Riverside County
Office on Aging

A Snapshot of Care Management in Riverside County

Prepared by:
Care Management Team
(a Subcommittee of the
No Wrong Door Team)

May, 2003

(Funding for this report was provided through a grant from Community Partnerships for Older Adults, a national program of the Robert Wood Johnson Foundation, and the Older Americans Act.)

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Introduction of the Problem

Gaps in Care Management Programs in Riverside County

In an effort to integrate long-term care services into a seamless continuum of care, presentations from various local care management programs were hosted to examine key components to be considered in planning and implementing the Coordinated Care Network. The presentations assisted the No Wrong Door Team and the Integration Feasibility Task Force in examining the various definitions, functions, and settings that described the care management services, programs, and systems; common roles and tasks of each program's care managers and social workers; and principles, values, and goals of the care management program or service. The Integration Feasibility Task Force developed a care management features grid to examine the commonalities and differences of the various care management programs and services in the County. Review of the current care management models in Riverside County revealed care management is a central piece in the integration and collaboration of services available as well as illustrating the complexity of attributes to be addressed in developing an ideal care management model.

Challenge

Our goal is to seek ways to reduce frustration, improve accessibility, integrate services and service providers, improve consumer driven care plans, assure services are sensitive to ethnic and cultural differences and improve technology to better serve consumers in extreme rural areas.

Introduction of the Problem, Continued

Challenge
(Continued)

To meet these challenges the No Wrong Door Team must explore opportunities to coordinate care management services and programs, provide a cooperative environment for medical and social-based social workers and care managers, seek methods to coordinate funding streams to provide a holistic delivery system while reducing duplication, investigate means to capture additional and alternative funding streams to achieve the shared vision and goals.

Objective of the Task Force

Directive

The objective of the Integration Feasibility Task Force was to address the complex, fragmented, duplicative, and uncoordinated long-term case management systems that currently exist in Riverside County. This objective was a direct result from the findings in the Community Assessment 2000 which documented that the elderly and disabled populations rely heavily on care management services, fall-through-the-cracks between medical and community based supportive care services when case management services are not appropriately in place, and wish to maintain independent in a homelike environment with assistance as requested and directed by the individual, as appropriate.

Presenters

Service Provider	Presenter
Medi-Cal Multipurpose Senior Service Provider (MSSP)	Don Britt
Older Americans Act Title IIIB Care Management	Renee Dar-Khan
Older Californians Act Linkages Program	Evelyn Rounds
In-Home Supportive Services (IHSS)	Karen Spencer
Adult Protective Services	Rae Bell
Medi-Cal Targeted Care Management	Kathy Karhu
Department of Mental Health Care –Older Adults Services	Barbara Mitchel
Medical Care Management	Katie Greene
Community Access Center	Paul Van Doran
Inland Regional Center	Marvin Franklin
Skilled Nursing Facility-Legacy Health Care	Chris Miller
Medical Social Worker	Karen DePriest

Analysis of Care Management Programs in Riverside County (based on presentations)

Access to Care Management

There exist a broad range of care management programs or services offered to the aged, blind, and disabled in Riverside County. Care management programs presented to the Integration Feasibility Task Force addressed medical health, mental health, home and community based health services, and assistance with physical disabilities. Provided services ranged from those who assist persons at risk of abuse or neglect, have mental illness, are in frail health, and live with disabilities to those who are diagnosed with retardation, epilepsy, cerebral palsy, or autism.

Care management services can be accessed through numerous avenues such as admission into the hospital or emergency room, a central intake 24 hour Hot Line, self-referral by client or care taker to any agency, or HelpLink. Services provided are based on a plethora of eligibility factors determined by complex funding streams with restrictions for each program or entity. Although major eligibility factors common were age, income, and degree of disability or frailty of the individual.

Unlike the social-based social worker/care manager terminology, on which titles are interchangeable due to similar roles and responsibilities, the principle role of a care manager in a medical setting, such as a hospital, is focused on the financial management of care. The medical care manager determines eligibility and payment for medical services needed through entities such as Medi-Cal, Health

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Access to Care Management (Continued)

Maintenance Organization (HMO), or other medical insurance. The care manager will assist the client to navigate all avenues of funding including secondary insurances and co payments.

The principle role of a social worker in a medical setting is focused on the clients, their families, and caregivers to ensure that each is provided information to reduce anxiety and frustration while soliciting individual needs, a secondary role for the social worker is to assist the medical staff to transition the client from unit to unit within the medical facility.

It is not until the client meets with the discharge planner that the process to coordinate care outside the hospital setting is discussed and planned. The discharge planner coordinates information from the physician, nursing staff, care manager, social worker, client and families to develop a realistic and individualized plan to meet the post hospital needs of the client.

The principle role of the social worker in the home and community based services field, such as Multipurpose Senior Services Program (MSSP), is to act as an advocate and liaison on behalf of the client and work collaboratively with medical institutions and other community based programs in order to execute, coordinate, or manage care, depending on the needs and assets of the individual.

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Program Eligibility

Eligibility for care management services is program specific. For instance, those individuals, ages 65 and over, who are currently receiving Medi-Cal and are in need of assistance with some activities of daily living (ADL's) will qualify for the Medi-Cal MSSP program. The same individual will also qualify for services under Older Americans Act Title IIIB Care Management program, Linkage Program, and services from the In Home Supportive Services (IHSS) program. However, between the ages of 60 and 65, the Older Americans Act Title IIIB Case Management is the only option unless the person is disabled. With the diagnosis of disability, retardation, epilepsy, cerebral palsy, or autism, services to keep individuals in their home and out of institutions may begin as early as birth, and are coordinated through local regional centers or independent living centers.

Program	Age	Income	Other
Multipurpose Senior Services Program (MSSP)	65 and over	Currently receiving Medi-Cal- (with no share of cost)	Certifiable for SNF or ICF level of care
Older Americans Act Title IIIB Case Management	60 & over and disabled	No income requirement	
Older Californians Act Linkages	Disabled adults 18 & older		Frail elderly & disabled adult at risk for premature institutionalization
In-Home Supportive Services-**	Over 65 or disabled persons, all ages (share of cost for excess income)	Meet SSI eligibility	
**IHSS-PCSP(Personal Care Services Program)-Disabled persons who are MediCal eligible			

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Program Eligibility (Continued)

Program	Age	Income	Other
Adult Protective Services	Disabled 18 to 64 & 65 and older		At risk of abuse or neglect
Medi-Cal Targeted Care Management	18 & older	Title XIX	Frail health at risk for premature institutionalization
Dept. of Mental Health Older Adult Services	60 and over		Mental illness diagnosis
Medical Case Management	All admitted patients		
Community Access Center	All ages	No income requirement	Clients with disability
Inland Regional Center	All ages		Diagnosed retardation, epilepsy, cerebral palsy, or autism

Assessment

Entry into a care management program or service begins with a nurse or social worker that performs an initial assessment of an individual and their care network. Assessments may include health, psychological, psychosocial, or physical, or a combination there of. A psychosocial assessment may include client description, significant history, living arrangements, environmental safety, cognitive/psychological functioning, physical functioning, and

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Assessment (Continued)

caregiver/family support. The psychosocial assessment will include current activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Health assessments will include medical history, review of systems, vital signs/diagnosis, medical care, medications, nutrition, and health habits. The psychological assessment is conducted in the home and is performed to primarily detect a mental illness. The psychological assessment will include an evaluation of the services already in place and structure assistance to strengthen resources the client can use including making psychiatrist and/or medical appointments.

Reassessment

Reassessments for home and community based services are generally conducted by a social worker or public health nurse on an average of every twelve months or when there is a significant change in the client's condition. Generally speaking, frequencies of reassessments are based on the requirements of the program(s) or services(s) an individual may be assigned. For example, although a majority of care management programs and services reassess annually, the Adult Protective Services performs a reassessment every 90 days until a case is closed. Adult Protective Services may make frequent home visits (e.g., one per month) depending on the seriousness and risk factors present for the client.

While formal reassessments are typically performed annually, contact does continue between the client and the care manager in the interim.

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Reassessment (Continued)

In the Medi-Cal (MSSP) and Older California's Act Linkages Program monthly contacts by phone and quarterly visits are performed.

Community Access Center maintains contact with monthly phone calls conducted by a coordinator or volunteers.

Program	Initial Assessment	Re-Assessment
Multipurpose Senior Services Program	Psychosocial or Health within 2 weeks-alternate discipline in 2 weeks*	Annually
Older Americans Act Title IIIB	Within 2 Weeks	Annually
Older Californians Act Linkages Program	Upon Enrollment	Annually
In-Home Supportive Services	Within 30 Days	Every 11 Months
Adult Protective Services	Within 10 Days	Every 3 Months
Medi-Cal Targeted Case Management	As Needed	Every 6 Months
Department Mental Health-Older Adults Services	Upon Enrollment	Annually
Medical Case Management/ Medical Social Worker	Completed Daily	Daily
Community Access Center	Upon Enrollment	Monthly
Inland Regional Center	Upon Enrollment	Annually
Skilled Nursing Facility**	Within 7 Days	Quarterly
Medical Social Worker	Upon Admission	Weekly

*Both disciplines can be completed in combination upon enrollment.
**As Presented by Legacy Health Care.

Care Management Operations

The uniqueness of each service and program is reflective in the day-to-day operations of each entity. In the Multipurpose Senior Services Program clients are assigned to a public health nurse or social worker

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Care Management Operations (Continued)

as a Primary Care Manager. Clients are contacted monthly by telephone and visited in their home quarterly. Under the Older Americans Act Title IIIB Care Management program, the social worker performs an assessment and develops a short term service plan with the client. Should a client require long-term care management, referrals are made to other care management programs. Adult Protective Services social workers investigate reports received from a 24-hour Hotline. With the victim's consent, a full psychosocial assessment is completed to determine the victim's needs and the risk factors for abuse and/or neglect, and short-term care management services are provided to assure the victim's safety. If the victim is not able to consent, Adult Protective Services may forward a referral to the Office of the Public Guardian. The Medi-Cal Targeted Care Management provides linkages and referrals to service providers, similar to the Older Californians Act Linkages Program. Mental health care management programs and services provide assessment, stabilization, and treatment for those clients diagnosed with a mental illness or condition. A licensed social worker, medical doctor, or psychiatrist furnishes integrated recovery-oriented care for a client. Evaluation of the current home setting is completed by the licensed social worker, medical doctor or psychiatrist and a plan of structured assistance strengthening existing services and seeking additional resources to keep the patient safe at the least restrictive environment.

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Care Management Operations (Continued)

The local independent living center provides coordinators to perform an assessment of the individual and the individual's environment. With direction from the client, the coordinator identifies physical and psychological needs, and from these needs establishes goals and objectives for each need in order to achieve self-sufficiency. These coordinators are not licensed or accredited, but are highly trained individuals.

Care Management Ratios

The depth of care management received by the individual is guided by the ratio of the number of clients to each care manager. Each social worker in the In Home Supportive Services (IHSS) will serve up to three hundred individuals where the social worker in Medi-Cal MSSP will provide services for up to forty individuals. The chart below provides a quick overview of the care manager to client ratio per program:

Program	Ratio (Client to Manager)
Multipurpose Senior Services Program	40 to 1
Adult Protective Services	20 to 1*
In Home Supportive Services	400 to 1
Older Americans Act, Title IIIB	25.1
Linkages	50 to 1
Independent Living Center	60 to 1
Department Mental Health-OAS	50 to 1
Medical Care Manager	14 to 1
Medical Social Worker	28 to 1

*Social Worker also carries 30 IHSS cases

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Client Tracking & Follow-up

Each program has defined the method and number of follow-up contacts for each individual. The ability to track and provide detailed and quality follow through by the care manager to the individual is greatly dependent on the number of cases (ratio) the social worker or care manager is handling. It is inherent with each program; the frequency of contact with the individual is relational to the number of services needed by the individual. Therefore, it is reasonable to see the follow-up with the client in In Home Supportive Services (IHSS) will be seen initially and not again for eleven months whereas the client in the Multipurpose Senior Services Program (MSSP) are contacted monthly by telephone, visited quarterly in their homes, and level of care recertification performed every six months alternated by nurse and social worker. Adult Protective Services conducts a face-to-face visit every thirty days or more often, depending on the seriousness and risk factors present for the consumer. Coordinators within the Community Access Center contact their clients monthly by phone to follow-up and document advances or psychological changes in physical health or services provided.

The medical care manager, medical social worker, and the discharge planner do not provide any follow-up with the patient after discharge unless the patient requests or the provider is unable to provide services. Follow-up conducted by the Care Manager within the Older Adult Section of the Department of Mental Health is dependent upon the evaluation and services that are required by the individual.

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Client Tracking &Follow-up (Continued)

Similarly, the Medi-Cal Targeted Care Management conducts client follow-up and tracking as needed, and directly dependent on the individual referral.

Improvements

Each presenter was queried about possible improvements to the care management system. The answers, while varied, centered upon greater collaboration and reduction of the client/manager ratio.

The Medi-Cal Multipurpose Senior Services Program and Older Californians Act Linkages Program stated it is imperative to reduce the staff to client ratio, enhance funding for the Linkages Program and increase the number of slots for the Multipurpose Senior Service Program, while dropping the age limit to allow younger adults to benefit from the program.

The Older Americans Act Title IIIB Care Management suggested increasing collaboration between agencies and increasing funding to increase the ability to purchase and expand services.

The In Home Supportive Services (IHSS) requested an increase in staff and greater collaboration between agencies.

Adult Protective Services indicated the need to share client data and shared resource data to promote better cooperation between key

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Improvements (Continued)

agencies and the development of a virtual Multiple Disciplinary Team (MDT) that could contribute greatly in assisting agencies in coordinating emergency services for high risk elders.

The representatives from the Department of Mental Health cited six specific improvements: 1) a mobile access team, 2) expanded programs, 3) increased staffing, 4) realistic transportation services, 5) decreased waiting periods for medical/psychiatric appointments, and 6) greater availability of community resources such as housing.

The coordinator from the Community Access Center Program stated changes must focus on reducing duplication and increasing coordination among fragmented, age-based systems.

The Skilled Nursing Facility representative from Legacy Health Care identified two vital improvements: 1) improve the quality and quantity of board and care facilities for low-income residents, and 2) develop a system to provide more timely placement, such as establishing a priority list.

The Care Manager from the Riverside County Regional Medical Center shared six realistic enhancements: 1) improve timely communication between the physician and the care manager especially in the area of discharge orders from the physician,

Analysis of Care Management Programs in Riverside County (based on presentations), Continued

Improvements (Continued)

2) increase patient training, education, and materials to enable the client to administer self care at home, 3) increase staffing, 4) utilize computerized documentation, 5) outreach into the community, and 6) maintain a care manager in the emergency room.

The Social Worker from the Riverside County Regional Medical Center offered five areas for potential betterment: 1) smoother transition and more choices to develop a continuity of care; 2) greater communication with staff, 3) increase discharge coordination, 4) expand the time between when the discharge planner receives a notice of discharge from the physician and the date and time of the actual client discharge from the hospital, and 5) increase staff support and programs for Spanish speaking patients.

Major Findings/Gaps

Strengths

Riverside County has strength in its broad ranges of services and many points of entry available to the aged, blind, and disabled. The challenge to the individual is the navigation through the complex system of requirements and eligibility. Social workers and discharge planners who currently provide the service of advocate and guide through the fragmented care system are overburdened with trying to provide service plans for too high a number of clients and the demand to move patients out of acute facilities quickly. Additionally, the knowledge of home and community based services system is a new, and expanding, pathway that contains many obstacles to meet the total need of the patient with the funding requirements of Medi-Cal.

Weaknesses

Although Riverside County prides itself on having stellar, innovative care management programs and services, a number of weaknesses emerged from the presentations, as discussed at the No Wrong Door Team and the Integrated Feasibility Task Force:

- Insufficient opportunities for individuals, families, and care managers to provide input into how, when, and where services are delivered.
- Minimal emergency-oriented care management services or programs exist in Riverside County.
- The current care management system has visible gaps and lacks supporting a true care continuum for the individual, family, and caregiver.
- Lack of consensus on the process, even though the end result is agreed upon.

Major Findings/Gaps, Continued

Weaknesses (Continued)

- Medical personnel, including discharge planners, lack knowledge of the current home and community based service system that results in inappropriate placement of individuals into institutional care facilities.
- Complex regulations and silo client tracking have resulted in the customer, family, or caregiver having to complete volumes of paperwork to obtain vital services.
- Qualified staffing has been a challenge to recruit due to the current demand nationally for care managers, social workers, and public health nurses, resulting in current case loads reaching the hundreds per staff member.
- Current funding does not match the need for care management services creating an unrealistic expectation to serve without adequate resources and personnel.
- Cultural, social, and spiritual complexities need to be integrated into the current delivery system of care management services and programs.

Recommendations

Recommendations for improvement to bring the existing delivery system to a coordinated network of medical, social, and home and community based services will need to address issues ranging from education to legislative changes at the state level. The following are a few of the areas the No Wrong Door Team have noted:

- Develop a centralized information and assistance database, accessible through the web or a toll free number,

Major Findings/Gaps, Continued

Recommendations (Continued)

incorporating real time information on home and community based services and service providers.

- Develop a comprehensive and standardized assessment encompassing functional needs and scope of services to remain safely in the home; ideally would incorporate assessments of IHSS and MSSP.
- Develop a centralized, electronic client record containing information such as medical history, assessments, care plan(s), providers, services, etc., that is accessible to all medical and support services with client control to accessibility.
- Give Care management the capacity to authorize *service specific* services rather than *program specific* services when developing a care plan.
- Allow long term care consumers the ability to design their own service plans within a set budget, funding to follow the client, not programs.
- Identify and remove incentives leading to cost shifting resulting in propensity toward institutionalization.
- Increase use of technology in both medical and in-home care; i.e. telemedicine, automatic pill dispensing, voice activated reminders, personal smart cards, and smart homes.
- Provide incentives for physicians and nurses to become certified as to palliative care and pain management options and opportunities.

Major Findings/Gaps, Continued

Recommendations
(Continued)

- Deliver and coordinate health education for long term care through prevention, choice of services, and training.
- Develop a user-friendly tool for consumers to evaluate and compare long-term care services and to navigate through the long term care system.
- Provide caregiver education and instruction directed to family members including information on state and federal family leave acts and identify and assist caregivers in accessing services prior to burnout

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