

Riverside County CA  
Dept. of Public Social Services  
Adult Services Division

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**How the Coordinated Care  
Initiative Inspired Opportunities  
to Improve Adult Protective  
Services...**

***Enhanced Care Management***



# *Workshop Overview*

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- ❖ Leading Organizational Change: From Model to Practice
- ❖ Background and Development of Enhanced Care Management (ECM) Model
- ❖ Application of the ECM Model: Case Example
- ❖ Riverside County's Implementation Lessons Learned
- ❖ Opportunities for Other Jurisdictions ?

# *A Quick Context*

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*Riverside County's caseload growth is higher compared to other similar-sized counties in California:*

- ❖ **28,000 IHSS clients** disabled and seniors, suffering from multiple debilitating health conditions and requiring daily living assistance to safely remain at home and prevent institutional placement
- ❖ **15,000 APS clients**, victims of neglect, physical abuse, sexual abuse, financial abuse, or emotional abuse
- ❖ **23,000 non/relative caregivers** providing IHSS assistance
- ❖ **68 APS and 160 IHSS social workers**



# *“Change Accelerators”*

## *in a FAST Changing Environment*

(John P. Cotter, 2012)

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- ❖ Create a sense of **URGENCY** around a single **BIG OPPORTUNITY**.
- ❖ Build and maintain a **GUIDING COALITION**.
- ❖ Formulate strategic **VISION** and develop a **CHANGE INITIATIVE** designed to capitalize on the big opportunity.
- ❖ Communicate the vision and the strategy to create **BUY-IN** and attract a growing **VOLUNTEER ARMY** (of change leaders).



# *“Change Accelerators”... in a FAST Changing Environment*

(John P. Cotter, 2012)

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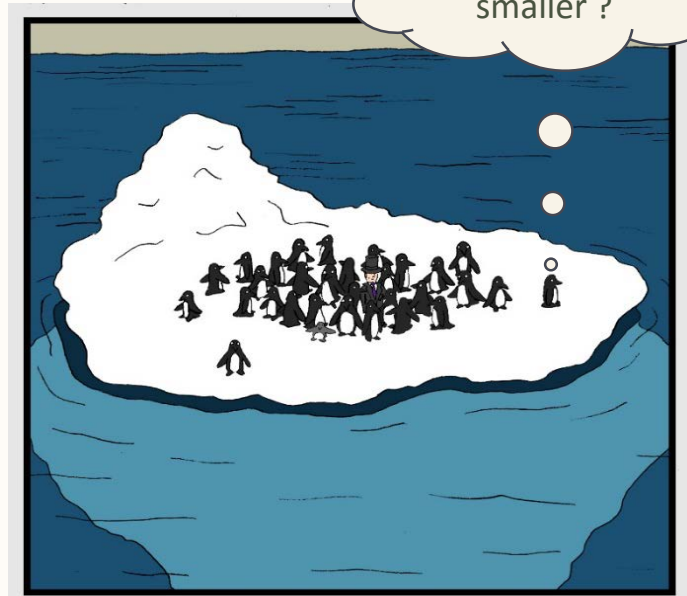
- ❖ Accelerate movement toward the vision and opportunity by ensuring the network **REMOVES BARRIERS**.
- ❖ Celebrate visible, significant **SHORT TERM WINS**.
- ❖ **“NEVER LET UP!”** Keep learning from the experience and don’t declare victory too soon.
- ❖ **INSTITUTIONALIZE** strategic changes in the culture.

# Urgent Demands for Change

*Different constituent groups will have different urgencies. What is urgent for executive staff, caseworkers, community partners, and clients?*

- ❖ Need to address high caseloads
- ❖ Need to collaborate and prepare social workers for working in an inter-professional environment
- ❖ Need to improve quality APS and IHSS casework practices
- ❖ Need to improve client outcomes

Is it me or is our iceberg getting smaller?



*What is the worst thing that could happen?*





# *Big Opportunity* Coordinated Care Initiative

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*California's Coordinated Care Initiative (CCI), implemented in April 2014 promotes integrated delivery of medical, behavioral, and long-term care Medicaid services, and also provides a road map to integrate Medicare and Medicaid for people on both programs, called "dual eligible beneficiaries."*

- ❖ **Managed Care Health Plans: Enrollment**
- ❖ **Health Risk Assessment Tool**
- ❖ **Coordinated Care Team Approach**
- ❖ **Data Sharing**
- ❖ **"Maintenance of Efforts" Funding Structure**



# *Building a Guiding Coalition*

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# *Strategic Vision*

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## *Enhanced quality of life for clients and their caregivers*

*We will strengthen the Adult Services System of Care by focusing on IHSS as...*

- ❖ a core prevention strategy for promoting safety, well-being, and independence; and
- ❖ an intervention strategy to avoid or reduce reoccurrence of elder abuse and neglect.

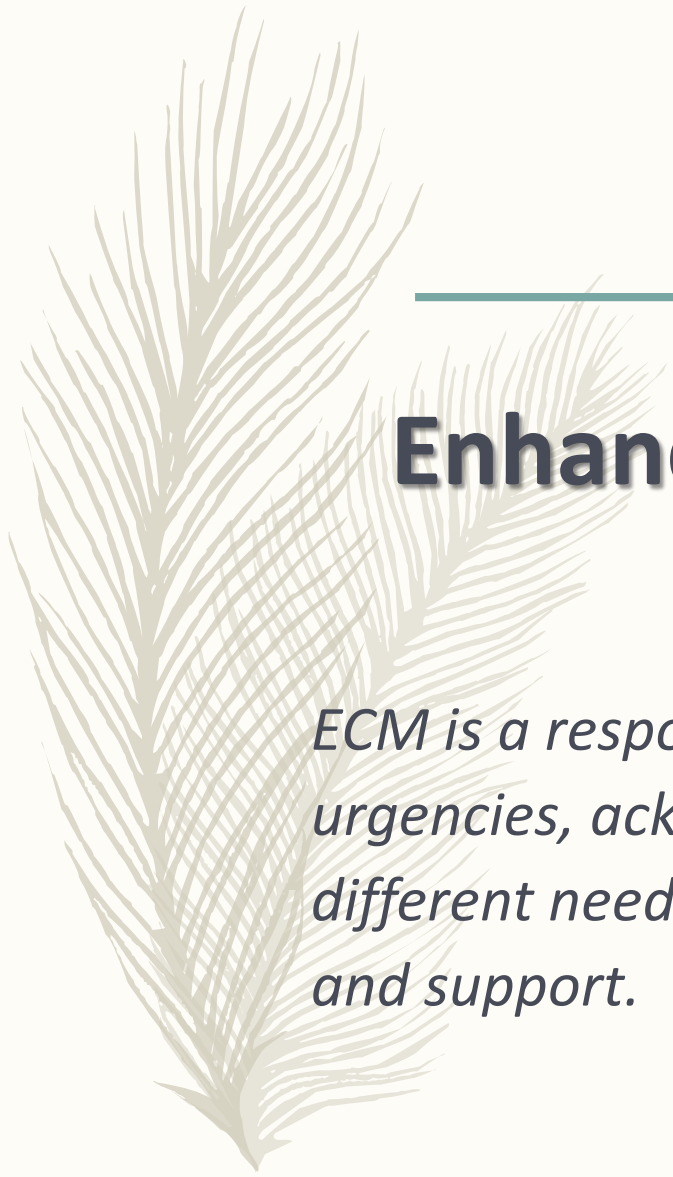


# *Creating a Change Initiative*

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## **Enhanced Care Management “ECM”**

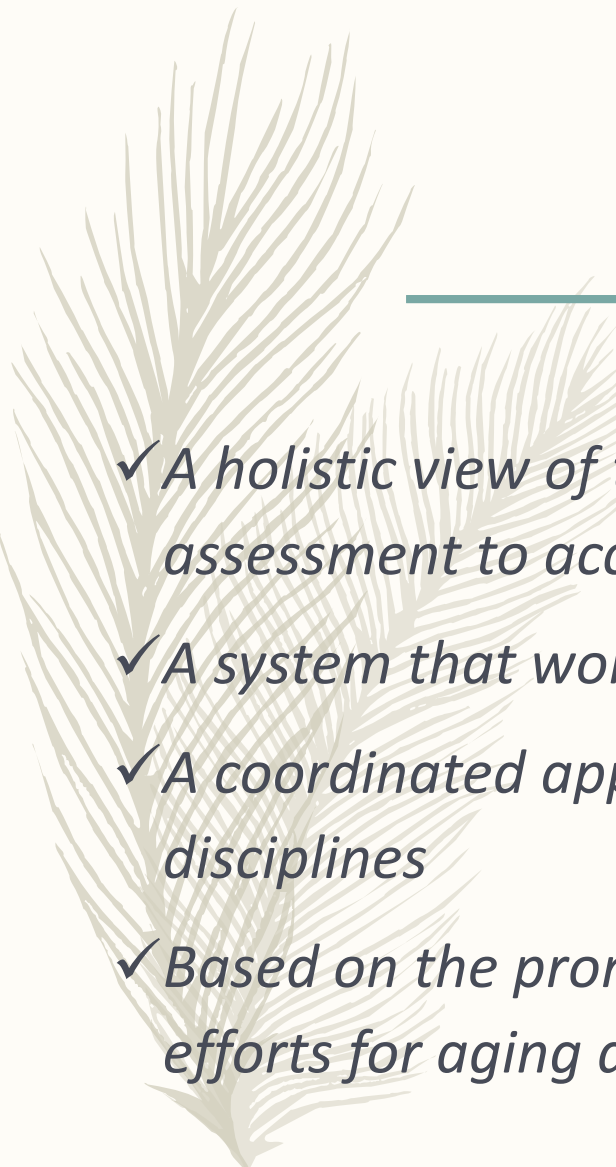
*ECM is a response to varying case complexities and urgencies, acknowledging that different cases have different needs, and will involve more time, resources and support.*





# *“ECM” is...*

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- ✓ *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 multiple disciplines*
  - ✓ *Based on the promising practices in past coordinated care efforts for aging and older adults*

# *ECM Guiding Principles*

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- 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



# From Vision to Outcomes

*If implemented, ECM will result in  
Better Client Outcomes:*

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- ❖ Decreased client risk
- ❖ Decreased re-occurrence in adult abuse and neglect
- ❖ Increased linkages to services
- ❖ Increased supportive services to caregivers





# Building a “*Growing Army*”

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- ❖ Do we want “Buy-In” or “Ownership”?
- ❖ How do we create and grow our ECM “army”?
- ❖ Who are the ECM champions inside and outside of our agency?
- ❖ How can we create a committed army who can share their passion with others?





# *Removing Barriers*

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- ❖ Shifting Agency Culture & Practice
- ❖ Reducing Caseload
- ❖ Improving Staff Recruitment and Retention
- ❖ Training Staff
- ❖ Re-Prioritizing Work
- ❖ Showing Results



# *Shift in Culture and Practice in IHSS*

Standard IHSS Practices	ECM Practices
Eligibility Work	Comprehensive social work
Determine IHSS Eligibility	Determine Eligibility for IHSS <u>and</u> 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 (siload 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

# *Shift in Culture and Practice in APS Consultation*

## APS Consultation Practices

Supervisor

Public Health Nurse

CARE Multidisciplinary Team

## ECM Consultation Practices

Supervisor

Public Health Nurse (non-geriatric)

Geriatric Home Visiting Nurse

Geriatrician, M.D.

Home Visiting Neuropsychologist

CARE Multidisciplinary Team

Health Plans

Public Authority

# Riverside County Coordinated System of Care (CSOC)

## Coordinated Care Overview

Client Target Population

Medical Assessment

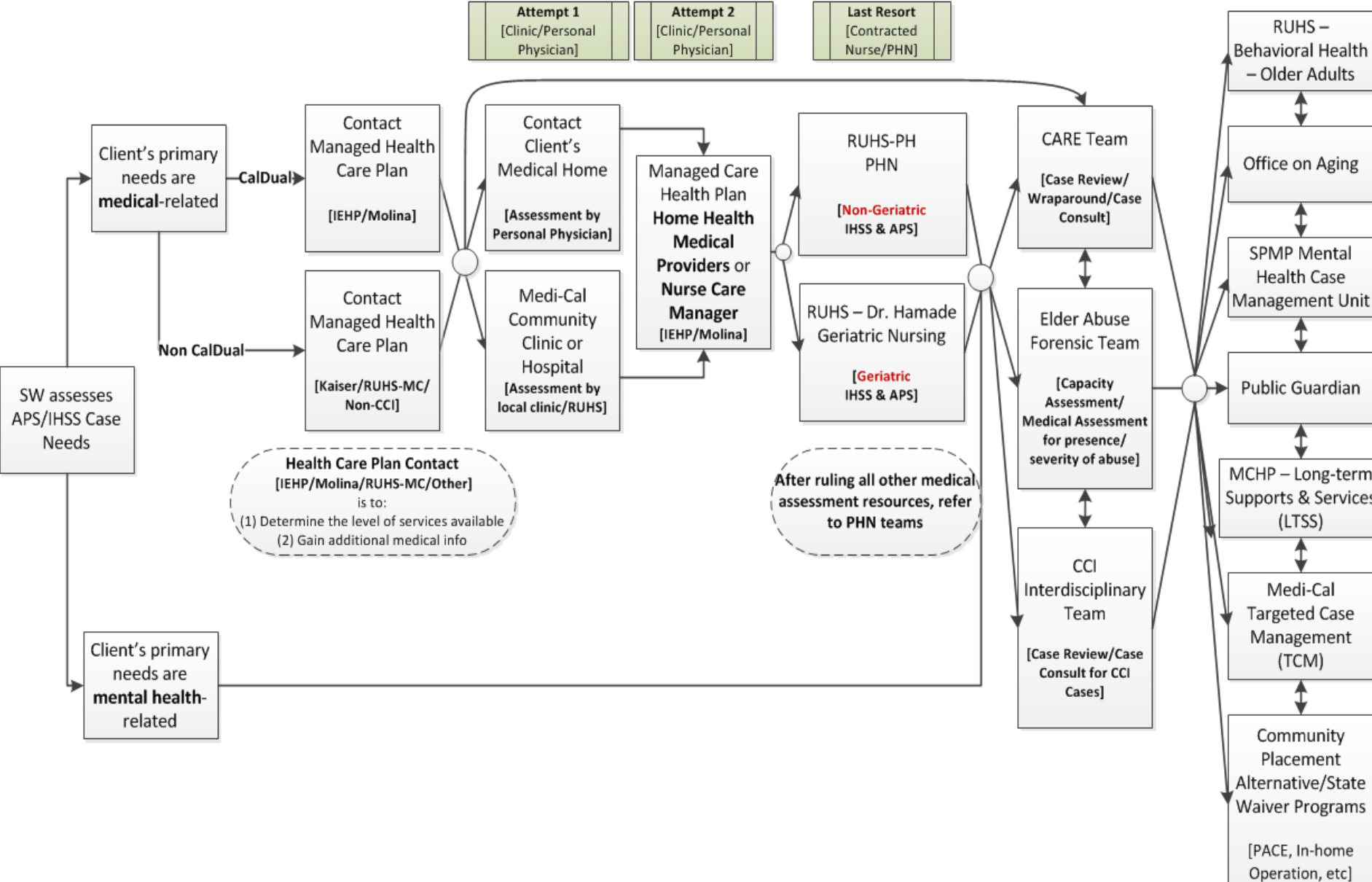
Multidisciplinary Team

Linkage

**Attempt 1**  
[Clinic/Personal Physician]

**Attempt 2**  
[Clinic/Personal Physician]

**Last Resort**  
[Contracted Nurse/PHN]



# *Creating Strategies*

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# *Creating Strategies*

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- ❖ Workforce Development, Readiness (Recruitment & Retention)
- ❖ Communication & Outreach—Internal & External
- ❖ Training & Coaching
- ❖ Stakeholder Partnership Development
- ❖ Data Sharing
- ❖ Interagency Case Collaboration
- ❖ Expansion of Service Array



# *ECM In Action: A Case Example*

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*Before*





## *After*

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*The social workers (PA, IHSS, APS) conducted coordinated care team meeting with Ms. S and health care providers and effectively advocated for the following:*

- Home health nutritionist, physical therapist and primary doctor to provide medical care to Ms. S at home*
- Hospital bed and wheel chair*
- Multiple IHSS providers monitored by the Public Authority to provide 70 hours of caregiving per week.*



# *Short Term Wins*

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- ❖ “ECM” is a part of the organization’s vocabulary
- ❖ Multiple examples of ECM principles in practice
- ❖ Improved outcomes for several clients
- ❖ Improved customer service feedback

***NEVER LET UP... WE ARE NOT DONE YET!***

# *Never Let Up:* **Lessons Learned so Far**

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## *We have more work to do...*

- ❖ Continue to hire and train additional social workers to result in a lower case load
- ❖ Implement centralized high risk medical and behavioral health case management model
- ❖ Determine performance measures and collect data
- ❖ Continue to monitor and address barriers/ make changes needed
- ❖ **Institutionalize!**



**An Opportunity for  
your Jurisdiction?  
Questions and Discussion**

