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CALCARES CAREGIVER NAVIGATION SYNTHESIS: PERSPECTIVES FROM HEALTH CARE AND HOME- AND COMMUNITY-BASED ORGANIZATION PROVIDERS

Synthesis of Provider Engagement in Imperial, Marin, and Sonoma Counties

March 2026

INTRODUCTION

In alignment with the Administration for Community Living's (ACL) National Strategy to Support Family Caregivers and California's Master Plan for Aging (MPA), the California Department of Aging is implementing a two-year initiative called California Caregiver Awareness, Resources, Education & Support (CalCARES).

CalCARES aims to improve awareness, navigation, and educational opportunities for California family caregivers who support older adults and people with disabilities. One objective is to understand how to maximize caregiver engagement and referrals to community services by identifying strategies to strengthen connections across home-and-community-based services (HCBS) and health care organizations. While current efforts are focused on three pilot counties (Marin, Imperial, and Sonoma), the goal is to replicate promising practices statewide.

In service of this objective, Collaborative Consulting interviewed providers from HCBS and health care organizations in Marin, Imperial, and Sonoma Counties to learn more about how providers understand, facilitate, and experience caregiver navigation in their communities.

METHODOLOGY

Between July and September 2025, 28 individual and small-group semi-structured interviews were conducted remotely, with one provider submitting written input via email. Please see Appendix A for the list of all participating organizations. These key informants shared their perspectives on awareness of services, familiar caregiver navigation pathways, referral intake and coordination processes, and service navigation challenges and solutions. The question guides are in Appendix B. We analyzed and synthesized the data into themes and referral pathways as the framework for this report.

All themes presented below are drawn solely from providers' perspectives, priorities, ideas, and experiences shared during the interviews. The findings are organized into the following sections:

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UNDERSTANDING PROVIDER AWARENESS AND CAPACITY TO SUPPORT CAREGIVERS

HCBS and health care organizations use various internal and external sources for referral information and navigation support. HCBS providers are more likely than health care providers (HCPs) to contact other organizations to exchange information about available services, but all providers face challenges staying current on available services.

Across organization types and counties, knowledge of caregiver services comes from similar sources. Sources include personal knowledge and experience, external and internal networks and lists, online searches, and shared databases (e.g., FindHelp). Providers also use their connections outside their organizations to share caregiver resource information through vendor and community partner meetings and professional networks. Some providers compile internal lists, databases, and resources. For example, social workers at a Sonoma County health system use group chats and a SharePoint site to share resources.

> *"To stay on top of resources, it's through different community partner meetings, newsletters, and just sharing the word between our teams."*

Dedicated resources specializing in assistance and referrals are key information sources. Across HCBS and health care organizations, internal staff and volunteers contribute to developing information repositories and building expertise. In health care organizations, internal sources of information include care or case managers, social workers, provider relations groups, community health workers (CHWs), and Enhanced Care Management (ECM) teams. In HCBS organizations, sources include care navigators, social workers, resource databank coordinators, care or case managers, resource offices, information specialists, volunteers, and program facilitators.

> *"We assign patients to case managers, as they have more knowledge of resources in the community. They provide us with the information after the patient is connected."*

Sometimes, providers access information through databases created for use beyond caregiving. This is most common in Sonoma County, where the following are used:

- The Sonoma County Aging and Disability Resource Hub (ADRH) is a closed-loop referral system that HCBS organizations use to refer caregivers to other HCBS. The ADRH also has public-facing resources, the 565-INFO line and the Aging & Disability Resource Directory.
- FindHelp has a public-facing directory and a secure resource platform for organizations to make provider-to-provider referrals (although interviewees using it note that few organizations in the database have that function enabled).
- 211 has a public-facing directory and a closed, secure resource platform for providers. It is integrated with electronic health record (EHR) systems (e.g., Epic).

HCBS and health care organizations lack an up-to-date directory of caregiver services. Available information on service offerings often excludes important details like eligibility, cost, and contact information, or is outdated. For example, a supervisor at a senior center in Marin County reports having a flyer on local caregiver resources that was last updated in 2018. Keeping internal materials up-to-date and double-checking external materials for accuracy is a capacity challenge. Even with substantial resources, the need to check multiple sources of information remains a challenge, especially for providers serving multiple counties.

"Not having so many different places to look for information would be incredibly helpful."

"Some websites are not updated, so we call first because we don't want to give clients a bad number or website information."

HCBS providers are more proactive in seeking information and raising awareness than HCPs. HCBS providers report participating in resource fairs, making presentations, and inviting other organizations to present to their staff. These efforts are ongoing because of the quantity of information, its tendency to change, and the multiple layers of staff that need the information. In contrast, only a few HCPs report engaging with HCBS providers (e.g., inviting them to give presentations on their services, checking whether resources are still active, etc.).

"For me, it works well to reach out to organizations myself, so I can name-drop when I follow up with patients, like, 'So, did you talk to so-and-so at Catholic Charities?'"

Despite HCBS providers' efforts, many HCPs lack awareness of local HCBS. HCPs have difficulty keeping track of resources, especially when patient volumes are high, appointment times are short, and capacity is limited. HCPs also tend to be less aware of and underutilize internal resources (e.g., case managers and CHWs) available to support caregiver referrals.

"We've done all the outreach; we just haven't seen results."

MAPPING CURRENT CAREGIVER NAVIGATION PATHWAYS

Caregivers may find services, either for themselves and/or the person(s) they care for, through an HCBS or a health care organization. Each path comprises multiple steps and processes, outlined below.

PATH 1: THROUGH AN HCBS ORGANIZATION. Caregivers can self-navigate to an HCBS organization through a word-of-mouth referral, an online search, or HCBS outreach. They may call an information line, submit an online query, or visit in person to establish contact.

"We've been around for many years now, so a lot of it is word of mouth."

The initial contact is crucial for triggering a needs assessment, intake process, or referrals. Sometimes, a caregiver may not be seeking HCBS, but in communicating with an HCBS provider about their loved one (the care recipient), the caregiver's needs may also be discussed, identified, and addressed. Incorporating caregiver screening questions into intake and training staff to ask about caregiving responsibilities can help ensure caregivers are recognized and supported early, rather than relying on caregivers to self-identify.

"Folks often call in for one thing, not knowing that there are other services they could benefit from."

Warm referral handoffs or follow-up protocols are rarely used. In making referrals, HCBS providers most commonly give a list of resources to the caregiver, who is then responsible for contacting the resources. Higher-touch processes are at the provider's discretion, depending on caregiver needs. While some HBCS organizations have relationships with other HBCS organizations, they rarely use formal referral systems. Strengthening referral practices, such as adopting warm handoffs for caregivers experiencing high stress or implementing closed-loop referral tools, could reduce caregiver burden and improve follow-through.

"We do fewer warm referrals – only if we need to."

Strengths in supporting caregiver navigation include organizations' reputation, awareness-building activities, and partnerships. Community members trust HCBS organizations as resources that can connect people to the right services. Through proactive outreach and awareness-building, HCBS organizations can reach caregivers directly and via word-of-mouth. This helps address current needs and prepares caregivers for potential future needs. Strong relationships among HCBS organizations help caregivers get connected with the right services. A hub (such as the Sonoma County ADRH) can be especially helpful in facilitating referrals. Continued investment in outreach and education, paired with advocacy for sustainable funding for navigation and referral functions, can help HCBS organizations maintain and expand this trusted role.

"Even if we can't support someone, we'll take the time to sit down with them to see what they need and where we can refer them."

HCBS providers' use of person-centered approaches is beneficial for caregivers. With dedicated information and/or referral staff, many HCBS organizations can provide a " human on the other end of the line" for caregivers who call. This is especially important for older adults who lack access to or comfort with digital technology. Other person-centered approaches include ensuring that digital resources are available in hardcopy, easy-to-digest formats; and using high-touch referral processes, such as warm handoffs, when caregivers are overwhelmed. Supporting HCBS organizations in adapting service offerings and workflows to address identified caregiver needs can support more consistent application of person-centered practices.

> *"We try to go a step further and tell clients, 'I'm going to tell them about you, so they'll expect your call.' In the Imperial community, culturally, that's just what makes more sense."*

Interviewees mention a few standout HCBS organization referral examples, including:

- The Aging and Disability Resource Hub (ADRH) in Sonoma County, wherein HCBS organizations that become official partners can search for other HCBS organizations, make referrals, and confirm that the referred organizations have been alerted within an online closed-loop system.
- Marin CIL and Marin Aging and Adult Services (Marin County) use a shared Google sheet and monthly check-in to facilitate and follow up on referrals.

These examples demonstrate how tools and practices can improve referral follow-through and accountability. Scaling similar approaches could enhance HCBS organizations' ability to respond to caregiver needs and contribute to a more coordinated, caregiver-responsive navigation system.

PATH 2: THROUGH A HEALTH CARE ORGANIZATION. A health care organization may refer a caregiver to an HCBS organization during a medical appointment, in conjunction with providing a diagnosis, or at patient discharge from acute care.

HCPs may either refer caregivers to HCBS organizations or make a handoff to internal case management. The referral process depends on the HCP's knowledge, time, and referral policies. Internal case management staff may conduct caregiver assessments when handling referrals. For example, CHWs at a Federally Qualified Health Center (FQHC) in Sonoma County use motivational interviewing to identify caregiver needs. Care coordinators use their knowledge and external resources (e.g., the 565-INFO line) to appropriately refer caregivers. The referral touch-level varies, with higher-need caregivers receiving additional support (e.g., a warm handoff). Designating staff (e.g., social workers, CHWs) to manage caregiver referrals helps lower the burden on HCPs and ensures more consistent follow-through.

> *"We do refer patients to social services in the clinic. Our community health workers also know community benefits better, so they can work with patients and find the resources they need."*

Formal referral processes are more common among health care organizations than HCBS organizations. Examples of health care organization referral processes include:

> *"Health care providers need to refer early. That would be the message. Refer before somebody is on tilt so that our services can be prophylactic instead of an emergency response."*

- The HCP offers the caregiver the phone number of an HBCS organization or a list of service options.
- The HCP contacts a trusted HCBS organization (e.g., an Area Agency on Aging or Independent Living Center) to make a referral, which results in an HCBS provider calling the caregiver.
- The HCP uses an established referral pathway or partnership to send a consent form, referral sheet, or list of individuals eligible for services to a partner organization (e.g., a Caregiver Resource Center, Alzheimer's Association, or Adult Day Health Care (ADHC)) or uses an HCP-specific platform (e.g., UniteUs) to reach an HCBS organization. An HCBS provider follows up with the caregiver.

Health care organizations' follow-up on referrals is not universal and varies in formality. When follow-up occurs, it can be informal, such as during a follow-up medical appointment attended by the caregiver, or formal through a referral pathway or partnership. For example, an ADHC in Imperial County has a formal care planning process that involves collaboration with a managed care nurse. This process requires a sign-off from an ADHC physician and includes a review of the care plan every six months. Establishing expectations for referral follow-up and incorporating closed-loop updates to the referring organization can strengthen accountability and continuity of care.

Strengths of health care organization referrals include the opportunity to identify caregivers' needs, case management expertise, and structured referral and follow-up processes. Health care organizations have a crucial opportunity to identify caregivers who may not self-identify as caregivers. Many health care organizations also benefit from staff, such as social workers or CHWs, who can facilitate successful referrals while lowering the burden on HCPs. These care coordinators conduct additional assessments of caregivers, build trust, and help to identify caregiver needs early, before a crisis occurs.

> *"Sometimes medical providers will schedule a loved one with a community health worker if they're not aware of what they need."*

Formalized referral partnerships between HCBS and health care organizations increase the likelihood of successful caregiver referrals. Some cross-sector partnerships exist in which health care organizations refer caregivers to HCBS organizations. Ideally, rather than the patient needing to call the HCBS organization, the HCBS organization will take over the contact. While this helps reduce the burden on HCPs and caregivers, one HCBS provider interviewee notes that the calls they make to caregivers after a health care referral sometimes result in confusion or a less productive conversation. Clear communication about the purpose of the referral, inclusion of caregiver consent, and shared expectations between health care and HCBS partners can help improve the quality of these handoffs and caregiver engagement.

> "Sometimes even though there is a referral from the medical provider, the call can almost feel a little bit like a cold call. When the caregiver is the person making the first contact, I feel like there's a higher likelihood that we'll have a productive conversation the very first time that we talk."

IDENTIFYING CROSS-CUTTING BARRIERS AND GAPS

Some common challenges emerged across HCBS and health care organizations' navigation pathways to caregiver services.

> *"Sometimes it's just a black hole of quiet after a referral is sent. It doesn't create a lot of comfort or confidence in our system."*

Caregivers often do not seek services until they are in crisis. Early navigation to services is essential to ensure caregivers have support before needs become more acute, but several factors limit caregivers' ability to self-navigate early. Some do not self-identify as caregivers, those in early stages of caregiving may not be ready to seek help, and those in later stages may feel too overwhelmed to engage with providers. Technology, cultural barriers, immigration concerns, disabilities, and physical isolation may also limit caregivers' self-navigation to services.

Early referrals to services do not occur as frequently as they should. Some HBCS providers (e.g., senior centers, information lines at AAAs or CRCs) may not collect extensive intake information or know that a caller is, or has, a caregiver. This may be due to limited capacity for long intake calls and a lack of caregiving screening questions. HCPs have an opportunity to identify caregiver needs early, as they see caregivers as patients and may communicate with them about their loved ones. However, many HCPs do not routinely screen for caregiver needs, especially when the care recipient is the patient. A key factor is time: high patient loads and short appointments make it difficult for HCPs to screen patients and caregivers, look for resources, and provide referrals.

> *"A lot of the times, we're just focused on the patient. There is no screening tool to identify if that caregiver is suffering, or if we could prevent suffering by providing resources before a crisis happens."*

The limited capacity of HCBS providers contributes to gaps in HCP knowledge. HCPs commonly report limited awareness of local caregiver resources, leading to inconsistent or inaccurate referrals. At the same time, HCBS providers desire greater visibility among HCPs but face a difficult balance: raising awareness can increase demand, but they may not have the capacity or staff to meet it. As a result, limited HCBS capacity discourages proactive outreach, perpetuating low awareness among HCPs. This cyclical challenge is compounded by high turnover among HCPs, requiring HCBS providers to repeatedly rebuild awareness and relationships.

> *"The kiss of death is doing a huge outreach, and then not being able to respond to people."*

Various structural factors impede timely and effective referrals to services. For some HCBS organizations, providing referral support or follow-up may not be a top operational priority due to competing demands and limited resources. HCBS providers and HCPs often face heavy caseloads and staffing shortages, leaving little time or capacity for proactive, high-touch referral coordination. These constraints are especially challenging when caregivers are overwhelmed and require additional support to navigate multiple systems or complete referral processes.

> *"Information and referral is helpful for our clients, but it's not the core of what we do."*

Siloed record systems create time-consuming manual processes or expensive upgrades for bidirectional information exchange. Particularly when there are no formalized follow-up mechanisms, such as a closed-loop referral system between HCPs and HCBS providers, referring providers and caregivers can lack visibility into whether referral requests have been received and whether the service has been delivered.

CONCLUSION

Key informant interviews with providers from HCBS and health care organizations reveal that caregivers' ability to find and access support depends on how effectively these providers communicate, coordinate, and connect. Across Marin, Imperial, and Sonoma Counties, providers express a strong commitment to supporting caregivers but face persistent challenges: fragmented information systems, limited capacity, inconsistent awareness of available resources, and few formal referral pathways.

Findings underscore the importance of investing in both sectors' infrastructure and relationships. HCBS organizations need the capacity, training, and funding to identify caregivers and manage referrals, while health care organizations need tools and workflows that make caregiver screening and referrals routine. Cross-sector collaboration can bridge gaps, streamline navigation, and make caregiver support more proactive and person-centered. By strengthening these connections, California can create a more coordinated, sustainable network that empowers caregivers, reduces crises, and advances the goals of the Master Plan for Aging and the National Strategy to Support Family Caregivers.

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APPENDIX A. INTERVIEWED PROVIDERS

Imperial County

- Imperial County Area Agency on Aging
- Southern Caregiver Resource Center
- InnerCare
- Access to Independence
- DayOut Adult Day Health Care
- Legacy Medical Group

Marin County

- Marin County Aging and Adult Services
- Family Caregiver Alliance
- Marin Center for Independent Living
- Marin Villages
- Vivalon
- Kaiser Permanente
- Margaret Todd Senior Center
- Novato Health Care
- Sutter Care at Home

Sonoma County

- Sonoma County Adult and Aging Division
- Sonoma County Human Services Department
- Santa Rosa Community Health
- West County Community Services
- Providence Health
- Redwood CRC
- Partnership HealthPlan
- Petaluma People
- West County Health Services
- Council on Aging

APPENDIX B. INTERVIEW QUESTIONS

Health Care Provider Questions

- How do you learn about community resources for patients/families/ caregivers?
- How prepared are you to refer patients/families/caregivers to community supports?
- Who do you refer families/caregivers to, and how?
- Why do referrals typically happen? What is the concern or reason for triggering the referral?
- What follow-up mechanisms do you use (if any) to ensure referrals happened and/or that support was received?
- What works well regarding referrals for families/caregivers?
- Where do referrals break down? What causes the referral breakdown?
- What barriers do you encounter when connecting caregivers with community providers?
- How would you improve how referrals work for caregivers? (i.e., partnerships, tools, information).
- What would help you better identify and address caregiver referral needs?

HCBS Provider Questions

- Who typically refers caregivers to your organization?
- Who do you refer caregivers to, and how?
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- What follow-up mechanisms do you use (if any) to ensure referrals happened and/or that support was received?
- What works well regarding referrals?
- Where do referrals break down? What causes the referral breakdown?
- What barriers do you encounter when referring caregivers to community providers?
- How would you improve how referrals work for caregivers? (i.e., partnerships, tools, information).
- What would help you better identify and address caregiver referral needs?