San Francisco Department of Aging and Adult Services

Area Plan 2012 – 2016

Section #	TABLE OF CONTENTS	Page

AREA PLAN CHECKLIST

Enclose a copy of this checklist with your Plan

Section	Four-Year Area Plan Components	4-Year Plan	Annual Update
	All Area Plan documents are on single-sided paper	x☐	☐
	Original Area Plan and two copies are enclosed	x☐	☐
	Transmittal Letter with original signatures or official signature stamps	x☐	☐
1	Mission Statement	x☐	
2	Description of the Planning and Service Area (PSA)*	x☐	☐
3	Description of the Area Agency on Aging (AAA)*	x☐	☐
4	Planning Process / Establishing Priorities*	x☐	☐
5	Needs Assessment*	x☐	☐
6	Targeting	x☐	☐
7	Public Hearings	x☐	☐
8	Identification of Priorities*	x☐	☐
9	Area Plan Narrative Goals and Objectives:	■	
	Title III B Funded Program Development (PD) Objectives**	N/A☐	☐
	Title III B Funded Coordination (C) Objectives	x☐	☐
	System-Building and Administrative Goals & Objectives**	x☐	☐
	Title III B/VII A Long-Term Care Ombudsman Objectives**	x☐	☐
	Title VII B Elder Abuse Prevention Objectives**	x☐	☐
10	Service Unit Plan (SUP) Objectives**	x☐	☐
11	Focal Points*	x☐	☐
12	Disaster Preparedness	x☐	☐
13	Priority Services*	x☐	☐
14	Notice of Intent to Provide Direct Services	x☐	☐
15	Request for Approval to Provide Direct Services	x☐	☐
16	Governing Board*	x☐	☐
17	Advisory Council*	x☐	☐
18	Legal Assistance*	x☐	☐
19	Multipurpose Senior Center (MPSC) Acquisition or Construction Compliance Review	x☐	☐
20	Title III E Family Caregiver Support Program	x☐	☐
21	Organization Chart	x☐	☐
22	Assurances	x☐	N/A

* Required during first year of the Area Plan Cycle. However, updates only need to be included if changes occur in subsequent years of the cycle.

** Objectives may be updated at any time and need not conform to a twelve month time frame

^ If the AAA funds PD and/or C with Title III B.

TRANSMITTAL LETTER
Four-Year Area Plan
2012-2016

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

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

1. (Type Name) Edna James

_____ _____
Signature: Governing Board Chair[1] Date

2. (Type Name) Anna Maria Pierini

_____ _____
Signature: Advisory Council Chair Date

3. (Type Name) E. Anne Hinton

_____ _____
Signature: Area Agency Director Date

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

SECTION 1: MISSION STATEMENT

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

Vision

"San Francisco is a diverse community whose children, youth, families, adults and seniors are safe, self-sufficient and thriving."

Mission

"The Human Services Agency promotes well-being and self-sufficiency among individuals, families and communities in San Francisco."

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

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

SECTION 2: DESCRIPTION OF THE PLANNING & SERVICE AREA (PSA)

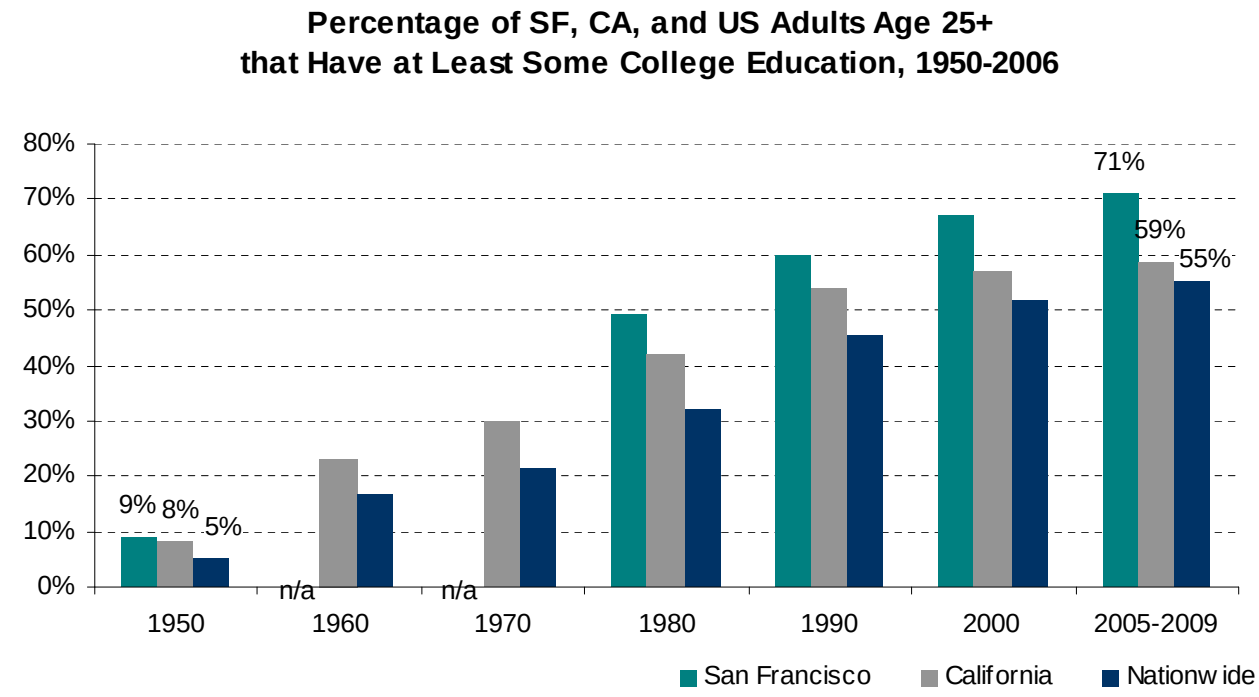
Only forty-nine square miles, the City and County of San Francisco is unique. It is characterized by its diversity, by its distinct neighborhoods, by an abundance of community-based service organizations that provide an array of services for seniors and adults with disabilities, and by a housing market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

San Francisco is also known for its hills and vistas. The housing stock is largely made up of old buildings that sit closely together, many of which have stairs. For seniors or younger persons with mobility impairments, these characteristics can present physical challenges. Seniors who would be mobile and active in other communities may be isolated at home in San Francisco because of steep hills, steep stairs, and steep prices.

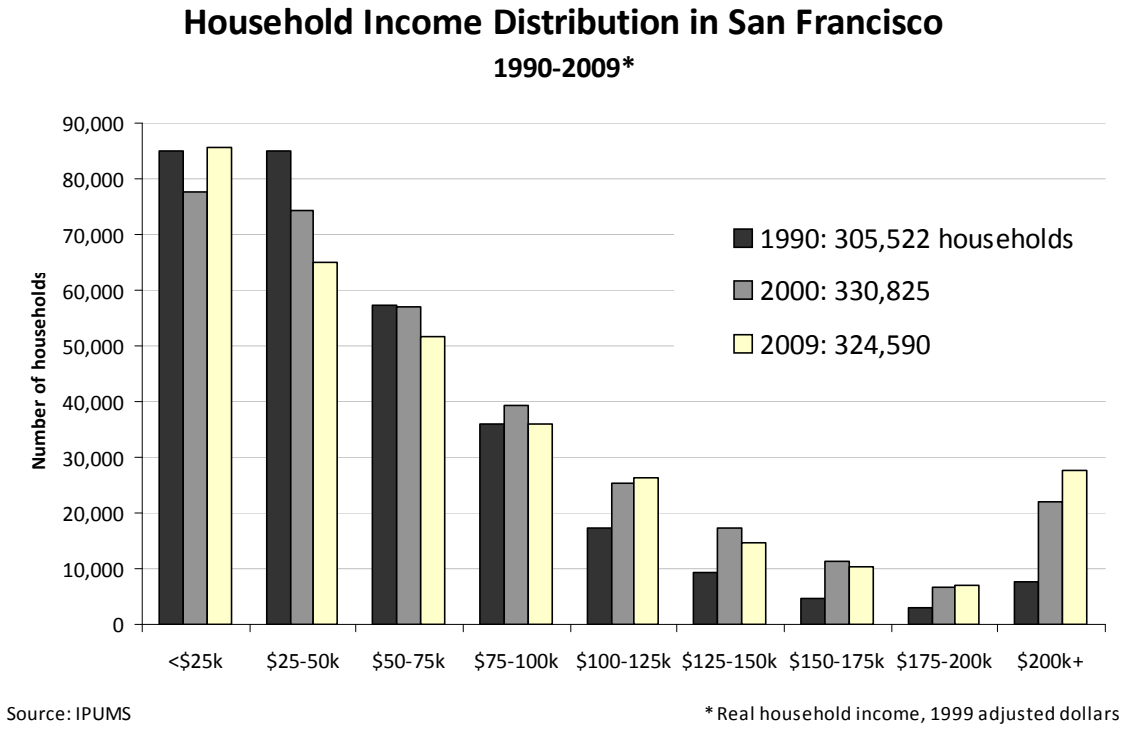
Physical Characteristics and Demographics

Only seven miles long, the City and County of San Francisco is unique. It is characterized by its classic hills and views, its distinct neighborhoods, its rich diversity, and by its intense housing and gentrification pressures. To remain safely in the community, seniors and younger adults with disabilities must contend with broader economic influences that have reshaped San Francisco. As illustrated in the following chart, the emerging knowledge economy has placed a premium on education, and San Francisco has had an influx of highly educated younger adults without children.

Salaries have risen to keep pace with education levels, consequently driving up the cost of living in a compact city with limited room for growth. The chart below illustrates changes in the proportion of households making more than $200,000 per year, and the corresponding drop in the number of middle income households. Low income households have increased since 2000, but likely reflect immigrants working in insulated labor markets in the city's ethnic neighborhoods.



Source: US Census Bureau, IPUMS; 2005-2009 American Community Survey 5-year estimates table B15002.



Source: IPUMS

* Real household income, 1999 adjusted dollars

The changes in the city's economy have created a disparity between very affluent and very low income communities. The chart below illustrates the city's "Gini Coefficient." This measures the disparity in a community's income. If one person had all of a community's income, the Gini Coefficient would be a perfect 1.0, and if all citizens shared income equally, the score would be zero. The highest Gini Coefficient score in the world, at .71, is in the African country of Namibia; the lowest, at .23, is Sweden.

San Francisco has a very high rate of income disparity that has grown rapidly in the last two decades. The city's economic context has manifold implications for seniors and persons with disabilities. For example, San Francisco has the lowest proportion of children of any major city in the United States. Only 14% of the city's population are minors, compared to a statewide rate of 28%. For seniors, this means that many of their adult children cannot afford to raise their families in the city where they grew up, and their aging parents remain behind without the informal support of family members. Because of the recession, many older persons are working longer. They tend to be less educated and may need to compete for low-wage jobs against younger adults who have college degrees. More broadly, the increasing social and economic distance between young, educated, affluent, adults without children – many of whom live in San Francisco for a only few years before moving to more affordable communities -- and the large number of older, low-income seniors and persons with disabilities raises concerns about the community's continuing capacity for support.

Rising income inequality

Household income Gini Coefficients 1990, 2009

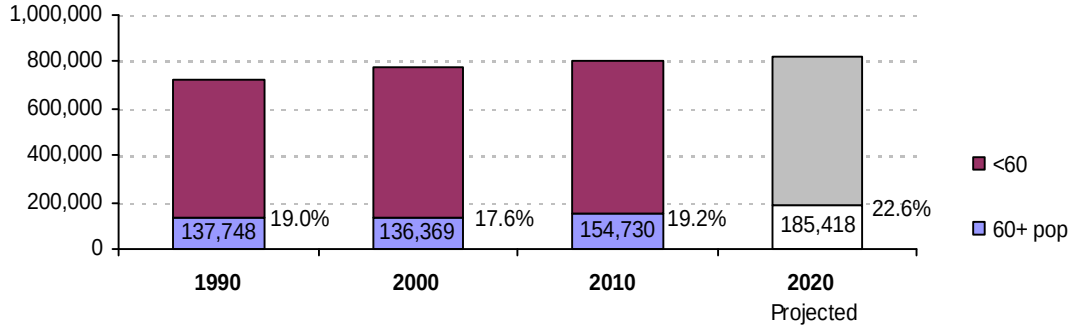
Sources: American Factfinder, *Central Intelligence Agency (2005)

Seniors by Age Group

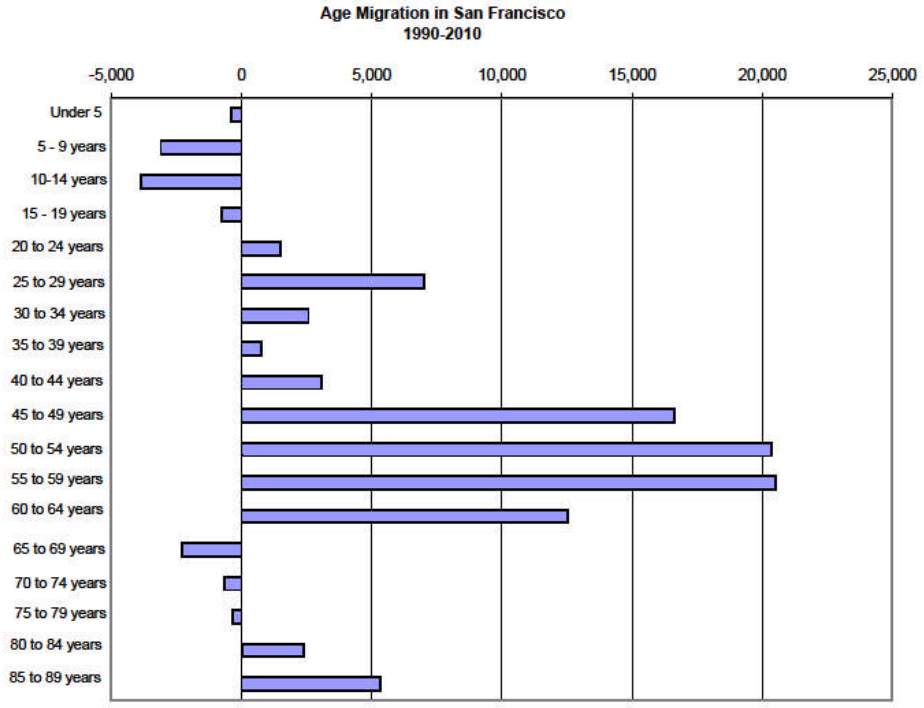
Between 1990 and 2010, San Francisco's total population grew from 723,959 to 805,235, an increase of 11%. During that time the number of seniors also increased by 11%. In San Francisco, the proportion

of the population age 60 and over is 19%; in California, 16%. Both the number and share of San Francisco's senior population are projected to increase over the next 10 years.

Population Growth: San Francisco's senior population grew by 18,000 from 2000 to 2010 with continued growth expected in the coming decade.
(Source: US Census 1990, 2000, 2010; CA Department of Finance projections, 2007 & 2011)



The accompanying chart illustrates changes in San Francisco's population by age. Since 1990 the city has lost many of its children, but it has gained many middle aged persons who are likely at the height of their earning power and apparently beyond their child-rearing years. San Francisco also appears to have more young adults without dependents, who possibly stay here for a limited period in their lives and careers before moving to more affordable communities. The drop in the number of persons age 65-79 corroborates that upon reaching retirement age, many San Franciscans also leave for more affordable communities. The increase in the number of persons over the age of 80 suggests that an earlier cohort, possibly a remnant of a different economic era, has remained here and aged.

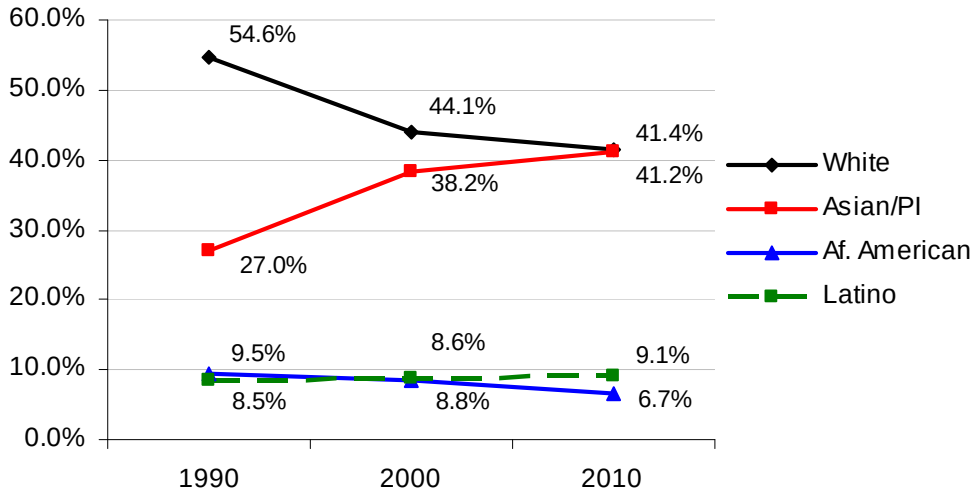


Race & Ethnicity

San Francisco's greatest asset is its diversity. As shown in the accompanying chart, whites made up 55% of the seniors in 1990, but declined by 2008 to 42%. Asian/Pacific Islanders increased from 27% to 40%. During that time, the number of white seniors decreased by over 9,000, while Asian/Pacific Islanders increased by almost 25,000. A significant portion of this growth is due to immigration: about 20,000 Asian and Pacific Islander seniors currently living in the city entered the United States after 1990. African Americans decreased slightly as a proportion of seniors, losing over 800 persons, while Latinos increased by over 3,500.

Population 60+ in San Francisco is increasingly Asian / Pacific Islander

(Source: Census and ACS-3yr-2010)



Fifty four per cent, the majority of senior San Franciscans, speak a language other than English. This includes individuals who speak both English, still the majority language, and another language. Chinese is the second most common language, spoken by 26% of those 60+, with most speaking Cantonese and a minority speaking Mandarin. Spanish (9%), Tagalog (6%), and Russian (4%) are the other most common languages among the older population.

Educational Attainment

As described earlier, San Francisco's population is one of the most highly educated in the country. As younger generations have aged, educational attainment among seniors in the city has risen: approximately 51% have at least some college, compared to 44% in 2000 and 34% in 1990. However, about one-fifth (21%) of San Francisco seniors have less than a 9th grade education, a higher share than the statewide rate of 14%. Seniors with lower levels of education may have greater trouble reading and writing, and when compounded by limited English proficiency, might not be able to read routine mail and notices. Knowing about available resources and navigating complex service systems may also be

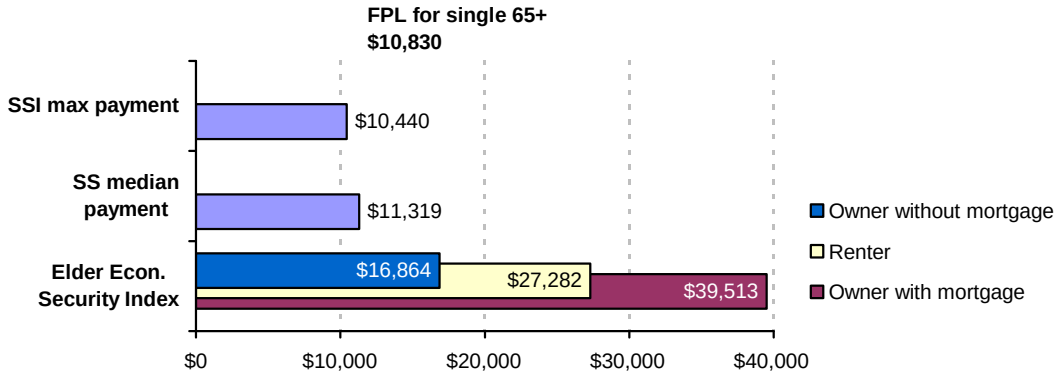
particularly challenging for these seniors. Moreover, more seniors are working than before, and they face significant disadvantages in seeking employment when younger applicants are highly educated.

Income and poverty

Among San Francisco's roughly 155,000 seniors, approximately 19,000 (12%) were living below the federal poverty line and more than a quarter (27%) were living below 150% of the federal poverty line in 2006-2008. The federal poverty line for a single person age 65 or older is $10,326 per year, or $13,014 for a two-person household.[2] The Federal Poverty Guidelines (FPL), however, fail to take into account regional variations in cost of living. Many individuals with incomes above the poverty line continue to struggle to make ends meet in San Francisco.

The California Elder Economic Security Standard Index estimates how much is needed for a retired older adult to adequately meet his or her basic needs – without private or public assistance.[3] The chart below shows that for an elder person in San Francisco, expenses for basic needs far outstrip the federal poverty guidelines. Expenses also exceed median Social Security (SS) payments and the maximum payments under the Supplemental Security Income (SSI) for older and disabled adults with little to no income. *Based on the Elder Economic Security Standard Index, 61% of San Franciscans seniors -- more than 65,000 people over the age of 65 -- do not have enough income to meet their basic needs.*

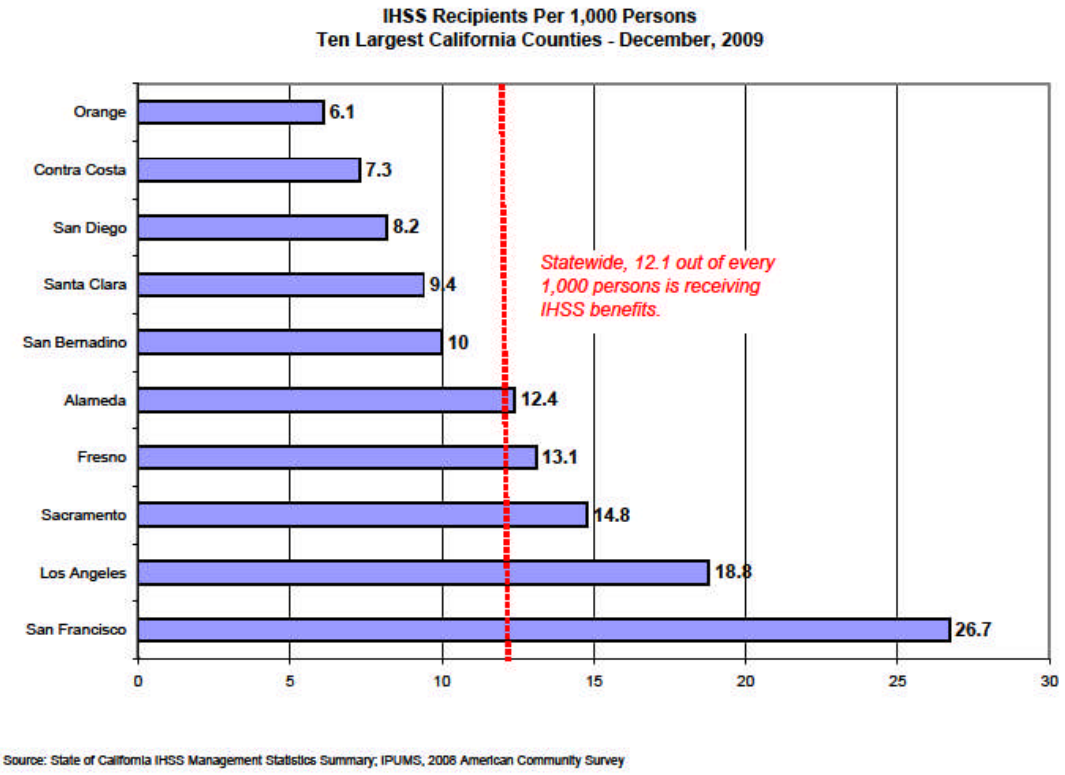
What it took to live in San Francisco in 2009 far outstripped both the federal poverty guidelines and government payments.
(Source: San Francisco County, Elder Economic Security Index 2009)



[2] Definition from 2008. Data retrieved 6-17-2011 from Census.gov › People and Households › Poverty Main › Poverty Data › Poverty Thresholds › 2008, http://www.census.gov/hhes/www/poverty/data/threshld/thresh08.html

[3] Basic costs include food, housing, medical care, transportation, and other necessary spending. For more information, see the Insight Center for Community Economic Development: http://www.insightcced.org/communities/cfess/eesiDetail.html?ref=39

California supplements federal SSI payments, but over the past two years has reduced its payments multiple times, resulting in lower payments to recipients.[4] The combination of these cuts reduced an individual recipient's 2010 income by more than $900.[5] Even before cuts, many SSI recipients in San Francisco were struggling to pay for basic necessities. SSI reductions have a pronounced impact in San Francisco, as so many of its low income citizens rely on SSI. [6] The accompanying chart, which is drawn from a 2009 analysis of San Francisco's public assistance, compares San Francisco's SSI rate among low –income persons compared to the other large counties in the state.



Compared to the rest of the state, an unusual proportion of SSI recipients in San Francisco are seniors. The program has two categories of recipients: 1) Blind and Disabled; and 2) Aged. Statewide, 29% of SSI benefits fall into the category of Aged; in San Francisco, 55%. One possibility for the difference is that the city has many seniors who immigrated in mid-life and did not have the time to accrue full Social

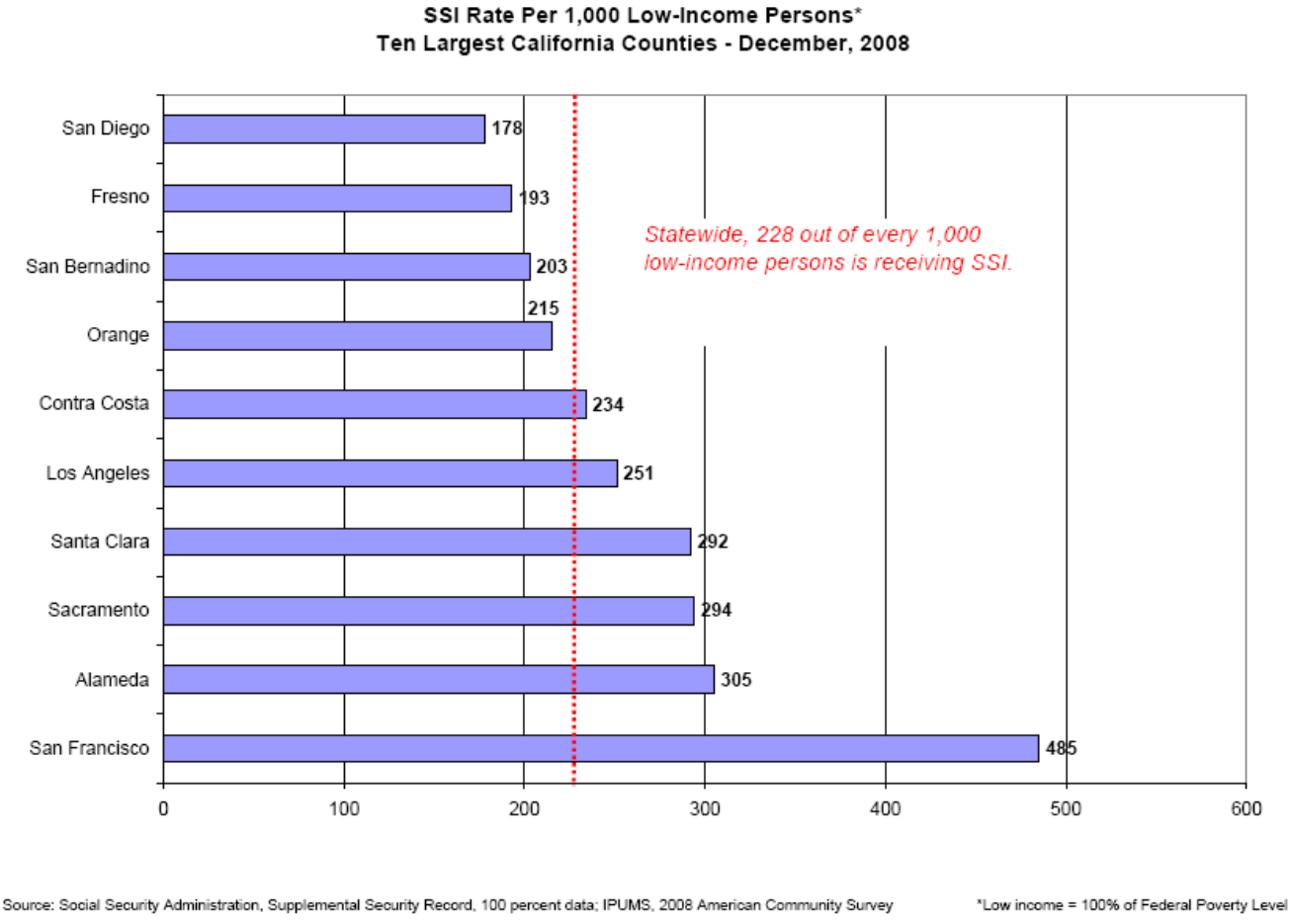
[4] It is unlikely that benefits will be reduced further because doing so would result in California losing Medicaid funding.

[5] According to the Social Security Administration, "California SSI State Supplement Reductions", the state's monthly rate for an individual dropped by $76 between May, 2009 and July, 2011.

[6] The reduction in SSI has also affected money coming into the county. According to Social Security records, county residents received $2 million less per month in December of 2010 than in December 2008. Some of this reduction is because of cuts to SSI, and some because fewer San Franciscans were SSI recipients in 2010. SSI Recipients by State and County, http://www.ssa.gov/policy/docs/statcomps/ssi_sc/

Security benefits, requiring them to rely on SSI. Seniors relying on SSI have heavy concentrations in the city's Chinatown and Ocean/Merced/Ingleside neighborhoods.

Correlated with San Francisco's high rate of SSI is its exceptionally high rate of In Home Supportive Services. San Francisco has more seniors and persons with disabilities who require assistance to remain in the community. The accompanying chart compares San Francisco's rate with that of other large California counties.



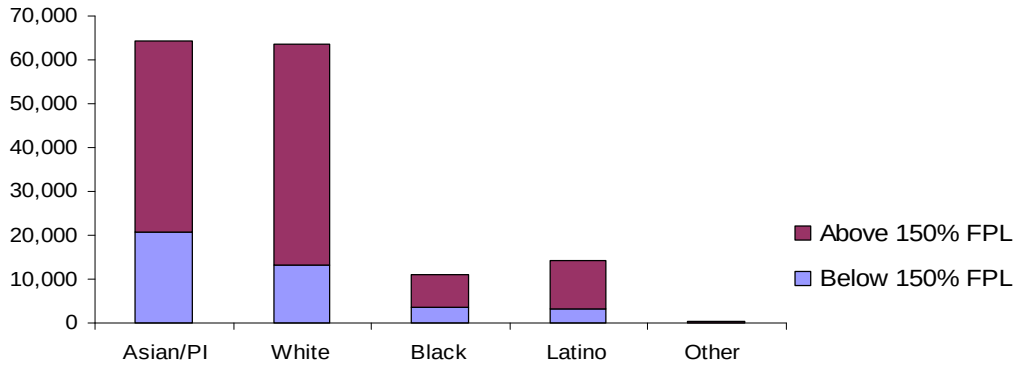
Poverty and Race/Ethnicity

More than 40,000 seniors (27%) live below 150% of the federal poverty line. The largest group of impoverished seniors is Asian/Pacific Islander, but as a share of their community, the seniors most likely to be low-income are African American. The shares of the population living below 150% of the Federal Poverty Line include[7]:

[7] Share of the American Indian / Native American and Other population in poverty is not listed because the population is too small for estimates based on ACS samples to be reliable.

- ❖ 38% of African-American seniors
- ❖ 30% of Asian and Pacific Islander seniors
- ❖ 23% of Latino seniors
- ❖ 23% of white seniors

Senior Population above and below 150% Federal Poverty Level by Race and Ethnicity, San Francisco (Source: ACS-3yr-2010)



Disability

The ACS has changed how it asked about disability twice over the last ten years, making it problematic to compare how the population with disabilities has changed over time.[8] However, since 2005 the estimated number of San Franciscans reporting any disability has been fairly stable at approximately 90,000 people. According to the 2009 ACS estimates, San Francisco was home to almost 34,500 younger adults with at least one disability (6.4% of the population 18-59) and 54,100 seniors 60+ (35%).[9] Disabilities occur at a higher rate within the senior population, and disability rates generally increase with age. Types of disability differ by age. Among younger adults, cognitive and ambulatory difficulties are the most common. Among older adults, the most commonly reported functional limitation is difficulty with walking, followed by difficulty in living independently.

[8] US Census, "New and Modified Content on the 2008 ACS Questionnaire: Results of Testing Prior to Implementation" http://www.census.gov/acs/www/methodology/person_questions/#disable

[9] These numbers exclude the approximately 1,371 persons 18-59 and 3,476 persons 60+ with a disability living in institutional group quarters, i.e. nursing homes, assisted living facilities, jails or halfway houses.

Types of disabilities in the younger and older non-institutionalized adult population, 2009 San Francisco[10]
(Source: ACS-1yr-2009, IPUMS)

Difficulty with:	Walking		Independent Living		Self Care		Remembering / Cognition		Hearing		Vision	
18-59	16,678	3.1%	14,454	2.7%	6,871	1.3%	19,548	3.6%	5,891	1.1%	6,582	1.2%
60+	37,652	24.4%	33,712	21.9%	18,997	12.3%	17,888	11.6%	19,590	12.7%	11,331	7.4%

Disability and Race

For both younger persons and seniors, the disability rates are higher for African Americans (around 18% of younger adults and 50% of seniors). Whites are the largest group of individuals with disabilities among younger persons; among seniors, Asian/ Pacific Islanders.

Estimated Disabled Non-Institutionalized Population by Age and Race, 2010 San Francisco
(Source: ACS-3yr-2010, IPUMS)

	Younger Adults 18-59		**Seniors 60+**	
	Rate[11]	Number	Rate[12]	Number
White	5%	12,110	30%	18,661
Asian / PI	4%	7,135	34%	21,637
Black / Af. Am.	19%	5,829	44%	4,752
Latino	7%	5,721	37%	5,222
Other	n/a	634	n/a	197
Total	**6%**	**31,429**	**33%**	**50,469**

Many younger persons with disabilities live in the Tenderloin and South of Market. These two neighborhoods, characterized by Single Room Occupancy hotels, are close to accessible transportation, but also have some of the highest concentrations of predatory crime and drug abuse in the city (Fribourg, 2009).

Isolated and Homebound Seniors and Adults with Disabilities

Social isolation, having no close friends and few contacts with the outside world, is linked to poor health (Seeman, 2001). No reliable way exists to calculate the number of San Franciscans who are socially isolated or homebound. A variety of rough estimates and proxies are listed below.

[10] Note that individuals can have more than one type of disability.
[11] Using a 90% confidence interval, disability rates for younger adults are within 2% for whites and Asian / Pacific Islanders, within 4% for Latinos, within 8% for blacks, and highly unreliable for other / Native Americans.
[12] Using a 90% confidence interval, disability rates for seniors are within 7% for whites and Asian / Pacific Islanders, within 17% for Latinos, within 20% for blacks, and highly unreliable for other / Native Americans.

Living Alone: In 2010 19% of the adult San Franciscans (133,000) lived alone, a larger share than in California or the US (10% and 13%, respectively). The rates of living alone increase with age (31% of those 65+ in San Francisco) and are higher still among older women (36% compared to 25% for men 65+). In all there are about 12,000 men and 22,000 women age 65+ living alone in San Francisco.

Limited Social Contact: According to a National Research Center 2008 phone survey of disabled and older San Franciscans, 9% of adults with disabilities and 7% of seniors had spent an hour or less socializing with friends or family over the past week. This share would indicate that between 8,000 and 11,000 adults with disabilities and older adults have limited social contact. A San Francisco Controller's Office 2011 phone survey found that 19% of San Franciscans over 60 needed assistance last year with socialization, (ETC Institute, 2011).

Difficulty with Activities of Daily Living as a Proxy for Homebound: Individuals who have trouble performing activities of daily living (ADLs) such as bathing, dressing, using the toilet, and eating, are more likely to be homebound. Applying national rates by age group to San Francisco population numbers results in estimates of the number of people with varying degrees of disability who may be homebound or "at risk" of being homebound or isolated (Kaye et. al. 2010).

Persons needing help with two or more ADLs:

- 8,000 San Franciscans, more than half of whom are 65+
- (3,380 adults under 65 and 4,531 adults 65+).

Persons needing help with only one ADL:

- 14,000 San Franciscans, with a similar share 65+
- (6,173 adults under 65 and 7,744 adults 65+).

In-Home Support Services as a Proxy for Homebound: Aggregated data from In-Home Support Services (IHSS) may also help estimate the number of homebound or potentially homebound adults. If IHSS consumers generally have incomes below 150% of the poverty line, then they make up anywhere from a quarter to over a third of the population in those age brackets[13]:

- 11,108 consumers need help getting in or out of bed
- 8,683 consumers live alone;
- 3,884 consumers are 85+.

Other Distinctive Populations

San Francisco is home to a diverse universe of seniors and persons with disabilities. The circumstances of individuals facing the same challenge can be quite different. For example, the affluent senior living alone, whose adult children have moved from the Bay Area, may suffer from isolation, but his or her experience of it is likely different from that of an elderly person living alone in a Tenderloin SRO room, or a Chinese senior who does not speak English. Some of San Francisco's distinctive populations are described below.

[13] About 27% of those 60+ earn less than 150% of the Federal Poverty Rate as do 35% of those 85+.

Lesbian, Gay, Bisexual, and Transgender (LGBT)

In California, an estimated 2.3% of adults ages 50-70 identify as lesbian, gay, or bisexual in 2007 (Wallace et. al, 2011). A National Research Center phone survey of San Franciscans found that 14% of adults with disabilities and 10% of older adults describe themselves are lesbian, gay or bisexual. LGBT seniors and persons with disabilities face the same challenges but often with unique characteristics, including:

- ***Caregiving*:** A recent study (Metlife, 2010) reported a high incidence of caregiving among LGBT people compared to the general population, (one in four is a caregiver versus one in five). LGBT boomers surveyed described their friendships as an important source of emotional support and were four times as likely to depend on a friend as a caregiver compared to the general population. They were also less likely to expect that they would rely on an adult child for care in the future (16% versus 7%).

- ***Health**:* According to the UCLA Center for Health Policy Research, California's aging gay and bisexual male population has higher rates of hypertension, diabetes, psychological distress symptoms, physical disability and fair/poor health status than heterosexual men with similar demographics.

- ***Isolation and Discrimination***: Fear of discrimination and abuse places LGBT seniors at elevated risk for isolation, and research suggests that mainstream social services may not always provide culturally competent care (Jensen, 2006).

Many LGBT seniors find that their sexual identity and experience of coping with discrimination has prepared them for aging by fostering personal resilience. Focus group participants were quick to highlight their history of fighting for their civil rights and acknowledged that for the LGBT movement to be its strongest, it should be intergenerational and should address racism other forms of within group discrimination and division.

Homeless Seniors and Adults with Disabilities

The 2011 Homeless Count in San Francisco reported 6,455 total homeless persons. It estimated that 8.8% of the total homeless population is over the age 60 (compared to 4% in the 2009 count). Data from the city's shelter system database shows that during FY10-11, about 11% of shelter users were 60+ and roughly 38% were 50+. A 2006 University of California longitudinal study found that between 1990 and 2003 the median age of homeless persons increased by nine years, from 37 to 46. The proportion over the age of 50 increased from 11.2% in 1990 to 32.3% in 2003. The study concluded that many had been homeless longer, growing old while on the street (Hahn et. al., 2006).

A 2009 SF-HSA analysis found that older persons were likely to stay longer in shelter than younger persons, with persons age 65 and older having spent a median of 64 nights in the past year in shelter. Older shelter residents were more likely to be white than non-seniors (47% vs. 34%), slightly more likely to be African American (32% vs. 29%), and less likely to be Latino (11% vs. 18%). In focus

groups, older shelter residents expressed distress about the tumultuous shelter environments and clashes with younger residents (Klienman and Shen, 2009).

A disproportionate number of homeless persons in San Francisco are disabled. According to San Francisco's 2011 homeless count, more than half of all homeless persons interviewed reported a disabling condition, including:

- 30% reporting a physical disability;
- 28%, a serious mental illness; and
- 5% HIV/AIDS.

Seniors and younger adults with disabilities who are homeless share many of the same needs and challenges. For example, tending to health care needs may become less of a priority when scrambling each day for shelter and food. It may be difficult to sequence the steps necessary to gain basic access to services when suffering from mental illness or dementia.

Grandparents as Caretakers

San Francisco is an expensive, difficult city in which to raise children. Parents are under enormous stress, much of it financial. For example, as a proportion of the family budget, child care costs consume 18% of the median San Francisco household income, and are particularly costly in low-income neighborhoods like the Bayview (28% of household income) and Chinatown (74%) (Health Development Measurement Tool, 2006). As a result of the stresses placed on families in San Francisco, many grandparents are asked to assist with the care and support of children. In San Francisco approximately 17,000 grandparents live with their own grandchildren under 18 years, and they comprise approximately 2.5% of all households.[14]

Working Seniors

The economic recession of the last few years depleted the savings of many older persons, forcing them to work past traditional retirement age or to re-enter the labor market after retirement. According to a 2009 national study by the Federal Reserve Board, more than two-thirds of household heads in the age 50-61 group reported that they expected to retire at least one year later than reported in 2007 (Duke, 2011). The annual median income for persons in the pre-retirement ages of 55 – 64 dropped during the recession by $2,000. Their wealth dropped by a median of $15.2 thousand, or 13.7% of their total wealth. The median loss for persons in the 65-74 age group was $13.9 thousand, or 18.2% of their total wealth (Bricker et. al., 2011) Since the start of the recession, the national number of persons age 65+ who were working increased by 14%.[15]

[14] 16,991 with a 7.6% margin of error, according to 2005-2009 5-yr ACS estimates. Of course, not all grandparents are 60+.

[15] U.S. Bureau of Labor Statistics. http://data.bls.gov/timeseries/LNU02000354. Downloaded on January 13, 2012.

According to the 2009 American Community Survey, 25% of San Franciscans between the ages of 65 and 74 are working. The City and County of San Francisco has developed a network of one-stop employment centers that provide job listings, access to computers, career planning, workshops on subjects like resume development, and skill development. Any San Franciscan, regardless of income, who is looking for work can drop-in to one of these centers. In 2011, the number of persons age 60+ who used the centers was 1,666. Of those, 1,614 were unemployed and seeking work. The most common services they utilized at the center were computer lab access, job search workshops, and meeting with career advisors.

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

The Department of Aging and Adult Services

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

The Area Plan budget, however, only includes funding related to the Office on the Aging, which allocates a FY 11/12 baseline of approximately $13.1 million of state, federal and local general funds to 50 community-based organizations, one city agency, and one internal Long Term Care Intake, Screening, and Consultation Unit. Funds included in the Area Plan budget are composed of the California Department of Aging state and federal allocations and local general fund, plus cash match and program income from the Office on the Aging contractors. The city dedicated $5.3 million (40%) in local general funds to Office on the Aging programs.

DAAS encompasses the following programs:

1. Office on the Aging

The Office on the Aging (OOA) is responsible for the program design, scope of services, and monitoring of all programs and services funded by the California Department of Aging. It contracts with 50 community-based organizations and one public agency to provide a full range of programs and services for adults aged 60 and older and for adults with disabilities. The Office on Aging targets frail, isolated, low income and ethnic minority groups of seniors, including elderly lesbian, gay, bisexual and transgender persons. Its services and programs include, but are not limited to, case management, nutrition programs, transportation, health promotion, legal, naturalization, and family caregiver support services.

The services that the OOA funds include:

- *Adult Day Care* (ADC)program is a community-base program that provides non-medical care to persons 18 years of age or older in need of personal care services, supervision or assistance essential for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis.

- *Alzheimer's Day Care Resource Centers:* day care specifically for those in the moderate to severe stages of Alzheimer's Disease or related dementia, whose care needs and behavioral problems make

it difficult for the individual to participate in existing day care programs.

- *Case Management:* care coordination for older adults or adults with disabilities who are experiencing a diminished capacity to function so that formal assistance is required. Services include: assessing needs; developing care plans; authorizing, arranging and coordinating services; follow-up monitoring; and reassessment.

- *Community Services*: services that maintain or improve quality of life such as health maintenance (exercise), education, translation, services that protect elder rights, services that promote socialization/participation, and services that assure access and coordination. Community Services are provided in senior centers or activity centers.

- *Congregate Meals:* meals provided in a group setting that consist of the procurement, preparation, transporting and serving of meals, as well as nutrition education.

- *Elder Abuse Prevention:* consultation with the Ombudsman Program and coordination with Adult Protective Services and other abuse prevention services to provide education, outreach, referral, and receipt of complaints on behalf of vulnerable seniors and adults with disabilities.

- *Family Caregiver Support Program:* outreach to caregivers who assist older adults about resources. Services include information and assistance, case management, transportation and assisted transportation, counseling, respite services and supplemental services to caregivers who have difficulty maintaining quality homecare or the ability to live independently at home.

- *Brown Bag:* surplus and donated food products, produce, and nutrition education to low-income older adults and adults with disabilities.

- *Health Insurance Counseling and Advocacy Program (HICAP):* counseling and information about Medicare, supplemental health insurance, long-term care insurance, managed care or related health insurance; community education activities; advocacy; and legal representation.

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- *Health Promotion:* provides evidence-based health promotion programs which have been proven to be effective in reducing older people's risk of disease, disability and injury and to empower people to take more control over their own health through lifestyle changes, including health education, wellness and exercise workshops.

- *Homecare Advocacy:* Homecare Advocacy is responsible for building collaborative networks; working collaboratively with coalitions and health care professionals toward the expansion and improvement of long-term care plans. It advocates for persons who are at risk for institutionalization, but unable to obtain affordable and timely IHSS help. Through efforts to coordinate, plan and strategize with community groups, unions, and local government, more seniors and adults with disabilities receive critical in-home care.

- *Home-Delivered Meals:* meals for persons who are homebound because of illness, incapacitating disability, isolation, or lack of a support network; includes nutrition education.

- *Housing Counseling/Advocacy:* information for individuals in jeopardy of being evicted and assistance in advocating for tenant rights. Also, training for individuals and groups so they can inform the public about the need for affordable and accessible senior housing.

- *Emergency In-Home Supportive Services:* personal care, homemaker, and chore services to allow older adults and adults with disabilities to remain at home as long as appropriate, thereby preventing premature institutionalization.

- *Legal Services:* legal advice, counseling and/or representation by an attorney person acting under the supervision of an attorney. Areas of expertise include: benefits appeals, eviction prevention, consumer rights, estate planning, etc.

- *LGBT Cultural Competency Training and Integration Program:* to educate social service providers about how to overcome service barriers that exist for LGBT consumers. The goal of the program is to improve access to services, thus improving the quality of life for LGBT consumers.

- *Linkages and Respite Purchase of Service:* prevention of premature or inappropriate institutionalization of elderly and functionally impaired adults, who may or may not be Medi-Cal eligible, by providing care management, and information and assistance services.

- *Medication Management:* provides medication screening and education to an individual and/or caregiver to prevent incorrect medication and adverse drug reactions.

- *Money Management*: assistance to consumers in the management of income and assets. This may include, but is not limited to, payment of rent and utilities, purchase of food and other necessities, and payment of insurance premiums, deductibles and co-payments.

- *Naturalization Services:* services that help legal permanent residents become naturalized citizens, such as: (1) learn English as a second language, (2) prepare for citizenship test, (3) increase awareness of resources, (4) assure access and coordination, (5) hands on assistance with completing N400 application, and (6) provide legal advice, counseling, and representation.

- *Ombudsman Services:* investigates allegations of abuse and neglect made by mandated reporters if the victim is in nursing homes, residential care facilities for the elderly, adult residential care facilities, and other settings in accordance with California Law. The Ombudsman also advocates for behavioral health consumers under 60 as well as the developmentally disabled who reside in these settings.

- *Aging and Disability Resource Center (ADRC):* This is a program implemented in FY 2009-2010. Apart from being centrally located in San Francisco, the ADRC has out-station staff in key underserved neighborhoods and communities throughout the city to provide information and assistance service, and consumer rights information, and to help consumers to remain living independently in the community.

- *Senior Companion*: supportive services for older adults to maintain independent living. Services involve retaining physical health and mental alertness, and enriching social contacts.

- *Empowerment for Seniors and Adults with Disabilities:* training programs for seniors and adults with disabilities in community organizing, leadership, conducting effecting meetings, accessing essential services, conflict resolution, promoting diversity and engaging in civic affairs and advocacy.

- *Social Support Services to Hoarders and Clutterers*: provides support groups and eviction assistance to individuals who compulsively acquire possessions and are unable to discard them. This program also provides education and training to professionals working with target population.

- *Taxi Vouchers:* provides taxi vouchers to seniors and adults with disabilities who cannot take public transportation to medical appointments and other community services. The service is provided by a non-profit.

- *Transportation:* Paratransit services through MUNI Accessible Services that provides wheelchair lift-van and group van transportation to seniors and adults with disabilities.

- *Supplemental Grocery Food Projects:* provide culturally appropriate supplemental groceries and delivery services to homebound seniors and adults with disabilities who live in SRO hotels, or underserved communities, or are on waiting list for home-delivered meals.

2. In-Home Supportive Services (IHSS)

IHSS provides home help workers to low-income elderly and disabled and/or blind adults to remain in their homes rather than reside in an institution. Home help workers assist physically fragile adults with household chores, non-medical personal care like bathing, grooming, feeding or dressing, cooking and more physically challenging home maintenance activities.

3. Public Administrator

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

4. Public Guardian

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

5. Public Conservator

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

6. County Veterans Service Office (CVSO)

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

7. Representative Payee Program

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

8. Adult Protective Services

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

9. Long Term Care Intake, Screening and Consultation Unit

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

10. Community Living Fund

In July 2006, the Mayor and Board of Supervisors of San Francisco created a $3 million locally-funded Community Living Fund (CLF), administered by DAAS. The goals of this fund are to: (1) provide

choices for adults of all ages with disabilities about services that provide them with assistance, care and support to live in the community; and (2) assure that no individual is institutionalized because of a lack of community-based long term care and supportive services. The purpose of the CLF is to:

- Enable adults with disabilities of all ages who are eligible for this fund to remain safely in their own homes and communities as long as possible.
- Provide financial support for home and community-based long term care and supportive services beyond what is currently available.
- Offer flexible funding to service providers to create "wrap-around" services that provide essential community-based assistance, care and support.
- Facilitate the development of service delivery models that strengthen the community-based long term care work force.
- Expand, not supplant, existing funding, in order to fill funding gaps until new sources of financial support for community-based long term care services can be secured through federal Medicaid waivers and other means.

Fully launched now, the Community Living Fund has recently begun funding emergency home-delivered meals, and is providing Share of Cost funding for CLF clients to its list of available services. In addition, funding for a Case Management Training Institute will be allocated in July 2009. The program relies exclusively on local general funds.

Aging and Adult Services Commission

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

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

The Commission meets monthly to vote on the various recommendations and reports of its Finance Committee. Other issues before the Commission may be related to the various local work-groups and state Committees and Commissions such as the Area Agencies on the Aging Council of California and the California Commission on the Aging and Adult Services.

Advisory Council to Aging and Adult Services Commission

The Advisory Council to Aging and Adult Services Commission serves as a public voice to review and advise DAAS's work and advise the services of the agencies it contracts with. Under the current leadership which has been very effective, Council members have expressed an interest in taking a more active role as advocates for the communities of aging and disabled persons.

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

The Advisory Council includes eleven members who are appointed by San Francisco's Board of Supervisors and eleven who are elected by the Council membership. The membership is made up of: 1) more than 50 percent older persons, including minority individuals who are consumers or who are eligible to participate in programs; 2) representatives of older persons; 3) representatives of health care provider organizations, including providers of veterans' health care; 4) representatives of supportive services provider organizations; 5) persons with leadership experience in the private and voluntary sectors; and 6) the general public.

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

Department of Aging and Adult Services

- Adult Protective Services
- County Veterans Service Office
- Long Term Care Intake, Screening and Consultation Unit/Information, Referral & Assistance -- Handles intake for Adult Protective Services, In-Home Supportive Services, Community Living Fund, and Home-Delivered Meals Clearinghouse
- In-Home Supportive Services
- Office on the Aging
- Public Administrator
- Public Conservator
- Public Guardian
- Representative Payee Program

Department of Human Services

- Food Stamp Program
- Housing and Homeless Program
- Medi-Cal Health Connections Program

Department of Public Health

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

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

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

The Long Term Care Coordinating Council

San Francisco's 2004 Living With Dignity plan found that the service structure to meet the needs of the city's senior population was fragmented. In response, the Mayor established the Long Term Care Coordinating Council (LTCCC), which is responsible for: (1) advising, implementing, and monitoring community-based long term care planning in San Francisco; and (2) facilitating the improved coordination of home, community-based, and institutional services for older adults and adults with disabilities. The LTCCC and its subcommittees are working to improve the quality of the care and support, to expand the system capacity and to build a coalition of community caregivers for the aging and persons with disabilities in San Francisco. The goals of the Area Agency on Aging for the next four years were aligned with the *Living With Dignity Plan* developed by the Long Term Care Coordinating Council. Specific objectives in the *Living With Dignity Plan* were adopted for PSA 6's Area Plan in order to create synergies in efforts to address the health and welfare of San Francisco's population.

The roles and responsibilities of the Long Term Care Coordinating Council are as follows:

Provide Leadership

DAAS, as the Area Agency on Aging, stands as San Francisco's lead public organization to represent seniors.

In June 2005 Anne Hinton became the new executive director of DAAS. Ms. Hinton's career spans more than 25 years including positions as the Director of Home Care, Care Management and Fiduciary Services Department for the Institute on Aging, the Director of Aging Services for San Francisco Catholic Charities and Director of the South San Francisco Senior Services. Ms. Hinton has experience as a lecturer/teacher in the field of Gerontology, and has co-authored an article on case management for the publication *San Francisco Medicine*. She has served on several boards, including the California Association of Area Agencies on Aging and the National Association of Area Agencies on Aging boards, professional associations and committees whose focus is long term care. Ms. Hinton works closely with DAAS's leadership team, who cumulatively bring over a hundred years of experience serving seniors and adults with disabilities.

Under Ms Hinton's leadership in the last 6 years, DAAS has developed and implemented a number of new initiatives and programs. These include, but are not limited to: evidence-based health promotion programs; an Aging and Disability Resource Connection; social support services for hoarders and clutterers; information, referral, and assistance for seniors in Housing Authority buildings; a new model for delivery of transitional care services, the Community Living Fund--a fund that provides coordinated

case management and purchased services for individuals at risk of institutionalization; and BTOP (Broadband Technology and Opportunities Program). In addition, DAAS has been the lead organization in the development of the San Francisco Diversion and Community Organization Program (DCIP), which addresses San Francisco's need for a dynamic long term care plan for residents who are either institutionalized or at-risk of being so and provides an integrated approach for individuals who are diverted or discharged from San Francisco county's public skilled nursing facility (SNF), Laguna Honda Hospital. It operates with the goal of placing individuals in the setting that is most appropriate to their needs and preferences, and focuses on appropriate housing, intensive case management and enhanced services.

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

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

One way by which the AAA ensures the involvement of older persons within the community is in the membership of the Long Term Care Coordinating Council (LTCCC). As mentioned above, the LTCCC oversees all implementation activities and service delivery improvements identified in the *Living With Dignity Strategic Plan*, comprises consumers and advocates. Fifteen of the 37 membership slots are reserved for consumers and advocates. Section 6 contains a full description of the membership and structure of the Council. This council plays a key role in ensuring that the programs and initiatives discussed in the Area Plan are carried out, and offers insight into its development.

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

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

A number of Agency initiatives speak to its efforts to support the independence and protect the quality of life of older San Franciscans. These include:

Community Partnerships. As described in Section 2, community partnerships were formed in 2004 in four historically underserved communities (African American; Asian & Pacific Islander; Latino; and Lesbian, Gay, Bisexual & Transgender communities) to strengthen collaborations among community-based service providers and consumers, build new collaborations, and evaluate home and community-based services from a racial, ethnic, and cultural perspective. Since then, the groups have been active, and produced a number of reports describing the status of those groups.

Community Living Fund: As described above, the Community Living Fund was created in order to facilitate transitions from institutional living to the community, and to support those who wish to continue living in their homes. Funded entirely at the local level, the program serves low-income seniors and younger adults with disabilities to live safely in their homes as long as possible.

Diversion and Community Integration Program (DCIP): As described in Section 2, this program is intended to bring the city's many resources together to oversee transitions from Laguna Honda Hospital to the community. DAAS is the lead agency of this multi-departmental effort, which brings an expert panel together to review each transition from or diversion from Laguna Honda Hospital to the community. The DCIP provides an integrated approach to this transition, including housing options and a community living plan for each individual consumer. The DCIP works with the consumer and various service providers to ensure that s/he will live safely in the least restrictive setting appropriate to his/her needs and preferences. Services include mental health services, case management, medical services, housing, in home supportive services, habilitation training and other services needed to ensure that the consumer will succeed in the least restrictive environment.

Aging and Disability Resource Connection (ADRC): In early 2008, San Francisco was selected to be one of the two new ADRCs in California. Currently there are four regional ADRCs developed with initial funding from the Centers for Medicare and Medicaid Services (CMS) and the Administration on Aging (AoA), and two additional ADRCS being funded through a CMS CHOICES Systems Change grant. A cornerstone of California's ADRC model involves using the infrastructure of the AAA and the Independent Living Centers (ILCs) to create a stronger, coordinated system of support for older adults, persons with disabilities and family caregivers. The initial funding from the California Department of Aging to the San Francisco ADRC ended on June 30, 2009. Collaboration between the Independent Living Resource Center of San Francisco, DAAS, and the Aging and Disability Resource Center continues through funding by the OOA.

Medicare Improvement for Patients and Providers Act for Beneficiary Outreach and Assistance (MIPPA): The current project of the ADRC includes the MIPPA, which will provide funds to three entities within the state: AAA, ADRC and HICAP. As San Francisco is one of the four ADRCs identified in California, it has received all three categories of funds to develop and implement MIPPA tentatively from July 2009 through June, 2012. The work is to identify and enroll consumers eligible for the Medicare Savings Plan or the Low-income Subsidy to help pay for the Medicare Prescription Drug Benefit (Part D) premiums.

The ADRC has also received from the Department of Health and Human Services an ADRC Enhancement Grant in FY 2010-2011, and additional funding for Options Counseling and Care Transition Intervention through June, 2012.

Evidence Based Health Promotion Programs: With some city funds, OOA staff worked with community partners to initiate a brand new Evidence-Based Health Promotion Program in 2006. This is consistent with the state's initiative "Empowering Older People to Take More Control of their Health through Evidence-Based Prevention programs." Currently three agencies (30th Street Senior Center (lead agency), San Francisco Senior Center, and University of San Francisco) are providing an EBHP program called "Always Active" to consumers of ten senior centers. As invited by CDA, OOA staff now sit on the state Steering Committee on EBHP program. OOA staff together with two community partners (Self-Help for the Elderly, and Curry Senior Center) have also obtained a small grant from St. Francis Hospital to develop and implement another EBHP program called "Healthier Aging." (i.e. CDSMP, Chronic Disease Self-Management Program, created by Stanford University). In FY 2010-12, additional ARRA funding has been granted to DAAS to run this CDSMP program at 30th Street Senior Center. DAAS has also enhanced the program with additional local funding. Due to the great outcomes of this evidence based

health promotion program, SF Health Plan has recently approached DAAS to give additional support to the CDSMP program.

AOA has recently announced the changes in Congressional appropriation of the Older Americans Act (OAA) Title III D funds, which have minimum requirements for Title III D programs to meet the evidence-based criteria. Before knowing the changes in legislation, DAAS has already planned to implement evidence-based programs funded by Title III D, which includes health promotion and medication management. The new evidence-based medication management program will start its implementation in July, 2012.

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

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

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

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

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

In the spring of 2007, HSA's planning unit developed an emergency response plan specifically for vulnerable populations. It lays out the Agency's plans to provide services to specific vulnerable populations, including support for elderly and disabled clients and relocation for pre-disaster homeless persons. Current disaster plans stipulate that HSA will use geographic information systems to help manage its disaster response. Before and after disasters, the Agency will map the residences of IHSS clients who lack social and formal on-site support. IHSS staff will be assigned a list of these clients. IHSS staff will be instructed to call and/or visit those clients within the first 72 hours of an emergency to check on their health and safety, determine whether or not they have access to necessary supplies, and, if necessary, develop a plan to remove them from their current living situation to a safer location. Neighborhood Emergency Response Team members– San Francisco residents that have attended

specialized disaster response trainings – may also assist with this function. In some instances, very vulnerable IHSS clients may be visited by both HSA staff and community volunteers but, given the risks for this population in an emergency, this level of attention is appropriate.

SECTION 4: PLANNING PROCESS/ ESTABLISHING PRIORITIES

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

Long Term Care Coordinating Council

In 2004, Mayor Gavin Newsom announced the appointment of the Long Term Care Coordinating Council to provide policy guidance regarding all issues related to improving community-based long-term care and supportive services. The Council was intended to be the single body in San Francisco that would evaluate how different service delivery systems interacted and make recommendations about how to improve service coordination. Membership on the Long Term Coordinating Council is comprised of three groups, with the largest group being consumers and advocates. Representing both seniors and persons with disabilities, consumers and advocates fill 15 of the Council's 37 seats. The Council also has 14 seats reserved for service providers, including representatives from services related to health, behavioral health, developmental disabilities, and other disabilities. Eight of the seats are designated for city and county departments, including the Department of Aging and Adult Services, the Department of Human Services, the Department of Public Health, the Mayor's Office on Disability, the Mayor's Office of Housing, the San Francisco Housing Authority, and the city's transportation department. Periodically, the Council has convened workgroups to address specific issues, including long term care integration design in the environment of Medi-Cal managed care.

The *Living With Dignity Strategic Plan 2009-2013* presents a comprehensive strategy to improve community-based care and support. In developing it, the LTCC first evaluated implementation of its 2004 strategic plan, reviewing documentation from various planning activities, assessing the current environment, and highlighting accomplishments and barriers. The LTCC elicited the perspective of stakeholders from every dimension of San Francisco's community-based long term care and supportive services network. This included 16 interviews with public sector organizations, ranging from the Department of Public Health to the transportation authority to the local housing authority. The LTCCC also convened six focus groups, as well as workgroups that concentrated on critical issues such as homecare workforce development, housing and services, mental health access, financing and public policy, and adult day services. The planning process held two community dialogues, one at a housing site for seniors and another at an activity center that served many adults with disabilities. The LTCC also conducted a Web-based survey, recruiting respondents from community service coalitions, advocacy councils, and service partners. The survey posed a series of questions about the strengths and weaknesses of the community support network, as well as its opportunities, and threats. The interviews,

focus groups, and survey also queried respondents about potential strategies for improving the lives of seniors and adults with disabilities.

The LTCCC used information from the evaluation, focus groups, community dialogues, and survey to analyze the system's strengths, weaknesses, opportunities, and threats. A list of potential goals, strategies, and objectives emerged from the analysis. These were aligned as closely as possible with other plans and activities, including the goals of the 2005-2009 Area Plan. A draft plan was presented to an LTCCC steering committee for feedback, and the final document was the *2009-2013 Living With Dignity in San Francisco* strategic plan.

The Area Plan and *Living With Dignity* report are intertwined plans and processes that are developed during different cycles and that successively update and inform each other. The priorities of the current Area Plan are aligned with those of the *2009 – 2013 Living With Dignity* plan. When the *Living With Dignity* plan is updated in 2014, it will draw from the information and framework of the *2009-2014 Area Plan*. For the last decade, the direction of the DAAS Commission and Advisory Council has been to synchronize the planning activities, goals and priorities of the two documents.

Interim Needs Assessments

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

- *Caregiver Support (2009):* This report estimated the number of family caregivers in San Francisco, their demographics, common challenges, and a comparison of existing caregiver support services and unmet need. This assessment was included as part of a request for proposals for caregiver support services.
- *Self Care and Safety (2010):* An analysis of the prevalence of abuse and self-neglect among seniors and younger adults with disabilities, this assessment was used to inform a request for proposals for ombudsman, suicide prevention, and abuse prevention services.
- *Consumer Advocacy (2010):* This report assessed the needs for a bundle of programs, including HICAP; Home Care Advocacy; Housing Advocacy; Legal Services; Long Term Care Consumer Rights Advocacy; Naturalization; and Senior Empowerment.

These assessments were updated and woven into the current DAAS needs assessment. In addition, DAAS produced a series of reports that inform the assessment, including:

- *San Francisco Baby Boomers (2008):* Using census data and available literature, this report projected the impact of the aging baby boomers on San Francisco's support system for seniors.

- *San Francisco's Single-Room Occupancy (SRO) Hotels: A Strategic Assessment of Residents and Their Human Service Needs (2009):* This report compiled, for the first time, data from the San Francisco Human Services Agency, San Francisco Department of Public Health, the Department of Building Inspections, as well as a series of key informant interviews, consumer focus groups, and community dialogues, that developed a comprehensive portrait of the service needs of seniors and persons with disabilities living in the city's SRO hotels.
- *Alzheimer's/Dementia Expert Panel (2009).* This report, which was funded and supervised by DAAS, examined research and developed recommendations related to the needs in persons with dementia.
- *Older Persons Study (2010):* This report examined research and administrative data related to the needs of older persons, age 50 – 64, who may have had needs similar to seniors, but who did not yet qualify for many senior services because of their age.

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2011-2012 Needs Assessment

The 2011-2012 needs assessment drew on recent planning and research efforts, but also developed new information about needs, available resources, and gaps in service. It contains not only information about Office on the Aging services and consumers, but also the broader needs of the community. For example, the assessment describes at length the housing pressures that confront vulnerable San Franciscans, a challenge far beyond the resources of the Office on Aging, but one that deeply affects all seniors, including Office on the Aging consumers. The sources of information for the assessment, both quantitative and qualitative, are detailed in the following table.

2011-2012 Needs Assessment Information Sources

Census 2010 and American Community Survey	Limited data from the 2010 Census was available at the time of this writing. Wherever possible the most recent data was used. As 2010 Census data is rolled out at more finite levels and with more specific variables, DAAS will continue to analyze it, update the assessment information, and disseminate it to the community. American Community Survey (ACS) single-year and 2006-2008 three-year sample data were used to augment the Decennial Census, particularly for statistics on disability, race and ethnicity, and income. The census mapped the universe of seniors and younger adults with disabilities in San Francisco.
Surveys	The California Health Interview Survey is a collaborative project of the UCLA Center for Health Policy Research, the California Department of Health Services, and the Public Health Institute. Local-level data are available for San Francisco and were included to augment local information. The assessment also drew from a survey of 4,000 San Francisco citizens that is conducted every other year, and which included two questions related to services for seniors. Additionally, DAAS contracted with the National Research Center in 2008 to conduct a phone survey of a telephone survey of older adults and persons with disabilities. These surveys provided a range of information about the needs of seniors and younger adults with disabilities and their knowledge and access to support services.
SF-GetCare Consumer Data	Nearly all consumers participating in OOA-funded programs are enrolled in an online database, SF-GetCare. Enrollment information identifies the programs in which each consumer participates, as well as the organization that provides

2011-2012 Needs Assessment Information Sources

	services. Consumer records also include personal characteristics, such as ethnicity, primary language, English fluency level, and zip code. This information was used to assess trends in the utilization of OOA services.
Administrative Data	Across its programs, SF-HSA serves over 120,000 unique persons in a city of approximately 800,000. To better understand the needs of specific populations, especially low-income communities, the assessment drew from the administrative data of SF-HSA's spectrum of programs, including Medi-Cal, food stamps, homeless shelters, workforce development, and In Home Supportive Services. The assessment also drew from SF-HSA's contract and fiscal databases to identify trends in financial support for senior programs. Finally, the analysis utilized administrative data from other city agencies, including the Department of Public Health, Housing Authority, and Mayor's Office on Housing. These information sources provided a broader context to understanding the needs of San Francisco seniors and adults with disabilities.
Literature Review	Staff conducted a literature review of relevant national, state, and local reports. It examined research articles, the needs assessment also drew from research literature that provided insights about needs and suggestions about best practices.
Community Forums	Community forums, open to the public, were held to reach a broad audience of consumers. During the summer of 2011, three forums were held with 20-50 seniors in attendance at each. The first was at the meeting of the DAAS Advisory Council. The second was held at Jackie Chan Community Center, and the third at Western Park apartments, a senior housing community. Using a facilitated conversation approach, participants provided information on the most pressing service, social, and environmental needs of seniors and adults with disabilities in San Francisco and suggested actions DAAS should take to address those needs.
Consumer Focus Groups	In order to gain additional perspective on the issues facing unique demographic groups in San Francisco, focus groups were held with the African American, Asian/Pacific Islander; Latino, lesbian, gay, bisexual, and transgender (LGBT) seniors, and younger adults with disabilities. These smaller, 7-14 person groups allowed participants to delve into the same topics addressed at the community forums, but focused specifically about the unique needs of their specific demographic group.

DAAS drew from the priorities and goals established by the Long Term Care Coordinating Council through the *Living With Dignity* plan. It reviewed these priorities in community forums, providing updated information about needs and services through the assessment. The Area Plan priorities were summarized and discussed at two public hearings, the first at the DAAS Advisory Council on April 18, 2012; the second at a meeting of the Aging and Adults Services Commission on May 2nd. The DAAS Advisory Council is a large body comprised of service providers, advocates, and consumers, and it makes policy recommendations to the Commission. The Aging and Adult Services Commission is responsible for setting DAAS policies. Public stakeholders, including consumers, have an opportunity to express concerns and present ideas at these public hearings.

SECTION 5: NEEDS ASSESSMENT

Since the last needs assessment, the United States has experienced the most severe economic recession in 70 years. The assessment studied how community needs have changed, and it appraised the state of support services for seniors and younger adults in San Francisco, comparing funding and service levels to five years earlier, examining not just the Office on the Aging budget, but the broader investments of the Department of Aging and Adult Services. The subjects of the assessment were organized by DAAS service categories, including:

1. Housing;
2. Nutrition;
3. Isolation;
4. Case management and transitional care;
5. Self care and safety;
6. Caregiver support;
7. Access to services; and
8. Consumer advocacy.

Housing

San Francisco's high cost of housing stresses every population group in the city, but especially seniors and adults with disabilities. Data from the Season of Sharing, a charitable fund promoted by the *San Francisco Chronicle*, suggests the pressure that housing places on many seniors and adults with disabilities. Of the 694 fund disbursements in the 2010-11 fiscal year, almost two-thirds of the recipients were either seniors or adults with disabilities. For seniors, the percentage of disbursements that were for housing deposits, delinquent rent or mortgage, or moving costs was 83%; for younger adults with disabilities, 95%. In focus groups and community forums conducted for this assessment, the need for affordable and appropriate housing was the concern most frequently voiced by participants. Once they had paid their rent, some participants said, they had little left over for other basic necessities like food or medicine.

Since 2006, the Mayor's Office of Housing (MOH), the San Francisco Redevelopment Agency (SFRA) financed 12 completed projects with units exclusively for seniors and adults with disabilities (882 units for very low income seniors; 54 for adults with disabilities). An additional six projects in the pipeline, creating 591 units exclusively designated for very low income seniors, plus 15 units for non-homeless adults with disabilities. The state Supreme Court recently upheld the legality of the Governor's proposal to require each redevelopment agency to relinquish large amounts of public funds to the state or close its doors. As a result, the San Francisco Redevelopment Agency is being dissolved. SFRA projects currently in process will be completed, however, and some of the agency's responsibilities are being transferred to MOH.

Public housing is another important housing resource for seniors and adults with disabilities. The San Francisco Housing Authority (SFHA) manages 45 different public housing complexes in neighborhoods throughout the city, providing over 6,500 affordable rental units to nearly 10,000 individuals. In 2011, 25% of public housing residents in San Francisco were seniors, and 21% of public housing units have a disabled householder. They lived not only in housing designated for them, but were also prominent in developments for families.

More low-income San Franciscans live in SRO hotels than live in public housing. A 2009 study by the San Francisco Human Services Agency (Fribourg, 2009)) found that approximately 18,000 persons lived in the city's 530 SROs. The median age of residents was 55, and an estimated 7,700 were age 60+. To address the needs of seniors in SROs, DAAS developed a program that delivers food to homebound residents in Chinatown SROs. It also amended its housing advocacy contract with the Senior Action Network (SAN) to include a special focus on SRO advocacy.

Despite the city's efforts, many seniors and persons with disabilities in San Francisco are homeless. The 2011 Homeless Count in San Francisco reported approximately 568 persons over the age of 60 who were homeless (SF-HSA & Applied Survey Research, 2011).[16] A 2006 University of California study showed that the median age of the homeless population in San Francisco and other cities is growing, along with the number of years that homeless persons have been on the street. San Francisco's chief strategy to address homelessness for extremely low-income, chronically homeless adults is permanent supportive housing. The Local Operation Subsidy Program, managed by the Mayor's Office on Housing, allocates operating subsidies to buildings that provide supportive housing for homeless individuals and families. SF-HSA and SF-DPH provide funding for the supportive services. The LOSP portfolio currently contains 669 total units, of which166 are in buildings targeted to seniors. Another 81 senior units are planned by FY12-13.

The long waiting lists for these housing opportunities can be deeply discouraging. A recent DAAS community forum participant reported that she had been on a waiting for five years, two of which she spent homeless. City-funded housing counselors help clients navigate the network of affordable housing opportunities. Keeping existing housing is another important element of the housing crisis, particularly as San Francisco has rent control ordinances, and landlords sometimes discriminate against longstanding senior tenants and younger adults with disabilities, finding reasons to evict them so that they can find a new tenant and raise the rent

The Department of Aging and Adult Services does not have a primary role in providing housing. It is focused on the provision of social services and lacks the financial capacity to increase the supply of affordable housing in San Francisco. Because of the vital nature of housing issues to its constituents, however, DAAS does fund some housing advocacy and counseling services in an effort to strategically improve the housing situation for seniors and adults with disabilities. In the last five years, DAAS has ended a contract for emergency housing grants, but the SF-HSA Housing & Homeless Division can provide such grants for seniors and persons with disabilities.

[16] A total of 1,006 surveys contained data on age. Of those, 89 respondents (8.8%) were aged 60+. Applied to a total homeless population of 6,455, that would come to approximately 568.

Nutrition

Nutritious food is a cornerstone of healthy living. A recent national study (U.S. Senate Committee on Health, Education, Labor & Pensions, 2011) found that since the Great Recession, 80% of senior-serving agencies reported an increased demand for nutrition assistance, but 20% also reported that they were unable to meet the increased demand. According to the study, 90% of low-income seniors who cannot afford proper nutrition have no access to federal meal programs.

In San Francisco, the high cost of living forces many low-income residents to choose between paying for rent, medications, or food. Concerned about losing housing or having utilities turned off, some reduce costs by cutting out more expensive foods such as fresh vegetables or high protein items. The importance of maintaining free meal and grocery programs was discussed at nearly all of the community meetings held for this needs assessment. In a citywide survey conducted in 2011, seniors 60 and older were asked if they needed assistance from meal programs in the past year (ETC Institute, 2011). Thirteen percent said "yes."

According to a 2008 phone survey, three percent of older San Franciscans (60+) and eight percent of adults with a disability (18+) needed but were not able to use home delivered meals programs. Rates of unmet demand for the congregate meal programs included 3% of seniors and 7% of adults with disabilities. These rates were largely stable compared to a similar survey conducted in 2006; however, congregate meals for adults with disabilities decreased from a 2006 total of 12%. Though the city's program is not means-test, the most common reason cited by older adults for being unable to use home delivered meals programs was the perception that their income was too high. For adults with disabilities, the most common reason was that respondents didn't know how to access the program (National Research Center, Inc., 2008).

The availability of free and low-cost nutrition programs has increased dramatically in the last five years. In particular, the number of seniors and adults with disabilities participating in the CalFresh program, formerly known has Food Stamps, has increased by 65%. In addition, over the last five years the amount of food provided to seniors through free grocery distributions increased by 31%. The transfer of intake and waiting list management responsibilities coincided with a significant decrease in the waiting time for home delivered meals, and DAAS-funded meals for younger adults with disabilities has more than doubled. In the last five years, DAAS has decreased the total nutrition budget by a small amount, less than one percent, but the number of meals provided with that funding has increased by seven percent, due largely to the implementation of new grocery distribution services and increases in funding to meal programs for younger adults with disabilities.

Services to Reduce Isolation

Isolation was a common theme during San Francisco needs assessment discussions. Participants in focus groups stressed the importance of resources that help to reduce isolation, including: senior centers; adult day programs; support groups; church communities; activities at cultural institutions, including libraries and museums; social and hobby-related clubs; and informal networks of family and friends. At a forum on senior isolation, participants stressed that the fear of losing independence often impeded seniors from

seeking connections (Family Service Agency of San Francisco, 2012). San Franciscans who experience unique issues related to isolation include:

Younger adults with disabilities: Many social programs and discounts at cultural institutions are targeted toward the senior population, not younger adults with disabilities. The vast majority (92%) of DAAS program participants in this area continue to be seniors.

Linguistically isolated seniors: The American Community Survey estimates that 31,532 (28%) of seniors age 65 or older are living in linguistically isolated households.[17] This is an increase compared to the 2000 Census, when 25% of seniors were linguistically isolated.

Individuals living alone, not in senior-specific or supportive housing: Focus group and community forum participants, especially the African American focus group, expressed concerns about individuals living in more isolated housing types. According to Elena Portocolone's study of isolated seniors in the Bay Area, those living in senior-specific housing or even in Single Room Occupancy hotels (SROs) are less likely to be isolated than those living in non-senior-specific housing (Portocolone, 2011).

LGBT seniors: LGBT seniors are at particular risk for social isolation. The pressure to live a closeted life as an LGBT senior is itself isolating, and LGBT seniors who are "out" sometimes struggle with lack of acceptance from family members.

The following program trends may have an impact on the issue of social isolation in the coming months and years:

Changes to Adult Day Health Care (ADHC) Programs: With the elimination of Medi-Cal funding for ADHC programs last year, all of San Francisco's programs faced possible closure. However, the state has developed another program Community Based Adult Services that will be similar to the Adult Day Health Care program. The current ADHC program serves 1,200 vulnerable older persons, and an initial analysis of the non-profit providers suggests that 90% of current participants will continue to receive services.

Expansion of on-line access and social networking tools: More than 50 sites, including senior centers, activity centers, adult day care centers, supportive housing sites, and housing authority sites, serving seniors and adults with disabilities will receive new computers funded by a federal grant, creating an initiative called the Broadband Technology Opportunities Program (BTOP). Volunteers from community based organizations will be teaching seniors and adults with disabilities basic computer skills as well as the use of social networking tools. This program will help in reducing social isolation. Internet-based tools have the potential to provide a forum to build and enhance personal relationships.

Village model: In the last two years, two "Village" organizations have opened in San Francisco. Included in the services of these membership organizations is the promotion of participation in social, cultural, and volunteer activities. While membership is still small, they represent a new local model for engaging isolated individuals and those who are at risk of isolation.

[17] IPUMS American Community Survey 3-year estimates 2007-2009.

In the last five years, DAAS funding for isolation and socialization programming has increased by $615,908 (22%), although nearly half of that increase was due to the BTOP grant. Funding and programming changes at DAAS included:

- *Community Services*, which focus on Senior/Activity Centers, had the largest increase ($226,449, 9%). The majority of this funding increase reflects Board of Supervisor add-backs, as well as outreach funding allocated to providers in this category.
- *Funding for Social Support for Hoarders and Clutterers* has increased, raising the number of professionals trained on the issue and the number of consumers receiving information and referral. This program has been threatened repeatedly by budget cuts, but has yet to see a significant cut after year-end Board of Supervisor add-backs are taken into account.
- *The Senior Companion program* showed a slight decrease in funding ($2,188, 9%), due to state cuts, and is now entirely supported by local General Fund.

Case Management and Transitional Care

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

The need for case management services is difficult to estimate. Many seniors and adults with disabilities successfully act as their own advocates or rely on friends or family for help. Others do not see the value in case management services until circumstances reach a crisis level. In a 2008 phone survey in San Francisco, 7% of adults with disabilities (any age) and 4% of older adults reported that they needed case management or social work services but were unable to access them. Of those, adults with disabilities reported that they did not know the programs existed or how to access them; older adults were also often unaware of program availability, but many also indicated that they believed that they did not qualify or had incomes that were too high (National Research Center, 2008).

The people most at risk of not having full access to needed services are those who live alone or have tenuous social networks. Immigrants and consumers who do not speak English face additional barriers, both because linguistically and culturally relevant services may be less available, and because of fears about utilizing public services. At community forums, participants also identified the need for social work assistance with issues that are more complex than those that can be addressed by information and assistance specialists, but less complex than those handled by intensive case managers.

According to staff from the DAAS Intake, Screening, and Consultation Unit, younger adults with disabilities, especially those without mental health diagnoses, face the biggest challenges in accessing case management programs. While OOA case management contractors do serve younger adults, they are often housed at senior-focused agencies where staff may be less familiar with the unique needs of younger adults. Ninety percent of OOA case management clients served in FY 10/11 were 60 or older.

The skills of case managers can vary. Clinical skills, expertise in specific medical or psycho-social issues, or linguistic and cultural competency – a range of factors can affect the quality of case management. While skills would be expected to vary depending upon the intensity of case management offered, it can be a challenge to ensure that consumers are connected with a case manager whose skills match their individual needs. A poor match can result in poor consumer outcomes. In recent years DAAS has made significant efforts to address variability in case management through the implementation of a case management clinical collaboration as well as a Case Management Training Institute, but the issue persists.

Case management plays an important role during patient transitions from hospital to home. After discharge from an acute-care hospital, San Franciscans with little or no family and caregiver support are vulnerable. Nationally, nearly 20% of Medicare discharges from hospitals are re-admitted within 30 days (U.S. Department of health and Human Services, 2011). A critical adjunct of case management is helping older persons manage their medications. Ten percent of all hospital admissions are related to patients not taking medications as prescribed (Schlenk et al., 2004). Memory and cognition difficulties, concerns about side effects, literacy, costs, and simple dexterity can interfere with an older person's ability to take his or her medications, and the burden of a family caregiver who administers medications can undermine adherence (Jackson, 2011). Emerging research on medication management emphasizes interdisciplinary decision-making that incorporates the patient's point of view (Miller, 2011), includes the pharmacist as a part of the care team (Hutchinson & Castleberry, 2011), and involves the caregivers and range of persons in an older person's life (Jackson, 2011).

Through a network of 12 contractors, DAAS funds long-term, short-term, and transitional case management services. Case management services are available in at least 13 languages. In FY 11/12, OOA-funded case management programs are contracted to serve approximately 2,250 consumers. Two hundred are served through the Linkages program, one of the only programs that: a) funds service purchases; and b) specifically targets younger adults with disabilities who do not have a primary mental health diagnosis. DAAS also funds the Community Living Fund, which will serve 500 consumers who were previously institutionalized or at risk of institutionalization.

The Department of Public Health (SF-DPH), through its Community and Behavioral Health Services division, also funds a variety of case management programs for individuals with behavioral health issues. SF-DPH case management services fall under the following categories: crisis services; acute services; residential services; supportive housing and shelter-based services; intensive case management; outpatient services; and substance abuse-related services.[18] The California Department of Aging directly funds the Multipurpose Senior Services Program, which serves Medi-Cal eligible seniors age 65 or older who have been certified for placement in a nursing facility. Finally, other local non-profits offer case management services that are not funded by DAAS, SF-DPH, or the California Department of Aging.[19]

[18] Detailed descriptions of DPH-funded services and associated service providers can be found on-line here: http://www.sfdph.org/dph/files/CBHSdocs/OrgProviderManual062011.pdf

[19] Examples include: Samoan Community Development Center, Italian American Community Services, Little Brothers/Friends of the Elderly, Northern California Presbyterian Homes and Services, Veteran's

Recent Trends Related to Case Management and Transitional Care

Over the last five years, DAAS has expanded the *capacity* of local case management for two specific populations: 1) individuals at imminent risk for entry or re-entry into skilled nursing facilities; and 2) the individuals transitioning to home from acute care hospital settings. These efforts include:

Community Living Fund: To prevent institutionalization of seniors and adults with disabilities, DAAS launched the Community Living Fund in March, 2007. It has broad and flexible authority to use funds in whatever way deemed necessary to allow seniors and adults with disabilities to reside in the community. The program's design and mission make it unique in the state. It served 512 unduplicated clients in the FY10/11, and had a waitlist of approximately 27 potential clients.[20]

Homecoming Transitional Care Network: In 2002, a partnership between The San Francisco Senior Center and Catholic Healthcare West[21] - Saint Francis Memorial Hospital resulted in the formation of the Homecoming Program, which bridges the gap between hospital discharge and successful recovery at home. Since its creation, the program has received funding through the Community Living Fund (starting in 2007), as well as a 2008 grant to add a full-time referral coordinator and expand the Homecoming Program to all San Francisco acute-care hospitals. It established a centralized referral process to enable hospitals to refer to a network of agencies.

Coleman Care Transitions Intervention (CTI): This is a federal funded program granted to SF DAAS by the California Health and Human Services, as SF DAAS is a designated Aging and Disability Resource Connection by the State. It empowers consumers to take a more active role in their health care and prevent re-hospitalization. It focuses on four areas: medication self-management; patient centered health records; primary care provider/specialist follow-up; and patient knowledge of red-flags for conditions that worsen. The Institute on Aging operates this program and has developed partnerships with St. Mary's Medical Center and Saint Francis Memorial Hospital. In FY 11/12, the program is contracted to serve 80 consumers.

New funding opportunities through health reform legislation: In December, 2011 DAAS worked with local hospitals and CBOs to submit a proposal to the Centers for Medicare & Medicaid Services for a "Community-Based Care Transitions Program" grant, which was funded through the Affordable Care Act. The grant program is intended to test models for improving care transitions for high risk Medicare beneficiaries, including transitions of beneficiaries from the inpatient hospital setting to other care settings. In addition, the state's new 1115 waiver, which is intended as a state-level bridge to implementation of the Affordable Care Act, includes a Delivery System Reform Incentive Pool through which the state can make payments to public hospitals to improve quality of care. This makes it likely that hospitals will have funding to make systemic improvements in care, some of which may be to improve transitional care.

Equity Center, Family Caregiver Alliance, Glide Foundation, Northeast Medical Services, South of Market Health Center, Saint Anthony Foundation, and others.

[20] Wait list estimate as of August 2011.

[21] Now known as Dignity Health.

Case Management Clinical Collaboration: Since 2007, through a model implemented by the OOA, most case management providers meet at least monthly as a group and weekly individually with a clinical supervisor to discuss cases and to receive in-service training, encouraging consistent case management standards and interaction between case managers.

Case Management Training Institute: DAAS community case management programs have long emphasized the importance of meeting the linguistic, cultural, and clinical needs of consumers. However, those programs have historically varied in focus, degrees of service provision, educational background, and skill types. Launched in 2009 with funding from the Community Living Fund, the Case Management Training Institute, administered by the Felton Institute, a program of Family Service Agency of San Francisco, which piloted and designed trainings modeled after the Motivational Care Management model, formerly known as the Strength-Based Care Management model.

Case Management Connect Project: In July, 2007, following two years of research and planning, the San Francisco Partnership, DAAS, and SF-DPH initiated a pilot project to improve coordination of services for clients who may be utilizing more than one of the city's diverse case management programs. The pilot project includes 14 case management programs under contract that partnered to coordinate services for their clients through the use of an electronic rolodex.

Diversion and Community Integration Program (DCIP): DCIP brings together the city's resources and experts to ensure that individuals who are diverted or discharged from San Francisco's public skilled nursing facilities have the ability to live independently. A team representing various services by and through DAAS and SF-DPH (e.g., In-Home Supportive Services, Community Behavioral Health Services, Housing and Urban Health, Laguna Honda administration, a home health agency, etc.) meet regularly to review the cases of eligible clients.
DCIP surveys Laguna Honda residents regarding their wish to leave the facility. In 2011, DCIP surveyed 360 patients. The number who wanted to stay in Laguna Honda was 224; wanting to leave, 126. Another ten said they might want to leave.

Changes to DAAS Programming

Although funding in some areas of case management has decreased, the overall DAAS funding to case management and transitional care programs has increased by $3 million (95%) since FY06/07. Significant trends within that overall increase in funding include:

- The Community Living Fund launched in FY06/07, with $512,837 of spending in that year. The annual general fund allocation for that program was $3 million annually, however, and leveraging of additional outside funds has resulted in a FY11/12 budget of $3.6 million. The development of this program has dramatically enhanced the availability of services for individuals being discharged from institutional settings and for those at imminent risk of institutionalization. Apart from intensive case management, many consumers receive purchase of services which are critical to help them living independently in the community.
- The District-Wide Social Services Worker program was eliminated in FY07/08, and the majority of its funding redirected to case management programs.
- In March 2012, DAAS has just released a request for qualifications, using Title III D funding and some general funds, to provide seniors and adults with disabilities with evidence based

medication management services. A pharmacist or group of pharmacists will be selected to work with all OOA-funded case management providers to provide medication education and counseling to consumers. Consumers are identified by a medication management and case management module that will provide alerts leading to the connection with the pharmacist.

- In FY09/10, the California Department of Aging eliminated all funding for Linkages and Respite Purchase of Services. DAAS has back-filled the majority, but not all, of that state cut with local general fund.

Self Care and Safety

Protecting seniors and adults with disabilities is central to the mission of DAAS. The department provides services directly through a range of programs, including Adult Protective Services, Community Living Fund, Public Guardian, Public Conservator, Representative Payee, and In Home Supportive Services. To augment this safety net, DAAS also funds a number of services through community service providers, including the suicide prevention and long-term care ombudsman programs. These programs address support in the home, safety both at home and in the community, social isolation that results in depression and even suicide, and abuse that can occur either in the community or in out of home care. In the last five years, with notable exceptions, most of the programs in this category have grown.

Support in the Home

As described in the needs assessment report, San Francisco has the state's highest rate of dependence on IHSS. In the last five years, IHSS funding has increased by 33%. The number of consumers served increased by 17%; the number of authorized hours, 21%. In every focus group and community forum conducted for this assessment, IHSS was mentioned as a critical need, preventing isolation, health issues, and more expensive institutionalization. In both the Bayview focus group and the Western Park community forum, participants mentioned the painful choices caused by the IHSS eligibility cut-off. Seniors just above the income threshold may require services, but find them unaffordable.

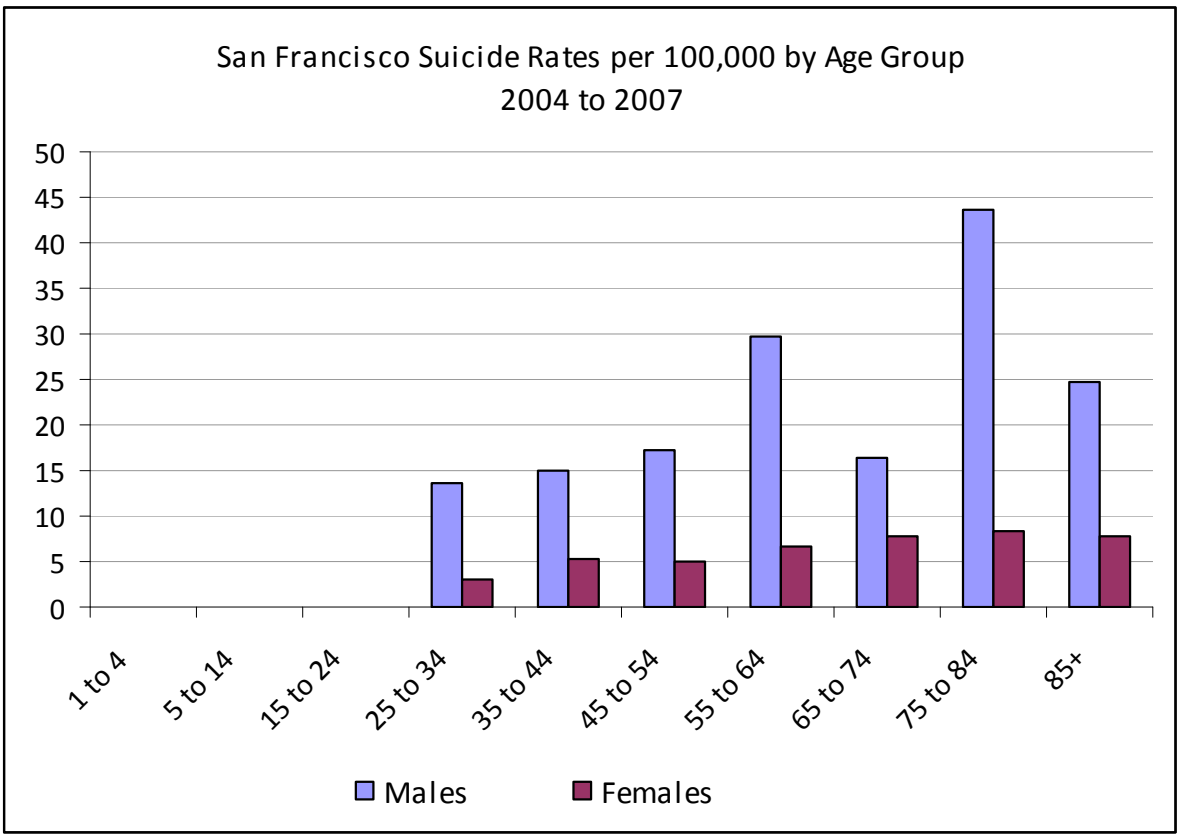
Personal Safety, Safety in the Community

Adults with disabilities living in the Tenderloin, as well as seniors in the Chinatown and Mission districts, expressed fear about crime and personal safety. Chinese seniors in focus groups were afraid of robberies on crowded buses, muggings on the street, and more generally about strangers waiting outside seniors' homes. Latino seniors mentioned recent robberies and the vulnerability of seniors leaving the bank. The issue of safety in housing developments and apartment complexes came up in different contexts.

Traffic safety was also a common theme raised in focus groups. A senior at the African American focus group mentioned the extra time needed as a pedestrian to cross the street. Older people are more vulnerable as pedestrians and suffer more injury complications as a result of pedestrian injuries; the rate of pedestrian fatalities for those 65+ is four times that of adults and twelve times that of children (San Francisco Department of Public Health, 2010).

Social Isolation and Suicide

As people age, they are more likely to live alone. As described in the first part of this assessment, a large number of older and disabled San Franciscans live alone. Social isolation is a major health risk. Social and medical research shows that risks for social isolation are comparable to the risk factors of obesity, sedentary lifestyles and possibly even smoking (Cacioppo et al., 2002). Social isolation also elevates the risk for depression and suicide. Older persons are the highest risk group for suicide, and seniors who attempt suicide are more likely to complete the act (Klinger, 1999). The accompanying chart, drawn from SF-DPH data, suggests seniors' increased risk for suicide.



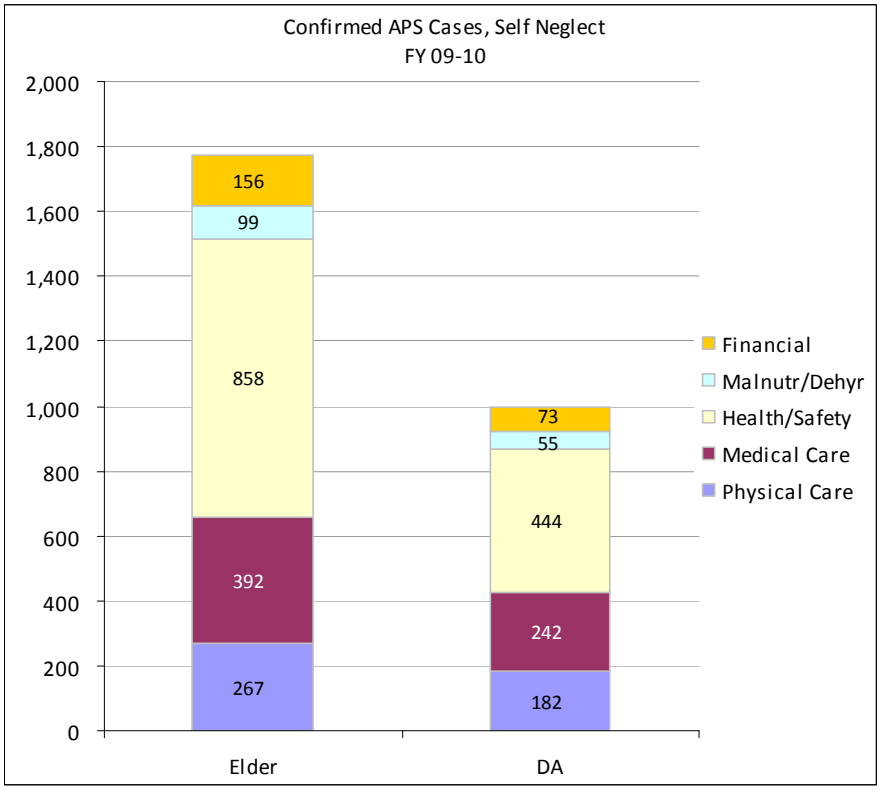
Local research suggests that social isolation is of considerable concern for both seniors and younger adults with disabilities. A 2008 phone survey of San Francisco seniors and adults with disability indicated relative levels of isolation. Seven percent of seniors and nine percent of younger adults with disabilities responded that they spent less than one hour or no hours per week socializing with family and friends (National Research Center, 2008).

Elder/Dependent Adult Abuse Prevention

National research on the prevalence of elder abuse varies widely from study to study, but it consistently estimates that reported incidents represent only a fraction of the true number of cases in any community (National Center on Elder Abuse, 2005). Statistics about the prevalence of abuse among the disabled adult population are scarce, but may mirror the rates of abuse among seniors.

According to a 2010 analysis of Adult Protective Services (APS) data, psychological or mental abuse was the most common type of abuse perpetrated by others against seniors and dependent adults, comprising 38 percent of all confirmed allegations. Seniors were more likely than dependent adults to suffer financial abuse at the hands of others, comprising 35 percent of all confirmed allegations involving seniors. Dependent adults were more likely to experience physical abuse, forming 24% of this group's confirmed allegations. The accompanying chart illustrates the types of allegations for the two groups.

Self-neglect is the most commonly reported type of elder abuse, both in California and in San Francisco, making up approximately 60% of all reported incidents.[22] These cases can be particularly challenging because the victim is often reluctant to accept help. Some people remain fiercely independent and are fearful of loss of control or institutionalization should APS intervene. Dementia, depression, substance abuse, and mental health issues also complicate care and elevate risk of self-neglect and other types of abuse.

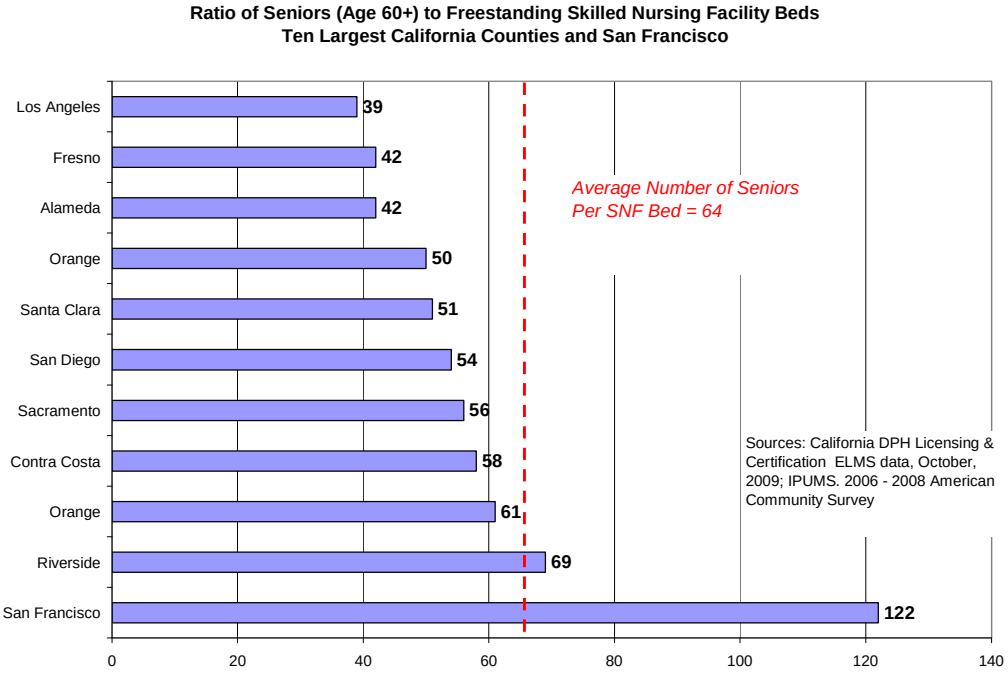


Abuse in Out of Home Care

One consequence of the gentrification of San Francisco is that the number of Medi-Cal-funded beds in the city's Skilled Nursing Facilities (SNFs) have dropped dramatically. For example, the California Pacific Medical Center Sutter is proposing to eliminate over 400 long-term care Medi-Cal beds (Nadell, 2010). The chart below illustrates San Francisco's lack of SNF options, highlighting the number of

[22] Based on SOC 242 reports, available at: http://www.cdss.ca.gov/research/PG222.htm

persons over the age of 60 to beds in "freestanding" SNFs, the facilities likely to be dedicated to long-term care, as opposed to SNF beds in acute care hospitals. Many seniors and persons with disabilities who require long-term care are being forced to move outside of the city, away from family and friends, becoming socially and culturally isolated in the later years of their lives.



SNFs have also converted beds from long-term care to short-term rehabilitation, shifting their funding from Medi-Cal to the more lucrative Medicare. These facilities are under financial pressure to complete the course of rehabilitation and discharge patients within prescribed time frames. They may tend to emphasize rehabilitative activities at the expense of custodial care, or they may hurry discharge without the needed supports in place for the patient to transition home safely. In addition to complaints about poor care (feeding assistance, unanswered call bells, etc.) in rehabilitation facilities, the San Francisco Ombudsman Program, which investigates complaints of seniors in care, frequently responds to complaints about rights related to discharge planning.

An analysis of the San Francisco Ombudsman activities in 2010 found that during the 2009 – 2010 fiscal year, the San Francisco Ombudsman responded to 1,011 complaints, which resulted in 696 cases being opened.[23] Eighty-eight per cent of these cases (584) were for residents of nursing facilities. Another 69 cases were for residents in board and care, assisted living, residential care and similar long-term facilities, both regulated and unregulated. Three cases were in other settings. The largest category of complaints – 268 – involved care. The second largest category was in the area of activities and social services, the majority of which were related to conflicts between residents. The third largest category of complaints was in the area of abuse, neglect, and exploitation (121), of which the largest group involved physical abuse (39).

[23] All data on San Francisco Ombudsman activities drawn from that office's "State Annual Ombudsman Repot to the Administration on Aging" for the 2009-10 fiscal year.

Changes in DAAS Programming

DAAS funding for Self Care and Safety programs has generally increased. In particular, IHSS has increased by 33% and now has a budget over $110 million dollars, with a continuing caseload of over 21,000 clients. It now forms 90% of the department's funding for services in this category. Yet the program faces uncertainty. In his 2011/12 budget, the Governor recently proposed that the number of service hours that IHSS consumers be cut across the board by 20%. This reduction was challenged in the courts, and has been delayed due to a court injunction. While the case goes through the legal process, the Governor's reduction is reflected again in the proposed budget for 2012/13. The latest budget also includes an elimination of domestic and related services to recipients who are living with others in a shared-housing situation, with an exception for households consisting entirely of IHSS recipients.

The budget proposes that, beginning January 1, 2013, IHSS and other home and community-based services, as well as nursing home care, become benefits of managed care. According to the proposal, all IHSS services will be included in the capitated rate paid to managed-care providers. A separate proposal, effective June 1, 2013, will expand Medi-Cal managed care from the current 30 counties to all 58 counties. Under this proposal, county IHSS programs continue to perform existing functions such as intake, assessment, and authorization of services through the 2013 calendar year. Starting on January 1, 2014, however, managed care plans would either contract with county social service agencies to continue to administer IHSS, or they would absorb IHSS and administer it directly. IHSS in its current structure – community based, with the consumer being the employer, and relatives being able to provide the service – would be a novel program within the realm of managed care. At the time of this report, the future of IHSS is cloudy, but its importance as a support that keeps vulnerable people in the community and out of institutional care is its best safeguard.

The programs funded by the Office on the Aging, though the smaller part of the department's self care and safety budget, provide vital services. Funding for some of the OOA programs has increased slightly, but for others has slipped. Suicide prevention services have increased by 63% to $90,000 in the 2012/13 budget year. Elder and dependent abuse prevention services, which include the Friendship Line and intensive case management, have increased by 134% to $112,207. The program had utilized federal funds for Targeted Case Management; however, the administrative burden of participating in that program proved too prohibitive, and funding has been shifted to local general fund to ensure that no funds were lost. The program has also added a forensic center, which coordinates the prosecution of crimes of financial abuse against seniors.

A significant change, however, has been the 20% drop in funding for the Ombudsman program. This program recruits, trains, and supervises volunteers to monitor the rights and well being of seniors and younger adults with disabilities living in out of home care. The state of California eliminated all funding for this program ($87,024). During a time when the environment of out of home care in San Francisco is changing, the Ombudsman's office has had to cope with steeper staffing and resource challenges. Although the Ombudsman continues to receive federal funding, DAAS has at every opportunity tried to offset state funding losses with local general fund.

Caregiver Support

The number of caregivers in San Francisco is difficult to estimate. The first section of this report provides data on the number of San Francisco residents who are disabled, and while not all of these persons require assistance, the statistics provide a sense of scale for the population who may rely on caregivers. A report written for DAAS estimated that 22,500 seniors are living with Alzheimer's or a related dementia in San Francisco (Alzheimer's/Dementia Expert Panel, 2009), but otherwise San Francisco-specific research about caregivers is limited to a single study conducted in 1999.

Applying percentages from state and nationwide studies is possible, but San Francisco has unique demographics and the resulting estimates need to be considered with caution. Almost 49 million adults, 21% of all adults according to The National Alliance for Caregiving's 2009 telephone survey, provide care to a friend or loved one. The survey also found that two-thirds of caregivers are female, that on average they are 48 years old, and the majority are taking care of either a relative (86%) or a parent (36%). Applying this survey's national rates to San Francisco's population would indicate about 171,000 people providing some amount of unpaid care to an adult friend or relative.

The need for support services among caretakers varies: a main finding from a UC Berkeley survey of California caregivers was that "the vast majority of caregivers apparently do not find caregiving as burdensome as some might believe" and that positive comments about caregiving outweighed negative comments 2 to 1 (Sharlach et al., 2003). The National Alliance for Caregiving's 2009 survey found that the burden of care is 'high' for approximately 9% of caregivers for those 18+, and moderately high for another 22%. *Applying these rates to the estimated 171,000 caregivers in San Francisco yields an estimate of 15,000-53,000 caregivers (9%-31%) with significant need for caregiver support.*

Trends Related to Caregiving

The isolation of San Francisco's seniors and adults with disabilities, combined with their diversity, compound challenges to providing caregiver support. According to the UC Berkeley Study, Asians and Latinos are much less likely to seek and access caregiver support services (Sharlach et al., 2003), possibly from a lack of knowledge about available services, but also as a result of cultural and linguistic barriers. It may also be connected to cultural expectations that support will be provided by family. The needs of seniors in the LGBT community, including high rates of caregiving and isolation, are discussed at length in the needs assessment report.

Changes to Programming

Federal and state funding changes have had impacts on local programming for caregiver services. Funding for caregiver support has declined both for the direct service programs offering support to caregivers of elders, and for programs providing indirect support, such as the Adult Day Health programs and Alzheimer's Day Care Resource Centers. Even before eliminating the funding for the Community Based Services Program (which includes both Respite and the Alzheimer's Day Care Resource Centers), the State had been gradually reducing funding. By the time DAAS used local general funds to backfill the State's final cut, the program had already seen its funding erode. Also, the federal government's Title III E Family Caregiver program has been reduced by approximately $20,000.

There has been a change in the definition of "family caregiver" in the Older American Act (title III E) in 2006. "'Family caregiver' means an adult family member, or another individual, who is an informal provider of in-home and community care to an older individual….". This change has enabled volunteers

providing caregiving to the LGBT seniors to be included as "family caregivers" and benefit from the Family Caregiver Support Program. Currently, Family Caregivers Alliance subcontracts with Openhouse to provide this service to volunteer caregivers that are helping the LGBT seniors.

Access

According to the 2011 City of San Francisco Community Survey, over half of seniors need services like personal care, meal programs, socialization, and assistance with getting on public benefits (EITC Institute, 2011). Just providing services, however, is not enough. Seniors and adults with disabilities need to be aware of them, travel to them if needed, and find them culturally consonant; in short, to have access. The issues of isolation -- physical, social, and linguistic – that are described elsewhere in this report are like a bright red thread running through the challenges of service access.

Information and Awareness

A 2008 phone survey found that about 8 in 10 San Francisco seniors and adults with disabilities were aware of senior centers, nursing homes, and nutrition services, but the level of awareness varied by income and ethnicity (National Research Center, 2008). Higher income persons, as well as white persons, tended to have a greater awareness of services. When asked where they seek information or helping in obtaining services, answers differed by age, but the first source of information was usually family and friends. The Web, phone books, doctors, and government offices also played an important role in distributing information, especially for persons who are isolated.

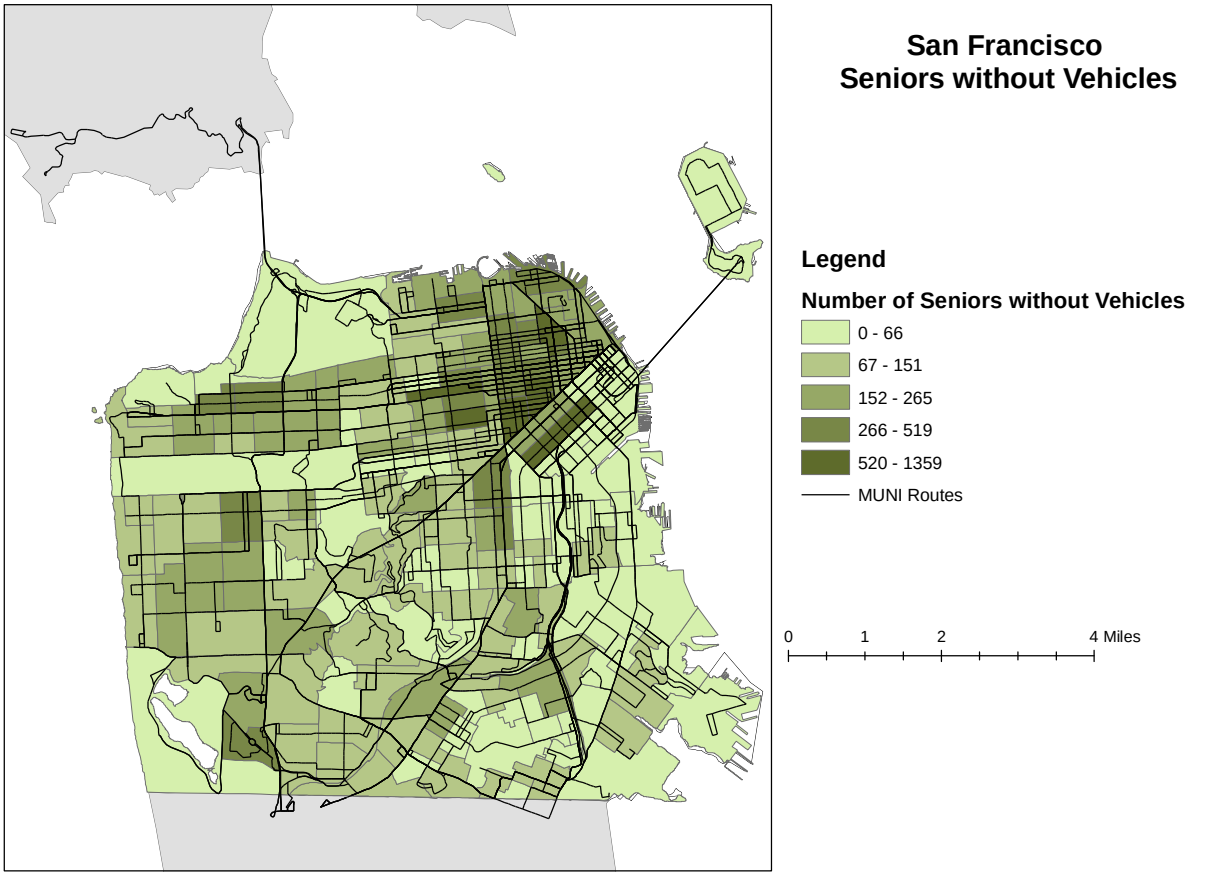
Thirty one percent of adults with disabilities look for information on the internet. Seniors are increasingly relying on technology for information, too, using the internet, email, and other forms of Web-based social networking. The National Research Council phone survey was conducted in 2006 and again in 2008, and the number of older persons who reported using the internet or email jumped from 36% to 52%. In focus groups convened for this needs assessment, participants who did not use computers stressed the need for printed resource guides. The most universal, accessible resource guide is the phone book.

As described in the section of this report on isolation, large numbers of older persons and disabled persons in San Francisco have limited English proficiency. During focus groups, seniors repeatedly cited the need for help with mail translation. Fliers, Web sites, resource guides, public service announcements, and other outreach materials need to be offered in San Francisco's diverse languages.

Transportation Needs

When compared with 40 metropolitan areas with 1 to 3 million residents, San Francisco ranked first in transit access for seniors, with only 12% projected to have poor transit access by 2015 (Transportation for America, 2011). Virtually every location in the city lies within a quarter of a mile of a transit route (San Francisco County Transportation Authority, 2004). The accompanying map shows the number of seniors without access to a vehicle in each San Francisco Census tract, with public transportation lines overlaid.

The majority of San Francisco seniors and adults with disabilities use Muni on a regular basis. According to the 2009 San Francisco City Survey, more than half of seniors and adults with disabilities ride MUNI at least once or twice per week, and another 30-35 percent ride on at least a monthly basis. Nationally, 80 to 90 percent of older adults do not use public transportation at all, compared to only 15 percent in San Francisco.[24] Another survey found that 81 percent of vulnerable adults[25] in San Francisco were able to get the public transportation they need, with few reporting that they were "not often" (13%) or "sometimes not able" (6%) to do so. Vulnerable adults who indicated that they rarely go out of their home were asked about the barriers they face to going out more, and only four percent identified "lack of transportation" (Kim & Cannon, 2009).



Data from the US Census Bureau & MUNI
H45. TENURE BY VEHICLES AVAILABLE BY AGE OF HOUSEHOLDER [35] - Universe: Occupied housing units
Data Set: Census 2000 Summary File 3 (SF 3) - Sample Data

Map produced by J. Murray, San Francisco Human Services Agency. August 2007.

Despite these many indicators of a strong local transportation system, consumers and service providers still often express the need for transportation improvements. According to a 2008 San Francisco phone survey, more than 60 percent of older adults identified "improving public transportation" as an issue that

[24] National rates vary by age. Local results may over-estimate the number of people who do not use public transportation if some paratransit riders interpreted "MUNI" to mean traditional services and indicated that they do not use MUNI at all.

[25] Vulnerable adults were defined as: (1) of advanced age (75 or older); or (2) age 60 to 74 years and met at least one of the following criteria: (a) needed help bathing; (b) used a cane, walker, or wheelchair; (c) rated their health as fair or poor; (d) were afraid to be alone for more than two hours; or (e) had a chronic health problem, such as diabetes, heart or lung problems, stroke, or kidney failure. They report does not provide an estimate of the total size of the vulnerable population in San Francisco.

was very or extremely important. Improvements to public transportation was also the most popular response to the question, "What one change would make the biggest improvement in making the community more "senior friendly" (Kim & Cannon, 2009).

Muni has made a major commitment to making its traditional bus and trolley system accessible to seniors and adults with disabilities, but some focus group participants complained that kneeling buses do not always kneel. In particular, adults with disabilities mentioned that disabilities are not always visible, and drivers are sometimes reluctant to make the buses kneel for persons who appear able-bodied. Other participants complained that other riders do not always give up their seats to seniors and persons with disabilities, and that the drivers do not enforce the rules.

Paratransit is a vital resource for seniors and persons with disabilities who cannot ride Muni. A 2008 survey found that eight percent of those of any age with a disability indicated that they had needed a door-to-door transportation service in the past year and been unable to use it. The majority (63%) said it was because they "did not know the program existed" or "did not know how to access the program" (National Research Center, 2008). Other than lacking information about the program, only three percent of adults with disabilities (~2,700 people) reported a service barrier to receiving door-to-door transportation. Independent customer satisfaction surveys of paratransit users show strong overall trends of satisfaction, improving over time.

Two major areas of concern persist. The first is the responsiveness of Ramp Taxis. Of the city's 1,500 taxis, 100 are ramp taxis that can accommodate wheelchairs. However, a 2007 report showed that 50 percent of test calls resulted in refusals of service and dispatch companies (City and County of San Francisco Taxi Commission, 2007). A recently-implemented debit card fare system for paratransit taxi service may help to improve ramp taxi pick-up rates. The second concern regards group van service. Adult day programs and senior center providers have long been dissatisfied with the quality of San Francisco Paratransit's group van services. Issues have included lateness, no-shows, and inadequate capacity to handle riders with wheelchairs or who need assistance getting on and off the van. Problems still occasionally arise, especially when new drivers or substitute drivers have not had adequate training (Eastman, 2010).

Changes to DAAS Programming

Since the last DAAS needs assessment, the service system for San Francisco seniors and persons with disabilities has faced serious funding pressures. To address these challenges, DAAS weighed priorities and: 1) sought new funding, aggressively pursuing grants and looking for opportunities to appropriately expand its fiscal claiming; and 2) looked for efficiencies, redesign some programs. Major changes include:

- *Integrated Intake:* In 2008, DAAS created the Integrated Intake Unit, unifying access to multiple programs through one phone number. Now one phone number serves as the hotline for making reports to Adult Protective Services and as the intake line for In Home Supportive Services. The line has also consolidated the senior meal clearinghouse, and is now the portal for referrals to the Community Living Fund. After hours, the line is diverted to the Institute on Aging for 24-hour coverage.

- *Computer Access:* In 2010 DAAS received $7.9 million from the National Institute for Standards and Technology and from the National Telecommunication and Information Administration to stimulate usage and adoption of broadband services for seniors and adults with disabilities. The adoption rate among this group is 42%, compared to 80% for the general population.

- *Services Connection:* DAAS received two federal Resident Opportunities and Self Sufficiency grants, the first one in 2008, to help seniors and persons with disabilities living in public housing to connect with community services. Federal funding expired in 2010, but DAAS extended the program with local dollars for the current fiscal year, and is exploring ways to sustain this initiative.

- *Aging and Disability Resource Centers (ADRCs):* These centers, which were located throughout the city, and educated consumers about services and made referrals, were redesigned. Rather than each center having its own site, the model changed to be more decentralized, with informal and referral specialists out-stationed at existing community centers rather than in stand-alone resource centers.

In 2008, San Francisco Department of Aging and Adult Services, and Independent Living Resource Center San Francisco (ILRCSF), were selected to be one of the Aging and Disability Resource Connection sites in California. This has created the beginning or a movement to connect the senior services and the disability services. Since that time, there has been a few funding allocations from the state to provide enhanced information and assistance services, transitional care and more recently options counseling to consumers. DAAS Integrated Intake, ILRCSF, and the Aging and Disability Resource Centers, are working very closely to promote access and independent living philosophy to seniors and adults with disabilities.

- *Transportation:* DAAS' overall budget for transportation services grew by 32%, with the largest increase being in its support of San Francisco Paratransit. However, increased costs of doing business have resulted in a net loss in the number of transportation trips provided with DAAS funding. To make senior centers more accessible to persons in Visitacion Valley, DAAS began funding a shuttle service. A transportation program for clients of the Public Conservator program was cut by the Department of Public Health and picked up by DAAS. A taxi scrip program through the Lighthouse for the Blind was increased slightly, and DAAS was not able to sustain a small program that provided escorts to persons requiring medically-related transportation.

The total budget for programs aimed at increasing access to services has grown by 81%, but that masks significant sacrifices that have been made in specific program areas. If the increase for creation of the Integrated Intake Unit and the BTOP grant were removed, the total budget for access to services would have decreased by two percent.

Consumer Advocacy

Advocacy programs ensure access to services and protect consumers' rights. They can work at the level of individual advocacy or by advocating more broadly for system change. Direct advocacy programs can educate consumers to fight for themselves, or they can deploy professional or volunteer staff to represent the consumer. System advocacy efforts are coordinated activities designed to influence specific planning processes, system changes, and/or legislation that will benefit seniors and adults with disabilities on key issues.

Health Insurance Advocacy

Persons with limited English proficiency, particularly those who are low-income, have difficult maneuvering within the Medicare system. San Francisco has roughly 120,000 Medicare beneficiaries.[26] Based on current levels of service provision, roughly two percent of all eligible persons are receiving Health Insurance Counseling & Advocacy Program (HICAP) services. HICAP utilizes volunteers to provide information and counseling about Medicare, helping consumers understand their rights and health care options. Given the pending wave of Baby Boomers enrolling in Medicare, the number of beneficiaries who will need assistance will rise. If the current penetration rate is maintained, the number of clients seeking services could increase by at least ten percent by 2015.[27]

Home Care Advocacy

Research conducted in 2003 found that more than a quarter of Californians age 40 and older needed "in-home care either for themselves or for a loved one" during the year preceding the study. The vast majority of adults receiving care at home get all their care from family or friends, but many of Californians in the same study (51%) felt that they would be unable to afford to pay for even two hours of in-home help per day if they needed it for six months or more (Grey et. al., 2003).[28] Single seniors may not have relatives available for help, relying instead on formal sources of in-home care (Johnson et al., 2006). San Francisco has an unusually high number of older persons who are living alone or otherwise isolated, and consequently, relying on formal care-giving programs.

A San Francisco Controller's Office analysis of home and community-based long term care services amplifies the enormous role that the publicly-funded IHSS program plays in the arena of community-based long term care services. IHSS comprised 81% of city appending on "immediate" support for persons at risk of entering institutions, and IHSS formed 97% of spending on services to preserve consumers' self care and safety (Kent et al., 2010). With over 21,000 consumers, IHSS is by far the largest home care program in the city.

Making IHSS fully response to consumer needs requires significant coordination between numerous constituent groups: consumers, providers, unions, DAAS management and line staff, the San Francisco

[26] There were 119,814 persons eligible for Medicare because of age or disability status in 2007. Source: Centers for Medicare and Medicaid Services, Medicare Enrollment Reports: http://www.cms.gov/MedicareEnrpts/.

[27] This percentage increase is based on a comparison of interpolated California Department of Finance Population Projections for the population 65+ to 2008 American Community Survey population estimates for San Francisco.

[28] Survey respondents were informed of an hourly cost of $15 for home care services.

Public Authority, the IHSS Consortium, hospitals, and other community-based service providers. Home care advocacy services help diverse IHSS stakeholders to identify priority issues, develop advocacy issues, and implement action plans.

Housing Advocacy

Between 2000 and 2008, over 4,920 new affordable housing units were added to San Francisco's housing stock, more than half set aside for seniors. Demand, however, far outpaces supply. For example, 30,000 persons are on the waiting list for the 6,000 apartments managed by the San Francisco Housing Authority. The shortage of affordable, accessible housing for younger adults with disabilities is particularly acute due to the funding stream requirements and federal and state fair housing laws. DAAS is focused on the provision of social services and lacks the financial capacity to directly affect San Francisco's supply of affordable housing. However, because housing needs so often dominate the lives of San Francisco seniors and persons with disabilities, DAAS does fund some housing-related services, including:

- *Housing Advocacy:* This is a "system-change" strategy that encompasses advocating for affordable and accessible housing for seniors and adults with disabilities. Advocates promote legislation that will increase the housing supply or improve living conditions.
- *Education and Outreach Activities:* Aimed at residents, these services include developing and distributing materials to inform diverse populations about their rights as tenants.
- *Housing Counseling:* These services include preventing eviction, working with landlords to improve housing habitability, referring to legal assistance or mediation through the San Francisco Rent Board, and navigating wait-lists for subsidized housing.[29]
- *SRO Advocacy:* Over 18,000 of the city's most vulnerable citizens, including almost 8,000 seniors, live in the city's 530 Single Room Occupancy (SRO) hotels (Fribourg, 2009). DAAS funds housing advocacy and counseling services that include a special focus on SROs.

Legal Services

Seniors have unique legal needs, including assistance with will preparation and advance directives. Legal services also help seniors and younger adults with disabilities remain in the community and out of institutions. Because many consumers have fixed incomes, events like eviction, illegal rent increases, or consumer fraud can be catastrophic. Abuse, either financial or physical, can jeopardize their security. When applying for public benefits like SSI, Medicare, Medi-Cal, or Cash Assistance Linked to Medi-Cal, seniors and persons with disabilities often have unique challenges that require legal assistance. Many San Francisco seniors and younger adults with disabilities lack the resources or do not know how to access legal assistance. In a 2008 telephone survey of a random sample of San Francisco older adults

[29] While the Mayor's Office of Housing also contracts with about a dozen community based organizations to provide housing counseling services in San Francisco. DAAS contracts are intended to ensure that providers are available who have experience working with seniors and adults with disabilities to ensure their unique challenges and needs are understood. For example, knowing which buildings are physically appropriate for the clients and/or have designated senior/disabled units is fundamental. Advocates specialize in particular communities, and cultural competency, language capacity and neighborhood location are also factors that determine who serves which clients.

(60+) and adults with disabilities, 10% of persons with disabilities and 5% of older persons needed, but were not able to use, legal services (National Research Center, 2008).

Long Term Care Consumer Rights Advocacy

While a variety of information and referral services support consumers in identifying available services, staff at those programs do not often have the experience or time to assist individuals who have needs related to long term care. Consumer rights advocacy services are intended to educate individual and targeted groups of consumers and providers about the basic rights guaranteed in the various long term care services in San Francisco, and to provide individual assistance in navigating dispute resolution, hearings, and other grievances as needed, thus filling a niche left fairly vacant by those other services. Not all situations require a lawyer; often, they can be resolved with consumer education and empowerment.

Naturalization

San Francisco has a lot of older adults who are immigrants. In focus groups, many seniors asked for more classes to help them pass citizenship exams. The goal of naturalization services is to help legal permanent residents, also known as green card holders, become naturalized citizens of the United States. The benefits are naturalization include increased financial security, reunification with family members, freedom of travel, and stability.

Empowerment for Seniors and Adults with Disabilities

Aging conjures many negative beliefs, most often associated with a decline in capacity and control, but researchers have begun to focus on seniors who have aged successfully, taking or regaining control of their lives (McMellon & Schiffman, 2002; Haber, 2009). A recent telephone survey of older San Franciscans suggests the need for empowerment programs. Asked how the community deals with the needs of frail older adults, 88% of the respondents indicated that either "a lot more" or "somewhat more" needs to be done, and nearly 36% of the respondents expressed a desire to be participating in more social activities (Kim & Cannon, 2009). DAAS contracts for senior empowerment programs for seniors and adults with disabilities in different neighborhoods and communities that train seniors to advocate for themselves, to increase their independence and quality of life, and to change the civic/political process through advocacy and volunteerism.

Changes to DAAS Programming

In the last five years, overall funding for DAAS consumer advocacy services has increased by 21%. [30] The increases, however, have not been uniform across programs, and units of service have not always been commensurate with funding changes as the cost of doing business has increased. HICAP's budget increased by 9%, and the number of consumers served jumped by 122. Housing advocacy increased by 6%, which included a shift of funds for SRO advocacy. Homecare and Long Term Care advocacy,

[30] For the purpose of this section, Housing Advocacy is included in the Consumer Advocacy budget rather than the Housing budget.

though each just 4% of this category's budget, saw large increases. The Long Term Care Advocacy program did not exist five years ago.

Conclusion

DAAS-funded services are arrayed against a formidable range of factors. Seniors in San Francisco are more likely than in other communities to be over 80, to have limited English skills, to be low-income, to live in inaccessible or precarious housing, and above all, to be living in isolation. Broad economic forces, impossible to reverse, create these conditions.
Affordable housing is San Francisco's chronic unmet need, the root of so many of its challenges. For example, because so much of their income goes to housing, seniors and younger adults with disabilities often lack money for adequate nutrition. Few affordable housing options exist that are wheelchair accessible, trapping adults with disabilities in housing with stairs, whether large, empty Victorian homes or tiny rooms in crowded SROs. Families that might be able to provide informal support to their grandparents and older relatives are crowded out of the city, forcing older persons to rely on formal, public systems of support. Isolation permeates the lives of many seniors and adults with disabilities.

Though demand for services has increased while public funds have decreased, DAAS has managed to preserve or even expand most of its services. It enhanced funding for socialization programs like senior centers, and has invested in new strategies, like fostering more access to technology and social media. DAAS has increased efficiency, as in centralizing its information and referral services, and has improved effectiveness, as in reorganizing its case management services. Younger adults with disabilities face many of the same challenges as seniors, but without a comprehensive system that is legislated to meet their multiple needs, and they instead have to rely on a fragmented collection of ad hoc supports. DAAS has looked for opportunities to serve this group, like funding meals specifically for younger adults with disabilities. DAAS has also expanded services to service adults with disabilities, including money management, legal services, support services for hoarders and clutterer. In the coming years, DAAS and the Mayor's Disability Council will be working closely to develop shared goals with regard to the connection between civil rights advocacy and social services provision,

Because San Francisco is a city and county, and because it benefits from the tax revenue tied to its expensive housing market, DAAS has often been able to offset losses in state and federal funding. San Francisco was not, however, able to fully compensate for all of the state cuts, and some local programs and consumers suffered. The single most important service for seniors and younger adults with disabilities is IHSS. The state, however, is considering moving IHSS into managed health care, a service environment so different that changes cannot be fully anticipated. Uncertainty continues to threaten San Francisco's service system. For the foreseeable future, seniors and adults with disabilities will continue to depend, often unknowingly, on the advocacy of citizens, the creativity of public policy-makers, and the resilience and dedication of service providers.

SECTION 6: TARGETING

This section describes services provided to those populations served by the Office on the Aging, and targeted by the Older Americans Act, which mandates that services are directed to older individuals with low incomes, as well as those with the greatest economic or social need, and those who are at risk for institutional placement, as well as older Native Americans.

Populations Served

During the 2011 calendar year, San Francisco's OOA served 24,273 unduplicated seniors and persons with disabilities. The profile of consumers reflects an emphasis on: 1) low-income seniors; and 2) seniors who have limited English-speaking ability. The accompanying table shows the diversity of OOA consumers.

Office on the Aging Consumer Profile, 2011		
	#	%
Total Enrollment	24,273	100
Female	13,892	57
Live Alone	9,176	38
Functionally Impaired	5,384	22
Low Income	15,500	64
Require Translation	5,975	25
Age		
Under 60	780	8
Age 60 – 74	10,709	44
Age 75 – 84	7,202	30
Age 85+	4,236	17
Ethnicity		
African American/Other African	2,765	11
Asian/Pacific Islander	10,814	42
Latino	2,782	14
Native American/Alaskan Native	92	0
White	5,313	22
Other/Decline to State/ Unknown	2,464	10

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

Low-Income Older Individuals

A number of the community-based organizations that DAAS contracts with serve low income seniors, both through neighborhood-based organizations and larger organizations that target low-income persons citywide. Examples include Bayview Hunters Point Multipurpose Senior Services, located in the city's largest African American neighborhood, and Catholic Charities, which serves low-income seniors citywide. These agencies provide community services, congregate meals, money management, case management and personal care. In 2011, 64% of OOA service consumers were low-income, including 35% who received SSI. Seventy-four percent of African American consumers are low-income, as are 71% of Asian/Pacific Islander, 76% of Latino, and 71% of White consumers. Fewer than 100 Native Americans were served, but 72% of those were low income.

LGBT Community

DAAS has begun collecting information about consumer sexual orientation. However, many consumers appear to want privacy and decline to state, and it may be that some providers feel uncomfortable or awkward in asking. When this variable was examined in 2011, only 494 consumers had identified themselves as being LGBT. In the next four years, DAAS will continue to provide training to case managers and social workers to increase their confidence and skills in asking about sexual orientation. DAAS funds programs to provide appropriate services specifically to the LGBT population and ensure that culturally competent services are available. Currently, Openhouse is funded to provide LGBT cultural sensitivity training for service providers, community services and family caregiver support services to the LGBT community.

Language Access

DAAS is dedicated to serving seniors with limited English proficiency by contracting with a number of community-based agencies that can offer services in a variety of languages. For example, Self Help for the Elderly is located in Chinatown, has historical roots there and is widely trusted. Clients depend on Self Help for the Elderly for a spectrum of needs, from reading mail to getting on housing lists to finding work.

Twenty-five percent of consumers required translation services in fiscal year 2007/08, including 40% of Asian/Pacific Islanders and 48% of Latinos. Even among white consumers, 15% were of Russian heritage and 34% of Russians required translation services. Multilingual services are an important piece of providing culturally competent services, both because many San Franciscan seniors and younger adults with disabilities are isolated and because even bilingual consumers are often more comfortable discussing personal issues in their first language. Many people return to their first language when they become ill later in life, even if they speak English well.

At Risk of Institutionalization

Consistent with the profile of consumers being low-income and having limited English, 47% of consumers served in fiscal year 2007-08 were age 75 or older. Twenty-two percent of the consumers had functional impairments consistent with severe disabilities. Thirty-eight percent lived alone. These

factors make many of these seniors at risk of institutionalization. Home safety is a critical issue for this population. People over 75 who fall are four to five times more likely to be admitted to a long term care facility for at least a year, and most of these falls (77%) occur in the home.[31] DAAS contracts with a variety of agencies that provide home-delivered meals, case management services, personal care and homemakers services.

A related and critical population are **those who care for those with Alzheimer's and other dementias**. DAAS contracts with the Family Caregiver Alliance and Edgewood Center for Children and Families to offer family caregiver support programs.

Younger Adults with Disabilities

Almost 800 OOA consumers were younger adults with disabilities in 2011. These consumers received a variety of services in the community, including money management (a program specifically geared for this population), home-delivered meals, congregate meals, community services, and resource centers. Several of the agencies serving younger adults with disabilities have the capacity and expertise to serve non-English speaking consumers.

Service Levels in Upcoming Years

DAAS is dedicated to serving these target populations. As described in Part II of the Community Needs Assessment, DAAS has used several strategies to counter state budget cuts of the last five years, including greater centralization and technology to improve service efficiency, reorganization of services to improve effectiveness, aggressive pursuit of federal and foundation funds, and when possible, use of local general funds. However, DAAS has not been able to offset all of the cuts, and the state funding environment continues to be challenging. To guide budget decisions, DAAS continues to rely on a set of principles developed several years ago at the onset of the recession, including:

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

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

SECTION 7: PUBLIC HEARINGS

PSA 6

PUBLIC HEARINGS
Conducted for the 2012-2016 Planning Period
CCR Title 22, Article 3, Section 7302(a)(10) and Section 7308; OAA 2006 306(a)

Fiscal Year	Date	Location	Number of Attendees	Presented in languages other than English?[32] Yes or No	Was hearing held at a Long-Term Care Facility?[33] Yes or No
2012-13	**April 18, 2012** **May 2, 2012**	1650 Mission St, 5th floor **San Francisco City Hall**	**24** **33**	**No** **No**	**No** **No**
2013-14					
2014-15					
2015-16					

Below items must be discussed at each planning cycle's Public Hearings

1. Discuss outreach efforts used in seeking input into the Area Plan from institutionalized, homebound, and/or disabled older individuals.

   All Office on the Aging contractors and interested parties were notified of the public meetings. A public notice was also announced in the San Francisco Chronicle. Members of the Advisory Council DAAS Commission, and the public were asked to provide feedback in meetings or via email.

2. Proposed expenditures for Program Development (PD) and Coordination (C) must be discussed at a public hearing. Did the AAA discuss PD and C activities at a public hearing?

☐ Yes x☐ Not Applicable if PD and C funds are not used

☐ No, Explain:

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

2. Summarize the comments received concerning proposed expenditures for PD and C, if applicable.
Not applicable

4. Were all interested parties in the PSA notified of the public hearing and provided the opportunity to testify regarding setting of minimum percentages of Title III B program funds to meet the adequate proportion funding for Priority Services?

x☐Yes

☐No, Explain:

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

None

6. Summarize other major issues discussed or raised at the public hearings.

At the public hearing on April 18, Advisory Council member Vera Haile asked why the Providers list was not included, and pointed out an error on the Advisory Council list. Denise Cheung responded that corrections would be made in the final draft submitted to the Commission in May. Ms Haile also asked why no town hall meetings were conducted for the Needs Assessment. Dan Kelly explained that in the past, it appeared that service providers organized their own consumers to attend and advocate for their specific program services, limiting the scope of the discussions. To reach a range of seniors and adults with disabilities, especially those who were not receiving services, the needs assessment relied on a series of focus groups targeting key populations.

At the public hearing on May 2nd, Commission President James lauded the work being done with hoarders and clutterers, but also inquired about services for seniors suffering from depression, suggesting it as a future priority. The Deputy Director of DAAS, Shireen McSpadden, described current efforts by DAAS and CBO staff to coordinate with the San Francisco Department of Public Health to screen and refer seniors with mental health needs. Denise Cheung, director of the Office on Aging, referenced an evidence based community treatment program for depression called the Program to Encourage Active Rewarding Lives for Seniors that would be worth further investigation. A representative from a community based organization commented on the need for more community outreach related to senior centers, and Ms. Cheung reported that the Office on the Aging was working closely with the DAAS Integrated Intake program and the Aging and Disability Resource Connection to develop a marketing plan for senior/disability services. Finally, Commissioner Crites pointed out that page 73 of the report contained directions from the California Department of Aging, and it seemed to be out of place. Before formally approving it, the Commissioners lauded the 2012-16 Area Plan.

7. List major changes in the Area Plan resulting from input by attendees at the hearings.

The Advisory Council list has been corrected. The list of Agencies and Services (FY 2011-2012) has been inserted as Appendix A in the final draft of the Area Plan. Per Commissioner Crites' comment, page 73 of the Plan has been deleted.

SECTION 8: IDENTIFICATION OF PRIORITIES

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

- **Legal Assistance Required Activities:** Legal Advice, Representation, Assistance to the Ombudsman Program and Involvement in the Private Bar.
- **In-Home Services:** Personal Care, Homemaker and Home Health Aides, Chore, In-Home Respite, Daycare as respite services for families, Telephone Reassurance, Visiting, and Minor Home Modification.
- **Access:** Case Management, Assisted Transportation, Transportation, Information and Assistance, and Outreach

The annual minimum allocation is determined by the AAA through the planning process. The minimum percentages of applicable Title III B funds listed below have been identified for annual expenditure throughout the four-year planning period[34]. These percentages are based on needs assessment findings, resources available within the PSA, and discussions at public hearings on the Area Plan. No changes have occurred in the allocation in the last five years, nor are any planned for the upcoming year. A public hearing to discuss the allocation is being held on May 2, 2012, and when minutes are available, they will be forwarded to the State.

Title III B Allocations

FY	Access	In-Home Services	Legal Assistance
2007-08	45.0	5.0	45.0
2008-09	45.0	5.0	45.0
2009-10	45.0	5.0	45.0
2010-11	45.0	5.0	45.0
2011-12	**45.0**	**5.0**	**45.0**

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

2012-2016 Four-Year Area Plan Cycle

Goal #1: Improve Quality of Life

Rationale: Quality community-based long term care goes beyond providing what services people need. It encompasses a broader, more fundamental issue: what people require for a good life. Disease prevention and health maintenance programs tend to improve or increase the health and well-being of older persons and persons with disabilities.

Objective Number & Objective	Projected Start and End Dates	Title III B Funded PD or C[35]	Update Status[36]
1a. OOA will expand health promotion and risk prevention services that support wellness and reduce risks for chronic illness by implementing two types of evidence-based health promotion programs: Evidence-based physical fitness and fall prevention programs and Chronic Disease Self-Management Program (CDSMP). An RFP will be issued in Spring 2012 to identify grantees to implement these programs. In the next four years, it is estimated that OOA will be able to serve 560 unduplicated consumers and train 25 Wellness Trainers annually who will be certified to conduct Health Promotion classes. Over the next four years, CDSMP will be able to serve 200 unduplicated participants, train 10 community leaders who will be certified to facilitate the CDSMP workshops, and train at least 4 Master Trainers annually.	July 2012 to June 2016		
1b. OOA will provide the evidence-based Medication Management services to seniors by issuing an RFP in Spring 2012. Selected agency will work with all OOA-funded Case Management providers to implement the program. This program will prevent incorrect medications and adverse drug reactions by providing a medication management module in collaboration with a pharmacist. This program will serve a total of 100 consumers and provide 500 contacts each year.	July 2012 to June 2016		
1c. OOA Staff, working with 8 contractors, Department of Technology, San Francisco Housing Authority, more	July 2012 to June 2016		

[35] Indicate if Program Development (PD) **or** Coordination (C) – **cannot be both**. If a PD objective is not completed and is continued the following year, the objective must be revised and restated with the remaining or additional tasks.

[36] Use for Area Plan Updates only: Indicate if objective is **New, Continued, Revised, Completed**, or **Deleted.**

than 30 community partners, and more than 300 volunteers will expand access to and use of broadband high-speed Internet services to enhance social connections and increase knowledge. Collaborative partners will seek to increase broadband adoption and sustainability by teaching computer and Internet skills and demonstrating the value of broadband based technologies, such as social media, video communication, and access to health and other benefits information. New technologies can be a bridge from isolation to inclusion for so many. These on-line tools - particularly social networking media - can create the communities, both real and virtual, to sustain seniors and persons with disabilities. With the Broadband Technology Opportunities Program (BTOP) funding, a federal ARRA grant, By September 2013, this project will provide training to about 9,000 consumers at 53 locations in six different languages: English, Chinese, Spanish, Russian, Vietnamese and Korean, and have 2,700 new subscribers			
1d. The Long Term Care Age and Disability Friendly San Francisco Work Group This new work group has come together to address some of the environmental issues impacting San Francisco's growing senior population, it was convened by the Long Term Care Coordinating Council (LTCCC), an advisory body to the Mayor's Office. The LTCCC evaluates all issues related to long term care (LTC) and supportive services, including how different service delivery systems interact. It makes recommendations about how to improve service coordination and system interaction. The LTCCC oversees all implementation activities and system improvements identified in the "Living with Dignity Strategic Plan." The LTC Age and Disability Friendly San Francisco Work group is focused on pro-actively addressing the needs of older adults, and the needs of adults of all ages with disabilities, as they remain in the community longer. Joining in the spirit of the World Health Organization (WHO) and a few other forward looking communities that have begun to respond effectively to the shifting demographics, this group comprising community stakeholders including consumers, service providers, City Planning Department, municipal transportation, local architects, hospitals, urban research organizations, senior	July 2012 to June 2016		

collaboratives such as Next Village and other interested parties, and staffed by the Area Agency, plans to take steps to make San Francisco a friendlier and more livable community.			
1e. Beginning with a thorough analysis of recent neighborhood Census data and guided by the Checklist of the Essential Features of Age Friendly Cities developed by the WHO, and other best practices, they will assess the city's strengths and deficiencies, neighborhood by neighborhood and develop a plan of action for implementable changes to improve the living environment. The work group will complete an analysis and decide on a geographical or environmental area to focus on for their initial efforts, design an intervention to make improvements in the area and work together to accomplish it. With incremental efforts they hope to engage the larger community in the challenge to make San Francisco more livable and friendly for people of all ages and abilities.	July 2012 to June 2016		

Goal #2: Establish Better Coordination of Services

Rationale: San Francisco has some of the most creative and effective community-based long term care programs in the country. But the City does not yet have a well coordinated network of home, community-based and institutional long term care services. Improved services will need to be provided through a well coordinated service delivery network that will enable older adults and adults with disabilities to remain as independent as possible in their homes and communities in the most integrated settings.

Objective Number & Objective	Projected Start and End Dates	Title III B Funded PD or C[37]	Update Status[38]
2a. A new Case Management module will be developed in Spring, 2012 for a pilot implementation by four Case Management providers. Full implementation will begin in July, 2012. Case Managers funded by OOA, will be using portable electronic devices to enter all the required information of the consumers, including assessment, care plan/ service plan, reassessment, medication, etc. This process will facilitate coordination of services, and help the consumers in meeting the objectives of the care plan/service plan.	July 2012 to June 2016		
2b. Initiate greater collaboration between programs that serve older adults and adults with disabilities, especially between the Department of Human Services, DAAS, the Mayor's Disability Council, community-based organizations, Planning Department and Department of Public Health. Greater coordination, collaboration, and cooperation between program managers and program line staff would improve services for consumers.	July 2012 to June 2016		
2c. Conduct monthly Multi-Disciplinary team meetings to coordinate services for elder abuse/dependent adult victims. These meetings bring together service providers, law enforcement, the Ombudsman and Adult Protective Services to problem solve complex elder abuse/dependent adult abuse cases and develop intervention strategies.	July 2012 to June 2016		
2d. Facilitate the collaborative efforts of DAAS-Adult Protective Services, the Long Term Care Ombudsman,	July 2012 to June 2016		

[37] Indicate if Program Development (PD) **or** Coordination (C) – **cannot be both**. If a PD objective is not completed and is continued the following year, the objective must be revised and restated with the remaining or additional tasks.

[38] Use for Area Plan Updates only: Indicate if objective is **New, Continued, Revised, Completed**, or **Deleted.**

the District Attorney and San Francisco Police Department through the Forensic Center. Such collaboration is much needed to improve service delivery and reduce the repetition and delay that can impair prosecution and service quality. In addition to the formal case review meetings, the Forensic Center will facilitate informal consultations between partnering agencies as needed to ensure rapid response.			

Goal #3: Increase Access to Services

Rationale: Adults with disabilities, older adults, and caregivers express difficulty in learning about community based long term care and supportive services. To address this, the network of services will need to be consumer-responsive and user-friendly, giving consumers and caregivers choices in the services they receive. It will need to be easily accessible and provide information about services in a culturally appropriate manner to address the varied needs of San Francisco's racially, ethnically and culturally diverse communities.

Objective Number & Objective	Projected Start and End Dates	Title III B Funded PD or C[39]	Update Status[40]
3a. Provide individualized long term care planning support to help older adults, adults with disabilities, and their caregivers/families when they need guidance and assistance about how best to access services and support. DAAS Integrated Intake Unit is working very closely with OOA, the Aging and Disability Resource Connection, and ILRCSF have established protocols for Options Counseling (OC) and short term service coordination. DAAS Intake and ILRCSF are currently participating in a State Pilot to offer intensive OC Jan 2012-June 2012. DAAS Intake is partnering with IRCSF in coordinating the outreach of this service and DAAS Intake plans on expanding this service past the pilot period through drop-ins, phone work, and an OC community based educational workgroup.	July 2012 to June 2016		
3b. Hold a cross-training forum for staff of all relevant information and referral sources, senior and disability service providers, and Community Alliance of Disability (CADA) members. The focus will be to explain I&R system changes, including points of entry,	July 2012 to June 2016		

[39] Indicate if Program Development (PD) **or** Coordination (C) – **cannot be both**. If a PD objective is not completed and is continued the following year, the objective must be revised and restated with the remaining or additional tasks.

[40] Use for Area Plan Updates only: Indicate if objective is **New, Continued, Revised, Completed**, or **Deleted.**

other key information access points, and the role of the DAAS Long Term Care Intake, Screening and Consultation Unit. This will increase knowledge about available community resources and the core strengths of each information and referral entity. DAAS Integrated Intake Unit runs a quarterly I&R work group including the Aging and Disability Resource Center, 211, 311, CVSO, the Mayor's Office on Disability, and ILRCSF representatives. The workgroup will continue to meet at least quarterly.			
3c. Promote independent living in the aging resource networks. Under the umbrella of the Aging and Disability Resource Connection, program partners will work together to reach diverse communities in San Francisco by: (a) continuing cross-training for the new Aging and Disability Resource Center (ADRC), DAAS Long Term Care Intake and Screening staff, ILRCSF staff; and (b) conducting an annual meeting between the DAAS Executive Director and the disability organizations. The ADRC partners will continue to explore other means of improving the quality of services of information and referral services of DAAS and ADRC and ILRCSF. ADRC partners DAAS Intake and ILRC will work on an outreach campaign on Options Counseling Services. ADRC partners have worked together on translating outreach material, printing ADRC material in multiple languages in 2012.	July 2012 to June 2016		
3d. Strengthen collaborations in historically underserved communities and assess service delivery from a racial, ethnic and cultural perspective. Four community partnerships (African American, Asian/Pacific Islander, Latino, and LGBT) are continuing to strengthen existing collaborations and build new collaborations to increase access to services.	July 2012 to June 2016		
3e. Continue to connect seniors and adults with disabilities living in public housing to services provided in the community. These public housing buildings are operated by the San Francisco Housing Authority (SFHA). The Services Connection Program administered by Northern California Presbyterian Homes and Services (NCPHS) continues, and the partnership between DAAS, SFHA, and NCPHS remains strong and collaborative. Service Coordinators work in fifteen SFHA buildings, bringing services and programs to residents. NCPHS and SFHA have applied for additional funding through the US Department of	July 2012 to June 2016		

Housing and Urban Development to target the final 7 SFHA buildings housing seniors			
3f. Use public information, outreach, and community education mechanisms to reach older adults, adults with disabilities, and their caregivers. DAAS Intake publishes multiple brochures and outreach materials on paper and on the internet. DAAS Intake and other ADRC partners host multiple outreach events, distributing this material. DAAS Intake and ILRC are partnering on a special outreach effort in advertising Options Counseling Services and will print ADRC brochures in multiple languages in 2012.	July 2012 to June 2016		
3g. OOA will continue working with the Mental Health Association of San Francisco, to provide Social Support Services for Hoarders and Clutterers.	July 2012 to June 2016		
3h. The San Francisco Strategy for Excellence in Dementia Care was published in February 2009. It includes 35 recommendations, that once implemented, will improve the care of people with Alzheimer's disease and other dementias in San Francisco. This strategy was developed by the Alzheimer's/Dementia Expert Panel appointed by then Mayor Gavin Newsom. This is the first municipal strategy in the nation to address the growing crisis in dementia care. A Dementia Care Excellence Oversight Committee has been created to oversee the implementation of all 35 recommendations included in this strategy. In addition, four implementation workgroups have been formed to explore the activities related to implementation for a specific subset of these recommendations. These include: (1) Education and Training Workgroup; (2) Medical Resources Workgroup; (3) Waivers, Demonstration Projects and Advocacy Workgroup; and (4) Additional Services and Settings Workgroup.	January 2012 to December 2014		

Goal #4: Improve Service Quality

Rationale: The network of community-based long term care services will need to comply with quality standards for city-funded services across settings to improve accountability and oversight. Quality standards will need to address issues such as program accountability, performance measures, and safety. Mechanisms to ensure compliance with quality standards will need to be put in place.

Objective Number & Objective	Projected Start and End Dates	Title III B Funded PD or C[41]	Update Status[42]
4a. Develop quality standards for OOA-funded home and community-based services across settings for those receiving community-based services, to improve accountability and oversight. Standards would address issues such as: program accessibility, outcome measures, and safety. DAAS will continue with case management training and clinical consultation for case managers and supervisors; and provide training to nutrition providers.	July 2012 to June 2016		
4b. Establish strong mechanisms to ensure OOA contractors meet quality standards including: (a) making sure contractors are educated about existing and new standards; and (b) tracking and measuring performance, (c) develop protocols for responding to non-compliance.	July 2012 to June 2016		
4c. Assess the ongoing capacity of the LTC Ombudsman program to provide oversight of institutional long term care services in light of budget shortfalls anticipated in the next four fiscal years. OOA staff will provide necessary technical assistance to the program staff of Ombudsman Program.	July 2012 to June 2016		
4d. Develop and implement training programs for the line-staff of City programs and community-based service providers: including sensitivity training and working with people with various types of disabilities, physical disabilities and behavioral health issues. DAAS has been hosting regular trainings at the Bethany Center for community-based line staff, as well as trainings for HSA staff. These efforts could be continued and expanded.	July 2012 to June 2016		
4e. Offer assistance to providers to meet stringent	July 2012 to		

[41] Indicate if Program Development (PD) **or** Coordination (C) – **cannot be both**. If a PD objective is not completed and is continued the following year, the objective must be revised and restated with the remaining or additional tasks.

[42] Use for Area Plan Updates only: Indicate if objective is **New, Continued, Revised, Completed**, or **Deleted.**

nutrition standards by having the OOA Nutritionist conduct quarterly nutrition providers' meetings to provide technical assistance, share resources and update new or changes in nutrition program standards.	June 2016		

Goal #5: Secure Financial and Political Resources

Rationale: San Francisco does not have fully-developed mechanisms to expand needed home and community- based services as the consumer population grows. The network of community-based long term care services will need to be able to expand as consumer needs change.

Objective Number & Objective	Projected Start and End Dates	Title III B Funded PD or C[43]	Update Status[44]
5a. Despite budgetary constraints, DAAS will continue to look for funding opportunities or collaboration with community partners in planning and developing innovative programs to meet the needs of seniors and adults with disabilities. In preparation for 1115 waiver implementation, DAAS is collaborating with other city departments, community partners, hospitals, health plans and health plans to apply for new funding under new initiatives of Affordable Care Act., including the Community Care Transitions Program and the Innovations Challenge Grant.	July 2012 to June 2016		
5b. DAAS in collaboration with the Mayor's Long Term Care Coordinating Council, has initiated an investigation of Medicaid Managed Care in order to better serve Medi-Cal eligible older adults and adults with disabilities in San Francisco. A 14-member Long Term Care Integration (LTCI) Design Group and three LTCI Subcommittees including: (1) Scope of Services/Service Delivery; (2) Finance; and (3) Communications, have been created to participate in this investigation. The firm of Chi Partners, with David Nolan and Terri Sult, has been retained to serve as the strategic planning team. These consultants will provide all planning and coordinating services required to support this investigation by the LTCI Design Group and its three LTCI Subcommittees.	January 2012 to May 2013		

[43] Indicate if Program Development (PD) **or** Coordination (C) – **cannot be both**. If a PD objective is not completed and is continued the following year, the objective must be revised and restated with the remaining or additional tasks.

[44] Use for Area Plan Updates only: Indicate if objective is **New, Continued, Revised, Completed**, or **Deleted.**

SECTION 10: SERVICE UNIT PLAN (SUP) OBJECTIVES

PSA 6

TITLE III/VII SERVICE UNIT PLAN OBJECTIVES
2012–2016 Four-Year Planning Period
CCR Article 3, Section 7300(d)

The Service Unit Plan (SUP) uses the National Aging Program Information System (NAPIS) Categories and units of service, as defined in PM 97-02. A blank copy of the NAPIS State Program Report with definitions is available at http://cda.ca.gov/aaa/guidance/planning_index.asp.
For services not defined in NAPIS, refer to the Service Categories and Data Dictionary available at: http://cda.ca.gov/aaa/guidance/planning_index.asp .
Report units of service to be provided with **ALL funding sources**.

Related funding is reported in the annual Area Plan Budget (CDA 122) for Titles III B, III C-1, III C-2, III D, VII (a) and VII (b). This SUP does **not** include Title III E services.

All service units measured in hours must be reported as whole numbers (no fractions/partial units can be reported). However, AAAs must track the actual time services were provided in their local database (i.e. minutes, fractions). The AAA's local software system must then round the total service units for each client by month and by service category to the nearest integer (i.e. can round up or down) when exporting these data to the California Aging Reporting System (CARS). Please note that this should not affect the actual data in the AAA database, only the service unit totals in the CARS export files. Due to rounding, CDA expects minor service unit discrepancies (not to exceed 5-10 percent) between the AAA database and CARS. Also see "CARS Overview and Guidance" document (once a PM is issued, we will insert the appropriate PM number).

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

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	660	1,2,3,4	
2013-2014			
2014-2015			
2015-2016			

2. Homemaker **Unit of Service = 1 hour**

Fiscal Year		Goal Numbers	Objective Numbers(if applicable)

	Proposed Units of Service		
2012-2013	750	1,2,3,4	
2013-2014			
2014-2015			
2015-2016			

3. Chore **Unit of Service = 1 hour**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	800	1,2,3,4	
2013-2014			
2014-2015			
2015-2016			

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

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	1,016,800	1,2,3,4	4.1a, 4.1 b, 4.2a
2013-2014			
2014-2015			
2015-2016			

5. Adult Day Care/Adult Day Health **Unit of Service = 1 hour**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013			
2013-2014			
2014-2015			
2015-2016			

6. Case Management **Unit of Service = 1 hour**

Fiscal Year	**Proposed**	Goal Numbers	Objective Numbers (if applicable)

	Units of Service		
2012-2013			
2013-2014			
2014-2015			
2015-2016			

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

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers(if applicable)
2012-2013			
2013-2014			
2014-2015			
2015-2016			

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

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2009-2010	717,445	1,2,3,4,	4.1a, 4.1b, 4.2a
2012-2013			
2013-2014			
2014-2015			
2015-2016			

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

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	1270	1,2,3,4	4.1a, 4.1b, 4.2a
2013-2014			
2014-2015			
2015-2016			

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

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	59,265	1,2,3,4	
2013-2014			
2014-2015			
2015-2016			

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

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	12,961	1,2,3,4	
2013-2014			
2014-2015			
2015-2016			

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

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013	36,000	1,2,3,4	4.1a, 4.1b, 4.2a
2013-2014			
2014-2015			
2015-2016			

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

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers(if applicable)
2012-2013	4200	1,2,3,4	3.1a, 3.1b, 3.1c, 3.3a
2013-2014			
2014-2015			
2015-2016			

14. Outreach **Unit of Service = 1 contact**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers(if applicable)
2012-2013			
2013-2014			
2014-2015			
2015-2016			

Instructions for Title III D /Health Promotion and Medication Management written objectives

Because of the nature of the Health Promotion and Medication Management activities, the AAAs are required to write objectives for all services provided with Title III D funds. The objective should clearly describe the **Service Activity** that is being performed to fulfill the service unit requirement. If you designate Title III D Health Promotion funds to support Title III C Nutrition Education and/or Nutrition Counseling services you would report the service units under Title III C NAPIS 9. Nutrition Counseling and/or NAPIS 12. Nutrition Education.

- **Service Activity:** List all the Title III D/Health Promotion specific allowable service activities provided. (i.e. health risk assessments; routine health screening; nutrition counseling/education services; evidence-based health promotion; physical fitness, group exercise, music, art therapy, dance movement and programs for multigenerational participation; home injury control services; screening for the prevention of depression and coordination of other mental health services; gerontological and social service counseling; and education on preventative health services. Primary activities are normally on a one-to-one basis; if done as a group activity, each participant shall be counted as one contact unit.)

  CDA Service Categories and Data Dictionary, 2011.

- **Title III D/Health Promotion and Medication Management requires a narrative program goal and objective.** The objective should clearly explain the service activity that is being provided to fulfill the service unit requirement.
- **Title III D/Health Promotion and Medication Management:** Insert the program goal and objective numbers in all Title III D Service Plan Objective Tables

16. Title III D Health Promotion **Unit of Service = 1 contact**
Service Activities: Evidence-Based Health Promotion (Chronic Disease Self Management Program)

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers(if applicable)
2012-2013	400	1,2,3,4	1.1a
2013-2014			
2014-2015			
2015-2016			

NAPIS Service Category 15 – "Other" Title III Services

- In this section, identify **Title III D**/Medication Management services (required); and also identify all **Title III B** services to be funded that were not reported in NAPIS categories 1–14 and 16 above. (Identify the specific activity under the Service Category on the "Units of Service" line when applicable.)

- Each **Title III B** "Other" service must be an approved NAPIS Program 15 service listed on the "Schedule of Supportive Services (III B)" page of the Area Plan Budget (CDA 122) and the Service Categories and Data Dictionary.
- **Title III D/Medication Management requires a narrative program goal and objective.** The objective should clearly explain the service activity that is being provided to fulfill the service unit requirement.
- **Title III D/Medication Management:** Insert the program goal and objective numbers in all Title III D Service Plan Objective Tables

Title III D, Medication Management [45] **Units of Service = 1 Contact**
Service Activities: Evidence based Medication Management program_____

Fiscal Year	**Proposed** Units of Service	Program Goal Number	Objective Numbers (required)
2012-2013	200	1,2,3,4	1.1b
2013-2014			
2014-2015			
2015-2016			

6 Refer to Program Memo 01-03

Title III B, Other Supportive Services [46]

For all Title IIIB "Other" Supportive Services, use appropriate Service Category name and Unit of Service (Unit Measure) listed in the Service Categories and Data Dictionary. All "Other" services must be listed separately. You may duplicate the table below as needed.

Service Category **Unit of Service**

Fiscal Year	**Proposed** Units of Service	Goal Numbers	Objective Numbers (if applicable)
2012-2013			
2013-2014			
2014-2015			
2015-2016			

PSA 6

2012–2016 Four-Year Planning Cycle

TITLE III B and Title VII A: LONG-TERM CARE (LTC) OMBUDSMAN PROGRAM OUTCOMES

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

Baseline numbers are obtained from the local LTC Ombudsman Program's FY 2010-2011National Ombudsman Reporting System (NORS) data as reported in the State Annual Report to the Administration on Aging (AoA).

Targets are to be established jointly by the AAA and the local LTC Ombudsman Program Coordinator. Use the baseline year data as the benchmark for determining FY 2012-2013 targets. For each subsequent FY target, use the most recent FY AoA data as the benchmark to determine realistic targets. Refer to your local LTC Ombudsman Program's last three years of AoA data for historical trends. Targets should be reasonable and attainable based on current program resources.

Complete all Measures and Targets for Outcomes 1-3.

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

Measures and Targets:

A. Complaint Resolution Rate (AoA Report, Part I-E, Actions on Complaints)
The average California complaint resolution rate for FY 2009-2010 was 73%.

1. FY 2010-2011 Baseline Resolution Rate: _77 % Number of complaints resolved_317__ + Number of partially resolved complaints__187__ divided by the Total Number of Complaints Received_655__ = Baseline Resolution Rate _77__%
2. FY 2012-2013 Target: Resolution Rate _78__% __(800 cases with a Close Partially resolved or full resolved 78%)
3. FY 2011-2012 AoA Resolution Rate ___% FY 2013-2014 Target: Resolution Rate 78%
4. FY 2012-2013 AoA Resolution Rate ___% FY 2014-2015 Target: Resolution Rate 78%
5. FY 2013-2014 AoA Resolution Rate ___% FY 2015-2016 Target: Resolution Rate 78% _
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: Objectives 2.3a, 2.3b, 4.1c,

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

1. FY 2010-2011 Baseline: number of meetings attended _27__
2. FY 2012-2013 Target: _30__
3. FY 2011-2012 AoA Data: ___FY 2013-2014 Target: _30__
4. FY 2012-2013 AoA Data: ___ FY 2014-2015 Target: _30__
5. FY 2013-2014 AoA Data: ___ FY 2015-2016 Target: _30_
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: Objectives 2.3a, 2.3b, 4.1c,

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

1. FY 2010-2011 Baseline: number of meetings attended_6__
2. FY 2012-2013 Target: number__8_
3. FY 2011-2012 AoA Data: ___ FY 2013-2014 Target: _8
4. FY 2012-2013 AoA Data: ___ FY 2014-2015 Target: _8
5. FY 2013-2014 AoA Data: ___ FY 2015-2016 Target: _8
Program Goals and Objective Numbers: Goals 1,2,3,4; Objectives 2.3a, 2.3b, 4.1c,

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

1. FY 2010-2011 Baseline: number of consultations_63__ (increase by 9%)
2. FY 2012-2013 Target: __73_
3. FY 2011-2012 AoA Data: ___ FY 2013-2014 Target: ___
4. FY 2012-2013 AoA Data: ___ FY 2014-2015 Target: ___
5. FY 2013-2014 AoA Data: ___ FY 2015-2016 Target: __

Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: Objectives 2.3a, 2.3b, 4.1c,

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

1. FY 2010-2011 Baseline: number of consultations_247__
2. FY 2012-2013 Target: _350__(SFLTCO will increase individual consultations by 30%)
3. FY 2011-2012 AoA Data: ___ FY 2013-2014 Target: _
4. FY 2012-2013 AoA Data: ___ FY 2014-2015 Target: __
5. FY 2013-2014 AoA Data: ___ FY 2015-2016 Target: _
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: Objectives 2.3a, 2.3b, 4.1c,

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

1. FY 2010-2011 Baseline: number of sessions__7_
2. FY 2012-2013 Target: __10_ (SFLTCO will increase Community Education by 10%)
3. FY 2011-2012 AoA Data: ___ FY 2013-2014 Target: __
4. FY 2012-2013 AoA Data: ___ FY 2014-2015 Target: __
5. FY 2013-2014 AoA Data: ___ FY 2015-2016 Target: _
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: Objectives 2.3a, 2.3b, 4.1c,

G. Systems Advocacy

1. FY 2012-2013 Activity: In the box below, in narrative format, please provide at least one new priority systemic advocacy effort the local LTC Ombudsman Program will engage in during the fiscal year.

Systems Advocacy can include efforts to improve conditions in one LTC facility or can be county-wide, State-wide, or even national in scope. (Examples: Work with LTC facilities to improve pain relief or increase access to oral health care, work with law enforcement entities to improve response and investigation of abuse complaints, collaboration with other agencies to improve LTC residents' quality of care and quality of life, participation in disaster preparedness planning, participation in legislative advocacy efforts related to LTC issues, etc.)

Enter information in the box below.

Systemic Advocacy Effort(s)
Collaboration with City and County of SF efforts to integrate LTC Services.
Participation in Dementia Care Additional Services Work group
Collaborate with ILRC Options Counselor and Section Q(MDS 3.0)
Participation in Forensic and Elder Death Meetings time permitting and Work at State Level through Association for Elder Abuse collaboration with Law Enforcement and APS
Transitional and Discharge Advocacy for Laguna Honda and all the SNF which have shifted to short term rehab.
Ombudsman services expansion to mental health clients.

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

Measures and Targets:

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

1. FY 2010-2011 Baseline: 69___% Number of Nursing Facilities visited at least once a quarter not in response to a complaint __13__ divided by the number of Nursing Facilities_26__.
2. FY 2012-2013 Target: _74__%
3. FY 2011-2012 AoA Data: ___% FY 2013-2014 Target: 74___%
4. FY 2012-2013 AoA Data: ___% FY 2014-2015 Target: _74__%
5. FY 2013-2014 AoA Data: ___ % FY 2015-2016 Target: 74___%
Program Goals and Objective Numbers: Quarterly visits are contingent on number of assigned staff and volunteers. Will try to visit SNF quarterly 74%Most SNF have switched to short term rehab. The Program responds to complaints in these facilities.

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

1. FY 2010-2011 Baseline: _1.3__% Number of RCFEs visited at least once a quarter not in response to a complaint __1_ divided by the number of RCFEs __93_
2. FY 2012-2013 Target: 15___%
3. FY 2011-2012 AoA Data: ___ % FY 2013-2014 Target: _15__%

4. FY 2012-2013 AoA Data: ___ % FY 2014-2015 Target: _15__ %
5. FY 2013-2014 AoA Data: ___ % FY 2015-2016 Target: ___%
Program Goals and Objective Numbers: The Program visits a lot of RCFE but not quarterly. This AoA measure under-represents the activity of Program in RCFE.

C. Number of Full-Time Equivalent (FTE) Staff (AoA Report Part III. B.2. - Staff and Volunteers) (One FTE generally equates to 40 hours per week or 1,760 hours per year) This number may only include staff time legitimately charged to the LTC Ombudsman Program. For example, the FTE for a staff member who works in the Ombudsman Program 20 hours a week should be 0.5. Time spent working for or in other programs may not be included in this number.
Verify number of staff FTEs with Ombudsman Program Coordinator.

1. FY 2010-2011 Baseline: FTEs__2.65__
2. FY 2012-2013 Target: _3.2__ FTEs
3. FY 2011-2012 AoA Data: ___ FTEs FY 2013-2014 Target: _3.2__ FTEs
4. FY 2012-2013 AoA Data: ___ FTEs FY 2014-2015 Target: 3.2___ FTEs
5. FY 2013-2014 AoA Data: ___ FTEs FY 2015-2016 Target: _FTEs
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: Objectives 2.3a, 2.3b, 4.1c, (The local Program will increase FTE when the State General fund dollars are forthcoming to address the State Mandates, and the Funding formula reverts to the IoM recommendation of 1 FTE for 2000 beds)

D. Number of Certified LTC Ombudsman Volunteers (AoA Report Part III. B.2. – Staff and Volunteers)
Verify numbers of volunteers with Ombudsman Program Coordinator.

1. FY 2010-2011 Baseline: Number of certified LTC Ombudsman volunteers as of June 30, 2010 __53_(It is an error. We only had 25)
2. FY 2012-2013 Projected Number of certified LTC Ombudsman volunteers as of June 30, 2013 __25_
3, FY 2011-2012 AoA Data: ___ certified volunteers FY 2013-2014 Projected Number of certified LTC Ombudsman volunteers as of June 30, 2014 ____

4. FY 2012-2013 AoA Data: ___ certified volunteers FY 2014-2015 Projected Number of certified LTC Ombudsman volunteers as of June 30, 2015 ___
5. FY 2013-2014 AoA Data: ___ certified volunteers FY 2015-2016 Projected Number of certified LTC Ombudsman volunteers as of June 30, 2016 ___
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: Objectives 2.3a, 2.3b, 4.1c, (The SFLCO volunteers had an inflated number for the 10-11. This could be data error. Our actually base line for June 30, 2010 was 25 Certified Volunteers. So with lay-off of Volunteer Manager we project a growth of 10 to replace the loss of 13 volunteers by July 2011.)

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

Measures and Targets:

A. At least once each fiscal year, the Office of the State Long-Term Care Ombudsman sponsors free training on each of four modules covering the reporting process for the National Ombudsman Reporting System (NORS). These trainings are provided by telephone conference and are available to all certified staff and volunteers. Local LTC Ombudsman Programs retain documentation of attendance in order to meet annual training requirements.

1. FY 2010-2011 Baseline number of Ombudsman Program staff and volunteers who attended NORS Training Parts I, II, III and IV _2_____ **Please obtain this information from the local LTC Ombudsman Program Coordinator.**
2. FY 2012-2013 Target: number of Ombudsman Program staff and volunteers attending NORS Training Parts I, II, III and IV ____2__
3. FY 2011-2012 number of Ombudsman Program staff and volunteers who attended NORS Training Parts I, II, III, and IV __2____ FY 2013-2014 Target _____
4. FY 2012-2013 number of Ombudsman Program staff and volunteers who attended NORS Training Parts I, II, III, and IV _____ FY 2014-2015 Target __4____
5. FY 2013-2014 number of Ombudsman Program staff and volunteers who attended NORS Training Parts I, II, III, and IV _____ FY 2015-2016 Target: _____
Program Goals and Objective Numbers: Goals: 1,2,3,4 Objectives: Objectives 2.3a, 2.3b, 4.1c,

PSA #6

2012–2016 Four-Year Planning Period

TITLE VII B ELDER ABUSE PREVENTION SERVICE UNIT PLAN OBJECTIVES

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

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

When developing targets for each fiscal year, refer to data reported on the Elder Abuse Prevention Quarterly Activity Reports. Set realistic goals based upon the prior year's numbers and the resources available.

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

- **Public Education Sessions** – Please indicate the total number of projected education sessions for the general public on the identification, prevention, and treatment of elder abuse, neglect, and exploitation.

- **Training Sessions for Professionals** – Please indicate the total number of projected training sessions for professionals (service providers, nurses, social workers) on the identification, prevention, and treatment of elder abuse, neglect, and exploitation.

- **Training Sessions for Caregivers Served by Title III E** – Please indicate the total number of projected training sessions for caregivers who are receiving services under Title III E of the Older Americans Act on the identification, prevention, and treatment of elder abuse, neglect, and exploitation.

- **Hours Spent Developing a Coordinated System to Respond to Elder Abuse** – Please indicate the number of hours to be spent developing a coordinated system to respond to elder abuse. This category includes time spent coordinating services provided by the AAA or its contracted service provider with services provided by Adult Protective Services, local law enforcement agencies, legal services providers, and other agencies involved in the protection of elder and dependent adults from abuse, neglect, and exploitation.

- **Educational Materials Distributed** – Please indicate the type and number of educational materials to be distributed to the general public, professionals, and caregivers (this may include materials that have been developed by others) to help in the identification, prevention, and treatment of elder abuse, neglect, and exploitation.

- **Number of Individuals Served –** Please indicate the total number of individuals expected to be reached by any of the above activities of this program.

PSA #6

2012–2016 Four-Year Planning Period

TITLE VIIB ELDER ABUSE PREVENTION SERVICE UNIT PLAN OBJECTIVES

Fiscal Year	Total # of Public Education Sessions
2012-13	20
2013-14	
2014-15	
2015-16	

Fiscal Year	Total # of Training Sessions for Professionals
2012-13	24
2013-14	
2014-15	
2015-16	

Fiscal Year	Total # of Training Sessions for Caregivers served by Title III E
2012-13	0
2013-14	0
2014-15	0
2015-16	0

Fiscal Year	Total # of Hours Spent Developing a Coordinated System
2012-13	160
2013-14	160
2014-15	160
2015-16	160

Fiscal Year	Total # of Copies of Educational Materials to be Distributed	Description of Educational Materials
2012-2013	2000	A typical packet at a training session includes the following items: • APS's Elder Abuse information fact sheet • IOA's Elder Abuse Fact Sheet (English & Spanish) • Bay Area Academy's Financial abuse fact sheet • SOC 341 including instructions about how to complete • UC Irvine Bruising Study • Break the Silence fliers in multiple languages • Copy of the PowerPoint presentation • California Penal Coders: elder abuse for law enforcement
2013-2014		
2014-2015		
2015-2016		

Fiscal Year	Total Number of Individuals Served
2012-13	4000
2013-14	
2014-15	
2015-16	

Goals: 1,2,3,4 Objectives: Objectives 2.3a, 2.3b

PSA #6

2012–2016 Four-Year Planning Period

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

This Service Unit Plan (SUP) utilizes the five broad federal service categories defined in PM 08-03. Refer to the Service Categories and Data Dictionary for eligible activities and service unit examples covered within each category. Specify proposed audience size or units of service for ALL budgeted funds.

All service units measured in hours must be reported as whole numbers (no fractions/partial units can be reported). However, AAAs must track the actual time services were provided in their local database (i.e. minutes, fractions). The AAA's local software system must then round the total service units for each client by month and by service category to the nearest integer (i.e. can round up or down) when exporting these data to the California Aging Reporting System (CARS). Please note that this should not affect the actual data in the AAA database, only the service unit totals in the CARS export files. Due to rounding, CDA expects minor service unit discrepancies (not to exceed 5-10 percent) between the AAA database and CARS. Also see "CARS Overview and Guidance" document (once a PM is issued, we will insert the appropriate PM number).

Direct Services

CATEGORIES	1	2	3
Direct III E Family Caregiver Services	***Proposed*** **Units of Service**	***Required*** **Goal #(s)**	***Optional*** **Objective #(s)**
Information Services	**# of activities and Total est. audience for above**		
2012-2013	# of activities: Total est. audience for above:		
2013-2014	# of activities Total est. audience for above:		
2014-2015	# of activities Total est. audience for above:		
2015-2016	# of activities: Total est. audience for above:		
Access Assistance	**Total contacts**		
2012-2013			
2013-2014			
2014-2015			
2015-2016			
Support Services	**Total hours**		
2012-2013			
2013-2014			

2014-2015			
2015-2016			
Respite Care	**Total hours**		
2012-2013			
2013-2014			
2014-2015			
2015-2016			
Supplemental Services	**Total occurrences**		
2012-2013			
2013-2014			
2014-2015			
2015-2016			

Direct III E **Grand parent Services**	***Proposed*** **Units of Service**	***Required*** **Goal #(s)**	***Optional*** **Objective #(s)**
Information Services	**# of activities and** **Total est. audience for above**		
2012-2013	# of activities: Total est. audience for above:		
2013-2014	# of activities: Total est. audience for above:		
2014-2015	# of activities: Total est. audience for above:		
2015-2016	# of activities: Total est. audience for above:		
Access Assistance	**Total contacts**		
2012-2013			
2013-2014			
2014-2015			
2015-2016			
Support Services	**Total hours**		
2012-2013			
2013-2014			
2014-2015			

2015-2016			
Respite Care	**Total hours**		
2012-2013			
2013-2014			
2014-2015			
2015-2016			
Supplemental Services	**Total occurrences**		
2012-2013			
2013-2014			
2014-2015			
2015-2016			

Contracted Services

Contracted III E Family Caregiver Services	***Proposed*** **Units of Service**	***Required*** **Goal #(s)**	***Optional*** **Objective #(s)**
Information Services	**# of activities and total est. audience for above:**		
2012-2013	# of activities: 29 Total est. audience for above:	1,2,3,4	
2013-2014	# of activities: Total est. audience for above:		
2014-2015	# of activities: Total est. audience for above:		
2015-2016	# of activities: Total est. audience for above:		
Access Assistance	**Total contacts**		
2012-2013	653	1,2,3,4	
2013-2014			
2014-2015			
2015-2016			

Support Services	**Total hours**		
2012-2013	2424	1,2,3,4	
2013-2014			
2014-2015			
2015-2016			
Respite Care	**Total hours**		
2012-2013	2520	1,2,3,4	
2013-2014			
2014-2015			
2015-2016			
Supplemental Services	**Total occurrences**		
2012-2013	116	1,2,3,4	
2013-2014			
2014-2015			
2015-2016			

Contracted III E Grandparent Services	***Proposed*** **Units of Service**	***Required*** **Goal #(s)**	***Optional*** **Objective #(s)**
Information Services	**# of activities and Total est. audience for above**		
2012-2013	# of activities: Total est. audience for above:		
2013-2014	# of activities: Total est. audience for above:		
2014-2015	# of activities: Total est. audience for above:		
2015-2016	# of activities: Total est. audience for above:		
Access Assistance	**Total contacts**		
2012-2013			
2013-2014			
2014-2015			
2015-2016			
Support Services	**Total hours**		

2012-2013			
2013-2014			
2014-2015			
2015-2016			
Respite Care	**Total hours**		
2012-2013			
2013-2014			
2014-2015			
2015-2016			
Supplemental Services	**Total occurrences**		
2012-2013			
2013-2014			
2014-2015			
2015-2016			

PSA #6[47]

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP)
2012–2016 Four-Year Planning Period

List all SCSEP monitor sites (contract or direct) where the AAA provides services within the PSA (Please add boxes as needed)

Location/Name (AAA office, One Stop, Agency, etc):
Street Address:
Name and title of all SCSEP staff members (paid and participant):
Number of paid staff ______ Number of participant staff ______
How many participants are served at this site?

Location/Name (AAA office, One Stop, Agency, etc):
Street Address:
Name and title of all SCSEP staff members (paid and participant):
Number of paid staff ______ Number of participant staff ______
How many participants are served at this site?

Location/Name (AAA office, One Stop, Agency, etc):
Street Address:
Name and title of all SCSEP staff members (paid and participant):
Number of paid staff ______ Number of participant staff ______
How many participants are served at this site?

47 If not providing Title V, enter PSA number followed by “Not providing”.

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

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

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

STATE & FEDERAL PERFORMANCE TARGETS: The Centers for Medicare and Medicaid Services (CMS) requires all State Health Insurance Assistance Programs (SHIP) to meet certain targeted performance measures. To help AAAs complete the Service Unit Plan, CDA will annually provide AAAs with individual PSA state and federal performance measure targets.

Section 1. Primary HICAP Units of Service

Fiscal Year (FY)	1.1 Estimated Number of Unduplicated Clients Counseled	Goal Numbers
2012-2013	1529	1,2,3,4
2013-2014		
2014-2015		
2015-2016		

Note: Clients Counseled equals the number of Intakes closed and finalized by the Program Manager.

Fiscal Year (FY)	1.2 Estimated Number of Public and Media Events	Goal Numbers
2012-2013	120	1,2,3,4
2013-2014		
2014-2015		
2015-2016		

Note: Public and Media events include education/outreach presentations, booths/exhibits at health/senior fairs, and enrollment events, excluding public service announcements and printed outreach.

Section 2: Federal Performance Benchmark Measures

Fiscal Year (FY)	2.1 Estimated Number of Contacts for all Clients Counseled	Goal Numbers
2012-2013	10,798	1,2,3,4
2013-2014		
2014-2015		
2015-2016		

Note: This includes all counseling contacts via telephone, in-person at home, in-person at site, and electronic contacts (e-mail, fax, etc.) for duplicated client counts.

Fiscal Year (FY)	2.2 Estimated Number of Persons Reached at Public and Media Events	Goal Numbers
2012-2013	15,750	1,2,3,4
2013-2014		
2014-2015		
2015-2016		

Note: This includes the estimated number of attendees (e.g., people actually attending the event, not just receiving a flyer) reached through presentations either in person or via webinars, TV shows or radio shows, and those reached through booths/exhibits at health/senior fairs, and those enrolled at enrollment events, excluding public service announcements (PSAs) and printed outreach materials.

Fiscal Year (FY)	2.3 Estimated Number of contacts with Medicare Status Due to a Disability Contacts	Goal Numbers
2012-2013	2254	1,2,3,4
2013-2014		
2014-2015		
2015-2016		

Note: This includes all counseling contacts via telephone, in-person at home, in-person at site, and electronic contacts (e-mail, fax, etc.), duplicated client counts with Medicare beneficiaries due to disability, and not yet age 65.

Fiscal Year (FY)	2.4 Estimated Number of contacts with Low Income Beneficiaries	Goal Numbers
2012-2013	4740	1,2,3,4
2013-2014		
2014-2015		
2015-2016		

Note: This is the number of unduplicated low-income Medicare beneficiary contacts and/or contacts that discussed low-income subsidy (LIS). Low income means 150 percent of the Federal Poverty Level (FPL).

Fiscal Year (FY)	2.5 Estimated Number of Enrollment Assistance Contacts	Goal Numbers
2012-2013	3558	1,2,3,4
2013-2014		
2014-2015		
2015-2016		

Note: This is the number of unduplicated enrollment contacts during which one or more qualifying enrollment topics were discussed. This includes <u>all</u> enrollment assistance, not just Part D.

Fiscal Year (FY)	2.6 Estimated Part D and Enrollment Assistance Contacts	Goal Numbers
2012-2013	3190	1,2,3,4
2013-2014		
2014-2015		
2015-2016		

Note: This is a subset of all enrollment assistance in 2.5. It includes the number of Part D enrollment contacts during which one or more qualifying Part D enrollment topics were discussed.

Fiscal Year (FY)	2.7 Estimated Number of Counselor FTEs in PSA	Goal Numbers
2012-2013	16.86	1,2,3,4
2013-2014		

2014-2015		
2015-2016		

Note: This is the total number of counseling hours divided by 2000 (considered annual fulltime hours), then multiplied by the total number of Medicare beneficiaries per 10K in PSA.

Section 3: HICAP Legal Services Units of Service (if applicable) [48]

State Fiscal Year (SFY)	3.1 Estimated Number of Clients Represented Per SFY (Unit of Service)	Goal Numbers
2012-2013	N/A	
2013-2014		
2014-2015		
2015-2016		
State Fiscal Year (SFY)	**3.2 Estimated Number of Legal Representation Hours Per SFY (Unit of Service)**	**Goal Numbers**
2012-2013	N/A	
2013-2014		
2014-2015		
2015-2016		
State Fiscal Year (SFY)	**3.3 Estimated Number of Program Consultation Hours per SFY (Unit of Service)**	**Goal Numbers**
2012-2013	N/A	
2013-2014		
2014-2015		
2015-2016		

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

SECTION 11: FOCAL POINTS

PSA #6

2012-2016 Four-Year Planning Cycle

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

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

Long Term Care Intake, Screening and Consultation Unit: 1650 Mission Street, 2nd Floor, San Francisco, CA 94103

Main ADRC Location: *Canon Kip Senior Center / Episcopal Community Services of San Francisco (ECS):* 705 Natoma at 8th Street, San Francisco, CA 94103

Aging and Disability Resource Center Outstations Administered through the Episcopal Community Services:
Episcopal Community Services Canon Kip Senior Center: 705 Natoma Street, San Francisco, CA 94103
Dr. Davis Senior Center (formerly the Bayview Hunters Point Multi-Purpose Senior Citizens Center): 1706 Yosemite Ave, San Francisco, CA 94124
Kimochi: JCCCNC (Issei Memorial Hall) 1st Floor, 1840 Sutter St., San Francisco, CA 94115
John King Senior Center: 500 Raymond Avenue, San Francisco, CA 94134
Richmond Senior Center: 6221 Geary Blvd. San Francisco, CA 94121
SF Senior Center-Downtown Branch: 481 O'Farrell Street, San Francisco, CA 94102
Sunset Senior Center: 1290 5th Avenue and Irving, San Francisco, CA 94122
OMI –Catholic Charities: 65 Beverly Street, San Francisco, CA 94132
30th Street Senior Center: 225-30th St. 3rd Fl., San Francisco, CA 94131
Lighthouse for the Blind: 214 Van Ness Avenue, San Francisco, CA 94102
Outer Sunset (PACE Learning Center): 2436 Judah, San Francisco, CA 94132
Janet Pomeroy Center: 207 Skyline Boulevard, San Francisco, CA 94132
Excelsior Senior Center: 4468 Mission Street, San Francisco, CA 94110
Chinatown Branch Library: 1135 Powell Street, San Francisco, 94108
Telegraph Hill Neighborhood Center: 660 Lombard Street, San Francisco, CA 94133
Family Service Agency of San Francisco: 6221 Geary Boulevard, 3rd Floor, San Francisco, CA 94121
Chinese Newcomers: 777 Stockton Street #104, San Francisco, CA 94108
*Western Addition Senior Center:*1390 1/2 Turk Street, San Francisco, CA 94115

Institute on Aging: 3575 Geary Boulevard, San Francisco, CA 94118

Aging and Disability Resource Center Outstations Administered by Self-Help for the Elderly:

Self-Help for the Elderly: 407 Sansome Street, San Francisco, CA 94111
Self-Help for the Elderly: 777 Stockton Street, San Francisco, CA 94108

SECTION 12: DISASTER PREPAREDNESS

PSA 6

Disaster Preparation Planning Conducted for the 2012-2016 Planning Cycle OAA Title III, Sec. 306(a)(17); 310, CCR Title 22, Sections 7529 (a)(4) and 7547, W&I Code Division 8.5, Sections 9625 and 9716, CDA Standard Agreement, Exhibit E, Article 1, 22-25, Program Memo 10-29(P)

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

San Francisco's AAA disaster preparedness is managed by its broader agency, the San Francisco Human Services Agency (SF-HSA). In addition to its oversight of the city's shelter system in the event of a disaster, SF-HSA has developed plans for outreach to the city's most vulnerable seniors and adults with disabilities. The City and County of San Francisco has developed a corps of Neighborhood Emergency Response Teams (NERTs), citizen volunteers who have been trained and registered to conduct outreach after a disaster. The NERTs are managed by the San Francisco Fire Department. SF-HSA's own staff has been trained, if off-duty, to first secure their own homes and then report to an emergency response center that will be activated at an SF-HSA site. SF-HSA updates on a quarterly basis the names and addresses of In Home Supportive Services recipients who have impairments and live alone without support. The agency will deploy its staff, in conjunction with the NERTs, to conduct wellness checks of these individuals within 72 hours of a major disaster. The home visitors will asses the consumers for medical and shelter needs, and when necessary, will coordinate with the Fire Department to provide medical attention and transportation.

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

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

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

3. Identify the Disaster Response Coordinator within the AAA:

Name	Title	Telephone	email

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

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

Critical Services	**How Delivered?**
a Wellness checks to most vulnerable seniors and adults with disabilities, assessing their status and connecting them with need attention for urgent health and housing needs **b** Emergency Shelter	**a** SF-HSA will keep current a list of IHSS recipients who have personal care needs and are living alone or without support. It will coordinate its staff with the San Francisco Fire Department's trained volunteers to visit these consumers. **b** SF-HSA has an MOU with the Red Cross to manage the city's emergency shelters in the event of a disaster. Through wellness checks, it will connect the city's most vulnerable seniors and persons with disabilities to these shelters.

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

SF-HSA has an MOU to coordinate emergency shelter operations with the American Red Cross.

6. Describe how the AAA will:
   - Identify vulnerable populations. As explained above, SF-HSA maintains a list of IHSS recipients who meet a defined profile of vulnerability, including needing personal care and living alone without support. In addition, seniors and disabled persons are able to register with the San Francisco Fire Department for wellness checks by the NERTs.

   - Follow-up with these vulnerable populations after a disaster event. As described above, SF-HSA will be coordinating its own staff with the NERTs to conduct wellness checks in the first 72 hours after a disaster.

SECTION 13: PRIORITY SERVICES

PSA 6

2012-2016 Four-Year Planning Cycle

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

The CCR, Article 3, Section 7312, requires the AAA to allocate an "adequate proportion" of federal funds to provide Access, In-Home Services, and Legal Assistance in the PSA. The annual minimum allocation is determined by the AAA through the planning process. The minimum percentages of applicable Title III B funds[49] listed below have been identified for annual expenditure throughout the four-year planning period. These percentages are based on needs assessment findings, resources available within the PSA, and discussions at public hearings on the Area Plan.

Category of Service and the Percentage of Title III B Funds expended in/or to be expended in FY 2012-13 through FY 2015-16

Access:

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

12-13	13-14	14-15	15-16
45%	45%	45%	45%

In-Home Services:

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

12-13	13-14	14-15	15-16
5%	5%	5%	5%

Legal Assistance Required Activities:[50]

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

12-13	13-14	14-15	15-16
45%	45%	45%	45%

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

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

Explain how allocations are justified and how they are determined to be sufficient to meet the need for the service within the PSA. There are no changes programmed from the existing priority service allocations. The Department does not anticipate changing any of the funding allocations as they have been adequately meeting the needs of the community.

SECTION 14: NOTICE OF INTENT TO PROVIDE DIRECT SERVICES

PSA 6

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

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

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

Check applicable direct services	Check each applicable Fiscal Year			
Title III B	**12-13**	**13-14**	**14-15**	**15-16**
☒ Information and Assistance	☒	☒	☒	☒
☐ Case Management	☐	☐	☐	☐
☐ Outreach	☐	☐	☐	☐
☐ Program Development	☐	☐	☐	☐
☐ Coordination	☐	☐	☐	☐
☐ Long-Term Care Ombudsman	☐	☐	☐	☐
Title III D	**12-13**	**13-14**	**14-15**	**15-16**
☐ Health Promotion	☐	☐	☐	☐
☐ Medication Management	☐	☐	☐	☐
Title III E [51]	**12-13**	**13-14**	**14-15**	**15-16**
☐ Information Services	☐	☐	☐	☐
☐ Access Assistance	☐	☐	☐	☐
☐ Support Services	☐	☐	☐	☐
☐ Respite Services	☐	☐	☐	☐
☐ Supplemental Services	☐	☐	☐	☐
Title VII A	**12-13**	**13-14**	**14-15**	**15-16**
☐ Long-Term Care Ombudsman	☐	☐	☐	☐

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

Title VIIB	12-13	13-14	14-15	15-16
☐ Prevention of Elder Abuse, Neglect and Exploitation	☐	☐	☐	☐

Describe the methods to be used to ensure target populations will be served throughout the PSA.
The DAAS long term care (LTC) and intake, screening, and consultation unit serves as a comprehensive intake service, determining the long term care needs of individuals. The unit provides referrals and information for consumers that help support their current level of independence and functioning. The intake unit is knowledgeable in community and institutional services for seniors and adults with disabilities, regardless of their economic status. Screening and referrals are taken for In-Home Support Services, home delivered meals, Adult Protective Services, and the Community Living Fund. Other screening needs not met by the department are referred to the appropriate community or institutional source.

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

SECTION 15: REQUEST FOR APPROVAL TO PROVIDE DIRECT SERVICES

PSA 6

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

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

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

Identify Service Category: _____

Check applicable funding source:[52]

☐ III B

☐ III C-1

☐ III C-2

☐ III E

☐ VII A

☐ HICAP

Request for Approval Justification:

☐ Necessary to Assure an Adequate Supply of Service OR

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

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

☐ 2012-13 ☐ 2013-14 ☐ 2014-15 ☐ 2015-16

[1]3 Section 15 does not apply to Title V (SCSEP).

Justification: Provide a cost-benefit analysis below that substantiates this request for direct delivery of the above stated service[53] :

[1]4 For a HICAP direct services waiver, the managing AAA of HICAP services must document that all affected AAAs are in agreement.

SECTION 16: GOVERNING BOARD

PSA 6

GOVERNING BOARD MEMBERSHIP
2012-2016 Four-Year Area Plan Cycle

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

Total Number of Board Members: 7

Name and Title of Officers:	**Office Term Expires:**
Edna James, President	1/24/15
Gustavo Serina, Vice President	7/21/12

Names and Titles of All Members:	**Board Term Expires:**
Rosario Carrion-Di Ricco	6/15/12
Thomas Crites	7/5/12
Richard Ow	1/15/12
Michael DeNunzio	1/15/16
Katie Loo	1/15/16

SECTION 17 - ADVISORY COUNCIL **PSA #6**

ADVISORY COUNCIL MEMBERSHIP
2012-2016 Four-Year Planning Cycle

45 CFR, Section 1321.57
CCR Article 3, Section 7302(a)(12)

Total Council Membership (include vacancies) 22 (3 Vacancies)

Number of Council Members over age 60 13

	% of PSA's 60+Population	% on Advisory Council
Race/Ethnic Composition		
White	_____	#10 _____
Hispanic	_____	#0 _____
Black	_____	#6 _____
Asian/Pacific Islander	_____	#3 _____
Native American/Alaskan Native	_____	#0 _____
Other	_____	#0 _____

Name and Title of Officers:	**Office Term Expires:**
Anna Maria Pierini, President (Supportive Services)	12/31/14
Alexander MacDonald, 1st Vice President (Low income)	12/31/14
Leon Schmidt, 2nd Vice President	12/31/14
Marian Fields, Secretary	12/31/14

Name and Title of other members:	**Office Term Expires:**
Cathy Russo	3/31/14 -P
Sharon Eberhardt (Health Care Provider)	3/31/13 -P
Gracia Wiarda	3/31/10 -H
Vera Haile (Leadership in Voluntary Sector)	3/31/13
Ken Prag (Family Caregiver)	3/31/14-P
Elinore Lurie	3/31/14-P
Sergio Alunan (Disabled)	3/31/12-H
Anne Kirueshkin	3/31/14
Walter DeVaughn	3/31/14
Eileen Ward	3/31/14

Benny Wong	3/31/10-H
Jerry Wayne Brown	3/31/14
Louise Hines	3/31/14
Bettye Hammond	3/31/14
Marcy Adelman	3/31/14

P= Re-Appointment by District Supervisor is currently in Process.
H= Hold Over (County permits Holdover in Seat until replacement is appointed).

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

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

Explain any **"No"** answer(s): Although our CSL Members frequently attend meetings, none of them have been available to join the Council. We are currently recruiting for other candidates who are elected officials

Briefly describe the local governing board's process to appoint Advisory Council members: Half of the Members of the Advisory Board are appointed by the Aging and Adult Services Commission. All other members are appointed –one each- by their County District Supervisor.

SECTION 18: LEGAL ASSISTANCE

PSA 6

2012-2016 Four-Year Area Planning Cycle

This section must be completed and submitted with the Four-Year Area Plan.
Any changes to this Section must be documented on this form and remitted with Area Plan Updates.[54]

1. Specific to Legal Services, what is your AAA's Mission Statement or Purpose Statement? *Statement must include Title III B requirements: "Provide leadership in addressing issues that relate to older Californians; to develop community-based systems of care that provide services which support independence within California's interdependent society, and which protect the quality of life of older persons and persons with functional impairments; and to promote citizen involvement in the planning and delivery of services.*

2. Based on your local needs assessment, what percentage of Title III B funding is allocated to Legal Services? *45%*

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

   There has been no definitive change in local needs in the past four years. Funding levels remain basically the same with the exception of a slightly lower availability of local general funds.

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

   The targeted senior populations continue to include low-income, communities of color, immigrant families, LGBT and most vulnerable seniors. We also provide specific services to younger adults that are living with disabilities through our Adults with Disabilities legal services supported by local General Funds. The senior legal service providers are out in the community at various community events, networking functions, and educational forums and this aids in outreach. The providers publish a Senior Rights Bulletin (in three languages) at least twice a year on timely and relevant topics of interest to our target population. At least three of the four senior legal service providers participate in the Latino, African-American, Asian Pacific Islander and/or LGBT Partnership Groups to connect with other service providers and consumers in their respective communities.

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

Fiscal Year	# of Legal Assistance Services Providers

[54] For Information related to Legal Services, contact Chisorom Okwuosa at 916 419-7500 or COkwuosa@aging.ca.gov

2012-2013	4
2013-2014	4
2014-2015	4
2015-2016	4

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

PSA 6 does not have a singular hotline for legal services but there are three major telephone based referral sources: 1) DAAS Integrated Intake Unit receives calls from consumers and caregivers and are provided appropriate referrals to the senior legal service provider(s); 2) Aging and Disability Resources Center (ADRC) provides neighborhood coverage and multi-lingual information and assistance to both phone callers and walk-in consumers; and 3) DAAS maintains a good working relationship with the United Way Helpline and this long-standing information and referral service guides consumers to the senior legal service provider groups.

7. What methods of outreach are providers using? Discuss:

Senior Legal Service providers in S.F. frequent various community meetings, neighborhood fairs, educational forums, etc. They also publish and widely distribute a Senior Rights Bulletin in multiple languages at least twice a year using local general fund resources and this is used as an outreach tool. Many providers are well-known in San Francisco because of the legal clinics and outstation services they make available to communities.

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

Fiscal Year	**Name of Provider**	**Geographic Region (Neighborhood Districts in San Francisco) covered**
2012-2013	a. Asian Law Caucus b. Asian Pacific Islander Legal Outreach c. La Raza Centro Legal d. Legal Assistance to the Elderly	a. Citywide (primarily in Chinatown, Visitacion Valley, North and South of Market, Richmond, etc.) b. Citywide (primarily in Chinatown, Bayview-Hunters Point, Visitacion Valley, South and North of Market, Richmond, Western Addition, etc.) c. Citywide (primarily Mission, Bernal Heights, Excelsior, North and South of Market, etc.) d. Citywide (primarily North and South of Market, Bayview-Hunters Point, Western Additions, Richmond, etc.)
2013-2014	a. same as above b. c.	a. same as above b. c.

2014-2015	a. same as above b. c.	a. same as above b. c.
2015-2016	a. same as above b. c.	a. same as above b. c.

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

Older adults contact the legal service providers directly by calling or dropping in to the agencies. Another method is by accessing legal services staff at various outstations or legal clinics held throughout PSA 6. Often times case managers and intake and referral specialists will refer consumers to the senior legal service providers.

10. Identify the major types of legal issues that are handled by the Title III-B legal provider(s) in your PSA. Discuss (please include new trends of legal problems in your area):

Resolving housing issues continues to be a major trend in PSA 6. Our legal providers devote an enormous amount of time to tenant's rights issues and eviction prevention issues. There is a severe shortage of accessible and affordable housing in San Francisco. This shortage means that low-income seniors and adults with disabilities are at extreme risk for homelessness. With an advocate on their side, many consumers can overcome or successfully fight eviction proceedings. A newer trend is the increase of Ellis Act evictions and evictions caused by the foreclosures of income properties.

Another significant area for legal issues in San Francisco is within the Individual Rights area, e.g., Immigration/Naturalization and Elder Abuse cases. PSA 6 is very rich in terms of its diverse immigrant communities; LSPs are key in assisting Legal Permanent Residents (LPR) to apply for citizenship. The legal service providers help resolve red flag issues that arise during the citizenship application process. In the area of Elder Abuse Prevention (e.g. issuing temporary restraining orders, advising consumers on their rights, etc.), cultural competent legal providers are the key to ensuring a safe outcome for the consumer.

During the recent nationwide economic downturn, many older adults are finding themselves overwhelmed with consumer debt problems. LSPs provide intervention and assist with consumer rights matters.

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

Essentially there is no change in the range of legal issues, what does vary is the prevalence of some issues over others. Our LSPs handle a wide-array of legal issues in the most professional, cultural competent and linguistically appropriate manner. They are well-regarded in the community and effective in bringing resolution to a high percentage of the cases they open. The quality of life for PSA 6 senior population is greatly enhanced by the services provided by our four (4) LSPs.

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

Language access remains the most difficult barrier to overcome but PSA 6 LSPs are very well equipped to handle multiple languages. Another barrier is the lack of awareness in some communities that such services exist. We have identified a need to let certain communities that are not necessarily our "target population" (in particular those with incomes above the low-income levels that senior legal services are not means tested services and they too may qualify for assistance. To help us communicate in these communities our Senior Survival School and Senior University programs (Senior Empowerment, curriculum based training) will hold sessions geared to these seniors.

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

Legal Service Providers coordinate with several senior centers and other senior serving agencies throughout PSA 6. They attend various constituency group meetings (Latino, African-American, Asian Pacific Islander and LGBT Partnership Groups). In addition, the fours LSPs meet as a LSP Workgroup on an as-needed basis to help coordinate any new reporting requirements, legal standards or emerging trends. The four (4) LSPs also meet as a group to coordinate the publishing of the Senior Rights Bulletin.

SECTION 19: MULTIPURPOSE SENIOR CENTER ACQUISITION OR CONSTRUCTION COMPLIANCE REVIEW[55]

PSA 6

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

☒ No. Title III B funds not used for Acquisition or Construction.

☐ Yes. Title III B funds used for Acquisition or Construction. **Complete the chart below.**

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

[1]6 Acquisition is defined as obtaining ownership of an existing facility (in fee simple or by lease for 10 years or more) for use as a Multipurpose Senior Center.

SECTION 20: FAMILY CAREGIVER SUPPORT PROGRAM

PSA 6

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

2012–2016 Four-Year Planning Cycle

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

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

Family Caregiver Services

Category	2012-2013	2013-2014	2014-2015	2015-2016
Family Caregiver Information Services	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract
Family Caregiver Access Assistance	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract
Family Caregiver Support Services	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract
Family Caregiver Respite Care	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract
Family Caregiver Supplemental Services	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract	☒Yes ☐No ☐Direct ☒Contract

Grandparent Services

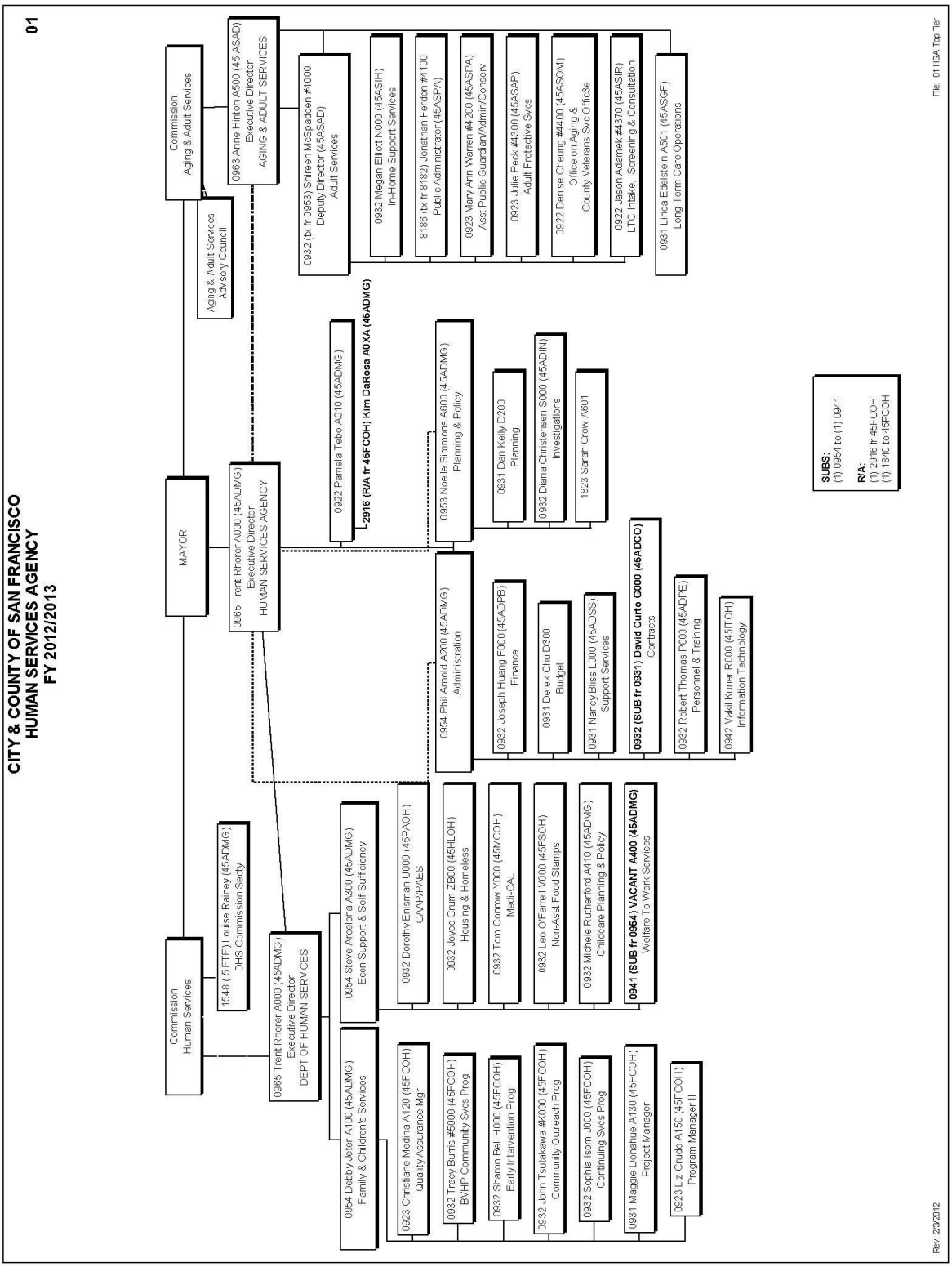
Category	2012-2013	2013-2014	2014-2015	2015-2016
Grandparent Information Services	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract
Grandparent Access Assistance	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract
Grandparent Support Services	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract
Grandparent Respite Care	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract
Grandparent Supplemental Services	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract	☐Yes ☒No ☐Direct ☐Contract

*Refer to PM 11-11 for definitions for the above Title III E categories.
Justification: For <u>each</u> service category checked "no", explain how it is being addressed within the PSA. The justification must include the following:

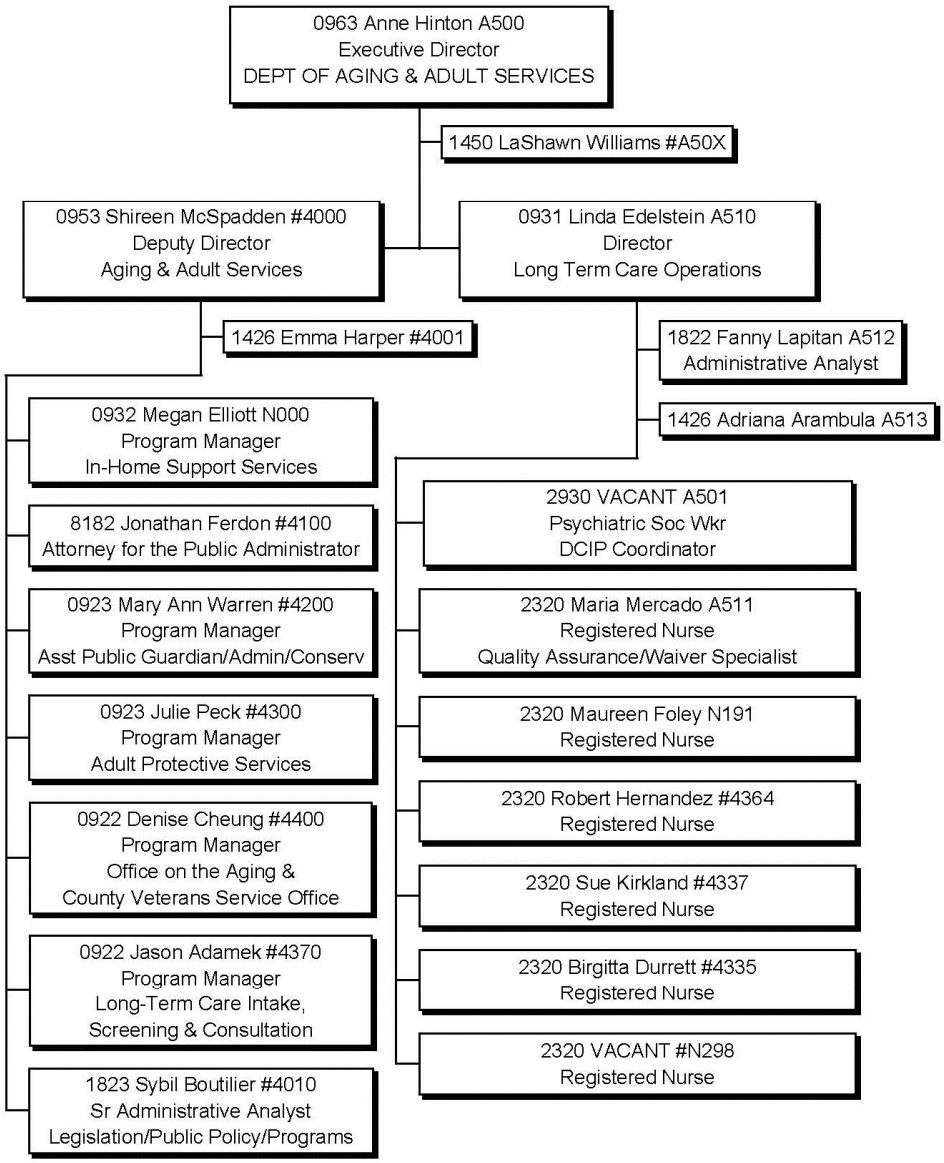
- Provider name and address of agency
- Description of the service
- Where the service be provided (entire PSA, certain counties, etc.)
- Information that influenced the decision not to provide the service (research, feedback from needs assessment, survey of senior population in PSA, etc.)
- How the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

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

SECTION 21: ORGANIZATIONAL CHARTS



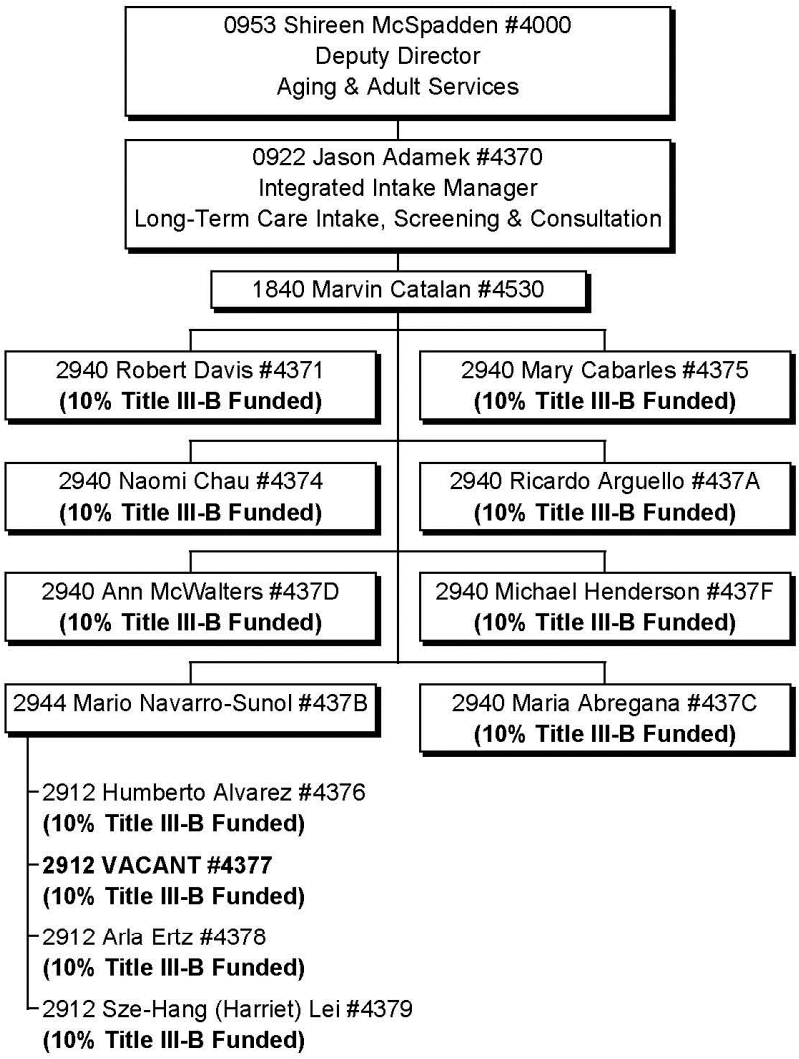
DEPT. OF AGING & ADULT SERVICES
FY 2012/2013



Rev. 1/30/2012

File: 026 DAAS OVERALL

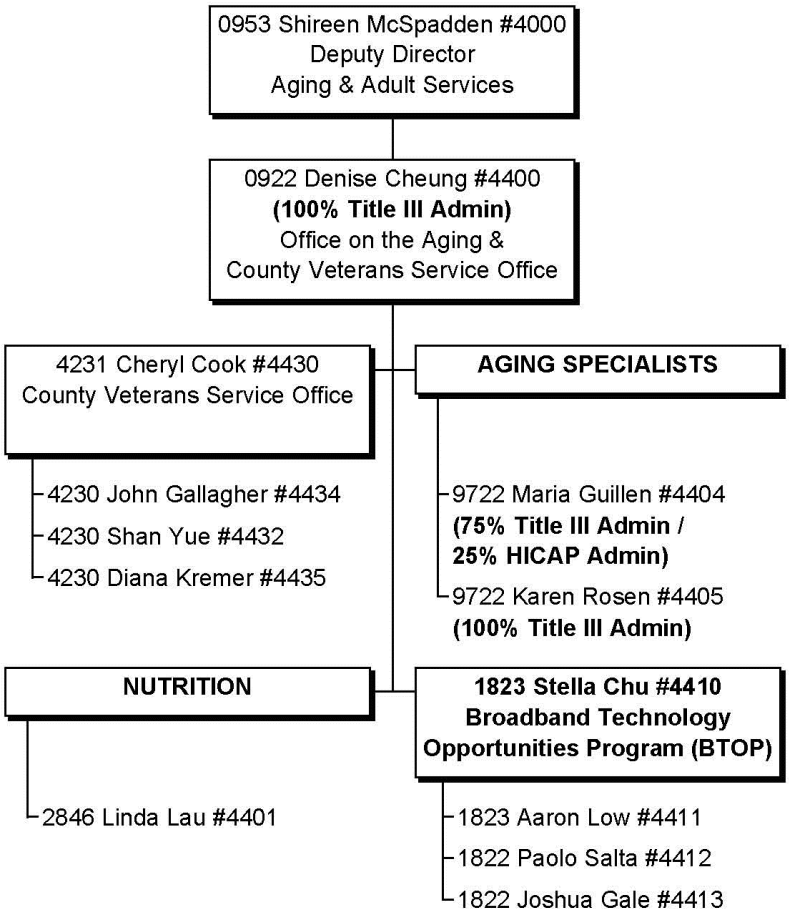
Dept. of Aging & Adults Services
Long-Term Care Intake, Screening & Consultation
FY 2012/2013



Rev. 1/30/2012

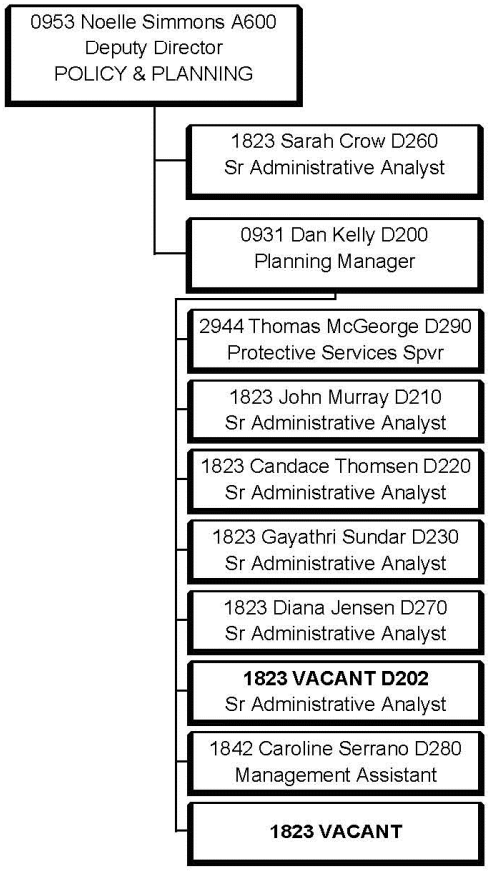
File: 032 DAAS LTC-ISC #4500

Dept. of Aging & Adults Services
OFFICE ON THE AGING & COUNTY VETERANS SERVICES
FY 2012/2013



Rev. 2/10/2012 File: 030 DAAS OOA #4400

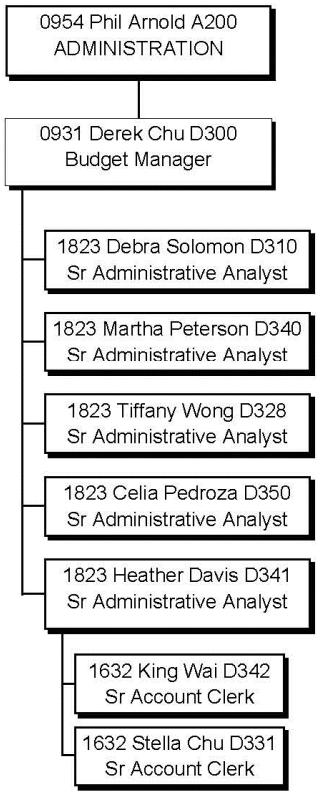
Human Services Agency
POLICY & PLANNING
FY 2012/2013



Rev. 1/30/2012

File: 09 HSA POLICY & PLANNING

Human Services Agency
BUDGET UNIT
FY 2012/2013



Rev. 1/30/2012

File: 03 HSA Budget

SECTION 22: ASSURANCES

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

A. Assurances

1. OAA 306(a)(2)

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

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

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

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

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

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

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

   (II) include proposed methods to achieve the objectives described in (aa) and (bb) above.

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

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

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

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

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

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

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

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

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

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

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

   Use outreach efforts that —

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

      (I) older individuals residing in rural areas;

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

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

      (IV) older individuals with severe disabilities;

      (V) older individuals with limited English proficiency;

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

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

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

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

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

7. OAA 306(a)(5)

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

8. OAA 306(a)(9)

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

9. OAA 306(a)(11)

   Provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as ''older Native Americans''), including—

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

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

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

10. OAA 306(a)(13)(A-E)

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

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

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

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

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

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

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

11. 306(a)(14)

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

12. 306(a)(15)

Funds received under this title will be used—

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

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

B. Additional Assurances:

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

Requirement: OAA 307(a)(7)(B)
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

Requirement: OAA 307(a)(11)(A)

(i) enter into contracts with providers of legal assistance, which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

Requirement: OAA 307(a)(11)(B)

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

Requirement: OAA 307(a)(11)(D)

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

Requirement: OAA 307(a)(11)(E)

Give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

Requirement: OAA 307(a)(12)(A)

In carrying out such services conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for -

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

Requirement: OAA 307(a)(15)

If a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area -

(A) To utilize in the delivery of outreach services under Section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability.
(B) To designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include:

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effective linguistic and cultural differences.

Requirement: OAA 307(a)(18)

Conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to Section 306(a)(7), for older individuals who -

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

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

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

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

CFR [1321.53(a)(b)]

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

(b) A comprehensive and coordinated community-based system described in paragraph (a) of this section shall:
(1) Have a visible focal point of contact where anyone can go or call for help, information or referral on any aging issue;
(2) Provide a range of options:

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

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

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

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

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

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

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

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

Appendix A: Agencies & Services Funded
(FY 2011-2012)

Asian Law Caucus
Legal Services, Naturalization Services

Asian Pacific Islander Legal Outreach
Legal Services, Naturalization Services, Elder Abuse Prevention, Legal Services for Adults with Disabilities
(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, 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, Aging and Disability Resource Center

Family Caregiver Alliance
Family Caregiver Support Program (Subcontracts with Kimochi, Self-Help for the Elderly and openhouse)

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

Glide Foundation
Congregate Meals

Golden Gate Senior Services
Community Services

Independent Living Resource Center San Francisco
Options Counseling

Institute on Aging
Alzheimer's Day Care Resource Center, Elder Abuse Prevention, Linkages, Case Management, Clinical Collaboration, Home-Delivered Meals Assessment for Adults with Disabilities, Care Transition Intervention, Suicide Prevention

International Institute of San Francisco
Naturalization Services

Jewish Community Center of SF
Congregate Meals

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

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

La Raza Centro Legal
Legal Services, Naaturalization

Legal Assistance to the Elderly
Legal Services

Lighthouse for the Blind and Visually Impaired
Community Services, Taxi Vouchers

Meals on Wheels of San Francisco
Home-Delivered Meals, Home-Delivered Meals for Adults with Disabilities

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 (Group Vans, Grocery Trips)

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, Community Services

Planning for Elders in the Central City
Homecare Advocacy, Empowerment for Seniors and Adults with Disabilities, Long –Term Care Consumers' Right Program

Project Open Hand
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 Care Network

San Francisco Food Bank
Brown Bag, Food Outreach Programs

San Francisco Senior Center
Case Management, Community Services, Transitional Care Case Management

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, Congregate Meals for Adults with Disabilities, Home-Delivered Meals for Adults with Disabilities, Naturalization Services, Health Insurance Counseling and Advocacy Program (HICAP), Chinatown Information and Assistance Service

Senior Action Network
Housing Advocacy, Empowerment for Seniors and Adults with Disabilities

Southwest Community Corporation
Community Services

St. Francis Living Room
Community Services

Veterans Equity Center
Community Services

Vietnamese Elderly Mutual Assistance Association
Community Services

YMCA of San Francisco
Community Services

Broadband Technology Opportunities Program (BTOP) Sub-Recipients
Community Living Campaign
Community Technology Network
Conard House
Northern California Presbyterian Homes and Services
National Council on Aging
San Francisco Adult Day Services Network
Self-Help for the Elderly