M E M O R A N D U M

DATE: June 18, 2013

TO: Aging and Adult Services Commission

FROM: Department of Aging and Adult Services (DAAS)
Anne Hinton, Executive Director
Linda Edelstein, 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 2013 to June 2014

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 13/14, which has been prepared by the Department of Aging and Adult Services (DAAS) for the continuing implementation of the CLF Program.**

The DAAS LTC Director of Operations, Linda Edelstein, 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;
- 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, Interim Director of Housing and Urban Health;
- Kelly Hiramoto, Director of Placement, DPH

COMMUNITY LIVING FUND ANNUAL PLAN
FY 2013/2014

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) and San Francisco General Hospital (SFGH) 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. The first of these sub-populations is the top priority for the program. Historically, that group has constituted approximately 30 percent of all clients, though the percentage was higher (47%) in the first six months of FY 12/13.

PROGRAM IMPLEMENTATION PLAN

The basic structure of the CLF remains unchanged from FY 12/13, 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. A smaller number of clients receive expedited transitional care or emergency meals services from the San Francisco Senior Center/Northern California Presbyterian Homes and Services (SFSC/NCPHS) or Meals on Wheels.

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. If clients need transitional care or emergency meals, they are referred on to SFSC/NCPHS or Meals on Wheels for expedited services. All other clients who meet initial eligibility criteria are referred on to the IOA for a final review. The client is 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 partner agency 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 MediCal Waiver (IHO).

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, 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. Case managers are making notable progress in connecting clients to mental health treatment.

ANTICIPATED BUDGET AND POLICY CONSIDERATIONS

Going into FY 12/13, CLF expenditures have continued to be stable with a small surplus. The plans for this upcoming year include:

- SF Health Plan will contract with DAAS to provide assessment and case management services for CBAS participants enrolled in their health plan. DAAS will provide these services through CLF infrastructure. The expectation is a census of 400 or more, a small portion of whom may be enrolled in the full CLF program if additional services are needed and not available through any other source.
- CLF, in collaboration with Laguna Honda Social Services, is focusing on engaging Diversion and Community Integration Program (DCIP) clients in meaningful community activities prior to discharge. This includes enrolling at City College of San Francisco, initiating services with vocational rehab programs, or visiting Community Based Adult Services (CBAS) sites before leaving Laguna Honda. This, along with engaging with providers from CLF and

IHSS early on in the discharge process helps manage some of the anxiety and uncertainty of the transition.

- Through its work with the Medi-Cal waiver programs and California Community Transitions project, CLF continues to transition a small number of individuals home from non-Laguna Honda long term SNF beds in San Francisco. Housing for these non-DCIP SNF residents continues to be the primary barrier.
- CLF is partnering with SF acute hospitals and with the DAAS Adult Protective Services program to target high need clients. In some cases those clients need additional support to return to the community and in other cases the program facilitates remaining stable in the community.

LONG TERM CARE INTEGRATION STRATEGIC PLAN FOR SAN FRANCISCO

Long-term care integration (LTCI) is defined as the integration of home and community-based long-term care services with the delivery of primary and acute care services, and institutional long-term care services, for older adults and adults with disabilities.

With the development and implementation of California's Coordinated Care Initiative, the state has begun the process of integrating health care and supportive services while looking to reduce escalating health care costs. To address these issues, San Francisco has developed a Strategic Plan with recommendations to guide improvements in the organization, availability, and financing of long-term services and supports. The CLF is expected to serve as a model for understanding best practices for assisting individuals to return to community living from institutional settings.

In particular, one recommendation from the LTCI strategic plan states that: *Given the current direction of CMS regarding de-institutionalization, DAAS and DPH should examine the value provided by best practice program models that assist older adults and adults with disabilities to return to community living. The use of such models could be beneficial for transitions from all nursing homes throughout the City. Specifically, DAAS and DPH should undertake a programmatic and financial analysis of the Diversion and Community Integration Program (DCIP). DAAS alone should undertake a programmatic and financial analysis of the Community Living Fund (CLF). Following the analyses, DAAS and DPH should formulate a plan to utilize these and/or similar programs to assist older adults and adults with disabilities residing in nursing homes throughout San Francisco to return to community living. Toward this end, DAAS and DPH should also use these or similar programs in close collaboration with the San Francisco Health Plan and Anthem Blue Cross, San Francisco's two managed care Health Plans, to facilitate community living for their clients.*

DAAS CARE MANAGEMENT TRAINING INSTITUTE

In April 2013, DAAS released a new RFQ for the Case Management Training Institute. The program is expected to start July 2013. The scope of services aims to avoid duplication of

prior training for continuing staff, and takes into consideration the changing environment of services in the context of managed care.

ACCOUNTABILITY: REPORTING, EVALUATION, AND COMMUNITY INPUT

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

Data Collection & Regular Reporting

Both the DAAS Long Term Care Intake and Screening Unit and the CLF contractor collect client data. The CLF contractor will continue to work closely with DAAS and the HSA Planning Unit staff to ensure that the program protocols will allow for appropriate and accurate collection of data for evaluation and program design analysis. In FY 13/14, staff will continue to fine-tune data collection and reporting at the DAAS I&S unit and at the CLF lead contractor agency.

Six Month Reports: DAAS will share highlights of program referral demographics, common barriers to community living, program activities and challenges, and summaries of costs incurred, with the Commission on Aging and Adult Services, the Board of Supervisors, the Mayor's Office, the Long Term Care Coordinating Council, and the Department of Public Health every six months.

Annual Reports: The CLF contractor will report annually on the following outcome objectives:

- Improved and streamlined CLF program design, population targeting, and data collection mechanisms. This will be achieved via participation in DAAS program evaluation activities, as needed, which will provide a feedback mechanism to identify barriers to implementation and provision of services.
- Clients served through the program will be satisfied with the services received and find that they are beneficial and improve quality of life, as measured by a satisfaction survey or assessment tool.
- Successfully support community living for a period of at least six months for at least 80% of CLF clients who are being discharged from LHH at the time of enrollment. Identify reasons for re-institutionalization when it occurs.
- Successfully support community living for a period of at least six months for at least 80% of CLF clients who were at imminent risk of institutionalization at the time of enrollment. Identify reasons for institutionalization when it occurs.

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.

Anonymous yearly surveys are mailed to participants to determine if their needs are being met through the program. Survey results are compiled and reviewed by the Supervisor, the

IOA Site Director and the Partner Agencies. Surveys are mailed monthly to consumers who have been discharged from CLF the previous month, and annually to all continuing clients. Survey results are regularly reported in the CLF 6-month reports.

TIMELINE

The DAAS Long Term Care Director of Operations 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 2013/2014	
Quarter 1: July – September 2013	▪ *August:* Prepare Six-Month Report on CLF activities from January through June 2013. ▪ *August/September:* Share information with LTCCC
Quarter 2: October – December 2013	▪ *October:* 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 2014	▪ *January:* Prepare Six-Month Report on CLF activities from July through December 2013. ▪ *January:* Share information with LTCCC ▪ *February:* 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 2014	▪ *April/May:* Prepare FY 14/15 CLF Annual Plan draft, seeking input from the LTCCC and DPH. ▪ *June:* Submit FY 14/15 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 12/13, it is estimated that the CLF program will have spent a total of $21.7 million since the program's inception. As a result of time studying by staff of the IOA and partner agencies, the CLF program funding will continue projecting expenditures and revenues of $3.8 million for FY 13/14. In May, 2013, the IOA Contract was modified to include the expenditure of several different revenues and corresponding expenditures or pass throughs, mainly in the arena of the evolving Community Based Adult Services (CBAS) replacement of the Adult Day Health Center (ADHC) program. For FY 13/14, there is an expenditure increase of approximately $176,000, as well as corresponding revenue from the SF Health Plan, to reflect the CBAS assessment service that is being contracted.

	FY 13/14 Budget
IOA Contract and subcontractors	
Purchase of Service	$1,250,683
Case Management	$1,742,438
Operating and Capital	$529,605
Indirect	$323,316
Total IOA Contract	**$3,846,042**
Grace Funding	($94,668)
Local Revenue for CBAS assessments	($176,000)
CCT/IHO Reimbursement	($140,000)
Unspent funds from overall CLF program	($484,454)
DAAS Internal	
Staff Salaries	$356,075
Fringe Benefits	$156,994
Case Management Training Institute	$120,000
DPH RTZ work order	$120,000
Additional Program-Related areas:	
Emergency Meals program through Meals on Wheels	$91,800
Homecoming Services Network through San Francisco Senior Center	$38,150
TOTAL	**$3,833,939**

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: $34,470 plus savings/assets of no more than $6,000 (Excluding assets allowed under Medi-Cal). Reflects the 2013 Federal Poverty guideline of $11,490.
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	15 – 22 intensive cases; 10-20 banked cases
IOA Subcontractors*:*		
Catholic Charities CYO	1 Citywide Care Manager.	15 - 22 intensive
Conard House	1 Money management Care Manager	40-50 cases
HealthRight 360	1 Care Manager with substance abuse expertise.	15 - 22 intensive
Expedited Services		**Annual caseload**
SF Transitional Care Program: SFSC/NCPHS	Transitional care purchase needs for immediate post acute hospital discharge.	100-150 persons/year; 10/month
Meals on Wheels	Short-term emergency home-delivered meals	Approx 150 persons/year