San Francisco's
Strategy for Excellence in Dementia Care

Background

In 2007 - the Long Term Care Coordinating Council identified need to focus on people with dementia and their caregivers.

In 2008 - then Mayor Gavin Newsom provided $100,000 to DAAS and appointed an **Alzheimer's/ Dementia Expert Panel**

In 2009 - ***Strategy for Excellence in Dementia Care*** completed.

http://www.sfhsa.org/1051.htm

San Francisco's Strategy - a 10 year vision

<u>2020 Foresight</u>:

10 Year Plan with a Mission to: Improve the quality of care for people with Dementia and their Caregivers

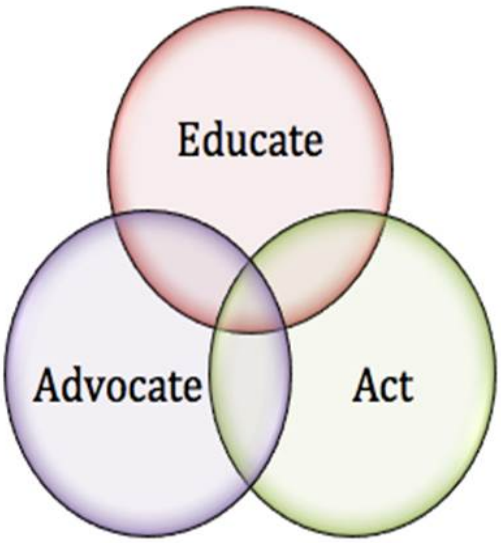
Vision: A better-coordinated, more integrated network of services and supports that enables people with mild cognitive impairment (MCI), Alzheimer's and other dementias, and their loved ones, to flourish.

San Francisco's *Strategy*

35 recommendations for implementation over a 10 year period (2010 to 2020)

Dementia Care Excellence Oversight Committee

- Receiving presentations from four implementation workgroups
- Monitoring progress on implementation activities
- Overseeing initiation of pilot and demonstration projects
- Promoting guidelines and standards of c
- Undertaking advocacy to influence state national legislation
- Evaluating options to dovetail all implementation activities with available state and federal program and funding opportunities:



Implementation Workgroups

- **Four Implementation Workgroups** who reported to the Oversight Committee were formed to explore the details to implement all of the 35 recommendations:

(1) Training, Education & Standards
(2) Medical Resources
(3) Additional Services & Settings
(4) Waivers, Pilot Projects, Demonstration Projects & Advocacy

IMPLEMENTATION

Success would be measured by the following goals:

- Expanded **community education & training**
- Promotion & dissemination of **standards & guidelines** for care
- Improved **service coordination**
- **Education & training** for service providers
- **Shared** client information
- Improved and early **access to resources & services**
- **Team-based** care
- **Delayed need for more intensive services** in later stages

Recognition

- **In March 2010, DAAS received the 2009 Rosalinde & Arthur Gilbert Foundation award for innovation in *Alzheimer's Disease Caregiving*** in the category of policy and advocacy for the development of this *Strategy* and the Alzheimer's/ Dementia Summit held in July 2009.

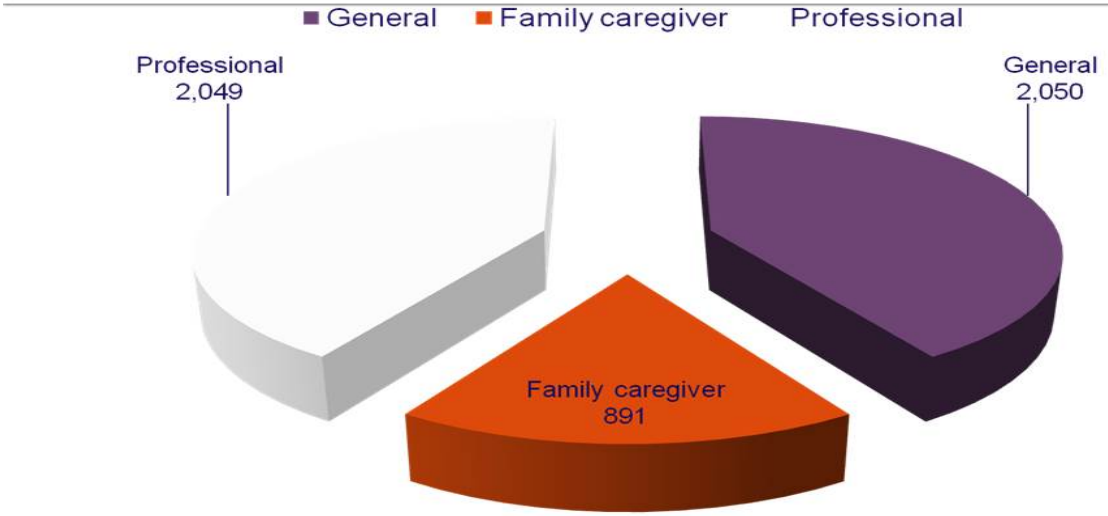
- The $20,000 award has been used to assist in implementation activities related to training and education.

Education and Training

Alzheimer's Association contracted with the Department of Aging and Adult Services to implement education and training recommendations, which focused on:

- Community – Caregivers and general public
- Professionals working in the field of dementia care
- Medical Providers – Physicians, nurses and others
- First Responders
- Airport security and TSA agents

Number of attendees Education & Training FY 2011 & 2012



San Francisco Dementia Support Network

In September 2010, $320,700 was awarded to UCSF along with DAAS, Alzheimer's Association, & Kaiser San Francisco, by U.S. Administration on Aging (AoA)

Goals:

- Improve ability of medical systems to diagnose Alzheimer's and other dementias
- Connect caregivers of high risk individuals for hospitalization to needed educational and support services

Background

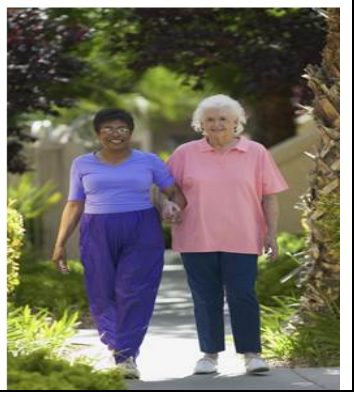
Goals:

- Improve ability of medical systems to diagnose Alzheimer's and other dementias
- Connect caregivers of high risk individuals to needed educational and support services

- Project implementation began November 2010, participant enrollment to be completed by April 2013, with final report by September 2013.
- Only AoA-funded project under this federal initiative to improve dementia care in California

Intervention

- Connected with a Dementia Expert MSW
- Dementia Care Plan
- Referral to Alzheimer's Association of Northern California and Northern Nevada
- Contacted to complete follow-up survey



Outcomes

105 Diads enrolled.

- 40% reduction in hospitalizations
- Identification of people with dementia
- in acute hospital settings, and connection to better care and supportive services helped them to live in the community and not have to resort to a hospital stay.
- Coordination, collaboration and communication were critical;
- The Social Worker was the lynchpin in the education process - providing strong education and empowerment of individuals around dementia care management at home

Waivers, Pilot Projects, Demonstration Projects & Advocacy

- Medicare Wellness Check cognitive assessment now in place.
- Home and Community based waiver – Managed Care Initiative now going forward
- Working on efforts to remove barriers for people with dementia
- Hospice care extended

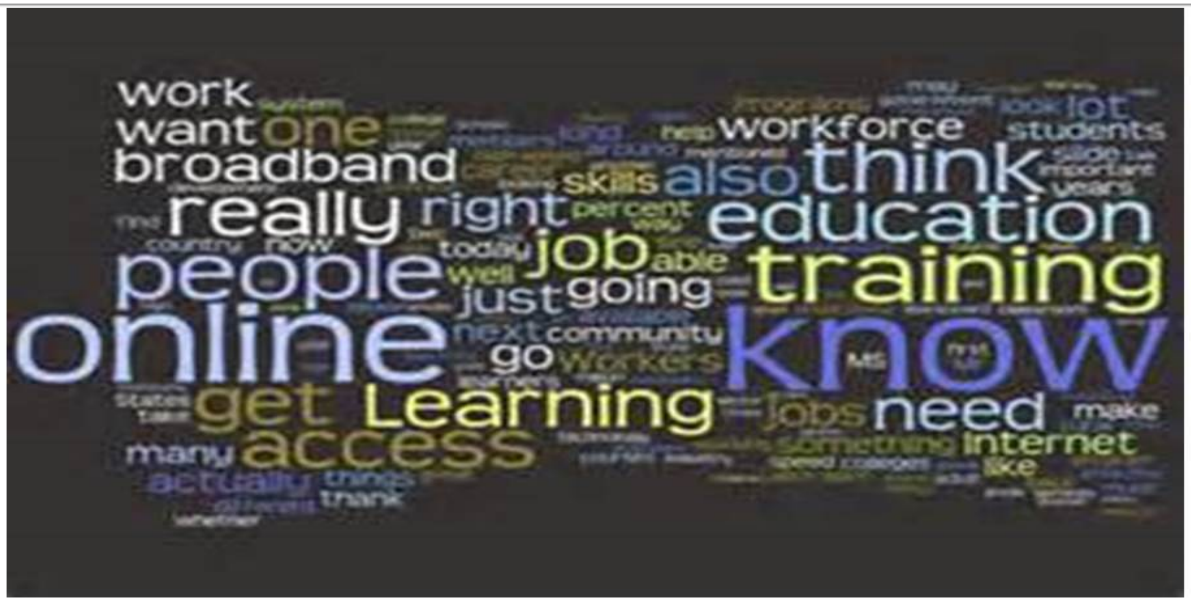
Additional Services and Settings

- Explored transitional and permanent housing as well as range of settings for people with dementia
- Recommendations are underway that will 1) define respite care 2) recommend ways to improve support for people with MCI 3) review best practices for various "housing" settings for people with Dementia

Medical Resources Workgroup

- San Francisco Hospital Summit took place on March 2013 bringing together ER and Hospitalists from around the City to discuss best practices. Follow up conferences are planned
- Recommendations are made to provide a "mobile medical records" for people with dementia to ensure identification goes with these individuals into various settings.

Additional Areas of Success



CPMC – Brain Health Center

- A single donor from San Francisco, inspired by the work of the San Francisco Strategy, funded the development of a Brain Health Center at California Pacific Medical Center in 2011.
- This program has a neurology team along with social workers to focus on cognitive impairments. One specially trained social worker works for the Alzheimer's Association and whose sole focus is to help families of those with Alzheimer's disease and coordinate their service delivery and provide education and support to local services.

Feb 2013 – Emergency Dept Perceptions Survey

1) As high as 60% of the people arriving at the ER's have some form of dementia

2) As many as 70% have no true medical reason for the visit and no other alternative of places to go for help.

3) Of the people with dementia arriving at the ER's, a range of 40-95% arrive alone.

February 2013 – Hospitalization Conference

- The conference was geared to physicians, social workers, and geriatricians.
- The focus was on the need to identify cognitive impairment and dementia, and how to address the needs of patients admitted with delirium.
- One topic was the impact on patients of psychotropic meds like Haldol.
- It was notable the number of people looking for services and resources in the community who did not know what is available.
- There are follow up hospital conferences on this theme in planning.

In process

- There is a new partnership between UCSF, the Alzheimer's Association, Kaiser and CPMC's Brain Health Center called, BACCE, the Bay Area Collaboration for Cognition Education.
- This group of physicians and allied professionals is offering free grand rounds to SF hospitals. As of December 2013, we've approached two institutions who enthusiastically agreed to receive training.
- Transportation work group now underway

Continued keys to success

Implementation requires a unified, proactive, long term response.

Sustained effort from 2010 to 2020.

Shared responsibility.

Visible leadership across city departments

Opportunity:

Community Conversation on Alzheimer's disease

- Sponsored by Eli Lilly has allowed DAAS and AA to convene a series of meetings.
- These focus on key stakeholders and new partners to take into account current gaps and opportunities that were not available when the SF Plan was developed.
- We hope to identify new recommendations and refresh the current Strategic Plan. Our third meeting is scheduled for May 19th.

Opportunity

Investigating Long Term Care Integration (LTCI) in San Francisco

- LTCI will integrate home & community-based long term services and supports with the delivery of primary and acute care services, and institutional long term care services, for older adults and adults with disabilities who are eligible for both Medicare and Medi-Cal.

Investigating Long Term Care Integration (LTCI) in San Francisco - continued

When LTCI is implemented in San Francisco:

- CBAS (Community-Based Adult Services)
- IHSS (In Home Supportive Services)
- MSSP (Multi-Purpose Seniors Services Program)
- Skilled Nursing Facility Services

would become part of a Medi-Cal and Medicare managed care service delivery system.

Challenges

- Dementia competency in all levels of our system of care is critical.
- Funding poses challenges to implement or continue some programs
- Frequent initiation of educational or partnership offerings is essential for success.

Questions?