ISSUE BRIEF: Community Supports

*NOTE: Part 2 of a 2 part discussion focused on the **Community Support & Health Services domain***

Overview: Community supports are critical to ensuring that San Franciscan's remain healthy, engaged, and independent for as long as possible. For this memo, community supports are the social services and organizations that support the day to day needs of San Franciscan's and may include innovative programs, polices, or themes focused on nutrition, legal advocacy, wellness programs, among others.

Issue Brief Sections:

EXPECTATIONS: Please review this memo with particular focus on Sections I - IV. Please be prepared to provide feedback, suggestions, and discuss draft recommendations on **Wednesday, March 8th.**

I. AGE & DISABILITY FRIENDLY CRITERIA

Below are the criteria – based on the World Health Organization's framework, focus groups, and other research – that we believe contribute to an age- and disability-friendly San Francisco, specifically with regards to Community Supports & Health Services.

CRITERIA	DESCRIPTION

Services are accessible.	• Community support services are **well-located**, including:
	  ○ Easily accessible for persons with functional impairment
	  ○ Near public transportation options
	• **Widespread awareness** of where and how to get support;
	• Support is provided in a **culturally appropriate** manner;
	• **Information** about resources is available; and
	• **Economic barriers** impeding access to services are minimal.

A wide range of community supports are available.	Community services that support an individual's psychosocial wellbeing as well as **enhances their quality of life**, including: • **Protective services** such as abuse and self-neglect prevention, • **Enrichment opportunities** through such programs as arts programing, access to gardens or choir; • **Advocacy & empowerment** including health care counseling and legal services; • **Physical and mental health** programs such as physical activity programs, counseling, and support; • **Education & trainings**, focusing on healthy aging, caregiving, adult learning classes, and fall prevention are available.

CRITERIA	DESCRIPTION
There is a robust workforce & volunteer support.	• Service professionals have **appropriate skills and training** to communicate with and effectively serve older adults and adults with disabilities; and • Volunteers are available **to help fill gaps** in social services that support independent living, such as: o Providing transportation o Helping with errands, like grocery shopping or pet care o Socialization and preventing isolation
People are supported where they live.	• A **wide range of home support** is available so that people can **live independently within their own homes** as long as possible; and • **Caregivers** are **recognized**, **supported**, and **included** in decisions and opportunities where appropriate; • Older adults and people with disabilities are **safe** from abuse and neglect.
Residential facilities for those unable to live at home.	**Services** and **supports are available** for those who live in residential care facilities.
Health & social services collaborate.	Efforts should be made to **coordinate** and **collaborate** between health and social services to **reduce duplication**, **streamline access**, and **reduce gaps** in service. This may include: • Co-locating health and social services • Streamlining the application processes • Clear eligibility criteria and process
Ensure efficient use of public resources.	By prioritizing needs, encouraging collaboration and leveraging existing resources, San Francisco can ensure that public and private resources are being leveraged efficiently, to maximize impact.

II. SAN FRANCISCO ASSETS

Below are some assets in the Community Supports area that contribute to an age- and disability-friendly San Francisco. This is not an exhaustive list and we welcome suggestions from task force members to be included in the final report.

ASSETS	EXAMPLES
A variety of nutrition support and wellness services are available.	Achieved through a variety of means, including policy, innovative programs, and prioritizing funding, such as: • **SF Food Security Task Force (DPH):** a city-wide plan for addressing food security, including data collection, education, and advocacy.[1] • The City funds many **nutrition support programs**, including but not limited to home-delivered meals and groceries, congregate meals, the Eat SF Voucher program, and the Gold card food program. • **Wellness activities** including evidence-based physical fitness classes and disease prevention programs.
Local investment in services and supports.	**Robust network of community based organizations** that provide wellness services and healthy aging programs to adults with disabilities and seniors, such as: ○ Adult day health centers in many neighborhoods ○ Concentration of multilingual social service providers ○ Diversity of CBO's that provide a range of services specific to cultural or ethnic groups, identity, languages, or abilities • **Dignity Fund (Prop I):** A voter-approved charter amendment that protects a required set-aside to fund services for seniors and adults with disabilities. • **Community Living Fund:** A program that provides seniors and adults with disabilities currently or at risk of institutionalization with the necessary supports and services to live safely in the community.[2] • **The Aging and Disability Resource Center** network: providing one-stop shop information and assistance through 12 neighborhood hubs

[1] https://www.sfdph.org/dph/comupg/knowlcol/meetingsgroups/agendasminutes.asp
[2] https://www.ioaging.org/services/all-inclusive-health-care/community-living-services/community-living-fund

ASSETS	EXAMPLES
Efforts to collaborate across silos.	Efforts to collaborate can take various forms, including multidisciplinary bodies, such as: ○ **LTCCC[3]:** Long Term Care Coordinating Council ○ **CASE[4]**: Coalition of Agencies Serving the Elderly ○ **Interfaith Council[5]:** represent San Francisco's faith based communities Collaboration can also take the form of programs or models, including: ○ **The Elder Abuse Multidisciplinary Team Meeting[6]:** an innovative process to investigate elder abuse by engaging police, district attorney, legal services, and a range of support services. ○ **The PACE model[7]:** now a nationwide model, PACE serves as a comprehensive "one stop, one shop" model of service that provides medical care, specialists, adult day care, hospital and nursing care, home health care, and transportation as needed by the client.

[3] http://www.ltcccsf.org/
[4] http://sfseniors.org/about-us
[5] http://www.sfinterfaithcouncil.org/
[6] http://www.sfhealthyaging.org/hawp/wp-content/uploads/2014/09/2014-Forensic-Center-and-Elder-Abuse-Prevention-FAQ.doc
[7] http://pacepartners.net/what-is-pace/

ASSETS	EXAMPLES

A range of community based supports.	Information, resources, and counseling services specific to seniors and adults with disabilities, including:
	• **Protective services** to protect our most vulnerable residents, including:
	  ○ Adult Protective Services self-neglect unit
	  ○ The Elder Abuse Prevention Center (IOA)
	• **Enrichment opportunities** through such programs as
	  ○ Art with Elders[8]
	  ○ Accessible gardening[9] and park programing[10]
	• **Advocacy & empowerment** services, including:
	  ○ Health Insurance Counseling and Advocacy Program (HICAP), which assists Medicare-eligible persons in free, confidential counseling in navigating the system;
	  ○ Legal services and advocacy;
	  ○ Housing advocacy, counseling, and support programs; and
	  ○ The Ombudsman Program, which advocates for residents living in skilled nursing homes and residential care facilities.
	Physical and mental health programs, such as:
	  ○ **Mental Health Association:** support, identify gaps, and reduce eviction for residents with hoarding and cluttering challenges;
	  ○ **SF Rec & Park's** senior fitness programs[11]
	  ○ **Always Active** in various senior and community centers[12]
	• **Education & trainings**, focusing on healthy aging, caregiving, and fall prevention are available, including:
	  ○ **Senior Disability Action's** Senior & Disability Survival School[13]
	  ○ **MTA's** Travel Training[14]

Notes on Assets:

[8] http://www.artwithelders.org/
[9] http://www.sfgate.com/homeandgarden/article/City-program-helps-disabled-gardeners-develop-an-3237216.php
[10] http://sfrecpark.org/recprogram/adaptive-recreation/
[11] http://sfrecpark.org/recprogram/senior-program/
[12] http://alwaysactive.org/
[13] https://sdaction.org/programs/senior-disability-survival-school/
[14] https://www.sfmta.com/getting-around/accessibility/travel-training

III. SAN FRANCISCO GAPS

Below are areas in the Community Supports that would benefit from improvements, thereby increasing the age- and disability-friendliness of San Francisco.

GAPS	EXAMPLES
Lack of service options for "middle income" SF residents.	Middle income poor* in San Francisco, whose incomes exceed federal eligibility requirements but still can't afford to pay for much needed services, such as: • Limited safety net for people who require a personal assistant but are not eligible for IHSS; and • Options limited regarding affordable memory care and adult day health programs[15]. **incomes between $14,700-55,000 a year*
Services are inaccessible for certain populations.	Existing senior centers and community spaces have limitations that include: ○ Inadequate transportation assistance ○ Health care providers may have limited knowledge of available community services ○ Lack of awareness for many residents of how to access services, including residents living in care facilities
Specific populations aren't best served by existing services.	The followings are examples of gaps in existing services as they relate to certain populations: ○ Limited removal resources for seniors and adults with disabilities struggling with hoarding and cluttering; ○ Young adults with developmental disabilities are not being served by many existing day programs; and ○ The need for end of life planning support for residents and their families prior to hospice or palliative care.

[15] https://www.dropbox.com/s/zvcfnymoh4ptgrm/Middle%20Income%20Population%20Study.pdf?dl=0

IV. DRAFT RECOMMENDATIONS.

Below are some possible recommendations to improve the age- and disability-friendliness of our Community Supports. These are only meant as a starting point and **the role of the task force is to develop the final recommendations**, either based on these draft ideas or to address gaps not covered in these recommendations.

GOALS	RECOMMENDATIONS
Facilitating accessible care.	Addressing accessibility barriers for specific, underserved populations, including: • Transportation services to senior centers and day programs; and • Improving options and access of services by younger adults with disabilities.
Maintaining a wide range of health services and community supports.	
Ensuring that there is a robust workforce & volunteer support.	Strengthen the training and capacity of social service providers to recognize, engage, and provide family caregivers referrals to services within the community.[16]

[16] Committee on Family Caregiving for Older Adults et al., *Families Caring for an Aging America*.

GOALS	RECOMMENDATIONS
Supporting people where they live.	Ensuring there are community supports available for hospitalized persons transitioning home, especially: • People with cognitive impairment; • Caregivers and family members that will be supporting the patient and assisting with the care plan; and • People that need minor home modifications or temporary in home support in order to remain independent.
Residential facilities for those unable to live at home.	
Health & social services collaborate.	
Ensure efficient use of public resources.	

Notes on recommendations:

APPENDIX A. OTHER AGE & DISABILITY FRIENDLY EFFORTS

A. BEST PRACTICES.

Wellness & Fall Prevention:

Hawaii's Fall Prevention Consortium: Collaboration between the Department of Health, four supermarkets, Kaiser Permanente, the Hawaii Community Pharmacy Association, and a local hardware store, the team has developed a robust and diverse program aimed at fall prevention through public service announcements, medication reviews, balance testing, tai chi workshops, and educational presentations[17].

Kūpuna Care: Hawaii also has a statewide program that provides long-term services and supports to older adults aging in place. Administered by the Offices on Aging, it provides a wide range of services, including transportation, home delivered meals, in-home care. The program aims to serve a "gap population", those that do not qualify for public benefit programs but don't have the resources to pay market rate costs, and therefore would not have access to other services and is funded using state funds.[18]

Dementia Friendly Planning:

New Orange Plan, Japan: recognizing that by 2025, 1 in 4 Japanese elders will have dementia, they've developed a comprehensive plan that incorporates early detection methods, increased research, more in-patient facilities, home visits, and long-term consultation for patients and their families. Based on a volunteer initiative started in Matsudo, the Orange Patrol trains volunteers in dementia awareness. The trainings are brief, 60-90 minutes, and the content is customized to the participants, such as crossing guards, pharmacies, bank tellers, and post office workers. According to Matsudo staff, the purpose of the training isn't to make people an expert, but rather to "support those with dementia, as well as their families, and make this a town where it's more comfortable for them to live."[19]

[17] http://health.hawaii.gov/injuryprevention/news/summer-2016-falls-prevention-campaign/
[18] https://www.elderlyaffairs.com/site/454/services_faq.aspx
[19] http://www.npr.org/sections/health-shots/2016/08/23/489629931/japan-offers-dementia-awareness-courses-to-city-workers

B. EXAMPLES OF OTHER CITY'S AGE & DISABILITY FRIENDLY PLANS:

Table 1: Washington, DC. Age Friendly DC: Strategic Plan (2014-2017)[20]

RECOMMENDATION	IDEAS
Increase consumer awareness of and access to preventive, primary, urgent and long-term care.	• Expand a team of navigators to assist residents with identifying, understanding and accessing appropriate services and programs through the No Wrong Door program. • Provide cross-training for navigators and a series of fact sheets on accessing financial planning, will and estate planning, Medicaid qualification, and long-term resources for individuals, families, spouses, and domestic partners. • Require continuing education units in geriatric care and cultural competency training to be obtained by licensed healthcare providers, first responders, caseworkers, and caregivers. • Continue progress toward federal approval to implement the Program for All-Inclusive Care for the Elderly (PACE), using a hub and spoke model to reach more residents closer to home. • Expand compensated respite care for low-income unpaid caregivers of Medicaid-eligible residents.
Promote safety, wellness, livability and activity in the community.	• Make progress toward becoming a healthier, cleaner, greener, and more biodiverse city. • Create incentives, partnerships, and training for the establishment of new, and expansion of existing, programs to increase access to fresh produce and healthy foods. • Establish and implement evidenced-based falls prevention program for residents 50+, particularly those with balance and mobility issues. • Expand number of peer counseling and support programs and increase the number of older adult peer counselors. • Establish awareness campaign and regular drop-off locations for safe disposal of over-the-counter and prescription medications.

Table 2: Portland, Oregon. Action Plan for an Age-Friendly Portland (2013)[21]

Community Services	
Improve the Age Friendliness of Neighborhood Centers.	• Identify locations in Portland that lack adequate services and infrastructure to meet the needs of older adults (e.g.,

[20] https://agefriendly.dc.gov/publication/age-friendly-dc-strategic-plan-2014-2017
[21] https://www.pdx.edu/ioa/sites/www.pdx.edu.ioa/files/Age-Friendly%20Portland%20Action%20Plan%2010-8-13_0.pdf

	sidewalks, curb cuts and safe crossings; government services; fresh and affordable food) and address deficiencies in. • Reduce barriers to providing affordable, accessible housing within town. • Ensure that libraries are age-friendly hubs and that neighborhood schools are transformed into multi-functional facilities to meet the needs of a range of residents of all ages. Lists potential partnerships.
Improve Emergency Preparedness and Systems for Ensuring the Safety for Older Adults and People with Special Needs.	• Improve the existing plan for dealing with vulnerable populations in emergency situations by strengthening the mechanisms for coordinating Portland's response systems with those of other local and regional agencies. • Engage a broad range of community members - including older adults and people with disabilities – in emergency preparedness training. • Improve knowledge of mental health issues and procedures and practices for dealing with people with such conditions as dementia in emergency situations. Also lists potential partnerships.

Table 3: New York City, New York. Age Friendly NYC (2009)[22]

Health & Social Services Agenda	**Goal:** Ensure access to health and social services to support independent living.
Wellness & Healthcare Planning	• Increase HIV awareness and health literacy among older New Yorkers. • Redesign senior centers to focus on wellness and develop health outcomes. • Establish fitness club discount for older New Yorkers. • Increase awareness about health insurance options through HIICAP program.
Assistance to At-Risk Older Adults	• Implement citywide falls prevention initiative. • Provide free air conditions to at-risk New Yorkers. • Conduct outreach to older New Yorkers at risk of social isolation. • Add Silver Alert to Notify NYC. • Expand "Savvy Seniors" campaign to educate older New Yorkers about identify theft and fraud.

[22] http://www.nyc.gov/html/dfta/downloads/pdf/age_friendly/agefriendlynyc.pdf

Access to Nutritious Food	• Improve older New Yorkers' access to food stamps by implementing telephone application process and outreach campaign. • Implement NYC Green Cart program and form supermarket commission to address needs of neighborhoods underserved by supermarkets. • Provide bus service to access grocery stores. • Increase efficiency in City's case management and home-delivered meals programs.
Caregiving & Long-Term Care	• Provide counseling and support services to grandparents raising grandchildren. • Expand educational materials and supports available to family caregivers. • Explore policies that would allow more New Yorkers to take family leave when needed. • Conduct outreach and workshops on long-term care and caregiving resources for employers in NYC. • Increase access to community-based care. • Expand training opportunities and other supports for paid caregivers. • Promote awareness and education about long-term care insurance.
Palliative Care & Advance Directives	• Promote palliative care. • Expand existing HHC palliative care programs. • Promote advance directives. • Advocate for State legislation authorizing family members or domestic partners to act as surrogates to make health care decisions on behalf of an incapacitated adult.

APPENDIX B. RELATED RESEARCH & REFERENCES

A wide range of health services are available.

- Research indicates that many older adults do not receive preventative services, particularly if they are poor. According to one study, 90% of flu related deaths occur among those 65 years or older, and influenza and pneumonia are among the leading causes of death for individuals in this age group.[23]
- Fitness programs for older adults result in increased physical activity and slower decline in cognitive and physical functioning.[24]

People are supported where they live.

It is shown that having home and/or community based support services is associated with "improved physical functioning, reduced depressive symptoms, increased life satisfaction, and a greater sense of mastery."[25]

Additionally, further evidence shows that formal community supports (such as evidenced based programs) may also reduce the risk of nursing home placement and an evaluation of Medicaid waivers in Indiana found that "for each additional 5 hours per month of personal care, the risk of nursing home placement dropped by 5%."[26]

[23] Scharlach and Lehning, *Creating Aging-Friendly Communities* (112).
[24] Scharlach and Lehning, *Creating Aging-Friendly Communities* (113).
[25] Scharlach and Lehning, *Creating Aging-Friendly Communities*. (116)
[26] Scharlach and Lehning, *Creating Aging-Friendly Communities* (116)