M E M O R A N D U M

DATE: September 11, 2014

TO: Aging and Adult Services Commission

FROM: Department of Aging and Adult Services (DAAS)
Anne Hinton, Executive Director
Linda Edelstein, 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 2014 to June 2015

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 14/15, 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, Linda Edelstein, 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 2014/2015

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) and San Francisco General Hospital (SFGH) 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. The first of these sub-populations is the top priority for the program. That group constituted approximately 38% of clients in FY 13/14, which is consistent with program trends.

PROGRAM IMPLEMENTATION PLAN

The basic structure of the CLF remains unchanged from FY 13/14, 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 expedited transitional care or emergency meals services from the San Francisco Senior Center/Northern California Presbyterian Homes and Services (SFSC/NCPHS) and/or Meals on Wheels.

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 transitional care or emergency meals, they are referred on to SFSC/NCPHS or 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, 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. Case managers are making notable progress in connecting clients to mental health treatment.

ANTICIPATED BUDGET AND POLICY CONSIDERATIONS

Going into FY 14/15, CLF expenditures have continued to be stable with a small 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 whom are enrolled in the full CLF program as additional services are needed and not available through any other source.
- CLF, in collaboration with Laguna Honda Social Services, is focusing on engaging shared clients in meaningful community activities prior to discharge. This includes enrolling at City College of San Francisco, initiating services with vocational rehab programs, or visiting Community Based Adult Services (CBAS) sites before leaving Laguna Honda. This, along with engaging with providers from CLF and IHSS early on in the discharge process helps manage some of the anxiety and uncertainty of the transition.

- Through its work with the Medi-Cal waiver programs and California Community Transitions project, CLF continues to transition a small number of individuals home from non-Laguna Honda long term SNF beds in San Francisco. Housing for these residents continues to be the primary barrier.
- CLF is partnering with SF acute hospitals and with the DAAS Adult Protective Services program to target high need clients. In some cases those clients need additional support to return to the community and in other cases the program facilitates remaining stable in the community.
- In May, a report on CLF and the Diversion and Community Integration Program (DCIP) was completed. In addition to providing a history and overview of this local model of deinstitutionalization, the report analyzed trends in the consumers served and costs associated with the programs. A key finding of the report was that consumers dually served by these programs tend to be middle-aged and male. Additionally, the cost of providing care through this local model was estimated to be significantly less than the cost of institutional care at Laguna Honda Hospital. Report findings have been shared with the Long Term Care Coordinating Council and will help drive future decisions related to long term care supports and services. The report is attached to this Annual Plan.

DAAS CARE MANAGEMENT TRAINING INSTITUTE (CMTI)

In January 2014, CMTI started a training program that engages entry, mid and advance level practitioners through applications of best practice models that assess, support and advance the knowledge and skills of community based care managers. CMTI offers advance learning environments that value client engagement, advocacy, and diversity and provides learners the best evidence- and knowledge-based education and training. It is designed to improve service delivery through client-centered planning and collaborative work practices.

ACCOUNTABILITY: REPORTING, EVALUATION, AND COMMUNITY INPUT

DAAS's plans for reporting and evaluation of the CLF Program are detailed below.

Data Collection & Regular

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 plans to shift focus to new performance measures in order to assess other important areas of performance. These two new performance 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 2014/2015	
Quarter 1: July – September 2014	▪ *August:* Prepare Six-Month Report on CLF activities from January through June 2014. ▪ *August/September:* Share information with LTCCC
Quarter 2: October – December 2014	▪ *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 2015	▪ *January:* Prepare Six-Month Report on CLF activities from July through December 2014. ▪ *January:* Share information with LTCCC ▪ *February:* 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 2015	▪ *April/May:* Prepare FY 15/16 CLF Annual Plan draft, seeking input from the LTCCC and DPH. ▪ *June:* Submit FY 15/16 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 13/14, it is estimated that the CLF program will have spent a total of $25.5 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 $3.8 million for FY 14/15, which now incorporates the additional revenue from the SF Health Plan for CBAS.

Through the local addback process, DAAS has received one time funding of $200,000 to hire a consultant to assist both the Department and local CBOs to explore the development of a Managed Services Organization (MSO) to help guide and develop business agreements in the wake of Managed Care.

FY 14/15 Community Living Fund Budget	
IOA Contract and subcontractors	
Purchase of Service	$1,020,091
Case Management	$1,481,593
Operating and Capital	$546,883
Indirect	$294,765
Total IOA Contract	**$3,343,331**
Additional Offsetting Revenues:	
Local Revenue for CBAS assessments	($176,000)
CCT/IHO Reimbursement	($140,000)
Unspent funds from overall CLF program	($101,829)
	($417,829)
DAAS Internal Staff Position Funding	
Staff Salaries	$369,804
Fringe Benefits	$165,086
Additional Program-Related areas:	
Case Management Training Institute	$120,000
DPH RTZ work order	$120,000
Emergency Meals program through Meals on Wheels	$93,597
Homecoming Services Network through San Francisco Senior Center	$38,150
Board of Supervisor's Addback for Managed Services Organization (MSO) Consultant for local CBO's	$200,000
TOTAL	**$4,032,139**

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: $35,010 plus savings/assets of no more than $6,000 (Excluding assets allowed under Medi-Cal). Reflects the 2013 Federal Poverty guideline of $11,670.
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**
SF Transitional Care Program: SFSC/NCPHS	Transitional care purchase needs for immediate post acute hospital discharge.	100-150 persons/year; 10/month
Meals on Wheels	Short-term emergency home-delivered meals	Approx 150 persons/year

APPENDIX C: REPORT ON THE COMMUNITY LIVING FUND (CLF) AND DIVERSION AND COMMUNITY INTEGRATION PROGRAM (DCIP)

Supporting seniors and persons with disabilities to live outside of institutional care:

An assessment of San Francisco's Community Living Plan Model

A report prepared for the
San Francisco Department of Aging and Adult Services

by Rose Johns, Graduate Student
School of Social Work & Goldman School of Public Policy
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June 16, 2014

Executive Summary

Over the last six years, San Francisco has developed an innovative approach to reducing unnecessary institutionalization of seniors and persons with disabilities (SPDs). In particular, this model targets those currently residing at Laguna Honda Hospital & Rehabilitation Center (LHH) or at risk of entering the facility – a population that tends to have particularly complex care needs.

This approach – termed the "San Francisco Community Living Plan (CLP) Model" in this report – is driven by two programs: the Community Living Fund (CLF) and the Diversion and Community Integration Program (DCIP). At the heart of the CLP model is a personalized care plan that incorporates the preferences of the consumer and is developed with the input of local program and service experts. The following four components support the community living plan and this model of care:

- The *multi-disciplinary team* (the DCIP Core Group) that typically creates the care plan;
- *Intensive case management* provided through CLF to help consumers transition and stabilize;
- *Housing* with a spectrum of supportive options; and
- *Flexible funding* to purchase necessary items and services for which there is no other payer.

At this point in time, San Francisco is interested in a retrospective review and analysis of this approach to supporting community-based care. In addition to describing the model and reviewing early challenges, this report focuses on consumers with a LHH discharge between 2010 and 2012 to explore:

- *Trends in the consumer population served by this model;*
- *Trends in program enrollment of these consumers; and*
- *Trends in cost* (CLF flexible funding costs alone and then including costs of other programs).

With this wide scope, this report has several interesting findings:

- **Population trends**
  - This population tends to be middle age (average age is 52) and male (77%).
  - Consumers are more likely to need help with instrumental activities of daily living, such as food preparation, than more fundamental activities like eating and bathing.
- **Program enrollment trends**
  - Consumers are typically enrolled in intensive case management for 19 months
  - The DCIP Core Group typically reviews each case 4 times.
  - Of other services for which data was available, most consumers receive housing (65%) and In-Home Supportive Services (IHSS) (57%).
- **Flexible funding cost trends**
  - Most consumers are relatively low-cost – the average amount spent on each consumer in the 6 months before discharge through 12 months in community is $2,465.
  - Purchases are clustered around time of discharge – a minority of consumers (28%) receives a purchase after 6 months in the community.
  - Home care is a particularly expensive purchase area but is accessed by few consumers.
- **Total cost trends**
  - Costs for housing, IHSS, and CLF ICM far outweigh the cost of CLF flexible funding.
  - The average cost per consumer increases to $31,597 for the first year in the community (comparatively, based on $574 to $800 estimated per patient day cost, LHH is estimated to cost between $209,510 and $292,000 per year).

This report provides an initial exploration of the rich data available for these consumers and this model. Further research into consumer trends, full cost analysis, and outcomes data would serve to greatly enhance understanding of how and for whom this model works best.

Contents

I. Introduction

With the Community Living Fund (CLF) and Diversion and Community Integration Program (DCIP), San Francisco has created an innovative model that supports the ability of seniors and persons with disabilities to live safely and actively in community settings. The foundation of this model is a personalized community living plan designed in collaboration with community-based organizations, local government programs, and the consumer who has expressed a desire to reside in the community rather than institutional settings.

Though CLF and DCIP performance data is regularly reviewed for quality assurance and regular reports on each program are provided to the appropriate oversight bodies, a comprehensive review of this Community Living Plan (CLP) model has not been completed to describe its core components or assess trends in the consumers served and services provided in this model of care. Such an assessment may be especially valuable as San Francisco prepares for health plans to assume more authority over healthcare for SPDs (e.g., the shift to managed care and Cal MediConnect). Moreover, other counties and organizations may be interested in learning about the model – including the start-up phase and current operations – for possible partial or complete replication.

With this goal in mind, this report aims to:

1. Describe the Community Living Plan model, including early challenges and key lessons learned; and
2. Identify trends in consumers served by the program with attention to variation in need and services provided to consumers.

II. Background

National, state, and local attention to seniors and persons with disabilities (SPDs) has increased considerably over the last two decades. In particular, the last ten years has seen an increase in services and programs that specifically aim to meet the needs of the SPD population. A primary goal of this movement is to maximize integration and participation of SPDs in the community – these individuals should not simply live in a group home that is isolated from the community but be active members of their communities as much as possible. This section of this report provides a brief overview of key policies before focusing on efforts in San Francisco.

The 1999 Supreme Court decision in *Olmstead v. L.C.* was arguably the impetus for many of today's policies and provides the basis for many programs. In the *Olmstead* decision, the Supreme Court held that institutional isolation of a person with a disability is a form of discrimination under the Americans

with Disabilities Act. In this decision, the Supreme Court also held that mental illness is a form of disability and that states have a responsibility to provide necessary supports for community living.[1]

The federal government has initiated several notable policies and programs to support community living. One example of this focus is the Centers for Medicare & Medicaid Services' Money Follows the Person Rebalancing Demonstration, which began in 2007. With $4 billion in funding over 9 years, this initiative is one the largest Medicaid demonstration projects of its kind in the agency's history. The underlying goal of this project is to reduce reliance on institutional care and redirect consumers (and funding) to community-based services. Called California Community Transitions in California, this program provides funding for transition-related costs and a one-year stabilization period in the community for those who have continuously resided in state-licensed health care facilities for over 90 days. Local organizations are contracted to serve as "lead organizations" and facilitate these transitions.

The 2012 creation of the Administration for Community Living is additional evidence of the growing orientation towards services for SPDs. This new agency unites the Administration on Aging, the Office on Disability and the Administration on Developmental Disabilities, and is focused on supporting cross-cutting initiatives and efforts based on the unique needs of individual groups (e.g., children with developmental disabilities or seniors with dementia).[2] A primary goal of the agency is to increase access to community supports and achieve full community participation for people with disabilities and seniors.

San Francisco Programs

Locally, San Francisco offers many services and programs that specifically target SPDs. The city goes well beyond minimum funding requirements to provide services that support this population. A notable example of the city's orientation towards SPDs is the Long Term Care Coordinating Council established by Mayor Gavin Newsom in 2004. The Council provides policy guidance to the Mayor's office and is charged with advising, implementing, and monitoring community-based long term care planning in San Francisco, as well as facilitating the improved coordination of home, community-based, and institutional services for SPDs. The Council maintains several workgroups that focus on specific issues, including the unique needs of LGBT and minority SPDs, in order to fully meet the needs of the local population.

San Francisco's efforts have also been motivated in part by legal action. Echoing the federal Olmstead decision, two lawsuits were filed against San Francisco and its public skilled nursing facility, Laguna Honda Hospital and Rehabilitation Center (LHH). The following settlements encouraged San Francisco to enhance its services to better support community living:

- The Davis Settlement focused on an approach of diversion and discharge from LHH by promoting appropriate community-based alternatives and creating a new Targeted Case

[1] U.S. Department of Justice. *Olmstead: Community Integration for Everyone*. Retrieved from http://www.ada.gov/olmstead/olmstead_about.htm

[2] U.S. Department of Health & Human Services. (16 April 2012.). A Statement from Secretary Sebelius on the Administration for Community Living. Retrieved March 14, 2014, from http://www.hhs.gov/news/press/2012pres/04/20120416a.html

Management program within the Department of Public Health that provides assessments, service/discharge planning and ongoing case management.

- The Chambers Settlement focused on the enhancement of community-based living options through the provision of wrap-around services and housing.

In response to these national and local forces, the San Francisco Department of Aging and Adult Services (DAAS) created two new innovative programs: the *Diversion and Community Integration Program* (DCIP), and the *Community Living Fund* (CLF). Through these programs, DAAS works in collaboration with other city departments to create and carry out dynamic and personalized community living plans for SF residents. Specifically, these programs serve individuals who are either at imminent risk of admission to an institutional setting or currently residing in institutional settings but have expressed a preference to live in the community and are deemed ready for community transition. More information about these programs is provided below and in *Section IV: Description of the Community Living Plan Model* in this report.

Community Living Fund

In 2007, the City and County of San Francisco dedicated $3 million to establish a Community Living Fund (CLF). This funding is renewed every year and is used for goods and services that help at-risk individuals continue living independently in their homes or leave institutions and return to community living. The program uses a two-pronged approach of (1) intensive case management and (2) purchased services/items to provide resources not available through any other mechanism to vulnerable older adults and younger adults with disabilities. CLF is considered the payer of last resort. Eligibility for CLF is restricted to individuals with income up to 300% of the federal poverty level.[3]

The CLF program is administered by DAAS through contracts with community-based organizations that are selected through a competitive bidding process. The primary contract is currently held by the Institute on Aging (IOA). Smaller contracts have been awarded to organizations that provide services that support community living, such as emergency home-delivered meals and transitional care for individuals returning home after a hospital stay. Funding has also been used to develop a training institute for professional case managers that work with SPDs.

Since its inception,[4] CLF has spent approximately $23.5 million and served 2,409 clients. Over the last year, the program has maintained an active caseload between 400 and 500 clients. The average monthly cost per client has been in the $600 range. Through IOA's enrollment as a Medi-Cal provider and local lead organization for California Community Transitions, CLF has been able to leverage $600,000 of Medi-Cal funding to support CLF over four years.[5]

[3] Please see Appendix 1 for additional information about eligibility criteria.

[4] Data from June 2007 to December 2013.

[5] As a Medi-Cal provider, IOA submits claims through the California Department of Health Services In-Home-Operations Nursing Facility/Acute Hospital Waiver (NF/AH) and the California Community Transitions (CCT)

Diversion and Community Integration Program

The Diversion and Community Integration Program (DCIP) is a collaborative effort by DAAS and the San Francisco Department of Public Health (DPH). Essentially, DCIP is a multi-disciplinary team of individuals from key programs from or funded by DAAS and DPH. Some of the DCIP Core Group members include In-Home Supportive Services (IHSS), Community Behavioral Health Services (CBHS), Housing and Urban Health (HUH), LHH social services, and CLF.[6] DCIP's target consumer population is current residents of LHH and those at risk of admission to LHH.

The power of this decision-making team is two-fold: core group members bring significant expertise working with this population and also have the authority to authorize and commit to service needs. The team holds twice monthly meetings to review cases of eligible clients, who are typically LHH consumers that will soon be ready for discharge (or former LHH residents that DCIP has already transitioned to the community that may need revisiting). The group develops a Community Living Plan for every eligible client to facilitate either discharge from Laguna Honda Hospital or diversion of LHH admission. This plan always includes the client's preferences and assessed needs, and it specifies services that have been or will be arranged. Common services include IHSS home care, housing assistance, and intensive case management provided by CLF.

Since its inception, the DCIP Core Group has considered 537 cases.

Money Follows the Person demonstration project. Accessing CCT and any other waiver programs is a recommended part of the model if replicated elsewhere.

[6] See *Section IV: Description of the Community Living Plan Model* for a full list of Core Group members.

III. Project Methodology

The first two major sections of this report – *Section IV: Description of the Community Living Plan Model* and *Section V: Early Challenges and Key Lessons Learned* – are based on key informant interviews and review of planning and reporting documents from the early years of CLF and DCIP operations.[7]

The third major section of this report – *Section VI: Assessment of the CLP Model* – integrates data from:

- CLF database and program records;
- DCIP database and program records;
- CARS database for services funded by the Office On Aging (OOA);
- In-Home Supportive Services (IHSS) CMIPS database records;
- SF Department of Public Health's Direct Access to Housing (DAH); and
- West Bay Housing Corporation (WBHC)

Population parameters

The assessment of the CLP model focuses on consumers who were (1) discharged from LHH between January 1, 2010, and December 31, 2012 and (2) active with both CLF and DCIP at time of discharge.[8]

The first parameter (discharge date restriction) is applied so that project findings will be reflective of the current model and to support exploration of potential changes in services a full year after discharge. Both CLF and DCIP underwent significant change in early years of operation. By limiting the population in this way, this project is more likely to capture the trends of the more streamlined version of the current CLP model.

The second parameter (active with both CLF and DCIP at time of discharge) is applied to capture the full power of the model. While consumers may benefit from the CLP model without dual enrollment in DCIP and CLF, the combined power of these two programs is considered critical for this particular population (those at risk for institutionalization in a skilled nursing facility). Future analysis could attempt to delineate the separate impact of each program (perhaps by focusing on services and outcomes for CLF-only and DCIP-only consumers) to help further understand the impact of these programs.

With these parameters applied, this report finds that the total number of consumers active with both programs at the time of a discharge between January 2010 and December 2012 is 131.[9] Unless otherwise specified, all data in this report refers to this population of 131.

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[7] Interviews regarding program history and the CLP model were conducted with staff from: DAAS CLF; Institute on Aging, primary CLF contractor; West Bay Housing Corporation; DAAS Integrated Intake Unit; HSA Planning; DCIP Quality Assurance; LHH Social Services; and RTZ Associates, the data management vendor for CLF and DCIP.

[8] "Active" CLF case is based on dates of enrollment and disenrollment in CLF with a two month buffer on the enrollment side. An intensive case manager may begin working with a consumer before all assessments are complete and the individual is formally enrolled in CLF. "Active" DCIP case is based on occurrence of at least one DCIP Core Group review note in the time period six months before or six months after discharge (to allow for delays in manual entry of Core Group meetings notes into database) or a Case Review by the DCIP Coordinator.

[9] 178 consumers with both DCIP and CLF records have LHH discharge dates between January 2010 and December 2012. However, only 150 matched to the list of individuals with a Core Group Review. 10 consumers with a Case

Time period of interest: Transition through first year in the community

This project focuses on eighteen months surrounding discharge: six months prior to discharge through one year post-discharge. The time span from six months before discharge to six months after discharge is considered the "transition period." The transition from LHH to community living is a big change for consumers. During this time, individuals are at heightened risk for readmission to LHH, and most require significant support to achieve stability. This project reviews program enrollments and purchases during this time period. Additionally, the second six month after discharge (6 months post-discharge through 12 months in the community) is included to allow for exploration of how consumer needs may change over time and to provide a full picture of key social services needed to support these consumers in their first year back in the community.

Additional notes on CLF and cost analysis

Analysis of flexible funding: This report focuses on cost rather than number of purchases. Analysis of purchases by number is complicated by variation in recording method; for the same one week period, the same service may be purchased multiple times or recorded as one large purchase. For example, a week of home care may be recorded as purchases by shift or a single large purchase. Similarly, a housing assistance purchase may be for a single item or multiple items purchased in a single transaction.

Cost calculations. Wherever possible, this report attempts to capture the full cost of the provided services rather than identifying costs by payer. For example, the amount a consumer contributes to rent is not separated out because the point of interest is the full cost of that housing. More notes below on this decision:

- *IHSS cost calculation*. This analysis uses $16 as the cost of an IHSS provider hour (wage and benefits), which is based on the weighted average of an hour provided by an independent provider ($15.54) and an hour of care by a Consortium provider ($32.16). The vast majority (97%) of IHSS hours in San Francisco are provided by independent providers. Private home care in San Francisco costs approximately $25 per hour. Some of the cost estimates in *Section VII: Analysis of CLP Model: Trends in Costs* are recalculated in Appendix 6 using this higher rate to provide an estimate of the cost of this model if provided to those not eligible for Medi-Cal.
- *Housing cost calculation*. Per 2014 data from WBHC, the unit average is approximately $1,700 but unit rates are increasing along with the local real estate market. Units procured more recently tend to be closer to $2,000 per month, which is the figure used in this calculation. The cost of DAH units is kept low because DPH tends to master-lease entire buildings on a long-term basis, which has preserved access to lower rental rates as housing costs have increased. According to DPH staff, $1,500 per month is a reasonable cost estimate per unit, which is the figure used in this calculation.
- *Office on the Aging meals cost calculation*. Per contractual agreements with organizations that provide meals, the approximate cost of a meal is $6. Actual cost of meal may be higher than this figure but varies by provider; the actual cost and variation was not available for this report, which uses the contract rate. This report assumes consumers receive 1 meal 6 days per week.

Review by the DCIP Coordinator were added back in. Of these 161 consumers, 131 were active with both DCIP and CLF at time of discharge. 7 consumers had an active DCIP case but no CLF; 7 consumers were enrolled in CLF but were not active with DCIP. Review of case files indicates many of the "dropped" consumers passed away prior to transition back to the community (expiration is recorded as a discharge at LHH) or were moved to a higher level of care.

IV. Community Living Plan Model

The Community Living Plan (CLP) model is part of broader efforts in San Francisco to support community dignity, independence and healthy living for local SPDs. *Although the focus of the CLP model is community living, it is important to note that the top priority is that consumers receive the most appropriate care given their individual circumstances and preferences*. While the model will go to significant lengths to support community living, readmissions are not necessarily considered a failure. Consumers may need to enter institutional care for short-term,[10] long-term, and sometimes permanent stays as condition naturally and unavoidably declines or needs change over time.

Description of the CLP Model

The model is structured around four major components centered on creation of a personalized CLP for each consumer intended to support safe and sustainable community living:

- **Multi-disciplinary team** (DCIP Core Group) whose members possess varied areas of expertise, experience with the client population, and power to authorize services;
- **Housing** that includes a range of options to meet client needs and preferences;
- **Intensive case management (ICM)** to support clients through transition and stabilization in the community and to facilitate access to existing community services and supports; and
- **Flexible funding** to meet any needs not covered by existing programs and for services and/or items that may be reimbursable but for which funding is not available in advance.

The power of this model is centered on the availability and integration of these four components. Figure 1 below provides a visual depiction of the interaction of these four components around the core of the model – the personalized community living plan developed for each consumer. While this explanation of the model will presume that all four components are involved, it may be the case that some consumers may benefit from singular components of this model or transition with only one or two components.

The community living plan at the heart of the model requires strategic consideration of a consumer's individual circumstances, preferences, and needs. Creation of the plan involves identification of services and supports that will meet needs and support stability in the community. This approach can help service providers, such as the intensive case managers, consider the major service areas in which these consumers may need help and ensure that needed services are in place prior to transition. The community living plan serves as a guide and will be amended as consumer's needs change or the plan no longer adequately meets needs. While much of the planning period may be focused on supporting the initial transition, the community living plan is intended to support consumers beyond the immediate period; though services may be reduced or removed after a consumer has stabilized, the care plan is created to address needs on a long-term basis.

[10] Short-term stays are often related to caregiver respite needs or medical restabilization.

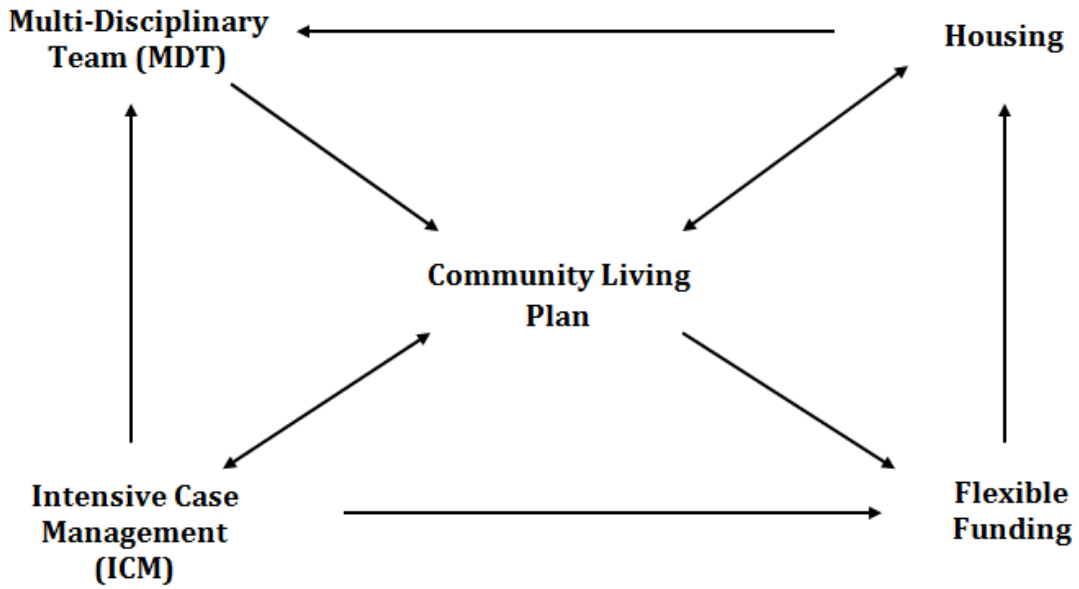
As noted in the diagram of the model below, there are *three primary sources of input into the CLP*: the Multi-Disciplinary Team (DCIP Core Group), CLF intensive case management (ICM), and Housing. CLF ICM and Housing are part of the DCIP Core Group; their initial input into a CLP is captured in the arrow from the MDT to the CLP. The CLP may include specific actions for CLF ICM and Housing to complete, which is represented by the arrows leading out of the CLP to these entities.

CLF ICM and Housing are also typically involved with a consumer after the DCIP Core Group MDT has stepped back from a case, which typically occurs after a consumer moves into the community and achieved initial stability. Occasionally, CLF ICM and Housing may make small updates to the CLP that do not require full review by the DCIP Core Group MDT; this possibility is indicated by the arrows from these entities into the CLP. Alternately, if the CLP requires a significant update or input from the experts on the MDT, CLF ICM and Housing may request that the DCIP Core Group MDT return to a case; this possibility is indicated by arrows from these entities back to the MDT.

Finally, the use of CLF Flexible Funding may be the result of the CLP or based on decisions by CLF ICM regarding particular consumer needs. A common use of Flexible Funding at time of transition is for purchase of items related to housing, such as a rental deposit or to fund modification of a unit (e.g., installation of a grab bar).

Finally, while most consumers in this model may simply need support during a transition back to the community, it is also understood that some consumers may need the type of support offered by this model on a more long-term basis.

Figure 1. San Francisco Community Living Plan (CLP) Model



Foundational Components of the CLP Model

❖ **Multi-disciplinary team (MDT)**

The DCIP Core Group meets twice monthly to review new cases, share updates on consumers preparing for discharge, and grant final approval for consumers ready for discharge with a CLP in place. The DCIP Core Group also reviews a consumer's status 30 to 90 days post-discharge to confirm the consumer is achieving stability in the community and amend the CLP as needed.

DCIP consumers become "active" DCIP cases when a Case Review is completed and submitted to the DCIP Coordinator. The DCIP coordinator determines if the case should come before the DCIP Core Group; while the majority of DCIP cases are presented to the full team, consumers with less complex needs may not need the attention of the full group if needs are minimal and a LHH social worker or CLF intensive case manager has already put together a comprehensive community living plan.

The power of the DCIP Core Group lies in in large part with the expertise and authority of its members. Members have significant experience working with this population. Consequently, they are familiar with consumer behavior patterns and service needs, and they understand how best to support vulnerabilities and meet needs. Additionally, many of these members are program managers or directors with significant authority. When they say in the meeting that IHSS needs will be reassessed or that a consumer will be taken to look at a potential housing unit, they have the authority to make that decision and ensure it is carried out.

The members of the DCIP Core Group include:

- Laguna Honda Hospital and Rehabilitation Center (LHH)*
  - Social Services
  - Substance Abuse Treatment Services (SATS)
- Community Behavior Health Services*
  - Treatment Access Program (TAP)
  - Behavioral Health Access Centers (BHAC)
- Health and Urban Housing*
  - Direct Access to Housing (DAH) program
  - Health at Home
- Scattered Site Housing contractor: West Bay Housing Corporation (WBHC)*
- Community Living Fund primary contractor: Institute on Aging (IOA)^
- Adult Protective Services (APS)^
- In-Home Supportive Services (IHSS)^
- IHSS Consortium (contract mode IHSS)

**= SF Department of Public Health*

^ = SF Department of Aging & Adult Services

❖ **Housing**

Housing is provided primarily by two sources: the Direct Access to Housing program (DAH) and a contractor that provides scattered site housing units, West Bay Housing Corporation (WBHC). DAH units are part of the Housing and Urban Health section of the Department of Public Health and provide permanent supportive housing for low-income San Francisco residents who are homeless and have special needs. As a "low threshold" program, DAH accepts adults into permanent supportive housing directly from hospitals and long-term facilities. Consumers with more complex needs are often offered

DAH units, as this program is oriented to help consumers stabilize and improve health outcomes despite co-occurring mental health, substance use problems, and/or complex medical conditions. With representatives from DAH in the DCIP Core Group, the CLP model has access to these valuable units.

Scattered site housing offered through WBHC is a valuable method of expanding housing availability in a city with limited residential space. WBHC holds master and corporate leases with private properties and subleases units to consumers; these units may be in supportive housing sites or market-rate properties. Consumers are required to pay half of their monthly income towards rent[11] and must work with a money management service. Housing retention specialists conduct weekly check-ins during the first month and then transition to monthly check-ins with consumers to assess condition of the unit and check in with the consumer. These specialists also touch base with property managers monthly to help maintain positive relationships and learn about any potential concerns. Because these visits persist throughout a consumer's residence in a WBHC-procured unit, these specialists often maintain the longest contact with consumers. This contact can be a critical component of the CLP model; if a consumer's needs have changed and previous community living plan is no longer adequate, WBHC can alert the DCIP Core Group to reactivate the case and update the plan, thus potentially warding off an acute episode or preventable decline in condition. These units are often a better fit for more stable consumers that may have greater physical care needs but fewer behavioral health issues.[12]

A third – and less common – source of housing support comes from the CLF flexible funding. A small number[13] of consumers receive monthly funding for board and care. Additionally, CLF flexible funding may be used for one-time housing-related payments, such as a security deposit.

❖ **Intensive case management (ICM)**

Most intensive case management (ICM) is provided through the primary CLF contractor, the Institute on Aging (IOA). IOA has a small number of subcontracts with local community-based organizations to expand its capacity to provide intensive case management. These case managers typically have 15-22 intensive cases at a given time.

Intensive case management focuses on preparing consumers for discharge[14] and supporting stabilization during the transition period. As compared to other case management, this case management is considered intensive due to the high level of follow up and interaction with consumers, as well as the complexity of this population's needs. Intensive case managers conduct a thorough assessment of consumers that includes physical needs, psychological and mental cognition, substance use history,

[11] Consumers with a Medi-Cal Share of Cost pay half of their remaining income after the Share of Cost is paid.
[12] Refer to Section V ("Early Challenges and Lessons Learned") for more information about consumer-unit fit.
[13] Per a 2013 DCIP Project to Date report, approximate 9% of consumers were placed in board and care facilities (this number is provided as a rough estimate; it does not include CLF-only consumers and may include consumers not receiving assistance from CLF flexible funding).
[14] Refer to *Section V: Early Challenges and Lessons Learned* for more information about the importance of early ICM involvement.

medical equipment needs, and medical history to comprehensively understand a consumer's needs and strengths. During the immediate period post-transition, intensive case managers conduct a minimum of 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; however, contact may be more frequent as needed. This system of progression allows consumers to incrementally assume responsibility and become more independent. Intensive case managers participate in psychologist-facilitated care conferences twice a month; these meetings include an in-depth case review, follow-up on previous cases, and skill-building training.

As described below, intensive case managers can purchase necessary services or items when no alternate resources are available. Like other case managers, these case managers make referrals to other services and programs as appropriate and follow up to make sure the client receives the services.

❖ **Flexible funding**

In the context of this model, flexible funding is administered by CLF through its primary contractor, IOA.[15] Flexible funding is used for a variety of services and items. This system was purposefully designed to maximize flexibility and ensure consumers receive anything critical to stable community living. As a comparison, the Medi-Cal Multipurpose Senior Service Program (MSSP) also permits case managers to purchase services but only those from a designated State-approved list. Typical CLF purchases include hospital beds, installation costs for grab bars, bed linens, and additional home care hours.

Intensive case managers must request approval from a clinical supervisor to purchase necessary services or items. When recording purchases in the CLF database, they follow special coding protocols for purchases that may be reimbursable through the California Community Transitions (CCT) or the Nursing Facility In-Home Operations Medi-Cal Waiver (IHO) – IOA is enrolled as a Medi-Cal provider and serves as the lead agency for CCT in San Francisco. Accessing these funding sources is a recommended part of the model if replicated elsewhere.

Part of the role of the intensive case manager is to support CLF's role as payer of last resort by ensuring that all other alternative payer sources are exhausted prior to purchase using flexible funding. All purchase decisions must be justified as necessary to support community living and avoid institutionalization. Additionally, the IOA accepts donations and reallocates items (such as wheelchairs) whenever possible to preserve flexible funding reserves.

[15] As noted in Section II ("Background"), CLF funding is also used by DAAS to fund additional services that fall outside the focus of this model, such as emergency home-delivered meals. These additional services are intended to support the CLF-population but do not require individuals to enroll in ICM or register with CLF.

Reflection: Early Challenges and Key Lessons Learned

Established in the late 2000s, the CLF and DCIP programs were thoughtfully created and modified in the early years as staff learned more about how to best support consumers to live safely and successfully in the community. This section of the report summarizes key challenges, identifies major lessons learned, and describes strategies utilized to overcome these hurdles as San Francisco developed its community living model. While this section focuses primarily on the initial start-up phase (2007 – 2010), it is important to note that the model is constantly evolving as new services are created or integrated and as community needs change.

Challenge: Communication across departments, sectors and fields.
Lesson: Clearly articulated communication process increases accountability.

The San Francisco community living model is based on intensive collaboration across city departments, the public and private sector, and professional fields (e.g., social work, medicine, housing). While any new program or process is likely to necessitate creation of new communication paths and procedures, the early years of CLF and DCIP required careful and dynamic planning. As the active consumer base increased, it became more apparent that articulation and implementation of a clear communication process was needed to ensure efficient processing of DCIP cases.

The following procedures were incorporated into the DCIP process in 2010:

- ***Update within 6 weeks of initial presentation***. To encourage the discharge process and minimize "stalling" of cases, DCIP requests an update 6 weeks after the initial presentation to the DCIP Team.
- ***Assignment of a lead case management agency***. When the DCIP Team gives a final approval for discharge, the lead case management agency is identified and documented in the case review tab of the database.
- ***Review all cases after discharge***. The DCIP Team reviews all cases 30-90 days after discharge for continuing provider communication. The audits are documented in the DCIP database.

Challenge: Consumer anxiety surrounding transition.
Lesson: Involve community service providers in discharge planning.

Despite desire to live in the community, consumers can experience anxiety related to discharge. Many are nervous to leave the supportive community at LHH, where they may have lived for years and know that their needs will be met by competent staff. Consumers are often worried about resuming responsibilities or returning to environments that may tempt their recovery; they may also doubt the ability of care providers to meet their needs. This anxiety can result in resistance to transition planning and instability after a transition has concluded.

To alleviate consumer anxiety and support post-transition stability, the DCIP core group purposefully modified its protocol to strategically integrate the following services into discharge planning:

- ***Home care****.* Clients often have complex care needs. Prior to discharge, the San Francisco IHSS program assesses need and authorizes hours and IHSS care providers are trained by LHH staff to reduce the risk of failure due to inadequate physical care in the community. This approach allows consumers to start building relationships with providers and be reassured that their new provider will understand their particular care needs.
- ***Intensive case management (ICM)****.* Prior to a client's discharge from Laguna Honda, CLF case managers begin working with consumers in collaboration with Laguna Honda Social Services. Part of this involvement is focused on engaging consumers in organized community activities, such as enrollment at City College of San Francisco, initiation of vocational rehab services, or visits to Community Based Adult Services (CBAS) sites. In addition to establishing trust between the consumer and their new case manager, planning for these activities can help manage consumer feelings of anxiety, isolation, and uncertainty during transition.
- ***Housing***. Consumers are typically taken to visit their future housing unit prior to discharge from LHH. These visits allow an individual to assess the suitability of a living space for their individual needs and visualize where they will be living, which can help allay anxiety and support engagement with transition planning. These visits give consumers the opportunity to accept or decline a unit, which is in keeping with San Francisco's commitment to client-centered planning and belief in an individual's right to self-determination.
- ***Mental health and/or substance abuse services*****.** Involvement of Behavioral Health Treatment Access Program (TAP) facilitates a client's early engagement with mental health and/or substance abuse services. Through motivational interviewing, TAP clinicians explore treatment options directly with Laguna Honda residents. Their recommendations for the most clinically and culturally appropriate treatment settings, ability to quickly respond to clients seeking treatment and assistance in addressing risks and reducing barriers that clients are likely to encounter immediately following hospital discharge have been extremely beneficial.
- ***Peer mentor****.* Individuals who have successfully transitioned to community living provide a reassuring example for LHH residents and can understand the perspective of LHH residents in a different way than the other professionals involved in discharge planning. Established in 2009, the IHSS Public Authority Consumer Peer Mentor Program provides support and guidance to LHH residents transitioning to the community; this popular program has grown steadily since its inception. Peer Mentors partner with LHH Activities staff to coordinate twice-monthly small group outings for residents in the initial stages of considering independent living and also partner with LHH Social Services staff to host a weekly open house/focus group. These activities increase consumer interest in transition and provide additional opportunities to discuss concerns about return to the community.

Challenge: Staff overwhelmed by complexity of consumer needs.
Lesson: Provide additional training opportunities and support for line staff.

Though trained and experienced in case management, CLF case managers were initially challenged by the scope and intensity of this population's needs. In particular, staff expressed a need for help related to consumers' mental health and substance use needs. The DCIP core group also identified a need for training for WBHC housing retention specialists that manage SSH units. Though intensive case management concludes when consumers have achieved stability in the community, WBHC staff conduct regular check-ins with consumers throughout their residence in SSH units. However, the housing retention specialists were not necessarily trained to work with this population.[16]

In response to these challenges, the following actions have been taken:

- ***Creation of a Care Management Training Institute for DCIP partners*.** In 2009, CLF funding was used to create a training institute to increase staff capacity to work with this population. Trainings in Strengths-Based Case Management and Motivational Interviewing are provided regularly for key DCIP partners, including staff from LHH, CLF, Placement, and WBHC. Courses are intended to promote staff understanding of people and their capacity to change (or not), build more collaborative alliances with challenging clients, and develop strategies to elicit client engagement.
- ***Addition of a psychologist to CLF*.** In 2012, CLF noted an increase in consumers struggling with mental health issues that affected their ability to live independently. A part-time psychologist was added to the CLF staffing structure to work directly with both consumers and case managers. The psychologist supports a program of psychology students that provide short-term home-based therapy as a bridge to community-based services for consumers less inclined to access services in the community (perhaps due to physical limitations or resistance to mental health services). The psychologist works with case manager to improve understanding of how mental and behavioral health issues can affect a client's change capacity and consults with case managers to develop strategies to engage clients with particularly difficult behaviors and personality disorders in DPH mental health services.
- ***Property management-related trainings***. WBHC also identifies opportunities to expand staff knowledge of property management, which improves housing retention specialists' ability to understand the perspective of SSH property managers.

Challenge: Availability of appropriate housing.
Lessons: (1) Develop and maintain strong relationships with SSH property managers.
(2) Be judicious in housing arrangements.

The limited availability of housing units in San Francisco is a consistent threat to the CLP model's ability to transition clients into the community. Units procured by WBHC may be in older buildings in the city, which can present accessibility challenges for consumers with limited mobility. Especially in the early

[16] In addition to behavioral health training, housing staff needed training in end-of-life care and support.

years of operation, transitions were sometimes delayed while waiting for approval for necessary unit modifications, such as installation of a roll-in shower. More recently, some property managers have indicated a desire to stop using corporate lease structure.[17] Additionally, property managers may have concerns about working with this population and its complex care needs. If a consumer acts out in a SSH unit, there is a risk that the property manager may decide to evict the consumer or stop working with WBHC altogether, which would negatively affect other consumers.

In response to this challenge, the model has incorporated changes based on the following two lessons:

- ***Build strong relationships with SSH property managers***. After property managers reported feeling that they had lost control of their units after signing corporate leases, WBHC instituted regular meetings with property managers to discuss any updates or concerns. These regular meetings have helped establish a sense of teamwork and trust. WBHC makes a point to be responsive – from always answering phone calls to instituting immediate crisis intervention when necessary – and property managers have expressed appreciation for that responsiveness. As a result, housing modifications typically proceed more quickly and WBHC has been able to push back against a significant number of lease non-renewals to maintain units.
- ***Thoughtfully match consumers to housing options***. Clients with complex medical and perhaps behavioral issues, as well as those with prior history of long periods of homelessness, may have more early success living in residential hotels or DAH units where property management is more familiar and has more experience working with the challenges presented by this population. In placing consumers in market rate properties with multiple SSH units, WBHC attempts to provide a balance of consumers higher and lower level need.

Challenge: Client stability when returned to the community.
Lessons: (1) Assess consumer's motivation.
(2) Engage client in services prior to transition.
(3) Be judicious in housing arrangements.
(4) Confirm medication refills.
(5) Engage consumers in meaningful activities to prevent social isolation.

While overall rates of readmission to LHH are low, consumers sometimes fail to thrive in the community. Consumers may end up in acute care at a local hospital, go AWOL from housing, or resume problematic behaviors (e.g., substance use). The explanations and lessons described below provide some insight into strategies used to support stability.

- ***Importance of consumer motivation.*** The DCIP core group has identified consumer motivation as a critical indicator of potential success. Those who participate in activities at LHH and have agreed to engage in services in the community – or have already began to participate in

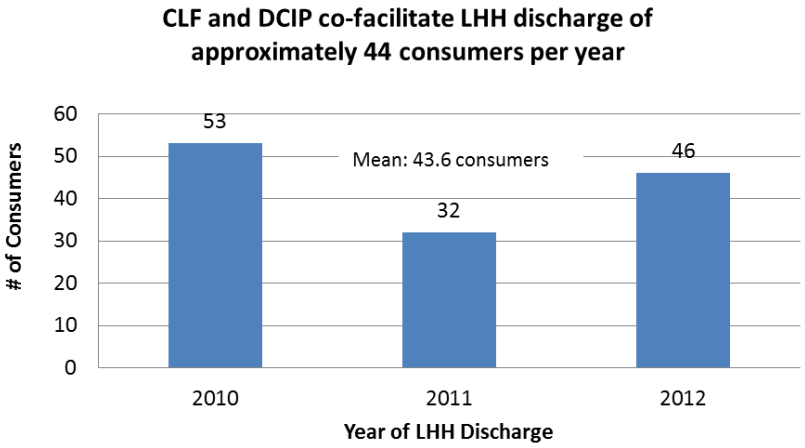
[17] While this preference may be driven in part by negative experience with consumers, it is also believed that property managers want to have more freedom to take advantage of the rapidly increasing market rental rates.

community-based services – tend to be less likely to resume problematic behaviors and are more likely to achieve stability in the community.

- ***Early engagement in services***. In addition to alleviating anxiety regarding the transition to community living, early involvement of community-based services – especially the CLF case manager and TAP mental/behavioral health services – supports continued engagement in services when living in the community. Consistent involvement with these programs can help clients resist negative influences and support stability.
- ***Thoughtful assignment to housing***. While there are common trends among the LHH population, DCIP has learned that variation in individual preferences and needs should be taken into account when matching consumers to housing options. More specifically:
    - Many SSH and DAH units are located in or near neighborhoods with significant substance use. Despite making significant strides towards recovery while at LHH, consumers with a history of substance use may find it challenging to maintain recovery in these environments. In such cases, DAH housing with wraparound support services on-site is often a better match than a SSH unit directly in the mainstream community. However, given that these DAH units are expensive and limited in number, these spaces must be reserved for those with the highest level of need or at most risk for problematic behaviors (e.g., resumption of substance use). Additionally, clients in these units are monitored through quality assurance visits and by community case managers for changes in need that might allow a move to more independent housing. Such moves also support turnover and availability of these units.
    - Similarly, the DCIP core group found that some consumers – particularly those with a previous period of homelessness – are uncomfortable in newer housing and would prefer to live in older housing or a residential hotel. If it is clear that the consumer is motivated to live healthfully and engage with services and that this housing preference is not related to plans to resume substance use behavior, matching a consumer to a "less nice" housing unit may promote stability.
- ***Medication refills in the first month must be confirmed***. Early in DCIP operations, it was discovered that some consumers were missing their first appointment with a new primary care provider and consequently were not obtaining needed medication refills. Many of the medications taken by this population are critical for both mental and physical health. To ensure continued compliance with medication regimen after 30 days post discharge, DCIP instituted a process by which case managers collaborate with the DPH Housing and Urban Health clinic to ensure access to medication. CLF case managers also emphasize the importance of attending the first primary care appointment to their clients.
- ***Help consumers engage in meaningful activities to mitigate social isolation***. Leaving the LHH community may result in a sense of social isolation, especially for those who lack social ties in their new community. Some consumers would take the bus back to LHH during the day to spend time in their former community. Helping consumers find meaningful ways to spend their time outside of institutional care can encourage formation of new relationships and prevent this sense of isolation.

V. Analysis of CLP Model: Trends in Consumer Population[18]

This section explores both demographic trends and service/item needs of this consumer population. However, first it is worth noting that CLF and DCIP tend to co-facilitate approximately 44 consumer transitions per year.[19]



Part 1: Trends in Demographic Characteristics

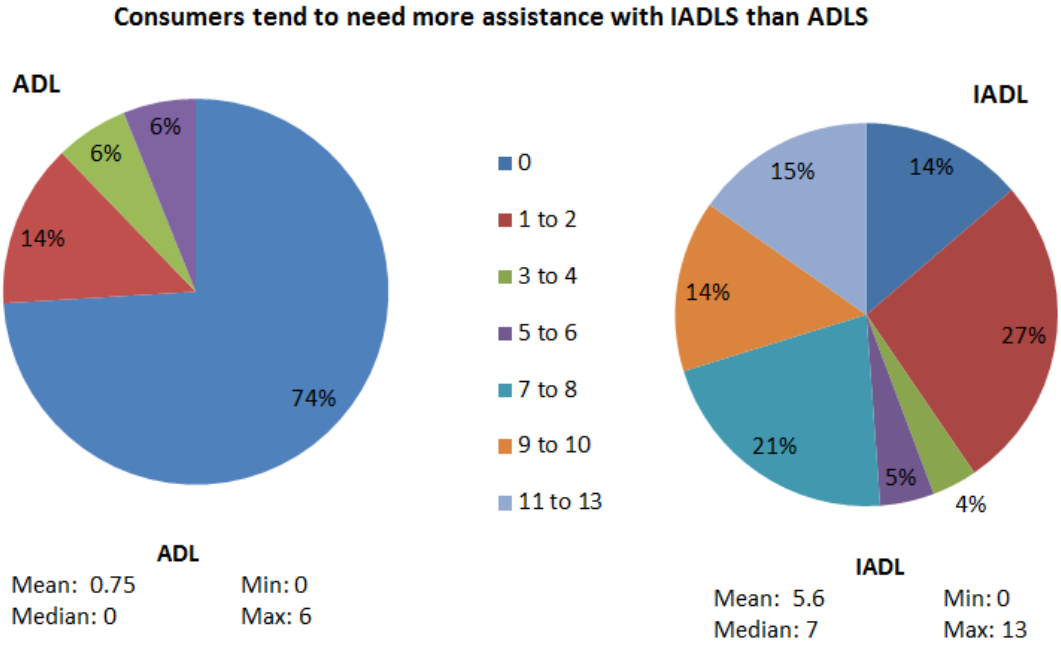
- ***Age***: CLF-DCIP consumers tend to be middle-aged. The mean and median age is approximately 52 at time of discharge from LHH.
- ***Race***: Race data is missing for almost half of CLF-DCIP consumers (48%). Of records with race indicators completed, consumers tend to be white (44%), African-American (34%), or Latino (12%).
- ***Gender***: Most CLF-DCIP consumers are male (77%).
- ***Education***: Approximately 35% of consumers have completed at least some education at a higher level. However, the majority of consumers have a high school education or less (61%).
- ***Income***: Consumers typically have income between $800 and $1,000. Given that the median income is $845, it is likely that most of these consumers receive Supplemental Security Income (SSI) – the maximum monthly SSI benefit is in the $800 range. Additionally, while 18% of consumers are listed with no monthly income, it may be the case that the CLF assessment was completed prior to submission of an SSI application and that these consumers later became eligible for some monthly income. The mean income is $707.
- ***Healthcare coverage***: Most consumers have healthcare coverage through Medi-Cal (92%). Notably, less than one-third (32%) have some form of Medicare coverage, which is a major healthcare program for disabled and elderly adults (and low-income individuals are potentially eligible for premium-free Medicare). Seven consumers (5%) have no insurance indicated in the CLF assessment.

[18] Data tables available in Appendix 2.

[19] Per conversation with CLF and DCIP Core Group members, this figure seems low. However, review of the data extracts and project methodology substantiates this number. It should be noted that this analysis does not consider repeat discharges as distinct consumers; only a consumer's first discharge in the time window is explored, which likely reduces numbers.

Part 2: Trends in Consumer Needs

- ***Activities of Daily Living and Instrumental Activities of Daily Living***: Review of CLF needs assessment data indicates that consumers are more likely to need help with one or more Instrumental Activity of Daily Living (IADL) than Activity of Daily Living (ADL).[20]



  As noted in the previous section, this population tends to be younger individuals – not older adults in the last years of their lives, which is often the stereotype of nursing home residents. The anecdotal impression of CLF staff is that these younger disabled consumers can typically take care of their basic needs but need help with other parts of community living, such as meal preparation, laundry, and behavioral health issues. This data supports this anecdotal impression.

- ***Medical conditions***: Consumers tend to be diagnosed with multiple medical conditions. **Approximately 70% of consumers have been diagnosed with 3 or more medical conditions**. The most commonly diagnosed condition is HIV/AIDs (47% of consumers). Other common diagnoses (38% to 34%) include circulatory, genital/urinary, infections, endocrine/gastrointestinal, and neurological conditions.
- ***Mental health issues***: CLF intensive case managers tend to identify that **on average consumers have 3 psychological functioning issues**. The most common issues are depression (69%), anxiety (62%), and grief (58%).
- ***Equipment***: In conducting needs assessments, intensive case managers identify medical or home equipment that consumers require to live safely in the community. **Most consumers require 6 or 7 items**. The majority of consumers have need for at least one bathroom-related item: 76% require a shower-related modification and 68% require a bath bench. Most consumers (53%) require a wheelchair or scooter, and many (31%) require a cane.

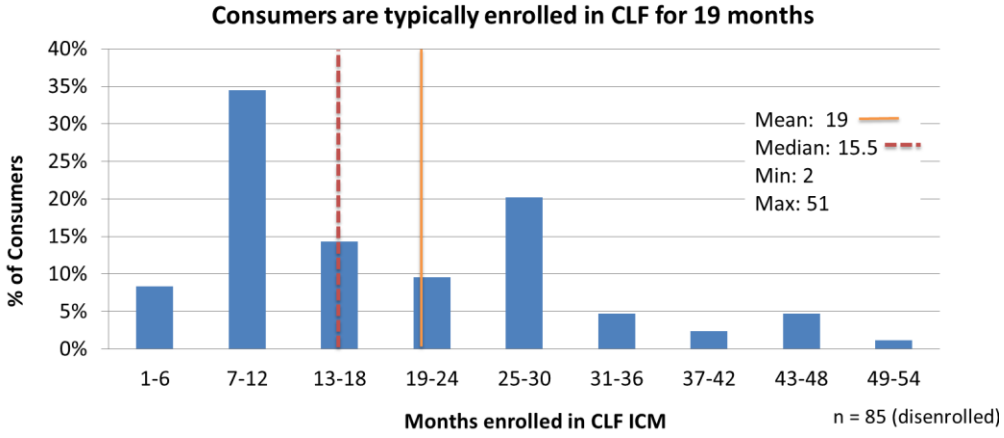
[20] ADLs and IADLs are measured on a scale of "Independent" to "Paramedical." For the purpose of this analysis, only activities in which a consumer needs "Lots of Human Help" or more assistance were counted. When "Some Human Help" is included, more consumers have expressed need but the trend remains – 44% do not need help with a single ADL, while only 2% are independent with IADLs and 82% need assistance with 5 or more IADLs.

VI. Analysis of CLP Model: Trends in Program Enrollment[21]

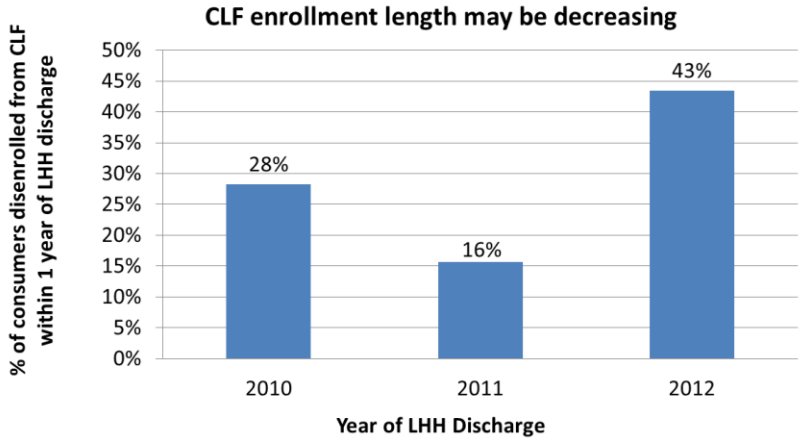
This section explores CLF enrollment length and number of DCIP Core Group reviews, as well as enrollment in other relevant services (IHSS, OOA meals, and housing).

Consumers tend to be enrolled in CLF for approximately 19 months – but data indicates enrollment length may be decreasing.

As shown in the chart below, consumers tend to be enrolled in CLF for 19 months (albeit with a significant range on either side).[22]



Analysis of percentage of cases closed within 1 year of discharge suggests that CLF enrollment length *may* be decreasing. As shown in the chart below, the rate of CLF disenrollment within the first year after discharge was much higher for individuals discharged in 2012: 43%.



While more data and analysis are needed to confirm this trend, it is reasonable to speculate that the CLP model may have become more efficient over time. IOA has focused on caseload turnover and put increased emphasis on utilizing other less-intenstive case management progams as part of the "step

[21] Data tables available in Appendix 3.

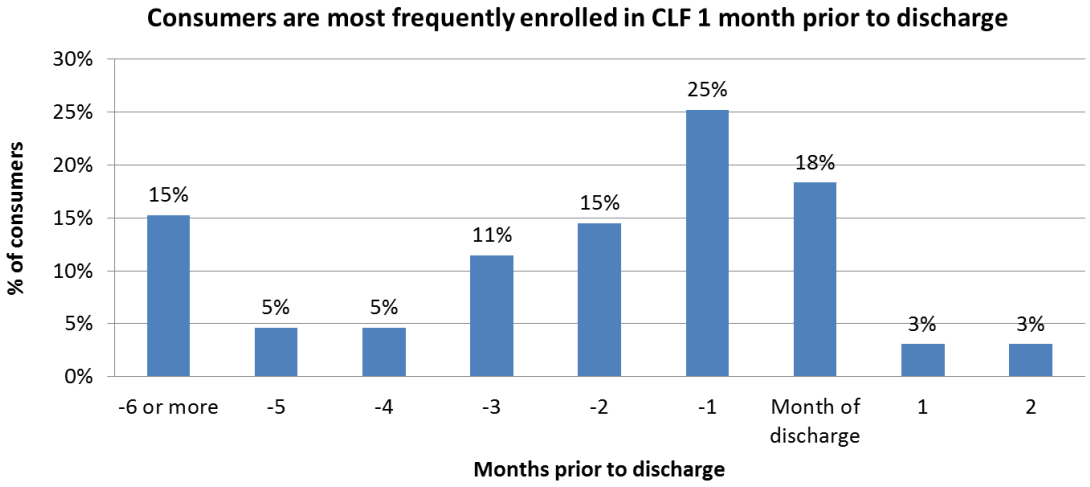
[22] This data refers to disenrolled consumers only. Analysis of enrollment is complicated by the fact that those currently enrolled obviously do not have a finite enrollment length, and it is impossible to know how long their total enrollment will be. This average estimate is biased downward because those who are still enrolled are likely to have longer enrollment and will increase the average enrollment length. With all consumers included the mean and median increase to 21.

down" proces. Re-referrals are also given priority at the top of the waitlist to encourage intensive case managers to disenroll clients when possible.

However, this data may also be reflective of changes in the consumers targed by the Core Group over time and the approach of LHH Social Services staff. The former DCIP coordinator recollects that the Core Group initially focused on consumers that were near-ready for discharge to help make space at LHH for others more immediately. Then they started targeting more entrenched, long-term LHH residents, who may have had more complex needs or been less psychologically prepared for independent living, which may explain the longer enrollment among those discharged in 2011. More recently, LHH Social Services and the DCIP Core Group have started discharge planning earlier so that transition can begin as soon as a consumer becomes medically stable. This proactive approach that focuses on return to the community may promote psychological resilience and reduce the need for extended support after transition.

Consumers typically enroll in CLF prior to discharge – most commonly in the month prior to discharge.

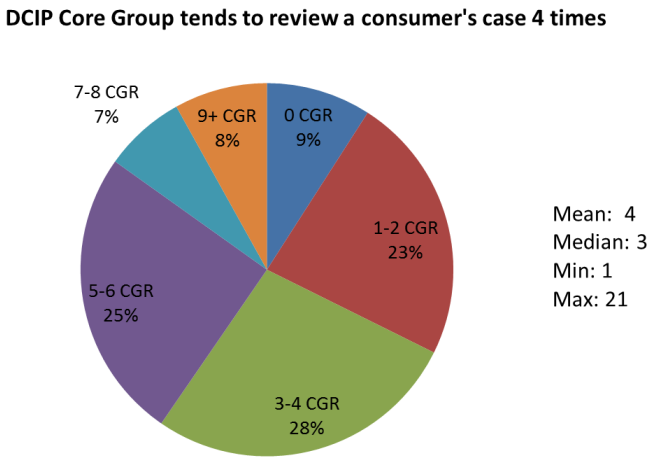
As shown in the chart below, consumer enrollment in CLF typically occurs in the few months prior to discharge or in the month of discharge from LHH. This data reflects the CLP model goal of initiating intensive case management early to support smooth transition into the community.



Most consumers are discussed by the DCIP Core Group 4 times.

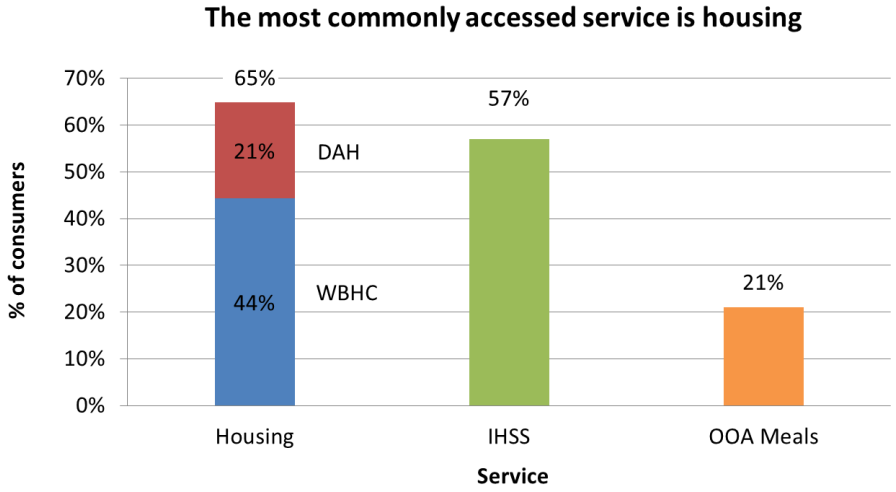
The DCIP standard for case review has evolved over the years to the current protocol of 4 Core Group Reviews (CGR): the initial presentation, an update during preparation for the transition, final Core Group approval for the discharge, and then an update within 90 days after transition. The mean (4) reflects this policy. The median (3) likely reflects that there was less structure in the early years.

The higher numbers likely reflects the fact that some consumers have more challenges associated with the transition and/or maintenance of stability and thus require more attention and planning from the DCIP Core Group.



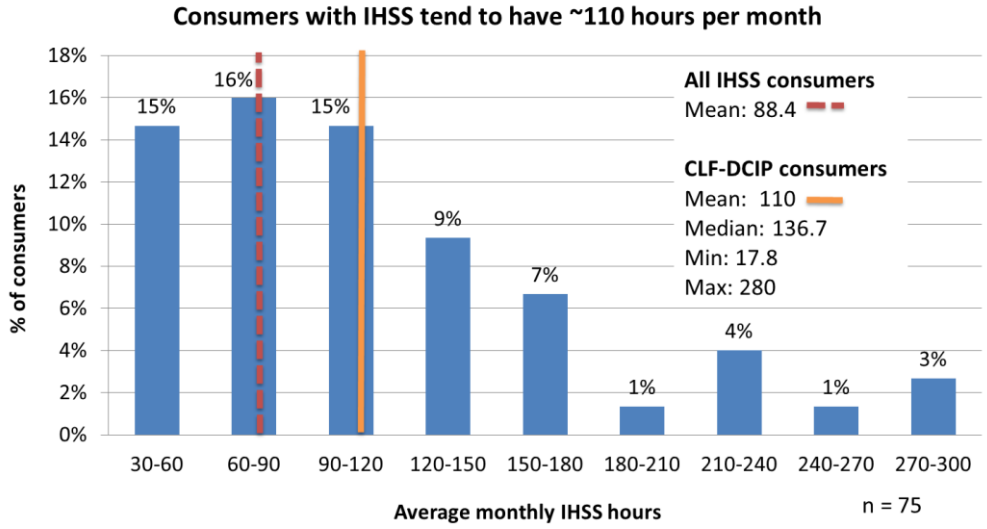
Of other key social service programs, housing is most commonly accessed by these consumers.

Of the major local programs for which data was available, consumers are most likely to receive housing assistance (65% are housed by either WBHC or DAH). Most consumers (57%) also access In-Home Support Services (IHSS) at some point within 1 year of discharge. A smaller percentage of consumers (21%) access home-delivered or congregate meals through the Office on the Aging (OOA), which is interesting given that these consumers have quite limited income and, as SSI recipients, are likely ineligible for food stamps.



CLF-DCIP consumers with IHSS tend to receive 110 hours of care per month, which is slightly higher than the full IHSS caseload average of approximately 88.4 hours.

Consumers enrolled in IHSS for home care typically receive approximately 110 hours of care per month from the Medi-Cal benefit program. This figure is higher than the full IHSS caseload average of 88.4 hours per month.[23] This variation likely reflects the fact that this population tends to have complex care needs.



[23] Based on 2013 IHSS data

VII. Analysis of CLP Model: Trends in Costs[24]

This section focuses first on CLF flexible funding spent to purchase of services and items for consumers and then estimates more comprehensive cost calculations that include IHSS, housing, and OOA costs.

Part 1: CLF flexible funding expenditures

This section analyzes trends by purchase area and per consumer costs. This analysis describes multiple data points that center on two underlying key findings:

- ***In the time period explored in this project, CLF flexible funding purchase and costs are clustered around discharge from LHH.***

  The total amount spent is $322,953, which is used primarily to purchase items and services that support transition (e.g., rental deposits and non-medical home equipment). After discharge, fewer consumers received purchased services and items, total amount spent on purchase decreases, and fewer types of purchases are made. For example, no housing assistance purchases were made for these consumers between 6 and 12 months after discharge. This suggests that ongoing purchase needs are not common among this population but that early investment is needed to help them reintegrate in the community.

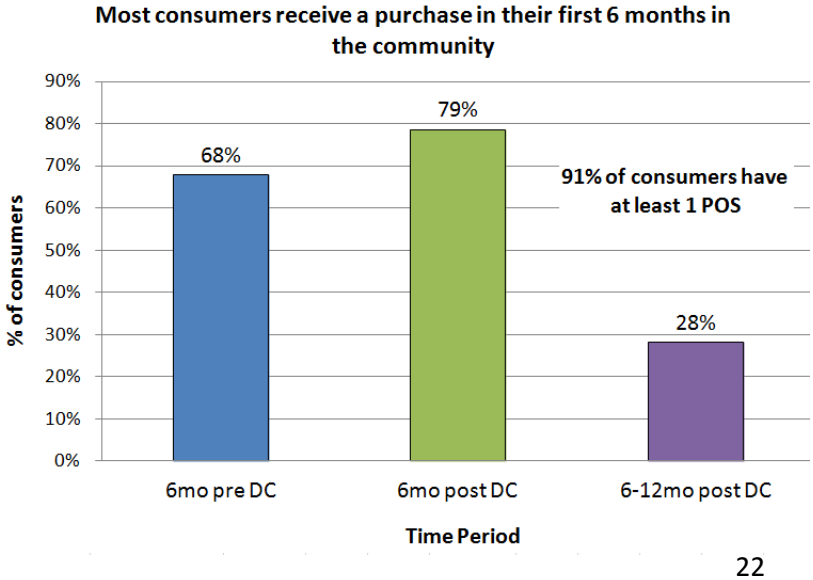
- ***Consumer costs are typically quite low – a small percentage of individuals consume a disproportionately high share of this flexible funding.***

  Review of individual-level data on total flexible funding expenditures indicates that the vast majority of consumers benefit from a disproportionately small portion of funding – 90% of consumers account for only 50% of the total flexible funding. Total expenditures are driven by a small number of consumers; the 4 most expensive consumers represent 3% of the population and receive 25% of flexible funding expenditures. Half of consumers receive purchases totaling $1,658 or less.

The evidence below supports these two findings:

- ***Consumers are most likely to receive purchase during their first 6 months in the community.***

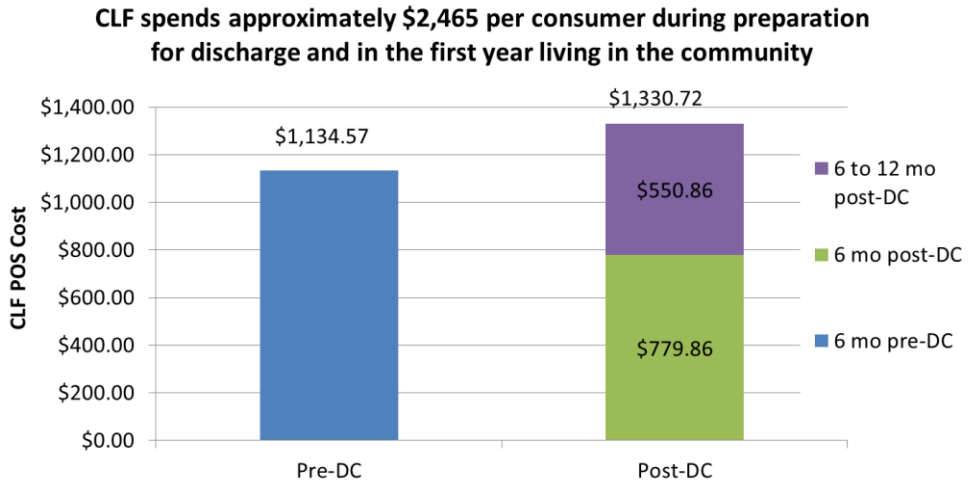
The vast majority – but not all – consumers receive at least one purchased service or item. The time period in which most consumers receive a purchase is the first 6 months in the community. This data suggests purchases for most consumers are for discharge-related needs, such as items needed to prepare a housing unit for habitation.



[24] Data tables available in Appendix 3.

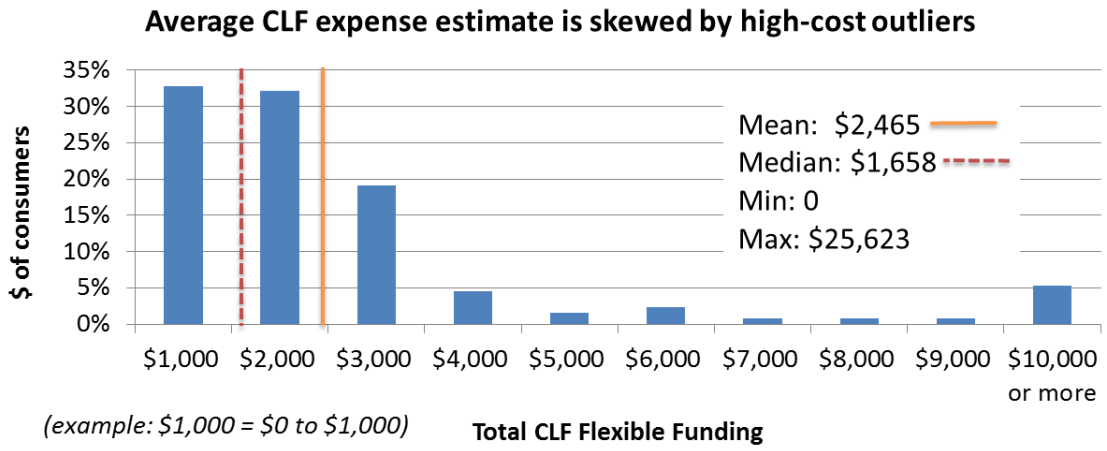
- ***On average, $2,465 of CLF flexible funding is spent per consumer in the lead up to discharge and in the first year living in the community – and almost half is spent during prior to discharge.***

On average, intensive case managers purchase $2,465 worth of services and items for consumers to support the first year of community living. This calculation includes all consumers, including those for whom no purchase is made.[25]



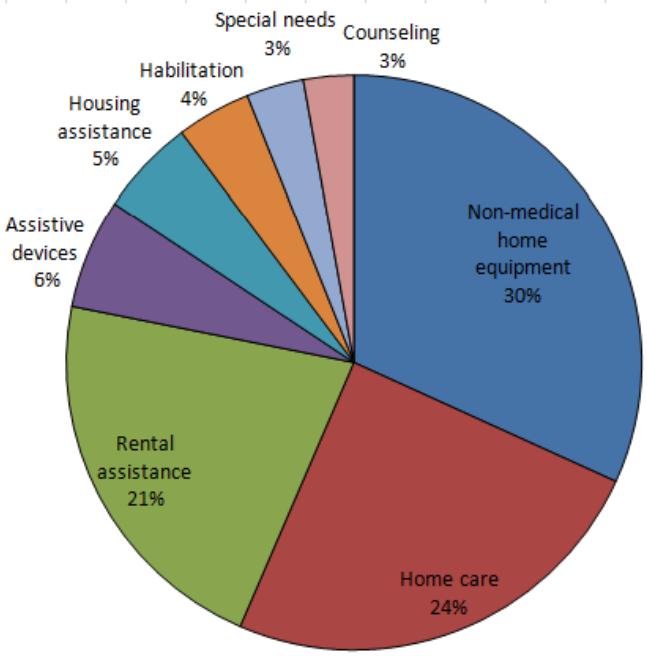
As depicted in the chart above, a little over a thousand dollars is spent on average in the 6 months prior to discharge. Interestingly, though fewer consumers receive a purchase in this time period, this cost is higher than the first 6 months in the community. The cost in the first 6 months in the community is typically lower at about $780. After living in the community, the average cost is lower at about $551. While these purchases tend to be concentrated around the time of discharge, it is worthwhile to calculate this aggregate figure as a per-month cost for the first year in the community: $205.

Notably, as shown in the chart below, further exploration of average total CLF spending per consumer indicates that this average is biased upward by high-cost outliers.



[25] By including all consumers in the calculations above, the estimates represent the most accurate average cost of flexible funding use for this population. If the calculation is changed to focus only on consumers with at least 1 purchase, the average cost increases slightly to $2,714. Average time period costs increase as follows: $1,249 pre-discharge; $859 in the first 6 months; and $607 in the 6 to 12 months after discharge. The per-month cost is $226.

- ***Of the $322,953 of CLF flexible funding spent on consumers, the most funding was spent on non-medical home equipment (32%). When considered together, housing-related purchases total 56% of spending.***

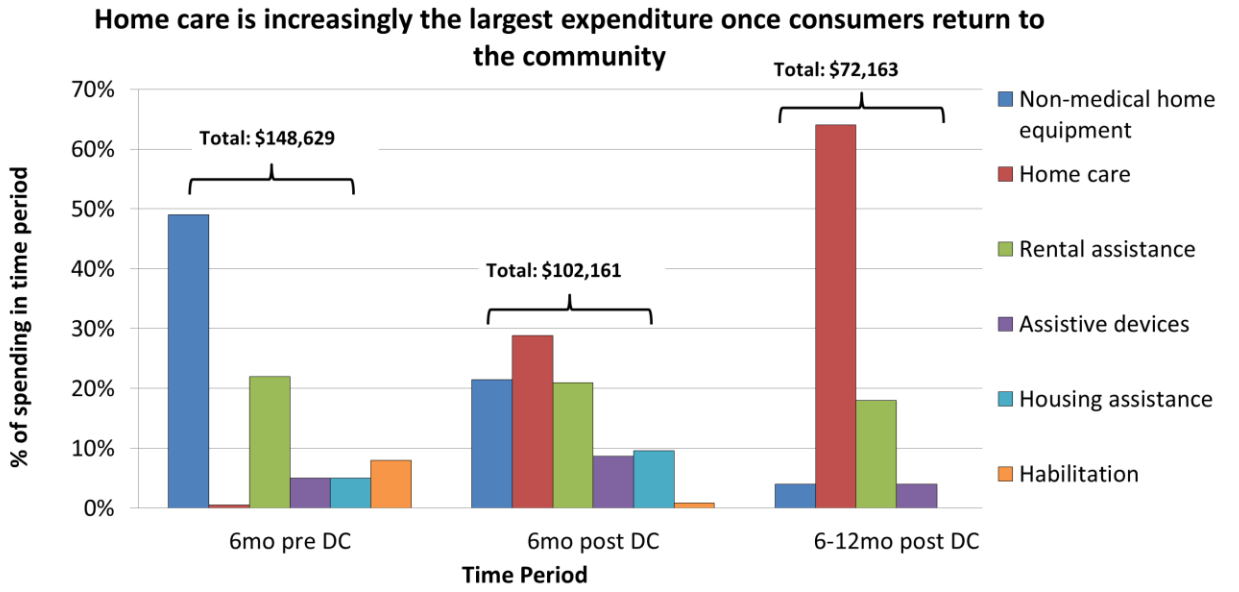


In the 6 months pre-discharge through 1 year post-discharge, **$322,953 was spent to purchase items and services not covered by other programs** for the 131 consumers that met this project's parameters.

Housing-related purchases total 56% of spending. The largest single-category purchase area was non-medical home equipment ($98,096 or 32%). Many of the higher-cost purchases (in the $1,000 range) were furniture items. Rental assistance – primarily security deposits and other one-time assistance payments – represent 22% of the cost or $66,834 of total funds spent. Housing assistance – primarily home modifications and bed bug treatments – comprised 5% of spending or $16,764. The largest non-housing related purchase area was private home care purchases, which represent 25% of the cost and total $76,154.

- ***Purchases change over time, with home care becoming increasingly the largest purchase area as consumers live in the community.***

As shown in the chart below, the largest cost area shifts from non-medical home equipment to home care after discharge. Additionally, the total cost spent as consumers stabilize in the community decreases significantly from a total cost of $148,629 in the 6 months pre-discharge to $72,163 in the 6 to 12 months post-discharge. This data suggests that once a consumer's home is established, they do not tend to need additional or significant purchases in that area.

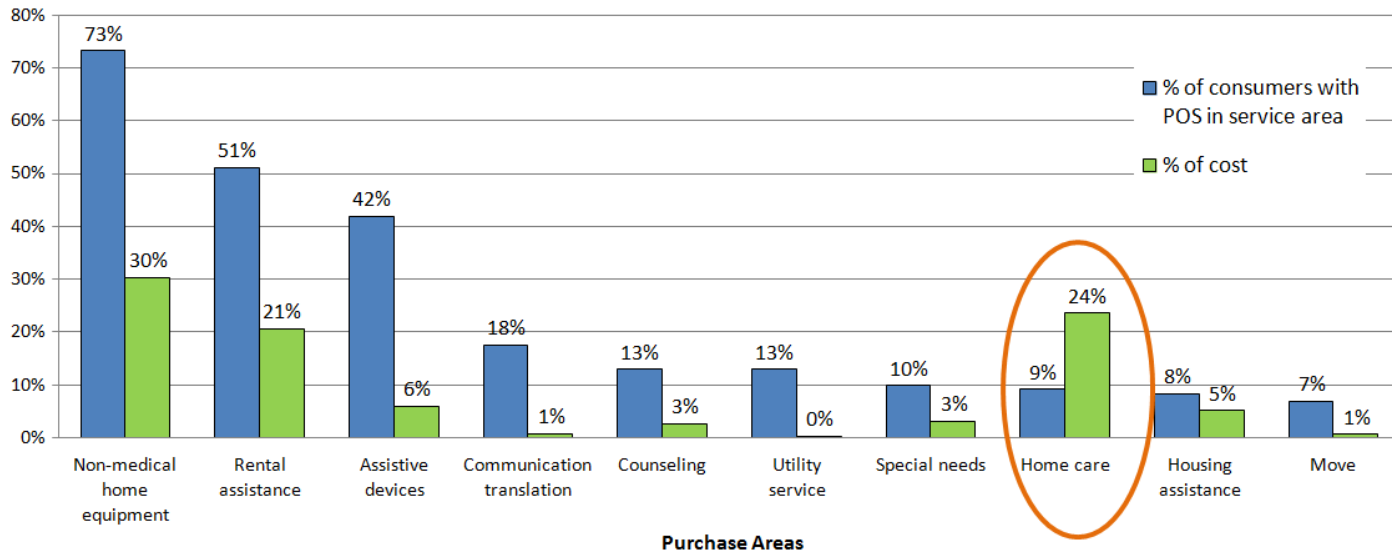


- ***Flexible funding tends to be spent in "universal" purchase areas (accessed by many consumers) – with the exception of home care.***

As shown in the chart below, the purchase areas in which the most funding is spent tend to be those accessed by a significant portion of consumers. This data also suggests that common purchase areas tend to have lower costs; if otherwise, the expenditure would likely represent a disproportionate amount of the total flexible funding.

For example, though a majority of consumers (73%) receive at least one non-medical home equipment purchase, the aggregate cost of non-medical home equipment purchases is only 30% of the total flexible funding. Conversely, homecare purchases stand out with a disproportionately high cost for the portion of consumers served – purchases represent 24% of total spending but go to only 12 consumers (9%).[26]

Home care purchases represent a disproportionately high portion of flexible funding



Another way to explore this data and identify "high cost" purchases is **cost per consumer served in a purchase area**. The aggregate cost data used above reflects both purchase cost *and* universality. Cost per consumer served in a purchase area is an average that only considers the consumers that received a purchase in a service area.

This indicator – listed in Table 1[27] – is arguably a more accurate indicator of high-cost purchase areas than aggregate cost because it reduces the influence of frequency. For example, even though the most funding is spent on non-medical home equipment purchases, the high number of consumers served means that this purchase area is has a moderate cost per consumer served – $1,022. Conversely, home care is quite an expensive purchase area because only 12 consumers are served –$6,346.

Table 1. Purchase Areas Sorted by "Cost per Consumer Served"

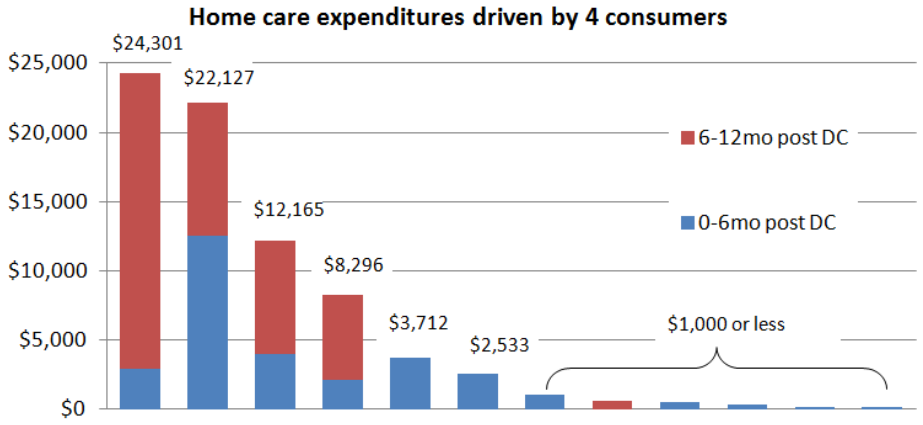
Purchase area	Total $	# of consumers	$ per consumer served
Home Care	$76,154.20	12	$6,346.18
Habilitation	$12,900.00	3	$4,300.00
Employment/Recreation/Edu	$3,462.25	1	$3,462.25
Housing Assistance	$16,764.07	11	$1,524.01
Non-Medical Home Equipment	$98,095.56	96	$1,021.83
Rental Assist	$66,833.76	67	$997.52
Medical Services	$1,989.99	2	$995.00
Special Needs	$9,936.74	13	$764.36
Counseling	$8,718.75	17	$512.87
Health Care	$2,434.00	5	$486.80

[26] For more complete data on purchase area cost and consumers served, see Appendix 4.
[27] Please see Appendix 5 for a complete table.

➢ ***Even among those who receive home care purchases, cost tends to be low – expenditures in this purchase area are driven by a small number (4) of consumers.***

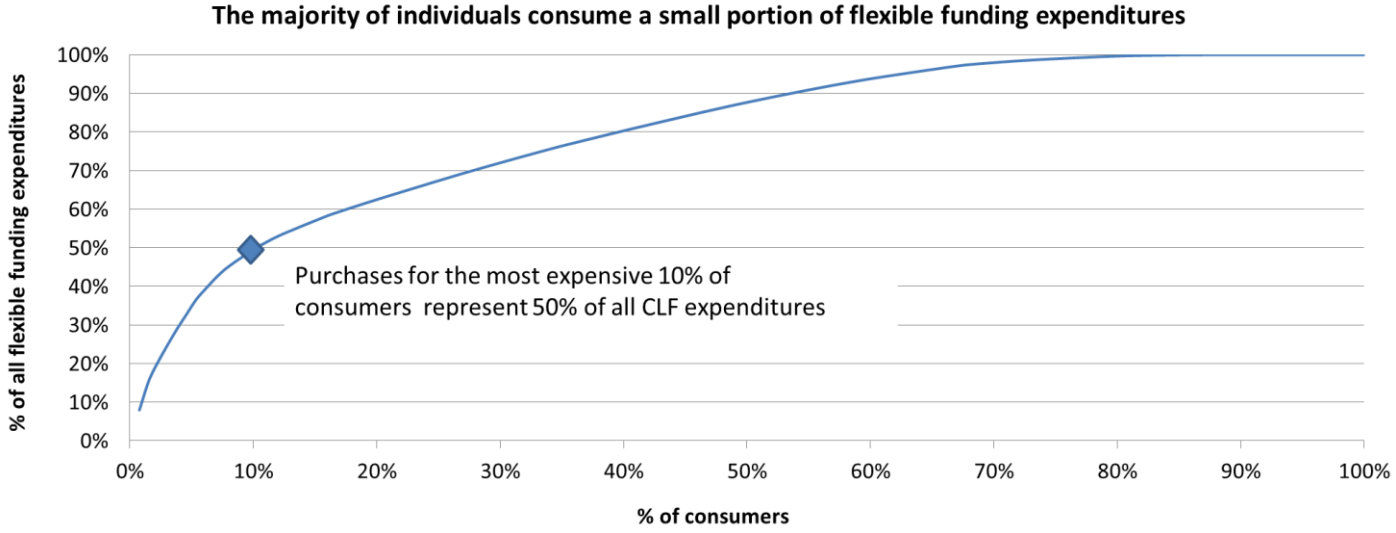
As noted, few consumers (12) receive purchased home care. Further analysis reveals that an even smaller subgroup of consumers is driving the cost of this purchase area. The average cost per consumer served in home care is $6,328. However, the *median* cost per consumer served is much lower: $1,777.

In the chart to the right, each bar represents a consumer with at least one home care purchase. The cost for most consumers is under $4,000, and these purchases tend to occur in the first six months after discharge. Conversely, for the four consumers with high cost of home care purchases, purchases continue throughout the first year in the community and total cost ranges from $8,296 to $24,301.[28]



➢ ***The majority of individuals are "low-cost" consumers of flexible funding, while a small portion of individuals receive a disproportionately large share of flexible funding expenditures.***

Review of all flexible funding purchases similarly suggests that this funding is not spent proportionately among all consumers. As shown below, half of consumers account for approximately 12% of the total flexible funding spent. At the other end of the cost spectrum, the top 10% of consumers (the most expensive individuals) receive purchases that represent 50% of flexible funding expenses.



Even within this group, the expenditures are driven by a smaller handful: the top 3% receive purchases that represent 25% of all expenses. These consumers received a mix of purchases, which commonly included home care and rent assistance (e.g., security deposit). One consumer received almost $9,000 in habilitation services, which prepares individuals to manage tasks like grocery shopping on a budget.

[28] Of these 4 consumers, only 1 was at the maximum monthly IHSS hours and needed CLF to cover additional home care (two were on the IHO waiver and one was having temporary problems with the Working Disabled Program).

Part 2. All costs (CLF flexible funding expenditures + other services)

This section integrates additional key services (housing, IHSS, CLF ICM staffing costs, and services provided through the Office on the Aging) to capture a more comprehensive picture of total expenditures needed to support community living. This analysis is also available in Appendix 6 recalculated using the higher IHSS provider rate of $25.

Supported by data points described in this section, the predominant finding of this analysis is:

❖ ***When other major services are considered, cost increases significantly and flexible funding becomes minimal portion of community living cost – housing dominates cost.***

A more comprehensive cost estimate identifies housing as the largest cost in this model, though CLF ICM and IHSS are also significant expenditures. Accessed by more consumers and with a higher per unit cost, WBHC units represent the largest expenditure area and constitute the majority of housing costs. Additionally, the aggregate cost of the model increases significantly from the $322,953 to the $4,139,148. The average cost for all consumers in the 6 months before discharge through first year in the community increases from $2,465 to $31,596.

Given the high cost of living in San Francisco, it is possible that housing (and home care provider wage) costs represent a larger portion of cost than might be found in other locations. However, these costs are still likely to make up the majority of costs anywhere, because they are relatively universal services (accessed by a majority of consumers) and tend to be needed on a consistent basis – unlike flexible funding purchases that are more likely to be one-time purchases.

➢ ***With IHSS, housing, intensive case management, and OOA meals, the cost of this model grows significantly – and housing becomes the dominant cost.***

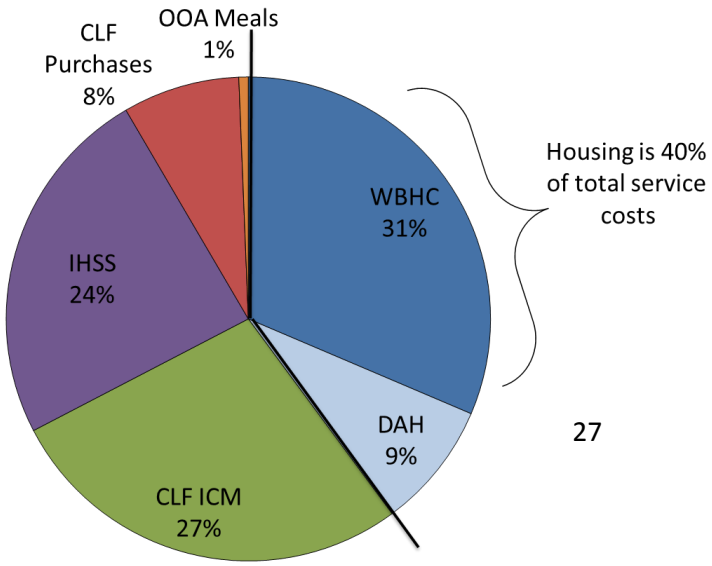
When additional services for which data was available are added to the cost calculation, the **total cost of serving consumers in this model is $4,139,148**. This estimate is approximately twelve times larger than the flexible funding expenditures alone. The table below provides the aggregate cost of each service, and the chart depicts the percentage of total spending by program.

As evidenced below, CLF flexible funding becomes a much smaller portion of the total cost of supporting community living. Housing costs are the dominant cost; WBHC, which serves more consumers and has a higher per-unit cost, represents 31% of the total cost, and the cost of DAH units represents approximately 9% of the costs of this model. Supportive services – CLF ICM and IHSS – are also significant expense areas.

Table 2. Total costs by program.

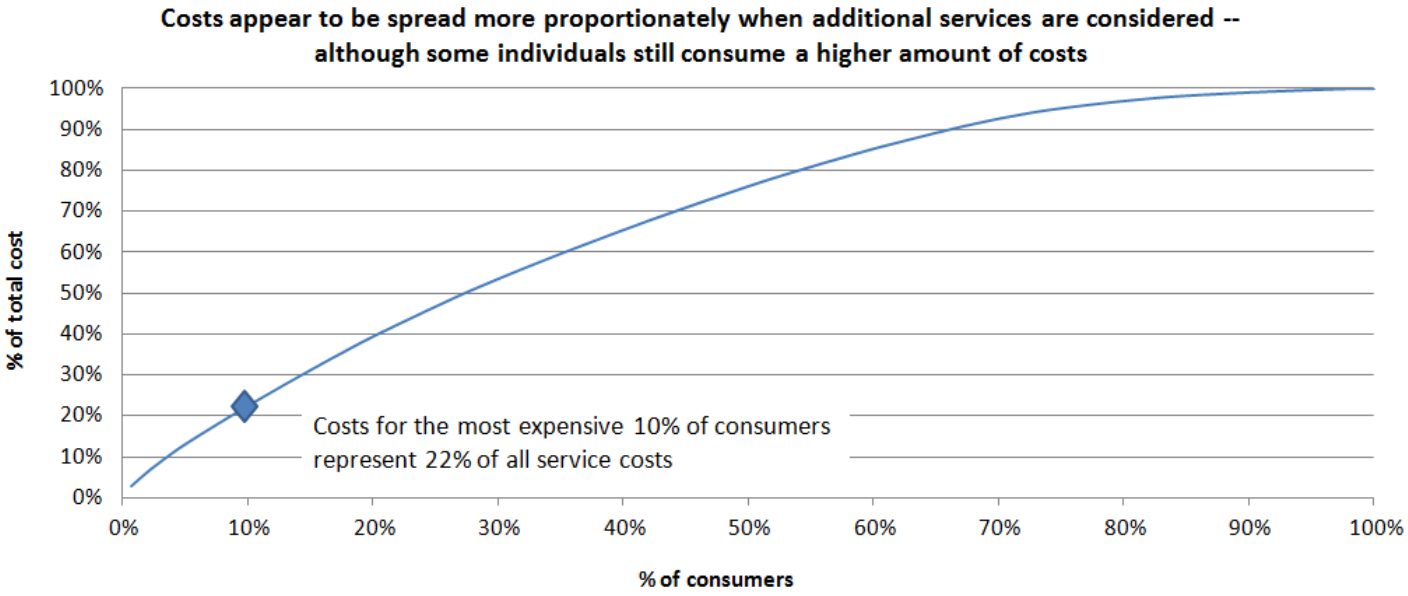
Program	Total $	% of Total Cost
Housing	$1,651,000	40%
WBHC –$1,300,000	.	*WBHC – 31%*
DAH – $351,000	.	*DAH – 9%*
CLF ICM	$1,137,402	27%
IHSS	$1,001,633	24%
CLF flexible funding	$322,953	8%
OOA meals	$26,100	1%
Total cost	**$4,139,148**	**100%**

Housing is the largest expense – followed by ICM and IHSS



- ***With additional services considered, costs appear to be spread more equally among consumers – although a small portion of consumers still benefit from a disproportionately large share of costs.***

As shown in the chart below, cost is spread more equally when IHSS, housing, OOA meals, and CLF ICM are considered in addition to the flexible funding. **The average cost for all consumers with these additional services is $31,596**. There are still a small number of individuals receiving services with a disproportionately high total cost – cost for the top 10% of consumers ranges from $56,519 to $107,280.



Again, there is variety in the services received by the top 10% but trends can be identified. Ten of these 13 individuals live in WBHC units, and the other three are in DAH units. All receive over 100 IHSS hours per month and were enrolled in CLF for over a year.

- ***Additional data***

Tables 3 and 4 provide more detail on cost per consumer – both as an average of the entire population and as the cost per consumer served – and are provided here to further illustrate the variation in cost by service and cost per consumer served.

Table 3. Major program costs calculated as consumer average.

	Cost per consumer (full population average)	% of consumers served	Cost per consumer served
Housing	$12,603	65%	$19,424
WBHC	*$9,924*	*44%*	*$22,414*
DAH	*$2,679*	*21%*	*$13,000*
IHSS	$7,646	57%	$13,355
CLF ICM	$8,682	100%	$8,682
CLF flexible funding	$2,465	91%	$2,714
OOA meals	$200	21%	$969

Table 4. All services calculated as cost per consumer.

	Cost per consumer (full population average)	% of consumers served	Cost per consumer served
Housing (aggregate)*	**$12,603**	**65%**	**$19,424**
Housing: WBHC	$9,924	44%	$22,414
CLF: ICM	**$8,682**	**100%**	**$8,682**
IHSS	**$7,646**	**57%**	**$13,355**
Housing: DAH	$2,679	21%	$13,000
CLF: All flexible funding*	**$2,465**	**91%**	**$2,714**
CLF: Non-Medical Home Equipment	$749	73%	$1,022
CLF: Home Care (Chore, Homemaker, Personal Care)	$581	9%	$6,346
CLF: Rental Assist	$510	51%	$998
OOA meals	**$200**	**21%**	**$969**
CLF: Assistive Devices	$146	42%	$348
CLF: Housing Assistance	$128	8%	$1,524
CLF: Habilitation	$98	2%	$4,300
CLF: Special Needs	$76	10%	$764
CLF: Counseling (Professional, Interns)	$67	13%	$513
CLF: Employment/Recreation/Edu	$26	1%	$3,462
CLF: Health Care	$19	4%	$487
CLF: Communication & Translation	$18	18%	$103
CLF: Medical Services	$15	2%	$995
CLF: Move	$15	7%	$219
CLF: Utility Service	$8	13%	$63
CLF: Transportation	$4	8%	$55
CLF: Legal Assistance	$3	1%	$340
CLF: Heavy House Cleaning	$1	1%	$140
CLF: Adult Day Health Care	$0	1%	$65
CLF: Food	$0	1%	$3

* = Aggregate cost of program with multiple components (components also listed in table)
bold = Major program

VIII. Analysis of CLP Model: Exploration of "High Need" Consumers

Finally, this report briefly explores a potential method for identification of "high need" consumers. Due to the variety and complexity of this population's needs, it is difficult to settle on basic assumptions that would help identify these consumers. For example, an individual may require a small amount of help in multiple service areas. Another consumer may be completely dependent in one service area and require supplemental home care, which is an expensive service but not need any other assistance from CLF or housing programs. In both of these examples, arguments could be made that these consumers are high or low need.

This section provides a preliminary analysis of three ways that "high need" could be conceptualized:

- Length of enrollment in CLF;
- Number of DCIP Core Group Reviews; and
- Total cost in all service areas.

To identify high need consumers in each of these areas, the consumer population is broken down into quartiles. Table 5 below provides the parameters of each quartile by indicator. For example, consumers that might be considered "high need" based on CLF enrollment length are enrolled for 28 to 51 months; the majority of consumers (75%) have a shorter enrollment length. These types of indicators can be used to look for trends or even to observe characteristics of "high need" consumers. However, it should be remembered that the small consumer population becomes even smaller when broken into four quartiles, which means a one or two outliers may strongly impact this data. This data is best used for exploratory purposes; further analysis with a larger population would help confirm any trends.

Table 5. Parameters for "High Need" consumers by indicator.

		CLF Enrollment Length	# of DCIP Core Group Review	Total cost of all services
	mean	*19*	*4*	*$31,597*
Lowest need →	Quartile 1	2-9	0-2	$826 - $13,574
	Quartile 2	10-16	3-4	$13,574 -$32,608
	Quartile 3	17-28	5-7	$32,608 - $42,365
Highest need →	Quartile 4	28-51	7-21	$42,365 - $107,280

While this report does not provide a full analysis of these characteristics, a handful of data points are highlighted below. Additionally, Appendix 6 contains complete tables with descriptive statistics of these quartiles (e.g., average age of individuals in the each cost quartile).

Interesting trends by CLF enrollment length quartile:

- *ADLs and IADLs increase slightly by quartile*: consumers with longest enrollment tend to need help with 1.7 ADLs and 7.7 IADLs (compared to 0.2 ADLs and 3.6 IADLs in the shortest quartile).
- *WBHC is more common among consumers with longer CLF enrollment*: 80% of consumers in the longest enrollment quartile live in WBHC units. Among the other quartiles, 33% or less live in

WBHC. CLF tends to stay involved longer with consumers living in WBHC to support the WBHC housing specialists; comparatively, DAH units tend to have higher level of onsite services and supports, so CLF intensive case managers can step back earlier.

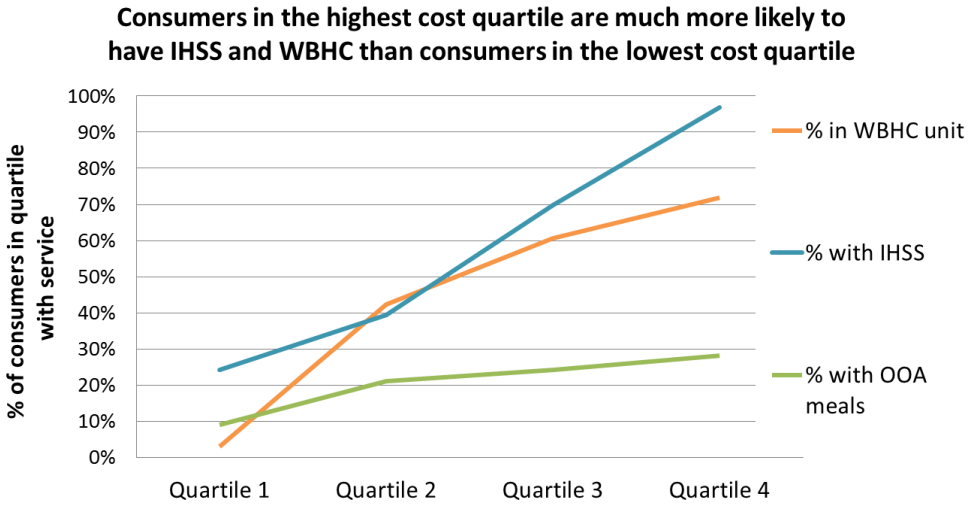
- *Both total CLF expenditures and total cost are much higher for consumers with the longest CLF enrollment*.

Interesting trends by DCIP total Core Group Review quartiles:

It is difficult to identify any trends among these quartiles, which may be due to the changes over time in the DCIP Core Group protocol for reviewing cases. Additionally, much work by the DCIP Core Group members takes place outside of the biweekly meetings. It may be the case that this variable is simply not a good indicator of how much Core Group attention is given to consumers.

Interesting trends by total cost quartiles:

- *Consumers in the highest cost quartile tend to have higher ADL and IADL needs*. These individuals may require more home care; the average IHSS cost is highest for this quartile.
- *Consumers in the highest cost quartile tend to have longer CLF enrollment*: 30 months compared to an average 11 month enrollment among the lowest cost quartile.
- *Consumers in the highest cost quartile are most likely to have IHSS and live in a WBHC unit*. Given that these services are the main cost drivers, this correlation may not be that surprising. However, it can be helpful to observe the variation among high and low cost individuals as depicted in the chart below. As illustrated in the chart below, the increase in access of these key services among cost quartiles is dramatic.



Comparison of consumers in top quartiles

Notably, the individuals in the top quartiles for these indicators do not completely overlap, meaning that the most costly consumers are not necessarily the most time intensive consumers. In particular, the number of DCIP Core Group does not appear to correlate with either of the other indicators. However, 9 individuals (7%) are in both the top cost and longest CLF enrollment quartiles. The size of this group is small enough that analysis would arguably be unreliable; however, it might be helpful to reexamine these groups when the population has grown in size.

IX. Future Steps

This analysis is intended to serve as an initial foray into a new and innovative service system. More research into the CLP model would significantly expand understanding of consumers served, key service components, and overall effectiveness. Potential directions for future research include:

- *Analysis of model effectiveness using outcomes data.*

  This model is believed to be effective, but research has not explored its effectiveness at reducing negative outcomes, such as readmissions to LHH or acute episodes (e.g., emergency room visits). Through the LHH readmission rate – as tracked by the DCIP Coordinator – is low, it would be helpful to investigate the cases that fail due to a lapse in a CLP. Additionally, a percentage of these consumers have acute episodes that may be preventable. Evaluation of effectiveness could help demonstrate the benefit of this type of model – or potentially help identify ways the model could be further strengthened to reduce negative incidents.

- *Analysis of comprehensive costs and costs by payer*.

  This analysis considers a significant portion of the programs and services accessed by this population; however, to truly understand the full cost of this model – and to ascertain cost effectiveness – more analysis is needed. Two potential avenues for further exploration are:

  a) *More comprehensive cost calculation*: This project's cost estimate is not a comprehensive calculation. It is likely that some consumers receive additional services not included in this cost estimate. These services may be regular or sporadic. For example, the acute episodes mentioned above are typically quite costly. If a consumer has multiple visits to the emergency room, the financial benefit of this care approach will be diminished and the cost estimate a significant underestimate. Additionally, this analysis does not incorporate overhead costs of programs like CLF or calculate the cost of staff time spent in DCIP meetings. *However, even with these costs, it is unlikely that the cost of care in the community will exceed LHH costs, which are reportedly $800 per patient day or $292,000 per year.* [29]

  b) *Analysis of costs by payer*: This report has not distinguished costs by payer. For example, as mentioned, some CLF flexible funding is spent on items later reimbursed by Medi-Cal waiver projects. It may be of interest to break comprehensive costs down by payer (e.g., federal, state, and local government, as well as non-profit fundraising).

To explore these two topics, additional data will be needed – much of which will likely come from the SF DPH.

[29] Per estimates from the LHH deputy finance officer, the $800 per patient day estimate is a fully-loaded rate with all the new hospital's facility costs (including capital equipment and debt services from bonds that funded construction of the new LHH building). The most recent audited Medi-Cal Cost Report projected the per patient day cost to be $574, which would equal an annual cost of $209,510. Because this report is based on 2009 data from before LHH moved to its new facility, this figure does not accurately represent growth in operating costs. However, even with this lower estimate, the cost of a year in LHH is significantly higher than the average $31,596 estimate calculated in this report.

X. Conclusion

The CLP Model developed in San Francisco helps reduce unnecessary institutionalization by providing older adults and younger adults with disabilities with options for where and how they receive assistance, care, and support. From a moral or social justice perspective, all individuals willing and able to live in the community should be able to so. This model helps coordinate and provide necessary supportive services to sustain community living. From a financial standpoint, this model appears to significantly reduce the cost of care for these individuals. While this analysis does not conduct a comprehensive financial analysis, the average cost of supporting a year in the community is approximately 11% of the annual cost of residence at LHH: $31,596 to support transition and a year in the community compared to $292,000 per year at LHH.

From any perspective, this model represents an innovative and interesting approach to long-term care for seniors and persons with disabilities. Further exploration of this data has the potential to shed important light on this population and this approach to providing care.

Appendices

Appendix 1. Eligibility Criteria for the Community Living Fund.

Taken from a public announcement about the Community Living Fund:

The following groups of people will be served:

- Top priority. Patients of Laguna Honda Hospital (LHH) and San Francisco General Hospital (SFGH) who are willing and able to be discharged to community living.
- Nursing home eligible individuals on the LHH waiting list (some of whom are at SFGH and other hospitals) who are willing and able to remain living in the community.
- Individuals who are at imminent risk for nursing home or institutional placement, willing and able to remain living in the community with appropriate support.

Eligibility Criteria for Services under the CLF Program Be 18 years and older

- Be a resident of San Francisco
- Be willing and able to be living in the community with appropriate supports
- Have income up to 300% of Federal poverty level for a single adult: $34,470 plus savings/assets of $6,000 (Excluding assets allowed under Medi-Cal)
- Have a demonstrated need for a service and/or resource that will serve to prevent institutionalization or will enable community living.
- 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 functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transfer, bathing, toileting, and grooming; **or**
    - Having a medical condition to the extent requiring the level of care that would be provided in a nursing facility; **or**
    - Being unable to manage one's own affairs due to emotional and/or cognitive impairment; and have 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, using telephone 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 2. Population trends.

Age	#	%
20-25	2	2%
30-35	8	6%
35-40	10	8%
40-45	12	9%
45-50	23	18%
50-55	27	21%
55-60	21	16%
60-65	15	11%
65-70	6	5%
70-75	5	4%
75-80	1	1%
80-85	1	1%
Mean	51.4	.
Median	52.4	.

Gender	#	%
Male	101	77%
Female	29	22%
Transgender	1	1%

Education level	#	%
2 - 1st through 4th Grade	1	1%
3 - 5th through 8th Grade	3	2%
4 - 9th Grade	3	2%
5 - 10th Grade	8	7%
6 - 11th Grade	8	7%
7 - 12th Grade - No Diploma	10	8%
8 - High School Grad. - Diploma or Equivalent	42	34%
9 - Some College - No Degree	26	21%
10 - Associate Degree	5	4%
11 - Bachelor's Degree	11	9%
12 - Master's Degree	1	1%
13 - Other	4	3%
Total	122	100

Race	#	%
Unknown	36	27%
Not Stated	27	21%
White	30	23%
Black/African American	23	18%
Latino/Latina	8	6%
Asian	3	2%
Native Hawaiian/ Other Pac. Islander	2	2%
Other	2	2%

ADLs	#	%
0	97	74%
1	12	9%
2	6	5%
3	5	4%
4	3	2%
5	1	1%
6	7	5%
Mean	0.75	.
Median	0	.

IADLs	#	%
0	18	14%
1	21	16%
2	14	11%
3	2	2%
4	3	2%
5	3	2%
6	3	2%
7	10	8%
8	18	14%
9	6	5%
10+ IADLs	33	25%
Mean	5.6	.
Median	7	.

Equipment	#	%
Shower	99	76%
Smoke alarm	94	72%
Bath bench	89	68%
Grabbar (all)	83	63%
Handheld Shower	80	61%
Transit chair (e.g., wheelchair)	69	53%
Tub	67	51%
Cane (all)	40	31%
Incontinence supplies	37	28%
Raised toilet	36	27%
Emergency alarm	35	27%
Hospital bed	32	24%
Bedside commode	29	22%
Nonskid bath mat	12	9%
Catheter (not self care)	6	5%
Bed rail	4	3%
Catheter (not self care)	3	2%
Syringe tube fed by IV	2	2%
Ostomy	1	1%
Adaptive eating utensils	1	1%

Medical conditions	#	%
HIV/AIDS	61	47%
Circulatory	50	38%
Genital/Urinary	48	37%
Infections	47	36%
Endocrine…	46	35%
Neurological	45	34%
Stroke	34	26%
Respiratory	33	25%
Arthritis	31	24%
Diabetes	29	22%
Cancer	25	19%
Kidney	21	16%
Disability	4	3%

Psych functioning issues	#	%
Depression	90	69%
Anxiety	81	62%
Grief	76	58%
Combative	28	21%
Suicidal	23	18%
Dementia	23	18%
Paranoid	20	15%
Delusion	19	15%
Wandering	7	5%
Cognitive	6	5%

Appendix 3. Service enrollment.

CLF Enrollment Length

Months	#	%
1-6	8%	7
7-12	35%	29
13-18	14%	12
19-24	10%	8
25-30	20%	17
31-36	5%	4
37-42	2%	2
43-48	5%	4
49-54	1%	1

Months enrolled in CLF prior to LHH discharge		
Months	**#**	**%**
-6 or more	20	15%
-5	6	5%
-4	6	5%
-3	15	11%
-2	19	15%
-1	33	25%
Month of discharge	24	18%
1	4	3%
2	4	3%

Service enrollment		
Program	**#**	**%**
IHSS	75	57%
WBHC	58	44%
DAH	27	21%
OOA Meals	27	21%
CLF POS	117	89%
CLF ICM	131	100%

DCIP Core Group Reviews		
Total	**#**	**%**
0 CGR	9	7%
1-2 CGR	23	18%
3-4 CGR	27	21%
5-6 CGR	25	19%
7-8 CGR	7	5%
9+ CGR	8	6%

Monthly IHSS Hours		
Total	**#**	**%**
0-30	0	0%
30-60	11	15%
60-90	12	16%
90-120	11	15%
120-150	7	9%
150-180	5	7%
180-210	1	1%
210-240	3	4%
240-270	1	1%
270-300	2	3%
Total	53	100%
Mean	110.35	.
Median	136.71	.

Appendix 4. CLF flexible funding purchase data.

POS in 6 months pre DC

Service	# Services	Total $	# of consumers	% of purchases	% of consumers with POS in service area	% of cost	$ per consumer (with POS in service area)	$ per consumer (full average)
ADULT DAY HEALTH CARE	0	$0.00	0	0%	0%	0%	$0.00	$0.00
ASSISTIVE DEVICES	16	$7,173.09	11	4%	8%	5%	$652.10	$54.76
COMMUNICATION/TRANSLATION	17	$521.69	8	4%	6%	0%	$65.21	$3.98
COUNSELING (Professional, Interns)	10	$500.00	1	2%	1%	0%	$500.00	$3.82
EMPLOYMENT/RECREATION/EDU	11	$2,384.75	1	3%	1%	2%	$2,384.75	$18.20
FOOD	0	$0.00	0	0%	0%	0%	$0.00	$0.00
HABILITATION	53	$12,050.00	3	13%	2%	8%	$4,016.67	$91.98
HEALTH CARE	1	$1,380.00	1	0%	1%	1%	$1,380.00	$10.53
HEAVY HOUSE CLEANING	0	$0.00	0	0%	0%	0%	$0.00	$0.00
HOME CARE (Chore, Homemaker, Personal Care)	8	$736.00	1	2%	1%	0%	$736.00	$5.62
HOUSING ASSISTANCE	9	$6,921.57	7	2%	5%	5%	$988.80	$52.84
LEGAL ASSISTANCE	1	$340.00	1	0%	1%	0%	$340.00	$2.60
MEDICAL SERVICES	1	$11.99	1	0%	1%	0%	$11.99	$0.09
MOVE	7	$632.84	6	2%	5%	0%	$105.47	$4.83
NON-MEDICAL HOME EQUIPMENT	173	$73,257.34	74	42%	56%	49%	$989.96	$559.22
RENTAL ASSIST	82	$32,623.07	50	20%	38%	22%	$652.46	$249.03
SPECIAL NEEDS	15	$9,928.72	12	4%	9%	7%	$827.39	$75.79
TRANSPORTATION	0	$0.00	0	0%	0%	0%	$0.00	$0.00
UTILITY SERVICE	10	$168.03	6	2%	5%	0%	$28.01	$1.28
Total	**414**	**$148,629.09**	131					
			89 with POS					

POS in 0 - 6 months post DC

Service	# Services	Total $	# of consumers	% of purchases	% of consumers with POS in service area	% of cost	$ per consumer	$ per consumer (full average)
ADULT DAY HEALTH CARE	1	$64.83	1	0%	1%	0%	$64.83	$0.49
ASSISTIVE DEVICES	70	$8,878.17	42	10%	32%	9%	$211.39	$67.77
COMMUNICATION/TRANSLATION	34	$1,284.77	16	5%	12%	1%	$80.30	$9.81
COUNSELING (Professional, Interns)	75	$3,750.00	12	11%	9%	4%	$312.50	$28.63
EMPLOYMENT/RECREATION/EDU	6	$957.50	1	1%	1%	1%	$957.50	$7.31
FOOD	1	$3.40	1	0%	1%	0%	$3.40	$0.03
HABILITATION	4	$850.00	1	1%	1%	1%	$850.00	$6.49
HEALTH CARE	9	$999.00	3	1%	2%	1%	$333.00	$7.63
HEAVY HOUSE CLEANING	1	$140.00	1	0%	1%	0%	$140.00	$1.07
HOME CARE (Chore, Homemaker, Personal Care)	283	$29,488.25	11	40%	8%	29%	$2,680.75	$225.10
HOUSING ASSISTANCE	11	$9,842.50	6	2%	5%	10%	$1,640.42	$75.13
LEGAL ASSISTANCE	1	$0.00	1	0%	1%	0%	$0.00	$0.00
MEDICAL SERVICES	0	$0.00	0	0%	0%	0%	$0.00	$0.00
MOVE	7	$1,341.83	5	1%	4%	1%	$268.37	$10.24
NON-MEDICAL HOME EQUIPMENT	125	$21,967.30	58	18%	44%	22%	$378.75	$167.69
RENTAL ASSIST	51	$21,372.19	33	7%	25%	21%	$647.64	$163.15
SPECIAL NEEDS	1	$8.02	1	0%	1%	0%	$8.02	$0.06
TRANSPORTATION	25	$526.82	10	4%	8%	1%	$52.68	$4.02
UTILITY SERVICE	9	$686.65	8	1%	6%	1%	$85.83	$5.24
Total	714	**$102,161.23**	**131**					
			103 with POS					

POS in 6 - 12 months post DC

Service	# Services	Total $	# of consumers	% of purchases	% of consumers with POS in service area	% of cost	$ per consumer	$ per consumer (full average)
ADULT DAY HEALTH CARE	0	$0.00	0	0%	0%	0%	$0.00	$0.00
ASSISTIVE DEVICES	9	$3,089.19	14	2%	11%	4%	$220.66	$23.58
COMMUNICATION/TRANSLATION	18	$560.91	7	3%	5%	1%	$80.13	$4.28
COUNSELING (Professional, Interns)	71	$4,468.75	12	13%	9%	6%	$372.40	$34.11
EMPLOYMENT/RECREATION/EDU	2	$120.00	1	0%	1%	0%	$120.00	$0.92
FOOD	0	$0.00	0	0%	0%	0%	$0.00	$0.00
HABILITATION	0	$0.00	0	0%	0%	0%	$0.00	$0.00
HEALTH CARE	1	$55.00	1	0%	1%	0%	$55.00	$0.42
HEAVY HOUSE CLEANING	0	$0.00	0	0%	0%	0%	$0.00	$0.00
HOME CARE (Chore, Homemaker, Personal Care)	422	$45,929.95	5	75%	4%	64%	$9,185.99	$350.61
HOUSING ASSISTANCE	0	$0.00	0	0%	0%	0%	$0.00	$0.00
LEGAL ASSISTANCE	0	$0.00	0	0%	0%	0%	$0.00	$0.00
MEDICAL SERVICES	1	$1,978.00	1	0%	1%	3%	$1,978.00	$15.10
MOVE	0	$0.00	0	0%	0%	0%	$0.00	$0.00
NON-MEDICAL HOME EQUIPMENT	12	$2,870.92	9	2%	7%	4%	$318.99	$21.92
RENTAL ASSIST	17	$12,838.50	4	3%	3%	18%	$3,209.63	$98.00
SPECIAL NEEDS	0	$0.00	0	0%	0%	0%	$0.00	$0.00
TRANSPORTATION	2	$28.07	2	0%	2%	0%	$14.04	$0.21
UTILITY SERVICE	5	$223.43	3	1%	2%	0%	$74.48	$1.71
Total	**560**	**$72,162.72**	**131**					
			37 with POS					

ALL

Service	# Services	Total $	# of consumers	% of purchases	% of consumers with POS in service area	% of cost	$ per consumer	$ per consumer (full average)
ADULT DAY HEALTH CARE	1	$64.83	1	0%	1%	0%	$64.83	$0.49
ASSISTIVE DEVICES	95	$19,140.45	55	6%	42%	6%	$348.01	$146.11
COMMUNICATION/TRANSLATION	69	$2,367.37	23	4%	18%	1%	$102.93	$18.07
COUNSELING (Professional, Interns)	156	$8,718.75	17	9%	13%	3%	$512.87	$66.56
EMPLOYMENT/RECREATION/EDU	19	$3,462.25	1	1%	1%	1%	$3,462.25	$26.43
FOOD	1	$3.40	1	0%	1%	0%	$3.40	$0.03
HABILITATION	57	$12,900.00	3	3%	2%	4%	$4,300.00	$98.47
HEALTH CARE	11	$2,434.00	5	1%	4%	1%	$486.80	$18.58
HEAVY HOUSE CLEANING	1	$140.00	1	0%	1%	0%	$140.00	$1.07
HOME CARE (Chore, Homemaker, Personal Care)	713	$76,154.20	12	42%	9%	24%	$6,346.18	$581.33
HOUSING ASSISTANCE	20	$16,764.07	11	1%	8%	5%	$1,524.01	$127.97
LEGAL ASSISTANCE	2	$340.00	1	0%	1%	0%	$340.00	$2.60
MEDICAL SERVICES	2	$1,989.99	2	0%	2%	1%	$995.00	$15.19
MOVE	14	$1,974.67	9	1%	7%	1%	$219.41	$15.07
NON-MEDICAL HOME EQUIPMENT	310	$98,095.56	96	18%	73%	30%	$1,021.83	$748.82
RENTAL ASSIST	150	$66,833.76	67	9%	51%	21%	$997.52	$510.18
SPECIAL NEEDS	16	$9,936.74	13	1%	10%	3%	$764.36	$75.85
TRANSPORTATION	27	$554.89	10	2%	8%	0%	$55.49	$4.24
UTILITY SERVICE	24	$1,078.11	17	1%	13%	0%	$63.42	$8.23
	1688	$322,953.04	131					
			119					

Appendix 5. CLF flexible funding expenditures

Purchase area	Total $	# of consumers	Average cost per consumer (all consumers)	$ per consumer served
Home Care	$76,154.20	11	$581.33	$6,346.18
Habilitation	$12,900.00	3	$98.47	$4,300.00
Employment/Recreation/Edu	$3,462.25	1	$26.43	$3,462.25
Housing Assistance	$16,764.07	11	$127.97	$1,524.01
Non-Medical Home Equipment	$98,095.56	96	$748.82	$1,021.83
Rental Assist	$66,833.76	67	$510.18	$997.52
Medical Services	$1,989.99	2	$15.19	$995.00
Special Needs	$9,936.74	13	$75.85	$764.36
Counseling	$8,718.75	17	$66.56	$512.87
Health Care	$2,434.00	5	$18.58	$486.80
Assistive Devices	$19,140.45	55	$146.11	$348.01
Legal Assistance	$340.00	1	$2.60	$340.00
Move	$1,974.67	9	$15.07	$219.41
Heavy House Cleaning	$140.00	1	$1.07	$140.00
Communication/Translation	$2,367.37	23	$18.07	$102.93
Adult Day Health Care	$64.83	1	$0.49	$64.83
Utility Service	$1,078.11	17	$8.23	$63.42
Transportation	$554.89	10	$4.24	$55.49
Food	$3.40	1	$0.03	$3.40

Appendix 6. "All Cost" calculations with higher IHSS rate.

This Appendix contains the same charts and tables from Part 2 of *Section VII: Analysis of CLP Model: Trends in Costs* but uses the higher $25 per hour private home care rate.

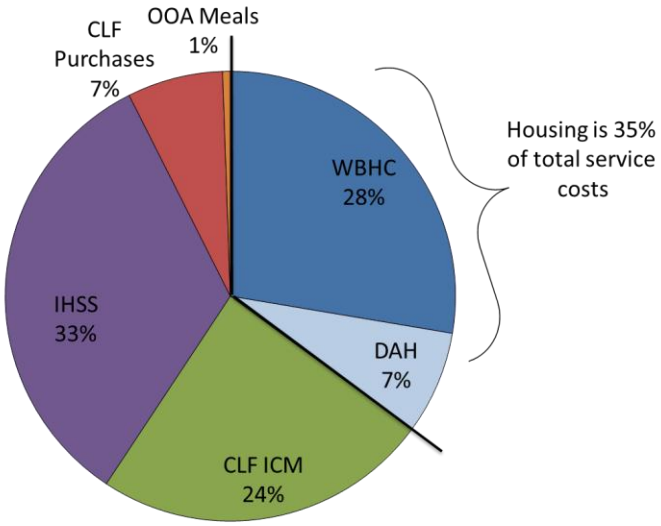
- ***With IHSS, housing, intensive case management, and OOA meals, the cost of this model grows significantly and housing becomes the dominant cost – followed closely by IHSS.***

With the higher home care rate, housing remains the largest purchase area (35% of costs) but is closely followed by IHSS (33%). IHSS costs increase by $563,419 using the higher rate of $25 per hour for a total of $1,565,052.

Table 2. Total costs by program.

Program	Total $	% of Total Cost
Housing	$1,651,000	35%
WBHC – **$1,300,000**	.	*WBHC – 28%*
DAH – **$351,000**	.	*DAH – 7%*
IHSS	$1,565,052	33%
CLF ICM	$1,137,402	24%
CLF flexible funding	$322,953	7%
OOA meals	$25,800	1%
Total cost	**$4,702,207**	**100%**

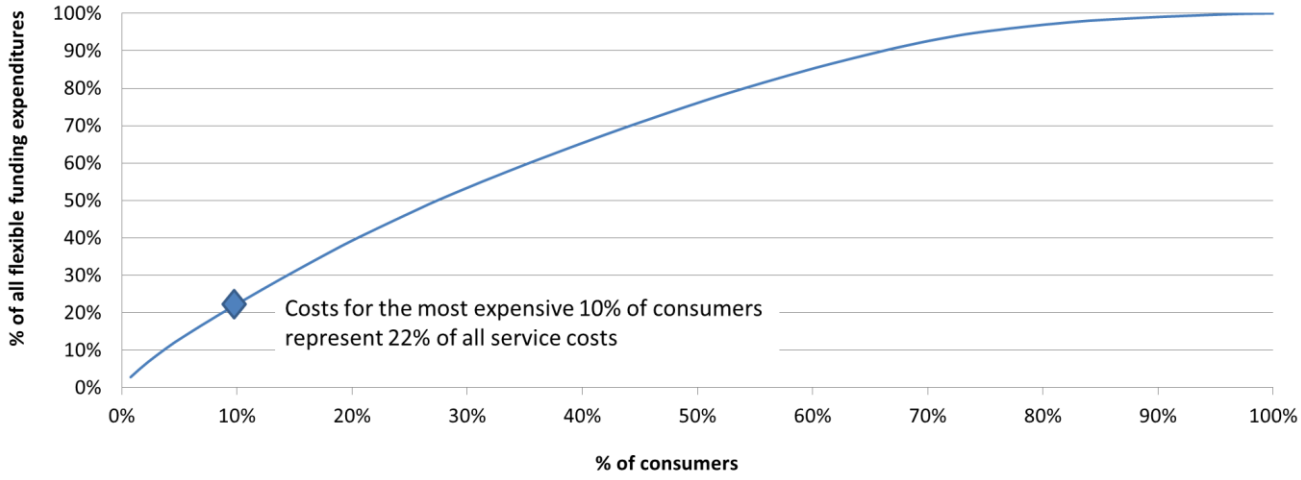
Housing is the largest expense (35%) – followed closely by IHSS (33%)



- ***With additional services considered, costs appear to be spread more equally among consumers – although a small portion of consumers still benefit from a disproportionately large share of costs.***

As shown in the chart below, cost is spread more equally when IHSS, housing, meals, and CLF flexible funding are considered. **The average cost for all consumers with these additional services is $35,897**. The cost of all services provided to the top 10% of consumers ranges from $64,834 to $132,510 – again, there are a small number of individuals receiving services with a high total cost.

Costs appear to be spread more proportionately when additional services are considered -- although some individuals still consume a higher amount of costs



➢ ***Additional data***

Tables 3 and 4 provide more detail on cost per consumer – both as an average of the entire population and as the cost per consumer served – and are provided here to further illustrate the variation in cost by service and cost per consumer served.

Table 3. Major program costs calculated as consumer average.

	Cost per consumer (full population average)	% of consumers served	Cost per consumer served
Housing	$12,603	65%	$19,424
WBHC	*$9,924*	*44%*	*$22,414*
DAH	*$2,679*	*21%*	*$13,000*
IHSS	$11,947	57%	$20,867
CLF ICM	$8,682	100%	$8,682
CLF flexible funding	$2,465	91%	$2,714
OOA meals	$200	21%	$969

Table 4. All services calculated as cost per consumer.

	Cost per consumer (full population average)	% of consumers served	Cost per consumer served
Housing (aggregate)*	**$12,603**	65%	**$19,424**
IHSS	$11,947	57%	$20,867
Housing: WBHC	$9,924	44%	$22,414
CLF: ICM	$8,682	100%	$8,682
Housing: DAH	$2,679	21%	$13,000
CLF: All flexible funding*	**$2,465**	91%	**$2,714**
CLF: Non-Medical Home Equipment	$749	73%	$1,022
CLF: Home Care (Chore, Homemaker, Personal Care)	$581	9%	$6,346
CLF: Rental Assist	$510	51%	$998
OOA meals	$200	21%	$969
CLF: Assistive Devices	$146	42%	$348
CLF: Housing Assistance	$128	8%	$1,524
CLF: Habilitation	$98	2%	$4,300
CLF: Special Needs	$76	10%	$764
CLF: Counseling (Professional, Interns)	$67	13%	$513
CLF: Employment/Recreation/Edu	$26	1%	$3,462
CLF: Health Care	$19	4%	$487
CLF: Communication & Translation	$18	18%	$103
CLF: Medical Services	$15	2%	$995
CLF: Move	$15	7%	$219
CLF: Utility Service	$8	13%	$63
CLF: Transportation	$4	8%	$55
CLF: Legal Assistance	$3	1%	$340
CLF: Heavy House Cleaning	$1	1%	$140
CLF: Adult Day Health Care	$0	1%	$65
CLF: Food	$0	1%	$3

***** = Aggregate cost of program with multiple components (components also listed in table)
bold = Major program

Appendix 7. "High Need" Quartiles.

Descriptive Statistics by CLF Enrollment Length Quartiles

	"Lowest Need"			"Highest Need"
Variable	**Quartile 1**	**Quartile 2**	**Quartile 3**	**Quartile 4**
Age	52.8	51.3	49.0	52.1
# of ADL	0.2	0.4	0.7	1.7
# of IADL	3.6	5.2	5.3	7.7
# of equipment items	4.2	5.2	6.4	6.9
# of medical diagnoses	3.6	3.4	3.2	3.7
# of psychological diagnoses	2.7	2.8	3.3	2.1
# of mental concerns	0.2	0.3	0.3	0.3
% in DAH unit	14%	29%	28%	15%
% in WBHC unit	32%	25%	33%	80%
% with CLF rental assistance	14%	33%	50%	70%
% with any housing assistance	45%	67%	78%	95%
% with IHSS	45%	46%	61%	60%
% with OOA meals	9%	38%	28%	10%
Average WBHC cost	$6,545	$6,000	$8,000	$17,000
Average DAH cost	$0	$4,500	$3,500	$1,800
Average OOA cost	$55	$375	$320	$132
Average IHSS cost	$5,337	$8,269	$11,425	$10,310
Average CLF $ (no home care)	$486	$929	$1,892	$3,656
Average CLF $ spent on home care	$176	$964	$141	$449
Average total CLF $	$661.82	$1,893.30	$2,033.00	$4,104.54
% listed as Low Risk	50%	42%	39%	10%
% listed as Medium Risk	0%	17%	6%	10%
% listed as High Risk	0%	0%	17%	10%
Average # DCIP CGR	4.2	3.9	3.5	5.5
Average CLF Enrollment Length	6.6	12.5	23.9	36
Average # CLF POS	4.9	18.2	10.7	41.35
Average total cost	$12,588.14	$20,896.84	$25,084.89	$33,346.22
Observations	22	24	18	20
Parameters (months enrolled CLF)	2-9	10-16	17-28	28-51

Descriptive Statistics by Total DCIP CGR Quartiles

	"Lowest Need"			"Highest Need"
Variable	**Quartile 1**	**Quartile 2**	**Quartile 3**	**Quartile 4**
Age	52.2	49.4	50.6	56.9
# of ADL	0.6	0.6	0.7	1.4
# of IADL	5.7	4.4	6.9	5.9
# of equipment items	5.8	5.7	6.9	7.4
# of medical diagnoses	4.3	3.4	4.3	3.6
# of psychological diagnoses	3.1	2.6	2.9	2.9
# of mental concerns	0.4	0.0	0.3	0.3
% in DAH unit	10%	21%	21%	38%
% in WBHC unit	36%	56%	61%	14%
% with CLF rental assistance	49%	63%	50%	29%
% with any housing assistance	51%	86%	86%	67%
% with IHSS	54%	58%	61%	57%
% with OOA meals	18%	26%	21%	14%
Average WBHC cost	$8,000	$12,372	$14,571	$2,286
Average DAH cost	$1,846	$2,860	$2,357	$4,286
Average OOA cost	$172	$251	$184	$109
Average IHSS cost	$15,706	$9,223	$12,096	$10,346
Average CLF $ (no home care)	$1,763	$1,892	$1,895	$2,116
Average CLF $ spent on home care	$22	$1,473	$103	$395
Average total CLF $	$1,784	$3,365	$1,997	$2,511
% listed as Low Risk	51%	28%	39%	62%
% listed as Medium Risk	8%	14%	14%	19%
% listed as High Risk	13%	5%	11%	10%
Average # DCIP CGR	1.6	3.4	5.6	10.6
Average CLF Enrollment Length	20.8	20.9	21.4	21.2
Average # CLF POS	8.8	49.3	12.6	50.3
Average total cost	$27,401	$28,018	$31,116	$19,485
Observations	39	43	28	21
Parameters (# CGR)	0-2	3-4	5-7	7-21

Descriptive Statistics by Total Cost Quartiles

	"Lowest Need"			"Highest Need"
	Quartile 1	**Quartile 2**	**Quartile 3**	**Quartile 4**
Age	55.6	45.4	52.2	53.6
# of ADL	0.24	0.70	0.64	1.44
# of IADL	4.73	4.30	4.97	8.31
# of equipment items	5.42	5.27	6.18	8.22
# of medical diagnoses	3.64	3.58	4.21	4.06
# of psychological diagnoses	3.09	2.73	2.58	3.00
# of mental concerns	0.30	0.36	0.18	0.13
% in DAH unit	18%	21%	21%	22%
% in WBHC unit	3%	42%	61%	72%
% with CLF rental assistance	21%	52%	58%	72%
% with any housing assistance	33%	82%	82%	94%
% with IHSS	24%	39%	70%	97%
% with OOA meals	9%	21%	24%	28%
Average WBHC cost	$0	$9,091	$14,303	$16,500
Average DAH cost	$0	$3,000	$3,818	$3,938
Average OOA cost	$73	$175	$269	$285
Average IHSS cost	$1,029	$4,026	$8,326	$17,503
Average CLF (no home care)	$640	$1,581	$1,613	$3,766
Average CLF $ spent on home care	$117	$37	$18	$2,196
Total CLF $	$757	$1,618	$1,631	$5,962
CLF: Low Risk	45%	36%	45%	44%
CLF: Medium Risk	12%	18%	0%	22%
CLF: High Risk	3%	12%	12%	9%
# DCIP CGR	4.1	3.6	3.7	4.7
CLF Enrollment Length	11.1	18.9	24.3	30.1
# CLF POS	7.3	7.5	17.6	75.4
Total $	$6,439	$25,706	$38,384	$56,615
Observations	33	33	33	32
Parameters (total cost)	$826 - $13,574	$13,574 - $32,608	$32,608 - $42,365	$42,365 - $107,280