Goal 1. Care & services are accessible.

1a. Identify and develop recommendations that address discrimination experienced by residents within the emergency room and medical services. Actions may include:

- Educating professionals about bias against pain medications; and
- Ableism and disability training for health care providers and caregivers.

1b. Develop an awareness campaign that focuses on increasing community awareness regarding key services, access or information points.

1c. Train first responders and urgent care clinicians to be dementia capable and implement dementia friendly practices, supporting professionals in being able to identify cognitive impairment and refer clients appropriately.

1d. Identify eligibility requirements with local programs and seek to increase the supports available for middle income seniors and adults with disabilities. Considerations may include:

- Identification of the greatest needs of this population;
- Assessment of the State eligibility requirements as it relates to the middle income population;
- Evaluation of local policies and programs to determine if they can be more flexible about eligibility requirements and wherever possible, consider a sliding scale;
- Consideration of additional local programs that may cover or reduce costs for moderate income residents, such as Free MUNI, Support at Home, and Healthy SF.

Goal 2. A wide range of community & health services are available.

2a. Promote health services to be thoroughly inclusive by incorporating a cultural humility approach to race, ethnicity, sexuality, and disability/ableism. Actions may include:

- Identifying data collection practices, policies, and training among hospitals and clinics;
- Identifying and promoting best practices in hospitals with policies and/or training that directly addresses cultural humility; and
- Developing a pilot or program to test out services, ensuring that they are accessible, culturally appropriate, etc.

2b. Ensure that all essential medical equipment is available to those who need it, such as wheelchairs and other durable equipment.

2c. Prioritize addressing the needs of unique populations, such as:

- Prioritize, develop and support programs that **prevent isolation for caregivers and people with dementia.**
- **Ensure that the needs of younger adults with disabilities are addressed and considered,** such as offering access points that are not housed within senior centers.
- **Ensure that outreach, service and program options are available for people living alone with cognitive impairment.**

Goal 3. There is a robust workforce & volunteer support.

3a. Expand services and support for caregivers, **to ensure that seniors and adults with disabilities are able to live independently for as long as possible.** Actions may include:

- Address the current home care workforce crisis, which includes wages, benefits, and lack of eligible workers; and
- Provide respite support and options for caregivers.
- Strengthen the training and capacity of social service providers to recognize, engage, and provide family caregivers referrals to services within the community.[1]
- Implement a range of effective caregiver support strategies to better address the multiple needs of informal caregivers.

3b. Develop meaningful partnerships with local universities and volunteer-based organizations to recruit volunteers and interns, including:

- Streamlining the volunteer or internship process;
- Making efforts to work across departments; and
- Engaging local nonprofit partners.

3c. Develop education and training for staff to better identify early stages of dementia (cognitive impairment) and ensure that clients are referred and connected to relevant medical and social services.

[1] Committee on Family Caregiving for Older Adults et al., *Families Caring for an Aging America*.

Goal 4. People are supported where they live.

4a. Ensuring there are community supports available for hospitalized persons transitioning home.

4b. Develop a community services master plan that complements the Health Care Services Master Plan, and serves to connect residents with services appropriate for their need and level of independence. Actions may include:

- Facilitating collaboration & opportunities to link the Health Care Services Master Plan and community based services.

4c. Look for places where technology and social services can collaborate more efficiently, allowing people to live independently. Actions may include:

- Training and education for people to access and learn to use technology;
- Ensure technology services remain affordable; and
- All efforts should be informed by the community.

Goal 5. Residential facilities for those unable to live at home.

5a. Address the discrimination LGBT seniors and people with dementia face in residential care facilities through trainings, incentives, and education.

5b. Ensure that all seniors and adults with disabilities living in residential care facilities have a surrogate decision maker. Actions may include:

- Assessing and proposing specific support for people with cognitive impairment;
- Ensuring that caregivers and family members that are supporting the patient and assisting with the care plan are included; and
- Assessing and supporting services for people that need minor home modifications or temporary in-home support in order to remain independent.

Goal 6. Health & social services collaborate.

6a. Promote and support choice for end of life care. Actions may include:

- Developing a resource directory, educational opportunities, and outreach strategies that focus on palliative care services;
- Raise the awareness for the need of an Advanced Care Directive & end of life discussions through education, outreach and events;

6b. Support community based ("holistic") case management programs navigating a range of services, programs, and connections. Support may include coordinating:

- Facilitating paid caregivers;
- Identifying and/or coordinating enrichment services;
- Nurses, doctors, and medical appointments;
- Health & wellness services;
- Community based programs; and
- Transportation services.

Goal 7. Ensure efficient use of public resources, through active collaboration.

7a. Ensure that community efforts, City agencies, and non-profit organizations are collaborating when developing plans. Actions may include:

- The Age & Disability Friendly effort could support the work of the Health Care Services Master Plan planning process.

7b. Combine/repurpose seniors centers and community centers, which may include:

- Assessing overlap of services;
- Developing and implementing intergenerational programing similar to community center models;
- Inclusion of wellness and social programs for younger adults with disabilities; and
- Increased access to food and other services.