

REVISED EXHIBIT A

**SETTLEMENT AGREEMENT BETWEEN PLAINTIFFS AND
DEFENDANT CITY AND COUNTY OF SAN FRANCISCO**

Davis v. CHHS, C00-2532-SBA

December 12, 2003

1.0 INTRODUCTION

- 1.1 The individual named Plaintiffs, Charles Davis, Jackie Del Rosario, Jesse Fitchett, Lorraine Robles, Gerald Scott, Hong T., and M.W; the plaintiff class members; and the organizational Plaintiff, Independent Living Resource Center of San Francisco (ILRCSF); and Defendant City and County of San Francisco (Defendant San Francisco) enter into this Settlement Agreement (“Agreement”) to resolve the issues raised in Plaintiffs’ Third Amended Complaint and the Defendants’ Answer. The Third Amended Complaint alleges that Defendant San Francisco has failed to inform class members of their right to home and community based services, assess them for such services, and provide them with such services in order to avoid unnecessary institutionalization at Laguna Honda Hospital and Rehabilitation Center (“LHH”).
- 1.2 Defendant San Francisco has at all times denied Plaintiffs’ claims, and both Plaintiffs and Defendant San Francisco recognize the ultimate result of this litigation cannot be predicted with certainty. Moreover, these parties recognize that continuation of the litigation would involve substantial additional legal fees and costs.
- 1.3 WHEREAS, the parties enter into this Agreement in mutual recognition and support of class members’ goals to live in integrated settings of their choice with appropriate services and supports.
- 1.4 WHEREAS, toward this end, the parties acknowledge the following:
- 1.4(a) Screening, assessment, and service/discharge planning to achieve community integration shall be performed by trained case managers and assessors who are not employees of either LHH or SFGH.
- 1.4(b) The stated purpose of the San Francisco Department of Aging and Adult Services is to assist older and functionally impaired adults and their families to maximize self-sufficiency, safety, health and independence, so they can remain living in the community for as long as possible and maintain the highest quality of life.

- 1.4(c) A strategic goal of the San Francisco Department of Public Health is to expand community based alternatives and decrease the need for institutional care.
- 1.4(d) Laguna Honda Hospital and Rehabilitation Center's (LHH) Community Reintegration Philosophy supports each resident's goal to live in the community setting of his or her choice, which is applied through:
- i. Admitting, relocating, and discharging residents from LHH;
 - ii. Linking residents to community services and supports;
 - iii. Collaborating with residents and their families in community reintegration and discharge planning; and
 - iv. Assisting residents to retain and/or gain skills needed to live in the community.
- 1.4(e) Decisions and recommendations regarding community services shall be person-centered and be driven by each individual's needs and informed choices as appropriate.
- 1.4(f) Screening, assessments and service/discharge planning shall be conducted by interdisciplinary teams comprised of individuals who are qualified and knowledgeable about currently and potentially available community-based services and supports. Assessments and service/discharge planning must be made in collaboration with the individual and, as appropriate, family members and other support persons involved in his or her life.
- 1.4(g) No class member shall be discharged to a community living arrangement unless the requirements of all applicable rules and regulations, including but not limited to 42 C.F.R. sections 482.43 and 483.12, have been met, except pursuant to the express, informed request of the individual.

1.5 WHEREAS, by entering into and complying with this Agreement, no party makes any concession as to the merits of the opposing party's claims or defenses.

It is, therefore, mutually agreed between the Plaintiffs and Defendant San Francisco, subject to approval by the Court, as follows:

2.0 DEFINITIONS

- 2.1 "Plaintiffs" means the individual named Plaintiffs, the plaintiff class, and the organizational Plaintiff.
- 2.2 "Class Members" means: All adult Medi-Cal beneficiaries who: (1) are or will become residents of Laguna Honda Hospital and Rehabilitation Center, or (2) are or will be on waiting lists for Laguna Honda Hospital and Rehabilitation Center; or (3)

are or will be within two years of discharge from Laguna Honda Hospital and Rehabilitation Center; or (4) are or will become patients at San Francisco General Hospital or other hospitals owned or controlled by the City and County of San Francisco, who are eligible for discharge to Laguna Honda Hospital and Rehabilitation Center.

- 2.3 “At Risk” class member means class members who are or will be, during the term of this Agreement, on a waiting list for Laguna Honda Hospital and Rehabilitation Center and/or who are or will become, during the term of this Agreement, patients at San Francisco General Hospital or other hospitals owned or controlled by the City and County of San Francisco, who are eligible for discharge to Laguna Honda Hospital and Rehabilitation Center.
- 2.4 “Defendant San Francisco” means Defendant City and County of San Francisco.
- 2.5 “LHH” means Laguna Honda Hospital and Rehabilitation Center in San Francisco, California.
- 2.6 “SFGH” means San Francisco General Hospital in San Francisco, California.
- 2.7 “ILRCSF” means Organizational Plaintiff Independent Living Resource Center of San Francisco
- 2.8 “Person-centered” means focused on the person’s expressed goals, desires, cultural and language preferences, abilities and strengths, as well as health/wellness/behavioral issues and skill development/training needs relevant to community living.
- 2.9 “Targeted Case Management” means case management to assist class members in gaining access to needed medical, social, educational and other services, pursuant to State law. Covered activities also include assessment, service planning, and monitoring services and supports to ensure they are meeting a beneficiary’s needs.
- 2.10 “HCBS Waivers” means any one and/or all of California’s Home and Community Based Services waivers pursuant to Section 1915(c) of the Social Security Act, codified at 42 U.S.C. § 1396n including the Multi-Purpose Senior Services Program Waiver, the Nursing Facility A/B and Sub-Acute Waivers, the In-Home Medical Care Waiver, the AIDS Waiver, and the Developmental Disabilities Waiver, and the Assisted Living Waiver (to the extent that waiver is operational).
- 2.11 “Active Caseload” means caseload consisting of clients currently in the TCM Program. These clients have completed the screening, assessment and service plan/discharge plan, as appropriate, and have been deemed eligible for primary ongoing case management services by the TCM Program.

- 2.12 “Most integrated setting” means the most integrated setting appropriate to the individual class member’s needs in accordance with the Americans with Disabilities Act, 42 U.S.C section 12131 *et seq.* and 28 C.F.R. section 35.130(d).
- 2.13 “Transition services” means services to assist a class member in the transition from an institutional to a community based setting, including counseling, habilitation, skill development or training, peer mentoring, site visits, move-in costs or other services as appropriate.
- 2.14 “PAS/PASRR Level I Screen” means the form completed prior to admission to a nursing facility to identify individuals suspected of having a mental health or developmental disability, pursuant to Pre-Admission Screening and Resident Review requirements in 42 U.S.C. Section 1396r and 42 C.F.R. Section 483.100 *et seq.*
- 2.15 “PASRR Level II Evaluation” means the evaluation completed for individuals identified on the PAS/PASRR Level I Screen as having a suspected mental health or developmental disability, pursuant to Pre-Admission Screening and Resident Review requirements in 42 U.S.C. Section 1396r and 42 C.F.R. Section 483.100 *et seq.*
- 2.16 “Specialty Mental Health Targeted Case Management” or “SMH TCM” means Services that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary’s progress; and plan development. (Cal. Code Regs., tit. 9 § 1810.249).
- 2.17 “Active Discharge Planning” means activities to prepare a class member for discharge from LHH which occur on a frequent and consistent basis, and which involve more than periodically placing class members on housing or other waitlists.

3.0 TARGETED CASE MANAGEMENT PROGRAM

- 3.1 By March 29, 2004, Defendant San Francisco agrees to implement a Targeted Case Management Program within the Department of Public Health to conduct screening, assessments, service/discharge planning and ongoing case management for class members. The Targeted Case Management Program will be composed of nurses and social workers who will report to the Placement Division of Community Programs. Community Programs include Behavioral Health Services (mental health and substance abuse) Primary Care, Housing and Preventive Health Care.
- 3.2 The screening, assessments and service/discharge planning will be consistent with the Division of Community Program’s goal to place class members in the most integrated setting appropriate for their needs and desires. Further, a major component of the Division’s work is to avoid unnecessary institutionalization and assure appropriate utilization of hospital and nursing home resources by promoting

appropriate community-based alternatives. The nurses and social workers in the Targeted Case Management Program shall not be employees of SFGH or LHH.

3.3 Staff of the Targeted Case Management Program will carry an average caseload of no more than 15 individuals at a time during the calendar year. "Average Caseload" is the total number of clients in the case manager's active caseload during the year divided by 12.

3.4 Responsibilities of the TCM Program: In addition to the ongoing case management responsibilities set forth in Section 6.0, the staff of the Targeted Case Management Program will have the following-responsibilities:

3.4(a) Screening, comprehensive assessment, and service/discharge planning as set forth in Sections 4.3 - 4.7 using the designated screening tool and assessment and service/discharge planning instruments in Attachments 1, 2, 3 and 6;

3.4(b) Work closely with hospital social workers and case managers to determine alternatives to long-term care;

3.4(c) Maintain frequent communication with all members of the Service Planning Team as described in Section 4.7(f);

3.4(d) Be reasonably informed about and familiar with the array of potential and currently available home and community based services in San Francisco.

3.5(e) Provide and/or arrange for transition services to class members, prior to discharge, to facilitate placement in the community, including but not limited to: counseling about community options; assistance in overcoming concerns or anxieties about community living; site visits, including overnights as appropriate; peer mentoring; or other services as appropriate.

3.4(f) Assist clients, including accompaniment to appointments, to secure community resources, including housing and entitlements, to facilitate discharge to the community;

3.4(g) Submit housing application(s) for clients who are homeless or at risk for being homeless, provided the clients cooperate with submitting those applications;

3.4(h) Make their best efforts to assure that the necessary community resources are in place prior to discharge;

3.4(i) Provide ongoing case management into the community for a reasonable time after discharge to assure that necessary services, including community-based case management, are in place to minimize unnecessary readmission and/or transfer to a higher level of care.

4.0 SCREENING, ASSESSMENT AND SERVICE/DISCHARGE PLANNING

4.1 Purpose

4.1(a) **Purpose of Screening:** The purpose of screening is to identify class members who are eligible for assessment, and service/discharge planning from the TCM Program. The TCM Program shall screen all referrals to the Program to determine whether class members are eligible for services from the TCM Program. Those individuals who meet the screening criteria set forth in Attachment 1 shall be provided with assessment and service/discharge planning.

4.1(b) **Purpose of Assessment and Service/Discharge Planning:** The purpose of assessment and service/discharge planning is to collect information about the class member's needs and choices with respect to living arrangement and services and supports; provide complete information about the array of home and community based services and supports; consider the most integrated setting appropriate and eligibility for home and community-based services without regard to current availability of services; develop a comprehensive individual written plan that will document, with specificity, the class member's goals and services to be provided to meet those goals; and determine eligibility for ongoing case management services.

4.2 Designation of Screening, Assessment and Service/Discharge Planning Instruments

4.2(a) The parties agree that Defendant San Francisco will utilize the screening, assessment, and service/discharge planning instruments attached hereto as Attachments 1, 2, 3, and 6.

4.2(b) Defendant San Francisco shall have the flexibility to modify or update the designated instruments to keep up with best practices, advances in the field, and the needs of class members.

4.2(c) Defendant San Francisco shall notify Plaintiffs' counsel of any changes, modifications, and/or updates to the instrument(s) within two (2) weeks, and provide copies of the instrument(s) with changes, as well as new and/or updated protocols and reasons for the changes.

4.3 Screening, Assessment, Service/Discharge Planning Process and Timelines for At-Risk Class Members

4.3(a) By March 29, 2004, San Francisco shall begin to screen, assess, and develop service/discharge plans as appropriate for at-risk class members in accordance with the agreed-upon protocols and procedures set forth in sections 4.5-4.7.

- 4.3(b) At-Risk Class Members will be provided with screening, assessment, and service/discharge planning services pursuant to the protocols and standards set forth in sections 4.5 – 4.7 and according to the process and timelines set forth below:
- i. Every effort shall be made to assess at risk class members while at SFGH or before admission to LHH. For individuals who are admitted to LHH before an assessment has been completed, the assessment and individual service/discharge plan shall be completed within 14 days of admission.
 - ii. For individuals in the TCM program who are admitted to LHH, assessments and individual service/discharge plans shall be reviewed quarterly and updated by the Targeted Case Management Program for the first year of LHH residency and annually thereafter.
 - iii. All individuals who are admitted to LHH, who, after screening have been found to not meet the criteria for inclusion in the TCM program will be reassessed by the TCM Program upon request of the individual, his or her family, or authorized representative, and/or upon a change in circumstances.

4.4 Screening, Assessment, Service/Discharge Planning Procedure and Timelines for LHH Residents.

- 4.4(a) By March 29, 2004, San Francisco shall begin to screen and assess all current LHH residents, and develop service/discharge plans as appropriate, in accordance with the agreed-upon protocols and procedures. At least 50 percent of all current LHH residents who have not been previously screened by the TCM Program shall be screened, assessed, and provided with service/discharge planning services as appropriate, by the TCM Program by September 29, 2004. All current LHH residents shall be screened and assessed, and provided with a service/discharge plan as appropriate, by the TCM Program by March 29, 2005.
- 4.4(b) LHH residents will be screened, assessed, and provided with an individual service/discharge plan, as appropriate, using agreed upon protocols and procedures pursuant to sections 4.5 – 4.7 of this Agreement, in the following priority order:
- i. All named plaintiffs;
 - ii. All LHH residents in the existing LHH Social Services Database:
(1) identified in the MDS Section Q as having expressed a desire for discharge; (2) identified by the LHH treatment team as believing the resident has discharge potential even if not reflected in MDS and patient has not expressed desire; or (3) residents who did not express desire on MDS but later express desire for community placement.

- iii. All residents in RUG categories: “Physical Function Reduced,” “Behavior Only,” and “Impaired Cognition” in ascending order of RUG score;
 - iv. All others.
- 4.4(c) All LHH residents may self-refer to the TCM Program, or be referred by a family member, or an authorized representative. LHH residents who request screening, assessment, and/or service/discharge planning services from the TCM Program shall receive screening within three (3) days, and assessment, and service/discharge planning as appropriate from the TCM Program in accordance with the protocols and procedures set forth in sections 4.5 – 4.7.
- 4.4(d) Every effort shall be made to begin the assessment within three (3) business days of screening, but in no case shall the assessment and service/discharge plan be completed more than 14 days after screening.
- 4.4(e) The TCM Program shall review the assessments and service/discharge plans of all LHH residents at least annually, to ensure that recommendations are being implemented.

4.5 Screening Protocols and Standards

- 4.5(a) By January 29, 2004, Defendant San Francisco shall develop and provide to Plaintiffs’ counsel protocols and procedures by which class members are screened to determine eligibility for TCM Program assessment, service/discharge planning, and ongoing case management services. Plaintiffs’ counsel will have an opportunity to provide written comments to Defendant San Francisco for consideration within 14 days of receipt.
- 4.5(b) The protocols and procedures shall include the following:
- i. **Who will be screened by the TCM Program:** All Class members referred by SFGH or the LHH Screening and Admissions Committee and all current LHH residents, as set forth in sections 4.5 and 4.4 respectively.
 - ii. Class members shall be screened utilizing the screening criteria set forth in Attachment 1.
 - iii. When an LHH applicant is accepted for admission, or earlier if practicable, the LHH Screening and Admissions Committee shall refer the applicant to the TCM Program for screening.
 - iv. Class members may be referred to the TCM Program for screening by: him or herself; a family member; an authorized representative staff; or SFGH or LHH.

- v. Screening shall occur within three (3) business days of referral to the TCM Program.
- vi. At the time of referral to the TCM Program, SFGH or LHH staff will include a copy of the PAS/PASRR Level I Screen Form, if available.
- vii. **Referral to HCBS Waivers:** Upon screening, or as soon as practicable thereafter, the TCM Program will provide, and document provision of, information about HCBS waivers and refer the class member to all appropriate HCBS waivers.

4.6 Assessment Protocols and Standards

- 4.6(a) By January 29, 2004, Defendant San Francisco shall develop and provide to Plaintiffs' counsel protocols and procedures by which class members are assessed. Plaintiffs' counsel will have an opportunity to provide written comments to San Francisco for consideration within 14 days of receipt.
- 4.6(b) Protocols and procedures for assessment shall, at a minimum, include the standards set forth below and be consistent with the Targeted Case Management assessment process.
- 4.6(c) **Who will receive Assessment:** All individuals who meet the screening criteria as set forth in Attachment 1.
- 4.6(d) Person-centered assessments shall occur face-to-face and will use all available sources of information about the individual, including the individual him/herself, and with the individual's permission, family and friends with the individual's permission, informal and formal caregivers, and the medical record, and assessor observations.
- 4.6(e) Decision-making capacity shall be assessed by trained professionals and if an individual is unable to make decisions, an advocate or surrogate will be appointed, consistent with California law.
- 4.6(f) The person-centered assessment will identify class members' needs and preferences, in areas to include the following:
 - i. Medical/mental condition, health/substance abuse, including assessment by other professionals;
 - ii. Housing/physical environment;
 - iii. Physical functioning, including ADLs and IADLs;
 - iv. Physical needs, such as food and clothing, auxiliary aids and assistive technology;

- v. Familial/social support system, such as socialization and recreation;
 - vi. Training needs for community living, such as activities of daily living;
 - vii. Social/emotional status;
 - viii. Cultural, language, and spiritual considerations;
 - ix. Vocational/educational needs;
 - x. Preference of type and location of care provider; and
 - xi. Financial resources available.
- 4.6(g) The assessment process shall include collaboration with the class member, and, as appropriate, his or her family, friends, authorized representative, and others as desired by the class member. The assessment shall ascertain the class members' goals and choices regarding living arrangement and services and supports needed to achieve the class members' goals.

4.6(h) **Mental Health Assessment and Coordination with PASRR Level II Evaluation:**

- i. The PASRR Level II evaluation, revised pursuant to settlement of the present case between Plaintiffs and State Defendants and submitted to the court as Exhibit B to the Settlement Agreement between Plaintiffs and State Defendants (Exhibit 2 to Swain Declaration) may be used as an alternative to the TCM assessment when the revised PASRR Level II evaluation is available for the TCM staff to review. As appropriate, the TCM staff will attempt to participate with the Department of Mental Health (DMH) consultants when the revised PASRR Level II evaluation is administered. Following the administration of the revised PASRR Level II evaluation, a service/discharge plan will be developed which may include a referral to Specialty Mental Health services or State Department of Developmental Services (DDS). The service/discharge plan will also take into consideration the recommendations of the PASRR Level II consultant.
- ii. The current PASRR II evaluation form in use at the time of the drafting of this Agreement shall not be used in lieu of assessment by the TCM Program. If the revised PASRR II evaluation is not available at the time of assessment, the TCM Program shall assess class members, as set forth below in section iii using the RAI-HC and the InterRAI Mental Health Supplement, attached hereto as Attachments 2 and 6. The InterRAI Mental Health Supplement shall be completed by a qualified mental health professional.

- iii. The following class members shall receive the Mental Health Supplement: (1) individuals whose PAS/PASRR Level I screen indicates the presence of a mental health diagnosis; (2) individuals referred from the acute psychiatric unit at SFGH; (3) any other individuals who, in the professional judgment of TCM Program staff require such assessment.

4.7 Service/Discharge Planning Protocol and Standards

- 4.7(a) By January 29, 2004 Defendant San Francisco shall develop and provide to Plaintiffs' counsel protocols and procedures by which class members are provided with service/discharge planning. Plaintiffs' counsel will have an opportunity to provide written comments to San Francisco for consideration within 14 days of receipt.
- 4.7(b) **Who will receive Service/Discharge Planning:** All individuals who meet the screening criteria, set forth in Attachment 1, and have completed the assessment process set forth in section 4.6.
- 4.7(c) Protocols and procedures for service/discharge planning shall, at a minimum, include the standards set forth below and be consistent with the Targeted Case Management service planning process.
- 4.7(d) The service/discharge planning process shall:
 - i. Determine the most integrated setting appropriate to class members' needs;
 - ii. Determine whether the individual meets the essential eligibility requirements for community supports and services in accordance with individual needs and preferences; and
 - iii. Include consideration of all community supports and services for which the individual may be eligible, including those outlined in Attachment 4. Consideration of community supports and services shall not be limited to currently available resources.
- 4.7(e) The service/discharge planning process shall include collaboration with the class member, and, as appropriate, his or her family, friends, authorized representative, and others as desired by the class member. Service/discharge planning shall address the class members' goals and choices regarding living arrangement and services and supports needed to achieve the class members' goals.
- 4.7(f) Once the assessment is completed, a Service Planning Team (or individual representative of the team) will collaborate with the individual to provide meaningful information to the individual about short and long-term service options, including the community supports and services for which he or she

is eligible.

- 4.7(g) The Service Planning Team will be comprised of the class member, and as appropriate, his or her family, friends, authorized representative, and others as desired by the class member; and Targeted Case Management Program staff, in consultation with professionals that shall include a social worker, nurse, physician, independent living specialist, and/or other professionals as needed and appropriate (*e.g.*, geriatrician or physiatrist, substance abuse specialist, psychiatrist, nutritionist, occupational or physical therapist).
- 4.7(h) The Service Planning Team shall memorialize the determinations of services and supports in a single, comprehensive, written Individual Service Plan/Discharge Plan, which shall include documentation of:
- i. All areas of assessed need;
 - ii. The class member's stated preferences;
 - iii. The specific services recommended to meet the class member's identified needs and the nature, frequency and duration of the services to be provided;
 - iv. The community programs, housing, persons, agencies, services, and/or waitlists to which the class member will be referred;
 - v. Specific actions required to meet identified service needs and choices of class members (including person responsible, and timeframes for completion);
 - vi. Transition services including counseling, including habilitation, skill development or training, peer mentoring, site visits, move-in costs or other services as appropriate; and
 - vii. Signatures of assessor(s), class member, and authorized representative (if appropriate).
- 4.7(i) The class member will have a reasonable amount of time to review the recommendations and the right to disagree with the result of the service/discharge plan. Any such objections will be noted on the plan.

5.0 STAFF TRAINING

- 5.1 Prior to conducting screening, assessments, and service/discharge planning, all Targeted Case Management Program staff, with the exception of clerical staff, will be trained using the curriculum and materials set forth in Section 5.4. Staff will be trained and provided updated information on a regular basis, and at least annually.

- 5.2 TCM and LHH staff will collaborate on and implement a training program for LHH medical social work staff that includes the components contained in sections 5.4 (a)-(f), as appropriate.
- 5.3 Defendant San Francisco shall provide plaintiffs with a description of the training curricula for both TCM Program and LHH Staff, including agendas, all training materials, as well as a list of all trainers and their credentials or curriculum vitae prior to beginning training. Plaintiffs will have 14 days to provide written comments on the training curriculum and materials to San Francisco for consideration.
- 5.4 The training curriculum and materials will include at a minimum, the following topics and components:
 - 5.4(a) Use of the designated screening, assessment, and individual service/discharge planning instruments, contained in Attachments 1, 2, 3, and 6;
 - 5.4(b) Eligibility requirements, services covered, and referral information for all applicable home and community-based services available under the State Medicaid Plan, Medi-Cal home and community-based waivers, and other state and local programs, including but not limited to the programs specified in Attachment 4, such as: programs that provide or fund housing, supportive housing, attendant care, meals, transportation, mental health treatment, advocacy, case management, money management, residential and crisis facilities, supported living, independent living training, habilitation, substance abuse treatment, socialization/recreation, advocacy/legal, emergency response, and assistive technology;
 - 5.4(c) Person-centered planning and consumer rights, relationship building with clients;
 - 5.4(d) Site visits to community based programs providing the services specified in section 5.4(b), including but not limited to: On Lok, Assertive Community Treatment Programs, supported housing programs, Presentation Day project, the Institute on Aging, housing providers, shelters, hotels, GA, Adult Day Health Programs, Senior Resources;
 - 5.4(e) Meetings or visits with, and/or presentations by individuals with disabilities, including severe disabilities, who live in the community;
 - 5.4(f) Training shall be provided by persons experienced and knowledgeable about the topics, who may include consultants and/or staff from public and private agencies and services providers, including the Department of Public Health, Community Behavioral Health Services, case management programs, Emergency Department Case Management Program, CRT, Medical Emergency Department Higher Utilizer of Services Case Management Program, Department of Public Health targeted case

management finance office, Department of Human Services—In-Home Supportive Services (IHSS), Department of Public Health Housing Division, Behavioral Health Programs including outpatient services and Residential and Housing Services, Independent Living Resource Center, and the Public Guardian Office and providers serving people with disabilities in the community.

6.0 ONGOING CASE MANAGEMENT SERVICES

6.1 Class members who meet the screening criteria and have received an assessment and Service/Discharge Plan shall receive primary case management from the TCM Program if the TCM Program determines that:

6.1(a) The class member is reasonably likely to be discharged to the community within 180 days of development of the Service/Discharge Plan; OR

6.1(b) The class member has progressed on the Service/Discharge Plan to be within 180 days of discharge; OR

6.1(c) The class member may require active discharge planning for a period that exceeds 180 days.

6.2 Class members who meet the screening criteria and have received an assessment and Service/Discharge Plan shall receive primary case management from LHH social worker/discharge planning staff if the TCM Program determines that the individual does not meet the criteria above.

6.3 LHH staff will refer residents to the TCM Program who, at any point in time, are likely to be discharged from LHH within 180 days.

6.4 Class members will be informed orally and in writing of the name and contact information of their primary case manager at the time of such designation and at any time such designation is changed.

6.5 **Active Discharge Planning Responsibilities of TCM Staff:** In accordance with the assessment and individual service /discharge plans developed pursuant to sections 4.0 -4.7 of this agreement, the staff of the Targeted Case Management Program will ensure that services are provided in accordance with the individual service/discharge plan of each class member on his or her active caseload by promptly:

6.5(a) Referring class members to currently available housing and community based services and supports and assisting them when necessary in placing them on all applicable waiting lists;

6.5(b) Providing direct, hands-on assistance in accessing services (*e.g.* arranging for appointments and transportation to medical, social, educational and

other services, including housing, and facilitating communication, including translation services);

- 6.5(c) Providing assistance as needed to ensure that housing, including services needed to maintain housing, is stabilized, and intervention to avoid crises that may lead to hospitalization and/or institutionalization;
- 6.5(d) Provide regular and periodic follow up case management to clients in the community for a reasonable time after discharge to assure that necessary services, including community-based case management, are in place to minimize unnecessary readmission and/or transfer to a higher level of care.

6.6 LHH Case Management: In the case where LHH staff maintains primary case management responsibility:

- 6.6(a) LHH staff shall take primary responsibility for implementation of the Service/Discharge Plan, including making referrals to housing and service providers on an ongoing basis;
- 6.6(b) TCM Program case manager and LHH social work staff will meet as often as necessary but no less than quarterly to review the class member's service/discharge plan.

6.7 Eligibility for and Referral to Specialty Mental Health Targeted Case Management (SMH TCM)

- 6.7(a) Class members will be referred to SMH TCM when:
 - i. The PASRR II or Individual Service/Discharge Plan indicates a desire/appropriateness for community placement that requires specialty mental health services; or
 - ii. The PASRR II indicates a specialized need for mental health services that cannot be provided by LHH; or
 - iii. The class member continues to require the skilled nursing needs of LHH but their mental health needs cannot be met by the specialized mental health services of the psychosocial units of LHH.
- 6.7(b) Referrals to Specialty Mental Health will be made directly to the Director of Adult and Older Adult Services for his/her dissemination to the appropriate service.
- 6.7(c) All referrals will be tracked with the following information:
 - i. Date of Referral
 - ii. Copy in Individual Service/Discharge Plan

- iii. Name of individual receiving referral from Director of Adult and Older Adult Services (*e.g.* Clinic, Case Management service, SPR, etc.)
 - iv. Request will be made by the TCM Program for quarterly follow-up on individuals' progress and implementation of Service/Discharge Plan recommendations.
- 6.8 Defendant San Francisco is not required to make referrals to home and community-based services and supports for a class member, if the class member knowingly opposes the provision of such services and supports. Any opposition shall be based on the preference of the class member, only after the person has made an informed decision not to accept such services and supports. An informed decision shall consist of the class member:
- 6.8(a) Having an opportunity to express his or her interests and preferences and reason for opposing home and community-based services;
 - 6.8(b) Being informed of appropriate community alternatives in a manner that reflects the person's ability to understand and communicate information;
 - 6.8(c) Having the opportunity to visit and observe appropriate community settings and options; and
 - 6.8(d) Being provided with appropriate transition services, including as specified in his/her individual service/discharge plan.
 - 6.8(e) Efforts under (a)-(d) above will be clearly documented by the TCM Program.
- 6.9 For those class members who reside at LHH and who oppose any home and community based services, Defendant San Francisco will review the discharge potential of the resident quarterly. Discharge planning activities will be resumed at any time that the individual expresses the desire to move to the community.

8.0 COMMUNITY ADVISORY COMMITTEE

- 8.1 **Establishment and Operation of a Community Advisory Committee:** By February 15, 2004, Defendant San Francisco, in collaboration with Plaintiffs' counsel, will establish a Community Advisory Committee ("CAC"). Membership on the CAC shall consist of at least two members, or 25 percent of CAC members, whichever is greater, designated by Plaintiffs' Counsel. Members may include consumers of long term care services, community providers and advocates for people with disabilities, including seniors, and governmental representatives responsible for carrying out this agreement, including at least one designee from the Targeted Case Management Program and one from the Department of Aging and Adult Services. The first meeting will be held in March, 2004. The CAC shall meet on at least a quarterly basis thereafter and more often if needed to carry out its

responsibilities. Meetings shall be open to the public and Plaintiffs' counsel will be informed of meetings in writing at least two (2) weeks in advance if the meetings are changed from the regularly scheduled quarterly date.

8.2 **Responsibilities of the Community Advisory Committee:** Upon its establishment, the CAC will reside as a committee within Department of Public Health and engage in the following activities:

8.2(a) **Review of Data Collected:** The CAC shall review aggregate data reported pursuant to Section 11.1 and provide recommendations to Defendant San Francisco. Such recommendations may concern ways to improve the functions of the Targeted Case Management Program or long term care services provided to class members. Defendant San Francisco shall consider, and adopt as appropriate and feasible, recommendations made by the CAC. The recommendations of the CAC shall be submitted to the Department of Public Health and the Department of Aging and Adult Services for evaluation and action as appropriate within that Department's charge of service coordination for disabled and senior services in the community.

8.2(b) **Consumer Satisfaction Survey:** Beginning in April 29, 2004, Defendant San Francisco will ensure that a consumer satisfaction survey is conducted with each class member who has received services through the TCM Program, including assessment, service planning and/or case management. Such survey shall contain the questions and information set forth in Attachment 5. The survey will be conducted by TCM staff or other personnel designated by the CAC including governmental officials, community providers, advocacy agencies, volunteers, and/or a combination of these. The results of the survey will be reported to the CAC on a quarterly basis. Participation in the survey will be voluntary on the part of class members and names of individuals will be kept confidential. Class members surveyed will be given the option of providing their names and contact information to Plaintiffs' counsel.

8.3 **Collaboration with Defendant San Francisco Regarding Class Members Rights and Education:** Pursuant to sections 9.1 - 9.2 below, the CAC will provide input to Defendant San Francisco regarding the staffing and development of a Community Resource Center for class members at LHH and the development of a training curriculum for residents.

9.0 CLASS MEMBER RIGHTS AND EDUCATION

9.1 **Community Resource Center at LHH:** By February 2, 2004 Defendant San Francisco shall designate a portion of the existing LHH Patient Library to serve as a Community Resource Center at LHH where residents can gain access to information about community options and services, receive training, attend presentations by community providers about community options, receive peer

counseling regarding community living, or talk to community advocates. The Community Resource Center shall include up-to-date written materials about community programs, access to computer and internet services for residents, and provide instructions on how to access a telephone and fax so that residents can inquire and receive information about housing and services in the community and/or arrange for visits. Residents will be encouraged to use the Community Resource Center and will receive assistance from LHH staff to access it. The Community Resource Center will be staffed by peer mentors employed through Defendant San Francisco to the extent available, and/or trained volunteers. Staffing and development of the Community Resource Center will be coordinated with input from the Community Advisory Committee established in sections 8.0 – 8.3. The Community Resource Center shall be under the supervision and management of LHH staff and shall not be the responsibility of the TCM Program.

- 9.2 **Presentations to Class Members at LHH:** By March 19, 2004, The TCM Program shall develop a curriculum for residents of LHH to include at least the following components, and consider any input from the Community Advisory Committee:
- 9.2(a) Specific community based programs, services and housing options;
 - 9.2(b) Specific community living skills, such as using public transportation, managing attendants, community participation and other topics as appropriate and desired by residents;
 - 9.2(c) Self-advocacy and exercising personal choice in the assessment and service/discharge planning process;
 - 9.2(d) How to use the LHH Community Resource Center;
 - 9.2(e) On at least a bi-monthly basis, Plaintiffs' Counsel or its designee shall be permitted to conduct a presentation on class members' rights. Such training will be open to LHH staff and the members of the TCM Program.
 - 9.2(f) Inclusion of presentations by community providers and members;
 - 9.2(g) List of presenters for various training topics;
 - 9.2(h) Schedule of presentations and topics for the first two years; and,
 - 9.2(i) Consideration video taping appropriate presentations or information, to be maintained and available for viewing in the Community Resource Center.
- 9.3 **Peer Mentors:** To the extent peer mentors are available, the Targeted Case Management Program shall include the services of peer mentors for any class members who request such assistance, as well as those class members who, in the opinion of the staff in the Targeted Case Management Unit, could benefit from such assistance. All class members shall be informed of the availability of peer

mentor assistance during the assessment and service/discharge planning process. Peer mentors shall be individuals with disabilities who live in the community and are knowledgeable about community living. The services provided by peer mentors may include:

- 9.3(a) Meeting initially with class members during the assessment and service/discharge planning process to discuss community living options and rights and choices around assessments and service/discharge planning;
 - 9.3(b) Ongoing assistance during and after the assessment and service/discharge planning process to help the class member transition to a community setting, including advising class members on retaining their housing and household goods and making practical arrangements;
 - 9.3(c) Accompaniment of class members to visit community programs and/or housing options;
 - 9.3(d) Participation on service/discharge planning teams, as desired by the class member, to assist the class member to understand community options;
 - 9.3(e) Assistance in using the Community Resource Center at LHH;
 - 9.3(f) Post-discharge to provide transition assistance as desired by the class member;
 - 9.3(g) Other services as needed and desired on an individual basis.
- 9.4 Beginning in January, 2004, on a monthly basis, Plaintiffs' Counsel shall be provided with space at LHH to conduct private meetings with LHH residents. LHH staff shall assist in posting notices of upcoming meetings and transporting residents to the meetings, as needed.

10.0 INDIVIDUAL NOTICE AND APPEALS

10.1 **Notice to Class Members:** A proposed notice to the Class is attached to Swain Declaration as Exhibit 3. Should the Court rule that notice to the class is not required, the parties nonetheless agree that notice to the class will be issued as follows:

- 10.1(a) By January 2, 2004, Plaintiffs' counsel will submit to Defendant San Francisco a draft of a consumer-friendly notice to class members to include at least the following information:
 - i. A description of the settlement, including a description of the terms of settlement of the PASRR claims against the State;
 - ii. Class member rights under the settlement agreement, including notice and appeal rights;

- iii. Brief descriptions of home and community based services available in San Francisco;
 - iv. An explanation of the screening, assessment and service/discharge planning process;
 - v. How to request advocacy assistance; and
 - vi. Contact information to find out more about the settlement, to request an assessment, and to inquire about rights under the settlement.
- 10.1(b) Defendant San Francisco will provide any comments and/or proposed changes to Plaintiffs' counsel, in writing, within 14 days of receipt for consideration by Plaintiffs as appropriate. Plaintiffs will provide San Francisco with a final notice by February 2, 2004.
- 10.1(c) By April 1, 2004, Defendant San Francisco will translate the notice into Spanish and Chinese writing and alternative formats (e.g. audio cassette) and provide the translated notice to Plaintiffs' counsel upon completion. Plaintiffs' counsel will proofread and provide comments to San Francisco within 14 days. Defendant San Francisco will distribute the notice to all class members at LHH. San Francisco will also post a copy of the notice at LHH in the Administrative Office and on each floor of the LHH Main Building and Clarendon Hall through March 15, 2005, and at SFGH. For at risk class members, not identified at the time of the initial notice, a copy of the notice will be provided within three (3) days of being identified as a class member. Defendant San Francisco will maintain a list of individuals who received notification in accordance with this section for the through March 15, 2005.

10.2 Appeal, Notice of Appeal Rights and Referral to Advocacy Assistance:

- 10.2(a) Class Members have the right to appeal, to the extent currently available under law, through the Medi-Cal hearing process set forth in 22 CCR section 51014.
- 10.2(b) Defendant San Francisco will maintain an up-to-date list of advocacy resources, including Protection and Advocacy, Inc. and ILRCSF available to class members.
- 10.2(c) Class Members will be given information regarding their right to appeal pursuant to section 10.2(a) and advocacy resources from which they may receive assistance, as specified in 10.2(b) above, both verbally and in writing: (1) at the time of each assessment or reassessment, including initial development and/or modification of the individual service/discharge plan; and, (2) on a quarterly basis in conjunction with 10.3 below.

- 10.3 **Written notification of status of referrals:** On a quarterly basis, the TCM Program and LHH medical social work staff will provide written notice to each class member residing at LHH for whom they are primarily responsible as to the status of his/her referrals, and waitlists, housing and community based services.

11.0 DATA COLLECTION AND REPORTING

- 11.1 **Data Collection.** By March 29, 2004, Defendant San Francisco will develop a data collection system to track outcomes for all class members who are provided with screening, assessment, service/discharge planning and/or case management. Information available shall include:

- a. Numbers of class members screened for eligibility for the TCM Program, the number found ineligible and the reasons for ineligibility;
- b. Consumer profile information and demographics, including language preferences, source of income and onset of disability;
- c. Current address and any previous addresses since being entered into the database;
- d. Availability of community housing at time of assessment;
- e. Length of stay at LHH;
- f. Availability of family/friends supportive of discharge;
- g. Location and dates of completion of assessments and reassessments;
- h. Preferences of class members (including living arrangement and types of services);
- i. Results of assessment, and service/discharge planning (including types of community supports and services appropriate to individual need including frequency);
- j. Barriers to discharge and/or placement in a home or community setting;
- k. Dates of referral for all community based services, programs, and supports;
- l. Dates for referral for home and community based waiver services;
- m. Dates for referral for housing and specific housing programs;
- n. Services actually provided and dates;
- o. Waitlist information, including when placed on waitlist and current status;

- p. Significant events, such as death, readmission to hospital or nursing facility, decline in health, homelessness, and Adult Protective Services or police intervention;
- q. Number of residents at LHH at the time of reporting;
- r. Number of transfers or admissions to LHH and projected length of stay;
- s. Number of discharges from LHH to the community and location of discharge;
- t. Number of discharges from SFGH to the community and location of discharge;
- u. Length of time members remain in the community; and
- v. Number of class members who oppose community placement.

11.2 Reporting

11.2(a) **Monthly Reporting:** During the period *prior to* resolution of San Francisco's Motion for Compliance, San Francisco shall provide to Plaintiffs' counsel by the 10th of each month, a written report on activities undertaken with respect to each section of this Settlement Agreement during the previous month, which shall include detailed progress of the establishment of the TCM Program, and updated information on implementation of the screening, assessment, and service/discharge planning processes, and other components of the Agreement.

11.2(b) **Reporting After Screening, Assessments, and Service/Discharge Planning Begins:** Once screening, assessments, and service/discharge planning begins, San Francisco will provide to counsel for Plaintiffs

- i. aggregate data as specified in section 11.1 of this Settlement Agreement; and
- ii. a random sample of 15 percent of the screens, assessments, (including PASRR II evaluations if used in lieu of the TCM assessment) and service/discharge plans, completed for each month by the TCM Program, but no less than a total of 15 assessments and service/discharge plans. These assessments and service/discharge plans shall include a sample from both at risk class members and those residing at LHH.
- iii. If the complete data set forth in subpart 11.1 above is not available by the 10th of the month, San Francisco will provide Plaintiffs with a copy of each and every screen, assessment and individual

service/discharge plan completed by the TCM Program during the preceding month.

- iv. As soon as available, but no more than 14 days after completion of each of the items set forth below, San Francisco will provide to Plaintiffs' counsel the information specified as follows:
 - a. Screening, Assessment, and Service/Discharge Planning instrument changes or updates, as specified in section 4.2;
 - b. Protocols and procedures for screening, assessment, and service/discharge planning for class members, as set forth in sections; 4.5 – 4.7.
 - c. Training curriculum and materials and trainer information, as set forth in sections 5.0-5.4;
 - d. Information regarding efforts to inform and provide transition services to class members, as set forth in section 6.8;
 - e. Membership, agendas, and minutes of the CAC, as set forth in section 8.1;
 - f. Consumer survey results and names of consumer volunteers, as set forth in section 8.2(b).

F:\DOCS\LHH\SETTLEMENT\CCSF Settlement Agrmnt REVISED Exhibit A - FINAL - 12-15-03.doc
Updated 12/15/2003 12:46 PM