



Federation of Protestant Welfare Agencies

Concept Paper for the Provision of Case Management Services to the Elderly: FPWA's Response

July 9, 2007

For 85 years, the Federation of Protestant Welfare Agencies (FPWA) has been a leading policy advocate for individuals and families served by our more than 300 member agencies and affiliated churches. FPWA's mission is to promote the social and economic well-being of greater New York's most vulnerable by strengthening human service organizations and promoting just public policies.

The Federation of Protestant Welfare Agencies appreciates the opportunity to offer comments on the Department for the Aging's (DFTA), "Concept Paper for the Provision of Case Management Services to the Elderly," released on May 25, 2007. FPWA has sixty-two agencies that provide services to seniors, with four of those agencies providing DFTA funded case management services. After discussions with our providers, we would like to share with you in this document our impressions and concerns regarding case management and other senior services.

Our providers agree that the process of developing a concept paper and inviting comments is a valuable tool in the contracting process and we congratulate DFTA in this regard. We are encouraged by the affirmation of the importance of a coordinated and integrated senior services model where case management agencies link seniors to a wide range of community-based services providing a continuum of care with an emphasis on cultural competency. Of utmost importance to our older adult population is that case management helps seniors find the most appropriate blend of medical and social services that fits their individualized need, thus delaying or preventing the need for institutional care. We believe in the goal to provide seniors with a menu of services that allows them to continue to live at home and to be engaged in their communities for as long as possible.

We see case management as one of the most critical points of entry into the system of long term care for frail and vulnerable elderly over the age of 60. We also agree that the case manager is the care coordinator – not just responsible for referral, but for assuring access to a menu-driven continuum of services that emphasizes choice for consumers at a neighborhood level.

We would now like to take the opportunity to issue comments on several aspects of the concept paper.

Regionalization & Partnerships

We agree with the proposal in the concept paper regarding the flexible case management model and ensuring consumers have access to a variety of services and supports.

However, we are concerned that regionalizing case management services and the development of large service areas could greatly impact home-bound seniors as well as those elderly who are more mobile. Under this new regionalized model, case management may not be readily available to older adults within close geographic proximity to their homes. This relocation of service will take away the neighborhood focus and personal touch of our current case management system. Seniors who live geographically far could potentially fall through the cracks.

Further illustrating the importance of neighborhood-based services, our case management agencies frequently get referrals from neighbors who walk into the facilities and refer an isolated senior for service. Close linkages have been established within these localities where seniors, many of whom have little to no family support, are tracked and monitored by agency personnel. This degree of time and attention may not be possible if case management is located outside of the senior's immediate community. Our providers feel strongly that the larger the service area, the more difficult it is for those who are home-bound to be helped in a comprehensive manner. In addition, for those more mobile seniors, there is concern as to how they will get to the case management provider if it is far from their homes. In the current system, seniors often access case management services to engage in an array of programs that help them before the need for home delivered meals or other more intensive services develops.

Finally, it is important to emphasize that close linkages and partnerships between agencies already exist. Partnering with more providers, creating satellite offices and sending more case managers into neighborhoods is costly. It is not clear in the concept paper where there will actually be improved efficiencies rather than simply a movement of services from one place to another. Similarly, we are concerned that current partnerships that work very well may be compromised and even lost. Does DFTA intend to assist agencies to maintain and even strengthen existing collaborations?

One of the stated purposes of the Case Management RFP is to make it easier for older consumers to learn about and access existing services and supports. Inherent in this statement is the need to conduct outreach to seniors who may not be aware of available services. Clarity needs to be provided on where the responsibility for outreach falls. Will DFTA play a major role in educating the public about services or is that outreach left to the case management agencies? If left to the agencies, DFTA must consider the administrative burden this will put on the agencies and ensure that adequate resources are included to support outreach activities across a diverse population.

As a result of outreach efforts and a broader scope of services contained under the case management umbrella, some regions may see a significant increase in caseloads; this, rather than current caseloads, must be factored in when considering the size of the new regions. For instance, it may be necessary to break some of the largest regions into two smaller regions to allow for caseload increases due to outreach.

In addition, the division of regions must also take into account demographic-related caseload increases. For example, there will be additional, unaccounted for increases in caseloads due to the inclusion of seniors not currently counted in the caseload, such as those currently assigned to meals providers or senior centers conducting their own assessments.

We recommend that consideration be given to building up the current array of neighborhood services and working with stakeholders in each community district to enhance what is already available in these areas. Providers have spent years developing collaborations and linkages with other agencies in the communities, which serve as valuable and caring resources for seniors. DFTA must be very clear about what is expected in terms of partnerships and how much already strong connections will be weighted or valued compared with new or proposed partnerships? The RFP should be very clear about how providers can show intent and ability to follow-through on identified partnerships. Finally, there must be adequate funding to benefit agencies on both sides of the partnerships or there will be little incentive to work collaboratively.

Cultural Competency

We believe the emphasis on providing culturally competent services is of great value. It is critical to note, however, that some of the regionalized service areas cover multi-ethnic neighborhoods and vary greatly in size. It will be challenging to develop partnerships to provide services when such great diversity exists, particularly in the larger regions. This is particularly true for highly specialized interventions.

The RFP should require providers to demonstrate knowledge of cultures and ethnicities in the region and their approach to serving those populations appropriately.

Timing

Since service areas have been redrawn in the concept paper, and in some cases dramatically changed, providers will need time to hire staff with knowledge and experience in assisting the new and potentially more culturally diverse neighborhoods they will be serving. Secondly, providers will need a reasonable period of time to develop the relationships with potentially new service providers with whom they will be dealing within these redrawn service areas to achieve optimal services at a neighborhood level.

To meet the needs of diverse populations, we recommend extending the new case management timeline by six months with contracts to begin July 1, 2008. At the very least, a reasonable amount of time must be given to contract recipients to form collaborations and Memorandums of Understanding after the award announcement date. Similarly, a flexible process must be included where case management agencies can evaluate the effectiveness of partnerships and terminate, adjust or form new partnerships in a way that promotes quality services.

Of course, a transition period is also needed to allow for the orderly and compassionate case transfer from agencies no longer funded to conduct case management services.

Duplication

We agree that it is necessary for clients to have a coordinated and integrated senior services model and that comprehensive case management is needed to link seniors to community-based services that provide a continuum of care that will delay institutional care. However, a concern has emerged among our service providers that seniors could be subjected to duplicative case management assessments and multiple case managers. For

example, if the senior lives in the Naturally Occurring Retirement Community (NORC) and has a comprehensive assessment from the NORC case manager, will that client still be required to get another assessment from the DFTA case manager?

We recommend exempting NORCS, programs mandated to provide assessments and other multiservice agencies already providing model holistic services to seniors from the new case management program. At a minimum, a universal assessment tool must be developed that can be shared among entities to avoid duplication.

In addition, in the RFP, comprehensive case management or what has also been termed as “holistic case management” must be defined and expected activities articulated. For example, we envision the following as being activities included in holistic case management for consumers and/or caregivers experiencing diminished functioning capacities, personal conditions or other circumstances that require the provision of formal services:

- Intake
- Comprehensive needs assessment
- Case Plan Development (including the consumer and caregivers)
- Case Plan Implementation including a menu of services such as:
 - Home Delivered Meals
 - Nursing Services
 - Homemaker Services
 - Chore Services
 - Assistive Devices
 - Adult Day Services
 - Respite
 - Transportation
 - Legal Intervention for Senior Facing Eviction
 - Facilitation of Medical Services
- Review and Evaluation (Including Intervals and Methods)
 - Follow-up
 - Reassessment
- Case Closure

Outcome Measures/Technology

Meaningful outcome measures must be identified and providers must play a role in determining what these measures are. Further, the measures must go beyond quantifiable services to include quality of life issues as well. **Additionally, the financial burden of upgrading or instituting the use of new technologies must fall on DFTA and not the community-based organizations. Technology must support the delivery of service – not lead it.**

Reimbursement

It is clear from the concept paper that linkages will need to be established with other providers; however, what is unclear is who the billing agency for services covered by Medicaid, DFTA or other funding streams will be.

Furthermore, DFTA must realize that there will be more of an administrative burden on case management agencies who must monitor and manage an array of partnerships. Thus, costs for administrative infrastructure must be included as part of the RFP, in addition to investing in case managers. We are concerned by statements made by DFTA indicating there will be administrative cost savings and believe these administrative costs will remain and simply be shifted from DFTA to the selected case management agencies and also to current contractors proposed for elimination. This puts in question the idea of cost savings that can be transferred, dollar for dollar, into expanded case management capacity.

Expanding case management services must include the recognition that to provide quality services, caseload limits must be met and adhered to. Providers indicate that caseloads should not exceed 45 clients if comprehensive case management is the goal; current caseloads sometimes run as high as 75 and 80. It is important to note that when current contracts are eliminated, new contractors will conduct their own assessments of seniors already in the system, putting a large burden on the new contractors. We have reports from some agencies currently conducting their own assessments/case assistance with caseloads as high as 125.

Technical Assistance and Staff Development

Given that the vision for comprehensive case management has not been clearly articulated nor expectations fully identified, it is critical that DFTA provide formal training to both administrators and case managers once the contract agencies are selected.

Conclusion

The Federation of Protestant Welfare Agencies looks forward to partnering with the Department for the Aging in creating a larger vision for senior services in New York City, in addition to comprehensive case management services. We appreciate the opportunity to participate in the *Citywide Planning Summit to Develop Strategies for Modernizing Aging Services in NYC* and look forward to the release of the ideas that resulted from the Summit. We strongly encourage DFTA to share its larger vision with its nonprofit partners to help them prepare for change with an eye to the whole as opposed to a more fragmented, piece by piece roll-out of change.

To reiterate, the largest concern we are hearing from our membership is the procurement timeline. We strongly urge DFTA to delay the timeline by 6 months to allow agencies the time necessary to develop partnerships and design services that comport with a shared vision of services that is yet to be clearly articulated.