DIGNITY ■ INDEPENDENCE ■ CHOICE

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 Two of Two

2009-2013

- **Background**
- **Environmental Review**

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 Strategic Plan 2009 – 2013: Background and Environmental Review

Part Two of Two

This is a companion document to *Living with Dignity Strategic Plan 2009-2013.* It provides the background and environmental context for that strategic plan, as well as detail regarding the planning process.

TABLE OF CONTENTS

LIST OF ACRONYMS 1

BACKGROUND 3

Outcomes of the 2004 Living With Dignity Strategic Plan: Accomplishments and Challenges 3

Development of the Living With Dignity Strategic Plan 2009-2013 8

TODAY'S LONG TERM CARE ENVIRONMENT 12

San Francisco's Older Adults 12

San Francisco's Adults with Disabilities (All Ages) 14

Low- and Moderate-Income Populations 16

Informal Caregivers 17

Issues Related to Dementia 18

Medically Complex Needs and High-Risk Circumstances 18

New Policy Trends Since 2004 18

1. San Francisco Lawsuit Settlements 18
2. Implementation of Existing Medicaid Home and Community-Based Services Waivers 20
3. Efforts to Develop a New Medicaid Home and Community-Based Services Waiver specifically for San Francisco 21
4. Money Follows the Person Demonstration: California Community Transitions 22
5. Policy Issues Related to Housing 23
6. Policy Issues Related to End-of-Life Planning 23

New Local Program Initiatives Since 2004 24

1. Community Living Fund 24
2. DAAS Long Term Care Intake and Screening Unit 25
3. Downsizing of Laguna Honda Hospital 25
4. Diversion and Community Integration Program (DCIP) 25
5. Dementia/Alzheimer's Expert Panel 25
6. Public Information and Community Education 26

Other Current and Promising Innovations 26

1. Aging & Disability Friendly Communities 26
2. *Project 2020:* Building on the Promise of Home and Community-Based Services 27
3. Beacon Hill Village/San Francisco Village 28
4. Continuing Care at Home Model 28
5. Community Living Campaign 29
6. Recent Research 29

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS 31

Overview 31

Key Findings 32

The Role of the Long-Term Care Coordinating Council 34

APPENDICES 36

Appendix A: Summary of Accomplishments from Implementation of Original Living With Dignity Strategic Plan (2004 to 2008) 36

Appendix B: List of San Francisco Partnership for Community-Based Care & Support Members 40

Appendix C: 2008 Strategic Planning Participants and Questions 42

Appendix D: World Health Organization Checklist of Essential Features of Age-Friendly Cities 54

Appendix E: SWOT Analysis Key Findings 59

TABLE OF FIGURES

Table 1: SWOT Analysis Key Findings.. 32

LIST OF ACRONYMS

The following acronyms and/or abbreviations, used throughout this report and the accompanying *Living with Dignity Strategic Plan 2009-2013*, are defined as follows:

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

(List continued on next page)

NCPHS Northern California Presbyterian Homes and Services

NF/AH Nursing Facility/Acute Hospital (Waiver)

OAA Older Americans Act

PACE Program of All-Inclusive Care for the Elderly

PRC Prevention Research Center

RC Resource Center for Seniors and Adults with Disabilities

RCFCI Residential Care Facility for the Chronically Ill

RCFE Residential Care Facility for the Elderly

RFP Request for Proposals

SFGH San Francisco General Hospital

SFHA San Francisco Housing Authority

SFRA San Francisco Redevelopment Agency

SUA State Unit on Aging

SCPP Services Connection Pilot Project

SWOT Strengths, Weaknesses, Opportunities, and Threats

TCM Targeted Case Management

WDD Workforce Development Division

WID World Institute on Disability

BACKGROUND

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

The 2004 LWD plan identified significant service delivery improvement recommendations in the form of five goals, 19 strategies, and 86 objectives. All were intended to trigger initiatives that would result in improvements in community-based long term care and supportive services for adults with disabilities and older adults. Between April 2004 and September 2008, a significant amount of work was undertaken toward achieving these initiatives. It is important to state that no initiative to improve services is ever fully accomplished. This is because further refinements in service delivery methods and procedures, and in service quality, capacity, and financing, are periodically made.

The activities required to implement the 2004 recommendations were accomplished through the involvement of an extensive public-private partnership. This became a broad effort that necessitated significant collaboration between many community-based organizations, City agencies, and consumer advocates.

A summary of all accomplishments that resulted from implementation of the recommendation listed in the 2004 LWD Strategic Plan can be found in Appendix A.

Following is a review of some of the major accomplishments. Challenges, where identified, are discussed following each of the accomplishments.

1. Long Term Care Coordinating Council

The 2004 LWD plan identified the following barrier to making service delivery system improvements: "no committee is responsible to oversee implementation of all strategic plan recommendations". In response, in November 2004, Mayor Gavin Newsom appointed the LTCCC to: (1) advise, implement, and monitor community-based long term care planning in San Francisco; and (2) facilitate the improved coordination of home, community-based, and institutional services for older adults and adults with disabilities.

Specifically, the LTCCC was assigned the responsibility of overseeing all implementation activities and service delivery improvements identified in the LWD Strategic Plan. Toward this end, the LTCCC had all workgroups identified in the LWD Strategic Plan investigate a specific issue, prepare findings and recommendations, and present periodic reports on the progress of implementation.

The Mayor appoints 29 of the 37 membership slots under the categories of Service Provider Organizations, and Consumers and Advocates. The additional 8 slots are represented by various City and County departments including: Human Services, Aging and Adult Services, Public Health, Office of Disability, Housing, San Francisco Housing Authority, and the Municipal Railway.

Workgroups of the LTCCC:

- LTC Financing and Public Policy Workgroup
- Ad Hoc Community Living Fund Planning Committee
- Housing and Services Workgroup
- Behavioral Health Access Workgroup (previously, Mental Health Access)
- Homecare Workforce Workgroup
- Transitional Care Workgroup
- Community Placement Plan Workgroup (currently inactive)

2. San Francisco Partnership for Community-Based Care & Support

In May 2004, the San Francisco Partnership for Community Based Care & Support (SF Partnership) was formed as part of the CPFOA project, funded by the Robert Wood Johnson Foundation from February 2004 to January 2008. This SF Partnership is an extensive network of 70 community-based long term care and supportive service providers dedicated to strengthening the network of community-based care and support for adults with disabilities and older adults.

The list of San Francisco Partnership members is in Appendix B.

During the four-year CPFOA grant period, the purpose of the SF Partnership was to: (1) enhance collaboration, cooperation, and communication between member agencies in the delivery of services; (2) promote the services provided by member agencies via a multi-faceted media campaign; and (3) be an increasingly visible and powerful voice in service organization and service coordination. The Partnership also had lead responsibility for the oversight and implementation of four key service delivery system improvements:

A. Strengthen and sustain community partnerships in historically underserved communities.

B. Improve service coordination through a case management collaborative.

C. Enhance the recruitment, training and retention of homecare workers.

D. Create and implement improved public relations and marketing strategies, and develop a public relations and marketing plan.

Over the four years of the grant period, representatives from agencies participating in the SF Partnership joined together in workgroups and community partnerships, along with DAAS, to better understand and address these key strategic system improvements. The impact of the Partnership has been broad and positive. Participating agencies became part of something larger than themselves: a network of community-based service providers collaborating to meet the needs of older adults and adults with disabilities.

The final SF Partnership luncheon, held in October 2007, celebrated the work accomplished by the Partnership over the four years of its operation and provided a forum to explore the future of the Partnership. Participants discussed whether or not the SF Partnership should continue in the future and, if so, what could be the most important focus of its work.

Participants identified the following reasons for continuing the San Francisco Partnership: (1) the SF Partnership: (1) assists service providers to be part of a larger collaboration, (2) service providers need community-building to overcome isolation, (3) there is more creative involvement from community-based organizations, (4) the SF Partnership provides an opportunity to network and share information among the agencies, (5) it helps to reduce duplication of services, (6) shared expertise results in more cross-referrals, and (7) the SF Partnership creates new opportunities for leadership development.

Participants discussed potential areas of future work for the San Francisco Partnership:

- Participate in a sustainable network of services and support (housing, services, transportation)
- Work for increased funding for community services
- Advocate for affordable housing
- Build infrastructure to sustain diverse partnerships
- Expand communication tools
- Cultivate unified advocacy

Challenge: Since February 2008, when the CPFOA project was concluded and the grant funding was terminated, the active role of the SF Partnership has been placed on hold. A new role needs to be considered for the San Francisco Partnership for Community-Based Care & Support by DAAS and the LTCCC. During this transition period, the communications functions of the Partnership have been cut back. While DAAS is supporting the majority of Partnership initiatives, the Partnership newsletter and semi-annual luncheons have been discontinued for the time being due to limited funding and staff support.

3. Community Partnerships

In May 2004, community partnerships were formed in four historically underserved communities (African American; Asian & Pacific Islander; Latino; and Lesbian, Gay, Bisexual & Transgender communities) to strengthen collaborations among community-based service providers and consumers, build new collaborations, and evaluate home and community-based services from a racial, ethnic, and cultural perspective:

In 2005 and 2006, the African American Community Partnership researched and prepared a report: *Disparities In Health And Social Services For African American Elders & Adults with Disabilities*, and advocated for increased funding for services. Members conducted a successful advocacy campaign that resulted in improved sanitary conditions and food quality at FoodsCo, the only market in the Bayview-Hunters Point neighborhood.

Since 2004, the Latino Community Partnership researched and prepared a 2005 report entitled *The Status of Services for Hispanic/Latino Seniors and Adults with Disabilities in San Francisco*. It organized a televised six-part series on aging Latinos, and it participated in the creation of *Latinos Visibles.*

Since 2004, the LGBT Community Partnership increased collaboration among LGBT and mainstream service providers. It advocated for LGBT sensitivity training for local service providers. The San Francisco Planning Commission approved openhouse, another member agency, to develop LGBT senior affordable housing.

Since 2006, the Asian & Pacific Islander (API) Community Partnership has undertaken a dialogue with DAAS about the department's needs assessment. In July 2007, it published its Community Resource Guide for API Seniors.

4. Caregiver Training Institute

In June 2004, the Home Care Workforce Workgroup, which included public and nonprofit home care providers, began its extensive work to develop a home care training institute to increase the pool of well-trained home care workers. In July 2006, a detailed concept paper for the creation of a Home Care Training Institute was completed. Best practice models were visited in Tucson, New York City, and Washington. Harvard Community Partners assisted in the development of an operating budget. However, after extensive research, it was determined a new model for the development and operation of the institute would be needed. In 2007, the Workgroup restructured its concept paper and redesigned its financial model.

In March 2008, with the participation of the DAAS Executive Director, Anne Hinton, the Workgroup hosted a meeting of Bay Area and California foundations entitled "Workforce Development and the Home Care Tsunami". The intent was to get their financial support, along with significant county funding, to develop and operate a model home care training institute that sets the standard for training high quality paraprofessionals. This will be called the Caregiver Training Institute.

In September 2008, Margaret Baran, Workgroup Chair, reported she has been asked by the Weinberg Foundation for a proposal for the Caregiver Training Institute, to be submitted in October 2008. The California Endowment will also be approached for funding. Ms. Baran is working with Para-professional Healthcare Institute (PHI) in New York City on a state of the art training curriculum, as well as on program design and evaluation design.

5. Community Placement Plan

In July 2005, after extensive research, the Community Placement Plan was completed. It was developed to promote safe and healthful transitions from LHH and other institutional settings to successful placements in the community for adults with disabilities and older adults.

While this plan primarily focused on individuals discharged from LHH and other institutional settings willing and able to return to community living, it was also used to guide safe and healthful transitions for older adults and younger adults with disabilities who wanted to remain living in the community, but who needed: (1) a different setting such as a residential care facility or supportive housing; or (2) an array of assistance, care, and support services.

The Community Placement Plan built on information provided by the then City Controller, Ed Harrington, in his report dated May 2005 entitled: *"Laguna Honda Replacement Program Where do we go from here?"* That report stated "Of the people able to leave a skilled nursing facility and return to the community, (currently 84% of the Laguna Honda Hospital residents according to data from the Targeted Case Management Program), Targeted Case Management staff estimate that 25% would want to live in a board and care facility, 50%

would want supportive housing, and 25% would want to return to their own home or live in independent housing (with outside supports)."

Following adoption by the LTCCC, the Community Placement Plan provided a point of consensus and a road map for diverse groups that approached community placement and transitional care from different perspectives. This was a plan that advocates for community placement and transitional care could build upon and return to, because it had the force of the LTCCC behind it and the support of key City departments. During this period, LHH replacement plans continued to be explored. Not everyone agreed about the ultimate size of LHH, but this plan had general consensus.

6. Public Information and Community Education

In December 2005, the Public Relations and Marketing Workgroup, under the auspices of the SF Partnership and DAAS, launched a six-component media plan. The purpose was to convey the message that a rich array of home and community-based services are available in San Francisco. The major component, the Home Alone Campaign, was designed to increase knowledge about how to access to services for older adults and adults with disabilities living alone, and was first run in 2006. This run was so successful that it was repeated three times in 2007. The Home Alone campaign was a joint effort of the SF Partnership, DAAS, and United Way's 211 Community Services Information line. Ads were placed in mainstream media like the San Francisco Examiner, numerous ethnic and cultural news media, and on Muni bus lines. The first two runs were funded by DAAS and the final run was funded by the SF Partnership.

7. Services Connection Pilot Project (SCPP)

In April 2006, following the completion of a 2005 survey of the needs of seniors and adults with disabilities living in public housing by the SF Partnership, planning between DAAS and the San Francisco Housing Authority (SFHA) explored how to build collaboration between the SFHA, DAAS, and community-based service providers. [The initial survey was undertaken in response to recommendations made in the original LWD plan to assess the needs of homebound seniors living in senior public housing operated by the SFHA.]

In January 2007, SCPP began as a collaborative effort between DAAS, the SFHA, Resource Centers for Seniors and Adults with Disabilities, and community-based service providers. SCPP linked seniors and adults with disabilities living in public housing with services provided in the community, and increased collaboration among service providers and the Housing Authority. SCPP also provided an opportunity for isolated residents to meet and socialize with each other. In 2007, the strategy was to create "service teams" to visit two SFHA buildings (350 Ellis and 666 Ellis) twice a month. In 2008, SCPP was expanded to include three additional senior public housing buildings: Rosa Parks and the two Clementina Towers.

Services Connection Program
In August 2007, based on this success, DAAS, the SFHA, and a third organization, Northern California Presbyterian Homes and Services, applied for and received a $375,000 ROSS (Resident Opportunities for Self Sufficiency) grant from HUD to establish the Services Connection Program. An additional $611,000 was obtained from the City and County of San Francisco for this program. Accordingly, $986,000 was committed to place

service coordinators in five of the 23 senior/disabled building operated by the SF Housing Authority.

NOTE: In August 2008, DAAS, the SF Housing Authority, and NCPHS applied for a second ROSS grant from HUD, in the amount of $720,000, for more service coordinators to participate in the Services Connection Program. An additional $100,000 in cash match is being obtained from the City and County of San Francisco plus $681,000 in in-kind services from community based service providers. If this second ROSS grant is received, it will enable service coordinators to be placed in 11 additional public housing buildings.

8. Case Management Connect Pilot Project

In July 2007, following two years of research and planning by the Case Management Collaboration Workgroup, the SF Partnership, DAAS, and DPH, initiated a pilot project to improve how case management programs work together to better coordinate services. The pilot project includes 14 case management programs under contract to DAAS or DPH that are partnering to coordinate services for their clients through the use of an Electronic Rolodex. This tool enables participating agencies to see and get contact information for all case management programs serving the same client.

Through the development of an MOU, all participating case management programs are now part of the DPH Safety Net, and have the capacity to get additional information about other services being provided to the same client, which further helps to improve care coordination. This project is an example of breaking silos through improved cross-departmental collaboration.

Development of the Living With Dignity Strategic Plan 2009-2013

In March 2008, the LTCCC Steering Committee agreed to initiate a strategic planning process to update the original LWD plan. Updating the plan would serve the following purpose:

- assess the accomplishments and challenges faced by the implementation of the original LWD plan.
- identify goals, strategies, and objectives to either continue to work toward, change, delete, or add to the original LWD plan.
- provide a continuing roadmap for the LTCCC as it is charged to oversee all implementation activities identified in the LWD plan to make improvements in the community-based long term care service delivery system.
- determine the most appropriate structure for continuing to make service delivery system improvements – through current channels or others.

Evaluating 2004 Living With Dignity Strategic Plan Implementation

In April 2008, extensive background research began to examine the environmental context of this planning process. First, the goals, strategies, and objectives of the original 2004 LWD plan were reviewed and compared with documented accomplishments.

Second, reports and documentation from various planning activities conducted between 2006 and 2008 were reviewed to examine the environmental context within which the 2004 plan was implemented and assess the current long term care environment. These included: the 2006 DAAS Needs Assessment; a series of meetings in 2007 with SF Partnership members; random telephone surveys with a representative sample of older adults and adults with disabilities, a 2008 analysis of baby boomer population trends; and analyses of U.S. Census data conducted by the Human Services Agency.

Key Stakeholders: Interviews, Focus Groups, and Community Dialogues

Key stakeholder interviews and focus groups were conducted to solicit thoughts on current issues, as well as ideas for the prioritization and implementation of goals and strategies in the new plan. Focus groups were held with workgroups within the LTCCC and the SF Partnership, and also with the SF Adult Day Services Network. Interviews were held with representatives from public and private organizations providing aging and disability services, including consumer advocates. A total of 22 interviews and focus groups were conducted.

For a complete list of interviews and focus groups, see Appendix C.

The interviews and focus groups covered five key service delivery improvement areas: barriers to meeting the critical needs of San Francisco's long term care services network; current strengths, weaknesses, opportunities and threats of this network; and concrete strategies for improvements. In addition, participants were asked about their perceptions of the Long Term Care Coordinating Council.

Community dialogues were conducted with the two primary DAAS constituencies: adults with disabilities or disability advocates; and older adults or older adult advocates. The dialogues were held at two apartment complexes for older adults and adults with disabilities managed by the SF Housing Authority. Twenty-eight attendees participated in the dialogue concerning older adults and twenty-four attendees participated in the dialogue concerning adults with disabilities. Limited time and staff resources precluded conducting more than two consumer dialogues, however to supplement these community dialogues, transcripts from ten consumer focus groups with historically underserved populations were reviewed. These focus groups were conducted as part of the 2006 DAAS needs assessment.

Electronic Survey

An internet-based survey (using Survey Gizmo) to solicit input on current issues, as well as goals and strategies was conducted. The purpose of the survey was twofold. First, questions were framed within four sections to conduct a SWOT analysis: strengths, weaknesses, opportunities, and threats. Second, the survey would ask specific questions to confirm or disconfirm results, which emerged from the key stakeholder interviews, focus groups, and community dialogues.

Appendix C includes the content of the electronic survey. Research on web-based survey tools determined that Survey Gizmo was the most accessible application available to create a survey which would be accessible to various forms of assistive technology to support people with disabilities.

The content of this survey was developed from the results the completed interviews and focus groups, and community dialogues with service providers, consumers, and advocates.

The findings from these interviews, focus groups, and community dialogues were analyzed for recurrent themes and similarities regarding what respondents viewed as the strengths and weaknesses of the current home and community-based service systems. Potential opportunities as well as specific factors that pose threats to home and community-based services to meet critical needs were also identified through this process. Finally, the interviews and focus groups resulted in a list of potential strategies that could be included in the 2009 update of the LWD plan.

Accordingly, the electronic survey posed a series of strengths, weaknesses, opportunities, and threats for respondents to provide feedback on, and then asked respondents to prioritize the series of potential strategies, which arose from the interviews, focus groups, and community dialogues previously conducted.

The electronic survey was web-based and anonymous. Survey respondents were recruited by sending an e-mail with a link to the survey to the following groups:

- Coalition of Agencies Serving the Elderly (CASE)
- Community Alliance of Disability Advocates
- Mayor's Disability Council
- Long Term Care Coordinating Council
- Aging and Adult Services Commission
- Aging and Adult Services Advisory Council
- San Francisco Partnership for Community-Based Care & Support

A total of 115 surveys were submitted by respondents, of which 73 of these were fully completed. Sixty percent of respondents were employees of non-profit agencies and 28 percent represented public agencies. Other respondents were either not employed (3%) or represented other organizations such as private for-profits (5%), or other non-specified organizations (5%). There was broad geographic representation throughout the City with 19 zip codes reported. The majority of employed respondents were managers and program directors (39%), with executive directors (18%), analysts/planners (11%), and case managers/social workers (11%) also largely represented. Other respondents included direct service providers, supervisors, and the self-employed. Service providers represented those who serve both older adults and younger adults with disabilities, offering a wide array of services delivered by small, medium and large organizations. Respondents represented agencies with less than 10 paid, full-time staff (25%), between 11-26 paid full-time staff (28%) and those with more than 50 paid full-time staff (47%).

Strengths, Weaknesses, Opportunities, and Threats (SWOT) Analysis

The results of the interviews, focus groups, dialogues, and electronic survey were analyzed using a framework of identifying key strengths, weaknesses, opportunities, and threats which emerged from the data. From these items, a list of potential goals, strategies, and objectives was drafted. (See the SWOT Analysis section of this plan on page 31 for a summary of those results.)

Finally, once the goals, strategies, and objectives were drafted, the LWD staff workgroup ensured they were aligned and coordinated to the maximum extent possible with various plans and activities citywide, such as:

(1) The goals and objectives of the 2005-2009 Area Plan

(2) The DAAS 2006 Community Needs Assessment

(3) The Community Living Fund annual plans

(4) All other DAAS long term care planning efforts

(5) Agency-wide (HSA) planning and performance measurement efforts

(6) The long term care planning efforts of other city departments such as DPH, MOH, MOD, Muni, and the HSA Housing & Homeless program

Upon the completion of this process, a draft plan was presented to the LWD Steering Committee and the LTCCC steering committee for feedback. This feedback was incorporated and consensus was reached regarding the goals, strategies, and objectives presented in this current plan, which will be distributed to LTCCC members and other key stakeholders.

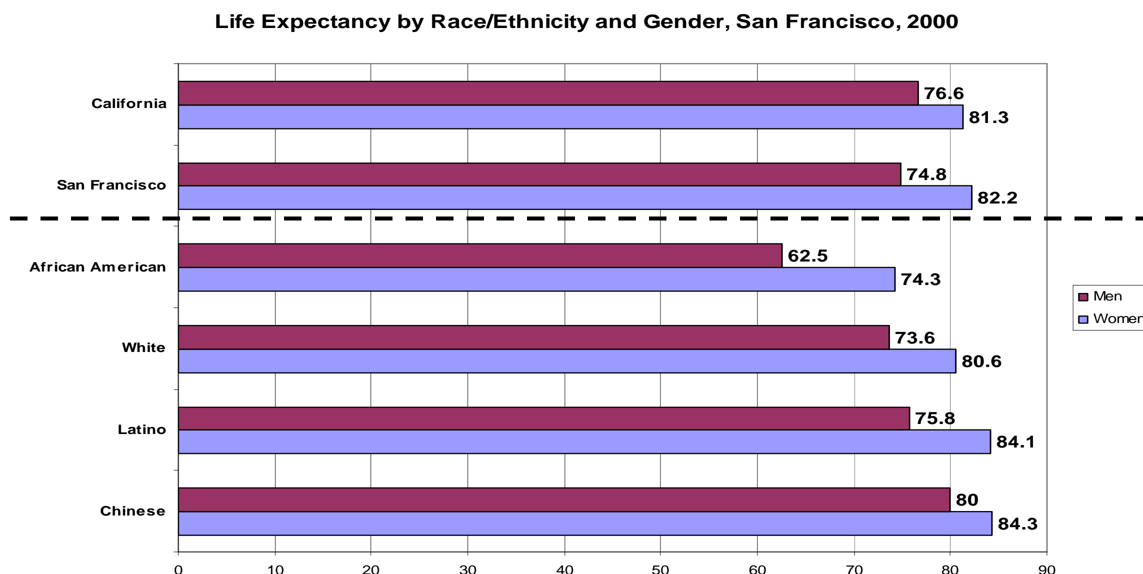
TODAY'S LONG TERM CARE ENVIRONMENT

San Francisco's Older Adults

Demographic Diversity

2000 Census data estimated that San Francisco was home to more than 136,000 seniors, defined as adults at least 60 years of age. Seniors made up a higher proportion of the city's population (17.6%) than they did statewide or nationally (14% and 16.5%). Mid-Census estimates suggest that the senior population has grown to over 145,000 as of 2007. San Francisco's senior population is also tremendously more diverse, requiring a strong emphasis on culturally relevant programming with broad language capacity. The majority (56%) of San Francisco's seniors are non-White, compared to only 30 percent statewide.

Asians and Pacific Islanders are more likely than other demographic groups to be over 60. They are 31 percent of the city's total population, but 37 percent of its seniors. Latinos, however, tend to be younger. While they are 14 percent of the city's total population, Latinos comprise 22 percent of its children and just 9 percent of its seniors. Relatively high life expectancy rates among Chinese and Latino San Franciscans is likely to contribute to a relative growth in their share of the overall senior population in coming years.



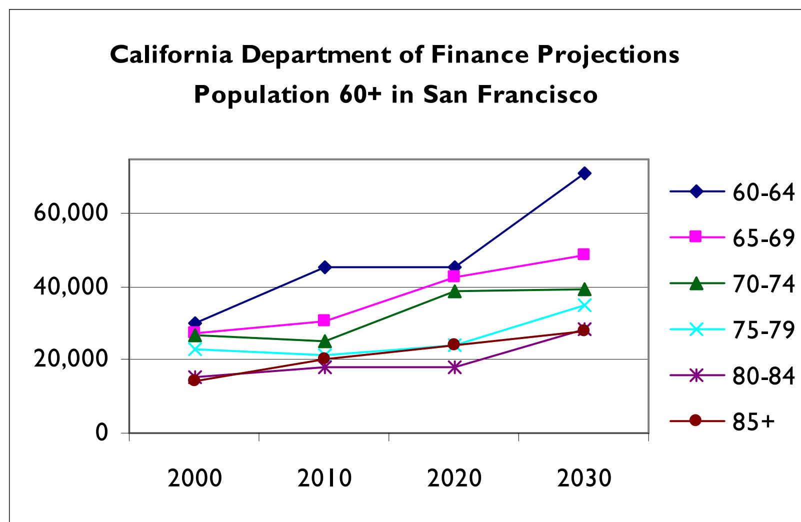
Many San Francisco residents do not speak English well. Census 2000 data estimate that 30,301 (28%) of San Francisco seniors speak English "not well" or "not at all," a much higher rate than that for individuals age 18 to 64 (12%). Nearly three quarters of those seniors speak Asian or Pacific Island languages. As Chinese seniors make up by far the largest number of Asian/Pacific Islander seniors overall (71%), it is likely that the majority of these individuals are Cantonese-or Mandarin-speaking. Monolingual groups with relatively small populations (e.g., Southeast Asian communities or indigenous groups) find few bilingual and bicultural staff at public and non-profit service agencies, and application forms are often unavailable in less common foreign languages. The recent national discourse on immigration has caused heightened fear of accessing services among immigrant populations.

Diversity in San Francisco goes beyond race, ethnicity, and language. San Francisco is also home to a large population of LGBT seniors. A 2002 report from the National Gay and Lesbian Task Force Foundation estimates that three to eight percent of all seniors nationwide are lesbian, gay, bisexual, or transgender.[1] It is difficult to estimate the exact size of this population in San Francisco, especially because older adults are more likely than their younger peers to remain closeted. However, local service providers estimate that as high as 17 percent of San Francisco's older adults may be LGBT.

Projected Population Growth for Older Adults

Advances in medical technology are likely to result in an increase in the relative size of the "older old" population both nationally and in San Francisco as life expectancies increase and fertility levels decrease.[2] Additionally, the aging of the Baby Boom generation (adults born between 1946 and 1964) is likely to cause a significant increase in the senior population in San Francisco.

According to July 2007 growth projections from the California Department of Finance (DOF), by 2030 the aging of the baby boomers will swell the population of 65 to 85 year-olds from 10 to 16 percent in California and from 13 to 18 in San Francisco as compared to 2000 Census figures.



The population of "older old" seniors in San Francisco (age 85+) is projected to nearly double by 2030. This segment is more likely to be female, poor and in need of long term care services. Fifty percent of this group has self-care limitations, mobility limitations, or both. After age 85, the risk of developing Alzheimer's disease rises to nearly 50 percent.[3] The needs of this segment will largely drive the City's demand for home and community-based long-term care services.

It is worth noting that some analysts consider the DOF projections to be unrealistic for San Francisco. Projections made by the Association of Bay Area Governments (ABAG) based on the 2000 Census show lower, but still considerable increases. ABAG predicts the senior population, currently 148,200, to reach 174,000 by 2020. This dramatic increase represents the coming wave of older adults. While not all of these individuals will need long term care

[1] Sean Cahill, Ken South, and Jane Spade, *Outing Age: Public Policy Issues Affecting Gay, Lesbian, Bisexual and Transgender Elders* (New York, NY: Policy Institute of the NGLTF Foundation, 2002), 8.
[2] Kinsella, K., and D.R. Phillips, "Global Aging: The Challenge of Success," *Population Bulletin* 60*, no.* 1 (March 2005): 3-40.
[3] Alzheimer's Association's Northern California and Northern Nevada Website: http://www.alz.org/alzheimers_disease_causes_risk_factors.asp. Accessed October 24, 2008:

services, many will require some form of assistance and support to maintain their ability to remain in their homes and community-based settings.

Some local analysts also speculate that some baby boomers who currently own homes in San Francisco may choose to move to lower cost areas as they age, "cashing out" their real estate assets. It is unclear what the impact of the current housing market crisis will have. Although the market in San Francisco has seen some slow-down to date, it has been more resilient than that of the greater Bay Area or of the state as a whole. Thirty-eight percent of households headed by a baby boomer were owner occupied at the time of the 2000 Census.

San Francisco's Adults with Disabilities (All Ages)

According to the 2007 American Community Survey, nearly 100,000 San Franciscans have at least one disability. Disability prevalence is highest among seniors, with 45 percent of seniors reporting one or more disabilities, but the total number of younger adults age 21 to 64 with a disability approximately the same size as the number of seniors with disabilities.

Number of People with Disabilities by Age Group (ACS 2007 Estimates)

Age	Total number of people	Number with one or more type of disability	Percent in this age group with a disability
5 to 15	59,121	2,701	5%
16 to 20	33,522	2,467	7%
21 to 64	519,167	44,958	9%
65 and older	109,508	49,598	45%
Total	*721,318*	*99,724*	*14%*

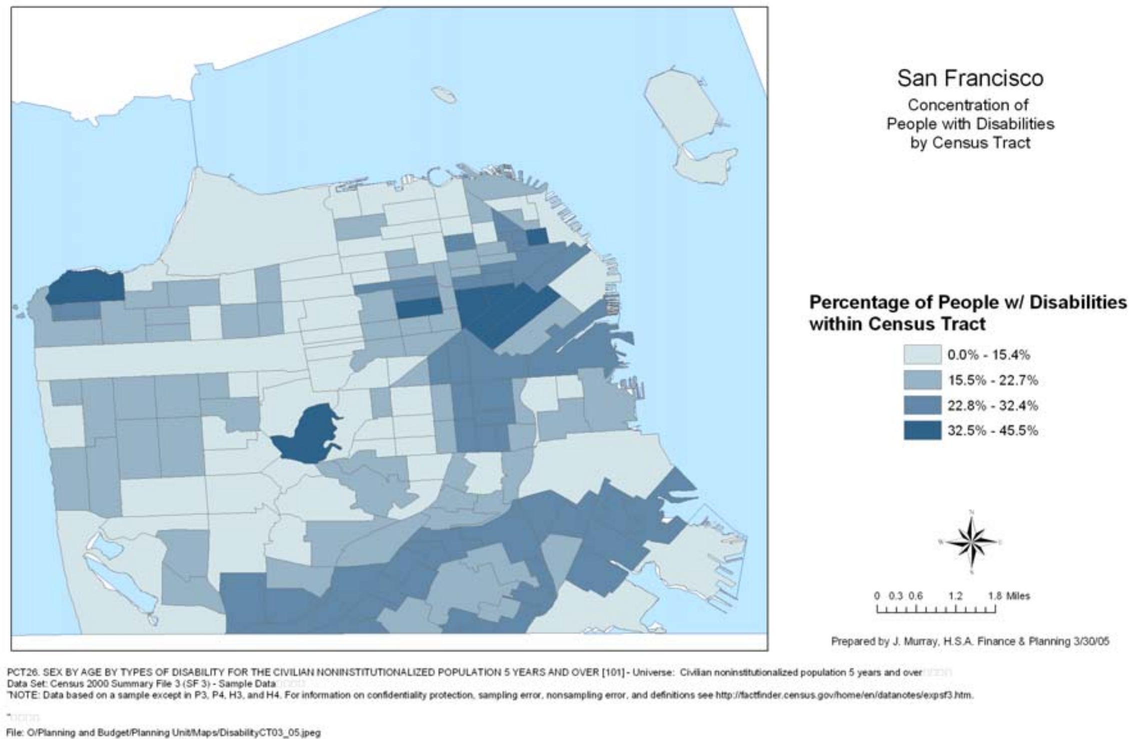
The table below compares the types of disabilities and their frequencies for persons age 16 and over in San Francisco. In a city known for its hills, more than 60,000 adults have physical disabilities. In absolute numbers, more young persons have mental disabilities than do seniors. Seniors are much more likely to have difficulties with self care. Among persons between the ages of 16 and 64, over 27,000 (5%) have two or more disabilities; among persons 65 or older, nearly a third, or over 34,000 have two or more disabilities.

Types of Disabilities for Persons Age 16 and Over (ACS 2007 Estimates)

Age	Total Population	Self Care		Go Outside the Home		Physical		Mental		Sensory	
		#	%	#	%	#	%	#	%	#	%
16-64	552,689	6,868	1%	10,601	2%	23,691	4%	22,081	4%	10,031	2%
65+	109,508	17,279	16%	28,199	26%	38,952	36%	19,972	18%	20,621	19%

The map below shows where persons with disabilities live in San Francisco, and it suggests that people with disabilities tend to either live in low-income neighborhoods like the Tenderloin and South of Market areas, which have more accessible housing and are central to BART and Muni streetcar routes, or else live in affluent neighborhoods like St. Francis

Woods/West Portal and Sea Cliff, neither of which is known for accessibility. Chinatown, which has many hotels and apartments without elevators, also has a large concentration of people with disabilities.[4]



2007 estimates show that Whites and Asians have the highest numbers of younger persons (age 16 to 64) with disabilities (20,771 and 9,929 respectively), compared to 7,673 African Americans and 7,172 Latinos. African Americans have the highest rate of disability, as 23% of African Americans in this age range have a disability, compared to just 8% of Whites, 6% of Asians, and 9% of Latinos.

Diversity within the disability community goes well beyond traditional demographic issues. Adults with disabilities have tremendously diverse experiences and stigmas depending on factors such as: the type of the disability they have (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. These individuals may or may not welcome their new status as "older" or as having a disability, which presents additional challenges in providing appropriate services.

[4] Map developed by the San Francisco Human Services Agency planning unit in March 2005.

Low- and Moderate-Income Populations

The older a person is, the more likely he or she is living in poverty. The chart below compares poverty levels across the different senior age groups. Almost one in three people age 75 or older in San Francisco lives in poverty.[5]

Younger disabled persons are much more likely to be living in poverty than their non-disabled peers. Persons with disabilities are also likely to earn less than their counterparts in the general population. The 2004 American Community Survey indicates that 22 percent of younger persons with disabilities (11,395 total) in San Francisco are living below the federal poverty line. The Social Security Administration reports that 17,966 San Franciscans between the ages of 18 and 64 are receiving SSI, making up 39 percent of all San Franciscan receiving SSI.[6]

Many higher income individuals struggle to make ends meet in San Francisco. The Federal Poverty Guidelines (FPL) is based on an outdated methodology that fails to take into account housing and transportation costs, geographic differences in the cost of living, and medical costs. A newly developed measure, the California Elder Economic Security Standard Index, estimates how much income is needed for a retired, older adult to adequately meet his or her basic needs – without public or private assistance.[7] The chart below shows that the Elder Index is nearly three times the FPL for renters in San Francisco, and close to four times the FPL for homeowners with a mortgage to pay.

[5] *City and County of San Francisco Area Plan on Aging: Fiscal Year 2005-2009* (2005), 14. Available on-line at: http://www.sfhsa.org/specialnotice.htm
[6] United States Social Security Administration Office of Policy Data, *SSI Recipients by State and County, 2007* (May 2008). Available on-line at: http://www.socialsecurity.gov/policy/docs/statcomps/ssi_sc/2007/
[7] More information about the California Elder Economic Security Standard is available on Insight CCED's website: http://www.insightcced.org

Many moderate-income San Francisco residents fall through the cracks when they begin to need community-based long term care services. Their incomes or assets are too high to qualify for public programs that target low-income adults, but they cannot afford to pay out of pocket for private pay services without quickly becoming impoverished. Some residents of new affordable housing developments struggle; the rent subsidies they receive are only one piece of the puzzle, and their incomes are too high to qualify for many means-tested services.

Informal Caregivers

More than three quarters of American adults who receive long-term care at home get all their care from unpaid family and friends, mostly wives and adult daughters. Another 14 percent receive some combination of family care and paid help. Only eight percent rely on formal care alone.[8]

Precise caregiver statistics are unavailable for San Francisco County. Using a variety of estimation methods, the 2006 DAAS Community Needs Assessment estimated that the number of caregivers in San Francisco could be anywhere between 50,000 and 150,000. If the UC Berkeley's Center for the Advanced Study of Aging study is accurate in estimating that 30 percent of caregivers have unmet need for support services,[9] then an estimated 15,000 to 45,000 San Francisco caregivers may need more caregiver support services. While these estimates are inexact, they provide a sense of scale for the size of this population.

Common challenges associated with caregiving roles include: (1) *Financial strain* due to reduced work hours, time out of the workforce, family leave, or early retirement; (2) *Physical and emotional stress* that can result in burnout without adequate support systems, especially for caregivers of those with dementia; and (3) *physical and mental health issues*, including depression, anxiety, anger, and guilt. Many caregivers of older adults are themselves elderly – of those caring for someone aged 65 or older, and average age of caregivers is 63 years old with one-third of these in fair to poor health.[10]

The population of caregivers in San Francisco is diverse, and certain populations face unique challenges. For example, caregivers of younger adults with disabilities are likely to remain in their caregiving role for many years, which can increase stress, financial strain, and risk of burnout. These caregivers may also struggle with how to balance the younger person's need for autonomy and independence with the safety and economic necessity of having family members provide care. Ethnic minorities, especially Asians and Latinos, are less likely than other groups to see caregiver support services. When they do seek support, lack of culturally and linguistically relevant services can create a barrier to access. LGBT caregivers struggle with discrimination and insensitivity by community providers, paired with fragile or few connections to broader family networks.

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[8] Feinberg, Lynn Friss, Kari Wolkwitz, and Cara Goldstein, *Ahead of the Curve: Emerging Trends and Practices in Family Caregiver Support* (National Center on Caregiving, Family Caregiver Alliance: March 2006), 1.
[9] Scharlach, Andrew et al, *A Profile of Family Caregivers: Results of the California Statewide Survey* (University of California, Berkeley, Center for Advanced Study of Aging Services: 2003).
[10] Administration on Aging, *NFCSP Complete Resource Guide*, (September 2004). Available on-line: http://www.aoa.gov/prof/aoaprog/caregiver/careprof/progguidance/resources/nfcsp_resources_guide.asp

Issues Related to Dementia

According to a 2007 policy memorandum prepared by the LTCCC's Mental Health Access Workgroup, San Francisco will see a dramatic increase in the number of residents living with Alzheimer's disease and other dementias. Figures from the Alzheimer's Association of Northern California and Northern Nevada suggest that the number of seniors with Alzheimer's disease will increase by more than 10 percent by 2015. Increasingly, older adults with dementia are living in the community in San Francisco, resulting in a rising need for associated medical and nursing services. At present, 70% of people with dementia are cared for in community-based settings or at home, but late stage dementia requires institutional care in some cases.

Medically Complex Needs and High-Risk Circumstances

Adults with medically complex, mental health, or substance abuse conditions comprise a significant group of people in need of long term care services, and includes both older adults as well as younger adults with disabilities. Gone untreated, chronic mental health and substance abuse problems lead these adults to age faster, thus becoming more gravely disabled, and in need of long term care services earlier than their peers. While the exact number is unknown, it is estimated that 600 individuals in the In-Home Supportive Services (IHSS) Program alone fall into this category. It is also estimated that 1,900 individuals living on the street fall into this category.

A 2006 longitudinal study of the homeless population shows that each calendar year, the average age of the homeless population increases, consistent with trends in several other cities. According to this study, "It is likely that the homeless are static, aging population cohort. The aging trends suggest that chronic conditions will become increasingly prominent for homeless health services. This will present challenges to traditional approaches to screening, prevention, and treatment of chronic diseases in an aging homeless population."

New Policy Trends Since 2004

1. San Francisco Lawsuit Settlements

Building on the foundation of the United States Supreme Court's Olmstead decision of 1999, which determined that states must provide community-based services for persons with disabilities who would otherwise receive institutional care, two lawsuits have been initiated and settled that have already had an impact on San Francisco:

Settlement of the Davis v. California Health and Human Services Agency lawsuit

In July 2000, residents of LHH and the Independent Living Resource Center of San Francisco (ILRCSF) sued the City and County of San Francisco and several state departments because residents claimed they wanted care in the community rather than at Laguna Honda Hospital. Specifically, the lawsuit claimed that LHH and the state departments did not inform the class members about, assess for, offer or provide home and community-based services instead of services at LHH.

The Davis v. California Health and Human Services Agency lawsuit was settled in December 2003 and implementation was initiated in March 2004. The settlement included the following major provisions. San Francisco had to:

- **Implement a Targeted Case Management (TCM) Program** within DPH composed of nurses and social workers who report to the Placement Division of Community Programs in DPH. Community Programs include Behavioral Health Services (mental health and substance abuse) Primary Care, Housing and Preventive Health Care.
- **Conduct screening, assessments and service/discharge planning** and **ongoing case management** consistent with the Division of Community Program's goal to place people in the most integrated setting appropriate for their needs and desires.
- Avoid unnecessary institutionalization and assure appropriate utilization of hospital and nursing home resources by **promoting appropriate community-based alternatives**.

Settlement of the Mark Chambers, et al v. City and County of San Francisco, and Laguna Honda Hospital

In October 2006, residents of LHH and the ILRCSF again sued the City and County of San Francisco, alleging discrimination in the form of unnecessary institutionalization under the Americans with Disabilities Act. In November 2007, the parties reached a settlement focused on the enhancement of community-based living options, through the provision of services and housing, to class members.[11] The settlement includes the following major provisions. San Francisco had to:

- Take steps to make operational the **Med-Cal Nursing Facility/Acute Hospital Waiver (NF/AH Waiver)**, including appointing a waiver point person, referrals class members to the NF/AH Waiver, recruiting providers and providing housing to match waiver services.
- Establish a **Diversion and Community Integration Program (DCIP)**, which will be a collaborative unit of Departments of Public Health and Aging and Adult Services. The DCIP will conduct assessments and prepare a Community Living Plan for each class member referred to and/or recommended for discharge from LHH. The Community Living Plan will set forth the services to be provided for class members to live in the most integrated setting based on

[11] The class, as certified by the Court in July 2007, consists of Medi-Cal recipients who reside at LHH, are on the waitlist for LHH, are within two years post discharge from LHH or are patients at SFGH and are eligible for discharge to LHH.

their assessed need and preferences. San Francisco will refer class members for or provide them with the case management and appropriate wrap-around services, as needed.

- Secure and subsidize **scattered site, accessible, independent housing** for approximately 500 class members over the five years following the settlement. Other provisions exist in the settlement for maintaining housing during periods of hospitalization or institutionalization; providing housing options other than independent housing when appropriate; modifying units as necessary and feasible; and developing a housing inventory and waitlist database.
- **Enhance mental health and substance abuse services** by providing access to appropriate primary care and mental health services in the community, making recommendation as to coordination of mental health services at LHH and in the community, and providing access to mental health services and case management as appropriate for class members.
- Agree that **the mission of a rebuilt LHH facility** shall include as a goal that the facility is for short-term, rehabilitative treatment. Operationally, LHH will provide services and supports that focus on enhancing community living skills, including a full range of transition services.

The settlement agreement also included provisions for grievance procedures, data collection and reporting, quality assurance, and settlement monitoring.

2. Implementation of Existing Medicaid Home and Community-Based Services Waivers

Many states have taken steps to increase the range and depth of community-based care options. Several, like California, have Medicaid waivers to provide long term care services in assisted living facilities as well as in the homes of those who otherwise would be in an institutional setting. Home and Community-Based Services (HCBS) Waivers are programs that waive certain federal Medicaid rules in order to provide different or more services than the State offers to other Medicaid (Medi-Cal) eligible people.

DPH and DAAS are actively working to implement two recent Medicaid waivers as of the writing of this plan:

State Nursing Facility and Acute Hospital Waiver

In January 2007, three pre-existing waivers[12] administered by the California Department of Health Services were combined to form a new waiver: the Nursing Facility/Acute Hospital (NF/AH) Waiver. This new state waiver brings in additional waiver slots to allow California residents to access services, added "community transition" and "habilitation" services, and added non-profit providers as qualifying case management and habilitation providers.[13] Most importantly, this new state waiver will allow for 500 new waiver slots, across California, of which 250 are reserved for people transitioning out of institutions. Many of the additional slots may go to people at LHH. The 500 new waiver slots will enable the purchase of

[12] The pre-existing waivers were the Nursing Facility A/B waiver, the Subacute waiver, and the In-Home Medical Care waiver.
[13] A helpful fact sheet is available about this waiver on the internet: http://www.pai-ca.org/advocacy/HCBSWaivers/WaiverFactSheet.htm

additional services – meals, caregivers, and other services that allow people to remain in the community. This waiver does not cover the cost of housing.

The advantage of this waiver is that it can provide increased funding for qualifying individuals. The cost cap is $77,600 per person per year for people in distinct part nursing facilities like LHH. People must reside at LHH for a 30-day period and meet the distinct-part care needs to be eligible. For people in freestanding nursing facilities, this cost cap may be raised to $48,000, as proposed by the governor. The state must comply with cost neutrality: it cannot cost more to serve people in the community on the waiver than would have been paid without the waiver.

While the new waiver is seen as an excellent opportunity for funding community-based long-term care services, implementation has been slow. A limited number of community agencies had completed application process to become approved providers, and state assessments of potentially eligible consumers have yielded fewer-than-expected actual participants.

Assisted Living Waiver

Several states, including California, are experimenting with new waiver policies that would allow Medi-Cal-eligible individuals the option of assisted living as an alternative to long-term placement in a skilled nursing facility. A 2000 California state law (AB 499 - Aroner) required the State Department of Health Care Services to test Medi-Cal funding of long term care in assisted living settings, subject to federal approval. The Centers for Medicare and Medicaid Services (CMS), the responsible federal agency, approved the pilot project in June 2005.

In March 2006, Medi-Cal began paying for assisted living care to select residents of Los Angeles, Sacramento and San Joaquin counties. A three-year pilot project, the Assisted Living Waiver Pilot Project is operated by the California Department of Health Care Services. It offers Medi-Cal-eligible persons the option of assisted living as an alternative to long-term placement in a skilled nursing facility. There are two types of assisted residences, Residential Care Facilities for the Elderly (RCFEs) and publicly subsidized housing. The intent of the project is to enable seniors and persons with disabilities the opportunity to age in place in a community setting rather than facility placement.

Eligibility is determined by an assessment administered by a Care Coordination Agency. The RCFE providers include both large and small facilities. The publicly subsidized housing settings are an experimental design with a home health agency providing a 24-hour presence in the housing site to render the assisted care bundle of services. Other benefits include skilled nursing transition, community transition assistance, translation and interpretation, consumer education and environmental accessibility adaptations.

3. Efforts to Develop a New Medicaid Home and Community-Based Services Waiver specifically for San Francisco

AB 2968 (Leno) requires the State Department of Health Care Services (DHCS) to seek a federal Medicaid waiver to increase community-based care options for San Franciscans with chronic or disabling health conditions who would otherwise be homeless, living in shelters, or institutionalized. The waiver will provide Medi-Cal funds for a range of assisted living

and supported housing type services (the services people need to remain in their own housing). This is called the Medi-Cal Community Living Support Benefit.

There are two target populations: (1) people at LHH or at imminent risk of entering LHH – meeting nursing home level of care (this is the standard requirement for a HCBS waiver); (2) people who are homeless and not at LHH, who are high users of services like ambulance services, inpatient services (acute medical and psychiatric) and behavioral health services (an "at-risk" group). Currently, many of this second group end up at SFGH or LHH and/or back on the streets, and the intent is to avoid this outcome.

DHCS is interested in two distinct programs operated under two separate authorities. Two concept papers are being developed by DPH for programs consistent with AB 2968 for San Francisco. They will explain conceptually how the programs would be implemented, the target groups, services, the sites, and the operators.

This waiver will create a designated Medi-Cal reimbursement rate structure for Medi-Cal "wrap-around" services such as personal care, intermittent nursing and intensive case management, necessary for individuals with multiple service needs to live in community-based settings rather than in more expensive institutional settings.

This will be a specific waiver for San Francisco to enable residents to have essentially "assisted living". In California, assisted living facilities are licensed as Residential Care Facilities for the Elderly and regulated by the State Department of Social Services. California has two assisted living pilot projects, one of which is in San Diego. The Leno bill is much more pro-active. San Francisco is going to draft this waiver.

4. Money Follows the Person Demonstration: California Community Transitions

The Money Follows the Person (MFP) Demonstration is a five-year federal grant to the State of California, which gets enhanced federal matching money for services provided to participants in the first year post-discharge from an inpatient facility.[14] While the demonstration project is not itself a waiver, the funding will eventually transition onto an existing waiver.

California's plan is to help 2,000 individuals residing in nursing and other health facilities transition into the community, with access to home and community-based services. This Demonstration runs through September 2011.[15] Four counties are currently enrolled and there is a plan to recruit an additional seven over the five-year period. Each enrolled county has one lead agency that takes responsibility for creating a comprehensive service plan, facilitating transition to community living and following the participant for up to three months post-discharge to ensure a seamless transfer of services. Since the MFP is not a waiver, the participant may also be receiving services from waivers such as the NF/AH waiver or the Multi-Purpose Senior Services (MSSP) waiver at the same time. A primary purpose for the MFP is to provide extra dollars and assistance during the initial period of

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[14] Demonstration participants must have lived continuously in an inpatient facility (freestanding NF or DP/NF, acute or ICF/DD) for six months or longer; must be a Medi-Cal beneficiary for at least 30 days; and would continue to require the "level of care" provided in a health care facility.
[15] The five-year period began in 2007, which was used as a planning year.

planning for, and transitioning to, the community. Each individual's demonstration participation ends 12 months from the date of discharge from the facility

In September 2008, an initial meeting was held with the California Department of Health Care Services, DAAS, and DPH to explore San Francisco's application to begin a county participating in the MFP demonstration.

5. Policy Issues Related to Housing

Limited availability of affordable and accessible housing continues to be a primary issue in San Francisco's community-based long-term care environment. Federal housing development policies can exacerbate this issue by targeting new housing development for certain populations while neglecting others. As of fall 2006, for example, a third of the units under construction with oversight by MOH or SFRA were for homeless persons. An additional 20 percent were targeted to older adults. Less than one percent would serve adults with disabilities who are neither formerly homeless nor elderly (San Francisco Human Services Agency, 2006). Furthermore, most housing development projects do not include comprehensive planning for the integration of both licensed and non-licensed community-based long-term care services, which can create an additional barrier to access for individuals who require those services in order to maintain independent living.

Options for affordable residential care also continue to disappear in San Francisco. Medi-Cal does not cover residential care and payments from SSI/SSP are below operating cost, resulting in a drastic loss of assisted living options for low-income individuals. Residential care slots for non-ambulatory individuals are scarce.

For seniors and adults with disabilities who own their homes, city codes that regulate remodeling sometimes have unintended consequences that restrict seniors and adults with disabilities from executing the home modifications that are necessary for aging in place.

For FY 2008-09, San Francisco allocated $1 million for housing related to the Chambers lawsuit settlement. This funding was provided to DPH Housing and Urban Health to provide additional financial resources for scattered site housing for people discharged from Laguna Honda Hospital and for diversions from San Francisco General Hospital.

6. Policy Issues Related to End-of-Life Planning

In addition to existing law guiding the use of advance directives in California, two new laws that affect end-of-life planning will be effective January 1, 2009. AB 3000 provides consumers with a new mechanism – Physician Orders for Life-Sustaining Treatment (POLST) – to ensure that their wishes are honored regarding medical treatment towards the end of life. POLST was developed initially in response to seriously ill patients receiving medical treatments that were not consistent with their wishes. The goal of POLST is to honor patient's end-of-life treatment preferences either to have or to limit treatment, even when transferred from one care setting to another. POLST is most appropriate for seriously ill persons with life-limiting illnesses or advanced frailty characterized by significant weakness and extreme difficulty with personal care activities. Unlike advance directives, POLST is a medical order; it turns treatment wishes of an individual into actionable medical orders. POLST does not replace traditional advance directives, which are still recommended

for all adults in order to allow individuals to express their wishes and appoint someone they would like to make health care decisions if they are not able to do so. When available, an advance directive would accompany a POLST form but would not be required for the orders to be valid. In adopting the POLST form, California joins several other states that have adopted or are developing the form.

AB 2747 addresses consumer information related to end-of-life care and treatment. When a healthcare provider makes a diagnosis of a terminal illness, this new law requires that the provider shall, upon the patient's request, provide comprehensive information and counseling regarding legal end-of-life options. The information shall include hospice; prognosis with and without the continuation of disease-targeted treatment; the right to refuse or withdraw from life-sustaining treatment; the right to continue disease-targeted treatment, with or without concurrent palliative care; the right to comprehensive pain and symptom management, including, adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue; and advance care planning.

New Local Program Initiatives Since 2004

Since the development of the 2004 Living with Dignity Strategic Plan, several program initiatives have been launched, altering the community-based long term care landscape.

1. Community Living Fund

In July 2006, the Mayor and Board of Supervisors of San Francisco created a $3 million locally-funded **Community Living Fund (CLF)**, administered by DAAS. The goals of this Fund are to: (1) provide choices for adults of all ages with disabilities about where and how they receive services that provide them with assistance, care and support to live in the community; and (2) assure that no individual is institutionalized because of a lack of community-based long term care and supportive services. The purpose of the CLF is to:

- Enable adults of all ages with disabilities who are eligible for this Fund to remain living safely in their own homes and communities as long as possible.
- Provide financial support for home and community-based long term care and supportive services beyond what is currently available.
- Offer flexible funding to service providers to create "wrap-around" services that provide essential community-based assistance, care and support.
- Facilitate the development of service delivery models that strengthen the community-based long term care work force.
- Expand, not supplant, existing funding, in order to fill funding gaps until new sources of financial support for community-based long term care services can be secured through federal Medicaid waivers and other means.

In July 2008, DAAS received an additional $1 million to augment the CLF for services to assist people being discharged from Laguna Honda Hospital and for those being diverted from institutional settings.

2. DAAS Long Term Care Intake and Screening Unit

In March 2007, DAAS began the process of transforming its internal Information and Referral line and staffing into a **Long Term Care Intake and Screening Unit**. The unit coordinates existing Information and Referral services with previously disparate access points to the following services: Home-Delivered Meals, Adult Protective Services, In-Home Supportive Services, and the Community Living Fund. Once fully implemented, consumers or caregivers seeking services will have access to comprehensive information about available resources without needing to make multiple calls to a variety of public programs.

3. Downsizing of Laguna Honda Hospital

Laguna Honda Hospital is a licensed acute care hospital with a distinct part that is a skilled nursing facility and a rehabilitation-care facility. Previously, it operated 1200 beds and was the largest municipally owned single-site long term care facility in the nation. The new Laguna Honda Hospital will be comprised of three new buildings, which will include 780 beds, a new library, cafeteria, kitchen, radiology services, a gift shop, and a beauty and barbershop.

The three buildings will include the South Residence Building, the Link Building, and The East Residence Building. All new construction is phased to ensure that all the residents continue to receive the skilled care they require without any disruption in services. Phase One of the new construction began in mid 2005 and will add the 780 beds; the first two buildings will be ready for residents in late 2008. The 140 Assisted Living units will be completed in 2013.

4. Diversion and Community Integration Program (DCIP)

In December 2007, as a result of the Chambers lawsuit settlement the City entered into with residents of Laguna Honda Hospital, DAAS began collaborating with the Department of Public Health to create a new unit known as the **DCIP**. The DCIP will provide an integrated approach to provide supportive services primarily for individuals who are diverted or discharged from Laguna Honda Hospital. The DCIP will operate with the goal of supporting individuals in the setting that is most appropriate to their needs and preferences, and will focus on enhancing services that allow clients to live in the community as long as possible. In addition, as established in the settlement agreement, the DCIP will be used to identify and secure housing and services for 100 eligible Laguna Honda Hospital clients each year over a period of five years.

5. Alzheimer's/Dementia Expert Panel

In June 2007, after several months of investigation, the Mental Health Access Workgroup presented to the LTCCC a series of recommendations related to the growing crisis in dementia care. In October 2007, the LTCCC submitted these recommendations, including a recommendation for the formation of an Alzheimer's/Dementia Expert Panel, to the Mayor's Office for consideration. In response to rising concerns presented in this LTCCC policy memorandum, the Mayor's Budget for FY 2008-09 included $100,000 for DAAS for an investigation of the issues raised about the growing crisis in dementia care and the anticipated need for additional services.

In September 2008, DAAS sought a Project Management Team to work with the department and the Alzheimer's/Dementia Expert Panel, to facilitate all activities related to: (1) an evaluation of current dementia care services, research and summarization of all existing services; (2) projection of the need for and types of additional services over the next 12 years; (3) economic analysis of projected costs (inflation adjusted) and funding sources; and (4) facilitation of the Expert Panel's work in development of a report and realistic recommendations for how to address the anticipated need for additional services which will include best practices and local publicly funded services from other parts of the country. The Project Management Team will begin on November 1, 2008. The Alzheimer's/ Dementia Expert Panel is to complete its work between December 1, 2008 and April 30, 2009, with a final report and recommendations due on May 31, 2009.

6. Public Information and Community Education

In 2008 and 2009, DAAS will be continuing the implementation of a series of successful public relations strategies that began from 2005 to 2007 under the auspices of the SF Partnership. This is an effort to: (1) promote the awareness of and availability of community-based services for older adults and adults with disabilities; and (2) undertake an advocacy campaign concerning the crisis in dementia care. The oversight body for this public relations effort is DAAS, which will provide guidance for all implementation activities.

This public information and community education effort is promoting supportive services for older adults and adults with disabilities. Components include: (1) the Aging Well Campaign (previously called the Home Alone Campaign), (2) Community and Agency-Based Communication, (3) Advocacy Campaign on the Crisis in Dementia Care, and (4) Targeted Broadcast Media Campaign.

Advocacy Campaign on the Crisis in Dementia Care

In July 2008, DAAS working with a new Public Information and Community Education Advisory Committee, began to structure an advocacy campaign on the growing crisis in dementia care. This will increase awareness of the crisis. The campaign will explain the different types of dementia, its progression, the role of caregivers, and support available in the community. The campaign will advocate for more dementia care-ready community-based service providers, especially for those with mild to moderate dementia. This campaign will take place in the fall of 2008.

Other Current and Promising Innovations

1. Aging & Disability Friendly Communities

Cities and towns throughout the United States are aging rapidly, with the senior population due to double in the next 25 years; yet, most communities are not prepared. Many cities are considering and implementing strategies for creating "age and disability friendly communities," helping their communities respond effectively to shifting demographics.

Age and disability friendly communities: (1) address the needs for accessible and affordable housing, and public safety; (2) improve access to parks, open space and recreation; (3)

maximize independence through accessible transportation; (4) mobilize resources to facilitate living at home; (5) increase support for families and caregivers; (6) provide opportunities to be meaningfully engaged in the life of the city; and (7) support community activities that enhance personal well-being. This collaborative effort is taking place across the country - in Atlanta, Boston, New York, and many other cities.

In October 2008, DAAS began conversations with the local City Planning department to determine what might be involved in making the communities throughout this city more age and disability friendly.

Appendix D provides a checklist of essential features of age-friendly cities, according to the World Health Organization.

2. Project 2020: Building on the Promise of Home and Community-Based Services

The National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (n4a), conscious of the financial pressures facing states and the federal government, have developed a coordinated national long-term care strategy that will generate savings in Medicaid and Medicare at the federal and state levels while enabling older adults and individuals with disabilities to get the support they need to successfully age where they want to — in their own home and community.

The strategy, which has evolved from long-term care initiatives of the U.S. Administration on Aging (AoA), CMS, Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) and others, was incorporated into the reauthorized Older Americans Act (OAA) in 2006.

The strategy builds on the historic role of State Units on Aging (SUAs), Area Agencies on Aging (AAAs) and Title VI Native American aging programs (Title VIs). It is a comprehensive and integrated approach to enabling the elderly and individuals with disabilities to make their own decisions, to take steps to manage their own health risks, and to receive the care they choose in order to remain in their own homes and communities for as long as possible, avoiding unnecessary and unwanted institutionalization. AoA, in cooperation with SUAs and AAAs, has been testing best practices in community-based long-term care that have been demonstrated to reduce the need for more expensive institutional care and prevent "spend down" to Medicaid for people of all ages with disabilities.

NASUA and n4a have embraced these proven strategies as requirements for infrastructure development and participation in this program. This three-pronged approach will allow communities to provide services to this growing population at a lower cost to consumers and to Medicaid and Medicare.

Project 2020's goal is to provide the resources to implement consumer-centered and cost-effective long-term care strategies authorized in the 2006 reauthorization of the Older Americans Act. Empower the Aging Services Network to implement these strategies through a three-pronged program encompassing person-centered access to information, evidence-based disease prevention and health promotion activities, and enhanced nursing home diversion services.

The key elements of this approach include:

1. Person-Centered Access to Information
2. Evidence-Based Disease Prevention and Health Promotion
3. Enhanced Nursing Home Diversion Services

For the long-term care strategies and solutions proposed, n4a and NASUA are seeking funding to support federal outlays of $2.4 billion over five years to be administered through the Aging Services Network of State and Area Agencies on Aging.

3. Beacon Hill Village/San Francisco Village

Within the last several years, a group of residents in Boston launched Beacon Hill Village, an innovative membership organization that allows members to remain in their own homes as they age by facilitating access to social and cultural activities, exercise, household and home maintenance services, as well as medical care and assisted living at home. Members pay an annual fee, which guarantees access to certain services for free and others at a reduced rate as negotiated by the non-profit. San Francisco Village is a new organization modeled on the same concept, providing health and wellness services, social and cultural activities and supports; volunteering opportunities; and daily living supports. It is scheduled to launch services in January 2009.

4. Continuing Care at Home Model

A Continuing Care Retirement Community (CCRC) is a residential community chosen for the remainder of one's life, with a choice of services and living situations. Seniors can move between Independent Living, Assisted Living, and Nursing Home Care based on changing needs at each point in time.

In seven (7) states (Illinois, Maryland, New Jersey, Ohio, Pennsylvania, Tennessee and Washington, DC), aging services providers offer consumer-preferred, in-home care by utilizing area "continuing care retirement communities" to provide a comprehensive, continuous system of care. These "Continuing Care at Home" programs are operated out of the local CCRC and provide an array of services in the senior's private residence tailored to his or her specific needs. These services range from home maintenance, remote monitoring, meals, assistance with activities of daily living, provision of medications to skilled nursing care. The costs of these services to the consumer are significantly lower than moving into a CCRC, yet offer many of the benefits of the CCRC model.

In late 2005, Aging Services of California convened a policy summit to explore the continuing care at home model in depth and examine obstacles that might prevent California providers from providing this type of care. It was determined that if existing providers were to offer services in seniors' private residences, the residences themselves must be licensed as a Residential Care Facility for the Elderly (as defined in Health & Safety Code 1569 et seq.). A task force was formed, comprised of providers, residents, representatives from the Department of Social Services and legal experts, to craft a legislative solution to this problem.

In September 2008, this legislation was vetoed by Governor Arnold Schwarzenegger, but this concept may be explored in California at some point in the future.

5. Community Living Campaign

In January 2008, the Community Living Campaign began working to make San Francisco a good place for seniors and persons with disabilities, inspired by the social network development of the PLAN Institute for Caring Citizenship of Canada. Toward this end, the campaign is helping people with personal and social support networks to have a good life that includes:

- Building supportive and loving relationships.
- Living in a place of one's own.
- Contributing to the well being of others.
- Making one's own decisions.
- Achieving basic financial security.
- Participating in communities that respect and celebrate diversity.
- Being part of a community that promotes fairness, equality and justice.

6. Recent Research

Dramatic national projections of growth in the senior population are leading to increased research focus on a variety of issues related to long-term care. The following list provides a snapshot of the research that is being pursued and released by a variety of universities, think tanks, and other organizations.

- The policy and research arm of AARP has an extensive collection of reports, issue briefs, fact sheets, and other products released by the AARP Public Policy Institute. A variety of research topics are available, including long term care finance, quality, and reform (both nationally and by state), housing and mobility, health and wellness, Medicare, and work/retirement. (Website: http://www.aarp.org/research/)
- The Centers for Disease Control and Prevention (CDC), through their Prevention Research Centers (PRC), funds applied research on disease prevention and health promotion for people of all ages. One example of a PRC is the University of Pittsburgh's Center for Healthy Aging, which publishes, among other things "Keys to Healthy Living" handouts for older adults. More information on the PRC program can be found on the CDC website (http://www.cdc.gov/prc) while the Center for Healthy Aging website is at: http://www.healthyaging.pitt.edu
- The Center for Home Care Policy & Research (http://www.vnsny.org/research/) is a research institute of the Visiting Nurse Service of New York. The Center's research focuses on the following primary areas: homecare quality, cost effectiveness, and outcomes; analyzing and informing public policy related to home care; and supporting communities to promote successful aging. One of the Center's programs, the AdvantAge Initiative, is a model program which helps local communities create livable communities for people of all ages, and prepare for the growing number of older adults.
- The Center for Retirement Research at Boston College focuses research on Social Security; employer-sponsored pension plans; household saving; and about market trends among older workers. Research on these topics, including policy briefs on topics such as alternatives for reforming current systems for long-term care financing, is available on their website. (http://crr.bc.edu/).

- The Institute for the Future of Aging Services is an applied research organization within the auspice of the American Association of Homes and Services for the Aging. Their primary initiatives include workforce quality and development, expanding housing with services, and nursing home quality improvement. The purpose of their work is to bridge the research, policy, and practice of long term care and supportive services. Their website is rich with long term care news, as well as publications and reports produced by IFAS. (http://www.aahsa.org/ifas.aspx)
- The Institute for Health and Aging at the University of California - San Francisco includes multiple research Centers, including the Disability Statistics Center. That Center produces and disseminates policy-relevant statistical information on the demographics and status of people with disabilities in American society. The Center's work focuses on how that status is changing over time with regard to employment, access to technology, health care, community-based services, and other aspects of independent living and participation in society. More information about the Disability Statistics Center is available on their website (http://dsc.ucsf.edu/). The Institute for Health and Aging is also on-line at: http://sbs.ucsf.edu/iha/
- The National Institute on Disability and Rehabilitation Research (NIDRR) (http://www.ed.gov/about/offices/list/osers/nidrr/index.html), an office of the US Department of Education, sponsors research related to improving the abilities of people with disabilities to perform activities of their choice in the community, and also to expand society's capacity to provide full opportunities and accommodations for its citizens with disabilities. NIDRR's focus includes research in areas such as employment; health and function; technology for access and function; independent living and community integration; and other associated disability research areas.
- The World Institute on Disability (WID) is an internationally renowned public policy center which conducts research, advocacy, and public education around issues related to independent living and people’s ability to live full and independent lives. The WID, organized by and for people with disabilities, runs a variety of programs and has published a variety of research materials in the areas of workplace and community accessibility, long term care, international development, and technology, among others. (Website: http://www.wid.org/)

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS

Overview

Questions posed to participants in this strategic planning process were framed within four sections to conduct a SWOT analysis: strengths, weaknesses, opportunities, and threats. The framework of the SWOT analysis consisted of two dimensions. First, the following updated list of critical needs was used to guide the process:

- Improved Quality of Life
- More Secure Financial and Political Resources
- Better Coordination of Services
- Easier Access to Services
- Improved Service Quality
- Expanded Service Capacity

Second, the information solicited through key stakeholder interviews, focus groups with providers and consumers, and the electronic survey was analyzed through the perspective that strengths, weaknesses, opportunities and threats exist within each of these areas of critical need. The SWOT analysis was applied to each area. We defined our "SWOT" terms as follows:

Strengths
What San Francisco's network of home and community-based service providers does well.

Weaknesses
What San Francisco's network of home and community-based service providers does NOT do well.

Opportunities
The things that the network can take advantage of over the next four years that will help address the critical needs.

Threats
The things that threaten the network's ability to address the critical needs identified.

Key Findings

The following table summarizes the key strengths, weaknesses, opportunities, and threats related to the six critical needs which emerged from the 2008 information gathering process. (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 E.*)

Table 1: SWOT Analysis Key Findings

Critical Needs	Strengths	Weaknesses	Opportunities	Threats
Quality of Life[16]	(None mentioned)	▪ Not enough focus on preventive services	(None mentioned)	▪ Limited access to information for consumers (or potential consumers)
More Secure Financial and Political Resources	▪ Strong will among networks to improve services	▪ There is too much competition for funding between non-profit agencies.	▪ Growing population of older adults/baby boomers represent a valuable resource ▪ Reaching out to less traditionally involved groups could lead to new ways to address needs ▪ The emergence of new funding through federal Medicaid waivers	▪ Not enough funding to meet demand ▪ Lack of awareness of among policymakers of the key issues ▪ Anticipated SF budget cuts due to reduced City funds in 08-09, 09-10, 10-11 ▪ Anticipated CA budget cuts due to: (1) the slowing economy, (2) the national credit crunch, and (3) the troubled housing market
Better Coordination of Services	▪ There is a broad array of services	▪ Service providers not aware of all services available Lack of collaboration/ communication between City departments	Centralized phone lines: DAAS intake, 211 (community services), and 311 (municipal services) could serve as information centers	▪ Lack of collaborative planning among service providers ▪ Lack of information sharing between service providers about existing programming

[16] The critical need "Quality of Life" was added as a result of feedback from the SWOT analysis. As a result, stakeholders were not asked directly to comment on strengths, weaknesses, opportunities, and threats for this category. This explains why there were no strengths or opportunities mentioned.

Critical Needs	Strengths	Weaknesses	Opportunities	Threats
Easier Access to Services	▪ Home and community-based services are diverse and culturally sensitive	▪ Consumer do not know about available services ▪ The service network is fragmented and confusing to consumers	▪ Flexibility of the Community Living Fund to fill gaps caused by silos	▪ Separate, silo-like funding streams ▪ Duplication in eligibility applications for public programs (lack of "presumed eligibility")
Improved Service Quality	▪ Providers are compassionate and dedicated	▪ There are fewer supportive services and less expertise available for younger adults with disabilities than for older adults ▪ Definitions of service quality are lacking	(None mentioned)	▪ High staff turnover in non-profit agencies threatens program quality
Expanded Service Capacity	▪ Providers bring expertise and creativity to meeting needs	▪ Shortage of services for moderate-income people ▪ Shortage of mental health services ▪ Few opportunities for organizational capacity-building	▪ Reaching out to less traditionally involved groups could lead to new ways to address needs	▪ Waiting lists for services

The Role of the Long-Term Care Coordinating Council

The LTCCC is the policy body responsible for overseeing the implementation of the Living With Dignity Strategic Plan. For this reason, it is important for the LTCCC to understand the effectiveness of its role in the implementation process. To help facilitate this understanding, part of the key stakeholder interviews and focus groups conducted solicited information about the perceived role and challenges faced by the LTCCC. The following bullet points summarize these findings.

Perceptions of the LTCCC:

- The LTCCC provides the broadest table in the city, with the greatest variety of long term care interests. This venue brings together:
  - Breadth and depth of expertise;
  - Diverse points of view, including those of service providers from wide range of services and systems; and
  - Representation from a wide range of policy-makers and advocates, as well as service providers, representing both public and private sectors.
- The broad interests of the participants gives it more weight and a greater focus on the issues and concerns, and service needs, of older adults and adults with disabilities.
- As a result of the work of the LTCCC, departmental coordination and collaboration among community-based service providers is increased.
- The LTCCC uses a collaborative, policy-focused approach and it develops credible recommendations.
- Larger policy issues are presented to the Mayor's Office.
- The LTCCC is a uniquely effective, well-facilitated advocacy group and sounding board.
- The LTCCC provides one unified voice for the development of long term care policy; it provides an opportunity to integrate the variety of interests.

Challenges of the LTCCC:

- The LTCCC needs more political muscle power and follow-through on recommendations.
- The LTCCC is in danger of not having the role it could in developing or affecting policy because it is not getting the full attention of the Mayor, or does not have the status necessary from his office or the Board of Supervisors. It was suggested that having a representative from the Board of

Supervisor's might be helpful, possibly from the office of Supervisors Bevan Dufty or Carmen Chu.

- Supervisors should be asked to sponsor specific legislations, work should be done directly with the Mayor's Office key staff, and the Controller's office should be asked to conduct any needed financial or data calculations.
- The LTCCC is a challenge for one staff person; staffing also needs to do organizing within the community to make sure the substantive goals – not just the procedural ones – are kept on track.
- Workgroups are not always clearly focused or kept on track. Suggestions for improvements include the following:
    - Each Workgroup should be required to identify a specific purpose statement, which should be placed on the top of every agenda, set of minutes, and any report prepared. This will help to ensure that all selected work, investigation, research, and discussion can be tied to that specific purpose.
    - The LTCCC Steering Committee should have annual meetings with each Workgroup chair (or co-chairs) to assess their effectiveness, and their interest and willingness in serving in a leadership capacity.
    - The LTCCC Steering Committee may want to consider an annual rotation of chairs among Workgroup members.
- The work of the LTCCC is not evenly distributed. Not all LTCCC serve on workgroups. Suggestions for improvements include the following:
    - The LTCCC Steering Committee should evaluate the distribution of work among LTCCC members.
    - The LTCCC Steering Committee should request that LTCCC members not serving on a workgroup plan to volunteer for one.
    - New Workgroups should consist of LTCCC members and others in the community with a specific expertise.
- More consumer representation was suggested, especially in area of mental health.
- Because the LTCCC undertakes advocacy and policy development, it needs to place greater emphasis on cultural competency of the membership.

APPENDICES

Appendix A: Summary of Accomplishments from Implementation of Original Living With Dignity Strategic Plan (2004 to 2008)

Accomplishments are in italics.

<table>
<tr><th><u>GOALS</u></th><th>STRATEGIES</th></tr>
<tr><td>GOAL 1
Establish Better Coordination of Services</td><td>A. Enable better transitions between home, community-based, and institutional long term care and supportive services.
o Community Placement Plan
o Homecoming Services Program
o LTC Intake and Screening Unit - DAAS
o Community Living Fund - $3 million annually
o Diversion & Community Integration Program (DCIP) - DAAS & DPH
(DCIP: A response to the Chambers lawsuit settlement – developing and implementing a community living plan for those being discharged from LHH or at risk of placement in LHH)
o Transitional Care Workgroup*
o Community Advocacy

B. Improve how case management programs work together to coordinate services.
o Case Management Connect Pilot Project (CMCPP)** - DAAS & DPH
(CMCPP: 16 case management programs are partnering to coordinate services for their clients. All programs are now part of the DPH safety net)
o CaseCare - RTZ Associates software for CLF network of agencies through the Institute on Aging (IOA)
o Plans for a case management training institute

C. Increase the use of shared information systems among city departments, service providers, community members, consumers and caregivers.
o CMCPP** - DAAS & DPH
(CMCPP Electronic Rolodex – to see and get contact information for all case management programs serving the same client)
o CaseCare - RTZ Associates software for CLF network of agencies through the IOA</td></tr>
</table>

** Workgroups & Initiatives under the Long Term Care Coordinating Council*
*** Workgroups & Initiatives under the SF Partnership for Community-Based Care & Support*

GOAL 2 **Increase Access to Services**	**A. Expand information and referral services by implementing an improved information, referral and assistance program.**
	o *LTC Intake and Screening Unit – DAAS*
	o *Resource Centers for Seniors & Adults with Disabilities – DAAS*
	o *Collaboration with United Way – 211 Community Services Info Line*
	o *Collaboration with CCSF – 311 Municipal Services Info Line*
	o *Network of Support for Community Living website – DAAS*
	o *Diversion & Community Integration Program (DCIP) – DAAS & DPH*
	(DCIP: A response to the Chambers lawsuit settlement – developing and implementing a community living plan for those being discharged from LHH or at risk of placement in LHH)
	B. Strengthen and sustain community partnerships for vulnerable older adults in underserved communities.
	o *Community Partnerships***
	  o *African American*
	  o *Latino*
	  o *Asian/Pacific Islander*
	  o *Lesbian, Gay, Bisexual, Transgender*
	o *Partnership Peer Advocacy Program***
	o *Services Connection Pilot Project (SCPP)* - DAAS & SFHA*
	(SCPP: a pilot project linking seniors and adults with disabilities living in public housing with community services)
	C. Create and implement improved public relations and marketing mechanisms.
	o *Public Relations and Marketing Workgroup***
	  o *Home Alone PR Campaign*
	  o *Partnership Newsletter- Quarterly*
	o *Continuing relationship - Wide Angle Communications & DAAS*
	D. Improve linkages between home and community-based care and supportive services, and mental health services.
	o *Mental Health Access Workgroup**
	  o *Recommendations to address crisis in dementia care*
	o *Services Connection Pilot Project (SCPP) - DAAS & SFHA*
	E. Alleviate the "bottleneck" within involuntary service programs
	o *Public Guardian - DAAS*
	o *Public Conservator - DAAS*
	o *Representative Payee - DAAS*
	o *Money Management funded through CLF*
	F. Address issues related to the needs of adults with disabilities in the long term care and supportive service delivery system.
	o *Home Delivered Meals Program*
	o *Congregate Meals Program*
	o ***Services Connection Pilot Project (SCPP) - DAAS & SFHA***
	o *Hoarding and Cluttering Task Force*
	o *Home Alone PR Campaign*
	o *Community Advocacy*

* *Workgroups & Initiatives under the Long Term Care Coordinating Council*
** *Workgroups & Initiatives under the SF Partnership for Community-Based Care & Support*

GOAL 3
Improve Service Quality
	A. Assess the capacity and quality of long term care and supportive services on an ongoing basis.
	o *New Position: Director of Quality Assurance/Improvement - DAAS*
	
	B. Ensure the provision of efficient and fiscally responsible services by supporting the implementation of recommendations from the Non-Profit Contracting Task Force.
	o *Implementation is the responsibility of the Human Services Agency (HSA) Office of Contracts Administration. Accomplishments include:*
	  o *90% of the streamlining recommendations for DAAS grants have been accomplished.*
	  o *HSA is selectively moving to master agreements that will allow faster approvals and renewals.*
	  o *HSA is working to streamline the Scope of Services requirements for contracts and monitoring reporting formats.*
	  o *HSA is facilitating the electronic submission of invoices, and most standardized and simplified contract forms.*
	  o *HSA has established monitoring protocols for over one year.*
	  o *HSA has consolidated across departments with DCYF, DPH, MOH and MOCD in joint solicitations, Board add-backs, & work orders.*
	  o *HSA has consolidated 53% of contracts into master agreements.*
	  o *HSA has learned all consolidations are not necessarily the best option for all parties.*
	  o *This is an ongoing process and is not as yet completed.*
	
	C. Enhance the recruitment, training, and retention of homecare workers.
	o *Homecare Workforce Workgroup***
	o *Plans for a Homecare Training Institute*

GOAL 4
Secure Financial and Political Resources
	A. Establish oversight and accountability of long term care service delivery improvements that are implemented as a part of this strategic plan.
	o *Appointment of LTCCC in November 2006 by Mayor Newsom*
	o *Community Advocacy*
	
	B. Optimize access to federal, state, and local financial resources.
	o *LTC Financing and Public Policy Workgroup**
	o *Nursing Facility/Acute Hospital Waiver - DPH*
	o *Assisted Living Waiver (Leno) - DPH*
	o *Community Advocacy*
	
	C. Support leadership and collaboration among advocacy & other organizations.
	o *SF Partnership for Community-Based Care & Support*
	o *Community Partnerships***
	  o *African American*
	  o *Latino*
	  o *Asian/Pacific Islander*
	  o *LGBT*
	o *Diversity and Cultural Sensitivity Training - DAAS*

GOAL 5 **Expand System Capacity**	A. Support efforts to increase availability of safe, affordable & accessible housing ○ *Housing and Services Workgroup** ○ *Success At Home Program (SAHP) – DPH* *(SAHP: augmenting existing placement options by securing a network of existing scattered site housing units to facilitate timely discharge from LHH.)* ○ *Rent subsidies funded through CLF* ○ *Accessibility modifications funded through CLF* ○ *Community Advocacy* B. Support actions to increase community acceptance of affordable housing and promote accessibility by endorsing recommendations in the 2003 SF Analysis of Impediments to Fair Housing. ○ *Housing and Services Workgroup** C. Support efforts to improve access to safe, affordable & accessible transportation. ○ *LTCCC* ○ *Muni Accessible Services* ○ *Community Advocacy* D. Support efforts to explore additional funding to expand service capacity. ○ *LTC Financing and Public Policy Workgroup** ○ *Community Living Fund – $3 million annually* ○ *Community Advocacy*

* *Workgroups/Initiatives under the Long Term Care Coordinating Council*
** *Workgroups/Initiatives initially under the SF Partnership for Community-Based Care & Support*

Appendix B: List of San Francisco Partnership for Community-Based Care & Support Members

30th Street Senior Center – On Lok
AARP - California State Office
Aging Matters, Inc.
Alzheimer's Association
Aunt Ann's Home Care
Asian Law Caucus
Asian Pacific Islander Legal Outreach
Bay Area Vital-Link
Bernal Heights Neighborhood Center
California Advocates for Nursing Home Reform
Canon Kip Senior Center/Episcopal Community Services
Catholic Charities CYO
Central City Older Adult Mental Health
Centro Latino de San Francisco
Chinatown Community Development Center
Chinese Newcomers Service Center
Community Health Resource Center
Compassionate Community Care
Curry Senior Service Center
DAAS Adult Protective Services
DAAS County Veterans Services Organization
DAAS IHSS Program
DAAS Information Referral & Assistance
DAAS Public Guardian
DAAS Representative Payee Program
DHS Medi-Cal Health Connections
Family Caregiver Alliance
Family Service Agency of San Francisco:
- Ombudsman Program
- Adolescents and Seniors Respite Program
- Foster Grandparent Program
- Geriatric Services West
- Outpatient Mental Health Services
- Senior Companion Program
- Senior Peer Counseling

Hearing and Speech Center of Northern California
Hospice by the Bay
IHSS Consortium
IHSS Public Authority
Independent Living Resource Center - SF
Institute on Aging
Italian-American Community Services Agency
Janet Pomeroy Center (formerly RCH)
Jewish Community Center
Jewish Family and Children's Services
Kimochi, Inc.

Laguna Honda Hospital Social Services Department
Lao Seri Association
Latina Breast Cancer Agency
Lighthouse for the Blind & Visually Impaired
Little Brothers Friends of the Elderly
Mayor's Office on Disability
McCarthy's Interactive Physical Therapy
Meals on Wheels of San Francisco, Inc.
Mission Neighborhood Centers, Inc.
Network For Elders
New Leaf Services for Our Community
NICOS Chinese Health Coalition
North & South of Market Adult Day Health
OMI Community Action Organization
On Lok Senior Health Services
On The Level Walking Tours
openhouse
Planning for Elders
Prevent Blindness Northern California
Project Open Hand
Resource Centers for Seniors and Adults With Disabilities

- (1) Richmond
- (2) Western Addition/Marina
- (3) Northeast
- (4) Central City/Potrero Hill
- (5) Mission/Noe Valley/Bernal Heights/Buena Vista/Eureka Valley
- (6) Bayview-Hunter's Point
- (7) Visitation Valley/Excelsior/Portola Valley
- (8) OMI/St. Francis Wood/Miraloma Park
- (9) Inner Sunset/Haight Ashbury
- (10) Outer Sunset

Samoan Community Development Center
San Francisco Adult Day Services Network
San Francisco Community Clinic Consortium
San Francisco Senior Centers, Inc.
Self Help for the Elderly
Senior Action Network
St. Luke's Hospital
Stegner Registry
United Way of the Bay Area – HELPLINK 211 Bay Area
University of California San Francisco

- Center for Workforce Studies
- Center for Aging in Diverse Communities
  - Community Liaison Core
- Redes En Accion

Veterans Equity Center
Vietnamese Elderly Mutual Assistance Association
Western Addition Senior Citizens' Services

Appendix C: 2008 Strategic Planning Participants and Questions

Participants

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. The following provides a list of the participants in the planning process.

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

The staff workgroup conducted key stakeholder interviews and focus groups with representatives from San Francisco's community-based long term care and supportive

services network, and then hosted two community dialogues. A list of those interviewees, focus groups, and community dialogues is provided below.

Participants in Key Stakeholder Interviews		
Interview Date	*Organization*	*Interviewees*
5/20/2008	Department of Aging and Adult Services (DAAS) - Administration	Anne Hinton, Shireen McSpadden, Linda Edelstein, Tony Nicco
5/28/2008	DAAS - Adult Protective Services	Mary Counihan
6/18/2008	DAAS - Advisory Council Exec Committee	Connie Little, Cathy Russo
5/28/2008	DAAS - County Veterans Service Office	Cheryl Cook
5/21/2008	DAAS - Office on the Aging	Denise Cheung, Maria Guillen, Linda Lau, Karen Rosen
6/20/2008	DAAS - Public Conservator	Ron Patton
5/8/2008	DAAS - Public Guardian, Public Conservator, Public Administrator, Representative Payee programs	Mary Anne Warren
6/11/2008	Department of Human Services	Jim Buick
6/9/2008	Department of Public Health (DPH) – Long Term Care	Liz Gray, Kelly Hiramoto
6/26/2008	DPH – Behavioral Health Services	Barbara Garcia
6/3/2008	Human Services Agency - Planning	Diana Jensen, Dan Kelly, Noelle Simmons
7/9/2008	Mayor's Budget Office	Catherine Dodd, Kate Howard
6/12/2008	Mayor's Office on Disability	Susan Mizner
7/1/2008	Mayor's Office of Housing	Joel Lipski, Anne Romero
7/23/2008	Muni	Annette Williams
7/17/2008	San Francisco Housing Authority	Belinda Jeffries
Focus Groups		
Date	*Group*	
6/11/2008	Adult Day Services Network	
6/30/2008	LTCCC - Homecare Workforce Workgroup	
6/18/2008	LTCCC - Housing & Services Workgroup	
6/19/2008	LTCCC - Mental Health Access Workgroup	
6/20/2008	LTCCC – Financing and Public Policy Workgroup	
5/8/08	LTCCC - Steering Committee	
Community Dialogues		
Date	*Location and Focus*	
7/11/2008	Clementina Towers – Older Adults	
7/14/2008	Rosa Parks – Adults with Disabilities	

Questions for Key Stakeholder Interviews and Focus Groups

Key stakeholder interviewees and focus group participants were provided with background material about the previous Living with Dignity Strategic Plan and about the Long Term Care Coordinating Council. They were then asked to respond to the following questions.

1. As you may know, San Francisco's Long Term Care Coordinating Council (LTCCC) includes representation from service provider organizations, consumers, advocates, and city departments, and is tasked with providing policy guidance to the Mayor's Office. What do you see as the unique role or expertise of the LTCCC?

2. In looking at the list of critical needs identified in the 2004 LWD plan (listed below), what do you see as barriers preventing San Francisco from addressing these needs?
    - Improved, Well-Coordinated Services & Support
    - Easier Access to Services
    - Improved Quality of Services
    - Increased Political & Financial Resources
    - Expanded Service Capacity
3. Can you think of any opportunities to take advantage of over the next four years that will help address the critical needs?
4. What do you think San Francisco's network of home and community-based service providers does well (including both non-profit and public sector providers)? In other words, what do you see as the strengths of home and community-based services that help older adults and adults with disabilities live at home?
5. What do you think this network does not do well? What do you see as weaknesses of home and community-based services (including both non-profit and public sector providers)?
6. Do you have any specific, concrete ideas (strategies) for how to address the weaknesses you have identified? If so, how can your agency participate in implementing these ideas?
7. From those ideas (strategies) just discussed in #6, and from the list of critical needs and strategies listed on page 2 in this handout, which strategies would you consider the top two for the LTCCC to consider implementing over the next year?

8. Can you think of any critical needs missing from the list on page 2?

9. Is there anything else you'd like to share that we have not covered?

Questions for Community Dialogue Participants

Community dialogues were conducted with the two primary DAAS constituencies: adults with disabilities or disability advocates; and older adults or older adult advocates. The following questions were used at the community dialogues, along with a hand-out that listed the critical needs that had been identified in the first Living with Dignity strategic planning process.

1. What barriers do you – and other people in your community – face when they are trying to find support services for themselves or someone else?
2. What one support service do you think is the most needed but least available in this community?
3. Do you agree or disagree with the critical needs on the hand-out?
4. What do you think is missing – about how to support people with disabilities to live at home and in the community?
5. Can you think of any concrete strategies the City can take to address the critical needs identified or other needs you think are important?
6. If you needed to prioritize these critical needs, which one would you give the highest priority?
7. Are you interested in being informed or involved in future development of this strategic planning effort?

Electronic Survey Questions

Finally, staff conducted an internet-based survey (using Survey Gizmo) to solicit input on current issues as well as goals and strategies. The questions included in that survey are provided, below:

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Page 1

Thank you for participating in this survey being conducted by the San Francisco Long Term Care Coordinating Council (LTCCC).

The purpose of this survey is to solicit input into the update of the Living With Dignity Strategic Plan. Your participation is highly valued. Your responses will help to plan improvements in San Francisco's home and community-based services for older adults and adults with disabilities. The information you provide will be used to formulate goals, strategies, and objectives that will be implemented over the next four years (2008 - 2012).

Your answers will be anonymous and will not be linked to you in any way. However, if you wish to be contacted in the future, there will be a question at the end of the survey where you may provide contact information.

Would you like to read a description of the Long Term Care Coordinating Council before starting the survey?
__Yes [GO TO NEXT SCREEN]   __No [SKIP TO PAGE 3: STRENGTHS]

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Page 2

The Long Term Care Coordinating Council (LTCCC) is an advisory group appointed by the Mayor to provide policy guidance to the Mayor's Office regarding long term care and supportive services for older adults and adults with disabilities in San Francisco. The LTCCC is made up of 37 members representing a variety of non-profit service providers, consumer advocates, and city

agencies, and is charged to: (1) advise, implement, and monitor community-based long term care planning in San Francisco; and (2) facilitate the improved coordination of home, community-based, and institutional services for older adults and adults with disabilities. The LTCCC is charged to oversee all implementation activities identified in the Living With Dignity Strategic Plan that will make improvements in the community-based long term care service delivery system.

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Page 3

I. STRENGTHS (Section 1 of 6):
What does San Francisco's network of home and community-based service providers do well?

The statements below suggest strengths of San Francisco's network of non-profit and public home and community-based service providers.

To what extent do you agree or disagree with each statement?

0 = Strongly disagree
1 = Disagree
2 = Neither agree nor disagree
3 = Agree
4 = Strongly agree
9 = Don't know or don't wish to respond

a. Home and community-based services for older adults and adults with disabilities in San Francisco are diverse and culturally sensitive.
b. There is a broad array of home and community-based services for older adults and adults with disabilities in San Francisco.
c. The relationship between City departments and private non-profits is collaborative.
d. Service providers are compassionate and dedicated.
e. Service providers bring expertise and creativity to their work in meeting consumer needs.
f. The network provides a unified voice for advocating for older adults and adults with disabilities in San Francisco.
g. Collaboration between older adult services and disability services networks has increased recently.
h. Competition between private agencies has decreased recently.
i. There is a strong will among the aging and disability networks to improve home and community-based services in San Francisco.

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Page 4

II. WEAKNESSES (Section 2 of 6):
What does San Francisco's network of home and community-based service providers NOT

do well?

The statements below suggest weaknesses of San Francisco's network of non-profit and public home and community-based service providers.

To what extent do you agree or disagree with each statement?

0 = Strongly disagree
1 = Disagree
2 = Neither agree nor disagree
3 = Agree
4 = Strongly agree
9 = Don't know or don't wish to respond

a. There are fewer supportive services and less expertise available for younger adults with disabilities than for older adults.
b. There is a shortage of mental health services.
c. There is a shortage of substance abuse services.
d. Service providers are not aware of all services available to their clients.
e. Consumers do not know about all of the services available to them.
f. There is a lack of collaboration/communication between City departments.
g. Definitions of service quality, success, and standards are lacking.
h. High staff turnover in non-profit agencies threatens program quality.
i. There is too much competition for funding among non-profit agencies.
j. The service network is fragmented and confusing to consumers.
k. There is a shortage of services for middle income people.
l. There is not enough focus on preventive services.
m. There are few opportunities for organizational capacity-building

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Page 5

III. THREATS (Section 3 of 6):

In the 2004 Living With Dignity Strategic Plan, the following critical needs related to home and community-based services were identified:
• Improved, Well-Coordinated Services & Support
• Easier Access to Services
• Improved Quality of Services
• Increased Political & Financial Resources
• Expanded Service Capacity

To what extent do you think each factor below threatens the ability of San Francisco's network of service providers to address the critical needs listed above?

Use a scale of 0 to 5 with zero being no threat at all and five being the most severe threat.

0	1	2	3	4	5
No threat					Severe threat

a. Limited language capacity of nonprofit and public service providers
b. Lack of information sharing between service providers about existing programming
c. Separate, silo-like funding streams
d. Lack of collaborative planning among all (public and nonprofit) service providers
e. Separate budget planning among City departments
f. Separate Request for Proposals (RFP) solicitation among City departments
g. Limited access to information for consumers
h. Waiting lists
i. Duplication in eligibility applications for public programs (e.g., not having "presumed eligibility" of some programs)
j. Not enough funding to meet service demands
k. Lack of awareness among policymakers regarding key issues
l. Are there other factors you think threaten the ability of the network of service providers to address critical needs?________________________

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Page 6

IV. OPPORTUNITIES (Section 4 of 6):
Through a series of interviews and focus groups over the last several months, the items listed below emerged as opportunities to take advantage of in order to address the critical needs of home and community-based service systems.

While several opportunities arose, the list below refers to opportunities specifically for systems improvements.

To what extent do you agree or disagree that each item below offers an opportunity to address critical needs related to home and community-based services?

0 = Strongly disagree
1 = Disagree
2 = Neither agree nor disagree
3 = Agree
4 = Strongly agree

9 = Don't know or don't wish to respond

a. The growing population of older adults, particularly the Baby Boomer generation, is a potentially valuable resource for the community.
b. The downsizing of Laguna Honda Hospital (LHH) could result in the ability to shift funds from institutional to community-based services.
c. The emergence of new funding through federal Medicaid Waivers is an opportunity to increase financial capacity of home and community-based programs.
d. The flexibility of the Community Living Fund is an opportunity to fill service gaps caused by the silo-effect in funding.
e. Reaching out to less traditionally involved groups will bring opportunities to address critical needs in new ways (e.g., city planning advocates, AARP, volunteer organizations, corporate sponsors, Board of Supervisors staff, Police and Fire departments).
f. DAAS intake, 2-11, and 3-11 phone lines are opportunities to serve as central information centers for older adults and adults with disabilities.
g. The settlement of the Chambers lawsuit against LHH is an opportunity to improve how San Francisco provides home and community-based services.
h. The formation of the Diversion and Community Integration Program will provide a venue for increased collaboration between DPH, DAAS, and community providers.
i. Are there other opportunities you'd like to share?
____

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Page 7

V. PRIORITIES (Section 5 of 6):

Below is a list of strategies suggested to address weaknesses in the network of home and community-based services in San Francisco.

Please choose a priority level for implementing each strategy listed below.

3. High priority
2. Medium priority
1. Low priority
0. Should not be considered at this time
9. Don't know/no answer

A. Policy, Planning, and Funding Strategies:

i. Undertake shared planning and budgeting efforts among City departments based on a common vision of community long term care services.

ii. Involve DAAS in the rebuilding of the Housing Authority properties and surrounding communities (ie, HOPE-SF).

iii. Approach city planning networks (i.e., SF Planning Dept, SF Planning & Urban Research Assoc.) to collaborate on creating aging and disability-friendly communities.

iv. Tap private sector funding opportunities (corporate, small business).

v. Take advantage of federal Medicaid waiver opportunities to increase financial resources for community living.

vi. Coordinate RFP development across City departments.

vii. Increase the LTCCC involvement in existing planning efforts at MOH, Muni, City Planning, DPH Behavioral Health Services, and Laguna Honda Hospital

B. Communications and Advocacy Strategies

i. Initiate outreach and public education for providers and consumers of aging and disability services at diverse venues.

ii. Organize to achieve equity in funding for community-based services in comparison with institutional long term care.

iii. Tap into Baby Boomer generation for resources (in-kind or financial).

iv. Get the City's public and private sector "movers and shakers" involved to support the community living concept

v. Promote an independent living philosophy, emphasizing consumer choice, self determination and participation.

vi. Achieve more diverse representation on the LTCCC.

C. Workforce Strategies

i. Introduce incentives to prevent employee turnover

ii. Collaborate between City's workforce development programs, disability networks, community-based service providers, and DAAS/IHSS

D. Strategies for Program and Service Collaboration

i. Within RFPs, offer financial incentives for program collaboration.

ii. Include aging and disability representatives in "housing pipeline" communications (at monthly meetings or other venues).

iii. Include Veterans' entitlement review in all Intake and Screening processes to maximize use of federal funding.

E. Program and Service Expansion Strategies

i. Increase and improve the capacity of coordinated case management to ensure easier access to services

ii. Expand health promotion and risk prevention programs – focusing on maintaining wellness

iii. Expand programs and services for underserved populations, including: adults and transitional youth (18-22 year olds) with disabilities; people who are homebound; veterans; and those in need of mental health or substance abuse services.

F. Strategies to Improve Service Quality

i. Develop standards for home and community-based services.

ii. Evaluate community placement after nursing home discharge.

iii. Provide technical assistance for City-funded agencies.

G. Other innovations

i. Recruit less traditional partners to assist with specific initiatives (such as corporate sector, city planners, AARP, civic engagement professionals, Baby Boomers, and others).

ii. Recruit community ambassadors for word of mouth outreach campaigns.

iii. Strengthen natural alliances with labor, addiction and recovery programs, and the HIV/AIDS community.

iv. Enable easier access to community services on the Internet

H. Any other ideas for specific, concrete strategies for the LTCCC to initiate?

____

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Page 8

VI. RESPONDENT INFORMATION (Section 6 of 6):

The following questions help us determine the extent to which this survey represents a broad array of respondents. Your answers are anonymous and optional.

a. Which selection best describes the organization where you are employed?

[DROP DOWN MENU]

i. Public/government agency

ii. Private non-profit

iii. Private for-profit

iv. Not currently employed [SKIP TO QUESTION g]

b. What is the zip code where you work? ___________

c. Which of the following most closely matches your current job title?

[DROP DOWN MENU]
Executive Director/CEO/Administration
Manager/Program Director
Supervisor
Analyst/Planner
Self-employed
Case Manager or Social Worker
Other Direct Service Provider
Other ____________________

d. What types of services does your agency provide (check all that apply)?

[CHECKLIST]
Adult Day Health Care
Advocacy or Education (including Ombudsman services)
Assisted Living/Residential care
Behavioral health services
Caregiver support
Caregiver Support (for informal caregivers, including grandparents raising grandchildren)
Case management
Home care (including in-home support, home health and hospice)
Housing
Information & Referral
Legal Assistance
Meals
Planning, policy, or research
Primary health care
Skilled Nursing Facility
Socialization
Substance abuse treatment
Transportation
Wellness (health promotion/risk prevention)
Other social services _______________
Other _________________

e. To the best of your knowledge, what is the number of paid FULL-TIME (or FTE) staff employed by your agency?

Less than 10 paid staff

10-25 paid staff

26-50 paid staff

More than 50 paid staff

f. What population does your agency serve (check all that apply)?

Older adults (60 or over)

People with disabilities age 18 and over

Other ________________

g. Which of the following groups are you a member of (check all that apply)?

- Coalition of Agencies Serving the Elderly (CASE)
- Community Alliance of Disability Advocates (CADA)
- Long Term Care Coordinating Council (LTCCC)
- Department of Aging and Adult Services (DAAS) Commission
- DAAS Advisory Council
- San Francisco Partnership for Community-Based Care & Support
- None of the above
- Other

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Page 9

This completes the survey. Thank you for taking the time to complete it. All of the answers you provided were anonymous. If you wish to participate in the implementation of the updated Living With Dignity Strategic Plan, please enter your contact information below.

Do you wish to be contacted in the future regarding the Living With Dignity Strategic Plan? ____Yes (info will be asked) ___No [SKIP TO PAGE 10 – THANK YOU PAGE]

What is your name?
What is your e-mail address?
What is your daytime phone number?

****

Page 10 – Thank you

Thank you for taking this survey. Your responses are very important as they will help shape home and community-based service delivery in San Francisco. We look forward to sharing the updated Living With Dignity Plan with you in Fall 2008.

For more information contact Bill Haskell at bill.haskell@sfgov.org

Appendix D: World Health Organization Checklist of Essential Features of Age-Friendly Cities

The following checklist of essential age-friendly city features is based on the results of the World Health Organization's (WHO) Global Age-Friendly Cities project consultation in 33 cities in 22 countries. The checklist is a tool for a city's self-assessment and a map for charting progress. More detailed checklists of age-friendly city features are to be found in the WHO Global Age-Friendly Cities Guide.

Available on-line at: *http://www.who.int/ageing/age_friendly_cities/en/index.html*

Outdoor spaces and buildings

- ☐ Public areas are clean and pleasant.
- ☐ Green spaces and outdoor seating are sufficient in number, well-maintained and safe.
- ☐ Pavements are well-maintained, free of obstructions and reserved for pedestrians.
- ☐ Pavements are non-slip, are wide enough for wheelchairs and have dropped curbs to road level.
- ☐ Pedestrian crossings are sufficient in number and safe for people with different levels and types of disability, with non-slip markings, visual and audio cues and adequate crossing times.
- ☐ Drivers give way to pedestrians at intersections and pedestrian crossings.
- ☐ Cycle paths are separate from pavements and other pedestrian walkways.
- ☐ Outdoor safety is promoted by good street lighting, police patrols and community education.
- ☐ Services are situated together and are accessible.
- ☐ Special customer service arrangements are provided, such as separate queues or service counters for older people.
- ☐ Buildings are well-signed outside and inside, with sufficient seating and toilets, accessible elevators, ramps, railings and stairs, and non-slip floors.
- ☐ Public toilets outdoors and indoors are sufficient in number, clean, well-maintained and accessible.

Transportation

- ☐ Public transportation costs are consistent, clearly displayed and affordable.
- ☐ Public transportation is reliable and frequent, including at night and on weekends and holidays.
- ☐ All city areas and services are accessible by public transport, with good connections and well-marked routes and vehicles.

- ☐ Vehicles are clean, well-maintained, accessible, not overcrowded and have priority seating that is respected.
- ☐ Specialized transportation is available for disabled people.
- ☐ Drivers stop at designated stops and beside the curb to facilitate boarding and wait for passengers to be seated before driving off.
- ☐ Transport stops and stations are conveniently located, accessible, safe, clean, well-lit and well-marked, with adequate seating and shelter.
- ☐ Complete and accessible information is provided to users about routes, schedules and special needs facilities.
- ☐ A voluntary transport service is available where public transportation is too limited.
- ☐ Taxis are accessible and affordable, and drivers are courteous and helpful.
- ☐ Roads are well-maintained, with covered drains and good lighting.
- ☐ Traffic flow is well-regulated.
- ☐ Roadways are free of obstructions that block drivers' vision.
- ☐ Traffic signs and intersections are visible and well-placed.
- ☐ Driver education and refresher courses are promoted for all drivers.
- ☐ Parking and drop-off areas are safe, sufficient in number and conveniently located.
- ☐ Priority parking and drop-off spots for people with special needs are available and respected.

Housing

- ☐ Sufficient, affordable housing is available in areas that are safe and close to services and the rest of the community.
- ☐ Sufficient and affordable home maintenance and support services are available.
- ☐ Housing is well-constructed and provides safe and comfortable shelter from the weather.
- ☐ Interior spaces and level surfaces allow freedom of movement in all rooms and passageways.
- ☐ Home modification options and supplies are available and affordable, and providers understand the needs of older people.
- ☐ Public and commercial rental housing is clean, well-maintained and safe.
- ☐ Sufficient and affordable housing for frail and disabled older people, with appropriate services, is provided locally.

Social participation

- ☐ Venues for events and activities are conveniently located, accessible, well-lit and easily reached by public transport.

- Events are held at times convenient for older people.
- Activities and events can be attended alone or with a companion.
- Activities and attractions are affordable, with no hidden or additional participation costs.
- Good information about activities and events is provided, including details about accessibility of facilities and transportation options for older people.
- A wide variety of activities is offered to appeal to a diverse population of older people.
- Gatherings including older people are held in various local community spots, such as recreation centres, schools, libraries, community centres and parks.
- There is consistent outreach to include people at risk of social isolation.

Respect and social inclusion

- Older people are regularly consulted by public, voluntary and commercial services on how to serve them better.
- Services and products to suit varying needs and preferences are provided by public and commercial services.
- Service staff are courteous and helpful.
- Older people are visible in the media, and are depicted positively and without stereotyping.
- Community-wide settings, activities and events attract all generations by accommodating age-specific needs and preferences.
- Older people are specifically included in community activities for "families".
- Schools provide opportunities to learn about ageing and older people, and involve older people in school activities.
- Older people are recognized by the community for their past as well as their present contributions.
- Older people who are less well-off have good access to public, voluntary and private services.

Civic participation and employment

- A range of flexible options for older volunteers is available, with training, recognition, guidance and compensation for personal costs.
- The qualities of older employees are well-promoted.
- A range of flexible and appropriately paid opportunities for older people to work is promoted.
- Discrimination on the basis of age alone is forbidden in the hiring, retention, promotion and training of employees.
- Workplaces are adapted to meet the needs of disabled people.

- Self-employment options for older people are promoted and supported.
- Training in post-retirement options is provided for older workers.
- Decision-making bodies in public, private and voluntary sectors encourage and facilitate membership of older people.

Communication and information

- A basic, effective communication system reaches community residents of all ages.
- Regular and widespread distribution of information is assured and a coordinated, centralized access is provided.
- Regular information and broadcasts of interest to older people are offered.
- Oral communication accessible to older people is promoted.
- People at risk of social isolation get one-to-one information from trusted individuals.
- Public and commercial services provide friendly, person-to-person service on request.
- Printed information – including official forms, television captions and text on visual displays – has large lettering and the main ideas are shown by clear headings and bold-face type.
- Print and spoken communication uses simple, familiar words in short, straightforward sentences.
- Telephone answering services give instructions slowly and clearly and tell callers how to repeat the message at any time.
- Electronic equipment, such as mobile telephones, radios, televisions, and bank and ticket machines, has large buttons and big lettering.
- There is wide public access to computers and the Internet, at no or minimal charge, in public places such as government offices, community centres and libraries.

Community and health services

- An adequate range of health and community support services is offered for promoting, maintaining and restoring health.
- Home care services include health and personal care and housekeeping.
- Health and social services are conveniently located and accessible by all means of transport.
- Residential care facilities and designated older people's housing are located close to
- services and the rest of the community.
- Health and community service facilities are safely constructed and fully accessible.
- Clear and accessible information is provided about health and social services for older people.

- Delivery of services is coordinated and administratively simple.
- All staff are respectful, helpful and trained to serve older people.
- Economic barriers impeding access to health and community support services are minimized.
- Voluntary services by people of all ages are encouraged and supported.
- There are sufficient and accessible burial sites.
- Community emergency planning takes into account the vulnerabilities and capacities of older people.

Appendix E: SWOT Analysis Key Findings

Key Findings
The following table summarizes the key strengths, weaknesses, opportunities, and threats related to the six critical needs which emerged from the 2008 information gathering process.

Critical Need: *Quality of Life*
Strengths: None mentioned.
Weaknesses: Not enough focus on preventive services.
Opportunities: None mentioned**.**
Threats: Limited access to information for consumers (or potential consumers).
NOTE: The critical need "Quality of Life" was added as a result of feedback from the SWOT analysis. As a result, stakeholders were not asked directly to comment on strengths, weaknesses, opportunities, and threats for this category. This explains why there were no strengths or opportunities mentioned.

Critical Need: *More Secure Financial and Political Resources*
Strengths: Strong will among networks to improve services.
Weaknesses: There is too much competition for funding between non-profit agencies.
Opportunities: Growing population of older adults/baby boomers represent a valuable resource; Reaching out to less traditionally involved groups could lead to new ways to address needs; The emergence of new funding through federal Medicaid waivers.
Threats: Not enough funding to meet demand; Lack of awareness of among policymakers of the key issues; Anticipated SF budget cuts due to reduced City funds in 08-09, 09-10, 10-11; Anticipated CA budget cuts due to: (1) the slowing economy, (2) the national credit crunch, and (3) the troubled housing market.

Critical Need: *Better Coordination of Services*
Strengths: There is a broad array of services.
Weaknesses: Service providers not aware of all services available; Lack of collaboration/ communication between City departments.
Opportunities: Centralized phone lines: DAAS intake, 211 (community services), and 311 (municipal services) could serve as information centers.
Threats: Lack of collaborative planning among service providers; lack of information sharing between service providers about existing programming.

Critical Need: *Easier Access to Services*
Strengths: Home and community-based services are diverse and culturally sensitive.
Weaknesses: Consumer do not know about available services; The service network is fragmented and confusing to consumers.
Opportunities: Flexibility of the Community Living Fund to fill gaps caused by silos.
Threats: Separate, silo-like funding streams; Duplication in eligibility applications for public programs (lack of "presumed eligibility").

Critical Need: *Improved Service Quality*
Strengths: Providers are compassionate and dedicated.

Weaknesses: There are fewer supportive services and less expertise available for younger adults with disabilities than for older adults; Definitions of service quality are lacking.
Opportunities: None mentioned**.**
Threats: High staff turnover in non-profit agencies threatens program quality.

Critical Need: *Expanded Service Capacity*
Strengths: Providers bring expertise and creativity to meeting needs.
Weaknesses: Shortage of services for middle-income people; Shortage of mental health services; Few opportunities for organizational capacity-building.
Opportunities: Reaching out to less traditionally involved groups could lead to new ways to address needs.
Threats: Waiting lists for services.