M E M O R A N D U M

DATE: May 8, 2024

TO: Disability and Aging Services Commission

FROM: Department of Disability and Aging Services (DAS)
Kelly Dearman, Executive Director
Michael Zaugg, Director of Office of Community Partnerships

SUBJECT: **Community Living Fund (CLF) Program for Case Management and Purchase of Goods and Services - Annual Plan for July 2024 – June 2025**

Section 10.100-12 of the San Francisco Administrative Code created the Community Living Fund (CLF) to fund aging in place and community placement alternatives for individuals who may otherwise require care within an institution. The Administrative Code requires that the Department of Disability and Aging Services (DAS) prepare a CLF Annual Plan that will be submitted to the Disability and Aging Services Commission after a public hearing process, which will have input from the Department of Public Health (DPH) and the Long-Term Care Coordinating Council (LTCCC). Attached is the CLF Annual Plan for FY 24/25, which has been prepared by DAS for the continuing implementation of the CLF Program.

The Director of Office of Community Partnerships at DAS, Michael Zaugg, continues to actively develop and maintain relationships with key stakeholders at the Department of Public Health and other City agencies, including:

- Dr. Grant Colfax, Director, Department of Public Health;
- Roland Pickens, Interim Chief Executive Officer, Laguna Honda Hospital (LHH) and Rehabilitation Center, and Director, San Francisco Health Network;
- Janet Gillen, Director of Social Services, LHH;
- Dr. Albert Lam / Dr, Neda Ratanawongsa, Interim Medical Directors, LHH;
- Luis Calderon, Director of Placement, Targeted Case Management;
- Edwin Batongbacal, Director of Adult and Older Adult Services, Community Behavioral Health Services;
- Dee Rosado-Chan, Deputy Director for Programs, Department of Homelessness and Supportive Housing;

COMMUNITY LIVING FUND ANNUAL PLAN
FY 2024/2025

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PROGRAM PURPOSE, TARGET POPULATION, AND ELIGIBILITY

The CLF Program (CLFP) reduces unnecessary institutionalization by providing older adults and younger adults with disabilities or significant medical conditions with options for where and how they receive assistance, care, and support. No individual willing and able to live in the community need be institutionalized because of a lack of community-based long-term care and supportive services.

The CLF Program serves adults whose incomes are up to 300% of the federal poverty level and unable to live safely in the community without existing supports and funding sources (for detailed eligibility criteria, see Appendix A). The target population includes two primary sub-populations: (1) Patients of Laguna Honda Hospital (LHH), Zuckerberg San Francisco General Hospital (ZSFG), and other San Francisco skilled nursing facilities (SNFs) who are ready for discharge and are willing and able to live in the community; and (2) Individuals who are at imminent risk for nursing home or institutional placement but are willing and able to remain living in the community with appropriate supports.

PROGRAM IMPLEMENTATION PLAN

The mission of the CLF Program remains unchanged from FY 24/25. The program is expected to achieve a broader reach with the addition of services provided through contract with the San Francisco Health Plan Enhanced Care Management service as part of the CalAIM (California Advancing and Innovating Medi-Cal) program.

Overview

The CLF Program provides the resources and services necessary to sustain community living when those services are not available through any other mechanism. Most CLF participants receive case management and/or purchased goods and services from the CLF lead contractor, the Institute on Aging (IOA), and its subcontractors.

- In FY 23/24, the CLF Program began the implementation of Enhanced Care Management (ECM) services through the CalAIM (California Advancing and Innovating Medi-Cal) state initiative for members of the San Francisco Health Plan (SFHP) who are adults living in the community who are at risk for long-term care institutionalization as well as nursing facility residents transitioning to the community. Enhanced Care Management for these two populations of focus align with the goals of CLFP. The CLFP and relevant stakeholders have gone through a review of the program's procedures, data management system, referral and intake process, and community education and outreach strategies. In FY 24/ 25, the CLFP will continue delivering ECM services. Additionally, providing Community Supports through SFHP will be operationalized. During the upcoming year, expanding this program to Anthem members will also be explored.

Program Access and Service Delivery

Prospective CLFP participants continue to be screened by the DAS Intake and Screening Unit for program eligibility and offered referrals for alternative resources when they are available. ECM participants are initially identified by the San Francisco Health Plan or community referents. These referrals are then sent to DAS Intake and Screening Unit for outreach; participants who meet CLFP eligibility criteria are referred to case management and/or purchase only services. The CLFP enrolls participants after obtaining consent to receive CM services. Participants then are accepted or placed on a waitlist depending on their acuity and clinical and social care needs. Nursing facility residents continue to be prioritized to ensure a safe discharge to the community and reduce risk of re-institutionalization. Moreover, the program continues to have an emphasis on decreasing disparities in the access to care and promotes culturally responsive care to meet the social and health care needs of the diverse communities in San Francisco offering services intended to support language, culture and/or service needs and preferences.

The CLFP Care Manager then contacts the participant, confirms the participant's desire to enroll in the program, completes a formal application, and conducts an in-home or in-hospital assessment. The initial assessment is the tool with which the CLFP Care Manager, the participant and family, or other informal support systems, determine what is needed for the participant to live safely in the community. A plan to address those needs is also developed. If the participant is already working with another community care manager, the CLFP Care Manager will coordinate the home assessment with provider The entire assessment process should be completed within one month.

In addition to the traditional CLFP model of intensive case management with purchase of goods and services, there are many participants who already have a community care manager but need tangible goods or other services to remain stably housed in the community. The CLFP Care Coordinator role, which is a purchasing care manager at Catholic Charities, can assist these participants who have a purchase-only need. With a caseload size of about 30-40 participants, the CLFP Care Coordinator completes a modified assessment for expedited enrollment which allow participants who meet CLFP eligibility and are enrolled in other case management to access the purchase of goods and services more efficiently. This flexibility allows CLFP to serve more participants and have a more extensive community reach to prevent premature institutionalization.

ANTICIPATED BUDGET AND POLICY CONSIDERATIONS

Going into FY 24/25, CLF expenditures have continued to be stable. The plans for this upcoming year include:

- The Integrated Housing Model continues into FY 24/25 and will facilitate care coordination for CLF referrals who meet criteria for Scattered Site Housing (SSH) through a contract with Brilliant Corners (BC). The Community Options and Resource Engagement (CORE) is a multi-disciplinary team meeting that is held bi-monthly and is coordinated and led by Laguna Honda Hospital staff. CORE meetings include the CLFP provider (Institute on Aging), BC, DAS, and LHH to discuss referrals of participants and their transition needs. A robust pipeline is essential for effective and efficient transitioning of individuals from LHH and other SNFs to the community. Access to the SSH slots is only available after CLFP approval and are based on participant needs and placement appropriateness. The SSH units

continue to add flexibility to the CLFP housing portfolio in transitioning individuals who would have otherwise not been able to return to the community due to lack of appropriate housing options.

- The CLF Program continues to partner with the DAS Public Guardian (PG) Office to provide housing subsidies available to participants connected to PG that are meet criteria for CLFP services and have the highest level of financial needs with no other alternatives available. CLFP received 3 new referrals in FY 23/24 and reached the target of 6 enrollments. While there have since been disenrollments, CLFP has worked with the PG office to identify additional referrals and will continue collaborating with the PG office to support new referrals in the next months. During FY25 the program will explore expanding PG housing subsidies to additional community members.

- CLFP is committed to offer responsive and inclusive services to the diverse community of San Francisco. The program will continue to implement outreach initiatives to access the Asian and Pacific Islander and the LGBTQ+ communities. The CLFP will recruit and hire an Outreach Coordinator. A primary job function of this role is focused outreach, including education on CLFP services to potential clients and community organization. This role will allow the CLFP to continue to expand access to case management services. The program will also continue its focus on professional development and related opportunities that support and promote cultural humility and competencies of CLFP staff in the services offered to the community. In FY 23/24, the CLFP continued to collaborate with Openhouse Mental Health Program for LGBTQ Elders and this organization is now a part of the CLF Advisory Committee. In FY 24/25, the CLFP will participate in community partnerships and continue to explore new partnerships to promote greater access to services.

- During FY 24/25, the CLF Program will follow guidelines from the Department of Public Health (SFDPH) and Centers for Disease Control and Prevention (CDC) to respond to the needs of the community in the prevention of COVID-19 spread. California's COVID-19 State of Emergency is over, however COVID-19 cases are still being reported by CLFP participants so IOA will continue to keep taking steps to support community members enrolled in the program. The program will offer remote services when requested by participants and will supply staff in the field with enhanced Personal Protective Equipment for essential visits when indicated. This approach will continue through FY 24/25, as necessary.

- CLFP is committed to continue its partnership with the San Francisco Aging and Disability Resource Connection (ADRC). The CLFP program works closely with community partners to support the ADRC advisory committee and their efforts to increase access to home and community-based long-term services for older adults, adults with disabilities, family caregivers, and residents in long term care facilities in SF. This collaboration is essential so community members can access a more coordinated system with reliable information and streamline access to Long Term Service and Supports (LTSS).

ACCOUNTABILITY: REPORTING, EVALUATION, AND COMMUNITY INPUT

Plans for reporting and evaluation of the CLF Program are detailed below.

Data Collection & Reporting

DAS is committed to measuring the impact of its investments in community services. The CLF Program consistently meets and exceeds its goals to support successful community living for those discharged or at imminent risk of institutionalization. In FY 15/16, DAS shifted the focus of CLFP on the measures below:

- ❖ Percent of participants with one or fewer admissions to an acute care hospital within a six-month period. Target: 85%.

The CLF Program is anticipated to continue to exceed this performance measure target of participants having one or fewer unplanned admissions.

- ❖ Percent of care plan problems resolved, on average, after one year of enrollment in the CLF Program (excludes participants with ongoing purchases). Target: 70%.

The CLF Program will continue to make progress towards this performance measure target in FY 24/25. This measure reflects the complexity of the population served as CLFP participants tend to have high personal and safety needs to live safely in the community. For many, care plan interventions take time to develop and resolve. However, while a subset of participants will always have less than 100% of their care plan problems resolved due to ongoing care needs, the program will continue to ensure care plan items are updated throughout enrollment through ongoing supervision, training, and oversight on database utilization.

CLFP has been meeting the city ordinance that requires collection of sexual orientation and gender identity data effective July 2017. IOA has adopted DAS' standardized demographic indicators and the reporting of sexual orientation and gender identity.

Consumer Input –

The CLFP Advisory Council first met in January 2009 and continues to meet quarterly. The Council is comprised of representatives from consumers, partner agencies, and community representatives. The Advisory Council reviews the consumer satisfaction surveys, waiting list statistics, program changes and other issues which may affect service delivery.

IOA obtains consumer input through the Satisfaction Survey for CLFP participants. On an annual basis, participants who are enrolled in the CLF Program are asked to complete a satisfaction survey that covers satisfaction with general services, social worker satisfaction, service impact, and overall satisfaction with the entire CLF Program. In 2022, 95% of participants reported that the CLF Program helped them maintain or improve their quality of life. For 2023, the Satisfaction Survey will

be administered in April/May 2024 and results from the responses will be available in the next public reporting.

TIMELINE

The DAS Office of Community Partnerships and IOA will review monthly reports of service utilization and referral trends, as described in the reporting section above. The following table highlights other important dates for public reporting.

Timeline of Public Reporting – FY 2024/2025	
Quarter 1: July – September 2024	▪ *August:* Prepare Six-Month Report on CLF activities from January through June 2024.
Quarter 2: October – December 2024	▪ *October:* Submit Six-Month Report to Disability and Aging Services Commission for review and forward to the Board of Supervisors, Mayor's Office, LTCCC, and DPH.
Quarter 3: January – March 2025	▪ *February:* Prepare Six-Month Report on CLF activities from July through December 2024. ▪ *March:* Prepare FY 25/26 CLF Annual Plan draft, seeking input from the LTCCC and DPH.
Quarter 4: April – June 2025	▪ *April:* Submit Six-Month Report and FY 25/26 CLF Annual Plan to Disability and Aging Services Commission for review and forward to the Board of Supervisors, Mayor's Office, LTCCC, and DPH.

ANTICIPATED EXPENDITURES

At the conclusion of FY 23/24, it is estimated that the CLF Program will have spent a total of $91 million since the program's inception. For FY 24/25, the CLF Program is projecting a total of $9.5 million in expenditures.

IOA contract	$ 4,869,766
Brilliant Corners contract	$ 3,417,407
DAS internal staff positions	$ 706,504
PG Housing Fund	$ 354,752
RTZ Contract	$ 96,000
Unprogrammed	$ 14,772
TOTAL	$ 9,459,201

APPENDIX A: ELIGIBILITY CRITERIA

To receive services under the CLF Program, participants must meet all the following criteria:

1. Be 18 years or older.
2. Be a resident of San Francisco.
3. Be willing and able to live in the community with appropriate supports.
4. Have income of no more than 300% of federal poverty level for a single adult, plus savings/assets of no more than $130,000 (excluding assets allowed under Medi-Cal). For Purchase of Service only clients, the asset limit is $6,000.
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. To be considered "at imminent risk of institutionalization," 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. Be unable to manage one's own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of 3 Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone.

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: CLFP CONTRACTORS

Agency	Specialty	Average Caseload per Care Manager
Institute on Aging	Program and case management supervision, 9.5 FTEs city-wide intensive Care Managers	17–22 intensive
IOA Subcontractors:		
Catholic Charities CYO	1 Care Coordinator	30-40 cases
Conard House	1 Money Management Care Manager	40-50 cases
Self Help for the Elderly	1 Care Manager/Social Worker	17-22 intensive