

FY 15/16 BUDGET GUIDELINES

Business Case

Policy and Operational Justification

Budget Request Title: Enhancing Expertise for High Quality Dementia Care

Agency Budget Request Priority: High

Brief Description of Budget Change Request: New \$490,000 annual appropriation to the Department of Health through the Office of Primary Care for contracted services

Detail on Budget change Request (respond to the following questions)

1. Background and Problem Definition
 - a. Given that state programs and services currently function without this item being funded, what is the specific need? How does this proposal relate to the agency's core mission?

High quality care for Utah citizens with dementing diseases is often unavailable or poorly utilized. Current programs and services are uncoordinated, inefficient and provided by those without sufficient expertise. This new appropriation will improve the quality of care for individuals with dementing disease through sustaining, expanding and disseminating expertise in dementing disease in Utah. The Utah State Plan for Alzheimer's Disease and Related Disorders (hereafter the Utah State Plan), developed under the leadership of Lt. Gov. Greg Bell and adopted by the Utah State Legislature as S.J.R. 1 on February 22, 2012, identified current deficiencies and provided a blueprint for action. This project will follow this blueprint to address the most urgent of the recognized need . This budget request will sustain and enhance the availability of expertise in dementing disease necessary to achieve a Dementia-aware Utah (Goal 1 of the Utah State Plan) and a Dementia-competent Workforce (Goal 4). In addition, it will provide access to dementia specialists for citizens in rural, currently underserved parts of the state through dementia teleconsultation at Department of Health supported Community Health Clinics using the existing Utah Telehealth Network (Goals 2 and 4).

The proposed program is within the Department of Health's core mission of promoting public health. As acknowledged in the Utah State Plan, Alzheimer's disease presents a current public health crisis. As the agency of state government charged with responsibility for public health, the Department of Health is in the strongest position to serve as the lead agency to address this crisis. The mission of the Primary Care Office in the Division of Family Health and Preparedness at the Department of Health aligns well with the goals of the High Quality Dementia Care program. The responsibility of the Primary Care Office is to coordinate local,

state and federal resources to improve access to care and health professional workforce availability.

Legislation currently is being considered that would designate the Department of Health as the lead state agency for coordinating efforts addressing Alzheimer's disease and related disorders. If this legislation is passed, then it is likely the Department of Health will develop a process involving stakeholders. In that respect, our program would be supportive and reflect that effort. Designating the Department of Health as the lead state agency for Alzheimer's disease and related disorders is consistent with the recommendation of the National Alzheimer's Disease Advisory Council that each state designate a single state government agency to coordinate dementia related activities.

- b. What is the problem being solved? Are there alternative ways to define the problem that would open up the consideration of other solutions?

Utah has the highest per capita growth rate in Alzheimer's disease prevalence, projected at 127% from 2000 to 2025. This is due to the confluence of the aging of the baby boom generation, the growth of the state population, the tendency of elderly individuals to move to Utah or remain here, and the greater longevity of our elders. Implementation of the State Plan requires a private-public partnership. Private partners already are in place and committed to implementing the state plan. These include the Alzheimer's Association Utah Chapter, the Sorenson Foundation, and the 140,000 family members caring for someone with dementing disease in Utah without compensation. Successfully addressing this public health problem requires the participation and leadership of public partners and established dementia expertise in the state. The top priority for the state should be to retain and grow dementia expertise to assure all Utah citizens have access to health professionals that can provide high quality, medically necessary services for memory disorders and dementing diseases.

- c. What population is being served?

The lack of dementia care expertise affects the quality of life for patients and their families. It impairs the work productivity and income of Utah's 140,000 family caregivers. This funding request would have a beneficial impact for all of these people and more, including the employers of family caregivers and those citizens who will develop dementia in the future. It will benefit health care providers who can draw upon the knowledge and guidance of dementia experts. Sustaining and increasing the expertise in dementing disease also will have a beneficial effect on the design and implementation of many policies and functions of government including law enforcement, the justice system and health systems in the state.

- d. Explain why this activity constitutes a proper role of government/what market failure justifies government intervention.

State government agencies do not currently employ dementia experts nor does this program propose that state government develop this expertise in house. Instead, the Primary Care Office, Division of Family Health and Preparedness in the Department of Health, would provide funds through a standard, competitive RFP process to an organization with a multidisciplinary team meeting the criteria of being composed of individuals who, by virtue of training, national certification and experience, are recognized experts in dementia care. Furthermore, this team must 1) be currently active in providing care and training in dementia care to community groups, health professionals, health professions students and 2) be providing expert advice about dementia care to local, state and federal agencies.

Market forces alone have not been adequate to establish and sustain programs where people with cognitive impairment can receive expert multidisciplinary care or have these forces alone been sufficient in Utah to provide specialists with expertise to provide leadership and training. There currently is only a single multidisciplinary dementia specialty clinic in Utah. This clinic was established (but is not sustainable) only after a significant philanthropic donation to the University from an anonymous donor – considerable funding is needed to recruit the experts and establish such a clinic. Several years ago Intermountain Healthcare closed the only other similar clinic in Utah at LDS Hospital when it was unable to attract a neurologist with recognized dementia expertise and because of inadequate financial margin, despite high patient and family satisfaction with the services provided. Consequently, it is clear that state government participation is needed to address this serious public health problem. Utah already is significantly underserved with board-certified specialists in dementia care and has not widely developed high quality services because of current adverse financial incentives in the health care system. For example, the only board-certified geriatric and behavioral neurologists and the only practicing board-certified geriatric psychiatrist and neuropsychologists in Utah are at the Center for Alzheimer's Care, Imaging and Research at the University of Utah, an academic health care institution. No private health-care system has hired such specialists. Last year for the first time, despite the increasing need for high quality dementia care, reduced reimbursement for clinical services and research funding has forced the Center for Alzheimer's Care, Imaging and Research to reduce its staff and terminate its recruitment of an additional dementia specialist physician.

Utah is at a distinct disadvantage for attracting and retaining dementia care expertise in comparison to other states that have programs to support dementia expertise. Dementia experts are in high demand throughout the country. Even in these times of state budget constraints, many states have recognized the benefits of providing substantial financial support for dementia specialist expertise. Particularly states recognized as having

conservative fiscal policies such as Indiana, North Dakota, Texas, Wisconsin and Arizona, have recognized the value of coordinated dementia programs and provided funding to support of multidisciplinary dementia expert teams.

- e. Explain why the state is the proper level of government to handle this issue.

State government, rather than the federal government, is best prepared to handle the issue of dementia care and expertise. Utah has many unique features that suggest a tailored statewide response would be most effective. This is the rationale for the Utah State Plan. It is unlikely that the federal government would provide the leadership to implement the recommendations contained in the Utah State Plan. Indeed, more than 20 states have now developed and are in the process of implementing their own plan designed to meet their own state level identified needs. These state plans are diverse, indicating that the best solutions for one state are not necessarily applicable to another although patients have the same disease and complications.

With the mal-distribution of dementia expertise, this is not a problem that local government can address adequately. Family members spread throughout the state often share in caring for a single person with a dementing illness. Thus, statewide access to expertise is needed. Likewise, training opportunities to expand dementia expertise are now primarily provided through state and regional, rather than local institutions of higher education. Professional schools and medical residencies and fellowships are highly centralized in Utah.

Since long-term care for dementing illness is primarily a Medicaid, not a Medicare, responsibility, the State of Utah is the largest single payer for dementia-related health care services. The state government through its programs and leadership with other stakeholders can determine the quality and timing of these health care services. Consequently, it can partially determine the costs it faces with the "silver tsunami" of baby boomers at high risk for dementing diseases. Utilizing expertise supported by this budget proposal, the rate of institutional care can be limited, community care prolonged, the risk of spend down decreased and the projected increase of state costs attributed to dementing disease reduced. High quality and proactive outpatient services can replace crisis institutional care. Indeed in areas where high quality care is available there is evidence that better control of risk factors is decreasing the age-specific incidence of Alzheimer's disease.

- f. What other agencies should be involved in dealing with this issue?

Alzheimer's disease and related disorders are complex with multiple personal, family and societal consequences. As a consequence, the Utah State Plan was developed as a multiple agency effort including the Department of Health, Department of Human Services and the

Department of Mental Health. Each of these agencies and others will continue to play a critical role in dealing with the issue of dementing disease. Caregiver education and support programs operate through the Division of Aging and Adult Services, Department of Human Services. The criteria for services the Department of Mental Health currently uses almost completely excludes individuals with dementing diseases. Consequently this Department plays a perhaps unexpectedly small role in dementia care, even though behavioral complications of dementing diseases are common. Nevertheless, patients frequently need behavioral services and the expertise at this agency can be very valuable in designing solutions.

As outlined in the Utah State Plan, a number of other agencies not typically thought of as related to health (e.g. law enforcement, the legal system, and others) will need to play a role in dementia care and can benefit from the expertise supported through this project.

- g. How are outcomes expected to change relative to current practice if the item is not funded?

Utah has the highest per capita growth rate in Alzheimer's disease prevalence, projected at 127% from 2000 to 2025. If not appropriately address now, this drastic increase in patients and their families will overwhelm State and private resources. More families will feel inadequate and isolated without clear guidance. Many families will become estranged from each other in the face of nearly impossible demands of unsupported caregiving. The majority of the Medicaid expenditures for the elderly are for long-term institutional care for individuals with cognitive impairment. Activities that decrease the risk of cognitive impairment and delay or decrease the need for institutional care will not be recognized and encouraged significantly increasing the growth of burden and expenditures.

2. QT/OE and SUCCESS Initiative principles

- a. How does the budget change request improve the ration of QT/OE – quality (Q) throughput (T) / operating expense (OE)? Specifically what changes in Q and T are being purchased with the proposed OE? For non-cabinet agencies or if a SUCCESS system has not been formally designated, describe in detail how this proposed increase in operating expense (OE) will impact outcome measures related to this system's quality (Q) and throughput (the agency's capacity to meet the demand for services) (T)?

Care for individuals with cognitive impairment is currently provided through the state's existing health care system. Our health system is not prepared to manage dementing disease well. New diagnostics and treatments are not being well utilized. The Governor's Task Force on Alzheimer's Disease and Related Disorders that generated the Utah State Plan found through testimony from citizens at meetings held throughout the state that the quality of care was severely deficient with little education or support given to family members,

diagnostic evaluations not performed, no linkage to existing community services, and frequent preventable hospitalization and institutional long-term care. The proposal improves the ratio of QT/OE by increasing QT and decreasing OE. QT will increase with the availability of dementia expertise to patients, families, community agencies, health systems, advocacy groups and state and federal agencies setting public policy. OE to the entire state budget will decrease with the declines in the expenditures for the most expensive and least desirable forms of care – emergency and institutional care, as well as costs and burdens for family caregivers.

Quality of the awardees will be judged on external indicators such as professional board certification, experience with dementia care, published research and community recognition. Considerable evidence also suggests that expertise needed is multidisciplinary and coordinated. The awardee will be selected based upon being able to offer these kinds of experiences to trainees.

Operating expenses for this program are minimized through utilizing existing expertise and infrastructure rather than creating these anew within government and developing new expertise among professional trainees likely to remain in the state to provide services. While some of the budget will be allocated to the Department of Health to administer the contract awarded, this expense will be small and most of the appropriation will go directly to supporting and enhancing dementia expertise. Over time if the projected increase in the prevalence of dementing diseases is not altered, there is the possibility that the size of the program will need to grow over time to meet the demand for expertise. However, because contractors will be utilized this could occur without increasing the size of state government agencies.

- b. If the request relates to a change in throughput (the agency's capacity to meet the demand for services (T)), what does the evidence suggest about the durability of the change in throughput? Is the change in throughput truly ongoing, or is it seasonal or temporary?

The Department of Health will be providing services through a third party, which has other sources of funding to assure its durability. Since one part of the proposal is training other health professionals, the change in throughput will truly be ongoing as these trainees begin practice and sustain a new higher quality standard of care. Likewise expertise available to policy makers will improve and increase the efficiency of many activities outlined in the Utah State Plan.

- c. What impact will this requested increase in current OE have on future OE? Will the proposed request create future costs or savings? If savings, are they hard cost savings or foregone costs/cost avoidance?

State government through its Medicaid program is the single largest payer for dementia care. Currently only the most expensive and least desired care is paid – institutional care and drugs. Greater dementia expertise will permit earlier recognition and treatment of cognitive impairment. Coordinated care and family support will permit families to care for their loved ones longer at home utilizing community services health teams can be instructed to direct them to such as support groups, adult day activities, and respite care. This will result in a significant reduction in the number of people qualifying for Medicaid through spend-down and in cost savings per beneficiary through avoidable hospitalizations and emergency visits. High quality care in the case of dementing diseases is cheaper than the currently typical uncoordinated, chaotic and inconsistent care.

- d. What future budget cost pressures would this budget change request create? If the state proceeds down this path, what can it expect in terms of related future budget requests?

Dementing disease is a public health crisis that is projected to increase over the next decades. Improving the quality of dementia care will mitigate, but not prevent the costs associated with this crisis. However, retaining and enhancing expertise in the state is essential to meeting these needs. Designed as a continuing and stable program, no major associated budget requests are envisioned. Indeed, stable funding to support dementia expertise in Utah may attract additional funding from other sources including federal grants, private philanthropy, and foundation support to help achieve program goals.

- e. Are the requested additional resources being directed to the control point of the system or somewhere else?

The Utah State Plan focuses on early diagnosis and treatment of dementing diseases and early support of family caregivers. This is the control point that determines management and subsequent care, including opportunities to avoid future costs created by care crises and failures of a patient's care network.

- f. What operational strategy will be put in place to ensure that activities of the program lead to the desired outcomes?

Involvement of private and public stakeholders will ensure the activities of the program lead to desired outcomes. Educational institutions and health professions training programs that will be involved in training have their own oversight processes that will ensure high quality training. Patient satisfaction will be surveyed for clinical activities and modifications made as appropriate.

3. Use of Existing Capacity

- a. What efforts have been taken to date to maximize the use of existing capacity?

State agencies do not have dementia expertise. Existing capacity in the community is at risk as current philanthropic funding for dementia experts become depleted and health systems and universities in other states (often with substantial state support) compete for available experts. Current financial incentives discourage existing experts from devoting their efforts to carry out the goals of the Utah State Plan. Existing funding is not permitting the training of health professionals with dementia expertise (funding is controlled by hospitals that direct training to inpatient care and performance of highly reimbursed services).

- b. What lower-priority activities can be stopped or reduced to free up existing resources for this purpose?

Without specific knowledge of agency budgets, it is not possible to speak to this question for state efforts. No existing resources in the private or academic sector are available that can be applied to this effort.

- c. If this program is a priority for the agency, what funds can be redirected to pay for it (i.e., which lower priority programs can be reduced or eliminated to generate savings to fund the program)?

Without specific knowledge of agency budgets, it is not possible to speak to this question.

- d. Are there legal (statute, executive order, rule, policy) or other impediments to redirecting funds to this priority? What changes to law or policy could be made to free up other resources to this program?

Without specific knowledge of agency budgets, it is not possible to speak to this question. Additional resources would not be made available through a change in law or policy.

4. Evidence-Based Practice and Evaluation Plans

- a. How does this request align with the agency's core mission?

The proposed program aligns with the core mission of the Department of Health's core to promote public health. As acknowledged in the Utah State Plan, Alzheimer's disease presents a public health crisis. As the public health agency of state government, the Department of Health is in the strongest position to serve as the lead agency to address this crisis. The Department of Health incorporates physicians and health professionals, as employees and as contractors who understand medical and neurological illnesses and their complications and

complex interactions. In this respect the Department is well suited to administer and evaluate the proposed program. Furthermore, the Department of Health includes the Office of Health Care Statistics, the Office of Public Health Assessment, the Medicaid Program that all are resources that can be used to assess the success of the program and the Utah State Plan. The Bureau of Facility Licensing, Certification and Resident Assessment and the Bureau of Health Promotion also could benefit from the proposed program in being able to draw upon its dementia expertise to carry out their mission. The mission of the Primary Care Office in the Division of Family Health and Preparedness at the Department of Health aligns well with the goals of the High Quality Dementia Care program. The responsibility of the Primary Care Office is to coordinate local, state and federal resources to improve access to care and health professional workforce availability.

- b. What is the objective of the program? What is the product or service being produced?

The objective of the Program is to improve the quality of dementia care by sustaining, expanding, and providing access to dementia expertise in Utah. It will do this by providing a multidisciplinary team of dementia experts available to provide statewide consultation and training in collaboration with an array of private and public stakeholders.

- c. Precisely what are the expected improvements in outcomes?

An increased public awareness and understanding of dementing diseases, a more dementia-competent workforce, improved quality of care for persons with dementing diseases and their families, and public policy informed by dementia expertise.

- d. What evidence is there (will there be) that this program will achieve (has achieved) its desired outcomes? How quantifiable are the projected outcomes? How much margin or error exists in the proposed measurements?

If the legislature and governor designate the Department of Health as the lead state agency for coordinating dementia services, a number of metrics will be possible to assess whether the program has achieved its desired outcomes. These include Medicaid spend-down rates, rates of preventable hospitalizations and antipsychotic medication use in the Medicaid program, and stakeholder objectives. These projected outcomes are subject to Departmental priorities. They are extremely valuable and relevant but also are subject to interpretation and error.

The quantifiable outcomes within the program are easily measured and not subject to a margin of error:

- a. *Identification of stakeholders and the number of individual and group meetings of dementia experts with these stakeholders.*
 - b. *Number of health professional students receiving training in high quality dementia care in a multidisciplinary specialty clinic.*
 - c. *Number of patients and family members served through dementia teleconsultations.*
- e. Has this been tried before here or elsewhere? If so, was an evaluation of the program performed? Were there data-driven studies that demonstrated results?

State programs supporting dementia expertise in the medical community (usually at state medical schools) have existed for more than a decade. In general, they have been very successful and received continuous funding over many years and across Democrat and Republican administrations. Some of the references provided below in section i. The size of these programs varies greatly and ranges from \$500,000 to more than \$20 million. Some of these programs focus on clinical care, others on supporting training and service missions, and others on promoting dementia research. They usually serve as the focus for implementing improvement in dementia services. Almost all NIH Alzheimer's Disease Centers received significant state support before success in receiving federal funding and continue to receive significant state support to retain expertise required to be competitive. These are the major competitors that threaten the retention of multidisciplinary dementia expertise in Utah. Additional information about individual state programs is available through the Alzheimer's Association.

- f. Who will perform future evaluations of the program's effectiveness in achieving intended results? What form will the evaluation take?

The awardee will provide the Office of Primary Care an annual report of activities supported by the Project. The Office will evaluate the effectiveness and level of activities and judge them against the Utah State Plan recommendations and goals. In consultation with the awardee and stakeholders, changes will be recommended and implemented as indicated.

- g. What should happen to the program if future evaluation plans find that the program did not meet the intended objectives?

If the Office of Primary Care and Stakeholders do not find the program meets its intended objectives even after recommendations have been made, funding for the program will be deleted from the Department budget.

- h. Should the program be sunset to ensure a future review? If so, what is an appropriate sunset date?

This program should not have a sunset date. No treatment is currently in sight that will reduce the need for the expertise to provide coordinated, high quality dementia care to Utah citizens and their families. Consequently, the need for this expertise is expected to continue and increase over time.

i. For new or untested programs or services:

i. What are the long-term (longitudinal) results anticipated that help fulfill the goal?

The ultimate goal of this proposal is to achieve the objectives of the Utah State Plan. This proposal specifically will improve the quality of care to people with dementing disease by achieving a more dementia-aware Utah and a workforce that is more dementia-competent. These goals would be reflected in greater family caregiver empowerment and satisfaction and a delayed institutional long-term care. As spend-down is decreased, the proportion of elderly individuals qualifying for Medicaid would decrease and Medicaid expenditure for emergency visits and preventable hospitalization would decrease.

ii. What activities and associated (proximate) measures are available to show progress?

d. *Identification of stakeholders and the number of individual and group meetings of dementia experts with these stakeholders.*

e. *Number of health professional students receiving training in high quality dementia care in a multidisciplinary specialty clinic.*

f. *Number of patients and family members served through dementia teleconsultations.*

iii. Are there any available resources (studies, research, etc.) showing how program activities are linked to overall system goals (evidence-based)?

Arling G, Buhaug H, Hagan S, Zimmerman D. Medicaid spenddown among nursing home residents in Wisconsin. Gerontologist 1991;31:174-182.

Chodosh J, Mittman BS, Connor KI, et al. Caring for patients with dementia: how good is the quality of care? Results from three health systems. J Am Geriatr Soc 2007;55:1260-1268.

Geldmacher DS, Kirson NY, Birnbaum HG, et al. Implications of early treatment among Medicaid patients with Alzheimer's disease. Alzheimers Dement 2014;10:214-224.

Gifford DR, Holloway RG, Frankel MR, et al. Improving adherence to dementia guidelines through education and opinion leaders. A randomized, controlled trial. Ann Intern Med 1999;131:237-246.

Greene R, Feinberg LF. State initiatives for caregivers of people with dementia. Generations 1999;23:75-77.

Hebert LE, Scherr PA, Bienias JL, Bennett DA, Evans DA. State-specific projections through 2025 of Alzheimer disease prevalence. Neurology 2004;62:1645.

Menzin J, Lang K, Friedman M, Neumann P, Cummings JL. The economic cost of Alzheimer's disease and related dementias to the California Medicaid program ("Medi-Cal") in 1995. Am J Geriatr Psychiatry 1999;7:300-308.

Moritz DJ, Fox PJ, Luscombe FA, Kraemer HC. Neurological and psychiatric predictors of mortality in patients with Alzheimer disease in California. Arch Neurol 1997;54:878-885.

Vickrey BG, Mittman BS, Connor KI, et al. The effect of a disease management intervention on quality and outcomes of dementia care: a randomized, controlled trial. Ann Intern Med 2006;145:713-726.

A more extensive list is available through the Alzheimer's Association.

5. Timing

- a. How long will the program take to implement?

Implementation of the program can occur as soon as the Office of Primary Care awards the funds. Changes in resident and fellow training would begin in July of the next academic year or when new fellows are identified and recruited.

- b. What steps will be taken to ensure timeliness in implementation?

Because there are continuing demands for expertise in dementia, no delay is expected for most programs. The dementia teleconsultation program is already ongoing through support from the Sorenson foundation for initiation and only will rely on this program for sustainment.

- c. How long will it be before measurable results can be evaluated?

- a. *Identification of stakeholders and the number of individual and group meetings of dementia experts with these stakeholders. – Available as soon as funding is received, preferably with annual accounting*
- b. *Number of health professional students receiving training in high quality dementia care in a multidisciplinary specialty clinic. – Two years, since training can begin only after*

alterations in the curriculum and trainee rotations begin in the academic year after the training program receives funding.

- c. *Number of patients and family members served through dementia teleconsultations. – Two years, since it is generally accepted that 2 years are needed to establish a new clinical program.*

6. Funding Source

- a. If the request is for an allocation of General Fund or Education Fund revenues, what funds/resources other than the General Fund or Education Fund are available (federal funds, local funds, restricted funds, dedicated credits, private funds, etc.)?

No other funding source is available.

7. Stakeholders

- a. Who are the stakeholders associated with or impacted by this request?

- a. *Individuals with dementing disease*
- b. *Family members providing care to a person with dementing disease*
- c. *Health professional trainees*
- d. *Employers*
- e. *Health insurers and Medicaid*
- f. *State agencies and policymakers*
- g. *Dementia experts in Utah*
- h. *Health care providers and health systems*

- b. How will stakeholders be impacted if the request is funded?

- a. *Individuals with dementing disease: This program will allow individuals with dementing disease to receive definitive and specific diagnosis much more quickly. Definitive diagnosis ensures that the most advantageous treatments are started as quickly as possible. It is proven that early diagnosis and treatment lead to improved outcomes, including delayed disease progression, increased independence, and the ability to remain at home.*
- b. *Family members providing care to a person with dementing disease: When patients with dementing disease receive high quality treatment, family members also benefit. Less work is missed because of patient crises, work quality and family life are less likely to suffer because of stress, and it is less likely that family members will have to bear the financial burden of long-term skilled care.*

- c. Health professional trainees: The project will bring a new option for specialized training. This will be an excellent career choice, as the need for trained dementia specialists will increase as the population ages.*
 - d. Employers: Employers will benefit from reduced absenteeism and employees who are less distracted by concerns about their demented loved ones.*
 - e. Health insurers and Medicaid: Specialized dementia care will result in reduced health care costs, primarily because of reduced emergency room visits and reduced dependence on long term skilled care.*
 - f. State agencies and policymakers: Funding of this program will allow state agencies and policymakers to respond thoughtfully and proactively to the escalating number of citizens with dementia, rather than being forced into action after the epidemic has already reached the crisis point.*
 - g. Dementia experts in Utah: This program will allow Utah dementia experts to offer the highest quality of care, it will allow them to utilize telehealth technology to reach even the most remote regions in the state, and it will attract more dementia experts to the state.*
 - h. Health care providers and health systems: This program will shift the responsibility for diagnosis and care from less-qualified health care providers and emergency rooms to those with specialized training and expertise.*
- c. How will stakeholders be impacted if the request is not funded?
- a. Individuals with dementing disease: These individuals will continue to experience frustration and delay as they encounter extreme difficulties in obtaining definitive diagnosis and treatment. These delays will lead to a more rapid progression of the disease, and most will ultimately be placed in long term skilled residential care.*
 - b. Family members providing care to a person with dementing disease: Without diagnosis, direction or hope, family members will continue to experience the extreme stress of trying to cope with unexplained or inadequately explained changes in their loved ones. Family finances may be strained and savings depleted.*
 - c. Health professional trainees: Health professional trainees will continue to receive no, or very little, education in dementia care.*
 - d. Employers: Employers will continue to deal with absenteeism and distraction in the dementia patient's loved ones.*
 - e. Health insurers and Medicaid: Health insurers, particularly Medicaid, will bear the financial brunt of long term skilled residential care for patients who, with proper diagnosis and treatment, could have been effectively treated at home.*
 - f. State agencies and policymakers: State agencies and policymakers will be forced to deal with the epidemic of dementia when it reaches crisis proportions. At that point, it is much more likely that "Band-Aid" solutions will be applied.*

- g. Dementia experts in Utah: Dementia experts in Utah will continue providing the best possible care to those who have adequate financial resources.*
 - h. Health care providers and health systems: Health care providers and health systems will continue their efforts to deal with a problem without have the expertise needed to provide effective intervention.*
8. Legislation
- a. Describe any legislation needed to implement this request.

None