PREMIER home health care services, inc.

Leveraging Our Greatest Asset:

The Home Health Worker

RTD—Real Time Data in Home Care

One constant in health care is change. The evolving nature of health care financing, delivery systems, and technology demands that those involved in any aspect of the health care system innovate, transform, and identify the best ways to manage change and complexity. Premier Home Health Care Services, Inc. (Premier) is a company that thrives on the change and challenge of creating solutions to meet the evolving needs in the health care system. Premier's newly launched, RTD—Real Time Data approach to leveraging the home health care workers, an often overlooked asset that home care has at its disposal, is already demonstrating solid outcomes and is poised to transform the delivery of long term care, chronic and transitional care management, and reduce potentially avoidable hospitalizations (PAHs)/readmissions.

Health care system changes 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 changes—the "graying" of the nation—while simultaneously needing to navigate the challenges of alternative payment models such as value based payment.

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 of more chronic conditions and one in five Medicare beneficiaries are readmitted to the hospital within a month of discharge. This creates both service delivery and fiscal challenges in the health care system.

These demographic changes have significant implications for long term care sector, as there will be fewer people available to care for an increasing number of seniors and a need to identify innovative solutions to keep people healthier and in less costly home and community-based care settings for longer.

Complicating efforts to address these demographic shifts are changes to payment models and health care system fiscal pressures requiring providers to:

- ✓ Do more with less as reimbursement decreases and costs increase;
- ✓ Link financing to outcomes, such as quality incentive bonuses (positive/carrot) or hospital readmission penalties (negative/stick); and
- ✓ Transition to upside/downside Value Based Payment (VBP) risk arrangements.

The changing financial landscape is requiring all payers and direct care providers to shift their thinking and change their approach to service delivery. Success in avoiding penalties and capturing financial savings/quality bonus dollars requires service delivery interventions that can ensure both timely identification of patient issues and deployment of targeted resources that address an individual's health and supportive care needs to prevent higher cost interventions in facility-based settings. Home and community-based care providers are well-positioned to offer these solutions if they are willing and able to develop and implement innovative solutions that capitalize on their strengths—home care workforce, data collection opportunities, access to technology, and understanding service delivery in a community-based setting.

As New York's health care system shifted toward managed care and measuring value through outcomes, Premier made strategic adjustments that included the creation of additional training (the Observe, Ask, Report—OAR Program), a focus on data collection (OAR trigger questions), analyzing relevant data (***RTD—Real Time Data*** EDGE Dashboard), and initiating timely interventions to improve outcomes and reduce potentially avoidable hospitalizations (RTD P-QIP Unit).

While only in its third year of implementation, both internal and external data are confirming positive results. On all measurement fronts, data is demonstrating improvement in quality outcomes, medication adherence, and reductions in Potentially Avoidable Hospitalizations (PAHs)/readmissions. These results bring benefits to:

- ✓ 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, management of chronic diseases, and the ability to remain at home.

Valuable Resources—Home Health Aides, Access to Data, Timely Interventions

Identifying and preparing for market change are hallmarks of Premier's approach to care delivery, as is the use of data to inform the strategies developed to embrace such change. As aggressive policy efforts to link health care funding to provider/payer success at delivering positive member outcomes were implemented, Premier identified how to utilize existing resources and strengths to achieve these successes. The preliminary strategy was simple, and yet a resource frequently undervalued and historically overlooked—the home health aide in the home.

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 members/families, contribute immensely to securing positive health outcomes and turning observations into actionable data.

Leveraging the contributions of the home health aide and entire interdisciplinary team (IDT)—aide, coordinator, clinicians, administrative and management staff—became the platform on which Premier's ***RTD—Real Time Data*** initiative was built. Supporting the contributions of the IDT then prompted the development of a training, data gathering, and technology solution to impact both individual and broader population health goals, and became the premise on which Premier launched: a company-wide training initiative; data collection platform; and intervention solutions to improve member health care outcomes, reduce potentially avoidable hospitalizations, collect and aggregate population health data, and further efforts to engage in successful VBP arrangements.

Training—OAR Programs

The Observe, Ask, Report (OAR) Campaign was first developed in 2016. The goal of the training was to prepare home health aides and the entire home care interdisciplinary team (IDT)—all management, administrative, coordinator, clinical, and aide staff—for their roles in improving member health outcomes. The training was multi-pronged and targeted:

- Providing a general understanding of health care system changes and quality measures;
- Detailing why quality measures are important to members, aides, and health plans; and most importantly
- What to "Observe, Ask and Report" when the aide is in the member's home to affect changes in the Person-Centered Service Plan and improve member health care outcomes.

Premier launched training in OAR I in 2017, and quickly thereafter, following company-wide training with one health plan, preliminary findings showed Premier improved in the following quality measure scores over the same period from the prior year:

- Annual Flu Vaccine
- No Falls
- Dyspnea
- Not Lonely/Distressed
- Bladder Control
- Pain Intensity
- Involved in Decision Making
- Quality of the Home Health Aide

OAR I became the conceptual platform that Premier has used to expand a knowledge base for home health aides and other IDT staff to contribute to improving health outcomes and reducing potentially avoidable hospitalizations (PAHs). Since the initial OAR module was developed, Premier has expanded the targeted OAR training approach and has created additional copyrighted OAR modules that address PAHs, Social Determinants of Health, and Behavioral Health & Chronic Disease Management, with new content planned regarding HEDIS and MA Star Measures for the coming year.

In order to meet the needs and support a culturally competent workforce, each OAR training module and related resource materials were translated from English into five (5) additional languages—Russian, Korean, Chinese, Spanish, and Creole.

From the initial OAR module development in late 2016 to early 2019, Premier has trained 10,000 aides in OAR I and 10,000 OAR II and is initiating training this year in OAR II and OAR IV. Training in all modules is ongoing and new staff receive OAR training as part of their orientation. The OAR philosophy is now Premier culture.

Observe, Ask, Report
OAR I—Quality Measures: Provides definition and an overview of targeted MLTSS and other quality incentive measure sets, why they are important, and skills training to improve member quality outcomes through observation, asking certain questions, and reporting.
OAR II—Potentially Avoidable Hospitalization: This module summarizes the six PAH diagnoses currently being tracked by CMS and NYS for outcome improvement regarding PAH. This module provides insight into each disease state, symptoms and when and what to report via a "real-time" EVV reporting option.
OAR III—Social Determinants of Health: This sequence defines social issues related to access to health care, education, economic stability, community, and the environment that impact health outcomes and provides examples of solutions to these issues. The Program has been designed to meet NYS DOH VBP contracting requirements.
OAR IV—Behavioral Health & Chronic Disease Management: Provides an understanding of key chronic diseases that frequently result in re-hospitalization, the impact of behavioral health issues on chronic disease management, and strategies to impact and improve member behaviors and ultimately PAH outcomes.

RTD—Real Time Data

A strong educational foundation is critical to enacting change in an organization, but so is the use of data. Once the educational foundation from the OAR Program was underway, discussions about how to sustain and continuously improve health care outcomes became the focus.

Very quickly, there was a realization that the observations and reports made by home health aides as part of the OAR Program were generating invaluable data about the member and in order to collect and effectively act on the information, there needed to be a real time, streamlined, and consistent approach to data collection.

As part of an initial pilot project with a New York health plan, Premier developed an effective, yet simple, data collection system that utilized the telephonic Electronic Visit Verification (EVV) system that aides already used during each home care visit. At the end of each shift, the home health aide answers a series of yes/no questions that tie back to specific quality measures, PAH diagnoses, or other plan-specific data collection measures, and any "negative" data triggers from the in-home, real time EVV transmission results in follow-up intervention strategies to address the member's well-being in a timely manner, thus preventing PAHs and less optimal health outcomes.

RTD-Real Time Data Goals

- ✓ Improve member health care outcomes through enhanced aide and agency staff training and population management with Real Time Data.
- ✓ Improve health plan quality incentive measures and potentially avoidable (PAH) scores through aide training, Real Time aide reporting technology, and timely member interventions.
- ✓ Promote and create an interdisciplinary team (IDT) environment to improve member health outcomes and experiences by involving aides, member/family, care managers, assessment RNs, home care RNs, and coordinators.

Turning RTD Dashboard Data into Interventions

The telephonic data collection and related interventions tested as part of the initial pilot project showed great preliminary outcomes and Premier made the decision to

invest in the necessary infrastructure to support an expansion of the program.

While there is simplicity to collecting data through a telephonic EVV system, in the background there must be complex data and process workflows to ensure that the data is utilized to impact outcomes positively. As a result, Premier's in-house technology and operations teams built the RTD EDGE Dashboard and established the Premier Quality Incentive Program Unit (P-QIP). These two infrastructure components take the RTD—Real Time Data that flows from members' homes on a daily basis and turns 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, screening, PCP visits; and
- target other interventions that can improve member health outcomes and success in meeting person-centered care plan goals.

RTD EDGE Dashboard Data

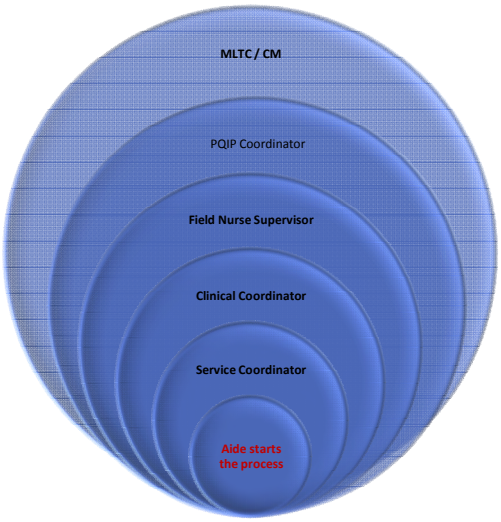
- ✓ Member Daily Quality Measure Alerts
- ✓ Member Daily PAH Alerts
- ✓ Social Determinants of Health/Behavioral Health Alerts
- ✓ Per-Universal Assessment Data Review/Low Score Targeting
- ✓ Flu Immunizations
- ✓ Other Immunizations/Screenings
- ✓ Medication Adherence
- ✓ Aide Lateness
- ✓ Member Grievances

The **RTD EDGE Data Dashboard** is a sophisticated tool providing data aggregation, detailed trend analyses, and process workflows. Although it is complex, the **RTD EDGE Data Dashboard** processes incoming data from OAR trigger questions and provides easy to follow alerts, status reports, and helps guide users at different levels through the process of addressing members' identified needs and associated intervention workflows. It is designed to involve all levels of the IDT (aide, service coordinator, clinical coordinator, field nurse supervisor, and care manager) in managing a member's care. The RTD EDGE Dashboard is designed to accommodate access by any stakeholder connected to the care management process—home care agency IDT, health plan care managers, and hospital discharge planning or transitional care teams.

The **RTD P-QIP Unit** serves as the data management hub and communication liaison for internal (home care agency IDT) and external (health plan care managers/hospital systems) stakeholders to ensure that all issues identified by incoming data triggers are resolved timely and care management and home care IDT members communicate, implement, and close out all appropriate member interventions.

The RTD EDGE Dashboard has workflows, follow-up scripts, and processes that are driven by the specific quality measure or the particular OAR trigger being addressed, the IDT member involved in the ntervention, and desired outcome. For instance, follow-up interventions on flu vaccine triggers will vary significantly from triggers related to falls. These processes are very flexible, however, and education, data points, and tracking can be adapted and built-out to address any specific payer, provider or plan need. For example, a traditional MLTSS program may be held to particular quality measures, but a PACE or Medicare Advantage Program will be responsible for additional or different measures based on services offered and particular measures by which ratings are generated for their product lines.

Turning Real Time Data into Results



The success of a new program or investment is never clear until the data begins to arrive and Premier has been exceedingly pleased with initial results for both quality measures and PAH rates following the OAR training and RTD implementation. Both internal data analysis, and more importantly, external data from the New York State Department of Health and specific health plans demonstrates steady improvement in quality measures over time and reductions in overall PAH rates and for targeted PAH diagnoses.

Quality Measure Results—

Premier has been fortunate to work with health plans in New York that provide "scorecard" data that allows Premier to track its performance on targeted quality measures. The data collected through one health plan partnership demonstrates that Premier's Quality Incentive Scores have steadily improved from 2016-2018. The increases in both actual and weighted scores for targeted quality measures have coincided with the implementation of each component of our RTD-Real Time Data roll out. From December 2016, prior to OAR I training, to December 2018, after training in OAR I & II and implementation of P-QIP & RTD, quality incentive scores have increased from 3.07 to 3.39 out of a 5-point scale. These improvements mean there have been better managed care member outcomes over time and shared quality incentive funding from the health plan, which helps support innovative infrastructure initiatives. Quality measure scores with other plans reflect similar results.

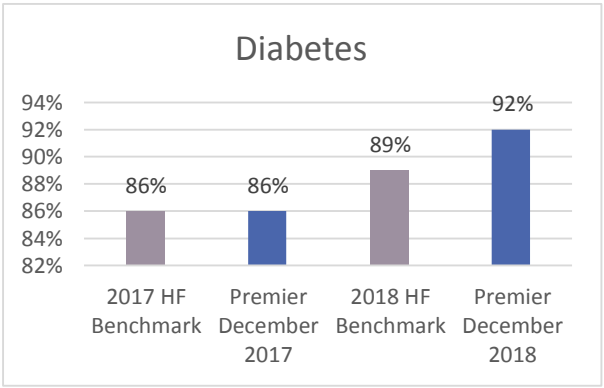
Premier's 2016-2018 Health Plan Partnership Quality Incentive Scores

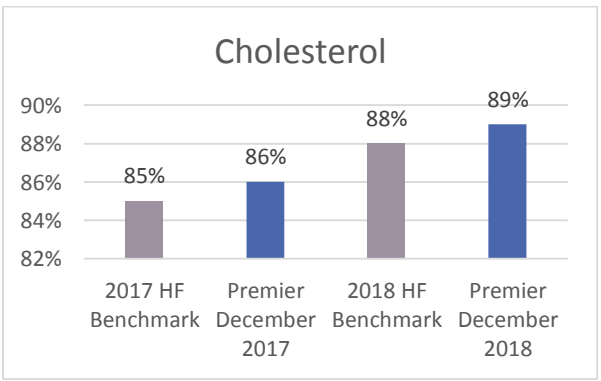
Date	Weighted Score	Actual Score	Project Initiation
16-Dec	3.0	3.07	Pilot HF
17-Jun	3.0	3.23	OAR I
17-Dec	3.5	3.29	OAR II
18-Jun	3.5	3.30	P-QIP
18-Dec	3.5	3.39	RTD
1/19-6/19			OAR III
7/19-12/19			OAR IV

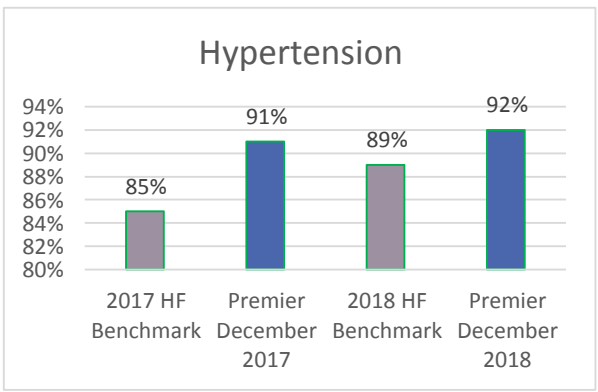
Scores are on a 5-point scale

Medication Adherence Results—

RTD EDGE Dashboard Data includes medication adherence monitoring and reporting based on specific health plan needs. The RTD trigger questions collect data regarding prescription refills and whether members are taking their medications. If there are negative answers to the trigger questions, interventions are implemented. Since the implementation of OAR training and RTD EDGE Data, Premier's medication adherence results, based on plan claims data, have increased year over year and are consistently higher than the plan benchmark. These results are particularly valuable to members and payers given the correlation between inadequate medication management and hospital admissions/readmissions.







Potentially Avoidable Hospitalization Results—

Preliminary results in reductions in Potentially Avoidable Hospitalization rates also have been exciting. Data from both internal and external sources are already demonstrating positive results. This is particularly remarkable given that the OAR training that focused on the six PAH diagnoses (sepsis, anemia, electrolyte imbalance, UTI, respiratory infection, and CHF) and implementation of ***RTD—Real Time Data*** did not begin until mid-2018. It is anticipated that these results will continue to improve as the impact of broad-based training and ***RTD—Real Time Data*** interventions are reflected fully in the data.

Internal ***RTD—Real Time Data*** EDGE Dashboard data, has shown that Premier's percentage of hospitalizations related to PAH diagnoses has decreased significantly from 2017 to 2018 and Premier's positive PAH rate results also have been validated from recent data released by the NYS Department of Health. The DOH data, which is plan specific, in one instance shows Premier's PAH rate has gone down from 2017 to 2018. For another plan, Premier's PAH rate beats overall plan performance and the statewide average by a full point.

RTD—Real Time Data

For over 25 years, Premier's efforts in home and community-based care have helped shape the home care industry and positioned the organization to play a strategic role in the transformation of the health

care system. The complexities of the health care system and the challenges to find cost-effective, innovative ways to care for a growing population of high needs individuals with chronic care needs are very real. Utilizing the resource already at hand, Premier has developed an innovative, simple solution to care for these individuals.

RTD—Real Time Data already is demonstrating that by combining the contributions that the aide makes when Observing, Asking, and Reporting on their members' health care status; capturing simple data from the home to target timely interventions; and aggregating data to make changes at the population health level, the results are improvements in health outcomes and reductions in potentially avoidable hospitalizations/readmissions. These results are wins for providers, payers, and most importantly, members.

This Program is replicable throughout the health care delivery system. The processes developed for ***RTD—Real Time Data*** are very flexible and education, data points, and tracking can be adapted and built-out to address any specific payer, provider or plan need. Additionally, Premier has the capability to work collaboratively with other strategic partners—plans, home care agencies, health care systems to implement ***RTD—Real Time Data*** on a larger scale and enter into VBP Level 2 arrangements. The utility of ***RTD—Real Time Data*** also goes beyond the traditional home care construct and be used with family caregivers to extend resources, improve outcomes for members, and reduce costs.

Additionally, the utility of ***RTD—Real Time Data*** goes far beyond the traditional home care construct. While developed to use with home health aides, the training, trigger questions, and ***RTD—Real Time Data*** EDGE Dashboard is entirely applicable for use with family caregivers. As human resources for direct service delivery become increasingly scarce, family caregivers will need to increase their involvement in caring for loved ones and effective and simple tools to help them achieve similar outcomes will be critical. RTD—Real Time Data can be adapted to support families in need and improve outcomes for payers.

About Premier Home Health Care Services, Inc.

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.

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