Four-Year Area Plan on Aging

July 1, 2016 to
June 30, 2020

PSA 6

San Francisco
Department of Aging and Adult Services

May 2016

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CDA Components

Area Plan Sections

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2016-2020 4-YEAR AREA PLAN REQUIRED COMPONENTS CHECKLIST

PSA #6

To ensure all required components are included, "X" mark the far-right column boxes.
Enclose a copy of the checklist with your Area Plan; *submit this form with the Area Plan due 5/1/16 only*

Section	Four-Year Area Plan Components	4-Year Plan
	Transmittal Letter – *must have original, ink signatures or official signature stamps- no photocopies*	☐
1	Mission Statement	☒
2	Description of the Planning and Service Area (PSA)	☒
3	Description of the Area Agency on Aging (AAA)	☒
4	Planning Process / Establishing Priorities	☒
5	Needs Assessment	☒
6	Targeting	☒
7	Public Hearings	☒
8	Identification of Priorities	☒
9	Area Plan Narrative Goals and Objectives:	☒
9	Title IIIB Funded Program Development (PD) Objectives	☐
9	Title IIIB Funded Coordination (C) Objectives	☐
9	System-Building and Administrative Goals & Objectives	☐
9	Title IIIB/VII A Long-Term Care Ombudsman Objectives	☒
9	Title VII Elder Abuse Prevention Objectives	☒
10	Service Unit Plan (SUP) Objectives and Long-Term Care Ombudsman Outcomes	☒
11	Focal Points	☒
12	Disaster Preparedness	☒
13	Priority Services	☒
14	Notice of Intent to Provide Direct Services	☒
15	Request for Approval to Provide Direct Services	☒
16	Governing Board	☒
17	Advisory Council	☒
18	Legal Assistance	☒
19	Multipurpose Senior Center Acquisition or Construction Compliance Review	☒
20	Title III E Family Caregiver Support Program	☒
21	Organization Chart	☒
22	Assurances	☒

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TRANSMITTAL LETTER

2016-2020 Four Year Area Plan/ Annual Update

Check one: ☒ FY 16-20 ☐ FY 17-18 ☐ FY 18-19 ☐ FY 19-20

AAA Name: San Francisco Department of Aging and Adult Services PSA #6

This Area Plan is hereby submitted to the California Department of Aging for approval. The Governing Board and the Advisory Council have each had the opportunity to participate in the planning process and to review and comment on the Area Plan. The Governing Board, Advisory Council, and Area Agency Director actively support the planning and development of community-based systems of care and will ensure compliance with the assurances set forth in this Area Plan. The undersigned recognize the responsibility within each community to establish systems in order to address the care needs of older individuals and their family caregivers in this planning and service area.

1.Edna James
(Type Name)

_____ _____
Signature: Governing Board Chair [1] Date

2. Leon Schmidt
(Type Name)

_____ _____
Signature: Advisory Council Chair Date

3. Shireen McSpadden
(Type Name)

_____ _____
Signature: Area Agency Director Date

[1] Original signatures or official signature stamps are required.

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SECTION 1. MISSION STATEMENT

The San Francisco Human Services Agency has developed and adopted the following agency-wide vision and mission statements:

- Vision: "San Francisco is a diverse community whose children, youth, families, adults and seniors are safe, self-sufficient and thriving."
- Mission: "The Human Services Agency promotes well-being and self-sufficiency among individuals, families and communities in San Francisco."

As the Area Agency on Aging, the Department of Aging and Adult Services maintains the more specific mission to:

- "Provide leadership in addressing issues that relate to older Californians; to develop community-based systems of care that provide services which support independence within California's interdependent society, and which protect the quality of life of older persons and persons with functional impairments; and to promote citizen involvement in the planning and delivery of services."

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SECTION 2. DESCRIPTION OF THE PLANNING AND SERVICE AREA (PSA)

Note: Senior population characteristics are described in more detail in Section 5 (Needs Assessment).

Only forty-seven square miles, the City and County of San Francisco is unique. It is characterized by its diversity, its distinct neighborhoods, an abundance of community-based service organizations that provide an array of services for seniors and adults with disabilities, and a housing market that is often untenable for low- and middle-income persons. As a single-county Planning and Service Area (PSA), San Francisco is also unique in that it is entirely urban. The Department of Aging and Adult Services (DAAS), a department of the San Francisco Human Services Agency, acts as the Area Agency on Aging (AAA).

Physical Geography and Climate

San Francisco is also known for its hills and vistas. The housing stock is largely made up of old buildings that sit closely together, many of which have stairs. For seniors or younger persons with mobility impairments, these characteristics can present physical challenges. Seniors who would be mobile and active in other communities may be isolated at home in San Francisco because of steep hills and stairs. While home modifications can help make homes more accessible, these solutions are unaffordable to many older persons. Additionally, not all units can be modified due to layout and design constraints.[2]

Heat waves are an emerging risk associated with climate change. A city known for its temperate climate, San Francisco is projected to experience a substantial increase in the number of hot days. Historically, the city has had an average of 12 days per year of temperature over 80 degrees, but in the near-term the number of hot days is expected to increase to 20. The increase is not likely to be linear, as many more hot days may occur in any given year, may last for extended periods, and may reach higher peaks. By mid-century San Francisco is projected to experience 32 – 46 hot days per year, and by the end of the century, 70 – 94. San Francisco's temperatures may not rise as high as those in Los Angeles, which recently had temperatures as high as 119 degrees, but the city is particularly vulnerable because only 11% of its households have air conditioning.[3,4] During heat waves, seniors and persons with disabilities and low income persons are at particular risk of illness and even death. They often have pre-existing health conditions such as diabetes that can be aggravated by the heat. Low-income persons are less likely to have air conditioning, and heat waves are often associated with energy blackouts, which may isolate seniors in their homes without working refrigerators, fans, and elevators.

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[2] 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.

[3] San Francisco Planning & Urban Research Association (2011). Climate change hits home: Adaptation strategies for the San Francisco Bay Area. May, 2011. Accessible at http://www.spur.org/publications/library/report/climate-change-hits-home

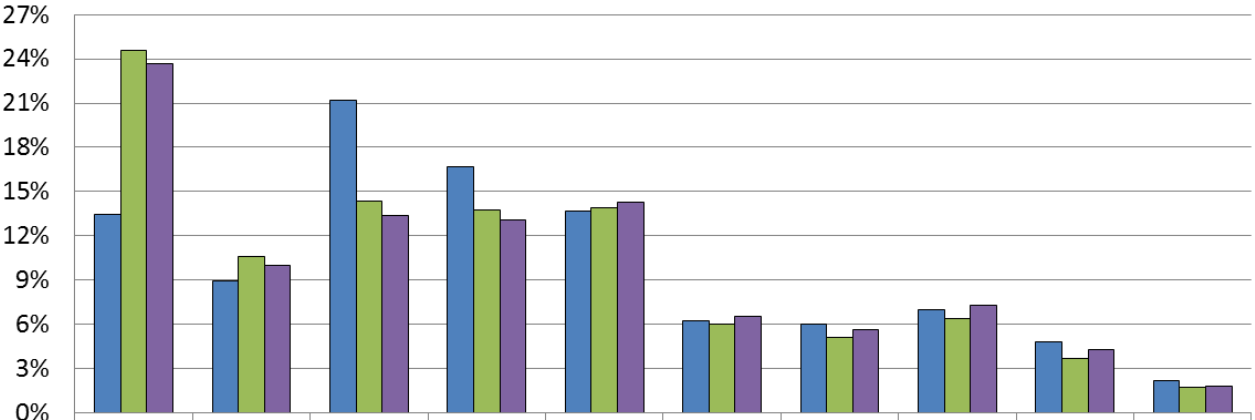
[4] Miller, N.L.; Jin, J.; Hayhoe, K.; and Auffhammer, M. (2007). Climate Change, Extreme Heat, and Electricity Demand in California. For: California Energy Commission, August, 2007.

Population Demographics

Over eight hundred thousand people live in San Francisco. Most (67%) are adults between age 18 and 59. The child population has been declining in San Francisco as families have moved to more affordable areas; in 1990, 16% of the population was under age 18 but now 13%. Twenty percent – 161,777 individuals – are older adults age 60 and older.

Compared to state and national trends, San Francisco residents are more likely to be younger adults between age 25 and 34: 21% compared to less than 15% of the state and national populations. Similar trends are evident for adults age 35 to 44. The child population is significantly smaller in San Francisco than elsewhere.

Age Distribution of San Francisco, California, and United States Population

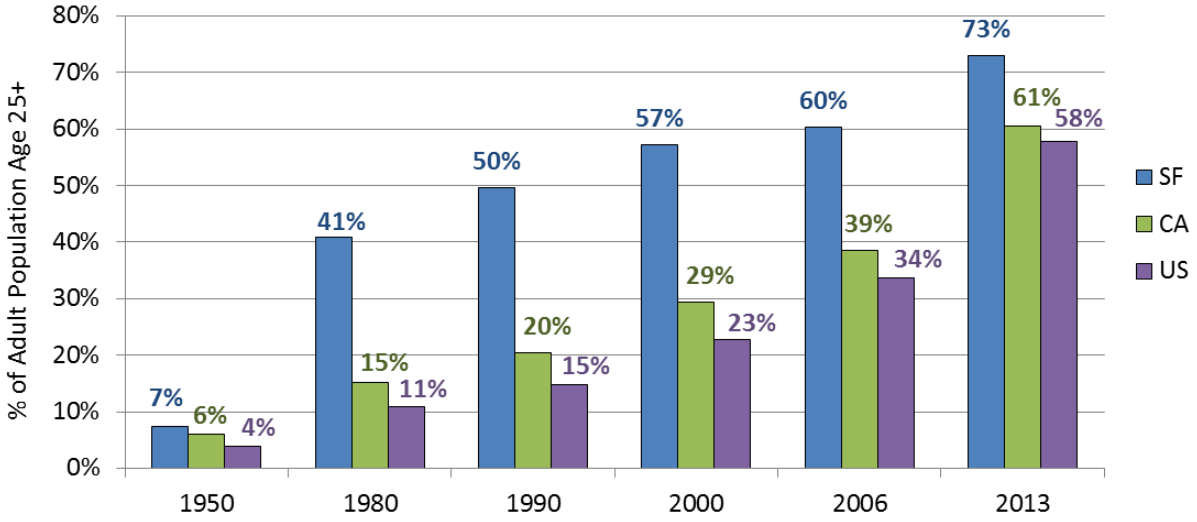


	0 to 17	18 to 24	25 to 34	35 to 44	45 to 54	55 to 59	60 to 64	65 to 74	75 to 84	85+
SF	13%	9%	21%	17%	14%	6%	6%	7%	5%	2%
CA	25%	11%	14%	14%	14%	6%	5%	6%	4%	2%
US	24%	10%	13%	13%	14%	7%	6%	7%	4%	2%

Source: IPUMS 2012 3-Year Samples (SF & CA); ACS 2013 5-Year Sample (US)

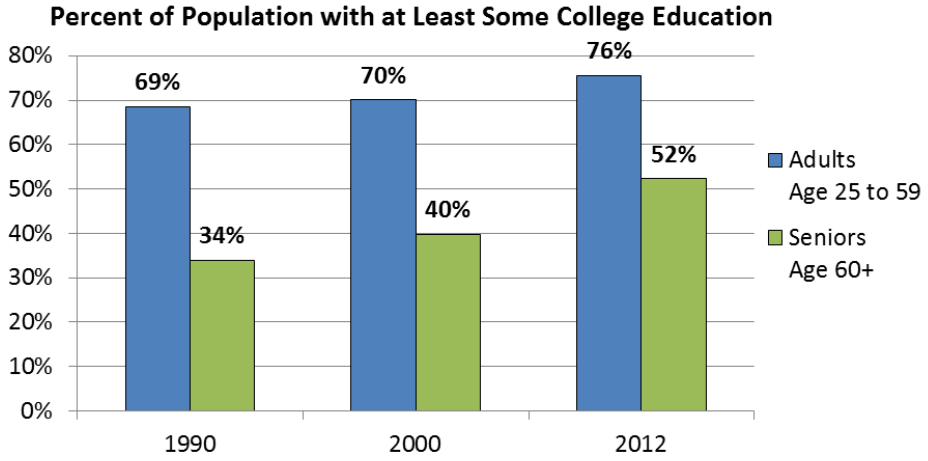
The local labor market plays a major role in these trends. As shown below, San Francisco has long had pronounced rates of higher education compared to state and national trends. Urban areas tend to have higher rates of educational attainment, and higher education is more common among young people compared to older generations. The knowledge economy in San Francisco – firmly established and growing larger – places a premium on education and attracts younger adults without children.

Percent of Adults Age 25+ with At Least Some College Education



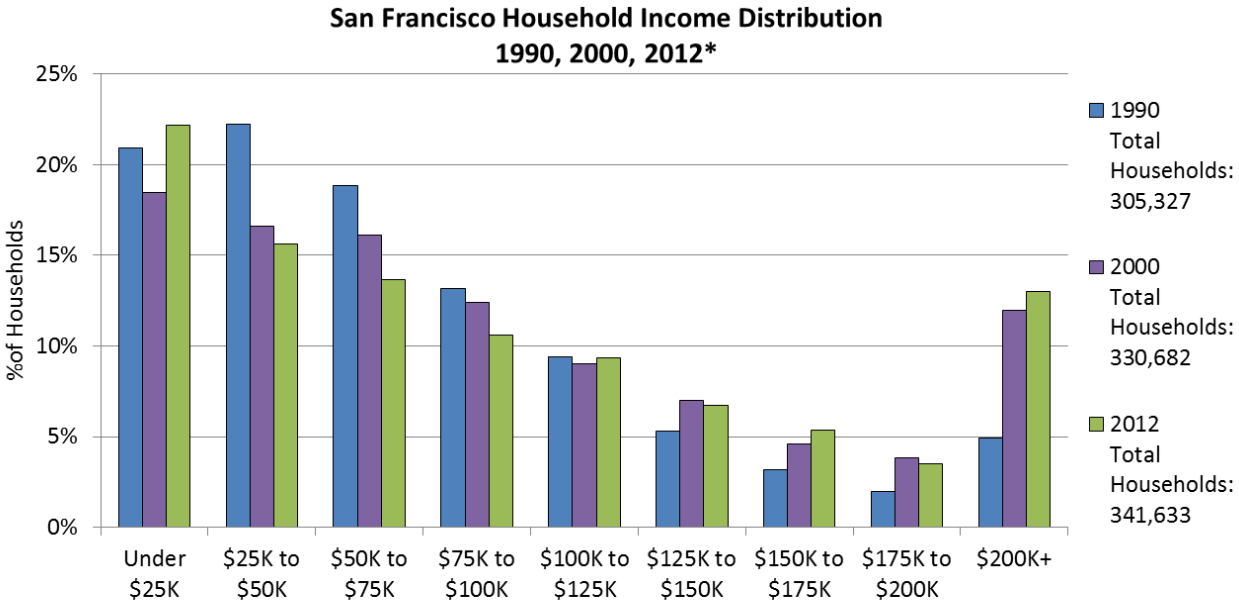
Source: IPUMS (1950 - 2006 samples), ACS 2013 5-Year (2013)

Older adults have lower levels of higher education and are less likely to benefit from local job growth in the technology industry. Already at risk of for ageism, they may be turned away from high-paying positions because a bachelor's degree is increasingly becoming a minimum requirement.



Source: IPUMS 1990 5% sample, 2000 5% sample, ACS 2012 3-Year Sample

Salaries have risen to keep pace with education levels, consequently driving up the cost of living in a compact city with limited room for growth. The chart below illustrates changes in the proportion of households making more than $200,000 per year, and the corresponding drop in the number of middle income households.



** Adjusted to 2012 dollars*
Source: IPUMS 1990 5% Sample, 2000 5% sample, 2012 ACS 3-Year Sample

These trends have many implications for the senior population. Many older persons are working longer, in part to make up for lost wages and savings due to the 2008 recession and also in response to the soaring cost of living. They may need to complete for low-wage jobs against younger adults who have college degrees. As adult children leave for more affordable areas to raise their own families, their aging parents are often left behind without the informal support of nearby family. More broadly, the increasing social and economic distance between young, educated, affluent adults without children – many of whom live in San Francisco for only a few years before moving to more affordable communities – and

the large number of older, low-income seniors raises concerns about social cohesion and the community's continuing capacity for support.

San Francisco's greatest asset is its diversity. Population demographics have shifted over the last two decades. As shown to the right, whites are still the most common ethnic group but this is changing. The city is increasingly Asian-Pacific Islander (API). African-Americans now constitute a smaller portion of the city's population, decreasing from eleven to six percent. Latinos have increased from 13% to 15%.

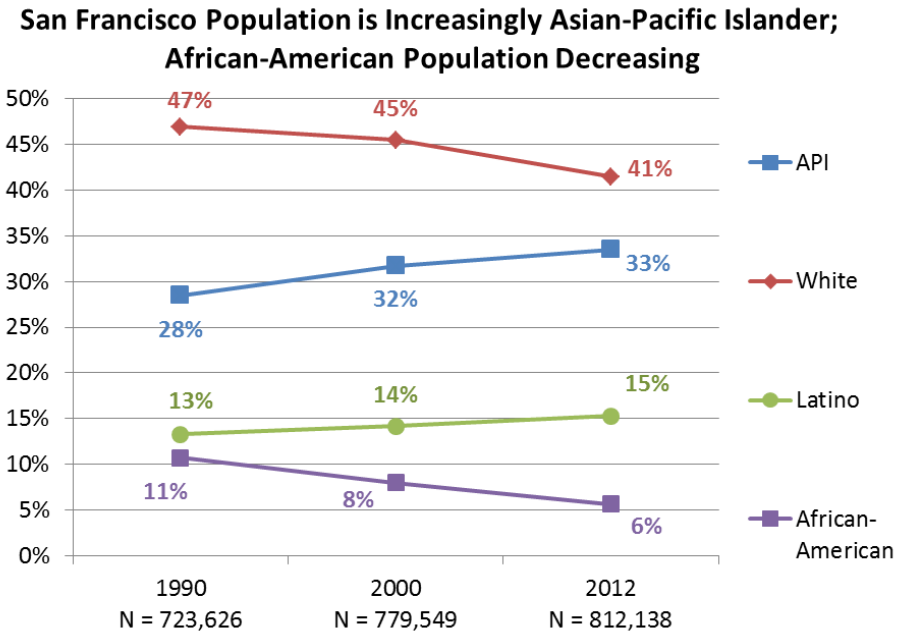


Chart reflects major ethnic groups. "Other" not shown
Source: IPUMS

As highlighted in the Needs Assessment in this Area Plan (Section 5), these trends are heightened in the senior population. Seniors are most likely to be API (42%).

Thirteen percent of San Franciscans have limited English proficiency. Among adults age 18 to 59, this is closer to 10%. Seniors are more likely to have limited English: 30%. Overall, slightly more than half of the city speaks English as their primary language. The most common other languages are Chinese (18%) and Spanish (11%). Among the senior population age 60 and older, slightly less than half speak English as their primary language. *See Needs Assessment Part I (Section 5) for more information about senior population trends.*

San Francisco is able to meet the diverse needs and preferences of its residents in part through partnerships with community-based organizations, many of which focus on serving specific cultural groups. This service provider network is a major asset. The DAAS Office on Aging, which facilitates the Older Americans Act-funded services, contracts with over 50 agencies that provide services at over 100 sites throughout the city. Some services are not tied to brick-and-mortar locations but are provided at the client's residence, such as home-delivered meals. Through these community partners, DAAS funds services provided in English, Cantonese, Mandarin, Russian, Tagalog, Japanese, Vietnamese, and Korean. Congregate and home-delivered meals are tailored to meet a variety of preferences, including Western, American-Southern, Chinese, Latino, Japanese, kosher, and Samoan/Hawaiian.

The local provider network maintains a strong advocacy focus, another important resource for PSA 6. Community advocates work tirelessly to secure attention, resources, and support for seniors and adults with disabilities. In recent years, the Coalition of Agencies Serving the Elderly has been successful in securing additional funding for community services and the Aging and Disability Resource Center network. The Long Term Care Coordinating Council (an advisory body appointed by the Mayor) made a

recommendation to the Mayor and Board of Supervisors that additional funding be extended to the Community Living Fund, which received an annual budget increase of $1 million in FY 15-16. Other community-based organizations focus on improving collaboration and efficiency of the service system, as well as empowering seniors and adults with disabilities how to advocate for themselves on a personal level and in the community.

San Francisco's long history of activism extends benefits for PSA 6 beyond the provider network. City leaders have dedicated significant funding for services that support the ability of seniors to age safely and vibrantly in the community, well beyond the required match for Older Americans Act funding. While the rising cost of living risks forcing low- and middle-income persons out of San Francisco, it also provides enhanced revenue, allowing the city to increase funding for social services. This has allowed DAAS to expand existing services and explore innovative new programs, such as the Community Living Fund, home-delivered groceries, and the Village model.

PSA 6 also faces notable resource constraints. Surrounded on three sides by water, the city has limited space to develop additional housing. Real estate rates reach new levels each month, making it harder for non-profit organizations to procure space to develop affordable housing. As market rental rates continue to skyrocket, the amount of revenue lost for each unit offered as affordable housing unit increases, disincentivizing developers to voluntarily designate units for low- and middle-income households.

The increasing cost of living impacts the availability of support for seniors. As highlighted earlier, middle-income families tend to leave the city for more affordable areas, leaving their aging parents without adult children nearby to provide informal support. Paid service providers who support seniors are also at risk of being forced out; because nearby counties have also become more expensive, they may end up in more distant areas, such as Antioch and Vallejo. The commute in to San Francisco is long and expensive for these workers. Many of DAAS's community partners face challenges maintaining staff, who leave for higher paying positions with the county and/or in the healthcare field.

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SECTION 3. DESCRIPTION OF THE AREA AGENCY ON AGING (AAA)

This section describes the local Area Agency on Aging (AAA), as well as its key partner agencies, and outlines how the AAA carries out its role as a leader on aging issues.

San Francisco Department of Aging and Adult Services

In July 2000, the City and County of San Francisco created the Department of Aging and Adult Services (DAAS) to provide humane and protective services for vulnerable adults, including people with disabilities, mentally ill persons, veterans and seniors. Its mission is to provide leadership in the area of aging and adult services, promote the involvement of older individuals and their caregivers in San Francisco, develop community-based systems of services to support the independence and protect the quality of life for older persons, and coordinate activities and develop disaster preparedness plans for this population. *As a public sector organization for the City and County of San Francisco, DAAS serves as the AAA for the City and County of San Francisco*.

The Area Plan budget, however, only includes funding related to the Office on the Aging, which allocates a Fiscal Year (FY) 2015-16 baseline of approximately $33.2 million of state, federal and local general funds to 50 community-based organizations, one city agency, and one internal Integrated Intake and Referral Unit. Almost 80% of the OOA FY 15-16 budget comes from local general funds. Funds included in the Area Plan budget are composed of the California Department of Aging state and federal allocations and local general fund, plus cash match and program income from the Office on the Aging contractors.

DAAS programs can be broadly categorized into four major divisions. These divisions and the included services are described in detail below:

DAAS Division: Community Services

There are three primary programs in the DAAS Community Services division: Office on Aging, Integrated Intake and Referral Unit, and the County Veterans Service Office. These programs consist of services provided through partnership with community-based organizations and services that help consumers living in the community access appropriate services.

❖ Office on the Aging

The Office on the Aging (OOA) is responsible for the program design, scope of services, and monitoring of all programs and services funded by the California Department of Aging. It contracts with over 50 community-based organizations and one public agency to provide a full range of programs and services for adults aged 60 and older and for adults with disabilities. The OOA targets frail, isolated, low income and ethnic minority groups of seniors, including elderly lesbian, gay, bisexual and transgender persons. The services that the OOA funds include:

- *Adult Day Care*: Community-based program that 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.
- *Aging and Disability Resource Center (ADRC):* Provides information, referral, and assistance services at community hubs in neighborhoods throughout the city. Service is offered in a variety of languages.

- *Alzheimer's Day Care Resource Centers*: Day care specifically for those in the moderate to severe stages of Alzheimer's disease or related dementia, whose care needs and behavioral problems make it difficult for the individual to participate in existing day care programs.
- *Brown Bag:* Provision of surplus and donated food products, produce, and nutrition education to low-income older adults and adults with disabilities.
- *Case Management:* Care coordination for older adults or adults with disabilities who are experiencing a diminished capacity to function so that formal assistance is required. Services include: assessing needs; developing care plans; authorizing, arranging and coordinating services; follow-up monitoring; and reassessment.
- *Community Services*: Services that maintain or improve quality of life such as health maintenance (exercise), education, translation, services that protect elder rights, services that promote socialization/participation, and services that assure access and coordination. Community Services are provided in senior centers or activity centers throughout the city.
- *Congregate Meals:* Meals provided in a group setting that consist of the procurement, preparation, transporting and serving of meals, as well as nutrition education.
- *Elder Abuse Prevention:* Consultation with the Ombudsman Program and coordination with Adult Protective Services and other abuse prevention services to provide education, outreach, referral, and receipt of complaints on behalf of vulnerable seniors and adults with disabilities.
- *Emergency short-term homecare for seniors:* Time-limited personal care, homemaker, and chore services to allow older adults to live safely in the community, thereby preventing premature institutionalization.
- *Empowerment for Seniors and Adults with Disabilities:* Training programs for seniors and adults with disabilities in community organizing, leadership, conducting effecting meetings, accessing essential services, conflict resolution, promoting diversity and engaging in civic affairs and advocacy.
- *Family Caregiver Support Program:* Outreach and support for caregivers who assist older adults. Services include information and assistance, support groups, counseling, respite services and supplemental services to caregivers who are having difficulty maintaining quality homecare.
- *Health Insurance Counseling and Advocacy Program (HICAP):* Counseling and information about Medicare, supplemental health insurance, long-term care insurance, managed care or related health insurance; community education activities; advocacy; and legal representation.
- *Health Promotion:* Provides evidence-based health promotion programs which have been proven to be effective in reducing older people's risk of disease, disability and injury and to empower people to take more control over their own health through lifestyle changes, including health education, wellness and exercise workshops.
- *Homecare Advocacy:* Responsible for building collaborative networks; working collaboratively with coalitions and health care professionals toward the expansion and improvement of long-term care plans. It advocates for persons who are at risk for institutionalization, but unable to obtain affordable and timely IHSS help. Through efforts to coordinate, plan and strategize with community groups, unions, and local government, more seniors and adults with disabilities receive critical in-home care.
- *Home-Delivered Meals:* Meals for persons who are homebound because of illness, incapacitating disability, isolation, or lack of a support network; includes nutrition education.
- *Home-Delivered Groceries:* Delivery of grocery bags to low-income persons who are in need of additional nutrition resources but are unable to visit local food pantries or transport food home. Recipients must have ability to store food and prepare meals.

- *Housing Counseling/Advocacy:* Information for individuals in jeopardy of being evicted and assistance in advocating for tenant rights, as well as training for individuals and groups so they can inform the public about the need for affordable and accessible senior housing.
- *Legal Services:* Legal advice, counseling and/or representation by an attorney person acting under the supervision of an attorney. Areas of expertise include: benefits appeals, eviction prevention, consumer rights, estate planning, etc.
- *LGBT Cultural Competency Training and Integration Program:* To educate social service providers about how to overcome service barriers that exist for LGBT consumers. The goal of the program is to improve access to services, thus improving the quality of life for LGBT consumers.
- *Linkages and Respite Purchase of Service:* Prevention of premature or inappropriate institutionalization of elderly and functionally impaired adults, who may or may not be Medi-Cal eligible, by providing care management, and information and assistance services.
- *Medication Management:* Provides medication screening and consultation for clients enrolled in OOA case management services to prevent incorrect medication and adverse drug reactions.
- *Money Management:* Assistance to consumers in the management of income and assets. This may include, 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.
- *Naturalization Services:* Services that help legal permanent residents become naturalized citizens, such as: (1) learn English as a second language, (2) prepare for citizenship test, (3) increase awareness of resources, (4) assure access and coordination, (5) hands on assistance with completing N400 application, and (6) provide legal advice, counseling, and representation.
- *Ombudsman Services:* Investigates allegations of abuse and neglect made by mandated reporters if the victim is in nursing homes, residential care facilities for the elderly, adult residential care facilities, and other settings in accordance with California Law. The Ombudsman also advocates for behavioral health consumers under 60 as well as the developmentally disabled who reside in these settings.
- *Senior Companion*: Funds a small number of older persons to provide assistance to other older adults. Supportive services provided by companions are intended to help clients maintain independent living while also enriching social interaction and providing a small stipend for companions.
- *Social Support Services to Hoarders and Clutterers*: Provides support groups and eviction assistance to individuals who compulsively acquire possessions and are unable to discard them. This program also provides education and training to professionals working with target population.
- *Taxi Vouchers:* Provides taxi vouchers to seniors and adults with disabilities who cannot take public transportation to medical appointments and other community services. The service is provided by a non-profit.
- *Transportation:* Additional Paratransit services funded through MUNI and provided primarily by community-based organizations to offer wheelchair lift-van and group van transportation to seniors and adults with disabilities.
- *Village Programs*: 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. DAAS funding is used to subsidize membership fees for low-income persons.

❖ **DAAS Integrated Intake and Referral Unit**

Created to make services more accessible, the DAAS Integrated Intake and Referral Unit provides 24-hour information, referral and assistance for older adults and adults with disabilities, caregivers, and community-based organizations serving older adults and adults with disabilities. It is the hotline for screening for In Home Supportive Services and referrals to Adult Protective Services, Home Delivered Meals, Community Living Fund, Information, Referral and Consultation, and other types of calls. The staff maintains a database for analysis and monitoring purposes. The Intake, Screening and Consultation's Information and Referral service is, in part, funded by the Older American's Act and is DAAS's only direct service funded by the Office on Aging. This office works closely with the Aging and Disability Resource Center (ADRC) in providing information and referral services.

❖ **County Veterans Service Office (CVSO)**

The County Veterans Service Office assists veterans, most of whom are disabled, and their dependents in obtaining U. S. Department of Veterans Affairs' benefits and entitlements. The Veteran's Office represents veterans, their dependents and survivors during the benefits claims process. One of the goals of CVSO is to provide outreach and service to homeless veterans. Currently the CVSO staffs a main office and five out-stations.

DAAS Division: Long-Term Care Operations

The Long-Term Care Operations Division consists of newer innovative programs focused on assisting those in the community to avoid institutionalization and helping people transition back to the community after a period of institutionalization. These programs are the Community Living Fund, Care Transitions, and Clinical Quality and Assurance Unit.

❖ **Community Living Fund**

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 preferred location. CLF 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. However, the primary use of the funding is an intensive case management program that also provides purchase of services and items needed to live safely in the community for which there is no other payer.

❖ **IHSS Care Transitions Program**

The IHSS Care Transitions Program (CTP) is a new program in 2015. It is a revised continuation of a transitional care system that DAAS developed through a Medicare demonstration project. This program is focused on helping new IHSS applicants who are hospitalized transition smoothly back to the community. This transitional care service is provided by staff from the DAAS Integrated Intake and Referral Unit.

❖ **Clinical Quality and Assurance Unit**

In FY 15-16, the DAAS Clinical and Quality Assurance (CQA) Unit was developed to provide clinical consultations by Registered Nurses (RN) and Licensed Clinical Social Worker (LCSW) for IHSS and APS consumers with complex clinical needs (e.g., complex medical, nursing and behavioral health needs). The CQA unit creates client centered service plan and will refer client to community resources who will best assist in recovery from trauma, mental or physical illness. In particular, the LCSWs advocate on behalf of clients to resolve crises; they support some of the most complex IHSS cases.

DAAS Division: Protective Services

The DAAS Protective Services Division consists of five services – Adult Protective Services, Public Administrator, Public Conservator, Public Guardian, and Representative Payee – that support the most vulnerable seniors and adults with disabilities who are require or are at imminent risk of institutionalization due to difficulty meeting their basic needs.

❖ Adult Protective Services

Adult Protective Services investigates possible abuse or neglect of seniors and dependent adults. The abuse may be physical, emotional, financial, neglect by others, or self-neglect. If abuse or neglect is suspected, social workers provide short-term counseling, case management and referral services that ensure the ongoing safety of the person. Adult Protective Services will involve the courts if necessary and if the victim agrees. It operates a 24-hour hotline seven days a week.

❖ Public Administrator

The Probate Code charges the Public Administrator to investigate and administer the estates of persons who die with no known next of kin or without a will. One of the Public Administrator's main responsibilities is investigatory: attempting to locate next of kin, locating and protecting the assets of the deceased person and locating a will. Once a next of kin is located, the family member is often named as the personal representative of the estate. However, for a variety of reasons, but largely when no next of kin can be found or the estate is at risk for loss, waste or misappropriation, the Superior Court appoints the Public Administrator as the personal representative of the estate and instructs it to administer the estate. The Public Administrator is frequently appointed by the court as a neutral stake holder in contested estates.

❖ Public Conservator

The Public Conservator program provides mental health conservatorship, a legal procedure that authorizes psychiatric treatment of a person found by the Court to be gravely disabled due to mental illness and who is unable or unwilling to accept voluntary treatment. Public Conservator services include reports for placement hearings, psychosocial evaluations for the Superior Court, medical consents, psychiatric medication consents, supervision of treatment, advocacy, placement and case management of conservatees placed outside of San Francisco County.

❖ Public Guardian

The Public Guardian program operates under the authority and direction of the Superior Court to provide conservatorship of person and estate for people who are frail, elderly, and/or disabled and who are substantially unable to provide for their own personal needs or manage finances or resist fraud or undue influence. Conservatorship services include: developing a care plan for both immediate and long-term care; conferring and advocating on behalf of the conservatee and managing finances, and marshalling and protecting assets.

❖ Representative Payee Program

The Representative Payee program manages money for seniors and adults with disabilities who are unable to manage their own finances to ensure that daily living needs are met and that well-being and independence are protected. These services are voluntary, and the consumer must have a case manager to be eligible.

DAAS Division: In-Home Supportive Services

❖ **In-Home Supportive Services**

In-Home Supportive Services (IHSS) provides home help workers to low-income elderly and disabled and/or blind adults to remain in their homes rather than reside in an institution. Home help workers assist physically fragile adults with household chores, non-medical personal care like bathing, grooming, feeding or dressing, cooking and more physically challenging home maintenance activities. Over 22,000 seniors and disabled adults are enrolled in IHSS, and over 19,000 caregivers serve as independent providers for IHSS clients.

As the Area Agency on Aging for PSA 6, DAAS works closely with several partner agencies to solicit the input of consumers and support community-based systems of services that support the independence and protect the quality of life of older individuals, adults with disabilities, and their caregivers.

Aging and Adult Services Commission

The San Francisco Aging and Adult Services Commission is a charter commission of the City and County of San Francisco and **serves as the Governing Board for the AAA**. Its purpose is to formulate, evaluate and approve goals, objectives, plans and programs and to set policies consistent with the overall objectives of the City and County that are established by the Mayor and the Board of Supervisors. It has seven members.

The Commission maintains an annual statement of purpose, outlining its areas of jurisdiction, authorities, purpose and goals, subject to review and approval by the Mayor and the Board of Supervisors. After public hearing, the Commission hears the DAAS budget and any budget modifications or fund transfers requiring the approval of the Board of Supervisors. This is subject to the Mayor's final authority to initiate, prepare and submit the annual proposed budget on behalf of the executive branch and the Board of Supervisors' authority.

Other issues before the Commission may be related to the various local work-groups and state Committees and Commissions such as the Area Agencies on the Aging Council of California and the California Commission on the Aging and Adult Services.

Advisory Council to Aging and Adult Services Commission

The Advisory Council to Aging and Adult Services Commission **serves as a public voice to review and advise DAAS's work**. Established by the Area Agency on Aging, the Council carries out advisory functions that further the area agency's mission to develop and coordinate community-based systems of services. San Francisco's Advisory Council to the Aging and Adult Services Commission advises DAAS on: 1) developing and administering the area plan; 2) conducting public hearings; 3) representing the interest of older persons and adults with disabilities; and 4) reviewing and commenting on community policies, programs and actions which affect older persons and adults with disabilities. Members also visit the OOA-contracted agencies each year to assess their work and to gain a comprehensive understanding of the senior services network.

The Advisory Council includes eleven members who are appointed by San Francisco's Board of Supervisors and eleven who are elected by the Council membership. The membership is made up of: 1) more than 50 percent older persons, including minority individuals who are consumers or who are eligible to participate in programs; 2) representatives of older persons; 3) representatives of health care

provider organizations; 4) representatives of supportive services provider organizations; 5) persons with leadership experience in the private and voluntary sectors; 6) representatives of the lesbian-gay-bisexual-transgender (LGBT) community; 7) members of the California Senior Legislature; and 8) the general public.

Long Term Care Coordinating Council

A key partner for DAAS is the Long Term Care Coordinating Council (LTCCC), established by Mayor Gavin Newsom after the San Francisco's 2004 Living With Dignity plan found that the service structure to meet the needs of the city's senior population was fragmented. The LTCCC is responsible for: (1) advising, implementing, and monitoring community-based long term care planning in San Francisco; and (2) facilitating the improved coordination of home, community-based, and institutional services for older adults and adults with disabilities. The LTCCC and its subcommittees are working to improve the quality of the care and support, to expand the system capacity and to build a coalition of community caregivers for the aging and persons with disabilities in San Francisco. Consumers and service providers hold the majority of seats on the Council. The goals of the AAA have been aligned in the past with the *Living With Dignity Plan* developed by the LTCCC. The 2016-2020 Area Plan for PSA 6 reflects the *Long Term Care Integration Strategic Plan*, a joint project of the LTCCC and DAAS finalized in 2013, as well as topics investigated by LTCCC workgroups and discussed by the entire council over the last four years.

Role of the AAA

As the local AAA, DAAS is one critical part of a larger service delivery system for community-based long term care. The DAAS programs and those of other key county agencies are listed below.

Department of Aging and Adult Services
- Adult Protective Services
- Community Living Fund
- County Veterans Service Office
- Integrated Intake and Referral Unit
- In-Home Supportive Services
- Office on the Aging
- Public Administrator
- Public Conservator
- Public Guardian
- Representative Payee Program

Department of Human Services
- Food Stamp Program
- Housing and Homeless Program
- Medi-Cal Health Connections Program

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

Department of Parks and Recreation
Mayor's Office of Community Investment
Mayor's Office on Disability
Mayor's Office of Housing
Municipal Transportation Agency
San Francisco Housing Authority
San Francisco "311" Municipal Services Information Line

Many critical services are provided by community-based organizations that are best suited to serve San Francisco's senior population, including those organizations that offer congregate meals, case management services, and community services. Some CBOs focus on particular sub-populations, making their services invaluable. For example, the LGBT Cultural Competency Training and Integration Program, and the Social Support Services to Hoarders and Clutterers Program each work directly with

groups of consumers with specialized needs, allowing those providers to offer highly specialized and appropriate services.

Provide Leadership

As the Area Agency on Aging, DAAS stands as San Francisco's lead public organization to represent seniors. Between June 2005 and December 2015, Anne Hinton served as the executive director of DAAS. Ms. Hinton's career spanned more than 35 years, including many director-level positions in community-based organizations serving older persons. Ms. Hinton's experience also included serving as a lecturer/teacher in the field of Gerontology and has served on several boards, including the California Association of Area Agencies on Aging and the National Association of Area Agencies on Aging boards, professional associations and committees whose focus is long term care. In her ten years at the agency, she led DAAS to develop and implement a number of new initiatives and programs. These include, but are not limited to: evidence-based health promotion programs; an Aging and Disability Resource Connection; social support services for hoarders and clutterers; information, referral, and assistance for seniors in Housing Authority buildings; a new model for delivery of transitional care services; the Community Living Fund; and the SF Connected computer technology and lab program.

In April 2016, Shireen McSpadden was appointed Executive Director of DAAS by Mayor Edwin Lee. Prior to that appointment, she had served as Interim Executive Director since December 2015, and prior to that role, as Deputy Director of the department since 2003. Ms. McSpadden has more than 25 years' experience providing services to people with disabilities and seniors, in both the nonprofit and public sectors. Ms. McSpadden has served on the boards of local community organizations and committees such as Glide, Habitat for Humanity San Francisco, Rebuilding Together San Francisco, and the advisory board of UCSF's Center for Aging in Diverse Communities. She has also served on statewide organizations such as the California Association of Area Agencies on Aging, the California Association of Public Administrators, Public Guardians, and Public Conservators, and the Probate and Mental Health Advisory Committee of the California Judicial Council. Ms. McSpadden has a Master's Degree in Nonprofit Administration from the University of San Francisco. She is an alumna of Leadership San Francisco, Class of 2006.

The Aging and Adult Services Commission and the Advisory Council to Aging and Adult Services Commission support the leadership of the Area Agency on Aging in significant ways. Their roles are discussed earlier in this section.

Promote the involvement of older individuals and their caregivers within its community

One way by which the AAA ensures the involvement of older persons within the community is in the membership of the Long Term Care Coordinating Council (LTCCC). As mentioned above, the membership of this body is comprised largely of consumers and advocates – 17 of the 40 membership slots are reserved for consumers and advocates. The LTCCC also maintains several workgroups that focus on key issues for the disabled and aging populations, including but not limited to housing, technology, and palliative care. Workgroup participation is not limited to council members, and many workgroup members are seniors, adults with disabilities, caregivers, and advocates from the community. This council and its workgroups plays a key role in ensuring that the programs and initiatives discussed in the Area Plan are carried out, and offers insight into its development.

In addition, as mentioned above, the Advisory Council membership includes seniors, adults with disabilities and caregivers. This council plays a key role in ensuring that the programs and initiatives discussed in the Area Plan are carried out, and offers insight into its development.

Develop community based systems of services to support the independence and protect the quality of life of older persons and adults with disabilities

A number of Agency initiatives speak to its efforts to support the independence and protect the quality of life of older San Franciscans. These include but are not limited to:

- *Community Living Fund*: As described above, the Community Living Fund was created in order to facilitate transitions from institutional living to the community, and to support those who wish to continue living in their homes. Funded almost entirely at the local level, the program serves low-income seniors and younger adults with disabilities to live safely in their homes as long as possible.
- *Aging and Disability Resource Connection*: 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. In FY 14-15, DAAS changed the service model. Previously, a single agency visited over 15 service sites for a handful of set hours per week. However, 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. Two of the most popular services provided at these hubs are translation and assistance completing forms, including benefit applications. These referrals and service connections help clients access services that will help them live safely and vibrantly in the community. The initial funding from the California Department of Aging to the San Francisco ADRC ended on June 30, 2009. This program is now funded locally by DAAS.
- *Options Counseling*: DAAS has been providing Options Counseling since 2012. Social workers in the community and staff from the DAAS Integrated Intake and Referral Unit help seniors and people with disabilities learn more about their long-term care options, think through the client's preferences for their future, and create an action plan with specific steps for the client.
- *Evidence-Based Health Promotion Programs*: DAAS currently funds health promotion programs to help reduce fall risk and empower seniors to take control of their health through lifestyle changes. DAAS uses local funding to provide the evidence-based "Always Active" program, offering physical fitness and falls prevention classes for seniors throughout the city. Classes are led by certified wellness trainers and focused on strength and flexibility, low-impact aerobics, balance, and fall prevention. Using local and Older Americans Act funding, DAAS also contracts with a community-based organization to provide an evidence-based chronic disease self-management program called "Healthier Living."
- *Village model*: 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.
- *Enhancements to case management*: OOA has enhanced its community-based case management program to maximize the impact for program clients. In FY 14-15, the Clinical Consultant

Collaborative was expanded to increase support for case managers, particularly new/less-experienced case managers and those working at organizations with only one or two case managers. Through the Collaborative, case managers receive individual consultation and participate in group case review to support skill development. Additionally, OOA contracts with a consulting pharmacist to review client medication regimens for adverse drug reactions. A part-time project manager is devoted to enhancing the online medication management module used in the case management program database. In FY 16-17, the DAAS Integrated Intake and Referral Unit will assume responsibility for case management program intakes and maintaining a centralized database to support efficient access to service.

- *Transitional care after hospitalizations*: In 2012, DAAS applied to participate in the Affordable Care Act's Community Care Transitions Program, which was 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. 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. When the demonstration concluded in May 2015, DAAS saw an opportunity to utilize the relationships and referral networks developed through that project to support IHSS clients and created the IHSS Care Transitions Program (CTP). The DAAS Integrated Intake and Referral Unit provides this service and aims to serve 1,000 clients in FY 15-16.

Coordinate activities and develop disaster preparedness plans, with local and state emergency response agencies and organizations

According to the California Department on Aging, the responsibilities of the Agency related to disaster preparedness are:

- Prepare the organization, staff, and subcontractors to meet the challenges of a disaster.
- Support the emergency management community to ensure that the essential disaster-related needs of older individuals and persons with disabilities are included in overall community disaster planning.
- Document and report information to CDA and local Office of Emergency Services (OES) regarding the impact of the disaster on service recipients, and where feasible, other older individuals, their family caregivers, and persons with disabilities within their PSA.

All CDA entities, including AAAs, must prepare for disasters and participate in disaster-assistance activities on behalf of older persons and persons with disabilities within their span of control. The Human Services Agency (SFHSA) – the umbrella agency that encompasses the Department of Adult and Aging Services – is meeting these responsibilities.

As a department within SFHSA, DAAS is included in coordinating activities and the development of disaster preparedness plans. SFHSA is the city department responsible for mass care and shelter after a disaster. As such, the first priority of the Agency will be activation of the Department Operations Center and set up of the Care and Shelter response. The Agency will work closely with the American Red Cross and other members of the Care and Shelter response team to ensure that affected individuals and pets are housed, fed, and otherwise cared for as quickly as possible after an emergency is declared. All SFHSA employees are deemed Disaster Services Workers and are trained in emergency procedures.

In the spring of 2007, SFHSA's planning unit developed an emergency response plan specifically for vulnerable populations. It lays out the Agency's plans to provide services to specific vulnerable populations, including support for elderly and disabled clients and relocation for pre-disaster homeless persons. Current disaster plans stipulate that SFHSA will use geographic information systems to help manage its disaster response. Before and after disasters, the Agency will map the residences of In Home Supportive Services (IHSS) and Adult Protective Services clients who lack social and formal on-site support. IHSS staff will be assigned a list of these clients. IHSS staff will be instructed to call and/or visit those clients within the first 72 hours of an emergency to check on their health and safety, determine whether or not they have access to necessary supplies, and, if necessary, develop a plan to remove them from their current living situation to a safer location. Neighborhood Emergency Response Team members– San Francisco residents that have attended specialized disaster response trainings – may also assist with this function. In some instances, very vulnerable IHSS clients may be visited by both SFHSA staff and community volunteers; given the risks for this population in an emergency, this level of attention is appropriate.

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SECTION 4. PLANNING PROCESS / ESTABLISHING PRIORITIES

The current assessment is based on a series of research and planning efforts that have been conducted over the last four years. A key foundation was the work of the Long Term Care Coordinating Council (LTCCC). The Area Plan draws on the needs, service priorities, and goals identified by the Council. Over the last year, DAAS has also conducted needs assessments that were tied to specific requests for proposals, and these have been incorporated into the current assessment and planning process. DAAS extended these ad hoc efforts with needs assessment analysis specifically for this Area Plan.

Long Term Care Coordinating Council

As discussed in the prior section, the LTCCC was created in 2004 to provide policy guidance for City Hall leadership regarding all issues related to improving community-based long-term care and supportive services. The Council was intended to be the single body in San Francisco that would evaluate how different service delivery systems interacted and make recommendations about how to improve service coordination. Membership on the Long Term Coordinating Council is comprised of three groups. The largest group is **consumers and advocates** with 17 of the Council's 40 seats dedicated to representing seniors and adults with disabilities. Fifteen seats are reserved for **service providers**, including representatives from services related to health, behavioral health, developmental disabilities, and other disabilities. Eight seats are designated for **city and county departments**, including the Department of Aging and Adult Services, Human Services Agency, the Department of Public Health, the Mayor's Office on Disability, the Mayor's Office of Housing and Community Development, the San Francisco Housing Authority, and the San Francisco Municipal Transportation Agency.

The LTCCC researches and makes recommendations relevant to seniors and adults with disabilities in its regular monthly meetings of the full council, as well as in smaller workgroups focused on specific issues. Current workgroups are focused on housing, HIV/Aging, age- and disability-friendly efforts, palliative care, dementia care excellence oversight, and finance and policy aspects of long-term care. Members of the public not on the Council are welcome to join workgroups. These workgroups offer space to further research population needs and develop potential programmatic and policy solutions to meet these needs. These findings are reported back to the large group for discussion and evaluation. The full Council frequently hears presentations from city agencies and non-profit organizations and makes recommendations to improve these efforts based on the group's collective knowledge and expertise. DAAS is frequently called upon to present on its work, including sharing plans for new programs and discussing needs assessment work. The DAAS Executive Director is an LTCCC member and DAAS staff participates in the smaller workgroups, offering additional opportunities for the LTCCC to less directly shape the department's understanding of population needs and its work.

The LTCCC has also produced strategic plans that inform the Area Plan. The *Living With Dignity Strategic Plan 2009-2013* presented a comprehensive strategy to improve community-based care and support. In developing it, the LTCCC gathered information from key informant interviews, workgroup research, focus groups, community dialogues, and an online survey to analyze the local service system's strengths, weaknesses, opportunities, and threats. A list of potential goals, strategies, and objectives emerged from this work that drew from the 2005-2009 Area Plan. These new goals were integrated into the 2012-2016 Area Plan and carry over into the 2016-2020 Area Plan. The LTCCC and DAAS also closely collaborated on the *Long Term Care Integration Strategic Plan* published in 2013. This plan

provided recommendations to guide improvements in the organization, availability, and financing of long-term care, particularly in the context of the state's Coordinated Care Initiative.

Interim Needs Assessments

The information for the current needs assessment draws both from new research and from analyses that have been conducted at different intervals over the last four years. Rather than have one intensive period of assessment every four years, DAAS produced a series of smaller efforts that were aligned with its cycle of requests for proposals from community service providers, marshalling information on specific target areas of need and incorporating the results into the description of needed services. This approach made the assessments more timely, and it allowed the agency to utilize its resources more evenly. Assessments that were conducted in the last two years, and that were incorporated into the 2012 needs assessment, included:

- *Emergency Short-Term Home Care for Seniors (2015)*: This report analyzed census data to identify population demographics and discussed local trends in out-of-home placement options to highlight the importance of temporary home care for seniors.
- *Consumer Advocacy (2015)*: This report assessed the need for a bundle of programs, including HICAP; Home Care Advocacy; Housing Advocacy; Legal Services; Long Term Care Consumer Rights Advocacy; Naturalization; and Senior Empowerment.
- *Nutrition Needs Assessment (2015)*: This report focused on the utilization of OOA-funded nutrition programs and highlighted areas with potentially unmet need. This analysis supported the allocation of $2.6 million in addback funding from the Mayor and Board of Supervisors.
- *Population Demographics by Supervisorial District* (2014): This work analyzed population demographics of seniors and adults with disabilities by supervisorial district.
- *Caregiver Support* (2013): This report analyzed local caregiver population characteristics and estimated unmet need for caregiver support services.

The current DAAS needs assessment also drew from analysis led and/or supported by DAAS, including:

- *LGBT Aging at the Golden Gate (2014)*: This report summarizes key findings and recommendations from the LGBT Aging Policy Task Force about necessary improvements to meet the needs of LGBT seniors in San Francisco. This report draws on other research completed and published with the support of DAAS staff and analysts.
- *Nutrition Needs Assessment for Hearing on the Status of Hunger and Food Security* (2014): This memo provided an overview of the DAAS nutrition programs and analyzed current capacity, needs, and costs.
- *Increasing Broadband Access for Seniors and Adults with Disabilities in San Francisco* (2013): This report assessed the impact of the Broadband Technology Opportunities Program (BTOP). It also determined barriers for access and identified improvements to encourage seniors and adults with disabilities to use technology and high-speed internet to overcome social isolation and access resources for healthy aging (among other potential positive impacts).

2015-2016 Needs Assessment

The 2015-2016 needs assessment drew on recent planning and research efforts but primarily relied upon new analysis about needs, available resources, and gaps in service. It contains not only information about OOA services and consumers but all DAAS services and focuses also on the broader needs of the community. For example, the assessment describes at length the housing pressures that confront vulnerable San Franciscans – a challenge far beyond OOA or DAAS resources but one that deeply

affects all seniors. The sources of information for the assessment, both quantitative and qualitative, are detailed in the table below.

2015-2016 Needs Assessment Information Sources

American Community Survey census data (2012 & 2013)	This assessment relies on census data from the American FactFinder estimates and the Integrated Public Use Microdata Series (IPUMS) datasets that provide more flexibility and original analysis. Wherever possible the most recent data was used. At the time the assessment was completed, the most recent FactFinder data was the 2013 5-Year estimates and the most recent multiyear IPUMS dataset was the 2012 3-Year sample. As more recent data is rolled out at more finite levels and with more specific variables, DAAS will continue to analyze it, update the assessment information, and disseminate it to the community. This assessment also used 5% sample data from the 1990 and 2000 decennial census to track trends over time.
Surveys	The California Health Interview Survey is a collaborative project of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. Local-level data are available for San Francisco and were included to augment local information. Additionally, DAAS has long worked with the San Francisco Controller's Office to develop questions for seniors and adults with disabilities in the biennial survey, which is conducted by a consultant firm and utilizes a representative random sampling of city residents. Responses from this survey help DAAS understand the experience and unmet needs of seniors and adults with disabilities. In 2013, DAAS helped lead a survey of LGBT seniors to learn about unmet needs sand barriers to service utilization; this work is integrated into the assessment.
CA-GetCare Consumer Data	Nearly all consumers participating in OOA-funded programs are enrolled in an online database, CA-GetCare. Enrollment information identifies the programs in which each consumer participates, as well as the organization that provides services. Consumer records also include personal characteristics, such as ethnicity, primary language, English fluency level, and zip code. This information was used to assess trends in the utilization of OOA services.
Administrative Data	Across its programs, SFHSA serves over 200,000 unique persons in a city of approximately 800,000. DAAS serves approximately 52,000 unique seniors and adults with disabilities. To better understand the needs of specific populations, especially low-income communities, the assessment drew from the administrative data of SFHSA 's spectrum of programs, including CalFresh, homeless shelters, In Home Supportive Services, Adult Protective Services, County Veterans Service Office, Community Living Fund, and the DAAS Integrated Intake and Referral Unit. The assessment also drew from SFHSA's contract and fiscal databases to identify trends in financial support for senior programs. Finally, the analysis utilized administrative data from other city agencies, such as the Housing Authority. These information sources provided a broader context to understanding the needs of San Francisco seniors and adults with disabilities.
Literature Review	Staff conducted a literature review of relevant national, state, and local reports. It examined research articles, the needs assessment also drew from research literature that provided insights about needs and suggestions about best practices.
Consumer Focus Groups	In order to gain additional perspective on the issues facing unique demographic groups in San Francisco, focus groups were held with caregivers and younger adults with disabilities, as well as African American, Asian/Pacific Islander, Latino, and homeless seniors. These smaller, 7-14 person groups allowed participants to delve deeply into important topics, focusing specifically on the unique needs of their demographic group.

2015-2016 Area Plan Goals and Objectives

The 2016-2020 Area Plan goals are carried over from the prior Area Plan. These are: (1) Improve quality of life; (2) Establish better coordination of services; (3) Increase access to services; and (4) Improve service quality. These goals were drawn from the LTCCC *Living With Dignity* plan and remain the underlying motivation for DAAS's current work. These priorities were reviewed in community forums and also summarized and discussed at two public hearings for the prior Area Plan (at the DAAS Advisory Council in April 2012 and the second at a meeting of the Aging and Adults Services Commission in May 2012). The DAAS Advisory Council is a large body comprised of service providers, advocates, and consumers, and it makes policy recommendations to the Commission. The Aging and Adult Services Commission is responsible for setting DAAS policies. Public stakeholders, including consumers, have an opportunity to express concerns and present ideas at these public hearings.

The objectives for the 2016-2020 Area Plan outline more specific action items that support these high-level goals. These objectives reflect priorities highlighted by the LTCCC and its workgroups, as well as ideas and concerns raised by stakeholders through a variety of avenues. Every year, DAAS provides a series of budget presentations forecasting the upcoming fiscal year: once for the DAAS Advisory Council and twice before the DAAS Commission. These presentations offer opportunities for consumers, other community members and service providers to ask questions and share concerns. Also, the DAAS Advisory Council and a group of service providers, the Coalition of Agencies Serving the Elderly, deliver monthly reports at the DAAS Commission meetings to spotlight key areas of concern. These entities are also frequently in direct contact with DAAS leadership to give input on the needs of seniors and adults with disabilities and make recommendations for department action. The current Area Plan objectives also draw on the DAAS Five Year Plan strategies developed for the Mayor's Office; these priorities were developed with input from DAAS program managers and staff. Prior to the Area Plan submission to the California Department of Aging, these priorities were presented at public hearings (at the April 2016 Advisory Council and DAAS Commission meetings).

Please see Section 10 of this Area Plan for the comprehensive presentation of goals, the rationale for these goals, and the more specific objectives. Over the next three years, DAAS will provide an update on progress in these areas.

SECTION 5. NEEDS ASSESSMENT

In preparation for the Area Plan, DAAS completes a large-scale needs assessment report every four years. This needs assessment analysis is published as a stand-alone report, used by a wide range of stakeholders to learn about population and programmatic trends and to inform advocacy and policy decisions. Because DAAS is also charged to serve younger adults with disabilities age 18 to 59, this population is included in the needs assessment.

This needs assessment analysis is structured in two parts:

- Part I: Demographic Profile (begins on page 27 of this Area Plan)
- Part II: Analysis of Needs and Services (begins on page 93 of this Area Plan)

This analysis is presented before the DAAS Commission, DAAS Advisory Council, and Long-Term Care Coordinating Council. The written assessment is made available on the DAAS website.

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San Francisco Department of Aging and Adult Services

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

Part I: Demographic Profile

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

Needs Assessment Part I – 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. DAAS has extended the focus of its attention to include the needs of younger adults with disabilities. This report contains the findings of the 2015 needs assessment process.

This assessment is divided into two volumes. This first report is a broad quantitative and qualitative profile of San Francisco's seniors and persons with disabilities, intended as an inventory of information, a reference for citizens, non-profit service providers, public sector planners, and researchers. The second report examines the key service categories of the Office on the Aging, discussing more specifically the needs and rationale that underlie the services, and comparing trends in funding.

Highlights from this first report related to the senior population include:

- 20% of the city's population is 60 or older: 161,777 individuals. This population has grown by 18% since 2000 (compared to 4% overall city growth). This growth is anticipated to continue as the Baby Boomer generation ages.
- Over the last two decades, these seniors have become predominantly an immigrant population. Most commonly, these immigrants were born in China and have become naturalized citizens.
- 54% of seniors speak a primary language other than English.
- 16% have income below the federal poverty line (FPL), which was $11,770 for a single household in 2015. Approximately half have income below 300% FPL.
- An estimated 12% of seniors identify as part of the lesbian-gay-bisexual-transgender (LGBT) community.

Key findings regarding adults with disabilities include:

- 35,145 adults between age 18 and 59 report disabilities in the census. Most (88%) live in the community, but about 4,000 reside in group quarters, such as skilled nursing facilities and adult group homes.
- Half of this population reports cognitive disabilities – difficulty remembering, concentrating, or making decisions due to a physical, mental, or cognitive problem.
- Compared to the overall adult population, African-American and Latino adults are overrepresented in this group and Asian-Pacific Islander adults are underrepresented. This may be due in part to uneven rates of reporting in the census.
- This population tends to have very low income. One-third has income below 100% FPL. Sixty-nine percent have incomes below 300% FPL.

Methodology

Sources of Information

This assessment integrates data and information from a variety of sources, relying on both existing analysis, such as the work by the LGBT Aging Policy Task Force, and new analysis generated specifically for this assessment. Major sources of information are described below.

U.S. Census Bureau

Census data provides valuable insight into current and historic population trends. The majority of the demographic analysis in this needs assessment is based on census data accessed from the following data sources:

- University of Minnesota Integrated Public Use Microdata Series (IPUMS):
    - 1990 5% population sample
    - 2000 5% population sample
    - 2012 Three-Year American Community Survey sample[5]
- U.S. Census Bureau American FactFinder:
    - 2013 Five-Year American Community Survey tables

Using both the IPUMS sample data and the American FactFinder table provides a more comprehensive understanding of seniors and adults with disabilities. Each source has strengths and limitations:

- The IPUMS sample data contains weighted respondent-level data, which allows for customized analysis. For example, these datasets allow for creation of more meaningful definitions of low-income status and cross-tabulations of populations of interest by key demographic factors (e.g., income and ethnicity). However, these datasets have limited geographic data and thus do not support meaningful analysis of trends by location within San Francisco. Also, the most recent multiyear IPUMS dataset is for the 2009 to 2012 period (though a review of slightly more recent FactFinder tables suggests the trends remain consistent).
- The American FactFinder tables provide data at the census tract level, permitting analysis of trends by location. However, this source provides only aggregate data in tables with preset population definitions, which do not always align with DAAS population definitions. For example, few tables are focused on adults with disabilities, and the data that is available uses an age threshold of 18 to 64 that is inconsistent with the Office on Aging age threshold of 18 to 59. Similarly, much of the more specific data on seniors, including poverty, is focused on adults age 65 and older.

There is important nuance to note about three census variables that are particularly relevant for the populations DAAS serves:

- **Location**. As noted above, the data available by location is in a fixed format that does not necessarily meet the population or income definitions used by DAAS. Poverty data uses an age 65 threshold for seniors and an age range of 18 to 64 for adults with disabilities.

[5] As this report was undergoing final preparation for publication, the 2013 Three-Year IPUMS sample was released. Review of this data indicates the trends described in this assessment remain consistent. The total city population is 825,669 with 165,138 seniors age 60 and older (20%) and 35,101 aged 18 to 59 reporting disabilities (4%).

Also, the data on adults with disabilities is limited; not all of the topics available for seniors are provided for the disabled adult population. As much as possible, this needs assessment uses the DAAS population definitions and provides comparable analysis for both populations.

- **Group Quarters**. The census data includes individuals living in two types of group quarters. People under formally authorized, supervised care or custody are categorized as residing in "institutional group settings," such as skilled nursing facilities, in-patient hospice, mental/psychiatric hospitals, and correctional facilities. Group quarters like college dormitories, adult group homes and residential treatment facilities, and workers' group living quarters, are classified as "non-institutional group quarters." For this needs assessment, all seniors and adults reporting disabilities are included in the analysis unless otherwise specified. Residence in facilities may not be permanent and certain DAAS programs support people in facilities. For example, the Community Living Fund helps those wanting to transition out of skilled nursing residential care facilities.

- **Disability**. Two aspects of the census disability data are important to highlight. First, to improve accuracy and reduce non-response rates, the census questions measuring disability were changed in 2008. The Census Bureau cautions against comparing trends in disability across that time period. Accordingly, analysis of the census disability data in this assessment is focused on the most recent time period. The U.S. Census Bureau has analyzed the current questions in comparison to its Survey for Income and Program Participation survey, which is a more nuanced survey focused on disability and service needs (unfortunately, this study does not provide recent data at the county level). This analysis suggests that the revised census questions approximate results in line with this survey, suggesting that the current questions are an improvement and do provide useful insight into trends in disability (Brault, 2009).

  Second, disability data in the census is self-reported based on questions about "difficulty" in key functional areas. As such, this data is best viewed as indicative of population trends but should not be construed to represent factual data on disability as diagnosed/assessed by a medical or social work professional. One reason for this suggested perspective is that self-reported data is subject to misreporting. This may occur for many reasons. A key attribute of certain mental health conditions is lack of insight into the illness; individuals who do not acknowledge their disability will not self-report it in the census. Stigma surround disabilities, particularly mental health conditions, may inhibit reporting. Cultural variation in perceptions of disability may result in variation in rates of self-reporting. In particular, it seems likely that the Asian-Pacific Islander (API) population underreports disability. Approximately 31% of the adult population age 18 to 59 is API; however, APIs only constitute 18% of adults reporting disabilities in the census. While it is possible that disability is less prevalent in this population, it is likely that cultural reticence may be partly responsible. When asked about this issue, many San Francisco service providers that work with the API population saw merit in this theory. Unfortunately, there is not research to estimate the rates of underreporting that may exist among certain communities.

Despite these limitations, census data provides critical insight into population trends and is of value to DAAS in planning its efforts to meet the needs of local seniors and adults with disabilities.

Program data
This needs assessment also relies heavily on service enrollment data to both assess client service needs and gather population information. The primary databases are listed below. Most analysis focuses on program trends from Fiscal Year 2014-15.

Database	Program(s)
CA GetCare	Office on Aging
SF GetCare	DAAS Integrated Intake & Referral Unit and DAAS Transitional Care programs
CASECare	Community Living Fund
Case Management, Information and Payrolling System II (CMIPS II)	In-Home Support Services
APS Automated Client Tracking System (AACTS)	Adult Protective Services
CalWIN	CalFresh
VetPro	County Veterans Service Office (CVSO)

Survey data
This assessment also draws on survey data gathered by external sources. Two of the primary surveys integrated into this analysis are:

- **Biennial City Survey**. The San Francisco Controller's office funds a citywide survey every two years to learn about city residents' needs and experiences with local government. Conducted by an outside consultant, this telephone survey is designed to randomly sample city residents throughout the city, offering a valuable opportunity to gather feedback from seniors and adults with disabilities outside of the DAAS service network. In addition to survey specific to DAAS services, this survey offers the unique and valuable opportunity to understand how seniors and adults with disabilities experience other parts of city life.
- **California Health Interview Survey (CHIS)**. A collaborative project of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute, the California Health Interview Survey (CHIS) is a telephone survey of adults, adolescents, and children from all parts of the state. Local-level data are available for San Francisco and were included to supplement local research.

Qualitative data
In addition to the quantitative data described above, this assessment draws on qualitative data. Over the last year, a series of focus groups were held throughout the city to reach San Francisco's diverse communities. The goal of these focus groups was to gather insight into the experience of being a senior or person with disabilities living in San Francisco, as well as to gather suggestions for ways to better serve these populations. Participants included African-American, Asian-Pacific Islander, Latino, white, LGBT, homeless seniors, and adults were disabilities. Focus groups were also held with family caregivers and Adult Protective Service workers, as well as homeless older persons. This assessment is also shaped by qualitative information from key informant interviews with service providers and city staff serving seniors and adults with disabilities. See Appendix A for a complete list of focus groups.

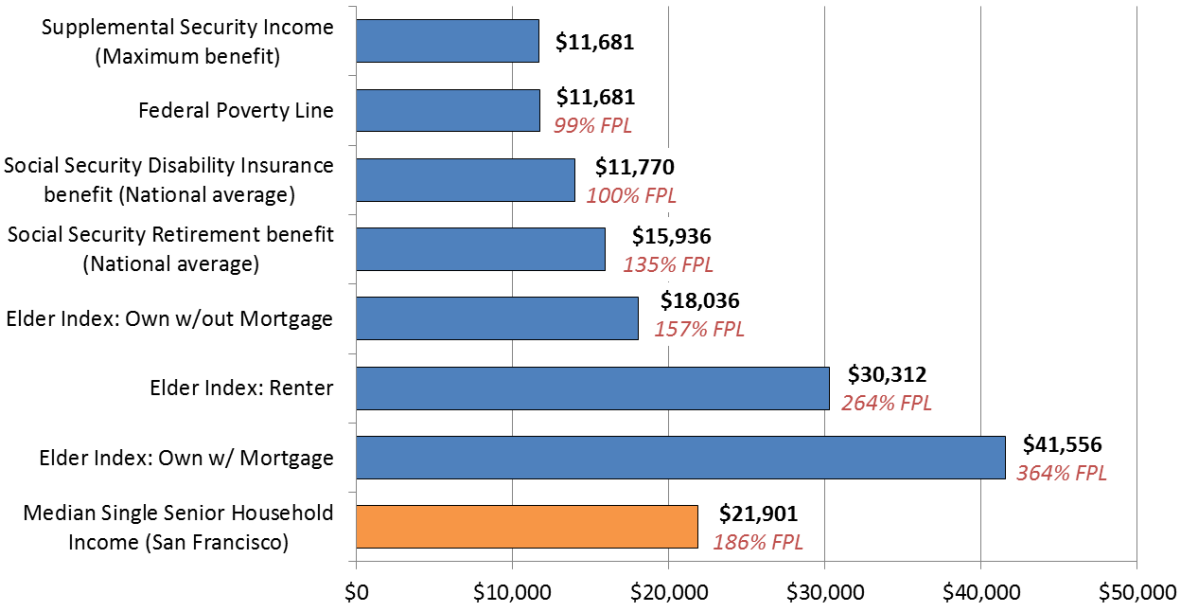
Definitions of Poverty and Low-Income Status

While many of its programs do not adhere to strict means testing policies, DAAS is charged with focusing its efforts on the most vulnerable seniors and adults with disabilities, including those with low incomes. With the soaring cost of living in San Francisco and the uniform nature of the federal poverty thresholds, the federal poverty line (FPL) is arguably not the most suitable method for identifying and assessing the needs of low-income individuals. In 2015, FPL for a single individual was $11,770; it is beyond doubt that many individuals with income above this official poverty level likely struggle to make ends meet.

The limitations of relying on FPL to assess need are highlighted by a recent study by the UCLA Center for Health Policy Research. This study used the Elder Economic Security Standard Index, which incorporates variation in cost of living by county and by housing tenure to estimate a basic self-sufficiency standard, to identify the hidden poor. Findings from this study suggest that approximately 30% of single seniors and 29% of senior couples age 65 and older are among the hidden poor – their income is above the federal poverty line but below the Elder Index thresholds for a decent standard of living. In total, an estimated 57% of single senior households and 39% of two-person senior households have inadequate income to meet a basic standard of living, representing at least 38,000 San Franciscans age 65 and older.

As shown in the chart below, the estimated cost of living in San Francisco far exceeds federal poverty guidelines and government benefits. Supplemental Security Income (SSI), the federal supplemental income stipend for the most impoverished older adults and persons with disabilities, provides a maximum benefit lower than the federal poverty line; anyone receiving SSI benefits is living in poverty. The national average Social Security retirement benefit is slightly less than $16,000 per year (135% of FPL). Retirees without alternate retirement benefits or significant savings would likely to struggle to make ends meet in San Francisco at this income level.

The Cost of Living in San Francisco Far Exceeds Federal Poverty Guidelines and Government Benefits



Sources: Social Security Administration, Supplemental Security Income in California (2015)
U.S. Department of Health & Human Services, 2015 Poverty Guidelines
Social Security Administration, What is the Average Monthly Benefit for a Retired Worker?, January 2015
UCLA Center for Health Policy Research, Elder Economic Security Standard Index 2013
IPUMS 2012 3-Year Samples

The preceding chart also contains the elder index standards for single seniors. Depending on home ownership status, the minimum income necessary to meet a basic standard of living ranges from $15,936 annual income (157% FPL) to $42,556 (364%). In reality, the median income for a single senior household in San Francisco is approximately $21,901, which equates to 186% FPL (monthly income of $1,825).

In the context of San Francisco's high cost of living, FPL is a crude threshold. Given the discrepancy between official poverty standards and the local cost of living, as well as the fact that many DAAS programs do not employ means testing or use higher income thresholds, this assessment takes a more nuanced approach to identifying and analyzing low-income populations. Specifically, three income tiers are used to identify those with family[6] income:

- Below 100% FPL;
- Between 100% and 199% FPL; and
- Between 200% and 299% FPL.

The table below provides a reference for the annual income equivalent of these thresholds by household size. For example, a single adult in the "lowest-income" group has annual income below $11,770. A single adult with slightly higher income would fall into the middle "low-income" group with annual income between $11,770 but below $23,540. The "upper poor" low-income group in this analysis includes single adults with annual income between $23,540 but below $35,310.

2015 Federal Poverty Line (Annual Income)			
Household Size	**100% FPL**	**200% FPL**	**300% FPL**
1	$11,770	$23,540	$35,310
2	$15,930	$31,860	$47,790
3	$20,090	$40,180	$60,270
4	$24,250	$48,500	$72,750
5	$28,410	$56,820	$85,230
6	$32,570	$65,140	$97,710

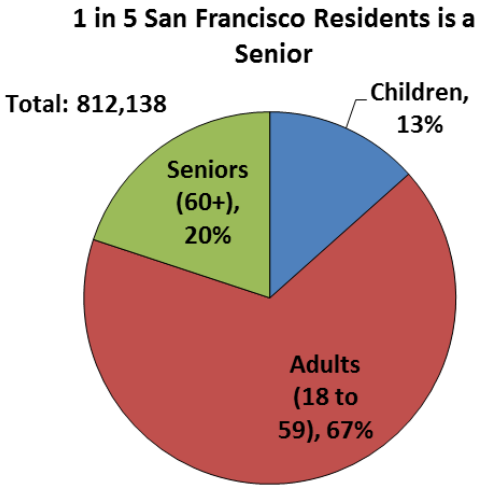
[6] The U.S. Census Bureau defines a family as those living in the same household who are related by birth, marriage or adoption. Family income is the aggregated personal income of all family members.

San Francisco Seniors

Seniors: Population Size

Approximately 161,777 people age 60 or older live in San Francisco. They are 20% of the city population, consistent with population trends over the last 20 years. Approximately 14% of city residents are age 65 and older.

Though the *percentage* of the population that is age 60 and older has remained consistent, the *size* of the senior population has increased significantly and outpaced the general population growth. Over the last 12 years, the senior population has grown by almost 25,000 individuals, an increase of 18%. In comparison, the overall city population has grown by only four percent during this time.

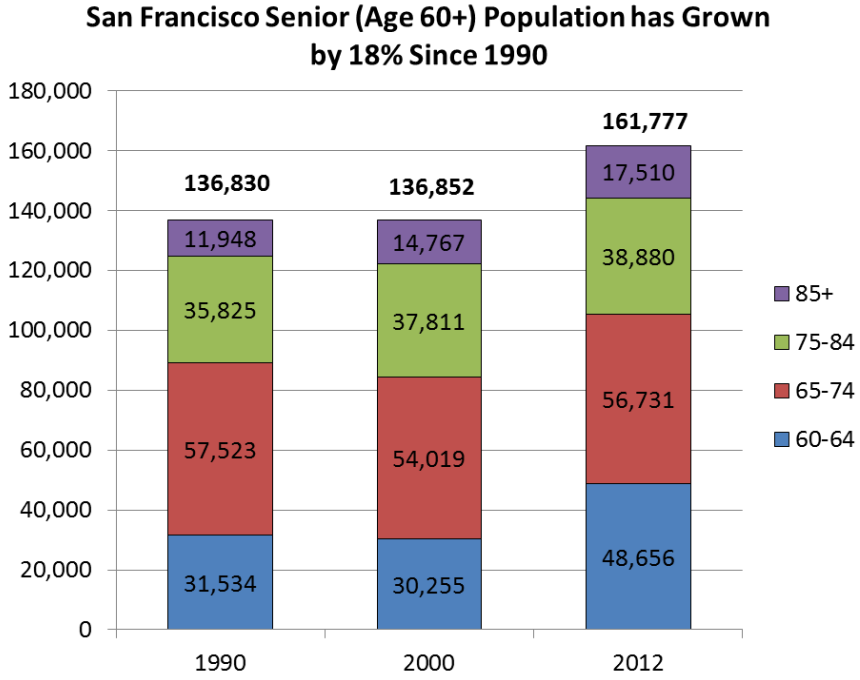


Source: IPUMS 2012 3-Year Sample

Population	2000	2012	# change	% change
Children (Under 18)	111,683	108,941	-2,742	-2%
Adults (Age 18-59)	531,014	541,420	10,406	2%
Seniors (Age 60+)	136,852	161,777	24,925	18%
Total Population	779,549	812,138	32,589	4%

Source: IPUMS 2000 and 2012 ACS Samples

As shown in the chart below, the senior population size remained static between 1990 and 2000 but surged over the last decade. This growth is driven by the younger senior population aged 60 to 64. Between 2000 and 2012, this group grew by approximately 18,400 individuals (an increase of 61%) as Baby Boomers began to reach age 60. As described on the next page, this trend is likely to continue as the younger Baby Boomer reach age 60.

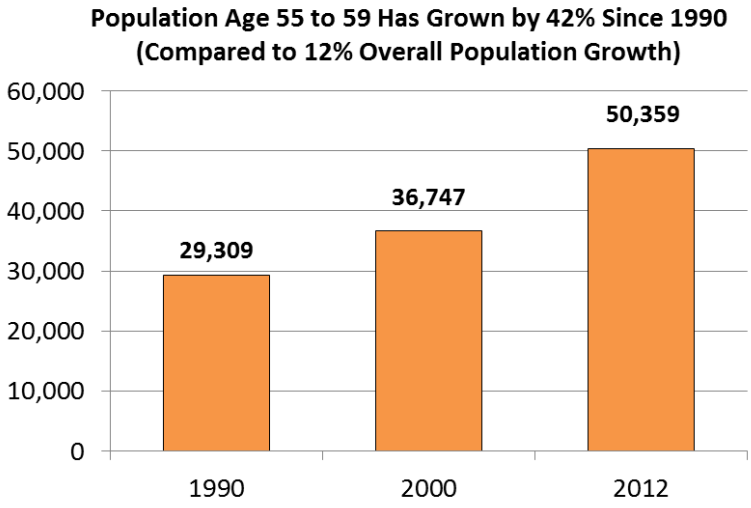


Source: IPUMS 1990 5% sample, 2000 5% sample, 2012 3-year sample

The oldest old group of individuals – age 85 or older – has also grown, increasing by more than 5,500 individuals between 1990 and 2012. Though the size of this group is small in comparison to the younger seniors, the change is significant; this older population tends to be more vulnerable and frail and typically has significantly higher care needs.

Seniors: Anticipated Population Growth

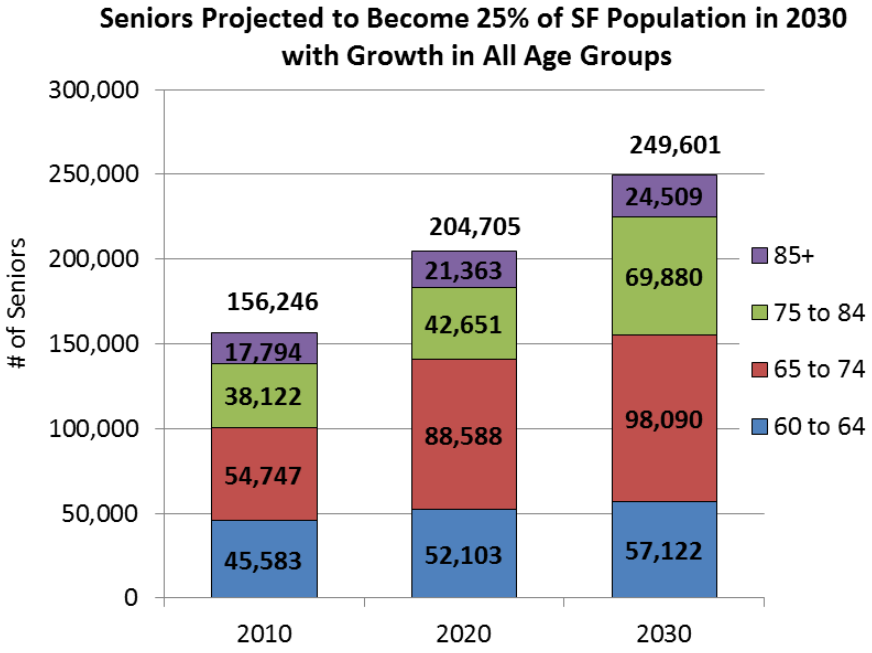
The senior population in San Francisco is expected to continue increasing. As shown to the right, the population of adults age 55 to 59 is growing. In the next five years, 50,359 adults in San Francisco will reach age 60.



Source: IPUMS 1990 5% sample, 2000 5% sample, 2012 3-year sample

Some of these individuals may leave the city, fleeing the high cost of living. However, nearby counties have also experienced increases in cost of living, making it challenging for older persons on fixed incomes – particularly those in rent-controlled apartments – to find similar accommodation for less or even similar cost in surrounding counties. The Controller's Office biennial city survey suggests that most adults age 55 to 64 intend to stay in San Francisco. Most respondents in this age range indicated they are "not at all" likely to move out of San Francisco in the next three years. Respondents age 65 and older said the same; in fact, the percentage indicating they do not intend to leave the city has increased from 57% of senior respondents in 2005 to 73% in 2015.

As shown below, the senior population age 60 and older is expected to grow by almost 100,000 individuals between 2010 and 2030 (California Department of Finance, 2014). This growth is anticipated to occur across age groups within the senior population. Seniors age 60 and older comprise 20% of San Franciscans today but are projected to be 26% by 2030.



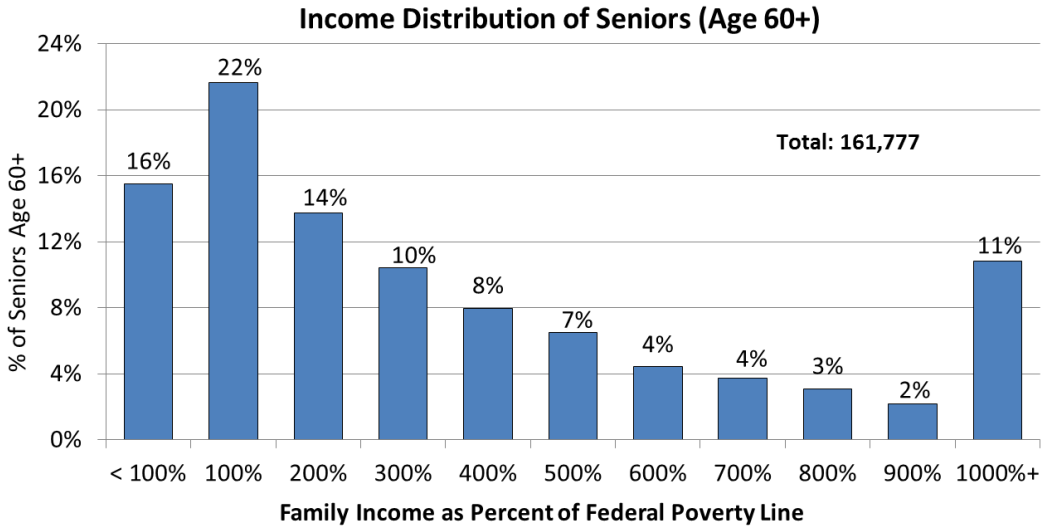
Source: State of California, Department of Finance, P-2 State and County Population Projections by Race/Ethnicity and Age (5-year groups), 2010-2060.

San Francisco needs to plan for this growing population. The Public Policy Institute of California suggests that the state's senior population in the coming decades is less likely to have family for informal support and thus will be more reliant on formal supportive services (Beck & Johnson, 2015).

Seniors: Income & Poverty

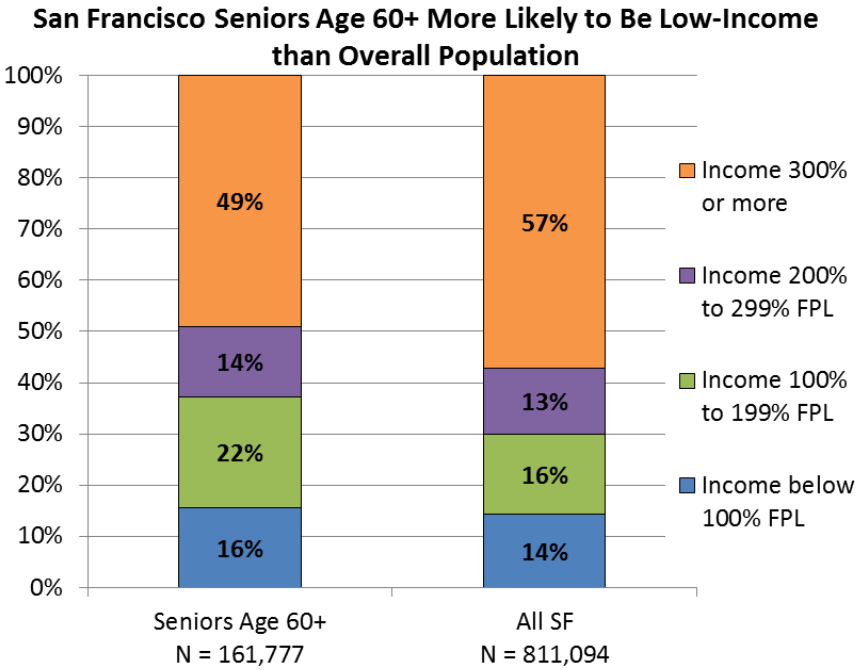
Please refer to "Definitions of Poverty and Low-Income Status" in the Methodology section of this report for more information about the low-income thresholds used in this analysis.

Older adults in San Francisco tend to be low income. As shown below chart, 16% of seniors – 25,103 individuals – have family income below the poverty line.



Source: IPUMS ACS 2012 3-Year Samples

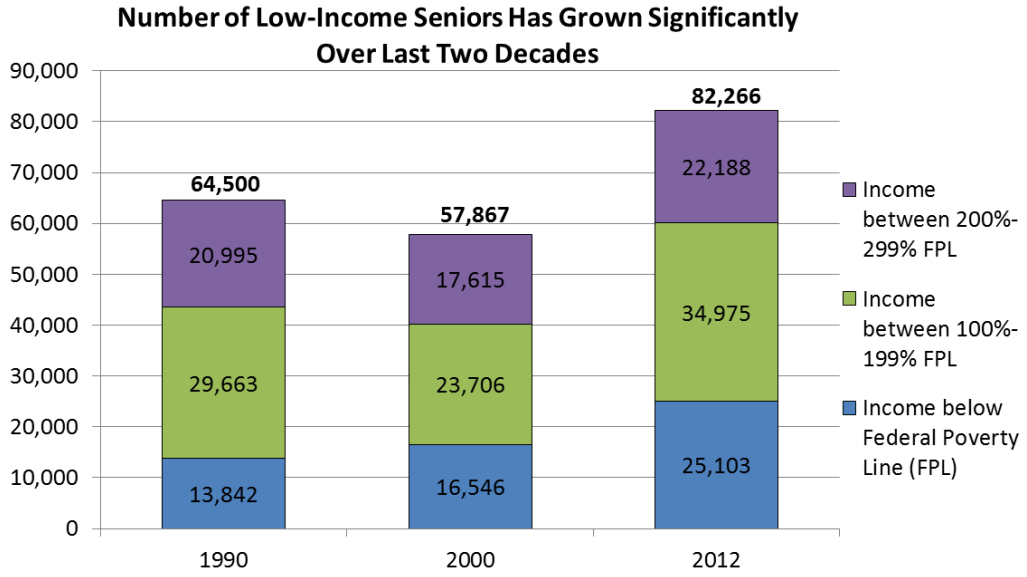
Many more San Francisco seniors have inadequate income to meet their needs. Approximately 22% or 34,975 seniors have income between 100% FPL and 199% FPL; at this income level, these seniors are likely ineligible for public benefits like Medi-Cal but may struggle to meet needs. An additional 14% – 22,188 seniors – fall into the "upper poor" group (those with income between 200% FPL and 299% FPL). In total, half of San Francisco seniors live on less than 300% of the poverty threshold ($2,943 monthly income for a single person).



Source: IPUMS 2012 3-Year Samples

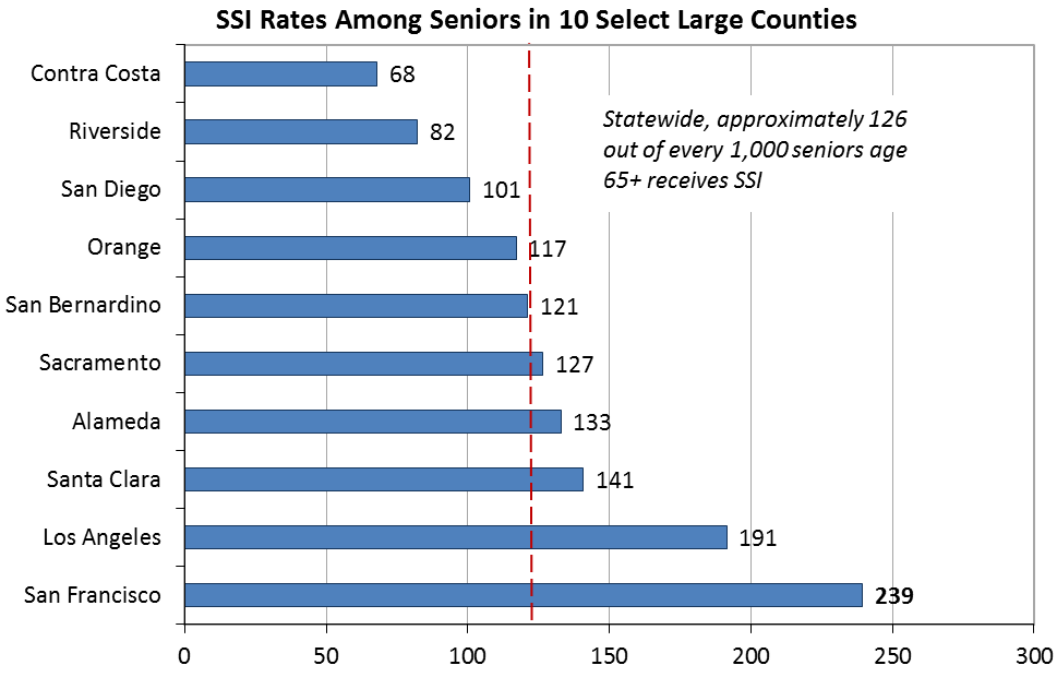
Elderly persons in San Francisco are more likely than the overall population to be poor. A slightly higher percentage lives below poverty than the general population. Twenty-two percent of San Francisco's seniors live just above the federal poverty level, just above destitution. Citywide, the rate is 16%.

Overall, poverty rates within the senior population have remained relatively steady over the last two decades – about 50% of seniors have consistently had income below 300% FPL. However, given the growth of the senior population, the *number* of seniors living on sparse income has significantly increased. As shown in the chart below, most of this growth has occurred in the lowest income group – those living below the federal poverty line. In 1990, approximately 11% of seniors had income below 100% FPL. Today, 25,103 seniors have income below 100% FPL ($981 monthly income for a single person).



Source: IPUMS 1990 5% sample, 2000 5% sample, 2012 3-year sample

Seniors in San Francisco are more likely to be low-income than seniors in other major counties. As shown below, the Supplemental Security Income (SSI) rate is significantly higher among San Francisco seniors age 65 and older than other parts of the state. Approximately 239 out of every 1,000 San Francisco seniors receive at least a partial SSI benefit. By comparison, the statewide rate is 126.

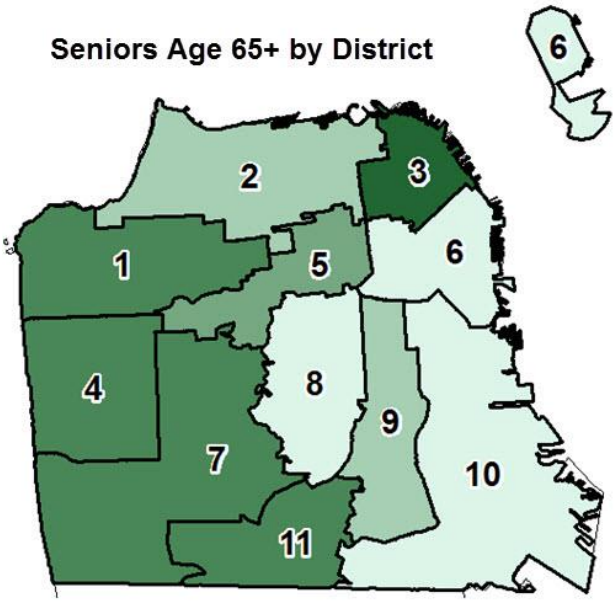


Source: Social Security Administration, 2013; ACS 2013 5-Year Estimates, Table S0103

Seniors: Location

As described in the methodology section of this report, census data on income by location is only available using age 65 as the senior threshold. For consistency of comparison, this analysis describes general population trends using this threshold. The distribution of the general senior population age 60 and older shows similar trends. Please see Appendix B for a map of supervisorial districts and neighborhoods and Appendix C for complete senior data by district.

San Francisco seniors live in every San Francisco neighborhood. The map to the right depicts total senior population age 65 and older by supervisorial district. District 3 (Chinatown, Nob Hill, North Beach) is home to the largest senior population: 13,736 or 12% of the city's seniors live in this area. This district tends to be older than other areas of the city –18% residents of District 3 are over age 65 compared to 14% citywide. Other areas of the city with larger senior populations include District 11 (in particular, the Excelsior and OMI neighborhoods), District 4 (Outer Sunset), District 7 (Twin Peaks and Inner Sunset), and District 1 (Richmond). Each contains over 10% of the city's senior population.

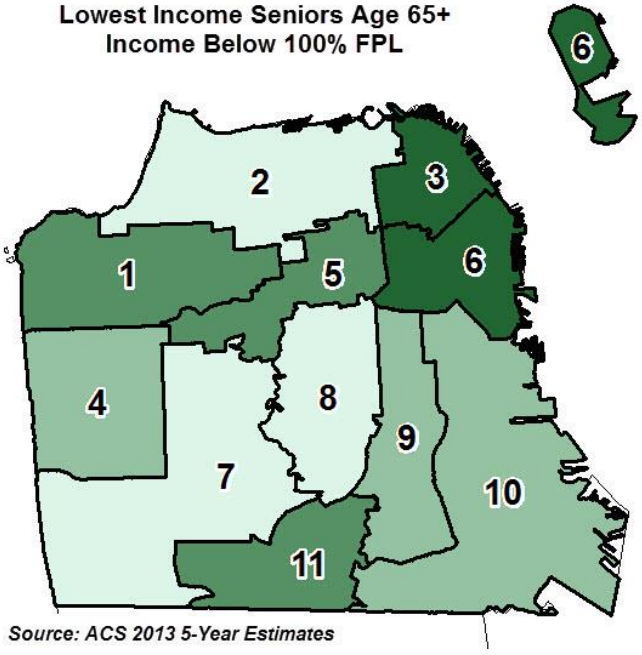


Source: ACS 2013 5-Year Estimates

However, as shown below, low-income seniors tend to be concentrated in certain areas of the city. The size of the total senior population size within a district does not necessarily correspond with the size of the low-income senior population.

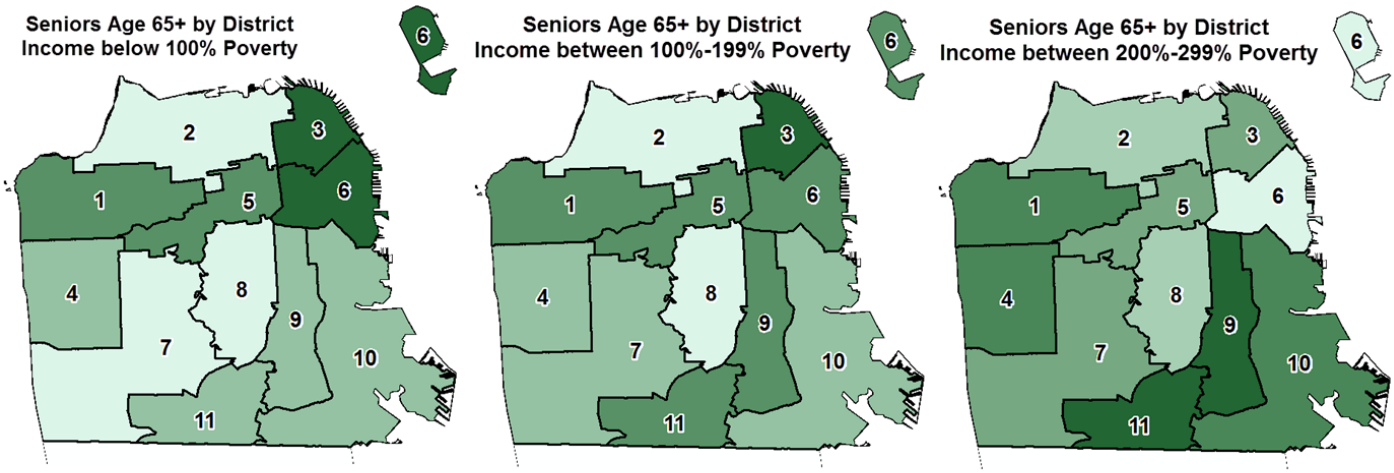
The lowest-income seniors – age 65 and older with income below the poverty threshold – are most likely to reside in District 3 or District 6 (SOMA, Tenderloin). Approximately 3,365 or 21% of the city's lowest-income seniors live in District 3. Were the population evenly distributed, nine percent would live in each district. District 6 has the smallest senior population but the second largest population of the seniors living in poverty: 16% or 2,642 older persons. District 5 is also home to a disproportionate share of the city's low-income seniors: 12% or 1,932 very low-income older persons. The trend in District 5 appears to be driven by residents of the Western Addition and Haight Ashbury neighborhoods.

Taking a wider view of low-income status



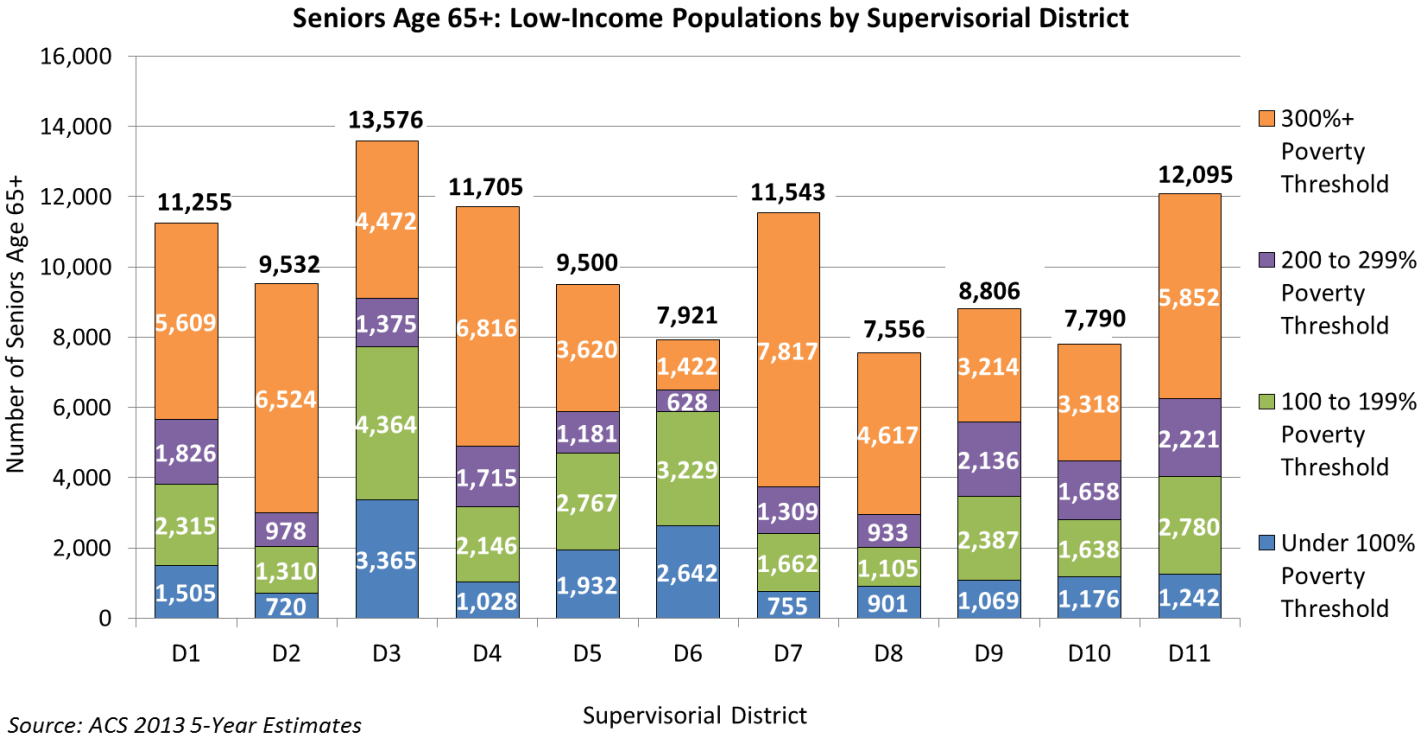
Source: ACS 2013 5-Year Estimates

highlights important nuances in the low-income population throughout the city. As shown below, the geographic distribution of seniors with slightly higher income – between 100% and 199% FPL – is similar to the lowest income group. However, different trends emerge in the seniors with income between 200% and 299% FPL. Approximately 14% of this "upper poor" population lives in District 11, which includes the Excelsior, Ingleside, and OMI neighborhoods, and 13% live in District 9, which includes the Mission and Bernal Heights.



Source: ACS 2013 5-Year Estimates

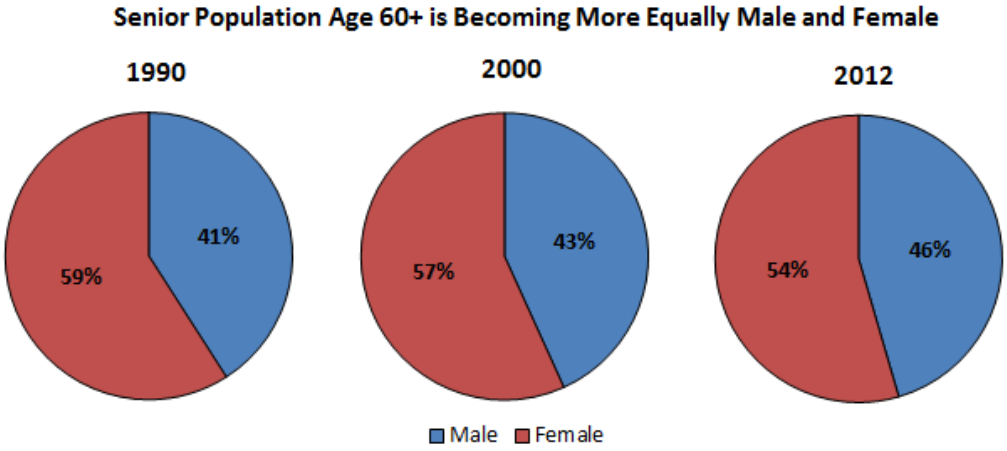
It can also be useful to consider poverty rates within each district. The chart below depicts the total senior population age 65 and older by income level within each supervisorial district, further illustrating that poverty rates vary significantly around the city. For example, 82% of District 6 seniors – 6,499 older persons – have income below 300% FPL. Services placed in this district have a strong likelihood of reaching those with significant financial need. *Please see Appendix C for data in table format with calculated poverty percentages.*



Source: ACS 2013 5-Year Estimates

Seniors: Gender

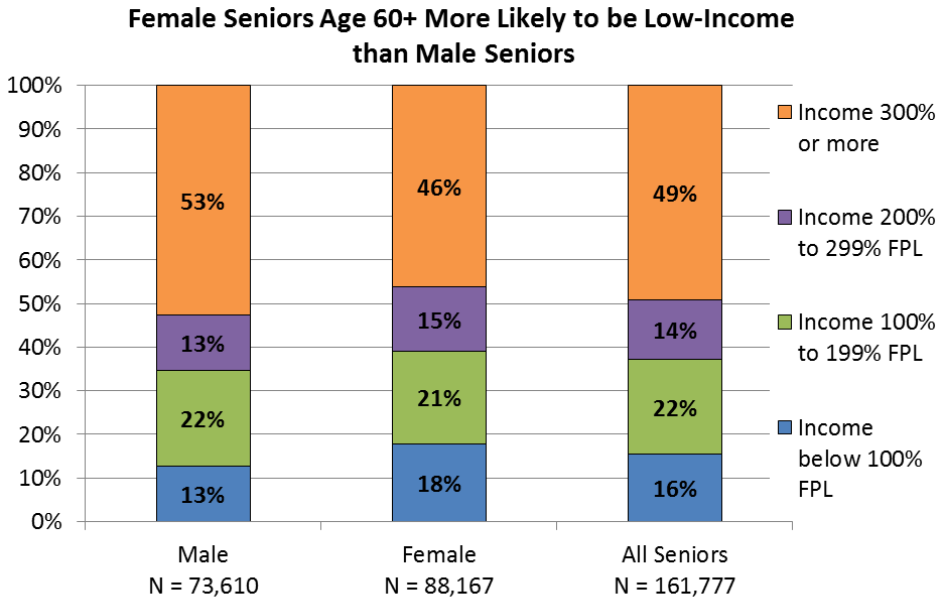
Because women tend to live longer than men, senior populations have historically been predominantly female. While this trend persists in San Francisco, it appears to be shifting. In 1990, almost 60% of seniors age 60 and older were female. By 2012, the percentage decreased to 54%. This change is consistent with state and national trends. Review of gender by ethnic group suggests that this local change is driven by the white and African-American senior populations shifting from 60% female in 1990 down to 51%. The Asian-Pacific Islander (API) and Latino senior populations remain consistently and predominantly female (57% and 58%, respectively).



Source: IPUMS 1990 5% sample, 2000 5% sample, 2012 3-year sample

Older women are more likely to be living in deep poverty than men. Approximately 63% of seniors with income below the federal poverty line are women. As shown in the chart below, 18% of women age 60 and older have income below 100% FPL compared to 13% of men.

This trend is likely due in large part to two key factors. Women are likely to have lower retirement income and savings due to interrupted work history related to childrearing and lower wage rates. Also, this analysis is based on family income levels and, as discussed in more depth later in this analysis, women tend to live longer than men and are more likely to live alone late in life than men.



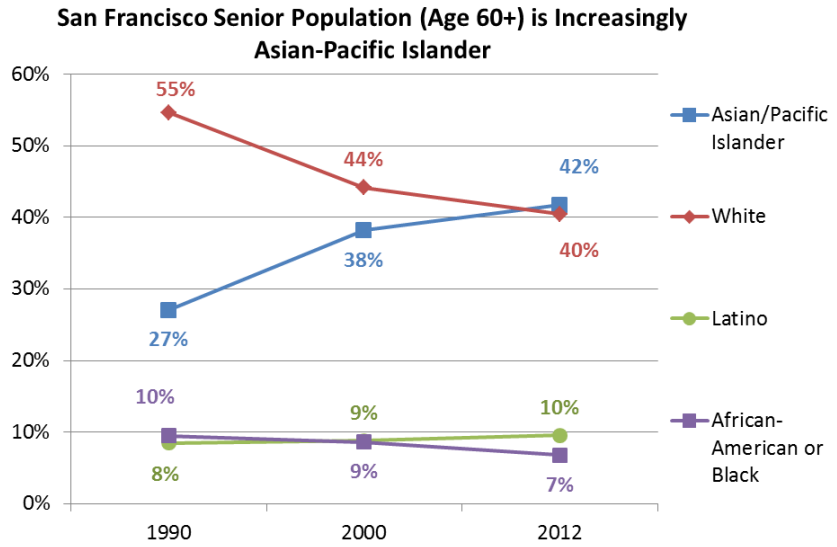
Source: IPUMS 2012 3-Year Samples

While this variation is important to recognize and understand, it should not obfuscate the fact that 47% of male seniors are also low-income.

Seniors: Race/Ethnicity

San Francisco seniors are primarily API (42% of the senior population) and white (40%). The majority of the 67,452 API seniors are Chinese (49,000) and Filipino (9,250). Latinos and African-Americans represent ten and seven percent of the senior population.

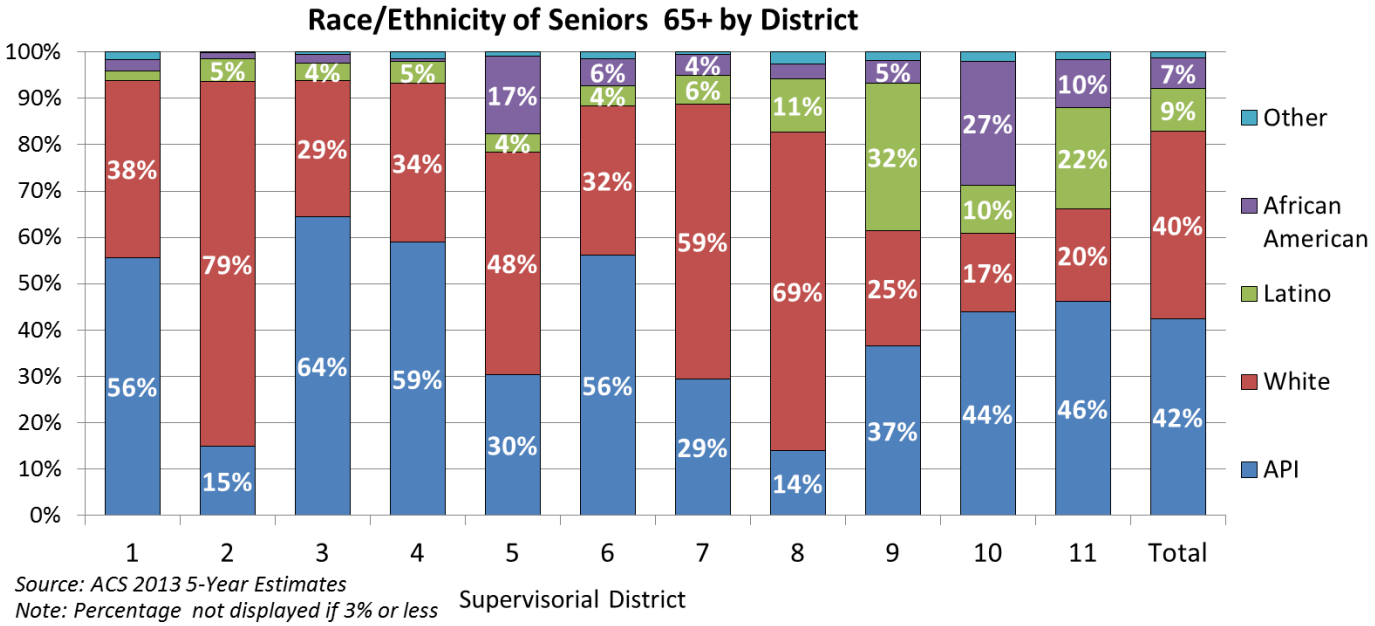
As shown to the right, the senior population has changed significantly since 1990, when the majority (55%) was white. During this time, the local African-American population has declined, while Latinos have increased slightly, mirroring general citywide trends related to gentrification and immigration.



Source: IPUMS 1990 5% sample, 2000 5% sample, 2012 3-year sample

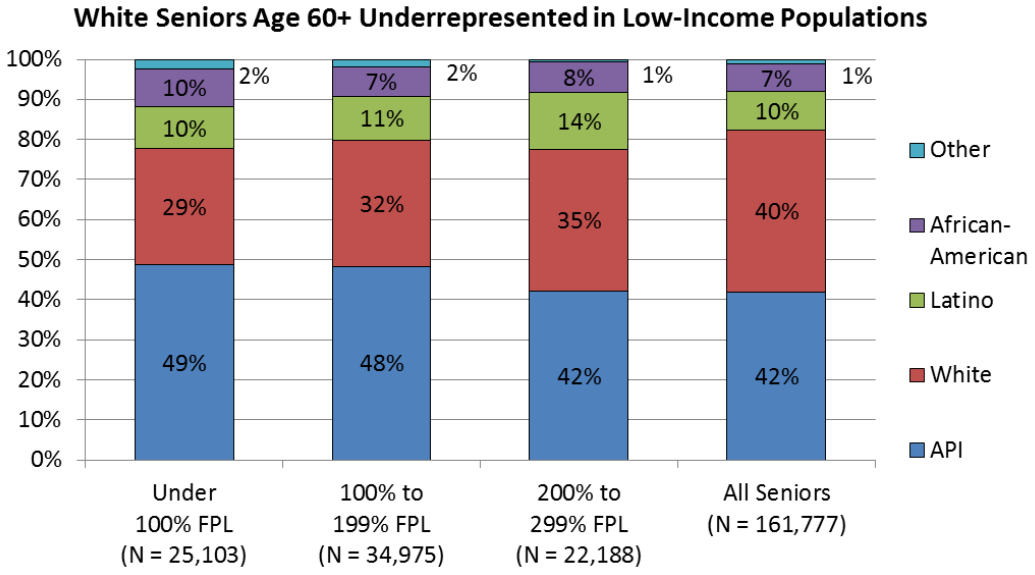
A review of senior populations by supervisorial district indicates significant variation and unique populations by district, suggesting potential targeting strategies by race and ethnicity:

- API seniors are the majority of older persons in District 1 (Richmond), District 3 (Chinatown, Nob Hill), District 4 (Outer Sunset, Parkside), and District 6 (SOMA, Civic Center).
- Latino seniors are a significant proportion of older persons in District 8 (Castro, Mission), District 9 (Mission, Bernal Heights), District 10 (Visitation Valley, Bayview), and District 11 (Excelsior, Outer Mission).
- African-American seniors represent larger portions of the population in District 5 (Western Addition) and District 10 (particularly in the Bayview area).



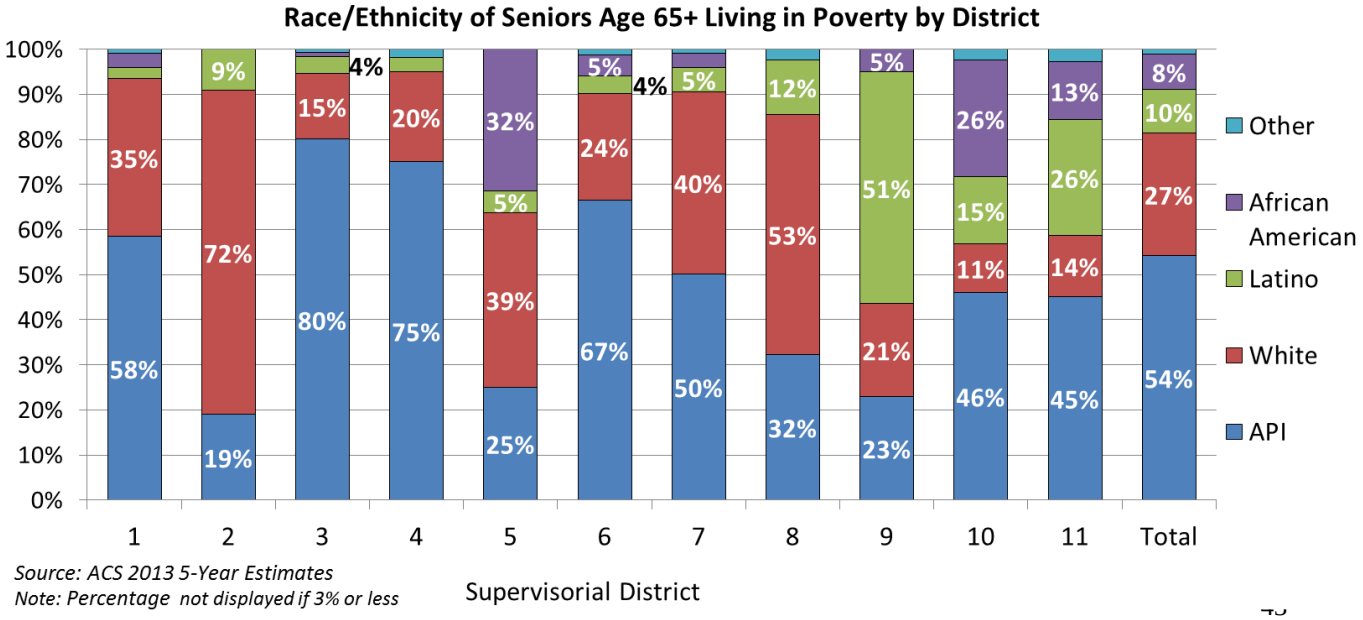
Source: ACS 2013 5-Year Estimates
Note: Percentage not displayed if 3% or less

Ethnicity trends among low-income seniors generally tend to mirror the general senior population but with an important distinction: minorities are overrepresented among low-income seniors. As shown below, whites represent 40% of the overall senior population but smaller portions of the low income groups. Although whites represent 40% of seniors, they are only 29% of the lowest-income seniors. API seniors are overrepresented in this income group: 49% compared to 42% of the general senior population. Similarly, African-American seniors are overrepresented in the lowest income group: ten percent compared to seven percent of the overall senior population. Latinos are slightly overrepresented among seniors with family income between 200% to 299% FPL.



Source: IPUMS 2012 3-Year Samples

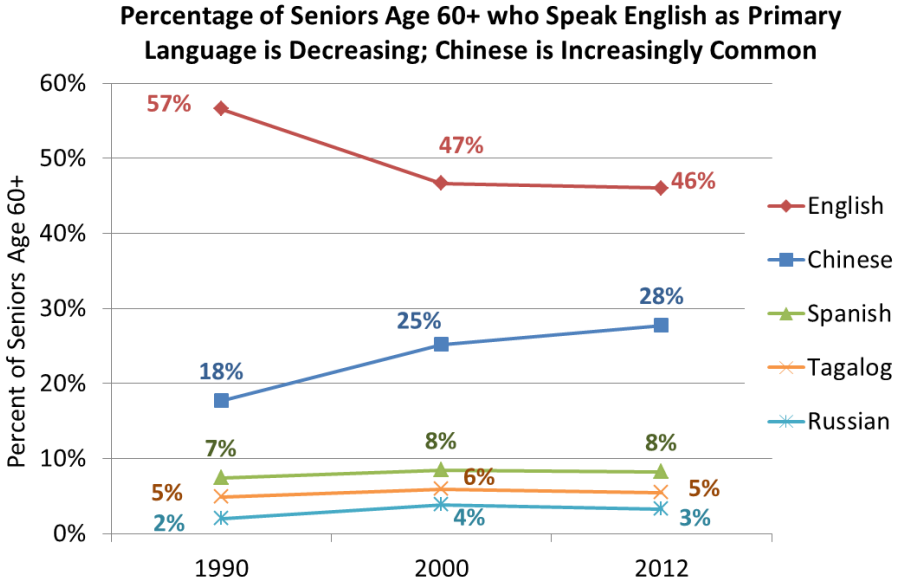
The chart below shows the ethnic profile of seniors with income below 100% FPL by district. In reviewing this data, it is useful to keep in mind that the size of the low-income senior population varies by district. *Please see Appendix C for population data by district.*



Source: ACS 2013 5-Year Estimates
Note: Percentage not displayed if 3% or less

Seniors: Language & English Fluency

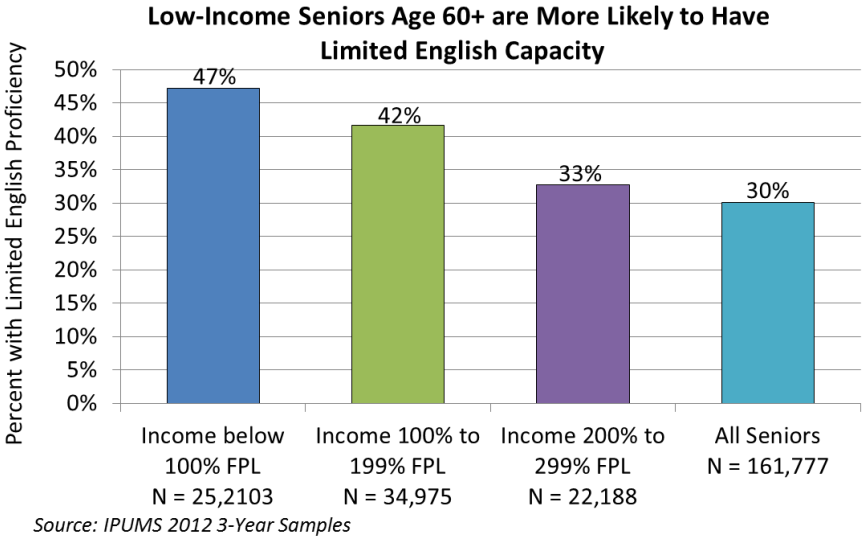
Fifty-four percent of San Franciscans over the age of 60 speak a primary language other than English, up from the 1990 rate of 43%. In particular, as the API population has increased over the last two decades, so has the percentage of Chinese-speaking seniors. Russian-speaking seniors have also increased. This group may have preferences and needs that differ from the white seniors who were born U.S. citizens.



Source: IPUMS 1990 5% sample, 2000 5% sample, 2012 3-year sample

Approximately 30% of San Francisco seniors speak English "not well" or "not at all." By comparison, only eight percent of the non-senior population in San Francisco has limited English proficiency. San Francisco is different than the rest of the state – statewide, only 15% of seniors have limited English proficiency. Of the 48,699 San Francisco seniors with limited English proficiency, the most common primary languages are Chinese (66%), Spanish (11%), Russian (7%), Tagalog (5%), and Vietnamese (3%).

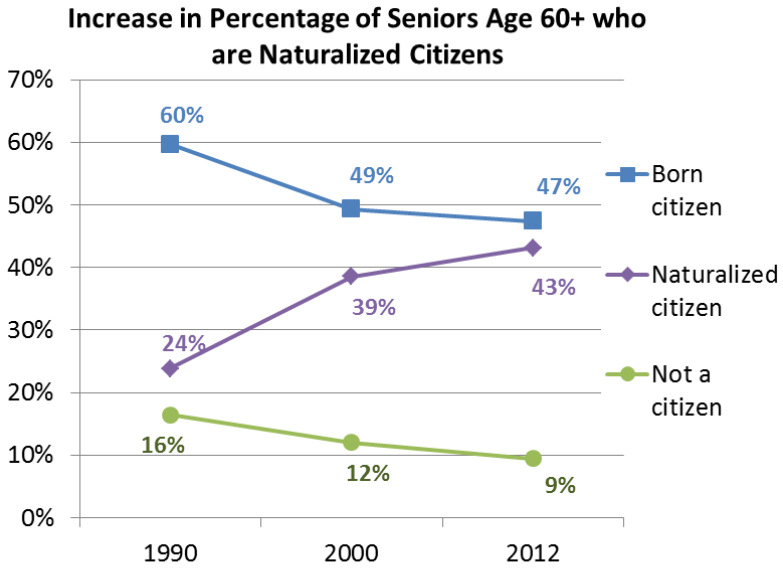
As shown below, low-income seniors are more likely to have limited English proficiency than the general senior population. The most common languages spoken by low-income seniors are Chinese, Spanish, and Russian – similar to the trends of the general senior population.



Source: IPUMS 2012 3-Year Samples

Seniors: Citizenship

Over the last two decades, San Francisco seniors have become a predominantly immigrant population. In 1990, the majority of seniors were U.S. born citizens, but today over half of the local senior population (53%) are immigrants. Most commonly, they are naturalized citizens from China. Local trends contrast with the statewide pattern: 32% of California seniors are immigrants.



Source: IPUMS 1990 5% sample, 2000 5% sample, 2012 3-year sample
Note: Percentages may not add up to 100% due to rounding

Notably, there has been a shift within the foreign-born senior population towards naturalization. In 1990, 84% were citizens; by 2012, 91%. Since citizens are eligible for federal benefits, this trend is significant. However, there are still 15,315 immigrant seniors (9%) who are not naturalized and may be unable to access key benefits, such as SSI and Medi-Cal. Most of these seniors are API (in particular, Chinese) and Latino.

Immigrant seniors are more likely to be low-income. In particular, those who are not naturalized are most likely to have low income levels; two-thirds have family income below 300% FPL. This may be due in part to the impact that immigration can have on work ability and history. For example, immigration regulations can restrict eligibility for work and language barriers may reduce employment opportunities. Moreover, immigrants may arrive with education deficits that limit employment opportunities or may be unable to work in their career field without completing additional education or obtaining certain certifications in the United States.

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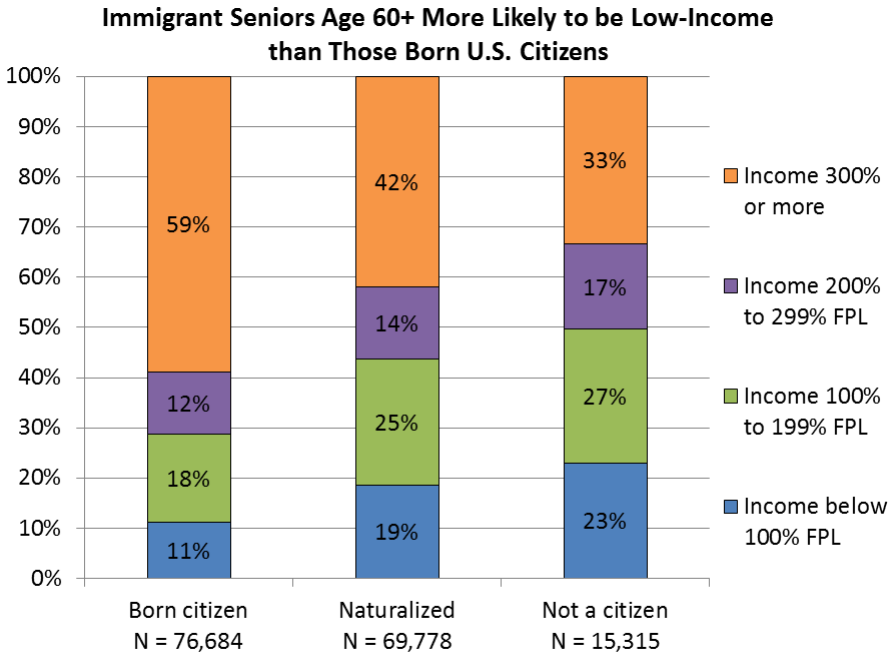
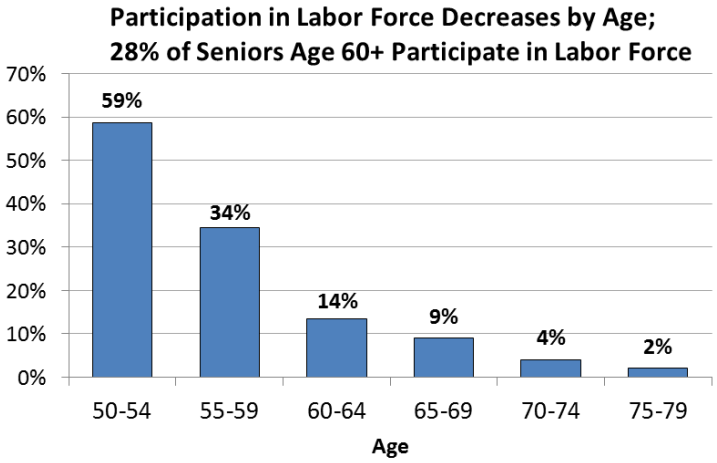


Source: IPUMS 2012 3-Year Samples

Seniors: Employment

Approximately 45,832 or 29% of San Francisco seniors age 60 and older are in the labor force. Most (41,919) are employed. They tend to be younger – most (85%) are below age 70.

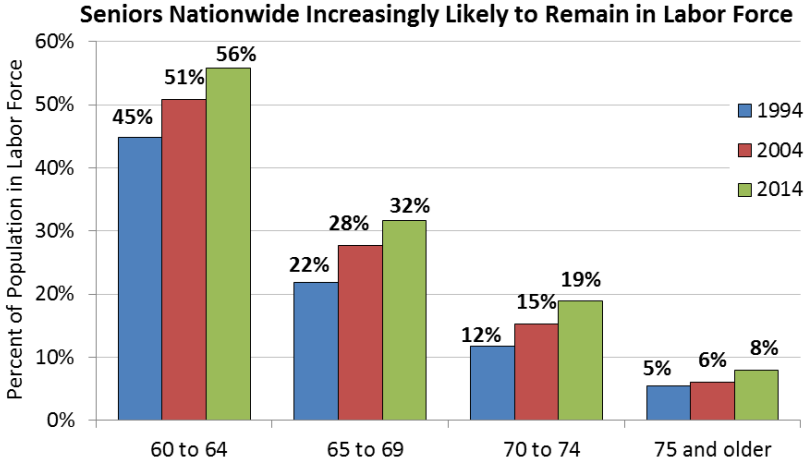
As shown to the right, labor force participation rate decreases by age. Over half of the youngest seniors age 60 to 64 are in the workforce compared to less than ten percent of adults over age 75. San Francisco seniors in the labor force tend to be white (48%) and API (37%), reflective of the senior population demographics.



Source: IPUMS 2012 3-Year Samples

Nationwide, seniors today are more likely to remain active in the labor force than prior generations: 19% of seniors age 65 and older participated in the labor force in 2014 compared to 14% in 2004.[7] As shown below, this trend is consistent across age groups.

Many factors contribute to this trend. The age threshold for Social Security retirement benefits has increased from age 65 to 66 for those born after 1943, keeping many in the workforce for an additional year. Research also suggests older adults today tend to experience fewer years of disabling conditions (Cutler et al, 2013); the higher rate of workforce participation may be due in part to better health of younger seniors today.



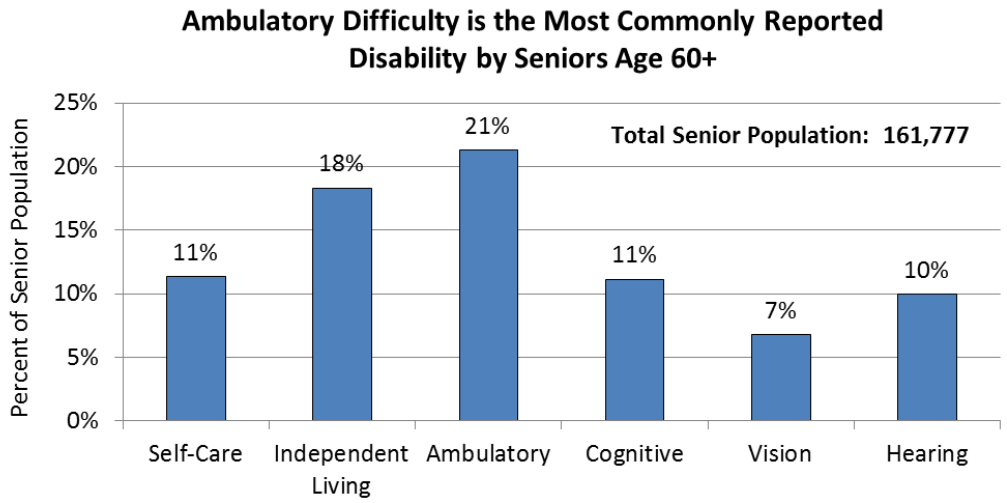
Source: Employment Projections program, U.S. Bureau of Labor Statistics, December 2015

In San Francisco, the increasingly high cost of living requires many older adults to work in order to ends meet. Remaining in the workforce can help supplement monthly income, maximize future pension benefits, or augment savings prior to retirement. Approximately 19% of seniors in the labor force have family income below 200% of the poverty threshold (as a reference, the 2014 poverty threshold for a single senior was $11,254). Notably, 31% of seniors in the labor force are API immigrants; it may be that these individuals have fewer prior years of earnings due to immigration status and must work due to low (or nonexistent) pensions.

[7] Census questions regarding employment changed in 2008 to improve consistency with other surveys, preventing analysis of local employment trends over time. Because the U.S. Census and Bureau of Labor Statistics use different methodologies, the analysis should not be directly compared but provides a broad estimate of how local and national trends compare.

Seniors: Disability

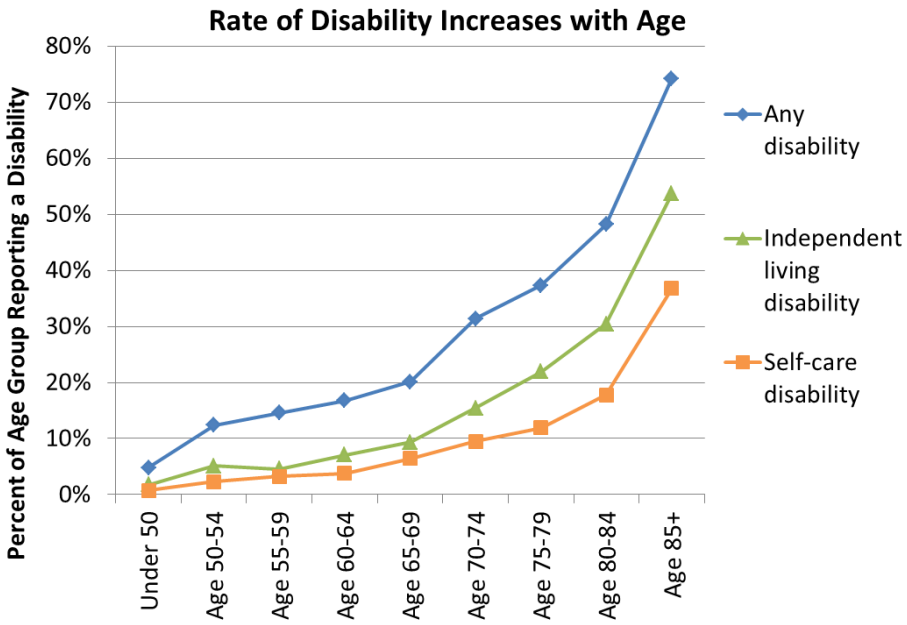
According to the census, 51,791 older persons – 32% of those age 60 and older – report at least one type of disability.[8] Ambulatory difficulty (e.g., difficulty walking or climbing stairs) is the most commonly reported. An estimated 34,445 – 21% of all seniors – report this type of disability.



Source: IPUMS 2012 3-Year Samples

Independent living disabilities, defined as difficulty doing errands alone due to a physical, mental or emotional problem, are also relatively common (18% of seniors). About 18,000 or 11% of seniors report difficulty with self-care, described as difficulty bathing or dressing in the census questionnaire. Similarly, 18,014 seniors – 11% – report a cognitive disability, broadly defined as difficulty remembering, concentrating, or making decisions.

As shown to the right, disability rates increase significantly with age. Among persons age 60 to 64, 20% report a disability; among persons age 85 and older, 74%. Rates of self-care and independent-living difficulty – intended to capture difficulty with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) – follow similar trends.

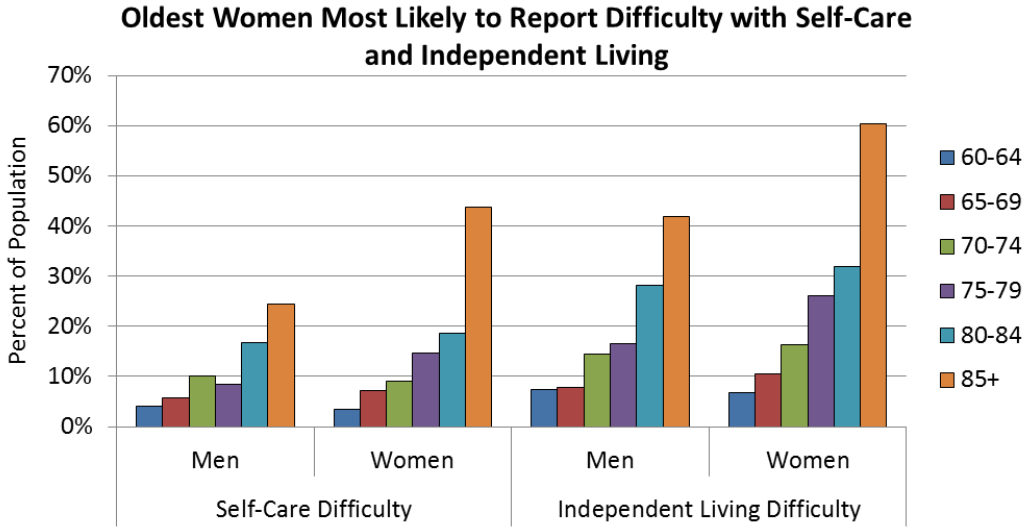


Source: IPUMS 2012 3-Year Samples

[8] This analysis includes seniors living in institutional settings (approximately 3,306 or two percent of seniors). The population trends described here are consistent when this small subgroup is removed.

Research indicates that higher prevalence of disability among certain groups of elders. A review of census data indicates that these trends are consistent in San Francisco:

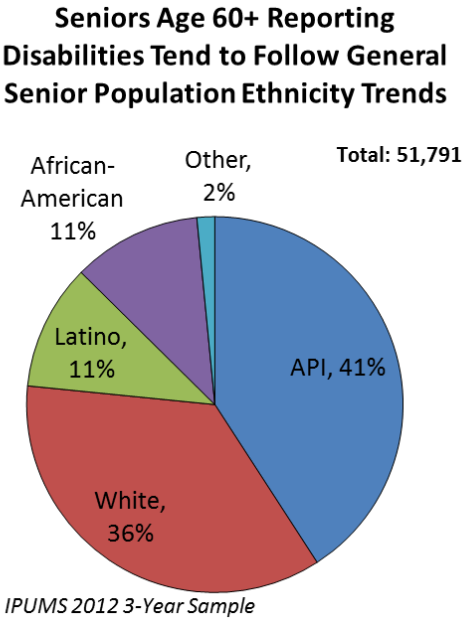
- **Gender**: Although women tend to have higher life expectancy than men, they are also more likely to experience disability in their old age compared to men of the same age. Research suggests this disparity is not due to bias in reporting but instead likely the result of higher rates of comorbidity and chronic health problems (Newman & Brach, 2001) and nonfatal disabling conditions in women than men (Murtagh, & Hubert, 2014) . As shown below, this gender disparity becomes especially apparent as San Francisco seniors reach old age. For example, 60% of female seniors age 85 and older report independent living difficulty compared to 42 % of men. Making this disparity especially concerning is the fact that women are more likely to live alone in their old age, whereas older men with disabilities are more likely to be cared for by a spouse (Newman & Brach, 2001).



Source: IPUMS 2012 3-Year Samples

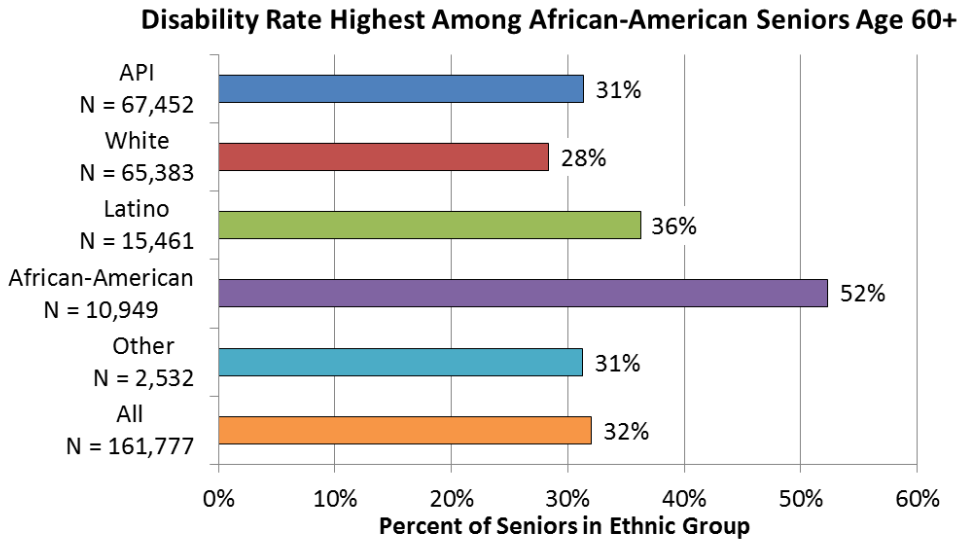
- **Ethnicity**: Racial and ethnic disparities in health status have a profound impact on health and disability in late life. While research suggests that disability rates decreased between 1982 and 2002, racial and ethnic disparities largely persist (Schoeni et al, 2005).

  In San Francisco, most older persons who report disabilities are API and white, mirroring the overall senior population profile. However, African-Americans are overrepresented in this group – eleven percent of seniors reporting disabilities compared to seven percent of seniors overall. A review of disability rates by ethnicity indicates a significantly



Source: IPUMS 2012 3-Year Sample

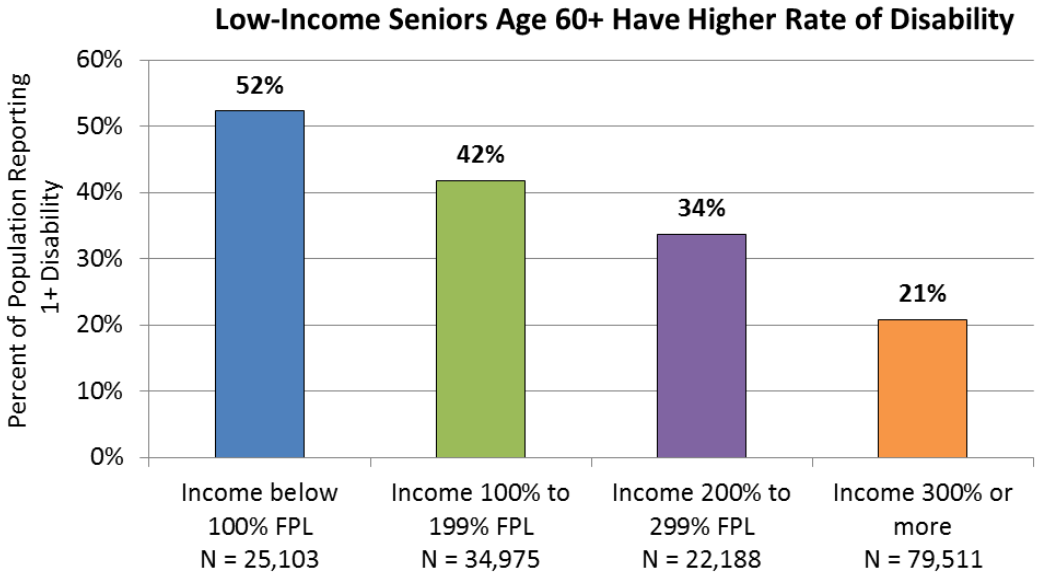
higher prevalence of disability is higher among African-American seniors. Over half of African-American seniors report at least one disability compared to one-third of all seniors.



Source: IPUMS 2012 3-Year Samples

Overall, these disabled seniors tend to report similar prevalence of the specific types of disabilities.

- **Income**: Disability rates are also linked closely with income. Lower income persons face environmental hazards, greater barriers to healthcare, poorer health status, and have higher rates of disability (Schoeni et al, 2005). Concomitantly, adults with disabilities are more likely to be unemployed, underemployed, or restricted to lower-wage positions, which reduces their retirement income late in life. While 51% of the general senior population in San Francisco has income below 300% FPL, the rate of the disabled senior population is 68%. The chart below further highlights the disparity in disability prevalence by income level of seniors age 60 and older in San Francisco.

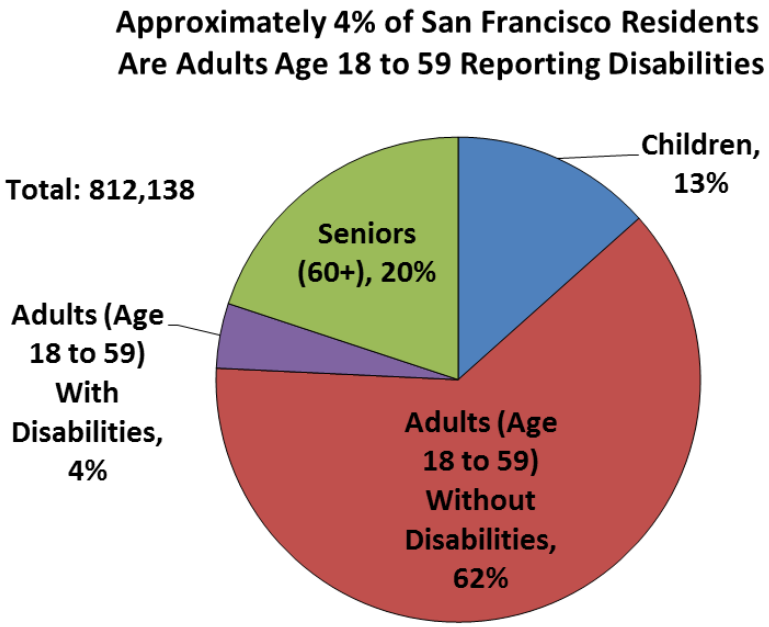


Source: IPUMS 2012 3-Year Samples

San Francisco Younger Adults with Disabilities

Adults with Disabilities: Population Size

Six percent of adults age 18 to 59 – 35,145 individuals – report at least one disability in the census. As shown below, these adults represent approximately four percent of the overall San Francisco population.



Source: IPUMS 2012 3-Year Samples

Almost 12% or 4,043 of adults reporting disabilities live in facilities. Of this subgroup, 30% are in institutional settings, described in the census as places that provide formally authorized, supervised care or custody, such as skilled nursing facilities, correctional facilities, and psychiatric hospitals. The 70% of this small subgroup – 2,819 individuals – are in non-institutional facilities, such as residential homes. Except where otherwise noted, this analysis is focused on all adults reporting disabilities regardless of community or group setting. Please refer to the Methodology section of this report for additional information on these distinctions.

Adults with Disabilities: Income & Poverty

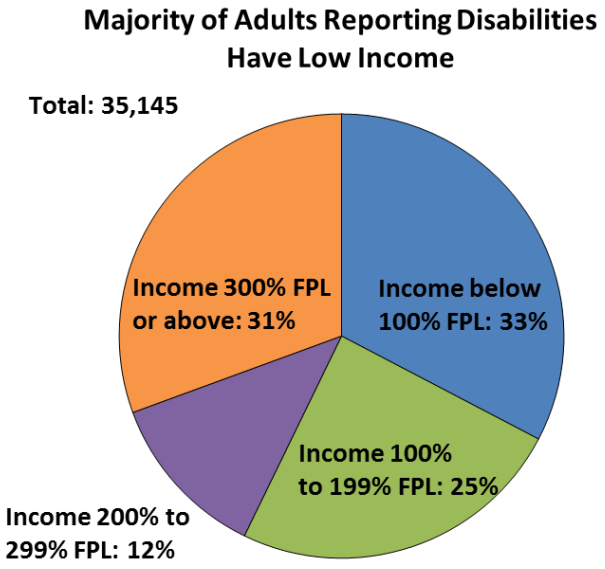
Please refer to the Methodology section of this report for more information about the low-income thresholds used in this analysis.

As shown in the chart below, adults with disabilities age 18 to 59 are very likely to have low incomes. One-third of the population or 11,482 individuals have income below the federal poverty line. As a reference, 100% FPL for a single individual was $11,770 in 2015. Sixty-nine percent of adults with disabilities – 624,393 individuals – have income below 300% FPL.

The disabled adult population in facilities is almost entirely low-income. Seventy-five percent of this group has income below 100% FPL. In fact, it may be this low-income status that makes these adults eligible for residence in these facilities (e.g., Medi-Cal funded assisted living).

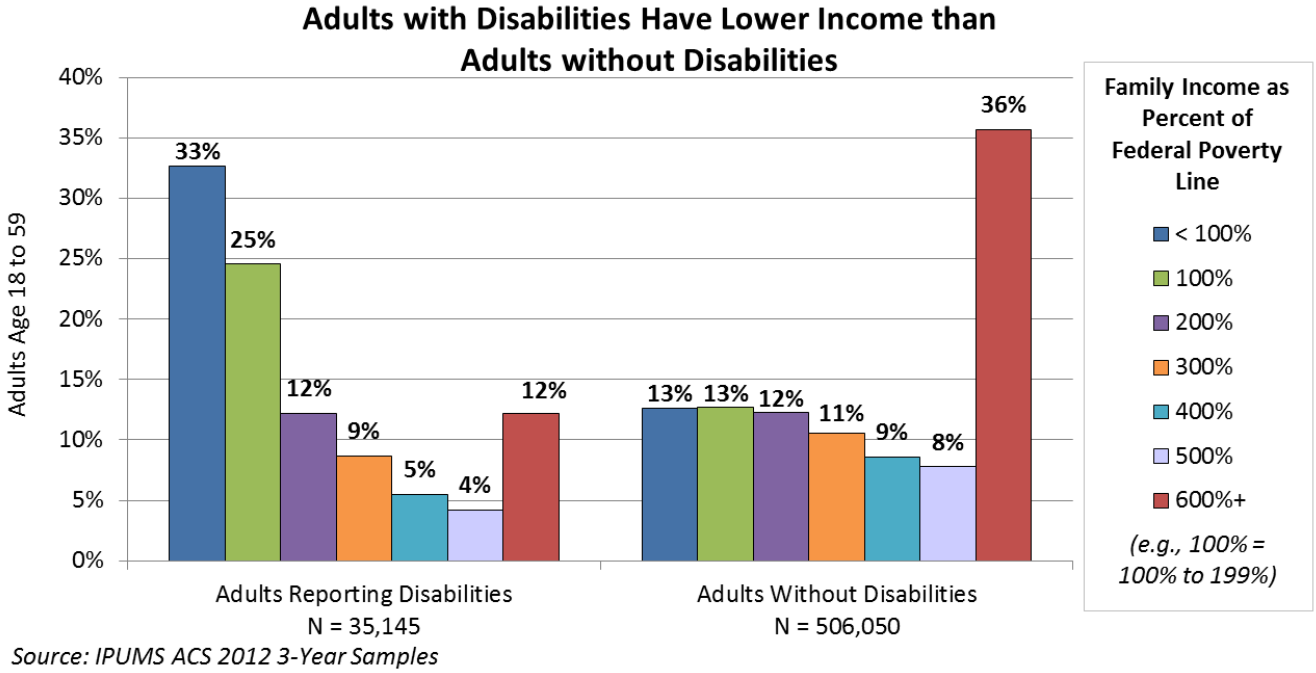
Most of the 31,102 adults with disabilities living in the community are low-income:

- 24% have income below 100% FPL;
- 22% have income between 100% and 199% FPL; and
- 12% have income between 200% and 299% FPL.



Source: IPUMS 2012 3-Year Samples

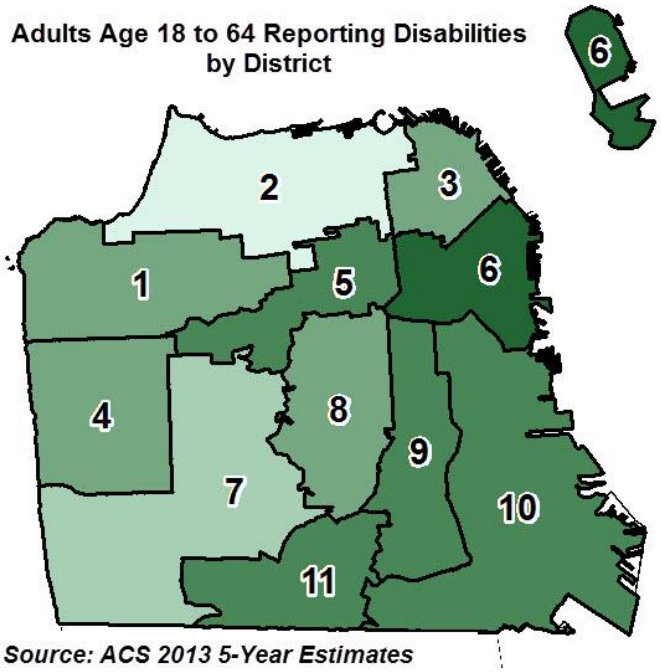
Adults reporting disabilities are more likely to be low-income than those without disabilities. Only 13% of the non-disabled population has income below 100% FPL compared to 35% of adults with disabilities. Approximately 64% of non-disabled adults have income over 300% FPL in comparison to 31% of the disabled adult population.



Source: IPUMS ACS 2012 3-Year Samples

Adults with Disabilities: Location

Location and poverty data is only available with for adults with disabilities with the age threshold 18 to 64 and at the poverty threshold level. Please see Appendix B for a map of supervisorial districts and neighborhoods and Appendix D for complete information on adults with disabilities by supervisorial district.

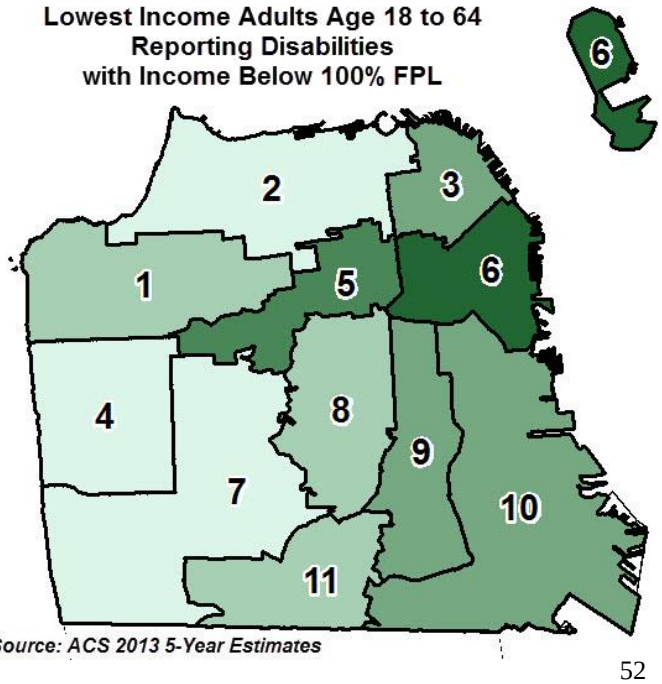


Source: ACS 2013 5-Year Estimates

Adults age 18 to 64 live throughout the city. However, adults with disabilities are concentrated in certain neighborhoods. In particular, District 6 (Tenderloin, SOMA) is home to approximately 17% of adults reporting disabilities. Other areas with large portions of this population include District 5 (Western Addition, Haight), District 10 (Bayview, Visitacion Valley), and District 11 (Excelsior, Ingelside). Each of these districts is home to 11% of the city's adults with disabilities.

These trends likely reflect larger city-wide trends related to income and affordability. These districts tend to have more low-income persons, and persons with disabilities are more likely to be low-income. By comparison, District 2, which includes the wealthier Pacific Heights and the Marina neighborhoods, has only four percent of the city's adults with disabilities.

These trends are exaggerated when focusing on the lowest-income adults reporting disabilities (those with income below 100% FPL). As shown in the map below, this population tends to live on the eastern side of the city. In particular, 29% of this group lives in District 6. This trend makes sense given the array of inexpensive housing options (including both government subsidized and historically low-cost Single Room Occupancy hotels), prevalence of social services (e.g., congregate meal sites), and proximity to public transportation options.

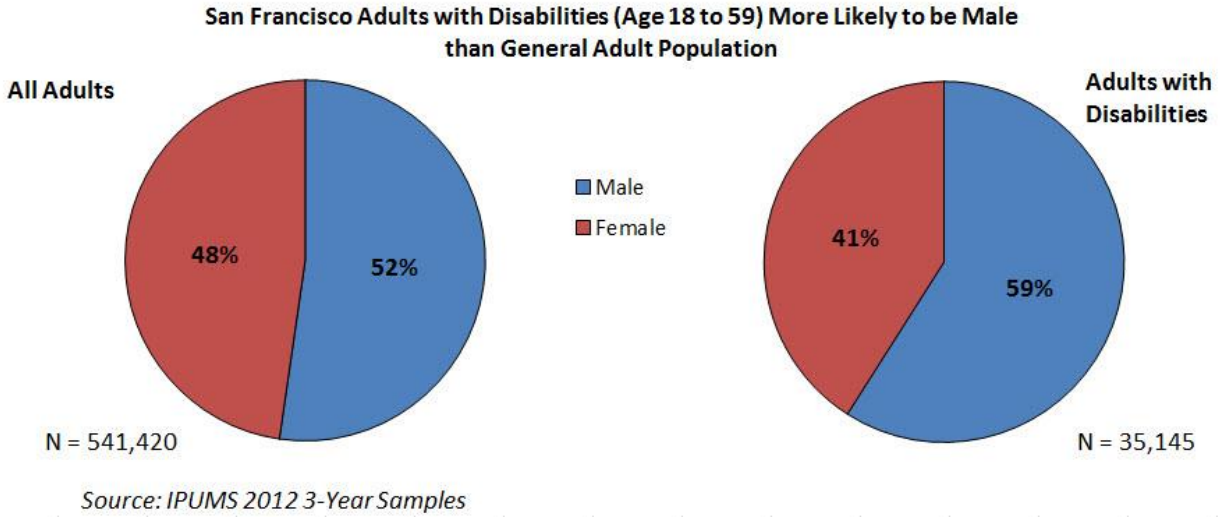


Source: ACS 2013 5-Year Estimates

The lowest income persons with disabilities also tend to live in District 5. Fourteen percent – approximately 1,749 individuals – live in this area in the middle of the city. Most (approximately 1,000) are in the Western Addition neighborhood.

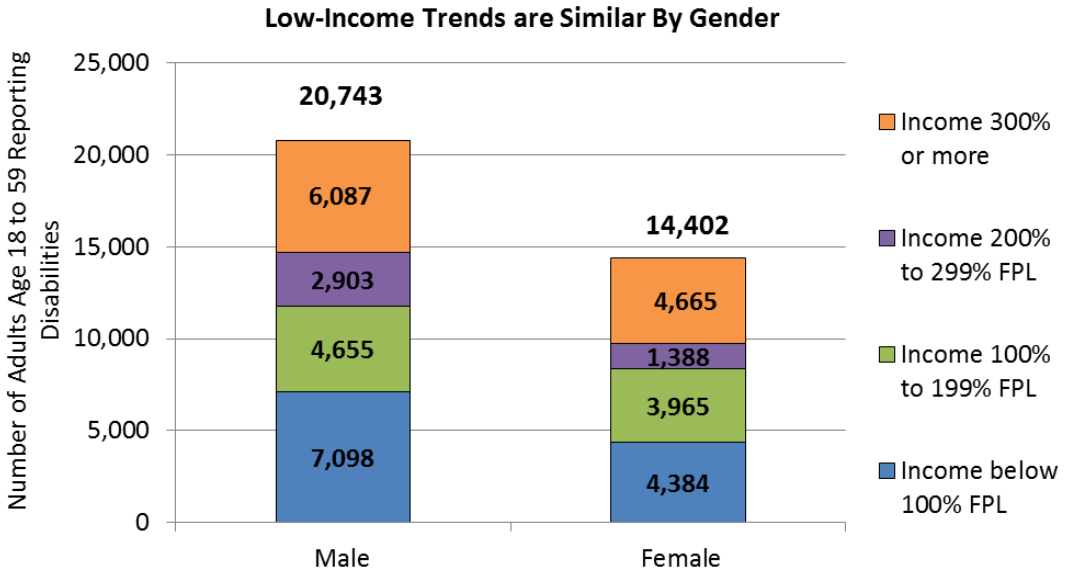
Adults with Disabilities: Gender

Adults age 18 to 59 reporting disabilities are predominantly male (59%), compared to a division of 48% female and 52% male in the overall adult population. This disproportion of males is consistent among disabled persons in the community and those in facilities. However, white and Latino adults reporting disabilities are more likely to be male: 66% and 60%. Comparatively, the genders are more equally represented among African-American and API adults reporting disabilities: 51% and 53% are male.



Source: IPUMS 2012 3-Year Samples

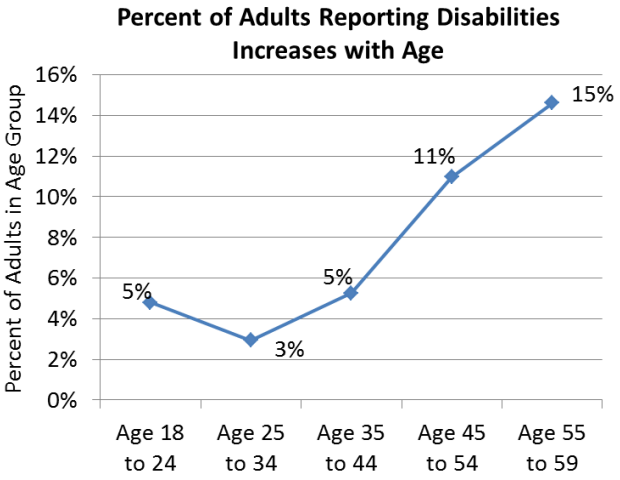
As shown below, poverty among disabled persons is high for both men and women. Thirty-four percent of men with disabilities – 7,098 individuals – live in destitution with incomes below 100% FPL. Among women, this figure is closer to 30% – 4,384 individuals.



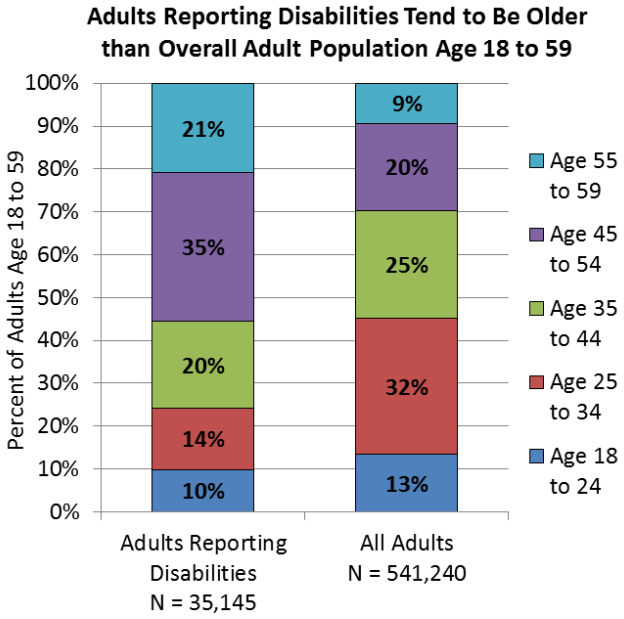
Source: IPUMS 2012 3-Year Samples

Adults with Disabilities: Age

As noted earlier regarding disability in the senior population, disability rates increase with age. This trend is evident in the chart below to the left. Approximately 15% of pre-senior adults between ages 55 to 59 report at least one disability; by comparison, disability rates among younger adults tend to be closer to five percent. This trend is independent of general adult population trends, such as an older population overall. As shown in the chart below to the right, older age groups are overrepresented among adults reporting disabilities.

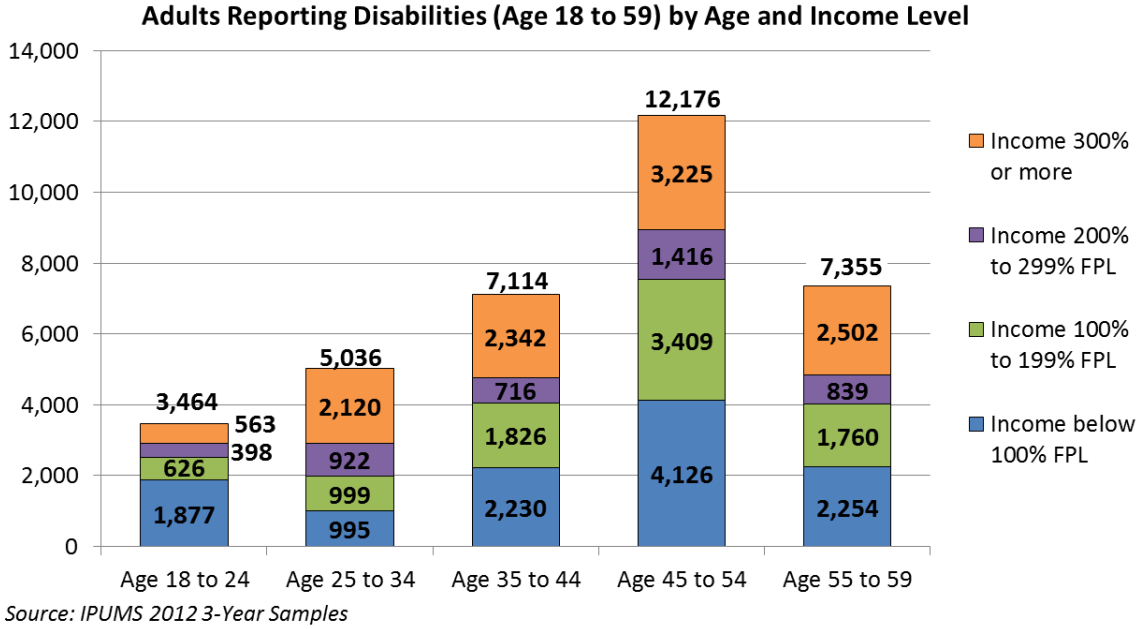


Source: IPUMS 2012 3-Year Samples



Source: IPUMS 2012 3-Year Samples

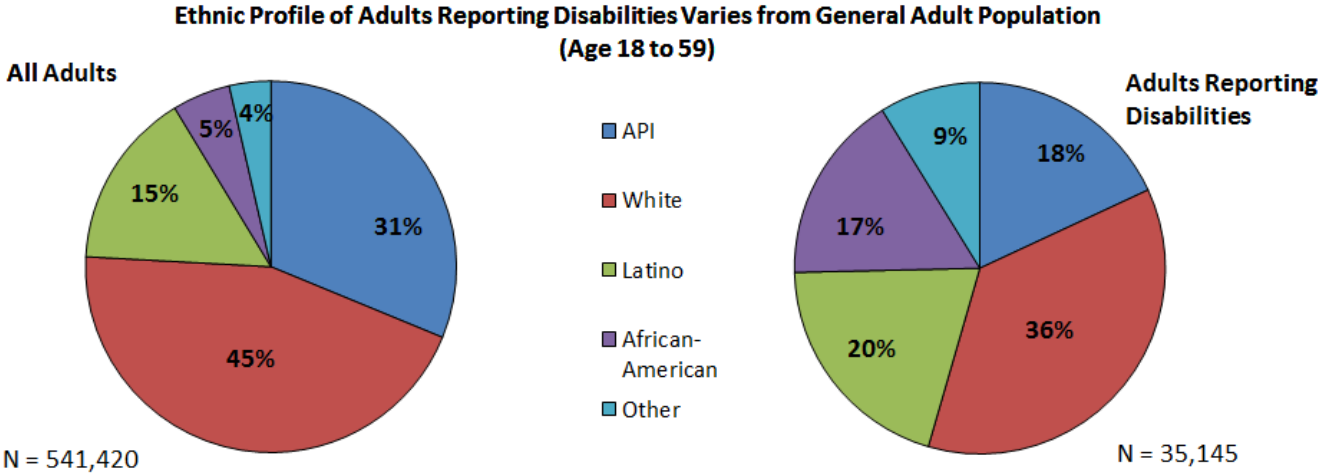
Across all age groups, the majority of the disabled adult population is low-income. Poverty rates are highest among the youngest adults reporting disabilities (those between age 18 and 24); over half of this age group has income below 100% FPL. This trend likely reflects variation in work experience; adults who develop disabilities later in life are more likely to have enough work history to qualify for employment-based disability benefits, which tend to be higher than the SSI benefits received by those without any significant income source.



Source: IPUMS 2012 3-Year Samples

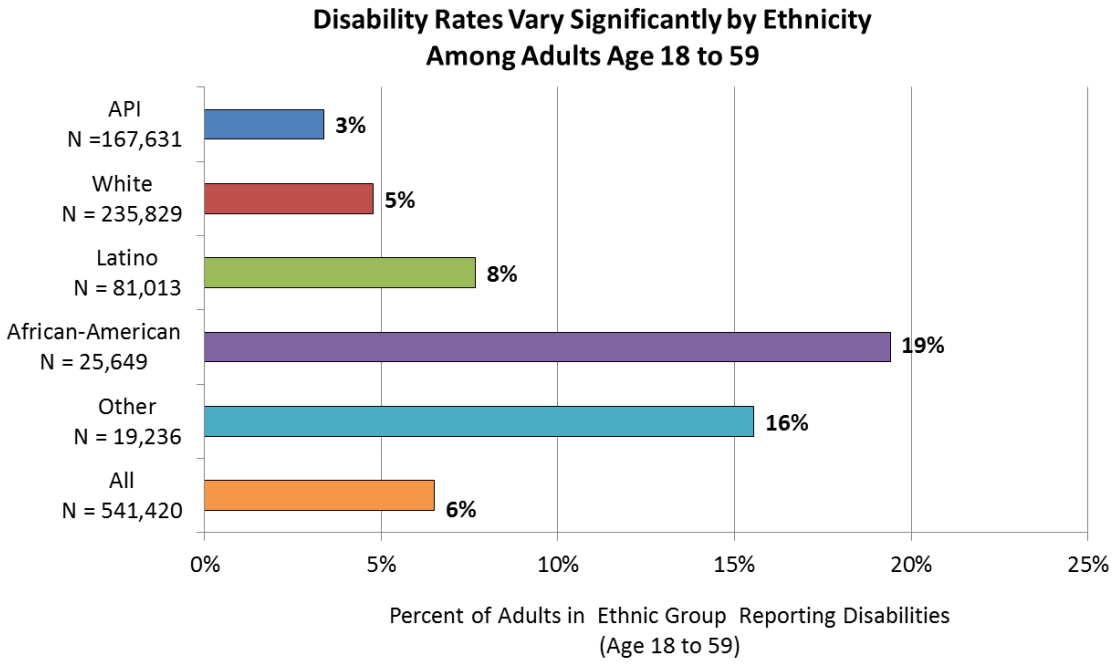
Adults with Disabilities: Race/Ethnicity

As discussed in the methodology section of this assessment, cultural factors in the API community likely limit the reporting of disabilities – and may impede service utilization. Based on the information that is available, it appears that adults reporting disabilities in the census are more likely to be Latino and African-American compared to the overall adult population. The disabled adult population is also more likely to be classified as an "other" ethnicity, defined in the census as those who identify with multiple ethnic groups or not report an ethnic identification.



Source: IPUMS 2012 3-Year Samples

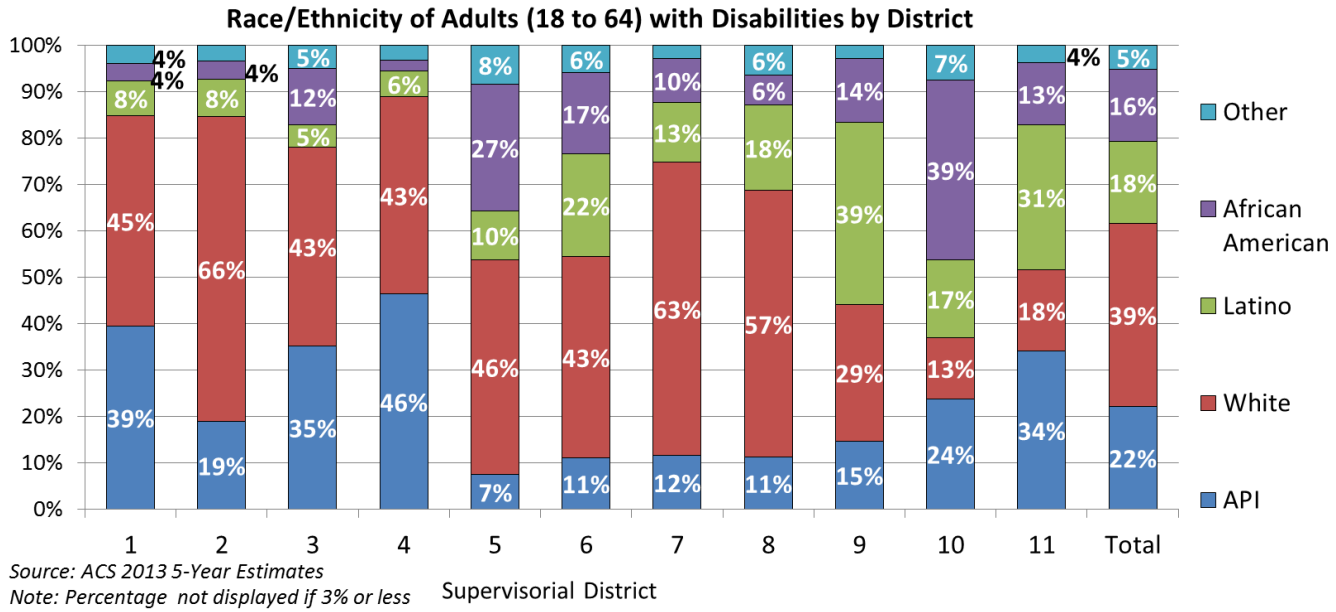
The chart below depicts the rates of disabilities by ethnicity. Similar to the senior population, the rate of disability within the African-American adult population is much higher than other major ethnic groups: 19%. By comparison, the disability rate within the full adult population is six percent.



Source: IPUMS 2012 3-Year Samples

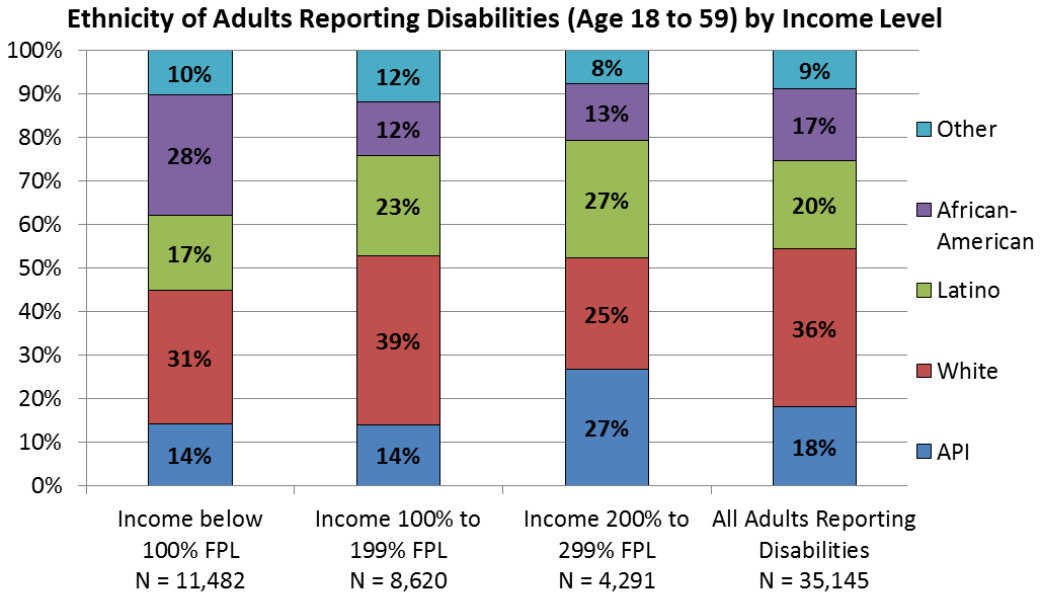
As noted earlier, location data for adults with disabilities is only available using the age range 18 to 64. While it is possible that the population distribution varies, the disabled adult population between ages 18 to 64 has a similar ethnic profile to the disabled adult population age 18 to 59.

As shown below, the ethnicity of disabled adult population varies by supervisorial district, which is important when devising outreach strategies and identifying the most culturally appropriate agencies to provide services in different parts of the city. For example, Latinos are the largest contingent of adults reporting disabilities in District 9, which includes the Mission neighborhood. District 4, which covers the Sunset/Parkside neighborhoods, is almost equally API and white. Total population size varies by district. *Please see Appendix D for complete information by district.*



Source: ACS 2013 5-Year Estimates
Note: Percentage not displayed if 3% or less

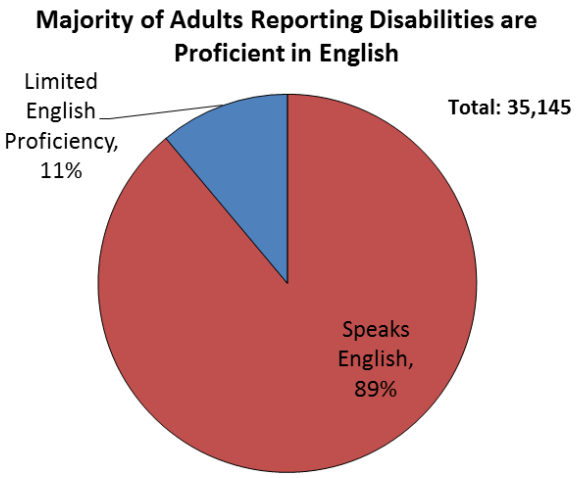
Adults with disabilities report varying levels of income. As depicted below, the lowest-income disabled adult population is almost equally likely to be white and African-American. Latinos and API adults are larger portions of those with slightly higher income.



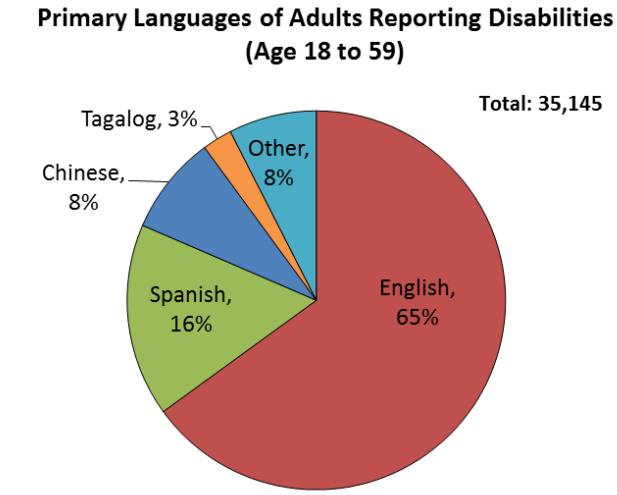
Source: IPUMS 2012 3-Year Samples

Adults with Disabilities: Language & English Fluency

Primary language and English fluency rates among adults reporting disabilities reflect the ethnic profile of the population. As shown below, the majority of adults aged 18 to 59 reporting disabilities speak English. Approximately 65% speak English as their primary language, and 89% total are English proficient. The most common other languages spoken by this population are Spanish (16%) and Chinese (8%).

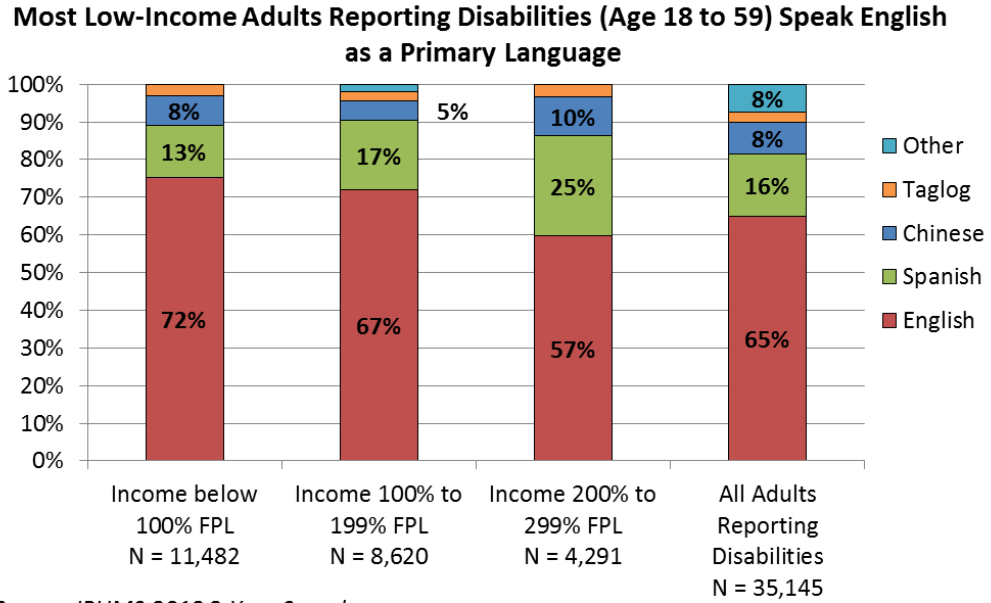


Source: IPUMS 2012 3-Year Samples



Source: IPUMS 2012 3-Year Samples

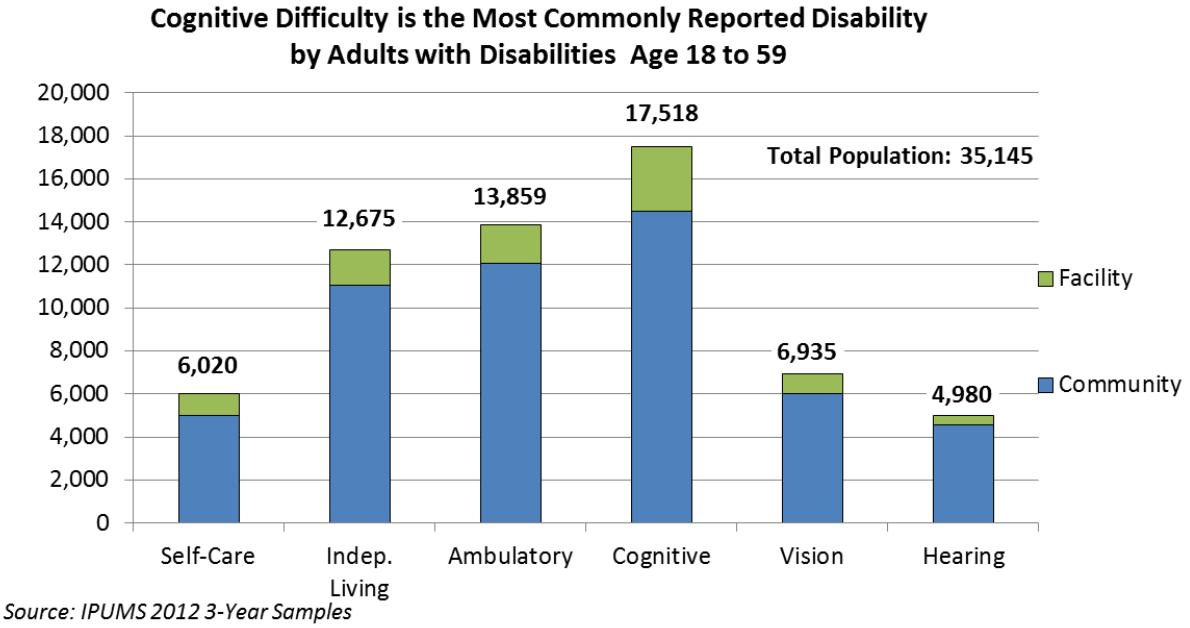
As shown below, these trends appear to be consistent among low-income adults with disabilities with English as the primary language for the majority of all low-income levels. The increase in the percentage that speaks Spanish and Chinese in the slightly higher income groups mirrors the ethnic trends discussed in the prior section. Overall, across these low-income groups, the English proficiency rate remains above 85%.



Source: IPUMS 2012 3-Year Samples
Note: Percentage not displayed if 3% or less

Adults with Disabilities: Type of Disability

As shown in the chart below, the most common type of disability reported by adults age 18 to 59 is cognitive difficulty. Approximately 17,518 or 50% of adults reporting disabilities indicate a cognitive difficulty. Described broadly in the census as "difficulty remembering, concentrating, or making decisions" due to a "physical, mental, or cognitive problem," this category may encapsulate a variety of conditions (e.g., mental health diagnosis, traumatic brain injury, etc). Ambulatory or physical difficulty – defined as serious difficulty walking or climbing stairs – is the second most common type of disability, reported by 13,859 individuals (39%).



Source: IPUMS 2012 3-Year Samples

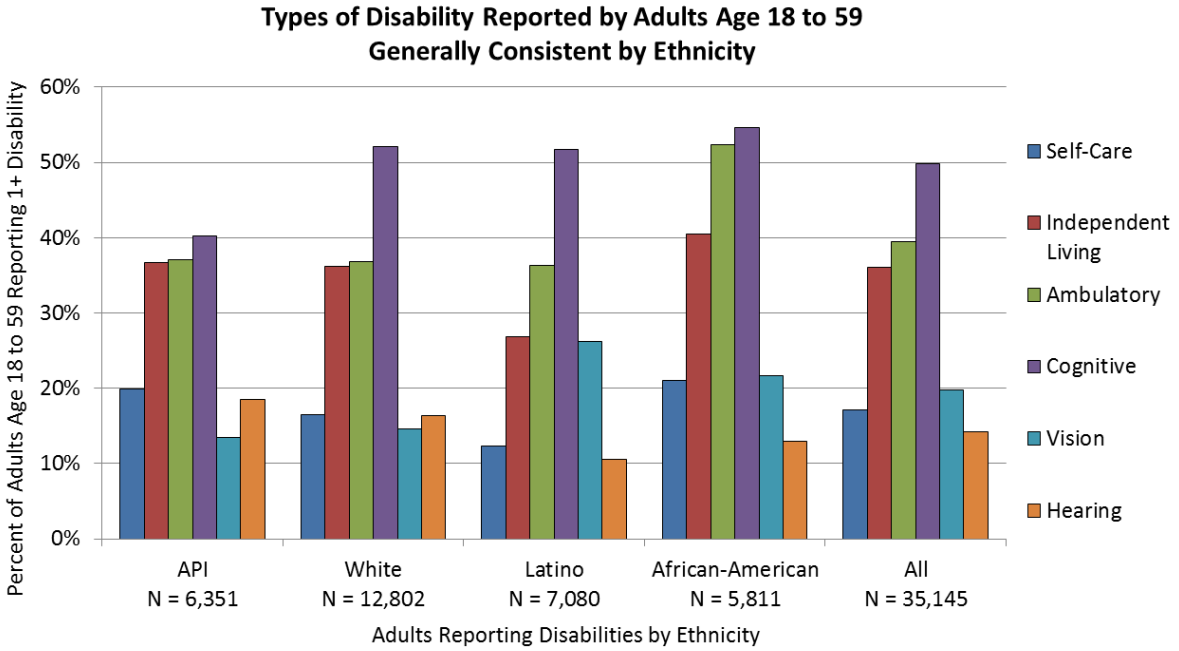
A review of the census questions intended to gauge impairment in Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) indicates that adults reporting disabilities are more likely to experience difficulty with IADLs.[9] Termed "independent living" and defined as having difficulty doing errands alone due to a physical, mental, or emotional problem, 12,675 or 36% of this population report difficulty with these tasks. Self-care difficulty or ADL difficulty, described as "difficulty dressing or bathing" in the census, is reported by 6,020 or 17% of adults reporting disabilities.

As is evident in the above chart, the general frequency of disability by type is consistent for those in the community and those in facilities. Approximately 74% of the 4,043 individuals living in facilities report cognitive difficulty. Given the broad definition of this difficulty in the census questionnaire, it is difficult to understand the exact nature of these disabilities.

The overall trends in frequency of disability type are also generally consistent across gender. Women reporting disabilities are slightly more likely to report independent living difficulty: 41% compared to 32% of men. The male disabled adult population reports slightly higher rates of difficulty with hearing: 16% compared to 11% of women.

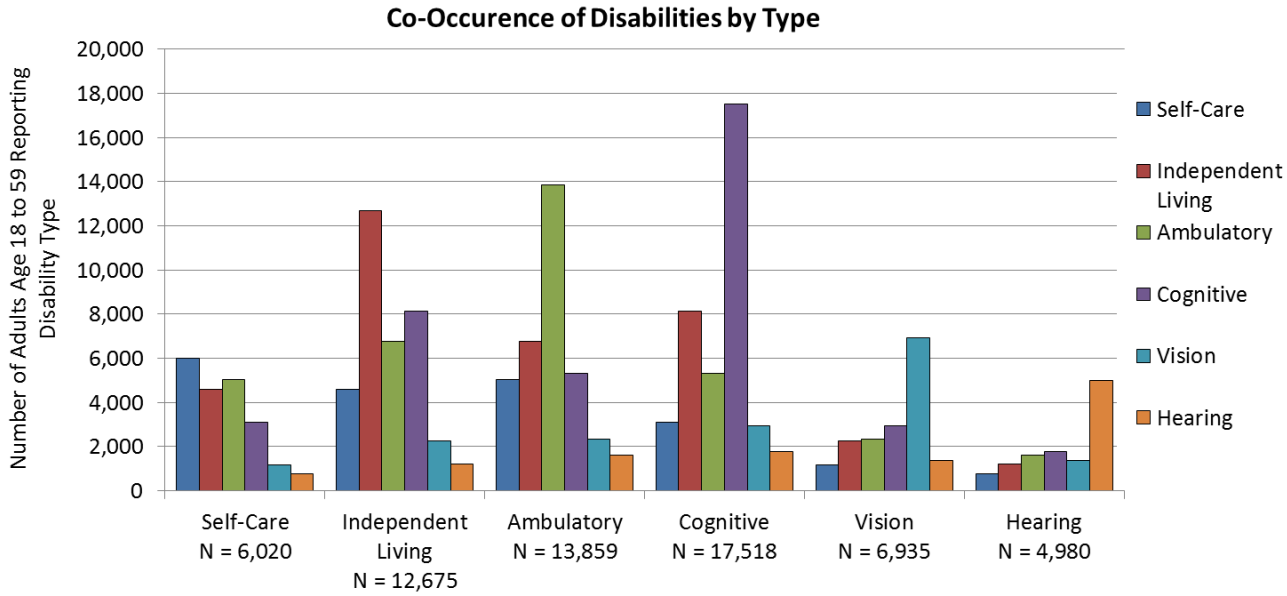
[9] Activities of Daily Living (ADLs) are basic self-care tasks, such as eating/feeding and bathing. Instrumental Activities of Daily Living (IADLs) are more complex skills needed to live independently, such as grocery shopping and managing medications.

As shown below, the general trends in disability type are similar across ethnicities. Cognitive difficulty is the most common disability type reported, followed by ambulatory and then independent living. However, there is some notable variation. For example, over half of African-American adults reporting disabilities indicate they experience ambulatory difficulty, which is a much higher rate of this particular disability than is reported by other major ethnic groups. There is a much lower rate of cognitive disability by API adults reporting disabilities: 40% compared to over 50% of other groups.



Source: IPUMS 2012 3-Year Samples

Another interesting way to consider types of disability is in the context of other reported disabilities. The chart below highlights the frequency with which disabilities are concurrently reported. For example, 12,675 adults report independent living and slightly more than 8,000 of this group also reports cognitive disability. While this data is self-reported and medical field could provide more clinical data, this type of analysis may be useful when considering the types of services and potential service linkages that may be useful for adults with disabilities.

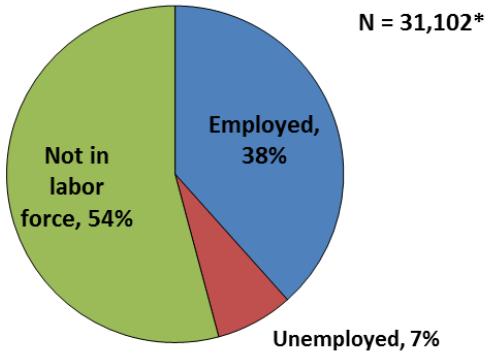


Source: IPUMS 2012 3-Year Samples

Adults with Disabilities: Employment

While many persons have disabilities that prevent them from working, systemic barriers can further impede employment and discourage potential workers from seeking employment. This population tends to face difficulties looking for work, finding positions that provide necessary accommodations, and obtaining accessible and consistent transportation (U.S. Department of Labor, 2001). When considering the employment rates of this population, it is important to remember that some of those out of the labor force are likely discouraged workers who would be interested and able to work with appropriate support.

Less than Half of Adults Reporting Disabilties Age 18 to 59 are in the Labor Force

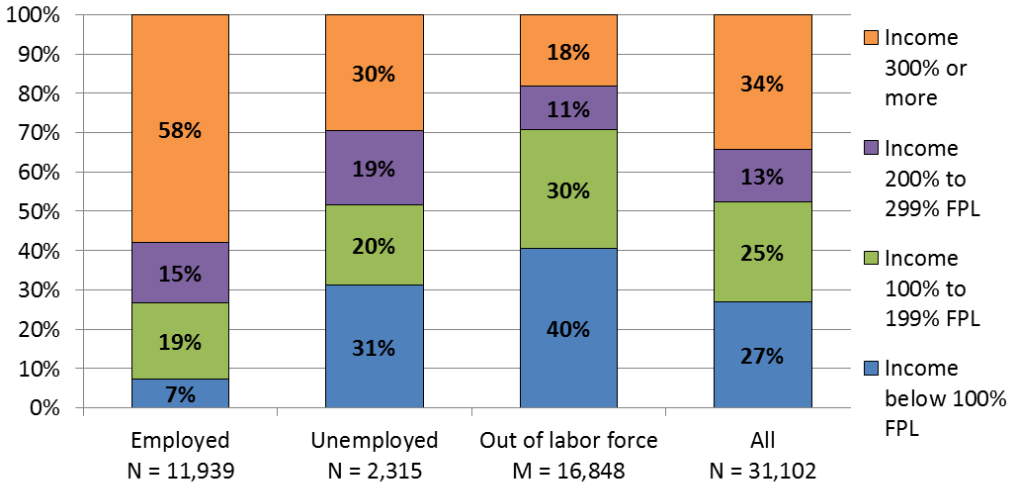


**Data pertains to those living in the community*
Source: IPUMS 2012 3-Year Samples

Most adults who report disabilities in the census are out of the labor force (not employed and not seeking employment): 59% of all adults with disabilities and 54% of those living in the community. The chart above is focused on those in the community, showing that approximately 45% of this population is in the labor force. By comparison, 86% of adults in this age range without disabilities are in the workforce.

Approximately seven percent of the population is unemployed. This equates to 2,315 individuals, suggesting that the unemployment rate for the disabled adult population in the labor force is approximately 16% (2,315 of the 14,254 persons with disabilities in the labor force). The unemployment rate for non-disabled persons is closer to eight percent.[10]

Income Level of Adults Reporting Disabilities by Employment Status



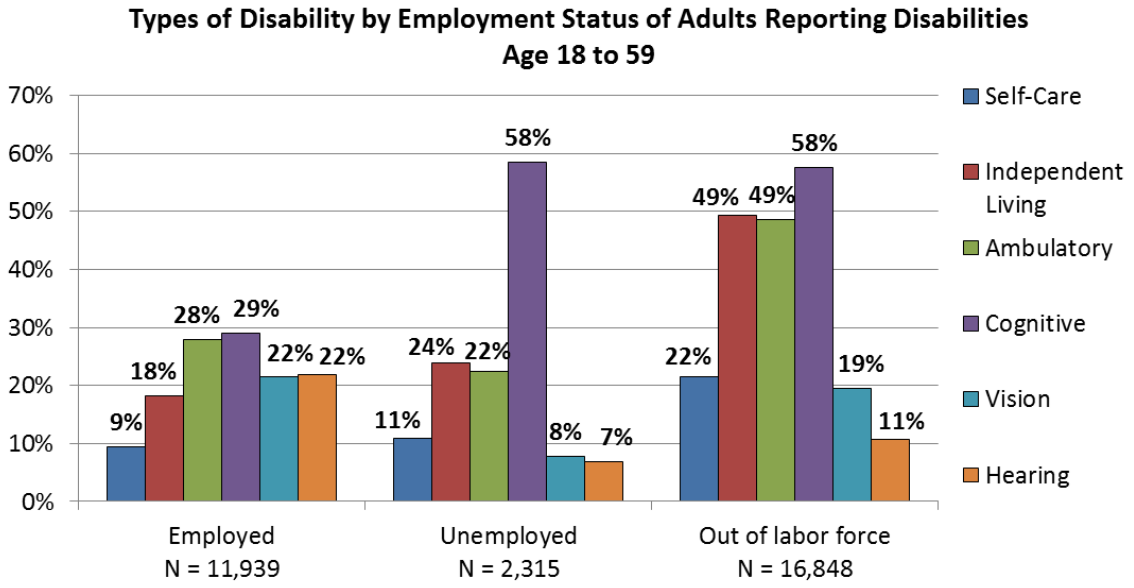
Source: IPUMS 2012 3-Year Samples

As might be expected, those who are employed tend to have higher income than those who are unemployed or out of the workforce. However, over 40% of adults with disabilities who are working can still be classified as low-income. These individuals

[10] Census data provides a sense of trends by specific population but is a less precise methodology than official labor statistics maintained by employment and labor agencies. The California Employment Development Division estimates that the current unemployment rate for the entire San Francisco population in January 2016 is approximately 3.3%.

may be underemployed or working low-wage positions that do not provide enough income to meet a basic standard of living. Those who are unemployed but in the workforce are likely to have higher income than those who are completely out of the workforce; this may be due to sporadic employment throughout the year.

The chart below depicts the frequency of disability types reported by employment status. Those who identify as out of the workforce tend to report multiple types of disabilities. They also are much more likely to report types of disability that potentially can have a significant impact on ability to work (e.g., independent living difficulty). Over half of unemployed adults with disabilities report cognitive disabilities. This group may have difficulty finding appropriate positions that accommodate their needs and support their capabilities.



Source: IPUMS 2012 3-Year Samples

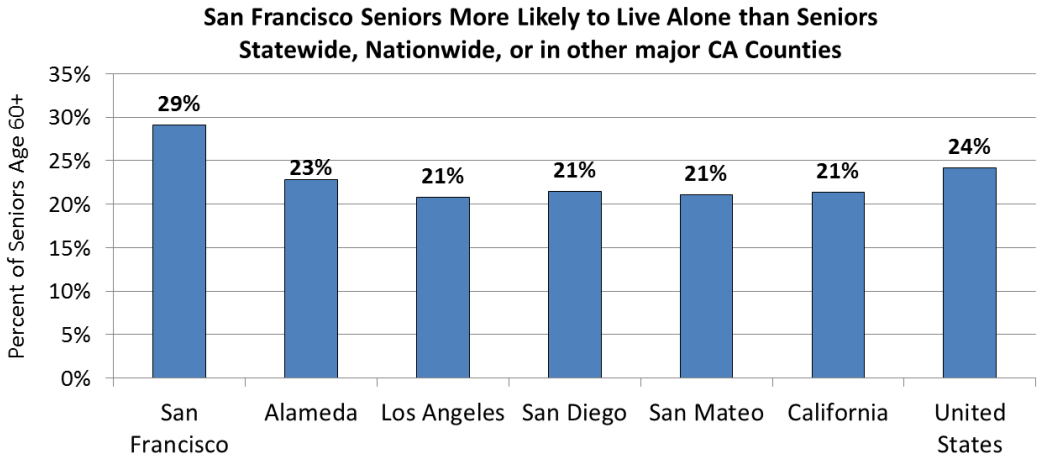
Distinct Populations

Isolated & Homebound Seniors & Adults with Disabilities

Isolation is connected to poor health, cognitive functioning, and emotional wellbeing (Charles & Carstensen, 2010). Those who live alone and those who are homebound individuals may be at heightened risk for isolation. While there is no single metric to identify this population, there are a number of proxies that can at least provide some direction in estimating the size of this population.

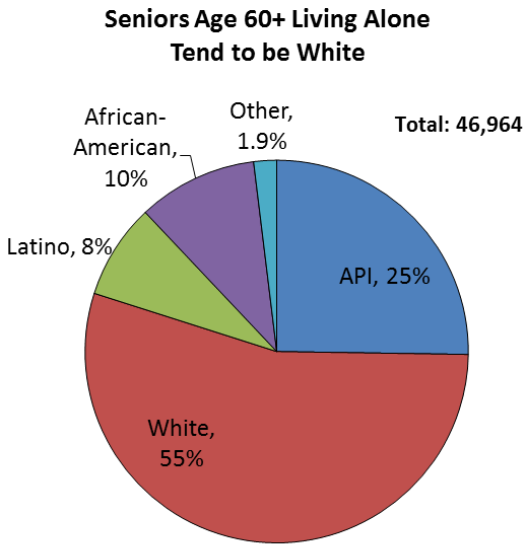
Living Alone

San Francisco seniors age 60 and up are more likely to live alone than seniors statewide or in other major California counties. Approximately 46,964 individuals or 29% of San Francisco seniors are living alone. In other major California counties, the rate is closer to 21%.

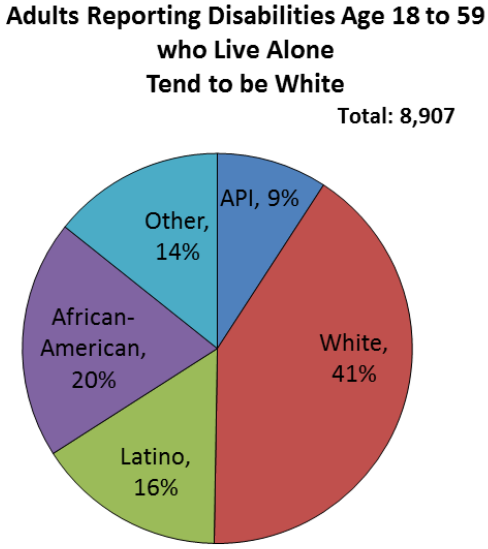


Source: ACS 2013 5-Year Estimates

As shown below, San Francisco seniors and adults with disabilities who live alone are most likely to be white and African-American. Compared to the ethnic profiles of these populations discussed earlier in this assessment, these groups are overrepresented among those living alone. These trends are generally consistent among the low-income populations but with two notable shifts – focusing in on all with income below 300% FPL, API make up a larger portion of seniors living alone (32%) and African-Americans constitute a larger percentage of the disabled adult population living alone (25%).

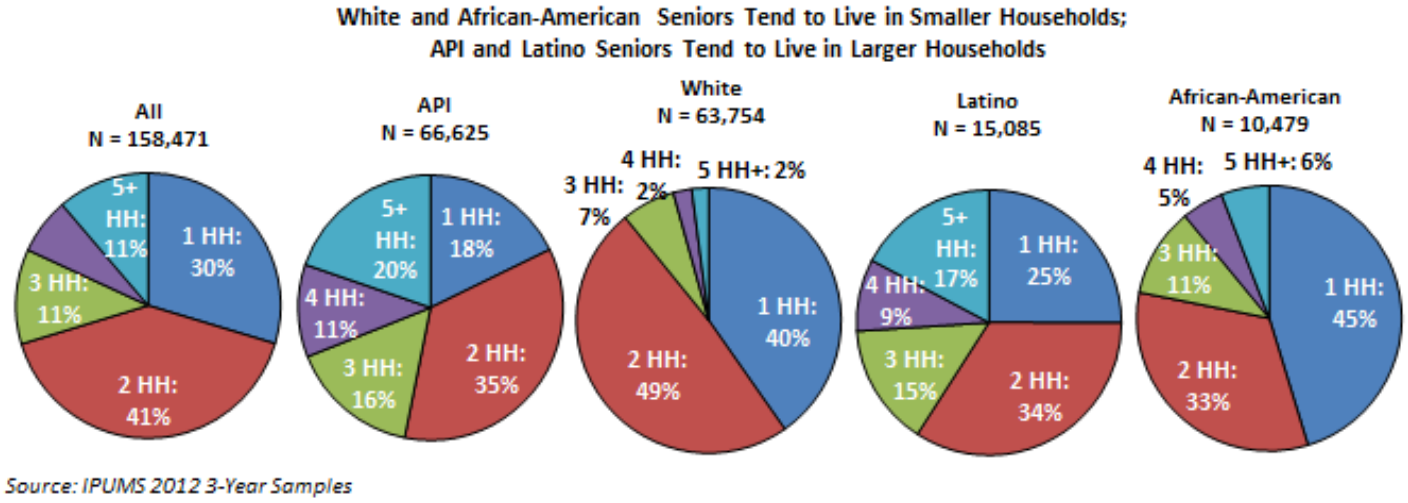


Source: IPUMS 2012 3-Year Sample



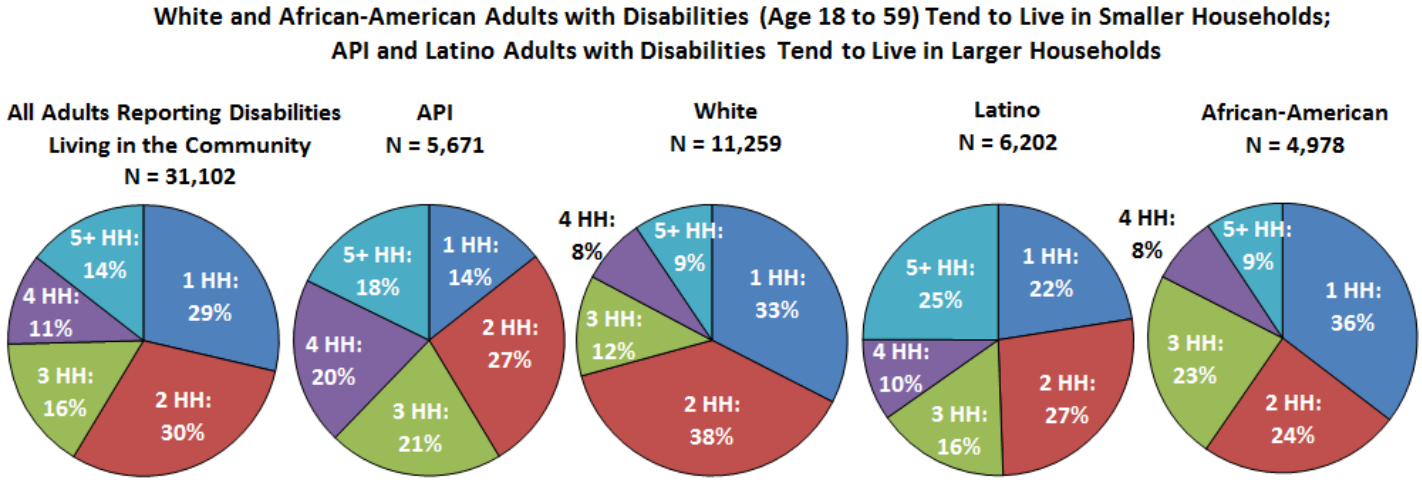
Source: IPUMS 2012 3-Year Sample

Focusing on trends within the major ethnic groups represented in San Francisco reveals additional nuance in household size. Among seniors, African-Americans and whites are much more likely to live in small households of one to two individuals. As shown below, 45% of African-American seniors and 40% of white seniors live alone. By comparison, only 25% of Latino seniors and 18% of API seniors are living on their own; these seniors tend to live in larger households with family members. API seniors are more likely to live in a household of five or more than live alone.



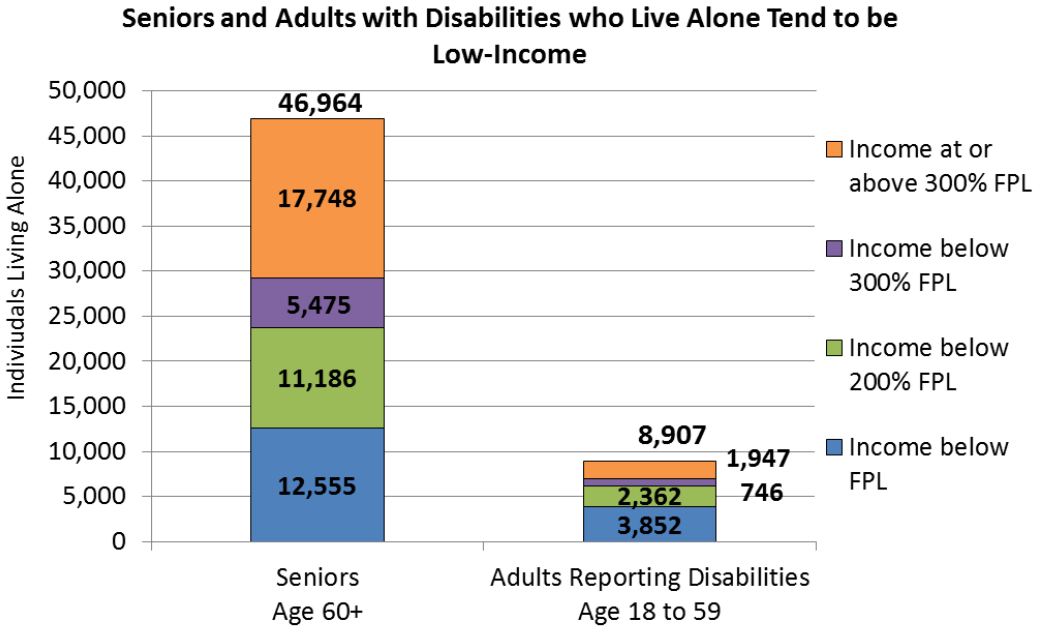
Source: IPUMS 2012 3-Year Samples

Similar trends are visible in the disabled adult population. As shown below, 29% of adults age 18 to 59 who report disabilities live in single person households. Rates of living alone are highest among the African-American and white adults with disabilities. Notably, this population overall is more likely to live in a larger household of three or more; this appears to be driven in part by the tendency of younger adults reporting disabilities to live with their parents.



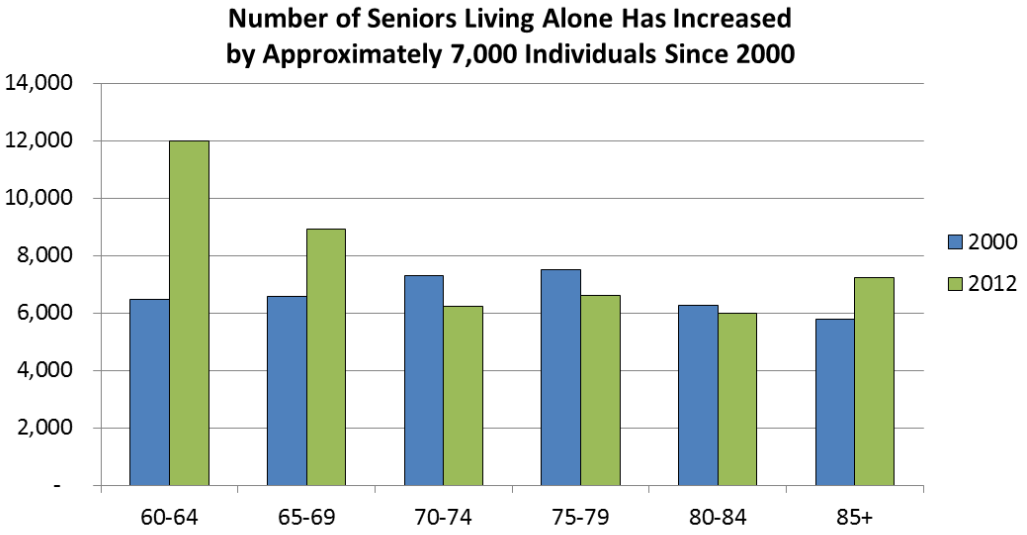
Source: IPUMS 2012 3-Year Samples

Overall, 46,964 seniors and 8,907 adults reporting disabilities who reside in the community live alone (a total of 55,871 individuals). As shown below, most of these individuals are low-income. Approximately 29,216 or 27% seniors living alone have income below 100% FPL. This prevalence is even higher among adults with disabilities: 43% of those living alone have income below the federal poverty line.



Source: IPUMS 2012 3-Year Samples

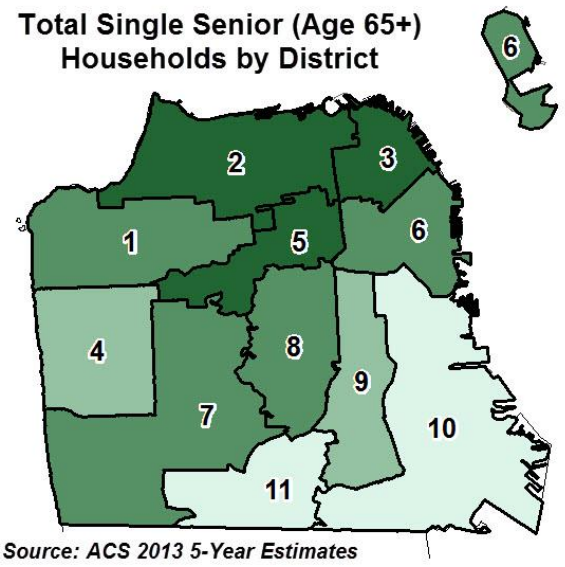
The census provides an additional level of detail regarding the senior population that lives alone. A review of historic data indicates that the number of seniors living alone increased over the last decade. As shown in the chart below, the increase mirrors trends in the overall population trends with the growth driven by the youngest and oldest senior populations. Given the correlation of disability and age, the growth in the population of seniors age 85 and up who live alone should be noted; this population has increased by 1,500 individuals over the last decade.



Source: IPUMS 2012 3-Year Samples

As shown to the right, seniors living alone are most likely to live in the northern and middle part of the city. Most of the city's single senior households are found in District 3 (Chinatown, North Beach, and Nob Hill). There are 5,673 single senior households in this area, comprising 16% of the city's seniors who live alone.

Other areas with significant single senior populations are District 5 (Western Addition, the Haight, and Inner Sunset) with 4,595 or 13% of this population and District 2 (Marina, Pacific Heights, and part of Russian Hill) with 4,226 or 12% of this population.



Difficulty with ADLs

Persons who have difficulty with activities of daily living, such as bathing and dressing, are more likely to be homebound. Based on the census indicator for self-care difficulty, there are approximately 15,986 seniors age 60 and older and 5,006 adults with disabilities at heightened risk of being homebound. Of this population, approximately 38% also live alone. Approximately 7,166 (89%) of those with self-care disabilities who live alone have income below 300% FPL.

Self-Care Difficulty and Living Alone			
	Seniors Age 60+	**Adults Age 18 to 59**	**Total**
Difficulty with Self-Care – All	15,986	5,006	20,992
Difficulty with Self-Care – Living Alone	6,570	1,454	8,024
% Live Alone	41%	29%	38%

Source: IPUMS 2012 3-Year Samples

Using broader parameters for the potentially homebound population (independent living and/or ambulatory difficulty) results in a significantly larger population estimate: 56,731 who are potentially homebound, and almost 20,000 (35%) of that group live alone. An estimated 16,782 or 84% of this population has income below 300% FPL.

Self-Care, Independent Living, and/or Ambulatory Difficulty and Living Alone			
	Seniors Age 60+	**Adults Age 18 to 59**	**Total**
Difficulty with Self-Care, Independent Living, and/or Ambulation	17,756	38,975	56,731
Live Alone	4,999	14,775	19,774
% Live Alone	28%	38%	35%

Source: IPUMS 2012 3-Year Samples

Receives In-Home Supportive Services

The In-Home Supportive Services (IHSS) program serves Medi-Cal clients who need assistance with ADLs and IADLs. This program data provides valuable insight into the location of low-income persons with disabilities who are at high risk of being homebound. As of June 2015, there are 18,063 seniors age 60 and 4,089 adults age 18 to 59 enrolled in IHSS.[11] Approximately 40% of these clients live alone.

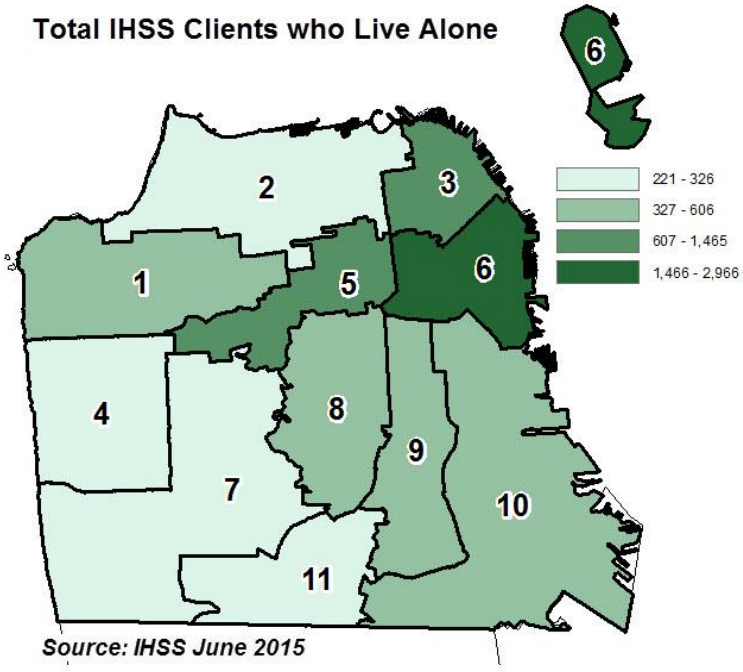
In-Home Support Services Clients			
	Seniors Age 60+	**Adults Age 18 to 59**	**Total**
Total Clients	18,063	4,089	22,152
Living Alone	7,315	1,600	8,915
% Living Alone	40%	39%	40%

Source: IHSS June 2015

IHSS clients who live alone tend to reside in the eastern supervisorial districts. District 6 is home to 21% of all IHSS clients and 33% of those living alone. District 3 is home to 15% of IHSS clients and 16% of IHSS clients who live alone. District 5 houses 11% of IHSS clients and 14% of those that live alone.

These district-level trends are centered on certain neighborhoods. The two neighborhoods with the largest population of senior IHSS clients living alone are in District 6: the Tenderloin with 17% of senior IHSS clients living alone (1,220 clients) and SOMA with 12% (895 clients). Chinatown in District 3 also has many people in this population (776 individuals), as does the Western Addition (700 clients).

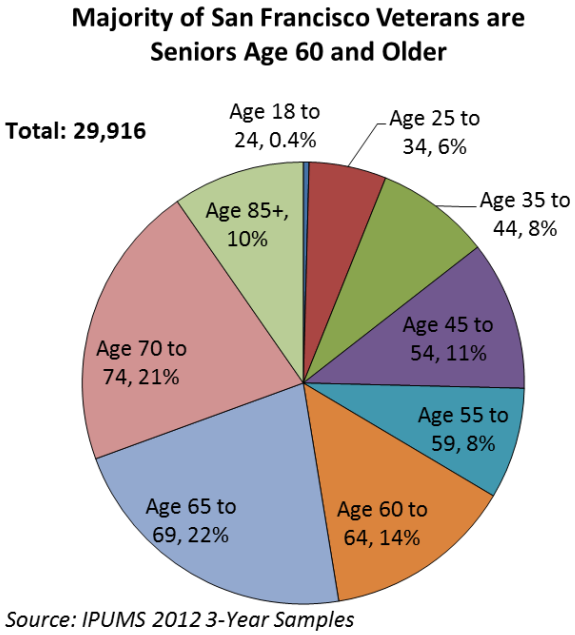
The younger IHSS client population between age 18 and 59 shows similar tendencies. Twenty-nine percent of younger adult IHSS clients living alone – 462 clients – are in the Tenderloin (462 clients). Fourteen percent – 226 clients – are in SOMA. However, this population does not tend to live in Chinatown (only 29 clients). They are more likely to live in Bayview-Hunters Point (121 individuals or 8% of adult IHSS clients living alone).



[11] As a Medi-Cal benefit, the IHSS program uses age 65 as the threshold for seniors. In keeping with the Older Americans Act definitions, the analysis here uses age 60 to delineate seniors from younger adults with disabilities.

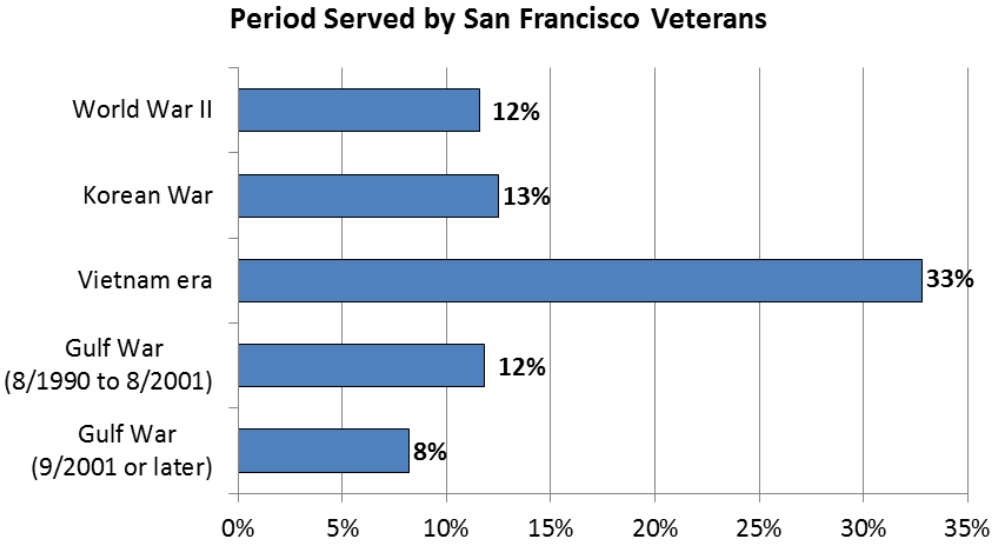
Veterans

The number of San Franciscans who are veterans of military service is 29,916. They comprise four percent of the city's adult population, a little lower than the statewide veterans rate of seven percent and the nationwide rate of nine percent, but they tend to be older persons. The chart to the right illustrates that two-thirds of the city's veterans are over the age of 60, and 10% (2,899) being over the age of 85.



Source: IPUMS 2012 3-Year Samples

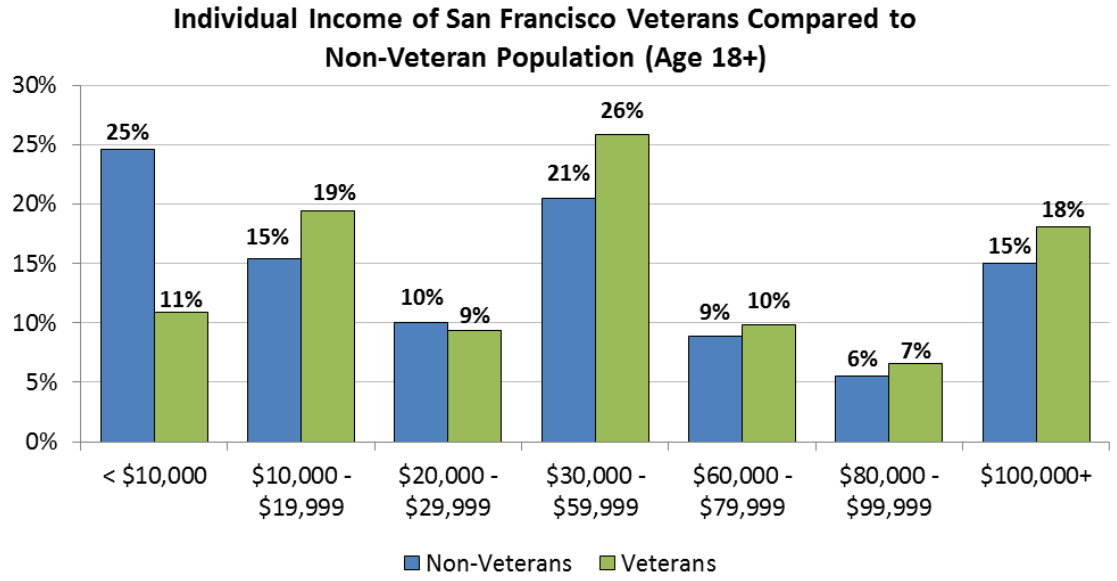
Research on the effects of military service has tended to dwell on its short-term impact. An emerging body of research, however, is examining the lifespan impact, discovering that military service may be a hidden variable in both positive and negative outcomes later in life. Some variants of post-traumatic stress may remain buried until late in life, surfacing as older persons face new stressors like retirement, the loss of a loved one, or physical decline. Latent trauma from earlier stages of life may surface and exacerbate the physical and psychological challenges of aging. For older veterans, the legacy of their wartime service is often tied to the popularity of the war they served in and the unique nature of combat in each war. The chart below illustrates the periods served by San Francisco veterans.



Source: ACS 2013 5-Year Estimates

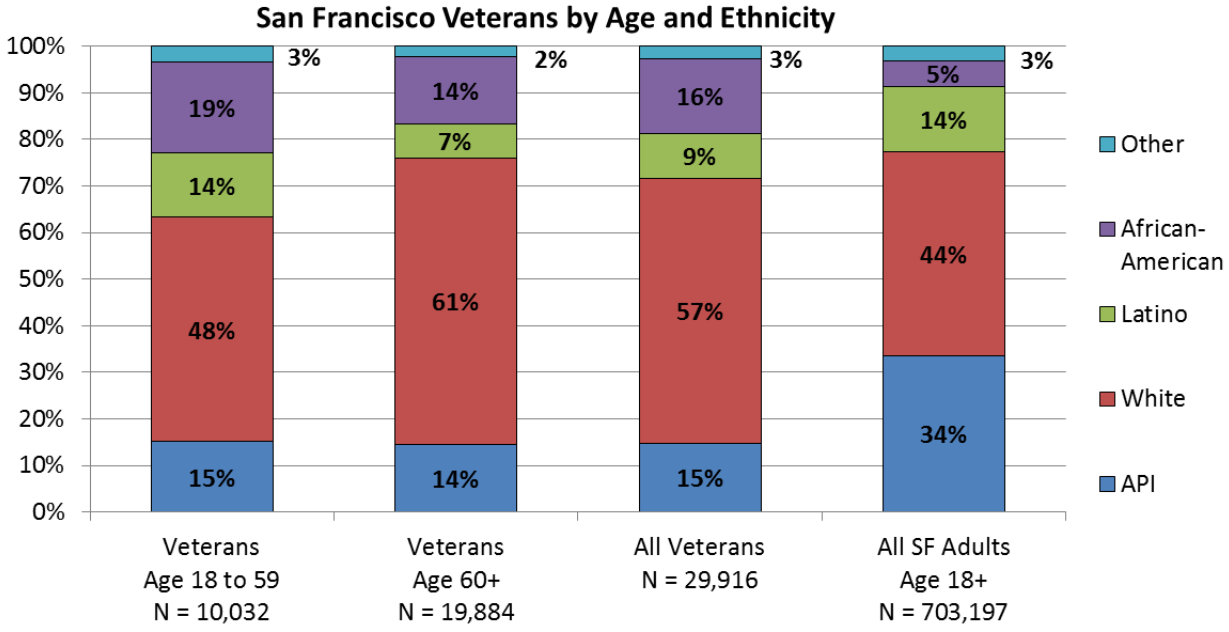
Too often the human services discussion of military service dwells on negative outcomes like post-traumatic stress and addiction, mental illness and homelessness. However, lifespan research reveals the positive values that veterans often draw from military service (Chatterjee et al, 2009). Older persons who served in the military often emerge from the experience with greater

resilience and wisdom. They describe the value of discipline and enduring friendships, of a broader perspective and a sense of gratitude and satisfaction with life. The chart below suggests the prevalence of positive adjustment among the city's veterans, illustrating that they tend to have higher incomes than non-veterans.



Source: IPUMS 2012 3-Year Samples

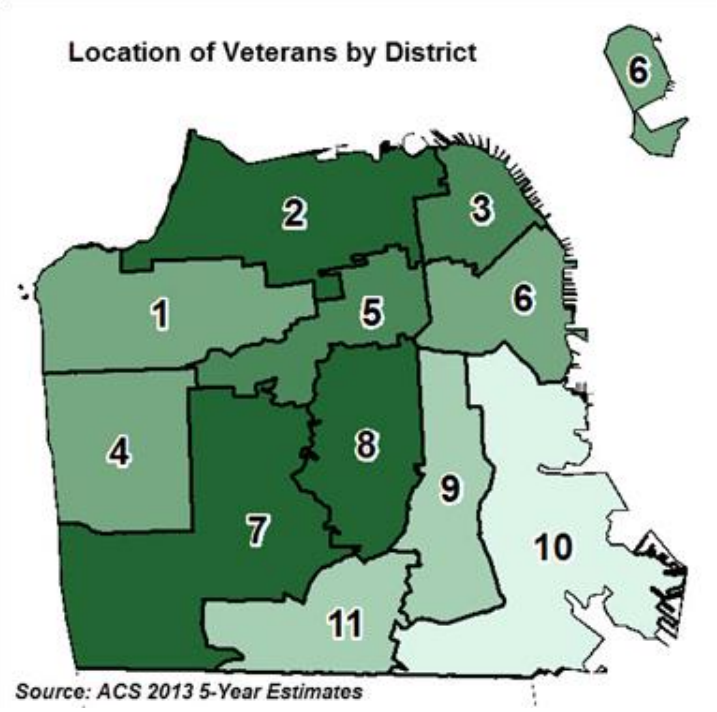
The demographics of veterans in the city lean toward older white males. The chart below shows their ethnicity and age. Ninety one percent of San Francisco's veterans are male, and 57% are white. Veterans under age 60 are more likely to be Latino and African-American than older veterans.



Source: IPUMS 2012 3-Year Samples

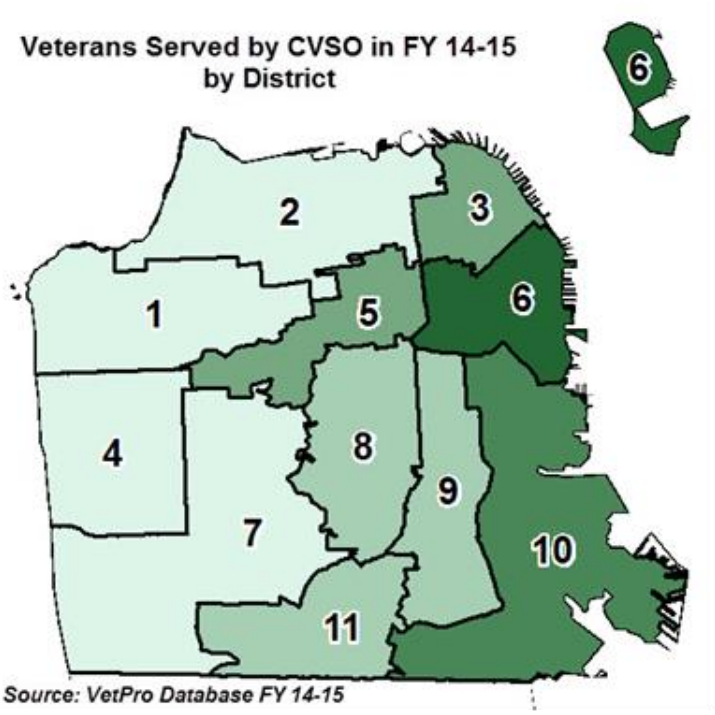
The largest groups of veterans live in District 7 (Western Twin Peaks and Lake Merced), District 8 (Diamond Heights, Upper Market/Eureka, and Noe Valley), and District 2 (Presidio, Marina, Seacliff, and Pacific Heights). *Please see Appendix E for population information by district.*

In the last fiscal year, over six percent of San Francisco's veterans (1,727 total) utilized the services of the Office on Aging. Most often they used the agency's congregate and home-delivered meal programs, as well as its community services programs that offer opportunities for socialization and assistance from social services specialists.



The DAAS County Veterans Services Office (CVSO) helped 2,265 veterans in FY 14-15. Most lived in San Francisco, although this office also serves those from the surrounding region. The office is a direct client service program, targeting homeless and disabled veterans, their dependents and survivors, and helping them apply for benefits like service-connected disability compensation and pension, vocational rehabilitation, GI Bill, death pension for surviving spouses, college benefits for surviving dependents, and assistance for the homebound.

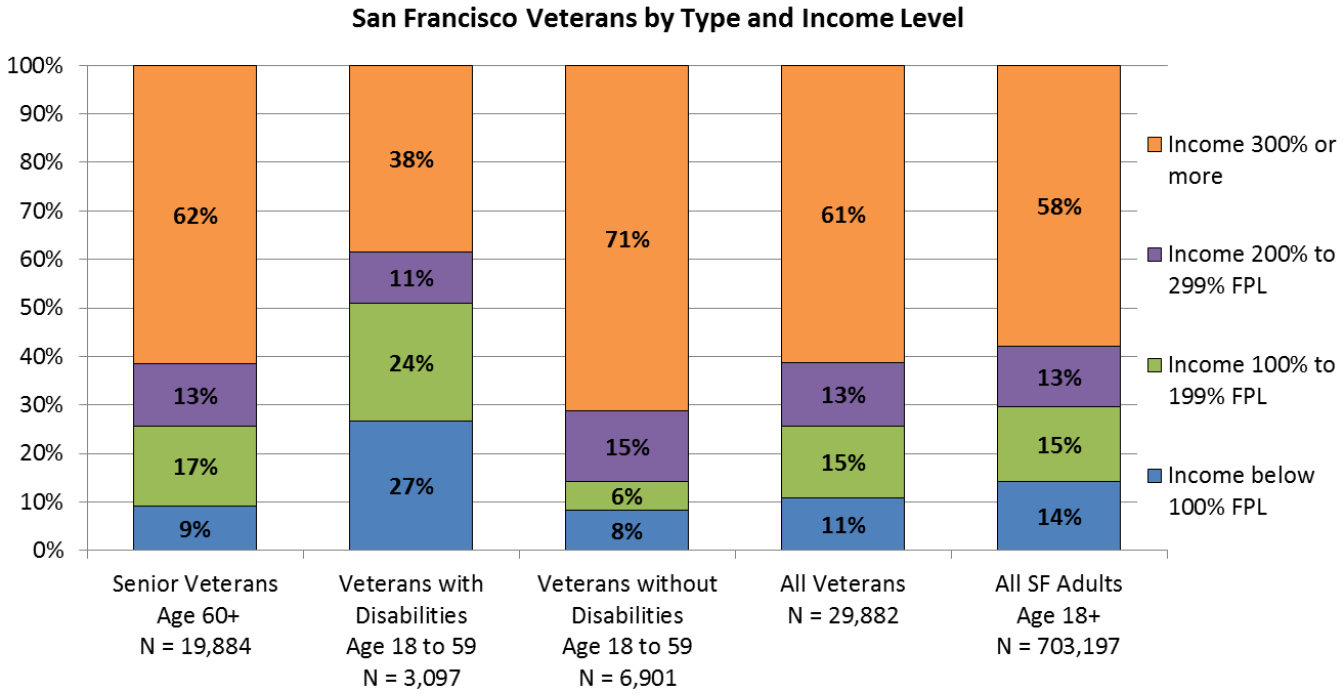
While the largest concentrations of veterans are in the city's western districts, those using CVSO services tend to live on the eastern side of the city. This trend may be due to the downtown location of the CVSO office. With increased staffing in FY 15-16, the CVSO has expanded its outreach efforts, including satellite hours at the VA Medical Center in the Outer Richmond neighborhood (District 1).



One-third of San Francisco veterans – 10,032 individuals – are younger adults below age 60. Within this group, 31% (3,097) report disabilities. Disability rates vary by ethnicity with the highest frequency among African American (58%), Latino (32%), and white (26%) veterans, with just 10% of API veterans reporting a disability.

While the prevalence of difficulties amongst veterans is often overstated, a substantial number of younger veterans are living with disabilities. The nature of combat has changed, and many veterans are returning home from recent wars with injuries that would have proven fatal in previous wars. The proportion of soldiers discharged after the Afghan and Iraq conflicts with mental health diagnoses was as high as 20% (Frain et al, 2010).

As discussed earlier in this report, adults with disabilities tend to have low income, and this experience is no different for younger veterans with disabilities. More than one in four of this group lives in extreme poverty with income below the federal poverty line (monthly income of $981 for a single individual). However, older veterans and those without disabilities tend to have higher income levels than the general San Francisco adult population.

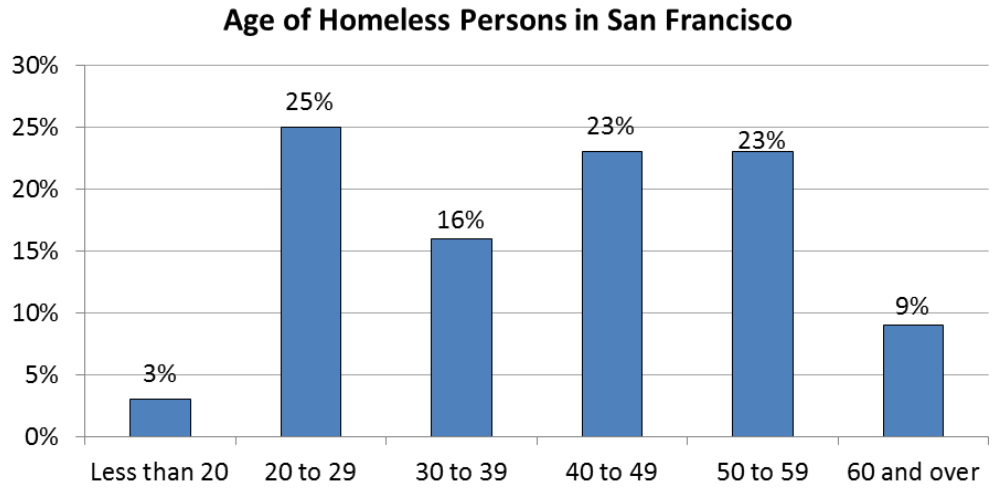


Source: IPUMS 2012 3-Year Samples

The single most visible social issue in San Francisco is homelessness, and according to the city's most recent homeless count, the number of homeless veterans is 598 (Applied Survey Research, 2015). More than half are unsheltered, living on the street. These individuals often seek support from DAAS programs: the number of younger veterans with disabilities using the Office on the Aging's services in the last fiscal year was 126. Over 90% of the younger veterans with disabilities who sought OOA services were homeless, and they were most often drawn to its meal programs, community services, and case management. The CVSO served 978 homeless veterans – of any age – and they most frequently helped them submit claims for monetary benefits.

Homeless Seniors

A decade ago researchers began noting that older persons were an increasing proportion of the homeless population in San Francisco, creating new challenges for service providers, particularly within the city's health system (Hahn et. al, 2006). Studying cohorts of homeless persons, Kushel (2016) observed that during the 1990s a little more than 10% of the homeless population was over the age of 50. San Francisco's 2015 Homeless Count found that about 30% of homeless persons were 50 or over. Nine percent were 60 or over, a proportion that has more than doubled since the 2009 homeless count (Applied Survey Research, 2015; Applied Survey Research, 2009) The Homeless Research Institute estimates that elderly homelessness will increase by a third nationwide by the year 2020 (Sermons, 2010).



Source: Applied Survey Research, San Francisco Homeless Survey, 2015.

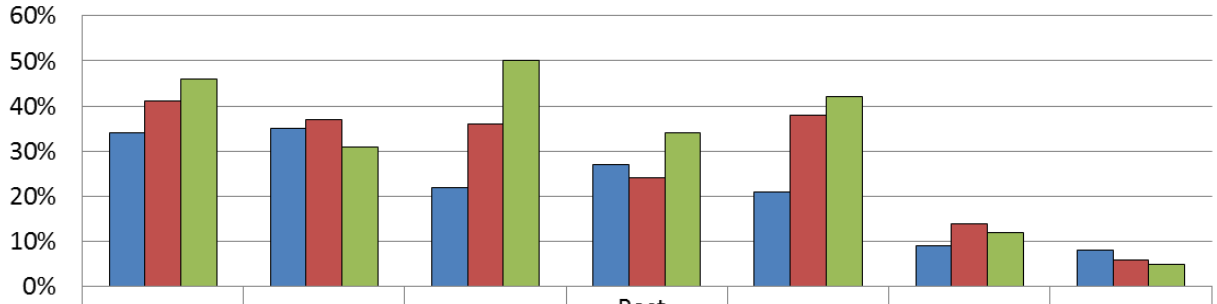
Homelessness hastens aging. The trauma of life on the street can make a homeless person biologically old well beyond his or her years (Cohen, 1992, Gonyea et al, 2010, Hibbs et al, 1994, Morrison, 2009, Ploeg et al, 2008). "Many homeless people in their 50s," says researcher Margot Kushel, "have physical and cognitive disabilities more commonly seen in people in their 70s and 80s" (University of California San Francisco, 2016; National Health Care for the Homeless, 2013). And there are more homeless persons in their 50s. In 2009 the median age for persons using homeless shelters in San Francisco was 45; in 2016, it was 49. Twenty percent of shelter occupants were age 60 or older.

San Francisco Homeless Shelter Clients Age 50+ by Year										
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Average Monthly Shelter Users	2,200	2,312	1,924	1,962	1,955	1,941	1,903	1,888	1,926	1,878
# 50+	917	914	794	806	798	866	891	899	948	985
% 50+	42%	40%	41%	41%	41%	45%	47%	48%	49%	52%
# 60+	270	215	200	210	207	263	267	296	367	377
% 60+	12%	9%	10%	11%	11%	14%	14%	16%	19%	20%
Source: CHANGES database										

The nature of homelessness blurs many of the normal distinctions between age groups, between young and old, between mid-life and later life. Many homeless persons are disabled. Some arrive on the streets because of health conditions, and some develop health conditions because life on the streets is so harsh.

San Francisco's 2015 Homeless Count survey collected data on rates of disability amongst homeless persons. For the purpose of this study, that information was cross-tabulated by age, revealing higher rates of physical disabilities and chronic health conditions amongst older homeless persons, while seniors were slightly less likely to have psychiatric disabilities. Older persons were also more likely to have issues with addiction, although this needs to be understood within the context of aging, as described subsequently within this report. The chart below highlights the general prevalence of disabilities.

Disabling Conditions Among Homeless Persons by Age



	Drug or Alcohol Abuse	Psychiatric or Emotional Conditions	Physical Disability	Post-Traumatic Stress Disorder (PTSD)	Chronic Health Problems	Traumatic Brain Injury	AIDS/HIV Related
Less than 50	34%	35%	22%	27%	21%	9%	8%
50 to 59	41%	37%	36%	24%	38%	14%	6%
60 and over	46%	31%	50%	34%	42%	12%	5%

Source: Applied Survey Research, San Francisco Homeless Survey, 2015.

The reasons for premature aging are multiple, but it is useful to distinguish between people who have been homeless for many years and persons who become homeless later in life. The former may have lifelong patterns of neglecting their health, while the latter may become homeless because of health conditions.

A longitudinal study now underway in Oakland has found that 43% of homeless seniors did not lose housing until their 50s. "These are people who worked their whole lives doing physical labor," said the lead researcher, Margot Kushel in a recently published interview. "Many of these people are the people who have been the janitors, who have been stocking the shelves" (McCamy, 2015). For a laborer, a back injury can ruin his or her later years, especially when living in an expensive city. A New York City study found that over half of older homeless persons led "conventional lives" prior to becoming homeless (Shinn et. al, 2007). Research suggests two pathways for persons who become homeless late in life: gradual decline and/or trigger events. Factors that are manageable in early life – uncertain employment, poor health,

shaky social connections, drug use or depression – may gradually erode resilience, leading to an eventual loss of housing. Trigger events like the death of a loved one who provided help, domestic violence, or family breakdown can aggravate underlying vulnerabilities and lead to a sudden loss of stability (Crane & Arnes, 2005; Gonyea et al, 2010, Grenier, 2013, McDonald et al, 2004, Morris et al, 2005).

The other half of homeless older persons tend to live rough lives, cycling through jail, prisons, and hospitals, struggling with mental illness and addiction. A lifetime of alcohol and drug abuse, combined with smoking, poor access to health care, poor nutrition, violence, and high stress takes its toll on this group's health (Kushel 2013).

Regardless of pathway, the experience of homelessness is different for older persons. They are more likely to have cognitive impairments, including problems with memory, information processing, and following directions (Garibaldi et al, 2005; Kim et al. 2010; Grenier, 2013). In a focus group conducted for this assessment, homeless seniors expressed confusion at the complicated system for gaining access to shelter. Older homeless persons are also more likely to have functional impairments, including difficulty with daily tasks such as dressing, bathing and toileting, as well as deteriorating hearing and vision. Because of mobility impairments, they often have greater barriers to seeking treatment and services, having to walk long distances to reach service providers (Kushel, 2016). Focus group participants stressed how difficult it was to carry their belongings as they moved about from day to day, their loads made heavier by injuries and illness.

The burden of possessions adds to the stigma that many older homeless persons experience. "One of the main problems in being homeless is our stuff," said one focus group participant. "I can't take it into a restaurant or business. I immediately get stereotyped as homeless, as a bum – a dirty, filthy old man."

Older homeless persons often experience stigma when they seek treatment or services, confronting the assumption that they must have done something to bring their situation upon themselves. Kushel and Miaskowski (2006) found that older homeless persons were sometimes denied end-of-life treatment unless they complied with admonitions to maintain sobriety. Older homeless persons frequently require specialized treatment services that shelters and clinics for homeless people are not prepared to provide. Yet general health clinics focused on serving seniors may not be sensitive to the unique needs of older homeless persons.

Violence stalks homeless seniors. One study found that 32% of older homeless women and 27% of men had been assaulted in the previous year. They are seen as easy targets for robbery and financial exploitation (Grenier, 2013). "As an older man," one focus group participant said, "you are vulnerable. People know you have an SSI check." He explained that younger homeless persons sometimes lurk a few feet away when they see an older person go to an ATM machine. "If you ask them to go away, that's grounds for them to start something." Another focus group participant was a woman who had been assaulted on the street – "in the wrong place at the wrong time" – injuring her shoulder and making it more difficult for her to "schlep" her stuff around. Focus group participants agreed that the level of violence varied by neighborhood. The Tenderloin was seen as too risky, and some even avoided housing opportunities there, and "the Haight is not safe anymore," a development the seniors tied to a rough crowd of younger

homeless adults. To protect themselves, the participants relied on a network of street allies. They viewed the shelters as relatively safe.

A structural barrier for older seniors is the lack of access to the labor market. Older persons who lose housing because of unemployment often have difficulties competing with younger workers. They may be discriminated against because of age, or they may not be able to compete because of physical limitations. Because they are less likely to reintegrate into the workforce, the duration of homeless episodes tends to be longer for older persons (Caton et al, 2005; Grenier, 2013). In a focus group, several older homeless persons expressed pride in their earlier work histories and found themselves facing unexpected considerations in returning to work. "If I could find someone who understands that I have low immunity and understands the circumstances of my life, I would work," said one participant. Other participants cited the potential impact of work earnings on their Social Security and health care benefits; they were volunteering or finding small entrepreneurial opportunities like babysitting and selling handicrafts.

The experience of homelessness among older persons varies by gender. Men are four times more likely than women to be homeless (Cohen et al, 1992), but older women face different challenges. While men's homelessness is often connected to the loss of employment or longstanding behavioral health issues, women are more likely to become homeless due to a change in family circumstances such as becoming a widow or getting divorced. Spousal abuse, family violence, and disputes with family and friends are common pathways into homelessness for older women. Women's disproportionate involvement in the work of unpaid care, or part-time work, or work for lesser wages makes them more susceptible to life-changing trigger events (Hecht & Coyle, 2001, Kosor et al, 2002). Once homeless, women are more vulnerable to violence. About a third report having been physically assaulted in the previous year; nine percent report having been raped (Crowe & Hardill, 1993; Kushel et al, 2003). Women's health complaints are also different: older homeless women are more likely to report difficulties with arthritis and bladder control while men are more likely to suffer from skin and back problems (McDonald et al, 2004; Grenier, 2013).

San Francisco's homeless system faces unique challenges serving older clients. The system was developed during an era when the population was largely younger, but an older homeless population requires housing providers to assist with more medical concerns. One key informant for this assessment noted that existing supportive housing options tend to provide generic case management services, lacking the clinical pathways needed by older homeless persons. As a result, seniors in supportive housing often find their way to health treatment by way of behavioral health interventions, being "5150'd" for psychiatric events only to end up in a skilled nursing facility.

While a general assumption in the field is that older homeless persons may choose life on the streets rather than exchanging their SSI assistance for housing, it may be that they do not ask for housing assistance while in shelter and require targeted outreach. As of the fall of 2015, 1,168 persons age 60 or older lived in permanent supportive housing developed by the San Francisco Human Services Agency, yet last year about 1,000 seniors spent at least one night in shelter.

The aging of the homeless population has even greater significance for the city's health system. Homeless persons over the age of 50 are 3.6 times more likely than younger homeless adults to

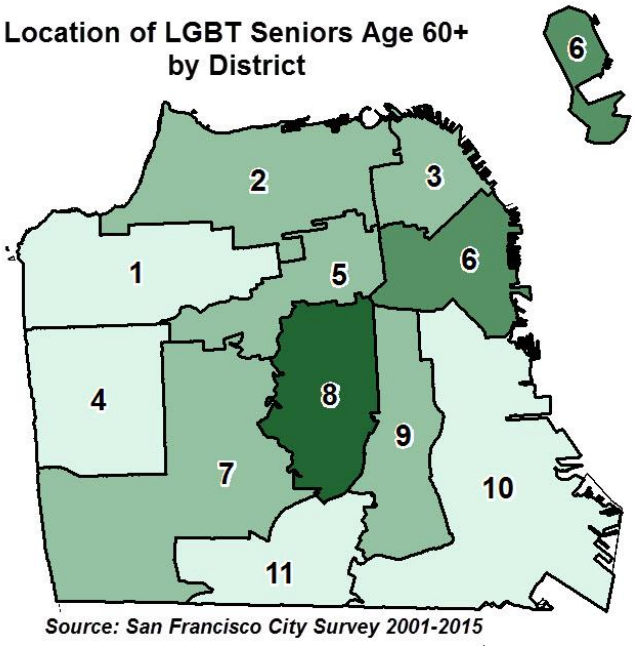
suffer from a chronic health problem, and one study found that the likelihood of having a mental health problem doubled for homeless persons over the age of 42 (Kim et al, 2010; Grenier, 2013). According to research, health care providers for homeless persons tend to focus on younger adults, emphasizing substance abuse treatment, traumatic injuries and infections, treating them with short-term care. But an older population needs help to manage chronic diseases like diabetes and heart and lung disease (Crane & Warnes, 2001, Gonyea et al, 2010; Grenier et al, 2013; McDonald et al, 2004). Older homeless persons die at a rate four to five times higher than the general population of older persons, passing away 20-30 years earlier, but the cause of death is often for conventional causes like heart disease and cancer. Even if a person becomes homeless late in life, his or her health is likely to decline precipitously (Kushel, 2016).

Research also indicates that older homeless persons with terminal illnesses are likely to receive end-of-life care in expensive hospital settings, the disorder of their lives making it difficult to provide outpatient palliative care (Kushel & Miaskowski, 2006). In key informant interviews, hospice providers cited the general lack of end-of-life care services for homeless persons. Many of the hospice facilities that serve homeless persons were created at the outset of the AIDS epidemic, and their services tend to be limited to men. Women with terminal illnesses may be more likely to be discharged from hospitals to the street. Informants also decried the lack of service options for homeless persons who are very ill, but do not qualify for hospice services and cannot afford housing, much less in-home care, and are left to fend for themselves on the street while coping with serious illnesses.

LGBT Seniors

In state and local surveys, as much as 12.4% of San Francisco's seniors age 60 and older identify as LGBT (Jensen, 2012). This amounts to approximately 20,060 LGBT seniors. However, even in a city known as a hub for lesbian, gay, bisexual, and transgender populations, LGBT seniors report a level of stigma that can impact willingness and comfort to disclose their sexual orientation. The city likely has more LGBT seniors who are closeted or hesitate to disclose their sexual orientation or gender when accessing services or responding to surveys.

The map to the right depicts the location of LGBT seniors by supervisorial district based on responses in the biennial city survey. About 24% of seniors identifying as LGBT live in District 8, which includes the Castro neighborhood. District 6, which includes most of the Tenderloin, SOMA, and Mission Bay, is also home to a significant percentage of the city's LGBT seniors: 16%. Other areas that tend to have slightly higher-than-average portions of this population include District 3 (10%) and District 5 (9%). *Please see Appendix C for complete information by district.*



Recent groundbreaking work in San Francisco has helped to develop information about the local LGBT seniors and shed light on critical challenges faced by this population (Jensen., 2012; Fredriksen-Goldsen et al, 2013). Findings from these efforts include:

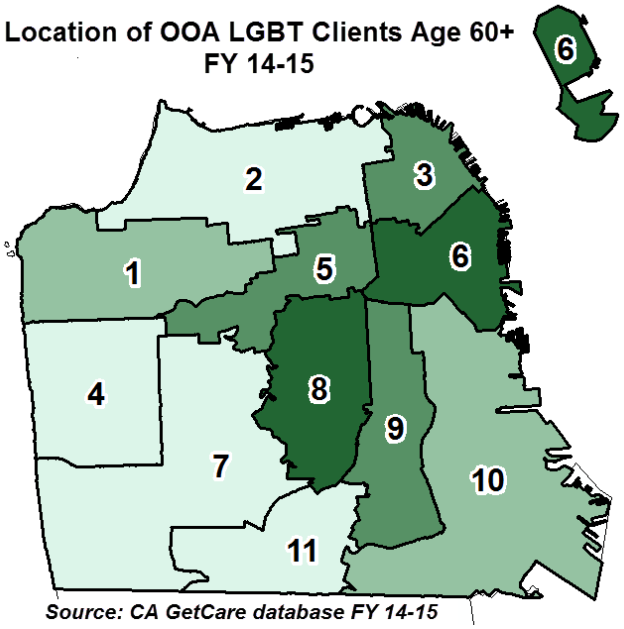
- San Francisco's LGBT senior population tends to be on the younger side. Most LGBT seniors in available datasets were under age 70, which may be due in part to increased closeting as LGBT seniors age.
- This population is more white and more likely to be fluent in English than the general senior population. These trends may be biased by uneven rates of closeting.
- They are more likely to be HIV-positive than heterosexual seniors. Approximately 72% of seniors receiving HIV Health Services are LGBT (note that this group only makes up three percent of the projected LGBT senior population).
- The most frequently needed programs and services by this population are health services, health promotion, mental health services, housing assistance, case management/assistance from a social worker, telephone/online referrals, and meal site/free groceries. The population reports a high rate of unmet need for: health promotion, door-to-door transportation, caregiver support, day programs, housing assistance, in-home care, and telephone/online referrals.

LGBT seniors are at higher risk of isolation than heterosexual seniors. They are less likely to be married or to have children to rely on in their older age. Many are alienated from their biological family. LGBT seniors are twice as likely to live alone than the general senior population – compared to 29% of the general senior population, 60% of this population lives alone

(Fredriksen-Goldsen et al, 2013). While most LGBT seniors living in San Francisco cannot imagine leaving the city, they also sometimes feel left out of LGBT culture (San Francisco Human Rights Commission, 2003). The younger LGBT community sometimes feels unwelcoming. LGBT focus group participants described a sense of becoming invisible as they have aged. While efforts have been made to bring younger and older LGBT people together, this has not always been successful.

LGBT seniors also face unique challenges as survivors of the AIDS epidemic. While advances in medicine have transformed HIV/AIDS from what was once a fatal diagnosis into a more manageable chronic disease for many patients, living through the AIDS epidemic had a lasting impact on this population. Many LGBT seniors did not expect to live into old age. They may be struggling with survivor's guilt or behavioral health conditions that resulted from the trauma of losing loved ones (Cox, n.d.). Many did not make long-term plans for later in life. This population tends to be low income, due partly to periods of unemployment earlier in life while they were ill, caring for others, or grieving loss. A comment from an LGBT service provider at a meeting of agencies serving the elderly underscores these issues. He said, "We are new to the table [of agencies serving the elderly]. We never expected to be here."

In FY 14-15, the Office on Aging (OOA) served 1,025 seniors age 60 and older who identified as LGBT. They were four percent of all OOA senior clients.[12] These clients most frequently live in Districts 8 and 6 – 20% resided in each of these areas. About 12% percent lived in District 5, while Districts 3 and 9 were each home to close to 10% of this group.



The most common OOA service used by this group was community services, which provides opportunities for socialization and assistance from social work staff. Seventy percent of LGBT clients – 715 individuals – visited community service sites in FY 14-15. Most were enrolled at Open House. Another popular service was the congregate meal program, accessed by 338 clients (33%). The home-delivered meal program served 171 LGBT seniors.

Notably, LGBT seniors from all over the city traveled to service sites in the Castro neighborhood in District 8, highlighting the connection they feel to this neighborhood. Also, LGBT seniors living in District 6 were more likely than others to enroll in the home-delivered meal program, suggesting that those living in this area may be more likely to be homebound and/or isolated.

[12] While progress has been made with data collection efforts on sexual orientation and identity, there is still room for improvement. The LGBT data fields were blank for approximately 40% of OOA senior client records. Focusing on clients with a response in these data fields, approximately 7% identify as LGBT.

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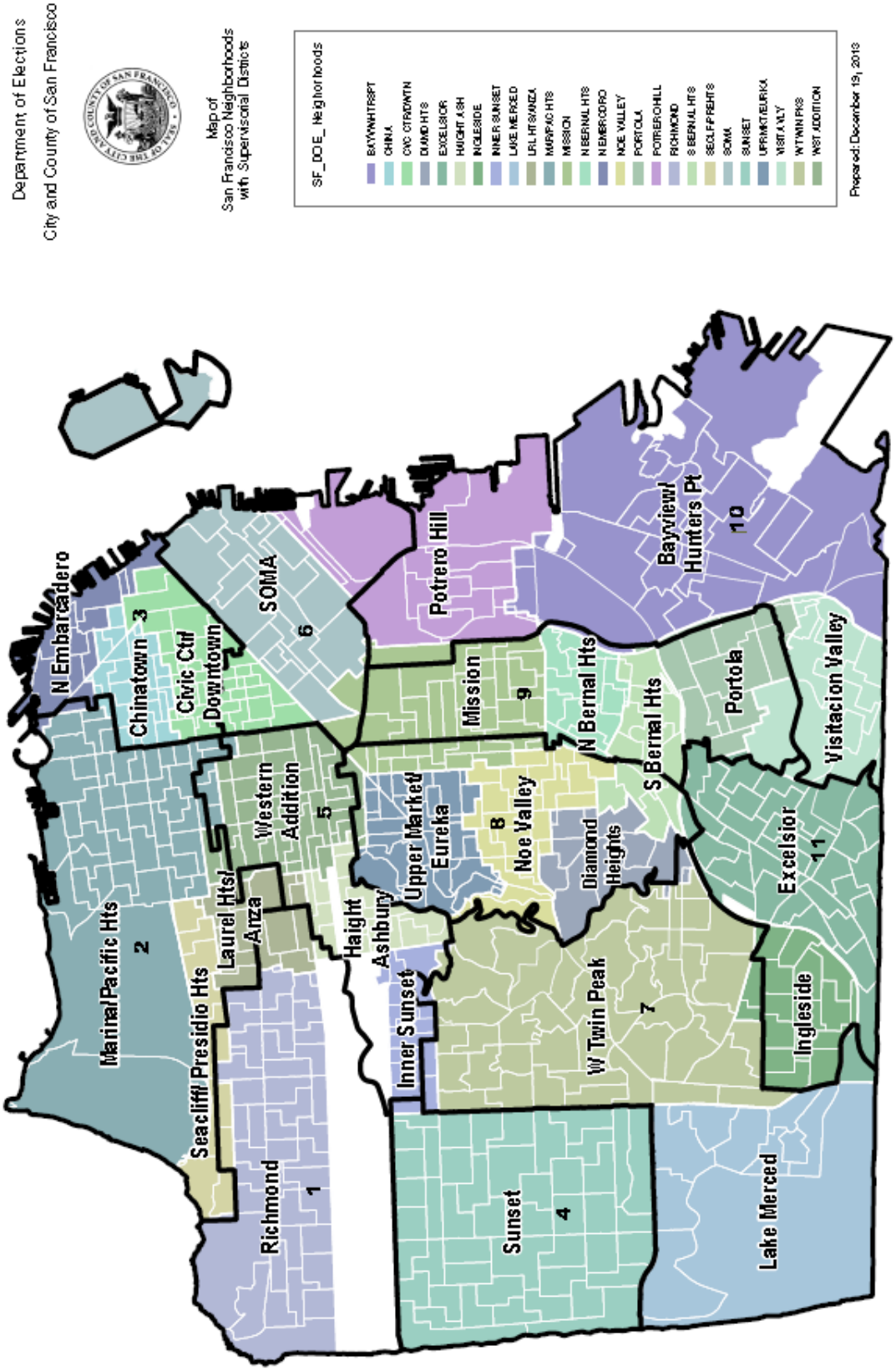
Appendix A. Focus Groups.

Over the last year, a series of focus groups were held with seniors and adults with disabilities living in communities throughout the city.

Location	Date	# of Participants	Target Population
1650 Mission St	2/4/2015	9	Adult Protective Service social workers
South Sunset Senior Center	4/30/2015	11	Seniors living in the southwest part of the city
1650 Mission St (DAAS)*	5/7/2015	11	General (seniors age 60)
1099 Sunnydale*	8/6/2015	9	African-American seniors
Independent Living Resource Center*	8/19/2015	12	Adults with disabilities
Mission Neighborhood Center	9/2/2015	10	Latino seniors
North Beach/NEXT Village*	9/3/2015	11	Seniors living in the north part of the city
International Hotel (Chinatown Community Development Center)	11/17/2015	9	Cantonese-speaking seniors living in Chinatown
Bayview Hunters Point ADHC	12/14/2015	5	Caregivers
Canon Kip Senior Center	12/29/2015	9	Homeless seniors
Jackie Chan Senior Center^	1/21/2016	18	Seniors in the Richmond District
***Conducted in collaboration with the Age- and Disability-Friendly SF baseline assessment efforts** **^Part of a Controller's Office study on long-term care needs**			

Appendix B. Map of San Francisco Supervisorial Districts.

Accessible online at
http://sfgov.org/elections/sites/default/files/SF_Neighborhoods_June_2014.pdf



Appendix C. Demographics of Senior Population by Supervisorial District

	Supervisorial Districts											
Population	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
All ages	77,453	64,849	76,373	73,665	80,297	60,944	71,496	69,750	83,000	74,870	84,804	817,501
60-64	4,971	3,054	5,115	5,553	3,851	3,716	5,107	4,090	4,055	4,066	5,291	48,869
65-74	5,775	4,898	6,294	5,648	4,782	4,384	5,730	4,225	4,593	4,292	6,434	57,055
75-84	3,823	3,090	5,003	3,838	3,231	2,687	4,109	2,311	3,301	2,646	4,014	38,053
85+	1,857	1,720	2,324	2,336	1,902	862	1,984	1,043	1,039	1,044	1,911	18,022
Total Senior Population 60+	16,426	12,762	18,736	17,375	13,766	11,649	16,930	11,669	12,988	12,048	17,650	161,999
Seniors as % of District	21.2%	19.7%	24.5%	23.6%	17.1%	19.1%	23.7%	16.7%	15.6%	16.1%	20.8%	19.8%
Distribution, by District, of Seniors 60+	10.1%	7.9%	11.6%	10.7%	8.5%	7.2%	10.5%	7.2%	8.0%	7.4%	10.9%	100.0%
Total Senior Population 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
Seniors 65+ as % of District	14.8%	15.0%	17.8%	16.0%	12.3%	13.0%	16.5%	10.9%	10.8%	10.7%	14.6%	13.8%
Distribution, by District, of Seniors 65+	10.1%	8.6%	12.0%	10.4%	8.8%	7.0%	10.5%	6.7%	7.9%	7.1%	10.9%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B01001)												

	Supervisorial Districts											
Gender, Age 60+	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Male	6,965	5,511	8,740	7,863	6,337	5,579	7,694	6,439	5,937	5,597	7,048	73,710
Female	9,461	7,251	9,996	9,512	7,429	6,070	9,236	5,230	7,051	6,451	10,602	88,289
% Female	58%	57%	53%	55%	54%	52%	55%	45%	54%	54%	60%	54%
(Source: American Community Survey 2013 5-Year Sample, Table B01001)												

	Supervisorial Districts											
Ethnicity of Senior Population, 65+	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
One race	11,286	9,643	13,470	11,623	9,784	7,722	11,661	7,401	8,650	7,831	12,133	111,204
One race %	98.5%	99.3%	98.9%	98.3%	98.7%	97.3%	98.6%	97.7%	96.8%	98.1%	98.2%	98.3%
African American	284	141	263	75	1,664	459	520	251	451	2,131	1,281	7,520
African American %	2.5%	1.5%	1.9%	0.6%	16.8%	5.8%	4.4%	3.3%	5.0%	26.7%	10.4%	6.6%
Asian/Pacific Islander	6,375	1,441	8,780	6,964	3,015	4,457	3,484	1,057	3,264	3,502	5,697	48,036
Asian/Pacific Islander %	55.7%	14.8%	64.5%	58.9%	30.4%	56.2%	29.5%	13.9%	36.5%	43.9%	46.1%	42.5%
Native American/Alaskan Native	14	0	27	21	13	0	28	29	90	52	65	339
Native American/Alaskan Native %	0.1%	0.0%	0.2%	0.2%	0.1%	0.0%	0.2%	0.4%	1.0%	0.7%	0.5%	0.3%
White (Alone)	4,512	8,019	4,324	4,511	5,013	2,656	7,563	5,820	3,912	1,884	4,590	52,804
White (Alone) %	39.4%	82.6%	31.7%	38.2%	50.6%	33.5%	64.0%	76.8%	43.8%	23.6%	37.1%	46.7%
Other race	101	42	76	52	79	150	66	244	933	262	500	2,505
Other race %	0.9%	0.4%	0.6%	0.4%	0.8%	1.9%	0.6%	3.2%	10.4%	3.3%	4.0%	2.2%
Two or more races	169	65	151	199	131	211	162	178	283	151	226	1,926
Two or more races %	1.5%	0.7%	1.1%	1.7%	1.3%	2.7%	1.4%	2.3%	3.2%	1.9%	1.8%	1.7%
Latino/Latina	222	473	501	554	378	350	744	866	2,833	825	2,700	10,446
Latino/Latina %	1.9%	4.9%	3.7%	4.7%	3.8%	4.4%	6.3%	11.4%	31.7%	10.3%	21.8%	9.2%
White (Alone, Not Hispanic)	4,377	7,644	4,002	4,052	4,765	2,548	7,003	5,212	2,227	1,359	2,477	45,666
White (Alone, Not Hispanic) %	38.2%	78.7%	29.4%	34.3%	48.1%	32.1%	59.2%	68.8%	24.9%	17.0%	20.0%	40.4%
Total Senior Population, 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
(Source: American Community Survey 2013 5-Year Sample, Tables B01001A to B01001I)												

	Supervisorial Districts											
Estimate of Language Ability Indicators, 65+	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Senior Population, 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
English Proficient: English as primary language or speaks English "Very well" or "Well"	7,696	8,832	6,868	7,088	7,258	3,783	10,123	6,692	5,697	5,201	7,639	76,877
Limited English: Speaks English "Not well" or "Not at all"	3,759	876	6,753	4,734	2,657	4,150	1,700	887	3,236	2,781	4,720	36,253
Limited English, % of Seniors 65+ in District	32.8%	9.0%	49.6%	40.0%	26.8%	52.3%	14.4%	11.7%	36.2%	34.8%	38.2%	32.0%
Spanish	29	48	153	81	54	141	60	325	1,346	326	1,043	3,606
Spanish %	0.3%	0.5%	1.1%	0.7%	0.5%	1.8%	0.5%	4.3%	15.1%	4.1%	8.4%	3.2%
Indo-European Languages*	520	439	109	346	908	966	368	192	164	72	329	4,413
Indo-European %	4.5%	4.5%	0.8%	2.9%	9.2%	12.2%	3.1%	2.5%	1.8%	0.9%	2.7%	3.9%
Asian-Pacific Island Languages	3,184	389	6,461	4,225	1,685	3,021	1,257	363	1,726	2,383	3,336	28,030
API %	27.8%	4.0%	47.4%	35.7%	17.0%	38.1%	10.6%	4.8%	19.3%	29.9%	27.0%	24.8%
Other Languages^	26	0	30	82	10	22	15	7	0	0	12	204
Other %	0.2%	0.0%	0.2%	0.7%	0.1%	0.3%	0.1%	0.1%	0.0%	0.0%	0.1%	0.2%
Distribution, by District, Limited English %	10.4%	2.4%	18.6%	13.1%	7.3%	11.4%	4.7%	2.4%	8.9%	7.7%	13.0%	100.0%
*Examples of Indo-European languages include Russian, French, German, Persian, and Hindi.												
^Examples of Other languages include Hebrew and Arabic, as well as Native American and African languages.												
(Source: American Community Survey 2013 5-Year Sample, Table B16004)												
	Supervisorial Districts											
Senior Households	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Households with Persons 60+	9,543	8,830	12,683	9,191	9,622	8,372	10,159	8,190	6,948	6,145	7,295	96,978
Owner Occupied	4,995	4,904	2,663	7,028	2,894	871	7,779	4,958	4,178	3,959	5,960	50,189
Renter Occupied	4,548	3,926	10,020	2,163	6,728	7,501	2,380	3,232	2,770	2,186	1,335	46,789
Renter Occupied %	47.7%	44.5%	79.0%	23.5%	69.9%	89.6%	23.4%	39.5%	39.9%	35.6%	18.3%	48.2%
Distribution, By District, Renter Occupied	9.7%	8.4%	21.4%	4.6%	14.4%	16.0%	5.1%	6.9%	5.9%	4.7%	2.9%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B25007)												
Total Households with Persons 65+	8,094	7,486	10,593	8,229	7,686	6,262	8,353	6,120	6,169	5,635	7,840	82,467
Lives Alone	3,002	4,226	5,673	2,556	4,595	3,843	3,068	3,109	2,034	1,571	1,570	35,247
Lives Alone %	37.1%	56.5%	53.6%	31.1%	59.8%	61.4%	36.7%	50.8%	33.0%	27.9%	20.0%	42.7%
Distribution, by District, Lives Alone	8.5%	12.0%	16.1%	7.3%	13.0%	10.9%	8.7%	8.8%	5.8%	4.5%	4.5%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B11007)												
	Supervisorial Districts											
Lesbian, Gay, Bisexual, Transgender (LGBT) Population Estimate, 60+	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Senior LGBT Population	828	972	2,196	1,109	991	1,805	1,152	2,190	741	590	752	17,211
Senior LGBT Population %	5.3%	7.8%	11.7%	6.8%	7.4%	16.3%	7.2%	19.8%	5.9%	5.2%	4.7%	11.1%
Source: San Francisco City Survey 2001-2011. Note that seniors were defined as 60+ for all years except 2011, in which they were defined as 65+. The sum of the estimates for the districts do not total the estimate for the entire city; each percentage, including that for all districts, are applied independently.												

	Supervisorial Districts											
Poverty Status (Estimates Based on Poverty Threshold)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Seniors 65+ <100% PT	1,505	720	3,365	1,028	1,932	2,642	755	901	1,069	1,176	1,242	16,335
Total Seniors 65+ 100%-199% PT	2,315	1,310	4,364	2,146	2,767	3,229	1,662	1,105	2,387	1,638	2,780	25,703
Total Seniors 65+ 200% PT	7,435	7,502	5,847	8,531	4,801	2,050	9,126	5,550	5,350	4,976	8,073	69,241
Seniors 65+ for whom poverty status was determined	11,255	9,532	13,576	11,705	9,500	7,921	11,543	7,556	8,806	7,790	12,095	111,279
Total Senior Population 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
% of seniors in this district with incomes below:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
100% PT	13.1%	7.4%	24.7%	8.7%	19.5%	33.3%	6.4%	11.9%	12.0%	14.7%	10.0%	14.4%
200% PT	33.3%	20.9%	56.7%	26.8%	47.4%	74.0%	20.4%	26.5%	38.7%	35.3%	32.5%	37.2%
Distribution, by district, of seniors with incomes below:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
100% FPL	9.2%	4.4%	20.6%	6.3%	11.8%	16.2%	4.6%	5.5%	6.5%	7.2%	7.6%	100.0%
200% FPL	9.1%	4.8%	18.4%	7.6%	11.2%	14.0%	5.7%	4.8%	8.2%	6.7%	9.6%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B17024)												
	Supervisorial Districts											
Race & Ethnicity of Seniors 65+ with Incomes below Poverty Threshold	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
One race	1,471	720	3,321	1,017	1,906	2,580	747	875	990	1,154	1,195	15,976
One race %	97.7%	100.0%	98.7%	98.9%	98.7%	97.7%	98.9%	97.1%	92.6%	98.1%	96.2%	97.8%
African American	47	0	36	0	423	161	28	0	66	334	152	1,247
African American %	3.1%	0.0%	1.1%	0.0%	21.9%	6.1%	3.7%	0.0%	6.2%	28.4%	12.2%	7.6%
Asian/Pacific Islander	867	155	2735	720	628	1787	367	236	340	518	550	8,903
Asian/Pacific Islander %	57.6%	21.5%	81.3%	70.0%	32.5%	67.6%	48.6%	26.2%	31.8%	44.0%	44.3%	54.5%
Native American/Alaskan Native	0	0	13	4	0	0	0	0	23	19	0	59
Native American/Alaskan Native %	0.0%	0.0%	0.4%	0.4%	0.0%	0.0%	0.0%	0.0%	2.2%	1.6%	0.0%	0.4%
White (Alone)	538	565	481	293	841	574	352	639	418	204	451	5,356
White (Alone) %	35.7%	78.5%	14.3%	28.5%	43.5%	21.7%	46.6%	70.9%	39.1%	17.3%	36.3%	32.8%
Other race	19	0	56	0	14	58	0	0	143	79	42	411
Other race %	1.3%	0.0%	1.7%	0.0%	0.7%	2.2%	0.0%	0.0%	13.4%	6.7%	3.4%	2.5%
Two or more races	34	0	44	11	26	62	8	26	79	22	47	359
Two or more races %	2.3%	0.0%	1.3%	1.1%	1.3%	2.3%	1.1%	2.9%	7.4%	1.9%	3.8%	2.2%
Latino/Latina*	38	77	152	32	81	125	40	107	454	118	339	1,563
Latino/Latina %	2.5%	10.7%	4.5%	3.1%	4.2%	4.7%	5.3%	11.9%	42.5%	10.0%	27.3%	9.6%
White (Alone, Not Hispanic)	529	488	414	261	790	542	312	532	191	165	154	4,378
White (Alone, Not Hispanic) %	35.1%	67.8%	12.3%	25.4%	40.9%	20.5%	41.3%	59.0%	17.9%	14.0%	12.4%	26.8%
Total Senior Population 65+ in Poverty	1,505	720	3,365	1,028	1,932	2,642	755	901	1,069	1,176	1,242	16,335
(Source: American Community Survey 2013 5-Year Sample, Tables B17001A to B17001I)												
*Non-white races may include a few individuals who identify as Latino, but the total is relatively low.												

	Supervisorial Districts											
Seniors Reporting Disabilities	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Senior Population, 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
Seniors Reporting Disabilities	4,357	3,085	5,901	4,151	4,192	4,344	3,597	2,416	3,461	3,152	4,579	43,235
Seniors with Disabilities as % of District	38%	32%	43%	35%	42%	55%	30%	32%	39%	39%	37%	38%
Distribution, by District, of Seniors Reporting Disabilities	10%	7%	14%	10%	10%	10%	8%	6%	8%	7%	11%	100%
(Source: American Community Survey 2013 5-Year Sample, Table S18130)												

	Supervisorial Districts											
Disability Characteristics* of Senior Population (Age 65+)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Hearing difficulty	1,945	1,310	1,916	1,584	1,287	1,205	1,221	941	1,289	1,116	1,572	15,386
Hearing %	45%	42%	32%	38%	31%	28%	34%	39%	37%	35%	34%	36%
Vision difficulty	1,015	659	1,337	940	873	1,016	731	429	776	693	781	9,250
Vision %	23%	21%	23%	23%	21%	23%	20%	18%	22%	22%	17%	21%
Cognitive difficulty	1,318	939	2,030	1,401	1,375	1,475	1,115	654	1,030	997	1,449	13,783
Cognitive %	30%	30%	34%	34%	33%	34%	31%	27%	30%	32%	32%	32%
Walking (Ambulation) difficulty	2,861	1,949	4,134	2,511	3,079	3,332	2,172	1,590	2,026	2,125	3,356	29,135
Walking (Ambulation) %	66%	63%	70%	60%	73%	77%	60%	66%	59%	67%	73%	67%
Self Care difficulty	1,276	1,072	2,386	1,170	1,706	1,876	1,192	1,036	915	1,173	1,542	15,344
Self Care %	29%	35%	40%	28%	41%	43%	33%	43%	26%	37%	34%	35%
Independent Living difficulty	2,659	1,521	4,069	2,465	2,441	2,765	2,139	1,332	1,730	1,784	2,450	25,355
Independent Living %	61%	49%	69%	59%	58%	64%	59%	55%	50%	57%	54%	59%
Seniors Reporting Disabilities	4,357	3,085	5,901	4,151	4,192	4,344	3,597	2,416	3,461	3,152	4,579	43,235

* The census disability definitions are:
- Hearing difficulty: deaf or having serious difficulty hearing.
- Vision difficulty: blind or having serious difficulty seeing, even when wearing glasses.
- Cognitive difficulty: Because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions.
- Ambulatory difficulty: Having serious difficulty walking or climbing stairs.
- Self-care difficulty: Having difficulty bathing or dressing.
- Independent living difficulty: Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping.

(Source: American Community Survey 2013 5-Year Sample, Tables S18130)

	Supervisorial Districts											
Seniors Reporting Disabilities with Income Below Poverty Threshold	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Senior Population, 65+	11,455	9,708	13,621	11,822	9,915	7,933	11,823	7,579	8,933	7,982	12,359	113,130
Seniors Reporting Disabilities	4,357	3,085	5,901	4,151	4,192	4,344	3,597	2,416	3,461	3,152	4,579	43,235
Seniors Reporting Disabilities with income below the poverty threshold	765	460	1,858	252	1,199	1,566	500	525	495	433	602	8,655
% of Seniors with Disabilities with income below the poverty threhsold	17.6%	14.9%	31.5%	6.1%	28.6%	36.0%	13.9%	21.7%	14.3%	13.7%	13.1%	20.0%
Distribution, by District, of Seniors Reporting Disabilities with income below the poverty threshold	8.8%	5.3%	21.5%	2.9%	13.9%	18.1%	5.8%	6.1%	5.7%	5.0%	7.0%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table S18130												

Appendix D. Demographics of Adults with Disabilities by Supervisorial District

	Supervisorial Districts											
Population	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Adult Population (18 to 64) with Disabilities	3,441	1,422	3,599	2,929	4,355	6,951	2,272	3,295	4,076	4,371	4,298	41,009
Total Adult Population (18-64)	55,606	47,460	56,979	50,464	63,208	46,671	48,096	54,677	61,027	50,704	57,671	592,563
Adult Population (18 to 64) with Disabilities %	6.2%	3.0%	6.3%	5.8%	6.9%	14.9%	4.7%	6.0%	6.7%	8.6%	7.5%	6.9%
Distribution, by District, of Adults with Disabilities	8.4%	3.5%	8.8%	7.1%	10.6%	16.9%	5.5%	8.0%	9.9%	10.7%	10.5%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B18101)												
	Supervisorial Districts											
Gender, Adults (18 to 64) with Disabilities	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Male	1,547	802	1,944	1,559	2,207	4,903	1,194	2,287	2,403	2,019	1,935	22,800
Female	1,894	620	1,655	1,370	2,148	2,048	1,078	1,008	1,673	2,352	2,363	18,209
Female %	55%	44%	46%	47%	49%	29%	47%	31%	41%	54%	55%	44%
(Source: American Community Survey 2013 5-Year Sample, Table B18101)												
	Supervisorial Districts											
Ethnicity of Adult Population (18 to 64) with Disabilities	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
One race	3,269	1,393	3,429	2,798	4,017	6,576	2,208	3,057	3,932	4,115	4,125	38,919
One race %	95.0%	98.0%	95.3%	95.5%	92.2%	94.6%	97.2%	92.8%	96.5%	94.1%	96.0%	94.9%
African American	124	56	441	68	1,191	1,215	217	211	566	1,699	573	6,361
African American %	3.6%	3.9%	12.3%	2.3%	27.3%	17.5%	9.6%	6.4%	13.9%	38.9%	13.3%	15.5%
Asian/Pacific Islander	1,358	268	1,266	1,358	324	771	262	369	598	1,040	1,462	9,076
Asian/Pacific Islander %	39.5%	18.8%	35.2%	46.4%	7.4%	11.1%	11.5%	11.2%	14.7%	23.8%	34.0%	22.1%
Native American/Alaskan Native	72	20	11	0	60	148	14	0	118	139	0	582
Native American/Alaskan Native %	2.1%	1.4%	0.3%	0.0%	1.4%	2.1%	0.6%	0.0%	2.9%	3.2%	0.0%	1.4%
White (Alone)	1,625	1,015	1,643	1,334	2,233	3,597	1,655	2,291	2,022	940	1,460	19,815
White (Alone) %	47.2%	71.4%	45.7%	45.5%	51.3%	51.7%	72.8%	69.5%	49.6%	21.5%	34.0%	48.3%
Other race	90	34	68	38	209	845	60	186	628	297	630	3,085
Other race %	2.6%	2.4%	1.9%	1.3%	4.8%	12.2%	2.6%	5.6%	15.4%	6.8%	14.7%	7.5%
Two or more races	172	29	170	131	338	375	64	238	144	256	173	2,090
Two or more races %	5.0%	2.0%	4.7%	4.5%	7.8%	5.4%	2.8%	7.2%	3.5%	5.9%	4.0%	5.1%
Latino/Latina	261	113	170	162	454	1,538	291	607	1,598	728	1,343	7,265
Latino/Latina %	7.6%	7.9%	4.7%	5.5%	10.4%	22.1%	12.8%	18.4%	39.2%	16.7%	31.2%	17.7%
White (Alone, Not Hispanic)	1,560	936	1,543	1,246	2,020	3,011	1,438	1,894	1,201	578	757	16,184
White (Alone, Not Hispanic) %	45.3%	65.8%	42.9%	42.5%	46.4%	43.3%	63.3%	57.5%	29.5%	13.2%	17.6%	39.5%
Adult Population (18 to 64) with a Disability	3,441	1,422	3,599	2,929	4,355	6,951	2,272	3,295	4,076	4,371	4,298	41,009
(Source: American Community Survey 2013 5-Year Sample, Tables B17001A to B17001I)												

Supervisorial Districts												
Disability Characteristics* of Adult Population (18 to 64)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Hearing difficulty	535	408	648	422	497	707	525	633	592	765	924	6,656
Hearing %	15.5%	28.7%	18.0%	14.4%	11.4%	10.2%	23.1%	19.2%	14.5%	17.5%	21.5%	16.2%
Vision difficulty	514	343	802	324	597	1,545	413	580	775	808	763	7,464
Vision %	14.9%	24.1%	22.3%	11.1%	13.7%	22.2%	18.2%	17.6%	19.0%	18.5%	17.8%	18.2%
Cognitive difficulty	1,507	580	1,922	1,480	2,280	4,322	1,135	1,596	1,632	1,923	1,916	20,293
Cognitive %	43.8%	40.8%	53.4%	50.5%	52.4%	62.2%	50.0%	48.4%	40.0%	44.0%	44.6%	49.5%
Walking (Ambulation) difficulty	1,510	529	1,589	1,381	2,153	3,356	812	1,226	2,055	2,372	1,838	18,821
Walking (Ambulation) %	43.9%	37.2%	44.2%	47.1%	49.4%	48.3%	35.7%	37.2%	50.4%	54.3%	42.8%	45.9%
Self Care difficulty	823	182	681	581	886	1,035	369	623	710	1,112	991	7,993
Self Care %	23.9%	12.8%	18.9%	19.8%	20.3%	14.9%	16.2%	18.9%	17.4%	25.4%	23.1%	19.5%
Independent Living difficulty	1,306	443	1,333	1,064	1,798	2,405	823	1,261	1,387	1,999	1,631	15,450
Independent Living %	38.0%	31.2%	37.0%	36.3%	41.3%	34.6%	36.2%	38.3%	34.0%	45.7%	37.9%	37.7%
Adult Population (18 to 64) with Disabilities	3,441	1,422	3,599	2,929	4,355	6,951	2,272	3,295	4,076	4,371	4,298	41,009
Total Adult Population (18-64)	55,606	47,460	56,979	50,464	63,208	46,671	48,096	54,677	61,027	50,704	57,671	592,563

* The census disability definitions are:

- Hearing difficulty: deaf or having serious difficulty hearing.
- Vision difficulty: blind or having serious difficulty seeing, even when wearing glasses.
- Cognitive difficulty: Because of a physical, mental, or emotional problem, having difficulty remembering, concentrating, or making decisions.
- Ambulatory difficulty: Having serious difficulty walking or climbing stairs.
- Self-care difficulty: Having difficulty bathing or dressing.
- Independent living difficulty: Because of a physical, mental, or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping.

(Source: American Community Survey 2013 5-Year Sample, Table S1801

Supervisorial Districts												
Poverty Status of Adult Population with Disabilities (Estimates Based on Poverty Threshold)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Adults (18 to 64) with Disabilities below the poverty threshold	685	313	1,180	389	1,749	3,735	419	870	1,431	1,304	827	12,902
Total Adults (18 to 64) with Disabilities above the poverty threshold	2,636	1,109	2,340	2,540	2,584	3,128	1,731	2,425	2,645	2,999	3,471	27,608
Total Adults (18 to 64) with Disabilities for whom poverty status is determined	3,321	1,422	3,520	2,929	4,333	6,863	2,150	3,295	4,076	4,303	4,298	40,510
Total Adults (18 to 64) with Disabilities	3,441	1,422	3,599	2,929	4,355	6,951	2,272	3,295	4,076	4,371	4,298	41,009
% of Adults (18 to 64) with Disabilities in district with incomes below 100% PT	19.9%	22.0%	32.8%	13.3%	40.2%	53.7%	18.4%	26.4%	35.1%	29.8%	19.2%	31.5%
Distribution, by district, of Adults (18 to 64) with Disabilities <100% PT	5.3%	2.4%	9.1%	3.0%	13.6%	28.9%	3.2%	6.7%	11.1%	10.1%	6.4%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B18130)												

Supervisorial Districts												
Employment Status of Adults (20-64) with Disabilities in Poverty	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Employed	94	34	75	45	289	326	58	102	77	103	107	1,310
Employed %	14%	11%	6%	12%	17%	9%	14%	12%	5%	8%	13%	10%
Unemployed	60	25	101	36	139	275	49	72	135	192	91	1,175
Unemployed %	9%	8%	8%	9%	8%	7%	12%	8%	10%	15%	11%	9%
Not in labor force	531	240	1,004	302	1,308	3,123	311	696	1,191	972	629	10,307
Not in labor force %	78%	80%	82%	79%	75%	84%	74%	80%	85%	77%	76%	80%
Total Adults (20 to 64) with disabilities <100% FPL	685	299	1,228	383	1,736	3,724	418	870	1,403	1,267	827	12,840
Total Adults (20 to 64) with poverty status determined	3,291	1,408	3,560	2,904	4,243	6,852	2,149	3,270	3,998	4,236	4,284	40,195
% of Adults (20 to 64) with disabilities in this district with incomes below 100% PT	20.8%	21.2%	34.5%	13.2%	40.9%	54.3%	19.5%	26.6%	35.1%	29.9%	19.3%	31.9%
Distribution, by district, of Adults (20 to 64) with disabilities <100% PT	5.3%	2.3%	9.6%	3.0%	13.5%	29.0%	3.3%	6.8%	10.9%	9.9%	6.4%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table B23024)												

Appendix E. Demographics of Veterans by Supervisorial District

	Supervisorial Districts											
Population	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Adult Population (Age 18+)	67,249	57,268	70,632	62,358	73,274	55,470	60,127	62,305	69,986	58,879	70,116	707,664
Total Veteran Population (Age 18+	2,622	3,109	2,708	2,545	2,739	2,625	3,409	3,140	2,301	1,955	2,325	29,478
Adult Population (18 to 64) with Veteran Service %	3.9%	5.4%	3.8%	4.1%	3.7%	4.7%	5.7%	5.0%	3.3%	3.3%	3.3%	4.2%
Distribution, by District, of Veterans	9.5%	8.1%	10.0%	8.8%	10.4%	7.8%	8.5%	8.8%	9.9%	8.3%	9.9%	100.0%
(Source: American Community Survey 2013 5-Year Sample, Table S2101)												
	Supervisorial Districts											
Gender, Adult Veterans (18+)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Male	2,395	2,828	2,643	2,316	2,633	2,501	3,220	3,009	2,163	1,814	2,167	27,689
Female	227	281	65	229	106	124	189	131	138	141	158	1,789
Female %	9%	10%	2%	10%	4%	5%	6%	4%	6%	8%	7%	6%
(Source: American Community Survey 2013 5-Year Sample, Table S2101)												
	Supervisorial Districts											
Age, Adult Veterans (18+)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
All ages	2,622	3,109	2,708	2,545	2,739	2,625	3,409	3,140	2,301	1,955	2,325	29,478
Age 18 to 34	259	90	85	213	186	226	93	138	200	193	207	1,890
18 to 34 %	10%	3%	3%	8%	7%	9%	3%	4%	9%	10%	9%	6%
Age 35 to 54	541	490	487	517	570	921	463	643	555	551	666	6,405
35 to 54 %	21%	16%	18%	20%	21%	35%	14%	20%	24%	28%	29%	22%
Age 55 to 64	467	522	550	507	483	731	662	663	486	388	386	5,845
55 to 64 %	18%	17%	20%	20%	18%	28%	19%	21%	21%	20%	17%	20%
Age 65 to 74	584	945	592	489	535	429	816	828	488	388	550	6,644
65 to 74 %	22%	30%	22%	19%	20%	16%	24%	26%	21%	20%	24%	23%
Age 75 and older	771	1,062	994	819	965	319	1,375	868	572	435	516	8,697
75 and older %	29%	34%	37%	32%	35%	12%	40%	28%	25%	22%	22%	30%
Total 65+	1,355	2,007	1,586	1,308	1,500	749	2,191	1,696	1,060	823	1,066	15,342
Total 65+ %	52%	65%	59%	51%	55%	29%	64%	54%	46%	42%	46%	52%
(Source: American Community Survey 2013 5-Year Sample, Table S2101)												

	Supervisorial Districts											
Ethnicity of Veteran Population (18+)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
One race	2,553	3,046	2,676	2,477	2,640	2,545	3,313	3,069	2,105	1,860	2,263	28,548
One race %	97.4%	98.0%	98.8%	97.3%	96.4%	97.0%	97.2%	97.7%	91.5%	95.1%	97.3%	96.8%
African American	193	138	208	117	706	644	198	200	258	933	514	4,109
African American %	7.4%	4.4%	7.7%	4.6%	25.8%	24.5%	5.8%	6.4%	11.2%	47.7%	22.1%	13.9%
Asian/Pacific Islander	851	227	654	634	303	277	432	240	358	271	434	4,681
Asian/Pacific Islander %	32.5%	7.3%	24.1%	24.9%	11.1%	10.6%	12.7%	7.6%	15.6%	13.9%	18.7%	15.9%
Native American/Alaskan Native	14	21	0	31	25	7	0	16	25	65	24	228
Native American/Alaskan Native %	0.5%	0.7%	0.0%	1.2%	0.9%	0.3%	0.0%	0.5%	1.1%	3.3%	1.0%	0.8%
White (Alone)	1,485	2,618	1,804	1,617	1,555	1,581	2,625	2,529	1,329	493	1,055	18,691
White (Alone) %	56.6%	84.2%	66.6%	63.5%	56.8%	60.2%	77.0%	80.5%	57.8%	25.2%	45.4%	63.4%
Other race	10	42	10	78	51	36	59	84	135	98	236	840
Other race %	0.4%	1.4%	0.4%	3.1%	1.9%	1.4%	1.7%	2.7%	5.9%	5.0%	10.1%	2.8%
Two or more races	69	63	32	68	99	80	96	71	196	95	62	931
Two or more races %	2.6%	2.0%	1.2%	2.7%	3.6%	3.0%	2.8%	2.3%	8.5%	4.9%	2.7%	3.2%
Latino/Latina	77	177	111	186	136	113	247	248	568	216	535	2,615
Latino/Latina %	2.9%	5.7%	4.1%	7.3%	5.0%	4.3%	7.2%	7.9%	24.7%	11.1%	23.0%	8.9%
White (Alone, Not Hispanic)	1,434	2,536	1,693	1,553	1,470	1,517	2,479	2,394	1,021	432	742	17,271
White (Alone, Not Hispanic) %	54.7%	81.6%	62.5%	61.0%	53.7%	57.8%	72.7%	76.2%	44.4%	22.1%	31.9%	58.6%
Adult Veteran Population (Age 18+)	2,622	3,109	2,708	2,545	2,739	2,625	3,409	3,140	2,301	1,955	2,325	29,478
(Source: American Community Survey 2013 5-Year Sample, Tables B17001A to B17001I)												

	Supervisorial Districts											
Disability, Adult Veterans (18+)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
No Disability	1,964	2,352	1,940	1,787	1,837	1,418	2,675	2,394	1,732	1,424	1,764	21,287
Disability	658	757	768	758	902	1,207	734	746	569	531	561	8,191
Percent of Veteran Population with Disabilities	34%	32%	40%	42%	49%	85%	27%	31%	33%	37%	32%	38%
Distribution, by District, of Veterans with Disabilities	8%	9%	9%	9%	11%	15%	9%	9%	7%	6%	7%	100%
(Source: American Community Survey 2013 5-Year Sample, Table S2101)												

	Supervisorial Districts											
Poverty, Adult Veterans (18+)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Total**
Total Veteran Population above Poverty Threshold	2,475	2,891	2,375	2,370	2,351	1,817	3,273	2,814	2,000	1,782	2,162	26,310
Total Veteran Population below Poverty Threshold	147	218	333	175	388	808	136	326	301	173	163	3,168
Percent of Veteran Population below Poverty Threshold	6%	8%	14%	7%	17%	44%	4%	12%	15%	10%	8%	12%
Distribution, by District, of Veterans below Poverty Threshold	5%	7%	10%	6%	12%	26%	4%	10%	10%	5%	5%	100%
(Source: American Community Survey 2013 5-Year Sample, Table S2101)												

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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

Needs Assessment Part II – 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.[13] 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

[13] 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).

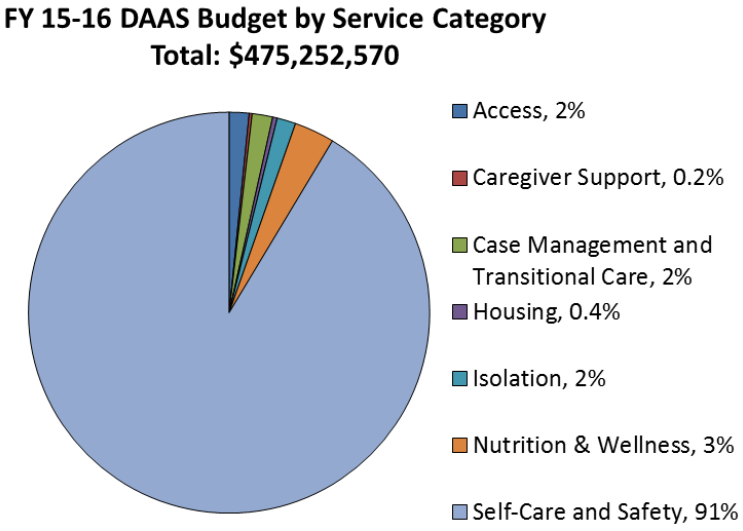
Overview of Service Areas

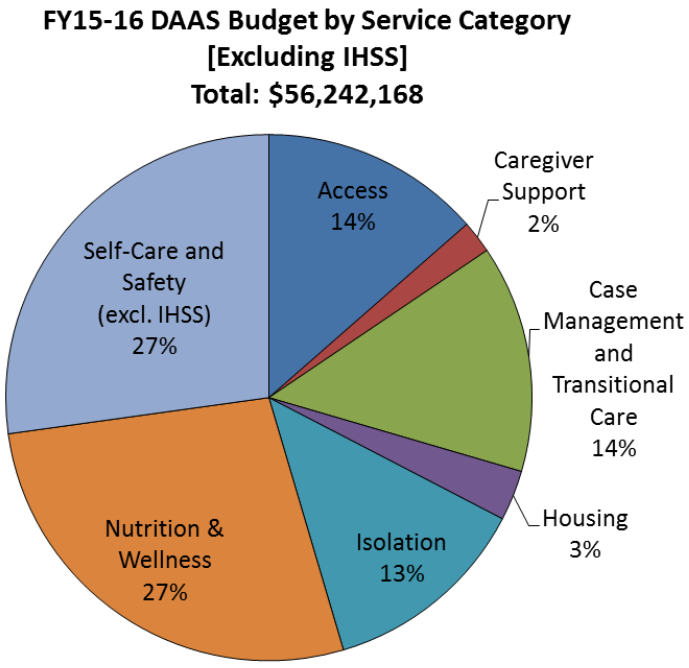
This report includes analysis of funding levels, focused on the direct cost of providing services. It does not include centralized administrative costs not associated with directly providing a service.[14] The FY 15-16 budget is based on original budgeted amount, while prior year data is based on expenditures (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,

[14] 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.

and Isolation Prevention each 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%

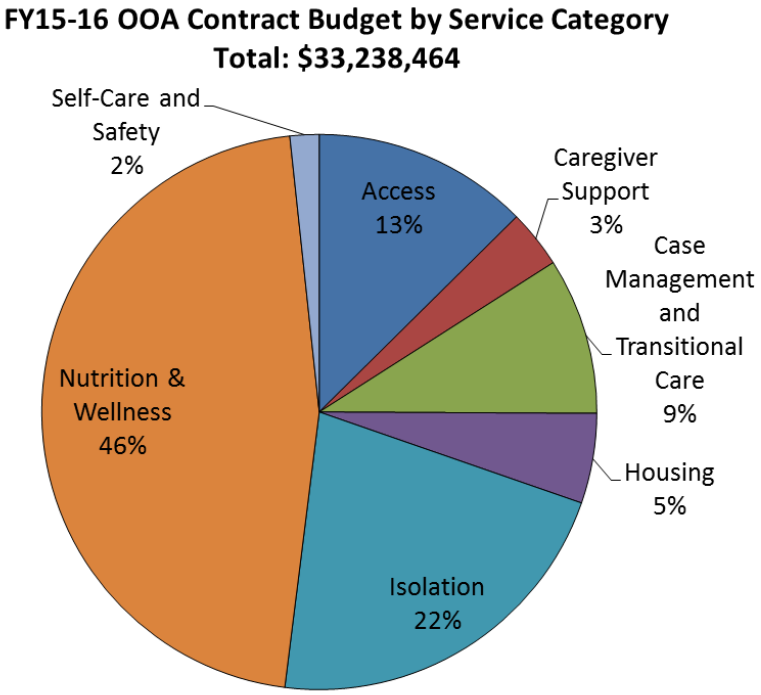
**Excluding IHSS, Self-Care and Safety budget is $2.2 million larger than FY 12-13 expenditures (17% increase for non-IHSS Self-Care and Safety services).*

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:

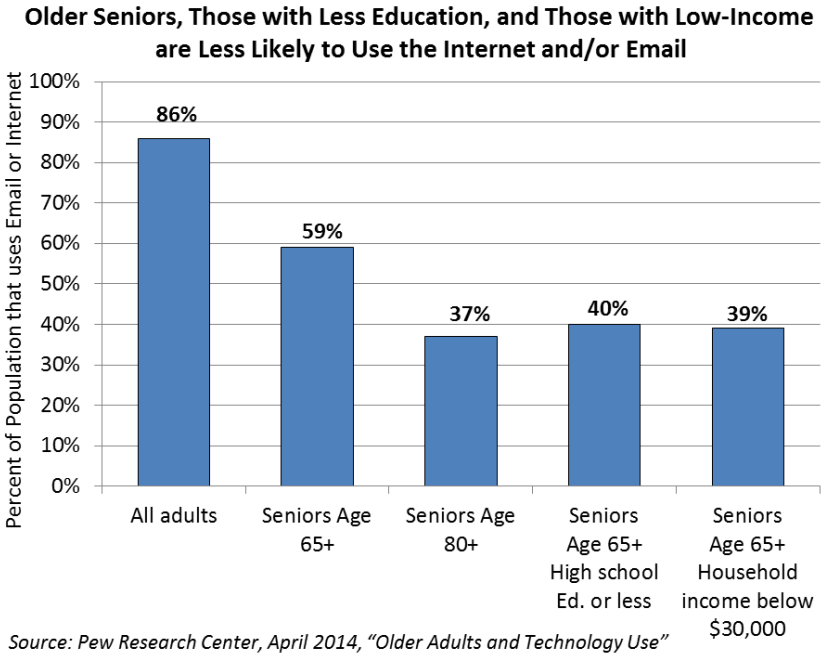
- Promote community awareness of services;
- Support clients to travel to receive services; and
- Provide advocacy and empowerment services to help clients access services to which they are entitled.

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.

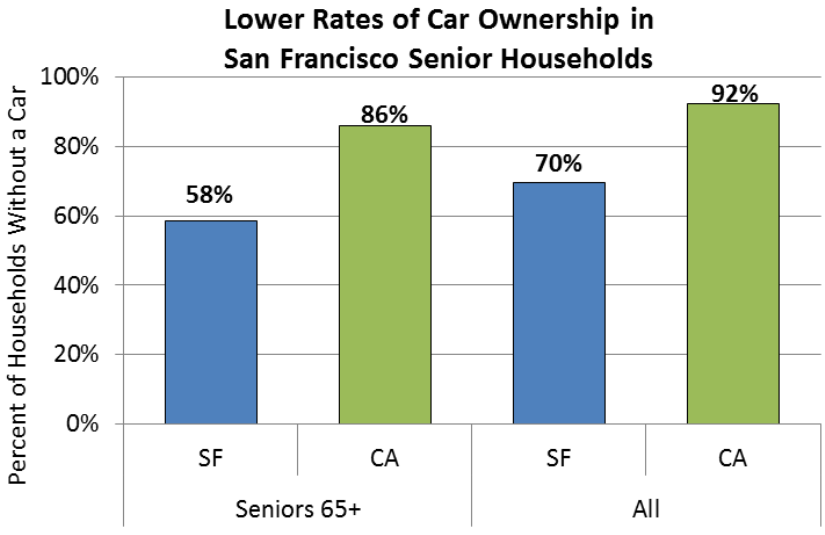
❖ ***Services Connection Program***

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. Perspectives on public



Source: ACS 2013 5-Year Estimates

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.

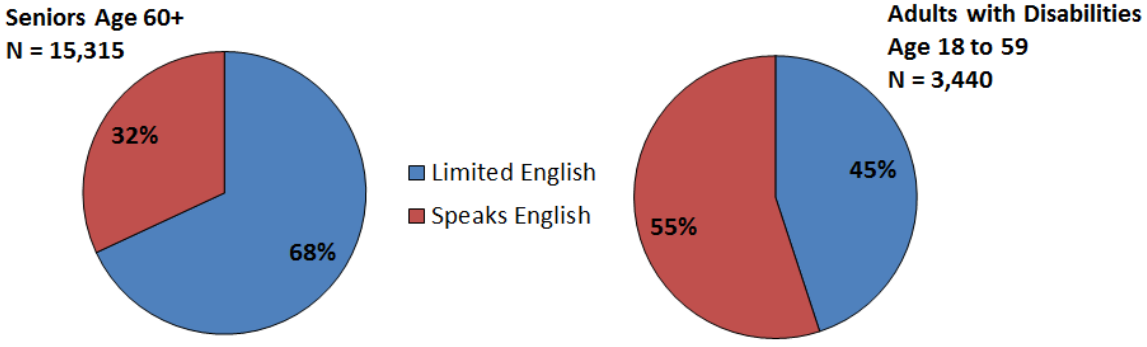
❖ ***Naturalization [OOA]***

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



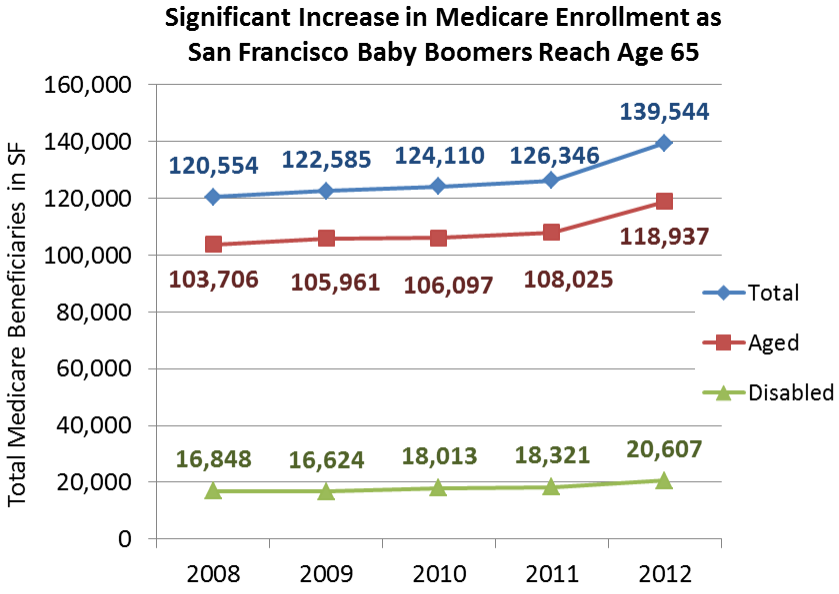
Source: IPUMS 2012 3-Year Samples

❖ ***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.

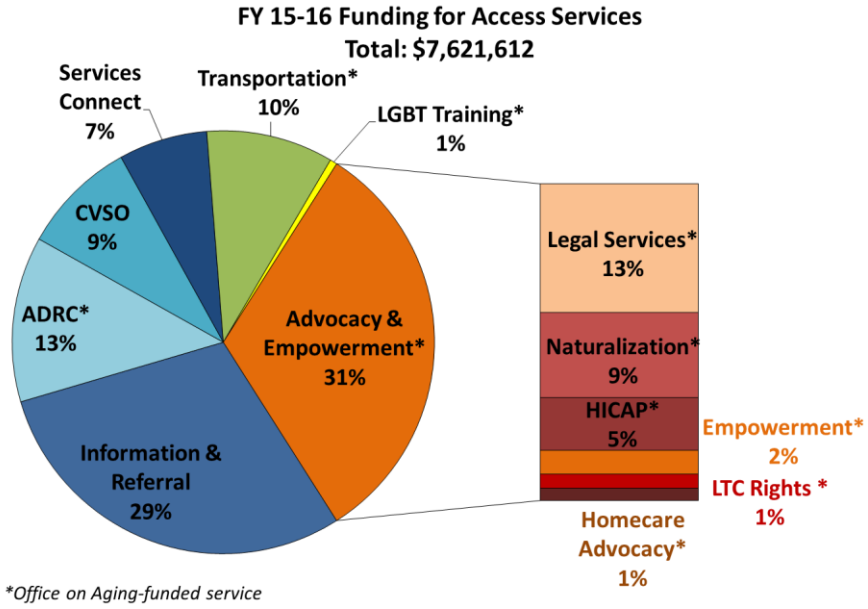
❖ ***LGBT Training [OOA]***

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

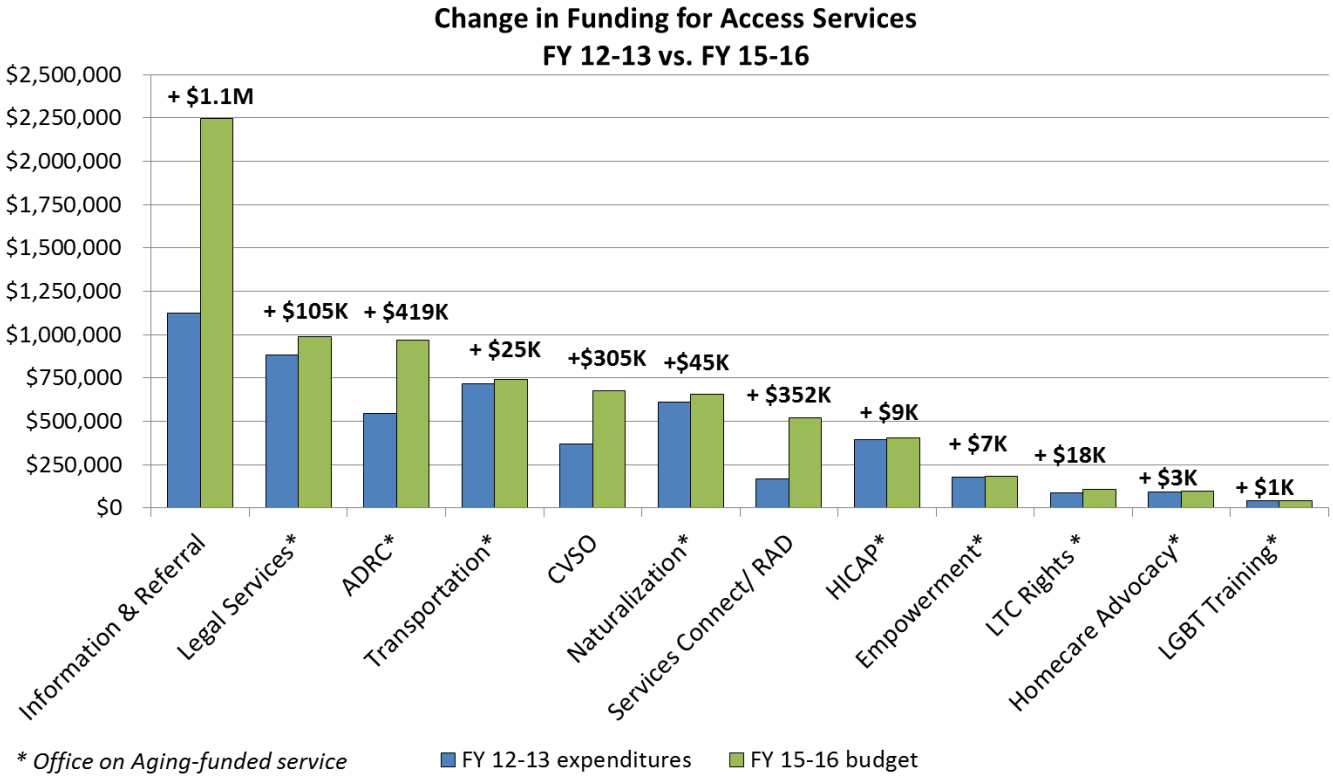
The DAAS budget for Access services in FY 15-16 is $7,621,612. As shown to the right, most of the Access funding goes to services supporting Information, Awareness, and Connection (in shades of blue). The largest single service is the DAAS Integrated Intake and Referral Unit, which accounts for 29% of 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.[15] This

[15] 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.[16] 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.

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

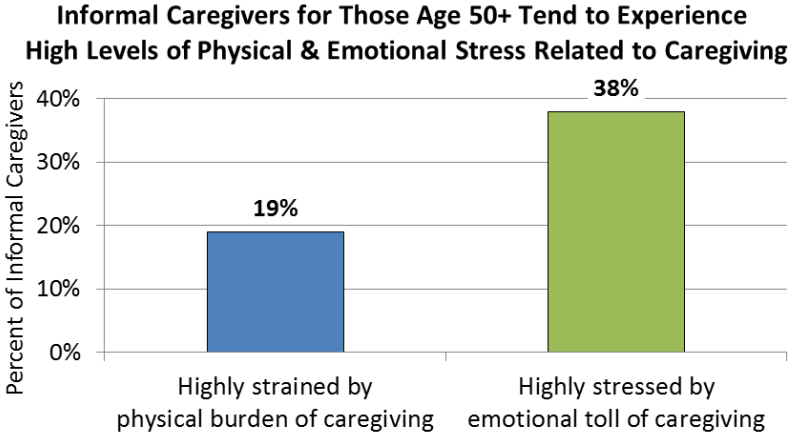
Caregiver Support

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.[17] 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.

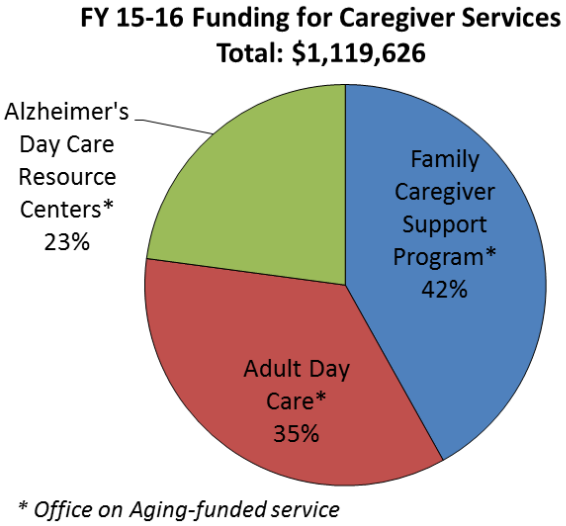
Recent Trends Impacting Caregiver Services

- **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.

[17] 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.

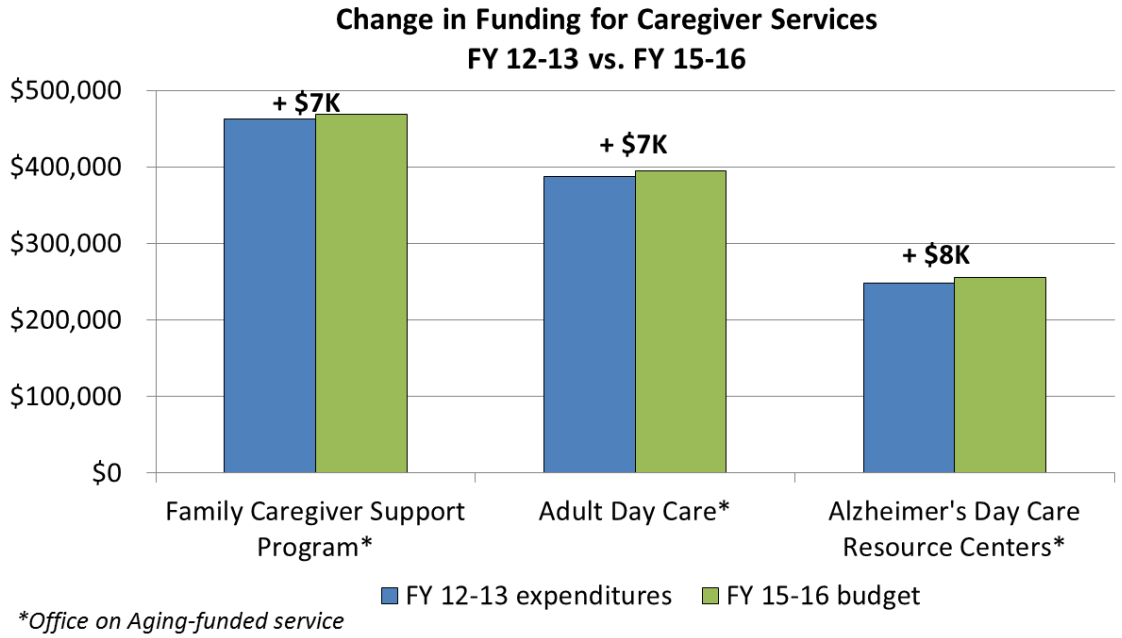
❖ ***Alzheimer's Day Care Resource Centers [OOA]***

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**.

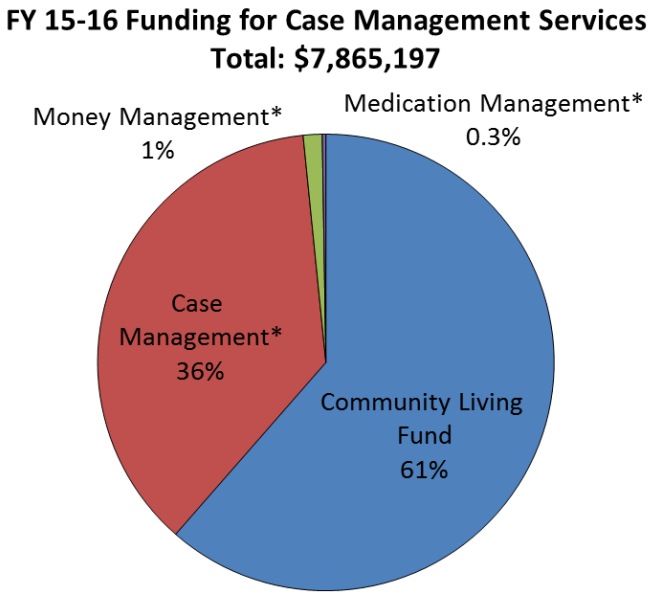
Unfortunately, this program has not been active since the demonstration project ended in May 2015. DAAS has replicated the program on a smaller scale targeted at IHSS applicants, serving a subset of those who likely need this type of support (the IHSS Care Transitions Program is described in more detail 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.

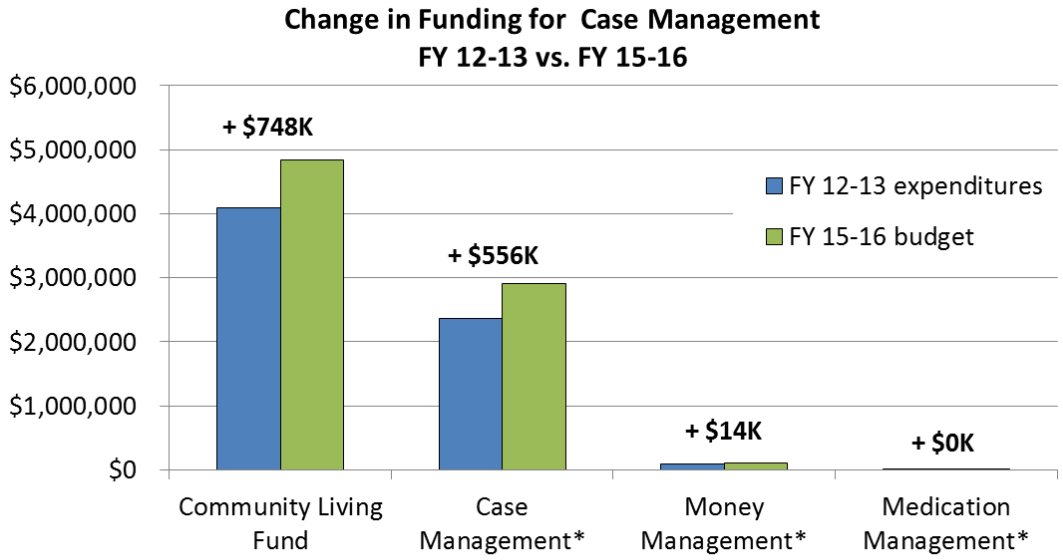
❖ ***Money Management [OOA]***
FY 15-16 Service Target: 105 clients
Money Management helps seniors and adults with disabilities in the daily management of their income and assets. This includes but is not limited to payment of rent and utilities, purchase of food and other necessities, and payment of 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.[18] 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 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

[18] 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.

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

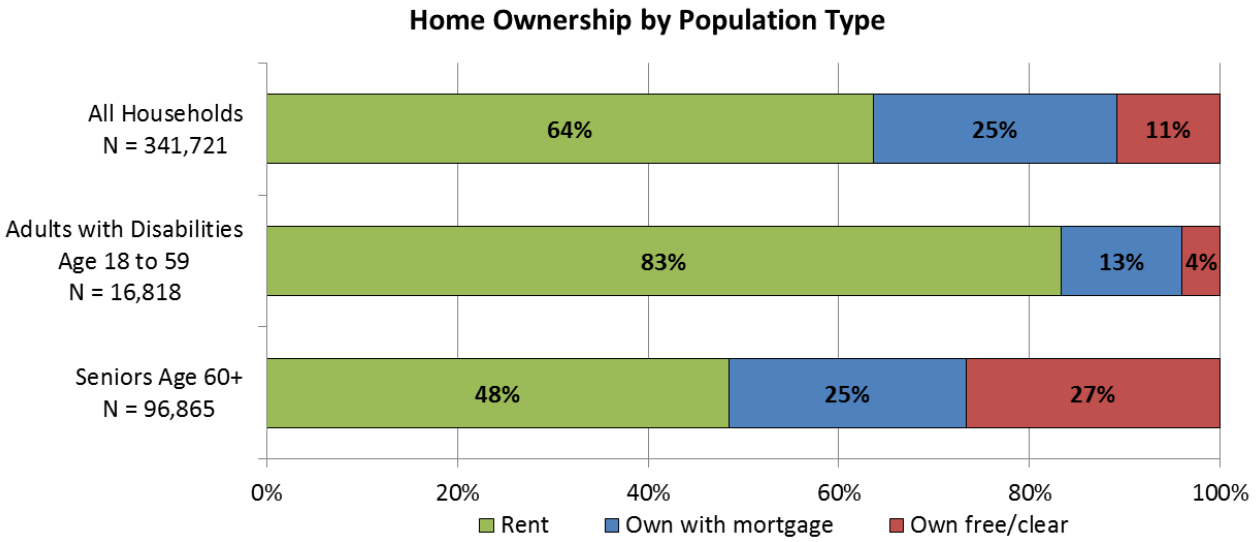
clients. The case management training institute can help orient less experienced case managers to the program but will not replace seasoned professionals or lessen service disruption for clients. DAAS should consider strategies to secure additional funding for the program and/or consider options for 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.[19] 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.[20] 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%.

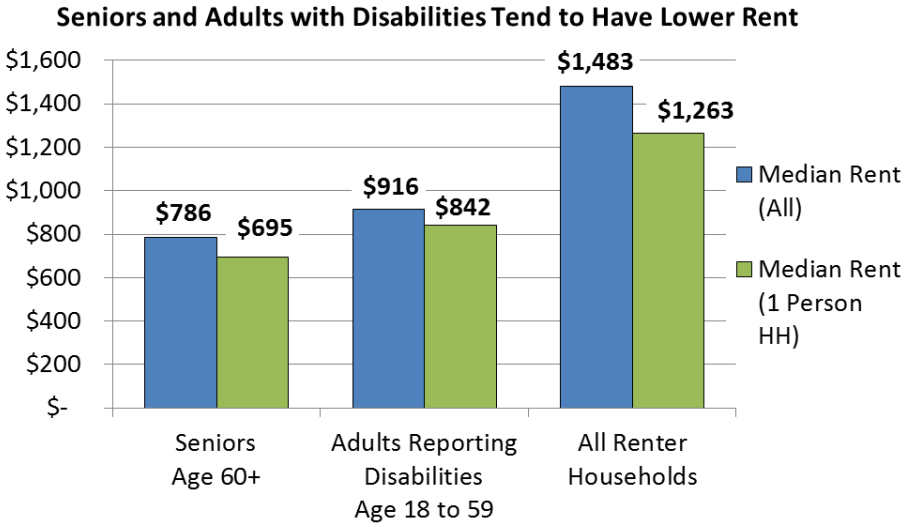


**Households categorized based on head of household*
Source: IPUMS 2012 3-Year Samples

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.

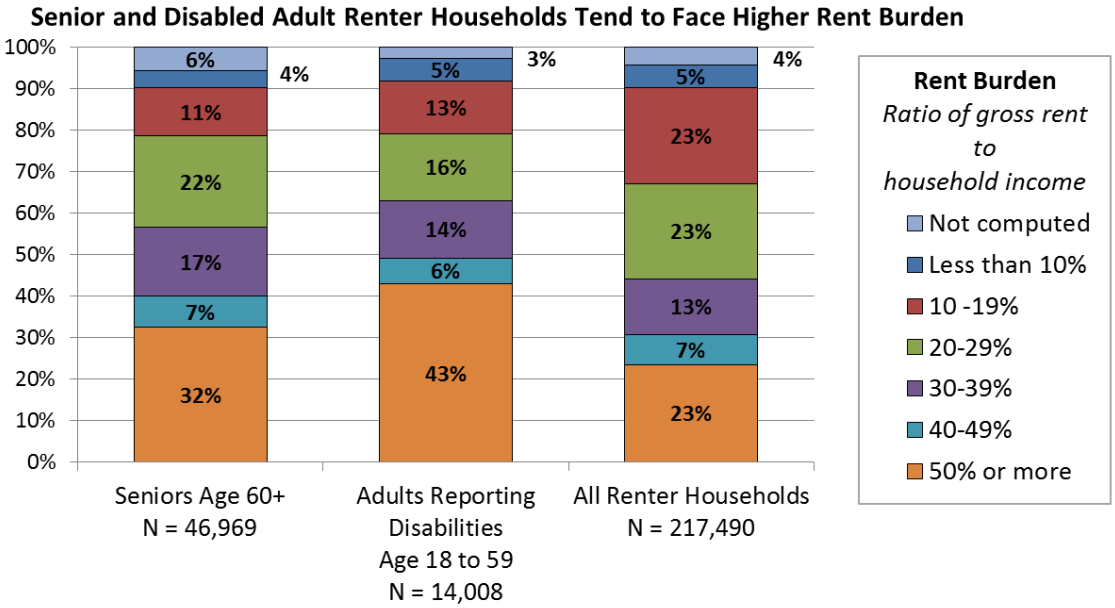
[19] Data from Zillow, a real estate service that tracks market rate trends. Estimates based on San Francisco and California median home value index as of December 2015.
[20] Rent data from Zillow, a real estate service that tracks market rate trends. Estimates based on San Francisco index as of December 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[21] 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

[21] 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

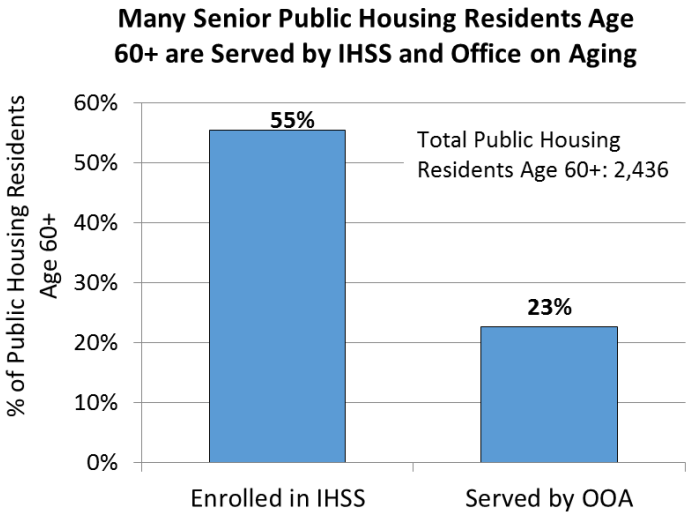
(Mayor's Office on Housing, 2013). A theme in senior focus groups, particularly among long-time homeowners, was concern that the potential onset of mobility impairments will force them to leave their homes as they age.

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.

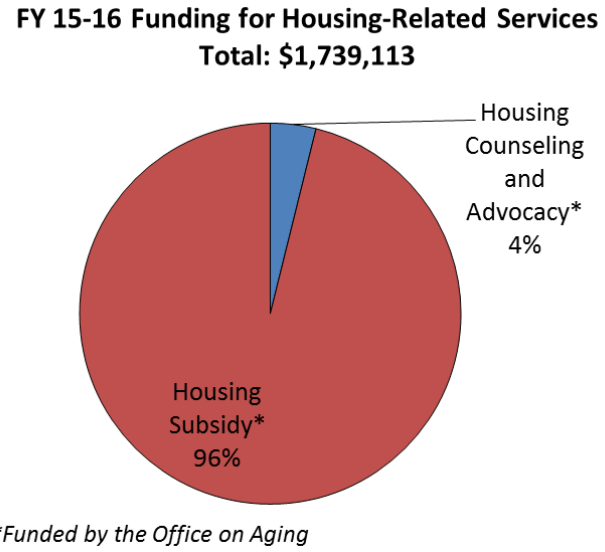
Trends related to Housing

- **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:

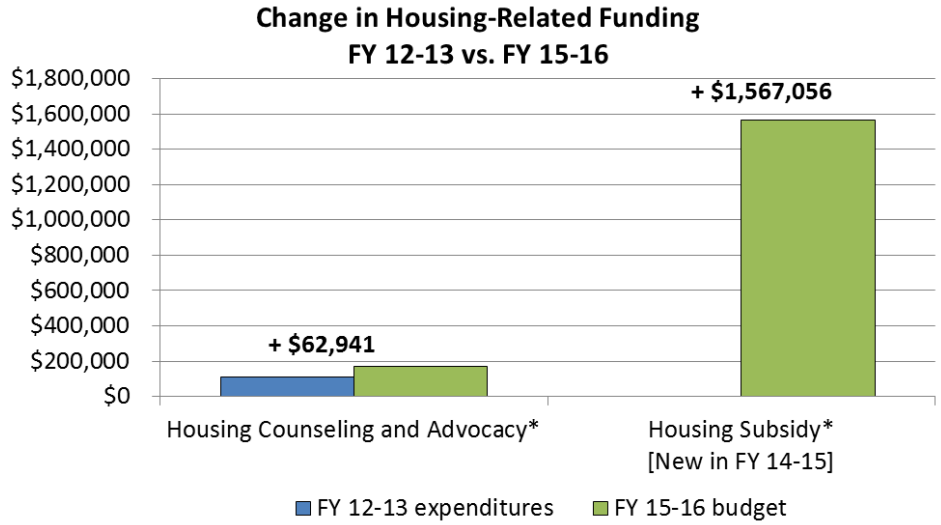
- Counseling assistance to individuals on tenant's rights and eviction prevention;
- Referrals to appropriate agencies for legal representation when necessary;
- Assistance with training counselors for emergency housing counseling
- Development and ongoing support of housing rights coalitions
- Hosting 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

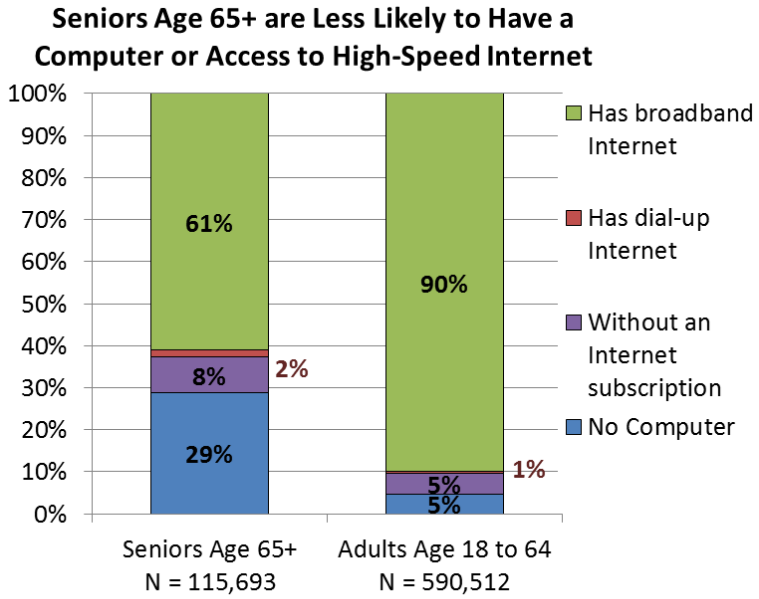
- **Unmet need for housing counseling and advocacy** – In FY 14-15, 419 clients received housing counseling, well over the contracted service level of 250 clients. The current service provider reports that they have to triage requests and refer clients to other agencies in order to keep up with demand. 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[22] 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.



Source: ACS 2013 1-Year Estimates

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).

San Francisco offers a rich variety of

[22] 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.

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.[23] 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

[23] 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.

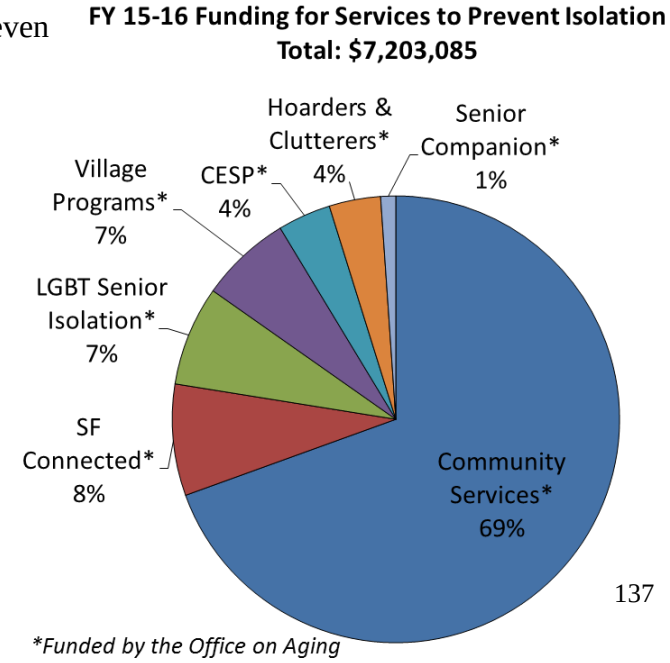
Trends Related to Isolation

- **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.

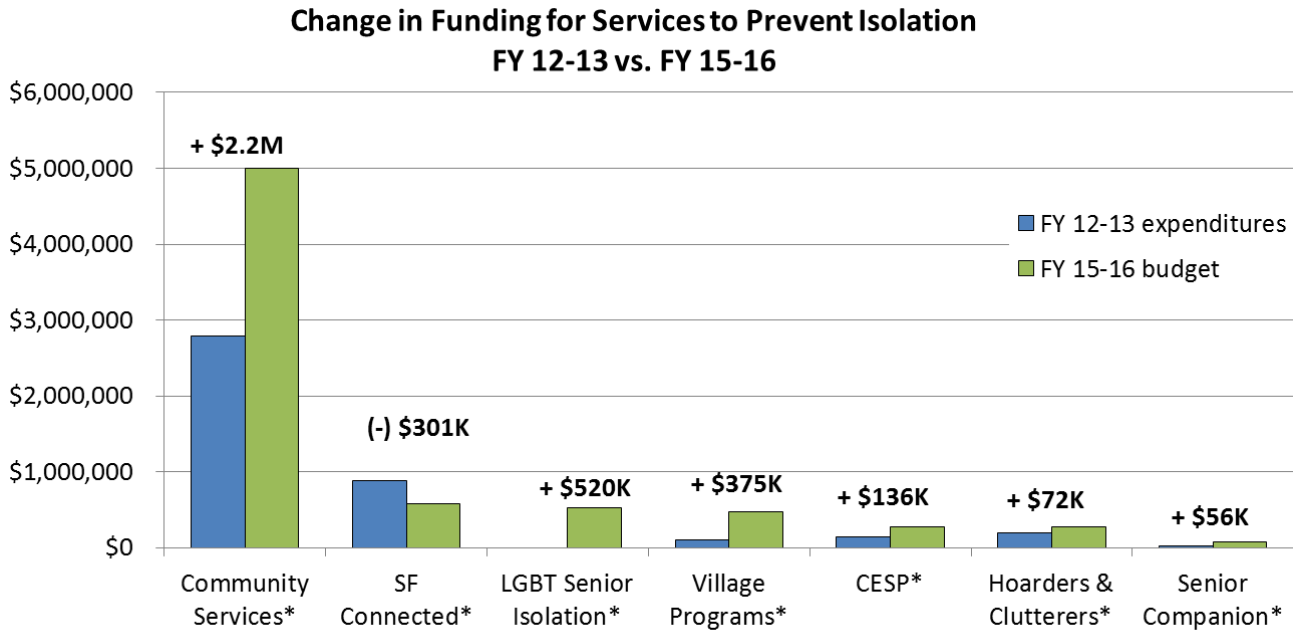
- ***Senior Companion [OOA]***
  FY 15-16 Service Targets: 15 volunteers, 75 clients

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.

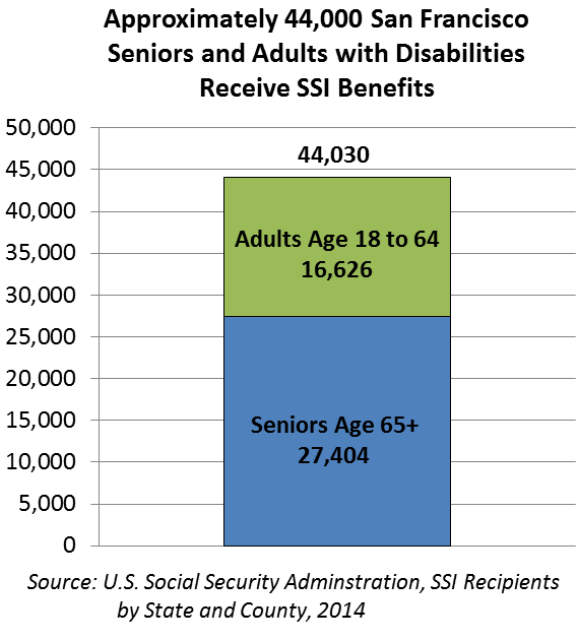
  DAAS may wish to re-assess the approach of serving younger adults with disabilities through senior sites. It may be more feasible in the current context to develop specific sites for this population. This group may prefer an alternate model for this type of support and engagement.

- **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).

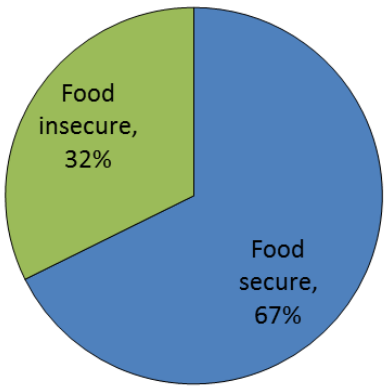
Food insecurity and subsequent malnutrition can contribute to poor health (Stuff et al, 2004). Malnutrition can lead to loss of weight and strength, greater susceptibility to disease, confusion, and disorientation (National Resource Center on Nutrition, Physical Activity, and Aging, 2015). Several of 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

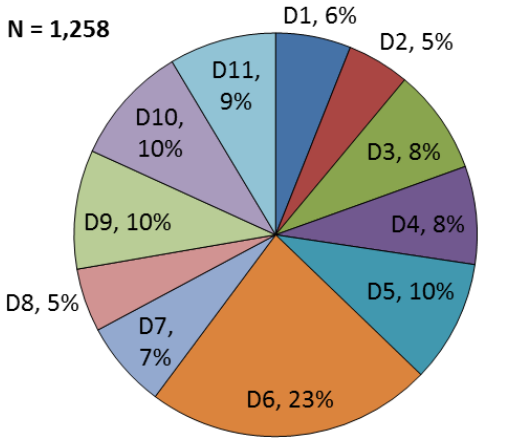
The 2015 City Survey indicates the following for senior and disabled adult respondents:

- 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.

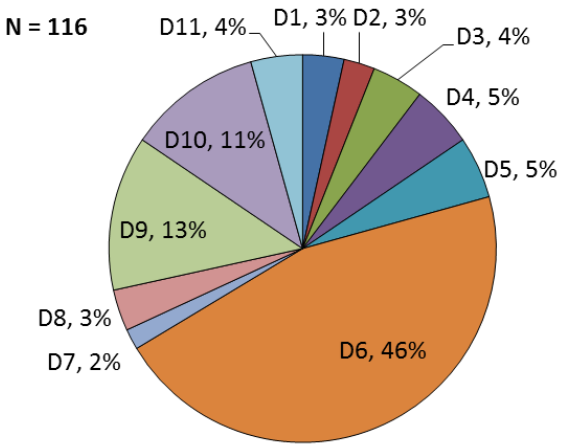
A review of the **FY 14-15 OOA Home-Delivered Meal waitlist data** suggests the need for HDM service is highest in District 6 for both seniors and adults with disabilities.[24] Demand for this service is also strong in Districts 9 and 10 for both groups, as well as in Districts 5 and 11 for the senior 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



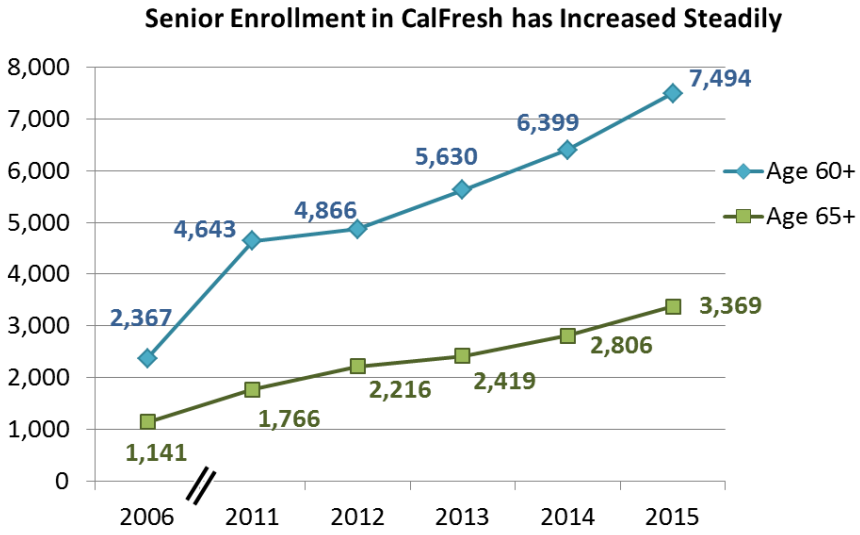
Source: IR2 and CA GetCare databases, FY 14-15

[24] 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

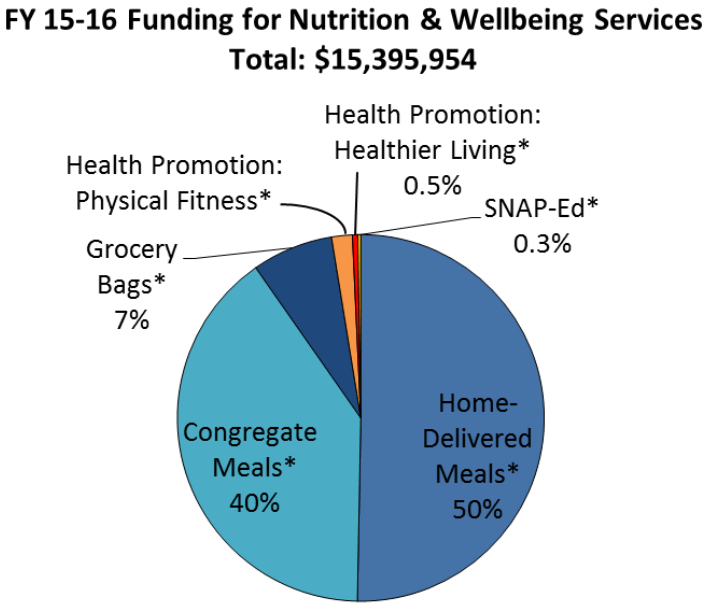
was passed after strong advocacy from the Food Security Task Force and the Tenderloin Hunger Task Force. This resolution required city agencies to report on unmet need for nutrition assistance and provide recommendations for how the city could better meet these needs. Annual status updates are provided 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.[25] 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*

[25] 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[26] 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

[26] 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

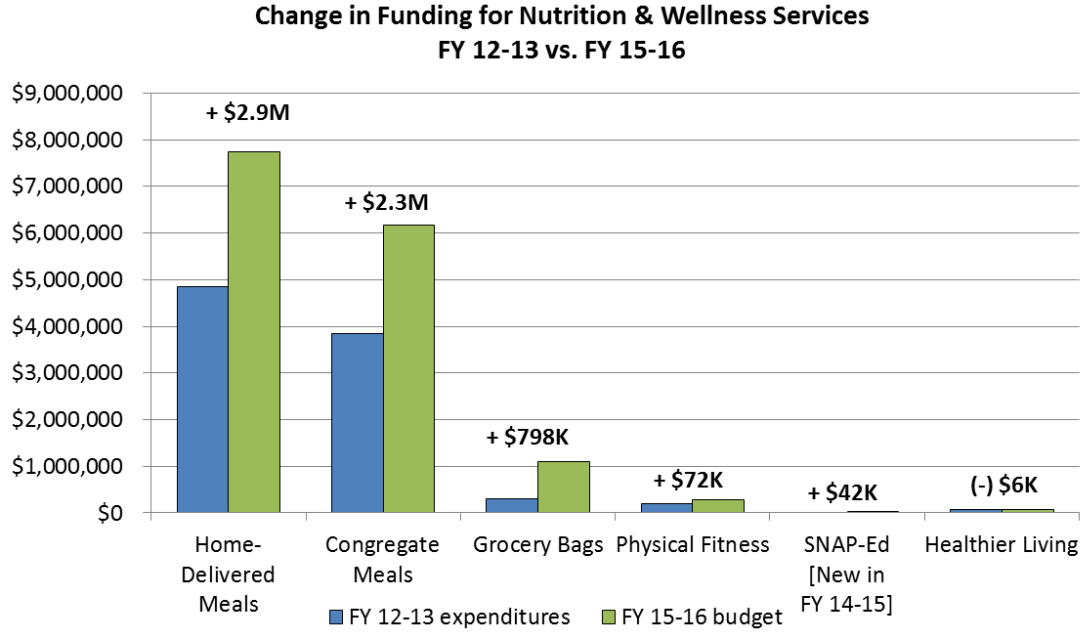
Adopted from Stanford University, this evidence-based program consists of community workshops over a period of six weeks to help people learn how to manage chronic disease. Course curriculum is focused on appropriate behavior modifications and coping strategies that enable participants to manage their 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.[27] 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.[28] Meal providers often overserve their contracts, leveraging

[27] Including those with independent living and ambulatory disabilities increases this estimate to 16,782.
[28] 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"[29] 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*

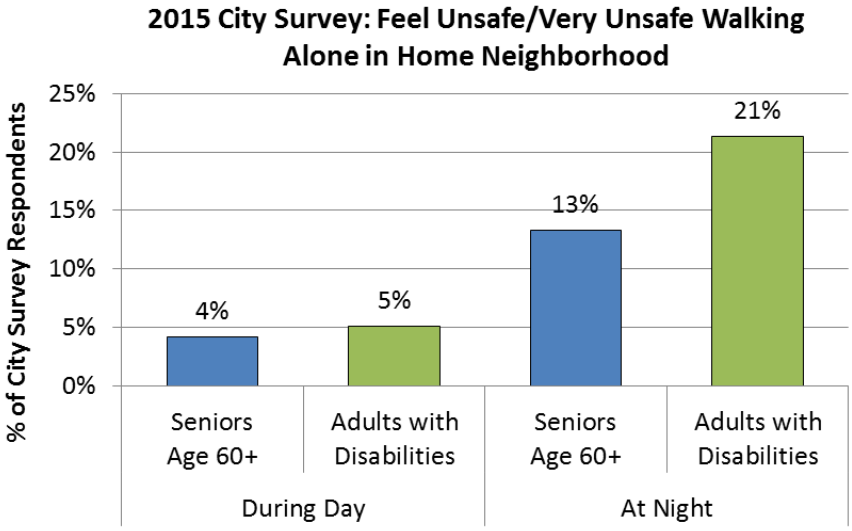
Seniors and adults with disabilities also expressed fear about crime but acknowledged this varied by neighborhood – the downtown areas (Tenderloin, Civic Center, and SOMA) were seen as the

[29] "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

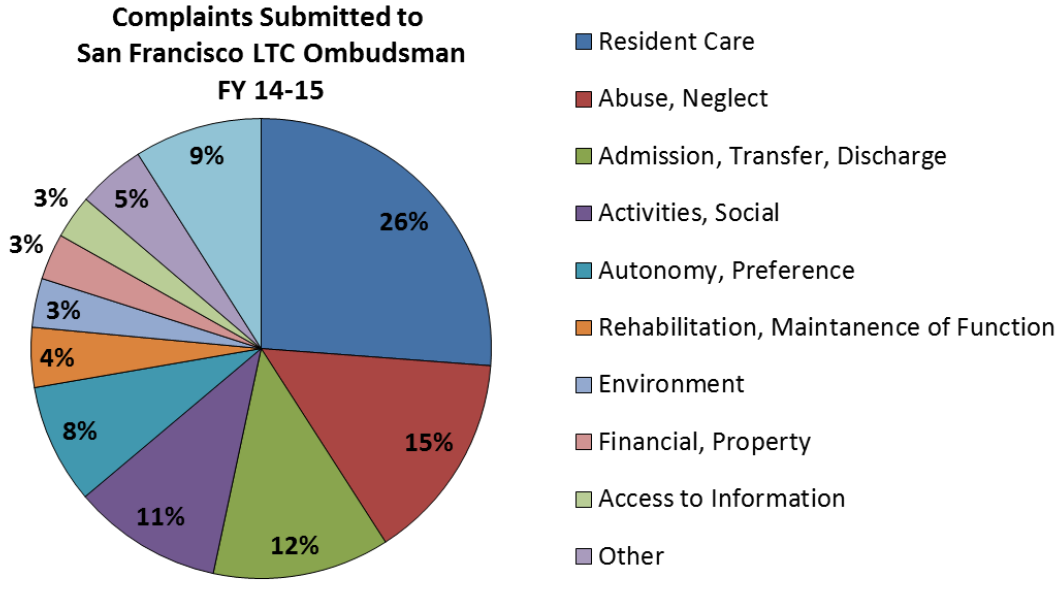
Many older persons reside, at least temporarily, in supportive out-of-home facilities. According to California's Office of Statewide Health Planning and Development records, there are 2,759 skilled nursing facility (SNFs) beds in San Francisco. Located in hospital and free-standing long-term care facilities, 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).

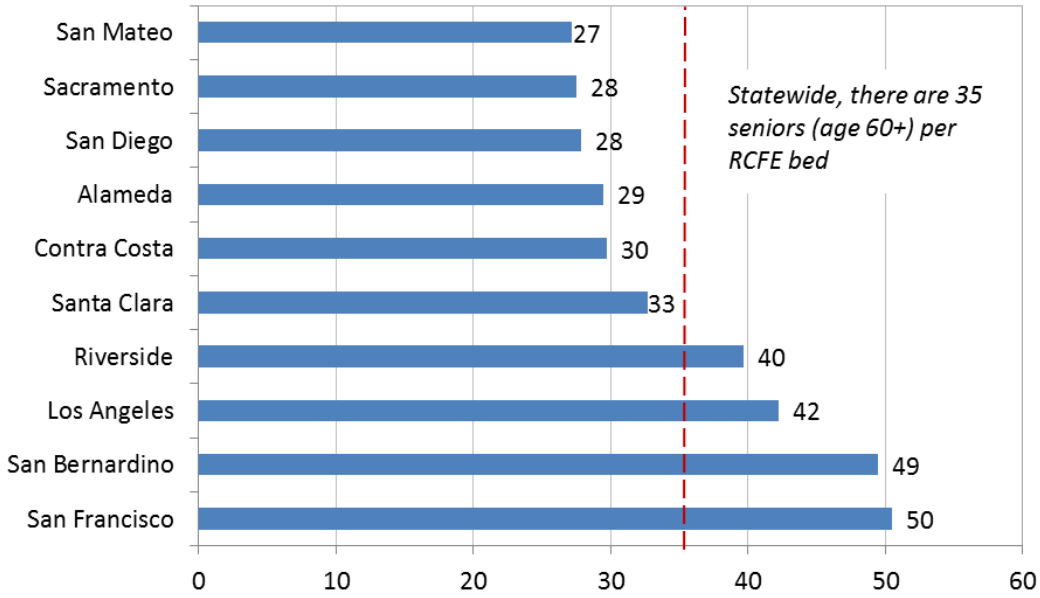
In FY 14-15, the office closed 360 cases, which involve more in-depth gathering of evidence and resolution support. Out of 523 complaints, most were related to resident care (26%), abuse and gross neglect (15%), and admission/transfer/discharge issues (12%). The LTC Ombudsman program resolved 70% of 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%)**.[30] 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.

Ratio of Seniors (60+) per Residential Care Facility for the Elderly Beds in 10 Select Large Counties



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**[31] (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.

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

[31] 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.

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

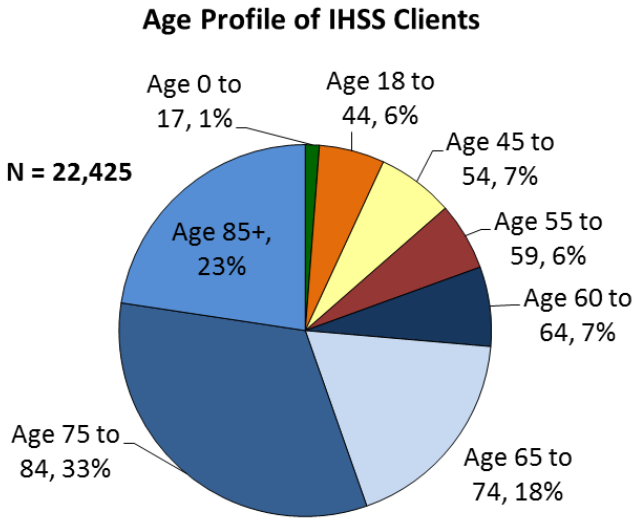
Self-Care & Safety: Support in the Home

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:[32]

- *Age*: Most (74%) are seniors age 65 and older.[33] 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



Source: DAAS Data Book June 2015

[32] Please see Appendix B for additional detail.

[33] 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.

younger adult population speaks English.

- *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.[34] 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

[34] 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.

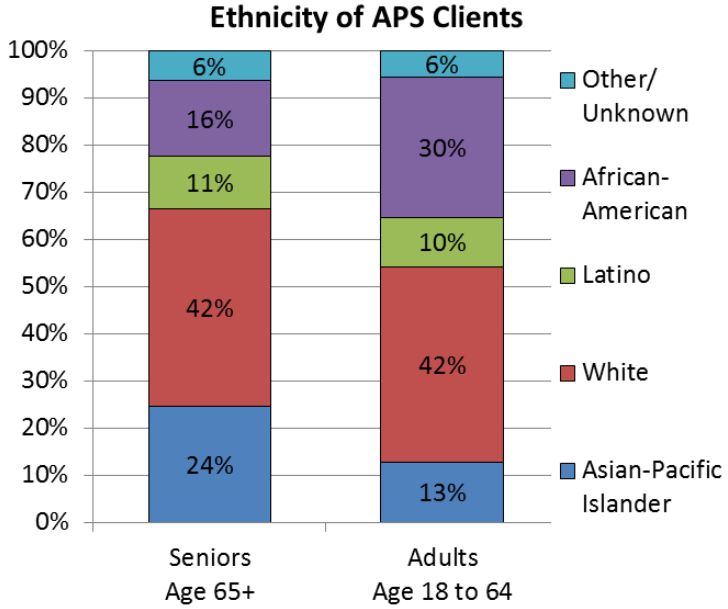
with abuse in institutional settings, underreporting makes it difficult to pinpoint the prevalence of abuse in the community. Older adults and persons with disabilities may be reluctant to report abuse by another person for fear of retaliation, lack of physical or cognitive ability to report, or concern 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:[35]

- *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



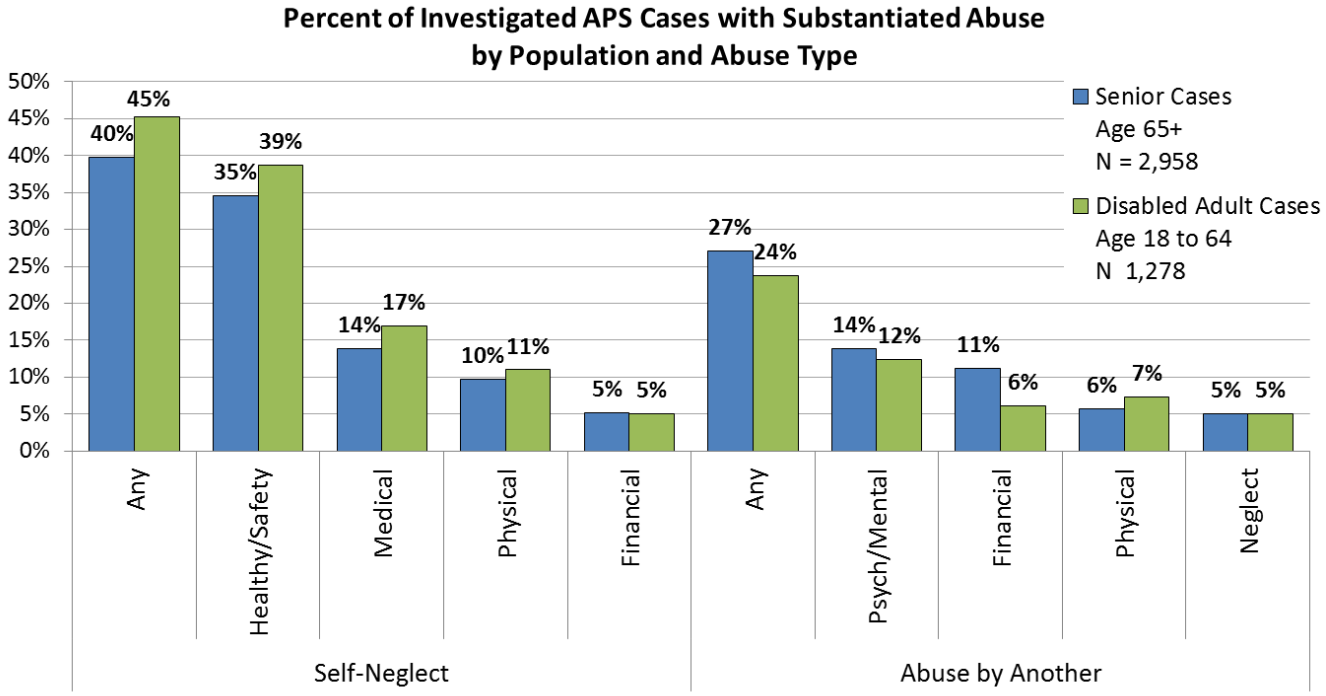
Source: AACTS database FY 14-15
Analysis based on unduplicated clients with 1+ report of abuse

[35] Please see Appendix C for additional detail.

disabled adults). Ten percent of 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.[36] 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

[36] 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).[37] 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.

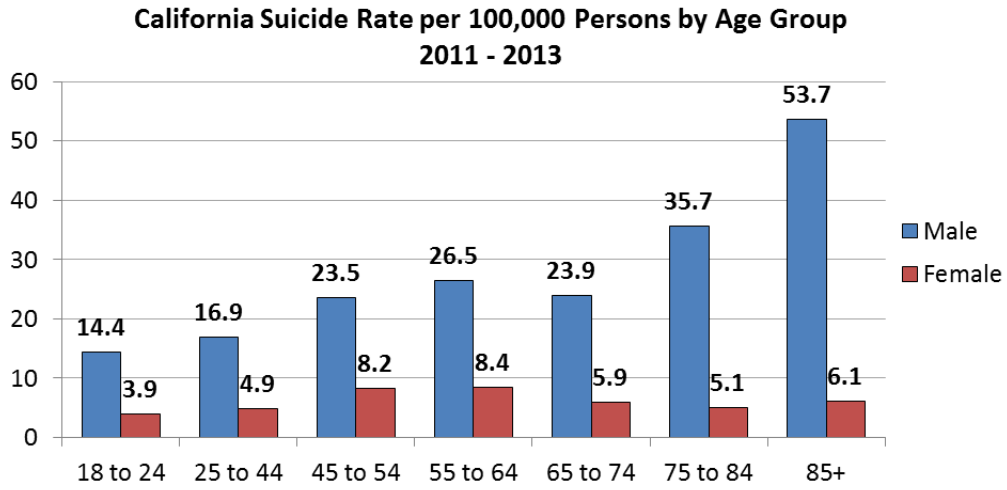
Self-Care & Safety: Social Isolation and Depression

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.

[37] 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.

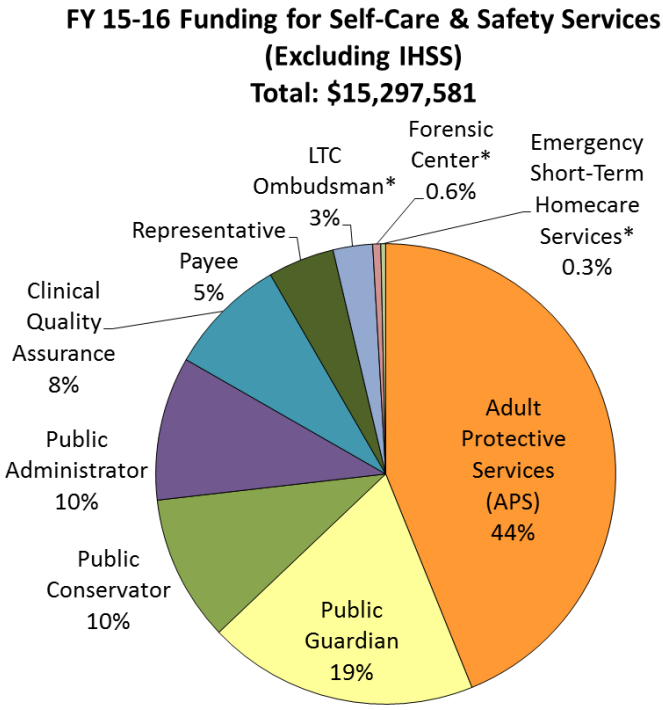
Recent Trends related to Self-Care and Safety

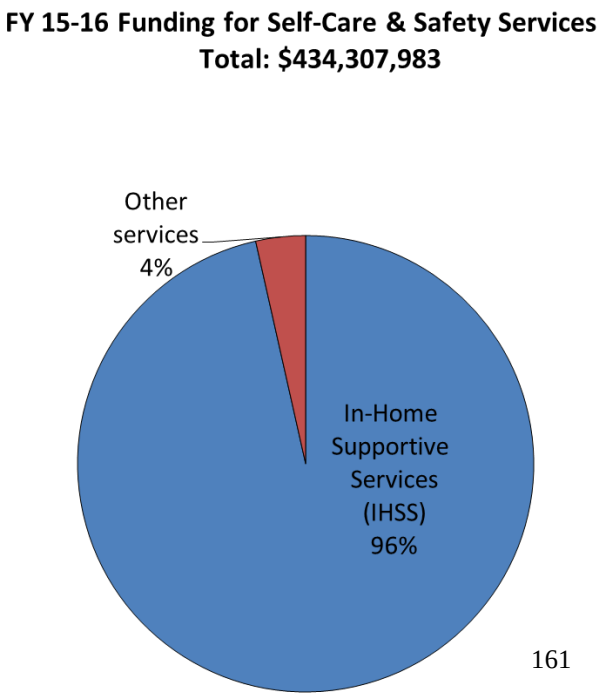
- **Traffic safety improvements** – In 2014, the San Francisco Municipal Transit Agency (SFMTA), Board of Supervisors, and Mayor Lee adopted a Vision Zero safety campaign aiming to eliminate all fatalities and major injuries from traffic collisions by 2024. Within the first two years of this campaign, 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.

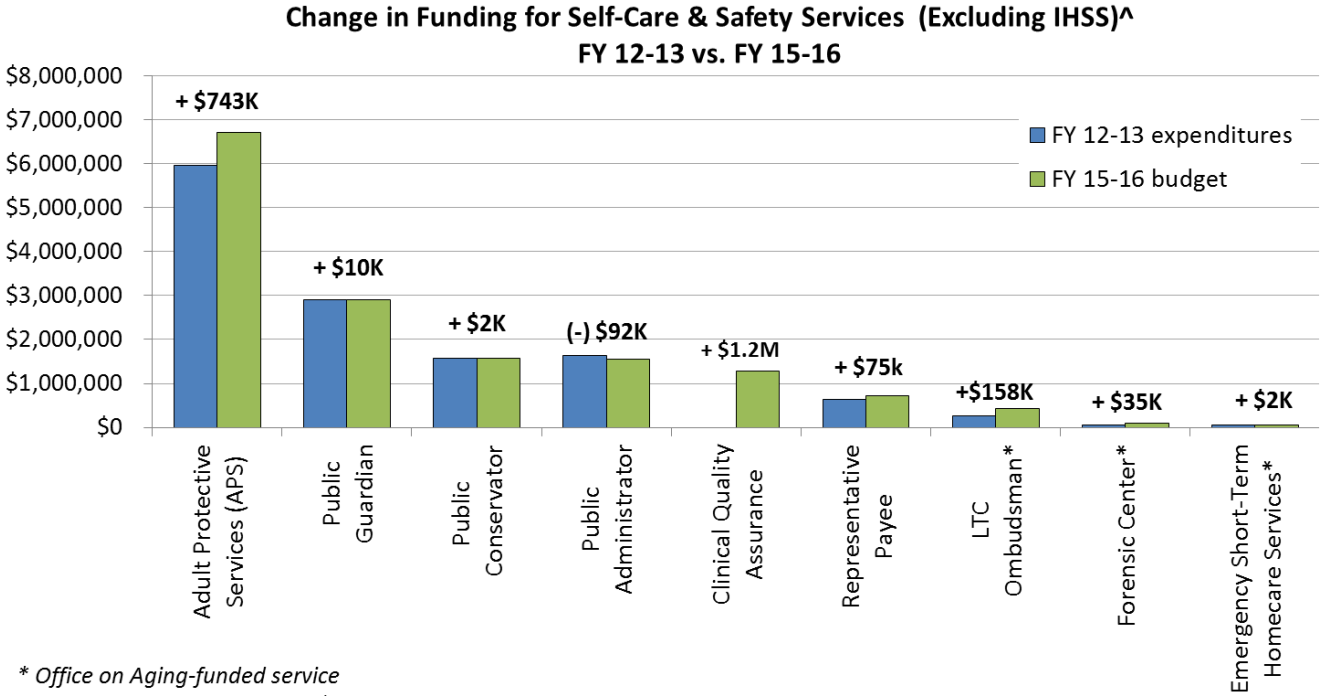
❖ ***Emergency Short-Term Homecare Services [OOA]***
FY 15-16 Service Target: 180 clients in each service

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.

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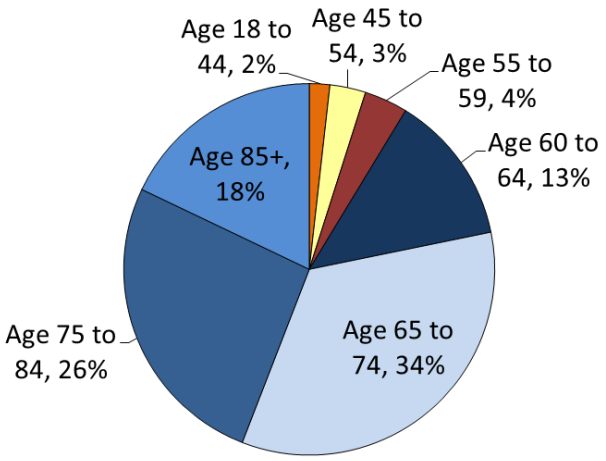
Appendix A. Client Profile – Office on Aging.

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

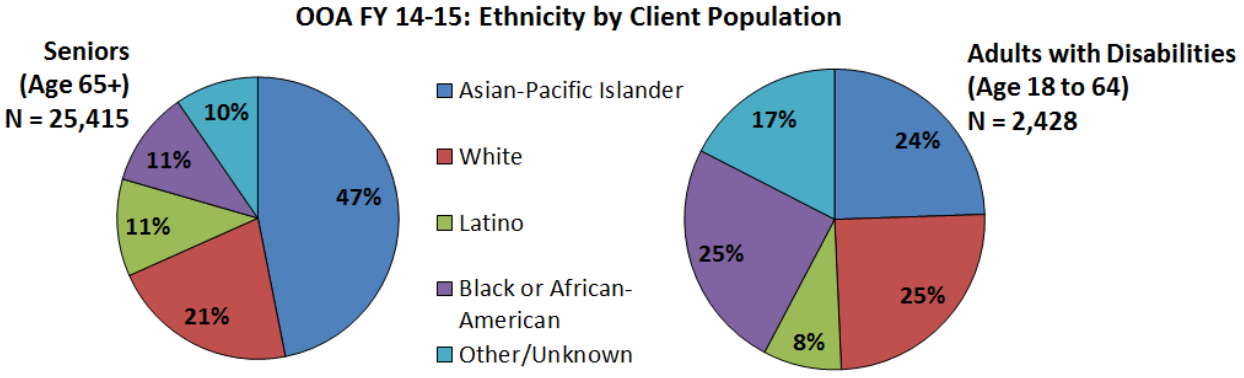
OOA FY 14-15: Clients by Age		
Age Group	**#**	**%**
Age 18 to 44	497	2%
Age 45 to 54	871	3%
Age 55 to 59	1,053	4%
Age 60 to 64	3,647	13%
Age 65 to 74	9,493	34%
Age 75 to 84	7,291	26%
Age 85+	4,991	18%
Total	27,843	100%

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%

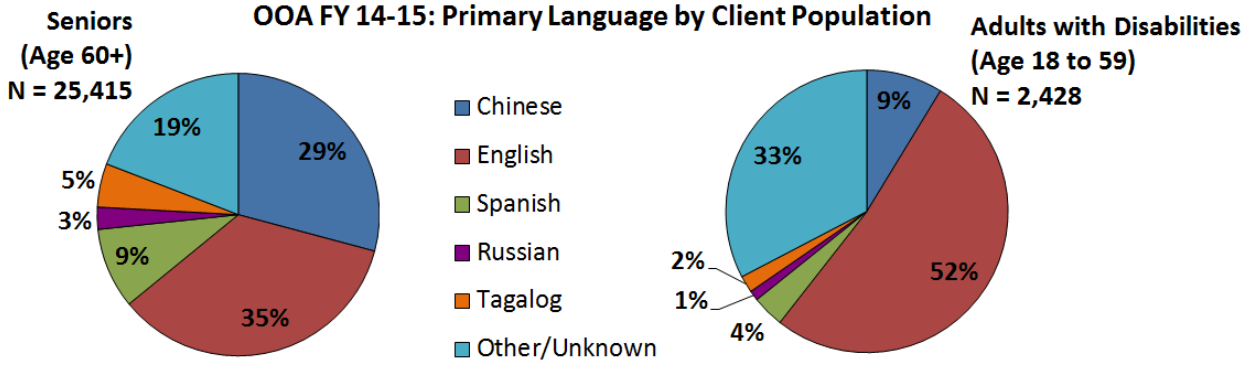
**LGBT subgroup total exceeds total LGBT, because sexual orientation varies among transgender persons.*

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%



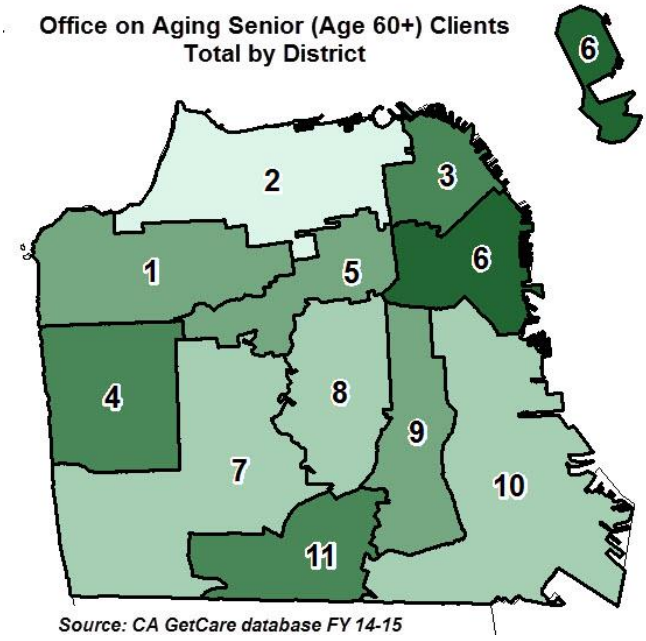
Source: CA GetCare database FY 14-15

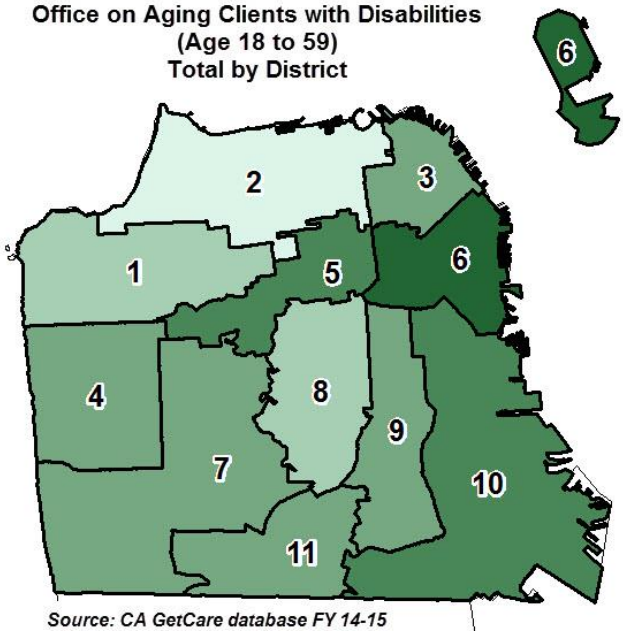
OOA FY 14-15: Primary Language by Population Type						
Primary Language	Senior Age 60+		AWD Age 18 to 59		All	
	#	%	#	%	#	%
Chinese	7,411	29%	212	9%	7,623	27%
English	8,880	35%	1,259	52%	10,139	36%
Spanish	2,345	9%	89	4%	2,434	9%
Russian	644	3%	28	1%	672	2%
Tagalog	1,267	5%	47	2%	1,314	5%
Other/Unknown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

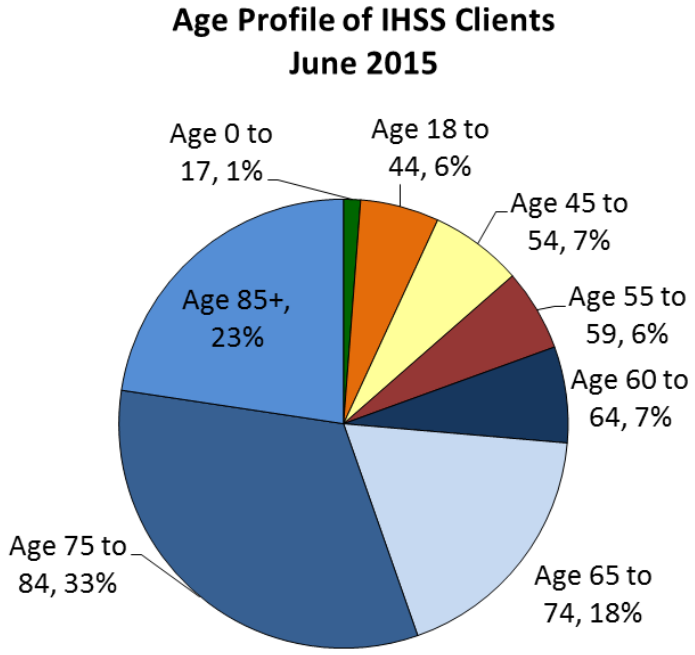
**Clients are not required to disclose their home address*

^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).

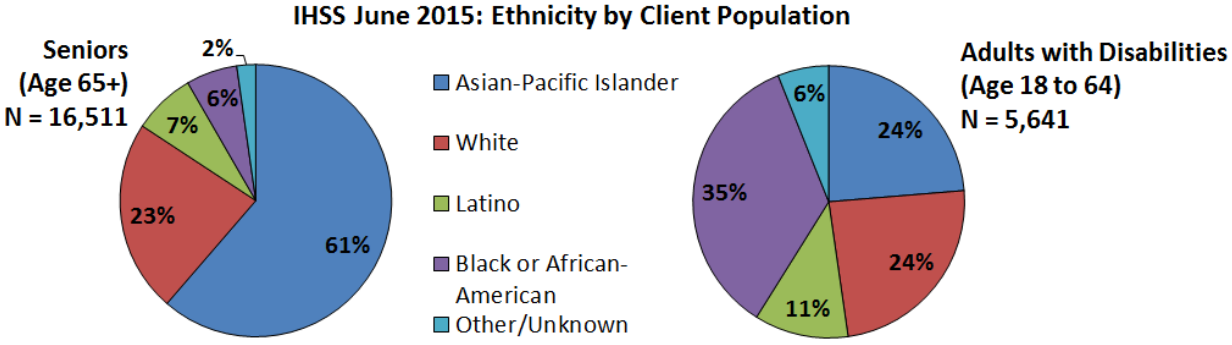


Source: CMIPS II database June 2015

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%

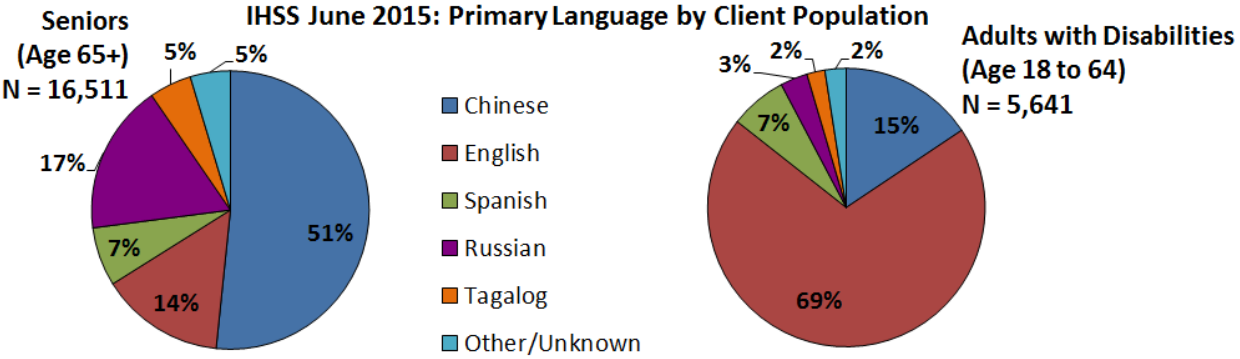
IHSS June 2015: Gender by Population Type						
Gender	**Senior Age 65+**		**AWD Age 18 to 64**		**All**	
	#	**%**	**#**	**%**	**#**	**%**
Female	10,912	66%	2,831	50%	13,743	62%
Male	5,599	34%	2,810	50%	8,409	38%
Total	16,511	100%	5,641	100%	22,152	100%

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%



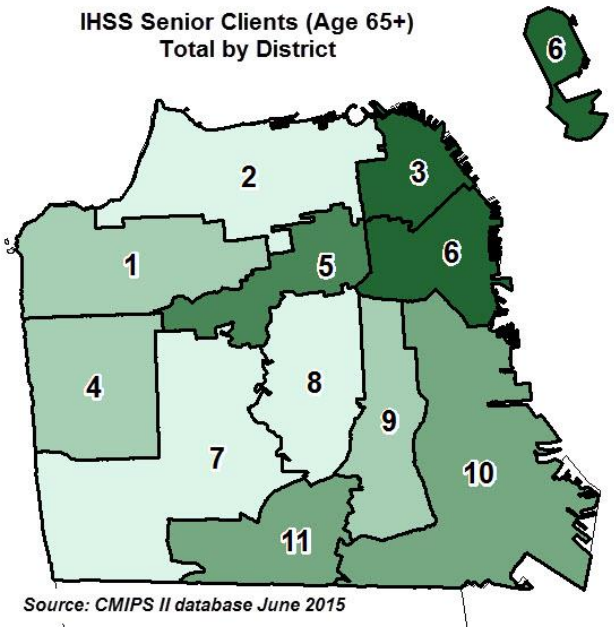
Source: CMIPS II database

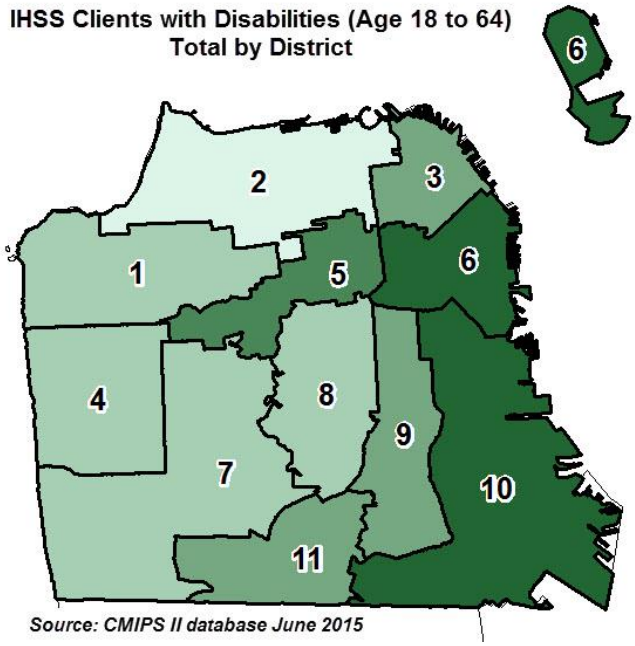
IHSS June 2015: Primary Language by Population Type						
Primary Language	Senior Age 65+		AWD Age 18 to 64		All	
	#	%	#	%	#	%
Chinese	8,356	51%	868	15%	9,224	42%
English	2,341	14%	3,887	69%	6,228	28%
Spanish	1,108	7%	369	7%	1,477	7%
Russian	2,822	17%	176	3%	2,998	14%
Tagalog	798	5%	117	2%	915	4%
Other/Unknown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

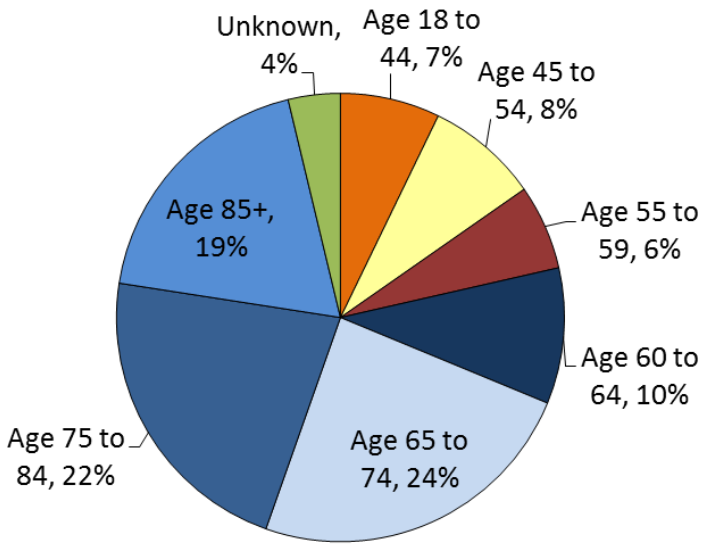
This section describes unduplicated clients with at least one report of abuse to Adult Protective Services (APS) in FY 14-15. A single case may have several associated reports of abuse, and a single client may have more than one case open throughout the year. All reports of abuse are investigated.

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



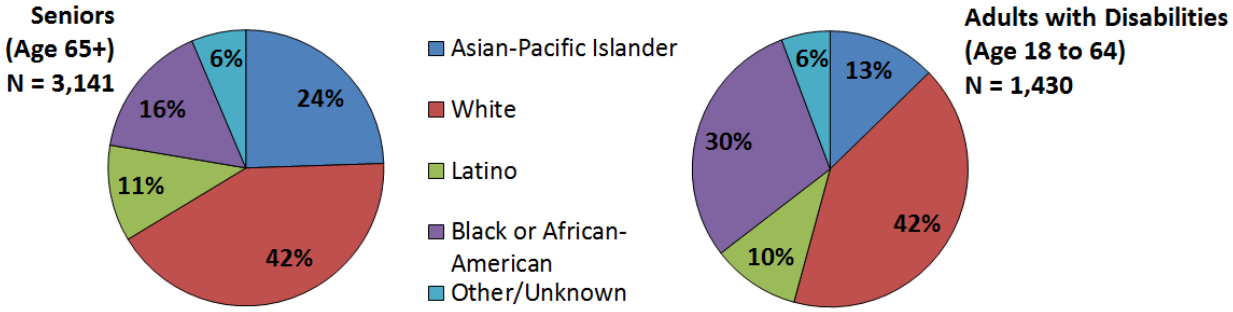
Source: AACTS database FY 14-15

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%

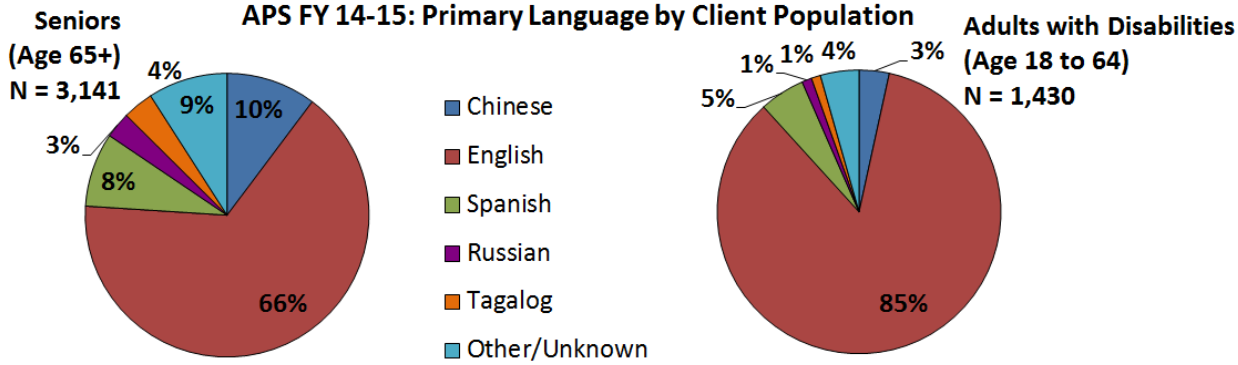
APS FY 14-15: Ethnicity by Client Population



Source: AACTS database FY 14-15

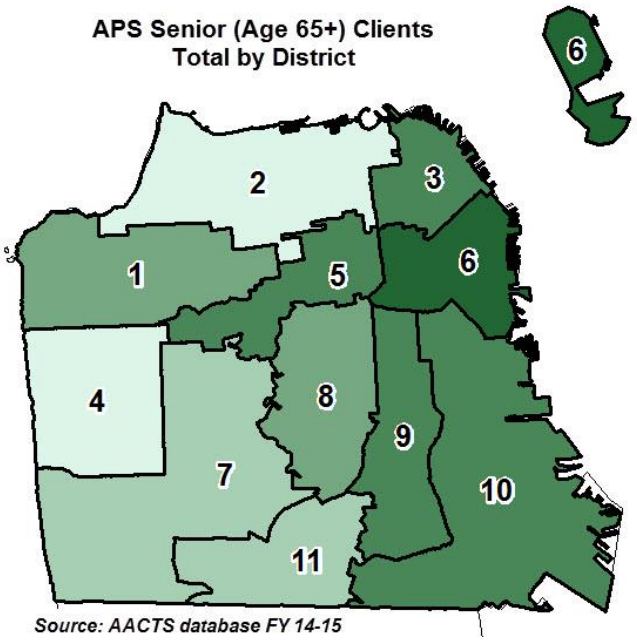
APS FY 14-15: Primary Language by Population Type						
Primary Language	Senior Age 65+		AWD Age 18 to 64		All	
	#	%	#	%	#	%
Chinese	322	10%	49	3%	371	8%
English	2,066	66%	1,214	85%	3,280	72%
Spanish	265	8%	74	5%	339	7%
Russian	93	3%	16	1%	109	2%
Tagalog	110	4%	15	1%	125	3%
Other/Unknown	285	9%	63	4%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

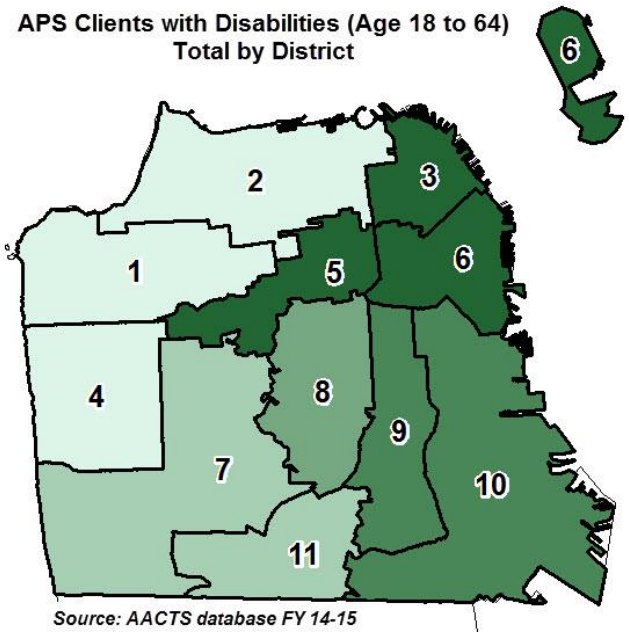
APS FY 14-15: Primary Language by Client Population



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%





SECTION 6. TARGETING

This section describes services provided to those populations served by the Office on the Aging, and targeted by the Older Americans Act, which mandates that services are directed to older individuals with the greatest economic or social need and those who are at risk for institutional placement. The Act indicates that particular attention should be given to minority populations, those who are low-income, minorities, and/or persons with limited English proficiency. Guidance from the Administration on Aging outlines that "greatest social need" includes isolation caused by racial or ethnic status but also extends to isolation caused by other factors, such as minority religious affiliation, sexual orientation, and gender identity.

Populations Served

During FY 2014-15, San Francisco's OOA served 27,742 unduplicated seniors and persons with disabilities. The profile of consumers reflects an emphasis on: 1) low-income seniors; and 2) seniors who have limited English-speaking ability. The accompanying table shows the diversity of OOA consumers.

Office on the Aging Consumer Profile, FY 2014-15		
	#	**%**
Total Enrollment	27,742	100%
Female	15,545	56%
Live Alone	10,692	39%
Functionally Impaired	4,800	17%
Low Income	16,359	59%
Require Translation	6,587	24%
Lesbian-Gay-Bisexual-Transgender	1,190	4%
Age	**#**	**%**
Under 60	2,381	9%
Age 60 – 74	13,049	47%
Age 75 – 84	7,300	26%
Age 85+	5,012	18%
Ethnicity	**#**	**%**
African American/Other African	3,365	12%
Asian/Pacific Islander	12,548	45%
Latino	3,027	11%
Native American/Alaskan Native	98	0.4%
White	6,026	22%
Other/Decline to State/ Unknown	2,678	10%

DAAS emphasizes serving low-income older individuals, those with limited English proficiency, and other target populations by contracting with community-based organizations that have expertise and history with the targeted population. Examples are described below.

Low-Income Older Individuals
A number of the community-based organizations that DAAS contracts with serve low income seniors, both through neighborhood-based organizations and larger organizations that target low-income persons citywide. Examples include Bayview Hunters Point Multipurpose Senior Services, located in the city's largest African American neighborhood, and Catholic Charities, which serves low-income seniors citywide. These agencies provide community services, congregate meals, money management, case management and personal care. In FY 14-15, 59% of OOA service consumers were identified as low-income (below 100% FPL). Forty percent reported receiving SSI benefits. Sixty-seven percent of African American consumers are low-income, as are 64% of Asian-Pacific Islander, 78% of Latino, and 53% of White consumers. Fewer than 100 Native Americans were served, but 70% of those were low income.

LGBT Community
DAAS has begun collecting information about consumer sexual orientation, and OOA has made emphasized the importance of this information with provider agencies. However, many consumers appear to want privacy and decline to state, and it may be that some providers feel uncomfortable or awkward in asking. While response options include "declined to state" and "unknown" to respect client privacy, about 35% of client records lack any response for these fields. Still, it is important to recognize the progress that has been made with these data collection efforts: only 494 consumers had identified themselves as LGBT when this variable was examined in 2011 and by FY 14-15 this has increased to 1,190 consumers. DAAS will continue to provide training to its partner agencies to increase their confidence and skills in asking about sexual orientation.

LGBT seniors may hesitate to seek services that they need due to fears of social stigma and lack of trust.[38] DAAS funds programs to provide appropriate services specifically to the LGBT population and also to ensure that culturally competent services are available. Currently, DAAS funds Openhouse, an organization dedicated to serving the LGBT community, to both provide direct services for clients (e.g., community services, case management) and conduct LGBT cultural sensitivity training for service providers. In FY 15-16, DAAS is developing new services for the LGBT community, including a dementia training program and a care navigation program to assist those with emotional or behavioral health challenges that may impede ability to access services.

Language Access
DAAS is dedicated to serving seniors with limited English proficiency by contracting with a number of community-based agencies that can offer services in a variety of languages. For example, Self Help for the Elderly is located in Chinatown, has historical roots there and is widely trusted. Clients depend on Self Help for the Elderly for a spectrum of needs, from reading mail to getting on housing lists to finding work. A key service provided by the ADRC information hubs located throughout the city is translation and assistance completing forms.

Twenty-four percent of consumers required translation services in FY 14-15, including 39% of Asian-Pacific Islanders and 42% of Latinos. Even among white consumers, 11% were of Russian heritage and 38% of Russians required translation services. Multilingual services are an important piece of providing culturally competent services, both because many San Franciscan seniors and younger adults with disabilities are isolated and because even bilingual consumers are often more comfortable discussing

[38] Fredriksen-Goldsen, K. I., Kim, H. J., Hoy-Ellis, C. P., Goldsen, J., Jensen, D., Adelman, M., & De Vries, B. (2013). Addressing the needs of LGBT older adults in San Francisco: Recommendations for the future. Institute for Multigenerational Health University of Washington.

personal issues in their first language. Many people return to their first language when they become ill later in life, even if they speak English well.

At Risk of Institutionalization
Approximately 44% of consumers served in FY 14-15 were age 75 or older. Of all clients served in this year, 17% had functional impairments and 39% lived alone. These factors make many of these consumers at risk of institutionalization. Home safety is a critical issue for this population. People over 75 who fall are four to five times more likely to be admitted to a long term care facility for at least a year, and most of these falls (77%) occur in the home.[39] DAAS contracts with a variety of agencies that provide home-delivered meals, case management services, personal care and homemaker services. A related and critical population is those who care for those with Alzheimer's and other dementias. DAAS contracts with the Family Caregiver Alliance and Edgewood Center for Children and Families to offer family caregiver support programs.

Younger Adults with Disabilities
Almost 2,400 OOA consumers were younger adults with disabilities in FY 14-15. These consumers received a variety of services in the community, such as home-delivered meals, congregate meals, community services, and money management. Many visit the ADRC information hubs. Several of the agencies serving younger adults with disabilities have the capacity and expertise to serve non-English speaking consumers.

Service Levels in Upcoming Years

DAAS is dedicated to serving these target populations. As described in Part II of the Needs Assessment, the DAAS budget has increased in recent years due primarily to a strong local economy. However, the funding environment is never completely secure, and DAAS has experienced many years of budget cuts. To guide budget decisions, DAAS continues to rely on a set of principles developed several years ago at the onset of the last recession, including:

- Serve the most vulnerable consumers, including those who are isolated, in need of protective services, and those who are living in poverty.
- Maintain access to information and services.
- Utilize a targeted rather than across-the-board approach to budget reduction.
- Maintain and improve communication between DAAS and community-based organizations.
- Continue to seek out other financial/revenue streams.
- Encourage and reward collaborative ventures between community-based organizations and city departments.

[39] Abt Associates, Inc. (2004). Center for Health and Long Term Care Research. US Department of Health and Human Services. *The Effect of Reducing Falls on Long-term Care Expenses: Literature Review.*

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SECTION 7. PUBLIC HEARINGS

PSA #6

At least one public hearing must be held each year of the four-year planning cycle.
CCR Title 22, Article 3, Section 7302(a)(10) and Section 7308, OAA 2006 306(a)

Fiscal Year	Date	Location	Number of Attendees	Presented in languages other than English?[40] Yes or No	Was hearing held at a Long-Term Care Facility?[41] Yes or No
2016-17	**a. 4/6/2016** **b. 4/20/2016**	**a. San Francisco City Hall** **b. DAAS (1650 Mission St)**	**a. 51** **b. 22**	**a. No** **b. No**	**a. No** **b. No**
2017-18					
2018-19					
2019-20					

The following must be discussed at each Public Hearing conducted during the planning cycle:
Summarize the outreach efforts used in seeking input into the Area Plan from institutionalized, homebound, and/or disabled older individuals.

PSA: All Office on the Aging contractors and interested parties were notified of the public meetings. A public notice was also announced in the San Francisco Chronicle. The draft Area Plan was posted online with the agenda items for the April 6, 2016, meeting and an announcement was sent out. Members of the Advisory Council, DAAS Commission, and the public were asked to provide feedback in meetings or via email.

2. Were proposed expenditures for Program Development (PD) or Coordination (C) discussed?

☐ Yes. Go to question #3

☒ Not applicable, PD and/or C funds are not used. Go to question #4

3. Summarize the comments received concerning proposed expenditures for PD and/or C

[40] A translator is not required unless the AAA determines a significant number of attendees require translation services.
[41] AAAs are encouraged to include individuals in LTC facilities in the planning process, but hearings are not required to be held in LTC facilities.

4. Attendees were provided the opportunity to testify regarding setting minimum percentages of Title III B program funds to meet the adequate proportion of funding for Priority Services

☒Yes. Go to question #5

☐No, Explain:

5. Summarize the comments received concerning minimum percentages of Title IIIB funds to meet the adequate proportion of funding for priority services.

PSA: FY 16-17: No comments were made about the minimum percentages of Title IIIB funds.

6. List any other issues discussed or raised at the public hearing.

PSA: FY 16-17: At the public meeting on April 6, DAAS Commissioner Gustavo Seriña asked about the reliability of census data and the potential for undercounting. Rose Johns discussed factors that may inhibit data collection for certain groups (e.g., persons with disabilities, low-income) but noted DAAS and HSA are confident in its usability. DAAS Commissioner Neil Sims asked about the size of the senior population living on Treasure Island and asked if the numbers were small. Ms. Johns confirmed this trend. Commission President Edna James asked about the African-American and Latino partnership groups and asked for an update on those groups at the next Commission meeting. President James also noted that isolated seniors and adults with disabilities require targeted outreach the event of a disaster. At the public meeting on April 20, there was discussion about the need to support employment opportunities for seniors and adults with disabilities.

7. Note any changes to the Area Plan which were a result of input by attendees.

PSA: n/a

SECTION 8. IDENTIFICATION OF PRIORITIES

PSA #6

The CCR, Article 3, Section 7312, requires that the AAA allocate an "adequate proportion" of federal funds to provide Access, In-Home Services, and Legal Assistance in the PSA.

DAAS uses Title III B funds to provide the following:

- **Legal Assistance Required Activities**, including Legal Advice, Representation, Assistance to the Ombudsman Program and Involvement in the Private Bar.
- **In-Home Services**, including Personal Care, Homemaker, and Chore services.
- **Access:** Transportation and Information/Assistance/Outreach

The annual minimum allocation is determined by the AAA through the planning process. The minimum percentages of applicable Title III B funds listed below have been identified for annual expenditure throughout the four-year planning period.[42] These percentages are based on needs assessment findings, resources available within the PSA, and discussions at public hearings on the Area Plan.

No changes have occurred in the allocation in the last five years, nor are any planned for the upcoming year. A public hearing to discuss the allocation is being held on April 6, 2016, and when minutes are available, they will be forwarded to the State.

Title III B Allocations			
FY	Access	In-Home Services	Legal Assistance
2011-12	45%	5%	45%
2012-13	45%	5%	45%
2013-14	45%	5%	45%
2014-15	45%	5%	45%
2015-16	45%	5%	45%

[42] Minimum percentages of applicable funds are calculated on the annual Title III B baseline allocation, minus Title III B administration and minus Ombudsman. At least one percent of the final Title III B calculation must be allocated for each "Priority Service" category or a waiver must be requested for the Priority Service category(s) that the AAA does not intend to fund.

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SECTION 9. AREA PLAN NARRATIVE GOALS AND OBJECTIVES

PSA #6

2016 – 2020 Four-Year Area Plan Cycle

Goal #1: Improve Quality of Life			
Rationale: Quality community-based long term care goes beyond providing what services people need. It encompasses a broader, more fundamental issue: what people require for a good life. Disease prevention and health maintenance programs tend to improve or increase the health and well-being of older persons and persons with disabilities. Services that offer opportunities for social interaction and engagement reduce the risk of isolation.			
Objective	**Projected Start and End Dates**	**Title IIIB Funded PD or C**	**Update Status**
1a. OOA will continue to provide health promotion and risk prevention services that support wellness and reduce risks for chronic illness and fall prevention by implementing evidence-based health promotion programs. Using Title IIID health promotion funds, OOA has implemented two evidence-based Chronic Disease Self-Management Education (CDSME) promotion programs that meet the Administration on Community Living's (ALC) highest criteria. These are included in the evidence-based program list created by the ACL and National Council on Aging. One is the "**Healthier Living" Chronic Disease Self-Management Program** (CDSMP), which was developed/licensed by Stanford Patient Education Research Center and includes a series of 2.5 hour workshops presented over a 6-week period by two trained leaders (more information: http://patienteducation.stanford.edu). The other CDSME program funded by Title IIID is the **Diabetes Empowerment Education Program** (DEEP), which was developed by University of Illinois at Chicago and consists of a six week series of two hour workshops facilitated by a certified peer educator. This program provides interactive hands-on group learning activities and games including visual aids and demonstrations. The Curriculum is based on National Diabetes Care and Diabetes Self-Management Education Guidelines and Recommendations (more information: http://mwlatino.uic.edu/deep-program). Using non-Title IIID funding, DAAS also offers Physical Fitness and Fall Prevention Programs, such as Tai Chi for Arthritis and Fall Prevention, Matter of Balance, and Always Active.	July 2016 to June 2020		

1b. Employment offers seniors and adults with disabilities the chance to form/maintain social connections, earn extra needed income in an expensive city, and achieve self-actualization. DAAS has been working to develop its capacity to support employment of seniors and adults with disabilities by expanding and creating part-time positions within the Senior Companion program and new DAAS Benefits and Resource Hub. DAAS will continue to work with community partners and other city departments to expand employment opportunities for these populations. In FY 16-17, DAAS will assume responsibility for the ARC SF employment contract with HSA.	July 2016 to June 2020		
Objective	**Projected Start and End Dates**	**Title IIIB Funded PD or C**	**Update Status**
1c. Limited supportive services are available to address the emotional, behavioral, health, and social isolation challenges faced by lesbian, gay, bisexual, and transgender (LGBT) seniors. DAAS will establish a new program to provide care navigation and peer volunteer support for LGBT clients in order to help this population to access needed services. This program will enroll 75 to 100 clients per year.	July 2016 to June 2020		
1d. The LTCCC Age- and Disability-Friendly San Francisco workgroup is focused on pro-actively addressing the needs of older adults, and the needs of adults of all ages with disabilities, as they remain in the community longer. Joining in the spirit of the World Health Organization (WHO) and AARP Livable Communities initiatives, this group of community stakeholders includes consumers, community-based service providers, city staff, and research partners. The work group is working on a baseline assessment and will develop an action plan with measurable indicators to make San Francisco a more livable and friendly for seniors and adults with disabilities.	July 2016 to June 2020		
1e. OOA-funded congregate meals provide thousands of seniors and adults with disabilities with nutritious meals and opportunities for socialization every year. In recent years, DAAS has added two Choosing Healthy and Appetizing Meal Plan Solution for Seniors (CHAMPSS) meal sites, which provides meals at neighborhood restaurants. DAAS will consider additional innovative models for the provision of congregate meals and work to add CHAMPSS sites in other parts of the city.	July 2016 to June 2020		

1f. The SF Tech Council advances digital inclusion for older adults and people with disabilities so all can participate in the City's connected community, accessing technologies that enhance their quality of life and age in the place of their choice. DAAS representatives will attend monthly meetings of the Tech Council to provide population knowledge and help develop opportunities for collaboration between government, community providers, and private businesses. In addition to the main Tech Council meeting, staff serve on the Steering Committee and the Learning and Access workgroup to support technological innovation and access for all.	July 2016 to June 2020		

Goal #2: Establish Better Coordination of Services			
Rationale: San Francisco has some of the most creative and effective community-based long term care programs in the country. But the City does not yet have a well-coordinated network of home, community-based and institutional long term care services. Services will need to be provided through a well-coordinated service delivery network that will enable older adults and adults with disabilities to remain as independent as possible in their homes and communities in the most integrated settings.			
Objective	**Projected Start and End Dates**	**Title IIIB Funded PD or C**	**Update Status**
2a. DAAS collaborates with several community partners and criminal justice agencies to prevent and mitigate abuse of elders and adults with disabilities. The Forensic Center convenes a multi-disciplinary team of service providers, law enforcement, the Ombudsman and Adult Protective Services to collaborate around the resolution of complex cases of abuse, neglect, and self-neglect. Providing outreach and education to mandated reporters as well as the community, is a key focus for the Elder Abuse Prevention program. This program has recently launched a new initiative aimed at educating veterans, their families, and service providers about financial exploitation targeting Veterans Administration benefits. Prevention activities will include education to veterans and their providers, a public awareness campaign, as well as stakeholder collaboration to improve identification and response to financial abuse.	July 2016 to June 2020		
2b. A 2014 addendum to the 2009 San Francisco Strategy for Excellence in Dementia Care identified new areas of work for the Dementia Care Excellence Oversight Committee. The committee continues to meet quarterly to develop and support strategies for serving persons with dementia. DAAS will provide staffing support, as well as program and community services knowledge to further the efforts of the workgroup. The current work of the committee is focused on supporting implementation of cognitive and screening tools in service programs like Adult Protective Services, as well as developing potential pilot programs to explore strategies to better serve persons with dementia.	July 2016 to June 2020		
2c. The Long Term Care Coordinating Council (LTCCC) is an advisory body to the Mayor's Office. It evaluates all issues related to long term care (LTC) and supportive services, including how different service delivery systems interact, and it makes recommendations about how to improve service coordination and system interaction. LTCCC workgroups with representatives from client populations, service providers, and city agencies focus on specific topic areas, such as palliative care, housing, and HIV/Aging. DAAS will provide staffing support, as well as population and program knowledge, to support the sustainability and efficacy of the LTCCC.	July 2016 to June 2020		

Objective	Projected Start and End Dates	Title IIIB Funded PD or C	Update Status
2d. In FY 15-16, the DAAS Integrated Intake and Referral Unit created the IHSS Care Transitions Program (CTP) to support IHSS applicants transitioning home after a hospitalization. This program is a smaller, more targeted version of the SF Transitional Care Program developed through a Medicare demonstration project that concluded in 2015. CTP aims to reduce readmissions after discharge by offering up a variety of services during the first few weeks back in the community, such as: temporary home care; home-delivered meals; transportation to a follow up doctor's appointment; mediation review; and review of health plan goals. DAAS will provide this service to 1,000 applicants a year.	July 2016 to June 2020		

Goal #3: Increase Access to Services			
Rationale: Adults with disabilities, older adults, and caregivers express difficulty in learning about long term care and supportive services. To address this, services need to be consumer-responsive and user-friendly, giving consumers and caregivers choices in the services they receive. Information must be easily accessible and provided in a culturally appropriate manner to address the varied needs of San Francisco's racially, ethnically and culturally diverse communities.			
Objective	**Projected Start and End Dates**	**Title IIIB Funded PD or C**	**Update Status**
3a. In late FY 15-16, the DAAS Benefits and Resource Hub for People with Disabilities and Seniors was opened at 2 Gough Street. The DAAS Integrated Intake and Referral Unit, DAAS eligibility workers, and the County Veterans Service Office (CVSO) are co-located at this site, helping to break down service silos and enhance opportunities for cross-referral across programs. Clients visiting this site may be connected with a variety of programs, including In-Home Supportive Services (IHSS), Medi-Cal, CalFresh, CVSO, and the intake and referral services provided by the Intake Unit (e.g., home-delivered meals, Community Living Fund, etc). DAAS anticipates 600 clients per month will visit the site.	July 2016 to June 2020		
3b. Through the Aging and Disability Resource Center (ADRC) network, DAAS promotes independent living in the community by providing information, referral, and assistance services. ADRC workers link consumers with community-based supports and also provide translation services, assist clients in filling out forms and provide hands on assistance with applying for services such as housing opportunities. In recent years, the program capacity has increased by shifting to a new model with Information and Assistance specialists at eight community-based organizations and increasing to a full 1.0 FTE at each site. Reaching diverse communities throughout the city, this program will serve 16,230 clients in FY 16-17.	July 2016 to June 2020		

Objective	Projected Start and End Dates	Title IIIB Funded PD or C	Update Status
3c. DAAS program staff visiting clients in their homes have valuable opportunities to identify unmet need for supportive services among vulnerable seniors and adults with disabilities. DAAS has already began to utilize these opportunities by training IHSS social workers to assess for nutrition risk and potential eligibility for home-delivered groceries. DAAS will further expand the capacity of program social workers to screen for dementia and depression identify at-risk clients and make referrals to the Clinical Quality Assurance unit or other community services as indicated.	July 2016 to June 2020		
3d. 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 Worker to serve IHSS and APS consumers with complex clinical needs, including complex medical, nursing and behavioral health needs. Working collaboratively within DAAS and with outside healthcare professionals, CQA staff evaluate clients' medical and/or behavioral health needs, assess client's readiness for change and engagement with services, and create client-centered service plans. The CQA unit will serve 500 consumers in FY 16-17.	July 2016 to June 2020		
3e. Established in 2005 by San Francisco Board of Supervisors, the Food Security Task Force (FSTF) is responsible for creating a city-wide plan addressing food security. The lead OOA nutritionist attends monthly FSTF meetings, providing insight into population trends, service provision levels, and unmet needs related to seniors and adults with disabilities. This participation supports collaboration and service coordination to improve support for all age groups. A key focus of this group is monitoring/reporting on progress and making recommendations towards the city's resolution to End Hunger by 2020.	July 2016 to June 2020		
3f. Under the Rental Assistance Demonstration (RAD) Project that began in FY 15-16, community-based organizations will provide on-site supportive services for people living in public housing developments. Historically, these residents have been underserved and living in subpar housing conditions. The goals of this effort are to provide supportive services and service connection to seniors and adults with disabilities, enhance residents' abilities to age in place, avoid premature institutionalization, and build community in their environments. DAAS is responsible for managing 11 contracts for 866 units at housing sites serving seniors and adults with disabilities. In FY 16-17, this will grow to 20 total contracts (approximately 2,000 units citywide).	July 2016 to June 2020		

Goal #4: Improve Service Quality			
Rationale: Quality standards help maximize the positive impact of services for seniors and adults with disabilities. Key components of quality include program accountability, performance measurement, cultural competency, and continuous improvement. Technical assistance supports service quality.			
Objective	**Projected Start and End Dates**	**Title IIIB Funded PD or C**	**Update Status**
4a. OOA programs providing personalized service to clients with complex needs and/or operating within stringent program standards benefit from regular group meetings with OOA analysts. These meetings offer the opportunity to discuss population trends, collaboratively strategize on how best to meet client needs, and provide technical assistance. OOA staff will hold quarterly meetings with service providers in the following programs: Nutrition, Legal Services, Naturalization, Community Services, and Case Management.	July 2016 to June 2020		
4b. LGBT seniors and adults with disabilities have unique needs but may hesitate to access needed services due to concerns about stigma. It is imperative that all DAAS service providers offer a welcoming environment to this population, so that this population is comfortable accessing services. DAAS will expand on its existing training on serving LGBT population to incorporate issues related to the intersection of aging and dementia. This training will be provided on an ongoing basis, offering provide 25 trainings for a total of 250 providers each year.	July 2016 to June 2020		
4c. OOA case management is a core DAAS program, facilitating critical service connections for seniors and adults with disabilities struggling to manage their needs. To strengthen this program and maximize its effectiveness, DAAS has developed a variety of strategies in recent years, including the expansion of the Clinical Consultant Collaborative and online medication management model. In FY 16-17, the DAAS Integrated Intake and Referral Unit will assume responsibility for centralized intake process and single waitlist for this service.	July 2016 to June 2020		
4d. Adult Protective Services clients that experience chronic self-neglect are more likely to be referred back to the program within one year of case closure. These clients typically require greater levels of engagement and case management on the part of the social worker in on order to achieve stabilization, when compared with other APS clients. The APS program will develop clinically-based strategies to improve the effectiveness of intervention with these clients and develop mechanisms for tracking the outcomes of clients that are continually re-referred to APS for self-neglect.	July 2016 to June 2020		

Objective	Projected Start and End Dates	Title IIIB Funded PD or C	Update Status
4e. DAAS will work with the LTC Ombudsman program to ensure service is meeting the diverse needs of the local senior and disabled populations. This includes maintaining capacity to serve Chinese-speaking clients, as well as ensuring proper implementation of recent City of San Francisco legislation related to LGBT residents.	July 2016 to June 2020		
4f. Launched in 2015, the DAAS staff training program is intended to ensure all staff is aware of key issues related to aging and disability. It consists of a mandatory core curriculum focused on basic population topics, as well as optional sessions focused on specialized content. All DAAS staff is expected to complete the core requirements within two years of initial implementation or their start date.	July 2016 to June 2020		

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SECTION 10. SERVICE UNIT PLAN (SUP) OBJECTIVES

PSA #6

TITLE III/VIIA SERVICE UNIT PLAN OBJECTIVES
CCR Article 3, Section 7300(d)

The Service Unit Plan (SUP) uses the National Aging Program Information System (NAPIS) Categories and units of service. They are defined in the NAPIS State Program Report (SPR)
The Service Unit Plan (SUP) uses the National Aging Program Information System (NAPIS) Categories and units of service. They are defined in the NAPIS State Program Report (SPR)

For services not defined in NAPIS, refer to the Service Categories and Data Dictionary and the National Ombudsman Reporting System (NORS) Instructions.

Report the units of service to be provided with ALL funding sources. Related funding is reported in the annual Area Plan Budget (CDA 122) for Titles IIIB, IIIC-1, IIIC-2, IIID, and VIIA.

1. Personal Care (In-Home) **Unit of Service = 1 hour**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	460	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

2. Homemaker (In-Home) **Unit of Service = 1 hour**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	520	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

3. Chore (In-Home) **Unit of Service = 1 hour**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	520	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

4. Home-Delivered Meal **Unit of Service = 1 meal**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	1,478,480	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

5. Adult Day/ Health Care (In-Home) **Unit of Service = 1 hour**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017			
2017-2018			
2018-2019			
2019-2020			

6. Case Management (Access) **Unit of Service = 1 hour**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017			
2017-2018			
2018-2019			
2019-2020			

7. Assisted Transportation (Access) **Unit of Service = 1 one-way trip**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017			
2017-2018			
2018-2019			
2019-2020			

8. Congregate Meals **Unit of Service = 1 meal**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	797,220	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

9. Nutrition Counseling **Unit of Service = 1 session per participant**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	1,730	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

10. Transportation (Access) **Unit of Service = 1 one-way trip**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	40,000	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

11. Legal Assistance **Unit of Service = 1 hour**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	12,636	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

12. Nutrition Education **Unit of Service = 1 session per participant**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	43,000	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

13. Information and Assistance (Access) **Unit of Service = 1 contact**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017	4,200	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

14. Outreach (Access) **Unit of Service = 1 contact**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (if applicable)
2016-2017			
2017-2018			
2018-2019			
2019-2020			

15. NAPIS Service Category – "Other" Title III Services

- Each Title IIIB "Other" service must be an approved NAPIS Program 15 service listed on the "Schedule of Supportive Services (III B)" page of the Area Plan Budget (CDA 122) and the CDA Service Categories and Data Dictionary.

- Identify Title IIIB services to be funded that were not reported in NAPIS categories 1–14 and 16. (Identify the specific activity under the Other Supportive Service Category on the "Units of Service" line when applicable.)

Title IIIB, Other Priority and Non-Priority Supportive Services

For all Title IIIB "Other" Supportive Services, use the appropriate Service Category name and Unit of Service (Unit Measure) listed in the CDA Service Categories and Data Dictionary.

Other Priority Supportive Services include: Alzheimer's Day Care, Comprehensive Assessment, Health, Mental Health, Public Information, Residential Repairs/Modifications, Respite Care, Telephone Reassurance, and Visiting

Other Non-Priority Supportive Services include: Cash/Material Aid, Community Education, Disaster Preparedness Materials, Emergency Preparedness, Employment, Housing, Interpretation/Translation, Mobility Management, Peer Counseling, Personal Affairs Assistance, Personal/Home Security, Registry, Senior Center Activities, and Senior Center Staffing

All "Other" services must be listed separately. Duplicate the table below as needed.

Other Supportive Service Category **Unit of Service**

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers
2016-2017			
2017-2018			
2018-2019			
2019-2020			

16. Title IIID/ Disease Prevention and Health Promotion

Instructions for Title IIID Disease Prevention and Health Promotion: Enter the proposed units of service and the Program Goal and Objective number(s) that provides a narrative description of the program and explains how the service activity meets the criteria for evidence-based programs described in PM 15-10.

Unit of Service = 1 contact

Service Activities: _____Chronic Disease Self-Management Program_____

Title IIID/ Disease Prevention and Health Promotion: Enter required program goal and objective numbers in the Title III D Service Plan Objective Table below:

Fiscal Year	Proposed Units of Service	Goal Numbers	Objective Numbers (Required)
2016-2017	730	1,2,3,4	1.a
2017-2018			
2018-2019			
2019-2020			

TITLE IIIB and Title VIIA:
LONG-TERM CARE (LTC) OMBUDSMAN PROGRAM OUTCOMES

2016–2020 Four-Year Planning Cycle

As mandated by the Older Americans Act, the mission of the LTC Ombudsman Program is to seek resolution of problems and advocate for the rights of residents of LTC facilities with the goal of enhancing the quality of life and care of residents.

Each year during the four-year cycle, analysts from the Office of the State Long-Term Care Ombudsman (OSLTCO) will forward baseline numbers to the AAA from the prior fiscal year National Ombudsman Reporting System (NORS) data as entered into the Statewide Ombudsman Program database by the local LTC Ombudsman Program and reported by the OSTLCO in the State Annual Report to the Administration on Aging (AoA).

The AAA will establish targets each year in consultation with the local LTC Ombudsman Program Coordinator. Use the yearly baseline data as the benchmark for determining yearly targets. Refer to your local LTC Ombudsman Program's last three years of AoA data for historical trends. Targets should be reasonable and attainable based on current program resources.

Complete all Measures and Targets for Outcomes 1-3.

Outcome 1. The problems and concerns of long-term care residents are solved through complaint resolution and other services of the Ombudsman Program. [OAA Section 712(a)(3),(5)]

Measures and Targets:

A. Complaint Resolution Rate (AoA Report, Part I.E, Actions on Complaints)
The average California complaint resolution rate for FY 2013-2014 was 73%.

1. FY 2014-2015 Baseline Resolution Rate: Number of complaints resolved 198 + Number of partially resolved complaints 175 divided by the Total Number of Complaints Received 538 = Baseline Resolution Rate 69% FY 2016-17 Target Resolution Rate 70%
2. FY 2015-2016 Baseline Resolution Rate: Number of complaints resolved _____ + Number of partially resolved complaints _____ divided by the Total Number of Complaints Received _____ = Baseline Resolution Rate _____% FY 2017-18 Target Resolution Rate _____%
3. FY 2016-2017 Baseline Resolution Rate: Number of complaints resolved _____ + Number of partially resolved complaints _____ divided by the Total Number of Complaints Received _____ = Baseline Resolution Rate _____% FY 2018-19 Target Resolution Rate _____%

4. FY 2017-2018 Baseline Resolution Rate: Number of complaints resolved _____ + Number of partially resolved complaints_____ divided by the Total Number of Complaints Received _____ = Baseline Resolution Rate _____% FY 2019-20 Target Resolution Rate _____%
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

B. Work with Resident Councils (AoA Report, Part III.D.8)

FY 2014-2015 Baseline: number of Resident Council meetings attended 23 FY 2016-2017 Target: 23
2. FY 2015-2016 Baseline: number of Resident Council meetings attended _____ FY 2017-2018 Target: _____
3. FY 2016-2017 Baseline: number of Resident Council meetings attended _____ FY 2018-2019 Target: _____
4. FY 2017-2018 Baseline: number of Resident Council meetings attended _____ FY 2019-2020 Target: _____
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

C. Work with Family Councils (AoA Report, Part III.D.9)

1. FY 2014-2015 Baseline number of Family Council meetings attended 6 FY 2016-2017 Target: 6
2. FY 2015-2016 Baseline number of Family Council meetings attended _____ FY 2017-2018 Target: _____
3. FY 2016-2017 Baseline number of Family Council meetings attended _____ FY 2018-2019 Target: _____
4. FY 2017-2018 Baseline number of Family Council meetings attended _____ FY 2019-2020 Target: _____
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

D. Consultation to Facilities (AoA Report, Part III.D.4) Count of instances of ombudsman representatives' interactions with facility staff for the purpose of providing general information and assistance unrelated to a complaint. Consultation may be accomplished by telephone, letter, email, fax, or in person.

1. FY 2014-2015 Baseline: number of consultations 90 FY 2016-2017 Target: 90
2. FY 2015-2016 Baseline: number of consultations _____ FY 2017-2018 Target: _____
3. FY 2016-2017 Baseline: number of consultations _____ FY 2018-2019 Target: _____
4. FY 2017-2018 Baseline: number of consultations _____ FY 2019-2020 Target: _____
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

E. Information and Consultation to Individuals (AoA Report, Part III.D.5) Count of instances of ombudsman representatives' interactions with residents, family members, friends, and others in the community for the purpose of providing general information and assistance unrelated to a complaint. Consultation may be accomplished by: telephone, letter, email, fax, or in person.

1. FY 2014-2015 Baseline: number of consultations 240 FY 2016-2017 Target: 240
2. FY 2015-2016 Baseline: number of consultations _____ FY 2017-2018 Target: _____
3. FY 2016-2017 Baseline: number of consultations _____ FY 2018-2019 Target: _____
4. FY 2017-2018 Baseline: number of consultations _____ FY 2019-2020 Target: _____
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

F. Community Education (AoA Report, Part III.D.10) LTC Ombudsman Program participation in public events planned to provide information or instruction to community members about the LTC Ombudsman Program or LTC issues. The number of sessions refers to the number of events, not the number of participants.

1. FY 2014-2015 Baseline: number of sessions 10 FY 2016-2017 Target: 10
2. FY 2015-2016 Baseline: number of sessions _____ FY 2017-2018 Target: _____
3. FY 2016-2017 Baseline: number of sessions _____ FY 2018-2019 Target: _____
FY 2017-2018 Baseline: number of sessions _____ FY 2019-2020 Target: _____
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

G. Systems Advocacy

In the box below, in narrative format, provide at least one new priority systemic advocacy effort the local LTC Ombudsman Program will engage in during the fiscal year. If the systemic advocacy effort is a multi-year initiative, provide a systemic advocacy objective that explains progress made in the initiative during the prior fiscal year and identifies specific steps to be taken during the upcoming fiscal year. A new effort or a statement of progress made and goals for the upcoming year must be entered each year of the four-year cycle.

Systems Advocacy can include efforts to improve conditions in one LTC facility or can be county-wide, State-wide, or even national in scope. (Examples: Work with LTC facilities to promote person-centered care and reduce the use of anti-psychotics, work with law enforcement entities to improve response and investigation of abuse complaints, collaboration with other agencies to improve LTC residents' quality of care and quality of life, participation in disaster preparedness planning, participation in legislative advocacy efforts related to LTC issues, etc.

Enter information in the box below.

Systemic Advocacy Effort(s) for the current fiscal year
Ombudsman will work with the LGBT Aging Policy Task Force towards implementation of the LGBT Senior Long Term Care Facilities Bill of Rights legislation recently passed by the City of San Francisco. It is to be implemented at all skilled nursing facilities in San Francisco. Ombudsman staff will continue to attend the Elder Death Review Panel at the City of San Francisco Medical Examiner's Office in order to provide multidisciplinary analyses of possible abuses and neglect contributing to the deaths of elders. Ombudsman staff will also continue to play a role in the legislative process by attending state and local government hearings on matters related to SNF and RCFEs. Ombudsman staff will also provide testimony at these legislative hearings when appropriate.

Outcome 2. Residents have regular access to an Ombudsman. [(OAA Section 712(a)(3)(D), (5)(B)(ii)]

Measures and Targets:

A. Facility Coverage (other than in response to a complaint), (AoA Report, Part III.D.6)
Percentage of nursing facilities within the PSA that were visited by an ombudsman representative at least once each quarter not in response to a complaint. The percentage is determined by dividing the number of nursing facilities in the PSA that were visited at least once each quarter not in response to a complaint by the total number of nursing facilities in the PSA. NOTE: This is not a count of *visits* but a count of *facilities*. In determining the number of facilities visited for this measure, no nursing facility can be counted more than once.

1. FY 2014-2015 Baseline: Number of Nursing Facilities visited at least once a quarter not in response to a complaint 15 divided by the total number of Nursing Facilities 21 = Baseline 71.4% FY 2016-2017 Target: 71.4%
2. FY 2015-2016 Baseline: Number of Nursing Facilities visited at least once a quarter not in response to a complaint _____ divided by the total number of Nursing Facilities _____ = Baseline _____% FY 2017-2018 Target: _____%
3. FY 2016-2017 Baseline: Number of Nursing Facilities visited at least once a quarter not in response to a complaint _____ divided by the total number of Nursing Facilities _____ = Baseline _____% FY 2018-2019 Target: _____%
4. FY 2017-2018 Baseline: Number of Nursing Facilities visited at least once a quarter not in response to a complaint _____ divided by the total number of Nursing Facilities _____ = Baseline _____% FY 2019-2020 Target: _____%
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

B. Facility Coverage (other than in response to a complaint) (AoA Report, Part III.D.6)
Percentage of RCFEs within the PSA that were visited by an ombudsman representative at least once each quarter during the fiscal year not in response to a complaint. The percentage is determined by dividing the number of RCFEs in the PSA that were visited at least once each quarter not in response to a complaint by the total number of RCFEs in the PSA.
NOTE: This is not a count of *visits* but a count of *facilities*. In determining the number of facilities visited for this measure, no RCFE can be counted more than once.

FY 2014-2015 Baseline: Number of RCFEs visited at least once a quarter not in response to a complaint 33 divided by the total number of RCFEs 79 = Baseline 41.8% FY 2016-2017 Target: 41.8%
FY 2015-2016 Baseline: Number of RCFEs visited at least once a quarter not in response to a complaint _____ divided by the total number of RCFEs _____ = Baseline _____% FY 2017-2018 Target: _____%
FY 2016-2017 Baseline: Number of RCFEs visited at least once a quarter not in response to a complaint _____ divided by the total number of RCFEs _____ = Baseline _____% FY 2018-2019 Target: _____%
FY 2017-2018 Baseline: Number of RCFEs visited at least once a quarter not in response to a complaint _____ divided by the total number of RCFEs _____ = Baseline _____% FY 2019-2020 Target: _____ %
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

C. Number of Full-Time Equivalent (FTE) Staff (AoA Report Part III. B.2. - Staff and Volunteers)
This number may only include staff time legitimately charged to the LTC Ombudsman Program. Time spent working for or in other programs may not be included in this number. For example, in a local LTC Ombudsman Program that considers full-time employment to be 40 hour per week, the FTE for a staff member who works in the Ombudsman Program 20 hours a week should be 0.5, even if the staff member works an additional 20 hours in another program.

1. FY 2014-2015 Baseline: 6.0 FTEs FY 2016-2017 Target: 6.0 FTEs
2. FY 2015-2016 Baseline: _____ FTEs FY 2017-2018 Target: _____ FTEs
3. FY 2010-2011 Baseline: _____ FTEs FY 2013-2014 Target: _____ FTEs
4. FY 2010-2011 Baseline: _____ FTEs FY 2014-2015 Target: _____ FTEs
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

D. Number of Certified LTC Ombudsman Volunteers (AoA Report Part III. B.2. – Staff and Volunteers)

FY 2014-2015 Baseline: Number of certified LTC Ombudsman volunteers 10 FY 2016-2017 Projected Number of certified LTC Ombudsman volunteers 10
FY 2015-2016 Baseline: Number of certified LTC Ombudsman volunteers _____ FY 2017-2018 Projected Number of certified LTC Ombudsman volunteers _____
3. FY 2016-2017 Baseline: Number of certified LTC Ombudsman volunteers _____ FY 2018-2019 Projected Number of certified LTC Ombudsman volunteers _____
FY 2017-2018 Baseline: Number of certified LTC Ombudsman volunteers _____ FY 2019-2020 Projected Number of certified LTC Ombudsman volunteers _____
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: 2a, 4e

Outcome 3. Ombudsman representatives accurately and consistently report data about their complaints and other program activities in a timely manner. [OAA Section 712(c)]

Measures and Targets:
In the box below, in narrative format, describe one or more specific efforts your program will undertake in the upcoming year to increase the accuracy, consistency, and timeliness of your National Ombudsman Resource System (NORS) data reporting.

Some examples could include:

- Having Ombudsman Program staff and volunteers regularly attend NORS Consistency Training provided by the OSLTCO
- Hiring additional staff to enter data
- Updating computer equipment to make data entry easier
- Initiating a case review process to ensure case entry is completed in a timely manner

Recruitment and training of new staff and volunteers will increase infrastructure and ability to report in a complete, accurate, and timely manner.

TITLE VIIA ELDER ABUSE PREVENTION
SERVICE UNIT PLAN OBJECTIVES

Units of Service: AAA must complete at least one category from the Units of Service below.

Units of Service categories include public education sessions, training sessions for professionals, training sessions for caregivers served by a Title IIIE Family Caregiver Support Program, educational materials distributed, and hours of activity spent developing a coordinated system which addresses elder abuse prevention, investigation, and prosecution.

When developing targets for each fiscal year, refer to data reported on the Elder Abuse Prevention Quarterly Activity Reports. Set realistic goals based upon the prior year's numbers and the resources available. Activates reported for the Title VII Elder Abuse Prevention Program must be distinct from activities reported for the LTC Ombudsman Program. No activity can be reported for both programs.

AAAs must provide one or more of the service categories below.
NOTE: The number of sessions refers to the number of presentations and not the number of attendees

- **Public Education Sessions** –Indicate the total number of projected education sessions for the general public on the identification, prevention, and treatment of elder abuse, neglect, and exploitation.
- **Training Sessions for Professionals** –Indicate the total number of projected training sessions for professionals (service providers, nurses, social workers) on the identification, prevention, and treatment of elder abuse, neglect, and exploitation.
- **Training Sessions for Caregivers Served by Title IIIE** –Indicate the total number of projected training sessions for unpaid family caregivers who are receiving services under Title III E of the Older Americans Act (OAA) on the identification, prevention, and treatment of elder abuse, neglect, and exploitation. OAA 302(3) 'Family caregiver' means an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual or to an individual with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction.
- **Hours Spent Developing a Coordinated System to Respond to Elder Abuse** – Indicate the number of hours to be spent developing a coordinated system to respond to elder abuse. This category includes time spent coordinating services provided by the AAA or its contracted service provider with services provided by Adult Protective Services, local law enforcement agencies, legal services providers, and other agencies involved in the protection of elder and dependent adults from abuse, neglect, and exploitation.
- **Educational Materials Distributed** –Indicate the type and number of educational materials to be distributed to the general public, professionals, and caregivers (this may include materials that have been developed by others) to help in the identification, prevention, and treatment of elder abuse, neglect, and exploitation.
- **Number of Individuals Served** –Indicate the total number of individuals expected to be reached by any of the above activities of this program.

TITLE VIIA ELDER ABUSE PREVENTION SERVICE UNIT PLAN OBJECTIVES

The agency receiving Title VIIA Elder Abuse Prevention funding is: Institute on Aging

Fiscal Year	Total # of Public Education Sessions
2016-2017	12
2017-2018	
2018-2019	
2019-2020	

Fiscal Year	Total # of Training Sessions for Professionals
2016-2017	25
2017-2018	
2018-2019	
2019-2020	

Fiscal Year	Total # of Training Sessions for Caregivers served by Title IIIE
2016-2017	0
2017-2018	
2018-2019	
2019-2020	

Fiscal Year	Total # of Hours Spent Developing a Coordinated System
2016-2017	160
2017-2018	
2018-2019	
2019-2020	

Fiscal Year	Total # of Copies of Educational Materials to be Distributed	Description of Educational Materials
2016-2017	3,000	A typical packet at a training session includes: • APS's Elder Abuse information fact sheet • IOA's Elder Abuse Fact Sheet (English & Spanish) • Bay Area Academy's Financial abuse fact sheet • SOC 341 including completion instructions • UC Irvine Bruising Study • Break the Silence fliers in multiple languages • Copy of the PowerPoint presentation California Penal Coders: elder abuse for law enforcement
2017-2018		
2018-2019		
2019-2020		

Fiscal Year	Total Number of Individuals Served
2016-2017	4,000
2017-2018	
2018-2019	
2019-2020	

TITLE IIIE SERVICE UNIT PLAN OBJECTIVES

CCR Article 3, Section 7300(d)

2012–2016 Four-Year Planning Period

This Service Unit Plan (SUP) uses the five broad federally-mandated service categories defined in PM 11-11. Refer to the CDA Service Categories and Data Dictionary Revisions Effective July 1, 2011 for eligible activities and service unit measures. Specify proposed audience size or units of service for ALL budgeted funds.

Direct and/or Contracted IIIE Services

CATEGORIES	1	2	3
Family Caregiver Services Caring for Elderly	***Proposed*** **Units of Service**	***Required*** **Goal #(s)**	***Optional*** **Objective #(s)**
Information Services	**# of activities and Total est. audience**		
2016-2017	# of activities: 35 Total est. audience for above: 700	1,2,3,4	
2017-2018	# of activities: Total est. audience for above:		
2018-2019	# of activities: Total est. audience for above:		
2019-2020	# of activities: Total est. audience for above:		
Access Assistance	**Total contacts**		
2016-2017	670	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

Access Assistance	**Total contacts**		
Support Services	**Total hours**		
2016-2017	2,439	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			
Respite Care	**Total hours**		
2016-2017	2,520	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			
Supplemental Services	**Total occurrences**		
2016-2017	116	1,2,3,4	
2017-2018			
2018-2019			
2019-2020			

Direct and/or Contracted IIIE Services

Grandparent Services Caring for Children	***Proposed*** **Units of Service**	***Required*** **Goal #(s)**	***Optional*** **Objective #(s)**
Information Services	**# of activities and Total est. audience for above**		
2016-2017	# of activities: Total est. audience for above:		
2017-2018	# of activities: Total est. audience for above:		
2018-2019	# of activities: Total est. audience for above:		
2019-2020	# of activities: Total est. audience for above:		

Grandparent Services Caring for Children	***Proposed*** **Units of Service**	***Required*** **Goal #(s)**	***Optional*** **Objective #(s)**
Access Assistance	**Total contacts**		
2016-2017			
2017-2018			
2018-2019			
2019-2020			
Support Services	**Total hours**		
2016-2017			
2017-2018			
2018-2019			
2019-2020			
Respite Care	**Total hours**		
2016-2017			
2017-2018			
2018-2019			
2019-2020			
Supplemental Services	**Total occurrences**		
2016-2017			
2017-2018			
2018-2019			
2019-2020			

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP)

List all SCSEP monitor sites (contract or direct) where the AAA provides SCSEP enrollment services within the PSA (Do not list host agencies)

Enrollment Location/Name (AAA office, One Stop, Agency, etc.):	
Street Address:	
Name and title of all SCSEP paid project staff members (Do not list participant or participant staff names):	
Number of paid staff	Number of participant staff
How many participants are served at this site?	

Enrollment Location/Name (AAA office, One Stop, Agency, etc.):	
Street Address:	
Name and title of all SCSEP paid project staff members (Do not list participant or participant staff names):	
Number of paid staff	Number of participant staff
How many participants are served at this site?	

Enrollment Location/Name (AAA office, One Stop, Agency, etc.):	
Street Address:	
Name and title of all SCSEP paid project staff members (Do not list participant or participant staff names):	
Number of paid staff	Number of participant staff
How many participants are served at this site?	

HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM (HICAP)
SERVICE UNIT PLAN
CCR Article 3, Section 7300(d)

MULTIPLE PSA HICAPs: If you are a part of a multiple-PSA HICAP where two or more AAAs enter into an agreement with one "Managing AAA," to deliver HICAP services on their behalf to eligible persons in their AAA, then each AAA must enter State and federal performance target numbers in each AAA's respective SUP. Please do this in cooperation with the Managing AAA. The Managing AAA is responsible for providing HICAP services in the covered PSAs in a way that is agreed upon and equitable among the participating parties.

HICAP PAID LEGAL SERVICES: Complete Section 3 if your Master Contract contains a provision for using HICAP funds to provide HICAP Legal Services.

STATE & FEDERAL PERFORMANCE TARGETS: In FY 2014, the State Health Insurance Assistance Program (SHIP) was transferred from the Centers for Medicare & Medicaid Services (CMS) to the Administration for Community Living (ACL). ACL has continued CMS' policy requiring all SHIPs to meet established performance measures. Based on ACL guidelines and to assist AAAs in completing the Service Unit Plan, CDA provides State (1.1 and 1.2), and federal (2.1 through 2.7) performance measures (PM) annually. To download these measures and view definitions, visit https://www.aging.ca.gov/ProgramsProviders/AAA/Planning/

Section 1. State Performance Measures

Fiscal Year (FY)	PM 1.1 Clients Counseled (Estimated)	Goal Numbers
2016-2017	1,864	1,2,3,4
2017-2018		
2018-2019		
2019-2020		

Fiscal Year (FY)	PM 1.2 Public and Media Events (PAM) (Estimated)	Goal Numbers
2016-2017	110	1,2,3,4
2017-2018		
2018-2019		
2019-2020		

Section 2: Federal Performance Measures

Fiscal Year (FY)	PM 2.1 Total Client Contacts (Estimated)	Goal Numbers
2016-2017	6,219	1,2,3,4
2017-2018		
2018-2019		
2019-2020		

Fiscal Year (FY)	PM 2.2 Persons Reached at PAM Events (Estimated)	Goal Numbers
2016-2017	6,664	1,2,3,4
2017-2018		
2018-2019		
2019-2020		

Fiscal Year (FY)	PM 2.3 Contacts with Medicare Beneficiaries Due to Disability (Estimated)	Goal Numbers
2016-2017	588	1,2,3,4
2017-2018		
2018-2019		
2019-2020		

Fiscal Year (FY)	PM 2.4 Low-income Medicare Beneficiary Contacts (Estimated)	Goal Numbers
2016-2017	6,286	1,2,3,4
2017-2018		
2018-2019		
2019-2020		

Fiscal Year (FY)	PM 2.5 Contacts with One or More Qualifying Enrollment Topics (Estimated)	Goal Numbers
2016-2017	5,603	1,2,3,4
2017-2018		
2018-2019		
2019-2020		

Fiscal Year (FY)	PM 2.6 Total Part D Enrollment/Assistance Contacts (Estimated)	Goal Numbers
2016-2017	2,275	1,2,3,4
2017-2018		
2018-2019		
2019-2020		

Fiscal Year (FY)	PM 2.7 Total Counseling Hours (Estimated)	Goal Numbers
2016-2017	2,983	1,2,3,4
2017-2018		
2018-2019		
2019-2020		

Section 3: HICAP Legal Services Units of Service (if applicable) [43]

Fiscal Year (FY)	3.1 Estimated Number of Clients Represented Per FY (Unit of Service)	Goal Numbers
2016-2017	N/A	N/A
2017-2018		
2018-2019		
2019-2020		

43 Requires a contract for using HICAP funds to pay for HICAP Legal Services.

Fiscal Year (FY)	3.2 Estimated Number of Legal Representation Hours Per FY (Unit of Service)	Goal Numbers
2016-2017	N/A	N/A
2017-2018		
2018-2019		
2019-2020		

Fiscal Year (FY)	3.3 Estimated Number of Program Consultation Hours Per FY (Unit of Service)	Goal Numbers
2016-2017	N/A	N/A
2017-2018		
2018-2019		
2019-2020		

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SECTION 11. FOCAL POINTS

PSA #6

COMMUNITY FOCAL POINTS LIST

CCR Title 22, Article 3, Section 7302(a)(14), 45 CFR Section 1321.53(c), OAA 2006 306(a)

In the form below, provide the current list of designated community focal points and their addresses. This information must match the total number of focal points reported in the National Aging Program Information System (NAPIS) State Program Report (SPR), i.e., California Aging Reporting System, NAPISCare, Section III.D.

Designated Community Focal Point	Address
Western Addition Senior Center (BHPMSS)	1390 1/2 Turk St, San Francisco, 94115
Bayview Senior Connections (BHPMSS)	5600 3rd St, San Francisco, 94124
OMI Senior Center (CCCYO)	65 Beverly St, San Francisco, 94132
Richmond Senior Center (GGSS)	6221 Geary Blvd, San Francisco, 94121
30th Street Senior Center (On Lok)	225 30th St, San Francisco, 94131
Open House	1800 Market St, San Francisco, 94102
SF Senior Center (SFSC)	481 O'Farrell St, San Francisco, 94102
Aquatic Park Senior Center (SFSC)	890 Beach St, San Francisco, 94109
South Sunset Senior Center (SHE)	2601 40th Ave , San Francisco, 94116
Self-Help for the Elderly	601 Jackson St, San Francisco, 94133
Geen Mun Activity Center (SHE)	777 Stockton St, San Francisco, 94108
Toolworks	25 Kearny St, San Francisco, 94108
DAAS Benefits and Services Hub	2 Gough St, San Francisco, 94103

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SECTION 12. DISASTER PREPAREDNESS

PSA #6

Disaster Preparation Planning Conducted for the 2016-2020 Planning Cycle OAA Title III, Sec. 306(a)(17); 310, CCR Title 22, Sections 7529 (a)(4) and 7547, W&I Code Division 8.5, Sections 9625 and 9716, CDA Standard Agreement, Exhibit E, Article 1, 22-25, Program Memo 10-29(P)

1. Describe how the AAA coordinates its disaster preparedness plans and activities with local emergency response agencies, relief organizations, state and local governments, and other organizations responsible for emergency preparedness and response as required in OAA, Title III, Section 310:

PSA: San Francisco's AAA disaster preparedness is managed by its broader agency, the San Francisco Human Services Agency (SFHSA). In addition to its oversight of the city's shelter system in the event of a disaster, SFHSA has developed plans for outreach to the city's most vulnerable seniors and adults with disabilities. Each agency program has a continuity of operations plan that is reviewed and updated annually. The City and County of San Francisco has developed a corps of Neighborhood Emergency Response Teams (NERTs), citizen volunteers who have been trained and registered to conduct outreach after a disaster. The NERTs are managed by the San Francisco Fire Department. The San Francisco Department of Emergency Management holds regular meetings to review and update existing emergency operational plans. SFHSA staff (including the OOA Lead Nutritionist) is frequently invited to attend these meetings.

In the event of a disaster, SFHSA's own staff has been trained, if off-duty, to first secure their own homes and then report to an emergency response center that will be activated at an SFHSA site. SFHSA executive staff (including the DAAS Executive Director) is prepared to serve as the commander of the SFHSA emergency operations center. The agency will deploy its staff, in conjunction with the NERTs, to conduct wellness checks of these individuals within 72 hours of a major disaster. On a quarterly basis, SFHSA gathers the names and addresses of In Home Supportive Services recipients who have impairments and live alone without support, as well as high-risk Adult Protective Services clients. The home visitors will assess the consumers for medical and shelter needs, and when necessary, coordinate with the Fire Department to provide medical attention and transportation.

SFHSA also has a disaster response plan to bring its services back to normal functioning within a rapid time frame, and includes arrangements for space, access to information technology, and emergency resources for consumers.

2. Identify each of the local Office of Emergency Services (OES) contact person(s) within the PSA that the AAA will coordinate with in the event of a disaster (add additional information as needed for each OES within the PSA):

Name	Title	Telephone	Email
Rob Stengel	Emergency Planner, Office of Emergency Services	Office: 415-487-5015 Cell: 415-760-4203	Rob.Stengel@sfgov.org

3. Identify the Disaster Response Coordinator within the AAA:

Name	Title	Telephone	Email
Benjamin Amyes	Emergency Response Coordinator	Office: 415-557-5370 Cell: 415-760-1390	Benjamin.amyes@sfgov.org

4. List critical services the AAA will continue to provide after a disaster and describe how these services will be delivered:

Critical Services	**How Delivered?**
a. Wellness checks to most vulnerable seniors and adults with disabilities, assessing their status and connecting them with need attention for urgent health and housing needs b. Emergency Shelter	a. SFHSA will keep current a list of its most vulnerable clients, including IHSS & APS recipients, who have personal care needs, are living alone or without support and/or are at risk. The Agency, through its Disaster Operations Center, will coordinate wellness checks post disaster utilizing its existing staff and other city staff. b. SFHSA has an MOU with the Red Cross to manage the city's emergency shelters in the event of a disaster. Through wellness checks, it will connect the city's most vulnerable seniors and persons with disabilities to these shelters.

5. List any agencies with which the AAA has formal emergency preparation or response agreements.

PSA: SFHSA has an MOU to coordinate emergency shelter operations with the American Red Cross.

6. Describe how the AAA will:

- *Identify vulnerable populations.*

PSA: On a quarterly basis, the IHSS and APS programs query their caseloads to identify its most vulnerable clients using prescribed parameters particular to the program. This data is stored on an encrypted flash drive and stored in an emergency bin within the Agency's Disaster Operations Center. In addition, the data is also stored on a limited "shared" drive on the Agency's network.

- *Follow-up with these vulnerable populations after a disaster event.*

PSA: Following a disaster, HSA will attempt to make contact with its pre-identified most vulnerable clients. Initial contact will be attempted through telephone, text or email. If the Agency fails to make contact, it will send out Agency and city staff to make a home visit.

SECTION 13. PRIORITY SERVICES

PSA #6

2016-2020 Four-Year Planning Cycle

Funding for Access, In-Home Services, and Legal Assistance

The CCR, Article 3, Section 7312, requires the AAA to allocate an "adequate proportion" of federal funds to provide Access, In-Home Services, and Legal Assistance in the PSA. The annual minimum allocation is determined by the AAA through the planning process. The minimum percentages of applicable Title III B funds[44] listed below have been identified for annual expenditure throughout the four-year planning period. These percentages are based on needs assessment findings, resources available within the PSA, and discussions at public hearings on the Area Plan.

Category of Service and the Percentage of Title III B Funds expended in/or to be expended in FY 2016-17 through FY 2019-20

Access:

Transportation, Assisted Transportation, Case Management, Information and Assistance, Outreach, Comprehensive Assessment, Health, Mental Health, and Public Information

2016-17 45% 17-18 45% 18-19 45% 19-20 45%

In-Home Services:

Personal Care, Homemaker, Chore, Adult Day / Health Care, Alzheimer's, Residential Repairs/Modifications, Respite Care, Telephone Reassurance, and Visiting

2016-17 5% 17-18 5% 18-19 5% 19-20 5%

Legal Assistance Required Activities:[45]

Legal Advice, Representation, Assistance to the Ombudsman Program and Involvement in the Private Bar

2016-17 45% 17-18 45% 18-19 45% 19-20 45%

Explain how allocations are justified and how they are determined to be sufficient to meet the need for the service within the PSA.

PSA: There are no changes programmed from the existing priority service allocations. The Department does not anticipate changing any of the funding allocations as they have been adequately meeting the needs of the community.

[44] Minimum percentages of applicable funds are calculated on the annual Title IIIB baseline allocation, minus Title IIIB administration and minus Ombudsman. At least one percent of the final Title IIIB calculation must be allocated for each "Priority Service" category or a waiver must be requested for the Priority Service category(s) that the AAA does not intend to fund.

[45] Legal Assistance must include all of the following activities: Legal Advice, Representation, Assistance to the Ombudsman Program and Involvement in the Private Bar.

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SECTION 14. NOTICE OF INTENT TO PROVIDE DIRECT SERVICES

PSA #6

CCR Article 3, Section 7320 (a)(b) and 42 USC Section 3027(a)(8)(C)

If an AAA plans to directly provide any of the following services, it is required to provide a description of the methods that will be used to assure that target populations throughout the PSA will be served.

☐ Check if not providing any of the below listed direct services.

Check applicable direct services	Check each applicable Fiscal Year			
Title IIIB	**16-17**	**17-18**	**18-19**	**19-20**
☒ Information and Assistance	☒	☒	☒	☒
☐ Case Management	☐	☐	☐	☐
☐ Outreach	☐	☐	☐	☐
☐ Program Development	☐	☐	☐	☐
☐ Coordination	☐	☐	☐	☐
☐ Long-Term Care Ombudsman	☐	☐	☐	☐
Title IIID	**16-17**	**17-18**	**18-19**	**19-20**
☐ Disease Prevention and Health Promo.	☐	☐	☐	☐
Title IIIE [46]	**16-17**	**17-18**	**18-19**	**19-20**
☐ Information Services	☐	☐	☐	☐
☐ Access Assistance	☐	☐	☐	☐
☐ Support Services	☐	☐	☐	☐
Title VIIA	**16-17**	**17-18**	**18-19**	**19-20**
☐ Long-Term Care Ombudsman	☐	☐	☐	☐
Title VII	**16-17**	**17-18**	**18-19**	**19-20**
☐ Prevention of Elder Abuse, Neglect and Exploitation	☐	☐	☐	☐

[46] Refer to PM 11-11 for definitions of Title III E categories.

Describe methods to be used to ensure target populations will be served throughout the PSA.

PSA: The DAAS Integrated Intake and Referral Unit serves as a comprehensive intake service, determining the long term care needs of individuals. The unit provides referrals and information for consumers that help support their current level of independence and functioning. The intake unit is knowledgeable in community and institutional services for seniors and adults with disabilities, regardless of their economic status. Screening and referrals are taken for In-Home Support Services, home delivered meals, Adult Protective Services, transitional care, and the Community Living Fund. Other screening needs not met by the department are referred to the appropriate community or institutional source.

Long term care refers to a range of social, health, mental health, medical, supportive housing, and other supportive services to assist people in maintaining their independence and assure their individual dignity and choice. They include prevention and health promotion services such as nutrition programs, transportation, senior centers, adult day health care services, case management, and caregiver services. These services support independence, maintain functional ability, and prevent further disability in the individual. Long term care and supportive services can be provided in community-based settings as well as in institutional settings, depending on a person's need and choice.

The DAAS Integrated Intake and Referral Unit is staffed by workers who speak English, Spanish, Cantonese, Mandarin, Vietnamese, and Tagalog, using language line services to accommodate those who speak other languages. The unit conducts outreach throughout the city using a variety of methods, such as distribution of informational materials at sites populated by seniors and persons with disabilities and participating in service fairs. The unit works closely with the Aging and Disability Resource Center (ADRC) network to ensure these information hubs have up-to-date information about available services and how to help clients apply for services.

SECTION 15. REQUEST FOR APPROVAL TO PROVIDE DIRECT SERVICES

PSA #6

Older Americans Act, Section 307(a)(8)
CCR Article 3, Section 7320(c), W&I Code Section 9533(f)

Complete and submit for CDA approval a separate Section 15 for each direct service not specified in Section 14. The request for approval may include multiple funding sources for a specific service.

☒ Check box if not requesting approval to provide any direct services.

Identify Service Category: _____

Check applicable funding source:[47]

☐ IIIB

☐ IIIC-1

☐ IIIC-2

☐ Nutrition Education

☐ IIIE

☐ VIIA

☐ HICAP

Request for Approval Justification:

☐ Necessary to Assure an Adequate Supply of Service OR

☐ More cost effective if provided by the AAA than if purchased from a comparable service provider.

Check all fiscal year(s) the AAA intends to provide service during this Area Plan cycle.

☐ 2016-17 ☐ 2017-18 ☐ 2018-19 ☐ 2019-20

Justification: Provide a cost-benefit analysis below that substantiates this request for direct delivery of the above stated service[48] : _____

[11] Section 15 does not apply to Title V (SCSEP).
[12] For a HICAP direct services waiver, the managing AAA of HICAP services must document that all affected AAAs are in agreement.

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SECTION 16. GOVERNING BOARD

PSA #6

GOVERNING BOARD MEMBERSHIP
2016-2020 Four-Year Area Plan Cycle

CCR Article 3, Section 7302(a)(11)

Total Number of Board Members: 7

Name and Title of Officers:	Office Term Expires:
Edna James, President	1/24/15
Gustavo Seriña, Vice President	7/21/16

Names and Titles of All Members:	Board Term Expires:
Katie Loo	1/15/16
Kaushik Roy	1/15/16
Neil Sims	7/5/16
Richard Ow	1/15/16
Samer Itani	6/16/16

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SECTION 17. ADVISORY COUNCIL

PSA #6

ADVISORY COUNCIL MEMBERSHIP
2016-2020 Four-Year Planning Cycle

OAA 2006 306(a)(6)(D)
45 CFR, Section 1321.57
CCR Article 3, Section 7302(a)(12)

Total Council Membership (include vacancies) 22 (9 vacancies)[49]
Number of Council Members over age 60 13

	% of PSA's 60+Population	% on Advisory Council
Race/Ethnic Composition		
White	40%	47%
Hispanic	10%	0%
Black	7%	47%
Asian/Pacific Islander	42%	6%
Native American/Alaskan Native	0.2%	0%
Other	1%	0%

Name and Title of Officers:	Office Term Expires:
Leon Schmidt, President	3/31/2017
Cathy Russo, Secretary	3/31/2016
Elenore Lurie, 1st Vice President	3/31/2017
Anna Maria Pierini, 2nd Vice President	3/31/2016

Name and Title of other members:	Office Term Expires:
Alexander McDonald	3/31/2016
Anne Kirueshkin	3/31/2017
Anne Warren (Ex Officio)	3/31/2017
Betty Hammond	3/31/2017
Diane Lawrence	3/31/2016
Louise Hines	3/31/2017
Marcy Adelman	3/31/2017
Patti Spaniak	3/31/2017
Walter DeVaughn	3/31/2017
William Marotta (pending confirmation)	*tbd*
Kay Parekh (pending confirmation)	*tbd*
Beverly Taylor (pending confirmation)	*tbd*

[49] There will be six remaining vacancies if the three pending candidates are approved by the DAAS Commission.

Indicate which member(s) represent each of the "Other Representation" categories listed below.

	Yes	No
Low Income Representative	☒	☐
Disabled Representative	☒	☐
Supportive Services Provider Representative	☒	☐
Health Care Provider Representative	☒	☐
Family Caregiver Representative	☒	☐
Local Elected Officials	☒	☐
Individuals with Leadership Experience in Private and Voluntary Sectors	☒	☐

Explain any "No" answer(s):

Briefly describe the local governing board's process to appoint Advisory Council members:

PSA: Half of the Members of the Advisory Board are appointed by the Aging and Adult Services Commission. All other members are appointed – one each – by their County District Supervisor.

On August 19, 2015 the Advisory Council Bylaws were amended (Article 2, Section 4, E, 2)

E. Serve as a principal advocacy body on behalf of the population served, i.e.:

2. Select delegates for the California Senior Legislature; CSL members are ex officio members of the Advisory Council

SECTION 18. LEGAL ASSISTANCE

PSA #6

2016-2020 Four-Year Area Planning Cycle

This section must be completed and submitted with the Four-Year Area Plan.
Any changes to this Section must be documented on this form and remitted with Area Plan Updates.[50]

1. Specific to Legal Services, what is your AAA's Mission Statement or Purpose Statement? Statement must include Title IIIB requirements:

PSA: Provide leadership in addressing issues that relate to older Californians; to develop community-based systems of care that provide services which support independence within California's interdependent society, and which protect the quality of life of older persons and persons with functional impairments; and to promote citizen involvement in the planning and delivery of services.

2. Based on your local needs assessment, what percentage of Title IIIB funding is allocated to Legal Services?

PSA: 45%

3. Specific to Legal Services, has there been a change in your local needs in the past four years? If so, please identify the change (include whether the change affected the level of funding and the difference in funding levels in the past four years).

PSA: Requests for housing related legal assistance continue to be the most frequent need of LSP clients and show signs of increasing over the past two to three years. From FY 13-14 to FY 14-15, there was over a 20% increase in housing-related cases opened by LSPs. Service levels for the first half of FY 15-16 indicate this increased demand is ongoing. Additional funding has not been allocated to LSPs.

4. Specific to Legal Services, does the AAA's contract/agreement with the Legal Services Provider(s) (LSPs) specify that the LSPs are expected to use the California Statewide Guidelines in the provision of OAA legal services?

PSA: Yes.

5. Does the AAA collaborate with the Legal Services Provider(s) to jointly establish specific priorities issues for legal services? If so what are the top four (4) priority legal issues in your PSA?

PSA: Priority areas are identified based on needs assessment analysis provided by the agency Planning Unit and input from LSPs about the areas in which they receive the most requests. The top issues currently are: Housing, Individual Rights (Elder Abuse, Immigration/Naturalization), Income Maintenance, and Consumer/Finance.

[50] For Information related to Legal Services, contact Chisorom Okwuosa at 916 419-7500/chisorom.okwuosa@aging.ca.gov

6. Specific to Legal Services, does the AAA collaborate with the Legal Services Provider(s) to jointly identify the target population? If so, what is the targeted senior population in your PSA AND what mechanism is used for reaching the target population? Discussion:

PSA: The AAA uses Older Americans Act guidelines, as well as needs assessment analysis prepared by the agency Planning Unit and input from the LSPs to identify target populations. (See #7 below for more detailed info on target population and outreach mechanisms.)

7. Specific to Legal Services, what is the targeted senior population and mechanism for reaching targeted groups in your PSA? Discussion:

PSA: The targeted senior populations continue to include low-income, minorities, non-English speaking, LGBT, frail, and most vulnerable older adults. In order to reach these targeted groups, the LSPs are active in the community: attending and participating in various community events, hosting on and off-site educational events, and staffing off-site legal clinics. The LSPs also publish and widely distribute a "Senior Rights Bulletin" at least twice a year on timely and relevant topics of interest to our target population. The bulletin is available in three languages and contains contact info for each LSP.

8. How many legal assistance service providers are in your PSA? Complete table below.

Fiscal Year	# of Legal Assistance Services Providers
2016-2017	4
2017-2018	
2018-2019	
2019-2020	

9. Does your PSA have a hotline for legal services?

PSA: PSA 6 does not have a singular hotline for legal services but there are three major telephone based referral sources: 1) DAAS Integrated Intake Unit receives calls from consumers and caregivers and are provided appropriate referrals to the senior legal service provider(s); 2) Aging and Disability Resources Center (ADRC) provides neighborhood coverage and multi-lingual information and assistance to both phone callers and walk-in consumers; and 3) Consumers can also access information and referral services by calling "211" (new format for the previous United Way Helpline) and the City of San Francisco run "311" information line.

10. What methods of outreach are Legal Services providers using? Discuss:

PSA: LSPs in PSA 6 frequent various community meetings, neighborhood fairs, educational forums, and network with other service providers throughout the area. Using local General Fund resources, the LSPs publish and widely distribute a Senior Rights Bulletin in multiple languages at least twice a year, which serves as a valuable outreach tool. Many providers are well-known in San Francisco because of their organizational age and long history of service in the community as well as ongoing legal clinics and outstation services they offer.

11. What geographic regions are covered by each provider? Complete table below.

Fiscal Year	Name of Provider	Geographic Region covered
2016-2017	**a.** Asian Americans Advancing Justice - Asian Law Caucus **b.** Asian Pacific Islander Legal Outreach **c.** La Raza Centro Legal **d.** Legal Assistance to the Elderly	**a.** Citywide (primarily in Chinatown, Visitacion Valley, North and South of Market, Richmond, etc.) **b.** Citywide (primarily in Chinatown, Bayview-Hunters Point, Visitacion Valley, South and North of Market, Richmond, Western Addition, etc.) **c.** Citywide (primarily Mission, Bernal Heights, Excelsior, North and South of Market, etc.) **d.** Citywide (primarily North and South of Market, Bayview-Hunters Point, Western Addition, Richmond, Sunset, etc.)
2017-2018	a. b. c.	a. b. c.
2018-2019	a. b. c.	a. b. c.
2019-2020	a. b. c.	a. b. c.

12. Discuss how older adults access Legal Services in your PSA:

PSA: Older adults contact the legal service providers directly by calling or dropping in to the agencies. Clients are also able to access legal services staff at various outstations or legal clinics held throughout PSA 6. Often times case managers or intake and referral specialists will refer consumers to the senior legal service providers. As more and more seniors and younger adults with disabilities become more tech savvy, they are also using the internet to search for resources.

13. Identify the major types of legal issues that are handled by the Title IIIB legal provider(s) in your PSA. Discuss (include new trends of legal problems in your area):

PSA: The major issues are described below:

- *Housing*: Housing related assistance is the top requested issue seen by LSPs. Our legal providers devote an enormous amount of time to tenant's rights and eviction prevention issues. Housing cases opened by LSPs has grown even further over the last 2 years. There is a severe shortage of accessible and affordable housing in San Francisco while rents continue to skyrocket. The shortage means that low-income seniors and adults with disabilities are at extreme risk for homelessness. Our LSPs also continue to see the trend of increasing Ellis Act and Owner-Move-In evictions as a result of the housing shortage.
- *Elder Abuse*: In the area of Elder Abuse Prevention, our legal providers remain busy working on behalf of clients for the issuance of elder abuse restraining orders and working with clients to resolve incidents of financial abuse.
- *Consumer Protection*: Older adults who find themselves overwhelmed with consumer debt problems are able to seek intervention and assistance from LSPs. Many of these consumer debt problems are tied to fraud and identity theft. Sometimes these types of cases involve predators

are family members and crosses-over with Elder Abuse. LSPs are able to advise clients as to their rights and often intervene on their behalf to address the myriad of issues.

- *Naturalization*: PSA 6 is very rich in terms of its diverse immigrant communities, and the LSPs are key in assisting Legal Permanent Residents (LPR) to apply for citizenship. The legal service providers help resolve red flag issues that arise during the citizenship application process. These issues have increased due to the recent addition of increasingly complex questions about the "activities" of the LPRs in their home countries. These are very sensitive issues that must be guided by legal counsel.
- *Income / Benefit Maintenance*: LSPs continue to provide assistance related to Social Security, Pensions, Medicare, Medi-Cal, and other retirement benefit related issues.

14. In the past four years, has there been a change in the types of legal issues handled by the Title IIIB legal provider(s) in your PSA? Discuss:

PSA: There is no change in the type of legal issues, but what has varied is the prevalence of some issues over others. Demand has increase for services related to Housing, Elder Abuse, and Consumer Protection/Fraud.

15. What are the barriers to accessing legal assistance in your PSA? Include proposed strategies for overcoming such barriers. Discuss:

PSA: Language access remains a barrier to overcome, but PSA 6 LSPs are very well equipped to handle multiple languages through the hiring of a multi-lingual staff. Awareness (or the lack thereof) of LSP assistance as well as a general understanding of one's legal rights also continues to be a barrier. The LSPs publish a widely distributed "Senior Rights Bulletin" which is designed to educate readers on legal issues and also provides contact info for the LSPs. Outreach by the LSPs into the community and continued coordination with ADRCs and other referral sources seeks to heighten awareness of LSP services.

16. What other organizations or groups does your legal service provider coordinate services with? Discuss:

PSA: Legal Service Providers coordinate with several senior centers, ADRCs, and other senior serving agencies throughout PSA 6. In addition, the LSPs meet as a LSP Workgroup on at least a quarterly basis to help facilitate communication regarding any new reporting requirements, legal standards or emerging trends. The LSPs also meet as a group to coordinate the publishing of the Senior Rights Bulletin.

SECTION 19. MULTIPURPOSE SENIOR CENTER ACQUISTION OR CONSTRUCTION COMPLIANCE REVIEW

PSA #6

CCR Title 22, Article 3, Section 7302(a)(15)
20-year tracking requirement

☒ No. Title IIIB funds not used for Acquisition or Construction.

☐ Yes. Title IIIB funds used for Acquisition or Construction.
Complete the chart below.

Title III Grantee and/or Senior Center	Type Acq/Const	IIIB Funds Awarded	% of Total Cost	Recapture Period MM/DD/YY Begin	Ends	Compliance Verification (State Use Only)
Name: Address:						
Name: Address:						
Name: Address:						
Name: Address:						

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SECTION 20. FAMILY CAREGIVER SUPPORT PROGRAM

PSA #6

Notice of Intent for Non-Provision of FCSP Multifaceted Systems of Support Services
Older Americans Act Section 373(a) and (b)

2016–2020 Four-Year Planning Cycle

Based on the AAA's review of current support needs and services for family caregivers and grandparents (or other older relative of a child in the PSA), indicate what services the AAA intends to provide using Title III E and/or matching FCSP funds for both family caregivers and grandparents/older relative caregivers.

Check YES or NO for each of the services* identified below and indicate if the service will be provided directly or contracted. If the AAA will not provide a service, a justification for each service is required in the space below.

Family Caregiver Services

Category	2016-2017	2017-2018	2018-2019	2019-2020
Family Caregiver Information Services	☒Yes ☐No ☐Direct ☒Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract
Family Caregiver Access Assistance	☒Yes ☐No ☐Direct ☒Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract
Family Caregiver Support Services	☒Yes ☐No ☐Direct ☒Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract
Family Caregiver Respite Care	☒Yes ☐No ☐Direct ☒Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract
Family Caregiver Supplemental Services	☒Yes ☐No ☐Direct ☒Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract

*Refer to PM 11-11 for definitions for the above Title IIIE categories.

Grandparent Services

Category	2016-2017	2017-2018	2018-2019	2019-2020
Grandparent Information Services	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract
Grandparent Access Assistance	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract
Grandparent Support Services	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract
Grandparent Respite Care	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract
Grandparent Supplemental Services	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract	☐Yes ☐No ☐Direct ☐Contract

*Refer to PM 11-11 for definitions for the above Title IIIE categories.

Justification: For each service category checked "no", explain how it is being addressed within the PSA. The justification must include the following:

- Provider name and address of agency
- Description of the service
- Where the service is provided (entire PSA, certain counties, etc.)
- Information that influenced the decision not to provide the service (research, needs assessment, survey of senior population in PSA, etc.)
- How the AAA ensures the service continues to be provided in the PSA without the use of Title IIIE funds

PSA: With the exception of Supplemental Services, all other grandparent services continue to be provided throughout San Francisco County (the entire PSA) without the use of Title III-E funds. The provider offering these services with the support of general funds is Edgewood Center for Children and Families, and their offices are located at 1801 Vicente St, San Francisco CA 94116.

SECTION 21. ORGANIZATION CHARTS

As noted earlier, the Area Agency on Aging for PSA 6 is the San Francisco Department of Aging and Adult Services (DAAS). DAAS is located within the San Francisco Human Services Agency (SFHSA), an umbrella agency that also includes the Department of Human Services (provides CalFresh, Family and Children's Services, Medi-Cal, Welfare to Work, and more) and the Office of Early Care and Education. *The organization chart on page 245 provides the SFHSA structure*.

As described in Section 3 of this Area Plan, DAAS provides several programs. *See page 246 for the DAAS organization chart*.

Services funded by the Older Americans Act (OAA) are facilitated by the DAAS Office on Aging (OOA). *Please see page 247 for the OOA organization chart*. The positions in the OOA include:

- **0923 - OOA Director** (Denise Cheung): Under the general direction of the Deputy Director of the Department of Aging and Adult Services (DAAS), the Director of Office on the Aging and County Veterans Service Office assumes responsibility for coordinating and implementing program planning; defining organizational structure, staffing requirements, resource allocation and identification of future resource needs for the following: the Office on the Aging, the County Veterans Service office, and the SF Connected Program; and any other programs as assigned by the Deputy Director of DAAS. This position is responsible for managing all the programs funded by California Department on Aging, and coordinated with other HSA offices that support this work. This includes supervising all the related activities including (but not limited to) Needs Assessment, Area Plan and Area Plan update, Area Plan budget, Reports to the state, Request for Proposals and program monitoring.
- **2917 - OOA Program Analysts** (Michael Zaugg, Monte Cimino, and Linda Murley): Under the direction and supervision of the Director of Office on the Aging and County Veterans Office (OOA Director), the OOA Program Analyst designs programs, develops program standards, proposes program outcomes, and policies and procedures for OOA funded programs for seniors and adults with disabilities; develops evaluation criteria and monitors these programs to ensure compliance to OOA, state and federal rules and regulations; helps the AAA in planning, coordination, and implementation of programs and services, as well as the development of the Area Plan and annual updates; provides technical assistance to OOA funded agencies; and acts as consumer advocate to ensure programs are consumer-driven. One position (Michael Zaugg) is responsible for the OAA-funded HICAP service.
- **2917 & 2846 - OOA Nutritionists** (Linda Lau, two vacant positions): Under the direction of the Director of Office on the Aging and County Veterans Service Office, the Nutritionists (Registered Dietitian, RD) monitors all the nutrition programs funded by OOA, including congregate meals programs, and home-delivered meals programs, for seniors and for younger adults with disabilities. The RDs are also in charge of the Health Promotion programs funded by OOA. The RDs are responsible for ensuring compliance with contract requirements and, in particular, the program's quality and effectiveness in delivering service, compliance with health and safety standards, and other program requirements. This position also acts as a departmental consultant on nutrition education resources/nutrition issues and develops and conducts training for OOA and contractors, as needed. These positions are not funded with Title IIIB funding.
- **1823 & 1822 - SF Connected Analysts** (Aaron Low and Paulo Salta): Under the direction of the Director of Office on the Aging and County Veterans Service Office, the SF Connected analysts manage the development and implementation of the SF Connected Program. This includes: developing scopes of service; managing barriers to the delivery of services; developing metrics

for monitoring service delivery; coordinating regular provider meetings; providing technical assistance to strengthen the operation of the SF Connected Program. These analysts also may liaise with other city departments, such as the Department of Technology, to promote the use of technology and adoption of broadband technology throughout senior and disabled adult communities in San Francisco. This work is supported by a 1404 clerk (Karen Perez). These positions are not funded with Title IIIB funding.

- **1842 - Management assistant** (Gloria Carniglia): Under the direction of the Director of Office on the Aging and County Veterans Service Office, the management analyst position provides data collection support to OOA and is responsible for the OOA's quarterly and annual data report submission to the CDA. This position also provides technical assistance related to the CA GetCare database for provider agencies and schedules database trainings to support data collection efforts.

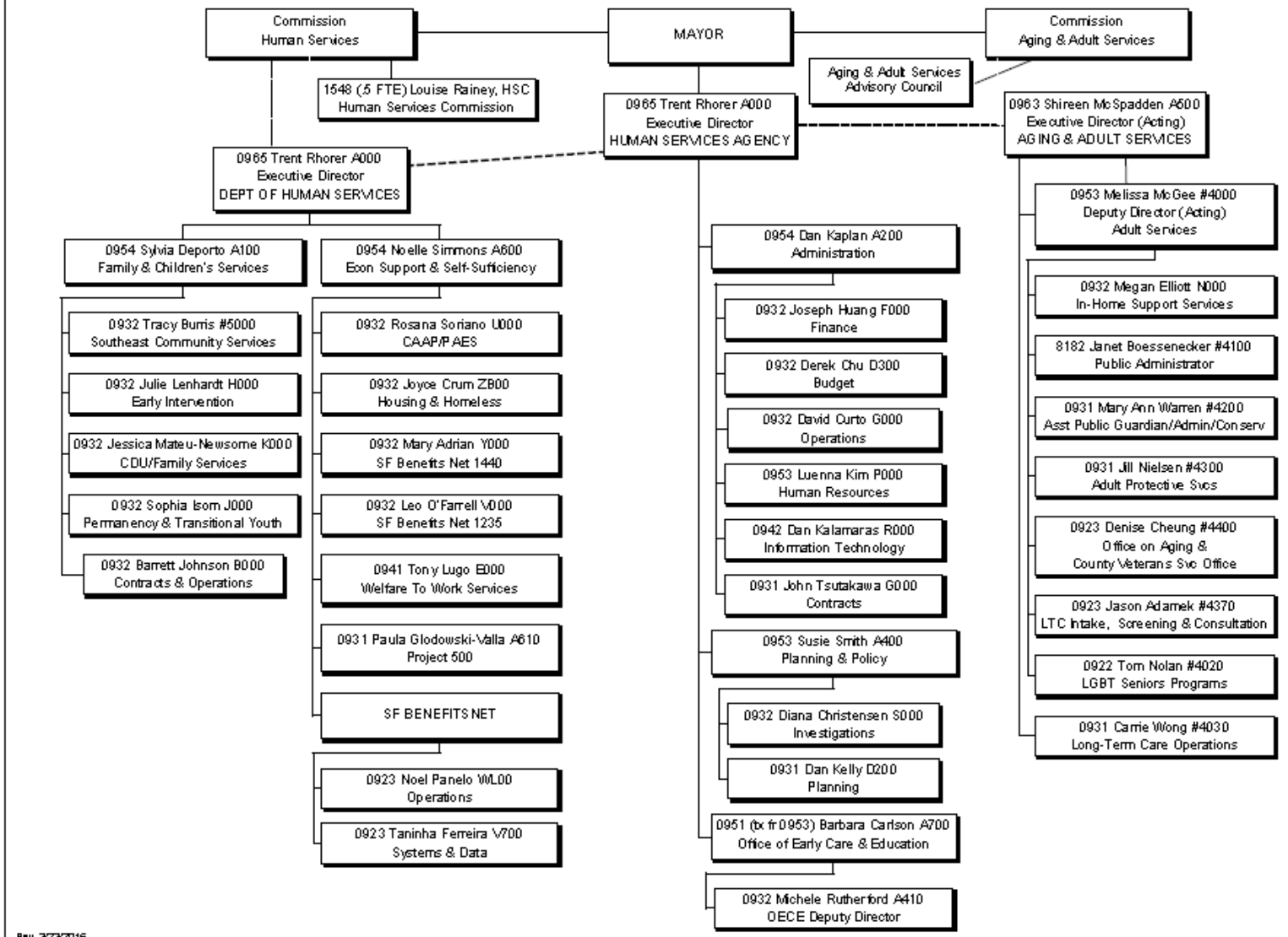
The DAAS Integrated Intake, Screening, and Consultation Program provides information and assistance services and also helps consumers complete intake forms for DAAS services, including In Home Supportive Services, the Community Living Fund, home-delivered meals, and transitional care. In this integrated unit, staff is cross-trained so all positions can provide these services. All staff provides information and assistance services. *The organization chart for this program is on page 248.*

OOA also receives support from the SFHSA Budget and Planning Units. These positions do not use Title IIIB funding. These positions are:

- **1824 - Budget – Principal Administrative Analyst** (Martha Peterson): Under the general supervision of the Human Services Agency's Budget Manager, this position is a lead analyst in developing the Agency's $835 million annual budget. Essential functions include, but are not limited to: performing professional-level analytical and administrative work including developing, analyzing, and negotiating the department and division/program budgets and/or policy issues with the Mayor's Office, the Board of Supervisors, and the Controller's Office; analyzing, developing, and implementing new or improved standard operating procedures for budget and/or fiscal operations; directing and performing difficult complex and/or sensitive projects for executive management on issues concerning HSA budget, finance, and legislative policy and operational issues; preparing revenue and expense analyses to determine the fiscal impact of various program initiatives and State, Federal and Municipal mandates; collaborating with other City departments and community providers on budget and fiscal policy affecting social services; coordinating activities relating to the application for and management of grants, revenues, and subventions from private, State, and Federal sources. *See page 249.*
- **2917 - Planning – Program Support Analyst** (Dorothy Rose Johns): Under the general supervision of the Human Services Agency's Planning Director, this position performs a variety of highly complex and responsible professional administrative and analytical duties. Essential duties include but are not limited to: conducting specific, comprehensive analyses of a wide range or policies involving organization, procedures, finance ,and services; conducts studies and develops recommendations on systems, methods, procedures, and general administrative duties; prepares and presents reports and surveys; participates in a variety of complex and detailed responsibilities involving problem solving; acts as a representative of the agency for internal and outside meetings, committees, and commissions; and recommends goals and objectives for programs. This position takes the lead in conducting the DAAS Needs Assessment and preparation of the Area Plan. *See page 250.*

CITY & COUNTY OF SAN FRANCISCO
HUMAN SERVICES AGENCY
FY 2016/2017

01



Rev. 3/23/2016

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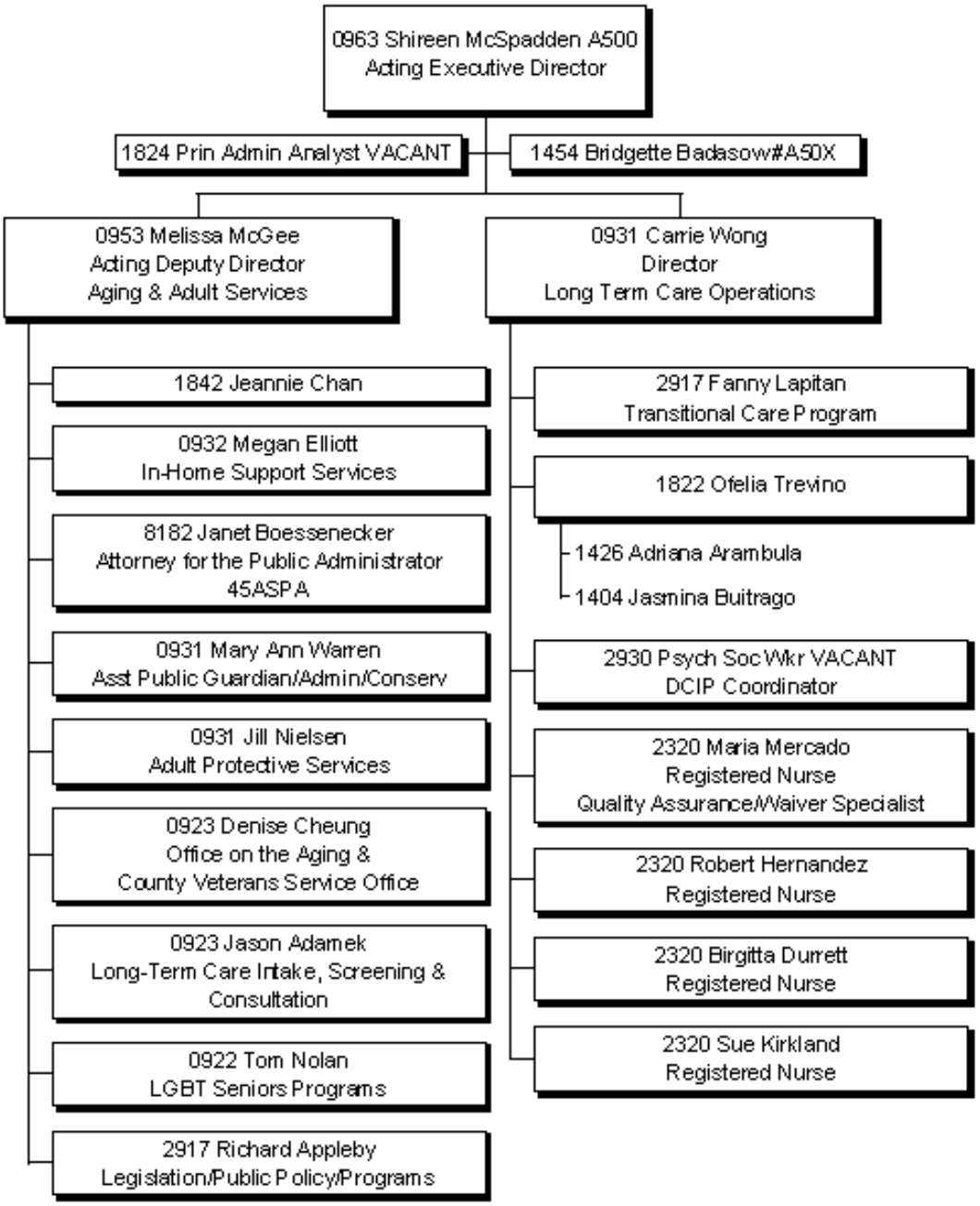
DEPT. OF AGING & ADULT SERVICES
FY 2016/2017

26

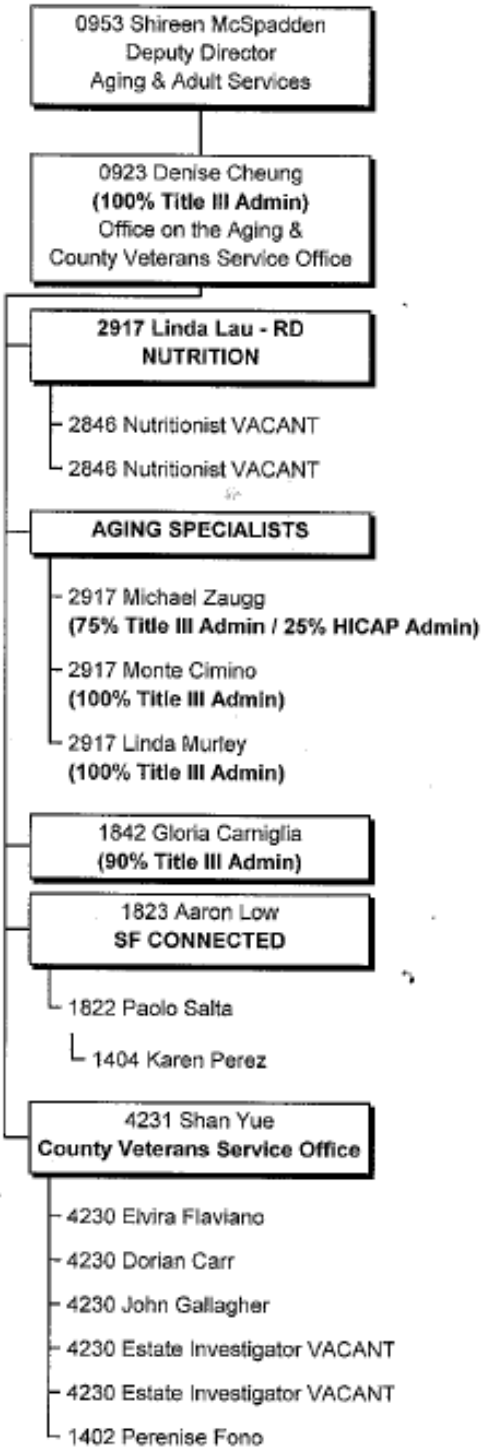


Rev. 3/24/2016

File: 026 DAAS AGING SVCS

Dept. of Aging & Adults Services
OFFICE ON THE AGING & COUNTY VETERANS SERVICES
FY 2016/2017

30



Rev. 3/24/2016

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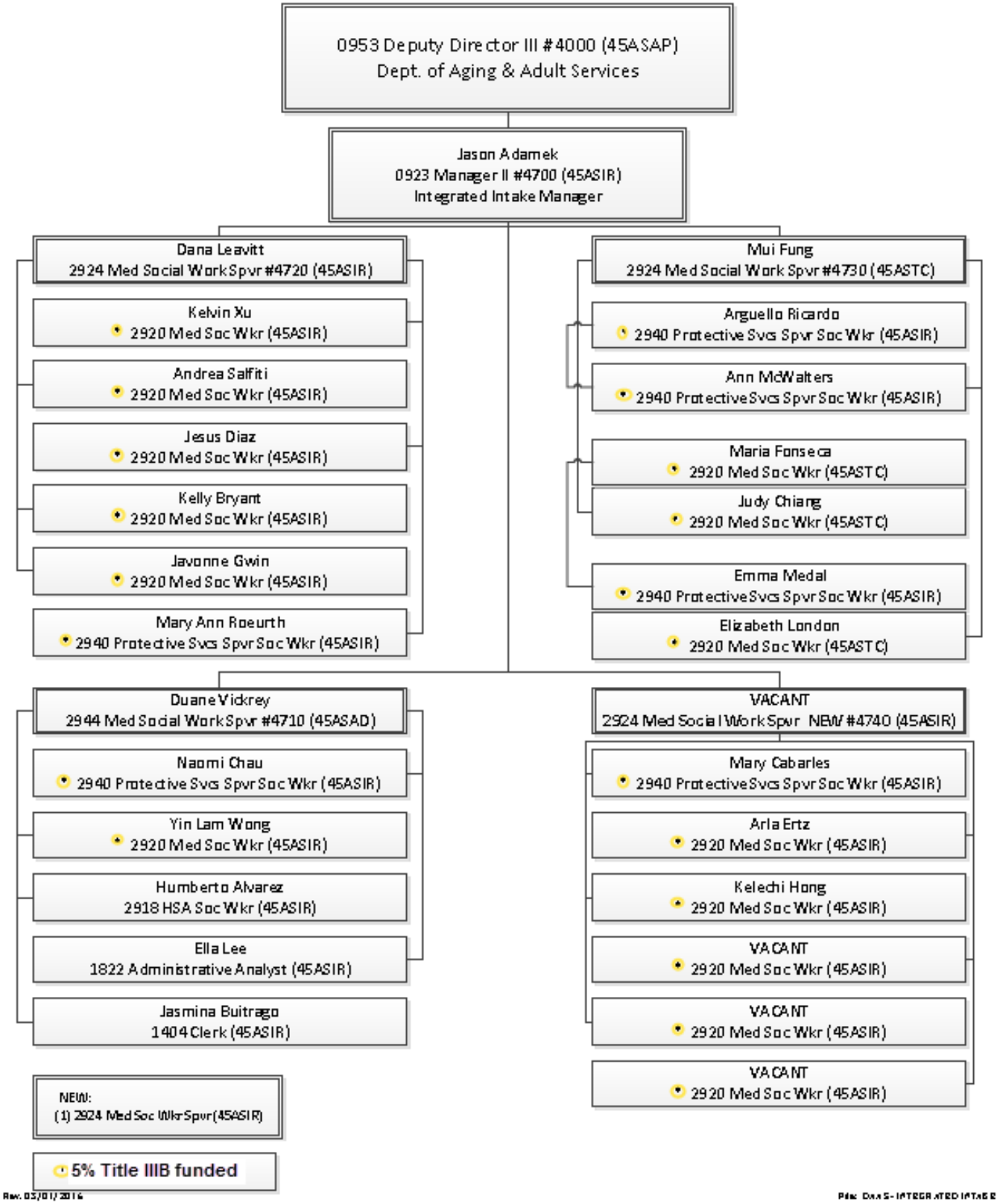
DEPARTMENT OF AGING & ADULT SERVICES
DAAS – INTEGRATED INTAKE, SCREENING & CONSULTATION
FY 2016/2017

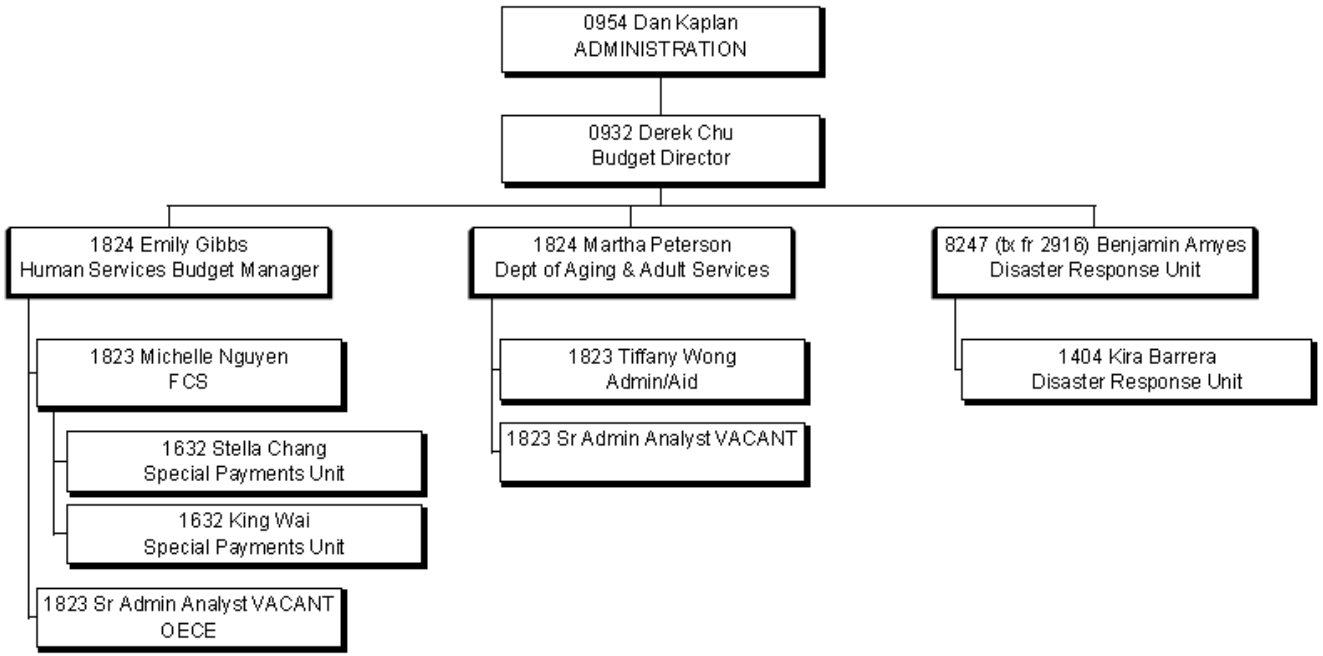


Rev. 03/01/2016

File: DAAS - INTEGRATED INTAKE

Human Services Agency
BUDGET
FY 2016/2017

03

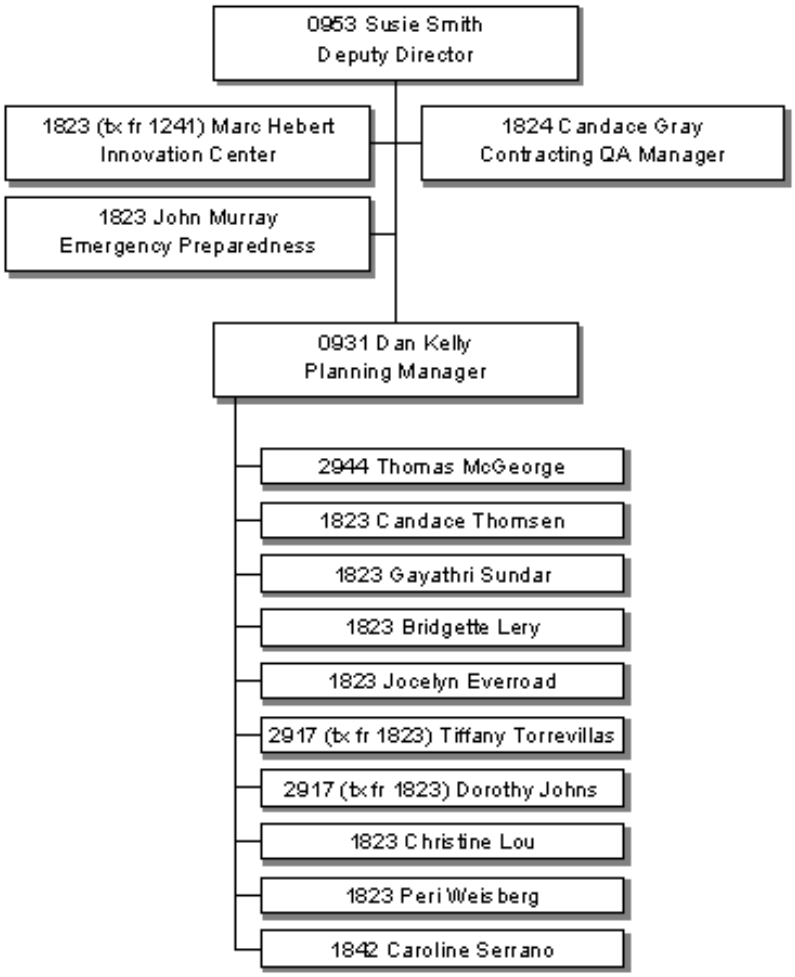


Rev. 3/23/2016

File: 03 HSA Budget

Human Services Agency
POLICY & PLANNING
FY 2016/2017

10



Rev. 3/23/2016

File: 10 HSA POLICY & PLANNING

SECTION 22. ASSURANCES

Pursuant to the Older Americans Act Amendments of 2006 (OAA), the Area Agency on Aging assures that it will:

A. Assurances

1. OAA 306(a)(2)

   Provide an adequate proportion, as required under OAA 2006 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

   (A) services associated with access to services (transportation, health services (including mental health services) outreach, information and assistance, (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

   (B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

   (C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

2. OAA 306(a)(4)(A)(i)(I-II)

   (I) provide assurances that the area agency on aging will -

      (aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

      (bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and;

   (II) include proposed methods to achieve the objectives described in (aa) and (bb) of subclause (I);

3. OAA 306(a)(4)(A)(ii)

   Include in each agreement made with a provider of any service under this title, a requirement that such provider will—

   (I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

   (II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area;

4. OAA 306(a)(4)(A)(iii)

   With respect to the fiscal year preceding the fiscal year for which such plan is prepared—

   (I) identify the number of low-income minority older individuals in the planning and service area;

   (II) describe the methods used to satisfy the service needs of such minority older individuals; and

   (III) provide information on the extent to which the area agency on aging met the objectives described in assurance number 2.

5. OAA 306(a)(4)(B)

   Use outreach efforts that —

   (i) identify individuals eligible for assistance under this Act, with special emphasis on—

      (I) older individuals residing in rural areas;

      (II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

      (III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

      (IV) older individuals with severe disabilities;

      (V) older individuals with limited English proficiency;

      (VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

      (VII) older individuals at risk for institutional placement; and

   (ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance;

6. OAA 306(a)(4)(C)

   Ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas;

7. OAA 306(a)(5)

   Coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement with agencies that develop or provide services for individuals with disabilities;

8. OAA 306(a)(9)
   Carry out the State Long-Term Care Ombudsman program under OAA 2006 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title;

9. OAA 306(a)(11)
   Provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as ‘‘older Native Americans’’), including—

   (A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

   (B) to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

   (C) make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

10. OAA 306(a)(13)(A-E)
    (A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

    (B) disclose to the Assistant Secretary and the State agency—

        (i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

        (ii) the nature of such contract or such relationship;

    (C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

    (D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

    (E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

11. 306(a)(14)
    Not give preference in receiving services to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

12. 306(a)(15)

Funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in OAA 2006 306(a)(4)(A)(i); and

(B) in compliance with the assurances specified in OAA 2006 306(a)(13) and the limitations specified in OAA 2006 212;

B. Additional Assurances:

Requirement: OAA 305(c)(5)
In the case of a State specified in subsection (b)(5), the State agency; and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

Requirement: OAA 307(a)(7)(B)
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.
Requirement: OAA 307(a)(11)(A)
(i) enter into contracts with providers of legal assistance, which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

Requirement: OAA 307(a)(11)(B)
That no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

Requirement: OAA 307(a)(11)(D)
To the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

Requirement: OAA 307(a)(11)(E)
Give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

Requirement: OAA 307(a)(12)(A)
In carrying out such services conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for -

(i) public education to identify and prevent abuse of older individuals;
(ii) receipt of reports of abuse of older individuals;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(iv) referral of complaints to law enforcement or public protective service agencies where appropriate.

Requirement: OAA 307(a)(15)
If a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area -
(A) To utilize in the delivery of outreach services under Section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability.
(B) To designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include:
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effective linguistic and cultural differences.

Requirement: OAA 307(a)(18)
Conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to Section 306(a)(7), for older individuals who -
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

Requirement: OAA 307(a)(26)
That funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency, or an area agency on aging, to carry out a contract or commercial relationship that is not carried out to implement this title.

Requirement: OAA 307(a)(27)
Provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

C. Code of Federal Regulations (CFR), Title 45 Requirements:

CFR [1321.53(a)(b)]
(a) The Older Americans Act intends that the area agency on aging shall be the leader relative to all aging issues on behalf of all older persons in the planning and service area. This means that the area agency shall proactively carry out, under the leadership and direction of the State agency, a wide range of functions related to advocacy, planning, coordination, interagency linkages, information sharing, brokering, monitoring and evaluation, designed to lead to the development or enhancement of comprehensive and coordinated community based systems in, or serving, each community in the Planning and Service Area. These systems shall be designed to assist older persons in leading independent, meaningful and dignified lives in their own homes and communities as long as possible.

(b) A comprehensive and coordinated community-based system described in paragraph (a) of this section shall:
(1) Have a visible focal point of contact where anyone can go or call for help, information or referral on any aging issue;
(2) Provide a range of options:
(3) Assure that these options are readily accessible to all older persons: The independent, semi-dependent and totally dependent, no matter what their income;
(4) Include a commitment of public, private, voluntary and personal resources committed to supporting the system;
(5) Involve collaborative decision-making among public, private, voluntary, religious and fraternal organizations and older people in the community;
(6) Offer special help or targeted resources for the most vulnerable older persons, those in danger of losing their independence;
(7) Provide effective referral from agency to agency to assure that information or assistance is received, no matter how or where contact is made in the community;
(8) Evidence sufficient flexibility to respond with appropriate individualized assistance, especially for the vulnerable older person;
(9) Have a unique character which is tailored to the specific nature of the community;
(10) Be directed by leaders in the community who have the respect, capacity and authority necessary to convene all interested individuals, assess needs, design solutions, track overall success, stimulate change and plan community responses for the present and for the future.

CFR [1321.53(c)]
The resources made available to the area agency on aging under the Older Americans Act are to be used to finance those activities necessary to achieve elements of a community based system set forth in paragraph (b) of this section.

CFR [1321.53(c)]
Work with elected community officials in the planning and service area to designate one or more focal points on aging in each community, as appropriate.

CFR [1321.53(c)]
Assure access from designated focal points to services financed under the Older Americans Act.

CFR [1321.53(c)]
Work with, or work to assure that community leadership works with, other applicable agencies and institutions in the community to achieve maximum collocation at, coordination with or access to other services and opportunities for the elderly from the designated community focal points.

CFR [1321.61(b)(4)]
Consult with and support the State's long-term care ombudsman program.

CFR [1321.61(d)]
No requirement in this section shall be deemed to supersede a prohibition contained in the Federal appropriation on the use of Federal funds to lobby the Congress; or the lobbying provision applicable to private nonprofit agencies and organizations contained in OMB Circular A-122.

CFR [1321.69(a)]
Persons age 60 and older who are frail, homebound by reason of illness or incapacitating disability, or otherwise isolated, shall be given priority in the delivery of services under this part.