Evaluation of the San Francisco Support at Home Program: Year 3 Report

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Abstract

The purpose of this report is to outline the findings from the third year (July 1, 2019-June 30, 2020) of the San Francisco Support at Home (S@H) pilot program. This report provides some background information on the program, but more information and context can be found in the Year 1 and Year 2 reports. Overall, the evaluation has two purposes: (1) support continuous quality improvement of the S@H program through ongoing rapid data collection and analysis, and (2) assess the overall efficacy of the program in maintaining residence at home, reducing hospitalizations and emergency department visits, controlling costs, and supporting a high quality of life. This report provides: (1) a brief introduction to the S@H program; (2) demographic, care and financial need, home care services, and overall programmatic data for enrollees; (3) effects of S@H on quality of life and health oucomes; (4) results from enrollee focus groups; (5) results from the friend and family caregiver survey; (6) results from the independent care provider survey; (7) financial analysis of the S@H program; (8) results from interviews of Institute on Aging (IOA) and Department of Disability and Aging Services (DAS) staff members; and (9) considerations for the future.

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- The Arc San Francisco
- Bay Area Care Council
- Bayview Senior Services
- California Domestic Workers Coalition
- Caring Across Generations
- Changing One Mind At A Time (COMAAT)
- Community Alliance of Disability Advocates
- Community Living Campaign
- Community Living Policy Center at UCSF
- Creative Explored
- Family Caregiver Alliance
- Felton Institute, Senior Division
- Gray Panthers
- Hand in Hand: The Domestic Employers Network
- Homebridge
- IHSS Public Authority
- Independent Living Resource Center-SF
- Institute on Aging
- Jobs with Justice
- La Colectiva
- Mujeres Unidas y Activas
- National Domestic Workers Alliance
- S@H Advisory Committee
- San Francisco Long Term Care Coordinating Council
- San Francisco Board of Supervisors
- San Francisco Disability and Aging Services Commission
- Senior and Disability Action

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Chapter 1 – Introduction

The purpose of this project is to conduct a three-year formative and summative evaluation of the San Francisco Support at Home (S@H) pilot program. The Support at Home program provides financial support (a “voucher”) for the purchase of home care services by adults living in San Francisco. The eligible population is comprised of those who have a demonstrated need of assistance with two or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs), income up to 100% area median income in San Francisco, assets up to $40,000 (excluding one house and one car), a demonstrated need for financial assistance paying for home care, and who agree to pay a copayment towards the purchase of additional home care services and participate in program evaluations. Anticipated enrollment is 175 to 250 unduplicated individuals per year of the program. The original program plan was that half of enrollees would be aged 60 years and older, and half would be under 60 years old.

Enrollees are required to contribute copayments for home care services prior to availability of the voucher, with the copayment rate based on the enrollee’s financial need demonstrated by monthly income. Those with low financial need pay 40% of the voucher amount towards home care services, those with medium financial need pay 30% of the voucher amount towards home care services, and those with high financial need pay 20% of the voucher amount towards home care services. Voucher values are based on the level of functional need demonstrated by the enrollee, which is determined by an assessment of the individual’s limitations in 17 ADLs and IADLs ranging from independent through dependent/paramedical levels of need. Enrollees can elect 1) to purchase home care services directly from an independent provider paid bi-weekly through an approved payroll service in agreement with the Support at Home program or 2) to purchase services monthly in advance through an approved home care agency at an hourly cost determined by each agency in agreement with the Support at Home program. The total hours of service received per week are determined by each enrollee’s choices regarding provider and scheduling of home care services.

The Support at Home program is administered by the Institute on Aging (IOA) via a contract from the San Francisco Department of Disability and Aging Services (DAS). The University of California San Francisco is conducting an independent evaluation of the program via a contract from DAS.

This evaluation has two purposes:

(1) Support continuous quality improvement of the Support at Home program through ongoing rapid data collection and analysis, and

(2) Assess the overall efficacy of the program in maintaining residence at home, reducing hospitalizations and emergency department visits, controlling costs, and supporting a high quality of life.

The evaluation uses a mixed-methods approach, incorporating qualitative, survey, and quantitative data. In order to assess the unique impact of the Support at Home program, the evaluation intends to compare the data from S@H enrollees with a comparison group of individuals who applied for S@H services but do not receive them because they did not meet income or asset eligibility requirements, chose to not enroll for any reason, or disenrolled from the program. Members of the comparison group might be receiving assistance at home informally from family and friends or formally by paying for it themselves.

Limitations

Some discretion should be exercised when interpreting the enrollee comparisons and the between-group comparisons presented in this report for three reasons.

First, there is variation in the follow-up periods of enrollees and comparison group members. Both groups completed initial surveys about their quality of life, either at the time of enrollment into S@H (enrollees) or at the time of S@H rejection, decision not to enroll, or disenrollment (comparison group). Comparison group members received their second survey six to nine months after the initial survey. In contrast, enrollees could have received the second survey anywhere from three to 12 months after their initial survey. Furthermore, when enrollees and comparison group members actually completed their surveys in relation to when the surveys were sent varied; some people completed their surveys sooner after receiving them than others. Consequently, the timeframes of the various measures compared between the two groups are not perfectly consistent.

Second, because all survey questions were voluntary, not every person answered every question on each survey. Therefore, the number of cases (Ns) presented in each analysis can vary.

Third, the comparison group is composed of individuals who did not enroll in S@H. For those who met enrollment qualifications, their reasons for not enrolling might have influenced the changes they experienced over time. Thus, differences in changes between the comparison and enrollee groups may be due to differences in the characteristics of the individuals rather than due to enrollment vs. non-enrollment.

Chapter 2 – Support at Home Enrollees & Comparison Group Members

The data presented here are as of March 7th, 2020 (prior to implementation of shelter in place directives due to the COVID-19 pandemic). While Year 3 of the program technically ended June 30th 2020, for purposes of this report, we have operationalized these March data in the Tables as the "End of Year 3." This report only includes data for individuals who were enrolled in S@H as of March 7th, 2020. Readers should refer to the previous Year 1 report and Year 2 report to make side-by-side comparisons to previous years.

At the end of Year 3, 170 people were enrolled, 145 people had been discharged, and 50 had disenrolled from the program. People may leave the program for various reasons and successfully re-enroll if they meet the eligibility criteria upon re-enrollment and if a voucher is available.

The comparison group is comprised of previous S@H applicants who either did not qualify for the program, chose not to enroll, or originally enrolled in the program and later disenrolled. There were a total of 146 comparison group members.

Demographics

As seen in Table 1, 36% of the total eligible population is 18-59 years of age, yet only 8.8% of the enrollees are under 60 years old at the end of Year 3. Comparison group members are similar in age to S@H enrollees.

Table 1. Age distribution of Support at Home program enrollees and eligible population

AGE CATEGORY	S@H ENROLLEES, END OF YEAR 3	S@H COMPARISON GROUP	ELIGIBLE POPULATION*
18-59 years	8.8%	6.2%	36.1%
60-79 years	45.3%	48.6%	32.9%
80 years & older	45.9%	45.2%	31%
Total	100%	100%	100%
Number of people	170	146	27,940

*The eligible population was calculated using data from the American Community Survey (Appendix A).

While there are a number of reasons why people under 60 years old may be underrepresented among S@H enrollees and despite numerous efforts to reach this population, enrolling this age group into S@H remains a challenge. Some challenges include:

- More than half of eligible people in this age group have a cognitive disability (as reported in the American Community Survey) and may not perceive themselves as matching the services S@H offers. Thus, the targeted population of those under 60 years old may be as small as 5,000 (compared to 10,086).
- Many of those in the eligible population under 60 years old are employed, and two-thirds live with other people. Although these individuals may benefit from enrollment in S@H, they may perceive that they do not have additional care needs because they are managing their employment effectively and have other household members who support them.

Table 2 presents the racial/ethnic composition of the S@H enrollee population at the end of Year 3 of the program, the comparison group, and the eligible population; note that differences in percentages between the enrollee, comparison group, and eligible population for the 18-59 year age group appear large due to the small number of enrollees in this group. Among those 18-59 years old, Latinos are significantly underrepresented among enrollees (none enrolled by the end of Year 3 vs. 27.1% eligible). Asians are similar to the eligible population with three enrolled (20% enrolled vs. 20.9% eligible). Blacks/African-Americans are overrepresented (33.3% enrolled vs. 11% eligible), and those of other race/ethnicity (6.7%) are similar to the eligible population (6.1%). Among those 60 years and older, Blacks/African-Americans are significantly overrepresented (27.1% enrolled vs. 9.6% eligible). Latinos are slightly underrepresented (9.7% enrolled vs. 11.1% eligible), and Asians are significantly underrepresented (16.8% enrolled vs. 36.4% eligible). Other races/ethnicities are overrepresented (5.8% enrolled vs. 1.3% eligible).

Among comparison group members 18-59 years old, Blacks/African-Americans (0% in comparison group vs. 11% eligible) and Latinos (22.2% in comparison group vs. 27.1% eligible) and Asians (11.1% in comparison group and 20.9% eligible) are underrepresented. Those reporting other race/ethnicity (22.2% in comparison group) are overrepresented (6.1% eligible). Among comparison group members 60 years and older, Latinos (11%) are similar to the eligible population (11.1%) and Asians (19.9% in comparison group) are underrepresented (36.4% eligible). Other race/ethnicity (3.7% in comparison group vs. 1.3% eligible) and Blacks/African-Americans are overrepresented (23.5% in comparison group vs. 9.6% eligible).

Table 2. Race/Ethnicity of Support at Home program enrollees and eligible population, by age group

RACE/ ETHNICITY	S@H ENROLLEES, END OF YEAR 3		S@H ENROLLEES, COMPARISON GROUP		ELIGIBLE POPULATION	
	18-59 years	60 years & older	18-59 years	60 years & older	18-59 years	60 years & older
WHITE	6 40%	63 40.7%	4 44.4%	57 41.9%	3,516 34.9%	7,435 41.6%
LATINO	0 0%	15 9.7%	2 22.2%	15 11%	2,735 27.1%	1,980 11.1%
ASIAN	3 20%	26 16.8%	1 11.1%	27 19.9%	2,102 20.9%	6,492 36.4%
BLACK OR AFRICAN AMERICAN	5 33.3%	42 27.1%	0 0%	32 23.5%	1,111 11%	1,711 9.6%
OTHER RACE/ETHNICITY*	1 6.7%	9 5.8%	2 22.2%	5 3.7%	620 6.1%	238 1.3%
TOTAL	15 100%	155 100%	9 100%	136 100%	10,084 100%	17,856 100%

*Other race/ethnicity includes *American Indian or Alaska Native*, *Native Hawaiian or Pacific Islander*, *two or more races*, and *some other race*. Estimate of *some other race* population ages 60 & older is based on fewer than 30 sample observations.

About 8.2% of S@H enrollees identify as gay/lesbian/same-gender-loving (4.7%) or bisexual (3.5%), and about 11.6% of the comparison group identify as gay/lesbian/same-gender-loving (8.3%) or bisexual (3.3%). According to the most recently available American Community Survey (2005), approximately 15.4% of San Francisco's population is gay or lesbian;[*] S@H enrollees and the comparison group slightly underrepresent this population.

Individuals from single-person households are overrepresented among S@H enrollees at the end of Year 3 of the program, as seen in Table 3. There may be two reasons for this. First, individuals living in multi-person households may receive assistance from other household members and not perceive that they need additional assistance. Second, the analysis of American Community Survey data may understate the income of multi-person households and fewer people in these household are potentially eligible than estimated. Note that enrollees of

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[*] Gates, Gary. Same-sex Couples and the Gay, Lesbian, Bisexual Population: New Estimates from the American Community Survey. The Williams Institute, UCLA School of Law, October 2006.

Asian/Native Hawaiian/Pacific Islander and Hispanic/Latino backgrounds are more likely to live in multi-person households (see Year 1 report). The lower enrollment rates among those living in multi-person households may be associated with the under-enrollment of individuals in some racial/ethnic groups.

Table 3. Household size of enrolled and eligible population, by age group

HOUSE-HOLD SIZE	S@H ENROLLEES, END OF YEAR 3			ELIGIBLE POPULATION		
	18-59 years	60 years & older	All ages	18-59 years	60 years & older	All ages
1 person	73.3%	81.3%	80.6%	33.4%	41.2%	38.4%
2 people	20%	17.4%	17.7%	26.7%	33.2%	30.8%
3 or more people	6.7%	1.3%	1.8%	39.9%	25.6%	30.8%
Total	100%	100%	100%	100%	100%	100%

*This measure of household size is based on survey responses; it does not account for dependent family relationships and how those relationships would determine income eligibility. Number of sample cases in American Community Survey=1,335.

Care Needs and Financial Needs

As part of the enrollment process, the Support at Home team determines care needs through a multifaceted functional assessment. Eligibility and voucher amount is determined by a functional needs assessment. As seen in Table 4, the share of enrollees with low functional need was 47.7%, the share of enrollees with medium functional need was 35.3%, and the share of enrollees with high functional need was 17.1%.

Table 4. Enrollee functional need level distribution

LEVEL OF FUNCTIONAL NEED	S@H ENROLLEES, END OF YEAR 3
High	29 17.1%
Medium	60 35.3%
Low	81 47.7%
Total	170 100%

The initial assessment collects detailed information about functioning levels for specific activities. The activities for which enrollees are most often fully dependent on assistance are laundry (63.5%), housework (63.5%), shopping and errands (60.6%), transportation (58.2%), and meal preparation and cleanup (54.1%). The activities for which they are most often independent are eating (81%), telephone use (69.4%), toileting (63.5%), indoor mobility (57.7%), and transferring (54.1%).

The enrollment process also includes a complete review of applicants’ financial situations. At enrollment, enrollees are grouped into three categories: high financial need (0-35% of annual median income), medium financial need (36-70% of annual median income), and low financial need (71-100% of annual median income).

These categories are based on the San Francisco Mayor’s Office of Housing and Community Development income definitions, which are sourced from the U.S. Department of Housing and Urban Development; these data were published on March 28, 2016, April 14, 2017, April 1, 2018., April 1, 2020. The thresholds for each group have changed periodically due to updated data from the Mayor's Office and programmatic adjustments.

The enrollee's level of financial need determines the share of home care they will need to pay. As seen in Table 5, 38.2% enrollees were considered high financial need, 52.4% of enrollees were considered medium financial need, and 9.4% of enrollees were considered low financial need.

Table 5. Enrollee financial need level distribution

LEVEL OF FINANCIAL NEED	S@H ENROLLEES, END OF YEAR 3
High	65 38.2%
Medium	89 52.4%
Low	16 9.4%
Total	170 100%

As seen in Table 6, enrollees with medium financial need make up the majority in each functional need category (10.6% for high functional need, 17.1% for medium functional need, and 24.7% for low functional need) in Year 3.

Table 6. Enrollee level of financial need by functional need, Year 2

LEVEL OF FUNCTIONAL NEED	HIGH FINANCIAL NEED		MEDIUM FINANCIAL NEED		LOW FINANCIAL NEED		TOTAL	
	#	%	#	%	#	%	#	%
High	7	4.1%	18	10.6%	4	2.4%	29	17.1%
Medium	22	12.9%	29	17.1%	9	5.3%	60	35.3%
Low	36	21.2%	42	24.7%	3	1.8%	81	47.7%
Total	65	38.2%	89	52.4%	16	9.4%	170	100%

Table 7 summarizes enrollees' monthly household income. Enrollees reported monthly household incomes ranging from $991.47 to over $7,798 by the end of Year 3; note that this includes households of all sizes. Note that an individual could be eligible for Medi-Cal but not qualify for fully-paid in-home support services, and thus would be eligible for Support at Home.

Table 7. Monthly total household income of enrollees*

	S@H ENROLLEES, END OF YEAR 3
Mean	$2,596.30
Median	$2,222.50
Minimum	$991.47
Maximum	$7,798.78

*Data include all household sizes.

At the end of Year 3, enrollees who were not already receiving home care more often had high financial need than those receiving home care (73.3% vs. 34.8%) (Table 8). Those without existing home care at time of S@H enrollment had either medium or high financial need (none had low financial need). Enrollees who reported they had some home care services (which includes both formal/paid and informal/unpaid caregivers) were also asked during their assessment whether their care needs were being met by their current services. Most (69.7%) reported that their care needs were not being met prior to enrollment in S@H.

Table 8. Total Enrollee financial need level by home care status, Year 3

	RECEIVING HOME CARE AT TIME OF ASSESSMENT			
LEVEL OF FINANCIAL NEED	Yes		No	
	#	%	#	%
High	54	34.8%	11	73.3%
Medium	85	54.8%	4	26.7%
Low	16	10.3%	0	0%
Total	155	100%	15	100%

During the initial assessment, completed at the time of enrollment, Support at Home staff ask enrollees questions about their stress level given their current financial responsibilities, health and wellbeing, and note any additional comments enrollees may have about their home care or lack thereof. As seen in Table 9, which summarizes the additional comments, enrollees expressed concern about their financial status, stating that there is a heavy burden associated with paying for home care. In regards to their health and wellbeing, some enrollees commented that they were concerned about the potential for harm (e.g., hospitalized, anxious, depressed, living in an unclean home) because they did not have care or did not have enough care. Others had family members that were able to provide some care, but these family members were stressed about caregiver costs. In terms of their home care status overall, many enrollees shared that they had varying degrees of help via informal and formal means, but that informal caregivers often had other responsibilities (e.g., job, other family) and that purchasing additional, needed home care would be expensive.

Table 9. Initial Assessment Comments

QUESTION	CUMULATIVE RESPONSES	PREVALENT THEMES	YEAR 3 QUOTES
HOW WOULD YOU RATE YOUR STRESS LEVEL TODAY BASED ON YOUR CURRENT FINANCIAL RESPONSIBILITIES?	370	• Financial independence • Debt • Cost of home care • Forgoing home care	• "Budget is tight” • "Unable to afford extra expenses" • "There is no way I can afford homecare out of pocket" • "Limited income with a lot of expenses" • "I am currently living off my savings and it won’t last forever, so I’m stressed"

MOOD ASSESSMENT - HEALTH AND WELLBEING COMMENT	304	• Potential for harm • Household tasks/Family • Need for help/Stress • Affordability/Budget	• “I am frail, one fall will hurt me. I need homecare or there could be much harm” • “If I don’t have homecare my health is at risk” • "Not harmed because husband caring for her” • “Prospective client reports not feeling harmed; embracing help” • “Client is overwhelmed by homecare burden of cost” • “Prospective client’s daughter reports that while family is providing help, they are overwhelmed” • “Not able to keep the place clean and free of harm would harm client”
DO YOU HAVE ANY COMMENTS ABOUT YOUR HOME CARE OR LACK OF HOME CARE?	426	• Help from friends and family • Availability of help • Temporary vs. permanent help • Affordability	• “Prospective client’s family provides temporary support in the following areas: grooming, stair climbing, and housework” • " All informal care from family is permanent but limited based on work and school schedules” • “All care is on-going and provided by family” • "Informal Help spouse manages care and will continue to do so even if unpaid"

Programmatic Comments While Enrolled

Enrollees were asked to share programmatic-related comments during their monthly service plan reviews (Table 10). Many enrollees commented that they experienced a high satisfaction with the program and shared their desire for a consistent caregiver.

Table 10. Monthly Service Plan Review Comments

QUESTION	CUMULATIVE RESPONSES	PREVALENT THEMES	YEAR 3 QUOTES
MONTHLY REVIEW COMMENTS	2438	• Satisfaction with program • Scheduling • Continuity of care	• "Client is grateful for our program and reports satisfaction with homecare" • “Client is satisfied with caregiver; likes the possibility of switching to Agency with 3 hour minimum shift but prefers to stay with caregiver he already knows and like”

During quarterly service plan reviews, enrollees shared their thoughts about their general mood and the program overall (Table 11). A change from the comments in Year 1 and 2, the comments in Year 3 were overwhelmingly positive. Many enrollees felt that the program relieves stress and that the program was extremely helpful to meeting their needs. Many enrollees continued to express gratitude for what the program does for them, yet some noted they could still use additional hours of assistance.

Table 11. Quarterly Service Plan Review Comments

QUESTION	CUMULATIVE RESPONSES	PREVALENT THEMES	YEAR 3 QUOTES
MOOD COMMENT	730	• Stress • Satisfaction with program	• "Client reports that Support at Home funding and care has been a tremendous help more than anything she's grateful she is able to remain independent and feels like her mental wellbeing has improved” • "Client reports that program is very helpful to her family and her" • "Client reports stress to pay his copayment” • “Client’s son reports that she requires a lot of help and the home care is financially very hard”
QUARTERLY REVIEW COMMENTS	982	• Satisfaction with program • Need for more caregiver hours	• " This is a great program that has helped in so many ways " • “Client is grateful for the program and says it relieves financial stress” • “Client is still falling a lot and feels that the hours are not enough to cover his care. Client needs more hours of care than what he currently has”

Chapter 3 – Effect of the Support at Home Program on Quality of Life and Health Outcomes

Quality of life benefits to enrollees

The assessments, phone calls, and surveys conducted by Support at Home and UCSF include many questions to evaluate enrollees' quality of life. Enrollees completed surveys at enrollment (initial survey), at their annual reassessment, and periodically in between. The surveys conducted of comparison group members also include many of the same questions to allow for comparison before and after enrollment for enrollees and over time for the comparison group.

Financial stress

Enrollees and comparison group members were asked, "How would you rate your stress level today based on your current financial responsibilities to pay for your home care?" In this question, a rating of 1 indicates lower stress and 5 indicates the highest stress level. As seen in Table 12, enrollees' ratings after enrollment indicated lower levels of stress associated with the financial responsibility of paying for home care. The average score declined over time, and the change was statistically significant. In contrast, there was essentially no change among comparison group members.

Table 12. Rating of stress level based on financial responsibility for home care*

	Enrollees of S@H		**Comparison group**	
	Initial assessment	Most recent report	Initial survey	Most recent survey
Score (1-5 with 5=highest stress)				
1	16.9%	28.2%	19.1%	19.1%
2	5.4%	24.9%	12.7%	14.3%
3	19.8%	22.4%	27.0%	23.8%
4	18.2%	12.5%	19.8%	19.1%
5	39.8%	12.0%	21.4%	23.8%
Number of cases	314	241	126	63
Matched pairs				
Mean score	3.60	2.55	3.25	3.18
Difference	-1.05		-0.07	
Statistically significant?	Yes (p<0.001)		No (p=0.69)	

*The question asked in the assessment and during quarterly phone calls is: "How would you rate your stress level today based on your current financial responsibilities to pay for your home care?"

Enrollees were asked in their initial assessment and each reassessment, "How much of a financial strain would you say paying for home care is/would be for you?" A score of 5 indicated the highest level of strain. There was a statistically significant decrease in the average score between the initial assessment and most recent annual reassessment (Table 13). The comparison group was not asked a similar question.

Table 13. Rating of financial strain produced by paying for home care*

	Enrollees of S@H	
	Initial assessment	Most recent annual reassessment
Score (1-5 with 5=highest strain)		
1	5.7%	19.1%
2	3.2%	10.9%
3	16.9%	28.2%
4	17.5%	13.6%
5	56.7%	28.2%
Number of cases	314	110
Matched pairs		
Mean score	4.25	3.21
Difference	-1.04	
Statistically significant?	Yes (p<0.001)	

*The question asked in the assessment and reassessment is: "How much of a financial strain would you say paying for home care is/would be for you?" The comparison group is not asked a similar question.

Enrollees were asked during their initial assessment and quarterly phone calls, "How would you rate the harm to your health and well-being today based on your current financial responsibilities to pay for your caregiver expenses?" As seen in Table 14, the average rating of harm significantly decreased between the initial assessment and the most recent report. The comparison group was not asked a similar question.

Table 14. Rating of harm to health and well-being due to cost of home care

	Enrollees of S@H	
	Initial assessment	Most recent report
Score (1-5 with 5=highest harm)		
1	26.4%	35.3%
2	6.4%	27.4%
3	20.4%	25.3%
4	15.6%	6.2%
5	31.2%	5.8%
Number of cases	314	241
Matched pairs		
Mean score	3.22	2.20
Difference	-1.02	
Statistically significant?	Yes (p<0.001)	

*The question asked in the assessment and during quarterly phone calls is: "How would you rate the harm to your health and well-being today based on your current financial responsibilities to pay for your caregiver expenses?" The comparison group is not asked a similar question.

Quality of life

The surveys conducted by UCSF ask respondents to rate their overall quality of life on a scale of 1-5, with 5 indicating the highest quality of life. As seen in Table 15, there was an increase in the average quality of life score among enrollees between their first survey and most recent survey, although the change was not statistically significant. The average score decreased among comparison group members, but this change also was not statistically significant.

Table 15. Rating of quality of life as a whole

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent survey or annual reassessment	Initial survey	Most recent survey
Score (1-5 with 5=highest quality)				
1	5.0%	1.7%	5.4%	5.1%
2	14.4%	16.4%	19.4%	27.1%
3	39.1%	37.1%	41.1%	40.7%
4	33.7%	29.3%	24.8%	18.6%
5	7.9%	15.5%	9.3%	8.5%
Number of cases	202	116	129	59
Matched pairs				
Mean score	3.24	3.38	3.02	2.96
Difference	0.14		-0.06	
Statistically significant?	No (p=0.16)		No (p=0.68)	

Table 16 provides detailed information about specific quality of life items included in the UCSF survey. The items with the highest percentages of respondents saying they "agree" or "strongly agree" during the initial assessment included "I feel safe where I live," "I get pleasure from my home," "I take life as it comes and make the best of things," and "I feel lucky compared to most people."

Table 16. Enrollee responses in initial survey for specific quality of life components

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I enjoy my life overall	4 2.7%	25 16.9%	18 12.2%	83 56.1%	18 12.2%
I look forward to things	4 2.7%	16 10.9%	32 21.8%	76 51.7%	19 12.9%
I am healthy enough to get out and about	18 12.2%	44 29.9%	26 17.7%	48 32.7%	11 7.5%
My family, friends, or neighbors would help me if needed	11 7.5%	19 12.9%	11 7.5%	63 42.9%	43 29.3%
I have social or leisure activities/hobbies that I enjoy doing	14 9.5%	36 24.3%	22 14.9%	62 41.9%	14 9.5%
I try to stay involved with things	8 5.4%	31 21.1%	29 19.7%	65 44.2%	14 9.5%
I am healthy enough to have my independence	25 16.9%	36 24.3%	32 21.6%	45 30.4%	10 6.8%
I feel safe where I live	2 1.4%	7 4.7%	15 10.1%	81 54.7%	43 29.1%
I get pleasure from my home	2 1.4%	7 4.8%	23 15.9%	77 53.1%	36 24.8%
I take life as it comes and make the best of things	5 3.4%	7 4.8%	24 16.3%	85 57.8%	26 17.7%
I feel lucky compared to most people	4 2.7%	16 10.9%	18 12.2%	76 51.7%	33 22.5%
I have enough money to pay for household bills	12 8.1%	32 21.6%	33 22.3%	60 40.5%	11 7.4%

Number of respondents = 142-148, depending on the question.

The average of the quality of life items can be used as an overall measure of quality of life, as presented in Table 17. Among both enrollees and comparison group members, there were small, statistically insignificant increases in the average composite scores.

Table 17. Composite score of Quality of Life (mean of individual items)

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent survey or annual reassessment	Initial survey	Most recent survey
Mean (1-5 with 5=highest quality)	3.48	3.49	3.38	3.34
Number of cases	223	143	146	67
Matched pairs				
Mean score	3.46	3.50	3.33	3.37
Difference	0.04		0.04	
Statistically significant?	No (p=0.40)		No (p=0.69)	

Depression

Enrollees and comparison group members were asked two questions from a standardized depression screening scale. Responses indicate that depression is a concern for many S@H enrollees and comparison group members (Tables 18 and 19). Among both enrollees and comparison group members, there was very little change in the percentages of respondents reporting they frequently had “little interest or pleasure with doing things.” There was a decrease in the frequency of this among enrollees and a small increase among comparison group members, but both changes were statistically insignificant. Among enrollees, there was a decreases in the percentages reporting that they frequently were “feeling down, depressed, or hopeless,” but this change was not statistically significant. There was a small increase among comparison group members for this question, but this change also was not statistically significant.

Table 18. Frequency of “little interest or pleasure with doing things” (from PHQ-2 depression screening)

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent survey or annual reassessment	Initial survey	Most recent survey
Score				
0 = not at all	27.2%	31.4%	33.8%	25.4%
1 = several days	31.0%	34.3%	30.3%	44.4%
2 = more than half the days	20.2%	19.3%	14.8%	14.3%
3 = nearly every day	21.6%	15.0%	21.1%	15.9%
Number of cases	213	140	142	63
Matched pairs				
Mean score	1.31	1.18	1.15	1.23
Difference	-0.13		0.08	
Statistically significant?	No (p=0.20)		No (p=0.56)	

Table 19. Frequency of "feeling down, depressed, or hopeless" (from PHQ-2 depression screening)

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent survey or annual reassessment	Initial survey	Most recent survey
Score				
0 = not at all	29.6%	40.3%	30.56	29.03
1 = several days	31.5%	28.1%	31.94	38.71
2 = more than half the days	21.6%	18.0%	21.53	12.90
3 = nearly every day	17.4%	13.7%	15.97	19.35
Number of cases	213	139	144	62
Matched pairs				
Mean score	1.19	1.07	1.18	1.23
Difference	-0.12		0.05	
Statistically significant?	No (p=0.16)		No (p=0.70)	

Maintenance of financial status

The S@H program seeks to reduce financial barriers to receipt of home care for adults in San Francisco. For some individuals, additional support may enable them to increase their employment or leverage their earnings more effectively. During the initial assessment and each reassessment, enrollees are asked to detail their income and specify the sources of income. Table 20 summarizes the total monthly income of enrollees. Average income of enrollees was $2,535 at the initial assessment, and $2,669 at the most recent annual reassessment. A comparison of changes in income among those who have been reassessed reveals a statistically insignificant increase in average income of about $91.

Table 20. Income variation from initial assessment and most recent annual reassessment for enrollees

	Initial assessment	Annual reassessment
Average monthly income	$2,535.13	$2,669.21
25th percentile income	$1,669.00	$1,662.00
Median income	$2,191.25	$2,190.07
75th percentile income	$3,037.64	$3,310.00
Number of cases	314	110
Matched pairs		
Average income	$2,578.37	$2,669.21
Difference	$90.84	
Statistically significant?	No (p=0.11)	

Enrollees are also asked to report the assets they have in their checking account, savings account, other investments, and other assets. As seen in Table 21, average assets of enrollees were about $7,966 at the initial assessment and about $7,886 at the most recent annual reassessment. A comparison of those with reassessments found a statistically significant decrease in average assets of more than $1,800.

Table 21. Asset variation from initial assessment and most recent annual reassessment for enrollees

	Initial assessment	Annual reassessment
Average total assets	$7,966.39	$7,885.91
25th percentile assets	$671.18	$605.03
Median assets	$2,555.50	$2,707.88
75th percentile assets	$10,354.81	$12,136.02
Number of cases	314	110
Matched pairs		
Average assets	$9,688.34	$7,885.91
Difference	-$1,802.43	
Statistically significant?	Yes (p=0.02)	

Physical health of enrollees

The evaluation instruments include self-reported questions about health, as well as questions about emergency department visits, hospitalizations, falls, and attendance at medical appointments.

Self-rated health suffering

As seen in Table 22, a smaller percentage of enrollees and comparison group members indicated that their health suffered due to their inability to afford home care in the most recent survey as compared with the initial survey. The changes were statistically significant for both enrollees and comparison group members. Note that at the time of the initial survey, most enrollees were not receiving home care services.

Table 22. Percent reporting their health suffered due to inability to afford home care

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent report	Initial survey	Most recent survey
Percent “yes”	52.2%	27.3%	47.7%	24.6%
Number of cases	314	110	130	65
Matched pairs: significant?	Yes (p<0.001)		Yes (p=0.02)	

Use of emergency departments

At the initial assessment and during quarterly service plan reviews, enrollees are asked if they had any visits to the emergency department during the prior three months, and how many visits they had (if any). Comparison group members are also asked about emergency department visits as part of the surveys they are asked to complete. As seen in Table 23, there was a statistically significant decrease in the average number of emergency department visits between the initial assessment and the most recent report among enrollees. In addition, a significantly greater percentage of enrollees indicated that they had no emergency department visits in the most recent report compared with the initial report. In contrast, there was an increase in the average number of emergency department visits among comparison group members (not statistically significant), and essentially no change in the percentage of comparison group members reporting they had no emergency department visits over the prior three months.

Table 23. Number of emergency department visits in prior 3 months

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent report	Initial survey	Most recent survey
Number of visits				
0	70.2%	83.9%	61.5%	64.1%
1	18.0%	11.2%	19.7%	17.2%
2	5.6%	2.9%	4.9%	10.9%
3	4.3%	1.2%	8.2%	3.1%
4	0.3%	0.0%	2.5%	1.6%
5 or more	1.6%	0.8%	3.3%	3.1%
Number of cases	305	242	122	64
Matched pair test of mean number of ED visits				
Mean ED visits	0.48	0.24	0.60	0.78
Difference	-0.24		0.18	
Statistically significant?	Yes (p<0.001)		No (p=0.44)	
Matched pair test of zero ED visits				
Percent with zero ED visits	69.0%	83.9%	65.6%	64.1%
Difference	0.15		-0.02	
Statistically significant?	Yes (p<0.001)		No (p=0.85)	

Hospitalizations

At the initial assessment and during quarterly service plan reviews, enrollees are asked if they had any hospitalizations during the prior three months, and how many they had (if any). Comparison group members are also asked about hospitalizations as part of the surveys they are asked to complete. As seen in Table 24, there was a statistically significant decrease in the average number of hospitalizations reported by enrollees, and the percentage reporting no hospitalizations also significantly increased. In contrast, those in the comparison group had an increase in the average number of hospitalizations, although this change was not statistically significant. Comparison group members had an insignificant increase in the percentage with no hospitalizations between their first and most recent surveys.

Table 24. Number of hospitalizations in prior 3 months

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent report	Initial survey	Most recent survey
Number of hospitalizations				
0	60.2%	83.1%	50.8%	63.1%
1	26.4%	12.8%	22.5%	20.0%
2	9.6%	3.3%	8.3%	4.6%
3	2.2%	0.8%	11.7%	7.7%
4	1.0%	0.0%	1.7%	1.5%
5 or more	0.6%	0.0%	5.0%	3.1%
Number of cases	314	242	120	65
Matched pair test of mean number of hospitalizations				
Mean hospitalizations	0.50	0.22	0.69	0.86
Difference	-0.28		0.17	
Statistically significant?	Yes (p<0.001)		No (p=0.42)	
Matched pair test of zero hospitalizations				
Percent with no hospitalizations	64.0%	83.1%	58.5%	63.1%
Difference	0.19		0.05	
Statistically significant?	Yes (p<0.001)		No (p=0.52)	

Medical appointments

At the initial assessment and during quarterly service plan reviews, enrollees are asked to report the number of medical appointments they attended during the prior three months. Comparison group members are also asked about medical appointments as part of the surveys they are asked to complete. As seen in Table 25, enrollees of Support at Home reported a significant and large decrease in the average number of visits, from 7.8 to 4.8, between their initial assessment and most recent report. There also was a significant decrease in the percentage of enrollees with any attended appointments in the prior three months. However, there was no significant change in the average number of medical appointments attended by members of the comparison group between their initial and most recent surveys. Recent studies have linked high-quality home care with reduced demand for primary care visits and interpreted this as an indication that home care services can improve overall care coordination.[†] Thus, the decline in medical appointments attended by enrollees can be viewed as a sign of better overall care.

[†] Forder, J., Gousia, K. & Saloniki, EC. (2019). The impact of long-term care on primary care doctor consultations for people over 75 years. European Journal of Health Economics, 20: 375. https://doi.org/10.1007/s10198-018-0999-6.

Table 25. Number of medical appointments attended in prior 3 months

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent report	Initial survey	Most recent survey
Number of appointments attended				
0	8.9%	17.8%	6.7%	8.5%
1	13.1%	18.2%	17.5%	13.6%
2	11.5%	14.1%	10.8%	11.9%
3	11.2%	12.4%	20.0%	11.9%
4	7.6%	7.0%	10.0%	13.6%
5-9	21.3%	16.1%	20.0%	30.5%
10 or more	26.5%	14.4%	15.0%	10.2%
Number of cases	314	242	120	59
Matched pair test of mean appointments attended				
Mean appointments attended	7.75	4.80	7.47	5.65
Difference	-2.95		-1.82	
Statistically significant?	Yes (p<0.001)		No (p=0.21)	
Matched pair test of any attended appointments				
Percent with any attended appointments	90.0%	82.2%	84.7%	91.5%
Difference	-0.08		0.07	
Statistically significant?	Yes (p=0.005)		No (p=0.21)	

Enrollees and comparison group members also are asked to report the number of medical appointments they missed during the prior three months. Although a decrease in the number of appointments attended can be viewed as a sign of improving care for enrollees, missed appointments should not be considered as a positive indicator. There was a small but significant decrease among enrollees in the average number of appointments missed between their initial assessment and most recent report, while there was a small, statistically insignificant decrease in the percentage reporting they missed no appointments (Table 26). There were no significant changes in missed appointments for comparison group members.

Table 26. Number of medical appointments missed

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent report	Initial survey	Most recent survey
Number of appointments missed				
0	80.6%	81.8%	65.4%	67.7%
1	9.6%	12.8%	14.2%	8.1%
2	5.7%	2.1%	10.2%	14.5%
3	1.6%	1.2%	3.9%	3.2%
4	1.9%	0.8%	1.6%	3.2%
5 or more	0.6%	1.3%	4.7%	3.2%
Number of cases	314	242	127	62
Matched pair test of mean appointments missed				
Mean appointments missed	0.37	0.33	0.72	0.79
Difference	-0.04		0.07	
Statistically significant?	No (p=0.69)		No (p=0.68)	
Matched pair test of no missed appointments				
Percent with no missed appointments	83.8%	81.8%	59.7%	67.7%
Difference	-0.02		0.08	
Statistically significant?	No (p=0.52)		No (p=0.25)	

Falls

At the initial assessment and during quarterly service plan reviews, enrollees are asked if they had any falls during the prior three months and how many they had (if any). Comparison group members are also asked about falls as part of the surveys they are asked to complete. Among enrollees, there was a significant decrease in the average number of falls reported, and there was a statistically significant increase in the percentage of enrollees reporting no falls, from 51.7% to 65.7% (Table 27). In contrast, there was an increase (although not statistically significant) in the average number of falls among comparison group members, and essentially no change in the percentage of comparison group members reporting no falls.

Table 27. Number of falls in prior 3 months

	Enrollees of S@H		Comparison group	
	Initial assessment	Most recent report	Initial survey	Most recent survey
Number of falls				
0	49.0%	65.7%	45.7%	49.2%
1	19.4%	16.5%	20.9%	17.5%
2	11.2%	7.9%	11.6%	15.9%
3	6.7%	5.4%	10.9%	7.9%
4	3.2%	0.4%	4.7%	3.2%
5 or more	10.5%	4.1%	6.2%	6.4%
Number of cases	314	242	129	63
Matched pair test of mean falls				
Mean falls	1.55	0.82	1.18	1.27
Difference	-0.74		0.08	
Statistically significant?	Yes (p<0.001)		No (p=0.075)	
Matched pair test of no falls				
Percent with no falls	51.7%	65.7%	47.6%	49.2%
Difference	0.14		0.02	
Statistically significant?	Yes (p<0.001)		No (p=0.81)	

ADL/IADL status

During enrollees’ initial assessments, detailed information about difficulties with activities of daily living and instrumental activities of daily living is collected using the Level of Care Assessment Tool (LOCAT). The individual items in the LOCAT are converted into a score ranging from 0 to 72 points, with 72 points indicating the highest possible level of need for assistance. This information is used to determine how many hours of care will be supported by the program. The data are also collected when enrollees are reassessed to determine whether a change in service is needed. The comparison group surveys collect similar self-reported data. As seen in Table 28, enrollees’ average scores increased significantly between their initial assessment and most recent annual reassessment, indicating the increasing frailty of many enrollees. Members of the comparison group did not report a similar increase in their scores.

A comparison of LOCAT scores for enrollees who had annual reassessments revealed that 71.7% of enrollees had increases in their scores between initial assessment and most recent annual reassessment. Among those with higher scores upon reassessment, the average increase was 12.7%, and among those with lower scores, the average decrease was 42.2%.

Table 28. Average total score from LOCAT assessment tool

	Enrollees of S@H		Comparison group	
	Initial assessment	Annual reassessment	Initial survey	Most recent survey
Mean (0-72 with 72 is highest need)	31.9	38.2	22.9	29.4
Number of cases	314	110	164	65
Matched pairs				
Mean score	30.9	38.2	28.4	29.4
Difference	7.3		1.0	
Statistically significant?	Yes (p<0.001)		No (p=0.59)	

Chapter 4 – Experiences of Enrollees as Reported in Focus Groups

Methods

Two focus groups were held with clients of the Support at Home Program (S@H), one in-person at the Institute on Aging (IOA) on Tuesday, February 4th 2020 at 3pm, and one remotely (using Zoom) on Wednesday, February 5th 2020 at 1pm; they were held at different locations and times to accommodate clients' schedules and mobility capabilities. Seven clients attended the in-person group and two clients attended the remote group. In each group, there was a mix of recent enrollees (joined the program within the past year) and longer-term enrollees (joined the program over a year ago). A few family caregivers accompanied clients to the in-person session. Both groups were asked similar questions that focused on three areas: general questions regarding program administration, questions about caregivers and the care they provide, and questions about the program's impact on participants' lives. To compare findings to the prior focus groups held in January 2019, we aimed to maintain similar questions across all focus group sessions.

Results

Administration of the Support at Home Program

Focus group participants made several comments related to program administration, which consisted of both positive and constructive feedback. Participants' concerns focused on S@H program administration policies and staff communication.

Clients in both focus groups found it difficult to reach S@H staff and perceived that there were restrictions on how they could communicate with the S@H staff. Clients reported that they were told that no communication would occur via email, requiring that all communication happen by telephone.

At the previous focus groups, in January 2019, participants raised concerns regarding the burden of the assessment process. Since then, the S@H team has made adjustments to the admissions process, and thus we asked the clients who enrolled within the past year how the experience was for them. One of the newer clients reported, *"I just remember [the enrollment process] being really easy."* There was audible elation from the longer-tenure clients when newer enrollees raised no concerns about the sign-up process. One long-tenure client said, *"[The enrollment process] must have improved dramatically because ..., yes, [in the beginning] it was very complex. Yeah, I thought you had to have a CPA to figure it out,"* while another remarked that the changes that occurred *"are for the better."*

Three of the nine focus group participants were enrolled in independent provider (IP) mode and the rest were enrolled in agency mode. The clients enrolled in IP mode that interacted with HomeWork Solutions (HWS) had mixed experiences with the company. One client commented that *"HomeWork Solutions is part of what makes it so easy to be on [IP mode]. They always send me an email when hours are due, which is helpful because I never remember to fill it out on my own. They take care of all of the taxes…everything is streamlined."* However, another client commented on some components of HWS which s/he found problematic, stating, *"HomeWork Solutions is on the East Coast, so you have to submit your hours by noon East Coast time. That's 9am Pacific time, which is too early…the font that HomeWork Solutions is very small and difficult for seniors to read. Because HomeWork Solutions is geared more toward [household] payroll, they apply a lot of their same/normal rules to disabled and elderly adults, which can be a struggle."*

Caregivers and the Care They Provide

Compared to the first set of focus groups, the S@H clients in these focus group noted improvements in relationships with their caregivers. Clients stated that the beginning was challenging, but once everything was *"ironed out,"* the process of working with a caregiver was smooth and clients, in general, had a positive experience with their caregiver. Focus group participants noted that caregivers assisted them with multiple activities, including housework, grocery shopping, preparing meals, carrying large packages and mail up the stairs, scheduling medical appointments, and transportation to medical appointments.

Feedback about agency quality was mixed. Concerns raised about the agencies mainly focused on lack of communication. Such issues included the agency not notifying clients about changes related to their caregiver or the agency not discussing caregiver logistics with the client. One client commented, *"It's pretty confusing. Like, [the agency] will call my mother who can't hear that well, so I have to call them back. I'm sorry to say [the process is] very cumbersome. This person is coming once a week to help out in the house. It's always 'okay now she's coming at nine, now she's coming at one.' That's very irritating. And I'm sorry to say I think it's just taking advantage of the senior citizen. You know, I can be flexible on my schedule, but I don't like that. I work. We appreciate the help but being more organized would help."*

Despite these types of reported issues, other clients noted positive experiences with agencies. One client said, *"[The people at the agency] are always accommodating. I just had a [surgery]. And they went out of their way to, you know, to make sure that I was covered."*

Impact of the Support at Home on Participants' Lives

Despite any challenges that clients reported regarding administration of the program during its start-up, clients overwhelmingly said that S@H has significantly improved their quality of life and that they cannot imagine their lives without it. In fact, several clients stated they wanted to attend the focus group for the specific reason of ensuring the continuation of the S@H program. One client noted that she tires easily because of her chronic health condition and that receiving help through the program has allowed her to feel more energetic; she is very appreciative of the care she receives. Some clients said that the number of hours of support they receive from S@H is not enough to help them achieve their full potential. As a result, some clients reported that they rely on other programs and resources where possible (e.g., paratransit, Meals on Wheels, Project Open Hand, friends/neighbors), pay out of pocket for additional care, or, as one client said, *"do the best that I can without more help."*

"[The Support at Home Program has] improved my quality of life. My son is my caregiver and he does not have to go out and get a job so that he can stay at home and he can help me. There's a lot of times when I'm home and I can't do things for myself and other times where he'll take me out walking because, for example, I may see the red light, but it's not clicking into my brain."'

"I can't do the motions of sweeping and mopping. I have hardwood floors throughout my apartment, so they show every little speck of dirt. When I first moved in, I tried to do it. I swept for five minutes and would be in bed for six hours. [The program] has made my life a lot better."

"I am absolutely ecstatic about the S@H program. I had gotten to the point where, you know, I could not take care of myself anymore, and having that burden lifted… it's very depressing if you're at home and you love to have a nice environment…and you can't do anything to make it better… and also emotionally, somebody comes and you

know, they're all very nice…so it's a win-win all the way around. I used to abuse my pain medication to try to, you know, to do [my daily tasks] and I couldn't even do it with the pain meds."

"I think that Support at Home is extremely important. It's important for the mental stability of that person to not have to move out of their place and go to some other place. A familiar place for aging is necessary…when you have people in their homes and in familiar areas, you do not have the kind of mental anxiety that happens as you age."

Due to their overall happiness with the S@H program, some participants were eager to learn about other services provided by IOA or expressed interest in receiving information about additional resources that IOA might help them access. One client said, *"I've been trying to find out information [on resources] because I am younger. It's like there's a lot of things for seniors and everybody knows that if you're a senior you can receive services. But as a person who was disabled young, I didn't know that all this was out there for me too. Yeah. And so my friend said, well, you should try. You should at least ask and then I started to find out that I can get Support at Home. And it's great because it is for people under 65."*

Chapter 5 – Effect of Support at Home on Friend and Family Caregivers of Enrollees

Overview

Clients of the Support at Home Program (S@H) have the option of providing the names of their unpaid friends and/or family members who take care of them informally (i.e., not independent providers that are paid through S@H) via the S@H client quality of life surveys. The names and the contact information for these friend/family caregivers (email and/or phone numbers) were entered into a database. The friend/family caregivers were sent a survey via email or filled it out over the phone with a member from the evaluation team soon after the first quality of life survey was received for the S@H client that they care for. The purpose of this survey was to capture their feelings about and opinions of caregiving prior to their friend/family member’s enrollment in S@H. A second survey was sent to the friend/family caregivers at the end of the pilot phase of S@H to capture their feelings about and opinions of caregiving at the end of the pilot. Friend/family caregivers who did not fill out the survey toward the beginning of their loved one’s enrollment were contacted via phone near the end of the pilot and were asked to complete both surveys at the same time, specifying that they should provide distinct responses for how they felt before vs. at the end of their loved one’s enrollment.

A total of 96 friend/family caregivers filled out both the friend/family member pre- and post-enrollment surveys. Caregivers were allowed to skip questions that they did not want to answer. All surveys completed over email were in English. Most surveys completed over the phone were in English; two were completed in Spanish, and two were completed in Cantonese. Below, the results of the surveys are described.

Caregivers’ Demographics

Almost three-quarters (73.7%) of the respondents were female. Respondents represented a variety of racial and ethnic backgrounds, including Black or African American (32.6%), Asian/Native Hawaiian/Pacific Islander (14.1%), White (Non-Hispanic) (25%), Hispanic or Latino/a (12%), and multi-ethnic (5.4%). Almost half (49.5%) held a Bachelor’s Degree or greater as their highest level of education. Caregivers’ ages ranged from 15 to 92, with the mean age being 59 years.

Caregiving Impact on Finances & Paid Employment

Table 29 shows how informally caring for friend/family members impacts caregivers’ finances. In the friend/family member pre-enrollment survey, over half of respondents said they have dipped into personal savings to cover expenses (63.2%) and that they have cut back on personal spending to cover expenses (62.8%). Almost one-third of respondents said that they have reduced how much they save for retirement. About one quarter of respondents said they have dipped into retirement savings to cover expenses (24.2%) or took out a loan, borrowed money from a friend/family member, or assumed other debts to cover expenses (24.5%). Seventeen percent of respondents said that they have cut back on their own health care spending.

Table 29. Impact of Caregiving on Finances

	YES
DIPPED INTO YOUR PERSONAL SAVINGS TO COVER EXPENSES	60 (63.2%) n=95
DIPPED INTO YOUR RETIREMENT SAVINGS TO COVER EXPENSES	23 (24.2%) n=95
REDUCED HOW MUCH YOU SAVE FOR RETIREMENT	29 (31.2%) n=93

TOOK OUT A LOAN, BORROWED FROM A FRIEND OR FAMILY MEMBER, OR ASSUMED OTHER DEBTS TO COVER EXPENSES	23 (24.5%) n=94
CUT BACK ON PERSONAL SPENDING TO COVER EXPENSES	59 (62.8%) n=94
CUT BACK ON SPENDING FOR YOUR OWN HEALTH CARE	16 (17%) n=94

Table 30 shows the impact of caregiving on respondents' paid employment. In the friend/family member pre-enrollment survey, almost half of respondents said that they went in late, left early, or took time off during the day to provide care (46.7%), and over 40% said that they have worked different hours at their job (41.6%). About one quarter said that they had taken a leave of absence (26.9%) and had worked more hours at their job (24.4%). Nearly 22% of respondents said that they went from working full-time to part-time or cut back their hours.

Table 30. Impact of Caregiving on Paid Employment

	YES
WENT IN LATE, LEFT EARLY, OR TOOK TIME OFF DURING THE DAY TO PROVIDE CARE	43 (46.7%) n=92
TOOK A LEAVE OF ABSENCE	25 (26.9%) n=93
WENT FROM WORKING FULL-TIME TO PART-TIME, OR CUT BACK YOUR HOURS	20 (21.7%) n=92
TURNED DOWN A PROMOTION	4 (4.4%) n=92
LOST ANY OF YOUR JOB BENEFITS	7 (7.7%) n=91
GAVE UP WORKING ENTIRELY	7 (7.6%) n=92
RETIRED EARLY	8 (9.1%) n=88
RECEIVED A WARNING ABOUT YOUR PERFORMANCE OR ATTENDANCE AT WORK	12 (13.3%) n=90
WORKED MORE HOURS AT YOUR JOB	22 (24.4%) n=90
WORKED DIFFERENT HOURS AT YOUR JOB	37 (41.6%) n=89
TOOK AN ADDITIONAL JOB	7 (7.8%) n=90

Caregivers' Employment Hours, Wages, & Other Job Specifics

Respondents listed their professions and worked in a variety of fields, but the plurality of respondents (11) worked in education (e.g., teacher, tutor, paraprofessional). Several others worked in transit (e.g., taxi driver, bus operator, transportation officer) (6), administration (e.g., executive assistant) (6), home care (e.g., caregiver, instructor) (5), security (e.g., security guard) (5), and social/community work (e.g., social worker, community specialist, donations associate) (5). Additional represented industries included technology/IT, human resources, health care, communications/media, real estate, restaurant, grocery, and cleaning, among others.

Table 31 presents respondents' employment status. The same percentages of respondents were employed full-time both pre- and post-friend/family member enrollment in S@H (43.8%), and about 4% fewer respondents were employed part-time post-friend/family enrollment compared to pre-enrollment (pre: 13.5%, post: 9.4%). Nearly 15% more respondents indicated that they were disabled post-friend/family enrollment compared to pre-enrollment (pre: 6.3%, post: 20.8%). None of these differences were statistically significant.

Table 31. Respondent Employment Status Pre- and Post-Friend/Family Member Enrollment in S@H

	EMPLOYED FULL-TIME		**EMPLOYED PART-TIME**		**NOT EMPLOYED**		**RETIRED**		**DISABLED**	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
WHAT IS YOUR EMPLOYMENT SITUATION?	42 (43.8%)	42 (43.8%)	13 (13.5%)	9 (9.4%)	19 (19.8%)	22 (22.9%)	21 (21.9%)	20 (20.8%)	6 (6.3%)	20 (20.8%)
NUMBER OF CASES	96	96	96	96	96	96	96	96	96	96
STATISTICALLY SIGNIFICANT?	Same values		No (p=0.21)		No (p=0.32)		No (p=0.74)		No (p=0.57)	

Tables 32-34 present years worked, hours worked, and wage amounts. On average, respondents had been doing caregiving work for about 18 years pre-friend/family member enrollment and over 16 years post-friend/family enrollment. The average amount of hours worked by respondents was about 37 hours a week, and the average amount earned was about $945/week both pre and post-friend/family member enrollment. None of the observed differences were statistically significant. More than half of respondents reported having a salary rather than being paid hourly both pre- and post-friend/family member enrollment (pre: 55.4%, post: 52.9%).

Table 32. Years Worked Pre- and Post-Friend/Family Member Enrollment in S@H

	AVERAGE		**MEDIAN**	
	Pre	Post	Pre	Post
HOW MANY YEARS HAVE YOU BEEN DOING THIS TYPE OF WORK?	18.03	16.30	16	15.5
NUMBER OF CASES	63	54	63	54
MATCHED PAIRS	51			
MEAN SCORES	17.78	16.65		
DIFFERENCE	1.14			
STATISTICALLY SIGNIFICANT?	No (p=0.27)			

Table 33. Hours per Week Worked Pre- and Post-Friend/Family Member Enrollment in S@H

	AVERAGE		**MEDIAN**	
	Pre	Post	Pre	Post
ABOUT HOW MANY HOURS PER WEEK DO YOU WORK, ON AVERAGE?	36.60	36.69	40	40
NUMBER OF CASES	56	54	56	54
MATCHED PAIRS	50			
MEAN SCORES	35.7	36.3		
DIFFERENCE	-0.66			
STATISTICALLY SIGNIFICANT?	No (p=0.66)			

Table 34. Money Earned per Week Pre- and Post-Friend/Family Member Enrollment in S@H

	AVERAGE		**MEDIAN**	
	Pre	Post	Pre	Post
HOW MUCH MONEY DO YOU EARN PER WEEK, ON AVERAGE? (IN DOLLARS)	$943	$945.3	$900	$800
NUMBER OF CASES	25	20	25	20
MATCHED PAIRS	15			
MEAN SCORES	$1044.3	$1046.3		
DIFFERENCE	-2			

STATISTICALLY SIGNIFICANT?	No (p=0.99)

Tables 35-36 show that fewer respondents were self-employed post-friend/family enrollment compared to pre-enrollment (pre: 15.1%, post: 10.7%); this finding was not statistically significant. Among respondents who did not report that they were self-employed, about 5% more respondents reported that their supervisor did know about their caregiver responsibilities post-friend/family enrollment compared to pre-enrollment (pre: 70.6%, post: 76.9%); this finding was statistically significant.

Table 35. Respondent Self-Employment Status Pre- and Post-Friend/Family Member Enrollment in S@H

	YES	
	Pre	Post
ARE YOU CURRENTLY SELF-EMPLOYED OR DO YOU OWN YOUR OWN BUSINESS?	11 (15.1%)	8 (10.7%)
NUMBER OF CASES	73	75
STATISTICALLY SIGNIFICANT?	No (p=0.08)	

Table 36. Respondent Supervisor Knowledge of Caregiving Responsibilities Responsibilities Pre- and Post-Friend/Family Member Enrollment in S@H

	YES	
	Pre	Post
DOES YOUR SUPERVISOR KNOW THAT YOU ARE CARING FOR YOUR FAMILY MEMBER OR FRIEND?	36 (70.6%)	40 (76.9%)
NUMBER OF CASES	51	52
STATISTICALLY SIGNIFICANT?	Yes (p=0.03)	

There are numerous benefits that respondents received from their jobs, yet these benefits remained stable. About 6% more respondents reported receiving health insurance for additional family members (pre: 31.3%, post: 37.5%) and about 7% more respondents reported receiving health insurance for themselves (pre: 41.7%, post: 49%) post-friend/family member enrollment compared to pre-enrollment. About 7% more respondents reported receiving a pension (pre: 21.9%, post: 29.2%) and a retirement savings account (pre: 24%, post 32.3%) post-friend/family enrollment compared to pre-enrollment.

Caregivers' Health and Quality of Life

Table 37 shows the self-reported health statuses of survey respondents before and after their friend/family member enrolled in S@H. Both before and after friend/family enrollment, most respondents reported that their health was "good." Prior to S@H enrollment, 35.8% of caregivers reported "excellent" or "very good" health, and 45.8% reported "excellent" or "very good" health after enrollment. At the same time, there was a small increase in the percentage of family and friends who reported fair or poor health after enrollment (pre: 13.7%, post: 15.6%). The difference between mean scores for general heatlh pre and post friend/family enrollment was not statistically significant.

Table 37. Self-Reported Respondent Health Pre- and Post-Friend/Family Member Enrollment in S@H

	Pre	Post
Overall health in general		
1 = excellent	15 (15.8%)	13 (13.5%)
2 = very good	19 (20%)	31 (32.3%)
3 = good	48 (50.5%)	37 (38.5%)
4 = fair	11 (11.6%)	14 (14.6%)

5 = poor	2 (2.1%)	1 (1%)
Number of cases	95	96
Matched pairs	95	
Mean score	2.64	2.58
Difference	0.06	
Statistically significant?	No (p=0.52)	

Table 38 shows how informally caring for their friend/family member impacts caregivers' quality of life. Largely, respondents felt similarly both before and after friend/family member enrollment. However, there was an increase of almost 7 percentage points between the initial and final survey in the percentage of caregivers that said that their relationships with other family members, relatives, and friends were suffering as a result of the care they provide (pre: 34.7%, post: 41.1%); an increase of 7 percentage points of respondents who said that wished they could "run away" from their situation from time to time (pre: 44.1%, post: 51%); and an increase of almost 10 percentage points of respondents who said that the care that they provide takes a lot of their strength (pre: 63.8%, post: 72.6%). At the same time, there was a decrease of about 6 percentage points in respondents who said that they are worried about their future because of the care that they provide (pre: 29.8%, post: 23.2%).

Table 38. Agreement with Factors Related to Stress of Providing Informal Care Pre- and Post-Friend/Family Member Enrollment in S@H

	Strongly diagree (1)		**Disagree (2)**		**Agree (3)**		**Strongly agree (4)**		**Number responding**	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
My life satisfaction has suffered because of the care	18 (18.8)	23 (24.5%)	25 (26%)	24 (25.5%)	42 (43.8%)	33 (35.1%)	11 (11.5%)	14 (14.9%)	96	94
I often feel physically exhausted	12 (12.5%)	11 (11.6%)	17 (17.7%)	16 (16.8%)	45 (46.9%)	33 (34.7%)	22 (22.9%)	35 (36.8%)	96	95
From time to time I wish I could "run away" from the situation I am in	30 (32.3%)	32 (34%)	22 (23.7%)	14 (14.9%)	25 (26.9%)	32 (34%)	16 (17.2%)	16 (17%)	93	94
Sometimes I don't really feel like "myself" as before	14 (15.2%)	22 (23.4%)	39 (42.4%)	30 (31.9%)	26 (28.3%)	30 (31.9%)	13 (14.1%)	12 (12.8%)	92	94
Since I have been a caregiver my financial situation has decreased	15 (15.8%)	14 (15.1%)	24 (25.3%)	25 (26.9%)	39 (41.1%)	38 (40.9%)	17 (17.9%)	16 (17.2%)	95	93
My health is affected by	19 (20%)	25 (26.3%)	28 (29.5%)	26 (27.4%)	35 (36.8%)	29 (30.5%)	13 (16.7%)	15 (15.8%)	95	95

the care situation										
The care takes a lot of my own strength	11 (11.7%)	9 (9.5%)	23 (24.5%)	17 (17.9%)	41 (43.6%)	49 (51.6%)	19 (20.2%)	20 (21.1%)	94	95
I feel torn between the demands of my environment (such as family) and the demands of the care	19 (20%)	20 (21.3%)	32 (33.7%)	23 (24.5%)	36 (37.9%)	42 (44.7%)	8 (8.4%)	9 (9.6%)	95	94
I am worried about my future because of the care I give	26 (27.7%)	33 (34.7%)	40 (42.6%)	40 (42.1%)	20 (21.3%)	11 (11.6%)	8 (8.5%)	11 (11.6%)	94	95
My relationships with other family members, relatives, friends and acquaintances are suffering as a result of the care	27 (28.4%)	27 (28.4%)	35 (36.8%)	29 (30.5%)	18 (19%)	28 (29.5%)	15 (15.8%)	11 (11.6%)	95	95

The 10 individual items regarding stress associated with providing informal care can be averaged to obtain a composite score. A score of 4 would indicate the highest level of stress, and a score of 1 indicates a low level of stress. As seen in Table 39, the overall composite stress score averaged 2.42 among family and friends providing informal care pre-enrollment and 2.44 post-enrollment. This difference was not statistically significant.

Table 39. Composite Score of Stress of Providing Informal Care

	Pre	Post
Mean (0-4 with 4 being highest stress)	2.42	2.44
Number of cases	86	86
Difference	-0.02	
Statistically Significant?	No (p=0.62)	

Chapter 6 – Survey of Independent Care Providers of Support at Home Enrollees

Overview

Clients of the Support at Home Program (S@H) have the option to choose between agency mode or independent provider (IP) mode upon hiring a paid caregiver. If the client chooses IP mode, their providers are offered a training hosted by S@H. IPs were surveyed after they attended this training on a rolling basis; Qualtrics surveys were sent via SMS or email, and sometimes both if a response was not received via the first medium. One last attempt to increase participation through a paper survey was distributed at the final training, which yielded 25 returned surveys. Surveys could be taken in English, Spanish, or Chinese. A total of 95 individuals completed the Independent Provider Survey. Below, the results of these surveys are described.

Demographics

Nearly half of respondents were female (49.5%). Respondents represented a variety of racial and ethnic backgrounds, including Black or African American (23.2%), Asian/Native Hawaiian/Pacific Islander (16.8%), White (Non-Hispanic) (11.6%), Hispanic or Latino/a (9.5%), and multi-ethnic (6.3%). The plurality of respondents (27.4%) had at least some college as their highest level of education. Ages ranged from 19 to 80, with the mean age being 50.6 years. Sixty-one percent of respondents reported that their health was good or very good, and 15.8% reported living with disabilities.

Hours, Wages, Commute, & Other Jobs/Responsibilities

Self-reported weekly hours of care provided to Support at Home (S@H) clients ranged from two to 50, with a mean of 20.46 hours. Reported median weekly earnings before taxes from S@H caregiving work ranged from $15 to $1,714, where the mean was $289. The majority (n=40, 53.3%) reported that they do not commute to provide care to S@H enrollees. The same number (n=24, 55.8%) also reported that they were live-in caregivers.

In addition to their paid caregiving job, 40% of respondents reported holding at least one other paid job. Given that the reported number of total hours worked per week from additional jobs ranged from five to 66, with a mean of 34.24 (median 40); overall, at least 20 of the 95 respondents were working more than 40 hours per week across all jobs. About 20% of respondents reported that they provided unpaid care for one or more friends or family members in addition to their paid caregiving job(s). Almost 10% percent reported missing time from paid work because of the unpaid care that they provide to family members or friends in the past month, with the number of hours missed ranging from three to 20.

Over one-third (n=34, 35.8%) reported already working as unpaid caregivers before caring for S@H clients as their IP. Few (n=11, 11.6%) reported providing care to more than one S@H client. Among the 38 IPs who held other paid jobs, 20 had previously provided unpaid care to S@H clients. A Pearson chi-square test found the relationship between holding other jobs and previously providing unpaid care to S@H clients to be statistically significant (p=0.001).

Narrative Insights from Independent Providers

The survey also contained two free-response questions, which allowed IPs to provide narrative insights. Regarding their perceptions of how S@H affects clients, comments highlighted the program's positive impacts, financial support, help with daily tasks, and improvements to quality of life. As one IP wrote, *"It gives her a better* *quality of life. She's able to receive showers, have her house chores completed, and be driven to all appointments."*

Several comments noted how S@H allows clients to be able to employ a family caregiver. One IP wrote that *"It made my mother happy to know I was earning a little money for all that I was doing."*

Finally, the caregivers talked about not only the financial benefit of the program, but also the overall impact of S@H on the client's quality of life, including the impact of caregiver choice within IP mode. One IP said, *"If [the client] did not have this kind of help...she could not afford this on her own. {The program] leaves her with a little extra money at the end of every month. She needs someone there for grocery shopping, cleaning the kitchen, etc. If it weren't for this program, I don't know what [the client] would do. She is in a weird bracket where she is barely making it, but her share of cost for Medi-Cal is too high. This program has been a life saver in a lot of ways. When they approved her for the program, it was right before she had her neck and back surgery. It took her longer than expected to recover. Since then, she has had a couple of falls, which has set her back. She has had to learn to give up some of her independence, which she values. It's been a learning curve for her and for me. [The client] also has some vision trouble. She does pretty well, but she gets tired easily. A lot of things are going on with her, where suddenly she wasn't independent anymore. She has expressed many times how grateful she is that I can help her. She wouldn't trust a stranger. This is a program that is really valuable to [the client]."*

Independent Care Provdier Feedback for & Recognition of Program Improvement

Other than several IPs asking for higher wages and an increase in hours, the IPs provided a considerable amount of feedback to improve the current program. Some noted that more frequent reassessments and/or a process for reassessments should be provided. One IP commented, "*When they approved [my client] for the program, she was doing well on her own (didn't need as many hours), and she now needs more help. I am not being paid for the amount of hours that I am putting in*." However, according to S@H policy, annual re-assessments are a *minimum* program requirement. Ad hoc re-assessment can be completed any time there is a significant change in financial or functional status. The potential for additional reassessments should be made clearer to the IPs, or there should be a clear process for IPs to initiate a reassessment if they feel like there is a need.

Other IPs noted improved processes to the payment system. However, some experienced challenges with the technological aspect payment system. One IP stated, "*Technology is difficult for me. [The client] can't go online to get copies of pay stubs. When it comes time for the W-2...it gets tricky. [It's] difficult to do anything online*", whereas others welcomed the use of technology and expressed a desire for enhanced technological capabilities: "*I wish we were able to confirm the number of hours through an app*."

Chapter 7 – Financial Analysis of Support at Home Program

Framework for Comparing Costs and Benefits

This cost-benefit analysis examines trends among enrollees and the comparison group to measure the unique impact of S@H. While this analysis includes both financial and non-financial (e.g., quality of life) benefit data, there was not a comparison group analysis for the analysis of enrollees' maintenance of financial status because the comparison group is not asked to report details of their financial status.

The cost-benefit analysis of the Support at Home (S@H) pilot program is guided by the evaluation logic model (Appendix B). The S@H program engages in outreach activities to identify potentially qualified applicants for the program. From that pool, those that enroll receive financial support to purchase home care services, including domestic, non-medical personal and accompaniment services, from either a home care agency or an independently-hired caregiver. These services help enrollees accomplish activities of daily living (ADLs) and instrumental activities of daily living (IADLs), receive recommended health care services, and enhance their social engagement. As a result, the services are anticipated to lead to a set of benefits, including higher self-reported quality of life,[‡] lower risk of nursing home admission or other residential changes,[§,**] lower risk of hospitalization and emergency department visits,[††] and lower burden on informal family and friend caregivers. In turn, these benefits will lead to additional benefits, including greater employment (either paid outside work or as a paid caregiver) and satisfaction of family members. Finally, the program may lead to lower health care costs, primarily due to reduced hospitalizations, emergency department visits, and nursing home admissions.[‡‡,§§,***,†††] The cost-benefit analysis compares the benefits of the program – both monetary and non-monetary – with the costs of the program.

Costs of the Support at Home Program

The Support at Home program incurs costs for payment for home care services and for operating the program. The costs of home care services are shared between Support at Home and enrollees, with enrollees' copayments based on their functional need and their financial need. Table 40 summarizes the voucher amounts paid by Support at Home for home care services, from the inception of the program through March 7th, 2020, as well as the copayments made by enrollees for home care service. The analysis included 1,812 monthly payments made for agency services and 4,114 biweekly payments made for independent care providers. The biweekly payments were converted to monthly equivalent payments in order to summarize costs on a monthly basis, by multiplying by

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[‡] Low L-F, Yap M, Brodaty H. (2011) A systematic review of different models of home and community care services for older persons. BMC Health Services Research 11:9.

[§] Kane RL, Lum TY, Kane RA, Homyak P, Parashuram S, Wysocki A. (2013) Does home- and community-based care affect nursing home use? J Aging Soc Policy 25(2):146-60.

[**] Thomas KS, Keohane L, Mor V. (2014) Local Medicaid home- and community-based services spending and nursing home admissions of younger adults. Am J Public Health 104(11):e15-7.

[††] Xu H, Weiner M, et al. (2010) Volume of home- and community-based Medicaid waiver services and risk of hospital admissions. J Am Geriatr Society 58(1):109-115.

[‡‡] Segelman M, Intrator O, Li Y, Mukamel D, Veazie P, Temkin-Greener H. (2017) HCBS Spending and Nursing Home Admissions for 1915(c) Waiver Enrollees. J Aging Soc Policy. 2017 Apr 17:1-18.

[§§] Mitchell G 2nd, Salmon JR, Polivka L, Soberon-Ferrer H. (2006) The relative benefits and cost of Medicaid home- and community-based services in Florida. Gerontologist 46(4):483-94.

[***] Harrington C, Ng T, Kitchener M. (2011) Do Medicaid home and community based service waivers save money? Home Health Care Serv Q. 30(4):198-213.

[†††] Newcomer RJ, Ko M, et al. (2016) Health Care Expenditures After Initiating Long-term Services and Supports in the Community Versus in a Nursing Facility. Medical Care 54(3):221-8.

26/12. Some payments might not be included in this analysis if records had missing values or other database issues.

As seen in Table 40, the average monthly value of voucher payments for home care services was $564.35 per enrollees, with an interquartile range of $293.52 to $714.86. The average monthly copayment was $214.62, with an interquartile range of $113.10 to $295.56. In sum, the total copayments by all enrollees for home care services was $796,409 and the total voucher payments were $2,094,176.

Table 40. S@H Voucher payments and enrollee copayments for home care services, monthly values, current and discharged enrollees (342 enrollees included, data not weighted for varying numbers of months of service for each enrollee)

	Voucher payments	Enrollee Copayments
Number of monthly payments made	1,812	
Number of biweekly payments made	4,114	
Average per enrollee per month	$564.35	$214.62
25th percentile per enrollee per month	$293.52	$113.10
Median per enrollee per month	$502.13	$170.31
75th percentile per enrollee per month	$714.86	$295.56
Total	$2,094,176	$796,409
Net Voucher payments	$1,297,767	
Percentage of total vouchers paid through copayments	38.0%	

IOA incurs costs to manage the Support at Home program, which are mostly comprised of personnel costs. As seen in Table 41, total IOA spending on S@H was $1,876,019 over the first 38 months of the pilot program. Of this, $142,955 were start-up and evaluation-related costs, which would not exist in a permanently-operating program. The operational expenditures totalled $1,733,064, averaging $45,606.95 per month. These expenses include the costs of the assessment coordinators, who coordinate and conduct assessments, a financial manager who ensures all billing, invoices, and vouchers are processed, a project manager, and other costs associated with program operations.

Table 41. Institute on Aging operational costs for Support at Home Pilot Program

	FY16-17	FY17-18	FY18-19	FY19-20	Total
Number of months	2	12	12	12	38
Total expenditures	$50,125.00	$556,895.00	$638,103.00	$630,896	$1,876,019
Start-up and evaluation costs	$50,125.00	$75,000.00	$16,730.00	$1,100	$142,955
Operational expenses only (without start-up/evaluation)	$0	$481,895.00	$621,373.00	$629,796	$1,733,064
Average total spending per month	$25,062.50	$46,407.92	$53,175.25	$52,574.67	$49,368.92
Average operational spending per month (without start-up/evaluation)	$0.00	$40,157.92	$51,781.08	$52,483.00	$45,606.95

* The FY19-20 data cover 12 months, whereas the evaluation data cover 8.5 months.

Cost of DAS contracting / oversight

The San Francisco Department of Disability and Aging Services (DAS) also incurs costs for operation and oversight of the program. The total budgeted costs for DAS are summarized in Table 42. During the 2016-17 fiscal year, DAS dedicated staff time for 9 months, followed by 3 full years of staff time. The total for the pilot program was $204,721, with an average monthly cost of $4,549.36.

Table 42. Department of Disability and Aging Services operational costs for Support at Home Pilot Program

	FY16-17	FY17-18	FY18-19	FY19-20	Total
Number of months	9	12	12	12	45
Total expenditures	$41,226	$54,968	$54,686	$53,840	$204,721
Average spending per month	$4,580.67	$4,580.67	$4,557.17	$4,486.67	$4,549.36

Comparison of the benefits and costs of the Support at Home program

Financial benefits of changes in nursing home admissions, hospitalizations, and emergency department visit use

The financial value of reductions in nursing home admission, hospitalization, and emergency department use were estimated by gathering data from the published literature. Some benefits are accrued by private insurance companies (e.g., Medicare Advantage plans), some are received by San Francisco (Medicaid), and some are received by other levels of government (e.g., the federal government for Medicare). The cost savings presented in this report do not distinguish by beneficiary of savings.

Financial savings associated with reduced hospitalizations

A reduction in the number of hospitalizations among S@H enrollees has a financial benefit. Data from the Healthcare Cost Utilization Project of the U.S. Agency for Healthcare Research and Quality reported that the average cost for a hospitalization among patients aged 45 to 84 years was $14,500 in 2016,[‡‡‡] which is equivalent to $15,613 in 2020 dollars using the Consumer Price Index.[§§§] The data indicate that S@H enrollees experienced a statistically significant decrease in hospitalization rates after enrollment, whereas the comparison group did not. The decreased hospitalization rate for enrollees has a financial value of $1,457.23 per enrollee per month, as detailed in Table 43.

Table 43. Cost savings from change in hospitalizations

	Enrollees	Comparison group
Initial average hospitalization rate (quarterly)	0.50	0.69
Most recent average hospitalization rate	0.22	0.86*
Change in hospitalizations per enrollee	-0.28	0.00*
Cost per hospitalization	$15,613.16	
Cost change per enrollee per quarter	-$4,371.68	$0.00
Net cost change per enrollee per quarter	$4,371.68 savings	
Net cost change per enrollee per month	$1,457.23 savings	

* Change was not statistically significant.

[‡‡‡] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb246-Geographic-Variation-Hospital-Stays.pdf

[§§§] https://www.bls.gov/data/inflation_calculator.htm

Cost of Emergency Department visits

Avoided emergency department visits also have a financial value. Data form the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey reported an average cost of $1,431 per emergency department visit for people 65 years and older insured by Medicare and private insurance plans in 2016.[****] Using the Consumer Price Index, the inflation-adjusted cost per visit is $1,540.86 in 2019 dollars.[††††]
S@H enrollees experienced a statistically significant decrease in the rate of emergency department visits, but comparison group members did not. As seen in Table 44, the financial value of the decrease in emergency department visits is $123.27 per enrollee per month.

Table 44. Cost savings from change in emergency department visits

	Enrollees	Comparison group
Initial average ED visit rate (quarterly)	0.48	0.60
Most recent average ED visit rate	0.24	0.78*
Change in ED visits per enrollee	-0.24	0.00*
Cost per ED visit	$1,540.86	
Cost change per enrollee per quarter	-$369.81	$0.00
Net cost change per enrollee per quarter	$369.81 savings	
Net cost change per enrollee per month	$123.27 savings	

* Change was not statistically significant.

Cost of unneeded physician visits

Physician visits are expensive, and a benefit of well-coordinated home care can be a reduction in the need for physician services. The financial value of this was calculated by using data derived from the Medicare program.[‡‡‡‡] The average cost of a follow-up visit of moderate complexity in Northern California was reported as $121.45 in 2013 ($134.71 in 2020 dollars). When applied to the statistically significant decrease in physician visits reported among S@H enrollees, this is linked to cost savings of $132.46 per enrollee per month (see Table 45).

Table 45. Cost savings from change in physician visits

	Enrollees	Comparison group
Initial average physician visit rate	7.75	7.47
Most recent average physician visit rate	4.80	5.65*
Change in physician visits per enrollee	-2.95	0.00*
Cost per physician visit, moderate complexity	$134.71	
Cost difference per enrollee per quarter	-$397.39	$0.00
Net cost change per enrollee per quarter	$397.39 savings	
Net cost change per enrollee per month	$132.46 savings	

* Change was not statistically significant

Total Costs of Support at Home Program

[****] https://meps.ahrq.gov/mepsweb/data_stats/tables_compendia_hh_interactive.jsp?_SERVICE=MEPSSocket0&_PROGRAM=MEPSPGM.TC.SAS&File=HCFY2014&Table=HCFY2014_PLEXP_E&VAR1=AGE&VAR2=SEX&VAR3=RACETH5C&VAR4=INSURCOV&VAR5=POVCAT14&VAR6=REGION&VAR7=HEALTH&VARO1=4+

[††††] https://www.bls.gov/data/inflation_calculator.htm

[‡‡‡‡] http://truecostofhealthcare.org/medicare_part_b/

The total costs of the Support at Home program are summarized in Table 46. Total costs of the program throughout its operation were $4,031,961, and the monthly cost per enrollee was $1,086.55. The computations are based on the equivalent of 3,710.8 service months for enrollees, as calculated from the numbers of monthly and biweekly voucher payments.

Table 46. Costs of Support at Home program, total and per service month (3,710.8 service months)

	Total cost	Average monthly cost per enrollee
Enrollee Copayments	$796,409	$214.62
Voucher Payments by S@H	$1,297,767	$349.73
IOA operational costs	$1,733,064	$467.03
DAS operational costs	$204,721	$55.17
Total	**$4,031,961**	**$1,086.55**

Net Financial Impact of Support At Home

The costs and financial savings of S@H can be compared, as seen in Table 47. The total savings from reduced hospitalizations, emergency department visits, and physician visits are $1,712.96 per month per enrollee. These savings do not include additional potential savings from increase ability of informal caregivers who provide support to enrollees who can maintain or increase their employment due to S@H providing home care services. The cost of operating the program, including the costs of vouchers to IOA, the costs of vouchers to enrollees, operational costs, and oversight costs, are $1,086.55 per month per enrollee. The program thus costs $626.41 per month per enrollee less than saved, with a total net savings to San Francisco of $2,324,491 to date. These savings have come primarily from reduced hospitalizations.

Table 47. Summary of financial benefits and costs of Support at Home

	Per month per enrollee	Total (1,864 enrollee-months)
Savings		
Hospitalizations	$1,457.23	$5,407,489
Emergency department visits	$123.27	$457,430
Physician visits	$132.46	$491,533
Total savings	**$1,712.96**	**$6,356,452**
Total program costs	**$1,086.55**	**$4,031,961**
Net	**-626.41**	**-2,324,491**

Chapter 8 – Perspectives of Institute on Aging, Department of Disability and Aging Services, and Support at Home Advisory Committee

Overview

In May and June 2020, the UCSF evaluation team conducted interviews of seven key informants. These key informants represented Institute on Aging (IOA) Support at Home (S@H) pilot program staff, advisory committee members, and the San Francisco Department of Disability and Aging Services (DAS). Due to COVID-19 shelter-in-place restrictions, all seven interviews were conducted online using the Zoom teleconference application.

Methods

Interviewees were contacted with an introductory email that described the evaluation and invited them to participate in an interview as part of the evaluation. When respondents agreed to an interview, they were contacted to schedule a one-hour Zoom interview. At the beginning of the interview, participants were given an overview of the interview process and research confidentiality and consent protocol. They were informed that all questions were voluntary. Interviews lasted between 30-60 minutes; most lasted the full hour. In order to uphold the interview team's objectivity and facilitate the interviewees' openness in providing responses, the interviews were conducted by two members of the UCSF research team who were not directly involved with primary activities of the evaluation. Both interviewers took notes during the interviews and the interviews were recorded if permission was granted by the interviewee.

Analysis

The interviewers on the study team reviewed interview notes separately to code and identify key themes. Following that, the interviewers compared and discussed the themes to come to a consensus on overall findings.

Key Themes

Purpose of the Program

There was general agreement among all the interviewees of the aims of the S@H pilot program. Some quoted directly from the original program proposal submitted to the city government. As one interviewee summarized:

"It was to expand the number of people getting home care and to make sure people who didn't qualify for [In-Home Support Services] IHSS, but couldn't afford to pay privately for as much as support as they needed to be able to get those hours and to have some financial relief. "

In other words, S@H's pilot project aim was to fill a void in long-term care services by providing access to affordable home care for low- and middle-income San Franciscans. Interviewees also described how S@H allows seniors and adults with disabilities to stay in their homes and avoid institutional care.

Interviewees who were involved prior to and throughout program implementation agreed that the organized disability community were the key advocates for the program, first identifying the need and then bringing the concept for the program to the San Francisco Board of Supervisors

How Clients Benefittied from the Program

Interviewees generally agreed that clients benefit from being enrolled in the S@H program. The program was most successful in reaching one of its target populations, middle- and low-income seniors living in San Francisco. Citing data that was shared to program staff and DAS in regular meetings and reports, interviewees mentioned how the program met the enrollment targets for this population that were outlined in the original project proposal. Interviewees offered various examples of how clients benefit from the program. These include the tangible benefits of receiving home care, as well as socioemotional benefits such as eased concerns about one's safety, increased peace of mind, and the ability to be more active in one's community. Representative quotes include the following:

"I've seen it transform lives. I have seen individuals that physically need the support to keep clean, and they're able to do that with their caregiver. And even just with having contact with somebody encourages their spirit and they're able to participate more in their occupational therapy or physical therapy. ripple effect. I've seen so many different ways in which [this program] has helped the community, individuals, families, and of course that impacts the whole structure of the health system."

Challenges for Clients in the Program

Interviewees mentioned several challenges and limitations of the program to clients. These include financial challenges and challenges in adequately meeting all clients' care needs. Limitations of the program included potential recipients that could not be reached, enrolled, or were outside the need criteria of the program and the overall scope of the program in terms of the enrollee capacity and criteria.

Financial challenges

As mentioned by several interviewees, one of the main challenges of the enrollment process was verifying clients' financial eligibility for the program. As part of the eligibility screening process for S@H, a potential client must share their financial information (e.g., statements of income, assets, and expenses or expense estimates). Interviewees noted that many potential clients were uncomfortable with sharing this information because of privacy concerns. Or, they had difficulty navigating the different complex financial documents, which made it difficult for assessment coordinators to collect this information during the initial assessment visits to clients' homes. For example, one interviewee described:

"There are a few folks who have IRAs or over $40,000 [in assets]. We get into discussions about what are considered liquid assets, what is what, and that's been challenging for some adults with disabilities. People who don't want to face penalties for breaking into accounts. We also look at expenses. Expenses don't weigh in and sometimes people have a hard time with that. For instance, they might say that they have medical expenses and feel that it makes them higher need for financial assistance. And it's really just based on the income."

The solution to the latter challenge was for the S@H program/accounting coordinator to send a summary of the potential client financial information needed to the assessment coordinator prior to the assessment interview.

Moreover, one interviewee mentioned one significant change that took place during the pilot: how the program adapted its financial eligibility categories (high, medium, and low) in response to the updated Area Median Income (AMI) for San Francisco, which changes every year. Because the AMI was used to determine financial eligibility, this change consequently affected the financial eligibility categories for some clients each year.

Another interviewee pointed out that even after a client is enrolled in S@H, they may still have difficulty paying for their care, especially at the beginning of their enrollment. This is because when clients enroll in S@H, they are required to pay their copayment a month in advance, and many clients may not be able to afford to pay two copayments up front.

Receiving Care

Caregiver matching was expressed as a challenge, especially for clients who chose the agency model of care. The program allowed clients to switch models of care up to three times before being disenrolled from the program. Interviewees acknowledged that switching caregivers could be disruptive to care. However, one interviewee mentioned that IOA had set the three times switch limit "because it takes time [for clients] to build rapport with caregivers" and that "it wasn't an issue, people were pretty much abiding by that policy."

Home Care Delivery Mode

One interviewee reported that there was a near-even split between clients choosing the agency mode versus independent provider (IP) mode of home care. Interviewees were asked about feedback they had received from independent providers or home care agencies that the program contracted with. Most interviewees did not have any direct contact with the independent providers or home care provider agencies. However, from the interviewees' responses, the researchers were able to identify key differences between the two modes, such as their respective benefits and challenges, as well as clients' motivations for choosing one mode over the other

Agency Mode

For clients, a key benefit of agency mode was that they could delegate more of the responsibilities of coordinating care to the agency (e.g., choosing a caregiver, setting a schedule). However, one limitation of the agency model is that its clients may receive less hours of care compared to those enrolled in IP mode. One interviewee explained how the hourly rate for agency mode care is higher, and clients who go through an IP are able to access more care with the same copay amount. The interviewee also noted that clients' social networks may influence their choice of care:

"It's so hard because then they're even more isolated and then they access less care because they just can't afford that higher rate…We walk [clients] through both options, but some are like, 'Wait I don't know anybody [that could be my IP caregiver]'. And then they go with the agency, and don't have as much care."

Independent Provider Mode

Several interviewees reported that many clients may favor the IP mode of care for several reasons. The primary benefit is consumer choice of caregiver. For instance, before enrolling in S@H, some clients were already receiving care from a caregiver (paid and/or unpaid); the IP mode allowed them to establish care with this caregiver. One interviewee's impression was that coordinating or initiating care after enrolling in S@H was a faster and easier process for IP mode clients "because the IP and the client seem to have [a more direct employee-employer relationship]".

Several interviewees reported that worker training is an important component of home care. The program required IP caregivers to attend a one-hour training provided by the National Domestic Workers Alliance before they started working for a S@H client. The training covered workers' rights, and IP caregivers were paid for attending it. IP caregivers also had the opportunity to attend an optional second hour-long training that focused on additional topics, such as communication with clients.

Administrative Challenges

All three IOA staff interviewees mentioned ongoing administrative challenges to running the pilot program. The primary challenges mentioned were ensuring that the enrollment process for each client went smoothly and adequately communicating what the S@H pilot program offers. Interviewees mentioned solutions that had already been implemented, as well as planned program changes for the future.

Staff interviewees mentioned that completing initial enrollment paperwork could be difficult for some clients due to physical or cognitive barriers. One interviewee emphasized that this could even be a barrier to enrollment for some clients or complicate the enrollment process: "Sometimes, the first interaction we have with clients can come off like, 'Hey, understand all this information and sign all of this', and that can be kind of hard." To address this, the interviewee described how the program adopted an electronic single acknowledgement form for signing documents; under this process, paperwork was thoroughly described with clients, and only one signature was needed to sign all documents.

Program Challenges in Meeting Objectives

Outreach to Diverse Populations

Throughout the pilot, the challenges that the S@H program faced in reaching diverse populations were most evident in the disproportionately low enrollment numbers among Asians and adults with disabilities. Interviewees reported that White, Black, and English-speaking clients made up a disproportionately higher share of S@H clients. In contrast, as one interviewee described, “considering the large number of Chinese and Asian-American seniors in San Francisco, those [enrollment] numbers [for those communities] are disturbingly low.” Another interviewee’s response suggested that demand for S@H among the Asian community was perhaps lower due to cultural differences, and that this trend may not have necessarily been unique to S@H:

"I see this across the board for most of the programs [our organization] manages. The one thing we do see is that culturally, Asians have that familial support. So even if they would qualify for a program, they tend not to refer because they feel that they already are supported through their family or other support system…Other than that, maybe we could do more work with marketing, and meeting that language barrier up front when we get referrals."

The most frequently mentioned program challenge was the difficulty in recruiting and enrolling adult clients under age 60 who had disabilities. Interviewees noted that this demographic was “a very difficult [client population]” to reach. Interviewees reported that one of the goals outlined in its original request for proposal was to serve 175 to 255 clients, of which 50% would be under age 60; the S@H pilot program was unable to meet this goal. One interviewee described that much of the original advocacy for developing the S@H program came from the disability community, “In the beginning, we really thought there would be a greater number of disabled adults participating in the program. Instead, we’re seeing that 90% of the program are seniors and older adults."

Several interviewees shared possible explanations for the difficulty in enrolling disabled adult clients. Two interviewees mentioned how the organization’s name, “Institute on Aging”, may have dissuaded potential clients, because “disabled people might think that they can't be served or they're just not going to feel comfortable.” Two interviewees mentioned how the lack of data on youths and adults with disabilities was a barrier to understanding this population and developing relevant outreach and marketing efforts that would boost program visibility to this population.

Interviewees reflected on existing and potential solutions for boosting enrollment among disabled adults. Two interviewees mentioned how the program had launched a citywide bus advertisement campaign. Two interviewees mentioned social media marketing efforts; for instance, the program started collaborating with a disability advocate and blogger. Two interviewees mentioned utilizing additional marketing channels such as doctors’ offices, youth disability organizations, and university disability departments, which S@H did implement. Despite all these efforts, S@H has not been able to attract a high volume of adults with disabilities to the program.

Future Program Funding

Although S@H had been made a permanent city program beginning in fiscal year 2021 and IOA had renewed its contract with DAS to administer it, several interviewees expressed concerns as to whether the program had sufficient funding and governmental support to grow, or even maintain its existing client base. At the time of the interviews, S@H was not enrolling new clients and had approximately 300 people on the waiting list. Several interviewees mentioned needing additional funding for future program success. As another interviewee suggested, the viability of future funding for the program may likely be contingent on the broader City and County of San Francisco government’s commitment to permanently supporting S@H and fiscal constraints brought on by the COVID-19 pandemic.

Partnerships

In general, all interviewees shared some positive feedback about how partnerships functioned throughout the pilot. Those partnerships included IOA’s relationships with the S@H advisory committee, city and county government (DAS), contracted home care agencies, administrative and operations support organizations, and the research evaluation team.

To illustrate the strength of the partnerships, one interviewee noted how maintaining client safety was a primary shared concern between IOA and the agencies:

“When there's an issue, we have to be able to call someone and resolve it. For example, not every single agency is providing PPE during COVID. We had 24 clients last month put their care on hold because of [COVID-related] concerns because of isolation, PPE, [etc.]. So being able to call those providers and ask how we can help your staff ensure that you have PPE because these clients are refusing care with it? Certainly, the voucher isn't going to be collected and the copay isn't going to be collected as clients decline care. It’s all a matter of how strong our relationships are. I can tell you that we have the ability to pick up the phone."

The relationship between IOA and the S@H advisory committee also received praise. One interviewee cited the citywide bus advertising campaign as an example of the program utilizing the committee’s input on how to outreach to the disabled adult population. Another interviewee who was a member of the committee highlighted the plurality of viewpoints represented on the board, such as *“academic voices, evaluation voices, city voices, home care agencies, consumers talking about consumer needs."* However, another committee member’s response suggested that the committee’s impact was ultimately limited.

One interviewee pointed out that IOA and DAS were longtime partners on several other city programs, which made it easy for the two organizations to work together; consistent communication and good rapport were established between the two organizations.

Program Outcomes

In general, interviewees felt that the S@H pilot met most of its intended outcomes and “performed well, contractually.” Three interviewees reported that the program met most of the service objectives outlined in IOA’s request for proposal (e.g., number of clients served, improved health outcomes for clients, etc.), but acknowledged that the pilot had not met the specific objective of having half of clients served be under age 60.

The same two interviewees mentioned how S@H relieved clients’ financial need by helping low- and middle-income individuals above the Medi-Cal eligibility limit afford home care. However, both interviewees noted that S@H’s program design narrowed its impact in addressing care and affordability gaps. One interviewee acknowledged that the original advocacy behind S@H was to support the population above the Medi-Cal limit, but pointed out that many people in the Medi-Cal population also struggle to afford home care. The other interviewee pointed out that while S@H enabled some individuals to start receiving home care services, it may not have addressed the needs of individuals who were already receiving home care and needed more care, but could not afford more care:

“We haven't found people who have significant disabilities, and people who were already hiring attendants and didn't have enough hours or were being pushed into poverty from trying to pay for it. I think they found a lot of older people who need some help with housecleaning, or help with getting in and out of the bath, but not people who need an attendant to survive and who may already be hiring attendants, but are struggling to pay for it. We know those people exist, but we haven't found them. Because so much of it is off the books and people are embarrassed to talk about it, it's incredibly hard to find that information."

Two interviewees mentioned how the academic evaluation of the pilot was successful in collecting detailed data and expanding the existing knowledge base around home care. However, one interviewee shared reservations about the extent to which the evaluation’s findings could be applied in practice:

“The good news is that what we’ve learned that it’s a complexly nuanced conversation around choices that consumers have to make between care, acuity of need, and acuity of financial situation. I think the advocacy communities are like ‘Yeah, that’s great, what are we going to do to meet it?’ and are going to care less about the nuances about the acuity and the financial and care choices you can make, and more about the overall size of unmet need, which is what we knew when we began this project. From an academic perspective, we’re happy to have a deeper level of knowledge. And now, what are we going to do with that knowledge?”

Chapter 9 – Summary and Considerations for The Future

Based on the success of the pilot, the S@H program has been made a permanent city program. Throughout the three years of the pilot program, IOA has continued to adapt the S@H program as needed in light of gaining more knowledge about the targeted population and their needs. Data in this report suggest that the program significantly benefits enrollees' quality of life while also reducing costs, especially costs related to utilization of health care services (e.g., emergency room visits). Specifically, the S@H program experienced the following outcomes:

- At the end of Year 3, 170 people were enrolled, 145 people had been discharged, and 50 had disenrolled from the program.
- There were significant efforts to ensure racial/ethnic diversity of the enrollees, especially among the Black/African American community.
- The program has had difficulty enrolling adults under 60 with disabilities and Spanish- and Asian language-speaking clients.
- Enrollees experienced a high satisfaction with the program and felt that the program relieves stress and was helpful to meeting their needs.
- Enrollees indicated lower levels of stress associated with the financial responsibility of paying for home care.
- There was an increase in the average quality of life scores between the first and most recent survey, although this was not statistically significant.
- There was a statistically significant decrease in emergency room visits.
- There was a significant decline in medical appointments. The decline can be viewed as a sign of better overall care.
- There was a significant decrease in the average number of falls reported.
- There was a significant increase in frailty among S@H enrollees.
- The total savings from reduced hospitalizations, emergency department visits, and physician visits are $1,712.96 per month per enrollee.
- There is a total net savings to the City and County of San Francisco of $2,324,491 to date. These savings have primarily come from reduced hospitalizations.

Enrollees and their caregivers have commented on the positive impact that the program has had on their lives. Data collected from friend and family (informal, or non-paid) caregivers at the time of their loved ones' enrollment into S@H indicated that they are stressed about providing care, demonstrating that they may also benefit from the program. While some of the quantitative measures do not show statistically significant changes pertaining to quality of life, the qualitative comments from clients and caregivers confirm that the program is having a substantial impact on their well-being.

Enrollment in the program has remained stable over the past year, although IOA is striving to increase enrollment, particularly for those under 60 years of age and among communities of color, especially Latinos and Asians. IOA has made an exhaustive effort towards increasing enrollment numbers through multiple outreach and advertising modalities. The program is continually challenged by frequent transitions among those who do not enroll and those who are discharged or disenrolled from the program. There are myriad reasons for clients to either not participate in the first place (e.g., denied need, unwilling to disclose financial information), disenroll (e.g., unable to maintain contact and/or care), or discharge from the program (e.g., transfer to long-term care or deceased). Given the significant resources needed to assess client eligibility, increased assessment coordination efforts were added.

Future Considerations

Moving forward, the S@H program should consider a sustainability plan that focuses on maintaining growth, streamlining the assessment process, and identifying strategies to minimize attrition. Ongoing reviews and assessments conducted by IOA will track the continuing impact of S@H on the well-being of San Franciscans. Such efforts should especially prioritize those who are under 60 years of age, those who come from non-white communities, and those from non-English speaking backgrounds. Given that these groups are most likely to already be connected to wider social support networks than White and African American residents, creative and purposive outreach is needed.

The program should also focus on a plan for continuous quality improvement, especially on working with the agency providers to help improve the “matching” process for clients. This includes strategic negotiations on minimum caregiving hours per shift, reasonable hourly rates, and caregiver compensation. The S@H program should continue to enhance the process and information provided to clients to help them make informed choices when deciding on a provider to ease the client-reported burden of feeling overwhelmed and/or frustrated with the initial stages of the program or when the caregiver-client dyad is not a good fit. Assessing caregiver-agency-client satisfaction is another consideration to increase program satisfaction. Finally, ensuring that all communication materials (e.g., enrollment, payroll) are user-friendly, especially to accommodate those with disabilities, is critical.

Enrollees and caregivers desired increased communication about additional programs and other resources they could benefit from to maximize aging in place. Some clients reported having their own social worker who could help them navigate all of the necessary resources in order to keep them living successfully in the community. Other clients and family members were eager to know how they could gain access to such, and other, resources.

Conclusion

The evaluation results support the significant and vital role of the S@H program. S@H provides a critical means of financial support for low- and middle-income San Franciscans who could not otherwise afford home care, especially amongst seniors. Many clients and their caregivers enrolled in S@H have experienced improved health outcomes and quality of life.

The clients that the S@H program serves are important citizens of our diverse aging city. Equally, the caregivers in the S@H program are core members of San Francisco’s workforce and are actively contributing to the city’s vital employment activity.The S@H program is part of an action plan to collectively ensure that San Francisco is an equitable and inclusive place for people of all abilities to live as independently as possible with dignity.

Appendix A: Data and methods for describing the targeted population

Data from American Community Survey (ACS), which is conducted by the U.S. Census Bureau, were used to measure and describe the targeted population in San Francisco. The merged 2012-2016 5-year Public-Use Microdata Sample housing and population for the public-use microdata areas (PUMAs) defining San Francisco County were analyzed. This was the same regional definition used in reports that guided development of the Support at Home program.

The population of individuals potentially eligible for Support at Home was constructed by excluding all vacant housing units and the institutionalized population, and including only sample cases where age of person was reported as 18 or older with at least one of the specified disability conditions:

- VA service-connected disability rating
- Cognitive difficulty
- Ambulatory difficulty
- Independent living difficulty
- Self-care difficulty

From this population, cases where health insurance coverage was reported as “Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability” were excluded.

The approach used to evaluate the income status of this potentially eligible population approximated Medicaid eligibility rules, which are based on an applicant’s tax filing status (e.g. individual, married couple, head of household, dependent). Because the American Community Survey does not include this information, assumptions were made regarding household size and dependent relationships. For most households the relationships are relatively straightforward, such as for a single-person household, a two-person husband-and-wife household, or single adult head of household with two of her own children present. Other households are more challenging to assess in terms of size and dependent relationships, such as a multigenerational household with married and unmarried adult children who may or may not report income and who may or may not have children themselves (who also may be married and who may or may not report income), in addition to the presence of married or unmarried in-laws or other relatives, who may or may not report income.

Individuals who were identified as potentially eligible, and who were living in multi-person non-family households, were treated as a single person household. The exception to this was households with unmarried partners, who were treated as a married couple (with dependents if own children were present). Biological children under the age of 18 were assumed to be dependents, as were unmarried adult children who were either not in the labor force or who reported income of less than $10,000 per year, grandchildren under the age of 18 living in the care of a grandparent, and unmarried adult grandchildren living in the household of a grandparent who were not in the labor force or who reported income of less than $10,000 per year.

When the relationship could be clearly determined, non-head of household married couples living in the household of a related adult were treated as any other married couple (e.g. a mother and father-in-law, one of whom has a qualifying disability and meets the income requirements, and the couple resides in the house of an adult child). A single parent or in-law living in the household of an adult child was treated as an individual (i.e., a single person household), regardless of reported income. Adult siblings were treated as a single person household, regardless of reported income.

Based on this set of assumptions, an individual’s income eligibility was evaluated in terms of household size using the 2016 Unadjusted Area Median Income (AMI) for HUD Metro Fair Market Rent Area (HMFA) that contains San

Francisco. Individuals with household income greater than 100% of the area median for household size were considered not eligible. Note that personal income as reported in the ACS may not be the same as the income used by Support at Home to determine eligibility, and information about assets (e.g., savings accounts, investments) is not available in the ACS.

In most cases, cell sizes presented in tables that include American Community Survey data are based on sample count of at least 30 observations. Sample sizes were too small to explore some demographic combinations, such as the cross-tabulation of age group with disability type. Exceptions to this criterion are noted.

Appendix B: Logic Model