

## Premier Home Health Care Services, Inc.

"RTD—Real Time Data"

New York State Department of Health Long Term Care Planning Project May 13, 2019



## **Company & Service Summary Overview**

- Established in 1992 and Headquartered in NY
- Operate in 7 states: NY, NJ, CT, MA, IL, NC and FL
- Provide Licensed Home Care, Care Management, Nursing Assessment, and MCO Technology Services
- > Service approximately 34,000 long term and acute care members monthly



- Personal Care Aide Services 9,000 patients served daily
- ➤ Aide driven RTD—Real Time Data for VBP outcome management
- Technology Platform (ATSP & RTD)
- Care Management/Utilization Review Services 22,000 patients (NY/IL)
- ➤ RN & Nurse Practitioner Assessments 3,000 monthly
- Private Duty RN / LPN Services Pediatric
- Certified Home Health Agency in NYC Includes Physician Services





## Health Care System Changes—Necessitates Change

- Linking Financing to Outcomes—quality measure incentives/readmission penalties
- Increasing Focus on Chronic Disease Management/Transitional Care
- Transitioning to Value Based Payment—upside/downside risk
- Doing More with Less—reimbursement decreasing while costs and demand for services are increasing
- Changing Demographics—"graying" of the nation

## **Leveraging Our Greatest Assets**

- Home Health Aides—LHCSA Interdisciplinary Team (IDT)
- Access to Invaluable Data
- Understanding and Analyzing Data from the Home
- Timely Interventions





#### RTD-Real Time Data Overview

Provide *RTD*—*Real Time Data* transmitted by the Aide from the Member's home to *improve health care outcomes*.

- Comprehensive Training Platform—Aide & LHCSA IDT Training Observe, Ask, Report
  - OAR I MLTC Quality Incentive Measure training
  - OAR II PAH, RTD Technology, and IDT Model Training
  - OAR III Social Determinates of Health
  - OAR IV Behavioral Health
- Electronic Visit Verification System Data Transmission—"Alert" Trigger Questions
  - Quality Incentive Measure
  - PAH Disease Specific
  - Social Determinants of Health Jeopardizing Outcomes
  - Behavioral Health Worsening Chronic Disease Status
  - Medication Adherence
- Dashboard Intervention & Data Management—Premier Quality Incentive Program Unit (P-QIP) manages "Alerts" and data to drive outcomes



#### RTD—Real Time Data

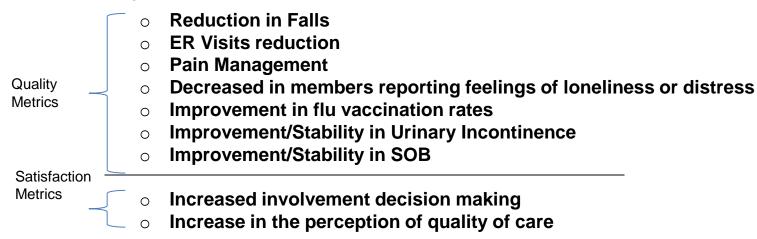
Premier Quality Incentive Program Unit (P-QIP) manages data to drive LHCSA outcomes and maximize potential quality incentives and VBP income. Current *RTD*—*Real Time Data* capabilities:

- Pre-UAS Assessment Quality Measure Outcome Management
- Daily Member Quality Measure and PAH Alerts and Intervention Scripts
- Social Determinants of Health Alerts and Intervention Scripts
- Behavioral Health Alerts and Intervention Scripts
- Flu Vaccination & Other Immunizations & Screening Management
- Medication Adherence Management
- PCP Visit Monitoring Adherence
- Satisfaction Measure Management Grievances, Aide Lateness
- Population Data Aggregation



## Observe, Ask, Report—OAR I

- OAR I solely focuses on educating staff about MLTC Quality Incentive Measures with the goal of improving patient health outcomes relative to those measures.
- Educates administrative, aide, and clinical field staff to identify signs and symptoms of worsening conditions and specific lifestyle changes to manage the chronic conditions that focus on these MLTC Quality Measures
- The following educational modules were developed for the original OAR I program:





#### OAR II & RTD-Real Time Data

- OAR II provided an extensive focus on the 6 diagnoses for Potentially Avoidable Hospitalizations (PAH). General topics included in the OAR II Program include:
  - A description of key diagnoses for Potentially Avoidable Hospitalization (PAHs) including:
    - Sepsis
    - Anemia
    - Electrolyte Imbalance
    - Respiratory Infection
    - UTI
    - CHF
  - System Training for Real-Time Data in-home, aide-based telephonic reporting for changes in condition relative to OAR I (QIM)/OAR II (PAH) data
  - The Care Management cycle, roles of Care Team Members, and the IDT
  - Overview of Cultural Competency, Behavioral Health, and Health Literacy as it relates to ensuring patient-centered care that supports improvement in quality measures and VBP success.

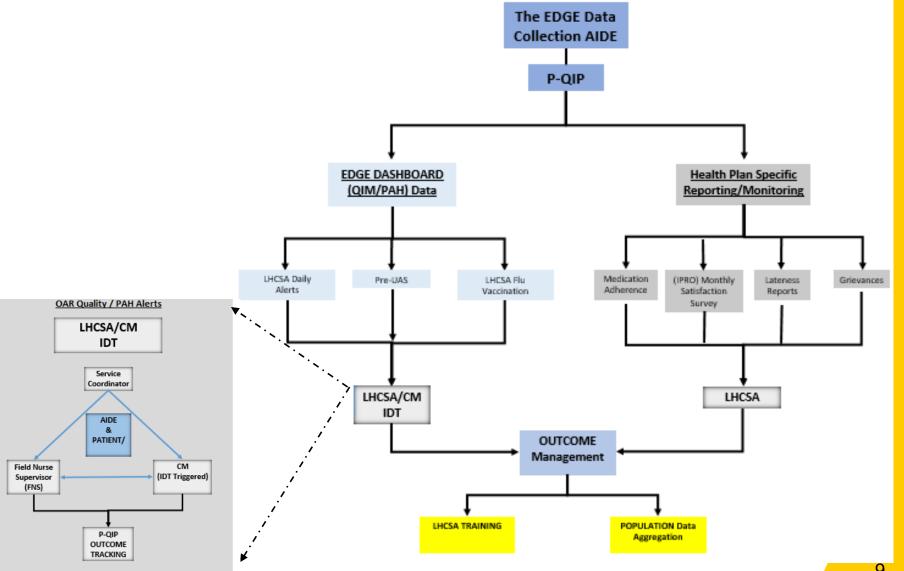


## Observe, Ask, Report-OAR III & IV

- OAR III—Social Determinants of Health: This sequence in OAR defines social issues related to social determinants that impact health care outcomes and provides examples of solutions to these issues. The program has been designed to meet NYS DOH VBP II contracting requirements and covers.
  - Education/Health Literacy
  - Economic Stability
  - Social & Community
  - Health & Health Care Access
  - Neighborhood & Environment
- OAR IV—Behavioral Health & Chronic Disease Management: Provides an understanding of:
  - Key chronic diseases that frequently result in re-hospitalization
    - CHF
    - COPD
    - Diabetes
  - The impact of behavioral health issues on chronic disease management
  - Strategies to impact and improve member behaviors and ultimately PAH outcomes.



# Premier *RTD*—Real Time Data Dashboard





#### **Premier's 2016-2018 Healthfirst Quality Scores**

Score Date	Weighted core	Actual Score	Project Initiation Date
			Pilot HF
16-Dec	3.0	3.07	July '16
			OAR I
17-Jun	3.0	3.23	Developed
			OAR II
17-Dec	3.5	3.29	Developed
			OAR I & II
			Apr-Dec
18-Jun	3.5	3.30	'18 WIO
			RTD &
			Dashboard
18-Dec	3.5	3.39	August '18
		4/19-9/19	OAR III
		10/19-4/20	OAR IV



#### Observe/Ask/Report (OAR)

- OAR I: Quality Incentive Measure Training
- OAR II: Potentially Avoidable Hospitalization & Real-Time Data Training
- OAR III: Social Determinants of Health Training
- OAR IV: Behavioral Health & Chronic Disease Management Training
- Note: RTD Real Time Data Reporting
- Note: The above data is based on NYS DOH UAS data. Note: OAR I & II training to continue through 3/31/19.



#### **Questions & Contact Information**



Christy Johnston, MPH VP Governmental & Managed Care Services

cjohnston@phhc.com
914-506-7135
www.premierhomehealthcare
.com