M E M O R A N D U M

DATE: June 4, 2025

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 Program - Annual Plan for July 2025 – June 2026**

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 in an institution. The Administrative Code requires that the Department of Disability and Aging Services (DAS) prepare Annual Plans to be submitted to the Disability and Aging Services Commission after a public hearing process and have input from the Department of Public Health (DPH). Attached is the Annual Plan for FY 25-26, which has been prepared by DAS for the continuing implementation of the Community Living Fund Program administered by Institute on Aging.

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:

- Daniel Tsai, Director, Department of Public Health
- Roland Pickens, Interim Chief Executive Officer, Laguna Honda Hospital and Rehabilitation Center, and Director, San Francisco Health Network,
- Janet Gillen, Director of Social Services, Laguna Honda Hospital
- Todd Barrett, Chief Medical Officer, San Francisco Health Network
- Luis Calderon, Director of Placement, Department of Public Health
- Marion Sanders, Chief Deputy Director, Department of Homelessness and Supportive Housing

COMMUNITY LIVING FUND ANNUAL PLAN
FY 2025 - 2026

I. PROGRAM PURPOSE, TARGET POPULATION, AND ELIGIBILITY

The Community Living Fund Program (CLFP) reduces unnecessary institutionalization. It supports older adults and adults with disabilities with the resources, services, and care coordination needed to live in the community.

CLFP serves adults whose incomes are up to 300% of the federal poverty level, willing and able to live in the community with support as an alternative to institutionalization (for detailed eligibility criteria, see Appendix A on page 9). The two populations of focus include: (1) skilled nursing facility residents who are transitioning back to the community; and (2) individuals living in the community who are at imminent risk of being institutionalized.

Nursing facility residents continue to be prioritized to ensure a safe discharge to the community and reduce the risk of re-institutionalization. CLFP remains focused on reducing disparities in access to care and promoting culturally responsive services that address the social and health needs of diverse communities. The program offers tailored services to support clients' language, cultural, and service preferences.

II. PROGRAM IMPLEMENTATION PLAN

A. Service Overview

The mission of the CLFP remains unchanged for FY 25-26 with the following four major service components.

1. Traditional CLFP services
2. Public Guardian Housing Fund Services
3. DAS Enhanced Care Management (ECM) through CalAIM
4. DAS Community Supports Services through CalAIM

The traditional CLFP component uses a two-pronged approach including Intensive Case Management and Purchase of Services. This model delivers essential resources that are otherwise unavailable to clients through other channels.

The program also offers housing assistance to Public Guardian clients who meet the traditional CLFP eligibility criteria. These clients receive subsidies that support their ability to remain safely housed in the community.

In addition to the two service components above, the program continues to expand CLFP-like services - DAS ECM and Community Supports services - as part of the CalAIM (California Advancing and Innovating Medi-Cal) initiative. The ECM and Community Supports components

are funded through two contracts between San Francisco Health Plan and DAS. DAS, in turn, subcontracts with IOA to deliver these services through CLFP. San Francisco Health Plan partially reimbursements DAS for providing ECM and Community Supports services, and the revenue received is used to offset the County General Fund expenditures.

The ECM services aim to deliver comprehensive and coordinated care to individuals with complex health and social needs, with the goal of improving health outcomes and minimizing avoidable hospitalizations. These services will continue to be provided through a collaborative, team-based model that ensures clients receive holistic, individualized support.

The relatively new DAS Community Supports component will be further expanded in FY 25–26. This component includes the following two types of services:

1. Community Transition Services (CTS) to Private Residences
   CTS assist nursing facility residents transitioning to a private home with housing options and home set-up to ensure a clinically appropriate setting for safe community living.

2. Nursing Facility Transition/Diversion (NFT/D) to Assisted Living Facilities
   NFT/D services support individuals requiring the assisted living level of care with facility placement and on-going subsidies.

Furthermore, CLFP works closely with a separate program, the Scattered Site Housing and Rental Subsidy Administration, managed by Brilliant Corners. This program is also funded by CLF and provides housing opportunities and rental subsidies to support affordable and independent community living.

B. Program Access and Service Connection

Referrals to the traditional CLFP component continue to be screened by the DAS Intake and Screening Unit for program eligibility. Individuals deemed eligible are referred to CLFP for case management and/or purchase of services.

DAS ECM clients are initially identified by San Francisco Health Plan or community referents. These referrals are sent to DAS Intake and Screening Unit for outreach and subsequently sent to CLFP for continued outreach and seeking consent to enroll in services. The entire outreach process can take up to 8 weeks.

DAS Community Supports clients can be identified by San Francisco Health Plan, community referents, or internally by a CLFP Care Manager who is currently providing ECM services. An individual referred to the DAS Community Supports program must also be eligible for and enrolled in the DAS ECM program for care coordination.

When CLFP receives a referral, a Care Manager contacts the participant, confirms the participant's consent for services, completes a formal application, and conducts an in-home or in-hospital assessment. The initial assessment is the tool with which the CLFP Care Manager, the participant, family, and/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 then developed. If the participant is already working with another community care manager, the Care Manager will coordinate the home assessment with that service provider. The entire assessment process should be completed within one month.

In addition to the model of a combination of case management and purchase of services, some clients with an existing external Case Manager only need some goods or services to remain stably housed in the community. The CLFP Care Coordinator at its subcontractor, Catholic Charities, supports these purchase-only clients by conducting a streamlined assessment, enabling eligible participants in other care management programs to access needed goods and services more efficiently. This flexible approach expands CLFP's reach and helps prevent premature institutionalization.

III. ANTICIPATED BUDGET AND POLICY CONSIDERATIONS

The plans for FY 25-26 include:

1. DAS is planning to provide additional funding for Community Supports service delivery. In FY 24-25, Community Supports component was launched, and the implementation included developing procedures and workflows that integrate into the CLFP service model. More clients are expected to be served in FY 25-26 for the two types of services within the Community Supports component: estimated 20 clients for Nursing Facility Transition/ Diversion and estimated 10 clients for Community Transition Services.

2. CLFP will continue to partner with Brilliant Corners in implementing the Integrated Housing Model. Both parties collaborate in care coordination for CLFP clients referred to the Scattered Site Housing and Rental Subsidy Administration program. Access to the scattered site housing options requires CLFP's approval based on the client's needs and placement appropriateness. These housing opportunities continue to add flexibility to the CLFP housing portfolio in transitioning individuals who would otherwise not have been able to return to the community due to lack of appropriate housing options.

3. The Community Options and Resource Engagement (CORE) meetings will keep going. CORE is a multi-disciplinary team led by Laguna Honda Hospital and has bi-weekly meetings. CORE meeting participants include Laguna Honda Hospital, the CLFP provider (Institute on Aging), the Department of Public Health, the Department of Homelessness and Supportive Housing, In-Home Supportive Services, Homebridge,, and other agencies

relevant to client cases. The meetings discuss clients' needs and coordinate effective and efficient transitioning of individuals from skilled nursing facilities to the community.

4. CLFP will maintain the partnership with the DAS Public Guardian Office to provide housing subsidies for Public Guardian clients that meet the eligibility criteria for CLFP services. CLFP has been serving six (6) unduplicated clients and anticipates maintaining this number in FY 25-26. The program and the Public Guardian office will continue to collaborate closely to identify additional clients as the budget allows.

5. CLFP upholds the commitment to offering responsive and inclusive services to our clients. Last year, the program hired a dedicated Outreach Coordinator and will continue to seek out pathways to promote greater access to services. With implementation of CalAIM services, CLFP has had the opportunity to partner closely with several facilities that primarily serve the Asian and Pacific Islander communities. CLFP will continue to build on these relationships in FY 25-26. The program will put on-going effort in engaging the community and seeking partnerships to increase accessibility to its services. The program will also continue to offer professional development and training opportunities to CLFP staff as part of the ongoing commitment to advancing equity and inclusion in services.

6. CLFP will continue to protect staff and participants from respiratory viruses as participants continue to report cases of respiratory viruses, following guidelines from the Department of Public Health and Centers for Disease Control and Prevention. Remote services and personal protective equipment will be provided for clients and staff as needed.

IV. ACCOUNTABILITY: REPORTING, EVALUATION, AND COMMUNITY INPUT

A. Data Collection & Reporting

DAS is committed to measuring the impact of its investments in community services. The following two performance measure targets will remain in FY 25-26. Due to the launch of the CalAIM service components and the related database development, the data for the performance measures were not available in the past two fiscal years. The report on the performance is anticipated to be available in the next year.

1. Percent of clients who experienced one or fewer unplanned admissions to an acute care hospital within a six-month period (Target: 85%)

2. Percent of clients who achieved their annual care plan goals within one year of enrollment in the program (Target: 70%)

B. Stakeholder Input

The CLFP Advisory Council was established 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, program updates, and other topics that may affect service delivery.

Institute on Aging obtains clients' input through annual satisfaction surveys, including questions on general services, social worker satisfaction, service impact, and overall satisfaction with the entire CLFP. In FY23-24, 94% of the survey participants reported that CLFP helped them maintain or improve their ability for successful community living. The FY 24-25 survey will be completed by the end of May 2025, and the results from the responses will be available in the next report.

V. TIMELINE

The DAS Office of Community Partnerships and Institute on Aging review monthly reports of service utilization and referral trends. The following table outlines the important dates for public reporting.

Timeline of Public Reporting – FY 2025-2026	
Quarter 1: July – September 2025	▪ August: Prepare Six-Month Report on CLFP activities from January through June 2025.
Quarter 2: October – December 2025	▪ October: Submit Six-Month Report to Disability and Aging Services Commission for review and forward to the Board of Supervisors, Mayor's Office, and DPH.
Quarter 3: January – March 2026	▪ February: Prepare Six-Month Report on CLF activities from July through December 2025. ▪ March: Prepare FY 26/27 CLF Annual Plan draft, seeking input from the LTCCC and DPH.
Quarter 4: April – June 2026	▪ April: Submit Six-Month Report and FY 26-27 CLF Annual Plan to Disability and Aging Services Commission for review and forward to the Board of Supervisors, Mayor's Office, LTCCC, and DPH.

VI. ANTICIPATED EXPENDITURES

At the conclusion of FY 2024-25, it is estimated that CLFP will have spent a total of $106 million since the program's inception. For FY 2025-26, the programs funded by CLF is projected to be a total of $11.3 million in expenditure.

IOA contract	$ 6,658,738
Brilliant Corners contract	$ 3,438,758
DAS internal staff positions	$ 762,760
PG Housing Fund	$ 369,660
RTZ Contract	$ 96,000
TOTAL	**$ 11,325,916**

VII. PROJECTED CalAIM REVENUE RECEIVED

By the end of FY 2024-25, CLFP is projected to receive approximately $1,063,000 through CalAIM for the delivery of DAS ECM and Community Supports Services since the launch of these programs. Estimated revenue for FY 2025–26 is roughly $1,831,000.

APPENDIX A: ELIGIBILITY CRITERIA

A. Traditional CLFP Eligibility - all of the following criteria for a person who is:

1. Aged 18 years or older;
2. A resident of San Francisco;
3. Living in an institutional setting or assessed to be at imminent risk of institutionalization primarily due to functional or chronic health needs;
4. Willing and able to live in the community with appropriate support;
5. Having an income at or below 300% of federal poverty level;
6. Having individual assets up to $130,000 for case management services or up to $6,000 for purchase of services only;
7. Demonstrating a need for services or resources to prevent institutionalization and support community living.

Preference is given to the following groups of people who are willing and able to live in the community with appropriate support.

1. Patients of Laguna Honda Hospital and Zuckerberg San Francisco General Hospital
2. Patients at other San Francisco acute care hospitals and skilled nursing facilities
3. Nursing home eligible individuals on the waiting lists of Laguna Honda Hospital, Zuckerberg San Francisco General Hospital, or other hospitals
4. Individuals at imminent risk of institutional placement

B. Public Guardian Housing Fund Eligibility – both of the following criteria for a person who is:

1. An existing client with DAS PG program;
2. Meeting the traditional CLFP eligibility criteria (see section A).

C. DAS Enhanced Care Management (ECM) Eligibility - all of the following criteria for a person who is:

1. A member of San Francisco Health Plan (SFHP);
2. A resident of San Francisco;
3. An adult belonging to one of the following populations of focus:
   a. Adults living in the community and at risk of long-term care institutionalization;
   b. Adult nursing facility residents transitioning to the community;
4. An individual who is willing and able to live in the community with appropriate support.

D. DAS Community Supports (CS) Eligibility

1. Community Transition Services Eligibility - all of the following criteria for a person who is:
   a. Eligible and enrolled in DAS ECM program (see section C);
   b. Currently receiving medically necessary nursing facility level of care (LOC) services and opting to transition to a home setting—rather than remain in a nursing facility or Medical Respite—while continuing to receive the required LOC services;
   c. Living in a nursing home and/or medical respite setting for 60+ days.

2. Nursing Facility Transition to Assisted Living Facilities Eligibility – all of the following criteria for a person who is:
   a. Eligible and enrolled in DAS ECM program (see section C);
   b. Living in a nursing home and/or medical respite setting for 60+ days;
   c. Requiring placement in an Assisted Living Facility or a similar level of care setting based on assessment;
   d. Willing and able to safely transition to an Assisted Living Facility.

3. Nursing Facility Diversion to Assisted Living Facilities Eligibility – all of the following criteria for a person who is:

   a. Eligible and enrolled in DAS ECM program (see section C);

   b. Requiring nursing facility level of care services based on assessment;

   c. Willing and able to receive medically necessary nursing facility level of care services at an Assisted Living Facility in lieu of a nursing facility.

APPENDIX B: CLFP CONTRACTORS

Agency	Specialty	Average Caseload per Care Manager
Institute on Aging	Program and case management supervision, 8 FTEs city-wide intensive Care Managers	17–22 intensive
IOA Subcontractors:		
Catholic Charities CYO	1 Care Coordinator	30-40 cases
Conard House	1 Money Management Care Manager	40-50 cases
Self Help for the Elderly	1 Care Manager/Social Worker	17-22 intensive