Assessment of the Needs of San Francisco Seniors and Adults with Disabilities

Part II: Analysis of Needs and Services

Department of Aging and Adult Services
Office on the Aging

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Part II: Service Analysis
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I. INTRODUCTION

The Older American's Act (OAA) and the Older Californians Act require that the Department of Aging and Adult Services (DAAS), San Francisco's Area Agency on Aging, conduct a community needs assessment every four years to determine the extent of need for services and to aid in the development of a plan for service delivery for older adults.

This is the second of two reports summarizing the findings of the 2011 needs assessment process. The first report detailed demographic trends among seniors and adults with disabilities in San Francisco using a variety of data sources. This report provides a more detailed examination of community needs related to specific DAAS service categories. The two reports are complementary and provide a comprehensive portrait of the service system and the community that it serves.

The second report of the needs assessment examines the targeted funding categories of DAAS' Office on the Aging, discussing more specifically the needs and rationale that underlie the services, and comparing trends in funding and volume of services with levels from five years ago, prior to the recession. It draws on data from the San Francisco Human Services Agency budget and statistics from SF GetCare, the on-line database the collects information from service providers. To provide seniors and persons with disabilities a voice in this assessment, a series of focus groups were convened in the summer of 2011, and the comments of participants are threaded through this narrative and collected in an appendix. Subject areas of the second report include:

1. Housing;
2. Nutrition;
3. Isolation;
4. Case management and transitional care;
5. Self care and safety;
6. Caregiver support;
7. Access to services; and
8. Consumer advocacy.

II. HOUSING SERVICES

San Francisco's high cost of housing affects every population group in the city. Data from the Season of Sharing, a charitable fund promoted by the *San Francisco Chronicle*, suggests the pressure that housing places on many seniors and adults with disabilities. Of the 694 fund disbursements in the 2010-11 fiscal year, almost two-thirds of the recipients were either seniors or adults with disabilities. For seniors, the percentage of disbursements that were for housing deposits, delinquent rent or mortgage, or moving costs was 83%; for younger adults with disabilities, 95%.

> *If a person can live happily under a roof, they can build a better community. – Chinese Focus Group Participant*

In focus groups and community forums conducted for this assessment, the need for affordable and appropriate housing was the concern most frequently voiced by participants. Once they had paid their rent, some participants said, they had little left over for other basic necessities like food or medicine.

The Department of Aging and Adult Services does not have a primary role in providing housing. It is focused on the provision of social services and lacks the financial capacity to increase the supply of affordable housing in San Francisco. Because of the vital nature of housing issues to its constituents, however, DAAS does fund some housing advocacy and counseling services in an effort to strategically improve the housing situation for seniors and adults with disabilities. The 2006 DAAS Needs Assessment described the different types of housing and associated gaps in services for seniors and younger adults with disabilities. Rather than repeating the information detailed in the 2006 report, this assessment focuses on recent highlights related to some key categories of housing and housing-related challenges.

NON-PROFIT AFFORDABLE HOUSING

The Mayor's Office of Housing (MOH), the San Francisco Redevelopment Agency (SFRA) and the Department of Housing and Urban Development (HUD) each finances non-profit developers to build and operate affordable housing buildings. The state Supreme Court recently upheld the legality of the Governor's proposal to defund Redevelopment Agencies.[1] As a result, the San Francisco Redevelopment Agency is being dissolved. SFRA projects currently in process will be completed, however, and some of the agency's responsibilities are being transferred to MOH.

Since 2006, MOH and SFRA financed 12 completed projects with units exclusively for seniors and adults with disabilities (882 units for very low income seniors; 54 for adults with disabilities). An additional six projects in the pipeline, creating 591 units exclusively designated for very low-income seniors, plus 15 units for non-homeless adults with disabilities. These targeted buildings are a subset of the new and planned affordable housing financed by MOH/SFRA. All buildings serve both seniors and adults with disabilities within broader eligibility criteria.

Ninety percent of San Franciscans live in privately owned, market-rate homes and apartments. Seniors garner a sizable share of public-financed affordable housing, heading the household in 36% of the affordable properties, but the amount of available housing is small. They often have to wait several years for an appropriate unit.

The outlook for future levels of non-profit affordable housing development is uncertain. Federal sources of funding through Housing and Urban Development (HUD) are facing budget cuts (e.g., HUD's HOME program). State funding through the Housing and Emergency Shelter Trust Fund Act (Proposition 1C) has vanished. The city is still assessing the long-term impact of the court decision allowing the state to disband local redevelopment agencies.

[1] *California Redevelopment Association v. Matosantos*, 53 Cal. 4th 231 (2011).

PUBLIC HOUSING

The San Francisco Housing Authority (SFHA) manages 45 different public housing complexes in neighborhoods throughout the city, providing over 6,500 affordable rental units to nearly 10,000 individuals. In 2011, 25% of public housing residents in San Francisco were seniors, and 21% of public housing units have a disabled householder. Not only did developments set aside units for seniors and persons with disabilities, but they also made many available for families.

Distribution of Seniors in Public Housing Developments

Type of Development	Residents Age 60+	All Residents
Developments for Seniors & Persons with Disabilities	1,619	2,177
Developments for Families	835	7,515
Total	2,454	9,692

To address the ongoing deterioration of San Francisco's public housing stock, particularly in light of diminishing federal assistance, MOH developed an initiative known as HOPE-SF. It rebuilds targeted public housing developments, transforming them into a mix of subsidized and market-rate housing, with a careful strategy for retaining existing public housing residents. The city has committed $95 million dollars to HOPE-SF, the largest local commitment to public housing in history. The Hunters View development is currently under construction. The Alice Griffith site is in the planning stage and was recently awarded $30.5 million from HUD's Choice Neighborhoods Implementation Grant. The Sunnydale site is also in the planning stage, and MOH reports that it will have 150 units set aside for very low-income seniors. HOPE SF is working with the Mayor's Office on Disability to promote accessibility in all of the rebuilt sites.

Single Room Occupancy (SRO) Hotels

More low-income San Franciscans live in SRO hotels than live in public housing. A 2009 study by the San Francisco Human Services Agency (Fribourg, 2009) found that approximately 18,000 persons lived in the city's 530 SROs. The median age of residents was 55, and an estimated 7,700 were age 60+. For many older persons and younger adults with disabilities, the SRO hotels represent cheap housing that allows them to remain in the community. Findings from the study included:

- Asian Pacific Islanders comprised 37% of the city's seniors, but among senior citizens living in SRO hotels, they were 61%
- Seniors in SROs were exceptionally poor, but had none of the rental protections of seniors in public housing.
- Seventy one percent of seniors in SROs lived alone.

While Chinatown's 144 SROs house the highest proportion of seniors, only nine of its hotels have elevators. Fragile residents have to be careful of torn linoleum, tottering stair banisters, community bathrooms that lack grab bars, and other hazards. SROs in the Tenderloin and South of Market are more likely to have elevators, but seniors and persons with disabilities must cope with dangerous, predatory neighborhoods. Much of the city's attention to SROs has focused on

forcing owner compliance with building codes, but the city has not developed a cross-department, coordinated strategy for meeting the social and human service needs of SRO residents, the largest community of low-income persons in San Francisco (Fribourg, 2011).

To better address the needs of seniors, DAAS developed a program that delivers food to homebound residents in Chinatown SROs. It also amended its housing advocacy contract with the Senior Action Network (SAN) to include a special focus on SRO advocacy. SAN has been charged to work with established SRO Collaboratives, the Department of Building Inspection, and other city agencies and CBOs to advocate for improved living conditions. Connecting residents to supportive services relevant to an aging and disabled population is also a goal of this contract. In November, 2011 the San Francisco Board of Supervisors convened a public hearing, and SAN, DAAS, service providers, and seniors described the living conditions for seniors in SROs (Knight, 2011).

HOMELESSNESS

The 2011 Homeless Count in San Francisco reported approximately 568 persons over the age of 60 who were homeless (SF-HSA & Applied Survey Research, 2011).[2] The results are discussed further in the first section of this report. A 2006 University of California study showed that the median age of the homeless population in San Francisco and other cities is growing, along with the number of years that homeless persons have been on the street. Years of self-neglect and exposure to harsh conditions accelerate the deterioration of homeless seniors' health. The study warned that without concentrated care homeless older persons would further crowd hospital emergency rooms. In 2014, federal healthcare reform will require states to make indigent single adults eligible for Medicaid. Barring an adverse decision by the Supreme Court this year, single homeless persons in San Francisco will no longer have to rely on charity care, and with Medi-Cal funding the city may be able to develop more preventive health care attention for older homeless persons.

> *It affects your health when you don't have affordable housing. You lose your sense of security, get depressed, and can't afford food and health care.*
> *– Western Park Community Forum*

San Francisco's chief strategy to address homelessness for extremely low-income, chronically homeless adults is permanent supportive housing. At the time of the 2006 DAAS Needs Assessment, permanent supportive housing was provided through SF-DPH's Direct Access to Housing (DAH), and SF-HSA's Master Lease/Housing First and Shelter+Care programs. Beginning in FY07-08, MOH also began administering the city's Local Operation Subsidy Program (LOSP). The program allocates operating subsidies to buildings that provide supportive housing for homeless individuals and families. SF-HSA and SF-DPH provide funding for the supportive services. The LOSP portfolio currently contains 669 total units, of which 166 are in buildings targeted to seniors. Another 81 senior units are planned by FY12-13.

[2] A total of 1,006 surveys contained data on age. Of those, 89 respondents (8.8%) were aged 60+. Applied to a total homeless population of 6,455, that would come to approximately 568.

HOUSING WAIT LISTS

Information on affordable housing is complex and non-centralized. Successfully navigating affordable housing opportunities and application processes can require literacy, persistence, English proficiency, and internet access. Once on the lists, the long wait times can be deeply discouraging. A recent DAAS community forum participant reported that she had been on a waiting for five years, two of which she spent homeless. MOH and SFRA publicize vacancies and provide information on their Web sites. City-funded housing counselors help clients navigate the network of affordable housing opportunities.

HOUSING DISCRIMINATION

In a highly competitive housing market, seniors and younger adults with disabilities are vulnerable to discrimination. To raise rent for a new tenant, landlords sometimes wrongfully evict older persons who have low rents protected by rent control, according to a focus group of Latino seniors convened for this assessment. Landlords also perceive risks with having an elderly persons or adult with disabilities as a tenant, focus group members explained.

Fair housing rights are protected under the Fair Housing Act of 1968. Through MOH and the Department of Building Inspections, the City and County of San Francisco funds community based organizations to conduct outreach and education about housing rights. These organizations typically offer housing counseling and/or legal services, including guidance on fair housing rights, reasonable accommodations, renter protections, rent control, and landlord obligations. The city's Human Right's Commission is charged with processing complaints and conducting outreach and education specifically on fair housing topics.[3] Data on such complaints made between 2007 and 2010 show that disability-related complaints are the most common (over 1,000 complaints were associated with a disability during this period). Age was the fourth most common basis for a housing complaint, with over 200 age-related complaints during the period.

SAFE LIVING IN EXISTING HOMES AND APARTMENTS

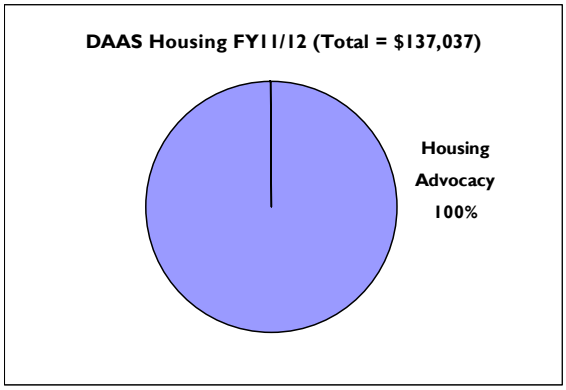
Improving home safety and accessibility for seniors and adults with disabilities can decrease premature institutionalization and improve their quality of life. Efforts can range from major renovations to make a building accessible to small modifications such as grab-bar installation to reduce fall-related injury. Some focus group participants also noted the need for security cameras to increase building safety. Multiple programs aim to increase accessibility and safety, including the community based organization Rebuilding Together, the San Francisco Department of Public Health educational program, Community and Home Injury Prevention Project for Seniors (CHIPPS), and MOH's CalHOME program. None of the programs reportedly work as well for renters as they do for homeowners because requests for assistance must come from the home owner.

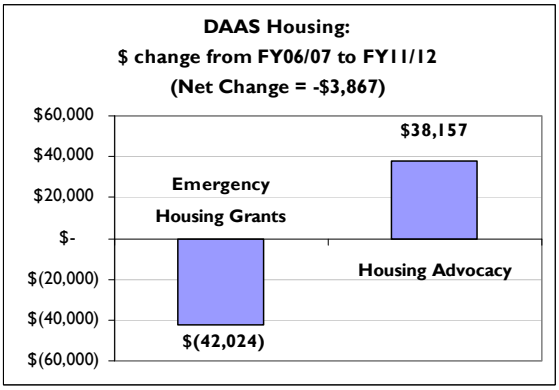
[3] Complaints may also be lodged with HUD's Office of Fair Housing and Equal Opportunity and the California Department of Fair Employment and Housing.

CHANGES TO DAAS PROGRAMMING SINCE FY 06/07

Overall, DAAS funding to housing-related contracts has stayed relatively stable since FY06/07, with a decrease of $3,867 (3%). Some budget changes in that period include:

- The contract for emergency housing grants (totaling $42,024 annually) was ended because other SF-HSA programs were available to provide rental assistance and rent subsidies that seniors and persons with disabilities can access. These programs are managed by the SF-HSA Housing & Homeless Division and their general fund allocation for FY11-12 is approximately $5 million.
- The funding for housing advocacy increased by $38,157 (39%). In FY06-07, the Senior Action Network (SAN) was the sole contractor for these services. In FY07-08, Housing Advocacy underwent a request-for-proposals process and the total available funding was increased to $133,880. The SAN contract was bumped up to $109,960, and the Chinatown Community Development Center was awarded $23,920 to focus on Chinatown residents. Since then, the SAN contract was again increased modestly to $113,747, and programming has shifted away from more general education and outreach activities toward advocating for improved living conditions and access to supportive services for SRO residents.





DAAS also funds about $900,000 in legal assistance each year (described in more detail within the Consumer Advocacy section of this report). The legal services provided are often for housing-related issues, including preventing eviction, resolving landlord/tenant disputes, preventing foreclosure, and fighting discrimination. In addition, the Long Term Care Coordinating Council has a Housing and Services workgroup that focuses on a range of housing-related issues with the goal of improving the housing situation of DAAS constituents.

III. NUTRITION SERVICES

Malnutrition can lead to lost weight and strength, greater susceptibility to disease, confusion and disorientation. Older adults at nutritional risk tend to make more visits to physicians, hospitals and emergency rooms (National Resource Center on Nutrition, Physical Activity, and Aging,

2011). Poor nutritional status is also associated with increased mortality for patients in hospitals, a higher rate of discharge to nursing homes, and a longer length of stay (Van-Nes et al, 2001).

Other causes of malnutrition include: disabilities and functional impairments that create barriers to shopping and cooking (Wolfe et al., 2003); chronic diseases associated with malnutrition; medications associated with loss of appetite, reduced taste and smell, and nausea; and the loss of teeth or other dental problems that result in problems with chewing or swallowing (National Resource Center on Nutrition, Physical Activity, and Aging, 2011). A recent study examining CalWORKs and SSI benefit recipients found that physically disabled households in California were especially likely to have gone hungry because they utilized the local food bank less than recipients whose disability was mental (Child & Family Institute of California, 2010).

A recent national study (U.S. Senate Committee on Health, Education, Labor & Pensions, 2011) found that since the Great Recession, 80% of senior-serving agencies reported an increased demand for nutrition assistance, but 20% also reported that they were unable to meet the increased demand. The report also noted that approximately half of health conditions affecting older persons are related to poor nutrition, often leading to early entry into long-term care facilities. One year of home-delivered meals costs about the same as one day in a hospital. According to the study, 90% of low-income seniors who cannot afford proper nutrition have no access to federal meal programs.

In San Francisco, the high cost of living forces many low-income residents to choose between paying for rent, medications, or food. Concerned about losing housing or having utilities turned off, many low income seniors may reduce costs by cutting out more expensive foods such as fresh vegetables or high protein items. As depicted in the first report of this needs assessment, San Francisco seniors are extraordinarily likely to rely on SSI. Yet the maximum SSI benefit covers only 62 percent of the basic costs of living for a San Francisco senior who owns her home outright, and 38 percent of those costs for a renter, according to the Insight Center's Elder Economic Security Index.[4]

The three major types of nutrition programs available to seniors and adults with disabilities are described in the table below:

Types of Nutrition Programs

Program Type	Examples
1. Prepared Meal Programs	• Congregate and home-delivered meal programs targeted to older adults and younger adults with disabilities • Other, non-targeted, meal programs at local non-profits, such as churches, etc. • Meals provided in adult day program settings
2. Free Grocery Programs	• Federal commodity distributions • Food pantries • Free grocery delivery programs

[4] Basic costs include food, housing, medical care, transportation, and other necessary spending. For more information, see the Insight Center for Community Economic Development:(http://www.insightcced.org/communities/cfess/eesiDetail.html?ref=39)

Types of Nutrition Programs

Program Type	Examples
	• Free produce at community farms
3. Food Voucher Programs	• CalFresh (formerly Food Stamps) • Senior Farmers' Market Nutrition Program

The importance of maintaining free meal and grocery programs was discussed at nearly all of the community meetings held for this needs assessment. The Older Americans Act (OAA) funds congregate and home-delivered meal programs provide important nutrition to seniors. A national survey of Office on the Aging OOA congregate and home-delivered meal program participants found that the program meals represent half to two-thirds of the food for the day for them (Rabinovech & McNutt, 2004). Participants' feedback from the DAAS FY 2010-11 Annual Consumer Satisfaction survey indicated that over 90% of the participants were satisfied with the quality of meals and service and that they benefited from their congregate and home-delivered meal programs.[5] In addition to the nutritional value, a secondary benefit for participants is an increase in social networking and access to other services.

Local nutrition providers struggle to maintain and improve program operations with flat or declining funding even as the cost of doing business rises. Participants discussed the following challenges and areas for improvement related to current nutrition programming:

- *Low quality of food* at some congregate meal sites can reduce participation;
- *Low nutritional value of food, lack of fresh produce, and the need for culturally appropriate products* at some food pantries, especially for programs in the Bayview where there are few grocery stores;
- *Difficulty in accessing free grocery distributions, standing in line, and/or transporting food home* for people with physical disabilities.

ESTIMATING UNMET NEED FOR NUTRITION SERVICES

In a citywide survey conducted in 2011, seniors 60 and older were asked if they needed assistance from meal programs in the past year (ETC Institute, 2011). Thirteen percent said "yes." Rates were highest in the following supervisory districts:

- District 6, which encompasses the South of Market neighborhood and a large part of the Tenderloin, (19.4%);
- District 5, which draws from the Western Addition, Lower Haight, and Japantown neighborhoods (19.1%);
- District 8, which includes the Castro and Inner Mission areas (15.4%); and
- District 7, which includes West Portal and extends to the Lake Merced area (14.5%).

When survey results were analyzed by ethnicity, Asian/Pacific Islander respondents had the highest rates of need for meal programs (14.7%). Extrapolating from this survey, approximately

[5] FY 2010-11 Survey respondents: 2,802 in Congregate Meals and 1,006 in Home-Delivered Meals, DAAS

20,000 seniors need assistance from meal programs. The results, however, do not show clearly how many need assistance with meal programs but were unable to access those services.

The 2009 California Health Interview Survey estimated that 29% of San Francisco seniors (age 60+) with incomes below 200%of the poverty level were food insecure, lacking sufficient resources to obtain food on a stable basis. This is a significant increase from the 2005 rate of 22%. More than half (54%) of low-income younger adults with disabilities reported that they were food insecure. That rate has been relatively stable over time. The lower rate of food insecurity among low-income seniors may reflect the greater availability of free and low-cost nutrition programs targeted at that population.

According to a 2008 phone survey, 3% of older San Franciscans (60+) and 8% of adults with a disability (18+) needed but were not able to use home delivered meals programs. Rates of unmet demand for the congregate meal programs included 3% of seniors and 7% of adults with disabilities. These rates were largely stable compared to a similar survey conducted in 2006; however, congregate meals for adults with disabilities decreased from a 2006 total of 12%. Though the city's program is not means-test, the most common reason cited by older adults for being unable to use home delivered meals programs was the perception that their income was too high. For adults with disabilities, the most common reason was that respondents didn't know how to access the program (National Research Center, Inc., 2008).

RECENT TRENDS RELATED TO NUTRITION

The availability of free and low-cost nutrition programs for seniors and adults with disabilities has increased dramatically in the last five years. The following program expansions have resulted in an overall estimated increase of more than 4.25 million meals to seniors and adults with disabilities:

- The **CalFresh** program, formerly known as Food Stamps, has seen significant increases in caseloads and benefits for seniors and adults with disabilities. In that time, the number of Food Stamps/CalFresh cases with a senior or adult with a disability increased by 65 percent, and the average grant received from the program for each of these cases increased by 36 percent. Based on September 2011 program data, senior and disabled households will receive approximately $18.3 million in CalFresh benefits in FY 11/12. At approximately $5 per meal, this would be 3.7 million meals provided, 2 million more meals annually than were provided through that program five years ago.

  Senior enrollments increased significantly. These increases are due to: a) the re-branding of the program to CalFresh, "better food for better living," which reduced stigma among all populations; b) implementation of an online application in June 2009; c) a policy change that eliminated asset limits for applicants, including senior and adults with disabilities, in April 2011; d) a partnership between CalFresh staff and local Aging and Disability Resource Centers (ADRCs) to provide outreach; and e) cross-training of IHSS staff to take CalFresh applications from consumers in that program who do not also receive SSI. *Due to the outreach efforts and the new resources rules, the CalFresh senior caseload increased, in just t seven months, by over 500.*

- Food provided to seniors through **free grocery distributions** has increased by 31 percent.
- **Senior Farmers Market Coupon** funding increased from $30,000 in 2006-07 to $32,000 in 2011-12, resulting in a slight increase in meals.
- The **transfer of intake and wait list management responsibilities** to DAAS has coincided with a significant decrease in the waiting time for home delivered meals. In June, 2007, the average wait to receive home delivered meals was 70 days, compared to 29 days as of June, 2011.
- **Senior meals funding** has fluctuated, but compared to five years ago has remained level. Funding has generally shifted, however, from congregate to home-delivered meals. Between 2006-07 and 2011-12, the funding for congregate meals dropped by 14%, and the number of meals served fell by 8%. Home-delivered meals funding increased by almost 19%, and the number of meals increased by almost 30%. In 2009-10 the DAAS budget for meals dropped by $312,735, but providers were able to leverage non-DAAS funding and increase use of donated food from the San Francisco Food Bank and other sources to sustain nearly the same volume of meals. The total number of meals contracted for 2011-12 is 1.7 million.
- **DAAS-funded meals for younger adults with disabilities** have more than doubled since 2006-07 due to the availability of new funding. These programs, however, still only account for five percent of all meals funded by DAAS for FY 11/12.

CHANGES TO DAAS PROGRAMMING

The majority (93%) of DAAS nutrition funding continues to be for congregate and home-delivered meal programs, with about 42% of funding from federal and state sources. In the last five years, DAAS has decreased the total nutrition budget by a small amount, less than one percent, but the number of meals provided with that funding has increased by seven percent, due largely to the implementation of new grocery distribution services and increases in funding to meal programs for younger adults with disabilities. Capping meal costs for senior congregate and home-delivered meal programs resulted in more than $500,000 of savings to the program, and only 9,000 reduced meals.

DAAS Program Changes from FY 06/07 to FY 11/12

	$ Change	Estimated Meals Change
Grocery distributions: SRO Food Assistance Program, OMI Food Network Program, and Home Delivered Grocery Program	$165,095	149,867 (bags of groceries)
Meals for Younger Adults with Disabilities	-$11,517	69,793
Meals for Seniors	-$19,244	253,479
Total change	**$134,334**	**473,139**

IV. SERVICES TO REDUCE ISOLATION

Many seniors have been taken advantage of so they're wary of people… This topic is hard because a lot of seniors don't want services even though they need them.
-- African American Focus Group Participant

The issues of isolation – physical, social, and linguistic – that are described elsewhere in this report are like a bright red thread running through the challenges of service access. Isolation was a common theme during San Francisco needs assessment discussions. Social isolation, having no close friends and few contacts with the outside world, is linked to poor health (Seeman et al., 2001). It is comparable to the risk factors in obesity, sedentary life styles and possibly even smoking (Cacioppo et al., 2002). The risk of isolation increases with age, as frailty increases and social circles shrink (Rathbone-McCuan & Hashimi, 1982). For individuals who are homebound due to functional impairments, social isolation can be severe. The first part of this report provides data on isolation, but no reliable way exists to calculate the number of San Franciscans who are socially isolated or homebound, and one of the biggest challenges in addressing isolation is simply identifying isolated individuals and building their trust.

Participants in needs assessment focus groups stressed the importance of resources that help to reduce isolation, including: senior centers; adult day programs; support groups; church communities; activities at cultural institutions, including libraries and museums; social and hobby-related clubs; and informal networks of family and friends. Community and senior centers were cited as offering a place for people to congregate with others, including those who speak their primary language, as well as a free way to have fun, eat a good meal, and dispel depression and loneliness. Not all isolated seniors need services, one participant at a community forum noted, they often just need opportunities to socialize. Trust is often a critical first step in breaching the isolation of seniors and adults with disabilities. At a forum on senior isolation, participants stressed that the fear of losing independence often impeded seniors from seeking connections (Family Service Agency of San Francisco, 2012).

This community center is like a second family.
– Jackie Chan Community Forum Participant

The first report of this needs assessment reviews demographic information about various groups that have unique needs and challenges, including isolation. Other San Franciscans who experience unique issues related to isolation include:

Younger adults with disabilities: Many social programs and discounts at cultural institutions are targeted toward the senior population, not younger adults with disabilities. The vast majority (92%) of DAAS program participants in this area continue to be seniors. Working with younger disabled populations requires much more than providing physical accessibility. In fact, the 2009 American Community Survey found that the most common type of disability for younger adults in San Francisco was serious difficulty with concentrating, remembering or making decisions because of a physical, mental, or emotional condition, followed closely by serious difficulty with walking or climbing stairs.

Linguistically isolated seniors: The American Community Survey estimates that 31,532 (28%) of seniors age 65 or older are living in linguistically isolated households.[6] This is an increase compared to the 2000 Census, when 25% of seniors were linguistically isolated.

Individuals living alone, not in senior-specific or supportive housing: Focus group and community forum participants, especially the African American focus group, expressed concerns about individuals living in more isolated housing types. According to a study of isolated seniors in the Bay Area, those living in senior-specific housing or even in Single Room Occupancy hotels (SROs) are less likely to be isolated than those living in non-senior-specific housing. These residents may be less likely to have relationships with immediate neighbors, and their buildings are less likely to be targeted for outreach regarding local socialization activities for seniors (Portocolone, 2011).

LGBT seniors: Some of the challenges faced by LGBT seniors are discussed in the first report of this assessment; however, they are at particular risk for social isolation. The pressure to live a closeted life as an LGBT senior is itself isolating, and LGBT seniors who are "out" sometimes struggle with lack of acceptance from family members.

> *I live at the library because it's the only place to go. I try to go to senior days with my grandchildren and they don't let me in. Those days are good for people with disabilities because they are not so crowded. I could go on free day for everyone, but it's not good because of my mobility issues. –Adults with disabilities focus group participant*

RECENT TRENDS RELATED TO ISOLATION

The following trends may have an impact on the issue of social isolation in the coming months and years:

Closure of Adult Day Health Care (ADHC) Programs: With the elimination of Medi-Cal funding for ADHC programs last year, all of San Francisco's programs faced possible closure. However, the state has developed another program, the Community Based Adult Services (CBAS), that will be similar to the Adult Day Health Care program. CBAS is an outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries.

All of the current ADHC participants who are eligible for the new program will have a direct transition. They will be eligible if they meet Nursing Facility Level of Care criteria, or if they have a cognitive brain impairment such as moderate to severe Alzheimer's Disease or other dementia, a brain injury, chronic mental illness, or are developmentally disabled, and meet certain medical necessity and eligibility criteria. The current ADHC program serves 1,200 vulnerable older persons, and an initial analysis of the non-profit providers suggests that 90% of current participants will continue to receive services.

Expansion of on-line access and social networking tools: Several San Francisco community-based organizations serving seniors and adults with disabilities will receive new computers funded by a grant through the American Recovery and Reinvestment Act (ARRA). The initiative is called the Broadband Technology Opportunities Program (BTOP). One

[6] IPUMS American Community Survey 3-year estimates 2007-2009.

organization, the Community Living Campaign, is particularly focused on reducing social isolation and eliminating barriers to the aging community through the use of internet-based tools that provide a forum to build and enhance personal relationships. The Community Living Campaign is a San Francisco-based organization that has led the trainings of various social media tools like Facebook, Skype, Tyze (a new social media networking Website to connect family and friends).

Village model: In the last two years, two "Village" organizations have opened in San Francisco (see "Access" section of this report for more details). Included in the services of these membership organizations is the promotion of participation in social, cultural, and volunteer activities. While the memberships of the villages is still fairly small (approximately 160), they represent a new model for engaging isolated individuals and those who are at risk of isolation. [7]

California Center for Dignity, Social Inclusion and Stigma Elimination: The Mental Health Association of San Francisco recently received a three-year grant, funded through the California Mental Health Services Act, to create a technical assistance, research, and training center with the goal of reducing stigma and promoting the social inclusion of adults with psychiatric disabilities. The center will provide communities and practitioners with leading-edge research in stigma-reduction and social inclusion.

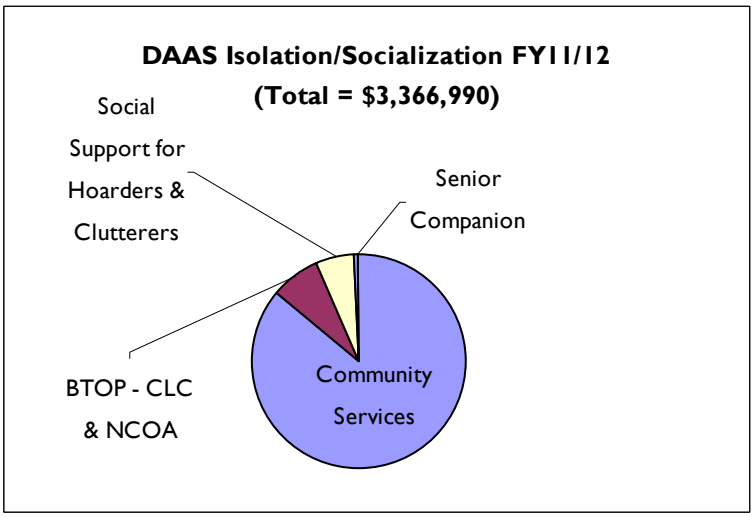
CHANGES TO DAAS PROGRAMMING OVER LAST FIVE YEARS

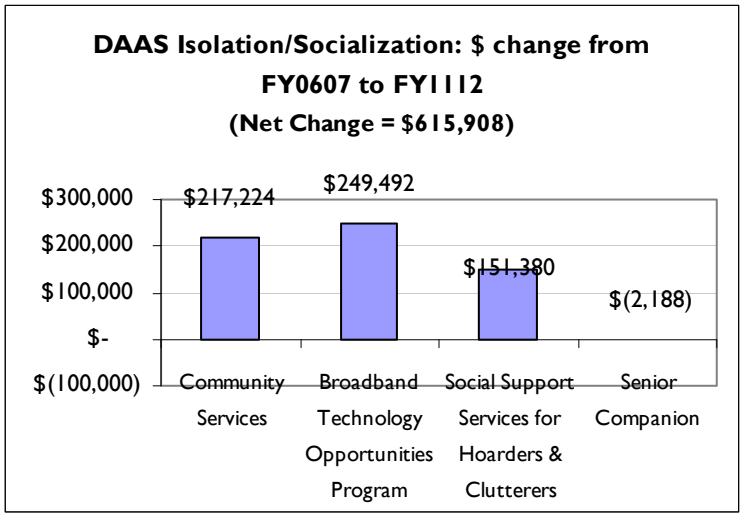
Over the last five years, DAAS funding for isolation and socialization programming has increased by $615,908 (22%). Nearly half of that increase was due to the BTOP grant, which included, among other services, internet-based community building initiatives through the Community Living Campaign, National Council on Aging, and other contractors. Other funding and programming changes at DAAS included:

- *Community Services*, which focus on Senior/Activity Centers, had the largest increase ($226,449, 9%). The majority of this funding increase reflects Board of Supervisor add-backs, as well as outreach funding allocated to providers in this category. While the number of hours of services appears to have declined significantly during this same period, that largely reflects redefinitions of service units at the time of the last solicitation for services – new definitions excluded preparation, clean-up, and follow-up time from activity scheduling hours, and clarified translation hours to prevent double-reporting of those hours with activity scheduling.
- *Funding for Social Support for Hoarders and Clutterers* has increased by $151,380 (378%). Funding for this service began in April 2007, and the first few months of programming were focused on laying the groundwork for a task force focused on hoarding and cluttering issues. Thus, contracted service levels have increased dramatically since FY06/07, especially with respect to the number of professionals trained on the issue and the number of consumers receiving information and referral. This program has been threatened repeatedly by budget cuts, but has yet to see a significant cut after year-end Board of Supervisor add-backs are taken into account.

[7] For more details, please refer to the San Francisco Village Website: http://www.sfvillage.org/

- *The Senior Companion program* showed a slight decrease in funding ($2,188, 9%), due to state cuts. This has decreased the number of seniors the program is contracted to serve. The state no longer funds this program; it is now entirely supported by local General Fund.





IV. CASE MANAGEMENT AND TRANSITIONAL CARE

Often seniors and younger adults with disabilities find themselves overwhelmed by unfamiliar circumstances that accompany major life changes such as deteriorating health, the death of a loved one, discharge from a hospital or rehabilitation facility, or unexpected financial hardship. When their needs become complex, many consumers need help navigating available supports, advocating for services to meet their needs, and following up to ensure consistent service. While some need only short-term assistance during an unexpected crisis, others benefit from ongoing support to help them age in place safely. Case management programs often provide this support.

The type of case management that is most appropriate depends on the consumer's level of independence and the acuity of his or her circumstances. Services range from short-term, intermittent support for consumers capable of managing most needs on their own to longer-term support and supervision for those whose needs are complex. Individuals who are unstable due to multiple diagnoses, recent homelessness, and/or recent discharge from a hospital or institution often require the most intense case management services and benefit from providers with specialized training. Because case management is a broadly defined service, providers' skills in handling issues such as complex medical problems, psycho-social issues, and dementia can vary.

Through a network of 12 contractors, DAAS funds long-term, short-term, and transitional case management services. Case management services are available in at least 13 languages. In FY 11/12, OOA-funded case management programs are contracted to serve approximately 2,250 consumers. Two hundred are served through the Linkages program, one of the only programs that: a) funds service purchases; and b) specifically targets younger adults with disabilities who do not have a primary mental health diagnosis. DAAS also funds the Community Living Fund, which will serve 500 consumers who were previously institutionalized or at risk of

institutionalization. The Community Living Fund, a remarkable commitment from the City and County of San Francisco, is described in more detail below.

The Department of Public Health (SF-DPH), through its Community and Behavioral Health Services division, also funds a variety of case management programs for individuals with behavioral health issues. SF-DPH case management services fall under the following categories: crisis services; acute services; residential services; supportive housing and shelter-based services; intensive case management; outpatient services; and substance abuse-related services.[8] The California Department of Aging directly funds the Multipurpose Senior Services Program, which serves Medi-Cal eligible seniors age 65 or older who have been certified for placement in a nursing facility. Finally, other local non-profits offer case management services that are not funded by DAAS, SF-DPH, or the California Department of Aging.[9]

ESTIMATING UNMET NEED FOR CASE MANAGEMENT SERVICES

The need for case management services is difficult to estimate. Many seniors and adults with disabilities successfully act as their own advocates or rely on friends or family for help. Others do not see the value in case management services until circumstances reach a crisis level. In a 2008 phone survey in San Francisco, 7% of adults with disabilities (any age) and 4% of older adults reported that they needed case management or social work services but were unable to access them (National Research Center, 2008).

The people most at risk of not having full access to needed services are those who live alone or have tenuous social networks. Immigrants and consumers who do not speak English face additional barriers, both because linguistically and culturally relevant services may be less available, and because of fears about utilizing public services. At community forums, participants also identified the need for social work assistance with issues that are more complex than those that can be addressed by information and assistance specialists, but less complex than those handled by intensive case managers.

> *We need one-on-one counselors at senior center so we can discuss what problems we are having and get advice on where to go. Like the school nurse, but a social worker.*
> *–Advisory Council*

According to staff from the DAAS Intake, Screening, and Consultation Unit, younger adults with disabilities, especially those without mental health diagnoses, face the biggest challenges in accessing case management programs. While OOA case management contractors do serve younger adults, they are often housed at senior-focused agencies where staff may be less familiar with the unique needs of younger adults. Ninety percent of OOA case management clients served in FY 10/11 were 60 or older. The Linkages program targets younger adults, but has a significant wait list. The criteria for eligibility for the Community Living Fund preclude many younger adults from receiving those services. Persons with mental

[8] Detailed descriptions of DPH-funded services and associated service providers can be found on-line here: http://www.sfdph.org/dph/files/CBHSdocs/OrgProviderManual062011.pdf

[9] Examples include: Samoan Community Development Center, Italian American Community Services, Little Brothers/Friends of the Elderly, Northern California Presbyterian Homes and Services, Veteran's Equity Center, Family Caregiver Alliance, Glide Foundation, Northeast Medical Services, South of Market Health Center, Saint Anthony Foundation, and others.

health diagnoses may access case management services through the SF-DPH clinics, but some resist engagement in those services.

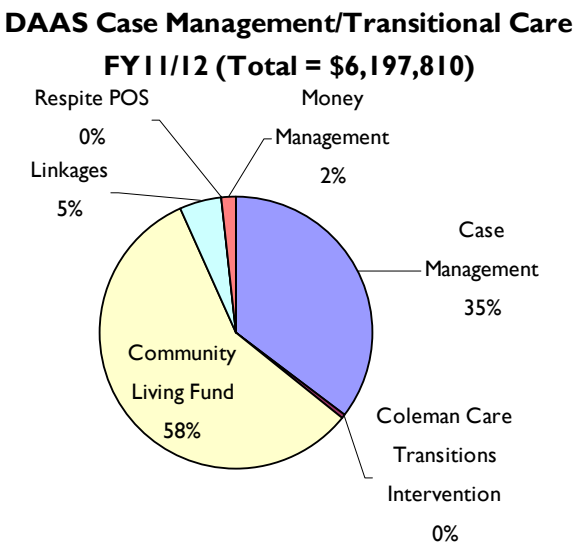
The skills of case managers vary. Clinical skills, expertise in specific medical or psycho-social issues, or linguistic and cultural competency are all factors can affect the quality of case management. While skills would be expected to vary depending upon the intensity of case management offered, it can be a challenge to ensure that consumers are connected with a case manager whose skills match their individual needs. A poor match can result in poor consumer outcomes. In recent years DAAS has made significant efforts to address variability in case management through the implementation of a case management clinical collaboration as well as a Case Management Training Institute, but the issue persists. (See the summary of recent trends in case management, below, for more detail on these initiatives.) Finally, case managers serving monolingual consumers are often snagged by the added burden of translating mail and billing statements, an inefficient use of a skilled case manager's time.

OOA-funded providers in FY 2010/2011 did not serve the contracted number of consumers. Some over-served their contracts, and a survey of contractors revealed that several maintain waiting lists for case management services. The majority do not. Two of the contractors with waiting lists provide specialized mental health services that may not be available elsewhere. To reduce wait times, case management programs could refer more clients to each other.
Case management plays an important role during patient transitions from hospital to home. After discharge from an acute-care hospital, San Franciscans with little or no family and caregiver support are vulnerable. Isolated and low-income seniors and adults with disabilities may suffer from chronic health setbacks, nutrition insecurity, medication mismanagement, and limited mobility. One study found that 22 percent of patients with one or more transitions in care had at least one problem within 30 days of transition (Ivey et al., 2005). Nationally, nearly 20% of Medicare discharges from hospitals are re-admitted within 30 days (U.S. Department of health and Human Services, 2011). A 2008 report analyzed the need for improved transitional care in San Francisco, offering a range of recommendations, including: enhanced discharge planning staffing; stronger hospital discharge protocols; consumer/patient empowerment strategies; improvements in relevant legislation; training; and many others.

A critical adjunct of case management is helping older persons manage their medications. Ten percent of all hospital admissions are related to patients not taking medications as prescribed (Schlenk et al., 2004). Transitions from hospital to home in which the medications are managed badly can result in greater use of emergency room services and hasten returns to the hospital (Crotty et al., 2004; Flora et al., 2012). Memory and cognition difficulties, concerns about side effects, literacy, costs, and simple dexterity can interfere with an older person's ability to take his or her medications, and the burden of a family caregiver who administers medications can undermine adherence (Jackson, 2011). Conflicts can arise between a prescribing physician's disease model orientation and the older patient's desire for independence, pitting the physician's quality of care concerns against the patient's concerns about quality of life (Miller, 2011). Emerging research on medication management emphasizes interdisciplinary decision-making that incorporates the patient's point of view (Miller, 2011), includes the pharmacist as a part of the care team (Hutchinson & Castleberry, 2011), and involves the caregivers and range of persons in an older person's life (Jackson, 2011).

RECENT TRENDS RELATED TO CASE MANAGEMENT AND TRANSITIONAL CARE

The accompanying chart illustrates the current level of DAAS funding for case management and transitional care services. Over the last five years, DAAS has expanded the *capacity* of local case management for two specific populations: 1) individuals at imminent risk for entry or re-entry into skilled nursing facilities; and 2) the individuals transitioning to home from acute care hospital settings. These efforts include:



Community Living Fund: To prevent institutionalization of seniors and adults with disabilities, DAAS launched the Community Living Fund in March, 2007. It has broad and flexible authority to use funds in whatever way deemed necessary to allow seniors and adults with disabilities to reside in the community. Low-income San Franciscan adults are eligible if they: a) are transitioning into the community from an institutional setting or are at imminent risk for institutional placement; or b) have an assessed need for a resource that will prevent institutionalization that cannot be provided through any other funding source. The program's design and mission make it unique in the state. It served 512 unduplicated clients in the FY10/11, and had a waitlist of approximately 27 potential clients.[10]

Homecoming Transitional Care Network: In 2002, a partnership between The San Francisco Senior Center and Catholic Healthcare West - Saint Francis Memorial Hospital[11] resulted in the formation of the Homecoming Program, which bridges the gap between hospital discharge and successful recovery at home. Since its creation, the program has received funding through the Community Living Fund (starting in 2007), as well as a 2008 grant to add a full-time referral coordinator and expand the Homecoming Program to all San Francisco acute-care hospitals. It established a centralized referral process to enable hospitals to refer to a network of community agencies. A 2009 review of the program resulted in a strategic plan developed by a steering group comprised of stakeholders from CBOs, hospitals, and DAAS. The California Pacific Medical Center and Saint Francis Memorial Hospital funded a transitional care pilot, studying whether hospital readmission rates could be reduced by improving partnerships between hospital staff and community-based case managers. The resulting Homecoming Transitional Care Network model included eight participating agencies.

[10] Wait list estimate as of August 2011.
[11] Now known as Dignity Health.

Coleman Care Transitions Intervention (CTI): This program empowers consumers to take a more active role in their health care and prevent re-hospitalization. It focuses on four areas: medication self-management; patient centered health records; primary care provider/specialist follow-up; and patient knowledge of red-flags for conditions that worsen. The Institute on Aging operates this program and has developed partnerships with St. Mary's Medical Center and Saint Francis Memorial Hospital. In FY 11/12, the program is contracted to serve 80 unduplicated consumers. The current funding stream for this initiative ends in March 2012, but DAAS and the Institute on Aging plan to include funding for continuation of the model in an upcoming grant application (see below).

New funding opportunities through health reform legislation: In December, 2011 DAAS worked with local hospitals and CBOs to submit a proposal to the Centers for Medicare & Medicaid Services for a "Community-Based Care Transitions Program" grant, which is funded through the Affordable Care Act. The grant program is intended to test models for improving care transitions for high risk Medicare beneficiaries, including transitions of beneficiaries from the inpatient hospital setting to other care settings. In addition, the state's new 1115 waiver, which is intended as a state-level bridge to implementation of the Affordable Care Act, includes a Delivery System Reform Incentive Pool through which the state can make payments to public hospitals to improve quality of care. This makes it likely that hospitals will have funding to make systemic improvements in care, some of which may be targeted to improve transitional care.

Case Management Clinical Collaboration: Since 2007, through a model implemented by the OOA, most case management providers meet at least monthly as a group and weekly individually with a clinical supervisor to discuss cases and to receive in-service training, encouraging consistent case management standards and interaction between case managers across the city.

Case Management Training Institute: DAAS community case management programs have long emphasized the importance of meeting the linguistic, cultural, and clinical needs of consumers. However, those programs have historically varied in focus, degrees of service provision, educational background, and skill types. Launched in 2009 with funding from the Community Living Fund, the Case Management Training Institute was designed to: a) allow for expansion and integration of services among existing community case management programs; b) establish an innovative model/standard of practice relating to community based case management; and c) create core knowledge and practice skills that translate into accessible, efficient, and effective client-centered service delivery. The program is administered by the Felton Institute, a program of Family Service Agency of San Francisco, which piloted and designed trainings modeled after the Motivational Care Management model, formerly known as the Strength-Based Care Management model. The core curriculum promotes a client-centered empowerment model that supports the mission and goals of DAAS. More than 20 case management agencies, including CLF, Diversion and Community Integration Program, and community partners such as the WestBay Housing Corporation, Laguna Honda Hospital, and Targeted Case Management have participated in the curriculum development, education, training, and coaching. Each training session is tailored to the assessed needs of the participants, including both case managers and supervisors.

The Case Management Training Institute is training case management supervisors to coach existing and new case managers. In addition, the program's full curriculum will be available on-line for new case managers who have not yet attended the original training sessions. Participation in these efforts is voluntary now, which may lead to increased disparities in training and practice between new and veteran case managers.

Case Management Connect Project: In July, 2007, following two years of research and planning, the San Francisco Partnership, DAAS, and SF-DPH initiated a pilot project to improve coordination of services for clients who may be utilizing more than one of the city's diverse case management programs. The pilot project includes 14 case management programs under contract to DAAS or SF-DPH that partnered to coordinate services for their clients through the use of an electronic rolodex. This tool enables participating agencies to look up a client and see contact information for other service providers known to DAAS/ SF-DPH who share the same client (e.g. case managers, social workers, and medical providers). Joining the project entails that all DAAS case management programs became part of the SF-DPH network of providers, certifying their compliance with the privacy standards of the Health Insurance Portability and Accountability Act (HIPAA). Non SF-DPH hospital providers (e.g. emergency room staff) are being trained to meet HIPAA standards and are also joining the rolodex system that shares client information for the purpose of improving treatment.[12] Additional plans to further integrate the rolodex system with other local databases (e.g. the GetCare system) are currently on hold pending a transfer of rolodex data into a new high capacity data warehouse.

Diversion and Community Integration Program (DCIP): DCIP brings together the city's resources and experts to ensure that individuals who are diverted or discharged from San Francisco's public skilled nursing facilities have the ability to live independently. A team representing various services by and through DAAS and SF-DPH (e.g., In-Home Supportive Services, Community Behavioral Health Services, Housing and Urban Health, Laguna Honda administration, a home health agency, etc.) meet regularly to review the cases of eligible clients. This core group can authorize program services to meet consumer needs. The group develops a Community Living Plan for every eligible client to facilitate either discharge from Laguna Honda Hospital or diversion from a hospital. Client's preferences and assessed needs are always included in the plan, as well as services that have been or will be arranged. Most DCIP clients are also enrolled into the CLF program. The DCIP Coordinator functions as the liaison between DCIP team members, Laguna Honda Hospital, community agencies, and service providers and ensures that all components of the plan are in place. In the roughly two years since the DCIP was created, it has managed the discharge and long-term care of over 200 vulnerable San Franciscans. Of these, 80% were provided with City-funded specialized housing. These clients have retained that housing at a rate of 85%.

DCIP surveys Laguna Honda residents regarding their wish to leave the facility. In 2011, DCIP surveyed 360 patients. Forty three percent of the respondents were white; 27%, African American; 16% Asian/Pacific Islander; 12%, Latino; and 2%, Native American. *The number who wanted to stay in Laguna Honda was 224; wanting to leave, 126. Another ten said they might want to leave.* The responses did not vary significantly between racial and ethnic groups;

[12] Information about participation in certain types of programs (e.g. substance abuse, HIV/AIDS services) is not shared.

however, age did make a difference. The percentage of patients age 60+ who wanted to leave was 43%; persons under 60, just 27%. For those who want to leave, it is an urgent desire, as detailed in the table below. The majority of older persons want to live independently in a new living situation, while younger persons are more likely to want to return to their prior living arrangement in the community. Both groups want independent housing rather than assisted living. Details are in the table below.

2011 Survey of Laguna Honda Hospital Residents

Desire to Leave Laguna Honda				
	Want to Stay	*Might Want to Leave*	*Want to Leave*	*Total*
Age 60+	66	4	78	148
<60	158	6	48	212
Importance of Leaving				
	Low Importance	*Medium Importance*	*High Importance*	*Total*
Age 60+	3	14	61	78
<60	6	7	42	55
Preferred Location to Live				
	Prior Living Situation	*New Situation in SF*	*New Situation Outside SF*	*Total*
Age 60+	27	47	8	82
<60	29	24	2	55
Preferred Housing Type				
	Independent Housing	*Assisted Living*	*Other*	*Total*
Age 60+	64	14	4	82
<60	46	2	4	52

CHANGES TO DAAS PROGRAMMING

Although funding in some areas of case management has decreased, the overall DAAS funding to case management and transitional care programs has increased by $3 million (95%) since FY06/07. Significant trends within that overall increase in funding include:

- The Community Living Fund launched in FY06/07, with $512,837 of spending in that year. The annual general fund allocation for that program was $3 million annually, however, and leveraging of additional outside funds has resulted in a FY11/12 budget of $3.6 million. The development of this program has dramatically enhanced the

availability of services for individuals being discharged from institutional settings and for those at imminent risk of institutionalization.

- The District-Wide Social Services Worker program was eliminated in FY07/08, and the majority of its funding redirected to traditional case management programs. OOA analysts determined that this shift would allow for a better allocation of human resources, as the needs of program clients had typically been either case management or information and referral that could be provided through a redesigned Aging and Disability Resource Center model. The increases in caseloads and case management hours provided by OOA contactors parallels the increase in funding. This may reflect a shift of less intense case management consumers from the District-Wide model into the case management pool.
- In the spring of 2012, DAAS will be releasing a request for proposals, using Title III D funding, to provide seniors with evidence based medication management services. A pharmacist or group of pharmacists will be selected to work with all OOA-funded case management providers to provide medication counseling and education to consumers identified as being at risk of medication mismanagement.
- In FY09/10, the California Department of Aging eliminated all funding for Linkages and Respite Purchase of Services. DAAS has back-filled the state cut with local general fund, saving the program. The 16% reduction in Linkages funding caused a commensurate decline in the number of consumers who receive those services.

V. SELF CARE AND SAFETY

Protecting seniors and adults with disabilities is central to the mission of DAAS. The department provides services directly through a range of programs, including Adult Protective Services, Community Living Fund, Public Guardian, Public Conservator, Representative Payee, and In-Home Supportive Services. To augment this safety net, DAAS also funds a number of services through community service providers, including the suicide prevention and long-term care ombudsman programs. These programs address support in the home, safety both at home and in the community, social isolation that results in depression and even suicide, and abuse that can occur either in the community or in out of home care. In the last five years, with notable exceptions, most of the programs in this category have grown.

SUPPORT IN THE HOME

As described in the first part of this needs assessment, San Francisco has the state's highest rate of dependence on IHSS. In the last five years, IHSS funding has increased by 33%. The number of consumers served increased by 17%; the number of authorized hours, 21%. In every focus group and community forum conducted for this assessment, IHSS was mentioned as a critical need, preventing isolation, health issues, and more expensive institutionalization. Many participants were worried about the impact of proposed state-wide cuts to IHSS. Chinese focus group participants saw IHSS as more basic than adult day health care centers. African American participants expressed concern that some seniors were already not getting enough services and that caseworkers needed to be more thorough in their assessments.

In both the Bayview focus group and the Western Park community forum, participants mentioned the painful choices caused by the IHSS eligibility cut-off. Seniors just above the income threshold may require services, but find them unaffordable. Spending down assets may be an option for individuals with stable housing, but as one participant mentioned, the cost of housing is so high and waiting lists for affordable housing so long that she felt it too risky in such an expensive city to spend down her assets. "What good is IHSS," she said, "if you don't have a house to live in?"

PERSONAL SAFETY, SAFETY IN THE COMMUNITY

Adults with disabilities living in the Tenderloin, as well as seniors in the Chinatown and Mission districts, expressed fear about crime and personal safety. Chinese seniors in focus groups were afraid of robberies on crowded buses, muggings on the street, and more generally about strangers waiting outside seniors' homes. Latino seniors mentioned recent robberies and the vulnerability of seniors leaving the bank. Policing was perceived to be more focused on pulling over young men in cars rather than safety of seniors on the street. Several seniors in the Mission district expressed fear about sexual assaults and had known of other seniors who had been attacked in their homes.

The issue of safety in housing developments and apartment complexes came up in different contexts. In both the LGBT focus group and the advisory council community forum, seniors noted an increase in the number of younger people moving in with older relatives as a result of the economic downturn, creating tensions with neighbors. Participants spoke about the need for these younger residents to follow the rules, as well as safety concerns that accompanied these new younger occupants. One participant described how a neighbor's nephew had moved in with his pit bull. Residents were afraid of the pit bull, but did not know if they had any recourse.

Traffic safety was also a common theme raised in focus groups. A senior at the African American focus group mentioned the extra time needed as a pedestrian to cross the street. Older people are more vulnerable as pedestrians and suffer more injury complications as a result of pedestrian injuries; the rate of pedestrian fatalities for those 65+ is four times that of adults and twelve times that of children (San Francisco Department of Public Health, 2010). With the Third Street rail project, street car stops are spaced further apart than in the old bus routes, forcing seniors to walk further and to cross more streets in order to board public transportation. Third Street renovations have reduced traffic lanes, creating more safety issues for seniors, particularly where cars exit the freeway.

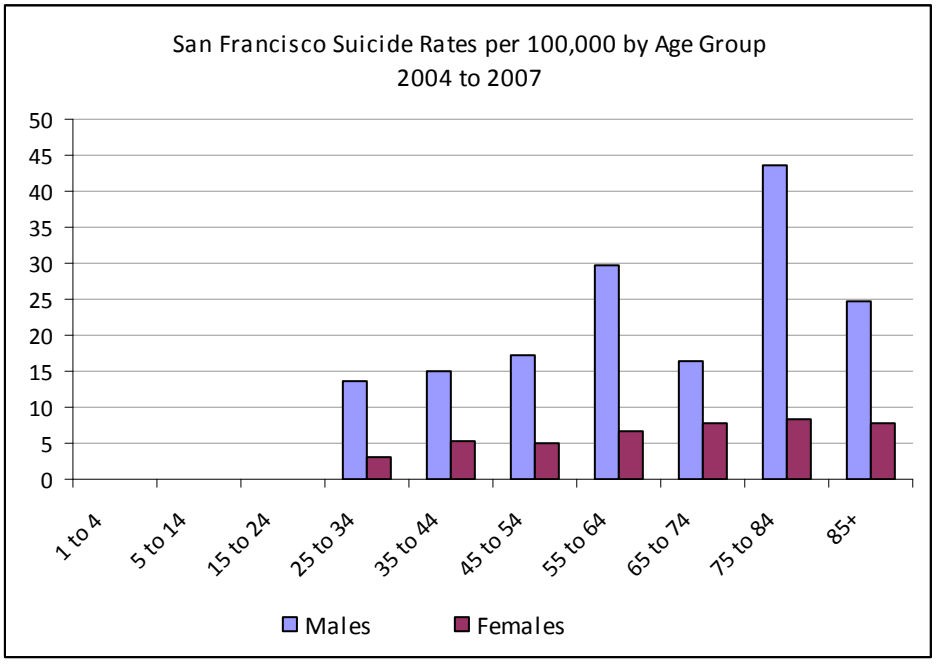
Older drivers in two focus groups expressed growing anxiety about the number of bike lanes and bicyclists. "As a driver," one senior said, "all the bicycles are about to drive me out of the city!" The San Francisco Metropolitan Transportation Agency has noted that injury accidents involving bicyclists have doubled as a proportion of all accidents involving injuries in the last decade. Collisions involving older (65+) drivers (301) or pedestrians (116) have remained consistently high over the last decade (San Francisco Metropolitan Transit Authority, 2009).[13] Participants

[13] Trends from 2000 to 2006 for older drivers (65+) and pedestrians were positive but spiked in 2007 and as of 2009 had not declined to 2006 levels. Almost a third of seniors have no access to a car, a higher share than among those 18-59.

suggested that city planners engage in concerted efforts to involve senior residents in decisions regarding bike lanes in their neighborhoods.

SOCIAL ISOLATION AND SUICIDE

As people age, they are more likely to live alone. As described in the first part of this assessment, a large number of older and disabled San Franciscans live alone. Social isolation is a major health risk. Social and medical research shows that risks for social isolation are comparable to the risk factors of obesity, sedentary lifestyles and possibly even smoking (Cacioppo et al., 2002). Social isolation also elevates the risk for depression and suicide. Older persons are the highest risk group for suicide, and seniors who attempt suicide are more likely to complete the act (Klinger, 1999).



Source: San Francisco Department of Public Health

Local research suggests that social isolation is of considerable concern for both seniors and younger adults with disabilities. A 2008 phone survey of San Francisco seniors and adults with disability indicated relative levels of isolation. Respondents were asked how much time they spent socializing with family and friends in a typical week, either on the phone or in person. Seven percent of seniors and nine percent of younger adults with disabilities responded that they spent less than one hour or no hours per week (National Research Center, 2008).

ELDER/DEPENDENT ADULT ABUSE PREVENTION

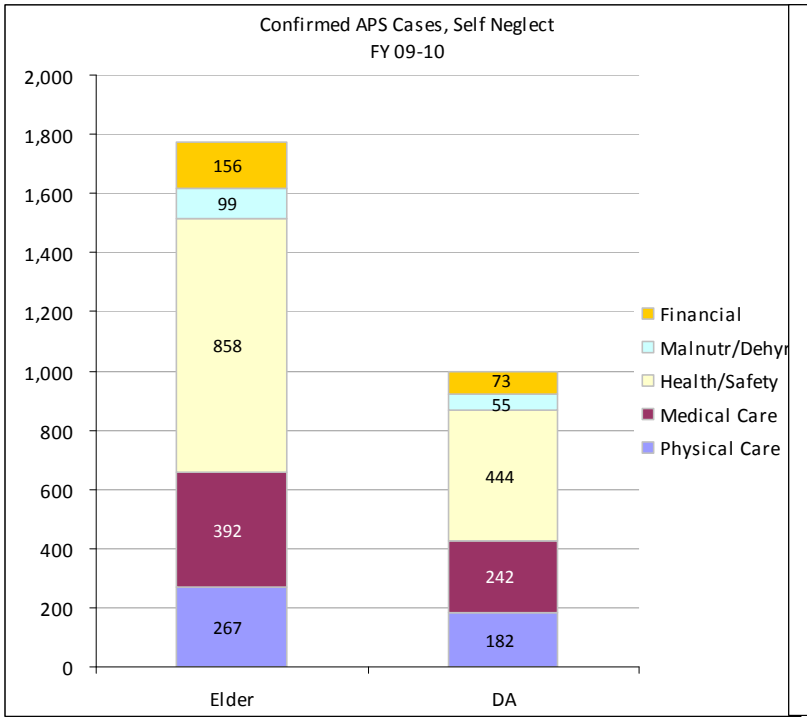
National research on the prevalence of elder abuse varies widely from study to study, but it consistently estimates that reported incidents represent only a fraction of the true number of cases in any community (National Center on Elder Abuse, 2005). Statistics about the prevalence of abuse among

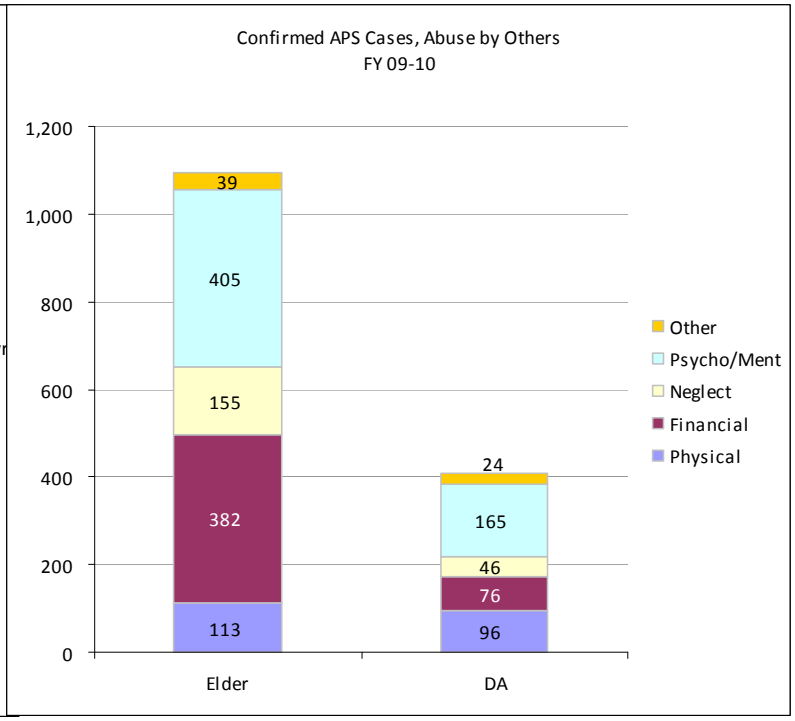
the disabled adult population are scarce, but may mirror the rates of abuse among seniors.

According to a 2010 analysis of Adult Protective Services (APS) data, psychological or mental abuse was the most common type of abuse perpetrated by others against seniors and dependent adults, comprising 38% of all confirmed allegations (see accompanying chart). Seniors were more likely than dependent adults to suffer financial abuse at the hands of others, comprising 35%of all confirmed allegations involving seniors. Dependent adults were more likely to experience physical abuse, forming 24% of this group's confirmed allegations. The accompanying chart illustrates the types of allegations for the two groups.

Self neglect is the most commonly reported type of elder abuse, both in California and in San Francisco, making up approximately 60% of all reported incidents.[14] These cases can be particularly challenging because the victim is often reluctant to accept help. Some people remain fiercely independent and are fearful of loss of control or institutionalization should APS intervene. Dementia, depression, substance abuse, and mental health issues also complicate care and elevate risk of self neglect and other types of abuse.

The most common type of self-neglect allegation involved health and safety hazards, which entails the failure to protect oneself from risk, danger, or harm.[15] Compared to the rest of the state, a higher proportion of self neglect confirmed cases in San Francisco are related to health and safety hazards (47% in San Francisco and 33% statewide). This no doubt reflects the higher rates of isolation among San Francisco seniors and younger persons with disabilities, as well as less accessible housing. The accompanying chart reflects the types of confirmed self-neglect allegations for seniors and for dependent adults. For seniors, 48 percent of confirmed self-





[14] Based on SOC 242 reports, available at: http://www.cdss.ca.gov/research/PG222.htm
[15] Please note that a single report can contain multiple allegations.

neglect allegations involved health and safety hazards; for dependent adults, 45 percent.[16] This percentage has been rising in recent years.

ABUSE IN OUT OF HOME CARE

One consequence of the gentrification of San Francisco is that the number of Medi-Cal-funded beds in the city's Skilled Nursing Facilities (SNFs) have dropped dramatically. For example, the California Pacific Medical Center Sutter is proposing to eliminate over 400 long-term care Medi-Cal beds (Nadell, 2010). The chart below illustrates San Francisco's lack of SNF options, highlighting the number of persons over the age of 60 to beds in "freestanding" SNFs, the facilities likely to be dedicated to long-term care as opposed to SNF beds in acute care hospitals. Many seniors and persons with disabilities who require long-term care are being forced to move outside of the city, away from family and friends, becoming socially and culturally isolated in the later years of their lives.

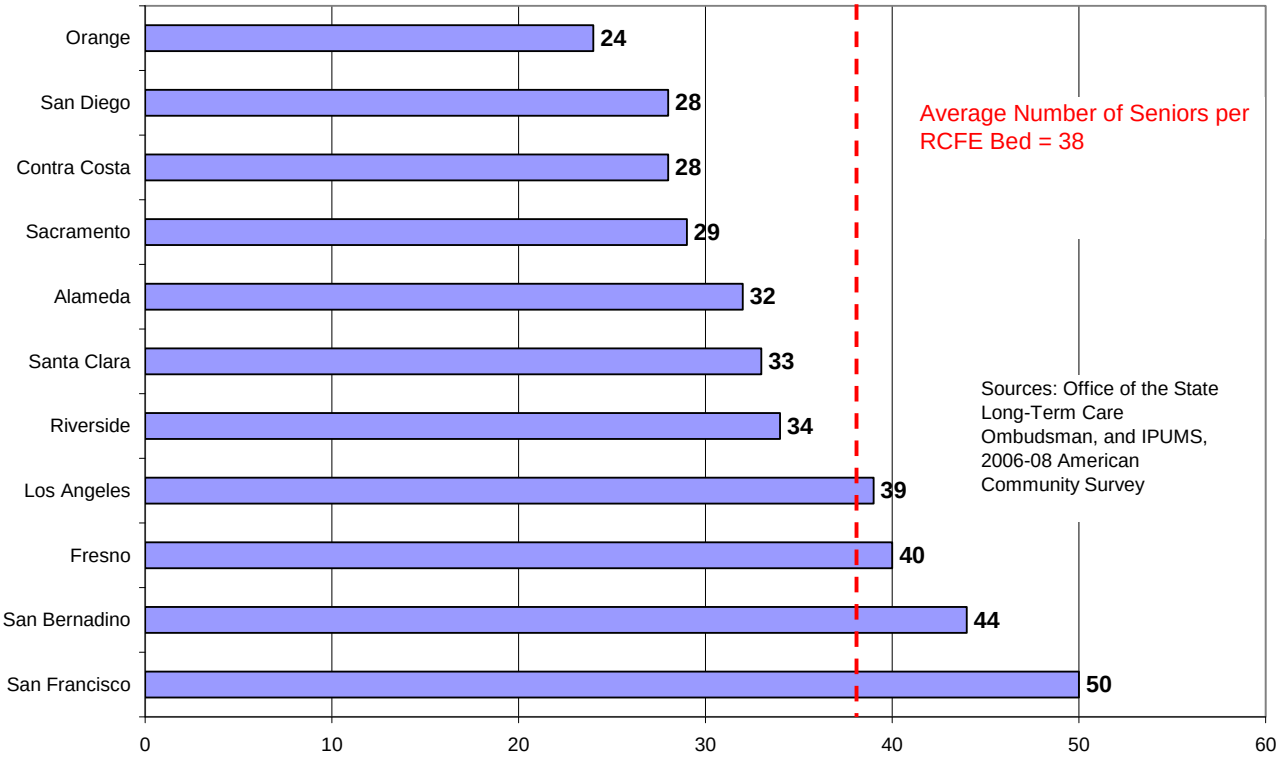
SNFs have also converted beds from long-term care to short-term rehabilitation, shifting their funding from Medi-Cal to the more lucrative Medicare. These facilities are under financial pressure to complete the course of rehabilitation and discharge patients within prescribed time frames. They may tend to emphasize rehabilitative activities at the expense of custodial care, or they may hurry discharge without the needed supports in place for the patient to transition home safely. In addition to complaints about poor care (feeding assistance, unanswered call bells, etc.) in rehabilitation facilities, the San Francisco Ombudsman Program, which investigates complaints of seniors in care, frequently responds to complaints about rights related to discharge planning.

Long-term residential facilities are also scarce. San Francisco has only 93 residential care facilities for the elderly, with 3,100 beds (Office of the State Long Term Care Ombudsman, 2008). Only 24 accept persons receiving SSI, none of which can serve non-ambulatory residents. These facilities are largely filled with younger persons who have psychiatric disabilities. Meanwhile, newer assisted living facilities for seniors are very expensive (Nadell, 2010). The accompanying chart illustrates the comparative shortage of San Francisco's residential care facilities for the elderly.[17]

[16] Statistics based on FY09-10 confirmed APS cases reported in SOC242 reports, available at: http://www.cdss.ca.gov/research/PG222.htm

[17] Data for chart derived from Office of the State Long Term Care Ombudsman for fiscal year 2007-08. Please note that the ombudsman service area for Sacramento also include Placer, Yolo, Yuba, and Sutter counties. Los Angeles has two ombudsman service areas that have been consolidated for this chart. The Fresno service area includes Madera County.

Ratio of Seniors (Age 60+) to Residential Care Facility for the Elderly Beds
Ten Largest California Counties and San Francisco



An analysis of the San Francisco Ombudsman activities in 2010 found that during the 2009 – 2010 fiscal year, the San Francisco Ombudsman responded to 1,011 complaints, which resulted in 696 cases being opened.[18] Eighty-eight per cent of these cases (584) were for residents of nursing facilities. Another 69 cases were for residents in board and care, assisted living, residential care and similar long-term facilities, both regulated and unregulated. Three cases were in other settings. In open cases, the largest portion of complaints (27%) was made by facility administrators, staff, or former staff. Twenty percent of complaints came from residents, and about 9% came from relatives or friends of residents. In residential care settings, the largest number of reports (35%) came from social service or health program staff.

The Ombudsman Program responded to a range of complaints. The largest category – 268 complaints – involved care. In this category, complaints involving accidents, or injuries of unknown origin, or improper handling were the most common (67). Also within this category, 52 complaints involved the failure to respond to requests for assistance. The second largest category was in the area of activities and social services, the majority of which were related to conflicts between residents. The third largest category of complaints was in the area of abuse, neglect, and exploitation (121), of which the largest group involved physical abuse (39).

[18] All data on San Francisco Ombudsman activities drawn from that office's "State Annual Ombudsman Repot to the Administration on Aging" for the 2009-10 fiscal year.

Of all complaints, 81% were either fully or partially resolved. Another 7% needed no action, and 5% of complaints were withdrawn. Less than 3% of complaints were not resolved to the satisfaction of the resident or complainant. To achieve this level of performance and respond to the full volume of complaints, it is essential that the Ombudsman effectively recruit, train, and supervise volunteers. In addition, the Ombudsman is responsible for educating groups of seniors, their friends and relations, and community organizations, and facility staff about long-term care residents' rights.

The table below details the categories of complaints received by the San Francisco Long Term Care Ombudsman during the 2009-10 fiscal year.

Complaint Categories for the San Francisco Ombudsman Program, FY 2009 – 10

Category	Nursing Facility	Residential Care	Total
Care	236	33	269
Activities and Social Services	145	7	152
Abuse, Gross Neglect, Exploitation	109	12	121
Admission, Transfer, Discharge, Eviction	89	9	98
Autonomy, Choice, Exercise of Rights, Privacy	67	4	71
Staffing	46	8	54
System/Others	36	9	45
Maintenance of Rehabilitation	40	4	44
Dietary	36	7	43
Financial, Property (excluding financial abuse)	37	5	42
Other	22	3	25
Environment	19	4	23
Access to Information	18	0	18
Total*	900	105	1,005

*Six additional complaints were about services in other than long term care facilities.

CHANGES IN DAAS PROGRAMMING

DAAS funding for Self Care and Safety programs has generally increased, as detailed in the table below, but several programs have seen significant drops in funding. DAAS' largest effort, by far, to support the self care and safety of seniors and younger adults with disabilities is the In-Home Supportive Services program. Other major efforts by the department include the Adult Protective Services and Conservator programs. In the past five years these programs have grown.

In particular, IHSS has increased by 33% and now has a budget over $110 million dollars, with a continuing caseload of over 21,000 clients. It now forms 94% of the department's funding for services in this category. Yet the program faces uncertainty. In his 2011/12 budget, the Governor recently proposed that the number of service hours that IHSS consumers be cut across the board by 20%. This reduction was challenged in the courts, and has been delayed due to a court injunction. While the case goes through the legal process, the Governor's reduction is reflected again in the proposed budget for 2012/13.[19] The latest budget also includes an elimination of domestic and related services to recipients who are living with others in a shared-housing situation, with an exception for households consisting entirely of IHSS recipients.

The budget proposes that, beginning January 1, 2013, IHSS and other home and community-based services, as well as nursing home care, become benefits of managed care. According to the proposal, all IHSS services will be included in the capitated rate paid to managed-care providers. A separate proposal, effective June 1, 2013, will expand Medi-Cal managed care from the current 30 counties to all 58 counties. Under this proposal, county IHSS programs continue to perform existing functions such as intake, assessment, and authorization of services through the 2013 calendar year. Starting on January 1, 2014, however, managed care plans would either contract with county social service agencies to continue to administer IHSS, or they would absorb IHSS and administer it directly. IHSS in its current structure – community based, with the consumer being the employer, and relatives being able to provide the service – would be a novel program within the realm of managed care. At the time of this report, the future of IHSS is cloudy, but its importance as a support that keeps vulnerable people in the community and out of institutional care is its best safeguard.

The programs funded by the Office on the Aging, though the smaller part of the department's self care and safety budget, provide vital services. Funding for some of the OOA programs has increased slightly, but for others has slipped. Suicide prevention services have increased by 63% to $90,000 in the 2012/13 budget year. Elder and dependent abuse prevention services, which include the Friendship Line and intensive case management, have increased by 134% to $112,207. The program had utilized federal funds for Targeted Case Management; however, the administrative burden of participating in that program proved too prohibitive, and funding has been shifted to local general fund to ensure that no funds were lost. The program has also added a forensic center, which coordinates the prosecution of crimes of financial abuse against seniors.

A significant change, however, has been the 20% drop in funding for the Ombudsman program. This program recruits, trains, and supervises volunteers to monitor the rights and well being of seniors and younger adults with disabilities living in out of home care. The state of California eliminated all funding for this program ($87,024) during the fiscal year of 2008/09., though the Ombudsman's Office continues to receive federal funding. During a time when the environment

[19] If the state is ultimately unable to implement this reduction, the Governor's budget sets aside funding in the current and budget years to cover the lost savings. http://www.lao.ca.gov/analysis/2012/ss/supportive-services-031912.pdf

of out of home care in San Francisco is changing, the Ombudsman's office has had to cope with steeper staffing and resource challenges. DAAS has tried to offset state funding losses with local general fund at every opportunity.

Changes in Consumer Advocacy Funding

Service Area	Current Funding	Changes Since 06/07	% of Current Budget	% Without IHSS
Health Promotion/Active Aging Program	$236,210	(Program did not exist in 2006/07)	>1%	3%
Adult Protective Services	$5,459,036	17%	5%	70%
Elderly Suicide Prevention	$147,277	166%	>1%	2%
Elder/Dependent Abuse Prevention	$112,207	134%	>1%	1%
Health Screening	$55,619	-1%	>1%	1%
In Home Supportive Services	$110,759,902	33%	94%	-
IHSS Emergency Services	$50,000	-0.0083	>1%	1%
Medication Management	$17,420	-11%	>1%	0%
Ombudsman Program	$264,781	-20%	>1%	3%
Public Conservator	$1,418,008	-13%	1%	18%
Total	$118,437,251	31%	100%	-
Total Excluding IHSS	$7,760,558	13%		100%

Italics = programs funded through the Office on the Aging.

VI. CAREGIVER SUPPORT

The number of caregivers in San Francisco is difficult to estimate. The first section of this report provides data on the number of San Francisco residents who are disabled, and while not all of these persons require assistance, the statistics provide a sense of scale for the population who may rely on caregivers. A report written for DAAS estimated that 22,500 seniors are living with Alzheimer's or a related dementia in San Francisco (Alzheimer's/Dementia Expert Panel, 2009), but otherwise San Francisco-specific research about caregivers is limited to a single study conducted in 1999.

Applying percentages from state and nationwide studies is possible, but San Francisco has unique demographics and the resulting estimates need to be considered with caution. Almost 49 million adults, 21% of all adults according to The National Alliance for Caregiving's 2009 telephone survey, provide care to an adult friend or loved one. The survey also found that two-thirds of caregivers are female, that on average they are 48 years old, and the majority are taking care of either a relative (86%) or a parent (36%). Applying this survey's national rates to San Francisco's population would indicate about 171,000 people providing some amount of unpaid care to an adult friend or relative.

Caregiving can be a rewarding and positive experience, but can also be characterized by emotional, physical, and financial strain (Sharlach et al., 2003; Schulz & Beach, 1999). The need for support services among caretakers varies: a main finding from a UC Berkeley survey of California caregivers was that "the vast majority of caregivers apparently do not find caregiving as burdensome as some might believe" and that positive comments about caregiving outweighed negative comments 2 to 1 (Sharlach et al., 2003). About 20% of respondents fell into the "most stressed" category, indicating a high level of financial strain and physical and emotional stress due to their caregiving activities, and 30% indicated unmet needs as caregivers. The National Alliance for Cargiving's 2009 survey found that the burden of care is "high" for approximately 9% of caregivers of adults, and moderately high for another 22%. *Applying these rates to the estimated 171,000 caregivers in San Francisco yields an estimate of 15,000-53,000 caregivers (9%-31%) with significant need for caregiver support.*

TRENDS RELATED TO CAREGIVING

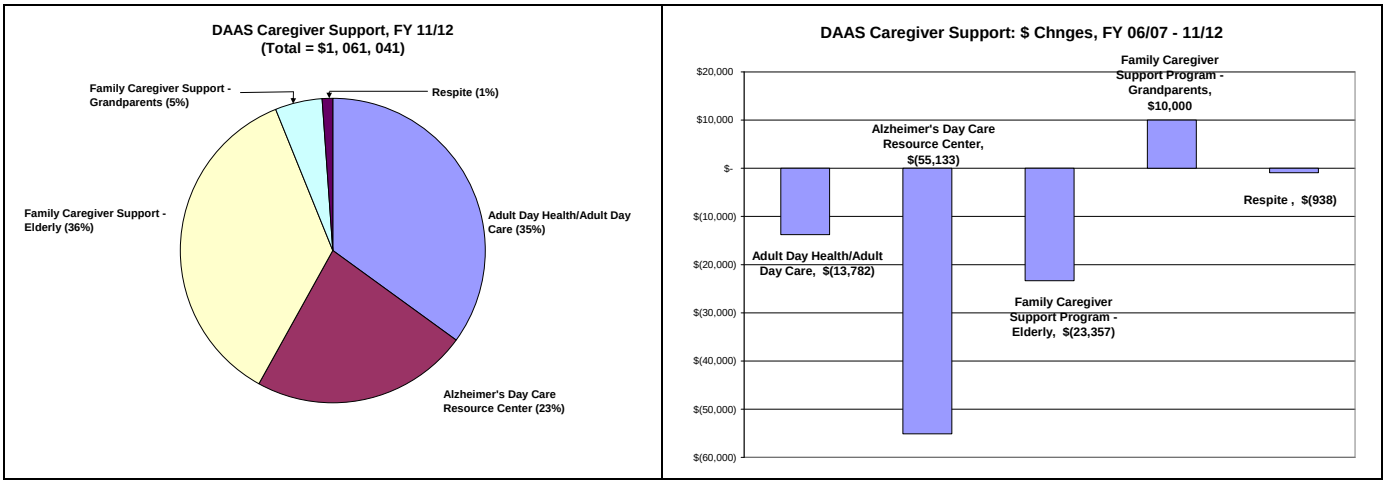
The isolation of San Francisco's seniors and adults with disabilities, combined with their diversity, compound challenges to providing caregiver support. According to the UC Berkeley Study, Asians and Latinos are much less likely to seek and access caregiver support services (Sharlach et al., 2003), possibly from a lack of knowledge about available services, but also as a result of cultural and linguistic barriers. It may also be connected to cultural expectations that support will be provided by family. In focus groups for the 2006 DAAS Community Needs Assessment, however, Latino and API seniors noted that relatives had become more dispersed, often moving away from their families because of school or jobs or affordable housing.

The needs of seniors in the LGBT community, including high rates of caregiving and isolation, are discussed in the first section of this report. While spouses and partners in the LGBT community often care for one another, many seniors have transplanted to San Francisco and have fragile or few connections to family. Moreover, as one focus group participant stated, many may be reluctant to accept or request care and support for fear that it would undermine their independence.

CHANGES TO PROGRAMMING

Federal and state funding changes have had impacts on local programming for caregiver services. Funding for caregiver support has declined both for the direct service programs offering support to caregivers of elders, and for programs providing indirect support, such as the Adult Day Health programs and Alzheimer's Day Care Resource Centers. Even before eliminating the funding for the Adult Day Health Centers (which includes both Respite and the Alzheimer's Day Care Resource Centers), the State had been gradually reducing funding. By the time DAAS used local general funds to backfill the State's final cut, the program had already seen its funding erode. Also, the federal government's Title III E Family Caregiver program has been reduced by approximately $20,000.

Two types of family caregiver support programs exist – those for caregivers of seniors, and those for grandparent caregivers of children. While both existed in FY06-07, funding for the two types of programming was made distinct in the last five years, and during that time period the reported service units for these programs also changed. Since the state's reporting requirements for units of all of the family caregiver services has changed significantly in the last year, making historical comparisons is not feasible. However, the number of persons served and the units of service provided have dropped.



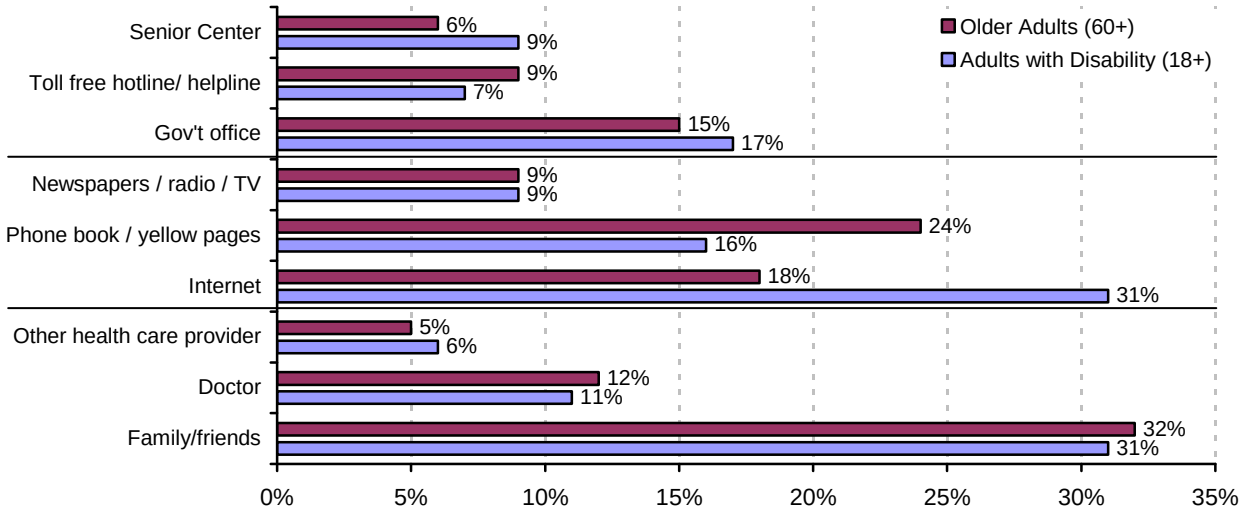
VII. ACCESS

According to the 2011 City of San Francisco Community Survey, over half of seniors need services like personal care, meal programs, socialization, and assistance with getting on public benefits (EITC Institute, 2011). Just providing services, however, is not enough. Seniors and adults with disabilities need to be aware of them, travel to them if needed, and find them culturally consonant; in short, to have access. The issues of isolation – physical, social, and linguistic – described in an earlier section, are particularly relevant in a discussion of access.

INFORMATION AND AWARENESS

A 2008 phone survey found that about 8 in 10 San Francisco seniors and adults with disabilities were aware of senior centers, nursing homes, and nutrition services, but the level of awareness varied by income and ethnicity (National Research Center, 2008). Higher income persons, as well as white persons, tended to have a greater awareness of services. When asked where they seek information or help in obtaining services, answers differed by age, but the first source of information was usually family and friends. The Web, phone books, doctors, and government offices also played an important role in distributing information, especially for persons who are isolated.

Sources of Information About Services
(National Research Council, 2008)



As illustrated in the accompanying chart, 31% of adults with disabilities look for information on the internet. Seniors are increasingly relying on technology for information, too, using the internet, email, and other forms of Web-based social networking. The National Research Council phone survey was conducted in 2006 and again in 2008, and the number of older persons who reported using the internet or email jumped from 36% to 52%.

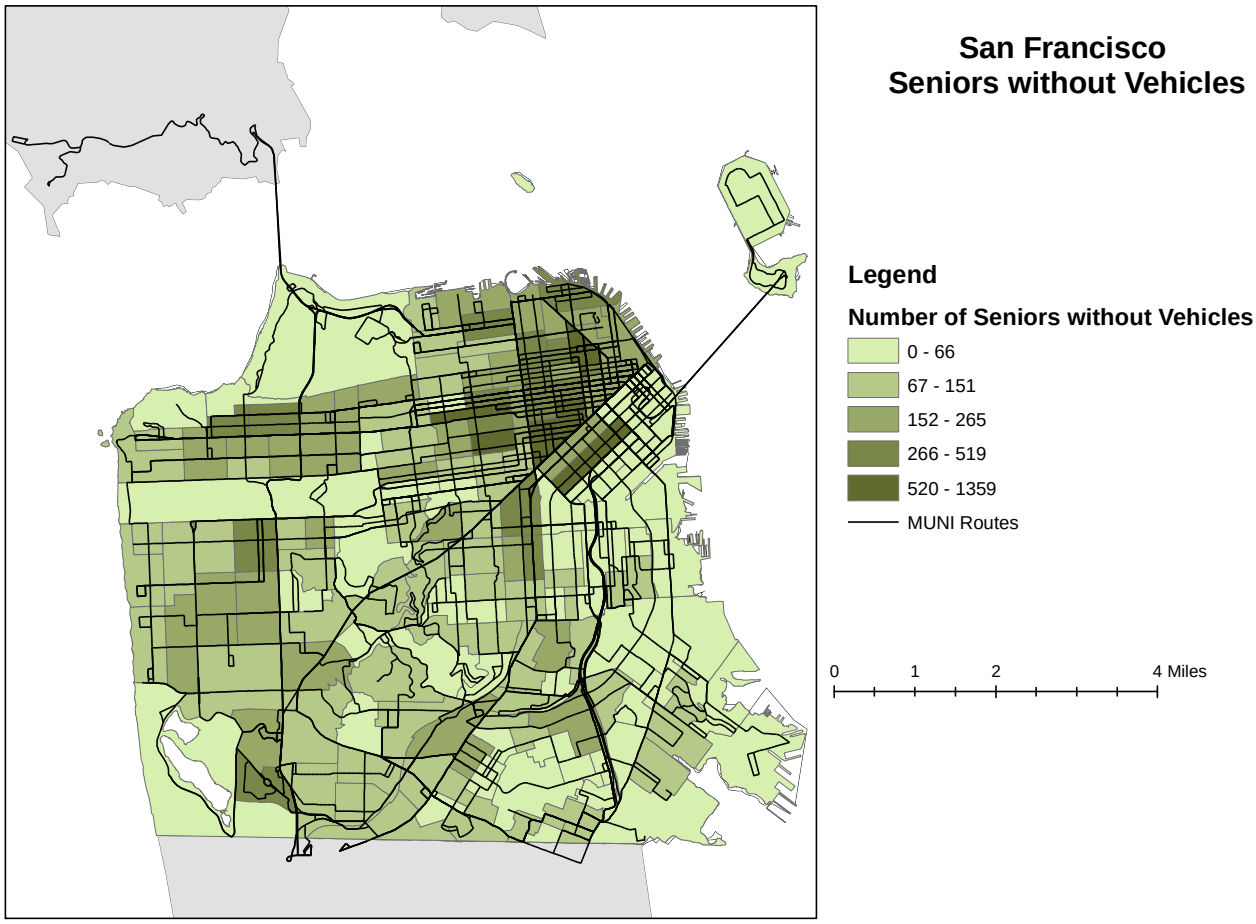
In focus groups convened for this needs assessment, participants who did not use computers stressed the need for printed resource guides. The most universal, accessible resource guide is

the phone book. Twenty four percent of seniors in the 2008 survey said they relied on information in the phone book. Due to a recent ordinance, however, citizens now have to opt-in rather than opt-out on having a phone book delivered (Gordon, 2011). Seniors rely on the phone book for information, and focus group participants also cited the value of having printed guides available at housing sites and resource centers.

As described in the section of this report on isolation, large numbers of older persons and disabled persons in San Francisco have limited English proficiency. During focus groups, seniors repeatedly cited the need for help with mail translation. Fliers, Web sites, resource guides, public service announcements, and other outreach materials need to be offered in San Francisco's diverse languages.

TRANSPORTATION NEEDS

When compared with 40 metropolitan areas with 1 to 3 million residents, San Francisco ranked first in transit access for seniors, with only 12% projected to have poor transit access by 2015 (Transportation for America, 2011). Virtually every location in the city lies within a quarter of a mile of a transit route (San Francisco County Transportation Authority, 2004). The



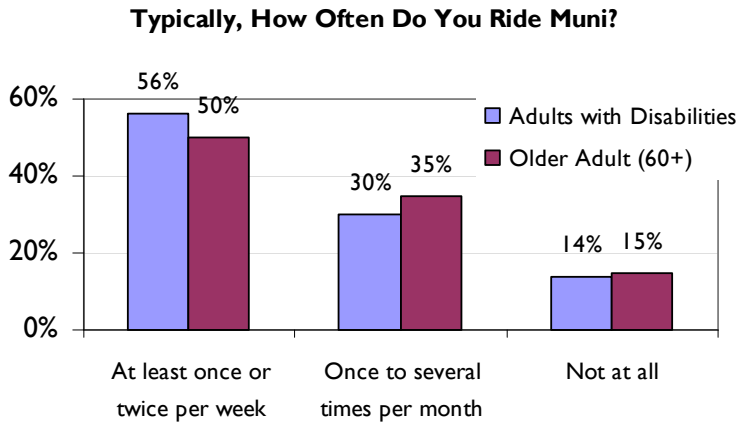
Data from the US Census Bureau & MUNI
H45. TENURE BY VEHICLES AVAILABLE BY AGE OF HOUSEHOLDER [35] - Universe: Occupied housing units
Data Set: Census 2000 Summary File 3 (SF 3) - Sample Data

Map produced by J. Murray, San Francisco Human Services Agency. August 2007.

accompanying map shows the number of seniors without access to a vehicle in each San Francisco Census tract, with public transportation lines overlaid.

The majority of San Francisco seniors and adults with disabilities use Muni on a regular basis. According to the 2009 San Francisco City Survey, more than half of seniors and adults with disabilities ride MUNI at least once or twice per week, and another 30 to 35 percent ride on at least a monthly basis. Nationally, 80 to 90 percent of older adults do not use public transportation at all, compared to only 15 percent in San Francisco.[20] It is likely that some portion of San Francisco's 15 percent drive. Fifty-four percent of senior households in San Francisco have access to a car.[21] As described in the first report of this assessment, San Francisco has approximately 90,000 disabled adults, and city has issued over 53,000 disabled placards (San Francisco Metropolitan Transportation Authority, 2011).

Another survey found that 81 percent of vulnerable adults[22] in San Francisco were able to get the public transportation they need, with very few reporting that they were "not often" (13%) or "sometimes not able" (6%) to do so. Vulnerable adults who indicated that they rarely go out of their home were asked about the barriers they face to going out more, and only four percent identified "lack of transportation" (Kim & Cannon, 2009).



Despite these many indicators of a strong local transportation system, consumers and service providers still often express the need for transportation improvements. According to a 2008 San Francisco phone survey, more than 60 percent of older adults identified "improving public transportation" as an issue that was very or extremely important. Improvements to public transportation was also the most popular response to the question, "What one change would make the biggest improvement in making the community more "senior friendly" (Kim & Cannon, 2009).

Seniors in a Bayview Hunters Point focus group expressed frustration that the stops for the new T-Third light rail line are further apart than the previous bus lines. Opened in 2007, the line connects the Bayview with both downtown and Visitacion Valley, and it has nine stops in

[20] National rates vary by age. Local results may over-estimate the number of people who do not use public transportation if some paratransit riders interpreted "MUNI" to mean traditional services and indicated that they do not use MUNI at all.

[21] American Community Survey, 2006 – 08.

[22] Vulnerable adults were defined as: (1) of advanced age (75 or older); or (2) age 60 to 74 years and met at least one of the following criteria: (a) needed help bathing; (b) used a cane, walker, or wheelchair; (c) rated their health as fair or poor; (d) were afraid to be alone for more than two hours; or (e) had a chronic health problem, such as diabetes, heart or lung problems, stroke, or kidney failure. They report does not provide an estimate of the total size of the vulnerable population in San Francisco.

Bayview's primary residential stretch, Evans to LeConte. The number of blocks between these stops varies from two to five. The longer stretches, such as between LeConte and Gilman streets, and between Carroll and Williams, can tax the stamina of elderly passengers. Bayview seniors were also dissatisfied with a lack of connections to other neighborhoods.

Muni has made a major commitment to making its traditional bus and trolley system accessible to seniors and adults with disabilities, but some focus group participants complained that kneeling buses do not always kneel. In particular, adults with disabilities mentioned that disabilities are not always visible, and drivers are sometimes reluctant to make the buses kneel for persons who appear able-bodied. Other participants complained that other riders do not always give up their seats to seniors and persons with disabilities, and that the drivers do not enforce the rules.

Paratransit is a vital resource for seniors and persons with disabilities who cannot ride Muni. A 2008 survey found that eight percent of those of any age with a disability indicated that they had needed a door-to-door transportation service in the past year and been unable to use it. The majority (63%) said it was because they "did not know the program existed" or "did not know how to access the program" (National Research Center, 2008). Other than lacking information about the program, only three percent of adults with disabilities (approximately 2,700 people) reported a service barrier to receiving door-to-door transportation.

Independent customer satisfaction surveys of paratransit users show strong overall trends of satisfaction, improving over time. A 2008 paratransit survey found than nearly nine in ten consumers (87%) were very or somewhat satisfied with the services provided by San Francisco Paratransit, and 93% rated the quality of service on the "surveyed" trip as excellent or good. Two major areas of concern persist, however:

1. The Responsiveness of Ramp Taxis: Of the city's 1,500 taxis, 100 are ramp taxis that can accommodate wheelchairs. However, a 2007 report showed that 50 percent of test calls resulted in refusals of service and dispatch companies, despite being required to do so, did not offer to call another dispatch company for service. Of those that did respond, only half met the city's response time goal of 20 minutes (City and County of San Francisco Taxi Commission, 2007). A recently-implemented debit card fare system for paratransit taxi service may help to improve ramp taxi pick-up rates. San Francisco Paratransit is now able to monitor the number of pick-ups by each taxi agency and follow-up when issues arise. Focus group participants also expressed frustration with paratransit taxi drivers who are not trained or willing to help seniors and disabled persons get in and out of the taxis.

2. Group van service: Adult day programs and senior center providers have long been dissatisfied with the quality of San Francisco Paratransit's group van services, especially during times of van provider transition. Issues have included lateness, no-shows, and inadequate capacity to handle riders with wheelchairs or who need assistance getting on and off the van. Problems still occasionally arise, especially when new drivers or substitute drivers have not had adequate training (Eastman, 2010).

All persons who are eligible for Americans with Disabilities Act accommodations qualify for paratransit. DAAS also supplements San Francisco Paratransit's budget to serve those who have impairments, but may not meet ADA thresholds. In coming years, the number of ADA-eligible people is projected to increase, putting additional strain on the paratransit system and requiring long-term, dedicated sources of funding.

CHANGES TO DAAS PROGRAMMING

Since the last DAAS needs assessment, the service system for San Francisco seniors and persons with disabilities has faced serious funding pressures. To address these challenges, DAAS pursued two strategies: 1) seek new funding by aggressively pursuing grants and looking for opportunities to appropriately expand its fiscal claiming; and 2) look for efficiencies by redesigning some programs. Major changes include:

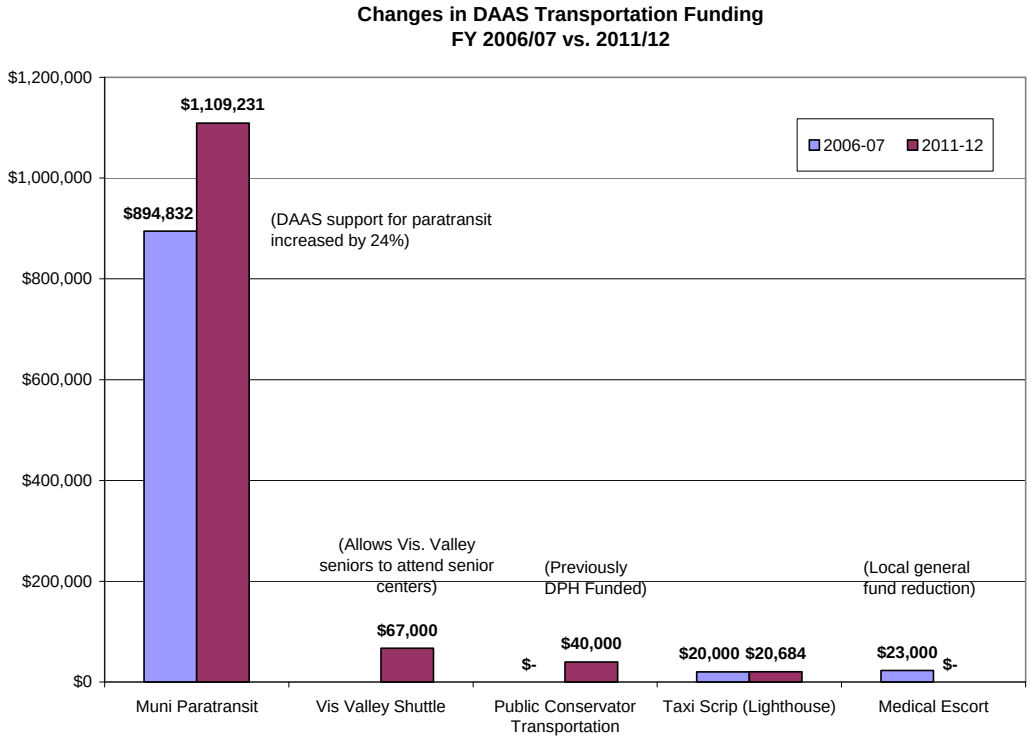
- **Integrated Intake:** In 2008, DAAS created the Integrated Intake Unit, unifying access to multiple programs through one phone number. Previously, the process of finding services was splintered and difficult to navigate. The agency's information and referral line did not have the staff for continuous coverage, and separate intake numbers existed for different programs. Now one phone number serves as the hotline for making reports to Adult Protective Services and as the intake line for In-Home Supportive Services. The line has also consolidated the senior meal clearinghouse, and is now the portal for referrals to the Community Living Fund. Potential consumers can call the same line and receive informed referrals to the full panoply of community services for seniors and persons with disabilities. After hours, the line is diverted to the Institute on Aging for 24-hour coverage. Drawing on staff from other programs like IHSS and Adult Protective Services, the information and assistance program has expanded from responding to 5,385 calls in 2006-07 to 22,400 projected for 2011-12.

- **Computer Access:** In 2010 DAAS received $7.9 million from the National Institute for Standards and Technology and from the National Telecommunication and Information Administration to stimulate usage and adoption of broadband services for seniors and adults with disabilities. The adoption rate among this group is 42%, compared to 80% for the general population. The nascent Broadband Technology Opportunity Program (BTOP) provides broadband and computer equipment and customized training and education programs that will: 1) teach basic computer and internet skills; 2) provide social media tools to help individuals overcome isolation and access resources for healthy aging; 3) slow or prevent cognitive impairment; and 4) teach skills to increase income. The initiative reaches consumers by engaging them in senior centers and adult day centers, and also through community promotion, such as a bus placard campaign in four languages and radio public service announcements.

- **Services Connection:** DAAS received two federal Resident Opportunities and Self Sufficiency grants, the first one in 2008, to help seniors and persons with disabilities living in public housing to connect with community services. Federal funding expired in 2010, but DAAS extended the program with local dollars for the current fiscal year, and is exploring ways to sustain this initiative.

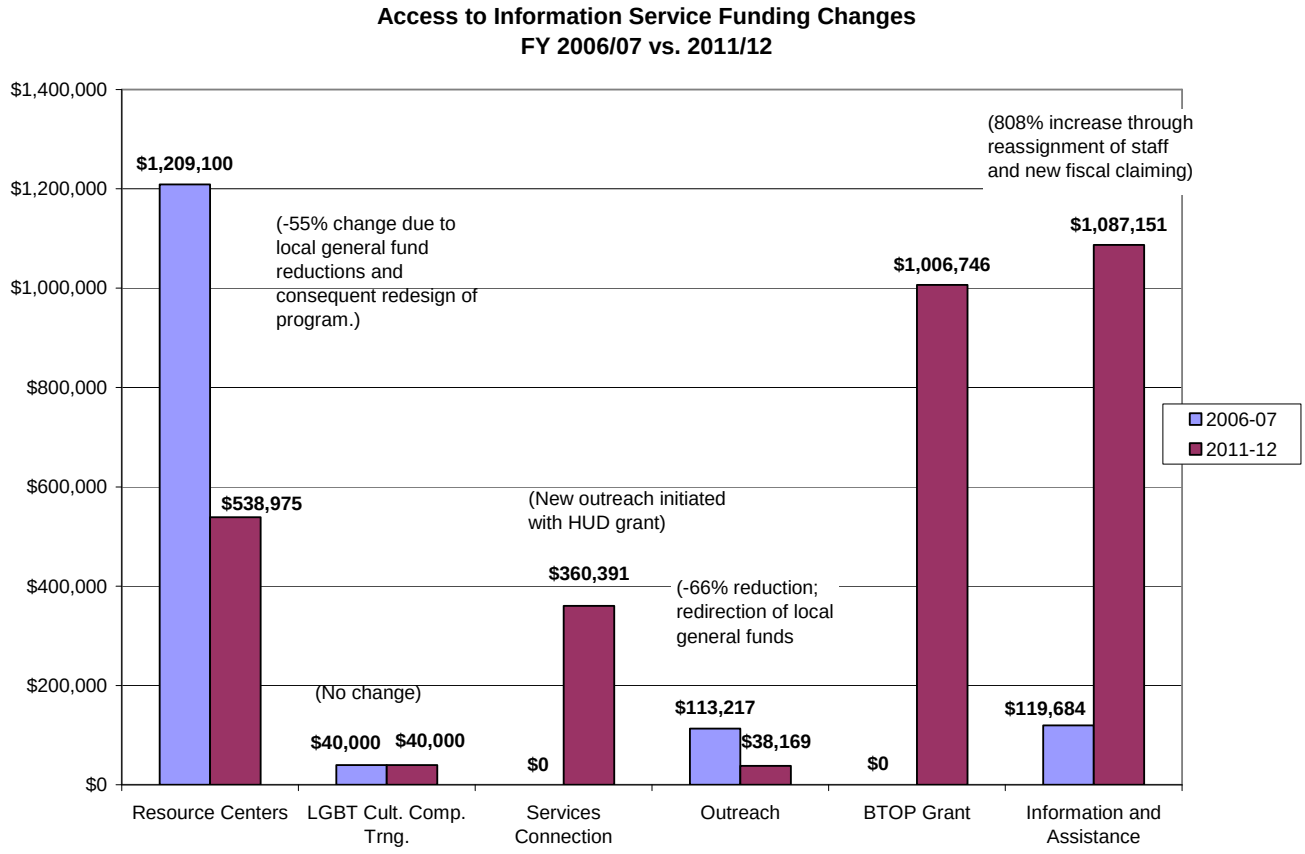
- **Aging and Disability Resource Centers (ADRCs):** Not to be confused with the Adult Day Health Centers, the ADRCs, which were located throughout the city, and educated consumers about services and made referrals, were redesigned. Rather than each center having its own site, the model changed to be more decentralized, with referral specialists out-stationed at existing community centers rather than in stand-alone resource centers. The budget for the ADRCs declined by 55%, but in the new model their units of services decreased by only 15%.

- **Transportation:** DAAS' overall budget for transportation services grew by 32%, with the largest increase being in its support of San Francisco Paratransit. However, increased costs of doing business have resulted in a net loss in the number of transportation trips provided with DAAS funding. As mentioned, much of this funding is to serve persons who have impairments that make it difficult for them to use Muni, but who do not meet the ADA threshold criteria to otherwise qualify for paratransit. To make senior centers more accessible to persons in Visitacion Valley, DAAS began funding a shuttle service. A transportation program for clients of the Public Conservator program was cut by the Department of Public Health and picked up by DAAS. A taxi voucher program through the Lighthouse for the Blind was increased slightly, and DAAS was not able to sustain a small program that provided escorts to persons requiring medically-related transportation.



The total budget for programs aimed at increasing access to services has grown by 81%, but that masks significant sacrifices that have been made in specific program areas. If the increase for creation of the Integrated Intake Unit and the BTOP grant were removed, the total budget for

access to services would have decreased by two percent. The ADRCs represent the largest decrease, down by 55%, but DAAS also had to reduce a small fund used for local media campaigns advertising services, and as mentioned, it eliminated the medical escort program. The accompanying chart illustrates budget changes in both the information and referral cluster of services and in transportation.



VIII. CONSUMER ADVOCACY

Advocacy programs ensure access to services and protect consumers' rights. They can work at the level of individual advocacy or by advocating more broadly for system change. Direct advocacy programs can educate consumers to fight for themselves, or they can deploy professional or volunteer staff to represent the consumer. System advocacy efforts are coordinated activities designed to influence specific planning processes, system changes, and/or legislation that will benefit seniors and adults with disabilities on key issues. DAAS funds consumer advocacy in the following service areas:

Consumer Advocacy Programs

	Types of Advocacy Provided	
Service Area	**Direct Service**	**Systems**
Health Insurance Counseling and Advocacy Program (HICAP)	✓	
Homecare Advocacy		✓
Housing Advocacy	✓	✓
Legal Services	✓	
Long Term Care Consumer Rights Advocacy	✓	✓
Naturalization	✓	
Senior Empowerment	✓	

HEALTH INSURANCE ADVOCACY

Persons with limited English proficiency have difficulty maneuvering within the Medicare system. San Francisco has roughly 120,000 Medicare beneficiaries.[23] Based on current levels of service provision, roughly two percent of all eligible persons are receiving Health Insurance Counseling & Advocacy Program (HICAP) services. HICAP utilizes volunteers to provide information and counseling about Medicare, helping consumers understand their rights and health care options. Given the pending wave of Baby Boomers enrolling in Medicare, the number of beneficiaries who will need assistance will rise. If the current penetration rate is maintained, the number of clients seeking services could increase by at least ten percent by 2015.[24] Growth in demand will make volunteer training and recruitment especially critical to preventing increases in service wait times. In focus groups, seniors who were already receiving Medicare expressed anxiety and confusion about the impact of federal health reform legislation.

HOME CARE ADVOCACY

Research conducted in 2003 found that more than a quarter of Californians age 40 and older needed "in-home care either for themselves or for a loved one" during the year preceding the study. The vast majority of adults receiving care at home get all their care from family or friends, but many of Californians in the same study (51%) felt that they would be unable to afford to pay for even two hours of in-home help per day if they needed it for six months or more (Grey et. al., 2003).[25] Single seniors may not have relatives available for help, relying instead on formal sources of in-home care (Johnson et al., 2006). As described in Part I of this assessment, San Francisco has an unusually high number of older persons who are living alone or otherwise isolated, and consequently relying on formal care-giving programs.

A 2009 San Francisco Controller's Office analysis of home and community-based long term care services amplifies the enormous role that the publicly-funded In-Home Supportive Services

[23] There were 119,814 persons eligible for Medicare because of age or disability status in 2007. Source: Centers for Medicare and Medicaid Services, Medicare Enrollment Reports: http://www.cms.gov/MedicareEnrpts/.
[24] This percentage increase is based on a comparison of interpolated California Department of Finance Population Projections for the population 65+ to 2008 American Community Survey population estimates for San Francisco.
[25] Survey respondents were informed of an hourly cost of $15 for home care services.

(IHSS) program plays in the arena of community-based long term care services. IHSS comprised 81% of city spending on "immediate" support for persons at risk of entering institutions, and IHSS formed 97% of spending on services to preserve consumers' self care and safety (Kent et al., 2010). With over 21,000 consumers, IHSS is by far the largest home care program in the city.

Making IHSS fully responsive to consumer needs requires significant coordination between numerous constituent groups: consumers, providers, unions, DAAS management and line staff, the San Francisco Public Authority, the IHSS Consortium, hospitals, and other community-based service providers. Home care advocacy services help diverse IHSS stakeholders to:

1. Identify priority home care advocacy issues;
2. Develop specific advocacy strategies and action plans related to those issues, taking into consideration the need to align activities with related work groups (e.g., transitional care work groups); and
3. Implement action plans.

HOUSING ADVOCACY

Part I of this assessment describes the extreme pressure that an expensive housing market places on seniors and persons with disabilities. Ninety percent of all San Franciscans live in private, market-rate homes and apartments. Between 2000 and 2008, over 4,920 new affordable housing units were added to San Francisco's housing stock, more than half set aside for seniors. Demand, however, far outpaces supply. For example, 30,000 persons are on the waiting list for the 6,000 apartments managed by the San Francisco Housing Authority. The shortage of affordable, accessible housing for younger adults with disabilities is particularly acute due to the funding stream requirements and federal and state fair housing laws. For example, HUD's "202" program typically provides three times as much funding for new affordable housing developments for seniors, compared to the "811" program that serves younger adults with disabilities. In a city with 34,500 younger adults with disabilities, this policy has a significant impact.

DAAS is focused on the provision of social services and lacks the financial capacity to directly affect San Francisco's supply of affordable housing. However, because housing needs so often dominate the lives of San Francisco seniors and persons with disabilities, DAAS does fund some housing-related services, including:

- *Housing Advocacy:* This is a "system-change" strategy that encompasses advocating for affordable and accessible housing for seniors and adults with disabilities. Advocates promote legislation that will increase the housing supply or improve living conditions.
- *Education and Outreach Activities:* Aimed at residents, these services include developing and distributing materials to inform diverse San Francisco populations about their rights as tenants. Providers also disseminate information about affordable housing options, vacancies and waiting lists.

- *Housing Counseling:* These services include preventing eviction, working with landlords to improve housing habitability, referring to legal assistance or mediation through the San Francisco Rent Board, and navigating wait-lists for subsidized housing.[26]
- *SRO Advocacy:* Over 18,000 of the city's most vulnerable citizens, including almost 8,000 seniors, live in the city's 530 Single Room Occupancy (SRO) hotels (Fribourg, 2009). DAAS funds housing advocacy and counseling services that include a special focus on SROs. The contractor works with established SRO Collaboratives, which are composed of advocates, city department representatives, landlords, and CBOs, to advocate for improved living conditions.

LEGAL SERVICES

Seniors have unique legal needs, including assistance with will preparation and advance directives. Yet according to a recent phone survey, 45% of vulnerable San Francisco older persons (either of advanced age or requiring personal care) have not signed a durable power of attorney for health care or living will, nor have 50% of non-vulnerable seniors, rates higher than other communities surveyed (Kim & Canon, 2009). Legal services also help seniors and younger adults with disabilities remain in the community and out of institutions. Because many consumers have fixed incomes, events like eviction, illegal rent increases, or consumer fraud can be catastrophic. Abuse, either financial or physical, can jeopardize their security.

Many San Francisco seniors and younger adults with disabilities lack the resources or do not know how to access legal assistance. In a 2008 telephone survey of a random sample of San Francisco older adults (60+) and adults with disabilities, 12% of persons with disabilities and 5% of older adults had used legal services in the previous year. However, another 10% of persons with disabilities and 5% of older persons needed, but were not able to use, legal services. Twenty three percent of seniors in this group did not know that legal services were available through DAAS, and 11% did not know how to access them. Twenty nine percent of adults with disabilities reported that they could not afford the services, and 24% did not know how to access them (National Research Center, 2008).

When applying for public benefits like SSI, MediCare, Medi-Cal, or Cash Assistance Linked to Medi-Cal, seniors and persons with disabilities often have unique challenges that require legal assistance. Applying for benefits sometimes entails a high probability of initial denial that can be resolved on appeal. Legal advice is particularly important to immigrants, who because of their immigrations status may be leery of seeking public benefits.

Whether on public benefits or not, low-income persons face enormous pressures related to housing and have a limited range of options. The neighborhoods that are most likely to house

[26] The Mayor's Office of Housing also contracts with about a dozen community based organizations to provide housing counseling services in San Francisco. DAAS contracts are intended to ensure that providers are available who have experience working with seniors and adults with disabilities to ensure their unique challenges and needs are understood. For example, knowing which buildings are physically appropriate for the clients and/or have designated senior/disabled units is fundamental. Advocates specialize in particular communities, and cultural competency, language capacity and neighborhood location are also factors that determine who serves which clients.

low income seniors and persons with disabilities are also those with the highest rates of evictions and rent disputes: almost 40% of all tenant petitions requesting assistance from the Rent Board came from just three neighborhoods: the Tenderloin, Mission, and Ingleside. The Tenderloin, with its large concentrations of seniors and persons with disabilities living in SRO hotels, had the highest proportion, with 20% of the total (Wolf, 2010).

Legal services protect seniors and persons with disabilities from mistreatment and abuse. According to a recent study, 11% of persons over the age of 60 reported some form of mistreatment during the previous year, though this is likely a lower bound. Risk factors for mistreatment included living in a low-income household, minority racial status, poor health, and required help with activities of daily living (Acierno et al., 2007). Without the support and counseling of legal services, particularly in immigrant communities, vulnerable people often do not report abuse. Talking to an expert in a trusted setting, seniors and persons with disabilities broach difficult situations and overcome their fear. After initial consultations, legal services often arrange for restraining orders for victims of physical abuse, estate arrangements for victims of financial abuse, and negotiated settlements with landlords.

LONG TERM CARE CONSUMER RIGHTS ADVOCACY

Consumer rights advocacy services are intended to educate individual and targeted groups of consumers and providers about the basic rights guaranteed in the various long term care services in San Francisco, and to provide individual assistance in navigating dispute resolution, hearings, and other grievances as needed, thus filling a niche left fairly vacant by those other services. Not all situations require a lawyer; often, they can be resolved with consumer education and empowerment.

NATURALIZATION

As described in Part I, San Francisco has a lot of older adults who are immigrants. In focus groups, many seniors asked for more classes to help them pass citizenship exams. The goal of naturalization services is to help legal permanent residents, also known as green card holders, become naturalized citizens of the United States. The benefits are naturalization are multiple, including:

- *Financial Security*: Unless naturalized, immigrants are not eligible for federal benefits such as Social Security, SSI, or food stamps. These benefits often allow older or disabled immigrants to remain in the community, aging in place rather than relying on institutional care or charity.
- *Family Reunification*: Seniors who are legal permanent residents may lack the informal family support that would allow them to continue living safely in the community. Naturalized citizens can petition to have their married children immigrate, while legal permanent residents can only petition unmarried children.
- *Freedom of Travel*: Since 9/11, legal permanent residents have faced heightened scrutiny when traveling to and from their home countries. Maintaining connection with family abroad is an important aspect of healthy aging for immigrants.

- *Stability*: Naturalized citizens cannot be deported. The security of naturalization may allow seniors and disabled persons to seek more preventive health care and services and avoid costly, disruptive emergency care and potential institutionalization.

SENIOR EMPOWERMENT

Aging conjures many negative beliefs, most often associated with a decline in capacity and control, but researchers have begun to focus on seniors who have aged successfully, taking or regaining control of their lives (McMellon & Schiffman, 2002; Haber, 2009). One key for successful aging has been increasing or preserving one's sense of fulfillment (Wray, 2003). Empowerment programs facilitate increased control and fulfillment in various areas of seniors' lives, including economics, socialization, and health (Paswan et al., 2005), housing and community, (Haber, 2009) and shifting from the mentality of being a client to one of being a consumer (Kane, 2009).

A recent telephone survey of older San Franciscans suggests the need for empowerment programs. Asked how the community deals with the needs of frail older adults, 88% of the respondents indicated that either "a lot more" or "somewhat more" needs to be done, and 28% described a lack of faith in local officials to take into account the interest and concerns of seniors. Nearly 36% of the respondents expressed a desire to be participating in more social activities (Kim & Cannon, 2009).

DAAS contracts for senior empowerment programs that provide activities that help participants to learn the various components of community organizing, leadership, conducting effective meetings, accessing essential services, conflict resolution, diversity training and political advocacy. A range of programs in different neighborhoods and communities train seniors to advocate for themselves, to increase their independence and quality of life, and to change the civic/political process through advocacy and volunteerism.

CHANGES TO DAAS PROGRAMMING

In the last five years, overall funding for DAAS consumer advocacy services has increased by 21%.[27] The increases, however, have not been uniform across programs, and units of service have not always been commensurate with funding changes as the cost of doing business has increased. While the budget for legal services increased by 15%, the number of consumers served fell by 12%, now just below 2,000 per year. Legal service hours declined by 6%. Funding for naturalization services grew by 11%, but the number of clients served went down by 17%, and now stands at 1,088 per year.

Smaller programs expanded. HICAP lost all local general fund in FY 2008/09, but this was temporarily offset by support from a grant through the Medicare Improvements for Patients and Providers Act. Compared to five years ago, HICAP's budget has increased by 9%. The number of consumers served jumped by 122%, to 1,470 per year. Empowerment services for seniors and younger adults with disabilities bumped up by 2%, but the annual number of consumers served

[27] For the purpose of this section, Housing Advocacy is included in the Consumer Advocacy budget rather than the Housing budget.

tumbled by 40% and is now 225. Housing advocacy increased by 6%, which included a shift of funds for SRO advocacy. Homecare and Long Term Care advocacy, though each just 4% of this category's budget, saw large increases. The Long Term Care Advocacy program did not exist five years ago.

Changes in Consumer Advocacy Funding

Service Area	Current Funding	Increases Since 06/07	% of Current Budget
HICAP	$370, 264	9%	17%
Homecare Advocacy	$90,347	201%	4%
Housing Advocacy	$137,037	39%	6%
Legal Services	$879,686	15%	37%
Long Term Care Consumer Rights Advocacy	$97,474	(Program did not exist in 2006/07)	4%
Naturalization	$609,282	11%	26%
Senior Empowerment	$182,754	2%	8%
Total	$2,366,847	21%	100%

VIII. CONCLUSION

DAAS-funded services are arrayed against a formidable range of factors. Seniors in San Francisco are more likely than in other communities to be over 80, to have limited English skills, to be low-income, to live in inaccessible or precarious housing, and above all, to be living in isolation. Broad economic forces, impossible to reverse, create these conditions.

Affordable housing is San Francisco's chronic unmet need, the root of so many of its challenges. For example, because so much of their income goes to housing, seniors and younger adults with disabilities often lack money for adequate nutrition. Few affordable housing options exist that are wheelchair accessible, trapping adults with disabilities in housing with stairs, whether large, empty Victorian homes or tiny rooms in crowded SROs. Families that might be able to provide informal support to their grandparents and older relatives are crowded out of the city, forcing older persons to rely on formal, public systems of support. Isolation permeates the lives of many seniors and adults with disabilities.

Though demand for services has increased while public funds have decreased, DAAS has managed to preserve or even expand most of its services. It enhanced funding for socialization programs like senior centers, and has invested in new strategies, like fostering more access to technology and social media. DAAS has increased efficiency, as in centralizing its information and referral services, and has improved effectiveness, as in reorganizing its case management services. Younger adults with disabilities face many of the same challenges as seniors, but without a comprehensive system that is legislated to meet their multiple needs, and they instead have to rely on a fragmented collection of ad hoc supports. DAAS has looked for opportunities to serve this group, like funding meals specifically for younger adults with disabilities. San Francisco was selected by the state as an Aging and Disability Resource Center, which has

connected the senior and disability communities in the city and created new opportunities for collaboration.

Because San Francisco is a city and county, and because it benefits from the tax revenue tied to its expensive housing market, DAAS has often been able to offset losses in state and federal funding. San Francisco was not, however, able to fully compensate for all of the state cuts, and some local programs and consumers suffered. The single most important service for seniors and younger adults with disabilities is IHSS. The state, however, is considering moving IHSS into managed health care, a service environment so different that changes cannot be fully anticipated. Uncertainty continues to threaten San Francisco's service system. For the foreseeable future, seniors and adults with disabilities will continue to depend, often unknowingly, on the advocacy of citizens, the creativity of public policy-makers, and the resilience and dedication of service providers.

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Focus Groups & Community Forums

- Adults with Disabilities Focus Group, Public Housing Site, July 13, 2011
- Chinese Focus Group, Chinatown Community Development Center, July 7, 2011
- Latino Focus Group, The Women's Building, July 11, 2011
- Community Forum, Jackie Chan Recreation Center, Richmond District, July 20, 2011
- African American Focus Group, Bayview, July 21, 2011
- Community Forum-Advisory Council, June 15, 2011
- Community Forum, Jackie Chan Recreation Center, Richmond District, July 12, 2011
- LGBT Focus Group, SF Department of Aging and Adult Services, July 14, 2011
- Community Forum on the Social Isolation of San Francisco Seniors, convened by Family Service Agency of San Francisco, March 7, 2012.

X. APPENDIX B – COMMUNITY FORUM AND FOCUS GROUP NOTES

Matrix of Focus Group and Community Forum Comments

	Advisory Council	Jackie Chan	Western Park	Chinese	Latino	African American	LGBT	Adults with Disablities	Solutions from Community
Housing	Affordable senior housing, home repairs	Senior housing; nursing homes close by so easier to visit parents	Waiting list too long	More affordable housing	Fear of eviction and discrimation when searching for housing		Affordable housing, safety concerns in housing		Clear rules in housing, espcially with younger people (AC), convert commercial to housing (CCDC)
Transpor-tation	Protected shelters, improved taxi service, no muni increases for seniors, tranportation to medical appts	Instructions and changes need to be more clearly explained i.e. clipper card.	Transport to congregate meals	People need to give up seats	Free Muni pass, issues with Clipper, disrespectful bus drivers	T line is not as useful as bus, need to let community know when there is a traffic change, like a new bike lane, cabs won't go up 'the hill', taxi drivers do not assist seniors.	Need van service for social events, problem with driving and bikes	Hard to get Paratransit, issue with people not offering seats on public transit	
Healthcare	Dental, vision, hearing, podiatry, mental	Vision, Dental	vision, dental, medical equipment, increasing cost of copays and prescriptions	Dental, health copayments too high	Dental, vision, medication	IHSS, need lower cost or free lifeline	Health settings not LGBT friendly	Problem getting medicine (MediCal bureaucracy), problem with requirment to switch insurance and doctors with MediCal, need for exercise, acupunture, meditation, need mental health services	Create a medical center with specialties all under one roof (Latino), Major hostipals should support community clinics, run labs there (Af.Am.)
IHSS/ Caregiving			IHSS, incl. culturally appropriate workers; IHSS too expensive if don't qualify	IHSS			Some LGBT seniors do not have caretakers lined up		
Nutrition	Congragate meals, grocery delivery, grocery stores	Congragate meals, culturally appropriate foods from food bank	Lighter food boxes; food box deliver to building		More pantries and meal sites	Need nearby grocery stores, better food at congragate meals, nutrition classes	Congragate meals	Need home delivered meals or groceries	Community gardents (AC)
Social	Outings, recreation, friendly visitors	Senior Centers like Jackie Chan; help securing more space at South Sunset Sr. Center	Need ADHC; cable TV with native language news	Need ADHC		Isolation and trust are problems, need ADHC, social activies and outings	Isolation is a problem	Need for free social activities	Leverage churches (Af. Am.)
Access/ Info	Helpline	I&R specialists						Need a resource guide or other way of getting info, need computer classes and access	Counselors or I & R specialists at senior centers, make support services at HUD buildings available to greater neighborhood, press # for senior specific resources (AC)
Finacial support	Need cost of living increase, suppport for middle income people that fall through the cracks		Income support	Increase SSI					

Matrix of Focus Group and Community Forum Comments

	Advisory Council	Jackie Chan	Western Park	Chinese	Latino	African American	LGBT	Adults with Disablities	Solutions from Community
Translation	Translation for medical services	Translation to read mail and fill out forms						Translation of mail	
Safety		Traffic signals at 22 & Geary	emergency response buttons ($30/month)	Roberies and pick pockets	Robberies (esp. leaving the bank) and rape	More street lights, issue of trash and trash cans on the street		Safety issues in public housing in the TL	Neighborhood watch (AC), more foot patrols (CCDC)
Misc.	Positive images of seniors	Naturalization classes	Fraud prevention or education	Remove graffiti		Legal assitance to create will	Need grief counseling	Need for education program like City in the different neighborhoods	

Adults With Disabilities Focus Group Notes

Who: 5 women and 3 men who are residents from 666 Ellis and 350 Ellis
What: Needs Assessment Adults with Disabilities Focus Group, Public Housing Site
When: Wednesday, July 13th 2011
Where: 666 Ellis Street

Responses to the Vignette (about adults with disabilities at senior centers)

- Obama said something about SS yesterday (debt ceiling effect on social security) and we have to be prepared. We better all go back to the country
- I think they should have something for adults. You have to be over 60 for everything. I'm 56 and I still don't get anything.
- I am disabled but my mind is like a youngster. I want to do things and go places but money is an issue. I don't have many friends. I'm sorry I'm so emotional but I just had surgery. I live at the library because it's the only place to go. You have to be 60 to get anything. I don't even get a food bag. I try to go to senior days with my grandchildren and they don't let me in. Those days are good for people with disabilities because they are not so crowded. I could go on free day for everyone, but it's not good because of my mobility issues.
- OnLok has a drop-in place for people with disabilities. We need social activities on site, but the problem is getting folks to show up. Staying inside makes a person depressed.

Question 1: What are the **most pressing needs** of adults with disabilities in your community?

Nutrition

- Food. My biggest problem is getting food. I cannot stand in line at a pantry and I cannot make it out everyday to get pre-made meals. I need basic staples and then my IHSS worker could prepare food for me. There is nothing for people under 55 who are not terminally ill. It doesn't matter if it's groceries or meals, the issue is that I cannot afford food.

Transportation

- Muni and BART do not enforce the senior and disability rules. There are often kids sitting in the front seats. I recently told the bus driver and he just pushed the button that says the seats are reserved in 3 languages. But no one moved and he didn't do anything else. A senior finally moved for me.
- Bus drivers don't lower the bus for you to step up. This is especially hard when you have bags. I may not look disabled, but it is hard for me to step up.
- Sometimes the bus driver will not pick me up in my wheelchair because they say the wheelchair lift is broken.
- I got to the Potrero Health Center but it is up a hill. Muni gave me a ballot box to get people to sign saying that they wanted a line to go up the hill. And I got many people to sign. How many more do I have to get in order to get service there? I go there for chiropractic and acupuncture appointments, which help me, but all the good is ruined by having to climb that hill.
- It's almost impossible to get Paratransit.

Health

- Medication is a big need. I need an inhaler for asthma but they won't allow me to get as many as I need. Refill timelines are unreasonable. Need to get a TAR (Medi-Cal Treatment Authorization Request), but it is very difficult to do. TAR takes days and days and I end up having to call the ambulance. I missed a few appointments so they won't call in my prescription. (Two others echoed this issue.)
- I have problems getting my insulin and I have Medi-Cal. The bureaucracy is a problem.
- The Department of Public Health moved me from regular Medi-Cal to a regular HMO, Blue Cross, and the problem is that my doctors don't take this plan and I have to switch which I really don't like. Then I get a letter saying I can be on regular Medi-Cal but when I called they said it was a mistake. No one knows what is going on there.
- We need opportunities for exercise, like an exercise machine or like Wii exercise videogames in the TV room.
- Need acupuncture and meditation to encourage wellness.

Information/Translation

- I don't know who to call to get services for disabled people.
- People put things on signs in the building, but not everyone can or does read them.
- We have problems here because people who have trouble with English need help reading their mail. Before we had social workers. When the staff is not bilingual it's hard.
- We have a language line for translation, but it is very expensive (from the Tenant Services Coordinator).
- There is a large Korean population, but it is especially hard to find translators.
- When automated answering services have the messages that ask you to press a key for a certain language, they are often very confusing.
- We know that everything is going to computers. We should have access to computers here. The city should give us their old ones they were going to throw away when they get new ones. The library is packed and the waiting list is very long. (Some one mentioned resources at St. Anthony's and she responded, "How do I get information like that? I am blind to that.")
- In the 90's there used to be a one page sheet of social services. We need something like that again. We need to have the free print shop (freeprintshop.org) sheets printed out and in the lobby.

Drug and alcohol abuse

- We need a form of harm reduction, like classes or support groups (from the daughter of a participant).

Mental Health

- I need someone to talk to. I have depression and I lost my therapist. Having folks to talk to really helps.
- It takes forever to get into public housing and it is traumatizing, some of us have PTSD from it. It took me seven years, and for two years I was homeless. We need support to recover from this trauma.

- The attitude the services providers and people have with me is that I am just looking for a handout. I have depression so when this happens I just give up easily.
- We need more grief counseling because we are dealing with a lot of different types of loss including murder. When traumatic things happen in wealthy communities, they bring in those supports (from daughter of participant).

Safety

- Residents mix drugs and medicine and go crazy. They broke a gate. The security did not write a report. There is smoke in the building and people throw trash out of the windows. I went to church in the evening and when I came back the door was broken and there was someone sleeping inside the gate. It was very scary.
- I also have safety concerns because there are people trying to get in my apartment in the middle of the night, knocking on my door. People bring in their friends who are disruptive.
- People bring in prostitutes and then kick them into the hall.
- They need more classes here, like at City College. People need to know that education is out there. There is an older adult education program, they have walking and swimming classes, and they also have tutors and mentors (from the daughter of a participant). They should bring these into the community.

Question 2: What **creative solutions** can the city consider to deal with these issues?

Translation: More coordination between providers with translation access (Diana's idea).

Information: Building meet ups can provide a time to talk about sharing resources.

Bring resources into the building, like therapy.

Organize trips and activities. The challenge is that they need to be free and it's hard to get folks to participate. They could be on free days at places like the zoo or Exploratorium.

Informal support groups to talk about various social/service issues and share knowledge.

Question that arose: What is the transition plan to ease the process of the move from to HMOs with MediCal the doctor changes?

Focus Group with Chinese American Seniors

Who: Eight Chinese (Cantonese-speaking) seniors, two men and six women living in various Chinatown CDC buildings. Translator: Enoch Fung, tenant services coordinator.
What: Needs Assessment Chinese Focus Group, Chinatown Community Development Center
When: Thursday July 7, 3-5:30
Where: 777 Broadway (30-unit senior apartment building; community space)

Responses to the Vignette (about dentures):

- Teeth are very important for seniors; if the government has no money for this and gets rid of the benefit seniors will be helpless. We hope the welfare fund is sufficient to take care of seniors.
- I get SSI; for seniors teeth are very important but for those of us on SSI there's not enough money to pay for things like dentures. The war is the main reason that the government doesn't have enough money; SSI was cut three times last year. Before I came to the US I thought of it as a strong and rich country. Now China is rising and the US is facing so many budget cuts.
- One senior in my building has only one tooth. It's hard for her to eat and she has no money for dentures that cost $2000. She's becoming weak because of lack of nutrition.
- SSI is cut; I live with my wife and get only $703 a month now. It's hard to fund dental care with that much. There are so many expenses and $700 is not enough. The war in Afghanistan is wasting lots of money.
- (I'm glad we're having this meeting so we can let the government know how we feel and help develop solutions!)
- As you get older your eyes, teeth, and mobility deteriorates. And then your welfare gets cut. It's hard to have a happy life.
- The US wants to be the savior and police for the whole world but doesn't take care of its poor.
- Medical expenses are high and getting more expensive.

Question 1: What are the **most pressing needs** of seniors in your community? (One by one around the table, each person listing their top one or two.)

- *Affordable housing*: need to build more for seniors. If a person can live happily under a roof, they can build a better community. I came from Hong Kong. Housing in SF is so expensive! Once I got a CCDC house I was so comfortable, and now I can volunteer and help build community.

- *Affordable housing for families.* There are lots of places in Chinatown with many families living in one small house.
- *Graffiti* on cars and houses and in buses. Americans are so civilized and educated, why is there so much graffiti?
- *Homeless* people living on the streets, along Broadway and all over the city. They are destroying the hygiene of the city.

- *Welfare* for seniors / money. The welfare money for seniors should be increased. Look at Hong Kong and Macau. In Macau they distribute money from casinos to people. Hong Kong also distributes money to residents. Don't waste money on the war, spend it on people. Three times benefits were cut last year. The state is not doing a good job.

(Follow up question: any other impacts of the recession and budget cuts?)

- *Safety:* there are more robberies, pick pocketing and attempted robberies on the street and robberies in the neighborhood. Seen pick pocketing going on aboard the 8x bus.

- *Welfare* for seniors. The state is cutting too much. State representatives are getting paid very well. $400/day or more; that's half our monthly income. When state representatives are cutting the budget they just cut senior money without consultation! They can't agree how to cut the budget but they can agree to cut money for seniors.

- *Housing prices and rent* are very expensive. I get SSI but pay $300-$400 on rent – 50% of my income. When new housing opens up 5-8,000 people apply. There's enormous demand.

- *Safety.* Robbers are sometimes waiting outside the door of your apartment.

- *Muni and transit:* youth don't give up their seats. The youth don't respect seniors.
- Hope they won't cut senior welfare. I've heard they're cutting IHSS hours and might cancel Adult Day programs.
- *Medicare*: copayments are increasing which is a problem.
- *Dental care*: hope this will be provided.

(Follow up on ADHC and IHSS)

- ADHC: seniors can go to centers during the day which lets sons and daughters go to work, means that sons and daughters don't have to stay home and take care of seniors.
- IHSS is more important (in my opinion) because it's more basic – it provides help with daily needs and daily life. ADHC is good, but not as important as IHSS.
- IHSS: abuse of the system. Some seniors don't need the service but are still getting it. They could walk around and do shopping but they're getting help with that. There's also abuse when family members get paid but don't actually do the work they're being paid for. Some places (like NY perhaps) can't give money to family members, you have to get services from an agency provider. (A few other people agreed with this observation.)

Question 2: What **creative solutions** can the city consider to deal with these issues?

Housing:

- There are lots of vacant commercial properties in the city; convert some of those to residential space. Increase the supply because demand is huge. If a tiny room in an SRO goes for $500 per month that means there's lots of excess demand for housing.

Safety:

- Organize volunteers to patrol their neighborhoods. This is common in China. Help volunteers to be effective in keeping pickpockets away. Local people understand local surroundings.
- Police foot patrols are important. They shouldn't always be in their cars.
- Guns are also a problem and should be regulated, especially for children.

Transportation:

- Keep frequent muni service. Seniors can't stand at the bus stop waiting for long periods of time.
- Cable cars are expensive but sometimes so empty. Some tickets don't let you on without paying $6; get rid of this restriction.

Medical:

- Learn from Hong Kong and Macau which have free medical care.
- Free medical care is good for people. Government should raise money from donations.
- Tax high income people to provide funding.
- The war is using lots of money that could be redirected towards this.

Focus Group with Latino Seniors

Who: Nine Latino (Spanish speaking) seniors, two men and seven women who are participants of and volunteers for The Women's Building Immigrant Assistance Food Pantry
What: Needs Assessment Latino Focus Group, The Women's Building
When: Monday July 11, 8:30-10:00
Where: 3543 18th Street (non-profit)

Responses to the Vignette (about dentures):

- She cannot afford even the low cost dentures because no one can live on the amount of money we receive from SSI. The most important thing is that they return what was taken from MediCal-eye care and dental.
- Dramatic, sad, painful, critical, fear
- Without glasses, I cannot see anything. Imagine that. What is happening is unjust. We need exams to be covered too.
- I had to go to my country to have my teeth fixed. I have MediCal, but still the costs are too high. It is less expensive, even when I include the cost of travel, to go to Mexico. (Four other participants echoed that they had also returned home at some point to have dental work done. Most of the participants also told me about the cost of each dental procedure they had or that they need to have done).

Question 1: What are the **most pressing needs** of seniors in your community? (One by one around the table, each person listing their top one or two.)

- *Eye care/Glasses* (Top issue for 7 participants)
    - Eye care benefits were cut in MediCal and we need to make sure that our benefits are restored. We need to fight for this. We have given our lives in this country, and it is time for the country to give to us. We have been honest and paid our taxes. We have given our youth and cannot work anymore. We are grateful for this country where we have given our best years, but now we cannot defend ourselves and to have our eye care and dental taken away is unjust.
    - SSI is not enough to live on. I sometimes have to choose between rent and my vision, or food and my vision. I choose vision over food because I have to be able to see to get around and take care of myself.
    - Vision is not just glasses, it about eye conditions such as glaucoma too. These are important health problems.
    - This is one of my biggest expenses. I need assistance to pay it.

- *Dental* (Top issue for 7 participants)
    - Dental benefits were cut in Medical and we need to make sure that our benefits are restored. We need to fight for this.
    - Dentures are too expensive. Without them it is hard to eat.

- *General Health*
    - We don't have the money to pay for medicine.

- I have MediCal but I never go to the doctor because it is too expensive. I have MediCal, but I was diagnosed with breast cancer and I could not afford the co-pays for treatment here so I went home to Mexico to be treated. I had the same issue with back problems. Everything in this country is so expensive.
- I cannot afford medicine for my pain and itching. I ask the pharmacist and they tell me I need a prescription, but I cannot afford to go to the doctor.
- I have trouble hearing and people think its bad manners to speak loudly, but I need them to. I have to ask people to shout sometimes.
- I worked for 24 years as a housekeeper in a hotel and I thought my health would be taken care of when I could no longer work. Cuts to MediCal have been terrible for me.
- I applied for MediCal, but they didn't give it to me. All I got was emergency MediCal.
- When we go to the doctor or the clinic they don't pay attention to us because we are poor. The doctor knows that we are on MediCal, so they say that we don't have anything wrong with us.
- I went to General Hospital with a broken ear drum and they wouldn't attend me. They said nothing was wrong. I also have leg and nerve problems and they said it was nothing, that it just hurts because you are getting old. But it's not nothing and there are things that can be done to help me.
- When I go to the doctor I paid $25 per visit but I told the people there I can no longer pay because I have to go every three months. Now they do not charge me for the visit, but I do still have to pay for the medicine.
- The only benefit or support I get is the food here at The Women's Building.
- When you turn 65 you get some funds taken out of your SSI to cover MediCal and the services are severely reduced.
- I am diabetic but I have to get my medicine from my home country because I cannot afford to buy it here. Also, the waits for an appointment are so long. I once had to wait months for an appointment in the Castro, so I had to go to the hospital. Now that's where I go every time. Plus when I go there it's free.
- To get medical care, they send you everywhere. You have to fight for it, prove yourself with many documents and appointments. For a young person this would be hard, but for seniors like us, it is very hard.

- *Safety*
  - Seniors are vulnerable because we cannot fight back. (Three participants had heard of recent mugging or robberies and two participants told stories about seniors being the victims of rape. One occurred during a burglary in the Haight Street home of an 80 year old woman while the daughter was away. The other was of a 76 year old woman and occurred on the street. Both women did not go to the police due to embarrassment.)
  - The police are not concerned about our safety in the street. They are more interested in pulling over the young Latino man in a car. Racial profiling is a big problem.
  - It is especially dangerous when we leave the bank.

- *Transportation*
    - I have to be able to get around to live, transportation is a necessity not a luxury. I use it daily. We need free bus passes for seniors. We don't work, we should not be asked to pay to get around.
    - Too expensive and transfers are too short.
    - The clipper card is not worth it. It has stolen my money, and a large quantity because you pre-load them. I went to report it and they told me that I had to go to where I put in the money to report and in the end I never got my money back. Clipper is not worth the pain. (Two participants echoed this issue).
    - Some bus drivers should be more respectful of seniors. Some are rude and start moving before seniors have time to sit down, which is very dangerous. My friend fell because she was sill standing when the bus took off and she fell and broke her back. She had to be rushed to the hospital.

- *Food* (Top issue for 2 participants)
    - We need more places like The Women's Building, pantries are good. We also need group meals.
    - Increase food stamps

- *Translation*
    - We need interpretation in court and at the doctors. Sometimes you have to pay for your own translator and it is very expensive and that makes it impossible.
    - I have a hard time at the pharmacy where I need to fill my prescriptions but the people don't speak Spanish. (3-4 participants also expressed that the pharmacy is the place where the need for translation is greatest).

- *Housing*
    - It is impossible to find a place because people don't want to rent to seniors because they are afraid that they will fall and be a legal liability.
    - Landlords want to get rid of seniors so that they can raise the rent. The do sneaky things to push the seniors out. I lived next to a Chinese family that did not speak English. The landlord gave them a 70 day eviction notice. I went and found a lawyer for them and they fixed the issue by requiring that they landlord compensate the family for the move.
    - Latinos are not chosen for affordable housing in the lotteries. It is because the higher ups are Asian and they give preference for Asian seniors.
    - I like to have plants but my landlord doesn't like it. He doesn't let me use the hose, so I have to fill pails in the bathroom and carry them to each plant. It's heavy and difficult, but I love my plants. They nurture me.

- *Information and discrimination*
    - The city and the government only halfway give information about services or rights. It's like they act like they are giving it, but only try halfway.

The participants also did a lot of sharing resources, for example, when someone mentioned the need to get a mammogram, another person chimed in with where to go.

Question 2: What **creative solutions** can the city consider to deal with these issues?

Housing:

- Don't discriminate again seniors. Don't leave us out because we are old.

Transportation:

- Make it free.

Medical:

- Dedicate more of the budget to services especially for seniors because we have special needs, such as eye and ear specialist. The clinics are far away, so there should be more in every neighborhood. It is helpful if all services are in one place.
- Senior patients need to be treated with more respect.
- Seniors should be allowed to have visitors in the hospital.

Community Forum, Jackie Chan Recreation Center
Western Parks Apartments Community

Who: Around 20 Seniors. Around 15 people from the building or community and 5 service providers, including one of the building service providers. Mandarin and Russian speakers present with occasional need for translation.
What: Community Forum, Jackie Chan Recreation Center, Richmond District. Facilitated by Corrin Buchanan with translation by Emily Zhao (intern from DAAS). Notes by Miranda Dietz, Corrin Buchanan and Emily Zhao.
When: Tuesday July 20, 1-3
Where: 1280 Laguna

Responses to the Vignette (about dentures):

- I identify with the need. I've been looking, and even sliding scale dentistry is so expensive. I'd like to know the name of the dentist in Oakland.
- I thought dental was covered? – Now only cleaning and pulling.
- I've had the same dentures for 30 years and I need new ones.

Question 1: What are the **most pressing needs** of seniors in your community?
Affordable senior housing

- It affects your health when you don't have affordable housing. You lose your sense of security, get depressed, can't afford food and health care.
- There are such long waiting lists, there's no guarantee you'll get affordable housing. And what good is anything else if you don't have a place to live? I need surgery but I keep putting it off because if it doesn't go well and I become disabled, what will happen to me? I'll lose my job, I won't be able to pay my rent, I'll be out on the street. And what good is IHSS if you don't have a house to live in?
- The waitlist for section 8 housing is so long. It's $938 for an apartment here, market rate.
- Food stamps take into account what you're paying for rent, but something like IHSS does not. Rent is so high and requires so much of my income that I should qualify for these programs because I can't pay.

SSI cuts and the cost of daily living

- The cost of living is going up but incomes are not keeping up.
- Cuts to SSI are very difficult. Some of us are immigrants who haven't worked in the US for long enough to have a real retirement fund. We don't have the money to live in retirement.
- We immigrated here because the US takes good care of seniors. But what's the point if it just keeps getting cut?
- Health insurance copays keep going up. $100 for a visit to the hospital is too much.
- Medical equipment is often not covered by Medi-Cal. Walkers with chairs, for example. They're expensive, but you need them for a good quality of life.
- Emergency response buttons: these cost $30 per month. But you don't want to be lying on the floor and unable to call anyone to help you.

- Comcast cable bill – it's $100 per month and going up all the time. People here watch the English news and/or the news in Russian or Chinese. They need this, but it's just another expense that keeps going up.
- The baby boomers will see internet as a must-have as well; another expense.

Health, dental & vision services

- Get on a greyhound bus and go to Mexico. You can get a tooth taken out for $10 there. I've heard of people doing this.
- Hearing aids, too.
- Cutting off vision and dental just turns your world upside-down. I can't live without my glasses!

IHSS

- IHSS hours are important for preventing the need for nursing homes. They make sense and save money in the long run. They prevent isolation and health issues.
- Important to have culturally appropriate IHSS workers; Chinese want Chinese food cooked, etc.
- If you make too much money to get free IHSS and have to pay a share of cost it's still a lot to pay and everything else costs so much that I don't think I could afford it.
- My children can't support me; they don't have the money and they're working.

Food

- The supplementary food box I get used to be delivered every month. We would share the food that we didn't need, everybody wins. Now they don't deliver to us anymore. I don't know why – they still deliver to Eastern Park Apartments. The box is so heavy! I can't lift it and carry it home, so now I don't get the food anymore. I can't get my IHSS worker to get it for me because the box only comes once a month and the schedule doesn't work out. I have a good IHSS worker who I really like, so I'm not going to switch just so she can pick up food for me.
- We have home delivered grocery program too, but who's going to bring it up to the apartments? The staff here can't; everyone here is elderly, frail, or disabled. They're too heavy.
- Food in the food boxes is not always needed. It's hard to coordinate because one person likes this, the other likes that.

Community and Organizing:

- We know that government services are never going to be enough. We think it's really important to foster community among people so that we can figure out how to cover the gaps and so that people feel connected. Need to know where to go to get help maximizing what they get from the system.

ADHC

- I'm concerned with the closure of these centers. They help those who are isolated by providing a community that speaks the same language, where people can get food and medical attention. I don't want the state to eliminate access to this opportunity. It will really hurt people's quality of life.

Fraud & scams

- I see things on TV, get things in the mail, like for a free scooter, or "even if you don't qualify for social security. How do I tell if these are real?

Transportation

- Even to go to congregate meals it's hard to get there.

Question 2: What **creative solutions** can the city consider to deal with these issues?

- Government should save money on the things that aren't absolutely necessary and invest in the future and the necessities, like education, libraries, health, seniors, and adults with disabilities.
- The manager is trying to negotiate with Comcast, but we don't know if it will help. Can the city put pressure on Comcast to give seniors a deal?
- The government talks too much and acts too little. I wish they would just cut their salary by 1%; that would help.
- Get someone (a volunteer or paid person) to deliver the food boxes again.

Notes from cards and brainstorm lists:

Dental (6)

I have had full dentures for over 30 years and I need to replace them.

Vision (3)

Health

Adult Day Health Centers are needed to prevent isolation. (2)
IHSS is needed to help people to stay in their home (4)
IHSS to prevent isolation, depression and health issues
Accessibility
The waiting time to see a doctor is too long.
Medicine benefits have been cut and you have to pick it up every month rather than every few months.
Need shoe pads in order to avoid the need for a wheelchair.
MediCal used to provide you with a roller walker but not it is not covered and I really need it.
I need a wheelchair, but Kaiser won't even allow me to rent one from them.
I'm worried about how Obama's health plan will effect me in the future. We hear a lot of information, but I don't always know what is true or what it means.
I need IHSS to help me shop, get to doctor's visits, and just to get around.
The new increase in hospital fees are going to be very challenging for our community.
Medical equipment
Emergency bottom. It's a small plastic necklace that you can press if you are having an emergency. It is very useful for people that don't speak English. It is very expensive, about $30 per month.

Transportation (2)

The increase in the Muni fare was very hard. One dollar doesn't sound like a lot, but when you are on a fixed income, it really adds up fast.

Financial
Inflation is a problem. (2)
The rising cost of living is not matched by increases in benefits. In fact, benefits are being cut as costs rise.
There is a big problem for middle income people because they are not eligible for benefits but they cannot afford them on their own.
Need financial benefits
My husband and I only get $1400 per month. We have to pay $400 rent for our room, $100 for phone, cable, and computer (Internet?) services. So only $900 is left to cover our daily living expenses, which is very tight. Therefore, please do not further cut our income. We also need more senior housing (monthly rent around $400).

Food
Don't have enough money to buy food. Nutrition affects our wellbeing.
The food delivery boxes are too heavy to pick up.

Housing (5)
Having housing affects a person's sense of security and their mental health. Without good housing, people are very nervous.

Legal
Legal help to prepare a will.

Recreation/Entertainment
I cannot walk for exercise, so I joined the Jewish Community Center because they have a pool where I can walk laps in the water. It was $100 to join and costs $58 per month. We need more affordable recreation and exercise opportunities for seniors.
Affordable television/cable. This is important for people who are homebound to stay connected to what is happening in the world and for their quality of life. For these people it is not a luxury, but a necessity to fight boredom. For people who don't speak English, we need cable to get stations in our language. Television also helps people learn English.
Community and social supports help people feel safer and supported

Education
I work with adults with disabilities and due to cuts at CCSF we don't have the same access to classes for our clients. Seniors want to go, but its take a lot of energy to get the locations. It would be great if classes were offered where we live.

Translation
Sometimes the staff use the computer or a telephone service to translate. But especially with the computer, the translations are not so good and the messages in Chinese don't make any sense.

Community Forum Notes, Jackie Chan Community Center

Who: Around 50 Seniors. We assume most are from the Jackie Chan meal site and the Day Care center on site. One Russian senior and her case manager. Some of the seniors may have been from other sites because we distributed the flier to contractors.
What: Community Forum, Jackie Chan Recreation Center, Richmond District. Facilitated by Miranda Dietz with Translation by Tiffany Wong and Emily Zhao (intern from DAAS). Notes by Corrin Buchanan and Diana Jensen.
When: Tuesday July 12, 9:30-11:30
Where: 5757 Geary

Responses to the Vignette (about dentures):

- I also have denture problems that make it hard to eat. I deal with related illness and depression and coming to this center makes everything better. Services have been cut and we should increase taxes on the rich and get donations to support programs like this one.
- I get $400 from SSI each month and I have to pay to see the doctor. Having my teeth removed will be covered, but dentures are not and they cost $2000-3000. I also need eye surgery. How can I pay for these things on my $400 income? I also need transportation. Even to get here. I have to ask my children to take the day off to drive me. (I remember according to the person this is what the situation was like before. It seems now the person can get transportation to the center. But another senior that talked to me later said she came to the center alone by bus.) I really appreciate the help with transportation that I get. We cannot endure more cuts, especially to IHSS. We need more money dedicated to seniors and people with disabilities.

Question 1: What are the **most pressing needs** of seniors in your community?

Senior Centers/Adult Day Services

- We need more senior centers and I & R specialist in Russian. These services were cut two years ago. I am a case manager and I have to deal with the clients who are most in need because I have a caseload of over 70 and those with less severe problems fall through the cracks. There is too much pressure on case managers who have to double as I & R Specialists. We need more services and I & R specialists in the Russian Community so that we can help seniors do things like fill out forms and with translation.
- We need more daycare services. Don't cut IHSS/SSI and don't raise medical costs.
- Senior centers/Adult Day Services are important because my children can go to work and not worry about me. It is important to have someplace to go during the day and I need this center because of my health issue-I have diabetes and mobility issues.
- Need more daycare social workers.
- We need more help with translation to fill out forms, read mail, and understand billing statements.
- We need more senior centers like this one.
- This community center is like a second family.

- For people with disabilities and mental health problems such as depression, these centers are very important.
- Senior centers should be the highest priority, especially as the baby boomers are becoming seniors. These centers are important if you have a disability and also help families to function better because our children know that we in a safe place with a social worker who is helping us with our needs.
- I go to the senior center in the Sunset and we need to move. We are now at South Sunset (2601-40 Ave., SF, CA 94116). We need a place nearby that can hold over 80-100 people, with two restrooms. If possible, we hope that our current place can be expanded, maybe a second floor could be built. We hope that we could get together and listen to health/nutrition lectures at the new place We also hope that the center can help us solve more problems, such as reading letters for us. We need more social workers and volunteers to help us, and we hope that transportation to and from the center can be provided.
- We need more in-home supportive services.
- I have diabetes, high blood pressure, and osteoporosis, therefore staying home alone is very dangerous for me. I need more day care services at home (IHSS).
- I have been in the US for 24 years, 16 years of which I was working very hard, and I paid taxes all those years. Due to my low income and health problems, I cannot afford to travel or go anywhere else to have fun. Therefore coming to the senior center and hanging out with people here is the only way and chance that I can have some fun. I hope the government will not shut down such centers but build more if possible.
- I have SSDI, but I am not eligible to apply for SSI, because I have bought $3,000 plus worth of life insurance. However it is very hard to survive with my limited SSDI income.

Nutrition

- The food service is important at this center because I cannot cook.
- The food box is not useful because I cannot eat everything that is in it. It is wasteful and the funds could be used for something else, such as senior centers.

Health/Vision/Dental

- It is hard to pay full price for dentures and glasses. Glasses cost $600-700 and although there is a Community Living Fund, it is very limited. In the Russian community we do have dentists who will do payment plans without interest, so that helps somewhat.
- I need to have my teeth removed but I don't have the money.
- I appear healthy, so social workers don't help me, but I actually have very serious help conditions. They didn't listen to what my doctors say and didn't follow doctors' instructions when taking care of me. I used to have a social worker helping me at my place while now I don't, but I really need one.
- We are opposed to increasing the cost of medical care.
- Help with dental care and vision care is among our most pressing needs.

Housing

- Housing is an important need. Some of us have parents who live in nursing homes around the Bay Area and it is hard to got and see them because of the distance. (Dispersed families)

- We need more senior apartments.

Naturalization

- We need to become U.S. citizens so that we can access benefits but we need to take the test. The government provides a bilingual training class (naturalization classes) but the number of classes and teachers are insufficient.

Transportation

- We need for transportation to be clearly explained to seniors. There have been many problems with the role out of the clipper card.
- We need a signal on the corner here on Geary and 22nd because there are many seniors coming to the center and traffic does not stop.
- Seniors with health problems need transportation.

Question 2: What **creative solutions** can the city consider to deal with these issues?
Main issues:
Senior Centers/Adult Day Services
Housing
Medical (and dental and vision)
Transportation

- Adult Day Services Coop (similar to a childcare coop). This would reduce the number of staff necessary and save money.
- Set funding aside for seniors in the same way it is done for children.
- Cut civil servant salaries by 5 or 10%.
- Improve accessibility in all areas, like the example of the clipper card transition which was unclear for seniors. Also many public benefits are moving to online applications and seniors who are not tech savvy may be missing out even though they qualify.
- Cut Section 8 and increase the funding for senior centers because Section 8 is not serving the most needy due to fraud.
- Senior apartment improvements. We have two people living in a small room and it is very inconvenient. We need a larger room and access to a kitchen. It is not fair because there are people with a room to themselves and they are paying the same rent.
- I am not an American citizen so I cannot get social services. I need to become a citizen but I need the training class (bilingual naturalization classes).
- Invest in community centers so that the city will save money because seniors are less likely to end up in the hospital.
- Prevent fraud in welfare. The government should check up on recipients better.
- We need more social workers (IHSS) in the home and they need to follow the doctor's instructions. Due to cuts I no longer receive in home assistance. (Is this an issue of training?)
- Invest in community centers to reduce IHSS hours and nursing homes and so that our children can work and pay taxes to pay for places like this.
- The U.S. should be less involved in war and should save that money for seniors.
- Do city-wide fundraising for most needy senior services.

- Reward first-line (social) workers and program workers.

Question 2: What **creative solutions** can the city consider to deal with these issues?

Translation: More coordination between providers with translation access (Diana's idea).

Information: Building meet ups can provide a time to talk about sharing resources.

Bring resources into the building, like therapy.

Organize trips and activities. The challenge is that they need to be free and it's hard to get folks to participate. They could be on free days at places like the zoo or Exploratorium.

Informal support groups to talk about various social/service issues and share knowledge.

Note: What is the transition plan to ease the process of the move from to HMOs with MediCal the doctor changes?

Community Forum-Advisory Council
6/15/2011

24 seniors in attendance

Facilitated by Diana Jensen, San Francisco Human Services Agency planner, with assistance from Miranda Dietz and Corrin Buchanan (SF-HSA interns)

Forum was held during the regularly scheduled Advisory Council meeting as a opportunity to both get the input of Advisory Council members and also to try out the "stickie wall" approach to forum facilitation. Participants were engaged in individual brainstorms and small group discussion and the stickie wall allowed for the distillation of the main areas of need. Advisory Council members were encouraged to bring a friend of neighbor to the meeting to get a broader group of participants and some did bring guests.

Vignette:
Reactions:

Gap in coverage, isolation and being embarrassed to go out, discomfort of dental pain and lack of dentures, bewildered, being unsure of where to go?, depression resulting from situation, being on a downhill road, going through it myself.

Personal stories:

- One man explained that he has been "trying to work out something at the clinic where I go to get free dentures".
- A woman shared: "If you don't have someone to look out for you, you're lost. I took care of my mother before she passed, but now I'm the senior. Who do we depend on when we can't walk?"

Questions:

What are the service, social, and physical needs of senior and adults with disabilities in San Francisco? (Answers in normal text)

What are actions that DAAS can take to address these needs? (Answers in italics)

- Meals, socialization
- Access to nutritious food, quality food ("Hostess cupcakes aren't quality food. We need food to nourish people's body, soul, and spirit")
- Free grocery delivery

Access to food delivery
Promotion of community gardens
Advocacy for improved access to stores with nutritious foods, some neighborhoods don't have options

- Outing programs/sight seeing activities
- Socialization, visits, activities, something to take the mind off of problems
- Support groups

- Affordable, accessible, safe, age-specific housing
- Shared housing-need ways to support it

Safe housing-cameras, education about rules and responsibilities especially with younger residents
Real affordable housing, no more SROs

- Easy to find helpline; know where to go to get connected, don't have to search
- Communication and education about resources available

One-on-one counselors at senior centers: discuss what problems you're having and get advice on where to go. "Like the school nurse, but a social worker."
Easier access to senior services from 311 and 211, e.g. "press 2 for senior services" on both lines.

- Money, no federal cost of living increase, state is sitting on some federal money
- Muni prices are going up; SSI went down. Not big but added up makes a difference. (One service provider explained that as advocates we need to make the cuts tangible by explaining what that means for recipients, i.e. have to skip meals.)

Stronger criteria to avoid fraud so money meets the real needs. (Service provider suggested that some funding is being used inefficiently or fraudulently by DAAS contractors but did not give details.)
Systemic solutions, more revenue especially from corporations so that they pay their fair share.

- Health, dental, vision, mental, hearing, podiatry services – these services have been cut and are really important (e.g. podiatry for diabetics)

- Translation for medical services

Health centers that reach all neighborhoods. Some neighborhoods are resource poor.

- Bus stop protected shelters and seats at the bus stops so seniors can wait for the bus sitting down and out of the rain
- Diverse transportation, taxi service

Advocacy for transportation and income
Advocacy for policy change; current groups might get treated nicely but get ignored when decisions are really made (e.g., transportation advocates)

- Revision of senior centers (if adult day lose money, need transportation, some should go away, focus on keeping people from being institutionalized)

- Afraid to reach out because don't want to be institutionalized

- Advocacy for individuals through neighborhood watch (e.g., calls, rides, meals, safety, support groups)

HUD funded housing make space and/or support services available to the surrounding areas.
Take advantage of the staff members (case workers) at housing sites by extending scope of their work.

Models of volunteer activities for churches/high schools to use to help to do volunteer work
Orient churches to those in need around them, especially when they can learn from one another

- Positive images of seniors

Individual Brainstorms (broad categories added afterwards – *in italics* –)
- *information & outreach* -
Information and referral contact or helpline (4)
Having a case manager to help people in need connect with those people or agencies that can provide help. (Maybe seniors having a 30 minutes or hour one-on-one with a counselor.)
Education and outreach about what is available
More outreach to people about a range of services

- *social activities, visits* -
Socializing (3)
Daily contact with someone for elderly to make sure they are alive
Friendly visiting options/phone, email, in person
Senior companion
Support Group
Individualized shopping events/outings
Free or low-cost fun things to do
Revision of the Senior Centers to cater to elderly with limitations in ADL
Activity options
Stimulating activities

- *food & nutrition* -
Food (5)
Congregate meal options if can go out
Nutrition sites
More home delivered groceries
Access to super market with fresh fruit and vegetables

- *transportation* -
Transportation (8)
Transportation for shopping and medical appointments (2)

- *health services* -
More healthcare including mental health and adult day health (5)
Mental health (3)
Exercise locations
Homecare
Provision of basic personal care to persons with medical issues

- *income* -
Income increase

Employment opportunities

- *housing* -
Affordable, accessible housing (7)
Age appropriate housing for those with physical limitations
Rent control
Home repairs
Housing across generations
Home help, shopping, cleaning, safety checks
Neighborhood watch

- *safety* -
Safety in HUD housing
Safety

- *family & caregiver services* -
Caregiver support
Family/friend support
Family consultations for remediation/reparation of broken relationships

- *other* -
Advocacy (4)
Senior elected officials
Financial advice (2)
Legal advice (2)
Language assistance or service in multiple languages (2)
Larger signs
Improved accessibility
Positive image of aging
Middle income seniors fall through the cracks