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Care at Home

The Value Proposition of Private Duty

HCA
HOME CARE ASSOCIATION
OF NEW YORK STATE

September 6, 2018

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Objectives

- Why Private Duty needs to re-invent itself
- Steps to becoming part of the solution
- Financial Benefits to Stakeholders
- Marketing as a Supportive Partner to Stakeholders

LIFETIME *Care at Home*, LLC

- 19 year affiliation with VNA Community Healthcare and Hospice
- Private pay services include Live In, PCA, Homemaker/Companion
- Revenue $4.1 million FY18
- Increased bottom line contribution from -$133,247 to $287,436
- Client census of 97, caregiver census of 112
- 75% Close Ratio

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Private Duty Services

Non-medical in home care

Activities of Daily Living (ADLs)

- Bathing and grooming
- Eating
- Dressing/undressing
- Toileting
- Ambulation
- Memory care and stimulation

Instrumental Activities of Daily Living (IADLs)

- Preparing meals/disease specific
- Shopping
- Housekeeping
- Laundry

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I Can Read Your Mind

Who's Going to Pay???

They Can't Afford It!!!

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Financial Options

Available Programs:

- Area Agencies on Aging
- Home Care Program for Elders
- Alzheimer's Respite Program
- Veterans Aid & Attendance and Housebound Pension

Resources:

- Credit Cards
- Savings and Investments
- Reverse Mortgage
- Long Term Care Insurance
- Life & Term Insurance Policies – Cash Value

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Connecticut Statistics

- Total Population – 3,588,000
- Medicare population – 658,348
- Medicare represents18% of total population
- CT does not require Private Duty agencies to be certified
- Department of Consumer Protection oversight

Home Healthcare Agencies in CT = 91

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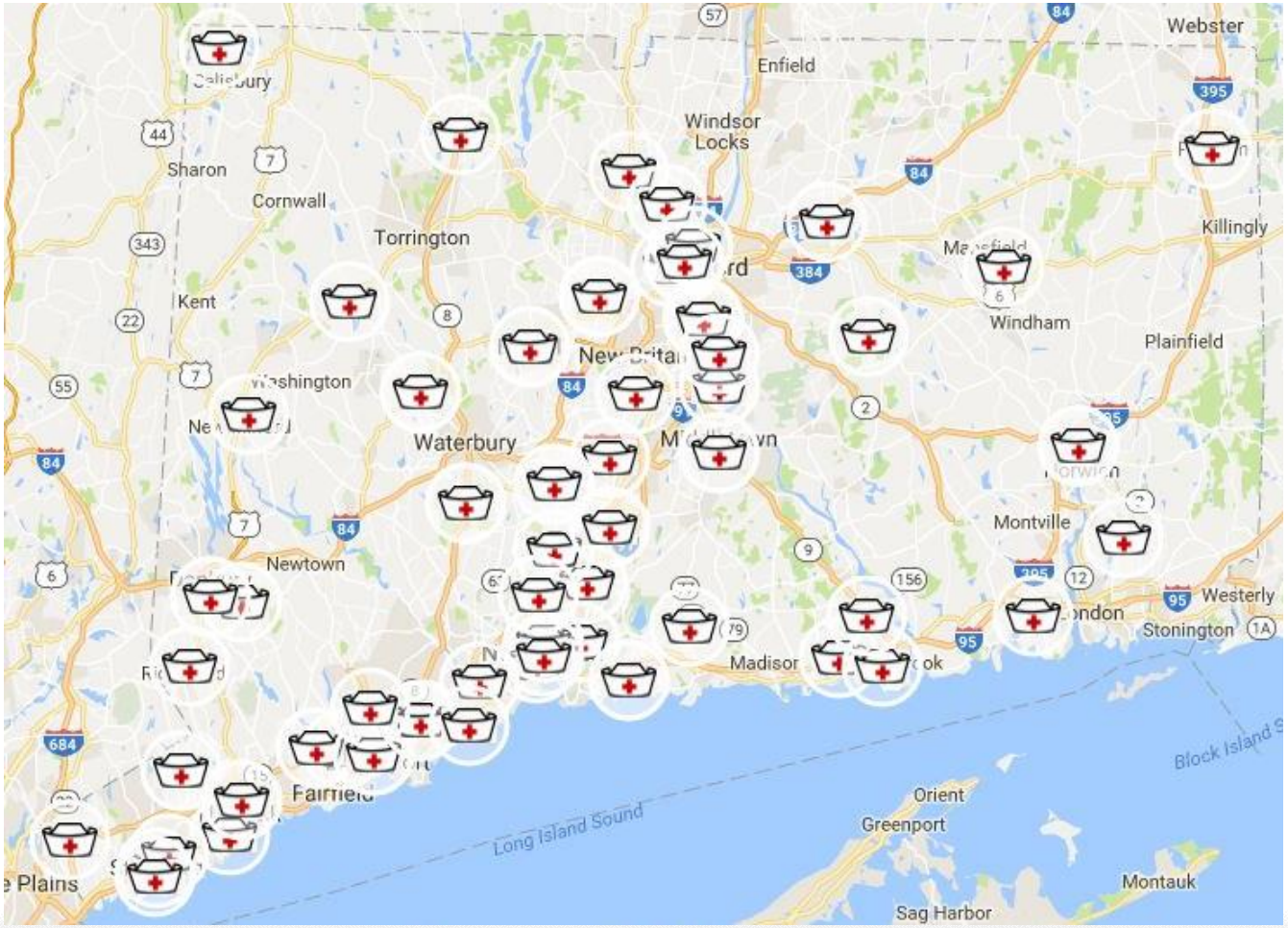

Homemaker Companion Agencies in CT = 699

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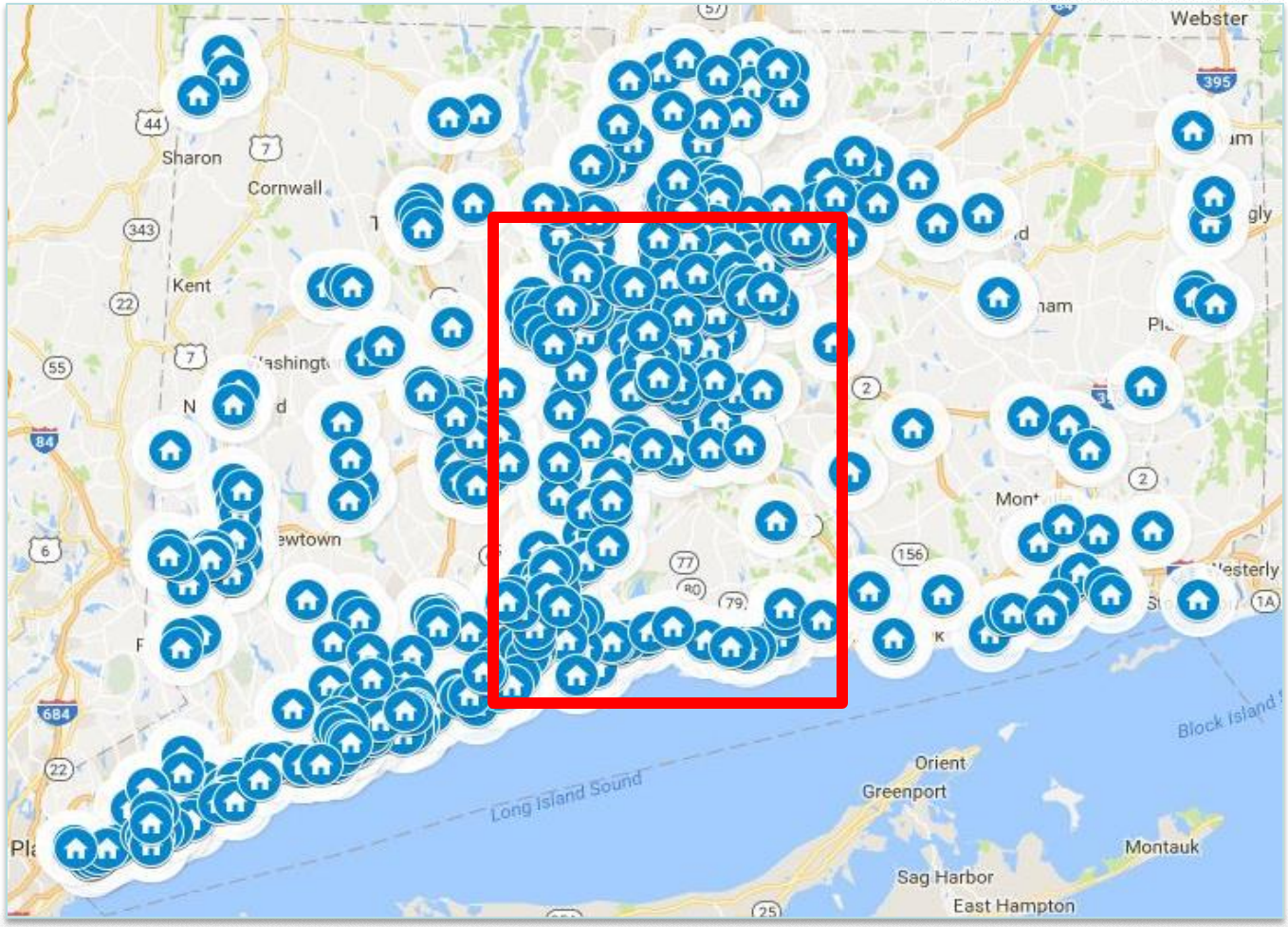

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Changing Landscape

- Volume Based to Value Based Care
- Providing Care to Managing Care
- Hospitals penalized for **re-admission** of specific conditions i.e. CHF, Pneumonia, etc.
- Alternative Payment Models (APM's): Accountable Care Organizations (ACO's), Bundled Payments, Pay for Performance, Medicare Advantage
- Data and Outcomes

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On the Horizon

- Technology – “Interoperability”, texting, remote patient monitoring, patient portals
- By 2019 90% of all Medicare healthcare payments (including physician’s) will be tied to **VALUE-BASED PURCHASING MODELS**
- “DISRUPTORS” – Honor (Digital), Amazon, CVS, Insurance Companies purchasing Private Duty Agencies
- Private Duty to Home Care

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The Paradigm has shifted from

How MUCH a Provider Does

to

How WELL the Patient Does

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Why the Change

Medicare Payment Advisory Commission (Medpac) estimates that 76% of Medicare hospital readmissions could have been avoided –

Resulting in approximately $17 billion*

*The Remington Report. November/December 2016

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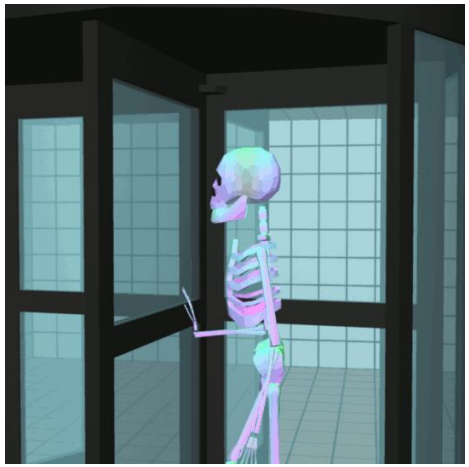
CMS



The key driver behind the readmission revolving door is the lack of *coordination of care* after discharge.

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Rehospitalization Risks

- Medication Errors
- Falls within first 24/48 hours of discharge
- Lack of follow up with Primary Care Physician – Transportation to appointment
- Nutrition – shopping, meal prep, prescribed diet

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Realization

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Private Duty as a Supportive Partner

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Value Proposition

Private Duty provides supportive services in reducing re-hospitalizations.

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GOAL

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Positioning as the Supportive Partner

Think like you

Talk like you

Be like you

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What Private Duty is Doing

- Provide assistance up to 24/7
- Observe & Report changes in condition
- Early intervention before emergency visit
- Managing family dynamics
- Geriatric Care Management
- Referrals for medical and nonmedical professional services

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Whom Private Duty is Helping

Clients:

- Anxiety/Depression/Hording
- CHF/COPD
- Dementia with sun downing and wandering
- Diabetes
- Neurological Disorders – ALS, Parkinson's
- Stroke with memory or physical impairments
- Ostomy Bags/Catheters
- Visual and Hearing impairments
- End of Life Care

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How Private Duty Assists

Devices:

- Hoyer Lifts
- Sara Lifts
- Stair Lifts
- Gait Belts
- Shower Chairs
- Special Diet Prep – Low Sodium, Low Sugar, Thick It
- Oxygen
- Nebulizer treatments

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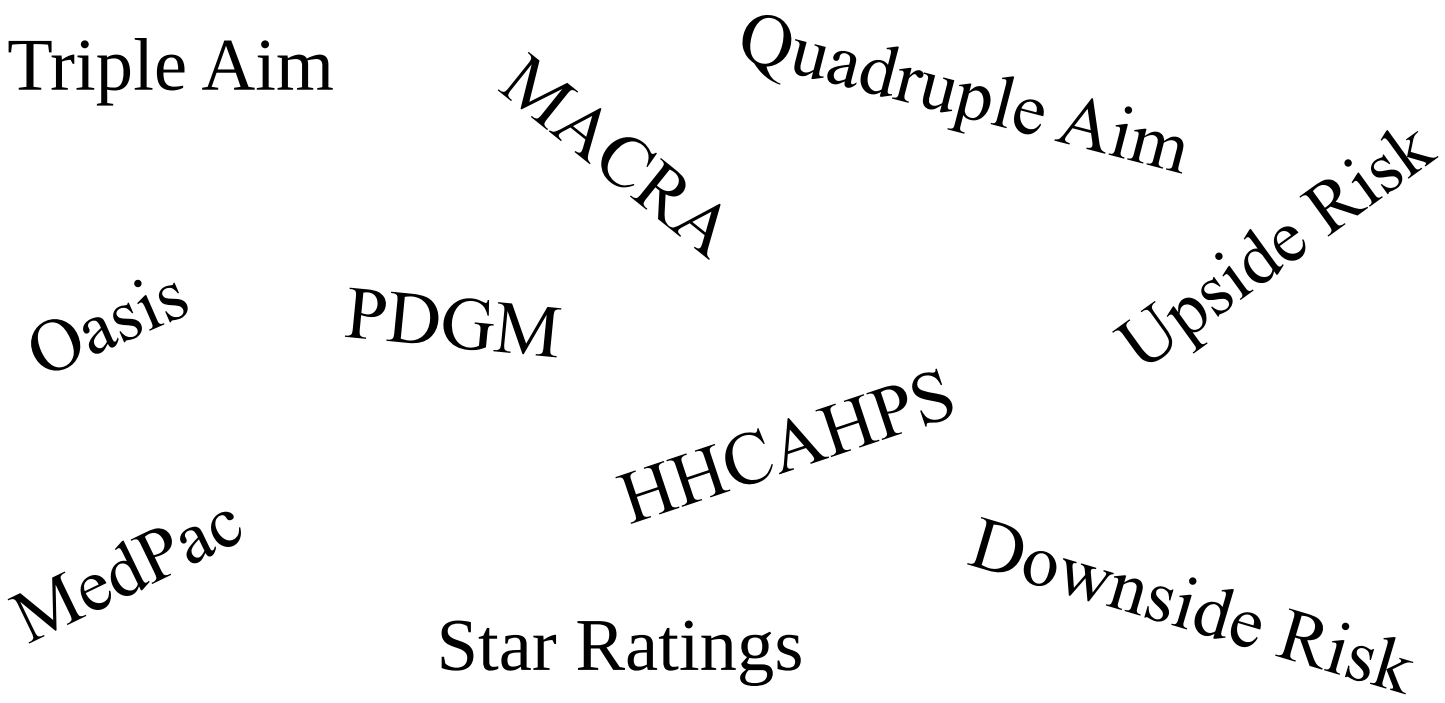
Learn a new Vocabulary



Triple Aim Concept

Quality
Patient Outcomes

(Five Star Ratings)
OASIS

Value

Cost of Care

Service
Patient Satisfaction

HHCAHPS

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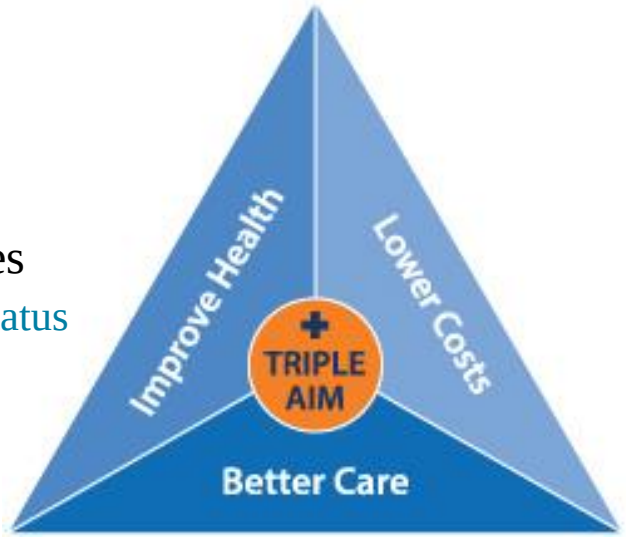
Private Duty Model

Quality
Patient Outcomes
Improved/Maintained Status



Value
Cost of Care
Re-hosptialization

Service
Patient Satisfaction
Client Satisfaction

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Quadruple Aim Concept

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Home Health Care & Private Duty Survey Questions

Customer Satisfaction

Home Health Care	Private Duty
HHCAHPS	Home Care Pulse
How often did the home health provider seem informed and up to date about the treatment you got at home?	Please rate the ability of the caregivers to meet your needs as described in the care plan.
Did someone from the agency tell you what care and services you would get?	Did your provider communicate the services that you would be receiving?
When you contacted the agency's office, did you get the help or advice that you need?	Are you confident in the office staff when calling with questions or concerns?
Would you recommend this agency to your family or friends if they needed home health care?	Would you recommend this provider to family or friends who need help at home?

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Home Health Care & Private Duty Survey Questions

Measurable Outcomes

Home Health Care	Private Duty
OASIS	**Client Status Reports**
RN rates patient ability on a scale of 0 – 5	Case Manager rates client ability on a scale of 0 – 5
How often home health patients had to be admitted to the hospital.	In the past 60 days, have you had an unplanned hospitalization?
How often patients got better at walking or moving around.	Please rate current mobility.
How often patients got better at bathing.	Please rate current ability to perform personal care.

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Survey Form

Evaluations done at SOC, 30 days, 60 Days and 90 days

On a scale of 0 – 5, rate level of assistance:

- Overall Assistance
- Personal Care
- Mobility
- IADLs

In last 60 days:

- Unplanned ER/Urgent Care visit
- Hospitalization
  (If Yes, Heart Related?)

Qualifications for Participation

LIFETIME Care at Home - Client Status Report

Client Name: _____

Client ID: ☐☐☐☐☐☐

	SOC	30 Days	60 Days	90 Days/D/C
Date of Evaluation:				
Overall Assistance: (0-5)				
Personal Care: (0-5)				
Mobility: (0-5)				
IADL: (0-5)				

In Last 60 days - Y/N	SOC Y	SOC N	30 Days Y	30 Days N	60 Days Y	60 Days N	90/D/C Y	90/D/C N
Unplanned ER/Urgent Care:								
Hospitalization:								
If Yes, was it Heart related?								
ex. CHF, COPD, Heart Disease								

0 No Assistance Needed
1 Stand by Assistance Needed
2 Assistance needed occasionally
3 Assistance needed daily with some tasks
4 Assistance always needed with all tasks
5 Total Care - unable to perform on own

- New Start of Care
- Receiving personal care
- Length of service of more than 30 days

Quadruple Aim Outcomes

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Program Information

Start Date: May 2016
Client Enrollment to Date: 137
30 Day Evaluations: 123
60 Day Evaluations: 92
90 Day Evaluations: 75
Results through June 2018

Hospitalization Statistics	Clients	%
Clients hospitalized within 60 days prior to Start of Care	80	58%
Clients re-hospitalized within 30 days post Start of Care	11	9%
Clients re-hospitalized within 60 days post Start of Care	8	9%
Clients re-hospitalized within 90 days post Start of Care	3	4%

Measure	Improved or Maintainted Status since SOC		
	at 30 days	at 60 days	at 90 days
Overall	97.6%	96.7%	96.0%
Personal Care	97.6%	96.7%	96.0%
Mobility	97.6%	96.7%	96.0%
IADL	96.7%	95.7%	94.7%

Client Satisfaction - all clients	Score (1-10)
Overall Satisfaction	9.0
Recommend Provider	8.7
Impact of Services on Daily Life	8.7
Work Ethic of Caregivers	9.1
Ability of Caregivers	9.1
Compassion of Caregivers	9.3
Communication from Provider	8.8
Client/Caregiver Compatibility	9.0

Care Team Satisfaction - all caregivers	Score (1-10)
Overall Satisfaction	9.2
Recommend Employer	9.0
Training Received	9.2
Office Staff Support	9.2
Caregiver Recognition	8.8
Openness to New Ideas	9.3
Clear Expectations	9.3
Client/Caregiver Compatibility	9.5

HomeCare Pulse Survey Results July 2017- June 2018

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VALUE has to be supported by

DATA

For some – it's

SHOW ME THE $$$$$$

Cost of Care - CHF

Managed Medicare Patients – 30 day re-hospitalization rate

Home Health Agency

- 165 SOC – Month
- 17% (28 CHF)
- 22% re-hospitalization rate (6 patients)

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- 11% (3 clients)

Difference of 3 patients @ $13,000 per re-hospitalization –
$39,000/m $468,000/yr

**The Healthcare Cost Utilization Project – "Statistical Brief #142," 2009 Data*

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Marketing

Presenting the Value to Stakeholders

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Value to Home Health Agencies

Patient Satisfaction

Extension of an episode

Make it part your brand

Agency's RN/LPNs perform 30/60/90 day evaluations

Patient outcome data specific to agency

Fall Prevention/Safe Transferring

Alternative Payment Models (APMS)

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Value to Hospitals

Patient Satisfaction

First 30 days for high risk patients

Able to provide:

- Transportation to physician appointment within 2 weeks
- Medication Reminders
- Fall Prevention
- Support good nutrition/hydration

Up to 24/7 care & observation

Reporting change in status to physician for early intervention.

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Value to Physicians

Patient Satisfaction

Ensure patients make their scheduled appointments

Reporting change in status for early intervention

Medication Reminders

Up to 24/7 care & observation

Part of bundled program

Chronic Care Management Program (CCM)

Preferred Provider Status

Current:

Home Health Agencies:	4
Independent Living Communities:	2
Short Term Rehab:	2

Pending:

ACO – Hospital	1
Bundled Program (Orthopedic Group)	1
Joint Replacement Rehab Program – Hospital	1

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In Progress

Interoperability – Community Portal

Re-hospitalization Risk Score based on Client Status Report

If/Then action plan from data entered by caregiver

Technology integrated to address social, medical and safety needs

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"Your organization's market position can be a predictor of your future sustainability."

~ Remington Report September 2016

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Polaroid

BLOCKBUSTER VIDEO®

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Questions?