



Meet the Caregiver Nation

- Numbers 66 million strong, of which 45 million are caring for someone aged 50+
- Provide an estimate of \$520B in unpaid care to loved ones
- 86% are caring for a relative and 72% live within 20 minutes of the care recipient
- Spend 4.6 years on average as a caregiver
- Work an average of 20.4 hours a week as a caregiver



In Massachusetts...

Caregivers

850,000

% of population

13%

Hours of care

786 million

Value

\$11.6B

Care Coordination: Fragmentation of care

Frustration among providers and caregivers

Percentage of Physicians Identifying Problems Coordinating Care with Different Providers and Entities

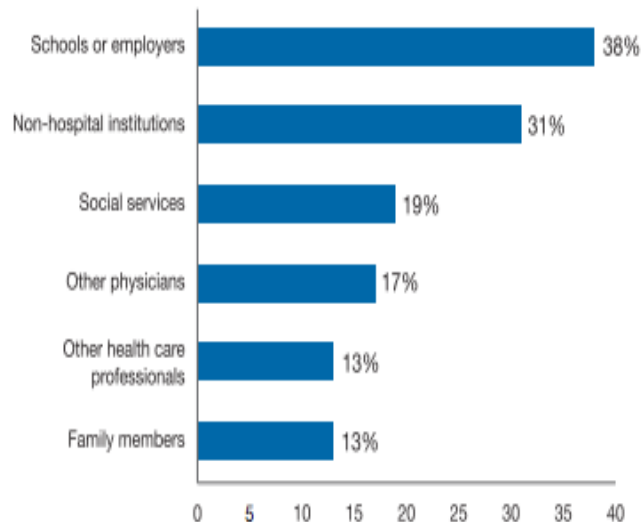


Chart from the Robert Wood Johnson Foundation: <http://rwjf.org/pr/product.jsp?id=50968>.

Percentage of Population with Chronic Conditions Reporting They Receive Inadequate Information

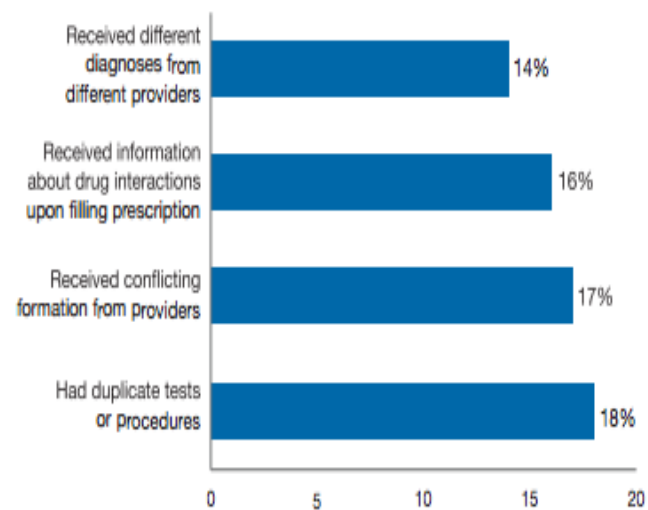
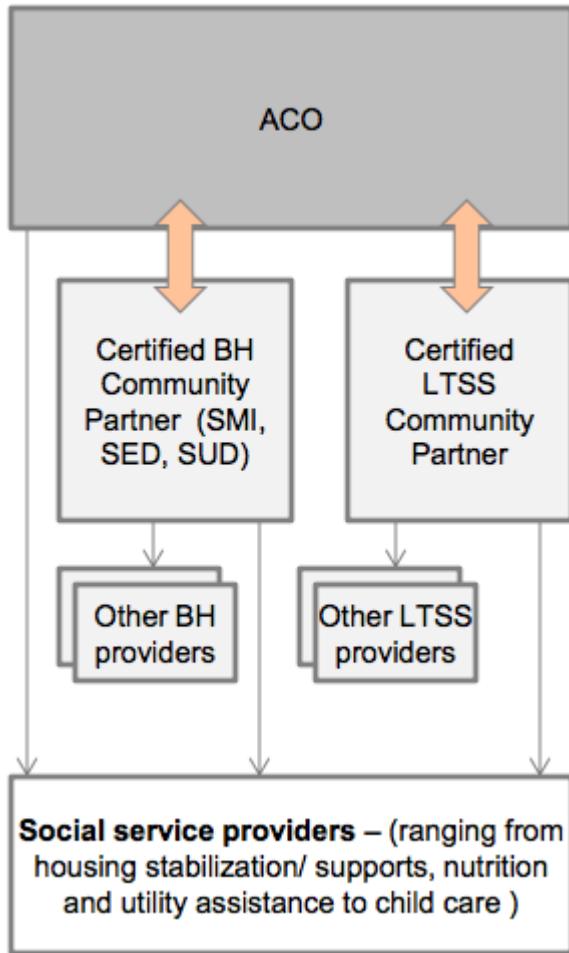


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MassHealth Delivery System Restructuring:

Long Term Services and Supports



Source: Baker Administration
4/2016

Structured Family Care Giving

Designed for MassHealth Standard eligible patients 16+yrs who need supervision with at least one ADL

- Full-time, 24/7 support and supervision from a live-in caregiver (not spouse or legal guardian)
- Oversight of caregivers from nurse and care manager
- Daily communication via electronic note reviewed by care team
- Monthly assessment and coaching from care team for both consumer and caregiver
- Person-centered care plan highlighting individual goals, needs, barriers, and steps to strengthening caregiver support
- Tax-free stipend to the caregivers with medical leave/ non-medical leave days

Why Caregiver Work Effort Matters

Who We Serve

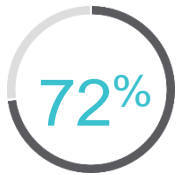
7K+ Consumers in 6 States ¹



6 OUT OF 10
are Duals

26%

are enrolled in a
Medicaid MCO



72%
dependent for
2+ ADLs



83%
have 5 or more medications

2 OUT OF 3

have indicators of
depression, anxiety,
and/or **mood disorder**

40%

exhibit **behaviors**
that make **caregiving**
difficult

35%

diagnosed with
a **behavioral health**
condition



Coordination

- ▶ Skilled Home Health
- ▶ O/P Rehab
- ▶ BH/Substance Abuse SOAP
- ▶ Day Programs
- ▶ Medically Complex Care Team

Results

↓30%
fewer ER Visits

↓50%
lower Hospital Utilization

NBER Working Paper: What is the Marginal Benefit of Payment Induced Family Care, May 2016; "The hospital utilization measures we examine include: any emergency room use; any hospital inpatient days; the number of inpatient hospital days; time until hospitalization; any Medicaid inpatient spending; the number of months with inpatient spending; and the total Medicaid inpatient expenditure."

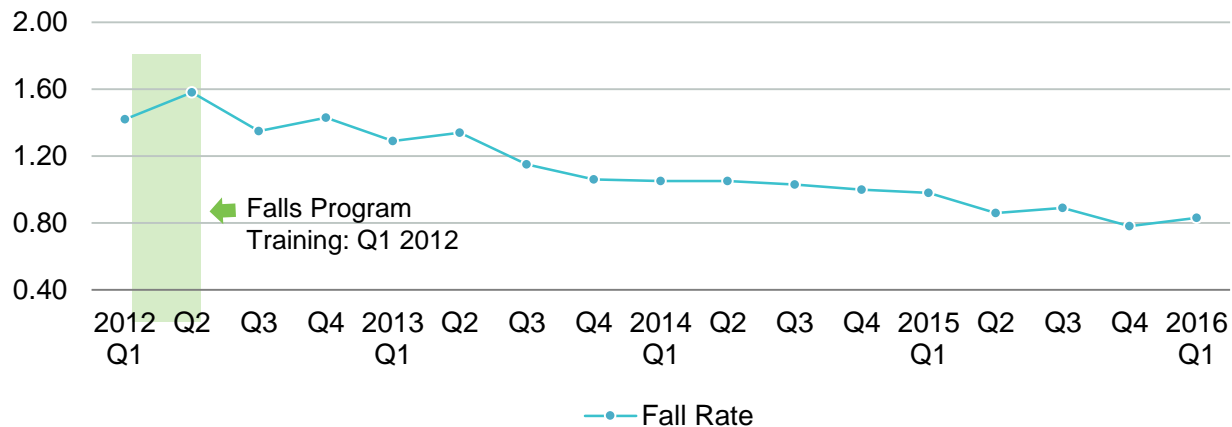
Caregiver Homes is the first Home and Community Based Services (HCBS) provider in the nation to receive case management accreditation



Source: Caregiver Homes, Data on file 8

Managing Predictable and Preventable Episodes: Falls Prevention

Rate of Falling per 1,000 Consumer Days



Falls Rates Comparison



Nursing Home
5/1,000



Hospital
1.3 to 8.9/1,000



Caregiver Homes
.83/1,000

INSIGHT

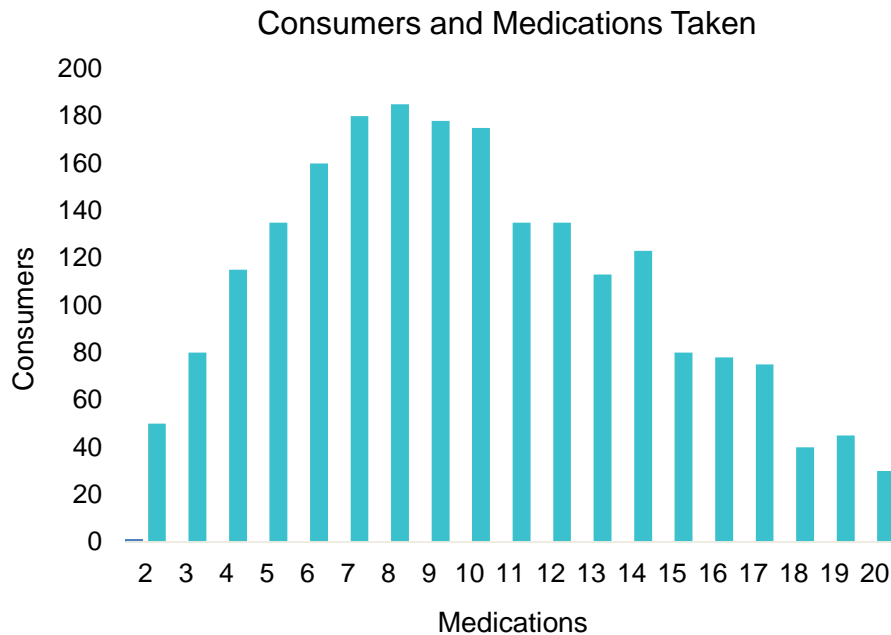
Falling in the community can be assessed, predicted and managed for consumers at varying levels of risk. Caregivers, as the most proximate person to the consumer, make observations that serve as early indicators

PROOF

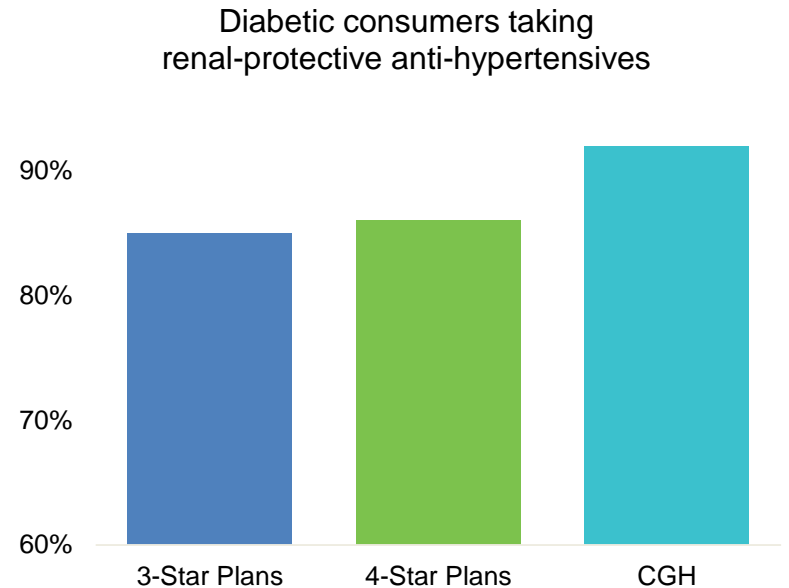
Our data suggest:

- Consumers with worsening behaviors (wandering, care resistance) are 48% more likely to have a hospitalization and 58% more likely to be admitted to a SNF
- Consumers with health conditions that make cognition, ADLs, or behavior patterns unstable are 122% more likely to fall over the next 180 days

Managing High Cost Outcomes: Medications



- The range of medications for Caregiver Homes (CGH) consumers is 2-20; average is 10.4
- Lack of adherence to a medication regime is the key driver for hospitalizations



- Caregiver Homes (CGH) has achieved 5-Star level adherence because of the proximity of a trained caregiver

Caregiver Homes: Impact

Remain at home

90% of people prefer to remain at home; Caregiver Homes reduces placements, ED, and hospital utilization.

Less costly

A CMS Beneficiary Study* compared care recipients in our program to those in a Medicare group with similar conditions and needs.

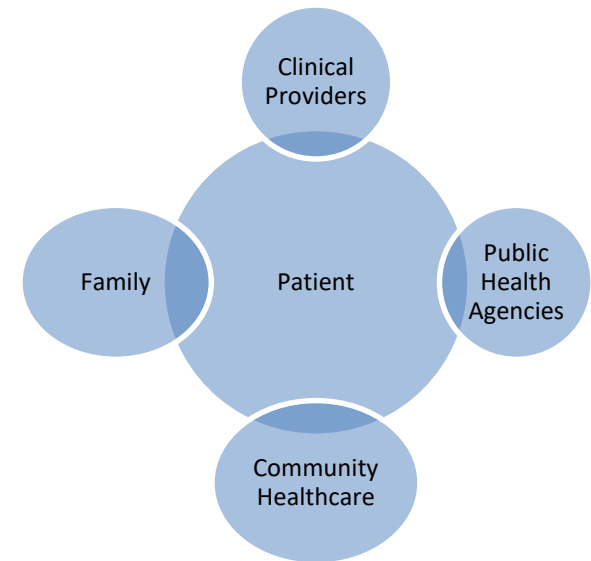
The results showed:

- The Medicare group spent nearly 3 times more on care delivery
- The Medicare group required 6.5 more home health visits, 2 times more physician visits, and 4 times more days in a skilled nursing facility.

Better results

Closing the loop on community based care

- Creating sustainable, effective linkages between the clinical and community settings improves patients' access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live. These linkages connect clinical providers, community based health care, and public health agencies. (AHRQ, 2015)
- Clinicians get help in offering services to patients that they cannot provide themselves.
- Patients and families receive the support, education and connections they need.



To help with a referral to Caregiver Homes:

Please provide client
name, DOB and caregiver
name and contact
information
to Emily at:

 enavetta@caregiverhomes.com