

MEMORANDUM

DATE: November 2, 2016

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 2016 to June 2017

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 16/17, 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, 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, DSHS;
- ❖ Kelly Hiramoto, Acting Director Transitions, SF Health Network

COMMUNITY LIVING FUND ANNUAL PLAN FY 2016/2017

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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 15/16, 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 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 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 16/17, CLF expenditures have continued to be stable with a surplus. The plans for this upcoming year include:

- SF Health Plan continues to contract with DAAS to provide assessment and case management services for CBAS participants enrolled in their health plan. DAAS provides these services through CLF infrastructure. The continuing expectation is a census of over 400, a small portion of who are enrolled in the full CLF program as additional services are needed and not available through any other source.

- The Community Options and Resource Engagement (CORE) is an inter-disciplinary, multi-agency team focused on issues related to skilled nursing facility to community discharges including trends, gaps, and opportunities. This team will also be a resource for clients who may need additional collaboration and support to stably remain in the community. This collaboration of city-wide providers and services including city agencies, community-based organizations, and health plans with the aim to close the gap on system issues or challenging situations that often overlap multi-systems of service delivery. More information will be provided in the near future.
- CLF is collaborating with and expanding outreach efforts to SNFs in San Francisco to evaluate clients who are willing and able of living at a lower level of care. Expanding the reach of services to San Franciscans has allowed clients at SNFs throughout the City to engage in the transition process to a lower level of care (including independent housing and assisted living).
- During FY 15/16, the CLF baseline budget increased by \$1 million in City funding to expand the total number of clients served as well as to serve unmet needs in housing, home care, and home modifications. While the first year was focused on building infrastructure and staffing needs, CLF anticipates being able to serve more clients this fiscal year in the below areas:
 - **Housing assistance** addresses the demand, which is unquestionably a barrier for individuals living in Skilled Nursing Facilities (SNFs) who are capable of living in the community. Two housing strategies include Board and Care and independent scattered-site housing subsidies. Current projections estimate 5 new clients served during a 6-month period.
 - Many CLF referrals are unable to access ongoing **home care** to support independent living. The prohibitive variables are large Medi-Cal share of cost and undocumented status. Current projections estimate 5 new clients served during a 6-month period.
 - Given the limited stock of affordable and accessible housing in San Francisco, **home modifications** are a critical yet relatively inexpensive strategy for helping individuals with mobility impairments stay in the community. These include installation of stair lifts, wheelchair ramps, and bathroom modifications. Current projections estimate 40 new clients served during a 6-month period.
- CLF has a robust Quality Improvement Plan focused on increasing client and stakeholder feedback, improving client grievance procedure processes, and expanding quality assurance reporting. This will include utilization reviews and cultural competency training throughout the year to further enhance the delivery and quality of services.
- DAAS received a scattered site housing (SSH) contract with Brilliant Corners that was transferred from DPH. At the point of the transfer, there were 103 units that were already occupied with long-term clients and included a short waitlist. DAAS is allocating new housing slots to CLF to expand housing options, to allow for more flexibility in determining target population, and to focus on the needs of those stepping down to community living. Brilliant Corners provides person-centered property management in market-rate apartments, including rental subsidies, home modifications, and housing retention services. As units become available, eligible CLF clients leaving institutions will have access to these vacancies.

Scattered site housing is ideal for those who can live independently without onsite supportive services. Criteria for these SSH and waitlists are based on appropriateness and need.

DAAS CASE MANAGEMENT TRAINING INSTITUTE (CMTI)

The Case Management Training Institute (CMTI) is a training program for community-based case managers and service providers at all levels of education and experience, including skill-building and continued education. This training program promotes excellence in case management and related disciplines in the delivery of human services in San Francisco by advancing learning environments that value client engagement, advocacy, diversity and; and by providing evidence-based, knowledge-based, and value-informed education and training designed in improving service delivery. The core curriculum promotes client-centered service planning and engagement through motivational interviewing and care management. CMTI uses both classroom training and coaching to promote the development of new practice habits in order to meet the diverse and complex needs of the clients. A new contract cycle for this program will begin in FY 16/17.

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 towards target this year to improve the number of services that were marked as resolved or transferred in the service plan. While a subset of clients will always have less than 100% performance due to ongoing care needs, this performance reflects a combination of issues: additional training so that care plans are updated regularly, complex client needs that take time to resolve or new care needs that evolve later.

In FY 16/17, 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.

DAAS has made additional data improvements to standardize demographic data and the reporting of sexual orientation. This includes additional training and required fields to ensure data integrity. Beginning FY 16/17, the Six Month Reports will include a section that provides demographics of enrolled clients.

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.

Telephonic surveys, titled The Participant Experience Surveys for HCBS for Elderly and Disabled Clients, were administered during July 2016 with Mayor’s Youth Employment and Education Program (MYEEP) trained high school student volunteers. These results will be considered for programming in the coming year. Survey results are compiled and reviewed by the Supervisor, the IOA Site Director and the Partner Agencies. This process is managed by the IOA Quality Improvement Director. Survey results are regularly reported in the CLF 6-month reports.

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 2016/2017	
Quarter 1: July – September 2016	<ul style="list-style-type: none"> ▪ <i>August:</i> Prepare Six-Month Report on CLF activities from January through June 2016.
Quarter 2: October – December 2016	<ul style="list-style-type: none"> ▪ <i>November:</i> 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 2017	<ul style="list-style-type: none"> ▪ <i>February:</i> Prepare Six-Month Report on CLF activities from July through December 2016. ▪ <i>March:</i> 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 2017	<ul style="list-style-type: none"> ▪ <i>April/May:</i> Prepare FY 17/18 CLF Annual Plan draft, seeking input from the LTCCC and DPH. ▪ <i>June:</i> Submit FY 17/18 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 15/16, it is estimated that the CLF program will have spent a total of \$33 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 \$4.6 million for FY 16/17, which incorporates the additional revenue from the SF Health Plan for CBAS assessments and an additional \$1 million that the program received during the FY 15/16 budget. Per agreement with the Department of Public Health, the Brilliant Corners contract, with a \$3.1M annual budget, has shifted over to the CLF program. . The additional funds will be used to purchase board and care slots, scattered site housing subsidies, additional home care and home modifications.

FY 16/17 Community Living Fund Budget	
IOA Contract and subcontractors	
Purchase of Service	\$1,969,438
Case Management	\$1,791,626
Operating and Capital	\$510,802
Indirect	\$371,793
Total IOA Contract	\$4,643,659
<i>Additional Offsetting Revenues:</i>	
Local Revenue for CBAS assessments	(\$202,840)
CCT/IHO Reimbursement	(\$140,000)
Unspent funds from overall CLF program	(\$593,760)
	(\$936,600)
<i>DAAS Internal Staff Position Funding</i>	
Staff Salaries	\$397,379
Fringe Benefits	\$159,610
<i>Additional Program-Related areas:</i>	
Case Management Training Institute	\$120,000
Medication Management Review	\$10,000
Shanti/PAWS	\$75,000
DPH RTZ work order	\$96,000
Transfer of the Scattered Site Contract from DPH (Brilliant Corners)	\$3,075,814
TOTAL	\$7,640,862

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: \$35,640 plus savings/assets of no more than \$6,000 (Excluding assets allowed under Medi-Cal). Reflects the 2016 Federal Poverty guideline of \$11,880.
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
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