# Developing Specifications for the Competitive Bidding of Intake, Assessment & Case Management Services

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*An Overview of Common & Best Practices
for Intake, Assessment, and Case Management Services for the
Butler County Elderly Services Program*

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# BACKGROUND

The Council on Aging of Southwestern Ohio (COA) contracted with the Scripps Gerontology Center, Miami University to develop recommendations to be used in developing competitive bidding specifications for intake, assessment and case management services provided in the Butler County Elderly Services Program. While intake, assessment and referral services are a subset of case management, two separate sets of recommendations were requested because Butler County ESP has a single, separate entity performing intake and assessment, countywide, and four separate entities performing general case management.

The first part of this report covers intake and assessment (commonly referred to as I & A), followed by a section on case management. This order mirrors current operating procedure as the I&A function precedes any referral to and follow-up by case managers. The report provides recommendations about bid specifications and the procurement process and includes a series of recommendations on program monitoring and quality improvement components of Butler County ESP that can be affected through the bidding process.

Intake, assessment and referral (I & A or I & R) usually comprise the initial steps in accessing home and community-based services (HCBS). I & A generally refers to the process of talking with clients and/or their families via telephone, assessing their physical, mental and social situation, determining their specific needs, providing information, and referring these clients to services available to them.

Case management is defined as "a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes" (Case Management Society of America). It is becoming increasingly important and prevalent as a service option for older Americans.

The need for expanded intake, assessment and case management services – integral to home and community-based services for older persons – will surely grow in the years to come. In the past two decades, the United States has seen a dramatic growth in the home and community-based services for older people who experience a disability (CBO, 2006). This has been particularly true of Butler County, one of 64 Ohio counties expanding home and community services through senior service property tax levies (Ohio Dept. of Aging, 2007), as well as through federal and state allocations.

The growth in home and community services is likely to continue at an even faster pace as the older population in this country is expected to nearly double over the next 25 years – from roughly 37 million in 2005 to 70 million in 2030 (U.S. Bureau of the Census, 2008). These rising national figures – and predicted increasing disability rates – are reflected in Butler County, where today roughly 12,500 older persons have a moderate or severe disability and 19,000 older persons in the county are projected to be moderately (13,000) or severely (6,000) disabled by the year 2020 (Mehdizadeh, Roman, Wellin, Ritchey, & Kunkel, 2004). Whether these disabled older persons need care in an institution or assistance with services in their own homes, intake, assessment and referral will likely be the entry point to the services they need.

# METHODS

This study relies on information collected in a variety of ways. First, an extensive literature review was conducted to gather materials regarding evidence-based and best practices in intake, assessment and referral. Thorough internet searches were made to gather existing requests for proposals, service specifications, standards and/or other documentation from states, area agencies on aging (AAAs), and other organizations providing intake, assessment and referral services in a variety of settings. Key informant interviews were held with representatives from several of these organizations, many of them from out of state. Summaries of previous interviews with case managers and I & A personnel from a recent study of Butler County's ESP were also examined.

To examine current practices in Butler County ESP, several activities were undertaken. First, observations of telephone intake and in-person assessments were made at the four case management organizations in Butler County: Hamilton Senior Citizens, Inc. (SCI); Middletown Senior Citizens; Oxford Senior Citizens; and LifeSpan, Inc. In-person interviews were also conducted with case manager supervisors at three of the sites.

Three of the four agency directors were also interviewed. In addition, existing data on time use, client impairment, and caseload were all examined. This variety of methods and approaches offers a well-rounded look at case management and intake practices from a local to national perspective.

# COMPETITIVE BIDDING OF CASE MANAGEMENT

Prior to our presentation of the intake and case management material, we provide a review of the literature examining programs that have used competitive bidding practices for intake and case management services as well as observations regarding other programs' examples of bid specifications for case management and I & A services. It is important to note that our ability to examine examples of other case management bid specifications was limited since we could locate only a few organizations using the competitive bid process for case management and I & A services. Most HCBS organizations view case management as an administrative function with clear separation from the provision of services.

A Canadian study based on a competitively-bid home care program provided an extensive description of the bid process used. The report calls for improved consistency in procurement procedures and states that competitive bidding "should be based on well-managed procurement where competition is for quality first and price second." The emphasis should be on achieving "value for the money." The report cautions that the ability to determine value can be hindered by a lack of consistent information about clients; limited research upon which to base benchmarks and best practices; inconsistent contracting and employment practices across case management agencies and service providers; disincentives for innovation, quality and access; and frequent transitions in contracts, leading to instability in practice and process.

Key recommendations from the report having relevance for Butler County ESP include:

- Allow for longer-term contracts for those providers who demonstrate excellence in service to clients.

- Provide more choice, more flexibility, and better information for clients and their families about care options and rights.

- Establish ways to standardize and collect better information for the use of service providers and to better measure progress, improvement and success.

Their first recommendation aims to foster the continuity of care that is a critical component of quality service delivery. The bonds between service providers and clients and case managers and their clients are key components of successful delivery of home-based services. The shifts that occur when different agencies are awarded contracts can undermine this continuity. This has particular importance for case management where oversight of services and knowledge about complex client needs and preferences may be developed over a long-standing relationship. Awarding long contracts is an attempt to ameliorate one of the possible negative outcomes of the competitive bidding process.

On a less positive note, another report from Canada notes that competitive bidding may not always be the most cost-effective strategy. On the contracting side, the effort of developing bid specifications and managing the bid process is costly. The expense of responding to the request for bids and managing evaluation bids on the contractor side become factored in as a cost of providing service. In areas with limited competition among providers costs increased under the competitive model (Randall, 2007).

From this report and from a variety of case management requests for proposals obtained, we observed three strategies used by other aging service organizations across the country in preparing their proposals.

1. Stipulate and outline exactly what the specifications are in each service category itemized. For example, an organization might require bidding case management agencies to require three years experience for all case management supervisors.

2. Ask providers to forward information about their current and planned practices for managing the program. The contracting organization then determines which organizations provide the best solutions. For example, the bid specifications might say "Describe your case manager training program."

3. (Mixed strategy) - Ask providers to meet specific requirements in some areas while providing latitude for the agencies to describe a range of structures, processes and outcomes in other areas. For example, the RFP might state: "Messages left during evenings and on weekends must be returned the next business day. We also require some, if not complete, weekend and night coverage. Please describe your regular operating days and hours and strategies for additional weekend and evening coverage."

In our review of bids and standards, none of these strategies were more prevalent than the others. However, the mixed strategy does allow the contracting organization to express its expectations in areas viewed as critical to performance, while letting bidding organizations vary in areas where standardization is perceived as less important.

## SECTION 1.  INTAKE AND ASSESSMENT

A review of the literature and other research indicates variation in the type of assessment activities conducted by I & A Centers. The U. S. Administration on Aging (AoA) and Center for Medicaid & Medicare Services (CMS) requirements for Aging and Disability Resource Centers (ADRCs) include extensive linkages with a range of services (Gillespie, 2005). In other settings, the intake function is strictly an eligibility screening process for services offered by that program.

Much has been written about intake and assessment services but information on best practices and related bidding specifications is harder to come by. The intake and assessment process has standards covering a wide spectrum of organizational aspects – from personnel to auditing. Given that Aging and Disability Resource Centers (ADRCs) and the National Association of State Units on Aging have adopted the Alliance of Information & Referral Systems (AIRS) *Standards for Professional Information and Referral*, it is likely that many of the AIRS standards will have relevance for practice in ESP as well. For example, AIRS Standards suggest that intake specialists should make direct contact with other agencies through three-way calling, notifying the agency of the client's expected call, or scheduling an appointment for the client with the agency. This would require the contractor to have three-way calling capabilities which are within the range of most organizations.

The ADRC model also stresses local collaborations, and a nationwide 211 model for social services is growing. Currently, the Butler County 211 service is provided by the Oxford Community Counseling and Crisis Service. Linkage and collaboration with the County 211 service should be explored. The I & R literature describes the goal of

creating an intake infrastructure in which one phone call from a consumer can result in meeting his or her needs for information or services.

As previously mentioned, the I & A function involves assessing the clients' needs and determining what services they are likely to be eligible for. Generally, a prescribed set of questions comprise this screening assessment. Numerous studies have been conducted on the content of the screening instrument, and agree that the instruments to be used should be supported by empirical research and targeted to the population being screened (Fries, James, Hammer, Shugarman, & Morris, 2004). Other studies have also extensively studied the mode of the screening. While most find comparability between telephone, in-person, and mailed screening tools, there are concerns when the answers to the screening tool determine service eligibility.

Fries et al. (2004) conducted an empirical examination of Michigan's Medicaid waiver screening system, which operates similar to the PASSPORT screening system. Michigan uses the MDS Home Care tool as both a telephone pre-screening and in-person assessment. In a telephone screening protocol, followed by in-person assessments, they determined that telephone screening was only partially successful at determining functional eligibility or a specific level of client need. In general, the telephone screen identified more clients as impaired, and found clients designated as impaired even more impaired than did a follow-up in-person assessment.

On the other hand, telephone screening was a cost-effective way to screen out those who definitely did not meet medical eligibility. It was also effective as a strategy to identify those who warranted a full, in-person assessment. Fries' study also calculated the cost-effectiveness of the telephone screen compared to the in-person screen. It found that

the telephone screen ran to about $3.35 in staff costs while an in-person assessment costs from $30-$70 including travel costs.

## ELEMENTS OF INTAKE AND ASSESSMENT

The elements of intake and assessment are described here in three major areas adapted from Donabedian's now-classic discussion of the elements of quality in healthcare organizations: 1) Organizational Structure, 2) Practices and Processes, and 3) Quality and Outcome Monitoring.

### ORGANIZATIONAL STRUCTURE

**Personnel**

The National Aging I & R support center has published a list of job skills for I & R personnel. These competencies revolve around extensive knowledge of the aging network, aging services and communication and technical skills. No particular background or educational experience is mentioned. Given that ESP intake and assessment is a screening process, rather than having a true I & R function, it seems that experience with older adults and/or knowledge of aging services would be important attributes. As screening and eligibility determination functions are standardized, the telephone intake process is primarily about good communication and good customer service.

The National Association of State Units on Aging (NASUA) points out the need for sufficient numbers of personnel to meet the anticipated number of requests for information. An analysis of current call volume and staff would assist in determining the appropriate number of FTE staff. NASUA also notes the need for increasing multi-lingual capabilities of the I & R system, as younger immigrants bring their parents with

them. Although 2006 Census estimates show that Butler County led the Southwestern Ohio region in the growth of the Hispanic population, only 2.3% of the population is currently Hispanic. The multi-lingual issue could become more important in the future.

The experience and credentials of personnel are important, but so too are the hours of operation. Intake should be available outside of normal working hours, since people may call on the weekends or in the evening when they are not at work themselves. If extended hours are not available then an answering service or automated message service system becomes important. Standards for return messages left outside of normal operating hours should be developed.

CMS and AoA require that ADRCs be able to track client intake, assessment, care plans, utilization and costs (Gillespie, 2005). The I & A contractor should have the capability to link to COA and the case management contractors. The intake screening MIS system should be linked to these agency databases.

### INTAKE PRACTICE AND PROCESSES

Referrals to ESP come from a variety of community contacts including: hospitals, senior centers, case managers, family, friends, and individuals themselves. Butler County ESP provides a 1-800 number for individuals who are in need of services. The assessment department that receives these calls is located at LifeSpan.

Assessors use the assessment tool found on the Q database, a management information system that links all ESP sites together within Butler County. Assessors go through line by line, filling in information provided by the potential ESP client. This assessment tool helps the intake workers gather information on the following constructs: demographic information such as gender and date of birth, type of health insurance,

eligibility for foods stamps, personal information about any informal caregivers, medical diagnoses, ability to perform activities of daily living (ADLs) (e.g. bathing, dressing) and instrumental activities of daily living (IADLs) (e.g. shopping, housecleaning), prior hospitalizations, emergency room visits, health factors, dietary factors, presenting problems, environmental issues and nutritional risks.

One of the main tasks of intake and assessment is to determine tentative eligibility for residents who call the program. Do the individuals meet the ADL/IADL or financial requirements? Final determination of eligibility for services is determined by the case managers at the four sites across Butler County: LifeSpan, Hamilton Senior Citizens Inc, Oxford Senior Center, and Middletown Senior Citizens.

If the caller is found to be PASSPORT eligible (but not enrolled) during the assessment, the staff will contact COA. However, COA will only follow up if the individual gives verbal permission. The individual is also informed that if PASSPORT eligibility is determined, then he or she will have to enroll in that program for services. An ESP telephone assessment is completed because clients could get ESP services such as home-delivered meals (HDM), before enrolling in PASSPORT. Eligibility determination can sometimes be lengthy, so ESP can provide a bridge to those services. Information is stored in Q (ESP's data management system). In cases in which the individual is denied ESP or PASSPORT services, the information stays in Q and a denial letter is sent out. Staff will make a referral to community agencies that receive ESP funding.

If a client calls in requesting assistance with other programs or issues other than ESP, such as the home energy assistance program (HEAP), staff will provide the

necessary phone number for the client to call. If staff doesn't have an immediate answer they call the client back when they have found one. If a client wants a referral to a private service provider rather than relying on ESP the I & A worker can provide the contact information for ESP providers who also accept private-pay clients. Only those providers who are certified to provide services under ESP are in the referral database.

## QUALITY OUTCOMES MONITORING

Follow-up is an important aspect of intake and assessment according to the American Institutes of Referral Services (AIRS) standards for I & R Practice. AIRS suggests that a sample of callers be phoned back to see if they received the information they wanted, the services needed, and/or other types of assistance they were seeking. AIRS standards stress that follow-ups should also be made when the intake staffer suspects that the inquirer does not have the capacity to follow through on referrals and resolve problems. Unlike case management, where the follow-up satisfaction surveys could be an annual event, the I & R call is a one-time event that might be forgotten unless followed up immediately. Currently, postcards go out to 10% of clients who recently received assistance from the intake and assessment department. Questions address unmet needs, prompt response, professionalism, and timeliness.

## INTAKE AND ASSESSMENT RECOMMENDATIONS

1. **A general recommendation is that the process currently known as Intake & Assessment might more accurately be called screening. All activity occurs on the telephone with a primary goal of determining whether client needs and abilities are likely to qualify them for enrollment in**

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**home-based services. The actual enrollment (intake) and comprehensive assessment occurs as clients are referred to case management agencies**.

PERSONNEL RECOMMENDATIONS:

1. **Specific degrees are not necessary, but the intake organization should attempt to hire those with experience in working with older persons.**

2. **Staff should be trained to consistently administer a standardized intake /screening tool and apply clear criteria to determine whether clients appear to be eligible for ESP or PASSPORT.**

3. **Indicate a preference for organizational experience with services to older persons in bid specifications.**

4. **Offer longer contracts to organizations with good performance on annual audits and consumer-satisfaction surveys.**

DATA COLLECTION RECOMMENDATION:

1. **Use a database of services beyond those service providers who contract with ESP through better collaboration with COA of Southwestern Ohio and the Butler County 211 system.**

PRACTICE AND PROCESS RECOMMENDATIONS:

1. **Provide at least some evening and weekend hours.**

2. **Return calls to inquirers who leave messages no later than the next business day.**

3. **Consider implementing a one-stop phone system so that callers could be transferred directly to the Butler County 211 agency, PASSPORT or the COA of Southwestern Ohio I & R number.**

QUALITY AND OUTCOME MONITORING RECOMMENDATIONS:

1. **Follow-up with clients referred to ESP, PASSPORT and other agencies to determine if they received services they desired or found the answer to their service question.**

2. **Develop a plan for consumer satisfaction with the I & A service. We recommend ongoing satisfaction surveys for a random sample of clients who recently contacted the I & A organization.**

## SECTION 2.  CASE MANAGEMENT

ELEMENTS OF CASE MANAGEMENT

For the purposes of this report, case management has been organized into three basic elements that should be examined in the development and review of bid specifications.

As seen in Table 1,  those elements are: (1) **Organizational Structure**  (including finances, personnel qualifications/job descriptions and experience); (2) **Practices and Processes** (including time frames for intake and assessments, timing of actual service initiation, and service procurement); and (3) **Client/Service Outcomes and Quality Monitoring** (including client satisfaction with case management and home-care services, and quality monitoring of client eligibility and appropriateness of services).

**Table 1**. Elements of Service Specifications Developed and Reviewed for Case Management Bid Proposals

| Organizational Structure | Practice and Processes** | Client Outcomes/ Quality Monitoring |
|---|---|---|
| Personnel Requirements | Intake, Assessment And Referral | Client Satisfaction with Services |
| Financial Stability | Care/Service Planning and Procurement | Client Audits for Appropriate Services |
| Data Collection & Communication Capacity | Time to Service | Client Audits For Successful Outcomes |
| Experience | Care Management Caseloads | |

ORGANIZATIONAL STRUCTURE

**Personnel**

General case manager job qualifications include requirements specifying educational background, initial training/orientation once hired, and continuing education requirements. From our review of practices nationwide, the most common requirement for a case manager is a bachelor's degree, and the two most common degree areas are nursing and social work.

Some agencies allow for "other human service degrees." For example, some specify gerontology, as well as "human services or related field" (Rhode Island). New York City requires bachelor's level training and also includes psychology as an acceptable field for case managers. An RN with one year's related work experience is also considered to be qualified. New York City also expresses a preference for agencies to employ a master's degree-level social worker.

Difference in requirements is driven by the fact that case management has varying nuances of meaning and application in diverse fields. Social workers (often involved in aging services), for example, may approach case management differently than nurses or others in the healthcare industry. A consortium of professional organizations representing social workers has issued *Social Workers Best Practice Case Management Standards*. These standards identify a list of case management components that case mangers should, ideally, be able to oversee:

- Psychosocial Assessment & Diagnoses/Planning/Intervention
- Financial Assessment/Planning/Intervention
- Case Facilitation
- Patient and Family Counseling
- Crisis Intervention
- Quality Improvement
- Resource Brokering/Referral/Development
- Discharge Planning
- System Integration
- Outcome/Practice Evaluation
- Teamwork/Collaboration
- Patient/Family Education
- Patient/Family Advocacy

The extent to which these competencies should be specified in job descriptions and case manager performance evaluations is an area for consideration.

Some requests for proposals require submission of case manager and case management supervisor job descriptions. The list above provides a starting point for evaluating whether the case management positions in the bidding organization's job descriptions capture the full range of expected case management activities.

Other requirements for case managers, besides educational credentials, include criminal background checks. This requirement is stipulated in Ohio law for those who work with elders. Several organizations in other states require case managers to be

certified through a state-sponsored program. Some require specific training on a particular assessment tool, while others require eight hours of training that covers all aspects of case management. Some organizations require an additional four-hour minimum of continuing education per year. In the case of licensed professionals, such as RNs and social workers, maintaining licensure requirements covers their continuing education requirements. Training for these professionals is done in-house or by outside training organizations.

The range of recommended experience for supervisors in our nationwide research is two to four years. New York also recommends that supervisors have an MSW. One organization also requests information about the experience and qualifications of the organization's director. Requirements for the position were not outlined, but a full resume of the director was requested.

**Financial Stability**

One concern across most of the requests for proposals examined in this study is the stability of the bidding organizations. This is addressed most often by requiring financial statements, proof of insurance, and other evidence that an organization has a safe operating margin that will continue if awarded the contract. New York City has a complicated financial and cost calculation worksheet to assist bidders in calculating their costs. The NYC Department for the Aging also has in-person discussions with those who have the lowest cost bids in order to make sure those organizations have considered all of their costs before awarding contracts.

The city wants to ensure that an organization does not come back and try to renegotiate costs or go out of business before the contract is completed (personal

communication, 2007). NYC would like to move to a "per-client" rather than a "per-unit"

cost, but recognizes that the city and its contracting case management organizations don't

have enough of the right kind of information to reasonably estimate per-client costs.

Information about the governing boards of organizations submitting bids is

usually required. This may include lists of board members, by-laws, board training

activities, and anything else that indicates the extent to which those guiding the

organization have the experience and knowledge to be effective. Most of the standards

and bids collected in our research did not indicate any specific requirements in this area,

but reviewers valued information that described the organization's current board and

management structure as well as the type of ownership (profit or not-for-profit) and legal

structure (type of incorporation, if any).

**Data Collection**

As previously mentioned, there is a need for consistent data collection. New York

stipulates the type of computing and communication infrastructure required. Rather than

express standards in this area, most organizations recognize that the variation in

computing equipment and infrastructure is large and express only the requirements

necessary to gather client and service provider data as warranted by program

requirements.

**Experience**

The remaining item for consideration regarding organizational infrastructure is

the experience of the organization with case management and with providing services to

older adults. The optimum organization is one that has experience in both. Case

management standards (CMSA, 2002) suggest that case managers need to provide

culturally appropriate services, i.e., tailored to diverse demographic groups. One might consider age to be an important demographic variable influencing how services should be provided. Thus, it seems important for organizations that have no experience in services for older adults to explain how their current experience might be tailored to best meet the needs of older clients.

## PRACTICES AND PROCESSES

### Assessment

The initial contact and subsequent assessment of a client is seen by some as the most important step in case management. While many agencies and government programs have clearly defined procedures for assessment of clients, a lengthy literature review found little in the way of best practices in this area. A Case Management Society of America (CMSA) document, *"Standards of Practice for Case Management,"* emphasizes the importance of intake assessments being comprehensive. Most programs use a standardized assessment tool with clearly established criteria for determining eligibility for services as well as the type and quantity of services provided. The amount and type of training that case managers receive with the assessment tool varies, but is typically described in most bid specifications.

As previously mentioned, some studies found a need to allow two to three hours for these initial assessments. This likely accommodates the assessment itself, as well as travel to and from the client's home. However, previous research (McGrew & Quinn, 1997) found that telephone assessments and periodic monitoring are cost-effective. Still, others feel that for clients with more intense service needs, in-person assessments and re-assessments are essential (Scharlach, Dal Santo, & Mills-Dick, 2005). Where

environmental modifications are part of an available service package it seems logical to include an in-person assessment that also examines the client's environmental needs.

**Care/Service Planning and Procurement**

One of the issues identified in the case management literature addresses the independence of case managers in the development of the plan of care. The majority of home care programs in the United States have created a structure in which the provision of case management must be independent of service delivery. The argument for this position is that service providers doing case management would have an incentive to order the kind of services their agency provides rather than the services most needed by the client. In some instances, such as in the State of Connecticut's Home-Care program, separate case management and service delivery is required by law. In a small proportion of programs case management and service delivery are located within the same entity, and proponents of this model argue that it is more efficient and client responsive. Programs from a range of geographic locations, such as the Kentucky Statewide Home-Care Program and the New York City In-Home Service Program, use this approach. These programs, which are not typical, describe a clear separation between case managers and the service component of the agency as an important administrative structure.

**Time to Service**

After assessment and development of a care plan, the work of a case manager encompasses getting services to clients in a timely fashion and then monitoring those services and ensuring that the care plan continues to meet the client's needs. When clients or their families call in for services, they often need an answer quickly, sometimes with

an impending hospital or nursing home discharge necessitating the immediate need for care at home. One of the first standards presented in most case management specifications is the timing required to get services in place. There are three steps involving timing requirements: 1) time from the client's intake phone call to when the phone call is returned; 2) time to assessment from the intake phone call; and 3) the time services are started from the time of assessment.

There are a number of factors outside the case manager's control that influence the time from intake to assessment and from assessment to services. Often, the client or caregiver's schedule is such that an immediate assessment cannot be scheduled. It is the client's decision to delay the process. Also, clients may request a service provider not able to immediately fill the service request, rather than accepting the first provider that can meet their needs. Accordingly, assigning standards is difficult, since case management organizations may not be able to meet them through no fault of their own.

The state of Texas's Department of Aging and Disability Services, however, offers a comparison standard for timeframes from intake to face-to-face (and other types of) response to actual service provision. Texas uses a triage system of response times, with required times from consumer intake to assessment ranging from 24 hours to 2 weeks. Consumers with immediate needs are seen within 24 hours, expedited consumers are seen within 5 calendar days and routine response consumers are seen within 14 calendar days. This strategy ensures that those who need services immediately get them — the case manager is also authorized to use verbal referrals to providers as quickly as the day after the assessment visit is made rather than putting the service request in writing.

**Care Management Caseloads**

Programs across the United States have struggled with determining the optimum caseload size. On one hand, it is important that case managers have enough time to perform core activities, both at the initial stage of enrollment and for ongoing monitoring of the client's progress and condition. On the other hand, because case management is a costly intervention, a program that has too few participants assigned to each case manager will not be cost effective. The challenge lies in arriving at that optimum number.

In looking at programs in Ohio and across the nation, evidence indicates that the number of people served by case managers can vary dramatically. For example, case managers working in Ohio's PASSPORT program average 64 clients per-worker. In contrast, Butler County ESP case managers, who oversee generally less impaired persons, carry an average caseload of 141 clients. PASSPORT clients are very frail and are required to meet a nursing home level of care admission criteria while ESP clients who are less impaired qualify for services. PASSPORT participants each average three activities of daily living impairments and have an average care plan of more than $1,000 per month. In contrast, ESP clients average monthly care plan is about $350.

In order to increase our understanding of caseload size and address what an appropriate caseload size should be, we reviewed the current literature about the role and function of case managers, completed key informant interviews, and examined current Butler County ESP practices at the four current case management sites.

While a review of the literature identifies the complexities in determining caseload size, empirical research linking caseload size to client outcomes is limited. The literature does include several studies on how case managers allocate their time. Some of the professional associations, such as the National Association of Social Workers

(NASW) and the Case Management Society of America (CMSA), have attempted to identify the factors that are important in determining caseload size based on professional practice experience. For example, NASW addresses caseload size in terms of case difficulty, impact on quality, cultural competence, and availability of supervision. CMSA is currently developing an approach to calculating appropriate caseload sizes. Case manager skill level and organizational structure are among 22 structural factors, along with client complexity (55 different factors) and caregiver information, which are included in the calculation. Aspects of the care management plan or intervention and its complexity are also considered. Finally, expectations of future outcomes – such as changes in environmental barriers and improved health-related quality of life – are considered. This model is much more applicable to medical case management or disease management; but it does illustrate the complexity of the caseload size question, as well as the importance of accurate and complete client and caregiver data to guide in the determination of appropriate caseloads.

Several studies do provide important descriptions about the time required to case manage home-based services for older adults. Sagan, Hadjistavropoulos, & Bierlien (2004) found that case managers spend about 51 minutes per-client, per-month. Additional non-core case management factors, such as staff meetings, training, and other activities, fill in the remaining time on the job. The researchers used the findings to enhance current case management practice by: increasing awareness of current case management practices; estimating case managers' workload; identifying clients with too much or too little case management; and training new workers.

Hekkers (2003) recommends that case managers spend approximately 120 hours of client-centered activity per month (about 75% of a full-time employee's job). Client-centered activities include time either in-person or on the phone with patients, families and service providers. An appropriate caseload for medical case management can range from 30-50 cases, suggesting much more time spent per-client than the 51 minutes found by Sagan et al. Generally, however, medical case management seems more time intensive than managing home-based service long-term care services, such as ESP.

Finally, Massie (1996) found that case managers devoted 57% of their time to core case management functions. These activities included telephone contact (20%), travel (14%), record keeping (12%), and in-home visits (12%). Supervisors spent 20% of their time on supervisory functions, such as direct supervising and advising. Zero to 6% of their time was spent on core case management functions. Most of their time was spent on "other" project and non-project related functions. Case managers' caseloads ranged from 1 to 40, and supervisor caseloads ranged from zero to 20. Full-time equivalent pilot-project case managers had a weighted average caseload of 30. In similar programs, where the population was less impaired, caseloads were larger, ranging from 45 to 70. In the studies above, a complex set of factors – including the required functions of the case manager, the operation of the case management organization, the characteristics of the client and their support system as well as the quality outcomes that are expected – all influence the recommended caseload size.

The most important question when judging appropriate caseload is, "What is the role of the case manager?" The answer depends, somewhat, on the type of case management provided. Two types of case management models are described in the

literature: service management and intensive case management. With service management it is the case managers' job to determine the services needed, link the individual to the needed services and manage those services. Intensive case management allows for more frequent visits and a more intensive relationship with the client. For instance, for a client with complex medical needs and no informal support, the case manager might accompany the person to the doctor's office.

The service management model allows for case managers to carry larger caseloads and monitor clients less frequently. A key informant in our study defined this style of case management as "task mastery."  A prescribed number of contacts are made according to a previously determined schedule. Contacts outside the schedule are usually in response to a problem or an adverse event.

An example of a program using both service management and high intensity case management is Senior Options, a senior-service levy program in Franklin County, Ohio. Currently, service management case managers carry a caseload of 120 and are responsible for follow-ups every two years. For these case managers, the vast majority of contacts with clients and providers are phone contacts. Short-term clients who expect to use services less than 30 days are likely never to meet their case managers in person.

Case managers performing intensive case management in the Options program are working with a smaller, more complex caseload (50) and have more frequent interactions with clients including in-person assistance, monthly phone calls, and regularly scheduled quarterly visits. Clients assigned to intensive case management could be assigned based on medical condition, but level of informal support is also seen as a big contributor to the

determination of high intensity case management. Additionally, mental health issues and unstable medical conditions are likely to result in intensive case management services.

As shown in the previous example, the type and amount of case management services delivered to clients will have an impact on caseload size. For instance, with more time available, case managers may be able to develop a plan of care and initiate services more quickly. Case managers with more time may be able to develop a more thorough care plan that may provide a better balance between formal and informal services. If there are too many clients, case managers may find it challenging to provide timely support when needed. Higher caseloads might create a tendency to be more reactive, responding to cases only when a crisis occurs.

## CLIENT OUTCOMES AND QUALITY MONITORING

The third area of importance in case management of home and community-based services is client outcomes and quality monitoring. Establishing standards for personnel, organizations, practice and processes are first steps in the quality effort, but assessing client outcomes is the ultimate goal of quality assessment. Quality monitoring activities – such as counting the number of services delivered as well as complaints received, along with chart audits – provide a system of checks that, at a minimum, ensures that services are being provided to eligible clients, by providers who are qualified, on a schedule and respectful of client preferences.

Case management agencies also include financial accountability as part of quality monitoring activities. These generally include practices in which case managers monitor providers through input from clients, and supervisors monitor case managers on their

timeliness, their care plan development and other practices. In addition, case management

agencies monitor contracting providers on their fiscal performance.

**Client Satisfaction**

Client satisfaction is a key goal in service provision of any type. Current standards

and specifications for the monitoring of client-satisfaction in case management often

outline the tool to be used, the method, the proportion of clients to be sampled, and other

specifics. A range of client satisfaction tools are used across the United States. The

Service Adequacy and Satisfaction Instrument (SASI) tool used by COA is considered by

national experts to be one of the better instruments now available (AHRQ 2008).

**Client Audits for Appropriate Services**

Most case management agencies require supervisors to periodically audit client

charts, as well as having the contracting agencies perform annual audits of a given

percentage (usually 10%) of client charts. The percentage and frequency of client charts

reviewed are important components of auditing strategy. Questions that could be

addressed in an audit include:  Is the care plan appropriate given the documentation of

client impairments?  Are client preferences noted?  Is information about the caregiver and

social support clearly documented?  Were timelines from intake to assessment and

service procurement adhered to?  If not, why not?

These questions essentially determine whether the assessment or reassessment,

service plan, and client information is complete. An audit plan should clearly specify

what will be examined. These performance indicators should be clearly outlined so that

each case manager can be trained to gather the same complete information and put

together similar care plans for similar clients. The goal of equality, regardless of

geography or case manager preferences, should guide quality monitoring.

**Client Audits for Successful Outcomes**

Assessing client outcomes is at the heart of monitoring activities. The Institute of

Medicine, in its 2001 report on health care quality, provided six key dimensions having

significant relevance for client outcomes in home care in general, and case management

specifically (Folkemer & Coleman, 2006). Ideally, according to the IOM, case managed

long-term care services should be:

> 1) Safe — Patients should never be harmed by interventions intended to help them.
>
> 2) Effective — Services should be provided based on scientific evidence to all eligible persons who can benefit, while refraining from providing care to those unlikely to benefit. In the realm of case management of home care services, there are few, if any, evidence-based practices suggesting the importance of rigorous client data collection and intervention measurement.
>
> 3) Patient-centered — Care and services should be responsive to individual preferences, needs, and values. Information is essential for consumers to make appropriate decisions about their own care.
>
> 4) Timely — Reduction of waits and potentially harmful delays should be an over-arching goal. In terms of case management, this should mean striving not only to meet but to exceed programmatic time limits.
>
> 5) Efficient — Avoiding waste, including equipment, services and energy.
>
> 6) Equitable — providing care that doesn't vary because of geographic differences, provider differences, or consumer characteristics. (Institute of Medicine, 2001)

# CURRENT BUTLER COUNTY ELDERLY SERVICES PROGRAM PRACTICES

## BUTLER COUNTY ESP PRACTICE — PERSONNEL REQUIREMENTS

### Credentials

Similar to case management agencies across the country, Butler County ESP case managers are required to have a bachelor's degree in nursing or social work. Although the majority of case managers at the four Butler County sites were licensed social workers or registered nurses, each of the four agencies has hired individuals without these credentials. In order to do so, COA of Southwestern Ohio has exempted these job candidates from the requirement. Interviews with case management supervisors clearly identified experience working in human services as one of the main reasons individuals in "related fields" were hired. Per Ohio law, ESP case managers have criminal background checks performed before starting their positions.

### Training

All four agencies provide initial training in-house for new case managers. First, case managers are required to thoroughly review the policy and procedure manual. The next step typically involves "shadowing." New case managers accompany and observe more experienced case managers (including the CM supervisor) conducting face-to-face new client assessments, yearly visits, and intervention phone calls. Eventually, the experienced case managers observe new case managers do face-to-face and yearly visits and complete intervention phone calls. Case management supervisors at all sites accompany new case managers on client visits and review all of their new charts for the first 30 to 90 days. New case managers are trained on how to enter data into the

Management Information System, which is called "Q." The case managers are also required to visit the Intake and Assessment department at LifeSpan and the Council on Aging of Southwestern Ohio.

Ongoing training also occurs. Most case managers with licenses are given the opportunity to attend trainings to gather their required continuing education units (CEUs). As a whole, Butler County ESP case managers spend 1% of their time attending trainings, although this percentage differs between sites (Time Study, 2007).

**CM Supervisors**

Butler County ESP Case Manager Supervisors began as case managers in their agencies. After gaining experience, they were moved into their current positions. Each is a licensed social worker. All case management supervisors at the Butler County ESP sites carry a reduced caseload, however, the number of clients managed depends on staff turnover. For instance, one case management supervisor is carrying a higher caseload due to staffing issues.

**Data Collection**

As mentioned previously, consistent data collection is crucial to providing and monitoring case management. Butler County ESP uses a centralized management information system linked to the Council on Aging of Southwestern Ohio.

## BUTLER COUNTY ESP PRACTICE — PRACTICES AND PROCESSES

**Assessment**

ESP case managers have ten days from the client intake call to schedule and conduct an in-home face-to-face assessment. Case manager supervisors make assignments based on geographic location and case manager caseload size. For instance,

if one case manager lives in West Chester, he or she is more likely to get those cases. However, if one case manager starts receiving too many clients in one area, then that region will be shared with another case manager. Case manager supervisors felt the benefit of localizing the caseload was that case managers would "start to learn about the resources" in a particular area.

Case managers print out the information gathered by intake and assessment using the form found on Q, the management information system. All case managers observed used this print-out. Case managers did not use laptops during the face-to-face assessment to fill out the documentation. They instead use the intake and assessment form and enter the additional assessment information when they return to the office.

All case managers begin the assessment by verifying items on the intake form. Each asks about the client's current needs, physical condition, supports, income and medical expenses. Sites use this time to verify ADL/IADL impairments and make co-pay determinations through verification of financial statements given during intake, although all did not require paper verification of finances from clients. In addition to the assessment documentation, case managers at all sites work from a folder that includes brochures describing ESP services, the organization's programs, and other services available in the area, such as TRIAD, and Alzheimer's Association *Caregiver Education Support Programs*. Also, forms requiring client signatures are included. The documents are: Acknowledgement of Receipt and Notice of Privacy Practices and Client Rights and Responsibilities, Authorization of Release of Information, Financial Information Regarding Income and Medical Expenses, Client Agreements, Home Delivered Meals Disclosures, and an Environmental Assessment Checklist. Finally, the case manager

provides the client with a magnet with his/ her case manager's name and phone number on it.

Observations by Scripps research staff found ESP assessments ranging from one to two hours. Supervisors at all sites mentioned that there was no required time limit. Closely linked to the issue of timing is the type of assessment required. All agencies require face-to-face initial assessments. This allows the case manager to assess the needs of the client as well as any environmental issues that might affect the client's ability to safely receive in-home services.

When case managers complete the face-to-face assessment, they enter information into Q and determine an intensity level for the client. These intensity levels help determine the amount and type of services clients receive and the amount of case management involved. The intensity level, ranging from 1 to 4, determines how often clients are contacted and represents an attempt to standardize the intervention schedules for case management. For instance, if the assessment shows the client to be physically impaired, socially unconnected, and unwilling or unable to communicate with a case manager, then he or she could be designated as a Level 1. This would standardize a series of visits and phone calls throughout the upcoming year. Table 2 provides a description of the criteria considered when determining intensity level.

**Table 2. Intensity Level Criteria for Butler County ESP**

| LEVEL 1 | LEVEL 2 | LEVEL 3 | LEVEL 4 |
|---|---|---|---|
| Available to clients with unstable health conditions, do not have a willing or able informal support system or the ability to monitor own health status and/or service delivery to ensure health and safety | Available to clients with unstable health conditions, have adequate informal support but still need assistance with monitoring their own health status and/or service delivery to ensure their health safety | Available to clients with varying degrees of health concerns, have adequate informal support, may lack the ability or willingness to manage their own care but are able to communicate effectively with the CM or have a caregiver who would do so | Available to clients or caregivers who are willing and able to self-manage services. Clients or caregivers are able to advocate for themselves with minimal assistance in the form of education and guidance from the CM once services are approved and setup. |

Note:  Taken from Butler County ESP handbook

A review of intensity level assignments by case managers shows that a small proportion of cases are categorized as Intensity levels 1 or 2, with only 7 percent of cases in Butler County having these designations. LifeSpan case managers categorize their clients at these levels nearly 12% of the time, with SCI using this category for less than 3% of the participants.

Moving from Level 1 to Level 4, the number of standardized contacts is reduced. Level 3 is the most common intensity level with more than 9 out of 10 cases across Butler County designated as Level 3.

## BUTLER COUNTY ESP CARE/SERVICE PLANNING AND PROCUREMENT

Using intake and assessment information, the case manager, in conjunction with participants and their families, develops the plan of care. The process involves recognizing the balance between informal and formal service provision and is done within the cost constraints of the program. ESP also offers consumers an option to self-

direct. Under this approach ESP clients can receive services from a relative, friend, or neighbor, rather than a formal agency.

As touched on earlier, there is potential for conflicts of interest – or the appearance thereof – when the agency providing case management also provides the actual services clients receive, which is the case with Butler County ESP.

Our review of ESP data indicates that the service patterns do not appear to be influenced by the type of services provided by the case management agencies. Table 3 provides a listing of service use for each of the four sites. No consistent patterns emerge regarding higher or lower utilization among the case management organizations that also provide contracted services.

**Table 3. Proportion of Clients Receiving Service by Agenc**y

| Service | Oxford (%) | Senior Citizens Inc (%) | LifeSpan (%) | Middletown (%) |
|---|---|---|---|---|
| Home-delivered meals | 38* | 56* | 45 | 55* |
| Homemaker | 49 | 51 | 55* | 50* |
| EMS | 50 | 55 | 49 | 57 |
| DME (Durable Medical Equipment | 1 | 8 | 2 | 5 |
| Medical Transportation | 4 | 25* | 27 | 34* |
| Personal Care | 17 | 12 | 13* | 11 |
| Respite | 0 | 2 | 2* | 2 |
| Senior Companion Services | 0 | 6* | 8* | 4* |
| Independent Living Assistance | 3* | 13* | 10* | 3* |
| Adult Day Care | 7* | 1 | 3 | 1 |
| Consumer Direction | 7 | 5 | 4 | 3 |

*Agency provides service through ESP

**BUTLER COUNTY ESP - TIME TO SERVICE**

As previously mentioned, case managers have a window of 10 days from the time the intake department receives a call until the face-to-face assessment. Data are recorded in the Q system and used for monitoring purposes. During July 2007, the average time from Intake and Assessment to the in-person assessment in Butler County was 6.7 days, with a low of 5.9 days and a high of 7.7 days.

All case management supervisors interviewed attempted to make the time from intake to the assessment a priority. However, it was noted that time to a face-to-face interview is not always an accurate measure of good practice. For instance, the time until a new client is seen may have more to do with the client's own schedule or physical condition, and less to do with the case manager's responsiveness.

Case managers do, however, have the ability to monitor the initial receipt of services. For instance, after a case manager completes his or her face-to-face assessment, he or she goes back to the office and inputs information into the Q system for agencies to bid on services. Providers must respond within 24 hours. The Middletown Senior Citizens organization noted that case managers call clients just to let them know who will be contacting them. Then, at thirty days, they usually call to ensure that services are scheduled and have begun.

**BUTLER COUNTY ESP - CARE MANAGEMENT CASELOADS**

Observation of Butler County's ESP program and other case-managed senior-service programs, indicate the following basic practices provide guidelines for the day-to-day job of a case manager: 1) Timing of intake, assessment, and services; 2) The scope of an initial assessment and the strategies for accomplishing such; 3) The recommended

caseload for ESP case managers; and 4) The type and frequency of ongoing client monitoring.

Case managers in the Butler County ESP program average 141 clients (full-time case managers as of 9/4/2007) with a high of 160 and a low of 100. Since clients in Butler County ESP are less frail, on average, than Ohio PASSPORT program participants, have less costly service plans, and receive fewer services, it is not surprising that the caseload for case managers in ESP would be higher. The critical question is: "How much higher is appropriate?" A review of each of the four Butler County ESP sites demonstrates caseload sizes varying from a low of 100 to a high of 160 participants, on average, per full-time case manager.

**Table 4. Average Caseload Size per Full-Time Employee as of 9/24/2007**

|  | Oxford | Middletown Area Senior Citizens | LifeSpan | Senior Citizens Incorporated | Butler County |
|---|---|---|---|---|---|
| Caseload Size | 100 | 139 | 126 | 160 | 141 |

What is unclear is why there are such large differences in caseload sizes. From our literature review, factors such as client need and level of disability, and amount of time spent on cases by each case manager were stated reasons for a high or low caseload. Are there differences in client impairments, intensity levels, or activities performed across the sites that would warrant such large variation?

While there is some variation across sites on ADL/IADL and intensity measures (See Table 5), overall we do not find a relationship between client characteristics and caseload size. For example, review of the ADL measure shows no significant differences

between the three sites reporting the highest impairment levels, with LifeSpan recording

the highest ADL impairment levels and having a mid range caseload size of 126.

**Table 5. Intensity and Impairment Levels Among Butler County Case Mgt. Sites**

|  | Oxford | Middletown Area Senior Citizens | LifeSpan | Senior Citizens Incorporated | Butler County |
|---|---|---|---|---|---|
| Caseload size | 100 | 139 | 126 | 160 | 141 |
| Average ADL impairments | 3.8 | 3.43 | 3.95 | 3.73 | 3.67 |
| Average IADL impairments | 3.45 | 3.1 | 3.48 | 3.47 | 3.33 |
| Proportion Intensity Level 1 or 2 | 5.2 | 7.7 | 11.5 | 2.7 | 7.0 |

Impairment level may not be the most important indicator of appropriate caseload

size as it is only one factor that may or may not determine the amount of core case

management time required per client. Intensity level may be a better indicator of how

much time a participant may need from a case manager. For instance, an intensity level of

1 or 2 would mean more time for in-home monitoring activities and reassessments,

whereas a higher intensity such as 3 or 4 requires fewer visits and telephone contacts.

As reported earlier, there is small variation in intensity levels, with LifeSpan

having more clients in the level 1 or 2 intervention categories, however, overall, the

majority of clients (over 85%) in all sites are classified as level 3, suggesting that this

may not play a factor in the varying caseload sizes.

Another factor that may have an impact on the caseload is the amount of time

spent on core case management activities like assessment, reassessment, monitoring, and

planning. Using the time study performed in July 2007, we see that there are relatively

few differences across the four Butler County ESP agencies in relationship to caseload

size. For instance, the percentage of time spent on home visits, home visit documentation,

and time spent contacting clients and providers – either by phone, e-mail, or faxes – are not significantly different (See Table 6).

**Table 6. Proportion of Time Spent on Case Mgt. Activities Among Sites**

| Activity | LifeSpan | Middletown | Senior Citizens Inc* |
|---|---|---|---|
| Home Visit/ Documentation | 25.4 | 30.4 | 26.1 |
| Intervention Calls | 4.8 | 2.3 | 2.2 |
| Consumer and Provider Contact | 38.0 | 43.8 | 38.9 |

*Time per case manager at Oxford Senior Center included as time within Senior Citizens Inc.

The empirical data on activities of daily living (ADLs), intensity level, and time use do not explain the dramatic differences in caseloads across the different agencies. To supplement our data collection, we also talked with staff at each site. Their interviews provide additional insights into how the programs are implementing the ESP intervention.

Respondents at each of the sites were asked their opinions about caseload size and program structure. Attitudes about caseload size were closely related to the actual caseload size of the organization. For example, Hamilton County Senior Citizens Inc., the organization with the largest average caseload size, thought that their current number of cases (140 to 150) was "perfect."

> *Right now, case managers are busy, but they are not swamped … day flies by, but they are not drowning.*

The case manager supervisor at the Middletown Senior Center had similar thoughts about the agency's current caseload size, around 140.

> *It is a good ratio. Any more, they [case managers] would be stressed out. Don't get enough time to do what needs to be done. Anything more, you are just doing the bare minimum.*

On the contrary, case management supervisors at LifeSpan thought that approximately 120 should be the optimum caseload carried. Case managers at the site carried caseloads of around 126.

> *Too high of a caseload and individuals don't have time. At varying intensity levels, there is a lot going on, phones ringing, providers calling or needing to be called, contacts with consumers and families. One can't effectively case manage, and with too many one might have confusion about particular cases.*

One additional point mentioned by the case management supervisor was that the case managers didn't want to be strictly reactive:

> *"We meet the need first," instead of intervening. "I don't think we are over case managing."*

Attitudes towards the caseload sizes are consistent with the caseload average currently available in our nationwide research, although sites seem to recognize limits to how high or low they thought a case manager can go, and what an appropriate caseload is – even if it's not consistent with what they are currently carrying.

**Assessing Impact of Caseload Size**

What is even more difficult to determine is the impact of caseload size on quality. It is a commonly held belief that too many cases lead to poorer quality of service delivery, due to the impact on case manager responsiveness and professionalism, among other factors. Assessing the quality of case manager processes is easier to determine than the impact on caseload sizes on clients' attitudes towards their case managers.

The following processes can be determined by chart reviews and data reporting from the Q system. Annually, COA of Southwestern Ohio does chart documentation audits. (Oxford's case manager is reviewed along with Senior Citizens Incorporated.) Results of the chart audit show that each organization "demonstrates a working

knowledge of ESP policies and procedures." There were no significant differences

across agencies on the quality compliance rates.

## CLIENT OUTCOMES/QUALITY MONITORING

### BUTLER COUNTY ESP-CLIENT SATISFACTION

Assessing the impact on the program from the client's perspective is more

problematic. Butler County ESP organizations have been asked by COA of Southwestern

Ohio to survey consumers about quality regarding case management services. Each site

has developed a protocol to assess its consumers. However, each agency is asking

different questions and sampling different populations, making comparisons across sites

difficult.

All sites mail surveys to clients on a monthly basis. The clients included in the

sample differ across sites, however. For instance, one site chooses to assess only those

who met with their case managers for an annual reassessment during the month, while

another site opts to contact those who had a face-to-face interview or a reassessment that

month. Still another site chooses to contact closed cases.

The survey tools also differ across sites, with each assessing different areas in

more or less detail. Each survey tool addresses – among other items – demographics,

length of services, whether clients needs were met, whether clients took part in care

planning, and whether case manager responses were timely. One site has greater detail

about the initial visit and impact of services. Two of the three sites had just started the

process, so little was discussed about how to use this information, if at all, for quality

improvement. Each site has complied with the COA request by developing a protocol to

assess its consumers. However, each agency is asking different questions and sampling different populations, making comparisons across sites impossible.

**BUTLER COUNTY ESP - CLIENT AUDITS**

All four ESP organizations use the chart auditing tool supplied by Butler County ESP (although LifeSpan has added a section). In addition to appropriateness of services, the tool also assists in auditing the following topics:

- Assessment
- Income/Expense Review
- Service Outcomes
- Case Manager Interventions
- Care Plan
- Case Note documentation
- Whether documents such as client agreement and ESP HIPAA privacy forms are in physical file
- Case Manager Interventions

As mentioned, LifeSpan has one section that differs from the other sites. This section includes determination of high risk cases, mandatory reporting requirements, and after-care planning. Hamilton County Senior Citizens, Inc., and Middletown follow the Butler County ESP standard for frequency of auditing: i.e., two chart reviews every month per case manager. Supervisors are audited by the case management team.

LifeSpan's chart review approach is more specific than the standards provided by ESP. The approach includes a 10% audit per case manager, per-quarter. For instance, if a case manager had 130 cases, then the supervisor will do 13 audits. Audits are distinguished between "Active, Closed, at Risk" cases. Every case manager chart audit includes one case that is closed, two categorized as high risk, and the rest are active. LifeSpan's approach features a focus on high-risk cases, mandatory reporting

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requirements and after-care planning. Again, LifeSpan case management supervisors audit 10 percent of each case manager's cases each month. Hamilton County Senior Citizens, Inc., and Middletown perform two chart reviews every month, per case manager – in accordance with ESP standards.

Client satisfaction surveys have some obvious areas of overlap with outcome audits. As stated under the ESP *Client Satisfaction* heading, all four sites, in line with COA Southwestern Ohio recommendations, perform client satisfaction surveys via mail. These and other monitoring measures at the four sites, however, are not standardized.

All four sites strive for the six basic service outcomes put forth in the aforementioned IOM report, stressing the safety and well-being of clients; the value of client input; timeliness; effectiveness; efficiency and providing equitable care, regardless of who the particular provider may be. Standardization of case manager monitoring among the four sites would be a positive step toward ensuring the quality of services.

## CASE MANAGEMENT RECOMMENDATIONS

**Recommendation:**

1. **A general recommendation is that the core elements (i.e., caseload, training of case managers, and quality and monitoring strategies) of the Butler County ESP be standardized across all case management sites.**

**Discussion:** This recommendation drives the subsequent recommendations for case management that follow. Butler County ESP should be one program, and county residents should receive the same basic ESP services, regardless of the agency providing the case management service. This standardization can be accomplished through RFPs specifying core standardized expectations as part of the bidding process.

**ORGANIZATIONAL STRUCTURE RECOMMENDATIONS:**

1. **Standardize training programs for all ESP case managers and case management supervisors at all four sites, particularly regarding assessment, intensity levels and care planning.**

2. **Standardize Requests for Proposals to include information on bidding organizations' experience in providing case management services and/or services to older persons.**

3. **Continue using personnel representing various areas of expertise (nurses, social workers, gerontologists) to perform intake and case management functions.**

**Discussion**: The current approach of using a broad range of personnel to perform the ESP case management position is a good one. Although nurses and social workers are most commonly found performing the case management task, the literature identifies a number of programs that have successfully broadened the qualifications of case managers. Using a range of professionals with four different case management agencies does, however, result in some variation in case management practice. While we recommend allowing some non-licensed professionals to work as case managers, we also believe that compensatory appropriate experience should be required. While some practice differences are going to occur and in fact should exist, it is essential for ESP to have a standardized training program for all ESP case managers and supervisors. Also, organizational experience with case management and working with older adults should be emphasized as such when reviewing competitive bids for services, as well as for the hiring of individuals.

## EXPERIENCE AND DATABASE RECOMMENDATIONS:

1. **Require description of experience in providing case management and services to older persons in Request for Proposals.**

2. **Require information on hours of service operation (e.g., weekends/nights).**

3. **Develop a plan for enforcing contract compliance. Offer longer contracts to agencies with good performance on audits and client-satisfaction surveys.**

## PRACTICE AND PROCESSES ASSESSMENT RECOMMENDATIONS:

1. **Standardize uniform collection and interpretation of assessment data (to include information on informal support).**

2. **Standardize training on assessment policies and procedures, particularly those applying to intensity levels.**

**Discussion:** Standardized training is crucial in the assessment process. Review of data and interviews with staff suggest that there are important differences across sites on how data are collected and interpreted. The ADL and IADL assessment data vary across sites and seem to be collected using a different scoring system, especially when compared to PASSPORT client characteristics. Without accurate indicators of client impairment it is difficult to ensure that assessments result in appropriate care plans and actual client eligibility for services.

## CARE PLANNING RECOMMENDATIONS:

1. **Implement policy measures ensuring a clear separation between case management and the service-delivery functions of the organization.**

2. **Mandate that case managers inform clients that they are free to choose the provider agency of their choice.**

**Discussion:** Because ESP uses a model combining case management and service provision, it's critical that there be a clear separation between the case management and service-delivery functions of the organization to avoid even the appearance of conflicts of interest when ordering services. ESP data do not indicate that problems now exist, but it will be important for standardized training and the quality and monitoring functions to emphasize the importance of this principle.

## CASELOAD SIZE RECOMMENDATION:

1. **Standardize caseload size to 125 clients per full-time equivalent care manager.**

**Discussion**: This review has found considerable variation in caseload size by site and little empirical evidence to explain these differences. Although research linking caseload to client outcomes is limited, our recommendation is based upon CMSA guidelines coupled with our review of the Butler County ESP experience. Both consumer and staffing factors could affect this ratio; e.g., the use of case aides would influence the number per case manager, as would intensity levels of the caseload. This means that some case managers with highly impaired clients might carry fewer cases than case managers with less impaired clients. Accurate assessment and recording of client impairment data is crucial to further examine these caseload requirements. Caseload size should be reviewed continually in the context of performance and cost. This recommendation is made with the assumption that a service management model is used in ESP.

QUALITY AND MONITORING RECOMMENDATIONS:

1. **Standardize quality and monitoring measurement policies and tools so that they are applied uniformly at all ESP sites.**

2. **Include, as part of chart monitoring, the examination of data related to assignment of intensity levels (e.g., caregiver information and data used to assess ADLs and IADLs).**

3. **Use the same measuring tool, the same sampling frame and the same mode at the same time at all ESP sites in assessing client satisfaction.**

4. **Standardize chart auditing procedures, and review the same proportion of case manager charts at all ESP sites.**

**Discussion:** Consumers served by all case management agencies should have the opportunity to provide feedback, and case managers at all agencies should have the same opportunity to receive it to ensure optimum service provision and help update and fine-tune services on a continuing basis.

## SUMMARY

This report has outlined the major issues in determining standards and specifications for case management and intake and assessment in-home care programs serving older adults. The bid process for these types of services is not prevalent across the United States and poses its own set of challenges. One of the major challenges with implementing such a process is ensuring continuity of care for clients. Case managers, in many cases, are the single most important problem-solvers and advocates for many older adults. Ensuring continuity of this relationship is of paramount concern, particularly

when the case management agencies today may not receive the contracts tomorrow. For this reason the use of competitive bidding for case management services is relatively rare in the aging network. If such a bidding process is used, contracts should be awarded for an extended period of time and should be modified only when performance is not acceptable. Strategies for easing such a transition must also be considered as part of the bid letting process.

It should be emphasized that we view these recommendations as starting points for discussion among COA staff, ESP board committees and the full ESP board. The decisions to be made have a context that includes the vision for the case management role and function within ESP, the role of ESP in the larger long-term and health care systems, and the outcomes that ESP expects for its consumers.

Decisions about these issues provide an important backdrop for the detailed standards and specifications that can be outlined in a request for proposals. The bid specification process provides an opportunity for COA and the ESP Board of Directors to make these decisions and clearly articulate their expectations for quality case management and intake services to older adults in Butler County.

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