

**2020 FORESIGHT:
SAN FRANCISCO'S STRATEGY FOR EXCELLENCE IN DEMENTIA CARE**

*A Plan and Recommendations to address the growing crisis in dementia care,
and an economic analysis of that care.*

**REPORT SUMMARY*
FOR ALZHEIMER'S/DEMENTIA SUMMIT**

**Final report to be released in September 2009*

July 8, 2009

By

Alzheimer's/Dementia Expert Panel

For

Department of Aging and Adult Services

SAN FRANCISCO'S STRATEGY FOR EXCELLENCE IN DEMENTIA CARE

Alzheimer's/Dementia Expert Panel

BACKGROUND INFORMATION

San Francisco is facing a crisis in the dementia care. In the San Francisco Bay Area, one out of every two persons 85+ has some type of dementia. Between now and 2020, San Francisco will experience a dramatic increase in the number of its citizens with Alzheimer's disease and other dementias.

PURPOSE:

The Alzheimer's/Dementia Expert Panel, formed by Mayor Gavin Newsom in November 2008, investigated the growing crisis in dementia care. The Expert Panel was charged with developing a plan to address the demand for services related to Alzheimer's/dementia care the year 2020, and an economic analysis of that care.

BACKGROUND:

The Department of Aging and Adult Services (DAAS) led and managed this initiative. In September 2008, DAAS retained the services of a research team consisting of Gibson & Associates, Resource Development Associates, and the Mental Health Association of San Francisco. This team worked with the Expert Panel and DAAS staff to undertake an evaluation of San Francisco's current dementia care services, project the need for additional services, and with guidance from the Expert Panel, prepare a plan and recommendations to address the needed services during the next 11 years (2009 to 2020). The plan includes financial projections related to the cost of care. The work of the Alzheimer's/Dementia Expert Panel took place between December 2008 and May 2009. There were 6 Expert Panel meetings. Four sub-committees researched specific topics and reported back to the Expert Panel to assist in its deliberations. Each subcommittee met approximately 5 to 7 times.

The research team worked with DAAS staff and the Expert Panel to facilitate all activities related to:

1. Research including:
 - a. An environmental scan of existing Alzheimer's and dementia care services and resources;
 - b. Summarizing all existing Alzheimer's and dementia care services, both for people with dementia and for their caregivers;
 - c. A national and international literature review related to evidence-based practice and emerging research, as well as promising practices and emerging trends;
 - d. An evaluation of data already compiled and compilation of additional data, as well as data and economic analyses;
 - f. A review of local publicly funded care programs and their costs;
 - g. Interviews focused on family and informal care giving, existing dementia care services, program administration and oversight. Interviewees to include people in government and non-profit as well as for-profit agencies.
2. Assessment of the need for and types of additional services over the next 11 years;
3. Economic analysis of projected costs (inflation adjusted);
4. Consideration of potential new funding sources or expanded existing funding sources; and
5. Preparation of the Expert Panel's a final report, including a plan and recommendations for how to address the anticipated need for additional services, to include best practices and any local publicly funded services found in other parts of the country, not already provided in San Francisco.

SAN FRANCISCO'S STRATEGY FOR EXCELLENCE IN DEMENTIA CARE

Alzheimer's/Dementia Expert Panel Members

1. Department of Public Health:
 - o Laguna Honda Hospital **Gail Cobe**, Clinical Nurse Specialist, Dementia Program
 - o San Francisco General Hospital **Edgar Pierluissi**, MD, Medical Director, ACE Unit
 - o Community Behavioral Health Services **Robert Cabaj**, MD, Director, CBHS
2. Department of Aging and Adult Services **Anne Hinton**, ED, DAAS
3. Family Caregiver Expert **Kathy Kelly**, ED, Family Caregiver Alliance, CO-CHAIR
4. Long Term Care Ombudsman **Benson Nadell**, Ombudsman, Family Service Agency
5. PACE Model Experts **Robert Edmondson**, ED, On Lok, Inc
David Werdegar, President & CEO, Institute on Aging
6. Homecare Expert **Margaret Baran**, ED, IHSS Consortium
7. Labor **Richard Thomason**, Policy Director, SEIU United Healthcare Workers West
8. Aging Experts **Anni Chung**, ED, Self Help for the Elderly
Gay Kaplan, RN, Director of Services, Curry Senior Center
Martin Lynch, ED, Over 60 Health Centers, Berkeley
9. Care Coordination Experts **Susan Garbuio**, Director, Community Living Fund, Institute on Aging
Linda Fodrini-Johnson, Founder and ED, Eldercare Services (Geriatric Care Management)
10. Economic Expert **Patrick Fox**, PhD, UCSF Health and Aging
11. Alzheimer's Experts **Bruce Miller**, MD, Director, UCSF Memory & Aging Center
Ruth Gay, Public Policy & Advocacy, Alzheimer's Association of Northern California and Northern Nevada
Nader Robert Shabahangi, PhD, President & CEO, Age Song Therapeutic Environments
12. Foundation **Carmen Mendieta**, Brookdale Foundation, focusing on enhancing quality of life for the elderly
13. Long Term Care Coordinating Council **Vera Haile**, Behavioral Health Access Workgroup Co-Chair
14. Caregiver/Partner/Consumer **Willard Harris**, RN, caregiver and older adult
15. Medical Care Provider **Jay Luxenberg**, MD, Director and Geriatrician, Jewish Home, CO-CHAIR
16. Researcher **Adam Boxer**, MD, Alzheimer's Disease Researcher & Professor of Neurology, UCSF Memory & Aging Center

SAN FRANCISCO'S STRATEGY FOR EXCELLENCE IN DEMENTIA CARE

Subcommittees Members

Evidence-Based Practices & Emerging Research Subcommittee

Ruth Gay, Director, Public Policy and Advocacy, Alzheimer's Association of No. California and No. Nevada, CHAIR

- **Bruce Miller**, UCSF, Memory and Aging Center
- **Marilyn Williams**, Kaiser Permanente
- **Karyn Skultety**, Institute on Aging
- **Eva Schmitt**, Institute on Aging
- **Sherrie Matza**, Family Caregiver
- **Vera Haile**, Long Term Care Coordinating Council
- **Carmen Mendieta**, Brookdale Foundation
- **Kathy Kelly**, Family Caregiver Alliance
- **Jay Luxenberg**, MD, Jewish Home
- **Cindy Barton**, VA Medical Center
- **Adam Boxer**, UCSF Memory and Aging

Services & Systems Subcommittee

Cindy Kauffman, Institute on Aging, Vice President, Adult Day Programs and Health Services, CHAIR

- **Patty Clement**, Catholic Charities CYO
- **Gail Cobe**, Laguna Honda Hospital, Dementia Care Services
- **Benson Nadell**, Long Term Care Ombudsman
- **Bob Cabaj**, Community Behavioral Health Services
- **Karen Garrison**, Bernal Heights Neighborhood Center
- **Anni Chung**, Self Help for the Elderly
- **Linda Fodrini-Johnson**, Private Care Manager
- **Donna Schempp**, Family Caregiver Alliance
- **Margaret Baran**, IHSS Consortium
- **Willard Harris**, Caregiver
- **Susan Garbuio**, Community Living Fund

Finance Subcommittee

Patrick Fox, Co-Director, UCSF, Institute for Health & Aging, expert in the economic costs of illness, CHAIR

- **Brooke Hollister**, UCSF, Professor – Institute for Health and Aging
- **Tom Mesa**, DPH Community Behavioral Health Services
- **Marty Lynch**, Lifelong Medical Care
- **Martha Peterson**, HSA Finance and Planning
- **Steve Shane**, IHSS Consortium CFO
- **Rick Zawadski**, RTZ Associates

Education & Prevention Subcommittee

Elizabeth Edgerly, Program Director, Alzheimer's Association, & National spokesperson for the Maintain Your Brain program, CHAIR

- **Alvaro Fernandez**, CEO and co-founder of SharpBrains
- **Bonnie Bollwinkel**, Alzheimer's Association
- **Nancy Brundy**, Institute on Aging
- **Bridgett Brown**, Independent Living Resource Center
- **Nelu Zia**, San Francisco Adult Day Services Network

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Subcommittee Descriptions

Evidence Based Practice & Emerging Research, which reviewed findings from the most recent research regarding dementia, including: (1) evidence-based best practices for: dementia care services, treatment, and prevention; (2) the role of the family and the larger community; (3) strategies to provide caregivers with support; (4) protective factors and prevention strategies; and (5) promising practices and emerging trends. This involved a national and international literature review.

Services & Systems, which enumerated San Francisco's existing dementia care services and supports (for mild, moderate and severe levels). The subcommittee considered additional services needed to care for adults with dementia. Categories of services enumerated include: (1) adult day services; (2) advocacy and protection; (3) care management; (4) caregiver services and supports; (5) diagnostic assessment; (6) education; (7) information and referral; (8) in home supportive services; (9) legal services; (10) mental health services; (11) money management services; (12) nursing care and hospital services; (13) ongoing medical treatment; (14) public policy; (15) research and development; (16) residential care; and (17) respite care.

Finance, which examined the cost of operations of the current network of dementia care services and supports. It considered the costs to: (1) expand existing services; and (2) implement new initiatives and services currently not in place in San Francisco. It then projected these costs forward 10-12 years to anticipate how the costs might change to meet the needs of the expanding population. The subcommittee also identified a range of funding resources that could be accessed to support the recommended model system of dementia care services.

Education & Prevention, which developed effective training and education programs for community members, including caregivers, regarding dementia. Protective factors including brain fitness and risk factors, early identification and early access to services were evaluated. Recommendations consist of a total of nine content areas for education. Many of the content areas are also intended to address issues related to stigma regarding dementia. The subcommittee also addressed the need for educating professionals (e.g. doctors, psychiatrists, social workers, nurses, and paid caregivers), and others who find themselves working with people with dementia and their caregivers. Nine content areas were identified to be part of comprehensive education and prevention efforts, including: (1) risk reduction: (2) early identification of dementia; (3) what to expect as the disease progresses: (4) services and resources; (5) caregiver wellness and support; (6) disease management for mild, moderate, and advanced dementia, including end-of-life issues; (7) advanced care planning; (8) ethical issues; and (9) emergency preparedness and safety.

SAN FRANCISCO'S STRATEGY FOR EXCELLENCE IN DEMENTIA CARE

Mission, Values & Vision

The Mission:

The mission of this plan is to improve the quality of life for people with Alzheimer's disease and related dementias, and their caregivers, through easy access to a coordinated network of formal and informal non-judgmental services and supports that address the chronic care management needs of both older and younger individuals throughout the course of cognitive decline.

The Values in this plan emphasize:

- Services and supports that are developed and delivered using a person-centered and family-centered approach, based on an assessment of the unique needs and preferences of the individual and their loved ones, and that enable each of them to thrive.
- The importance of chronic care management*, through home and community-based services as well as institutional services, which offers a new framework for providing care and support for people with Alzheimer's and related dementias.
- The most appropriate dementia care, services and support will be provided in the least restrictive and most integrated setting, depending on need and choice.
- We will strive to ensure that people with dementia remain integral members of their communities, as appropriate to their health and safety.
- We acknowledge the importance of caregivers, both informal unpaid caregivers (family, partners, friends, neighbors, community members) and formal paid caregivers (homecare workers, home health care workers).
- We recognize that dementia care today places an undue burden on women as informal unpaid caregivers. We value the lives and contributions of women beyond care giving and we seek to reduce this burden.
- We strive to ensure high quality, culturally and linguistically appropriate dementia care, services and support.
- We understand that Alzheimer's and related dementias impact the whole person and their chosen family. With this in mind, the physical, mental, and spiritual issues of persons with dementia and their caregivers need to be attended.

The Vision:

Our vision is to create a well-coordinated network of services and supports that will enable people with Alzheimer's and related dementias, and their loved ones, to flourish throughout the continuum of the progression of these disorders. San Francisco will develop and promote an integrated model of dementia care, in which the needs of people with dementia and their caregivers will be addressed within the full range of medical, health, social, and caregiver needs of all older adults and adults with disabilities.

Services and support for people with Alzheimer's and related dementias and their caregivers will be integrated into San Francisco's existing long term care service delivery network, which includes a range of home, community-based, and institutional services. Within this network structure: (1) existing services will become dementia capable through education and training; (2) specific dementia care services will be expanded or developed as needed; (3) existing systems will provide services, care and support particularly for people with moderate and advanced dementia; and (4) new chronic care service delivery systems will be specifically designed and developed for older adults that will also address dementia care.

The community will be provided with training and education about dementia care resources, and about activities and other opportunities for risk reduction. The community will be well educated, sympathetic and supportive of people with Alzheimer's disease and related conditions, and their caregivers. Information will be easily accessible in each neighborhood throughout the city.

This vision goes beyond providing what dementia care, services and supports people with dementia and their caregivers need, to a broader, more fundamental issue: what people require for a good life. This includes: (1) the formation of personal and social support networks that promote the contributions of people with dementia, with the goal of strengthening our neighborhoods and communities; and (2) the creation of age- and disability-friendly communities that offer accessible and affordable housing, improved public safety, improved access to parks and recreation, and opportunities to be meaningfully engaged in the community.

A central concept woven throughout the *Strategy* is a commitment to a shift in how dementia care services are delivered, moving from primary reliance on institutionalization to the development of a strengthened capacity to serve individuals in the community. Chronic care management is an approach to community-based care for people who have chronic conditions that captures this approach, which is expressed in the second bulleted value and described in more detail below:

**Chronic Care Management: Widespread recognition of the need for ongoing chronic care management through home and community-based services is relatively new in the long term care arena. As older adults and adults with disabilities are living longer with functional impairments and chronic illnesses, they increasingly prefer to receive services in a community setting rather than an institutional setting.*

The evolving approach to chronic care management across the country, which relies substantially on community-based services and less on institutionalization, offers a new framework for thinking about how to provide services to people with chronic conditions. The Community-Based Long Term Care Report of 1998 identified chronic illness as "an illness or disability that persists for a long time, whether or not it causes death." Further more, they are "ongoing and not amenable to cure. They may range from mild to manageable to severe (potentially life threatening) physical or mental conditions. However, chronic conditions are changeable, so prevention of actual episodes and maintenance of functional ability are the primary goals. Those who may need help range from young spinal cord injury survivors to older adults with Alzheimer's disease." The report identified a new approach for long term care service provision as one that "blends traditional medical and social models in recognition that managing an illness or a disability over time requires an integrated approach with the consumer as the focus."¹

¹ Community-Based Long Term Care: Supporting Families Across the Generations (presentation), California Long Term Care Coalition, April 1998.

SAN FRANCISCO'S STRATEGY FOR EXCELLENCE IN DEMENTIA CARE

Objectives and Recommendations

The following objectives and recommendations are intended to address the growing crisis in dementia care, from early memory loss, to the progression to mild, moderate, and advanced dementia. However, if San Francisco could: (1) help people to learn about the initial signs of cognitive change; (2) provide increased resources and community-based services for those first experiencing memory loss and cognitive impairment; (3) offer training and support for caregivers and service providers; and (4) assist those experiencing dementia and their caregivers to manage symptoms and care issues in the early to moderate stages, the need for more intensive and costly services could be delayed. The advance of the disease cannot currently be halted. We should provide comprehensive, compassionate care for people and their care partners at each stage of the disease. Until there is a cure or disease-altering treatment for cognitive decline, achieving these objectives and implementing these recommendations will allow us to better manage each individual's complex medical conditions along with their dementia in a way that will improve quality of life.

Objectives and Recommendations

OBJECTIVES

1. Improve capacity to meet the needs of the whole person by delivering integrated care.
2. Improve public and professional awareness, and understanding of dementia.
3. Develop an informed and effective workforce for people with dementia.
4. Expand capacity to deliver high-quality early diagnosis and intervention for all.
5. Ensure availability of high-quality, culturally responsive information for those diagnosed with dementia and their caregivers.
6. Create expanded and easy access to care, support and advice following diagnosis.
7. Implement a range of effective caregiver support strategies to better address the multiple needs of informal caregivers.
8. Improve the quality of hospital and nursing home care for people with dementia.
9. Expand and improve the quality of community-based care for people with dementia.
10. Improve the quality of services in residential care homes for people with dementia.
11. Improve access to end of life care for people with dementia.
12. Advocate for effective state and national support for implementation of this *Strategy*, as well as other improvements for people with Alzheimer's and related dementias, and their caregivers.
13. Foster policies and practices that create a community sensitive to the needs of individuals with memory loss.
14. Facilitate and support an oversight body responsible for implementing this *Strategy* and advocating for the improvement of prevention, education, services and supports related to dementia.

OBJECTIVE 1: Improve capacity to meet the needs of the whole person by delivering integrated care.

RECOMMENDATION 1-1. Dementia care should be integrated into San Francisco's existing long term care service delivery network for older adults and adults with disabilities, which emphasizes ongoing chronic care management. This will enable the needs of the whole person to be considered and addressed.

Comments on recommendation: People with Alzheimer's and related dementias often have other chronic illnesses and conditions. Integrating expanded and improved dementia care services into the long term care service delivery network will enable issues of co-morbidity to be addressed. Efforts are now being made to integrate services across silos through increased collaboration, shared planning, and shared budgeting. Service providers in the long term care network should be educated and trained to address the full range of health, medical, social, spiritual, and caregiver (family and other informal support) needs of people with Alzheimer's and related dementias.

RECOMMENDATION 1-2. All agencies and programs delivering services to older adults and adults with disabilities in the long term care service delivery network should become dementia capable. This will require education, training, and support for service providers and families. Agencies and programs serving people with dementia will need to consider the stigma related to dementia, the concerns of existing clients, and the dignity of new clients experiencing cognitive impairment or dementia.

Comments on recommendation: More older adults with cognitive impairment or dementia will be served in the community by programs targeting older adults, including senior centers, adult day health care centers, social day programs, meal programs, specialized group programs, and residential facilities. To enable these agencies and programs to address the needs of older adults with cognitive impairment or dementia, and to respond to them with dignity and respect, training to become dementia capable will be necessary.

OBJECTIVE 2: Improve public and professional awareness, and understanding of dementia.

Public and professional awareness and understanding of dementia is to be improved and the stigma associated with it addressed. This should inform individuals of the benefits of timely diagnosis and care, promote the prevention of dementia, and reduce social exclusion and discrimination. It should encourage behavior change in terms of appropriate help-seeking and help provision.

RECOMMENDATION 2-1. Public education targeting those experiencing memory loss, mild cognitive impairment (MCI), and those newly diagnosed with Alzheimer's and related dementias, and their caregivers, as well as service providers, care managers, and health care professionals should be expanded and enriched.

- a. There should be an expansion of public education providing information about memory loss services and resources, and addressing the stigma connected to Alzheimer's and related dementias, in community-based education centers, possibly located in neighborhood public libraries. The centers should offer periodic presentations about memory-loss issues and serve to build better***

community understanding of Alzheimer's and related dementias, greater compassion, and an increased ability to identify individuals who might have MCI.

- b. There should be public education and training available on the following topics as part of a comprehensive education and prevention effort:
 - (1) Risk Reduction;*
 - (2) Early Identification of Dementia;*
 - (3) What To Expect as the Disease Progresses;*
 - (4) Services and Resources;*
 - (5) Caregiver Wellness and Support;*
 - (6) Disease Management - Mild, Moderate & Advanced Dementia;*
 - (7) Advanced Care Planning;*
 - (8) Ethical Issues;*
 - (9) Emergency Preparedness and Safety.**
- c. Public education should include feature films, works of art, and other expressions of gifts, talents, strengths and creativity of people with Early Memory Loss (EML) and MCI. This is low-cost strategy is designed to build a memory loss friendly, elder compassionate community.*
- d. A variety of community-based EML and MCI educational programs should be implemented throughout the city. These programs can serve as an introduction and access to supportive services for people with memory loss and their caregivers.*

Comments on recommendation: Services for people with EML, MCI, and early stage dementia are in short supply and opportunities for referrals to those services that exist are frequently missed. Educational presentations are one avenue of outreach to people with EML, MCI, and early stage dementia, and their caregivers, as part of a comprehensive education and prevention effort. People concerned about memory loss will be the audience for these forums, sessions, workshops, events and will sometimes connect with providers, clinicians, etc. Also, as part of the educational process, tailored services will be highlighted and hopefully referrals to services and care will flow from this education. Since some of the intended audience will be just learning about dementia, (gate keepers such as postal workers, paramedics, police, fire, emergency department staff, etc.), educating them about the warning signs, behaviors and needs of people with EML and MCI, may raise awareness and the ability to identify that a customer, client or neighbor may be experiencing memory loss.

Public education and training will target people with EML and MCI; people with Alzheimer's and related dementias; family caregivers, other family members, interested friends and neighbors; professional paid caregivers – including home care workers, assisted living staff, nursing home staff; physicians, health care providers and allied professions; Adult Protective Services staff; nutrition programs and meal site staff, first responders; and other community-based service providers.

OBJECTIVE 3: Develop an informed and effective workforce for people with dementia. Health and social services staff involved in the care of people with dementia should have the necessary skills to provide the best quality of care in the roles and settings where they work this is to be achieved by effective basic training and continuous professional and vocational development in dementia.

RECOMMENDATION 3-1. Gaining a better understanding of how best to work with and treat people with Alzheimer's disease and related dementias is critical. The most

current guidelines and standards for dementia care should be identified, promoted, and disseminated to professionals on a regular basis. Providing professionals, including community-based service providers and care managers, with guidelines and standards that inform their care practices will help to reduce stigmas, and improve the dignity and quality of care.

Comments on recommendation: We need to work toward de-stigmatizing dementia. Professionals, including community-based service providers and care managers, must understand the implications for care, and be open to what they can do to provide dignified care. Service providers need to be provided with current guidelines and standards for the care of people with dementia, including appropriate diagnosis, disease management, and late stage care. There needs to be a way of keeping guidelines and standards updated. One new piece of research can dispute a current guideline or standard. It is important to disseminate the most current information so individuals and agencies are not using antiquated information. One recommendation was to encourage some form of recognition or awards for agencies and individuals that implement standards effectively. Some standards could be incorporated into city contracts for services provided.

RECOMMENDATION 3-2. Training for professionals, including community-based service providers and care managers, should be expanded to facilitate implementation of the most current guidelines and standards for dementia care. Seek and obtain funding to enable the provision of this expanded training.

Comments on recommendation: If professionals, including community-based service providers and care managers, are to meet current dementia care guidelines and standards, expanded training will be needed to boost the capacity and capability of staff working at all levels of care. This could consist of a simple, reader-friendly monthly e-memo to primary care physicians about recommended standards of practice, guidelines and community resources as well as standards for training of all personnel responsible for serving older adults with chronic conditions including Alzheimer's and related dementias. Training and information should be provided to nurses, caregivers (paid and unpaid), case managers, and primary care physicians, and for expanded and mandated training for staff at assisted living facilities. Funding will be needed for this expanded training.

The monthly e-memo distribution should be expanded to all involved in dementia care, including other physicians, care coordinators, case managers, Adult Protective Services staff, home delivered meals program staff, assisted living facilities staff, and nursing home staff.

RECOMMENDATION 3-3. Training for primary care physicians, hospitalists, and the medical staff of primary care health centers and clinics operated by the Department of Public Health, the San Francisco Community Clinic Consortium, UCSF, Kaiser Permanente, and other primary care providers should be expanded related to diagnosis, medication prescriptions, managing difficult

behaviors and critical crisis care issues, and end-of-life care related to Alzheimer's and related dementias.

Comments on recommendation: Training for primary care providers is needed to ensure that medical and mental health conditions are properly diagnosed, medications are correctly used, and over-treatment is not employed to extend life against the wishes of the patient and/or caregiver. Consistent knowledge of the effective use of pharmacological and non-pharmacological interventions should be included in such training.

RECOMMENDATION 3-4. An electronic medical record (using a “patient dashboard”) should be researched and developed that will: (1) enable cross-system information sharing; and (2) improve service coordination.

Comments on recommendation: For services to be coordinated, service providers must have access to a patient medical record across sites and systems within San Francisco's service delivery networks. This record must capture current information from the standardized assessment (above), subsequent service use, and changes in medical, health and social conditions as the patient advances.

OBJECTIVE 4: Expand capacity to deliver high-quality early diagnosis and intervention for all. All people with dementia should have access to a pathway of care that delivers: a rapid and competent specialist assessment; an accurate diagnosis, sensitively communicated to the person with dementia and their caregivers; and treatment, care and support provided as needed following diagnosis.

RECOMMENDATION 4-1. Diagnosis of mild cognitive impairment (MCI) should be encouraged and facilitated with clear established diagnostic criteria. Every person who now has Alzheimer's and other dementias at one time had MCI. With proper diagnostic criteria, and specialized medical care, a meaningful MCI diagnosis can be made and should be evaluated regularly. These individuals, while not yet demented, still require care & support.

Comments on recommendation: There is emerging consensus that, as we gain better understanding of dementia, we will be identifying and treating people much earlier in disease progression. There is also emerging consensus that new treatments for Alzheimer's and related dementias will be most effective at MCI or earlier stages of disease progression. Most new treatments will be most effective if evaluation is done very early and identified at MCI or earlier, possibly before significant symptoms are evident, and when the individual can most benefit at the highest level of functioning. People with MCI are in a transitional medical state and may very well benefit from support and services offered to people with early stage dementia.

RECOMMENDATION 4-2. A standardized screening tool for chronic conditions and illnesses, which encompasses cognitive function, mood, activities of daily living, and caregiver or family observations, should be selected or developed. This should be used by health care professionals (primary care physicians, physician assistants, nurses, nurse practitioners, social workers & clinics) to assess the need for a more comprehensive evaluation for adults with memory complaints or cognitive change, possibly including referral to a specialist for more thorough diagnosis.

Comments on Recommendation: A standardized screening tool should be comprehensive and relate to chronic conditions and illnesses. If the use of the tool demonstrates the need for a more comprehensive evaluation and thorough diagnosis, these must be effectively and precisely done, to avoid stigmatized and inappropriate responses to people based on unfounded assumptions. Stigmas associated with this disease must be avoided when no diagnosis has been made, but assumptions about that person impact actions for care. This screening tool could also be used by psychologists.

RECOMMENDATION 4-3. A range of clinical geriatric fellowships should be developed at UCSF for physicians, nurses, and social workers training in geriatric practice, with fellows committing to a number of years working in community health services (primary care health centers and clinics operated by the Department of Public Health and the San Francisco Community Clinic Consortium), performing assessments, and managing the care of people with Alzheimer's and related dementias.

- a. UCSF geriatric fellowships should be offered for the following: geriatrician medical specialty, geriatric psychiatrist, geriatric neurologist, geriatric nurse practitioner and geriatric social work.
- b. Geriatric fellowships could also be developed at SF State University for geriatric care managers at SF Community College for geriatric registered nurses.***
- c. The development of these fellowships will require discussions and negotiations at each institution, as appropriate, and grant support.***

Comments on recommendation: There are an inadequate number of centers of excellence for diagnosis and management of dementia. UCSF can become this center of excellence with the addition of fellowships to train fellows to provide both diagnosis as well as ongoing dementia treatment and management. This is workforce development for medical professionals serving elder populations, both at UCSF and in public health clinics and health centers. There is workforce development legislation (loan forgiveness that Senator Boxer reintroduced) to provide incentives. NOTE: Additional financial incentives should be provided to recruit culturally diverse fellows that mirror San Francisco's demographics. Reimbursement for geriatric care is currently insufficient so doctors do not enter the geriatric field.

RECOMMENDATION 4-5. Barriers and financial disincentives to access services should not be based on a single diagnosis. Improving access to services in this way will help to reduce discrimination, and will encourage service providers to become more dementia friendly and capable. This is necessary because individuals with multiple

chronic care issues, one of which is dementia, may also need other services such as mental health services, adult day services, or assisted living.

- **Increase access to mental health services, adult day services, and assisted living, based on individual's capacity to thrive, not on diagnosis.**
- **Include anti-discrimination language in city-funded programs.**

Comments on Recommendation: Some adult day services or assisted living facilities may specialize in one or more kinds of services, and may not include dementia care. Also, at the present time, once an individual has a primary diagnosis of dementia, they are locked out of many payment systems. This is especially true for the mental health system in San Francisco, where there must be a mental health diagnosis in order to obtain reimbursement. It is always easier to have a primary mental health diagnosis first. There could also be primary physical health diagnosis. This has to be clinically justified. There could be a screen for depression. Ensure clinicians in medical homes screen primarily for a mental health diagnosis including depression and other affective disorders. Secondarily screen for dementia.

OBJECTIVE 5: Ensure availability of high-quality, culturally responsive information for those diagnosed with dementia and their caregivers. Provide people with dementia and their caregivers with good-quality information on the illness and on the services available, both at diagnosis and throughout the course of their care.

RECOMMENDATION 5-1. To enable easy access to quality information, people with cognitive impairment and dementia as well as their caregivers will benefit from the central door of San Francisco's "no wrong door" strategy. The DAAS Integrated Intake Unit, already in place to assist all people seeking information about services in the long term care network, is that central door. Its staff should be trained to provide expert information on a range of resources and services related to memory loss, cognitive impairment & dementia.

Comments on Recommendation: The DAAS Integrated Intake Unit currently coordinates Information and Referral to the following services: Home-Delivered Meals, Adult Protective Services, In-Home Supportive Services, and the Community Living Fund, as well as other long term care services. Consumers and caregivers seeking services have access to comprehensive information about available resources without needing to make multiple calls to a variety of programs. The Integrated Intake Unit staff will be trained about the full range of public and private dementia care services and supports available in San Francisco, and well acquainted with the range of memory loss and dementia care resources and services, and with the most appropriate referral locations where services can be obtained.

In addition to the "central door", there are multiple initial contact locations that will be able to provide information and linkage to appropriate services, including memory loss, cognitive impairment, and dementia care services and support. Any number of "doors" may admit an individual with MCI because all service providers will be trained to be sensitive to the needs of older adults with cognitive impairment. San Francisco is a diverse city and people access services in different ways. Service providers serving different racial, ethnic, and cultural

communities will be familiar with early stages of cognitive impairment and aware of the most appropriate referral locations where services can be obtained.

OBJECTIVE 6: Create expanded and easy access to care, support and advice following diagnosis. A dementia adviser should be available to facilitate easy access to appropriate care, support and advice for those diagnosed with dementia and their caregivers. Also, groups should be available to provide ongoing peer support that can provide practical and emotional assistance, as well as help to reduce isolation.

RECOMMENDATION 6-1. A team approach to dementia care and service delivery should be created, using care managers with dementia expertise working in health centers and hospitals, with a focus on primary care health centers and clinics operated by the Department of Public Health, the SF Community Clinic Consortium, UCSF, and Kaiser Permanente. This will result in a better-informed and coordinated delivery of services.

- a. A “Single Point of Contact” strategy should be incorporated: each person with Alzheimer’s and related dementias, and their caregivers, would have one care manager. This professional would be responsible for supporting the person and the caregivers as they move through the stages of the disease.***
- b. This approach could be a possible pilot project developed in collaboration between the Department of Aging and Adult Services, and the Department of Public Health, which is moving to the concept of a primary care medical home for each person covered by Medi-Cal.***

Comments on recommendation: A team approach would have care managers with dementia expertise assigned to primary care clinics. Immediately after diagnosis, the care manager would meet with the person and caregiver to begin treatment planning and to provide the caregiver with resources and information. The care manager should be at least affiliated with if not co-located at the clinic where the patient receives primary care. Patients and their social, home, and health information should be shared among agencies responsible for delivery of services (confidentiality safeguards honored). Standards of care would be developed for care managers possibly based upon the standards developed by the National Association of Geriatric Care Managers. Care managers would be the “single point of contact” for patients and caregivers and would be responsible for facilitating access to community resources and serve as a patient caregiver advocate. UCSF was identified as a provider of an education program related to transitions in care.

RECOMMENDATION 6-2. Structured peer support and learning networks should be developed for people with dementia and their caregivers. The establishment and maintenance of such networks will provide direct peer support. These networks can also provide practical and emotional support, reduce social isolation, and promote self-care.

Comments on recommendation: This effort to create peer support and learning networks focusing on dementia should expand on the efforts of other innovative programs in San Francisco to provide what older adults and adults with disabilities of all ages require to have a

“good life”. This includes the efforts of: (1) the *Community Living Campaign*, which is helping older adults and persons with

disabilities of all ages through the formation of personal and social support networks; (2) *San Francisco Village*, which is a membership program that provides the social, service, and support benefits of a retirement community without having to give up one’s independence and own home or apartment; and (3) *openhouse*, which through community organizing, is fostering the development of intentional lesbian, gay, bisexual and transgender senior communities throughout San Francisco so that members can support one another as they age.

OBJECTIVE 7: Implement a range of effective caregiver support strategies to better address the multiple needs of informal caregivers. Family caregivers are the most important resource available for people with dementia. Active work is needed to ensure that the services and supports are available for caregivers of people with dementia. Caregivers have a right to an assessment of their needs and can be supported through an agreed plan to support the important role they play in the care of the person with dementia.

RECOMMENDATION 7-1. A practice should be established of referring caregivers and family members to supports, such as education, counseling, caregiver assessment, and services. Referrals should begin once a loved one is diagnosed with cognitive impairment or related dementias, so that caregivers can have immediate and ongoing access to resources. These should include a comprehensive assessment of their needs, structured counseling and education programs, and a range of educational materials, as well as a follow-up call shortly after the diagnosis is received, when referrals can be made to additional resources.

Comments on recommendation: Frequently, people given a diagnosis of cognitive impairment or dementia, and their caregivers, are told to come back to see the physician in a year. No resources are provided to them at the time of diagnosis. A critical gap is that education of primary care physicians, neurologists and others working with early stage patients need education about the variety of resources for those in early stage.

- a) The caregiver assessment could be triggered any time, and not just initiated by the primary care provider. It would probably be carried out by an agency the provider referred to. Medical professionals should not be doing this. Assessment is voluntary. Ideally, a single number or referral system can be put in place so providers know who to call for an assessment.
- b) The California Alzheimer’s Association guidelines call for providing a pamphlet with information and resources. Follow up involves checking in about access to resources and providing additional resources.

RECOMMENDATION 7-2. Additional respite care services should be developed for people with Alzheimer’s and related dementias. Increased respite care should be part of the supports (that include education, counseling, assessment, and services) for caregivers and family members. Seek and obtain funding for respite care.

Comments on recommendation: There should be respite care options and choices available. Respite can be defined as in-home respite, group respite, and overnight respite. Adult day services and other community-based services such as homecare can provide respite. Homecare can even be provided overnight. Surveys of families have indicated that it is considered most desirable for someone to come into the home to provide respite. There are not enough respite care services and resources to meet the needs of San Franciscans. Funding available for respite is limited.

OBJECTIVE 8: Improve the quality of hospital and nursing home care for people with dementia. This should be done by defining improved dementia care practices and quality of care, establishing care pathways, and identifying dementia care leadership.

RECOMMENDATION 8-1. A meeting of acute care hospitals should be convened to review all existing care plans for patients with any type of dementia, identify best practices for the care of hospitalized adults with dementia, and implement best practices to improve their care.

Comments on recommendation: This could expand on the work being done by the Acute Care for Elders (ACE) Unit at SFGH. Its practices could be used as a basis for training staff in other hospitals.

RECOMMENDATION 8-2. Nursing homes can be the most appropriate setting, and the safest and wisest choice, for some adults with advanced dementia, and for their caregivers. Placement should not only be for the purpose of safety and containment of dementia related behaviors, but also for person-centered care with an array of services that address the person and not solely the diagnosis of dementia. Standards for quality should be met as defined in the recommendations for quality of care in facilities, found in the Alzheimer's Association's, "Recommendations for Assisted Living and Nursing Homes" and in the Federal Nursing Home Regulations. Training for staff in these quality standards should be provided.

Comments on recommendation: Many persons with late stage dementia may require 24-hour skilled nursing care. This is due to the progression of the disease and the often associated diminished impulse control leading to aggressive behavior, the lack of insight and subsequent refusal to accept care with bowel and bladder hygiene or assistance in walking, eating and bathing. Also, older adults often have coexisting critical medical problems that require continued professional oversight.

Successful placement in a nursing home is not just a matter of an available bed, but of a qualitative placement as envisioned in the recommendations mentioned above. There should be consistent assignment of caregivers, with dementia related training, and with an enriched activity program that would mitigate against a sole reliance on medications for behavior control. Nursing homes should contain dementia friendly physical environments, with green space, and areas for mobility, if appropriate. In San Francisco, Laguna Honda Hospital and the Jewish Home are best-practice providers of skilled nursing care, including advanced dementia care.

OBJECTIVE 9: Expand and improve the quality of community-based care for people with dementia. Community-based care should be expanded, improved, and accessible to people with dementia.

RECOMMENDATION 9-1. An expanded range of community-based services should be developed for people in the early stages of cognitive impairment or Alzheimer's and related dementias, based upon evidence-based practice and emerging research.

- a. There should be therapeutic Interventions including creative expression, intergenerational programs, and pet therapy - to be made explicit in the appropriate services and settings, and in the appropriate manner.*
- b. Additional grocery and meal delivery services, transportation services, money management, and legal and financial planning services are needed for people with Alzheimer's and related dementias, and their caregivers.*

Comments on recommendation: Research shows the beneficial impact of therapeutic interventions. Additional community based services will assist people to remain living in the community. These services also help to relieve stress on caregivers.

RECOMMENDATION 9-2. The full range of adult day services (Adult Day Health Care, Social Day Care, and Alzheimer's Day Care Resource Centers), appropriate for individuals at different stages of the disease, should be expanded and enhanced. All programs and staff should be equally well informed, trained, and capable of addressing the needs of individuals with cognitive impairment, or Alzheimer's and related dementias, and their caregivers.

- a. The Adult Day Health Care (ADHC) program at Laguna Honda Hospital closed in February 2009. The license for this ADHC is not now being used, and: (1) could be used by the Department of Public Health (DPH); or (2) should be made available to another organization to develop an additional ADHC center.*
 - A license is not transferable, but an ADHC business can be sold. A new owner would need to do a Change in Ownership.
- b. The fee to maintain this license should be paid by DPH annually until the license is used for another ADHC program.*

- The ADHC license was suspended by LHH effective March 20, 2009. The license can be placed in suspension for one year. LHH has paid the license renewal fees through November 15, 2009 (so this represents the length of time that it is currently in suspension), unless the license renewal fees are paid). The license renewal paperwork is expected to be mailed to LHH 120 days prior to expiration of the license. The license can then be renewed, and then suspended again until March 19, 2010.
- c. *A new ADHC or exiting ADHC(s) should consider a relationship with a Federally Qualified Health Center, which could result in additional funding for operations.*
 - d. *Additional Adult Day Programs (Social Day) should be developed. This program works well with people who have dementia. It is private pay and not covered by Medi-Cal.*
 - e. *The number of Alzheimer's Day Care Resource Centers (ADCRCs) should be increased. ADCRCs benefit caregivers, families, and neighborhoods, and help people to remain in the community. ADCRC is a designation that demonstrates expertise in dementia care. This is a specialty at ADHCs or Social Day Care Programs. Funding for the support of ADCRC status may need to be obtained from sources other than the State of California.*

Comments on recommendation: Some adult day services have an expertise in one or more areas, and may not include dementia care. Additional training and education could help to enhance capabilities at those centers not now specializing in dementia care. Also, a larger number of affordable, accessible adult day services should be available.

The goal is for all levels of day care to have the ability to be sensitive to and respond to individuals with Alzheimer's and related dementias. Finally, at present, three ADCRCs are funded primarily with state funds, which has not significantly increased in several years. More ADCRCs are needed and they need to be better funded. The financial reimbursement issues, as Medi-Cal doesn't reimburse sufficiently for ADHC, need to be addressed. San Francisco can fund innovative, community-based adult day services. City funds should bolster and not supplant existing federal and state sources of funding.

RECOMMENDATION 9-3. Services and support should be developed for people with cognitive impairment or Alzheimer's and related dementias who have no family, or who do not have family members living in close proximity to San Francisco. Because these people have no other available support, they should be red-flagged for care management. This could be a possible pilot project that addresses the needs of people with Alzheimer's and related dementias who are living alone without a primary caregiver.

Comments on recommendation: San Francisco has a high percentage of older adults who live alone, many with no family. Also, given evidence that in San Francisco up to 40% of individuals with cognitive impairment will not have a family member within one-hour's drive of San Francisco, care and support predicated upon daily involvement from family members will be unresponsive to a significant proportion of our population. The development of support

options that might support both the “un-befriended” population with no family involved as well as those elderly with family in the region, but not close enough to provide daily support is vitally important. NOTE: A workgroup may be required to explore the development of this pilot project.

RECOMMENDATION 9-4. A crisis intervention and assessment setting should be developed to place people with cognitive impairment or Alzheimer’s and related dementias who are no longer safe in their own environments and/or who have behavioral issues.

Comments on recommendation: This should be a resource for people who could be assessed for physical, cognitive and other impairments for wandering, agitation, or other challenging behavioral issues that need 24-hour care. This should also include assessment for other appropriate care settings.

RECOMMENDATION 9-5. Advocacy for changes in the mental health system should be undertaken, at the local and state level, to eliminate the carve-out of mental health services for people with a primary diagnosis of dementia. Encourage San Francisco’s mental health system & medical/health care system to collaborate more effectively in serving clients with dementia & mental illness, or those with Alzheimer’s, who develop mental health related conditions.

Comments on recommendation: People with a primary diagnosis of dementia cannot now be served by the mental health system. Dementia is a medical diagnosis, not a mental health diagnosis. At the present time, there must be a specific primary mental health diagnosis for a person to be served in the mental health system.

RECOMMENDATION 9-6. A plan should be developed to provide and fund services, particularly respite care, for people with Alzheimer’s and related dementias who are above Medi-Cal eligibility. The needs of these individual, who are often unable to get the services they require, should be addressed.

Comments on recommendation: People living above the poverty line are hit hard. Existing models to serve them include: the Community Living Fund (CLF) and a program through Community Behavioral Health Services that pays for “patch” services – e.g., board and care to avoid paying for hospitalization. CLF is for people up to 300% of poverty. The needs of people above Medi-Cal eligibility can also be addressed through educating professionals and service providers about Alzheimer’s/dementia. Recommendations: (1) Expand eligibility for Community Living Fund to 400% of poverty (from 300%); (2) use a sliding scale services for people above Medi-Cal eligibility; and (3) advocate for federal support for long-term assisted living, adult day health, in home supportive services.



OBJECTIVE 10: Improve the quality of services in residential care homes for people with dementia. Residential care alternatives for people with dementia. Also, improved quality of care for people with dementia by the use of exemplary practices and/or by the development of explicit leadership for dementia within the care homes. Improving dementia care practices and quality of care, establishing care pathways, and identifying dementia care leadership. Training provided for the staff of care homes in following these care practices and quality of care standards.

RECOMMENDATION 10-1. A range of residential care settings should be developed for people who require both residential and nursing care services. To do so will require working with the State Department of Social Services, Community Care Licensing, to explore existing licensing categories and consider developing new categories. Examples of residential care settings follow, each of which could be modified for dementia care:

- Residential Care Facilities for the Chronically Ill developed to address the needs of people with HIV/AIDS, which have a medical/nursing component.*
- Adult Residential Facilities for Persons with Special Needs developed to address the needs of persons with developmental disabilities.*
- The Green House model, which can be developed as a residential care facility or as a skilled nursing facility. This model provides smaller units that are residential in feeling, with more personalized care planning and greater autonomy for elders. Green Houses provide an environment in which residents receive nursing support and clinical care without this becoming the focus of their existence.*
- Board and Care Homes, which are a smaller version of Residential Care Facilities for the Elderly.*
- A local promising practice: DPH provides a patch to Residential Care Facilities For The Elderly and Adult Residential Care Facilities to cover the cost of housing and services for clients in the mental health system. The patch is above the SSI rate and is negotiated based on types of services provided.*
 - a. Affordable residential care settings on the Laguna Honda Hospital (LHH) campus. San Francisco should explore using one or more of these examples to develop affordable residential care on the LHH campus. LHH will employ an inter-disciplinary social-health model of care based on community reintegration and choice, which will provide rehabilitation, chronic care, dementia care, and end of life care. Having step-down residential alternatives on the LHH campus for people who require custodial care, including those with Alzheimer's and related dementias, who do not require 24 hour skilled nursing care, would provide a greatly needed and hopefully less costly resource, and would add a greatly needed residential component to the services at LHH.
 - b. Affordable residential care settings in underserved neighborhoods. San Francisco should explore using one or more of these examples to develop

affordable residential care settings in neighborhoods – specifically Bayview Hunters point. In particular, the Green House model should be explored and possibly developed so residential care settings would be available for people who require custodial care, including those with dementia, who want to remain living in this underserved community.

Comments on recommendation: There is a trend across the country and in the city to reduce the number of skilled nursing beds that have provided custodial care for older adults, including people with Alzheimer’s disease and advanced dementia. The intent is to move people to other types of care. Residential care facilities are needed that can provide custodial care with 24-hour coverage. Affordable residential care options will need to be developed throughout the city. However, by reducing institutionalization, Medi-Cal reimbursement for long term care service delivery is eliminated. This places the burden for the cost of care on the individual and the City.

Specifically, grades of residential care facilities should be created, including some with more nursing services and support. This would include a range of affordable residential care options responsive to different stages of dementia and different behavioral conditions. DSS Community Care Licensing needs to have an explicit statement about dementia care services and activities tracked and monitored in its licensed facilities. If nursing services are not allowed by the residential care facility rules and regulations, advocacy will be needed to change them similar to the Residential Care Facilities for the Chronically Ill (RCFCI) regulations. Also, a mechanism to pay for nursing services will need to be established. One possibility is a contract with a home health agency. Every effort should be made to retain Medi-Cal funds for the services and support provided in these new residential settings.

RECOMMENDATION 10-2. Residential care settings will increasingly be serving people with moderately severe dementia (mid-stage) or very severe cognitive decline (late-stage). Although placement may be needed for the purpose of safety and containment of dementia related behaviors, person-centered care with an array of services that address the person and not solely the diagnosis of dementia are equally important. Standards for quality should be met as defined in the recommendations for quality of care in facilities, found in the Alzheimer’s Association’s, “Recommendations for Assisted Living and Nursing Homes”. Training for staff in these quality standards should be provided.

Comments on recommendation: Many people with late stage dementia may require 24-hour skilled nursing care or 24-hour trained personal care. Placement in a residential care facility can forestall nursing home placement. At present, there are no low income or affordable residential care facilities that have a dementia-care focus in San Francisco.

A plan for dementia care services in any residential care facility should address quality issues: appropriate staffing levels and ratios per resident, with more than required training in dementia, individual-centered activities, and allowances for self-determination.

OBJECTIVE 11: Improve access to end of life care for people with dementia. End of life care, including hospice care, should be easily accessible. People with dementia and their caregivers should be involved in planning end of life care.

RECOMMENDATION 11-1. Advocacy should be undertaken for changes in policies – at a national level – that would enable individuals with late stage Alzheimer’s and related dementias to access hospice care without a primary medical diagnosis. Establishing diagnostic criteria that are more in line with the progression of late stage dementia, allow for the extension of time limits, and ensure palliative care as a criteria for people with dementia.

- ***Hospice care throughout Laguna Honda Hospital (LHH). At LHH, hospice and palliative care should be available to all terminally ill patients, including those with Alzheimer’s and related dementias, whether or not they reside in the Hospice Unit.***

Comments on recommendation: Hospice, a Medicare benefit and model of care that provides a constellation of support services at the end of life, is currently available in homes, skilled nursing facilities and assisted living facilities (ALFs). In the case of ALFs, the facility must apply for a waiver. It is up to the facility whether it can manage the care level - many do allow for this if a bed is available. The trouble with hospice care for someone with a primary diagnosis of dementia is that the criteria are very narrow - and many people with dementia don't fit until they have approximately 3 to 5 days to live. Doctors are reluctant to give a 6-month terminal diagnosis for someone with dementia because physically they may last much longer and this is difficult to determine. A primary diagnosis of cancer and dementia is clear because of the cancer criteria being more predictable.

Recognizing that Alzheimer’s and related dementias are a terminal condition with a far less certain timeline to end of life, a change in hospice policies should be considered – at the national level. Hospice care can be provided in nursing facilities. Hospice care can also be provided in some residential care facilities, but there needs to be non-ambulatory status for a facility in which it is provided. In San Francisco, LHH has a Hospice Unit, but dementia patients receive care throughout the hospital and are not currently admitted to that unit.

OBJECTIVE 12: Advocate for effective state and national support for the implementation of this Strategy. Appropriate state and national support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstration projects.

RECOMMENDATION 12-1. Education and advocacy for universal coverage for long term supports and services should be undertaken so that this is part of national health care reform. Work to assure that Medicare and Medicaid regulations are coordinated to allow for the best possible patient care.

- Comments on recommendation: Advocacy should be undertaken for a comprehensive long term care benefit as part of a national health care benefit. Respite should be included in this benefit. The comprehensive long term benefit should include adult day health, in home supportive services, and community-based long term care services. The California Association of Adult Day Services (CAADS) could assist with formulating advocacy concerning this issue.
- Medicare is not focused on long term care. There are a lot of individuals in assisted living facilities who are enrolled in Medicare. They have to go to adult day health centers during the day, but they have to pay \$90 a day. Would it be possible for Medicare to pay for adult day services – especially nursing, PT, OT, and speech therapy? Advocacy should include changes in Medi-Cal that affect reimbursement.
- San Francisco should advocate for these policy changes and educate people about the need for them.
- At a local level, the City and County of San Francisco should be considered the funder of last resort.

RECOMMENDATION 12-2. The City should advocate for legislation that would require the State Department of Health Care Services and Department of Social Services (DSS) to develop expertise in dementia care. In particular, the State DSS, Office of Community Care Licensing, should hire a nurse who could facilitate the development new licensing categories for the range of affordable residential care options for people who require custodial long term care, including people with Alzheimer’s and related dementias.

Comments on recommendation: The State, especially DSS, Community Care Licensing, needs this health care expertise to develop new licensing categories.

RECOMMENDATION 12-3. The City should explore: (1) participating in the California Assisted Living Waiver (renewed); or (2) using the Home and Community-Based Services Waiver (based on AB 2968) being designed specifically for San Francisco, to provide for services covered by Medi-Cal in affordable residential care options recommended for development. Each would retain Medi-Cal

funds in San Francisco for community-based services, including services for Alzheimer’s and related dementias.

Comments on recommendation: Participating in the Assisted Living Waiver could retain Medi-Cal funds in San Francisco for needed services

RECOMMENDATION 12-4. An enhanced nursing home diversion services project should be considered for development. The project would be developed in conjunction with the California Department of Aging, and funded by a grant from federal Administration on Aging.

Comments on recommendation: This initiative seeks to alleviate fiscal pressure on Medicaid and Medicare. The diversion services would target individuals at the same level of clinical need as Medicaid waiver eligibility, but who have assets in excess of Medicaid financial eligibility, not to exceed an average of \$25,000. The target for this project would be older adults and adults with disabilities, including people with Alzheimer’s and related dementias.

RECOMMENDATION 12-5. The feasibility of a managed chronic care demonstration project for older adults and adults with disabilities, including those with Alzheimer’s and other dementias should be explored. This could create an actual system of chronic care for adults with functional and cognitive impairments. This demonstration project would retain Medi-Cal funds in San Francisco for community-based long term services and supports, including services for Alzheimer’s and related dementias. A workgroup should be established to investigate this option.

Comments on Recommendation: This demonstration project could provide an actual system of chronic care for older adults with functional and cognitive deficits. In many ways, this could be similar to a PACE project (Program of All Inclusive Care for the Elderly), but it would need to be more inclusive and it could be citywide. This system of chronic care could complement Healthy San Francisco, a city program that makes health care services accessible and affordable for uninsured residents under 65.

A managed chronic care demonstration project would need to be based on a combination of:

- 1915(c) Home & Community Based Waiver, and
- 1115 Demonstration Waiver

Both of these waivers would provide access to Medicaid (Medi-Cal in California) funds for covered services in this managed care system because they waive the normal Medicaid requirements that focus more on covering the costs of institutional care. The cost of this managed chronic care program would have to be equal to or less than the cost of services provided without the waivers. This managed care pilot project would be similar a super Multi-Purpose Senior Services Program (MSSP), which San Francisco already has (MSSP is operated by the Institute on Aging).

OBJECTIVE 13: Foster policies and practices that create a community sensitive to the needs of individuals with memory loss.

RECOMMENDATION 13-1. Efforts should be undertaken to make San Francisco friendlier to people experiencing forgetfulness and cognitive impairment. This will benefit both individuals with memory loss and their caregivers. These efforts should be connected to the local, national, and international movements toward creating age and disability friendly communities.

Comments on recommendation: Making San Francisco friendlier to people increasingly experiencing forgetfulness should be tied in to the national movement toward creating age and disability friendly communities. We must seek non-traditional partners. Efforts should also be made to determine what can be done from an environmental perspective and how can we make the environment elder-friendly as well as forgetful-friendly.

This vision goes beyond providing what dementia care, services, and supports people need, to a broader, more fundamental issue: what people require for a good life. This includes: (1) the formation of personal and social support networks that promote the contributions of people with Alzheimer’s disease and related conditions, with the goal of strengthening our neighborhoods and communities; and (2) the creation of age- and disability-friendly communities that offer accessible and affordable housing, improved public safety, improved access to parks and recreation, and opportunities to be meaningfully engaged in the community.

OBJECTIVE 14: Facilitate and support an oversight body responsible for implementing this plan and advocating for the improvement of prevention, education, services and supports related to dementia.

RECOMMENDATION 14-1. A Dementia Care Excellence Oversight Committee should be established to be responsible for: (1) overseeing the implementation of this plan and recommendations; (2) monitoring the progress of workgroups, (3) monitoring the participation of partners; (4) undertaking advocacy efforts to influence state and national legislation; and (4) overseeing the exploration and initiation of pilot projects and demonstration projects.

Comments on recommendation: A dementia care oversight committee should be developed that will be responsible for the implementation of all recommendations in this plan. It could also be the forum for considering emerging research and recommending changes to standards, approaches and strategies as new promising practices emerge. This should be a standing

oversight committee determining how to implement the recommendations in this report. It should provide updates periodically to the Long Term Care Coordinating Council. The oversight body should have staffing from the City (DAAS) and hold quarterly meetings. New workgroups will be required to ensure implementation of specific recommendations.