UTAH DEPARTMENT OF HEALTH

Utah Health Status Update:
Alzheimer's and Related Dementias

May 2016

Dementia is not a specific disease, but rather an umbrella term used to describe a wide range of symptoms associated with a decline in mental ability that is severe enough to interfere with a person's daily life. There are several types of dementia including Lewy bodies dementia, frontotemporal dementia, vascular dementia, and dementia associated with another disease such as Parkinson's disease. However, Alzheimer's disease is the most common cause of dementia, and accounts for 60–80 percent of cases. It has been estimated that 1 in 9 people in the United States aged 65 and older has Alzheimer's disease.[1] The Baby Boomer generation is beginning to reach age 65, putting this large group in the range of greatest risk for Alzheimer's disease.

In 2014, Alzheimer's was one of the top five leading causes of death among those aged 65 and older in Utah (Figure 1). Roughly, 10 percent of Utah's population is 65 and older and by 2030 it is projected that 13 percent of Utahns will be 65 and older.[2] This presents a growing need for a long-term plan to address the needs of our increasing senior population. Dementia care has placed a large burden on our health care systems. A national study found that the average cost per person who died with dementia was significantly greater than that of those who died of heart disease, cancer, and other causes. The same study found that while Medicare expenditures were similar across groups, the average out-of-pocket spending for patients with dementia was 81 percent higher than that for patients without dementia.[3]

Included in Medicare coverage for those aged 65 and older is the Annual Wellness Visit (AWV), which is an assessment conducted at the primary care level. This visit assesses the physical health of older adults as well as the detection of any cognitive impairment. This component is essential in recognizing and diagnosing dementia in Medicare patients. There has been a slight increase in the percentage of Medicare AWV billing in Utah from 2012 to 2014 going from 6.6% to 12.4%, respectively (Figure 2). Promoting utilization of the cognitive assessment during the AWV will likely increase early diagnosis of dementia, reducing health care costs, and improving the quality of life of patients and their loved ones.[4]

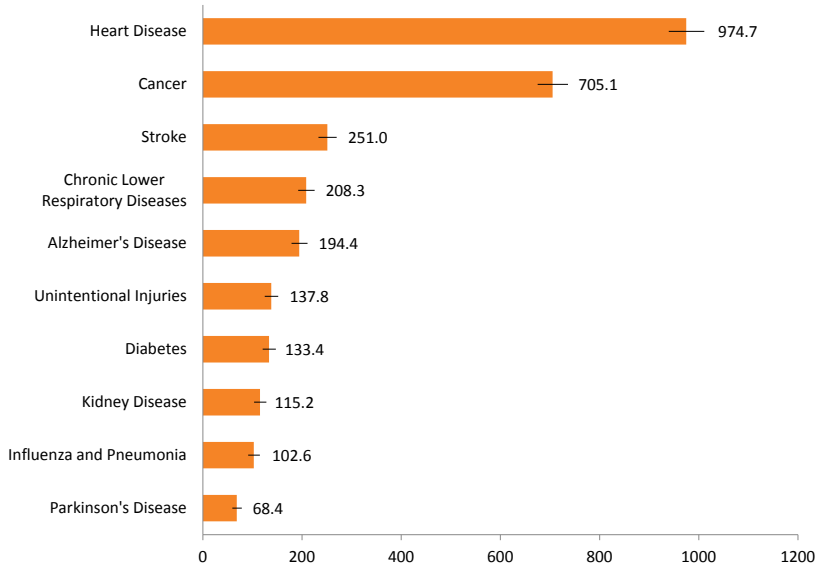
Dementia also has a large burden on families and those providing care for these individuals. There are 336,000 estimated caregivers in Utah who provide 90 percent of the care for seniors, with less than 1 percent of caregivers using state or local support services.[2] Caregivers provide 313 million hours of care which is valued at 4.2 billion dollars annually.[2] In Utah, in 2015, 59 percent of caregivers took time off from their employment, while 15 percent gave up working entirely.[2] Caregivers also

KEY FINDINGS

- **Dementia is an umbrella term for a wide range of symptoms associated with decline in mental ability and memory. Alzheimer's is the most common type of dementia and is one of the five leading causes of death in Utah among those aged 65 and older.**
- **Dementia places a large financial, physical, and social burden on patients and family caregivers.**
- **Use of the Medicare-covered Annual Wellness Visit has been increasing slightly (from 6.6% in 2012 to 12.4% in 2014), but can still be improved. Increasing utilization of the AWV and the cognitive assessment tool included in the AWV is crucial to improving rates of early diagnosis of dementia.**
- **There is a growing need for statewide data surveillance on dementia in order to establish dementia burden in Utah and the costs associated.**

Leading Causes of Death Among Persons Aged 65+

Figure 1. Leading causes of death per 100,000 population aged 65 and older, Utah, 2014



Source: Utah Death Certificate Database

have poorer physical health. Up to 35 percent of caregivers report their own health as fair or poor and are more likely to experience heart disease, stroke, sleep problems, and hypertension. Another study found that up to 50 percent of caregivers meet the diagnostic criteria for major depression.[2]

At this time, there is no system in place to collect statewide morbidity data on Alzheimer's and dementia. We need to be able to identify gaps in resources and improve services available to those with dementia. Collecting and utilizing accurate prevalence data helps guide funding efforts. Without reliable data on dementia, we are unaware of burden within the state and where best to allocate funding to be most cost-effective in efforts to deal with the increasing need for services and resources for those with dementia and their families.

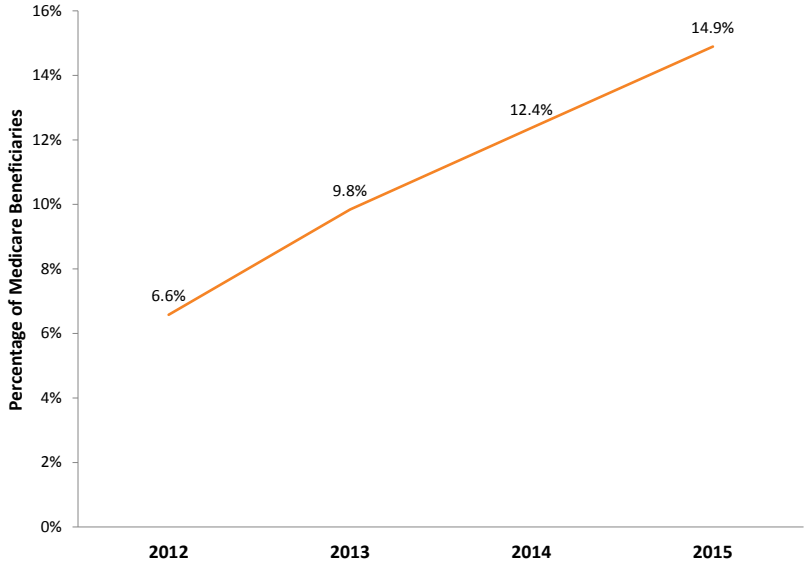
There is no long-term strategic plan to care for the growing population of seniors in Utah. In 2012, the Utah Legislature passed a bill to implement "Utah's State Plan for Alzheimer's and Related Dementias." For more information, see the Breaking News article.

References

1. *2016 Alzheimer's Disease Facts and Figures* (4th ed., Vol. 12, pp. 1–21) Alzheimer's Association.
2. Proctor, M. (2015). *Taking Care of Our Seniors, An Assessment of Utah's Aging Services* (pp. 1–15, Rep. No. 733). Utah Foundation.
3. Kelley, A. S., McGarry, K., Gorges, R., & Skinner, J. S. (2015). The Burden of Health Care Costs for Patients With Dementia in the Last 5 Years of Life. *Annals of Internal Medicine*, 163, 729–736.
4. Alzheimer's Association. "Early Detection, Diagnosis & Care Management For People With Dementia May Reduce Healthcare Costs". *alz.org|blog*. 2010. http://blog.alz.org/early-detection-diagnosis-care-management-for-people-with-dementia-may-reduce-healthcare-costs/.

Medicare Annual Wellness Visits

Figure 2. Estimated rate of subsequent annual wellness visits among Medicare patients by year, Utah, 2012–2015



*Data from 2015 are subject to claims maturity issues and should be considered preliminary.
Based on Medicare fee-for-service (FFS) claims only. Numerator includes number of FFS Medicare claims for Annual Wellness Visit, subsequent (G0439) in the calendar year. Denominator includes beneficiaries with 12 months of Part B enrollment and 6 months or less of Medicare HMO enrollment for the calendar year. Beneficiaries were counted who were alive as of the last day of the calendar year.
Data provided by HealthInsight, the Medicare Quality Innovation Network – Quality Improvement Organization for Nevada, New Mexico, Oregon, and Utah.

For additional information about this topic, contact Lynn Meinor, Alzheimer's State Plan Specialist, Utah Department of Health, (801) 538-6198, email: lmeinor@utah.gov or the Office of Public Health Assessment, Utah Department of Health, (801) 538-9191, email: chdata@utah.gov.

UDOH ANNOUNCEMENT:

The Division of Family Health and Preparedness has been developing the Direct Access Clearance System (DACS). DACS was developed to automate the background clearances of various health care provider's employees. The DACS system is a tool to help protect the most vulnerable of Utah's population. The providers using the system include Nursing Homes, Assisted Living, Home Health, Hospice providers and various other providers.

Breaking News, May 2016

Implementing Utah's State Plan for Alzheimer's and Related Dementias

In 2012, the Utah Legislature passed a bill to implement "Utah's State Plan for Alzheimer's and Related Dementias." This plan aims to improve the quality of care for individuals with dementing disease through sustaining, expanding, and disseminating expertise in dementias in Utah. This plan provided a blueprint for unified action through coordinated public-private partnerships. The Utah Department of Health (UDOH) has been charged with the responsibility to serve as the lead agency to address this growing public health issue. UDOH began receiving funding for the State Plan on July 1, 2015. A Coordinating Council was established which includes stakeholders from non-profit organizations, local county aging health services, and the medical community. The council is comprised of five workgroups. Each of the five workgroups focus on a goal in the State Plan: a dementia aware Utah, health and dignity for all with dementia, supported and empowered caregivers, dementia competent workforce, and expanded research in Utah. This will provide a unified and coordinated approach in addressing the growing impact of Alzheimer's and Related Dementias in Utah. The Coordinating Council Co-Chairs are Lynn Meinor, Alzheimer's State Plan Specialist, UDOH and Ronnie Daniel, Executive Director of the Alzheimer's Assocation. For additional information, please contact Lynn Meinor, lmeinor@utah.gov.

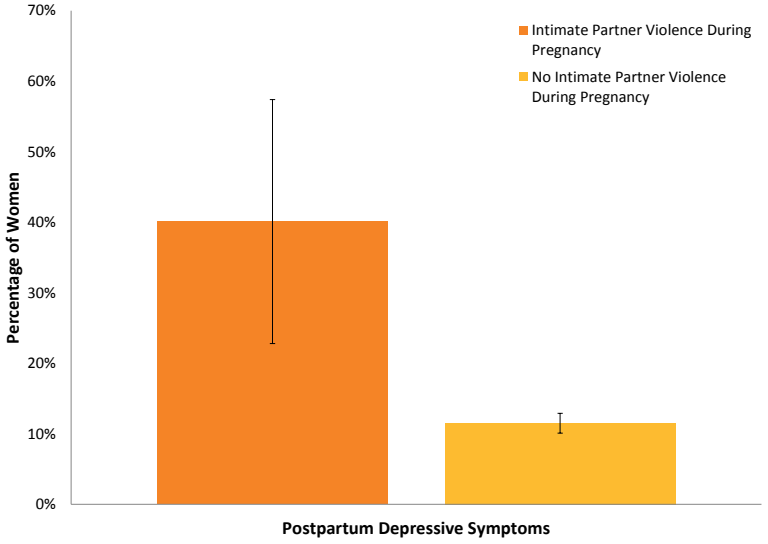
Community Health Indicators Spotlight, May 2016

Domestic Violence During Pregnancy

Women with histories of intimate partner violence (IPV) during pregnancy are at greater risk of adverse neonatal outcomes as well as depression and poor mental health through the first year postpartum. This is an important public health concern because postpartum depression (PPD) is associated with parenting difficulties and emotional, behavioral, and cognitive deficits in young children.[1]

To understand how IPV is associated with maternal experiences in Utah, the Pregnancy Risk Assessment Monitoring System (PRAMS) survey asks the question: *During your recent pregnancy, did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?* Data collected during 2012 and 2013, showed 1.4% of respondents (approximately 1,396 women) said they had been physically abused during pregnancy. Studies show the actual number may be much higher but that women may be reluctant to report IPV on the survey.[2] To assess postpartum depressive symptoms among respondents, the PRAMS survey uses questions adapted from the American Psychological Association's Public Health Questionnaire (PHQ-2). As shown in the accompanying figure, the percentage of women with postpartum depressive symptoms is significantly higher among women who reported IPV during pregnancy (40.1% vs. 11.5%, respectively).

Intimate Partner Violence and Postpartum Depressive Symptoms, Utah PRAMS, 2012–2013



While IPV during pregnancy has serious consequences, it is often undetected during prenatal visits.[3] Almost 70% of women responding to the PRAMS survey said their prenatal care provider did not ask about intimate partner physical abuse. The American Academy of Pediatrics recommends screening during the first prenatal visit, at least once per trimester, and at the postpartum checkup. The Utah Department of Health/Utah Domestic Violence Coalition provides a domestic violence screening tool for health care providers: "Clinical Guidelines for Assessment and Referral for Victims of Domestic Violence" which can be found at: www.health.utah.gov/vipp/pdf/DomesticViolence/HmHlthTrngMnl.pdf.

1. Valentine JM (2011) Recent Intimate Partner Violence as a Prenatal Predictor of Maternal Depression in the First Year Postpartum Among Latinas. *Arch Womens Ment Health* 14:135–143.
2. Bailey, BA (2010) Partner Violence During Pregnancy: Prevalence, Effects, Screening, and Management. *International Journal of Women's Health* 2:183–197.
3. Place, JM (2014) Detecting Intimate Partner Violence and Postpartum Depression. *Journal of Global Health*.

Monthly Health Indicators Report

(Data Through March 2016)

Monthly Report of Notifiable Diseases, March 2016	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (*Campylobacter*)	18	31	73	81	0.9
Shiga toxin-producing *Escherichia coli* (*E. coli*)	7	4	9	8	1.1
Hepatitis A (infectious hepatitis)	0	1	2	1	1.4
Hepatitis B, acute infections (serum hepatitis)	0	0	0	3	0.0
Influenza*	Weekly updates at http://health.utah.gov/epi/diseases/influenza				
Meningococcal Disease	0	1	1	2	0.6
Pertussis (Whooping Cough)	3	79	37	230	0.2
Salmonellosis (*Salmonella*)	35	26	85	61	1.4
Shigellosis (*Shigella*)	12	2	20	8	2.6
Varicella (Chickenpox)	21	36	88	96	0.9
Quarterly Report of Notifiable Diseases, 1st Qtr 2016	**Current Quarter # Cases**	**Current Quarter # Expected Cases (5-yr average)**	**# Cases YTD**	**# Expected YTD (5-yr average)**	**YTD Standard Morbidity Ratio (obs/exp)**
HIV/AIDS†	32	30	32	30	1.1
Chlamydia	2,412	1,981	2,412	1,981	1.2
Gonorrhea	513	197	513	197	2.6
Syphilis	11	11	11	11	1.0
Tuberculosis	5	8	5	8	0.7
Medicaid Expenditures (in Millions) for the Month of March 2016	**Current Month**	**Expected/ Budgeted for Month**	**Fiscal YTD**	**Budgeted Fiscal YTD**	**Variance - over (under) budget**
Capitated Mental Health	$ 9.8	$ 10.9	$ 126.1	$ 127.6	$ (1.5)
Inpatient Hospital	$ 9.8	$ 9.3	$ 83.3	$ 84.9	$ (1.6)
Outpatient Hospital	$ 3.1	$ 2.2	$ 31.2	$ 32.2	$ (0.9)
Long Term Care	$ 15.3	$ 15.8	$ 142.5	$ 143.6	$ (1.0)
Pharmacy	$ 9.1	$ 7.9	$ 78.4	$ 78.5	$ (0.0)
Physician/Osteo Services	$ 3.6	$ 3.6	$ 31.0	$ 36.2	$ (5.2)
TOTAL MEDICAID	$ 213.1	$ 209.2	$ 1,813.6	$ 1,816.2	$ (2.6)

Program Enrollment for the Month of March 2016	Current Month	Previous Month	% Change‡ From Previous Month	1 Year Ago	% Change‡ From 1 Year Ago
Medicaid	295,003	293,967	+0.4%	283,944	+3.9%
PCN (Primary Care Network)	18,602	18,748	-0.8%	16,760	+11.0%
CHIP (Children's Health Ins. Plan)	17,686	17,347	+2.0%	16,271	+8.7%
	Annual Visits			Annual Charges	
Health Care System Measures	**Number of Events**	**Rate per 100 Population**	**% Change‡ From Previous Year**	**Total Charges in Millions**	**% Change‡ From Previous Year**
Overall Hospitalizations (2014)	281,302	8.9%	-0.8%	$ 7,281.6	+11.8%
Non-maternity Hospitalizations (2014)	177,881	5.5%	-1.1%	$ 6,200.8	+11.6%
Emergency Department Encounters (2014)	710,266	22.9%	+2.6%	$ 1,760.5	+13.2%
Outpatient Surgery (2013)	404,303	13.1%	+7.3%	$ 2,167.9	+11.5%
Annual Community Health Measures	**Current Data Year**	**Number Affected**	**Percent/ Rate**	**% Change‡ From Previous Year**	**State Rank§ (1 is best)**
Obesity (Adults 18+)	2014	524,000	25.7%	+6.5%	8 (2014)
Cigarette Smoking (Adults 18+)	2014	197,800	9.7%	-6.1%	1 (2014)
Influenza Immunization (Adults 65+)	2014	171,300	58.0%	+1.0%	36 (2014)
Health Insurance Coverage (Uninsured)	2014	303,100	10.3%	-11.2%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2014	234	8.0 / 100,000	+20.2%	17 (2014)
Poisoning Deaths	2014	641	21.8 / 100,000	+0.4%	45 (2014)
Suicide Deaths	2014	555	18.9 / 100,000	-4.0%	41 (2014)
Diabetes Prevalence (Adults 18+)	2014	144,800	7.1%	-0.1%	8 (2014)
Poor Mental Health (Adults 18+)	2014	324,200	15.9%	-3.0%	19 (2014)
Coronary Heart Disease Deaths	2014	1,574	53.5 / 100,000	+2.5%	3 (2014)
All Cancer Deaths	2014	3,033	103.1 / 100,000	+1.0%	1 (2014)
Stroke Deaths	2014	854	29.0 / 100,000	+1.4%	31 (2014)
Births to Adolescents (Ages 15-17)	2014	537	7.9 / 1,000	-8.8%	12 (2014)
Early Prenatal Care	2014	39,005	76.2%	-0.2%	n/a
Infant Mortality	2014	251	4.9 / 1,000	-4.7%	13 (2013)
Childhood Immunization (4:3:1:3:3:1)	2014	36,700	74.6%	n/a#	24 (2014)

* Influenza-like illness activity is low/moderate in Utah. As of April 2, 2016, 1,005 influenza-associated hospitalizations have been reported to the UDOH since the start of the influenza season on October 4, 2015. More information can be found at http://health.utah.gov/epi/diseases/influenza/surveillance/index.html.

† Diagnosed HIV infections, regardless of AIDS diagnosis.

‡ Relative percent change. Percent change could be due to random variation.

§ State rank based on age-adjusted rates where applicable.

In 2014, NIS analysis for the complete 4:3:1:3:3:1 series was updated to provide a more accurate assessment of Haemophilus influenzae type B vaccination. Due to this change, the 2014 results for 4:3:1:3:3:1 coverage are not comparable to prior years.

Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for West Nile Virus will start in June for the 2016 season.