Appendix A: Services to be Provided
July 1, 2023 to June 30, 2027
Institute on Aging
Community Living Fund - Case Management and Purchase of Services

I. Purpose of Grant

The purpose of this grant is to provide case management and other services as part of the Community Living Fund (CLF) that is being administered by the Department of Disability and Aging Services. The CLF is used to subsidize services, or a combination of goods and services, that help individuals who are currently in or at imminent risk of being institutionalized.

The Community Living Fund Program (CLFP) is intended to reduce unnecessary institutionalization by providing older adults and younger adults with disabilities with options for where and how they receive assistance, care, and support. The design of the CLFP includes a two-pronged approach: (1) coordinated case management; and (2) purchase of services.

The CLFP will provide the resources and services not available by other means, to vulnerable older adults and younger adults with disabilities.

The Community Living Fund Program (CLFP) is consistent with the goals of the Community Living Fund (CLF), which are to:

A. Enable older adults and adults with disabilities who are eligible to remain living safely in their own homes and communities for as long as possible;
B. Provide financial support for home and community-based long-term care and supportive services beyond what is currently available;
C. Offer flexible funding to create "wrap-around" services that provide essential community-based assistance, care, and support;
D. Facilitate the development of service delivery models that strengthen the community-based long-term care systems and workforce;
E. Expand, not supplant, existing funding, to fill funding gaps until new sources of financial support for community-based long-term care services can be secured through federal Medicaid waivers and/or other means.

II. Eligibility for Services under the CLF Program

In order to obtain services, an individual must, at a minimum, be:

A. 18 years or older;
B. Institutionalized or deemed, at assessment, to be at imminent risk of being institutionalized;
C. A resident of San Francisco;
D. Willing and able to live in the community with appropriate supports;

E. At an income level of 300% of federal poverty or less plus assets up to $130,000 for case management services. Individuals with only purchase of service needs must have an income level of 300% of federal poverty or less plus assets up to $6,000.

Further, an individual must have a demonstrated need for a service and/or resource that will serve to prevent institutionalization or enable community living.

The following groups of people will be served:

1. The priority will be patients of Laguna Honda Hospital and Zuckerberg San Francisco General Hospital who are willing and able to be discharged to community living.
2. Patients at other San Francisco acute care hospitals and skilled nursing facilities.
3. Nursing home eligible individuals on the Laguna Honda Hospital waiting list (some of whom are at Zuckerberg San Francisco General Hospital or other hospitals) who are willing and able to remain living in the community.
4. Individuals who are at imminent risk for nursing home or institutional placement, willing and able to remain living in the community with appropriate supports.

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.

III. Definitions

ADL	Activities of daily living are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.
Adult with a Disability	A person 18-59 years of age living with a disability
BAA	Business Associate Agreement; establishes a legally binding relationship between HIPAA-covered entities and business associates to ensure complete protection of PHI
CalAIM	California Advancing and Innovating Medi-Cal, a program of the state Medi-Cal system with the goal of providing coordinated and equitable access to services throughout the lifespan; will provide for Enhanced Care Management, a person-centered care management approach, and provision of Community Supports, services to address social drivers of health such as housing support and medically supported foods.
CARBON	Contracts Administration, Reporting, and Billing Online System

Case Management	Case management is a formal strategy that coordinates and facilitates access to a variety of services in a timely manner for people who need assistance in organizing and managing their care and/or supportive services. It includes a standardized process of client intake, assessment, care planning, care plan implementation, monitoring, reassessment, and discharge/termination. This includes intensive case management services which may require frequent visits and follow up depending on care needs. Case management is an integral component of long-term care service delivery and is central to accessing additional services through the CLF Program.
Community Living Fund	The Community Living Fund (CLF), or "the Fund", was created in the San Francisco Administrative Code Section 10.100-12 to support aging in place and community placement alternatives for individuals who may otherwise require care within an institution. DAS oversees the administration of the Fund.
Community Living Fund Program	Funded by CLF, the Community Living Fund Program (CLFP) provides for home- and community-based services, or a combination of equipment and services, that will help those who are currently, or at risk of being, institutionalized to continue living independently in their homes, or to return to community living. This program, using a two-pronged approach of coordinated case management and purchased services, provides the needed resources, not available through any other mechanism, to vulnerable older adults and adults with disabilities.
DAS	Department of Disability and Aging Services
Disability	A condition or combination of conditions that is attributable to a mental, cognitive, or physical impairment, including hearing and visual impairments, that results in substantial functional limitations in one (1) or more of the following areas of major life activity: a) Self-care: activities of daily living (ADL), and instrumental activities of daily living (IADL); b) Capacity for independent living and self-direction; c) Cognitive functioning, and emotional adjustment
HIPAA	Health Insurance Portability and Accountability Act. A federal law that created national standards to protect patient health information from being disclosed without a patient's consent or knowledge.
HITECH	Health Information Technology for Economic and Clinical Health; creates incentives related to health care information technology, including incentives for the use of electronic health record (EHR) systems among providers
HSA	Human Services Agency of the City and County of San Francisco

IADL	Instrumental activities of daily living are the skills and abilities needed to perform certain day-to-day tasks associated with an independent lifestyle. These activities are not considered to be essential for basic functioning, but are regarded as important for assessing day-to-day quality of life and relative independence.
At imminent risk of institutionalization	To be considered at imminent risk of institutionalization, a person must have, at a minimum, one of the following: 1) functional impairment in a minimum of two Activities of Daily Living (ADL): eating, dressing, transfer, bathing, toileting, and grooming; or 2) a medical condition to the extent requiring the level of care that would be provided in a nursing facility; or 3) be unable to manage his/her own affairs due to emotional and/or cognitive impairment, evidenced by functional impairment in a minimum of three Instrumental Activities of Daily Living (IADLs): preparing meals, managing money, shopping for groceries or personal items, performing housework, using a telephone.
MOU	Memorandum of Understanding: describes a bilateral or multilateral agreement between two or more parties.
Older Adult	An individual who is 60 years of age or older
PHI	Protected Health Information; any information in a medical record that can be used to identify an individual, and that was created, used, or disclosed in the course of providing a health care service, such as a diagnosis or treatment
Purchase of Service	Purchased goods and services for clients deemed necessary by assessment; purchases may include equipment, modifications to residence, or needed support services
SOGI	Sexual Orientation and Gender Identity; Ordinance No. 159-16 amended the San Francisco Administrative Code to require City departments and contractors that provide health care and social services to seek to collect and analyze data concerning the sexual orientation and gender identity of the clients they serve (Chapter 104, Sections 104.1 through 104.9)

IV. Description of Services

Case Management Component

The Grantee will provide different levels of case management services including intensive case management service and moderate to minimal assistance. These levels of case management allow flexibility to tailor to individual needs to ensure stabilization and to avoid premature hospitalization and/or institutionalization.

Levels of case management are defined as below:

A. Intensive case management will be provided for persons with complex medical, cognitive, behavioral, and psychological needs who require a maximum amount of care and supervision and access to ongoing resources and services. Intensive case management for unstable clients with chronic and acute complex needs will require extensive coordination of and access to a full range of social, behavioral, mental health, and medical services.

B. Moderate case management will be provided for persons who require moderate to minimal assistance and support as well as access to one-time resources and services. Moderate case management can address needs of more stable clients with identified situations that require limited intervention to complete. This level of case management ensures stabilization and avoidance of hospitalization and nursing home placement.

Level of case management need and intervention will be determined on assessment by case manager.

Purchase of Services Component

The Grantee will manage purchased goods and services for clients, including those of their sub-contractors if used. The CLFP will support a menu of service options and level of assistance, care, and support, and a range of housing, and supportive services. These services must be deemed necessary by a CLFP case manager, and the funds are only used as a last resort, when all other payment options for that service have been exhausted. The CLFP will access and leverage state and federal funds whenever possible and incorporate processes in CLFP policies and procedures. Purchased services will supplement other available resources to ensure that each client receives the comprehensive array of appropriate services that are necessary to allow for community living.

Additional CLFP Initiatives

The CLFP also supports other program initiatives, and the Grantee will work collaboratively with these initiatives through the identified organization in providing services. All referrals through these initiatives must meet CLFP eligibility criteria. Current initiatives supported by CLFP include:

A. DAS Public Guardian (PG) Housing Fund - Supported by CLFP through the provision of administration of housing funds for CLFP eligible participants. In this initiative, the PG program provides program support including in-person visits, coordinated case management services, monthly approval of the housing subsidies, and other activities to ensure equitable access and appropriate use of the fund.

   Allowable purchases through the PG Housing Fund include:

   1. Supplement monthly subsidy (up to 100% as appropriate) for a licensed Assisted Living Facility (ALF), supportive housing, or similar; subsidies will be paid to vendors within the existing CLFP vendor network, and when required, new vendor agreements will be established.
   2. Move-related costs and purchases such as security deposits, moving boxes, transportation for move, care provider hours to pack and unpack belongings, furniture, and similar purchases.

B. Enhanced Care Management (ECM) - The current grant agreement also includes Enhanced Care Management services through the CalAIM 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. For ECM clients being served by the Grantee and participating in the SFHP CalAIM initiative, the Grantee shall abide by all service provision and documentation requirements as described in SFHP ECM Program Guide (attached). DAS will be responsible for data exchange and claims billing with SFHP, but Grantee will ensure database meets file specifications allowing for the exchange of data in a secure file. Grantee will also provide DAS access to files and database as well as a secure portal within database allowing for data exchange and claims billing.

Program Administration

The Grantee will:

A. Work with the DAS Benefits and Resource Hub for referrals to the CLFP. All referrals to the CLFP come through the DAS Benefits and Resource Hub, which is the initial entry point for accessing the fund. DAS Benefits and Resource Hub completes an initial screening and refers those presumed eligible for the fund to the CLFP Grantee.
B. Manage a waitlist with strategic decision making with DAS for financial considerations, prioritizations, and trends.
C. Coordinate all case management services through clinical supervision; including collaboration between multidisciplinary staff, across all sub-contracted organizations, through weekly scheduled case conferencing. There must be strong collaboration to share expertise.
D. Work collaboratively with other community organizations presently working with the client and additional ones who can provide specific expertise. When working in collaboration with other agencies or community-based organizations through sub-contracts, MOUs, and/or BAAs, respondent will assure that they will have staffing and experience in the appropriate areas.
E. Ensure that the purchase of all proposed goods and services is reasonable, prudent and properly procured following clearly written internal fiscal policies and procedures.
F. CLF is the fund of last resort in the purchase of goods and services. As such, all other viable options must be exhausted prior to utilization of CLF dollars.
G. Work collaboratively with DAS CLF Program Analyst to strategize program direction.
H. Develop and maintain collaborations with both City departments and community programs to reach the target population that is eligible for the services supported by the CLFP.
I. Conduct multidisciplinary meetings with stakeholders and partners monthly or as needed for the purposes of transitioning clients to the community and/or forwarding the mission of CLF.
J. Support a CLFP Advisory Council to provide a forum for consumer and community feedback. Members should include current and former program participants, representatives from community agencies, as well as a population representative of San Francisco.

K. Conduct activities that measure program impact such as participant improvements and outcomes in their quality of life as a result of program participation. These activities are conducted annually (at a minimum) to gather additional input from participants regarding their direct experience in an anonymous format.
L. Work closely with HSA Planning Unit staff to ensure appropriate and accurate collection of data for evaluation and program design analysis as well as with DAS in an ongoing evaluation of the program.
M. Utilize a dedicated database for the CLFP that tracks client information, assessments, care plans, progress notes, service authorizations and purchased services.
N. Manage complex billing with strong fiscal management, including the ability to leverage other state and federal funds.
O. Collect data detailing program impacts such as improvements in participant health outcomes and/or quality of life as a result of program participation.
P. Comply with requirements to provide time certifications for staff involved in service delivery and service support activities.
Q. Grantee shall provide interpretation for all limited English-speaking clients either directly or through a service.
R. Grantee shall provide services to clients in a culturally, ethnically, and linguistically appropriate manner.
S. Staff will have completed the appropriate training required for the level of care they are providing.
T. Staff will have the appropriate licenses in good standing, when applicable.
U. Staff will have no recent history (10 years) of criminal activity, including a history of criminal activities that endanger clients and / or their families.
V. Staff have no history of liability claims against them.
W. Staff have no history of fraud, waste, and / or abuse.
X. Grantee shall not differentiate or discriminate in the scheduling of appointments for services, treatment of clients, the quality of services, or in any other respect. Grantee shall not discriminate against clients on the basis of race, color, national origin, ancestry, religion, sex, marital status, health status, sexual orientation, physical, sensory, or mental handicap, age, socioeconomic status, participation in publicly financed programs of health care, or because any grievance or complaint has been filed by client. Services will be provided in the same manner, in accordance with the same standards, and within the same time availability.
Y. Grantee shall promptly notify DAS of receipt of any complaints from or on behalf of client and any professional liability claims filed or asserted regarding services provided by, or on behalf of, Grantee. Grantee shall cooperate with the DAS grievance procedure in resolving client complaints regarding provision of services and/or any other matter related to Grantee. Grantee shall cooperate with DAS resolution of any such complaints or grievances.
Z. Grantee shall maintain and require its subcontractors to maintain a case record for each client to whom Grantee or subcontractor renders services. The case record should be in such a form and detail as may be required by state and federal law, generally accepted and prevailing professional practice, and any federal, state, or local government agency. Records shall be maintained in a current, detailed, organized, and comprehensive

manner. Grantee shall comply with all federal, state, and local confidentiality and accuracy requirements.

AA. Grantee shall retain all client records, books, charges, and papers relating to Grantee's provision of services to clients, the cost of such services, and payments received. Grantee shall retain all records for at least ten (10) years after rendering services.

BB. Grantee and subcontractors shall comply with confidentiality, client and medical records and/or any other applicable state and federal laws and regulations with regard to any and all information directly or indirectly accessed or used by respective parties and their personnel, including HIPAA, HITECH, and all regulations promulgated thereunder. Grantee may have data access to Department of Public Health's system according to Business Associate Agreement. This provision shall not affect or limit Grantee's obligation to make available client or medical records, encounter data, and information concerning client care to DAS, any authorized state or federal agency, or other providers of services upon authorized referral.

V. Department Responsibilities (DAS)

DAS Intake and Screening Unit. All referrals to the CLFP come through the DAS Intake and Screening Unit, which is the initial entry point for accessing the Fund. While community-based long-term care services can be accessed in many ways, CLF is the fund of last resort and any request for support from the CLFP must come through this unit. The DAS Intake and Screening Unit completes an initial screening and refers those presumed eligible for the fund to the Grantee for the CLFP.

DAS will access other funding. DAS will leverage CLFP funding by qualifying for state and federal funding available through programs such as the Community Services Block Grant (CSBG). The Grantee is required to provide time certifications for staff involved in service delivery and service support activities. In addition, DAS will participate in CalAIM initiatives, including Enhanced Care Management, providing access to CalAIM funding.

VI. Collaborative Responsibilities (DAS and Grantee)

Management of the CLFP wait list is an important consideration for the Grantee and DAS. Financial considerations, prioritizations, and trends will be taken into account when considering strategies and decisions for caseload and wait list management.

The DAS Program Analyst, the DAS Intake and Screening Unit, and the Grantee will collaborate on undertaking outreach activities, as necessary, to ensure that the needs of the groups of people in the target population are identified and addressed. DAS and the Grantee will also work collaboratively with LHH to ensure referral pipeline for scattered site housing units is sufficient and ongoing.

The DAS Program Analyst, in collaboration with the DAS Director of Quality Management, will work with the CLFP Director to develop a quality assurance plan and process that fulfills the needs of both parties and the clients.

VII. Service Objectives

On an annual basis, Grantee will meet the following service objectives:

Objective 1: Number of unduplicated consumers receiving intensive case management and/or purchased services. **Target = 375**
Objective 2: Number of clients newly enrolled in CLFP. **Target = 175**
2. A. Number of clients enrolled in ECM. **Target = 120**
2. B. Number of clients enrolled in non-ECM. **Target = 55**
Objective 3: Number of clients enrolled in PG Housing Fund. **Target = 6**

Note: These service objectives will be reviewed by DAS and modified as needed.

VIII. Outcome Objectives

DAS is committed to measuring the impact of its investments in community services.

On an annual basis and as needed, Grantee will report progress towards meeting the following outcome Objectives:

A. Objective 1. Successfully support community living for a period of at least six months for at least 85% of CLFP clients who are being discharged from LHH at the time of enrollment. Identify reasons for re-institutionalization when it occurs.
B. Objective 2. At least 70% of care plan problems resolved, on average, after one year of enrollment in CLFP (excluding clients with ongoing purchases).
C. Objective 3. At least 90% of clients believe that CLFP services helped maintain or improve their ability for successful community living, through participation in a client satisfaction survey developed by the CLFP and approved by DAS.

IX. Reporting Requirements

Grantee will provide various reports during the term of the grant agreement:

A. Grantee will provide an annual report summarizing the contract activities, referencing the tasks as outlined in the negotiated Scope of Services. This report will also include accomplishments and challenges encountered by the Grantee. This report is due 45 days after the completion of the program year.

B. Grantee will enter all required data on the CLFP dedicated database and comply with reporting timelines for CLFP reporting requirements, including the CLFP 6-Month and Annual reports.

C. On an annual basis, Grantee will provide results of surveys detailing program impacts such as improvements in participant health outcomes and/or quality of life as a result of program participation.

D. Grantee will submit time studies to HSA/DAS for the months of February, May, August and November. The time study is due on the 10th day following the time study month and shall be entered online to this website link: https://calmaa.hfa3.org/signin

E. Quarterly and Annual Reports will be entered into the Contracts Administration, Billing and Reporting Online (CARBON) system.

F. Grantee will develop and deliver ad hoc reports as requested by HSA.

G. Grantee will develop and deliver a bi-annual summary report of SOGI data collected as requested by HSA/DAS. The due dates for submitting the summary reports are January 10th (for July 1 – December 31 data) and July 10th (for January 1 – June 30 data).

H. Grantee will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security rules to the extent applicable and to take all reasonable efforts to implement HIPAA and HITECH requirements.

I. Grantee will become a DAS Business Associate and able to sign and comply with the Business Associate Agreement

Reports requested to be sent via e-mail to the Program Analyst and/or Contract Manager to the following addresses:

Melissa McGee, Program Manager
Office of Community Partnerships
Department of Disability and Aging Services
PO Box 7988
San Francisco, CA 94120
melissa.mcgee@sfgov.org
AND
Tim Vo, Contract Manager
Office of Contracts Management
Human Services Agency
PO Box 7988
San Francisco, CA 94120
tim.vo@sfgov.org

X. Monitoring Activities

A. Program Monitoring: Program monitoring will include review of compliance to specific program standards or requirements; client eligibility and targeted mandates, back up documentation for the units of service and all reporting, and progress of service and outcome objectives; how participant records are collected and maintained; reporting performance including monthly service unit reports, maintenance of service unit logs; agency and organization standards, which include current organizational chart, evidence of

provision of training to staff regarding the Elder Abuse Reporting; program operation, which includes a review of a written policies and procedures manual, written project income policies if applicable, grievance procedure posted in the center/office, and also given to the consumers who are homebound, hours of operation are current according to the site chart; a board of director list and whether services are provided appropriately according to Sections VII and VIII. During annual monitoring, DAS will require Grantee to attest to Program Administration responsibilities.

B. Fiscal Compliance and Contract Monitoring: Fiscal monitoring will include review of the Grantee's organizational budget, the general ledger, quarterly balance sheet, cost allocation procedures and plan, State and Federal tax forms, audited financial statement, fiscal policy manual, supporting documentation for selected invoices, cash receipts and disbursement journals. The compliance monitoring will include review of Personnel Manual, Emergency Operations Plan, Compliance with the Americans with Disabilities Act, subcontracts, and MOUs, and the current board roster and selected board minutes for compliance with the Sunshine Ordinance.