The Value Proposition of Private Duty: What Stakeholders Across The Care Continuum Should Know

By: Guy Tommasi, Jr.

The value of private duty affects the Triple Aim, patient engagement, readmissions and better patient outcomes. What should stakeholders know to leverage its value?

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When was the last time you thought of Home Care (a.k.a.) Private Duty, as a supportive partner in keeping patients/clients from a rehospitalization visit? To be more precise, how often have hospitals, home health agencies, skilled nursing facilities and physician groups looked at, or even considered home care providers as a supportive partner? Based on my experience, not very often.

My theory is that we in the home care industry haven't done a very good job of educating the consumer and other health care providers about the value of these services. For years, this part of the industry was often looked upon, or dare I say looked down upon, as nothing more than glorified, over-priced babysitters. Private Duty can be confusing...there are employee based models, consumer based models, independents, free-standing, affiliated...who can you trust?

The Home Care Association of America (HCAOA), formally known as the Private Duty Association of America, has worked diligently at changing this perception by being an advocate at the federal level, in education at the consumer level, and setting higher standards set for its members, the awareness of home care has never been better. In addition, the changing landscape within the healthcare delivery system will force those providing home care services to adapt similar operational models more closely aligned with those of other post-acute care providers.

The paradigm has shifted from how much a provider does to how well the patient does - from providing care to managing care – fee-for-service to value based reimbursement. Medicare spent over $17 billion on hospital readmissions that could have been avoided. The key driver behind the readmission revolving door as determined by CMS, was the lack of coordination of care with post-acute care providers after a hospital discharge. CMS made it clear - provide good quality care, increase patient satisfaction, and reduce cost or be penalized. I would further add, that the possibility of being squeezed out of any provider/payer networks is a consequence. This was and remains a daunting task. Four years after the Hospital Readmission Reduction Program (HRRP) to reduce preventable readmissions was put into effect, the industry still grapples with the best solutions and practices for avoidable readmissions. (Remington TrendLens e-newsletter October 2017)

Private Duty as a Value-Added Partner

So, how can home care be a viable, value added partner in this rehospitalization frenzy?

If Home Care is to be invited to the table with ACO's, Hospitals, Physician Groups, and Home Health Agencies, then the expectations need to be on par with them.

I think it's important to first understand the nature of its business. Home care services help support independence so that clients/patients may thrive comfortably, safely and confidently in the environment of their choosing – home.

The expectation of other post-acute care providers looking to partner with a home care agency should be that all home care personnel are trained and capable performing these services.

Core Responsibilities Of Private Duty
Assistance with Activities of Daily Living (ALD's)

- Personal Hygiene
- Dressing
- Transferring
- Toileting
- Eating
- Walking

Instrumental ADL'S (IADL's)

* Light housekeeping
* Reminder to take medication
* Preparing Meals
* Shopping for groceries or clothes
* Using the telephone
* Managing money

What is home care also doing while in the home?

- Providing assistance up to 24/7
- Observing and Reporting changes and conditions of the client/patient:
  * This allows for early intervention avoiding a visit to the Emergency Department
- Managing family dynamics:
  * How many times are we confronted with siblings arguing over the level and frequency of care for their loved ones?
  * Children seeing the need for care but parent(s) refuse?
  * Siblings don't speak and we are the intermediary
- Geriatric Care Management:
  * Care plans written and reviewed
  * Organizing and planning doctor's visits, paying bills, etc.
- Referring for other services:
  * Home Health Care
  * Protective Services
  * Home and yard maintenance

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Chart 1

How is Home Care Helping Clients/Patients with:

- Anxiety/Depression/Hording:
  * Caregivers engage in motivational and focused activities
  * Bonding and trusting of caregiver – helps begin the "clean-up" process
- CHF/COPD:
  * Caregivers assist with exercise, low sodium meal preparation
  * Identification of "Red Flags" for timely intervention
  * Transportation to Physician appointments, etc.
- Neurological Disorders – (i.e. ALS, Parkinson's):
  * Caregivers are trained in understanding the progression of these diseases and how to care for the person and the family
- End of Life Care:
  * Part of a multi-disciplinary team

What Devices is Home Care Assisting with:

- Hoyer Lifts
- Sara Lifts
- Stair Lifts
- Gait Belts
- Shower Chairs
- Oxygen
- Nebulizer treatments

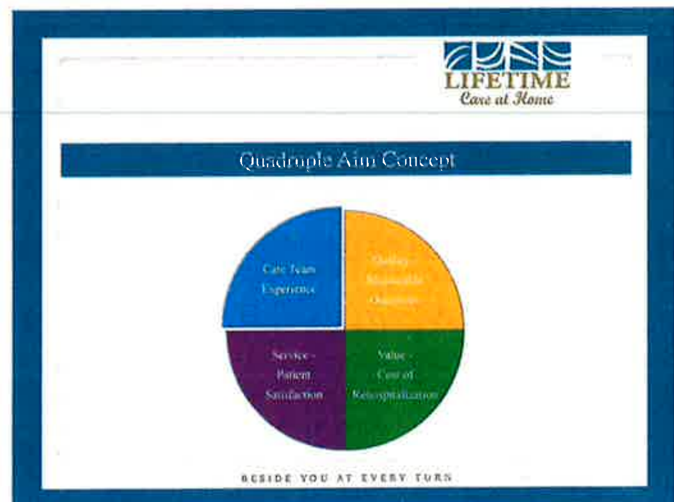
Value to Other Post-Acute Providers

Now that we've seen what Home Care can do in the home, let's look at how it provides value to other post-acute care providers.

Value to Home Health Agencies:

- **An extension of an episode:**
  * Several of the home health agencies we are working with have an average 45-day episode. However, they are accountable for the remaining 15 days (60-day episode). Home care can pick up the case and essentially be the eyes and ears up to 24 hours/day. While in the home, care is being provided and any change in status can be reported immediately back to the home health agency.
- **Make it part of your Brand:**
  * HHA's can include home care as a value-added resource with no out-of-pocket expense.
  * Competitive advantage as part of the HHA's system of care.
- **Referral to HHA:**
  * Home Care agency can be a referral source to the HHA
- **Bundled Payment:**
  * HHA's can more confidently participate in this program knowing coverage up to the full 90 days can be assured.
- **Fall Prevention:**
  * One of the top 3 reasons for rehospitalizations
  * Home care can be in the home up to 24 hours/day
- **Patient Outcome Data specific to Agency:**
  * At LIFETIME Care at Home, we provide agencies with 30,60,90-day patient quality outcome data, patient satisfaction data, and functional outcome data. This allows agencies to provide important data to ACO's, Hospitals, and Physicians.

Chart 2



Value of Home Care to Hospitals:

- Care provided to high-risk patients discharged who do not qualify for the Home Health benefit per CoP's.
- Studies show that readmissions tend to be higher within the first several days after discharge. Having a caregiver in the home can alert the physician for early intervention in the event of a change in status.
- Provide transportation to physician appointment within 2 weeks of discharge

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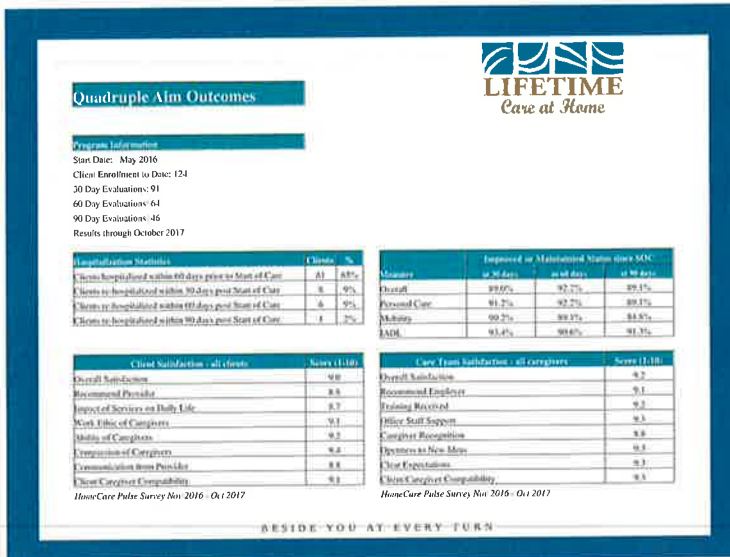
- Medication reminders
- Support good nutrition/hydration
- Fall Prevention:
  * Fall risk is highest within first 24-48 hours after discharge.
- Up to 24 hours of care.

Value of Home Care to Skilled Nursing Facilities:

- Home Care agency refers back to SNF if change in patient status rather than calling 911.
- Fall Prevention
- Medication reminders
- Patient outcome data specific to SNF
- 24-hour care and observation

Chart 3



LIFETIME Care at Home

Quadruple Aim Outcomes

Program Information

Start Date: May 2016
Client Enrollment to Date: 124
30 Day Evaluations: 91
60 Day Evaluations: 64
90 Day Evaluations: 46
Results through October 2017

Hospitalization Statistics	Clients	%
Clients hospitalized within 60 days prior to Start of Care	81	65%
Clients re-hospitalized within 30 days post Start of Care	8	9%
Clients re-hospitalized within 60 days post Start of Care	6	9%
Clients re-hospitalized within 90 days post Start of Care	1	2%

	Improved or Maintained Status since SOC		
Measure	at 30 days	at 60 days	at 90 days
Overall	89.0%	92.7%	89.1%
Personal Care	91.2%	92.2%	89.1%
Mobility	90.2%	88.3%	84.8%
IADL	93.4%	90.6%	91.3%

Client Satisfaction - all clients	Score (1-10)
Overall Satisfaction	9.0
Recommend Provider	8.8
Impact of Services on Daily Life	8.7
Work Ethic of Caregivers	9.1
Ability of Caregivers	9.2
Compassion of Caregivers	9.4
Communication from Provider	8.8
Client Caregiver Compatibility	9.1

HomeCare Pulse Survey Nov 2016 - Oct 2017

Care Team Satisfaction - all caregivers	Score (1-10)
Overall Satisfaction	9.2
Recommend Employer	9.1
Training Received	9.2
Office Staff Support	9.3
Caregiver Recognition	8.8
Openness to New Ideas	9.3
Client Expectations	9.3
Client/Caregiver Compatibility	9.3

HomeCare Pulse Survey Nov 2016 - Oct 2017

BESIDE YOU AT EVERY TURN

Value of Home Care to Physicians:

- Insures patients make their scheduled appointments
- Reporting change in status for early intervention
- Part of Bundled Payment – care of patient more cost effective and outcomes provided for quality measures within 90-day episode.

Value and the Triple Aim

The value of Home Care, impressive as it may be, should not be looked at only from what it can do, but more importantly, from what supportive data it can provide to justify its value as a partner. If Home Care is to be invited to the table with ACO's, Hospitals, Physician Groups, and Home Health Agencies, then the expectations need to be on par with them.

At LIFETIME Care at Home, we've adopted and modified the Triple Aim Concept - see Chart 1, which now includes the Quadruple Aim - see Chart 2, to align with services offered by Home Care. Each of the quadrants measure levels of client functionality, client and caregiver satisfaction, and rehospitlization rates within 30, 60, 90 days post start of care. Client and Caregiver satisfaction results and ratings are determined via monthly telephone surveys conducted by Home Care Pulse, a national management survey company. Client ADL/IADL functionality reviews are conducted by a Geriatric Care Manager and LPN. A monthly dashboard is than produced showing results specific to these quadrants. This dashboard can also be customized to any specific entity for the monitoring of patients referred to us - see Chart 3.

Finally, the one push-back that always occurs when talking about Home Care services is "Who Is Going To Pay," or "They Can't Afford It." My answer has and always will be "if you are a true advocate for your patient and claim to want the very best of care for them, please do not let price determine whether or not you make a referral." Why? It's unfair to the patient! The decision should be made by them or their families. Trust that the home care agency will look at and assist the patient/family in exploring all options.

A few resources available to address this concern:

- **Available Programs:**
  * Area Agencies on Aging
  * Home Care Program for Elders
  * Alzheimer's Respite Program
  * Veterans Aid and Attendance Pension
- **Resources:**
  * Savings and Investments
  * Reverse Mortgage
  * Long Term Care Insurance
  * Life and Term Insurance Policies
  * Credit Cards

The time is now for post-acute providers to include Home Care as a supportive partner in helping reduce rehospitalization. Those providers that can present a system of care that addresses the concerns of CMS – improved care, patient and caregiver satisfaction, cost effectiveness, will be much more attractive to those organizations establishing payer networks. Home Care's value to the healthcare delivery system should be leveraged as a "value" resource. ◆

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LIFETIME Care at Home is an affiliate of VNA Community Healthcare and Hospice

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