

Improving access to dementia diagnosis and treatment in communities and special populations

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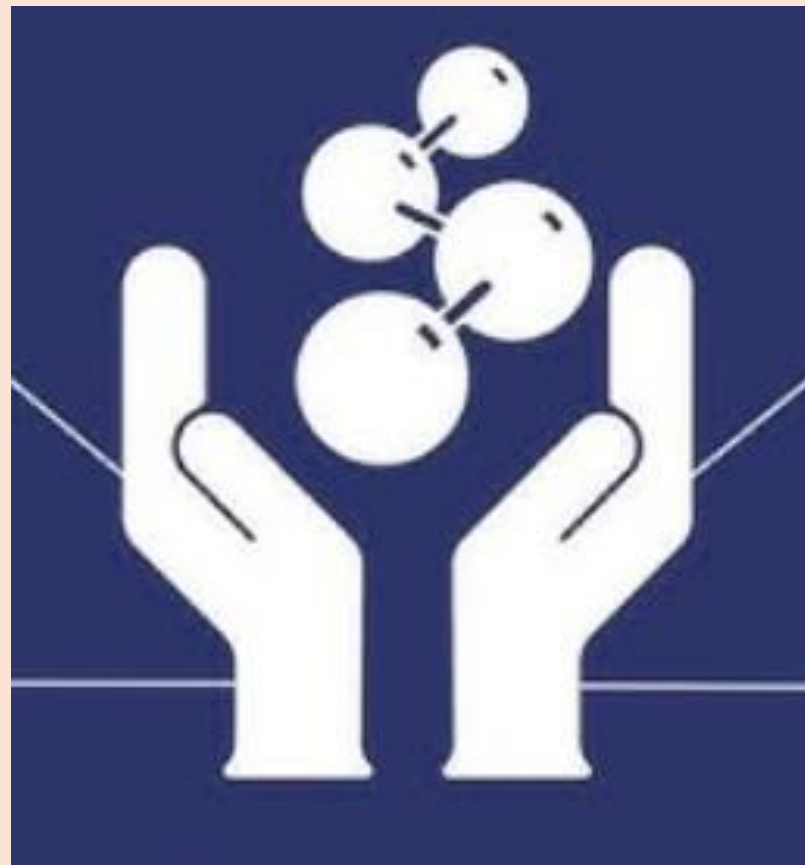
Icahn School of Medicine Mount Sinai



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I have no financial relationships to disclose in relation to this presentation.

**We bear
the responsibility
to improve dementia
care**



Brain health equity

- **The fair distribution of brain health determinants, outcomes, and resources within and between segments of the population, regardless of social standing.**



Health Disparities



- **Preventable** differences in health, health care, and disease burden between populations
 - Higher burden of illness, injury, disability, and/or mortality
- Occur across a broad range of marginalized identities
 - Race/ethnicity; socioeconomic status; gender; age; disability; sexual orientation; gender identity; geographic location, etc.
 - Intersectionality is critical
- Arise from a complex and interrelated set of historic societal and economic factors

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Racial disparities in neurologic health care access and utilization in the United States

Altaf Saadi, David U. Himmelstein, Steffie Woolhandler, Nicté I. Mejía







Altaf Saadi, MD

 Massachusetts General Hospital
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- Brain diseases disproportionately affect Black, Latinx, Asian, Native American, LGBTQ+, those in lower socioeconomic groups, individuals living in underserved geographies, and other marginalized populations in the United States.
- These are the same US populations that often experience lack of basic access to healthcare, neurological care, and other types of health disparities
 - Stroke
 - TBI
 - **Dementias**
 - Migraine
- Black and Latinx people are up to 40% less likely than White people to see a neurologist
 - More likely to be treated in the emergency department with prolonged hospital stays
 - Increased morbidity
 - Increased mortality
- Disparities occur not only within incidence & prevalence rates but along the entire care continuum

National Institute on Minority Health and Health Disparities Research Framework

| | | Levels of Influence* | | | |
|--|----------------------------|---|---|---|--|
| | | Individual | Interpersonal | Community | Societal |
| Domains of Influence <i>(Over the Lifecourse)</i> | Biological | Biological Vulnerability and Mechanisms | Caregiver–Child Interaction Family Microbiome | Community Illness Exposure Herd Immunity | Sanitation Immunization Pathogen Exposure |
| | Behavioral | Health Behaviors Coping Strategies | Family Functioning School/Work Functioning | Community Functioning | Policies and Laws |
| | Physical/Built Environment | Personal Environment | Household Environment School/Work Environment | Community Environment Community Resources | Societal Structure |
| | Sociocultural Environment | Sociodemographics Limited English Cultural Identity Response to Discrimination | Social Networks Family/Peer Norms Interpersonal Discrimination | Community Norms Local Structural Discrimination | Social Norms Societal Structural Discrimination |
| | Health Care System | Insurance Coverage Health Literacy Treatment Preferences | Patient–Clinician Relationship Medical Decision-Making | Availability of Services Safety Net Services | Quality of Care Health Care Policies |
| Health Outcomes | |  Individual Health |  Family/ Organizational Health |  Community Health |  Population Health |

National Institute on Minority Health and Health Disparities, 2018

*Health Disparity Populations: Race/Ethnicity, Low SES, Rural, Sexual and Gender Minority
Other Fundamental Characteristics: Sex and Gender, Disability, Geographic Region





Context: Mapped dementia diagnostic disparities

- Higher incidence, prevalence, burden, & mortality
- Manifested across the full range of disease course
- Diagnostic disparities
 - Location: Emergency rooms vs specialty clinics
 - Timing: Initial diagnosis more often at moderate stage
 - Nature: Less accurate
- Disparities have not shown much decline over the past two decades

Barriers to dementia diagnosis and care

- Systemic
 - Inadequate health insurance
- Institutional
 - Lack of specialty clinics
 - Staff w/limited language capacity
- Interpersonal/Individual
 - Dementia literacy
 - Transportation

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Improving access: Intervention for research

- Intentional methodologic design to expand the science
 - Clinical Research:
 - Recruitment
 - Tiered recruitment prioritizing special populations at first tier
 - Less restrictive exclusion criteria
 - Build in psychoeducation: videos, social media, mobilize community navigators
 - Data collection supports: home visits; budget for sensory/ergonomic needs
 - Scheduling flexibility for participant best time of day
 - Leverage technologies
 - Machine learning
 - Regular progress and experience/feedback checks
 - Transparency re: limitations/challenges in science communications

Improving access: Interventions for practice

- Setting
 - Shift to primary care
 - Community clinics
- Routine dementia screenings
- Care partner engagement/education
- Mobile memory clinics
- Targeted ADRD awareness campaigns in primary care clinics
 - Impacts on MCC care



Improving access: Knowledge Gaps

- Sustainability of interventions
- Telehealth & dementia disparities
- Mixed methods approaches to identify stakeholder perception of health condition hierarchy
 - Physicians
 - Medical staff
 - Family members
- Measured benefits in MCC management for early ADRD screening
- Improvement in end of life care/planning
- Healthcare cost savings
- Caregiver experience



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Thank you!