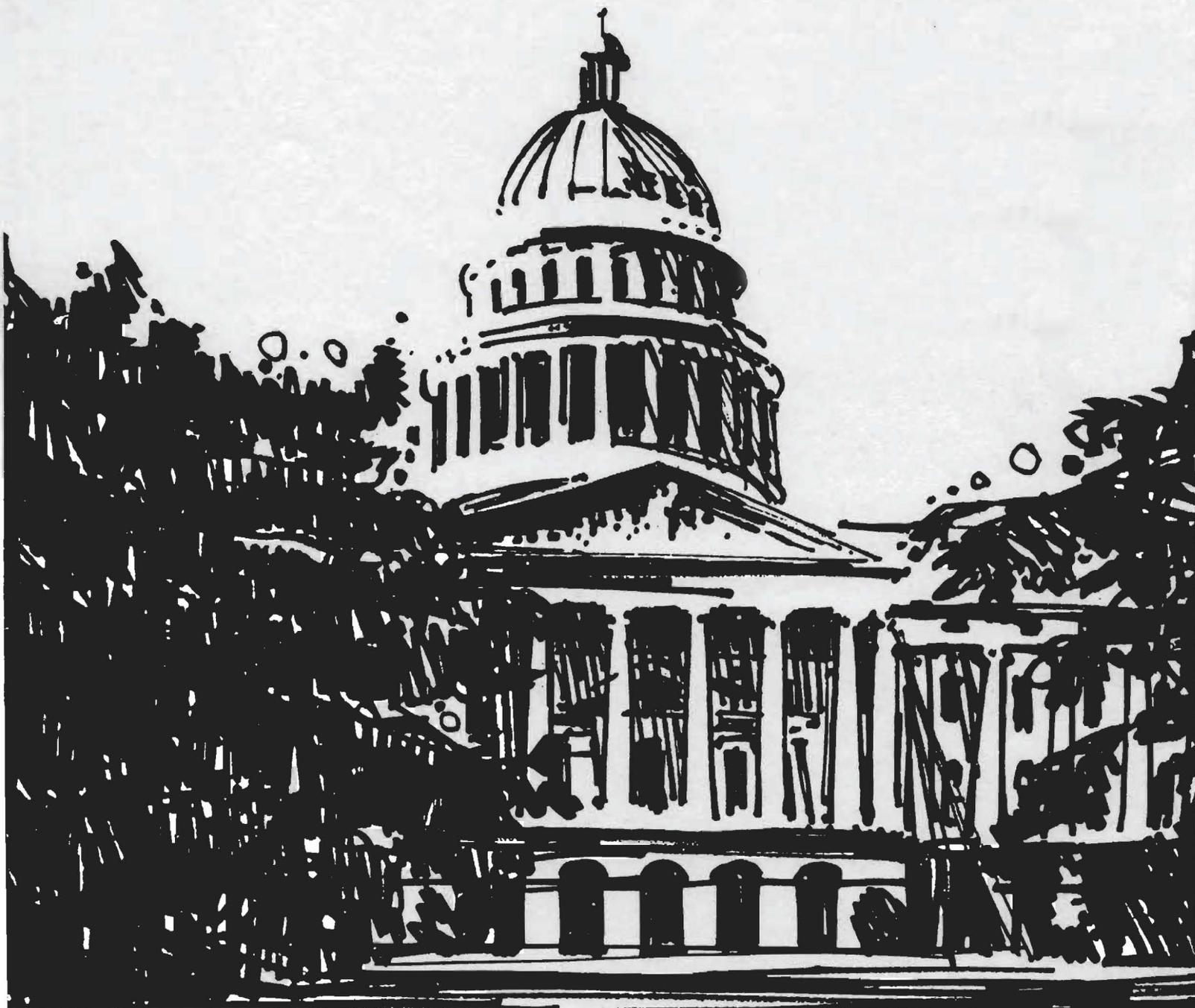




DEPARTMENT OF FINANCE

**REGIONAL CENTER AND CCSB
DIFFERENTIAL CASELOAD STAFFING**

A Staff Reference Report



REGIONAL CENTER AND CCSB
DIFFERENTIAL CASELOAD STAFFING

This is a Staff Reference report providing information, analyses or techniques which may contribute to the refinement of public policies and programs. It does not necessarily reflect the official policies or views of the California State Department of Finance.

PREPARED BY

STATE OF CALIFORNIA
DEPARTMENT OF FINANCE
PROGRAM EVALUATION UNIT

ROBERT L. HARRIS
PROGRAM BUDGET MANAGER

BERNARD P. DONNELLY
CHIEF, PROGRAM EVALUATION

APRIL 1980

PREFACE

The impetus for this study grew out of the 1979-80 budget discussions between the Department of Finance and Developmental Services regarding the appropriateness of existing case management ratios for the Community Care Services Bureaus and for Regional Centers. While it was not possible to determine definitive staffing ratios, several potential areas for management improvement were identified as a result of this study.

We would like to thank all those individuals who contributed time and information throughout the course of this project. The suggestions contained in this report should assist both the Department of Developmental Services and the Department of Finance in future budget formulation.

STEPHEN L. GOULD
PROJECT MANAGER

PREPARED UNDER THE
GENERAL SUPERVISION OF:

P. RICHARD SEEVERS AND
DON L. CALER
PRINCIPAL PROGRAM REVIEW ANALYSTS

TABLE OF CONTENTS

	<u>Page</u>
PREFACE	iii
LIST OF TABLES	vii
SUMMARY	ix
CHAPTER I. BACKGROUND	1
CHAPTER II. THE FUNCTIONS AND RESPONSIBILITIES OF CASE MANAGERS	5
CHAPTER III. TIME BUDGETS OF CASE MANAGERS	31
CHAPTER IV. THE CASE LEVELING SYSTEM	37
CHAPTER V. THE IMPACT OF SPECIAL INCIDENTS AND EVENTS ON CCSB CASELOAD	49
CHAPTER VI. MANAGING SHARED AND HOSPITAL CASES	63
CHAPTER VII. TRAVEL	73
CHAPTER VIII. CASELOAD RATIOS IN OTHER STATES	87
CHAPTER IX. THE PROFESSIONAL QUALIFICATIONS OF CASE MANAGERS	93
CHAPTER X. STAFFING RATIOS	101
APPENDIX A. EXAMPLE OF REPORTED EVENTS, ACTION STEPS, AND TIMES FROM CCSB SPECIAL EVENT STUDY (CHAPTER V)	113

TABLE OF CONTENTS (cont'd)

	<u>Page</u>
APPENDIX B BACKGROUND CALCULATIONS: THE EFFECT OF SPECIAL INCIDENTS AND EVENTS TIME EXPENDITURE ON CCSB AND REGIONAL CENTER COMPARATIVE PERFORMANCE	117
APPENDIX C ALTERNATIVE CASELOAD SENSITIVITY ANALYSIS, REFLECTING TIME REQUIRED FOR NONCASE MANAGEMENT ACTIVITIES	121

LIST OF TABLES

TABLE	<u>Page</u>
III-1 MAY, 1979 TIME ALLOCATIONS OF VALLEY MOUNTAIN REGIONAL CENTER CASE MANAGERS (% OF AVAILABLE TIME)	33
IV-1 INITIAL ESTIMATES OF THE PERCENTAGE OF CASELOAD BY LEVEL	39
IV-2 CURRENT, FORMAL CASE LEVELING STANDARDS	39
v-1 FREQUENCY AND TIME FOR CCSB SPECIAL INCIDENTS AND EVENTS	50
V-2 RANDOM SAMPLE OF REPORTED CCSB EVENTS AND TIMES	52
VI-1 SHARED CASE MANAGEMENT	64
VII-1 TRAVEL PATTERNS IN FIVE REGIONAL CENTERS	74
VIII-1 RATES OF HOSPITALIZATION FOR THE DEVELOPMENTALLY DISABLED PER 10,000 OF POPULATION, 1975	88
VIII-2 CASELOADS REPORTED BY A SAMPLE OF 34 STATES BY DEGREE OF COMPARABILITY TO CALIFORNIA	89
IX-1 ACADEMIC BACKGROUND OF CASE MANAGEMENT STAFF	94
X-1 OPINIONS OF REGIONAL CENTER CHIEF COUNSELORS ON STAFFING RATIO	103
X-2 ESTIMATED BREAKOUT OF CASES BY LEVEL FOR ALTERNATIVE CASELOADS ASSUMING 1,680 HOURS PER YEAR AVAILABLE FOR CASEWORK	106
C-1 ESTIMATED BREAKOUT OF CASES BY LEVEL FOR ALTERNATIVE CASELOADS ASSUMING 1,464 HOURS PER YEAR AVAILABLE FOR CASEWORK	122

SUMMARY

The initial purpose of this study was to recommend changes in the staffing ratios for case managers in the Department of Developmental Services' (DDS) regional centers and Community Care Services Bureau (CCSB). These ratios are now 62:1 and 67:1, respectively.

This objective was not attainable within our prescribed timeframe and resources. It would have required a multi-year effort on a large scale, using an experimental research design. Consequently, this study's focus shifted to the identification of opportunities for efficiency and effectiveness improvements. These issues are worth consideration both for their intrinsic merit and because resolution of particular problems will be useful as a basis for future research on staffing patterns.

The following is a summary of findings, by chapter.

CHAPTER I

There are 866 regional center case managers and 167 in CCSB. 1979-80 costs per position are approximately \$31,000, including salaries, overhead, supervision and clerical support. Total case management costs are \$32 million.

CHAPTER II

The main responsibilities of managers include:

- . Planning for clients.
- . Program implementation and advocacy.
- . Protection.
- . Limited counseling.
- . General assistance.

Precise definition of responsibilities by means of regulatory language is very difficult because each individual case contains variables, nuances, and practical conditions which make it virtually impossible to say whether a particular activity is always or never legitimate. First line supervision, rather than detailed regulation, is a primary control on a case manager. However:

- . There should be some standard, written criteria which describe expectations about how problems and activities will be handled. These criteria should include statements about the time which an activity will normally entail.

A compendium of standard case management practices would be a useful device for assuring that the State, regional center administrators, supervisors, and case managers share similar expectations about what a case manager must do in a particular situation, and how long it will take to accomplish this. Some standardization of expectations is also a necessary precursor to further study of the effectiveness of different staffing ratios.

One issue of continuing concern is whether case managers are responsible for long-term or therapeutic counseling. We believe that there is no statutory basis for this, and that counseling should be limited to what is necessary for planning and implementation.

This chapter addresses several other efficiency-related issues:

- . Individual Program Plans (IPP's) consume the largest portion of a case manager's time. They are mandated to occur at least once each year. This 12-month planning mandate is expensive, and is not supported by any more persuasive evidence than an 11- or 13-month time period. It should be reviewed.
- . Similarly, practices which require visiting clients in out-of-home placement on an inflexible periodic basis (often quarterly) should be reviewed. Some clients will need visits which are either more or less frequent. Some savings in staffing costs is possible if a more rational basis for protective visits is found.
- . Experiments with the computerization of IPP's and behavior modification instructions may result in greater efficiency and effectiveness. They too should be monitored.

By addressing these efficiency issues DDS can contribute to a greater standardization of case management practices.

CHAPTER III

This chapter presents factual information based on a time study of case managers at one regional center. One main finding is that the IPP process (including assessment) takes eight to twelve hours per client each year. This confirms the belief that the IPP is by a wide margin the largest single component of a case manager's time expenditure. Depending upon different assumptions, the precise expenditure is between 29 and 48 percent of a case manager's available working hours.

CHAPTER IV

Case leveling is a system now being implemented in regional centers which assigns each case a weight in terms of hours of casework required. We believe that:

- . The system is a very useful management tool.
- . It has possible budgetary applications. However, budgetary use of case leveling formulas should be delayed until they have been in practice for several years.
- . The use of five levels of difficulty rather than four would contribute to the system's usefulness as a budgetary device.
- . It is essential for the system to make allowances for non-case-related work, such as training, outreach, public information, or work with provider groups. Some of these functions are legislatively required, while others are realistically necessary. Failure to account for them makes the current case leveling system needlessly confusing. (See also Chapter 10).

Again, refinement of case leveling should occur prior to further efforts to identify the effectiveness of alternative staffing ratios.

CHAPTER V

We conducted a study of special events and incidents occurring in CCSB. These events--which occur on an unpredictable basis and which individually require large amounts of case management time--appear to account for 23 percent of case managers' aggregate workload. Major categories of special events are changes in residence and behavioral problems. This finding is important because:

- . Special events and incidents are undoubtedly the second largest consumer of a case manager's time.
- . Failure to deal with these events in the community can result in re-institutionalization in a State hospital, or in serious problems for the client or the community.
- . We believe that this is the first time that the magnitude of these special events has been measured. Such measurement is important because their aggregate importance may be undervalued by staffing studies which emphasize routine and predictable activities.

While we do not know whether the same percentage figure applies to regional centers, we believe that CCSB's workload may be somewhat

more difficult in this respect. Consequently, the reason for the difference in staffing ratios between CCSB and regional centers is brought into question.

CHAPTER VI

Shared case management is a system whereby clients of one regional center who are living outside the center's catchment area are case managed on a nonreimbursed basis by another regional center. We believe that:

- . This constitutes a significant burden for centers which receive more clients than they send.
- . The failure to use shared management or to use it fully creates excessive travel and work duplication.
- . The failure to use shared management for hospital cases has major cost consequences and results in a poorer quality of service to clients.

Systemwide efficiency could be improved by facilitating transfer of funds among regional centers to support the management of shared cases, and by tighter requirements on the use of shared management.

CHAPTER VII

Some regional centers have had caseload ratios as low as 43:1, justified by the contention that travel is more time-consuming in large, mountainous regions. However:

- . The average speed of automobile travel is not an important source of differences in travel time among different regional centers. Some rural travel is slow because of mountains and distances, but urban travel can also be slow due to travel on surface streets or freeway traffic jams.

- . Our data indicate that the particular center which has been staffed at a 43:1 ratio should in fact be staffed at 58:1, for a savings of \$186,000 per year.
- . Travel efficiency can be improved. The use of additional branch offices and volunteer or para-professional personnel would reduce travel needs.

CHAPTER VIII

A review of case management practices in other states indicated a wide variety of staffing patterns. There is no single, predominant model. Comparison is also made difficult by the fact that expectations for case managers in other states are either not spelled out with great accuracy or are implicitly quite different from what California law requires. Finally, the nature and difficulty of the cases in community placement appears to vary among the states. California is clearly the national leader in terms of removing cases from State hospitals, which means that cases in this State will often be more difficult to handle than elsewhere. Consequently, this aspect of our review reached no conclusions regarding ideal staffing ratios.

CHAPTER IX

This chapter is a brief review of the professional and academic qualifications of case managers.

- . MSW's vary from 3 percent to 93 percent of the case management staff at different regional centers.
- . The use of Master's degree personnel may add unnecessarily to case management costs.
- . Professional case managers--MSW's and experienced baccalaureate degree holders--are necessary for some but not all case management activities.
- . Community volunteers and professionals such as teachers and nurses can be useful and cost-effective substitutes for professional case managers in some specific activities.

Previous chapters have noted possibilities for the use of volunteers and others in small, remote communities; or for monitoring the physical well-being and treatment of clients in out-of-home placements.

CHAPTER X

Because client impact data could not be gathered without the use of a multi-year, experimental research design we did not attempt to recommend optimal staffing ratios. However, a survey of regional center chief counselors revealed that in their opinion an "ideal" ratio was 42:1. They pointed to 55:1 as a reasonable fiscally "constrained" ratio. 66:1 was termed "disastrous."

In a further effort to identify the outside boundaries or extreme limits within which an ideal ratio might fall, we reviewed case management responsibilities, legislative mandates, and the time standards used by the case leveling system. A ratio of under 45:1 or over 70:1 seems incompatible with facts established throughout this paper and with legislative direction. At a ratio in excess of 70:1 it becomes difficult to see how case managers can perform necessary duties. For example, at 75:1

- . 900 hours would be spent on IPP's and assessments (assuming 12 hours per case each year).
- . 433 hours would be spent on level 1 and 2 cases, the most difficult crises. This is derived from our special incident and event survey, which showed that at a ratio of 67:1, 23 percent of time is spent on such crises.
- . 369 hours would be spent on level 3 cases. These moderately difficult cases require an additional hour per month over and above what is needed for IPP's and assessment, and comprise an estimated 41 percent of total caseload.

These three figures sum to 1,702 hours, which is slightly in excess of the 1,684 hours per year available for work. Furthermore, no provision is made for:

- . Some level 2 cases (which are deemed to require 60 hours per year each).
- . Non case-related activities such as training, outreach, public information, and work with care providers.

The upshot of this analysis is that in order to consider a 75:1 ratio as reasonable we would have to:

- . Revise factual estimates of time required for certain activities; or
- . Reduce mandated work; or
- . Institute more efficient procedures.

Each of these is possible.

CONCLUSION

The identification of upper and lower boundaries within which an optimal staffing ratio will most likely be found does not imply that a mid-point between 45:1 and 70:1 is ideal. The point of identifying these boundaries is simply to say that:

- . Current staffing ratios are within the reasonable range.
- . Some adjustment to current ratios seems possible without clearly violating standards of efficiency and effectiveness.
- . The costs of a future effectiveness study would have to be weighed against the likelihood that results would not justify a ratio in excess of 70:1.

A future study could produce a significant savings, but this is by no means certain.

This paper has identified a number of problems which are worth addressing in their own right, and also as initial steps to producing a more definitive study of staffing standards. Some essential steps include:

1. Resolving efficiency issues.

- *The periodicity of IPP's (annual or otherwise).
- *Use of para-professionals and volunteers.
- *Shared case management, especially at hospitals.
- *Improving travel efficiency.

2. Identifying units of work.

- *Refinement of case leveling.
- *Compendium of standard case management practices.
- *Establishing time standards (e.g., for the IPP-assessment process).

From these steps there should evolve a clear understanding of what a case manager should be doing at current caseload levels. This understanding can serve as a basis for an experimental design study which tests client impact differences resulting from different caseload sizes. At experimental caseload sizes of, say, 50 and 80 it should be possible to delineate the additional functions which will be performed (at 50:1), and the activities and time expenditures which will be cut back (at 80:1).

CHAPTER I
BACKGROUND

This study of case management for the developmentally disabled grew out of an impasse in the Autumn, 1978 budget hearings. The Department of Developmental Services argued for caseload ratios which were lower than the 67:1 which prevailed in the Community Care Services Bureau (CCSB) and the 62:1 applied to Regional Centers. The Department of Finance countered that increases in caseload which had occurred in recent years had not seemed to result in any deterioration in the quality of services. Hence, caseload might even be increased. Neither side of the dispute could marshal compelling facts; and so the parties agreed to a study which might enlighten the 1979 budget hearings.

At stake in the hearings are 866 case management positions in the regional centers and another 167 in CCSB (1979-80). Salaries and fringe benefits exceed \$20,000 per case manager this year. Since each case manager generates both clerical and supervisory workload, as well as operating expenses, the addition of a single case manager costs an estimated \$31,000. Thus, case management will cost over \$32 million this year. If caseload ratios were reduced by one (to 61:1 and 66:1) the added cost in regional centers would be \$434,000; and in CCSB, \$77,500.

The cost figures are complicated by the reinstatement of a program called "opt-out." CCSB expects to manage 11,177 cases this year, compared to a projected 72,477 for regional centers. Several years ago, three regional centers opted out: they manage all cases generated within their catchment area without help from CCSB. Thirteen of the remaining eighteen regional centers have indicated that they too may opt out. If this happens, there will be automatic cost consequences when cases which were handled at the 67:1 ratio are redefined to fit the regional centers' 62:1 caseload. On the other hand, one of the arguments for opt out is that even when regional centers delegate a case to CCSB there is some duplication of effort. Removal of this duplication will allow some savings.

AN IDEAL STUDY

An ideal study of case management staffing ratios would focus on the client impact of various caseload sizes. Measuring client impact requires an experimental design, elaborate data gathering, and several years of observation. The key step would be the random assignment of cases to managers whose caseload differed by an extent which was significant enough (perhaps a range of 50:1 to 70:1) that clearly observable differences in client impact would result. In addition:

- * The study would require several years. Client progress is often slow enough (and complicated by occasional regression) that results from just one year of observation might not be definitive.
- * A large number of case managers would be needed. Case managers differ in their individual skill. Some regions of

the State have a high quality of purchased services, such as behavioral modification; while others do not. In some cases progress comes easily; in other cases it does not. A study would thus require a large number of cases and case managers.

Unfortunately, this study's goal of impacting 1979 budget hearings precluded such an ideal study.

It was in fact not even possible to simulate, ex post facto, some of the requisite conditions. Caseloads throughout California are and have been quite uniform. Where caseloads varied from 62:1 by any significant degree, they did so for reasons (such as the 42:1 caseload in the North Coast Regional center, which faces formidable geographical and travel problems) which precluded their use in comparative analysis. Until the Department instituted the Client Development Evaluation Report (CDER) in January of 1979, there was no diagnostic instrument available to provide comparable charting of cases throughout the State.

OVERVIEW

Chapters 2-5 are primarily descriptive. Chapter 2 focuses on what case managers do, while the others deal in different ways with the time required to complete the job. From this discussion there emerge at different points some efficiency-oriented suggestions. Not every idea for improved efficiency which appears in the text appears in the form of a suggestion: some observations don't lend themselves to clear-cut solutions, though they do deserve the attention of managers and supervisors.

The sixth and seventh chapters pertain to travel. Travel takes about one-eighth of case management time. It could take less. Some rather straightforward efficiency improvements are possible; but perhaps the most important single factor is the improved use of personnel resources which would follow from tightening standards for shared case management.

Chapter 9 examines some basic issues concerning the kind of personnel needed for case management, a question which is implicit at several other points in this report.

The final chapter draws together a number of points made throughout the study and focuses on the problem of the logical limits--both maximum and minimum--to staffing ratios. Regardless of efficiency improvement possibilities, case managers are not infinitely elastic: at some point, it is clear that required work can't be done because there isn't enough time to complete it. While we can't say what an optimal or desirable staffing ratio would be, we can tell with some clarity what it is not.

CHAPTER II
THE FUNCTIONS AND RESPONSIBILITIES OF CASE MANAGERS

"What should case managers be doing?" this is the question asked by the Department of Developmental Services--not, it must be added, because DDS doesn't know the answer; but because a delineation of case management responsibilities is unarguably the first step in determining optimal staffing rates.

Nevertheless, the question is somewhat misleading. It's fairly easy to generate a list of what case managers do or should do. In its most generalized form the list won't cause much debate. When we get to the fine points, however, there are often two sides to the question of "what?" For example, when a client wanders away from a care home should the case manager be involved in efforts to locate him? The general answer is:

Case managers have a responsibility for the well being of their clients. They should see to it that appropriate steps are taken by parents, care providers and the police to find a client who has wandered away.

Consensus breaks down when specific questions based on the particular situation of a client are raised.

- * Is responsibility limited to phoning parents, care providers and the police? Should the case manager consult his notes and phone some of the client's friends, or places where the client has been known to wander?
- * Does responsibility change when the client is very young, or is lost at a time of day in a section of the city where some serious abuse is likely to occur?

* What happens if the parents have no car? If the care provider can't join the search because s/he must look after other clients or if there are no involved parents; if it is known that the police won't look for a missing person unless they are missing overnight, should the case manager do more than just phone?

Subtly, the initial question of "what" becomes one of "how much" should a case manager do?

In terms of caseload staffing, we believe that the "how much" issue is a more dynamic and important one than "what?" In the example of the wandering client the "what" options are to spend 15 to 30 minutes making phone calls to appropriate agencies or persons; or no time at all. The "how much" question begins with the assumption that it will take perhaps a half hour to make the minimum contacts; but it ends with the alternative of spending 4-8 hours, or even more, in a search.

The problem is complicated by case managers' often-expressed desire to do as much as possible for every client. This is understandable for two reasons. People go into social work--which is how most case managers construe their job--because they desire to help others. This is a very positive motivation. Second, the administrative or bureaucratic framework within which case managers operate also points in the general direction of rendering assistance to clients. Regional centers and CCSB were, after all, created for a helping purpose. The combination of personal motivation and organizational purpose is a powerful tandem working on behalf of the notion that doing the most for clients is in fact best.

What balancing factors are working in the opposite direction?

The two main factors are:

- * The caseload ratio itself. At any staffing level, case managers must limit their activities on behalf of one individual in order to respond to the critical needs of others.
- * Supervisory restraint. When case managers use poor judgement by devoting excessive time to one case, supervisors may intervene to restore balance and equity to others; and to assure that required work gets done.

However, supervisors come from the ranks of case managers and may share the attitude that doing the most is best.^{1/} The attitude is tempered by administrative responsibility; but the organizations for which supervisors work are also geared to service. The upshot of this is that if ideal caseloads were objectively 70:1, there would be nothing in the system of restraints which would signal this.

Later in this chapter we will propose an approach for dealing with the "how much" problem. At this point the focus will be on what case managers do.

In March of 1976 regional center directors approved a "philosophical" statement on case management. Four major functions were described: planning, advocacy, counseling, and protection. The document discusses implementation as an integral part of planning.

^{1/}Table X-1 on page 103 illustrates the attitudes of chief counselors, who believe on the average that a 42:1 caseload ratio is ideal. Interviews with chief counselors indicated limited agreement with an idea introduced later in this chapter (p. 24), namely that doing too much for clients can discourage them from developing helpful contacts outside of the DD system.

Our own view is consistent with this, though some categories are rearranged and we have added an additional one ("general assistance") in order to provide a more explicit theoretical basis for commonly encountered activities. The main categories are thus: planning, implementation (including advocacy), protection, counseling, and general assistance. The following discussion elaborates on each category; relates it to a basis in law or practical necessity; describes typical activities; and points to key issues related to that category.

Planning

An annual Individual Program Plan (IPP) is required by Federal law (PL 94-103), State law (W&I Code, Section 4646), and by Joint Commission on the Accreditation of Hospitals (JCAH) standards.

Planning has two primary aspects, assessment and the plan itself. The Client Development Evaluation Report (CDER) is a state-mandated assessment form containing 80 questions on such topics as medical, emotional, social, motor, and cognitive functioning. As a part of the assessment process, professionals from fields such as medicine, psychology, nutrition and dentistry may make special inputs as needed; and service providers, relatives and other significant persons in the client's life are contacted for information on developmental status and needs. The case manager coordinates this process and contributes a social assessment. At this point the case

manager draws up a plan, with time bound and measurable objectives; and at an IPP conference (including the client, parents and others) the plan is discussed and approved.

This process has a double-edged goal. On the negative side, the requirement for an annual IPP is designed to prevent a client from stagnating or backsliding due to neglect. From a positive point of view the process indicates changes in need; and it encourages a coordinated effort to stimulate progress. Coordination is necessary. If, for example, a nutrition or weight problem is identified in the day program (e.g., a school), the care provider and/or parents will have to have consistent expectations of what the others are providing in the way of nutrition, and use reward or aversion techniques which are either identical or, at least, not conflicting.

Planning Efficiencies

There are various estimates of the time required for the planning process. The Regional Center of Orange County conducted a small--so small, we believe, as to be less than conclusive--study which indicated that the process takes 12 hours per year. The main process elements were interviews (3 hours), CDER (2 hours), dictation (1.5 hours), travel (1.3 hours) and items such as chart review, updating of a placement packet, financial status, and correspondence. Our time study at Valley Mountain Regional Center was also inconclusive (see following chapter), showing a range of 8-12 hours. Using the 12-hour

estimate, IPP's take 44 percent of the annual time available to a case manager carrying 62 cases; and 48 percent if the caseload is 67. Consequently, efficiency in this process has a significant bearing on staffing requirements.

The largest single issue is the requirement for an annual IPP. If IPP's occurred every 13th month, \$1.1 million in case management time alone would be saved.

There is no apparent proof of therapeutic need for an IPP every 12th month, as opposed to every 11th or every 13th month. The 12-month cycle appears to be justified by administrative convenience alone, though the advantage of this compared to an audit of performance on an 11-or 13-month cycle appears slight. It should be noted that the 12-month cycle is a minimum one, and that IPP's are done more frequently as needed. It is not known how often a full IPP is done ahead of the minimum schedule. Most changes take the form of an amendment to a particular objective, and this is not nearly as time-consuming as the full process.

Both law and JCAH standards encourage updates ahead of schedule. This reflects the fact that each individual's needs will differ. However, this is not mirrored by any provision which--based on differing needs--permits updating on a less than annual basis.

The need for what was referred to as the negative goal of the IPP process--the prevention of a client's stagnation resulting from long-term neglect--does mean that some maximum time limit is essential. This is consistent with possible alternatives to the 12-month cycle, such as:

- . Requiring an IPP for every client at least on a two-year basis, but also requiring each regional center or CCSB to average updates every 12 months. (This is a no cost tradeoff with possible effectiveness benefits.)
- . Requiring an IPP every two years, but requiring an average for all clients of one update every 13 months. (This would produce some savings.)

Both options allow greater professional discretion with respect to timing, yet contain inflexible maximum limits. The two-year limit used in these examples has no rationale other than as an illustration.

Both Federal and State laws require an annual IPP. Whether a change in law would be necessary if either of these options were implemented is not entirely clear. On the other hand, the annual mandate is open to some interpretation:

- . What standards are used for the administrative interpretation of compliance? Surely, an IPP done 366 days after the previous one would not be out of compliance except in the most exacting technical sense. Perhaps standards already allow updates every 13th month.
- . How does an interim change in a single objective affect requirements? Does the clock run for 12 months starting at that point, or is there some minimum requirement for completeness of an assessment and IPP which must be fulfilled?
- . Does "annual" mean once each calendar year or once every 12 months? If the former, a regional center could plan many updates every 13th month--January in the first year, February in the second year, then March, April, etc. When the need for an IPP revision on a less than 12-month basis came up, there would be a chance to set back the clock to January.

These questions imply a belief that some flexibility exists right now, and that the State could work with Federal authorities to obtain either more flexibility or at least a clarification of compliance standards.

In addition to the annual IPP issue, there are other reasons to believe that the IPP process is becoming or could become more efficient:

- . Time required for CDER's will decline as this new process becomes routinized.
- . The Department is now exploring the use of computerized IPP's, which may save some dictation time as well as provide standardization and other benefits.
- . Dictation time can be reduced by greater use of dictating equipment, changes in required formats, and a supervisorial insistence on brevity.

After reading case files in fifteen different locations, we are convinced that repetitive and unnecessary detail could be cut from much of the case managers' written work. Assessment documents written by case managers often contain information which is quite similar to the previous year's. An alternative to this would be to allow case managers to cross out obsolete material and attach amendment-style updates, including even marginal notes or references to other places in the case file where original material can be found. This is not very neat, but considering the fact that assessments can run three or more single-spaced pages for each client each year, it could save considerable time.

Implementation

Once assessments are made and IPP's are written, case managers act to implement the plan itself.

Implementation first requires either a purchase of service or advocacy to get a client included in a public program. Case managers face a number of problems in these areas:

- * Is services money available?
- * Is there a vendor in the area who provides the service?
- * Does the vendor (or public program) have slots?
- * Does the client need some explanation or counseling about what will be happening?
- * Are all parties (vendor, care provider, client) clear about what services will be provided, and when?

The majority of service purchases are probably quite straightforward, especially when the same service (e.g., out-of-home care) is being obtained year after year from the same provider. On the other hand, assuring implementation requires more than just filling out forms and assuming that good things will happen.

Clients are not simply assigned to a care home. Case managers must to some extent be familiar with the care homes available in the area, their respective quality, and their suitability for the individual. Some regional centers have simplified this decision by providing central information banks for the case managers or by having some individuals specialize in placement. The client, parents, or guardian are taken to a sampling of suitable homes. This can be an all-day task.

A client may need help moving to an out-of-home care facility. Required paperwork includes financial, medical, clients' rights and other forms, such as those specifying a care provider's part in IPP implementation. Some care providers require training in behavior

modification techniques.^{2/} Residential changes are often accompanied by changes in a client's day program. These involve another round of arrangements with a program provider, and the solution of possible transportation problems. While moving a client to a new facility and transportation to a day program are usually regarded as the care provider's responsibility, various circumstances can force a case manager's more intense involvement.

Case manager involvement continues after an initial placement is made. When care providers have trouble handling personal or behavioral problems, some counseling or IPP modification may be needed. Up to a point this is less expensive than making a new placement. For example, at one regional center we were told that several months of effort had gone into setting up a home for particularly problematical adults. The care home operator became discouraged, however, and until a case manager spent the better part of a week demonstrating behavior modification techniques, there was a good chance that the home would be closed. The alternative (finding a new placement for five difficult individuals) would have involved much more case management time.

^{2/}Valley Mountain has a portable computer which does this. It prints detailed instructions on a variety of behavioral modification programs, readable by lay persons, and can be taken to the care home.

Programs which run smoothly still require some monitoring. If expensive purchased services are not working, they must be modified or discontinued. On a more elementary level some steps--such as unannounced drop-in visits--must be taken to assure that services are even being delivered.

Advocacy is another aspect of program implementation. Even public programs to which any citizen is entitled are sometimes reluctant to take or fully serve developmentally disabled persons. Prior to PL 94-142 public schools were an example of this, and some regional center personnel contend that they still need to be pushed toward compliance. There are frequent problems with obtaining SSI benefits. Sometimes the success of a client is not always in the provider's interest: a workshop client who becomes so skilled that he can obtain private employment is an asset (as a productive employee) which a sheltered workshop may not want to lose.

All this takes time. One case manager at Loma Prieta, who had a temporary caseload of 108 due to some unusual circumstances, told us that he had for some time known of a client who was ready for private employment; but the workshop wasn't taking any initiative in this direction and he lacked the time to do so himself.

Protection

Planning is directly mandated by the Lanterman Act. Implementation responsibilities are clearly linked to planning. The Act is vague about the protective functions of case managers, though we believe that the responsibility is implicit. The Act does require

"advocacy for, and protection of, the civil, legal, and service rights of developmentally disabled persons as established in this division" (Section 4648(c)).

More broadly, the Lanterman Act as a whole sets up a network of community services which enable previously hospitalized persons to live in the community; and others to live in a more independent, normalized setting. While regional centers and CCSB can't possibly provide a level of protection similar to that of a hospital, neither can they sit idly by when clients get into some trouble not otherwise covered by an IPP. The inability of some clients to protect themselves, or to protect themselves in certain situations, is a service gap which is no less important than inability to brush teeth, dress, etc.

Some examples of a case manager's protective functions are:

- * Monitoring out-of-home care providers to assure that adequate food, clothing, and other services are provided; that home conditions are safe; and that unreasonable restraints or punishments are not used.
- * Assuring that some search has been organized for clients who have wandered away from a home or other service provider.
- * Assuring that clients who have been accused of violating the law have adequate legal protection.

Discerning when rights have been violated is not always easy.

We attended a meeting where several case managers (regional center and CCSB) had clients in a home where there was some suspicion of neglect. Clients themselves had given somewhat conflicting stories. A high functioning client had claimed that a lower functioning person had been left in a bathtub for an entire morning. The latter couldn't clearly confirm what had happened. Another of the center's clients had been

arriving at a workshop in a dirty, unkept condition. One of the case managers had talked to the care provider's husband, who "sounded drunk." The upshot of this one hour meeting was a coordinated plan whereby the five case managers involved agreed to make random, unannounced visits to the care home, talk frequently to their clients, and consult with both day program providers and with one another about conditions in the home.

A second example of the problem of discerning rights violations is CCSB's policy of requiring an immediate response to a client's request for an alternative placement. One case manager told us that such requests are sometimes manipulative, attention-getting devices. On the other hand, they may reflect neglect or abuse of a serious nature. Requests for a new placement are extremely time-consuming. At the minimum they require a round-trip to the care home and a discussion or counseling session. Even when no change in placement results, if a client initially insists on a new placement the case manager must review alternatives and will take the client to view other care homes, if appropriate facilities do exist.

Whether a case manager should go looking for a missing client is a touchy question. One professional advocate for the developmentally disabled told us, flatly, "no." He explained that the police are the appropriate community agency responsible in this situation; and that this is also the responsibility of care providers.

During our time study we came across one instance where a case manager did go looking for a client. The client was a Chinese girl who lived with her mother. The mother neither drove nor spoke English.

The girl wandered away during her first morning at a sheltered workshop. After being notified by the workshop, the case manager spent 2-1/2 hours looking in the vicinity of the workshop, talking to staff and to the client's relatives. Later in the day he spent another 45 minutes checking with these same people, notifying the police, and making some other contacts in the Chinese section of the city, where the girl was deemed likely to wander. On the following day he spent another half hour making phone contacts. Most of the case manager's time during the 24 hour period when the girl was lost was spent on other matters.

This approach seemed highly appropriate. The police do not, we were told, take such cases seriously until a person has been missing overnight. No one else was in a position to drive through the area where the workshop was located; and the case manager, also Chinese, was able to make some community contacts that the authorities might not have made. The time spent on searching did not seem excessive.

The appropriateness of yet another type of protective activity is somewhat less clear. We talked to one case manager who had spent an entire day (partially due to delays) accompanying a client to court. On the one hand, it can be argued that the client had a lawyer who would presumably protect his interests. On the other hand, the case manager believed that his presence would reassure the client; and that he was uniquely able to translate to the client the various choices of defense which the lawyer offered. On the whole, the case manager's time involvement seemed excessive.

Welfare Monitoring

"Welfare monitoring" is a term which we use to describe reviews of care providers for the purpose of assuring the adequacy of food, clothing, hygiene, etc., and assuring that clients are involved in appropriate activities while in the home or day program. (By contrast, we use the term program monitoring to describe reviews of the impact of services on IPP objectives.)

Case managers are not solely responsible for welfare monitoring: parents, teachers, and other members of the community are effective in this role; and licensing authorities have responsibility for some aspects of welfare, such as structural hazards around a home.

The need for this kind of monitoring is real. A year can go by without a case manager visiting a home, in part because various requirements for client contact can be met on the phone, in an office, or at a day program. This can be serious for a client who can't express problems to others or who has no parents or friends to look in on him. While we believe that most welfare monitoring is adequate, the system is prone to gaps.

On the other hand, there are some generally recognized inefficiencies in the current system. The most common is when clients who have different case managers--perhaps from CCSB and one or more regional centers--live in the same home. A drop-in visit by a case manager suffices for the welfare monitoring of his particular clients, but may be duplicated on the next day by a trip made by some other case

manager. CCSB tries to avoid this by assigning all clients in a particular facility to one case manager; but this doesn't guarantee coordination with the case managers from a regional center who have clients there.

A second inefficiency is that mandated welfare monitoring visits are, when required, on a fixed time schedule which does not reflect variations in need. Title XX requires quarterly face-to-face visits, though not necessarily in a home setting.^{3/} Some regional centers also have internal visitation requirements. However, the need for welfare monitoring varies according to such risk factors as:

- . The length of a care provider's experience.
- . The frequency of past complaints and violations.
- . The seriousness of complaints.
- . Type of client.
- . The quality of monitoring by day programs and parents.

Conceivably, some providers should be visited monthly or more often; while for others a semi-annual review would suffice.

Thirdly, we believe that welfare monitoring could take better advantage of human resources other than the case managers themselves. Some regional centers do use case aides for this purpose. A part-time case aide working between 5 and 9 p.m. (when clients are home from day programs) who visited two six-bed facilities each day could monitor over 600 cases each quarter for simple welfare purposes. Instead of

^{3/} CCSB staff have received Title XX funds, but regional centers have not.

making inefficient round trips (following the pattern of office to care home to office) the case aide could schedule a series of care homes for each day, saving travel time.

Another example of the improved use of human resources is the possibility of using volunteers for this work. It would take virtually no training for a layman to spot the worst abuses--such as a client who amuses himself by inappropriate activities such as playing with an electric toaster, or a total lack of clean clothes in the client's room. More training would produce greater sophistication in identifying problems, which could then be brought to the case manager's attention if needed.

Because volunteers and case aids are less expensive than a case manager, their use would allow more monitoring at the same cost or similar monitoring at a lower cost. In a very small regional center a single case aid could--by good scheduling, use of volunteers, and incorporation of reports from case managers who make home visits for primarily program monitoring purposes--take care of all needed welfare monitoring. This would have the side benefit of clarifying the case manager's own responsibilities: there would be no welfare monitoring reason for casual drop-in visits to a home, and the purpose of a visit would have to reflect a clear-cut program, IPP, or other need.

In sum, the improved scheduling, coordination and organization of welfare monitoring together with the use of more appropriate personnel could reduce costs and improve effectiveness.

Counseling

Counseling is a fourth general category of case management responsibility. It is a controversial topic because it is not mandated in the Lanterman Act; in fact the Act prohibits "direct treatment and therapeutic services" provided by regional centers, except in emergency situations.

Our acceptance of counseling as a regional center responsibility depends upon a specific construction of that term. We can distinguish among three types of counseling:

1. IPP-related. The Lanterman Act mandates client participation in an IPP. Beyond this mandate, it makes some sense for case managers to understand a client's perception of his own problems, plans, and preferences. It also makes sense for case managers to explain IPP alternatives to clients capable of understanding them, and to advise clients on what options might be best. For infants and for low functioning clients, discussions with parents are necessary. Case managers can provide parents of newborn clients with valuable information and immediate emotional support, both of which can impact the stability of a home and thus the client's supportive environment. (For example, in one instance frequent drop-in visits by a case manager were reported by a reliable source to have prevented an infant being placed in a care home, and possibly to have saved a marriage.) At the IPP implementation stage, case managers must have feedback from providers and clients; and can advise both parties on adjustments which may be necessary to make a program work. Such exchanges of advice and information do constitute counseling, are necessary for program planning and effective implementation, and are thus clearly implied by the Lanterman Act. Discussions with persons who helped draft the Act confirm this fact.
2. Personal, short-term counseling. When a client asks advice about marriage, getting a job, where to live (if he is in an independent living situation), or other vital matters, it is difficult for case managers to walk away from such queries. A response that "this isn't IPP-related, and therefore I can't advise you during working hours" would be nonsense. It would be socially abrasive--regardless of whether the person asking for advice were developmentally disabled. Since case management does require a bond of trust between clients and case managers; and since some issues noted above can be very important to a client's survival in the community, some time-limited counseling on these subjects seems

permissible under the Act. The frequency of such counseling and the amount of time devoted to it is a matter of judgment. The best point of control is the first line supervisor, who should be aware to some extent of the client's need and also of the case manager's general record of good judgment in the use of time.

3. Personal, long-term, therapeutic counseling. The Act clearly prohibits regional centers from direct treatment, except on an emergency basis. The prohibition is a source of considerable tension, because this is one of the primary things which MSW's are trained to do. Their inability to do such counseling--both because of caseload size and administrative control--leads to a sense of frustration among many case managers whom we have interviewed. They believe that they are being prevented from "doing their job". Nevertheless, we believe that the Lanterman Act requires that such counseling be performed on a contracted basis, or by other community agencies.

The distinction between the second and third categories is based primarily upon duration of the activity and subject matter.

General Assistance --"Helping"

"Helping" is the least clearly mandated aspect of case management work. As noted above, regional centers are not expected to offer direct services except on an emergency basis.

There are many instances, however, where helping makes some sense. For example:

- * A client has been evicted from an apartment and must move. He has few possessions, no car, and no friends to assist either in searching for a new apartment or in moving.
- * A client has an appointment to see a specialist on the other side of town. He doesn't know how to use the bus. The care provider has a conflict and can't drive him.
- * A client has moved for the first time into independent living. It appears that he doesn't know how to use the apartment's automatic dishwasher.

What these illustrations have in common is that they are all aspects of everyday living. Most people cope with them on a routine basis. Many developmentally disabled can also cope with them; but others will need some special help.

In addition, these are "one shot" episodes. They are not the kind of event which can be dealt with easily by means of a purchase of service or, necessarily, by any other community agency. It might be more difficult to effect a purchase of service than for a case manager to take direct action.

The importance of "helping" was illustrated by an early study of releasees from Pacific State Hospital. Robert B. Edgerton theorized that the most important factors in a person's success is the existence of a benefactor.^{4/} "It would not," he said, "be an exaggeration to conclude that, in general, the ex-patient succeeds in his efforts to sustain a life in the community only as well as he succeeds in locating and holding a benefactor." Of the 48 clients he studied:

- * 3 were independent of a benefactor.
- * 7 were "largely or periodically independent."
- * 17 were "heavily but not completely dependent."
- * 21 were "for all practical purposes" completely dependent.

^{4/}The Cloak of Competence (Berkeley: University of California Press, 1967) p. 204.

These benefactors helped with everyday problems, and with the delicate personal matters of "passing and denial"--that is, attempting to appear as normal, and denying the abnormality of retardation. While assistance in passing and denial often entailed merely treating the client as normal, there was also more overt moral support and counseling.

Who were the benefactors? There were 12 spouses, 10 employers, 5 landladies, and a variety of relatives, roommates, and lovers. Only four of the fifty identified benefactors were social workers, a fact which is partially explained by the independent living status of the group surveyed.

The results of the Edgerton study thus cut two ways. The help of a benefactor is essential. On the other hand, ex-patients found benefactors in a wide variety of places and not just in professional social service agencies. It can be argued--Edgerton does not speculate on this point--that assistance from volunteer benefactors is more efficacious than when it comes from social workers: it is more immediately available and more personal.

Our conversations with case managers indicate that many of them would like to be benefactors for their clients. However, the evident ability of clients to develop benefactors of their own, which Edgerton demonstrates, suggests that the need for case managers to assume this role is limited. This fact also raises the question of whether clients' motivation to seek outside benefactors would be impaired if staffing ratios were set to encourage widespread assumption of the benefactor role for case managers.

One alternative to the personal provision of miscellaneous help by case managers would be the development of ongoing contracts with providers. A "general assistance" provider--perhaps staffed by part-time personnel such as college students--could step in to provide clients with personal assistance in everyday living.

Summary

The five main responsibilities of a case manager are: planning, implementation (including advocacy), protection, counseling, and general assistance. Each of these categories contains a wide variety of specific activities. It is difficult to suggest that any specific activity is always or never legitimate. The question of legitimacy often hinges upon the particular circumstances of a client's case, and the amount of time devoted to the activity. We have noted inefficient or ineffective practices on the part of some individual case managers and other inefficiencies which seem endemic to specific agencies or throughout the case management system.

At the beginning of this chapter we noted that the issue of "what" case managers should be doing is less important for staffing purposes than the question of "how much." The two most important factors which restrain a case manager from excessive, inefficient, or ineffective activity are the caseload ratio itself and supervisory control. Neither of these factors is totally effective because at any

caseload ratio both staff and supervisors are motivated to do the most or best for clients. While this is a desirable motivation, it means that if an efficient case manager could handle 70 cases rather than 62 there would be no necessary signal either from the case manager or his supervisor to indicate this. Instead, the tendency would be to funnel "free" time into "nice" but otherwise questionable services to the client.

There is no quick fix for this problem. However, the Department of Developmental Services could, in cooperation with case management supervisors, develop a detailed compendium of standard and accepted case management practices. This compendium could include estimates of the range of time expenditures and of the average time required for particular activities and problems, and should be completed by December 31, 1980. This monograph would have the following advantages:

1. It would serve as a training tool for new staff, and also for veteran case managers.
2. It would help case managers to internalize the performance expectations of both supervisors and the Department.
3. It would provide a better basis of review of the performance of case managers as well as supervisors.
4. It would clarify the State's expectations of case management performance, and would thus provide a more objective basis for budgeting.

We do not suggest that this compendium should be treated as a book of binding rules. There are so many variables in the treatment of individual cases that the judgment and discretion of line personnel should not be fettered by a narrow regulatory approach. On the other

hand, we have repeatedly asked chief counselors and top CCSB personnel whether there are any written standards for case management which could be used in this study in order to help determine efficiency and effectiveness. There are very few. The standards that do exist are largely unwritten, and vary both among individuals and organizations.

The compendium's general function would be to set forth some common expectations for dealing with typical case management problems. Case managers themselves need this. Persons who are just out of school often need a specific orientation both to developmental disabilities and to California's laws and practical expectations. Job training and the informal process of socialization help; but there are many opinions on the right way of handling a situation with which neither the bulk of professionals nor the Department would necessarily agree. Even for experienced personnel some formalization of expectations would be useful as a check against poor work habits. In any event, because the case manager's judgement about priorities is often the most important determinant of his time allocation, it makes sense to influence these priorities in the direction of greater effectiveness. And, to the extent that either the individual, the organization (CCSB or a regional center), or the system as a whole is being evaluated, it is only fair to set forth criteria for evaluation in the clearest possible manner.

Many of the suggestions made in this chapter and elsewhere in this study are candidates for inclusion in such a compendium. We recommend that the compendium include guidelines on at least the following topics:

1. The main steps in the IPP-CDER-assessment process, and expected times for each step.
2. The update of annual assessments by amendment.
3. Brevity in writing.
4. Use of dictation equipment.
5. Frequency of IPP's.
6. Provision of transportation to clients by case managers.
7. The extent to which clients being placed in an out-of-home care facility should be shown alternative facilities.
8. The provision of direct behavioral modification, instructional, or other services by case managers.
9. Frequency and depth of monitoring of purchased services.
10. Mutual responsibilities of case managers and school systems in Individual Educational Plans and monitoring.
11. The frequency and extent of welfare monitoring.
12. Search for missing clients.
13. Support of clients who have been arrested or are in court.
14. Procedures for the investigation and determination of violations of client rights.
15. Definitions of IPP-related counseling; personal, short-term counseling; and personal, long-term therapeutic counseling.
16. Assistance to clients who are moving.
17. Assistance to clients who are applying for jobs.

To repeat, in each case the compendium should discuss the appropriateness of activities, situational variables, and time limits.

The foregoing list is by no means exhaustive.

Some topics addressed in this chapter require organizational or system-wide responses.

- A. The Department of Developmental Services can review the requirement for annual IPP's and the possibility of instituting standards which are explicit but which allow more realistically for professional judgement.

- B. The Department of Developmental Services can consider for statewide implementation computer-based systems for IPP's, for the selection of out-of-home care facilities, and for the printing of individualized behavioral modification programs.
- C. The Department of Developmental Services can develop standard procedures and expectations for welfare monitoring which incorporate the use of volunteers and para-professionals, and which are sensitive to the variations among clients and facilities in the frequency and extensiveness of needed monitoring.

CHAPTER III
TIME BUDGETS OF CASE MANAGERS

In order to get a better fix on how case managers spend their time, we conducted a time-budget survey at Valley Mountain Regional Center during the month of May, 1979.^{1/}

The technique of observing one month at one location was not intended to produce estimates which would be definitive either for the State or for Valley Mountain. We used this technique because the administration of such a survey precludes a widespread sample, unless extraordinary effort is made. Our objective was to identify the general distribution of case management time, and to verify by comparison some estimates which had been offered by other regional centers. In this respect the study was successful.

Table III-1 summarizes the study's results. It is misleading in one important sense: IPP Development is shown as taking 16 percent of total time. In a normal month it would be two or three times this amount. However, May is "camp month" when summer respite camp care is arranged for a large number of clients. It is apparent that this seasonal activity disrupted normal IPP work. One consequence may have been conflicting data on the amount of time spent per IPP. Our survey

^{1/}CCSB's Stockton and Modesto staff were also surveyed, but gaps in reporting prevented use of the statistical results.

showed this time to be 11 hours and 11 minutes, which would confirm the Regional Center of Orange County's empirically based estimate of 12 hours. However, clerical logs indicated that more IPP's were completed than our forms showed, and that the average time using those figures would have been 8 hours. This was the amount of time subjectively estimated by Valley Mountain's chief counselor prior to the study.

In the case leveling system (described more fully in the following chapter) level 4 applies to cases where only an IPP (including an assessment) is done, and where no other extensive services are provided. The leveling system assumes that these cases take 12 hours per year. The time studies at Orange County and Valley Mountain do not completely confirm the 12-hour estimate, but tend to do so. Thus, regardless of the conflicting data from Valley Mountain, a 12-hour estimate for a level 4 case is within reason and would be conservative if Orange County's figure were correct.

Another issue was the question of the split between case-related and non case-related time. The North Coast Regional Center had done a time study indicating that 18.3 hours per month were required for non case-related activities such as training, administrative housekeeping, community agency meetings, and vendor contacts.^{2/} At Valley Mountain,

^{2/}Letter from Robert A. Graham, Chief of Case Management Services at North Coast Regional Center, to James K. F. Bellotti, DDS Community Program Analyst, June 30, 1977.

TABLE III-1
MAY, 1979 TIME ALLOCATIONS OF VALLEY MOUNTAIN REGIONAL
CENTER CASE MANAGERS
(% OF AVAILABLE TIME)

*Intake	(9.51)	
*Travel	(12.32)	
IPP DEVELOPMENT		16.41
CDERS	(2.05)	
Personal Contact	(4.02)	
Chart Review	(1.69)	
Dictation	(4.48)	
Staffing	(3.26)	
Other	(.91)	
IPP IMPLEMENTATION		46.61
Client Contact	(8.05)	
Family Contact	(8.01)	
Provider Contact	(9.78)	
**Group Contact	(6.96)	
Dictation	(7.53)	
Case Consultation	(8.28)	
PAPERWORK		11.93
IN-SERVICE TRAINING		3.21
ADMINISTRATION		3.94
***BREAKS		8.90
MISCELLANEOUS		9.00

*Intake and travel were set up as overlapping categories. Time reported here was also reported under another category.

**Group contact was defined as simultaneous contact with two or more of the following: client, family, or provider. Contact was not necessarily face-to-face.

***Including lunch.

7.15 percent (10 hours per month) of reported time was devoted to in-service training and administrative housekeeping. In addition, we checked a sample of time survey forms for other non case-related activities. The forms were not always clear on this score; but while North Coast's estimate of 18.3 hours per month may be slightly high, Valley Mountain's experience confirms that it is generally reasonable.

It is worth noting that the non case-related activities reported at Valley Mountain were clearly legitimate under the Lanterman Developmental Disabilities Services Act. The Act requires case finding and outreach; community organization and program development, including liaison with community organizations and identification of unmet needs; public information; and consultation, training and technical assistance to other agencies. However, the case leveling system makes no formal allowance for training, administrative housekeeping, or any other type of non case-related activity.

Another useful result of the Valley Mountain survey was the conclusion that 12.32 percent of time is used for travel. This is close to the amount of travel time reported by Orange County for the IPP-CDER-assessment process. A later chapter will explore the travel issue more thoroughly.

When Valley Mountain's survey forms were compared to CCSB's, there was a striking difference in the way in which work days were organized. Regional Center staff typically worked on large numbers of cases during a given day. They would spend fifteen minutes on one problem, and then turn to another case. On an average day, for example, they averaged 9 phone calls both in and out.

By contrast, CCSB staff worked more intensively on a single case. There were several instances where an entire day or even more was spent with an individual client; but this never occurred at the regional center. The difference may be a matter of style; but it may also be related to the types of cases handled by the two agencies. CCSB's cases tend to be adults living in out-of-home care. In the absence of parents or guardians they are more likely to be highly dependent upon case managers during a crisis. This observation led us to undertake a more complete survey of special incidents and events in CCSB, which will be reported in a later chapter.

On the whole, the Valley Mountain time study was useful insofar as it produced some confirmation of other estimates of the time required for key processes. The fact that May was an atypical month limited the value of these findings. The estimate that 16 percent of time is devoted to IPP Development is clearly wrong. Even if this task took only 8 hours per case, IPP's would account for about 30 percent of total time. On the other hand, the study did confirm North Coast's analysis of non case-related time and produced useful information on travel and other topics.

CHAPTER IV
THE CASE LEVELING SYSTEM

Case leveling is a system whereby each case is assigned a particular weight according to its difficulty. The system was originated by chief counselors at several regional centers as a management tool. The problem they were addressing was the complaint of individual case managers that they were too busy to get certain things done. They recognized that this was often true even when a case manager had a caseload which was numerically equal to that of his colleagues. What made the difference was that one person might have unusually difficult cases, or might have experienced several time consuming "blow-ups" during a given month. By objectively defining various levels of difficulty and norms for the time which should be allocated at each level, the chief counselors hoped to get a better grasp on whether some individuals were overworked, or whether there were valid reasons for assignments which were missed entirely or late.

The initial case leveling study was conducted at Harbor Regional Center. Employees allocated cases to predefined categories and cooperated with a time and task analysis.^{1/} Three other regional centers conducted subsequent studies.

^{1/}Dean Furukawa, "Case Management for Developmentally Disabled Citizens: Time Study, Questionnaire, and Interview of Worker Attitudes Regarding a Regional Center Service Coordination Model," M.A. Thesis, Graduate School of Social Welfare, University of California, Los Angeles, 1978.

What emerged was an initial description of five levels, with level 1 as the most difficult. Each level is described:

- a. In general terms.
- b. In terms of typical clients or situations (e.g., of the five level 3 descriptors one reads "Situations where service provider contact is required quarterly.")
- c. In terms of typical tasks (e.g., for level 2 "coordinate use of consultant to help eliminate crisis/intensive situation.")
- d. In terms of typical time allocations and limits (e.g., at level 1, cases require a minimum of 10 hours per month; are not expected to remain at this level for more than two months; and a case manager carrying only level 1 cases would have a caseload of 13.)

The result was a constructive and empirically based taxonomy. In use, it allows case managers to describe (and supervisors to verify) workload on a basis which is objectively verifiable, at least in general terms.

The system itself is subject to manipulation:

- . It would be practically impossible to write air-tight definitions.
- . Descriptors themselves are a matter of opinion. (Does a family need monthly face-to-face contact--level 2--or quarterly contact--level 3?)
- . Some--probably a minority--cases fall between two possible levels. How do you treat a case which requires contact every eight weeks?
- . It is difficult to control for the case manager who designates a level of service which is "ideal" rather than one which is reasonable and practical.

Supervisory review is the primary control on manipulation. A supervisor will have some classificatory standards which he applies to all caseloads and employees; has some personal knowledge of specific cases; and is in a good position to spot deliberate or unintentional inflation. Such review is adequate when the impact of case leveling is limited to the assignment of equitable and balanced workloads or the

(as discussed below) case leveling becomes a basis for budgeting, tolerating inflation can be in the mutual interest of supervisors and employees.

Case leveling has important consequences for the budgetary process. Once a standard such as 10 hours per month for level 1 cases is accepted, the personnel complement required by a regional center for such cases can be calculated based upon their estimated number. Tables IV-1 and IV-2 show, respectively, the initial estimates of the breakdown of cases by level; and the formal estimate now being used for implementing the system.

IV-1
INITIAL ESTIMATES OF THE PERCENTAGE OF CASELOAD BY LEVEL

<u>Level</u>	<u>Hours/Month</u>	<u>Harbor</u>	<u>North Coast</u>	<u>Orange</u>	<u>North Bay</u>
Intake	10	4 %	16 %	N/A	5.6 %
I	10	1	8	4 %	2
II	6	10	9	11	7
III	3	27	26	41	41
IV	1	55	21	44	45
V	1/4	5	20	N/A	N/A

IV-2
CURRENT, FORMAL CASE LEVELING STANDARDS

<u>Level</u>	<u>Hours/Month</u>	<u>% of Cases</u>
I	10	4
II	5	11
III	2	41
IV	1	44

The following things occurred during the transformation from the initial formulation (IV-1) to the current standards (IV-2):

- a. 10 hours per month was accepted for intake cases, but since intake is governed by non-discretionary statutory standards this was dropped from the system.
- b. Level V was dropped because these are really inactive cases. All that was proposed for them was an annual phone call or contact letter, and no IPP was required.
- c. There was obvious disagreement among the regional centers as to the breakout of cases by level. This had to be resolved.
- d. The Department of Developmental Services insisted that the leveling system correspond to the statewide 62:1 caseload ratio. This required some "force fitting" of the initial data, which would have justified a caseload ratio in the mid-50's.
- e. Available work hours were expanded to 1,680 when the Department required that State Personnel Board estimates of potential working time be used.

The Regional Center chief counselors do not agree that the standards worked out to fit the 62:1 ratio accurately reflect their experience; but since the 62:1 ratio is an unavoidable fact, the standards in Table IV-2 are being used.

The standards now being used are equivalent to Orange County's initial experience. Orange is the only "opt-out" center among the four which had participated in the initial formulation of the system. It is thus the best reflection of what regional center caseload will be like when (as expected) the majority of regional centers have incorporated CCSB cases into their own workload.

A comparison between Orange and Harbor is valuable because the case leveling idea originated at Harbor, and Harbor has the most highly evolved experience with the system. Harbor's rate of level 1 cases (1%) is the lowest of all four regional centers. Harbor found that as

more experience was gained, the percentage of level 1 cases dropped. Orange County's rate of level 1, 2, and 3 cases is in each instance higher than Harbor's. We can conclude that CCSB-type cases are at least as demanding as those which are typical of regional centers today.

The most discrepant note in Table IV-1 is the high rate of level 1 cases reported by North Coast. Other than the possibility that North Coast's operational definitions are somewhat different, there are two potential explanations for this:

- * North Coast faces travel problems which are quite formidable compared to the other three regional centers. When a case "blows up" and requires the personal intervention of a case manager, the travel factor alone would shift cases from level 3 to level 2; and from level 2 to level 1.
- * In a survey of regional center chief counselors, North Coast was the only center using case leveling to report that its orientation was primarily toward social work (as opposed to a brokerage of services model). This emphasis on counseling increases the likelihood that cases which are not treated at the minimum level--level 4--will be more time intensive than would otherwise be the case.

These two factors may be related. If a North Coast case manager is going to travel several hours to visit a client, s/he will probably opt to deal quite thoroughly with the case so as to preclude the need for a second visit. This would seem to be less likely to happen if the travel distance were measured in minutes, as it is in the three other L.A. area centers. Moreover, the absence of some services in the remote areas of Northern California means in some cases that

time-intensive counseling will be the most practical means of dealing with a case whose problems would, in other parts of the State, be met by the purchase of services. Thus, while North Coast's estimate of 8% level 1 cases is quite out of line with those of the other regional centers, it cannot be discarded.

We would be concerned if the case leveling system were used in the budgetary process prior to 1982-83. If Harbor's experience is correct, it will take a year for the system to shake down and to produce consistent estimates of the breakout of cases by level, even within a single regional center. When that point is reached there will still be discrepancies among regional centers, some of which will be due to differences in the way case level definitions are applied and others of which may result from differences in policy, service resources, topography, etc.

It is even possible that some regional centers' cases will be more difficult than other centers'. In populations as large as those being served by a typical regional center, one would not expect to find large differences because the statistical tendency will be regression toward the mean. On the other hand, clients with identical underlying problems could be more prone to "level 1"-type blowups and problems if they live in large, crime-prone cities; or places where formal services or informal community support are lacking.

Sorting out the legitimate differences between regional centers from definitional differences will take time. The effort will be easier if regional centers first establish some internal consistency

within each organization, such that the percent of cases by level will be similar from month to month. Second, technical differences between centers will require resolution. After this, an analysis of remaining discrepancies should precede budgetary application. It is unlikely that all three processes could occur in time to provide useful information for the 1981-82 budget.

To the credit of the personnel who devised the case leveling system, it does contain some important safeguards against manipulation. No case can remain at level 1 for more than two months; and level 2 is limited to three months. The level 1 cases include:

- clients being placed in another residential facility.
- resolution of life-threatening hazards.
- acute behavioral/psychiatric problems, including dual MD/DD diagnosis, which require coordination with others.
- clients involved in court proceedings.
- parents in training to become program coordinators.
- acute medical problems requiring coordination with other agencies.

We have some misgivings about these definitions.

Our survey of CCSB special incidents and events (reported in the following chapter) found that an average change in residential placement--including ancillary activities such as adjustments in a client's day program--takes 9 hours. However, many changes were accomplished in half that time. Classifying every residential change as level 1 thus overstates the need by one hour.

Another problem is the inclusion of court cases. There are instances where a case manager should be present to interpret court proceedings for the client and to explain the client's choices to him, especially if the lawyer lacks the time or skill to do so. In other cases we believe that a case manager's time should be very limited, because a lawyer is professionally obligated to protect the client's rights. The extensive involvement of a case manager would be a duplication of effort.

In both instances our concern is that the definition of a case as being potentially level 1 will legitimate a degree of case management activity which goes beyond what is actually needed.

A related concern is that the transition from one level to another is quite abrupt in terms of the number of hours required. Level 1 requires twice the time of level 2; level 2 requires 2.5 times the effort of level 3; and level 3 is twice level 4. While the hours specified for each level are supposed to be an average for cases of a particular type--that is, level 2 cases may range from 3 to 7 hours--the abruptness of the transition from one defined level to another means that time requirements can vary quite significantly depending upon the difficult judgement of how a case should be categorized. If the percentage breakout by level were 5, 12, 40, and 43 percent respectively (that is, increasing levels 1 and 2 by one percentage point and reducing levels 3 and 4 by one percentage point each) the staffing ratio would drop from 62:1 to 60:1. Such a change would cost in the neighborhood of \$1 million.

One response to this problem would be to add another level to the four levels now used. This has the disadvantage of making classification of cases more complicated. On the other hand, by reducing the abruptness of transitions from one level to another it reduces the budgetary implications of each classification decision.

The compendium of standard case management practices recommended in Chapter II would also help resolve definitional problems. It would be particularly useful in reducing the chance that definitions of case levels will legitimate more activity than a case really requires. For example, when a client is faced with a court proceeding, the compendium could provide detailed examples of when time-intensive involvement is required and when it is not.

Case leveling does have another drawback as a budgetary device. It is a self-fulfilling prophecy. We have previously noted what is in some ways the very praiseworthy tendency of case managers to deliver a maximum amount of service to clients. If the system permits the assignment of 11% of cases to the level 2 category, most case managers will report 11% if it is at all possible to do so. The problem is more acute with levels 2 and 3 than with level 1 because they are somewhat less clearly defined.

Circularity can be a problem in the long run if the nature of the developmentally disabled population changes. The goal of the entire DD system is to raise the functioning of clients, and if the system lives up to raise the functioning of clients, and if the system

lives up to its brightest expectations, the number of level 4 cases should increase in proportion to others. Case management would then be over-budgeted, unless the circularity problem were solved.

Despite these drawbacks the system's ability to improve management control and accountability--the things for which case leveling was originally intended--are quite positive. The use of leveling by CCSB is particularly important. CCSB's role in case management is being reduced significantly by "opt out", whereby regional centers can now choose to take over all CCSB cases in their catchment areas. If CCSB staff is cut to a fraction of its current size, it can still play a valuable role (as we point out in more detail in the next chapter) as a yardstick for measuring the comparative performance of regional center case managers. The use of case leveling would enhance comparability.

The case leveling system now being instituted by many regional centers is a very positive step in the direction of improved managerial control and flexibility. It has potential as a budgetary tool. Its drawbacks for this purpose include:

- * The time that will be required to develop consistent application of the system.
- * The system's need for a fifth case level and for a compendium of standard case management practices which could be used as a guideline for case classification.
- * The system's circularity or lack of built-in mechanisms to signal changes in the actual distribution of cases by level.

The great advantage of case leveling is that it brings considerably more precision to the consideration of case management problems and responsibilities than has previously been true.

Until now there has been no standard methodology for defining the tasks and time appropriate to individual cases. Even where questions about classification or time allocation are raised, the system will facilitate empirical verification by providing hypotheses for tests.^{2/} Despite this advantage, the use of case leveling as a budgeting tool should be delayed at least until 1982-83, by which time there will have been enough experience that operational definitions will have become more consistent among regional centers. Regardless of its budgetary uses, case leveling should be instituted by all regional centers and by CCSB because of its advantages for management control.

^{2/}This is a technical point. One needs a much smaller sample to test the hypothesis that 11 percent of cases are level 2 than if there is no consensus on classification guides or percentages. And, of course, future researchers will have established classification records as a working base.

CHAPTER V
THE IMPACT OF SPECIAL INCIDENTS
AND EVENTS ON CCSB CASELOAD

The bulk of a case manager's responsibilities follow a predictable pattern of assessment, planning, purchase of service, and monitoring. When case managers are asked about their job, however, their response focuses on "war stories" about unusual episodes and events. Since anecdotes are not a sound basis for reviewing staffing standards, one objective of this chapter is to measure the frequency and time demands of these non-routine occurrences. By establishing the amount of "real" time spent on special incidents, we are in a better position to address the question of whether CCSB's higher caseload is justified because its cases are somehow easier than regional centers.

To assess the impact of special incidents and events we conducted a two-week long survey of all CCSB staff. Case managers were asked to write up a maximum of two events occurring in this period, and to estimate the number of additional, eligible events. Writeups consisted of a brief problem statement and a succinct listing of action steps taken, together with the time estimated for each step. To qualify as a special incident or event an activity had to be nonroutine (excluding IPP's, assessments, CDER's, etc.) and it had to take more than four hours during the two week period. The events surveyed would

	<u>Raw Data</u>	<u>Interpreted Data</u>
Participating Staff	117	117
Events Claimed	340	298
Events described	194	163
Total time, described events (hours)	1,572	1,170
Time per described event (hrs. min.)	8:06	7:11
Events claimed per staff member	2.91	2.55
Time per week (hours, minutes)	11:47	9:09
Percent of 40-hour week	29.5%	22.9%

The "interpreted data" figures in the table represent cuts from the raw returns when:

1. Writeups appeared to refer to events which happened primarily prior to the survey period. (31 events).
2. Estimates of events over and above the two which were written up appeared inflated. (11 events).
3. Time reported for a particular activity was excessive, or the activity seemed unnecessary. (77 hours).

These reductions were made in order to produce a deliberately conservative estimate of special event workload and to counterbalance any tendency on the part of case managers to exaggerate their activity. To validate the survey, we visited four offices which had been the source of 45 written reports. We examined case files in order to assure that the events had happened during the survey period. These four offices had initially reported 354 hours of time spent on the 45 cases. Our interpreted data cut this back to 259. As a result of examining working papers, we concluded that 270 hours had been spent. The four percent difference between the interpreted and re-examined data is statistically insignificant.

thus qualify as level 1 or 2 cases in the regional centers' case leveling system. Table V-1 summarizes the survey results.

Table V-2 is a sample of event descriptions. Appendix A contains three other events, together with action steps and associated times. One can categorize events as follows:

- 46% - Residential change. Changes include a client going to or from a hospital, parental home, independent living, or a mental health facility. They also include changes in out-of-home placement facilities. Most residential changes appear to have been precipitated by some behavioral outburst (and could thus have been placed in that category). Thus, changes in residence are often accompanied by activities aimed at dealing with such outbursts. Residential changes also require program changes in many cases. Incidents where several types of activities have occurred were placed in this category because the change of residence itself tended to be the most time-consuming activity.
- 16% - Behavioral problems.
- 10% - Program change.
- 6% - Neglect, assault, or abuse. Not all events in these categories are proven; but all required some investigative response.
- 5% - Sickness, pregnancy, or accident.
- 17% - Miscellaneous. Examples in this category include transportation problems, financial problems, lost Medi-Cal cards, counseling, etc.

One thing which these events have in common is that they rarely are initiated by case managers. Case managers reacted to external stimuli in a manner which could be described as "fire fighting."

For example, case managers have little choice in their reaction to situations where a residential change is indicated. Clients--by right--cannot be required to stay with a particular care provider; nor are providers (including day programs) required to take a particular client. Where a provider contends that a client has become unmanageable it makes little difference whether the provider's opinion

RANDOM SAMPLE OF REPORTED CCSB EVENTS AND TIMES

1. Transfer of client from school to workshop program. (5:50).
2. Special incident. Client hit another client and caretaker. (4:10).
3. Client was placed in Board & Care Home from State Hospital following pre-placement work and coordination of planning with hospital, B&C home, family, and day programs. (7:40).
4. On 6/14/79, client and two other boys were in his caretaker's backyard engaged in the act of orally copulating. The neighborhood boys became angry with client and stuck his penis with a safety pin. Client did not report this incident to care provider. Care provider found blood on client's sheets when changing bed on June 16. She took client to the medical center. (5:00).
5. Homosexual assault against client in program restroom facility. (5:25).
6. As of this week I have a client in an acute psych. hospital who needs commitment to Dev. Services and transfer to State Hospital. (10:33).
7. Client admitted to psychiatric ward. Family brought him because he is acting out and hitting people without provocation, not sleeping, disturbing people at night. (4:40).
8. Mother and guardian of client removed him from convalescent hospital to her home. She is questionably caring for his needs and she appears to be severely emotionally disturbed. Need for frequent visits and coordination with Adult Protective Services to assure safety and welfare of client. Client has no phone. (7:35).
9. I received a phone call from Valley Rehabilitation Industries, a sheltered workshop, that my client had become verbally and physically assaultive with his immediate work supervisor. The outcome of this episode was that my client was fired from his job. (6:15).
10. Client had been beaten and robbed in his home. (Client living alone in apartment near brother, had been referred to CCSB for placement but has been ambivalent about decision to accept placement.) (4:20).
11. Client's father killed client's younger sister, then committed suicide. Client's feelings toward his father had been ambivalent at best. He became extremely angry, upset and hostile when informed of the tragedy. (9:35).

have been too slow or uncertain. There are so many variables associated with action steps (including a case manager's intuition about how to handle a situation) that while additional steps could be questioned, we considered a cutback which amounted to 5 percent of the reported hours a conservative but reasonable adjustment.

Findings and Analysis

Twenty-three percent of CCSB case management time is devoted to special incidents and events. These events are equivalent to levels 1 and 2 in the case leveling system. In fact, the 23 percent figure understates the incidence of special incidents and level 1 and 2 cases because:

- . The raw data in Table V-1 were interpreted conservatively, to prune out potential overstatements of time expended.
- . The format of our survey precluded capturing all level 1 and 2 cases, or all special incidents or events. This was a two-week long survey. As such, it would have missed events which might have taken one or two hours during the survey period (and thus would not have qualified for the survey) but which took additional time during the month.

The following analytical sections examine this conservative finding and their effect on CCSB staffing. The first section uses case leveling standards to question whether it is possible for CCSB to complete required work, given the incidence of special events. The second section pinpoints dual diagnosis clients as a reason for the frequency of special events. Finally, some administrative justifications for a lower caseload are introduced.

The Impact of Special Incidents on Total Work Time
And Caseload Carrying Capability

We estimate that case managers have 1,464 working hours per year available for actual management activities.^{1/} At a 62:1 caseload ratio, the average case requires 23.6 hours of work (versus 21.8 hours at a 67:1 ratio). This means that if CCSB personnel spent the same time per case as their regional center counterparts, they would have to work an extra 110 hours per year in addition to their present activities.

Knowing something about the frequency of special incidents and events helps in translating this 110 hour difference into more vivid terms. (Appendix B provides details on how the following observations were derived.) Some possibilities are:

- * Between 20 and 33 per cent of the clients who should be served at level 3 --by regional center standards--are in fact being served at level 4.
- * Alternatively, level 4 clients (who constitute about half of all clients) receive about 3/4 of the time devoted to their regional center counterparts.

If CCSB cases are equal in difficulty to regional center cases, then clients of the former organization are shortchanged; and the frequency of CCSB special incidents and events indicates that cases are in fact similar in difficulty.

Dual Diagnosis

There is something to be said on both sides of the question of whether CCSB and regional center cases are equally difficult.

^{1/}The estimate is discussed further in Chapter 10. In essence, there are 1,680 hours available after deducting for holidays, breaks, etc. 216 hours are estimated for indirect activities such as work with a care provider, community activities, etc.

Regional center cases include a larger proportion of minors than CCSB. The regional centers contend that these cases are difficult because the rate of learning for children is comparatively fast, and that they thus demand considerable attention. Intensive time input by case managers is usually associated with transitional points in a clients's life, and children experience many critical transitions, such as:

- . infancy to childhood
- . childhood to school
- . changes in schools
- . puberty
- . school to work
- . home-leaving

On the other hand, CCSB's adult-oriented mix of clients could be more difficult to handle because:

- . Adults are more independent and thus more prone to special incidents and events.
- . Adults may become involved with law enforcement agencies while similar behavior by a child would not result in such involvement.
- . Behavioral outbursts among adults are harder to handle and are potentially more serious.
- . Adults are less likely to have a caring parent to help them, and this places a greater burden on personnel such as case managers who must deal with adults.
- . Marriage and pregnancy are more likely to occur among adults.
- . Adults may move to and from independent living situations, while this is not an option for children.
- . Childrens' school programs can be sufficiently encompassing that the net burden of the developmental disabilities system is reduced.

Some of these points take on special significance when the incidence of dual diagnosis cases--that is, both mentally and developmentally disabled--is considered.

In a 1978 survey CCSB reported that 7.77 percent of its clients were in need of mental health services.^{2/} The estimate was apparently based upon fairly serious outbursts, and not on the mere existence of mental health problems since various authors estimate a far higher rate of psychiatric problems among the developmentally disabled--over 40 percent, and even higher.^{3/}

CCSB's counterpart social work agency handling mentally disabled clients has a caseload ratio of 50:1. This is apparently justified by additional counseling needs and the difficulty of handling behavioral outbursts. Whatever the reason, if CCSB's dual-diagnosed clients were staffed at 50:1 we can ask the question of what the staffing ratio would be for all other clients if the average caseload were to be 67. Answers vary on the estimated rate of dual diagnosis:

- . If dual diagnosis is 7.77 percent, the answer is 70:1.
- . If dual diagnosis is 16.30 percent, the answer is 72:1.
- . If dual diagnosis is 41.10 percent, the answer is 88:1.

^{2/}Letter from Jack Ploscowe to Doug Arnold, 3/30/78

^{3/}Ronald W. Conley, The Economics of Mental Retardation, Baltimore: John Hopkins University Press, 1973, pp. 45-46, citing Paul V. Lemkow, "Epidemiological Aspects," in The Evaluation and Treatment of the Mentally Retarded Child in Clinics (New York: National Association for Mentally Retarded Children, 1956.) Another study cited by Conley claimed that 80 percent of all developmentally disabled children suffered from some personality disorder. Lemkow, ibid., reports that the most serious cases were 9.7 percent psychotic and 6.6 percent adult neurotics, for a total of 16.3 percent. 41.1 percent is his estimate for the proportion of all clients having psychiatric problems.

Another way of raising this issue is through a question: if 67:1 is appropriate for the developmentally disabled and 50:1 for the mentally disabled, what average ratio should CCSB have?

- . If dual diagnosis is 7.77 percent, the answer is 65:1.
- . If dual diagnosis is 16.30 percent, the answer is 63:1.
- . If dual diagnosis is 41.10 percent, the answer is 59:1.

It is widely understood that the current 67:1 ratio is an artifact of Proposition 13 budget cuts. This does not mean that it is irrational, or that it fails to reflect CCSB's dual diagnosis population. It could do so, but only by accident. The foregoing figures are thus illustrative of the sensitivity of staffing standards to the dual diagnosis factor, and are not compelling evidence of what staffing ratios really should be.

It is worth noting, however, that Chapter 10 develops a case that 70:1 is the upper limit of ratios which might be consistent with the Lanterman Act and which would allow case managers to perform required duties in a minimum way. If 7.77 percent of clients are dual calculations diagnosed and are staffed (in effect) at 50:1, and the remainder are staffed at 70:1, a 67:1 would result. This is, of course, CCSB's current ratio.

We have no reason to believe that the incidence of dual diagnosis among CCSB clients differs from regional centers. The behavioral consequences might be more exacerbating in CCSB, simply because adults are harder to control. Nevertheless, there is no strong reason to conclude that either system's cases are typically more difficult than the other's or that any difference which may exist is so

great that it ought to affect staffing ratios. We also have no reason to believe that the CCSB is more efficient than regional centers. Consequently, the conclusion reached in the previous section--that CCSB clients receive a lesser quantity of service than those of regional centers--is reinforced.

Administrative Considerations

Earlier this year the Department of Developmental Services reinstated its opt-out program. Opt-out gives a regional center the choice of serving all clients in its area directly, thus eliminating CCSB. Three regional centers had previously opted out, and 13 of the remaining 18 appear to be headed in this direction. This raises serious questions about CCSB's future role.

Even in its diminished situation CCSB could have a unique value for the State as a "yardstick" for measuring the comparative performance of regional centers. The argument here is analogous to that made by the proponents of the Tennessee Valley Authority in the 1930's, who believed that by putting some dams in the hands of the government they would be able to get a better fix on the performance and charges of private power companies. One facet of this argument is that a "yardstick" agency can act as a source of competition and innovation, where ideas can be tested and proved under controlled conditions.

To act as a "yardstick" it would be useful for CCSB to have a staffing ratio equal to that of the regional centers. The somewhat tortuous calculations shown earlier in this chapter illustrate how

difficult it is to compare the two organizations. While unequal caseload is one of several factors which complicate comparison, it is a basic one.^{4/}

Making staffing ratios equal has the potential side-benefit of reducing an artificial incentive to opt out. Right now, opting out is in general a "good thing" for clients because it has the automatic consequence of bringing them under the 62:1 staffing ratio. Presumably, this should not be a factor in the regional centers' considerations, but directly or indirectly, it probably is.

If all but five centers opt out, a rough estimate of the cost of bringing CCSB to a 62:1 ratio is \$124,000. If half of the 18 regional centers opted out, the cost would be \$217,000. Staffing parity would also result from trading off savings in regional centers for added CCSB costs. A ratio of approximately 62.6 to 1 would equalize both organizations at no added cost.

Summary

Conservatively, 23 percent of CCSB case management time is devoted to special events and incidents. Combined with CCSB's higher staffing ratio, this factor makes it unlikely that CCSB clients are served as well as those of regional centers. This is especially true because we cannot establish that either organization's cases are typically more difficult than the other's, or that there are systemwide differences in efficiency.

^{4/}Different procedures, policies, and clientele groups also make comparison difficult.

Considering the staffing ratio which might be appropriate for dual diagnosis clients, the 67:1 ratio which applies to CCSB appears to be the highest possible ratio consistent with the intent of the Lanterman Act.

There is some merit in using CCSB as a yardstick for measuring the performance of regional centers. This suggests that the two entities should have equal staffing ratios; and if parity were established, artificial incentives for opting out would be removed.

Finally, it appears that CCSB and regional centers be budgeted at identical caseload ratios. The best expectation is that this would cost \$124,000. A no-cost alternative would be to staff both organizations at approximately 62.6 to 1.

CHAPTER VI
MANAGING SHARED AND HOSPITAL CASES

Case sharing occurs when a client from Region A moves on a temporary basis to Region B, and the travel distance between the two is so great that it would be unreasonable for A to continue direct case management services. This occurs most often with minors, whose residence is defined by that of their parents but who need out-of-home placement facilities--usually specialized ones, such as those for the autistic--which may not be available in their home region. When a case is shared, the sending center continues to pay services costs; but the receiving center absorbs the client into its caseload without remuneration for case management. The receiving center must provide full case management services.

When a move to another regional center is a permanent one, the case is transferred. The Regional Centers Operating Manual (RCOM) requires the sending center to continue providing services funding, unless the receiving center has funds available or until the receiving center has an opportunity to obtain budgeted funds for the client.

In theory, both systems are equitable on the grounds that the movement of people among centers will balance out. In practice, there are a number of problems--not the least of which is that the theory is dead wrong.

Shared Management

At our request, the Shared Management Subcommittee of the regional centers' chief counselors sent out a questionnaire asking for policy and caseload information on this subject. While the returns were far from complete, they are indicative of current practice and are displayed in Table VI-1.

TABLE VI-1
SHARED CASE MANAGEMENT*

Center	Cases Sent	Cases Received	Policy on Following Cases	Travel Frequency	Travel Distance
East L.A.	38	0	Rarely or never	Rarely	No policy
Inland	8	116	Rarely or never	Rarely	No policy
North Coast	27	21	Very closely	Always	No policy
North L.A.	81	5	Very closely	75%	No policy
Orange	65	51	--	--	--
San Diego	41	86	Very closely	Always	No limit
San Gabriel	14	36	Very closely	Always	No limit
Tri-Counties	57	119	Very closely	Always	No limit
Valley Mt.	15	39	Very closely	Always	No policy

*The three policy questions and choices were:

1. When cases are sent, what is your policy toward following them?
(a) Very closely. (b) Only when convenient or in special circumstances. (c) Rarely or never.
2. How often do you follow cases to make face-to-face contacts or observe IPP's?
(a) Almost always. (b) 75%. (c) 50%. (d) 25%. (e) Rarely.
3. What is the policy on distances traveled when cases are followed?
(a) No policy. (b) No limit to travel. (c) 200 mile limit.
(d) 100 mile limit. (e) 50 mile limit.

In some instances, the imbalance between cases sent and cases received is enough to alter ratios by a factor of 2 (from 62:1 to either 60:1 or 64:1). In proportion to total caseload, Tri-Counties was the biggest "loser" and North L.A. the biggest beneficiary among the centers which responded. Because it is apparent that "facility rich" areas receive more cases than they send, it is likely that the balance of transferred cases is also skewed in the same direction as shared cases. (This is true for one regional center which provided us with information on net transfers). Consequently, there may be centers with de facto caseloads of as little as 59:1 or as much as 65:1. The impact of these differences on clients is not easily discernable, but some effects undoubtedly exist.

In addition to distorting actual caseload ratios, the system of shared case management has other problems:

1. Duplicate review of service purchases. Receiving centers must plan for purchased services, yet bills are paid by sending centers. This results in added paperwork and duplicate review of a proposed purchase.
2. Duplication of management services. Receiving centers are required to provide full case management services. Nevertheless, as Table VI-1 indicates, some sending centers continue to participate extensively in such activities as IPP's and face-to-face contacts.
3. Excess travel. Any duplicative case management activity requiring travel is per se excess. However, regional centers do not appear to distinguish between the case management time and travel costs of short trips and trips which may run the entire length of the State.

Three additional problems stem from the failure to ask for shared case management when it might otherwise be warranted.

4. Excess travel to adjacent areas. Many placements are made near to, but outside of, a regional center's catchment area. As a rule, these require more travel than if shared management were requested (assuming that the sending center did not try to duplicate the receiving center's management services.)

5. Policy conflict and duplication with respect to care homes. It is conceivable that a single six-bed out-of-home care facility must deal with six different case managers--from CCSB, or various regional centers. This can mean that:
 - a. The provider must deal with different forms, requirements and processes.
 - b. The process of reviewing the home's quality can be confused or duplicative. If problems occur (such as the one discussed on page 16) coordination of monitoring is more difficult.
 - c. While a single regional center can withhold placements in order to force a provider to rectify deficiencies, this discipline is less effective if the home can get placements from elsewhere.
6. Management of hospital cases is costlier and less effective than it could otherwise be. This will be discussed in greater detail below.

The Lanterman Act mandates regional center approval of hospital placements and referral of discharged patients to the regional centers. Since patients are necessarily regional center clients (and in the absence of any specific exemptions in the law), case management continues during the period when a person is hospitalized. Two reasons for this (other than the law itself) have been advanced. One is the client's need for an independent advocate within the hospital. Allegedly, an advocate who knows the hospital system will be able to "lobby" hospital staff for developmentally advantageous placements which might not be the easiest or most bureaucratically comfortable for the hospital to make; to detect and prevent abuses or neglect; and to push for a client's release. Second, it is argued that the regional center which will be receiving a released patient should know something about that person in order to arrange for an appropriate community placement, and to coordinate with parents.

The need for this advocacy is a matter of judgment. Presumably, if the State ran its hospitals according to the same standards applied by regional centers the advocacy would be a duplication of effort. The counter argument is that any administrative organization is subject to some self-serving tendencies, and that the injection of regional center case managers into the hospital setting provides a healthy tension which the hospital itself could not provide. Whatever the case, the law does require regional center involvement.

This involvement is relatively inexpensive. Case loads for hospital liaison staff often range between 100:1 and 150:1, implying a total cost of \$200 to \$300 per client each year.

However, there are instances where regional center staff must travel extensively in order to follow hospital cases. The worst case, to our knowledge, occurs from Prista Regional Center. It manages over 300 cases at Porterville State Hospital. The distance involved is 227 miles by car, or a flight from San Jose to Fresno plus 80 miles by car. The number of cases involved here is unusual and results from the fact that San Jose was on the northern fringe of Porterville's old catchment area. Other regional centers have a few cases which must be followed from one end of the State to the other. More typically, a center will have substantial placements in several hospitals which are one or two hours driving distance from the regional center headquarters.

In interviews with managers of hospital cases and as a result of accompanying one of them to several meetings on hospital grounds, it became apparent that case managers operate at an advantage when they

are familiar with staff and clients, and have an intimate knowledge of the strengths and weaknesses of different hospital programs. In one Individual Program Conference (IPC) we observed, the case manager obtained a change of wards which was advantageous to the client but which some staff members seemed reluctant to approve. It appeared that the success was due to close prior consultation with sympathetic hospital staff members and a thorough knowledge of the case. This case manager was approached by a number of clients in the hospital's corridors, and it was apparent that he was able to use these informal contacts to extract information about clients' progress and satisfaction with programs. In this instance the case manager was from Valley Mountain--located a few blocks from Stockton State Hospital. It is doubtful whether the quality of case management activity would have been as high if the hospital were 50 or 100 miles distant.

A related problem is the reluctance of some hospitals to schedule IPC or other meetings for the convenience of regional center staff. If a regional center has only two clients in some distant hospital, it is possible that one will be scheduled for an IPC on a Monday and another on a Wednesday. This causes a good deal of "dead" time; excess travel; or missed meetings. We have not heard the hospitals' side of this story; but while there is no doubt that they face scheduling problems, the time and cost for regional centers would seem in many cases to outweigh the problems of scheduling hospital staff for meetings.

The alternative to the present system's travel and scheduling difficulties is for regional centers to handle most hospital cases on a shared management basis.

One objection to this is that the regional center should be acting as a link between parents (who presumably live near the center) and the hospital; and that the center must have some knowledge of the client in order to prepare for a community placement. However:

1. Most clients will stay in the hospital for a long period of time. The argument that contact with a client's home regional center is necessary in order to make placement preparations is fatuous, unless discharge from the hospital is imminent.
2. Some--perhaps many--parents are only peripherally involved with their hospitalized children. By phone, their access to a local regional center or to the center nearest the hospital is equally easy. Alternatively, parents could ask their local center to obtain information from the center nearest the hospital about their children's programs, progress, or well being. That would be a low cost activity for the local center, compared to the travel which would be required if the local center actually managed the case.

Some regional centers would be reluctant to lose wholesale numbers of cases. However, in the absence of compelling evidence that such centers do a better job of managing cases than others, both treatment and cost considerations make shared management a preferred alternative.

It is possible for DDS to require shared case management for any client living outside a regional center's catchment area and to institute some simple exemptions to the requirement which fit the needs of exceptional cases. Such exemptions might include:

- a. Clients who will be returning to the regional center's catchment area within one year.

- b. Clients who reside very close to the regional center's catchment area, such that travel time to their place of residence is not appreciably greater (e.g., one half hour) for the sending center than would be for the receiving center.
- c. For hospital placements, a sending center might exempt from the shared management requirement a number of cases which is equal to twice the number of cases discharged from hospitals through that center during the previous fiscal year.
- d. Additional exemptions at the discretion of DDS, made on a case-by-case basis.

The special exemption for hospital cases (c) gives centers which have been successful in removing clients from hospitals greater control over cases. It responds to the concern of such centers that if their cases are managed by regional centers which have not demonstrated a great interest in making community placements, clients will languish in State hospitals for excessive lengths of time. Overall, a system such as this appears flexible yet adequate to assure that shared management will be used whenever there is a significant advantage in so doing.

One corollary to such a requirement is that a system would have to be established to reimburse receiving centers for case management costs. A center located near a hospital should not be asked to shoulder significant shared management costs without additional funds. DDS could establish standard reimbursement rates (different rates for hospital and non-hospital cases, since caseloads for each are usually quite different), and could arrange either a system of direct billing between centers or a State level clearinghouse for shared management payments.

Such a billing system might also be used for services costs, both in shared and transferred cases. Under current procedures sending centers must pay for the services costs related to each case. The (receiving) center actually handling the case arranges for services which it deems necessary. These decisions are ratified by the sending center or rejected in what could amount to a duplicative review and what is in any case an added paperwork process. Under some circumstances this also occurs when a case is permanently transferred, though this is for a limited period. One alternative would have the sending chapter automatically forward any funds budgeted for a case, so that duplicative review and special billing will occur only when those funds are exhausted. Receiving centers might use their own services funds for slight overages, since this would be simpler and less time consuming than special billing.

Summary

We have suggested requiring shared management of certain cases, and letting both case management and services money follow the client for both shared and transferred cases. These procedures will save travel time, eliminate duplicative review of purchased services, and (especially for hospital cases) contribute to more effective case management.

CHAPTER VII

TRAVEL

Several regional centers contend that their caseload ratios should be much lower than others because they face very difficult travel problems. North Coast has in the past justified a ratio of 43:1 because of the extent of territory it covers and because of the region's mountainous terrain and slow, winding roads. On the other hand, Far Northern (based in Redding and covering northern, inland counties) faces similar problems but operates with near-normal caseload ratios. This is also true for Valley Mountain's San Andreas-based staff.

In order to answer the question of what staffing adjustments are needed because of travel problems, we asked four regional centers to provide copies of all travel claims for the months of October-December, 1978. Two of the centers were based in Southern California. They were selected to provide an example of what travel frequency and distance might be when travel problems were minimal. North Coast was an example of maximum problems. Valley Mountain--which has offices in Stockton, Modesto and San Andreas--was expected to fall in between the extremes. Far Northern was not a part of our survey, but did provide some useful comparative data. Table VII-1 summarizes the results.

VII-1
TRAVEL PATTERNS IN FIVE REGIONAL CENTERS*

<u>Travel Per Case Manager</u>	<u>North Coast</u>	<u>Valley Mountain</u>	<u>Orange County</u>	<u>Lanterman (L.A.)</u>	<u>Far Northern</u>
miles/month	718	378	331	236	802
miles/trip	48.7	21.4	28.8	23.3	N/A
trips/month	14.7	17.7	11.5	10.1	N/A

*These figures exclude staff members who work exclusively with hospital cases and also exclude case aids who do not have an assigned caseload. Far Northern includes all staff, however.

Monthly travel mileage per case manager is very close to what was expected. Lanterman Regional Center (formerly Childrens Hospital of Los Angeles Regional Center) is based in a densely populated area. Orange County has a larger catchment area. Valley Mountain's is larger yet, and its 378 mile per case manager figure is lower than might have been expected. Because it encompasses a greater geographical area, Far Northern staff cover more ground than North Coast's.

The other data contain some anomalies. Far Northern and Valley Mountain staff make significantly more trips than do case managers in the South. This is contrary to the expectation that travel barriers would force them to economize on the frequency of trips. The second anomaly is that Valley Mountain's mileage per trip is lower than we would expect. In theory it should be higher than Orange County's, but instead it is the lowest of all.

The raw data contain an explanation for Valley Mountain's results. Many VMRC staff members--especially those based in the mountainous area--make and record what we might call serial trips. They go from their home (or headquarters) to visit client A; then to B; then to C; and so forth, until they return to base. We found some serial trips at other regional centers, but not as many. The travel pattern for most case managers is, by contrast, to make a round trip to a particular location from their headquarters office. The effect of Valley Mountain's practice is to raise the number of trips and to economize on mileage.

Table VII-1 is potentially misleading in the sense that the results (except for monthly mileage) may be artifacts of different travel recording practices. We doubt that this is so, or that more punctilious recording by the centers other than VMRC would make a significant difference in the comparative results. In most cases the staff at other centers did a good job in identifying the clients with whom they had worked or the different cities to which they had gone. Where there was reasonable doubt--for example, where a case manager was working with a single individual but showed travel to two different cities--we tallied two separate trips, even though the travel form showed a single, continuous trip. Thus, Table VII-1 appears to be generally accurate.

Even when Valley Mountain's serial trips are consolidated (dropping total trips for the three-month period from 777 to 661) VMRC

still averages 15 trips per case manager and 25.2 miles per trip.^{1/} This means that both North Coast and VMRC are similar in their trips per month; and that their staff travel more frequently than do personnel in the two Southern California Centers. Moreover, the question of why VMRC's artificially consolidated trip length average (25.2 miles) is less than Orange County's (28.8) still remains.

These questions can be answered only in the form of hypotheses:

1. Where topographical barriers to travel exist, clients may have trouble getting to a regional center. Some additional travel by case managers may be the only practical way to compensate for this.
2. It is possible that North Coast and Valley Mountain are different from the Southern Centers in terms of policies which affect travel.
 - a. Of 17 regional centers responding to a survey which was a part of this study, North Coast was one of two entities which stated that their philosophical model for case managers leaned strongly toward social work. This implies a greater preference for face-to-face contacts than may be present elsewhere. In addition, because counseling is time-intensive it would be comparatively difficult for a North Coast case manager to make serial trips during a single day. If significant amounts of time were spent with each client, this factor combined with long and slow travel would make it difficult to visit more than one client per day.
 - b. As a part of JCAH accreditation requirements, Valley Mountain staff must make more frequent face-to-face contacts than staff at some (but not all) other centers.
3. In examining the travel of Orange County case managers, we noted many long trips to out-of-county placements in such places as San Diego, San Bernardino, and Pomona. Apparently, many cases are not handled on a shared management basis. Thus, the Regional Center of Orange County serves a territory which is somewhat greater than the county's geographical boundaries suggest.

^{1/}Consolidation means taking four trips, for example, from point A to B, C, and D and treating it as one. While this has a significant effect on trips per month, it has a lesser impact on comparisons of miles per trip because the efficiencies of serial trips are still preserved in the form of less mileage than if all trips were on the pattern of office--field visit--return.

While these are no more than hypotheses, we believe they are correct and that they account for the data anomalies.

Travel Costs and Cost Reduction

The primary purpose of Table VII-1 was to demonstrate travel frequency. Where topography was no problem--in Southern California--we expected that case managers would travel more often than where travel was more difficult. This would have established a base or norm which, together with information on average trip length and speed, would have allowed a calculation of appropriate adjustments to the staffing ratios of centers where travel problems prevailed.

Because our findings were the opposite of what was expected, namely that case managers in the South traveled less often than those in the two Northern centers, straightforward calculations must be preceded by further analysis and by policy decisions. The experience of Orange County and Lanterman centers indicates that it is possible for case managers to do a reasonable job when making only 10-12 trips per month. The issue then becomes one of whether the State wishes to pay (through caseload ratio adjustments) for the extra travel by other centers. The issue splits out into three component questions:

1. Is a travel-intensive approach to case management a reasonable policy choice for centers which may be poor with respect to available facilities and services?
2. Are there possibilities for efficiency improvements?
3. What would all this cost?

The answers are not easy.

It is worth noting that the Lanterman Act (W&I 4651) includes an expression of legislative intent "to encourage regional centers to find innovative and economical methods of achieving the objectives contained in the individual program plans..." A reasonable interpretation of this provision is that the style of case management need not be the same everywhere in the State. On the other hand, the admonition that methods must be economical limits the extent to which styles can vary from an efficiency model, at least when there is no clear evidence that such variations have a compensating effect on IPP success.

There is some middle ground here. We have hypothesized that in part the more extensive travel in Northern counties may be due to a lack of facilities and programs in rural areas. This means that centers should be able to make some savings in services costs in order to fund additional trip frequency.^{2/} In short, if neither the department nor the regional centers affected can prove that more frequent travel has a compensatory positive effect on client progress, a limited tradeoff between services and case management money would allow regional centers to exercise their best judgement about "innovative" travel-intensive services without violating the criterion of economy.

Improving Travel Efficiency

We believe that there is considerable room for improvement in the efficiency of travel by case managers. Two examples have already

^{2/}As it happens, both North Coast and Valley Mountain have services costs which are greater than the State average. This shouldn't preclude making a tradeoff, but it does make it more difficult.

been discussed. In the previous chapter we recommended greater use of shared case management--especially for hospital cases. In this chapter, the only explanation for the greater-than-expected trip length of Orange County staff was the probability that shared management is not used often enough.

The second example of efficiency is better travel planning, which takes the concrete form of more "serial" travel and fewer trips which take the form of office-field visit-office round trips. The planning of daily work activities such as this is such an individual matter that it would be difficult to mandate or recommend any statewide standards. However, if case managers and supervisors would review travel records as we did, they would find many instances where reasonable forethought would have precluded unnecessary travel.

Beyond this, we found many examples where the need to travel was quite questionable. For example, at North Coast there were repeated examples of personnel from the Center's Ukiah office traveling to locations near (e.g., ten minutes travel time) the Eureka office, and vice-versa. The distance is over 300 miles, round trip, and represents over six hours on the road. The reasons for these visits were to look at potential placement homes, to make placements, and to visit clients. Pre-placement visits may--and placements do--require transportation of a client. At \$12.50 per hour of direct (not to mention overhead) case management salary costs and at \$8.50 per hour of transportation costs (.17¢ x 50 MPH) this is expensive bus service.

An alternative would be to hire a van to make one or more round trips per month, carrying clients in each direction. Staff at the receiving end could then provide pre-placement or placement service.

While this example involves only one regional center, our various surveys yielded many instances where cooperation between regional centers, CCSB offices, or between a regional center and CCSB would have precluded the need for day-long trips. Case managers are--or should be--competent professionals who have shared technical knowledge and experience. A person who is placing a client should be able to obtain adequate information about that facility by phoning other case managers who are familiar with it.

Another option is to make better use of case aids. At Far Northern, case aids are located in many counties. They perform welfare and program monitoring functions which in other parts of the State are usually the responsibilities of case managers. For many functions, the difference in performance between a case aid and a case manager is small or negligible. The salaries of case aids are usually much lower than for case managers, and when this fact is combined with reduced travel the potential savings are significant. For any given level of salary expenditure, case aids would be able to spend considerably more time working directly with clients than would a case manager. Thus, any technical competence lost in the tradeoff could be compensated at least in part by more time intensive services to the clients. This is not to suggest that case managers can be replaced completely, but only to say that a better and less costly mix of services is possible.

To elaborate further, there is no apparent reason why competent professionals outside of the developmental disabilities system could not perform valuable services. Schools now have a major responsibility for the developmentally disabled. Where a small and remote town has only one or two DD clients, a teacher, social worker, nurse or other professional could be enlisted to perform some case aid functions. Such a person could not only spend more time with the client than a case manager, but has the advantage of being on the spot. In case of an emergency, they have an intimate knowledge (unique in small towns) of factors affecting a client's environment which a case manager would rarely acquire. Such persons might be paid through the system where they are regularly employed; on an hourly basis by the regional center; or might even work as volunteers.

A final alternative would be for regional centers to establish more field offices. There are pro's and con's to this option. On the one hand:

- * There are some additional rent and facility costs.
- * Secretarial help must be arranged.
- * The manager must assume ministerial duties--such as arranging to have the carpets cleaned--which are handled more efficiently in a larger office.
- * Training and supervision are more difficult, and entail some travel costs which would otherwise be avoided.
- * Because of their visibility, branch offices could generate some new cases.

On the other hand:

- * Part-time secretarial help can be arranged on an as-needed basis, with no real addition in costs.
- * Where caseload is less than 62, the case manager presumably has some time to perform ministerial responsibilities. There would be no additional cost.

- * If clients are eligible for and need services, new clients are a positive factor. Regional centers have an outreach responsibility, and where caseload is less than 62 the marginal case management costs of a new client are negligible.
- * There are net travel savings.
- * When caseload is less than 62 the case manager can work more intensively with a given client, possibly substituting his time for the cost of a purchased service such as infant stimulation or counseling. Even when there is no such substitution, the quality of service is marginally greater.
- * There are some advantages to having a case manager living in a rather remote community, especially when emergency situations arise.

The case for establishing a branch office at a particular site depends upon a combination of its distance from a case manager's base of operations (either home or office), the number of clients to be served, and their precise location.

Each case should be treated individually. The only real dollar elements are travel cost savings and rent. When these factors come close to balancing out, the potential for service improvements suggest that it would be desirable to add an office.

We believe that branch offices would be more widely and effectively used if case management ratios and staffing formulas reflected these unusual situations. For example, if a branch office is justifiable in a location where there are 50 clients, the "deficit" between 50 and 62 would have to be picked up by other case managers. Their average caseload would rise fractionally to balance out the low caseload in the branch office. This subtle penalty could be eliminated if staffing for branches which are economically justified on other grounds were considered separately from overall caseload ratios.

Travel Costs

We estimate that the direct cost of travel is between \$17.60 and \$21.00 per hour. These figures are based on case managers' wages and

fringe benefits of \$12.50/hour and .17¢ per mile. The low cost represents a 30 MPH average speed and the high cost 50 MPH.

Chances are good that speeds do not vary significantly in different sections of the State. All regional centers are located in urban areas and many if not most of their clients are reached on surface streets. For these clients, travel speeds would be quite similar. In other cases freeways are available both in major metropolitan areas and in rural areas. Rural roads can be tortuously slow but jammed urban freeways can be slower. In North Coast's area the slowest roads are often reached by faster freeways. Another element of balance with the rest of the State is that even when a case manager travels at 35 MPH to reach a client in a small mountain community he is probably going as fast or faster than someone in a place such as Pomona, where all travel requires extensive movement on surface streets, stoplights, etc.^{3/}

Especially in view of the cost similarity (\$17.60 vs. \$21.00) of various speeds, the basic similarity of travel speed throughout the State leads to the conclusion that any adjustments in case management

^{3/}Putting this in statistical terms, for the State highway system in 1973 18 percent of vehicles moved at speeds of less than 35 MPH. By region, the percentages were: L.A., 18 percent; San Francisco, 27 percent; San Diego, 24 percent; Sacramento, 8 percent; Northern Counties, 28 percent; South Central Coast, 14 percent; San Joaquin Valley, 7 percent; and Eastern Sierra, 0 percent. When considering the problems of moving through off-highway traffic, the speed of vehicles in metropolitan areas may be slower than in places such as North Coast. See M. Mehdi Morshed, Inventory of Transportation Facilities and Equipment, State of California Business and Transportation Agency, 1976, p. 120.

staffing ratios for travel factors should be made on the basis of travel frequency and distance, and not speed.

35 MPH is a rough average of auto trip speeds in the most recent surveys in L.A., Sacramento, and San Diego.^{4/} Returning to Table VII-1, we can use this figure to compute staffing adjustments attributable to travel frequency and speed, as follows:

718	=	North Coast, average monthly mileage
331	=	Assumed normal mileage (based on Orange County)
718-331	=	387 miles
387 ÷ 35	=	11 hours additional travel time needed by each North Coast case manager.
20	=	Current number of North Coast case managers.
20 x 11	=	220 hours per month needed to compensate for travel difficulties.
140	=	assumed number of hours available for work on the part of each case manager.
220 ÷ 140	=	1.57 extra case managers needed.

As of October 7, 1978 North Coast was reported to have 1,002 active cases. At a 62:1 caseload ratio, 16.16 case managers would be needed. When 1.57 additional case managers are added, the total becomes 17.73; or 58:1.

This ratio is significantly different from the 43:1 ratio which North Coast has claimed to be justified in the past. At \$31,000 per position, there is an apparent potential for saving \$173,000 in case management costs by budgeting North Coast at a 58:1 ratio. It is worth

^{4/}Peter L. Hathaway, Movement of People in California, California Business and Transportation Agency, 1976, p. 29. This includes street and freeway travel. Specific figures were L.A., 33.8 MPH; Sacramento, 32 MPH; and San Diego, 38 MPH.

noting that the difference is based on North Coast's actual monthly travel average during the sampled months and does not reflect any adjustments for improved efficiency, reductions in trip frequency, etc.

Summary

Our survey of four regional centers revealed important differences in trip frequency, trip length, and total mileage traveled by case managers. While some of these differences may be due to the way in which case managers record travel, it appears that they are primarily attributable to a combination of geography, the availability of service resources, and management philosophy.

Travel efficiency can be improved by:

- * Greater use of shared management (as recommended in Chapter V).
- * Better travel planning by case managers and improved review and control by supervisors.
- * Eliminating unnecessary trips which occur when case managers fail to share information or cooperate in the placement process.
- * Finding alternatives to the use of case managers in the transportation of clients.
- * More use of case aids.
- * The use of branch offices, when economically justified.

In addition to these general points, we have identified a specific opportunity for saving \$173,000 at North Coast Regional Center. The methodology used in this estimate can be used elsewhere to justify additional staffing. However, we believe that it is unlikely that travel problems in any other regional center would require any significant adjustment from the statewide average staffing ratio.

CHAPTER VIII
CASELOAD RATIOS IN OTHER STATES

One approach to examining a difficult issue is to review the experience of other governments which face the same problem. This never yields a compelling answer: the other 49 states could be wrong! However, systematic comparison does signal whether California is seriously out of step with others. If so, one next asks why a difference exists.

Unfortunately, our effort yielded very little.

We queried 34 randomly selected states about the status of case management. Phone calls were followed up by requests for written information, which in most cases consisted of copies of the State's Developmental Disabilities Plan. What we found was that in many places there is no formal statewide caseload ratio. Many case management systems are in an embryonic stage.

P.L. 95-602 (1978) required that in order to receive Federal funding for the developmentally disabled, states must choose one of four operational models: child development, alternative living, case management, or non-vocational social development services. Many states appear to be following California's lead by selecting the case management model; and it is in fact California which is the focus of interstate comparison by other states. How were the developmentally disabled cared for prior to P.L. 95-602? It appears that many

clients were managed by non-profit community service agencies which are funded from a variety of sources and for which states seldom keep aggregate data. This approach is quite different from California's.

California's comparatively low rate of State hospitalization may be related to the early development of case management techniques. Table VIII-1 compares California's hospitalization rate for the developmentally disabled in 1975 to the nation's nine other largest states. Clearly, cases which are hospitalized in other

TABLE VIII-1
RATES OF HOSPITALIZATION FOR THE DEVELOPMENTALLY DISABLED
PER 10,000 OF POPULATION, 1975

U.S. Average	
--including California	78.7
--excluding California	82.5
CALIFORNIA	47.2
ILLINOIS	61.0
FLORIDA	65.9
OHIO	74.4
MICHIGAN	77.9
PENNSYLVANIA	84.6
NEW JERSEY	102.5
MASSACHUSETTS	103.0
NEW YORK	109.6
TEXAS	109.8

Source: Council of State Governments, State Responsibilities to The Mentally Disabled (Lexington: 1976), p. 9.

states have in California been released to the community. California would be in some trouble if its case management systems were not more sophisticated than elsewhere in the nation. This State's case management systems came into being when CCSB was formed to handle hospital out-placements as early as 1946. Whether the apparently loose network of community service agencies which serves the developmentally

disabled in other states would have served California's advanced program of de-institutionalization is a question which was apparently resolved some time ago.

The states which did have systematic information on caseloads are reported in data included in Table VIII-2. We determined the

TABLE VIII-2
CASELOADS REPORTED BY A SAMPLE OF 34 STATES, BY
DEGREE OF COMPARABILITY TO CALIFORNIA*

<u>Most Comparable</u>	<u>Caseload Ratio</u>	<u>Hospitalizations 10,000**</u>
NEBRASKA (NCOR ONLY)	35:1	64.7
ALBERTA (COMSERV		
--Children	35:1	N/A
--Adults	30:1	N/A
ARIZONA	52:1	47.2
CONNECTICUT	70:1	113.1
 <u>Possibly Comparable</u>		
COLORADO	90:1	67:1
MINNESOTA	70:1	91.7
UTAH	95:1	70.5
 <u>Least Comparable</u>		
FLORIDA	150:1	65.9
HAWAII	40:1	82.3
MAINE	70:1	55.3
OHIO	80:1	74.4
WASHINGTON	125:1	70.5

*Comparability was determined by primarily subjective factors, discussed in the text.

**California's rate of hospitalization per 10,000 of population was 47.2 in 1975. For hospitalization rates, see Council of State Governments, State Responsibilities to the Mentally Disabled (Lexington, 1976), p. 9.

comparability of state systems primarily on the basis of telephone interviews and a review of written information. Florida and Washington were moved from the "possibly" to the "least" comparable categories for the sole reason that their caseload ratios precluded the formulation of IPP's (including CDER's and annual reviews). IPP's are mandated by California law. When caseload ratios are over 100:1, we believe it would be impossible for a case manager to do anything approaching a minimum quality of work on this and other California activities.

The goals and objectives of California's laws appear to be comparable to Connecticut's. However, that state's very high rate of hospitalization indicates that the type of clients being served there could be quite different from typical California cases. The other comparable organizations--NCOR in Eastern Nebraska and COMSERV in the province of Alberta--are similar in their organization and goals to California's regional centers. They first came to our attention during a preliminary literature search which suggested their comparability and later were cited as being comparable by regional center personnel. Arizona is the one state which appears to be most comparable to California both in terms of the objectives of its programs, the responsibilities of its personnel, and its hospitalization rate.

This effort at interstate comparison does not lead to any definite conclusions. The number of truly comparable states or organizations is too small to allow generalization. Even if the number were higher, there is no assurance that organizations with very low caseload ratios--such as NCOR, COMSERV--are operating in an efficient

manner. For example, when we asked regional center chief counselors to name an ideal caseload ratio, only seven of the seventeen responses we received named a caseload of 35:1 or less.^{1/} Finally, even if we knew that the most comparable entities operated in an efficient and effective manner, the range of staffing ratios (from 35:1 to 70:1) is so great that it provides useful guidance only insofar as it illustrates a range of possibly acceptable practices. The data are not adequate to conclude that one caseload level or another is either an optimal or even a generally recognized standard.

^{1/}Ideal was defined as follows: "This assumes rather plentiful funding. It would allow not only for all necessary and clearly cost effective activities, but also for a reasonable amount of counseling, and humanistic, helping activity."

CHAPTER IX
THE PROFESSIONAL QUALIFICATIONS OF CASE MANAGERS

At various points in this study we have suggested additional use of case aids and volunteers. The usual response to this idea from regional center and CCSB personnel is that such persons lack professional qualifications. This response merits a direct discussion.

The MSW Degree

Table IX-1 shows the academic credentials of case managers at different regional centers. It confirms what some people have told us during this study, namely that for all practical purposes some regional centers believe that a Master's degree in social work (MSW) is a necessary hallmark of professional status.

The belief that case managers must have a Master's degree is troublesome for several interrelated reasons:

- . MSW's are costly. There is a correlation ($r^2 = 0.19$) between average salary and fringe benefit costs at regional centers and the percentage of Master's degree personnel on staff as case managers.
- . The standards recommended for regional centers in a 1977 consulting study on personnel^{1/} indicate that there should be equal pay for equal work in case management positions, regardless of academic background. This implies that at least some persons with bachelor's degrees can do work equivalent to that of MSW's.
- . The different hiring practices exemplified by Table IX-1 demonstrate serious disagreement among regional centers about appropriate standards.

^{1/}"Classification Guidelines for Association of Regional Center Contracting Agencies," Griffenhagen--Kroeger, Inc., 1977.

TABLE IX-1
ACADEMIC BACKGROUND OF CASE MANAGEMENT STAFF*

<u>Center</u>	<u>AA or HS Degree</u>	<u>Bachelor's</u>	<u>MSW</u>	<u>Other Post- Baccalaureate</u>
Alta California		19 %	81 %	
Central Valley	9 %	20	52	18 %
East Bay		7	93	
East L.A.	21	37	32	10
Far Northern		25	67	8
Golden Gate		24	76	
Harbor	3	73	3	20
Inland	14	18	52	16
Kern		22	22	56
Lanterman	4	15	46	35
North Bay	15	22	26	37
North Coast		58	25	17
North L.A.	5	26	44	26
Orange	8	47	27	19
San Diego	10	33	52	6
Tri-Counties			73	27
Valley Mountain	5	52	14	29
Western		29	71 **	

*Some centers did not respond to this survey. Figures exclude non case-carrying case aids, and may be slightly imprecise in some cases due to difficulties in making this distinction.

**Contains some persons with other post-baccalaureate degrees.

- . Credentialism can be a bar to equal opportunity hiring. At least one regional center with a very high proportion of MSW's had what we were told is a serious problem in finding adequate numbers of Spanish-speaking case managers.

These matters should be of direct concern to both the Department of Development Services and the regional centers.

Opportunities for Volunteers and Case Aids

In addition to cost and effectiveness implications, the equating of case management competence with an MSW degree is a bar to innovative staffing practices.

It is fairly clear that each active client needs a professional case manager. Professionals (regardless of whether they are MSW's) are needed for diagnosis, assessment, program planning, and as a central clearance point for forms and records. However, much of a case manager's time is spent on activities which could be performed by reasonably intelligent and sensitive "non-professionals".

This point of view is reflected by the Lanterman Act's requirement (W&I 4592) that area boards "encourage and assist in the establishment of independent citizen advocacy organizations that provide practical personal services" to the developmentally disabled. Some specific instances of where this help could be used have been discussed in earlier chapters, and include:

- "Welfare monitoring", which we have defined as checking into the basic health and well being of clients.
- "General assistance" with such everyday problems as transportation.
- Special responsibilities for clients living in remote communities which are not easily accessible to case managers.

The availability of volunteers for these duties is certainly not assumed. The point here is simply that "professionalism" should not be used to exclude volunteers or paid case aides when their abilities are appropriate to particular tasks.

A positive case for the competence of members of the general community can be made.

- Professional case managers have no monopoly on personal sensitivity or desire to help the developmentally disabled.
- Many non-professionals have formal training and experience which is almost indistinguishable from the general background of CFSB and regional center staff members. Teachers, nurses, county social workers, sociologists and psychologists are among the groups where there is some parallel training.
- By working with professional case managers, non-professionals can fill in gaps in their experience and knowledge.
- The ability to spend more time on a case might counter-balance a non-professional's lack of experience.
- Physical proximity to a client and a knowledge of the local community are assets which cannot be matched by a case manager who is based in an office which is far from a client's residence.

These strengths could be blended into the case management system to provide more effective and less expensive client services.

An Alternative Case Management Model

An alternative model would include the objective of providing for each client a primary community contact (PCC) who is not a professional case manager. Under some circumstances--such as geographical distance between the case manager and client--PCC's might be paid token amounts, such as \$5 or \$10 per month. Case aides could also be PCC's. The PCC's responsibilities would be commensurate with their skill, interest, time, and individual client need. Welfare monitoring would be a key function. A PCC might be required to visit with a client for a half-hour each month and to report to the case manager any problems needing attention.

Such frequent contact can pay dividends in terms of program monitoring and even diagnosis. If services aren't being received or don't seem to have any impact, a PCC may become aware of it long before a case manager would. Such frequent contact would also provide earlier warnings of a client's personal depression and turmoil, or of behavioral regression. This isn't to say that a PCC would be better at doing such things than a case manager, but only that he would have more time for observation.

We see no reason why PCC's couldn't help with personal services ranging from transportation to the selection of alternative residential facilities. Case managers should be able to obtain good descriptions of care homes from other professionals, and could work by telephone with the PCC to suggest possible placements and criteria for acceptability.

The objective of finding a PCC for each client doesn't mean that a suitable person will be found, or that each PCC can be trusted with such relatively sensitive problems as residential placement. However, if the system had been in place a decade ago and if the PCC had had a constant and harmonious relationship with the client throughout that time, there would be a track record which would allow a case manager to delegate important responsibilities to the community contact.

Savings From an Alternative System

The cost of a case manager is \$31,000 per year, including salary, fringe benefits, and the supervisory and clerical workload which case management positions generate. At 1,464 hours per year for case-related work, this comes out to \$21.17 per hour. An average case takes 23.6 hours per year of case-related work.

Let us assume that a case manager finds 10 PCC's to work with individual clients. They are paid:

3	PCC's @ \$0	(volunteers)
3	PCC's @ \$5/mo.	
3	PCC's @ \$10/mo.	
1	PCC @ \$20/mo.	

Adding an arbitrary 25% overhead factor to these costs results in an average cost of \$100 per year per PCC.

This assumed system reaches a break-even point when each PCC saves a case manager a net of five hours of time per year, and when that savings is translated into additional case carrying by the professional staff.

While there are too many "iffy" variables present to allow a prediction of potential savings, we believe that the use of primary community contacts (PCC's) could save considerable outlays and would have some benefit to clients. Clearly, certain types of cases recommend themselves strongly for inclusion in a PCC system. These would include:

- . Clients whose residence necessitates considerable case management travel time.
- . Clients who have parents or friends who are suitable as PCC's.
- . Clients whose problems are not very complex, and whose primary need is monitoring.
- . Clients who need simple but time consuming case management services.

The compendium of case management services discussed in Chapter II could contain refined guidelines concerning the types of cases where PCC's would be most useful and the appropriate division of labor between case managers and PCC's.

While a PCC network cannot be developed overnight, a multi-year strategy for developing this resource could eventually establish statewide standards which would have a major impact on residential services.

CHAPTER X
STAFFING RATIOS

This study's initial objective was to recommend an optimal caseload ratio for staffing purposes. We quickly concluded that no objective estimate could be made without the use of a long-term experimental model which would measure client impact. It next became our objective to recommend a range of possible, optimal ratios. However, the subjects we have addressed in the preceding chapters do not translate easily or objectively into this form.

We believe that there is enough information available to suggest an "outer range" of caseload ratios which are consistent with the intent of the law--but not necessarily optimal. While not as useful for budgetary purposes as an "inner" or optimal range, this approach does convey a sense of limits. For example, it has been asked why, if CCSB could absorb an increase in caseload to 67:1 without any apparent, disastrous result, the ratio shouldn't be 70:1 or even more. One answer is that at some point it will be impossible for case managers to do the minimal things expected by the Lanterman Developmental Disabilities Services Act. Whether this would be good or bad is another question.

Survey of Chief Counselors

Table X-1 reports the results of a survey of regional center chief counselors, made in April of 1979. The results are of course both judgmental and subject to some possible expression of self-interest. They are on the other hand the opinions of some of the most highly qualified persons in the State. What we can conclude is:

1. The regional centers' current caseload ratio is not "disastrous."
2. CCSB's caseload ratio of 67:1 is too high.

We had previously recommended reducing CCSB's caseload both for reasons of client impact and administrative comparability. This survey lends some force to the conclusion about client impact, especially since it is unlikely that chief counselors have any strong bias in favor of CCSB. Three respondents named 67:1 as the cutoff point for a "disastrous" ratio; so while it is likely that some chief counselors were thinking of CCSB while formulating their response, their answers constitute to some extent an assessment of how successful CCSB has been under its current staffing formula.

Other interpretations of this table are more speculative. The ideal ratio of 42:1 and the disastrous ratio of 66:1 provide some indication of what the "outer range" of acceptable caseload ratios might be. They are not conclusive, however. The fact that the constrained average of 54:1 is lower than current standards is a predictable response. It is worth noting that this figure is fairly close to 62:1; and that almost half of the chief counselors pointed to a figure of 60:1 or over as a definition of a constrained ratio.

TABLE X-1
OPINIONS OF REGIONAL CENTER CHIEF COUNSELORS ON STAFFING RATIOS*

<u>Center</u>	<u>Ideal</u>	<u>Constrained</u>	<u>Disastrous</u>
1	30	45	55
2	35	50	65
3	55	60	70
4	35	47	55
5	45	55	67
6	25	60	75
7	45	60	67
8	30	45	50
9	45	60	80
10	45	55	63
11	40	50	65-70
12	40	52	65
13	55	65	70
14	35	45	67
15	50-55	60-70	70-80
16	55	60	70
17	35	45	55
<u>Average</u>	<u>42</u>	<u>54</u>	<u>66</u>

*Definitions were:

Ideal: This assumes rather plentiful funding. It would allow not only for all necessary and clearly cost effective activities, but also for a reasonable amount of counseling and humanistic, helping activity.

Constrained: This is a ratio which you could "live with," though not necessarily like. It would allow for necessary and some optional activities, but would leave many case managers feeling that more could be done for clients.

Disastrous: At or above this level there would be clear harm to the client due to the regional center's difficulty in providing adequate plans, intervention, and monitoring.

One chief counselor replied that the case leveling system produced an "ideal" result. However, it was unclear whether the ratio referred to was 62:1 or the approximately 54:1 ratio which would have resulted from the chief counselors' initial formulation of the system. Four regional centers did not respond.

Sensitivity Analysis

In previous chapters we established that out of 1,680 hours per year of available work time, 216 are devoted to functions other than case carrying; and we have agreed that a level 4 case requires about 12 hours of effort per year. These facts allow us to ask "what if" caseloads varied from their present levels. Using the other standards of the case leveling system, it is possible to estimate the percentage of cases at each level which would result from any given caseload.

Table X-2 contains this analysis. It asks the question, "with a caseload of 'y', what would the real distribution of cases by level be if the hours a case manager spends on each case were those prescribed by current case leveling standards?" For example, the current assumption for a caseload of 62 is that 1 hour per month (level 4) can be spent on 44 percent of the cases. In other words, the case leveling system assumes that 44 percent of the cases really are and should be treated as level 4. With a caseload of 90 we would have to believe that 54 percent of the cases are level 4.

There is another way of looking at this, of course. At any given caseload level we could hold the percentage of cases constant, and assume that it is the time that is really needed for each case which varies from current case leveling standards. If 44 percent of all cases really are level 4, they could be accommodated within a caseload of 90, if substantially less than one hour per month were spent on the IPP and related work which constitutes typical level 4 activity.

We have not included a table which addresses time variations, in part because our studies at Valley Mountain and CCSB special incidents indicated that the case leveling standards were reasonably accurate. Basic IPP and assessment work takes roughly 12 hours per year for each case. It is the only substantial activity in a level 4 case, and represents half the time devoted to a level 3 client. This does not mean that assumptions about time per case at each level are entirely satisfactory: there was some ambiguity in that data we collected at Valley Mountain, and it might be worthwhile to establish in more definitive terms whether the IPP-assessment process takes 12 or (say) 11.5 hours. Furthermore, we have in previous chapters questioned the need for an annual IPP in all cases, and have raised other efficiency questions (the impact of computerized IPP's, travel, shared management, etc.) which by changing status quo procedures would alter time requirements.

In spite of these questions, assumptions about the underlying difficulty of cases--embodied in Table X-2--appear to be the most dynamic variable affecting the issue of caseload size. Table X-2 is thus useful in mulling the question: "If caseload is 'y', what would the breakout of cases by level of difficulty be, if time per case assumptions is reasonable?" Is the breakout consistent with what we know--from regional center time studies, or from our special incident survey in CCSB? At what point is the breakout so inconsistent that the designated caseload simply doesn't compare with known facts and policies?

TABLE X-2
ESTIMATED BREAKOUT OF CASES BY LEVEL FOR ALTERNATIVE CASELOADS
ASSUMING 1,680 HOURS PER YEAR AVAILABLE FOR CASEWORK*

	CASELOAD SIZE														
	<u>30</u>	<u>35</u>	<u>40</u>	<u>45</u>	<u>50</u>	<u>55</u>	<u>60</u>	62	<u>65</u>	67	<u>70</u>	<u>75</u>	<u>80</u>	<u>85</u>	<u>90</u>
Level 1	16	13	10%	8%	7%	6%	5%	4%	4%	3%	3%	2%	2%	1%	1%
Level 2	46	36	30	25	19	15	12	11	9	9	7	7	4	3	1
Level 3	38	40	40	39	41	41	40	41	43	45	45	41	41	44	44
Level 4	0	11	20	28	33	38	30	44	44	43	45	50	53	52	54

*The resulting percentage breakout was determined on the basis of 1,680 available hours per year. For any caseload size there are a number of different percent distributions, e.g., for a caseload of 80 there may be no level 1 cases and 8 percent level 2. This table uses two criteria. First, for any caseload size we have attempted to keep levels 1 and 2 roughly proportionate to the actual figures used in the case leveling system for a 62:1 ratio. Second, level 3 has been kept fairly constant on the grounds that it will be "picking up" the dropoff in level 1 and 2 cases which occurs as caseload rises.

If the breakout of cases by level is "reasonable" at 62:1, Table X-2 allows us to observe the dynamics of change using this point as a base. We can note that:

1. At ratios of between 60 and 65:1 the breakout is quite similar to the status quo.
2. At the 55:1 level, there are 50 percent more level 1 cases and 36 percent more level 2 cases than at the 62:1 base.
3. A 45:1 caseload more than doubles the number of level 1 and 2 cases, compared to the base.
4. An 80:1 caseload more than halves the number of level 1 and 2 cases.
5. At 30:1 and 95:1 whole levels begin to drop out.

The time base of table X-2 (1,680 working hours) does not make allowance for training, internal supervision, administration, required drills, or community service and education functions. Consequently, Appendix C develops a similar sensitivity analysis based upon the assumption that 216 hours per year are devoted to such activities.

The most important observation in Appendix C is that when we consider non case-related activities, level 1 cases drop out entirely at an 80:1 caseload ratio. At this point--quite clearly--some important policy gets scuttled:

- . If there really is no time for level 1 cases, the main alternative is to send the client back to the State hospital. This is contrary to the intent of the Lanterman Act.
- . If case managers make time for level 1 cases by giving short shrift to IPP's, the assessment and planning mandated in the law are substantially circumvented.
- . If training and supervision are cut, administrative quality and integrity decline.

Similar but more moderate effects would occur at a 75:1 ratio. Consequently, we conclude--and this is a matter of judgement--that a 70:1 caseload ratio is an upper limit to what is compatible with the general intent of the Lanterman Act.^{1/}

This is not to say that 70:1 is ideal or optimally cost-effective. Our data don't provide a basis for such a conclusion, because they lack client impact results. This is merely to say that at ratios above 70:1 it is very difficult to understand how necessary work could be accomplished.

Describing a lower limit is more difficult. The analysis hinges more directly on the impact of staffing ratios on the developmental rate of clients--something we could not measure without use of an experimental research design--than it does on the requirements of the law. It is also harder to use the percentage breakout of cases by level as an analytical tool, since it can be argued that--for example--5 or 10 percent of cases should be treated as level 1 and would benefit from intensive counseling therapy.

The most telling indication of where the lower limit might be is the chief counselors' response to our survey which indicated a numerical consensus that 42:1 was an "ideal" ratio.

Secondly, Table X-2 does show that at 40:1 level 1 and 2 cases are more than twice the estimates for the 62:1 ratio. Level 4 cases begin to drop out at 35:1 and disappear entirely at 30:1. In Appendix C

^{1/}To avoid giving a false impression of precision, we note that we would not disagree if this statement were changed to 69:1 or 71:1.

the doubling of level 1 and 2 cases occurs at 45:1, compared to 62:1. Doubling is a very rough and judgemental standard, of course; but it would be surprising if the number of cases now being served by the system at levels 1 and 2 were only half the number that should be served. If this were the case one would expect to find, in interviews with case managers, numerous and vivid examples of harm to clients resulting from inadequate time spent by the case managers. The only instances where such anecdotal material was observed were when we sought out people with extraordinarily high--better than 100--caseloads.^{2/} As for the "disappearance" of level 4 cases at very low caseload ratios, it would again be surprising if every person in the system merited and needed more than the minimum time allowed for level 4 cases. If this were true, it would be tantamount to saying that all developmentally disabled persons in the State are rather significantly underserved; and that is hard to believe.

A third factor pertaining to a description of a lower limit to caseload is the concept of normalization which underlies the Lanterman Act. Normalization is a theory which suggests that developmentally disabled persons develop more rapidly when surrounded by normal people and conditions than when they are placed in institutions or other settings where appropriate role models and learning opportunities are unavailable. We asked several staff members involved in drafting the Lanterman Act whether it was intended to implement the normalization

^{2/}This was at Loma Prieta Regional Center, and was a temporary condition.

theory, and they agreed that this was so.^{3/} These same persons gave some tentative support to the idea that when caseload ratios are very low, the interference of case managers in the lives of clients--however well intended--can limit normalization.

It should be said--and the language of the Act supports this--that the same staff members believed that economy and efficiency were perhaps more important to the definition of a lower limit for caseload ratios than the normalization argument. Nevertheless, the idea that reduced caseloads are always preferable is at some point wrong. Not only does the general economic rule of diminished marginal utility take effect but, in addition, opportunities for normalization are reduced. The most straightforward example of diminished marginal utility has been cited in previous chapters: among the releasees from Pacific State Hospital studied by Edgerton,^{4/} virtually all of them found "friends" in the community who did some of the same things that social workers would do, if social workers had the time.

Consistent with the analysis in Chapter 9, these patient benefactors in the community for some purposes may have performed as well as case managers would have; and perhaps their personal interest and motivation enabled them to perform better. Our analysis of professional qualifications in Chapter 9 led to the conclusion that professional case managers are most needed for IPP's, assessment, and similar activities

^{3/}"Normalization" is similar to the "least restrictive environment" concept found in Federal laws governing the education of handicapped persons.

^{4/}The Cloak of Competence, op. cit. The main discussion of this appears in Chapter 2.

which most require experience and training. These activities are usually related to level 4 cases, which disappear from the system as caseloads decline. The exception to this level 4 relatedness is long-term therapeutic counseling which, we concluded in Chapter 2, is not a legitimate case management service under the Lanterman Act. This was clearly confirmed by staff members who helped draft the Act. (Of course, counseling on a Purchase-of Service-basis is regarded as reasonable.)

The result of this rather speculative analysis is our conclusion that 45:1 is a lower limit to what is reasonable, normalizing, and efficient practice consistent with the Lanterman Act. This is not to say that 45:1 is optimally effective or that, given the judgemental nature of our reasoning, the true figure couldn't be 44:1, or 46:1.^{5/}

Conclusion

The finding that 45:1 and 70:1 define the lower and upper limits of efficient and effective case management can be helpful in future staffing discussions. It does not in any sense imply that an optimal balance will be found by splitting the numerical difference between the two figures.

The upper limit means that CCSB caseload cannot be increased by much without raising some serious questions about performance effectiveness. By the same token it supports indirectly the reduction of CCSB caseload which was recommended in an earlier chapter, both on grounds of performance and administrative criteria.

^{5/}In other words, we believe the correct figure would be closer to 45:1 than to either 40:1 or 50:1.

The finding that there is an upper limit to caseload does not have immediate consequences for regional center staffing ratios, as it does for CCSB. The regional centers' 62:1 ratio could well be optimal, and is far enough away from 70:1 that even somewhat reduced staffing would not conflict with the finding. The opportunities for improved efficiency recommended at various points in this report--notably with respect to shared case management and travel--will allow improved effectiveness if the staffing ratio remains unchanged or will maintain effectiveness at a moderately higher caseload ratio.

APPENDIX A

EXAMPLE OF REPORTED EVENTS, ACTION STEPS, AND TIMES
FROM CCSB SPECIAL EVENT STUDY (CHAPTER V)

- A. 25 year old MR woman ran away for 3rd time from work/activity (W/A) program. On two previous runaways she was picked up by strangers in cars and driven to BCH some 20 miles away.

<u>Activity</u>	<u>Minutes</u>
1. Phone call from workshop director to case manager from Salinas while in training session San Jose reporting run away.	5
2. Phone call from case manager to Salinas office to advise secretary of events and give instructions.	5
3. Phone call from secretary to case manager to advise a social worker from MD Unit in Salinas recognized client, picked her up on street and returned her to BCH.	5
4. Home visit to client and care providers.	60
5. Phone consultation with Director of Sav-A-Work W/A Program.	20
6. Phone consultation with client.	15
7. Staffing with client, care provider and W/A Director.	35
8. Phone call from W/A director--client refusing to attend W/A again.	5
9. Phone call to client. She does not want to go to W/A--she will run away again.	15
10. Phone call to staff member advising not to force attendance at work/activity.	10
11. Phone call to Operator of home to request her set set up appt. with psychiatrist for client.	10

<u>Activity</u>	<u>Minutes</u>
12. Phone call to mother of client.	10
13. Phone call to client to set up consultation.	10
14. Home visit to client and care provider re chronic resistance to attend W/A Therapeutic intervention via private psychiatrist or Monterey C. Mental Health needed--appears overmedicated.	<u>75</u>
Total (in hours and minutes)	4 hr., 40 min
B. Moving client from old facility to new facility. Client experiencing undue emotional stress.	
6/11 T/C to psychologist	15
T/C to psychiatrist	12
T/C to care provider	20
T/C to workshop	10
T/C to psychiatrist	15
6/12 T/C to regional center	18
T/C to care provider (twice)	30
Travel to facility	30
Home visit with client and care provider	45
Travel to office	30
6/13 Paperwork (forms and dictation)	85
Travel to facility	30
Moving belongings to car	30
Travel time to new facility	20
Admission to new facility	40
Moving belongings out of car	25
Travel time to office	35
6/14 Travel to new facility	30
Transport client to psychiatric evaluation	25
Waiting during client's interview	30
Met with psychiatrist	15
Transport client back to facility	25
Discuss new needs and plan with facility staff	<u>15</u>
Total time	10 hours, 30 min.

C. Client needed to be moved from one facility and placed in another.

<u>Activity</u>	<u>Minutes</u>
1. Paper Work	20 minutes
2. Telephone call to care provider	20 minutes
3. Telephoned parents to arrange for preplacement visit	5 minutes
4. Conference with Public Health Nurse	25 minutes
5. Travel to preplacement visit	20 minutes
6. Preplacement visit	45 minutes
7. Travel from preplacement visit	20 minutes
8. Telephone contact with parent	10 minutes
9. Telephone to other CCSB office RE: another facility	10 minutes
10. Conference with PSW this office regarding facility	5 minutes
11. Telephone contact with care provider	5 minutes
12. Telephone contact with care provider	10 minutes
13. Telephone contact with parent to arrange preplacement visit	10 minutes
14. Travel to and from preplacement visit	50 minutes
15. Preplacement visit	45 minutes
16. Conference with parent to sign paperwork	40 minutes
17. Paperwork	2-1/2 hours
18. Telephone contact Regional Center RE: funding	5 minutes
19. Travel to and from new placement to deliver packet	<u>50 minutes</u>
Total Time	9 hours, 5 minutes

APPENDIX B

BACKGROUND CALCULATIONS: THE EFFECT OF SPECIAL INCIDENTS AND EVENTS TIME EXPENDITURE ON CCSB AND REGIONAL CENTER COMPARATIVE PERFORMANCE

Given the fact that CCSB has a caseload of 67:1 and regional centers are staffed at 62:1, one of three things must be true: either CCSB is more efficient, its cases are easier, or the quality of its work is lower.

We can use the facts derived from the special incident survey and our knowledge of the case leveling system to compare CCSB and regional centers case management systems. Four points set the groundwork for comparison:

1. Given the fact that the incidents surveyed average 7 hours and 11 minutes, the ratio of CCSB's level 1 to level 2 cases is 4:5.
2. 22 percent of work time (based on the State Personnel Board work year standard which deducts for vacation, holidays, sick leave and breaks) equals 304 hours per year spent on special events.
3. From 1,260 hours per year of available work time, three subtractions leave us with an estimate of time available for level 1 and 2 cases not accounted for in our survey, and for level 3 cases.

Time Available:	1,260
Non case-related (training, internal administration, etc. @ 18 hours/month)	-216
IIR's, CER's, moral reviews (37 clients @ 12 hours/client/year)	-444
22 % of work time	-304
TIME REMAINING	296

4. For regional centers the "formal" system calls for a percentage breakout by case level of 4-11-44. However (see Chapter 3 and Table 3-2 for a more detailed explanation), if we deduct 216 hours from total time to reflect non case-related activities, the actual breakout is more like 3-7-62-36.

This said, we can focus on how CCSB's percentage breakout would compare to the 3-7-42-48 percent figures.

There are two ways to do this. One is to allocate the 276 unaccounted for hours only to level 3. The second is to make an "educated guess" about the number of level 1 and 2 cases not accounted for in the survey.

The first approach works out like this:

Level 1 = 3.41%
Level 2 = 4.26%
Level 3 = 34.32%
Level 4 = 58.01%

Even under this approach, CCSB has significantly less time for level 2 and 3 cases than regional centers.

The second approach assumes that our two-week time study format missed just one level 2 case, and no level 1 cases. The results:

Level 1 = 3.41%
Level 2 = 5.76%
Level 3 = 28.36%
Level 4 = 62.47%

Level 1 and level 2 are now more in line with the regional centers' 3-7-42-48 pattern. However, under this assumption CCSB is able to serve only 28 percent of its clients at level 3, compared to an estimated 42 percent for regional centers.

The 14 percent gap represents clients who may be underserved by CCSB. To be exact, it is one way of stating the problem of underservice. Another is to assume that the distribution of cases is similar to regional centers and that less time is spent on some cases by CCSB. Consider the following distribution:

Level 1 - 3.41%
Level 2 = 5.76%
Level 3 = 42.00% (set to be equal to regional centers)
Level 4 = 48.83%

This could be true if only 7-1/2 hours per year were spent on each level 4 case or if--for all 67 cases--the IPP-assessment-CDER process took 10 hours per case each year, including minimal implementation time.

The foregoing figures are different ways of viewing the impact of the different staffing ratios for CCSB and regional centers. If we assume that the two entities have cases which are similar in difficulty and that neither organization is more efficient than the other, the most likely result is that CCSB is either unable to respond to some problems--probably at level 3--or that it spends less time on IPP's than our analysis of regional centers leads us to believe is reasonable. The significance of these differences is a matter of judgement, in the absence of client impact information. Three observations provide a context for judgement:

1. Some regional center staff we have interviewed have been critical of CCSB's performance in completing IPP's of reasonable quality. The criticism may or may not be merited, but it is consistent with the hypothesis that CCSB handled its higher caseload by giving less time to the IPP-assessment-CDER process than regional centers.
2. The gap between 28 and 42 percent suggests that one out of three clients who should be served at level 3 are not getting this service. This is a fairly large difference.
3. Our line of analysis has been quite conservative and biased in the direction of minimizing the estimates of special incidents and events. A less conservative approach would have made differences appear more dramatic.

Our own conclusion is that the quality of service to CCSB clients does suffer in comparison to that given by regional centers, and that differences are meaningful.

ALTERNATIVE CASELOAD SENSITIVITY ANALYSIS, REFLECTING TIME
REQUIRED FOR NONCASE MANAGEMENT ACTIVITIES

Table X-2 in Chapter X is a framework for thinking about the difficulty of cases which is presumed by the current case leveling system's standards. For example, if a 62:1 caseload ratio is reasonable and the standard of 10 hours for a level 1 case, 5 hours for level 2, etc., is "right," it follows that within a case manager's annual time budget he can handle 4 percent level 1 cases, 11 percent level 2, 41 percent level 3, and 44 percent level 4. (The distribution could also be 3-13-44-40, respectively; but regional center studies claim that 4-11-41-44 is closer to reality.)

The reader who wishes to assert that 50:1 is a good caseload ratio is placed in a position of having to assert either that:

- . The real distribution of cases by level of difficulty is 7-19-41-33; or
- . The time standards implicit in Table X-2 are wrong, and that instead of spending 12 hours per month on a level 1 case perhaps 20 hours per month are needed.

Our own opinion is that the time standards are fairly though not completely accurate. This turns the focus on the outcome of the regional centers' studies, which underly the case leveling system, thereby misjudging the real distribution by level of difficulty. While Table X-2 doesn't provide any answers in and of itself, it facilitates the reader's own questioning. If one wants to support a lower caseload ratio he might assert that 7 percent of cases are really level 1 (as suggested by a 50:1 ratio); he might push an 8 percent figure (which would be reasonable at a 45:1 ratio), or 10 percent (40:1). At some point the assertions will become absurd. To say that a 30:1 ratio

the regional centers failed to identify 3/4 of the cases which should really be treated as level 1, etc. The same potential for absurdity appears at the other end of the scale, where advocacy of a caseload of over 90:1 carries the burden of asserting that there are no level 1 cases. (This easily could be disproven).

One problem with Table X-2 is that its basis of 1,680 hours does not allow time for training, internal supervision and administration, required drills, or community service and education functions. The chief counselors who formulated the leveling system did not build these things into it. They assumed that a level 1 case, for example, would take an average of 10 hours of actual casework per month, excluding training and supervisory time. Table C-1 demonstrates what the system would look like if a different approach had been taken, assuming 18 hours per month for non-casework activities. At 54:1 the breakout by level would be the same 4-11-41-44 percent pattern which appears for the 62:1 caseload in Table X-2.

TABLE C-1
ESTIMATED BREAKOUT OF CASES BY LEVEL FOR ALTERNATIVE CASELOADS,
ASSUMING 1,464 HOURS PER YEAR AVAILABLE FOR CASEWORK*

	<u>45</u>	<u>50</u>	<u>55</u>	<u>60</u>	<u>62</u>	<u>65</u>	<u>67</u>	<u>70</u>	<u>75</u>	<u>80</u>	<u>85</u>
Level 1	7%	5%	4%	3%	3%	3%	3	2%	1%	0%	0%
Level 2	17	14	11	9	7	5	3	3	3	2	0
Level 3	41	42	42	41	42	41	43	44	42	44	44
Level 4	34	40	43	47	48	51	51	51	54	54	56

*The assumptions here are the same as in Table X-2, namely that the proportion of level 1 and 2 cases for each caseload size should be similar to that set at 62:1, and that level 3 cases should remain fairly constant.

What is apparent from Table C-1 is that far fewer level 1 and 2 cases can be served than the formal 4-11-41-44 distribution would suggest. As a result, we would expect some "shorting" to occur: training and supervisory time might be reduced, and some cases will be given less time than their formal level allows. In the absence of client impact data it is hard to say whether this is good or bad. Regional centers have for some time gotten along with caseloads of higher than 54:1, and 62:1 is not "disastrous." Moreover, our estimate of 18 hours per month for non case-related work is an educated estimate and not an ideal. Finally, as discussed in Chapter 4 there is enough variation in the data upon which the leveling system is built that the figures used by chief counselors to estimate the percent breakout by level are themselves open to question.

Because Table C-1 is closer to reality than X-2, it is a more useful tool for defining the "outer range" of caseload ratios which are consistent with both client needs and the intent of the Lanterman Act. In Table C-1, level 1 cases disappear at an 80:1 caseload ratio. In the face of repeated examples of such cases--illustrated in Chapter 5's discussion of CCSB special incidents and events--this disappearance is strictly contrary to fact. One could argue that level 1 cases could be accommodated at an 80:1 ratio if there were fewer level 2 cases; or if less time were spent on each level 2-4 case. But at an 80:1 ratio there are only 2 percent level 2 cases; and if level 4 time were cut from our estimate of 12 hours per case each year to, say, 10 hours there wouldn't be enough hours generated to permit 1 percent of all cases to be treated as level 1!