

115TH CONGRESS
1ST SESSION

S. 2076

To amend the Public Health Service Act to authorize the expansion of activities related to Alzheimer’s disease, cognitive decline, and brain health under the Alzheimer’s Disease and Healthy Aging Program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 6, 2017

Ms. COLLINS (for herself, Ms. CORTEZ MASTO, Mrs. CAPITO, and Mr. Kaine) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To amend the Public Health Service Act to authorize the expansion of activities related to Alzheimer’s disease, cognitive decline, and brain health under the Alzheimer’s Disease and Healthy Aging Program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Building Our Largest
5 Dementia Infrastructure for Alzheimer’s Act” or the
6 “BOLD Infrastructure for Alzheimer’s Act”.

1 **SEC. 2. FINDINGS.**

2 Congress finds as follows:

3 (1) According to former Surgeon General and
4 Director of the Centers for Disease Control and Pre-
5 vention, Dr. David Satcher, “Alzheimer’s is the most
6 under-recognized threat to public health in the 21st
7 century.”.

8 (2) Deaths from Alzheimer’s disease increased
9 55 percent between 1999 and 2014 in the United
10 States, according to data from the Centers for Dis-
11 ease Control and Prevention.

12 (3) More than 5,000,000 people in the United
13 States are living with Alzheimer’s disease and, with-
14 out significant efforts to change the current trajec-
15 tory, as many as 16,000,000 people in the United
16 States will have Alzheimer’s disease by 2050. This
17 explosive growth will cause costs associated with Alz-
18 heimer’s disease to increase from an estimated
19 \$259,000,000,000 in 2017 to more than
20 \$1,100,000,000,000 in 2050 (in 2017 dollars).

21 (4) Among individuals living with Alzheimer’s
22 disease and other dementias, evidence indicates as
23 many as 50 percent have not been diagnosed.
24 Among individuals diagnosed with Alzheimer’s dis-
25 ease, only 33 percent are aware of the diagnosis.
26 Early detection and diagnosis of Alzheimer’s disease

1 and other dementias allow people to access available
2 treatments, build a care team, participate in support
3 services, and enroll in clinical trials. Early detection
4 can help physicians better manage a patient's co-
5 morbid conditions and avoid prescribing medications
6 that may worsen cognition or function.

7 (5) Among individuals living with Alzheimer's
8 disease and other dementias, 25.3 percent experience
9 a preventable hospitalization, and such preventable
10 hospitalizations cost the Medicare program nearly
11 \$2,600,000,000 in 2013.

12 (6) African Americans are about 2 times more
13 likely than White Americans to have Alzheimer's dis-
14 ease and other dementias. Hispanics are about one
15 and one-half times more likely than White Ameri-
16 cans to have Alzheimer's disease and other demen-
17 tias.

18 (7) In 2016, 15,900,000 family members and
19 friends provided 18,200,000,000 hours of unpaid
20 care to individuals with Alzheimer's disease and
21 other dementias, at an economic value of over
22 \$230,000,000,000. The physical and emotional im-
23 pact of caregiving of individuals with Alzheimer's
24 disease and other dementia resulted in an estimated

1 \$10,900,000,000 in increased caregiver health costs
2 in 2016.

3 (8) Strategy 4.B of the “National Plan to Ad-
4 dress Alzheimer’s Disease: 2017 Update” of the Of-
5 fice of the Assistant Secretary for Planning and
6 Evaluation of the Department of Health and Human
7 Services is to “work with State, Tribal, and local
8 governments to improve coordination and identify
9 model initiatives to advance Alzheimer’s disease
10 awareness and readiness across the Government.”.

11 **SEC. 3. PROMOTION OF PUBLIC HEALTH KNOWLEDGE AND**
12 **AWARENESS OF ALZHEIMER’S DISEASE, COG-**
13 **NITIVE DECLINE, AND BRAIN HEALTH UNDER**
14 **THE ALZHEIMER’S DISEASE AND HEALTHY**
15 **AGING PROGRAM.**

16 Part P of title III of the Public Health Service Act
17 (42 U.S.C. 280g et seq.) is amended by adding at the end
18 the following:

19 **“SEC. 399V-7. PROMOTION OF PUBLIC HEALTH KNOWL-**
20 **EDGE AND AWARENESS OF ALZHEIMER’S DIS-**
21 **EASE, COGNITIVE DECLINE, AND BRAIN**
22 **HEALTH UNDER THE ALZHEIMER’S DISEASE**
23 **AND HEALTHY AGING PROGRAM.**

24 “(a) DEFINITIONS.—In the section:

1 “(1) ALZHEIMER’S DISEASE.—The term ‘Alz-
 2 heimer’s disease’ means Alzheimer’s disease and re-
 3 lated dementias.

4 “(2) INDIAN TRIBE; TRIBAL ORGANIZATION.—
 5 The terms ‘Indian tribe’ and ‘tribal organization’
 6 have the meanings given such terms in section 4 of
 7 the Indian Health Care Improvement Act.

8 “(b) EXPANSION OF ACTIVITIES UNDER THE ALZ-
 9 HEIMER’S DISEASE AND HEALTHY AGING PROGRAM.—In
 10 addition to activities conducted by the Secretary under the
 11 Alzheimer’s Disease and Healthy Aging Program of the
 12 Centers for Disease Control and Prevention, the Sec-
 13 retary, acting through the Director of the Centers for Dis-
 14 ease Control and Prevention, subject to appropriations
 15 under subsection (g), shall award cooperative agreements
 16 under subsections (c), (d), and (e).

17 “(c) CENTERS OF EXCELLENCE IN PUBLIC HEALTH
 18 PRACTICE.—

19 “(1) IN GENERAL.—The Secretary shall award
 20 cooperative agreements to eligible entities for the es-
 21 tablishment or support of national or regional cen-
 22 ters of excellence in public health practice in Alz-
 23 heimer’s disease to—

24 “(A) advance the education of public
 25 health officials of States, of political subdivi-

sions of States, and of Indian tribes or tribal organizations, health care professionals, and the public on Alzheimer’s disease, cognitive decline, brain health, and associated health disparities;

“(B) advance the efforts of public health officials referred to in subparagraph (A) in applying evidence-based systems change, communications, and programmatic interventions for populations with cognitive impairment, including Alzheimer’s disease, and caregivers for such populations; and

“(C) expand public-private partnerships engaged in activities related to cognitive impairment and associated health disparities with demonstrated success or innovative programs (as determined by the Secretary).

“(2) REQUIREMENTS.—To be eligible to receive a cooperative agreement under this subsection, an entity shall submit to the Secretary an application containing such agreements and information as the Secretary may require, including an agreement that the center to be established or supported under the cooperative agreement will operate in accordance with the following:

“(A) The center will examine, evaluate, increase, and promote evidence-based and effective Alzheimer’s disease and caregiving-related interventions for health and social services professionals, underserved populations, families, and the public, after consultation with relevant State and local public health officials, private-sector Alzheimer’s disease researchers, and advocates for individuals with Alzheimer’s disease.

“(B) The center will prioritize its activities on the following:

“(i) Expanding efforts to educate State, local, and tribal officials and public health professionals in applying established data and evidence-based best practices to address Alzheimer’s disease.

“(ii) Supporting public health officials of States, of political subdivisions of States, and of Indian tribes or tribal organizations in implementing the most current version of the ‘Healthy Brain Initiative: Public Health Road Map’ of the Centers for Disease Control and Prevention.

“(iii) Supporting early detection and diagnosis of Alzheimer’s disease.

1 “(iv) Reducing the risk of potentially
2 avoidable hospitalizations of individuals
3 with Alzheimer’s disease.

4 “(v) Reducing the risk of cognitive de-
5 cline and cognitive impairment, including
6 Alzheimer’s disease.

7 “(vi) Enhancing support to meet the
8 needs of caregivers of individuals with Alz-
9 heimer’s disease.

10 “(vii) Reducing health disparities re-
11 lated to the care and support of individuals
12 with cognitive decline and Alzheimer’s dis-
13 ease.

14 “(viii) Supporting care planning and
15 management for individuals with Alz-
16 heimer’s disease.

17 “(3) CONSIDERATIONS.—In awarding coopera-
18 tive agreements under this subsection, the Secretary
19 shall consider, among other factors, whether the en-
20 tity—

21 “(A) has access to rural areas or other un-
22 derserved populations;

23 “(B) is located in an area where the aggre-
24 gate success rate for applications for National

1 Institutes of Health funding has been histori-
 2 cally low;

3 “(C) is able to build on an existing infra-
 4 structure of service and public health research;

5 “(D) has experience with providing care,
 6 caregiver support, and research related to Alz-
 7 heimer’s disease; and

8 “(E) is integrated into existing local gov-
 9 ernment and public health infrastructures.

10 “(4) DISTRIBUTION OF AWARDS.—In awarding
 11 cooperative agreements under this subsection, the
 12 Secretary, to the extent practicable, shall ensure eq-
 13 uitable distribution of awards based on geographic
 14 area, including consideration of rural areas, and the
 15 burden of the disease on sub-populations.

16 “(d) COOPERATIVE AGREEMENTS TO PUBLIC
 17 HEALTH DEPARTMENTS.—

18 “(1) IN GENERAL.—The Secretary shall award
 19 cooperative agreements to health departments of
 20 States, of political subdivisions of States, and of In-
 21 dian tribes and tribal organizations to promote cog-
 22 nitive functioning, address cognitive impairment for
 23 individuals living in such communities, help meet the
 24 needs of caregivers, and address unique aspects of
 25 Alzheimer’s disease, as follows:

1 “(A) The Secretary shall award core ca-
2 capacity cooperative agreements to such health
3 departments to support the development and
4 implementation of systems change, communica-
5 tions, and programmatic interventions with re-
6 spect to Alzheimer’s disease, including activities
7 involving—

8 “(i) educating and informing the pub-
9 lic based on established public health re-
10 search and data;

11 “(ii) supporting early detection and
12 diagnosis;

13 “(iii) reducing the risk of potentially
14 avoidable hospitalizations;

15 “(iv) reducing the risk of cognitive de-
16 cline and cognitive impairment;

17 “(v) enhancing support to meet the
18 needs of caregivers;

19 “(vi) supporting care planning and
20 management; or

21 “(vii) supporting the actions set forth
22 in the most current version of the ‘Healthy
23 Brain Initiative: Public Health Road Map’
24 of the Centers for Disease Control and
25 Prevention.

“(B) The Secretary shall award not less than 5 enhanced activity cooperative agreements to such health departments to carry out activities related to Alzheimer’s disease, including through public-private partnerships with organizations or other agencies, such as large employers, public housing agencies, large health care systems, and parks and recreation departments, that include—

“(i) expanding implementation of programs described in paragraph (2)(A) to reach larger segments of the population; and

“(ii) implementing the reports described in subparagraph (A)(vii).

“(2) OTHER CONSIDERATIONS.—

“(A) PREFERENCE.—In awarding cooperative agreements under paragraph (1), the Secretary shall give preference to applications that focus on addressing health disparities, including populations and geographic areas that are most in need of intervention.

“(B) CLARIFICATION ON ENHANCED ACTIVITY COOPERATIVE AGREEMENTS.—If the Secretary is unable to identify 5 eligible health

1 departments to receive a cooperative agreement
2 under paragraph (1)(B), the Secretary shall al-
3 locate any amounts reserved for such agree-
4 ments to additional cooperative agreements
5 under paragraph (1)(A).

6 “(3) ELIGIBILITY.—To be eligible to receive a
7 cooperative agreement under paragraph (1), a State,
8 political subdivision of a State, Indian tribe, or tribal
9 organization shall prepare and submit to the Sec-
10 retary an application at such time, in such manner,
11 and containing such information as the Secretary
12 may require, including a plan that describes—

13 “(A) how the applicant proposes to develop
14 or expand, programs to educate individuals
15 through partnership engagement, workforce de-
16 velopment, guidance and support for pro-
17 grammatic efforts, strategic communication,
18 and evaluation with respect to Alzheimer’s dis-
19 ease, and in the case of a cooperative agree-
20 ment under paragraph (1)(B), how the appli-
21 cant proposes to implement the most current
22 version of the ‘Healthy Brain Initiative: Public
23 Health Road Map’ of the Centers for Disease
24 Control and Prevention;

1 “(B) the manner in which the applicant
2 will coordinate with appropriate State and local
3 authorities as well as, in the case of a coopera-
4 tive agreement under paragraph (1)(B), rel-
5 evant public and private organizations or agen-
6 cies; and

7 “(C) the manner in which the applicant
8 will evaluate the effectiveness of any program
9 carried out under the cooperative agreement.

10 “(4) USE OF FUNDS.—A health department
11 awarded a cooperative agreement under paragraph
12 (1) shall use amounts received under such coopera-
13 tive agreement to—

14 “(A) develop, implement, disseminate,
15 evaluate, and if applicable, expand programs to
16 educate individuals on matters related to Alz-
17 heimer’s disease described in paragraph (1)(A);
18 and

19 “(B) in the case of a cooperative agree-
20 ment under paragraph (1)(B), implement the
21 most current version of the ‘Healthy Brain Ini-
22 tiative: Public Health Road Map’ of the Centers
23 for Disease Control and Prevention and evalu-
24 ate its implementation.

25 “(5) MATCHING REQUIREMENT.—

1 “(A) IN GENERAL.—Except as may be pro-
 2 vided in subparagraph (B), each health depart-
 3 ment that is awarded a cooperative agreement
 4 under paragraph (1) shall provide, from non-
 5 Federal sources, an amount equal to 15 percent
 6 of the amount provided under such agreement
 7 (which may be provided in cash or in-kind) to
 8 carry out the activities supported by the cooper-
 9 ative agreement.

10 “(B) WAIVER AUTHORITY.—The Secretary
 11 may waive all or part of the matching require-
 12 ment described in subparagraph (A) for any fis-
 13 cal year for—

14 “(i) a health department, if the Sec-
 15 retary determines that applying such
 16 matching requirement to the health depart-
 17 ment would result in serious hardship or
 18 an inability to carry out the purposes of
 19 the cooperative agreement awarded to such
 20 health department; or

21 “(ii) a rural or frontier region.

22 “(e) COOPERATIVE AGREEMENTS FOR ANALYSIS AND
 23 REPORTING OF DATA REGARDING COGNITIVE DECLINE
 24 AND CAREGIVING.—

1 “(1) IN GENERAL.—The Secretary may award
2 cooperative agreements to eligible entities for the fol-
3 lowing activities:

4 “(A) The analysis and timely public re-
5 porting of data on the State and national levels
6 regarding cognitive decline, including Alz-
7 heimer’s disease, caregiving, and health dispari-
8 ties experienced by individuals with cognitive
9 decline and their caregivers.

10 “(B) The monitoring of objectives on de-
11 mentia, including Alzheimer’s disease, and
12 caregiving in the program of the Secretary re-
13 garding health-status goals for 2020 (commonly
14 referred to as the ‘Healthy People 2020 re-
15 port’), and the development and monitoring of
16 such objectives in future Healthy People reports
17 of the Department of Health and Human Serv-
18 ices.

19 “(2) ELIGIBILITY.—To be eligible to receive a
20 cooperative agreement under this subsection, an en-
21 tity shall be a public or nonprofit private entity, in-
22 cluding institutions of higher education, and submit
23 to the Secretary an application at such time, in such
24 manner, and containing such information as the Sec-
25 retary may require.

1 “(3) SURVEILLANCE.—The analysis, timely
2 public reporting, and dissemination of data regard-
3 ing cognitive decline, cognitive impairment, caregiv-
4 ing, and health disparities on the State and national
5 levels under a cooperative agreement under this sub-
6 section may be carried out by eligible entities using
7 data sources such as the following:

8 “(A) The Behavioral Risk Factor Surveil-
9 lance System.

10 “(B) The National Health and Nutrition
11 Examination Survey.

12 “(C) The National Health Interview Sur-
13 vey.

14 “(f) DATA COLLECTION.—The Secretary shall collect
15 data on cognitive decline, cognitive impairment, caregiv-
16 ing, and health disparities on the State and national levels,
17 using the surveillance systems described in subparagraphs
18 (A) through (C) of subsection (e)(3).

19 “(g) NONDUPLICATION OF EFFORT.—The Secretary
20 shall ensure that activities under any cooperative agree-
21 ment awarded under this section do not unnecessarily du-
22 plicate efforts of other agencies and offices within the De-
23 partment of Health and Human Services related to—

1 “(1) activities of centers of excellence in public
2 health practice with respect to Alzheimer’s disease
3 described in subsection (c);

4 “(2) activities of public health departments with
5 respect to Alzheimer’s disease described in sub-
6 section (d); or

7 “(3) the analysis and public reporting of sur-
8 veillance data on cognitive decline, caregiving, and
9 health disparities of individuals with Alzheimer’s dis-
10 ease under subsection (e).

11 “(h) AUTHORIZATION OF APPROPRIATIONS.—For
12 each of fiscal years 2018 through 2025, there are author-
13 ized to be appropriated \$12,000,000 for purposes of car-
14 rying out subsection (c), \$20,000,000 for purposes of car-
15 rying out subsection (d), and \$5,000,000 for purposes of
16 carrying out subsections (e) and (f). Funds appropriated
17 under this subsection shall remain available until ex-
18 pended.”.

○