



Alzheimer's Disease and Related Conditions Advisory Committee (ADRCAC)

May 7, 2026 | 10:00 a.m. – 1:00 p.m.



Welcome & Meeting Operations



Carroll De Andreis

Manager, Master Plan for Aging (MPA), Stakeholder Engagement
California Department of Aging (CDA)

Meeting Operations



- **Join by smart phone, tablet, or computer:**

<https://aging-ca-gov.zoom.us/j/86595134724>

- **Join by phone (audio only):**

Tel: (888) 788-0099 | Meeting ID: 870 7120 8675

- **Meeting slides and recording** will be posted to the [CalHHS Alzheimer's Disease & Related Conditions Advisory Committee](#) webpage

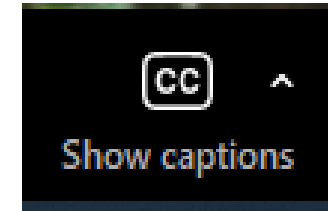
Accessibility



American Sign Language (ASL) interpretation is provided.

Closed Captioning is available during this meeting.

To initiate Closed Captioning (CC):



1. Click the CC icon on the Zoom toolbar
2. Click “Show captions” to display spoken meeting content as text
3. Click “View full transcript” to review previous caption text

If the CC icon does not appear on your toolbar select “More” then select “Captions” and begin at Step 1 above.

Safety and Evacuation for In-Person Meeting Attendees



- In the event of an evacuation order, evacuate the building immediately and remain with a CDA staff member.
- Proceed to the nearest stairwell/main stairway.
- Proceed to the primary relocation site – in front of 2890 Gateway Oaks (building located southwest of the meeting building).
- If the primary relocation is compromised, you will be directed secondary relocation site.
- A CDA staff member is available to support individuals needing evacuation assistance.

Virtual Meeting Operations



- The chat function is enabled for Committee Members, California Department of Aging and other state staff, and invited guests to share meeting-related resources and information. The public will be able to view content in the chat during the meeting.
- We invite the public to provide comments. Please hold comments until the designated Public Comment period(s).
- Additional public comments and questions can be posted in Zoom using the Question & Answer feature or sent via email to Engage@aging.ca.gov.

Public Comment



Time is reserved on the meeting agenda for public comment.

- **In-Person Comments:** Raise your hand or let the designated CDA staff member know you want to make a public comment.
- **Verbal Comments:** “Raise your hand” in the Reactions feature of Zoom or press *9 on your phone dial pad to enter the line for a verbal comment. The moderator will unmute your line and announce your name or the last 4 digits of your phone number.
- **Written Comments:** You may submit comments throughout the meeting using the Zoom Q&A or email Engage@aging.ca.gov.

Note: Public commentators will each have 2 minutes.

Welcome, Introductions & Meeting Minutes



Dr. Wynnelena Canlas Canio

Committee Chair

Behavioral Health Representative

Meeting Agenda



- 10:00 a.m.** | Welcome and Meeting Operations
- 10:05 a.m.** | Call to Order: Welcome, Introductions, & February 2026 Minutes
- 10:15 a.m.** | Opening Remarks from CDA Director
- 10:20 a.m.** | Older Adult Behavioral Health
- 12:00 p.m.** | Break
- 12:15 p.m.** | Legislative Updates
- 12:30 p.m.** | Public Comment
- 12:40 p.m.** | Finalize Recommendations for CalHHS Agency Secretary
- 12:55 p.m.** | Closing Comments, Upcoming Meeting Dates, & Next Steps
- 1:00 p.m.** | Adjourn



Committee Chairs

- **Dr. Wynnelena Canlas Canio**, *Kaiser Permanente, Behavioral Health Rep. (Chair)*
- **Carlos Olivas III**, *Family Member Rep. (Vice Chair)*

Committee Members

- **Senator Jesse Arreguín Rep.**, *Senate Rules Committee Appointee*
- **Sally Bergman**, *Elder Law Rep.*
- **Claire Day**, *Alzheimer's Association, Consumer Organization Rep.*

ADRCAC Member Introductions



ADRCAC Member Introductions (cont.)

- **Dr. Sarah Tomaszewski Farias**, *Alzheimer's Disease Diagnostic & Treatment Centers Rep.*
- **Tony Gonzales**, *Advocate, Persons Living with Alzheimer's or Related Conditions Rep.*
- **Dr. Jerry Jew**, *North-East Medical Services, Organization Providing Services to Persons Living with Alzheimer's or Related Conditions Rep.*
- **Barbra McLendon**, *Alzheimer's Los Angeles, Service Provider Rep.*
- **Dr. Jeanine Lynn Walter-Misirli**, *Kaiser Permanente, Family of Persons Directly Affected by Alzheimer's Disease or Related Conditions Rep.*

ADRCAC Member Introductions (cont.)



- **Dr. William Mobley**, *UC San Diego, Academic Medical Research Rep.*
- **Munir Moon**, *CEO, Persons Living with Alzheimer's or Related Conditions Rep.*
- **Stephanie Navarette**, *Organization providing services to persons living with Alzheimer's or Related Conditions Rep.*
- **Assemblymember Gail Pellerin**, *Speaker of the Assembly Appointee*
- **Dr. Faisal Qazi**, *California Commission on Aging Rep.*

ADRCAC Member Introductions (cont.)



- **Celine Regalia**, *Providence Community Health Napa Valley, Alzheimer's Day Care Resource Center Rep.*
- **Kate Schulenberg**, *San Joaquin Commission on Aging, Family of Persons Directly Affected by Alzheimer's Disease or Related Conditions Rep.*
- **Julie Souliere**, *California Health & Human Services Agency Rep.*
- **Dr. Dolores Gallagher Thompson**, *Stanford University, Social Research Rep.*



California Health and Human Services Agency is seeking to fill vacancies including:

- Individuals and organizations that represent first responders (emergency medical technicians (EMTs), paramedics, law enforcement, and firefighters).
- [Online Application for ADRCAC Member](#)



Committee Question & Answer, and Discussion

Opening Remarks



Susan DeMarois

Director

California Department of Aging (CDA)

Part I: Isolation and Loneliness in Older Adults



Carla Perissinotto, MD, MHS

University of California San Francisco



The effects of Loneliness and Isolation on Health: focus on cognition

CARLA PERISSINOTTO, MD, MHS

PROFESSOR OF MEDICINE

DIVISION OF GERIATRICS

UNIVERSITY OF CALIFORNIA SAN FRANCISCO



Overview

Definitions

Prevalence Rates

Mechanisms

Evidence of Correlations of Loneliness and
Social Isolation with Dementia

Evidence for Interventions

Potential Public Health Impact



1 Story

- ▶ Marvin Schur, 93, WHO FROZE TO DEATH HAD RECEIVED HEAT SHUT-OFF NOTICES

1 Story

BAY CITY

Relatives stunned to learn Marvin Schur died of hypothermia

“his neighbor found him.”

“he fell behind on his bills.”

“he was a loner, except for his marriage.”

“he was a widower.”

“He had no children”

“family had not seen him because of a family feud.”

A Piece of My Mind

July 5, 2022

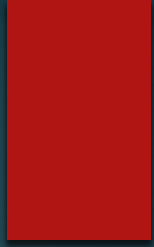
The True Cause of Death

Carla M. Perissinotto, MD, MHS¹

» Author Affiliations

JAMA. 2022;328(1):19-20. doi:10.1001/jama.2022.10406

I had met him at the Over 60 Health Center, a clinic founded by and created for the Gray Panthers, to serve the aging Black Panthers and others in the community. And now a short decade later, he is gone. A self-described lifelong revolutionary, a Black Panther and member of the Black August organizing committee, Roy's life was filled with stories, and those stories culminating into his immediate cause of death—metastatic cancer. His other



“

**Did isolation or
loneliness contribute
to his death?**

IS THERE A DIFFERENCE?



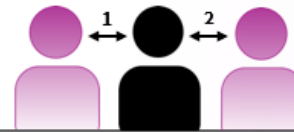
DEFINITIONS

SOCIAL CONNECTION

Is how we relate to and interact with others.

STRUCTURE

(numbers)



FUNCTION

(support, e.g. information, emotional)



QUALITY



LONELINESS

Hurts and happens when your relationships do not match what you want or need.



SOCIAL ISOLATION

Is having very few relationships or not seeing people often enough.



WHO Commission on
Social Connection

How do we Measure Loneliness?

UCLA Loneliness Scale:

1. DO you feel left Out
2. DO you feel Isolated
3. DO You lack companionship



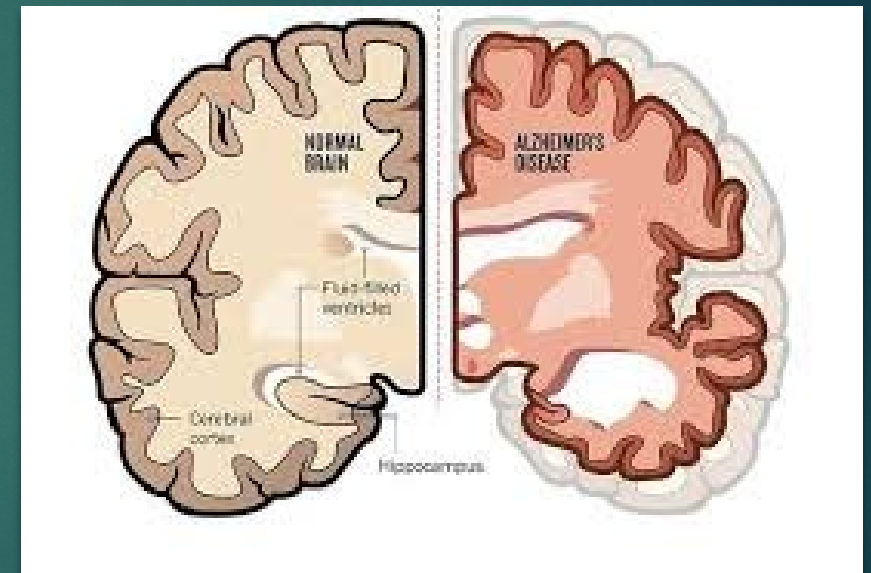
PREVALENCE OF LONELINESS AND SOCIAL ISOLATION (SIL)

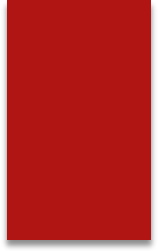
Current Prevalence Rates

- 43% of adults over the age of 60 experience loneliness (24 million)
- 1 in 6 WORLDWIDE
- 1 in 4 report social isolation
- 73% of teens and young adults are struggling with loneliness and social isolation
- Rates highest in young people and low-income countries

Prevalence of Alzheimer's Disease

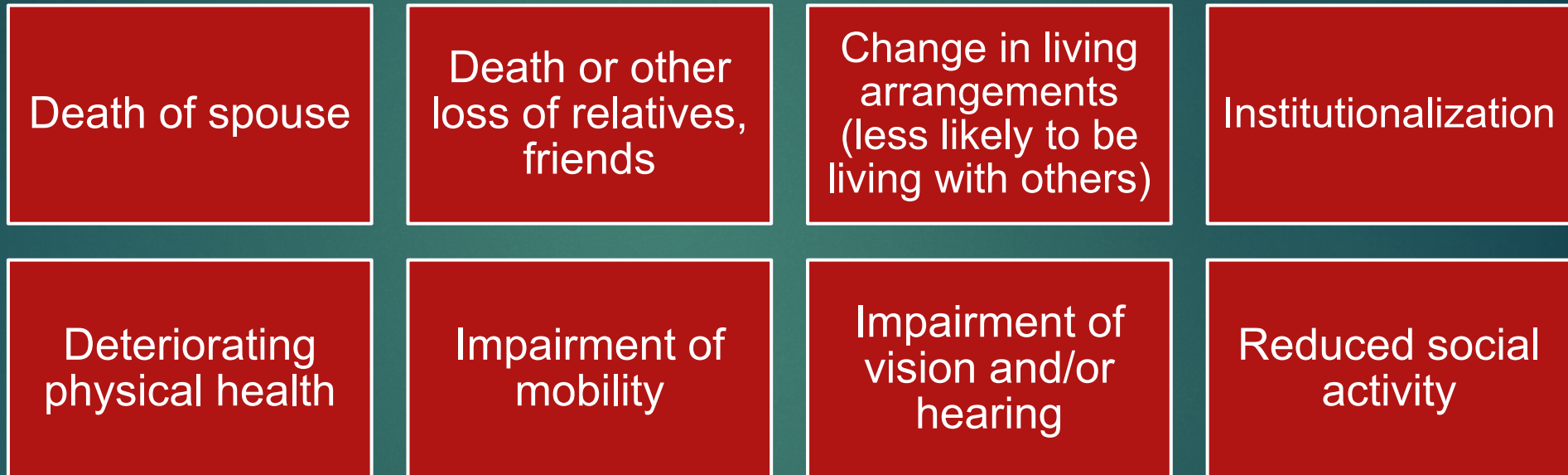
- ▶ 6.7 Million Americans are living with Alzheimer's
 - ▶ 73% are over age 75
 - ▶ Most are women
 - ▶ Older Black Americans and Latin people are at greater risk





Loneliness and Health

Losses predict increases in loneliness at the level of the Individual (and isolation)



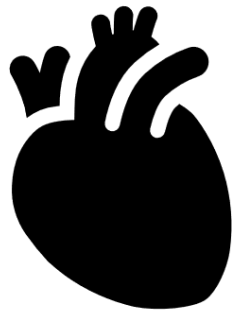
Health Effects



May be harmful at any age, and likely worse for older adults.

Social isolation and loneliness are associated with:

- Worsened heart disease
- Worse control of diabetes
- Poor Sleep and depression
- Frailty and functional decline
- HIGHER health care costs
- Increased mortality
- ****COGNITIVE IMPAIRMENT****



MECHANISMS SPECIFIC TO DEMENTIA

1. Psychosocial stress associated with systemic inflammation and neuroinflammation (which accelerate AD)
2. Specific immunological responses to loneliness (similar to social exclusion)—dysregulation and suppression
3. Loneliness as a correlate of social disengagement with reduced cognitive stimulation and reduced activation of cognitive, social cognitive and social reward circuits; also with reduced social influences on healthy behaviors.
4. Potential reverse causation.

MECHANISMS SPECIFIC TO DEMENTIA

JAMA Psychiatry | [Original Investigation](#)

Association of Higher Cortical Amyloid Burden With Loneliness in Cognitively Normal Older Adults

Nancy J. Donovan, MD; Olivia I. Okereke, MD, SM; Patrizia Vannini, PhD; Rebecca E. Amariglio, PhD;
Dorene M. Rentz, PsyD; Gad A. Marshall, MD; Keith A. Johnson, MD; Reisa A. Sperling, MD

- JAMA Psychiatry: novel association of loneliness being neuropsychiatric symptom for preclinical AD
- Translational Psychiatry: significant association between higher tau pathology in the right entorhinal cortex and greater loneliness
- American Journal of Geriatric Psychiatry: Evidence of low social engagement connected to older adults with AD pathophysiologic change

d'Oleire Uquillas et al. *Translational Psychiatry* (2018)8:282
<https://doi.org/10.1038/s41398-018-0345-x>

Translational Psychiatry

ARTICLE

Open Access

Regional tau pathology and loneliness in cognitively normal older adults

Federico d'Oleire Uquillas¹, Heidi I. L. Jacobs^{2,3}, Kelsey D. Biddle⁴, Michael Properzi¹, Bernard Hanseeuw^{2,5},
Aaron P. Schultz¹, Dorene M. Rentz^{1,4,6}, Keith A. Johnson^{1,2,6}, Reisa A. Sperling^{1,6} and Nancy J. Donovan^{4,6,7}

Amyloid and Cognitive Impairment

JAMA Psychiatry | [Original Investigation](#)

Association of Higher Cortical Amyloid Burden With Loneliness in Cognitively Normal Older Adults

Nancy J. Donovan, MD; Olivia I. Okereke, MD, SM; Patrizia Vannini, PhD; Rebecca E. Amariglio, PhD; Dorene M. Rentz, PsyD; Gad A. Marshall, MD; Keith A. Johnson, MD; Reisa A. Sperling, MD

- Cross-sectional, Harvard Aging Brain Study
- N=79
- Loneliness is seen as a neuropsychiatric symptom in pre-clinical AD
- Loneliness also higher in those APO-e carriers
- Other conclusions:
 - mechanisms stress and inflammatory related
 - Social disengagement associated with cognitive decline in population-based studies of older people, even in those individuals with relatively high baseline cognitive and functional status.

Associations between loneliness & cognitive decline

RESEARCH ARTICLE

International Journal of
Geriatric Psychiatry

Loneliness, depression and cognitive function in older U.S. adults

Nancy J. Donovan^{1,2}, Qiong Wu³, Dorene M. Rentz^{1,2,4}, Reisa A. Sperling^{1,4}, Gad A. Marshall^{1,4} and M. Maria Glymour^{5,6}

¹Center for Alzheimer Research and Treatment, Department of Neurology, Brigham and Women's Hospital, Harvard Medical School, Boston, MA, USA

²Center for Alzheimer Research and Treatment, Department of Psychiatry, Brigham and Women's Hospital, Harvard Medical School, Boston, MA, USA

³Institute of Social Science Survey, Peking University, Peking, China

⁴Department of Neurology, Massachusetts General Hospital, Harvard Medical School, Boston, MA, USA

⁵Department of Social and Behavioral Sciences, Harvard School of Public Health, Boston, MA, USA

⁶Department of Epidemiology and Biostatistics, University of California, San Francisco, USA

Correspondence to: Nancy J. Donovan, MD, E-mail: njdonovan@partners.org

-HRS data (N=8282)
-loneliness at baseline predicted accelerated cognitive decline over 12 years **independent of depression.**

But loneliness and depression are related

AND low cognitive baseline does not lead to worsening loneliness

Loneliness in mid life linked to higher odds for Alzheimer's (Interesting Recent Research)

Social Engagement and Dementia

The Association between Social Engagement, Loneliness, and Risk of Dementia: A Systematic Review and Meta-Analysis

Cite

Article type: Research Article

Authors: Penninkilampi, Ross^a | Casey, Anne-Nicole^{a, b} | Singh, Maria Fiatarone^{c, d} | Brodaty, Henry^{a, b; e; *}

Affiliations: [a] Dementia Centre for Research Collaboration, School of Psychiatry, University of New South Wales, Sydney, Australia | [b] Centre for Healthy Brain Ageing, School of Psychiatry, University of New South Wales, Sydney, Australia | [c] The University of Sydney, faculty of Health Sciences and Sydney Medical School Sydney, NSW, Australia | [d] Hebrew SeniorLife and Jean Mayer USDA Human Nutrition Center on Aging at Tufts University, Boston, MA, USA | [e] Academic Department for Old Age Psychiatry, Prince of Wales Hospital, Randwick, Australia

Correspondence: [*] Correspondence to: Dr. Henry Brodaty, Dementia Centre for Research Collaboration Sydney, AGSM Building, University of New South Wales, Sydney NSW 2052, Australia. E-mail: h.brodaty@unsw.edu.au.

Keywords: Alzheimer's disease, dementia, engagement, loneliness, meta-analysis, socialization, social isolation, systematic review

DOI: 10.3233/JAD-180439

Journal: *Journal of Alzheimer's Disease*, vol. 66, no. 4, pp. 1619-1633, 2018

Accepted 10 October 2018 | **Published:** 12 December 2018

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Supplementary Materials:

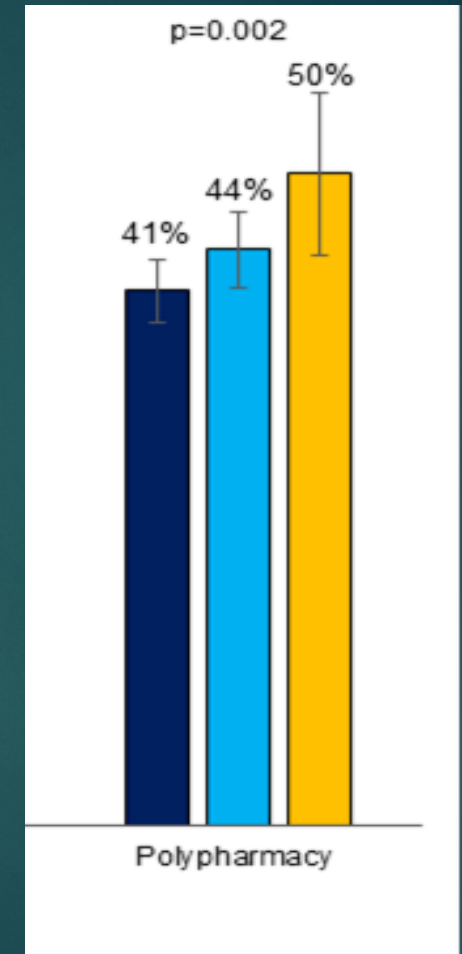
[Supplementary Material](#)

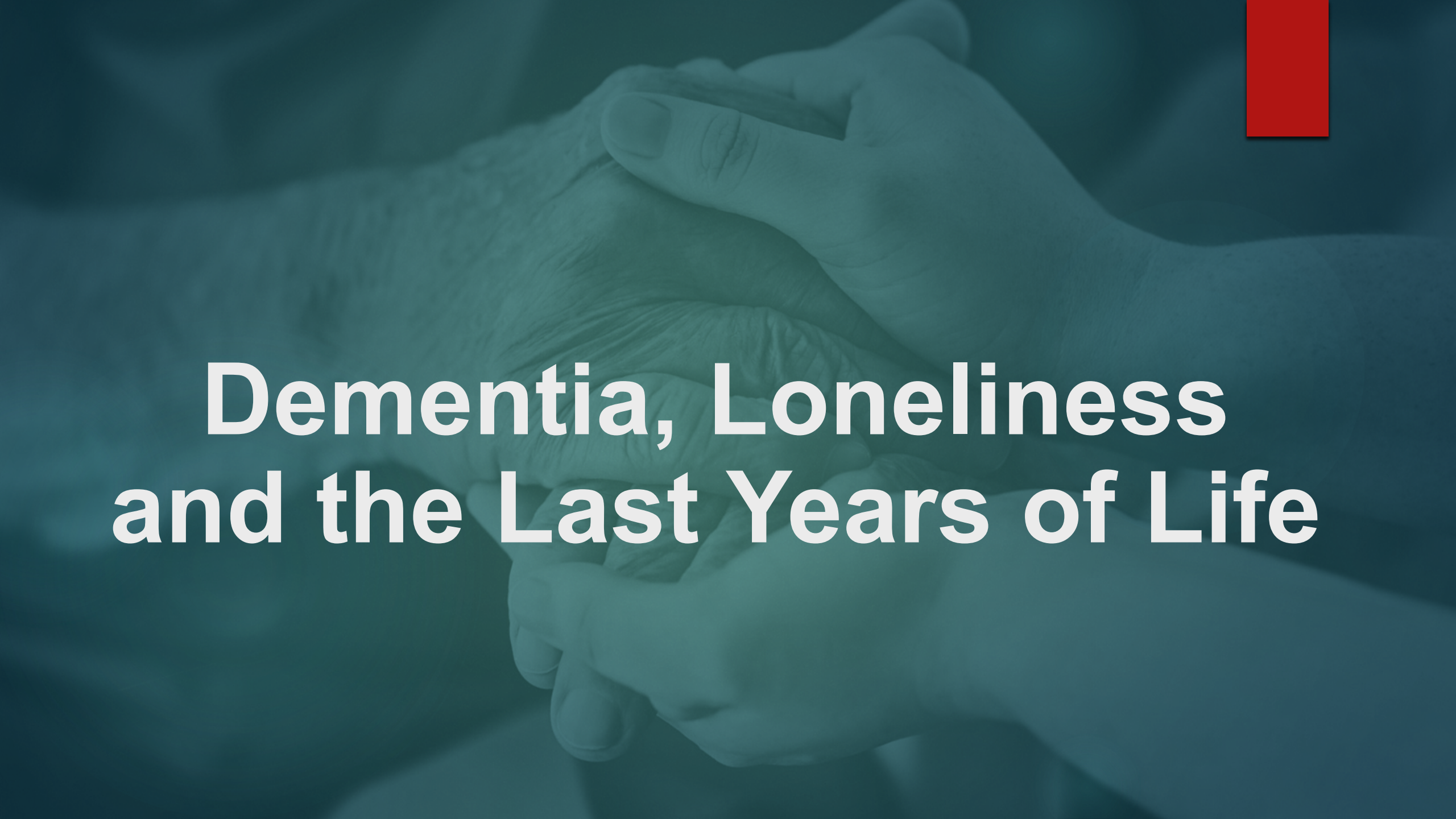
- 31 cohort and 2 case-control studies comprising 2,370,452 participants
- Poor social engagement associated with increased dementia risk (RR= 1.59, 95% CI 1.31–1.96)
- Poor social support (RR= 1.28, 95% CI 1.01–1.62)
- In long-term studies (≥ 10 years), good social engagement was modestly protective (RR= 0.88, 95% CI 0.80–0.96)
- Loneliness was non-significantly associated with increased risk (RR= 1.38, 95% CI 0.98–1.94; $I^2 = 45.32$)

[The Association between Social Engagement, Loneliness, and Risk of Dementia: A Systematic Review and Meta-Analysis](#)

POLYPHARMACY: Loneliness and Physical & Psychological Symptoms

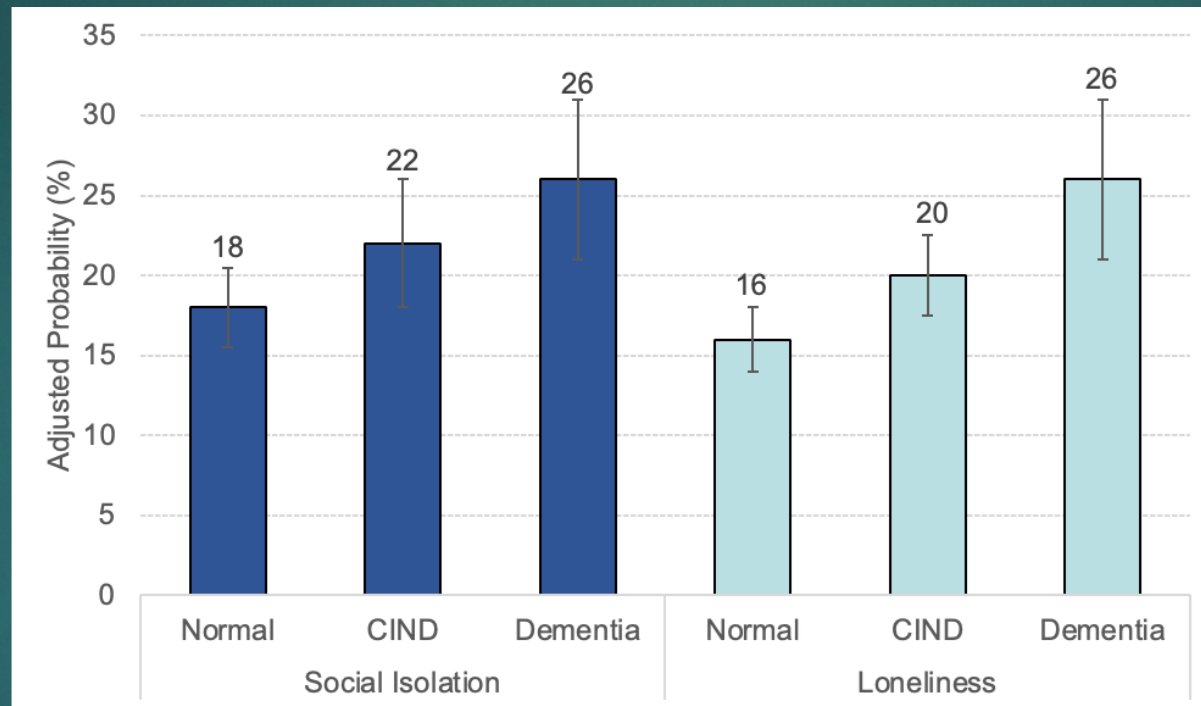
- Lonely older adults experience higher rates of:





Dementia, Loneliness and the Last Years of Life

Older Adults with Cognitive Impairment in the Last Years of Life



*Adjusted for time before death, age, sex, race/ethnicity, and education



At the end of life, socially isolated older adults with cognitive impairment have:

- Lower Hospice Use
- Lower end-of-life acute care (ED, hospital stays, ICU stays)

Experiences of Older Adults Living Alone with Dementia

- Preference of older adult with cognitive impairment
 - Actively avoiding health care and social activities
 - Experiencing shame or self-stigma
 - Concealing impairment from others
- Lack of Tailored Services
 - Difficulty accessing services
 - Example of sudden loss of drivers license

Portacolone, E., Rubinstein, R. L., Covinsky, K. E., Halpern, J., & Johnson, J. K. (2019). The precarity of older adults living alone with cognitive impairment. *The Gerontologist*, 59(2), 271-280.



“

**The voices of those
living with dementia ”**

Stigma & Avoidance

“[Wife]] notices that I-- my memory is not as good as it used to be or should be. Psychological, it's a big downer to know that I have Alzheimer's. **It's embarrassing ...** I think of people that have Alzheimer's as just slobbering, babbling idiots, and social, same thing, **why would I want to go out and look like a slobbering, babbling idiot.**”

Stigma & Avoidance

"My dad, especially when my mom was gone, was very scared and emotional and labile, and easy to trigger, and so a couple friends came by and got sort of scared off and started to get the feeling like, "I'm just-- I'm not helping by being here, so I just won't come." So very quickly, people didn't come. So he was pretty lonely, except for the caregiver and me. And my family. Yeah. I mean, very few visitors. Like, <laughs> yeah, very few."

Translating findings to Practice





TIME TO BENEFIT

How long do we have to experience loneliness before we see the negative health effects?

Or

Can we reduce the risk of negative consequences?

Or

How can we proactively protect our health

Social Prescriptions



Revisiting Our Case:

- Where did he get missed, or forgotten?
- Did anyone consider a social prescription?
- Were there STRUCTURAL issues?
- FUNCTION: he did not have some help with his bills
- QUALITY: he was a loner, bad relationship with family

Clinical Approach

1. Identify Loneliness and Social Isolation

- a. Loneliness: UCLA 3-item questionnaire
- b. Social isolation: Berkman-Syme Social Network Index, Many Others

2. Framework for clinical interventions

- a. Direct interventions: Social support, enhancing interactions, address maladaptive cognition
- b. Indirect interventions: Vision & Hearing, Functional Needs
- c. Downstream consequences: Early Advanced care planning, Address related Symptoms (pain, depression, trauma)

STRUCTURE: Direct: Opportunities for Social Connections

- Community-based programs
 - Peer support programs:
 - “It's just like having a friendship. A lot of folks I don't really want to be friends with. ... It's nice to have someone who you can talk to who doesn't look down on you, who doesn't find fault in anything you say or do, and just looks at you as a person. – Participant, 65-year-old woman”
 - Telephone Support
 - Caregiver support



IS TECH THE SOLUTION?

VIRTUAL CONNECTIONS
ARE NOT A SUBSTITUTE
FOR IN-PERSON
INTERACTIONS

Connectivity gaps intersect with other factors

- Older adults with low educational attainment (less than a high school degree) and incomes below \$25,000 are 10X more likely to be offline
- Ethnicity is a major factor
- Health status
- Geography
- Broadband gap varies by state

Source: [Aging Connected](#) report, OATS and the Humana Foundation (January 2021)

Evidence on interventions

Review

Why Loneliness Interventions Are Unsuccessful: A Call for Precision Health

Samia C. Akhter-Khan^{1,2,*} ✉, Rhoda Au^{3,4}

¹ Department of Psychology, Humboldt University of Berlin, 10117 Berlin, Germany

² Department of Psychology & Neuroscience, Duke University Graduate School, NC 27705, USA

³ Departments of Anatomy & Neurobiology and Neurology, Boston University Alzheimer's Disease Center, Framingham Heart Study, Boston University School of Medicine, Boston, MA 02118, USA

⁴ Department of Epidemiology, Boston University School of Public Health, Boston, MA 02118, USA

* Correspondence: Samia C. Akhter-Khan.

Received: 28 February 2020; Accepted: 15 June 2020; Published: 17 June 2020

This article belongs to the Virtual Special Issue "Heterogeneity in Alzheimer's Disease and Related Dementias"

ABSTRACT

Background: Loneliness has drawn increasing attention over the past few decades due to rising recognition of its close connection with serious health issues, like dementia. Yet, researchers are failing to find solutions to alleviate the globally experienced burden of loneliness.

Purpose: This review aims to shed light on possible reasons for why interventions have been ineffective. We suggest new directions for research on loneliness as it relates to precision health, emerging technologies, digital phenotyping, and machine learning.

- ▶ Need to be clear on measurement and definitions
- ▶ Be aware of heterogeneity
- ▶ Have a theoretical foundation for interventions
- ▶ One size does not fit all
- ▶ Interventions must be tailored

Loneliness and social isolation interventions for older adults: a scoping review of reviews

Summary

- ▶ Social Isolation and loneliness are prevalent
- ▶ There are growing numbers of people living with dementia
- ▶ There is a biological and plausible mechanism for the association of SIL with cognitive impairment (dementia)
- ▶ There are ways to identify SIL
- ▶ The data are overall limited for interventions for SIL (secondary and tertiary prevention)
- ▶ There is a public interest in having medical care incorporate SIL assessments
- ▶ There is hope that the GUIDE model will incorporate more social factors into care

Part II: Living Alone with Alzheimer's Disease and Dementia



Elena Portacolone, PhD, MBA, MPH

Professor, Institute for Health & Aging,
University of California San Francisco



University of California
San Francisco

LIVING ALONE

WITH COGNITIVE IMPAIRMENT



Strategies to support Californians living alone with cognitive impairment

Elena Portacolone, PhD MBA MPH

Institute for Health & Aging

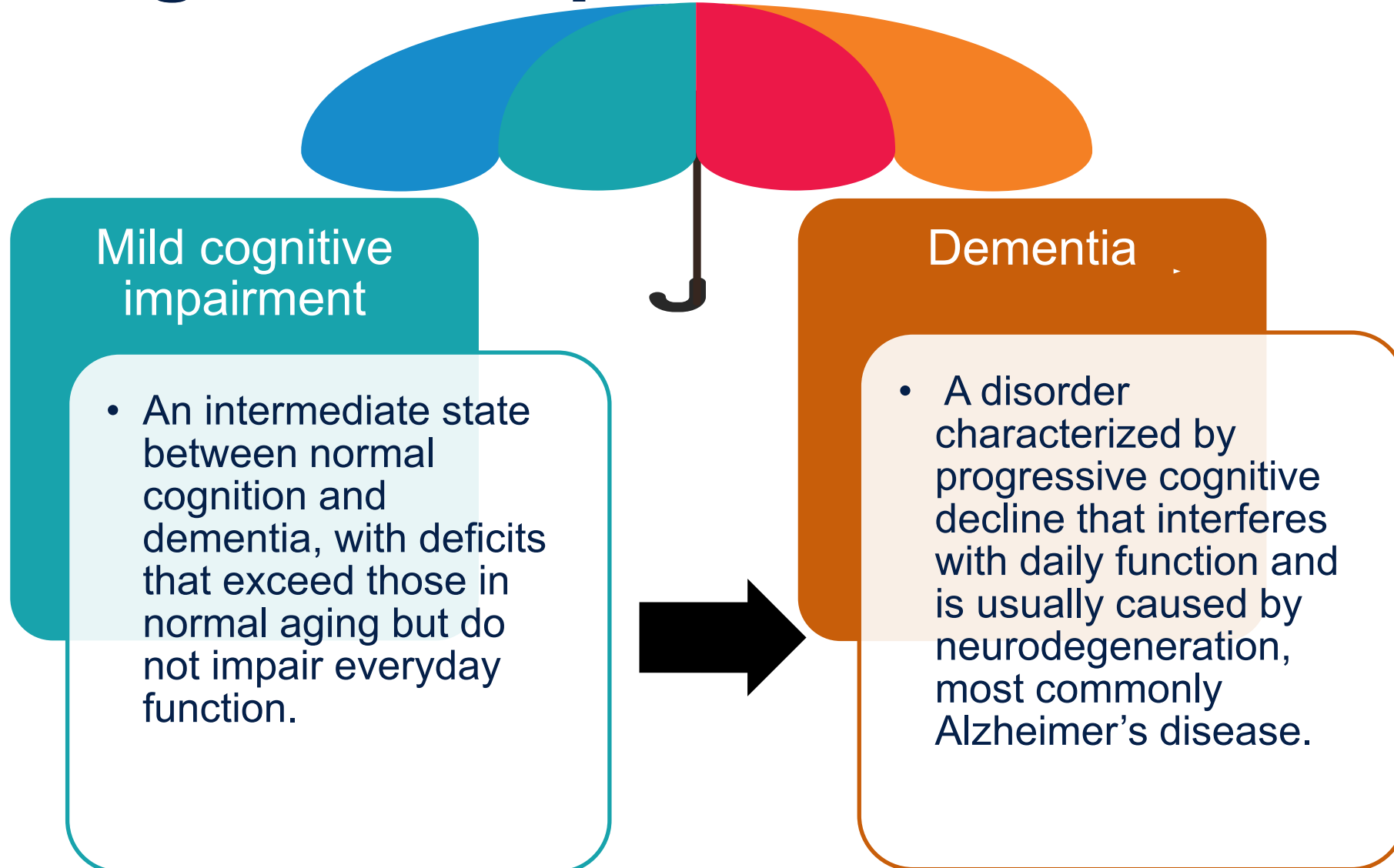
Philip Lee Institute for Health Policy Studies

University of California San Francisco

Elena.Portacolone@ucsf.edu

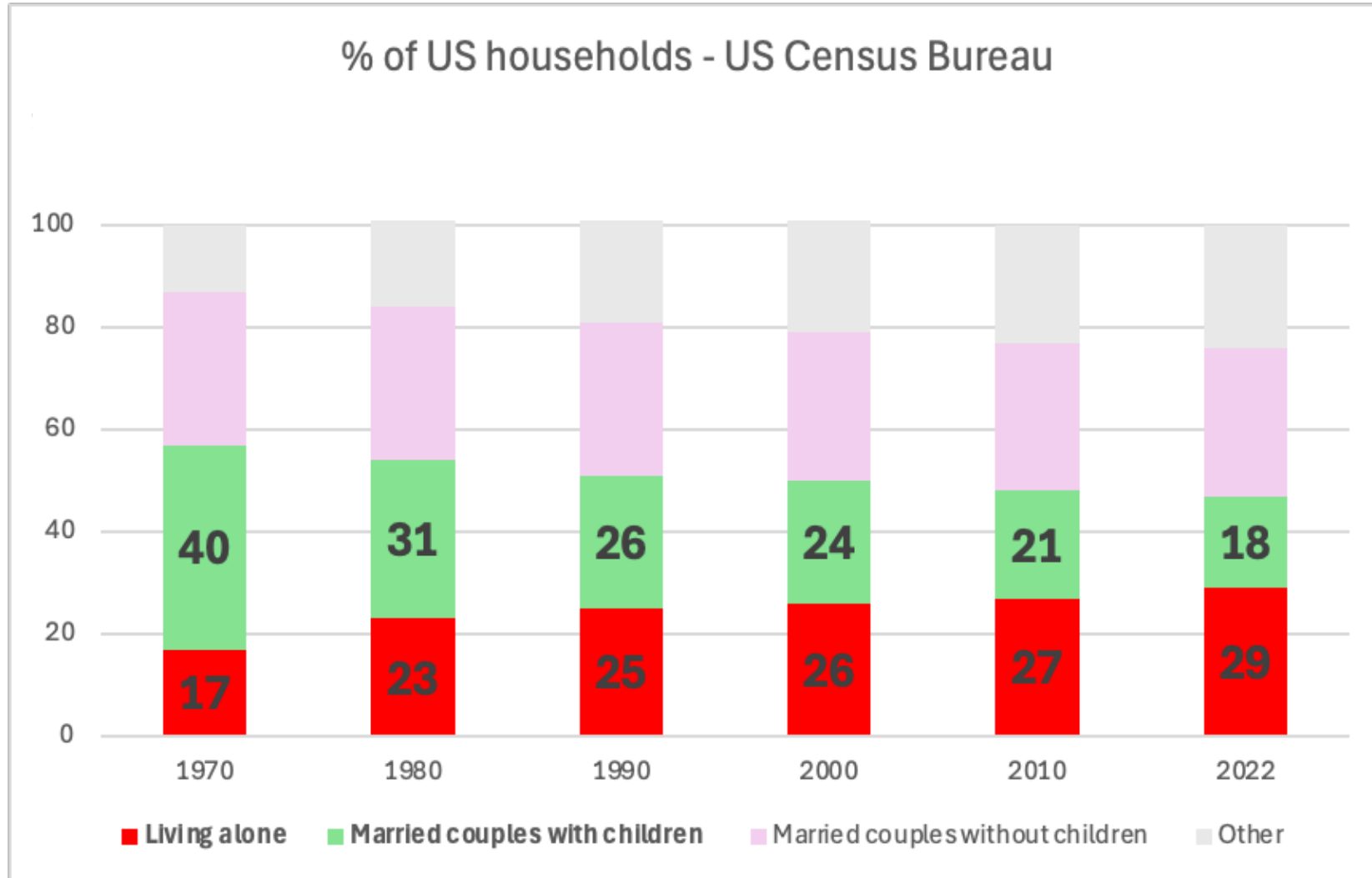
livingalone.ucsf.edu

Cognitive impairment includes:

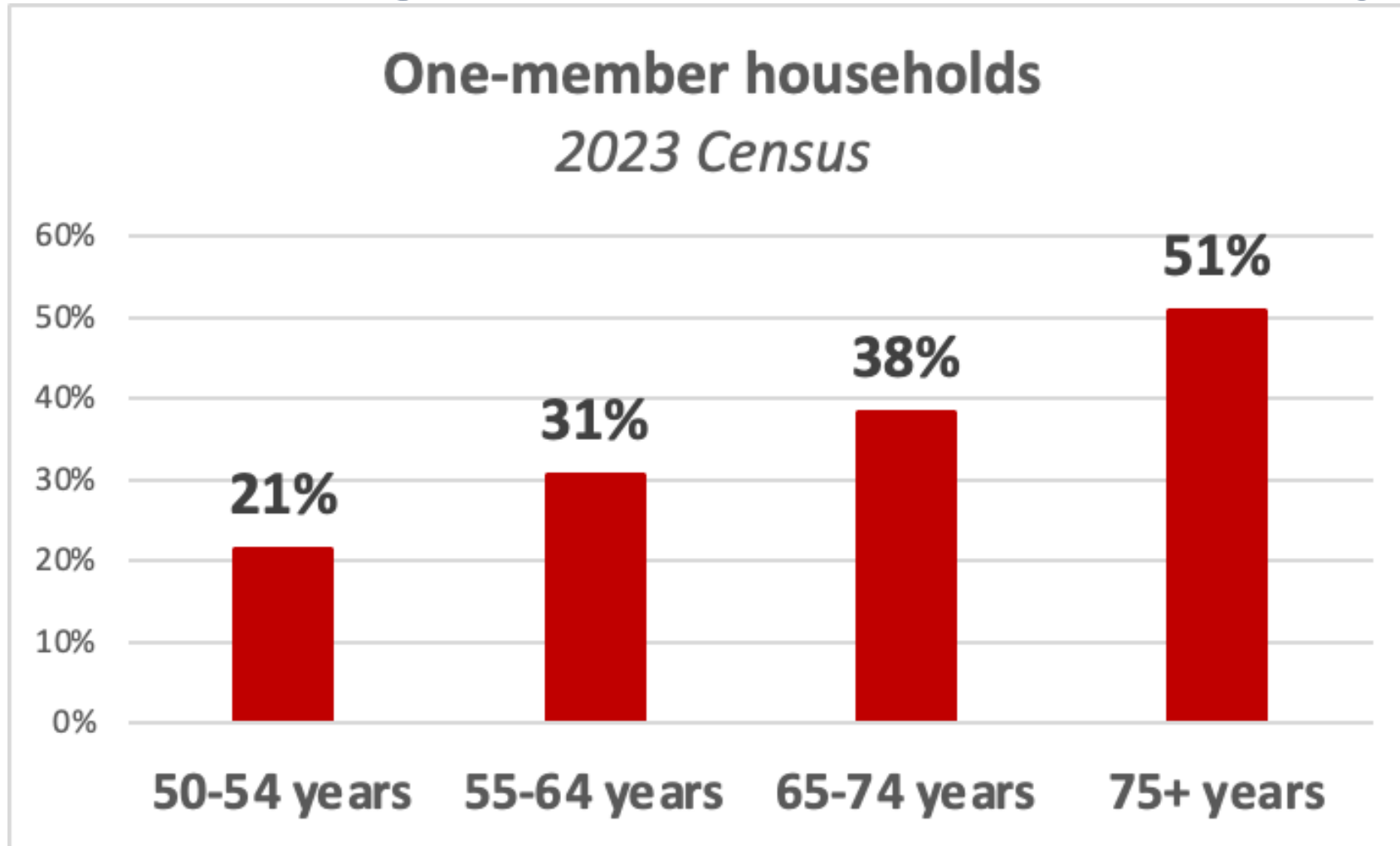




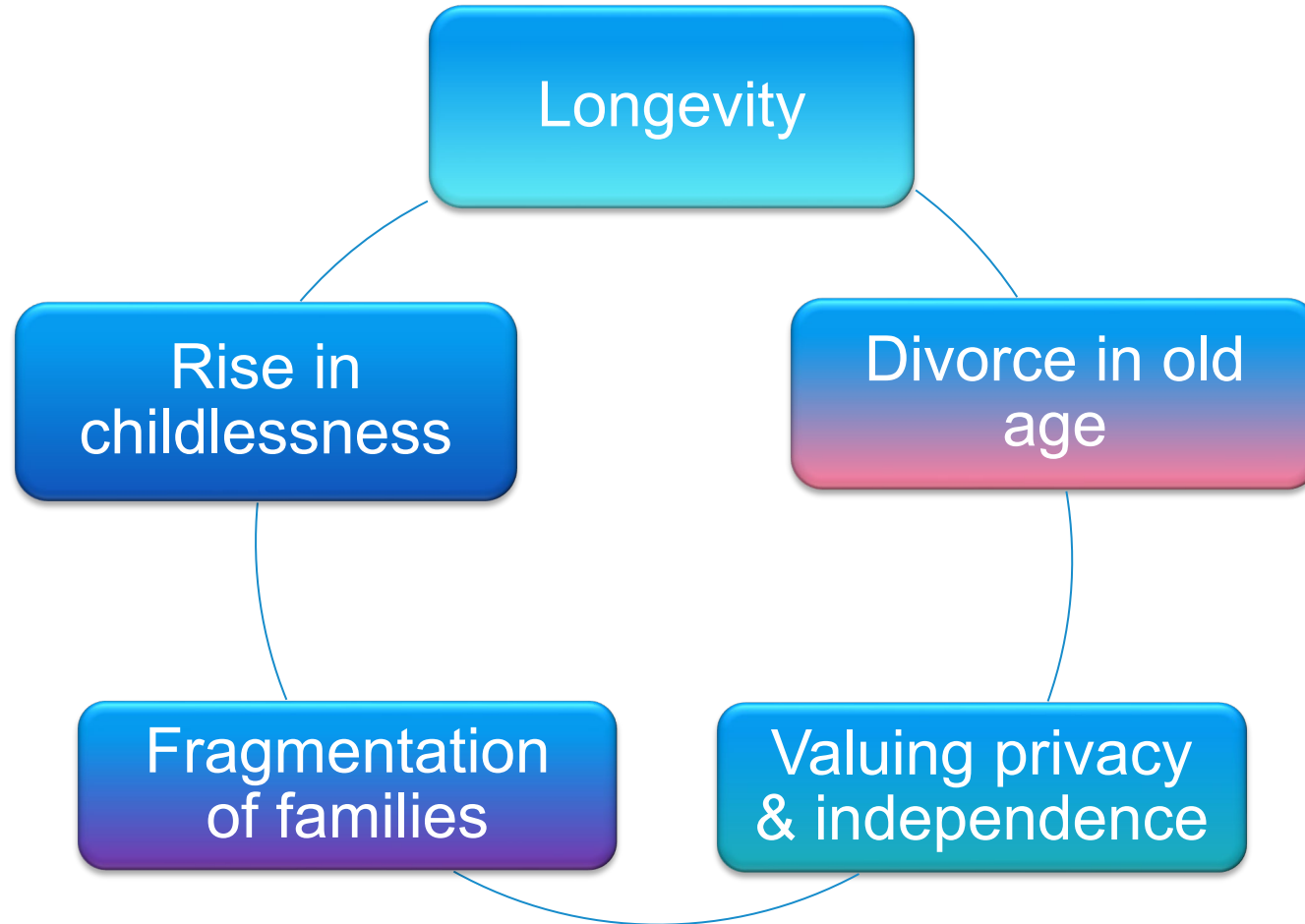
Households with people living alone have **doubled** since 1970



Half of US households with adults aged ≥ 75 consist of only



Living alone in old age is common



1 in 4 older adults with cognitive impairment lives alone in the US – 4.3 million people

Older adults with cognitive impairment who live alone are more likely to:

- be women, older, and Black
- not own a home
- have less wealth
- be widowed, divorced, never married
- not eligible for subsidized home care aides via Medicaid/Medi-Cal

Living alone with cognitive impairment has risks

- **Inadequate support from family members**
- **72%** older adults living alone with cognitive impairment report having **trouble getting any help**
- **Most likely to take at least one high-risk medication and not get help managing medications**
- **Cognitive impairment undiagnosed**
- **Suicide**
- **Vulnerable during natural disasters**

[3 policy briefs](#)

Woman, 93, Dies Trapped in Her Home After Blizzard Hit Southern California Mountains

Twelve people have been confirmed dead since California was first hit with snowfall last month, a spokesperson for the San Bernardino County Sheriff's Department said

By [Charmaine Patterson](#) | Published on March 9, 2023 12:44AM EST

4 Upload Errors
All Errors...

REMEMBERED AS FEISTY LAID WHO LOVED TO

KCAL NEWS CBS NEWS LOS ANGELES

NBA OKLAHOMA CITY 101 PHOENIX 132 F

5/7/2026

“I have a hard time remembering now, I really hate that. That’s tearing me apart. **And I don’t know what to do about that.**” - *Black woman*

I was very upset by this woman [neurologist]. She told me right off the bat I had Alzheimer’s[...] But the lady never explained anything. **And I’m left not knowing what to do about myself.** - *White woman*

“Nobody pushes me. There’s nobody telling me, ‘Did you take your pills already? Come on, take them.’” - *Chinese man*

“My house was always full. [...] And now I’m alone. In the past I wanted to cry. Now I don’t. Now I can talk about it. – *Latina woman*

“I want to end this because I don’t want this monster chasing me because this is a spooky film and I don’t want to live the film.” – *White man*

Recommendation: increase access to home care aides

Expand Medi-Cal eligibility so low-income older adults living alone with cognitive impairment can access Medi-Cal home care, even if they don't currently qualify

Create a state-funded program to provide home care aides to low-income older adults living alone with cognitive impairment who do not qualify for Medi-Cal home care, following models in Connecticut, Massachusetts, and Ohio

Living arrangement field in electronic (medical) records

Brief: Most older adults with cognitive impairment who live alone cannot access home care aides

The opportunity offered by GUIDE



**Organizations implementing GUIDE:
502 US
71 (14%) in CA**

Required Activities of GUIDE

| |
|--|
| 1. Comprehensive assessment , which includes clinical and psychosocial assessments, advance care planning, caregiver's needs assessment, home visit, and annual reassessments. |
| 2. Care plan that is person-centered and accessible by the primary care physician. |
| 3. Caregiver education and support , which includes training in caregiver skills, dementia diagnosis, support groups, plus tailored one-on-one support calls. |
| 4. Caregiver's respite in home , with option to refer beneficiaries with dementia in adult day center. |
| 5. 24/7 access to an interdisciplinary team or helpline. |
| 6. Ongoing monitoring and support via a care navigator with at least quarterly follow-ups. |
| 7. Care coordination and transitional care management , which includes specialists' referrals and recommendations, involvement of the primary care physician, and support with care-home transitions. |
| 8. Medication management and reconciliation , which includes reviews of prescribed medications, plus clinicians' coordination of prescribed medications. |
| 9. Referral and coordination of services & supports , which includes keeping an inventory of local resources, referrals to local supports, and, if applicable, referral to Health and Community Based Services (HCBS) via Medicaid. |

?
Unknown how/if providers manage to use GUIDE to support patients living alone

Elena.Portacolone@ucsf.edu

Cell phone: 510 830 9309



University of California
San Francisco

Patients with dementia without caregivers

All Errors...

Payment Amounts

Model participants will use a set of new G-Codes created for the GUIDE model in order to submit claims for the monthly Dementia Care Monthly Payment (DCMP). The DCMP is intended to cover the model's required care delivery activities.

Per Beneficiary Per Month Payment Rates

| | Monthly payment rates for beneficiaries with caregiver | | | Monthly payment rates for beneficiaries without caregiver | |
|---|--|-------------------------------|---------------------------|---|---|
| | Low complexity dyad tier | Moderate complexity dyad tier | High complexity dyad tier | Low complexity individual tier | Moderate to high complexity individual tier |
| First 6 months (New Beneficiary Payment Rate) | \$150 | \$275 | \$360 | \$230 | \$390 |
| After first 6 months (Established Beneficiary Payment Rate) | \$65 | \$120 | \$220 | \$120 | \$215 |

In order to support accurate billing, CMS will provide each participant with a monthly beneficiary alignment file that lists all beneficiaries aligned to that participant, their model tier assignment, and the length of their alignment to the participant.

MEDICARE

- Medicare Advantage plans with supplemental benefits that offer personal care should target people with cognitive impairment who live alone.
- Expand the Guiding an Improved Dementia Experience (GUIDE) model to allow people with cognitive impairment living alone without caregivers to hire home care services as a benefit equivalent to the respite benefit, which is already offered to caregivers through this demonstration program.

TAX CODE

- Allow tax credits (including refundable tax credits for low-income individuals who do not pay taxes) to older adults with cognitive impairment living alone who hire home care aides.
- Allow family caregivers of older adults with cognitive impairment who live alone to earn Social Security credits as part of their employment history.

Part III: Elevating the Voices of Individuals with Dementia and Caregivers and Behavioral Health



Carlos Olivas
Committee Vice-Chair

Dr. Wynnelena Canlas Canio
Committee Chair

Part IV: Understanding the Behavioral Health Services Act (BHSA)



Ana Acton

Assistant Deputy Director

CDA Division of Policy, Research, and Engagement

Barbra McLendon

**Associate Vice President, Public Policy,
Alzheimer's Los Angeles**



Understanding Behavioral Health Services Act

**Ana Acton, Assistant Deputy Director,
California Department of Aging**

May 7, 2026

Overview – Behavioral Health Transformation



Why: Modernize the BH Delivery System

How: March 2024 Voters Passed Proposition 1, including:

- 1. Behavioral Health Infrastructure Bond Act:** \$6.38 billion bond to construct, acquire, and rehabilitate behavioral health treatment beds, supportive housing units, and community sites.
- 2. Behavioral Health Services Act (BHSA)*:** reforms the Mental Health Services Act (MHSA), originally passed in 2004, by expanding services to include treatment for SUD, modernizing county funding allocations, and updating reporting requirements to focus on outcomes, accountability, and equity.

****Our efforts focus on the Behavioral Health Services Act***



Understanding the State's Role in BHSA Implementation

State-Level Investments and Initiatives



- **Lead Oversight and Implementation:** Department of Health Care Services (DHCS)
- **Workforce initiatives:** Department of Health Care Access and Information (HCAI)
- **Population-Based Prevention:** California Department of Public Health (CDPH)
- **Development of Outcome Measures:** DHCS





Understanding the Counties' Role in BHSA Implementation

Counties' Funding and Roles



90% of BHSA
funding goes to
Counties

Housing Intervention Programs (30%)

Full-Service Partnership (35%)

Behavioral Health Services and
Supports (35%)

Focus on: Behavioral Health Services and Supports Funding



Behavioral Health Services and Supports (BHSS) Funding:

- At least 51% of BHSS Funds shall be used for Early Intervention programs and services.
- At least 51% of funding allocated for Early Intervention programs and services must be used to serve people 25 years of age and younger.

Early Intervention Programs



- Counties are required to establish **Early Intervention Programs**
 - Designed to prevent mental illnesses and SUDs from becoming severe and disabling, while also addressing disparities in behavioral health outcomes.
 - Outreach to individuals and communities;
 - Access and linkage to medically necessary care; and,
 - Treatment services aimed at preventing the progression of behavioral health conditions
- Examples of Early Intervention Programs Targeting Older Adults

County Integrated Plans



Counties must engage with local stakeholders to develop each element of their Integrated Plan. Required stakeholder groups include:

- People with lived experience (including older adults and caregivers)
- Area Agencies on Aging
- Independent Living Centers
- Community-based organizations serving diverse communities
- Behavioral health providers, peers, and workforce representatives
- Other

Opportunities to Influence: Stakeholder Committees



- Behavioral Health Task Force (CalHHS)
- Behavioral Health Planning Council (DHCS)
- California Interagency Council on Homelessness (Cal ICH; co-led by CalHHS and BCSH)
- Behavioral Health Services Act Oversight and Accountability Commission (BHSAOAC)
- Also note: California Commission on Aging focus on OABH

Opportunities to Influence: Counties



How to support local partners in advocating for OABH investments at the county level?

Opportunities:

- County Integrated Planning Process
- County BHSA Stakeholder Engagement



Behavioral Health Services Act (BHSA): County Toolkit

Introduction

In March 2024, California voters passed Proposition 1, consisting of the Behavioral Health Services Act (BHSA) and the Behavioral Health Infrastructure Bond Act of 2024 (BHIBA). Together, the BHSA and the BHIBA build on California's broader efforts to reimagine and strengthen the entire behavioral health system—connecting services, expanding access, and improving outcomes for all Californians.

Proposition 1 is intended to enact sweeping behavioral health transformation by improving access to care, increasing accountability and transparency, and expanding the capacity of behavioral health facilities. The BHSA modernizes and expands upon the original Mental Health Services Act (MHSA) of 2004 to more effectively address the behavioral health needs of Californians. The BHIBA provides \$6.4 billion in funding for behavioral health treatment beds, residential care, supportive housing, community sites, and housing with a special emphasis on veterans with behavioral health needs. To review the state roles in Proposition 1, see **Appendix C**.

The BHSA includes new opportunities to address older adults' behavioral health needs. This marks a pivotal moment for stakeholders in the aging network to ensure older

Resources



- **California Department of Aging Older Adult Behavioral Health Resources for Stakeholders**: County toolkits and 2025 Behavioral Health Older Adult Survey Report
- **California Friendship Line**: 24/7 Warmline for adults ages 60 and older, adults with disabilities, and their caregivers
- **Landscape of California's Home and Community Based Services**: Designed for policymakers, service providers, and local planners



Committee Question & Answer, and Discussion



Break

The meeting will resume in 15 minutes

Legislative Updates



Tina Fung

Chief, Alzheimer's Disease Section
California Department of Public Health

Barbra McLendon

Associate Vice President, Public Policy,
Alzheimer's Los Angeles

Andrew Mendoza

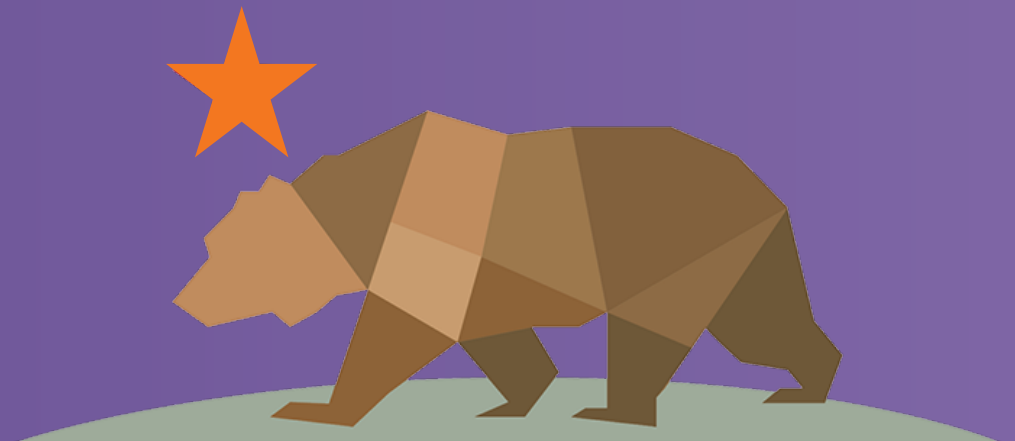
Government Relations Director, Alzheimer's Association



2026 State Legislative Session Update

Barbra McLendon, MSW
Associate VP, Public Policy

bmclendon@alzla.org





2026 State Legislation

Research Funding

SB 895 – California Science and Health Research Bond Act.

- Would establish the California Foundation for Science and Health Research
- Topics funded include biomedical, behavioral, and climate research
- Authorizes issuance of bonds up to \$23b
- If passed, would be on ballot of next statewide election



State Budget Request

Genetic Information and Access to Insurance

- **AB 1798 (Wilson- D)- Genetic Testing for Life and Disability Insurance.** The bill prohibits disability and life insurance carriers from seeking out genetic testing information and using that information to deny or cancel coverage.



State Legislation

Healthcare Legislation

- **SB 1088 (Blakespear-D) – Life Sustaining Treatment.**
Would allow POLST forms to be signed by Physician Assistants and Nurse Practitioners.

[Coalition for Compassionate Care of California](#)



State Legislation

Caregiver Legislation

- **SB 1149 (Durazo-D) – Expands access to up to five days of bereavement leave** by expanding the definition of family member to include a designated person [Press release](#)



State Legislation

Emergency Preparedness

SB 837 – Disaster and Emergency Preparedness

- Requires Aging and Disability Resource Connection programs to provide disaster and emergency preparedness training specifically designed to help older adults and people with disabilities prepare for emergencies and ensure their safety before, during, and after natural disasters and other emergency events.
- Requires that the training raise awareness of existing resources and guidance such as those developed by the CA Department of Aging.



State Legislation

Bill Package to reduce bureaucratic barriers and damage from H.R. 1- Support

- **AB 2161 (Bonta-D) - Medi-Cal work or community engagement requirements in HR 1.** Protect some Medi-Cal enrollees from harmful work requirements
- **AB 2201 (Boerner-D) - 6-month Medi-Cal redeterminations.**
Reduce renewal paperwork and administrative hurdles
- **AB 2208 (Stefani-D) - Medi-Cal cost sharing**
Ensure access to care through retroactive coverage and limited cost-sharing
- **SB 1202 (Weber-Pierson-D) - Medi-Cal dashboard and outreach**
Improve transparency and outreach on upcoming changes so Californians can be prepared

[Press release](#)

Alzheimer's Association Legislative Priorities

Andrew Mendoza, Government Relations Director


ALZHEIMER'S  ASSOCIATION®

SB 950 (Weber Pierson): Healthcare Coverage: Alzheimer's Treatment




Our sponsored bill requires state regulated private health insurance plans to cover FDA approved treatments for Alzheimer's disease, bans step therapy for anti-amyloid therapies, provides non-restrictive coverage criteria and makes denial appeals exigent circumstance.

This legislation improves access to disease modifying treatments for people with early onset Alzheimer's disease.

SB 950 – CHBRP Analysis



Senate Bill 950
Dementia
Analysis at a Glance
as introduced on 2/2/2026

| Bill Summary | Context and Benefit Coverage |
|---|--|
| <p>SB 950 would require coverage of all FDA-approved treatments for Alzheimer's disease and would prohibit step therapy for specified medications.</p> <p>Alzheimer's disease: A progressive, irreversible, neurological condition</p> <p>First symptoms include: memory, language, and cognitive processing challenges</p> | <p>Two types of medications that treat Alzheimer's disease:</p> <div style="display: flex; justify-content: space-around; align-items: center;">  Treat symptoms or  Slow rate of disease </div> <p>Barriers to treatment:</p> <ul style="list-style-type: none"> • Receiving a diagnosis • Limited supply of treating clinicians • Narrow eligibility for medication • Requires specialized testing and facilities <p>~4,800 CA adults aged 35-64 years have Alzheimer's disease (less than 1% of the total CA population with Alzheimer's disease)</p> <p>No enrollees have fully compliant coverage at baseline. <10% to 93%: baseline coverage of medications to treat symptoms 88%: baseline coverage for disease-modifying medications</p> |
| Insurance Subject to the Mandate | Utilization and Expenditures |
| <p>With 22.8 million Californians enrolled in state regulated insurance...</p> <div style="display: flex; align-items: center;">  <div style="margin-left: 10px;"> <p>13.8 million enrollees would have health insurance subject to SB 950.</p> </div> </div> <p><input checked="" type="checkbox"/> CDI and DMHC-Regulated (Commercial and CalPERS)</p> <p><input checked="" type="checkbox"/> Medi-Cal</p> | <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Receiving medications to treat symptoms</p> <p>Enrollees at Baseline: 1,086 Postmandate: +66</p> <p>+ \$660,000 in total annual premiums paid by employers & enrollees</p> </div> <div style="width: 45%;"> <p>Receiving disease-modifying medications</p> <p>Enrollees at Baseline: 89 Postmandate: +23</p> <p>+ \$0.03 in premiums per member per month</p> </div> </div> <p>+ \$1,310 - \$1,990 average annual cost sharing increase per new user of medications (both types)</p> |
| Public Health | How Effective are Alzheimer's Medications? |
| <p>No measurable public health impact due to small estimated increase in utilization and small population of patients aged 35-64 years with mild symptoms of Alzheimer's disease.</p> | <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>Medications to Treat Symptoms</p> <p>Evidence Varies - medications show generally small and inconsistent effects across medications, severity of disease, and outcomes</p> </div> <div style="width: 45%;"> <p>Disease-Modifying</p> <p>Some evidence - slow cognitive and functional decline</p> <p>Some evidence of harms (ARIA-E and ARIA-H) that are often asymptomatic but can occasionally result in serious harm</p> </div> </div> |
| <p>California Health Benefits Review Program (CHBRP), amyloid related imaging abnormalities (ARIA), California (CA), California Public Employee's Retirement System (CalPERS), California Department of Insurance (CDI), California Department of Managed Health Care (DMHC), Food and Drug Administration (FDA)</p> <p>www.chbrp.org</p> | |

There would be an extremely low cost resulting in a 3-cent increase for enrollees per month. Cost sharing would be \$1,310-1,990 for new users accessing both types of treatment.

SB 950 – CHBRP Analysis

Coverage for FDA approved treatments of Alzheimer’s varied with 88% of plans covering disease-modifying and 7%-93% covering the symptomatic treatments.

Table 2. Impacts of SB 950 on Benefit Coverage, 2027

| | Baseline | Postmandate | Increase/Decrease | Percentage Change |
|--|------------|-------------|-------------------|-------------------|
| Total enrollees with health insurance subject to state benefit mandates (a) | 22,842,000 | 22,842,000 | 0 | 0.00% |
| Total enrollees with health insurance subject to SB950 | 13,799,000 | 13,799,000 | 0 | 0.00% |
| Percentage of enrollees with fully compliant coverage for mandated benefit via medical benefit | | | | |
| Lecanemab (infusion) | 88% | 100% | 12% | 14.25% |
| Donanemab (infusion) | 88% | 100% | 12% | 14.25% |
| Percentage of enrollees with fully compliant coverage for mandated benefit via pharmacy benefit | | | | |
| Donepezil | 93% | 100% | 7% | 7.41% |
| Galantamine | 93% | 100% | 7% | 7.41% |
| Benzgalantamine | 7% | 100% | 93% | 1,397.85% |
| Rivastigmine | 33% | 100% | 67% | 200.46% |
| Memantine + Donepezil Combination | 12% | 100% | 88% | 718.49% |
| Memantine | 93% | 100% | 7% | 7.41% |

Current as of April 5, 2026

13

chbrp.org

Analysis of California Senate Bill 950



| | | | | |
|--------------------------|-----|------|------|---------|
| Lecanemab (subcutaneous) | 25% | 100% | 75% | 293.53% |
| Lecanemab (infusion) | 0% | 100% | 100% | 0.00% |
| Donanemab (infusion) | 0% | 100% | 100% | 0.00% |

Source: California Health Benefits Review Program, 2026.

Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.²²
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

Budget Request: Dementia Care Aware

Our sponsored \$5.4 million general fund budget request would sustain Dementia Care Aware for three years to train primary care teams on dementia screening, care navigation and case management.

Dementia Care Aware has trained more than 7,250 healthcare professionals - largely clinical providers - in nearly every county through remote and in-person sessions for free CEUs/CMEs.

AB 2052 (Stefani): Older and Dependent Adult Victims – Vertical Prosecutions

Our sponsored bill provides ‘Good Cause’ to a prosecutor assigned to a case, where a dependent or older adult is the victim in the alleged offense, to receive a continuance when needed in court for other obligations.

This bill supports District Attorneys who dedicate resources for Elder Abuse units with vertical prosecutions, where an attorney handles each stage of the case without handoffs.

SB 971 (Choi): Healthy Aging

This bill provides that a local health department, AAA, school district, or other county department, may establish community-based programs for older adults designed to promote healthy aging, social engagement, and independent living in collaboration with relevant local entities.

SB 991 (Menjivar) & AB 2135 (Kalra)

SB 991 requires the Department of Social Services to report the types of abuse substantiated as a violation at RCFEs.

AB 2135 requires long-term care facilities to provide residents with a notice of transfer or discharge at least 30 days before, and for the notice to be translated and signed by the individual and/or their representative.

SB 1047 (Niello): FTD

This bill expands data collection and reporting requirements for the California Neurodegenerative Disease Registry Program (CNDRP) to include frontotemporal degeneration.

This legislation also extends the CNDRP until January 1, 2030.

Public Comment



Time is reserved on the meeting agenda for public comment.

- **In-Person Comments:** Raise your hand or let the designated CDA staff member know you want to make a public comment.
- **Verbal Comments:** “Raise your hand” in the Reactions feature of Zoom or press *9 on your phone dial pad to enter the line for a verbal comment. The moderator will unmute your line and announce your name or the last 4 digits of your phone number.
- **Written Comments:** You may submit comments throughout the meeting using the Zoom Q&A or email Engage@aging.ca.gov.

Note: Public commentators will each have 2 minutes.



Finalize Recommendations for CalHHS Secretary Johnson and Meeting Topic Suggestions

2026 Meeting Schedule



- **August 6, 2026**
- **October 29, 2026**

Committee meetings held in-person in Sacramento with a virtual option

Meeting Resources



- [Master Plan for Aging \(MPA\)](#)
- [CalHHS Alzheimer's Disease & Related Conditions Advisory Committee](#)
- [ADRCAC Member Biographies](#)
- [Online Application for ADRCAC Member](#)
- [Health at Home Challenge](#)
- [No Wrong Door Report](#)
- [Fifth MPA Annual Report](#)
- [California Department of Aging \(CDA\)](#)
- [California Department of Aging: Older Adult Behavioral Health Resources for Stakeholders](#)
- [California Friendship Line](#)



Visit the [CalHHS Alzheimer's Disease & Related Conditions Advisory Committee](#) webpage for:

- ❖ More information about the Committee
- ❖ Upcoming meeting dates
- ❖ Presentations and recordings of past meetings

**Thank
you!**

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