Clinical & Quality Assurance Unit

Department of Aging and Adult Services (DAAS)

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Today’s Objectives

1. Provide an overview of the department and a demographic profile of the clients that we are serving.

2. Review the functions of the Adult Protective Services and In-Home Supportive Services programs.

3. Discuss the role of the Clinical and Quality Assurance Unit within the Department of Aging and Adult Services and review data on client outcomes that demonstrate the effectiveness of the CQA Unit.

5. Review case examples that will highlight how the CQA Unit collaborates with APS and IHSS programs to assist older adults and adults with disabilities.

6. Provide an overview of other functions carried by the CQA Unit as well as future directions.

City and County of
San Francisco
Human Services Agency

Department of Aging
and Adult Services

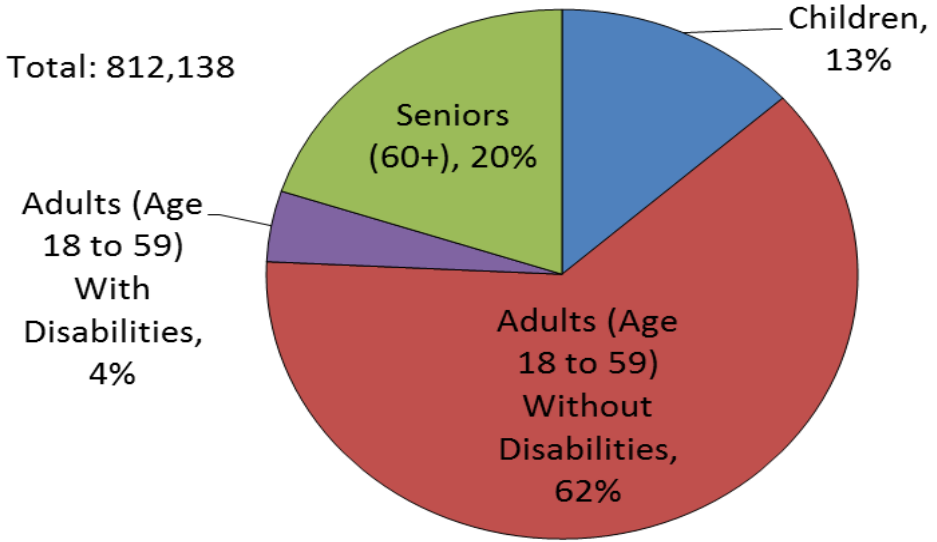
OVERVIEW

The Department of Aging and Adult Services (DAAS) coordinates services to seniors, adults with disabilities, and their families to maximize self-sufficiency, safety, health, and independence so that they can remain living in the community for as long as possible and maintain the highest quality of life.

DAAS Programs

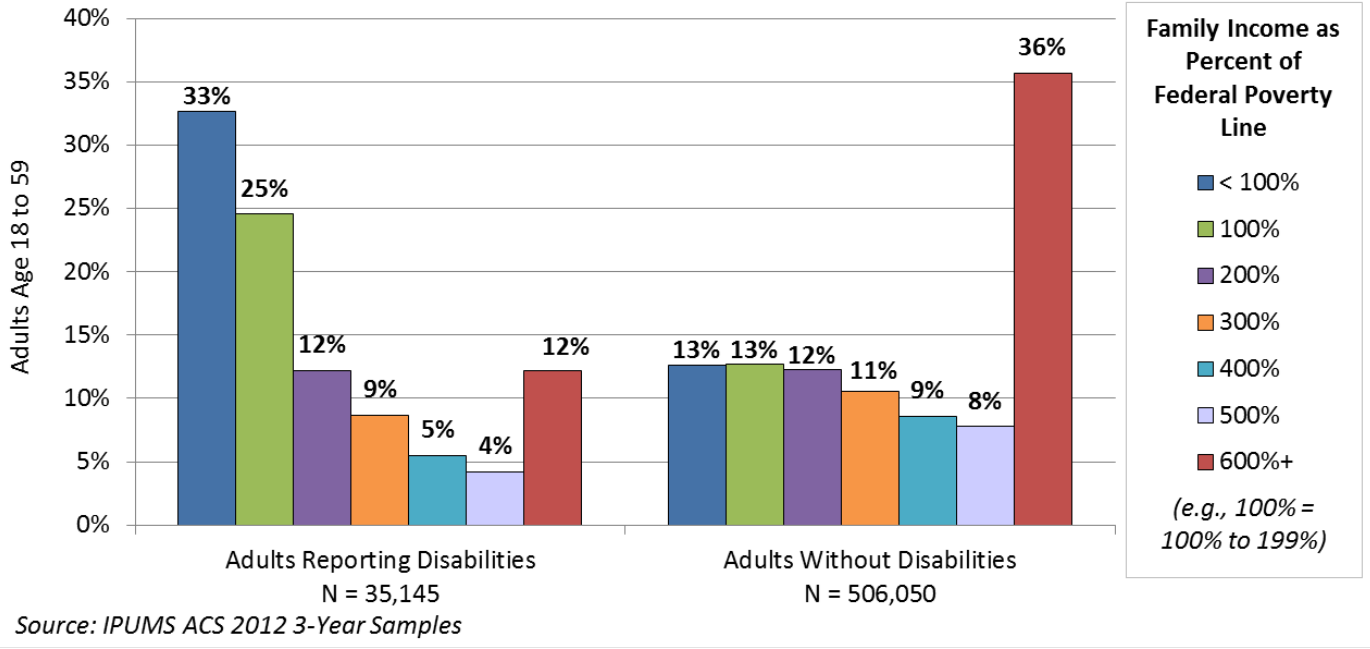
- Long Term Care Operations – CQA Unit
- Adult Protective Services
- In-Home Supportive Services
- Integrated Intake Program
- Office on Aging
- Public Guardian
- Public Conservator
- Public Administrator
- County Veterans Service Office

Almost 25% of San Franciscans are Seniors (Age 60+) or Adults with Disabilities (Age 18 to 59)



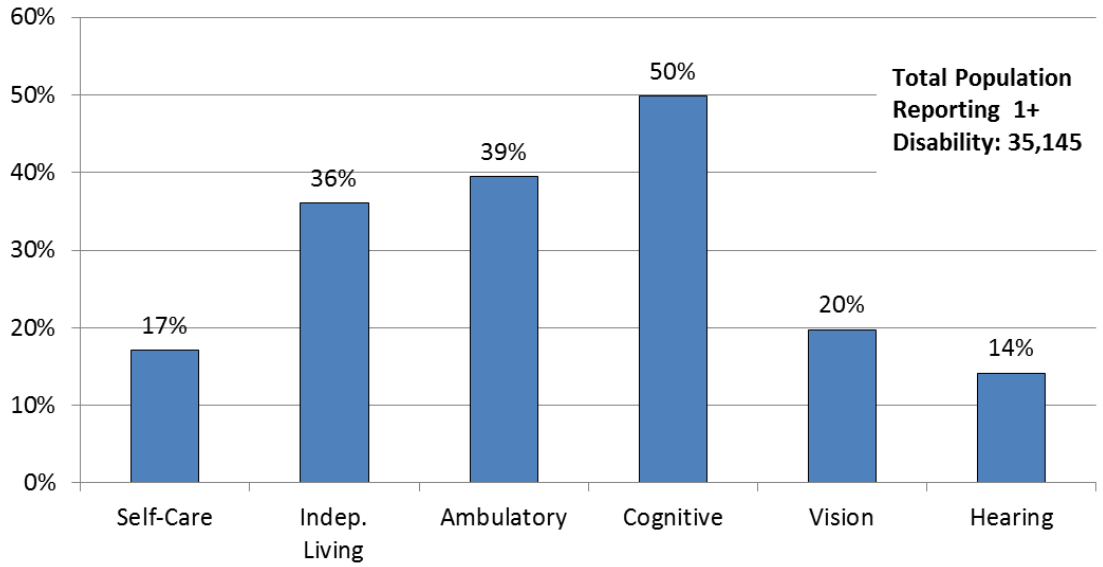
Source: IPUMS 2012 3-Year Samples

Majority of Adults with Disabilities Have Low Incomes



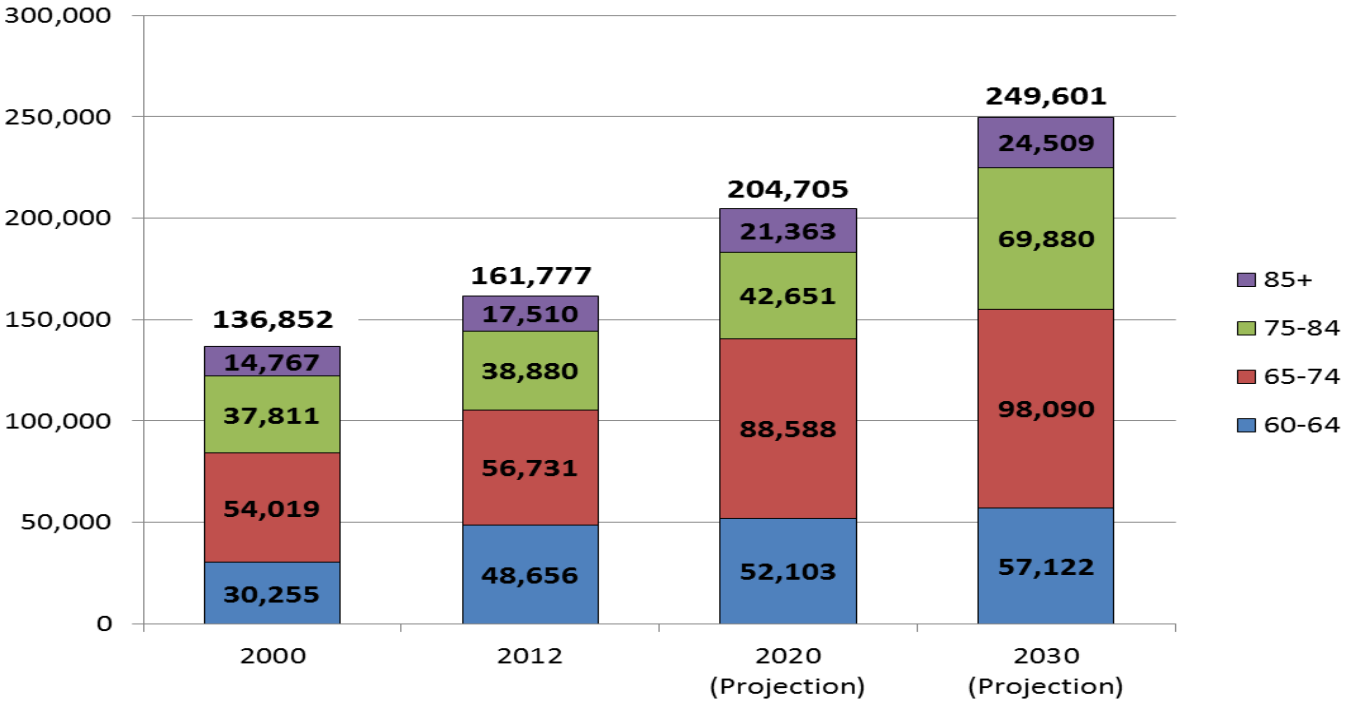
Source: IPUMS ACS 2012 3-Year Samples

Most Commonly Reported Types of Disability by Adults Age 18 to 59



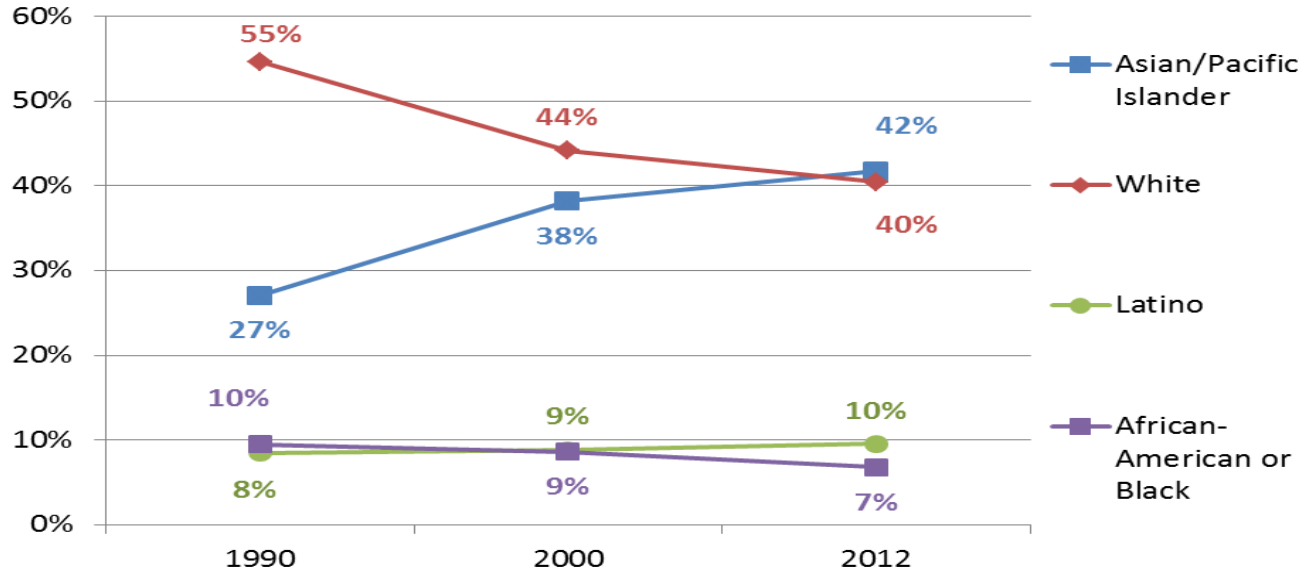
Source: IPUMS 2012 3-Year Samples

Senior Population (Age 60+) Has Grown by 18% Since 2000



Source: IPUMS 2000 5% & 2012 3-Year Samples
CA Dept. of Finance Projections

San Francisco Senior Population (Age 60+) is Increasingly Asian-Pacific Islander



Source: IPUMS 1990 5% sample, 2000 5% sample, 2012 3-year sample

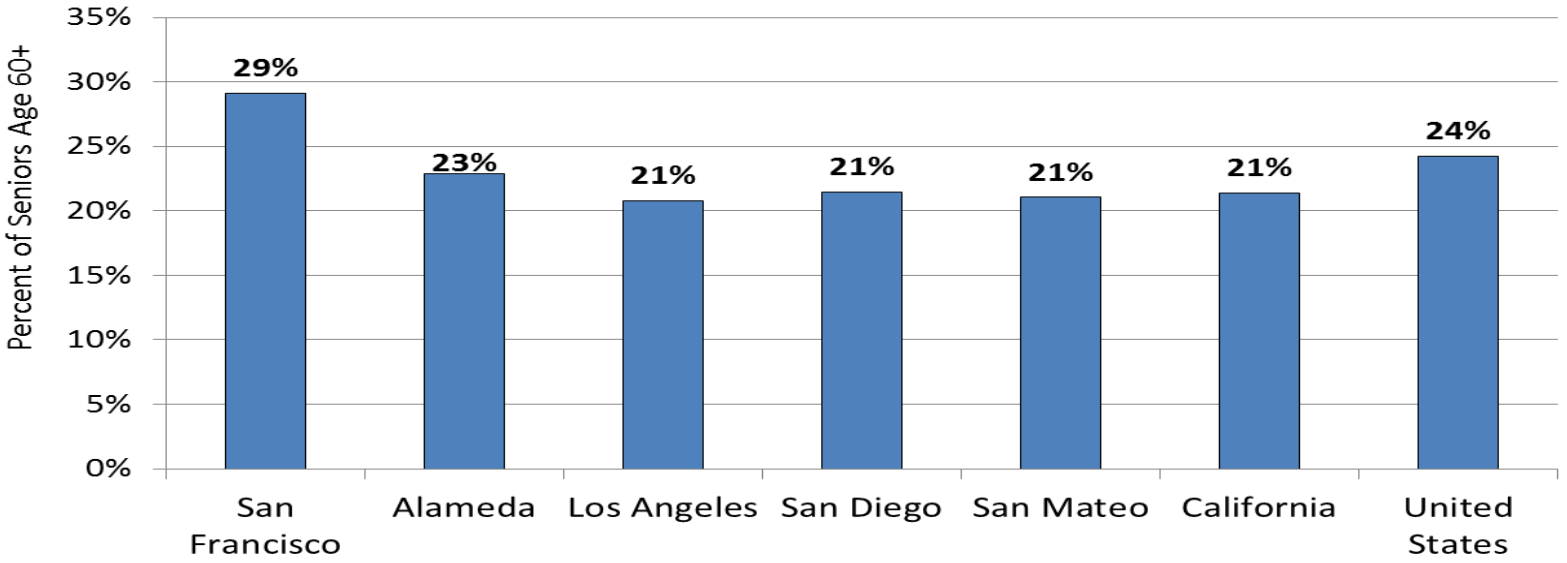
Dementia Rates in San Francisco

Between 2010 and 2030 there will be a 49% increase in the number of San Franciscans with Alzheimer's related dementia:

34,837 San Franciscans by 2030.

1 of every 2 people over the age of 85 will have some type of dementia.

San Francisco Seniors More Likely to Live Alone than Seniors in Statewide, Nationwide, or other Major CA Counties



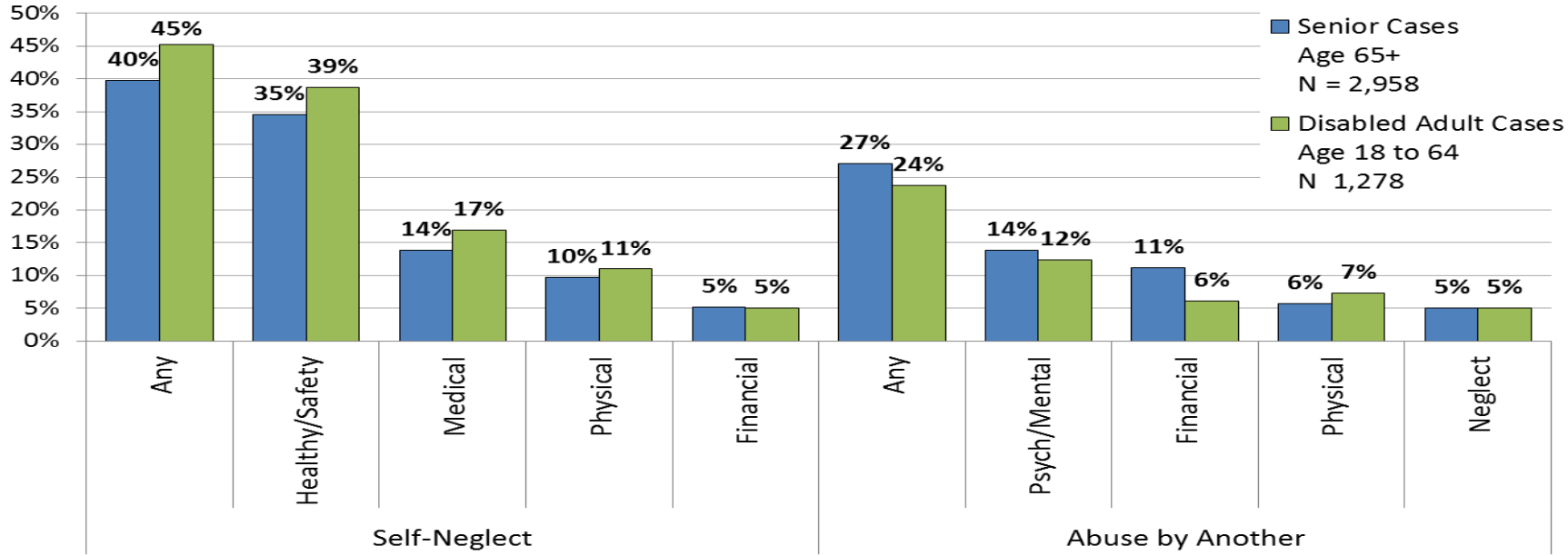
Source: ACS 2013 5-Year Estimates

Adult Protective Services

Adult Protective Services (APS) is a county-based program that intervenes to remedy or reduce danger to dependent adults and frail elders that are at risk of physical, sexual, mental or financial abuse, neglect or self-neglect.

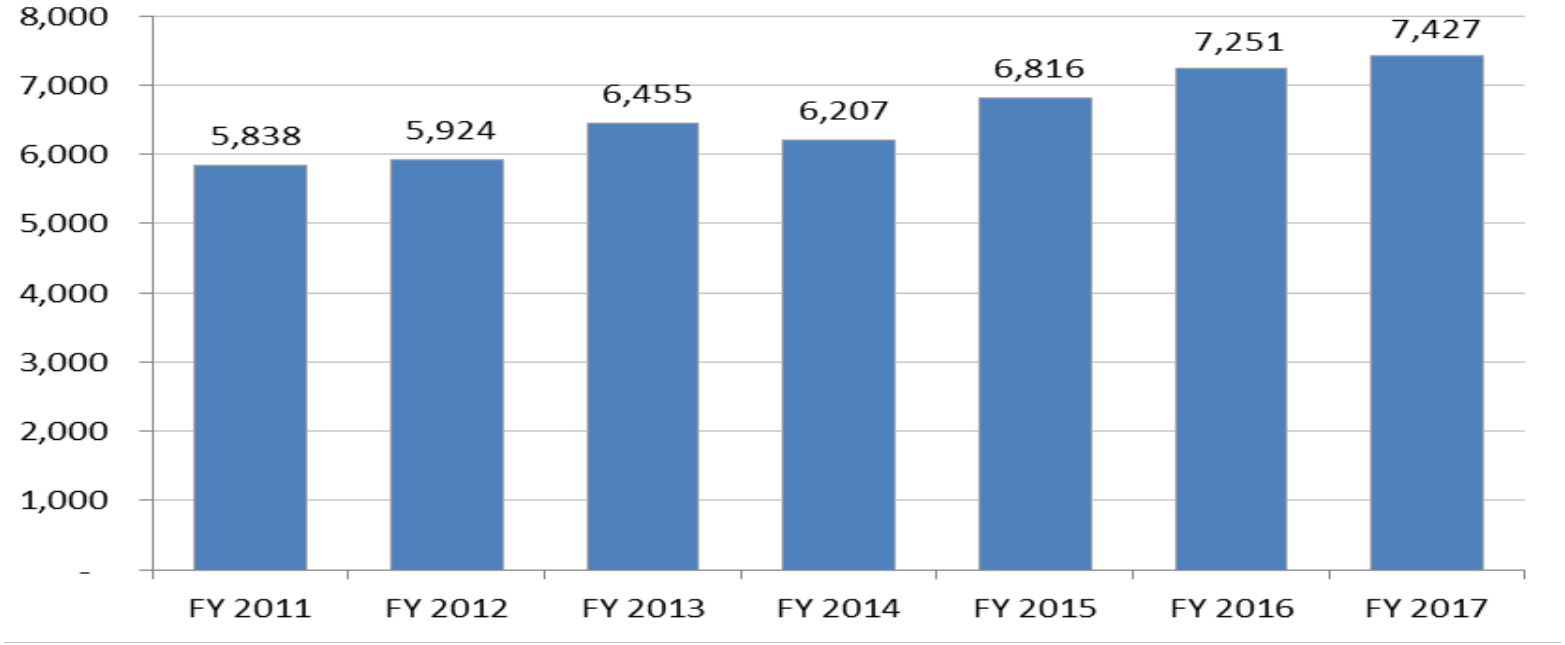
- **Physical Abuse**
- **Sexual Abuse**
- **Abandonment**
- **Isolation**
- **Financial**
- **Neglect**
- **Self-neglect.**
- **Mental suffering**

Percent of Investigated APS Cases with Substantiated Abuse by Population and Abuse Type

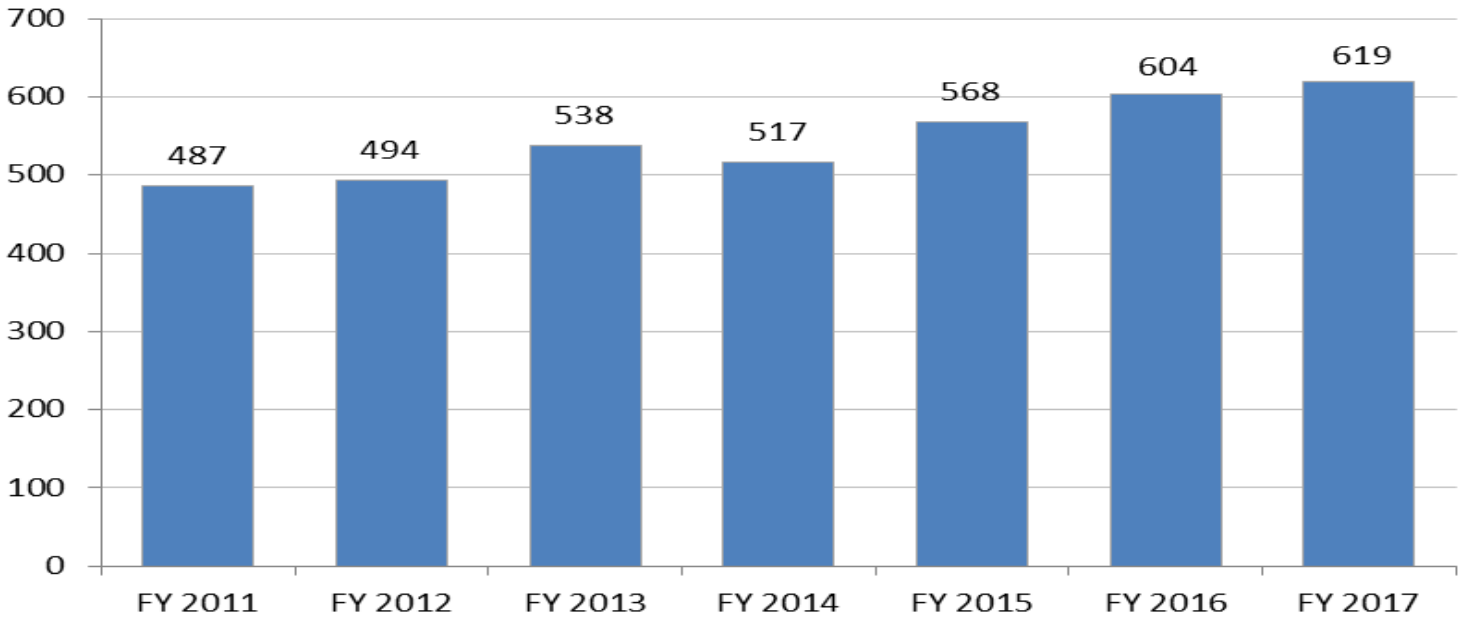


Source: AACTS database, FY 14-15 cases

Total SF APS Reports of Abuse by year



Average SF APS Reports Every Month



Overarching Framework for Adult Protective Services Interventions

APS Mission – To Maintain the Health and Safety of older adults and adults with disabilities in the least restrictive setting.

Guiding Principle – Every action taken by APS must balance the duty to protect the health and safety of the vulnerable adult with the right to self determination.

Structure of San Francisco Adult Protective Services

- 8 Units, one of which is the High Risk Self Neglect Unit
- 43 Protective Service Workers, 8 supervisors, and 3 Case Aides
- Institute on Aging in San Francisco – Multidisciplinary Team and Forensic Center that meets twice a month, to discuss cases of abuse: APS, CQA, Police, DA's Office, PG/PC, geriatrician, neuropsychologist

What do APS Workers do?

- Investigate Complex Situations of Abuse, Exploitation, and Self-Neglect
- Provide Crisis Response to Urgent Cases
- Accept and Respond to Reports on a 24 Hour Basis
- Collaborate with Local Law Enforcement
- Develop and Implement Service Plans to Promote Safety
- Assist Clients to Obtain Restraining Orders and Legal Services
- Refer Clients to Community Based Organizations
- Provide Advocacy, Counseling, and Support
- Evaluate the Need for Involuntary Services Including Conservatorship

The **In-Home Supportive Services** program provides services to eligible individuals who are unable to remain safely in their own homes without the physical assistance of another person to carry out housekeeping or personal care tasks.

San Francisco In-Home Supportive Services

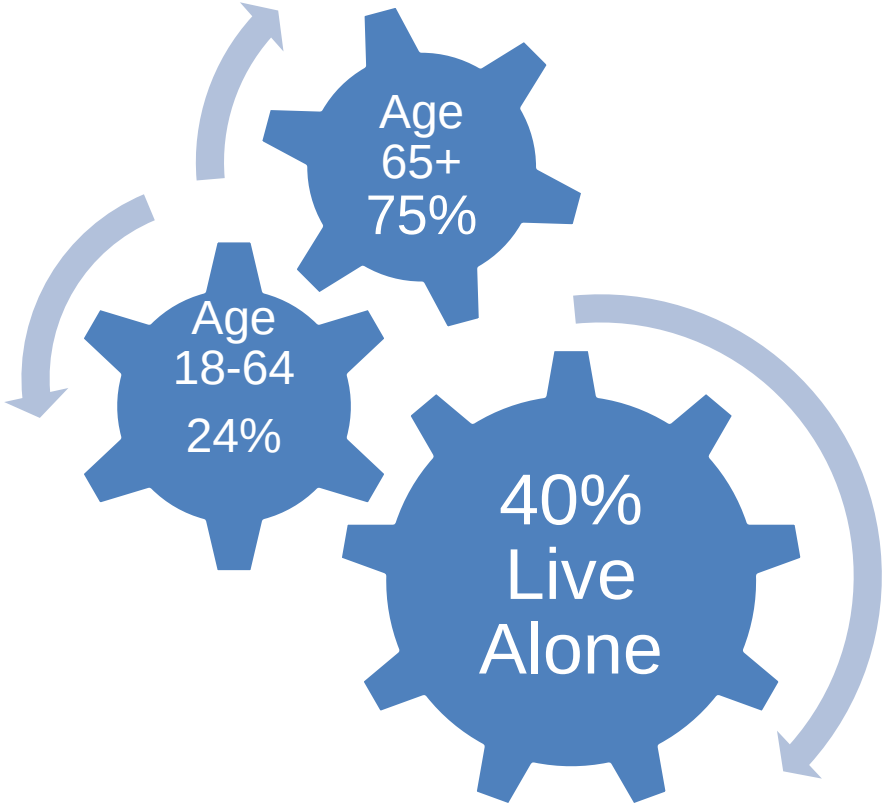
IHSS in San Francisco

Serves

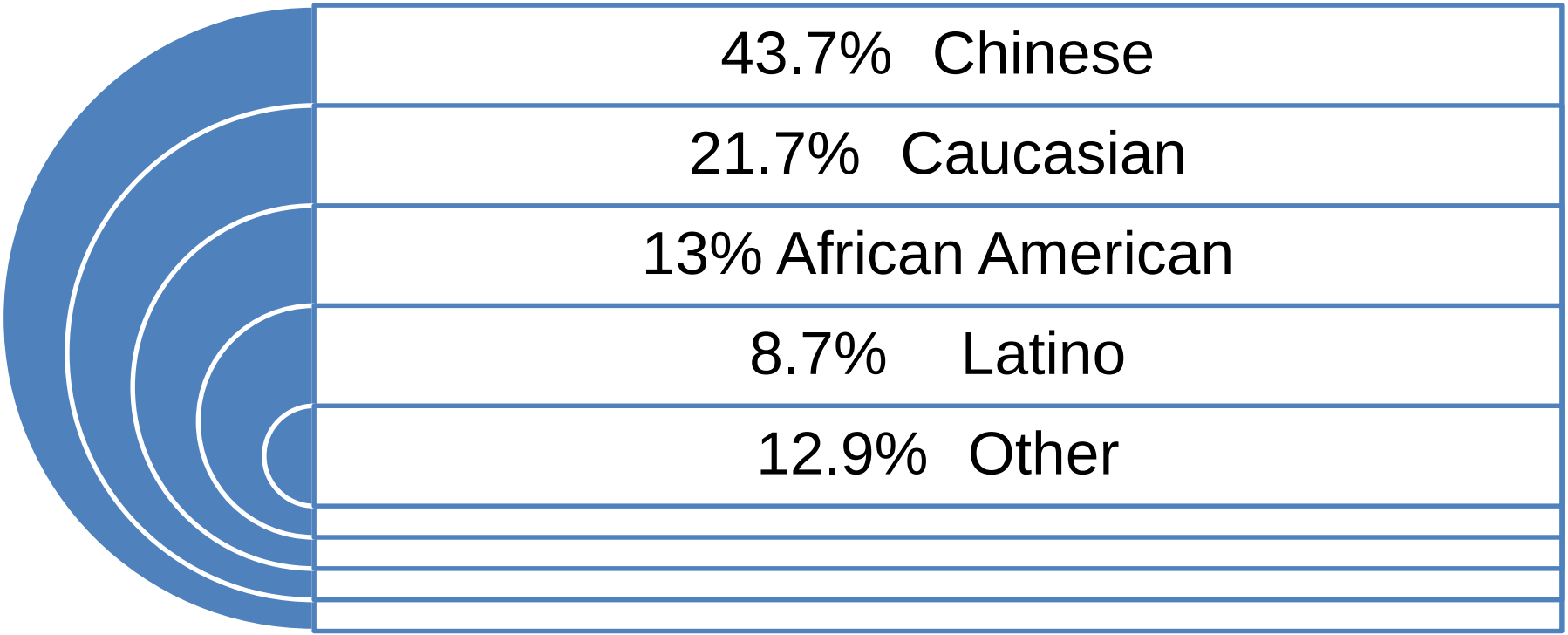
22,800+ Consumers

20,000+ Independent Providers

IHSS Consumers

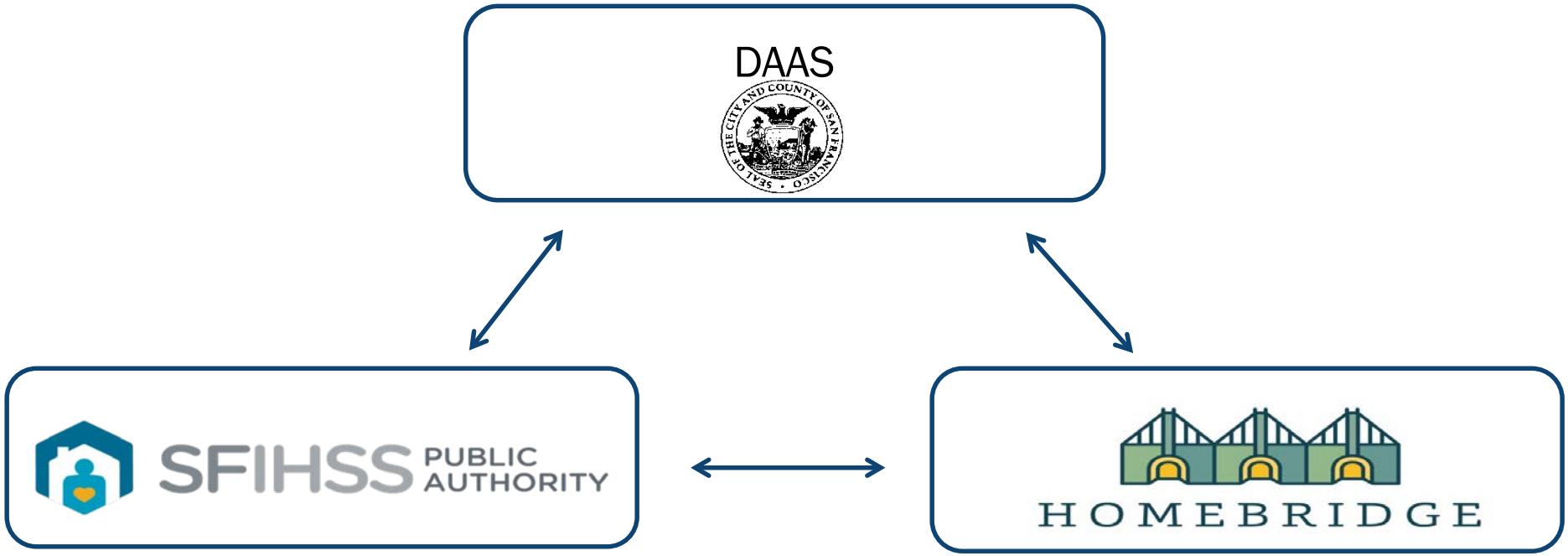


SF IHSS Consumers Ethnic Breakdown

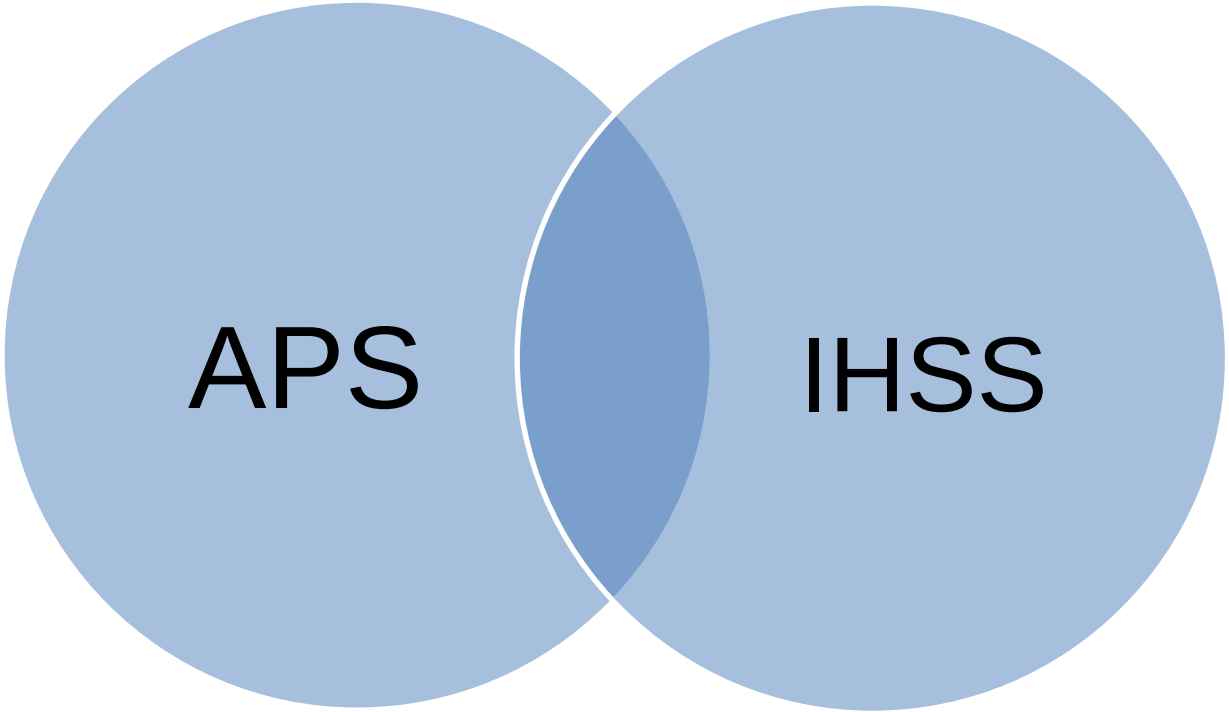


DAAS In-Home Supportive Services Program

IHSS in SF Service System Entities



34% of SF APS Clients are IHSS Consumers



IHSS Consumers have complex clinical needs.

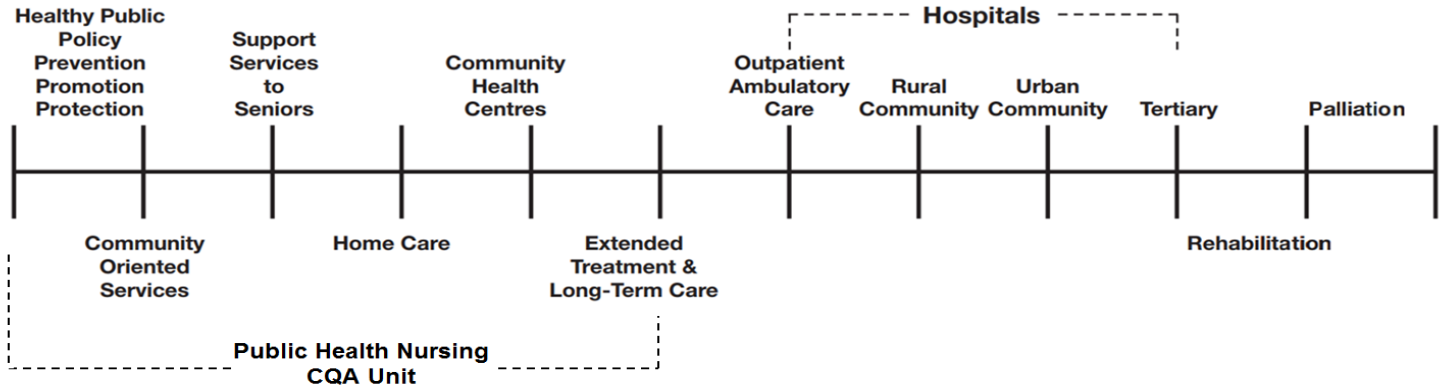
Clinical and Quality Assurance Unit
Mission & Vision

To set the standard for health prevention, disease management and crisis intervention for elders and adults with disabilities living in San Francisco and to improve the health of the public.

1. Engage and Support San Francisco's elderly and adults with disabilities by maximizing their ability to stay safe in the community through prevention and management of diseases as well as crisis intervention.

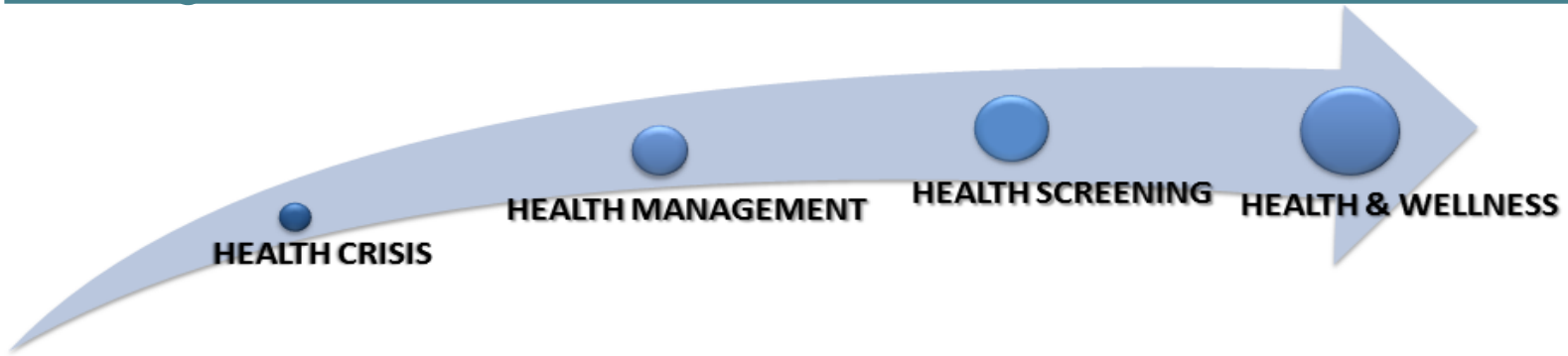
2. To improve health outcomes and promote the wellbeing of San Francisco's elderly and adults with disabilities through disease education, prevention, management and crisis intervention

Expanding role of public health nursing in addressing continuum of services



(Adapted from *Quality Health for Manitobans: The Action Plan, 1992) revised for SF DAAS CQA*

Paradigm Shift from Illness to Health, & Weakness to Strength



History of CQA Unit

The Clinical and Quality Assurance Unit within the Department of Aging and Adult Services (DAAS) provides needed clinical consultations involving

- 4 Registered Nurses (RN)
- 2 Licensed Clinical Social Workers (LCSW)

Who serve In-Home Supportive Services (IHSS) and Adult Protective Services (APS) consumers with complex clinical needs, including complex medical, nursing and behavioral health needs. Services will be provided across the continuum of care ranging from wellness to crisis. The team of clinicians will focus on the development and evaluation of Health Care Plans (HCP) and the monitoring of service plans to ensure access and interventions are efficient and effective.

STRUCTURE

- ➔ Evidence Based Screening Tools
- ➔ Competency Training

Demographics

"Who are the client's we are seeing?"

Age

69

average age

Live alone

66%

Race by Department

APS		IHSS	
8%	Latino	9%	Chinese
9%	Chinese	12%	Latino
15%	Others*	25%	Others*
21%	Black	22%	Black
47%	White	32%	White

Other: Korean, Asian/Pacific, Filipino, Japanese, Russian, Mexican, and Native American.

How many clients did the CQA Unit Serve?

Total: 885

736 Clients Were provided with client centered individualized Health Care Plans by CQA RN

149 Clients Triaged by the Nurse of the Week and received assessment, follow-up phone call, initial visit only, and service plan review.

Timeframe:

December 1, 2015

-

June 30, 2017

Agency

65% APS

34% IHSS

1% Other

Sex at Birth

49% Female

50% Male

1% Unknown

Gender Identification

1% Trans Female

1% Unknown

48% Female

50% Male

Sexual Orientation

47% Straight/Heterosexual

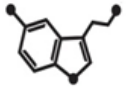
34% Not asked

19% Other

Other: Gay/Lesbian/Same-Gender Loving; Not listed, Incomplete/Missing Data; Unknown; Declined to Answer

*Full SOGI data collection started in 01/01/17

Demographics continued…
"Our clients are vulnerable"

	**702 clients** assessed for **Risk of Falls**
	**224 clients** assessed for **Cognitive Impairment**
	**355 clients** assessed for risk of **Depression**
	**703 clients** assessed for risk of **Pressure Ulcers**
	**528 clients** assessed for risk of **Pain**
	**539 clients** assessed for risk of **Poor Nutrition**

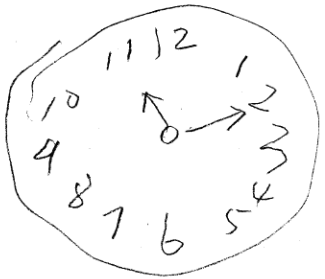
Evidence Based- Screening Tools

1. Fall Risk Assessment - **MAHC-10**
   a. age, diagnosis, prior history of falls, incontinence, visual impairment, impaired functional mobility, environmental hazards, polypharmacy, pain, cognitive impairment
2. Depression Risk Assessment - **PHQ-2**

1. Pressure Ulcer Risk Assessment - **Braden Scale**
   a. Sensory perception, moisture, activity, mobility, nutrition, friction and shear
2. Nutritional Assessment

1. Pain - **Wong-Baker FACES Scale**

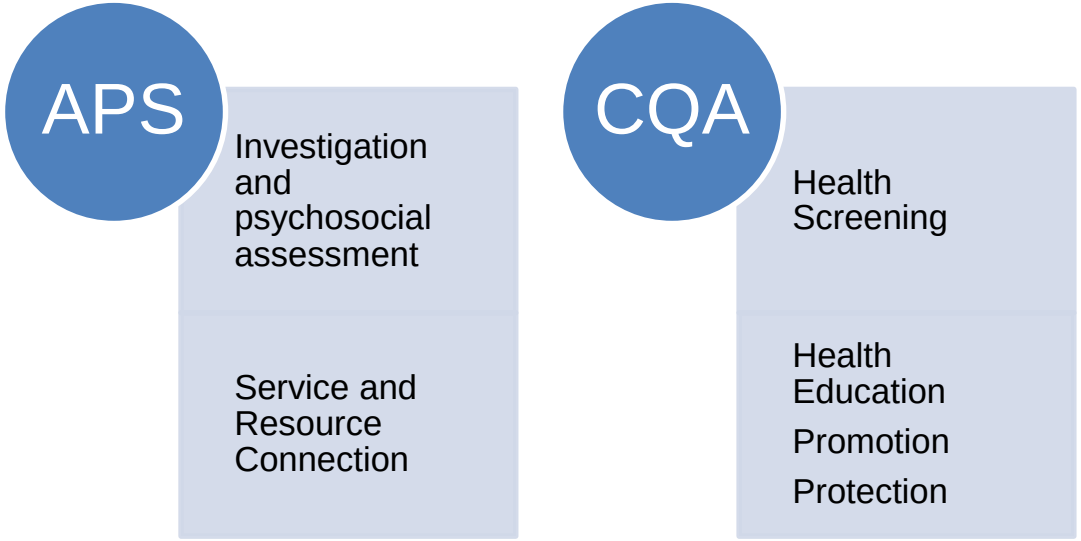
1. Cognition - **Mini-Cog & MOCA**



The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

APS and CQA- Conducting joint home visits to address caregiver neglect and self-neglect with older adults and adults with disabilities.



IHSS Clients Accessing Nursing Services

- Received individualized health care planning in the absence of community health care providers – facilitating Intake Process and completion of the Medical Certification Form and connecting clients to primary care providers (PCP).

- Received nursing services that focus on the health promotion and coordination of community based services.

- Received Home Safety Assessment, including medication monitoring, falls, DME

- Received education and training related to client's health care needs, medical diagnoses, risk factors and involves family and caregivers in the planning of care.

- Received health monitoring – detecting presence of health concerns through home visits.

- Received dynamic health advocacy and planning that utilize "motivated care planning" – using client's "Strengths First."

Client #1 Meet Ms. Wong…

87 y/ o female client who lives alone and left skilled nurse facility **Against Medical Advice (AMA)** after falling in the home and having a total hip replacement.

Upon Assessment:

No rehabilitation services in place

Client not aware of post surgical hip precautions

Client confused about new medications

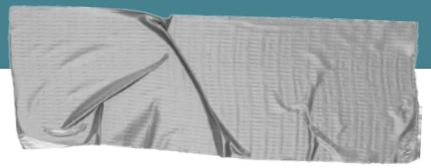
Client reported weakness/ swelling

Risk for recurrent falls

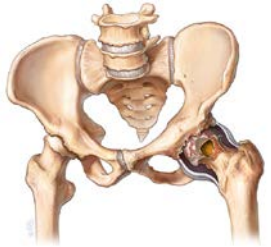
PCP unaware that client left facility AMA

NOTE:

Historically, prior to the creation of CQA Unit, all clients who left Against medical advice (AMA) were sent to the ER by social worker.



Ms. Wong



What happened to Ms. Wong after CQA involvement?

- **Short-term interventions**
  - CQA RN educated about post-hip precautions
  - CQA RN educated about fall prevention strategies
  - CQA RN provided home safety and DME evaluation
  - CQA RN contacted PCP to notify about AMA, to advocate for visiting physical therapy services advocating that client requires strength training as well as visiting RN for medication management. Services were set-up
  - CQA RN contacted client's family to make sure client has appropriate caregiver support in the home

- **Long-term Plan**
  - Ms. Smith now has visiting physical therapist and RN for medication management and strength training post-hip replacement.
  - Client was able remain safe in her home with appropriate level of care and support and without unnecessary re-hospitalization

Client outcomes after CQA Intervention ; " AMA"

Timeframe: December 1, 2015 - June 30, 2017

33 clients

Received clinical nursing assessment from CQA unit after leaving hospital/SNF AMA.

30% facilitated hospital admission due to acute care needs of clients who were initially refusing services

70% stayed in the community as the result of RN interventions; therefore prevented unnecessary hospitalization/ER visits

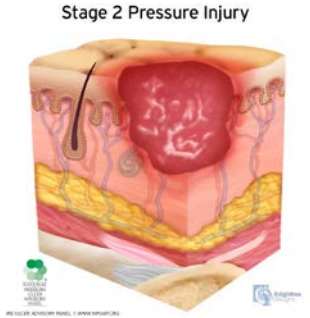
Client #2 Meet Mr. Ruiz...

94 year old male client living with elderly wife and 2 non-engaging sons. Client with very limited functional mobility requiring 1 person assist for ADLs/ IADLs and wheelchair transfers. Client referred to CQA unit for possible **presence of wounds.**

On Assessment:

- Client with untreated stage 2 pressure ulcer on his sacrum
- Client at risk for infection not receiving any wound care
- Client with inconsistent bowel/ bladder management
- Client homebound and unable to leave the home

Mr. Ruiz



What happened to Mr. Ruiz after CQA involvement?

➔ **Short-term interventions**

- CQA RN educated about pressure ulcer prevention and perineal care
- CQA RN educated about signs and symptoms of infection and when to initiate EMS
- CQA RN contacted PCP to advocate for Community Care program with visiting Nurse Practitioner to follow-up on all medical needs
- CQA RN advocated and coordinated home health services for visiting RN to provide wound care services for the client.

➔ **Long-term Plan**

- Mr. Ruiz now has visiting Nurse Practitioner as well as visiting RN for wound care on-going services until wound is healed.
- Client was able remain safe in his home with appropriate level of care and support and without unnecessary re-hospitalization.

APS and IHSS referred due to presence of “wound”.

Timeframe: December 1, 2015 - June 30, 2017

137 clients were referred to the CQA Unit with reports of presence of wounds. After CQA RN intervention/assessment:

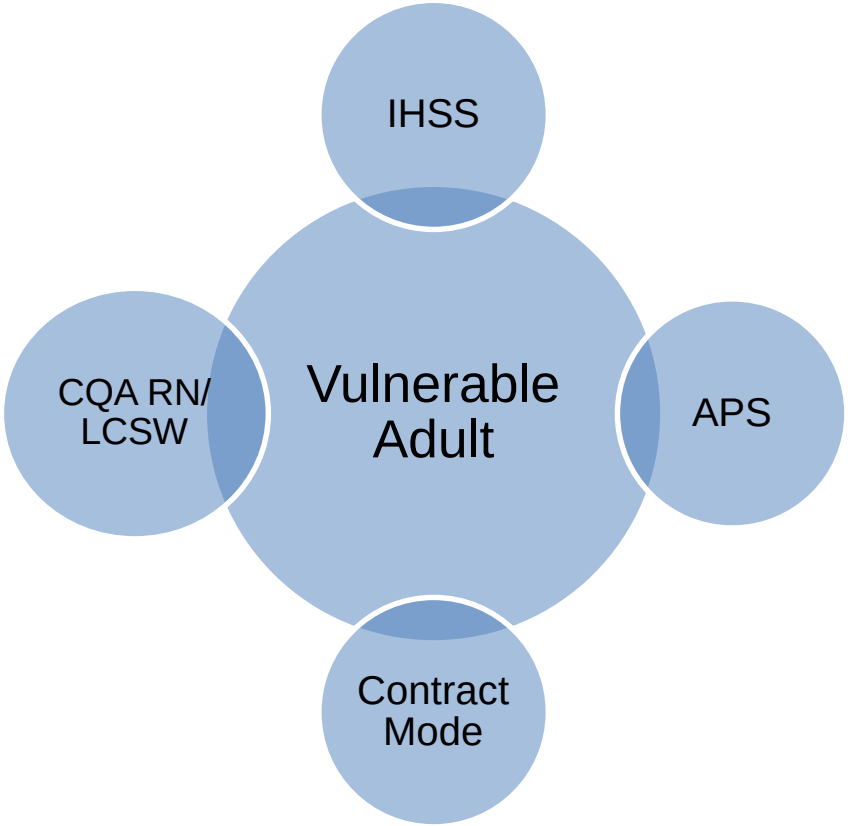
Stayed in the Community	Hospitalized
CQA RNs were able to prevent unnecessary ER Visits and hospitalization through coordination of services in the community.	100% were engaged by RNs and resulted in client receiving treatment/admission to hospital.

Types of Interventions:

- Partnering with existing skilled nurse services
- Connecting/ coordinating with PCP
- Initiating urgent care services
- Initiating home-care
- Connecting to wound clinic/ other
- Establishing gatekeeper for clients who refuse

IHSS Staffing

Weekly Meeting to Resolve Complex Cases



A common referral to APS: Self-Neglect

Self-Neglect:

Failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise, and to satisfy his or her needs of:

(1) personal hygiene, or food, clothing, or shelter.
(2) medical care for physical and mental health needs.
(3) self-protection from health and safety hazards.
(4) preventing malnutrition or dehydration.

as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.

(CA WIC 15610.57)

The Self- Neglect Equation

Cognitive impairment + Mental Health Issues + Multiple Medical Issues

Housing Issues + Co-Occurring Substance Abuse +

Hoarding Conditions − Reliable Support System

= Very challenging APS Case

High Risk Self Neglect and Eviction Prevention Unit

- Six licensed (LCSW and MFT) APS Workers.
- A licensed (LCSW) APS Supervisor overseeing the unit.
- Lower Caseload than rest of the unit (6-8 new cases per month).
- Intensive clinical training for APS Workers.
- Collaborative Casework with CQA Unit

Outcomes Matrix

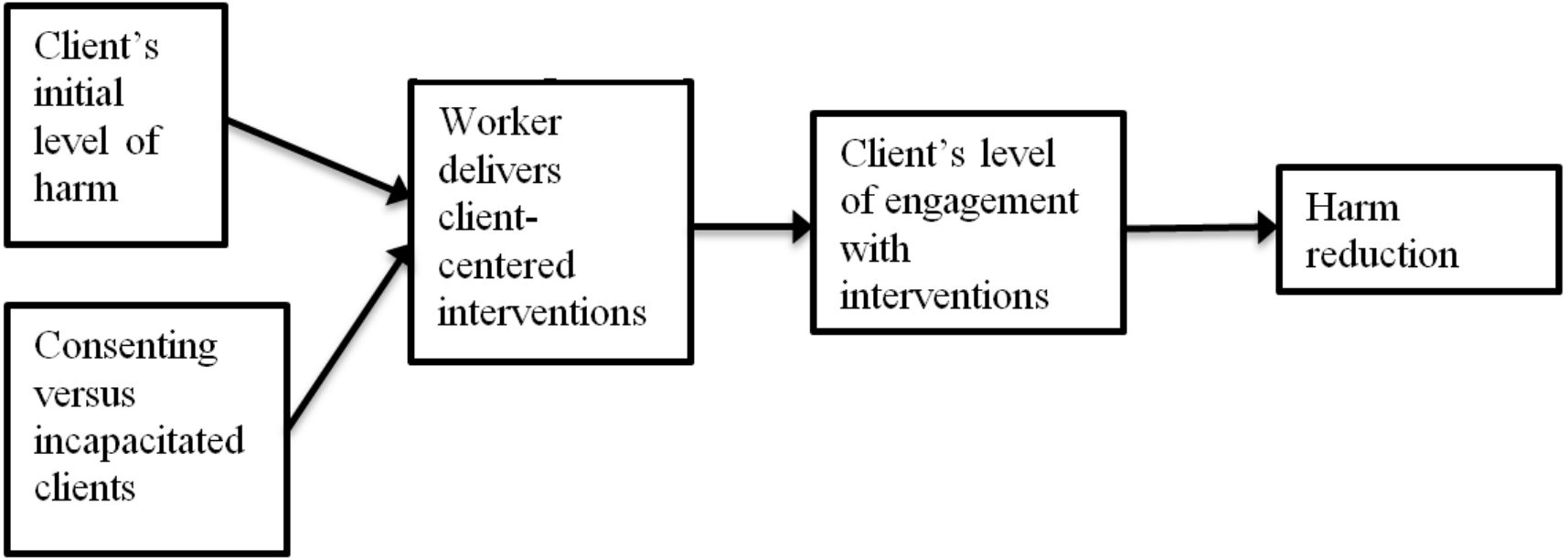


Figure 1. Conceptualization for Achieving Positive Outcomes through APS Intervention

High Risk Self Neglect Unit – Client Outcomes

of positive Outcomes.

	Outcome Level
ies ice and	1. In-Crisis, e.g. Significant evidence of lack of self-care or financial mismanagement that is resulting in extreme health/safety hazard(s) to the client, or substantial real or personal property loss. 2. Vulnerable, e.g. Evidence of lack of self-care or financial mismanagement that is resulting in moderate health/safety hazard to the client or real or personal property loss. ----------Stability Line *---------- 3. Stable, e.g. Housing/environment may not be ideal but there is no evidence of health/safety hazard(s) to the client, and client's real or personal property is adequately managed. 4. Safe, e.g. Client is engaged with a safety plan, which may include caregiver support, and there is no evidence of health/safety hazard(s) to the client. 5. Thriving, e.g. Caretaker(s) accesses available resources that improve the quality of care and functional ability of the client, e.g. client resides in a safe and nurturing environment.

At Case Closure:

Of reports closed from 7/22 thru 9/22 2017, 30 of 36 showed an outcome increase to the stability line (83%).

•Self Neglect Assessment – Short Form.

•4 relevant risk assessment questions (environmental hazards, unpaid bills, loss of housing, support system).

•PHQ-9 will be conducted again if was conducted previously.

Other measures to be included for future analysis:

•Risk reduction in key areas of unpaid bills/rent, loss of housing risk.

•PHQ-9 score comparisons (initial & closing).

•Recidivism.

Reducing Barriers, Facilitating Services

In-home supportive services (IHSS) is a statewide program administered by each county under the direction of the California Department of Social Services. It provides those with limited income who are disabled, blind or over the age of 65 with in–home care services to help them remain safely at home.

Barrier: SOC 873 form must be completed by a licensed professional in order for clients to receive services. ***However, not all clients have a primary care physician*** which prevents them from accessing needed services.

Solution: CQA RNs to make home visits to vulnerable clients and assist with form completion and connecting with primary care services.

NOTE:

Prior to the creation of CQA Unit, client's who lacked a PCP and needed IHSS were referred to Adult Protective Services

How many DAAS clients were in need of IHSS services in order to stay safe in the community?

234 clients

CQA Unit facilitated medical certification and clinical services for **84%** of those clients through completion of SOC 873 form.

How many of those clients were also in need of primary medical care providers (PCP)?

62 clients initially lacked a PCP → **39** clients were connected to a PCP**

**** Of the remaining 21 clients refused;***
2 clients already connected with PCP

Other CQA Unit Involvement

- **Grievances**
  - Internal
  - External
- **ADA Accessability**
  - Mayor's office on Disability
- **Infection & Exposure Control**
  - For DAAS employees
- **Facilitation of Community Living Options**

Training and Health Education for Staff

Issues from the field:

How do I protect myself from communicable diseases?

What do I do if my client has bedbugs and I sat in his chair?

Do I have to shake my client's hand if she has body lice?

Infection & Exposure Control

Infection and Exposure Control Guidelines in the Community has resulted from the management's desire to protect the San Francisco Department of Aging and Adult Services (DAAS) workers from potentially infectious materials and incidents when performing specific job activities.

1) CQA Unit provides Education & Training
   a) Standard Precautions
   b) Special Precautions; Lice, bed bugs or vermin
   c) Respiratory Hygiene
   d) Use of Personal Protective Equipment
   e) Prevention of needlestick/ sharp injuries

1) CQA Unit provides Personal Protective Equipment (PPE)

Satisfaction Survey

59 IHSS referred clients were surveyed within 6 months of program implementation.

93% clients
reported nurse met their healthcare needs

87% clients
reported nurse assisted in obtaining additional care and access to medical services in the community

What is next?

- Excellence in Dementia Care
  - Geriatric Workforce Enhancement Program
- Community Options & Resource Engagement (CORE)

- Expansion of Infection and Exposure Control Measures

How does your county utilize Nurses or Behavioral Health Clinicians to better serve older adults and adults with disabilities?

Questions?

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