M E M O R A N D U M

DATE: May 4, 2022

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 2022 to June 2023**

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 of Public Health;
- Michael Phillips, Chief Executive Officer, Laguna Honda Hospital (LHH) and Rehabilitation Center;
- Irin Blanco, Assistant Hospital Administrator-Clinical Services, LHH;
- Janet Gillen, Director of Social Services, LHH;
- Dr. Wilmie Hathaway, Medical Director, LHH;
- Luis Calderon, Director of Placement, Targeted Case Management;
- Edwin Batongbacal, Director of Adult and Older Adult Services, Community Behavioral Health Services;
- Salvador Menjivar, Director of Housing, Department of Homelessness and Supportive Housing;
- Roland Pickens, Director, San Francisco Health Network

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 21/22, 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 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 in order 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 22/23 and will facilitate care coordination for CLF referrals who meet criteria for Scattered Site Housing (SSH) through a contract with Brilliant Corners. IOA hosts a monthly multi-disciplinary team meeting that includes 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.

- CLF continues to support the contract with Shanti Project-PAWS (Pets are Wonderful Support) Animal Bonding Services for Isolated LGBTQ+ Older Adults and Adults with Disabilities. For many, pets are considered family members, and individuals will often delay or forego their own needs in order to meet their pets' 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 FY 20/21 included self-reports of positive health impacts and affirmation that the CLF-funded goods and services have reduced participants' risk for hospitalization (79%) and prevented isolation (92%). While FY 21/22 outcomes are not yet available, CLF anticipates continuing support in FY 22/23.

- The CLF Program continues to partner with the DAS Public Guardian (PG) Office to support the PG Housing Fund which provides individuals conserved by the PG, who also meet CLF eligibility criteria, with housing subsidies and assistance with move-related costs to licensed Assisted Living Facilities (ALF), supportive housing, or other similar types of housing. Due to insufficient financial resources and declining health, many individuals under PG conservatorship are marginally housed for prolonged periods of time while waiting for appropriate housing options. The PG Housing Fund through CLF is used to support their safety and housing stability. Approximately 5-10 individuals are being served annually by this partnership.

- 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 opportunities that support and promote cultural humility and competencies of CLF staff in the services offered to the community.

- During FY 21/22, the CLF program continued to engage in temporary policy changes in its operations to respond to the needs of the community during the Coronavirus pandemic. The program offered a hybrid model of services practicing remote and in-person care according to the needs of the participants and following guidelines from the Department of Public Health (SFDPH) and Centers for Disease Control and Prevention (CDC). The program allowed for remote communication technologies that are HIPPA compliant and supplied staff in the field with enhanced Personal Protective Equipment for essential visits. This approach will continue through FY 22/23, as necessary.

- When the COVID-19 pandemic started in March 2020, CLF collaborated with SFDPH Transitions Care Coordination and Placement, In-Home Supportive Services (IHSS), and Homebridge to assist individuals transitioning from Laguna Honda Hospital and Zuckerberg San Francisco General Hospital to Shelter-in-Place (SIP) hotel sites throughout the city. The

CLF Rapid Transitions Team was formed to provide a modified fast-tracked process for assessment and enrollment of participants and provide care coordination and purchase of goods to meet urgent needs. As the pandemic start to slow down and individuals at SIP hotel sites are being transitioned to more long-term placements, the CLF Rapid Transitions Team continue to support their stabilization and coordination of care. This effort will continue through FY 22/23 until the CLF Rapid Transitions Team is no longer needed as a response to the pandemic.

- 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 in an effort 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 21/22, CLF reestablished the utilization of the California Community Transitions (CCT) program to leverage supplemental funding through Medi-Cal and expand CLF's ability to support a larger number of participants in the community. As of September 2021, the CLF program has been collaborating with the California Department of Health Care Services (DHCS) in the review of enrollment processes and policy updates to support CCT enrollment of Medi-Cal beneficiaries that can transition from facilities to community settings. Since then, four (4) applications have been submitted to DHCS. Going into FY 22/23, CLF expects to see an increase in the number of participants enrolled in CCT as the program implements CCT's processes in the CLF assessment.

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: 80%.

The CLF Program will continue to make progress towards this performance measure target in FY 22/23. This measure reflects the complexity of the population served as CLF 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 2021, 91% of participants reported that the CLF Program helped them maintain or improve their quality of life with 87% having recommended the program to others. For 2022, the Satisfaction Survey will be administered in April/May 2022 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 2022/2023	
Quarter 1: July – September 2022	▪ *August:* Prepare Six-Month Report on CLF activities from January through June 2022.
Quarter 2: October – December 2022	▪ *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 2023	▪ *February:* Prepare Six-Month Report on CLF activities from July through December 2022. ▪ *March:* Prepare FY 23/24 CLF Annual Plan draft, seeking input from the LTCCC and DPH.
Quarter 4: April – June 2023	▪ *April:* Submit Six-Month Report and FY 23/24 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 21/22, it is estimated that the CLF Program will have spent a total of $81.53 million since the program's inception. For FY 22/23, the CLF Program is projecting a total of $9.05 million in expenditures.

IOA Contract	$ 4,684,015
Brilliant Corners Contract	$ 3,123,830
DAS Internal Staff Positions	$ 684,545
PG Housing Fund	$ 352,795
RTZ Contract	$ 96,000
Shanti Project/PAWS	$ 75,000
Unprogrammed Funds	$ 42,149
TOTAL	**$ 9,058,334**

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 live in the community with appropriate supports.
4. Have income of no more than 300% of federal poverty level for a single adult: $40,770 plus savings/assets of no more than $6,000 (excluding assets allowed under Medi-Cal). Reflects the 2022 Federal Poverty guideline of $ 13,590 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. Inability 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	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