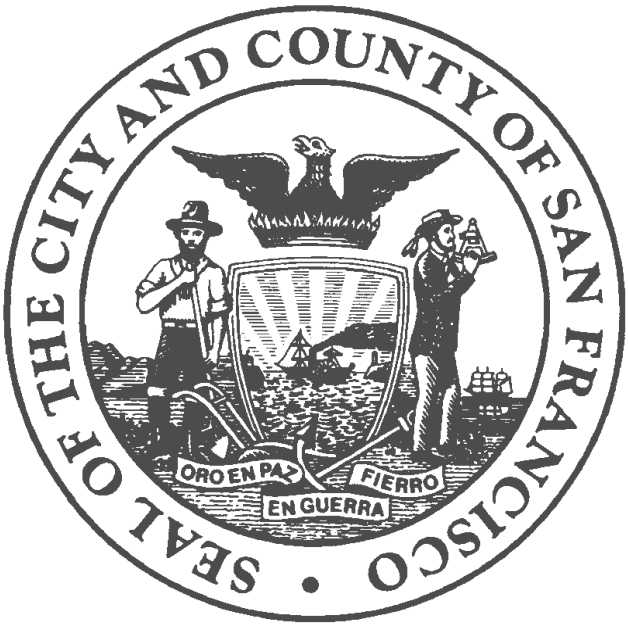

YEAR-END REPORT

AREA PLAN 2005 – 2009

FY 2008-09

DEPARTMENT OF AGING AND ADULT SERVICES
OFFICE ON THE AGING

TABLE OF CONTENTS
YEAR-END REPORT FY 2008-09

TRANSMITTAL LETTER: YEAR-END REPORT

AAA Name: City and County of San Francisco **PSA Number:** 06
Department of Aging and Adult Services/Office on the Aging

The Area Agency on Aging hereby submits to the California Department of Aging the Area Plan Year-End Report for Fiscal Year 2008-09.

This Year-End Report provides a retrospective account of the progress made by the Area Agency on Aging toward completing Area Plan Goals and Objectives. As the last Year-End Report for the 2005-2009 planning period, this report includes a discussion of the known impact of activities undertaken during the entire planning cycle and the status of Objectives set for the proceeding year.

The undersigned recognize the responsibility within each community to monitor systems of care in the Planning and Service Area (PSA) that address the needs of older individuals, their families and caregivers.

1. _____ Date_____
Gustavo Serina
President, Governing Board

2. _____ Date_____
Cathy Russo
President, Advisory Council

3. _____ Date_____
E. Anne Hinton
Executive Director, Area Agency on Aging

SECTION I: NARRATIVE OF SIGNIFICANT ACCOMPLISHMENTS

Introduction

The Area Plan Year-End Report is a public document that describes the key activities, major achievements and any significant difficulties encountered by the Department of Aging and Adult Services' Office on the Aging (DAAS/OOA) and related long-term care planning and programming entities during the past year. The report serves as an annual report. Its completion is a requirement of the California Department of Aging (CDA), which mandates that certain topics are addressed. The Year-End Report is submitted to the Board of Supervisors in accordance with the City Charter.

The OOA, formerly the Commission on the Aging (COA), is one of the divisions of the City and County of San Francisco Department of Aging and Adults Services (DAAS). DAAS is the designated Area Agency on Aging (AAA) for San Francisco. The OOA is the division implementing the mandate of the Older Americans Act, and in that capacity, it serves as the planning, advocacy, service coordination and systems development body for services for older persons. In 2000, the OOA began implementation of providing OOA-funded services to adults 18 to 59 years of age with disabilities.

The Year-End Report reaffirms the important role of the AAA as the advocate, planner, and administrator of programs for seniors and their caregivers, and adults with disabilities in San Francisco. The CDA requests that the status of each Area Plan goal and objective be clearly described. The Goals and Objectives section presents the progress toward accomplishing these work objectives as of the end of FY 2008-09.

When the abbreviation OOA is used in the Area Plan Year-End Report, it refers to the seven Aging and Adult Services Commissioners, the DAAS Advisory Council members, OOA-funded services providers, volunteers, consumers and OOA staff, all of whom work together to fulfill the Area Plan objectives.

Advisory Council to the Commission on Aging and Adult Services Report

The Advisory Council to the Commission on Aging and Adult Services continues to meet monthly and present a report at the monthly Commission Meeting.

The Council Legislative Committee meets monthly and now makes a report at the Commission Meeting. Bills relating to seniors and disabled adults are reviewed and, with Council approval, letters of support or concern are sent to Legislators. As an example, letters were sent to our local legislators supporting AB392 to restore Ombudsman Funding. On a local issue, the Council worked with the Commission to draw up a resolution requiring the closure of sub-acute beds to be put on hold while a comprehensive citywide health planning program could evaluate the need for post-acute services.

The Council and DAAS jointly sponsored a successful Boomer Research Forum in October 2008. Members put in many hours on research, discussion, and organizing.

A new Resource Center System was implemented in San Francisco. The Council met with the Director for a review of the new system and found it well organized. We recommended outreach to community members who served on advisory boards for the former Centers as we had heard expressions of resentment over being left out of the planning and implementation process. An effort has been made by the Center to communicate with the community residents in each area.

The Council had a presentation by the "Living With Dignity In San Francisco Program" and was impressed with the cooperation of programs and agencies in coordinating services. We also reviewed and approved the Draft of the Area Plan for 2009-2012. It was observed that the plan implementation was improved by the close association of DAAS with the Living With Dignity in San Francisco Program.

Ethics Training is scheduled each year. The Orientation Program is in the process of re-organization. The Council has worked closely with the Commission Nominating Committee in filling vacancies particularly supervisory appointments.

The past year has been one of increasing concerns over cuts in funding for social and health programs resulting in cuts in staffs and services. The In Home Supportive Services cuts are the latest danger to the senior and disabled adults. It is the Council's responsibility to assist in the identification of the needs and priorities of seniors and younger adults with disabilities who reside in our area. We are using our site visits as a means of monitoring the effects of the reduction in services. Members are also contacting residents and providers in their immediate communities. We have placed a priority on establishing positive, cooperative working relationships with our supervisors. Teams have been set up for each supervisory district and will be setting up appointments.

Highlights of OOA Accomplishments/Achievements

Aging and Disability Resource Connection (ADRC)

Early in 2008, San Francisco Department of Aging and Adult Services (DAAS) partnering with the Independent Living Resource Center San Francisco (ILRCSF), was selected to be one of the two new ADRCs in California.

A key part of the goals and objectives of this grant is to enhance Information and Assistance (I&A) services, to provide more information and outreach about long-term care options as a requirement of the Administration On Aging grant.

Under the umbrella of this new ADRC, DAAS Integrated Intake Unit, ILRCSF, and the ten Resource Centers for Seniors and Adults with Disabilities worked together to reach diverse communities in San Francisco. The ADRC collaborative has promoted independent living, and helped develop strategies for spreading independent living principles and resources into the aging resource networks. The ADRC engaged in a series of training programs for the providers in the aging and disability networks, better equipping staff to help consumers make informed choices. ILRCSF also collaborated with the Ombudsman program in cross-training of staff and volunteers, and also worked with Ombudsman volunteers to identify nursing home residents and advocate for their transition to the community.

The ADRC also worked with the San Francisco Partnerships for Community-based Care and Support (which includes: African American, Asian/Pacific Islander, Latino and Lesbian, Gay, bisexual and Transgender Community Partnerships) to develop an outreach and marketing plan and implement outreaching events and activities, to enhance coordination between the senior services and disability services providers.

Although the funding of this grant ended on June 30, 2009, our work and partnerships between the senior and disability communities has continued.

Aging and Disability Resource Center

As an outcome of the vision and collaborations created for the ADRC project, OOA changed our Resource Center Model. We issued an RFP in FY 08-09 and an award was made to Episcopal Community Services to create a new Aging and Disability Resource Center starting July 1, 2009. The ADRC (Center) and its outstations will provide the following services: (A) provides individuals with current information on opportunities and services available to the individuals within their communities, including information relating to housing, transportation, food assistance, assistive technology etc; (B) assesses the problems and capacities of the individuals; (C) links the individuals to the opportunities and services that are available; (D) to the extent practicable, ensures that the individuals receive the services needed, and are aware of the opportunities available by establishing adequate follow-up procedures; and (E) provides assistance and translation in filling out forms.

Family Caregiver Support Program (FCSP)

In fiscal year 08-09 OOA contracted with Family Caregiver Alliance and Kimochi Inc. for Caregiver Support Services and Edgewood Center for Kinship Services. Highlights of those activities are provided below.

Family Caregiver Alliance and Kimochi provide services to informal (unpaid) caregiver of adults sixty and older. Services provided include community outreach and education, counseling, support groups, respite care, legal services and bilingual service in Spanish and Japanese.

In fiscal year 08-09 a total of 665 caregivers received services. Of those served 41% were employed either full time or part time and 13% are taking care of more than one person. A total of 7,644 hours of respite services were provided by the contractors as well as 560 hours of counseling and 225 hours of information and assistance services to mention a few of the services provided.

In fiscal year 08-09 OOA contracted with Edgewood Center for Kinship services. This program provides services to grandparents or other relative caregivers (age 60 and over) who are caring for grandchildren or minors (18 years or under) related to the caregiver.

In fiscal year 08-09 220 relative caregivers received services from Edgewood. One hundred (100) caregivers attended support groups in English, Spanish, and Chinese. Other services provided include case management, food pantry, community outreach and information and assistance.

An Alzheimer's and Dementia Summit was conducted as a special project of the FCSP on July 8, 2009 to provide valuable information and education to family caregivers and others involved in caring of the Alzheimer's or demented people. It was a very successful event. Details are described in Section II.

Health Insurance Counseling and Advocacy Program (HICAP)

Organizationally, the San Francisco HICAP was strengthened by the hire of a competent team builder and a knowledgeable health care professional, approximately mid year. Through her efforts there was an increase in morale among existing volunteer counselors and an increase in the number of volunteer counselors recruited and trained. Paid staff has a strong, consistent presence in most San Francisco neighborhoods.

A summary of HICAP quantifiable accomplishments in FY 2008-09 include:

- Total Clients Counseled = 1296
- Clients Counseled had Limited English Proficiency = 695 (or 54%)
- Total Non-Counseling Quick Calls = 7483
- Total # of Volunteer Counselors at start of FY 2008-09 = 6

Total # of Volunteer Counselors at end of FY 2008-09 = 11
Several potential Volunteer Counselors were identified and are still in training as of October, 2009.

- Total # of Volunteer Counseling Hours = 513
- Total # of Paid Staff Counseling Hours = 1250
- Total # of Clients with Medicare Due to Disabilty = 214

San Francisco HICAP established many new key relationships within the aging and disability network. One in particular is working with the Aging and Disability Resource Center (as it was developing and then later implemented in July 2009). Another relationship, in particular, was with the Independent Living Resource Center San Francisco and this is credited with increasing service to clients that are living with a disability.

There is a diversity of languages, cultural backgrounds and sexual orientation among the new and potential volunteers recruited, reflecting the diverse population in San Francisco. While the Asian community was served in previous years, we see a dramatic increase in the percentage of Asians served during FY 2008-09 which is in alignment with the ethnic demographics in PSA 6.

Nutrition Programs

Nutrition Services for Seniors

We were on target with our contract goal and served 795,154 Congregate Meals to 14,805 seniors at 48 meal sites throughout San Francisco. These meals were provided by 15 nutrition providers with nine different types of meals (African-American, Chinese, Filipino, Japanese, Kosher, Korean, Latino, Russian, and Western-style meals).

We exceeded our contract goal by 10.3% (or 96,094 meals) and delivered 1,025,585 Home-Delivered Meals (HDM), including 563,921 modified diet meals, to 3,393 unduplicated seniors by eight nutrition providers. Nine different types of meals were served: Latino, African-American, Chinese, Russian, Japanese, Filipino, Kosher, Western and modified diets. Due to concerted efforts by DAAS Long Term Care Intake and Screening Unit, and local funding through the Community Living Fund, the average wait time for HDM service had significantly reduced from our target of 60 days to actual of 26 days.

65,855 units of Nutrition Education were presented to Congregate Meal Program participants. 12,616 sets of Nutrition Education materials were given to Home-Delivered Meals recipients. 1,070 hours of Nutrition Counseling were provided in 2,003 sessions to homebound seniors by two agencies.

Nutrition Services for Adults with Disabilities

Six different congregate meal nutrition contractors provided a total of 11,470 congregate meals to an unduplicated count of 401 adults with disabilities.. We provided 2,105 more meals or 22.5% higher than last fiscal year.

Four Home-Delivered Meals (HDM), contractors delivered a total of 82,741 meals for Adults with Disabilities to 204 unduplicated clients**.** We provided 1,991 more meals or 2.5% higher than last fiscal year. For FY 2008-09 Institute on Aging provided a total of 201 intakes for HDM-YAD, conducted a total of 174 reassessment and 123 initial comprehensive assessments for program clients.

Single Room Occupancy (SRO) Food Outreach Program

OOA provided funding to continue the SRO Food Outreach Program. This program is a collaboration between the San Francisco Food Bank (SFFB) and Chinatown Community Development Center (CCDS). SFFB helped to provide culturally appropriate supplemental food, while CCDC provided staffing and volunteers to administer the program on-site to consumers.

This program provided weekly supplemental groceries to homebound and/or very frail residents of five single-room occupancy (SRO) hotels in the Chinatown area. This program targeted to serve residents in five hotels managed by Chinatown Community Development Center. These SROs are located in Chinatown at: 665 Clay Street, 657 Clay Street, 523 Grant Avenue, 1527 Grant Avenue, and 534 Broadway.

In FY 2008-09, 170 unduplicated consumers are provided a weekly supplemental grocery, which is valued at $20 or more per bag. A total of 8,646 bags of grocery valued at $170,100 were distributed to senior participants. An average of 7 youths and 5 adults volunteered weekly on this project, including helping to deliver the grocery bags to the participant's home. An annual total of 133 volunteer hours (youth and adult) assisted with this program.

Health Promotion Program

Chronic diseases affect 88% of older adults and cause limitations in activities of daily living. People from low income and people of color are at greater risk of many chronic diseases. One of the goals for the health promotion program is to implement evidence-based programs which have been proven to be effective in reducing older people's risk of disease, disability and injury and to empower people to take more control over their own health through lifestyle changes. During FY 2008-09 OOA continued to support and expand the implementation of evidence-based health promotion programs through the following two programs.

Always Active[SM] Program

30[TH] Street Senior Center serves as the lead agency in a citywide, evidence-based health promotion program, called **Always Active** [SM], in collaboration with experienced providers. They are: the University of San Francisco's Department of Exercise and Sport Science (USF ESS), San Francisco

Senior Centers, Inc., and nine different senior services organizations. The health promotion program offers:

- Ongoing group exercise classes for strength training, balance and flexibility designed for older adults
- Fall Prevention Workshops designed for frail older adults
- Health and Wellness Education Presentations
- Capacity Building Training
- Wellness Trainer Workshop
- One-on-one consultation with professional personal trainers
- Wellness plan development

Nine (9) organizations participated in the Always Active ^{SM} program during this contract period, including: Aquatic Park Center, Capp Street Senior Center, Excelsior Senior Center, Castro Senior Center, Catholic Charities CYO-OMI Senior Center, Downtown Center, 30th Street Senior Center, Community Learning Center at St. James, and Self-Help for the Elderly.

Summary highlight of services provided FY 2008-09:

- Total of 614 unduplicated consumers served, which is 157 units or 34% over last fiscal year.
- 15,827 consumers served through presentations and classes, which is 5,470 units or 53% over last fiscal year.
- 660 consumers received individual fitness consultation, which is 110 units or 20% over last fiscal year.
- 702 wellness program outreach conducted
- Certified 24 Wellness trainers to work with seniors
- Conducted eight 4-hour Wellness Trainer Workshops
- 63 older adults participated in the Falls Prevention Classes

Healthier Living-Managing Ongoing Chronic Health Conditions

This is another evidence-based health promotion (EBHP) program that OOA is actively involved. An OOA staff has continued to participate in the EBHP Initiative Statewide Steering Committee The program consists of a series of 2 ½ hour workshops presented over a 6-week period by two trained leaders, one or both of whom are non-health professional with a chronic disease themselves. This award-winning program was developed by Stanford University. The curriculum includes workshops and appropriate behavior modifications and coping strategies to enable the participants to manage their chronic diseases and medications and increase physical activity levels. The program enables the participants to work on effective communication skills with family, friends, and health professionals.

20+ years of federal research showed that the Healthier Living program significantly improves people's lives and reduces health care costs with very small program investments. Studies show the reductions in healthcare costs will pay for Healthier Living within the first year.

OOA, collaborated with six community partners, including Partners in Care Foundation, Canon Kip Senior Center, Centro Latino de San Francisco, Curry Senior Center, Self-Help for the Elderly, and St.

Francis Memorial Hospital, to co-sponsor eight Healthier Living workshops and one Leader Training workshop during FY 2008-09. 131 consumers were enrolled in the Healthier Living workshops and 91 older adults successfully graduated from the program.

Keeping Seniors Connected- Digital TV (DTV) Project

OOA partnered with Self-Help for the Elderly to apply for a DTV grant from n4a, and was awarded $35,000. The purpose of the grant was to assist seniors and adults with disabilities transition from an analog signal to a "digital" signal for their TV. As of June, 2009, older televisions that were not able to receive a digital signal would no longer have any reception without a "converter box".

In 2009 we were able to assist 1,750 older adults and adults with disabilities obtain converter boxes and assist 2,156 older adults install converter boxes. Through an intensive outreach and media campaign we reached 20,311 older adults to provide assistance with coupon applications, tracking and troubleshooting coupon problems.

Approximately 60% of the consumers served in this program were monolingual Chinese speaking seniors. They received bilingual information and referral services as well as installation of DTV boxes by a bilingual technician. Many of the consumers served live in SRO's (single room occupancy hotels) rooms where they do not have an individual address and thus did not receive a converter box coupon in the mail. Self Help for the Elderly found many creative ways to serve this poverty level population, who would be extremely isolated without access to TV. This program was unique and very successful exceeding all contracted goals by a significant margin.

During the year, the program officer from NTIA which is the funder of this program, came for a site visit on this project. During her visit she visited a SRO in Chinatown for an installation of a DTV box. She was very impressed with the service provided by the bilingual technician under very difficult circumstances in a cramped one room occupancy! Until this visit the NTIA was not aware of the particular concern of SRO residents not having a designated address and thus not being able to apply for a DTV converter box coupon. As a result of this visit, this issue was brought up at a White House briefing on the DTV transition process.

Meals on Wheels of San Francisco (MOWSF) also administered an independent DTV Project with other resources. The project was also very successful. The agency was able to assist 113 clients with DTV conversion. MOWSF installed a total of 110 converter boxes. 88 antennas were provided to the seniors of its Home-Delivered Meals program. The program officer from NTIA was also very impressed with the commitment and hard work of this agency.

DAAS Long-Term Care and Intake Screening Unit (DAAS Integrated Intake Unit)

The DAAS long term care (LTC) and intake screening unit serves as a comprehensive intake service, determining the long term care needs of individuals. The unit provides referrals and information for consumers that help support their current level of independence and functioning. The intake unit is

knowledgeable in all community and institutional services for all seniors and adults with disabilities, regardless of their economic status. Screening and referrals are taken for In-home Supportive Services (IHSS), home delivered meals, the Community Living Fund (CLF), and Adult Protective Services (APS). Other screening needs not met by the department are referred to appropriate community or institutional sources. By having a one-stop application shop for DAAS services, staff recognize needs beyond the original concern or request. Staff generate multiple referrals at once, also referring out to community partners that serve the long term care interests of the individual.

The Intake Unit also performs the function of home-delivered meals (HDM) clearinghouse. DAAS Intake staff take home delivered meal referrals for people age 60 and above, monitoring a city-wide waiting list. The intake unit works closely with all OOA funded HDM providers, making sure that new cases are picked up by providers in a timely manner. Intake staff are knowledgeable about risk issues, able to prioritize emergency nutritional needs. If a referral requires an emergency response, the DAAS Intake supervisor coordinates with meal providers to serve a meal immediately. In addition, because the DAAS Intake unit takes referrals for In Home Supportive Services and Adult Protective Services, other emergency or long term care services are coordinated. On a monthly basis, staff call HDM waitlist clients to see if their needs have changed or if they have found alternative means of meeting their nutitrional needs. Staff also work with referents in exploring other alternatives to HDM, including meal pantries, congregate meal sites, and grocery delivery services.

The Intake Unit has also taken on a significant leadership role in coordinating the various I and R efforts and in disseminating information more widely in the community.

SECTION II: SUMMARY OF IDEAS

This section describes a summary of work done to generate recommendations related to service system changes based on the surge in the growth of the aging population in San Francisco.

Baby Boomer Research Forum

After releasing a report that included a research review and demographic analysis of San Francisco's local baby boomer demographic trends, a task force of the department and the Advisory Council hosted a Baby Boomer Research Forum in October 2008. The forum was open to service providers, researchers, and boomers themselves. It included and presentation of the initial report's findings, followed by breakout sessions on Healthy Aging, Home Care Workforce, Boomer Mental Health and Volunteer Management. Over 100 people attended the event, and evaluations showed high marks. The final portion of the program encouraged participants to discuss ideas for engaging and serving the baby boomer generation in San Francisco. In that discussion, participants suggested that San Francisco should:

- Provide intergenerational program models (e.g., gym settings for fitness activities over exercise classes at a senior center);
- Promote prevention programs, such as mental and physical health promotion;
- Learn from what other San Francisco organizations are already doing with respect to innovative programming (including both non-profit and for profit organizations);
- Learn about new service models by looking at examples in other cities (like Beacon Village in Boston) and other countries;
- Promote aging- and disability-friendly communities; and
- Find new mechanisms/models for providing venues for people to socialize (e.g., "conversation clubs," such as those formed in Belgium, may be more attractive to people who are not "joiners" than the traditional venue of the senior center.

Development of a Strategy for Excellence in Dementia Care

San Francisco is facing a crisis in the dementia care. In the San Francisco Bay Area, one out of every two persons 85+ has some type of dementia. Between now and 2020, San Francisco will experience a dramatic increase in the number of its citizens with Alzheimer's disease and other dementias. While advances are being made for the treatment of Alzheimer's disease and related dementias, currently there is no cure and treatments can only slow dementia's progression, not stop it or ease its symptoms, and not eliminate them. The human and fiscal burdens imposed by dementia are extraordinary. Demographic projections make clear that as the oldest segment of our adult population doubles over the next 20 years, the demand for services and supports will far outstrip our current capacity. To avoid a catastrophic human and fiscal crisis of unparalleled scope, significant changes in education and training, caregiver support, diagnosis, service delivery, fiscal regulations, and policy are essential.

The Long Term Coordinating Council's (LTCCC) Behavioral Health Access Workgroup conducted an initial investigate of these dementia care issues in 2007. That workgroup recommended that the Mayor's Office "establish a Dementia Care Task Force to evaluate service

needs and make recommendations for how to address the demand for additional services." The findings from the workgroup's initial investigation formed the foundation for a more detailed investigation.

A separate study conducted on behalf of DAAS, *San Francisco Baby Boomers – A Breed Apart?*, was released in July 2008. It projected a growing baby boomer population bubble about to explode in San Francisco. The baby boomer study used data from the July 2007 State Department of Finance population projections, which estimate that the total senior population age 65 and older will increase by 23 percent by 2020 and by 73 percent by 2030 as compared to 2000 Census figures. Combining those projections with prevalence rates from the Alzheimer's Association yields the following estimates as compared to 2000 Census figures:

- By 2020, the projected number of San Franciscans with dementia will increase by nearly 30 percent or almost 6,000 people, with almost all being over 85. That older old population is most likely to be suffering from advanced dementia, requiring more services, supports and institutional care.

- By 2030, the aging baby boomers in San Francisco is projected to swell the population age 65 to 85 from 13 to 18%. The population of "older old" seniors in San Francisco (age 85+) is projected to nearly double by 2030, more than half of whom are likely to have some form of dementia.

These projections indicate a significant and growing demand for services and supports is developing. It is evident that a growing number of San Franciscans will need a range of services and supports either because they are cognitively impaired or are caring for a loved one who is.

Collectively, the baby boomer analysis and the Behavioral Health Access Workgroup recommendations raised concerns that a human and fiscal crisis of staggering proportion related to dementia care is imminent. Mayor Gavin Newsom formed an Alzheimer's/Dementia Expert Panel in November 2008, and they investigated the growing crisis between December 2008 and May 2009. The charge for this Panel was to evaluate current dementia care services, assess the need for additional services, investigate national and international research and best practice models, and develop a plan and recommendations to address the need for services during the next 11 years (to 2020), including an analysis of projected costs. Their plan, *2020 Foresight: San Francisco's Strategy for Excellence in Dementia Care*, was designed to serve as a roadmap for local policy makers, administrators, advocates, service providers, and caregivers.

DAAS led and managed the planning process for the *Strategy for Excellence in Dementia Care*. In December 2008, DAAS convened the Alzheimer's/Dementia Expert Panel appointed by Mayor Newsom, which was comprised of a blend of Alzheimer's experts, aging experts, medical care providers, community-based service providers, advocates, researchers, economic experts, public agency administrators, and family caregivers. The diversity of the Panel ensured varied perspectives were incorporated throughout deliberations. San Francisco is blessed with an extraordinary level of local dementia-related expertise respected throughout the nation, with experts in research, policy, public administration and service provision.

The Expert Panel created four subcommittees where more substantive discussion of a wide range of issues could occur, with the subcommittees reporting their findings back to the full Panel. The four subcommittees included:

- ***Evidence Based Practice & Emerging Research***, which reviewed findings from the most recent research regarding dementia, including: (1) evidence-based best practices for: dementia care services, treatment, and prevention; (2) the role of the family and the larger community; (3) strategies to provide caregivers with support; (4) protective factors and prevention strategies; and (5) promising practices and emerging trends. This involved a national and international literature review.

- ***Services & Systems***, which enumerated San Francisco's existing dementia care services and supports (for mild, moderate and severe levels). The subcommittee considered additional services needed to care for adults with dementia. Categories of services enumerated include: (1) adult day services; (2) advocacy and protection; (3) care management; (4) caregiver services and supports; (5) diagnostic assessment; (6) education; (7) information and referral; (8) in home supportive services; (9) legal services; (10) mental health services; (11) money management services; (12) nursing care and hospital services; (13) ongoing medical treatment; (14) public policy; (15) research and development; (16) residential care; and (17) respite care.

- ***Finance***, which examined the cost of operations of the current network of dementia care services and supports. It considered the costs to: (1) expand existing services; and (2) implement new initiatives and services currently not in place in San Francisco. It then projected these costs forward 10-12 years to anticipate how the costs might change to meet the needs of the expanding population. The subcommittee also identified a range of funding resources that could be accessed to support the recommended model system of dementia care services.

- ***Education & Prevention***, which developed a range effective educational programs for community members regarding dementia. Protective factors including brain fitness and risk factors, early identification and early access to services were evaluated. Recommendations consist of a total of nine content areas for education. Many of the content areas are also intended to address issues related to stigma regarding dementia. The subcommittee also addressed the need for educating professionals (e.g. doctors, psychiatrists, social workers, nurses, caregivers-paid and family), and others who find themselves dealing with those who should be providing more in terms of care.

Earlier, in September 2008, DAAS retained a research team consisting of: (1) Gibson & Associates, (2) Resource Development Associates, and (3) the Mental Health Association of San Francisco. This team worked with the Expert Panel and DAAS staff to research best practice models for dementia care, undertake an evaluation of the City's dementia care services, explore the need to improve existing services, and prepare a plan and recommendations to address the demand for services during the next 11 years (2009 to 2020). Specifically, the research team:

- Facilitated all Expert Panel meetings;
- Supported the work of all subcommittees;

- Compiled a review of the literature, identifying evidence-based research, promising practices, and emerging trends, for each type of dementia-related service, and facilitated the Evidence-Based-Practice and Emerging Research Subcommittee's consideration of these findings;
- Conducted 42 key informant interviews with policy makers representatives of public and private agencies and more than 25 caregivers and caregiver organizations. The objectives were to: 1) improve understanding of the demographic context of the current demand for the full spectrum of services and supports needed for all stages of cognitive impairment; 2) appreciate how effectively the current array of services is meeting the existing demand; and 3) shed light on the current state of family and informal caregiver support. Through this work, and the work of the Services & Systems Subcommittee, developed an inventory of services for each stage dementia;
- Analyzed a variety of statistical models for capturing current costs and projecting future costs of caring for individuals with dementia; and
- Prepared the initial draft of the final report.

Over the seven month planning process, the Expert Panel discussed the strengths and weaknesses of the current service delivery network, identified principles and concepts that should characterize how San Francisco addresses the crisis in dementia care, and

- Developed a mission statement and vision statement, and a list of core values that are to guide implementation of the plan;
- Reviewed the summary of the research developed by the research team and vetted by the Evidence-Based Practice & Emerging Research Subcommittee;
- Evaluated an analysis of current costs for services and projected costs as the population of older adults grows over the next 20 years completed by the Finance Subcommittee;
- Learned from the Services & Systems Subcommittee about its summary of the current available dementia services and supports; and
- Reviewed the report from the Education & Prevention Subcommittee for extensive training and education.
- Made program and policy recommendations to improve dementia care services and develop new services as necessary.

DAAS staff and the research team used notes from all Expert Panel and subcommittee meetings to generate a preliminary list of 25 recommendations that were considered and revised by the Expert Panel. Subsequently, a list of 12 new recommendations was considered with all but one being advanced to this report. Once the recommendations were identified and approved, DAAS staff and the research team worked collaboratively in developing the recommendations and *San Francisco's Strategy For Excellence in Dementia Care,* identifying models cited in the literature review, clarifying necessary implementation steps, and identifying partners and resources necessary to implementing each recommendation.

The research team prepared the initial draft *Strategy*, which was revised, edited, formatted, and completed by DAAS staff, with continuing participation from research team members. The draft was reviewed by DAAS leadership and Expert Panel members. Finally, it was examined by an external

review team. The final version of *San Francisco's Strategy for Excellence in Dementia Care* is due for publication in November 2009.

Alzheimer's and Dementia Summit

A city-wide summit held on July 8, 2009 in City Hall highlighted findings and recommendations in the plan of the Alzheimer's/Dementia Expert Panel to address the crisis in dementia care, and provide valuable information and education targeting family caregivers and others involved in the care of people with Alzheimer's/dementia in a one-day format. Approximately 300 people attended this summit.

The morning session showcased the final report and recommendations of the Expert Panel, and included a panel discussion led by Anne Hinton, DAAS Executive Director, with caregivers and people with dementia. A UCSF neurologist, Adam Boxer, presented the latest research in the treatment of Alzheimer's and related dementias. Also, challenges and resources for caregivers were presented.

The afternoon session addressed family caregiver issues including: (1) the stigma regarding older adults and dementia: (2) culturally competent methodologies of supporting caregivers, and education and prevention methodologies necessary to address the diversity of San Francisco's population; and (3) the need for the education of professionals e.g. doctors, psychiatrists, social workers, nurses, and others who find themselves working closely with people with Alzheimer's/dementia and their family caregivers.

(Note: The entirety of the morning session continues to be screened on SFGOV-TV CHANNEL # 78 twice each week at these times: Sundays, 3:00 p.m.; and Wednesdays, 1:00 p.m. Closed captions are available. The Program is also available on the City's website by streaming video at: www.sfgovtv.org Click "View Additional Programs"; then "City Summits"; then "Alzheimer's/Dementia." Captioning transcript is also available online.)

SECTION III: STATUS OF GOALS AND OBJECTIVES

Goal One: To increase utilization of services by seniors, adults with disabilities and caregivers who have the highest economic and social needs			
Rationale: San Francisco has the highest per capita rate of homelessness in the nation, and 7% of persons using homeless shelter are age 60 or older. OOA objectives have not addressed this population in the past			
Objective 1.1 The OOA staff will work with their contractors, homeless shelter staff and outreach coordinators, and Single Room Occupancy hotels housing formerly homeless seniors to share resource information and increase the overall number of homeless and formerly homeless seniors receiving OOA services by 50%. *2006-07 Update:* One of the OOA contractor agencies, also an active member of SPAC, has headed the outreach effort by conducting presentations at three SRO's, a homeless shelter and a drop-in center. A data match of 2004-05 OOA consumers with San Francisco shelter consumers shows that at least 178 shelter clients also received OOA services. *2007-08 Update:* The HSA Planning Unit has used improved data sources to identify a more comprehensive baseline figure for the number of homeless or formerly homeless consumers receiving OOA services. In FY2006-07, the OOA also funded a drop-in for homeless seniors, serving approximately 300 individuals. *2007-08 Year-End Status:* Objective completed. For FY0607, the OOA database showed 304 homeless seniors had enrolled in services. The original baseline for this objective was 178, and this shows a 71% increase. (Data tracking systems have changed since the first measurement of these figures, which can make historical comparisons difficult, however.)	**Start & End Dates** 7/1/05-6/30/08	**Title III B Funded PD or C**	**Status** Completed

Goal One: To increase utilization of services by seniors, adults with disabilities and caregivers who have the highest economic and social needs			
Rationale: Current service providers do not utilize the range of caregiver support supplemental services that they can be funded for.			
Objective 1.2 The OOA will meet with community-based organizations to improve understanding of the variety and scope of services, particularly the supplemental services funded through the Family Caregiver Support Program, as well as feasible models of service delivery, and it will work with the Human Services Agency contract staff to develop a Request for Proposals that will address the various needs of caregivers. *2006-07 Update:* OOA staff worked with service providers and coordinated a presentation on the FCSP on Jan 25, 2006. Completed.	**Start & End Dates** 7/1/05-6/30/06	**Title III B Funded PD or C**	**Status** Completed

Goal One: To increase utilization of services by seniors, adults with disabilities and caregivers who have the highest economic and social needs			
Rationale: In interviews with key service providers, it was noted that many seniors and persons with disabilities are living in Single Room Occupancy hotels that have no elevators and are consequently homebound.			
Objective 1.3 The Human Services Agency planning unit will coordinate with the OOA staff, home-delivered meal providers, and outreach workers to assess the prevalence and the needs of seniors and younger adults with disabilities who are living in Single Room Occupancy hotels without elevators. The recommendations from this analysis will be incorporated into the ~~2006-07 Area Plan update~~ summary of the 2006 Needs Assessment. *2006-07 Update:* The Human Services planning unit obtained a list of Single Room Occupancy hotels (SROs) in the Chinatown district from the city Department of Building Inspections, and the state department of elevator inspections identified which buildings had elevators. Of the 297 SROs in Chinatown, only 9 had elevators (3%). The planning unit matched Medi-Cal caseload data with IHSS data for persons with mobility impairments, identifying vulnerable persons living in the SROs. The unit is preparing to administer a survey of this population in 2006-07. *2007-08 Update:* The Human Services Agency planning unit mailed a translated survey instrument to 336 IHSS recipients with disabilities who were living in Chinatown SRO's. The survey, which was discussed in the DAAS Community Needs Assessment, found seniors with disability impairments in Chinatown SRO's living in extreme isolation. One finding was that 40% of the respondents left their homes once a week or less. Completed.	**Start & End Dates** 7/1/05-6/30/07	**Title III B Funded PD or C**	**Status** Completed

Goal One: To increase utilization of services by seniors, adults with disabilities and caregivers who have the highest economic and social needs			
Rationale: Interviews with key service providers and subsequent surveys have revealed that seniors and persons with disabilities who live in Single Room Occupancy hotels in Chinatown are often very isolated from services and social opportunities.			
Objective 1.4 The OOA staff will coordinate with community-based organizations to pilot a new initiative that reduces isolation and provides additional nutrition to seniors and younger adults with disabilities who live in at least two Single Room Occupancy hotels in Chinatown. *2007-08 Year-End Status:* The SRO food project has been implemented effective April 2007. Chinatown Community Development Center (CCDC) and San Francisco Food Bank (SFFB) have collaborated to provide food pantry service to the tenants living in five Single Room Occupancy Hotels (SRO) in Chinatown. In FY 2007-08, 175 unduplicated consumers received a weekly grocery bag, and an average of 20 volunteers participated in food distribution weekly. *2008-09 Update:* CCDC and SFFB continues to collaborate to provide food pantry service to the tenants living in five SRO hotels in Chinatown. *2008-09 Year-End Status*: *:* CCDC and SFFB continues to collaborate to provide food pantry service to the tenants living in five SRO hotels in Chinatown. A total of 8,646 bags of supplemental grocery with total estimated value of $170,100 were distributed 170 unduplicated consumers. A total of 79 youths and 55 adults volunteered to make this program a success.	**Start & End Dates** 5/1/07-6/30/09	**Title III B Funded PD or C**	**Status** **Continued**

Goal One: To increase utilization of services by seniors, adults with disabilities and caregivers who have the highest economic and social needs

Rationale: The *Living with Dignity Strategic Plan* identified the necessity to explore and address the service needs of isolated older adults and adults with disabilities in senior/disabled public housing. The San Francisco Housing Authority (SFHA) operates 23 senior/disabled public housing buildings with 2,300 seniors and adults with disabilities. Many of these people have access to few supportive services.

Objective 1.5	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
DAAS will expand its Services Connection Pilot Project to three new Housing Authority buildings. The Services Connection Pilot Project is a collaborative effort between DAAS, the SFHA, San Francisco's Resource Centers for Seniors and Adults with Disabilities, and community-based service providers. The purpose is to link seniors and adults with disabilities living in public housing with services provided in the community. The pilot project service teams will initiate contact with approximately 75 residents at each building. Of these residents, the pilot project will target to reduce unmet service needs for 50 percent of resident participants by November 2008. *2007-08 Year-End Status:* The project has expanded to serve five senior/ disabled Housing Authority sites. Northern California Presbyterian Homes and Services will be implementing the next phase of the initiative, using ROSS grant funding from HUD, in FY 08-09. *2008-09 Update:* The pilot project run by Planning for Elders in the Central City has come to an end on December 31, 2008. The new project is funded by a HUD ROSS grant and the City for 3 years, is operated by Northern California Presbyterian Homes and Services (NCPHS) which has begun its start-up phase on August 1, 2008. NCPHS will hire and train four Service Coordinators to be placed in five San Francisco Housing Authority senior and disabled buildings with a combined total of 545 residents. 2008-09 Year-End Status: NCPHS hired and trained four Service Coordinators and they are on duty at five San Francisco Housing Authority buildings serving senior and adults with disabilities. The total number of unduplicated consumers served during FY 2008-09 is 371. The consumers served received 2,747 units of service throughout FY 2008-09 (i.e., information, referral, assistance and follow-up).	2/1/08-6/30/08		**Continued**

Goal Two: To improve the quality and capacity of OOA-funded home and community based services

Rationale: The home-delivered meals program has a waiting list of over 350 isolated and vulnerable seniors and persons with disabilities, while some congregate meal sites are underutilized.

Objective 2.1	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
The OOA staff will meet with nutrition providers to identify the most efficient means of reallocating resources to reduce the waiting list for home-delivered meals. *2006-07 Update:* OOA staff has met to begin preliminary discussions of this issue. *2007-08 Update:* OOA staff met with Nutrition Providers in the second quarter of 06-07 to discuss this issue. Due to the efforts of contractors, the average waiting time for a HDM has been reduced slightly, from our target of 60 days to 59 days from January to June 2006. Due to change in OOA's database system, such reports are as yet unavailable for 2006-07. *2007-08 Year-End Status:* In July 2007, DAAS brought the HDM Clearinghouse functions in-house as part of the Integrated Intake unit, which improved the efficiency and quality control of the data. In June 2007 the HDM wait list had about 250 people. By the end of November 2007 this list was reduced to 150 people. Also for FY 2007-08, DAAS has allocated additional funding for more HDM meals. DAAS has just implemented an emergency HDM program by utilizing the Community Living Fund. This will further reduce the wait-list. Between March and June 2008, the wait list dropped from 118 to 95, including 32 clients being served by the new HDM emergency meal program. *2008-09 Update:* The DAAS Integrated Intake Manager and the OOA Nutritionist had met with providers to discuss and implement efforts to provide service as soon as possible. DAAS Intake unit has also undertaken a number of tasks to reduce the waiting list: The HDM emergency meal program has given food immediately to 66 people since the beginning of 2008, thereby reducing the waiting list. The intake unit also regularly monitors the waitlist, calling people who have been waiting for two months or more, to identity urgent needs as well as consumers who no longer need a home delivered meal. Intake staff have been trained in offering alternative resources to the consumers such as IHSS and congregate meal sites. The Manager and/or supervisor of Intake Unit review each referral, providing another layer of screening to make sure referrals are appropriate. Excluding the consumers currently being served an emergency meal, the HDM waitlist as of 12/29/08 is 122 people. *2008-09 Year-End Status*: All the work as stated above has continued. As of 10/13/09, 97 individuals are on the waiting list. Due to concerted efforts by DAAS Long Term Care Intake and Screening Unit, and local funding through the Community Living Fund, the average wait time for HDM service had significantly reduced from our target of 60 days to actual of 26 days.	7/1/05 - 6/30/09		Continued

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: The network of community based organizations providing services to seniors and persons with disabilities benefit from the work of volunteers, but smaller organizations often do not have the capacity to recruit, train, and recognize volunteers.			
~~**Objective 2.2**~~ ~~To recognize and motivate volunteer activity for OOA contractors, the Human Services Agency Planning Unit will survey OOA contractors regarding their use of volunteers and will present the findings to the Advisory Council to the Aging and Adult Services Commission to discuss possible system-wide volunteer recruitment and recognition activities.~~	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
	~~7/1/05 - 6/30/06~~		Deleted

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: Research studies demonstrate the benefits of living a healthy, active lifestyle, but many service providers have not incorporated physical activities into their programs.			
Objective 2.3 The OOA will promote increased physical activity among older adults by providing technical assistance and/or resources to service providers, resulting in at least 3 service providers adding a new physical activity class for seniors. *2006-07 Update:* As of April 2006, one contractor has added a physical activity class. OOA staff is working with other contractors to add classes. *2007-08 Year-End Status:* Objective completed.	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
	7/1/05 - 6/30/07		Completed

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: To ensure the overall quality of food services, service providers need assistance to meet stringent nutrition standards.			
Objective 2.4 The OOA will conduct quarterly nutrition meetings to provide technical assistance and share resources that will assist providers in meeting and/or improving food safety and nutrition program standards, and will complete at least four meetings with the nutrition contractors, and two trainings for the staff of nutrition programs on nutrition risk assessment. *2006-07 Update:* Three meetings have been conducted, with a final meeting scheduled for May 2006. The two trainings on Nutrition risk assessment are also scheduled for completion by June 2006. OOA staff plan on conducting the same schedule of meeting and trainings in 2006-07. *2006-07 Year-End Status:* The two trainings on nutrition risk assessment are planned for 07-08. These meetings were deferred from 2006-07 due to lacking of staff resources. *2007-08 Year-End Status:* Four nutrition contractor meetings had been provided as of June, 2008. A nutrition risk assessment training for nutrition providers was conducted in May 2008. *2008-09 Update:* Two nutrition contractor meetings had been held as of December 2008. *2008-09 Year-End Status:* Four nutrition contractor meetings were held as of June 2009 to provide nutrition resources and technical assistance.	**Start & End Dates** 7/1/05 - 6/30/09	**Title III B Funded PD or C**	**Status** Continued

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: Currently OOA-funded contracts tend to reflect "inputs" and activities rather than reflecting client-based outcomes that would allow measurement of program effectiveness.			
Objective 2.5 To improve services to its consumers, the OOA staff will work with OOA contractors to develop and implement measurable, client-based outcomes for all OOA-funded programs. *2006-07 Update:* All outcome measures are scheduled for completion and inclusion in contract scope of services by June 2006. Completed.	**Start & End Dates** 7/1/05-6/30/06	**Title III B Funded PD or C**	**Status** Completed

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: To improve the effectiveness and efficiency of its services, the OOA needs to better define its program standards and include them in the requests for proposals.			
Objective 2.6 The OOA will develop, in consultation with service providers and consumers, program standards for Community Services, ~~District-wide Social Service Workers,~~ and Legal Services that will be incorporated into the service definitions of the respective Requests for Proposals. *2006-07 Update:* Three workgroups will begin meeting in May and June 2006. *2007-08 Update:* Objective modified to remove DWSSW, as funding for that program will be folded into Case Management in FY 2007-08. The Community Services Standards have been drafted and will be given to Contractors for input before finalization in 2007-08. Legal Services providers will sign off on the new State standards when they become available (and add on any additional local standards that may be developed), finalizing all standards in FY 2007-08. *2007-08 Year-End Status:* The Community Services Standards were finalized in January 2008. The Legal Services providers met in January 2008 and discussed the goal of finalizing standards in 2008-09. *2008-09 Update:* CDA implemented a new California Uniform Reporting System (URS) for Title III B Legal Services Providers, effective July 1, 2008. OOA staff provided technical assistance to providers on the new reporting system. The new reporting guidelines and the 2005 statewide guidelines for the program will form a base for finalizing local service standards in 2008-09. 2008-09 Year-End Status: The Community Service Standards are in effect and program monitoring includes a review of service providers' adherence to the standards. Legal Service providers are operating under the Legal Service standards and have all conformed to the new California Uniform Reporting System by reporting required quarterly data. Objective completed.	**Start & End Dates** 7/1/05 - 6/30/09	**Title III B Funded PD or C**	**Status** Revised, Completed

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: To improve the effectiveness and efficiency of its services, the OOA, in consultation with the California Department of Aging, is working to standardize and institutionalize program standards for care management and include them in its requests for proposals.			
Objective 2.7 The OOA staff will fully implement program standards for care management (Title III) by October 1, 2005, incorporating the standards into all Requests for Proposals and subsequent contracts. *2006-07 Update:* The OOA case management standards have been fully implemented from October 2005. *2007-08 Update:* Case Management Standards were incorporated into the RFP. Completed.	**Start & End Dates** 10/1/05-6/30/07	**Title III B Funded PD or C**	**Status** Completed

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: Currently OOA-funded contracts tend to reflect "inputs" and activities rather than reflecting client-based outcomes that would allow measurement of program effectiveness.			
Objective 2.8 The OOA staff,~~- working with the Human Service Agency Planning Unit, will develop an annual survey that differentiates levels of consumer satisfaction with specific aspects of service delivery, sampling a range of consumers and services, and compiling and analyzing the results. The OOA staff will review results with contractors once a year to make improvements in services.~~ will work with contractors to revise the consumer satisfaction surveys that will be implemented in 06-07 in order to capture contracted performance outcome measures of the different programs. *2006-07 and 2007-08 Updates:* In 2006-07 OOA staff held six meetings with contract providers to discuss consumer satisfaction surveys and identify changes. The new tools were developed and translated into eight different languages. Due to the time needed for proofreading, implementation occurred in 2007-08. *2007-08 Year-End Status:* Since November 2007, the revised consumer satisfaction survey forms for all OOA-funded programs have been available in nine languages: English, Chinese, Spanish, Russian, Tagalog, Japanese, Korean, Vietnamese, and Samoan. Objective completed.	**Start & End Dates** 1/1/06 - 6/30/08	**Title III B Funded PD or C**	**Status** Completed

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: AAA-funded health prevention and health maintenance programs tend to improve or increase the health and well-being of older persons and persons with disabilities. The AAA intends to promote its health related programs by continuing to serve the most vulnerable of its population within the City of San Francisco.			
Objective 2.9 The OOA staff, working with the contractors, and the public, will improve the overall health of older persons and adults with disabilities by providing and expanding health screening to the capacity of program budget. This service includes a brief examination to determine the need for more in-depth medical evaluation and referral. *2006-07 Update:* Curry Senior Center continues to provide these services to seniors and adults with disabilities in their primary care clinic. *2007-08 Update:* The OOA released an RFP for the continued provision of these services. Curry Senior Center was awarded funding through the RFP process. In 2007-08 Curry Senior Center provided health screening services to 924 unduplicated clients and rendered 1491 units (hours) of service. *2008-09 Update:* Curry Senior Center continues to provide Health Screening Program to the target population. *2008-09 Year-End Status*: Curry Senior Center continues to provide health screening services to seniors and adults with disabilities. . In this fiscal year Curry Senior Center provided 924 consumers with 1491 hours of health screening services.	**Start & End Dates** 1/1/06 - 6/30/09	**Title III B Funded PD or C**	**Status** Continued

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: AAA-funded health prevention and health maintenance programs tend to improve or increase the health and well-being of older persons and persons with disabilities. The AAA intends to promote its health related programs by continuing to serve the most vulnerable of its population within the City of San Francisco.			
Objective 2.10 Medication Management will prevent incorrect medications and adverse drug reactions by providing a one-on-one consultation to individuals concerning the appropriate use of prescribed drugs with follow-up as needed to each individual seeking advice and information. *2007-08 Update:* The OOA released a Solicitation of Interest (SOI) for the continued provision of these services. Curry Senior Center operated a Medication Management program, serving a total of 57 clients and 611 consumer contacts in FY 07-08. *2008-09 Update:* Curry Senior Center will continue to operate the Medication Management program in FY 2008-09. 2008-09 Year-End status: Curry Senior Center continues to operate the medication management program for the targeted population. During this year, a total of 72 clients received 408 contacts.	**Start** & End Dates 1/1/06 - 6/30/09	**Title III B Funded PD or C**	**Status** Continued

Goal Two: To improve the quality and capacity of OOA-funded home and community based services			
Rationale: Research studies demonstrate the benefits of living a healthy, active lifestyle, but many service providers have not incorporated physical activities into their programs.			
Objective 2.11 OOA staff will work with a lead agency to develop and implement evidence-based health promotion programs, in line with the State Initiative: Empowering Older People to Take More Control of their Health through Evidence-Based Prevention programs. *2007-08 Year-End Status:* Through an RFP process, 30th Street Senior Center has been awarded with funding to develop and implement evidence-based health promotion (EBHP) program "Always Active" targeted to reach 10 communities/neighborhoods. The OOA staff are now members of the EBHP Initiative Statewide Steering Committee. OOA also works in collaboration with Partners in Care Foundation, to implement the Healthier Living EBHP workshops with several community-based agencies. Two workshops were completed and 14 older adults had graduated from this program in FY 07-08. *2008-09 Update:* OOA continues to fund one EBHP program: "Always Active" and provides continuous staff and volunteer support to the state's EBHP program "Healthier Living". OOA Nutritionist had also been invited to attend the Annual EBHP National Conference in December, 2008. OOA also worked with two agencies and successfully won a small community grant from the Catholic Healthcare West to support the Healthier Living program. *2008-09 Year-End Status*: 30th Street Senior Center served as the lead agency to provide the EBHP, *Always Active* Program to consumers citywide by collaborating with nine different community-based organizations. A total of 614 unduplicated consumers were served and 24 Wellness Trainers were certified by *Always Active* Program. OOA also collaborated with six community-based organizations to co-sponsor eight Healthier Living workshops for participants and one Lay Leader Training workshop. A total of 131 consumers enrolled in the program and 91 successfully graduated from Healthier Living.	**Start & End Dates** 5/1/07 - 6/30/09	**Title III B Funded PD or C**	**Status** Continued

Goal Three: To improve coordination of services for seniors and adults with disabilities			
Rationale: According to the *Living With Dignity* strategic plan, the citywide system of services for seniors and persons with disabilities is hampered by fragmentation and a lack of coordination.			
Objective 3.1 The Deputy Director of Programs will designate an OOA liaison to attend the monthly meetings of the Long Term Care Coordinating Council to stay informed of the issues being explored and addressed, and of the policy positions being proposed to the Office of the Mayor. Attendance at these meetings will help the OOA effectively coordinate its program plans and funding priorities with the citywide effort to make strategic improvements to community-based long term care and supportive services for older adults and adults with disabilities. *2006-07 Update:* The OOA director, Denise Cheung, now attends the Long-Term Care Coordinating Council. Completed.	**Start & End Dates** 7/1/05 – 6/30/06	**Title III B Funded PD or C**	**Status** Completed

Goal Three: To improve coordination of services for seniors and adults with disabilities			
Rationale: District Advisory Councils are an underutilized community resource that would benefit from having a vehicle to formally consider issues and needs discussed at their meetings.			
Objective 3.2 District Advisory Councils convened by the Resource Centers for Seniors and Adults with Disabilities meet regularly with consumers and service providers to share information and discuss neighborhood problems. The OOA staff assigned to each of the ten District Advisory Councils (DACs) will work with the groups to formulate recommendations on how to improve coordination of services, and will incorporate recommendations in the 2006 - 07 Area Plan update. *2006-07 Year-End Status:* OOA staff attended DAC meetings in 2006. Input from the DACs was incorporated in the October 2006 Needs Assessment report. Completed.	**Start & End Dates** 7/1/05 – 6/30/07	**Title III B Funded PD or C**	**Status** Completed

Goal Three: To improve coordination of services for seniors and adults with disabilities			
Rationale: With nutrition cited as one of the top unmet needs, a publication that lists free or low-cost food will enhance the nutrition services provided by the Triple A.			
Objective 3.3 Working in collaboration with the Department of Public Health, the Department of Human Services, Department of Aging and Adult Services, and community-based nonprofit organizations, the OOA nutritionist will coordinate, publish and distribute a citywide low cost food, nutrition education and resource guide that will be distributed for use by staff at various city departments and community-based organizations. *2005-06 Year-End Status:* The collaboration completed the directory in September and distributed 2,000 hard copies and 300 CDs. An on-line directory is scheduled for development and implementation in June 2006. Completed. *2006-07 Year-End Status:* DAAS will post this resource on DAAS's web site and on HSA's Intranet by June 2007. Further completed.	**Start & End Dates** 7/1/05 – 6/30/06	**Title III B Funded PD or C**	**Status** Completed

Goal Three: To improve coordination of services for seniors and adults with disabilities			
Rationale: Many service providers experience rapid turn-over of staff, depleting the agency of the knowledge and experience of long-term employees.			
Objective 3.4 DAAS will work with the Services and Programs Advisory Committee to design and implement service provider training that will improve inter-agency communication and cooperation, including training on care-planning for care managers, one training on nutrition-risk screening for care managers, and two trainings for meeting the diverse needs of ethnic seniors and adults with disabilities. *2006-07 Update:* SPAC and DAAS staff conducted a number of trainings, including trainings in diversity, choosing homecare and board and care. Additional trainings are planned for 2006-07. *2007-08 Update:* DAAS provided four trainings as of March 2007 and will provide one more in May 2007. SPAC convened its last meeting in March, but its Training Committee will continue to meet to plan DAAS trainings. In 2007, six trainings were conducted, covering the topics of MediCal, IHSS, Immigration Status, Family Caregiving, Community Support for People with Disabilities, APS/Integrated Intake/Community Living Fund/Ombudsman issues, and Nursing Facility/Acute Care MediCal waivers. A joint committee of DAAS staff and members of the Advisory Council has been formed to develop the training schedule for 2008. New trainings include Mental Health Case Management Programs & Options, Palliative Care and End of Life Issues, LGBT Cultural Competency, Healthy Aging -from Self Care & Socialization to Sexuality. In addition to public trainings, DAAS will be initiating a new internal training program for staff beginning with a workshop on Recovery Based Models in the Behavioral Health System. 2008-09 Update: DAAS will provide two training tracks. First, DAAS will work with the Aging and Adult Services Advisory Council to continue to offer its service provider training aimed at improving inter-agency communication and cooperation. Trainings will include reaching LGBT Seniors with Culturally Sensitive Services, Aging with HIV, Aging and Sexuality, an introduction to DAAS services, and other trainings for community providers. Second, DAAS is launching a new training series aimed at educating internal staff on emerging issues in aging and disability services and providing them with continuing education units needed for upkeep of social work and nursing licenses. Scheduled trainings include dual diagnosis and medication, veterans and Post Traumatic Stress, mental health issues and older adults, and other related trainings. 2008-09 Year-End Status: DAAS provided two training tracks. Working with the Aging and Adult Services Advisory Council, four educational workshops were offered to community service providers aimed at developing provider knowledge and skill-sets, and improving inter-agency communication and cooperation. .DAAS also launched a new training series aimed at educating internal staff on emerging issues in aging and disability services. A total of 7 training sessions were held this year.	**Start & End Dates** 7/1/05 - 6/30/09	**Title III B Funded PD or C**	**Status** Continued

Goal Three: To improve coordination of services for seniors and adults with disabilities

Rationale: City intake systems for long-term care services are broken into program-level silos that make it difficult for consumers and caregivers to easily access the full spectrum of services that they may need.

Objective 3.5	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
The DAAS Intake Supervisor will coordinate the integration of intake units from the following programs: Information and Referral, Home-Delivered Meals, Adult Protective Services, In-Home Supportive Services, and the Community Living Fund (CLF) The new Long-Term Care Intake and Screening Unit will co-locate these intake staff, allowing callers to access any of these resources with one phone call. Staff will also be cross-trained as appropriate. *2007-08 Year-End Status:* A new electronic system has been established since January 2008 to track general information and referral calls as well as CLF intakes. Co-location of staff began in June 2008, and cross-training efforts continue to be ongoing. *2008-09 Update.* Intake staff were co-located in June 2008. Currently, intake is responsible for taking Adult Protective Services, Community Living Fund, home delivered meals, In Home Supportive Services, and general information and referral calls. Cross- training is continuous and due to budget cuts and the loss of two trained intake staff, more extensive training is needed in the coming year. Replacement staff will start in late February. Also in late February, a phone system which routes all phone numbers into one system should be operational. Currently, there is one main number to the unit, but IHSS uses a separate number. 2008-09 Year-End status: Since June 2009, all intake calls are routed through one main number. DAAS Integrated Intake Unit takes referrals for Adult Protective Services, general Information and Referral, home delivered meals, In Home Supportive Services, and the Community Living Fund. A caller can also access the County Veteran's Service Office on this hotline. The hotline has a multilingual prompt system, to serve Cantonese, Mandarin, and Spanish speaking callers. The unit is fully staffed and trained. Training on general information and referral calls is ongoing, due to changing resources in the community.	7/1/08 – 6/30/09		Continued

Goal Three: To improve coordination of services for seniors and adults with disabilities.

Rationale: Due to limited resources, the existing service delivery system for home-delivered meals has not always been able to provide home-delivered meals for clients in emergency circumstances as quickly as they are needed. During the first six months of FY2007-08, OOA-Net data shows that only one-third of emergency home-delivered meal requests had delivery start dates within 5 days of their initial request.

Objective 3.6	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
Working in collaboration with Meals on Wheels of San Francisco, the DAAS long-term care intake and screening unit and the Long-Term Care Operations Director will provide additional funding from the Community Living Fund for program expansion and implementing improvements to the home-delivered meals service system to ensure that consumers with emergency needs always receive meals within a maximum of three to five days, and effort to provide a meal within 1-2 days. *2007-08 Year-End Status:* Augment to the MOW contract for emergency meals began as of January 1, 2008. After a short period of program development, the expanded services started in March of 2008. *2008-09 Update.* As of 12/29/08, 66 clients have been served through this HDM emergency meal program which became fully operational in March 2008. 2008-09 Year-End status: As of 7/30/09, 38 more clients have been served through the HDM emergency meal program.	1/1/08–6/30/09		Continued

Goal Three: To improve coordination of services for seniors and adults with disabilities.			
Rationale: The FY 2007-2008 SHIP Grant requires the Department to use at least 5% of Federal SHIP funding to provide pharmaceutical (Part D) benefits assistance for dual eligible beneficiaries with mental illness.			
Objective 3.7 In order to support this requirement, the HICAP provider will conduct training sessions for its staff and volunteers on how best to provide pharmaceutical (Part D) benefits assistance for dual eligible beneficiaries with mental illness. The training will be provided by the HICAP provider (working with DAAS for consultation and assistance) during Spring 2008. In order to provide outreach and awareness beyond the HICAP staff, a subsequent training session will be held with community gatekeepers (i.e., Resource Centers, senior centers, etc). *2007-08 Year-End Status:* Continued training will be provided as needed. Additional outreach activities will commence to help further this goal. *2008-09 Update:* The HICAP provider conducted a training in September, 2008. Continued training and additional outreach activities will continue. 2008-09 Year-End status: The HICAP provider is continuing to train health care professionals (including mental health workers, pharmacists, social workers, etc.) Additional outreach activities are in place to seek harder to reach audiences.	**Start & End Dates** 4/1/08–6/30/09	**Title III B Funded PD or C**	**Status** Continued

Goal Four: To integrate San Francisco Department of Human Services (DHS) and Department of Aging and Adult Services programs for the benefit of OOA consumers

Rationale: Many seniors have not enrolled in the Food Stamp program. The integration Department of Aging and Adult Services and the Department of Human Services should allow consumers easier access to a wider range of resources.

Objective 4.1	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
To increase the participation of older adults in its services and programs, the San Francisco Department of Human Services will pilot targeted outreach activities and develop a special application process for OOA consumers to coordinate screening and enrollment activities for its Non-Assistance Food Stamps, Medi-Cal, and other programs, resulting in a 5% increase of OOA consumers using DHS program services. *2006-2007 Update:* Planning is underway to identify mechanisms for providing easier access to food stamps and other programs for seniors and people with disabilities, especially those on waiting lists for nutrition programs. In addition, one DAAS staff member participates in HSA's Outreach Committee, which coordinates the agency's outreach strategies and activities. *2007-08 Update:* In 2006-07, DAAS & HSA staff worked collaboratively with the SF Food Security Task Force regarding recommendations related to older adults in the report "Food Security For All: A Strategic Plan to End Hunger in Our City, January 2007". HSA planning staff will also advise on the implementation of $1 million grant to streamline screening and application processes to increase food stamps utilization. Older adults are one of the primary target populations of that initiative. *2007-08 Year-End Status:* In 2007-08 HSA and DAAS continue to actively participate in the SF Food Security Task Force. At the December 2007 meeting, the Task Force submitted a request to the Board of Supervisors to add a representative from DAAS as a voting member of the Task Force, which was granted. *2008-09 Update:* The Office on the Aging and the Long Term Care Intake and Screening Unit are working with the Food Stamps program to send targeted food stamps outreach letters to potentially eligible OOA consumers. Contingent upon program resources, the letter will be sent during FY2008-09. *2008-09 Year-End Status:* Due to recent budget cuts in Food Stamps, it was not feasible to do a massive outreach campaign to clients receiving home delivered meals. Also, due to a lack of specific financial information in meal referrals, the list of individuals who possibly could qualify for Food Stamps was too great. Currently, the DAAS Intake manager is working with IHSS and MediCal to determine who receives both services, but who do not receive SSI. Therefore, a smaller group can be targeted that would be eligible for Food Stamps. Food Stamps recently revised an outreach letter that DAAS can send out to IHSS clients, letting them know about the service. If Food Stamps capacity grows in the future, DAAS will look at a larger pool receiving home delivered meals, outreaching to them about food stamps.	7/1/05 - 6/30/09		Objective reworked and continued in 2009-2010

Goal Four: To integrate San Francisco Department of Human Services (DHS) and Department of Aging and Adult Services programs for the benefit of OOA consumers			
Rationale: Employees of the OOA are not familiar with DHS programs and conversely DHS employees are not familiar with the programs of the OOA.			
Objective 4.2 The OOA and DHS staff will cross-train front-line staff on their respective programs, which will increase the number of consumers receiving both DHS and OOA services will increase by a minimum of 5%, as compared to a baseline to be developed in 12/05. *2006-07 Update:* Joint meetings between DHS and OOA program managers have addressed the question of coordinating services and increasing utilization. The executive director of DAAS now sits in weekly meetings with the Deputy Director of DHS programs as well as the executive director of HSA to ensure coordinated strategies for serving common clientele. A focus on front-line staff will commence in 2006-07. *2007-08 Update:* Working with other city departments and community-based organizations in developing part of the California Nutrition Action Plan (CNAP), OOA Nutritionist and HSA staff will help in completing an outreach training presentation on food and nutrition programs offered in the city by April 2007. *2007-08 Year-End Status:* The food and nutrition programs training materials were completed in November 2007. OOA provided part of the training materials to nutrition service providers in February, 2008. OOA will complete another part of the training in May, 2008. HSA staff development is also working to include updated DAAS and DHS program liaisons information and specific program descriptions into a revised employee orientation training modules. *2008-09 Update*: No significant update. *2008-09 Year-End status:* This objective has been reworked and continued into the 2009-2012 Area Plan. That plan includes an objective to initiate greater collaboration between programs that serve older adults and adults with disabilities, especially between the Department of Human Services (DHS), DAAS, community-based organizations, Planning Department and DPH. Greater coordination, collaboration, and cooperation between program managers and program line staff will improve services for consumers.	**Start & End Dates** 7/1/05 - 6/30/09	**Title III B Funded PD or C**	**Status** Objective reworked and continued in the 2009-2012 Area Plan.

Goal Four: To integrate San Francisco Department of Human Services (DHS) and Department of Aging and Adult Services programs for the benefit of OOA consumers			
Rationale: It is believed that many seniors are unaware that they can use their Food Stamps for meals at senior nutrition sites.			
Objective 4.3 The DHS Food Stamp program will provide technical assistance to at least two congregate meal sites so that their consumers can swipe their electronic benefits card and deduct meal payments from their Food Stamps allocation. *2006-07 Update:* Two congregate meal sites have added this capability, and a third is working to do so. Completed.	**Start & End Dates** 7/1/05 – 6/30/06	**Title III B Funded PD or C**	**Status** Completed

Goal Five: To plan for the long-term care needs of underserved and emerging target populations			
Rationale: Some senior nutrition sites are experiencing a decline in participants, and it is believed that fresh models of senior centers and activities should be developed to reflect the new generation of younger seniors.			
Objective 5.1 As coordinated by the Advisory Council to the Aging and Adult Services Commission, the OOA staff will participate in a task force of current and future consumers, Advisory Council representatives, researchers, and service contractors **to discuss needs of baby boomers and gather existing information and trends and present to providers and the public.** *2006-07 Update:* The Advisory Council discussed this objective in its January meeting and expressed interest in working to form a task force in partnership with DAAS that will research these issues and convene a community education forum. *2007-08 Update:* The Advisory Council Baby Boomer Work Group met in March 2007 and plans to draft recommendations by June 30, 2007. *2007-08 Year-End Status:* The workgroup met six times since March 2007. The group has reviewed demographic data, gathered existing research, and surveyed service providers (November 2007) on the current status of planning for baby boomers and on the providers' needs to plan appropriately for baby boomers. The group issued a draft report to the Advisory Council on its findings in July 2008. *2008-09 Update:* The workgroup finalized its report and recommendations in July 2008. *2008-09 Year-End Status*: Objective completed.	**Start & End Dates** 7/1/05 - 6/30/09	**Title III B Funded PD or C**	**Status** **Revised, Completed**

Goal Five: To plan for the long-term care needs of underserved and emerging target populations			
Rationale: The large number of baby boomer seniors approaching status for eligibility of AAA-funded services mandates a new look at service delivery models.			
Objective 5.2 The Advisory Council to the Aging and Adult Services Commission will convene an educational forum with **baby boomers**, service providers, foundation representatives, researchers, and business leaders to develop recommendations for investments in services designed to meet the needs of "baby boomers." This plan will be the beginning of an ongoing effort to address the needs of the baby boomer generation and to make preparations for the increases in the numbers of persons growing older and living longer, and its recommendations will be incorporated into Area Plan updates. *2006-07 Update:* The Advisory Council discussed this objective in its January meeting and expressed interest in working to form a task force in partnership with DAAS that will research these issues and convene a community education forum. *2007-08 Update:* The Advisory Council is discussing this objective in coordination with their work on objective 5.1. *2007-08 Year-End Status:* The workgroup finalized a report from its research in Summer 2008. The group has begun planning for a forum, scheduled to take place in October 2008. *2008-09 Update:* The Advisory Council workgroup convened an educational forum in October 2008. *2008-09 Year-End Status*: Objective completed.	**Start & End Dates** 7/1/05 - 6/30/09	**Title III B Funded PD or C**	**Status** Completed (Modified)

Goal Five: To plan for the long-term care needs of underserved and emerging target populations			
Rationale: In focus groups, lesbian, gay, bisexual, and transgender (LGBT) seniors have commented on not feeling comfortable in services sites that are not oriented to them. Also, a taskforce on underserved communities of seniors and persons with disabilities is formulating recommendations that may include meal site locations, and new housing sites for formerly homeless seniors are opening up this year and may be suitable for meal sites.			
Objective 5.3 The OOA will provide technical assistance to identify at least one congregate meal site that will target the LGBT and/or other underserved communities. *2006-07 Update:* A LGBT meal site has begun operation in 2005-2006. Completed. *2007-08 Year-End Status:* The small LGBT meal site (which served two times a month) at New Leaf Services for our Community was closed in January 2008 due to very low attendance level. The coordinator has since been able to continue meeting with the consumers bi-weekly as a "brown bag" lunch program. Another meal site that targets LGBT consumers and serves meals 5 days a week, located at the Castro Senior Center, has grown and attracted more LGBT consumers in the meantime. Another new program with specific LGBT programming has been implemented in Castro Senior Center by the "openhouse", an agency specialized in LGBT training.	**Start & End Dates** 7/1/05 - 6/30/06	**Title III B Funded PD or C**	**Status** Completed

Goal Five: To plan for the long-term care needs of underserved and emerging target populations			
Rationale: The *Living With Dignity* strategic plan identified four target populations that are underserved by the city's long-term care service system for seniors and persons with disabilities.			
Objective 5.4 The OOA staff will work with the San Francisco Partnership for Community-Based Care & Support to develop recommendations on how to improve services for seniors and adults with disabilities in the following underserved communities: 1) African American; 2) Asian/Pacific Islander; 3) Latino; and 4) lesbian, gay, bisexual, and transgender. The recommendations will be incorporated into the 2006-07 Area Plan update. *2006-07 Update:* DAAS staff has been assigned to attend the community partnership meetings and the planning unit is actively working with Partnership groups to ensure representation in the needs assessment process. Recommendations will be incorporated into the 2006 Needs Assessment. *2007-08 Update:* The 2006 Needs Assessment included information from focus groups and interviews with each of the Partnership groups. After the Assessment was completed, HSA returned to each these groups and made presentations about the results of the Assessment and invite feedback. OOA staff will continue to attend meetings in FY2007-08. *2008-09 Update*: OOA staff continues to attend the Partnerships Meetings, and also participated in the ADRC Partnership events (see Objective 6.4). *2008-09 Year-End Status*: OOA staff continue to attend the Partnership Meetings.	**Start & End Dates** 7/1/05 – 6/30/09	**Title III B Funded PD or C**	**Status** Continued

Goal Five: To plan for the long-term care needs of underserved and emerging target populations

Rationale: Often, in the rehabilitation units of hospitals, patients are not provided with adequate information for long term care choices, and transitions out of these facilities are not adequately monitored. In order to meet the individual needs of the consumers and family members, it is important to assure that patients participate in both care and discharge planning through the Ombudsman support.

Objective 5.5	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
To advocate for safe discharge planning and to ensure that adequate long term care choices are provided, to patients of rehabilitation units of hospitals. To assure that patients participate in both care- and discharge planning through Ombudsman support. The Discharge Planning Ombudsman will visit all rehab SNFs weekly for purpose of outreach and complaint advocacy. The Discharge Planning Ombudsman will also provide an array of community-based options to the patient, family and utilization nurse prior to discharge when a complaint about process occurs. *2007-08 Year-End Status:* The Discharge Planning Ombudsman has continued to visit all rehabilitation SNFs weekly, and provide an array of community-based options to the consumers. This provides an added component of advocacy to residents *2008-09 Update:* Despite budget cuts from the state, the Ombudsman Program staff continue to provide an array of community based options to the consumer and family prior to discharge when a complaint arises. In addition, the Ombudsman will facilitate a care plan meeting to bring all parties together to help reduce misunderstandings. *2008-09 Year-End Status*: In FY 08-09 the Ombudsman program was impacted by a $96,000 budget cut in state funding. As a result, its gatekeeper position (discharge planning coordination and community placement outreach) and the board and care ombudsman were laid off. The volunteer coordinator's hours were also reduced. With the staffing cut, the Ombudsman program has a hard time fulfilling all the state and federal mandates.	7/1/07 – 6/30/09		Continued

Goal Six: To seek parity of services for younger persons with disabilities by identifying and utilizing local resources			
Rationale: The OOA needs to better understand the needs of younger persons with disabilities and make more appropriate referrals for the delivery of services.			
Objective 6.1 To improve services for younger adults with disabilities (YAD), the Human Services Agency planning unit will work with the OOA staff, adults with disabilities, and OOA-funded contractors to assess the service needs of this population, research service models and outreach strategies, identify potential funding sources, and make recommendations regarding training and program changes that will be incorporated into the 2006-07 Area Plan update. *2006-07 Update:* These issues have been included in the plan for the 2006 Needs Assessment process. *2007-08 Update:* The 2006 Needs Assessment integrated information about the needs of younger persons with disabilities, identifying gaps in service and identifying areas for further analysis. Also, a public hearing was convened in October 2006 to discuss programs meeting the needs of the younger disabled. These efforts contributed to a $200,000 RFP being issued in January 2007 for three specific programs to serve the YAD: legal services, money management, and social support services for hoarders and clutterers. *2007-08 Year-End Status:* Several new programs for YAD (home-delivered meals, congregate meals, legal services, money management, and social support services for hoarders and clutterers) were been implemented. Completed.	**Start & End Dates** 7/1/05 - 6/30/08	**Title III B Funded PD or C**	**Status** Completed

Goal Six: To seek parity of services for younger persons with disabilities by identifying and utilizing local resources			
Rationale: The OOA needs to better understand the needs of younger persons with disabilities and the most appropriate means of delivering services.			
Objective 6.2 The OOA will evaluate its pilot project to provide Home-Delivered Meals for younger adults with disabilities, eliciting input from consumers, meal providers, and service recipients, and will make recommendations on funding and program adjustments ~~for the 2006 - 07 Area Plan update~~. *2006-07 Update:* An evaluation survey of the pilot program has been completed, and a draft report will be completed by June 2006. *2006-07 Year-End Status:* DAAS has shared the results of the completed evaluation with the Advisory Council, Services and Program Advisory Committee, and the community. Additional baseline funding has been identified to continue and expand this program. Completed.	**Start & End Dates** 7/1/05-6/30/07	**Title III B Funded PD or C**	**Status** Completed

Goal Six: To seek parity of services for younger persons with disabilities by identifying and utilizing local resources

Rationale: The OOA needs to better understand the needs of younger persons with disabilities and the most appropriate means of delivering services.

Objective 6.3	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
The overall number of younger disabled persons served by the OOA-funded network of contracts will increase by 5%, as compared to a baseline that will be developed by 12/05. *2006-07 Update:* Implementation of a pilot home-delivered meal program for younger disabled adults, as well as provision of case management through the Institute on Aging and Neighborhood Resource Centers has significantly increased the number of younger disabled adults receiving services from OOA contractors. Data is still fragmented at this time, requiring more analysis to determine baseline and comparison figures. *2007-08 Update:* Due to additional funding earmarked for this population, DAAS conducted a public hearing in Oct 2006 about increasing services to the younger disabled. An RFP of new/additional services was issued. (See objective 6.1.) The OOA provided services to 582 persons under the age of 60 as of February 2007 this year. In addition, DAAS had provided home delivered meals to 206 younger persons as of the same time year. Congregate meal programming began in March 2007. *2007-08 Year-End Status:* Complete year-end enrollment information for FY 2006-2007 was analyzed for a baseline measure. A total of 1,259 unduplicated consumers under the age of 60 were enrolled in OOA-funded services according to the OOA-Net tracking system. Additionally, 501 younger adults received congregate or home-delivered meals (tracked separately from OOA-Net). In FY2008-09, planning and program staff will compare 06/07 and 07/08 enrollments to assess increased access. *2008-09 Update:* A comparison of 07/08 younger adult enrollments to those from 06/07 shows that nearly identical levels of program access. *2008-09 Year-End Status*: Comparison of 06/07 to 08/09 year-end data showed that we served a total of 1,703 unduplicated consumers in 08/09 for all programs citywide. This is an increase of 104 unduplicated consumers or an increase of 6.7%.	7/1/05-6/30/09		Completed

Goal Six: To seek parity of services for younger persons with disabilities by identifying and utilizing local resources

Rationale: The OOA needs to better understand the needs of younger persons with disabilities and the most appropriate means of delivering services.

Objective 6.4	**Start & End Dates**	**Title III B Funded PD or C**	**Status**
CDA has just awarded DAAS and the Independent Living Resource Center of San Francisco (ILRCSF) $80,000 to be another regional ADRC (Aging and Disability Resource Connection) partner in California. Under the umbrella of this new ADRC, DAAS Integrated Intake Unit, ILRCSF, and the ten Resource Centers for Seniors and Adults with Disabilities will work together to reach diverse communities in San Francisco. The ADRC collaborative will promote independent living, and it will help develop strategies for diffusing independent living principles and resources into aging resource networks. The ADRC will engage in a series of training programs for the providers in the aging and disability networks, better equipping staff to help consumers make informed choices. The Ombudsman program will also collaborate with ILRCSF in cross-training of staff and volunteers. *2007-2008 Year-End Status:* The ADRC project has also collaborated with the four community Partnerships (API, Latino, African American and LGBT) to provide outreach to the underserved communities, and to enhance coordination between the senior services and disability services providers. Although the state contract was approved effective August 2008, preparation work had been done to prepare for all the above training and outreaching activities. *2008-09 Update:* ILRCSF had conducted trainings to the staff of the ten Resource Centers for Seniors and Adults with Disabilities (RC) and DASS Integrated Intake Unit. ILRCSF and Ombudsman Program had also crossed trained their staff and volunteers. Four community events were held with the San Francisco Partnership for Community-Based Care & Support. Effective January 1, 2009, DAAS receives an additional $11,000 to continue the work of ADRC till June 30, 2009. *2008-09 Year-End Status*: With the additional funding, the Ombudsman program was able to hire two outreach Ombudsman specialists to identify residents in nursing home and assist them to come up with a transition plan whenever possible. This funding ended in June, 2009., but the Aging and Disability Resource Connection project has a very positive effect on the working relationship and services provided to seniors and people with disabilities. The relationship will continue in 2009-2010 and enhanced through two additional grants: the MIPPA (Medicare Improvement for Patients and Providers Act) and ADRC Enhancement Grant.	3/1/08 – 12/31/08		New and completed in 2008-2009. To continue in 2009-2010 as a new objective.

SECTION IV: TITLE III D HEALTH SCREENING AND MEDICATION MANAGEMENT

Health Screening
In FY 2008-09 Curry Senior Center provided health screening services to 924 unduplicated clients and rendered 1491 hours of service. As part of its health screening, Curry Senior Center staff conducted a brief health screening to discover and determine conditions that may require a referral for a more in-depth medical evaluation. In particular, clients are screened for chronic conditions, including hypertension, diabetes, cardiovascular, functional impairments, and preventive treatments, including whether they have received pneumovax (pneumonia vaccine) and other clinical indicators of quality care.

Medication Management
Curry Senior Center provides patient education on medications as an adjunct to delivery of medical treatment services. Pharmacists and nurses work with patients providing personalized, one-on-one medication review and information, answering questions and counseling seniors so that they understand, are following directions and taking medication properly and are monitored over time to ensure proper self administration. In addition, for some clients, weekly medication sets are prepared. During this year, a total of 72 clients received 408 contacts.

SECTION V: PROGRAM DEVELOPMENT OR COORDINATION

The California Department of Aging requires a section in the Year-End Report that discusses activities related to the use of Title III-B funds expended for federal "Program Development or Development" activities. San Francisco County does not use Title III-B funds for that purpose. Thus, there is nothing to report in this section.

SECTION VI: SUMMARY OF ACTIVITIES

The Department on Aging and Adult Services (DAAS) has participated in a continuing series of assessments and evaluations with the goal of improving its services. DAAS's 2006 Community Needs Assessment was the first comprehensive assessment of the senior and persons with disabilities communities in San Francisco. It influenced subsequent efforts, like the Baby Boomer forum and a community telephone survey. These various efforts crystallized in the *Living With Dignity Strategic Plan 2009-2013*, which is directly integrated with San Francisco's 2009 Area Plan. On a parallel track, DAAS was central to a strategic assessment conducted by SF-HSA to evaluate the organization's performance since its merger.

These efforts have been led by somewhat different goals and focuses, but together have yielded many overlapping findings. The *Living With Dignity* plan organized the common findings from the various assessments into a series of broad goals, including:

1. **Improve Quality of Life:** Seniors and persons with disabilities living in San Francisco are often isolated by social, linguistic, and physical barriers and need stronger support networks and greater access to the community.
2. **Establish Better Coordination of Services:** Across assessments, the theme of fragmented services was consistent. The lack of a cohesive system of care undermines the ability of older adults and adults with disabilities to live independently in the community.
3. **Increase Access to Services:** Related to the issues of isolation and service fragmentation, the assessments uncovered a persistent need for individuals to have better information about long term care and supportive services, more culturally sensitive services, and portals to the service system that lead to a range of services.
4. **Improve Services Quality:** The caliber of supportive services is often uneven, and the need for better performance standards and accountability was frequently cited as a need within the current service system.
5. **Expand Service Capacity:** To the extent possible in the new budget environment, San Francisco must enhance the capacity of its service system to meet the needs of an aging population that is likely to be living in the community with higher levels of risk.

A summary of the various needs assessments, including their process, methods, and findings, can be found in the matrix that begins on the next page.

The emerging vision culminated in the *Living With Dignity Strategic Plan 2009-2013*, which was explicitly linked to the goals, objectives, and priorities of the 2009-2012 Local Area Plan. The *Living With Dignity* plan included participation from the DAAS Advisory Council and the Aging and Adult Services Commission prior to being finalized by the Long Term Care Coordinating Council.

Summary of San Francisco Needs Assessment Activities, 2006 - 2009

Planning Effort	Process	Methods	Major Findings
2006 DAAS Community Needs Assessment	Identified needs of seniors and younger persons with disabilities, contrasted with existing services, and analyzed gaps in services and support.	*Quantitative*: Analyzed Census and American Community Survey, SF-HSA administrative data, including SF GetCare, and data from other city government agencies; 2006 phone survey of seniors and adults with disabilities. *Qualitative:* key informant interviews; roundtable discussions with service providers; consumer focus groups; recommendations from District Advisory Councils.	1) Increased partnership with other city departments. Such partnerships could lead to improvements in the quality and availability of services that address housing, isolation, self care and safety, and access needs. 2) Systemic Coordination of DAAS services to address common needs. Better system coordination could promote improvements in services in nearly all service areas. 3) Small program investments that can make a difference. Small investments that increase awareness, or those that provide simple evidence-based health promotion programs, can lead to stronger, healthier communities.
2008 Baby Boomer Task Force	Created by Advisory Council, Task Force gathered information, trends, and analyzed implications of Baby Boomer aging in San Francisco. Results shared at community forum.	Demographic overview comparing San Francisco to state and national levels; review of related literature and quantitative research; electronic survey of local service providers to gauge existing efforts.	1) San Francisco's Baby Boomers will cause increases in senior population, but not as dramatically as at the state and national levels. 2) Local Baby Boomers more likely to be low income than national trend. 3) Culturally relevant programming important as Baby Boomers in San Francisco more diverse. 4) Local Baby Boomers are even more educated than nationally or statewide. 5) Many Baby Boomers may postpone retirement due to financial pressures of living in expensive city. 6) Baby Boomers likely to live longer with chronic diseases.
2008 Phone Survey with Older Adults and Adults with Disabilities	Replication of 2006 phone survey conducted by National Research Center regarding service needs and awareness.	Random phone survey of 330 respondents, including 252 older adults and 167 adults with disabilities. Queried regarding awareness of services, preferred sources of information about resources, and current needs.	1) Seniors had high awareness of traditional services like senior centers, but were less aware of money management and home repair and modification services. 2) Low income adults were less aware of services. 3) Respondents relied on media for most information needs. 4) Adults with disabilities were most in need of home repair, visiting nurse, home health aide, assistance with forms, legal assistance, and information and referral services. 5) Seniors were most in need of door-to-door transportation, home repairs, visiting nurse services, adult day programs, legal assistance, and information and referral.
2008 SF-	Conducted by SF-	Extensive analysis of	1) SF-HSA has tremendous strengths and

Summary of San Francisco Needs Assessment Activities, 2006 - 2009

Planning Effort	Process	Methods	Major Findings
HSA Strategic Review	HSA as part of agency commitment to be learning organization that uses data and other information to inform program design and practice and that draws lessons from its efforts.	census, budget, and administrative data, including analysis of program performance measures; survey of SF-HSA staff; key stakeholder interviews with leaders in other city departments and community based organizations; and focus groups with consumers, including non-English speaking consumers.	has a profound impact on mitigating poverty, promoting self sufficiency, protecting vulnerable persons, and preventing institutionalization. 2) Agency resources have grown, but so have demands on those resources. The 2004 merger resulted in increased capacity, but new mandates and agency-initiative reforms have proliferated as well. 3) The populations and neighborhoods served by SF-HSA are changing, and the Agency must evolve its practice to meet new challenges. 4) Improved coordination of services would benefit the Agency's clients. SF-HSA's size and complexity can make it difficult for clients, partners, and even staff to navigate, as well as making it difficult for the Agency to link individual programs to broader strategies and reforms.
2008 Living With Dignity Strategic Plan	Review of implementation of original Living With Dignity Strategic Plan (2004 – 2008), evaluation of current long term care environment in San Francisco. Refined vision, strategies, goals, and objectives for 2009-20013.	Analysis of long term care environment in San Francisco, including new policy trends, new local program initiatives, and current and promising innovations. A strengths, weaknesses, opportunities and threats analysis conducted with extensive input from seniors, persons with disabilities, advocates, service providers and public sector leaders.	1) Insufficient communication takes place between home, community-based, and institutional service providers. 2) A lack of collaboration exists between community-based providers' case management programs. 3) Discharge from institutional settings is not yet well organized. 4) The capacity of home and community services, including supportive housing and transportation services, will likely need to be expanded as the city's population ages. 5) Potential consumers often express difficulty in learning about long term care and supportive services, as well as difficulty in accessing services. 6) Because publicly-funded programs have strict thresholds for eligibility, persons with moderate incomes or assets often have few options for services and support to remain in the community. 6) Long term care providers seldom have experience with providing cross-age and cross-disability services, thought the need is great.

APPENDIX A: AGENCIES & SERVICES FUNDED

(FY 2008-2009)

Asian Law Caucus
Legal Services, Naturalization Services

Asian Pacific Islander Legal Outreach
Legal Services, Naturalization Services, Elder Abuse Prevention
(Also subcontract with **Vietnamese Elderly Mutual Assistance Association** for Naturalization Services)

Bayview Hunters Point Multipurpose Senior Services, Inc.
Community Services, Congregate Meals, Money Management

Bernal Heights Neighborhood Center
Case Management, Community Services

Catholic Charities CYO
Case Management, Community Services, Homemaker, Personal Care, Alzheimer's Day Care Resource Center, Adult Day Care

Centro Latino de San Francisco
Community Services, Congregate Meals, Home-Delivered Meals, Congregate Meals for Adults with Disabilities, Naturalization Services

Chinatown Community Development Center
Housing Advocacy, Single-Room-Occupancy (SRO) Food Outreach Program

Conard House
Money Management, Money Management for Adults with Disabilities

Curry Senior Center
Case Management, Community Services, Health Screening, Medication Management

Edgewood Center for Children and Families
Family Caregiver Support Program—Kinship Program

Episcopal Community Services
Case Management, Community Services, Congregate Meals, Congregate Meals for Adults with Disabilities, Emergency Housing Assistance (Campos Fund)

Family Caregiver Alliance
Family Caregiver Support Program

Family Service Agency of San Francisco
Ombudsman, Senior Companion, Case Management

Golden Gate Senior Services
Community Services, LGBT Outreach Program

Independent Living Resource Center San Francisco
Aging and Disability Resource Connection

Institute on Aging
Alzheimer's Day Care Resource Center, Community Services, Elder Abuse Prevention, Linkages, Resource Centers for Seniors and Adults with Disabilities, Case Management, Home-Delivered Meals Assessment for Adults with Disabilities

International Institute of San Francisco
Community Services, Naturalization Services

Jewish Community Center of SF
Congregate Meals

Jewish Family and Children's Service
Case Management, Home-Delivered Meals, Naturalization Services

Kimochi, Inc.
Adult Day Care, Community Services, Congregate Meals, Family Caregiver Support Program, Home-Delivered Meals, Case Management

Korean Center, Inc.
Community Services, Congregate Meals

La Raza Centro Legal
Legal Services

Laguna Honda Hospital
Alzheimer's Day Care, Resource Center, Congregate Meals

Legal Assistance to the Elderly
Legal Services, Legal Services for Adults with Disabilities

Lighthouse for the Blind and Visually Impaired
Community Services, Taxi Vouchers
Little Brothers Friends of the Elderly
Medical Escort

Meals on Wheels of San Francisco
Case Management, Community Services, Congregate Meals, Home-Delivered Meals

Mental Health Association of San Francisco
Social Support Services for Hoarders and Clutterers

Mission Neighborhood Centers
Community Services, Naturalization Services

Municipal Transportation Agency
Transportation Services

Network for Elders
Case Management, Resource Centers for Seniors and Adults with Disabilities

New Leaf Services for Our Community
Community Services, Volunteer Caregiver Recruitment for LGBT Seniors and Adults with Disabilities

30th Street Senior Center
Case Management, Community Services, Congregate Meals, Home-Delivered Meals, Evidence-based Health Promotion program

openhouse
LGBT Cultural Sensitivity Training for Service Providers

Planning for Elders in the Central City
Homecare Advocacy, Senior Empowerment, Long Term Care Consumer Rights Initiative

Project Open Hand
Community Services, Congregate Meals, Congregate Meals for Adults with Disabilities

Russian American Community Services
Community Services, Congregate Meals, Home-Delivered Meals, Congregate Meals for Adults with Disabilities, Home-Delivered Meals for Adults with Disabilities

Samoan Community Development Center
Community Services

San Francisco Adult Day Services Network
Adult Day Health Care, Adult Day Health Care Enhancement

San Francisco Food Bank
Brown Bag, Single-Room-Occupancy (SRO) Food Outreach Program

San Francisco Senior Center
Case Management, Community Services

Self-Help for the Elderly
Alzheimer's Day Care Resource Center, Case Management, Community Services, Congregate Meals, Home-Delivered Meals, Personal Care, Homemaker, Chore, Naturalization Services, Resource Centers for Seniors and Adults with Disabilities, Congregate Meals for Adults with Disabilities, Home-Delivered Meals for Adults with Disabilities, Naturalization Services, Health Insurance Counseling and Advocacy Program (HICAP)

Senior Action Network
Housing Advocacy, Senior Empowerment

St. Francis Living Room Foundation
Community Services

Southwest Community Corporation
Community Services

Veterans Equity Center
Community Services

Vietnamese Elderly Mutual Assistance Association
Community Services

Visitacion Valley Community Center
Community Services

Western Addition Senior Citizens Service Center, Inc.
Community Services, Congregate Meals, Home-Delivered Meals, Congregate Meals for Adults with Disabilities, Home-Delivered Meals for Adults with Disabilities

YMCA of San Francisco
Community Services