Aligning Strategic Plans Across Health, Aging, and Dementia

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For technical assistance with plan alignment, contact

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INTRODUCTION

Why Cross-Plan Alignment Matters Now

Over the past decade, state health departments and state agencies on aging have become increasingly sophisticated in their use of strategic planning to prioritize organizational action and meet the needs of their communities.

Most state governments now have a health plan (State Health Improvement Plan or SHIP) and dementia plan (State Alzheimer's Disease and Dementia Plan), and all states are required to develop an aging plan (State Plan on Aging or SPoA) per the Older Americans Act.

As each of these sectors of state government seeks to address growing demand for action on brain health, dementia, and caregiving, this increases opportunity and need for aligned cross-sectoral priorities and collaborative action.

This Strategic Plan Alignment Tool provides a structured framework to:

- **Identity shared priorities across health improvement, aging, and dementia plans.**
- **Eliminate redundancies in planning and implementation efforts.**
- **Guide development of integrated approaches that address multiple goals simultaneously.**
- **Maximize resource utilization through coordinated activities**

Figure 1. Building Alignment Across State Plans

INTENDED AUDIENCE

This tool is designed primarily for senior health department officials, state aging directors, dementia coordinators, and planning staff responsible for developing and implementing state-level strategic plans.

WHEN TO USE THIS TOOL

Ideally, staff will implement this tool at the beginning of a planning cycle for any of the three plans, but can do so at any stage of the planning or implementation.

Tool Development: State Scan and Key Findings

In 2025, ASTHO conducted a scan of health, aging, and dementia plans across 5 states to understand opportunities for alignment and integration.

- **Plan alignment** refers to the strategic coordination of priorities, activities, and resources across different planning documents to establish a shared and cohesive vision.
- **Integration** involves the deliberate combining of previously separate resources into unified approaches that simultaneously enhance efficiency and impact.

ASTHO created a matrix (Figure 2) to compare dementia-related priorities across states and the three plan types. The following findings are based on their analyses.

FINDING 1:

Common Themes Across Plans

States often share **common priority themes** in how **all three plan types** (aging, health, and dementia plans) seek to address dementia, which typically falls under the following categories of action.

- Chronic Disease Prevention and Health Promotion
- Care Access and Quality
- Social and Economic Determinants
- Data and Information Systems
- Community Capacity and Engagement

FINDING 2:

Unique Features of Each Plan Type

When compared across states, health, **each plan type typically had distinct language and approaches** to addressing the five priority areas. These approaches reflect policy and funding priorities at the federal and state levels – and how they influence the state plan language, priorities, and mechanisms, based on which state government agency is at the helm.

Figure 2. Matrix of Common Themes by Plan Type

Plan Type	Chronic Disease Prevention & Health Promotion	Care Access & Quality	Social & Economic Determinants	Data & Information Systems	Community Capacity & Engagement
Health Plans	Disease Management, Healthy Behaviors	Healthcare Workforce, Value-based Care, Reducing Access Barriers	Housing Transportation, Food Security, Economic Stability	Data Modernization Initiatives, Surveillance Systems, Health Information Exchanges	Community Coalitions, Place-based Initiatives, Local Health Improvement
Aging Plans	Falls Prevention, Nutrition, Early Intervention	Care Coordination, Medicare Navigation, Specialized Services for Older Adults	Aging-in-Place Supports, Reducing Social Isolation, Economic Security for Older Adults	Resource Directories, Client Tracking Systems	Senior Centers as Hubs, Volunteer Engagement, Multi-generational Activities
Dementia Plans	Brain Health Awareness, Risk Reduction, Early Detection	Early Diagnosis, Specialized Dementia Care, Provider Education on Cognitive Assessments	Creating supportive Environments for People with Dementa	Dementia Resource Referrals and Service Access	Dementia-Friendly Communities

FINDING 3:

Opportunities for Plan Alignment

Finding a **shared vision** across topical areas can support state agency collaboration. Looking across the approaches each plan type uses to address dementia revealed **opportunities for alignment across plans** and state agency activities.

The following are examples of opportunities to align plans across each topic area that can open up possibilities for shared missions across agencies.

Chronic Disease Prevention and Health Promotion
Integrated prevention approaches across plans to reach people at all stages of life, allowing states to leverage existing cross-agency infrastructure and integrate cognitive health and general health.

Care Access and Quality
Unified provider training programs, coordinated telehealth initiatives, and integrated quality measurement systems that address both general healthcare needs and dementia-specific requirements within the same infrastructure.

Social and Economic Determinants
Coordinated approaches to transportation, housing, food security, and social connection that simultaneously address the needs of the general population while accommodating the specific requirements of older adults and people with dementia.

Data and Information Systems
Data sharing across agencies and developing integrated data architectures, unified resource directories, and coordinated referral networks that can seamlessly connect individuals to appropriate services while providing decision-makers with population-level data for planning and evaluation.

Community Capacity and Engagement
Dementia-friendly community efforts incorporated into broader community health initiatives, senior centers can serve as hubs for both aging services and public health programs, and community volunteers can be mobilized to address multiple priorities simultaneously, creating more sustainable and comprehensive approaches.

FINDING 4:

Opportunities for Integration

When states do focus on integrating their efforts, **seven key implementation strategies** can help state agencies integrate their efforts, mobilizing cross-agency collaboration and shared resources.

1. **Planning and coordination**, including **state roles** or **advisory bodies** to coordinate action across agencies, such as Alzheimer's Coordinating Councils or salaried dementia coordinator roles.

2. **Performance measurement systems**, such as through shared **dashboards or evaluation indicators** to track progress.

3. **Data systems and infrastructure**, including opportunities to leverage data modernization efforts at public health agencies, resource directories through aging agencies, and telehealth platforms for integrated dementia navigation, monitoring, and tracking.

4. **Partnership networks** vary across agencies and can be leveraged to support cross-functional efforts.

5. **Workforce development programs** can be co-designed by agency partners across aging, health, and dementia (and where appropriate, education or labor agencies) to better recruit, equip, and retain professionals they engage with or certify (e.g. nutrition, healthcare professionals, direct service workers, etc).

6. **Funding mechanisms** can involve **coordinate budget requests**, combining resources into **braided funding**, or **public-private partnerships** involving multiple agencies working with external partners.

7. **Existing programs and services** can be leveraged for **integrated approaches**, such as adding brain health components to existing programs (e.g. food security initiatives), ensuring cross-referrals across program types, or collaborating with existing transportation efforts at the state to improve access to health or aging services.

How to Use this Tool

STEP 1

Identify Purpose & Partners

- Form a cross-functional team with representatives from public health, aging services, and dementia programs. Pull in other state agencies who play a role in portions of the plan as needed (e.g. Medicaid, Disability, Education, Equity, Labor, etc.).
- Schedule a dedicated alignment session with key partners and gather current versions of all three plans.
- Clearly identify your state's reason for the alignment effort and who will be the core team.

STEP 2

Prepare for Alignment

- Categorize elements from existing plans using the standardized domains provided.
- Identify overlapping priorities, complementary strategies, and potential conflicts.
- Use the relationship mapping matrices to visualize connections.

STEP 3

Map Connection

- Categorize elements from existing plans using the alignment matrix provided below to map:
  - » How priority areas connect to specific goals across plans
  - » How goals connect to specific implementation strategies
  - » How strategies utilize existing resources
  - » Which partners are responsible for implementation
- Identify overlapping priorities, complementary strategies, and potential conflicts.

STEP 4

Identify Integration Opportunities

- Analyze matrices to pinpoint high-impact integration points.
- Prioritize opportunities based on feasibility, potential impact, and resource requirements.
- Document specific actions that could advance multiple plan objectives simultaneously.

STEP 5

Develop Implementation Approach

- Create shared timelines that sequence activities logically.
- Establish coordinated performance measures to track cross-plan progress.
- Define partner responsibilities across initiatives.

STEP 6

Monitor & Share

- Implement regular cross-plan progress reviews.
- Document outcomes and lessons learned.
- Share results with key parties and other states.

Figure 3. Example Alignment Matrix

Figure 3 demonstrates how one priority area—prevention—connects across all three plan types. Using this matrix can help not only identify overlapping goals, but also make visible the potential resources that can be aligned to operationalize shared action. This example illustrates how integration can maximize impact while respecting plan-specific priorities.

PURPOSE FOR ALIGNMENT:

To integrate prevention activities across our state's health, aging, and dementia plans, maximizing reach to older adults and coordinating relationships with partners.

PRIORITY AREA: *Risk Reduction*	SHIP FOCUS	AGING PLAN FOCUS	DEMENTIA PLAN FOCUS	INTEGRATION OPPORTUNITIES
Goals	Chronic disease management, Promote physical activity	Falls prevention, nutrition security	Brain health awareness, risk reduction	Unified brain health education across lifespan, with age-appropriate messaging integrated into chronic disease prevention and nutrition programs.
Key Strategies	Healthcare screening initiatives, community-based prevention programs	Evidence-based falls programs, nutrition education for older adults	Brain health public awareness, early warning signs education	Co-location of preventive services; cross-trained prevention specialists; joint training of providers on physical and cognitive health risk factors; caregiver education modules embedded in aging services.
Focus Population	General population with focus on disproportionately affected groups	Adults 60+ with emphasis on those experiencing social isolation	General public plus adults with cognitive concerns	Comprehensive approach spanning life course with specialized interventions; targeted outreach to populations with health disparities and elevated dementia risk.
Performance Measures	Chronic disease rates, physical activity levels	Fall incidence rates, nutritional risk scores	Cognitive assessment rates, Risk awareness retrics	Shared evaluation framework with integrated outcome tracking; tracking dementia risk reduction indicators (e.g., vascular health metrics, cognitive screening uptake).
Funding Source(s)	PHHS Block Grant, Medicaid 1115 waivers, DNPAO SPAN, state general funds	OAA Title III & Title IV Grants, DNPAO SPAN, Medicaid 1115 waivers	Title IV Grants, ADPI Cooperative Agreements, CDC BOLD	Braid existing PHHS Block Grant funding with OAA funding to support statewide prevention activities related to older adults; tie PHHS Block Grant aging work to BOLD activities; tie SPAN work across SHIP and SPoA to ADRD activities; etc.
Implementation Partners	Public health, healthcare providers	Area Agencies on Aging, senior centers	Alzheimer's Association, memory clinics	Coordinated partner engagement with unified referral protocols; community coalitions that bridge chronic disease, aging, and dementia caregiving sectors.

Figure 4. Alignment Matrix Template

GUIDANCE NOTES

Use this simplified template to identify connections and integration opportunities between your state's plans. Start with one domain, then expand to other priority areas as team capacity allows. Figure 4 below is a template provided in a fillable format.

1. Begin by selecting a domain that appears in multiple plans (e.g., chronic disease prevention, care access and quality, social and economic determinants, data and information systems, community capacity & engagement).
2. For each row, extract relevant elements from each plan and place in appropriate column.
3. In the final column, identify specific opportunities to align or integrate these elements. Consider gaining input from executive leadership, implementation teams, advisory bodies, and other partners to confirm alignment. Think through any barriers to address, existing models to use, or opportunities to innovate.

PURPOSE FOR ALIGNMENT:				
PRIORITY AREA:	**SHIP FOCUS**	**AGING PLAN FOCUS**	**DEMENTIA PLAN FOCUS**	**INTEGRATION OPPORTUNITIES**
Goals				
Key Strategies				
Focus Population				
Performance Measures				
Funding Source(s)				
Implementation Partners				

Outcome Sharing and Next Steps

How to Share Results

Executive Leadership: Present integration findings to leadership across departments to secure commitment for coordinated implementation.

Implementation Teams: Conduct joint briefings with staff responsible for executing plan strategies.

Advisory Bodies: Share matrices with advisory councils to gather feedback and strengthen recommendations.

External Partners: Engage key interested parties through coordinated communications about alignment priorities.

WHAT TO SHARE

- Completed alignment matrices highlighting key integration opportunities
- Proposed coordinated implementation timelines
- Resource-sharing recommendations
- Unified performance measurement approach

WHO SHOULD LEAD SHARING

Assign a designated cross-plan coordinator to manage communications and ensure consistent messaging. This role may rotate between departments or be assigned to a neutral facilitator.

CHANNELS FOR SHARING

Joint departmental meeting

Integrated dashboard visualization

Cross-program newsletters

Unified partner briefing

CONCLUSION

State planning efforts around health improvement, aging, and dementia are ripe for alignment. While many state agencies develop these plans separately, they often share overlapping goals, strategies, and partners. Evaluating and acting on synergies between state plans can boost collaboration and collective impact by pooling shared resources toward common goals, ultimately improving outcomes for aging populations.

This tool can help state agencies identify and act on opportunities for greater alignment across SHIPs, SPoAs, and dementia plans through a structured way to map connections, reduce duplication, and support more coordinated implementation. By translating complex planning landscapes into actionable insights, the tool empowers states to make more efficient use of limited resources and improve health outcomes across the lifespan.

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Additional Resources

Companion Article: Bridging Silos: Aligning State Health Improvement, Aging, and Dementia Plan

Suggested Recommendations or Alzheimer's Plans

Healthy Brain Initiative Road Map

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