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
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.
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

Promising Practices
Research Findings

- 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.

County Health Plan Key Findings

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

Coordinated Care Pathways for Aging and Older Adults (Pathways Model)

- 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

Assessment and Placement

Social Worker Touch Points

PACE

Impact/AIMS

Care Coordination

Ashby Village

Client Engagement

Kaiser/Sutter CM

Cal Medi Connect

Social Worker Role
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.

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

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

**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

**Health Plan Care Team Lead Matrix**

<table>
<thead>
<tr>
<th>Health Care Setting</th>
<th>Chronic</th>
<th>Episodic</th>
<th>Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute/Medical Care</td>
<td>NP/RN</td>
<td>NP/RN</td>
<td>RN/MedSW</td>
</tr>
<tr>
<td>Residential Care Facility for the Elderly</td>
<td>NP/RN</td>
<td>RN/MedSW</td>
<td>MedSW</td>
</tr>
<tr>
<td>Adult Residential Facility</td>
<td>RN/MedSW</td>
<td>MedSW</td>
<td>SW</td>
</tr>
<tr>
<td>Community Based/Home</td>
<td>SW</td>
<td>SW</td>
<td>Health Navigator</td>
</tr>
</tbody>
</table>

*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.

**Network of Care Across Care Settings**
- Long Term Care Supports & IHSS
- Physical Health Care
- Behavioral Health Care
- Family & Community Supports
- Health Plan Care Team Lead

**In collaboration with:**
- Child and Family Policy Institute of California
- California Social Work Education Center
- Alameda County Social Services Agency
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 rational
  - Reducing caseloads
  - Enhancing Services
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 urgencies, 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 Needs
- Individualized Supportive Services
- Enhanced Outcomes
- Community Based Care and Services
- Better Care through Healthy Caregivers
<table>
<thead>
<tr>
<th>Standard IHSS Practices</th>
<th>ECM Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance Driven</td>
<td>Outcome Driven</td>
</tr>
<tr>
<td>Determine IHSS Eligibility</td>
<td>Determine Eligibility for IHSS and other Community Resources</td>
</tr>
<tr>
<td>Time-per-Task Assessment</td>
<td>Global Assessment</td>
</tr>
<tr>
<td>Incident Focused</td>
<td>Focused on Prevention</td>
</tr>
<tr>
<td>Focused on the IHSS Client</td>
<td>Focused on the IHSS Client, Provider, Family System and Social Network</td>
</tr>
<tr>
<td>Annual Home Visit</td>
<td>Contact as Needed (in person or by phone)</td>
</tr>
<tr>
<td>Focused on Medical Condition</td>
<td>Focused on Holistic Situation</td>
</tr>
<tr>
<td>IHSS Social Worker is main Interventionist</td>
<td>Joint or MDT Approach to Case Management</td>
</tr>
<tr>
<td>Authorize IHSS Hours</td>
<td>Creation of Service Plan and Follow-up on Implementation of Services</td>
</tr>
<tr>
<td>Focused on Maintaining the Client in the Home</td>
<td>Focus on Overall Wellness – “Enhancing” all aspects of client’s life</td>
</tr>
</tbody>
</table>
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 Public 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 Readiness
III. Initial Implementation: ECM Service Array
IV. Full Implementation, Troubleshooting, & Evaluation
V. Program Sustainability
PATHWAYS: BASED ON PROMISING PRACTICES AND RESEARCH

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DISCUSSION
AN OPPORTUNITY FOR LEADERSHIP