Little Hoover Commission Public Hearing on Long Term Care
August 26, 2010

My name is Anne Hinton and I am the Executive Director of the Department of Aging and Adult Services for the City and County of San Francisco. Thank you for convening us today to explore best practices and potential solutions to the problems that have been identified in the course of the Commission study of long term care and for inviting me to share with you the extraordinary work taking place in San Francisco related to long term care.

Our model is built on several critical principals:

1. First, services and support must be consumer driven as well as person centered and culturally sensitive.

2. There needs to be a single point of entry. This provides consumers with a clear entry point and allows for meaningful quality assurance.

3. There needs to be available a comprehensive package of individualized services that change as the persons needs change (the needs of a younger adult with disabilities will look different at 70 than they did at 21, just as a person newly diagnosed with dementia who is 65 will have a different set of needs at age 85).

4. Transitions between care settings need to be seamless as this is where things frequently fall apart.

5. A service package needs to be designed based on a comprehensive assessment, that also includes the preferences of the consumer

6. Flexible funding to purchase goods and services needed by the consumer (including additional home care, housing, etc.)

7. A full range of services including: information and assistance, evidenced based interventions, prevention services, home and community based supports and services, linkages to and from institutional based services as necessary (i.e. money follow the person, NIF waiver, Coleman model, Healthy Aging out of Stanford, etc).

8. Clear lines of responsibility and oversight including quality assurance/quality improvement.

9. Flexibility to change the program design as needed.

And although SF has made these principles an integral part of our program these are qualities that have been discussed throughout the State by people committed to community based long term care. For years many of us responsible for IHSS, case management and AAA programs have discussed and implemented these principles where possible.

Before getting into the specifics of the SF Community Living Fund and the Diversion and Community Integration Program, I would like to share with you some information regarding San Francisco and the San Francisco Department of Aging and Adult Services.

San Francisco's population is approximately 800,000, of which 17.6% are over 60 years of age. Of the 60+ population, approximately 43% are Caucasian, 37% are Asian, 9% are Latino and 8 % are African-American. (The Statewide percentage of people 60+ is 14% and the national percentage is 16.3%).

By the year 2020 the 60+ population will increase by 28% and total 174,000. In other words, those 60+ will comprise 21.3% of the San Francisco population.

The City and County of San Francisco has the highest percentage of seniors receiving SSI and on Medicaid compared to other California counties. Of the 46,000 people on SSI, 58 % are seniors, with 3 out of every 10 adults over 50 living on less than $20,000 a year.

36.8% of SF seniors were born in another country compared to 26% State wide and that percentage is highest among our oldest residents. Fewer than 1 in 4 have children within 20 minutes compared to 40% in other cities.

DAAS is an integrated department, consisting of the following programs: In Home Supportive Services (IHSS), Adult Protective Services (APS), County Veterans Services Office (CVSO), Public Guardian, Public Administrator, Representative Payee (Rep Payee), Public Conservator, Office on Aging/Area Agency on Aging, Long Term Care Intake and Screening/Aging and Disability Resource Center, the Community Living Fund (CLF) and the Diversion and Community Integration Program. In IHSS we have an Independent Provider (IP) mode and a Contract mode, and we have continued to fund previously state funded programs such as Linkages and Alzheimer's Day Resource Centers, etc. We have developed and begun implementation of an Alzheimer's Strategic Plan, funded the development of curriculum for home care workers who work with hoarders and clutterers and provided funding to develop a Case Management Training Institute. We have been funding and working with local hospitals and non profits regarding transitional care and a "Know Your Rights" initiative related to community based long term care, just to name a few interesting things about us.

But moving on to Community Living Fund (CLF) and Diversion and Community Integration Program (DCIP)

The Community Living Fund is funded out of the San Francisco General Fund dollars at $3,000,000 annually and has been in place for 3 years. Its purpose is to redirect folks away from institutional care and assist people coming back into the community after being institutionalized, by providing community based long term care alternatives.

We designed the program using the Linkages and MSSP case management models which have "purchase of service" components. We also reviewed some excellent work going on in Philadelphia that is similarly designed. Thus we have a case management program with a purchase of goods and services component. You can receive one or both depending on need.

The target population is:

1. 18 years of age and older

2. San Francisco resident

3. Willing and able to live in the community with appropriate supports

4. Have an income 300% of Federal poverty level (single adult $31,200 and savings and/or assets of $6,000)

5. Have a demonstrated need for a service and/or resource(s) that prevents institutionalization

6. Be institutionalized or be deemed at assessment to be at imminent risk of institutionalization (imminent risk is functional impairment in a minimum of 2 activities of daily living, such as eating, dressing, transfer, bathing, toileting and grooming) or

7. Have a medical condition requiring the level of care that would be provided in a nursing home or

8. Be unable to manage your own affairs due to emotional and or cognitive impairment and have functional impairment of 3 instrumental activities (taking medications, stair climbing, mobility, housework, laundry, shopping, meal preparation, transportation, using the telephone and money management)

People enter CLF through our Department's Long Term Care Intake, Screening and Assessment unit. The Unit also screens for APS, IHSS, home delivered meals and other community based services. If the person on initial screen seems to qualify for CLF the information is electronically sent to a non profit provider who does a thorough screening including a financial assessment. Based on the assessment they may receive one-time-only CLF purchases or case management with other services, etc. CLF flexibility allows for a direct link to money management , transitional care, home delivered meals and allows for the ADHC to purchase goods and services for qualified clients without going through an additional assessment.

CLF: for people who are either institutionalized or at imminent risk of being so

The unduplicated client count program to date (started in mid 2007) is 1113
Case load size runs between 15 to 22

To date:
*785 unduplicated clients received case management and/or purchase of service. Of this group 609 received purchase of service

*Currently 224 clients are being served. Approximately 6% of the case load required case management only, and another 17% required only purchases, leaving 77% who required both CM and POS
*Average purchase of service cost/year was $2890 per client
*Average pos excluding home care and housing subsidies was $334 per year per client
At the conclusion of FY0910 it is estimated that CLF will have spent $11.7 million since the programs inception, or approximately $10,500 per person over the life of the program

The 2nd program that I would like to share with you is the Diversion and Community Integration Program. The purpose of the DCIP is to provide an integrated approach for folks referred for admission to our county run SNF (Laguna Honda Hospital), as well as to provide diversion and discharge from LHH.

The goal is to place individuals in the most integrated setting appropriate to their need and preference. The DCIP makes decisions about LTC access to services, including LHH admissions and discharges, access to housing and other community based services

This is a core group of decision makers who can authorize and commit to services and where city/county departments and community non profits work closely together. It consists of:

The DCIP coordinator (which is the only new position required for this model) sits at DAAS
IHSS
Department of Public Health Housing
Department of Public Health Behavioral health

Primary care clinics (access to community primary care services)
DAAS LTC intake and screening unit
LHH admissions, eligibility and screening
Health Department placement unit (short and long term access to residential care and residential treatment)
DAAS waiver specialist
Targeted Case Management staff from LHH and SF General
Community Living Fund – Intensive Community Case Managment
DAAS Quality Assurance
Laguna Honda Hospital Social Services

The DCIP: for people who are either institutionalized or at imminent risk of being so:
1,200 people currently in DCIP, status breakdown is as follows:

In SNF @ LHH
*41 = discharge ready (actively working on a discharge plan
*687 = not discharge ready (assessed quarterly for change in status)
Non responsive/severe dementia = 185
Medically unstable = 93
Decline to leave and meet SNF level of care = 306
Other reason = 103

*472 = in the community

*127 DCIP consumers receive IHSS and the average hours per month are 104.8
* Currently 129 people in DCIP receive a housing subsidy and are in independent housing

The DCIP core group is connected electronically. This of course is enormously helpful in the review of DCIP clients and means the group has the possibility of reviewing information prior to attending the group meeting. Electronically linked data includes information from the SNF, CLF, AAA and specific programs with the Health Dept. This electronic connection is an extension of previous work we did in collaboration with the health dept to link case managers round the City

The key to the success of this program has been having close collaboration between decision makers who have expertise and access to services in the program areas: i.e. IHSS, housing, primary care, behavioral health, CLF,

Another key factor has been dollars specifically for housing which allow for various consumer needs and provides subsidies for scattered site housing. Since everyone in the core group has decision making capacity a community living plan, which is different than a discharge plan is built, with the needs and preference of the customer always at the core.

I encourage the Commission to consider the principles I have outlined as well as the key components that have been established in the SF CLF and the DCIP