Suggestions for New Topics from the Community
July 5, 2016

Dr. Hugh Straley, Chair
The Bree Collaborative
C/O Foundation for Health Care Quality
705 Second Avenue, Suite 410
Seattle, WA 98104

RE: Support for a project to help create a set of standards and protocols for the diagnosis and treatment of dementias

Dear Chair Straley:

I want to thank you for having the fine work of the Bree Collaborative presented at our most recent Joint Legislative Executive Committee on Aging and Disability. The issues undertaken by the Collaborative are difficult and in need of coordinated discussions and reviews from clinicians and other professionals in order to establish best practices. The Bree Collaborative effort produces real progress in medical practice and health outcomes in our state.

That is why I am sending this letter as a request for the Bree Collaborative to undertake a project to help create a set of standards and protocols for the diagnosis and treatment of dementias. As you may know, I prime sponsored SSB 6124 of 2014, creating a Washington State Plan for Alzheimer’s and Other Dementias. One of the elements of that plan, which was adopted earlier this year, is a Dementia Action Collaborative. This collaborative effort has found that guidelines for practitioners are lacking and that fewer than half of patients who meet the diagnostic criteria for dementia have received that diagnosis from a clinician. It is also a concern that Medicare data indicates that African-Americans and Hispanics are less likely to be diagnosed than whites, and the impact of this is a higher cost of health care services and lower quality of life.

Another concern that needs to be addressed is the lack of mental health beds for dementia patients in need of psychiatric care. The current stand-off between Western State Hospital and a Pierce County Court Commissioner over the admission of one dementia patient throws a bright light on the lack of adequate mental health facilities, both in our communities and at our state hospitals. Although the Legislature directed that 30 geriatric patients at Western State Hospital be moved to community based facilities, those community services are still not available. While there are 32 patients at Western State diagnosed with dementia, some 70 patients remain on a waitlist for admission.
While only a tiny fraction of dementia patients need mental health beds and psychiatric care, many of our state’s adult family homes and nursing homes offer memory care and dementia care services. The Dementia Action Collaborative also has concerns about standards of care and protocols for the handling of behavioral health incidents in those settings, and attention by the Bree Collaborative with those providers would be very helpful as well.

As you probably know already, the aging of our state’s population indicates a growing incidence of Alzheimer’s and other dementias. The disease is already the state’s third leading age-adjusted cause of death, and over the next decade the rate of Alzheimer’s is predicted to increase by 40%.

I am confident the participants in the Dementia Action Collaborative would be most willing to collaborate with the Bree process to undertake a major effort to create new protocols and standards for the diagnosis, care and treatment of our citizens with dementia. I urge you to undertake this effort and would be pleased to assist you in any way that I can. Thank you very much for your consideration.

Always,

[Signature]

Senator Karen Keiser
33rd Legislative District

CC: Senator Randi Becker, Chair, Senate Health Care Committee
    Senator Annette Cleveland, Ranking Member, Senate Health Care Committee
    Senator Barbara Bailey, Co-chair, Joint Legislative Executive Committee on Aging and Disability
    Representative Eileen Cody, Chair, House Healthcare and Wellness Committee
    Sydney Forrester, Sr. Policy Counsel
    Jason McGill JD, Health Policy Advisor, Governor’s Office
    Josh Morse, MPH, Washington State Bree Collaborative Lead
    Terry Rogers MD, Bree Collaborative Vice Chair
    Representative Steve Tharinger, Co-chair, Joint Legislative Executive Committee on Aging & Disability
    Ginny Weir, MPH, Bree Collaborative Program Director
Request: The Alzheimer’s Disease Working Group (ADWG), convened through SSB 6124, developed the Washington State Plan to Address Alzheimer’s and Other Dementias. The Alzheimer’s Disease Working Group recommends that an expert panel identify and endorse a holistic set of Dementia guidelines to address the large variability in the degree to which primary care clinicians support patients with Dementia and their family caregivers. Guidelines would include pursuing a workup, starting and managing medications, managing co-morbid conditions, offering supportive care, support with advance care planning, and referring to other resources such as counseling, senior day programs or palliative care.

The problem: Although there are many benefits to early detection, estimates indicate that fewer than half of the people who meet diagnostic criteria for dementia have received that diagnosis from a clinician. As the number of people with Alzheimer’s and other dementias increases, so will their presence in health care systems.

People living with Alzheimer’s and other dementias are more likely to have other chronic conditions and experience more than triple the number of hospital stays per year than cognitively able older adults. Studies of Medicare data show that people with dementia have more potentially avoidable hospitalizations due to complications of diabetes and hypertension – conditions that could be prevented through active care management.

The U.S. Department of Health and Human Services has targeted this concern in its Healthy People 2020 initiative – setting a target to reduce preventable hospitalizations for people with Alzheimer’s disease and other dementias by 10% by 2020.

While undiagnosed Alzheimer’s is an issue for all groups, Medicare data indicate that African-Americans are less likely than whites to be diagnosed. And when diagnosed, African-Americans and Hispanics are generally diagnosed in later stages of the illness – the impact of this is a higher use of health care services and higher costs. Available statistics indicate that in the U.S. older African-Americans are twice as likely as older whites to have Alzheimer’s disease and other dementias. Hispanic/Latinos are about 1.5 times as likely to have dementia.

Key benefits of evidence based standards of care:

- There are few updated Dementia standards of care. Those that exist, focus primarily on medication.

- All patients deserve access to up-to-date, evidence based care. However, dementia management and diagnosis has dramatically changed since most practicing clinicians were in training.
With the clear rise in dementia prevalence, standard guidelines are necessary to allow primary care clinicians to confidently manage straightforward patients without waiting for limited availability of expertise.

Proper care and supports can help avoid preventable hospitalizations and delay the need for higher level of care.

Early detection and diagnosis would also increase access to valuable resources, and offer more timely opportunities for legal, financial and advance care planning at a time when those with dementia are able to be a part of such decisions.

**Why is Alzheimer’s and Dementia an important topic now?**

**Prevalence**
- Washington State has the 3rd highest rate of death from Alzheimer’s disease of any state.
- Alzheimer’s is Washington’s 3rd leading age-adjusted cause of death.
- State Alzheimer’s rate is expected to increase 40% in the next 10 years, 181% over the next 30 years.
- 83% of US workers are obese or have chronic conditions that increase their risk for Alzheimer’s.

**Costs**
- The total per client Medicaid payments for Medicare beneficiaries age 65+ with Alzheimer’s were 19x those for Medicare beneficiaries without.
- 3rd most costly health condition in 2016 with national annual cost ~ $236 billion.

**Affected Families**
- 324,000 unpaid caregivers provide 369,000,000 hours = $4.485 billion.
- $200 billion in additional health care costs for caregivers.
- Burden on family caregivers affects, in turn, Washington employers, both public and private.

**For more information:**
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Draft BREE Proposal
Improving the Medical Care for Sexual Minorities

**Background and Rationale**
Approximately 4-5% of Americans are sexually minorities\(^1\). This group includes persons who self-identify as being lesbian, gay, bisexual, or transgender (LGBT), as well as persons who identify as being heterosexual but have sex with persons of the same gender. LGBT persons have distinct healthcare needs, and failure to address those needs has profound implications, both for their personal health and for the public’s health.

In particular, men who have sex with men (MSM) and transgender persons are at elevated risk for HIV and other sexually transmitted infections (STI). The CDC estimates that almost 70% of all new HIV infections and half of all cases of gonorrhea occur in the 2% of the population that are MSM\(^2\). In WA State, almost 80% of all new HIV diagnoses, 50% of cases of gonorrhea, and over 90% of syphilis cases occur in the approximately 2% of the population comprised of MSM. MSM experience the highest rates of human papilloma virus (HPV) associated cancer of any definable risk group within the population, with anal cancer rates comparable to rates of cervical cancer observed prior to the advent of PAP smear screening\(^3\), and experience elevated rates of depression and substance use.

Meeting the needs of sexual minorities is a public health priority. End AIDS Washington (EAW), a statewide effort to reduce new HIV infections by 50% by the year 2020, includes improving the medical care of sexual minorities as one of its key objectives. WA is the only U.S. state with specific MSM STD screening guidelines and detailed PrEP implementation guidelines. Levels of HIV viral suppression in WA State (the proportion of infected persons who have an undetectable HIV viral load) are among the highest in the U.S.\(^4\) Thus, the state if making progress in the fight against HIV. At the same time, there is a great deal more to do. The goals of EAW are not achievable without changes in the medical care system.

At present, the health care system is largely blind to the existence to sexual minorities. Although many health care providers ask patients about their sexual orientation or gender of sex partners, many do not, and virtually none record that information in electronic medical records (EMRs) in a way that can be queried or used to improve care. At the same time, many EMRs have or could have data fields recording this information. Consistently recording such information is a critical first step in improving the care of sexual minorities.

Existing data suggest that many MSM, and likely other sexual minorities, want to receive care from medical providers with specific competence and commitment to the care of LGBT persons. In 2015, a team at UW conducted an online survey of almost 2000 MSM in 7 U.S. states, including WA; 82% of MSM reported that they would want to receive medical care from an MSM specialty provider, and 49% indicated that they would change primary care providers to a MSM specialty provider were such a person available to them.
This BREE proposal is designed to improve the healthcare system’s care of sexual minorities with the goal of both improving the individual health of sexual minority patients, and improving the public’s health through the advancement of a key strategy included in EAW.

Proposed actions by healthcare organizations:

1) Systematically collect information on the gender of patient’s sex partners and self-identified gender. This information should be recorded in EMRs in a queryable form that allows for the creation of prompts to improve care and monitoring of outcomes.

2) Develop cadres of medical providers with an interest and expertise to provide care to sexual minorities. This recommendation will require healthcare organizations to identify medical providers who want to provide care for LGBT patients and to develop trainings to ensure and improve their competence. (Training can potentially be developed using an online format that can be shared across healthcare organizations.)

3) Develop EMR-based prompts to improve the care of LGBT patients. Prompts could focus on improving adherence to state guidelines related to HIV and STI screening and the use of PrEP.

4) Monitor the success of actions identified above with the goal of ongoing quality improvement.

5) Ensure that all healthcare organizations have medical providers capable and willing to prescribe HIV pre-exposure prophylaxis.

6) Ensure that laboratories are able to test specimens for gonorrhea and chlamydial infection that are obtained from the rectum and pharynx, including specimens that are self-obtained.

7) Develop emergency department protocols for instituting non-occupational HIV post-exposure prophylaxis.

Proposed actions by health insurers:

1) All health plans should cover up to 4 times a year STI/HIV screening in accordance with local MSM HIV/STD screening guidelines. Patients should not have co-pays, co-insurance or deductibles to receive these services.

2) Persons meeting state guidelines to receive PrEP (both first and second tier recommendations) should be able to receive PrEP without co-pays, co-insurance or deductibles.

3) Persons with clinical indications for non-occupational prophylaxis for HIV should have that medication paid for without co-pays, co-insurance or deductibles.

References


• Move to align with Choosing Wisely
• Behavioral Health
  • Implement mental health parity
  • Behavioral and psychiatric health
  • Treatment of mental health in primary care - how do you get PCP to diagnosis and treat depression
  • Early screening for schizophrenia
  • Look at insurer reimbursement rates for mental health treatment
• Super bug solutions and initiatives in hospitals & by physicians
• Finding alternative pain meds & medicinal treatments versus opioids (not just few prescriptions by doctors)
• Shared decision making tools and training
• Increasing transparency in health care practices
• Palliative care and end of life decisions within health care
• Maternal Health CQI
• Preterm Birth Prevention
• Care Management and high risk care management of patients with complex comorbidities
• Diabetes in primary care
• Wellness and health promotion
• Shoulder surgeries
• Neuro surgeries