3. IN-HOME SERVICES;

Rosemary Meyer, Kittitas County Supervisor, presents BJ Jaderburg the Home Care Referral Registry - Excellence in Caregiving Award

HOME CARE QUALITY

The long-term care system is complex. It is driven by federal and state law, funding constraints, and the needs of growing numbers of older citizens. There are many entities, private and public, involved in carrying out the delivery of long term care service. In-home care service is closely intertwined with the entire spectrum of long-term care. One cannot discern the intricacies of quality in-home services, without first referencing its place in the long term care spectrum and the history of legislation impacting long term care (LTC).

With an aging society, changes in the acute care system, (i.e. diagnostic related groupings), and a public willing to support only a certain level of public funding for LTC services, the community-based system (a less costly approach than institution-based care) is serving more vulnerable clients in the community. The challenges and opportunities in LTC are great.

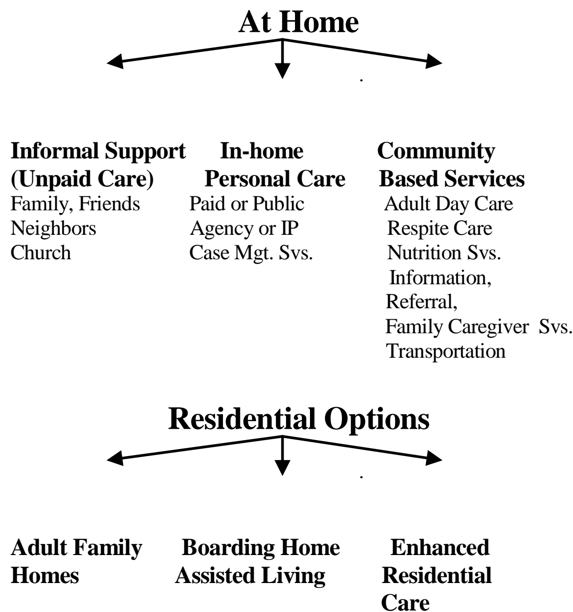
The long term care system is designed to meet the varying degrees of need of individuals with chronic physical and/or mental conditions that reduce their ability to function independently. It is comprised of a wide-range of health, social, community, and residential services.

Services can range from information and referral to skilled nursing care. Washington State's formal public long term care system is committed to ensuring a wide range of options and choices available to meet the needs of individuals with disabilities.

The formal care network, for the most part, is supported by public funds. The major players within the state’s long term care system include local organizations and state agencies that represent the disabled and older populations. They consist of: Aging and Disabilities Services Administration (ADSA) and its field offices, Home and Community Services (HCS); Department of Developmental Disabilities (DDD); Residential Care Services; thirteen Area Agencies on Aging (AAA); Mental Health Division; Division of Child and Family Services (DCFS); Department of Vocational Rehabilitation (DVR); and the Washington State Department of Health.

There are a host of private for-profit and non-profit health and social service providers throughout the state that also receive public funds to provide the broad range of long term care services.

The graphic below illustrates the different levels and options of service available in most communities in Washington State.



(There are progressive levels of care depending upon the facility. They are available for state or private pay. Case management is available for state-funded clients.)

Skilled Nursing Care

Intermediate or 24-hour skilled nursing care, rehabilitation and social activities

The preponderance of individuals using publicly funded long-term care services received community residential and in-home care. By Fiscal Year 2008, 78% of all ADSA clients were served in home and community settings (in-home or residential settings). As of July 2009, thirty-three-thousand (33,000) Washington residents receive services in their homes. Since 1995, the nursing home caseload has been reduced significantly by relocating and diverting individuals needing Medicaid LTC to in-home and other residential options.
The average daily cost of a nursing home is $217 per day. In-home and residential options continue to be cost effective.. Since 1995 Washington State has embarked on an effort in 1995 to rebalance the system and create a system that is most cost effective and better reflects the choices of its citizens. This effort has proven effective.

Legislation and policy have a ripple effect. Often the system is influenced by a “problem and response” approach. Legislation created to deal with one issue often creates other problems. For instance, rebalancing, in part, was propelled by the fact that Initiative 601 (which prohibits an increase in the state’s budget that exceeds the inflationary rate) was posing a problem for the State’s LTC budget. If the system had remained status quo, community based services would have been reduced substantially. As a result, Substitute House Bill (SBH) 1908 was passed. This LTC legislation focused on diverting and relocating individuals from nursing home care (a more expensive option) to community-based care (more cost-effective and consumer preferred). The goals for SBH 1908 are being met.

Washington State is ahead of the curve in long term care. While the rest of the nation grappled with ramifications from the passage of the Olmstead Act in 1999, Washington State demonstrated what is possible in home and community services. With the growing senior population, competition for federal and state funds, ensuring quality Medicaid in-home services will remain a challenge for the future.

The "Lewin Report—Medicaid Cost Containment," indicated to the legislature that Washington State is listed as one of the top five states with regard to its progressive LTC policies. The premises behind Washington's LTC polices are:

- Ensure client choice and self determination;
- Develop policy which, on a per capita basis, favors less costly services and builds equity of service between nursing facility and home and community based settings;
- Medicaid expenditures and in-home care services are growing at a rapid rate.

Yet, the Lewin Report suggests that Washington State could save considerable funding by increasing eligibility criteria for COPES and MPC and slowing this growth through capping COPES. They also proposed the option of eliminating MPC altogether.

The DSHS responded to the Lewin report by pointing out that Lewin's cost savings suggestions may result in savings in the short-run. However, the State's progressive policies were based on the premise that if it intervened at an early stage of terminal or chronic illness, it would delay and prevent more costly options of care, such as institutionalization. It was also built on the belief that such care reduces emergency room visits and hospitalizations. Thus, cost savings proposed by the report may not actually be realized in the long run.

Washington State has responded to a growing aging population and to limited public dollars by creating a system with a broad array of options. The long term care system has progressed with the demographic, social, and political changes of our communities. For instance, Washington State went from relying on nursing homes, a few community-based support systems and chore services in the 1970s to offering COPES, an in-home, community based alternative to a nursing home care, in the 1980s. In 1989, the state began offering respite care to unpaid caregivers and started the MPC program. Major advances in long term care came in 1995 when the COPES waivered services program was expanded and policy set in place to create equity between skilled nursing and community based LTC services. Residential options, such as Assisted Living and Adult Family Homes, blossomed throughout the state, offering more choices to clients. Adult Day Care and Adult Day Health programs are more widely available, as are foot care and many other community based services that help keep people in their homes as long as possible.

However, in 2009, the future of long term care in Washington State is uncertain. Like the rest of the nation, Washington State has been impacted by the recession. Revenue forecasts were short by 6 billion dollars. In the 2009 legislature there were many measures taken to reduce the DSHS/ADSA budget by 32.6 million dollars. One of the budget reductions consisted of reducing home care hours authorized. The reduction was calibrated against acuity levels reducing clients monthly hours from anywhere from 4 to 7 hours per month.

The other budget measures consisted of eliminating Adult Day Health for residential

clients, reducing nursing home rates and creating policy that would no longer allow family member providers to work for agencies but they must become individual providers. These aforementioned cost measures have been challenged legally. Temporary Restraining Orders (TRO) were mandated until the matters are heard, thereby cost savings have not been realized. This poses some significant challenges to the State budget in 2010.

QUALITY IN-HOME CARE BACKGROUND:

A vital component of the LTC system -- and the number one preferred choice of consumers -- is in-home care. In-home care has many contributors: the informal network of unpaid support consisting of friends, family, neighbors, church members and volunteers; the formal paid providers employed by a home health or home care agency or individual providers who privately contract with the recipient of service; HCS social workers who initially authorize state-paid service; AAA CMs who coordinate and reauthorize ongoing services; and the AAA Nursing Services registered nurses. Additionally, a host of ancillary and community-based support services augment the care plan and help keep vulnerable individuals in their own homes: nutrition, home health, respite services, adult day health, family caregiver, etc. Of course, the major in-home service participant is the client in need of in-home care services.

Although there is a private-pay market for in-home care services financed by third-parties (i.e. insurance companies, etc.), the majority of paid LTC services, including in-home care, are financed by state and federal dollars. This care typically supplements the informal care being provided to the individual.

The average monthly caseload for Medicaid in-home care mid-year 2009 was 33,000.. The average cost per client per month for home and community based clients averaged around $1,571.47 in the Washington State Fiscal Year 2008. The average monthly nursing home cost per client during the same fiscal year was $3,921.53 (*Histsumr 12-16-08.xls/ADSA.)*

In July of 2009, SE/ALTC case managed 3,182 clients receiving in-home care services.

PROFILE ON FRONT-LINE WORKERS:

At the heart of the in-home service delivery system are the dedicated individuals who provide personal care to the clients needing assistance with activities of daily living (ADLs). State-paid in-home care workers, also referred to as Personal Assistants or Individual Providers (IP), are either employed by an agency or independent contractors employed by the client, and contracted with the DSHS.

IPs are self-employed via a state contract and reimbursed at a rate from between $10.03 to $ 11.07 per hour, depending upon the years worked, as of July, 2009. IPs and agency providers alike are realizing increased benefits in health care and leave policies.

An in-home client with her IP

Statewide, IPs account for the majority of in-home care hours served. They also account for the pool of workers that service the most medically vulnerable, clients with the highest ADL scores. There is a growing trend toward a number of individuals being served by agency providers.

Agency providers are employed by a home care or home health agency, licensed by the Department of Health, and contracted with the State of Washington. As of July 2009, the agency provider rate is $17.38 per hour.

The IP program continues to account for the majority of in-home work performed. Reasons for this include the need for bilingual workers, more flexibility for evenings and weekend work, and client choice. However, this trend is changing a bit. Primarily, this is due to additional agencies contracted to provide care and because there is a level of supervision that is provided by contracted agencies not available with an IP.

The home care agency provides direct supervision of its workers, whereas supervision of the IP falls to the client employer. Home care agencies are mandated to provide two supervisory visits per year to the home of the client and to conduct client satisfaction surveys on an annual basis.

Qualifications for both IPs and agency providers are the same. Providers must not have a disqualifying crime. New providers must undergo a two-hour orientation. In addition, training requirements consist of twenty-eight hours of basic training entitled Fundamentals of Caregiving (FOC) within the first 120 days of state-paid employment. They must also complete a four-hour course of safety training. In 2011, the hours for FOC will extend to 75 hours of initial training and 12 hours of continuing education. All new providers in 2011 will be subject to certification through the Department of Health. Training requirements not met results in termination of payment until training is completed within the timeframes. After the initial round of training, providers must complete the number of continuing education per year.

ISSUES RELATED TO FRONT-LINE WORKERS:

Trained and available pool of workers.

Washington State has progressed significantly over the last decade in ensuring a competitive worker compensation package. Compensation has been at the heart of quality care issues. Providing a competitive wage with benefits, many experts believe, results in a higher quality of service and reduces turnover. Wages have increased significantly, and now in-home workers have access to health care and

Labor and Industries (L&I) coverage along with paid vacation. The IP union in Washington State has sponsored a statewide initiative that passed in 2008 resulting in a career ladder that includes increased training and other opportunities for IPs. The original IP training initiative was progressive, yet costly with the downturn in the economy. An initiative that was to move forward in 2010 will not be realized until 2011.

As the medical acuity rate of the in-home Medicaid client increases, there is a growing need for specialty training in the in-home provider work force. Expertise in working with medically complex, behavioral, and psychological issues is needed. The Washington State requirement for new employee orientation, the twenty-eight-hour Fundamentals of Caregiving training, and the four-hour safety training provide an excellent foundation for caregiving. The ten hours of continuing education required yearly is another important aspect of ensuring quality in-home care. However, individualized training in dealing with clients who may have drug, alcohol, or mental health issues or complex family dynamics, in conjunction with medical complexities, is needed.

The simultaneous goals of long term care are often at odds. Balancing the need to provide quality in-home care in a cost effective manner with the need to offer training and a competitive wage to the workforce providing that care is a challenge. There are budgetary limits to what a public system can and will provide, especially during the current economic crisis the county is experiencing. Requiring higher standards of training and better compensation comes with a higher price tag. In addition, the increase in senior population as the baby boomers reach retirement will likely mean an increase in the number of people needing in-home services. Providing additional training, higher wages and benefits coupled with a growing demographic needing Medicaid services has potential adverse effects on long term care options. When the country is looking for cost savings, the demand coupled with higher quality of care provider makes policy setting extraordinarily challenging. Should it become more costly to provide care in-home than in residential facilities, the state may have to raise eligibility requirements, reduce client hours, or institute waiting lists, all possibly placing vulnerable seniors at risk.

Use of Agency versus Individual Providers

In the past, the home care industry in Washington State has been divided over the use of IPs. Some in the industry claimed the increased use of IPs is driven by CM or social worker preference. It is also maintained that the "actual" cost of using IPs is skewed because of the difficulty in measuring the administrative costs incurred by CMs when providing informal supervision of IPs. Opponents also claim that IP served hours are nearly at 99%, indicating that there aren't good controls for time usage in the IP system.

Social workers and CMs contend that clients needing service are choosing IPs with whom they are already acquainted, such as family or friends. Another potential driver relates to the fact that clients are often being released from institutions and hospitals much sooner than they once and in more medically fragile states. They require more hours of service which is often provided by

a combination of paid and unpaid caregivers. Often it is family that is best able to fulfill these types of demands.

In the past, home care agencies have had difficulty finding providers for weekend and evening schedules. Agency concerns over liability issues and L&I costs restrict them from performing certain tasks. If a client is in need of care during unusual hours, or has certain care needs that the agency cannot perform due to their own policy restrictions, an IP may be the client's only option.

Although these issues have not all been resolved, the increased number of agency providers and nurse delegation in the home have all contributed to a higher use of agency providers. The trends are changing somewhat; IP usage is not as high as it once had been. In theory the cost of agency care is significantly higher on an hourly basis. However, many maintain that the cost of IP can't be fully measured due to the factors already mentioned.

Informally, the CM often takes on a "monitoring" role of the IP, assisting with finding replacement workers, ensuring tasks are being completed, verifying hours, etc. In a study conducted by the Office of Financial Management (OFM), reference was made to the IP system as being a "shadow caseload" of the CMs. The OFM study indicates that the younger physically disabled clientele, one that has grown twice as fast as that of the elderly population, also tend to prefer using IPs.

Although the system has changed its policies that once limited using agencies and despite the fact that consumers do drive the use of IPs, home care agency use is up. Using agency providers costs the state anywhere from $6.31 to $7.35 more per hour than using IPs in raw numbers. Policy changes have created differences in the trends and increased agency usage is increasing the costs of the in-home care.

Paid Family Caregivers

Paying family care providers for in-home care has been both beneficial and problematic. It has greatly benefited the in-home service delivery system in that it provides a pool of workers and authorizes the client with a provider with whom they are familiar. They may feel more comfortable having a family member perform some of the more intimate tasks. It is policy that helps support client choice. In Southeast Washington, where agencies have had difficulty recruiting bilingual staff, family members become a ready pool of in-home providers who speak the language and understand the culture of the client. Family providers often will perform tasks that others might be unwilling to perform and will work odd shifts and hours. This has helped to keep families intact economically when disabilities have undermined the earning power of the family.

There are times when the "paying family caregiver" policy can be a bit dubious, causing some unintended consequences. Family members serve an important advocacy role when a client is vulnerable. They often serve an informal role as a watchdog for quality care in the home. CMs frequently get calls from displeased family members concerned about their loved one's care. The value of this extremely important role cannot be minimized. It is often family members who first recognize quality control

issues. This informal role serves the system very well when the provider is someone other than a family member. However, this role may be usurped when that paid provider is a family member. It is more difficult to alert "authorities" to care quality issues when it is a brother, sister, mother, father, or grandchild that may be at fault.

Public policy, such as paying family members for care, enters into the unpredictable world of "family dynamics". A potential family informant has to consider betrayal issues, not to mention the economic issues that impact the family. Their loyalty is split. The other dilemma is being able to recognize abuse, neglect and exploitation within the family. For example, a father has a history of verbal and physical abuse of his/her child. However, there is not formal record of this within the "system". Dad becomes the paid provider. The verbal and physical abuse may look "normal" to many family members if a familial pattern has been long established. However, if this were an "outsider" interacting with the client in that manner, that same family would probably be able to recognize it for what it is, abuse. This is the strange world of family dynamics.

Washington Administrative Code (WAC) now exists that allows CMs and social workers to deny family providers the job of paid provider. One such indicator would be applying the "caregiver burden" scale. If a family member scored high on this scale, it would indicate a need for relief to the informal support provided by augmenting with state-paid care.

A growing trend among home care agencies in the State, however not as much in Southeast and Central Washington, was that agencies were hiring family members to provide care. Many maintained that this was a recruitment strategy for profit. Others countered that it was driven by clients wanting family members, but the Case Managers were concerned about the capacity to monitor quality of care, and that this was a way to better ensure quality care.

Due to the revenue shortfall, one budgetary savings strategy that was passed in the 2009 legislature was to discontinue allowing agency providers to hire family members to care for their loved ones. Rather, if the client wanted the family member, they had to contract as an individual provider. The cost savings was to be obtained through the hourly amount paid to providers. Substitute House Bill 2361 passed. There is current litigation underway regarding the SHB 2361.

GOAL: SE/ALTC will advocate and support quality in-home care services that emphasize choice and optimize effective and efficient service delivery.

OBJECTIVES FOR "FRONT-LINE" WORKERS:

- SE/ALTC will remain informed on the direction of IP and home care worker training and will contract with SEIU Training Partnership to provide the FOC and CE for our eight county area. ALTC will conduct a cost benefit analysis at the end of the contractual period and determine if they will submit a contract for 2011. ***December 2010.***

- SE/ALTC will continue to increase resources available to clients, family members, and paid providers by sponsoring training for them on a variety of subject matters to ensure well trained in-home care providers. ***Ongoing through December 2010***

- SE/ALTC will present information on the referral registry to CMs, social workers, and clients to ensure LTC clients are made aware of all provider options available. ***Ongoing through December 2010***

- SE/ALTC will continue to advocate for ancillary services supported by Senior Citizen's Services Act (SCSA) funds and State Family Caregiver dollars that help leverage and augment a variety of non-Medicaid services to help elderly persons who are in failing health and might otherwise fall through the cracks, or otherwise go onto Medicaid services as their health diminishes. ***Ongoing 2009-2011***