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HOME HEALTH AIDE WORKFORCE

How real time actionable data leverages new value for home health aides and stakeholders

By **CHRISTY JOHNSTON, MPH**

This is the first article in series of articles to discuss how to leverage and support a culturally competent home health aide workforce synchronized by real-time data.

Additionally, a six web-based Signature Education series provided by The Remington Report and Premier Home Health Care Services is offered to support company-wide training in the areas of:

- **Culture/Organizational Change,**
- **Workforce Value/Data Training,**
- **Payer Strategies,**
- **Alignment of Quality Measures**
- **Data Analytics, Technology Solutions and Workflows.**

See details on page 9.

One constant in the world of healthcare is change. The evolving nature of healthcare financing and delivery systems, along with changing demographics, demands that those involved in any aspect of the healthcare system innovate, transform, and identify the best ways to manage change and complexity.

All of this seems daunting and sometimes unmanageable, but without a doubt, home and community-based care providers are well-positioned to offer solutions. In fact, the solutions are right in front of us and they are simple approaches that capitalize on our strengths – home health aides, data collection opportunities, and our understanding of client needs and effective in-home interventions.

Premier Home Health Care Services, Inc. (Premier), a multi-state home care company with a comprehensive community-based service delivery platform, has capitalized on these strengths with the development of ***RTD—Real Time Data,*** which uses actionable data, secured by the home health aide, to bring the necessary value and quality outcomes to meet the evolving needs in the healthcare system.

THE CHANGING HEALTHCARE LANDSCAPE

Changes in healthcare are happening in all areas, but the long-term care sector, particularly home and community-based care, is under uniquely intense pressures as greater demands are placed on the system by demographic variations – the "graying" of the nation – while simultaneously there is the need to navigate the challenges of sweeping healthcare system changes.

Many are familiar with the Pew Foundation's reporting that 10,000 Americans will turn 65 every day through 2029. The US Census Bureau predicts that by the year 2035, the number of older adults (age 65 and over) will be larger than the number of children (under age 18). This will mark the first time in US

history when older adults will outnumber children.

Additionally, as the population ages, people are living longer with more chronic illnesses. Three out of four Medicare beneficiaries who also receive services through Medicaid (dual-beneficiaries) have three or more chronic conditions and one in five Medicare beneficiaries is readmitted to the hospital within a month of discharge. This creates both service delivery and fiscal challenges in the healthcare system.

These demographic changes and population characteristics have significant implications for the long-term care sector. Essentially, there will be fewer people available to care for an increasing number of seniors with more complex needs, which will further drive the need for providers and payers to identify innovative solutions to keep people healthier and in less costly home and community-based care settings for longer.

"With data, organizations can develop strategies to improve client outcomes; reduce potentially avoidable hospitalizations and readmissions; identify population trends; and increase the value of home and community-based care providers to myriad stakeholders."

– CHRISTY JOHNSTON, MPH IS VP OF GOVERNMENTAL & MANAGED CARE SERVICES FOR PREMIER HOME HEALTH CARE SERVICES, INC.

Meanwhile, as the population picture and demand for services continues to evolve, we also are experiencing sweeping changes in healthcare. In all sectors, service delivery has moved toward a focus on value versus volume and quality versus quantity, and as a result, financing models have followed suit. These changes are major shifts in thinking for anyone providing or paying for care and require access to actionable data and timely interventions to meet defined quality metrics of relevant stakeholders such as Accountable Care Organizations (ACOs), integrated healthcare systems, or managed care plans.

It is critically important for home and community-based care providers to shift their thinking and ask stakeholders about their needs and how home care can help them achieve their goals. Providers also must be prepared to remain flexible as stakeholder needs will vary by the incentives (quality bonuses for positive outcomes) and penalties (payment reductions for readmissions) to which stakeholders are being held. Whether the stakeholder is an ACO or an integrated healthcare system, a Medicare Advantage plan or a Medicaid Managed Care plan providing long term care services, an organization's success will be based on the quality of services they can provide and the value they can bring to the table.

THE HOME HEALTH AIDE'S CHANGING ROLE AND VALUE

Fortunately, home and community-based care providers are in a strong position to offer solutions to meet the needs of many stakeholders (payers, providers, clients) in the changing healthcare landscape and we need look no further than our own organizations for the most untapped and historically overlooked resource – the home health aide. As healthcare systems change, so must the role of the aide and our understanding of the full value that they bring to the equation.

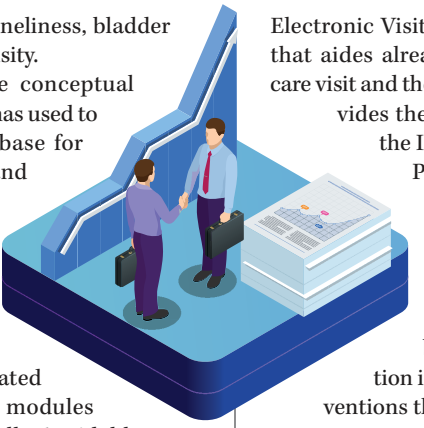
Home health aides are the eyes and ears in home care. Their presence in the home, their work to support members with activities of daily, and their often strong, emotional connection with clients and their families, contributes immensely to securing positive health outcomes.

In addition to the invaluable care and support that an aide provides in the home, they also must be viewed as a valued, contributing member to the Interdisciplinary Team that cares for a client and a key source of information. If aides are the eyes and ears in the home, we should rely on them to capture and transmit real time data about the client's status and turn their observations into actionable data.

In recent years, as Premier assumed more risk for client outcomes, the Company focused on making home health aides partners and began engaging and educating them to the fullest. In 2016, the Observe, Ask, Report (OAR) Training campaign was developed. The goal of OAR training is to prepare home health aides and the entire home care interdisciplinary team (IDT) – all management, administrative, coordinator, clinical staff and aides – for their roles in improving client health outcomes. The training is multi-pronged and focuses on educating aides on what signs and symptoms to "Observe, Ask, and Report" on when they are in the client's home. The OAR approach is then applied to specific quality measures that are important to payers, such as annual flu vaccine, falls,

shortness of breath, loneliness, bladder control, and pain intensity.

OAR I became the conceptual platform that Premier has used to expand a knowledge base for home health aides and other IDT staff and since the initial OAR module was developed, Premier has expanded the targeted OAR training approach and has created three additional OAR modules that address: Potentially Avoidable Hospitalization (PAH) diagnoses; Social Determinants of Health, and Behavioral Health & Chronic Disease Management. Future OAR modules will cover HEDIS measures and Medicare Advantage Star Measures. All of this training ties to the measures and concepts that are important to stakeholders.



HOW TIMELY DATA DRIVES INCREASES VALUE

Once aides understand the full role that they play in supporting the client and improving health outcomes, they understand the value of the information that they are able to collect and share with the IDT. But why is all this data important? It is simple – the organizations that have access to and can utilize timely data to improve outcomes, increase their value to stakeholders. With data, organizations can develop strategies to improve client outcomes; reduce potentially avoidable hospitalizations and readmissions; identify population trends; and increase the value of home and community-based care providers to myriad stakeholders.

Success in avoiding readmission penalties, capturing financial savings in a Value Based Payment (VBP) arrangement, or securing quality bonus dollars, is contingent on being able to hone in on issues in a timely manner and deploying health and supportive care resources to the client to prevent higher cost interventions.

In Premier's ***RTD—Real Time Data*** model, the home health aide helps ensure that client issues are identified so interventions happen. In order to support data collection, Premier developed an effective, yet simple approach that utilizes the telephonic Electronic Visit Verification (EVV) system that aides already use during each home care visit and then the transmitted data provides the information necessary for the IDT to support the client.

Premier's ***RTD—Real Time Data*** EDGE Dashboard and Quality Incentive Program Unit (P-QIP) take the data that aides send from clients' homes on a daily basis and turn the information into actionable, timely interventions that:

- Prevent members from being readmitted to hospitals;
- Slow disease progression by changing behavior or securing additional supports;
- Identify social determinants of health that may be impacting health outcomes;
- Manage medication adherence;
- Manage immunizations, screenings, PCP visits; and
- Target other interventions that can improve client health outcomes and success in meeting person-centered care plan goals.

THE NEW ROLE OF HOME CARE AIDE'S RESPOND TO HEALTHCARE'S TRANSFORMATION

Gone are the days when aide services are merely support with activities of daily living. It is critical, for the survival of home and long-term care, that aides now be viewed as the center of the IDT and the source of critical, actionable information to care for the client and support organizations as they manage the changing healthcare system and payment environment.

Observations and reports made by home health aides generate valuable, timely data from the home about the client. Collecting and acting effectively on the information, is critical to impacting client outcomes and supporting the goals of providers and payers with which you are working.

Providers that collect, analyze, and take action on data, can impact outcomes and improve quality measures, increase medica-

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Older Adults Stats

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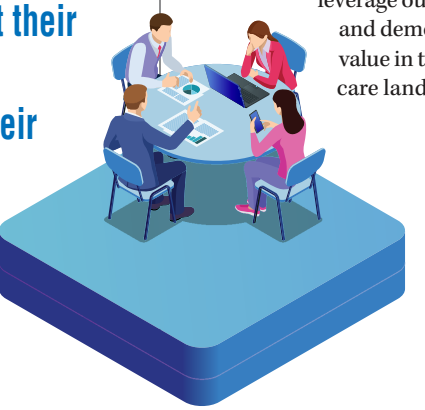
tion adherence, and reduce Potentially Avoidable Hospitalizations (PAHs)/readmissions, which benefits:

- Health plans and other payers by improving quality measures, star ratings, risk adjustment scores, and quality bonuses;
- Hospitals by reducing readmissions and lowering readmission penalties;
- Home care providers by improving quality measures, shared savings and quality bonuses; and most importantly;
- Members by providing better health outcomes, managing chronic diseases, and supporting them to help them remain at home.

"It is critically important for home and community-based care providers to shift their thinking and ask stakeholders about their needs and how home care can help them achieve their goals."

Premier's ***RTD—Real Time Data*** is exciting and transformative. The approach to leveraging the value of home health aides is already demonstrating significant positive outcomes and is transforming how healthcare system stakeholders view the value that home and community-based care providers bring to the evolving healthcare landscape. In the end, whether your organizations is prepared to develop your own tools and approaches to engaging your workers or if you choose to work collaboratively with other organizations to achieve your change, it is clearly time for home and community-based care providers to look at our most valuable assets and leverage them to their fullest.

As community-based care providers, we know the value that home care brings to the healthcare system. Home care is less costly and people prefer to be in control of their care, in settings in which they are comfortable – their homes. It is time to leverage our assets, utilize data, and demonstrate home care's value in this changing healthcare landscape.



About Premier Home Health Care Services

Established in 1992, Premier maintains its Corporate Headquarters in New York State and operates in seven states – New York, New Jersey, Connecticut, Massachusetts, Illinois, North Carolina, and Florida. Led by a management team with decades of experience in community-based home care, managed care, and care management services, Premier provides personal care and care management services to approximately 34,000 long-term care members on a monthly basis through both traditional and Value Based Payment (VBP) risk contracts with health plans and other payers.