M E M O R A N D U M

DATE: May 2, 2018

TO: Aging and Adult Services Commission

FROM: Department of Aging and Adult Services (DAAS)
Shireen McSpadden, Executive Director
Carrie Wong, Director, Long Term Care (LTC) Operations

SUBJECT: **Community Living Fund (CLF) Program for Case Management and Purchase of Resources and Services**

Annual Plan for July 2018 to June 2019

Section 10.100-12 of the San Francisco Administrative Code created the Community Living Fund (CLF) to fund aging in place and community placement alternatives for individuals who may otherwise require care within an institution. The Administrative Code requires that the Department of Aging and Adult Services prepare a CLF Annual Plan that will be submitted to the Aging and Adult Services Commission after a public hearing process, which will have input from the Department of Public Health (DPH) and the Long Term Care Coordinating Council (LTCCC). **Attached is the CLF Annual Plan for FY 18/19, which has been prepared by the Department of Aging and Adult Services (DAAS) for the continuing implementation of the CLF Program.**

The DAAS Long-Term Care Operations Director, Carrie Wong, continues to actively develop and maintain relationships with key stakeholders at the Department of Public Health, including:

- Barbara Garcia, Director of Public Health;
- Mivic Hirose, Executive Administrator, Laguna Honda Hospital (LHH) and Rehabilitation Center;
- Jennifer Carton-Wade, Assistant Hospital Administrator-Clinical Services, LHH;
- Janet Gillen, Director of Social Services, LHH;
- Colleen Riley, Medical Director, LHH;
- Luis Calderon, Director of Placement Targeted Case Management;
- Edwin Batongbacal, CBHS Director of Adult and Older Adult Services;
- Margot Antonetty, Manager of Direct Access to Housing/Homelessness/Outreach/Encampment Response, DHSH;
- Kelly Hiramoto, Acting Director Transitions, SF Health Network

COMMUNITY LIVING FUND ANNUAL PLAN
FY 2018/2019

PROGRAM PURPOSE, TARGET POPULATION, AND ELIGIBILITY

The CLF Program reduces unnecessary institutionalization by providing older adults and younger adults with disabilities or significant medical conditions with options for where and how they receive assistance, care and support. No individual willing and able to live in the community need be institutionalized because of a lack of community-based long-term care and supportive services.

The CLF serves adults whose incomes are up to 300% of the federal poverty level unable to live safely in the community with existing supports and funding sources (for detailed eligibility criteria, see Appendix A). The target population includes two primary sub-populations: (1) Patients of Laguna Honda Hospital (LHH), San Francisco General Hospital (SFGH) and other San Francisco skilled nursing facilities (SNFs) who are willing and able to live in the community and ready for discharge; and (2) Individuals who are at imminent risk for nursing home or institutional placement, willing and able to remain living in the community with appropriate support.

PROGRAM IMPLEMENTATION PLAN

The basic structure of the CLF remains unchanged from FY 18/19, as follows.

Overview
The CLF Program provides the resources and services necessary to sustain community living when those services are not available through any other mechanism. Most CLF clients receive case management and/or purchased services from the CLF lead contractor, the Institute on Aging (IOA), and its subcontractors.

Program Access and Service Delivery
Prospective clients are screened by the DAAS Intake and Screening Unit for program eligibility and offered referrals for alternative resources when they are available. For example, if clients need emergency meals, they are referred on to Meals on Wheels for expedited services. Clients who meet initial eligibility criteria are referred on to the IOA for a final review. Clients are accepted for service or placed on the wait list, depending on their emergent needs and program capacity at that time. When the referral is accepted, the IOA CLF Director will determine which Care Manager is best able to serve the needs of the individual, which will be based on language, culture and/or service needs (see Appendix B for a summary of partner agencies and their specialties).

The Care Manager then contacts the client, confirms the client's desire to participate in the program, completes a formal application, and conducts an in-home or in-hospital assessment. The initial assessment is the tool with which the Care Manager, the participant and family, or other informal support systems, determine what is needed in order for the participant to remain living safely in the community or return to living in the community. A plan to address those needs is also developed. If the participant is already working with another community Care Manager, the CLF Care Manager will coordinate the home assessment with him/her. The entire assessment process should be completed within one month.

CLF Care Managers make referrals to other services and follow-up on those referrals to be sure the client receives the services required. When there are no alternative resources available to provide identified services or goods, the CLF Care Manager purchases the necessary services or items, with approval from the clinical supervisor. Care Managers follow special database coding protocols for purchases that may be reimbursed to CLF through California Community Transitions (CCT) or the Nursing Facility In-Home Operations Medi-Cal Waiver (IHO) (IHO Waiver will replaced by the Medi-Cal Home and Community-Based Alternatives (HCBA) Waiver) (See updates on "Anticipated Budget and Policy Considerations".).

Once services are in place, the Care Manager monitors the situation by maintaining regular contact with the participant and/or family and primary community Care Manager if there is one. Care Managers see clients as often as necessary to ensure they are receiving the services they need to remain living safely in the community. Clients are expected to have a minimum of one home visit per month. For individuals who are discharged from Laguna Honda Hospital and other SF skilled nursing facilities (SNFs), Care Managers have weekly face-to-face contact for the first month post-discharge, then every other week for the next two months, and then monthly after that. Should new problems arise, they are incorporated into the existing service plan and addressed.

CLF continues with ongoing efforts to address the challenges of clients with substance abuse and mental health needs. Every Care Manager participates in psychologist-facilitated care conferences twice a month. These include an in-depth case review, follow-up on progress from previous case recommendations, and skill building training. Care managers continue to make notable progress in connecting clients to mental health treatment.

In addition to the traditional CLF model of intensive case management with purchase of services, there are many clients who already have a case manager but need tangible goods and purchases to remain stably housed in the community. The CLF Care Coordinator role, which is a purchasing Case Manager at Catholic Charities, can assist these clients who have a purchase-only need. With a caseload size of about 30-40 clients, the Care Coordinator completes a modified assessment for expedited enrollment will allow clients who meet CLF eligibility and are enrolled in other case management to access the purchase of goods and services more efficiently. This flexibility allows CLF to serve more clients and have a more extensive community reach to prevent premature institutionalization.

ANTICIPATED BUDGET AND POLICY CONSIDERATIONS

Going into FY 18/19, CLF expenditures have continued to be stable with a surplus. The plans for this upcoming year include:

- In December 2017, with support from DAAS, DPH, and SF Health Plan, Institute on Aging submitted a proposal to DHCS to serve as the designated 'Waiver Agency' in San Francisco for the new Medi-Cal Home and Community-Based Alternatives (HCBA) Waiver. Across the state, the HCBA Waiver will replace the In-Home Operations (IHO) NF Waiver. The HCBA Waiver doubles the total number of slots across the state and shifts more administration functions of the waiver to the local level. San Francisco residents currently

enrolled in IHO are expected to have the opportunity to transition their care to the HCBA Waiver. As done previously with the IHO Waiver and California Community Transitions, the intent is to leverage the CLF program infrastructure already in place at Institute on Aging to draw down these additional Medi-Cal resources. Institute on Aging received a 'Notice of Intent to Award' from DHCS in late February 2018. Contracting between DHCS and Institute on Aging is anticipated to occur in Spring 2018. In FY 18/19, clients with the IHO Waiver will be transitioned to HCBA Waiver.

- Concerted efforts to promote care coordination for CLF referrals who meet criteria for Scattered Site Housing (SSH) through the Brilliant Corners contract will continue into FY1819. The SSH housing units added flexibility to the CLF housing portfolio in transitioning individuals who would have otherwise not been able to return to the community due to lack of housing options. As the CLF population is generally frail when stepping down to community living, Brilliant Corners exchanged existing housing slots in order to accommodate equipment and overnight providers. Hosted by IOA, the multi-disciplinary team composed of CLF, BC, DAAS, and LHH will continue to meet monthly to discuss referrals and transition issues. Access to the SSH slots are only available after approval from the CLF and based on client needs and placement appropriateness.

- Since FY 16/17, CLF supported the contract with Shanti Project/PAWS (Pets are Wonderful Support) Animal Bonding Services for Isolated LGBT Seniors and Adults with Disabilities who meet CLF criteria. CLF increased the Shanti Project/PAWS capacity to assist low-income and frail individuals by funding the purchases of tangible goods and services such as pet food, pet supplies, medication, and pet health services. Outcomes included self-reports of positive health impacts and affirmation that the CLF-funded goods and services had reduced their risk for hospitalization (93%) and prevented institutionalization (87%). CLF is supporting this contract in FY 17/18 and anticipates continuing to the support in FY 18/19.

CASE MANAGEMENT TRAINING

Case management training is an essential component in building the capacity and overall workforce development. In FY 1819, in response to the needs of the community-based organizations to have flexibility and diversity of topics, these training funds will be distributed to case management contractors to provide training to their staff. Any training will be pre-approved by DAAS/OOA staff. This will replace Case Management Training Institute (CMTI) which ended in October 2016.

ACCOUNTABILITY: REPORTING, EVALUATION, AND COMMUNITY INPUT

DAAS's plans for reporting and evaluation of the CLF Program are detailed below.

Data Collection & Reporting

DAAS is committed to measuring the impact of its investments in community services. The CLF program consistently met and exceeded its goals to support successful community living for those discharged or at imminent risk of institutionalization. Beginning FY 15/16, DAAS shifted to focus on the measures below:

- Percent of clients with one or fewer admissions to an acute care hospital within a six month period. Target: 80%.

CLF program is anticipated to continue to exceed the performance measure target of clients having one or fewer unplanned admissions.

- Percent of care plan problems resolved, on average, after one year of enrollment in (excludes clients with ongoing purchases). Target: 80%.

CLF program will continue to make progress towards the target this year. This measure reflects the complexity of the population served: clients tend to have complex needs that take time to resolve or develop new care needs to remain stable in the community. However, while a subset of clients will always have less than 100% performance due to ongoing care needs, review of client records has identified that staff training related to database utilization is needed to ensure care plan items are updated throughout enrollment. In FY 18/19, DAAS and the CLF program will enhance staff training to ensure that documentation, and operational processes support data integrity and accuracy of these performance measurements.

CLF currently meets the new city ordinance that requires collection of sexual orientation and gender identity data effective July 2017. IOA/CLF has adopted DAAS' standardized demographic indicators and the reporting of sexual orientation.

Consumer Input

The CLF Advisory Council first met in January 2009 and continues to meet quarterly. The Council is comprised of representatives from consumers, partner agencies, and community representatives. The Advisory Council reviews the consumer satisfaction surveys, waiting list statistics, program changes and other issues which may affect service delivery.

CLF continues to obtain consumer input through Satisfaction Surveys for CLF participants. On an annual basis, clients who are enrolled in the CLF Program are asked to complete a satisfaction survey that covers satisfaction with general services, social worker satisfaction, service impact and overall satisfaction with the entire CLF program. For FY 18/19, Vital Research was retained to implement a mixed methodology of mailed surveys followed by telephone interviews.

TIMELINE

The DAAS Long Term Care Operations Director and the IOA will review monthly reports of service utilization and referral trends, as described in the reporting section, above. The following table highlights other important dates for public reporting.

Timeline of Public Reporting – FY 2018/2019	
Quarter 1: July – September 2018	▪ *August:* Prepare Six-Month Report on CLF activities from January through June 2017.
Quarter 2: October – December 2018	▪ *November:* Submit Six-Month Report to Aging and Adult Services Commission for review and forward to the Board of Supervisors, Mayor's Office, LTCCC, and DPH.
Quarter 3: January – March 2019	▪ *February:* Prepare Six-Month Report on CLF activities from July through December 2017. ▪ *March:* Submit Six-Month Report to Aging and Adult Services Commission for review and forward to the Board of Supervisors, Mayor's Office, LTCCC, and DPH.
Quarter 4: April – June 2019	▪ *April/May:* Prepare FY 18/19 CLF Annual Plan draft, seeking input from the LTCCC and DPH. ▪ *June:* Submit FY 18/19 CLF Annual Plan to Aging and Adult Services Commission for review and forward to the Board of Supervisors, Mayor's Office, LTCCC, and DPH.

ANTICIPATED EXPENDITURES

At the conclusion of FY 18/19, it is estimated that the CLF program will have spent a total of $53.7 million since the program's inception. As a result of time studying by staff of the IOA and partner agencies, the CLF program funding is projecting expenditures and revenues of $6.7 million for FY 18/19.

FY 18/19 Community Living Fund Budget	
IOA Contract and subcontractors	
Purchase of Service	$1,659,739
Case Management	$1,689,562
Operating and Capital	$629,814
Indirect	$292,406
Total IOA Contract	**$4,271,521**
Brilliant Corners (Scattered Site Contract)	$3,080,814
Additional Offsetting Revenues:	
CCT/IHO Reimbursement	($140,000)
Unspent funds from overall CLF program	($1,366,228)
	($1,506,228)
DAAS Internal Staff Position Funding	
Staff Salaries	$425,347
Fringe Benefits	$188,681
Additional Program-Related areas:	
Case Management Training Institute	$121,800
Shanti Project/PAWS	$75,000
DPH RTZ work order	$96,000
TOTAL	**$6,752,935**

APPENDIX A: ELIGIBILITY CRITERIA

To receive services under the CLF program, participants must meet all of the following criteria:

1. Be 18 years or older
2. Be a resident of San Francisco
3. Be willing and able to be living in the community with appropriate supports
4. Have income no more than 300% of federal poverty level for a single adult: $36,420 plus savings/assets of no more than $6,000 (Excluding assets allowed under Medi-Cal). Reflects the 2018 Federal Poverty guideline of $ 12,140 for individuals.
5. Have a demonstrated need for a service and/or resource that will serve to prevent institutionalization or will enable community living.
6. Be institutionalized or be deemed at assessment to be at imminent risk of being institutionalized. In order to be considered "at imminent risk", an individual must have, at a minimum, one of the following:
    a. A functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transfer, bathing, toileting, and grooming; or
    b. A medical condition to the extent requiring the level of care that would be provided in a nursing facility; or
    c. Unable to manage one's own affairs due to emotional and/or cognitive impairment; and a functional impairment in a minimum of 3 Instrumental Activities of Daily Living (IADL): taking medications, stair climbing, mobility, housework, laundry, shopping, meal preparation, transportation, telephone usage and money management.

Specific conditions or situations such as substance abuse or chronic mental illness shall not be a deterrent to services if the eligibility criteria are met.

APPENDIX B: CLF CONTRACTORS

Agency	Specialty	Average Caseload per Care Manager
Institute on Aging	Program and case management supervision, 11 city-wide intensive Care Managers; 1 Program Aide 1 IHO/CCT/QA CM	15–22 intensive 10-20 banked cases 30-40 non intensive
IOA Subcontractors*:*		
Catholic Charities CYO	1 Citywide Care Manager 1 Care Coordinator	15-22 intensive 40-50 cases
Conard House	1 Money Management Care Manager	40-50 cases
HealthRight 360	1 Care Manager with substance abuse expertise.	15-22 intensive