

**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.*

ADDENDUM

~ AUGUST 2014 ~

By
Dementia Care Excellence Oversight Committee

For
Department of Aging and Adult Services

DRAFT AS OF: June 27, 2014

Original Objectives:

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

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

OBJECTIVE 3: Develop an informed and effective workforce for people with dementia.

OBJECTIVE 4: Expand capacity to deliver high-quality early diagnosis and intervention for all.

OBJECTIVE 5: Ensure availability of high-quality, culturally responsive information for those diagnosed with dementia and for their caregivers.

OBJECTIVE 6: Create expanded and easy access to care, support and advice following diagnosis.

OBJECTIVE 7: Implement a range of effective caregiver support strategies to better address the multiple needs of informal caregivers.

OBJECTIVE 8: Improve the quality of hospital and nursing home care for people with dementia.

OBJECTIVE 9: Expand and improve the quality of community-based care for people with dementia.

OBJECTIVE 10: Improve the quality of services in residential care homes and expand the range of models of residential care for people with dementia.

OBJECTIVE 11: Improve access to end of life care for people with dementia.

OBJECTIVE 12: Advocate for effective state and national support for the implementation of this *Strategy*.

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

OBJECTIVE 14: Facilitate and support an Oversight Committee responsible for implementing this *Strategy*, and advocating for improvement of prevention, education and services related to dementia.

Background: The original *Strategy for Excellence in Dementia Care* was published in December 2009. Much has been accomplished since that time. However, the Dementia Care Excellence Oversight Committee decided earlier in 2014, after working on implementation activities for five years, that it is time to reassess the direction and focus of all such activities.

Following a series of three Community Conversations in 2013 and 2014, sponsored by the Alzheimer's Association of Northern California and Northern Nevada, the Department of Aging and Adult Services, and the Eli Lilly Corporation: (1) a new goal, (2) new strategies, and (3) a series of recommendations for new categories of work have been established, all of which will guide the direction and focus of all implementation activities from this point forward.

NEW GOAL:

Improve outcomes for people with dementia through the identification of gaps and ways to address them by improving Awareness, Detection, and Early Intervention.

NEW STRATEGIES:

- Create a new set of categories of work to be undertaken.
 - Reconstitute or dissolve existing workgroups:
 - a. Education and Training – reconstitute and assess who is able to work on these issues.
 - b. Services and Settings – dissolve
 - c. Medical Resources – reconstitute and assess who is able to work on these issues.
 - d. Waivers and Advocacy – dissolve
 - Configure additional new workgroups based on people’s expressed interest.
 - Integrate some workgroup members into new categories of work.
 - Expand the Dementia Care Excellence Oversight Committee.
 - Develop a new structure for implementation activities.
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RECOMMENDATIONS FOR NEW CATEGORIES OF WORK:

RECOMMENDATION 1. Develop a public awareness campaign that is culturally and linguistically appropriate, targeting awareness (of the annual wellness visit among other things), detection, and early intervention.

- This will address the need for translated materials, tools, dementia competency for diverse communities.
- The revamping of the Aging and Disability Resource Centers offers potential for providing better information about dementia and dementia care services available locally.
- All information and referral providers would be a good target of education – they usually refer people with questions about dementia to the Alzheimer’s Association, but that can delay people finding the services they need. I&R providers should be asking more questions to direct them to local services, such as those offered by LHH, FSA & FCA.
- At DAAS Integrated Intake, they get people who aren't caregivers calling the information line because of random red flags they see in the neighborhood, like an elder wandering – how can they partner to get resources to people earlier?
- Information & Referral should include products that are available, such as safe return bracelets; these can be a lifesaver and most people don’t know about them.
- Need to educate younger people, especially in immigrant communities, because a lot of family caregivers aren’t able to speak English or even read, but their kids can.
- CPMC is working w/younger people in the community, and has an agreement with UCSF that their pre-med students get class credit for volunteering at CPMC. This could be implemented in other scenarios. Information is available for replication.

RECOMMENDATION 2. Create a series of proposals for an effective response to people with dementia living alone without family or any community support.

- This will address the need of people living alone with dementia who are no longer safe in their current settings.
- How can we create the services and assistance so people who live alone don't have to be afraid to ask for help?
- DAAS funds family caregiver programs for the LGBT community, which has a lot of people who live alone, there's probably lessons in that.

RECOMMENDATION 3. Develop transportation options for people living with dementia.

- **Door to Door services.** Plans have been discussed to provide paid or volunteer senior outreach staff to allow people with dementia to have door-to-door support – from home to CBAS sites and back again.
- **Transportation Workgroup.** Several agencies are identifying clients who might need escorts to be safer on paratransit to programs like ADHC; idea is to have senior companions on paratransit in the afternoons, when paratransit has had issues with letting people off & thinking they're going home but then they don't show up at home. Want to leverage the programs we already have such as FSA's senior companion program. Looking to get funding for a pilot, will be meeting the first week of June and aim to get a pilot project up and running before the end of 2014.
- **Training.** Training is needed for paratransit and regular bus drivers.

RECOMMENDATION 4. Advocate for managed care health plans (including the San Francisco Health Plan, Anthem Blue Cross, and On Lok Lifeways), and health care providers, to incorporate an annual screening for cognitive impairment.

RECOMMENDATION 5. Make care management a routine response to a diagnosis of dementia, just as routine as it is for diabetes.

RECOMMENDATION 6. Advocate for a physician inside managed care health plans to be the bridge to the system of dementia care, services and resources available in San Francisco.

RECOMMENDATION 7. Employ the use of cognitive tools, some of which are identified at Actionalz.org.

- **Providers need an algorithm:** Diabetes management is very successful in part because there is a clear algorithm (set of instructions) of what to do after a diagnosis, that tells providers exactly what medications and referrals should be made. We could expand the algorithm developed by Minnesota to include local services and resources. We also have the LTR computer program to help us do chronic disease management: if you click on diabetes, it tells you how to treat it. DPH could implement a similar algorithm for dementia.

Physicians & other providers use algorithms developed to direct treatment for diabetes and other chronic conditions. Medical providers and family members should know where to find an algorithm for dementia from awareness to diagnosis, to services, to information and referral for services, to tell them what tests and resources are available.

- **Increased awareness and assessment.** DAAS could play a role here. Dementia assessment tools and algorithms could be incorporated into the case management model. Also, if staff in the DAAS funded nutrition programs could be trained in dementia, we would be further along in this process for increased awareness and assessment.
- **Depression screen.** IOA has a “gating screen” for depression: a quick 3-question screen that can trigger more intensive investigation and uncover what resources are needed. Could we create a gating screen for dementia that I&R could use to trigger resource referrals? Such a screen could be used in managed care. As the MCOs do their new patient assessment, is there a screen that could trigger a referral back to a doc for a cognitive assessment?
- **Cognitive screening should be mandatory:** This year, the California Senior Legislature recommended introducing a bill to mandate that doctors would have to offer a cognitive screen as part of the Medicare Annual Wellness exam. This bill did not proceed. Doctors should just do the cognitive screen as a matter of course, just like they weigh all patients who come in. Wendy Zachary said, in her experience, if she offers the screen, people often get offended, and it’s usually the people with cognitive impairment who get offended.

RECOMMENDATION 8. Develop tools for diverse racial, ethnic and cultural communities.

- Explore tools that would work effectively in Asian, Latino, African American, and LGBT communities.
- **LGBT Pilot.** Follow the effort to create and LGBT Seniors and Dementia Awareness Pilot Project in three counties (San Francisco, San Mateo, Santa Clara), now being explored.

RECOMMENDATION 9. Investigate the potential to develop a Geriatric Emergency Room at San Francisco General Hospital.

- Explore ways to include people with dementia in the target population for this unit.

RECOMMENDATION 10. Investigate the potential to develop a mobile crisis unit targeting people with dementia.

- **Other mobile crisis units and teams.** DPH has specialized mobile teams, such as mobile crisis. This could be related to HIV/AIDS, or Homeless Outreach Team. A dementia crisis unit/ team could follow in this model. This could move people to a lower level of care.
- **Palliative Care Task Force.** Follow the plans being developed by the Palliative Care Task Force, especially as it determines ways that might better serve people with dementia in their homes and communities.

RECOMMENDATION 11. Explore the potential to create transitional care resources, offering short-term intervention, medical stabilization, and respite care, or a temporary setting for people with dementia? Some people with dementia can be transitioned back into the home, and others cannot. What are the pathways?

Laguna Honda Hospital (LHH) gets people with dementia long past the early stages. Long term care includes services provided in the institutional setting as well home and community support. Where does LHH fit within this continuum?

- Is there a way to partner with LHH? Could the LHH SNF be a place for evaluations? This could be better than the hospital or the ER. This could be a transitional unit from the hospital and the home.
- Either way (mobile unit or LHH transitional care unit), someone could look at the home environment to see what could be done to make it safer and address behavioral challenges. Medicare makes it easier to admit a patient into a hospital than into a SNF, so this may require policy change.
- Could LHH be a place for short-term intervention, respite, medication stabilization?
- Could LHH be a place for crisis intervention versus hospitalization?
- A 5150 holds people until Alzheimer's/dementia is identified. Then they are excluded. But the Alzheimer's Association found that exclusion is not written into the law and 5150 can be used to hold people with dementia in distress, if the Board of Supervisors passes a resolution approving it. This is not being done anywhere else in California as far as the Alzheimer's Association knows, so this would make a huge difference.
- Could there be a registry for short term emergency attendant care?
- Respite care:
 - LHH offers respite care so families can have a rest and the person with dementia can be cared for at LHH.
 - Family Caregiver Alliance once gave long term respite grants. Funding was cut, and now only short term respite grants are given. Daylong respite retreats are provided now. New resources are learned about and relationships are built. This is caregiver support and education as well as respite.
 - MSSP helps people get respite, both in-home and out of home, so there are models, but if you're not hooked into those programs you won't know they exist, and MSSP funding is limited.
 - Self Help for the Elderly wants to be part of the solution for providing interim help. It has been able to take people whose caregivers got FCA respite grants, but it takes a week for them to get adjusted to a new environment and then it's time to go home.
 - The Alzheimer's Association offers some relevant services that should be included.
 - Medi-Cal and Medicare both cover respite care.

- **RECOMMENDATION 12. Continue to explore how best to address behavioral health issues related to people with dementia.**
 - The DPH Behavioral Health Older Adults unit can make home visits. Family Service Agency (FSA) is part of this system.
 - However, when dementia is the primary diagnosis, FSA cannot serve such people because Medi-Cal won't cover it.
 - DPH Behavioral Health predominantly works with severely mentally ill; the only way to get ahead of the curve is to deliberately shift funding from the severely mentally ill into prevention. Kelly Hiramoto would like us to talk about how we might do that.
 - Could this conversation be taken to the Hospital Council so that the resources can be distributed across the city?

APPENDIX 1. OUTCOMES FROM CURRENT STRATEGIC PLAN

~ *Between 2009 and 2014* ~

- **Dementia Support Network**
 - Partnership of Alzheimer's Association, Kaiser & UCSF, we were looking to improve self-efficacy & knowledge / skills of dementia caregivers, reduced medical utilization, and an increase in utilization of community services by people with dementia and caregivers. Recruited 105 caregiver / patient diads. All diads were connected to a dementia support expert care manager at Kaiser, very high level of satisfaction for caregivers & Kaiser providers who got training, caregivers rated their self-efficacy higher, and use of community services rose.
 - Interestingly, institutionalization increased over time, and we did not see evidence of reduced medical utilization. Project has evolved – Kaiser still has Melissa on staff, still provides support groups & education, and is identifying people with dementia in the electronic medical records. State Department of Aging has gotten funding for training care managers in the Dual Eligibles pilot project to be an element of the future management of care.
- **Education & Training Workgroup**
 - CPMC Brain Health Center opened over a year ago, first of its type as far as we know, clinic led by Dr. Catherine Madison through \$21M donation by an individual, medical care + social work + pharmacy, all in one place. The Alzheimer's Association has a Family Care Specialist onsite, collaboration built into the model so families are truly encircled w/ resources from the moment they're diagnosed until they die, resources are open to the public. We have also identified a group of physicians willing to do free grand rounds on dementia.

- **Medical Resources Workgroup**

- Summarized outcomes to date. Organized a very successful SF Hospital Summit on Best Practices in Dementia Care on 3/28/13, 80 people attended. Shared what works and what does not work in hospital settings. Heard similar things to what has been said here today, hope to do follow-up meetings. Workgroup trying to get a sense of how we want to do those follow-up meetings.
- **ER survey:** The Alzheimer's Association collaborated w/ Kaiser to survey SF Emergency Department directors to get qualitative data based on perception of the ED directors from each hospital. Asked 10 questions, sought to test whether things we were hearing anecdotally are true (e.g., people are showing up in ER because they need better social supports). We wanted to know how people showed up in ERs & where they went after discharge. Survey results found that, according to Directors, up to 60% of people showing up in ERs had some kind of dementia; as many as 70% of those people have no true medical reason for the visit & no other place to go for help; and that, of those w/ dementia arriving at ERs, 40-95% arrive alone (depending on hospital).

- **Services and Settings Workgroup**

- A great amount of implementation work was accomplished by this Workgroup on several different recommendations (see attached summary description). Overall Recommendation: Transition to more structured projects with identified outcomes. Identify interested individuals to take charge of projects or assign to existing groups with the ability to complete.

APPENDIX 2. TOPICS OR THEMES THAT PARTICIPANTS IN THE COMMUNITY CONVERSATIONS EXPRESSED INTEREST IN EXPLORING.

- Funding
- Translated materials
- Transportation resources
- A collaboration for identifying beds
- A collaboration for hospitals to come together on best practices
- A collaboration for social workers
- Could DAAS support some of these collaborations?
- Physician education: CPMC, Kaiser, UCSF – are all educating doctors on types of dementia.
- A major campaign that is everywhere – with message of early diagnosis and resources.
- A mobile crisis unit.
- The Alzheimer's Walk on September 20th – could this be leveraged? Could there be a team for the City?
- Educating the family or caregivers. Toileting, restlessness and other behaviors and strategies. Could be online and easy to access.
- DAAS will be putting together an addendum and all this information will be used

