# Innovations in Care Coordination

## *Rethinking* the Role of Home Care Workers

PHI Quality Care THROUGH Quality Jobs

SEIU

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# Introduction

In this time of healthcare innovation, the home care workforce has an important role to play in care coordination for those receiving long-term care services and supports. Home care workers, responsible for the bulk of day-to-day support for these consumers, are well-positioned to take on additional care responsibilities and, as part of the care team, help achieve the goals of better care at lower costs. Currently, there is significant impetus around care coordination for individuals dually eligible for Medicare and Medicaid, and while this is the primary focus of this paper, the concept would apply equally well for other individuals receiving home-based care. Further, we recognize that delivery systems vary greatly across states, providers and populations. As a result, this paper offers a broad vision of the potential of an advanced role for home care workers in care coordination teams which can and should be adapted to other emerging models of care delivery for persons needing long-term services and supports. The paper is intended to encourage public discourse and action among policymakers, legislators, providers, analysts and advocates on leveraging the potential of home care workers to improve care and lower costs.

The organizations listed below support a vision of a healthcare system that leverages the significant positive impact home care workers can have in improving care coordination for individuals with dual eligibility. Individuals with dual eligibility and others living with multiple chronic conditions across the country are among those who can most benefit from improved care coordination. Our organizations are calling upon federal and state policy makers to encourage and facilitate the creation of innovative coordinated care models that include and expand upon the services of the nation's home care workforce.

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Alzheimer's Foundation of America
Service Employees International Union
National Family Caregivers Association
Independence Care System
The National Consumer Voice for Quality Long-Term Care
Community Catalyst
National Alliance for Caregiving
Addus HealthCare
Commonwealth Care Alliance
National Hispanic Council on Aging
Council on Social Work Education

# Care Coordination and the Untapped Potential of Home Care Workers

The healthcare system in the United States is highly fragmented. In particular, Medicare and Medicaid are administered separately with multiple payment arrangements—especially under fee-for-service arrangements, but under many managed care frameworks as well. A lack of care coordination[1] is a challenge, but may be most significant for the nearly 9 million individuals eligible for both programs. These individuals often have the most significant health needs of all Medicare and Medicaid beneficiaries. Problems caused by the lack of coordination between Medicare and Medicaid services for these individuals are well-documented.[2]

Moreover, there is often little care coordination within Medicare and Medicaid so that one individual may receive care from several doctors operating under separate care plans. All too often, the fragmentation arising from the separate payment and delivery systems results in unnecessary, duplicative, or missed services and preventable aggravation of illness leading to expensive hospitalizations and institutional stays, as well as cost-shifting among payers.[3] Nationally, only 1.5 percent of all individuals with dual eligibility are enrolled in any kind of integrated care program that includes long-term, acute and primary care services.[4] For many, integrating long-term services and supports into care coordination programs is crucial because of their heavy reliance on these services.

Provisions of the Patient Protection and Affordable Care Act (ACA) provide new impetus for coordinated care. The newly formed Federal Coordinated Healthcare Office at CMS is working to align Medicaid and Medicare; the Center for Medicare and Medicaid Innovation is offering grants to states and private providers to test innovative models of care coordination; and other provisions for Accountable Care Organizations (ACO) are expected to facilitate the development of these organizations to help implement care coordination.

This paper discusses a crucial ingredient in any care coordination model—the unique role home care workers can play in a person-centered care coordination model which encompasses not just primary care and acute care services, but also long-term services and supports.

# The Unique Role of Home Care Workers in Long-Term Services and Supports

Within the existing system of long-term services and supports, home care workers—including both home health aides and personal care aides[5]—are a substantial and potentially powerful element. Overall, more direct-care workers are now employed in home- and community-based settings than in institutional settings. More than 1.7 million home care workers deliver daily, vital assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) for millions of people, including individuals with dual eligibility.[6] In addition, home health aides can perform medically related tasks (e.g., taking of vital signs, changing dry dressings). Under some circumstances, such as nursing delegation programs or certain consumer-directed programs, personal care aides can do this as well. The delivery of these services in individual's homes enables them to avoid more costly care.

Home care workers provide 70 percent to 80 percent of the paid, hands-on, direct long-term services and supports needed by individuals. Many individuals with dual eligibility need ADL assistance, thus, home care workers have regular contact with a large universe of these individuals. Fifty-two percent of individuals with dual eligibility need assistance with one or more ADLs: 23 percent need assistance with 1–2 ADLs, and 29 percent need assistance with 3–6 ADLs.[7] The ongoing, regular contact entailed in providing this assistance

enables home care workers to develop relationships and build trust with the individuals they serve and often with their families. This familiarity uniquely positions home care workers to notice slight changes in a client's health and social well-being—changes that, if not addressed properly, may lead to emergency care, in-patient hospitalization, or exacerbation of existing conditions.

Despite this central position in supporting clients' care, home care workers are often neither provided with the necessary training, nor afforded the opportunity to provide additional services or to leverage their detailed and up-to-the-minute understanding of a client's health and social well-being into better coordinated care.

# Expanding Roles to Improve Care Coordination and Service Delivery

Care coordination depends upon multiple individuals working together to both coordinate and manage care. Most current models of care coordination focus on primary care and acute care. A more fully integrated care coordination model that includes long-term services and supports would improve on primary/acute care models by capitalizing on the position of home care workers in providing some of the most essential long-term care services and coordinating individual care on a frequent and face-to-face basis. Two essential components of quality care coordination models are a multidisciplinary care team and a process for person-centered care planning which encompasses primary care, acute care, and long-term services and supports.

In an enhanced care coordination model, the home care worker would fill two additional essential roles:

1. Participation as part of the multidisciplinary care team including responsibilities for regular communication with care managers; and
2. Provision of an expanded range of services beyond the assistance with ADLs and IADLs, and the limited medically related services that some home care workers provide in existing models.

Because of regular and extensive individual contact, the home care worker has a unique role in the development and execution of the individual's care plan. Home care workers and clients spend significant portions of their days together, performing intimate tasks such as bathing, dressing and transferring. Nationally, home care workers typically spend an average of 31 hours per week delivering direct services and supports in the homes of multiple individuals.[8] This regular and intensive contact means a home care worker is likely to notice subtle changes in condition that another member of the care team —say, a doctor, in the course of a brief office visit—perhaps would not notice. This extensive contact also likely means a home care worker builds a unique relationship of trust with the individual. This heightened trust in turn means the dually eligible individual may be more likely to—and better able to—speak candidly with her home care worker about pain or other symptoms.

As a result, home care workers can serve as a conduit of information in two directions. The home care worker can share information with the care manager(s) that is crucial for minimizing decline and addressing exacerbations of conditions—information that would likely not otherwise come to the attention of the care manager or other providers. Similarly, with additional training, the home care worker can take any emergent issues identified by care managers into account when delivering care. This can prevent health and social issues from worsening to the point of requiring otherwise unnecessary services, and is likely to result in better health and social outcomes and lower expenditures.

Additionally, this care coordination approach would expand home care worker roles beyond assistance with ADLs and IADLs and the limited medically related tasks that some home care workers can currently provide to tasks that are traditionally within the scope of practice of registered nurses or other health professionals. Such tasks might include medication administration, assistance with physical therapy, wound care, administration of feeding tubes and glucose monitoring.[9] A trusted relationship with the client can also place the worker in the best position to be successful in providing preventive care such as educating and supporting the client in proper nutrition, exercise/mobility assistance, smoking cessation, completion of prescribed care and safe household maintenance—for example, ensuring the presence of handrails or functioning smoke detectors.

Depending on what new responsibilities the home care worker assumes and training s/he already has or additional training s/he receives, this model could offer a new rung in the career ladder for workers between certification as a Home Health Aide and becoming a Licensed Practical Nurse. For aides with less training and without certification, this model could offer advancement by allowing them to fully participate in care coordination teams and take on more advanced tasks as they are able. A care coordination model along these lines has significant promise for helping to prevent avoidable care—especially avoidable hospitalizations and nursing home stays—and, therefore, has significant promise to bend the medical cost curve, as well as improve health outcomes for clients.

This type of model is supported by findings from the October 2010 Institute of Medicine (IOM) report[10] on the future of nursing, which states that all healthcare professionals should work collaboratively in team-based models. The report also recommended care models that use every member of the team to the full capacity of his or her training and skills. Other research also provides significant evidence of the positive impact that family caregivers and formal paraprofessional caregivers can play in improving care coordination.[11]

# Implementation

A number of elements are crucial to the implementation of this concept: client consent, assurance of legal and regulatory compliance—especially around delegation and licensing requirements—and training and certification programs to ensure home care workers are properly prepared and educated to perform their roles as well as training for other professionals to support the home care worker and family caregivers.

## Individual Consent

Enhancing the role of the home care worker in a coordinated care system, if not done properly, may lead to concerns surrounding the privacy and consent of the individual being provided services and supports, especially in participant-directed home care programs. It is essential that a person-centered coordinated care system in these programs involve the individual's explicit consent to have their home care worker participate as part of the care coordination team, most notably in those circumstances where the client acts as—or is—the employer of the home care worker. These individuals must also be able to freely direct the home care worker within the plan of care, understanding the important role the home care worker plays in effectuating and assisting in the coordinated care delivery system.

## Reimbursement

For this model of care coordination to succeed, the home care worker must be recognized as a critical part of the multidisciplinary care team, and both the home care worker and licensed staff will need additional training in and responsibility for communication with care managers. Care coordination generally, and the additional services provided by home care workers as part of a coordinated care system, should also be reimbursed. In many states, care coordination services are not generally reimbursed by Medicaid or Medicare, creating a disincentive to coordinate care in existing fee-for-service payment structures. As the healthcare system moves toward capitated payment models, a broader and deeper role for home care workers can result in true cost efficiencies.

### Skill Development

As the role of the home care worker expands as part of the interdisciplinary care coordination team, the need for skill and knowledge development to meet the needs of individuals with multiple chronic conditions will also increase. Nurses and clinicians will have a crucial role to play in implementing and facilitating this development process, as home care worker skill development should include any skills needed to monitor and communicate specific medical conditions of individual clients and administer appropriate care for those specific needs. Skill development should not be limited to taking on additional healthcare tasks, but instead should be an integral part of a career ladder and access to further training if the worker or client so desire. Home care workers and other team members, including family caregivers, should also be trained in effective communication, which is especially important because members of the care team may not have experience working with one another or with providers in other settings.

### Negotiating Legal Barriers

In many states, the role of home care workers—or any medical paraprofessional—is limited by various laws and regulations. These may include Medicaid rules and regulations, Nurse Practice Acts, licensing requirements, legal liability issues, and other laws and regulations relating to the delivery of healthcare—all of which vary considerably from state to state. Such laws and regulations will need to be carefully examined and taken into consideration in any area where this concept is developed.

## Conclusion

Each day, home care workers across the country provide direct, intimate care giving services to individuals with dual eligibility individuals in their homes. With the profound changes emerging within our healthcare system, these essential home care workers now have the potential to serve as a crucial point of contact in a person-centered coordinated care model.

If provided a trusted role within the care coordination team, a home care worker can readily identify changes in a client's condition or circumstances, allowing the team to take appropriate preventive action to avoid costly (institutional) care and disruptive health issues. Further, if properly trained and supported, the home care worker can undertake augmented service roles that will allow the team to function in a more cost-effective manner compared to teams solely using professionals.

Our healthcare system already spends tens of billions of dollars on home care aides across the country every year, yet their roles are minimized and their contributions undervalued. By including the home care worker as a central member of the care coordination team, our healthcare delivery system will become more efficient, and individuals with dual eligibility will be far better served. For this reason: PHI, Community Catalyst, the Alzheimer's Foundation of America, Independence Care System, Service Employees International Union, Addus HealthCare, the National Family Caregivers Association, the Commonwealth Care Alliance, the National Alliance for Caregiving, the National Hispanic Council on Aging, the National Consumer Voice for Quality Long-Term Care, and the Council on Social Work Education urge state and federal governments to authorize, promote, and test care coordination models that rely upon the critical role home care workers can play in integrated and coordinated care.

1. As defined by the National Quality Forum: Care coordination helps ensure a patient's needs and preferences for care are understood, and that those needs and preferences are shared between providers, patients, and families as a patient moves from one healthcare setting to another. Care among many different providers must be well-coordinated to avoid waste, over-, under-, or misuse of prescribed medications, and conflicting plans of care
2. See Board of Healthcare Services, "Retooling for an Aging America Chapter 3: New Models of Care," Institute of Medicine Report, Committee on the Future Healthcare Workforce for Older Americans, April, 2008. http://www.iom.edu/Reports/2008/Retooling-for-an-Aging-America-Building-the-Health-Care-Workforce.aspx.; Lewin Group, "Increasing Use of the Capitated Model for Dual Eligibles: Wennberg, Shannon Brownlee, Elliott S. Fisher, Jonathan S. Skinner and James N. Weinstein, Dartmouth Atlas White Paper: "An Agenda for Change: Improving Quality and Curbing Healthcare Spending: Opportunities for the Congress and the Obama Administration," December 2008, http://www.dartmouthatlas.org/downloads/reports/agenda_for_change.pdf.
3. For a more thorough discussion see: "Increasing Use of the Capitated Model for Dual Eligibles," The Lewin Group; and "Integrating Medicare and Medicaid Data to Support Improved Care for Dual Eligibles,"Lindsay Palmer Barnette.
4. A further challenge to effective care coordination—not addressed in this paper—is that there has been little incentive for providers and states to coordinate care because the savings of coordination between the two programs is not shared, and may accrue primarily to Medicare. For discussion of this issue, see Sara Rosenbaum, Jane Hyatt Thorpe, and Sara Schroth, Policy Brief.
5. The federal government requires at least 75 hours of training for Home Health Aides working for Medicare- and Medicaid-certified home health agencies. Currently, there are no minimum federal training requirements for Personal Care Aides, though some states require training.
6. Activities of daily living (ADLs) and instrumental activities of daily living (IADLs) describe a person's level of functioning in performing everyday tasks. There are six basic categories of ADLs: Hygiene (bathing, grooming, shaving and oral care); Continence; Dressing; Eating (the ability to feed oneself); Toileting (the ability to use a restroom); Transferring (actions such as going from a seated to standing position and getting in and out of bed). IADLs are generally more complex and can include the following: Finding and utilizing resources (looking up phone numbers, using a telephone, making and keeping doctor's appointments); Driving or arranging travel (either by public transportation, such as Para-transit, or private car); Preparing meals (opening containers, using kitchen equipment); Shopping (getting to stores and purchasing necessities like food or clothing); Doing housework (doing laundry, cleaning up spills and maintaining a clean living space); Managing medication (taking prescribed dosages at correct times and keeping track of medications); Managing finances (basic budgeting, paying bills and writing checks).
7. Medicare Payment Advisory Commission, Data Book, June 2010, "Chapter 3 Dual Eligible Beneficiaries," http://www.medpac.gov/chapters/Jun10DataBookSec3.pdf.
8. "Understanding Direct Care Workers: A Snapshot of Two of America's Most Important Jobs, Certified Nursing Assistants and Home Health Aides", U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 2011.
9. Permitting HCWs to perform these tasks would likely require changes in the laws of various states——such as changes that would authorize RNs to delegate and supervise HCWs in the performance of these tasks, or that would permit individuals living with disabilities to delegate directly such tasks to a HCW. This is discussed in more detail later in this document.
10. "The Future of Nursing: Leading Change, Advancing Health," accessed at http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx
11. See generally: Mukamel, D. B., D. R. Peterson, H. Temkin-Greener, R. Delavan, D. Gross, S. J. Kunitz, and T. F. Williams, 2007," Program characteristics and enrollees' outcomes in the program of all-inclusive care for the elderly (PACE)," Milbank Quarterly 85(3):499-531.; Chatterji, P., N. R. Burstein, D. Kidder, and A. White, 1998, The PACE demonstration: The impact of PACE on participant outcomes, Cambridge, MA: Abt Associates, Inc.; Coleman EA, Parry C, Chalmers S, et al, "The care transitions intervention: results of a randomized controlled trial", Arch Intern Med., 2006;166(17):1822-8, [PubMed] Available at: http://www.caretransitions.org/documents/RCT.pdf]; Walsh, Edith G. et al., "Cost Drivers for Dually Eligible Beneficiaries: Potentially Avoidable Hospitalizations from Nursing Facility, Skilled Nursing Facility, and Home and Community-Based Services Waiver Programs," August 2010, Prepared for Centers for Medicare & Medicaid Services Office of Policy. RTI International. Susan Rheinhard, Heather Young, "Washington's Nurse Practice Policies for Home and Community Living," Rutgers Center for State Health Policy, State Policy in Practice Series, June 2006, Available online at http://www.cshp.rutgers.edu/downloads/6480.pdf; The New Jersey Nurse Delegation Pilot Project: There's No Place Like Home," Presentation by Susan Brennan McDermott, RN Project Director, Division of Disability Services New Jersey Department of Human Services, http://www.state.nj.us/humanservices/dds/projects/njndp/. Available online at http://www.nasuad.org/documentation/hcbs2010/PowerPoints/Sunday/Nurse%20Delegation%20in%20Home%20Care%20Agencies%20Serving%20Persons.pdf

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