Aging Well
CARE THAT EVOLVES AS WE DO

Culture and Care

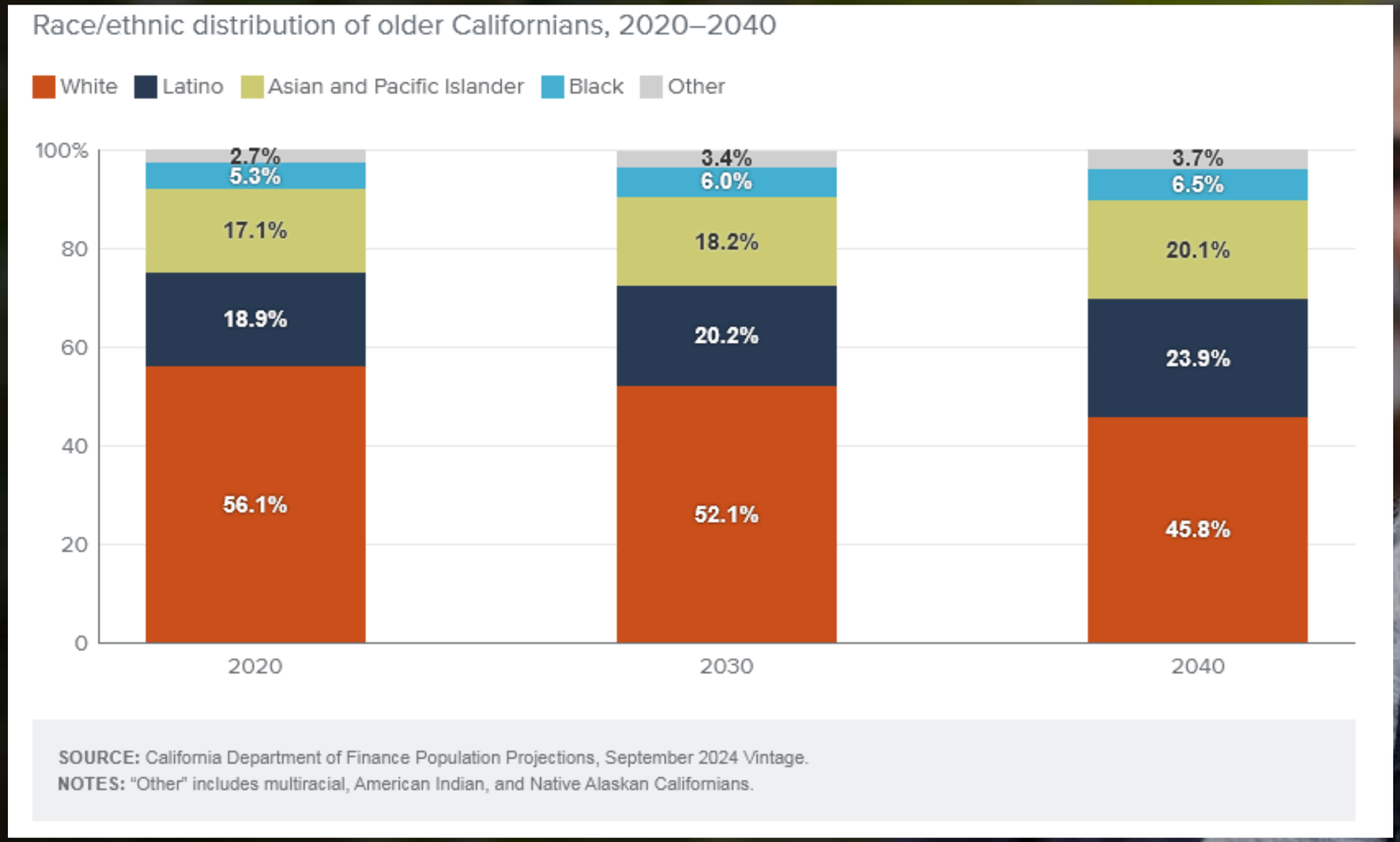
MODERATOR
Serwar Ahmed

PANELISTS
Rev. Cynthia Carter Perrilliat
Vinny Eng
Dr. Daveena Ma
Amy Ramirez

KAISER PERMANENTE®

“By 2040 no race or ethnic group will comprise a majority of California’s older adult population”

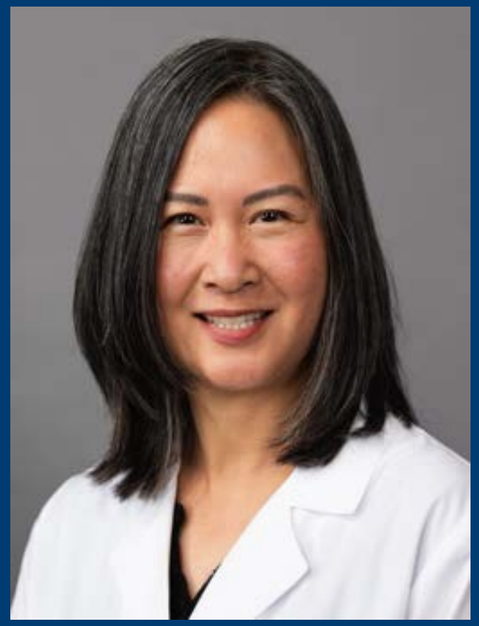
- Public Policy Institute of California



Culture and Care - Panelists

Rev. Cynthia Carter Perrilliat
Founder and CEO, AC Care Alliance

Vinny Eng
Interim Executive Director, Openhouse



Dr. Daveena Ma
Associate Chief Medical Officer, Asian Health Services

Amy Ramirez
Executive Director, Healthcare Foundation of Northern Sonoma County

AC Care Alliance (ACCA) Advanced Illness Care Program

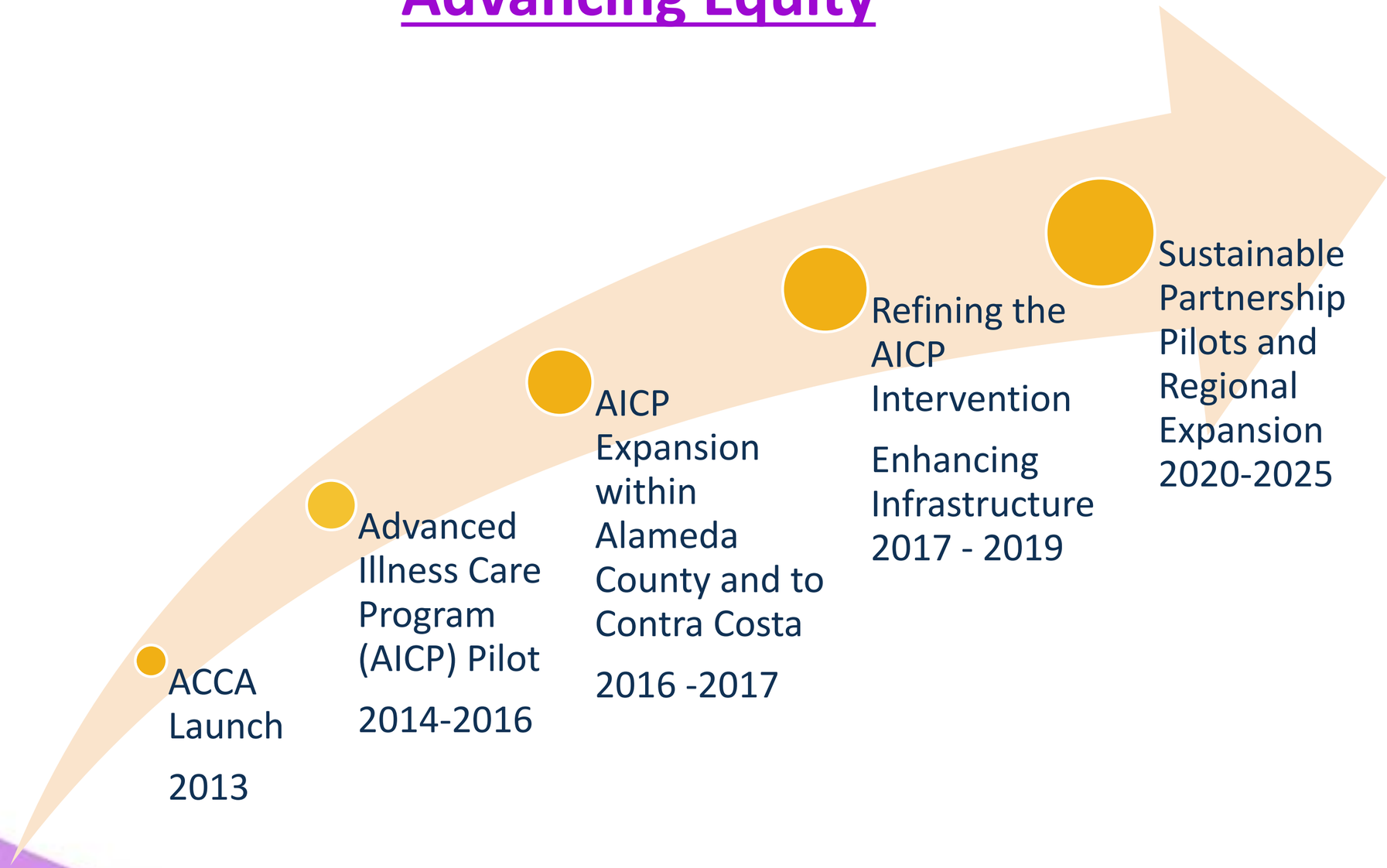
AC CARE ALLIANCE
FAITH & HEALTH CARING FOR THE COMMUNITY

Rev. Cynthia Carter-Perrilliat, Cofounder, CEO

AC Care Alliance

- **Vision**: *Spread* the Model of Care – *vibrant* Healthcare and Community partnership
- **Demonstrate**: Whole-Person Focused - Body-Mind-Spirit
- **New Paradigm**: Care-Alliance Care Navigators in *collaboration* with Health Systems/Plans
- **Goal**: Meet and address the preferences of *each person served*

AC Care Alliance: Bridging the Gap, Addressing Disparities, Advancing Equity



Advanced Illness Care Disparities among African Americans & Latinx

- Experience a **disproportionate burden of advanced illness** (compared to non-Hispanic whites).
- Have **less access to care** that relieves suffering and promotes quality of life.
- **Do not receive care that matches their stated preferences** for advanced illness treatment, as growing evidence suggests.

MORE	LESS
Prevalence of Advanced Illness	Pain/symptom management
Later detection	Guidance to make informed decisions
Care for loved ones at home	End-of-Life planning/conversations with loved ones and providers
Unmet needs (physical, spiritual, tangible resources)	Advance Directives, POLST
Medical mistrust	Access to palliative care/hospice
Preference for life-sustaining therapies	Care concordance with desired care

ACCA Advanced Illness Care Program™
Five Cornerstones

Series of 5-12 meetings between the Care Navigator and Person Needing Care or Caregiver over approximately 6 months

Program is personalized to individual participants' needs

Spiritual Needs

Prayer, meditation, and faith community support

Health Needs

provider communication, physical and emotional support

Planning for Advance Care

Understanding, choosing and documenting advance care choices

Social Needs

Transportation, meals, housing, socialization, financial/legal

Caregiving Needs

Respite care, support groups, support for caregivers

➢ ***Identify needs, provide trusted referrals/resources, empower individuals with tools & training***

Care Navigators Play a Critical Role

- 1 year – ECM : 6 months - AICP
- Identify needs and goals
- Provide trusted referrals/resources
- Empower individuals with tools & training
- Encourage participants to tell their stories

Outcomes

- **1,500** people served; **15,000** people touched (since 2016)
- Goal setting discussed at **100%** of visits
- Prayer provided at **85%** of visits
- Caregiver needs addressed at **53%** of visits
- **16%** of visits included applications for financial assistance
- **3.5** average social referrals per participant
- **50%** individuals completed an advance directive (compared to 15% national average)
- **High Participant and Pastoral Satisfaction!**

Engagement Partners

PUBLIC HEALTH INSTITUTE

UCDAVIS HEALTH | BETTY IRENE MOORE SCHOOL OF NURSING

STUPSKI FOUNDATION

KAISER PERMANENTE®

LifeLong Medical Care
Health Services For All Ages
a californiahealth+center

FAMILY CAREGIVER ALLIANCE®

RITA&ALEX HILLMAN FOUNDATION

jwH
JOHN & WAUNA HARMAN FOUNDATION

The Callison Foundation

C-TAC
COALITION TO TRANSFORM ADVANCED CARE

CSU The California State University
SHILEY INSTITUTE FOR PALLIATIVE CARE

SFF San Francisco Foundation

California Health Care Foundation

DAYBREAK
ADULT DAY SERVICES

community, services, and housing for LGBTQ+ seniors

openhouse

BUILDING ON CULTURES OF CARE

BY 2030, ALMOST 10 MILLION CALIFORNIANS WILL BE AGED 60 OR OLDER.

AT LEAST 5% IDENTIFY AS LGBTQ+ (500,000 CALIFORNIANS).

51% OF LGBTQIA+ OLDER ADULTS FEEL ISOLATED OR LONELY (VS. 36% OF STRAIGHT/CIS PEERS).

73% OF HIV+ LONG TERM SURVIVORS IN SAN FRANCISCO ARE 50+.

community, services, and housing for LGBTQ+ seniors

openhouse

THE POWER OF COMMUNITY-DEFINED SOLUTIONS

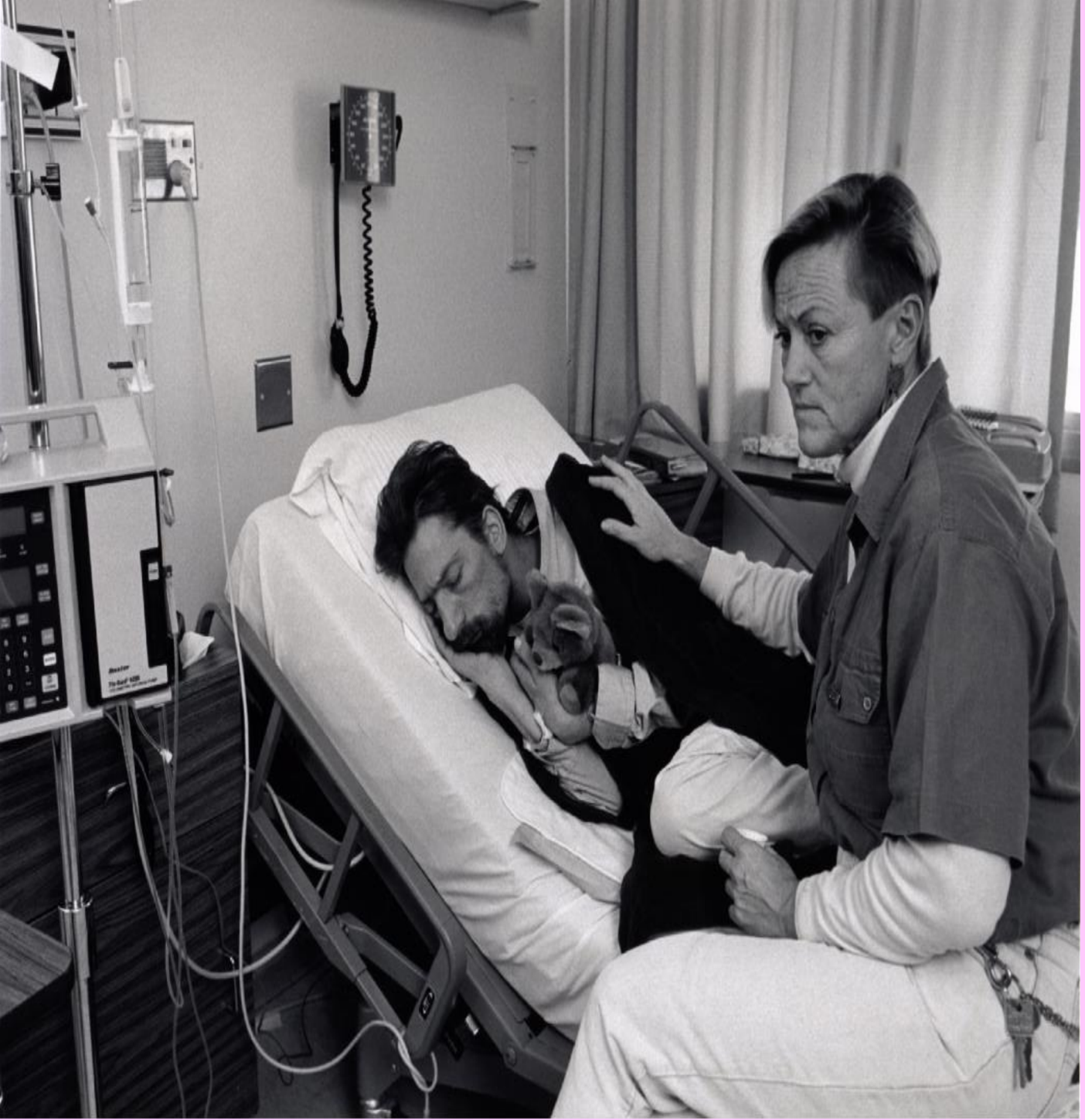
We empower San Francisco Bay Area LGBTQ+ older adults to overcome unique challenges through housing, direct services, peer support, and social programs.

Our campus at 75 laguna street includes an LGBTQ+ affirming senior center, disability and aging resource center, adult day program, support services, and affordable housing.

We serve over 3,600 LGBTQ+ older adults annually, centering their lived experiences and leadership.

community, services, and housing for LGBTQ+ seniors

openhouse



HOW CARE SYSTEMS EVOLVE

From lived experiences, we learn how communities provide care in the face of crisis and exclusion. Care systems can and must draw from this wisdom.

CULTURAL HUMILITY AS DAILY PRACTICE

Lifelong learning of what makes a person whole.

AFFIRMING A PERSON IS FOUNDATIONAL TO CAREGIVING

Culture of care curriculum, developed and co-facilitated with LGBTQ+ elders

community, services, and housing for LGBTQ+ seniors

openhouse

ASIAN HEALTH SERVICES

Inside the Silver Tsunami: Lessons from Asian Health Services

Asian Health Services: Who We Serve

92%

Medi-Cal, Medicare, Medi-Medi, or uninsured

29,000

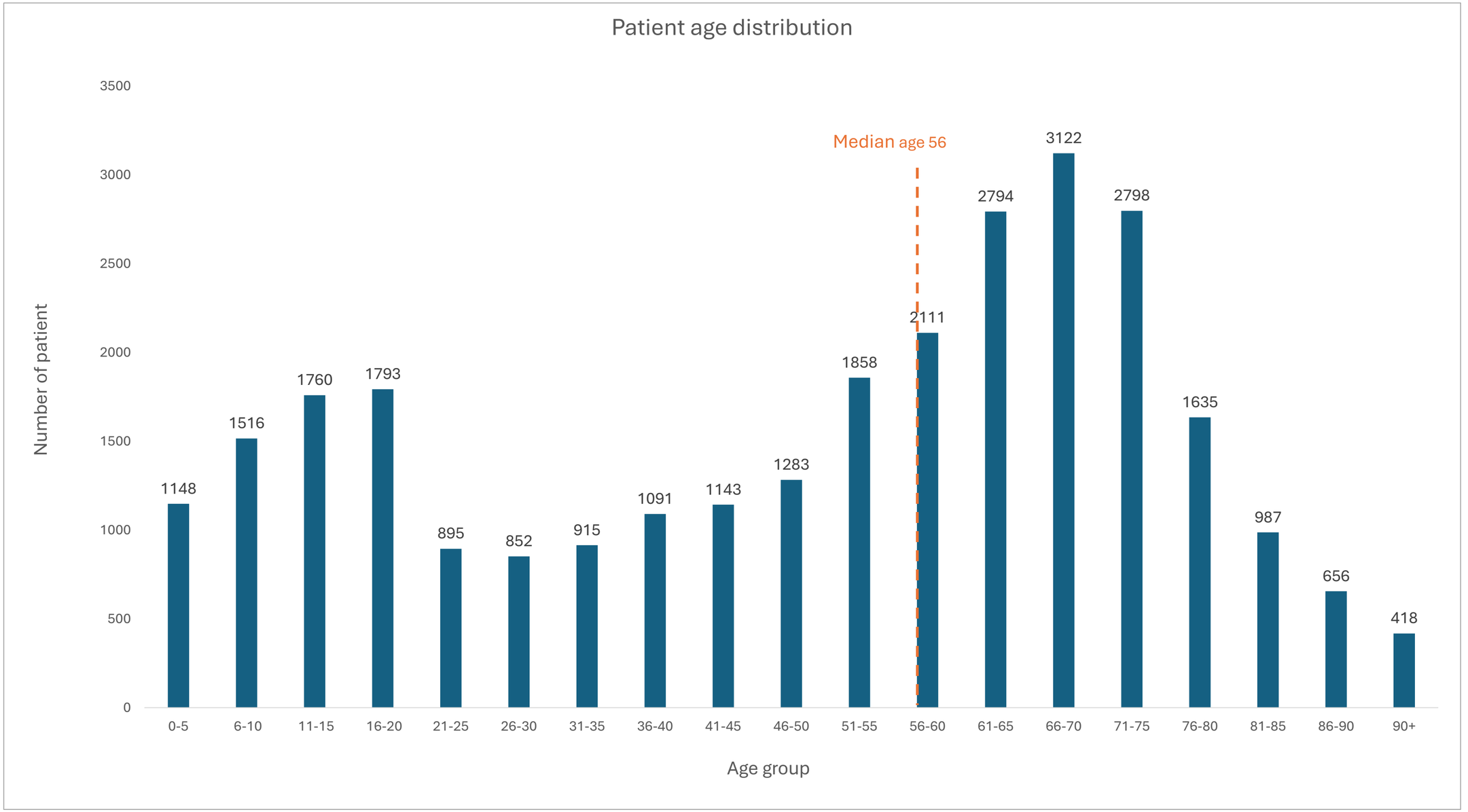
Medical, dental, and behavioral health patients

12

Asian languages

37%

patients 65+



data source: powerbi_data.dbo.Encounter_flat_file 2024 UDS
Age is calculated by 6-30-2024

2023 Geriatric Needs Assessment Findings

- While our physical sites are reasonably able to accommodate the needs of our geriatric patients, our specialty resources are limited.
- At the time of the assessment, we did not have any board-certified geriatricians.
- Both providers and patients noted dissatisfaction with 15-minute visits.
- Providers highlighted the need for specialized case management and the importance of community and connectivity in their patients' health
- Patients identified transportation, language concordance, food and housing as top needs.

Developments since 2023

- Piloted internal Chronic Care Management program for qualifying patients with 2+ chronic conditions – after enrollment, received monthly RN calls to review med reconciliation, care plan as designed by PCP, assess for and resolve barriers to getting medication, specialty appointments
- Hired board-certified geriatrician, RN case manager, and Community Health Worker to form our first Intradisciplinary Team in our enhanced geriatrics program
  - Referrals: dementia diagnosis and treatment, polypharmacy, fall assessment/prevention, Goals of Care
  - Transfers: 65+ with dementia/MCI, 75+ with at least one impaired ADL

Geriatrics Framework

Low Risk	Average Risk	High Risk	PACE Program
• 0-1 well-controlled chronic conditions • Primary Care PCP • Lifestyle medicine • Health Maintenance • Staying Healthy Assessment (SHA)/AWV	• 2+ controlled chronic conditions • Primary Care PCP • CCM, RPM, CGM • Geriatric consults • Annual Wellness Visit (AWV)	• 65+ with dementia or 75+ and at least one ADL impairment • Geriatrician PCP • Interdisciplinary Team: RN, CHW • CCM, TCM, RPM, CGM • Annual Wellness Visit (AWV)	• PACE PCP • PACE IDT

Thank You!

OCTOBER 2025

CLOVERDALE ECO GROUP

Our mission is to collaborate with others to design and implement anti-racist, joy-focused, equitable, sustainable, and affirming practices, initiatives, and policies. We strive to do our work with love, commitment, political action, and freedom dreaming.

MISSION

YEAR ONE ACCOMPLISHMENTS

“I WISH THIS COULD BE”

Main Themes

Infrasturcture Repairs

Housing Justice

Language Justice

Transportation Access

Access to Community Spaces

Healthcare Access and Support

ADVOCACY

HOUSING AND TENANT RIGHTS PETITION

NOVEMBER 13TH, 2024:

To the City of Cloverdale,

The Equity Community Organizing (ECO) Group, along with the undersigned organizations.....

LEARNINGS

NEW BEGINNINGS

OBJECTIVES

Objective 1: Establish a regular, safe space of belonging in Cloverdale

Objective 2: Assist with Establishing Cloverdale Master Plan on Aging Action Team

Objective 3: Increase knowledge of available resources and participate in local Civic Engagement and increase knowledge of local CalAIM services for continuity


EXIT

THANK YOU!