SAN FRANCISCO
DEPARTMENT OF AGING & ADULT SERVICES

COMMUNITY NEEDS ASSESSMENT
SEPTEMBER 2006

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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 report contains the findings of the 2006 needs assessment process, conducted by the San Francisco Human Services Agency (HSA) planning unit.

GOAL

The 2006 community needs assessment was guided by the following primary goal:

> To estimate the unmet needs for services for seniors and for adults with disabilities in San Francisco, taking into consideration services currently provided by DAAS and its contractors, other city departments, and other community-based providers.

The assessment provides, wherever possible, concrete quantitative estimates of and a qualitative context for service gaps citywide, by neighborhood, and for high-need communities. It identifies existing needs of seniors and of younger adults with disabilities. It then describes existing services that address those needs. By comparing needs with existing services, the assessment reveals gaps in services and supports. This gap analysis will provide valuable context as the department continues to refine future funding priorities.

SCOPE OF ANALYSIS

In order to maintain a feasible scope, analysis was limited to broad areas of need that mirror the social services focus of DAAS, though it is likely that other community needs are relevant to the missions of other public agencies (e.g., disease prevention or employment training). The needs assessment is broken into seven overarching topic areas:

- Housing
- Nutrition
- Isolation
- Case Management & Transitional Care
- Self Care & Safety
- Caregiver Support
- Access

Each chapter presents an overview of the issue, evidence of local needs, a description of existing local services, and an analysis of gaps.

The process of the assessment included both quantitative and qualitative analysis methods. The HSA planning unit conducted deep analysis of data from the US Census Bureau, supplementing it with other national, state, and local research. Staff also conducted numerous key informant interviews, roundtable discussions and focus groups with both service providers and consumers.[1]

While the assessment does clarify the current landscape of services and consumer needs in they city, it is likely to raise as many new questions as it answers old ones. Designed to be consumer-focused, the report does not focus on infrastructure or systems-development needs nor does it evaluate current programs on quality measures.

[1] The "Methods" section of this report includes a more detailed discussion of the needs assessment methods and rationale.

METHODS

PRINCIPLES

The design of this community needs assessment was driven by two overarching principles. First, the assessment would be consumer-focused, including both those consumers who currently receive services and those who have "unmet needs." Methods were intended to reveal the true needs of consumers, even for those unable to express them clearly. The design of the assessment was cautious not to simply reinforce existing systems for serving consumers by, for example, seeking feedback primarily from those consumers who are already receiving services from the DAAS network of providers. Second, the assessment relied upon the highest possible quality of information available for each topic. The methods rely upon a convergent approach, gathering information from both quantitative sources and from qualitative research wherever possible in order to prevent "blind spots" and to enhance the reliability of the findings when quantitative and qualitative sources reinforce each other.

QUANTITATIVE ANALYSIS

Quantitative analysis sought to concretely describe the landscape of needs and existing services in San Francisco without the subjective biases that are inherent to qualitative research. Data sources included:

Census 2000

While the American Community Survey provides sample-based updates to census questionnaire items, the assessment team chose to use Census 2000 data for most analyses. Census 2000 data provides a more comprehensive dataset that allows for more detailed analysis. For example, Census 2000 data can be analyzed to describe trends according to zip code or census tract, while ACS samples are too small to do geographic analysis within the city.

American Community Survey 2004

American Community Survey (ACS) 2004 data were also used to augment the Decennial Census for disability statistics. Disability data is considered to be more reliable in the ACS data than in the Census. According to the US Census Bureau, Census 2000 statistics likely overestimated go-outside-home disability and employment disability (Stern, 2005). Subsequent ACS mailed survey instruments were altered to fix potentially confusing instructions for questions regarding disability, leading to more accurate reporting of disability data. Because of this issue, assessment analysis relied upon ACS figures for issues related to disability status.

California Health Interview Survey

The California Health Interview Survey (CHIS) is a collaborative project of the UCLA Center for Health Policy Research, the California Department of Health Services, and the

Public Health Institute. It is a biennial 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.

SF-GetCare Consumer Data

Nearly all consumers participating in OOA-funded programs are enrolled in an online database, SF-GetCare. Enrollment information identifies the programs in which each consumer participates, as well as the organization where services were provided. Each consumer has one client record, but may have multiple enrollments if participating in multiple programs or at more than one site. Consumer records also include personal characteristics, such as ethnicity, primary language, English fluency level, and zip code. Planning unit staff used a data extract that included all enrollments from July 2005 through February 2006. While this timeframe did not cover a full fiscal year, it provided as current information as possible given the time constraints of the assessment process. The timeframe is sufficient to provide reliable information on the characteristics of program enrollees. For annual units of service, the assessment typically relies on FY2004/05 figures, as they were the most recent annual figures available.

Despite systematic efforts to ensure that consumers enrolled in SF-GetCare represent unduplicated individuals, data entry inconsistencies result in some duplicates. Planning unit staff took steps to remove duplicate consumers from the dataset before conducting any analysis. Most notably, consumers with duplicate social security numbers were collapsed to one data record, preserving all data regarding program enrollments. As the social security number is not a required field for data entry, it was impossible to tell whether those with blank social security numbers were unique consumers or duplicates. A comparison of the demographics of consumers with and without social security numbers revealed that they did not differ significantly in characteristics. Therefore, inclusion of these consumers is unlikely to alter findings with respect to demographics. Consumers without social security numbers remained in the analyses and were considered unique consumers.

Department of Human Services Administrative Data

Using individual-level (rather than household-level) data from April 2006, data extracts were examined for seniors participating in the following HSA programs:

- Medi-Cal
- Food stamps
- CalWorks
- County Adult Assistance Programs (CAAP)
- Cash Assistance Program for Immigrants (CAPI)
- Cash Assistance Linked to Medi-Cal (CALM)

These extracts were combined both with data from SF-GetCare to demonstrate the overlap between programs on an individual consumer basis.

As a separate analysis, seniors age 60 and over using homeless shelter programs during FY2005/06 were matched against the SF-GetCare consumer dataset to assess the extent to which homeless seniors utilize OOA-funded programs. Matches were only possible when

valid social security numbers were provided in both datasets, making the estimate of overlap a minimum figure.

In addition to these detailed analyses, existing quarterly or annual reports were culled and referenced when they summarized administrative data in a useful manner.

Other Human Services Agency (HSA) Administrative Data
Staff also analyzed data from Adult Protective Services, as well as In-Home Supportive Services to identify trends in overall caseload growth as well as consumer demographics.

Administrative Data from Other Government Agencies
The following other city departments provided data regarding the participation of seniors and younger adults with disabilities in their funded programs:

- Department of Public Health
- Mayor's Office on Housing
- San Francisco Housing Authority
- San Francisco Redevelopment Agency
- US Department of Housing and Urban Development San Francisco Regional Office

2006 Phone Survey of Seniors and Adults with Disabilities
The Department of Aging and Adult Services contracted with National Research Center (NRC) to conduct a telephone survey of a representative sample of older adults and persons with disabilities. The survey was intended to assess the effectiveness of the public awareness media campaign conducted by the San Francisco Partnership for Community-Based Care and Support while also supplementing needs assessment research. NRC conducted a telephone survey of randomly selected adults with disabilities (age 18 and over) and older adults (age 60 and over) living within the city of San Francisco. Surveys were conducted in English, Cantonese, Mandarin, Vietnamese, Russian, and Spanish. A total of 411 respondents completed the survey. Of the 411 respondents, 341 older adults (60+) and 193 adults with disabilities (18+) participated in the survey, with 123 falling into both categories. The overall response rate for the survey was 16%. Data were weighted by disability status, age, gender and race to better reflect the socio-demographics of these populations. The 95 percent confidence level for the survey is generally no greater than plus or minus five percentage points around any given percent reported for older adults (341 completed interviews) and no greater than plus or minus seven percentage points for adults with disabilities (193 completed interviews).

LITERATURE REVIEW

In order to supplement the data sources listed above, staff conducted a literature review of relevant national, state, and local reports. Information from this research provided an overview of each issue area and described San Francisco-specific needs and challenges.

QUALITATIVE RESEARCH

The qualitative portion of needs assessment research was informed by the data analysis and literature review. Qualitative research methods provided concrete opportunities for public input and helped to broaden the perspective of the needs assessment beyond what is possible using only quantitative sources.

Key Informant Interviews

Staff conducted interviews with more than 50 local key informants in order to understand the needs of populations with complex or often hidden needs (e.g., homebound seniors, consumers needing intense case management or legal assistance, adults needing Ombudsman advocacy) and to gain additional information about sub-populations often left out of needs assessment processes (e.g., younger adults with disabilities, LGBT seniors, minority and monolingual seniors).

Roundtable Discussions with Service Providers

Roundtable discussions were held with service providers at the four Neighborhood Partnerships of the San Francisco Partnership for Community-Based Care and Support in order to gain additional perspective on the unique issues facing the communities those groups represent: African American; Asian/Pacific Islander; Latino; and lesbian, gay, bisexual, and transgender (LGBT) seniors and younger adults with disabilities.

Consumer Focus Groups

Focus groups were valuable for two primary purposes:

- *To gather information on sub-populations for whom little hard data were available.* For example, one focus group with case managers from MSSP, Linkages, and Curry Senior Center provided insight into issues facing seniors and disabled adults with very complex needs. A focus group with peer advocates helped to highlight challenges facing isolated individuals.

- *To connect with individual consumers themselves.* While the needs assessment team delved into Census and other resources to broadly estimate the prevalence of certain needs in the community, focus groups with consumers helped to highlight the human dimension of those needs for various target populations.

District Advisory Councils (DACs)

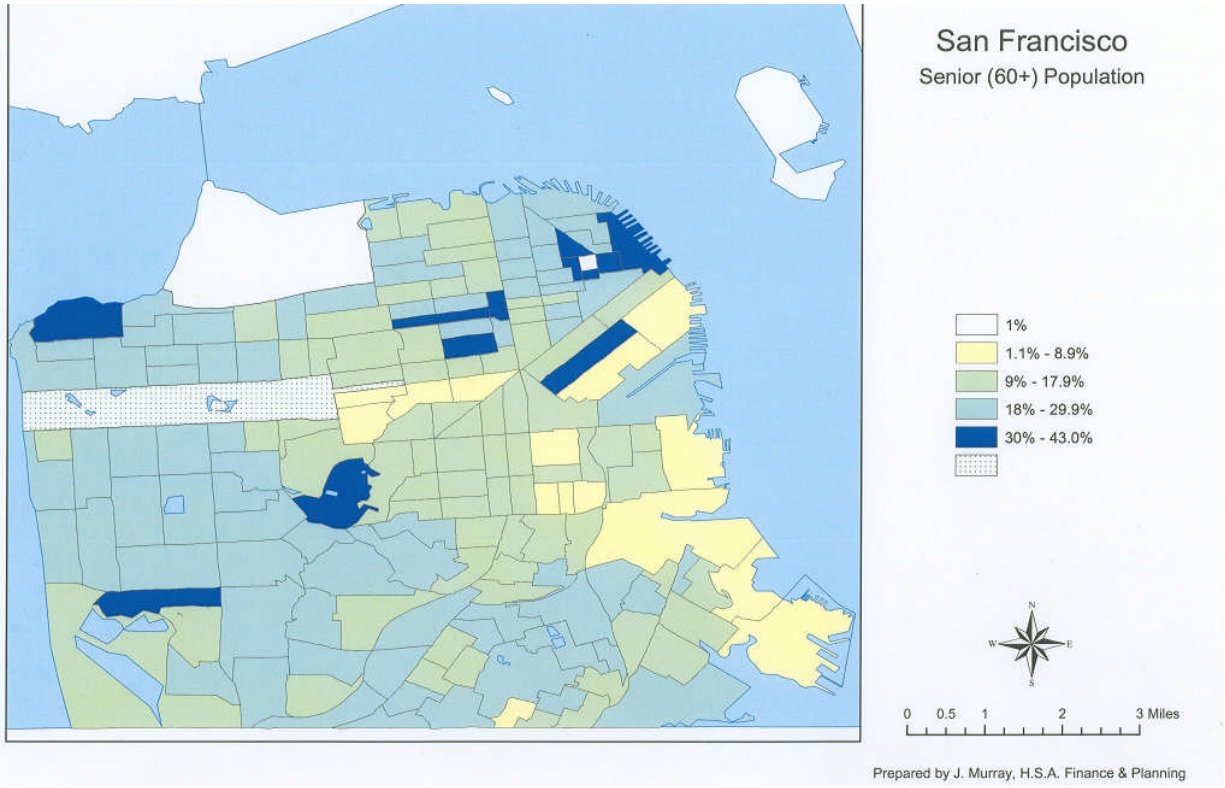
During June and July, Office on the Aging program analysts conducted discussions at the city's DAC meetings to learn about perceptions of the most important needs in the community, barriers to service, and to collect recommendations for improved coordination of the service delivery system. At this time of the writing of this report, summaries of eight out of ten of those meetings were available for inclusion.

PROFILE: SENIORS AND YOUNGER ADULTS WITH DISABILITIES

SENIORS

Census 2000 data estimate that San Francisco is home to 136,369 seniors age 60 and over. Seniors make up a higher proportion of the city's population (17.6%) than they do statewide or nationally (14% and 16.5%). The following map shows where seniors live – high concentrations of seniors live in Chinatown, Russian Hill and Polk Gulch, the West Portal/St. Francis Woods, South of Market, Western Addition, Seacliff, and Lakeside neighborhoods.

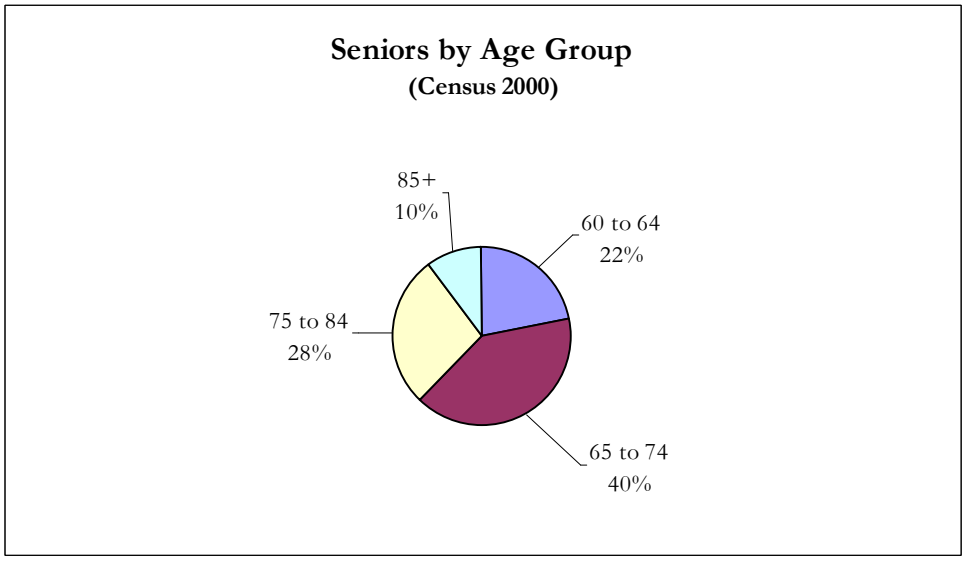
Map: Concentrations of Seniors Age 60 and Older in San Francisco



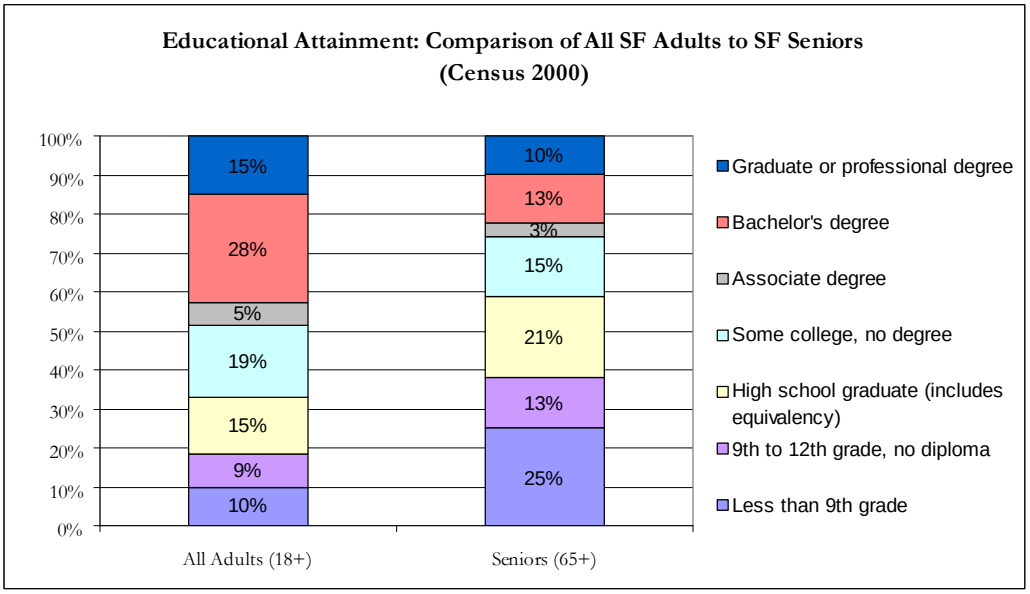
Demographics

Nearly forty percent of seniors are 75 years old or older. Advances in medical technology may increase the relative size of this "older old" population as life expectancies increase in the future. This segment of the population is more likely to be poor and in need of health care and in-home support to maintain their quality of life (Living with Dignity Policy Committee et al., 2004). Furthermore, the community has increased its focus on providing community-based long-term care services in housing environments, providing more alternatives to institutional care. To the degree this trend is successful in allowing seniors to "age in place" in service-enriched non-institutional environments, demand for community-based services may increase.

Older persons are more likely to be female. Women comprise 57 percent of all older San Franciscans, and 69 percent of those age 85 or older. Women are more likely to be living alone, or to have caregiving responsibilities when their spouses are still living (Living with Dignity Policy Committee, 2004). Nearly two-thirds of older people with severe disabilities are female (Johnson 2006).



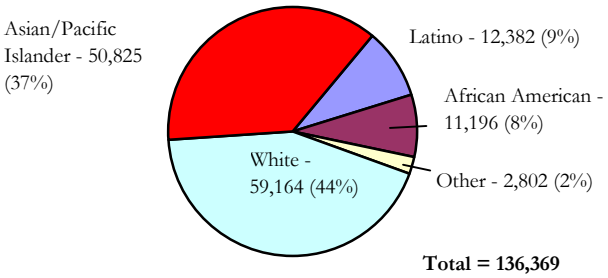
One quarter of seniors in San Francisco have less than a 9th grade education. More than half of all seniors have a high school level education or less. Twenty three percent of seniors have a bachelor's or graduate degree.



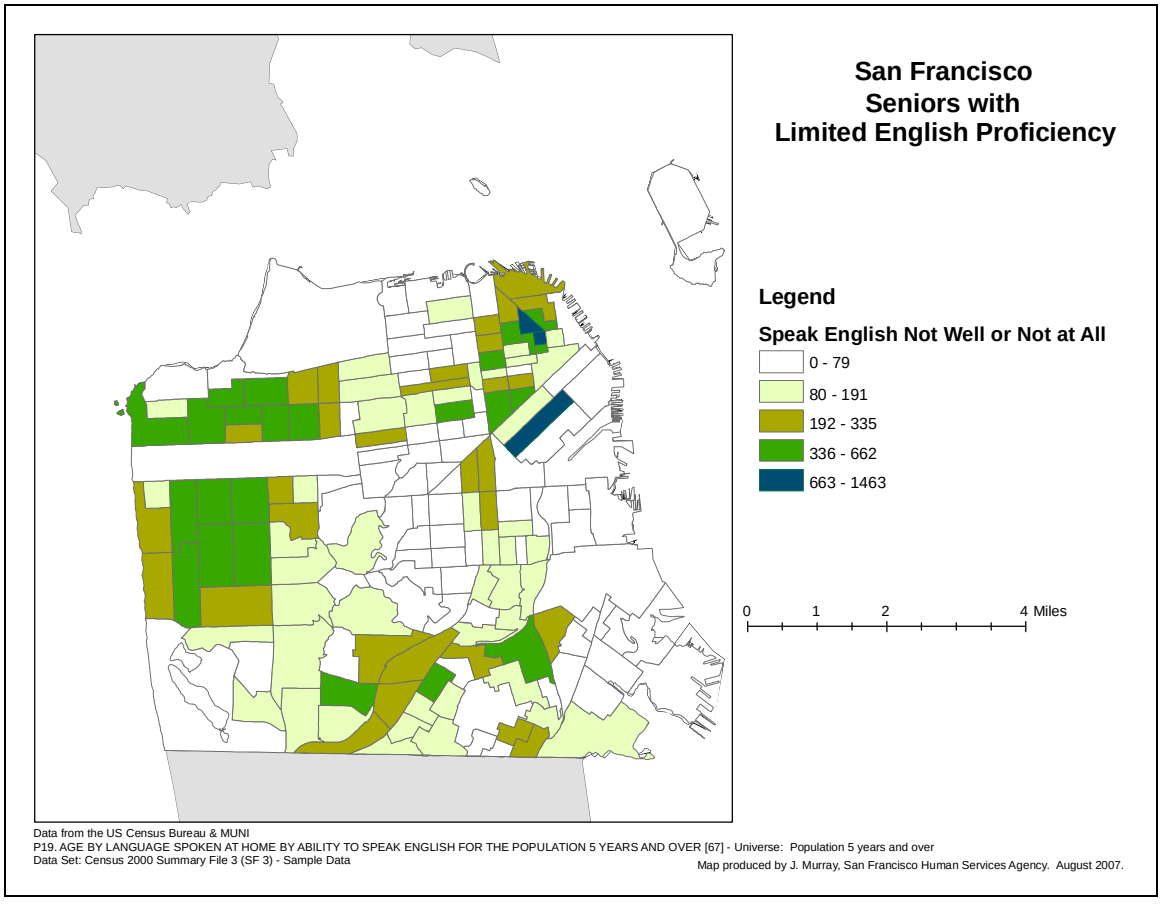
San Francisco's seniors are incredibly diverse. Only 44 percent of seniors age 60 and over are White, as compared to 70 percent statewide. Among seniors living below the poverty line, Whites make up an even smaller, though still significant proportion of the population (32%).[2]

Census 2000 data estimate that 28 percent of San Francisco's seniors have trouble with English.[3] Nearly three-quarters of those seniors speak Asian or Pacific Islander languages. The map below highlights where seniors with limited English proficiency live in San Francisco.

San Francisco Elders by Ethnicity/Race



Total = 136,369



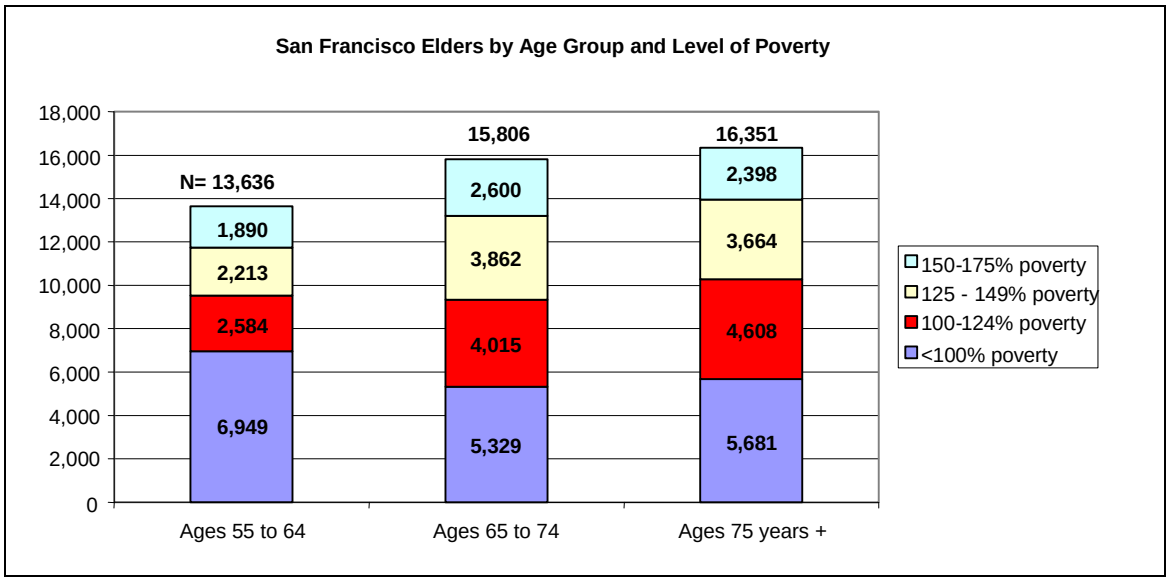
[2] Poverty statistics for seniors are only available for those aged 65 and older.
[3] This estimate includes those reporting that they speak English either "not well" or "not at all."

Diversity in San Francisco goes beyond race, ethnicity, and language. San Francisco is also home to a large population of LGBT seniors. A 2002 report from the National Gay and Lesbian Task Force Foundation (Cahill et al.) estimates that three to eight percent of all seniors nationwide are lesbian, gay, bisexual, or transgender (LGBT). Estimates for San Francisco are estimated at more than ten percent (San Francisco Human Rights Commission et al., 2003).

Low-Income Seniors

According to the California Budget Project's 2005 report, "Making Ends Meet: How Much Does it Cost to Raise a Family in California," the monthly cost of living for the typical single adult in the Bay Area[4] is $2,325, with rent alone costing $930. Meanwhile, the maximum SSI payment for a single adult is only $901.[5] Over 27,000 seniors age 65 and older receive SSI in San Francisco.

The older a person is, the more likely he or she is living in poverty. The poverty level varies with household size. For example, in 2006 the US Department of Health and Human Services' poverty guidelines were set at $9,800 annually for a single person and $13,200 annually for a two-person household. The chart below compares poverty levels across the different senior age groups. The "oldest old" group, age 75 and above, has the highest number of persons living at or near the poverty level. *Almost one in three people age 75 or older in San Francisco lives in poverty* (San Francisco Human Services Agency, 2005).



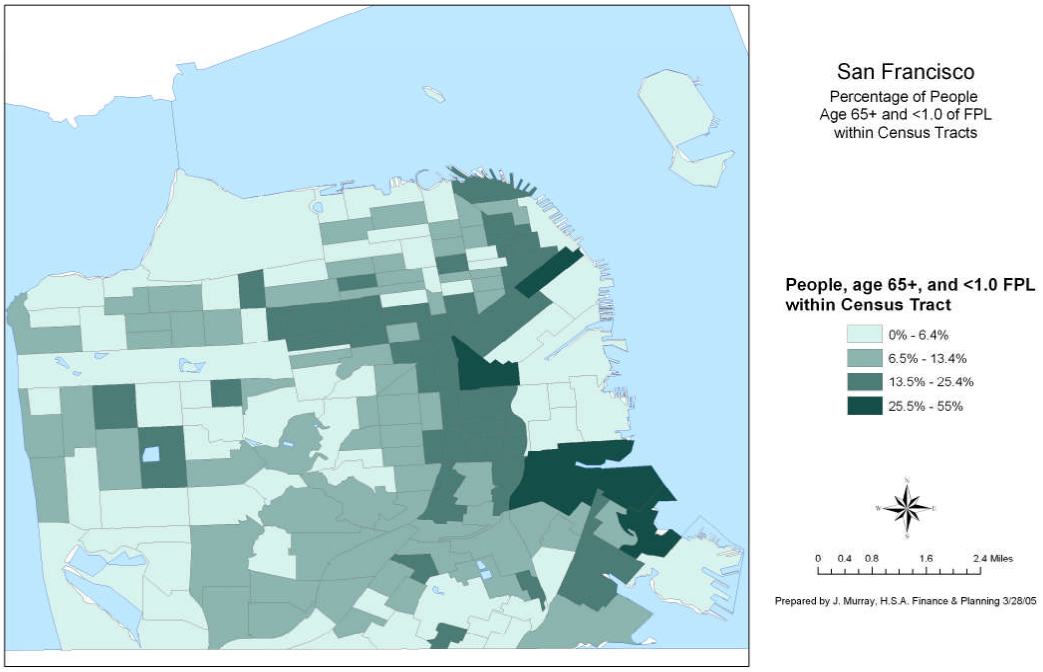
Asian, African American, and Latino seniors are more likely to be poor. The map on the next page shows where concentrations of seniors living at or below the poverty line are likely to live in San Francisco. A number of areas not highlighted in the general map of San Francisco seniors become prominent in this map, including the city's African American enclaves, Bayview Hunters Point and Western Addition, and the city's Latino neighborhood, the Mission. Several neighborhoods have single room occupancy hotels that serve seniors,

[4] This region also includes Alameda, Contra Costa, Marin, Napa, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma.

[5] This is the California SSI Blind rate for a single person with independent living status.

including the Tenderloin, South of Market, and Chinatown. Fifteen percent of Latinos and African American seniors are low-income, compared with 12% of Asians and 8% of whites. In absolute numbers, however, Asians have the most low-income seniors, with three times as many as other minority groups (San Francisco Human Services Agency, 2005).

Map: Concentrations of Low-Income Seniors in San Francisco



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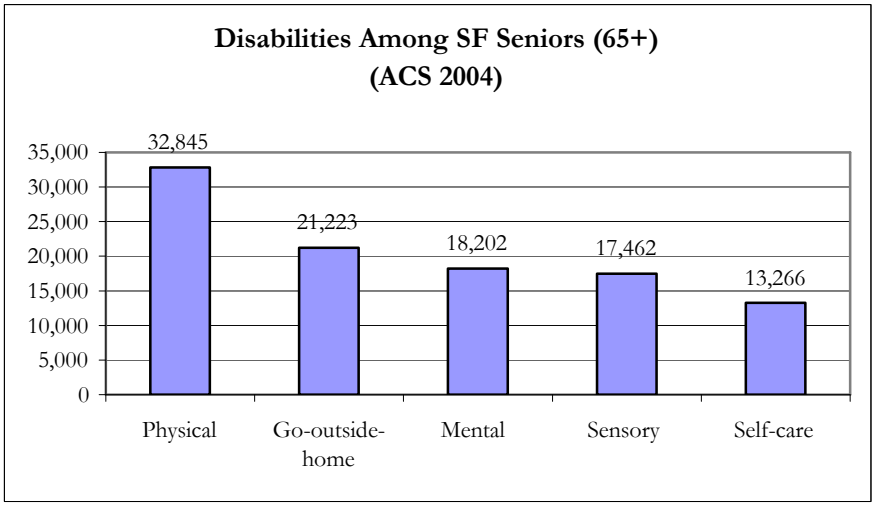
Disabilities

According to the 2004 American Community Survey, over 43,000 San Franciscans age 65 and older reported having one or more disabilities. Over three quarters of those with a disability have a physical disability. Smaller but significant numbers of seniors report having go-outside-home, mental, sensory, or self-care disabilities. The following table shows the number of seniors reporting each type of disability.[6]

[6] Numbers do not sum to 43,000 because individuals may report more than one disability type



YOUNGER ADULTS WITH DISABILITIES

This report marks the Department of Aging and Adult Services' first attempt to use its four-year assessment to examine the needs of younger adults with disabilities. It is a complicated challenge because of an unclear mandate about DAAS's responsibilities toward younger adults, a lack of definition about what types of disabilities qualify individuals for its services, and limited data about this group.

In 2000 the Commission on the Aging was merged with the Public Administrator/Public Guardian's Office from the Department of Public Health, the County Veteran's Office, and in 2002, with Adult Protective Services from the Department of Human Services (City and County of San Francisco, Office of the Controller, 2003). Prior to the merger, the Commission on the Aging had focused entirely on older adults, while the newly unified programs served both older adults and younger adults with disabilities. To reflect this expanded role, the new organization was named the Department of Aging and Adult Services. Its broader responsibility was amplified in 2004 when In Home Supportive Services (IHSS) joined DAAS. IHSS is much larger than DAAS, having a budget three times bigger, and 20 percent of the IHSS caseload is comprised of younger adults.

While specific DAAS programs have mandates to serve younger persons with disabilities, it is not clear what the mandate for the overall department is. A review of the city charter, the administrative codes for the department, and directives from the Mayor's Office has found no official mandate to serve younger persons with disabilities. According the City Charter, only the Mayor can reorganize a department, and the Board of Supervisors approves the changes. The only defining directive from the Mayor does not resolve this question. It was approved by the Board of Supervisors and can be found in the administrative provisions of the Annual Appropriations Ordinance (City and County of San Francisco, 2001) from that time:

> There shall be a Department of Adult and Aging Services under the Mayor. The department shall include functions of the Commission on

> the Aging, Public Guardian and the Mental Health Conservator, and any other duties and responsibilities assigned by ordinance or by the Mayor…."

Other rationales have been advanced as mandates for DAAS. Advocates have raised the issue of whether local funding for persons with functional limitations can be narrowed by age and still be consistent with the *spirit* of the Americans with Disabilities Act (Mizner, 2006). Also, DAAS clearly has a key role in San Francisco's response to the Olmstead Supreme Court decision, which affirmed the right of individuals with disabilities to live in their community and not be institutionalized. In particular, IHSS and the Public Conservator's office have crucial roles related to Olmstead. Neither rationale, however, is conclusive about the question of DAAS's broader mandate.

DAAS remains committed philosophically to serving younger adults who have disabilities, but the lack of a clear mandate has created confusion. After the merger, DAAS staff discussed making senior services available to younger persons with disabilities, a prospect that some service providers resisted. Yet it is not clear that younger persons want to participate in services with seniors or that such services are age-appropriate. The Older Americans Act funding that supports most of the Office on the Aging programs cannot be used for persons under the age of 60, which would make it necessary to use local general funds to augment these programs. Disability advocates have called for parity between seniors and younger adults in DAAS's general fund expenditures. Of the $23 million that DAAS funnels to contracts with community service providers, $17.8 million (77%) is derived from local general fund. Yet without clear guidelines DAAS is left to make funding decisions on an ad hoc rather than strategic basis.

DAAS is also hampered by not having a definition of disability to go by[7]. Definitions vary. Some definitions center on health conditions, others on activities of daily living, and still others on work disabilities. The State of California's definition far exceeds the federal one.

The universe of persons with disabilities is diverse, and DAAS has no guidelines about which groups to serve or which services to prioritize. Some groups like persons with traumatic brain injuries have few services now, while others groups have large service systems in place. For example, each year the Department of Public Health spends 35% more than the entire DAAS budget, and four times as much as the non-IHSS DAAS budget, on services for persons with mental illness. Yet persons with psychiatric disabilities still have profound unmet needs. Without guidelines, different groups of persons with disabilities can inadvertently be pitted against each other and against seniors competing for scarce DAAS resources.

This report explores the needs of younger persons with disabilities as they parallel those of seniors. To have examined every need of each segment of the community of younger persons with disabilities would have been beyond the scope and resources of this

[7] To view examples of definitions , please refer to the following weblinks, including: Americans With Disabilities Act definition, http://www.usdoj.gov/crt/ada/pubs/ada.txt; the Social Security Administration's definition, http://www.ssa.gov/dibplan/dqualify4.htm; and the State of California's definition, http://www.spb.ca.gov/civilrights/disability_info.htm.

assessment, and it would not have helped DAAS understand how its framework of services can benefit younger persons. For example, a number of informants and key documents cited employment as an urgent need for younger persons with disabilities, but DAAS has little experience with employment services, and other agencies have established systems in place for training and placing persons with disabilities in jobs. Instead, this report extends the discussion of challenges facing older persons' efforts to live in the community – isolation, access, transportation, etc. – to include younger persons with disabilities.

Data for Younger Persons

The data for younger persons with disabilities is spotty. Differing definitions of disability, divergent sources of data, and inconsistent survey methodologies together make it impossible to aggregate much of the data that is available. Estimates of the prevalence of persons with disability in San Francisco vary. The 2000 Census estimated that 18.8% of San Franciscans had a disability, while the 2004 American Community Survey estimated it to be 14.2%. Experts believe that the number of individuals with disabilities was inflated significantly in the 2000 Census. Though the 2004 ACS used sampling, it had a superior survey design and method, including enumerator follow-up questions (Israel, 2006; Stern, 2005). In particular, the 2000 Census appears to have significantly over-reported disabilities that interfered with people's going outside of the home and with employment. **This report relies on the 2004 American Community Survey data on disabilities.**[8] The accompanying table illustrates the prevalence of disabilities by age of person among San Francisco's population.

American Community Survey 2004 -- Estimates			
Age	**Total number of people**	**Number with one or more type of disability**	**Percent in this age group with a disability**
5 to 15	60,175	2,540	4%
16 to 20	24,340	1,342	6%
21 to 64	497,254	50,578	10%
65 and older	104,063	43,188	42%
Total	*685,832*	*97,648*	*14%*

The table below compares the types of disabilities and their frequencies for persons age 16 and over in San Francisco. In a city known for its hills, almost 60,000 adults have physical disabilities. In absolute numbers, more young persons have disabilities that impede them from going outside of their homes. Seniors are much more likely to have difficulties with self care, and as a proportion of their population, they are much more likely to have physical disabilities. Among persons between the ages of 16 and 64, over 28,000 have two or more disabilities; among persons 65 or older, 27,000.

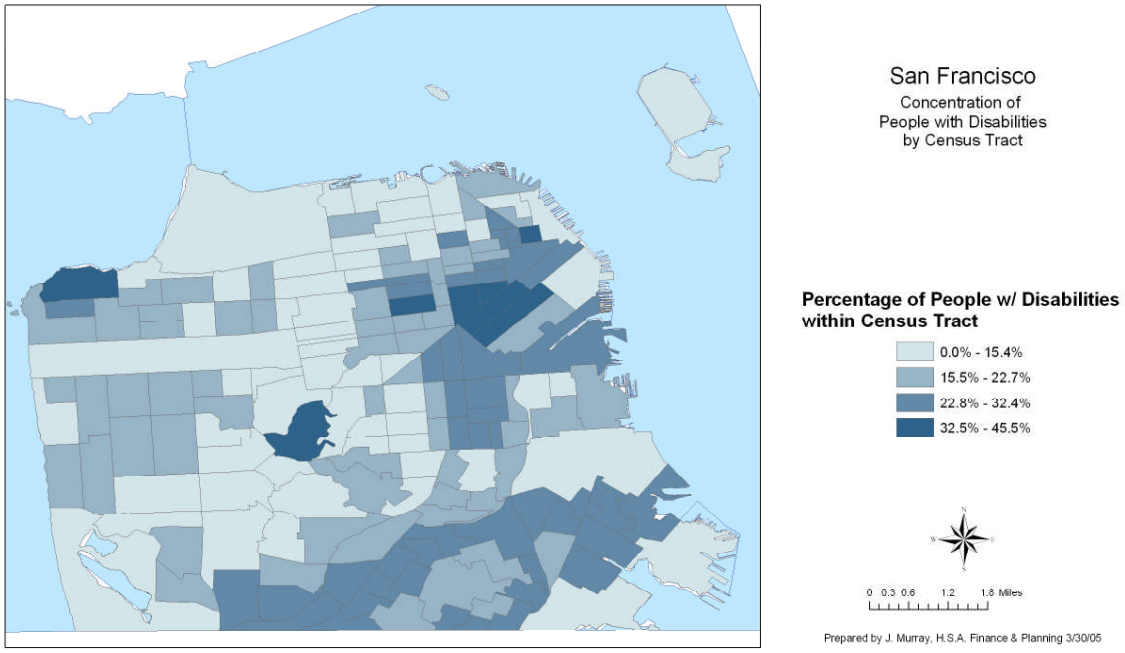
[8] As imperfect as its information is, however, the 2000 Census is the only survey that contains information about where people live. Therefore, it is used for the maps that appear in this report. As confusing as this might be, it is preferable to use accurate data whenever available.

Types of Disabilities for Persons Age 16 and Over

Age	Total Population	Self Care		Go Outside Home		Physical		Mental		Sensory	
		#	%	#	%	#	%	#	%	#	%
16-64	499,684	6,701	1%	19,836	4%	27,211	5%	12,322	2%	11,923	2%
65+	104,063	13,266	13%	18,202	17%	32,845	32%	17,462	17%	17,462	17%

The map below shows where persons with disabilities live in San Francisco, and it suggests that many people with disabilities either live in low-income neighborhoods like the Tenderloin and South of Market areas, which have more accessible housing and are central to BART and MUNI streetcar routes, or else live in affluent neighborhoods like St. Francis Woods/West Portal and Sea Cliff, neither of which is known for accessibility. Chinatown, which has many hotels and apartments without elevators, also has a large concentration of people with disabilities (San Francisco Human Services Agency, 2005).

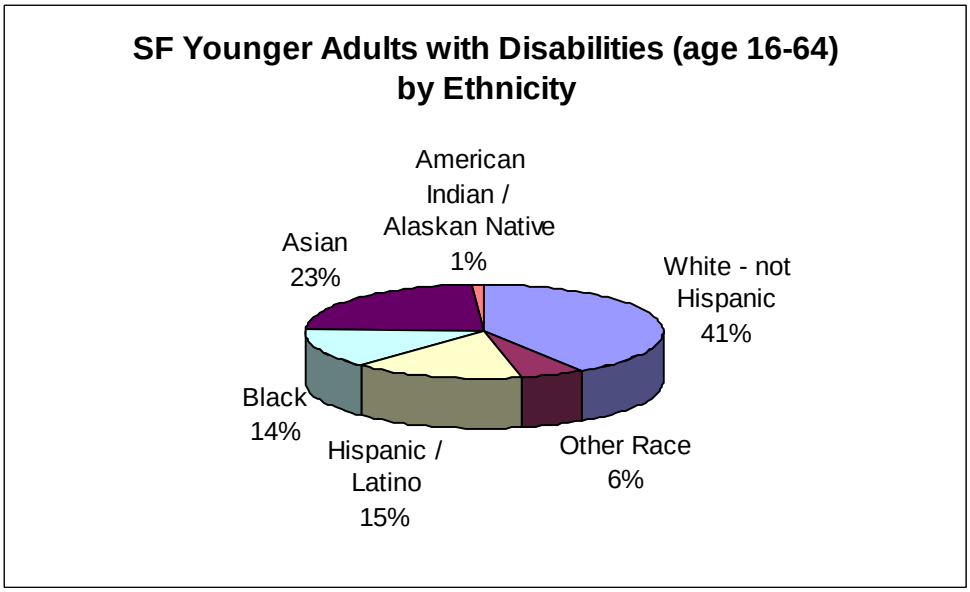
Location of People with Disabilities in San Francisco



PCT20. SEX BY AGE BY TYPES OF DISABILITY FOR THE CIVILIAN NONINSTITUTIONALIZED POPULATION 5 YEARS AND OVER [101] - Universe: Civilian noninstitutionalized population 5 years and over
Data Set: Census 2000 Summary File 3 (SF 3) - Sample Data
"NOTE: Data based on a sample except in P3, P4, H3, and H4. For information on confidentiality protection, sampling error, nonsampling error, and definitions see http://factfinder.census.gov/home/en/datanotes/expsf3.htm.

"
File: O/Planning and Budget/Planning Unit/Maps/DisabilityCT03_05.jpeg

The chart below illustrates the ethnicity and race of younger persons with disabilities according to the2004 American Community Survey. Whites and Asians have the highest numbers of younger persons with disabilities (21,651 and 12,268 respectively), compared to 7,391 African Americans and 8,062 Latinos. African Americans have the highest rate of disability, as 19% of African Americans in this age range have a disability, compared to just 8% of either Whites or Asians and 10% of Latinos.



Younger disabled persons are much more likely to be living in poverty than their non-disabled peers. Low income persons with work limitations are about half as likely to have worked during the past year than those without work limitations (39% versus 76%), suggesting that employment opportunities are especially scarce for low income persons with disabilities (Urban Institute, 2004). Another study found that 54 percent of persons with disabilities were working during a selected week, while 84% of the population without a disability was working. The highest employment rate for persons with disabilities was for those with sensory disabilities (Maag, 2006). Presumably, persons with disabilities are also likely to earn less than their counterparts in the general population. According to the American Community Survey, 22% of younger persons with disabilities (11,395 total) in San Francisco are living below the federal poverty line. The Social Security Administration reports that 17, 834 San Franciscans between the ages of 18 and 64 are receiving SSI, making up 39% of all San Franciscan receiving SSI (2006).

HOUSING

THE ISSUE: AFFORDABLE AND ACCESSIBLE HOUSING

Housing is one of the most difficult and complex issues facing seniors and younger adults with disabilities, yet the appropriate role for the Department of Aging and Adult Services (DAAS) to play remains ambiguous. Federal and state housing resources lie with other departments, and real-estate development is not feasible for a small department traditionally focused on social services. Because DAAS can have little direct impact on the total amount of affordable and accessible housing, the department instead supports advocacy, information and referral services, and legal assistance for low-income seniors. This section discusses the scope of the housing problem and highlights some potential opportunities for DAAS to consider.

Like many San Francisco residents, seniors and younger adults with disabilities struggle to find housing options that fit their budgets. In June of 2006, the median price of a San Francisco home was $778,000—21% higher than the Bay Area average ($644,000) (Dataquick, 2006). Not only is home-ownership out of reach for many city dwellers, but so are most apartments. The average monthly rent for a one-bedroom apartment in the second quarter of 2006 was $1,718, more than twice as much as the 2006 monthly SSI payment for a single SSI recipient (Social Security Administration, 2006).[9]

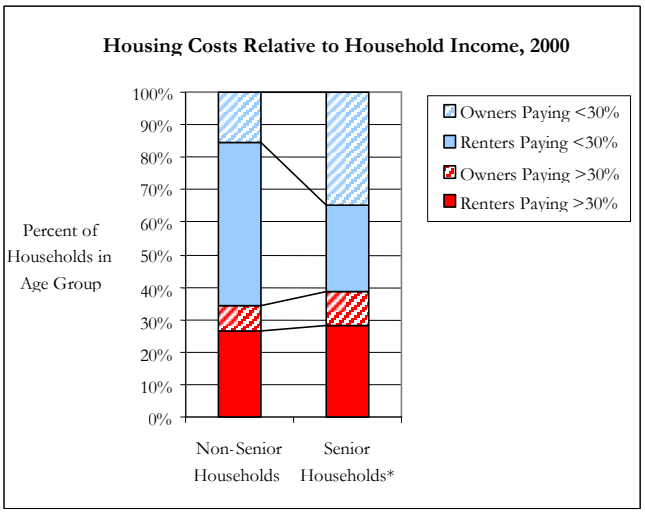
To mitigate housing costs, public agencies invest millions annually toward affordable housing. Nevertheless, these government-subsidized units constitute a very small portion of the total housing stock. Over 90% of San Franciscans live in privately owned homes and apartments (Mayor's Office of Housing, 2004). Owned homes and private apartment buildings are often overlooked in conversations about affordable housing, but they are critical assets for San Francisco seniors.

Nearly half (44%) of seniors over 65 are homeowners. Many of these homeowners bought their home decades ago, and now own them outright. In fact, over half (53%) of the senior homeowners moved in before 1970 (Census 2000). As a result, senior homeowners pay a smaller portion of their income for housing costs than younger homeowners.

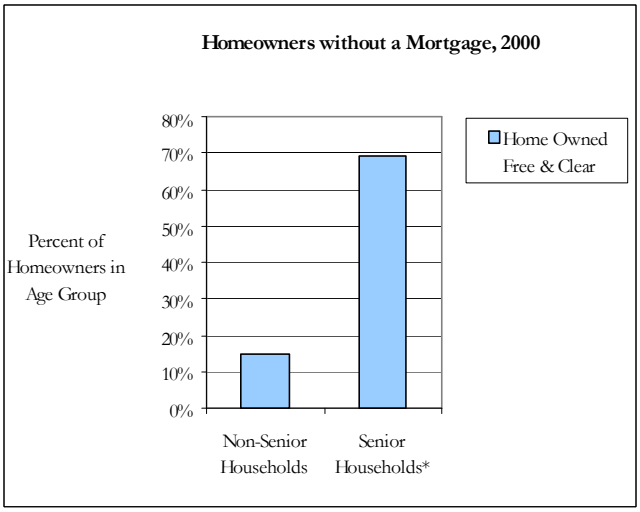
Similarly, many senior renters are protected from untenable housing costs as long-term residents in rent-controlled buildings. As of 2000, a majority of older apartment-dwelling households had lived in the same place for over 10 years[10] and 93% (16,000) lived in rent-controlled apartments.[11] Older renters pay less rent in absolute terms than the younger cohort, but even those who find themselves in relatively low-cost apartments bear a heavy rent burden relative to their incomes. The median household income of seniors in rent-controlled units was just $15,000 in 1997 (the most recent data available.)[12] Because new

[9] Single "aged" or "disabled" people living independently receive $836.00 for April-December of 2006.
[10] In 2000, 51.6% of 33,120 total renters 65+ had moved in prior to 1981.
[11] 85.6% of Non-senior rental households live in rent controlled units.
[12] Data from the US Department of the Census, 1998 American Housing Survey for the San Francisco Metropolitan Area are currently being updated.

housing and institutional care are both extremely expensive, "aging in place" is not only the preference of most elders, it is also a financial necessity.



Thirty-nine percent of senior–headed households pay over 1/3 of their income for housing (Census 2000).[13]



Nearly 70 percent of senior homeowners own their homes free and clear (Census 2000).

Equivalent data on tenure, housing costs, and duration of residence are not available for the younger adult population. However, because persons with disabilities are much more likely to be living in poverty than the rest of the general population, one can reasonably assume that few younger adults with disabilities are long-term homeowners. Thus, they are rarely shielded from high rental costs by means of ownership.

Even when housing is affordable, many seniors and younger adults with disabilities need additional supports in order to live safely. These supports range from "simple" modifications, like grab bars to prevent slips in the shower, to the need for social services, nursing supervision, and full wheelchair accessibility. For persons with disabilities, living in a city with wheelchair-inaccessible housing has far-reaching social implications. Persons with disabilities often live in less than fully accessible housing that prevents them from entertaining other friends with disabilities. Furthermore, those who need wheelchair accessibility not only face limited housing options, they are also isolated from their friends and must often miss parties, dinners, and family gatherings (Calderon, personal interview, July 28; 2006; Mizner, personal interview, August 11, 2006).

LOCAL NEED AND SERVICES: AFFORDABLE HOUSING

There is a massive unmet need for affordable housing in San Francisco. As of July 2006, over 30,000 people were on waiting lists for about 6,000 apartments managed by San

[13] Senior households are those in which the "head of household" is at least 65 years old. The total number of senior households in San Francisco, 2000, was 59,174. The total number of non-senior households=234,569. Housing costs for about 3% of households were not computed. These households excluded from above figure.

Francisco's Housing Authority. Nearly fourteen thousand (13,837) of those on the wait list were seniors and people with disabilities. Because turnover in public housing is low, applicants can expect to wait at least five years before they are offered a unit. Other subsidized housing is in equally high demand. A client hoping to move into affordable housing funded by the US Department of Housing and Urban Development (HUD) should expect to wait at least two to five years for a unit (Corcoran, personal interview, July 14, 2006.) Some popular developments, like Self Help for the Elderly's Lady Shaw senior building have wait lists over ten years long (Chung, personal interview, July 28, 2006). It is no wonder, then, that housing comes up in nearly every focus group conversation as one of the most frustrating issues facing seniors and younger adults with disabilities.

This issue has not gone unnoticed by the public sector. The Mayor's Office of Housing (MOH), the San Francisco Redevelopment Agency (SFRA), and HUD all help to fund non-profit organizations that build and manage "affordable housing developments." The Public Housing Authority also contributes to San Francisco's affordable housing stock, providing about 33,000 people with subsidized housing in projects and through the Section 8 Voucher program (Housing Authority Website). Efforts on every front have ensured that seniors are relatively well represented in subsidized developments.

The Housing Authority allocates a significant portion of its inventory to seniors and adults with disabilities. Two thirds of the Housing Authority's apartments are intended for low-income families, while the other third are in "Senior/Disabled" buildings. An additional 702 seniors and 750 younger people with disabilities reside in family housing. Section 8 vouchers are not targeted to particular populations, but 30% of voucher holders are over 62 and approximately 15% of voucher recipients are on SSI. (Ucciferri, personal interview, June 20, 2006; Sparks, personal interview, August 15, 2006). More than 25% of the people on the waiting list for Section 8 housing vouchers are people with disabilities (Mayor's Office on Disability, 2003).

Non-profit housing developers have also proven responsive to the need for low-cost senior housing. Ninety-five affordable properties in San Francisco with a total of almost 10,000 units receive federal assistance through the San Francisco HUD Office. More than half of these

The Challenge of Accessing Information about Affordable Housing

In non-profit affordable developments and Public Housing alike, consumers experience a myriad of difficulties accessing comprehensible information and maintaining their wait list status. With dozens of public, private, and non-profit organizations providing subsidized housing, vacancy listings are largely decentralized. Most seniors and younger adults with disabilities rely on word of mouth and a patchwork of publicity materials to identify apartment buildings they can afford.

Furthermore, staying on each wait list requires consumers to be savvy, proactive advocates. Any misstep can lead to a longer wait. Most buildings update their list annually or bi-annually to purge obsolete requests. If a senior moves or does not carefully attend to his or her mail, (s)he is likely to miss confirmation cards and will be unknowingly removed from the queue. This can be especially challenging for monolingual consumers (Corcoran, personal interview, July 14, 2006; Case managers focus group, June 27, 2006).

Obtaining information from the Housing Authority can be particularly frustrating. As the manager of 6,641 housing vouchers, and 6,096 apartments, the SFHA is the largest provider of deeply subsidized housing and often the primary hope for low-income seniors and adults with disabilities. As it expects to receive only 78 percent of its usual operating costs in the coming year, the SFHA will be unable support enough staff to assist current and prospective tenants with more timely information.

units are designated for seniors over the age of 62.

San Francisco Affordable Housing Units for Seniors & Younger Adults with Disabilities[14]		
	Affordable Housing supported by HUD and/or CCSF	SF Housing Authority Buildings
Units/beds targeted for Seniors	6,421	1,942
Units/beds targeted for Persons with Disabilities & Special Needs	4,480	
Total	**10,901**	**1,942**
Sources: MOH, SFRA, SF Housing Authority, and HUD administrative data.		

GAPS: AFFORDABLE HOUSING

Relatively little affordable housing is available to younger adults with disabilities. More affordable housing is needed for all low-income populations, and seniors are a particularly vulnerable population. However, the plight of adults with disabilities warrants special attention. As people age, income generally declines, but persons with disabilities have statistically higher unemployment and lower earnings throughout life. Meanwhile, few resources are available for housing targeted specifically for younger adults with disabilities.

Many new affordable housing developments for seniors and adults with disabilities receive some funding under the US Department of Housing and Urban Development's (HUD) "202" and "811" programs. Because approximately three times as much funding is available through the 202 program, which provides funding specifically for senior-targeted housing, seniors are better served. For example, in 2006 the San Francisco HUD office had funding for 148 units of "202/Senior" housing in San Francisco and 49 units of "811/ Disabled" housing.

Service enriched affordable housing and developments for unique populations receive funding from a variety of other federal, state, and local sources. Some funding streams are narrowly targeted. For instance, the federal McKinney Act Programs facilitate development of supportive housing for the homeless, while the HOPWA (Housing Opportunities for Persons with AIDS) Program targets persons with HIV and AIDS. Targeted federal programs have encouraged the development of housing for certain populations while neglecting others. A third of the units currently planned and under construction with oversight by MOH or SFRA are for homeless persons. An additional 20% will house seniors. Yet less than 1% will serve disabled persons who are neither formerly homeless nor elderly (see Appendix A).

[14] Notes on Table: Beds in residential care facilities, drug treatment programs, and transitional housing are included as 1 unit; Reports from MOH and SFRA rely on an inclusive definition of "Disabilities & Special Needs" including substance abuse recovery, HIV & AIDS, homeless with special needs, and mentally disabled.

Federal and State law compound the funding inequity for younger adults with disabilities. Fair Housing Law (24 C.F.R. Section 100.305) and California Civil code (section 51.3) both prohibit housing discrimination against households with children except in the case of senior developments. While Federal Law requires 80% of occupants to be senior citizens for such a designation, California goes a step further by requiring all initial occupants to be at least 55 years old. Thus, managers of older affordable buildings that were, at the time of construction, intended for both senior and younger disabled populations, must choose whether to serve exclusively seniors or open their doors to families and young single adults as well. Many now exclude younger disabled residents in order to keep out young residents who could disrupt the quiet atmosphere and strain senior-targeted services (Tedder, personal interview, July 5, 2006).

Finally, neighborhood resistance to affordable housing is a potent deterrent to new construction. Resistance to facilities serving younger adults, especially those with mental illness or substance abuse issues, tends to be even stronger than resistance to senior-only developments.

EVIDENCE OF LOCAL NEED: SUPPORT FOR SAFE LIVING IN EXISTING HOMES & APARTMENTS

Affordable housing is a coveted resource, but most seniors and younger adults with disabilities live in privately owned houses and apartments. Home safety is a critical issue for this population. People over 75 who fall are 4 to 5 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 (Abt Associates, 2004). By improving home-safety for seniors and adults with disabilities, DAAS can preserve the stock of affordable rent-controlled units, decrease premature institutionalization, and improve the quality of life for people aging in place.

Seventy-five percent of the housing units in San Francisco were built prior to 1960 (Census 2000), and the first accessibility requirements for publicly funded buildings were passed in 1968. These regulatory requirements ensure that accessible units are well represented in new affordable developments, but do little for existing single-family homes or older apartment buildings without elevators.[15] In Chinatown, for instance, most housing was built in the first half of 20th century for young, single laborers. Today, many seniors and families inhabit Chinatown's 297 Single Room Occupancy hotels (SROs), but the physical buildings remain unchanged. Only nine Chinatown SROs have elevators (3%) and narrow, uneven staircases that were once easily mounted by inhabitants, now trap seniors with limited mobility (San Francisco Human Services Agency, 2006).[16] While increasing the number of fully accessible units should remain a priority, major renovations of entire buildings are often financially infeasible. Many seniors and younger adults with disabilities would also benefit from smaller-scale enhancements to existing housing, like additions of grab bars.

[15] This is especially true for CA Title 24, which requires all multi-family units on the ground floor or served by an elevator to be accessible or adaptable.

[16] Fifteen percent of San Franciscans over 65 report significant difficulty climbing stairs (2001 CHIS)

EXISTING LOCAL SERVICES: SUPPORT FOR SAFE LIVING IN EXISTING HOMES & APARTMENTS

Home Improvement and Modifications Programs
There are several existing programs to increase the number of "partially" accessible units in San Francisco's existing housing stock. Rebuilding Together, a community based organization, recruits volunteers to improve the homes of low-income seniors and persons with disabilities. The Department of Public Health (DPH) offers workshops on home-safety and free home-safety assessments, and the Mayor's Office of Housing manages loan programs for home repairs and modifications.

- Rebuilding Together
    - Home Safety & Independence Program
    - Rebuilding Weekend
- San Francisco Department of Public Health
    - Community and Home Injury Prevention Project for Seniors (CHIPPS)
- San Francisco Mayor's Office of Housing
    - Community Housing Rehabilitation Program (CHRP)
    - Code Rehabilitation Fund (CERF)

For a detailed description of each of these programs, see Appendix B.

Legal Services & Rental Assistance to Prevent Eviction
DAAS currently funds four programs that provide free legal services for persons at risk for eviction: La Raza Centro Legal, Legal Assistance for the Elderly, API Legal Outreach, and the Asian Law Caucus. These programs keep low-cost rent-controlled apartments in the housing stock and provide an invaluable service for persons who are at risk of losing their home. In FY 2006/07, the four legal services programs funded by the Office on the Aging provided over 13,600 hours of service to just over 2,000 unduplicated consumers.

In addition to Legal Services, DAAS supports a small rental subsidy program for seniors and younger adults with disabilities. In order to receive grant money, tenants must owe back-rent and be threatened with eviction. The program services 100 younger adults and 200 people over 60 annually. The maximum grant amount is $400, so those who owe larger sums tap resources from other community providers of similar emergency grants (e.g., the Season of Sharing Fund, Rental Assistance Dispersement Component of the Eviction Defense Collaborative (RADCO), Catholic Charities).

GAPS: SUPPORT FOR SAFE LIVING IN EXISTING HOMES AND APARTMENTS

Awareness of current home modification programs is low, and many consumers resist taking on debt.
According to a 2006 San Francisco phone survey, 5% of older adults and 9% of disabled adults need, but cannot access home repair and modifications programs (National Research Center, 2006). Meanwhile, the CHIPPS program and Rebuilding Together's Home Safety

program are functioning at full capacity. Expanding or replicating these programs would reduce health hazards and prevent premature institutionalization.

Major renovations, such as installation of chairlifts or elevators, are a more complex issue than small modifications. Rebuilding Together receives calls "all the time" from people having difficulty climbing their front stairs, but the cost of such modifications exceeds the program's financial capacity (Wilson, personal interview, August 3, 2006).

Subsidized loan programs would appear to be an excellent solution, yet both CERF and CHRP are consistently undersubscribed. There are three primary reasons for under-utilization: lack of information, resistance to debt, and costliness. Only 31% of persons with disabilities and 33% of seniors in San Francisco are aware of financing home repairs programs (DAAS Survey, 2006). The programs needs better marketing. However, marketing alone will not enable the program to reach all who need home modifications. Many seniors are resistant to taking on debt, and home improvements financed through the CHRP program require use of city-approved contractors, which increases cost and delays. In FY 2005-2006, MOH changed the payment structure of CERF and CHRP to address long delays. DAAS may be able to help MOH monitor the impact of these changes and further expand this program by trouble-shooting barriers to utilization, such as poor financial literacy. (Wilson, personal interview, August 3, 2006; McSpadden, personal interview, July 26, 2006; Robinson, personal interview, June 21, 2006)

Few options are available for modifying rental units.
Although nearly 70% of San Franciscans are renters, there are virtually no programs to address safety and accessibility in apartment buildings (Mayor's Office on Disability, 2003). Younger persons with disabilities are even more likely to rent, and they often live in less than accessible housing. A few modifications can go a long way to making their living situations more tolerable (Ordover and Bennin, personal interview, August 22, 2006).

Renters in aging SRO and apartment buildings often negotiate steep and uneven stairways. One survey indicates that nearly a third of In-Home Supportive Services (IHSS) recipients in Chinatown SROs are completely homebound, going out of their building as infrequently as once a week (San Francisco Human Services Agency, 2006).[17] While Rebuilding Together's home safety program and CHIPPS can do small modifications in rental units, these programs focus on homeowners, and do not address major renovations or access issues.

Service gaps exist for those at imminent risk for eviction.
Eviction is a threat for many seniors, particularly those with cognitive impairments who fail to access supportive services. In the disability community, mentally ill renters are particularly vulnerable to eviction and other forms of housing discrimination because their behavior can be erratic. While rent control creates a financial incentive to evict, most landlords actually view eviction as a last resort. DAAS can have an impact this issue in several ways.

1) *Continue to ensure availability of legal services.* Low-income seniors and younger adults with disabilities need legal recourse. There are a number of agencies in San Francisco that

[17] All survey respondents had at functional limitation ranking of 3 or more ("requiring human assistance"). Thus, survey results may overstate the percentage of IHSS recipients who are homebound.

provide pro-bono legal services, but they are generally staffed by volunteers and take only a few cases.

2) *Improve access to case management services.* Legal services providers report that housing-related issues are among the most common reason seniors seek their assistance. In many cases, legal needs are complicated by the need for coordinated social services, and the lawyer spends time addressing these needs when a case management partner is unavailable.

3) *Increase emergency rental subsidies.* Several community-based organizations operate funds for emergency rental assistance and DAAS currently supports a small emergency housing fund. According to disability advocates at the Independent Living Resource Center (ILRC SF) and the Mayor's Office on Disability (MOD), these programs may warrant replication or expansion.

4) *Actively prevent institutionalization.* Several stakeholders in the community of younger adults with disabilities asked that DAAS take a lead role in screening persons who are referred to institutions. A panel that examines whether incremental measures such as minor home modifications or more flexible IHSS arrangements might be able to prevent seniors and persons with disabilities from entering institutions unnecessarily.

EVIDENCE OF LOCAL NEED: LICENSED CARE

According to the 2004 American Community Survey, San Francisco has 6,701 younger adults and 13,266 seniors over 65 who have self-care disabilities. Of these persons, it is difficult to know how many need a high enough level of care to warrant moving into a licensed facility. Many are best served in their own homes. Historically, too many consumers have been discharged to nursing home care after hospitalization, and there is a widespread desire for de-institutionalization amongst those who reside in unnecessarily restrictive settings.

Financial as well as ethical considerations fuel the efforts to prevent institutionalization. Licensed care in general, and particularly nursing home care, is an extremely costly form of housing. "Skilled nursing facilities account for 5 percent of the long-term care caseload and 52 percent of the long-term care expenditures. Home and community-based services account for 78 percent of the long-term care caseload, and 13 percent of long-term care expenditures" (CA Welfare and Institutions Code 9250).

However, for those who need 24-hour care, their safety and best interest should, in theory, trump financial considerations. Unfortunately, this is not the reality in San Francisco, where very few facilities are open to low-income seniors.

EXISTING LOCAL SERVICES: LICENSED CARE

Licensed facilities are as diverse as the individuals they serve, running the gamut from small board and care homes to large and luxurious "Life-Care" facilities to hospital-based nursing

care (see Appendix C a summary of licensed care types). Continuing Care Retirement Communities and Life Care Facilities advertise full course meals, dietitians, maid services, and recreational activities, as well as skilled nursing and acute care. For lower-income individuals, small family-run board and care facilities are more financially feasible. Here, assistance with daily activities is provided in a more modest, home-like environment. Lamentably, the quality of service in board and care homes can be uneven, and when a resident's health deteriorates, they must relocate to a nursing home.

GAPS: LICENSED CARE

Options for affordable residential care are disappearing in San Francisco.
Over the past 15 years, there has been a drastic loss of assisted living options for low-income seniors. (Nadell, Testimony from the Ombudsman Program, March 15, 2006). Medi-Cal does not cover residential care and payments from SSI/SSP are below operating costs,[18] so it is increasingly difficult for small board and care homes to remain open. In 1999 there were 427 SSI beds in residential care facilities of the elderly (RCFEs), today there are only 182 (Nadell, personal correspondence, August 11, 2006).[19] Many similar facilities for younger persons with psychiatric disabilities closed because they could not sustain their business given the economics of San Francisco. Others closed when the operators retired and sold their homes at tremendous profit (Mesa, personal interview, September 6, 2006).

Most mid to low-income seniors must look outside of the city for affordable care, to areas where operating costs are lower and the facilities are more economically viable. The move to Hayward or Oakland may be acceptable for some, but many seniors leave family and friends behind, becoming socially and culturally isolated in the late years of their life.

Even persons whose assets or income exceed SSI/SSP eligibility often find themselves in a bind when it comes to residential care. Persons with modest monthly incomes must use up their assets to pay privately for residential care. Once they have spent down to the $2,000 resource limit, they can apply for the SSI/SSP non-medical board and care benefit. Under these circumstances, "the facility cannot legally evict a person for failure to pay, because the SSI/SSP rate covers the full charge for all basic service" but in practice many facilities find loopholes and excuses to justify eviction (California Advocates for Nursing Home Reform Website).

Seniors who need nursing care are not much better off. There are currently 19 free-standing nursing homes in San Francisco, including Laguna Honda. Over two thousand (2,657) total beds in these facilities are reserved for persons on Medi-Cal but like SSI/SSP beds in board and care homes, space for low-income seniors in skilled nursing facilities is rapidly disappearing. Over the past 6 years, San Francisco has lost three small privately owned

[18] The maximum SSI/SSP non-medical board and care benefit is $1,015 for an individual. Of this, $898 goes to the facility as rent. (California Advocates for Nursing Home Reform, 2006)
[19] Furthermore, statewide nearly 30% of RCFE residents rely on SSI/SSP non-medical out-of-home grants(California Association of Health Facilities, 2006), but in San Francisco only 5.8% of the beds are available to SSI/SSP recipients.

nursing homes, and one larger facility which together had provided care to about 300 medically fragile seniors. (Nadell, personal interview, August 11, 2006)

Like seniors, younger adults who need 24 hour care have few residential options within San Francisco. Adult residential facilities with behavioral health services are overfull, and there are no facilities for people with physical disabilities who have neither developmental delays nor mental health needs. "Numerous times the Ombudsman Program has received phone calls for younger persons recently disabled, or with a progressive disability, asking for referrals to an adult facility. The outlook has been bleak." (Nadell, Testimony from the Ombudsman Program, March 15, 2006)

DAAS may be in a good position to convene conversations with long-term care providers in San Francisco to discuss opportunities for advocacy and planning. For instance, California is one of the only states that does not have a Medi-Cal waiver program for RCFEs. A bill currently under consideration would provide a "community-living support benefit" to eligible Medi-Cal beneficiaries,[20] and DAAS may consider how San Francisco can support this legislation. At the city level, there are other opportunities, such as a "patch" to supplement the SSI/SSP rate for RCFEs. DPH provides such a patch for residential facilities with behavioral health services, and may be open to collaborating with DAAS on a parallel program for small board and care facilities serving seniors and younger adults with disabilities.

CONCLUSION: FEASIBLE PROGRESS ON DIFFICULT HOUSING PROBLEMS

While the need for more affordable housing is clear, housing development is an awkward fit for DAAS, an agency focused on provision of social services. Furthermore, the magnitude of the housing affordability problem dwarfs DAAS's financial capacity. According to the San Francisco Mayor's Office of Housing, the Mission Creek Center, a development of 138 below market rate units, cost over $35.5 million to develop, which amounts to 30 percent of DAAS's entire FY2005/06 budget (SFRA & DHS administrative data, 2006).

Still, there may be opportunities for DAAS to improve access to regulated affordable housing for underserved groups and to help other seniors and adults with disabilities age safely in place in their current low-cost housing. While DAAS cannot change the cost of housing in San Francisco, the agency can become a more active advocate. "Decisions happen all the time" about the development of affordable housing, and the needs of low-income seniors and adults with disabilities are not always eloquently voiced (Jobling, personal interview, June 13, 2006). Some possibilities for collaboration suggested by informants from the Mayor's Office of Housing, the San Francisco Redevelopment Agency, DHS, DPH, and HUD are explained below.

[20] Assembly Member Mark Leno introduced AB 2968 February 24th, 2006.

OPPORTUNITIES FOR DAAS IN HOUSING

Become a presence in planning and monitoring affordable housing for seniors.
While subsidized housing comprises only a small percentage of homes in San Francisco, it is nonetheless a valuable resource for low-income seniors and younger adults with disabilities. Residents in these facilities not only benefit in monetary terms, but they may also be at lower risk for eviction and better able to access supportive services. Furthermore, the expertise DAAS can offer on senior housing needs is welcome and useful in the planning process. Advocacy and inter-departmental collaboration could influence prioritization and design of "senior" and "disabled" affordable housing.

Developments that serve extremely low-income populations with service needs require substantial public support to stay viable. Some senior developments have had trouble staying financially solvent, and other struggle to provide adequate service to residents (Robinson, personal interview, June 21, 2006). DAAS can help with service provision in these buildings. As one example of such a partnerships, the Long Term Care Coordinating Council has begun discussions to identify three public Housing Authority buildings for a pilot project to reach isolated residents.

Every month the Mayor's Office of Housing hosts a "pipeline" meeting in which developers and government administrators discuss projects underway. This is an opportunity to trouble-shoot stumbling blocks in their development and discuss on-site service needs. Here, DAAS could also provide feedback on the design of new funding proposals (NOFA's), and voice the needs of harder to serve seniors and adults with disabilities.

Partner with the Mayor's Office on Disability to ensure that accessible units are occupied by those needing special features.
Pursuant to federal law, HUD requires that their properties maintain a separate wait list for residents needing an accessible unit to ensure that accessible apartments are occupied by tenants who need their special features. Unfortunately, separate wait lists do not work as well as they could. Advocates in the disability community indicate that not all buildings maintain a separate wait list. Additionally, where one or two accessible units are available in multi-family buildings, these units are infrequently publicized to the disabled community (Calderon, personal interview, July 28, 2006; Corcoran, personal interview, July 14, 2006; Tedder, personal interview, July 5, 2006). DAAS may be able to partner with disability advocates, HUD, or MOH to ensure that resource lists of accessible units are comprehensive and the wait lists for these units are maintained.

Train on-site caseworkers and property managers about resources for senior tenants.
Seniors in affordable housing developments, SROs, and public housing are a uniformly low-income population and an appropriate target for DAAS services. Management level staff at HUD, the San Francisco Housing Authority, DHS, and DPH unanimously confirmed that many senior residents in their facilities would benefit from services provided by DAAS. Furthermore, seniors who suffer from mental illness or dementia and do not receive necessary supports are at elevated risk for eviction.

One logical goal is dissemination of information about DAAS services. On-site caseworkers and building managers can serve as intermediaries for DAAS services to reach more isolated seniors who are aging in place without adequate support. DAAS case management programs could also help higher need residents receive coordinated services when on-site staff have insufficient time and expertise.

Other suggestions offered by agency management include:

- Participate in the annual case manager training for HUD caseworkers.
- Facilitate expansion of peer outreach and friendly visitor programs into affordable developments using on-site staff as a point of contact. Ensure that volunteers are informed about resources DAAS and DHS can offer.
- Bring the Senior Survival School to shelters and senior housing projects.

HOMELESS SENIORS IN SAN FRANCISCO

A Typical Story:[21]

In 2003, Eloise lived in a small one-bedroom apartment in the Tenderloin. At 80, she lived independently, but left her apartment infrequently. She was weak and having a difficult time cleaning, climbing stairs, and getting around. Years of accumulated mail, clothes, and garbage rendered Eloise's apartment nearly impassible. Her landlord, although worried about fire safety and sanitation, was reluctant to evict a long-time resident and was concerned that Eloise was not physically or mentally equipped to compete in the rental market. But several fruitless conversations left him frustrated, and he finally threatened to evict. Scared and outraged, Eloise stopped paying rent and refused to speak with anyone in the building. The landlord called on Adult Protective Services (APS) for assistance, which provided a referral to Curry Senior Center's case management program. She was prioritized for an SRO unit in the DPH Direct Access to Housing program, narrowly escaping homelessness.

San Francisco's Strategy to Address Homelessness: Permanent Housing

The San Francisco Department of Human Service (DHS), Department of Public Health (DPH), and community-based organizations throughout the city have constructed a web of preventative services to intervene early with persons at risk for homelessness. But these services fail to reach many in need. At least 6,000 homeless live in San Francisco today, and over 10% of shelter residents on any given night are over 60.

DHS and DPH provide housing for homeless and extremely low-income single adults in three similar programs: Direct Access to Housing (DAH), Housing 1st, and Shelter + Care. The departments master-lease units in privately owned Single Room Occupancy hotels and offer the rooms at a subsidized rate to those in need. The physical amenities of DHS and DPH housing are generally equivalent – hotels are equipped with shared kitchen facilities and community living space. Some units have a private bath, while others (most Housing 1st Units) have a shared bath. The type and intensity of services differs between buildings. DAH and Shelter + Care target persons with disabilities including mental illness, substance abuse, and HIV. Residents in these buildings receive more intensive case management, medical treatment, and counseling than those offered through the Housing 1st program.

Permanent Supportive Housing for SF Homeless	Total Units	Units occupied by seniors 55+	Units occupied by people with disabilities
Housing 1st Care Not Cash	1,320	Unknown*	Unknown
Non-Care Not Cash	996	Unknown*	Unknown
Direct Access to Housing	671	49%	100%
Shelter + Care	531	24%	100%
San Francisco Homeless	Total	Seniors 55+	People with disabilities
Homeless Count 2006	5,642	Unknown	Unknown
Slept in shelter at least one night (FY2005/06)	8,622	17%	Unknown
Average number in shelter per night (FY2005/06)	912	23%	Unknown

[21] This hypothetical example based on three true stories related by Michael McGinley, LCSW, case manager at Curry Senior Center.

* With the exception of the Raman Hotel, Housing 1st does not allocate units specifically for seniors, nor maintain data on the age of residents. Care Not Cash does not serve many people over 65 because to qualify, persons must receive cash assistance from DHS' CAAP, CALM, or SIPP programs. Most low-income seniors receive income assistance from SSI rather than these programs. On the other hand, "Non-Care Not Cash" units serve many seniors on SSI (Walton, personal interview, July 7, 2006).

Conditions and Services for Seniors Remaining in Shelter

Direct Access to Housing and Non-Care Not Cash DHS buildings both receive referrals from affiliated community-based service providers such as hospitals, shelters, case management programs, and substance abuse programs. DAAS may be in a good position to ensure that all the agencies in contact with at-risk seniors and adults with disabilities are a part of this referral network, so that no consumer is barred from entry to SRO housing because they enter the system through the "wrong door."

DAAS can also help these community organizations provide more sensitive and effective assistance to homeless seniors and younger adults with disabilities. In a focus group at the Raman Hotel, formerly homeless seniors described feeling marginalized in shelters and clinics, intimidated by younger clients, and disrespected by program staff. One resident said, "you have to put on a front of being hard…even if it is obvious you can't compete in the jungle."

The shelter system is particularly daunting for those who are physically weak or have limited mobility. There are very few shelter beds set-aside for seniors or persons with disabilities (15 at MSC South and six at Next Door), and check-in can require traveling to the nearest homeless drop-in center, then waiting in line outdoors (Kintanar, personal interview, June 20, 2006; Raman Hotel Residents focus group, June 28, 2006). Accessibility is also a problem at many facilities, where bathrooms are poorly maintained, chaotic, and lack grab bars or safety measures. DAAS may be able to work with DHS to improve conditions and accessibility in shelters.

Problems with financial literacy and fear of isolation prevent many seniors from leaving the shelter system for a single, private room in permanent housing. Reluctant to relinquish control over their SSI income, seniors are often resistant to third party payee services (a requirement for entry into Direct Access to Housing). Chronically homeless seniors are also unaccustomed to budgeting for rent, and can fall deeply into debt once housed in an SRO unit. Furthermore, chronically homeless seniors often face new challenges and anxieties in confronting health issues after many years of self-neglect (Focus group, LeNain Hotel, February 10, 2005).

Many chronically homeless seniors are also accustomed to and comforted by group living quarters and apprehensive about being without the company and supervision of others. However, when placed in permanent housing with younger persons who have behavioral health issues, some seniors balk at the buildings' rules on behavior (Mesa, personal interview, September 6, 2006).

Strategies to House More Homeless Seniors

- Support groups including homeless and formerly homeless seniors help address fear of isolation and provide peer mentoring.
- Financial management and budgeting workshops for homeless seniors.
- Professional development and support for caseworkers in permanent housing programs, shelters, and non-profits serving homeless seniors and adults with disabilities. Educate these staff about DAAS to improve access to appropriate services.[22]
- Periodic forums can further enhance knowledge of housing resources and strategies for working with apprehensive consumers. (Walton, personal interview, July 7, 2006; Balanon, personal interview, July 27, 2006; Antonetty, July 19, 2006)

[22] Administrative data indicate that only 23% of the 702 persons 60 and older who stayed in shelter during FY 2005-06 used any DAAS services. Most of those who did accessed community services (14%) or the District-Wide Social Services Worker (12%). Only 18% accessed any DHS services such as "Non-Assistance Foodstamps" or Medi-Cal.

NUTRITION

THE ISSUE: NUTRITION

Nutritious food is a cornerstone of healthy living. Many low-income San Francisco residents must choose between paying for rent, medications, or food (San Francisco Food Bank, 2002). Concerned about losing housing or having utilities turned off, it can be easiest to reduce costs by cutting out more expensive foods such as fresh vegetables or high protein items. In the long run, these choices can lead to malnutrition and consequent health problems.

A common gauge of inadequate nutrition is "food insecurity," measured with a nationally-recognized series of 18 questions about behaviors and experiences which characterize households that are having trouble meeting their food needs due to inadequate financial resources. Nationwide, 5.9 percent of households with seniors present are estimated to be food insecure, while younger households report food insecurity at a much higher rate (11.6%). Food insecurity rates rise for seniors living alone or in urban areas, and especially for those with low incomes (Nord, 2002). According to the 2001 California Health Interview Survey (CHIS), 22 percent of San Francisco seniors with incomes below 200 percent of the poverty level were food insecure, a slightly lower rate than that of the city's total low-income population (26%). CHIS estimates suggest that at least 23,300 seniors are food insecure in San Francisco.

Malnutrition contributes to deteriorated health, especially for vulnerable populations. Food insecure seniors are more than twice as likely to report health status of "fair" or "poor" than are other seniors (Lee, 2001b). The risk for malnutrition is also higher among specific groups of older adults, including those who are low-income and those who are isolated or suffer from illness or diseases affecting independence. Many health conditions common in older people can start a malnutrition cycle due to symptoms of decreased response to taste or smell, or decreased salivation (Administration on Aging, 1994; Lee, 2001b). Medication side effects also contribute to this problem. Furthermore, functional impairments among both older and younger adult populations can create barriers to accessing and preparing nutritious meals (Wolfe, 2003); a person with functional impairments may find that they are able to prepare meals at home, but have trouble getting out to shop or carrying bulky items home from the store (Dahi, personal interview, 2006).

EVIDENCE OF LOCAL NEED: NUTRITION

San Francisco's high rents paired with fixed incomes force many seniors and younger adults with disabilities to make compromises between housing and adequate nutrition. The average monthly rent for a one-bedroom apartment in the second quarter of 2006 was $1,718, more than twice as much as the 2006 monthly SSI payment for a single SSI recipient (Social Security Administration, 2006).[23] To eat adequately, many seniors rely on free nutrition programs.[24]

[23] Single "aged" or "disabled" people living independently receive $836.00 for April-December of 2006.

The importance of free food resources was regularly mentioned in general discussions of critical service needs during the assessment process (Case managers focus group, June 27, 2006; Bayview DAC, July 14, 2006; Sunset DAC, July 19, 2006; Richmond DAC, July 11, 2006; Tenderloin/South of Market DAC, August 7, 2006; Visitacion Valley DAC, July 25, 2006).

Many seniors rely on free nutrition programs for a majority of their nutritional needs. The San Francisco Food Bank's 2006 survey of seniors participating in the Brown Bag program revealed that 70 percent relied on food pantries, commodity food boxes, or senior center lunches as their "primary food source." In a 2005 survey of guests of the Saint Anthony Dining Room, 61 percent of seniors said that they ate there more often than every other day, compared to 50 percent of all respondents. Sixty-four percent said that they also eat at other food programs (St. Anthony Foundation).[25] In a phone survey, nine percent of San Francisco seniors and 16 percent of younger adults with disabilities indicated that they had used hot meal or free grocery programs in the past year (National Research Center, 2006).

Other local research provides additional estimates of the need for nutrition services for seniors in San Francisco:

- In July 2006, the waiting list for home-delivered meals reached over 300 individuals.
- A phone survey completed in 2006 indicates a possible unmet need for home-delivered meals among seniors of over 5,400 individuals, with 4 percent of all older adults indicating that they have needed the service and been unable to use it (National Research Center, 2006).
- A survey of seniors living in public housing found that 11.6 percent of those who didn't receive home-delivered meals said that they needed them (SF Partnership for Community-Based Care & Support, 2006, March).
- Intense case managers participating in a focus group highlighted home delivered meals as among the primary critical services upon with their clients rely, but expressed frustration that it can be difficult to get new clients on the program quickly (Case managers focus group, 2006).

Seniors – Estimating the overall need

The following analysis aims to estimate the overall need for free or low-cost meals among seniors, and compares that need to existing services. As the inability to afford food is the standard focus of food insecurity measures, this analysis uses a basic measure of poverty to estimate the population needing nutrition services. Translating the number of individuals with various incomes into rough estimates of the number of meals needed allows for a comparison to existing food resources in the community, which will be catalogued in the next section.[26]

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[24] Both congregate and home-delivered meal programs include a suggested donation. Many participants do contribute a small donation, making them more "low-cost" than "free." Because donations are optional, this report describes all such programs as "free."

[25] Additional analysis of trends among seniors was performed by St. Anthony Foundation staff upon request of the HSA Planning Unit.

[26] Survey results measuring food insecurity are less useful for estimating the entire population of people needing supplemental nutrition resources, as respondents who already rely heavily on free food programs may find that their needs are met and therefore not report that they are food insecure.

Evidence from surveys of current free nutrition programs suggests that many low income seniors rely on free meal or grocery programs for the majority of their nutritional needs (San Francisco Food Bank, 2006; Saint Anthony Foundation, 2005). Also, many home-delivered meal recipients rely on those meals as their primary source of food. Those on fixed incomes but paying market rates for housing or those with incomes below the poverty level ($9,800 annually for an individual, lower than SSI) may need to rely on free or low-cost meals for as many as one or two meals per day.[27] Thus, it seems reasonable to suggest that, in order to ensure appropriate nutrition, seniors in the lowest income bracket (under poverty) might need, on average, 1.5 meals per day subsidized by public or community-based providers.[28] Those with slightly higher incomes (100 percent to 200 percent of poverty) may need fewer meals per day – perhaps one meal daily on average. For seniors age 65 and older in San Francisco, these assumptions suggest a need in the community for over 15 million free meals annually. Applying the same logic to seniors 60 to 64 (and assuming that they have similar poverty rates as those 65 and older[29]) suggests need for an additional 5.2 million meals annually citywide. (See table on page 37 for a comparison of these figures to the number of meals provided in FY2005/06.)

While there are certainly some low-income seniors who do not need supplemental meals, there will also be some in higher income brackets who do. Many higher income individuals needing meals may be those with functional or cognitive impairments that make a home-delivered meal necessary.

Seniors:
Estimated Need for Free Meals

	Low Income Seniors			
Poverty Status	*# age 60-64**	*# age 65+*	*Estimate: Meals needed daily*	*Meals needed annually*
below 100%	3,377	11,010	1.5	7,876,888
100 – 200%	9,102	25,476	1	12,620,914
Total	12,479	36,486	n/a	20,497,802

Source: Census 2000

** The number of seniors in poverty in this age group are estimated based on poverty rates of the older cohort, for whom data are available.*

Younger adults with disabilities – Estimating the need

Neither Census 2000 nor American Community Survey (ACS) 2004 data provides the level of detail necessary to conduct a parallel analysis of younger adults with disabilities at varying poverty rates, though the most recent data suggest that as many as 11,395 younger adults with disabilities in San Francisco live below the poverty level (American Community Survey, 2004). Again, assuming that these individuals need, on average, 1.5 meals a day of supplemental food, we can estimate a need for 6.2 million meals annually for that very low-income population alone. Statewide CHIS data also suggest that younger adults with disabilities have significantly

[27] Seniors fortunate enough to live in subsidized housing are likely to need fewer meals than those who pay market rate for housing. The 2006 survey of public housing residents reveals, however, that many residents still rely on free groceries (29%) or home delivered meals (31%) (Partnership for Community-Based Care and Support).

[28] Some may need three meals per day, some may need none. 1.5 meals per day is intended to estimate daily needs on average across the whole very-low income population of seniors.

[29] Census 2000 does not provide these poverty data for the age cohort 60-64, but instead uses age 65 and older as a cut-off for "seniors."

higher rates of food insecurity than do other low-income adults. Of younger adults who reported needing "special equipment or help with daily activities," 59 percent of respondents statewide were also food insecure (CHIS, 2001, 2003). Following the launch of a pilot program to provide home-delivered meals to younger adults with disabilities in San Francisco, all available slots filled rapidly. Moreover, eight percent of younger adults with disabilities indicated in the 2006 San Francisco phone survey that they needed but were unable to use home-delivered meal programs (National Research Center, 2006).

EXISTING LOCAL SERVICES: NUTRITION

Three primary types of programs exist in San Francisco to provide free or low-cost nutrition resources for seniors and younger adults with disabilities: the Food Stamps program, prepared meal programs, and free grocery programs. Excluding free grocery programs (which do not track unique consumers), analysis of administrative data reveals that meal programs and the food stamps program together serve approximately 12,700 unduplicated seniors. Most participants (97%) appear in either a meal program or receive food stamps, but not both. Because these programs track the age of consumers and not disability status, aggregate estimates of the number of meals provided to younger adults with disabilities annually is not possible.

Prepared Meal Programs

Many seniors and younger adults with disabilities benefit from the vast array of free or low-cost prepared meal programs available throughout the city. Many of these programs specifically target seniors and thus make efforts to ensure that menus are nutritionally tailored to that population's special needs (e.g., congregate, home-delivered, and adult day meal programs), but some seniors and younger adults with disabilities also access free meals from traditional soup kitchens or other community-based programs. In FY 2005-06, the Department of Aging and Adult Services' Office on the Aging (OOA) supported 50 congregate meal sites and 8 home-delivered meal providers using $3.3 million in federal and state funding and an additional $4.6 million in local general fund.

Free/Low-Cost Hot Meals Provided to Seniors FY2005-06[30]

Meals for functionally independent seniors	
OOA congregate meals	783,722
Hot meals from other providers	605,473
Subtotal	1,389,195
Meals for homebound/functionally-impaired	
OOA home-delivered meals	913,300
Adult day program meals	521,036
Subtotal	1,434,336
Grand Total	2,823,531

For those who are not homebound or functionally impaired, congregate meal programs and traditional soup kitchens are the primary sources for free or low-cost hot meals. In FY2005/06, Office on the Aging-funded congregate meal programs provided 785,450 hot meals, all but 1,728 of which were provided to seniors. Most hot meal programs not funded by the OOA are members of the San Francisco Food Bank, which regularly collects

[30] Sources: OOA administrative data; SF Food Bank administrative data; SF Adult Day Network personal correspondence; PACE program personal correspondence.

information on programs details such as the number of meals provided and the demographics of program participants. Analysis of these data suggests that other non-profit agencies provide over 600,000 free hot meals to seniors beyond those funded by OOA.

Meal programs targeting homebound seniors and those with significant limitations of activities of daily living include: (1) home-delivered meals programs, and (2) adult day programs, which typically provide a mid-day meal to participants. Meals on Wheels (MOW) is the largest home-delivered meal provider, serving more than half of all OOA funded home-delivered meal clients. While MOW delivers two meals per day to each client, other contractors typically provide only one meal daily.

OOA home-delivered contractors provided 913,300 meals to seniors and 38,920 meals to younger adults with disabilities in FY2005/06, and estimates from the Adult Day Network and the OnLok PACE program suggest that adult day programs provide approximately 521,000 meals annually to seniors.

Free Grocery Programs

The San Francisco Food Bank provides food for the majority of the existing free grocery programs in San Francisco, including large-scale programs serving low-income seniors. These programs provide dry goods along with at least four to five fresh produce items at each distribution. Since the San Francisco Food Bank moved into a new warehouse with a 1,800 square-foot refrigerator in 1996, it has been able to successfully partner with growers in California's produce-rich Central Valley to dramatically increase the availability of a broad variety of fresh produce at local food pantry distributions.

The San Francisco Food Bank coordinates five food pantry programs benefiting seniors and younger adults with disabilities. The Brown Bag program and Commodity Supplemental Food Program (SFP) target seniors specifically. The Brown Bag program reaches over 3,000 seniors, and SFP served an average of 10,121 individuals each month in FY2005/06. Brown Bag and SFP distributions are often hosted at senior centers or other senior service agencies.

Many SFP participants (approximately 40%) authorize proxies to pick up their monthly food boxes because it is physically difficult to do so themselves (Meredith Terrell, personal correspondence, 2006). Three other food bank programs (the Neighborhood Grocery Network, Immigrant Food Assistance Program, and Supportive Housing Pantries) serve all age groups but attract a large number of seniors. Among all five programs, the San Francisco Food Bank distributed an estimated 12 million pounds of free groceries to seniors in FY2005/06. Estimating 1.5 pounds per meal, these distributions amount to 8.8 million meals.[31]

The Senior Farmers Market Nutrition Program is a federally funded program that provides low-income seniors with coupons that can be exchanged for fresh produce at approved, certified farmers market vendors. In FY2005-06, OOA congregate meal providers distributed a total value of $30,000 of Senior Farmers Market coupons to 1,500 low-income seniors.

[31] America's Second Harvest, an umbrella organization representing many food banks nationwide, estimates that 1.28 pounds of donated food is equivalent to one meal. Rounding to 1.5 pounds per meal is a more conservative estimate, but helps to account for produce spoilage and any unused items.

Assuming a rate of $5 per meal, this program provided the equivalent of 6,000 additional meals to seniors.

Food Stamps

The Food Stamps program is a federally funded program that aims to eliminate hunger by providing eligible low-income individuals with cash-equivalent benefits that can be used only to purchase food items at both grocery stores and local farmer's markets. Elderly, disabled and homeless food stamps clients may even purchase prepared foods at authorized vendors through a unique San Francisco program.

As of April 2006, 2,479 seniors age 60 and older received food stamps in San Francisco, with an average monthly benefit of $113 per household. Estimating $5 per meal, these benefits supply approximately 604,545 meals annually to seniors. Figures on the number of younger adults with disabilities receiving food stamps are not available at this time. California is the only state in which individuals receiving SSI are ineligible to apply for additional food stamps support because all California SSI recipients also receive the State Supplemental Payment (SSP), which includes a small allocation for food. This excludes the nearly 46,000 SSI recipients from receiving any additional food stamps. Over 27,000 of those affected by this policy in San Francisco are seniors aged 65 and older, and nearly 18,000 are younger adults with permanent disabilities that prevent employment (Social Security Administration, 2006). For SSI recipients who do not have cooking facilities, SSI payments are supplemented slightly to include a "restaurant allowance." Estimates of the number of individuals receiving this allowance in San Francisco were unavailable at the writing of this report.

Free Groceries Provided to Seniors: FY 2005-06		
Food pantry programs	**Pounds[32]**	**Meals (= pounds/1.5)**
Commodity Supplemental Food Program	3,678,523	2,452,349
Brown Bag Program	2,023,105	1,348,737
Neighborhood Grocery Network	5,063,726	3,956,036
Immigrant Food Assistance Program	1,033,137	807,138
Supportive Housing Pantries	258,117	201,654
Grocery purchase programs	**$**	**Meals (= $/5)**
Food stamps	$3,022,728	604,545
Senior Farmers Market Coupons	$30,000	6,000
Grand Total		9,376,459

Younger adults with disabilities

DAAS's recent pilot program to provide home-delivered meals to younger adults with disabilities served an average of 107 clients daily for a total of 38,920 meals in FY2005/06. The department contracted with three community-based agencies, Meals on Wheels, Russian American Community Services, and Self-Help for the Elderly, to launch the pilot. The wait list for this program is currently 180 people.

[32] Pounds are determined by multiplying the annual poundage distribution for each program by the approximate percentage of that program's participants who are age 60 or older.

Congregate meal programs reported serving only 1,728 meals to this population this year. Younger adults with disabilities may participate at more mainstream soup kitchens, but it is not possible to quantify the extent of those services because most programs do not track disability status. Food pantries in San Francisco do not track the disability status of consumers, which makes it impossible to provide a numeric estimate of free grocery services provided to that population at this time. While younger adults with disabilities are welcome at Neighborhood Grocery Network food pantries, which are open to anyone in the community, it is notable that no other program currently targets that population for free groceries.

GAPS: NUTRITION

Seniors continue to need more free food resources in this very expensive city.
Across all food programs, San Francisco's seniors received approximately 12.2 million free meals in FY2005/06, though analysis of poverty statistics shows they may have needed as many as 20.5 million meals. Other methods for estimating unmet need suggest that a gap of 9 million meals may be slightly overestimated (See table below other methods).[33] This overestimation may be due, in part, to the difficulty in estimating the number of seniors receiving "restaurant allowances" via programs like SSI and In-Home Supportive Services. Regardless of the method used, gap estimates are in the millions of meals annually.

Methods for Estimating the Unmet Need for Meals for Seniors	
Gap estimation method	**Annual unmet need for meals**
Poverty gap analysis: (Detailed in text) Meals needed: 20.5 million - Hot meals provided: 2.8 million - Free groceries provided: 9.4 million Difference: 8.3 million	~8.3 million meals
Phone survey results: The survey estimates the proportion of the population needing but unable to access congregate and home-delivered meal programs (5% and 4%, respectively). Assume those people need an average of 1.5 meals per day.	Congregate/pantry: ~3.7 m Home-delivered: ~3.0 m Total: ~6.7 million meals
California Health Interview Survey: Estimates that 22 percent of low-income seniors are food insecure. Assume those people need an average of 1.5 meals per day. May underestimate need based on functional impairments (Lee, 2001a).	~5.9 million meals

Some existing programs serve individuals with functional impairments poorly.
With few food programs specifically targeted to the needs of younger adults with disabilities, that population is likely to be particularly underserved. Space limitations at food pantries often make it difficult for recipients sit while they wait in line, reducing access for younger

[33] Recent federal cuts to the Commodity Supplemental Food Program will exacerbate these gaps; the program already has a waiting list over 300 names long and is being forced to reduce the existing caseload by over 1,000.

adults with physical disabilities. Demand for the pilot home-delivered meals program outstripped supply quickly, suggesting that room for growth exists.

For adults with disabilities that restrict their access to the grocery store, home-delivered meal programs are the most commonly considered mechanism for providing supplemental food. However, some of these people may be able to cook within their homes, and thus could benefit from free groceries. In fact, in a 2001 survey, 80 percent of seniors living in Bernal Heights indicated that they cook for themselves (Maynard, 2001). The high proportion of SFP participants authorizing proxies to pick up monthly food boxes (40%) suggests demand exists for free groceries even among those with limited mobility. Although the Census and ACS provide estimates of the number of individuals with disabilities that restrict their ability to go outside the home, many people have formal or informal caregivers who do shopping and meal-preparation tasks for them.

IHSS clients who are ineligible to receive home-delivered meals represent a potential target group for this type of service: these consumers are low-income and often already have IHSS hours dedicated to food preparation. Even seniors and younger adults with disabilities who currently receiving home-delivered meals may benefit from creative expansion of grocery programs since many home-delivered meal programs only provide one meal per day.[34]

Some neighborhoods have fewer food resources for seniors than others.
Appendix D provides a comparison of the distribution of free food resources for seniors in each zip code as compared to the distribution of low-income seniors. The northeast sector of the city emerges as fairly underserved relative to the low-income population of seniors living there. The zip codes where many low-income seniors live, 94133 (North Beach/Telegraph Hill) and 94109 (Russian Hill/Nob Hill/Chinatown), receive less than a proportional share of free food resources for most if not all programs discussed in this section. Chinatown (94108) also shows fairly high number of seniors and lower proportions of free food resources.

In other neighborhoods, the availability of high quality groceries is an issue in certain neighborhoods. For example, a lack of mainstream grocery stores in the Bayview/Hunter's Point district makes it even more difficult for people without good transportation options to get access to groceries.

SSI policies reduce access to the Food Stamps program for seniors 65 and older.
The SSI policies significantly reduce the number of seniors who might be eligible to receive food stamps, heightening the need for alternative nutrition programs. Ninety-eight percent of seniors 65 and older with incomes below 150% of the poverty level in 2000 received SSI, making low-income seniors age 60 to 64 the primary target group for expanded senior food stamps participation under current policies.[35] A 2002 study conducted by Mathematica Policy Research, Inc. (Cunnyngham) found that SSI recipients who were elderly or disabled, living only with other SSI recipients, and having high out-of-pocket medical or shelter expenses

[34] Only one provider, Meals on Wheels, delivers two meals per day.
[35] Income eligibility for the food stamps program is complicated, as limits are enforced after a variety of allowable deductions. Federal law sets gross income eligibility for the program at approximately 130 percent of the federal poverty level.

would gain from a shift in policy to allow application for additional food stamps benefits. Younger adults with disabilities face significantly more stringent eligibility criteria for SSI.

ISOLATION

THE ISSUE: ISOLATION

Social isolation is a major health risk. Social and medical research shows that risks of social isolation are comparable to the risk factor in obesity, sedentary lifestyles and possibly even smoking (Cacioppo et al., 2002). This risk increases with age. A 1982 study on isolation highlighted four primary isolators: physical, psychological, economic, and social (Rathbone-MCCuan & Hashimi), all common among the elderly and younger adults with disabilities. The effects of social isolation can elevate risk for poor nutrition, elevated blood pressure, suicide and other health problems.

Social isolation can also heighten risk for depression, which is a serious issue for seniors. According to the National Institute on Mental Health (NIMH), symptoms of depression affect approximately 7 million Americans age 65 and older (2003). While many people believe that depression is a normal part of aging, symptoms are actually distinct from typical emotional experiences of sadness, grief, loss, or passing mood states, as they are persistent and interfere significantly with an individual's ability to function. Older persons with depression rarely seek help. Older adults are more likely than younger people to die by suicide. White men over 80 are at the greatest risk of all age, gender, and racial groups. The suicide rate for this group is approximately six times the rate for the general population (NIMH, 2003). Furthermore, numerous studies have demonstrated a connection between depression and dementia, though the exact nature of the relationship remains unclear (Boustani & Watson, 2004).

Several studies have found that loneliness, lack of companionship, and lack of emotional support creates vulnerability to heart disease in the elderly (Cacioppo et al., 2002; Sorkin et al., 2002). Having even one person around for emotional support has been shown to reduce this risk, while other healthy effects of social support require relationships with multiple individuals (Sorkin et al., 2002). Social supports help to moderate the detrimental effects of stress as well aid in adjustment to chronic illness.

EVIDENCE OF LOCAL NEED: ISOLATION

Indicators of social isolation citywide

As people age, they are more likely to live alone. According to Census 2000, 40 percent of all households with a resident aged 60 and over were single-person households in San Francisco, compared to 33 percent statewide. This constitutes nearly 40,000 individuals. Live-alone rates are even higher for senior householders 75 and older, of whom 19,737 live alone. This older population is more prone to isolation due to increased frailty and the loss of close friends as age advances. Recent demographic trends suggest that younger families are leaving San Francisco for more affordable areas. Seniors

> *"Isolation is the biggest enemy. If a senior shuts himself or herself in, no matter how good the nutrition and social services are, you can't reach them."*
>
> --Annie Chung
> Executive Director,
> Self-Help for the Elderly

left behind when adult children leave may become more socially isolated.

Live-alone rates vary by racial and ethnic group and by geographic area of the city. White seniors have the highest live-alone rate (53%), followed by African Americans (46%). Although they are least likely to live alone, API seniors are highly represented in the San Francisco population. Thus, more than twice as many API seniors live alone than do African American seniors, however.

While isolation is sure to occur among seniors living in every neighborhood in San Francisco, analysis of the prevalence of two isolation indicators from Census 2000 – living alone and difficulty speaking English – suggests that some neighborhoods may have higher concentrations of isolated seniors than others. The South of Market (94103), Chinatown (94108), North Beach/Telegraph Hill (94133), and Potrero Hill (94107) neighborhoods all have higher rates for both isolation indicators than does the city at large. (For a detailed summary of isolation indicators by zip code, see Appendix E.) The 94109 zip code, which includes Russian Hill, Nob Hill, and several blocks of Chinatown, has both the highest rate and by far the largest number of senior householders 65 and older who live alone (4,983, 68% of 65+ householders in that zip code). Seniors living alone there represent 15 percent of all senior live-alone households in the city. Poor accessibility in Single Room Occupancy hotels in Chinatown imposes additional isolation upon many seniors with mobility impairments. A Human Services Agency 2006 survey of IHSS clients with significant mobility impairments living in Chinatown revealed that roughly one-third of respondents were completely homebound, sometimes going out of their building as infrequently as once a week.

Isolated seniors calling 911

Captain Niels Tangherlini of the DPH HOME Team regularly encounters socially isolated seniors experiencing generalized anxiety and fear. The anxiety brings on the feeling of shortness of breath, prompting the individual to call 911. Once the EMS team arrives, the anxiety attack often subsides. Many of these people call EMS because they do not have anyone else to call, and EMS gets more of these types of calls during off hours when people feel that the support services they rely on otherwise are not available. Often the crew goes out to the same person several times and starts to recognize a pattern associated with anxiety. When these seniors also suffer from cognitive impairment, EMS sees even more frequent calls.

One isolated woman called 911 several times a day due to generalized anxiety; She had forgotten that the team had just been to her home.

Lack of transportation also contributes to isolation. In some higher crime neighborhoods, seniors often feel unsafe doing errands alone on foot, and pleasure outings (e.g., socializing with friends, getting out of the city, etc.) are very difficult to arrange for those with mobility impairments that restrict their ability to use public transit. Focus group participants often cite lack of transportation as a contributing factor to isolation (African American roundtable discussion, June 29, 2006; LGBT roundtable, June 14, 2006; LGBT seniors focus group, June 29, 3006; Peer advocates, June 23, 2006). (See the "Access" section of this report for more information on transportation issues.) For persons with visual impairments, some suggest that being able to use transportation may be the single most important need, even more than housing (Aaron, personal interview, September 12, 2006).

Local research suggests that social isolation is of considerable concern for both seniors and younger adults with disabilities in San Francisco. In a 2006 phone survey (National Research Center), respondents were asked how much time they spend socializing with family and friends in a typical week, either on the phone or in-person. Ten percent of both seniors and younger adults with disabilities responded that they spend less than one hour or no hours per week. One-third of respondents indicated that they spend one to five hours socializing, still less than one hour per day. A community needs assessment conducted among seniors in Bernal Heights in 2001 found that nearly 40 percent of those surveyed had three or fewer visits with family of friends in the thirty days preceding the survey (Maynard, 2001).

The California Health Interview Survey (2003) reinforces these estimates of the prevalence of social isolation among seniors. When asked about the "availability of someone who loves you and makes you feel wanted," 12.5 percent of seniors (65 and older) in San Francisco reported that "no one is available," more than twice the rate for seniors statewide (5.3%) and dramatically higher than the rate for all San Francisco adults (6.0%). In the same survey, nearly 18 percent of San Francisco seniors indicated that no one was available to "understand [their] problems." Again, this rate was more than twice the rate for seniors statewide (8.1%) and for all local adults (8.0%). These surveys suggest that anywhere from 17,000 to 24,000 seniors in San Francisco may suffer to some degree from social isolation. These reports may underestimate isolation if some respondents are reluctant to discuss the lack of contact they have with loved ones.

Isolation can heighten severe anxiety among seniors, especially during periods following an illness. These isolated seniors sometimes rely on the emergency medical system (911) for the support that they do not have elsewhere. According to Captain Niels Tangherlini of the DPH HOME Team,[36] isolated seniors are among the most frequent users of EMS services. As of June 2006, the Department of Public Health found that nearly 25 percent of "High EMS Users" were over age 60.[37] Isolation can also aggravate medical conditions and even result in delirium when seniors have no one to prompt them and monitor that they are taking their medications properly (Mesa, personal interview, September 6, 2006).

High-risk group: Seniors and younger adults with disabilities in public housing

The Partnership for Community-Based Care & Support conducted a survey of residents in eight of the San Francisco Housing Authority's "senior and disabled" buildings. The 23 senior public housing buildings are home to 2,200 low-income seniors and younger adults with disabilities, served by only two social workers. The survey not only revealed low utilization rates for a variety of community-based services, but also high rates of social isolation. Forty-one percent of respondents indicated that they participate in social activities less than once per month. Housing Authority staff expressed concern that isolation is a contributing factor to the low utilization of social services – residents become so socially isolated they begin to fear reaching out for help (Long Term Care Coordinating Council (LTCCC) minutes, May 2006). The Housing and Services Workgroup of the LTCCC has

[36] The HOME Team is the "Homeless Outreach and Medi-Cal Emergency Team," which engages frequent users of EMS, addresses their individual unmet needs and minimizes their frequent usage of 911.

[37] High Users are those who have been identified as having been picked up by EMS four or more times in any one month.

begun discussions to identify three buildings for a pilot project to reach these public housing residents.

High-risk group: LGBT Seniors

Local and national research suggests that lesbian, gay, bisexual, and transgender (LGBT) seniors are at especially high risk for isolation. Providers participating in a roundtable discussion about LGBT aging issues agreed that extreme isolation is "the norm" for those seniors. A report by the Policy Institute of the National Gay and Lesbian Task Force (2000) found that "LGBT elders do not utilize services on which other seniors thrive. Many remain in and are forced back into the closet reinforcing isolation and shame" (Cahill et al., 2000).

For many, isolation is a lifelong theme. Many LGBT seniors have experienced years of discrimination both from institutional systems as well as from families who might otherwise have provided care-giving support. Depression is common, putting LGBT seniors at risk for self-neglect, withdrawal, and substance abuse problems. Cultural stigma in minority communities forces many LGBT seniors of color to remain closeted, leading to loneliness and alienation. For LGBT seniors who do have strong social networks, many rely on friends, not family. These support systems are often unrecognized by health care systems, leaving LGBT seniors unnecessarily isolated when health needs become more critical. For example, LGBT seniors are barred from visiting their partners during "family-only" visiting hours at hospitals (LGBT Roundtable, 2006; City and County of San Francisco Human Rights Commission, et al, 2003).

Healthy LGBT seniors express fear of becoming isolated as they age. Referring to the aftermath of the AIDS epidemic in San Francisco, one gay focus group participant said, "All the people I expected to grow old with; they're all gone." In a 2004 community health assessment, an LGBT focus group discussed common fears of "facing old age, isolated and without children" (Building a Healthier San Francisco, 2004).

> *"I don't think I can successfully communicate or get people to understand, empathize with or care about how profoundly alone I am and how I feel. I struggle daily to cope and keep going. And I believe that there are many seniors like me."*
>
> -Lesbian senior
>
> *"Closeting is the more isolating and detrimental aspect of their welfare."*
>
> -Provider, discussing LGBT seniors

Discrimination, overt or otherwise, causes people to feel the need to hide their identity, even when it comes to life-altering events like the death of a partner. One resident at Curry Senior Center won't participate at the LGBT lunch program in his own building for fear of being recognized by other residents. Closeted seniors hear derogatory comments directed toward those who come out of the closet, reinforcing alienation. One participant in a focus group of LGBT seniors said, "The truth is that we [LGBT seniors] are not really welcome in senior centers. I spend a lot of time at a senior center, but I'm not out there."

Many individuals with mobility impairments face isolation, but those who are also LGBT face additional challenges. For those who live in residential settings that are unfriendly to LGBT seniors, the onset of mobility impairments results in tremendous isolation. Unable to drive to visit friends, they find that they can no longer go out to a friendly community, forcing them to be closeted all the time. Often, LGBT seniors do not even want a friendly visitor because they are worried that other residents and staff will identify the visitor as gay.

Finally, transgender seniors probably face the most intense stigma and thus the most severe isolation. Lifelong societal rejection often pushes transgender adults into marginal work without employer benefits, resulting in higher rates of senior poverty for this population.

High-risk group: Linguistically isolated individuals

Nearly thirty percent of San Francisco seniors are considered linguistically isolated (Census 2000). Many seniors in this community find that their children move away from San Francisco as they come of age because they find San Francisco unaffordable. Seniors who choose to live with their adult children are often isolated because they are far from the neighborhoods where their language is prevalent, and they become dependent on their adult children and feel obligated to provide house-keeping and child care during the day when they would rather be working outside the home (Visitacion Valley Chinese seniors focus group, August 22, 2006). Furthermore, isolation can be immediate when monolingual seniors enter long term care facilities where few staff speak their language, leading to depression and further deterioration of health. (For a more detailed discussion of the issue of cultural and linguistic competency as a barrier to access, see this report's chapter on Access.)

High-risk groups: Younger adults with disabilities

Public stereotypes about persons with disabilities can be very painful and isolating. These misperceptions are limiting in terms of employment, but they also exclude persons with disabilities from mainstream social opportunities. In particular, persons with psychiatric disabilities are often perceived to be dangerous and, as a consequence, suffer extreme isolation and loneliness (Mizner, personal interview, August 11, 2006; Ordover & Bennin, personal interview, August 22, 2006;).

Some groups of persons with disabilities have developed their own social networks, such as the community of persons with hearing impairments, and hold dances and community organizing events. Others groups are more dependent on professional organizations to provide socialization opportunities. For example, the San Francisco Park and Recreation Department holds monthly dances for persons with autism and Asperger Syndrome. The socialization programs developed for seniors, like senior centers and adult day programs, are dominated by the elderly, making younger adults with disabilities feel out of place, and their activities are often not age-appropriate for younger persons, who are more likely to be interested in dances than bingo (Mizner, personal interview, August 11, 2006; Aaron, personal interview, September 12, 2006).

Younger adults with disabilities often struggle with significant mobility impairments that can make it difficult to participant in mainstream social programming. The 2004 American Community Survey estimates that roughly 13,000 adults age 16 to 64 have a disability that significantly limits their ability to go outside the home. Even for those who are able to travel outside of their own homes, the lack of accessible housing in San Francisco often means that they cannot visit their friends and family who live in inaccessible housing (Calderon, personal interview, July 28, 2006).

EXISTING LOCAL SERVICES: ISOLATION

A variety of local services help to address issues of isolation among seniors and younger adults with disabilities. As part of their broader programming, senior centers and adult day programs provide activities that encourage socialization. Other programs connect one-on-one to isolated seniors in their homes.

Senior Centers

San Francisco is home to many senior centers, located throughout the city. The Office on the Aging funds 29 programs for "community services" programming, which includes a service objective of increasing socialization opportunities for seniors and younger adults with disabilities. In FY2004-05, these programs enrolled over 13,800 consumers and provided 94,000 hours of scheduled activities. A recent study assessing the relationship between senior center participation and "successful aging" found that over 90 percent of respondents reported having made close friendships since coming to the senior center, and 87 percent said that senior center friends provide them with emotional security (Aday, 2003). Approximately four out of every ten participants in OOA-funded community services programs report living alone.

Awareness and utilization of senior center programs is high in comparison to other social services programs in San Francisco; nearly 90 percent of seniors surveyed by phone this year reported awareness of senior center programs, and 17 percent reported having used such a program in the past year. Usage rates varied by respondent income level; those with incomes below $20,000 annually were more likely to have used a senior center than those with higher incomes (National Research Center, 2006).

Adult Day Programs

Adult day programs provide social and therapeutic services for individuals with chronic illnesses. They serve as a licensed alternative to nursing homes for many San Francisco seniors. Most participants are seniors, though some younger adults with disabilities also use adult day programs. Adult Day programs fall under several different program categories: Adult Day Health Care (medical model), Adult Day Programs (social model), and Alzheimer Day Care Resource Centers (specialized for participants with dementia). Each model has different licensing and reimbursement mechanisms – definitions are detailed in Appendix F. The centers of the San Francisco Adult Day Network, a countywide alliance of adult day programs, have a licensed capacity to serve 811 participants daily. In addition, the Program of All-Inclusive Care to the Elderly (PACE) at OnLok provides adult day programming to approximately 900 San Francisco participants. Finally, San Francisco is home to four Alzheimer Day Care Resource Centers (ADCRCs), which provide day services for persons with moderate to severe levels of impairment due to dementia.[38]

The network of adult day programs has potential to expand services in San Francisco, especially to individuals who are able to afford the fees of private pay. The San Francisco Adult Day Network found that the city's centers were 26 percent below their licensed capacity in April 2006, though availability of slots differs depending on the specific center (some

[38] The ADCRCs in San Francisco are located at the Institute on Aging, Laguna Honda Hospital, Self-Help for the Elderly, and Catholic Charities CYO.

centers are full with waiting lists). The Adult Day Services Network is currently working to hire a staff person to be visible in advocacy and outreach, in part to address the underutilization of these valuable programs.

Reaching adult day program capacity is wrought with challenges. Centers must balance the number of private pay clients with Medi-Cal eligible clients in order to break even with operations, leading to waiting lists for Medi-Cal clients while capacity remains for private pay. The Office on the Aging provides funding to subsidize private pay participants at adult day programs.[39] Centers must also maintain required staffing ratios in order to fulfill licensing requirements, and personnel shortages among RNs, PT/OT and social work staff are all too common. Furthermore, state level regulatory reform has resulted in a moratorium on expanding Medi-Cal reimbursements to adult day programs. Thus, while there is room to take in more participants at this time, those open slots are likely to be mostly private pay slots, not Medi-Cal slots (Clement, personal interview, June 13, 2006).

Results from the 2006 phone survey support the theory that there may be room for outreach for adult day programs. Fifty-three percent of seniors surveyed in San Francisco were aware of the existence of adult day programs, as compared to 89 percent who were aware of senior centers. However, the same proportion of seniors (4%) indicated that they had needed but been unable to use both senior centers and adult day programs (National Research Center).

One-on-one contact with isolated individuals

One of the responses to loneliness and depression from agencies serving the elderly has been to offer a possibility for companionship by providing a "friendly visitor." Friendly visitors are volunteers who enhance the lives of isolated elders by visiting them each week in their home. Friendly visitors provide social support to prevent depression and related health risks (e.g., poor adherence to medical regimes and self-care activities, heart disease, etc.). These programs reach out to frail elders who live alone and have few or no close friends or relatives to offer companionship. Telephone support programs also provide one-on-one contact to reduce isolation for seniors. Telephone support programs also provide one-on-one contact to reduce isolation for seniors.

The Bay Area *Elderkind Directory* lists 13 agencies in San Francisco with friendly visitor programs (listed in Appendix G), though numerous other agencies offer similar programs. The following list provides examples of different types of one-on-one support programs in San Francisco:

- *Companionship at Adult Day Health Centers:* The Family Service Agency of San Francisco's Senior Companion Program, funded by the Office on the Aging, offers low-income seniors an opportunity for volunteer employment as friendly visitors. Volunteers in this program assist ADHC clients by acting as companions throughout the day, enabling them to take part in field trips and other center activities. As of August 2006, this program served 118 clients through the services of 20 volunteers. Thirteen caregivers also received respite service through this program.
- *Home visits to isolated seniors:* A primary provider of friendly visiting services in San Francisco is Little Brothers – Friends of the Elderly, a national non-profit organization

[39] Funding in FY2006/07 is $131,833, supporting 83 clients.

committed to relieving isolation and loneliness among the elderly. Volunteers commit to visiting the same elder at least twice a month for a year. This organization worked with 835 elders across all its programs in 2005, and 184 seniors received friendly visits.

- *Telephone support:* One telephone support program is the Institute on Aging's *Friendship Line,* a 24-hour telephone line that offers emotional support and information for lonely, homebound or isolated seniors as well as grief counseling. This program is a part of that agency's Center for Elderly Suicide Prevention.
- *Friendly visiting and empowerment:* The Peer Advocates program was developed recently by Planning for Elders in the Central City as a part of the work of the San Francisco Partnership for Community-Based Care and Support. Peer advocates make home visits to isolated elders, phone calls to check on individuals and empower seniors to become their own advocates. Peer advocates receive a stipend to conduct outreach activities at churches, fairs and community agencies, focusing on the African American, Latino, API, and LGBT communities.

Broad, community-wide outreach

In an effort to increase awareness of services for seniors and younger adults with disabilities, the San Francisco Partnership for Community-Based Care and Support has recently launched the "Home Alone Campaign," a citywide media campaign. The campaign includes multilingual bus ads, as well as newspaper ads in several papers including ethnic media outlets. The ads direct people to call 2-1-1, which provides referrals in a variety of languages and is available 24 hours a day.

Mental Health Services

The Department of Public Health's Community Behavioral Health Services provides services to reduce depression. Annually, it screens over 3,000 seniors who have been referred by concerned relatives, physicians, or programs. It first provides differential diagnosis, determining if the person's behavior is the result of depression, delirium, or dementia. Depression is treatable with medications and therapy, and delirium is typically the result of mismanaged medications and often requires brief hospital stays for detoxification. Individuals suffering from dementia receive care from primary care providers. Community Behavioral Health Services provides over half of its services for seniors in clients' homes. San Francisco has two county-operated mental health facilities, and Community Behavioral Health Services contracts with community-based organizations for a range of services that help seniors cope with the challenges of isolation, loss, and depression. For example, Family Service Agency of San Francisco provides intensive case management services, Progress Foundation provides residential treatment, and Curry Senior Center provides substance abuse treatment. A senior only needs the proper mental health diagnosis to participate in these programs. In addition, seniors can use Medicare to see a private psychiatrist (Mesa, personal interview, September 6, 2006).

Programs for younger adults with disabilities

Services for younger adults with disabilities are often organized according to diagnosis or condition. For example, the Golden Gate Regional Center funds a range of socialization, independent living skills instruction, and employment programs for persons with developmental disabilities like the ARC and the Janet Pomeroy Center for persons. The Lighthouse for the Blind and the National Association for Visually Handicapped provide a

variety of educational, recreational, rehabilitative and socialization opportunities to persons with varying degrees of visual impairment. The Deaf Counseling Referral Agency provides counseling, education, independent living skills instruction, workshops and field trips, including for deaf seniors. ToolWorks provides employment and community skills to help persons with hearing impairments to participate in their community.

The Independent Living Resource Center offers information, support and advocacy for persons with disabilities, including peer counseling. It primarily serves persons with physical disabilities, as well asthose with psychiatric disabilities. Each of these agencies has made particular efforts to serve persons with disabilities who have limited English proficiency.

Persons with psychiatric disabilities are largely served through the Department of Public Health's Community Behavioral Health Services. Programs like the San Francisco Clubhouse can provide both social day program and independent living activities.

Other programs target younger adults with specific illnesses (e.g., AIDS, cancer or mental illness), but do not provide socialization opportunities for the community more broadly. Some programs, such as the peer advocates program, include younger adults with disabilities as a target population, but currently serve mostly seniors in practice.

GAPS: ISOLATION

The most isolated people are hardest to reach.
It is likely that the biggest gaps in service are for those who are the most severely isolated, who are also the most difficult to locate. Because most people seek out services via word of mouth, those with few social contacts become cut off from the city's social services.

As such, it is important to seize upon opportunities to reach isolated individuals when it becomes clear where to find them. For example, recent local research identified concentrated pockets of isolated seniors and younger adults with disabilities living in public housing buildings. The Long Term Care Coordinating Council's Housing and Services Workgroup has begun discussions with the Housing Authority, proposing a three-phase pilot project at several buildings to (1) build confidence of residents and provide increased access to services; (2) integrate community-based services into buildings; and (3) integrate peer advocates and other visiting programs.

LGBT seniors are at high risk for isolation and few programs target that community.
Fear or discrimination and abuse places LGBT seniors at elevated risk for isolation, and research suggests that mainstream social services may not always provide culturally competent services to make these individuals feel welcome. DAAS provided a $10,000 grant for LGBT cultural competency trainings in FY2005/06 and is dedicating $60,000 in FY2006/07 to volunteer recruitment for LGBT seniors related to caregiving. These trainings are an important first step toward increased sensitivity to LGBT aging issues among mainstream providers, though it is likely that gaps continue to exist among programs that bring together LGBT seniors to reduce isolation.

There are opportunities to expand utilization of adult day programs.
Availability of slots at current adult day programs suggests that barriers to access may prevent full utilization of these programs. In a 2006 San Francisco phone survey, three quarters of respondents saying that they needed but were unable to use adult day programs said that they didn't use them because they didn't know how to access the program (National Research Center). The San Francisco Adult Day Network plans to increase outreach for these programs in order to address this issue, but continued subsidization of private pay fees may be necessary to ensure broader access.

Few social programs are targeted to younger adults with disabilities, and many of the programs that exist are not age-appropriate.
As described above, many programs that combat isolation are targeted to seniors, not younger adults with disabilities, and their activities are not age appropriate for younger persons. For persons who depend on weekday programs to provide social stimulation, weekends may be extremely lonely. Many of the existing services for persons with disabilities are organized by the person's diagnosis or condition. This may be due in part to the nature of the private fundraising that each organization has to do and the lack of significant public funding to help these diverse programs cohere. However, many persons have multiple disabilities and multiple needs and do not respond well to such a fragmented system (Aaron, personal interview, September 12, 2006; Mizner, personal interview, August 11, 2006; Ordover & Bennin, personal interview, August 22, 2006).

THE ISSUE: CASE MANAGEMENT & TRANSITIONAL CARE

At some point, many 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, or 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 individuals need only short-term assistance during an unexpected crisis (acute transitions), others benefit from ongoing support to help them age safely in place (non-acute transitions). Often, this support comes from case management programs.

Case Management Overview

Depending on the level of independence and acuity of circumstances of the consumer, case management programs provide different levels of service. The case management workgroup of the Partnership for Community Based Care and Support has identified four primary types of case management services, each with different recommended caseload levels: consumer directed, service brokerage, and two levels of provider-coordinated care. This categorization gives a sense of the diversity among both consumers and providers. See table for details.

Levels of Case Management		
Level of Case Management	**Description**	**Maximum Recommended Caseload**
Level 1: Low level	*Consumer directed*. For persons who require minimal assistance and intermittent support. This provides specialized assistance for persons interested in and capable of managing their own care. These services tend to be provided on a short-term basis.	No maximum
Level 2: Moderate level	*Service brokerage.* For persons who require more frequent support and supervision. This is comprised of case management broadly available through community-based providers that connect clients to services, which is critical in each neighborhood.	100 clients (average 40-60) per case manager
Level 3: Intensive & stable	*Provider-coordinated care.* For persons with more complex needs who require a maximum amount of care and supervision on at least a weekly basis. Providers offer intensive coordination of and access to a full range of social, health, and medical services.	40 clients per case manager
Level 4: Intensive & unstable	*Provider-coordinated care.* Ensures stabilization and avoids hospitalization. For persons with multiple diagnoses who are or have recently been homeless or discharged from an institution, and require an intense and maximized amount of care and supervision on at least two or more visits a week.	20 clients per case manager

Source: San Francisco Partnership for Community-Based Care and Support

Acute Transitions

Coordination of care is particularly critical during times of significant change, especially changes set in motion by a traumatic event. Both national and local literature highlight hospital discharge as among the most critical and common acute transitions that seniors and adults with disabilities face; most seniors eventually experience some form of hospitalization for either illness or injury. Traumatic events such as hospital admission and discharge can worsen existing dementia or confusion, which is often reversible if recognized quickly but can become permanent if left untreated. Physical and mental health conditions often deteriorate after hospital discharge, and research shows that many patients experience breakdowns in care during this transition period. (Pages 56-57 include a detailed discussion of hospital discharge issues.)

Common Acute Transition Events (types may overlap)	
Traumatic events: ▪ Hospital discharge ▪ Onset of major illness ▪ Injury (often due to a fall) ▪ Death of a loved one ▪ Change housing/care setting ▪ Retirement	*Isolating events:* ▪ Loss of the ability to drive ▪ Loss of mobility ▪ Loss of hearing or sight

Non-Acute Transitions

Not all dangerous transitions occur suddenly. The development of cognitive impairments, physical deterioration, or the onset of depression can occur slowly. Unnoticed and unattended, these issues can ultimately lead to crises as an individual forgets to pay bills or pursue important home maintenance, fails to re-enroll in Medi-Cal, becomes increasingly unsteady and falls down, or becomes severely isolated in his or her home (Garrison & Villela, personal interview, June 27, 2006). As people transition from independent and active lifestyles to needing more support, they can become at risk for both self-neglect and fiduciary elder abuse. For those willing to accept help during a non-acute transition, a lower level case manager can be the linking mechanism that keeps a senior or younger adult with disabilities safely at home. But too often, people are already in crisis by the time they connect with an organization that can help to coordinate services (Hinton, personal interview, June 13, 2006; Case managers focus group, June 27, 2006).

Interviews with service providers and with peer advocates revealed that often crises are avoided with non-acute transitions when family, friends and service providers vigilantly watch for behavior changes. A decline in the frequency of program attendance, increased number of bruises, heightened confusion, or a change in dressing or grooming habits might indicate that a transition is underway (Garrison & Villela, personal interview, June 27, 2006; Peer advocates focus group, June 23, 2006).

People who live alone and those who have weak social networks are naturally at higher risk of failing to acquire the full set of services that they need. Left to fend for themselves,

deterioration may progress undetected. Timely case management can prevent unnecessary hospitalization, institutionalization, and self-neglect.

Case Study from a Peer Advocate

Fran's* 80 year old neighbor's husband had recently died, and she noticed that the woman hadn't picked up her mail in two days. When Fran knocked on her door to make sure she was alright, there was no answer. Concerned, Fran banged on the door again until she finally heard a weak reply from the other side. The neighbor had a fever so high that she couldn't open the door on her own. First obtaining permission, Fran was able to force the door open and call 911. Medical staff later indicated that getting there quickly may have saved her neighbor's life. Fran feels that her story has a lesson for all: "It is so important to keep our eyes open and notice when things don't seem quite right."

**Peer advocate's name has been changed.*

Immigrant groups may also be at higher risk due to fear of accessing public services or lack of familiarity with the health and social service systems, leading to delayed interventions during transition periods and the potential need for legal services. When culturally- or linguistically-competent services are unavailable, many minority groups may not seek services until the transition has reached a crisis point (Case managers focus group, June 27, 2006).

EVIDENCE OF LOCAL NEED: CASE MANAGEMENT & TRANSITIONAL CARE

It is not possible to provide estimates of the total number of people needing service coordination. Many seniors and younger adults with disabilities successfully act as their own advocates or rely on friends or family for help. Furthermore, some who need case management choose not to accept formal services.

However, a 2002 analysis of data from the 1994 National Long-Term Care Survey (NLTCS) gives a sense of the prevalence of acute transitions. That study revealed that nearly 18 percent of seniors age 65 and older nationwide had one or more transitions in care during the 2-year period of the study. Thirty-eight percent of these transitions consisted of either hospital to paid home-care or paid to unpaid home care services. Of those with one or more transitions, 22 percent had one or more problems within 30 days of the transition (Ivey et al., 2005). While it is difficult to know if San Francisco trends would mirror these historical national trends exactly, they are useful to provide a sense of scale for the problem. Applying these findings to San Francisco's demographics, an estimated 19,000 seniors 65 and older would experience a transition in care setting within a two-year period, and 4,200 would experience problems soon after the transition.[40] In 2005, Benson Nadell of the San Francisco Ombudsman program highlighted the needs of patients being discharged from short-term skilled nursing facilities (SNFs). He estimated that as many as 800 patients being discharged

[40] Calculations: (Senior 65+) * (18% with transitions) = (# with transitions) : 106,111*.18=19,100;
(# with transitions) * (22% with problems = (# with problems): 19,100*.22=4,202.

from short-term SNFs would benefit from a formal advocate to ensure better access to and coordination of care.[41]

An analysis of existing local services further suggests unmet needs in the community. Current programs are strained by high demand. For example, Catholic Charities CYO, Curry Senior Center, the Jewish Family & Children's Services, Meals on Wheels, and San Francisco Senior Center are all functioning at or above capacity even though they rarely publicize their services. Furthermore, case managers at Linkages and Multipurpose Senior Services Program (MSSP), the largest programs providing level 3 case management for seniors and younger adults with disabilities, carry caseloads of 40 to 50, respectively, despite the fact that the National Association of Adult Protective Services Administrators recommends an average caseload size of 25 for intensive case management clients (Hiramoto, personal correspondence, June 1, 2006). Over-stretched case management resources may represent the tip of the iceberg of unmet need for these services.

EXISTING LOCAL SERVICES: CASE MANAGEMENT & TRANSITIONAL CARE

It is difficult to accurately catalogue the programs in San Francisco that provide service coordination for seniors and younger adults with disabilities. Social workers often aid consumers in locating and accessing services as a part of other programs not technically defined as "case management."

The Office on the Aging (OOA) contracts with 12 community-based agencies to provide case management for seniors and younger adults with disabilities. At least nine additional organizations are funded by the Department of Public Health, and several other non-profits rely on outside funding to provide case management services. (For a list of OOA and DPH case management programs, see Appendix H.) MSSP and Linkages case managers have the added capacity via state funding to purchase services when necessary for their clients, a fairly unique program characteristic. Linkages is the primary community-based program funded by DAAS to offer case management services to younger adults with disabilities. That program serves approximately 225 unduplicated clients annually, of which 60 percent of slots are held for individuals under 60.

A Typical Client of the Multipurpose Senior Services Program (MSSP)…

- Average age: 81
- Low-income
- Lives Alone
- Has significant mobility impairments
- Wants to remain at home

Sources: MSSP administrative data; Hinton, personal interview, June 13, 2006; Case managers, focus group, June 27, 2006.

The San Francisco Senior Center's "Homecoming Program" is the only program with the primary goal of offering transitional case management services for seniors and who need help

[41] San Francisco has 575 short-term stay SNF beds affiliated with hospitals. Benson Nadell, San Francisco's Long-Term Care Ombudsman, estimates that these beds have an 80 percent turnover rate monthly, which translates to approximately 5,520 post-acute discharges annually.

coordinating their care following hospital discharge. The program has served more than 200 individuals.

The OOA also funds ten District-Wide Social Services Workers, social workers who sometimes provide level 1 coordination services that help to mitigate the effects of less acute transitions. At programs that serve active seniors, such as senior centers and congregate meal programs, staff and social workers often notice transitions underway and are able to intervene. For homebound seniors, home-delivered meal programs emphasize the importance of making contact with the client each day to look for signs that a dangerous transition may be under way. Friendly visitor programs, such as Little Brothers Friends of the Elderly, also play an important role in reaching isolated seniors and connecting them to services.

GAPS: CASE MANAGEMENT & TRANSITIONAL CARE

Long-term and transitional intensive case management are in short supply.
Programs that specialize in intensive case management and that serve younger adults have long waitlists, further signifying a substantial unmet need for these services. At the Institute on Aging, MSSP often has a waitlist of over a year. It is an ongoing challenge for other providers to keep caseloads at OOA-recommended levels, and most programs can accept only a portion of the consumers who request services. They select among referrals for cases that are a good fit geographically, while balancing the client's urgency of need against staff capacity. People who have very complex needs (e.g., those with mental health issues or those whose primary issue is housing) often wait longer for service since many programs are reluctant to take these difficult and time-consuming cases (Kelly Hiramoto, personal correspondence, August 10, 2006; Kathleen Mayeda, personal correspondence, August 11, 2006).

Transitional case management following hospital transitions is particularly lacking. San Francisco Senior Center's "Homecoming Services" program is the only local program specializing in case management for post-discharge stabilization, and it has yet to be brought to scale. Other community-based case management programs have a limited capacity to serve post-discharge consumers while maintaining attentive service to other clients.

Younger adults with disabilities with complex needs still face waitlists for case management, and others would benefit from more flexible alternatives.
Case management for younger persons with disabilities can be a sensitive issue. Some interviewees believe that programs are too quick to thrust case management on persons with disabilities. They feel that persons with disabilities more often need access to information and assistance in learning how to manage resources, not the intrusive attention of a case manager (Ordover & Bennin, personal interview, August 22, 2006). Yet the Linkages program has a long waitlist of younger adults with disabilities (three months), demonstrating that the needs of younger persons with disabilities likely fall along a broad spectrum. Given the history of institutionalization and discrimination against adults with disabilities, it is critical that consumers maintain autonomy in decision-make and be respected no matter what the model of case management. Some younger adults with disabilities may only need case management for a short time, and there may be alternative service models that would be more appropriate. For example, a flexible fee-for-service model may make it possible for programs to arrange for

mobility training or other services without necessitating case management interventions (Aaron, personal interview, September 12, 2006).

Collaboration between providers needs improvement.

Despite the rich array of social service providers in San Francisco, the fairly organic emergence and growth of community-based services and the development of programs around distinct funding sources has left the service delivery system disjointed. Consumers and their caregivers must navigate the service delivery system independently, attempting to align a complex constellation of services to address the consumer's needs. Even for individuals who do have case managers, poor communication and confusion on the part of the consumer can result in duplicative or incomplete services during transitions. A 2005 survey of direct service case managers and program supervisors conducted by the San Francisco Partnership for Community-Based Care and Support revealed that 62 percent of case managers work with clients that have more than one case manager, and that it is uncommon that one serves as a lead. A lead case manager can serve as a critical linking mechanism, removing some of the burden from the consumer and ensuring that *all* necessary services are in place moving forward.

Local examples of strong coordination do exist as models. For example, the success of OnLok's PACE program stems, in part, from the coordination of services, easing the intensity of acute transitions. Lower-level case management programs that are co-located with senior centers or other programs serving independent seniors or younger adults with disabilities also catch consumers in less acute transition periods. For example, when a participant suddenly stops coming to the program, case managers are able to follow up and capitalize on the trust that the individual already has with the organization.

The case management collaborative pilot project proposed by the Partnership for Community-Based Care and Support seeks to improve coordination across both DAAS and DPH programs by leveraging the technology utilized by DPH to make any DPH case management client a part of the San Francisco "safety net." An electronic tool allows DPH case managers to see a client's history with other DPH service providers when s/he arrives at the door of another program. Many seniors, either intentionally or unintentionally, obtain case management services from more than one provider. This effort seeks to improve efficiency by reducing redundancy and confusion among providers.

Continued investment by DAAS, DPH, and the Partnership for Community-Based Care and Support promises to move San Francisco's service delivery system "from fragmentation to improved coordination," strengthening the city's rich service network to ensure safety and stability for all consumers.

HOSPITAL DISCHARGE PLANNING: ISSUES AND OPPORTUNITIES

HOSPITAL DISCHARGE ISSUES

Nationally, one-third of all patients and caregivers report unmet needs and dissatisfaction with hospital-to-home transition processes. Part of the reason for this includes hospital cost-containment efforts that create pressure to discharge patients earlier, resulting in increasingly complex home care (Ivey et al., 2005). Simultaneously, hospital discharge planners carry large caseloads that prevent them from conducting significant follow-up with patients after discharge. As a result, many seniors have a difficult recovery and, in the most extreme cases, deterioration can lead to premature institutionalization.

Not only are discharge plans themselves often hastily prepared,[42] but patients and caregivers report that they feel excluded from the discharge planning process and receive too little education regarding the in-home treatment plan (Ivey et al., 2005). Local research has historically revealed that there is little accountability to ensure that discharge planning is done according to safe standards in San Francisco (Health Action Team, 1999). The Ombudsman program regularly receives complaints from clients in short term skilled nursing facilities regarding transitions home.[43]

Many patients are unaware of their rights and of resources available to them, and those without an advocate (even a friend or family member) fair more poorly than those who do have an advocate. (Health Action Team, 1999). This problem is particularly critical among new immigrants who are likely to be less informed about the health care system and managed care (Health Action Team, 1999).

Patients living alone and with complex needs (such as multiple health problems, a history of depression, and moderate to severe functional impairments) are also at heightened risk for poor outcomes. These isolated seniors are most in need of more comprehensive case management services following discharge (Ivey et al., 2005). Unfortunately, most community-based providers lack the capacity to take on level 4 case management cases, and have limited ability to take on hospital discharge cases. Only San Francisco Senior Center's "Homecoming Services" program specializes in case management to ensure post-discharge stabilization.

[42] National research estimate that between 20 and 40 percent of care plans upon discharge are deficient, and local analysis indicates that planning is especially weak with regard to planning for services that will be necessary for health maintenance once the patient has reached a recovery plateau but remains somewhat functionally dependent (Ivey et al., 2005; Stern, et al, 2004).

[43] Common complaints include: insufficient therapy to return home safely, poor coordination of home-care and community-based services, reluctance to enter a nursing home.

OPPORTUNITIES FOR IMPROVING TRANSITIONS

Empower advocates

With over two-thirds of home care provided by family members, better education, preparation and support for caregivers are important strategies for improving hospital-to-home transitions. Assessments of educational interventions targeted at both patients and caregivers often show improved health outcomes for post-hospitalized seniors and fewer symptoms of depression for their caregivers (Ivey et al., 2005).

Local reports also cite the importance of having an informed advocate to help navigate services upon discharge (Healthcare Action Team Report, 1999; Nursing Home Discharge Task Force, 2003). The Ombudsman program can only take on a fraction of cases needing advocacy, and it estimates that as many as 800 clients discharged from short-term SNFs annually would benefit from formal advocacy, empowerment, and care planning to improve their transitions back into the community (Benson Nadell, April 7, 2005). Possible strategies for providing advocates:

- Expanded training of caregivers who provide the majority of post-discharge home care;
- Expansion of advocacy role of Ombudsman program to include post-acute facilities;

Improve Coordination

For persons without caregiver support or with very complex needs, there also needs to be a better formal connection between hospital discharge planners and community-based case management programs. Local and national research has identified the following possible strategies for improving transitional care coordination include:

- Create a consent mechanism for patients to approve sharing of information among providers at inpatient, outpatient, and post-discharge care sites.
- Assign responsibility to hospital staff or volunteers to follow up with patients after discharge.
- Expand and replicate case management programs specializing in discharge transitions, like the Homecoming Program.
- Generate centralized information on available resources (in appropriate languages) for discharge planners and consumers.
- Work with the Hospital Council to improve communication and coordination of services, specifically focusing on transportation, housing, access to IHSS and other community services.
- Cease Friday discharges without arrangements for shelter and home health care or homecare over the weekend.

(Health Care Action Team, 1999; Hospital and Nursing Home Discharge Task Force, 2003; Brown-Williams, 2006; Planning for Elders in the Central City, 2004).

SELF CARE & SAFETY

Adults with mobility or cognitive impairments are at elevated risk for injury or abuse. This section addresses three issues associated with self care and safety for seniors and younger adults with disabilities: in-home care, abuse, and risk of injury due to falls.

THE ISSUE: IN-HOME CARE

Many people need help with non-medical personal care and/or basic chores in order to remain safely in their own homes. Without adequate support, seniors and younger adults with disabilities face higher rates of adverse events that affect both quality of life and long-term care costs (e.g., dehydration, falls, burns, missed meals, and missed doctor's appointments). Community-based in-home services facilitate living at home, which most people prefer, rather than moving to institutional settings (Weiner et al., 2004).

Research conducted in 2002 by the Family Caregiver Alliance (FCA) found that more than a quarter of Californians age 40 and older needed "in-home care either for themselves or for a loved one" during the year preceding the study. The vast majority of adults receiving care at home get all their care from family or friends, but many of Californians in the same study (51%) felt that they would be unable to afford to pay for even two hours of in-home help per day if they needed it for six months (FCA, 2002).[44] For single seniors, the need for formal in-home care may be more prevalent because many do not receive help from relative caregivers (Johnson et al., 2006).

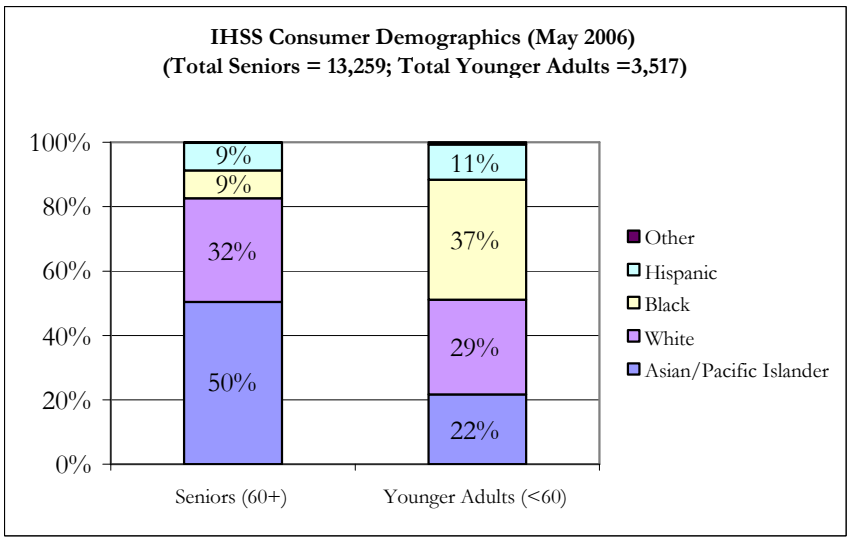
The need for in-home care is often particularly critical following hospital discharge, and failing to secure adequate support can result in poor recovery or re-hospitalization. In some cases, the lack of in-home and other services upon discharge can result in a client being referred to Adult Protective Services (APS). This report's "Service Coordination" section details issues related to discharge planning.

EVIDENCE OF LOCAL NEED: IN-HOME CARE

According to the 2004 American Community Survey, nearly 20,000 adults in San Francisco report having a self care disability, of whom 34 percent are younger adults (age 16-64) and 66 percent are seniors (65 and older).[45] Because it is common for people to receive informal care from family or friends, it is difficult to estimate how many people might need free or low-cost home-care services. Furthermore, the definition of "self care disability" is inadequate for accurately estimating the number of people who need a broader variety of in-home supports.[46]

[44] Survey respondents were informed of an hourly cost of $15 for home care services.
[45] Disability status is self-reported, and people may report more than one disability.
[46] Census 2000 asks: "Because of a physical, mental, or emotional condition lasting 6 months or more, does this person have any difficulty in doing any of the following activities -- Dressing, bathing, or getting around the home?"

However, 16,776 individuals received In-Home Supportive Services (IHSS) support during the month of June 2006, and most were seniors age 65 and over (12,483, or 74%). Nearly 90 percent of IHSS recipients also receive SSI. A 2006 San Francisco survey of seniors and younger adults with disabilities suggests that six percent of seniors 60 and over needed but were unable to use home care services[47], with rates slightly higher (8%) among disabled adults of all ages. The most common reason cited for not being able to access such services was that respondents "didn't know how to access the program," though it is worth noting that 14 percent of all adults with disabilities said that they "did not qualify" for such programs (National Research Center). Using Census 2000 estimates of the total population of seniors, this survey suggests that 8,192 seniors had an unmet need for home care services.[48] These estimates mirror those of a 2003 local phone survey, which found that approximately 8 percent of "vulnerable adults" did not receive enough help with daily activities. The study estimates that this proportion amounts to approximately 7,300 vulnerable adults needing additional help at home (Black et al.).[49] It is likely that some of these individuals would be eligible to receive IHSS services, but asset limits for the program preclude many from getting additional support outside of the private pay network.[50]



IHSS caseload has grown steadily at five percent over the last year, and the program has struggled to keep up with the increased demand with existing staff. DAAS requested funding for additional staff in June 2006, citing concerns that determinations of eligibility, which under state regulations are supposed to be completed within thirty days, then required between 90 and 120 days. While staffing will increase to address the current caseload issues, it seems that

[47] Specifically, survey respondents were asked about "home health aide, personal care attendant, homemaker or other assistant who helps with personal needs at home including personal care, such as bathing or grooming or homemaking, cooking, cleaning, chores around the house or shopping."

[48] Calculation: (# seniors 60+)*(% needing service and unable to receive) = (# needing and unable to receive, 60+): (136,369)*(.06) = (8,182)

[49] "Vulnerable adults" were defined in this study as those age 60 and over who meet at least one of the following criteria: need help bathing; used a cane, walker or wheelchair; rated their health as fair or poor; was afraid to be alone for more than two hours; had a chronic illness; or was of advanced age (75 or older). The report estimates there to be 91,266 vulnerable older adults in San Francisco.

[50] Asset limits are currently $2,000 for an individual and $3,000 for a couple.

it may only be a matter of time before capacity concerns re-emerge if the active caseload continues to grow at roughly 300 new cases per quarter.

Even among those who already receive IHSS services, many feel that they need more help than they are authorized to receive from the program. In June 2005, 44 percent of the 242 respondents to a survey of San Francisco IHSS consumers reported receiving fewer IHSS service hours than they needed (RTZ Associates, 2005). With so few respondents and a self-declaration of need without follow-up assessment, it is difficult to know from these results how large an issue this might be among all current IHSS recipients. However, the findings do suggest that there may a local need for additional home-care services even among those who are already engaged with the service delivery system to receive it. Those maxed out on IHSS hours but still needing more support sometimes even resort to calling EMS for help (Tangherlini, personal interview, June 13, 2006).

EXISTING LOCAL SERVICES: IN-HOME CARE

IHSS is by far the largest provider of personal and non-medical home care services for low-income individuals in San Francisco, providing nearly 17,000 individuals with services that include personal care such as bathing, grooming, feeding, dressing or toilet assistance, and cleaning, laundry, shopping, cooking, washing dishes. Most consumers hire and supervise their IHSS providers through the "independent provider" (IP) mode. In some cases, consumers are unable to use the IP mode (e.g., due to forgetfulness, inability to follow directions, lack of support, or inability to relate to the IP) and are thus referred to the IHSS Consortium for a provider through the "contract" mode. IHSS has recently expanded the discharge liaisons function to full unit status, which will be fully up and running in October 2006. This expansion responded to concerns about access to post-discharge expedited IHSS services, which were delayed for sometimes 30 days or more. The wait for expedited post-discharge service has been eliminated by this program enhancement.

Other programs also offer similar types of services, but on a much smaller scale. For example:

- The OnLok's *Program of All-Inclusive Care for the Elderly (PACE)* provides home care services to the clients who are a part of their system. Program staff estimates that roughly 50 percent of the 950 San Francisco clients receive in-home services;
- The Office on the Aging (OOA) funds in-home services, including chore, homemaker and personal care services, through community-based organizations. These programs served approximately 1,000 unduplicated consumers in FY2004-05, often providing emergency services to individuals being discharged from the hospital.
- The San Francisco Department of Public Health's Health at Home program also serves approximately 100 clients who are frail elderly, those with chronic and disabling illness and others recovering from an acute episode or trauma. This program includes not only home care aide services, but also nursing care, social work, and rehabilitation therapy, as well as volunteer, bereavement and spiritual support.
- Many home care organizations in San Francisco also provide both medical and non-medical in-home services for a fee.

GAPS: IN-HOME CARE

Data suggest that many seniors and younger adults with disabilities do not receive enough in-home care. Some people with unmet need will be those who feel their current IHSS or privately paid hours are insufficient, while others may rely entirely upon inadequate informal care.

As detailed above, local surveys estimate that the unmet need for in-home services, among low-income individuals or otherwise, may be in the range of 7,300 to 8,192 seniors. It is difficult to know whether these individuals might be in need of additional home health services, which are typically Medicare-eligible and short term, or home-care services such as those provided primarily through IHSS. Because DAAS programs focus on home care services, unmet need for that type of programming is discussed here. Fortunately, because IHSS is an entitlement program, eligible low-income individuals needing those services will not encounter waitlists as they do for other critical services.

Slightly higher income individuals sometimes have trouble accessing the in-home care that they need.

Providers emphasize that the most difficult gap in in-home service is for individuals who have incomes or assets too high to be eligible to receive free IHSS services but too low to be able to afford to pay for services out of pocket. Consumers with higher incomes may still receive services by paying a "share of cost" as long as their financial assets are still within eligibility limits. However, some consumers are unable to afford the share of cost, especially when it is in the hundreds of dollars monthly. Only two percent of all active cases pay a share of cost. A "Share of Cost Pilot" program pays 70 percent of the share of costs for eligible new applicants,[51] but that program is now capped at $300,000 annually citywide. A recent increase in funding to the program eliminated the waiting list, but program staff anticipates that it will fill to capacity again quickly. Once the program is full, low turnover of IHSS cases leads to a waiting list. Also, those with assets higher than state-regulated limits ($2,000 for an individual and $3,000 for a couple) are ineligible for IHSS under any model and must rely on informal caregivers if they cannot afford private pay.

Adaptive equipment and accommodations are often a necessary part of self care and independence, but funding is often absent and requires navigating bureaucratic mazes.

For many younger adults with disabilities and seniors, adaptive equipment allows them to perform self care tasks for which they would otherwise need to rely on others, but assistive technology is not covered by insurance or the Department of Rehabilitation. The bureaucratic requirements for getting funding for adaptive equipment can be an ordeal. For example, Medi-Cal pays for grab bars to allow persons to bathe independently, but it does not cover the installation costs. Unless a person has a diagnosed mobility impairment, insurance companies will not fund a commode. Insurance companies only cover durable equipment, not gloves and other types of items that may make it possible for a person to take better care of himself. Stair-lifts that allow persons with disabilities to come and go independently are also not

[51] Eligible applicants must be authorized for personal care services, be eligible for the program without the pilot, not living in subsidized housing, and have a share of cost of $1,000 or less.

covered (Ordover & Bennin, personal interview, August 22, 2006). For clients who have both Medi-Cal and Medicare, it can be tortuous to get one or the other to pay for equipment, as each will insist that the other is responsible. Medi-Cal often sets unrealistic limits on what it will pay for. For example, it will only fund lower-end power wheelchairs that are not suitable for getting around in the community. Medi-Cal is also perceived to be paying less and less for equipment, and many equipment vendors are refusing to accept it (Calderon, personal interview, July 8, 2006).

THE ISSUE: ABUSE

Elder abuse is widely recognized as a serious and under-reported safety problem. The National Center on Elder Abuse (NCEA) recognizes seven different types of elder abuse: physical abuse, sexual abuse, emotional abuse, financial exploitation, neglect, abandonment, and self-neglect. The prevalence of elder abuse is unknown, and research suggests that the number of reported cases may be just the tip of the iceberg. According to NCEA, for every one case of elder abuse, neglect, exploitation, or self-neglect reported to authorities, about five more go unreported (2005).[52] Elder abuse of the "oldest old" is believed to occur at higher rates than other elders, and family members are the most common abusers (SafeState.org).

Self-neglect is the most commonly reported type of elder abuse, both in California and in San Francisco, making up approximately half of all reported incidents (Counihan, personal interview, August 25, 2006). These cases can be particularly challenging because the victim is often reluctant to accept help. Some people remain fiercely independent and are fearful of loss of control or institutionalization should Adult Protective Services (APS) intervene. Dementia, depression, substance abuse, and mental health issues also complicate care and elevate risk of self-neglect and other types of abuse.

Elder abuse in institutional settings, including nursing homes, is also widely considered to be a common occurrence, though less research has been conducted regarding its nature and causes. Forms of elder abuse found in nursing homes mirror those in domestic settings, but also include institutional practices resulting in chronic neglect, substandard care, overcrowding, authoritarian practices, and failure to protect residents against abusive worker, residents, or visitors (Nerenberg, 2002). In 1990 researchers conducted a random sample survey of confidential interview with nurses and aides: 36 percent of those interviewed indicated that they had witnessed other employees physically abuse residents, and 81 percent had observed psychological abuse in the previous year (Nerenberg, 2002).

Research consistently shows that women with disabilities, regardless of age, race, ethnicity, sexual orientation or class, are assaulted, raped, and abused at twice the rate of women without a disability. The risk of being assaulted for adults with developmental disabilities is four to ten times higher than it is for other adults (United States Department of Justice (US DOJ), 2002). Other studies demonstrate that physical or emotional abuse from husbands, live-in partners or other family members tends to last longer for women with disabilities than for other women. (US DOJ, 2002). Recent research suggests that men with disabilities may be

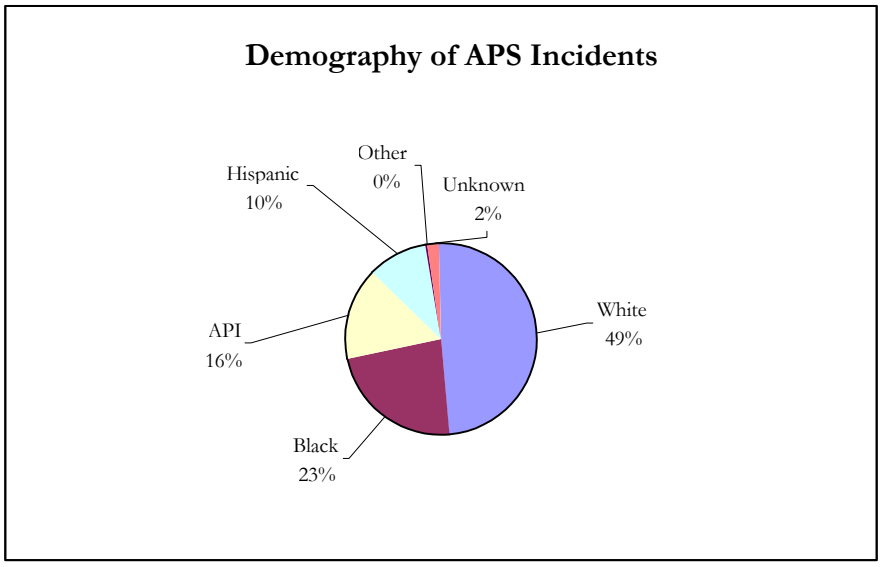
[52] Due to the difficulty in making such estimates, NCEA recognizes that prevalence studies for elder abuse are more helpful for illuminating the seriousness of the problem than they are for making numerical estimates.

less likely to report abuse, in part due to male cultural norms which discourage men from asking for help or seeking abuse intervention (Saxton et al., n.d.).

EVIDENCE OF LOCAL NEED: PROTECTION FROM ABUSE

National research on the prevalence of elder abuse varies widely from study to study, but it consistently estimates that reported incidents represent only fraction of the true number of cases in any community (NCEA, 2005). San Francisco has recently started to see more of those previously un-reported cases. Since May 2005, when an elder abuse-related news story hit the San Francisco papers, referrals to APS increased by more than 20 percent and continued to grow. In March 2006, APS had the highest number of reports ever received in one month, 45 percent higher than the average number of calls preceding the incident. Call volume has remained steady near the March level. Staffing has lagged behind the growth in demand, though the department is making an effort to address those gaps by adding several new positions in 2006-07.

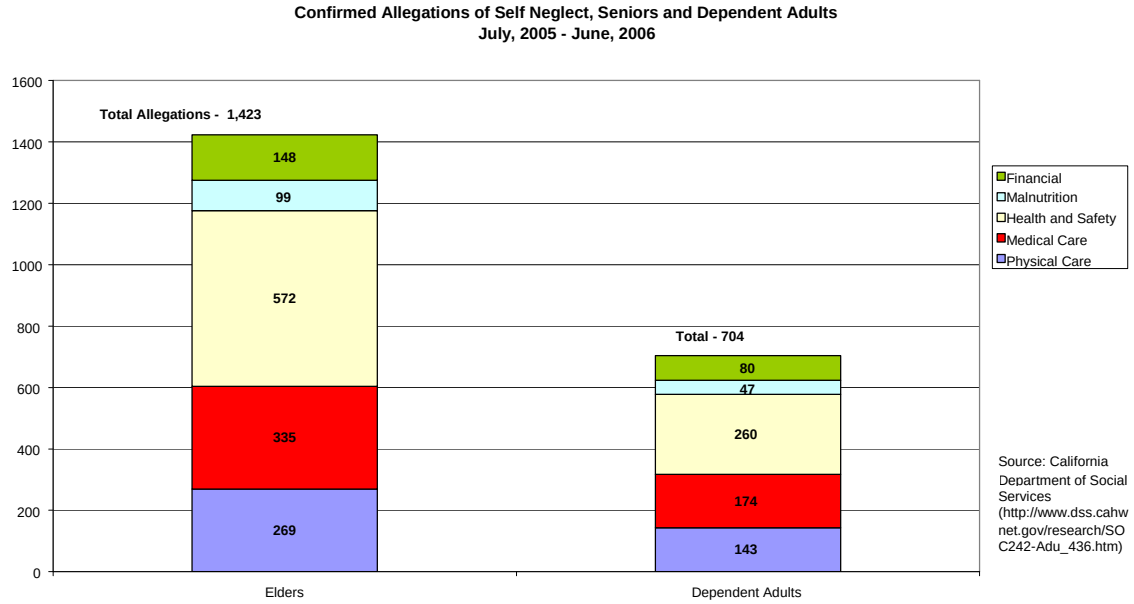
Some demographic groups are even less likely to report elder abuse. Reporting rates in the Asian/Pacific Islander (API) community are especially low when the abuser is a spouse or adult child. Local research shows that reporting abuse has the potential to sever "the relationship with [the] abuser or […] bring stigma and shame upon the family. Many API cultures place value on self-sacrifice for group stability and thus API seniors are the least likely to seek help in cases of physical, emotional, and financial abuse" (API Legal Outreach, 2005). Demographics of APS incidents from FY2005/06 supports this theory in San Francisco – Asian/Pacific Islanders make up only 16 percent of incidents, much less than expected based on the demographics of the entire community (see chart below).



During FY2005/06, Adult Protective Services fielded a total of 3,714 reports, including 2,613 for elders (72% of total) and 1,003 for dependent adults (38%). Approximately 60 percent of reports of abuse were confirmed. One report can have multiple allegations, and 57 percent of

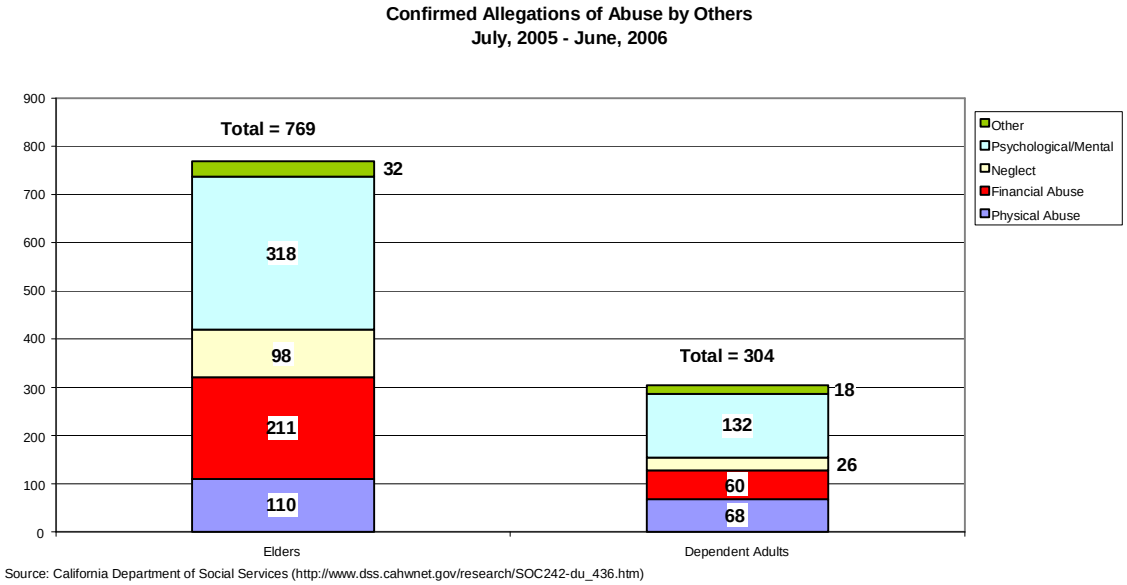
the allegations involved self-neglect rather than abuse by others. Because of limitations in the database for Adult Protective Services, it is only possible to count reports, not how many unique individuals were the subjects of reports, nor how many had multiple reports. As a result, it is not possible to calculate the rate of abuse among seniors in the total population.

The most common type of self-neglect allegation involved health and safety hazards, which entails the failure to protect oneself from risk, danger, or harm.[53] As documented in past studies (Human Services Agency, 2005), a much higher proportion of self-neglect allegations in San Francisco are related to health and safety hazards than statewide. This no doubt reflects the higher rates of isolation among San Francisco seniors and younger persons with disabilities, as well as less accessible housing. The chart below reflects the types of confirmed self-neglect allegations for seniors and for dependent adults. For seniors, 40 percent of confirmed self-neglect allegations involved health and safety hazards; for dependent adults, 37 percent.



The most common type of abuse perpetrated by others was psychological or mental abuse, comprising 42 percent of all confirmed allegations (see chart below). Elders were more likely than dependent adults to suffer financial abuse at the hands of others, comprising 27 percent of all confirmed allegations involved elders. Dependent adults were more likely to experience physical abuse, comprising 22 percent of its confirmed allegations. The chart on the next page illustrates the types of allegations for the two groups.

[53] Please note that a single report can contain multiple allegations.



Source: California Department of Social Services (http://www.dss.cahwnet.gov/research/SOC242-du_436.htm)

Abuse in institutional settings is also an issue for San Francisco seniors and younger adults with disabilities. The Long-Term Care Ombudsman program, which responds to abuse in institutional settings through outreach and complaint investigation, responds to roughly 900 complaints about care at nursing homes annually.

EXISTING LOCAL SERVICES: PROTECTION FROM ABUSE

Within DAAS, four primary programs serve to protect seniors and younger adults with disabilities living in the community: Adult Protective Services, Public Guardian, Public Conservator, and Representative Payee.

Adult Protective Services, which is administered by DAAS, is the primary San Francisco program responding to abuse allegations for seniors and younger adults who are dependent or have disabilities. The goal of Adult Protective Service is to provide protective services to elders and dependent adults who are unable to protect their own interests or to care for themselves. It is important to note that services are provided only with the consent of the client – APS cannot impose service on a victim of abuse if the individual is deemed competent and refuses to accept help. APS investigates possible abuse or neglect of elders and disabled/dependent adults, including those who:

- are unable to protect their own interests
- are harmed or threatened with harm
- receive a physical or mental injury due to action or inaction of another person
- receive an injury because of their own action as a result of ignorance, illiteracy, incompetence, mental limitation, substance abuse, or poor health
- are lacking in adequate food, shelter, or clothing

Since January 2006, APS has received an average of 355 reports of incidents monthly, each of which must be followed up by staff either within 24 hours or 10 days, depending on the level of emergency.

Under the authority and direction of the Superior Court, the *Public Guardian* provides 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. This program typically serves a caseload of 300 to 350 people. Because the Public Guardian receives referrals from APS, caseloads of the two programs have grown together in the last year.

For individuals found by the Court to be gravely disabled due to mental illness and who are unwilling to or unable to accept voluntary treatment, the *Public Conservator* may provide mental health conservatorship to authorize psychiatric treatment. These conservatorships are usually time-limited. The Public Conservator is also administered by DAAS and has a caseload of 800 to 900 people.

The *Representative Payee* program manages money for frail elderly and adults with disabilities 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. Approximately 1,500 individuals currently receive this service.

A number of community-based programs also offer services related to elder abuse. For example:

- The Institute on Aging's *Consortium of Elder Abuse Prevention* is a network of over 40 public and private agencies that seeks to address the needs of abused and vulnerable seniors in San Francisco. The Consortium maintains updates on developments and resources in the field of elder abuse, organizes training and outreach events, produces materials, consults in cases, and leads collective advocacy and outreach efforts. The OOA provides $46,600 in funding for community-based elder abuse prevention programs in FY2006/07.
- *Legal services* programs interact with those experiencing abuse or self-neglect, sometimes in partnership with social workers from APS, and sometimes providing independent consultation outside of that system. Legal services can arrange a restraining order for victims of physical abuse, help to prevent financial abuse by helping to manage estate issues when property might be divided between family members, or even place legal pressure on a landlord to arrange a schedule for payment of back rent in place of evicting an at-risk senior. In a July 2006 discussion about unmet needs, providers also emphasized the importance of community education about legal issues, for which there is little funding. The OOA funds four legal services providers.
- Other community-based organizations collaborate directly with the District Attorney's Office. For example, a staff person from that office comes one day per week to the Chinese Newcomer's Service Center. Because senior clients trust the non-profit agency, they take advantage o the District Attorney's presence to make complaints that they would probably never have initiated otherwise. Complaints range from reports of

physical abuse to having had a contractor collect payment from a senior and not do the work. In some cases, it has been necessary to engage APS.

- Other organizations provide outreach and education on issues of predatory lending, estate planning and trusts. These education programs help to protect individuals in two ways: (1) educating those are house rich and cash poor about the danger of predatory lending; and (2) helping low- and moderate-income people to engage in estate planning, avoiding the potential loss of assets in probate.[54]

San Francisco's Family Service Agency is home to the Long-Term Care Ombudsman program, which investigates and resolves complaints regarding the care of individuals living in residential care facilities. The program investigates elder abuse complaints in long-term care facilities and in residential care facilities for the elderly (RCFEs), monitors facilities, and provides community education. The Ombudsman program receives approximately $254,000 in funding from DAAS annually.

GAPS: PROTECTION FROM ABUSE

Increased referrals create high caseloads.

As elder abuse is widely recognized to be a mostly hidden problem, gaps in service are likely to be large. More measurable gaps are related to the capacity of staff to handle increases in reporting following the 2005 high profile case. APS referrals increased by more than 20 percent in less than a year, and DAAS responded with a request to increase staffing. Referrals to the Public Guardian's office have also seen an increase, stretching the resources of current staffing for that program.

Fragmentation in the city's service system makes it challenging to help seniors with complex needs.

While seniors typically have multiple needs, fragmentation in the current service system can create barriers to effective response. In particular, over half of seniors age 85 or older suffer from some degree of dementia, but the State of California does not consider dementia a form of mental illness, although most persons concerned about dementia first seek the services of a psychiatrist. As a result, most persons with dementia are served through the primary health care system, even though the symptoms and problems that evoke concern tend to be behavioral. The Community Behavioral Health Services program of the San Francisco Department of Public Health tries to overcome the schism in the service system and provide assistance with the behavior, anxiety, or psychosis of these persons through outreach and co-location when possible. The strategic vision for the Department of Public Health is to eventually integrate its primary care and behavioral health services, but the current split makes the system less responsive for persons with dementia who are at risk for self-neglect (Mesa, personal interview, September 6, 2006).

Increased community awareness can help to prevent abuse.

As is evidenced by the recent spike in reports of abuse to APS, public awareness plays an important role in identifying and responding to elder abuse. Legal services providers have also

[54] The San Francisco Housing Development Organization recently gave a presentation to the Commission on Aging and Adult Services, discussing the outreach and education they provide regarding predatory lending.

emphasized the importance of community education in helping seniors and younger adults with disabilities to protect themselves from common types of abuse. Such education serves to heighten awareness in the community about existing abuse while also playing a preventative role.

The fundamental challenge to the current behavioral health service system is not that it has gaps in services, but that it is not well designed to engage seniors. The city's Community Behavioral Health Services program has adequate capacity for seniors seeking mental health or substance abuse treatment. The majority of behavioral health services for seniors, including psychiatric services, occur in the clients' homes. Yet behavioral health services are still organized according to a traditional clinic model, which assumes that clients want services. Many seniors are resistant. These services carry a greater stigma for older generations, and seniors may fear a surrender of personal control. To engage seniors it is necessary to use creative strategies that employ the right messenger. For example, peer support services may first engage the isolated senior and eventually bridge him or her to treatment (Mesa, personal interview, September 6, 2006). Without such creative strategies, many seniors remain isolated and suffer from deteriorating mental health and self neglect.

THE ISSUE: FALLS

Injury due to falls is a serious issue for seniors. According to the National Safety Center's 2005 White Paper, falls are the leading cause of unintentional injury death among older adults, and half of those who survive a fall never return to their prior level of mobility or independence. The Administration on Aging reports that thirty percent of community-living persons over 65 years and 50 percent over 80 years fall each year, with 10 percent of falls resulting in serious injury (US Department of Health and Human Services, 2003).

The National Safety Center identifies a broad range of approaches that help to reduce the number of falls in the home and community, including: home environment modifications; review of medication, vision and physical activity; enhancement of balance and strength; and fall prevention counseling.

EVIDENCE OF LOCAL NEED: FALLS

Research from the San Francisco Injury Center confirms that falls are as much a problem for San Francisco seniors as they are nationally. The center's 2004 report cautions that older adults suffering a fall have very high rates of hospital discharge to institutional settings, often marking the end of independence. In San Francisco, 62 percent of those over 65 who were hospitalized after a fall were discharged to a long-term care facility. The likelihood of this type of discharge increases with age. The report also found that falls are the most common cause of injury death for San Franciscans over the age of 65, and also the most common cause of hospitalization. The rate of hospitalization for injuries from a fall for adults over 55 rises to almost 30 times that of 45 to 54 year olds. Falls account for 15 times as many hospitalizations as the next leading cause for the San Francisco population over age 65. The 2001 Bernal Heights Needs Assessment (Maynard) of seniors further emphasizes that falls are a common and dangerous occurrence among San Francisco's elderly: a quarter of survey respondents

indicated they had experienced a fall in the last year. Use of medication can exacerbate this problem, either due to drug interactions, side effects, or improper usage.

Housing risks

As is discussed in more detail in this report's "Housing" section, many of San Francisco's rental units have poor physical accessibility, placing frail residents at risk for injury. In January 2006, the Human Services Agency (HAS) planning unit, with the assistance of San Francisco District Office of the Division of Occupational Safety and Health sought to learn more about this issue for seniors with mobility impairments living in Single-Room Occupancy hotels (SROs) in Chinatown without elevators.

Out of 297 SROs in Chinatown, only seven had working elevators, confirming that mobility would be a critical issue for seniors in case of emergencies. The planning unit conducted a survey of existing IHSS clients with functional limitations that required human help for functioning who were also residents in Chinatown SROs in July 2006. Findings paint a troubling profile of life for seniors with mobility impairments in the buildings. Of the 174 respondents:

- 51 percent lived alone
- 40 percent leave their buildings once a week or less
- 29 percent reported having difficulty getting to or safely using the community bathroom in the building;
- Nearly half (49%) bathe in their rooms;
- Half (50%) cook in their rooms.

EXISTING LOCAL SERVICES: FALLS

Cataloguing fall prevention activities in San Francisco is very difficult. Many seniors concerned about this issue may engage in simple fall prevention exercises recommended by their doctors or participate in classes at the gym or in the park to improve balance. Senior centers and adult day programs often offer activities that promote balance and strength. The 30th Street Senior Center has even dedicated two rooms in its facility to exercise equipment for its "Happy Heart" program. The San Francisco Adult Day Services Network was recently awarded an 18-month grant from the Archstone Foundation to support the expansion of a program that examines the effectiveness of clinical care guidelines for fall prevention. The OOA also provides funding to the Curry Senior Center to provide medication management services, which can help prevent dangerous drug interactions or misuse of medication that can lead to falls and other problems.

Injury prevention in housing

Several programs, detailed in this report's Housing section, provide support for home modifications that aim to prevent accidental injuries in the home. Public programs focused on this issue are largely funded through the San Francisco Department of Public Health, as injury prevention is a major area of focus for that department's Community Health Education programming within the Community Health Promotion and Prevention Branch.

GAPS: FALLS

Many seniors could benefit from fall prevention efforts.
The prevalence and consequences of falls for the elderly in San Francisco suggest that there is room for more preventative services in this arena, though it is difficult to quantify an "unmet need" for those services. Potential opportunities to increase fall preventative services could include home modification programs (discussed in more detail in the Housing section of this report), as well as other wellness programs that promote strength and balance or educate seniors about protecting themselves from unsafe environmental hazards.

CAREGIVER SUPPORT

"The contributions of informal caregivers are irreplaceable. We could not, as individuals or as a society, afford to pay the costs of replacing all informal caregivers with paid personnel."

- Administration on Aging

The vast majority of American adults who receive long-term care at home get all their help from unpaid family members and friends. Most informal caregivers find their roles personally rewarding. About a third, however, also find their caregiving duties burdensome and feel that they need more assistance (Sharlach, 2003). Consequently, some frail older adults do not receive all the help they need and many caregivers are challenged with balancing caregiving duties, work, other family responsibilities, and personal wellbeing.

Caregiver support services mitigate these ill-effects: they help honor seniors' desires to age in place, lead to better outcomes for both caregivers and care recipients, prevent or delay institutionalization of the care recipient, and reduce the social costs of long term care.

THE ISSUE: CAREGIVER SUPPORT

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

California has approximately 3.2 million informal caregivers, providing 3.4 billion hours of caregiving annually at a market value of over $30 billion (Link, 2006). The yearly contribution of informal caregivers to our national health care system is valued at $257 billion, far exceeding the combined expenditures on home health care ($32 billion) and nursing home care ($92 billion).

Informal caregivers are a large piece of the community-based service system for San Francisco's seniors and younger adults with disabilities, for whom long-term care needs could never be met by formal, paid services alone. To ensure that informal caregiving remains sustainable and of high quality, however, it is important to recognize and mitigate the emotional, physical, economic, and social burdens that it imposes on caregivers themselves.

Challenges of Caregiving

Informal caregivers often experience common challenges associated with their caregiving roles, including:

Financial strain. Because of their caregiving duties, many caregivers lose wages due to reduced work hours, time out of the workforce, family leave, or early retirement. Fifteen percent of California caregivers report high levels of financial hardship (Scharlach, 2003). On average,

caregivers lose $659,130 over a lifetime in reduced salary and retirement benefits (MetLife et al., 1997). This is especially burdensome for caregivers who had lower incomes at the outset.

Stress. A 1999 Commission on the Aging study, "Coming of Age in San Francisco," reports that 22 percent of San Francisco caregivers find their caregiving duties physically "stressful" or "very stressful." Roughly one quarter found the emotional stress in providing care to another person to be "stressful or very stressful." More than one fifth of California caregivers have no one they can go to for support and understanding (Scharlach, 2003). Forty-four percent of caregivers assist someone who has mental health, emotional, or behavioral problems. Caregivers of seniors with dementia or mental incapacities are particularly at risk for burnout and other negative side effects.

> Many caregivers of older people are themselves elderly. Of those caring for someone aged 65 or older, the average age of caregivers is 63 years old with one-third of these in fair to poor health.

Health issues. Twenty-eight percent of California caregivers report health or emotional problems, including depression, anxiety, anger, and guilt. One quarter of caregivers report themselves to have fair or poor health (Scharlach, 2003).

Caregiver Support

Literature, along with focus groups and key informant interviews, consistently reports the need for the following types of caregiver support services:

Increased information and assistive services. Disseminating information about caregiving is a cost-effective intervention that prevents or delays more expensive long-term care. However, lack of knowledge about available services and how to access them is frequently cited as the major reason caregivers do not use services. Native English-speaking consumers often report that information about available services is difficult to navigate. Monolingual consumers found it virtually impossible to learn about and access services without outside help, typically from friends or family.

Caregiving training. Without the requisite caregiving skills, some caregivers may be unnecessarily strained – physically or mentally – and the caregivers and care recipients may be at risk for burnout or harm. As a one report states: "Changes in our health care delivery system have sent relatives home from the hospital 'sicker and quicker'" (Feinberg, 2005). However, many caregivers do not have the adequate medical training to perform activities such as operating medical equipment, monitoring and regulating medication for care recipients, and wound care. Better training, including care planning, best practices, and caregiver assessment and feedback would reduce the stress of the most at-risk caregivers and help ensure that care recipients are appropriately and safely cared for.

Respite Care. Key informants from caregiver service providers and focus group participants cited a high consumer demand for increased and more flexible provisions of subsidized respite care, including unplanned, emergency respite care, day, partial-day, in-home, institutional, and overnight care. The caregivers with the greatest unmet needs for respite care were identified as those whose incomes were too high to qualify for subsidized aid but too low to afford paid services.

Professional counseling and support groups. Caregivers are often overstressed and need emotional support, especially when they care for people with dementia, behavioral disorders, paralysis, or those who have suffered a stroke. San Francisco caregiver support organizations cited a need for increased individual and family professional counseling services and caregiver support groups.

Legal and financial advice. Caregivers frequently report needing legal aid regarding their rights and obligations as care providers, and information and advice on durable power of attorney for health related issues, living wills, and trusts for their care recipients. For those with lower incomes, it is especially important to have access to free or low cost services.

Culturally and linguistically appropriate services. Caregiving related attitudes, values, and behaviors vary based on caregivers' country of origin, number of years or generations in the United States, acculturation, generational status in the family, gender, and other individual characteristics. Participants from nearly all needs assessment focus groups – African-American, Latino, LGBT, Asian and Pacific Islander, and case managers – stressed the need for multi-lingual and culturally competent service workers that are able to cook traditional meals and speak the language of the care recipient.

EVIDENCE OF LOCAL NEED: CAREGIVER SUPPORT

Precise caregiver statistics are unavailable for San Francisco County. San Francisco specific caregiver prevalence research is limited to one study conducted by the Commission on the Aging. Although several state and national studies estimate the prevalence of caregiving, the definition of the term "caregiver" and size of the populations measured vary significantly across all of the studies. Applying the state and nationwide percentages found in these studies to a city as unique as San Francisco yields potentially useful but statistically uncertain results.

The study "Coming of Age in San Francisco," estimates 27,000 San Franciscan caregivers (1999). However, the study only counts caregivers of care recipients aged 55 and older, suggesting a floor estimate of caregiving prevalence.[55] Given that caregivers of younger adults are uncounted in the study, the number of caregivers within San Francisco is potentially much larger.

Disability statistics may help estimate the size of the population that may need caregiving. According to the 2004 American Community Survey for San Francisco County,[56] **34,159** San Franciscans have a disability that makes it difficult for them to go outside their homes and **20,328** have a self care disability.

[55] "Coming of Age in San Francisco" reports 16.4 percent of San Francisco's population 55 and over to be caregivers (n=500), and 25.3 percent of those providing care desiring more emotional support or respite services (n=77). It is important to note that funds from the National Caregiver Support Program may only be used to support caregivers of older persons. However, there are likely many caregivers of younger adults with disabilities or chronic illness who face many of the same challenges of caregiving.

[56] Disability statistics are self-reported and people may belong to more than category.

The Center for the Advanced Study of Aging Services, UC Berkeley, is one of the leaders for caregiver research in California. A 2003 study profiling California caregivers reports that 16 percent of households in California have at least one caregiver for someone age 50 or over. The US Administration on Aging suggests a higher prevalence of caregiving, reporting one out of every four persons to be a caregiver for someone age 20 or over. If these rates hold true in San Francisco, then the number of adult caregivers in San Francisco would likely fall somewhere within a range of 51,509 to 153,974.[57] If, as the Berkeley study suggests, 30 percent of caregivers have unmet need, then an estimated **15,453** to **46,192** San Francisco caregivers may need more caregiver support services.

While these studies provide a wide range of estimates of the number of caregivers, they do provide a sense of scale – the population of San Francisco caregivers is likely to be at least in the tens of thousands.

Unique Groups

San Francisco is home to one of the most diverse caregiving populations in the nation, including sizeable populations of non-English speaking people from numerous ethnicities to vulnerable groups such as LGBT seniors. Although much of the national and state level research profiling caregivers and their general needs also apply to the county, San Francisco's numerous linguistic, cultural, and other subgroup caregivers report unique challenges in addition to those apparent in the state or nationwide.

The Lesbian, Bisexual, Gay, and Transgender Community. According to the Family Caregivers Alliance, 50 percent of LGBT individuals receiving in-home or institutional care experience discrimination or harassment from their caregivers. LGBT caregivers of older adults provide on average 48.5 hours of direct care per week and many do not utilize any outside resources for assistance, in some cases for fear of harassment or discrimination by a community provider. Almost half of LGBT caregivers serving seniors have experienced LGBT insensitivity, discrimination, or harassment from a community program (SF HRC, 2003). And while partners certainly care for one another, most of the LGBT focus group participants expressed concern and fear about needing care in the future: "Most of us don't have children. How are we going to get the care we need when we need it?" Many LGBT seniors have transplanted to San Francisco and have fragile or few connections to family. Moreover, as one focus group participant stated: "many gays are severely independent" and consequently reluctant to accept or request care and support.

Younger Adults with Disabilities. Statistics about caregivers of younger adults with disabilities in San Francisco are unavailable and difficult to estimate. Most of the literature about the prevalence of caregiving focuses on caregivers of older adults. According to the 2004 American Community Survey, San Francisco is home to approximately 51,920 younger (16-64) adults with a disability. A significant proportion of younger adults with disabilities are likely to have long-term caregiving needs, placing their caregivers at risk of high stress and burnout. Many younger persons with disabilities rely on family members for caregiving. For example, an analysis of Golden Gate Regional Center data on persons with developmental disabilities reveals that an overwhelming majority of them live with parents until much later

[57] Low: (ACS 2004: # of SF households)(.16) = estimated # of caregivers = (321,931)(.16) = 51,509
High: (ACS 2004: Population SF 18+)(.25) = estimated # of caregivers = (615,895)(.25) = 153,974

years (San Francisco Human Services Agency, 2005). Of persons under the age of 45 who receive In Home Supportive Services, 59 percent rely on relatives as their IHSS service providers. Many families struggle with how to balance the younger person's need for autonomy and independence with the safety and economic necessity of having family members provide care.

> *"No tengo dinero, pero tengo familia." (I don't have money, but I have family.)*
>
> – Latino Senior

Ethnic Minorities. According to a UC Berkeley Study, Asians and Latinos are much less likely to seek and access caregiver support services (Scharlach, 2003). In one focus group of Latino participants, all of the participants knew one or more Latino caregivers who needed caregiver support assistance. However, none of the caregivers had accessed caregiver support services available. This lack of service utilization often stems from a lack of knowledge about available services, but it is also the result of cultural and linguistic barriers. In some cases, ethnic minorities are reluctant to seek available services because of past experiences of insensitivity, harassment, or discrimination. Some Japanese seniors, for instance, are wary of seeking services from government institutions due to past experiences of imprisonment in internment camps during World War II (Sawamura, personal interview, July 28, 2006).

Focus group participants stressed eroding familism as a family caregiving concern. Ethnic minorities are often perceived as having tight-knit families with strong supportive networks. Although many children of immigrants continue to honor family caregiving traditions, recent Latino and API focus group participants noted that as successive generations of immigrant families have become more educated, affluent, and acculturated, they are less likely to hold to their culture's traditional family values and expected roles. They are also more likely to be geographically dispersed, often moving away from their families because of advanced schooling or jobs or affordable housing. In the Asian and Pacific Islander roundtable discussion with providers (July 19, 2006), many participants noted shifting attitudes about traditional Asian perceptions of family obligations and caregiving for elders, citing evictions of Chinese elders in Chinatown by younger family members. As one participant stated: "What are the traditions of Asian Americans? Are we supposed to take care of our parents? I don't know anymore."

Grandparent caregivers. According to the 2004 American Community Survey, 3,988 San Franciscan grandparents are responsible for grandchildren under 18 years of age. Grandparents raising grandchildren are significantly more likely to be unmarried and to be living in poverty than other grandparents (Minkler, 2003). San Francisco's child welfare policies emphasize placing children with relatives rather than in group homes or institutions. Forty-six percent of foster children live with relatives. While this policy supports family bonds, and San Francisco does target some services for these families, it often places an enormous amount of stress and responsibility on aging aunts, uncles, and grandparents.

EXISTING LOCAL SERVICES: CAREGIVER SUPPORT

In Home Supportive Services (IHSS)
IHSS allows disabled and elderly individuals to remain at home, but it also benefits relative caregivers. It can reduce the physical toll on the caregiver of tending to the recipient's self-care needs. It can provide respite to overburdened caregivers and allow them time to run errands or relax. Providing care to a relative can be particularly demanding emotionally, and having an IHSS provider come into the house can allow a relative some "breathing room" from the constant intimacy of care. Many family caregivers themselves have disabilities or self-care needs, and the presence of an IHSS worker reduces the hazards of having one frail or disabled person providing care to another. For example, over 4,500 IHSS recipients live with at least one other IHSS recipient, suggesting that many families have more than one person with self-care needs. For younger disabled persons who are living independently, having a professional IHSS provider allows them more control over their lives than if they were to rely only on the availability of family members for their care.

IHSS can also offset the financial strain of care-giving duties. Forty-four percent of recipients (7,387) rely on relatives to provide their IHSS services. Depending on IHSS for household income, however, creates its own dilemmas. Though relatives may not have the proper training or skills or temperament, recipients may be compelled to use them as their providers out of financial necessity. If the relative care provider is also working outside of the home, then chores are more likely to be performed at the convenience of the caregiver, not the client. For the recipient, the financial necessity of hiring a relative to provide care may make supervision much more sensitive (Chung, personal interview, July 28, 2006). Chinese IHSS clients are much more likely to utilize relative caregivers. Seventy two percent of Chinese IHSS recipients rely on relatives to provide IHSS services, while only 26% of white IHSS recipients use relatives.

National Family Caregiver Support Program
Created by the Older Americans Act Amendments of 2000, the National Family Caregiver Support Program (FCSP) grants funding to state agencies on aging to provide caregiver support services through Area Agencies on Aging and community and service organizations. The mandated support services include:

1. Information to caregivers about available services;
2. Assistance to caregivers in gaining access to services;
3. Individual counseling, organization of support groups, and caregiver training to caregivers to assist the caregivers in making decisions and solving problems relating to their caregiving roles;
4. Respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities; and
5. Supplemental services, on a limited basis, to complement the care provided by caregivers.

The San Francisco Department of Aging and Adult Services (DAAS) FY2006/07 expenditures for the FCSP are projected to total $585,797. FCSP funds and county matching grants fund caregiver support programs through three community-based organizations: Edgewood Center for Children and Families, Family Caregiver Alliance (FCA), and Kimochi.

The following table lists the types of caregiver support services the Office on Aging contracted each organization to provide.[58]

San Francisco Family Caregiver Support Programs FY2006/07 Contracted Services			
	FCA	**Kimochi**	**Edgewood**
SERVICE INFO			
Outreach	X		X
Community Education	X		X
ACCESS			
Information and Assistance	X		X
Comprehensive Assessment	X		X
Case Management	X		X
CAREGIVER SUPPORT			
Support – Counseling	X	X	
Caregiver Support Group	X	X	X
Caregiver Training		X	X
RESPITE			
In Home	X	X	
Day Care	X	X	
Institutional	X	X	
SUPPLEMENTAL SERVICES			
Translation		X	
Legal Assistance	X		

Family Caregiver Alliance (FCA) is designated by the state as the Bay Area's Caregiver Resource Center. Headquartered in San Francisco County, FCA provides caregiver support services to five Bay Area counties. Aging services experts and the other local caregiver support providers consider FCA to be one of the most innovative and progressive caregiver support organizations in the nation. As the recipient of the over half the OOA's caregiver support funding, FCA provides the widest range and largest quantity of caregiver support services in the city. As such, FCA's caregiver support programs bear more detailed mention here. Free and low-cost services offered by FCA include:

- *Information* about providing care and accessing caregiving support services, with most written materials printed in English, Spanish, and Chinese.
- *Outreach* to caregivers and policymakers.
- *Caregiver skills training;*
- Short-term *individual counseling services*. Six to eight sessions annually, offered on a sliding scale fee schedule.

[58] The table lists only the services that are fully or partially subsidized by NFCSP funds or city matching grants. The organizations listed may provide additional caregiver services to San Francisco clients using outside funding.

- *Respite care (three types):*
  - $800 granted annually to each eligible client,[59] which pays for about one week total of respite care. There are no income requirements to qualify for respite care.
  - $3,600 granted for one year for caregivers of persons who are mentally incapacitated. There is a four to five year wait list for this program through the San Francisco Department of Public Health.[60]
  - Weekend retreats for both caregivers and care recipients.
- *Support groups*, including a Spanish speakers support group and an internet-based support group.
- Free *legal consultations*.
- *Case management.*

Other Supports

Other programs are important for providing relief to caregivers. For example, Adult Day Programs provide a needed break for caregivers by offering social and therapeutic services for individuals with chronic illnesses (see Appendix F for detailed definitions of these programs). Most centers in San Francisco are Medi-Cal reimbursable and use a sliding scale per diem fee structure for private pay.

The Edgewood Center for Children and Families has developed a kinship support network that assists families headed by grandparents and non-parent relatives who are the primary care providers for children. Most often the children's parents are not available due to drug abuse, incarceration, or death. Funded in part by the Human Services Agency, Edgewood provides case management services, family support, education, and respite care for these relative caregivers.

GAPS: CAREGIVER SUPPORT

The scale of the need for caregiver support far outstrips available services.

OOA-funded agencies served just over **700** total caregivers with support services in fiscal year 2004-2005. Recall that an estimated **15,453** to **46,192** San Francisco caregivers may need more caregiver support services. While caregiver support agencies do provide additional services beyond those reported here, it seems clear that the scale of services provided does not match the potential need for all caregiver support services.

The greatest gaps in services identified by key informants, focus group participants, and literature reviews were as follows.

[59] Federal and state regulations do not allow FCA to provide respite care to paid In-Home Supportive Services (IHSS) workers. Consequently, the 44 percent of paid IHSS workers that currently provide care to relatives are ineligible for respite services provided by FCA.

[60] Once the grant funding has been depleted or the year has passed, the caregiver must sign onto the waitlist again to continue with the program.

Caregivers need more information about services.
Many caregivers find that they need additional information about how to access services, improve caregiving skills, and receive training on providing care for particular types of illnesses.

Respite care is inadequate.
Providers and consumer focus group participants alike cited a high demand for increased availability of low-cost or free respite care services. For example, the waitlist for FCA's $3,600 annual respite care for caregivers of those who are mentally incapacitated is four to five years long through the San Francisco Department of Public Health. Once the grant funding has been depleted or the year has passed, the caregiver must sign onto the waitlist again to continue with the program.

Culturally competent services are not always available.
Culturally competent services are needed particularly for underserved and un-served populations, such as LGBT caregivers and members of groups that do not seek services due to language or cultural barriers, including both Asian and Latino communities.

ACCESS: INFORMATION, CULTURAL COMPETENCY, & TRANSPORTATION

THE ISSUE: ACCESS

While the bulk of this needs assessment report focuses on gaps in direct services in San Francisco, this section examines three barriers that consumers may face in attempting to access those services.

- **Information about Services:** Lack of knowledge of existing programs or how to access them prevents consumers who need services from accessing them.
- **Cultural and Linguistic Competency:** Lack of cultural competency in social services provision can make consumers feel unwelcome when they first interact with services, in some cases preventing access altogether. Language competency is particularly critical in settings where consumers need to communicate complex concerns with providers.
- **Transportation:** Without adequate transportation, consumers cannot make their way to the programs they need.

> *"… Many seniors are not aware of what to do or who to call."*
> –Peer Advocate

EVIDENCE OF LOCAL NEED: INFORMATION

The existing evidence is somewhat mixed about the knowledge among seniors and disabled adults of available services in San Francisco. Consumers and providers are concerned about information gaps, and they describe a lack of awareness about many services in the community especially among populations that are isolated and vulnerable. Indeed, in focus groups with LGBT seniors, Latino seniors, and even with peer advocates who themselves had received training to educate them about existing services, participants learned of services that they did not know about before. In recent discussions with District Advisory Councils regarding community needs, concern about poorly informed consumers and the need for outreach was mentioned at every meeting.[61] This may be because of an overall lack of awareness about services in San Francisco, or because there are so many services in San Francisco that it is difficult for consumers to know about all of them. Moreover, consumers may not remember information about services at the time when they need them most or may not recognize their individual need for a service until they reach a crisis.

Two independent research organizations have studied the extent of consumers' knowledge about long-term care and community-based services in San Francisco. A 2003 phone survey suggests that, compared to similar populations in 12 other communities, San Francisco older adults knew less about house-keeping or cleaning services, visiting nurse services, personal assistance services, or door-to-door transportation than seniors in other cities.[62] However, the majority of those who sought a particular service (e.g., senior lunch program or visiting nurse

[61] At the writing of this report, OOA staff had completed 8 of 10 DAC discussions.
[62] "Older adults" in this study was defined as age 50 and older.

service) found it either "very easy" or "somewhat easy" to access those services (Black et al., 2003).

A similar study done in 2006 found that, for many consumers reporting unmet service needs, the most common reason they had been unable to access services was because they did not know they existed or they did not know how to access them (National Research Center, 2006). However, awareness of most services was high for the general population of seniors and younger adults with disabilities. This report indicated that about 80 percent of each population was aware of senior centers, nursing home services, meals-on-wheels or other home-delivered meal programs in the San Francisco area. About 70 percent said that visiting nurse, home health aide, door-to-door transportation and legal assistance services were available. Lower percentages of both populations knew about home repair and modification installation and financing programs, and money management services. A relatively small percentage (ranging from 2 to 9 percent) of seniors and adults with disabilities reported that they needed these home repair and money management services but were unable to access them.

EXISTING LOCAL SERVICES: INFORMATION

A number of resources are available in San Francisco to inform consumers about services. The most significant services include information and referral phone and walk-in resources, internet resources, and peer education programs.

A Summary of San Francisco Information Resources

Resource	Population	Description
Phone Lines		
HelpLink/2-1-1	All San Franciscans	A social service hot line that connects callers to a variety of services. Total call volume for 2005: 15,445. 1,440 total calls by primary language. 45% of calls were in Spanish; 39% in Cantonese; 9% via interpreter service in Russian; 4% in Mandarin.
DAAS Information & Referral	Seniors and younger adults with disabilities	The DAAS Information, Referral and Assistance program had over 6,750 contacts in 2005, averaging approximately 560 contacts per month.
3-1-1	All San Franciscans	Will provide San Francisco residents with a single point of contact for all city services. **Launch planned for March 11, 2007.*

(Table Continued on Next Page)

A Summary of San Francisco Information Resources (Continued)		
Resource	**Population**	**Description**
Independent Living Resource Center Information & Referral	Adults with disabilities	Maintains hundreds of listings of community resources. **Services have been reduced in FY2006-07**
Walk-In I&R		
Resource Centers for Seniors and Adults with Disabilities	Seniors and younger adults with disabilities	Neighborhood Resource Centers served nearly 17,500 individuals each year, offering referral services as well as on-site services such as form-filling and translation.
Internet Resources		
Network of Support	Seniors and younger adults with disabilities	Provides listings of community-based services for seniors and younger adults with disabilities online, with database support from HelpLink.
Peer Education		
Partnership Peer Advocacy Project	Seniors and younger adults with disabilities	As a part of the Partnership's Robert Wood Johnson grant, 15 peer advocates currently provide services to homebound and isolated individuals.
Senior Survival School	Seniors and younger adults with disabilities	A free multi-lingual class offered 4-5 times a year in different neighborhoods to provide seniors and younger adults with disabilities the information, understanding and contacts necessary to: empower and motivate, increase independence, enhance quality of life, and assure access to health, housing, transit, and other support services.

GAPS: INFORMATION

Consumers are unaware of telephone helplines, and they more often seek information via word-of-mouth.

There seems to be a lack of information about telephone helplines generally in San Francisco: 43 percent of both seniors and adults with disabilities indicated in a recent phone survey that they were not aware of this resource (National Research Center, 2006). In addition, a different survey of seniors and adults with disabilities in San Francisco's public housing buildings found that only 13 percent had ever used the DAAS Information Referral and Assistance, and only 17 percent had used the Neighborhood Resource Centers (San Francisco Partnership for Community-Based Care & Support, 2006).

Marketing phone-based information and referral services raises its own set of issues, as it is not clear that hotlines are the best way to spread information. Most consumers look to people or organizations they know and trust when they are searching for referrals to services. One

local study reports that older and disabled adults would most likely turn to family or friends (37%) for advice on personal care at home, followed by the phone book or yellow pages (21%) or their doctor (18%). Only 2 percent of seniors said that they would call a helpline (National Research Center, 2006). Qualitative research confirms this finding. Consumer focus groups and key informant interviews confirm these findings (Latino seniors focus group, June 30, 2006; Chung, personal interview, July 28, 2006; Villela & Garrison, personal interview, June 27, 2006).

Because seniors and others tend to get their information by word of mouth, grass roots efforts to inform communities about services may yield a larger effect. A few programs currently reaching out to specific communities may offer good models to provide information in a way that is likely to be passed via word of mouth. The Partnership's Peer Advocacy project, for example, trains advocates identified by agencies serving the African American, Asian/Pacific Islander, Latino and LGBT communities about available services so they can reach out to isolated individuals. The Senior Survival School trains seniors and adults with disabilities directly about available services in a variety of languages with the explicit goal to empower them and increase their independence.

Information and referral resources for younger adults with disabilities are complicated by the need for accommodation across service systems and the fragmentation of services by disability type.

For younger adults with disabilities, services are even more fragmented. The emphasis on private fundraising accentuates the fragmentation of the system for younger persons with disabilities. Services tend to be organized by diagnosis or medical condition, and no unifying thread of public funding weaves the various programs together (Aaron, personal interview, September 12, 2006). Persons with disabilities often have multiple needs that cannot be served through one agency, and they do not know where to go, as they do not fit well with any one program or resource. For many others, the nature of their disability makes it difficult for them to sequence the steps necessary to avail themselves of existing services and opportunities. (Aaron, personal interview, September 12, 2006; Mizner, personal interview, August 11, 2006; Ordover & Bennin, personal interview, August 22, 2006; Mesa, personal interview, September 6, 2006).

When persons with disabilities seek assistance through mainstream agencies, they may encounter physical and practical barriers, become discouraged and stop seeking services. For example, many programs use queues to distribute benefits, a service delivery mechanism that inherently discriminates against persons with physical disabilities who cannot stand in lines. Without an advocate to press for changes in the design of programs and service systems, persons with disabilities typically must seek accommodations on their own as individuals, which ultimately limits the effectiveness of their advocacy (Calderon, personal interview, July 28, 2006; Aaron, personal interview, September 12, 2006; Mizner, personal interview, August 11, 2006; Ordover and Bennin, personal interview, August 22, 2006).

Language barriers present a challenge in providing information services.

San Francisco's diverse population raises an additional issue for accessing information in a variety of languages. The DAAS Information and Referral phone line staff only speaks English, but it contracts with a language-line translation service to handle the needs of non-English-speaking consumers. Resource centers employ many bilingual staff in an effort to

provide language access. Some staff work part-time, however, making it impossible to ensure that all languages are always represented throughout the city. Staffing is designed to mirror the primary demographics of each district, but Resource Center staff report that there are times when it can be challenging to help consumers due to language limitations. This trend may worsen as immigrant communities disperse to new neighborhoods. Many consumers in San Francisco already travel across the city to find a resource center with the staff language capacity to serve them.

Current efforts to reduce the knowledge gap may make a difference.
Several efforts are underway to inform seniors and younger adults with disabilities about available services. The Partnership for Community-Based Care and Support has launched a media campaign to inform the community, particularly isolated older adults and adults with disabilities, about available services. The campaign will include multilingual bus ads, as well as newspaper ads in several papers including ethnic media outlets. The ads will direct people to call 2-1-1, which can provide referrals in a variety of languages and is available 24 hours a day.

In addition, the Network of Support website may be an important resource for populations comfortable with web-based information. San Francisco's younger adults with disabilities are more likely than seniors to look for service information on the web (National Research Center, 2006). One study found that San Francisco seniors and younger adults with disabilities were also more likely than their peers in other cities to use the web (Black, 2003). This searchable resource might also be a valuable resource for service providers.

EVIDENCE OF LOCAL NEED: CULTURAL AND LINGUISTIC COMPETENCY

> *"It is nearly impossible to develop new friendships."*
> -Provider, Latino Partnership. Commenting on the effect on a monolingual senior when she moves into a residential care facility where no one speaks Spanish and the culture is unfamiliar.

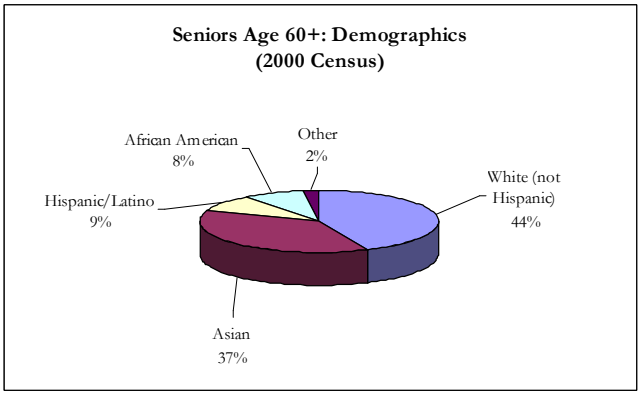
Research demonstrates the importance of culturally and linguistically appropriate social services. For example, recent studies of Chinese Americans with mental illness suggest a high need for culturally sensitive case management for this community (Wong, n.d.). The study highlights the critical importance of culturally appropriate and bilingual health counseling settings, given that cultural stigma surrounding mental health, paired with a lack of services provided in the primary language of choice, creates barriers to help-seeking in this community. Other studies have documented the value of cultural competence in the arena of health care provision, caregiver support, and other service delivery areas (Betancourt, 2005; Scharlach, 2003).

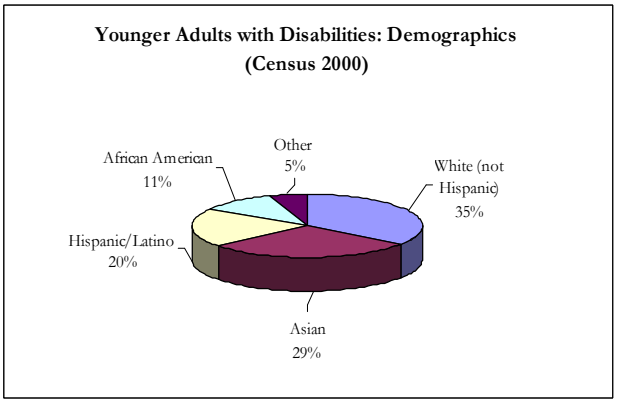
Cultural competency is becoming a central theme in nearly every discussion of gaps in services. Academic research emphasizes that minority groups encounter significant barriers to access to medical and social services when staff and programming are not culturally sensitive. While San Francisco's service system may be the envy of other California counties with respect to its breadth of culturally competent service providers, the diversity of the city and the increasing dispersion of minority populations throughout the city's neighborhoods present

ever increasing demands for culturally and linguistically appropriate services. For example, Chinese elders living in Visitacion Valley reported that they seldom go to Chinatown and instead expect services in Cantonese in their own neighborhood (Focus group with Chinese Seniors in Visitacion Valley, August 22, 2006). As Latinos move away from the Mission, Asians move into the Bayview/Hunters Point and other southeast neighborhoods, and small but highly isolated Southeast Asian immigrant groups find their way into the city, neighborhood-based providers find it increasingly difficult to provide culturally competent services to all residents who come through their doors.

A diverse community

Census 2000 data on both racial and ethnic composition and on linguistic isolation paint a picture of diverse target populations. More than half of seniors (56%) and younger adults with disabilities (59%) are non-White in San Francisco according to Census Bureau estimates. Providers and consumers representing African American, API, Latino, and LGBT communities all highlighted the importance of culturally competent services as a key issue during the needs assessment process. These groups indicated that lack of cultural competency is a barrier to service when consumers feel unwelcome. Worse, lack of cultural competency can create barriers to building trust. Consumers who do not trust providers sometimes resist honestly sharing important personal details about their health status, financial circumstances, or medication management, putting the consumer at risk.





Language barriers

Multilingual services are an important piece of providing culturally competent services, both because many San Franciscan seniors and younger adults with disabilities live in linguistically isolated households and because even bilingual consumers are often more comfortable discussing personal issues in their native languages. Many people return to their native language when they become ill later in life, even if they learned to speak English very well earlier in life.

Many San Francisco residents do not speak English well. Census 2000 data estimate that 30,301 (28%) of San Francisco seniors speak English "not well" or "not at all," a much higher

[*] This report typically uses Census 2000 data for discussions of the population of older adults and the American Community Survey 2004 for younger adults with disabilities (see Methods section for further discussion of this issue). In these charts, Census 2000 is used in order to compare across one dataset. However, ACS 2004 data suggest slightly different demographics for younger adults with disabilities than shown here – White (41%); Asian (23%); Hispanic/Latino (15%); African American (14%), and Other (7%).

rate than that for individuals age 18 to 64 (12%), perhaps because younger persons have more of an economic imperative to learn English or because of generational patterns of immigration (Chung, personal interview, July 28, 2006). If the same percentage (28%) holds true for seniors age 60 to 64, the total number of seniors age 60 and over with limited or no English skills would be 38,592.

Connecting to services and navigating complex systems is significantly more difficult for individuals who have limited English proficiency. The vast majority of linguistically-isolated seniors in San Francisco speak Asian and Pacific Island languages (Census 2000). As Chinese seniors make up by far the largest number of Asian/Pacific Islander seniors overall (71%), it is likely that the majority of these individuals are Cantonese-or Mandarin-speaking. The Census does not break down these data for younger adults with disabilities.[63]

In focus groups and interviews, consumers and providers often discussed language access issues. Mental health, in-home care, case management, and EMS were all cited as examples of services where a lack of language competency can result in barriers to service. Monolingual groups with relatively small populations (e.g., Southeast Asian communities or indigenous groups) find few bilingual and bicultural staff at public and non-profit service agencies, and application forms are often unavailable in less common foreign languages. Meanwhile, providers of all types often lament the challenge of hiring and retaining and qualified bilingual staff and volunteers.

Challenges for Immigrants

Immigrants have additional needs for culturally competent services. Nearly 37 percent of all San Francisco residents are foreign born, and of those over 40 percent are not yet naturalized citizens. Service providers in the API, Latino and Russian communities routinely describe monolingual immigrants as feeling overwhelmed by the task of securing services in a complex, foreign system (API roundtable, July 19, 2006; Latino roundtable, July 10, 2006; Ling, personal interview, July 24, 2006). The recent national discourse on immigration has caused heightened fear of accessing services among immigrant populations. One Latino services provider described the situation as fairly dire: "People are afraid to go to the store, the bank, or even to school."

Of seniors (65+) who are linguistically isolated,[64] which languages do they speak?

Language	#	%
Spanish	2,617	10%
Other Indo-European Languages	4,954	18%
Asian and Pacific Island Languages	19,078	71%
Other Languages	218	1%
Total Linguistically Isolated Senior Households:	26,867	100%

Source: Census 2000

[63] For all linguistically isolated younger adults age 16 to 64, 67 percent speak API languages, with higher numbers speaking Spanish (24%) and other Indo-European languages (18%). Data are unavailable for younger adults with disabilities.

[64] The 2000 Census defines "linguistically isolated households" as those in which "no member 14 years old and over (1) speaks only English or (2) speaks a non-English language and speaks English "very well." In other words, all members 14 years old and over have at least some difficulty with English."

LGBT Cultural Competency

The need for cultural competency extends beyond issues of race, ethnicity, and language. Participants in the assessment's roundtable discussion with LGBT service provider identified cultural competency as a top access issue facing LGBT seniors. With some studies estimating that 17,000 San Francisco seniors may be LGBT (San Francisco Human Right Commission et al., 2003), cutting across all demographic groups, a systemic approach to culturally competent service is paramount. LGBT-focused providers expressed concern that mainstream providers sometimes "dump" LGBT seniors "like a hot potato" by referring them to New Leaf.[65]

LGBT Cultural Competency:
Consumer Experiences

Several men in a focus group of LGBT seniors were long-time participants at the Castro Senior Center, which has worked over the last several years to become a more inclusive and safe environment for the LGBT community.

In the past, they couldn't reveal or discuss their sexual orientation at senior centers or other service providers. They felt that they had to hide their personality and act "neutral." They agreed that things have changed for the better.

One gay man said, now we "feel affirmed, and [we] don't have to hide or worry about what one says or how one says it."

Providing sensitive services to LGBT seniors can be a delicate matter. Direct service providers must offer services that are sensitive to LGBT aging issues while respecting the consumer's personal decision on whether or not to be out of the closet. Many LGBT seniors have strong memories of times when public and community-based services were unsafe for them (e.g., historical police abuse, rejection by religious organizations, rejection by other consumers, etc.). This history of discrimination creates a barrier to access due to fear that mainstream providers do not often actively address.

As with other groups, lack of cultural competency is a particularly critical issue for long-term care programs such as in-home personal care services or residential facilities. Care recipients often feel that they have to become closeted due to the homophobia of the professional caregiver. This is additionally problematic when the services needed involve significant physical contact from a homophobic caregiver. The consumer is left feeling uncomfortable with the caregiver and fearing loss of services should his or her sexual orientation be revealed.

Younger adults with disabilities

Serving younger adults with disabilities is not just a matter of accommodations, but also requires sensitivity and respect. Persons with disabilities are often resistant to systems that want to "medicalize" all of their needs or create dependency on services rather than promote a more appropriate and challenging context of community living, social participation, and civil

[65] "New Leaf: Services for our Community" is the only comprehensive mental health, substance abuse, HIV/AIDS, and social support organization in San Francisco specifically for the LGBT community.

rights. Service providers need to respect the younger client's ability to make his or her own decisions without unnecessary intrusion. (Mizner, personal interview, August 8, 2006; Ordover & Bennin, personal interview, August 22, 2006).

EXISTING LOCAL SERVICES: CULTURAL AND LINGUISTIC COMPETENCY

Quantifying cultural competency is incredibly difficult, but a survey of existing services suggests that San Francisco is a city acutely focused on this issue. Attempts to assess linguistic competency must also be realistic about the challenge of providing multilingual staffing throughout all programs in the city in every language that consumers speak. Analysis of gaps in this area will focus instead on current efforts to ensure cultural and linguistic competency. A demographic analysis of current consumer populations assesses whether a lack of cultural or linguistic competency appears to result in under-representation of any populations in the current consumer population.

Efforts to provide culturally competent services

DAAS provides the vast majority of its direct service programming through contracts with community-based providers. Contracting organizations are located throughout the city and many have long histories of targeting particular underserved minority communities. Consumers often form strong bonds with local providers when services are offered in familiar and comfortable cultural settings. For example, among Latino seniors participating in a focus group at 30th Street Senior Center, many were long-time consumers at that program and indicated that they would go there first if they had additional needs. In fact, 30th Street Senior Center reports that Latino seniors come there from all over the city to receive culturally appropriate services. In neighborhoods where there are fewer social services agencies, culturally competent senior services agencies can become a catchall support for the community. For example, Self-Help for the Elderly finds that Chinese families in Visitacion Valley often come to their local providers for help with translating mail, financial literacy, tax assistance, landlord disputes, employment, and a host of other extemporaneous issues (Ling, personal interview, July 24, 2006; Chung, personal interview, July 26, 2006; Focus group with Chinese seniors in Visitacion Valley, August 22, 2006). These agencies are challenged to meet these informal as well as formal needs, and this pattern of attachment to one agency makes information and referral services for non-English speakers that much more complex.

Providers at a roundtable discussion of the needs of the LGBT community highlighted a handful of successes in providing culturally competent programming to that community, including the development of more culturally competent services for LGBT seniors at the Castro Senior Center. That center's Pride Celebration boasted more than 100 participants this year. This year's senior survival school schedule also included a session targeting LGBT seniors, and some grassroots outreach programs (e.g., volunteers from Little Brothers Friends of the Elderly, peer counselors at the Family Service Agency) have made conscious efforts to recruit staff or volunteers who can provide culturally competent service.

Efforts to ensure language access

The Office on the Aging makes great efforts to promote bilingual services in the programs it funds. For example, of the 24 Information and Assistance Specialists at Resource Centers for

Seniors and Adults with Disabilities, 21 speak at least on language other than English. Nine of ten District-Wide Social Services Workers are at least bilingual, speaking Cantonese, French, Japanese, Korean, Mandarin, Russian, and Spanish. Given that the Department contracts with 44 organizations with many more locations, it is not possible at this time to catalogue the composition of the entire direct-service staff at each program.

Many agencies serving younger persons with disabilities have made admirable efforts to conduct outreach to non-English speaking communities. For example, the Independent Living Resource Center and Support for Families of Children with Disabilities have co-located staff at Cantonese and Spanish-speaking agencies (Ling, personal interview, July 24, 2006; Ordover & Bennin, personal interview, August 22, 2006). The Deaf Counseling, Advocacy, and Referral Agency has long had special programs for immigrants, as well as seniors and LGBT persons. Publicly funded programs like In Home Supportive Services are legally mandated to have staff who speak the major languages of their clients.

GAPS: CULTURAL AND LINGUISTIC COMPETENCY

Quantitative analysis of demographic gaps reveals strong representation of minorities and monolingual consumers in OOA programs.

A common method for identifying cultural or language barriers to access is to compare demographics of existing programs to the demographics of the target population in the community. When a group appears under-represented relative to their proportion in the general target population, one possible explanation is that cultural or linguistic barriers to access exist. While unmet need for services continues to exist in every community of seniors and younger adults with disabilities, the following analysis suggests that the department's emphasis on culturally and linguistically competent services has been successful in ensuring impressive diversity in the community that *does* receive services.

Demographic comparison analysis for OOA programs focused *only* on program participants age 60 and over, as lack of reliable data for younger adults with disabilities made it too difficult to run useful comparisons for that population. In order to account for the higher prevalence of need for services in the low-income community, and to account for higher poverty rates among minority seniors, the analysis compared OOA program enrollee characteristics to Census 2000 figures for seniors earning less than 150 percent of the federal poverty level.[66]

Demographics of OOA consumers largely mirror demographics of low-income seniors in the community. Analysis of the demographics of OOA consumers reveals that existing consumers mirror the demographic composition of the city's low-income seniors. Minority racial and ethnic groups are well represented among OOA consumers, with Latinos, Asian/Pacific Islander groups, and African Americans each making up a higher percentage of all OOA consumers than they do of the population of low-income seniors. Together, minority groups

[66] The US Census only provides ratio of poverty analysis for seniors age 65 and older. Because racial and ethnic demographics of seniors age 65 and older are not appreciably different from those 60 and older in the general population, it is assumed that the same holds for low-income seniors age 60 to 64.

represent no less than 74 percent of all OOA consumers.[67] Running the same demographic comparisons for the five OOA programs with the largest number of enrollees (Community Service, Congregate Meals, Home-Delivered Meals, District Wide Social Services Workers, and Case Management) reveals a similar story of success in minority representation generally, but highlights some nuance. (See Appendix I for detailed tables.)

- **Community service** enrollments show strong representation of all major minority groups.

- Demographic discrepancies across **meal programs** appear to balance out. For example, African Americans and Whites have lower representation in congregate meals but higher representation in home-delivered meals as compared to low-income Census figures. API seniors show the opposite pattern, with lower proportions in home-delivered meals. It is difficult to know for sure, but these patterns may reflect the higher live-alone rates of White and African American seniors in San Francisco, potentially leading them to seek home-delivered meals at higher rates.

- **District Wide Social Services Workers (DWSSW).** Non-White seniors represent nearly all DWSSW enrollees (90 percent). API seniors make up a higher proportion of enrollees compared to the low-income senior population (68.5 percent vs. 43.7 percent), and African American seniors show low utilization (6.0 percent of enrollees compared to 10.2 percent of low-income seniors).

- **Case Management** demographics show the opposite pattern, with African American seniors showing proportionally higher enrollment numbers and API seniors appearing at lower rates than in the low-income senior population as a whole. There may be greater need for level 1 case management (translation services, responding to mail, explanation of benefits, etc. that are common for DWSSW interactions) amongst persons who do not speak English as a first language, but also it appears that API seniors are underserved by case management programs.[68]

- Latino representation is the same or higher than low-income Census proportions for all OOA programs.

Non-White In-Home Supportive Services (IHSS) consumers make up approximately 70 percent of program participants. Because eligibility for this program includes both low-income and disability criteria, it is difficult identify the appropriate comparison statistics from the Census or American Community Survey.

Analysis of the demographics of seniors in DHS programs also reveals proportionally high utilization of services by minority groups – 85 percent of all consumers in April 2006 were

[67] Throughout this discussion, consumers without a reported ethnicity are excluded from analysis. This "minimum" estimate, however, assumes that all such consumers were White.

[68] Not only are these populations showing up less frequently in DAAS services, but MSSP & Linkages also report a higher proportion of African Americans and lower API. Out of 515 MSSP recipients, 20.2% were African American and 23.9% were Asian/PI (Kelly Hiramoto, received 8/16/06).

non-White.[69] African Americans are the only minority group with a lower proportion of DHS consumers than expected in comparison to low-income seniors (6.9 percent compared to 10.2 percent in the Census). This trend is mirrored in the Food Stamps program and in Medi-Cal participation, where all minority groups show higher than expected participation in CAAP based on low-income Census figures.

Looking to the future, California Department of Finance (2004) projections suggest the next 40 years will see growth in many of San Francisco senior populations. Latino and API groups are projected for the fastest growth, followed by Whites. Current projections suggest that the population of African American seniors will remain fairly steady. Thus, when program expansion opportunities occur, the department will need to continue to partner closely with culturally competent organizations and provide cultural competency training to those who need it.

Many seniors with limited English skills use OOA programs, though their participation is lower in home-delivered meals and case management programs.
Analysis of SF-GetCare data suggests that a large proportion of seniors accessing DAAS-funded services have either limited English proficiency or need translation services. This suggests that efforts on the part of community contractors and DAAS to promote services where monolingual seniors feel comfortable have been fairly successful. Nearly 50 percent of 2005-06 SF-GetCare enrollees were flagged as either having "Limited English Proficiency" or "Needs Translation." Census 2000 data indicates that 28 percent of all San Francisco seniors 65 and over report some difficulty with English, though that rate is likely somewhat higher among low-income seniors. (See Appendix J for more detailed charts of OOA consumer English fluency.)

The Census estimates that 30 percent of Spanish-speaking seniors in San Francisco have trouble speaking English,[70] but a much larger proportion (80%) of Spanish-speaking OOA consumers report that they are not fluent in English. Similarly, 90 percent of OOA consumers with Cantonese as a main language are not fluent in English, while the Census estimates that 50 percent of seniors speaking API languages have trouble speaking English. As such, it appears that current bilingual staffing has been fairly successful at attracting limited-English consumers, though there may be many monolingual seniors who continue to have unmet needs. As programming expands, the department will need to remain focused on the language capacity of providers to ensure that new monolingual consumers continue to have access.

These rates do vary by major program type, however. English fluency rates for OOA consumers are much higher for home-delivered meals (70%) and case management (62%) enrollees than they are for congregate meals (42%), community service (43%), and DWSSW (16%).

[69] Analysis excludes participants in Medi-Cal, as those numbers are much larger than the numbers of seniors participating in other programs. Medi-Cal participation shows the same pattern, however, with proportionally lower representation of African American seniors and higher representation of API seniors. The proportion of White seniors is low compared to demographics of low-income seniors overall, and Latinos are represented at approximately the same rate as in the general low-income population.
[70] The 30 percent figure refers to those reporting that they speak English either "not well" or "not at all."

Curiously, further analysis of data from a 2005 survey of seniors living in San Francisco public housing buildings revealed that non-English-speaking respondents generally showed higher service utilization rates across 19 service types than did their English-speaking counterparts. Utilization rates were the same across the two groups for legal and mental health services. The only services for which non-English-speaking respondents showed lower rates were participation in social activities and in employment services. This may point to the power of the social networks within immigrant communities to spread the word about services, or it may reflect higher isolation rates of White and African American seniors who more often live alone.

Cultural competency may be lacking regarding LGBT aging issues.
Across all programs included in the demographic analysis, datasets do not track the sexual orientation of consumers, making it impossible evaluate any lack of program cultural competency quantitatively. However, roundtable discussions with LGBT senior service providers and a focus group with consumers revealed a concern that mainstream senior service providers often lack training about (and thus cultural sensitivity to) LGBT aging issues.

Some estimates suggest that 17% of San Franciscans are LGBT, but current programming serves only about 1,200 LGBT seniors, or less than 1% of all seniors (LGBT roundtable, June 14, 2006). Provider participants in roundtable discussion on LGBT aging issues focused on the need for increased leadership among mainstream community-based providers, recognizing the "professional and ethical responsibilities to the LGBT community," creating a safe environment for LGBT older adults and marketing LGBT-friendly services beyond those offered at organizations that specifically target that population. They emphasized the importance of outreach and training, and discussed that broad outreach is often more successful in mainstream media publications because they often reach more LGBT seniors than do LGBT-oriented press. Finally, they expressed concern that many mainstream service providers still need training on providing culturally sensitive services while respecting decisions on outing (LGBT roundtable discussion, June 14, 2006).

The service system for younger adults with disabilities is fragmented and some programs lack accessibility or sensitivity.
No cohesive framework exists for meeting the needs of such a diverse community of younger adults with disabilities, who often must navigate mainstream agencies that are not accessible or sensitive to their unique needs. Existing services tend to be organized by disability type, but many people have more than one disability. When expected services and resources are not accessible for younger persons with disabilities, the default "solution" is too often institutionalization.

EVIDENCE OF LOCAL NEED: TRANSPORTATION

Many seniors and younger persons with disabilities rely on public transportation to overcome San Francisco's hilly topography. Public transportation is an absolute necessity for them to go to work, get medical care, shop, socialize, and participate in programs. When transportation is inconsistent or in disrepair or just not available, seniors and younger persons with disabilities are effectively excluded from society. The city's policy of helping seniors "age in place" and

remain in their own homes is likely to increase the demand for paratransit services in the future.

Fifty percent of seniors in San Francisco do not have access to a car (Census 2000), and according to one study in the Bernal Heights neighborhood, more than 40 percent of seniors were unable to drive without assistance (Maynard, 2001). Yet Metropolitan Transportation Commission (2002) found that many seniors do not use public transit because they are not familiar with it and are used to relying on cars. In the Bernal Heights study, nearly 25% cannot use the bus without assistance (Maynard, 2001).

Public Transportation

According to a 2003 San Francisco phone survey, eighty eight percent of vulnerable adults in San Francisco are able to get the public transportation they need, with very few reporting that they are "not often" (7%) or "sometimes not able" (5%) to do so. San Francisco was one of 12 communities surveyed, and the sample size of the San Francisco portion of this survey was too small to determine the reasons for difficulties in getting needed transportation. In the overall survey, however, the most common difficulties cited by those who had trouble getting transportation included: 1) physical or other impairments (37 percent); 2) unavailable or inconvenient public transportation (24%); and 3) lack of a car (21%) (Black et al., 2003).

Paratransit

Those who are unable to independently use regular buses due to a disability or health related condition often require door-to-door transportation services. In a 2006 San Francisco phone survey of seniors and younger adults with disabilities, more than seventy percent knew about door-to-door transportation programs, and ten percent of those of any age with a disability indicated that they had needed such a service in the past year and been unable to use it. Of those reporting an unmet need, 24 percent indicated that they "did not qualify" for the service and another 24 percent said that they "did not know how to access the program" (National Research Center, 2006).

In interviews and focus groups, many community stakeholders cited specific inadequacies in San Francisco's paratransit system. Of the city's 1,300 taxis, 75 are ramp taxis that can accommodate persons in wheelchairs. Since the regular sedan service is more lucrative, the city has some difficulty retaining ramp taxi providers. Moreover, ramp taxis can pick up any passenger, but their priority is supposed to be individuals in wheelchairs, and paratransit has no centralized system for dispatching ramp taxis (Williams, personal interview, September 12, 2006). In the past, San Francisco had a few big taxi companies, but now there are many smaller companies, and these companies are not always responsive. According to one interviewee, the smaller taxi companies often say, "there is no one in your neighborhood," stranding the disabled person (Calderon, 2006**)**. Some riders have the cell numbers of ramp taxi drivers and call them directly rather than going through the companies. At particular times, such as Friday afternoons, it can be very difficult to get a ramped taxi (Williams, personal interview, September 12, 2006).

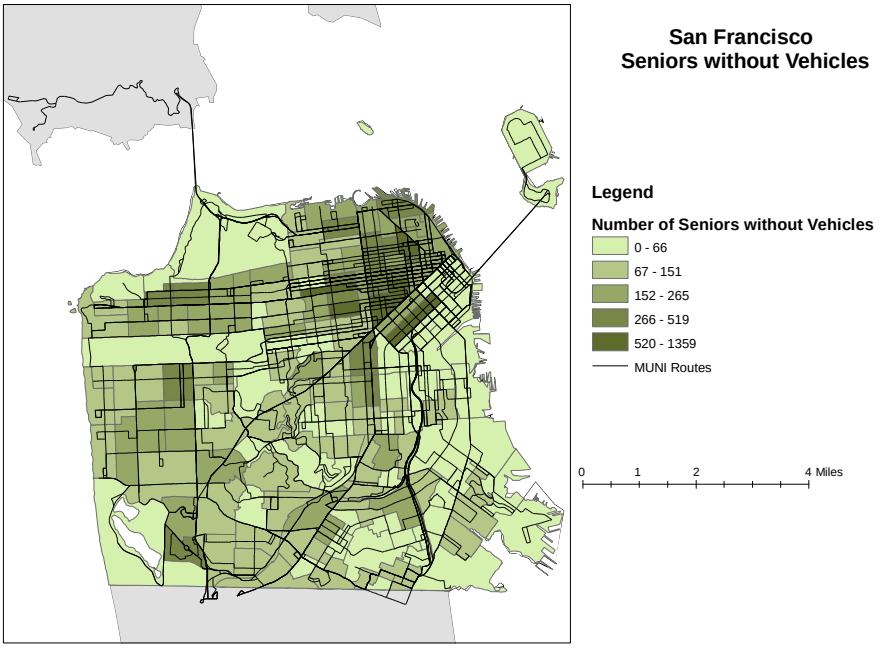
Paratransit services came up often during discussions with community partnerships and providers. Adult day program and senior center directors expressed concerns about the quality of paratransit services, especially since a recent transition in van service providers. In particular, community participants complained of lateness, no-shows, and inadequate capacity

to handle riders with wheelchairs or who need assistance getting on and off the van. In addition, one of the two vendors for group van service is no longer operating, placing pressure on the system. Community members expressed concerns that many of the group vans are unreliable and of poor quality, that drivers do not have sufficient safety training, and mentioned the need for neighborhood-based paratransit scheduling.

EXISTING LOCAL SERVICES: TRANSPORTATION

Public transportation

Compared to other urban areas, San Francisco has an enriched transportation system, and it has made a major commitment to making its bus and trolley system accessible to seniors and adults with disabilities. San Francisco Municipal Railway (MUNI) has replaced almost all of its buses with "kneeling" buses or ones with lifts. Only the 41 Union bus line does not have wheelchair accessible buses, and the city's trolleys have a longer life span and take longer to replace (Williams, personal interview, September 12, 2006). At least one interviewee, however, reported that MUNI buses often have broken lifts,[71] which can make MUNI unreliable for adults with disabilities (Calderon, 2006). Fares are lower for seniors and adults with disabilities.[72] The map below shows the number of seniors without access to vehicles in each San Francisco Census tract, with public transportation lines overlaid. San Francisco has six transit operators. According to the 2004 San Francisco Countywide Transportation Plan, virtually every location in the city lies with a quarter mile of a transit route.



[71] If a bus lift is broken, MUNI asks that riders report it by calling 415-701-4485. MUNI's protocol is to replace that bus before the next run.

[72] 50 cents per ride for seniors and adults with disabilities, compared with a $1.50 regular fare, and $10 for a monthly senior bus pass, compared to $45 for a regular pass.

Paratransit

Provided as part of the requirements of the Americans with Disabilities Act (ADA), San Francisco Paratransit serves individuals who are unable to independently use regular buses due to a disability or health related condition. To provide accessible, door-to-door service, San Francisco Paratransit contracts with organizations that offer a range of services to ADA eligible riders, including Lift Van and ADA Access (pre-scheduled, door-to-door services), group van services, and Taxi Services, including ramp taxis for persons in wheelchairs. The Lift Van mode was established for individuals who need lift-assisted services (mainly wheelchair users). The ADA Access, originally called "Mixed Mode," is intended to fill the needs of more ambulatory consumers. Consumers can pre-schedule trips one to seven days in advance. ADA paratransit trips cannot be limited by trip purpose, and one type of trip cannot be prioritized over another type of trip (San Francisco Paratransit Program, 2003).

Shuttles and taxis fill additional needs that are too specific to be served effectively by MUNI. Currently, many organizations provide shuttle services for consumers or clients. Examples of shuttle services in San Francisco include the Chinatown TRIP shuttle, and the weekend shuttle in Golden Gate Park connecting with MUNI, among others (San Francisco County Transportation Authority, 2004).

Group van service provides transportation to groups of people attending programs such as nutrition centers, work sites or an adult day health centers. The group van service is a significant aspect of the paratransit program. Nearly 70% of the group van trips are to clients going to Adult Day Health Care centers (San Francisco Paratransit Program, 2003). The number of rides funded by MUNI was historically capped at a level lower than the licensed capacity of the adult day service center, creating a barrier to service for those programs. These caps were lifted recently as the funding mechanism was changed from a per-rider basis that allowed for more flexibility and improved capacity (Williams, personal interview, September 12, 2006). The costs of paratransit are rising rapidly, however, and it will face continuing challenges in meeting the need for group van services. Adult day programs pay the cost of these rides for their program participants, and are concerned by recent rate increases because Medi-Cal reimbursements do not cover the additional costs. The programs' ability to expand their capacity is limited by available transportation for clients.

DAAS also supports a small program with paratransit funding to provide shopping trips for seniors. Five community-based organizations provide the shopping trips. 6,285 one-way trips were provided in FY2005-06. DAAS will also fund Little Brothers Friends of the Elderly in FY2006/07 to provide escorts to medical appointments for people who cannot take MUNI, paratransit, or taxis without without assistance. This year's contract will serve 60 unduplicated consumers.

Paratransit challenges include the strict requirements for accommodating all requested trips with the result that operators around the Bay are seeing rapid increases in demand and cost. The number of ADA eligible people is projected to increase in the coming years, putting additional strain on this system and requiring long-term, dedicated sources of funding. Moreover, many seniors cannot travel independently on paratransit. To the degree that driver assistance is limited, paratransit may become unusable for seniors and disabled adults who are particularly frail or subject to confusion (San Francisco Paratransit Program, 2003). A

continuing challenge for MUNI is integrating different types of riders. It provides accessible transportation for job commuters who are very concerned about punctuality and for seniors who want service to their front door. With more resources, MUNI could create a better blend of limited or express services and local lines (Williams, personal interview, September 12, 2006).

The Human Services Agency "work orders" $764,816 a year to MUNI for paratransit services. This includes $624,816 for the paratransit broker, an amount that is based on van trips. Through these funds, six paratransit providers offer over 54,000 one-way van trips to 25 different non-profit agencies. HSA funds are also used to provide transportation for medical and shopping trips. Five different paratransit providers render 6,300 shopping trips a year using these funds. During the 2006-07 budget, the Board of Supervisors added $150,000 to the Human Service Agency's paratransit budget, and plans are still being developed for the best use of these new funds.

GAPS: TRANSPORTATION

Gaps in transportation can make day-to-day activities difficult.

Although there is a high level of public transportation in San Francisco, there are some populations that will not find it useable for a variety of reasons, including relative isolation from transportation routes for those with limited mobility, hills that make it difficult for disabled or frail persons to get to bus stops, even those that are near, or areas with high crime that make standing at a bus stop unsafe and/or feel unsafe. Focus group participants mentioned the need for transportation for social visits and activities, and the lack of transportation to grocery stores, particularly in the Bayview area. Many providers and consumers have suggested that there is a lack of service to meet this need (African American roundtable, June 29, 2006; LGBT roundtable, June 14, 2006; LGBT seniors focus group, June 29, 2006; Western Addition/Marina DAC, July 12, 2006; Richmond DAC, July 11, 2006). Another concern for the future is helping seniors make the transition from relying on cars to using public transportation. Accustomed to driving themselves, many seniors may be resistant to using public transportation when their driving abilities decline.

> *"I don't want to be a prisoner in my own home just because I can't take MUNI."*
>
> -Consumer focus group participant

Paratransit services are sometimes inadequate and inconsistent, but they are challenging and expensive to fix.

People with disabilities and older adults often turn to paratransit to fill the holes that public transportation leaves. As mentioned above, one of the two vendors for group van service is no longer operating, aggravating concerns about gaps in service and quality. Negotiations with paratransit operators are ongoing, and the status of these services may change in the coming months. Community members have recommended in public meetings that DAAS exert pressure on MUNI and paratransit providers to increase the safety and reliability of paratransit services for DAAS clients. Other concerns related to paratransit include the challenges of coordinating trips into other counties. In particular, paratransit trips to San Mateo County require a transfer between companies and riders can experience lengthy delays. While DAAS does not carry the primary responsibility for providing paratransit services, the

target population of the program makes any perceived inadequacy in paratransit services a concern for the department.

SUMMARY OF FINDINGS

The Department of Aging and Adult Services (DAAS) invests in services that respond the many of the needs addressed in this assessment. The following table describes the department's FY2006/07 service funding allocations, broken down by overarching category of need. In some cases, service types address more than one area of need and thus appear more than once in the table.

Department of Aging and Adult Services Budget Allocations FY2006/07 By Needs Assessment Categories[73]		
Housing	**Total**	**874,065**
	Emergency Assistance	40,800
	Housing Advocacy	131,000
	Legal Assistance	702,265
Nutrition	**Total**	**8,839,827**
	Brown Bag	51,000
	Congregate Meals	4,362,830
	Home Delivered Meals Clearinghouse	76,500
	Home Delivered Meals – Seniors	3,606,839
	Home Delivered Meals – Adults with disabilities	645,675
	Nutrition Education	96,983
Isolation	**Total**	**3,628,462**
	Adult Day Health/Adult Day Care	297,335
	Alzheimer's Day Care Resource Center	299,338
	Community Services	2,553,689
	Naturalization	406,515
	Senior Companion	24,585
	Tenderloin Senior Drop-In	47,000
Case Management & Transitional Care	**Total**	**2,609,308**
	Case Management	902,738
	Case Management (intensive long-term and transitional)	800,000
	District-Wide Social Services Workers	432,309
	Linkages	305,234
	Targeted Case Management	169,027

(Table continued on next page.)

[73] Notes on funding chart: Some programs address multiple needs and appear in more than one category. The entire program budget is listed for each appearance of each service type. $328,514 has been allocated for additional services for adults with disabilities, but that funding is excluded from this chart because exact allocations are yet undetermined. The Community Living Fund ($3,000,000) is also excluded from this chart because those funds will be used to address many areas of need. $346,274 in COLA increases are excluded from these figures because contract adjustments had not been finalized at the time of writing. Budget items of the San Francisco Partnership for Community-Based Care and Support are also exluded for simiplicity.

Department of Aging and Adult Services Budget Allocations FY2006/07 By Needs Assessment Categories (Continued)		
Self Care & Safety	**Total**	**92,742,559**
	Active Aging Program (RFP)	200,000
	Adult Protective Services (APS)[74]	4,469,263
	APS – Emergency	190,375
	Elder Abuse Prevention	46,650
	Health Screening	49,799
	In-Home Supportive Services (IHSS)[75]	82,274,882
	IHSS – Title III-B	277,854
	IHSS Advocacy	75,000
	Legal Assistance	622,265
	Medication Management	18,580
	Ombudsman Services	324,082
	Public Conservator	1,399,575
	Public Guardian	2,172,535
	Representative Payee	621,699
Caregiver Support	**Total**	**1,151,919**
	Adult Day Health/Adult Day Care	297,335
	Alzheimer's Day Care Resource Center	299,338
	Family Caregiver Support Program	485,797
	Respite – Purchase of Services	9,449
	Volunteer Recruitment – LGBT	60,000
Access	**Total**	**3,381,732**
	Community & Senior Empowerment	170,182
	District-Wide Social Services Workers	432,309
	HICAP	359,543
	Housing Advocacy	131,000
	IHSS Advocacy	75,000
	Outreach (RFP or modify contracts 06/07)	150,000
	Paratransit	889,816
	Resource Centers for Seniors and Adults with Disabilities	1,173,882

Despite these investments and those of other city departments and community-based agencies, needs assessment research revealed many remaining gaps in services. What follows is a brief discussion of the key gaps in service, along with a discussion of opportunities for DAAS to begin to address them. The body of the report contains more detailed analysis of each of these identified service gaps.

[74] Includes entire APS budget, including salaries and benefits.
[75] Includes entire IHSS budget, including provider wages & benefits, share of cost pilot expenses, etc.

HOUSING

Housing is among the most commonly mentioned needs for seniors and younger adults with disabilities in San Francisco. All of the city's low-income populations struggle to find affordable housing options, and adults with mobility impairments often need additional accessibility accommodations. For seniors who are "aging in place," the need for home modifications to improve accessibility often increases over time. The assessment identified the following key gaps in housing:

Affordable housing

- Existing affordable housing is insufficient to meet all the needs of low-income seniors and younger adults with disabilities.
- Relatively little affordable housing is available to younger adults with disabilities.

Support for Safe Living in Existing Homes and Apartments

- Awareness of current home modification programs is low, and many consumers resist taking on debt.
- Few options are available for modifying rental units.

Licensed Care

- Options for affordable residential care are disappearing in San Francisco.

NUTRITION

The high cost of living in San Francisco forces many seniors and younger adults with disabilities to make difficult decisions between paying for high quality food and paying for rent, utilities, and prescription drugs. The following gaps emerged from assessment analysis:

- Seniors continue to need more free food resources in this very expensive city.
- Some existing programs serve individuals with functional impairments poorly.
- SSI policies reduce access to the Food Stamps program for seniors 65 and older.
- Some neighborhoods have fewer food resources for seniors than others.

ISOLATION

Isolation is common among the elderly and can lead to depression and other related negative health outcomes. Various local data sources, verified by consumers and providers, suggest that isolation is a significant issue for San Francisco seniors and younger adults with disabilities. The assessment highlighted the following key issues:

- The most isolated people are hardest to reach.
- LGBT seniors are at high risk for isolation and few programs target that community.

- Few social programs are targeted to younger adults with disabilities, and many of the programs that exist are not age-appropriate.

CASE MANAGEMENT & TRANSITIONAL CARE

At some point, many seniors and younger adults with disabilities find that they are overwhelmed by unfamiliar circumstances that accompany major life changes such as deteriorating health, the death of a loved one, or 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. Some individuals need short-term assistance during an unexpected crisis or transition, while others find that they need ongoing support. This type of support often comes from case management programs. Gaps in these services include:

- Long-term and transitional intensive case management are in short supply.
- Younger adults with disabilities with complex needs still face waitlists for case management, and others would benefit from more flexible alternatives.
- Collaboration between providers needs improvement.
- Insufficient resources (e.g., education for consumers and caregivers, advocacy, and case management services) are available to ensure smooth transitions home following hospital discharge.

SELF CARE & SAFETY

Adults with mobility or cognitive impairments are at elevated risk for injury or abuse. The following three issues associated with self care and safety for seniors and younger adults with disabilities were examined in the assessment: in-home care, abuse, and risk of injury due to falls. The assessment identified the following gaps:

In-Home Care

- Slightly higher income individuals sometimes have trouble accessing the in-home care that they need.
- Adaptive equipment and accommodations are often a necessary part of self care and independence, but funding is often absent and requires navigating bureaucratic mazes.

Protection from Abuse

- Increased referrals create high caseloads for Adult Protective Services.
- Increased community awareness can help to prevent abuse.
- Fragmentation in the city's service system makes it challenging to help seniors with complex needs.

Injury due to Falls

- Many more seniors could benefit from fall prevention efforts.

CAREGIVER SUPPORT

The vast majority of American adults who receive long-term care at home get all their help from unpaid family members and friends. Most informal caregivers find their roles personally rewarding, but many also find caregiving duties burdensome and feel that they need more assistance (Sharlach, 2003). Consequently, some frail older adults, as well as younger adults with disabilities, do not receive all the help they need and many caregivers in San Francisco are challenged with balancing caregiving duties, work, other family responsibilities, and personal wellbeing. Identified gaps in caregiver support include:

- The scale of the need for caregiver support far outstrips available services.
- Caregivers need more information about services.
- Respite care is inadequate.
- Culturally competent services are not always available.

ACCESS

While the bulk of this needs assessment report focuses on gaps in direct services in San Francisco, this section examines three barriers that consumers may face in attempting to access those services.

- *Information about Services:* Lack of knowledge of existing programs or how to access them prevents consumers who need services from accessing them.
- *Cultural and Linguistic Competency:* Lack of cultural competency in social services provision can make consumers feel unwelcome when they first interact with services, in some cases preventing access altogether. Language competency is particularly critical in settings where consumers need to communicate complex concerns with providers.
- *Transportation:* Without adequate transportation, consumers cannot make their way to the programs they need.

Information

- Consumers are unaware of telephone helplines, and they more often seek information via word-of-mouth.
- Information and referral resources for younger adults with disabilities are complicated by the need for accommodation across service systems and the fragmentation of services by disability type.

- Language barriers present a challenge in providing information services.

Cultural and Linguistic Competency

- Many seniors with limited English skills use OOA programs, though their participation is lower in home-delivered meals and case management programs.
- Cultural competency may be lacking regarding LGBT aging issues.
- The service system for younger adults with disabilities is fragmented and some programs lack accessibility or sensitivity.

Transportation

- Gaps in transportation can make day-to-day activities difficult.
- Paratransit services are sometimes inadequate and inconsistent, but they are challenging and expensive to fix.

OPPORTUNITIES FOR ADDRESSING GAPS

While this community needs assessment reveals many gaps in services for seniors and younger adults with disabilities, it also highlights opportunities for DAAS to make strategic improvements in the coming years. These opportunities fall into three broad categories:

1. Increased partnership with other city departments.
2. Systemic coordination of DAAS services to address common needs.
3. Small program investments that can make a difference.

These categories are described in more detail below, with examples that relate to the broad categories of needs discussed in the assessment.

1. Increased partnership across city departments will leverage each department's core competency to best serve seniors and younger adults with disabilities.

Housing

DAAS will not be a significant financial player in providing new housing, but opportunities exist for the department to become a presence in planning and monitoring affordable housing in ongoing pipeline discussions. This will help to ensure that the needs of seniors and younger adults with disabilities are taken into consideration.

The department might also partner with the Mayor's Office on Disability and the Department of Public Health (DPH) on issues of housing accessibility and home modification, helping seniors and younger adults with disabilities to remain safely in existing owned and rental housing units.

Isolation
Because the most isolated seniors are difficult to locate, it is important for the department to take advantage of opportunities to reach those that it *can* identify. The recent survey of seniors and younger adults with disabilities living in public housing buildings revealed a pocket of low-income isolated seniors (SF Partnership for Community-Based Care and Support, 2005), presenting an opportunity for DAAS to partner with the San Francisco Housing Authority to conduct targeted outreach. The recent study of seniors and adults with disabilities living very isolated lives in single room occupancy hotels suggests there may be an opportunity for DAAS to partner with the Department of Public Health, the Department of Building Inspections, MUNI, and home-visiting programs to contact these seniors and make it easier for them to leave their hotels and have contact with the community.

Self Care & Safety
The Department of Public Health houses the majority of the city's fall prevention home modification programs. The target population for these programs, seniors and younger adults with disabilities, begs collaboration with DAAS. Due to both lack of knowledge of the programs and resistance to take on the liens required for participation, DPH home modification programs are underutilized. There may be an opportunity for DAAS to work with DPH to improve access to these programs.

Access
MUNI is the lead organization providing transportation services for seniors and younger adults with disabilities. The overlap of target populations between paratransit services and DAAS consumers makes it important for DAAS to be an active partner.

2. Departmental leadership in addressing common unmet needs systemically can increase efficiency and improve consumers' experience accessing programs.

Housing
There are opportunities for DAAS to work with property managers and on-site social workers at existing housing, providing training about community resources that allow residents to age safely in place.

Nutrition
DAAS is well-positioned to play a role in systemic coordination that promotes more strategic and efficient nutrition programs for seniors and younger adults with disabilities. For example, the department can target neighborhoods that are underserved by all types of nutrition programs, and it can play a role in facilitating creative new partnerships that might increase the availability of groceries to those who experience barriers to access via the current service system.

Isolation
Programs that reduce the negative effects of isolation typically come in two forms. Some draw isolated individuals out of their homes to participate in center-based programming, and others reach out to isolated individuals in their own homes. The department is well-placed to consider the current constellation these services in order to strengthen the capacity of the system as a whole. Analysis of current participation trends suggests that there may be an

opportunity to expand utilization of adult day programs in San Francisco, for example. There may also be opportunities to encourage collaboration between friendly visitor programs and other community-based providers to enhance visitors' ability to educate isolated seniors about other existing services.

Case Management & Transitional Care

The San Francisco Partnership for Community-Based Care and Support has begun to address the issue of systemic collaboration for case management services through its Case Management Connect Pilot Project (CMCPP). The findings from this project, which includes case management partners from DAAS and from other city departments, will likely lead to recommendations for enhancing systemic collaboration. This effort may ultimately be valuable as a model for improving community-based support of hospital discharge transitions as well. Finally, the implementation of the Community Living Fund's proposed Intake and Screening Unit will present opportunities for the department to investigate methods for coordinated provision of case management services depending on the needs of individual consumers.

Caregiver Support

Caregivers in San Francisco are often uninformed about existing programs, and cultural norms can create barriers to seeking support. There may be opportunities for DAAS to investigate a more coordinated way that the service system can reach out to caregivers through traditional programs that typically target care recipients. For example, case management programs can have greater success when they also engage caregivers, linking them to training and other support services to create a healthier and more sustainable home care environment. Outreach for other programs, such as adult day programs, can also translate to respite for caregivers in addition to offering benefits for the care recipient.

Access

The Resource Centers for Seniors and Adults with Disabilities and the DAAS Information and Assistance phone line both have untapped capacity to serve the community. Other efforts to inform the public of services include, for example: the launch of 2-1-1, the media campaign of the San Francisco Partnership for Community-Based Care and Support, and efforts to improve LGBT cultural competency of mainstream service providers. In this context, it will be important for the department to target further investments in outreach in ways that leverage the full capacity of the existing information and referral system.

With respect to transportation needs, the diversity of programs, funding sources, and departmental responsibility requires DAAS to use strategies that take the entire existing system into consideration and target the small available departmental funding accordingly. Given the difficulty of providing adequate paratransit and similar service for all consumers who need it, DAAS might take the opportunity to consider a variety of models for investing its transportation resources.

Serving Younger Adults with Disabilities

The largest gap that younger persons with disabilities face might be the lack of priority that mainstream service systems give to their right to live in the community, participate fully in its activities, and assume responsibility for themselves. During interviews key stakeholders repeatedly cited the need for departmental leadership to make community resources more

accessible and accommodating (Aaron, personal interview, September 12, 2006; Calderon, personal interview, Ordover & Bennin, personal interview, August 22, 2006; Mizner, personal interview, August 11, 2006). Some suggested that the department be more assertive about preventing individuals from entering institutions, such as creating a panel that reviews referrals to institutions and looks for creative, commonsense remedies (e.g., housing modifications, additional IHSS hours, or respite for relative caregivers) to keep persons with disabilities safely at home. Without a clear mandate for serving younger persons with disabilities, however, DAAS will likely have difficulty identifying its appropriate role. DAAS may wish to work with community members and city leaders to clarify its responsibilities. This would prevent confusion in the future as DAAS funds services for younger persons with disabilities, and it would give the department more secure footing in ongoing advocacy.

3. Opportunities for small investments that make a difference.

Housing

Legal services, case management, and emergency rental subsidies can be critical services for seniors and persons with disabilities who are at imminent risk of institutionalization or eviction. Small home modification investments can also dramatically improve safety in housing. Existing programs provide these services, and the community living fund will be a valuable new element to support the city's most vulnerable populations in the coming years.

Isolation

While home modification programs typically aim to address housing or safety issues, some home modifications also reduce isolation. Improved stair railings, along with more expensive stair lifts, can enable seniors or younger adults with disabilities to safely get out of the home or receive disabled visitors.

Self Care & Safety

The Administration on Aging (AoA) has recently focused research on evidence-based health promotion programs. This initiative has highlighted numerous successful programs, including fall prevention and physical activity programs. Such national research, paired with local analysis of San Francisco trends, will help to focus future departmental efforts to implement programming that promotes safe and healthy aging.

Access

The potential impact of small investments in ongoing public relations campaigns may be large. The current "home alone" media campaign of the San Francisco Partnership for Community-Based Care and Support is a valuable model. It targets a broad audience through multiple ethnic media outlets, aiming to increase awareness of services and build trust in the system in the broader community. This campaign presents an opportunity to investigate what public relations methods work best for informing San Francisco's diverse community about services for seniors and younger adults with disabilities.

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- Raman Hotel Residents Focus Group, Raman Hotel, June 28, 2006.
- Visitacion Valley Chinese Seniors Focus Group, Visitacion Valley Community Center, August 22, 2006.

Focus Groups – Providers

- African American Partnership, June 29, 2006.
- Asian/Pacific Islander Partnership, July 19, 2006.
- Latino Partnership, July 10, 2006.
- LeNain Hotel Case Managers, February 10, 2005.
- LGBT Partnership, June 14, 2006.
- Peer Advocates, June 23, 2006.
- Case Managers (MSSP, Linkages, Curry Senior Center), June 27, 2006.

District Advisory Council Meetings

- Bayview District, July 14, 2006.
- Mission District, June 22, 2006.
- OMI District, June 21, 2006.
- Outer and Inner Sunset District, June 19, 2006.
- Richmond District, July 11, 2006.
- Tenderloin/South of Market, August 7, 2006.
- Western Addition/Marina District, July 12, 2006.
- Visitacion Valley District, July 25, 2006.

APPENDICES

APPENDIX A: AFFORDABLE HOUSING UNITS DETAIL

San Francisco Housing for Persons with Disabilities and Unique Needs							
	Homeless	HIV & AIDS	Developmental & Mental Disabilities	Physical Disabilities	Substance Abuse Recovery	Unclassified/Other Special Needs	Total[76]
Units/Beds	2109	357	185	49	340	1459	4,434
Percent	48%	8%	4%	1%	8%	33%	100%

Sources: MOH and SFRA administrative data.

Affordable Housing Pipeline Units					
Chronically Homeless	Very Low Income Seniors	VL/Low Income Families	Disabled	Homeown Moderate Income	Total
1,043	641	1,073	10	441	3,208
33%	20%	33%	0%	14%	100%

Sources: MOH and SFRA administrative data

[76] In cases where a building is targeted toward more than one of the above groups, such as formerly homeless persons with HIV & AIDS, the units are counted in both categories. 65 total units are counted in multiple categories. Thus, the simple sum of all "Units/Beds" cells exceeds 4,434 -- the actual total.

Program	Goal	Type of Assistance	Target Population	Income Requirement	Program Scale
CERF	Ameliorate "conditions which the City has determined in violation of the existing building code," prioritizing health and safety issues.	**Loans** (interest free) for $250-$15,000	Low-Income homeowners	Less than 80% of the median income*	(Detail not available)
CHRP	Help homeowners address more costly maintenance issues. May be used to increase accessibility, but recipient must bring home in compliance with building code regulations.	**Loans** (3% interest, payment can be deferred until time of sale) for $75,000-$150,000	Low-Income homeowners	Less than 80% of the median income*	$2.5 million available annually
Rebuilding Together Weekend	Enhance resident's quality of life	**Free services**: Substantial repairs and renovations including new cabinetry, carpeting, plumbing, carpentry, electrical, weatherization, appliances, clean up and debris removal, painting, yard work	Low-Income elderly and disabled homeowners	Less than 100% of the median income**	Approx 30 homes annually
Rebuilding Together Home-Safety and Independence Program	Increase home safety and accessibility	**Free services**: Small repairs and modifications including secure handrails, bathroom safety equipment, smoke detectors. Cost per job $150-$250	Low-Income elderly and disabled homeowners and renters	Less than 100% of the median income**	Approx 150-175 homes annually
CHIPPS	Prevent injuries in the home	**Community Education/ Free services**: Workshops in the community increase awareness. Home safety assessments available to any attender. Small repairs, modifications, and installations provided as needed.	Owners and renters 65+	None	100 home assessments annually (budget of $150,000)

Residential Setting		Description	Population Served	Payment Type and Rates	Approx # of Beds
Residential Care Facilities for the Elderly (RCFE)[77]	Small (0-9)	Staff provides meals, supervision, and assistance with activities of daily living, such as bathing and grooming. Diverse sizes and services.	Seniors 60+ who are unable to provide for their own daily needs but do not need 24-hour medical supervision. Residents in vary in means and health needs. Special license required to serve non-ambulatory persons.	SSI/ Private pay. SSI rate= $900.00/Mo. Private pay rate =$2,500 to $3,000/Mo[78]	300
	Medium/Large (>10)	Facilities vary greatly in size. Larger facilities (>30 beds) offer private rooms or apartments and have common areas for activities and meals.	<same as above>	Usually private pay only: $2,000 to $5,000/month	2800
Adult Residential Facilities (ARF)		Staff provides meals, supervision, and assistance with activities of daily living, such as bathing and grooming.	Adults (18-59) who are unable to provide for their own daily needs but do not need medical supervision. May have physical, developmental, and/or mental disabilities. Special license required to serve non-ambulatory persons.	Most accept SSI/SSP - Services to Regional Center clients are paid at a higher rate.	872
Residential Care Facilities for the Chronically Ill (RCFCI)		24-hour medical care and supervision. State licensing regulations limit size to 25 beds.	People with disabling HIV and AIDS.	SSI/SSP	117

(Table Continued on Next Page)

[77] 99 total RCFE facilities exist in San Francisco (2006).
[78] California average. Varies by facility and service needs.

Residential Setting (Continued)	Description	Population Served	Payment Type and Rates	Approx # of Beds
Continuing Care Retirement Communities (CCRC)/ Life Care Facilities	Offer a continuum of care within one facility, including independent living in homes or condominiums, assisted living, and skilled nursing.	Older adults of varying health needs	Private pay only, most expensive option	750
Community Based Skilled Nursing Facilities (SNF)	24 hour nursing care.	People with long-term medical needs.	Medi-Cal/ Private Pay:[79] Average CA Medi-Cal reimbursement: $3,450/mo. Average private pay: $5,000/mo.	19 facilities. 2,657 Medi-Cal certified beds
Hospital Based Skilled Nursing Facilities (DP SNF)	Short-term post-acute care in an institutional setting.	Recently hospitalized persons needing rehabilitative care and 24-hour medical supervision.	Medi-Cal/ Private Pay	4 facilities
Day Health Housing[80]	Offer a continuum of care in one facility (e.g., affordable apartments, case management, skilled nursing, and behavioral health services for seniors).	Low-Income Seniors 62+	Rent subsidized by HUD and other sources. Many residents only pay 30% of income.	231 units

Sources: California Association of Health Facilities. http://www.cahf.org. California Advocates for Nursing Home Reform. http://www.canhr.org. California Department of Social Services, Community Care Licensing Division: http://ccl.dss.cahwnet.gov/FacilityTy_1727.htm

[79] Most certified for Medi-Cal

[80] All forms of assisted living delineated are licensed by the state with the exception of day health housing. In this case only the day health program is licensed, not the housing.

Distribution of Senior Poverty and Food Program Resources by Zip Code

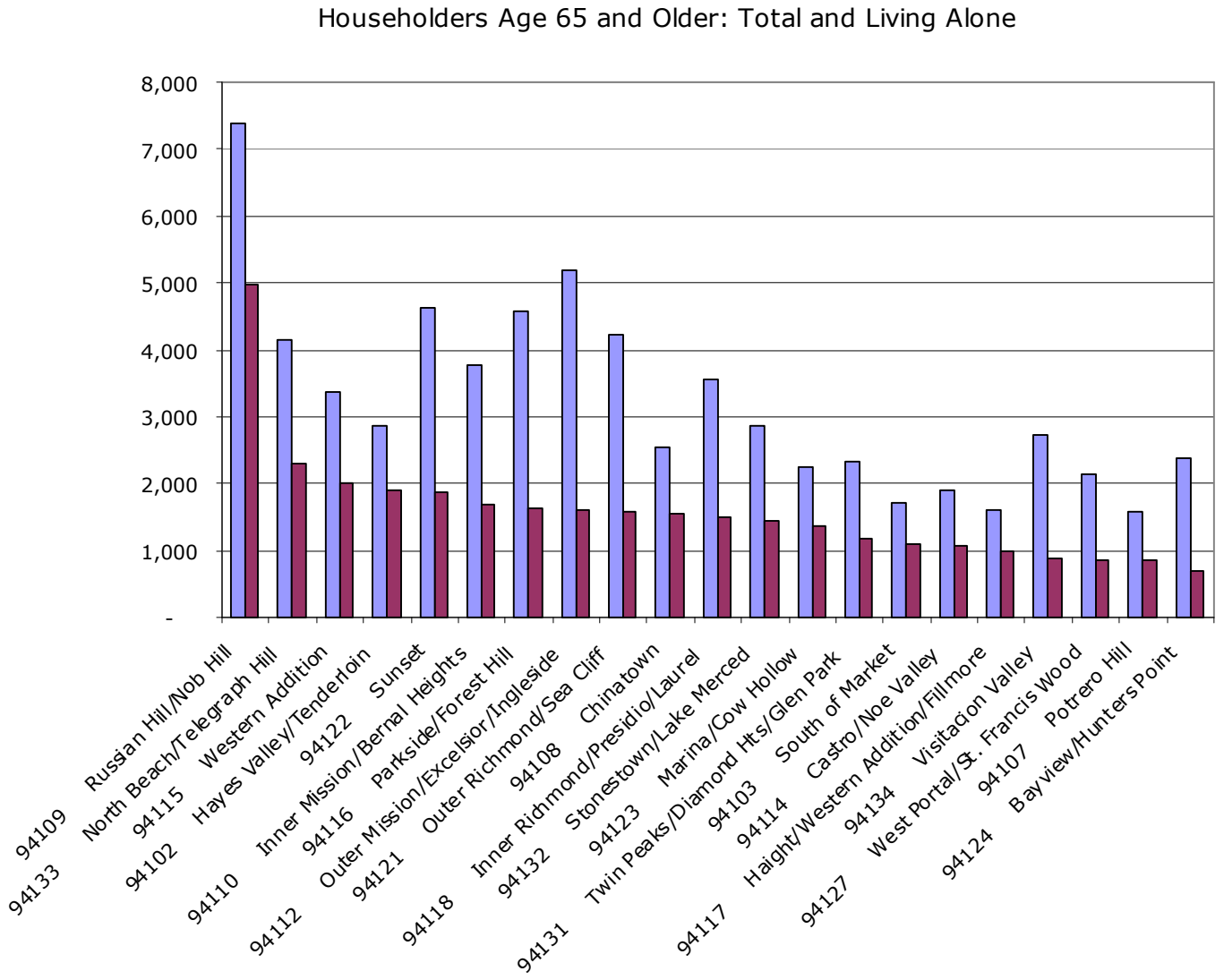
(cells are shaded when percentage of service to that neighborhood is lower than the percentage of low-income seniors there)

	Distribution of San Francisco seniors with incomes below 150% of poverty	Congregate Meals Distribution (60+)	HDM Distribution (60+)	SFP (60+)	Appox. Food pantry bags to seniors (based on pantry location)	Food Stamps recipients (60+)
94109 Russian Hill/Nob Hill/Chinatown	10%	9%	8%	8%	4%	8%
94133 North Beach/Telegraph Hill	10%	5%	3%	10%	4%	9%
94108 Chinatown	6%	3%	2%	4%	6%	4%
94127 West Portal/St. Francis Wood	3%	1%	2%	1%	3%	1%
94117 Haight/Western Addition/Fillmore	3%	2%	3%	2%	2%	2%
94121 Outer Richmond/Sea Cliff	5%	7%	6%	4%	3%	4%
94118 Inner Richmond/Presidio/Laurel	4%	6%	3%	4%	3%	3%
94102 Hayes Valley/Tenderloin	7%	6%	6%	10%	8%	9%
94116 Parkside/Forest Hill	4%	7%	6%	3%	2%	5%
94107 Potrero Hill	3%	4%	2%	3%	6%	1%
94131 Twin Peaks/Diamond Hts/Glen Park	2%	2%	3%	1%	1%	1%
94111 Embarcadero/Gateway	1%	0%	1%	1%	0%	1%
94103 South of Market	6%	6%	5%	9%	12%	7%
94115 Western Addition	6%	6%	6%	8%	8%	3%
94122 Sunset	5%	6%	5%	4%	1%	6%
94124 Bayview/Hunters Point	4%	2%	7%	5%	14%	5%
94132 Stonestown/Lake Merced	2%	3%	4%	2%	1%	3%
94123 Marina/Cow Hollow	1%	1%	1%	0%	0%	1%
94110 Inner Mission/Bernal Heights	7%	9%	10%	8%	12%	7%
94112 Outer Mission/Excelsior/Ingleside	6%	8%	10%	9%	7%	13%
94114 Castro/Noe Valley	1%	2%	3%	1%	1%	1%
94134 Visitacion Valley	4%	4%	4%	5%	5%	7%

Sources: Census 2000; OOA Administrative Data; DHS Administrative Data; SF Food Bank Administrative Data.

APPENDIX E: ISOLATION INDICATORS

(Source: Census 2000, Zip codes with small populations excluded)



(Source: Census 2000, Zip codes with small populations excluded)

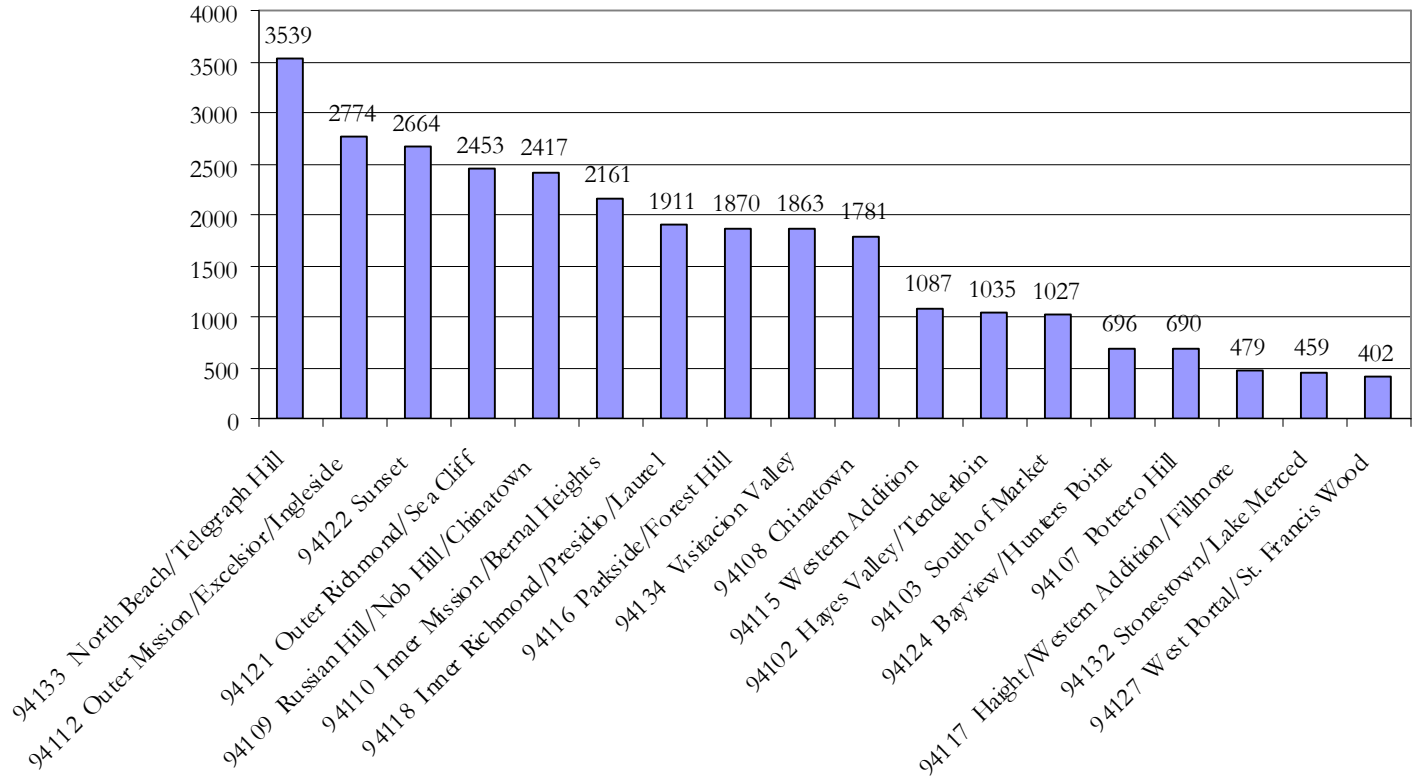
Isolation Indicators: Number of Seniors/Senior households who…			
	Number of Seniors 65+	Live Alone	Speak English "not well" or "not at all"
94109 Russian Hill/Nob Hill/Chinatown	9,590	4983	2417
94133 North Beach/Telegraph Hill	5,900	2307	3539
94115 Western Addition	4,631	2016	1087
94102 Hayes Valley/Tenderloin	3,664	1901	1035
94122 Sunset	8,104	1886	2664
94110 Inner Mission/Bernal Heights	6,165	1697	2161
94116 Parkside/Forest Hill	7,571	1645	1870
94112 Outer Mission/Excelsior/Ingleside	10,619	1597	2774
94121 Outer Richmond/Sea Cliff	7,301	1590	2453
94108 Chinatown	3,198	1548	1781
94118 Inner Richmond/Presidio/Laurel	5,780	1489	1911
94132 Stonestown/Lake Merced	4,217	1433	459
94123 Marina/Cow Hollow	2,997	1361	241
94131 Twin Peaks/Diamond Hts/Glen Park	3,473	1174	256
94103 South of Market	2,649	1102	1027
94114 Castro/Noe Valley	2,551	1077	239
94117 Haight/Western Addition/Fillmore	2,507	989	479
94134 Visitacion Valley	5,266	874	1863
94127 West Portal/St. Francis Wood	3,957	849	402
94107 Potrero Hill	2,043	844	690
94124 Bayview/Hunters Point	3,689	707	696

Source: Census 2000: Tables P19, H45, H19
Language information is individual level data, live-alone status describes households.

The following zip codes are excluded from this table because of the very small number of seniors living there: 94104, 94105, 94111, 94129, 94130.

(Source: Census 2000, Zip codes with small populations excluded)

Seniors (65+) that speak English "not well" or "not at all"



(Source: Census 2000, Zip codes with small populations excluded)

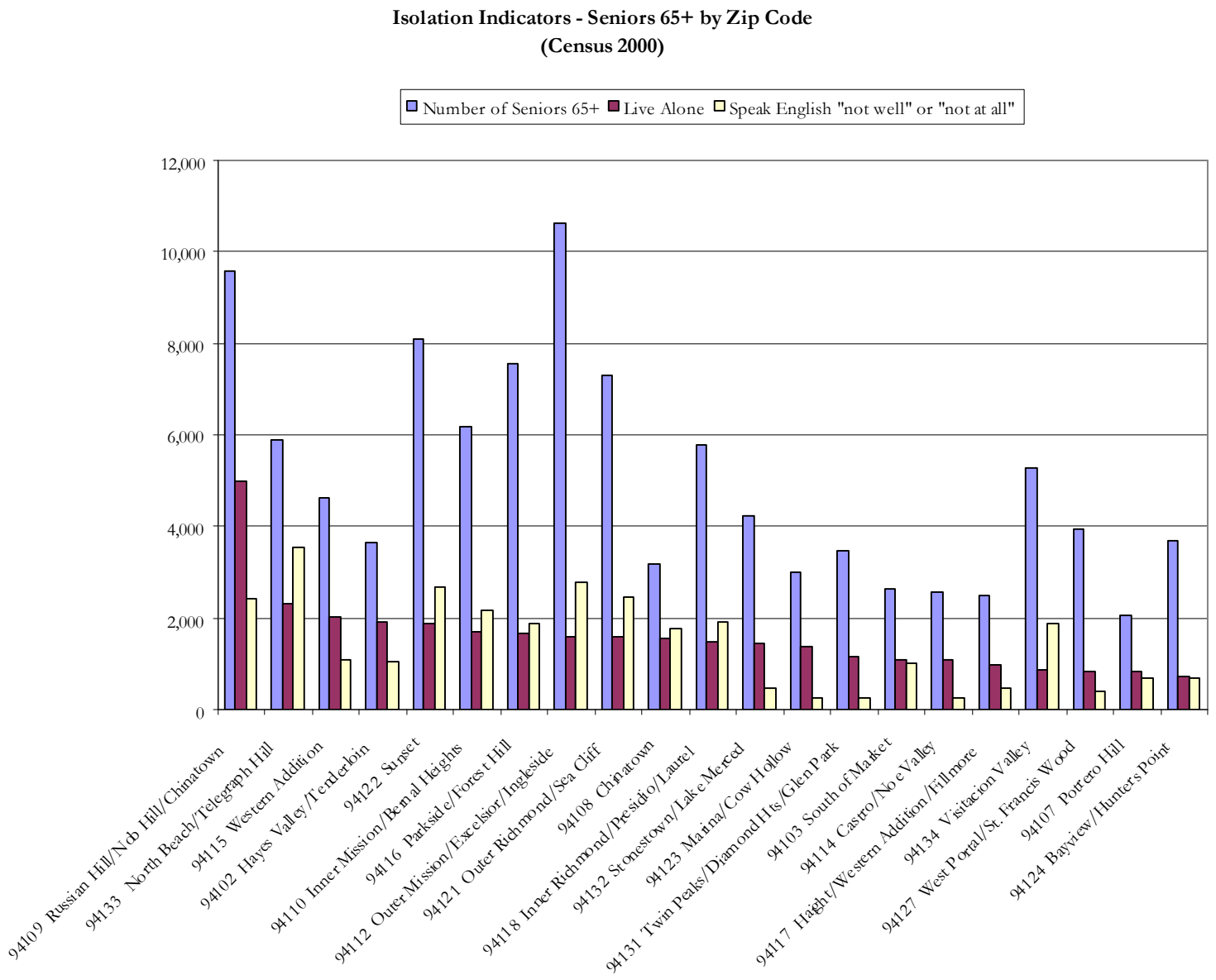
Isolation Indicators by Zip Code: High Rates for Seniors (65+) *(rates higher than the citywide rate are shaded)*			
		Live Alone	Speak English "not well" or "not at all"
		% of those living in this zip code	
San Francisco citywide		***49%***	***28%***
94103	South of Market	64%	39%
94108	Chinatown	61%	56%
94133	North Beach/Telegraph Hill	56%	60%
94107	Potrero Hill	54%	34%
94109	Russian Hill/Nob Hill	68%	25%
94102	Hayes Valley/Tenderloin	66%	28%
94117	Haight/Western Addition/Fillmore	61%	19%
94123	Marina/Cow Hollow	60%	8%
94115	Western Addition	60%	23%
94114	Castro/Noe Valley	57%	9%
94131	Twin Peaks/Diamond Hts/Glen Park	50%	7%
94132	Stonestown/Lake Merced	50%	11%
94110	Inner Mission/Bernal Heights	45%	35%
94118	Inner Richmond/Presidio/Laurel	42%	33%
94122	Sunset	41%	33%
94121	Outer Richmond/Sea Cliff	38%	34%
94134	Visitacion Valley	32%	35%
94127	West Portal/St. Francis Wood	40%	10%
94116	Parkside/Forest Hill	36%	25%
94112	Outer Mission/Excelsior/Ingleside	31%	26%
94124	Bayview/Hunters Point	30%	19%

Source: Census 2000: Tables P19, H45, H19

Language information is individual level data, live-alone status describes households.

The following zip codes are excluded from this table because of the very small number of seniors living there: 94104, 94105, 94111, 94129, 94130.

(Source: Census 2000, Zip codes with small populations excluded)



APPENDIX F:
ADULT DAY PROGRAM DEFINITIONS AND LICENSES

Adult Day Health Care (ADHC) - licensed Medi-Cal certified health facilities that treats the health and supportive needs of older adults with multiple, chronic conditions in a safe, homelike day setting. ADHC provides expert, specialized care to individuals who have: Alzheimer's disease or related dementia, post-stroke complications, cardiovascular disease, diabetes with complications, neurological diseases, depression, head or spinal cord injury, developmental disabilities and mental illnesses. The goal of ADHC is to prevent or delay placement into nursing homes or other more expensive care settings. This is done by improving and preserving each individual's physical and mental health, improving their quality of life. Older adults with chronic conditions are able to successfully live in the community while a benefit for the caregiver is regular respite from 24-hour caregiving responsibility.

ADHC provides many health and social services under one roof for one set daily fee. Persons attending ADHC are pre-approved by the Medi-Cal field office (if a Medi-Cal beneficiary). Non Medi-Cal participants pay out-of-pocket. Many centers have sliding fee scales.

Services provided on an individual basis include nursing supervision and assistance, medication monitoring, physical therapy, occupational therapy, speech therapy, and social work. Assistance with daily tasks such as eating and walking are provided by trained program assistants. Group activities provide companionship and social stimulation and are designed with the participants level of ability and interests in mind. A noon meal, transportation to and from the center, caregiver support groups, community outreach and education and other services may also be provided.

Adult Day Program (ADP) - centers licensed by the California Department of Social Services (DSS) - Community Care Licensing Division. These centers provide non-medical care to elderly persons and other adults with physical and/or cognitive impairments who require personal care services, protective supervision or assistance in activities of daily living on less than a 24-hour basis. Services are provided according to an idividual plan of care in a structured, comprehensive program that offers therapeutic activities tailored to the individual's abilities; nutrition services; basic health monitoring; transportation corrdination; and respite and support for families. ADP centers are not reimbursed by MediCal.

Alzheimer's Day Care Resource Centers (ADCRC) provide care for persons with Alzheimer's disease or other dementias, and support and education for caregivers and the community. County Area Agencies administer these programs.

Programs of All Inclusive Care for the Eldery (PACE) provide 24-hour medical and long-term care for frail seniors who need nursing home care but want to remain at home. The Department of Health Services regulates these programs, which maintain clinic, home health and ADHC licenses.

Source: San Francisco Adult Day Network – www.sfadultday.org

Bay Area Elderkind Directory
Friendly Visitor Programs Listed for San Francisco County

- Bay Area Jewish Healing Center
- Bernal Heights Neighborhood Center
- Center for Elderly Suicide Prevention
- Episcopal Community Services of San Francisco
- Italian-American Community Services
- Jewish Family and Children's Services
- Kimochi, Inc.
- Lighthouse for the Blind
- Little Brothers-Friends of the Elderly
- Meals on Wheels
- New Leaf Outreach to Elders
- Network for Elders
- Eldergivers (formerly San Francisco Bay Area Ministry to Nursing Homes

Department of Aging & Adult Services Case Management Programs		
Name of Organization	**Level[81]**	**Capacity**
In Home Supportive Services (IHSS) Consortium	Level 2/3/4	10 FTE
DAAS Adult Protective Services (APS)	Level 3/4	31.5 FTE
Institute on Aging's Linkages	Level 2/3	4 FTE
Institute on Aging's Multipurpose Senior Services Program (MSSP)	Level 3	12.9 FTE
Bernal Heights Neighborhood Center	*	*
Catholic Charities (CYO)	Level 1/2/3	2 FTE
Curry Senior Center	Level 2/3	2.75 FTE (2FT, 2PT)
Episcopal Community Services	Level 1/2	4 FTE
Jewish Family and Childrens Services	Level 2/3	1.55 FTE (5 PT)
Network For Elders	*	*
Meals On Wheels of San Francisco	Level 2/3	2 FTE (1 FT, 3 PT)
On-Lok Day Services	*	*
San Francisco Senior Center	Level 1/2/3	3 PT
Self-Help for the Elderly	Level 1/2	8 FTE
Veterans Equity Center	Level 1/2/3	1 FTE

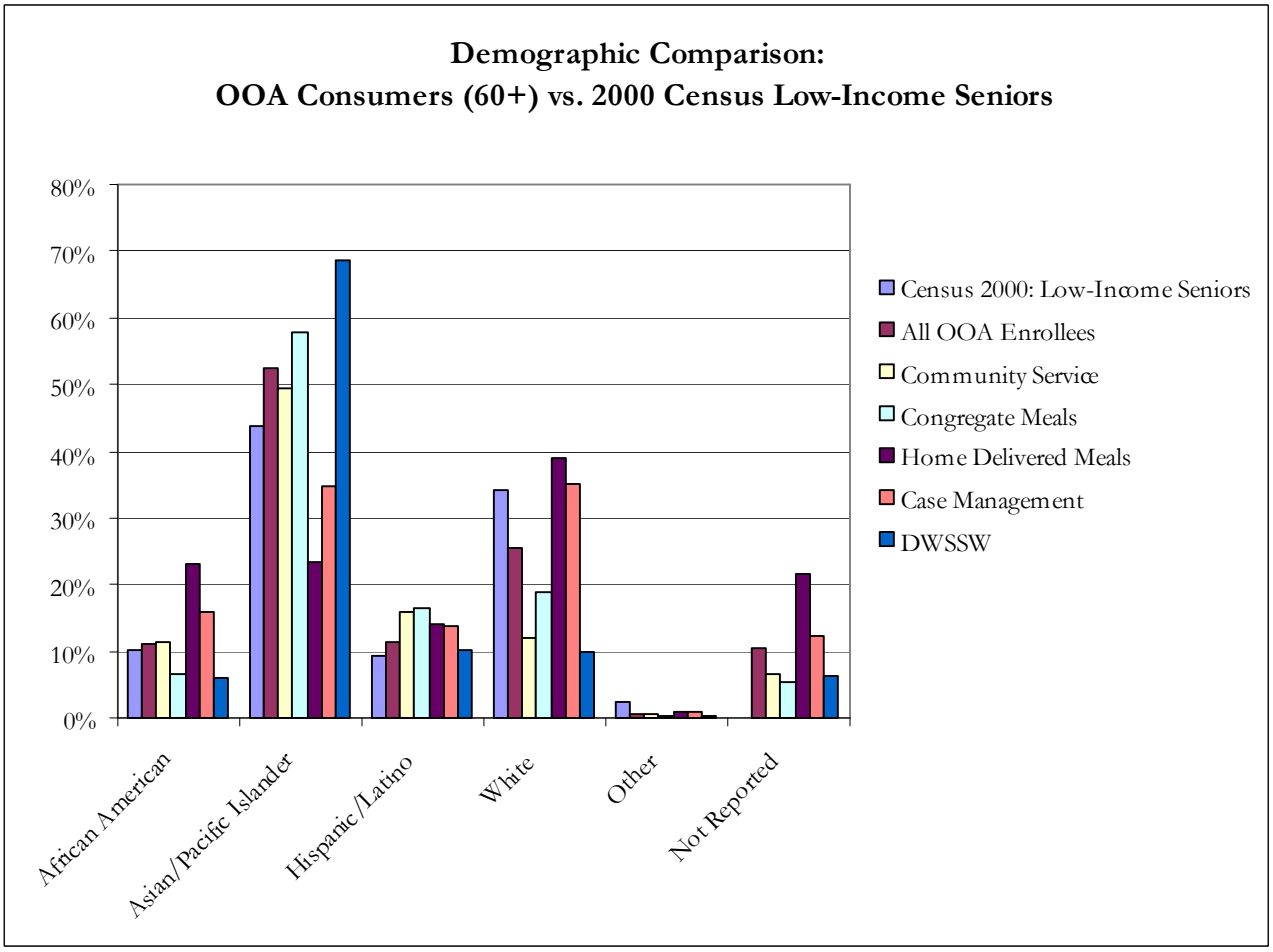
**Information unavailable at the time of report publication.*

Non-DAAS Case Management Programs
Department of Public Health
Placement (Includes Targeted Case Management)
Alternatives Program
Bayview Hunter's Point Mental Health Clinic
Citywide Case Management Team and Citywide Forensics
Family Services Agency
Mission ACT
Westside ACT
UC Community Focus
Department of Psychiatry-ED Case Management
Other Programs
Northern California Presbyterian Homes and Services
Family Caregiver Alliance
Glide Foundation
Haight Ashbury Free Medical Clinic
Kimochi, Inc.
Northeast Medical Services
South of Market Health Center
TODCO
Saint Anthony Foundation Senior Outreach Program

[81] Most agencies that provide level 3 case management indicate that they only have the capacity to take a few of these more intensive cases.

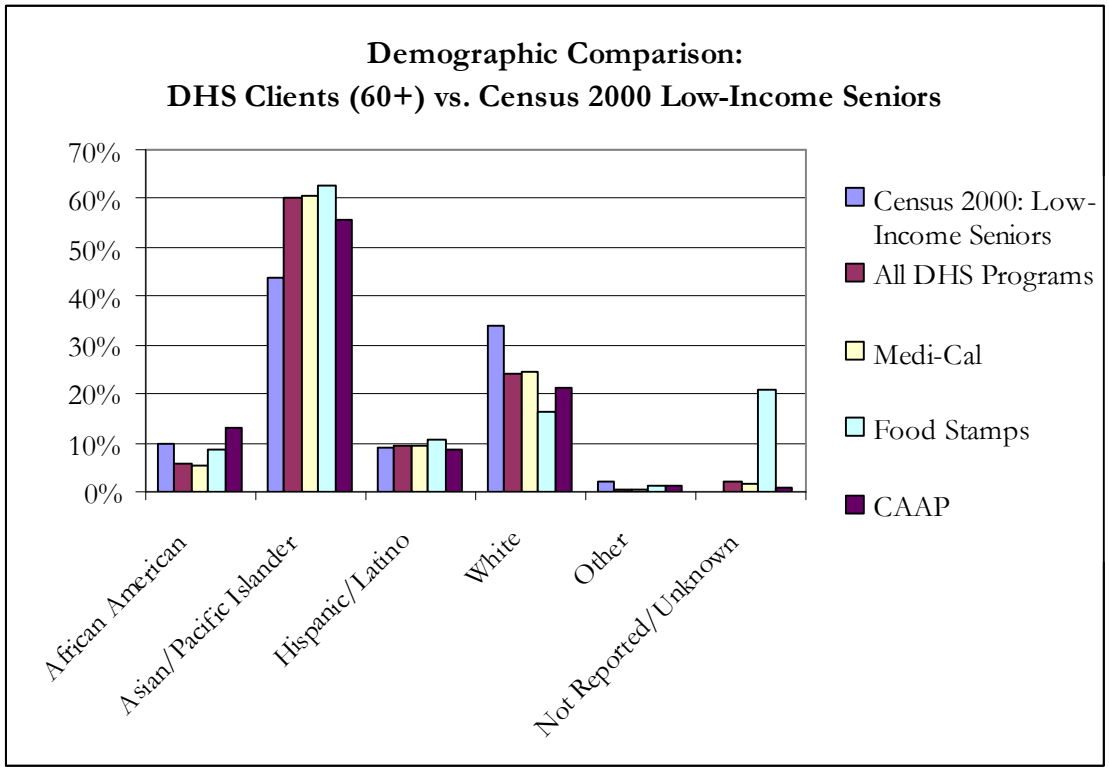
APPENDIX I: CONSUMER DEMOGRAPHICS

Office on the Aging Programs Demographics							
Reported Ethnicity	**Census 2000: Low-Income Seniors***	**All OOA Enrollees**	**Community Service**	**Congregate Meals**	**Home Delivered Meals**	**Case Management**	**DWSSW**
African American	10%	11%	11%	7%	23%	16%	6%
Asian/Pacific Islander	44%	52%	50%	58%	23%	35%	69%
Hispanic/Latino	9%	11%	16%	16%	14%	14%	10%
White	34%	25%	12%	19%	39%	35%	10%
Other	2%	1%	1%	0%	1%	1%	0%
Not Reported		10%	7%	5%	21%	12%	6%

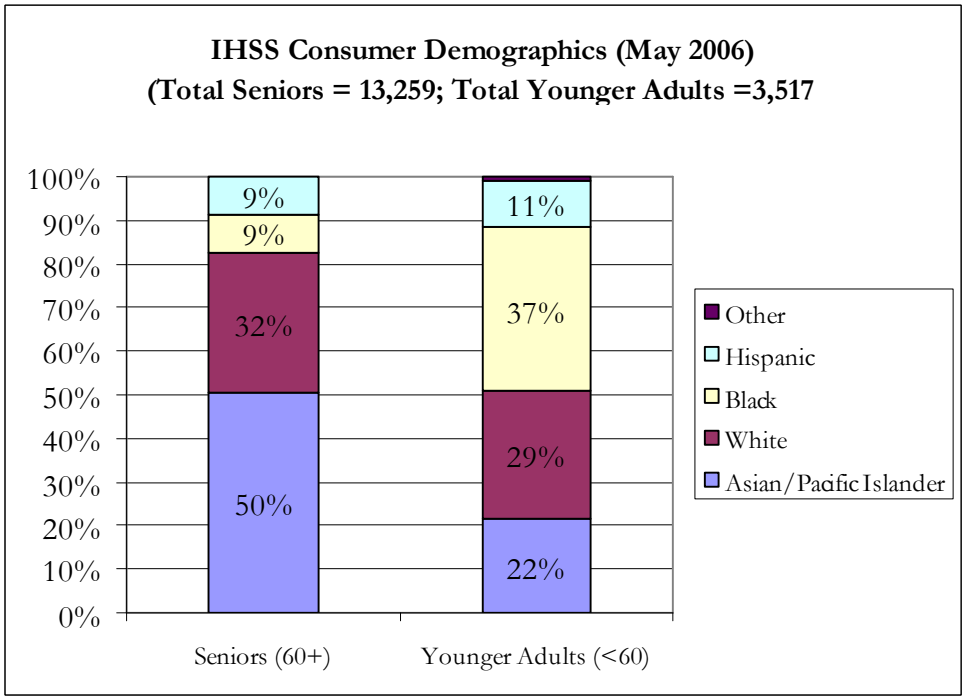


* "Low-Income Seniors" are individuals aged 65 and older with incomes below 150% of the poverty level.

Department of Human Services Programs Demographics					
Reported Ethnicity	**Census 2000: Low-Income Seniors***	**All DHS Programs**	**Medi-Cal**	**Food Stamps**	**CAAP**
African American	10%	6%	5%	9%	13%
Asian/Pacific Islander	44%	60%	61%	63%	56%
Hispanic/Latino	9%	9%	9%	11%	9%
White	34%	24%	25%	17%	21%
Other	2%	0%	0%	1%	1%
Not Reported/Unknown		2%	2%	21%	1%

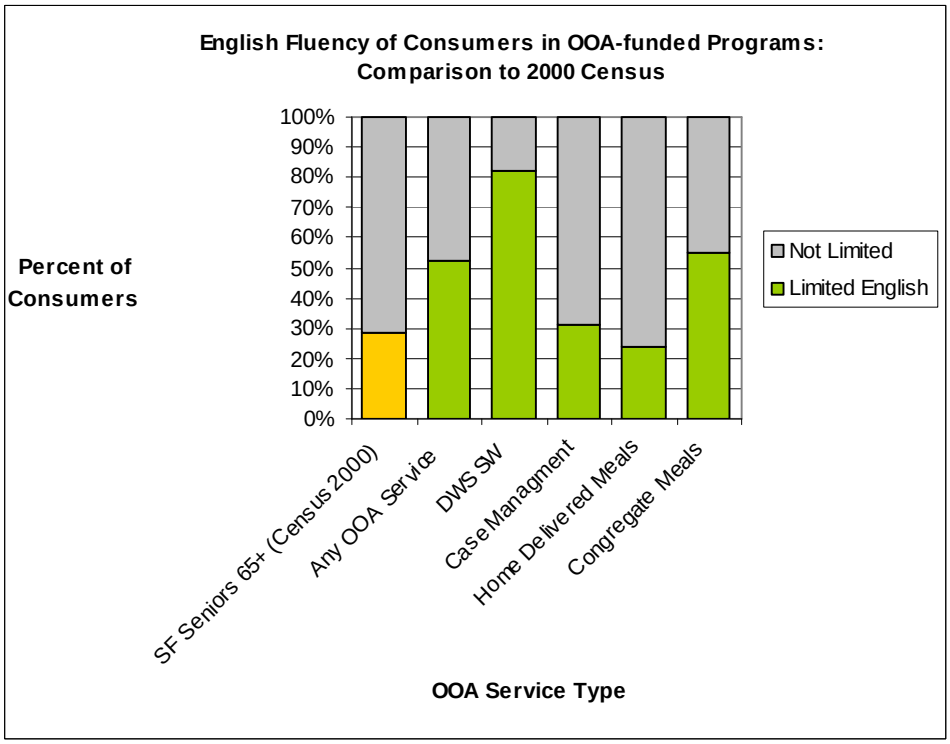


* "Low-Income Seniors" are individuals aged 65 and older with incomes below 150% of the poverty level.

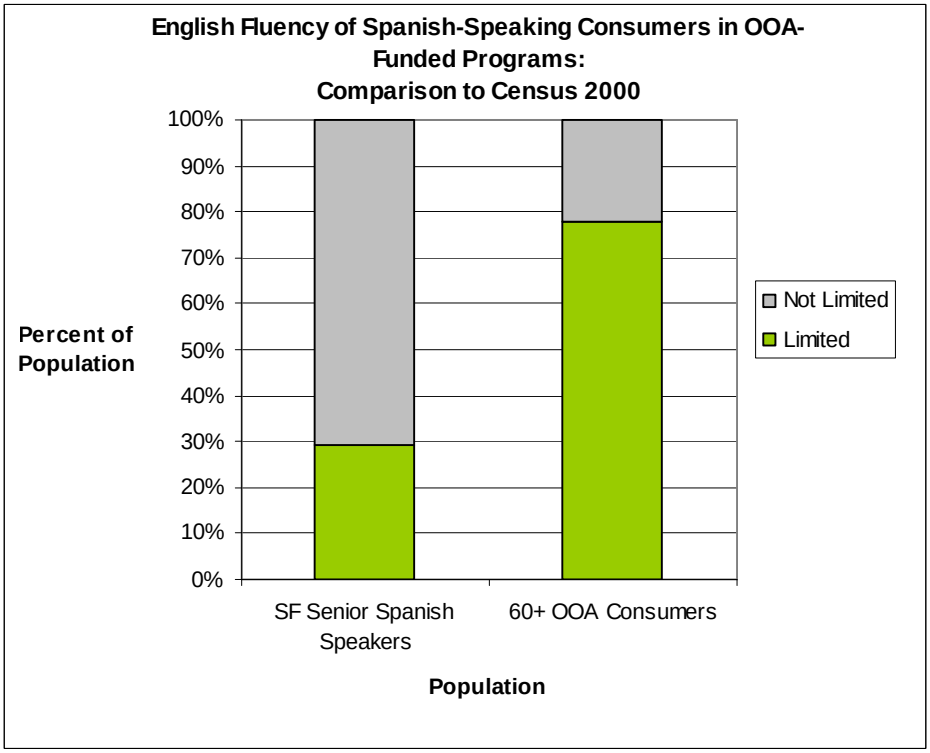

IHSS Consumer Demographics (May 2006)
(Total Seniors = 13,259; Total Younger Adults =3,517
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
9%
9%
32%
50%
11%
37%
29%
22%
Seniors (60+)
Younger Adults (<60)
Other
Hispanic
Black
White
Asian/Pacific Islander

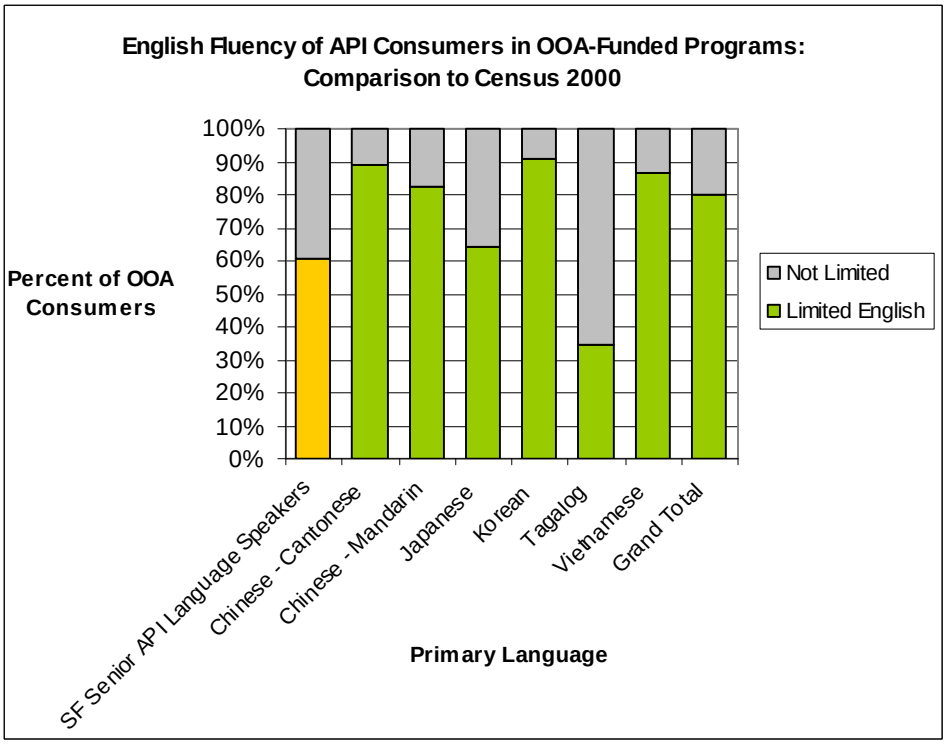
APPENDIX J: ENGLISH FLUENCY

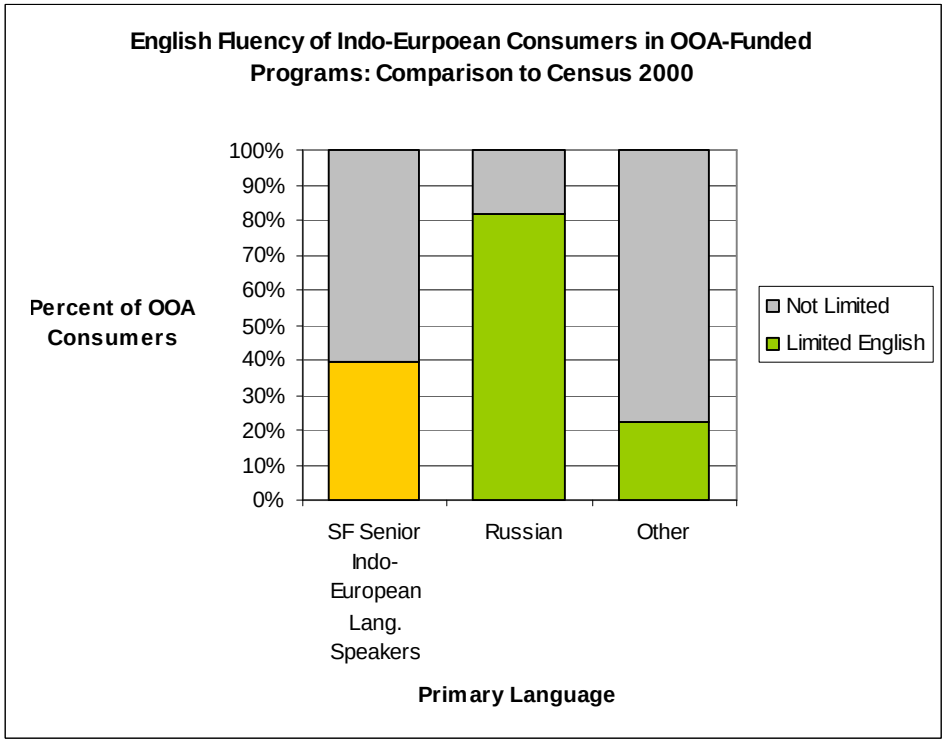
The following charts compare English fluency rates for seniors as measured by Census 2000 with reported English fluency of Office on the Aging program consumers. The first bar of each chart shows the Census fluency rate for seniors who speak the relevant languages. The next bars show fluency rates of OOA consumers for various languages.



The next pages provide detail for specific language groups.


English Fluency of Spanish-Speaking Consumers in OOA-Funded Programs:
Comparison to Census 2000
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percent of Population
Not Limited
Limited
SF Senior Spanish Speakers
60+ OOA Consumers
Population


English Fluency of API Consumers in OOA-Funded Programs:
Comparison to Census 2000
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Percent of OOA Consumers
Not Limited
Limited English
SF Senior API Language Speakers
Chinese - Cantonese
Chinese - Mandarin
Japanese
Korean
Tagalog
Vietnamese
Grand Total
Primary Language


English Fluency of Indo-Eurpoean Consumers in OOA-Funded Programs: Comparison to Census 2000
Percent of OOA Consumers
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
SF Senior Indo-European Lang. Speakers
Russian
Other
Primary Language
Not Limited
Limited English