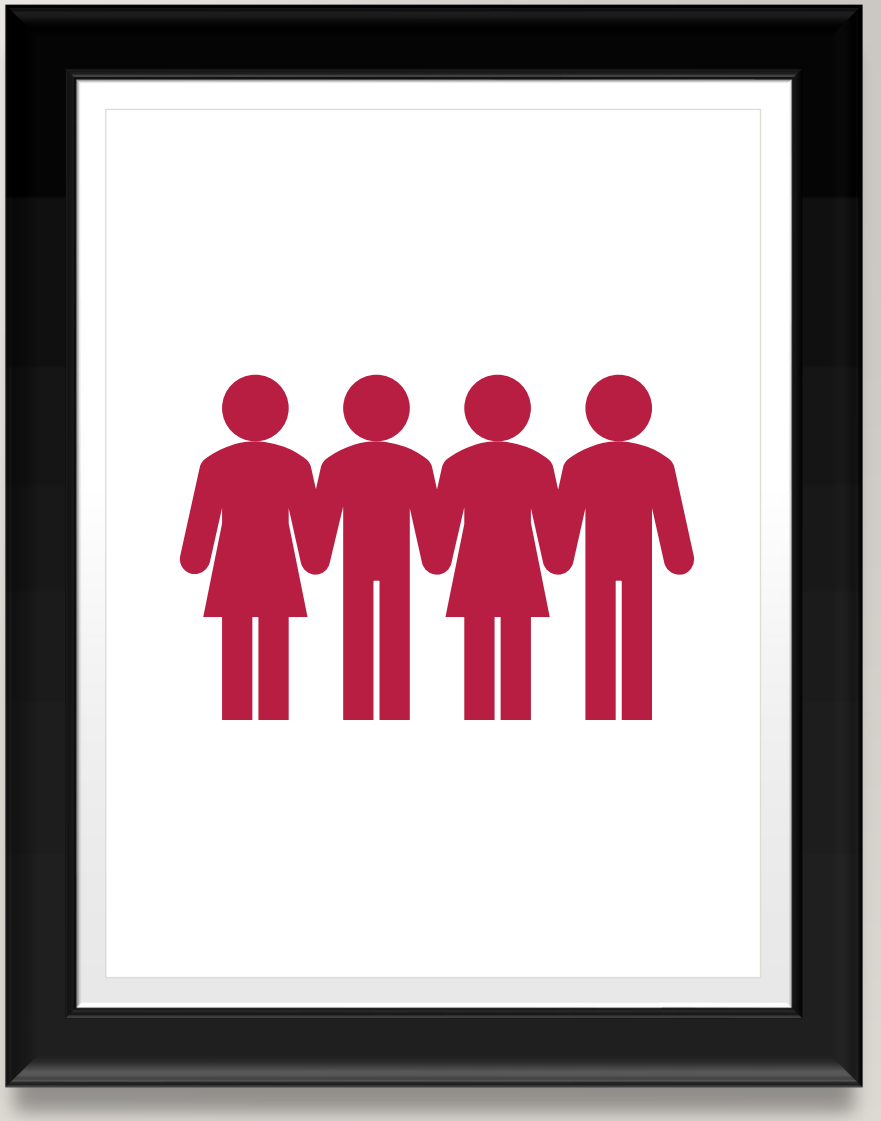
ADDRESSING THE HOMECARE WORKFORCE CRISIS

INNOVATIONS IN CONSUMER-DIRECTED SERVICES



MARC
MID-AMERICA REGIONAL COUNCIL
Aging and Adult Services

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TERMINOLOGY

- Care Recipient: this is the individual receiving the care. This individual may or may not be the employer or "client."
- Authorized Representative (AR): If the Care Recipient is unable to manage directing the program, they may designate someone as their AR. If this is the case, the AR is the employer. If an AR is not needed, the Care Recipient is the employer.
- MARC Staff: we contract with Care Management agencies in the community as well as Individual Contractors – when we mention MARC Staff making a home visit, it could be a contractor or internal staff.

THE DUAL PROBLEM: SHORTAGE OF WORKERS & MORE OLDER ADULTS NEEDING HELP

Shortage of In-Home Care Workers

A report released before the COVID-19 pandemic identified high rates of turnover in the direct care workforce with **more than half** of workers leaving the job within the first year. Additionally, there are **decreasing applicant pools** to replace these critical positions **due to low wages, limited or no benefits, lack of advancement opportunity and uncertain hours**

https://www.phinational.org/8-signs- the-shortage-in-paid-caregivers-is-getting-worse

More Older Adults Needing Help

- In 2020, approximately 45 million Americans are age 65 or older
- By 2030 (just eight years from now), that number will reach 73 million Americans
- At that point, fully one in five Americans will be older than 65

https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf.

HOW THE DUAL PROBLEM CAN AFFECT AREA AGENCIES ON AGING

- 94% of AAAs are seeing an increase in the number of Older Adults requesting help or services
- People are aging at an unprecedented rate
- One of the Older American's Act programs is In-Home Services, yet we are unable to sign up participants due to workforce challenges in agencies
- New agencies may not want to contract with AAAs because they do not have enough staffing for private-pay, let alone state-paid care
- Older adults at risk of institutionalization could often stay in their home longer with some extra help with ADLs and IADLs

https://www.healthyagingpoll.org/report/older-adults-preparedness-age-place, 2022

EVALUATE WHAT HAS WORKED FOR OTHER PROVIDERS: MEDICAID HCBS & VETERAN DIRECTED CARE

Medicaid Home and Community-Based Services (HCBS) Consumer-Directed Services (CDS)

- This program first became available in 1983 when Congress added section 1915(c) to the Social Security Act, giving States the option to receive a waiver of Medicaid rules governing institutional care.*
- All states serve people with intellectual or developmental disabilities (I/DD), seniors, and adults with physical disabilities through HCBS waivers with home-based services being the most common waiver benefit across states and target populations. **

*https://www.medicaid.gov/Medicaid
**https://https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services

Veteran's Affairs Veteran-Directed Home and Community-Based Services (VD-HCBS)

(This program is now called Veteran Directed Care (VDC) in most areas)

- The VDC program was developed by the U.S. Department of Veterans Affairs (VA) and the U.S. Department of Health and Human Services (DHHS) Administration for Community Living (ACL) in 2008 and is currently offered at 70 VA Medical Centers across the country.*
- Veterans enrolled in VDC decide for themselves what mix of goods and services best meet their needs. This includes the ability to hire, schedule and supervise their workers.

*https://nwd.acl.gov/vdc

HOW CAN WE REPLICATE THOSE SUCCESSFUL PROGRAMS AT OUR AAA?

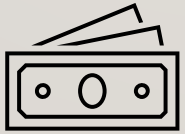
- Conduct an agency readiness evaluation
- Find a Financial Management Service (FMS)
- Develop materials: a handbook, an assessment, enrollment forms, and check-in forms
- Create a workflow
- Pilot the program with key staff members and community partners
- Enroll new Care Recipients and continue to evaluate and perfect the program

AGENCY READINESS EVALUATION

- What do we have?
  - An idea!
  - Title III money that is not being spent on agency-model in-home care
  - Care Managers (MARC contracts with Community-Based Organizations for our care management service line)
  - Independent Contractors who can work as Care Managers
- What do we need?
  - A Financial Management Service (FMS)
  - Materials – handbook, assessment forms, monthly reports
  - A plan to work with getting money to the FMS to pay workers
    - Financial services onboard and understanding of program
    - Breakdown of Personal Care vs. Homemaker services

FIRST STEP – FIND A FINANCIAL MANAGEMENT SERVICE (FMS) WILLING TO HELP YOU WITH THIS MODEL

- A good FMS will make or break this type of program.
  - Workers need to be paid in a timely fashion
  - Background checks completed
  - Care Recipient being made the "small business owner" with tax paperwork
  - Willing to train your staff, good partners with the AAA



WHERE DO I FIND AN FMS?

- What we did:
  - Asked our VDC FMS if they would do this work for us; they declined
  - Asked our local Center for Independent Living (CIL) if they would do this work for us; they did not express interest
  - Asked our internal financial staff if we could build an FMS in-house; we were told this was not possible at this time
  - Put out a Request for Proposal (RFP); received zero respondents
  - Asked a local HCBS Agency if they would be interested = we found an interested partner!

WORKING WITH OUR FMS

- After buy-in, we met several times with the owner
  - Negotiated per-person monthly rate
  - Discussed how this program is similar to Medicaid HCBS and how it's different
  - Trained our staff on enrollment
  - Discussions with our finance team of OAA required reporting and MARC required reporting
  - On-going support when issues arise

CREATING MATERIALS, TOOLS AND WORKFLOWS

- MARC created an **assessment** using several existing models – this gave us the information we needed about the Care Recipients
  - VDC Comprehensive Assessment
  - SDOH (Social Determinants of Health)
  - ASSM (Arizona Self-Sufficiency Matrix)
  - ADLs, IADLs and Nutrition Risk Screen required for other OAA programs

  - MARC created a **service authorization** (spending plan) based off the Care Recipient's ADLs and IADLs (as a starting point). This can be customized by using a person-centered approach to needs.
  - MARC created a **handbook** based off the VDC handbook that describes the policies and procedures in detail in layman's terms.
  - **Follow-up forms** are used on a monthly or quarterly basis. An annual reassessment is completed.

DEVELOP A WORKFLOW

- MARC's workflow:
  - Receive referral for new Care Recipient
  - Care Recipient finds at least one person to be the paid care giver (best to have this prior to intake)
  - Program Coordinator calls client to make sure they are a good fit for the program ("phone screening") and if an AR is needed
  - Care Recipient is assigned to a MARC Staff member for enrollment
  - Post-enrollment FMS engagement (activities will depend on your FMS and your agencies' internal financial workflow)

ENROLL NEW CARE RECIPIENTS: CLIENT FACING

- MARC Staff Member calls Care Recipient (or AR) to set up a home visit
- Home visit consists of:
  - Review of entire program and answering questions from the CDS Handbook
  - Completing the full assessment
  - Signing MARC enrollment forms
  - FMS Employer enrollment
  - FMS Employee enrollment

ENROLL NEW CARE RECIPIENTS: ADMINISTRATIVE

- After the visit(s), MARC Staff uploads all paperwork to SharePoint
- Program coordinator reviews paperwork for accuracy and completeness
  - Program coordinator creates the Spending Plan (Service Authorization)
  - Program coordinator notifies the FMS that documents are ready
- FMS completes HR and payroll functions – background checks, send tax forms to correct agencies, contact employer and employees with instructions on telephony system, payroll, etc.
- FMS contacts Care Recipient and Employee to provide official start date and answer any questions

CARE RECIPIENT FOLLOW UP

- MARC Staff follows this procedure:
  - First three months – phone-call check in to answer questions and make sure program is running smoothly
  - Quarterly – phone or in-person (based on professional judgement) to check in on program
  - Annual – in-person to conduct annual reassessment
  - At any time, Care Recipient can be enrolled in other MARC programs or referrals made to community-based organizations to meet needs.

SUCCESS STORY

- Care Recipient: 91-year-old female, who lived alone with no informal supports. She was unsteady on her feet with fear of falling, faced difficulties caring for herself and her home. Needed maximum assistance with most IADLs.
- In September of 2020, she began to receive Agency In-Home Services through MARC, but services were unstable. She did not have an agency worker for several months.

- Upon enrollment in CDS, Care Recipient was referred to MARC's Transportation and Home Mods programs.
- Very satisfied with her CDS caregiver.
- Care Recipient reports being very happy with the program!

THANK YOU FOR ATTENDING

- Documents and Slide Deck will be available in the Summit's Google Drive
- Questions? Please contact the following:
  - Kayla Hower, OAA Programs Supervisor (khower@marc.org)
  - Shannon Halvorsen, VDC Program Supervisor (shalvorsen@marc.org)
  - Rona Scott, CDS Program Coordinator (rscott@marc.org)