Senate Briefing: Innovations in Care Coordination: Rethinking the Role of Home Care Workers

Introductory Remarks
by Steven L. Dawson, President of PHI

We *could* begin this morning emphasizing, yet once more, the negative: How home care aides are paid so poorly that more than 40 percent must rely on some form of public assistance to make ends meet. That while, in real dollars during the last decade, per capita spending on health care has risen 39 percent, and the salaries of health care professionals rose 8 percent, the wages of home care workers *dropped* 1 percent. That many home care workers are today not even offered federal minimum wage and overtime protection. And that nearly one out of three home care workers, despite serving the health care system, are not themselves offered health insurance.

But we're not going to do that. Instead, we're going to talk about how home care workers are indeed a central part of the *solution* to Dr. Don Berwick's triple aim challenge: That is, how to improve "the experience of care and the health of populations, at a lower cost."

One Example

Let me offer one real-life example: PHI sponsors a managed long-term care plan in New York City called Independence Care System (ICS). ICS coordinates the care for more than 2000 individuals who are nursing home eligible, Medicaid-eligible, and living in their homes.

We have just completed a re-design of our inter-disciplinary care coordination team, which integrates nurses, social workers and a range of specialists—and for the first time includes a senior home care aide, Lillian Torres. Lillian is a full member of the care team. Lillian serves two roles on the team: 1) bridging communication between the home care workers who serve the client on a daily basis and the other members of the care team, and 2) acting as a support to those home care workers as a problem-solver and coach.

After six months of this pilot, the unanimous conclusion of the other members of the care coordination team is that Lillian sees things in the home that they were never

trained to see—what is happening for the client, the aide, the family members—and that Lillian can communicate with the client and his or her aides in ways they, as health care professionals, could never achieve. The other team members, despite some initial doubts, now understand that Lillian has made the application of their unique expertise far more effective—both separately and in true inter-coordination with the other team members.

We are now rolling out this design to all the other care coordination teams within ICS.

The Context of Care Coordination

As everyone knows, the answer to the triple aim challenge is indeed "care coordination"—whatever that might mean… The problem is that most everyone who is trying to define care coordination is sitting in an office somewhere—in a hospital, or a doctor's office, or a Congressional building.

Yet the people who are *receiving* the care—who are costing all this money, and who are doing things that send them back into the hospital—don't live in those buildings. They live out in the community, mostly in their homes. So, while most of the money and prestige and, therefore, power to make change are over in those buildings, the *answer* to the triple aim question, particularly for those living with chronic illnesses and disabilities, is what happens in the home, where people live. The answer is not really about a medical home, or a health home, it's about *home*.

And so, to truly re-think the role of the home care worker, we must first acknowledge that care coordination itself must be designed from the home outward, into the rest of the system. If instead coordination is centered on the outside, reaching into the home, then it's going to fail, as other reforms of the past have failed. If care coordination does not center around the home, then how else can we possibly live up to the rhetoric of "*person-directed services and support*?"

We all can debate differing definitions of "care coordination," but what we should agree on is that any successful design will require the rapid flow of accurate information—so that the right services can be provided to the client, by the right person, in a timely manner. You simply can't serve the triple aim otherwise.

And so, from the perspective of *home-based* care coordination, the role of the aide becomes plainly visible—not in isolation, but as an essential actor within the care coordination model. No other paid member of the care system is present in the home on a regular basis, to notice changes in condition over time; no other paid member has the

same type of *daily* relationship of trust with the client and family members; no other member holds such intimate knowledge of what is "really" happening in the home.

A Spectrum of Roles

What we are exploring today are ways to unlock the unrealized value of the home care aide—to make far better use of the $50 billion of public monies we are already spending annually on the services these home care workers provide, and to argue that with *additional*, targeted investments, home care aides can play a significant role in re-designing a genuinely effective care coordination model.

It is important to acknowledge, however, that augmenting the responsibilities of the aide can occur along a *spectrum of roles*. That is, there is *no one answer*—there is no one particular "advanced aide" role that is necessary for an effective care coordination model.

Rather, on one end of the spectrum is an augmented role that could impact nearly all aides—whether home health aide or personal care aide. For all aides, it is important to acknowledge that their day-to-day role can and should be strengthened—by requiring higher training standards and devising a more explicit information and education role with the client.

On the other end of the spectrum is a more advanced role for a subset of aides, creating a rung in the ladder between the home health aide and the LPN—without having to go to college. This role might include assisting with training, peer mentoring, and/or having a distinct, in-person role within the care coordination team, as does Lillian in our ICS pilot.

In between the two ends of the spectrum could be a range of specialized roles—a medication aide, dementia aide, or those specializing in end-of-life care.

What is important going forward is to be clear about what part of the spectrum we are discussing—because the implications are different for each, in terms of: 1) who is able to play these roles, 2) what level of training, support and oversight is required, 3) what scope of practice issues, if any, might be impacted, and 4) what augmented level of pay is justified.

Challenges

We see three challenges that have tended to blind us to the value that aides could play within the triple aim:

1) **Scope of Practice Concerns**. The nursing community has justifiable reasons to be cautious about expanding the clinical responsibilities of aides. However, the time is right to have this discussion: Given that nurses are forcefully arguing for raising the "ceiling" on their scope of practice, PHI believes this is an excellent time to explore ways in which nurses can be supported at the "floor" of their scopes, by expanding what tasks paraprofessionals can perform.

   But what I really want to emphasize here is that while an expansion of clinical tasks makes some sense, there are a number of ways in which the role and tasks of the aide can be expanded that might not raise scope of practice concerns at all. A very powerful and cost-effective opportunity exists to take advantage of the proximity, relationship, constancy and knowledge of the home care aide—by acknowledging and supporting the aide's role in information, education and reporting as a part of the care coordination process. To make the invisible, visible.

2) **The Bias of Low Expectations**. This is the challenge we have to address, within ourselves. There is often a class and race divide here, between the professionals and the paraprofessionals, and it limits all of us in solving the challenges we face. Just one example: In a funding proposal I recently reviewed, two roles were described, one for a professional, the other for a paraprofessional. In a brief description of each, the proposal noted that the paraprofessionals would be drug-tested, but curiously, no mention of drug testing was in the professional's description. Our own prejudices do blind us.

   What else can explain the continued design of care coordination and care transition models that don't even ask if an aide is already present in the home or explore the central role she can play in education, monitoring, and compliance? We have to ask *ourselves*—not just the payors and regulators—why these workers are invisible.

3) **The Fee-for-Service System (FFS)**. Finally, if the system only pays for a particular set of tasks, for a particular number of hours, the role of the aide will forever remain constricted. However, as reimbursements move away from FFS and toward global payments, that limitation is lifting across the country. This shift is precisely why PHI and SEIU believe we now have an historic opportunity to be creative.

Inevitability

And that is why I can end on an entirely positive note: I have been working in this field for more than 25 years. It seems we've been taxiing down this runway, of a more valued home care aide, for ages.

Fortunately, finally, I feel a little lift beneath the wings: many more organizations and policymakers are paying attention to these workers (for example, the IOM Report on the eldercare workforce; and the recent CMMI innovations call that explicitly requires attention to direct-care workforce issues).

Most importantly, though, the movement away from FFS and toward capitated payment structures is what will soon open up this world. A thousand experiments will bloom—because within a capitated environment, many of these innovations can be started small, and quickly pay for themselves, without needing massive amounts of dedicated funding or significant regulatory reforms.

In fact, I believe there is an inevitability to this concept of an augmented role for the home care aide, across the role spectrum. We're right on the edge of this opportunity, so let's together figure out how to make it happen well.

Φ Φ Φ Φ Φ