

# Living With Dignity In San Francisco

A strategic plan to make improvements in the network of community-based long term care and supportive services for older adults and adults with disabilities



## Part One of Two 2009-2013

- The Vision
- The Challenges
- Goals, Strategies & Objectives

Facilitating the coordination of home, community-based, and institutional services

Expanding the capacity of home and community-based services

Preparing for the increasing needs of older adults and adults of all ages with disabilities

**Long Term Care Coordinating Council  
Department of Aging and Adult Services  
City and County of San Francisco**

**February 2009**

**Living With Dignity In San Francisco**  
**Strategic Plan 2009 – 2013**

**The Vision**  
**The Challenges**  
**Goals, Strategies & Objectives**

**Part One of Two**

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## **BACKGROUND**

*Outcomes of the 2004 Living With Dignity Strategic Plan: Accomplishments and Challenges*

*Development of the 2009 Living With Dignity Plan Update*

## **TODAY'S LONG TERM CARE ENVIRONMENT**

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*San Francisco's Adults with Disabilities (All Ages)*

*Low- and Moderate-Income Populations*

*Issues Related to Dementia*

*Medically Complex Needs and High-Risk Circumstances*

*New Policy Trends Since 2004*

1. San Francisco Lawsuit Settlements
2. Implementation of Existing Medicaid Home and Community-Based Services Waivers
3. Efforts to Develop a New Medicaid Home and Community-Based Services Waiver specifically for San Francisco
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*Other Current and Promising Innovations*

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2. *Project 2020*: Building on the Promise of Home and Community-Based Services
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## **STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS**

*Overview*

*Key Findings*

*The Role of the Long-Term Care Coordinating Council*

## EXECUTIVE SUMMARY

San Francisco has some of the most creative and effective community-based long term care programs in the country. But the City does not yet have: (1) a well coordinated network of home, community-based and institutional long term care services; and (2) fully-developed mechanisms to expand the needed home and community-based services as the consumer population grows.

San Francisco's Long Term Care Coordinating Council (LTCCC) is responsible to oversee the implementation of the *Living With Dignity Strategic Plan (2009-2013)*. The critical question for the LTCCC is: how to ensure the provision of high quality community-based care and support for older adults and adults with disabilities who are able to live in the community? Furthermore, how can the network of long term care services support individuals in San Francisco to thrive in the community, thereby improving quality of life and preventing the need for high levels of care? San Francisco will need to address these challenges in the context of a growing population of individuals needing long-term care supports and shrinking resources due to the struggling economy.

Over the last four years (2004-2008), the LTCCC oversaw the implementation of the original *Living With Dignity in San Francisco* strategic plan (LWD plan), which focused on creating a more integrated model of service delivery. Since the conclusion of the original LWD plan timeline, in March 2008 a follow-up strategic planning process was initiated under the guidance of a new LWD Strategic Plan Steering Committee. This body oversaw the research as well as the development of the findings and recommendations required to make continued improvements in San Francisco's long term care and supportive services. These continued improvements will build on the momentum started by the successful implementation of the original 2004 LWD Plan. This document, the *Living With Dignity Strategic Plan 2009 - 2013*, is the result of the strategic planning process undertaken from March through October 2008.

This plan is intended to be used by the LTCCC to guide its oversight of the implementation of the recommended improvements in long term care service delivery. Each of the goals, strategies and objectives included in this plan is the result of the extensive investigation of the strengths and weaknesses of the current long term care service delivery network in San Francisco, and the opportunities and threats that exist in the local, state and federal environments. Unfortunately, those threats are likely to include state and federal budget cuts due to: (1) the slowing economy, (2) the national credit crunch, and (3) the troubled housing market. The San Francisco Mayor's Office is also projecting budget shortfalls are expected at the local level in the current and next several fiscal years.

It is intended that the LTCCC will evaluate this plan's recommendations in light of the current environment and decide which specific goals, strategies and objectives it would like to focus on each year, over the next four years.

**The mission** of this plan is to improve the provision of long term care and supportive services so they assure dignity, independence, and choice for the older adults (60+ years of age), adults with disabilities of all ages (18+ years of age), and informal caregivers who need assistance and require care or support.

**The values** in this plan emphasize:

- ❖ An independent living philosophy, which encompasses consumer choice and participation;
- ❖ An inherent respect for the people we serve and with whom we work; and
- ❖ A focus on high quality, culturally and linguistically appropriate services and support.

**The vision** of the Long Term Care Coordinating Council is that long term care and supportive services will be provided through a well coordinated service delivery network that will enable older adults and adults with disabilities of all income levels to remain as independent as possible in their homes and communities in the most integrated settings. Services will be provided by a range of community-based service providers and public agencies that collaborate effectively as part of a proactive public-private partnership. The network will include home and community-based services and, for those who require it, institutional care. The services and service delivery systems will be continuously monitored to evaluate the quality of services and the success of incremental improvements being made.

The network will be consumer-responsive and user-friendly, giving consumers and caregivers choices in the services they receive and opportunities to participate in oversight and accountability. Consumer direction is an option for consumers that will increase control, independence, and choice. No matter where people enter the network of services, they will get the information and services they need in a culturally and linguistically appropriate manner. Proactive outreach will be undertaken to those older adults and adults with disabilities who are isolated and alone, and often homebound.

At the heart of this plan are six broad goals, which will be achieved through the implementation of specific strategies and action-based objectives. The following goals and strategies provide an overview of the recommended improvements for the LTCCC and the community's stakeholders to pursue over the next four years. Specific objectives for each strategy are described in detail in the body of the full plan. During this four-year implementation period, regular public updates will be provided at LTCCC meetings.

## **GOAL 1. IMPROVE QUALITY OF LIFE**

### *Strategies:*

- A. Facilitate San Francisco becoming a city of “aging and disability friendly” communities.
- B. Support efforts to provide what older adults and persons with disabilities of all ages require to have a “good life.”<sup>1</sup>
- C. Optimize the physical and mental well-being of older adults and adults with disabilities.
- D. Assist moderate-income older adults and adults with disabilities who choose to live at home as they age - with resources, friends, and community connections that enable an active, healthy, and safe life.
- E. Advocate for nursing facilities to become interdisciplinary social-health models.

## **GOAL 2: ESTABLISH BETTER COORDINATION OF SERVICES**

### *Strategies:*

- A. Enable better transitions between home, community-based, and institutional long term care and supportive services.
- B. Improve how case management programs work together to coordinate care and services.
- C. Expand efforts to collaborate with existing and new partners.

## **GOAL 3: INCREASE ACCESS TO SERVICES**

### *Strategies:*

- A. Expand and improve information, referral and assistance services for people who are actively seeking services.
- B. Maintain community partnerships for vulnerable older adults and adults with disabilities in underserved communities.
- C. Create and implement improved public information, outreach, and community education mechanisms that inform all San Franciscans about community-based issues and services.
- D. Improve the linkages between home and community-based long term care and supportive services, and behavioral health services.

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<sup>1</sup> While it is difficult to define a “good life,” this plan supports the principles promoted by the PLAN Institute for Caring Citizenship of Canada and highlighted in the work of the Community Living Campaign, which is described in the companion document to this strategic plan, *Living With Dignity Strategic Plan 2009-2013: Background and Environmental Review*. It is included in the “Other Current and Promising Innovations” section of that document.

## **GOAL 4: IMPROVE SERVICE QUALITY**

### *Strategies:*

- A. Assess the capacity and quality of community-based and institutional services on an ongoing basis.
- B. Implement workforce development initiatives to enhance the recruitment, training, and retention of homecare workers in both agency and consumer-directed independent contractor modes of delivery, and other community-based long term care workers.

## **GOAL 5: SECURE FINANCIAL AND POLITICAL RESOURCES**

### *Strategies:*

- A. Optimize access to federal, state, and local financial resources.
- B. Promote and achieve equitable funding for home and community-based services.
- C. Educate and mobilize policy makers and clients.

## **GOAL 6: EXPAND SERVICE CAPACITY**

### *Strategies:*

- A. Support efforts to increase availability of a range of safe, affordable, and accessible housing options.
- B. Support efforts to improve access to safe, affordable, and accessible transportation services.
- C. Promote endeavors to undertake social enterprise and marketing activities for all income groups to expand service capacity.
- D. Implement Federal Medicaid Waivers and other innovative programs to help older adults and adults with disabilities to remain living in the community.



## ACKNOWLEDGEMENTS

Many thanks to the multitudes of people involved in putting this strategic plan together. Between March and October 2008, stakeholders from every dimension of San Francisco's community-based long term care and supportive services network participated in the strategic planning process by providing input through interviews, focus groups, electronic surveys, community dialogues, and discussions of various committees, workgroups, and task forces. More than 300 individuals participated in providing input into this strategic plan.

*A detailed account of the methods used to solicit extensive involvement of stakeholders in the strategic planning process is provided in the companion document to this strategic plan, Living With Dignity Strategic Plan 2009-2013: Background and Environmental Review.*

The Strategic Plan Steering Committee provided leadership and direction throughout the strategic planning process. Service providers as well as administrators of public and private agencies shared the challenges they face in providing long term care and supportive services, and recommended potential avenues for greater collaboration and improved service coordination. Consumers had the opportunity for input in a series of community dialogues and focus groups.

This strategic plan is intended to be a road map to further improve community-based long term care and supportive services. With this map as a guide for the Long Term Care Coordinating Council from 2009 to 2013, public, private, and nonprofit service providers, consumers, and advocates can work together to make strategic service delivery improvements with the goal of a better coordinated, more accessible, higher quality community-based services network that is well prepared to serve the current and future populations of older adults and adults with disabilities in San Francisco.

The following pages include membership lists of: (1) the Long Term Care Coordinating Council; (2) the Strategic Plan Steering Committee; and (3) the Strategic Plan Staff Work Group.

**Table 1: Long Term Care Coordinating Council - Membership Categories and Members**

<b>Service Provider Organizations</b>			
<b>Well Elder Service Providers</b> <ul style="list-style-type: none"> <li>Sandy Mori (Co-Chair) - Kimochi</li> <li>Valorie Villela - 30th Street Senior Services</li> <li>Robert Trevorrow - San Francisco Senior Center</li> </ul>		<b>Long-Term Care &amp; Supportive Service Providers</b> <ul style="list-style-type: none"> <li>Margaret Baran - IHSS Consortium</li> <li>Donna Calame - IHSS Public Authority</li> <li>Nancy Brundy - Institute on Aging</li> <li>Akiko Takeshita - Asian Pacific Islander Legal Outreach</li> <li>Vacant Membership Position</li> </ul>	
<b>Health Systems and Hospitals</b> <ul style="list-style-type: none"> <li>Eleanor Jacobs - San Francisco Community Clinic Consortium</li> </ul>			
<b>HIV/AIDS Services/Systems</b> <ul style="list-style-type: none"> <li>Bill Hirsh - AIDS Legal Referral Panel &amp; CADA</li> </ul>		<b>Developmental Disabilities Services/Systems</b> <ul style="list-style-type: none"> <li>Jennifer Walsh - adults with developmental disabilities</li> </ul>	
<b>Behavioral Health Services/Systems</b> <ul style="list-style-type: none"> <li>Steve Fields - Progress Foundation</li> </ul>		<b>Other Disability Services/Systems</b> <ul style="list-style-type: none"> <li>Margaret Miller - Hearing and Speech Center</li> </ul>	
<b>Consumers and Advocates</b>			
<b>Consumers &amp; Advocates: Adults with Disabilities</b>		<b>Consumers &amp; Caregivers: Older Adults</b>	
<ul style="list-style-type: none"> <li>Anita Aaron, Lighthouse for the Blind and Visually Impaired</li> <li>Moli Steinert, North and South of Market Adult Day Health</li> </ul>	<ul style="list-style-type: none"> <li>Sandy O’Neill</li> <li>Patricia Webb</li> <li>Abby Kovalsky</li> </ul>	<ul style="list-style-type: none"> <li>Norma Satten</li> <li>Eileen Kunz - On Lok</li> </ul>	<ul style="list-style-type: none"> <li>Vera Haile</li> <li>Marcia Peterzell</li> <li>Susan Poor, Health Care Specialist in services for older adults, including home and community-based services</li> </ul>
<b>At Large</b> <ul style="list-style-type: none"> <li>Marie Jobling (Co-Chair) – Community Living Campaign</li> </ul>		<b>Consumer Advocates/Organizations</b> <ul style="list-style-type: none"> <li>Cathy Davis - Bayview Hunters Point Adult Day Health</li> <li>Herb Levine - Independent Living Resource Center</li> <li>Benson Nadell - Family Service Agency of San Francisco &amp; Long Term Care Ombudsman</li> </ul>	
<b>Labor</b> <ul style="list-style-type: none"> <li>Tom Ryan - San Francisco Labor Council</li> <li>Vacant Membership Position</li> </ul>			
<b>City and County Departments</b>			
<ul style="list-style-type: none"> <li><b>Dept of Human Services</b> - Phil Arnold</li> <li><b>Dept of Aging and Adult Services</b> - Anne Hinton</li> <li><b>Dept of Public Health*</b> - Liz Gray - John Kanaley</li> </ul>		<ul style="list-style-type: none"> <li><b>Mayor’s Office on Disability</b> - Ken Stein</li> <li><b>Mayor’s Office of Housing</b> - Joel Lipski</li> <li><b>SF Housing Authority</b> - Belinda Jeffries</li> <li><b>Municipal Railway</b> - Annette Williams</li> </ul>	

## **Strategic Plan Steering Committee:**

*\* Indicates LTCCC Members*

- Nancy Brundy, Institute on Aging\*
- Anita Aaron, Lighthouse for the Blind and Visually Impaired \*
- Susan Poor, Health Care Specialist\*
- Benson Nadell, Family Service Agency of San Francisco & Long Term Care Ombudsman\*
- Ken Stein, Mayor's Office on Disability\*
- Bill Hirsh, AIDS Legal Referral Panel\*
- Norma Satten, Consumer and Caregiver, Older Adults\*
- Denise Cheung, DAAS Office on the Aging
- Grace Li, On Lok Lifeways
- Edna James, Aging and Adult Services Commission
- Cynthia Davis, North and South of Market Adult Day Health

## **Strategic Plan Staff Workgroup:**

- Bill Haskell, DAAS
- Diana Jensen, Human Services Agency Planning Unit
- Nancy Giunta, Ph.D., Consultant to DAAS and Assistant Professor at the Hunter College School of Social Work
- Sybil Boutilier, DAAS
- Anne Romero, Mayor's Office of Housing

## LIST OF ACRONYMS

The following acronyms and/or abbreviations, used throughout this report and the accompanying *Living With Dignity Strategy Plan 2009-2013: Background and Environmental Review*, are defined as follows:

<b>AAA</b>	Area Agency on Aging	<b>DPH</b>	Department of Public Health
<b>ABAG</b>	Association of Bay Area Governments	<b>FPL</b>	Federal Poverty Level
<b>ADRC</b>	Aging and Disability Resource Connection	<b>HSA</b>	Human Services Agency
<b>AoA</b>	Administration on Aging	<b>IHSS</b>	In-Home Supportive Services
<b>API</b>	Asian/Pacific Islander	<b>ILRCSF</b>	Independent Living Resource Center of San Francisco
<b>CAAP</b>	County Adult Assistance Program	<b>HCBS</b>	Home and Community-Based Services
<b>CADA</b>	Community Alliance of Disability Advocates	<b>IOA</b>	Institute on Aging
<b>CASE</b>	Coalition of Agencies Serving the Elderly	<b>LHH</b>	Laguna Honda Hospital
<b>CCRC</b>	Continuing Care Retirement Community	<b>LGBT</b>	Lesbian, gay, bisexual, and transgender
<b>CDC</b>	Centers for Disease Control and Prevention	<b>LTC</b>	Long Term Care
<b>CHAS</b>	Comprehensive Housing Affordability Strategy	<b>LTCCC</b>	Long Term Care Coordinating Council
<b>CLF</b>	Community Living Fund	<b>LWD</b>	Living with Dignity
<b>CMCPP</b>	Case Management Connect Pilot Project	<b>MFP</b>	Money Follows the Person Demonstration
<b>CMS</b>	Centers for Medicare and Medicaid Services	<b>MOCI</b>	Mayor's Office of Community Investment
<b>CPFOA</b>	Community Partnership for Older Adults	<b>MOD</b>	Mayor's Office on Disability
<b>DAAS</b>	Department of Aging and Adult Services	<b>MOH</b>	Mayor's Office of Housing
<b>DCIP</b>	Diversion and Community Integration Program	<b>MSSP</b>	Multipurpose Senior Services Program
<b>DHCS</b>	Department of Health Care Services	<b>Muni</b>	Municipal Railway
<b>DHS</b>	Department of Human Services	<b>NASUA</b>	National Association of State Units on Aging

*(List continued on next page)*

<b>NCPHS</b>	Northern California Presbyterian Homes and Services	<b>SFGH</b>	San Francisco General Hospital
<b>NF/AH</b>	Nursing Facility/Acute Hospital (Waiver)	<b>SFHA</b>	San Francisco Housing Authority
<b>OAA</b>	Older Americans Act	<b>SFRA</b>	San Francisco Redevelopment Agency
<b>PACE</b>	Program of All-Inclusive Care for the Elderly	<b>SUA</b>	State Unit on Aging
<b>PRC</b>	Prevention Research Center	<b>SCPP</b>	Services Connection Pilot Project
<b>RC</b>	Resource Center for Seniors and Adults with Disabilities	<b>SWOT</b>	Strengths, Weaknesses, Opportunities, and Threats
<b>RCFCI</b>	Residential Care Facility for the Chronically Ill	<b>TCM</b>	Targeted Case Management
<b>RCFE</b>	Residential Care Facility for the Elderly	<b>WDD</b>	Workforce Development Division
<b>RFP</b>	Request for Proposals	<b>WID</b>	World Institute on Disability

## INTRODUCTION

This plan is intended to be used by the Long Term Care Coordinating Council (LTCCC), from 2009 to 2013, to guide its oversight of the implementation of the recommended improvements in long term care service delivery. Each of the goals, strategies and objectives included in this plan is the result of the extensive investigation of the strengths and weaknesses of the current long term care service delivery network in San Francisco, and the opportunities and threats that exist in the local, state and federal environments. Unfortunately, those threats are likely to include state and federal budget cuts due to: (1) the slowing economy, (2) the national credit crunch, and (3) the troubled housing market. The San Francisco Mayor's Office is also projecting budget shortfalls at the local level in the current and next several fiscal years.

It is intended that the LTCCC will evaluate this plan's recommendations in light of the current environment and decide which specific goals, strategies and objectives it would like to focus on each year, over the next four years.

### ***History of the Living With Dignity Strategic Plan***

In 2002, members of San Francisco's aging and disability services network recognized a need to address significant challenges facing them. It was acknowledged that although San Francisco had a rich array of long term care and supportive services for the many older adults and younger adults with disabilities, these services were fragmented and uncoordinated. At the same time, the City faced the impending growth in its numbers of people with disabilities and older adults. This challenge resulted in the formation of the Living With Dignity Policy Committee and its successful application to the Robert Wood Johnson Foundation's Community Partnerships for Older Adults (CPFOA) program for a \$150,000 planning grant. With this grant, the Living with Dignity Policy Committee oversaw an extensive 18-month planning process to develop a strategic plan, titled *Living With Dignity in San Francisco*. The development of this Living With Dignity Strategic Plan (LWD plan) resulted in a second successful applications for a \$750,000 implementation grant from the CPFOA program to implement specific parts of the strategic plan over four years, from 2004 – 2008.

The original LWD plan was published in April 2004. In November 2004, the Long Term Care Coordinating Council was appointed by Mayor Newsom to oversee implementation of the LWD plan.

During the 2002-04 strategic planning process, the following critical needs of the long term care and supportive services delivery system were identified, with goals, strategies, and objectives identified in the initial LWD plan for addressing these critical needs:

- ❖ Better Coordination of Services
- ❖ Easier Access to Services
- ❖ Improved Quality of Services
- ❖ Increased Local, State and Federal Funding
- ❖ Expanded Service Capacity

In addition, an essential component of the original LWD plan was to highlight service delivery system improvements to better meet the needs of adults with disabilities, and specifically to address the following key issues: (1) improve visibility of adults with disabilities in San Francisco; (2) expand access to services; and (3) achieve parity with older adults in the availability of appropriate resources and services. The plan also recommended greater collaboration between the Department of Aging and Adult Services (DAAS) and the Mayor's Office on Disability (MOD) in assessing the unmet needs of adults with disabilities and subpopulations within that community.

Through a collaborative process, the Long Term Care Coordinating Council oversaw the implementation of the original *Living With Dignity in San Francisco* strategic plan, which concluded in February 2008. Highlights of the accomplishments and challenges of this implementation process are described in this current LWD plan.

### ***The Living With Dignity Strategic Plan 2009 - 2013***

Since the conclusion of the original LWD plan timeline, a follow-up strategic planning process was initiated under the guidance of a new LWD Strategic Plan Steering Committee. This body oversaw the research as well as the development of the findings and recommendations required to make continued improvements in San Francisco's long term care and supportive services. These continued improvements will build on the momentum started by the successful implementation of the original 2004 LWD Plan. This document, the *Living With Dignity Strategic Plan 2009 - 2013*, is the result of the strategic planning process undertaken from March through October 2008. A companion document, the *Living With Dignity Strategic Plan 2009-2013: Background and Environmental Review*, provides additional contextual background to supplement this plan.

**Mission:** This plan is guided by the mission to improve the provision of long term care and supportive services so they assure dignity, independence, and choice for the older adults (60+ years of age), adults with disabilities of all ages (18+ years of age), and informal caregivers who need assistance and require care or support.

**This includes older adults and adults with disabilities of all income levels, including those who:**

- have physical or mental disabilities
- have developmental disabilities
- have chronic illnesses
- have HIV/AIDS
- are veterans
- are younger adults with disabilities (18-24) aging out of systems focused on children
- are in acute care settings or nursing facilities and are willing and able to return to community living
- are aging in place in public housing
- are aging in place in their own homes and apartments
- are living in shelters
- are living in assisted living facilities
- are living in single room occupancy hotels
- are homeless

**Values:** The values in this plan emphasize:

- ❖ An independent living philosophy, which encompasses consumer choice and participation;
- ❖ An inherent respect for the people we serve and with whom we work; and
- ❖ A focus on high quality, culturally and linguistically appropriate services and support.

This updated LWD Strategic Plan presents a vision and a series of recommendations (goals, strategies and objectives) for implementing continued strategic improvements from 2009 – 2013. In order to provide context for those recommendations, it then provides highlights of the outcomes and accomplishments of implementing the 2004 LWD plan, an examination of the current long term care environment, and a description of the research and planning activities undertaken during the 2008 strategic planning process.



## IMPLEMENTING THE VISION

### *The Vision*

The vision of the Long Term Care Coordinating Council is that long term care and supportive services<sup>2</sup> will be provided through a well coordinated service delivery network that will enable older adults and adults with disabilities of all income levels to remain as independent as possible in their homes and communities in the most integrated settings. This network will be able to expand and contract as consumer needs change. Services will be provided by a range of community-based service providers and public agencies that collaborate effectively as part of a proactive public-private partnership. Some services will target low-income individuals, and others will be available on a sliding-scale or fee-for-service basis to accommodate consumers at all income levels.

The network will include home and community-based services and, for those who require it, institutional care. All people with disabilities and older adults who wish to live in the community will have the necessary services and housing to do so. Service provider satisfaction will be addressed in regard to job performance, provider training, professional development, supervision, support, salaries and benefits. The services and service delivery systems that are part of this network will be continuously monitored to evaluate, through data analysis and strategic planning, the success of incremental improvements being made.

The network will be consumer-responsive and user-friendly, giving consumers and caregivers choices in the services they receive. It will be easily accessible and provide information about services in a culturally appropriate manner to address the varied needs of San Francisco's racially, ethnically and culturally diverse communities. The network will provide culturally sensitive, fully accessible, and age appropriate services. No matter where people enter the network of services, they will get the services they need. The service delivery network will incorporate input from consumers and caregivers (formal and informal) to monitor and improve the quality of services received. Consumers will be involved in all boards and committees that provide for oversight and accountability. Consumer direction will be an option for consumers that will increase control, independence, and choice. Proactive outreach will be undertaken to those older adults and adults with disabilities who are isolated and alone, and often homebound.

This vision goes beyond providing what services people need, to a broader, more fundamental issue: what people require for a good life. This includes: (1) the formation of personal and social support networks that promote the contributions of older adults and persons with disabilities of all ages, with the goal of strengthening our neighborhoods and communities; and (2) the creation of age- and disability-friendly communities that offer accessible and affordable housing, improved public safety, improved access to parks and recreation, and opportunities to be meaningfully engaged in the community.

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<sup>2</sup> See Appendix A for a list of long term care service categories. Appendix B provides a sample of long term care service providers.

Quality of life principles are also critical in the arena of service delivery. For example, historical research shows that some elements of quality life are enhanced by (a) the relationships s/he has with others, (b) the exercise of personal autonomy, and (c) an environment that supports independence and privacy.

This plan presents goals, strategies, and objectives which, if implemented, will help to achieve this vision. Broadly, these fall into the following six action areas: (1) *investment* (major City focus, departmental energy, and funding) *in a well-organized and well-coordinated network* of long term care services that effectively utilizes home and community-based services, and institutional services, as appropriate; (2) *expansion of home and community-based services* as the consumer population grows; (3) *public information and community education* to raise awareness of, and easier access to, these services; (4) *development and implementation of quality standards* for key home and community-based services; (5) *formation of personal and social support networks* that value the contributions of older adults, adults with disabilities of all ages, and caregivers; and (6) the *creation of aging-friendly and disability-friendly communities* throughout the City.

### ***Long Term Care – What It Is Today***

Long term care services can be found in the community in health maintenance and medication management programs at a neighborhood senior center, in adult day services<sup>3</sup>, or in a Program of All-Inclusive Care for the Elderly (PACE). Today, there are many home and community-based options to assist older adults and adults with disabilities to maximize self-sufficiency, safety and health, while remaining in the community. Long term care no longer only means care in skilled nursing facilities. In fact “79% of those needing long term care live at home or in a community setting, not an institution.”<sup>4</sup>

*The Mandate for the Most Integrated Setting:* Providing home and community-based services is the law and a civil right. The City has an obligation to provide choice of how and where adults with disabilities and older adults want to live. This principle is established by the Olmstead decision of the Supreme Court. When delivering the Court opinion, Justice Ginsberg referenced the Americans with Disabilities Act (ADA), saying that state and local governments are required to place persons with disabilities in community settings rather than in institutions when it is determined that community placement is appropriate.<sup>5</sup> Further, the ADA requires that services must be provided in the most integrated setting, suitable to the needs of qualified individuals.

*Chronic Care Management:* Widespread recognition of the need for ongoing chronic care management through home and community-based services is relatively new in the long term care arena. As older adults and adults with disabilities are living longer with functional impairments and chronic illnesses, they increasingly prefer to receive services in a community setting rather than an institutional setting.

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<sup>3</sup> Adult day services include: Adult Day Programs (social model); Alzheimer’s Day Care Resource Center’s (ADCRC’s); and Adult Day Health Care (ADHC) Programs. For a more detailed description of these services, go to: <http://www.caads.org>.

<sup>4</sup> Deborah Reidy Keltch, *California Research Bureau 2002 Educational Tour Series Policy Number Brief 2 – Framework for Discussion: A Review of Long-Term Care Programs in California* (Sacramento, CA: California Research Bureau, 2003), 1.

<sup>5</sup> See Appendix C for a more detailed discussion of the Olmstead Decision.

The evolving approach to chronic care management across the country, which relies substantially on community-based services and less on institutionalization, offers a new framework for thinking about how to provide services to people with chronic conditions. The Community-Based Long Term Care Report of 1998 identified chronic illness as “an illness or disability that persists for a long time, whether or not it causes death.” Further more, they are “ongoing and not amenable to cure. They may range from mild to manageable to severe (potentially life threatening) physical or mental conditions. However, chronic conditions are changeable, so prevention of actual episodes and maintenance of functional ability are the primary goals. Those who may need help range from young spinal cord injury survivors to older adults with Alzheimer’s disease.” The report identified a new approach for long term care service provision as one that “blends traditional medical and social models in recognition that managing an illness or a disability over time requires an integrated approach with the consumer as the focus.”<sup>6</sup>

In San Francisco, along with nursing home care, long-term care refers to a range of community-based services, i.e. social, physical, mental health, case management, chronic disease management; supportive housing, and other services that assist people to remain living in the community, and assure their individual dignity and choice.<sup>7</sup> Community-based long term care services include:

- In-home supportive services; home health care; adult day services; paratransit services; home-delivered meals; supportive services in a hotel; care in residential care facilities, including board and care and assisted living; and other health and social services.
- Health promotion and risk prevention services such as congregate nutrition programs; other transportation services; senior centers; and caregiver services. These services support independence, maintain functional ability, and can prevent further disability.
- Education and advocacy services that prepare consumers and caregivers to successfully access the long term care system.

For those who need assistance to maintain health and functional abilities, long term care and supportive services are critical. Assistance is often needed with: (1) self care related to activities of daily living such as eating, dressing, bathing, getting in or out of bed, or using the toilet; and/or (2) household tasks related to instrumental activities of daily living such as housekeeping, buying groceries, managing medications, paying bills, and traveling outside the home.<sup>8</sup> Long term care and supportive services can be provided in home and community-based settings, as well as in institutional settings, depending on need and choice.

Case management is an integral component of community-based long term care service delivery. While some people can organize assistance, care and support for themselves, others need case management services to do this. The case manager helps the individual, family, and friends to identify the individual’s needs and options to meet them, and arranges for services. The case

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<sup>6</sup> Community-Based Long Term Care: Supporting Families Across the Generations (presentation), California Long Term Care Coalition, April 1998.

<sup>7</sup> For a more comprehensive list of long term care service categories, see Appendix A.

<sup>8</sup> Living With Dignity Policy Committee, *Living with Dignity in San Francisco* (April 2004), 25.

manager also monitors the situation and provides assistance as the individual's needs change, and facilitates movement between home and other types of living situations.

## *The Challenges*

**San Francisco has some of the most creative and effective community-based long term care programs in the country. But, the City does not yet have: (1) a well coordinated network of home, community-based and institutional long term care services; and (2) fully-developed mechanisms to expand the needed home and community-based services as the consumer population grows.**

San Francisco's long term care programs and services do not consistently operate as a well-coordinated network. There continue to be service gaps, duplication of services, and fragmentation of providers. Service providers often deliver uncoordinated health, medical, social, and support services that are not organized from a consumer perspective.

Insufficient communication takes place between home, community-based, and institutional service providers, both in the public and non-profit sectors. There is little or no accountability across settings. While significant improvements are currently being implemented as a result of the Chambers and Davis lawsuit settlements,<sup>9</sup> discharge from institutional settings, including both nursing and acute care facilities, into community-based care is not yet well organized. One major gap is the lack of collaboration among community-based providers' case management programs. Only a few case management programs consider the comprehensive long term care needs of the consumer. As a result, consumers may have several case managers overseeing different components of their service needs.

San Francisco's long term care service providers often do not have experience with providing truly cross-age group and cross-disability services. Some providers have a history of working primarily with either the disability community or older adults. Efforts to integrate the service communities sometimes suffer from a mutual lack of understanding about the other community's culture of service provision and most effective education or outreach techniques. Providers must also be sensitive to the diverse experiences and stigmas that adults with disabilities face depending on factors such as: the type of the disability (e.g., physical, mental, developmental, etc.); whether the person was born with the disability or it was acquired in mid- or later life; whether the disability results from or is complicated by an accompanying chronic illness; or the stigma that the person may experience due to the way that her disability is view in society as a whole or in her ethnic or cultural community. Finally, medical advances have resulted in: (a) many people who have disabilities as younger adults living longer than ever before, and (b) older adults living longer with disabling conditions that they may have acquired in their later years. As a result, people who may have entered the community-based long term care service sector seeking primarily disability services may find themselves needing senior-focused services, and vice versa.

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<sup>9</sup> Detailed descriptions of these two lawsuit settlements are included in the "Long Term Care Environment" section of the companion document to this strategic plan, *Living With Dignity Strategic Plan 2009-2013: Background and Environmental Review*.

There is a need for improved mechanisms to expand the capacity of home and community-based services, including supportive housing and transportation options. While DPH's Housing and Urban Health Division is continuing to expand targeted housing and coordinated resources, finding safe, affordable, supportive, and accessible housing remains a critical challenge for many of San Francisco's older adults and adults with disabilities. Housing and related supportive services help them to remain independent and "age in place." Safe, accessible, and reliable transportation services are also essential to help them to remain active and mobile. As the population of older adults and adults with disabilities increases, it will be essential to ensure that program capacity to provide all these services continues to grow. The Community Living Fund is an important new opportunity in this area, but more mechanisms will be needed to meet growing demand in the coming years.

Adults with disabilities, older adults, and caregivers express difficulty in learning about long term care and supportive services. These consumers often don't have knowledge about the range of service options available. They continue to experience difficulty in accessing services.

Finally, San Francisco also has a significant population of older adults and adults with disabilities who have moderate incomes and/or assets that can entirely prevent access to certain community-based services when those incomes or assets are above the limits allowable under publicly-funded programs. These people have very few options for services and support to remain living in the community.

In light of these challenges, the critical question is: how to ensure the provision of high quality community-based care and support for older adults and adults with disabilities who are able to live in the community?

### ***Meeting the Challenges***

To realize the vision laid out in this plan, San Francisco must bring together appropriate City departments and integral parties such as non-profit organizations and other community-based service providers to:

- (1) Identify and optimize all of the City's resource mechanisms, and those available through state and federal funding.
  - ⇒ The City needs to coordinate effectively its excellent, but disjointed home, community-based, and institutional long term care services by building on existing successful cross-departmental collaboration efforts, as well as on its partnerships with non-profit agencies.
  - ⇒ DAAS and the Department of Public Health (DPH) must maximize the resources available through existing funding mechanisms, such as the Community Living Fund, recently enhanced Medicaid waivers, and federal demonstration projects.<sup>10</sup>

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<sup>10</sup> Such mechanisms include: (1) the Medi-Cal Community Living Support Benefit (AB2968); the Nursing Facility/Acute Hospital (NF/AH) Waiver; and the Money Follows the Person Demonstration project. See the "Long Term Care Environment" chapter of this plan for more detail.

- ⇒ The City must actively pursue new funding mechanisms to support community-based long term care, such as new Medicaid waivers that benefit hard-to-serve populations.
- (2) Build increased capacity, both in City departments, and in the community-based programs and services already in place.
  - ⇒ The City must place community-based services at the center of its long term care service delivery network by undertaking a significant expansion of assistance, care and support provided in the community. This will help significantly to address the growing demand.
- (4) Address the limited financial resources available for home and community-based services so that adults with disabilities and older adults are served in the most appropriate, most integrated setting.
  - ⇒ The community-based long term care network must secure increased public and private funding commensurate with the growing demand for services, the increasing costs of doing business, and the infrastructure development necessary to achieve and integrated long term care network.
- (5) Create more opportunities for supportive housing environments for older adults and adults with disabilities.
  - ⇒ Supportive services in existing and new housing needs to be developed for the long term care population, just as the City is doing for the homeless, including those with dual and triple diagnoses.
  - ⇒ City policies and funding mechanisms must be refined to encourage the home modifications that make existing housing accessible for adults with disabilities and chronic illnesses aging in place.
  - ⇒ New housing and service models must be developed to take advantage of every opportunity to keep people in their existing housing (e.g., scattered site housing, integration of housing with long term care services, etc.).
- (6) Incorporate principles of universal design in the development of services and programs, including housing, that respond to the diverse needs of people from all age groups and with all abilities.
- (7) Ensure that public and private acute care and other medical services effectively intersect with community-based long term care services that individuals must access if they are to remain in the community.
- (8) Increase emphasis on health promotion and risk prevention strategies (including strategies for falls prevention) that help older adults and adults with disabilities to thrive at home by maintaining both physical and mental health and well-being.

- (9) Require that community-based long term care service providers are compensated for the actual costs of their services.
- (10) Implement strong quality standards for key home and community-based services provided both by nonprofit service providers and by City departments.
- (11) Support the formation of personal and social support networks that value the contributions of older adults and persons with disabilities of all ages.
- (12) Pursue the creation of age-friendly and disability-friendly communities throughout San Francisco, in collaboration with City departments, adults with disabilities, and older adults.
- (13) Ensure that services exist that will be sensitive to the diverse population of people aging with disabilities.
- (14) Allocate scarce discretionary resources for disability and senior services according to need, not age.

The next section of this report provides the goals, strategies, and objectives that will guide San Francisco's efforts to overcome the challenges faced by the long term care and support services network. The following section presents an overview of this plan's goals and strategies, followed by a list of objectives to be implemented in the next four years.

## Goals, Strategies, and Objectives

**Table 2: Summary of 2009 Strategic Plan Goals and Strategies**

(Note to screen-reader users reading an electronic version of this report: Use tab key to move from column to column; use up and down arrow keys to move from line to line. A reformatted version is also available in Appendix D.)

GOALS	STRATEGIES
<b><u>GOAL 1:</u> Improve Quality Of Life</b>	<ul style="list-style-type: none"> <li>A. Facilitate San Francisco becoming a city of “aging and disability friendly” communities.</li> <li>B. Support efforts to provide what older adults and persons with disabilities of all ages require to have a good life.</li> <li>C. Optimize the physical and mental well-being of older adults and adults with disabilities.</li> <li>D. Assist moderate-income older adults and adults with disabilities who choose to live at home as they age - with resources, friends, and community connections that enable an active, healthy, and safe life.</li> <li>E. Advocate for nursing facilities to become interdisciplinary social-health models.</li> </ul>
<b><u>GOAL 2:</u> Establish Better Coordination Of Services</b>	<ul style="list-style-type: none"> <li>A. Enable better transitions between home, community-based, and institutional long term care and supportive services.</li> <li>B. Improve how case management programs work together to coordinate care and services.</li> <li>C. Expand efforts to collaborate with existing and new partners.</li> </ul>
<b><u>GOAL 3:</u> Increase Access To Services</b>	<ul style="list-style-type: none"> <li>A. Expand and improve information, referral and assistance services for people who are actively seeking services.</li> <li>B. Maintain community partnerships for vulnerable older adults and adults with disabilities in underserved communities.</li> <li>C. Create and implement improved public information, outreach, and community education mechanisms that inform all San Franciscans about community-based issues and services.</li> <li>D. Improve the linkages between home and community-based long term care and supportive services, and behavioral health services.</li> </ul>
<b><u>GOAL 4:</u> Improve Service Quality</b>	<ul style="list-style-type: none"> <li>A. Assess the capacity and quality of community-based and institutional services on an ongoing basis.</li> <li>B. Implement workforce development initiatives to enhance the recruitment, training, and retention of homecare workers and other community-based long term care workers.</li> </ul>
<b><u>GOAL 5:</u> Secure Financial And Political Resources</b>	<ul style="list-style-type: none"> <li>A. Optimize access to federal, state, and local financial resources.</li> <li>B. Promote and achieve equitable funding for home and community-based services.</li> <li>C. Educate and mobilize policy makers and clients.</li> </ul>
<b><u>GOAL 6:</u> Expand Service Capacity</b>	<ul style="list-style-type: none"> <li>A. Support efforts to increase availability of a range of safe, affordable, and accessible housing options.</li> <li>B. Support efforts to improve access to safe, affordable, and accessible transportation services.</li> <li>C. Promote endeavors to undertake social enterprise and marketing activities to expand service capacity.</li> <li>D. Implement Federal Medicaid Waivers and Other Innovative Programs to help older adults and adults with disabilities to remain living in the community.</li> </ul>



The objectives listed under the following goals and strategies are intended as a guide for implementing specific improvements in long term care services. While the primary work is identified in each objective, lead agencies and workgroups undertaking the work may amend objectives, as necessary, in the course of implementation. Organizations listed under “Shared Responsibility” are suggestions, and may not represent a comprehensive list of possible partners for achieving each objective.

## **GOAL 1. IMPROVE QUALITY OF LIFE**

Strategy A. Facilitate San Francisco becoming a city of “aging and disability friendly” communities.

*Objectives:*

1. **Initiate a series of meetings to explore the creation of “age and disability friendly” communities.**

*Lead Responsibility: Long Term Care Coordinating Council, DAAS*

*Shared Responsibility: City Planning, Community Development, Mayor’s Office of Housing, Public Works, Parks & Recreation, Public Library, San Francisco Planning and Urban Research (SPUR), Chamber of Commerce, San Francisco Partnership for Community-Based Care & Support, ILRCSF, among others.*

2. Collaborate with the Mayor’s Office of Housing and other City departments to **participate in the planning for HOPE-SF** to rebuild eight Housing Authority buildings, and recreate the areas around them as economically and socially integrated neighborhoods.

*Lead Responsibility: Mayor’s Office of Housing*

*Shared Responsibility: San Francisco Housing Authority, Aging and Disability Network, Housing and Services Workgroup, DAAS*

Strategy B. Support efforts to provide what older adults and persons with disabilities of all ages require to have a “good life.”<sup>11</sup>

*Objectives:*

1. Build financial and programmatic **support for the Community Living Campaign**, which is helping older adults and persons with disabilities of all ages through the formation of personal and social support networks.

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<sup>11</sup> While it is difficult to define a “good life,” this plan supports the principles that have been highlighted in the work of the Community Living Campaign, which is described in the companion document to this strategic plan, *Living With Dignity Strategic Plan 2009-2013: Background and Environmental Review*. It is included in the “Other Current and Promising Innovations” section of that document.

Community connectors need to be trained and matched with isolated, homebound seniors and adults with disabilities.

*Lead Responsibility: Community Living Campaign Leadership*

*Shared Responsibility: DAAS*

2. Expand **life skills and habilitation training** programs and services (e.g., budgeting, managing finances, managing personal assistants, performing activities of daily living, doing laundry) for people living in SROs, and for those being discharged from institutional settings or from incarceration.

*Lead Responsibility: Toolworks*

*Shared Responsibility: DPH Direct Access to Housing, DHS Housing and Homeless, IHSS Public Authority Consumer Peer Mentoring Program, The Arc of San Francisco, Conard House, Janet Pomeroy Center (SF TBI Net, Brainstorm programs), Mental Health Association*

3. Explore the creation of and seek resources to pilot **later life planning opportunities** and resources for older adults and families. This would include topics such as: financial planning, medical and services planning, spirituality, and advanced directives. This would require service providers to talk with their elder clients or patients about how to plan for the final stage of life.

*Lead Responsibility: Northern California Presbyterian Homes and Services RSVP Program*

*Shared Responsibility: Osher Lifelong Learning Institute (OLLI), Resource Centers for Seniors and Adults with Disabilities, Senior Centers, ILRCSF, San Francisco Community Clinic Consortium, Family Caregiver Alliance, San Francisco Bay Area Network for End-of-Life Care, City College, San Francisco Public Libraries, California Association for Nursing Home Reform, AARP, Family Caregiver Support Program providers*

4. Organize **transitional support programs and services for younger adults with disabilities** (18 to 24) aging out of systems focused on children.<sup>12</sup> This will:
  - a. Help to create a more coordinated care system for younger adults with disabilities and their caregivers as they age and transition into adult programs,
  - b. Assist youth to move into the community and live independently, and

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<sup>12</sup> Examples of this issue: Moving from Special Ed, where an individual educational program is available, to adult services, where no similar Special Ed Support exists, is a significant challenge in transitioning from systems focusing on children to systems focusing on adults. Moving from a Pediatric Care Medical System to an Adult Care System results in more limited resources and understanding, and significantly less care coordination. See the San Francisco Improving Transitions Project: <http://www.itopsf.org/>

- c. Expand LTCCC membership to include a representation from transitional age youth.

*Lead Responsibility: Improving Transition Outcomes Project (ITOP)*

*Shared Responsibility: Independent Living Resource Center, Community Alliance for Disability Advocates, transitional youth groups, San Francisco Unified School District, DPH, Golden Gate Regional Center, Chinese Families of Children with Disabilities*

Strategy C. Optimize the physical and mental well-being of older adults and adults with disabilities.

1. Expand **health promotion and risk prevention** services that support wellness and reduce risks for chronic illness.
  - a. Provide technical assistance, resources and training to promote evidence-based health promotion programs for well and frail people, including expansion of Healthier Living-Chronic Disease Self Management Program for adults with chronic illness. These would augment the wellness component of the long term care continuum of services.
  - b. Provide training and explore strategies to promote brain fitness as part of a comprehensive program of health promotion and wellness services at senior centers.
  - c. Provide technical assistance, resources and training to expand physical activity programs leading to cardio-vascular strength and flexibility with a goal of falls prevention.

*Lead Responsibility: DAAS Office on the Aging*

*Shared Responsibility: Always Active Program, 30<sup>th</sup> Street Senior Center, Self-Help for the Elderly, San Francisco Senior Center, Other Senior Centers, San Francisco Community Clinic Consortium, DPH, Lighthouse for the Blind and Visually Impaired, OnLok Lifeways, Janet Pomeroy Center, Mental Health Association, UCSF Personal Assistance Services Center, University of San Francisco*

Strategy D. Assist moderate-income older adults and adults with disabilities who choose to live at home as they age - with resources, friends, and community connections that enable an active, healthy, and safe life.

*Objectives:*

1. **Foster the development of membership programs, like San Francisco Village Northside**, and other emerging models, which will provide many of the benefits of a retirement community without having to give up one's independence, identity, and own home or apartment.

Members of San Francisco Village Northside will receive assistance with: practical, day-to-day tasks; health and wellness programs; social, cultural, and educational activities; and volunteer opportunities.

*Lead Responsibility: LTCCC*

*Shared Responsibility: SF Village Northside*

Strategy E. Advocate for nursing facilities to become interdisciplinary social-health models.

*Objectives:*

1. Participate in advocacy efforts to **move Laguna Honda Hospital (LHH) from a medical model to an inter-disciplinary social-health model of care**, based on a philosophy of community re-integration, choice, providing rehabilitation services, chronic care, dementia care, and end of life care.

*Lead Responsibility: Long Term Care Coordinating Council*

*Shared Responsibility: LTC Ombudsman, DPH (e.g., DPH Long Term Care, TCM), LTC Consumer Rights Center*

## **GOAL 2: ESTABLISH BETTER COORDINATION OF SERVICES**

Strategy A. Enable better transitions between home, community-based, and institutional long term care and supportive services.

*Objectives:*

1. **Expand transitional care into a citywide program.** This will cover all older adults and adults with disabilities discharged from acute hospitals to home, and put services in place to ensure a safe transition. To do this, it will be necessary to determine how to handle citywide capacity for transitional care. A subcommittee will examine various models of transitional care and make recommendations to the full Workgroup, the LTCCC and DAAS. Products and assistance to be provided include: (1) a consumer/caregiver discharge hand-out; (2) a discharge checklist; and (3) assistance with discharge for consumers and caregivers.

*Lead Responsibility: Transitional Care Workgroup*

*Shared Responsibility: DAAS, DPH (e.g., DPH Long Term Care, TCM)*

2. **Assess community placements after nursing home discharge and diversion.** In accordance with the Chambers lawsuit settlement, follow individuals placed in community settings for a two-year period. Identify successful placements and problematic issues.

*Lead Responsibility: Diversion and Community Integration Program (DCIP)*

*Shared Responsibility: DPH, DAAS, LTC Ombudsman*

Strategy B. Improve how case management programs work together to coordinate care and services.

*Objectives:*

1. **Continue the Case Management Connect Pilot Project.** Fourteen case management programs (affiliated with DAAS and DPH) will continue to collaborate in order to improve coordination of services for clients. This pilot project is intended to reduce the duplication of case management services and improve the effective use of resources. All programs are part of the DPH safety net, and are using an electronic rolodex designed by DPH to learn about and coordinate with other case management programs serving their clients. This electronic rolodex is part of the DPH Coordinated Case Management System.

This objective includes the following activities:

- d. Identify mechanisms to improve data quality.
- e. Expand the types of data sets included so that more information is available on the various services a client receives.
- f. Expand the number of participating agencies.
- g. Improve knowledge of all case management programs affiliated with DAAS and DPH

*Lead Responsibility: DAAS, DPH Community Behavioral Health Services*

*Shared Responsibility: Bernal Heights Neighborhood Center, Curry Senior Services, 30<sup>th</sup> Street Senior Center, Linkages, San Francisco Senior Center, Family Service Agency, Canon Kip Senior Center, In-Home Supportive Services (IHSS) Consortium, San Francisco General Hospital (SFGH) Emergency Department Case Management, Self Help for the Elderly, SFFD Emergency Medical Services, Meals on Wheels, LHH Social Services*

2. **Launch a Case Management Training Institute** to strengthen community case management and allow for increased access to the Community Living Fund (CLF) Program. This Training Institute will elevate standards of practice for non-profit service providers. It is designed to guide clinical supervisors; case managers and paraprofessionals through a comprehensive course of study that will prepare them to address the primary issues of serving older adults, adults with disabilities and their informal caregivers.<sup>13</sup>

*Lead Responsibility: DAAS Long Term Care (LTC) Operations Director*

*Shared Responsibility: Family Service Agency*

Strategy C. Expand efforts to collaborate with existing and new partners.

*Objectives:*

1. **Conduct outreach activities and strengthen natural alliances** with addiction and recovery programs, the lesbian, gay, bisexual and transgender (LGBT) community, the HIV/AIDS community including Residential Care Facilities for the Chronically Ill (RCFCI), health care providers, long term care researchers, labor, and agencies that might have more visibility like AARP.

*Lead Responsibility: Long Term Care Coordinating Council*

*Shared Responsibility: DAAS, DPH Community Behavioral Health Services, LGBT Community Partnership, Maitri AIDS Residential Care Facility (an RCFCI), Conard House, Progress Foundation*

2. **Initiate greater collaboration between programs** that serve older adults and adults with disabilities, especially between the Department of Human Services (DHS), DAAS, and DPH. Greater coordination, collaboration, and cooperation between program managers and program line staff would improve services for consumers. Examples of possible program collaborations are listed below:

- a. Implement a collaborative effort between DAAS Office on the Aging and the Food Stamp program to develop and implement an educational campaign to outreach to potential Food Stamp program participants.

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<sup>13</sup> As of September 2008, a contractor was being sought by DAAS to design, develop, and operate the Case Management Training Institute. Initially, DAAS had planned to issue an RFP by June 2007, with the contract to be awarded in summer 2007. During the initial steps of that process, DAAS was approached by a community-based organization with an offer to provide a pilot series of case management trainings, free of charge. This became a viable option and an opportunity to develop an understanding of the actual needs and a practical approach to addressing those needs. The pilot training program began in September of 2008, with the CLF case managers as the first trainees. It is anticipated an RFP for the Training Institute will be released in FY08-09.

- b. Forge strong partnerships between the San Francisco Health Plan’s Health Access Program, the San Francisco Community Clinic Consortium, other community-based medical services, and community-based long term care services.
- c. Initiate collaboration between the DAAS Office on the Aging and DPH with respect to health promotion and chronic illness management programming.
- d. Forge strong referral relationships between the San Francisco Health Plan – Health Access Program, the San Francisco Community Clinic Consortium, other community-based medical services and community-based long term care services.
- e. Identify neighborhoods that could benefit from interdisciplinary geographic caseload teams from DAAS, DHS, and DPH.
- f. Identify opportunities to offer long term care support services to seniors who may also act as foster parents or child care providers.
- g. Educate County Adult Assistance Program (CAAP) staff about the comprehensive array of long term care support services that might benefit clients who are aging and/or have a disability.
- h. Identify opportunities to implement more streamlined referral processes that would connect veterans to the County Veteran’s Service Office when they access other DAAS, DHS or DPH programs.

*Lead Responsibility: DHS, DAAS, DPH*

*Shared Responsibility: DAAS Office on the Aging, San Francisco Health Plan, San Francisco Community Clinic Consortium, ILRCSF, MOD, ADRC*

3. **Undertake an exploration of increasing collaboration on RFP development among city departments.** This could leverage each agency’s funding through collaboration and coordinated RFP development when departments provide funding for similar services and/or target populations. (For example, DPH, DHS, and DAAS all provide case management services.)

*Lead Responsibility: DPH, DAAS, DHS*

*Shared Responsibility: DPH Contracts, Human Services Agency (HSA) Contracts, DAAS Office on the Aging, DPH Behavioral Health, other City departments as appropriate*

### GOAL 3: INCREASE ACCESS TO SERVICES

Strategy A. Expand and improve information, referral and assistance services for people who are actively seeking services.

*Objectives:*

1. Provide individualized **long term care planning support** to help older adults, adults with disabilities, and their caregivers/families when they need guidance and assistance about how best to access services and support.

*Lead Responsibility: DAAS LTC Intake and Screening Unit*

*Shared Responsibility: Planning for Elders, Family Caregiver Alliance*

2. Investigate opportunities to reduce duplication and **achieve streamlined access to selected community-based services**. Consider developing cooperative agreements and combined assessment tools for older adults and adults with disabilities who need paratransit and other services such as adult day services, Linkages, Multi-purpose Senior Services, and Community Living Fund.

*Lead Responsibility: Streamlined Access Workgroup (PROPOSED)*

*Shared Responsibility: Muni, San Francisco Adult Day Services Network, Institute on Aging, DAAS LTC Operations Director, DAAS LTC Intake and Screening Unit, LTC Consumer Rights Center*

3. Develop **easier access to applications and eligibility information for community-based services on the internet**. DHS is arranging for internet access for food stamps, Medi-Cal, WIC and other programs. Veterans Services and other community-based services should be considered for addition. DHS is approaching Healthy San Francisco to participate. This could be a collaboration to expand access to services or it could be a separate model for a web-based application for home and community-based services.

*Lead Responsibility: Department of Human Services*

*Shared Responsibility: DAAS, San Francisco Department of Technology and Information Services (DTIS)*

4. Continue to **implement the Diversion and Community Integration Program (DCIP)**, which is structuring an integrated approach to provide supportive services for individuals diverted or discharged from Laguna Honda Hospital, as well as for other members of the community. Periodic reports on implementation will be provided to the LTCCC.

*Lead Responsibility: DAAS LTC Operations Director*

*Shared Responsibility: DAAS, DPH, ADRC*



5. Hold a **cross-training forum for staff of all relevant information and referral sources, senior and disability service providers, and Community Alliance of Disability (CADA) members.** The focus will be to explain I&R system changes, including points of entry, other key information access points, and the role of the DAAS Long Term Care Intake and Screening Unit. This will increase knowledge about available community resources and the core strengths of each information and referral entity.

*Lead Responsibility: DAAS LTC Intake and Screening Unit, and MOD*

*Shared Responsibility: 211, 311, Resource Centers for Seniors and Adults with Disabilities, DAAS Office on the Aging, Community Alliance of Disability Advocates, and interested service providers in the aging and disability network*

6. **Promote independent living in aging resource networks.** Under the umbrella of the new Aging and Disability Resource Connection (ADRC) Program, program partners will work together to reach diverse communities in San Francisco by: (a) continuing cross-training for Resource Centers for Seniors and Adults with Disabilities, DAAS staff, Ombudsman and ILRCSF staff; and (b) conducting an annual meeting between the DAAS Executive Director and the disability organizations. The ADRC partners will continue to explore other means of improving the quality of services of information and referral services of DAAS and Resource Centers and ILRCSF.<sup>14</sup>

*Lead Responsibility: DAAS Office on the Aging, ILRCSF*

*Shared Responsibility: All other ADRC participants (Resource Centers for Seniors and Adults with Disabilities, DAAS LTC Intake and Screening Unit)*

7. Develop a **Long Term Care Consumer Rights Initiative (Advocacy Program)**, to enable an independent, consumer-focused organization to provide education, training, outreach, options counseling, advocacy and support for seniors, adults with disabilities, and caregivers when accessing long term care services. The initiative would help individuals navigate complex home and community-based long term care services, including offering hands-on support in the areas of dispute resolution, hearings and other grievances.

*Lead Responsibility: DAAS Office on the Agency*

*Shared Responsibility: Successful bidder of the RFP (Issued October 2008)*

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<sup>14</sup> Note: The federal grant that supported the initial creation of the ADRC structure will end on December 31, 2008.)

Strategy B. Maintain community partnerships for vulnerable older adults and adults with disabilities in underserved communities.

*Objectives:*

1. **Strengthen collaborations in historically underserved communities**, and assess service delivery from a racial, ethnic and cultural perspective. Four community partnerships (African American, Asian/Pacific Islander, Latino, and LGBT) are continuing to strengthen existing collaborations and build new collaborations to increase access to services.

*Lead Responsibility: DAAS*

*Shared Responsibility: African American Community Partnership, Asian/Pacific Islander Community Partnership, Latino Community Partnership, LGBT Community Partnership, DAAS Office on the Aging*

2. Continue to **connect seniors and adults with disabilities living in public housing to services provided in the community**. These public housing buildings are operated by the San Francisco Housing Authority.
  - a. DAAS is collaborating with San Francisco's Resource Centers for Seniors and Adults with Disabilities, and community-based service providers, to **implement the Services Connection Pilot Project (SCPP)**, which is using service teams bi-weekly in senior/disabled public housing buildings. SCPP began in 2007 in two buildings. In 2008, SCPP moved to three more buildings. In 2009, SCPP will be moved to serve additional buildings.
  - b. DAAS is collaborating with Northern California Presbyterian Homes and Services (NCPHS), to **implement the Services Connection Program**, which is providing full-time and part-time Service Coordinators in five senior/disabled public housing buildings. This program began in 2008 and will run for three years, to 2011. Initially, this program will operate in five buildings. If fully funded, this program will serve 16 buildings.
  - c. DAAS is collaborating with SFHA to **address critical issues and improve access to IHSS and APS services for clients in distress** in all senior/disabled buildings. DAAS and SFHA are optimizing communications by developing effective communication system protocols.

*Lead Responsibility: DAAS, San Francisco Housing Authority*

*Shared Responsibility for Services Connection Pilot Project: Resource Centers for Seniors and Adults with Disabilities, On Lok Lifeways*

*Shared Responsibility for Services Connection Program: Northern California Presbyterian Homes and Services, DAAS Office on the Aging, ILRCSF*

Strategy C. Create and implement improved public information, outreach, and community education mechanisms that inform all San Franciscans about community-based issues and services.

*Objectives:*

1. **Use public information, outreach, and community education mechanisms to reach older adults, adults with disabilities, and their caregivers.** During 2008 and 2009, DAAS has a contract with Wide Angle Communications to implement a multi-faceted community education plan, which includes: (1) a Living Well public information campaign; (2) a Crisis in Dementia Care advocacy campaign; (3) an agency-based communications campaign; and (4) a targeted broadcast media campaign.

*Lead Responsibility: DAAS*

*Shared Responsibility: DAAS Public Information and Community Education Advisory Committee, Wide Angle Communications*

2. Explore new ways of **getting information and services to homebound people.** Establish a research group to identify strategies based on: (a) existing best practices from other localities, and (b) new ideas unique to San Francisco's diverse community. Include in this effort support of citywide efforts to help older adults and adults with disabilities with emergency preparedness.

*Lead Responsibility: DAAS Office on the Aging*

*Shared Responsibility: HSA Planning, DAAS LTC Intake and Screening Unit, DHS, DPH, IHSS Public Authority, IHSS Consortium, community-based service providers*

3. **Undertake proactive outreach to aging baby boomers** to attract their interest and attention to community-based care and support.
  - a. Begin public education tailored to the baby boomer population to ensure they are aware of available aging and disability consumer and caregiver support services;
  - b. Continue to pilot new programming efforts intended to attract and retain baby boomers in community-based programming (e.g., expanded hours, physical and educational activities, health promotion, brain health activities, etc.);
  - c. Update public websites, as they are likely to be a primary source of information for the baby boomer population; and

- d. Review and implement the recommendations in the DAAS Advisory Council's Baby Boomer Task Force report found in *Appendix E*.

*Lead Responsibility: DAAS*

*Shared Responsibility: Community-based service providers, Public Information and Community Education Committee*

Strategy D. Improve the linkages between home and community-based long term care and supportive services, and behavioral health services.

*Objectives:*

1. **Address the behavioral health needs of people receiving home and community-based services**, who could also benefit from improved access to behavioral health services.
  - a. Consider how to improve access to behavioral health services for people: (i) in the public system; (ii) on Medi-Cal and Medicare, and (iii) with health insurance in HMOs and PPOs.
  - b. Consider how to improve coordination across the range of behavioral health services. The Diversion and Community Integration Program (DCIP) is a model that could be followed.
  - c. Consider articulating the behavioral health system (outpatient, residential, acute diversion, institutional) so that it can be better understood.

*Lead Responsibility: Behavioral Health Access Workgroup (previously, the Mental Health Access Workgroup)*

*Shared Responsibility: DAAS, Family Service Agency, DPH Behavioral Health, IHSS Consortium, Curry Senior Center, Laguna Honda Hospital, Independent Living Resource Center, Self Help For The Elderly, Institute on Aging, Mental Health Association, DPH Mental Health Board*

2. **Respond to the growing crisis in dementia care.** Undertake: (1) an evaluation of current dementia care services; (2) a projection of the types of additional services needed over the next 12 years; (3) an economic analysis of projected costs (inflation adjusted) and funding sources; and (4) development of a report and recommendations for how to address the need for additional services.

The Alzheimer's/Dementia Expert Panel is to complete its work between December 1, 2008 & April 30, 2009. The report & recommendations are due on May 31, 2009.

*Lead Responsibility: DAAS, Alzheimer's/Dementia Expert Panel*

*Shared Responsibility: Behavioral Health Access Workgroup, Mayor's Office*

## GOAL 4: IMPROVE SERVICE QUALITY

Strategy A. Assess the capacity and quality of community-based and institutional services on an ongoing basis.

### *Objectives:*

1. Develop **quality standards for City-funded home and community-based services** across settings for those receiving community-based services, to improve accountability and oversight. Standards would address issues such as: program accessibility, performance measures, and safety.

*Lead Responsibility: DAAS Quality Management*

*Shared Responsibility: DAAS Office on the Aging, DAAS LTC Operations Director, DPH Community Behavioral Health Services, DHS Economic Support and Self-Sufficiency Programs, Human Services Network, MOD, community-based organizations*

2. Establish **strong mechanisms to ensure City contractors meet quality standards** including: (a) making sure contractors are educated about existing and new standards; and (b) tracking and measuring performance. Develop protocols for responding to non-compliance. Begin with DAAS contractors. Consider expanding to include DHS and DPH contractors.

*Lead Responsibility: DAAS Quality Management*

*Shared Responsibility: DAAS Office on the Aging, DAAS LTC Operations Director, DPH Community Behavioral Health Services, DHS Economic Support and Self-Sufficiency Programs, MOD*

3. **Assess the ongoing capacity of mandated programs**, such as the LTC Ombudsman program, **to provide oversight of institutional long term care services** in light of budget shortfalls anticipated in fiscal years 09-10, 10-11, and 11-12.

*Lead Responsibility: LTCCC*

*Shared Responsibility: DAAS, Family Service Agency*

4. Develop and implement a **technical assistance and training strategy for non-profit service providers** specifically related to program development, administration, infrastructure, operations, and board development. This could help to improve the quality and capacity of non-profit service providers. This could include a multi-departmental approach to providing technical assistance to troubled agencies.

*Lead Responsibility: Controller's Office – City Services Auditor Division, DPH, DAAS*

*Shared Responsibility: DAAS Office on the Aging, DPH Community Behavioral Health Services, DHS, MOD, and other city departments as appropriate*

5. **Strengthen the relationship between the LTCCC and the Paratransit Coordinating Council** in order to improve transparency in the oversight and accountability mechanisms for paratransit grievances. Consider developing a schedule on which a Municipal Railway (Muni) representative could report to the LTCCC on monthly paratransit performance reports and/or the annual paratransit consumer satisfaction survey. Feedback and discussion could also be provided from the DAAS representative from the Paratransit Coordinating Council.

*Lead Responsibility: LTCCC Steering Committee*

*Shared Responsibility: Muni, DAAS, Muni Accessibility Advisory Committee*

Strategy B. Implement workforce development initiatives to enhance the recruitment, training, and retention of homecare workers in both agency and consumer-directed independent contractor modes of delivery, and other community-based long term care workers.

*Objectives:*

1. Continue efforts to **develop a Caregiver Training Institute that will increase the pool of well-trained home care workers**, which sets the standard for training high quality paraprofessionals. Workers may include both agency employees and independent contractors hired by consumers of community-based long term care. Activities will focus on fundraising, training curriculum development, program design, and evaluation design.

*Lead Responsibility: IHSS Consortium, DAAS*

*Shared Responsibility: Home Care Workforce Workgroup, IHSS Public Authority, AlmaVia, OnLok, Institute on Aging, Catholic Charities CYO, Jewish Vocational Services*

2. **Coordinate workforce development activities** between the DHS and DAAS. Initiate discussions with DHS' Workforce Development Division (WDD) to determine strategies for that division to serve to (a) act as a recruitment and training resource for long term care services agency, and (b) assist older adults and adults with disabilities to gain and maintain employment.

*Lead Responsibility: DHS Workforce Development Division, DAAS*

*Shared Responsibility: San Francisco Office of Economic and Workforce Development*

3. **Continue to develop and implement training programs for the line-staff of City programs and community-based service providers.** DAAS has been hosting regular trainings at the Bethany Center for community-based line staff, as well as trainings for HSA staff. These efforts could be continued and expanded.

*Lead Responsibility: DAAS Deputy Director of Programs*

*Shared Responsibility: DAAS Office on the Aging, DAAS Quality Management, Institute on Aging*

## **GOAL 5: SECURE FINANCIAL AND POLITICAL RESOURCES**

Strategy A. Optimize access to federal, state, and local financial resources.

*Objectives:*

1. Seek and obtain a long term **commitment to a higher level of base funding for the Community Living Fund**, targeting those transitioning from a nursing facility or at imminent risk of entering one.

*Lead Responsibility: LTC Financing and Public Policy Workgroup*

*Shared Responsibility: DAAS*

2. Seek and obtain a **commitment of funding for people aging in place** – to support prevention services, targeting those not transitioning from a nursing facility or not yet at imminent risk of entering one.

*Lead Responsibility: LTC Financing and Public Policy Workgroup*

*Shared Responsibility: DAAS LTC Operations Director, DAAS Office on the Aging*

3. **Identify opportunities for and pursue shared planning and budgeting across City departments** to move toward implementing a common vision of community-based long term care service delivery. Achieve this through a survey of each department’s major planning processes, identifying (a) the most effective mechanisms for collaborative planning and (b) an accounting of city department investments that support community-based long term care, and (c) further clarification of the potential role of the LTCCC in shared planning and budgeting processes.

*Lead Responsibility: LTC Financing and Public Policy Workgroup*

*Shared Responsibility: Start with Human Services Agency (DHS, DAAS), DPH, and Muni. Consider adding Planning Department, Parks and Recreation, Mayor’s Office of Community Investment, Mayor’s Office on Disability, Mayor’s Office of Housing.*

4. **Undertake an analysis of San Francisco’ long term care services network, with the goal of establishing a strengthened framework for home and community-based services.** This might include (1) a cost and

financing analysis; (2) an operational and structural analysis; and (3) a comparative models review.

*Lead Responsibility: Controller's Office, DAAS, HSA, Mayor's Office*

*Shared Responsibility: LTC Financing and Public Policy Workgroup, Mayor's Office on Disability*

5. Determine how best to promote and eventually **achieve a unified long term care budget across City departments**. To do this, it will be necessary to develop a clear and well-defined statement of what is precisely included within community-based long term care services.

*Lead Responsibility: LTC Financing and Public Policy Workgroup, LTC Operations Director*

*Shared Responsibility: Human Services Agency, DHS, DAAS, DPH, Muni, Mayor's Budget Office*

6. **Investigate and promote promising strategies for financing services for "moderate-income" individuals** -- those whose incomes are too high to qualify for means-tested programs but too low to pay for market rate services out-of-pocket.

*Lead Responsibility: LTC Financing and Public Policy Workgroup*

*Shared Responsibility: To be determined*

7. **Participate in exploring a standard of economic security for older adults and adults with disabilities in addition to the federal poverty level, factoring in real living costs including health and long term care costs**. The goals are to: (1) have better information for planning and policy development; and (2) consider eligibility for programs based on what people can actually pay for services.

*Lead Responsibility: Community Living Campaign*

*Shared Responsibility: LTC Financing and Public Policy Workgroup*



Strategy B. Promote and achieve equitable funding for home and community-based services.<sup>15</sup>

*Objectives:*

1. Determine how best to **promote and eventually achieve equitable funding for home and community-based services** in relationship to institutional long term care services. For example:
  - a. Evaluate successful models of developing public-private partnerships.
  - b. Advocate for a City commitment to older adults and adults with disabilities as a constituency, similar to the City commitment to the youth constituency.
  - c. Obtain stories from the community about the issues and struggles that families and individuals face trying to age with dignity.
  - d. Establish a stronger, more unified community voice and a sense of urgency that moves the vision of an effective community-based long term care service delivery network closer to a reality.
  - e. Identify people who could be considered and approached to become a champion for home and community-based services to meet the increasing needs of older adults and adults with disabilities.

*Lead Responsibility: Financial Equity Promotion Workgroup (PROPOSED)*

*Shared Responsibility: LTCCC*

Strategy C. Educate and mobilize policy makers and clients.

*Objectives:*

1. Continue to **educate and engage the Mayor, and the Board of Supervisors**, and others about the need for an effective community-based long term care service delivery network.

*Lead Responsibility: LTC Financing and Public Policy Workgroup*

*Shared Responsibility: LTCCC, MOD*

2. Continue to **mobilize clients into engaged community members and family members** with the goal of greater public awareness about the benefits of effective community-based long term care services.

*Lead Responsibility: LTCCC*

*Shared Responsibility: Planning for Elders in the Central City*

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<sup>15</sup> Argument: Equity must be established between community-based services and institutional services. The current funding situation needs to change. Providing home and community-based services is not just what the City should do; it is the law and a civil right. This is an ongoing obligation of the City to provide choice of how and where people want to live. This is the principle upon which the Chambers lawsuit is based, and it is a principle established by the Olmstead decision of the Supreme Court.

## GOAL 6: EXPAND SERVICE CAPACITY

Strategy A. Support efforts to increase availability of a range of safe, affordable, and accessible housing options.<sup>16</sup>

### *Objectives:*

1. Continue to **expand capacity for housing and services for low-income residential care, and supportive housing**. This will include the development of more new affordable and accessible housing combined with services, making existing housing more accessible, and employing principles of universal design whenever possible.

*Lead Responsibility: Mayor's Office of Housing, DPH Housing and Urban Health, San Francisco Redevelopment Agency*

*Shared Responsibility: Housing and Services Workgroup, Mayor's Office of Community Investment, DHS, DAAS, San Francisco Housing Authority*

2. **Explore the possibility of targeting accessible housing units to people with disabilities who need them**. This could be accomplished either by: (1) layering the funding requirements to restrict the units to qualified applicants with disabilities; or (2) setting up a referral process and/or waiting list to get qualified people into the units. This is for locally financed accessible housing.

*Lead Responsibility: Mayor's Office of Housing*

*Shared Responsibility: MOD, DPH, San Francisco Redevelopment Agency (SFRA), DAAS/HSA, San Francisco Housing Authority, ILRCSF, The ARC, other nonprofit housing developers, Senior Action Network, and Council of Community Housing Organizations, Housing and Services Workgroup, DAAS Office on the Aging*

3. **Create an email alert system regarding opportunities to rent affordable housing** at initial lease-up of new projects or waiting list openings.

*Lead Responsibility: Mayor's Office of Housing*

*Shared Responsibility: SFRA, DPH, MOCI*

4. **Explore the creation of an ombudsman position for people with disabilities needing assistance with housing issues**. This position will: (1) serve as a reasonable accommodation for people who cannot navigate the system well or at all; and (2) screen civil rights violations for referral to MOD.

*Lead Responsibility: Housing and Services Workgroup*

*Shared Responsibility: Mayor's Office of Housing, Mayor's Office on Disability, Human Rights Commission*

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<sup>16</sup> Housing options could include, for example: emergency housing, supportive housing, assisted living, residential care, or traditional independent living.

5. **Establish a workgroup similar to the Comprehensive Housing Affordability Strategy (CHAS) Committee** to: (1) coordinate the City’s policy on the development of affordable housing among City departments and community organizations; (2) assist in the update and implementation of the Housing Impediments Report; and (3) address an array of policy issues related to affordable and accessible housing.
  - a. Include aging and disability network members (City Department Representatives, service providers and/or client advocates) in monthly meetings and housing pipeline communications, or other venues.

*Lead Responsibility: Mayor’s Office of Housing*

*Shared Responsibility: San Francisco Redevelopment Agency, Mayor’s Office of Community Investment, DHS, DAAS, DPH, San Francisco Housing Authority, City Planning, members of the aging and disability network, Housing and Services Workgroup, Council of Community Housing Organizations.*

6. **Participate in the design of trainings for staff of shelters and supportive housing** about how to assist older adults and adults with disabilities in access, and how to coordinate services. Training would need to be repeated regularly due to high staff turnover. This will address reasonable accommodations, and sensitivity to aging and disability issues.

*Lead Responsibility: DHS*

*Shared Responsibility: Housing and Services Workgroup, Mayor’s Office on Disability, DPH, DAAS, ILRCSF*

7. **Explore the increased potential for homeowner and tenant modifications** to make housing accessible for adults with disabilities and chronic illnesses, so that they can age in place.

NOTE: There are few programs for home modifications to rental units for tenants. For owner occupied units, the Mayor’s Office of Housing’s (MOH) existing programs (Community Housing Rehabilitation Program - CHRP, CalHOME) can be used for disability modifications already without any changes to the program. These two programs are for low-income home owners or for small buildings, in which the owner resides, with a rental unit.

*Lead Responsibility: Housing and Services Workgroup*

*Shared Responsibility: MOH, MOD, DPH, DAAS, ILRCSF*

Strategy B. Support efforts to improve access to safe, affordable, and accessible transportation services.

*Objectives:*

1. Implement a **grocery shopping shuttle targeting underserved neighborhoods and public housing sites**. Paratransit eligibility will not be

required for participation. Long term funding needs to be identified. A public private partnership may be pursued. This new program is based on a philosophy of independent living.

*Lead Responsibility: Muni*

*Shared Responsibility: Northern California Presbyterian Homes and Services, BVHP Multipurpose Senior Center, African American Community Partnership, DAAS, and Visitation Valley Senior Center, Kimochi, ILRC, CADA*

2. **Explore methods for addressing transportation barriers that prevent at-risk seniors and persons with disabilities from participating in exercise and socialization activities.** In particular, (a) identify concrete and perceived barriers to using existing transportation options, and (b) promote appropriate transportation solutions (e.g., Muni, group vans) based on the primary barriers identified and interested local activity centers.

*Lead Responsibility: DAAS, Muni*

*Shared Responsibility: San Francisco Paratransit office, DAAS Office on the Aging, Community-based activity centers, OMI Community Action*

3. **Increase community knowledge of the Paratransit program and its application process.** Specifically: (1) conduct outreach at health clinics, senior buildings, and senior centers; (2) provide training to social workers working with the target population on how to assist consumers to fill out the application.

*Lead Responsibility: Muni, San Francisco Paratransit Office, DAAS Office on the Aging*

*Shared Responsibility: ILRC SF, other community-based organizations*

Strategy C. Promote endeavors to undertake social enterprise and marketing activities for all income groups to expand service capacity.

*Objectives:*

1. **Encourage programs that target people living at home, willing and able to pay for home and community-based services.** This includes programs such as:
  - a. Purchased transportation services, like Silver Ride, which is marketed to people living at home and able to pay for transportation services.
  - a. Community-based continuing care retirement community programs, like the one provided at the Sequoias, which will be marketed to people living at home and able to pay for health care and social services.

*Lead Responsibility: Long Term Care Coordinating Council*

*Shared Responsibility: DAAS*

Strategy D. Implement Federal Medicaid Waivers and other innovative programs to help older adults and adults with disabilities to remain living in the community.

*Objectives:*

1. **Ensure the successful implementation and use of innovative waivers and program** including:
  - a. Nursing Facility/Acute Hospital (NF/AH) Waiver;
  - b. Home and Community-Based Services Waiver (AB2968) specifically for San Francisco; and.
  - c. Money Follows the Person demonstration program.

*Lead Responsibility: DPH, DAAS*

*Shared Responsibility: LTC Financing and Public Policy Workgroup*

## APPENDICES

### Appendix A: List of Long Term Care Service Categories

1. Adult day services:
  - Adult Day Care (Social Day)
  - Adult Day Health Care
  - Alzheimer’s Day Care Resource Centers
  - Supportive housing
  - Assisted Living
  - Independent Housing
  - Advocacy
2. Caregiver support services
3. Community networks
4. Community services:
  - Activities scheduling
  - Translation
  - Social services
5. Community health care services
6. Case management
7. District-wide social services workers
8. Education of consumers, families and others, in independent living skills training
9. End of life care
10. Elder abuse prevention
11. Emergency preparedness
12. Financial management services
  - Representative payee program
  - Money management
13. Conservatorship Programs
  - Probate & Mental Health (LPS)
14. Health care for the uninsured
15. Health Insurance Counseling and Advocacy Program (HICAP)
16. Health screening
17. Home care services
18. Home health care services
19. Home modification
20. Housing:
  - Emergency housing
21. Residential services
22. In-Home Supportive Services – chore, homemaker, personal care
23. Institutional long-term care
24. Independent living resources
25. Legal services
26. Linkage to primary and acute care
27. Medication management
28. Mental health services
29. Naturalization services
30. Nutrition services:
  - Home delivered meals
  - Congregate meals
  - Bags of groceries delivered
  - Food stamps
31. Ombudsman (complaint help for nursing home residents and board & care residents)
32. Pharmacy and medication services
33. Provider training and supportive services
34. Rehabilitation services
35. Respite care services
36. Resource centers
37. Senior centers
38. Senior empowerment (advocacy and training)
39. Transportation services:
  - Paratransit, Muni, Taxi
40. Veterans services

## Appendix B: Sample of Home, Community-Based, and Institutional Long Term Care and Supportive Services Providers (partial list)

### Home and Community-Based Long Term Care and Supportive Services Providers

- Alzheimer’s Association of Northern California and Northern Nevada
- Asian Law Caucus
- Asian Pacific Islander Legal Outreach
- Bayview Hunters-Point Multi-Purpose Senior Center
- Bernal Heights Neighborhood Center
- Catholic Charities
- Central City Hospitality House
- Centro Latino de San Francisco
- Chinatown Community Development Corp.
- Chinese Newcomer
- Curry Senior Center
- Episcopal Community Services
- Family Caregiver Alliance
- Family Service Agency
- Glide Memorial Church
- Golden Gate Regional Center
- Golden Gate Senior Services
- Hearing and Speech Center of Northern California
- IHSS Consortium
- IHSS Public Authority
- Independent Living Resource Center
- Institute on Aging:
  - Community Living Fund
  - Multipurpose Senior Services Program
  - Linkages
  - Center for Elders and Youth in the Arts (CEYA)
- International Institute of San Francisco
- Janet Pomeroy Center
- Jewish Community Center of San Francisco
- Jewish Family and Children’s Services
- Kimochi, Inc.
- Korean Center, Inc.
- La Raza Centro Legal
- Legal Assistance to the Elderly
- Lighthouse for the Blind and Visually Impaired
- Little Brothers Friends of the Elderly
- Long-Term Care Ombudsman
- Meals on Wheels Of San Francisco
- Mental Health Association
- Mercy Housing
- Mission Neighborhood Centers
- Network for Elders
- New Leaf Outreach to Elders
- Northern California Presbyterian Homes and Services
- On Lok, inc.
  - 30<sup>th</sup> Street Senior Center
  - OnLok Lifeways
- openhouse
- Operation Access
- Planning for Elders in the Central City
- Project Open Hand
- Resource Centers for Seniors and Adults with Disabilities
  - Richmond
  - Western Addition/Marina
  - Mission
  - Northeast
  - Central City/Potrero Hill
  - Bayview/Hunters Point

- Visitacion Valley/Portola
- OMI Community Action
- Inner Sunset/Haight Ashbury
- Outer Sunset
- Russian American Community Services
- Samoan Community Development Center
- Saint Anthony Foundation
- San Francisco Adult Day Services Network:
  - Bayview Hunters Point Adult Day Health
  - Catholic Charities Adult Day Services and Alzheimer’s Day Care Resource Center
  - Institute on Aging
    - Irene Swindells Center for Adult Day Services (Alzheimer’s care)
    - Ruth Ann Rosenberg Adult Day Health and Alzheimer’s Day Care Resource Center
  - Jewish Family and Children’s Services – L’Chaim Adult Day Health
  - Laguna Honda Hospital Adult Day Health and Alzheimer’s Day Care Resource Center
  - North & South of Market Adult Day Health
    - Mabini Day Health
    - Golden Gate Day Health
    - Presentation Day Health
    - Mission Creek Day Health
  - Self Help for the Elderly Adult Day Health and Alzheimer’s Day Care Resource Center
  - St. Mary’s Adult Day Health
- San Francisco Community Clinic Consortium
  1. Curry Senior Center
  2. Glide Health Services
  3. Haight Ashbury Free Clinics, Inc.
  4. Lyon-Martin Health Services
  5. Mission Neighborhood Health Center
  6. Native American Health Center
  7. North East Medical Services
  8. St. Anthony Free Medical Clinic
  9. San Francisco Free Clinic
  10. South of Market Health Center
- San Francisco Food Bank
- San Francisco Veterans Administration (VA) Medical Center
- Senior Centers – examples (48 in total)
  - 30<sup>th</sup> Street Senior Center
  - Bayview Hunters Point Multipurpose Senior Center
  - Canon Kip Senior Center
  - Curry Senior Center
  - San Francisco Senior Center
- Self Help for the Elderly
- Senior Action Network
- Swords to Plowshares
- Tenderloin Neighborhood Development Corporation
- The Arc of San Francisco
- TODCO Group
- United Cerebral Palsy of the Golden Gate
- United Way of the Bay Area/211
- Veteran Equity Center
- Vietnamese Elderly Mutual Assistance Association
- Visitacion Valley Community Services
- Western Addition Senior Citizen’s Service Center
- YMCA

**(Continued on next page)**



## County Long Term Care and Supportive Services Providers

### *Department of Aging and Adult Services*

- Adult Protective Services
- County Veterans Service Office
- Long Term Care Intake and Screening Unit/Information, Referral & Assistance --  
Handles intake for:
  - Adult Protective Services
  - Community Living Fund
  - Home-Delivered Meals
  - In-Home Support Services
- In-Home Supportive Services
- Office on the Aging
- Public Administrator
- Public Conservator
- Public Guardian
- Representative Payee Program

### *Department of Human Services*

- Food Stamp Program
- Housing and Homeless Program
- Medi-Cal Health Connections Program

### *Department of Public Health*

- Community Behavioral Health Services
- Health at Home
- Housing and Urban Health
- Laguna Honda Hospital
- San Francisco General Hospital

### *Department of Parks and Recreation*

### *Mayor's Office of Community Investment*

### *Mayor's Office on Disability*

### *Mayor's Office of Housing*

### *Municipal Transportation Agency*

### *San Francisco Housing Authority*

### *San Francisco "311" Municipal Services Information Line*

## Appendix C: The Olmstead Decision of the Supreme Court

The 1999 U.S. Supreme Court's Olmstead decision, which determined that states must provide community-based services for persons with disabilities who would otherwise receive institutional care, has impacted California and San Francisco. The Olmstead case involved two women in Georgia whose disabilities included mental retardation and mental illness who sued the state of Georgia. At the time the lawsuit was filed, both lived in state-run institutions although their treating professionals had determined they could be appropriately served in a community setting. The women alleged their continued institutionalization was a violation of their right under the federal Americans with Disabilities Act (ADA) to live in the most integrated setting appropriate.

In 1999, the United State Supreme Court concluded that states are obliged by the ADA to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (1) the state's treatment professionals have determined that community placement is appropriate; (2) the individual does not object to community placement; and (3) the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with disabilities.

The ADA provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in, or denied the benefits of the services, programs or activities, or is subjected to discrimination by any such entity. Under the ADA, states must "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program or activity."

The Supreme Court indicated that whether a modification results in "fundamental alteration" of a program is based on: (1) the cost of providing services to the individual in the most integrated setting appropriate; (2) the resources available to the state; and (3) how the provision of services affects the ability of the state to meet the needs of others with disabilities. The Court cautioned that the ADA does not require elimination of institutional settings for persons who choose not or are unable to be treated in community settings and that the state's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.

## **Appendix D: Summary of Goals and Strategies**

### **GOAL 1 - Improve Quality Of Life**

*Strategies:*

- A. Facilitate San Francisco becoming a city of “aging and disability friendly” communities.
- B. Support efforts to provide what older adults and persons with disabilities of all ages require to have a good life.
- C. Optimize the physical and mental well-being of older adults and adults with disabilities.
- D. Assist moderate-income older adults and adults with disabilities who choose to live at home as they age - with resources, friends, and community connections that enable an active, healthy, and safe life.
- E. Advocate for nursing facilities to become interdisciplinary social-health models.

### **GOAL 2 - Establish Better Coordination Of Services**

*Strategies:*

- A. Enable better transitions between home, community-based, and institutional long term care and supportive services.
- B. Improve how case management programs work together to coordinate care and services.
- C. Expand efforts to collaborate with existing and new partners.

### **GOAL 3 - Increase Access To Services**

*Strategies:*

- A. Expand and improve information, referral and assistance services for people who are actively seeking services.
- B. Maintain community partnerships for vulnerable older adults and adults with disabilities in underserved communities.
- C. Create and implement improved public information, outreach, and community education mechanisms that inform all San Franciscans about community-based issues and services.
- D. Improve the linkages between home and community-based long term care and supportive services, and behavioral health services.

### **GOAL 4 - Improve Service Quality**

*Strategies:*

- A. Assess the capacity and quality of community-based and institutional services on an ongoing basis.

- B. Implement workforce development initiatives to enhance the recruitment, training, and retention of homecare workers and other community-based long term care workers.

### **GOAL 5 - Secure Financial And Political Resources**

*Strategies:*

- A. Optimize access to federal, state, and local financial resources.
- B. Promote and achieve equitable funding for home and community-based services.
- C. Educate and mobilize policy makers and clients.

### **GOAL 6 - Expand Service Capacity**

*Strategies:*

- A. Support efforts to increase availability of a range of safe, affordable, and accessible housing options.
- B. Support efforts to improve access to safe, affordable, and accessible transportation services.
- C. Promote endeavors to undertake social enterprise and marketing activities to expand service capacity.
- D. Implement Federal Medicaid Waivers and Other Innovative Programs to help older adults and adults with disabilities to remain living in the community.

## **Appendix E: Baby Boomer Task Force Report Recommendations from the Advisory Council to the Aging and Adult Services Commission**

*(An excerpt from San Francisco Baby Boomers – A Breed Apart?)*

The following recommendations are directed to non-profit service providers, the Department of Aging and Adult Services, and other city departments.

### ***Recommendations to service providers***

Attend training sessions and information sessions that focus on the unique needs and preferences of baby boomers.

Acknowledge that although senior centers and services may change, the social need to congregate will remain. Such centers can be the contact sites connecting boomer seniors with services which may be needed in the future.

Continue to pilot new programming efforts intended to attract and retain baby boomers in senior programming (e.g., expanded hours, physical and educational activities, health promotion, brain health activities, etc.)

### ***Recommendations to service providers, DAAS, and other public agencies***

Begin public education tailored to the baby boomer population to ensure that they are aware of available consumer and caregiver support services.

Update public-facing websites, as they are likely to be a primary source of information for the baby boomer population.

### ***Recommendations to DAAS***

DAAS may consider including some of the following recommendations in its upcoming Area Plan.

Initiate citywide planning and policy development to address baby boomer issues.

Continue and expand training sessions that improve the capacity of non-profit and public service providers to address the needs of baby boomers.

Monitor enrollment levels and waitlist in DAAS programs in the coming years (e.g., Office on the Aging programs, APS, IHSS, etc.), especially among the baby boomer age cohort. Consider additional analysis about changes in consumers' needs, preferences, and choices over time.