THE ROLE OF ADULT SERVICES IN A CHANGING ENVIRONMENT:

AN OPPORTUNITY FOR LEADERSHIP

WORKSHOP OVERVIEW

- **Background and Development of Pathways Model**
- **Alameda County's Implementation Preparation Strategies and Challenges**
- **Riverside County's Implementation Preparation Strategies and Challenges**
  - *Enhanced Case Management "ECM" Model*
- **Opportunity for Leadership**

COORDINATED CARE PATHWAYS FOR AGING AND OLDER ADULTS

PROJECT DESCRIPTION

Developed in collaboration with:

CFPIC
Child & Family Policy Institute of California

CalSWEC
California Social Work Education Center

Alameda County
Social Services Agency

RDA

PROJECT BACKGROUND AND INITIAL FOCUS

May 2013

- The Child & Family Policy Institute of California (CFPIC), California Social Work Education Center (CalSWEC), and the Alameda County Social Services Agency (SSA) partnered with Resource Development Associates (RDA)
  - to develop a model for best practices in coordinating care for aging and older adults

The California Duals Demonstration project (or "Cal MediConnect Program")

- aims to create a more seamless continuum of care and supports for older adults that are covered by both Medi-Cal and Medicare.

PROJECT OVERVIEW

The model "Coordinated Care Pathways for Aging and Older Adults" (or Pathways Model) is

- based on the promising practices in past coordinated care efforts for aging and older adults ***and***
- on the use of social workers as the key drivers in successful treatment

The model describes:

- The optimal use of social workers in a team-based care model to provide the highest quality of care for older adults along a continuum of physical and psychosocial needs

Goal:

- If implemented, this model will result in better outcomes in the form of decreased hospitalizations and residential facility long-term care readmissions

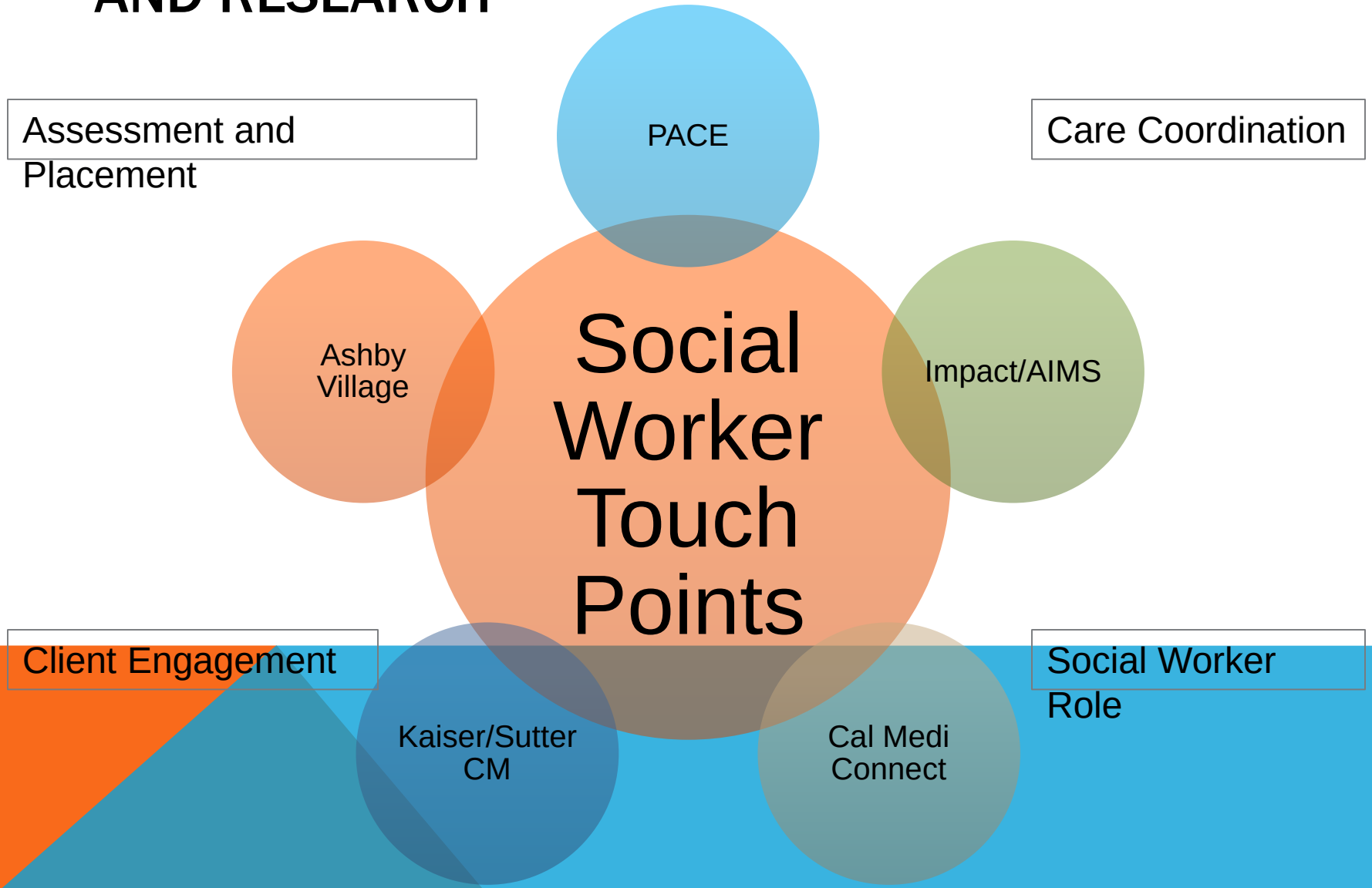
SUMMARY OF PROJECT PROCESS

- A review of best and promising practices in health care services for aging and older adults was conducted. Describes a range of care models– Key strengths from each of these models provide the foundation for the Pathways Model.

- Interviews with county health plans were conducted to better understand approach to care coordination for this particular population.

- Built from the perspective of reducing the total cost of care by creating a seamless continuum of services for clients/members along a spectrum of physical and psychosocial needs.

PATHWAYS: BASED ON PROMISING PRACTICES AND RESEARCH



Coordinated Care Pathways Model for Aging & Older Adults

Participant Entry

Duals Demonstration Pilot
Participant identified by qualifying managed health plans and automatically enrolled (Medi-Medi).

Other Participant Entry Paths:
- Phone-in application
- Mail-in application
- In-person application
- Warm hand-off from LTC or Acute Care facility
- APS referral
- Third party inquiry

Enters directly through county IHSS system

Participant Pre-Assessment

1. Health plan obtains and **analyzes data from county and CA CMS** to determine need and type of health assessment for participant.
2. Participant requests health assessment.
3. Health assessment requested by health plan based on other qualifying events.

Health Assessment

Purpose:
The health assessment determines a participant's:
- Level of frailty/risk
- Medical acuity for presenting health conditions
- Persistence of presenting health conditions

Who administers the health assessment?

Pre-Determined Medical Need	Pre-Determined Psychosocial Need	Unknown Health Need
• PHN/RN	• LCSW	• RN and/or SW

Health Assessment Data

Health Plan Care Team Lead Matrix

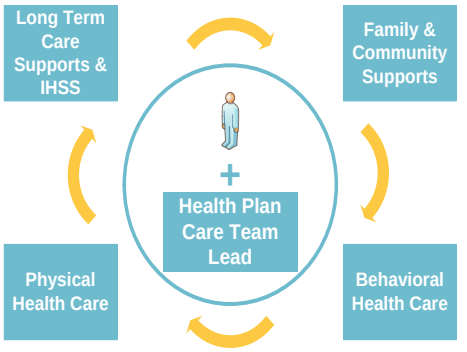
Based on the frailty, medical acuity, and persistence of presenting health conditions, health plans may assign participants to any one of the following professionals as the participant's Care Team Lead*:

	Chronic	Episodic	Maintenance
Acute/Medical Care	NP/RN	NP/RN	RN/MedSW
Residential Care Facility for the Elderly	NP/RN	RN/MedSW	MedSW
Adult Residential Facility	RN/MedSW	MedSW	SW
Community Based/Home	SW	SW	Health Navigator

*Regardless of the designated Care Team Lead, incorporating social workers into the care team is essential for connecting participants to services outlined in the care plan.

Participant Care Plan

Network of Care Across Care Settings



Reassessment

Reassessment occurs:
- Every 12 – 18 months
- When health conditions change
- Hospitalization occurs

List of Acronyms

LTC = Long Term Care
Medi-Medi = Medi-Cal and Medicare Eligible
NP = Nurse Practitioner
PHN = Public Health Nurse
RN = Registered Nurse
MedSW = Social Worker with additional training or certification emphasis in medical care
SW = Social Worker
LCSW = Licensed Clinical Social Worker

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Alameda County Social Services Agency

November 1, 2013
Prepared by *Resource Development Associates*

POTENTIAL NEXT STEPS FOR IMPLEMENTATION

Include MSW role in Acute Medical and Residential Care Chronic and Episodic phases

Identify in-service and pre-service training content and social worker competencies

Develop training and field practicum models to support implementation

ALAMEDA COUNTY'S EXPERIENCE

- **Duals Demonstration/ Coordinated Care Initiative**
- **Culture Shift**
  - Correcting deficiencies
  - Eligibility vs. casework
- **Budget Expansion**
  - Developing staffing rationa
  - Reducing caseloads
  - Enhancing Services

CalDuals

ALAMEDA COUNTY'S EXPERIENCE *CONT'D*

Care Coordination Teams

- Children
- Transitions
- Behavioral Health

Training

- IHSS Induction

Partnerships

Collapse of Coordinated Care Initiative

Next steps

RIVERSIDE COUNTY'S "TWIST": ENHANCED CASE MANAGEMENT (ECM)

- **What is ECM?**

  ECM is a response to varying case complexities and urgencie acknowledging that different cases have different needs, and will involve more time, resources and support.

  ✓A holistic view of the client, requiring a comprehensive client assessment to accurately classify clients based on need.

  ✓A system that works with the managed care environment.

  ✓A coordinated approach between APS, IHSS and Public Authority.

ECM GUIDING PRINCIPLES

- ***No Wrong Door***
- ***All Clients Assessed for Strengths and Ne***
- ***Individualized Supportive Service***

- ***Enhanced Outcomes***
- ***Community Based Care and Services***
- ***Better Care through Healthy Caregivers***

ECM Core Practices

Standard IHSS Practices	ECM Practices
Compliance Driven	Outcome Driven
Determine IHSS Eligibility	Determine Eligibility for IHSS and other Community Resources
Time-per-Task Assessment	Global Assessment
Incident Focused	Focused on Prevention
Focused on the IHSS Client	Focused on the IHSS Client, Provider, Family System and Social Network
Annual Home Visit	Contact as Needed (in person or by phone)
Focused on Medical Condition	Focused on Holistic Situation
IHSS Social Worker is main Interventionist (siloed approach)	Joint or MDT Approach to Case Management
Authorize IHSS Hours	Creation of Service Plan and Follow-up on Implementation of Services
Focused on Maintaining the Client in the Home	Focus on Overall Wellness – “Enhancing” all aspects of client’s life

WHY USE ECM FOR IHSS?

To strengthen the Adult Services System of Care and enhance the quality of life for both clients and their caregivers with IHSS as:

- a core **prevention** strategy for promoting safety, well-being, and independence;

as well as

- an **intervention** strategy to reduce reoccurrence of elder abuse and neglect.

ECM IN ACTION: A CASE EXAMPLE

- Ms. Smith came to our attention as a result of a systematic outreach effort by the Pubic Authority (PA).
- The PA staff discovered Ms. Smith needed immediate medical attention and contacted 911 as well as the IHSS and APS Social Worker.
- Although the hospital discharge plan strongly recommended that Ms. Smith be placed in a skilled nursing facility, she refused further institutional care and insisted on returning back home.
- ECM was applied to Ms. Smith's case in order to help ensure that Ms. Smith received care she needed so that she could remain safe at home.

ECM GUIDING PRINCIPLES IN ACTION

- ***No Wrong Door***
- ***All Clients Assessed for Strengths and Needs***
- ***Individualized Supportive Services***
- ***Community Based Care and Services***
- ***Better Care through Healthy Caregivers***
- ***Enhanced Outcomes***

ECM IMPLEMENTATION PHASES

I. Exploration & Getting Started

II. Communication & Workforce Readine

III. Initial Implementation: ECM Service A

IV. Full Implementation, Troubleshooting, & Evaluation

V. Program Sustainability

Phase I | Phase II | Phase III | Phase IV | Phase V

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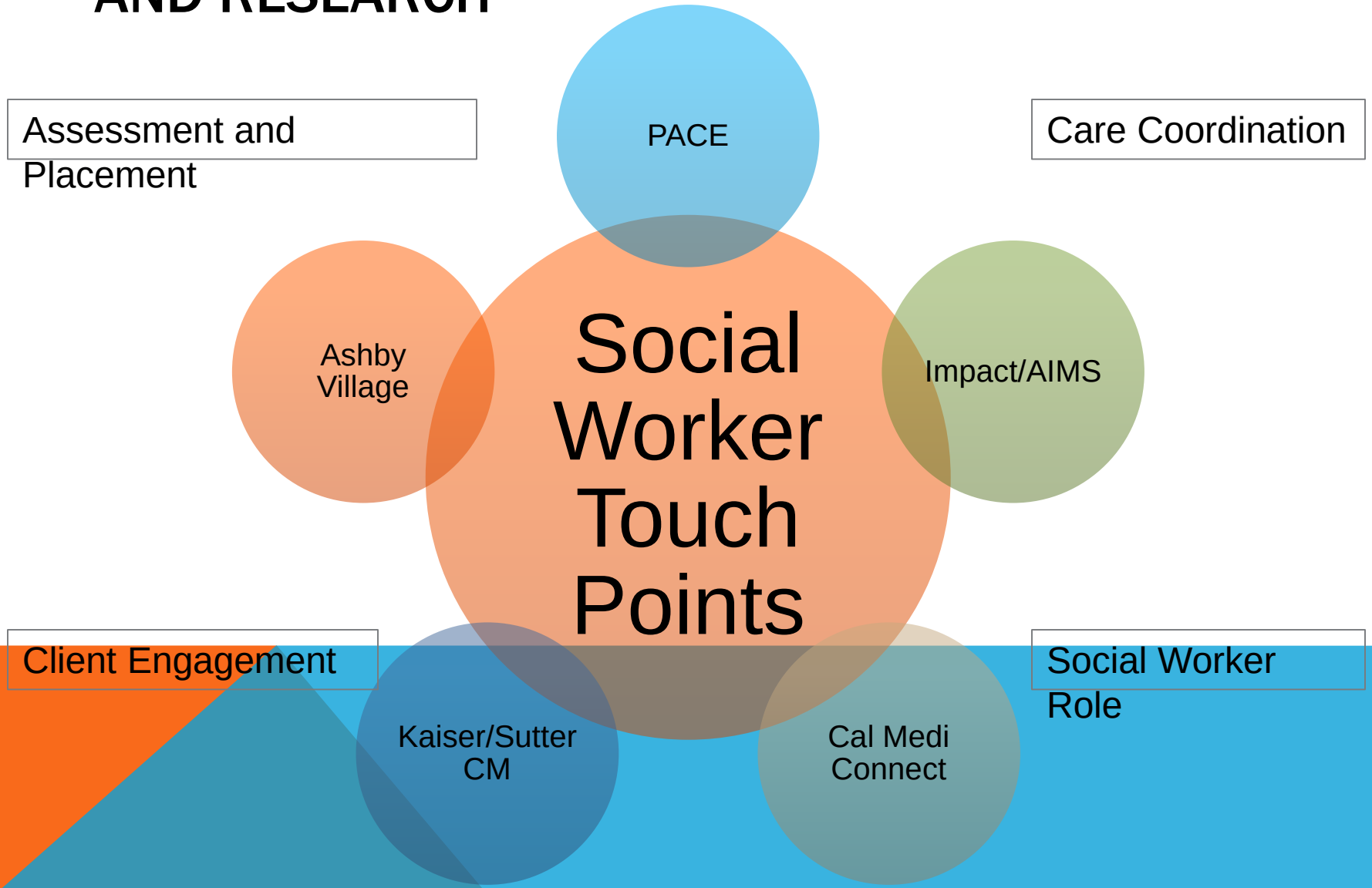

DISCUSSION

AN OPPORTUNITY FOR LEADERSHIP