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Intersecting Inequities and Solutions in Alzheimer Disease and Related Dementia Care in Connecticut

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PEER REVIEWED

Fatalities attributed to Alzheimer disease and related dementias (ADRD) more than doubled in the US between 2000 and 2024, increasing by 134.1% (1). This increase highlights the complexity of ADRD, which is shaped by both modifiable and nonmodifiable risk factors. Clinically, neurodegeneration from Alzheimer disease manifests through the accumulation of β-amyloid plaques and tau tangles: abnormal proteins that block neural pathways. Age is a major risk factor, with prevalence increasing from 11% among persons aged 65 years or older to 35.8% among those aged 85 years or older (1). Prevalence of Alzheimer disease also varies by race and ethnicity, affecting 19% of Black adults, 14% of Hispanic adults, and 10% of White adults (1). Socioeconomic status (SES) may influence exposure to environmental neurotoxins, health literacy, and access to specialized care because it is closely linked to education, occupation, and income (1).

The distribution of ADRD care centers may further exacerbate these inequities. Connecticut illustrates this divide through its stark socioeconomic contrasts: 6.9% of adults aged 65 years or older who live in Sherman, an affluent lakeside town, have ADRD, compared with 27.1% of older adults in central Hartford, a low-income community (2). Although new ADRD treatments lecanemab and donanemab, which target β-amyloid plaque removal in the brain, were approved in 2023 and 2024, respectively (1), access to these therapies is uneven due to persistent racial, socioeconomic, and geographic barriers. This essay examines the association between individual risk factors and local public health systems to reveal the inequities that shape Connecticut's divided ADRD care system and propose practical interventions to address these barriers.

Racial and Ethnic Barriers

Although Black adults aged 65 years or older are nearly twice as likely as White adults to develop Alzheimer disease (19% vs 10%), genetic factors alone are only partially responsible for this disparity (1). Research indicates that the influence of the APOE e4 gene variant, a key genetic Alzheimer disease risk factor, may be stronger among White adults than among Black adults (1). Inequities in health care are prevalent. In 2021, the Alzheimer's Association reported that, in the US, 42% of American Indian and Alaska Native adults, 34% of Asian adults, 50% of Black adults, and 33% of Hispanic or Latino (Hispanic) adults have experienced discrimination when seeking health care (3). Confidence that clinicians understand patients' racial or ethnic background is low: 47% of American Indian and Alaska Native adults, 63% of Asian adults, 48% of Black adults, and 59% of Hispanic adults reporting such confidence (3).

Systemic barriers to equitable access to health care can compromise timely ADRD diagnosis. In the US, American Indian and Alaska Native, Black, and Hispanic adults are twice as likely as White adults to report that they would not seek medical care when experiencing cognitive concerns (3). This hesitancy reflects differences in health literacy. Whereas 48% of White adults report concern about developing ADRD, 25% of American Indian and Alaska Native adults, 35% of Black adults, and 41% of Hispanic adults express similar concern (3). This combination of hesitancy and lower ADRD concern can delay timely medical evaluations for racial and ethnic minority populations, hindering an early Alzheimer disease diagnosis. Early detection is critical, as treatments and care planning are most effective during mild cognitive impairment, and early clinical stage in Alzheimer disease progression is characterized by subtle decline in memory and cognition (1). Therefore, disparities in health literacy and access to care may prevent racial and ethnic minority populations from receiving treatment during this optimal clinical window, underscoring persistent systemic barriers to ADRD care.

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Systemic Socioeconomic Barriers

Socioeconomic status (SES) is another critical barrier to equitable ADRD care. Ou et al reported that persons with higher SES and a healthy lifestyle are 81% less likely than those with lower SES and unhealthy lifestyles to develop ADRD (4). The study also identifies a significant interaction between SES and lifestyle: higher SES provides the structural stability needed to sustain neuroprotective behaviors, whereas lower SES is often associated with financial stressors and limited resources, potentially hindering the adoption of health-promoting practices and compounding ADRD risk among socioeconomically disadvantaged populations (4).

This elevated risk among low-SES populations is closely linked to education and cognitive reserve, defined as the brain's capacity to develop alternative neural pathways that preserve function despite damage, aging, or disease (5). Its clinical significance was first recognized in the 1980s, when autopsy studies revealed that persons with advanced pathology for Alzheimer disease showed no dementia symptoms during life, demonstrating the brain's ability to tolerate substantial structural damage before cognitive decline becomes apparent. The literature confirms that greater cognitive reserve can delay ADRD onset; however, this protective capacity is built over a lifetime through education, intellectual engagement, and curiosity (5). Because lower educational attainment is strongly associated with lower SES (4), persons in low-SES groups are often deprived of key opportunities to develop cognitive reserve, increasing vulnerability to earlier ADRD onset.

Despite this heightened vulnerability to earlier ADRD onset, persons with low SES are less likely to receive an early diagnosis that could alter their disease trajectory. Persons with sufficient health insurance coverage, which allows them access to ADRD specialists such as neurologists or geriatricians, are diagnosed much earlier than those who rely on general practitioners (1). Underinsured populations often experience delayed diagnosis compared with those with comprehensive coverage, reducing their likelihood of receiving treatment during the optimal therapeutic window (1). Therefore, socioeconomic conditions not only shape an individual's risk of developing ADRD but also influence access to timely and effective care, further highlighting inequities in ADRD treatment and outcomes.

Geographical Barriers: Urban vs Rural Communities

Geographic location further fragments ADRD care in Connecticut, a state with a rapidly aging population where 24.5% of residents are aged 60 years or older. Connecticut residents aged 65 years or older contribute to one of the highest dementia rates in New England (2). Rural communities, at first glance, may appear to have a lower prevalence of Alzheimer disease than urban areas. A 2020 report found that the highest number of cases were concentrated in 3 major urban counties (Fairfield, Hartford, and New Haven), each of which had more than 155,000 older adults and prevalence rates ranging from 12.1% to 12.4% among adults aged 65 years or older (6). In contrast, lower case counts were reported in the rural counties of Windham, Tolland, and Litchfield, which have smaller older populations of approximately 20,800, 25,400, and 40,900, respectively, and Alzheimer disease prevalence rates around 10.5%, nearly 2 percentage points lower than urban counties (6). These differences may reflect differences in diagnosis and care access, rather than true differences in disease prevalence.

Many rural counties face shortages of health care providers (1), suggesting that ADRD prevalence in these areas may be underestimated due to limited access to diagnostics. This pattern is reflected in Connecticut's health care infrastructure. Specialized ADRD facilities are concentrated in major cities across the state including Hartford, New Haven, and Stamford. The surrounding urban counties have both the highest density of care centers and the highest Alzheimer disease prevalence rates in Connecticut. Comparatively, counties with the lowest prevalence rates are in the northern corners of the state, where specialized ADRD care facilities are limited (Figure) (7,8). As a result, patients often travel longer distances for specialized care or rely on general practitioners for diagnosis; patients evaluated by nonspecialists can experience delayed diagnosis compared with those seen by specialists (1). Consequently, rural populations may face substantial geographic barriers to timely diagnosis, limiting their ability to receive treatment during the critical early stages of the disease.

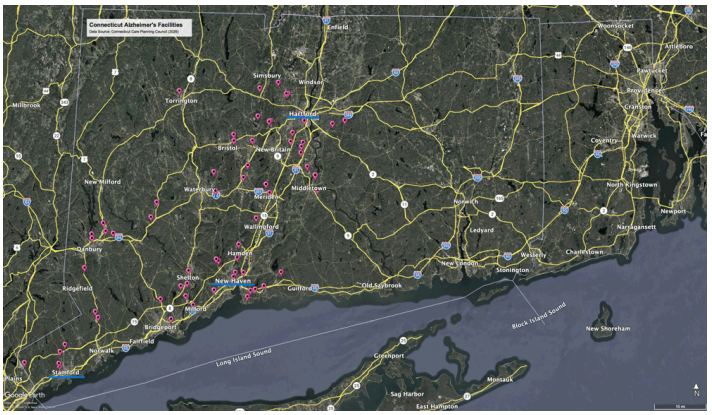


Figure. Spatial distribution of ADRD facilities in Connecticut. The author created the map using Google Earth Pro, version 7.3.7.1155 (2026) (7). Data source: Connecticut Care Planning Council (2026) (8). Abbreviation: ADRD, Alzheimer disease and related dementias.

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Recommendations

Three major barriers may limit early and effective ADRD treatments among medically disadvantaged populations: gaps in awareness, education, and trust in health care among racial and ethnic minority groups; financial burdens among low-income persons; and shortages of specialized facilities in rural areas. Addressing these challenges requires targeted solutions. First, improving awareness of ADRD and its early symptoms is important for reducing disparities in health literacy and trust. Public health campaigns should use culturally tailored, multilingual materials to enhance community understanding among racial and ethnic minority groups. In addition, health care providers should receive cultural competency training to improve access to health care for medically underserved populations. Second, state and federal policymakers must expand coverage policies to ensure Medicare and Medicaid fully encompass ADRD screening, diagnostic services, and treatment. These reforms would help prevent underinsured persons from being excluded from early detection due to cost barriers. Finally, greater health care intervention is needed to expand neurological and memory care services in rural areas. By redistributing resources and specialized care beyond urban centers, geographic barriers to timely diagnosis and treatment can be reduced. Together, these awareness, financial, and geographic interventions would promote a more equitable health care system, ensuring that access to ADRD care is not determined by race or ethnicity, SES, or place of residence.

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