M E M O R A N D U M

DATE: April 3, 2019

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 2019 to June 2020

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 19/20, 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:

- Dr. Grant Colfax, 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;
- Dr. Michael McShane, 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, HSH;
- Kelly Hiramoto, Director of Transitions, SF Health Network

COMMUNITY LIVING FUND ANNUAL PLAN
FY 2019/2020

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 Program serves adults whose incomes are up to 300% of the federal poverty level and unable to live safely in the community without 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), Zuckerberg San Francisco General (ZSFG) 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 supports.

PROGRAM IMPLEMENTATION PLAN

The basic structure of the CLF Program 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 Medi-Cal Home and Community-Based Alternatives (HCBA) Waiver (formerly Nursing Facility In-Home Operations Medi-Cal Waiver or IHO) (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.

The CLF Program 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 19/20, CLF expenditures have continued to be stable with a surplus. The plans for this upcoming year include:

- Beginning in Fall 2018, Institute on Aging (IOA) began serving 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 is replacing 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. During FY 18/19, all existing clients receiving the IHO Waiver will be transitioned to the HCBA Waiver.

- In January 2019, U.S. Congress passed stop gap funding for Money Follows the Person (known as California Community Transitions). If the funding continues into the FY 19/20, CLF may be able to continue to leverage this funding to transition individuals from skilled nursing facilities back into the community.

- The Integrated Housing Model will continue into FY 19/20 and will facilitate care coordination for CLF referrals who meet criteria for Scattered Site Housing (SSH) through the Brilliant Corners (BC) contract. IOA hosts the monthly multi-disciplinary team including BC, DAAS, and LHH to discuss referrals and transition issues. A robust pipeline is essential for effective and efficient transitioning of individuals from LHH to the community. Access to the SSH slots are only available after CLF approval and are based on client needs and placement appropriateness. The SSH housing units continue to add 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 appropriate housing options.

- CLF has been supporting the contract with Shanti Project/PAWS (Pets are Wonderful Support) Animal Bonding Services for Isolated LGBT Seniors and Adults with Disabilities since FY 16/17. For many, pets are considered family members, and individuals will often delay or forego own needs in order to meet their pet's needs. CLF helps increase the Shanti Project/PAWS capacity to assist low-income and frail individuals who meet CLF criteria by funding the purchases of tangible goods and services such as pet food, pet supplies, medication, and pet health services. Previous outcomes from FY17/18 included self-reports of positive health impacts and affirmation that the CLF-funded goods and services had reduced participants' risk for hospitalization (93%) and prevented institutionalization (87%). While FY 18/19 outcomes are not yet available, CLF anticipates continuing support in FY 19/20.

- Overseen by the California Department of Social Services (CDSS), Housing and Disability Income Advocacy Program (HDAP) is a county-administered program that assists individuals with disabilities who are experiencing homelessness apply for disability benefit programs and provides housing assistance during the application period. Since Spring 2018, the CLF program has been transitioning these individuals into housing identified by HDAP, using intensive case management and purchases of services when appropriate. Thus far, there have been 13 individuals served (Annual target is approximately 30 individuals.). CLF will continue to support the HDAP program in FY 19/20, with the goals to help access to HSA's robust Social Security Income (SSI) Advocacy Program; link to supportive housing though a subsidy; provide case management and housing stabilization services; and plan for a successful transition from the program when SSI is awarded.

- In FY 18/19, San Francisco's Adult Protective Services program was awarded $773,981 over two years to implement a pilot known as Home Safe, to provide flexible, short-term intervention to its clients at imminent risk of homelessness. The pilot, which will begin in July 2019, is based on a partnership between APS, the San Francisco's Department of Homelessness and Supportive Housing (HSH), and IOA. APS clients screened and deemed eligible for Home Safe will receive tailored interventions based on the CLF program model, including intensive case management services, purchase of goods and services to support

stability in the community, and emergency placement in assisted living facilities for those clients in need of a higher level of care. Clients who are not eligible for Home Safe will be served as traditional APS clients, and will receive protective service interventions and resource connections best suited to meet their needs and mitigate the risk of abuse and/or neglect, including self-neglect.

- The CLF Program aims to serve a population that is representative of San Francisco's diverse population. IOA has had focused efforts in FY 18/19 to increase reach to a broader ethnic demographic, specifically the Asian and Pacific Islander (API) population, including adding a partnership with Self-Help for the Elderly as well as hosting a number of API focused roundtables to assess unmet community needs. IOA will also continue outreach to other skilled nursing facilities in San Francisco, in addition to Laguna Honda Hospital. These and other efforts will continue into FY 19/20.

- After passing in both the State Assembly and State Senate, AB 2233 to expand the Assisted Living Waiver (ALW), operated by California Department of Health Care Services (DHCS), was vetoed by the Governor in September 2018. Advocacy for the needed expansion of this resource is necessary to increase the total number of waiver slots given the lengthy waitlist that began in 2017. The ALW leverages federal dollars resulting in ALW participants paying for their room and board, while Medi-Cal pays for care and services. Care Coordination Agencies are local organizations responsible for enrolling participants in the waiver by completing a standard assessment tool to determine level of care. IOA is currently administering ALW and ALW-like programs in San Mateo, Santa Clara, Riverside, and San Bernardino counties. IOA will seek to serve as a Care Coordinator Agency in San Francisco County.

- Case management training is an essential component in building the capacity and overall workforce development. In FY 19/20, a training curriculum will be launched to community-based organizations with a diversity of topics based on current trends and issues. Successful trainings in the past included Motivational Interviewing, Suicide Risk Assessment, Depression Screening, and Cognitive Behavioral Therapy.

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%.

The 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%.

The 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 19/20, 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. This includes upgrades to the service plan tool implemented in FY 18/19 that care managers use to set goals with clients and track progress towards these goals.

CLF currently meets the new city ordinance that requires collection of sexual orientation and gender identity data effective July 2017. IOA 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.

IOA obtains consumer input through the 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. In 2018, clients overall reported that the CLF Program meets or exceeds (92%) their needs and expectations with 93% having recommended the program to others.

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 2019/2020	
Quarter 1: July – September 2019	▪ *August:* Prepare Six-Month Report on CLF activities from January through June 2019.
Quarter 2: October – December 2019	▪ *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 2020	▪ *February:* Prepare Six-Month Report on CLF activities from July through December 2019. ▪ *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 2020	▪ *April/May:* Prepare FY20/21 CLF Annual Plan draft, seeking input from the LTCCC and DPH. ▪ *June:* Submit FY20/21 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 $61 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 $7.6 million for FY 19/20.

IOA Contract and Subcontractors	
Purchase of Service	$ 1,912,968
Case Management	$ 1,729,414
Operating and Capital	$ 617,800
Indirect	$ 339,817
*Housing & Disability Income Advocacy Program (HDAP)	$ 257,392
Total IOA Contract	**$ 4,857,392**
Brilliant Corners (Scattered Site Contract)	$ 3,075,814
Additional Offsets & Revenues:	
*HDAP	$ (257,392)
Federal Reimbursement for Community Services Block Grant	$ (1,096,321)
Unspent funds from overall CLF Program	$ 237,326
Total	$ (1,116,387)
DAAS Internal Staff Position Funding:	
Staff Salaries	$ 435,365
Fringe Benefits	$ 187,539
Additional Program-Related Areas:	
Shanti Project/PAWS	$ 75,000
RTZ Contract	$ 96,000
TOTAL	**$ 7,610,722**

**Additional City support outside of CLF*

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 2019 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	18–22 intensive
IOA Subcontractors:		
Catholic Charities CYO	1 Care Manager 1 Care Coordinator	18-22 intensive 24 cases
Conard House	1 Money Management Care Manager	40-50 cases
Self Help for the Elderly	1 Care Manager/Social Worker	18-22 intensive