CareForum 2022

The WellSky® Conference

Positioned for power:

The role of personal care in population health

Michael Slupecki, CEO, Griswold Home Care

Christina Sommerfield, VP Company Owned Offices, Griswold Home Care

Cindy Campbell, Director of Operational Consulting, WellSky

9/8/2022

CareForum 2022

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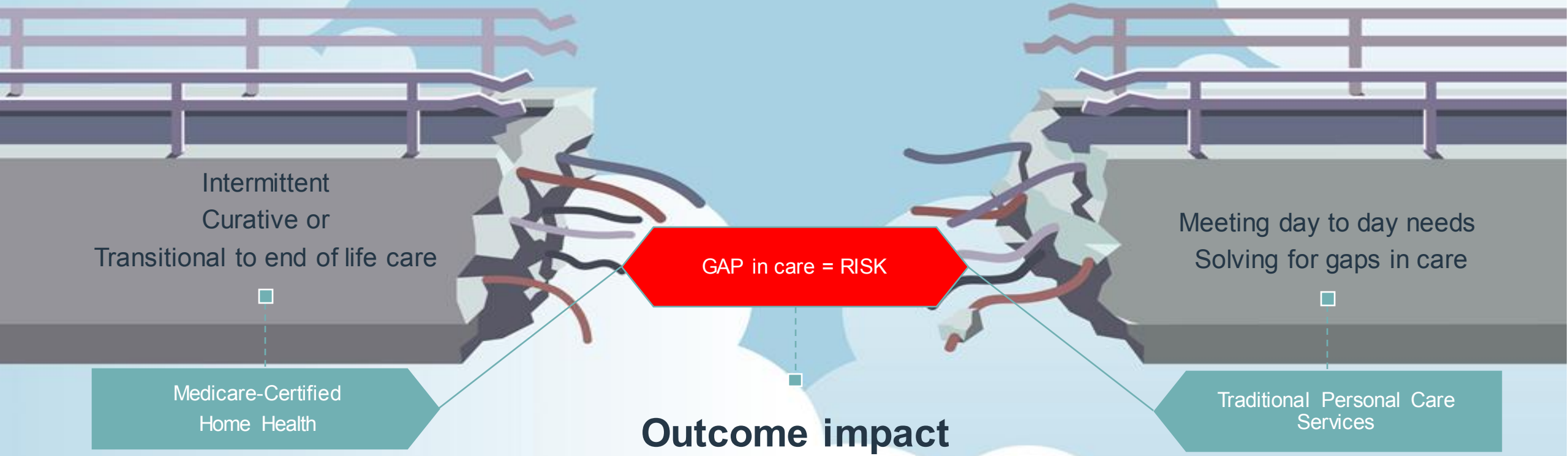
Today’s speakers

Cindy Campbell
Director Operational Consulting
WellSky

Michael Slupecki
CEO
Griswold Home Care

Christina Sommerfield
VP, Company owned offices
Griswold Home Care

Personal Care: Bridging the impact gap



Outcome impact

Cost impact

The Griswold journey

- Big picture thinking within large national franchise
- Board, culture and service evolution
  - Take what we have learned from certified home health and start to apply the thinking into how we design and deliver personal care
- 'Test lab' in wholly owned agencies, within the national franchise
  - Embracing market potential
  - Building deeper understanding of the business: adopting data and predictive analytics
- Early journey goals:
  - Use data to empower and focus care delivery
  - Establish power positioning within relatively 'young' thinking of Medicare Advantage, *and in the minds of our teammates/franchise owners*

Personal care gaining value in population health

36M

In next 10 years, the 65+ population will grow by 36 million people.

More Seniors

65%

65% of senior population have at least 2 chronic conditions

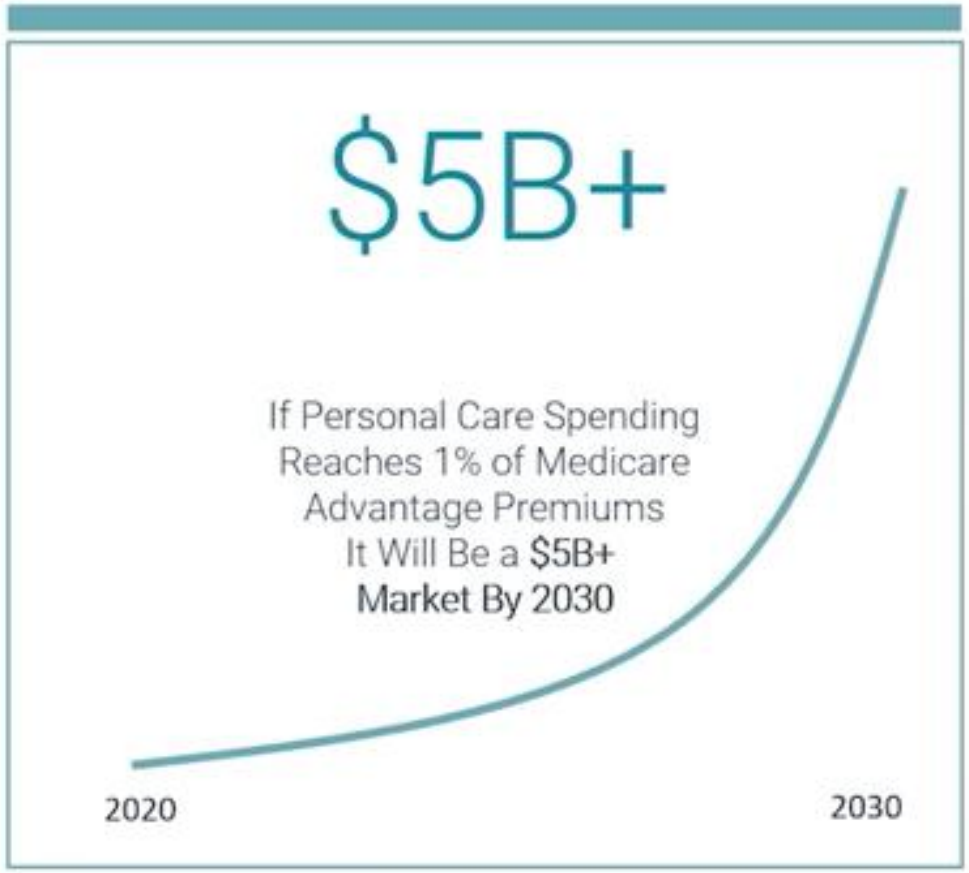
More Personal Care Needs

760

Medicare Advantage Plans offering home-based care services in 2021

Growing MA Care Offerings

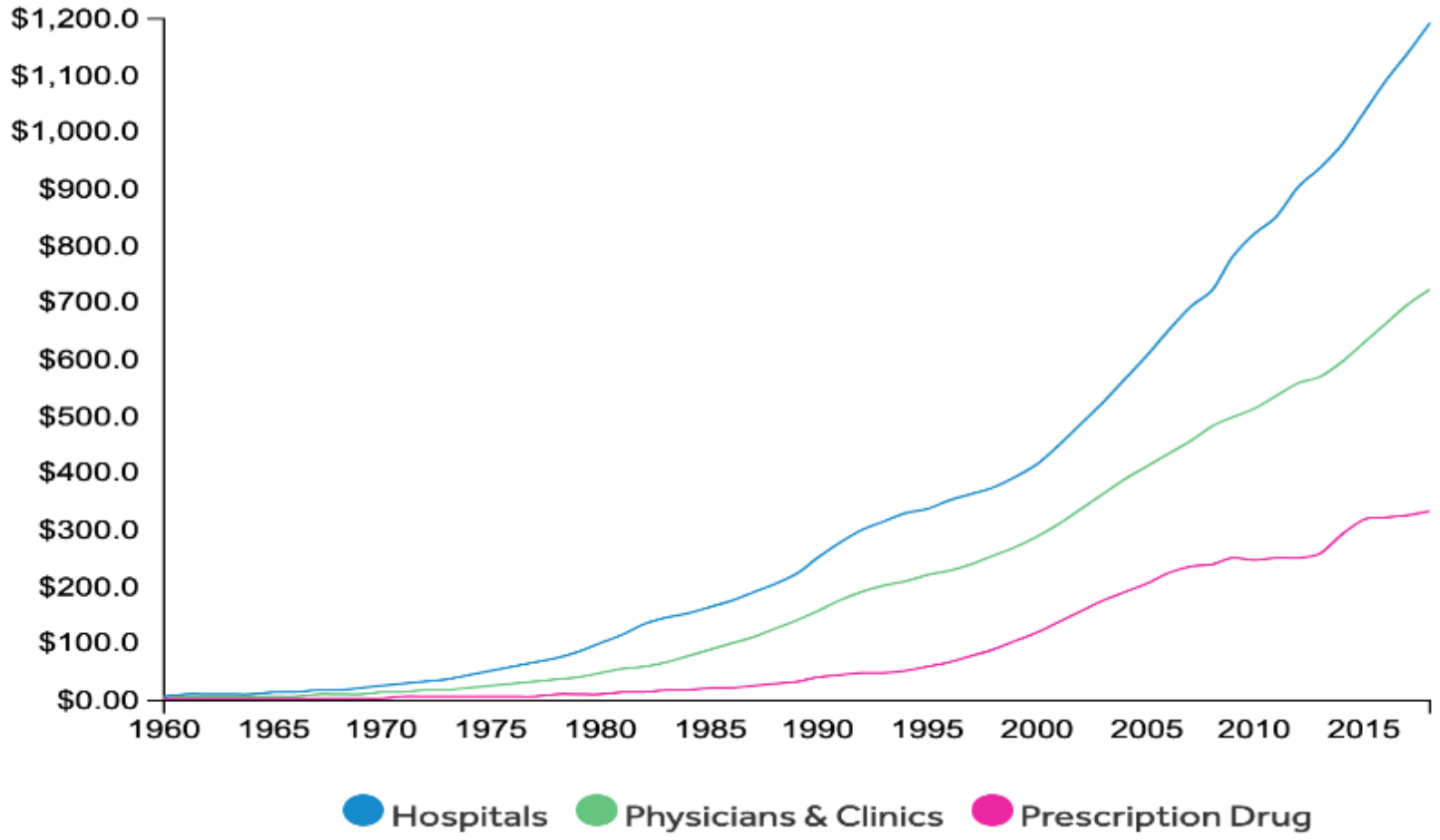
$5B+



Why?

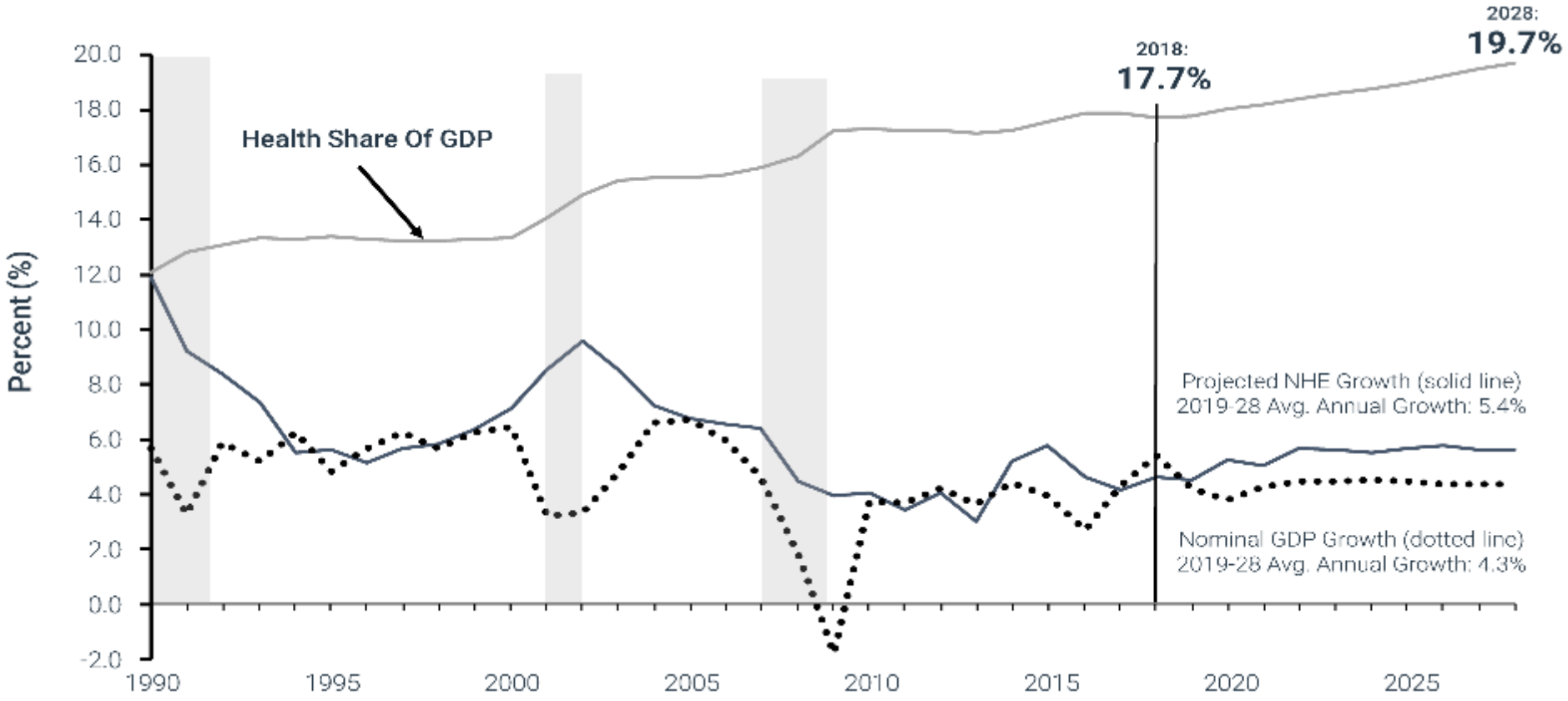
Context first: driving focus on cost and value

U.S. Health Expenditures 1960–2018



On Hospitals, Physicians & C
Prescription Drug by All Sources of
Funds (U.S. $ Billions)

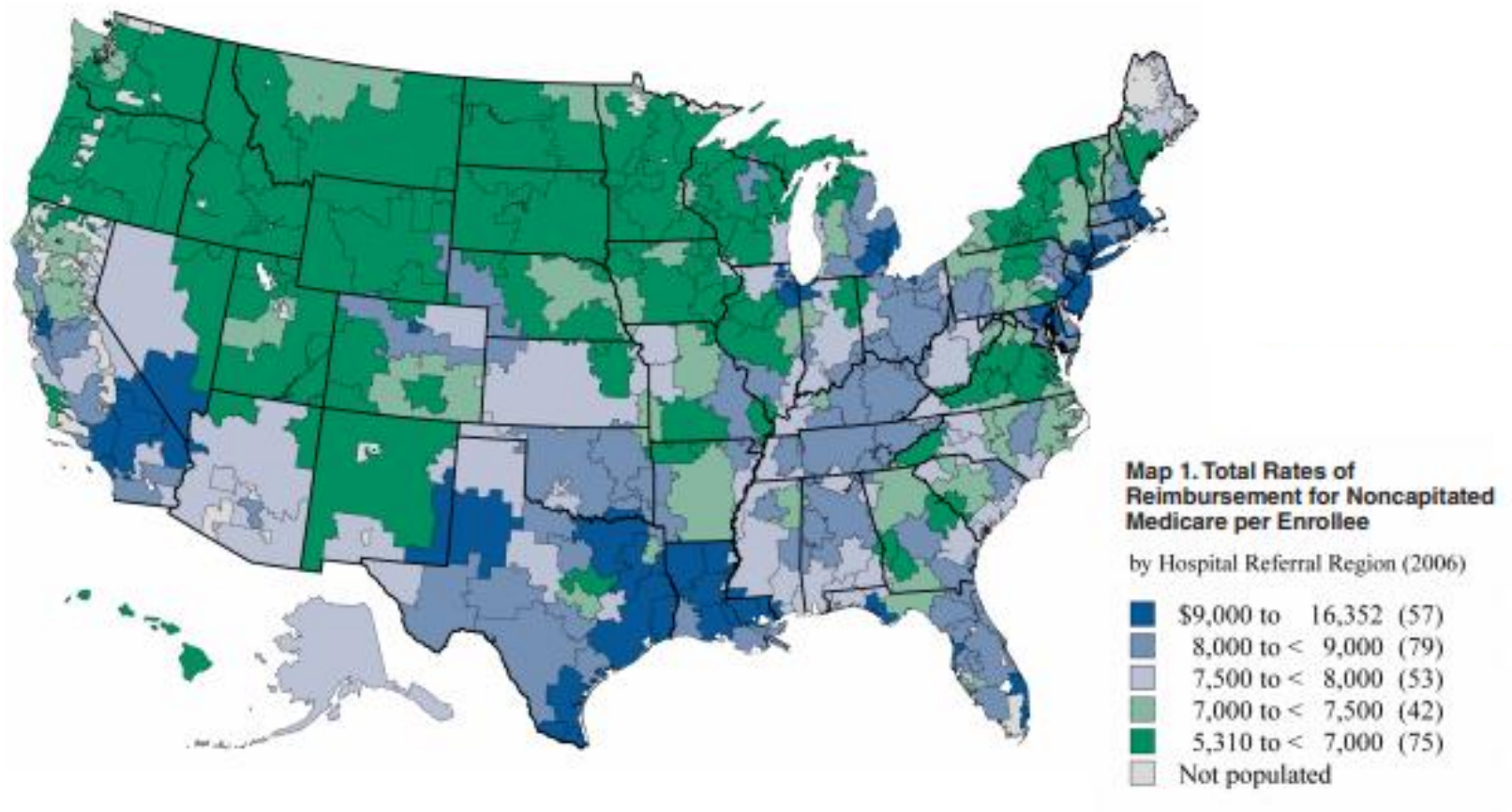
NHE, GDP Growth; Health Share of GDP



Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; Department of Commerce, Bureau of Economic Analysis; National Bureau of Economic Research.
Notes: Shaded areas for 1990-91, 2001, and 2007-09 represent recession periods.

High geographic variation in the ‘spend’

Ties directly to population density



https://www.dartmouthatlas.org/downloads/reports/Spending_Brief_022709.pdf

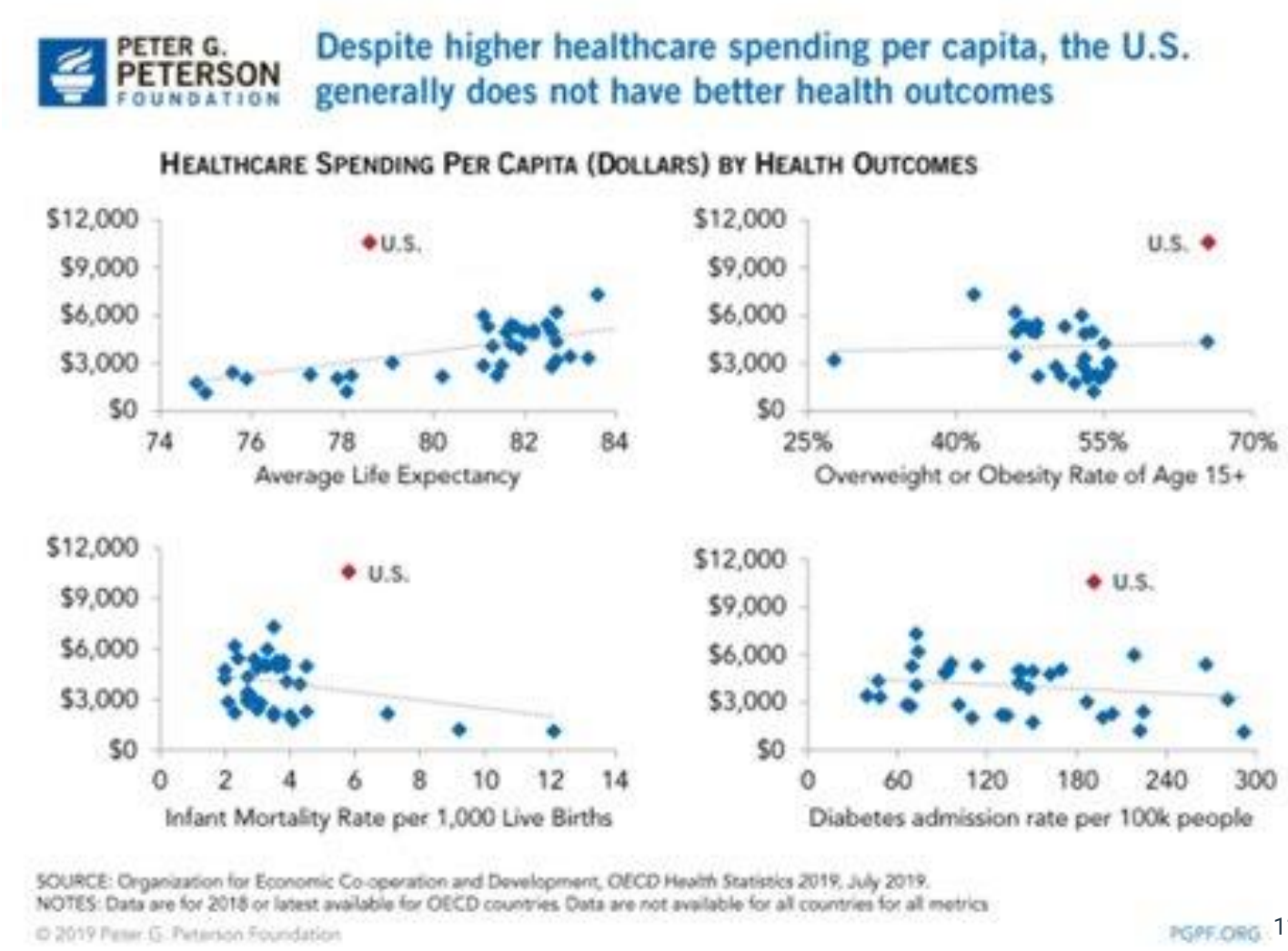
How much do we spend on healthcare?

~$4,800,000,000,000

Estimated for 2025, which is equivalent to $13,793 for each man, woman, and child (348 million) in the United States.

A disjointed healthcare system delivers poor value

- Variable quality
- High cost
- Unsatisfactory experience
- Workforce impact

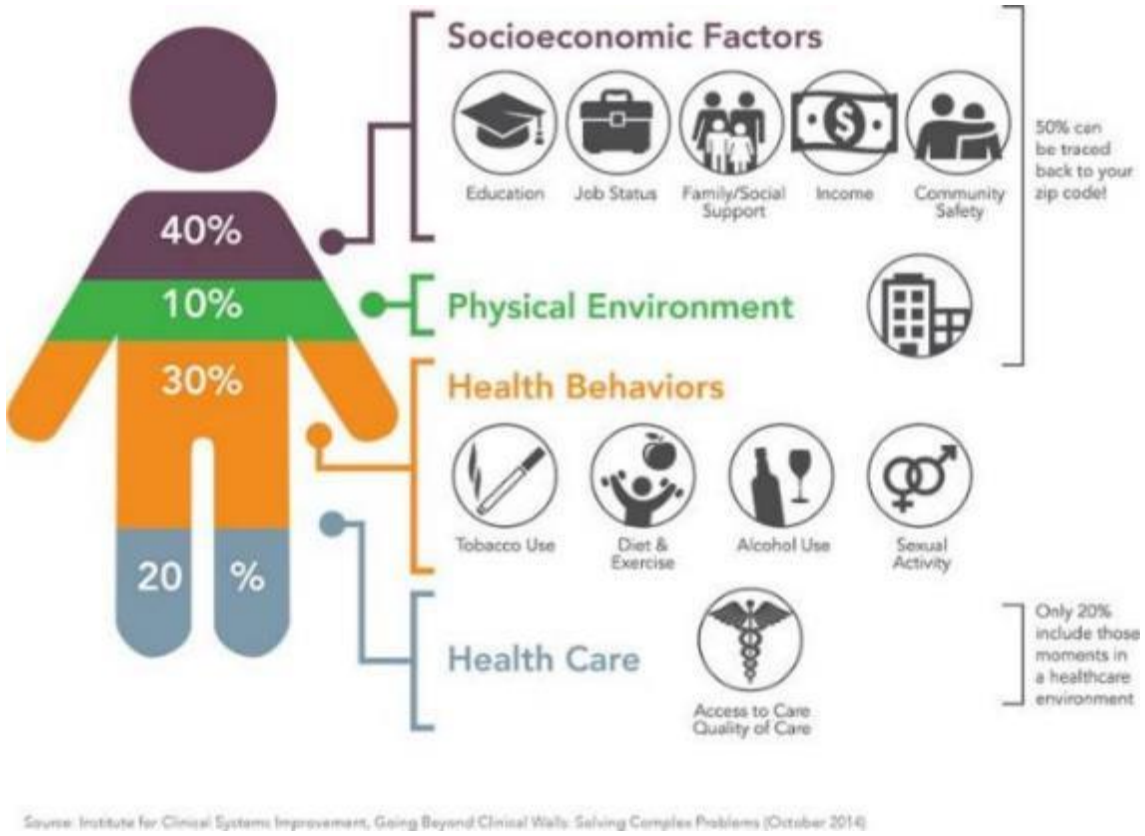


Welcome to the quadruple aim

- **Quadruple aim:**
  - A framework to measure outcomes around improvement in quality, cost, and experience
  - A step up from the triple aim: now adding the care team well-being
  - Think about how we can empower needed change through our work within the personal care space

Health related social needs (Social determinants of health)

The social determinants of health are the **conditions in which people are born, grow, live, work and age**. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The social determinants of health are **mostly responsible for health inequities** - the unfair and avoidable differences in health status seen within and between countries.



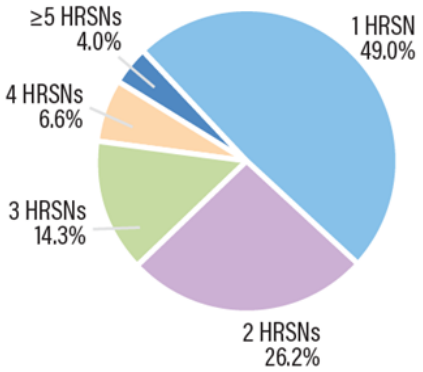
Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

http://www.who.int/social_determinants/sdh_definition/en/

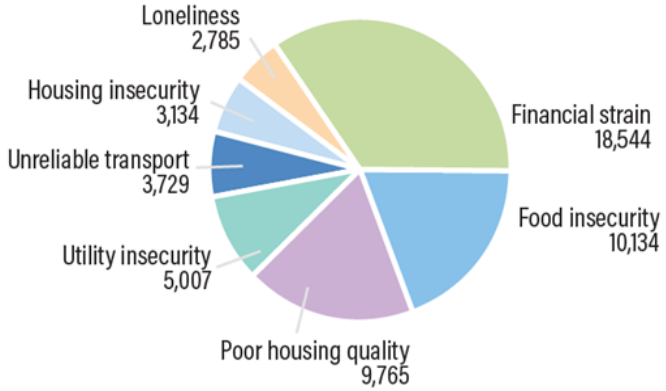
Health related social deeds (SDoH) drive admits

Select Characteristics of Study Population

Rates of beneficiaries experiencing ≥1 HRSN

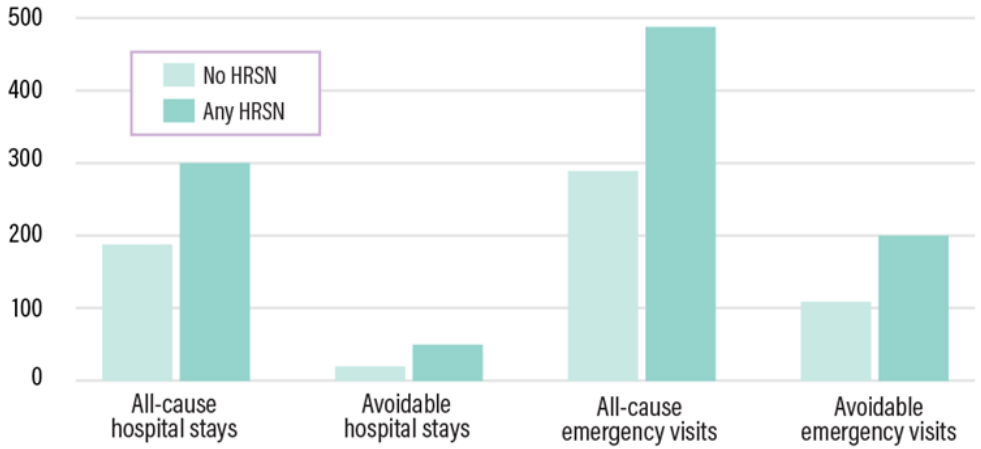


Number of beneficiaries reporting HRSNs



Unadjusted Rates of Acute Care Utilization by Presence of HRSNs

(No. of events per 1,000 beneficiaries)



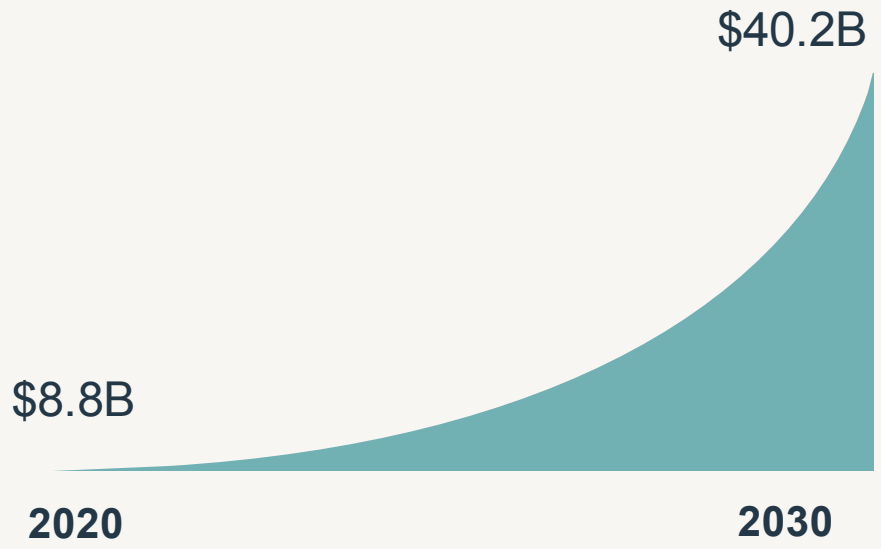
Marginal Effect of HRSNs on Rates of Inpatient Utilization per 1,000 Beneficiaries

HRSN	Hospital stays			Emergency visits		
Food insecurity						
All-cause	-2.9	11.9	26.7	29.6	50.9	72.2
Avoidable	-4.1	2.0	8.2	9.0	20.8	32.6
Financial Strain						
All-cause	14.2	26.5	38.9	20.5	37.6	54.8
Avoidable	9.4	14.7	20.4	8.9	18.6	28.3
Loneliness						
All-cause	-13.7	7.1	27.9	46.9	80.6	114.3
Avoidable	-6.9	1.8	10.5	25.1	44.4	63.8
Unreliable transport						
All-cause	30.7	51.2	71.8	65.3	95.5	125.8
Avoidable	2.2	10.9	19.5	10.9	26.8	42.6
Utility insecurity						
All-cause	-23.0	-6.5	10.0	-12.1	11.6	35.3
Avoidable	-7.4	-0.4	6.7	-7.3	6.0	19.3
Housing insecurity						
All-cause	-4.2	17.2	38.7	13.7	44.6	75.6
Avoidable	-5.3	3.8	12.9	-9.3	7.1	23.6
Poor housing quality						
All-cause	-20.2	-7.3	5.7	1.8	20.4	39.1
Avoidable	-4.2	1.6	7.3	6.5	17.2	27.8

SOURCE: "Association Between Self-Reported Health-Related Social Needs and Acute Care Utilization Among Older Adults Enrolled in Medicare Advantage," JAMA Health Forum, July 8, 2022.

Who has been paying attention?

MA expansion into care at home in next 8 years



Current spending is ~$9B, but will scale to $40B+ by 2030 through these 5 drivers

54M To 80M
MEDICARE ELIGIBLE POPULATION

34% To 50%
MEDICARE ADVANTAGE PENETRATION

4% To 5%
HOME HEALTH SPENDING AS % OF MA PMPM

0% To 2%
HOSPICE SPENDING AS % OF MA PMPM

0% To 1%
PERSONAL CARE SPENDING AS % OF MA PMPM

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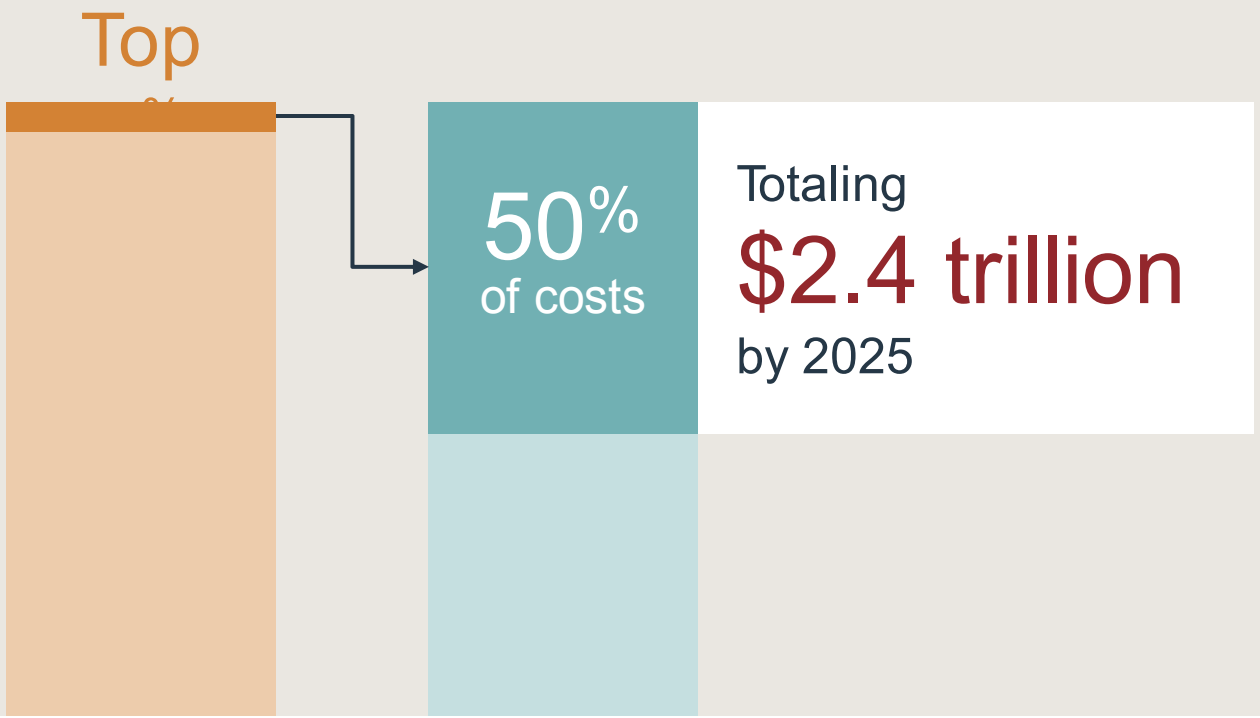
Who to focus on –
Top 5% of patients **driving 50%** of healthcare costs

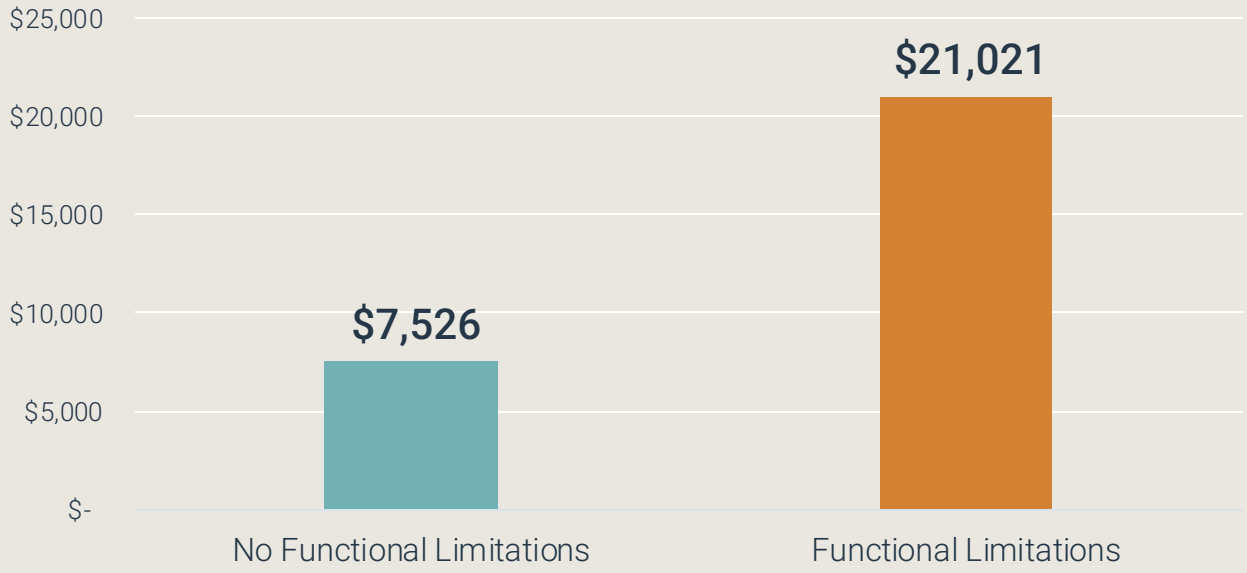


High-cost trifecta

1. Chronic conditions
2. Social determinants
3. Functional limitations

Sources: Pew Research Center, Census.gov, CDC, Department of Health and Human Services

Costs multiply 3x when a person cannot self-care, worth $740B annually

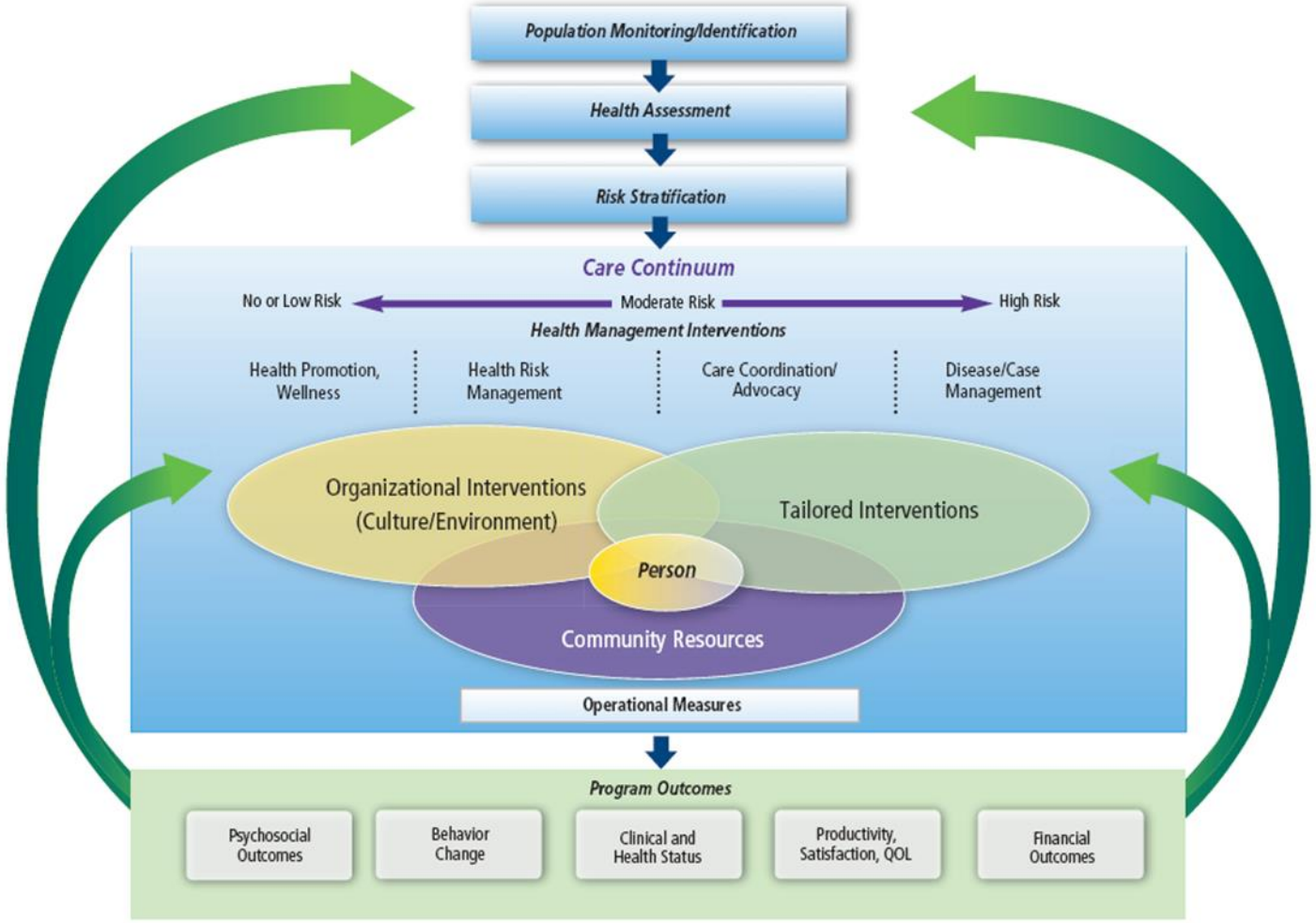


*Source: Commonwealth Fund

- **Half of the top 5%** have not just chronic conditions but also functional limitations
- **$740 billion per year of healthcare spending** due to functional limitations by 2025

Population Health and Personal Care

Population health management framework



Population health benefits from what we do

Health Outcomes for Populations Should Demonstrate:

- Reduced mortality
- Improved functional status
- Reduced disease burden
- Improved life expectancy
- Reduced preventable utilization
- Improved lifestyle
- Reduced risk factors

Trends reveal growth and value of personal care at home

- Fueled by demography and community need
- Reactive spending vs. proactive spending
  - Personal care enhances risk management to avoid unnecessary spending in emergent care and hospitalization
- **Note the variance in growth, told by the CMS Office of the Actuary in 2018 – (this before Covid-19 PHE):**
  - Nursing home spend in CCRCs and SNFs and increased by **1.4%**, to $168.5B
  - Home care spend increased by **5.4%**, to $102.2B
- Shift from out-of-pocket to long-term care plans
- Resurgence of Medicare Advantage (760 MA plans offering home based care in 2022)
- Managed Medicaid increasing in oversight of dually-eligible (Medicare/Medicaid) patients

Personal Care aligning solutions with identified need: social determinants and/or functional limitations

High needs: People who have 3+ chronic diseases and a social determinant or functional limitation that limits their ability to self-care.

Social Determinants:

- Living alone
- Food insecurity
- Lack of transportation
- Physical and geographical living conditions
- Economic status
- Access to healthcare

Functional Limitations:

- Inability to independently:
  - Bathe
  - Dress
  - Eat / drink
  - Prepare meals
  - Toilet
  - Shop
- Often due to dementia or Alzheimer's

Social determinants and functional limitations imply limited ability to self-care

Unmet need drives innovation and opportunity

Personal care clients that live alone are **1.3x more likely** to re-enter the hospital

Address client/patient-specific needs

Needs: Data, connection to resources, closed loop referrals

Progressive providers of effective care at home are learning more effective modes of **collaboration**, as machines clarify our view of need.

Home health patients with no assistance at home are **1.2x more likely** to re-enter the hospital

Whole person predictive analytics

Needs: Data, data, data (consistent usage, millions of records)

Managing healthcare over time, where we live

The home as site of care delivery:

Low cost	Rational	Desired

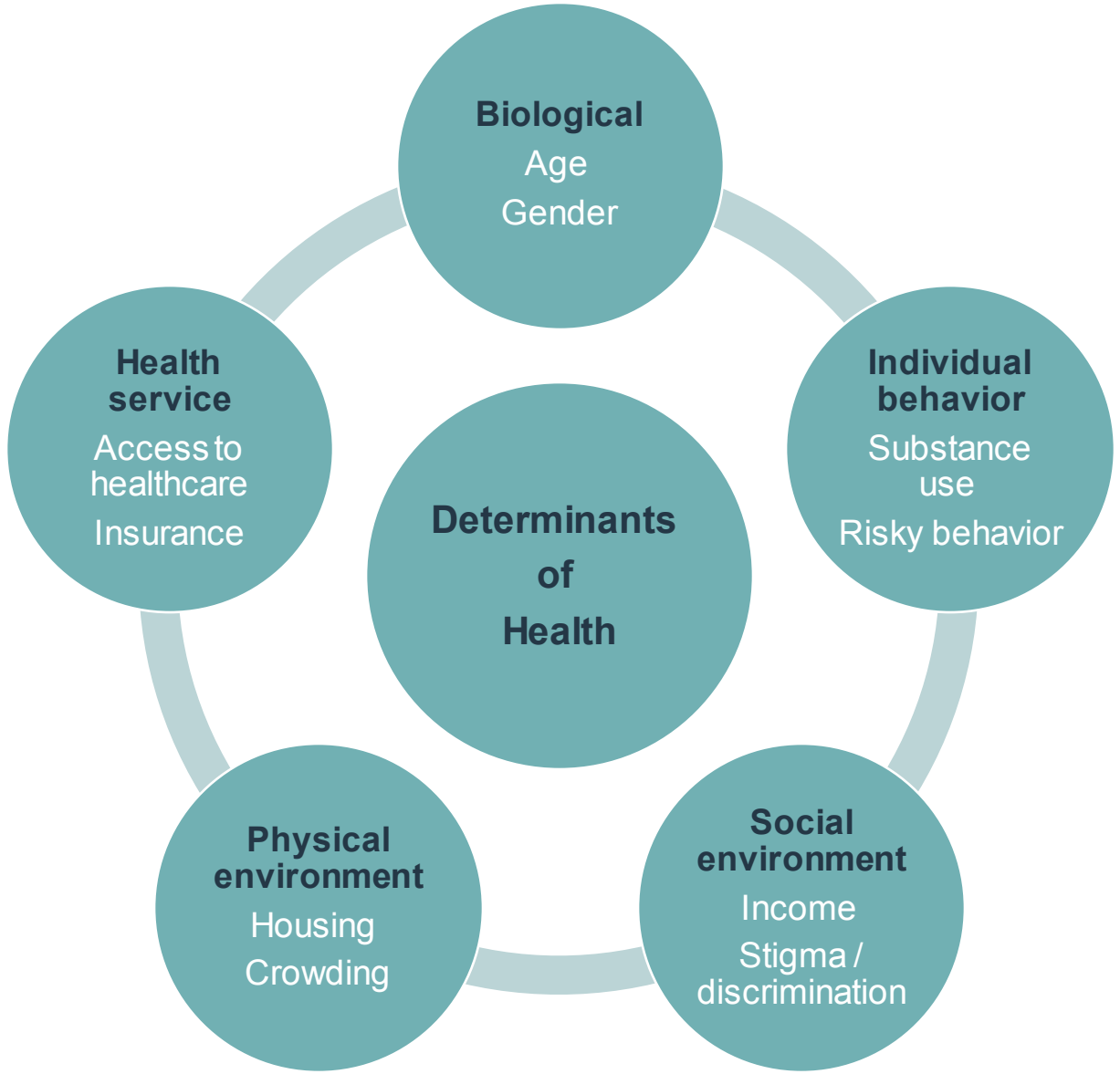
Innovative care platforms leveraging opportunity to bridge the gap between demand, supply and cost.

- Machines are learning, as are we, refining focus of delivery and associated market opportunity
- Focus on need and cost drivers compels a deeper look at Social Determinants of Health (SDoH) and functional impairment and what the machines have learned…

Your zip code is a better predictor of your health outcomes than your genetic code

Trends: Human services as preventative

- Creating a solution set that is “determinates of health aware” will drive better health outcomes.
- Integration of care and sharing of data are essential components of managing determinants of health.
- Ignoring any pillar can lead to diminished outcomes.
- Personal care agencies seizing opportunity, now, to evolve their positioning - helping to solve for specific, identified challenges.



Applied concepts

Embracing reality and leveraging opportunity

- **Covid** – even if operating well – workforce challenges have impacted your operations
- **Collaboration is key** – cannot wall off your agency from what is happening today
- **Compassion fatigue is real**
  - ***Proactive*** culture, aligned with **risk-informed management of care** and trained customer service helps build resilient teams
- **Build awareness in your teams** of high value generated within population health initiatives
  - Build clear expectations of the expected work
  - Managing patients with higher acuity (e.g., 2 or more comorbidities) – with goal of keeping them home
  - Evolve what has been known as simple 'sitter-services' to **key partners in a continuum of need and care**
- **Quality always counts!**

Do you know your own quality data?
How do you stack up in your market?

Risk = need & opportunity

- Machine learned capture of risk helps your teams position suggested care plans
- Analytics grab our attention with respect to care plan recommendations to payer/client based on evidence of risk
- Target meeting specific pockets of need with aligned and tailored services

Increase awareness and impact of SDoH – driving strategy for service

"Sometimes it is not a blood sugar issue, it's 'My daughter couldn't give me a ride to pick up my prescription'."

A health center reduced no-shows by 50% after determining **1 in 4 patients** had transportation related barriers

Address population-level gaps

Needs: Data, reporting, Connection to resources

Imagine what is in reach, benefitting many…

Examples abound:

"Recognizing that social isolation is a significant issue for aging adults and can have a major impact on overall health, MA plans in both the South and the Western U.S. implemented programs that connected members who self-identified as lonely with social workers and volunteer phone pals who regularly called or visited to build relationships.

The **phone pals** helped address the member's needs, whether assisting with transportation, accomplishing house chores, providing companionship, or providing other services—often alleviating the burden and stress on family caregivers while enriching the lives and combatting feelings of loneliness of older adults.

After implementing this program:, the Western MA plan saw an increase in member engagement with other programs (e.g., exercise programs) by 56%, a decrease in hospital admissions by 21%, and a decrease in emergency department use by over 3% (while the control group saw an increase in ED use by 20%)."

…

https://www.ahip.org/wp-content/uploads/SDOH-MA-IssueBrief-2021.pdf

Strategic business development

Large hospital system in the Northern VA / DC metro

- Readmission task force identified at risk patient population
- Nurse-owned proprietary in-home personal care agency
- Established a standing protocol for the health system (ACO) to refer and pay for in home caregivers 4 hours a day for 30 days for selected high risk patient cohort

Strategic business development

Medicare Advantage: In-home care west coast agency

- Aggressively pursued the MA opportunity for personal care and transfers
- Dedicated care coordinator
- Gained an average length of authorization = 20 hrs of care
  - Authorizations vary per plan, and most are short-term, averaging less than a month of care and during a transition. An average length authorization would be for 20 total hours of care
- Utilized 3rd party claims systems to bill
- Less than 1% of revenue was funded by plans in 2019 – this is anticipated to change given team that was on board to carefully manage risk and move forward with proactive payer positioning

https://homehealthcarenews.com/2020/07/24-hour-home-care-gets-candid-about-logistical-day-to-day-aspects-of-ma-partnerships/

Strategic business development – ‘Hospital at Home’ – Personal Care Alert!

Current model exploration:

- Large research-based hospital in the Midwest
- Commercial payer sources have committed hospital services, as well as post-acute partners:
  - Discussions with Medicare certified agency

Personal Care positioned as collaborative and essential resource to reduce costs associated with rehospitalization

Strategic business development SNF at Home

- Concepts rising to national attention
- Currently, roughly 25% of short-stay SNF episodes can be cared for in the home setting (Lincoln Healthcare Leadership)
- Question we have is this: will long range value-based population health programs extend this reach further?
- Home care providers already leveraging this positioning in successful program offerings
- Personal care again front and center in helping people stay home, potentially allowing portions of population to bypass institutional care in the age of COVID-19

Strategic business development …making the vision a plan

Current model exploration at home:

- Identify influencers and existing connections
- Identify a champion
- Understand the goals
- Identify alignment
- Define expectations
- Create tentative goals
- Set milestones

Strategic business development

Managed Medicare/ Medicaid

- Identify contracting specialists
- Know your agency's differentiators
- Be aware of your agency's ability to impact on Social Determinants of Health
- Generate process to know and track Hours “approved”, volume, claims submission
- Negotiate rates
- Future focus

Consider the fit

The AHA outlined three strategies – geared toward local health systems and community partners working to improve community health and decrease disparity

Think about these within the context of what you may provide, every day, as well as expanded service offerings

Three strategies from the AHA:

1. **Screening and information:** Providers systematically screen patients for health-related social needs and discuss the impact these challenges may have on their health with them

2. **Navigation**: Providers offer navigation services to assist patients in accessing community services

3. **Alignment**: Providers partner with community stakeholders to more closely align local services with the needs of local patients

Three opportunities flowing from strategies

1. Screening and information:

Providers systematically screen patients for health-related social needs and discuss the impact these challenges may have on their health with them

Personal care solution: Administer the PRAPARE dataset (SDoH) and perform basic functional assessment per standardized test and convey findings/risk profile to person/patient/designated/responsible party (parties).

2. Navigation:

Providers offer navigation services to assist patients in accessing community services

Personal care solution: Providers offer care navigation linking identified need to potential, identified resources: combination of tele-social services and care coordination associates (high level clerical associate)

3. Alignment:

Providers partner with community stakeholders to more closely align local services with the needs of local patients

Personal care solution: match and refine levels of service delivery, including screening, Care Navigation, as well as risk-informed, updated supports of assist with ADLs/IADLs in measured areas of functional deficits (such as bathing, toileting, ambulating, transferring, grooming)

Tech advancing operations and market opportunity

- Get your house in order with actionable DATA!

- An absence of risk-informed data, now, can leave you in less than a competitive position

- Do you track key, value-added metrics (think predictive risk)?

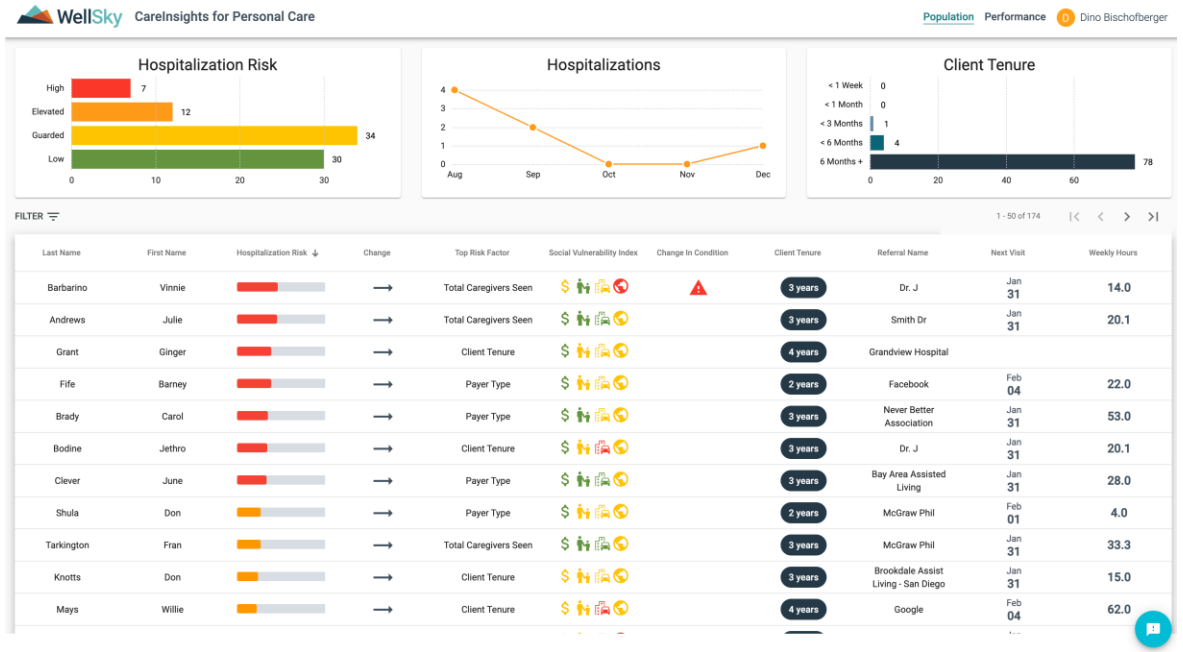
What contracts do you hold?

- Review the contracted payers
- Dive into the data and patient outcomes for those payers
- Do you know the strategic focus of those payers?
- Do they have a patient population focus?
- Do your homework and have a conversation
  - E.g. – you have a CHF readmission focus/accompanying RPM program, but you never approached HUMANA to say can we put this protocol in place
- The payers have their work to do, often feels like ‘fits and starts’ for providers, but the logic is clear and the evidence is in.

YOU HOLD SUBSTANTIAL VALUE
- how are you positioning it?

Step by step integration of people, process, and technology

- **DATA ACCESS:**
  - Do you have **access** to actionable data/analytics reflecting performance?
- **MEASURES OF SUCCESS:**
  - KPIs reflecting common goals, e.g.: acute care hospitalization rate, patient/family satisfaction, ability to remain in home vs. institutional transfer?
- **DATA INFORMED RISK MANAGEMENT:**
  - Managing risk at specific time points
  - Align services to reduce known risk and/or support identified need (SDoH)
- **PARTNER WITH TECHNOLOGY VENDER:**
  - Dig into the analytics to reveal your potential market opportunity

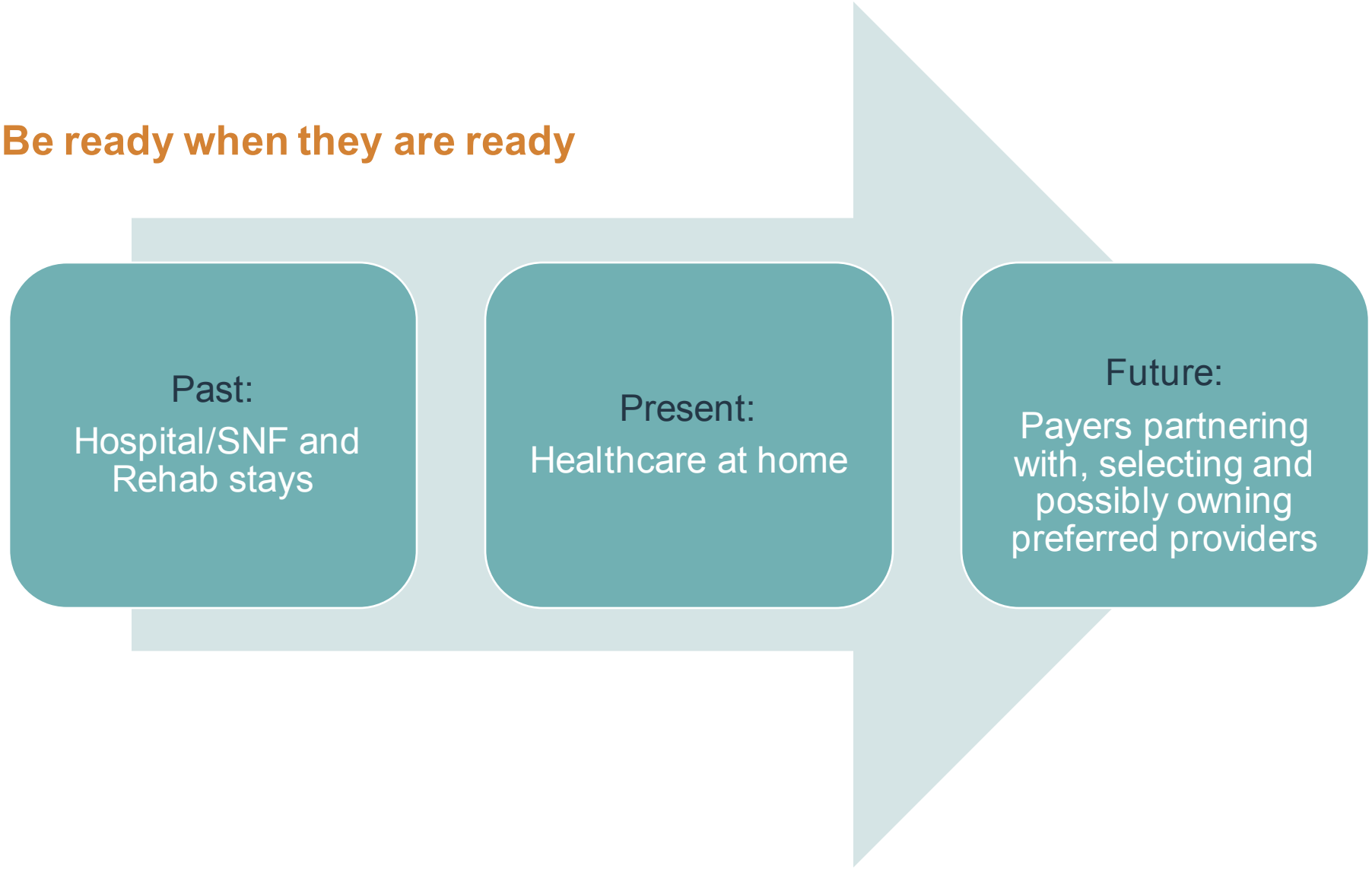


Positioning – a battleground in a busy market

- How do you rise above the noise?
- What matters most to your referral sources?
  - Ask! Market research: Quarterly alignment surveys
  - Do ratings and outcomes matter?
    - "YES" for payer-centric discussions
    - "MAYBE" for actual referral sources
      - Ease of referral, all things being = referral sources will take path of least resistance
- Take a hard look at your agency – Where do you NOT stack up?
  - QAPI integrated into personal care initiatives
- Collaborate with leadership to improve those areas
- Set your aligned sales and marketing strategy

Payers *early journey* to care at home

Be ready when they are ready



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Value of home and community-based care

1

Reduce medical expense

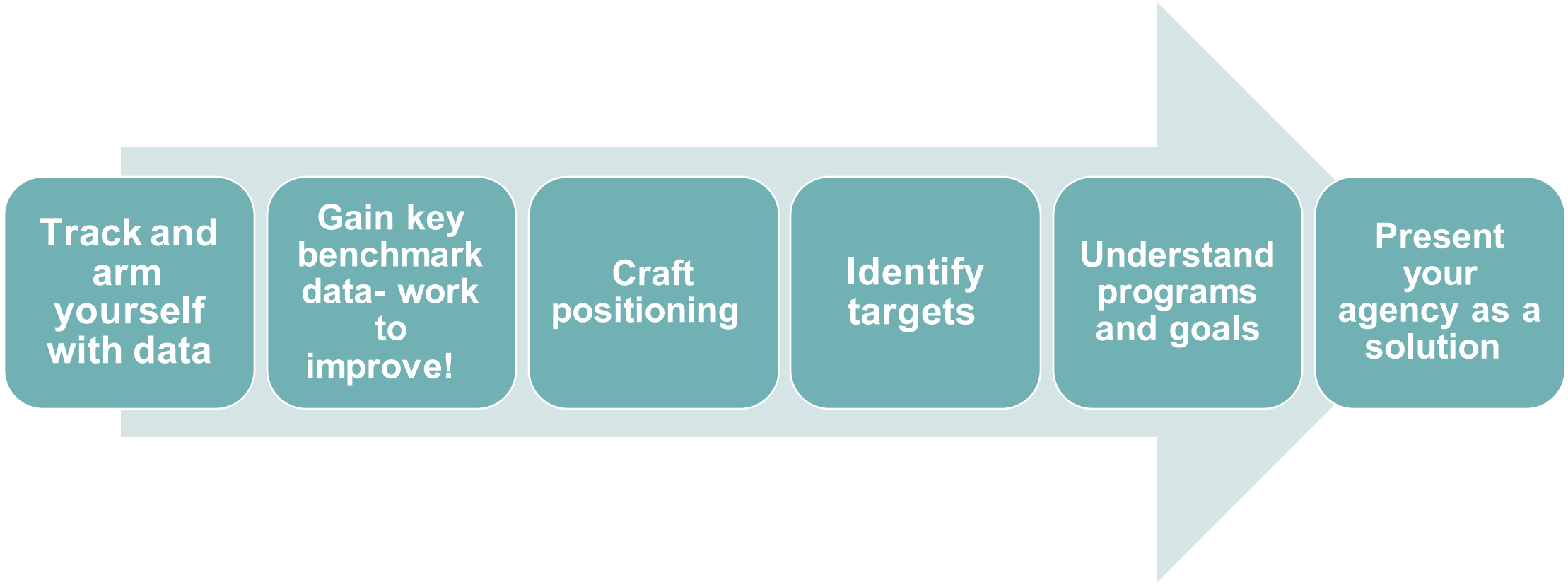
2

Drive higher quality

3

Serve patients where they want to be

Strategic business development




Build the bridge to better outcomes using risk-informed understanding of need

Questions?

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Thank you.

Contact us:

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