SAINT LOUIS UNIVERSITY

DEPARTMENT OF HEALTH MANAGEMENT AND POLICY

THE DISCERNMENT LAB:

THE SAINT LOUIS UNIVERSITY MASTER OF HEALTH ADMINISTRATION CASE SERIES

Case 001:

Building the Workforce for Care at Home

Authors: Kwamane Liddell, Marcea Walter, and Kimberly R. Enard

A shortage of paid caregivers leaves older adults and people with disabilities waiting for support to return home. Students consider how hospitals, health plans, public agencies, and community partners can expand caregiver capacity while addressing training, eligibility, payment and placement requirements.

Terms Used in This Case

Term	Plain-language definition
Activities of daily living (ADL)	Basic personal tasks such as bathing, dressing, eating, transferring, and using the bathroom.
Caregiver	A paid worker, family member, or other support person who helps an individual with daily needs. Payment eligibility depends on the program.
Consumer-Directed Services (CDS)	A Missouri Medicaid personal care model under the Home and Community Based Services (HCBS) program in which an eligible participant who can direct their own care and can live independently directs the attendant and an enrolled provider handles administrative and payroll functions on behalf of the participant.
D-SNP	A Dual Eligible Special Needs Plan, which is a type of Medicare Advantage (Part C) plan for people entitled to both Medicare and Medicaid.
Length of stay (LOS)	The amount of time a patient remains in a hospital or other care setting during an episode of care.

Medically ready for discharge	A patient no longer needs the hospital level of care but may still need services or support in another setting.
Medicare Advantage (MA, Part C)	A private health plan that contracts with Medicare to provide an alternative to Medicare Part A and Part B benefits and may offer additional benefits under plan-specific rules.
Personal care	Nonmedical help with activities of daily living and related household tasks.
Readmission	A return to the hospital after discharge, commonly measured within 30 days.
Skilled nursing facility (SNF)	A facility that provides short-term skilled nursing or rehabilitation services to eligible patients.
Transitions of care	The coordinated movement of a patient between care settings or levels of care.

Organizational Challenge

Gateway Community Care Partnership is a fictional cross-sector partnership in St. Louis, Missouri. Its governing council includes a hospital system, a Medicare Advantage organization with a D-SNP line of business, personal care providers, a disability advocacy organization, a workforce partner, and a public-program liaison. The council has 30 days to decide whether to authorize a six-month initiative for adult patients who are medically ready to leave the hospital but cannot return home safely because reliable personal care is not available.

The hospital system's care management team identified 64 recent cases in which the absence of a confirmed caregiver contributed to discharge delays. These cases accounted for 184 medically ready inpatient days. Some patients eventually returned home, some entered a skilled nursing facility (SNF), and others remained in another setting while arrangements continued. It is unknown whether caregiver availability alone caused every delay or readmission, but hospital leaders believe the pattern is large enough to require a coordinated response.

Once a patient is medically ready for discharge, three pathways are possible. 1) If a caregiver has been identified and is available, discharge can often occur the same day. The caregiver can provide essential information, including the patient's home address, medication list, and daily routine, and participate in discharge education with the nurse and social worker. 2) If no caregiver is available or confirmed, the patient may remain hospitalized despite no longer requiring acute medical care. 3) Alternatively, the patient may be transferred to a skilled nursing facility, but this requires an available bed, plan authorization, and formal acceptance by the facility. In the hospital's review, most patients and families expressed a preference for returning home.

A Transition Problem Across Organizations

The hospital wants safe, timely discharge, available beds, manageable care coordination workloads, and fewer avoidable returns to the hospital. The health plan is concerned with member experience, total cost, and the use of institutional care when home support may be appropriate. Personal care providers need adequate payment, a dependable referral process, and enough time to recruit, screen, train, and schedule workers. Disability advocates support access to home-based care but want to protect consumer self-direction, informed choice, and equitable access for people already living in the community.

The operational steps cross organizational boundaries. Hospital staff must identify the need early, document functional limitations, confirm the patient's preference, and communicate with the payer and provider. The payer or public program must determine whether the individual and requested services meet applicable requirements. A provider must locate a worker who is appropriately cleared, trained, available at the required time, and able to travel

to the patient's home. A missed step can delay the start of service even when every organization agrees that home is the preferred setting.

Two Caregiver Pathways

The partnership expects two broad patient pathways. Some patients have a family member or other trusted person who is willing to provide care. That person may still need screening, training, enrollment, a workable schedule, and confirmation that the applicable program allows payment. Additionally, family caregivers may face competing responsibilities and personal limitations, including employment, lack of childcare, health concerns, and transportation needs, that prevent them from providing continuous support or covering every shift. In a review conducted by the hospital system, the most common reasons family members were unable to bring a patient home were lack of job flexibility or paid leave, the caregiver's own health, and childcare responsibilities.

Other patients do not have an available caregiver. They require an external match through a personal care provider or another authorized arrangement. The provider must balance the patient's needs and preferences with worker availability, travel distance, schedule, training, and payment. A referral does not guarantee that a qualified worker can begin when the patient is ready to leave the hospital.

Coverage and Service Boundaries

Personal care is not the same as Medicare-covered skilled home health. Original Medicare generally does not pay for personal care when it is the only service a person needs. Medicare Advantage plans may offer qualifying in-home support as a supplemental benefit, but availability and eligibility vary by plan. D-SNPs coordinate care for people entitled to both Medicare and Medicaid, but covered services still depend on Medicare, Medicaid, state, and plan requirements.

Missouri's Consumer-Directed Services program is one possible Medicaid pathway for eligible adults with physical disabilities who can direct their own care and meet other program requirements. An eligible participant may select a family member as an attendant, but the attendant cannot be the participant's spouse or legal guardian. The program does not cover skilled nursing tasks. Based on the hospital's data, not every patient would qualify for this pathway.

A Limited Six-Month Initiative

Hospital and health plan leaders are considering equal contributions to a $180,000 total startup budget. The proposed budget would support one full-time coordinator for six months, recruitment and outreach, training access, screening and onboarding, a referral and matching process, and evaluation. It would not create permanent positions, replace provider management, change public payment rates, or guarantee a caregiver for every referral. Caregiver wages would continue to depend on an authorized payer or other approved payment source.

The workforce partner estimates that the initiative could produce 30 externally recruited caregivers who are cleared and available for priority schedules and locations during the six-month period. A separate family-caregiver pathway could prepare 12 eligible caregivers. These estimates are uncertain. The proposed referral volume is 60 patients, and the partnership has not agreed on which patients should receive priority if demand exceeds capacity.

The two pathways call for different work. The external recruitment pathway builds new supply. The workforce partner has identified three local sources that are not yet organized toward personal care: a community college personal care aide certificate, health science pathways at area high schools, and an adult education center with a large general educational development (GED) enrollment. The family-caregiver pathway formalizes care that is already happening through screening, training, and, where the applicable program allows, enrollment so that the caregiver is paid for work the family is already doing, with backup when the caregiver is working at another job.

Stakeholder Commitments and Limits

The hospital will identify potential patients and provide discharge information, but it will not guarantee benefit eligibility or assume long-term responsibility for personal care payment. The health plan will designate a benefit and authorization contact, but it will not waive product-specific requirements. Personal care providers will participate in matching and onboarding, but they cannot promise immediate placement. The workforce partner will recruit and coordinate training, but projected completion rates are not guaranteed. The disability advocacy organization will advise on autonomy, access, and patient communication, but it will not endorse a process that restricts individual choice.

The Third Chair

"When we picture a hospital room or an exam room, we picture two chairs: the clinician and the patient. For millions of patients, and especially the most complex ones, there is a third chair, and that is the caregiver. It might be a daughter caring for her father. It might be an aide the health plan assigned. That person bridges the gap in understanding, coordinates the home health aides and nurses, unlocks the door, and keeps the whole plan moving. Discharge starts at admission, and the caregiver question has to be asked on day one. Hospitals, health plans, and government agencies all want people to be able to heal at home. What is hard is getting three large institutions to move on one patient's timeline, so that someone admitted last night can be home by four o'clock today." – Kwamane Liddell

Unresolved Decision

Within 30 days, the Gateway Community Care Partnership governing council must decide whether and under what conditions to authorize the six-month initiative. The council must determine the priority patient population, accountable sponsor, workforce approach, applicable payment pathways, partner responsibilities, and key performance indicators (KPIs) that would justify continuation after six months.

Your Assignment

You serve as an adviser to the Gateway Community Care Partnership governing council. Recommend whether the partnership should authorize the six-month hospital-to-home caregiver initiative and state any conditions required for approval. Support your recommendation with evidence from the case; address operational feasibility, workforce capacity, payment and coverage limits, stakeholder responsibilities, patient choice and equity; and identify the KPIs and unresolved information that should guide the continuation decision.

Exhibits

Exhibit 1. Recent Transition-of-Care Experience

Period: Most recent 120 days in the case scenario. Units and definitions are shown below.

Data disclosure: All numerical data in this exhibit were created for teaching purposes and do not represent actual results from any organization.

Measure	Value	Definition or note
Cases reviewed by care management after being medically ready	418 cases	Adult inpatient cases receiving additional transition review
Cases with a delay attributed in part to no confirmed caregiver	64 cases	15.3% of 418 reviewed cases

Medically ready inpatient days associated with these 64 cases	184 days	2.9 days per affected case, on average
Eventually discharged home	41 cases	64.1% of the 64 affected cases
Eventually discharged to a skilled nursing facility	17 cases	26.6% of the 64 affected cases
Other disposition or arrangements still pending at measurement	6 cases	9.4% of the 64 affected cases
Thirty-day readmissions among the 64 affected cases	12 of 64	18.8%*
Thirty-day readmissions in a medically similar comparison group without a documented caregiver-related delay	52 of 385	13.5%; not risk adjusted and not evidence of causation
Coverage of the 64 affected cases	Medicare Advantage 29; Medicaid 12; dually eligible 14; commercial 6; uninsured 3	Medicare Advantage 45.3%; Medicaid 18.8%; dually eligible 21.9%; commercial 9.4%; uninsured 4.7%
Affected cases with a family member identified as a potential caregiver	38 cases	59.4% of the 64 affected cases; willingness, eligibility, and availability not yet confirmed
Of those 38, the potential caregiver is the patient's spouse	16 cases	42.1% of the 38; a spouse cannot be the paid attendant under Missouri Consumer-Directed Services

**Readmission rates are presented for descriptive comparison. The groups were not risk-adjusted, and the difference does not establish that caregiver-related delays caused readmissions.*

Exhibit 2. Illustrative Patient Pathways and Timing

Timing is measured in calendar days after a complete referral. Process steps may overlap.

Data disclosure: All timing estimates in this exhibit were created for teaching purposes and do not represent actual processing times from the partner organization or guaranteed timelines under any program or health plan.

Process step	Potential family caregiver	External caregiver match	Primary uncertainty
Confirm functional need and patient preference	0 to 1 day	0 to 1 day	Information may be incomplete until discharge needs stabilize
Confirm payer or program pathway	2 to 10 days	2 to 10 days	Eligibility, benefit, authorization, and provider rules differ
Screening, enrollment, and onboarding	5 to 15 days	May already be complete for an employed worker	Background checks, documentation, and provider capacity
Training or competency confirmation	1 to 5 days	1 to 5 days	Required content depends on tasks and program
Schedule and location match	1 to 3 days	3 to 21 days	Availability, travel, shift length, and start time

Backup coverage	Often limited	Depends on provider staffing	A single caregiver may not cover every required hour

Exhibit 3. Service and Coverage Considerations

This table provides general guidance. Eligibility and coverage must be confirmed for each individual under the applicable program or health plan.

Pathway	What it may support	Important limits	Case status
Original Medicare home health	Intermittent skilled services and limited aide services when eligibility requirements are met	Personal care alone is generally not covered; homebound and skilled-service requirements apply	Verified general rule
Medicare Advantage supplemental benefit	Qualifying in-home support when offered by the member's plan	Availability, eligibility, service limits, and authorization are plan-specific	Verified general rule; fictional plan details
D-SNP coordination	Coordination for members entitled to both Medicare and Medicaid	Does not create uniform benefits; state and plan requirements still apply	Verified general rule; fictional plan details
Missouri Medicaid Consumer-Directed Services	Personal care for eligible adults who can self-direct and meet program requirements	Not available to every patient; spouse or legal guardian cannot be the paid attendant; skilled tasks are excluded	Verified Missouri rule
Agency-model personal care	Personal care through an enrolled provider when authorized	Subject to program, provider, workforce, and payment requirements	General case pathway; specific rates unresolved
Hospital or plan startup support	Coordination, recruitment, training access, screening, matching, and evaluation	Does not establish long-term benefit eligibility or ongoing caregiver wages	Fictional case assumption

Note: General Medicare and Missouri Medicaid rules were verified as of November 3, 2026. Eligibility and coverage must be confirmed for each individual under the applicable program or health plan. Plan-specific details and hospital or plan startup-support arrangements are fictional and were created for teaching purposes.

Exhibit 4. Proposed Six-Month Workforce Funnel and Budget

Data status: fictional composite projections. The funnel is not a guarantee. Workforce measures represent an estimated number of caregivers at each step for each of the two pathways. Dollar amounts are proposed startup costs and exclude ongoing caregiver wages.

Workforce measure	**External recruitment pathway**	**Family-caregiver pathway**
1. Initial inquiries or referrals	120	20
2. Complete screening	80	16

3. Complete required onboarding or training	54	14
4. Cleared and available	42	12
5. Available for priority schedules and locations	30	12
6. Successfully matched with a patient during six months	24	12

Proposed startup use	**Six-month amount**	**Boundary**
One full-time coordinator, salary and benefits	$55,000	Temporary six-month position
Recruitment and community outreach	$25,000	No permanent recruitment commitment
Training access and instructional support	$35,000	Does not pay ongoing caregiver wages
Screening, onboarding, and administrative support	$20,000	Subject to provider and program requirements
Referral and matching workflow or technology	$25,000	Limited startup configuration and support
Evaluation and reporting	$10,000	Six-month assessment only
Contingency	$10,000	Requires co-sponsor approval
Total	$180,000	Proposed equal contributions of $90,000 from the hospital and health plan

Exhibit 5. Proposed Partner Commitments

Data status: fictional composite commitments for teaching.

Partner	Proposed contribution	Limit or concern	Possible measure
Hospital system	Referral identification, discharge information, $90,000	Cannot guarantee eligibility or long-term payment	Medically ready days and referral timeliness
Health plan	Benefit contact, authorization support, $90,000	Product-specific requirements remain	Authorization time and destination of care
Personal care providers	Screening, onboarding, matching, supervision	Workforce and payment capacity	Time to match and service starts
Workforce partner	Recruitment and training coordination	Completion and availability are uncertain	Funnel completion and availability
Disability advocacy organization	Patient communication and autonomy review	Will not support restricted choice or inequitable access	Patient choice and experience
Public-program liaison	Program guidance and escalation route	Cannot waive eligibility or payment rules	Complete referrals and resolved eligibility questions

References

Centers for Medicare & Medicaid Services. *Dual Eligible Special Needs Plans. https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/dual-eligible. Accessed October 28, 2026.*

Centers for Medicare & Medicaid Services. *Special Needs Plans. https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans. Accessed October 28, 2026.*

Medicare.gov. *Home Health Services. https://www.medicare.gov/coverage/home-health-services. Accessed October 28, 2026.*

Missouri Department of Health and Senior Services. *Home and Community Based Services Manual, Policy 3.25, Personal Care Assistance, Consumer-Directed Service Model. Revised January 2026. https://health.mo.gov/providers/manuals/home-and-community-based-services-manual/300-available-home-and-community-based-4. Accessed October 28, 2026.*

U.S. Bureau of Labor Statistics. *Occupational Outlook Handbook: Home Health and Personal Care Aides. https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm. Accessed October 28, 2026.*

Source or Fictional-Data Disclosures

This case is informed by practice insights shared by Kwamane Liddell, JD, MHA, BSN, and by the public sources listed above. Gateway Community Care Partnership, the hospital system, health plan, providers, advocacy organization, workforce partner, organizational roles, timeline, patient counts, operating measures, budget, workforce projections, patient pathways, and partner commitments are fictional or composite. Public sources support the general policy and workforce context but do not verify the fictional organizations, data, or events. Plan-

specific coverage and payment must be confirmed for an actual patient and plan. Rates, hours, and timelines that appear in Part A of the Case 001 Supplement are case assumptions and are not the rates or rules of any Missouri program or plan.

Permissions and Reproduction

Saint Louis University grants registered users a limited, non-exclusive, non-transferable license to use this document for their own educational, research, or internal business purposes. Registered users may make reasonable copies for such purposes, provided that all copyright and attribution notices remain intact. Registered faculty may also distribute the document to students enrolled in their courses, including through password-protected learning management systems accessible only to those students and authorized course personnel.

This document may not be:

· Posted on any website, learning management system, file-sharing platform, or social media site accessible to persons other than the original recipient;

· Redistributed to third parties;

· Sold, licensed, or otherwise commercially exploited;

· Modified and republished as the recipient's own work; or

· Incorporated into another publication or resource without prior written permission from Saint Louis University.

All rights not expressly granted are reserved by Saint Louis University.

Case Development and AI Use

This case was developed through a faculty-led process that included partner brainstorming, targeted research, partner review, and editorial and instructional review. Generative artificial intelligence assisted with organizing source material, drafting and revising text, and checking internal consistency. AI-generated content was not treated as an authoritative source. The authors reviewed the case, verified the cited information, made all substantive decisions, and accept responsibility for the final content.

About the Authors



Kwamane Liddell, J.D., M.H.A., B.S.N.
CEO of ThriveLink

Kwamane Liddell, J.D., M.H.A., B.S.N., is a trauma nurse, health care lawyer, and health care visionary whose career began as a hospital janitor and has evolved into leadership roles across some of the largest health systems and insurers in the United States, including CommonSpirit Health and UnitedHealth Group, where he led operations at entities throughout California.

Grounded in lived experience and frontline clinical practice, Kwamane founded ThriveLink to support older adults, people with disabilities, and individuals who face literacy and access barriers, helping them navigate complex health care and social systems to live healthier, more independent lives.

Under his leadership, ThriveLink's telephonic AI technology has helped families secure millions of dollars in critical resources while dramatically reducing administrative burden for health care organizations. His work has been recognized nationally, including being named the American Nurses Association National Innovator of the Year and winning the MIT Solve AI for Humanity Award.

Through this work, Kwamane is reimagining health care access and working to ensure that people are not left behind simply because they cannot read, use the internet, or navigate complex bureaucratic systems on their own.



Marcea Walter, M.H.S.A.
Director - Master of Health Administration
and Master of Science in Health Administration programs

Marcea Walter, M.H.S.A., is an assistant professor in the Department of Health Management and Policy and director of the Master of Health Administration and Master of Science in Health Administration programs at Saint Louis University. She is passionate about developing people and helping future health care leaders build the confidence, judgment, and practical skills needed to lead effectively. Her work centers on student development, experiential learning, professional preparation, and connecting classroom learning to the realities of health care management.



Kimberly R. Enard, PhD, MBA, MSHA, FACHE®
Interim Dean, College for Public Health and Social Justice;
Professor, James R. Kimmey Endowed Chair in Public Health

Kimberly R. Enard, PhD, MBA, MSHA, FACHE®, is Interim Dean of the College for Public Health and Social Justice, Professor of Health Management and Policy, and James R. Kimmey Endowed Chair in Public Health at Saint Louis University. Leveraging more than 25 years of management and consulting experience, Dr. Enard partners with communities and health systems to evaluate policies and practices that aim to advance health and social equity. Her teaching experience includes courses in healthcare management, health policy, healthcare quality improvement, and introduction to finance and economics.