Dementia Care Excellence Oversight Committee

Overseeing Implementing of San Francisco's Strategy for Excellence in Dementia Care

Department of Aging and Adult Services
1650 Mission Street, 4th floor, Mission Room
Monday, November 14th 3-4:30pm

Present: Ruth Gay (chair), Wendy Zachary, Amie Haltman-Carson, Jennifer Shannon, Benson Nadell, Marcy Adelman, Mivic Hirose, Susan Duong, Preston Burnes, Ed Ortiz, Melissa McGee, Andrea Korsunsky, Stefanie Bonigut, Edie Yau, Natasha Boissier

DAAS Staff: Valerie Coleman

AGENDA

PRESENTATION: SF General Hospitals ACE unit

Dr. Edgar Pierluissi spoke about SF General Hospitals "Acute Care for Elders" unit within the hospital, serving patients 65 and older, the MediCal population.
An initiative the hospital started prior to Dr. Pierluissi starting. 10th year anniversary next February. Also a site for teaching professional care, such as social work, primary care, pharmacist, nurses, etc.
Trying to create a seamless continuum that allows for coordination of care, more for "in-system" but it's a start.
A system of care and the focus is delivering services that allows to maintain function and allow patients to get back to where they were prior to hospitalization
Probably 200-300 ACE units and all range in how/what they provide.
Care plan made in an inter-professional way with the goal of removing barriers, generally driven by the CNA's. Focus on non-pharmacological approach and all staff have had specific training to work with this population.
Staff meets every day, for example today they have 10 new patients. Have a new 32 bed unit. 50-55% of patients have cognitive impairment and 10% of patients have delirium at any time; focus on medication, try to get them mobile as soon as possible and make sure to bring in family.
Have an outdoor roof-top garden, community dining to allow socialization.
Have great results – mobilize folks more than any other department in the hospital; folks that break hips, will leave walking 20% of the time vs. 8% of the time for other hospital departments.
This unit also focuses on nursing professional development.
Re-admission rates: no good data that it reduces re-admission rate; they were able to show less hospital readmission rate (10% in non-ACE and 6% in ACE)
Certification: pharmacists to UCLA (4 day program); nurses (2-3 Geriatric Nurses training)
Most of their patients go home (living independently), only a very small amount going to SNF's and not able to really capture great data for marginally housed or homeless seniors.
Huge need – patients that could function in the community, have some wandering problems and are low-income, but there isn't appropriate housing for the appropriate level of care. Often times folks are at higher levels of care because there's such a gap in care/housing.
Are there other gaps that prevent a safe discharge from the ACE program? Cognitive impairment and can't manage a complicated regime. They're really good at a non-pharmacological approach to care, such as take a walk or exercise (loath to use restraints)

and managing behaviors are a challenge outside of ACE – areas that patients and family need help with. Example: in jail with police outside his door because he hit someone. How do you address cognitive impairment during discharge? ¾ of patients are cognitively impaired, but they discovered, not the PCP. Recommend testing, develop a care plan that's aimed at addressing/preventing delirium and important because highly unlikely that the impairment didn't cause the placement to begin with. What are possible help – adult day health centers, more IHSS, support family, etc. Or saying that the need won't be met by current community resources, in which case they may recommend placement in a SNF or ALF.
How can we cause our health care systems to identify this earlier? More education for PCPs, families, how do you get mandated reporters to identify these folks? Banks are doing a good job (it seems).
How would you replicate the ACE model post-discharge? (personalized care coordination) keep program going in out-patient such as housing (can build into facilities more than 10 people in separate sites in the mission – that's very people intensive); keep the mobility going, social interaction and mental activities, that meds don't get restarted – tough to look at, no one wants to tackle that. Folks living independently or scattered housing makes the effort significantly more challenging.

ACE unit will open Summer 2018 at CPMC in the new hospital, as part of the community benefits agreement.

Ruth Gay will send out the "Hope Act", will be adopted by MediCal and Medicare

UPDATE: Workgroup Moving Forward (30min)

- LTCCC outline (fill out)
- How to move forward on the urgent care work
- LTCCC steering committee representative

UPDATE: ADI-SS Grant (10min)

Melissa McGee discussed the grant that is a partnership with Alzheimer's Association, Family Caregiver Alliance and UCSF to….
Arc's "Savvy Caregiver Program" (with translations), partnering with folks living alone in the RAD Housing, through the AA's "Live Alone Project"

UPDATE: LGBT Grant

Edie Yau spoke, partnering with OpenHouse and Family Caregiver Alliance, rolling out training to partners and families now. Focused on cultural humility in understanding dementia among LGBTQ seniors, beginning in January 2017 (get flyer from Edie) and will be a 2 year project, in Spanish and Chinese with CEU's.

(include report that Benson handed out) California has a mandatory reporting by Doctor if patient has dementia, reports to DMV. Being diagnosed does not mean incompetent, often times folks can live independently and are highly functional for a long time, so having assistance with decision making would be really beneficial. (possible agenda topic?)
Elder Court, similar to juvenile justice, when someone hits or causes damage while delirious or have cognitive impairment.

Next meeting – UCSF's (Natasha) behavioral clinic?