Home From the Hospital:

The In-Home Supportive Services Hospital Discharge Liaison Unit in San Francisco County

Millicent Miles and Margarita Zarraga

EXECUTIVE SUMMARY

Background

The In-Home Supportive Services (IHSS) program is administered in all 58 counties in California and funded through the California Department of Social Services. The purpose of the program is to provide services to help low-income elderly, disabled, and/or blind individuals, live safely in their own homes rather than in a nursing home or other group care facility. Typically, individuals apply for IHSS while living in their own homes, and the main role of the county is to conduct an initial assessment and an annual reassessment with each client to determine the number of care hours needed. Individuals must be on Supplemental Security Income (SSI) or have a Medi-Cal eligibility determination within 45 days from the date of the IHSS application. If eligible, IHSS recipients can be authorized up to 283 service hours per month based on an individual's need.

The type of available services which may be authorized include house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision services for individuals whose mental status or cognitive functioning poses a threat to their safety and well being. Under this program, IHSS recipients have the right to choose, hire, train, and terminate the employment of their IHSS provider.

Findings

One of the most vulnerable groups needing IHSS are those individuals being discharged from the hospital or from a similar health care facility. . The goal of the San Francisco City and County Hospital Discharge Liaison Unit is to minimize these events and provide a safe and positive recuperative period for every discharged patient in San Francisco County. It is through the collaborative efforts of discharge planners and the county staff that this model has been very successful.

The City and County of San Francisco has taken a proactive approach by dedicating an entire unit of IHSS social workers to assist those individuals being discharged from acute, long-term, and board and care facilities. To further enhance their commitment, a Registered Public Health Nurse and a Case Aide expand the services that this unit provides.

The successful outcomes and advantages of the San Francisco County's Hospital Discharge Liaison Unit are numerous. Three of the most significant are:

- The individual is less likely to be readmitted to a hospital or facility when the care at home is safe and adequate;

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- The program stimulates the local economy by providing jobs to the community; and,
- There are overall cost savings for the county and the individual because the cost of acute and long-term care is decreased or eliminated.

Recommendations

Based on the BASSC participants' joint review of the San Francisco City and County IHSS Hospital Discharge Liaison model, ideas and suggestions are being proposed for Alameda and Monterey Counties. Key recommendations include:

Alameda County

- Expand the utilization of the Service Management Access and Resource Tracking (SMART) automated system to provide essential reports and improve and enhance quality, timeliness, and consistency in the delivery of IHSS.
- Conduct an analysis to determine if the volumes of hospital discharge referrals justifies implementing a separate Hospital Discharge Liaison Unit.
- Collaborate with the Alameda County Medical Center and other local hospitals to increase awareness of the IHSS program and review the process by which patients being discharged from these facilities are referred for an IHSS evaluation.

Monterey County

- Increase IHSS program awareness and availability among the older adult and disabled population by conducting IHSS outreach to residents of Monterey County being discharged from the local hospitals and developing an IHSS informational brochure summarizing the program eligibility requirements and benefits. .
- Network with local hospital discharge planners to promote the IHSS program and to establish a protocol with local hospitals for IHSS referrals, and explore the feasibility of social workers meeting the client in the hospital prior to discharge to begin the application process.
- Develop and implement a fast track for Medi-Cal determinations in collaboration with the Community Benefits Branch.

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Introduction

Effective January 1, 2008, a new state law[1] requires local hospitals to provide patients who are anticipated to need long-term care at the time of discharge with contact information for the local Area Agency on Aging serving their county of residence. Additionally, local hospitals may request that the county agency provide information about available supportive services to distribute to patients and their caregivers. It also requires that the hospitals make appropriate post-hospital care arrangements prior to discharging a patient.

Addressing the need for a collaborative approach to this mandate, and providing necessary supportive services in a timely manner, could result in reducing the high cost of extended hospitalization caused by delays in authorizing IHSS benefits and subsequently, improving post-hospital care for those patients in need.

Two of the Bay Area Social Services Consortium (BASSC) Executive Development Program participants reviewed and studied the San Francisco City and County Hospital Discharge Liaison Unit. Alameda and Monterey County representatives were interested in the concept of an In-Home Supportive Services (IHSS) unit dedicated entirely to hospital discharge as neither of these counties currently has such a unit. The City and County of San Francisco is a very diverse community that approximately 780,000 individuals call home; those 55 and older comprise 22% of the population.[2] The governmental structure is unique in that the city and county function as one entity. As this model is evaluated for Alameda and Monterey Counties respectively, it is important to keep in mind the funding and community resources that are unique to the City and County of San Francisco.

Background

The State of California's Manual of Policy and Procedures (MPP) Section 30-755.12 states that an applicant's IHSS and Personal Care Services Program (PCSP) needs are to be preliminarily assessed and services authorized prior to the applicant's discharge from an acute care setting, skilled nursing facility, or convalescent home. This regulation allows for service authorization based on that assessment. The determination that an IHSS/PCSP applicant can return safely to his or her home is a decision that should be made in conjunction with the team, including the applicant, the applicant's physician, or responsible health care practitioner and, when possible, a responsible family member.[3]

The San Francisco City and County IHSS program is organized into three specialty units: Intake, Case Carrying, and Hospital Discharge Liaison Units. The intake unit is responsible for conducting initial assessments for all new applicants. The case-carrying unit is responsible for conducting annual reassessments and continuing case maintenance for

[1] Senate Bill (SB) 633, Chapter 472, Statues of 2007, enacted on October 11, 2007

[2] 2000 U.S. Census Bureau Report

[3] All-County Letter 02–68 dated August 30, 2002

existing clients in the IHSS program. The purpose of the Hospital Discharge Liaison Unit is to complete a preliminary assessment for IHSS on all San Francisco residents being referred at the time of discharge from various hospitals, nursing homes, or board and care facilities to ensure safe transition from the facility to home, and that any necessary supportive services are in place prior to discharge. The unit also assesses the need for IHSS services on some out-of county discharges when the patient is a resident of San Francisco, and completes courtesy assessments for residents of other counties when being discharged from an eligible facility in San Francisco.

The process begins with a hospital or facility discharge referral for new potential applicants resulting in an on-site visit conducted by a social worker prior to discharge, and a follow-up home visit and assessment after discharge. The purpose of this on-site visit is to introduce the program to the prospective applicant and to begin planning for services once he or she returns home. Normally, the assessment for actual care hours is conducted at the home visit. In situations where a referral is not followed by a hospital or home visit, the social worker contacts the discharged patient by telephone to ensure that he or she has returned to a safe environment and that all necessary supportive services are available.

The goal of the San Francisco Hospital Discharge Liaison model is to ensure that the transition from hospital to home is successful in addition to complying with state regulations and the Olmstead Settlement.

In 1999, the United States Supreme Court held in a decision called *Olmstead v. L.C.* that the unnecessary segregation of individuals with disabilities in institutions may constitute discrimination based on disability. The court ruled that the Americans with Disabilities Act may require states to provide community-based services rather than institutional placements for individuals with disabilities.

Continuation of unnecessary institutionalization was the basis for the more recent lawsuit filed in San Francisco. *Mark Chambers, et al. v. City and County of San Francisco* was filed in October 2006, and seeks relief from San Francisco that will enable plaintiffs and current and potential residents of Laguna Honda Hospital to leave or avoid placement in this hospital, and instead access affordable, accessible housing and services that will support full, independent, and productive lives. This case will potentially impact the rights of San Francisco's seniors and people with disabilities to receive services in the most integrated setting appropriate to their needs. The case will directly impact over 1,000 people and will also provide models for more effective and appropriate discharge and prevention of unnecessary institutionalization. Trial is set for June 2, 2008, in San Francisco. As of the date of this writing, two of the named plaintiffs have been discharged into the community and are living successfully in their own San Francisco apartments with the required needed supportive services.

As a result of the work of San Francisco's advocacy community, and the discharge planner at San Francisco General Hospital, the concept for a hospital discharge function was established in 1996, when it was acknowledged that there were too many unsafe hospital discharges, and it was believed that if IHSS was in place before the patient was discharged, the probability of a safe and speedy recovery would be enhanced.

Initially, there were only two social workers performing the hospital discharge function, but in 1997 it was expanded to three social workers and a Registered Public Health Nurse. In March 2007, the department officially launched a full unit devoted entirely to hospital discharge. The unit consists of a social work supervisor, eight social workers, one Registered Public Health Nurse, one case aide, and one clerk. Each social worker receives an average of eight new intake cases per week, and they carry the case until the client is enrolled and has a care provider in place.

In the beginning phase, English and Spanish were the only languages provided, but now the language capacity has expanded to include all languages included in the caseload. Seventy percent of IHSS recipients speak a language other than English; Can-

tonese and Russian are the most common languages in the total caseload of approximately 19,000.[4]

The Hospital Discharge Unit relies heavily on the services of the public health nurse assigned to work as a consultant in complex or medically critical cases. The nurse is a regular member of the unit and the salary is paid through the Health and Human Services budget. The nurse's assistance is critical, specifically with understanding medical terminology. The nurse orders supplies and medications, when needed, and maintains a caseload that includes patients with severe cases of dementia, Alzheimer's, HIV, major mobility issues, or tracheotomies. Currently, the nurse's caseload consists of thirty high-need recipients.

The unit also includes a case aide who supports the entire unit by coordinating and assisting with logistics that provide clients with needed safety net services while they are in the application process. The case aide also visits the home to assess its livability and makes appropriate referrals, as needed. The unit clerk provides clerical support to the entire unit.

IHSS social workers receive a total of six weeks of structured training; three of those are in the classroom and three are on the job. The IHSS program in San Francisco County has both a staff development and a quality assurance position dedicated entirely to training and to ensuring payment accuracy for the IHSS program. In addition to this training, the hospital discharge liaison social workers receive specialized training from the unit supervisor.

Observations and Findings

While the California Department of Social Services encourages counties to conduct preliminary IHSS assessments in a hospital or similar facility setting, it has not provided an increase in administrative funding for counties to finance the additional cost of activities related to the hospital discharge processes. As a result of the commitment of the Board of Supervisors to provide the resources necessary to successfully serve the IHSS population in San Francisco, the City and County of San Francisco allocates an overmatch to the IHSS program's federal and state funding. For FY 2007–08, the IHSS budget is $202.5 million with an overmatch of $50 million. The overmatch covers all aspects of the services, the independent providers' wages and benefits, the contract with the Consortium,[5] and administrative costs.

To assist staff with providing these services, an automated tracking and information system was developed by the City and County of San Francisco's Information and Technology Department. The IHSS Client Information System (ICIS) is an assessment tool which reduces duplication of data entry, makes the assessment process less paper intensive, automates routine calculations, and provides automated and accurate case tracking. This innovative use of technology improves service delivery for IHSS consumers, and has allowed IHSS staff to move from manual paper processes to an online system that streamlines work, and reduces tedious paper work, and increases accuracy.

The Hospital Discharge Liaison Unit receives an average of 250 referrals per month based on an average of 8 referrals per week for each of the eight social workers. These referrals come from hospitals, nursing homes, board and care and/or shelter facilities. As soon as the IHSS screener receives a referral, the information is entered into ICIS and submitted to the hospital discharge liaison supervisor for assignment to a social worker. The priority for assigning referrals is based on its type:

- **Priority #1**—when the individual's stay in a facility is expected to be at least three days; or,
- **Priority #2**—when the discharge date is not expected to exceed three days from the date of admission. These are more commonly referred to as "short-term stays".

Most IHSS recipients hire and manage their own home care providers, who are often family members or friends. However, when a recipient is not in receipt of free (no share of cost) Medi-Cal benefits, and is able to supervise their own services, but does not know anyone who can perform the work, they are

[4]Finance and Planning Human Services Agency IHSS Quarterly Report, July–September 2007

[5]A non-profit community based organization providing case management services for IHSS recipients

referred to the IHSS Public Authority (PA), a quasi-governmental agency that operates a registry of qualified workers who can provide in-home services. The recipient has the option of obtaining a referral from the PA, or they may elect to pay the PA directly for services provided by one of their registrants.

When a recipient is too frail, ill, or cognitively impaired to manage his or her own in-home services, the social worker refers the person to the IHSS Consortium. The IHSS Consortium is a non-profit community-based organization that provides direct in-home services to IHSS recipients under contract with the City and County of San Francisco. In addition to the direct services, the Consortium may also provide case management. It has a workforce of 527 home care providers and 56 case managers and serves an average of 1,500 clients annually. The Consortium was recently awarded a three-year contract from the City and County of San Francisco to deliver intensive case management and supervision to 1,400 unduplicated[6] elderly and disabled consumers. This contract is equivalent to 730,000 service hours at the rate of $26.77/hour, which includes the provider's hourly rate of $11.54 plus benefits of $0.56/hour and the associated overhead costs incurred by the Consortium. Recipients are also referred to the Consortium when they are unable to locate an Independent Provider (IP) and they are without an adequate support system at the time of discharge or when the recipient's IP is unable or unwilling to provide paramedical services and/or personal care. The Consortium is funded through the IHSS overmatch.

Networking, collaborating, and establishing informal partnerships have been vital to the success of the Hospital Discharge Liaison model. According to San Francisco IHSS management staff, there are no memoranda of understanding in place but a well-established working relationship is maintained with the local hospitals and other facilities. Both teams have a clear understanding of the program protocols and they make the process work in the most effective and efficient manner for the best outcome possible for the customer.

Additional Resources

The Hospital Discharge Unit also works closely with many community agencies and advocacy groups that provide additional resources to IHSS applicants and recipients such as:

- **Home Coming Program**—Assists with Laguna Honda Hospital discharges requiring intensive care. The program also monitors the client for up to 6 months after discharge and provides Targeted Case Management (TCM) as needed.
- **On-Call Registry**—Provides up to 20 hours of urgent care services to each recipient under management through the Public Authority. Income Eligible (IE) applicants can also use this service until their financial eligibility for IHSS has been established.
- **Self-Help for the Elderly**—100% Asian operated non-profit that provides free minor house cleaning services and prepared food for up to two days without any cost to the recipient.
- **The Community Living Fund**—A $3 million grant from the City and County of San Francisco provides funding to contract with non-profits to provide additional service hours above those authorized by IHSS. In these cases, the Community Living Fund pays the provider directly, for those non-IHSS services.
- **Independent Living Resources**—This resource is only available for patients discharged from Laguna Honda Hospital. This fund pays the cost of necessary non-medical equipment, not covered by Medi-Cal, up to $4,000 per year.
- **Institute on Aging**—A nurse provides intensive care services and assists with ordering medical supplies.

Case Studies

During the course of the BASSC internship, both participants had the opportunity to observe two hospital discharge cases.

- The first case involved a post-discharge intervention of a recently discharged 81-year old San Fran-

[6]The consumer is only counted once (even though they may have more than one provider)

cisco resident. Although initially contacted prior to discharge, he declined the services when the home assessment was completed. The IHSS Social Worker noted that he was not capable of successfully managing his affairs and, subsequently, an Adult Protective Services (APS) referral was made. As a result of the observations of the APS worker and the case manager from the Consortium, a case conference was convened. The APS Social Worker, Hospital Discharge Unit Supervisor, San Francisco Housing Authority representatives, IHSS Consortium Case Manager, and a facilitator attended the meeting. The IHSS consortium reported that the individual was in dire need of assistance with purchasing and preparing meals, and concern was expressed regarding livability conditions in his apartment. The Housing Authority and APS also shared this concern. Both agencies visited the apartment and took photographs to document the conditions. Each agency representative had the opportunity to express their concerns about the individual's well-being and provided suggestions for the best alternatives and next steps. All ideas and suggestions took into consideration the recipient's wishes and needs. APS advocated supporting the individual without forcing him to move out of his apartment. Assisted living arrangements or respite services to be provided by the Veteran's Administration were recommended, for a short period, until his apartment was ready for habitation. If respite care was not available, the Housing Authority offered to move him to an alternate unit while his unit was brought up to standards. There was also a recommendation for initiating a representative payee due to client's mental and medical conditions. This was an excellent example of how collaboration, networking, and exploration of available resources resulted in a positive outcome for the recipient, the department, and the community partners.

- The second case involved an upcoming hospital discharge for a 52-year old San Francisco resident from Laguna Honda Hospital. The woman had been a resident at the facility for two years, but her doctors and the discharge planner felt that with proper support services, she could be discharged back into the community. She suffered from a variety of medical conditions and required assistance with basic mobility. The referral was called in on 2/05/08 with a discharge date of 2/13/08. The hospital visit was completed on 2/07/08, and the social worker gave the patient an overview of the IHSS program and explained how the program could assist her with a safe return to the community. The social worker also considered other supportive services that the patient may be eligible for and indicated that appropriate referrals would be made. The patient indicated that she would be moving in with her longtime friend and that he could be her IHSS service provider. After the patient signed all of the necessary documents, a meeting with the discharge planner at Laguna Honda indicated that the hospital would be providing training to the provider in the tasks that would be required for the patient's successful transition to community living. After her discharge, the IHSS Social Worker completed the home assessment and the hours were authorized. This is another example of how coordinating the patient's return "home from the hospital" can impact and influence a successful transition back to living in the community.

Relevence/Value for Each of the Participating Counties

Alameda County

Alameda County's IHSS total budget for FY 2007-08 is $228 million, which provides $212 million in provider payments and $15 million in salaries and benefits for the IHSS Social Workers[7] who handle an average caseload of approximately 15,800 cases per month.[8] There is no county overmatch of IHSS funds for FY 2007–08.

Alameda County does not have a unit devoted specifically to handling hospital discharge referrals, and as a result, these referrals are assigned to the general IHSS intake staff. In addition, Alameda County does not have all of the community resources that are available to IHSS recipients in San Francisco

[7]Alameda County Budget for FY 2007–08

[8]Monthly Caseload Assistance Reports for February 2008

County, but it does have a process in place to assist and accommodate individuals being discharged from acute and long-term care facilities.

When a patient is ready for discharge, the facility discharge planner evaluates whether or not any supportive services are needed in order for the individual to remain safely in his or her home and manage their daily activities. If needed, the discharge planner completes an application for IHSS on behalf of the patient and contacts the Social Services Agency. The IHSS screener works with the Hospital Discharge Planner and expedites the request by assigning the application to one of the IHSS Intake Social Workers. Currently in Alameda County, there are twenty-five IHSS intake workers and each worker has two slots per month reserved for emergency referrals. An emergency referral is one that meets the "expedited" criteria: terminal illness, discharging out of a facility, and open/active APS cases in which the individual needs services in place to remain at home. Alameda County retains fifty slots for these expedited services compared to San Francisco County that can accommodate approximately 250 referrals per month.

On average, 487 applications for IHSS are received each month,[9] but the number of those that originate from acute care and other medical facilities cannot be distinguished at this time. Once an application from the discharge planner is assigned to an IHSS Intake Social Worker, a pre-discharge visit may be scheduled at the facility, but the actual service hours are authorized at the home visit when the assessment for services is performed. Unlike San Francisco County, patients in Alameda County must hire their own providers, so if the patient is not able to find someone to assist him or her, the county refers the individual to the Public Authority (PA) that administers the delivery of services and maintains a registry of service providers for IHSS customers. The PA also provides additional outreach for the special needs client by having three employees designated to work directly with these individuals to locate a provider once they have transitioned home. Every effort is made to assist the individual in locating a provider prior to authorization of hours; however, in the event a provider is not located, the individual's IHSS will still be approved and a referral is made to the PA to further assist the client with enrolling a provider. In contrast, the City and County of San Francisco has many agencies that can assist their clients in locating a provider and many provide in-home care services to any person who is unable to obtain services on their own, including those with special needs.

Alameda County has an automated tracking system, Service Management Access and Resource Tracking (SMART), but it differs greatly from the way in which San Francisco County's automated system, ICIS, is utilized. SMART is used primarily for indexing and case assignment only. However, it has the capacity to maintain a variety of tasks, including but not limited to: tracking case activities, calculating service hours, maintaining case narrative and identifying referrals, both received and made, including the sources from which they originated.

As a result of not having social workers dedicated exclusively to a hospital discharge function, it is possible that some individuals being discharged may not receive the immediate supportive care that is so essential to a successful recuperation period and transition back to community living. For example, in 2007, there were 23,108 discharges at the Alameda County Medical Center (ACMC) Highland Hospital Campus alone[10] resulting in an average of 1,925 discharges per month. Discharge numbers for Fairmont Skilled-Nursing Facility (SNF) and John George Psychiatric Facility would increase this number even further.

Referrals for IHSS are also initiated after the individual has returned home. However, considering the time-frame for processing the application and scheduling the home visit, an individual could lose valuable supportive services and could risk being subjected to adverse circumstances

Monterey County

The City and County of San Francisco far exceeds Monterey County in population, and the IHSS

[9]Based on an average extracted from FY 2007–2008 budget data

[10]Data received from the Alameda County Medical Center Business Office

business operation reflects this reality. As mentioned before, the City and County of San Francisco has a local overmatch of $50 million as opposed to Monterey County's total IHSS budget of $36 million. The San Francisco model serves a caseload of 19,000; Monterey's caseload is approximately 3,400 cases. The IHSS workforce in Monterey County consists of five intake workers and 10 case carrying workers. In addition, there is a Public Health Nurse (PHN) on staff who also works with Adult Protective Services. The PHN assists when an IHSS Social Worker has identified a health issue requiring medical assessment. In Monterey County, approximately 133 IHSS applications are submitted every month. Of those, only an average of five IHSS referrals or applications per month originates from local hospitals. This is important to mention since the average number of discharges from the Monterey County Hospital alone is approximately 600 individuals per month.

When analyzing and comparing San Francisco and Monterey's IHSS programs, it is important to keep in mind that the rules and regulations of the IHSS program are the same for all counties; the main goal of the program is to prevent institutionalization. Visiting people in the hospital and taking their application for the IHSS program prior to discharge is not a requirement. However, Senate Bill (SB) 633, enacted on October 2007, requires hospitals to have a written discharge planning policy and process. This policy requires that hospitals make appropriate post-hospital care arrangements prior to discharging a patient. Additionally, this new law requires hospitals to provide every discharged patient anticipated to be in need of long-term care with contact information for at least one public or nonprofit agency dedicated to providing information and referrals related to community-based long term care options. This bill is consistent with the US Supreme Court's decision in the 1999 case of *Olmstead v. L.C.* that requires federal, state, and local governments to develop cost-effective, community-based services to prevent or delay institutionalization. Enactment of this bill is a step toward improving procedures and tools that will enable more people to access the supportive services available in their communities.

In Monterey County there is no IHSS Hospital Discharge Unit, and the IHSS Social Workers typically visit the elderly and disabled individuals only in their homes. However, on occasion, the IHSS Social Worker initiates contact with an applicant in the hospital. Additionally, there is no formalized outreach to the local hospitals. Sporadically, designated IHSS staff participates in local discharge planning meetings with hospital discharge staff.

Studying the San Francisco IHSS model has been an invaluable experience for the BASSC participants. The IHSS program in Monterey County will benefit indirectly from this study because its purpose is to provide an impartial and objective approach for suggestions and/or recommendations for Monterey County IHSS operations related to expansion of services to discharged hospital and medical care facilities clients.

Recommendations and Opportunitites for Alameda and Monterey Counties

Reviewing the City and County of San Francisco's IHSS Hospital Discharge Liaison Unit and its processes, arrived at the conclusion that the establishment of this project took many years of work, many years of community advocacy, and finally a substantial commitment from the San Francisco City and County Board of Supervisors.

BASSC participants are jointly proposing that Alameda and Monterey Counties analyze and adopt the San Francisco City and County IHSS program's best practices and methodologies, as appropriate. The following are some identified ideas/suggestions specific to each county:

Alameda County

- Expand the utilization of the Service Management Access and Resource Tracking (SMART) system to provide essential reports that will assist in improving the quality, timeliness and consistency of service delivery.

- Track the origin of and type of all referrals for IHSS and evaluate the data to determine if the implementation of a Hospital Discharge Liaison Unit would be cost effective. If justified by the numbers, consider a Pilot Project using existing IHSS Social Workers to perform the Hospital Discharge Liaison function.
- Collaborate with the Alameda County Medical Center (ACMC) and other facilities to increase awareness of the IHSS program. Review the process by which Discharge Planners refer patients to IHSS.
- Continue to partner with the cities of Oakland and Fremont to explore ways of improving and expanding the delivery of services through the Multipurpose Senior Service Program (MSSP), Linkages, and Program of All-Inclusive Care for the Elderly (PACE).
- Explore other potential resources available in Alameda County to increase the pool of available programs and support services that will supplement the county's IHSS program.
- Advocate with the Board of Supervisors and solicit their support to increase awareness of the IHSS program in Alameda County.

Identifying those most vulnerable individuals who are at risk of post-discharge adversity during the up-front process is a proactive approach to closing service gaps. A successful collaboration with the ACMC and other health facilities can only benefit Alameda County, the Social Services Agency, and the community.

Monterey County

- Increase awareness among the older adult and disabled population about IHSS availability, by conducting IHSS outreach to residents of Monterey County being discharged from the local hospitals, and developing an IHSS informational brochure summarizing the program eligibility requirements and benefits. This could be accomplished by utilizing MC-Choice outreach workers, and enhancing the relationships between IHSS staff and hospital discharge planners.
- Network with local hospital discharge planners to promote the IHSS program and to establish a protocol with local hospitals for IHSS referrals, and explore the feasibility of social workers meeting the client in the hospital prior to discharge to begin the application process.
- Modify the current Area Agency on Aging contract for information and referral for seniors to include IHHS hospital discharge outreach.
- Develop and implement a fast track for Medi-Cal determinations in collaboration with the Community Benefits Branch.
- Invest in an IHSS tracking system similar to ICIS in San Francisco and use a "Uniform Assessment Tool" to determine functional abilities for the multiple supportive services available to elderly and disabled adults.
- Explore the feasibility of a financial partnership with local hospitals.

The IHSS Hospital Discharge Unit is a very significant component to the success of the San Francisco City and County model. In the current Monterey County IHSS model, these services may need to adapt and grow in order to serve an expected influx of older clients. This is especially imperative in Monterey County where the population of older adults is presently large and will continue to increase as baby boomers age. In addition to expanding, IHSS in Monterey County will also need to be tailored to meet the challenges and issues unique to the senior and disabled population.

While the philosophy and values of Monterey County will support the idea of some form of hospital discharge IHSS function, even at a lower scale, it is also evident that new funding must be identified.

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