M E M O R A N D U M

DATE: July 23, 2015

TO: Aging and Adult Services Commission

FROM: Department of Aging and Adult Services (DAAS)
Anne Hinton, 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 2015 to June 2016

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 15/16, 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;
- 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, Interim Director of Housing and Urban Health;
- Kelly Hiramoto, Acting Director Transitions, SF Health Network

COMMUNITY LIVING FUND ANNUAL PLAN
FY 2015/2016

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. Approximately 43% of referrals for CLF intensive case management in FY14-15 came from LHH, a consistent program trend for the last three years.

PROGRAM IMPLEMENTATION PLAN

The basic structure of the CLF remains unchanged from FY 14/15, 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. A smaller number of clients receive emergency meals services from Meals on Wheels. Purchases for Transitional Care clients are now provided directly from CLF at the IOA.

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. If clients need emergency meals, they are referred on to Meals on Wheels for expedited services. All other clients who meet initial eligibility criteria are referred on to the IOA for a final review. The client is 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 partner agency 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.

ANTICIPATED BUDGET AND POLICY CONSIDERATIONS

Going into FY 15/16, 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.
- A business agreement between DPH and DAAS is actively being developed in anticipation of moving forward with an interdisciplinary, multi-agency group similar to DCIP (Diversion and Community Integration Program) named CORE (Community Options and Resource Engagement).

- CLF has received additional City funding in order to expand the total number of clients served. CLF has identified that this funding is required in order to serve unmet needs in housing, home care, and home modifications.
    - **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.
    - 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.
    - 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.
- CLF helps prevent unnecessary re-hospitalizations by supporting transitional care services for clients discharged from acute hospitalization to the community. CLF funds limited service packages of home-delivered meals, homecare, and transportation to/from medical appointments during the first 30 days post-discharge when the most support is needed. Transitional care services were previously delivered by the San Francisco Transitional Care Program and shown to be successful in reducing readmission rates. The new DAAS IHSS Care Transitions continues transitional care services for the current and eligible IHSS clients.
- Improving access to data and technology support for evaluating potential pilot options will be a focus for CLF. Exploring available technology that promotes community living utilizing a case management model will be emphasized, with particular attention given to utilization and outcome data.
- CLF is developing a robust Quality Improvement Plan focused on increasing client and stakeholder feedback, improving client grievance procedure processes, and expanding quality assurance reporting.

DAAS CARE MANAGEMENT TRAINING INSTITUTE (CMTI)

The Case Management Training Institute (CMTI) continues to offer and provide relevant training needs to community based case managers and service providers. This year, property managers and Transitional Care Specialists are receiving training relevant to their needs. From the start, the core curriculum has promoted 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.

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 has consistently met and exceeded its goals to support successful community living for those discharged or at imminent risk of institutionalization. Given this demonstrated success, DAAS is shifting its focus to new measures in order to assess other important areas of performance. DAAS is currently refining the methodology for calculating these new measures, which will be reported in FY15-16. These measures will be:

- Percent of care plan problems resolved, on average, after one year of enrollment in CLF at, at least, 80% (excludes clients with ongoing purchases).
- Percent of clients with one or fewer admissions to an acute care hospital within a six month period, at least 80%.

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.

Anonymous yearly surveys are mailed to participants to determine if their needs are being met through the program. Survey results are compiled and reviewed by the Supervisor, the IOA Site Director and the Partner Agencies. Surveys are mailed monthly to consumers who have been discharged from CLF the previous month, and annually to all continuing clients. Survey results are regularly reported in the CLF 6-month reports.

TIMELINE

The DAAS Long Term Care Director of Operations 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 2015/2016	
Quarter 1: July – September 2015	▪ *August:* Prepare Six-Month Report on CLF activities from January through June 2015. ▪ *August/September:* Share information with LTCCC
Quarter 2: October – December 2015	▪ *October:* 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 2016	▪ *February:* Prepare Six-Month Report on CLF activities from July through December 2015. ▪ *February/March:* Share information with LTCCC ▪ *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 2016	▪ *April/May:* Prepare FY 16/17 CLF Annual Plan draft, seeking input from the LTCCC and DPH. ▪ *June:* Submit FY 16/17 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 14/15, it is estimated that the CLF program will have spent a total of $29 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 $4.8 million for FY 15/16, which incorporates the additional revenue from the SF Health Plan for CBAS and an additional $1 million that the program received in the FY15/16 budget from the Mayor's Office.

The additional funds will be used to purchase board and care slots, scattered site housing subsidies, additional home care and home modifications.

FY 15/16 Community Living Fund Budget	
IOA Contract and subcontractors	
Purchase of Service	$2,020,091
Case Management	$1,481,593
Operating and Capital	$546,883
Indirect	$294,765
Total IOA Contract	**$4,343,331**
Additional Offsetting Revenues:	
Local Revenue for CBAS assessments	($176,000)
CCT/IHO Reimbursement	($140,000)
Unspent funds from overall CLF program	($1,043,743)
	($1,359,743)
DAAS Internal Staff Position Funding	
Staff Salaries	$383,270
Fringe Benefits	$155,684
Additional Program-Related areas:	
Case Management Training Institute	$120,000
DPH RTZ work order	$96,000
Emergency Meals program through Meals on Wheels	$93,597
Mayor's Office Addback to expand housing, home care and home modifications	$1,000,000
TOTAL	**$4,832,139**

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: $35,310 plus savings/assets of no more than $6,000 (Excluding assets allowed under Medi-Cal). Reflects the 2015 Federal Poverty guideline of $11,770.
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.	15 - 22 intensive
Conard House	1 Money management Care Manager	40-50 cases
HealthRight 360	1 Care Manager with substance abuse expertise.	15 - 22 intensive
Expedited Services		**Annual caseload**
Meals on Wheels	Short-term emergency and Transitional Care home-delivered meals	Approx 150 persons/year