Careforth

Structured Family Caregiving:

An Innovative Solution Improving Outcomes in Populations with Complex Health Care Needs

Analysis by ATI Advisory for Careforth

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Executive Summary

The American healthcare system faces a growing crisis exacerbated by an aging population and a shortage of professional direct care workers. Family caregivers sit at the center of this crisis. The current and growing shortage of healthcare workers and professional direct care workers only intensifies the overwhelming burden on family caregivers who strive to maintain the quality of life for the person they care for at home.

As family caregivers navigate the fragmented and complex healthcare system with inadequate support, they may face significant mental, emotional, and financial strains. Solutions must be implemented to address these challenges and demonstrate the value— both clinical and financial— of family caregiver services in sustaining care at home, where people want to be.

Structured Family Caregiving (SFC), pioneered by Careforth over two decades ago, provides family caregivers with personalized coaching, customized tools and resources, and a stipend payment. By supporting family caregivers, the Medicaid beneficiaries they care for experience improved outcomes, enabling extended home-based care.

The Structured Family Caregiving Outcomes Analysis, performed by ATI Advisory (ATI) and commissioned by Careforth, highlights the significant benefits achieved for Medicaid members receiving care through Careforth's SFC service. The analysis reveals that Medicaid beneficiaries supported by Careforth's unique SFC service experience notable improvements in their health outcomes, including a statistically significant reduction in falls and emergency department visits.

Specifically, care recipients show:

- A 21% lower probability of visiting an emergency department within a year
- A 45% lower probability of sustaining any fall within a year

These findings underscore the effectiveness of SFC in reducing critical incidents and enhancing overall well-being for those in care.

Moreover, the SFC model delivered by Careforth has demonstrated its effectiveness in facilitating care at home and thereby reducing reliance on nursing facilities. A Careforth-led cost savings analysis estimated that these combined impacts result in an average annual cost saving of $61,600 per person. With an average length of stay exceeding 37 months, these savings accumulate to nearly $190,000 per person over the course of their tenure in SFC.

Concurrently, caregivers reported experiencing numerous benefits, including:

- Feeling supported in managing complex medical and behavioral issues
- Experiencing reduced burden
- Successfully maintaining care within the home environment

These findings underscore the SFC model's success not only in improving the quality of care for care recipients and supporting caregivers but also in delivering substantial cost savings compared to traditional nursing facility care.

Careforth is committed to ongoing research and evaluation to demonstrate the value of the SFC service model. By highlighting the impact and outcomes from evidence-based solutions, we will demonstrate to policymakers that effective approaches like SFC are available to enhance the quality of care delivered within homes across America.

Introduction

Current estimates suggest that over 30 percent of Americans are involved in home-based care, underscoring the pivotal role of family caregivers in the healthcare ecosystem. On any given day in the United States, there are 53 million caregivers grappling with challenges—mental, physical, emotional, and financial—that jeopardize both their well-being and the quality of care provided. Families looking for support are often unaware of the services and programs that they qualify for and already exist.

SFC is an innovative and proven care model that supports family caregivers to enable Medicaid beneficiaries with chronic and complex medical conditions or physical, intellectual, and developmental disabilities to live at home and engage in their communities. An alternative to traditional home care or nursing facility care, SFC allows beneficiaries to receive help with daily care from a family member or friend in their shared home.

In response to the challenges facing family caregivers, Careforth partnered with ATI on an outcomes evaluation of Careforth's Structured Family Caregiving (SFC) service. The findings underscore the transformative impact of caregiver-centered services like SFC in addressing the pressing needs of families across the nation. By equipping caregivers with tailored support and resources, Careforth not only enhances the quality of life for care recipients but also alleviates strains on the broader healthcare system. Statistically significant results included a reduction in falls (-45%) and emergency department (ED) visits (-21%) compared to a like group of Medicare-Medicaid dual eligible beneficiaries. The study utilized rigorous methodologies to compare outcomes, highlighting the tangible benefits of SFC in delaying nursing facility admission and reducing overall healthcare costs. Careforth estimates annual savings of $61,600 per care recipient through SFC, emphasizing its cost-effectiveness and quality-enhancing capabilities.

Careforth has invested in caregivers for more than 20 years, developing services and platforms that support the coaching, emotional needs, and overall well-being of caregivers.

Through Careforth's immense understanding of family caregivers, this research shows how its SFC service delivery guides caregivers and provides them essential learning opportunities. The service results in more knowledgeable family caregivers, which significantly improves the health and outcomes for care recipients while helping to address the nationwide shortage of direct care workers.

With the need for care far exceeding the current caregiver capacity, policymakers and payers continue to seek solutions for the ongoing shortage of direct care workers and the expense of home care. Understanding this intersection between well-supported caregivers and health outcomes via ATI's evaluation is the critical starting place to recognize the value of caregiver supports.

Methods

CAREFORTH SFC UTILIZATION

ATI conducted an analysis in December 2023 to determine the association between Careforth's SFC service and utilization outcomes. ATI analyzed the effect of the service on the following utilization outcomes:

- Emergency department (ED) visits (all-cause)
- Inpatient admissions (all-cause)
- 30-day readmissions (all-cause)
- Injurious falls
- Any falls (injurious and non-injurious)

ATI used data that Careforth collected from care recipients (consumers) and constructed a control group for analysis using data from the Centers for Medicare & Medicaid Service's (CMS) Medicare Current Beneficiary Survey (MCBS). ATI employed propensity score model weighting with inverse probability treatment weighting and linear regression models to account for differences between the intervention and control groups. Final regression models estimated the difference in the probability of each adverse outcome between Careforth's SFC service participation and the MCBS control group. Statistical significance was set at $p < 0.05$. See Methods Appendix for additional details.

Results

The probability of a Careforth SFC care recipient having at least one ED visit, injurious fall, and any fall, was significantly lower than for individuals in the control group. ATI reviewed utilization outcomes in inpatient admissions and 30-day readmissions, but did not observe statistically significant differences between the intervention and control groups. Full results of this analysis are available on Careforth's website.

The table below presents the statistically significant differences in the probability of having at least one utilization outcome event during the year for Careforth SFC care recipients, compared to individuals in the control group. A negative difference indicates the utilization outcome had a lower probability of occurring among Careforth SFC care recipients, when compared against the control group.

Table 1: Difference in the Probability of Utilization Outcomes between the Careforth SFC Intervention Group and the Control Group (2019 – 2021)

Utilization Outcome	Difference in Probability Compared to Control Group	p-value
1+ ED Visit	-20.6%	0.0010
1+ Injurious Fall	-45.5%	<0.0001
1+ Fall (Injurious and Non-injurious)	-45.0%	<0.0001

ANNUAL SATISFACTION AND COST SAVINGS

The home is the preferred setting for most individuals and is also financially beneficial for those covering the costs of care. As payers see rampantly growing costs for some of their members with complex health care needs, implementing programs and services to better support, educate, and coach family caregivers results in a richer benefit offering with quality and cost advantages.

99%

Over 99 percent of caregivers in Careforth's SFC service report that they feel confident managing medical incidents. Careforth's focus on building caregiver knowledge and confidence equips caregivers to feel ready to handle issues at home.

$61,600

Careforth has demonstrated meaningful reductions in the probability of a fall (45 percent), an ER visit (21 percent) and ultimately, extended community tenure. Careforth-led SFC cost savings analysis estimated that these combined impacts likely result in a $61,600 annual cost saving per person.

$190,000

With an average length of stay over 37 months, that savings grows to nearly $190,000.

Implications and Future Impact

The sustainability of America's healthcare system relies heavily on the resilience and effectiveness of family caregivers—mothers, fathers, siblings, spouses, partners, friends and neighbors—who provide essential care at home. Enabling populations with complex health care needs to receive care in the comfort of their own homes benefits individuals, families, the national economy, and alleviates pressure on our healthcare system.

To maximize caregiver involvement and effectiveness, support from health plans, case management agencies, and Area Agencies on Aging (AAAs) is crucial. These organizations help caregivers build knowledge and navigate the healthcare system to address their concerns, thereby enhancing their confidence and capacity to meet the needs of those they care for. The SFC model exemplifies this transformative support, delivering measurable improvements in health outcomes for Medicaid members.

Careforth's outcome analysis performed by ATI, underscores the effectiveness of SFC in reducing adverse health events, such as falls and emergency room visits, for Medicaid members, thereby delaying the need for more intensive care settings. These findings highlight the critical role of evidence-based caregiver support in mitigating healthcare costs and enhancing overall system sustainability.

With over two decades focused on caregiver support, Careforth has done the work and the research needed to identify the most impactful caregiver supports and services. In the latest Careforth customer satisfaction survey, almost 96 percent of caregivers indicated that Careforth has made their life better.

Caregivers deserve support that eases their burden and assures their ability to provide care. With the right support and structure in place through SFC, individuals and families in America can thrive at home.

Conclusion

The United States is facing a healthcare crisis with rising costs and severe workforce shortages that strain an already overburdened system. Careforth's SFC service directly addresses these challenges by enhancing outcomes, extending the viability of in-home care and proving the substantial impact of caregiver support through reducing reliance on emergency departments and long-term care facilities. This, in turn, drives down overall costs and lessens the strain on the healthcare system.

Careforth's SFC model effectively empowers caregivers by providing tailored support, personalized plans, and essential resources. This approach not only alleviates caregiver burden, stress, and burnout but also improves their ability to navigate the healthcare system and advocate for their loved ones. When supported by dedicated professional teams, the result is high-quality in-home care.

As policymakers and healthcare leaders seek innovative solutions to address aging demographics and workforce shortages, this study highlights the transformative impact of SFC. It underscores the service's ability to improve care at both household and community levels, offering a proven strategy for enhancing caregiver support and optimizing healthcare outcomes.

The time is now for widespread adoption and integration of SFC into healthcare policy and practice, recognizing its potential to drive substantial improvements in care quality and reduce costs. Family caregivers deal with the unknown each day, but do not need to do it unprepared or alone.

Careforth empowers families to sustain long-term, in-home care successfully.

Methods Appendix

ATI used data that Careforth collected from care recipients (consumers) in 2019, 2020, and 2021 to create the intervention group. As part of the SFC service, Careforth collected data from consumers in domains such as demographics, geography, insurance status, and functional abilities. To establish the association between Careforth's SFC service and utilization outcomes, ATI constructed a control group of individuals who resembled the individuals in receipt of Careforth's SFC service using the CMS MCBS. CMS administers the MCBS annually to approximately 14,000 individuals with Medicare (Traditional Medicare and Medicare Advantage), including those who are dual eligible for Medicaid. Results are weighted to represent the national Medicare population. The survey asks respondents questions about their demographics, functional limitations, chronic conditions and health utilization, among other domains. Additionally, the survey is linked to Medicare Fee for Service claims, which provide health utilization information for Traditional Medicare beneficiaries.[1]

Using combined MCBS response data from 2019, 2020, and 2021, ATI constructed a similar cohort of individuals to those in receipt of Careforth's SFC service. Individuals in the control group were living in the community (vs. living in a nursing facility), dual eligible for Medicare and Medicaid, and either 1) reported receiving help with at least three activities of daily living (ADLs), or 2) had a combination of self-reported Alzheimer's Disease or dementia diagnosis and reported receiving help with at least one instrumental ADL (IADL). To ensure balanced populations, ATI restricted the Careforth SFC intervention group to those who satisfied the same criteria. After applying the inclusionary criteria, the analyzed population counts were:

Careforth SFC Intervention Group	N = 10,804
MCBS Control Group	N = 1,442,177 (weighted)

After creating the control group, ATI accounted for differences between the intervention and control groups through propensity score model weighting with inverse probability of treatment weighting. To adjust for remaining confounders after achieving optimal balance through the propensity score process, ATI ran multiple linear regression models for each utilization outcome of interest. Regression models estimated the difference in the probability of each adverse outcome between Careforth's SFC service participation and the MCBS control group with statistical significance set at $p < 0.05$.

[1] ATI used Medicare FFS claims to identify ED visits, inpatient admissions, and 30-day readmissions among the MCBS control group, and MCBS respondent self-reported data for falls.

Though this analysis generates insights into the SFC service's impact, there are limitations to consider. The MCBS was the best source to create the control group for the SFC utilization analysis for many reasons, including its individual level data, indicators for dual eligibility, demographic characteristics, self-reported functional ability, and utilization information. However, a few important limitations remain:

- After applying the inclusionary criteria for the control group to best match the characteristics of SFC consumers, the sample size of the control group was relatively small (417 unweighted observations; 1,442,177 weighted observations).
- ATI went through a robust and thorough process to ensure that the intervention and control groups were optimally matched on key characteristics, but there are ways that the control group differs from the Careforth population that cannot be fully controlled for in the analysis (e.g., Careforth consumers, by nature, have more functional needs than the population surveyed through the MCBS).
- Because all data were de-identified, it is not possible to know if a Careforth consumer was also a respondent in the MCBS control group.
- There may be a differential in recall bias between Careforth consumers and MCBS respondents because Careforth consumers report their utilization outcomes as they occur (or soon after), and MCBS respondents respond to questions about past events.

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866.797.2333