baseline observations of change but do not need to continue using if the person has been formally diagnosed with neurocognitive disorder

Take Home Messages

- Family and staff are in the best position to recognize everyday changes in memory, thinking, behavior skills and ADLs for the people whom they know and support
- The ***NTG-EDSD*** is an administrative screening tool that can be used to capture information about observed changes in functioning of individuals with IDD
- Findings from the ***EDSD*** can aid and promote healthcare advocacy
- Findings can be shared with members of the Interdisciplinary Team and with Health Care Providers to make decisions about services, supports and treatments

Curriculum


Official website of the State of California
DDS Department of Developmental Services
Search
Individuals & Families
Services
Regional Centers
Vendors
Initiatives
Transparency
About
Home / Initiatives / Employee Development, Gro...
Employee Development, Growth, and Education (EDGE)
For questions, please email: EDGE@dds.ca.gov
EDGE is the Department's new online learning system where all Department training is stored and shared in one easy to find place, including the new DSP University. The name "EDGE" stands for employee development, growth, and education. EDGE helps learners take classes, complete assigned courses, and keep track of their trainings. As the system grows, EDGE will continue to serve as a central resource for regional centers, Department staff, Direct Support Professionals (DSPs), and community members.
DSPU DIRECT SUPPORT PROFESSIONAL UNIVERSITY
DSP University (DSPU)
DSP University is a training
Enroll in EDGE
DSPs can create an EDGE
EMPLOYEE DEVELOPMENT, EDGE GROWTH, AND EDUCATION
Log-in to EDGE
After you have created an EDGE

References

- Ryan, Margaret; Tuso, Allison; and Herge, OTD, Adel, "Usefulness of the NTG-EDSD: Evaluating the Validity of a Screening Tool for Dementia in Adults with Intellectual Disabilities" (2021). *Doctor of Occupational Therapy Program Capstone Presentations.* Paper 22. https://jdc.jefferson.edu/otdcapstones/22
- Silverman W, Krinsky-McHale SJ, Lai F, Diana Rosas H, Hom C, Doran E, Pulsifer M, Lott I, Schupf N; Alzheimer's Disease in Down Syndrome (ADDS) Consortium. Evaluation of the National Task Group-Early Detection Screen for Dementia: Sensitivity to 'mild cognitive impairment' in adults with Down syndrome. J Appl Res Intellect Disabil. 2021 May;34(3):905-915. doi: 10.1111/jar.12849. Epub 2020 Dec 13. PMID: 33314467; PMCID: PMC8356176.

References (Cont'd)

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Q&A

Part III: Guiding an Improved Dementia Experience (GUIDE) Model

Cheryl Brunk

Health Systems Director

Alzheimer's Association

Alzheimer's Association GUIDE Model Presentation

August 6, 2026

ALZHEIMER'S ASSOCIATION®

Ideal Patient Journey from Awareness of Cognitive Issues to Dementia Care Navigation

Memory Concerns

A person notices some changes to their memory and thinking and has some concerns

Conversation with PCP

Discusses with PCP who assesses medical history, conducts physical and cognitive tests as well as lab tests

Referral to Specialist

Suggestion of MCI on tests leads to referral to a dementia specialist who conducts further evaluations

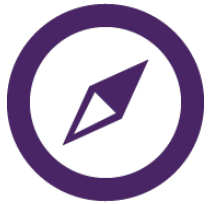
Biomarker Testing

Diagnostic biomarker testing and brain imaging are recommended after MCI confirmation

Treatment

Treatment options are discussed if beta-amyloid is confirmed by biomarker testing. Treatment is scheduled and monitored.

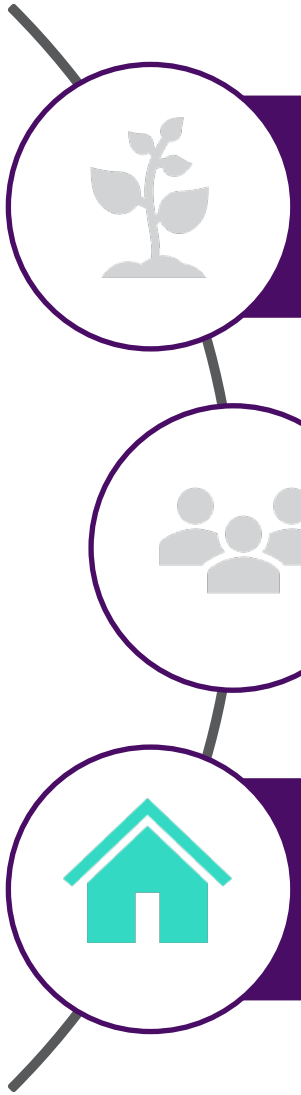
Dementia Care Navigation



Provide a quality evidence-based dementia care model and ongoing caregiver support ongoing

What is Guiding an Improved Dementia Experience (GUIDE) Model

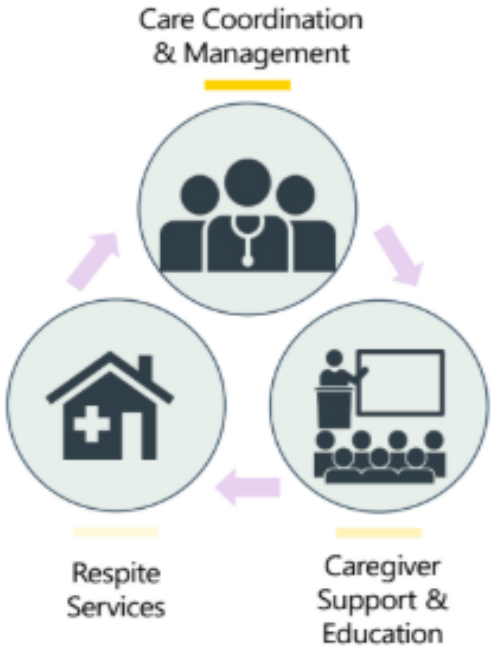
GOALS



- Improve the quality of life for people living with dementia
- Enhance support for caregivers of people living with dementia
- Help people living with dementia stay in their homes and communities longer

Model Purpose and Overview

The GUIDE Model is testing whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.



Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support.**

Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

Respite Services

GUIDE participants will be eligible to receive payment for respite services, up to a cap of **$2,500 per year per beneficiary,** for qualifying beneficiaries. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

CMS

GUIDING AN IMPROVED DEMENTIA EXPERIENCE

Care Delivery Requirements

Participants must provide specified services across the domains outlined below. Participants will tailor the exact mix of services based on each beneficiary's individual care plan.

COMPREHENSIVE ASSESSMENT
Beneficiaries and caregivers receive separate assessments to identify their needs and a home visit to assess the beneficiary's safety.

CARE PLAN
Beneficiaries receive care plans that address their goals, preferences, and needs, which helps them feel certain about next steps.

24/7 ACCESS
Beneficiaries and caregivers have 24/7 access to a member of their care team or help line (may be a 3rd party vendor during off-duty hours).

ONGOING MONITORING & SUPPORT
Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time.

REFERRAL & SUPPORT COORDINATION
Beneficiaries' care navigator connects them and their caregivers to community-based services and supports.

CARE COORDINATION & TRANSITION
Beneficiaries receive timely referrals to specialists to address other health issues, such as diabetes, and the care navigators coordinate with specialist.

RESPITE SERVICES
Eligible beneficiaries with caregivers may receive GUIDE respite services.

MEDICATION MANAGEMENT
Clinician reviews and reconciles medication as needed.

CAREGIVER EDUCATION & SUPPORT
Caregivers are given education and support via ad hoc calls and caregiver training.

CMS

GUIDING AN IMPROVED DEMENTIA EXPERIENCE

Why It Matters

Aligns with the Alzheimer's Association's mission to improve lives through real-world care

Opens doors for partnerships with health systems

Supports better outcomes for patients and caregivers

Encourages system-wide adoption of dementia care best practices

GUIDE Model Eligibility

✅ Who Is Eligible?

- Enrolled in Medicare Part A and B
- Has a diagnosis of dementia

❌ Who Is Not Eligible?

- Enrolled in Medicare Advantage
- On hospice care
- Participating in a PACE program
- Living in a long-term nursing home community

💡 **Patients who enroll in GUIDE have no out-of-pocket cost.**

The Role of the Alzheimer's Association

- Works with health systems to identify GUIDE participants in the area
- Works with health systems to develop dementia care navigation programs.
- Supports patients not eligible for the CMS GUIDE program
- Provides training, tools, and resources to care teams

Summary

The CMS GUIDE Model is a transformative step in dementia care and the Alzheimer's Association can help health systems adopt the model.

The Alzheimer's Association complements GUIDE by supporting broader access to care navigation

Together, we are reshaping the dementia care landscape

What about the rest of my patients?

How We Help

24/7 Helpline

The Alzheimer's Association 24/7 Helpline (800.272.3900) is available around the clock, 365 days a year, free of charge, offering confidential support and information to people living with dementia, caregivers, families and the public.

Free Education & Support

Find dementia and aging-related resources such as support groups that connect individuals facing dementia at alz.org.

DEMENTIA CARE NAVIGATION TRAININGS & SERVICE

COMMUNITIES

Association Community Based Resources, Support Groups and Education

ALZNAVIGATOR™ ALZHEIMER'S ASSOCIATION

ALZCONNECTED® ALZHEIMER'S ASSOCIATION

Education Center

24/7 Helpline

Community Resource Finder
ALZHEIMER'S ASSOCIATION AARP Family Caregiving

NEW Empowered Caregiver Education

Online Resources

PROFESSIONALS

Dementia Care Training Certification Products and DCN Roundtable

Project ECHO®

essentiALZ® ALZHEIMER'S ASSOCIATION

Dementia Care Navigator Training & Certification

ALZHEIMER'S® ASSOCIATION
Dementia Care Navigation Roundtable

Discussion & Questions

Part IV: Physician's Experience in Practice – Screening, Dedication, and Diagnosis

Dr. Wynnelena Canlas Canio

Committee Chair

2026 Alzheimer's Disease Facts and Figures Report

Claire Day

Chief Mission and Program Strategy Officer

Alzheimer's Association

2026 Alzheimer's Disease Facts and Figures Report

Claire Day
Chief Mission and Program Strategy Officer
Alzheimer's Association
Northern California Chapter

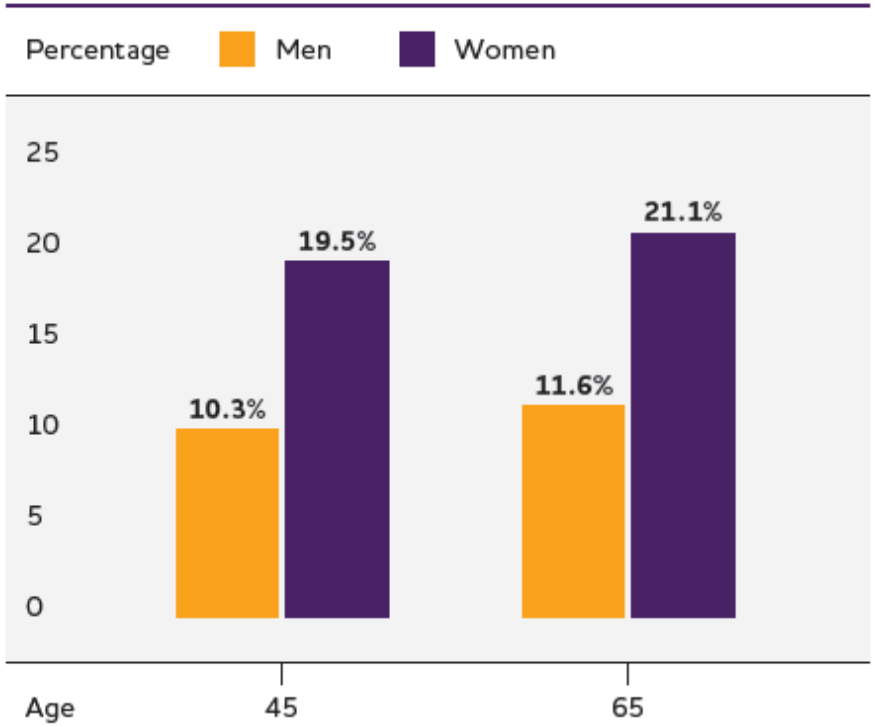
ALZHEIMER'S ASSOCIATION®

Key Takeaways: Main Report

- An estimated **7.4 million** Americans are living with clinical Alzheimer's dementia.
- Deaths due to Alzheimer's disease **more than doubled** between 2000 and 2024, increasing **134%**.
  - During this same period, deaths from heart disease - the leading cause of death in America - **decreased**.
- Nearly **13 million** Americans provided more than **19 billion hours** of unpaid care, valued at more than **$446 billion**.
- More than **772,00,000 more** direct care workers will be needed by 2034 to care for those living with dementia - more new workers than in any other single occupation in the United States.
- In 2025, the national cost of caring for people with Alzheimer's and other dementias is projected to be **$409 billion**.
  - By 2050, these costs could rise to nearly **$1 trillion**.

Population Differences in Alzheimer's Prevalence

Estimated Lifetime Risk for Alzheimer's Dementia, by Sex, at Ages 45 and 65



Created from data from Chene et al.[340]

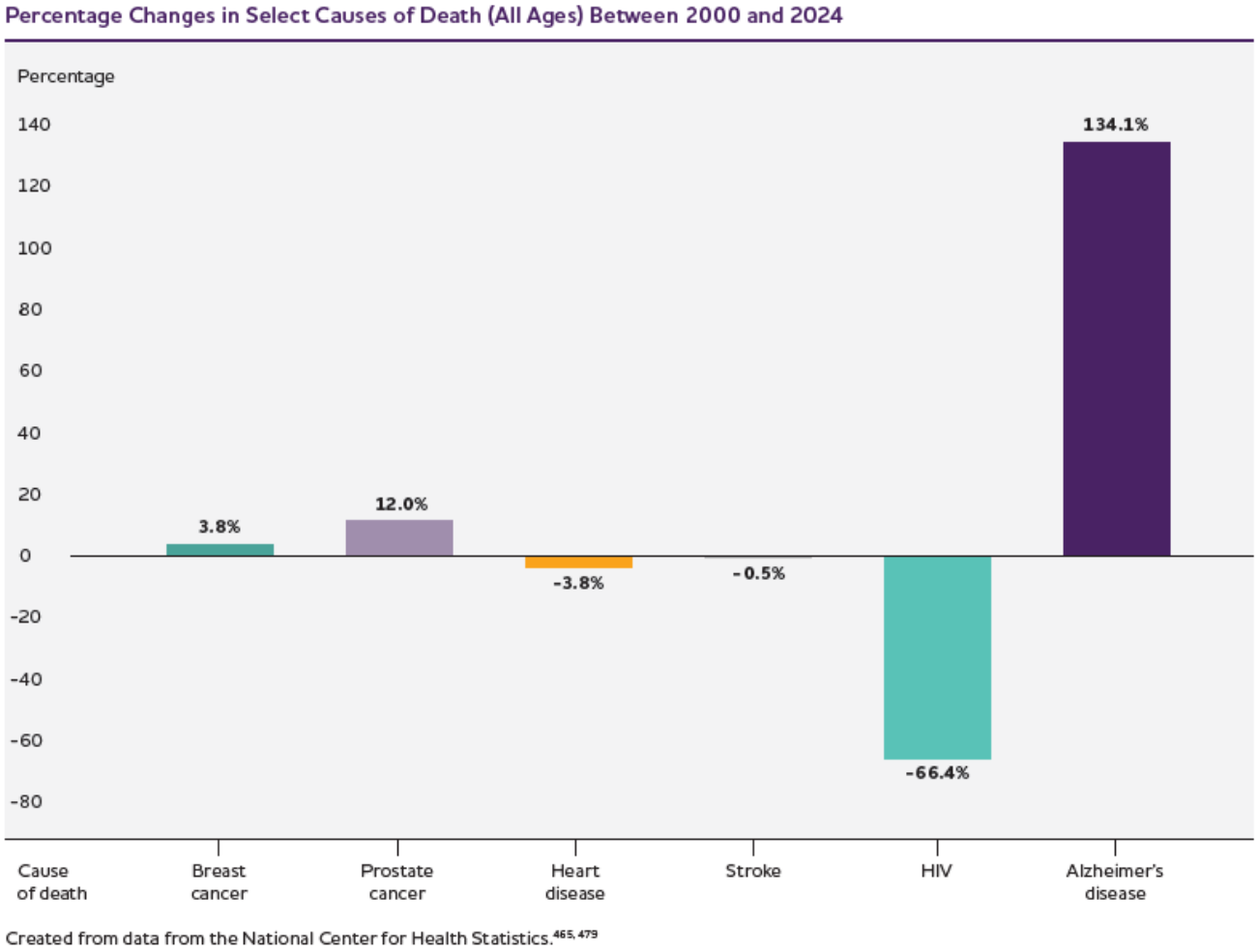
- **Almost two-thirds** of Americans with Alzheimer's are women.
- Older Blacks/African Americans and Hispanics/Latinos are **disproportionately more likely** than older non-Hispanic whites to have Alzheimer's or other dementias.
- **Population-based studies for other population groups are needed.**

Deaths Caused by Alzheimer's Disease

Alzheimer's is the **fifth**-leading cause of death for Americans 65+.

Between 2000-2024, Alzheimer's Deaths Increased by **134%.**

While deaths from the number 1 cause of death — heart disease — **decreased 3.8%.**



Slow and Burdensome Progression of Alzheimer's

- Alzheimer's disease begins 20 years or more before the onset of symptoms.
- People age 65+ survive an average of **four to eight years** after a diagnosis, yet some live as long as **20 years**.
- At age 80, approximately 75% of people with Alzheimer's dementia **live in a nursing home** compared with only 4% of the general population age 80.
- The long duration of the disease **contributes significantly to the public health impact** of Alzheimer's.

Caregiving

Nearly 13 million Americans
provide unpaid care for a family member or friend with dementia, a contribution to the nation valued at more than $446 billion.

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Unpaid Caregiving in the United States

- **83%** of care for older adults in the U.S. is provided by unpaid family members, friends, or other caregivers.
- **Nearly half (48%)** of caregivers are helping someone living with Alzheimer's or another dementia.
- More than 1 in 4 U.S. households and **nearly 40%** of extended families with an older adult include someone living with dementia.

Workforce

More than 772,000 additional direct care workers will be needed by 2034 – more new workers than in any other single occupation in the United States.

Dementia Care Specialists Shortage

The shortage of dementia care specialists is a barrier to timely and accurate diagnosis, delaying treatments, care delivery and supportive services.

- **55%** of PCPs caring for people living with Alzheimer's report there are **not** enough dementia care specialists in their communities.
- It is estimated that **34%** to **59%** of those age 65 years and older live in areas with potential dementia specialist shortfalls.
- **More than 14,000 geriatricians** will be needed to care for more than **10 million individuals** projected to have Alzheimer's dementia in 2050 — more than double the number of who were practicing in 2021.

Direct Care Workforce Shortage

- Direct care workers **play a vital role** in caring for people living with dementia in private homes, adult day services, residential care, skilled nursing homes and other settings.
- Between 2014 and 2024, direct care workers **increased from 3.5 million to 5.3 million**.
- Job growth reflects preference for “aging in place” and public policies expanding access to home and community-based services.
- Although sizable, these employment projections fall short of true workforce demand.
  - Turnover rates remain high — estimated at **79% annually** for direct care workers and **99%** for nursing assistants in nursing homes.

Use and Costs of Health Care, Long-Term Care and Hospice

In 2026, health and long-term care costs for people living with Alzheimer's and other dementias are projected to reach $409 billion.

Special Report

Brain Health in America: Understanding and Supporting Lifelong Cognitive Health

ALZHEIMER'S ASSOCIATION®

Survey Methods

- A survey of 3,829 U.S. adults age 40 and older was conducted from December 29, 2025, to January 13, 2026, by the University of Michigan National Poll on Healthy Aging.
  - ✓ The full sample included Asian, Black, Hispanic, and Native Americans for robust analysis of subgroups.
  - ✓ The survey was offered in English and Spanish, online or by phone.
- Survey explored knowledge, awareness, and attitudes toward:
  - ✓ How people think about brain health
  - ✓ Behaviors that contribute to it
  - ✓ Engagement in brain-healthy habits
  - ✓ Preferences for receiving information and resources to support brain health.

Key Takeaways: Special Report

Americans age 40+ show strong interest in brain health but lack clear guidance on how to support it.

- **Nearly 9 in 10 adults (88%)** say maintaining brain health as they age is very important, and 99% view it as equally or more important than physical health.
- Yet **only 9%** report knowing "a lot" about how to maintain brain health.

Most believe lifestyle behaviors play an important role in maintaining brain health, but fewer associate these behaviors with reducing dementia risk.

- **Three-quarters (75%)** say lifestyle behaviors are very important for maintaining brain health as they age.
- **Only 46%** say lifestyle behaviors are very important in reducing the risk of Alzheimer's and other dementia.
- Protecting against head injury (82%), Not smoking (72%), Managing stress (71%) and treating depression were cited as more important factors in supporting brain health.

Key Takeaways: Special Report (Cont'd) 1

While adults age 40 and older overwhelmingly believe healthy behaviors support brain health, many do not practice them consistently:

- Nearly all (99%) believe lifestyle behaviors such as sleep, diet, physical exercise and mentally stimulating activities are important for brain health, but engagement is inconsistent:
  - **Only half** (50%) report getting at least 7 hours of sleep daily or most days.
  - **Fewer than half,** say they eat a **healthy, balanced diet** (39%), engage in **mentally stimulating activities** (42%), and get **physical activity** (34%) daily or most days.

Adults are very interested in programs designed to support brain health, but barriers exist.

- **Nearly three-quarters (73%)** say they would be interested in participating in programs designed to support brain health. They are most likely to participate in: Cognitive exercises (57%); Health monitoring (46%), Nutrition 36%, Physical activity (26%)

Key Takeaways: Special Report (Cont'd) 2

- They prefer flexible formats that give them control over their participation:
  - 40% prefer self-guided activities at home.
  - 39% want a hybrid of self-guided and in-person sessions.
  - 8% prefer fully in-person sessions.
- Cost is biggest factor driving the decision to participate in a brain health lifestyle program (73%), followed by program location (67%), personal motivation (59%) and insurance coverage (58%).

Key Takeaways: Special Report (Cont'd) 3

- **Many adults view midlife (ages 35-64) as a key time to act for better brain health.**
  - **Nearly 2 in 5 (38%)** believe people should take steps to support brain health during midlife.
  - **Nearly half (46%)** say participation in formal programs should begin during this time
  - **About 1 in 3** say taking steps to support brain health is a lifelong endeavor, with actions appropriate at any age.
- **Most adults want guidance about brain health from their doctors, but these conversations are uncommon:**
  - **Two-thirds (66%)** say they would prefer to learn about brain health from their health care provider, yet only 14% report having a conversation about maintaining brain health with their doctor.

Path Forward

Health Care

- Developing clinical practice guidelines to integrate brain health into routine care
- Expanding interprofessional education through **accredited** training programs to strengthen clinical expertise in brain health, dementia risk reduction, early detection and care coordination
- New Project ECHO: ***Alzheimer's and Dementia Care for Brain Health*** supports primary care teams in promoting brain health.

Public Health

- Funding implementation science to translate U.S. POINTER into real-world practice in communities
- Translating the latest science on brain health and dementia risk into actionable tools, resources and messaging
  - Public Health Center of Excellence on Dementia Risk Reduction
  - Healthy Brain Initiative Road Map

In Summary

- Americans care about their brain health—but do not know where to turn for trusted guidance.
- There is a clear need for research-backed information that helps people take practical action.
- This year's survey offers robust insights to help inform our future work.
- By connecting efforts across individuals, communities, workplaces and health care, we can build a more equitable framework to support cognitive health and help reduce dementia risk for all Americans.

Committee Question & Answer, and Discussion

Break

The meeting will resume in 15 minutes

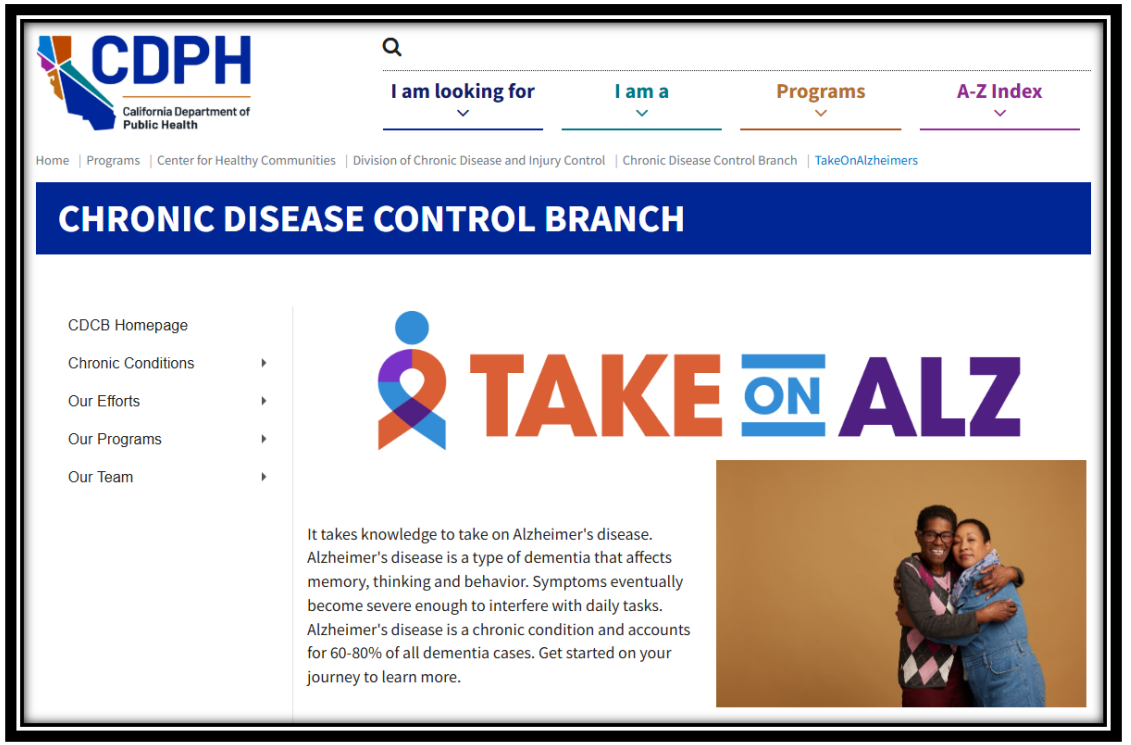
California Department of Public Health Update

Tina Fung, MPH

Chief, Alzheimer's Disease Section Chief
California Department of Public Health (CDPH)

Prevention

Take on Alzheimer's



- Media materials are available on ADP's webpage: TakeOnAlzheimers

California Healthy Brain Initiative

- Evaluation Report posted online
  2020-2022 California Healthy Brain Initiative Evaluation Report

https://www.alz.org/professionals/public-health/models-frameworks/hbi-road-map

Federal Grants

Block Grant

- Aims to expand the California Healthy Brain Initiative work to include outreach to tribal/rural communities that are not currently funded
- Continuing Community of Practice

BOLD Grant

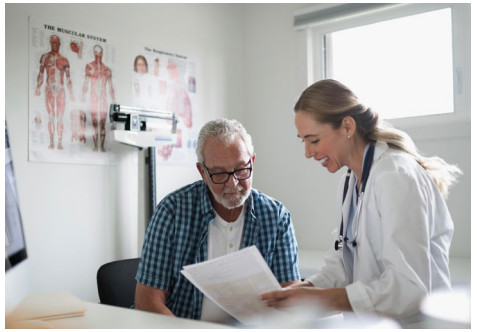
- Focus is on prevention
  - Working on BRFSS collection and analysis
  - Starting Community-Clinical Linkages

https://www.cdc.gov/phhs-block-grant/index.html
https://www.alz.org/professionals/public-health/models-frameworks/hbi-road-map-american-indian-alaska-native
https://www.cdc.gov/aging-programs/php/bold/index.html

Clinical & Caregiving

California Alzheimer’s Disease Centers (CADCs)

California Alzheimer's Disease Centers



- CADCs are a statewide network of ten dementia care Centers of Excellence
- Services offered:
  - Comprehensive assessment and treatment recommendations
  - Specialized training and education for health care professionals
- Started Year 4 of grant term (2023-2028)

Locations:

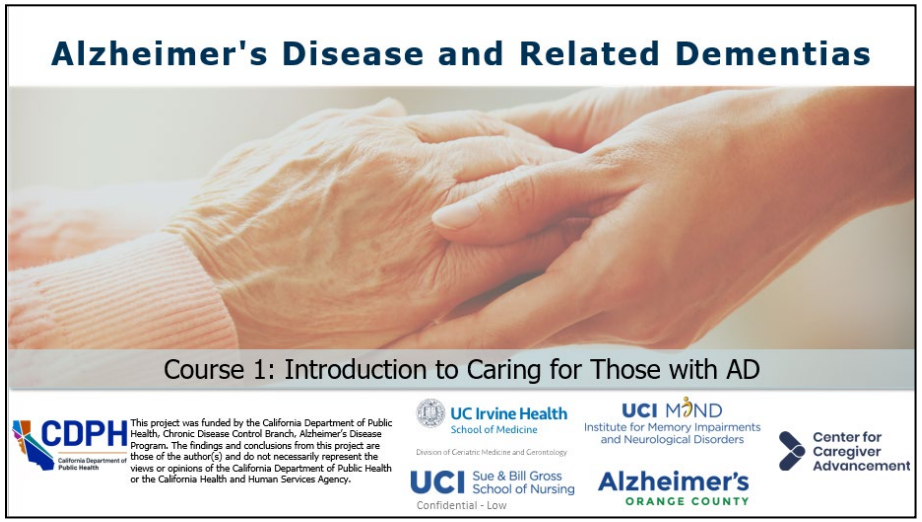
1. UC Davis - East Bay
2. UC Davis - Sacramento
3. UC Irvine - Irvine
4. UC San Diego - San Diego
5. UC San Francisco - Fresno
6. UC Los Angeles - Los Angeles
7. UC San Francisco - San Francisco
8. University of Southern California - Los Angeles
9. University of Southern California - Rancho Los Amigos
10. Stanford University - Palo Alto

California Alzheimer's Disease Centers

CDPH

Caregiver Training Program

University of California, Irvine (UCI)



University of California, San Francisco (UCSF) – Fresno

Research & Evaluation

Research Grants

- Purpose is to further understand and address the greater prevalence of dementia in underrepresented or disparate populations including women, communities of color, and populations historically underrepresented in research including Lesbian/Gay/Bisexual/Transgender/Queer/Questioning (LGBTQ+) communities and rural communities.

- Four-year research projects (2024-2028)
  - Grantees started Year 3 of grant term

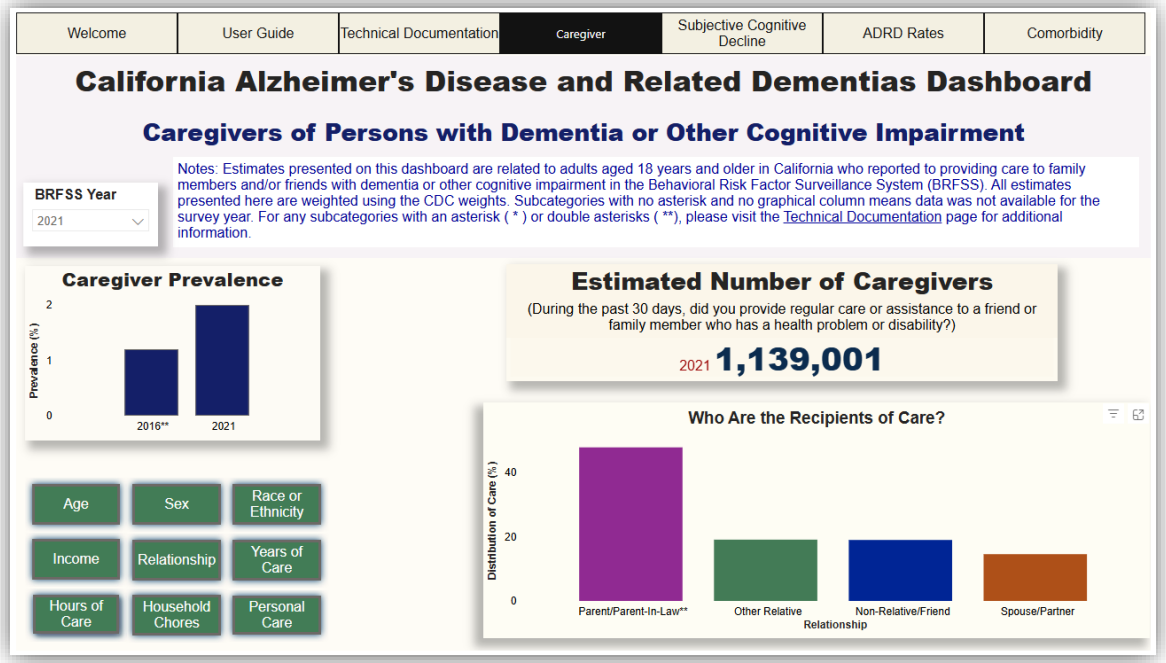
- ADP continues to provide technical assistance to grantees

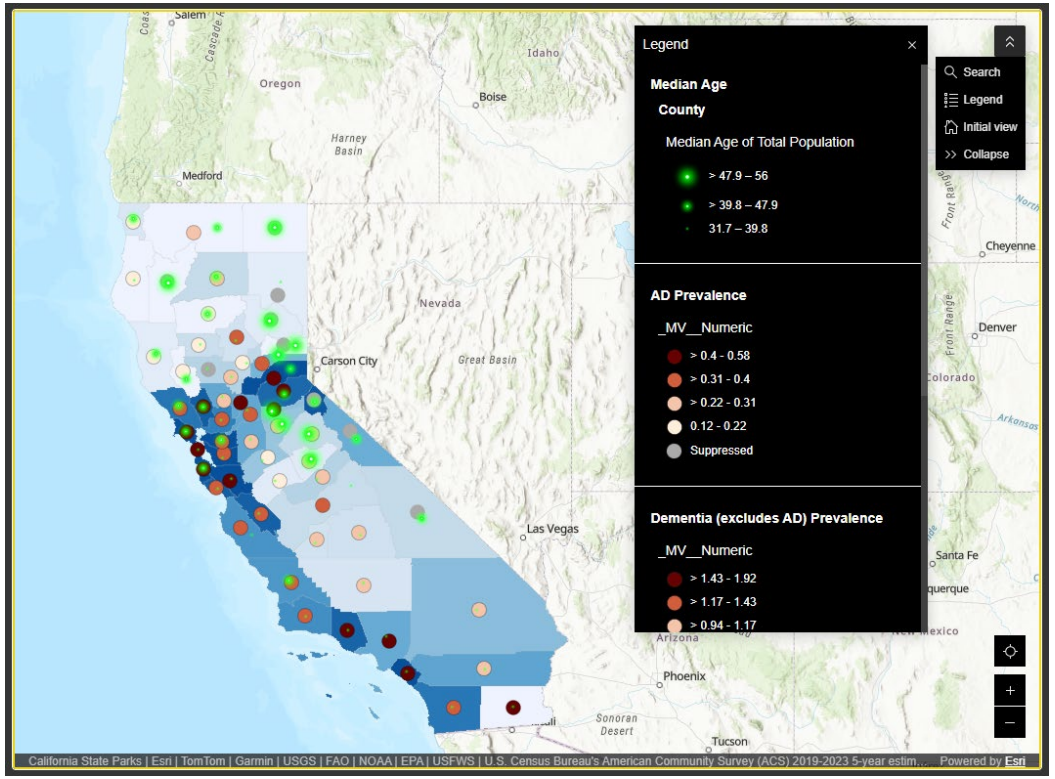
Surveillance

Health & Information Statistics Section

Chronic Disease Control Branch, CDPH

ADRD Data Dashboards





CDPH

Alzheimers Disease Program Dashboards

AlzheimersD@cdph.ca.gov

Legislative Updates

Barbra McLendon

Associate Vice President, Public Policy,
Alzheimer's Los Angeles

Andrew Mendoza

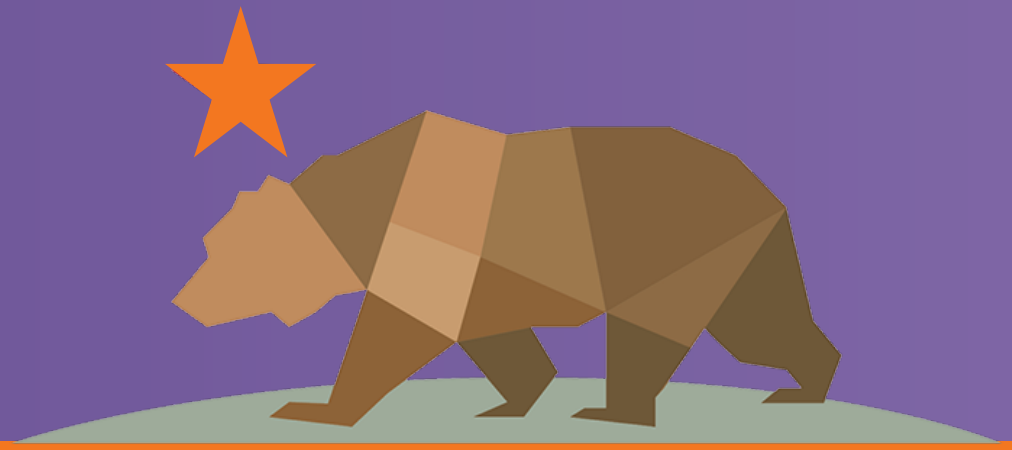
Government Relations Director
Alzheimer's Association

Alzheimer's LOS ANGELES

2026 State Legislative Session Update

Barbra McLendon, MSW
Associate VP, Public Policy

bmclendon@alzla.org



2026 State Legislation

Research Funding

SB 895 – California Science and Health Research Bond Act.

- Would establish the California Foundation for Science and Health Research
- Topics funded include biomedical, behavioral, and climate research
- Authorizes issuance of bonds up to $23B

November Ballot Measure

Immunotherapy Bond Measure

California Immunology Research and Cures Initiative

- On November 2026 ballot
- Would authorize $8.4B in state bonds to support immunotherapy research
- At least 50% of the research funding is mandated for cancer, heart disease, and Alzheimer's disease.
- This initiative focuses on leveraging the human immune system to develop vaccines and therapies
- Supported by: Californians for Immunology Research and Cures, sponsored by the Michelson Center for Public Policy

State Legislation

Genetic Information and Access to Insurance

- **AB 1798 (Wilson- D)- Genetic Testing for Life and Disability Insurance.** The bill prohibits disability and life insurance carriers from seeking out genetic testing information and using that information to deny or cancel coverage.

State Legislation

Neurodegenerative Disease Registry

SB 1047 (Niello- R)- Fronto-Temporal Dementia. This bill expands data collection and reporting requirements for the California Neurodegenerative Disease Registry Program (CNDRP) to include frontotemporal degeneration.

This legislation also extends the CNDRP until January 1, 2030.

State Legislation

Healthcare Legislation

- **SB 1088 (Blakespear-D) – Life Sustaining Treatment.**
  Would allow POLST forms to be signed by Physician Assistants and Nurse Practitioners.

  Coalition for Compassionate Care of California

State Legislation

Caregiver Legislation

- **SB 1149 (Durazo-D) – Expands access to up to five days of bereavement leave** by expanding the definition of family member to include a designated person Press release

State Legislation

Emergency Preparedness

SB 837 – Disaster and Emergency Preparedness

- Requires Aging and Disability Resource Connection programs to provide disaster and emergency preparedness training specifically designed to help older adults and people with disabilities prepare for emergencies and ensure their safety before, during, and after natural disasters and other emergency events.
- Requires that the training raise awareness of existing resources and guidance such as those developed by the CA Department of Aging.

State Legislation

Bill Package to reduce bureaucratic barriers and damage from H.R. 1- Support

- **AB 2161 (Bonta-D) – Medi-Cal work or community engagement requirements in H.R. 1:** Establishes state implementation requirements and consumer protections related to new federal Medi-Cal redetermination and community engagement requirements.
- **AB 2201 (Boerner-D) – 6-month Medi-Cal redeterminations:** Seeks to reduce procedural Medi-Cal terminations by strengthening automatic renewal and outreach processes.
- **AB 2208 (Stefani-D) – Medi-Cal cost sharing:** Limits cost sharing for certain Medi-Cal expansion adults, strengthens self-attestation protections, and improves oversight of eligibility systems and public-facing websites.
- **SB 1202 (Weber-Pierson-D)- Medi-Cal dashboard and outreach:** Improve transparency and outreach on upcoming changes so Californians can be prepared.

Press release

State Legislation

Facility Resident Protections

SB 991 (Menjivar-D) - Requires the Department of Social Services to provide more detail about violations that occur within facilities. Violation categories include: physical abuse; abandonment; abduction; financial abuse; isolation; mental suffering; neglect; or undue influence.

AB 2135 (Kalra-D) - Requires long-term care facilities to provide residents with a notice of transfer or discharge of 30 days, 14 days or as soon as practicable depending on reason for transfer, and for the notice to be translated and signed by the individual and/or their representative.

State Budget

Human Services

Medi-Cal Asset Test –

- Set at $21,000 for one person; $31,000 for two people; $1,550 for each additional household member
- Lower limits effective July 1, 2027

IHSS

- Rejects proposal to shift growing costs to counties
- Rejects elimination of IHSS Backup Provider System

State Budget

Human Services

Adult Protective Services

- Rejects proposal to move APS eligibility back to 65 years of age

Food Access

- Provides additional funding for CalFood and CalFresh outreach
- Additional county CalFresh workload support tied to HR 1

Federal Budget

Health and Human Services

The House Appropriations Committee advanced its Labor-HHS-Education funding bill, including:

- Overall HHS Funding is $110.8b- 4% cut
- ACL Aging and Disability Services- $2.523b.
  - $14m below FY2026 enacted budget.
  - $68.6m above President's FY 2027 request.

Federal Budget

Health and Human Services

Older Americans Act Programs

- Home and Community-based Supportive Services: flat funded
- National Family Caregiver Support Program: flat funded
- Long Term Care Ombudsman Program: funded at $23 million
- Senior Nutrition: $1.062b, small increase

Federal Budget

National Institutes of Health

NIH – $47.3b, an increase of $100m over FY 2026

- Flat funding for NIA
- Increase for NINDS – includes $25m increase for Alzheimer's research
- Caps NIH use of multi-year funding at 2025 levels

Federal Budget

Center for Disease Control

Centers for Disease Control

- Maintains funding for CDC's Alzheimer's and dementia activities at $41.5m
- Includes support for Healthy Brain Initiative and BOLD

Alzheimer's Association Legislative Priorities

Andrew Mendoza, Government Relations Director

ALZHEIMER'S ASSOCIATION®

SB 950 (Weber Pierson): Healthcare Coverage: Alzheimer's Treatment

Our sponsored bill requires state regulated private health insurance plans to cover FDA approved treatments for Alzheimer's disease, bans step therapy for anti-amyloid therapies, provides non-restrictive coverage criteria and makes denial appeals exigent circumstance.

This legislation improves access to disease modifying treatments for people with early onset Alzheimer's disease.

SB 950 (Weber Pierson) - Status

This bill has been referred to the Assembly Appropriations Committee. A hearing should be scheduled after the Summer Recess. It will likely fall under the threshold for the suspense file.

It will then move to the Floor before returning to the Senate for a concurrence vote on amendments, and then ultimately to the Governor's Office.

Budget Request: Dementia Care Aware

Our sponsored $5.4 million general fund budget request would sustain Dementia Care Aware for three years to train primary care teams on dementia screening, care navigation and case management.

Dementia Care Aware has trained more than 7,250 healthcare professionals - largely clinical providers - in nearly every county through remote and in-person sessions for free CEUs/CMEs.

Budget Request: Dementia Care Aware

This request was not included in the State Budget.

There is likely to be further budget action after the recess, but this will probably be when district-based requests are considered.

Caucus requests were the only requests included in the budget. This request was championed by two legislators but was not a caucus priority.

AB 2052 (Stefani): Older and Dependent Adult Victims – Vertical Prosecutions

Our sponsored bill provides ‘Good Cause’ to a prosecutor assigned to a case, where a cognitively impaired dependent or older adult is the victim in the alleged felony offense, to receive a continuance when needed in court for other obligations.

This bill supports District Attorneys who dedicate resources for Elder Abuse units with vertical prosecutions, where an attorney handles each stage of the case without handoffs.

AB 2052 (Stefani): Older and Dependent Adult Victims – Vertical Prosecutions

This bill is currently on the Senate Floor. It will be managed by Senator Susan Rubio and brought up for a vote after the recess.

Once we include chaptering out amendments, the bill will return to the Assembly for a concurrence vote and move to the Governor's office.

Public Comment

Time is reserved on the meeting agenda for public comment.

- **In-Person Comments**: Raise your hand or let the designated CDA staff member know you want to make a public comment.
- **Verbal Comments**: “Raise your hand” in the Reactions feature of Zoom or press *9 on your phone dial pad to enter the line for a verbal comment. The moderator will unmute your line and announce your name or the last 4 digits of your phone number.
- **Written Comments**: You may submit comments throughout the meeting using the Zoom Q&A or email Engage@aging.ca.gov.

Note: Public commentors will each have 2 minutes.

Finalize Recommendations for CalHHS Secretary Johnson and Meeting Topic Suggestions

2026 Meeting Schedule

October 29, 2026

10:00 a.m. – 1:00 p.m.

Committee meetings held in-person in Sacramento with a virtual option

Meeting Resources

- Master Plan for Aging (MPA)
- CalHHS Alzheimer's Disease & Related Conditions Advisory Committee
- ADRCAC Member Biographies
- Online Application for ADRCAC Member
- California Department of Aging (CDA)

Thank you!

Visit the CalHHS Alzheimer's Disease & Related Conditions Advisory Committee webpage for:

- More information about the Committee
- Upcoming meeting dates
- Presentations and recordings of past meetings

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