Chronic Disease and Aging

Health Education Administration Network

at The California Endowment

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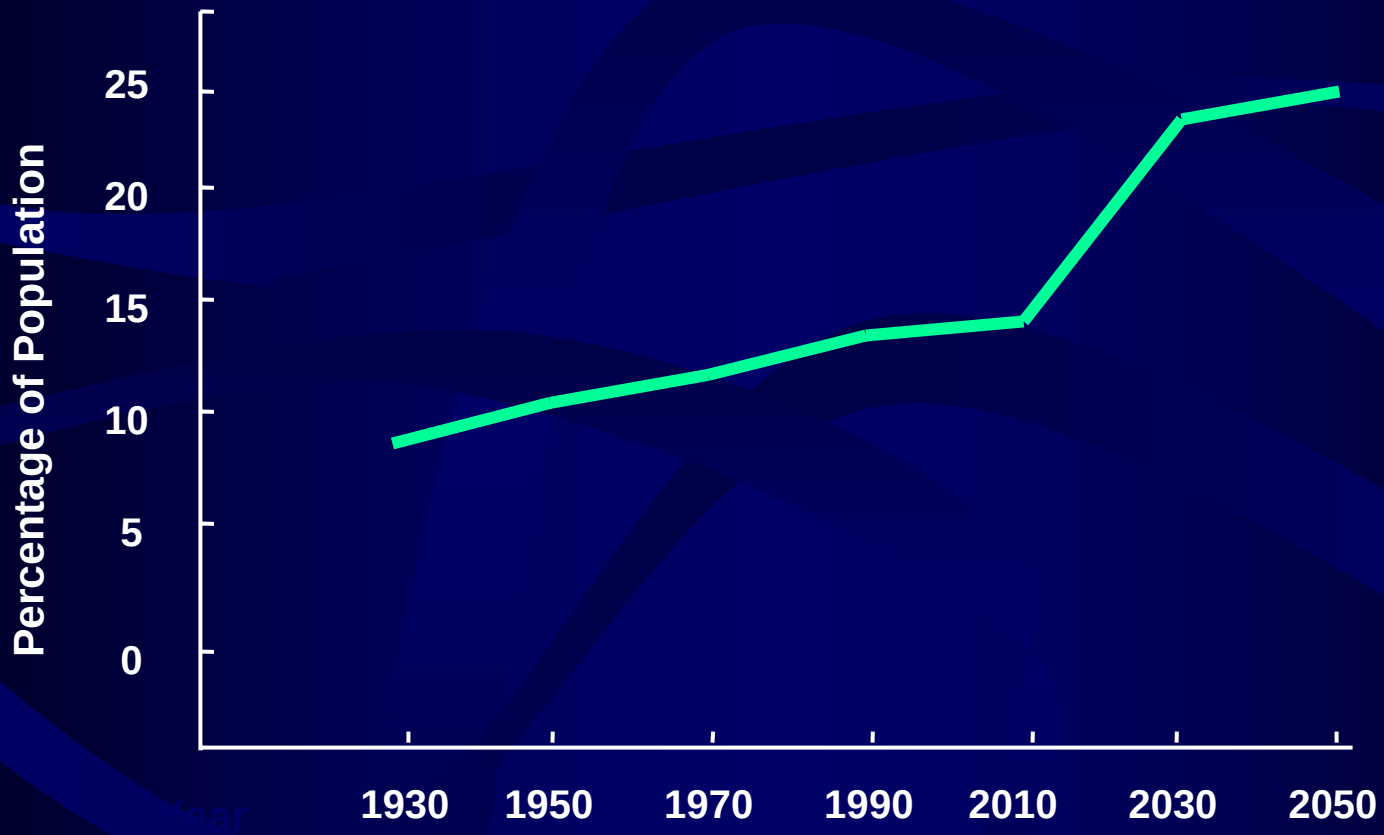
Overview

- The aging population in Los Angeles County
- Chronic disease burden in Los Angeles County
- Public health and aging
- Office of Senior Health

Los Angeles County – Background

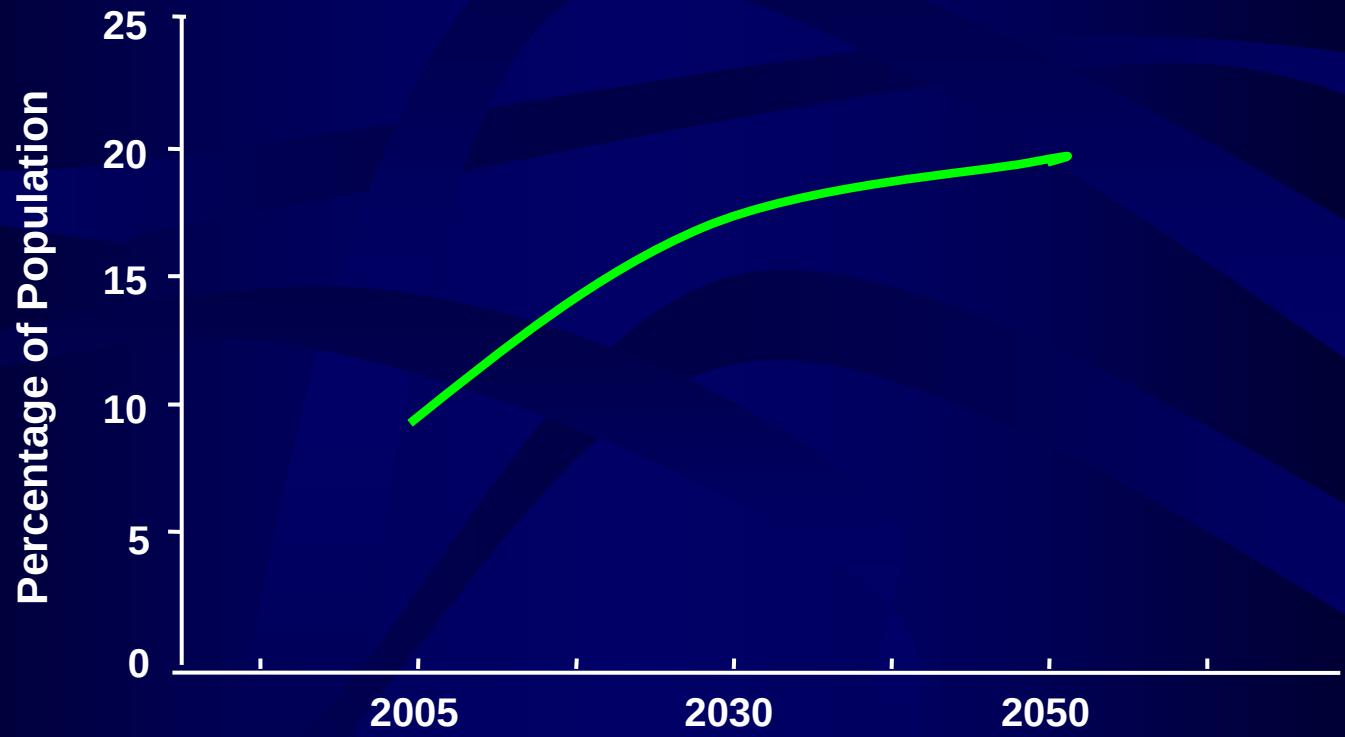
- 4,300 square miles
- 88 incorporated cities, unincorporated areas, and 2 islands
- Approx. 10.2 million residents (more than 42 States)
- 46% Latino, 32% White, 13% Asian/Pacific Islander, 10% African American, 0.3% American Indian
- Over 100 different languages spoken by significant size populations
- 15% living in poverty (14% of families & 24% <18)
- 22% of adults & 8% of children have no health insurance

An Aging Population: Percentage of U.S. Population over Age 65



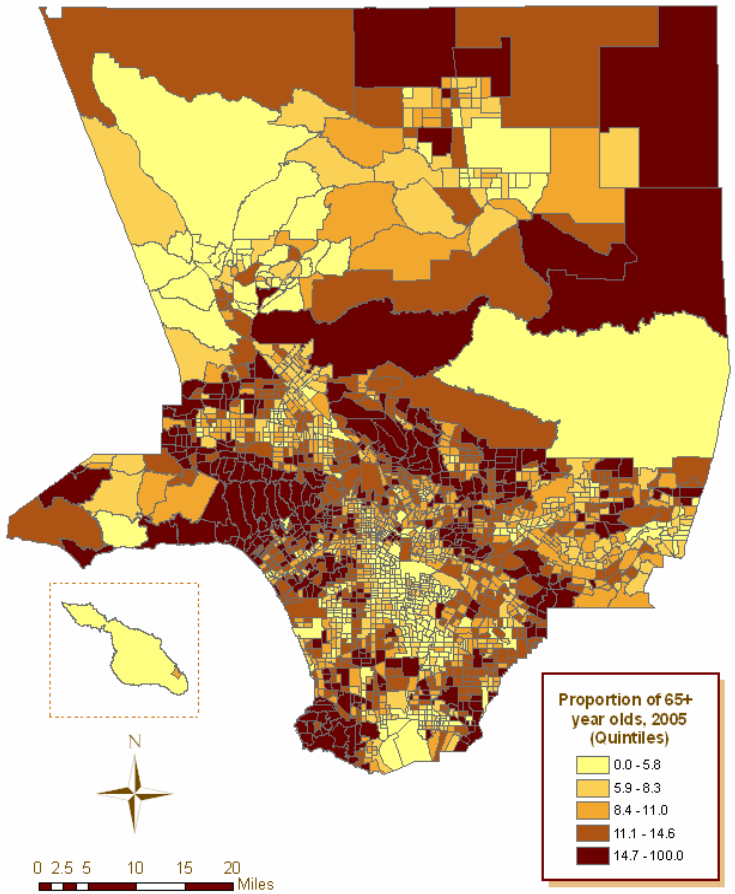
Source: From Baby Boom to Elder Boom: Providing Health Care for an Aging Population

An Aging Population:
Percentage of LA County Population over Age 65



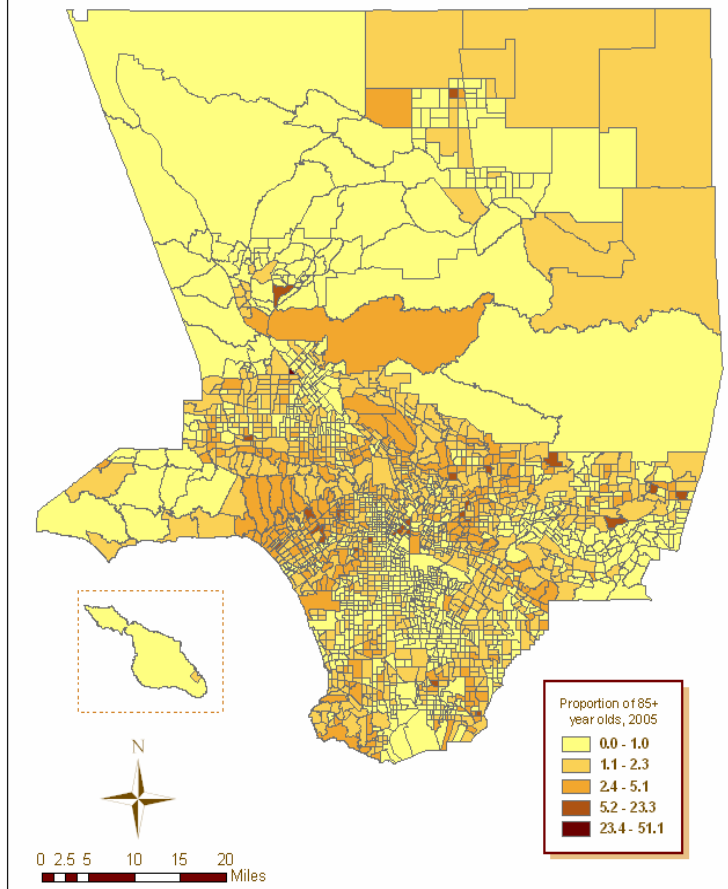
Source: Data from the California Department of Finance

Proportion of Los Angeles County Residents, 65 years and older, by 2000 Census Tract, 2005



Data Source: 2005 Population Projections, Data Collection Unit, Los Angles County, 2006
Evaluation Unit, Division of Chronic Disease and Injury Prevention, LVSmith, 04.18.07

Proportion of Los Angeles County Residents, 85 years and older, by 2000 Census Tract, 2005



Data Source: 2005 Population Projections, Data Collection Unit, Los Angles County, 2006
Evaluation Unit, Division of Chronic Disease and Injury Prevention, LVSmith, 04.18.07

Source: Data from the California Department of Finance & the U.S. Census

Chronic Disease and Aging

- Risk of developing a chronic disease increases with age
- Having concurrent chronic conditions (more than one) also increases with age
- Costs of emerging chronic conditions in this population (e.g., Alzheimer's, vascular dementia, osteoporosis)
- Generally, population is living longer; Baby Boomer generation may be working longer as well leading to potentially older workforce (workplace wellness?)
- But healthcare costs also rising
- Leading causes of death still largely lifestyle related or due to preventable risks (poor diet, physical inactivity, tobacco use, injuries, falls, etc.)
- Housing insecurity, transportation access, and food quality
- Long term care quality and costs (e.g., skilled nursing homes, custodial care, assisted living)

Table 27. Life expectancy at birth, at 65 years of age, and at 75 years of age, by race and sex: United States, selected years 1900–2004

[Data are based on death certificates]

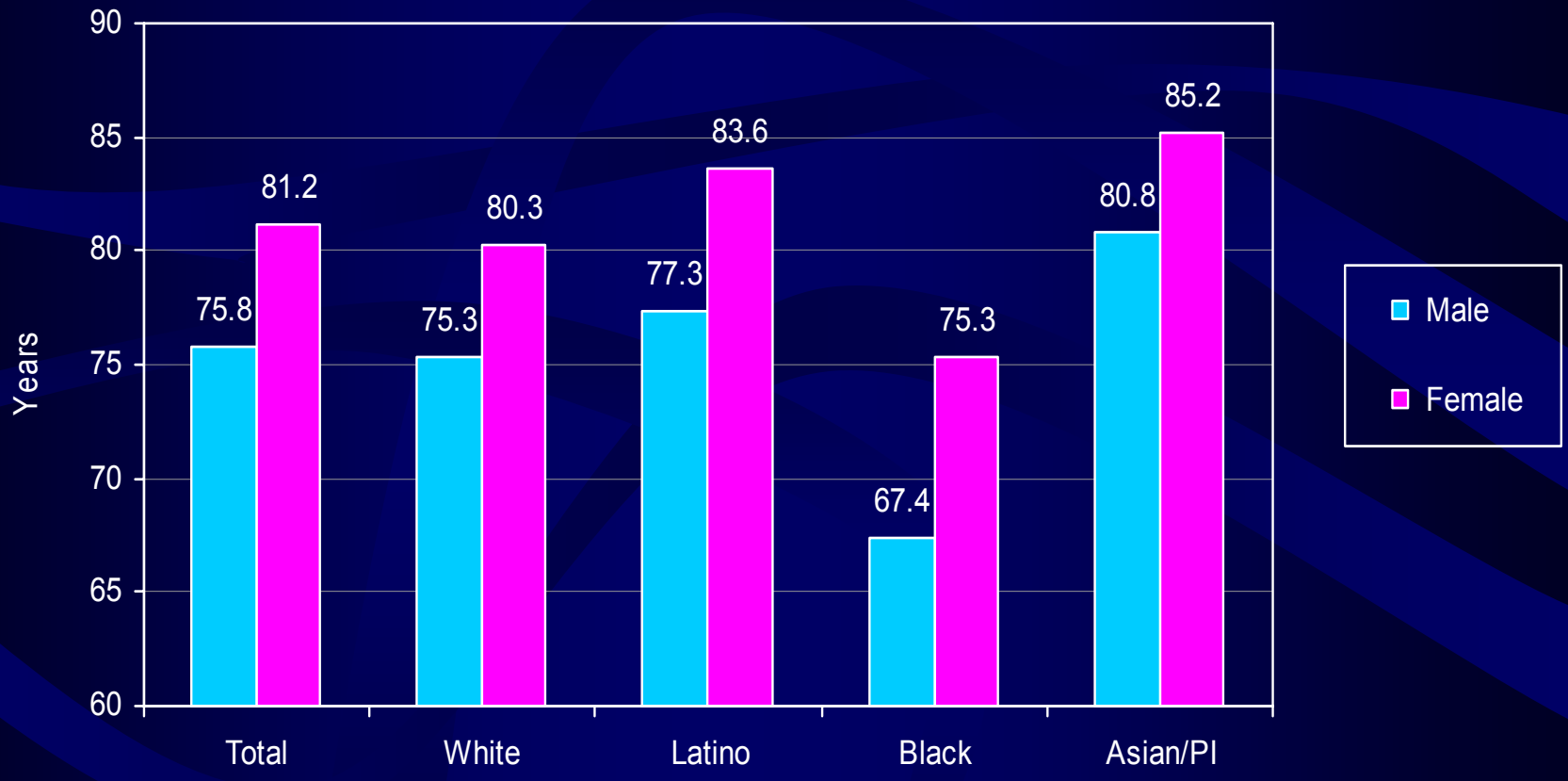
Updated February 2007

Click here for spreadsheet version

Specified age and year	All races			White			Black or African American[1]		
	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female
At birth	Remaining life expectancy in years								
1900[2,3]	47.3	46.3	48.3	47.6	46.6	48.7	33.0	32.5	33.5
1950[3]	68.2	65.6	71.1	69.1	66.5	72.2	60.8	59.1	62.9
1960[3]	69.7	66.6	73.1	70.6	67.4	74.1	63.6	61.1	66.3
1970	70.8	67.1	74.7	71.7	68.0	75.6	64.1	60.0	68.3
1980	73.7	70.0	77.4	74.4	70.7	78.1	68.1	63.8	72.5
1990	75.4	71.8	78.8	76.1	72.7	79.4	69.1	64.5	73.6
1995	75.8	72.5	78.9	76.5	73.4	79.6	69.6	65.2	73.9
1996	76.1	73.1	79.1	76.8	73.9	79.7	70.2	66.1	74.2
1997	76.5	73.6	79.4	77.1	74.3	79.9	71.1	67.2	74.7
1998	76.7	73.8	79.5	77.3	74.5	80.0	71.3	67.6	74.8
1999	76.7	73.9	79.4	77.3	74.6	79.9	71.4	67.8	74.7
2000	77.0	74.3	79.7	77.6	74.9	80.1	71.9	68.3	75.2
2001	77.2	74.4	79.8	77.7	75.0	80.2	72.2	68.6	75.5
2002	77.3	74.5	79.9	77.7	75.1	80.3	72.3	68.8	75.6
2003	77.5	74.8	80.1	78.0	75.3	80.5	72.7	69.0	76.1
2004	77.8	75.2	80.4	78.3	75.7	80.8	73.1	69.5	76.3

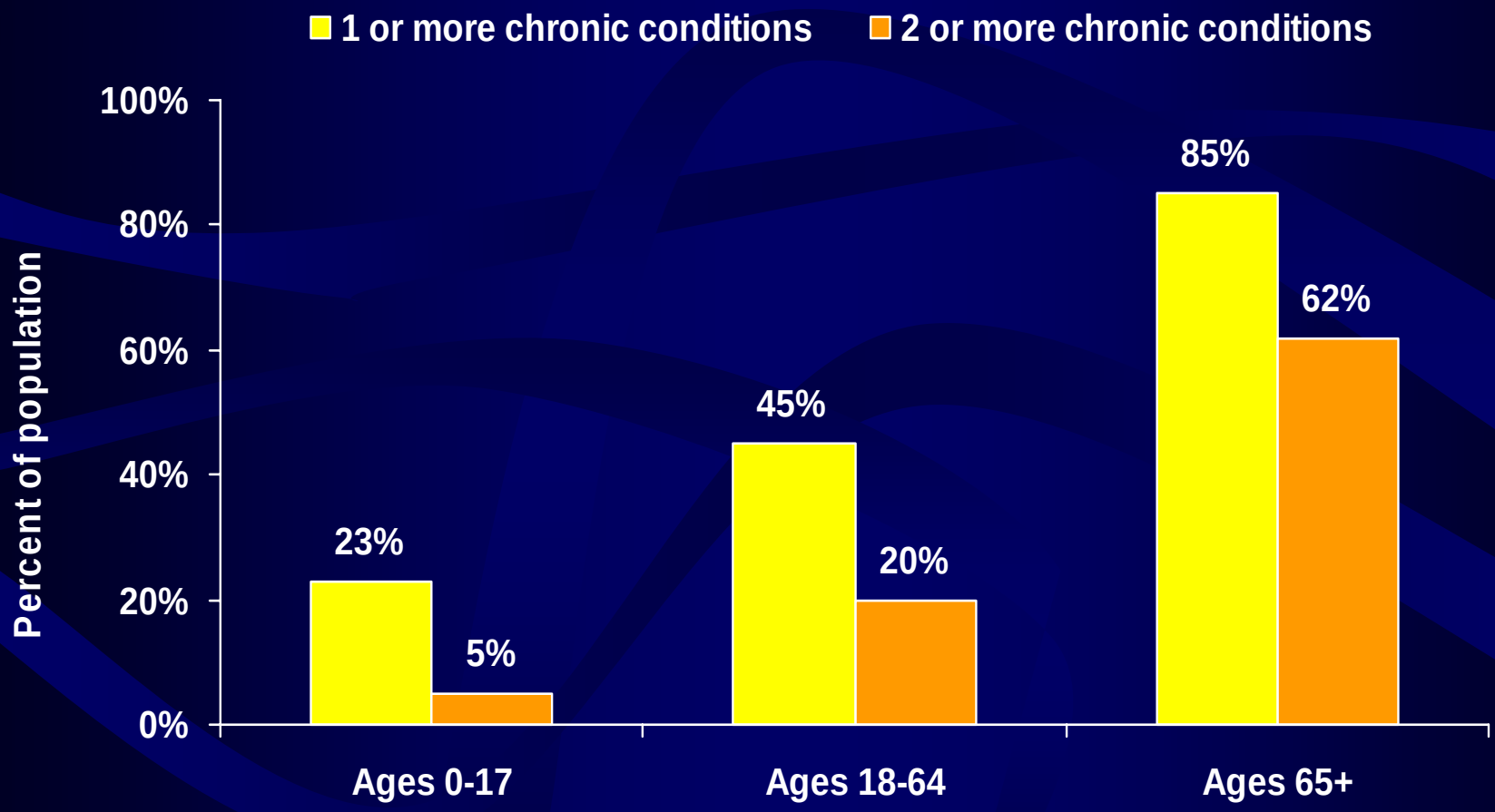
Life Expectancy at Birth by Sex and Race/Ethnicity, Los Angeles County, 2000

Life expectancy in LA County increased by approx 2.6 years from 1991 to 2000



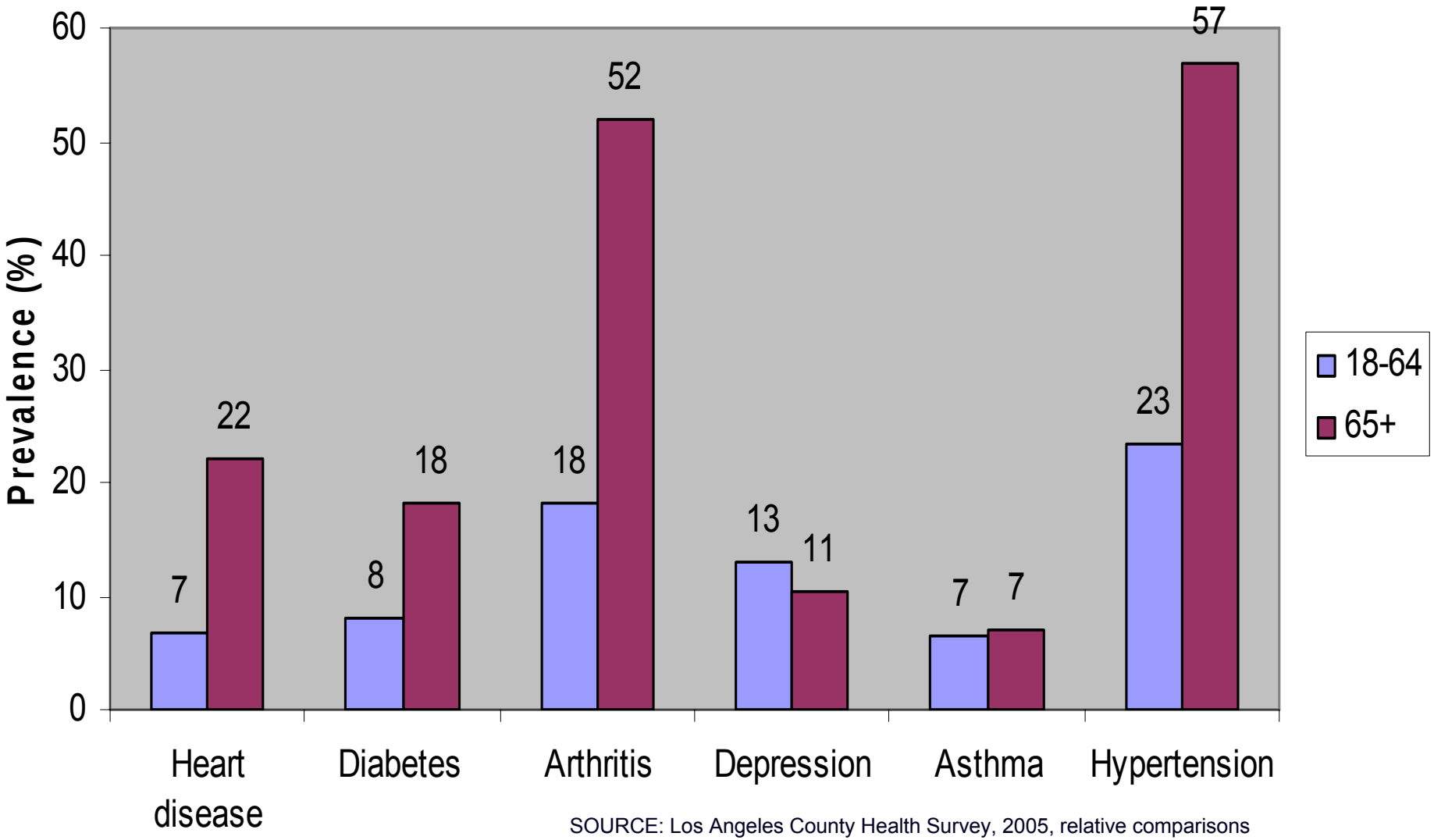
Source: 1991 PEPS and Census 2000 Summary File 1
Los Angeles County Public Health, Office of Health Assessment and Epidemiology

Prevalence of Chronic Conditions in the U.S. by Age Group, 1998



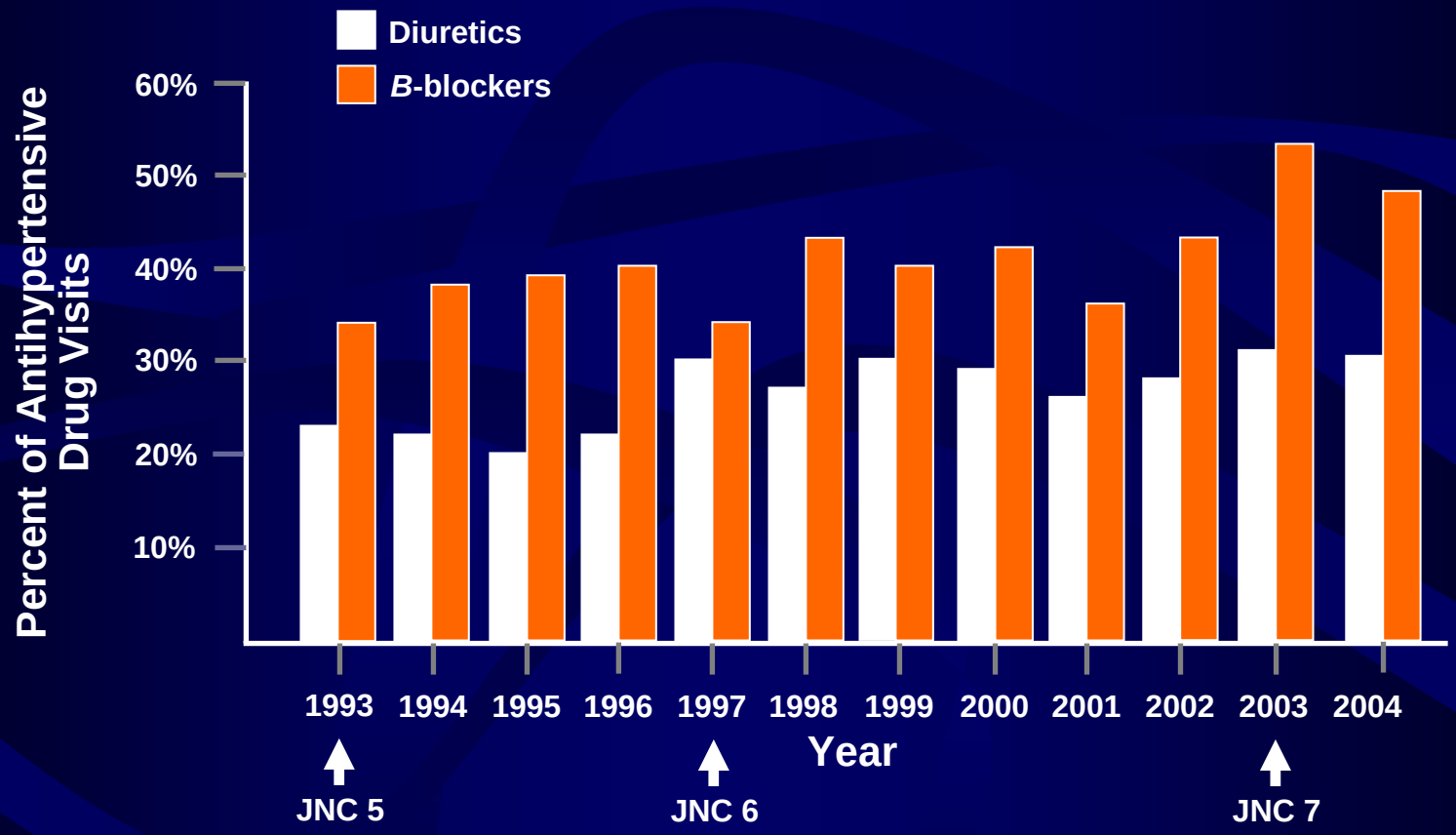
SOURCE: Medical Expenditure Panel Survey, 1998
Anderson, G., Public Health Reports, 2004

Prevalence of Selected Chronic Conditions among Adults in Los Angeles County (2005)



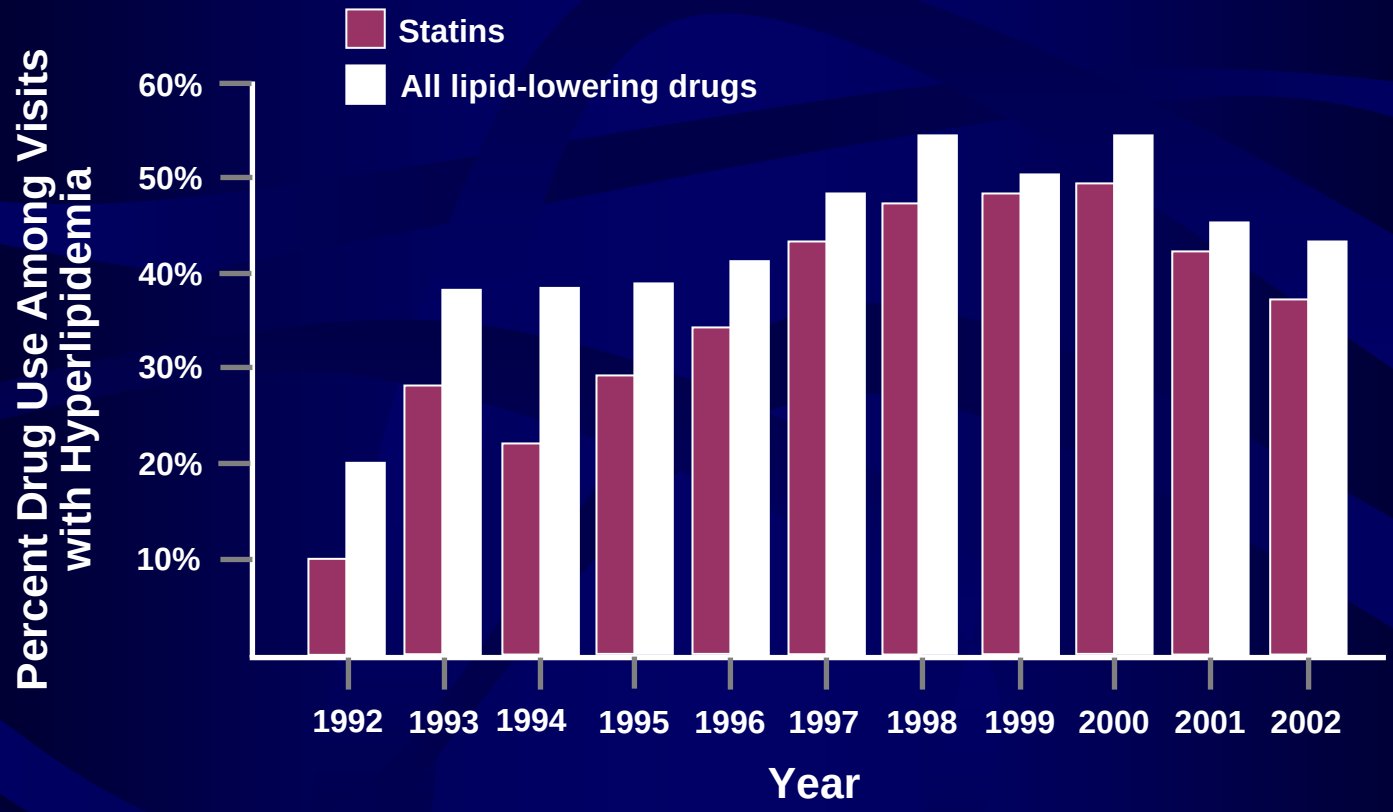
SOURCE: Los Angeles County Health Survey, 2005, relative comparisons

National Trends of Prescribing Diuretics and Beta-Blockers



Source: Ma, Lee, and Stafford (2005)

National Trends in Statin and Other Lipid-Lowering Drug Use



Source: Ma, Sehgal, Ayanian, and Stafford (2005)

Multiple medication use in the aging population

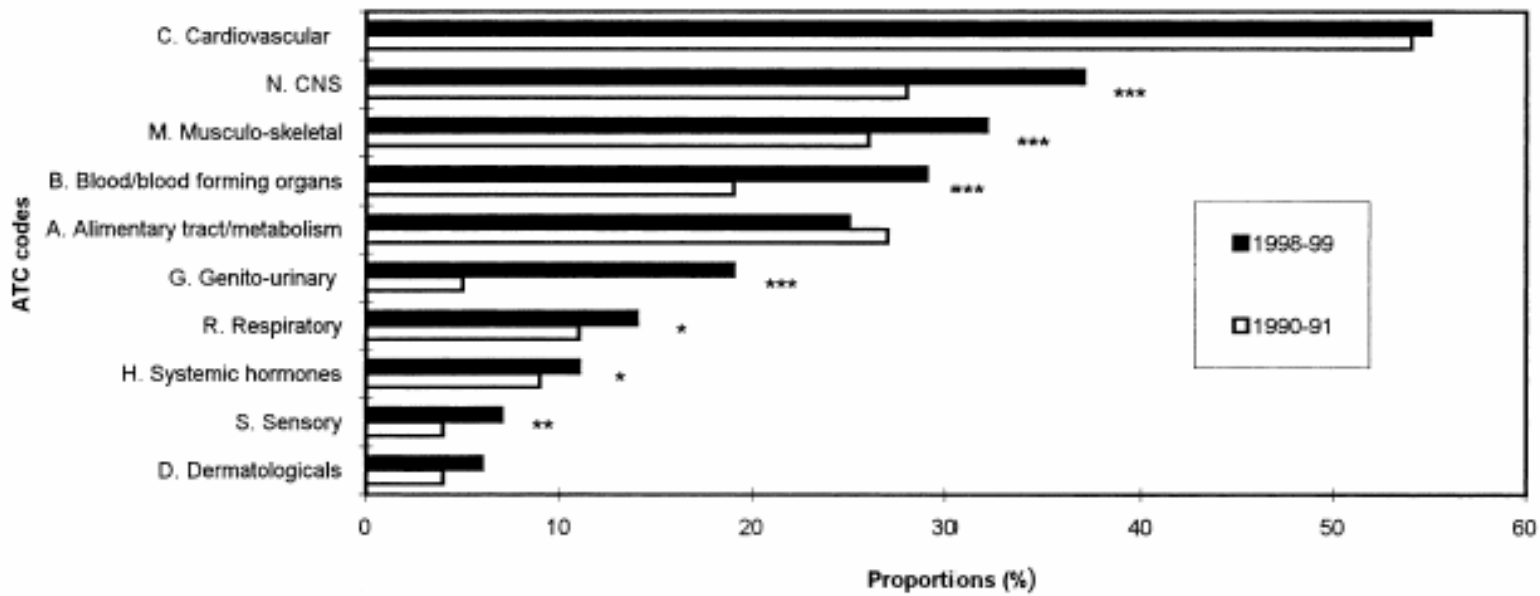


Fig. 3. Proportions (%) of users of prescription drugs among the community-dwelling elderly in Lieto in 1990–91 and 1998–99 by therapeutic classes (ATC codes) of medications. Information about medication use during seven days prior to the interview was collected. p-values are based on Chi-square test. *$p \leq 0.05$; **$p \leq 0.01$; ***$p \leq 0.001$.

Multiple medication use in the aging population

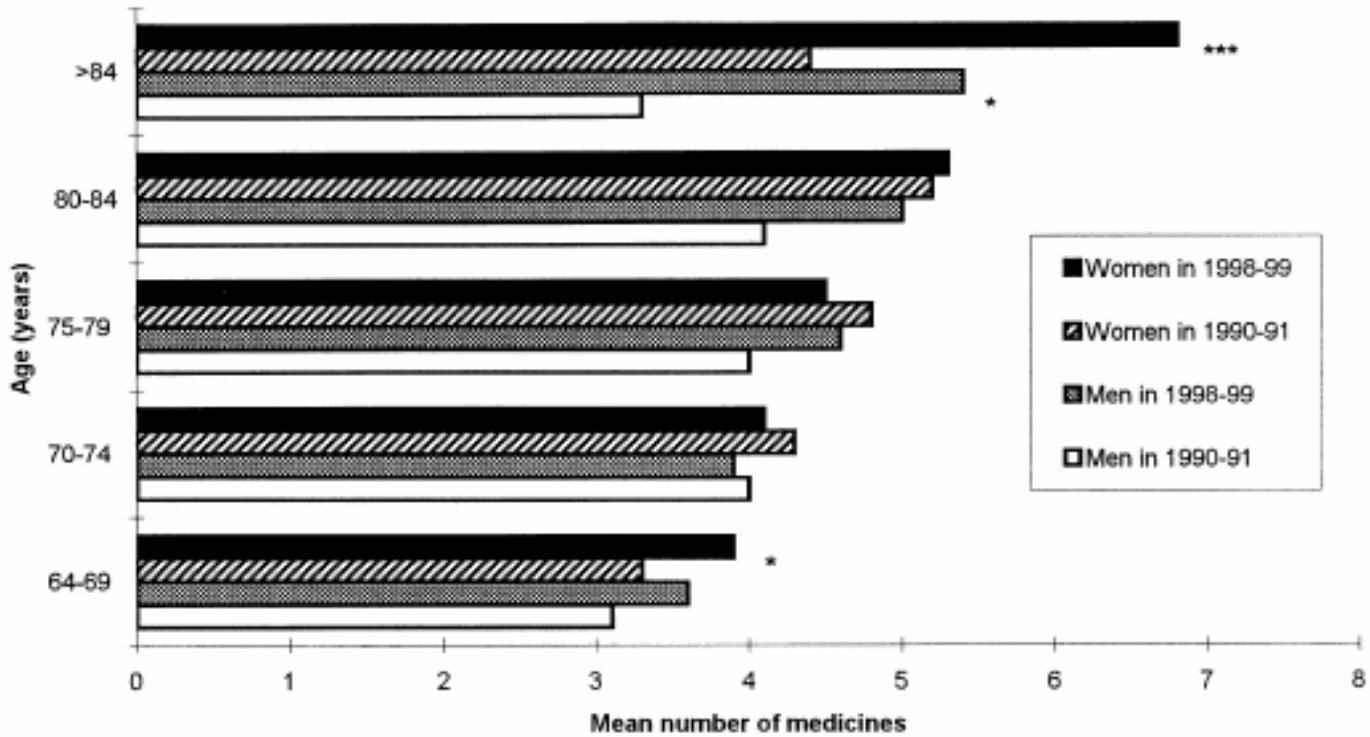


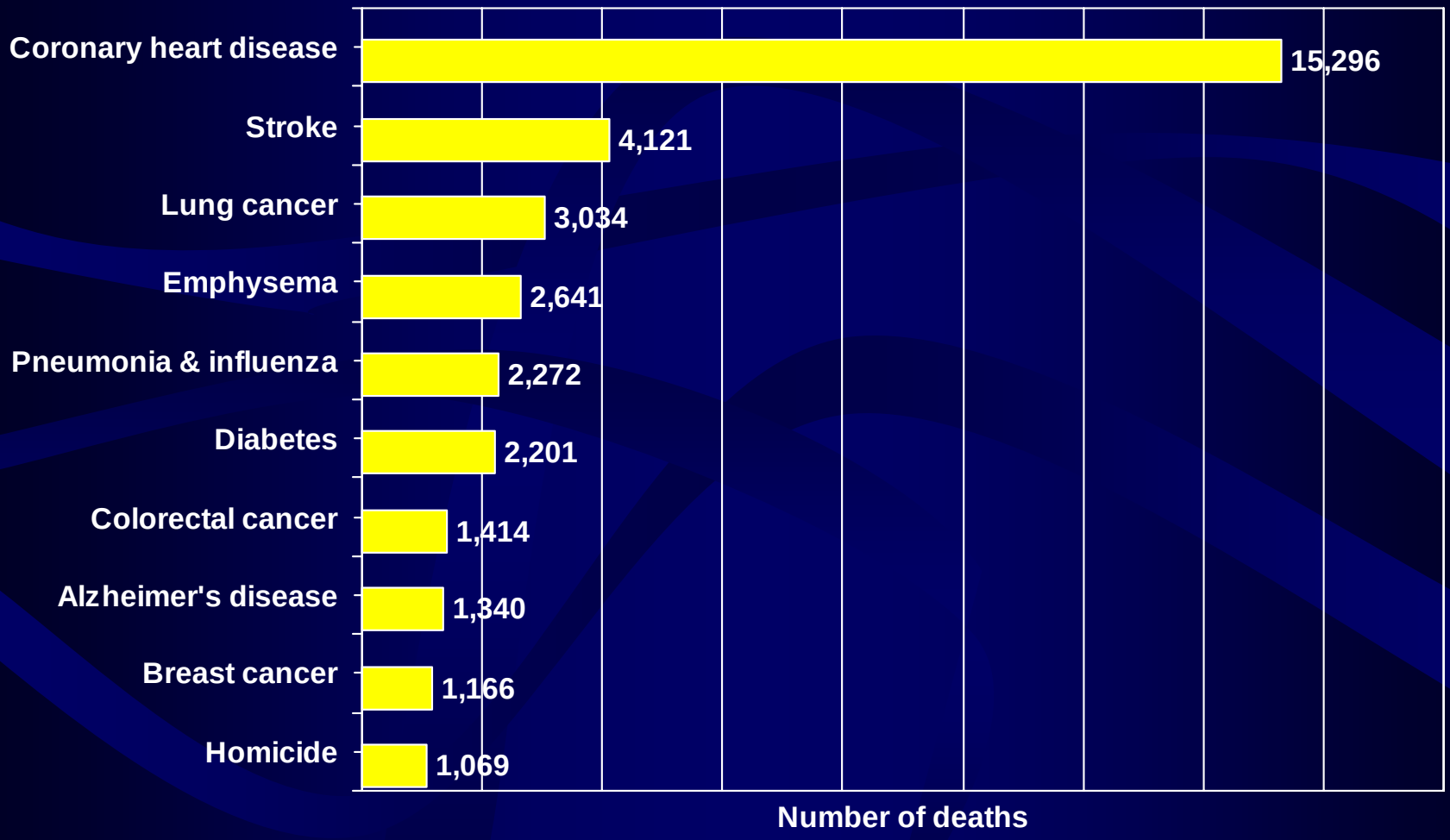
Fig. 2. Mean number of prescribed medicines in use among medication using elderly persons in Lieto in 1990–91 and 1998–99 by sex and age. Information about medication use during seven days prior to the interview was collected. p-values are based on t-test. *$p \leq 0.05$; **$p \leq 0.01$; ***$p \leq 0.001$.

Leading Causes of Death in the U.S. and LA County

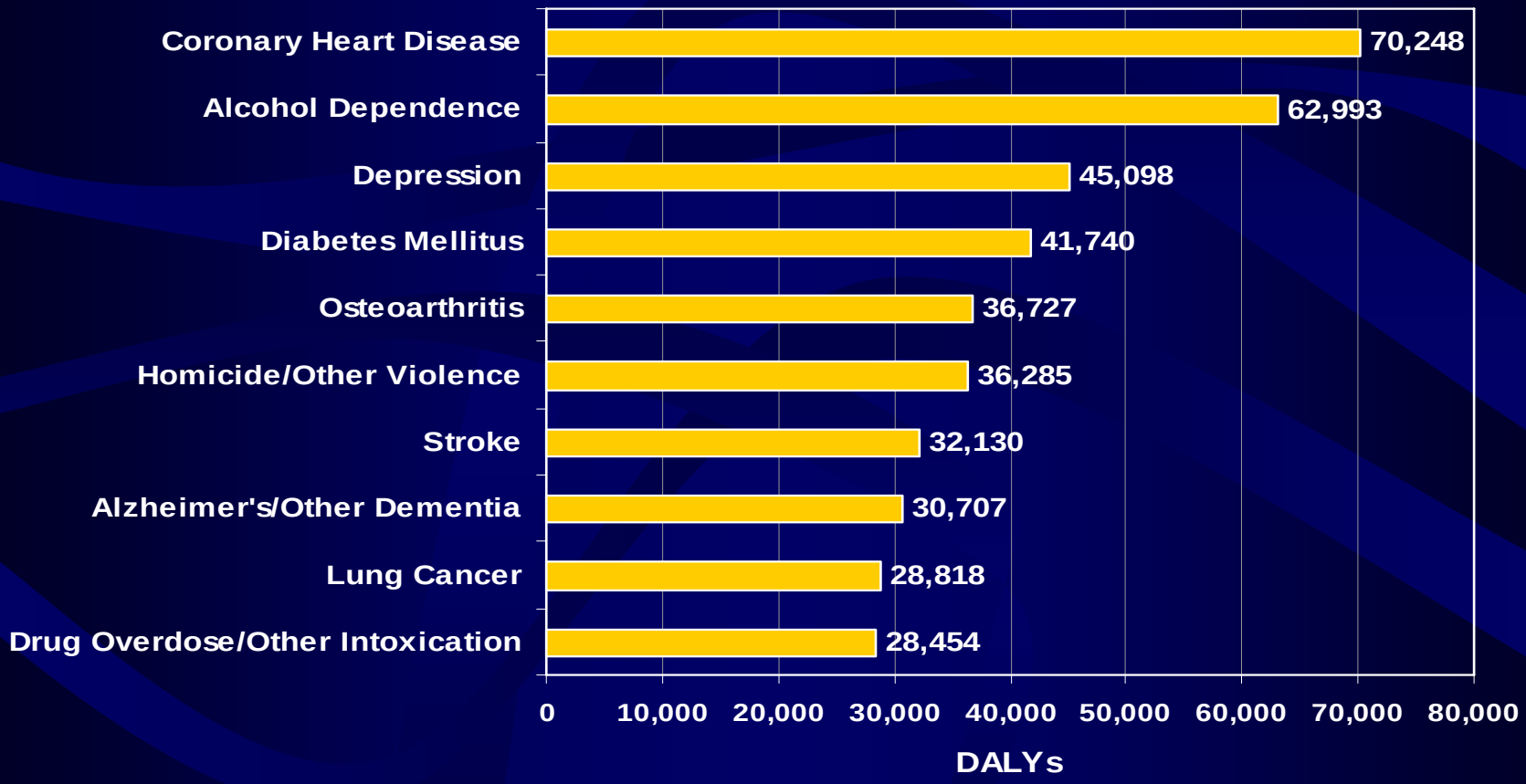
United States	Los Angeles County
Ischemic heart disease	Ischemic heart disease
Malignant cancers	Cerebrovascular disease
Cerebrovascular disease	Lung cancer
COPD/emphysema	COPD/emphysema
Accidents (unintentional)	Lower respiratory infections
Diabetes	Diabetes
Alzheimer's	Colon and rectum cancers
Lower respiratory infections	Alzheimer's
Renal diseases	Breast cancer
Septicemia	Homicide

SOURCE: CDC, LA County Public Health US (2004), LA County (2003)

Leading Causes of Death Based on Crude Mortality, Los Angeles County, 2004



Leading Causes of Disability-Adjusted Life Years (DALYs) in Los Angeles County, 1998



Mortality in Los Angeles County 2004

Figure 7. Comparison of the leading causes of death, by age group

Leading causes of death

Age group Number of deaths Age-specific death rate	#1 cause Number of deaths Age-specific death rate	#2 cause Number of deaths Age-specific death rate	#3 cause Number of deaths Age-specific death rate	#4 cause Number of deaths Age-specific death rate	#5 cause Number of deaths Age-specific death rate
Less than 1 year 757 490 per 100,000	Low birthweight/prematurity 137 89 per 100,000	**Congenital heart defect** **53** **34 per 100,000**	Fetal/neonatal hemorrhage 27 17 per 100,000	Respiratory distress 25 16 per 100,000	Complication of placenta/cord 23 15 per 100,000
1-4 years 140 23 per 100,000	**Birth defect** **29** **5 per 100,000**	Motor vehicle crash 18 --	Drowning 10 --	Pneumonia/influenza 10 --	**Homicide** **9** --
5-14 years 226 14 per 100,000	Motor vehicle crash 35 2 per 100,000	**Homicide** **25** **2 per 100,000**	**Birth defect** **19** --	Brain/CNS cancer 19 --	Leukemia 13 --
15-24 years 1,062 74 per 100,000	**Homicide** **441** **31 per 100,000**	Motor vehicle crash 196 14 per 100,000	Suicide 95 7 per 100,000	Drug overdose 32 2 per 100,000	**Birth defect** **19** --
25-44 years 3,655 116 per 100,000	**Homicide** **442** **14 per 100,000**	Motor vehicle crash 310 10 per 100,000	Drug overdose 265 8 per 100,000	HIV 258 8 per 100,000	Coronary heart disease 246 8 per 100,000
45-64 years 11,434 517 per 100,000	Coronary heart disease 2,355 107 per 100,000	Lung cancer 766 35 per 100,000	Liver disease 565 26 per 100,000	**Diabetes** **510** **23 per 100,000**	Stroke 509 23 per 100,000
65-74 years 9,401 1,782 per 100,000	Coronary heart disease 2,306 437 per 100,000	Lung cancer 896 170 per 100,000	Stroke 559 106 per 100,000	Emphysema/COPD 514 97 per 100,000	**Diabetes** **505** **96 per 100,000**
75+ years 32,470 6,442 per 100,000	Coronary heart disease 10,383 2,060 per 100,000	Stroke 2,948 585 per 100,000	Emphysema/COPD 1,850 367 per 100,000	Pneumonia/influenza 1,850 367 per 100,000	Lung cancer 1,331 264 per 100,000
Los Angeles County Total 59,153 669 per 100,000***	Coronary heart disease 15,296 176 per 100,000	Stroke 4,121 48 per 100,000	Lung cancer 3,034 35 per 100,000	Emphysema/COPD 2,641 31 per 100,000	Pneumonia/influenza 2,272 26 per 100,000

Notes: Los Angeles County Total includes persons of unknown age.

Source: 2004 LA County Mortality Report

Trends in the Leading Causes of Death, e.g., Los Angeles County, 1993-2004

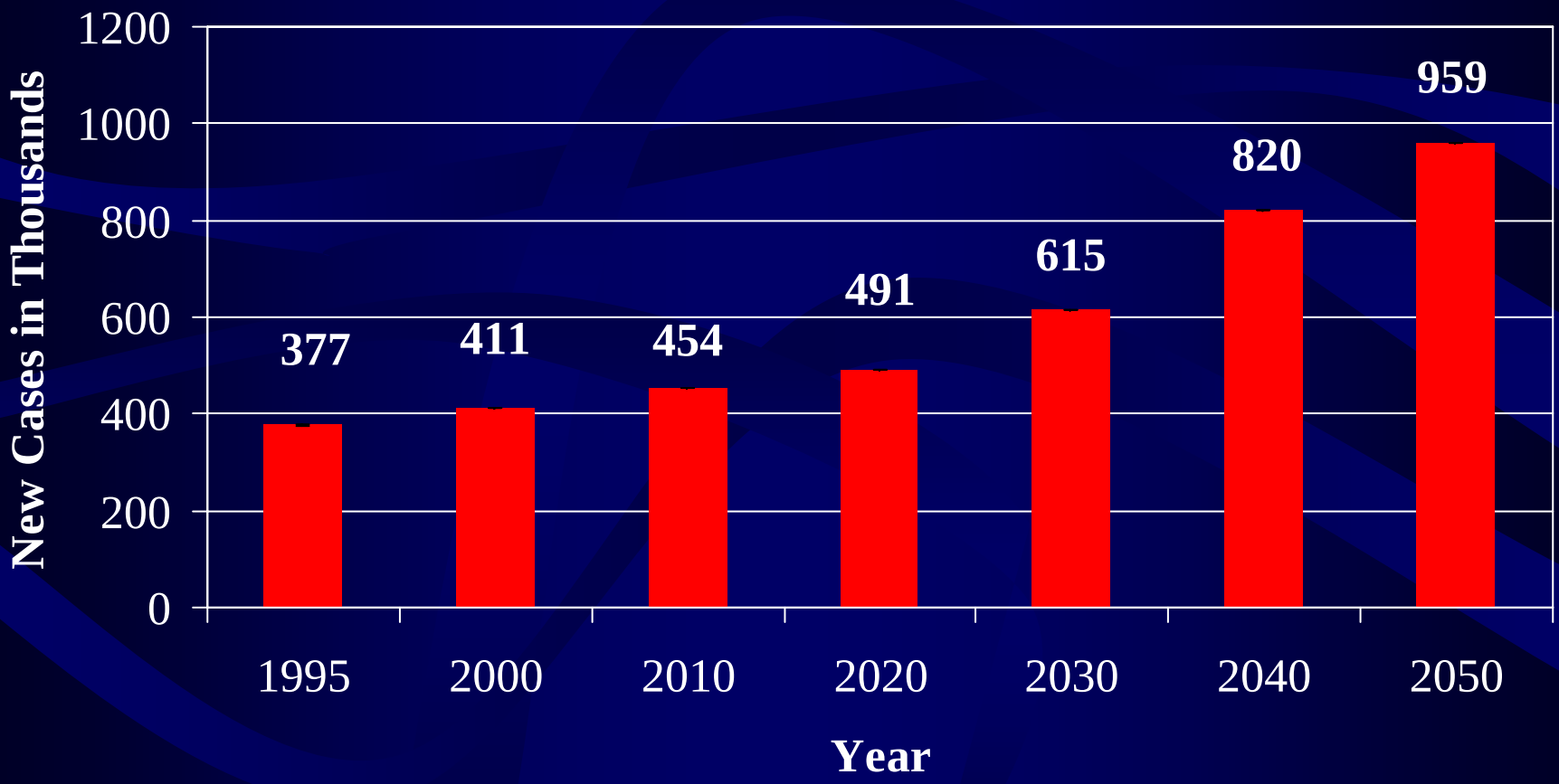
Cause of death	Rate (per 100,000) * 1993	2004	Percent change
Coronary heart disease	283	176	-37.8%
Stroke	63	48	-23.8%
Lung cancer	49	35	-28.6%
Emphysema	34	31	-8.8%
Pneumonia/influenza	45	26	-42.2%
Diabetes	16	25	+56.3%
Colorectal cancer	21	16	-23.8%
Alzheimer's disease	4	16	+300.0%
Breast cancer	30	23	-23.3%
Homicide	20	10	-50.0%
HIV/AIDS	26	5	-80.8%

* age-adjusted to year 2000 U.S. standard population

Movements in Wrong Direction

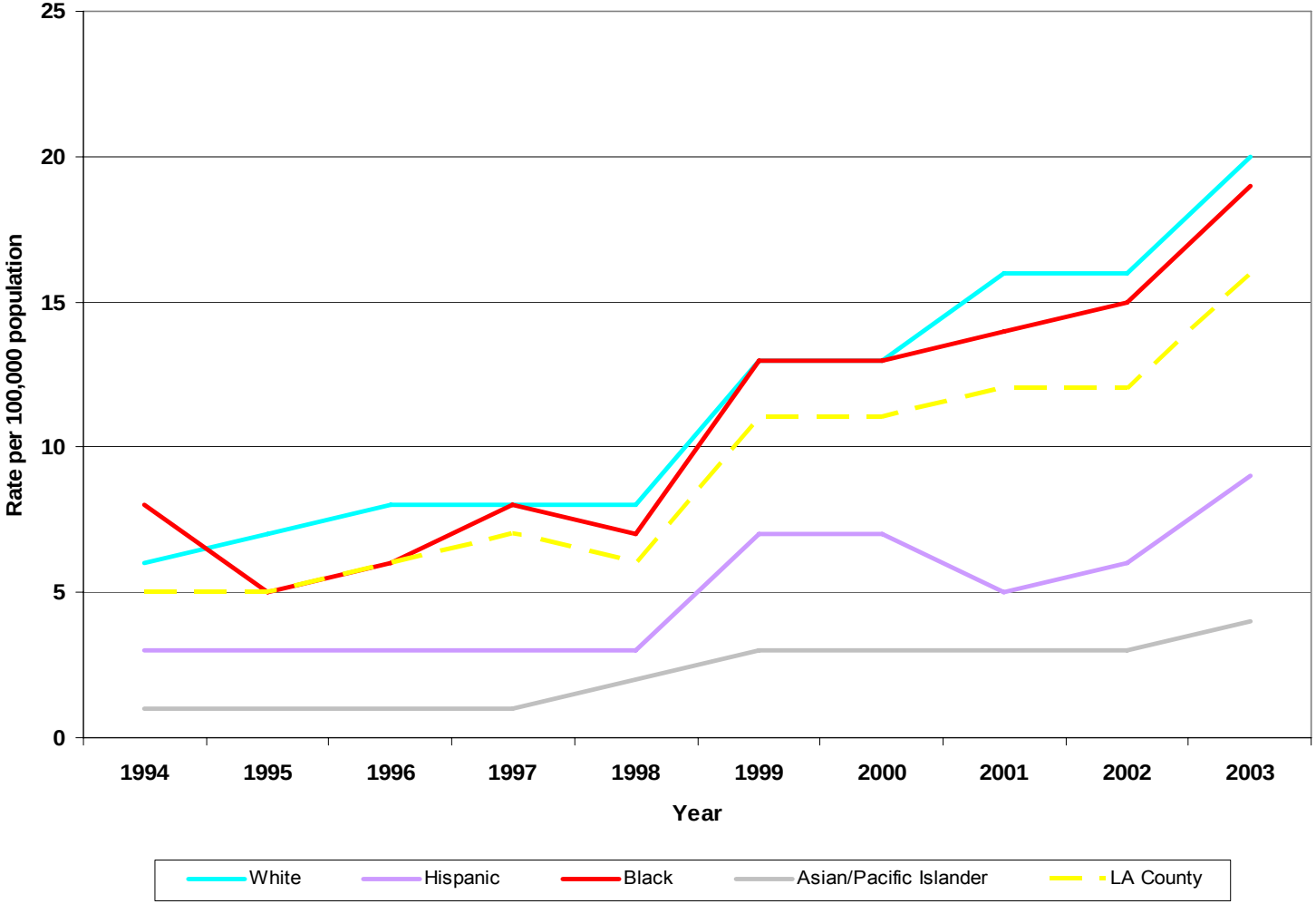
- Alzheimer's Disease – As population continues to live longer, disease will become more common
- Diabetes – Increase in all Type 2, directly correlated with increase in overweight and obesity
- While not on list, dental disease is very common, often inadequately treated—and mostly preventable

Estimated Number Of New Alzheimer Cases (In Thousands)



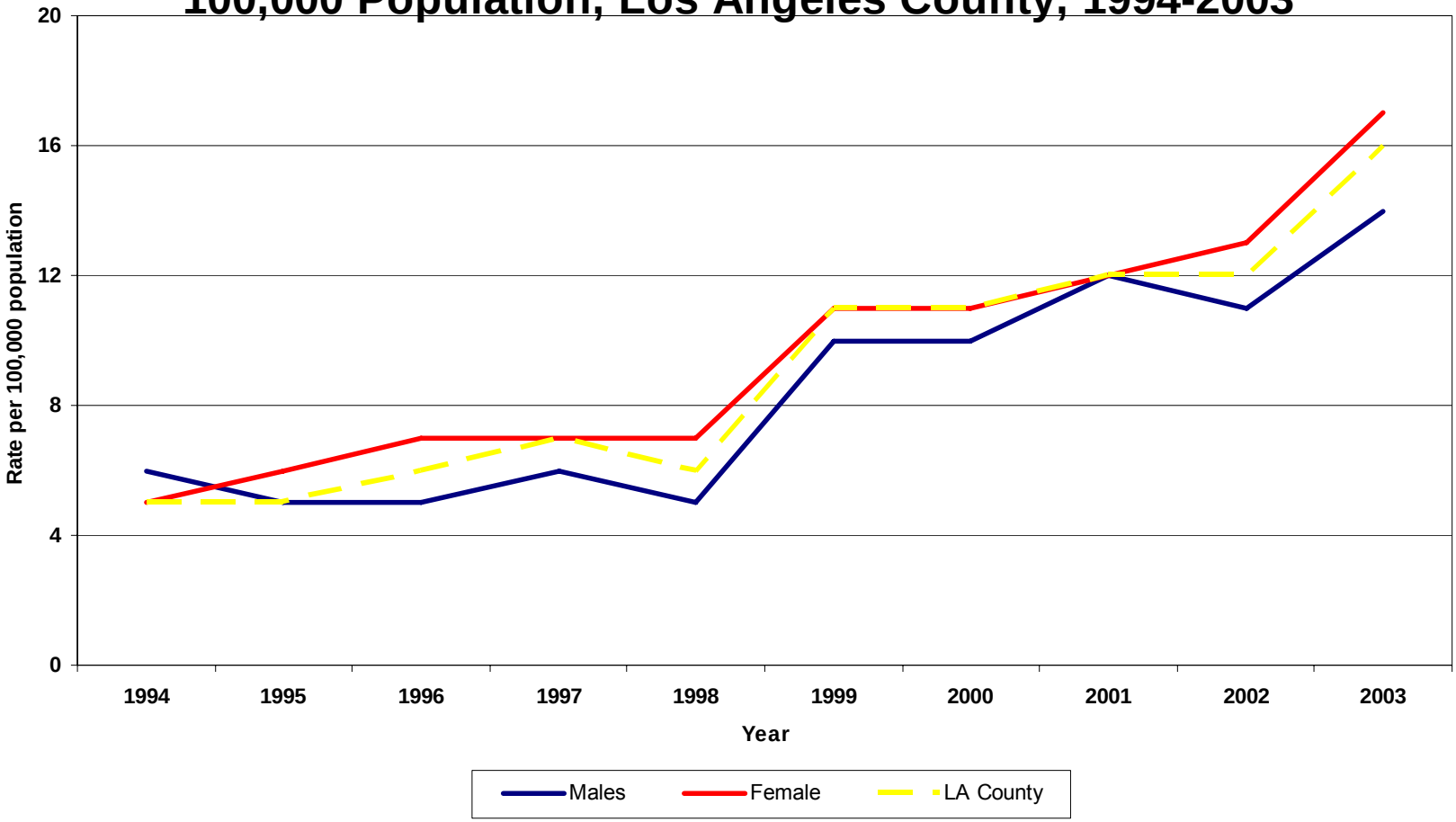
Source: Hebert et al. (2001). Alzheimer's Disease and Associated Disorders, 15(4), 169-173.

Alzheimer's Disease Age-Adjusted Rates* per 100,000 Population, by Race/Ethnicity, Los Angeles County, 1994-2003



*Death rates adjusted using the 2000 standard population published by the National Center for Health Statistics. ICD classifications changed in 1999; therefore, rate estimates may not be comparable to the change in classification system. Source: LA County Dept. Public Health (2006).

Alzheimer's Disease Age-Adjusted Mortality Rates* per 100,000 Population, Los Angeles County, 1994-2003



*Death rates adjusted using the 2000 standard population published by the National Center for Health Statistics. ICD classifications changed in 1999; therefore, rate estimates may not be comparable to the change in classification system. Source: LA County Dept. Public Health (2006). *Mortality in Los Angeles County, 2003* , p. 39.

Impact of Alzheimer's Disease

- **Healthcare costs – medical care; hospitalizations; skilled nursing; home care; long term care costs often lead to depletion of patient's personal savings and assets**
- **Personal costs – disease progression with memory loss, wandering, behavioral problems, injuries, depression**
- **Caregiving – caregiver stress, caregiver illness, paid and unpaid costs of caregiving**
- **Costs to businesses – absenteeism due to caregiving, lost productivity, etc.**

Impact of Alzheimer's Disease on Caregivers

- **Almost 10 million Americans are caring for a person with Alzheimer's disease and other dementias.**

- **In 2005, it is estimated that unpaid caregivers of people with Alzheimer's disease and other dementias provided 8.5 billion hours of care valued at almost $83 billion dollars.**

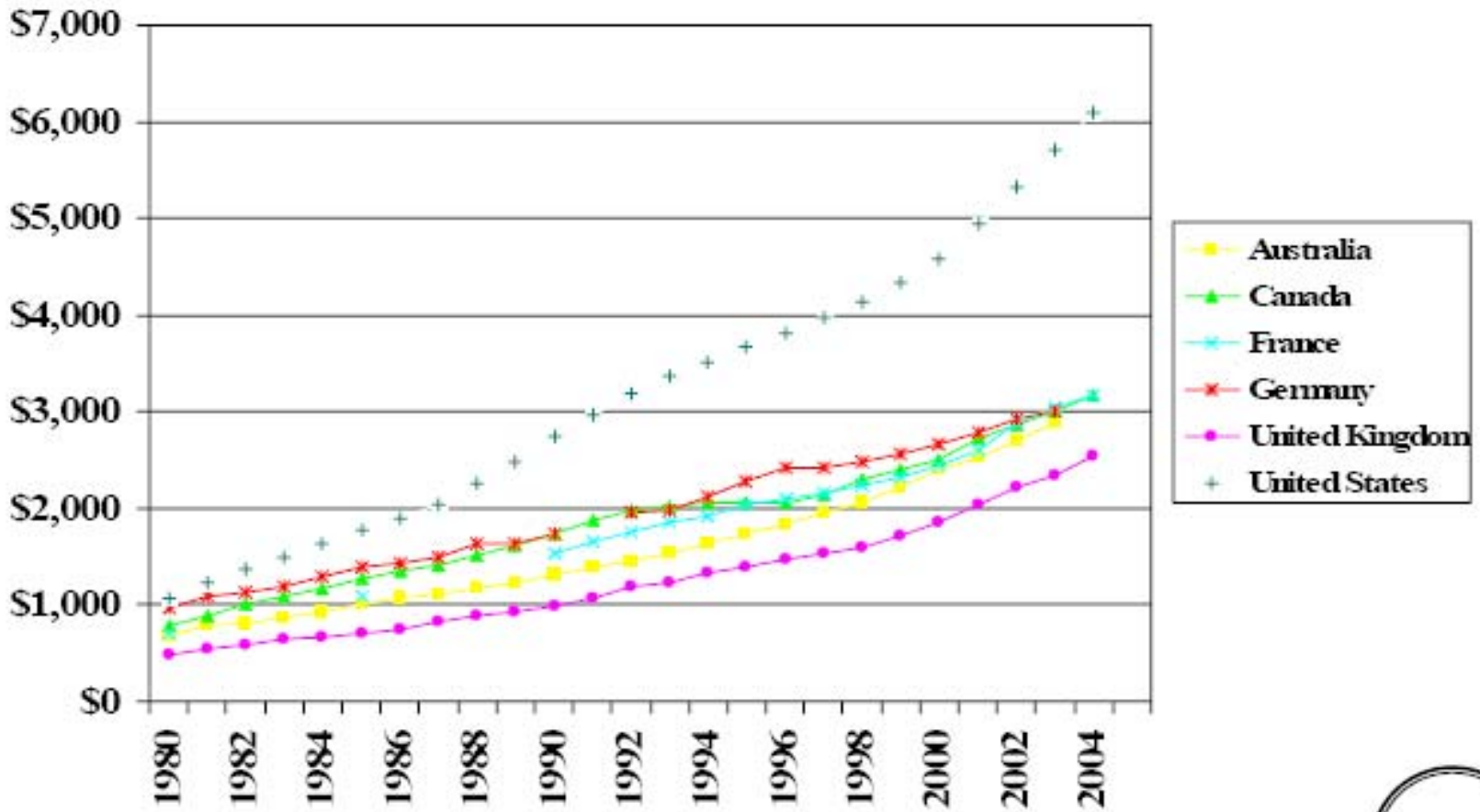
Chronic Disease & the U.S. Health Care System

- U.S. Health Care Expenditures: $2 trillion in 2006 (16% of GDP)
- Medicare and Medicaid accounting for more than $400 billion and $300 billion, respectively
- 47 million uninsured in the U.S.
- At least 16 million more underinsured
- Pressures from pharmaceuticals, technological advances, and globalization

Chart II-2

Health Care Spending per Capita from 1980 to 2004

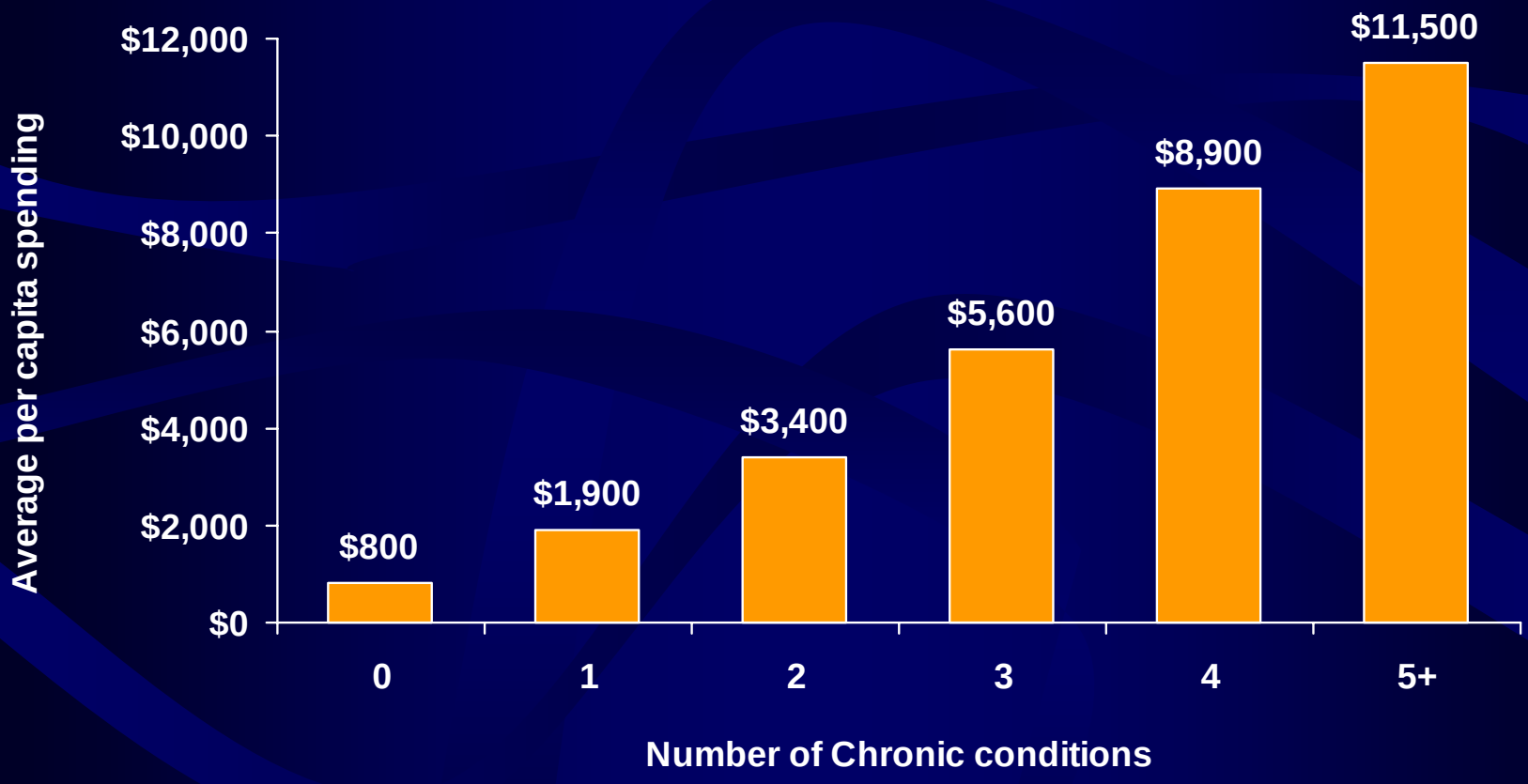
Adjusted for Differences in Cost of Living



Source: The Commonwealth Fund, calculated from OECD Health Data 2006.

THE COMMONWEALTH FUND

Per Capita Healthcare Spending in the U. S. by Number of Chronic Conditions, 1998



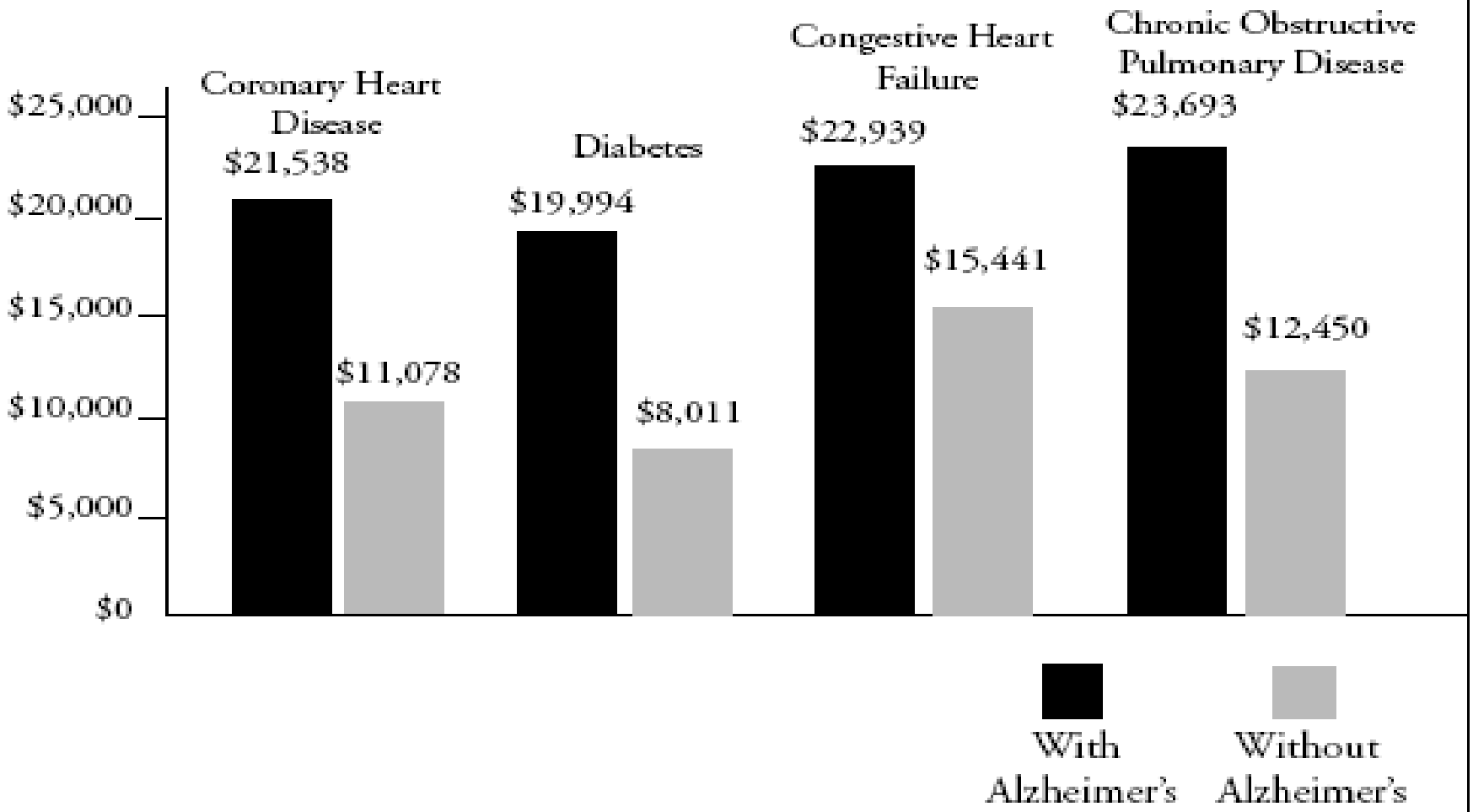
SOURCE: Medical Expenditure Panel Survey, 1998
Anderson, G., Public Health Reports, 2004

U.S. Healthcare Expenditures, 1970-2004

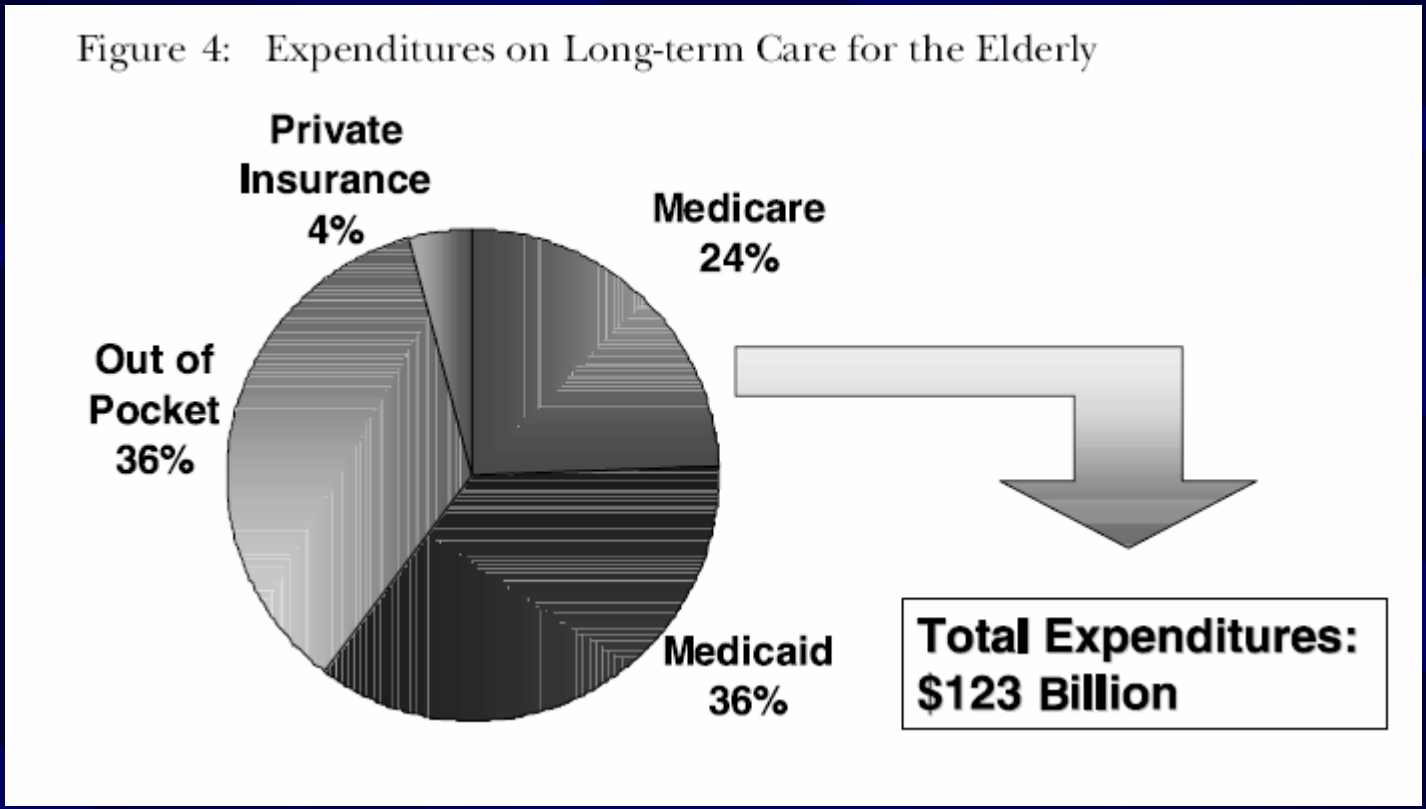
	1970	1980	1993	2000	2004
Total spending (billions $)	75	255	917	1,359	1,878
Spending per capita ($)	357	1,106	3,461	4,729	6,280
Spending as percent of GDP	7.2%	9.1%	13.8%	13.8%	16.0%

Source: Smith, et.al., Health Affairs, 2006

Average Costs for Chronic Conditions (with or without Alzheimer's Disease)



Long term care expenditures



Source: Knickman & Snell, HSR, 2002

Four "Aging Shocks"

Table 1: Expected Lifetime Costs of Significant "Aging Shocks" for a 65-Year-Old Today

• Uncovered Prescription Drugs	$12,000
• Uncovered Medical Care	$16,000
• Uncovered Insurance Premiums	$18,000
• Uncovered Long-term Care	$44,000

Estimates calculated by authors. See footnote 1 for assumptions used.

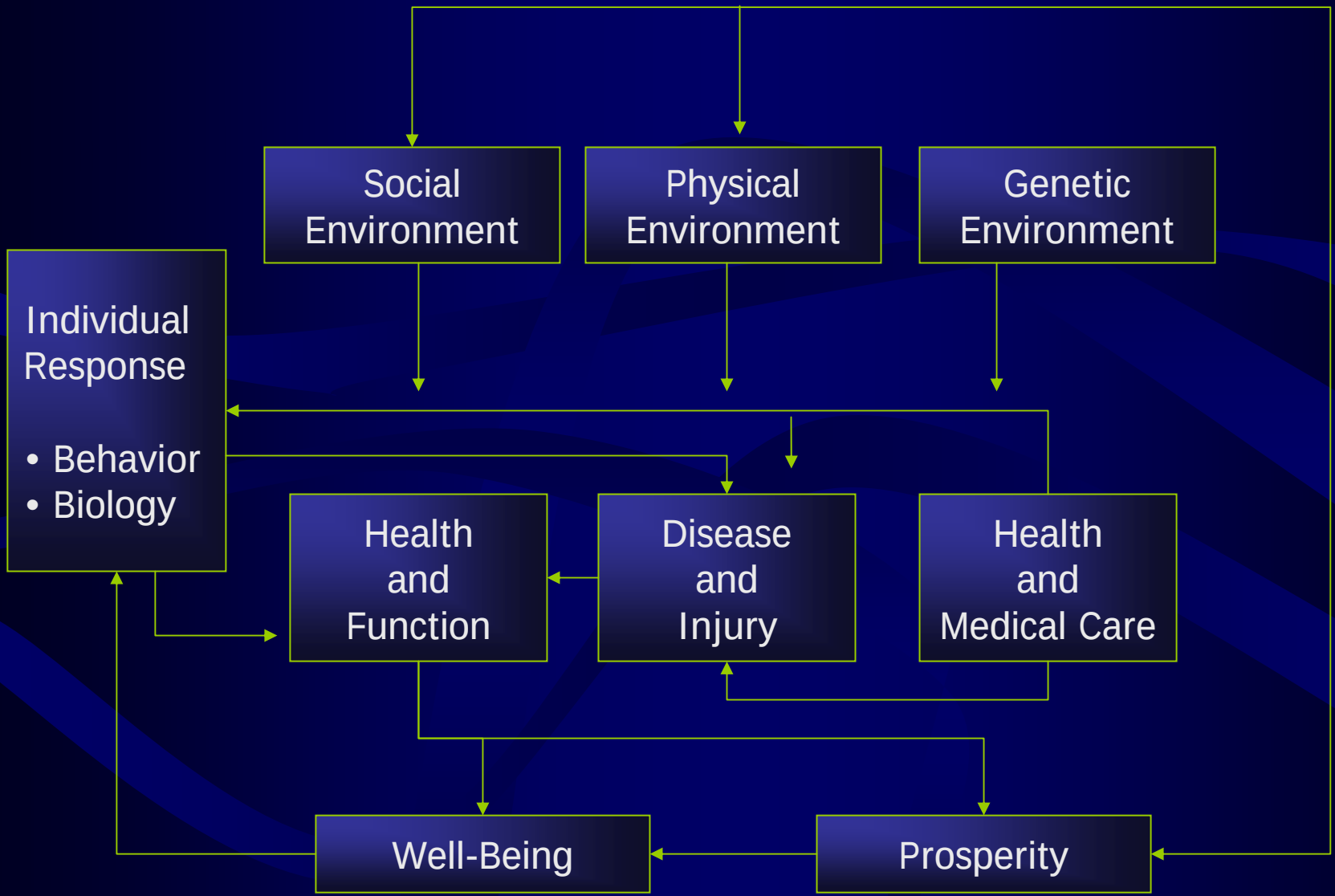
Source: Knickman & Snell, HSR, 2002

Solutions? What experts suggest…

1. Creating a finance system for long-term care that works
2. Building a viable and affordable community-based delivery system
3. Investing in healthy aging in order to achieve lower disability rates, and
4. Recharging the concept of family and the value of seniors in American culture.

Source: Knickman & Snell, HSR, 2002

Conceptual Framework for Patterns of Determinants of Health



Evans and Stoddart. Consuming Research, Producing Policy? *Am J Pub Hlth*. 2003;93(3):371-379.

Determinants of Health

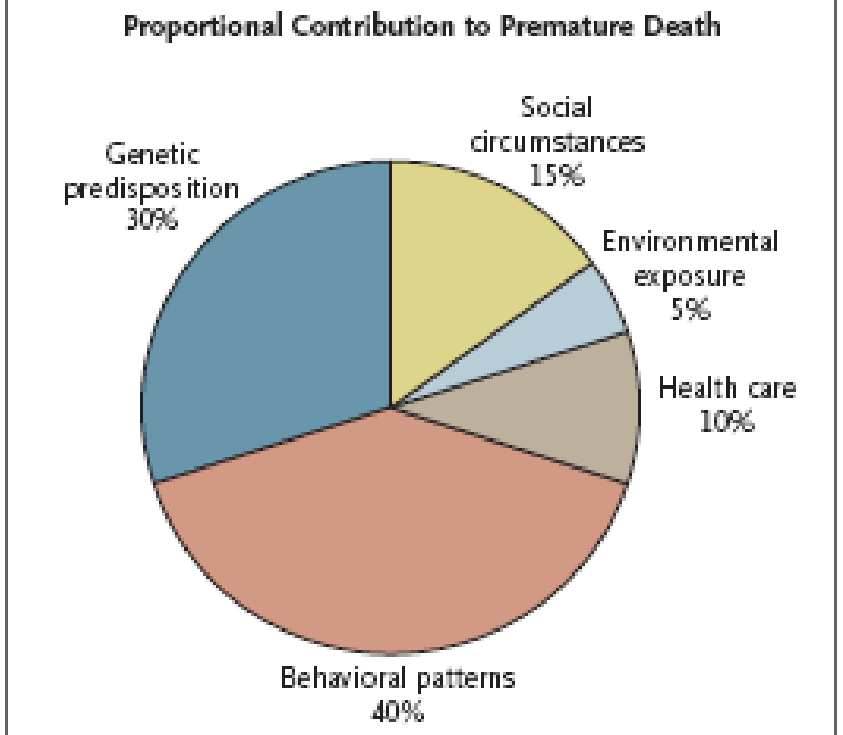


Figure 1. Determinants of Health and Their Contribution to Premature Death.

Adapted from McGinnis et al.[10]

Source: Schroeder, NEJM

Determinants of Health

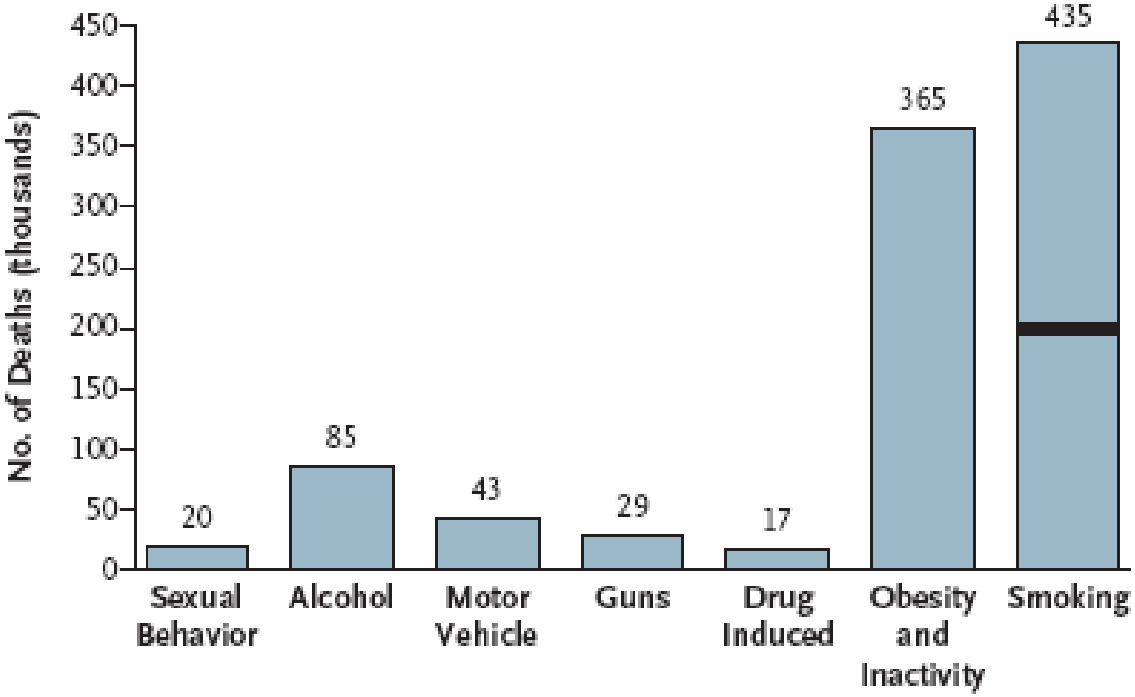


Figure 2. Numbers of U.S. Deaths from Behavioral Causes, 2000.

Among the deaths from smoking, the horizontal bar indicates the approximately 200,000 people who had mental illness or a problem with substance abuse. Adapted from Mokdad et al.[12]

Source: Schroeder, NEJM

How do we rank worldwide?

U.S. vs. other developed nations that make up the Organization for Economic Cooperation and Development

(OECD)

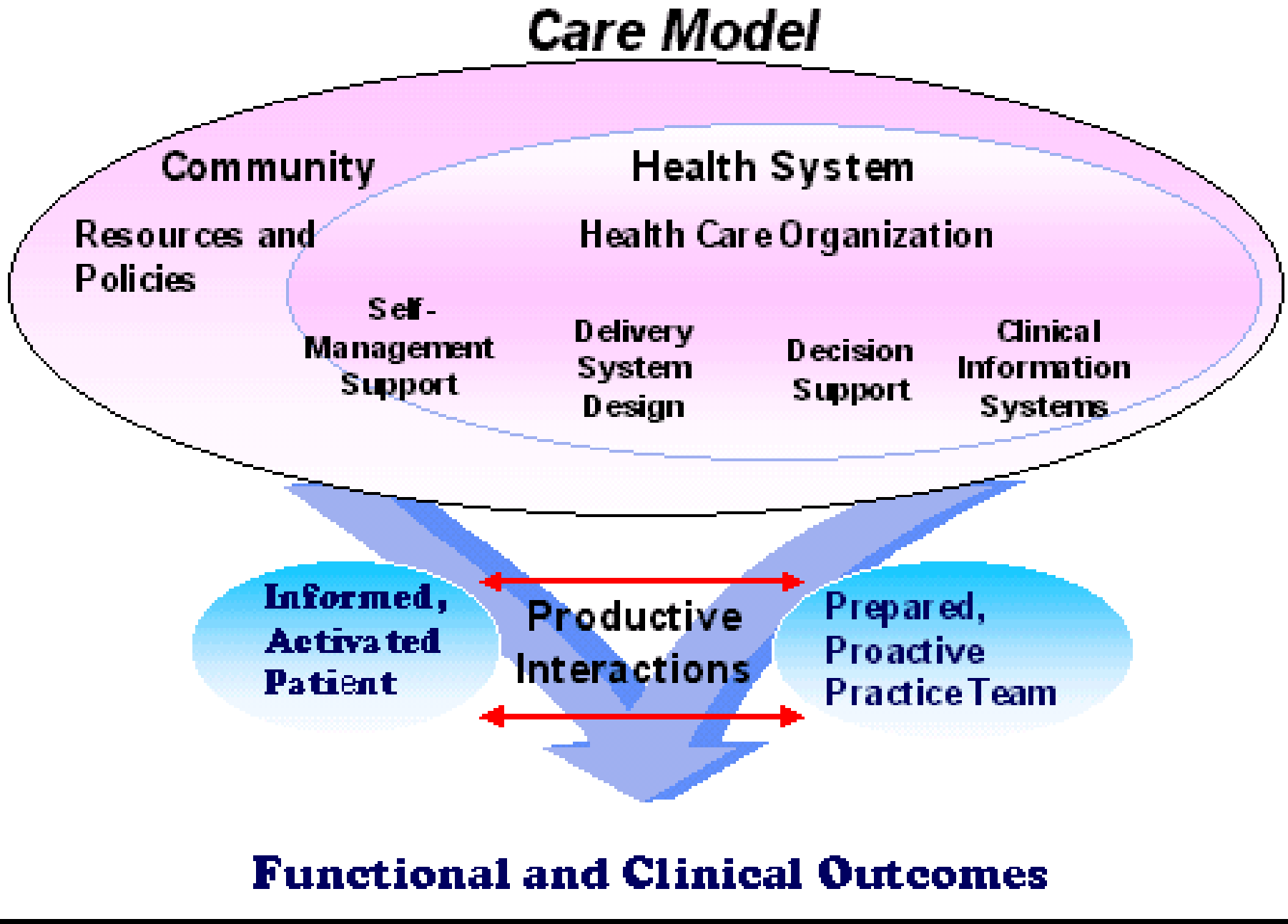
Table 1. Health Status of the United States and Rank among the 29 Other OECD Member Countries.

Health-Status Measure	United States	U.S. Rank in OECD	Top-Ranked Country in OECD*
Infant mortality (first year of life), 2001			
All races	6.8 deaths/ 1000 live births	25	Iceland (2.7 deaths/ 1000 live births)
Whites only	5.7 deaths/ 1000 live births	22	
Maternal mortality, 2001†			
All races	9.9 deaths/ 100,000 births	22	Switzerland (1.4 deaths/ 100,000 births)
Whites only	7.2 deaths/ 100,000 births	19	
Life expectancy from birth, 2003			
All women	80.1 yr	23	Japan (85.3 yr)
White women	80.5 yr	22	
All men	74.8 yr	22	Iceland (79.7 yr)
White men	75.3 yr	19	
Life expectancy from age 65, 2003‡			
All women	19.8 yr	10	Japan (23.0 yr)
White women	19.8 yr	10	
All men	16.8 yr	9	Iceland (18.1 yr)
White men	16.9 yr	9	

* The number in parentheses is the value for the indicated health-status measure.
† OECD data for five countries are missing.
‡ OECD data for six countries are missing.

How We Can Approach Chronic Disease

- Approach 1 – Treating disease condition
  - e.g. enhancing chronic disease management for such conditions as diabetes, congestive heart failure or hypertension
- Approach 2 – Reducing risk factors for disease
  - e.g. improve nutrition and increase physical activity to prevent chronic disease and functional decline
- Approach 3 – Focus on underlying determinants of disease
  - e.g. ensure opportunities for people to achieve optimal health by
    - Establishing better protocols or tools for health assessment and surveillance of common chronic diseases – quality data for policy development
    - Addressing policies and regulations which affect the health of older adults
    - Supporting community-based programs or initiatives that promote better diet and maintenance of functional status
    - Supporting the development and changes in the social and physical environments so people can be more physically active, adopt healthier lifestyles, and have access to social and health care services


Care Model
Community
Resources and Policies
Health System
Health Care Organization
Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Functional and Clinical Outcomes

Effectiveness of Chronic Disease Self-Management Programs

- **Of 780 studies screened, 53 studies contributed data to the random-effects meta-analysis**
- **Data on diabetes, osteoarthritis and hypertension:**

  Self-management interventions led to a statistically and clinically significant pooled effect size of:

  1) -0.36 (95% CI, -0.52 to -0.21) for hemoglobin A1c, equivalent to a reduction in HgbA1c level of about 0.81%.

  2) Decreased systolic blood pressure by 5 mm Hg (effect size, -0.39 [CI, -0.51 to -0.28]).

  3) Decreased diastolic blood pressure by 4.3 mm Hg (effect size, -0.51 [CI, -0.73 to -0.30]).

  4) Data on osteoarthritis statistically significant but clinically trivial for pain and function outcomes.

Chodosh et al. Meta-analysis: chronic disease self-management programs for older adults. Ann Intern Med. 2005;143:427-438.

Return-on-Investment From Changes in Employee Health Risks on A Company's Health Care Costs

- Estimate of the impact of corporate health-management and risk-reduction programs for The Dow Chemical Company using a prospective return-on-investment (ROI) model
- Methods: risk and expenditure estimates derived from multiple regression analyses
- Results: "Break-even" scenario would require company o reduce each of 10 population health risks by 0.17% points per year over course of 10 years
- Conclusion: results support continued investments in health improvement programs to achieve risk reduction and cost savings

Goetzel et al. Estimating the Return-on-Investment from changes in employee health risks on the Dow Chemical Company's Health Care Costs. J Occup Environ Med. 2005;47:759-768.

Example: Physical Activity Among Older Adults

- Decreases mortality
- Prevents obesity
- Improves functioning
- Improves health-related quality of life
- Decreases depression
- Risk reduction
  - Cardiovascular disease
  - Stroke
  - Cancer (coupled to changes in dietary factors)
  - High blood pressure
  - Diabetes
  - Cognitive impairment (e.g., vascular dementia)
  - And many more…

What is being done to promote physical activity among older adults?

- Good news
  - Solid evidence on the effect of various programs aimed to promote physical activity among older adults, but much more research and planning are needed
  - Most physical activity programs consist of aerobic, flexibility, strength, or balance exercises. Some are beginning to employ environmental strategies and home-based programming (e.g., crosswalk safety, older pedestrian safety, outdoor & indoor fall prevention)
  - Other approaches include interventions which identify and target factors that maximize adherence (e.g., improving self-efficacy, social networks, etc.)

What is being done to promote physical activity among older adults?

- Bad news
  - Many public health professionals and government leaders are unaware of this evidence for promoting physical activity among older adults
  - Aging population is growing rapidly, accounting for greater healthcare utilization and medical care costs; prevention messages often lost in the dialogue about chronic disease prevention and control (where health education can play a significant role not only for the public but for healthcare and social services providers

Ongoing Challenges to Determine Effective Interventions

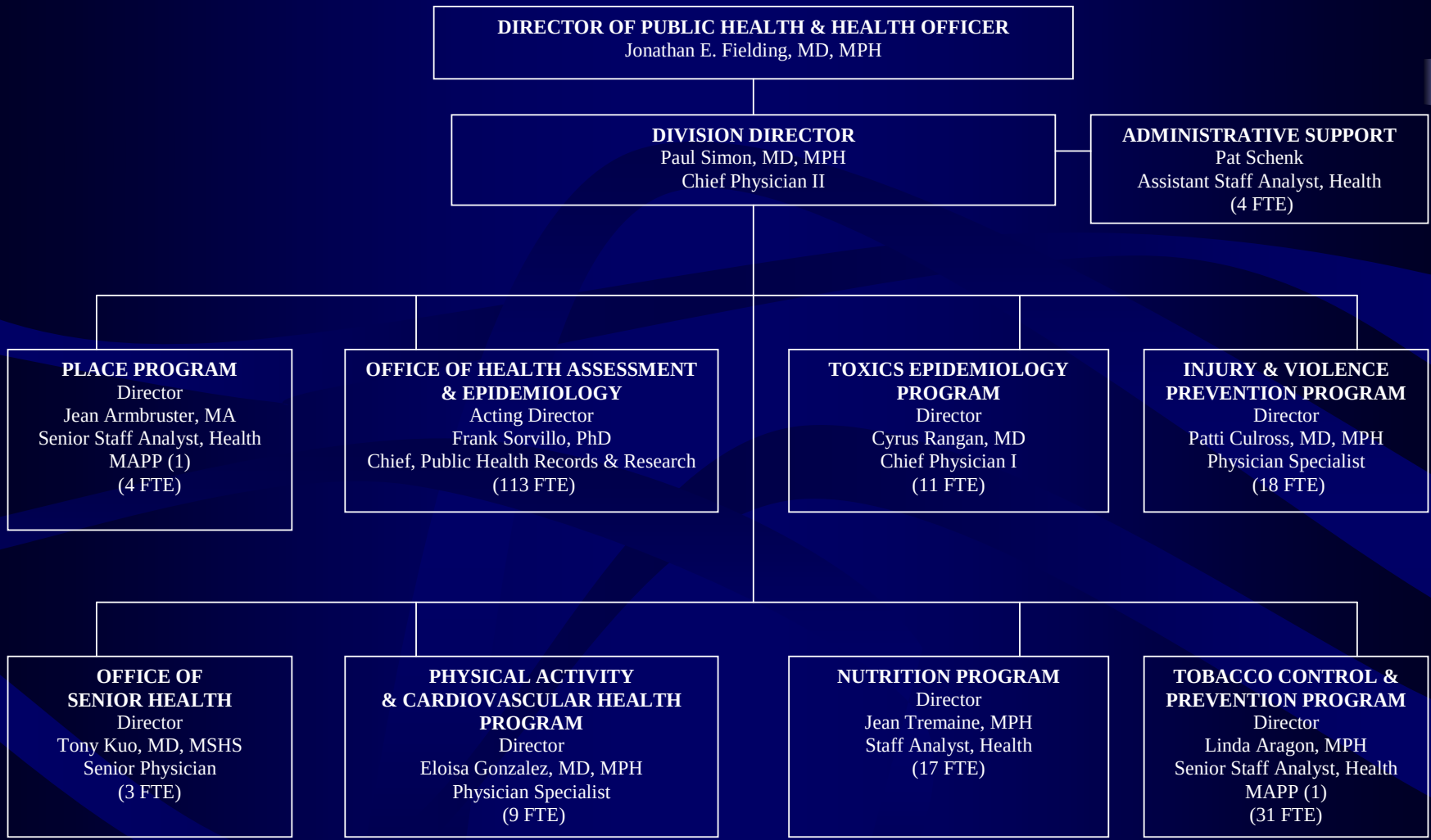
- Where is the research base?
- Relatively few studies
- Many studies not in “health” or “public health” literature
- Not amenable to design and methods used in most clinical trials

Office of Senior Health

Los Angeles County Department of Public Health

- Recently established
- Housed in the Division of Chronic Disease and Injury Prevention
- Represents public health commitment to improve the quality of life and to provide leadership and guidance in the prevention and control of common chronic diseases and other emerging public health problems in the aging population.
- Mission: “to maximize the health, quality of life, and access to best practices in health care and public health for all older adults and their families in Los Angeles County”

DIVISION OF CHRONIC DISEASE AND INJURY PREVENTION



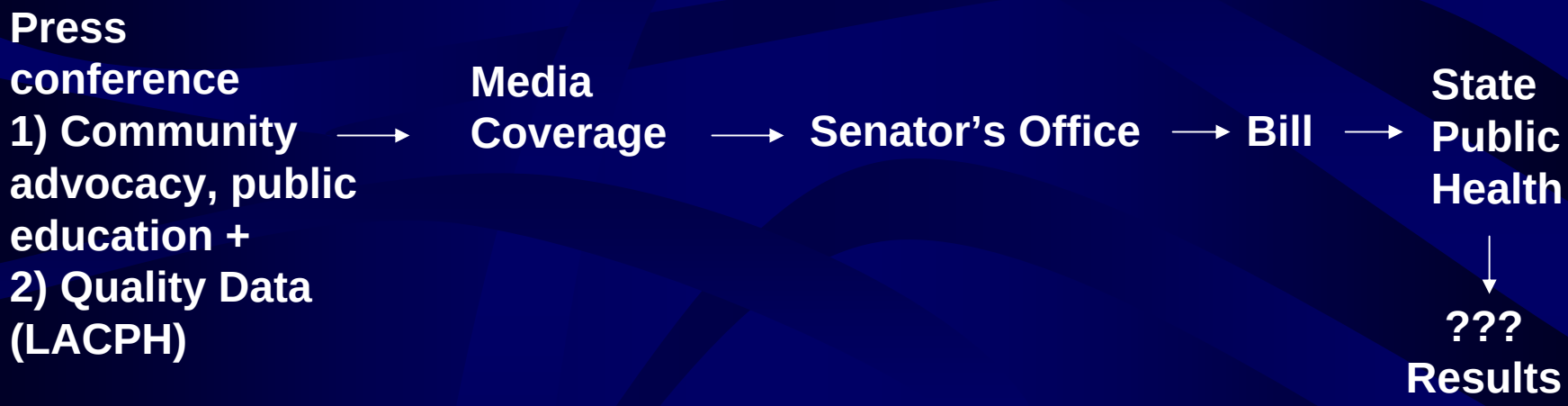
Goals

- **Visibility** (collaboration with community stakeholders and aging services network partners)
- **Credibility** (quality data for policy development)
- **Full-fill the 3 core functions of public health**
  - Health assessment, epidemiology (research) & surveillance
  - Policy development
  - Assurance/public safety/health education
- **Where we can thrive and have:**
  - quality data, policy development, and translation of evidence into practice (e.g., health education of the public *and* healthcare workforce

The Aging Services Network in Los Angeles County

- LA County Commission on Aging
- LA County Department of Community and Senior Services
- LA City Department of Aging
- The two Area Agencies on Aging (AAA's) – unique to LA County
- Community-based organizations
- Faith-based organizations
- Foundations

Policy Development & Implementation: Case Study -- Alzheimer's Disease



Healthcare Workforce: Training, Professional Development & Practice: e.g., Alzheimer's Disease Clinical Practice Guidelines

Guideline for Alzheimer's Disease Management

ASSESSMENT

Monitor Changes
Conduct and document an assessment and monitor changes in:
- Daily functioning, including feeding, bathing, dressing, mobility, toileting, continence, and ability to manage finances and medications
- Cognitive status using a reliable and valid instrument
- Comorbid medical conditions which may present with sudden worsening in cognition, function, or as change in behavior
- Behavioral symptoms, psychotic symptoms, and depression
- Medications, both prescription and non-prescription (at every visit)
- Living arrangement, safety, care needs, and abuse and/or neglect
- Need for palliative and/or end-of-life care planning

Reassess Frequently
Reassessment should occur *at least* every 6 months, and sudden changes in behavior or increase in the rate of decline should trigger an urgent visit to the PCP.

Identify Support
Identify the primary caregiver and assess the adequacy of family and other support systems, paying particular attention to the caregiver's own mental and physical health.

Assess Capacity
Assess the patient's decision-making capacity and determine whether a surrogate has been identified.

Identify Culture & Values
Identify the patient's and family's culture, values, primary language, literacy level, and decision-making process.

TREATMENT

Develop Treatment Plan
Develop and implement an ongoing treatment plan with defined goals. Discuss with patient and family:
- Use of cholinesterase inhibitors, NMDA antagonist, and other medications, if clinically indicated, to treat cognitive decline
- Referral to early-stage groups or adult day services for appropriate structured activities, such as physical exercise and recreation

Treat Behavioral Symptoms
Treat behavioral symptoms and mood disorders using:
- Non-pharmacologic approaches, such as environmental modification, task simplification, appropriate activities, *etc.*
- Referral to social service agencies or support organizations, including the *Alzheimer's Association's MedicAlert® + Safe Return®* program for patients who may wander

Non-Pharmacological Treatment First
IF non-pharmacological approaches prove unsuccessful, *THEN* use medications, targeted to specific behaviors, if clinically indicated. Note that side effects may be serious and significant.

Treat Co-Morbid Conditions
Provide appropriate treatment for comorbid medical conditions.

Provide End-of-Life Care
Provide appropriate end-of-life care, including palliative care as needed.

PATIENT & FAMILY EDUCATION & SUPPORT

Integrate Medical Care & Support
Integrate medical care with education and support by connecting patient and caregiver to support organizations for linguistically and culturally appropriate educational materials and referrals to community resources, support groups, legal counseling, respite care, consultation on care needs and options, and financial resources.
Organizations include:
- **Alzheimer's Association** (800) 272-3900 www.alz.org
- **Caregiver Resource Centers** (800) 445-8106 www.caregiver.org
- or your own social service department

Discuss Diagnosis & Treatment
Discuss the diagnosis, progression, treatment choices, and goals of Alzheimer's Disease care with the patient and family in a manner consistent with their values, preferences, culture, educational level, and the patient's abilities.

Involve Early-Stage Patients
Pay particular attention to the special needs of early-stage patients, involving them in care planning, heeding their opinions and wishes, and referring them to community resources, including the Alzheimer's Association.

Discuss Stages
Discuss the patient's need to make care choices at all stages of the disease through the use of advance directives and identification of surrogates for medical and legal decision-making.

Discuss End-of-Life Decisions
Discuss the intensity of care and other end-of-life care decisions with the Alzheimer's Disease patient and involved family members while respecting their cultural preferences.

LEGAL CONSIDERATIONS

Planning
Include a discussion of the importance of basic legal and financial planning as part of the treatment plan as soon as possible after the diagnosis of Alzheimer's Disease.

Capacity Evaluations
Use a structured approach to the assessment of patient capacity, being aware of the relevant criteria for particular kinds of decisions.

Elder Abuse
Monitor for evidence of and report all suspicions of abuse (physical, sexual, financial, neglect, isolation, abandonment, abduction) to Adult Protective Services, Long Term Care Ombudsman, or the local police department, as required by law.

Driving
Report the diagnosis of Alzheimer's Disease in accordance with California law.

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Office's Scope of Work
(Examples)

- **Senior Health Website**
- **Committee on Clinical Management Guidelines for Alzheimer's Disease**
- **Los Angeles County Elder Death Review Team**
- **Steering Committee for Community-Based Programs in Fall Prevention, Healthy Aging, and Chronic Disease Self-Management (U.S. Administration on Aging)**
- **Fitness Challenge Foundation (physical fitness promotion)**
- **Health assessment & chronic disease surveillance activities**
- **Other work-in-progress and emerging issues (e.g., transportation alternatives, fall prevention, etc.)**
- **The HHS Hispanic Elder's Health Project – learning network funded by a multi-agency group including AcademyHealth, AHRQ, CMS, HRSA, U.S. Dept. Health & Human Services, and the U.S. Admin on Aging**

Thank You!!!
Questions???