

Alzheimer's Disease & Related Dementias (ADRD) Program:

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Alzheimer's Disease and Related
Dementias Program - Tiffany Robb



2023 RECOMMENDATIONS TO ADDRESS ADRD IN IDAHO



IDAHO DEPARTMENT OF
HEALTH & WELFARE
ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

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Executive Summary

The 2023 Annual Alzheimer’s Disease and Related Dementias (ADRD) Report addresses state policy gaps for Alzheimer’s disease and dementias in Idaho. It highlights the prevalence of dementia, including early-onset cases, and emphasizes noncognitive disorders which are decreased mental functions due to a medical disease other than a psychiatric illness. Key issues addressed include the need for protective placements; enhanced training for direct care workers, law enforcement, and emergency responders; public education; and improved medical care.

The report outlines the financial burdens on families and the essential role of the ADRD Program and ADRD Alliance in coordinating statewide responses, emphasizing the need for systemic improvements in care and support for affected individuals and their caregivers.

The report also recommends policy changes to protect those living with dementia, especially in acute behavioral crisis, and proposes improvements in caregiver support, public safety, and healthcare provider education. Those recommendations are to:

- Establish a protective placement for people who have a dementia diagnosis and are experiencing an acute dementia-related behavioral crisis which may be illness-related.
- Establish protections for people who have dementia and reside in a residential assisted living facility subject to emergency discharge.
- Change the current IDAPA 16.03.22 to provide protections for people in an acute dementia-related behavioral crisis from immediate evictions without the involvement of an advocate such as a local ombudsman.
- Establish a training infrastructure providing evidence-based training for direct care workers, emergency respondents, and law enforcement, contributing to a centralized database and informed program activities.
- Require four hours of dementia training to be completed for law enforcement and first responders.
- Require hospitals to contribute data to a hospital discharge database system in the state of Idaho.
- Designate state funding to support family caregivers across the lifespan.



Introduction

Dementia is an umbrella term for several neurological conditions that cause symptoms such as impairment in thinking, remembering, and reasoning that interfere with a person’s daily living. Alzheimer’s disease tends to be the leading cause of dementia, but neither Alzheimer’s nor dementia are a normal part of aging. Alzheimer’s disease and other dementias affect people between the ages of 18 and 65. Although rare, “early-onset diagnoses have been increasing, especially for people between 30 to 64 years of age, with women being disproportionately impacted.”¹

Noncognitive (not related to conscious intellectual activity) symptoms and behaviors occur in up to 90% of the population with a dementia diagnosis. These symptoms are grouped into four categories:

1. Mood disorders – depression, apathy, and euphoria.
2. Sleep disorders – insomnia, hypersomnia, and night-day reversal.
3. Psychotic symptoms – delusions and hallucinations.
4. Agitation – pacing, wandering, sexual disinhibition, and aggression.²

Although dementia-related behaviors occur naturally due to brain degeneration and cognitive decline, medical issues can also cause dementia-related behaviors. Urinary tract infections, constipation, poor sleep, and pain are just a few examples of medical issues that can lead a person with dementia to have a serious dementia-related behavior.

As of 2020, Idaho had an estimated 27,000 individuals (65 and older) with a diagnosis of Alzheimer's disease.³ Unfortunately, there are no estimates of the total number of Idahoans currently living with a dementia diagnosis, because it is underdiagnosed and underreported on death certificates. It is estimated that if all types of dementia were grouped, dementia would be the third leading cause of death in Idaho.⁴

The number of Idahoans aged 65 and older with Alzheimer's disease is expected to increase to 33,000 by 2025.³ A person with an Alzheimer's disease or dementia diagnosis will require assistance with daily living activities.

Currently in Idaho, 65,000 family or informal caregivers of those with dementia provide unpaid care totaling over \$1.8 billion.³ Many caregivers work a full- or part-time job in addition to providing care. The steady increase in care required by a person with dementia forces many family caregivers into early retirement or to leave the workforce. This is compounded by the fact there is a limited number of memory units and beds in Idaho, the few available are unaffordable for the average Idahoan.

27,000

Idaho individuals (65 and older) had a diagnosis of Alzheimer's disease in 2020.

33,000

The number of Idahoans aged 65 and older expected to have Alzheimer's disease by 2025.

65,000

Family or informal caregivers providing unpaid care to people with dementia totaling over \$1.8 billion in Idaho.



Recommendations for State Policy Related to ADRD

As directed by 39-2701, Idaho Code, the Alzheimer’s Disease and Related Dementias Program (ADRD) is required to “provide this annual report, including information on recommendations for state policies, a review of services, public safety issues for those living with ADRD and their caregivers, public education, and services initiated and coordinated among public and private agencies to meet the needs of Idahoans with ADRD and their caregivers.” This report also includes an update on the progress being made by the statewide ADRD Alliance that the ADRD Program hosts, coordinates, and monitors.

Additionally, the Office of Performance Evaluation’s (OPE) [State Response to Alzheimer’s Disease and Related Dementias – Follow-up Report](#) released October 2023 identifies several opportunities. The ADRD Program has selected a few to highlight in this report as they align with existing work currently happening across the state.

What can the state do?

The ADRD Program suggests state policy be reviewed to address the following key areas to assist in establishing a statewide “safety net” to protect and serve people living with dementia and their caregivers in times of serious behavioral crises. The following policy areas may help Idaho with existing coordination and improve dementia response.

Establish a protective placement. Individuals with a “major” neurocognitive brain disorder (a decreased mental function due to a medical disease other than a psychiatric illness) may lose their ability to reason and communicate in a socially acceptable fashion. When a person with a neurocognitive brain disorder is in pain or is sick, they may lash out and become aggressive, which is also known as a serious or acute behavioral crisis. Currently, people with a neurocognitive brain disorder who are experiencing an acute behavioral crisis, are at risk of being tased or shot during a response by law enforcement for aggressive behavior, being placed in jail, being left at home with no immediate solution, or wrongly being diagnosed or assumed to be a person with mental illness and being placed under an involuntary hold in the hospital only to be released due to having a primary diagnosis of a neurocognitive brain disorder.

This population has been removed from the current mental health involuntary hold, 66-326 Idaho Code, and is at risk of not receiving the appropriate emergency response or medical attention.

A protective placement would allow peace officers to legally put the person under a protective placement and transport the individual, in a safe and dignified manner, to the nearest hospital for a medical assessment. This would also allow healthcare workers to determine if there is an underlying medical cause for the acute behavior crisis. The person with the neurocognitive brain disorder would be discharged within 24 hours of the initiation of the protective placement unless they, their caregiver, or the healthcare professional determine they should remain at the hospital for further medical care.

- Information to be aware of:
 - ◇ Law enforcement or peace officers will need extensive training on the protective placement and on the appropriate response for a person with a neurocognitive (a decreased mental function due to a medical disease other than a psychiatric illness) brain disorder.
 - ◇ Family caregivers need access to support and education, so they are more willing to take the person back home after an acute behavioral crisis incident.
 - ◇ Health systems and residential assisted living facilities will need to be educated on the change in statute and how to best support a person with a neurocognitive brain disorder who is experiencing an acute behavioral crisis and their family caregiver(s).

Establish protections for people who have dementia and reside in a residential assisted living facility. Currently, a person living in a residential assisted living facility who is behaving in a manner that infringes on the rights of others or puts self or others in danger, at the discretion or interpretation of facility staff, can be evicted without the ability to appeal and without a 30-day warning, according to [Title 39, Chapter 33](#).

At a time in Idaho when many of our residential assisted living facilities have closed or only accept private-pay residents, Idaho's vulnerable populations need more protections, especially if the serious behavior is not written into their care plan as per [IDAPA 16.03.22](#) and is being caused by an underlying medical condition.

One addition to IDAPA 16.03.22 would be the use of and incorporation of an independent medical assessment of individuals living in a residential assisted living facility who are experiencing an acute behavioral crisis, to determine if the resident's acute behavioral change is presenting as a threat of harm to self or others due to an underlying medical condition. If the person with a neurocognitive brain disorder is found to have an underlying medical condition that accounts for the behavior, the individual should not qualify as an emergency discharge and be evicted from the facility without the facility modifying the person's care plan and without sufficient warning.

The results of the independent medical assessment would be added to the resident's record along with updated behavior documentation outlined in 16.03.22.

Change IDAPA 16.03.22 to provide more details. Continuing from the above-stated recommendation, suggestions for possible language changes are as *follows in bold italics*:

- Section 152.03.b.x. "A resident who is violent or an *imminent* danger to themselves or others."
- Section 217. REQUIREMENTS FOR TERMINATION OF ADMISSION AGREEMENT.
 - ◊ 01.c. "Emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from harm *must provide a three (3) day written notice given by the provider to the resident, the resident's representative, and the local ombudsman.*"
 - ◊ 01.c. "Emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from *imminent* harm."
 - ◊ 02. "Facility Responsibility During Resident Discharge. The facility is responsible to assist the resident with transfer by providing a list of skilled nursing facilities, other residential assisted living facilities, and certified family homes that may meet the needs of the resident. The facility must provide a copy of the resident record, as described in Section 330 of these rules, within two (2) business days of receipt of a request signed and authorized by the resident or legal representative. *The facility must file electronic notification of termination of admission agreement to the State Ombudsman immediately upon determination.*"

- ◇ 03. “Resident’s Appeal of Involuntary Discharge. A resident may appeal all discharges, with the exception of an involuntary discharge in the case of nonpayment or emergency conditions that require the resident to be transferred to protect the resident or other residents in the facility from *imminent* harm *not caused by an underlying medical issue.*”
- ◇ 03.a. Before a facility discharges a resident, the facility must notify the resident, their representative, *and the local ombudsman* of the discharge and the cause.
- ◇ 04.d. The Residential Assisted Living Facilities Program website, where the appeal must be submitted *and notice that they may contact their local ombudsman if they need help completing the appeal form.*

Establish an evidence-based training infrastructure for direct care workers. Direct care workers often do not have sufficient dementia-specific knowledge to effectively support those with Alzheimer’s and other dementias. Often, the training provided does not cover the skills and competencies that will equip workers to appropriately care for those with a significant cognitive impairment. Even in states with dementia-specific training requirements, many of those policies are out of date, cover only a subset of workers, lack competency standards, and have inadequate enforcement mechanisms.

Dementia training for those involved in the delivery of care can improve the quality of care and experiences for individuals with Alzheimer’s and other dementias. A cornerstone of providing quality dementia care is to ensure all professional care staff involved in the delivery of care to people with dementia receive evidence-based dementia-specific training. Especially during a workforce shortage as Idaho is currently experiencing, facilities need to make sure even support staff such as kitchen, janitorial, and administrative can provide care.

Conducting a review and modification of the Idaho Administrative Code is necessary to mandate the development of a training infrastructure to track required training for all skilled nursing and residential assisted living facility staff to meet the needs of people with dementia. This can be done by:

1. Requiring a minimum of four hours of evidence-based dementia training for all those who serve individuals with dementia.
2. Ensuring continuing education to reinforce best practices in the care of those with dementia.

3. Implementing a culturally competent curriculum to incorporate principles of person-centered care.
4. Allowing portability of completed dementia care training across employment settings.
5. Ensuring trainers meet minimum requirements to qualify as instructors of a dementia curriculum.

First responders will often encounter individuals with dementia. First responders interact with people with Alzheimer's while searching for a lost person, stopping drivers who exhibit unsafe driving, rescuing people with dementia from abuse, and intervening in crisis or disaster situations. Individuals with Alzheimer's and other dementias can also be the victims of elder abuse; however, they may be unaware they are victims and may not know how to, or be able to, report the abuse.

Despite the frequency of interactions, in 2015 only 10 states, not including Idaho, had laws requiring dementia training for first responders/law enforcement personnel. Only six states, not including Idaho, required training for Adult Protective Service (APS) workers. Thankfully, Idaho's APS staff have all received training through the [Idaho Commission on Aging's Dementia Skills Training- 11-modules](#).

Require four hours of dementia training to be completed for law enforcement and first responders. An increased amount of dementia training should be completed during police academy training for law enforcement officers and during the certification process for other first responders. A minimum of two hours of annual continuing education on dementia should be required.

Dementia training for first responders provides tangible benefits. People with Alzheimer's may present as uncooperative, disruptive, and combative when they have difficulty communicating and understanding what is happening. First responders may not know how to work with people in these situations, leading to more confusion and potentially an exacerbation of behaviors. Education about the disease and training in de-escalation tactics can often effectively address the situation and ensure the safety of people with dementia, first responders, and law enforcement.

With resources and additional funding, the Alzheimer's Disease and Related Dementias (ADRD) Program is ideally situated to serve as a centralized hub to house evidence-based training, monitor dementia training programs, evaluate training effectiveness,

track state trends, allow portability of completed and ongoing dementia training across all employment settings, and ensure these align with state dementia training requirements.

The information gathered through regular data collection would allow the state program to make informed decisions in the development of plans and policies concerning efforts such as increasing public awareness about Alzheimer's and other dementias, and craft appropriate interventions, such as:

- ◇ Promoting early detection and diagnosis of the disease.
- ◇ Including cognitive health in other public health campaigns.
- ◇ Evaluating efforts at state and local levels to address the crisis.

Require hospitals to contribute data to a statewide hospital discharge database system. Idaho is one of last remaining states without a centralized database system of patients admitted into hospitals. Having such a system would enable the state to readily provide information on such topics as: how many Idahoans are hospitalized with neurocognitive disorders; whether admissions are increasing or decreasing; what patient population admissions are increasing (e.g., for certain age groups, sex, or other demographic groups); the average time these patients are hospitalized; and to where patients are discharged (residence or long-term care facilities). Having this information would be invaluable for understanding the magnitude of ADRD issues and in pinpointing what parts of the state are most in need of resources. The Idaho Hospital Association recently established a hospital discharge system; however, this system is currently voluntary for hospitals to provide data. As a result, only a small percentage of Idaho hospitals opt-in to providing data. Requiring all hospitals to opt-in to the Idaho Hospital Association data system would create a greatly improved understanding of ADRD issues. Similar legislation has been passed into law in multiple states.

Public Safety Issues for Idahoans Living with ADRD and Their Caregivers

Alzheimer's disease affects entire families and causes tremendous financial hardships. The lifetime cost of dementia is estimated to be more than \$390,000, including the value of unpaid caregiving. Families shoulder 70% of these costs.

The lifetime cost of care for individuals with Alzheimer's disease is more than twice the cost of healthcare incurred by people without Alzheimer's. Each year, a family spends, on average, more than \$10,000⁵ to pay the out-of-pocket health and long-term care costs of a senior with Alzheimer's or another dementia. This is more than four times greater than the average annual out-of-pocket costs of seniors without dementia.

In the last five years of the life of a person with dementia, family out-of-pocket healthcare spending totals more than \$86,000 — more than twice as much as for a person with cancer and nearly 75% higher than for a person with heart disease. On average, a third of a family's wealth is consumed by out-of-pocket healthcare spending in the last five years of the life of a person with dementia. This compares with 11% for people with other conditions. For a Black family, dementia in the last five years of life consumes, on average, more than 80% of the family's assets.⁵

\$390,000+

Lifetime cost of dementia including the value of unpaid caregiving.

\$10,000

Average expense for a family on health and long-term care costs of a senior with Alzheimer's or another dementia.

\$86,000+

Average cost a family pays for healthcare in the last five years of the life of a person with dementia.

The financial effects of Alzheimer's on families go beyond healthcare costs. Among care contributors nationally — those who are caregivers of people with Alzheimer's and/or contribute financially to their care — 48% cut back on their expenses (including food, transportation, and medical care) to pay for dementia-related care. Because of the economic burden of dementia, one in five care contributors must use their retirement savings, and 15% need to borrow money. One in nine cuts back on spending for their children's education. Many dementia care contributors must reduce their spending on food. In fact, they are 28% more likely than other adults to eat less or go hungry because they cannot afford to pay for their meals. Nearly half (47%) of family Alzheimer's caregivers report a good amount or a great deal of financial strain due to caregiving.⁵

Paying for these costs is often made even more difficult by the employment consequences for caregivers. More than one in six Alzheimer's caregivers had to give up their jobs to become a caregiver or because their caregiving duties became too burdensome. Among those who continue to work, 57% have had to go to work late, leave early, or take time off because of their caregiving responsibilities. Care contributors who must work fewer hours to support a person with dementia lose, on average, \$15,000 in annual income. Two out of five see a loss of income of at least 20%.⁵

Idahoans are no different from the national average, except more Idahoans who serve as family caregivers work a full- or part-time job while providing care. Idahoans who provide care don't have access to respite and direct care staff who could help keep their loved ones at home longer. Idahoans must keep their loved one with dementia at home even when they can no longer provide safe care or they have to move their loved one out of state because of the decreased number of and affordability of residential assisted living facilities available in Idaho. Since Idaho lacks appropriate facilities for people with dementia-related serious behaviors, many families are left with the burden of trying to figure it out and rely upon first responders to come to their home to attempt to de-escalate the behavior only to return the next day.

What can the state do?

Designate state funding to support family caregivers across the lifespan and help with respite. A state-funded respite program could augment federal funds to decrease abuse, neglect, and burnout, and could keep people with dementia with their families instead of being placed in a facility.

What the ADRD Program has done.

To assist family caregivers, the Alzheimer's Disease and Related Dementias (ADRD) Program applied for and was awarded the Administration for Community Living (ACL) grant that the Idaho Commission on Aging had previously held but was no longer able to continue to manage. This grant allows state agencies the opportunity to increase respite access and education for Idahoans across the lifespan. Currently in Idaho, respite funding for dementia care comes from the Older Americans Act and is awarded to the Idaho Commission on Aging.

Idaho Code 67-3516(2) restricts any federal funding received after annual appropriations until approval by the Division of Financial Management or the Board of Examiners.

The ADRD Program received two federal grants totaling \$850,000, both after annual appropriations were already approved and is awaiting legislative approval for spending authority to use the funds. The funds will expand coordinated efforts across the state for ADRD and family caregivers.

Recent Policy Adoptions by Other States:

- Maine passed a 1% increase in payroll tax that will be split 50/50 between employees and employers allowing workers to take up to 12 weeks of paid leave each year to care for sick family members. This was 10 years in the making.
- Minnesota will allow workers to take up to 12 weeks for family leave and up to 12 weeks for one's own serious medical condition, a max of 20 weeks annually. To fund this, payroll premiums will be split between employers and employees. Employees will be able to use this to care for someone not related by blood or marriage, such as a significant other, neighbor, or friend.
- Oklahoma is the first state in the nation to adopt an expansive caregiver tax credit with its Caring for Caregivers Act. The act will allow a tax credit of up to 50% of eligible caregiver costs, capped at \$2,000 per year for most participants and \$3,000 per year for veterans or people with dementia.

Public Education

The Alzheimer's Disease and Related Dementias (ADRD) Program uses the Public Health Prevention Framework (Figure 1) as its guide to address Alzheimer's disease and other dementias. The ADRD Program is coordinating efforts among partners and providing presentations on brain health, early detection, decreasing stigma, available supports and services, the value of the family caregiver, and reducing preventable hospitalizations.

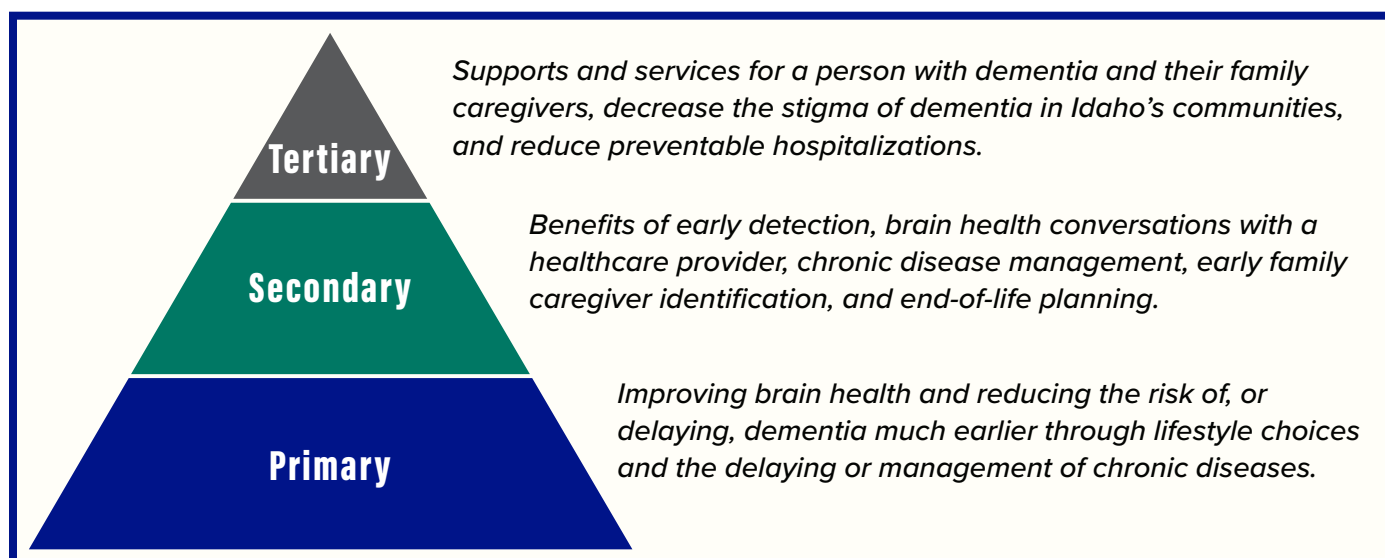


Figure 1.

What the ADRD Program has done.

The requirement of the program to provide public education across Idaho on brain health (prevention), early detection, and dementia and caregiver supports and services is enormous. To gradually accomplish this task, the ADRD Program has three priorities for education efforts: the layperson, the healthcare provider, and the emergency responder.

The Layperson

Educational campaigns:

Research has shown that reaching youth is how we will create behavioral change over time. For this reason, the Alzheimer’s Disease and Related Dementias (ADRD) Program invested state and federal dollars into the launch of a program called Noggin (Figure 2). The goal of Noggin is to reintroduce behavioral health choices to parents of children and youth through a fun character and a little play on words.

This campaign launched at the beginning of the 2023 school year. The program hopes to expand it to include exercise and diabetes management to help protect your noggin. The campaign used four creatives and ran on social media platforms; impressions are shown in Figure 3 below.

To be fiscally responsible, the ADRD Program partnered to bring educational materials to Idaho instead of recreating material. Some of these partnerships were with the [National Association of Chronic Disease Directors](#) and the [International Association for Indigenous Aging](#), bringing Healthy Aging and Healthy Brain rack cards to Idaho’s Area Agencies on Aging, local public health districts, senior centers, libraries, and other entities who would like to help educate their

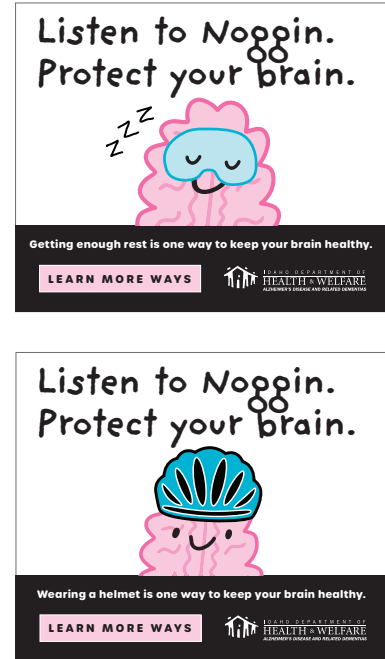


Figure 2.

Placement	2023 Youth ‘Noggin’ Campaign
Facebook & Instagram	566,415
Snapchat	476,750
StackAdapt	1,082,196
Total Impressions	2,125,361

Figure 3.

communities about brain health. Below is a list of materials that distributed and the total amount since spring 2023 (Figure 4).

Material	Number Distributed
2023-2028 ADRD Strategic Plan for Idaho Marketing Brochures	975
2023-2028 ADRD Strategic Plan for Idaho Marketing Flyers	300
2023-2028 ADRD Strategic Plan for Idaho (English and Spanish)	902
Healthy Blood Pressure. Healthy Brain. Rack Cards (English and Spanish)	3,850
Healthy Blood Sugar. Healthy Brain. Rack Cards (English and Spanish)	4,354
Healthy Body. Healthy Brain. Rack Cards (English and Spanish)	3,892
Healthy Diet. Healthy Brain. Rack Cards (English and Spanish)	3,905
Healthy Food. Healthy Brain. Rack Cards (English and Spanish)	14,450
Healthy Brain Flyers (English and Spanish)	1,800

Figure 4.

To increase general awareness of brain health and educate Idahoans on Alzheimer’s disease and other dementias, two media campaigns were implemented. The first focused on improving brain health, delaying the effects of dementia, and recognizing the signs. This media campaign is delayed until approval to spend federal funds in SFY25 is provided by the legislature.

Dementia Friends:

The stigma associated with dementia impacts Idahoans in many ways. They may not get a diagnosis or talk to a healthcare provider as soon as they experience symptoms because they are embarrassed. Or they may assume the symptoms of dementia are age-related. Once a diagnosis happens, they may isolate themselves from family and friends. To address this, the Alzheimer’s Disease and Related Dementias (ADRD) Program launched the [Dementia Friends Idaho](#) program and piloted it with the University of Idaho’s Extension Office to host information sessions. The sessions provide basic information on dementia, increases the understanding of what is and isn’t age-related change, and provides training on how to decrease stigma within communities. Idaho has 324 Dementia Friends across the state, but more work is being done to increase that number.



Excerpt from the University of Idaho Extension Impact Report:

As a result of this program 96% of participants reported that their awareness and understanding of dementia increased. Additionally, 93% of participants reported feeling more confident and equipped to recognize signs and offer support to the needs of a person living with dementia after attending an information session. One of the biggest outcomes of this program has been reducing the negative stigma associated with dementia. This can be seen by the comments from participants. One participant said, "I want them [those living with dementia] to feel like they belong and not be ashamed."

The program also developed five different informational webpages hosted on the Department of Health and Welfare's (DHW) website to help decrease frustration for people with dementia or their family caregivers. These informational sites include [ADRD](#), [Brain Health](#), Healthcare Providers (under construction), the [ADRD Alliance page](#), and the [Dementia Friends Idaho page](#).

The Healthcare Provider

Due to the extra years of training required and relatively low reimbursement rates, only a small percentage of healthcare professionals specialize in geriatrics. In fact, an additional year of geriatric training can reduce earnings power. Nationally in 2022, there were 411 geriatric fellowship positions offered. Nearly half of them went unfilled. Among primary care physicians, 69% say they learned very little or nothing about the diagnosis and care for Alzheimer's and other dementias in medical school.⁶

An overall lack of exposure to geriatrics during medical training means most physicians will enter the workforce with little exposure to the needs of older adults, including those with dementia.

The consequence is a physician workforce insufficient to meet the needs of today's older population, and this shortage is only expected to get worse.

More than half of primary care physicians report there are not enough dementia specialists in their geographic area to meet patient demand. In 2013, there was already a shortage of geriatricians, a physician who has additional training in treating adults 65 years and older. To meet the needs of those anticipated to have Alzheimer's in 2050, the number of geriatricians will need to nearly triple. In 2021, Idaho was deemed a "neurology desert" due to a shortage of neurologists (a physician who diagnoses, treats, and manages disorders of the brain and nervous system). At that time, Idaho had eight geriatricians. By 2050, Idaho will need to increase the number of geriatricians to 87 to meet demand.³

Recognizing Idaho does not have the necessary number of physicians or geriatricians, and to assist with the gap in healthcare provider education, the Alzheimer's Disease and Related Dementias (ADRD) Program funded two years of training sessions about Alzheimer's and other dementias for healthcare providers (to include nursing, social work, physician assistant, etc.) with University of Idaho's Project ECHO Program.

The first year a total of 259 hours of continuing education credits were issued to 139 individuals who participated across the six ECHO sessions between January and May 2023. The program is currently in its second year of funding these Project ECHO sessions. Each package of six sessions costs the program \$50,000. The program is evaluating whether this is the most effective use of funding.

Another healthcare provider education effort, also funded by the ADRD Program, is with the two Alzheimer's Association chapters that serve Idaho. The program has funded \$10,000 each year for the last two years, increasing its outreach and providing healthcare provider education on available resources in Idaho.

In the fall of 2023, the program also initiated a statewide dementia, resource, education, assessment, and management a.k.a. DREAM Team of healthcare professionals with the main goal of increasing brain health and ADRD education and assistance to primary care providers across Idaho. The program will continue to facilitate these meetings and evaluate progress.

The Emergency Responder

Emergency medical services (EMS) personnel, including police officers, paramedics, and firefighters, frequently encounter individuals with dementia. Equipping them with proper training on dementia can lead to a multitude of benefits, both for the individuals with dementia and for the emergency services personnel themselves, including:

- **Improved communication and de-escalation:** Training can help emergency personnel recognize signs and symptoms of dementia, understand common communication challenges, and employ de-escalation techniques tailored to individuals with dementia. This can lead to more peaceful and productive interactions, reducing stress and anxiety for both parties.
- **Reduced risk of harm:** Misinterpreting dementia symptoms can lead to unnecessary use of force or restraint. Training can equip personnel with strategies for managing situations safely and effectively, minimizing the risk of harm to individuals with dementia.
- **Better medical care:** Understanding dementia allows emergency personnel to provide more accurate medical assessments and treatment plans. This can lead to faster diagnoses, appropriate interventions, and improved overall health outcomes.
- **Enhanced safety and security:** Training can help individuals with dementia and their families develop safety plans and identify potential risks. Emergency personnel can then work collaboratively to ensure the safety and security of individuals with dementia in their communities.

The program has initiated education to EMS providers and connected with rural providers who need assistance with people who have dementia. Unfortunately, the program has not had the ability to dedicate staffing to expand efforts to date.

Review of Services Initiated and Coordinated Among Public and Private Agencies to Meet the Needs of Individuals with ADRD and Their Caregivers

As reported by the recent 2023 OPE evaluation of the Alzheimer's Disease and Related Dementias (ADRD) Program progress, the ADRD Program has taken the initiative to identify gaps in ADRD services and policies. To do this, the program has fostered improved collaboration statewide by engaging individuals and representatives from community organizations, hospitals, DHW programs, and other state, tribal, and federal agencies that serve people with dementia and their caregivers. The ADRD Program's efforts in building relationships statewide have led to the program becoming aware of or involved in several coordination efforts. These include:

- In North Idaho, the local chapter of the Alzheimer's Association, in partnership with One Site for Seniors, the local area agency on aging, the local public health district, and Kootenai Health hosted their first caregiver conference on Alzheimer's disease in 2023. This group continues to brainstorm how they can better serve the population in northern Idaho with few resources and staff volunteers.
- The Community Care Program, launched with state general funds through the Idaho Commission on Aging, has now been implemented for a year with four case managers across the state. The Community Care Program serves family caregivers of people with memory concerns, connecting caregivers or people with dementia to available resources, and getting them the necessary training.
- To increase collaboration within aging services, public health, clinical supports, and lifespan respite, the ADRD Program applied for two federal grants. The total amount awarded in July and August 2023 totaled \$850,000 annually for the next four to five years, depending on the funding stream. This is pending legislative spending authority approval. The Association of Community Living Lifespan Respite grant will allow the ADRD Program, in partnership with the Idaho Caregiver Alliance, to expand consumer-directed respite services in the disability community and allow for seed funding for community-led initiated respite opportunities. The Centers for Disease Control and Prevention BOLD Public Health grant will allow the ADRD Program to provide funding to initiate portions of the state strategic plan for Alzheimer's and other dementias, specifically around establishing or reinforcing the connection between aging services, public health, and clinical services.

Update on the Statewide ADRD Alliance

The Alzheimer’s Disease and Related Dementias (ADRD) Program continues to coordinate the ADRD Alliance and strategic plan implementation. Nineteen ADRD Alliance meetings were held between November 2021 and October 2023. Attendance ranged from a high of 56 at the first meeting to a low of 32 in spring 2022. At least five of the seven public health districts were represented at each meeting, with all seven represented at some (Figure 5).

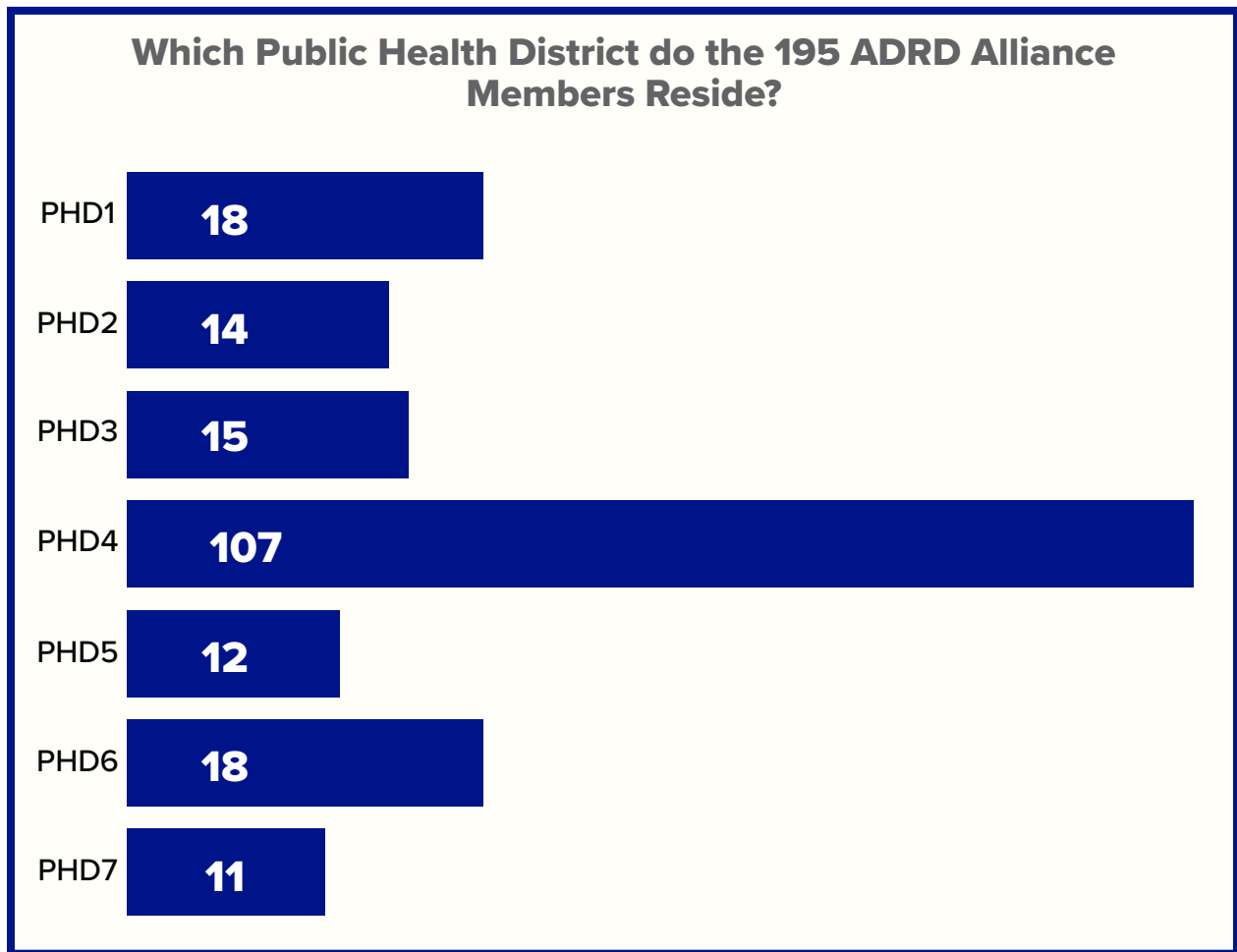


Figure 5.

ADRD Alliance meetings were held monthly while the strategic plan was being developed. The statewide alliance moved from monthly meetings to quarterly meetings with the establishment of the [Alzheimer's Disease & Related Dementias \(ADRD\) Strategic Plan for Idaho 2023-2028](#).

Since the spring of 2023, the ADRD Program has guided the alliance in moving from an established strategic plan to forming workgroups or goal teams to continue to meet over the next five years to help facilitate and track activities identified in the strategic plan.

Goal team focus areas are:

- 1.** Awareness of brain health and wellness and benefits of early detection.
- 2.** Proactive actions to improve quality of life.
- 3.** Training for healthcare professionals.
- 4.** Training for others in the community.
- 5.** Caregiver supports.
- 6.** Access and equity-enabling factors: Systems, funding, etc.
- 7.** Strengthening workforce.

These goal teams have been meeting every six to eight weeks since August 2023 and have already started making headway on activities within the strategic plan. Work has begun on 20 of the 39 strategies listed in the ADRD Strategic Plan for Idaho. In total, 38 individuals have participated in the goal team workgroups.

More Information

This report was prepared by:

Idaho Department of Health and Welfare Division of Public Health
Alzheimer's Disease and Related Dementias (ADRD) Program.

Tiffany Robb, Program Manager, ADRD Program

Angie Bailey, Section Manager, Chronic Disease

Jack Miller, Bureau Chief, Bureau of Community Health

Contacts:

Elke Shaw-Tulloch. Administrator, Division of Public Health, 208-334-5950,
Elke.Shaw-Tulloch@dhw.idaho.gov.

Tiffany Robb. Program Manager, ADRD, Division of Public Health,
208-810-0048, Tiffany.Robb@dhw.idaho.gov.

Niki Forbing-Orr. Communications and Policy Manager, Division of Public Health,
208-334-5935, Niki.Forbing-Orr@dhw.idaho.gov.

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IDAHO DEPARTMENT OF
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