LONG TERM CARE COORDINATING COUNCIL

Guiding the development of an integrated system of home, community-based, and institutional long term care services for older adults and adults with disabilities

HOUSING AND SERVICES WORKGROUP

Workgroup Meeting

July 27, 2006

Present: Bill Hirsh (Chair), Laura Byrne, Norma Satten, Meg Cooch, Marie Jobling, Paul Isakson, Tricia Webb, Joanna Fraguli, Belinda Jeffries

DAAS: Bill Haskell

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1. SUBCOMMITTEE ONE: Connecting Senior and Disabled Housing Residents with Services: Follow-up on the Services Connection Survey

Potential Housing Authority buildings for pilot project:

- 350 Ellis Street
- 666 Ellis Street
- 345 Arguello

People in these buildings are at-risk in their neighborhoods and at-risk for institutionalization. Given that this is a pilot, we want to gather as much data as we can. This pilot can be applied to other buildings. What is the average age in the buildings, average turnaround in the buildings?

We can look at people who are hospitalized and able to go home or someplace else. These people could get plugged in to a case manager. Someone could be their advocate and supporter to help them get back to their home.

Residents in these three buildings are disconnected from services. Can there be partnerships with supportive care?

PHASE ONE: Build confidence of residents and provide access to services.

1. Involve Resource Center and District-wide Social Services Worker on site in Housing Authority buildings, and at resident meetings.
2. Help tenant associations involved in deciding how best to spend their resources.
3. Contact nearby service providers and city agencies to begin to define their involvement in Phase Two.

Building Confidence

Register people in services in their buildings
Helping people in the intake process

Resident Meetings

Translation services and interpretation services

Presentations at meetings by service providers

PHASE TWO: Get services integrated into buildings by participating agencies.

1. Have a health, food, transportation and safety fair. Food fair – food stamps, food box, home-delivered meals.
2. Continue to build confidence and provide access and connections to services.
3. Get nearby service providers and city agencies to begin to provide services to Housing Authority residents on site.

Initial intent: to get people connected to services and integrated into their community. Ultimate goal: to make sure that residents can stay in their housing.

Adaptability: Reasonable accommodations information is provided by Housing Authority. This effort is not intended to be an advocacy group.

<u>This pilot project is another prevention strategy to keep people at home as long as possible</u>.

- Get people before deterioration happens.
- To help people to stay in place.

The Housing Authority has no staff on-site. There is some data about turnaround in the units.

Question: We can identify the current outcomes? We need to have a benchmark. If we have a list of buildings, we can get services into the buildings.

<u>Next Steps</u>:

- If Phase One and Phase Two are acceptable, can we identify the month to start. Then we create a planning group to get started.

- Phase 1is a matter of trust (how to spend the money). Some of the areas of need that need to be put in place.

- Present the Services Connection Survey findings to the Tenant Associations in the three buildings.

- Design a simple hand-out with 211. This would provide an entre to provide and track services.

ISSUE: Why do the residents need nutrition services. Belinda and Bill will investigate. Paul will bring this up at LHH. Possibly, a group van could bring people to the meal site.

Laura Byrne will find out how many Housing Authority residents are in On Lok.

Belinda will start with the data available on residents in each building. How many used services when we started

2. SUBCOMMITTEE TWO – Developing A Prevention Strategy: How to keep older adults and adults with disabilities in their own housing.

Give to Anne Hinton on needs for services for younger adults with disabilities.

This meeting is demonstrating demand for services.

Statistics were not provided. Legal assistance for seniors could be contacted about what spurs an eviction notice. People in need of mental health services. Ask Maritza Villagomez for United Way data about the types of calls that come in. Also ask about the follow-up calls. United Way is part of the response for getting the need.

Example: home modification is an issue. We need to get some clarity for what money there is for home modifications. MOD has money for nonprofits for real time captioning. MOD money is not for home modification. Joanna will look into funds from MOD. We need to put together who has what in terms of home modification.

- MOD – accessibility (possibly)
- MOH loans
- Season of Sharing
- Rebuilding Together
- GGRC
- Community Health Injury Prevention Program
- Some private foundations related to disability issues (lift, grab bars, shower, chairs)

<u>To Do</u>:

1. Quantify the demand for services:

    a. Get call data and follow-up data from United Way (Bill Haskell).
    a. Adult Protective Services (Meg Cooch)
    b. Legal Assistance for Seniors (Bill Hirsh)
    c. ILRC – Victoria Tenor (Tricia Webb)

2. Develop a list of home modification resources (Meg Cooch).

3. Create a grid about the supply of services (Marie Jobling and Norma Satten)

There is an array of services to keep people in their existing housing. We can come up with the top five services. Increased capacity in the top five.

NOTE: CMS announce a **$1.3 billion money follows the person** initiative. It will be available in January 2007. The goal of this program is to keep people in their own homes. Could there be a tie in between the Community Living Fund and this program?

NOTE: There is a Kaiser paper on Money Follows the Person.