San Francisco Department of Aging and Adult Services

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

Part II: Analysis of Needs and Services

Report by the San Francisco Human Services Agency Planning Unit
March 16, 2016

Contents

Introduction

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

This is the second of two reports summarizing the findings of the 2015 needs assessment process. The first report details population characteristics and trends among seniors and adults with disabilities in San Francisco, relying on a variety of data sources. This second report provides analysis of community needs and trends related to specific DAAS service categories. The two reports are complementary and provide a comprehensive portrait of the service system and the community that it serves.

The second report examines the targeted funding categories of DAAS's Office on the Aging, discussing more specifically the needs and rationale that underlie the services, and comparing trends in funding and volume of services with levels from four years ago. It draws on data from the San Francisco Human Services Agency budget and service utilization data from a variety of DAAS program databases.[1] This report also integrates feedback from seniors and persons with disabilities, gathered through a series of focus groups conducted over 2015 and in the biennial city survey. Their insight is threaded throughout this narrative. For more information about data used in this report, please review the methodology section of the first report of the DAAS Needs Assessment.

Subject areas of the second report are listed below. Many DAAS programs are multifaceted and span multiple service areas. This needs assessment categorizes services according to primary purpose.

1. Access to Services (includes Advocacy)
2. Case Management and Transitional Care
3. Caregiver Support
4. Housing
5. Nutrition and Wellness
6. Services to Prevent Isolation
7. Self-Care and Safety

[1] The primary databases include: CA GetCare (Office on Aging); SF GetCare (DAAS Integrated Intake and Referral Unit); CaseCare (Community Living Fund); CMIPS II (In-Home Support Services); AACTS (Adult Protective Services); and VetPro (County Veterans Services Office).

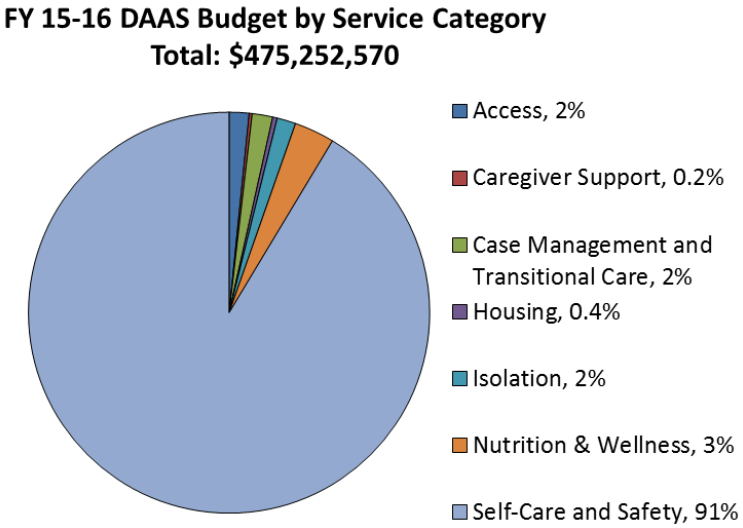
Overview of Service Areas

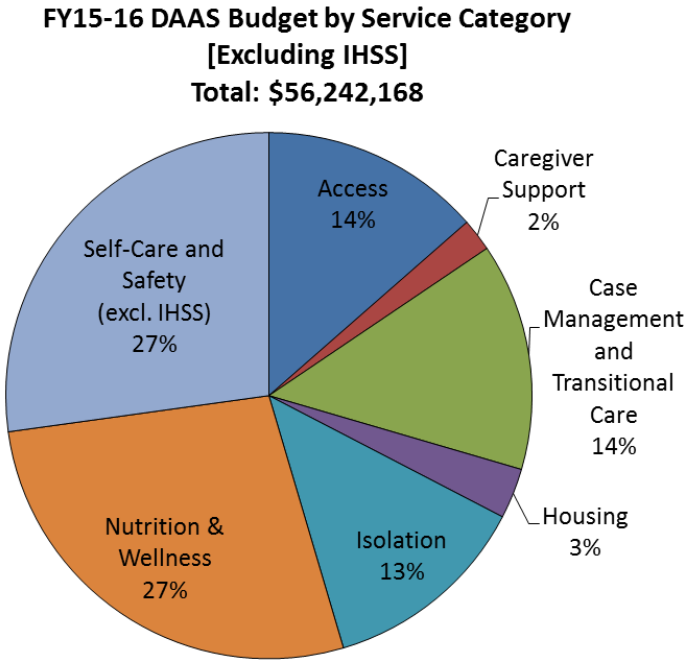
This report includes analysis of funding levels, focused on the direct cost of providing services. It does not include centralized administrative costs not associated with directly providing a service.[2] The FY 15-16 budget is based on original budgeted amount, while prior year data is based on expenditures (actual amount spent).

DAAS Budget by Service Area

The total DAAS service budget is $475.2 million. Almost $420 million (88%) of this budget is tied to the In-Home Support Services (IHSS) program – this includes the federal and state contributions that do not pass directly through DAAS, including provider wages.

Because this program dwarfs all other programs and curtails discussion of funding levels, it is useful to consider the DAAS budget with IHSS excluded. This approach permits exploration of funding choices over which City Hall and DAAS leaders have more control.





Excluding IHSS, the DAAS service budget is approximately $56.2 million. As shown to the left, most of this funding is split between Nutrition and Wellness services and Self-Care and Safety services. While the majority of the Self-Care and Safety budget funds mandated programs, the Nutrition and Wellness budget reflects chosen priorities established through the public budgetary process by the Mayor's Office, the Board of Supervisors, and DAAS, supported by strong community advocacy.

Service categories for Access, Case Management and Transitional Care, and Isolation Prevention each

[2] For example, the salaries for Adult Protective Service workers are included in this analysis because this is a direct service, but salaries for DAAS leadership and Office on Aging staff are not included. With these administrative and management positions included, the total DAAS budget is close to $478 million.

account for roughly equal portions of the budget. The majority of the programs are provided by community-based organizations.

After lean years following the 2008 economic recession, funding for DAAS services has increased over the last three years. The FY 15-16 budget is $98.9 million larger than FY 12-13 expenditures. As shown below, all service categories have larger budgets in FY 15-16 compared to prior expenditures. Excluding IHSS, the DAAS budget is $16.8 million larger than FY 12-13 expenditures, an increase of 42% for non-IHSS services. About $2.1 million is attributable to cost of doing business (CODB) increases.

DAAS Budget by Service Category				
Service Area	**2012-13 Expenditures**	**2015-16 Budget**	**Change since FY 12-13**	
			$ change	**% change**
Access	$ 5,208,711	$ 7,621,612	$ 2,412,901	46%
Caregiver Support	$ 1,097,496	$ 1,119,626	$ 22,130	2%
Case Management and Transitional Care	$ 6,552,645	$ 7,865,197	$ 1,312,552	20%
Housing	$ 109,116	$ 1,739,113	$ 1,629,997	1494%
Isolation	$ 4,126,392	$ 7,203,085	$ 3,076,693	75%
Nutrition & Wellness	$ 9,279,006	$ 15,395,954	$ 6,116,948	66%
Self-Care and Safety*	$ 349,937,604	$ 434,307,983	$ 84,370,379	24%
Total	$ 376,310,970	$ 475,252,570	$ 98,941,600	26%

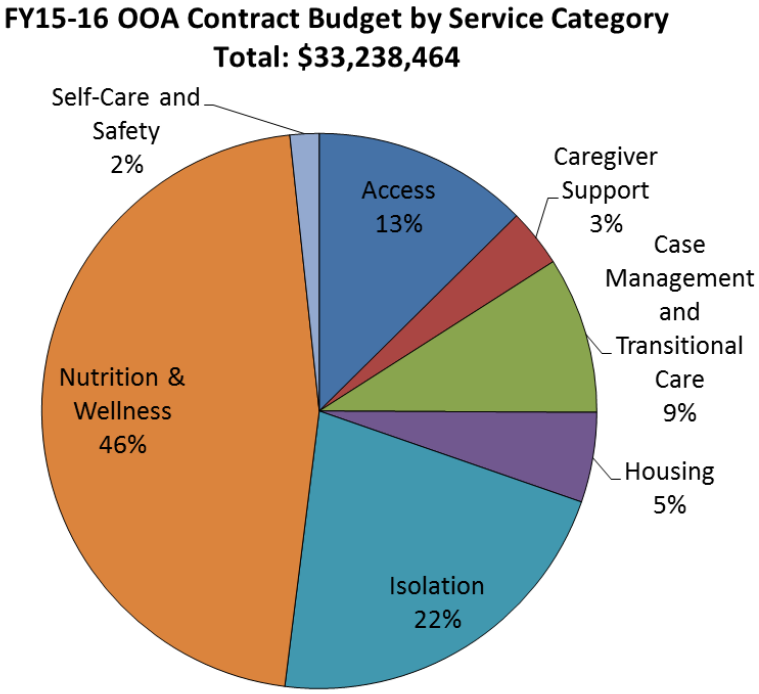
**Excluding IHSS, Self-Care and Safety budget is $2.2 million larger than FY 12-13 expenditures (17% increase for non-IHSS Self-Care and Safety services).*

The majority (79%) of this growth occurred in programs provided by community-based organizations. Sixty percent of this $16.8 million increase occurred in the following services: home-delivered meals ($2.9 million increase); congregate meals ($2.3 million); community services ($2.2 million); housing subsidy program ($1.6 million); and home-delivered groceries ($800 thousand).

Office on Aging Budget by Service Area

The OOA facilitates the provision of almost all DAAS-funded community-based services, including those supported by Older Americans Act funding. The chart below portrays the spending breakdown of the $33.2 million OOA contract budget.

Almost half the OOA budget goes to Nutrition and Wellness services. The largest program in this category is home-delivered meals (budgeted for $7.7 million). This is a service area the community and City Hall leaders have focused on in recent years. Services to prevent isolation are slated to receive about $7.2 million (22%) of OOA funding. Most of this goes to Community Services ($5 million).



Compared to spending in prior years, a few categories (Nutrition & Wellness, Isolation prevention, and Housing) represent a slightly larger portion of the budget, but the distribution has remained generally consist.

Overall, the OOA budget is $12.2 million larger than spending four years ago – an increase of almost 60%. This increase is the result of program-wide infusions (Home-Delivered and Congregate Meals, Community Services, and Aging and Disability Resource Centers) and accrual of smaller increases targeted to address unmet need for certain populations or geographic locations in the city. As shown below, all service areas contribute to this growth. These trends are described in more detail in the subsequent service sections.

Office on Aging Budget by Service Category				
Service Area	2012-13 Expenditures	2015-16 Budget	Change since FY 12-13	
			$ change	% change
Access	$ 3,551,891	$ 4,184,142	$ 632,251	18%
Caregiver Support	$ 1,097,496	$ 1,119,626	$ 22,130	2%
Case Management and Transitional Care	$ 2,468,317	$ 3,033,058	$ 564,741	23%
Housing	$ 109,116	$ 1,739,113	$ 1,629,997	1494%
Isolation	$ 4,126,392	$ 7,203,085	$ 3,076,693	75%
Nutrition & Wellness	$ 9,279,006	$ 15,395,954	$ 6,116,948	66%
Self-Care and Safety	$ 368,961	$ 563,486	$ 194,525	53%
Total	$ 21,001,179	$ 33,238,464	$ 12,237,285	58%

Access

San Francisco provides a rich array of social services for seniors and adults with disabilities. However, these services are of little value if they are not accessible. Ensuring that services are accessible is a critical responsibility for DAAS. The Department has developed three main strategies to this aim:

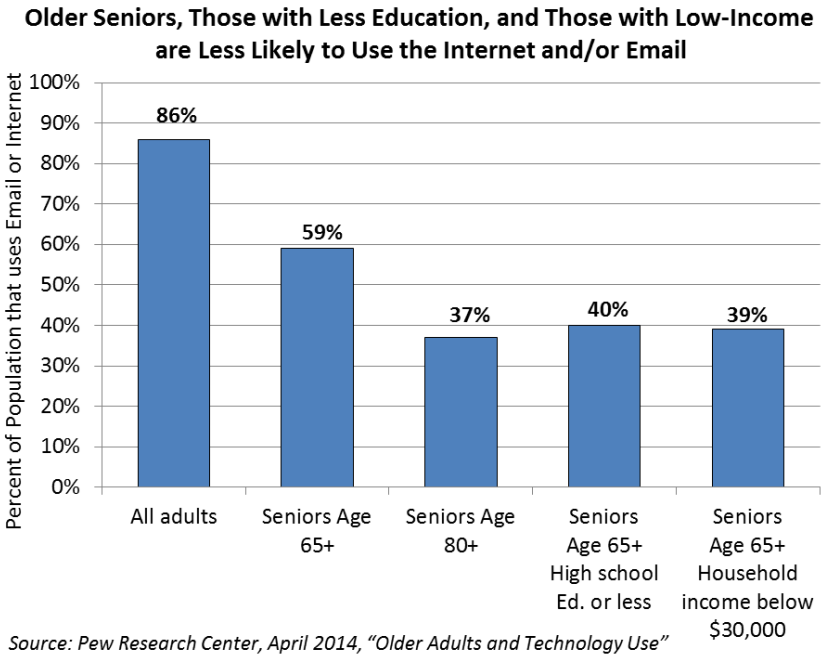
- Promote community awareness of services;
- Support clients to travel to receive services; and
- Provide advocacy and empowerment services to help clients access services to which they are entitled.

Additionally, services should be culturally and linguistically appropriate so that the diverse local population will feel comfortable making use of the supports available.

Access: Information, Awareness and Connection

San Francisco provides a multitude of services that support seniors and adults with disabilities to live safely in the community, leading engaged and fulfilling lives. DAAS provides more than 50 services through its own programs and via contracts with community providers. Most services are facilitated by the Office on Aging, contracting with over 50 agencies to provide services at over 100 sites throughout the city. Some services are not tied to a brick-and-mortar location but are provided at the client's residence, such as home-delivered meals. In addition to these DAAS-funded services, many other departments and community-based organizations offer relevant programming for these populations. With such a large and multifaceted service system, there is a significant risk that those in need of services may be unaware of the extent of the available services, confused by the array, and/or unsure of how to access these supports.

Today, many people turn to the internet for information. However, seniors and adults with disabilities are less likely to have access to computers and broadband technology. According to a 2014 survey by Pew Research Center, only 59% of seniors age 65 and older use the internet or email, and the rates dip significantly with age; among older seniors age 80 and over, only 37% use this technology. Low-income seniors and those with lower levels of education also have lower rates of access, closer to 40%. As technology becomes ubiquitous, it will be important to remember that more traditional methods of information sharing and access may still be the best option for reaching this population.



Source: Pew Research Center, April 2014, "Older Adults and Technology Use"

When asked how they find out about services, focus group participants tended to identify friends and family. This trend is consistent with a 2008 phone survey of San Francisco seniors and adults with disabilities (National Research Center, 2008). A common experience described by Chinese and Latino seniors was taking a parent to a senior center and then becoming a participant later in their own lives. A focus group with homeless seniors highlighted frustration with a complex social service system. Participants expressed dissatisfaction that there is not a single comprehensive source of information or guide to services for homeless persons; they tend to rely heavily on their peers to learn about services and how to get by without housing.

The 2015 City Survey asked seniors and adults with disabilities if they had accessed certain DAAS services and, if not, why. Of those who did not access services, most indicated it was because they did not need the service. However, of those who did not access meals or homecare services, the second most common reason – reported by eight percent of seniors and fourteen percent of adults with disabilities – was that they were not aware of the service. This percentage is relatively small but worth noting. In focus groups and a community forum for the Aging- and Disability-Friendly San Francisco project, participants vocalized the need for a universal information center specially focused on seniors and adults with disabilities, essentially describing the DAAS Integrated Intake and Referral Unit. These comments suggest a potential lack of awareness of this valuable resource.

DAAS Services related to Information and Awareness

- ***Information and Referral***
  FY 15-16 Service Target: 25,000 calls

The DAAS Integrated Intake and Referral Unit was established in 2008 to streamline access to social services and maximize service connections. Through a single call, seniors and adults with disabilities are able to learn about available services throughout the city and also apply for several DAAS services. In its role as the "central door" for DAAS services, the unit serves as the hotline for Adult Protective Service reports and completes intake applications for several services, including the Community Living Fund, In-Home Support Services (IHSS), transitional care for those discharging from the hospital, and home-delivered meals. The unit also manages the waitlist for the home-delivered meals program and serves as a clearinghouse for emergency meal requests; it will soon take on a similar function for the OOA case management program. Service is provided in multiple languages, including English, Cantonese, Mandarin, Spanish, and Tagalog.

- ***Aging and Disability Resource Centers (ADRC) [OOA]***
  FY 15-16 Service Target: 16,230 clients

The Aging and Disability Resource Center (ADRC) network provides one-stop shops for information and assistance (I&A) services for seniors and younger adults with disabilities. The current model consists of 12 hubs throughout the City that are staffed by I&A specialists and on-site supervisors. Two of the most popular services provided at these hubs are translation and assistance completing forms, including benefit applications. Housing is one of the most common topics that I&A specialists discuss with consumers.

❖ ***County Veterans Service Office (CVSO)***
FY 15-16 Service Target: 2,500 clients

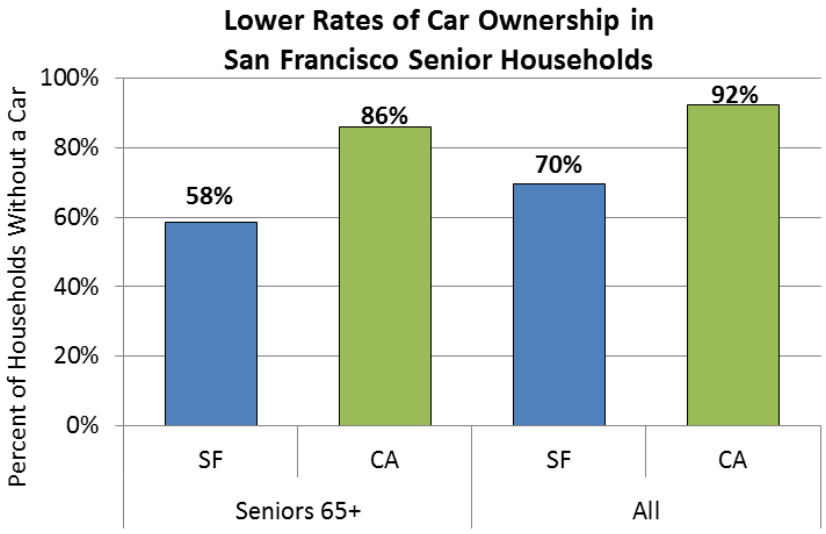
The County Veterans Service Office (CVSO) is a locally-funded service program that assists veterans and their families in accessing U.S. Department of Veterans Affairs benefits and entitlements, such as service-connected disability benefits and education benefits. CVSO staff are accredited Veterans Claims Representatives who represent these clients during the benefits claims process. The office provides outreach and services to homeless veterans and veterans with disabilities. In recent years, the CVSO has attempted to help clients utilize the VA's Fully Developed Claims (FDC) Program to more quickly access their benefits. Under this system, claimants who submit all relevant records with their claim and certify that they have no further evidence to submit can receive faster decisions on compensation, pension, and survivor benefit claims. Traditional, non-FDC claim typically take two or more years for determination.

❖ ***Services Connection Program***
FY 15-16 Service Target: 1,300 clients

The Services Connection Program aims to increase access to community-based services by seniors and adults with disabilities living in senior/disabled public housing. This program began as a pilot project with DAAS, the San Francisco Housing Authority, and a community-based organization in 2007 with a federal grant. Today, this service is funded entirely by with local San Francisco funds. Service coordinators perform outreach and provide direct social services, introducing residents to available services and benefits that can increase their functioning and socialization. In addition to service linkages, their work includes client assessments, case management, and advocacy on behalf of clients. They also organize activities and events to build community and foster engagement, combatting social isolation. This program has been integrated into the Rental Assistance Demonstration (RAD) project that is described in more detail below.

Access: Transportation

As adults age, they are less likely to drive. As shown to the right, senior-headed households are less likely to own cars. About 58% of San Francisco households headed by an adult age 65 or older have a vehicle compared to 73% of households headed by an adult under age 65. This trend makes an accessible and efficient public transportation system all the more important. Notably, all households in San Francisco are less likely to own cars than the statewide population.



Source: ACS 2013 5-Year Estimates

Perspectives on public transportation seem to vary significantly between seniors and adults with disabilities. Seniors tend to report positive experiences. In focus groups, they cited the reliability of Muni, its range of routes across the city, and respectful behavior from other riders and drivers (e.g., younger persons giving up seats for older adults). These opinions are mirrored in 2015 City Survey. Many focus group participants had enrolled in Free Muni, noting that every bit of savings is helpful for those living on a fixed income.

On the other hand, adults with disabilities under age 60 tend to have more negative views regarding public transportation. The primary issues appear to stem from a lack of respect and accommodation from drivers and fellow passengers. Focus group participants in wheelchairs described being passed by while waiting at bus stops; one participant had experienced this four times in the two weeks prior to the focus group. They also report difficulty moving through crowded busses or obtaining seats from non-disabled passengers. While drivers may try to help, passengers do not always listen. These concerns are evident in the 2015 City Survey; 41% of adults with disabilities age 18 to 59 rate Muni as "failing" or "poor" at managing crowds compared to 27% of seniors and 32% of non-disabled adults. Feedback regarding driver courtesy shows similar trends. While there was consensus in the focus group that Muni light rail tends to be more reliable and accommodating, this mode is not available citywide. These negative experiences with Muni may inhibit usage of public transit by this population, reducing quality of life and access to services.

An important component of public transportation for seniors and adults with disabilities is Paratransit, which is the door-to-door taxi and van service required by the Americans with Disabilities Act. A variety of Paratransit services are offered in San Francisco; the primary Paratransit services are listed below with FY 14-15 service levels.

Paratransit Service in FY 14-15		
Program	**Service**	**# Rides**
SF Access	Prescheduled door-to-door shared van	238,000
Taxi Services	Same day, general public taxis	260,000
Group Van*	Prescheduled, groups of individuals going to a single location (e.g., Adult Day Health Center)	245,000
Shop-a-Round	Taxi and van service to grocery stores	6,500
Van Gogh	Group van transportation to cultural & social events	1,311
*Program funded in part by DAAS		

Source: SFMTA Accessible Services. "Overview of SF Paratransit Programs." Presentation November 3, 2015. SFMTA Board of Directors Meeting.

While Paratransit is more accommodating for persons with disabilities, there are aspects of it that can limit its usefulness. Most services require advance planning and significant extra transit time, which can limit independence. Additionally, Paratransit rides cost $2.25 each way, which may be a barrier to frequent use. Senior focus group participants tended to have more positive views of the service than younger adults with disabilities. Part of the variation in experiences seemed to be related to frequency of use; younger adults with disabilities were more likely to describe relying on the service for regular use and having difficulty with the wide pick-up and drop-off windows.

In particular, the Group Van Paratransit service has experienced challenges in recent years. As Adult Day Health Center (ADHC) sites closed, many program participants were shifted to centers farther from their homes. As a result, ride times are longer, often exceeding the one hour time cap set by the state. This is exacerbated by increased traffic congestion. Because ADHC sites must adhere to strict operating hours, Paratransit services are unable to strategically stagger pick up and drop off times to reduce ride time. These clients tend to be frail, and the increased ride time has a significant impact on health and ability to attend the service. ADHC providers report that many clients have had to decrease days attending service or stop attending ADHCs entirely. MTA has shifted this service to a new contractor, which is reportedly doing a better job.

Recent Trends Related to Transportation

- **Free Muni for Seniors and Persons with Disabilities** – Following significant community advocacy, the San Francisco Municipal Transit Agency (MTA) created a program to provide free monthly Muni passes to low-income seniors and persons with disabilities beginning in January 2015. The program uses a self-reported income threshold of 100% Area Median Income to determine eligibility (100% AMI for a single household was $71,350 in 2015). The response from the community was significant and immediate; within two weeks, MTA had received 20,000 applications. As of January 2016, there are approximately 50,000 seniors age 65 and older and 12,800 adults with disabilities enrolled in the service. However, this program does not include Paratransit services, and the $2.25 cost per ride likely limits the use of this service by low-income persons with disabilities.
- **Peer Escort Pilot**. While many seniors and persons with disabilities ride Paratransit independently without problem, some clients would benefit from additional support, particularly given the challenges with the increased ride time. It can be difficult for Paratransit drivers to provide adequate support when transporting several high-need, at-risk clients in one trip. Community-based provider agencies and MTA have developed plans for a peer escort pilot in which volunteers will ride along with high risk clients to provide extra security and stability. While DAAS provided a small amount of seed funding in FY 15-16, this program will be grant-funded and managed by MTA.
- **Muni Bus Rapid Transit upgrades**. MTA has proposed a major upgrade on two of Muni's key bus routes: Van Ness Avenue between Lombard and Mission streets and the Geary corridor. Shifting from the traditional bus system to a Bus Rapid Transit (BRT) system, the new model will feature transit-only lanes, adjusted traffic signals to prioritize traffic and improve pedestrian safety, and enhanced boarding platforms. There will also be fewer stops. As highlighted by focus group participants from the affected parts of the city, this new system will likely have mixed consequences for seniors and adults with disabilities. More efficient service may reduce crowding and make it easier for some to use public transportation. However, fewer stops mean farther distances to walk, which may be difficult for older frail persons and those with mobility impairment.
- **MTA Information and Referral Center**. As part of its broader Mobility Management project, MTA plans to establish a transportation information and referral center with centralized information that will serve as a one-stop center for seniors and persons with disabilities. While still in the nascent stages of development, this is intended to include a telephone hotline staffed with multiple languages and provide personal trip-planning

conversations. MTA staff may also visit senior centers and community sites throughout the city to perform mobility assessments. This center has the potential to greatly lower barriers to accessing traditional transportation and Paratransit services.

- **New ride service models impacting taxi industry** – In FY 14-15, taxis performed 33% of all Paratransit trips, offering more flexibility and spontaneity than other Paratransit services. However, MTA reports that new transportation network companies, such as Uber and Lyft, are impacting the availability of this service. Taxi drivers are shifting to work in these new systems, and it is more difficult to recruit new drivers to the traditional system, particularly to operate the ramped taxis. Seniors are less likely to use these new app-based services; only 15% of senior respondents in the City Survey had tried one of these services compared to 50% of adults. MTA has developed a variety of strategies to mitigate the negative impact for Paratransit clients, including an extra payment incentive for wheelchair trips, recruiting experienced drivers for individual ramped taxi medallion leases, and integrating the Paratransit debit card into the existing taxi-hailing mobile app that also allows users to filter for ramped taxis. (SFMTA Accessible Services, 2015).

DAAS Services related to Transportation

❖ ***Paratransit Group Van***

FY 15-16 Service Targets for Group Van: 1,125 clients; 40,000 rides

OOA funds supplemental Paratransit services that are not required by the ADA. These services are intended to further support the ability of seniors and adults with disabilities to access social services but also travel to other necessary sites. Most of this funding is used to supplement the Paratransit Group Van program. OOA funding is primarily used to transport clients from their homes to OOA-funded Community Service sites. These rides are provided both by the MTA Paratransit vendor and Community Service providers.

DAAS also funds a small amount of a shopping shuttle service that transports clients between Community Service sites and grocery stores. Operated by the Community Service providers, this service is distinct from the Paratransit Shop-a-Round that is provided by the MTA Paratransit vendor. DAAS has funded approximately 7,000 rides per year for this service.

Access: Advocacy & Empowerment

San Francisco has changed rapidly in the last two decades, shaped by undercurrents of gentrification, immigration, housing, and economic crises. San Francisco's community of seniors and adults with disabilities is nestled within this larger context. To remain safely in the community, it is essential that they have access to the full range of available benefits and support resources. Because of specific barriers to service, many consumers require assistance with advocacy.

Consumer advocacy programs assist seniors and adults with disabilities to advocate for their rights and services either on an individual level or at the level of systems change. The direct service models of consumer advocacy are those that either: (a) strengthen consumers' ability to advocate on their own behalf to access services or defend rights; or (b) provide volunteer or professional staff to advocate on behalf of consumers. Systems advocacy efforts are coordinated

activities designed to influence specific planning processes, system changes, and/or legislation that will benefit seniors and adults with disabilities in key issue areas.

Due to the more specific nature of each of these advocacy areas, descriptions of need are grouped with details of service below.

DAAS Services related to Advocacy and Empowerment

❖ ***Legal Services [OOA]***

FY 15-16 Service Target: 1,874 clients

Legal services and intervention can be critical to maintaining or securing a better quality of life for seniors and adults living with disabilities. These populations may lack the resources to pay for legal support or be unsure of how to find a trustworthy legal advisor. OOA-funded legal services provide a variety of supports, including benefit appeals, eviction prevention, consumer fraud/issues, elder abuse prevention, will preparation, disability planning and advance directives, debt collection issues, and immigration matters. OOA contracts with several legal providers, including those with historic roots in minority communities, to ensure services are culturally and linguistically competent to promote the accessibility of these services.

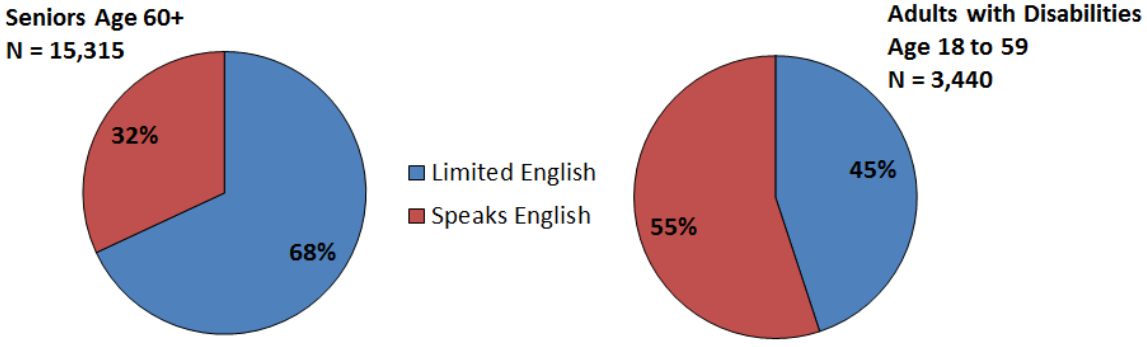
❖ ***Naturalization [OOA]***

FY 15-16 Service Target: 1,650 clients

Naturalization services support legal permanent residents in their preparation to qualify for U.S. citizenship. Services include English-as-a-Second Language (ESL) and citizenship classes, as well as personal assistance in preparing applications. By helping immigrant seniors and adults with disabilities become citizens, this service supports access to critical benefits. For example, non-citizens are unable to qualify for Supplemental Security Income (SSI) benefits, which places many immigrants in financial hardship. As with legal services, OOA contracts with a variety of providers that have demonstrated their ability to engage with the diverse local immigrant communities. Per the census population estimates, this service level will allow the program to serve approximately 10% of the non-citizen population.

According to the census, approximately nine percent of seniors age 60 and older and ten percent of adults reporting disabilities are not citizens. This equates to 15,315 seniors and 3,440 adults with disabilities. As shown below, these populations tend to have limited English proficiency. Most non-citizen seniors speak Chinese (6,540), Spanish (3,269), and Tagalog (1,330). The most common language among the adults with disabilities is Spanish (1,655). Navigating the complex immigration system is challenging for those proficient in English; those facing language barriers are especially likely to benefit from this service.

Non-Citizen Seniors and Adults with Disabilities Have High Rates of Limited English Proficiency

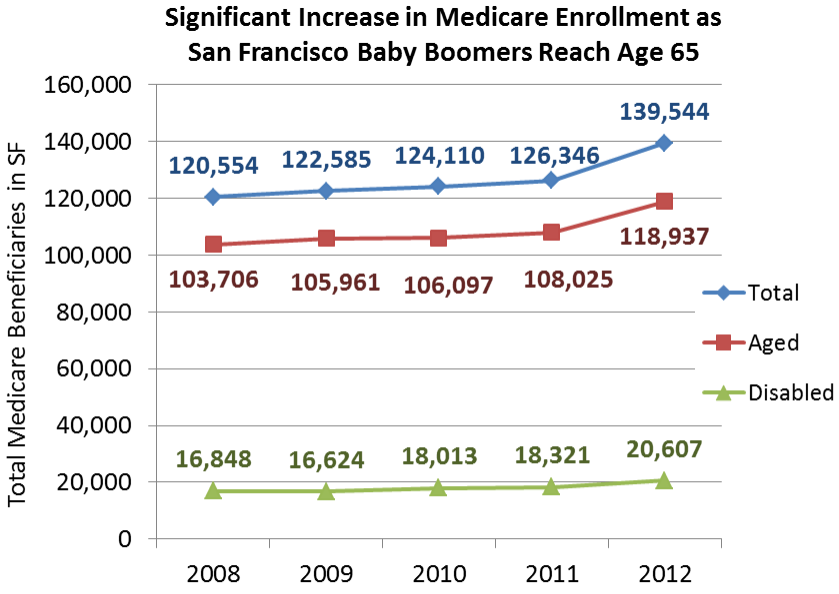


Source: IPUMS 2012 3-Year Samples

❖ ***Health Insurance Counseling and Advocacy Program (HICAP) [OOA]***
FY 15-16 Service Target: 1,674 clients

Many Medicare-eligible persons have difficulty navigating the Medicare system because of limited English proficiency, literacy, and issues related to poverty. The Health Insurance Counseling and Advocacy Program (HICAP) serves current Medicare beneficiaries and those planning for future health and long-term care needs. In addition to personal counseling and assistance filing health insurance claims, the contracted community provider also conducts community education and outreach. The counseling is confidential, free of charge and all efforts are made to maintain appropriate language capability.

Service utilization has remained steady over the last four years with approximately 1,600 to 1,700 clients served each year. These service levels tend to exceed the state-set benchmarks, which are closer to 1,300 consumers. The number of consumer contacts increased in several key areas between FY 13-14 and FY 14-15. In particular, contacts with low-income beneficiaries increased by 46% from the prior year, exceeding the CDA benchmark by approximately 4,700 contacts).



Source: Centers for Medicare & Medicaid Services, Medicare Aged and Disabled By State and County, 2008-2012

This service is likely to remain in demand as Baby Boomers become eligible for Medicare. As shown above, the growth is already noticeable. Between 2007 and 2012, San Francisco's Medicare-enrolled population increased by 16% to a total of almost 140,000 beneficiaries. Also visible is a slight but steady increase in the disabled population age 18 to 64 over the last four years.

❖ ***Empowerment [OOA]***
FY 15-16 Service Target: 200 clients

While advocates can – and do – perform valuable work on behalf of the senior and disability communities, San Francisco understands the great value in empowering consumers to self-advocate on both personal and community-level issues. Many seniors and adults with disabilities have the capacity and desire to be self-sufficient and to work proactively on behalf of their community. This service consists of two levels of empowerment education and training. Individual empowerment classes teach seniors and adults with disabilities how to gain access to community resources – such as transportation, housing, and health care – and how to advocate for themselves. Community empowerment classes teach individuals how to achieve systems-level change through the civic and political process using the tools of advocacy and volunteerism, training participants to be community organizers. Offered in multiple languages,

the program's curriculum includes sessions on community organizing, lobbying, meeting facilitation, public speaking, diversity, and leadership.

- ***Long-Term Care Rights Advocacy [OOA]***
  FY 15-16 Target Service: 250 clients

The changing landscape of home and community-based services can be confusing for consumers, caregivers, and providers alike. Recent years have shown significant fluctuations in the availability of a variety of home and community-based services. The IHSS program in particular has faced dramatic state cuts, only to have funding restored due to court interventions. The Medi-Cal expansion instituted new, less restrictive eligibility criteria for younger adults, expanding healthcare access to individuals who may have little experience with healthcare systems; however, these adults will face the more restrictive traditional Medi-Cal eligibility rules upon reaching age 65 and will have to confront difficult decisions and complex regulations to maintain access to healthcare services. Another issue is the significant loss of beds in skilled nursing and assisted living facilities over the last decade, reducing the options for frail persons staying in the community. While positive that seniors and adults with disabilities continue to reside in the community, these consumers will require a higher level of supportive services to live in the community safely. Without access to these services, they are likely to have a negative health event and/or may have to leave the city to find this care.

While there are a variety of information and referral services designed to support consumers in identifying available support (e.g., DAAS Integrated Intake, Aging and Disability Resource Centers, 211, 311), staff at those programs often do not have the experience or time to assist individuals who are experiencing access barriers. Legal services providers sometimes assist with a variety of program-related grievances, but many circumstances do not necessarily require the professional services of a lawyer and could be resolved more efficiently through consumer education and empowerment. Case managers often act as long term care consumer rights advocates, but many consumers do not require the care planning and social work component of those services. Long term care consumer rights advocacy services are intended to educate individual and targeted groups of consumers about the basic rights guaranteed in the various long term care services in San Francisco, and to provide individual assistance in navigating dispute resolution, hearings, and other grievances as needed, thus filling a niche left fairly vacant by those other services.

In addition to providing direct assistance to individuals and educating consumer groups, long term care consumer rights advocacy services are also intended to provide trainings to agencies and develop outreach materials in order to educate providers about consumers' rights and the relevant processes. This service is also intended to include strategic thinking about large-scale advocacy and tracking of issues related to long-term care for report to the Long-Term Care Coordinating Council.

- ***Homecare Advocacy [OOA]***
  FY 15-16 Service Target: N/A

Homecare advocacy is not a direct service provided to clients but instead consists of efforts to promote a seamless and responsive system to best serve seniors and adults with disabilities. For many seniors and adults with disabilities, homecare is a critical service to safely live in the

community. By far the largest homecare program in the city, the In-Home Supportive Services (IHSS) program has consistently been subject to programmatic changes that can cause significant confusion and upheaval for the participants. In San Francisco, many agencies are involved in the provision of IHSS, heightening the need for coordination and communication to provide service with minimal disruption for consumers. For over twenty years the IHSS Task Force has served as a place for stakeholders to plan, problem-solve, and coordinate local and state advocacy. The Office on the Aging's Home Care Advocacy funding supports the group. Examples of significant issues addressed by the Task Force in recent years include: (1) hospital discharge and transitional care issues related to IHSS; (2) access gaps for consumers whose income or assets are higher than the standard SSI rate; and (3) coordination of responses to state policy changes or proposed state budget cuts.

Note: OOA also funds housing advocacy (and counseling). This program is categorized in the Housing Services section of this report.

Recent Trends related to Advocacy

- **San Francisco Pathways to Citizenship Initiative –** This three-year public-private partnership between the City's Office of Civic Engagement & Immigrant Affairs (OCEIA), philanthropic organizations, and community-based naturalization service providers is focused on enhancing services that promote citizenship and civic participation among San Francisco residents who are eligible for citizenship. This partnership includes several of the OOA-funded legal and naturalization services providers. This initiative has supported collaborative relationships between these providers and strengthened the city's support system for persons working to become citizens.

Access: Training

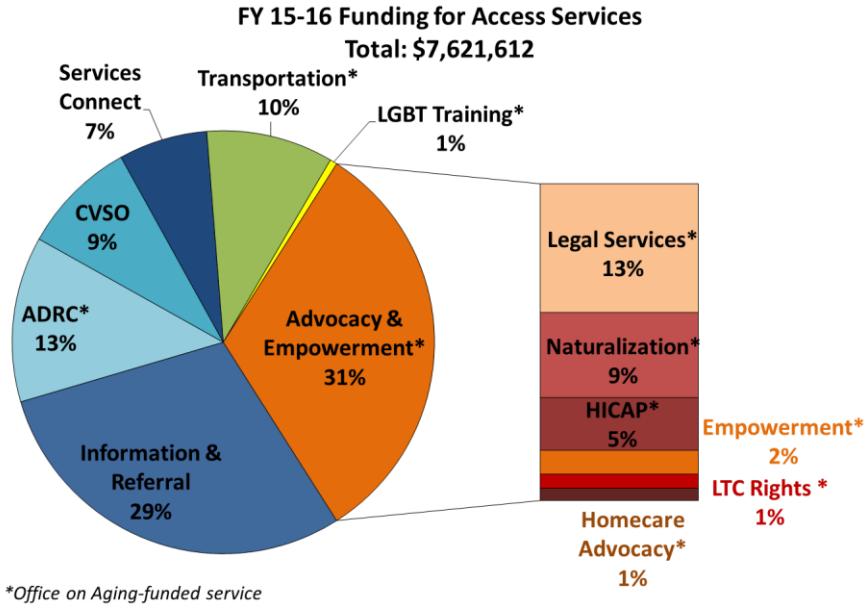
An important facet of accessible services is that they are equipped to serve the diverse local population. Seniors and persons with disabilities are unlikely to access services that do not make them feel comfortable and welcome.

❖ ***LGBT Training [OOA]***
FY 15-16 Service Target: 15 trainings, at least 150 participants

For seven years, OOA has funded a training program focused on educating service providers about how to create a welcoming culture for LGBT clients. As described in the first report of this assessment, the lesbian, gay, bisexual and transgender (LGBT) seniors are likely to hold back from accessing needed services due to concerns about stigma (Friedrikson-Goldenson et al, 2013). This training raises awareness of unique health and aging-related issues faced by LGBT seniors and adults with disabilities, reveals barriers that hinder service provision to this population, and demonstrates options to overcome these barriers. The overarching goal of this service is to improve functional independence and quality of life for LGBT elders and adults with disabilities who have been unable to access available services in San Francisco. *Note: Please see the section on Services to Prevent Isolation for information about a new training program that will specific target isolation issues for LGBT persons with dementia.*

Overview of DAAS Funding related to Access

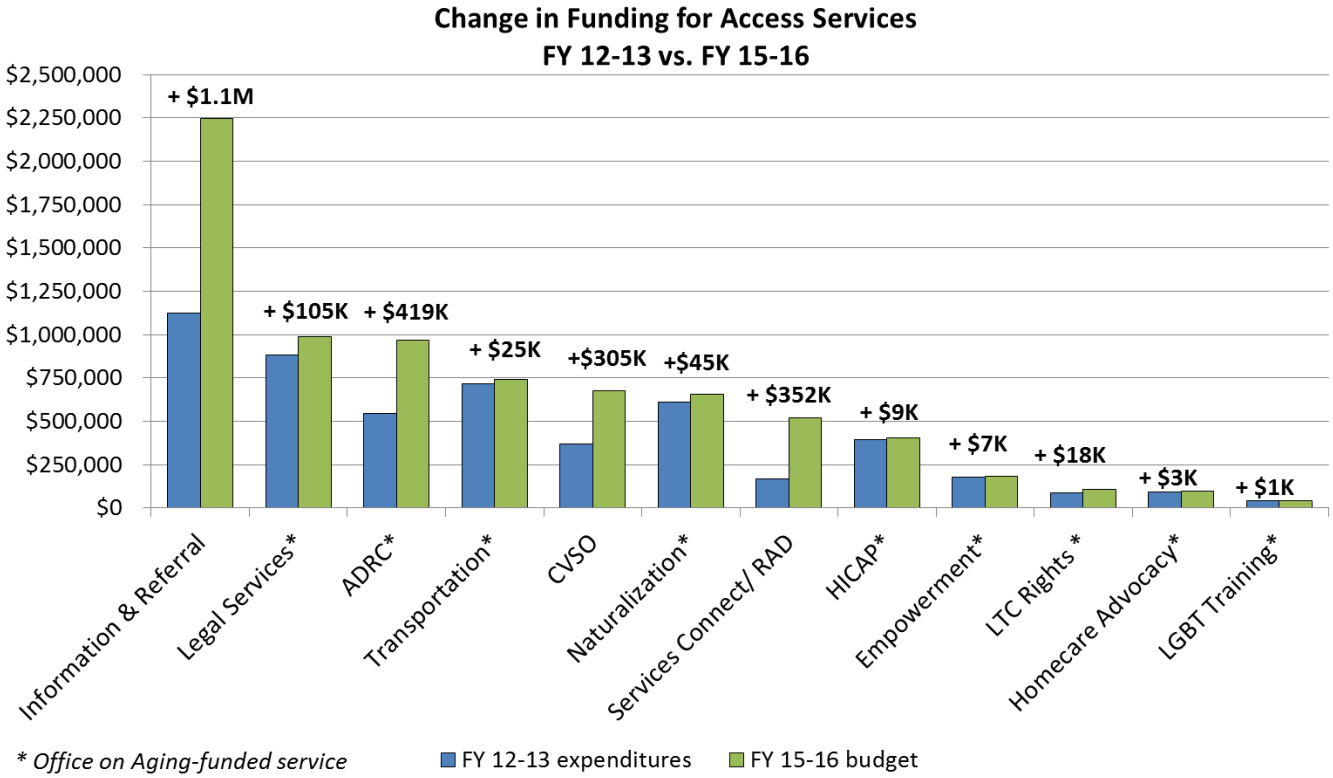
The DAAS budget for Access services in FY 15-16 is $7,621,612. As shown to the right, most of the Access funding goes to services supporting Information, Awareness, and Connection (in shades of blue). The largest single service is the DAAS Integrated Intake and Referral Unit, which accounts for 29% of the budget. Advocacy and Empowerment services (shaded in orange/red) receive almost one-third of the budget. Transportation constitutes 10% of Access services.



*Office on Aging-funded service

Changes in DAAS Programing related to Access

The FY 15-16 budget for Access services represents a $2,412,901 (46%) increase over FY 12-13 expenditures. All programs experienced an increase in funding. As shown below, the change was driven primarily by the growth of the DAAS Integrated Intake and Referral Unit, which accounts for slightly less than half the overall increase. Community-based programs, including the ADRC network and Services Connect program account for almost one third of this increase.



The programmatic changes responsible for the bulk of the funding changes include:

- **Expansion of DAAS Integrated Intake & Referral Unit** – Since FY 12-13, the unit has increased staffing from 13 FTE to 19.2 FTE to maintain its ability to efficiently respond to incoming calls, particularly as the unit has assumed responsibilities for additional program intakes. The funding increase also reflects increased wage and benefit costs.
- **Increased CVSO staffing** – In recent years, the CVSO has had limited ability to conduct outreach while still meeting service needs at the main office. In FY 15-16, the office added two new Veterans Claims Representative positions and a front desk clerk to engage drop-in visitors. These positions will allow CVSO to expand its outreach efforts and provide service at satellite locations, such as the VA Medical Center. The FY 15-16 budget of $673,555 represents an 83% increase from FY 12-13 funding level.
- **Reconfiguration of the ADRC network and increased staffing levels –** Advocacy by the Coalition of Agencies Serving the Elderly (CASE) resulted in addback funding that has significantly increased the budget for this program. The current FY 15-16 budget of $965,185 budget is a 77% increase over the FY 12-13 funding level. With this addback funding, DAAS has increased each I&A specialist position to be increased from a 0.8FTE to a 1.0 FTE to fully staff each ADRC hub. This funding also allowed for the addition of 1.5 FTE to supplement services at the most visited ADRCs. The ADRC network is expected to serve 16,000 in FY 15-16, service levels in prior years were closer to 11,000.

  The model for this service significantly changed in FY 14-15. Previously, this program was provided by a single agency that visited over 15 service sites for a handful of set hours per week. This system proved too inconsistent for clients to make regular use of the service, and DAAS updated the model to fund I&A specialists at nine community service sites. The new network has been more successful at attracting a wide variety of clients.
- **Inclusion of the Services Connect program in Rental Assistance Demonstration (RAD)** – Funding for the Services Connect program has increased due to the Rental Assistance Demonstration (RAD) Project. Intended to improve service for public housing residents, RAD relies on community-based service providers to provide onsite information and access assistance in over 20 public housing sites formerly managed by the San Francisco Housing Authority (see the Housing Services section for more detail). This is a significant expansion of a program that began in 2008 with federal grant funding and was continued with a lower level of local money when the grant expired in 2010.

Other notable changes to DAAS program operations in this area include:

- **DAAS Benefits and Resource Hub** – In FY 15-16, DAAS opened a one-stop client service center for seniors and persons with disabilities at 2 Gough Street. Services moved to this site include the DAAS Integrated Intake and Referral Unit, DAAS eligibility workers, and the CVSO. The DAAS eligibility workers currently focus on IHSS-enrolled Medi-Cal clients and applicants, but they will expand to serve additional subsets of the senior and disabled adult Medi-Cal caseload in the near future. Staff will also provide counseling to Medi-Cal clients at risk of becoming ineligible for coverage when they reach age 65 and are held to the stricter traditional Medi-Cal eligibility criteria.[3] This

[3] Under Medicaid expansion, adults age 18 to 64 can have income up to 138% FPL, and there is no asset limit. Seniors age 65 and older are held to the traditional eligibility criteria of 100% FPL and asset limits (e.g., $2,000 for a single individual). About 1,400 IHSS clients turn 65 each year.

brick-and-mortar site will increase the visibility of DAAS services and support new service connections across the full spectrum of the Human Services Agency.

- **Centralization of OOA Case Management Intake and Waitlist –** In July 2016, the DAAS Integrated Intake and Referral Unit will assume responsibility for OOA-funded community-based case management intakes and maintenance of a centralized waitlist for the service. Under the current system, clients must call around to 13 provider agencies to find service. Creating a centralized intake and waitlist process will make this service much more accessible, particularly given that this is a service for individuals struggling to make service connections on their own. The unit will also immediately begin connecting people with other services for which it manages intakes, such as IHSS, so that clients can more quickly access certain benefits.
- **DAAS Staff Training** – In FY 15-16, DAAS launched an internal training program to help staff develop their knowledge of important topics related to seniors and persons with disabilities and remain current on best practices. Consisting of core classes required for all staff and additional enhanced trainings focused in specialized topic areas, this curriculum is intended to ensure clients receive effective and accessible service. This training may be offered to community-based service providers in the future.

Suggestions for DAAS Consideration

- **Awareness of the DAAS Integrated Intake Unit** – As mentioned, the DAAS Integrated Intake and Referral Unit manages a high, steady volume of calls. The unit completed over 18,200 intakes and provided information and referral to at least 11,475 seniors and 1,535 adults with disabilities in FY 14-15.[4] However, this assessment process identified that some seniors and adults with disabilities are unaware of this service. While the opening of the DAAS Benefits and Resource Hub is expected to increase awareness of the unit's service, DAAS should consider a publicity campaign to spread awareness of the service, including new strategies to reach unserved populations.
- **Support transportation services**– OOA-funded Transportation services provide rides to some Community Service sites but not all. OOA may want to consider how this service may be expanded or otherwise utilized to include currently unserved sites. After years of understaffing, OOA has more capacity to provide technical assistance to these vendors and evaluate the efficacy of this program. This issue came up during a focus group with participants at the Mission Neighborhood Center. Some participants were aware that other Community Service sites have Group Van service, and they expressed concern that they would no longer be able to attend their activities when they became older and frailer.
- **Develop system to track need for legal services***:* Legal service providers have recently provided feedback to DAAS that at their current funding levels they feel unable to meet the demand for their services. They report having to triage a significant number of potential clients, providing less intensive service in order to support more people. For example, a complex legal issue that they would like to open as a case may instead get handled as a briefer referral session. However, it is difficult to estimate the exact number of clients that go unserved or may be underserved. It may behoove OOA and the legal service providers to develop a system to track these issues.

[4] Because all callers do not provide personal information, a unique client count is not available.

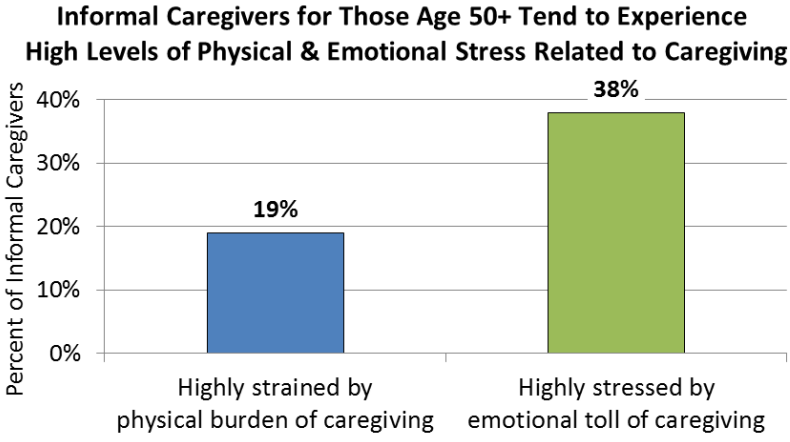
Caregiver Support

Estimating the size of the caregiver population in San Francisco is difficult. As outlined in the first report of this assessment, the city has almost 52,000 seniors age 60 and older reporting disabilities and 18,000 who report self-care difficulty. Of the 35,145 younger adults with disabilities, 6,020 report difficulty with self-care. There are estimated to be approximately 20,000 to 22,500 persons with Alzheimer's living in San Francisco (Alzheimer's Association, 2009; Alzheimer's/Dementia Expert Panel, 2009). However, it is unclear how many receive assistance from informal caregivers.

National and state-level statistics provide some insight into caregiver burden but should not be interpreted as definitive representations of local trends given the unique demographics of San Francisco. The National Alliance for Caregiving's 2015 telephone survey results suggest that 34.2 million adults or 14.2% of all adults provide care to a person age 50 or older. Extrapolating this prevalence level to the San Francisco adult population suggests that about 100,500 persons have provided care to a loved one.

Caregiving can be a rewarding and positive experience, but it can also be characterized by emotional, physical, and financial strain (Scharlach et al., 2003; Schulz & Beach, 1999). Nationwide, almost half of all caregivers are over age 50, putting them at higher risk for a decline in their own health, and one-third of these caregivers describe their own health as fair to poor (Administration on Aging, 2015). Approximately 20% of care recipients live in their caregiver's home, offering little chance of respite for the caregiver (National Alliance for Caregiving and AARP, 2015).

Caregivers active in the workforce tend to suffer work-related difficulties due to their dual roles. Almost 70% report making work accommodations because of caregiving, such as cutting back hours and changing jobs (Feinberg et al, 2011). On average, caregivers aged 50 and older who leave the workforce to care for a parent lose over $300,000 in lifetime income and benefits (MetLife Mature Market Institute, 2011). Many men provide care, but the majority of caregivers are women (National Alliance for Caregiving and AARP, 2015). Assuming the role of caregiver can significantly increase women's risk of living in poverty and relying on public assistance in late life (Wakabayashi, C., & Donato, K., 2006). However, despite these burdens, caregiving is also often associated with positive feelings. A study of end-of-life caregivers found that over two-thirds identified personal rewards associated with their helping role (Wolff et al, 2007).



Source: National Alliance for Caregiving and AARP (2015), Caregiving in the U.S., A Focused Look at Those Caring for Someone Age 50 or Older

The National Alliance for Caregiving's survey found that 19% of caregivers are "highly strained" by the physical burden of caregiving, and 38% are "highly stressed" by the emotional toll of caregiving. *Applying these rates to the estimated 100,500 caregivers in San Francisco yields an estimate of at least 19,000-38,000 caregivers with significant need for caregiver support.*

Caring for a person with dementia or Alzheimer's disease is particularly stressful and is associated with negative outcomes that include depression, sleep problems, physical health problems, and mortality (Schulz et al, 1995). Caregivers for those with dementia are more likely to visit the emergency department or be hospitalized if they are depressed or taking care of persons with high care needs (Schubert et al, 2008). The close relationship between caregiver and care recipient is full of shared emotions, experiences, and memories, which can place these caregivers at higher risk for psychological and physical illness as they witness their loved one suffer (Monin & Schulz, 2009).

The complex nature of the role was evident in a focus group with caregivers, who described their work as a labor of love but noted it was not without daunting challenges. In particular, they discussed the burden of serving as the sole caregiver, especially within the context of complex family dynamics. Acknowledging that not everyone has the mental capacity to serve as a caregiver, they struggled between a desire for more help from family members and a concern that others would not provide care correctly. They expressed appreciation for services like Adult Day Health Centers (ADHC) that give them a respite while providing their care recipient the opportunity to socialize. They said they enjoyed being in the focus group and talking with other caregivers who understood their experience – the caregiver experience can be very isolating.

> *"We caregivers need something to keep us together, to keep us united and bonded... we do this work out of love."*
> - *Focus group participant caring for a friend*

Caregiver burden and the increasing reliance on family and other sources of support for caregiving has prompted some to advocate for caregiving to be framed as a public health issue (Talley & Crews, 2007). As advancements in medicine have extended the average lifespan, people are most likely to die of complications from a chronic health condition, requiring high levels of support during the final years of life. Pressures on the hospital system, including shortages of nurses and healthcare workers and increasing costs, have resulted in patients being discharged more quickly from the hospital. Another factor increasing the reliance on informal caregiving is the shift towards community living instead of institutional care; with a decrease in assisted living and skilled nursing beds in San Francisco, there are more frail persons with high care needs living in the community.

Research suggests that there is variation in the caregiving experience by ethnicity. Minority caregivers tend to provide more care and are more likely to report poor physical health and depression than white caregivers (Pinquart & Sorenson, 2005). The type and source of support that caregivers receive varies by race and ethnicity (Chow et al, 2010). API caregivers are most likely to only receive help from informal sources, while white caregivers were most likely to access help only from formal sources of support. African-American caregivers were most likely to rely on a mix of formal and informal support. These findings underscore the importance of providing linguistically and culturally appropriate support outreach strategies and programming so that all caregivers are aware of available resources and feel comfortable accessing these services.

The capacity to care for one another is a notable strength of the LGBT community. Research suggests 21% of LGBT older adults receive informal care from a loved one and 26% provide

informal care (Fredriksen-Goldsen et al, 2013b). A recent survey of LGBT San Francisco seniors age 60 and older found that 10% overall need caregiver support, but need is much higher among those who are transgender (42%) and bisexual (30%) (Fredriksen-Goldsen et al, 2013a). Despite this need, caregivers may hesitate to seek support for fear of discrimination for being LGBT or concern that their care recipient may be mistreated (Family Caregiver Alliance, n.d.).

A note on "informal" caregivers: Much of caregiver advocacy is focused on informal or unpaid caregiving. A driving purpose of this distinction seems to be the desire to distinguish between those hired in a professional capacity and those who are family or friends supporting a person with whom they have a preexisting relationship. This approach risks excluding a critical component of the local caregiver population: those providing care to a family member enrolled in In-Home Support Services (IHSS). There are approximately 12,000 family caregivers serving as independent providers for IHSS clients. While these caregivers receive payment for this service, many provide several additional hours of *unpaid* care per week due to program regulations limiting hours.[5] Two participants in the caregiver focus group provided 24-hour care to family members but receive payment for less than10 hours per day. Each of the focus group participants discussed many of the issues that supportive services for caregivers are designed to address, including feelings of burnout, the need for respite, and the desire for support groups with other caregivers.

> *"People say 'You get paid.' Well, no. I get paid for 9 hours a day, but she needs care for 24 hours a day."*
> - *Focus group participant serving as an IHSS provider for a family member with Alzheimer's disease*

These providers also observed that they have willingly made many sacrifices to care for a loved one but receive relatively little recompense for their efforts; there is a sense that "the system" relies on their willingness to make these sacrifices for their care recipients. Some had given up fulltime positions with benefits to step in and support an ill family member. They expressed a desire for more supportive benefits in their IHSS provider role, highlighting the need for paid time off and a pension system. These types of benefits would significantly reduce their high stress levels by meeting their immediate need for respite and reducing concerns about their long-term economic security.

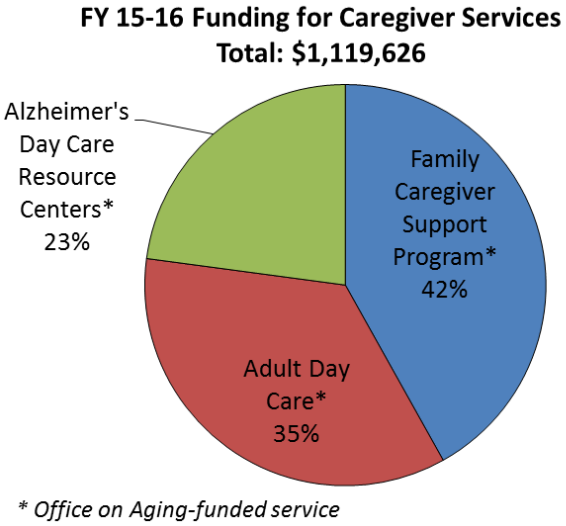
Recent Trends Impacting Caregiver Services

- **Decrease in formal long-term care services for persons with high care needs**. Many ADHC sites in San Francisco have closed, driven by the program's conversion to the current Community-Based Adult Services (CBAS) model and low reimbursement rates from Medi-Cal. Similarly, over the last ten years, the number of skilled nursing beds in hospital and free-standing facilities has decreased by 22% (OSPHD, 2003; OSPH, 2013). As the capacity of these systems has decreased, clients with high care needs have had to increasingly rely on friends and family members to provide care. In addition to likely increasing the number of informal caregivers throughout the city, these changes have also increased the burden experienced by those providing care.

[5] IHSS caps hours at 283 per month, which equates to 67 hours per week or 9.6 hours per day. Those with an able-bodied spouse may receive less hours if their spouse is able to perform certain activities.

DAAS Programming for Caregiver Support Services

The total budget for Caregiver Support services in FY 15-16 is $1,119,626. This represents approximately 0.2% of the total DAAS budget (2% of the budget when IHSS is excluded). As shown to the right, there are three funded services in this category. Each program receives a significant portion of funding for this service category. These services are discussed in more detail below:



❖ ***Family Caregiver Support Program [OOA]***
FY 15-16 Service Target: 500 clients

The Family Caregiver Support Program (FCSP) receives the most funding (41%). This program focuses on two caregiver populations: family caregivers and seniors providing kinship care.

The majority of FCSP funding is used for informal caregivers who support older adults age 60 and older and those supporting younger adults with a diagnosis of Alzheimer's disease. These eligibility criteria are set by the federal government. These types of services provided by this program are listed below:

Family Caregiver Service Program – Services	
Service	**Description**
Information Services	Creation and dissemination of informational materials, as well as outreach and education activities, about caregiving and available resources for caregivers.
Access Assistance	Outreach activities, provision of information and assistance to caregivers, and provision of interpretation/translation services to help caregivers support their care recipients and access resources for themselves.
Support Services	More intensive direct service activities provided to caregivers, including assessment of caregiver capacity and support needs, counseling (including peer counseling), caregiver support groups, caregiver training, and case management for those experiencing a diminished capacity to provide care.
Respite Care	Provide a brief period of relief or rest from caregiving responsibilities and are provided on a short-term basis based on caregiver needs and preferences. This respite may be intermittent (e.g., a few hours once a week to give the caregiver a small break), occasional (e.g., time off to attend a special event), or emergency (e.g., extended break to address intervening circumstance).
Supplemental Services	Assistance to caregivers that enables their ability to provide care. Examples of these services include legal assistance to resolve issues related to caregiving responsibilities or connection with a caregiver registry for those wanting to purchase caregiving services.

DAAS also funds a small amount of services that support older adults providing kinship care and serving as the primary caregiver to a younger relative. The main components of this service are information and a small amount of respite. This program serves 30 caregivers per year.

❖ ***Adult Day Care [OOA]***

FY 15-16 Service Target: 135 clients

Approximately 36% of Caregiver Support services funding goes to Adult Day Care (ADC). This community-based program provides non-medical care to persons 18 years of age or older in need of personal care services, supervision or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis. These facilities are licensed by the California Department of Social Services/Community Care Licensing. ADCs provide a variety of social, psychological and related support services to promote quality of life for program participants. Most clients enrolled in this service pay out-of-pocket to attend a certain number of days per week. OOA funding is used to support sliding scale slots at four ADC sites around the city that serve a diverse client population.

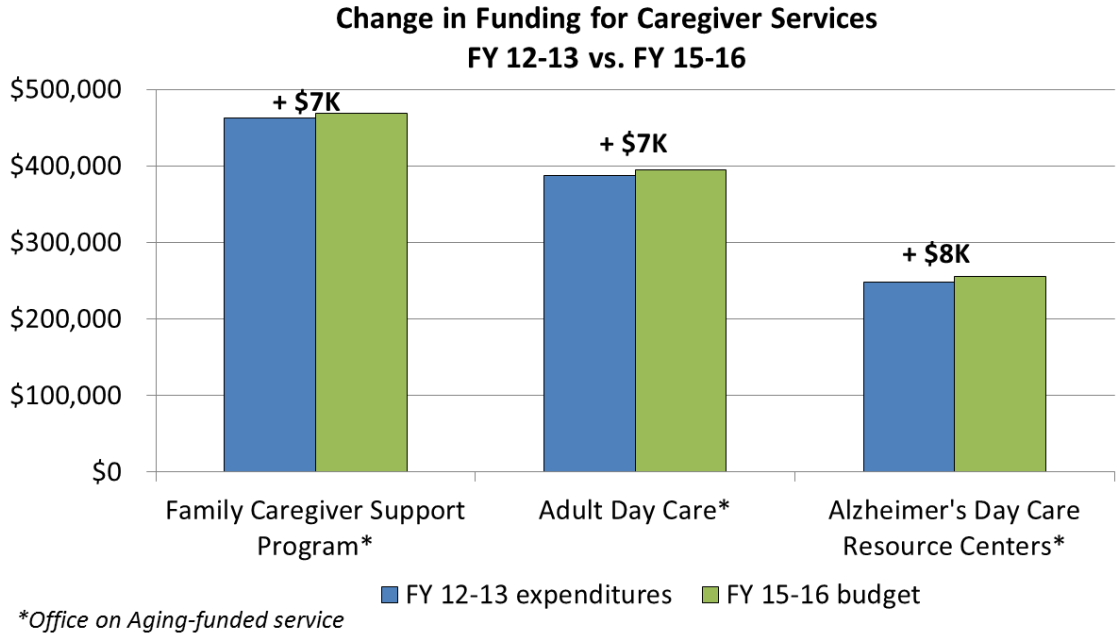
❖ ***Alzheimer's Day Care Resource Centers [OOA]***

FY 15-16 Service Target: 115 clients

Twenty-three percent of funding for Caregiver Support services goes to Alzheimer's Day Care Resource Centers (ADCRC). These are community-based sites that serve persons with Alzheimer's disease or dementia and, in particular, those in the moderate to severe stages whose care needs and behavioral problems make it difficult for them to participate in other day care programs. These ADRCs operate within the framework of a licensed Adult Day Health Care Center or Adult Day Care Center. The primary goals of this service are to assist individuals with Alzheimer's and related dementia to function at the highest possible level; and to provide respite care for families and caregivers. These facilities also to assist caregivers by providing information, counseling, and care planning and establishing or assisting with support groups. Like ADC, this is a private pay service, and OOA funding subsidizes a sliding scale system.

Changes in DAAS Programing related to Caregiver Support

As shown below, funding for this service category has remained relatively static over the last four year, with nominal increases. Overall, the budget for this service category has increased by about $22,000 (2%). Service levels have remained generally consistent.



**Office on Aging-funded service*

Case Management & Transitional Care

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

The people most at risk of not having full access to needed services are **those who live alone or have tenuous social networks**. As described in the first report of this assessment, 46,964 seniors and 8,907 adults reporting disabilities (55,871 total) live alone. Sixty-five percent of this group – 36,177 individuals – has income below 300% FPL. As the senior population has grown, so has the number of older persons living alone. There are approximately 7,000 more seniors age 60 and older living alone today than there were in 2000.

Immigrants and persons who do not speak English also face additional barriers to accessing services, both because linguistically and culturally relevant services may be less available and due to fears about utilizing public services. Almost 53,000 seniors and adults reporting disabilities have limited English proficiency. Seventy percent – 36,883 individuals – have family income below 300% FPL. Sixteen percent – 8,315 individuals – are living alone.

Younger adults with disabilities also face difficulty accessing services. Many services are housed within senior-focused agencies, and it may be unclear to the younger disabled adult population which services are also available to them. Persons who have become disabled midlife may be unfamiliar with the social services available or how to access them. As described in the first report of this assessment, the most common type of disability among adults aged 18 to 59 is cognitive difficulty. Fifty percent of the disabled adult population – 17,418 individuals – reports this type of difficulty, which may include a variety of conditions (e.g., mental health diagnosis, traumatic brain injury, etc). These individuals may hesitate to access services due to stigma or have difficulty navigating care systems.

Many people are stable in everyday life and generally able to meet their needs but require support during certain events, particularly **hospitalized persons transitioning home**. Older adults with multiple chronic conditions and complex treatment regimens are particularly at risk during this time. They typically receive care from multiple providers, move frequently within health care settings, and are particularly vulnerable to breakdowns in care (Naylor & Keating, 2008). Medicare data suggests one in five patients is readmitted to the hospital within 30 days of discharge (Health Affairs, 2013). As highlighted in a forthcoming report on the local San Francisco Transitional Care Program, local analysis found that individuals at high risk for readmission had two or more of the following criteria:

- Emotional and/or cognitive impairment;
- Two or more readmissions within the prior six months;
- Lack of support, lives alone or is a caregiver for someone else;

- Taking 8 or more medications;
- Multiple co-morbidities (3+) and/or chronic illness;
- Needs assistance with 2 or more Activities of Daily Living; and/or
- Demonstrated need for services/resources that will serve to avoid re-hospitalization.

Case Management
There are a variety of case management programs in San Francisco. The type of case management that is most appropriate depends on the consumer's level of independence and the acuity of their circumstances. Services range from short-term and/or intermittent support for consumers capable of managing most needs on their own to longer-term support and supervision for those whose needs are complex. Individuals who are unstable due to multiple diagnoses, homelessness, and/or substance use often require the most intensive case management services and benefit from providers with specialized training.

Many case management programs serve specialized subsets of the senior and disabled adult population with distinct needs. Below is a partial list of these types of concentrations:

- *Behavioral health needs* – Persons with mental health and substance use challenges have multifaceted needs. Often, major aspects of life have become negatively affected by their behavioral health conditions. Case management is a key service modality within the programs provided through the San Francisco Department of Public Health (SFDPH) Community and Behavioral Health Division. A key component of this service is linking clients to services and supports that have been detrimentally affected, such as housing, income assistance, and physical health care.
- *High-use healthcare users* – Seniors and persons with disabilities who are high users of healthcare systems can benefit from additional care coordination and support. Through SFDPH, San Francisco residents with five or more visits to the emergency department at Zuckerberg San Francisco General Hospital are referred to case managers who assist patients in arranging housing, financial assistance, physical and mental health care, substance abuse referrals, and other needed social services. SFDPH also provides primary care-based complex care management targeted at patients with three or more hospitalizations per year. This is an interdisciplinary care team model with a Registered Nurse backed by a medical doctor and social worker.
- *Persons living in supportive housing* – Many low-income seniors and adults with disabilities live in supportive housing developments, benefiting from low-cost housing and on-site support. Much of this housing is funded by SFDPH and the Human Service Agency's Department of Human Services. More recently, the Rental Assistance Demonstration (RAD) Project has expanded on-site services to public housing developments. At these sites, social services staff helps connect residents with needed services and may provide some care coordination. They also help to broker payment plans for residents who fall behind in rent payments, helping residents avoid eviction.
- *Persons at risk of long-term care institutional placement* – Many seniors and adults with disabilities who are frail and/or experiencing high levels of functional impairment prefer to remain in the community rather than residing in institutional long-term care facilities. These individuals benefit from case management to arrange needed supports and services to live safely in the community. The California Department of Aging directly funds the Multipurpose Senior Service Program (MSSP) for frail adults aged 65 and older who are

certifiable for placement in a nursing facility but wish to remain in the community. The goal of the program is to coordinate and monitor the use of community-based services to prevent or delay premature institutional placement. The services must be provided at a cost lower than that for nursing facility care. The DAAS-administered Community Living Fund (CLF) also targets this population, historically focusing on patients leaving Laguna Honda Hospital and Rehabilitation Center (LHH). This program is described in more detail later in this section.

- *Adults with developmental disabilities* – Adults with developmental disabilities receiving services from the Golden Gate Regional Center are assigned an on-going case manager who is focused on helping individuals and families make and implement informed decisions about their specific needs and unique preferences. This population may also access health-related case management through the Center for Health and Wellness at the Arc San Francisco; this program was initially developed when the Arc noticed its older clients having trouble aging safely in place and managing health conditions developed later in life.

Transitional Care

Transitional care services support patients transferring between systems of care. DAAS has long supported transitional care programs to facilitate smooth transitions for seniors and persons with disabilities returning home after a period of hospitalization.

In 2012, DAAS applied to participate in the Affordable Care Act's Community Care Transitions Program, designed to increase collaboration between community- and hospital-based providers in order to improve transitions of care across settings, reduce avoidable hospital readmissions, and generate cost savings. DAAS was awarded a contract for December 2012 through May 2015, leading to the creation of the San Francisco Transitional Care Program (SFTCP). Integrating components of existing transitional care services, this program was a hybrid coaching and/or care coordination model with tangible service packages targeted for Medicare fee-for-service clients. A key component was transition specialists assisting patients to understand their hospital discharge plan and medication regiment, secure services to support recovery in the community, and ensure attendance at first primary care appointment. The intervention was designed to last up to six weeks and was provided in eight of San Francisco's ten hospitals.

When the demonstration concluded in May 2015, SFTCP had served 5,154 clients (San Francisco Department of Aging & Adult Services, 2016). Evaluation of client records indicates the most commonly needed services include: transitional specialist support (86%); counseling and support (68%); assistance communicating with family and caregivers (66%); and medication review (64%). **The average readmission rate for SFTCP clients was 7.4% compared to a Medicare average of 19.5%, demonstrating that this type of care can effectively reduce readmission rates**.

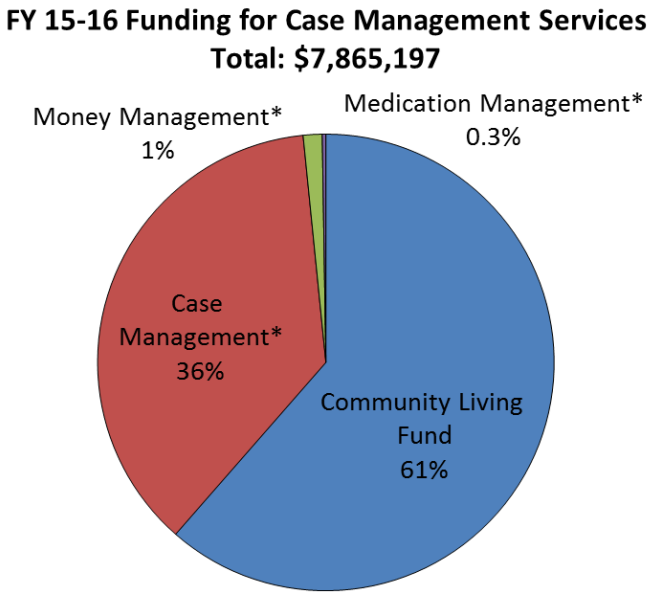
Unfortunately, this program has not been active since the demonstration project ended in May 2015. DAAS has replicated the program on a smaller scale targeted at IHSS applicants, serving a subset of those who likely need this type of support (the IHSS Care Transitions Program is described in more detail later in this section). Hospitals provide transitional care support on their own, but the model and extent of service varies.

Recent Trends related to Case Management & Transitional Care

- **Suspension of Diversion and Community Integration (DCIP)** – DCIP was a collaborative effort by DAAS and SFDPH to help those currently institutionalized or at imminent risk of institutionalization live in the community. Focused primarily on LHH residents, a core group of multidisciplinary professionals created and carried out dynamic and personalized community living plans, working with clients both pre- and post-discharge to ensure safe transitions to the community and client access to all necessary supports. This group ceased in May 2014 when the settlement agreement that initiated the sharing of private healthcare information between SFDPH and DAAS expired. Since that time, SFDPH and DAAS have been working towards a revised version of this program that is anticipated to begin sometime next year and will be called the Community Options and Resource Engagement (CORE) Program. In the interim, LHH and CLF staff has continued to collaborate (albeit with a lower level of data sharing and without the benefit of the multidisciplinary team).

DAAS Programming for Case Management and Transitional Care

The total budget for case management and transitional care services is $7.9 million. As shown to the right, most of this funding is for the Community Living Fund. Slightly more than one-third of this funding supports the more traditional OOA community-based case management. Smaller amounts of funding go to medication and money management services that provide lower levels of targeted/specific support.



** Office on Aging-funded service*

❖ ***Community Living Fund***

FY 15-16 Service Target: 375 clients

The Community Living Fund (CLF) is a unique San Francisco creation. Launched in March 2007, this fund is focused on preventing unnecessary institutionalization of seniors and adults with disabilities and helping those currently institutionalized transition back to the community if that is their preference. It has an income limit of 300% FPL, as well as asset limits (e.g., $6,000 for a single individual). DAAS has broad and flexible authority to use funds in whatever way deemed necessary to allow seniors and adults with disabilities to reside in the community. Relatively small portions of this funding have been used for services like emergency home-delivered meals and transitional care in the past. Currently, $120,000 per year funds a case management training institute supporting skill development and continuing education of DAAS-funded case management providers.

The primary use of the funding is the CLF intensive case management program that includes purchase of services and items needed to live safely in the community for which there is no other

payer. About 41% of clients receive purchased services, mostly small, one-time purchases like the installation of grab bars. A small percentage receives on-going home care or board and care subsidies. The lead community-based agency contractor, the Institute on Aging, partners with three other agencies to provide this program.

❖ ***Case Management [OOA]***

FY 15-16 Service Target: 1,877 clients

The OOA-funded case management program is focused on connecting seniors and adults with disabilities with services that will enable them to live safely in the community. This service is intended to be time-limited; once all needed service connections are facilitated, the case will be closed. This work is a collaborative process – case managers work with clients to identify their motivation and desire, keeping the work a collaborative process to promote empowerment and prevent clients from becoming dependent on the case manager. DAAS funds thirteen agencies to provide case management, offering a range of culturally- and linguistically- appropriate options for the diverse local senior and disabled adult populations.

Within its case management program, OOA continues to fund Linkages, a case management program that also includes a small amount of funding to purchase services. This program has been funded locally since the state eliminated funding in FY 09-10. The program requirements and services are similar to the traditional case management program. Compared to the traditional OOA case management programs, a larger percentage of Linkages clients are under age 60 – but most of its clients are seniors.

❖ ***Medication Management [OOA]***

FY 15-16 Service Target: 1,165 clients

Medication Management provides evidence-based medication management services to seniors or adults with disabilities enrolled in the OOA Case Management program. Adverse drug reactions and medication errors, particularly in the context of biologicals associated with aging and disease can increase mortality risk. Through this service, a consultant pharmacist works with case managers to help at-risk seniors and adults with disabilities manage their use of over-the-counter and prescription medications, vitamins, minerals, and herbal supplements.

❖ ***Money Management [OOA]***

FY 15-16 Service Target: 105 clients

Money Management helps seniors and adults with disabilities in the daily management of their income and assets. This includes but is not limited to payment of rent and utilities, purchase of food and other necessities, and payment of insurance premiums, deductibles and co-payments. This is a voluntary service provided by two community-based organizations. *Note: The DAAS Representative Payee program, categorized in Self-Care and Safety Services, provides a similar service but is focused on the most vulnerable at-risk population served by the DAAS protective services division and involves a formal fiduciary appointment by the Social Security Administration.*

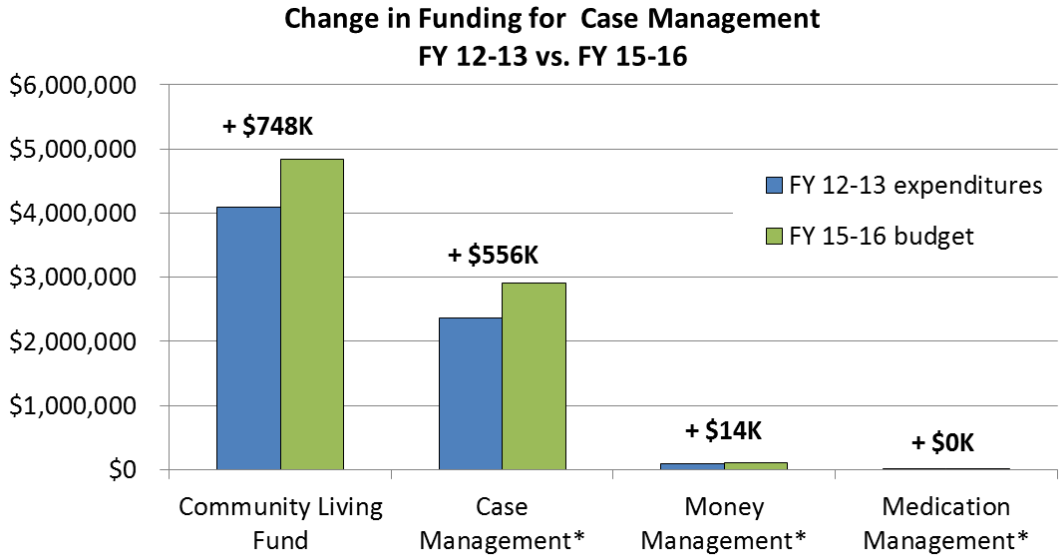
❖ ***IHSS Care Transitions Program***

FY 15-16 Service Target: 1,000

The IHSS Care Transitions Program (CTP) is a new program in FY 15-16 that supports new IHSS applicants who are transitioning back to the community after a hospitalization. This program is a revised and smaller version of the SFTCP program developed during the Medicare transitional care demonstration project between 2012 and 2015. When this demonstration project concluded, DAAS saw an opportunity to utilize the relationships and referral networks developed through that project to support IHSS clients. The cost of this program is absorbed in the DAAS Integrated Intake and Referral Unit, which provides these services.

Changes in DAAS Programing related to Case Management and Transitional Care

The FY 15-16 budget for this service category is $1,312,522 (20%) larger than FY 12-13 expenditures of approximately $6.5 million. As shown below, over half of this increase is due to an increase in the baseline Community Living Fund budget. However, there was also a sizable increase in case management funding expenditures, which totaled $550,831 (23% over FY 12-13 spending levels).



** Office on Aging-funded service*

The programmatic changes driving these shifts include:

- **Increase in CLF baseline funding** – In FY 15-16, the Mayor's office increased the annual Community Living Fund baseline budget by $1 million, bringing the total local General Fund budget from $2.5 million to $3.5 million.[6] The program also draws down federal and state revenue through time studying to the Community Services Block Grant, bringing the total budget for this program up to $4.8 million. The additional $1 million will help the CLF intensive case management program serve clients needing housing

[6] The Community Living Fund was established with an annual $3 million budget. However, when city departments were required to reduce their annual operating budgets during the recession, this fund was decreased to $2.5 million. DAAS was able to leverage outside funding sources, drawing down federal and state funding through time studying, so the program never felt a loss of funding.

patches and home care for clients ineligible for IHSS – two services identified as key barriers impeding discharge from skilled nursing facilities. CLF has also created a new purchasing case manager position at a partner agency that will coordinate purchase of service for clients enrolled with other community-based case management who meet CLF eligibility criteria. *Note: FY 12-13 expenditures include program funds carried forward from prior years, which obscures the full $1 million increase in FY 15-16 in the above chart.*

- **Case management program enhancement –** The Case Management budget for FY 15-16 is about $556 thousand larger than FY 12-13 expenditure level. This increase is mostly due to the accrual of addback funding from the Mayor and Board of Supervisors over the last three years. Addback funding has focused on supplementing service in underserved areas rather than providing an across-the-board increase. This growth is also due to FY 14-15 enhancements to strengthen the quality of this program. One component was the expansion of the Clinical Consultant Collaborative, providing individual consultation and group case review to support skill development (particularly for new, less experienced case managers and to provide support to those organizations with only one or two case managers). The other piece of this FY 14-15 enhancement was a contract for a part-time project manager focused on improving the usability of the case management module in the CA GetCare database, including the development of a medication management module.

Another notable change is the **centralization of case management intake process and waitlist at the DAAS Integrated Intake and Referral Unit**. Historically, consumers and advocates have had to call agencies directly to request case management or even find a spot on a waitlist. Clients are more likely to be successfully connected with service when they and their advocates only have to call one place to request service. Centralization of the intake process will also allow DAAS to better gauge both the amount of potentially unmet need and possible changes in the acuity of need. Additionally, the DAAS Integrated Intake and Referral Unit can submit applications for programs like IHSS and home-delivered meals, reducing the time that consumers are waiting for these critical services. The centralization of intake is currently underway and should be active in FY 16-17.

Suggestions for DAAS Consideration

- **Unmet need for case management** – Without centralized intake data, it is difficult to reliably gauge unmet need for case management. An informal survey of OOA case management agencies suggested that up to 120 clients were waiting for service from OOA case management and Linkages in January 2015. Providers also report a sense that clients are presenting with more complex situations. Once sufficient data is collected through the DAAS Integrated Intake and Referral Unit, DAAS should assess unmet need and take appropriate steps to ensure the OOA case management program is functioning efficiently and has the capacity to meet needs.

  An important facet related to the availability of case management is staff turnover. The community-based organizations providing OOA case management services have struggled to meet contract requirements in recent years. A key driver in this situation is staff turnover driven by low salaries – experienced case managers are leaving for higher-

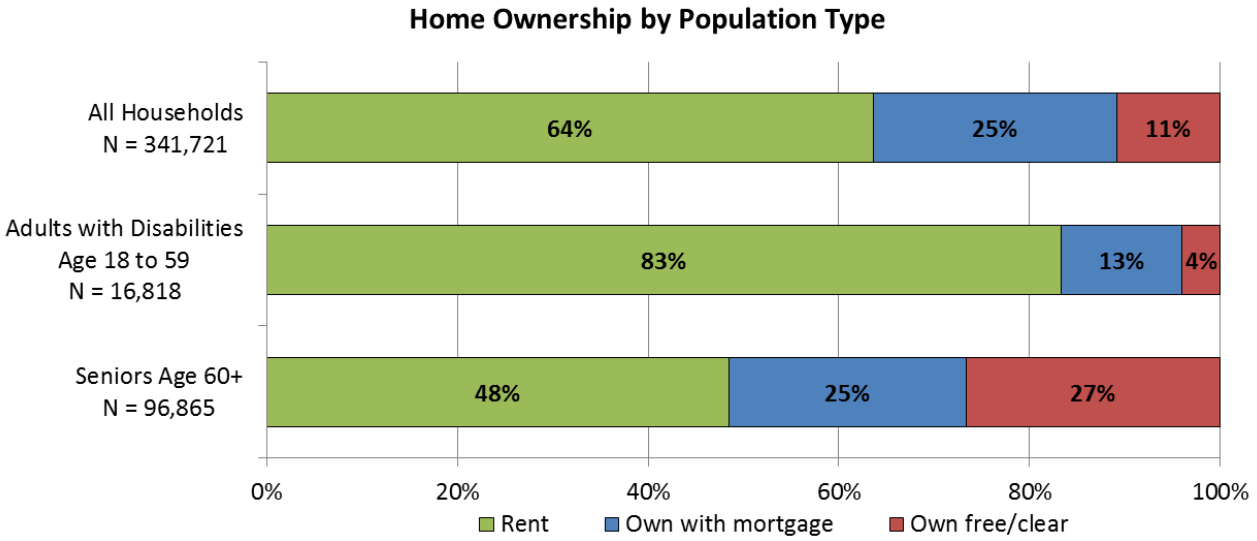
paying positions with medical systems and city agencies. Consistently high rates of turnover are likely reducing the quality of the service provided to case management clients. The case management training institute can help orient less experienced case managers to the program but will not replace seasoned professionals or lessen service disruption for clients. DAAS should consider strategies to secure additional funding for the program and/or consider options for increasing salaries within the existing budget during the next RFP cycle.

- **Availability of case management for younger adults with disabilities** – Most OOA community-based case management is housed at senior-focused agencies, where staff may be less familiar with the unique needs of younger adults and/or the agency mission may preclude significant outreach to this younger population. The majority (87%) of OOA case management clients were 60 or older in FY 14-15. Only four percent of clients were under age 50. While the OOA-funded Linkages case management program targets younger adults, it has a significant wait list and tends to focus on those with behavioral health challenges. Persons with mental health diagnoses may access case management services through SFDPH clinics, but some may resist engagement in those services, waitlists can be long, and these services are primarily available to Medi-Cal clients. DAAS should evaluate the efficacy of its current model and consider strategies to better serve this population. Data collected through centralized intake will help inform this review.

Housing Services

The stress of the high cost of living pervades all aspects of life in San Francisco, especially urgent for seniors and adults with disabilities. San Francisco real estate is among the most expensive in the country, with the median home value of $1.1 million compared to the state median of $457 thousand.[7] At $3,400, the median market rate rent for a 1-bedroom unit in San Francisco is well over two times the average Social Security retirement check and well over three times the maximum SSI payment.[8] Concerns related to housing were prevalent in focus group discussions with seniors and adults with disabilities, who are very aware of these pressures and anxious about both their personal housing situations and the impact that the market changes are having on the overall city population.

Approximately 61,000 households in San Francisco headed by a senior or person with a disability are renter-occupied, making them potentially vulnerable to fluctuations in the rental market. As shown below, 83% of households headed by a disabled adult are renter-occupied. Senior households are more evenly split between renters and homeowners with a quarter in the process of paying off a mortgage. Notably, senior households in San Francisco are much more likely to be renters than seniors statewide: 48% compared to 27%.

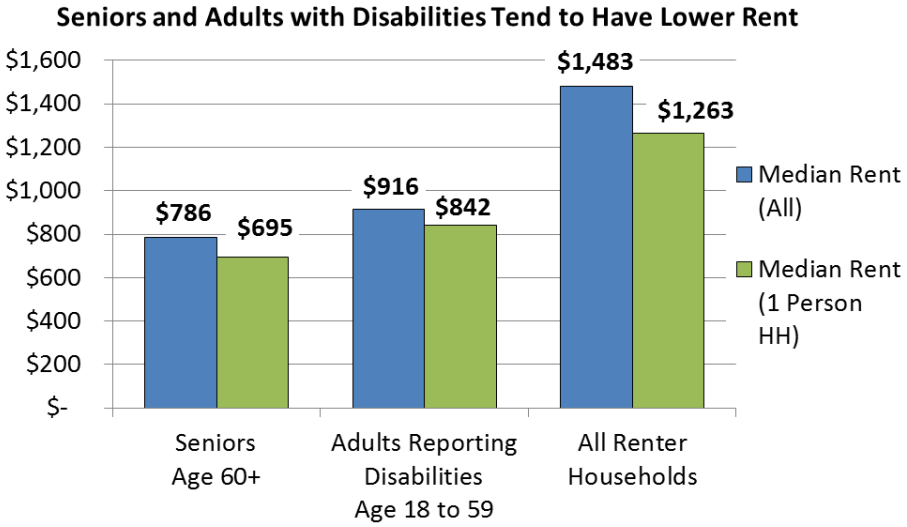


**Households categorized based on head of household*
Source: IPUMS 2012 3-Year Samples

Low-income households are much more likely to be renting. Among those with income below 300% FPL, the rental rates increase to approximately 67% of senior households and 94% of disabled adult households.

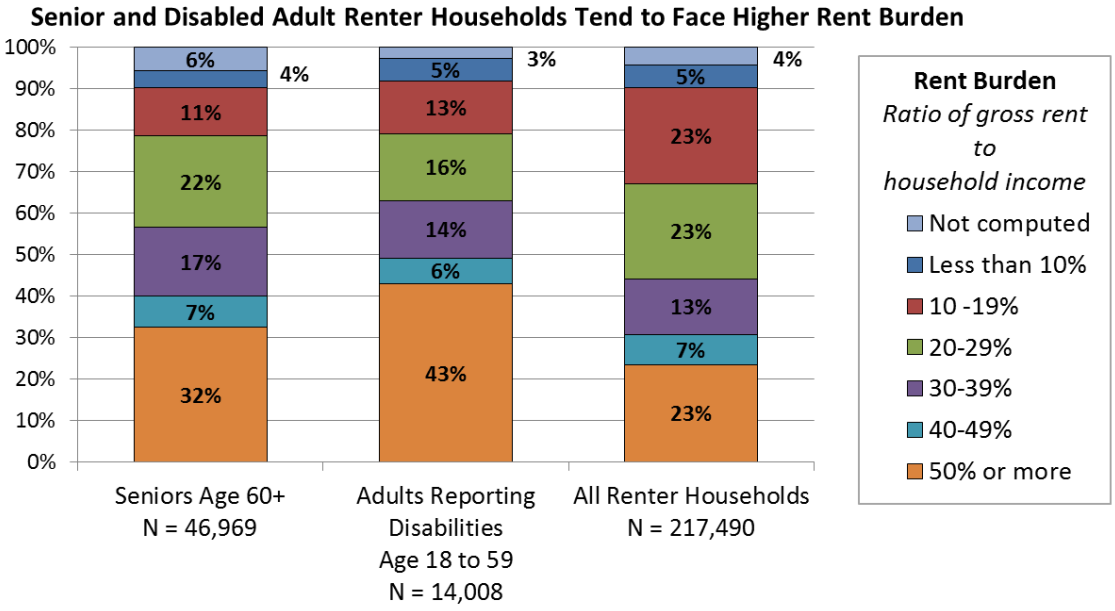
[7] Data from Zillow, a real estate service that tracks market rate trends. Estimates based on San Francisco and California median home value index as of December 2015.
[8] Rent data from Zillow, a real estate service that tracks market rate trends. Estimates based on San Francisco index as of December 2015. The average Social Security retirement payment in San Francisco is approximately $1,259 per month (as of 2014) and the maximum monthly payment for an aged or disabled SSI recipients is $973.

As shown to the right, census data[9] indicates seniors and disabled adult households tend to pay lower rent than the full renter population. This trend holds for single-family households, indicating this difference is not due to variation household size. This tendency is likely to due in large part to rent control protections, particularly for long-time senior renters.



**Households categorized based on head of household*
Source: IPUMS 2012 3-Year Samples

However, *rental rates must be considered within the context of income*. Though these populations tend to have lower rental rates, they are much more likely to face high rent burden. According the U.S. Department of Housing and Urban Development (HUD), a household that pays more than 30% of its income towards housing costs is considered rent burdened. As shown below, approximately 57% of senior-headed households and 63% of disabled adult households meet this criterion. By comparison, the rent burden rate among the full renter population is closer to 44% (which is also quite high). The higher rate among the disabled adult population is likely a reflection of this population's low income levels.



**Households identified by characteristics of head of household*
Source: IPUMS 2012 3-Year Samples

[9] This data is based on gross rent paid, not market rates for newly-available apartments. Given the rapidly changing state of the housing market, census data on rent is useful as a point of reference but may be somewhat outdated.

This data shows that though seniors and adults with disabilities tend to pay lower rent, their capacity to absorb any rental increase is minimal. If their current housing is lost, these populations will face extreme difficulty finding a new affordable location within the city. With market rates rising throughout the Bay Area, consumers may no longer be able to find a new home nearby and may end up quite far from the community and services they rely on.

The risk for eviction and pressure to accept a tenant buyout payment are a issue of significant concern for San Francisco seniors and adults with disabilities. There are special protections for these populations that limit owner move-ins under certain circumstances and require additional relocation payments. However, as noted by staff from the San Francisco Rent Board and by focus group participants, these populations may still be targeted for eviction, because low-rent units offer the largest potential rent increase if property owners are able to vacate and re-rent these units at the current market rate. Seniors in particular are likely to have long tenure and may seem like lucrative targets. Because eviction statistics are not tracked by tenant age or disability status, it is not possible to know how many seniors and adults with disabilities have been affected by eviction. Additionally, beyond the number formally evicted, an unknown number of tenants have accepted informal cash buyouts to vacate. This will change due to a March 2015 ordinance requiring that details of these buyouts be filed with the Rent Board. The local media has highlighted several egregious instances in which older persons and those with disabilities have been forced out of their long-time homes.

Focus group participants with disabilities, consistent with this population's tendency to rent, expressed relief that they currently have housing but were well aware that if they lost their housing they would likely have to leave the city. One participant noted that her ability to live in San Francisco is predicated on the availability of her parents' in-law unit, saying "If I ever couldn't have that [unit], I would have to move to the East Bay. [Housing] is the number one problem facing our city." Other participants agreed with her concerns that the city will lose its diversity if it becomes a place affordable only to the wealthy.

Senior focus group participants highlighted an important indirect impact of these housing trends: although they may have relatively secure housing, their friends and family are often forced to move away. Whether across the city or outside of San Francisco altogether, this distance can have a critical impact on their socialization and support networks, increasing the need for formal supportive services. As explained by a senior living in Chinatown, "It is not reliable to ask kids to help, because they live far away…we are better off going to community centers or social workers if we need help."

Accessibility

Another housing challenge for seniors and adults with disabilities is accessibility. While new developments must now comply with state and federal regulations regarding accessibility, much of San Francisco's housing stock is old and inaccessible for persons in wheelchairs or those who have difficulty climbing stairs. Many Single-Room-Occupancy (SRO) hotels lack working elevators, limiting the ability of persons with mobility impairment to live in these buildings or confining them to their rooms with trips outside only when absolutely necessary. As new units are developed in the below market rate (BMR) system, the application and waitlist process makes it difficult for those in need of an accessible apartment to secure an appropriate unit

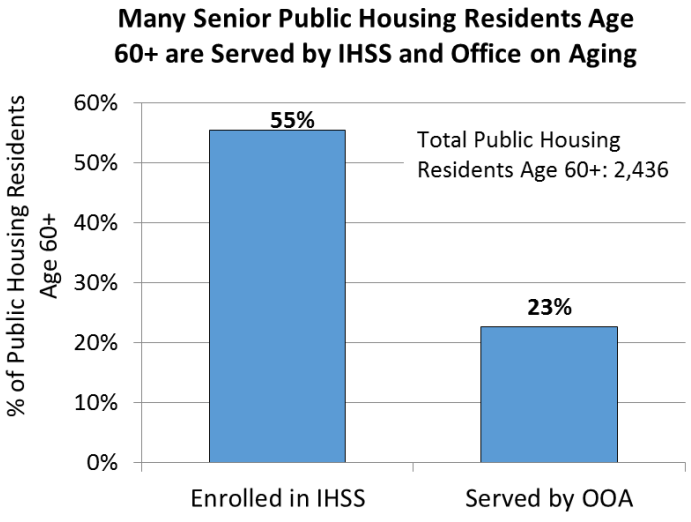
(Mayor's Office on Housing, 2013). A theme in senior focus groups, particularly among long-time homeowners, was concern that the potential onset of mobility impairments will force them to leave their homes as they age.

Home modifications can help make some units more accessible but may be unaffordable for those with low-income. In publicly-subsidized housing, the cost of accessibility accommodations is born by property owners, but private landlords are not required to fund modifications. As noted earlier, many seniors own their homes. Multiple programs aim to increase accessibility and safety, including the community-based Rebuilding Together, the San Francisco Department of Public Health's educational program Community and Home Injury Prevention Project for Seniors (CHIPPS), and the Mayor's Office of Housing and Community Development CalHOME program (available when the state allocates funding). However as noted in the *2013-2018 Analysis of Impediments to Fair Housing Choice*, not all units can be made accessible through modifications due to layout and design constraints. These challenges underscore the risks associated with losing an accessible unit.

Public Housing

Over 40 public housing sites with more than 6,000 units are located throughout San Francisco, offering low-income housing to over 9,000 individuals. Approximately 2,436 (25%) of residents in FY 13-14 were seniors age 60 and older.

Many residents are connected to DAAS programs. Recent efforts to analyze service utilization by public housing residents suggest that 19% of public housing residents – 1,846 individuals – are In-Home Support Services (IHSS) clients. Of residents age 60 and older, this rate is closer to 55%. An additional five percent of residents are IHSS independent providers. There is also significant enrollment by public housing residents in Office on Aging (OOA) services. The most commonly accessed OOA services include congregate meals, community services, and home-delivered meals. OOA served approximately 22% of public housing residents age 60 and older.



Source: Client match of SF Housing Authority and IHSS Clients in FY 13-14

In accordance with the HUD definition of rent burden, public housing residents pay no more than 30% of their income towards rent. While certainly less than a market rate apartment, this threshold can feel unaffordable to persons with low incomes. For example, a person receiving the SSI maximum benefit may pay less than $300 in rent – a tenth of the market rent rate for many apartments today. However, after paying rent, the client will only have $600 to meet all other expenses, which may seem less tolerable than being unhoused for some. The complexity of this choice was evident in a focus group with current and formerly homeless seniors. While most

indicated they would or already had readily give up part of their income for housing, two participants strongly expressed that they would rather live on the street and have their full monthly income than give up their income for housing.

The demand for these subsidized public housing units has long exceeded the supply, and there is also a long waitlist for these housing units. After more than four years of closure, the waitlist was opened for six days in January 2015. In this short time, approximately 10,400 pre-applications were submitted and placed on the waiting list.

Non-Profit Affordable Housing

The Mayor's Office of Housing and Community Development (MOHCD) supports two affordable housing rental programs. The Inclusionary Housing below market rental (BMR) program requires for-profit developers to set aside a percentage of units in new developments for persons with low income or pay fees to fund affordable housing elsewhere. The city also finances non-profit organizations to develop and manage affordable rental housing programs. Several of these projects have units exclusively for seniors and persons with disabilities. To be eligible for affordable housing, household income must be within a set range expressed as a percentage of the area median income (AMI). The income range varies based on program.

As noted by the *2013-2018 Analysis of Impediments to Fair Housing Choice* reports from San Francisco's Mayor's Office on Housing, very low-income persons and, in particular, adults with disabilities are sometimes excluded from affordable housing because their rent would be more than 35% of their income. The report suggests that minimum income requirements be reduced for this population so that they are able to pay a higher percentage of their income but will have access these units.

Homelessness Services

The most extreme expression of the city's housing adversity is homelessness. San Francisco has an extensive array of services to support currently and formerly homeless persons. The San Francisco Department of Public Health (SFDPH) manages homeless outreach teams, provides stabilization rooms and permanent supportive housing, offers a variety of behavioral health services, and operates health clinics focused on meeting the medical, psychological, and social needs of homeless persons. The San Francisco Human Service Agency (HSA) provides a variety of community-based programs for adults and families through its Division of Housing and Homeless Programs, including but not limited to shelter beds and permanent supportive housing (much of which is master-leased units in SROs) throughout the city.

San Francisco's homeless system was designed for a younger homeless population needing short term treatment, but increasingly the people living on the city's streets are struggling with chronic health conditions and physical disabilities that require continuing care. As discussed in the first report of this assessment, persons age 60 and over comprise 20% of the homeless people seeking shelter. However, the experience of homelessness hastens aging, and research has found that homeless persons age 50 often have health conditions associated with persons in their 70s. More than half of the persons seeking shelter in San Francisco are age 50 or older.

"I did not expect to be homeless for that long…I did not expect it to be so difficult to find housing." - Formerly homeless focus group participant who was unable to afford his rent after he became disabled

Potential loss of housing due to short-term institutionalization
When SSI recipients enter institutional care, their monthly benefit is typically withheld to cover part of the cost of this care and they receive only a nominal amount of their monthly benefit. As a result, these consumers are unable to pay for their housing in the community, putting them at risk of losing this housing. As discussed earlier, the current rental market makes it almost impossible for low-income persons who lose their housing to find replacement lodging within San Francisco. While exceptions may be made for institutional placements of less than 90 days, many vulnerable persons may require a longer stay for their health to stabilize. Unfortunately, data on the number of persons displaced as a result of such scenarios is unavailable, although the local Long-Term Care Ombudsman cites these situations as a key area of unmet need. The Community Living Fund will cover rent costs for its clients in this situation, but this program only serves a subset of this population.

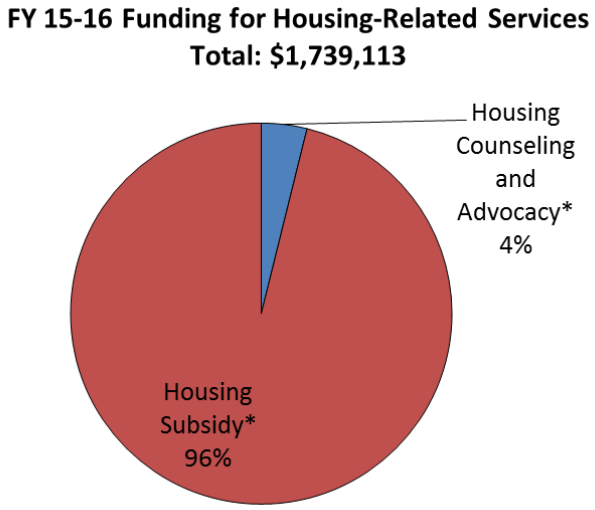
Trends related to Housing

- **Efforts to streamline application process for affordable housing** – Led by MOHCD, efforts are underway to simply and streamline the application process for affordable housing. The initial focus has been to consolidate the various applications used by housing sites into a single universal application that will be used consistently around the city. The other major component of this work is an affordable housing database portal that will consolidate all listings into a single location and serve as a universal application portion.
- **Improvements in public housing sites**: There are two large-scale projects underway that will improve the quality of public housing sites:
    - **HOPE SF redevelopment of public housing sites** – San Francisco is in the process of a large-scale public housing revitalization project that will replace dilapidated public housing sites and create mixed income communities that integrate green buildings, schools, business, and onsite resident services. Many residents at these HOPE SF family developments – Hunters View, Potrero Terrace and Potrero Annex, Sunnydale, and Alice Griffith – are seniors and adults with disabilities. Approximately 270 (15%) of the IHSS clients living in public housing reside in the HOPE SF sites. While the new sites will provide safer and more vibrant communities, these types of redevelopment projects have the potential to disrupt community, which can be especially impactful for seniors and persons with disabilities who rely on neighbors for support. Much effort has been made to engage the community and avoid resident displacement; it will be imperative that these efforts are maintained as the project continues.
    - **Rental Assistance Demonstration** – Another major shift related to public housing sites is the Rental Assistance Demonstration (RAD). This federal program is intended to improve public housing by transferring responsibility for managing these sites to private developers and community-based organizations that will provide onsite services. Led by the Mayor's Office of Housing and Community Development, over 20 sites are scheduled for inclusion. This program is expected to have significant positive effects for the many seniors and adults with disabilities living in public housing, who have struggled for years with difficult living conditions (e.g., broken elevators and vermin).
- **Housing bond** – In November 2015, voters approved a $310 million housing bond that will fund rehabilitation of existing units and development of new affordable housing units. These programs serve a variety of income levels, from those living in poverty to middle income households struggling to keep up with the rising costs of living in San Francisco.

- **Legalization of in-law units** – As of May 2014, persons with unauthorized in-law units may apply for these dwellings to be legalized and part of the housing market. This policy shift has the potential to expand the availability of accessible housing; many of these units are converted ground-floor garages, which may be more accessible for persons with mobility impairment.
- **Creation of a new city department on homelessness** – In December 2015, Mayor Lee announced plans to reorganize city services for homeless persons into a consolidated city department beginning in FY 16-17. Services for this population have tended to be organized into siloes across city departments, primarily SFDPH and HSA. The new department will absorb tasks performed by these agencies and oversee street outreach teams, homeless housing services, and certain mental health programs. The integrated system is expected to improve efficiency by removing barriers to collaboration and streamlining access to services. The Mayor hopes to house 8,000 homeless persons over the next four years.

DAAS Programming related to Housing Services

With a FY 15-16 budget of $1,739,113, DAAS funds two services related to housing. As shown the chart to the right, the vast majority of this budget goes to the Housing Subsidy program. A smaller amount – approximately $172,056 (4%) – funds Housing Counseling and Advocacy. These services are described below.



**Funded by the Office on Aging*

❖ ***Housing Subsidy [OOA]***
FY 15-16 Service Target: 61 clients
As discussed earlier, seniors and persons with disabilities who lose their housing face seemingly insurmountable barriers procuring new living space. The OOA Housing Subsidy program seeks to prevent loss of housing for by identifying currently-housed persons facing imminent eviction and helping to stabilize their housing situation through the use of a housing subsidy payment. The subsidy amount varies based on client income and rent amount but with the universal goal to bring the rent burden to 30%. A critical part of this program is a full client assessment to identify additional service linkages that would benefit the client, including those that may increase the client income and reduce overall household expenses (e.g., enrollment in CalFresh).

New in FY 14-15, this program served 35 consumers by the year's end; staff were careful to ramp up slowly to preserve this service for those most in need. Most of those served were seniors, and the average monthly subsidy amount was $720. The average rent burden clients faced was 108% (average rent of $1,034 and average income of $893).

❖ ***Housing Counseling and Advocacy*** **[OOA]**

FY 15-16 Service Levels: 250 clients

DAAS lacks the financial capacity to develop housing and instead has historically focused on funding housing advocacy and counseling services in an effort to strategically improve the housing situation for seniors and adults with disabilities. These services include:

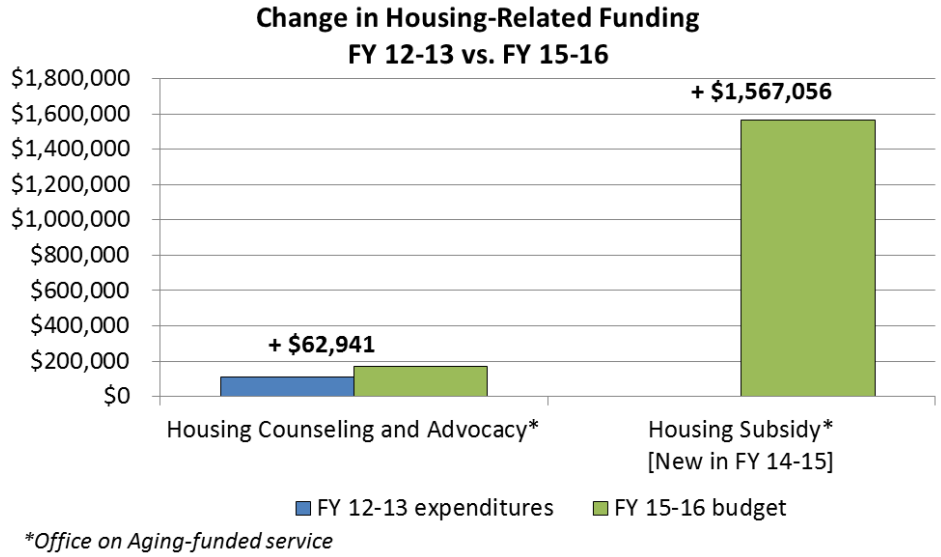
- Counseling assistance to individuals on tenant's rights and eviction prevention;
- Referrals to appropriate agencies for legal representation when necessary;
- Assistance with training counselors for emergency housing counseling
- Development and ongoing support of housing rights coalitions
- Hosting and/or participating in public meetings and events to educate the public about the need for affordable housing for seniors and persons with disabilities;
- Participation in public hearings, group meetings, and other public gatherings intended to advocate for housing options for these populations; and
- Collaboration with established Single Room Occupancy (SRO) hotels, city representatives, and other concerned community-based organizations to advocate for improved living conditions and access to supportive services for SRO residents.

Note: There are other DAAS programs that provide housing-related support but for the purposes of this assessment they are categorized in the primary service area associated with the service. These include:

- *Community Living Fund* – This intensive case management program includes a purchase of service component. On average, it provides approximately 25 consumers with board and care subsidies and 47 consumers with more general, time-limited housing-related assistance (e.g., security deposit). The program has funded 25 stair lifts to date. As noted above, CLF will cover rent for its clients when they are temporarily institutionalized, but this is not extended to persons outside of the intensive case management program.
- *Services for Hoarders & Clutterers* – In addition to reducing isolation, this OOA service attempts to resolve housing-related issues and reduce eviction risk for persons struggling with hoarding and cluttering disorder. It served 91 clients in FY 14-15.

Changes in DAAS Programing related to Housing Services

The budget for DAAS-funded Housing Services has grown by $1,629,997 since FY 12-13. The programmatic changes responsible for this increase are described on the following page.



**Office on Aging-funded service*

- **Housing Subsidy program** – As shown on the preceding chart, the increase in funding for Housing services is almost entirely due to the new Housing Subsidy program. This program began in FY 14-15. The program budget grew to $1.6 million due to $750,000 in addback funding for FY 15-16. However, at the time of this assessment, it is unclear if this most recent addback funding will be maintained beyond the current year. If the funding is not continued, the program budget will decrease to approximately $750,000 for future years, and service will be scaled back to approximately 30 slots.
- **Housing Counseling and Advocacy** – The budget for Housing Counseling and Advocacy is $62,941 (58%) larger than FY 12-13 expenditures. This additional funding has been used to expand service and also reflects work the contractor, Senior and Disability Action, completed on behalf of the SCAN Foundation.

Suggested Areas for Consideration

- **Unmet need for housing counseling and advocacy** – In FY 14-15, 419 clients received housing counseling, well over the contracted service level of 250 clients. The current service provider reports that they have to triage requests and refer clients to other agencies in order to keep up with demand. The need for a one-stop advice and counseling service focused on seniors and adults with disabilities was a key theme in focus groups and a community forum conducted as part of the Aging- and Disability-Friendly San Francisco efforts. There is concern that these populations are unfamiliar with their rights at tenants and may buckle to pressure to vacate.
- **Availability of housing subsidies** – While a goal of the new housing subsidy program is to transition clients off of the subsidy, it is questionable that this goal will be achievable for most clients. Non-permanent housing subsidy programs typically focus on increasing employment income to support clients' self-sufficiency, particularly programs serving younger and able-bodied populations, or leveraging other benefit programs to increase income. Given the target population for this new OOA service, these approaches seem less feasible. With average client income of $893, it is likely that many are SSI recipients and thus ineligible for major benefits, such as CalFresh. Thirty percent are age 70 or older, unlikely to rejoin or expand participation in the workforce. The most likely strategy for transitioning clients off of this service will be a service linkage to another housing program. However, as discussed earlier, the waitlists for subsidized housing programs are extensive. Housing subsidies are very expensive, and the continuing need of seniors for rental assistance is likely to limit this approach over time.
- **Opportunity to collaborate with city departments to serve homeless seniors** – As highlighted in the first report of this needs assessment, an increasing percentage of the city's homeless population are seniors. Historically, services for this population have tended to be organized into siloes across city departments (though the new department on homelessness will attempt to integrate these programs). DAAS may have an opportunity for leadership in starting or at least supporting a conversation about the unique needs of this group and a potential remodeling of the service system to reduce the presence of frail and chronically ill seniors on San Francisco's streets. The prevalence of seniors among homeless persons, as well as the high rates of disability within this population, is relevant to the mission of DAAS and deserves attention and support.

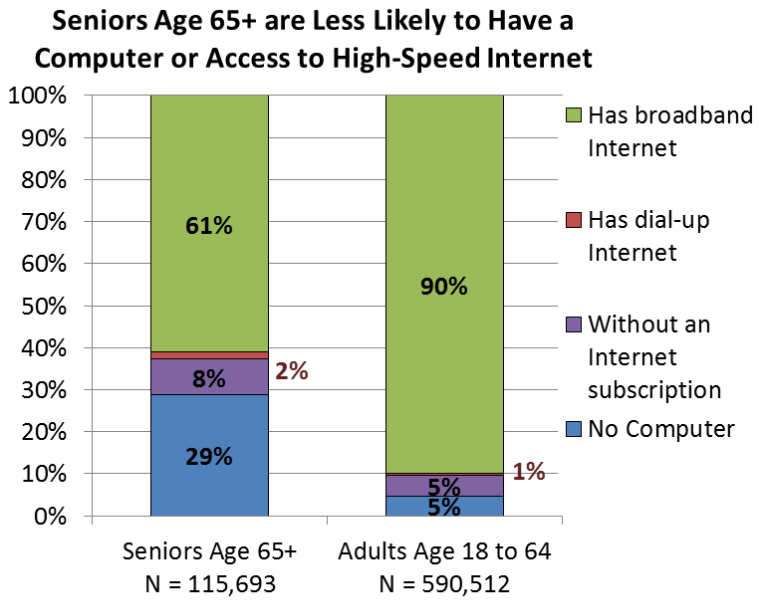
Services to Prevent Isolation

Seniors and adults with disabilities are at heightened risk for isolation. A combination of factors lead to this risk, including living on a fixed income, experiencing mobility impairment, and – particularly for seniors – losing social contacts as peers pass away or suffer declining health (Steptoe et al, 2013). As estimated in the first report of this needs assessment, 7,166 to 16,782[10] seniors and adults with disabilities in San Francisco may be at heightened risk of isolation. They live alone, report disabilities that may result in being homebound, and have income below 300% FPL.

Isolation poses risks for a variety of negative outcomes. Social isolation and loneliness are associated with higher rates of mortality, likely due in part to lack of a support network to encourage medical attention when acute symptoms develop (Steptoe et al, 2013). Research also suggests that isolation can lead to greater use of certain components of the healthcare system, including emergency room visits and admission to nursing homes (British Columbia Ministry of Health, 2004). Feelings of loneliness are linked to poorer cognitive function and faster cognitive decline (Cacioppo & Hawkley, 2009). The National Council on Aging (2016) reports that isolated seniors are at heightened risk for abuse by others, which may be an intentional choice by abusers seeking to minimize risk of discovery. Social isolation is also linked to poor health (Seeman et al., 2001) and has even been compared to the risk factors in obesity, sedentary life styles and possibly even smoking in its impact on health (Cacioppo et al., 2002).

Many younger people use the internet and social media to communicate, but this technology has not been adopted at the same rate among older persons and those with disabilities. As shown in the chart below, 29% of seniors age 65 and older do not have computers. An additional 8% have computers but lack access to the Internet. By comparison, 90% adults age 18 to 64 have computers with broadband access.

Internet use also varies by income: only 25% of seniors with household income below $30,000 have broadband at home compared to 82% of seniors with household income over $75,000 (Pew Research Center, 2014). Similarly, rates of access to broadband are lower among California adults with disabilities: 56% compared to the population average of 72% (Public Policy Institute of California, 2013).



Source: ACS 2013 1-Year Estimates

[10] Range is based on type of disability reported. The 7,166 estimate includes only those reporting self-care difficulty, which represents Activities of Daily Living. The 16,782 estimate includes those who report independent-living difficulty (Instrumental Activities of Daily Living) and/or mobility impairment.

San Francisco offers a rich variety of events and activities. Many social programs and discounts at cultural institutions are targeted toward the senior population and are not available for younger adults with disabilities. While there are a variety of low-cost and free events offered by different city departments, it can be difficult to learn about and keep track of all of the events. In the 2015 City Survey, 29% of seniors and 23% of adults with disabilities indicated that they had used a social activity program in the prior year. Most of those who did not participate indicated it was because they had no need; however, 10% of seniors and 17% of disabled adults indicated they were not aware of these types of services. About five percent of each group indicated these services were too problematic or logistically complicated to use.

"We are like a family at the [community] center." "This is my second home."
- Latino focus group participants

Focus group participants stressed the importance of services that prevent isolation, emphasizing community centers. They appreciated having a space to interact with other older persons and those who speak their primary language, as well as the opportunity to enjoy a meal and participate in free activities, such as games and exercise. Many seniors are alone during the day while their adult children work or have no other family nearby.

Community centers can be especially important for non-English speakers, particularly those who immigrated later in life, leaving behind their social network. One focus group participant said that her elderly mother, home alone during the day, would stare out at the ocean all day longing for Hong Kong. But once she started attending a senior center and made friends, she became happier, insisting on going every week. Several Spanish-speaking seniors explained that after expressing feelings of loneliness and depression, a doctor or social worker referred them to a neighborhood senior center. They were concerned that if they lose mobility as they aged, they would again become isolated. As expressed by one senior, "Right now we can walk [to the center], but later we won't be able to. How will we get here?" Caregivers also described the importance of adult day programs that provide onsite support. Without these services, their care recipients would have little opportunity to leave the house and interact with anyone besides the caregiver.

Another key theme in focus groups across the city was concern from seniors about changing neighborhood dynamics and the attitude of younger generations toward older people. In some neighborhoods, there was concern that gentrification has led to commercial establishes catering to younger people, creating environments that are not senior friendly (e.g., loud music, unsafe and uncomfortable stool seating). Churning – people moving into apartments, staying for a few years, and moving to a less expensive area or a suburb to raise a family – has increased, eroding the sense of community and resulting in the loss of informal support networks. While some shared positive impressions of younger generations, many seniors voiced concerns that they lack understanding or do not care about the needs of older people. Several suggested that the city develop more opportunities for intergenerational interaction.

"Some [young people] are very friendly, but some aren't. They don't come over and introduce themselves. It was very different when I moved in here. There was a strong sense of community."
- North Beach focus group participant

Groups that are especially likely to face isolation include:

- *Adults with disabilities*: As discussed in the first report of this assessment, cognitive and independent living disabilities are prevalent among the disabled adult population. Stigma around mental illness may compel some of these individuals to avoid others. Almost 40% of adults with disabilities have mobility impairments, potentially limiting their ability to get out and socialize with others.
- *Linguistically isolated seniors*: An estimated 25% of seniors age 60 or older in the community – 39,600 individuals – are living in linguistically-isolated households.[11] This percentage is consistent with the 2000 Census, although the overall number of linguistically-isolated seniors has increased from 32,481 seniors.
- *Individuals living alone, not in senior-specific or supportive housing:* As reported in the first report of this needs assessment, 55,871 seniors and adults with disabilities live alone. According to a study of isolated seniors in the Bay Area, those living in senior-specific housing or even in Single Room Occupancy hotels (SROs) are less likely to be isolated than those living in non-senior-specific housing. SRO residents may be less likely to have relationships with immediate neighbors, and their buildings are less likely to be targeted for outreach regarding local socialization activities for seniors (Portocolone, 2011).
- *LGBT seniors:* As discussed in the first report of this assessment, LGBT seniors are at particular risk for social isolation. They are more likely than other seniors to live alone and less likely to seek out needed services. The pressure to live a closeted life as an LGBT senior is itself isolating, and LGBT seniors who are "out" sometimes struggle with a lack of acceptance from family members. Many LGBT seniors lost friends and family due to the AIDS epidemic and may be lacking support in late life.

City departments beyond DAAS provide services that mitigate isolation among seniors and adults with disabilities. Through its main and branch locations throughout the city, the San Francisco Public Library (SFPL) system offer seniors and adults with disabilities the opportunity to get out of their homes, enjoy reading materials and the internet, and interact with others. Many locations offer a variety of classes and events that can be useful for these populations, including Google search skills, resources for job seekers, and book discussion groups. Some classes are offered in partnership with DAAS. One-third of seniors and 46% of disabled adult respondents in the 2015 City Survey reported visiting the main library or a branch location at least once per month. The SFPL recently developed a Veteran Resource Center staffed by volunteers who offer information about benefits, collaborating with the DAAS County Veteran's Service Office for ideas and information.

The San Francisco Recreation and Parks Department also offers a variety of activities and classes for seniors at over 20 sites citywide. A primary hub for these services is the Golden Gate Park Senior Center, open seven days a week and hosting over fifty classes onsite. Activities are designed to meet a variety of interests, including art, exercise, and mahjong. All classes are free for senior participants age 55 and older. The Citywide Senior Services Program Director reports that the department's programming attracts older persons from all over the city and across income spectrums. While there are also activities specifically for persons with hearing or vision

[11] Linguistically-isolated households are defined as those in which everyone age 14 or older speaks a primary language other than English and none of these individuals speaks English "Very Well." This estimate is from the IPUMS 2012 3-Year samples.

impairments, all services are intended to be accessible for all, and the Recreation and Parks Department has a Therapeutic Recreation and Inclusion Services division to support participation by persons with disabilities.

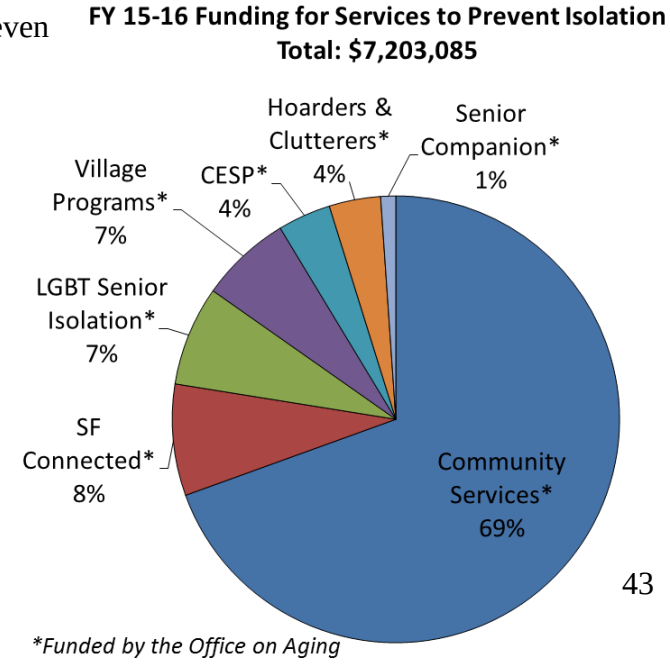
Trends Related to Isolation

- **Low-Cost High-Speed Internet for Seniors** – In FY 15-16, Comcast launched a pilot program to offer low-income seniors access to low-cost broadband technology. This pilot is an extension of Comcast's Internet Essentials program and allows seniors age 62 and older to purchase broadband access for ten dollars per month. Eligibility is based on enrollment in a government assistance program, such as Medi-Cal, CalFresh, or the Low-Income Home Energy Assistance Program.
- **Expansion of San Francisco Recreation and Parks Department programming** – In recent years, the Recreation and Parks Department has significantly expanded its programming. With additional funding, the department now offers activities seven days per week, allowing more flexibility in attendance and more classes to meet demand. Additionally, SF Rec and Park has reopened closed clubhouses around the city, expanding its reach into underserved areas and providing nearby services for those with mobility impairment who may have difficulty traveling long distances. For seniors in particular, the department has increased mahjong activities, as well as exercise and wellness classes to meet the demand of more active older adults.
- **San Francisco Public Library Branch Library Improvement Program** – The SFPL system plays a critical role in developing community throughout the city. The recently completed Branch Library Improvement Program – which represents the largest rebuilding campaign in SFPL history – modernized and expanded services, making local branches more accessible and comfortable for seniors and persons with disabilities. Through this project, the number of public access computers has increased by 135%, and 27 branch libraries offer free public WiFi (BERK Consulting, 2015). Many branches provide public and private meeting space. A focus of this project was improving compliance with the Americans with Disabilities Act at inaccessible branch libraries.

DAAS Programming for Services to Prevent Isolation

With a budget of $7.2 million, DAAS funds seven services focused on reducing isolation among seniors and persons with disabilities. All of these services are provided by community-based organizations and funded through OOA.

These services are described in more detail on the following pages.



**Funded by the Office on Aging*

❖ ***Community Services [OOA]***

FY 15-16 Service Target: 15,080 clients

Over two-thirds of funding in this service area is used to fund Community Services programs. Community Services consist of activities and services that focus on the physical, social, psychological, economic, educational, recreational, and/or creative needs of older persons and adults with disabilities. In San Francisco, Activity/Senior Centers are credited with being more than just a meeting place for older adults. In addition to providing a positive avenue to create new friendships and social networks, the centers offer a wide array of activities and programming to enhance the cultural, educational, mental and physical well-being of participants. Focus is placed on the centers being inclusive of the various diverse communities that comprise San Francisco. Activity/senior centers are often times the entry point for many seniors/adults with disabilities in need of additional services. OOA funded 35 Community Service sites in FY 14-15.

❖ ***SF Connected [OOA]***

FY 15-16 Service Target: 1,794 clients

The SF Connected program receives the second largest amount of funding of services targeted at reducing isolation: $581 thousand (8%). This program supports the use of technology by seniors and adults with disabilities. SF Connected is the locally-funded continuation of the Broadband Technology Opportunities Program (BTOP), which began in 2010 through an American Recovery and Reinvestment act grant. This grant allowed DAAS to establish technology labs with broadband (high-speed internet) and computers at over 50 sites throughout the city. These tech labs remain a core component of the program – accessible computers connected to broadband (high-speed internet) at a variety of sites frequented by seniors and adults with disabilities. The other major component of the program is free computer tutoring and support provided by community-based organizations. Clients may also bring in their own technology for personalized support and training. An evaluation of the BTOP program in 2013 indicated that this program is well-placed to target those at risk of isolation and those unlikely to purchase computers of their own; 50% of clients lived alone, more than 80% had income below $25,000, and financial problems were a key barrier cited in preventing personal computer ownership (Wu et al, 2013).

❖ ***LGBT Senior Isolation [OOA]***

FY 15-16 Service Target: TBD

OOA is currently working with service providers to develop two new programs to address issues related to isolation in the LGBT senior community. One program will be focused on the needs of older LGBT adults living with dementia and related conditions, such as mild cognitive impairment. This service will provide training to mainstream and LGBT service providers to obtain services and support for physical, social, emotional and behavioral health challenges that will enable them to remain in their homes and avoid institutionalized care. The other program will be focused on supporting care navigation and utilize peer support volunteers to support isolated, underserved LGBT older adults living with emotional and behavioral health challenges.

- ***Village Programs [OOA]***
  FY 15-16 Service Target: 545 clients

The Senior Village is a rapidly growing model of senior services programming that promotes independent living and helps clients develop enhanced support networks. The model is a membership organization through which paid staff and a volunteer cadre coordinates a wide array of services and socialization activities for senior members. Volunteers are typically a mix of Village members and outside persons, such as high school students. These volunteers may help drive a member to a doctor's appointment or bring groceries over if a member is ill. Socialization activities are frequently based around common interests, such as a book clubs or opera group. There are currently two Village programs in San Francisco; one intends to serve the entire city (although members thus far tend to live in the west and northern parts of the city) and another that is focused in District 3. Over half of Village members reportedly live alone. OOA funding is used to subsidize membership fees for low-income persons.

- ***Center for Elderly Suicide Prevention [OOA]***
  FY 15-16 Service Target: 250 clients

The Center for Elderly Suicide Prevention (CESP) is focused on maintaining or improving the well-being of seniors and adults with disabilities who may need suicide prevention services, emotional support or intervention/assessment due to grief resulting from death of a loved one, or other crisis intervention services based on isolation in the community and/or lack of access to other supportive services. Services include but are not limited to crisis intervention, peer counseling, professional psychological counseling, telephone reassurance, grief counseling, support groups and information and referral services to appropriate agencies. Services are provided via phone and in clients' home.

- ***Services for Hoarders & Clutters [OOA]***
  FY 15-16 Service Target: 68 clients (60 in support group, 8 in treatment group)

Services for Hoarders and Clutterers consist of direct services to clients and systems-level activities to improve services for this population. Clients struggling with hoarding and cluttering may participate in weekly support groups to work on issues they face in their lives related to compulsive hoarding and receive assistance support group members with creating goals for their recovery. A smaller number of clients are also directly served in annual clinician-led 16 week treatment groups, which utilize Cognitive Behavioral Therapy (CBT) to work with individuals with hoarding and cluttering challenges who want to set clear goals and work through them utilizing treatment. Indirect services to enhance the service system include community trainings and education, as well as convening quarterly meetings of the Hoarding and Cluttering Task Force.

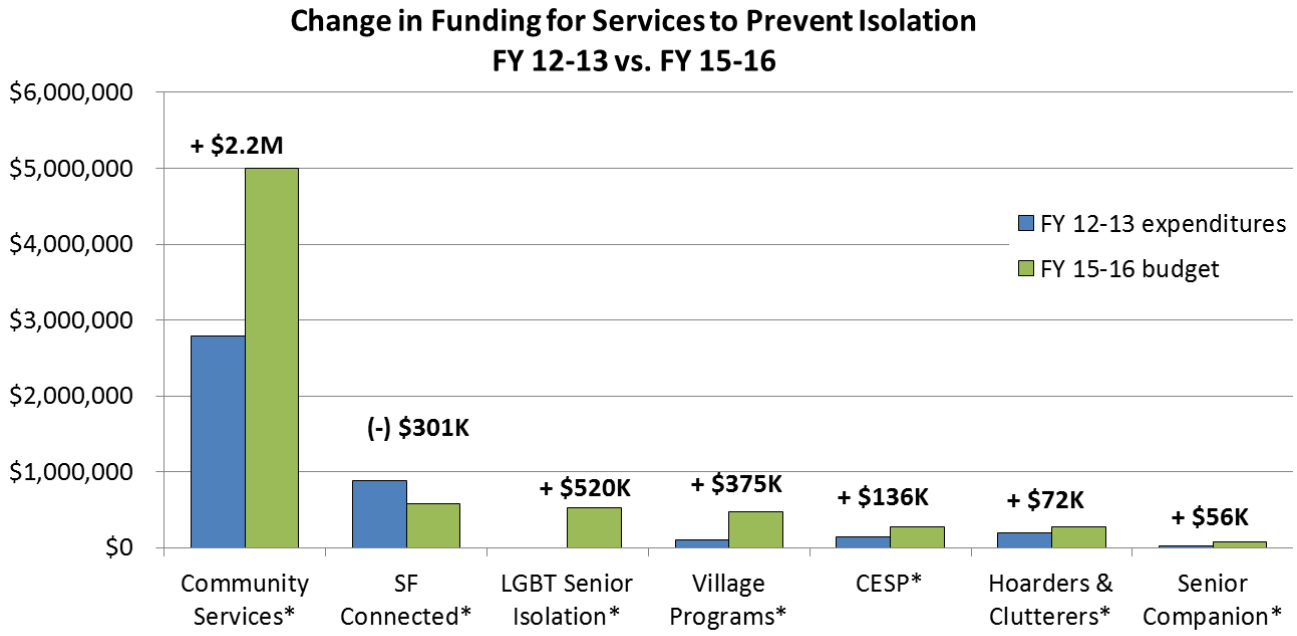
- ***Senior Companion [OOA]***
  FY 15-16 Service Targets: 15 volunteers, 75 clients

The Senior Companion program is provides volunteer service opportunities for a small number of low-to-moderate income older persons. In addition to a small stipend, these positions help volunteers maintain a sense of self-worth, retain physical health and mental alertness, and enrich their social contacts. However, the impact of this program goes beyond those serving as the designated companions. These volunteers expand capacity at local community-based sites; they

may visit and assist homebound seniors with chores and grocery shopping, provide one-on-one social interaction, and assist with transportation to medical and other appointments.

Changes in DAAS Programming to Prevent Isolation

The FY 15-16 budget for this service category is $3.1 million larger than FY 12-13 expenditures. The chart below details funding changes by program within this category.



**Office on Aging-funded service*

The programmatic changes driving this increase are:

- **Increase in funding for Community Services** – The majority (72%) of the funding increase for Isolation services is due to the Community Services program. Compared to FY 12-13 spending, the FY 15-16 budget for this service represents a $2.2 million (80%) increase. This increase has accrued over the last three fiscal years due to addback funding. In prior years, addback funding was targeted area-specific funding from the Board of Supervisors intended to supplement service in underserved areas. However, the FY 15-16 addback cycle included $500,000 that has been distributed among all of the Community Service providers to provide much needed infrastructure support. Funding for this service will continue to increase in FY 16-17, as the latest round of addback funding included an additional $500,000 to become available next year.
- **New funding targeted to reduce isolation among LGBT seniors** – As described earlier, OOA is working with community partners to develop two new services to mitigate isolation among LGBT seniors. In accordance with recommendations from the LGBT Aging Policy Task Force, one service will be provide outreach and training to enhance supportive services for LGBT seniors with dementia and other cognitive impairment. The other service will provide care navigation assistance and peer support for LGBT older adults with emotional and behavioral challenges. Approximately $520,000 has been budgeted for these services.

- **Funding expansion for Village models** – The budget for the Village programs has increased by $375,000 (375%) over the last three years. Typically these programs are funded primarily by membership fees. While DAAS initially envisioned its support would be time-limited (e.g., start-up funding), the Board of Supervisors has continued to indicate its desire to support this type of model.
- **Decrease in funding for SF Connected** – Since the federal grant for the BTOP program ended in FY 12-13, the program has been locally-funded. The $580,851 budget for FY 15-16 is consistent with funding levels since the grant ended. *Note: These amounts do not include the two OOA analyst positions that support this program.*

Suggested Areas for Consideration

- **Community Services for adults with disabilities** – DAAS currently funds Community Services at the same sites for both seniors and adults with disabilities, a choice historically driven by static funding levels. However, the vast majority (92%) of DAAS Community Service clients continue to be seniors. Most of the Community Service agencies are focused on the senior population and do not consider serving the younger disabled adult population as a core part of their mission. As a result, they may not be conducting significant outreach to this population, and younger adults with disabilities appear underserved.

  Furthermore, while the physical care needs of younger adults with disabilities may be similar to the senior population, working with younger disabled populations requires much more than providing physical accessibility. As described in the first report of this needs assessment, the most common type of disability for younger adults in San Francisco is cognitive difficulty; these challenges may require a different skillset or more nuanced approach to engagement in services. Additionally, these groups are at different stages of life. They may not share similar interests or enjoy the same types of activities as the older adult population.

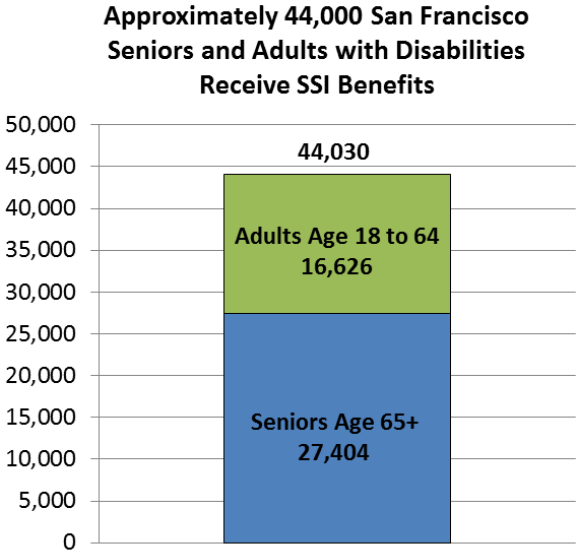
  DAAS may wish to re-assess the approach of serving younger adults with disabilities through senior sites. It may be more feasible in the current context to develop specific sites for this population. This group may prefer an alternate model for this type of support and engagement.

- **Opportunities for collaboration with other city departments** – DAAS should consider opportunities to increase collaboration with the San Francisco Public Library and Department of Recreation and Parks, both of which provide classes specifically targeted for older adults. These programs may offer valuable opportunities for DAAS to connect with older persons it may not currently serve. DAAS could conduct general outreach to increase awareness of its services among the senior population. Alternately, staff in these programs – *if aware of DAAS services* – may help initiate service connections for consumers they notice are in need of extra help. For example, many seniors are long-time participants in Recreation and Park services, allowing staff to potentially observe when a client starts to decline and would benefit from DAAS services. Additionally, closer collaboration with these other city departments will reduce the potential for service duplication, maximizing the use of funding.

Nutrition & Wellness

Older adults and persons with disabilities are at risk for food insecurity, which is closely connected to poor health status and negative health events. Over the last ten years, the percentage of the national senior population age 60 and older that faces the threat of hunger has increased by 45% (Ziliak & Gunderson, 2015). In California, an estimated 16.3% of seniors face the threat of hunger, and the state has the eleventh highest rate of senior food insecurity in the nation (United Health Foundation, 2015). Approximately 34% of households with an adult whose disability prevents labor force participation are food insecure (RTI, 2014).

Income is a significant factor in food insecurity. In San Francisco, the cost of food is estimated to be 23% higher than the national average (Wallace, 2015). Low-income neighborhoods tend to lack full-service grocery stores, leaving residents to shop at small corner stores where fresh produce and healthy items are often limited and more expensive than less healthy alternatives (Beaulac et al, 2009). About 44,000 adults age 18 and older receive Supplemental Security Income (SSI) benefits and thus are ineligible for CalFresh, the primary supplemental nutrition program for low-income persons. Given that the low benefit amount leaves SSI recipients in poverty, these people are especially likely to benefit from alternate nutrition programs. Comparing these enrollment figures to census population estimates suggests that 24% of seniors (age 65 and older) and 41% of disabled adults (age 18 to 64) in San Francisco depend on SSI benefits and thus are ineligible for CalFresh benefits.



Source: U.S. Social Security Adminstration, SSI Recipients by State and County, 2014

Many individuals with income above the SSI limit or poverty line also face food insecurity and are at risk of malnutrition. Research suggests that about 30% of seniors with income between 100% and 200% of the federal poverty line face the threat of hunger (Ziliak & Gunderson, 2015); this equates to 10,500 adults age 60 and older in San Francisco.

A variety of medical, physical, and social factors also contribute to food insecurity and malnutrition. Disease can cause a decrease in appetite or poor absorption of nutrients. Dental issues may inhibit the ability to eat, and aging is also associated with a loss of taste and smell, reducing enjoyment and interest in eating (Donini, Salvina & Canella, 2003). Individuals with functional impairments may be unable to shop for groceries or prepare meals. Persons experiencing depression, anxiety, and dementia are also at risk for malnutrition. Lifestyle and social factors, including isolation, loneliness, and knowledge of how to prepare nutritious meals, can also have a significant impact on nutrition status (Hickson, 2006). Research indicates that households that have low income, are minority, are socially isolated, or have physical or mental impairments are at increased risk for food insecurity and hunger (Hall & Brown, 2005).

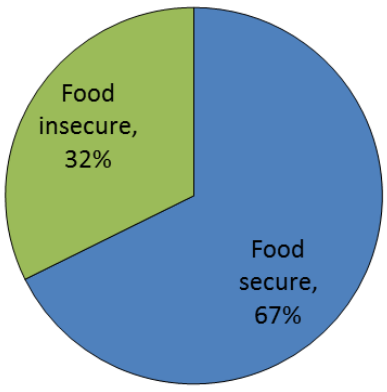
Food insecurity and subsequent malnutrition can contribute to poor health (Stuff et al, 2004). Malnutrition can lead to loss of weight and strength, greater susceptibility to disease, confusion, and disorientation (National Resource Center on Nutrition, Physical Activity, and Aging, 2015). Several of the most common diseases that affect older persons, including cardiovascular disease, diabetes, osteoporosis, and cancer, are all affected by diet (World Health Organization, 2015). Malnutrition is also associated with increased length of stay, discharge to higher level of residential care, and mortality risk in senior surgical patients (Charlton et al, 2012), as well as fall risk and emergency room admissions (Meijers et al, 2009; Vivani et al, 2009).

Nutrition is best understood in the context of health promotion, and a related issue is fall risk. Older persons and those with disabilities are at risk of falls and reduced health status due to the more universal impacts of aging and disability. Dizziness and imbalance, reported by many older persons, may be the result of multiple underlying causes (Iwasaki & Tatsuya, 2015). A key potential contributor to unsteadiness and falls is sarcopenia, the degenerative loss of muscle mass and strength that begins as early as the fourth decade of life (Walston, 2012). According to the Centers for Disease Control and Prevention (2016) one out of three older persons age 65 and older fall each year. Approximately 20% of falls result in a serious injury, such as a broken bone (Sterling, O'Connor & Bonadies, 2001). Even if not injured, many of those who fall become afraid of falling again and consequently may limit their daily activities, putting their health at risk and increasing the likelihood of another fall in the future (Vellas et al, 1997). The 2011-2012 California Health Interview Survey (CHIS) results estimated that 12% of San Francisco seniors age 60 and older had fallen more than once in the prior year.

Several sources provide useful insight into the local need for nutrition assistance. The **2013-2014 CHIS** suggests that almost one in three San Francisco seniors with income below 200% FPL is food insecure or unable to afford enough food. This equates to 19,225 seniors.

The **2015 City Survey** indicates that 13% of seniors and 26% of disabled adult respondents had accessed food or meal services. Most had not accessed these services and indicated it was because they had no need (75% of seniors, 56% of adults with disabilities). However, seven percent of seniors and ten percent of adults with disabilities reported they were not aware of these services. About four to five percent of each population said the services were not available to them. These respondents represent those who would potentially benefit from services but may require additional outreach or live in areas less served by programs like congregate meals.

Approximately One-Third of Low-Income* San Francisco Seniors (Age 60+) Are Reportedly Unable to Afford Enough Food



** Low-Income defined as below 200% FPL*
Source: California Health Interview Survey, 2013 & 2014

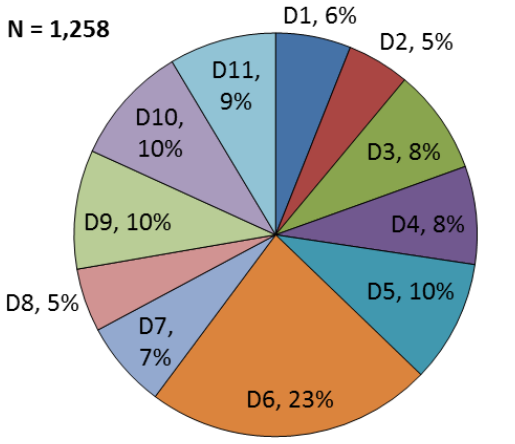
The 2015 City Survey indicates the following for senior and disabled adult respondents:

- Those most likely to have used food and meal services live in District 5 (Western Addition, Inner Sunset), District 6 (SOMA, Tenderloin), District 10 (Bayview-Hunter's Point, Visitacion Valley), and District 11 (Excelsior, OMI).
- Of those who did not access food and meal services, people living in the southeast part of the city in Districts 9 (Mission), 10, and 11 were more likely to explain that they were unaware of services or services are not available – 20% to 23% of those who did not access services.
- Utilization rates were highest among African-American (32%) and Latino (20%) survey respondents.
- API respondents were most likely to report they did not use these services because they were unaware of them or services were not available.

In focus groups held across the city, participants of all ethnic groups spoke about the importance of nutrition services. In particular, they highlighted congregate meals, saying they appreciate both the social aspect of sitting down to a midday meal with others and the opportunity to get a low-cost or free meal – every bit of savings can be helpful. Some expressed mild displeasure with redundant meal schedules, voicing a desire for more variation. Other participants travel around to different community service sites and meal programs to participate in different activities and mix up their meal schedule. At some sites, seniors volunteer to help serve meals to their peers or collect donations at the door.

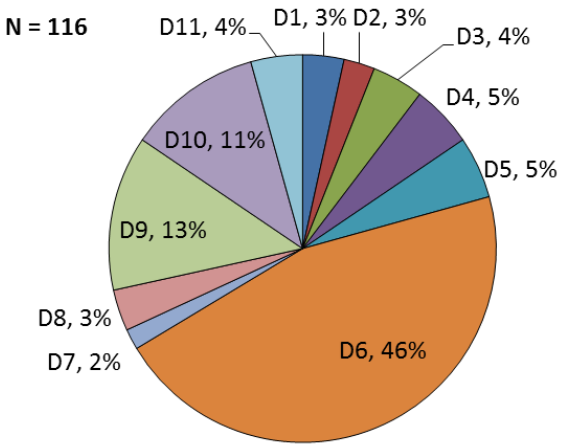
A review of the **FY 14-15 OOA Home-Delivered Meal waitlist data** suggests the need for HDM service is highest in District 6 for both seniors and adults with disabilities.[12] Demand for this service is also strong in Districts 9 and 10 for both groups, as well as in Districts 5 and 11 for the senior population age 60 and up. This distribution is generally consistent with the demographic analysis of low-income groups discussed in the first report of this assessment.

Regular Senior HDM Requests by Client Supervisorial District



Source: IR2 and CA GetCare databases, FY 14-15

Regular AWD HDM Requests by Client Supervisorial District



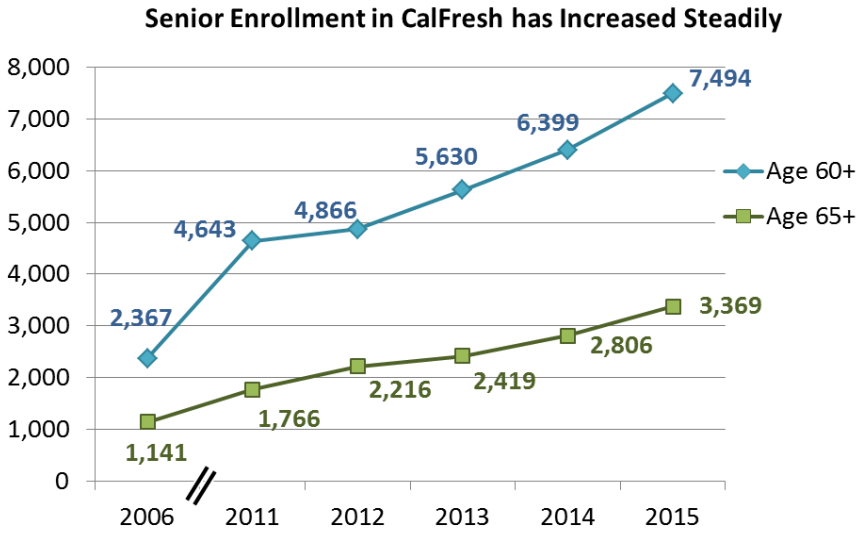
Source: IR2 and CA GetCare databases, FY 14-15

[12] This analysis is based on all clients added to the HDM waitlist in FY 14-15. For total enrollment by district, please see Appendix A.

CalFresh

The primary non-DAAS social service that aims to support food security among low-income persons is CalFresh, also referred to as "food stamps" or "SNAP" (based on the federal name for this program, Supplemental Nutrition Assistance Program). The benefit amount varies based on household size and income level with a maximum monthly benefit for a single household of $194. As of December 2015, 43,533 individuals are enrolled in the program. Seventeen percent of CalFresh clients – 7,494 individuals – were age 60 and older.

As shown to the right, the number of older persons who receive CalFresh has increased steadily over the last several years, growing by an annual average of 730 clients over the last five years. Since 2006, the CalFresh senior client population has grown by 5,127 individuals (216%). A review of enrollment rosters suggests this growth has been driven by new enrollments rather than the aging of the existing caseload.



Source: CalWIN Non-Assistance Food Stamps Individual Extracts, December files

This enrollment increase suggests that the efforts outlined in the last DAAS Needs Assessment to make CalFresh more accessible – such as rebranding to reduce stigma and promote the healthy aspect of CalFresh, elimination of asset limits, and partnerships between CalFresh staff and the Aging and Disability Resource (ADRC) hubs – have made inroads into an underserved population. However, as noted earlier, the ineligibility of SSI recipients means that this program will never be able to serve all in need of nutrition support unless state regulations are changed.

The CalFresh program contains special provisions for seniors and adults with disabilities. CalFresh benefits are typically restricted to the purchase of grocery items, but seniors, adults with disabilities, and homeless persons can use their benefits to purchase prepared meals through the Restaurant Meals Program. Intended to support those who may have difficulty preparing or storing food, this program also provides the opportunity to socialize and participate in the community in a way that these clients might otherwise be unable to afford. Additionally, seniors and adults with disabilities face slightly less strict income eligibility standards for CalFresh. They are not held to a gross income limit (most households are held to a 200% FPL limit), and they can also deduct non-reimbursed medical expenses, including Medi-Cal share of cost payments, to qualify for the program.

Recent Trends Related to Nutrition & Wellness

- **End Hunger by 2020** – In 2013, the San Francisco Board of Supervisors unanimously passed a resolution to end hunger and food insecurity in the city by 2020. This resolution

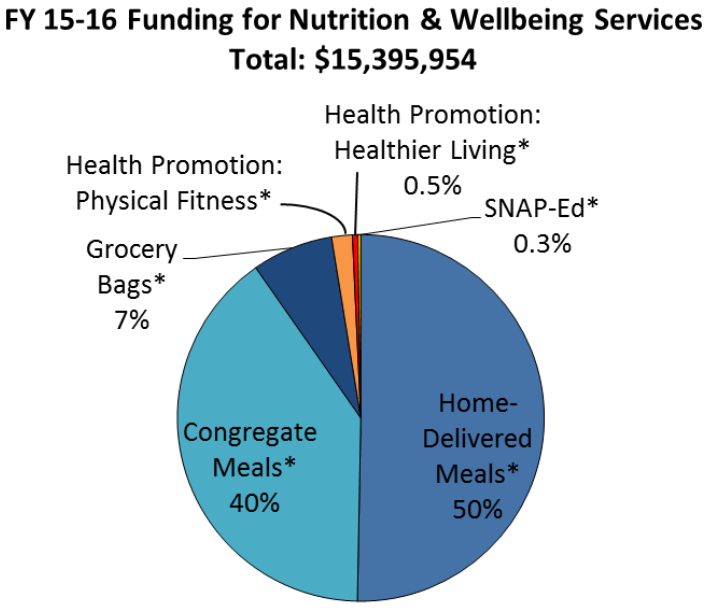
was passed after strong advocacy from the Food Security Task Force and the Tenderloin Hunger Task Force. This resolution required city agencies to report on unmet need for nutrition assistance and provide recommendations for how the city could better meet these needs. Annual status updates are provided to the Mayor's office and Board of Supervisors, covering the impact of addback funding, remaining service gaps and unmet need, and recommendations.

- **CalFresh Periodic Reporting** – Per state instructions, the CalFresh recertification process for households with senior and disabled residents is changing to require a written report at the one year mark of their two year certification report to notify the program of any changes and supply verification. Prior to this 2016 change, households were simply asked to make a verbal or written report *if* changes occurred. This may cause confusion in the short-term and adds a potential barrier to benefit maintenance for these populations.
- **Pilot Projects** – A number of small pilot programs have been started in recent years to promote consumption of produce and healthy foods. The Eat SF Voucher program, for example, provides low-income residents of the Tenderloin with vouchers that can be used to purchase fresh and frozen fruits and vegetables at local corner stores. In addition to supporting the health of those directly served by the program, a goal of this program is to boost the ability of local food vendors to maintain a supply of healthy food, addressing the food desert problem.
- **San Francisco Department of Recreation and Parks** – The Citywide Senior Services Program Coordinator for the Department of Recreation and Parks reports that as the Baby Boomer generation has aged, there has been increased interest in exercise and wellness classes. As a result, they have increased the department's capacity to offer several fitness and health-related activities, such as tai-chi, qi gong, hiking, and low-impact movement.

DAAS Programming for Nutrition and Wellness Services

With a budget of approximately $15.4 million, DAAS funds six different nutrition and health promotion programs. The Nutrition and Wellness services make up the second largest part of the DAAS budget.[13] These programs go hand-in-hand to support health and well-being, offering an educational component to foster health management and improve nutrition status. As shown to the right, most of this funding is used on nutrition services (shaded in blue), with almost 2.5% dedicated to health promotion activities.

These services are described in more detail on the following pages.



**Office on Aging-funded service*

[13] The Self-Care and Safety service category, which includes IHSS, receives the most funding.

❖ ***Home-delivered meals [OOA]***

FY 15-16 Service Target: 5,050 clients

The home-delivered meal (HDM) program targets target frail, homebound or isolated individuals and, in certain cases, their caregivers and/or spouses. This program receives half of the funding for this service area. HDM supports well-being and can help prevent institutionalization (Shapiro & Taylor, 2002). In addition to the nutrition component, the meal delivery also serves as a daily wellness check and opportunity for face-to-face contact and social engagement. HDM is often the first in-home service that an individual receives and can serve as an access point for connection to additional resources (Administration on Aging, 2015). A recent study suggests increased state investment in community-based services – especially home-delivered meals – is associated with proportionately fewer low-need persons living in nursing home residents (Thomas & Mor, 2013).

❖ ***Congregate meals [OOA]***

FY 15-16 Service Target: 18,444 clients

The congregate meal program is the second largest program in this service area, receiving 40% of funding. It provides nutrition services in communal settings at various community-based sites. In addition to the nutrition component, these programs offer seniors and adults with disabilities valuable opportunities for social engagement with peers and connection to additional resources that are often offered on-site (e.g., community service activities and social work staff). The program includes two meal sites under the Choosing Healthy and Appetizing Meal Plan Solution for Seniors (CHAMPSS) model in which meals are served in a neighborhood restaurant. The 2013 National Survey of Older Americans Act Participants report highlights the benefits of congregate meals, especially among among low-income respondents[14] and those living alone. Approximately 80% of low-income respondents and 76% of those living alone agreed that they ate healthier meals as a result of congregate meal programs; similarly, 84% and 83% of these respective groups indicated that they saw their friends more due to these programs.

❖ ***Grocery Bag programs (Home-delivered groceries & food pantry pick up) [OOA]***

FY 15-16 Service Target: 2,831 clients

DAAS values innovation and creativity to meet the changing needs of the diverse local population of seniors and adults with disabilities. The home-delivered grocery (HDG) program is a newer service that has grown rapidly in recent years, currently constituting seven percent of funding in this service area. A conceptual hybrid of the classic food pantry system and HDM, the program is based on the understanding that many seniors and adults with disabilities are able to prepare food and would benefit from free groceries but are unable to wait in line or transport the heavy food bags home from a food pantry. This program employs a variety of models, such as an on-site food pantry in Chinatown SROs with youth volunteers delivering bags and IHSS providers bringing bags to their care recipients. DAAS also funds traditional food pantry grocery bags for seniors and adults with disabilities who are able to transport the groceries home.

❖ ***"Always Active" – Physical Fitness & Fall Prevention [OOA]***

FY 15-16 Service Target: 850 clients

This evidence-based program provides exercise and health education with the goal of reducing risk of falls and injury, improving fitness levels, and empowering seniors to take control of their

[14] Defined in the National Surve of Older Americans Act Participants as those with income below $20,000.

health through lifestyle changes. Classes are led by certified wellness trainers and focused on strength and flexibility, low-impact aerobics, balance, and fall prevention. The lead contractor (currently On Lok's 30th Street Senior Center) collaborates with other community agencies so that services are offered throughout the city by a diverse array of service providers. Annual consultations with a trained staff member including exercise recommendations and a personalized wellness program are available to all participants. This service is currently provided at 12 sites throughout the city.

- ***"Healthier Living" – Chronic Disease Self-Management (CDSMP) [OOA]***
  FY 15-16 Service Target: 630 clients

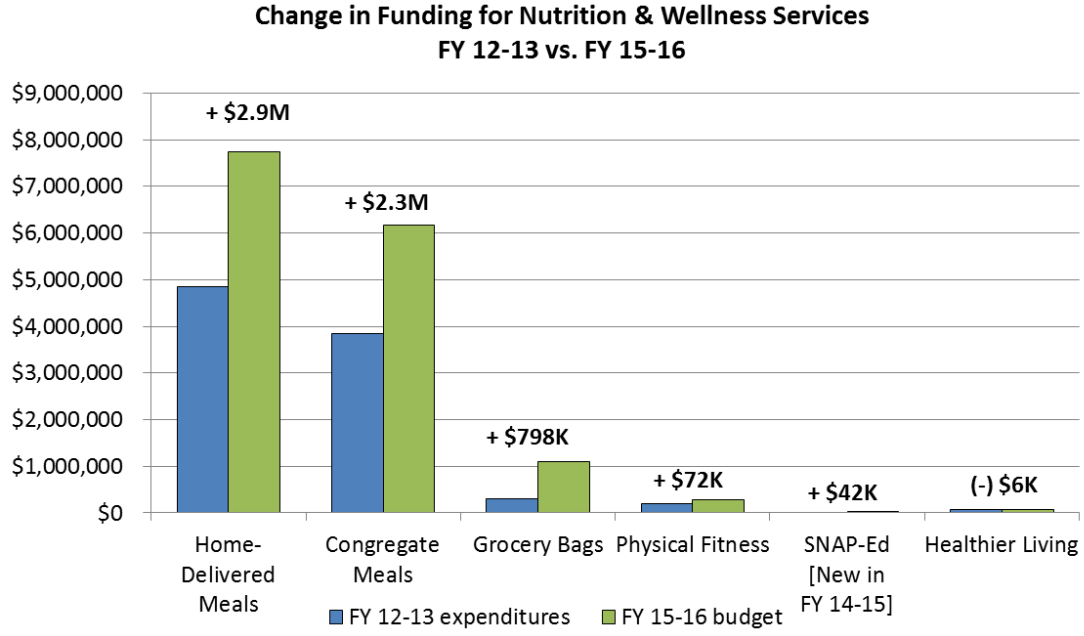
Adopted from Stanford University, this evidence-based program consists of community workshops over a period of six weeks to help people learn how to manage chronic disease. Course curriculum is focused on appropriate behavior modifications and coping strategies that enable participants to manage their chronic diseases and medications, improve their eating habits, and increase physical activity levels. The program also supports effective communication skills with family, friends, and health professionals.

- ***Supplemental Nutrition Assistance Program-Education (SNAP-Ed) [OOA]***
  FY 15-16 Service Target: 745 clients

With a state SNAP-Ed grant awarded in FY 14-15, DAAS has established three additional services that are focused on reducing the prevalence of obesity and the onset of related chronic diseases. The services offered through this program are: (1) Nutrition education focused in part on obesity prevention; (2) Urban gardens to increase physical activity and access to healthy food; and (3) Tai Chi for Arthritis and Fall Prevention, which is an evidence-based program with classes led by community volunteers who are certified by a trainer.

Changes in DAAS Programing related to Nutrition and Wellness

Funding for Nutrition and Wellness services has grown significantly in recent years. The FY 15-16 budget represents a $6.1 million increase over FY 12-13 expenditures. As shown below, most of the increase has occurred in the nutrition service programs.



**Funded by the Office on Aging*

Major programmatic changes driving these funding increases include:

- **Home-Delivered Meals**: Of the three DAAS meal programs, the HDM program has seen the largest growth in funding and meals served. This growth is primarily the result of significant addback funding in the last two fiscal years, which the Food Security Task Force and community members have highlighted in their advocacy efforts. This growth has allowed DAAS to increase service levels significantly. Overall, funding has increased by $2,890,175 (66%). The number of DAAS-funded meals has grown from 1,078,791 to 1,701,145 (58% increase). This has allowed DAAS to fund service for almost one thousand additional clients.
- **Congregate Meals**: The congregate meals program has also benefited from significant addback funding in recent years, growing by $2,320,651. This has allowed DAAS to fund an additional 197,781 meals and service for 3,657 additional clients. In addition to increasing service levels and supporting infrastructure, this funding has also allowed DAAS to develop a new congregate meal model: Choosing Healthy Appetizing Meal Plan Solutions for Seniors (CHAMPSS). DAAS currently funds two CHAMPSS sites (located in Districts 4 and 7). With their CHAMPSS swipe card, clients can enjoy a nutritious meal in a restaurant setting. This program offers a higher level of flexibility, both in terms of menu choice and dining time. It has been popular with younger seniors who are less interested in the traditional congregate meal setting.
- **Grocery Bags**: The Grocery Bag program has grown from a series of small pilots to an established program in recent years. FY 15-16 funding of $1.1 million represents a 264% increase over FY 12-13 expenditures of $300 thousand. This additional funding has allowed DAAS to create new home-delivered grocery models and increase service levels.

Suggestions for DAAS consideration

Due in large part to the End Hunger by 2020 efforts, the DAAS nutrition programs have been a focal point, receiving significant funding from the Mayor and Board of Supervisors to expand service. Despite this expansion, DAAS is unable to serve all those potentially in need of service. Additionally, DAAS may need to further develop new program models to serve all of those in need – the traditional service models are not appropriate or preferred by all. More specifically:

- **Unmet need for home-delivered meals**: As noted in the first report in this needs assessment, there are 7,166 seniors and adults with disabilities who have income below 300% FPL, live alone, and report self-care disabilities.[15] Current service levels would reach a significant portion of this population – about 70% – but not all. Additionally, this estimate is just the population described as those likely to be in most dire need for this service – there are many more who may be living with others or do not report disabilities who would still benefit significantly from this service.

  Additional evidence of unmet need for this service is found in the waitlist and service level data. The HDM waitlist maintained by the DAAS Integrated Intake and Referral Unit is consistently over 200 clients and frequently reaches over 300 clients. While DAAS received additional funding in FY 15-16 to reduce the waitlist, it will likely grow back once clients are served.[16] Meal providers often overserve their contracts, leveraging

[15] Including those with independent living and ambulatory disabilities increases this estimate to 16,782.
[16] When waitlists are long, clients are less likely to be referred for the service and the list will be relatively static; however, as a waitlist begins to decrease, referrals typically increase again.

other funding sources to meet the need. In FY 14-15, meal providers reported serving 270,000 additional meals beyond their contracted service level.

- **Expansion of congregate meal service models**: DAAS has tended to provide its congregate meal program in the traditional approach of providing service at senior centers and, to a lesser extent, at senior housing sites. This model is reportedly less popular with younger seniors and limits the program's ability to serve younger adults with disabilities (see below). The new CHAMPSS congregate meal model has helped DAAS reach new clients and tends to be more attractive to younger seniors who are used to having more choice. DAAS should consider expanding this model and/or identifying additional innovative models to support the diverse preferences of the local population.
- **Meal services for adults with disabilities**: As noted in the last DAAS Needs Assessment, a population subset that appears to be underserved is younger adults with disabilities. While DAAS has significantly increased service levels for this population in the last year, the disparity compared to seniors remains due to disproportionate funding. HDM service slots for younger adults with disabilities age 18 to 59 have increased from 572 to 955 (67%); however, this population accounts for 12% of funded meals. In the congregate meal program, spots for adults with disabilities have increased from 621 to 876 (41%), but this population accounts for five percent of all congregate meal slots. While Older Americans Act regulations prohibit significant use of its funding for non-seniors, the majority of nutrition funding is local money that allows for more flexibility. DAAS should continue considering opportunities to expand service for this population, which may require developing alternate models, securing additional funding, and/or funding new service providers to meet the preferences and needs of this population.
- **Demand for grocery bags**: There is no centralized waitlist for the Home-Delivered Groceries or the Food Pantry program that is specific to seniors and adults with disabilities. Outreach has been limited and many of these models operate on a neighborhood scale. However, provider agencies and OOA staff report that this program could easily find new clients in need of the service if funding were available to provide service. DAAS should investigate creation of a centralized waitlist.
- **Expansion of health promotion activities**: The Always Active program does not maintain waitlists but is at capacity. It is a flexible model can be scaled up relatively easily without significant cost –classes can be held in space available for a few hours per week without requiring a senior-specific or dedicated full-time space. As highlighted in focus groups, an added benefit of this program is the socialization and camaraderie developed by this program, going beyond the positive health benefits of the physical activity. The Healthier Living program has capacity for English-speaking workshops but not other languages. DAAS may want to focus on strengthening these programs.

Self-Care & Safety

Protecting seniors and adults with disabilities is central to the mission of DAAS. While older and disabled persons possess a variety of strengths and many are increasingly able to live independently in the community without assistance, many benefit from supportive services that promote their safety. Safety was a key theme across focus groups, highlighting a variety of issues: safety in public spaces, support in the home, social isolation and risk for depression, and abuse that can occur either in the home or community.

Because risk factors are complex, it can be challenging to estimate population need. Much of the data in this area comes from existing programs designed to support and protect the most vulnerable seniors and adults with disabilities.

Self-Care & Safety: Public Spaces

While the general walkability of the city and proximity of services were frequently highlighted as major assets of city living, seniors and adults with disabilities have significant concerns about their safety on the streets. Focus group participants were well aware that they are higher risk for traffic collisions and fatalities, sharing many anecdotes of close encounters. Older persons are more likely to suffer a fatal injury when involved in a collision than younger populations (San Francisco Department of Public Health, 2014). Between 1995 and 2004, 14% of the city's population was age 65 and older, but this group constituted 41% of traffic fatalities (Pedestrian Safety Project, 2015).

In focus groups, persons with disabilities stressed their concern about traffic incidents. Drivers seem frustrated by the slower pace of persons with mobility impairments and may not see those in wheelchairs because they are at a lower height. The focus group participants identified specific driver behaviors that make them feel unsafe, such as drivers "blocking the box"[17] and jumping the light to rush through a turn instead of waiting for pedestrians to cross. They did not believe that these behaviors were an enforcement priority for the San Francisco Police Department.

The participants described a variety of safety strategies. One relied on her cane to serve as an indicator that she will require additional time to cross the street. Many avoid dangerous intersections, like 9th Street and Market. One woman in a wheelchair said that she lives a short distance from Stonestown mall but will take a circuitous route involving three buses to get to the mall when she does not have an able-bodied person to accompany her across 19th Avenue. Traffic safety concerns were not just focused on vehicular traffic; seniors also felt threatened by fast-moving bicyclists who flout traffic regulations.

> *"I carry this cane because I get tired and also as a signal to others – especially drivers – that I will need extra time crossing the street."*
> *- Focus group participant with a disability*

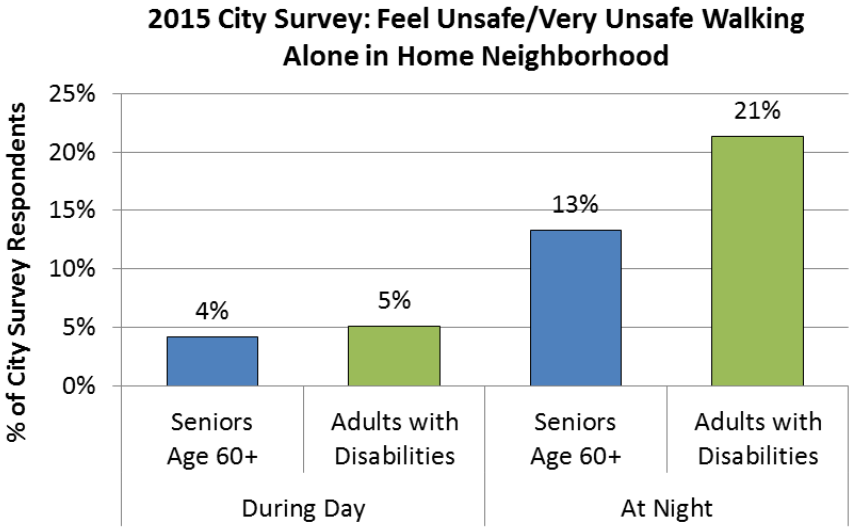
Seniors and adults with disabilities also expressed fear about crime but acknowledged this varied by neighborhood – the downtown areas (Tenderloin, Civic Center, and SOMA) were seen as the

[17] "Blocking the box" occurs when drivers attempt to make it through a light and get stuck in the intersection and/or crosswalk, leaving pedestrians to wait for the next light or venture out into traffic to cross the street.

most unsafe. Homeless older persons felt vulnerable to robbery and financial exploitation. One participant explained, "As an older man, you are vulnerable. People know you have an SSI check." They might be pressured into giving away some of their limited resources to avoid a fight or larger robbery. Some declined subsidized housing opportunities in the Tenderloin because the area was too dangerous, preferring to wait for an opportunity in another neighborhood. Latino seniors living in the Mission also brought up safety concerns. Generally, their neighborhood feels safe, and they feel connected to their local community, but they have noticed an increase in drug sales and graffiti (believed to be gang-related) in recent years, making some parts of the area feel scary. Participants agreed with a peer who said, "After dark, [gangs] are the rulers of the Mission."

This variation in perceptions of safety based on location and time of day is consistent with the 2015 City Survey. As shown below, both seniors and adults with disabilities feel less safe walking alone at night than during the day (a feeling shared by all survey respondents). Adults with disabilities are much more likely to feel unsafe than seniors and the overall population.

A review of responses by district indicates that those living in District 6 (Tenderloin, SOMA), District 10 (Bayview-Hunters Point), and District 11 (Excelsior) are much less likely to feel safe at night: 27-42% report feeling "unsafe" or "very unsafe" at night. These are areas where younger disabled adults tend to live, which influences in the higher response in the chart to the right.



Source: 2015 City Survey

Self-Care & Safety: Out-of-Home Care Facilities

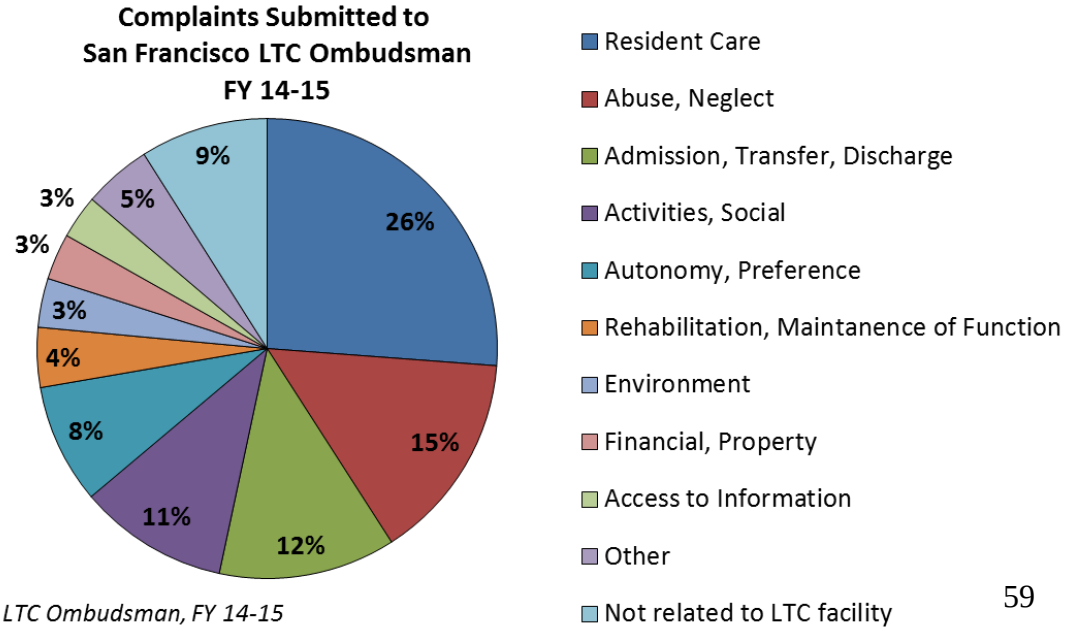
Many older persons reside, at least temporarily, in supportive out-of-home facilities. According to California's Office of Statewide Health Planning and Development records, there are 2,759 skilled nursing facility (SNFs) beds in San Francisco. Located in hospital and free-standing long-term care facilities, these beds serve those who require a level of medical care. Residential Care Facilities for the Elderly (RCFE), serving those who do not require skilled nursing support but benefit from on-site personal care, provide an additional 3,190 beds (CDPH, 2015); these facilities are frequently referred to as "assisted living" or "board and care." Approximately 980 (31%) RCFE beds are in Continuing Care Retirement Communities, indicating a portion of these beds are actually independent living apartments for those who do not yet require supportive services.

Persons living in institutional settings are often at particular risk for abuse and neglect. Most suffer from chronic diseases that can impair physical and cognitive functioning, making them dependent on others. They may be unable to report abuse or fear retaliation if complaints are made (Hawes, 2003). A review of the literature suggests 24-29% of nursing home residents may experience abuse by staff (Castle et al, 2015). However, given the underreporting of abuse, it is difficult to estimate prevalence with certainty. Other sources suggest that up to 44% of nursing home residents have experienced abuse (National Center on Elder Abuse, 2012). Notably, it is not just staff posing a risk; residents are also vulnerable to mistreatment from other residents, including verbal, emotional, and physical abuse (Castle et al, 2015).

LGBT seniors face unique risks associated with out-of-home placement, particularly transgender persons. This population is more likely to depend on facility-based care, because they are less likely to have informal caregivers to support them in the community. Approximately 80% of long-term care is provided by biological family members and, while many LGBT people have chosen families to rely on, many of these chosen family members of the same age and are facing similar challenges (MAP & Sage, 2010). Once in a facility, LGBT seniors are at risk of discrimination and may feel pressure to hide their sexual orientation. In a national study, almost half of LGBT seniors, their family and friends, and service providers reported experiencing or witnessing discrimination (National Senior Citizens Law Center, 2011).

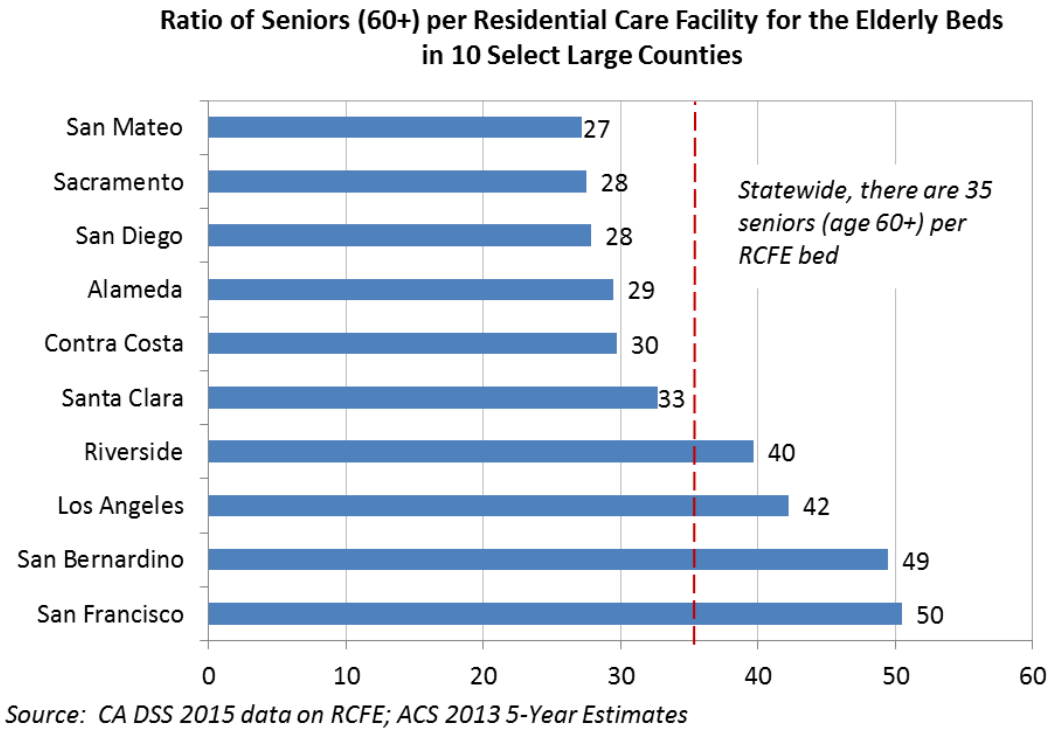
The Long-Term Care Ombudsman is responsible for investigating allegations of abuse against persons living in institutional care. In FY 14-15, the local office provided support (e.g., information, consultation) to 2,449 clients **This is a 28% increase over FY 11-12 service levels, when 1,910 clients were served**. This increase is partially the result of increased LTC Ombudsman staffing level but is also likely related to increased turnover in SNF beds (due to a shift towards short-term rehabilitation stays – described in more detail on the next page).

In FY 14-15, the office closed 360 cases, which involve more in-depth gathering of evidence and resolution support. Out of 523 complaints, most were related to resident care (26%), abuse and gross neglect (15%), and admission/transfer/discharge issues (12%). The LTC Ombudsman program resolved 70% of these complaints.



Source: LTC Ombudsman, FY 14-15

A critical facet of out-of-home placement is the decreasing availability of these beds, particularly for Medi-Cal clients. **Between 2003 and 2013, the number of SNF beds in San Francisco declined by 765 beds (22%)**.[18] In contrast, most other large California counties saw an increase in SNF beds during this time. A recent report by the San Francisco Department of Public Health found that the city has 22 SNF beds per 1,000 adults age 65 and older. To maintain this bed rate, the city would need 4,287 SNF beds by 2030 – an increase of almost 70% (SF Department of Public Health, 2016). The city also faces a short supply of RCFE beds, particularly in comparison to other large California counties. As shown below, there are 50 seniors age 60 and older for every RCFE bed in San Francisco, compared to a statewide rate of 35 seniors.



Source: CA DSS 2015 data on RCFE; ACS 2013 5-Year Estimates

These trends are driven by low reimbursement rates for long-term care. SNFs have been shifting to providing short-term rehabilitation beds to capture the more lucrative Medicare reimbursement rates. **The estimated bed rate for long-term Medi-Cal SNF beds is 14 beds per 1,000 adults age 65 and older**[19] (SF Department of Public Health, 2016). The state-set RCFE rate for persons on SSI (~ $1,000/month) is so low that all RCFEs in San Francisco only accept private pay clients who can afford at least $3,500 per month or clients with a "patch" subsidy from another payer. The majority of these patch subsidies are only available to persons connected to SFDPH. The San Francisco LTC Ombudsman estimates that only 20 out of the 75 of San Francisco RCFE facilities accept "patched" SSI clients.

The other major factor in the loss of out-of-home care options is gentrification. RCFE facilities

[18] Based on OSPHD Annual Utilization Reports for hospital and free-standing LTC facilities

[19] Free-standing LTC facilities are not required to delineate SNF beds used for long-term care or short-term rehabilitation in their annual utilization reports. For these facilities, this estimate relies instead on analysis of payment source – residents whose principal payer is Medi-Cal are assumed to be in long-term care beds.

face the same cost of living increase as the general population, requiring them to increase their rates. Some RCFE facilities have informally shared with DAAS staff that the $3,500 monthly bed rate is their breakeven threshold; this is likely to rise as minimum wage increases. In particular, many of the smaller RCFE facilities – home to six or fewer clients – have chosen to close or have been unable to reopen after negative events like a destructive fire.

This decline in placement options puts vulnerable and frail persons at risk for negative health events and increased mortality. While supporting clients to live in the community is an appropriate goal for most older and disabled persons, many need the higher level of care available in out-of-home placement. With the loss of these options, these individuals either live at high risk in the community or are forced to leave San Francisco to find placement. Additionally, SNF facilities, facing financial pressure to discharge rehabilitation patients within prescribed time frames, may send clients home without adequate supports in place for a safe transition. The San Francisco Ombudsman investigated 54 complaints about rights related to discharge planning in FY 14-15.

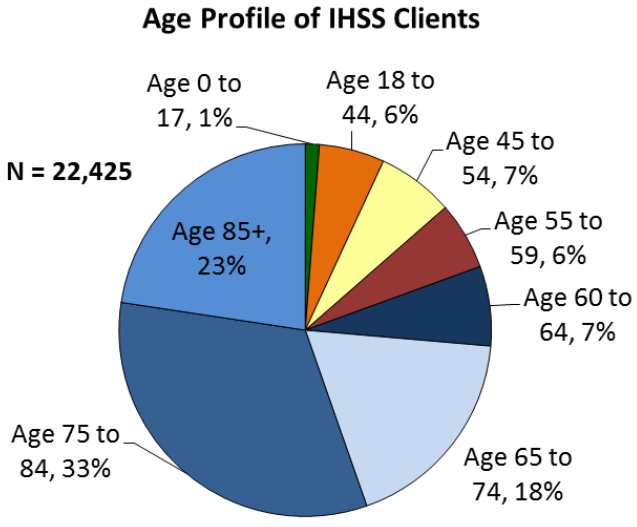
Self-Care & Safety: Support in the Home

With the loss of out-of-home options and the focus on community living, support in the home has become increasingly important. Many persons with disabilities can live safely in the community with in-home assistance. This assistance may support the fundamental *activities of daily living* (ADLs), such as bathing and dressing, or the more complex *instrumental activities of daily living* (IADLs) that support community living, such as grocery shopping and housework.

The primary formal source of in-home support is the In-Home Supportive Services (IHSS) program, a benefit for Medi-Cal clients with disabilities. Through this program, clients can receive up to 283 hours per month of in-home care. Housed within DAAS, the San Francisco IHSS program has one of the largest caseloads of major counties in California, suggesting that the service has achieved significant penetration in the disability community. After growing by 33% between 2005 and 2012, the caseload has stabilized around 22,300 clients in recent years.

The characteristics of the IHSS caseload include:[20]

- *Age*: Most (74%) are seniors age 65 and older.[21] Over half are 75 and older.
- *Ethnicity*: Senior IHSS clients tend to be API (61%) and white (23%). Younger adult clients are mostly African-American (35%) and white (24%).
- *Language*. Most senior IHSS clients speak a Chinese language (51%) or Russian (17%). Sixty-nine percent of the younger adult population speaks English.



Source: CMIPS II database June 2015

[20] Please see Appendix B for additional detail.

[21] Medi-Cal uses age 65 as the senior threshold. The IHSS program serves a small number of disabled children, most of whom are severely disabled and require paramedical-level services.

- *Location*. Senior clients are most likely to live in District 6 (20%) and District 3 (17%). Adult clients tend to live in District 5 (25%) and District 10 (18%).
- *Functional assessment*. The most common areas in which both seniors and adults are assessed as being dependent or in need of significant help are: housework, laundry, shopping, and meal preparation.
- *Hours*. On average, both groups receive about 91 hours of care per month (21 hours/week).

Overall, senior IHSS clients tend to have higher rates of dependence in functional areas impacted by mobility impairment. Assessed functional impairment and mode of service delivery suggests that younger adult clients are more likely than seniors to need support for psychiatric challenges. They are more likely to be assessed by IHSS workers as impaired in the areas of orientation and judgment (e.g., 37% of younger adults are assessed with impaired judgment capability compared to 13% of seniors). About 11% of younger adults are enrolled in "contract mode" service in which a community-based organization manages the home care worker because the client is determined to need assistance.

While the IHSS program is critical for many low-income persons living in the community, many in need of in-home support are ineligible for no-cost Medi-Cal.[22] In particular, those just above eligibility – frequently referred to as the "upper poor" or "hidden poor" – are at risk of being unable to obtain consistent, quality care. At the $28 median hourly rate for private home care in San Francisco, it would cost $2,546 per month to purchase the level of care received by the average IHSS client (Genworth, 2015). Share-of-cost Medi-Cal allows individuals to maintain only a minimal portion of their monthly income, making it unfeasible for most given the high San Francisco cost of living; for example, a single individual is generally allowed to keep only $600 of monthly income and must pay the rest to access care. Many must rely on a patchwork of informal caregiving to meet needs (see the Caregiver Support Services section of this report for more information).

Recent studies by the San Francisco Controller's Office and the Budget and Legislative Analyst Office have focused on those ineligible for no-cost Medi-Cal but unable to afford private service, providing a foundation for service providers and policymakers to consider potential strategies to support this population. Using similar but distinct methodologies, these studies suggest:

- *Controller's Office* study: Between 24,771 and 45,921 seniors and adults with disabilities in 1-2 person households may be unable to afford long-term care if it were needed.
- *Budget and Legislative Analyst* report: 14,419 seniors age 65 and older are likely in need care but are ineligible for IHSS and unable to afford private care.

Self-Care & Safety: Abuse and Self-Neglect in the Community

Older persons and adults with disabilities living in the community are also at risk for abuse by others, as well as self-neglect. This abuse can take many forms, including health and safety hazards, financial exploitation, caregiver neglect, physical abuse, forced isolation, and more. As with abuse in institutional settings, underreporting makes it difficult to pinpoint the prevalence of

[22] Seniors age 65 and older are held to the traditional Medi-Cal thresholds of monthly income below 100% FPL (closer to 125% FPL with income disregards) and asset limitations (e.g., $2,000 for a single household). With the Affordable Care Act Medicaid expansion, adults age 18 to 64 are eligible for no-cost Medi-Cal if their income is below 138% FPL.

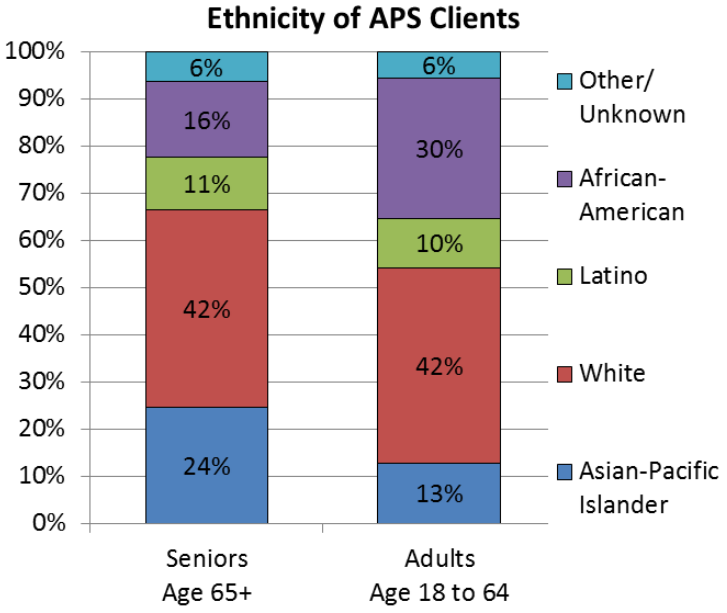
abuse in the community. Older adults and persons with disabilities may be reluctant to report abuse by another person for fear of retaliation, lack of physical or cognitive ability to report, or concern about getting the abuser in trouble (many abusers are family members and friends), as well as cultural dynamics related to shame. Persons who are self-neglecting may lack insight into their circumstances or fear loss of independence if they ask for help. For every incident reported to authorities, an estimated 14 to 24 incidents likely go unreported (National Center on Elder Abuse, 1998; Lifespan of Greater Rochester Inc, 2011).

Research has attempted to estimate prevalence by conducting population surveys, though much of this work is focused on abuse by others. One study found that 10% of seniors age 60 and older had experienced abuse in the prior year, primarily emotional abuse (Acierno et al, 2010). Applying that percentage to the local population equates to slightly over 16,000 older adults. Research suggests that up to 70% of persons with disabilities may experience neglect or emotional and/or physical abuse in their lifetime (Powers et al, 2002; Powers et al, 2008). Persons with dementia are also at greater risk of abuse. One study suggested close to 50% of persons with dementia will experience some kind of abuse from a caregiver – verbal and psychological abuse were the most commonly self-reported behavior by the surveyed caregivers (Cooper et al, 2009).

The San Francisco Adult Protective Services (APS) program provides the most detailed local information on abuse among elders and adults with disabilities. Located within DAAS, this program relies on masters-level social workers to investigate allegations of abuse, collaborate with criminal justice partners, and conduct short-term intensive case management to facilitate service connections and help stabilize vulnerable individuals. In FY 14-15, APS received 6,751 reports of abuse, a five percent increase over FY 12-13 levels (and fourteen percent increase over FY 11-12 levels). These allegations focused on 4,752 unduplicated individuals and resulted in 5,804 APS cases.

Client characteristics include:[23]

- *Age*: Most (65%) are seniors age 65 and older (used as the age threshold for senior). Over 40% are age 75 and older.
- *Ethnicity*: Senior APS clients tend to be white (42%) and API (24%). Younger adult clients are mostly white (42%) and African-American (30%). Compared to the population demographics discussed in the first report of this needs assessment, API are underrepresented.
- *Language*. Most APS clients speak English (66% of seniors and 85% of disabled adults). Ten percent of



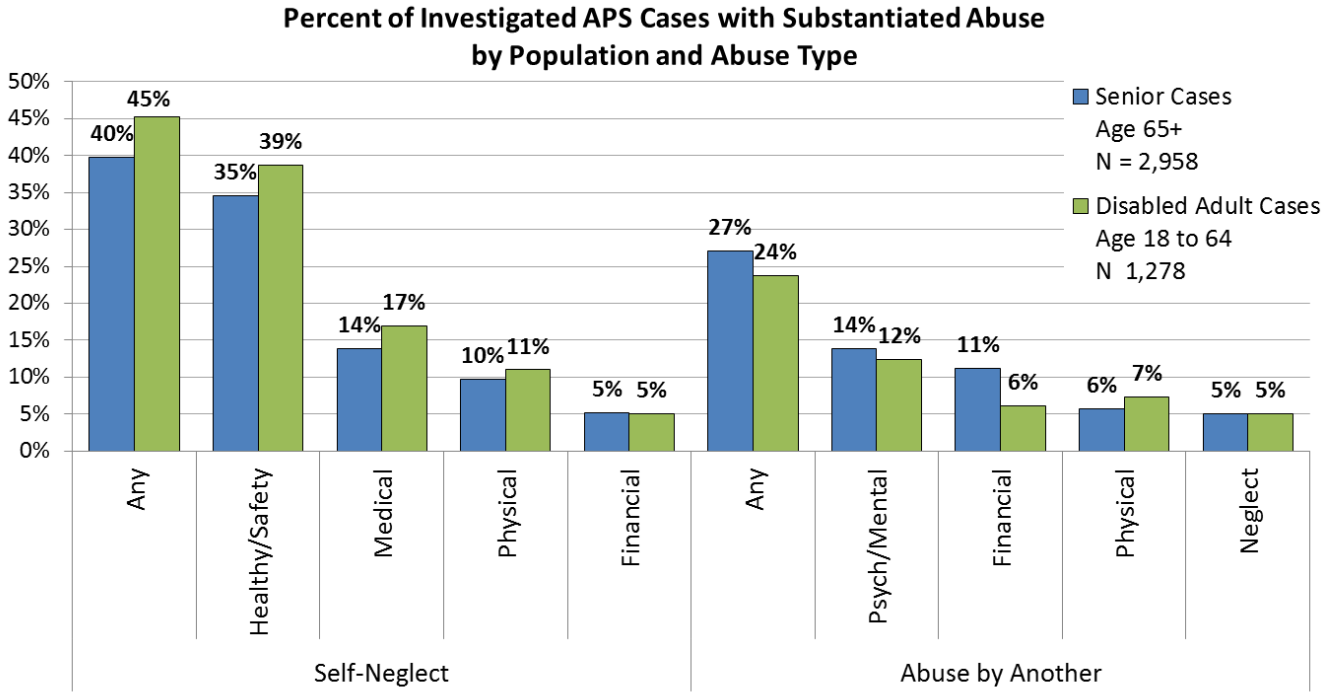
Source: AACTS database FY 14-15
Analysis based on unduplicated clients with 1+ report of abuse

[23] Please see Appendix C for additional detail.

seniors speak Chinese and eight percent speak Spanish.

- *Location*. Senior clients are most likely to live in District 6 (14%), as well as District 3 and District 5 (11% in each). Adult APS clients tend to live in District 6 (32%), as well as Districts 5, 9, and 10 (9 to 11% in each).
- *Assessed risk.* APS workers assess client risk across a variety of risk factors. The most common risk areas for both seniors and adults with disabilities are: unmanaged health/frailty, poor judgment and insight, and a current state of crisis with significant risk to client health and safety. About 30% of seniors and 28% of adult clients have moderate to high risk in these areas. Cases for adults with disabilities also tend to involve significant risk related to mental health concerns (21% of adult cases).

APS completes full, formal investigations for approximately 70% of cases.[24] In these investigated cases, the most common type of confirmed abuse is self-neglect, documented in 40% of senior cases and 45% of disabled adult cases. Confirmed abuse by another person is less common – about one in four investigated cases results in this finding. Overall, trends are similar between seniors and adults with disabilities. Seniors are slightly more likely to experience abuse by another, while the younger adult population has slightly higher rates of self-neglect than senior clients.



Source: AACTS database, FY 14-15 cases

A unique subset of APS clientele is people struggling with hoarding and cluttering disorder. By the time APS is contacted, they are often at risk for losing their housing. Approximately 170 APS cases per year involve high risk related to environmental hazards (defined as highly unsafe or unsanitary living conditions and/or excessive hoarding that poses a significant health and

[24] APS follows up on every report of abuse within its jurisdiction. However, because APS is a voluntary service, clients may decline to cooperate. Additionally, if another agency is already intervening to assist a client, APS staff may not take an active role.

safety hazard to client).[25] Most are seniors (65%) and exhibit risk related to poor judgment/lack of insight (82%) and mental health (42%). Approximately 38% were at risk for losing housing. The APS program recently carried out a pilot study focused on hoarding prevention and housing preservation. The findings underscore the complexity of these issues. On average, clients were connected to three additional service providers, requiring a significant amount of staff time to coordinate their intervention efforts. It tends to take more effort and time to engage clients with hoarding disorder and motivate them to change their behavior. In this study, it took four months on average to resolve health hazards and slightly longer to reduce the threat of eviction; by comparison, the average APS case is closed within 45 days. Through this more intensive and collaborative approach to supporting these clients, APS helped 75% of clients at risk for eviction preserve their housing, and 88% resolved their health and safety code violations.

Another important issue for APS is recidivism, defined as a new case opened within one year of a prior case closure. In FY 14-15, 31% of clients – 1,425 individuals – had at least one recidivist case. About 3% – 155 individuals – were high-use recidivists with three or more recidivist cases. Research suggests executive function impairment is a risk factor for recidivism in APS referrals (Terracina et al, 2015). In the local APS program, five percent of non-recidivist clients were assessed with high risk related to judgment compared to 13% of the recidivist client population and 30% of the high-use recidivist group. There is also notable overlap between recidivism and the high-risk environmental hazards group: 54% of clients with high environmental hazard risk were recidivist clients. The APS program is working to develop new strategies to track and support these clients, including partnering with UC Berkeley graduate students for an evaluation of client characteristics.

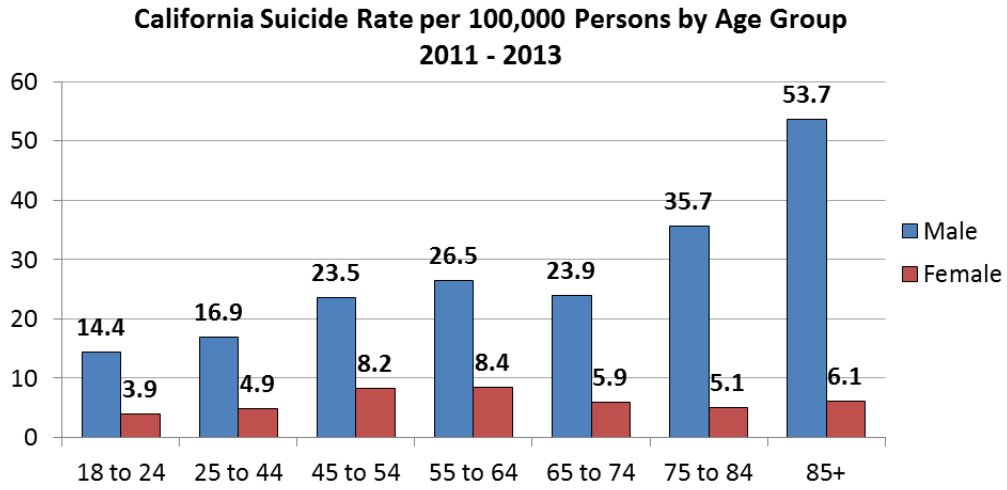
Self-Care & Safety: Social Isolation and Depression

As people age, they are more likely to live alone and are at higher risk of becoming isolated. Isolation and loneliness put seniors and adults with disabilities at risk for a variety of negative outcomes, including depression and suicidality (Centers for Disease Control and Prevention, 2016). As discussed in the first report of this assessment, about 30% of seniors and adults with disabilities – 55,871 individuals – live alone. Seven thousand more seniors live alone today compared to 2012.

Risk factors for suicide in late life include physical illness and pain, mobility impairment, fear of becoming a burden, and isolation (Van Orden & Conwell, 2011). Due in part to discrimination and mental health challenges, LGBT seniors are at higher risk for suicidal ideation. A recent study of LGBT seniors in San Francisco found that 15% had seriously considered taking their own lives in the prior year (Fredriksen-Goldsen et al, 2013a).

Suicide rates are highest among older persons. While younger persons make more attempts, seniors are more likely to complete the act because they tend to use more lethal methods. The American Foundation for Suicide Prevention (2016) estimates that the ratio of suicide attempts to suicide death in youth is about 25:1, compared to about 4:1 among older adults. The chart on the following page illustrates this variation.

[25] An additional 450 to 490 cases per year are assessed with moderate risk related to environmental hazards, defined as "moderate hoarding or evident safety hazards in home posing potential risk to client."



Source: Centers for Disease Control and Prevention. National Center for Health Statistics. Health Data Interactive. www.cdc.gov/nchs/hdi.htm. Accessed February 26, 2016.

Cultural factors influences perception and reporting of depression, as well as access to treatment. Research indicates that older white adults are more likely to be diagnosed and treated for depression than minorities (Akincigil et al, 2011). Stigma, as well as mistrust of medical establishment and/or Western medicine, can prevent those experiencing depression from seeking help. Additionally, minority patients may be more likely to present with physical aspects of depression (e.g., sleep problems or pain) or use cultural idioms to describe their symptoms (Alegría et al, 2008). Interventions must take these cultural factors into account to accurately identify depression and support all who need help.

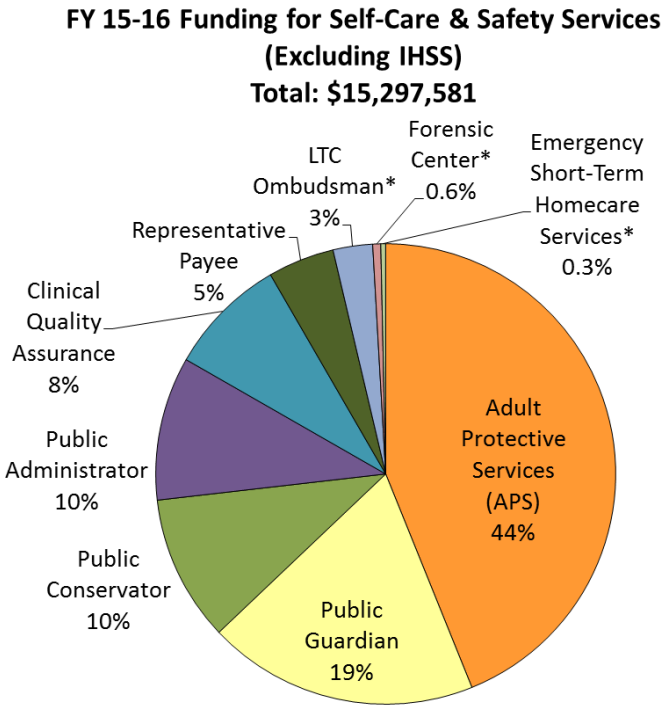
Recent Trends related to Self-Care and Safety

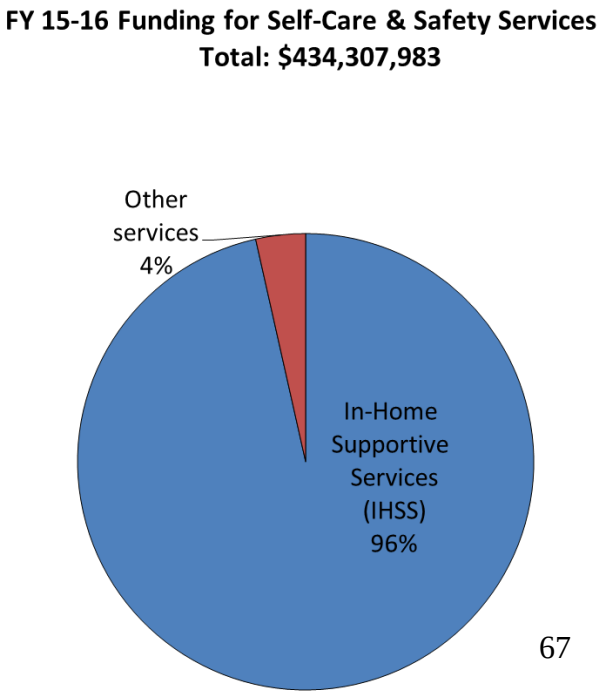
- **Traffic safety improvements** – In 2014, the San Francisco Municipal Transit Agency (SFMTA), Board of Supervisors, and Mayor Lee adopted a Vision Zero safety campaign aiming to eliminate all fatalities and major injuries from traffic collisions by 2024. Within the first two years of this campaign, SFMTA completed 24 projects to improve safety on San Francisco streets and sidewalks, including removing obstructions at 119 intersections to improve visibility (particularly for children and persons in wheelchairs), installing painted safety zones at 27 intersections to keep cars farther from pedestrians, and modifying traffic signal timing at 41 intersections to give pedestrians a head start crossing streets. As this campaign continues, the streets of San Francisco will become safer for older persons and those with disabilities.
- **Availability of institutional care options** – As described earlier in this section, there has been a significant decrease in the number of SNF beds over the last ten years. Moreover, many of the remaining beds have been converted to short-term rehabilitation care, reducing the local options for frail persons in need of skilled nursing care and putting these individuals at risk for living unsafely in the community or having to leave San Francisco. Assisted living RCFE beds are increasingly expensive and unavailable for low-income persons, even those with a patch subsidy. The San Francisco Department of Public Health has recently led efforts to further analyze these trends. This work is expected to continue with a citywide Post-Acute Care Collaborative to continue delving into the problem and develop policy solutions as appropriate.

- **Implementation of 5270 30-day involuntary hold** – In October 2014, the San Francisco Board of Supervisors voted to implement the Welfare and Institutions Code § 5270, allowing for an additional 30 days of involuntary treatment for persons certified by the Court as gravely disabled due to mental illness. This gives medical and psychiatric professionals additional time to stabilize clients before – or in lieu of – making a referral to the Public Conservator program for a longer involuntary conservatorship. This 30-day period occurs after a client has been held on a 3-day 5150 hold and a subsequent 14-day 5250 hold. Giving mental health professionals additional time to evaluate need and provide support will better support persons with mental health challenges that do not immediately rise to the level of conservatorship.
- **Decrease in acute psychiatric care beds** – Over the last sixty years, treatment of mental illness has changed significantly, shifting from state-based hospitals to community-based care managed at the county level. While community-based care can provide intensive treatment for those with high needs, people with severe mental illness may require acute inpatient treatment at times. However, the availability of such treatment is increasingly limited. At the national, state, and local level, the number of acute psychiatric care beds has declined significantly. Between 1995 and 2013, California lost almost 2,700 beds, a decline of almost 30% (California Hospital Association, 2015). In San Francisco, most of these beds have historically been located at San Francisco General Hospital. In FY 13-14, San Francisco General Hospital maintained 63 inpatient acute psychiatric beds (SFDPH, n.d.); as of 2016, the bed total is 44 (UCSF, n.d.).

DAAS Programming related to Self-Care and Safety

The IHSS program dominates spending on Self-Care and Safety Services, accounting for 96% of the FY 15-16 budget for this service area. Notably, 93% of the $434.3 million IHSS budget funds wages, benefits, and services for care providers. To allow for review of spending on other Self-Care and Safety services, the chart below on the left excludes IHSS. Of the $15.3 million spent on other services, most (83%) goes to mandated services provided by DAAS: APS, Public Guardian, Public Conservator, and Public Administrator.





**Office on Aging-funded service*

These Self-Care and Safety services – some of which were highlighted earlier in this section – are described briefly below:

- ***In-Home Support Services (IHSS)***
  FY 15-16 Service Target: 22,500 clients

The IHSS program is a Medi-Cal benefit that provides non-medical, in-home care for persons with disabilities. While the county is responsible for determining eligibility and monthly hours, care is provided by independent providers selected and managed by the care recipient. A small percentage of clients (5%) are deemed incapable of this responsibility and are served through contract mode delivery (care coordinated/managed by a community-based organization). Types of assistance provided ranges from dressing and bathing to tasks like grocery shopping and meal preparation.

- ***Adult Protective Services (APS)***
  FY 15-16 Service Target: 6,100 reports of abuse

APS is a state-mandated program that investigates possible abuse or neglect of elders and adults with disabilities. Abuse may be physical, emotional, financial, neglect, or self-neglect. Clients have the right to refuse APS services unless a penal code violation is suspected to have occurred, or unless a client lacks the ability to understand the risks associated with their decisions. The APS program collaborates with a variety of public and community-based partner agencies for the protection of vulnerable clients, including the San Francisco Police Department (SFPD) and the District Attorney's office around the investigation and prosecution of suspected abuse. A critical part of this work is the coordination of a wide range of services in order to stabilize clients. When necessary, the APS program will refer clients to community-based case management for more long-term support and care coordination or to the Public Guardian for conservatorship.

- ***Public Guardian***
  FY 15-16 Service Target: 360 clients

The Public Guardian program supports people whose physical and mental limitations make them unable to handle basic personal and financial needs. Most clients have dementia or experienced Traumatic Brain Injuries (TBI) that have permanently impacted their capacity. A mandated program, Public Guardian staff is responsible for managing medical care, placement, and financial resources. Referrals are often made by APS workers, hospital staff, and other service providers who have identified vulnerable seniors and adults with disabilities living in the community who lack capacity to act in their own interest or are subject to undue influence. These conservatorships are reviewed by the Probate court annually but typically last for life or until there is a successor conservator.

- ***Public Conservator***
  FY 15-16 Service Target: 700 clients

The Public Conservator provides mental health conservatorship services for San Francisco residents who are gravely disabled (unable to provide for their food, clothing or shelter) due to mental illness and who have been found by the Court unable or unwilling to accept voluntary treatment. Referrals are only accepted from psychiatric hospitals. Mental health conservatorship is a legal procedure that appoints a conservator of the person to authorize psychiatric treatment. The client must meet a narrow definition of grave disability by reason of a mental disorder.

Conservatorships are generally time limited – one year or less – and must be renewed annually if the client needs continuing support.

❖ ***Public Administrator***

FY 15-16 Service Target: 500 cases

When a San Francisco resident dies and there are no family members to take care of his or her affairs, the Public Administrator program will manage the estate. In this role, staff search for family members and wills, arrange for disposition of remains, locate and manage all assets, monitor creditor claims, reviews taxes and provide all services necessary to administer each estate through distribution to heirs and beneficiaries. This is a mandated program.

❖ ***Clinical Quality Assurance***

FY 15-16 Service Target: 500 referrals

The DAAS Clinical and Quality Assurance (CQA) unit was launched in FY 15-16 to provide clinical consultations by Registered Nurses and Licensed Clinical Social Workers to serve IHSS and APS consumers with complex clinical needs, including complex medical, nursing and behavioral health needs. The CQA unit works collaboratively within DAAS and outside healthcare professionals in order to evaluate clients' medical and/or behavioral health needs, as well as to assess client's readiness for change and engagement with services. They create a client-centered service plans and refer clients to community resources that will best assist in recovery from trauma, mental or physical illness. Staff also provides clinical interventions to DAAS clients who have been screened for dementia, depression, and suicide risk.

❖ ***Representative Payee***

FY 15-16 Service Target: 1,350 clients

The Representative Payee is similar to the OOA Money Management service but is provided directly by DAAS staff. It is categorized within the Self-Care and Safety section because of its target client population and close association with the other protective service programs. This program was developed within the Public Guardian to support high-risk, vulnerable clients who do not require a full conservatorship but require a moderate level of financial support. In this program, Representative Payee staff is appointed by the Social Security Administration as the payee on record, and monthly benefit checks are sent directly to the DAAS office. The program also manages pension benefits for some clients.

❖ ***Long-Term Care Ombudsman [OOA]***

FY 15-16 Service Target: 2,250 clients

The Long-Term Care Ombudsman protects and promotes the rights of residents in long-term care facilities, such as skilled nursing facilities. The program is responsible for investigating and resolving complaints, maintaining a regular presence in long-term care facilities, and addressing patterns of poor practice. Ombudsman services also include public education and empowerment, as well as systems-level advocacy.

❖ ***Forensic Center [OOA]***

FY 15-16 Service Target: Twice monthly Elder Abuse Forensic Center meetings

The Forensic Center is responsible for improving communication and supporting collaboration among the legal, medical, and social service professionals who investigate and intervene in cases

of elder and disabled adult abuse. To accomplish this aim, the Forensic Center coordinates a multi-disciplinary team comprised of the San Francisco Police Department, the District Attorney's Office, Adult Protective Services, Public Guardian program, and paid consultants (e.g., Geriatrician, a Geriatric Psychiatrist or other professionals deemed integral to the Forensic Center case discussions). This team meets on a regular basis to discuss cases of dependent adult and elder abuse with the goal of sharing expertise and resources to provide further direction, which might involve prosecution, to the cases being discussed.

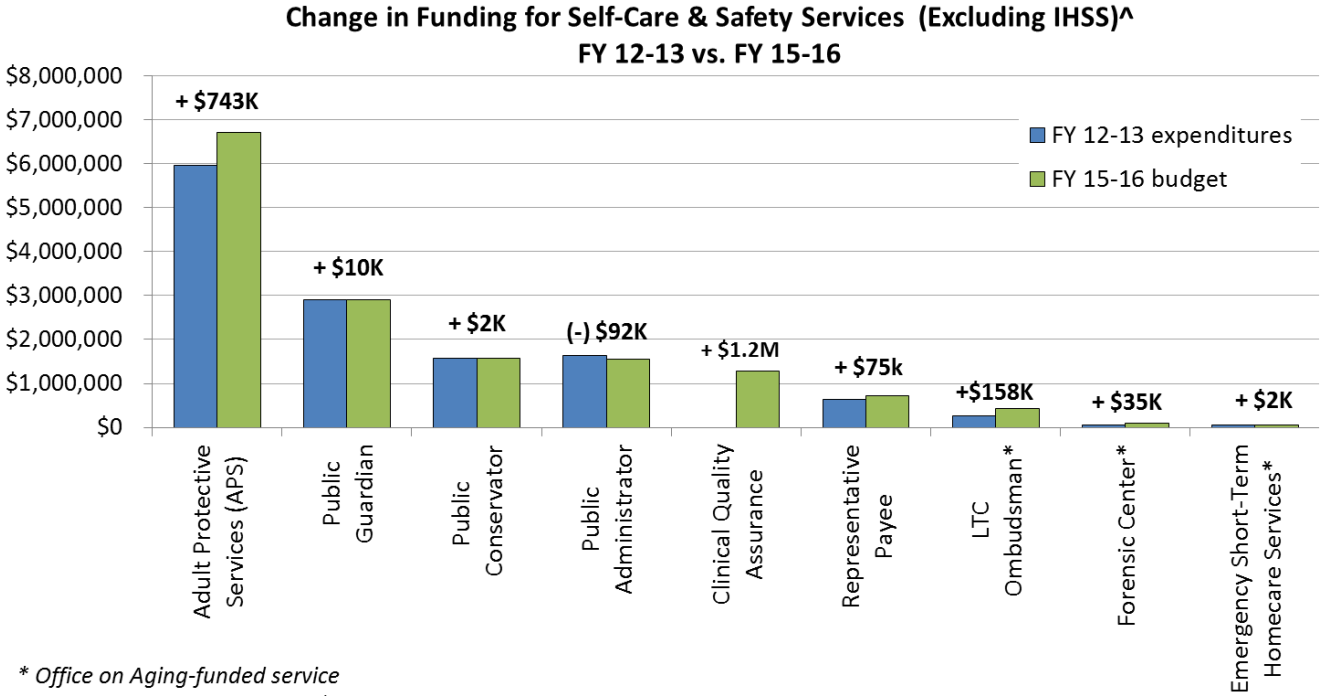
❖ ***Emergency Short-Term Homecare Services [OOA]***
FY 15-16 Service Target: 180 clients in each service

Emergency short-term homecare services provides up to 12 hours of in-home support for seniors who (a) are experiencing difficulty in their home with activities of daily living, (b) have been discharged from a hospital or institution, or (c) are in the process of applying for the IHSS benefits but need more immediate assistance. There are three types of services provided: homemaker, chore, and personal care support.

Note: DAAS also funds the Center for Elderly Suicide Prevention (CESP), which is categorized in the section on Services to Prevent Isolation.

Changes in DAAS Programing related to Self-Care and Safety Services

The FY 15-16 budget for Self-Care and Safety Services is $84,370,379 (24%) larger than FY 12-13 expenditures. The majority of this increase is due to the IHSS program, budgeted for $82.2 million more than FY 12-13 expenditures of $336.9 million. The FY 15-16 budget for the other Self Care and Safety services is $2,213,074 larger (17%) than FY 12-13 expenditures. This increase is due primarily to the new CQA unit and increased APS program costs.



** Office on Aging-funded service*
^ The IHSS FY 15-16 budget is $82.2M larger than FY 12-13 expenditures (excluded from this chart to allow for analysis of change in smaller programs)

More specifically, this funding is driven by:

- **Growth in IHSS caseload and increase in costs**: IHSS is an entitlement program that all eligible persons are allowed to access. Over the last four years, the caseload has grown by almost 600 clients and the total weekly authorized hours grew by 46,000 hours. Provider costs have also increased: minimum wage rose from $10.24 to $12.25, the monthly health and dental cost per client increased, and more providers have enrolled in this coverage. Local funding – about $78 million – accounts for 19% of anticipated IHSS costs in FY 15-16, and most of this is the local contribution to provider wages and benefits.
- **Creation of the CQA Unit**: The new CQA unit was created largely by reassigning existing staff into a single unit under supervision of a Registered Nurse. This is the first time these positions are being attributed to a single program in the Self-Care and Safety service area.
- **Increase in staffing costs**: The APS FY 15-16 budget is 12% larger than FY 12-13 expenditures. This increase is primarily the result of increased costs associated with existing staff. Only two new positions were created in this time period. The program budget for its emergency payment fund – used for services like bed bug extermination and short-term placement – accounts for about $60,000 of this increase.
- **Expansion of LTC Ombudsman**: The LTC Ombudsman program model outlined by the Older Americans Act relies on volunteers to complete much of its work. In practice, this approach has been a challenge. After years of low funding, DAAS was able to secure additional resources for this program, allowing for a staffing expansion from 3.45 FTE to 6.3 FTE (partially provided through subcontracts to meet language and expertise needs).
- **Public Administrator**: The slight decrease in funding for Public Administrator program occurred when an administrative support position was reassigned to support the OOA.

Suggestions for DAAS consideration

- **Implementation of the Fair Labor Standards Act** – As of February 2016, IHSS independent providers fall under the protections of the Fair Labor Standards Act (FLSA). They will now be eligible for overtime, as well as travel pay when traveling between clients. In response to this change, the California Department of Social Services has issued a variety of new regulations. These changes have substantially altered program operations, increasing the complexity and time required for a variety of tasks. These requirements are ongoing, and DAAS should monitor staffing needs as the regulations take full effect.
- **Strategies for serving high-need APS clients** – Currently, the APS program does not have specialized units or staff that have specialized caseloads. This approach has many benefits, including allowing flexibility to respond to changing client and staffing needs and ensuring staff remain competent in the investigation and management of all abuse areas. However, high-need clients – particularly recidivists and those struggling with hoarding and cluttering disorder as well as those clients that are at risk of eviction – take significant time to engage and stabilize. In the current system, APS workers risk neglecting the rest of their caseload to serve these high-need clients or may not be able to provide the needed support to these more complex clients. It is likely unfeasible to create a specialized unit with existing program resources. APS workers currently receive an average of 17 new cases per month (in addition to those carried over from the prior month). DAAS should explore strategies to better serve these high-need clients while not

placing an undue burden on staff and balancing the demands of a diverse program caseload.

- **Investigate low rate of API participation in APS program** – About 24% of senior APS clients are API, but this group represents closer to 42% of the city's senior population. Utilization is particularly low among Chinese seniors: they are 31% of the population but only 13% of the APS caseload. While it may be that this trend is an accurate reflection of population trends, it is also possible that cultural factors influence reporting rates and that this group requires a revised approach. DAAS has highlighted this issue with the community contractors providing elder abuse prevention and outreach services, particularly Asian Pacific Islander Legal Outreach (APILO). While APILO works on this issue from an outreach perspective, DAAS should consider a deeper dive into this issue to learn more about what may be driving this discrepancy.
- **Support LGBT Bill of Rights in LTC facilities** – The LGBT Aging Policy Task Force report to the Board of Supervisors included a recommendation for the creation of an LGBT Bill of Rights for persons living in institutional care. This report also called for the monitoring of this program to ensure compliance. The LTC Ombudsman program has expressed a desire to implement these recommendations but has limited capacity to do so given their current workload. DAAS should consider opportunities to procure funding and/or support this work through other means.
- **Future of federal and state funding for LTC Ombudsman** – Older Americans Act funding for the LTC Ombudsman program uses a formula based on the number of LTC beds in the area. If the current decline in LTC beds continues, DAAS will receive less outside funding for this program in the future. Currently, the majority (75%) of this program budget is local funding, but DAAS should bear in mind that the outside share may decrease in coming years.

Conclusion

San Francisco faces unique challenges and opportunities. Recent economic prosperity has allowed the city to significantly expand its support of older adults and persons with disabilities. Yet at the same time, the skyrocketing cost of living has made it harder for these populations to make ends meet, making this public support increasingly critical.

Almost one in four city residents is a senior or an adult with disabilities. Driven by the aging of the Baby Boomer generation, this group is growing. Over the last two decades, the population age 60 and older has increased by almost 25,000 individuals. Currently 20% of the city's population, seniors will comprise 26% of city residents by 2030. The oldest group of seniors aged 85 and older – those most likely to need significant support to live safely in the community – has grown by almost 5,500 individuals. Systems of care must be prepared to support this population growth. Recent funding increases have strengthened some services but not all have received this reinforcement.

Affordable and accessible housing remains an acute issue for seniors and adults with disabilities because these populations tend to live on low fixed incomes. In a city where the median market rate for a one-bedroom apartment is $3,880 per month ($46,560 per year), the median household income for a single senior is around $22,000. Adults with disabilities living alone report a median annual income closer to $12,000. While large-scale housing programs are outside the scope of DAAS services, the department should collaborate with housing and homeless systems to support service for seniors and adults with disabilities, including the aging population of homeless persons.

Isolation is another persistent and pervasive risk. Loneliness and isolation are connected with poor health status, risk of abuse and self-neglect, and depression. In San Francisco, seniors are more likely to live alone than those in other communities. With every dollar needing to stretch farther as costs rise, low-income seniors and adults with disabilities face difficulty accessing opportunities for interaction and other necessary supports. Free and low-cost services in the community, as well as services that reach out to homebound persons, can have a significant impact for these persons.

Major demographic shifts have occurred over the last twenty years as San Francisco has become increasingly diverse. These trends must be accounted for in order to provide culturally- and linguistically- appropriate services. Compared to a 1990 senior population that was predominantly white and English-speaking, the senior population today is increasingly API and 54% speak a primary language other than English. Over the same period, the African-American population has faced significant strain, declining from ten percent of seniors to seven percent. The city must support this population's ability to remain in San Francisco as its members age.

San Francisco is a city that supports both innovation and the ability of people to live safely in the community of their choice. These values are evident in DAAS programs, such as the Community Living Fund, new and expanded nutrition service models, and transitional care services. DAAS must continue working creatively with community partners to meet the diverse and evolving needs of the city's seniors and adults with disabilities.

Sources

Administration on Aging. "National Family Caregiver Support Program." Accessed January 4, 2016, at http://www.aoa.acl.gov/AoA_Programs/HCLTC/Caregiver/.

Alzheimer's Association. (2009). *Alzheimer's Disease Facts and Figures in California: Current Status and Future Projections*. Downloaded on January 4, 2016, at http://alz.org/CAdata/FullReport2009.pdf.

Alzheimer's/Dementia Expert Panel (2009). *San Francisco's Strategy for Excellence in Dementia Care: Research, Recommendations, and an Action Plan to Address the Growing Crisis in Dementia Care, and an Economic Analysis of that Care.* For: San Francisco Department of Aging and Adult Services. Downloaded on January 4, 2016, at http://www.sfhsa.org/asset/ReportsDataResources/DementiaStrategyPartONEofTWO.pdf

Alzheimer's Association, 2011 Alzheimer's Disease Facts and Figures, Alzheimer's and Dementia , Vol.7, Issue 2.

BERK Consulting. (2015). *Reinvesting and Renewing for the 21st Century: A Community and Economic Benefits Study of San Francisco's Branch Library Improvement Program*. Accessed online February 9, 2016, at http://sfcontroller.org/Modules/ShowDocument.aspx?documentid=6804.

British Columbia Ministry of Health. (2004). *Social Isolation Among Seniors: An Emerging Issue*. Accessed online January 6, 2016, at http://www.health.gov.bc.ca/library/publications/year/2004/Social_Isolation_Among_Seniors.pdf.

Schubert, C. C., Boustani, M., Callahan, C. M., Perkins, A. J., Hui, S., & Hendrie, H. C. (2008). Acute care utilization by dementia caregivers within urban primary care practices. Journal of General Internal Medicine, 23(11), 1736-1740.

Cacioppo, J. T., & Hawkley, L. C. (2009). Perceived social isolation and cognition. *Trends in cognitive sciences*, *13*(10), 447-454.

Cacioppo, J., Hawkley, L., Crawford, L.E., Ernst, J., Burleson, M., Kowalewski, R., Malarkey, W., Van Cauter, E., & Berntson, G. (2002). Loneliness and Health: Potential Mechanisms. *Psychosomatic Medicine,* 64: 407-417.

California Hospital Association. (2015). *California's Acute Psychiatric Bed Loss*. Accessed online March 5, 2016, at http://www.calhospital.org/sites/main/files/file-attachments/psychbeddata.pdf.

Centers for Disease Control and Prevention. (2016). "Important Facts About Falls." Accessed online February 9, 2016, at http://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html

Chow, J. C. C., Auh, E. Y., Scharlach, A. E., Lehning, A. J., & Goldstein, C. (2010). Types and sources of support received by family caregivers of older adults from diverse racial and ethnic groups. *Journal of Ethnic & Cultural Diversity in Social Work*, *19*(3), 175-194.

Corey, Canapary, & Galanis. (2015). *2015 San Francisco City Survey*. Data extract provided by San Francisco Controller's Office in August 2015.

Family Caregiver Alliance. (n.d.) "Special Concerns of LGBT Caregivers." Accessed online March 3, 2016, at https://www.caregiver.org/special-concerns-lgbt-caregivers.

Feinberg, L., Reinhard, S. C., Houser, A., & Choula, R. (2011). *Valuing the Invaluable: 2011 update*. AARP Public Policy Institute. Accessed online February 8, 2016, at http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf.

Fredriksen-Goldsen, K. I., Kim, H. J., Hoy-Ellis, C. P., PhC, J. G., Diana Jensen, M. P. P., Adelman, M., & Costa, L. M. (2013a). Addressing the needs of LGBT older adults in San Francisco. *Seattle: Institute for Multi-generational Health.[Online] Available at: San Francisco Human Rights Commission. www. sf-hrc. org*.

Fredriksen-Goldsen, K. I., Kim, H. J., Goldsen, J., Hoy-Ellis, C., Emlet, C., Erosheva, E., & Muraco, A. (2013b). LGBT older adults in San Francisco: Health, risks, and resilience—Findings from caring and aging with pride. *Seattle, WA: Institute for Multigenerational Health*.

Health Affairs. (2013). *Health Policy Brief: Medicare Hospital Readmissions Reduction Program.* Accessed online March 5, 2016, at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_102.pdf

Iwasaki, S., & Yamasoba, T. (2015). Dizziness and imbalance in the elderly: age-related decline in the vestibular system. Aging and disease, 6(1), 38.

Meijers, J. M. M., Halfens, R. J. G., Neyens, J. C., Luiking, Y. C., Verlaan, G., & Schols, J. M. G. A. (2012). Predicting falls in elderly receiving home care: the role of malnutrition and impaired mobility. *The Journal of Nutrition, Health & Aging*, *16*(7), 654-658.

MetLife Mature Market Institute. (2011). *The MetLife Study of Caregiving Costs to Working Caregivers: Double Jeopardy for Baby Boomers Caring for Their Parents.* Westport, CT. Accessed online February 6, 2016, at http://www.caregiving.org/wp-content/uploads/2011/06/mmi-caregiving-costs-working-caregivers.pdf.

Monin, J. K., & Schulz, R. (2009). Interpersonal Effects of Suffering in Older Adult Caregiving Relationships. *Psychology and Aging*, *24*(3), 681–695. http://doi.org/10.1037/a0016355

National Alliance for Caregiving and AARP. (2015). *Caregiving in the U.S., A Focused Look at Those Caring for Someone Age 50 or Older,* Bethesda, MD: National Alliance for Caregiving, Washington, D.C.

National Council on Aging. "Elder Abuse Facts." Accessed online January 6, 2016, at https://www.ncoa.org/public-policy-action/elder-justice/elder-abuse-facts/.

National Research Center, Inc. (May 2008.) *City of San Francisco Aging and Adult Services Telephone Survey Draft Report of Results.* Boulder, CO.

Naylor, M., & Keating, S. A. (2008). Transitional Care: Moving patients from one care setting to another. *The American Journal of Nursing*, *108*(9 Suppl), 58–63. http://doi.org/10.1097/01.NAJ.0000336420.34946.3a

Older Adults and Mental Health: Issues and Opportunities, Chapter 4 - Supportive Services and Health Promotion. Administration on Aging. January 10, 2000. Available at: http://www.aoa.dhhs.gov/mh/report2001/chapter4.html.

Paukert, A. L., Pettit, J. W., Kunik, M. E., Wilson, N., Novy, D. M., Rhoades, H. M., & Stanley, M. A. (2010). The roles of social support and self-efficacy in physical health's impact on depressive and anxiety symptoms in older adults. *Journal of clinical psychology in medical settings*,*17*(4), 387-400.

Pew Research Center. (2014). "Older Adults and Technology Use." Accessed online December 1, 2015, at http://www.pewinternet.org/2014/04/03/older-adults-and-technology-use/.

Pinquart, M., & Sorensen, S. (2005). Ethnic differences in stressors, resources, and psychological outcomes of family caregiving: A meta-analysis. *The Gerontologist*, *45*(1), 90-106.

Portacolone, E. (2011). *Precariousness Among Older Adults Living Alone in San Francisco: an Ehtnography*. PhD dissertation, University of California in San Francisco, September 6, 2011

Public Policy Institute of California. (2013). California's Digital Divide. Accessed online January 6, 2016, at http://www.ppic.org/content/pubs/jtf/JTF_DigitalDivideJTF.pdf.

Ruggles, S., Genadek, K., Goeken, R., Grover, J. & Sobek, M. Integrated Public Use Microdata Series: Version 6.0 [Machine-readable database]. Minneapolis: University of Minnesota, 2015.

San Francisco Board of Supervisors Budget and Legislative Analyst Office. (2016). *Memo to Supervisor Mar: In Home Care for Seniors*. Accessed online February 17, 2016, at http://sfbos.org/Modules/ShowDocument.aspx?documentid=54932.

San Francisco Office of the Controller. (2015). *Long Term Care Middle Income Study - Population Analysis*.

Schulz, R., O'Brien, A. T., Bookwala, J., & Fleissner, K. (1995). Psychiatric and physical morbidity effects of dementia caregiving: prevalence, correlates, and causes. The Gerontologist, 35(6), 771-791.

San Francisco Department of Aging and Adult Services. (2016). "San Francisco Transitional Care Program: December 2012 – May 2015." Report forthcoming.

San Francisco Mayor's Office on Housing and Community Development. (2013). *2013-2018 Analysis of Impediments to Fair Housing Choice*. Accessed online October 1, 2015, at http://sf-moh.org/modules/showdocument.aspx?documentid=6333.

Scharlach, A., Sirotnik, B., Bockman, S., Neiman, M., Ruiz, C., & Dal Santo, T. (2003). A profile of family caregivers: Results of the California statewide survey of caregivers. Center for the Advanced Study of Aging Services, University of California Berkeley, Berkeley.

Schulz, R, and Beach, S.R. (1999). Caregiving as a Risk Factor for Mortality. *Journal of the American Medical Association*, 282 (23):2215-9.

Seeman T.E., Lusignolo T. M., Albert M., & Berkman L. (2001). Social relationships, social support, and patterns of cognitive aging in healthy, high-functioning older adults: MacArthur studies of successful aging. *Health Psychology: Official Journal of the Division of Health Psychology, American Psychological Association*. 20(4): 243-55.

SFMTA Accessible Services. "Overview of SF Paratransit Programs." Presentation November 3, 2105. SFMTA Board of Directors Meeting,

Steptoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences*, *110*(15), 5797-5801.

Sterling, D. A., O'Connor, J. A., & Bonadies, J. (2001). Geriatric falls: injury severity is high and disproportionate to mechanism. Journal of Trauma and Acute Care Surgery, 50(1), 116-119.

Talley, R. C., & Crews, J. E. (2007). Framing the public health of caregiving. American Journal of Public Health, 97(2), 224-228.

Terracina, K. A., Aamodt, W. W., & Schillerstrom, J. E. (2015). Executive Function Impairment and Recidivism in Adult Protective Services Clients Referred for a Decision Making Capacity Assessment. *Journal of elder abuse & neglect*, *27*(2), 91-99.

U.S. Social Security Administration. (2014). *SSI Recipients by State and County, 2014.* Accessed online December 1, 2015, at http://www.socialsecurity.gov/policy/docs/statcomps/ssi_sc/2014.

UCSF Department of Psychiatry. (n.d.). "Division of Acute and Emergency Services." Accessed March 5, 2016, at http://psych.ucsf.edu/sfgh/aes.

Vellas, B. J., Wayne, S. J., Romero, L. J., Baumgartner, R. N., & Garry, P. J. (1997). Fear of falling and restriction of mobility in elderly fallers. Age and ageing, 26(3), 189-193.

Vivanti, A. P., McDonald, C. K., Palmer, M. A., & Sinnott, M. (2009). Malnutrition associated with increased risk of frail mechanical falls among older people presenting to an emergency department. *Emergency Medicine Australasia*, *21*(5), 386-394.

Wakabayashi, C., & Donato, K. M. (2006). Does caregiving increase poverty among women in later life? Evidence from the Health and Retirement Survey. *Journal of Health and Social Behavior*, 47(3), 258-274.

Walston, J. D. (2012). Sarcopenia in older adults. *Current Opinion in Rheumatology*, *24*(6), 623–627. http://doi.org/10.1097/BOR.0b013e328358d59b

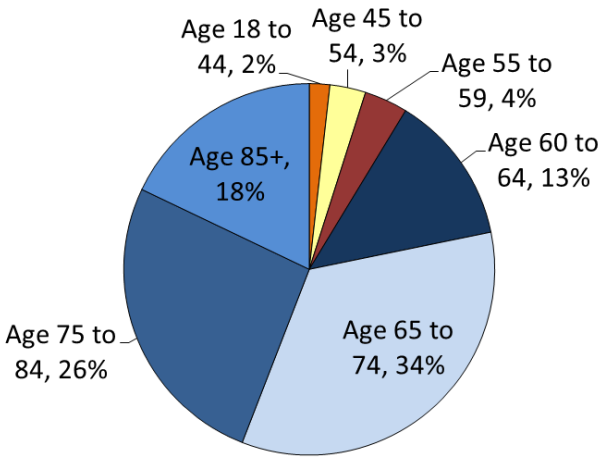
Wolff, J. L., Dy, S. M., Frick, K. D., & Kasper, J. D. (2007). End-of-life care: findings from a national survey of informal caregivers. Archives of Internal Medicine, 167(1), 40-46.

Wu, S., Li, F., & Jin, H. (2013). *Increasing Broadband Access for Seniors and Adults with Disabilities in San Francisco: Impact of the Broadband Technology Opportunities Program.* University of Southern California. Report prepared for the San Francisco Department of Aging & Adult Services. Accessed online November 1, 2015, at http://www.sfhsa.org/asset/ReportsDataResources/BTOPEvaluationReportUSC.pdf.

Appendix A. Client Profile – Office on Aging.

This section describes clients enrolled in OOA services through the CA GetCare database in FY 14-15. These figures represent an unduplicated client count. For a list of the programs this includes, please see the table on the final page of this appendix.

Age Profile of Office on Aging Clients FY 14-15



Source: CA GetCare database, FY 14-15

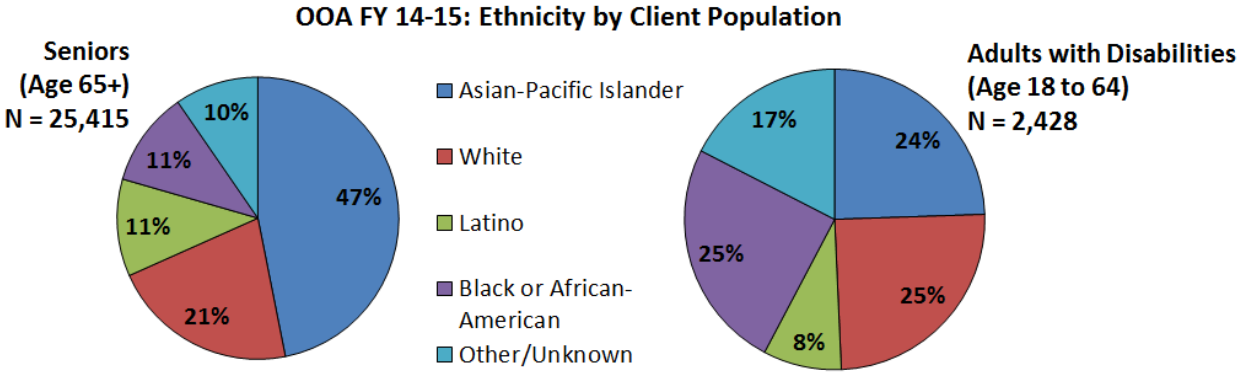
OOA FY 14-15: Clients by Age		
Age Group	**#**	**%**
Age 18 to 44	497	2%
Age 45 to 54	871	3%
Age 55 to 59	1,053	4%
Age 60 to 64	3,647	13%
Age 65 to 74	9,493	34%
Age 75 to 84	7,291	26%
Age 85+	4,991	18%
Total	27,843	100%

OOA FY 14-15: Gender by Population Type						
	Senior Age 60+		**AWD Age 18 to 59**		**All**	
Gender	**#**	**%**	**#**	**%**	**#**	**%**
Female	14,466	57%	1,079	44%	15,545	56%
Male	9,704	38%	1,136	47%	10,840	39%
Declined to State	37	0.1%	8	0.3%	45	0.2%
Unknown	1,208	5%	205	8%	1,413	5%
Total	25,415	100%	2,428	100%	27,843	100%

OOA FY 14-15: Sexual Orientation by Population Type						
LGBT Status	**Senior Age 60+**		**AWD Age 18 to 59**		**All**	
	#	**%**	**#**	**%**	**#**	**%**
Straight, Not Transgender	14,321	56%	713	29%	15,034	54%
LGBT*	1,025	4%	162	7%	1,187	4%
Lesbian	*100*	*0%*	*13*	*1%*	*113*	*0%*
Gay	*634*	*2%*	*106*	*4%*	*740*	*3%*
Bisexual	*197*	*1%*	*25*	*1%*	*222*	*1%*
Transgender	*125*	*0%*	*25*	*1%*	*150*	*1%*
Decline to State	1,069	4%	67	3%	1,136	4%
Unknown	9,000	35%	1,486	61%	10,486	38%
Total	25,415	100%	2,428	100%	27,843	100%

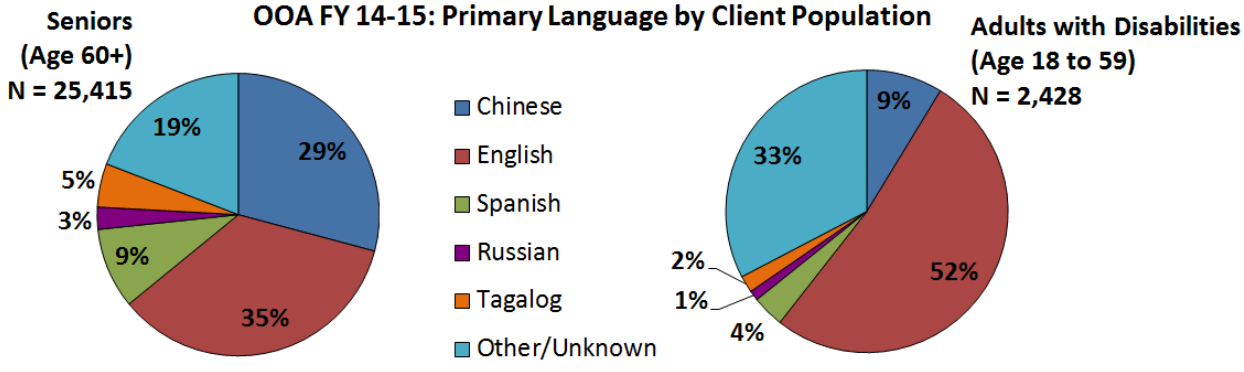
**LGBT subgroup total exceeds total LGBT, because sexual orientation varies among transgender persons.*

OOA FY 14-15: Clients by Population Type and Ethnicity						
Ethnicity	Senior Age 60+		AWD Age 18 to 59		All	
	#	%	#	%	#	%
Asian-Pacific Islander	11,913	47%	594	24%	12,507	45%
White	5,453	21%	603	25%	6,056	22%
Latino	2,832	11%	205	8%	3,037	11%
Black or African-American	2,772	11%	602	25%	3,374	12%
Other/Unknown	2,445	10%	424	17%	2,869	10%
Total	25,415	100%	2,428	100%	27,843	100%



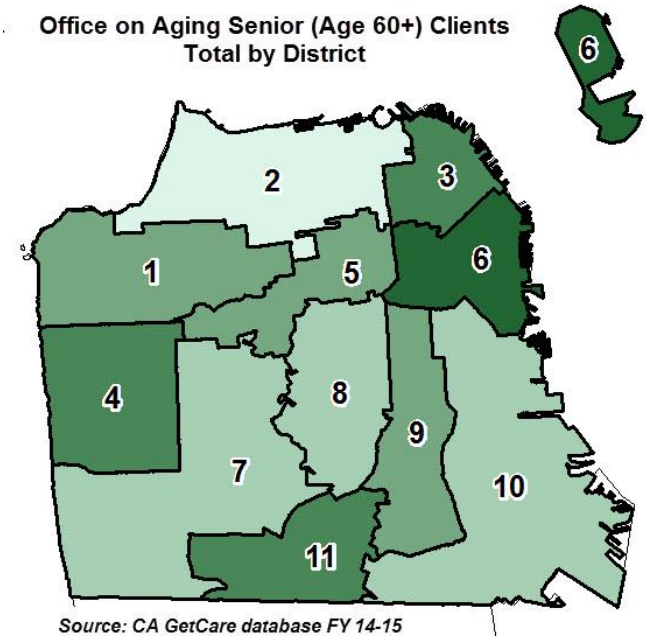
Source: CA GetCare database FY 14-15

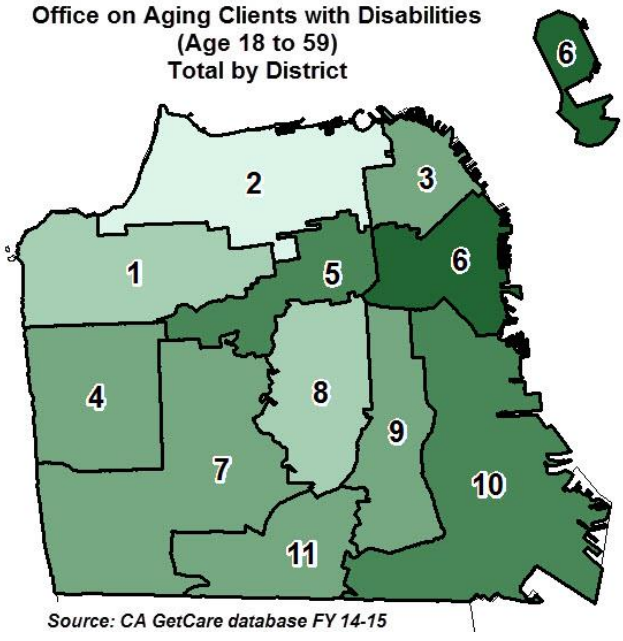
OOA FY 14-15: Primary Language by Population Type						
Primary Language	Senior Age 60+		AWD Age 18 to 59		All	
	#	%	#	%	#	%
Chinese	7,411	29%	212	9%	7,623	27%
English	8,880	35%	1,259	52%	10,139	36%
Spanish	2,345	9%	89	4%	2,434	9%
Russian	644	3%	28	1%	672	2%
Tagalog	1,267	5%	47	2%	1,314	5%
Other/Unknown	4,868	19%	793	33%	5,661	20%
Total	25,415	100%	2,428	100%	27,843	100%



Source: CA GetCare database FY 14-15

OOA FY 14-15: Clients by Population Type and Client District						
Client District	Senior Age 60+		AWD Age 18 to 59		All	
	#	%	#	%	#	%
District 1	1,873	7%	116	5%	1,989	7%
District 2	783	3%	46	2%	829	3%
District 3	2,445	10%	163	7%	2,608	9%
District 4	2,268	9%	169	7%	2,437	9%
District 5	1,927	8%	185	8%	2,112	8%
District 6	4,050	16%	569	23%	4,619	17%
District 7	1,643	6%	145	6%	1,788	6%
District 8	1,449	6%	90	4%	1,539	6%
District 9	2,027	8%	158	7%	2,185	8%
District 10	1,593	6%	219	9%	1,812	7%
District 11	2,448	10%	152	6%	2,600	9%
Unknown	2,909	11%	416	17%	3,325	12%
Total	25,415	100%	2,428	100%	27,843	100%





OOA FY 14-15: Unduplicated Clients by Program and Client District													
OOA Program	**Client Home District**												**Total enrollment**
	D1	**D2**	**D3**	**D4**	**D5**	**D6**	**D7**	**D8**	**D9**	**D10**	**D11**	**Unknown***	
Alzheimer's Day Care Resource Centers (ADCRC)	20	11	3	20	11	0	14	3	5	3	7	13	110
Adult Day Health/Social Care	34	16	9	24	25	2	13	9	8	6	17	23	186
Case Management	81	37	225	71	148	302	58	77	94	147	140	132	1,512
Community Services	1,000	438	1,151	1,395	1,050	1,993	1,152	1,001	1,485	772	1,767	1,875	15,079
Congregate Meals (Senior)	1,007	297	1,209	1,357	1,015	2,150	702	555	945	834	941	1,528	12,540
Congregate Meals (AWD)	19	9	48	4	84	138	10	14	31	94	9	178	638
Family Caregiver Support Program	50	17	43	46	53	18	33	38	30	34	53	103	518
Home-Delivered Meals (Seniors)	335	139	401	273	444	989	271	267	366	373	325	62	4,245
Home-Delivered Meals (AWD)	16	13	26	13	32	208	13	13	30	38	13	5	420
Health Promotion	59	99	85	70	59	26	53	132	117	55	127	67	949
Home Care	83	52	96	81	88	106	58	40	24	27	49	5	709
Housing Subsidy	2	0	5	0	0	10	1	7	1	1	2	1	30
Money Management	3	1	9	0	6	34	6	7	5	37	2	9	119
Nutrition Counseling	61	55	140	80	166	396	118	116	128	163	153	21	1,597
SF Connected	126	27	209	76	81	376	70	61	148	74	101	442	1,791

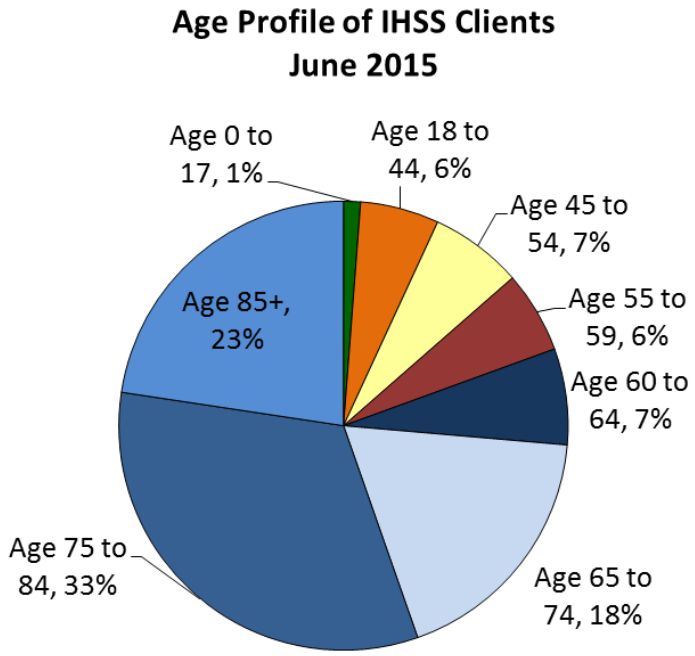
**Clients are not required to disclose their home address*

^Senior = Age 60+. AWD = Adults with disabilities age 18 to 59.

Appendix B. Client Profile – In-Home Support Services.

This section describes unduplicated clients active in the In Home Support Services (IHSS) program in June 2015. This monthly snapshot data is representative of all clients served in the year – characteristics of the IHSS caseload tend to remain relatively steady; once enrolled, most clients tend to remain in the program. IHSS serves a small number of children under age 18 (less than one percent of the caseload); since the target DAAS population is seniors and adults with disabilities, the analysis below is primarily focused on these populations.

This analysis uses the IHSS age threshold of 65 for seniors (65) and 18 to 64 for adults with disabilities (AWD).

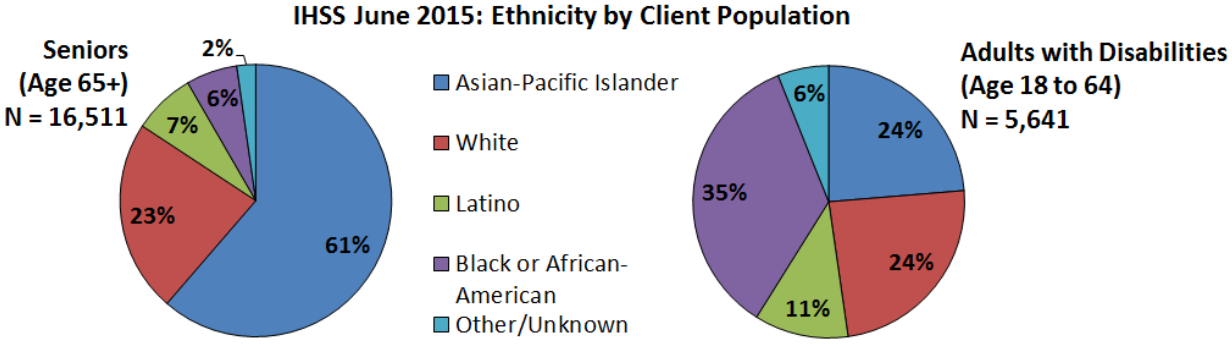


Source: CMIPS II database June 2015

IHSS June 2015: Clients by Age		
Age Group	**#**	**%**
Age 0 to 17	273	1%
Age 18 to 44	1,273	6%
Age 45 to 54	1,494	7%
Age 55 to 59	1,322	6%
Age 60 to 64	1,552	7%
Age 65 to 74	4,096	18%
Age 75 to 84	7,343	33%
Age 85+	5,072	23%
Total	22,425	100%

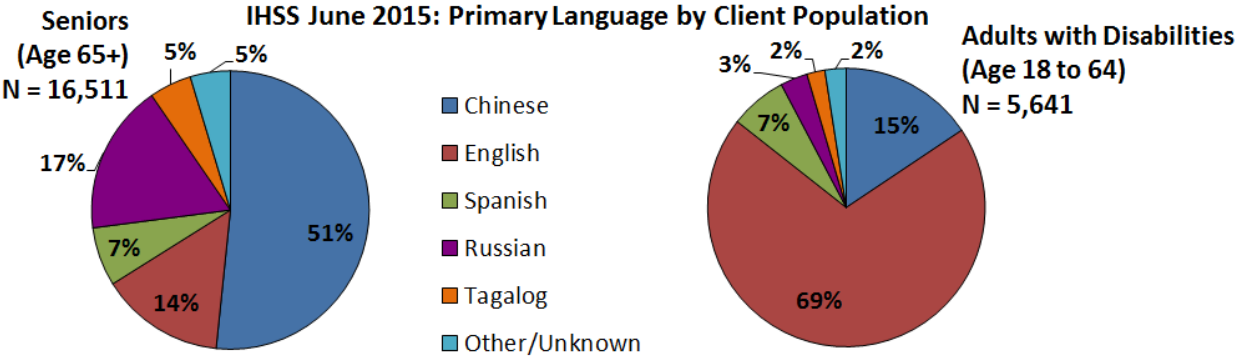
IHSS June 2015: Gender by Population Type						
Gender	**Senior Age 65+**		**AWD Age 18 to 64**		**All**	
	#	**%**	**#**	**%**	**#**	**%**
Female	10,912	66%	2,831	50%	13,743	62%
Male	5,599	34%	2,810	50%	8,409	38%
Total	16,511	100%	5,641	100%	22,152	100%

IHSS June 2015: Clients by Population Type and Ethnicity						
Ethnicity	Senior Age 65+		AWD Age 18 to 64		All	
	#	%	#	%	#	%
Asian-Pacific Islander	10,132	61%	1,336	24%	11,468	52%
White	3,778	23%	1,356	24%	5,134	23%
Latino	1,222	7%	632	11%	1,854	8%
Black or African-American	1,007	6%	1,974	35%	2,981	13%
Other/Unknown	372	2%	343	6%	715	3%
Total	16,511	100%	5,641	100%	22,152	100%



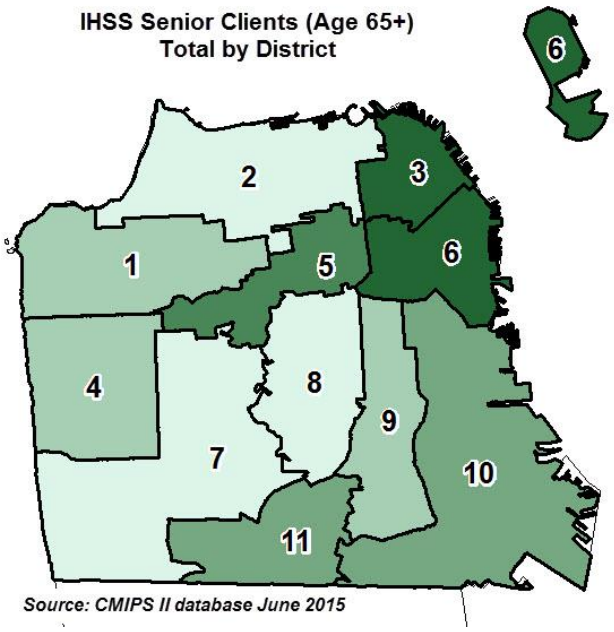
Source: CMIPS II database

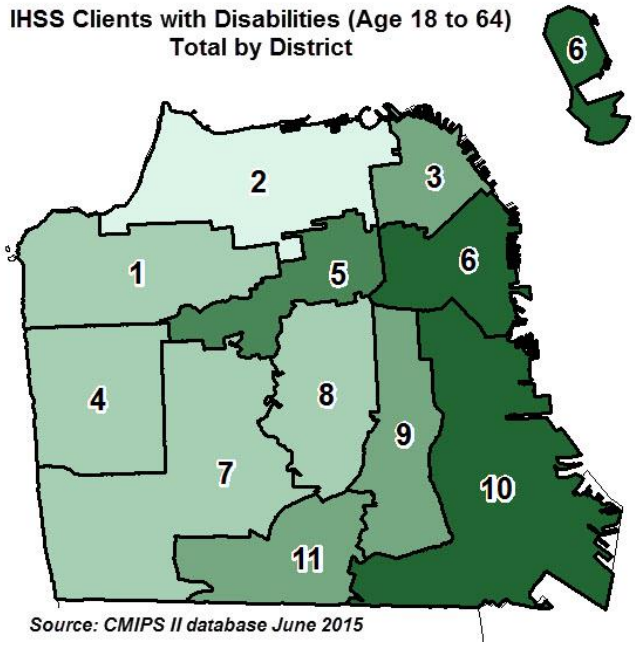
IHSS June 2015: Primary Language by Population Type						
Primary Language	Senior Age 65+		AWD Age 18 to 64		All	
	#	%	#	%	#	%
Chinese	8,356	51%	868	15%	9,224	42%
English	2,341	14%	3,887	69%	6,228	28%
Spanish	1,108	7%	369	7%	1,477	7%
Russian	2,822	17%	176	3%	2,998	14%
Tagalog	798	5%	117	2%	915	4%
Other/Unknown	756	5%	138	2%	894	4%
Total	16,511	100%	5,641	100%	22,152	100%



Source: CMIPS II database

IHSS FY 14-15: Unduplicated Clients by Population Type and District								
	Senior Age 65+		AWD Age 18 to 64		Child 0 to 17		All	
Client District	#	%	#	%	#	%	#	%
District 1	1,306	8%	272	5%	20	7%	1,598	7%
District 2	436	3%	91	2%	5	2%	532	2%
District 3	2,859	17%	412	7%	10	4%	3,281	15%
District 4	1,184	7%	282	5%	25	9%	1,491	7%
District 5	1,909	12%	631	11%	16	6%	2,556	11%
District 6	3,230	20%	1,409	25%	22	8%	4,661	21%
District 7	739	4%	223	4%	21	8%	983	4%
District 8	627	4%	246	4%	16	6%	889	4%
District 9	1,193	7%	481	9%	36	13%	1,710	8%
District 10	1,486	9%	1,030	18%	45	16%	2,561	11%
District 11	1,374	8%	433	8%	45	16%	1,852	8%
Unknown	168	1%	131	2%	12	4%	311	1%
Total	16,511	100%	5,641	100%	273	100%	22,425	100%





Appendix C. Client Profile – Adult Protective Services.

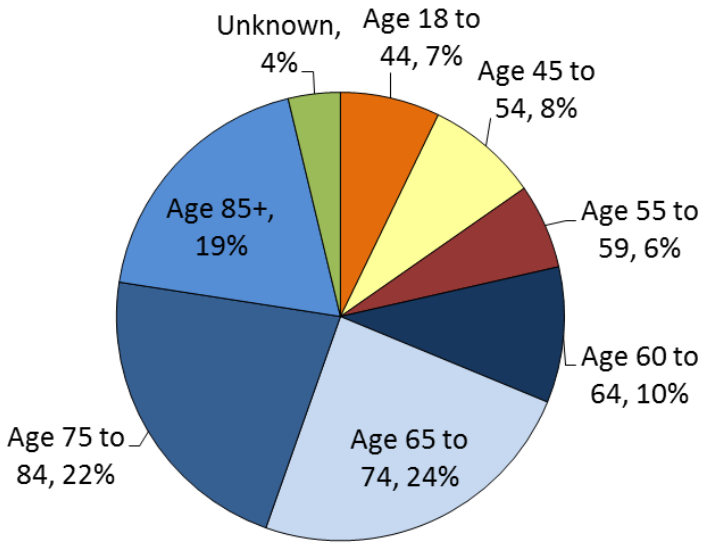
This section describes unduplicated clients with at least one report of abuse to Adult Protective Services (APS) in FY 14-15. A single case may have several associated reports of abuse, and a single client may have more than one case open throughout the year. All reports of abuse are investigated.

In FY -14, the APS program handled:

- 6,751 reports of abuse
- 5,804 cases opened
- 4,752 clients served

This analysis uses the APS age threshold of 65 for seniors (65) and 18 to 64 for adults with disabilities (AWD).

Age Profile of Adult Protective Services Clients FY 14-15

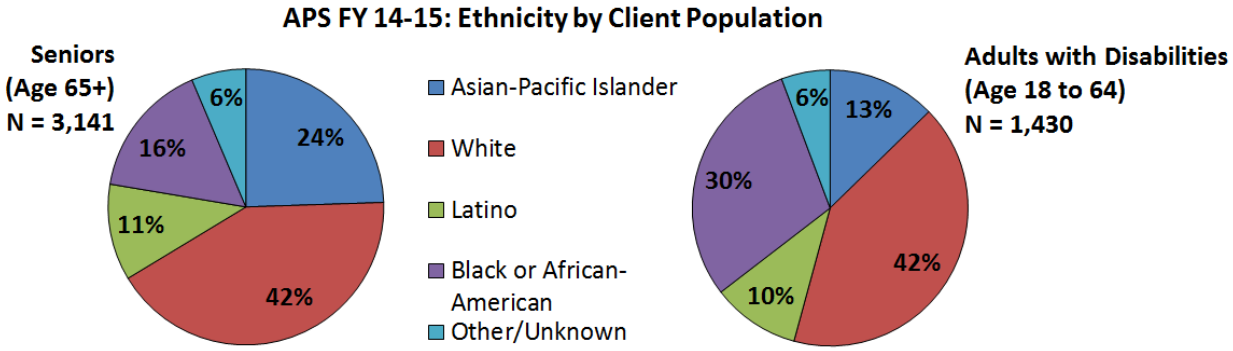


Source: AACTS database FY 14-15

APS FY 14-15: Clients by Age		
Age Group	**#**	**%**
Age 18 to 44	329	7%
Age 45 to 54	371	8%
Age 55 to 59	280	6%
Age 60 to 64	448	10%
Age 65 to 74	1,105	24%
Age 75 to 84	1,008	22%
Age 85+	859	19%
Unknown	172	4%
Total	4,572	100%

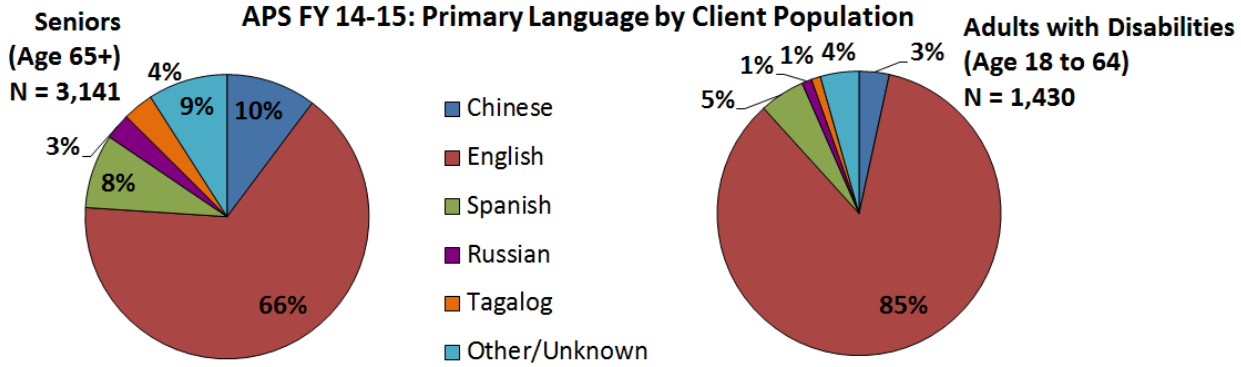
APS FY 14-15: Gender by Population Type						
Gender	**Senior Age 65+**		**AWD Age 18 to 64**		**All**	
	#	**%**	**#**	**%**	**#**	**%**
Female	1,778	57%	697	49%	2,475	54%
Male	1,363	43%	734	51%	2,097	46%
Total	3,141	100%	1,431	100%	4,572	100%

APS FY 14-15: Clients by Population Type and Ethnicity						
Ethnicity	Senior Age 65+		AWD Age 18 to 64		All	
	#	%	#	%	#	%
Asian-Pacific Islander	769	24%	182	13%	951	21%
White	1,315	42%	594	42%	1,909	42%
Latino	355	11%	148	10%	503	11%
Black or African-American	501	16%	425	30%	926	20%
Other/Unknown	201	6%	82	6%	283	6%
Total	3,141	100%	1,431	100%	4,572	100%



Source: AACTS database FY 14-15

APS FY 14-15: Primary Language by Population Type						
Primary Language	Senior Age 65+		AWD Age 18 to 64		All	
	#	%	#	%	#	%
Chinese	322	10%	49	3%	371	8%
English	2,066	66%	1,214	85%	3,280	72%
Spanish	265	8%	74	5%	339	7%
Russian	93	3%	16	1%	109	2%
Tagalog	110	4%	15	1%	125	3%
Other/Unknown	285	9%	63	4%	348	8%
Total	3,141	100%	1,431	100%	4,572	100%



Source: AACTS database FY 14-15

APS FY 14-15: Unduplicated Clients by Population Type and District						
	Senior Age 65+		AWD Age 18 to 64		Total	
Client District	#	%	#	%	#	%
District 1	194	6%	70	5%	264	6%
District 2	193	6%	36	3%	229	5%
District 3	348	11%	130	9%	478	10%
District 4	210	7%	47	3%	257	6%
District 5	353	11%	152	11%	505	11%
District 6	450	14%	463	32%	913	20%
District 7	230	7%	58	4%	288	6%
District 8	253	8%	78	5%	331	7%
District 9	275	9%	123	9%	398	9%
District 10	288	9%	138	10%	426	9%
District 11	239	8%	63	4%	302	7%
Unknown	108	3%	73	5%	181	4%
Total	3,141	100%	1,431	100%	4,572	100%