INNOVATIONS IN HOME CARE

New Roles, Career Pathways, and Technology
H CAP Spring Conference, March 15, 2018
HOME HEALTH CARE 101

- Licensed Home Care Services Agency
- Certified Home Health Agency
- Consumer Directed Program
- Private Pay, Medicare, Medicaid
- Managed Long Term Care Plan
- Independent Provider
- Personal Care Aide
- Home Health Aide
- Training Requirements
CURRENT CONTEXT for SERVICE DELIVERY

- Quality metrics, risk sharing and Value Based Payment contracts reward effective service, improved health outcomes, and reduced ED visits and preventable hospitalizations
- NYS Medicaid Redesign Team recommendations informed system transformation through two programs- Delivery Service Redesign Incentive Payment Program (DSRIP) and Long Term Care Workforce Investment Program
- Healthcare providers need effective strategies to reduce expenses and support high risk/high need patients
- Workers need enhanced skills and opportunities to meet the demands of new service delivery models
Perspectives of Home Care Workers who Care for Adults with Heart Failure: Society of General Internal Medicine 2018 Grant Winner

What Did We Learn About You?

Caught in the middle
- Different agencies
- Dual HHA and PCA roles
- Communication is fragmented
- Client, family, nurse, doctor, agency

The work is hard
- Few days off
- Difficult clients/families
- Physical strain
- Burnout
- Social isolation

Don’t feel valued by the system
- Low wages
- Client turnover
- Variable support from agencies
- Often ignored by other healthcare providers

Love the job
- Healthcare
- Helping people
- Creative
- Problem solvers

Dedicated to clients and family
- Positive relationships
- Challenging relationships
- Feel needed
UN-TAPPED VALUE OF HOMECARE SECTOR

- 1199SEIU union members
- Access to health, pension and education benefits
- Innovative employers
- Engaged in their community
- Language and culturally diverse
- Access to patients/clients/consumers, family members, primary health care team, visiting nurses and more!
- Excellent context for effective Labor-Management Partnerships
Gap Aide Program Aim and Goals

- Aim of program is to reduce avoidable Emergency Room visits and/or hospital readmissions for high-risk Medicaid members admitted to Brookdale Hospital.

- Goals of Program include: Increased Cost Savings & Improved Healthcare utilization (↓ hospitalizations, ↓ ER visits, ↑ PCP / Specialist visits, ↑ medication fills)
Gap Aide Responsibilities (1)

– Meet the patient at hospital prior to discharge, become acquainted with their discharge plan including medications, medical equipment for the home and health contact information
– Escort patient home and fill prescriptions
– Check home for safety, cleanliness and proper ventilation
– Shop for fresh, healthy food and discard spoiled food in refrigerator and cabinets
Gap Aide Responsibilities (2)

- Schedule follow up doctors visits, arrange transportation and accompany patient to doctor
- Document patients’ health status in real time using e-caring and report recent behaviors to care team, visiting nurse and MD
- Stay with patient until stabilized (up to 10 days) to lower risk of re-hospitalization and to avoid unnecessary ER visits
- Will make sure patient has first MD appointment and will arrange whatever transportation necessary to get member there
Gap Aide Pilot at Brookdale:

Targeting Medicaid readmissions and preventable admission (PQI) events

- 2016 Medicaid (MCD) only initial readmission rate = 17.3%
  - Total 2016 MCD admits = 1,797
  - Percent of initial admissions that resulted in readmission within 30-days

<table>
<thead>
<tr>
<th>Top 10 Conditions</th>
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<tbody>
<tr>
<td>Hereditary hemolytic anemias</td>
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<tr>
<td>Asthma*</td>
<td></td>
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<tr>
<td>Diabetes mellitus*</td>
<td></td>
</tr>
<tr>
<td>Heart failure*</td>
<td></td>
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<tr>
<td>Epilepsy</td>
<td></td>
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<tr>
<td>Other current conditions in the mother classifiable elsewhere</td>
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<tr>
<td>Pneumonia, organism unspecified*</td>
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<tr>
<td>Septicemia</td>
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<tr>
<td>Chronic bronchitis*</td>
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- Overall 2016 preventable admission (PQI) rate = 20.8
  - Worse than Healthfirst average

<table>
<thead>
<tr>
<th>PQI Distribution</th>
<th>Percent of Total</th>
<th>Count</th>
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<tbody>
<tr>
<td>Angina w/o procedure</td>
<td>4.4%</td>
<td>25</td>
</tr>
<tr>
<td>Bacterial pneumonia*</td>
<td>12.8%</td>
<td>73</td>
</tr>
<tr>
<td>CHF*</td>
<td>17.9%</td>
<td>102</td>
</tr>
<tr>
<td>Dehydration</td>
<td>8.1%</td>
<td>46</td>
</tr>
<tr>
<td>Diabetes*</td>
<td>17.2%</td>
<td>98</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3.0%</td>
<td>17</td>
</tr>
<tr>
<td>Respiratory</td>
<td>30.9%</td>
<td>176</td>
</tr>
<tr>
<td>UTI</td>
<td>5.8%</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>570</td>
</tr>
</tbody>
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*Target condition
AIM: significantly improve Brookdale’s index readmission rate

- Need to reduce 44 initial readmission events for significant improvement
- Average admissions per member in 2016 = 1.4 admits per year (1709 total admits across 1,258 members)
- N = 182 members
Brookdale: Medicaid Member Targeting (2)

- Inclusion criteria:
  - Medicaid LOB; Age range ≥ 18 years
  - ADL / IADL needs: medical necessity
  - Top driving conditions for inpatient admissions and PQI events
  - ER super utilizers: ≥ 4 or more ED visits within last 12 months
  - Prior admission history: ≥ 1 admission to hospital within last 30 days.

- Exclusions:
  - Members with an existing personal care assistant (PCA)/(HHA) or private duty nursing (PDN) authorization
  - Maternity cases
  - Specific high risk conditions, e.g. cancer, end stage renal disease (ESRD), HIV
  - Catastrophic events
  - LIP-SHP members, Medicare & Integrated Products
Gap Aide Pilot Implementation

- Aides train for up to full week with pay (35 hours)
- Aides will attend two “booster” sessions - one per month after initial training and work assignment
- RNs and home care supervisors, care managers and discharge team will also be trained or oriented to the project
- Employers will structure gap aides to receive guaranteed 30 hours of work per week and a higher hourly wage to ensure job quality and retention
Training Curriculum Includes:

- Introduction to New Roles
- Effective Communication
- Common Chronic Disease Care
- Reporting and Actions Steps for Chronic Diseases
- Health Coaching / Monitoring Towards Compliance
- eHealth / eCaring
- Working with Challenging Behaviors
- Safety in the Home - Preventing Slips, Trips and Falls
- Positioning, Skin and Wound Care
- Nutrition, Hydration and Unplanned Weight Changes
eHealth - WHY eCaring?

- Designed especially for use by the Home Care Worker
- Captures unstructured, real-time data from the home
- Easy-to-use, intuitive icon-based system
- Real-time actionable alerts provide early interventions

Behavioral, clinical and medication adherence data

Two-way Notes for Communications between Care Managers and in-home Caregivers

Home Care Services Alliance
Caregiver entered “Confused.” Care Manager immediately called home, informed by caregiver who had been working with patient for three years that patient didn’t remember her.

**INTERVENTION:** Care Manager sent visiting nurse into home to perform lab work, discovered patient had a UTI, treated in the home, avoiding ER visit.

1. Caregiver / Patient enters information in eCaring.
2. Pre-determined alerts sent to Care Management team.
3. Alerts enable immediate intervention to prevent escalation.
4. Quick responses reduce ER / hospital use and lower medical expenses.

*The best way to deal with a crisis is to avoid it in the first place!*
A SOLUTION FOR IMPROVED CARE

• Integrate the home care worker into the clinical and discharge team
• Create supports for home care workers, patients and their family caregivers
• Innovate with new models, technology, and redesign
• More research on expanding interdisciplinary team to include the homecare aide
Thank You!

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