October 2018 LTCCC meeting: LTC System Priority Areas & Potential Policies

Reminder: The objective was to identify gaps and policies that:

- The LTCCC can support (based on current understanding of the LTC System),
- The LTCCC can partner with existing efforts (not within LTC System or duplicative effort)
- Or gaps/challenges that local, state, and/or federal agencies should be addressing.

The ultimate goal is to identify key policy areas that the LTCCC will focus on in the coming year(s), including ensuring that existing LTCCC work groups are reflective of these priority areas. Please review gaps as shared by groups – if there's anything to add, please send to Valerie.

Next steps: the Steering/F&P group will meet to prioritize these and recommend next steps.

Behavioral Health:

Gaps identified:

- Integrated behavioral health care is needed. Siloes in aging, mental health, etc. One idea: A short-term, focused LTCCC workgroup could bring together providers to focus on recommendations for education/training and creating more effective networks for integrated behavioral health care.
- A need for an increase in city and contracted Older Adult Mental Health services, as the older adult population increases.
- A need to address/support Dementia: Services and policy gaps

Housing:

Gaps

- Home modifications
- Eviction prevention
- Housing subsidies
- Deeply affordable housing**:** for people on SSI/SSDI
    - Section 8 at the city level
- Housing priorities/preferences – MOH, SFHA
- Preserve deeply affordable housing (eviction policy)
    - New creative programs like Home Match, Transition Age Youth
- Saving licensed beds? (maybe)

Transportation:

Gaps/Challenges

- Labor/Workforce to support paratransit
- Navigating program eligibility and benefits
- Accessibility and affordability of TNCs and taxis

- Opportunities

- More active participation/representation on SFMTA advisory committees (PCC, MAAC, CAC)
- Participate in CPUC rulemaking process/workshops mandated by SB1376 – TNC Accessibility for Persons with Disabilities

Workforce:

Gaps:

- Identity barriers to recruiting, training, and adequately paying personal care assistants
- Health care systems refer everyone with disabilities to regional center system because they think the regional centers have a lot of money and they don't and are terribly overwhelmed- training for better referrals.
- PWD can work anywhere - integration and inclusion needs to be more of a priority when it comes to employment decisions - if as an agent you serve PWD, you should hire PWD - same for older adults
- The jobs identified are most professional - need more peer and para professional positions.
- If you are going to focus on employment, really need to move beyond internships the don't lead to employment. Addressing barrier to employment and provide incentives for more older adults and people with disability to be hired.
- More proactive help coordinate employment with benefits to more toward that goal of dignity.

Personal Care & Health Care:

Gaps

- Functional care being left out or separated out from other workforce discussions
- a link between medical and social case management **–** long term intensive case management, following the person
- having a public model similar to private case management: knows all the services available, helps to navigate people through the system, etc.
- Consider better utilization or more efficient scheduling of care workforce: high turnover of IHSS, a task rabbit for caregiving?
- Care management for those not extremely low-income: such as Support @ Home
- Many folks that can't get on MediCal because of assets (have a little too much to get on), but people have fears of spending down
- Assistive technology not covered but is critical for people with disabilities
- Dept of Rehabilitation – have representation on the LTCCC or ways to share/better understand their services and what their gaps
- People's knowledge about what is covered or not covered with Medicare – such as RCFE's
- Home based primary care that can do a home evaluation, help/identify equipment needs, such as home modifications (HEAL) and provide tools that can keep people safe at home
- Assessing IADL's for discharge planning
- Medical/legal partnership – people in the hospital are referred to lawyer to for important documents (will, Advanced care directive, signing up for medicare, etc)

Nutrition

Gaps

- HDM policy goal is to serve seniors/AWD on the waiting list within 30 days, and 2-5 in an emergency. The waiting time for seniors is close to 30 days due to annual expansion, however the waiting time for AWD is months long. HDM for AWD is not funded by Older Americans Act or the Older Californians Act.
- IHSS hours/policies for food prep and food access need updating with HDM and HDG so that IHSS recipients are food secure. IHSS does not include direct access to prepared meals or money to buy groceries, only hours for food preparation. The IHSS waiting list for HDG is over 1,000, and IHSS hours are reduced if recipients receive HDM.
- Clients receiving both HDM and HDG programs are not client centered, but program centered.
- The "short-term" HDM Transitional Care program (hospital to home) is too short with a duration of 2 weeks and should be funded by the health care sector.