M E M O R A N D U M

DATE: May 3, 2023

TO: Disability and Aging Services Commission

FROM: Department of Disability and Aging Services (DAS)
Kelly Dearman, Executive Director
Michael Zaugg, Director of Office of Community Partnerships

SUBJECT: **Community Living Fund (CLF) Program for Case Management and Purchase of Goods and Services - Annual Plan for July 2023 – June 2024**

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 Disability and Aging Services (DAS) prepare a CLF Annual Plan that will be submitted to the Disability and Aging 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 22/23, which has been prepared by DAS for the continuing implementation of the CLF Program.

The Director of Office of Community Partnerships at DAS, Michael Zaugg, continues to actively develop and maintain relationships with key stakeholders at the Department of Public Health and other City agencies, including:

- Dr. Grant Colfax, Director, Department of Public Health;
- Roland Pickens, Interim Chief Executive Officer, Laguna Honda Hospital (LHH) and Rehabilitation Center, and Director, San Francisco Health Network;
- Irin Blanco, Director of Care Coordination, LHH;
- Janet Gillen, Director of Social Services, LHH;
- Dr. Claire Horton, Interim Medical Director, LHH;
- Luis Calderon, Director of Placement, Targeted Case Management;
- Edwin Batongbacal, Director of Adult and Older Adult Services, Community Behavioral Health Services;
- Dee Rosado-Chan, Deputy Director for Programs, Department of Homelessness and Supportive Housing;
- Laura Liesem, Chair, Long Term Care Coordinating Council

COMMUNITY LIVING FUND ANNUAL PLAN
FY 2022/2023

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 Hospital (ZSFG), and other San Francisco skilled nursing facilities (SNFs) who are ready for discharge and are willing and able to live in the community; and (2) Individuals who are at imminent risk for nursing home or institutional placement but are 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 22/23. An additional component of the program is the addition of services provided through contract with the San Francisco Health Plan Enhanced Care Management service as part of the CalAIM (California Advancing and Innovating Medi-Cal) program.

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 participants receive case management and/or purchased goods and services from the CLF lead contractor, the Institute on Aging (IOA), and its subcontractors.

Program Access and Service Delivery

Prospective participants are screened by the DAS Intake and Screening Unit for program eligibility and offered referrals for alternative resources when they are available. For example, if participants need emergency meals, they are referred on to Meals on Wheels for expedited services. Participants who meet initial CLF eligibility criteria are referred on to IOA for a final review. Participants 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 CLF Care Manager then contacts the participant, confirms the participant's desire to enroll 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 CLF Care Manager, the participant and family, or other informal support systems, determine what is needed for the participant to live safely 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 participant receives the services required. When there are no alternative resources available to provide identified goods or services, the CLF Care Manager purchases the necessary items or services, with approval from the CLF Clinical Supervisor.

Once services are in place, the CLF Care Manager monitors the situation by maintaining regular contact with the participant and/or family and primary community care manager, if there is one. CLF Care Managers see participants as often as necessary to ensure they are receiving the services they need to remain living safely in the community. Participants are expected to have a minimum of one home visit per month. For individuals who are discharged from Laguna Honda Hospital and other San Francisco skilled nursing facilities (SNFs), CLF 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 thereafter. 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 participants with substance abuse and mental health needs. Every CLF 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. CLF Care Managers continue to make notable progress in connecting participants to mental health treatment.

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

ANTICIPATED BUDGET AND POLICY CONSIDERATIONS

Going into FY 22/23, CLF expenditures have continued to be stable. The plans for this upcoming year include:

- The Integrated Housing Model continues into FY 23/24 and will facilitate care coordination for CLF referrals who meet criteria for Scattered Site Housing (SSH) through a contract with Brilliant Corners. The Community Options and Resource Engagement (CORE) multi-

disciplinary team meeting is held bi-monthly and includes the CLF provider (Institute on Aging), BC, DAS, and LHH to discuss referrals of participants and their transition needs. A robust pipeline is essential for effective and efficient transitioning of individuals from LHH and other SNFs to the community. Access to the SSH slots are only available after CLF approval and are based on participant needs and placement appropriateness. The SSH 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.

- The CLF Program continues to partner with the DAS Public Guardian (PG) Office to provide housing subsidies available to participants connected to PG that are meet criteria for CLF services and have the highest level of financial needs with no other alternatives available. While CLF has not received any new referrals during this period, one participant was successfully connected to the Assisted Living Waiver and disenrolled for CLF services. The program will continue collaborating with the PG office to support new referrals in the next months.

- CLF is committed to offer responsive and inclusive services to the diverse community of San Francisco. The program will continue to implement outreach initiatives to access the Asian and Pacific Islander and the LGBTQ+ communities by participating in community partnerships, coordinating training services, and providing in-service presentations to local organizations. The program will also continue its focus on professional development and related opportunities that support and promote cultural humility and competencies of CLF staff in the services offered to the community. During FY23/24 The CLF Program plans to refer participants to the Openhouse Mental Health Program for LGBTQ Elders and explore other opportunities for collaboration between the two organizations.

- During FY 23/24, the CLF program will follow guidelines from the Department of Public Health (SFDPH) and Centers for Disease Control and Prevention (CDC) to respond to the needs of the community in the prevention of COVID-19 spread. California's COVID-19 State of Emergency is over, however COVID-19 cases are still being reported by CLFP participants so IOA will continue to keep taking steps to prevent the spread. The program will offer remote services when requested by participants and will supply staff in the field with enhanced Personal Protective Equipment for essential visits when indicated. This approach will continue through FY 23/24, as necessary.

- The CLF Program will include Enhanced Care Management services through the CalAIM (California Advancing and Innovating Medi-Cal) state initiative for members of the San Francisco Health Plan (SFHP) who are adults living in the community who are at risk for long-term care institutionalization as well as nursing facility residents transitioning to the community. Enhanced Care Management for these two populations of focus align with the goals of CLFP.

- CLF continues to be a core partner of the San Francisco Aging and Disability Resource Connection (ADRC) and has a representative that serves on the ADRC advisory committee. The goal of the ADRC is to develop long-term support infrastructure to increase consumer access to home and community-based long-term services and supports and to divert persons

with disabilities and older adults from unnecessary institutionalization. The ADRC brings together key stakeholders to streamline community-based services for older adults and people with disabilities, educate the public about the rich array of services available to support community-based living and aging in place, and provide human service organizations with an avenue through which knowledge, resources, and opportunities can be shared.

- During FY 23/24, CLF program plans to continue the utilization of the California Community Transitions (CCT) program to leverage supplemental funding through Medi-Cal services. This program has been beneficial in the ability for CLFP to support LHH participants that require caregiver supports while waiting to be connected to a provider from In Home Social Services (IHSS). Going into FY 23/24, CLF will continue to collaborate with the Department of Health Care Services (DHCS) to connect participants to CCT and other waivers and Long-Term Services and Supports (LTSS) that can promote community living.

ACCOUNTABILITY: REPORTING, EVALUATION, AND COMMUNITY INPUT

Plans for reporting and evaluation of the CLF Program are detailed below.

Data Collection & Reporting

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

❖ Percent of participants with one or fewer admissions to an acute care hospital within a six-month period. Target: 85%.

The CLF Program is anticipated to continue to exceed this performance measure target of participants having one or fewer unplanned admissions.

❖ Percent of care plan problems resolved, on average, after one year of enrollment in the CLF Program (excludes participants with ongoing purchases). Target: 70%.

The CLF Program will continue to make progress towards this performance measure target in FY 23/24. This measure reflects the complexity of the population served as CLFP participants tend to have high personal and safety needs to live safely in the community. For many, care plan interventions take time to develop and resolve. However, while a subset of participants will always have less than 100% of their care plan problems resolved due to ongoing care needs, the program will continue to ensure care plan items are updated throughout enrollment through ongoing supervision, training, and oversight on database utilization.

CLF has been meeting the city ordinance that requires collection of sexual orientation and gender identity data effective July 2017. IOA has adopted DAS' standardized demographic indicators and the reporting of sexual orientation and gender identity.

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 Survey for CLF participants. On an annual basis, participants 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 2022, 95% of participants reported that the CLF Program helped them maintain or improve their quality of life. For 2022, the Satisfaction Survey will be administered in April/May 2023 and results from the responses will be available in the next public reporting.

TIMELINE

The DAS Office of Community Partnerships and 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 2023/2024	
Quarter 1: July – September 2023	▪ *August:* Prepare Six-Month Report on CLF activities from January through June 2023.
Quarter 2: October – December 2023	▪ *October:* Submit Six-Month Report to Disability and Aging Services Commission for review and forward to the Board of Supervisors, Mayor's Office, LTCCC, and DPH.
Quarter 3: January – March 2024	▪ *February:* Prepare Six-Month Report on CLF activities from July through December 2023. ▪ *March:* Prepare FY 24/25 CLF Annual Plan draft, seeking input from the LTCCC and DPH.
Quarter 4: April – June 2024	▪ *April:* Submit Six-Month Report and FY 24/25 CLF Annual Plan to Disability and Aging Services Commission for review and forward to the Board of Supervisors, Mayor's Office, LTCCC, and DPH.

ANTICIPATED EXPENDITURES

At the conclusion of FY 22/23, it is estimated that the CLF Program will have spent a total of $91 million since the program's inception. For FY 23/24, the CLF Program is projecting a total of $9.5 million in expenditures.

IOA contract	$ 4,869,766
Brilliant Corners contract	$ 3,417,407
DAS internal staff positions	$ 706,504
PG Housing Fund	$ 354,752
RTZ Contract	$ 96,000
Unprogrammed	$ 14,772
TOTAL	$ 9,459,201

APPENDIX A: ELIGIBILITY CRITERIA

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

1. Be 18 years or older.
2. Be a resident of San Francisco.
3. Be willing and able to live in the community with appropriate supports.
4. Have income of no more than 300% of federal poverty level for a single adult, plus savings/assets of no more than $130,000 (excluding assets allowed under Medi-Cal). For Purchase of Service only clients, the asset limit is $6,000.
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. To be considered "at imminent risk of institutionalization," 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. Be unable to manage one's own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of 3 Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone.

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, 10 city-wide intensive Care Managers	15–22 intensive
IOA Subcontractors:		
Catholic Charities CYO	1 Care Manager 1 Care Coordinator	15-22 intensive 30-40 cases
Conard House	1 Money Management Care Manager	40-50 cases
Self Help for the Elderly	1 Care Manager/Social Worker	15-22 intensive