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STAFF REPORT ON HOME HEALTH AND THE MEDICARE THERAPY THRESHOLD

PREPARED BY THE STAFF OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

SEPTEMBER 2011

Printed for the use of the Committee on Finance

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Introduction

The United States Senate Committee on Finance (Committee) has a duty to conduct oversight of the programs in its jurisdiction, including Medicare and Medicaid. This duty includes the responsibility to monitor payments made by the Centers for Medicare and Medicaid Services (CMS) for home health services in order to protect taxpayer dollars from waste, fraud, and abuse.

In May 2010, the Committee initiated an inquiry into home health therapy practices at Amedisys, LHC Group, Gentiva, and Almost Family, the four largest publicly traded home health companies, after a *Wall Street Journal* analysis of therapy utilization patterns at those four companies suggested they were taking advantage of the Medicare therapy payment system by providing medically unnecessary patient care.[1]

The Committee staff reviewed documents provided by Amedisys, LHC Group, Gentiva, and Almost Family. All companies cooperated with the Committee's investigation.

In its review, the Committee found Amedisys, LHC Group, and Gentiva encouraged therapists to target the most profitable number of therapy visits, even when patient need alone may not have justified such patterns:

- Therapy visit records for each company showed concentrated numbers of therapy visits at or just above the point at which a "bonus" payment was triggered in the prospective payment system (PPS).
- Internal documents from Amedisys show that, prior to the 2008 CMS therapy payment changes, managers were encouraged to meet the 10-visit therapy threshold.
- An "A-Team" set up by Amedisys corporate management developed therapy programs after the release of the 2008 proposed PPS changes to target the most profitable Medicare therapy treatment patterns, including adding therapy visits to clinical tracks that previously did not involve therapy.
- Amedisys pressured therapists and regional managers to adhere to new clinical guidelines developed to maximize Medicare reimbursements.
- Internal e-mails identify top LHC Group managers, including the company's CEO, who instructed employees to increase the number of therapy visits provided in order to increase case mix, a measurement of patient acuity, and revenue.
- Internal documents show that Gentiva developed a competitive ranking system for their management aimed at driving therapy visit patterns toward more profitable thresholds.

[1] Barbara Martinez, "Home Care Yields Medicare Bounty," *Wall Street Journal*, April 26, 2010; Barbara Martinez, "Senators Question In-Home Caregivers," *Wall Street Journal*, May 13, 2010.

- Internal documents show that Gentiva management discussed increasing therapy visits and expanding specialty programs to increase revenue.

The home health therapy practices identified at Amedisys, LHC Group, and Gentiva at best represent abuses of the Medicare home health program. At worst, they may be examples of for-profit companies defrauding the Medicare home health program at the expense of taxpayers.

Background on Therapy Thresholds

The Balanced Budget Act of 1997 (BBA) changed the way Medicare paid for home health services by requiring the implementation of a home health prospective payment system (PPS). Prior to the establishment of PPS, Medicare paid on a cost-based reimbursement system, in which Medicare paid separately for items and services furnished by each home health agency.[2]

In creating the PPS, the Centers for Medicare and Medicaid Services (CMS) established a basic unit of payment for home health services in which home health agencies would receive payment for a 60-day episode of care. This single payment was intended to cover the skilled care needs of individuals who were restricted to their homes for a 60-day period.[3] These services included nursing care; physical, occupational, and speech therapy; medical social work; home health aide services; and certain routine medical supplies.[4]

CMS also developed a patient classification system to adjust payments, also known as a "case-mix adjustment," in the home health PPS based on each patient's health characteristics and use of services. The patient classification system originally consisted of 80 Home Health Resource Groups (HHRGs). Home health agencies would determine each patient's health characteristics using the Outcome and Assessment Information Set (OASIS) and each patient would be assigned to an HHRG based on that assessment. Figure 1 outlines the pre-2008 clinical, functional, and service metrics from OASIS used to determine each patient's HHRG.[5]

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[2] Office of Inspector General, "Medicare Program; Prospective Payment System for Hospital Outpatient Services, Background," *Federal Register* 65:68 (7 April 2000), pp. 18434, 18436.

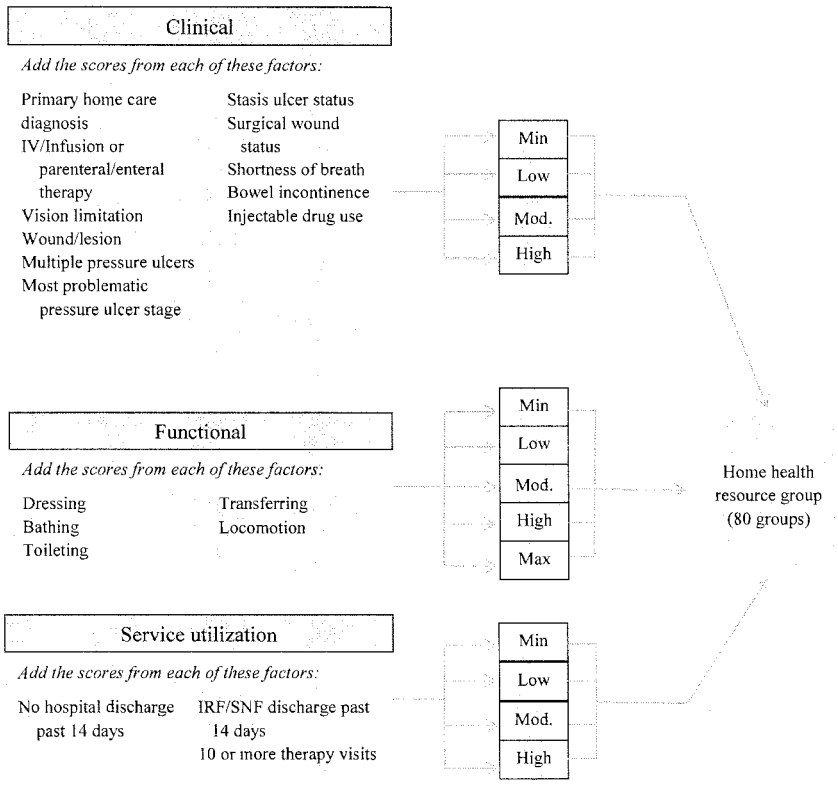
[3] Medicare Program, "Prospective Payment System for Home Health Agencies," *Federal Register* 64:208 (28 October 1999), pp. 58134, 58143.

[4] Office of Inspector General, "Medicare Program; Prospective Payment System for Hospital Outpatient Services, Background," *Federal Register* 65:68 (7 April 2000), pp. 18434, 18442.

[5] MedPAC, "Health Care Services Payment System," Revised October 2008; MedPAC, "Report to the Congress: Issues in a Modernized Medicare Program," June 2005.

Figure 1: Pre-2008 OASIS calculation for HHRG

Clinical, functional, and service information from OASIS determines a patient's home health resource group.



Source: MedPAC, "Report to the Congress: Issues in a Modernized Medicare Program," June 2005

The 10-Visit Threshold

One of the most significant factors outlined in Figure 1 is the inclusion of OASIS "score" metrics that indicate each patient's clinical, functional, and service utilization characteristics. These characteristics are combined to determine each patient's HHRG, which ultimately dictates the reimbursement payment to each home health agency. The payment system through 2007 included a therapy "bonus" when a home health agency provided at least 10 therapy visits. This bonus was substantial, and CMS recognized in its original rulemaking that a 10-visit threshold was "susceptible to manipulation."[6] According to data from CMS, providing 10 visits as opposed to 9 visits increased reimbursement on average 97.5 percent (over $2,000) in 2007.

Figure 2: Average Home Health Episode Payment by Number of Therapy Visits, 2007

Number of Therapy Visits	Payment Amount	Percentage Increase	Number of Therapy Visits	Payment Amount	Percentage Increase
1	$1,600.19		16	$4,431.62	0.43%
2	$1,728.28	8.00%	17	$4,420.06	-0.26%
3	$1,828.10	5.78%	18	$4,475.52	1.25%
4	$1,925.85	5.35%	19	$4,495.57	0.45%
5	$2,124.98	10.34%	20	$4,548.37	1.17%
6	$2,148.46	1.10%	21	$4,514.26	-0.75%
7	$2,162.31	0.64%	22	$4,546.42	0.71%
8	$2,188.76	1.22%	23	$4,540.15	-0.14%
9	$2,198.56	0.45%	24	$4,666.77	2.79%
10	$4,342.66	97.52%	25	$4,572.56	-2.02%
11	$4,390.12	1.09%	26	$4,610.77	0.84%
12	$4,604.31	4.88%	27	$4,642.40	0.69%
13	$4,445.15	-3.46%	28	$4,749.19	2.30%
14	$4,453.79	0.19%	29	$4,796.61	1.00%
15	$4,412.86	-0.92%	30	$4,720.55	-1.59%

Source: CMS

When the PPS system was first implemented, the payment increase threshold was set at 10 therapy visits. CMS implemented the measure in part to discourage "stinting," a term used within the industry to describe agencies rendering the lowest level of service necessary to collect Medicare payment. CMS officials determined 8 hours of combined physical, speech, or occupational ther-

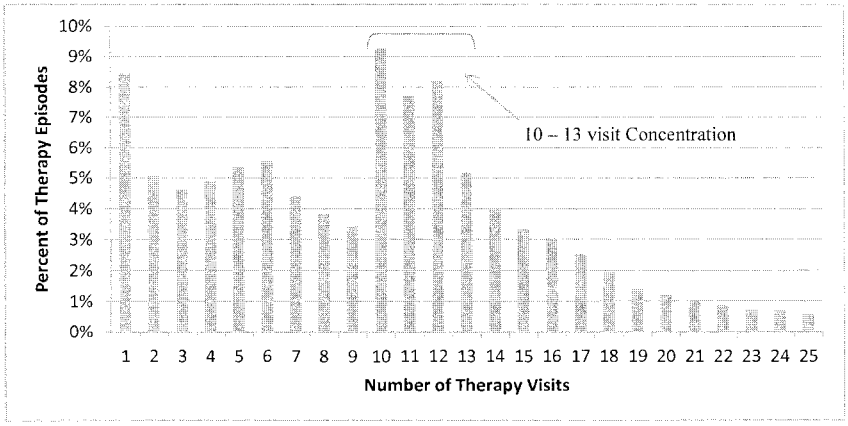
[6] Medicare Program, "Prospective Payment System for Home Health Agencies, Final Rule," *Federal Register* 65:128 (3 July 2000), pp. 41128, 41148.

apy over a 60-day episode would provide a suitable level of care for patients with significant therapy needs; however, a study by Abt Associates commissioned by CMS indicated few patients received that level of care prior to the implementation of PPS. CMS divided the 8 hours into 10 therapy sessions, lasting 48 minutes each, to determine the visit number threshold.[7]

Not surprisingly, the home health episodes that utilized therapy services, also referred to as therapy episodes, demonstrated a concentrated number of visits at or just above thresholds where payments were much greater. The Medicare Payment Advisory Commission (MedPAC) found that episodes with the number of therapy visits between 10 and 13 increased by about 90 percent between 2002 and 2007 at an annual rate of 13.8 percent. However, the percentage of episodes just above and below the 10 to 13 therapy visit range remained relatively unchanged during the same period.[8]

CMS noted similar results, finding the threshold system "might have distorted service delivery patterns."[9] CMS found that the 10- to 13-visit range had the highest concentration of therapy episodes among cases that utilized home therapy. Of all episodes at or above the 10-visit threshold, half were concentrated in the 10 to 13 range.[10]

Figure 3: National Distribution of Episodes with Therapy Visits, 2007



Source: CMS

CMS Attempts Reform: Policy Gamed

In response to the change in home health agencies' practices and evidence of clustering visits just above the 10-visit threshold, CMS proposed significant changes to the therapy reimbursement system

[7] *Id.* 41148.
[8] MedPAC, "Report to Congress," March 2011.
[9] Medicare Program, "Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008, Proposed Rule," *Federal Register* 72:086 (4 May 2007), pp. 25356, 25362.
[10] *Id.*

in 2007, to take effect in 2008.[11] However, CMS retained a tiered therapy threshold system, despite evidence that a threshold system might be gamed or "padded" to increase reimbursement to home health agencies.[12]

Prior to the promulgation of the final rule, CMS considered alternatives to the therapy threshold system. Specifically, the agency evaluated whether using pre-admission status, status of activities of daily living (ADL), specific diagnoses, and additional OASIS variables could enable CMS to determine a patient's need for therapy without a tiered threshold system.[13] CMS ultimately determined none of those variables were sufficient and opted to maintain a threshold system in the final rule with therapy thresholds at 6, 14, and 20 visits. Home health agencies saw a substantially higher payout for those episodes that reach the thresholds within each 60-day period. Smaller graduated steps were also implemented between the thresholds, though they were not as significant as the 6, 14, and 20 visit payment increases.

Figure 4: Average Home Health Episode Payment by Number of Therapy Visits, 2008

Number of Therapy Visits	Payment Amount	Percentage Increase	Number of Therapy Visits	Payment Amount	Percentage Increase
1	$1,544.03		16	$5,010.47	6.48%
2	$1,639.59	6.19%	17	$4,947.58	-1.26%
3	$1,742.85	6.30%	18	$5,275.00	6.62%
4	$1,803.85	3.50%	19	$5,276.52	0.03%
5	$1,925.24	6.73%	20	$6,809.22	29.05%
6	$2,546.26	32.26%	21	$6,834.21	0.37%
7	$3,012.44	18.31%	22	$6,805.92	-0.41%
8	$3,016.42	0.13%	23	$6,841.38	0.52%
9	$3,023.28	0.23%	24	$6,888.63	0.69%
10	$3,532.60	16.85%	25	$6,897.02	0.12%
11	$3,930.55	11.27%	26	$6,909.06	0.17%
12	$4,076.06	3.70%	27	$6,926.91	0.26%
13	$3,954.84	-2.97%	28	$6,994.30	0.97%
14	$4,788.38	21.08%	29	$6,991.55	-0.04%
15	$4,705.76	-1.73%	30	$6,926.49	-0.93%

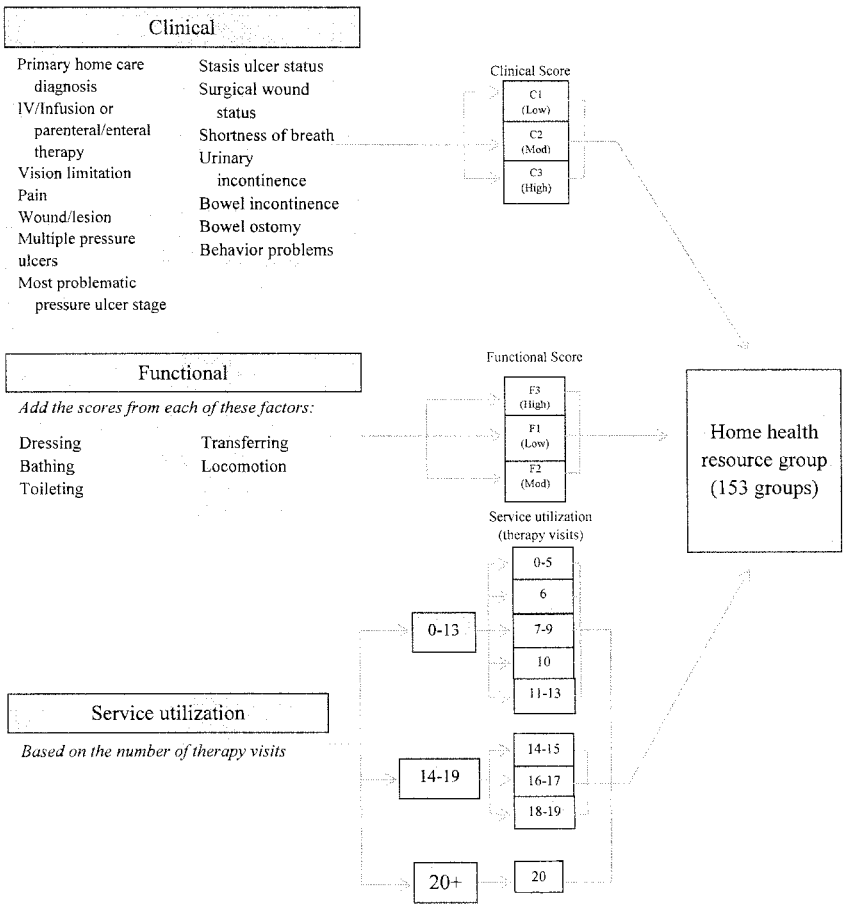
Source: CMS

[11] Medicare Program, "Home Health Prospective Payment System Refinement and Rate Update for Calendar Year 2008, Final Rule," *Federal Register* 72:167 (29 August 2007), pp. 49762, 49836.
[12] *Id.* 49764.
[13] *Id.* 49835.

CMS also increased the number of payment groups used in determining HHRG from 80 to 153 individual metrics, and provided higher payments for the third and subsequent home health episodes.[14]

Figure 5: 2008 Final Rule OASIS calculation for HHRG

Clinical, functional, and service information from OASIS determines a patient's home health resource group.



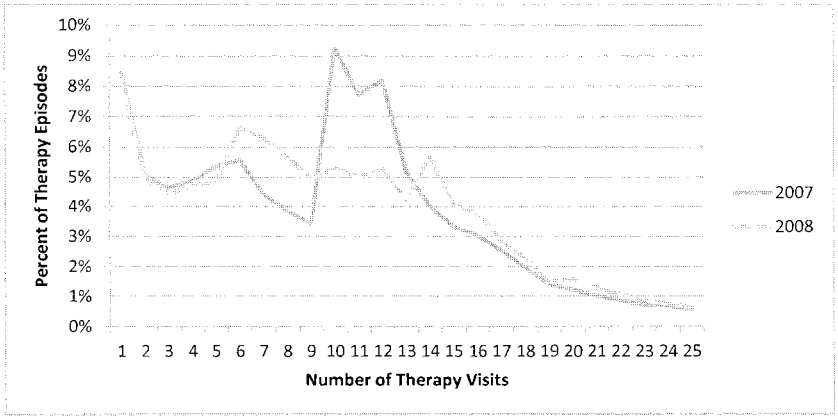
Source: MedPAC, "Health Care Services Payment System," Revised October 2008

Home health agencies rapidly altered their treatment patterns to match the new system, producing what MedPAC called "the swiftest one-year change in therapy utilization since PPS was imple-

[14] *Id.* 49762.

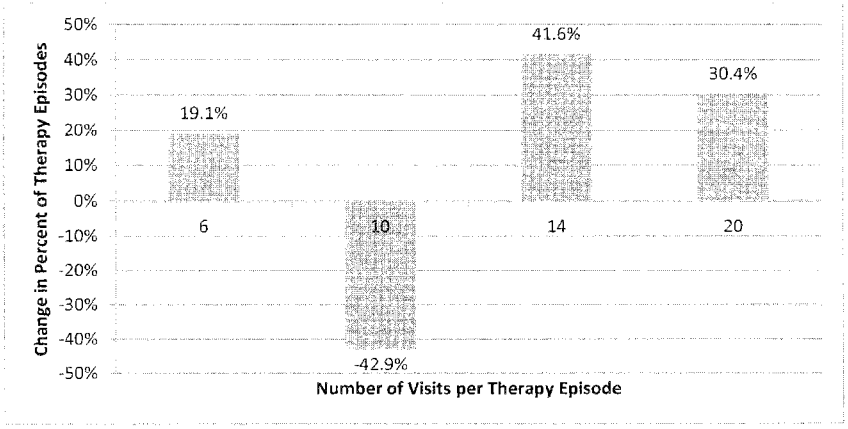
mented."[15] Therapy visits furnished by home health agencies shifted from the original 10-visit threshold to the new 6, 14, and 20 visits. According to MedPAC, "payment for episodes with 6 to 9 visits increased by 30 percent, and the share of these episodes increased from 8.6 percent to 11.6 percent. Payment for episodes with 14 or more therapy visits increased by 26 percent, and the share of these episodes increased from 12 percent to 14.5 percent." In addition, the number of episodes at the 10 to 13 therapy visit range dropped approximately 28 percent.[16]

Figure 6: National Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: CMS

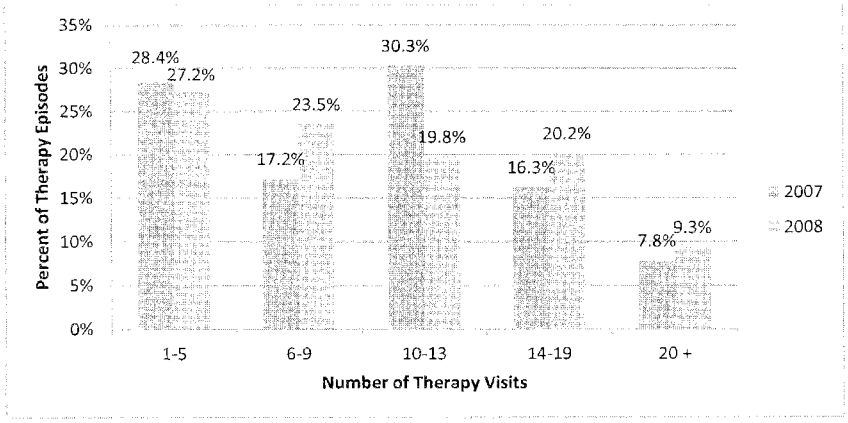
Figure 7: National Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: CMS

[15] MedPAC, "Report to Congress," March 2011, p. 183.
[16] *Id.*

Figure 8: National Distribution of Episodes with Therapy Visits, 2007 vs. 2008



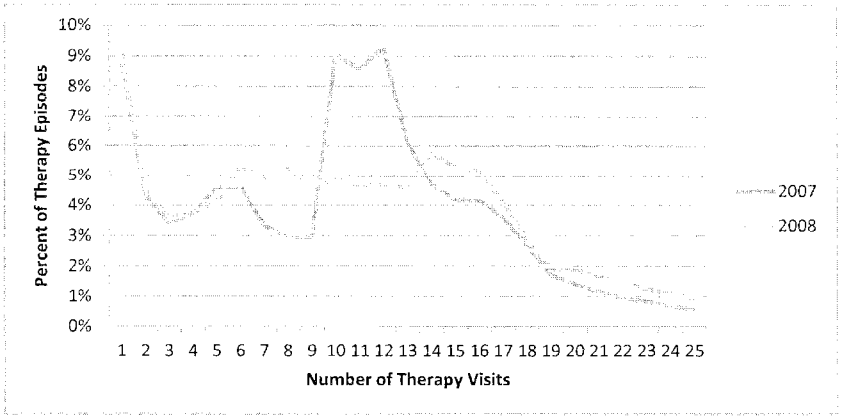
Source: CMS

Amedisys

A review of internal documents and communications provided to the Committee by Amedisys shows that Amedisys management directed employees to adjust the number of home health therapy visits to maximize Medicare payout to the company after the 2008 changes to the Medicare payment system.

In addition, the Committee's review substantiates concerns raised by the Medicare Payment Advisory Commission that the "incentives of the therapy thresholds encourage providers to consider payment incentives, and not necessarily patient characteristics, when determining what services to provide."[17]

Figure 9: Amedisys Distribution of Episodes with Therapy Visits, 2007 vs. 2008



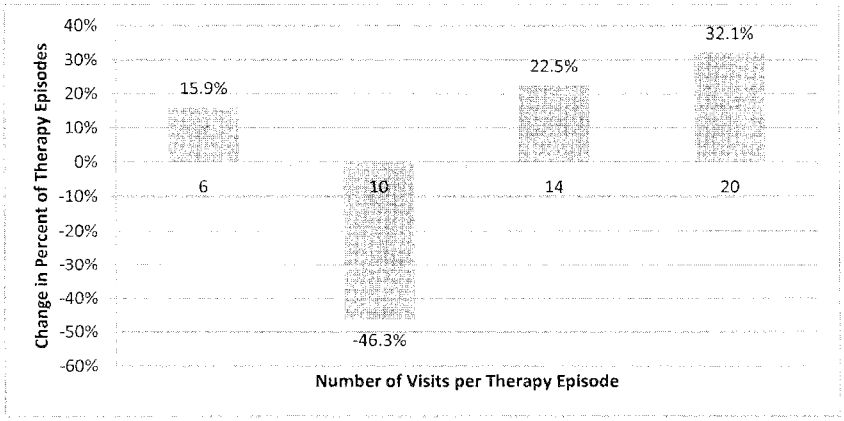
Source: Amedisys

[17] MedPAC, "Report to Congress," March 2011, p. 183.

Therapy Metrics

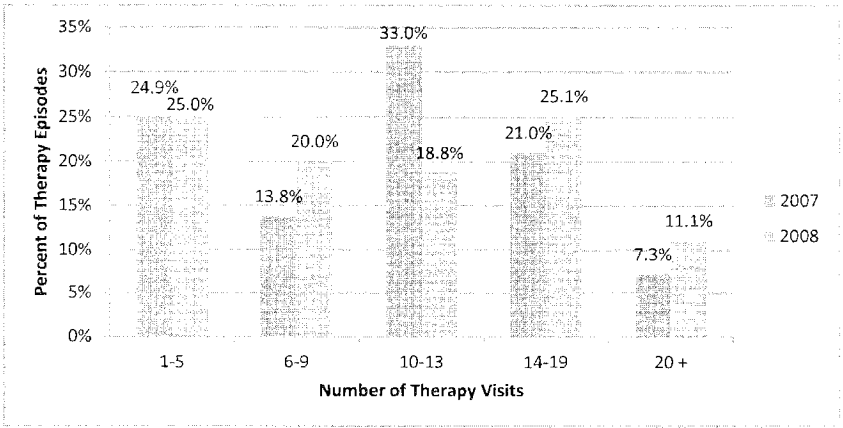
As Figure 9 indicates, in 2007, 9.1 percent of Amedisys's therapy episodes received 10 visits while 2.9 percent of the therapy episodes received 9 visits. In 2008, after the CMS PPS therapy changes, the number of therapy episodes that received 10 visits dropped to 4.9 percent. Also from 2007 to 2008, the number of therapy episodes receiving 6 visits increased from 4.6 percent to 5.3 percent, and the number of therapy episodes receiving 14 visits increased from 4.7 percent to 5.8 percent.[18]

Figure 10: Amedisys Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: Amedisys

Figure 11: Amedisys Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: Amedisys

[18] Amedisys Therapy Episode Distribution, AMEDSFC00000001—AMEDSFC00000002.

Home health episodes with therapy reimbursements accounted for 71 percent of Amedisys's Medicare revenue in 2009 at $878,535,009. Amedisys's total Medicare revenue for 2009 was $1,229,755,214.[19] Medicare reimbursements consisted of 88 percent of Amedisys's revenue in 2009.[20]

The 10-Visit Therapy Threshold Prior to 2008

The large disparity between the percentage of Amedisys therapy episodes receiving 9 and 10 visits prior to the 2008 CMS PPS payment changes is not surprising given the employee training materials in circulation at the time. A 2006 PowerPoint presentation encouraged Amedisys managers to generate a report to help "the [Directors of Office Operations (DOOs)] focus on therapy utilization." The presentation instructed Amedisys DOOs to "Look for patients that have 7, 8, 9 visits and try to get the 10 visits to make therapy threshold."[21]

The same presentation also encouraged DOOs to use an Adjusted Revenue Report "to identify patients that have had or will have revenue adjustments made to the expected payment amount. . . . This report gives you the best opportunity to convert or prevent [Low Utilization Payment Adjustments (LUPA) patients] and non therapy threshold patients."[22]

LUPAs are patients "with four or fewer home health visits" and "are reimbursed under the Low Utilization Payment Adjustment (LUPA) on a per-visit basis and payment varies depending on the type of health care professional making the visit."[23] Generally, home health agencies see LUPA cases as less profitable than mid- or high-therapy utilization cases.

Another educational document stated that when patients are "close to the 10-visit threshold," therapists should ask, "What is the patient's rehab potential. . . . Does that patient have any balance issues that might create a high risk for falls. . . . Is the patient appropriate for other therapy services or disciplines?"[24]

Amedisys Management's Response to the 2008 CMS Payment Changes

Amedisys's corporate management saw the proposed 2008 CMS PPS changes as an opportunity to increase its reimbursements from Medicare by altering internal clinical and marketing practices. A document outlining Amedisys CEO Bill Borne's strategic plan stated that the proposed changes in the 2008 home health PPS system "provides an opportunity for Amedisys to refine internal practices in order to enhance shareholder value despite the payment changes."[25]

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[19] Amedisys Medicare Reimbursement, AMEDSFC00000003.

[20] Amedisys 2010 Annual Report, p. 14, *http://www.amedisys.com/pdf/Amedisys_annualrep10.pdf*.

[21] Amedsys PowerPoint, Help with Reports, 2006, AMEDSFC00001477—AMEDSFC00001543, *AMEDSFC00001484.

[22] *Id.*

[23] Home Health Study Report prepared for CMS by L&M Policy Research, January 11, 2011, p. 6.

[24] Amedisys PowerPoint, Home Health Care Team Conference Overview, 2006, AMEDSFC00001544—AMEDSFC00001593, *AMEDSFC00001583.

[25] Amedisys Board Meeting Minutes, October 27, 2007, AMEDSFC00000812—AMEDSFC00000845, *AMEDSFC00000820.

According to the minutes of an Amedisys board meeting held at the Las Ventanas Hotel in Los Cabos, Mexico on July 24, 2007, Chief Information Officer Alice Ann Schwartz reported, "the Company had formed a committee called the 'A-Team' whose specific purpose was to develop strategic clinical programs and cost-cutting/efficiency measures to address the proposed case mix refinements." [26]

Creating Therapy-Based Programs to Boost Revenue

A list of talking points used during a June 13, 2007 conference call regarding the proposed PPS changes contained a strategy for "Clinical Development," which included "Data Mining of most profitable/least profitable diagnoses and the financial impact. . . . Develop an infrastructure to track monthly percentage growth in desirable cases. . . . Recommendations of new programs with conceptual framework submitted based on analysis/data mining." [27]

During this conference call, a document was distributed titled "Data Mining Strategies Handout" which ranked medical diagnoses by average profit per episode. The document laid out a comprehensive strategy to increase therapy visits for certain therapy episodes that were beneath key thresholds, adding therapy visits into non-therapy episodes, and substituting physical therapy for skilled nursing visits. The document stated that a therapy based wound care program in which "[physical therapy] replaces [skilled nursing] visits in wound care episodes w/o therapy" would bring an "Added Revenue" of "$1,400,000." [28]

Additionally, an August 2007 training document stated, "If we added only 6 Therapy visits to 3% of [congestive heart failure] patients who are F2F3 but received no therapy—8809 episodes, net to company almost half a million. Imagine what the revenue for the agencies will be!" [29]

In addition to discussing clinical development strategies based on the most profitable and least profitable diagnoses, the team also discussed "Developing a strategic sales focus upon preferred patient mix." [30]

Notes from a conference call on August 2, 2007 led by Amedisys Chief Operating Officer Larry Graham stated that a "Key Operational Initiative" of Amedisys's "Case Mix Refinement Strategy" was "Growth of Focused [Disease Management] Programs in 2008" and a "New Therapy Clinical Tracks rollout" on September 15, 2007.[31]

A PowerPoint presentation introducing Amedisys's "therapy wound care initiative," which added physical therapy visits to home health episodes, noted that treating a wound care patient with 14

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[26] Amedisys Board Meeting Minutes, October 27, 2007, AMEDSFC00000812—AMEDSFC00000845, *AMEDSFC00000816.

[27] Conference Call agenda, June 13, 2007, AMEDSFC00093064—AMEDSFC00093068, *AMEDSFC00093067.

[28] Conference Call agenda, June 13, 2007, AMEDSFC00093064—AMEDSFC00093068, *AMEDSFC00093065.

[29] Therapy and Specialty Program Initiatives, VP/RA/RDBD Education, August 15, 2007, AMEDSFC00076748—AMEDSFC00076775, *AMEDSFC00076766.

[30] Conference Call agenda, June 13, 2007, AMEDSFC00093064—AMEDSFC00093068, *AMEDSFC00093068.

[31] Conference Call with Larry Graham, August 2, 2007, Case Mix Strategy Handouts, AMEDSFC00064385—AMEDSFC00064395, *AMEDSFC00064394.

and 20 physical therapy visits would more than double the company's Medicare reimbursement for the episode in two examples. One example explained that the 2008 Medicare reimbursement without therapy services would be $2,908.13, as opposed to $6,011.67 with 14 physical therapy visits under the new system.[32]

According to an Excel spreadsheet used to track tasks of the "A-Team" committee, Amedisys management decided, as part of its clinical strategy, to incorporate "therapy into [the congestive heart failure] program" and institute "Aggressive [Balanced For Life] and multi-disciplinary therapy program launches in 2008."[33]

A 2007 document titled "Therapy Initiatives Update" was distributed during an August 31, 2007 "A-Team" conference call. The document indicates that the average HHRG for Balanced for Life reimbursement was $4,100 in 2007. In 2008, the document noted a projected HHRG reimbursement increase to $4,700 because occupational therapy was added to the Balanced for Life program.[34]

Altering Patient Care Guidelines to Hit Therapy Thresholds

Amedisys altered its clinical recommendations for the number of therapy visits, known as "clinical tracks," as a result of the CMS payment changes in 2008. The new clinical tracks correspond to the new payment thresholds.

Prior to the CMS payment changes, the "Better Balance At Home" and "Better Strength At Home" programs had a recommended 3 to 12 therapy visits.[35] An internal Amedisys PowerPoint presentation stated that "New case mix weight adjustments proposed by medicare provided a great opportunity to make some company wide changes in the rehab clinical tracks" and the new "Rehabilitation @ Home" program "Replaces Better Strength and Better Balance."[36] However, the new clinical recommendations changed after CMS implemented its payment changes. Instead of the number of visits being in the 3 to 12 range, the new visit range for "Rehabilitation @ Home" became 8, 16, or 22 visits. All 3 of these visit tracks were 2 visits above each therapy payment threshold.[37]

Amedisys Staff was Pressured to Adhere to New Patient Care Guidelines

While the training material regarding clinical track changes in 2008 stated "visit numbers are guidelines" and "Care plans are made patient specific and appropriate to the needs of that patient," e-mails and documents provide evidence that Amedisys executives pressured employees to reach specific therapy payment thresholds.

An Amedisys PowerPoint authored by Amedisys Vice President of Disease Management Anne Frechette describes "Key Operational

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[32] Amedisys PowerPoint presentation, Therapy Wound Care, September 26, 2007, AMEDSFC00070246—AMEDSFC00070276, *AMEDSFC00070273.

[33] A-Team Case Mix Committee Action Items, December 2007, AMEDSFC00070083—AMEDSFC00070103, *AMEDSFC00070085.

[34] "Therapy Initiatives Update," August 30, 2007, AMEDSFC00076174—AMEDSFC00076177, *AMEDSFC00076177.

[35] Amedisys Rehab Clinical Track Options, AMEDSFC00001347—AMEDSFC00001350, *AMEDSFC00001347.

[36] "Amedisys Rehabilitation 2007–2008, AMEDSFC00001846—AMEDSFC00001862, *AMEDSFC00001848.

[37] Clinical Track Guidelines—Revised, AMEDSFC00001935.

Initiatives" for 2008 including an initiative to "Improve compliance with scheduling according to clinical tracks" by transferring that responsibility from the agency clinical manager to a [Quality Care Coordinator].[38] The Quality Care Coordinator's job is to oversee clinical decisions and documentation at Amedisys agencies.[39]

On February 25, 2008, Amedisys Vice President of Quality Management and Analytics Tasha Mears distributed an e-mail with the subject line, "Therapy Management in 2008." The e-mail reminded Amedisys management of the "company wide differences in reimbursement in 2008 versus 2007 based on the total therapy visits per episode." The e-mail also included a chart showing "changes in revenue per episode, moving from 'bucket' to 'bucket' in 2008." Lastly, the e-mail included a report ranking "individual agencies, AVP's and VP's by 14+ total therapy visits per episode, and shows how many episodes are in each therapy 'bucket'."[40]

The following day, Amedisys Area Vice President of Operations in North Alabama Teresa B. Mills wrote in an e-mail urging conformance with the new clinical tracks:

> It is imperative that we are compliant with the clinical tracks for Rehab that were made available to your agency December 2007. After reviewing each of the agencies Episode Statistics for Feb.1 thru today it is evident that we as a region are not following the established guidelines for clinical management of therapy utilization. 65 percent or greater of your episodes that have ended this month fell under the 2008 PPS rules and discovery is that most of your episodes have fallen into the Grouping Step 1 or Grouping Step 3 with 0–13 therapy visits. The Rehab Clinical Traction Options selection sheet is based on the therapist's assessment of the geriatric rehab patient with attention to the clinical and functional scoring established on the evaluation. There are only 3 of the 14 Therapy Tracks that have less than 14 visits to be scheduled—they are Rehab at Home–DO1 for CIF1–8 visits recommended, Dysphagia at Home–001 for C2–3 F2–3 for 8 SLP visits, and Orthopedics I–001 for C1–2 F1 for 8 PT visits. Most patients in this clinical and functional status would not be a patient in home health for any length of time. Most of your patients fall into a C2F2–3 status or greater and would more appropriately be placed on the other tracks having 14–22 visit options and are based on Clinical 2–3 and Functional 2–3 scoring on the OASIS. This is your guideline and the Clinical Managers are to work with the therapists to obtain the accurate track selection—do not use any of the old therapy tracks.[41]

A February 27, 2008 e-mail from the Amedisys Vice President of Florida Operations Dan Cundiff to Amedisys managers in Florida stated:

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[38] Amedisys Powerpoint presentation, Key Operation Initiatives—2008, VP of Disease Management, Anne Frechette, AMEDSFC00066778—AMEDSFC00066899, *AMEDSFC00066798.

[39] "Remote Quality Care Coordinators," AMEDSFC00064470—AMEDSFC00064499, *AMEDSFC00064482.

[40] E-mail from Amedisys Vice President of Quality Management and Analytics, Tasha Mears, February 25, 2008 and attachments, AMEDSFC00072633—AMEDSFC00072642; AMEDSFC00072702—AMEDSFC00072709; AMEDSFC00072769, *AMEDSFC00072634.

[41] E-mail from Amedisys Area Vice President Teresa Mills, February 26, 2008, AMEDSFC00092129.

> We need to work immediately to adjust our '10 therapy threshold' mindset. See the email from Tasha yesterday. At 10, our episode value drops by over 880.00 14–15 is where we need to be . . . and yes, I understand that our visits per episode will go up . . . but I would rather be profitable than have a low visits/episode. At 7–9 we have upside, but the overall episode value is less than I would like to see for cases involving therapies. If we continue to drive meeting 10 therapies . . . we will be cooked. 11–13 as well.[42]

Another e-mail by Mr. Cundiff to Amedisys managers in Florida on February 29, 2008 stated:

> We still drove to a 10 therapy threshold . . . and thus, our values per episode were HAMMERED. We must stop thinking that 10 therapies maximizes our reimbursement.
>
> The new upper level threshold is now 14 therapy visits. **When clinically appropriate**, lets drive to that number. From 10–13 visits, we become significantly less profitable . . . to the tune of an 800.00+ negative adjustment from 2007 rates. [emphasis in original]
>
> Falling in the 10–13 range without a solid set of reasons is real shame, and the only acceptable reason is that it was absolutely the best thing for the patient. [sic] I will never . . . NEVER argue that point, but I would also suggest, that in most cases, patients benefit from additional therapy beyond 10–13 visits.
>
> Let's get with the newer reimbursement schedule . . . improve our outcomes by more therapy patient contact . . . and win all around. Lastly, let's not be overly concerned about visits per episode . . . until we maximize our revenue opportunities . . . when supported by clinical standards.[43]

Internal reports about Amedisys branches in Missouri also cited the need for clinical tracks to be followed. One report stated that the "Rev/Episode is low due to the under utilization of therapy" and recommended that in order to "Increase Revenue per episode via episode management from $1619 to $2500" that the area vice president of operations should "Work with DOO to insure [sic] usage of clinical tracks."[44]

Gentiva

Therapy Metrics

As Figure 12 indicates, in 2007, 7.7 percent of Gentiva's therapy episodes received 10 visits while 3.6 percent of the therapy episodes received 9 visits. In 2008, the number of therapy episodes that received 10 visits dropped to 5.8 percent.[45]

Also from 2007 to 2008, the number of therapy episodes receiving 6 visits dropped from 6.5 percent to 6.1 percent. However, the per-

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[42] E-mail from Amedisys Vice President for Florida Operations Dan Cundiff, "January," February 27, 2008, AMEDSFC00092016.

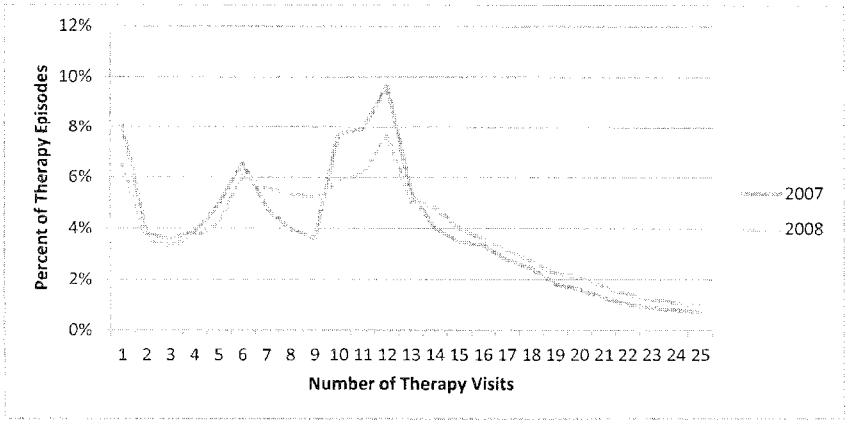
[43] E-mail from Amedisys Vice President for Florida Operations Dan Cundiff, "episode follow up," February 29, 2008, AMEDSFC00092017.

[44] E-mail from Mike Hamilton to Jill Cannon and William Mayes, March 10, 2008 and attachments. AMEDSFC00093359—AMEDSFC00093371, *AMEDSFC00093360.

[45] Gentiva Therapy Episode Distribution, GEN 000015.

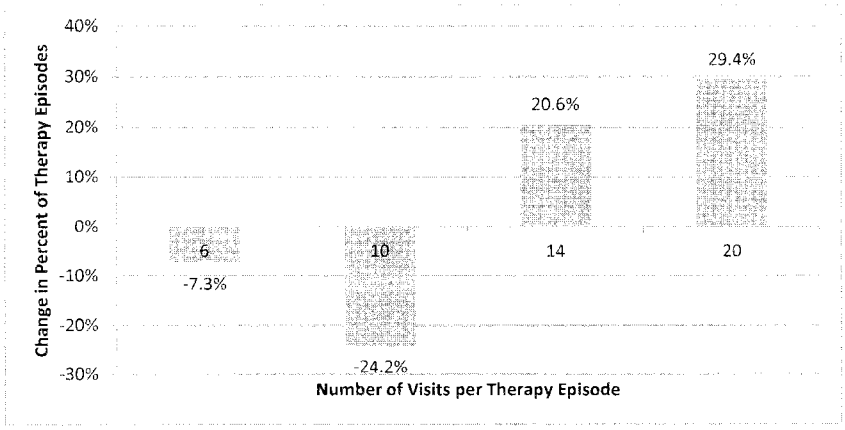
centage of therapy utilization in the 6-visit through 9-visit range increased, from 18.9 percent in 2007 to 22.1 percent in 2008. The number of therapy episodes receiving 14 visits increased from 4.0 percent to 4.8 percent. And the number of therapy episodes receiving 20 visits increased from 1.6 percent to 2.1 percent.[46]

Figure 12: Gentiva Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: Gentiva

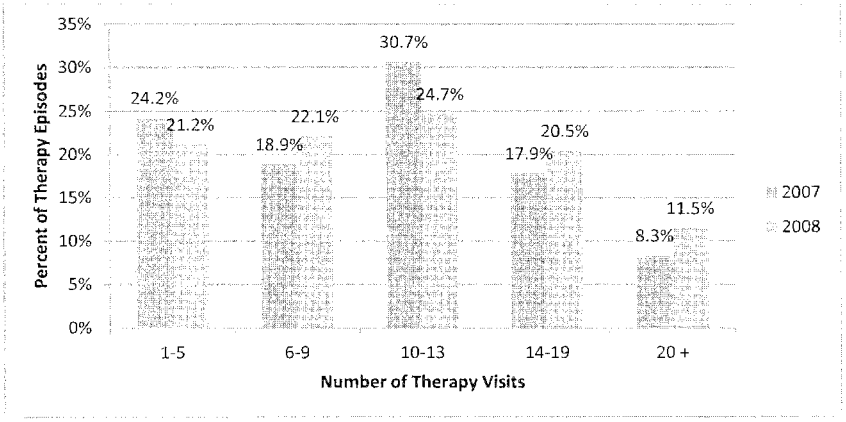
Figure 13: Gentiva Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: Gentiva

[46] *Id.*

Figure 14: Gentiva Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: Gentiva

Home health episodes with therapy reimbursements accounted for 78 percent of Gentiva's Medicare revenue in 2009 at $606,921,660. Gentiva's total Medicare revenue for 2009 was $773,673,026.[47] Medicare reimbursements consisted of 82 percent of Gentiva's revenue in 2009.[48]

Gentiva Management Response to the 2008 CMS Payment Changes

Internal documents and e-mails show that Gentiva's management discussed increasing therapy visits and expanding specialty programs to increase Medicare reimbursements as a result of the proposed 2008 CMS payment changes.

Vice President and Chief Clinical Executive Susan Sender wrote in a January 5, 2007 e-mail regarding the CMS payment changes that there was "an internal group . . . crunching utilization and outcomes data to determine whether revisions to our therapy protocols are clinically defensible."[49]

According to a Gentiva Excel spreadsheet analyzing the proposed 2008 CMS payment changes, the company would earn an additional $11 million from Medicare if "[t]herapy visits provided increased 2 to 4 visits to reach 6 and 14 visit plateaus."[50]

Gentiva Competitive Ranking System

Gentiva developed a competitive ranking system for their management that served to drive therapy visit patterns toward the more profitable thresholds. Through the ranking system, known internally as the Key Indicator Report (KIR), Gentiva administrators assigned team names to each region of operation, such as the Mid-

[47] Gentiva Medicare Reimbursement, GEN 000017.

[48] Gentiva 2010 Annual Report, page 18, *http://files.shareholder.com/downloads/GTIV/1328045690x0x456437/CEA1782E-FB2C-4850-A530-9CF06AA6C55B/Gentiva__AR__2010.pdf*.

[49] E-mail from Vice President and Chief Clinical Executive Susan Sender, RE: PPS Refinements Proposed Regulations, E–GEN 079938.

[50] Changes in Profitability due to Proposed Changes in Therapy Reimbursement, GEN 013823.

Atlantic "Spider Monkeys" and the Carolina "Killer Bees."[51] Teams were then ranked based on a list of 21 individual, weighted metrics primarily designed to maximize profits.[52]

A February 16, 2009 e-mail noted that the company planned to eliminate one metric, visits per episode over the last 4 months, from the ranking system because it "runs counter to our initiative to increase [physical therapy.]"[53] The company later indicated that this metric was not eliminated from the KIR reports.[54]

The highest-ranking teams received encouraging company-wide e-mails such as "The Killer Bees . . . have a taste for victory, served best with a side of Spider Monkey . . ." and "The race is getting closer for #1 . . . I keep hearing the south will rise again?"[55] First place teams also received a monetary bonus during an annual company meeting.[56] In 2007, KIR bonuses totaled $161,811.[57]

In January 2010, Gentiva administrators added two new KIR metrics that would increase a region's rank based on the percentage of therapy visits that fell in the most profitable therapy visit range, between 7 and 20 sessions.[58]

There is also evidence of a direct push toward therapy thresholds in Gentiva's internal educational materials. A presentation titled "PPS Refinements" noted "About 12% of Gentiva's episodes have LUPA adjustments, less than five visits in the episode." The document stated that it is "Interesting how many are at 5, could we have done one more visit??"[59]

An internal analysis presented to CEO Tony Strange in a September 7, 2007 e-mail found that "increasing therapy visits by an average of 2 visits per episode will increase revenue by approximately $350 to $550 per episode. Adding therapy services (6 visits) to patients with high functional needs will increase revenue by about $700 per episode."[60]

An October 2007 presentation showed that a Gentiva employee was tasked to "Build the case to substantiate increased therapy, including PT, OT, and ST."[61]

In a September 29, 2008 e-mail, Area Vice President for Financial Operations Pete Cavanaugh wrote, "I'd like to know what overall impact we'll get if we push for an increase in therapy."[62]

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[51] E-mail from Vice President of Finance, Investor Relations Brandon Ballew, "KIR Regional Rankings though October 2009," December 11, 2009, E–GEN 024576—E–GEN 024600, *E–GEN 024578.

[52] Response to June 17 2011 SFC Set of Supplemental Questions, June 24, 2011, GEN 000003—GEN 000004, *GEN 000003.

[53] E-mail from Area Vice President Pete Cavanaugh, "AVP Rankings," February 16, 2009, E–GEN 042577.

[54] E-mail, "Regional Ranking April 2010," June 2, 2010, E–GEN 024576—E–GEN 024600, *E–GEN 024577.

[55] E-mail, "AVP Rankings through April 2009," May 27, 2009, E–GEN 024576—E–GEN 024600; e-mail, "Regional Ranking April 2010," June 2, 2010 E–GEN 024576.

[56] Gentiva Response, June 16, 2011, GEN 000001—GEN 000002, *GEN 000002.

[57] Response to June 17 2011 SFC Set of Supplemental Questions, June 24, 2011, GEN 000003—GEN 000004, *GEN 000004.

[58] *Id.*

[59] Gentiva PowerPoint, "PPS Refinements," GEN 013811—GEN 013820, *GEN 013814.

[60] E-mail from Perri Southerland to CEO Tony Strange, PPS Refinements, Therapy Analysis, September 7, 2007, E–GEN 025083.

[61] Gentiva PowerPoint, "Gentiva Rehab," October 2007, GEN 013799—GEN 013810, *GEN 013808.

[62] E-mail, "PPS Therapy Impact Analysis," September 29, 2008, E–GEN 024516—E–GEN 024517, *E–GEN 024517.

In the same e-mail string, Area Vice President of Finance John N. Norlander wrote "Andrew can work with the PPS Files to see if we move 1% of <7 visits and see the last 6 months impact by Region—Net Revenue, Gross Margin and EBITDA."[63]

Senior Vice President and Chief Clinical Officer Dr. Charlotte Weaver wrote in a January 7, 2009 e-mail that "operations did a . . . management assignment" which "addressed getting more therapy visits in an episode of care."[64]

In a May 3, 2010 letter to CEO Tony Strange, one departing physical therapist expressed disappointment with the direction of Gentiva. "I see the push to treat by metrics not by what the patients need," the employee wrote. "Treating by numbers is . . . making the clinicians feel their professional judgment is being questioned. Again, not sitting on plateaus is understandable but pushing to thresholds based on what their diagnosis is, not by what the patient needs is just wrong."[65]

In addition to discussions about increasing the number of therapy visits performed to increase revenue, Gentiva management discussed expanding therapy intensive specialty programs. An Excel spreadsheet listed "Specialty Programs (Orthopedics) increasing visits" as a means to increase revenue in the face of the 2008 CMS changes.[66]

CEO Tony Strange wrote in a July 29, 2008 e-mail that, "Amedisys is on our heals [sic] related to growth in Specialties. I want to see us kick it up a notch related to launches. Especially, in the programs that drive high % Medicare growth."[67]

LHC Group

LHC Group Therapy Metrics

Therapy metrics provided to the Committee by LHC Group point to a pattern of attempting to achieve the most profitable number of therapy visits. As Figure 15 indicates, in 2007, 20 percent of LHC Group's therapy episodes received ten visits while only 2.6 percent of the therapy episodes received nine visits. In 2008, the number of therapy episodes that received ten visits dramatically dropped to 6.9 percent. Also, from 2007 to 2008 the number of therapy episodes receiving six visits increased from 2.5 percent to 5.5 percent. The number of therapy episodes receiving 14 visits increased from 4.6 percent to 8 percent. And the number of therapy visits receiving 20 visits increased from 0.7 percent to 2.1 percent.[68]

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[63] *Id.* *E–GEN 024516.

[64] E-mail from Senior Vice President and Chief Clinical Officer Charlotte Weaver, January 7, 2009, E–GEN 028021—E–GEN 028022.

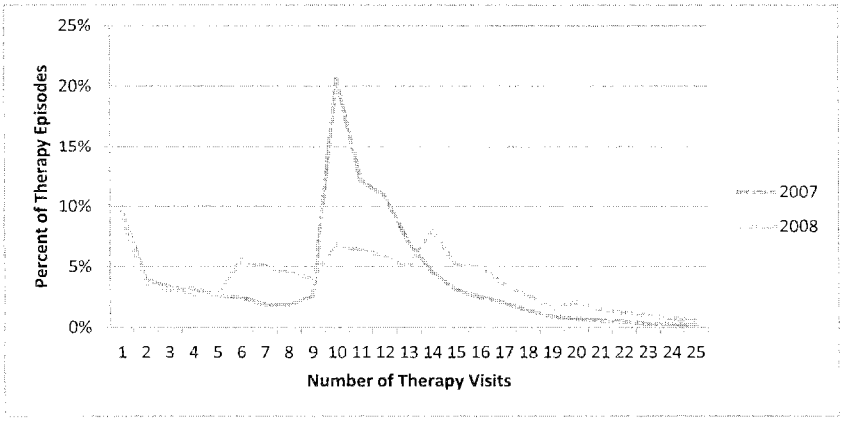
[65] E-mail to CEO Tony Strange, "Parting Comments," May 3, 2010, E–GEN 034749.

[66] Gentiva data analysis, GEN 014163—GEN 014175.

[67] E-mail from CEO Tony Strange, "RE: Specialties growth," July 29, 2008, E–GEN 037384—E–GEN 037384, *E–GEN 037384.

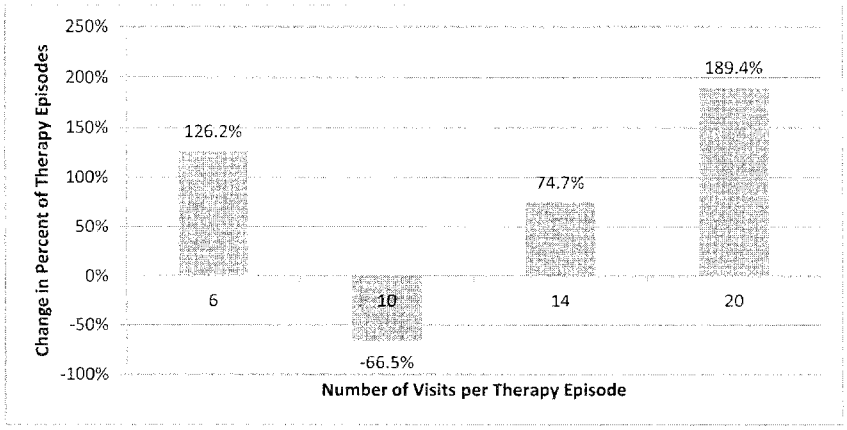
[68] LHC Group Therapy Episode Distribution, LHCGROUP__00000001.

Figure 15: LHC Group Distribution of Episodes with Therapy Visits, 2007 vs. 2008



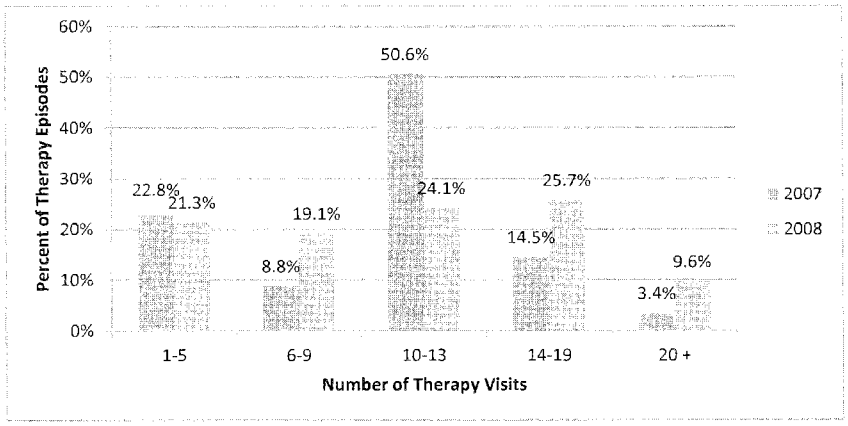
Source: LHC Group

Figure 16: LHC Group Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: LHC Group

Figure 17: LHC Group Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: LHC Group

Home health episodes with therapy reimbursements accounted for 50 percent of LHC Group's Medicare revenue in 2009 at $184,571,930. LHC Groups's total Medicare revenue for 2009 was $366,673,596.[69] Medicare reimbursements consisted of 81.7 percent of LHC Group's revenue in 2009.[70]

LHC and the 10-Visit Threshold Prior to 2008

A January 30, 2008 e-mail written by the Vice President of Quality and Performance Improvement, Barbara Goodman indicates that the primary consideration for determining the number of visits in LHC Group's therapy programs was financial. She wrote, "Most of our programs (low vision, Pelvic Floor) called for ten visit [sic] because it was at that threshold that we actually made additional revenue for therapy."[71]

Additionally, there is evidence that therapists were pressured to hit the 10-visit threshold even when 10 visits may not have been medically necessary. A June 5, 2007 e-mail from Mississippi Regional Manager Cindy Keeton shows administrators considered calling on physical therapist Rocky Goodwin to counsel a fellow therapist who refused to trend toward the 10-visit threshold:

> "It has been a constant battle with her regarding the 10 visit threshold. She even bucks when a MD orders a specific frequency and if she feels they do not need it then she refuses. . . . You can see that I have an unusual situation in getting this employee educated on home health therapy as related to hospital. It was suggested that you might have a therapist that

[69] LHC Group Medicare Reimbursement, LHCGROUP__000000003, LHCGROUP__000000004.
[70] LHC Group 2010 Annual Report, p. 13, *http://files.shareholder.com/downloads/LHCG/1328064157x0x466257/715C478B-B77C-4F20-9EC2-346E81F15C23/LHC_AR_Final.pdf*.
[71] E-mail from LHC Group's Barbara Goodman, January 30, 2008, LHCGROUP__00007923—LHCGROUP 00007928, *LHCGROUP__00007923.

> would be willing to come here and work with her. I think the name Rocky was mentioned." [72]

A July 8, 2007 e-mail shows that LHC Group physical therapist Rocky Goodwin wrote, after meeting with another physical therapist on a separate occasion, that he tried to convey "several pointers as to how to 'finish out' a therapy episode where only 6–9 visits are on the book and he needs something else to do to get to 10 visits. There are several old tricks up my sleeve that I told him about from a clinical standpoint that he should feel better about using to get to the 10 visits." [73] Another e-mail, dated October 1, 2007 describes Rocky Goodwin as a "PT . . . who assists the start up team occasionally in an education role in our region." In the e-mail, Area Manager Liz Regard recommended Goodwin as a resource to help train staff on the new therapy visit threshold rates based on the 2008 CMS changes.[74] The same e-mail went on to request "information that would tell us the types of patients that Medicare would see justification for 6 therapy visits, 14 therapy visits, etc." [75]

LHC Group Response to 2008 CMS Payment Changes

In a September 21, 2007 e-mail following the announcement that CMS was changing its therapy payment structure, LHC Group Division Vice President Liz Starr proposed the "Development of new therapy programs that will now be VERY financially sound but would not have been in the past PPS reimbursement program." [76]

In an April 4, 2008 e-mail to an Arkansas area sales manager written after CMS altered the therapy payment thresholds, LHC Group CEO Keith Myers wrote about the need to increase the number of therapy visits performed by LHC Group in order to increase case mix and revenue:

> It's all in the therapy Kevin. Episodes in the 0–5 therapy buckets have been hit the worst. We have over 70% of episodes in the 0–5 bucket since January 1, 2008. We are looking at freestanding agencies in business development that are doing much better than we are with regard to 2008 case mix and most of them actually have a pick up under the new rule. The key is that they have less than 50% of their episodes in the 0–5 therapy buckets. We took a financial hit for any therapy provide [sic] below 10 visits in the past, but under the new system an episode with 6 therapy visits is better than episode [sic] with 0–5 therapy visits. The new "10 visit threshold" is actually 6 visits on the low side and 20 visits on the high side. In other words, once you get to 6 visits, the more therapy visits provided the better, up to 20 visits. We need to move episodes out of the 0–5 buckets and up to the 6 and 7–9 buckets on the

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[72] E-mail from LHC Group Area Manager to Rocky Goodwin/LAHCG, June 13, 2007, LHCGROUP__00046851—LHCGROUP 00046852, *LHCGROUP__00046851.

[73] LHC Group physical therapist Rocky Goodwin, July 8, 2007, LHC—00046855—LHCGROUP 00046856, *LHC—00046855.

[74] E-mail from LHC Group Area Manager to Jessica VanBuskirk, October 1, 2007, LHCGROUP__00053367.

[75] *Id.*

[76] E-mail from LHC Group Division Vice President Liz Starr to Senior Vice President of Operations Don Stelly, September 22, 2007, LHCGROUP__00020460—LHCGROUP 00020463, *LHCGROUP__00020460.

> low end, and look for higher therapy need cases on the high end.
>
> I think our sales people should be working closely with operations to recruit and employee [sic] more PT's, PTA's, OT's and COTA's. Sales incentives are driven by admission × case mix, and the only way to get case mix up is to increase therapy utilization. We need to look for opportunities especially within the OT area, i.e. low vision, etc.[77]

Similar instructions were issued by LHC Group Division Vice President of Home Based Operations, Angie Begnaud, who wrote in a January 18, 2008 e-mail, "We want to do more therapy visits. The point was made by Johnny that we still see our agencies doing only 10–12 visits, when in fact some of these patients we could be doing 14–20 visits if needed." [78]

The instructions from LHC Group management to alter therapy practices in the face of the 2008 PPS changes stood in contrast to advice offered in an internal company presentation that read, "Be cautious of any deliberate plan to alter therapy practice patterns in response to a threshold change. Shifts in practice in order to maximize revenue may draw unwanted attention from Medicare and are NOT recommended." [79]

LHC Employees Pressured to Boost Therapy

Despite LHC Group's claim in its June 4, 2010 letter to the Committee that "at LHC, patient decisions are made by the local caregiver and the patient's physician—reimbursement is not a factor to be considered," a number of examples illustrate that therapists and branch managers at LHC Group were pressured by supervisors to achieve a higher number of therapy visits.[80]

An e-mail written by Division Vice President of Home Based Operations Angie Begnaud on April 2, 2008 demonstrates a centralized push from LHC Group management to increase the number of therapy visits performed. According to the e-mail written by Begnaud, LHC Group President and Chief Operating Officer Donald Stelly held a conference call to:

> stress the urgency of the problem with LUPAs and downgrades, and also the need for our [Directors of Nursing] to communicate with the therapists the problem with projecting visits and not completing them. The therapist [sic] also need to look at increasing the number of therapy visits if warranted to move these patients into the higher therapy buckets. In looking at all 2008 episodes, the company has a 10% LUPA rate and a 10% therapy downgrade rate for a 20% adjustment rate. Don has asked for us to have all hands on deck to look at all open episodes. He also asked that all DONs and BMs report to the state director weekly on the number of LUPAs and

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[77] E-mail from Chairman and CEO Keith Myers, LHC Group, April 4, 2008, LHCGroup__00048299—LHCGROUP__00048300, *LHCGroup__00048299.

[78] E-mail from Division Vice President Angie Begnaud, January 18, 2008, LHCGROUP__00053618—LHCGROUP 00053619, *LHCGROUP__00053618.

[79] Therapy Practice in the Refined PPS Environment: Challenges and Opportunities, LHCGROUP 00047210, LHCGROUP 00047230, *LHCGROUP 00047230.

[80] LHC Group Letter to the Finance Committee, Re: Letter of Inquiry dated May 12, 2010, June 4, 2010.

> downgrades. The last thing that he requested was that by the end of this week, all DONs and BMs call all of the therapists that do work for them to re-educate them on the final rule and to stress the urgency of not having the downgrades, and the need to really provide the amount of therapy visits necessary to move those patients into the higher buckets. Presently on our RAP claims, 47% of our therapy patients are receiving 0–5 therapy visits. This cannot continue to happen and the therapists need to get back with the agency asap after evaluation to let them know how many therapy visits they will be doing.[81]

In another example, a top manager of LHC Group's agencies in Kentucky suggested increasing therapy utilization "to get more profitable." An October 22, 2009 e-mail from LHC Group Kentucky State Director of Operations Lana Smith to LHC Group employee Carolyn Cole asked, "Considerations to get more profitable: Would you be able to increase therapy utilization in improve case mix and Op Margin? [sic] Both of these would improved [sic] financials."[82]

An employee in West Tennessee encouraged staff to attend a teleconference "so that we can get the higher paying buckets FULL." In the e-mail, LHC Group DON/Administrator in West Tennessee, Kim Bradberry, encouraged staff to attend a "MANDATORY" teleconference called "Therapy in the PPS Final Rule." She wrote "In looking at SVP tools for each [West Tennessee] office yesterday, the greatest % of visits are in the dreaded 0–5 bucket for each office. Let's all make a point of attending this, so that we can get the higher paying buckets FULL . . . we want to be able to say our '20+ buckets runneth over'! :-)"[83]

Another LHC Group administrator based in Tennessee, Susan Sylvester, instructed branch managers:

> When speaking with your therapists about downcodes, please discuss front loading of visits. It appears that many of the patients begin to improve and decide to refuse the remainder of their therapy, go to outpatient, or are rehospitalized. The more therapy visits we've gotten in before that happens, the better off we are, as well as the patient. Obviously our goal is to improve the patient's overall condition and functionality, however if we are providing 5 therapy visits or less, we have incurred all of the expense of the therapy without any of the reimbursement. If the visits are frontloaded, ie 3w4, 2w4, 1w1, we may be able to get in enough visits early enough to complete (or nearly complete) our plan of care.[84]

On the subject of "discussions/emails about downcodes, LUPA's and therapy utilization over the past week or so," Susan Sylvester said, "This is a MAJOR push for Sr. Management at this time, as well as for all of us, in order to continue to operate successfully."[85]

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[81] E-mail from Angie Begnaud to Pam Wigglesworth, April 2, 2008, LHCGROUP__00009896.
[82] E-mail from Group Kentucky State Director of Operations Lana Smith to Pam Barnett, October, 22, 2009, LCHGROUP__00018983.
[83] E-mail from LHC Group DON/Amin Kim Bradberry, April 18, 2008, LHCGROUP__00014651—LHCGROUP__00014653, *LHCGROUP__00014651.
[84] Branch Manager Pamela Harris e-mail to Susan Sylvester, April 8, 2008, LHCGROUP__00014716—LHCGROUP__00014717, *LHCGROUP__00014716.
[85] *Id.*

An LHC Group branch manager who received these instructions reported a conversation with a company therapist in which the therapist agreed to "frontloading as well as going back after a couple of week [sic] to see if patients are following their exercise program or are functionally declining, in an attempt to raise the number of visits." [86]

The post-2007 therapy payment rules had an obvious effect on an LHC Group agency in West Virginia. The local agency manager wrote to Becky McCoy, the state director for Ohio/West Virginia, "[name redacted] now has an understanding of the therapy buckets. He now places his patient's [sic] in 6, 10, or 14 visit ranges." [87]

A July 8, 2009 e-mail from LHC employee Katy Lebauve to LHC Group employee Kimberly Gordon stated: "You have 20% in the 7–9 therapy bucket range. Please get with the therapists and have them reeval [sic] those to see if any can or need to be bumped up please." [88]

Additionally, LHC Group managers may have implicitly encouraged higher therapy utilization by discussing the higher revenue of some therapy thresholds. For example, the LHC Group Division Vice President Ammy Lee based in Lafayette, LA told an LHC branch manager in Guntersville, AL after reading the weekly report for December 1, 2009, "I see 19 patients in the 12–14 therapy bucket. Were you aware that there is an 18% difference in revenue between this bucket and the next highest one (15–16)?" [89]

Almost Family

Therapy Metrics

An examination of the therapy metrics suggests that the company was responsive to the incentive changes in the CMS payment model. As Figure 18 indicates, in 2007, 9.4 percent of Almost Family's therapy episodes received 10 visits while 3.2 percent of the therapy episodes received 9 visits. In 2008, the number of therapy episodes that received 10 visits dropped to 5.2 percent. Also from 2007 to 2008, the number of therapy episodes receiving 6 visits increased from 4.5 percent to 6 percent, and the number of therapy episodes receiving 14 visits increased from 4.6 percent to 6.1 percent.[90]

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[86] *Id.*

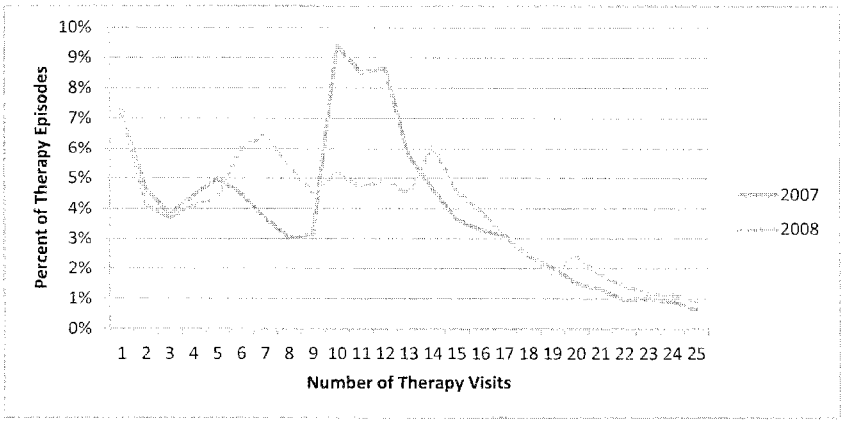
[87] E-mail from LHC Group Branch Manager Melissa Ayers to State Director Becky McCoy, October 20, 2008, LHCGROUP__00040048—LHCGROUP__00040049, *LHCGROUP__00040048.

[88] E-mail from Katy LaBauve to Kimberly Gordon, July 8, 2009, LHCGROUP__00050805.

[89] E-mail From LHC Group Division Vice President Home Based Operations to Area Sales Manager, December 2, 2009, LHCGROUP__00048771—LHCGROUP__00048774, *LHCGROUP__00048771.

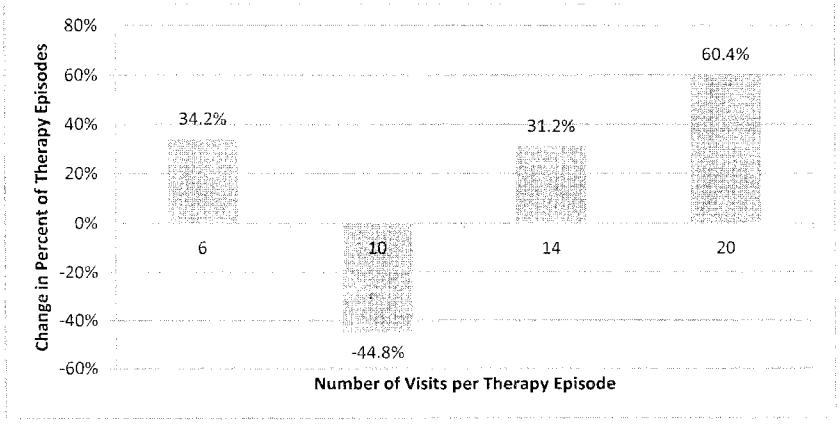
[90] Almost Family, Therapy Distribution.

Figure 18: Almost Family Distribution of Episodes with Therapy Visits, 2007 vs. 2008



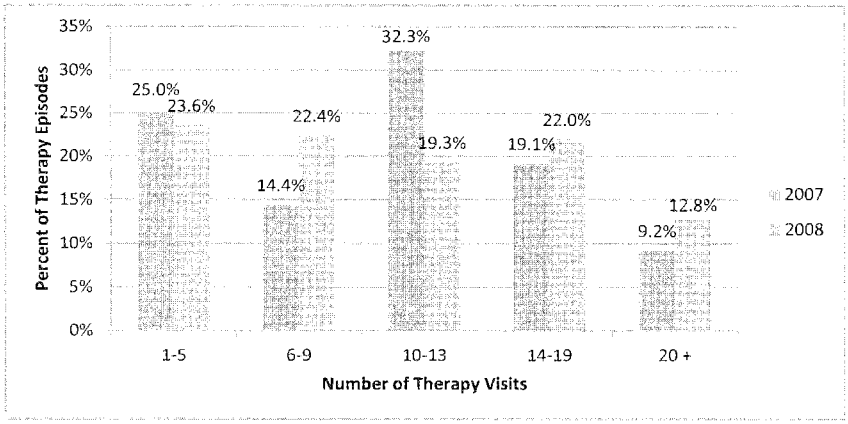
Source: Almost Family

Figure 19: Almost Family Change in Percent of Therapy Episodes at Critical Points, 2007 to 2008



Source: Almost Family

Figure 20: Almost Family Distribution of Episodes with Therapy Visits, 2007 vs. 2008



Source: Almost Family

Home health episodes with therapy reimbursements accounted for 75 percent of Almost Family's Medicare revenue in 2009 at $165,489,710. Almost Family's total Medicare revenue for 2009 was $218,011,583.[91] Medicare reimbursements consisted of 77 percent of Almost Family's revenue in 2009.[92]

The Committee notes Almost Family had a significant decrease in the percentage of patients receiving 10 therapy visits per episode from 2007 to 2008. At the same time, Almost Family increased the number of patients receiving 6, 14, and 20 therapy visits.[93] The change in the distribution of therapy visits performed by Almost Family after the implementation of the 2008 PPS rule represents a behavioral shift similar to that of other home health agencies within our investigation, some of which implemented aggressive, top-down programs explicitly instructing employees to target specific therapy visit thresholds. However, none of the documents provided to the Committee by Almost Family show that executives ever pushed therapists to target thresholds or pursue more profitable clinical regimens.

CMS Must Move Toward Taking Therapy Out of the Payment Model

Over the last 2 years CMS has taken several steps to address the overutilization of home therapy episodes.

In a CY 2011 final rule, CMS concluded from data analysis that the industry may be "padding" their treatment plans to reach the higher-paying therapy visit thresholds. Under the rule, CMS modified therapy coverage policies to require stronger documentation, with the intent to slow the growth of case-mix. Such modifications include periodic patient function assessments by qualified thera-

[91] Almost Family Letter, Medicare Reimbursements.
[92] Almost Family Annual Report 2010, page 6, *http://almostfamily.ir.edgar-online.com/EFX_dll/EDGARpro.dll?FetchFilingCONVPDF1?SessionID=A7jUF5M1mZimg3h&ID=7757385.*
[93] Almost Family Response to June 12, 2010 Request to Almost Family, Inc., June 4, 2011.

pists. The rule also requires thorough documentation of therapy progress with measurable outcomes.[94]

In the CY 2012 proposed rule released on July 5, 2011, CMS stated, "Our review of HH PPS utilization data shows a shift to an increased share of episodes with very high numbers of therapy visits. This shift was first observed in 2008 and it continued in 2009." CMS data also showed that, ". . . the share with 14 or more therapy visits continued to increase while the share of episodes with no therapy visits continued to decrease. The frequencies also indicate that the share of episodes with 20 or more therapy visits was 6 percent in 2009. This is a 50 percent increase from the share of episodes of 2007, when episodes with at least 20 therapy visits accounted for only 4 percent of episodes." [95]

Under the proposed rule, CMS plans to redistribute PPS dollars from high therapy payment groups to other payment groups including groups with little to no therapy. This change is being proposed as an attempt to discourage unnecessary utilization of therapy services.[96] The additional steps CMS has taken to crack down on "padding" of therapy episodes and the potentially unnecessary utilization of therapy services documented in this report are encouraging. While comprehensive change may take several years to implement, it appears CMS's home health PPS enhancements are moving in the right direction.

This investigation has highlighted the abrupt and dramatic responses the home health industry has taken to maximize reimbursement under both a 10-threshold model and a 6–14–20 therapy threshold model. Under the home health PPS, providers have broad discretion over the number of therapy visits to provide patients and therefore have control of the single-largest variable in determining reimbursement and overall margins.

This dynamic was highlighted in an e-mail from LHC Group CEO Keith Myers to senior executives throughout the firm:

> Sales incentives are driven by admissions × case mix, and the only way to get case mix up is to increase therapy utilization. . . . Take a look at the chart below. This shows you how much of an impact therapy has on case mix, and case mix is what determines revenue.[97]

---

[94] Medicare Program, "Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices, Final Rule," *Federal Register* 75:221 (17 November 2010), p. 70372.

[95] Medicare Program, "Home Health Prospective Payment System Rate Update for Calendar Year 2012, Proposed Rule," *Federal Register* 76:133 (12 July 2011), p. 40988.

[96] *Id.*

[97] E-mail from Chairman and CEO Keith Myers, LHC Group, April 4, 2008, LHCGroup__00048299—LHCGROUP__00048300, *LHCGroup__00048299.

Total Therapy Visits	Average Case Mix	% of All Episodes
20+	3.05	2.6%
18-19	2.36	1.3%
16-17	2.22	3.1%
14-15	2.08	7.4%
11-13	1.77	6.1%
10	1.60	2.9%
7-9	1.38	4.1%
6	1.17	2.2%
0-5	.86	70.4%

Another e-mail from CEO Myers stated: "I think we can safely say that higher therapy utilization results in higher absolute margins and higher margins as a percentage of revenue under the current case mix weights."[98] This e-mail was based on an additional chart circulated at LHC Group that analyzed the payment changes made by CMS.

[Number] Therapy Visits	Average Reimbursement	Average Cost	Average Margin Per Episode	Average % Margin Per Episode
0-5	$1,900	$1,521	$378	19.93%
6	$2,617	$2,084	$532	20.34%
7-9	$3,057	$2,377	$680	22.26%
10	$3,493	$2,671	$821	23.52%
11-13	$3,831	$2,944	$886	23.14%
14-15	$4,418	$3,183	$1,234	27.94%
16-17	$4,725	$3,424	$1,301	27.54%
18-19	$5,091	$3,767	$1,324	26.01%
20+	$6,540	$4,648	$1,892	28.94%

MedPAC, in conjunction with the Urban Institute, is developing an alternative payment model that relies on patient characteristics rather than therapy utilization to determine reimbursement levels.[99] CMS should closely examine any approach that focuses on patient well-being and health characteristics, rather than the numerical utilization measures. Further, CMS should continue efforts to assess the efficiency and effectiveness of various post-acute care settings and the services they provide. This includes the Continuity Assessment Record and Evaluation (CARE) tool, a standardized patient assessment system intended to measure health outcomes of post-acute Medicare patients.[100]

The Committee also looks forward to receiving reports on future demonstration projects implemented by the 2010 Affordable Care Act, notably an alternative payment model pilot program for post-acute Medicare patients, which includes bundled payments; and the establishment of the Center for Medicare and Medicaid Innovation (CMI) which is charged with testing innovative payment and service delivery models to reduce program expenditures and en-

[98] E-mail from LHC Group CEO Keith Myers, May 29, 2009, LHCGROUP 00012744—LHCGROUP 00012746.
[99] MedPAC, "Report to Congress," March 2011.
[100] CMS, "Agency Information Collection Activities: Submission for OMB Review; Comment Request," *Federal Register* 72:217 (9 November 2007), p. 63612.

hance quality of care.[101] [102] We anticipate these programs will further shed light on the deficiencies within the PPS system and highlight new, innovative reimbursement methods that may encourage high-quality, patient-centered care, and discourage abuse of the Medicare program.

[101] Patient Protection and Affordable Care Act, Pub L. no. 111–148, § 3023, 124 Stat 401 (2010).
[102] Patient Protection and Affordable Care Act, § 3021, 124 Stat 389.

APPENDIX

SELECT DOCUMENTS CITED IN THIS REPORT

Footnote 18

Amedisys, Inc.
Senate Finance Comittee Request
Response #1

Episodes by Therapy Visit Count

by Year

Therapy Visit Category	Year 2006		Year 2007		Year 2008		Year 2009	
	Episode Count	% Therapy	Episode Count	% Therapy	Episode Count	% Therapy	Episode Count	% Therapy
1 Visit	8,702	8.8%	11,038	8.9%	17,064	8.9%	21,131	8.4%
2 Visits	4,256	4.3%	5,285	4.2%	8,361	4.4%	10,659	4.3%
3 Visits	3,345	3.4%	4,156	3.3%	6,704	3.5%	8,077	3.2%
4 Visits	3,519	3.6%	4,533	3.6%	6,975	3.7%	8,549	3.4%
5 Visits	4,556	4.6%	5,649	4.5%	7,605	4.0%	9,015	3.6%
6 Visits	4,347	4.4%	5,643	4.5%	9,934	5.2%	11,215	4.5%
7 Visits	3,013	3.0%	4,077	3.3%	9,182	4.8%	10,902	4.4%
8 Visits	2,413	2.4%	3,628	2.9%	9,769	5.1%	12,496	5.0%
9 Visits	2,513	2.5%	3,605	2.9%	8,572	4.5%	10,573	4.2%
10 Visits	10,441	10.5%	11,149	9.0%	9,093	4.8%	9,824	3.9%
11 Visits	9,314	9.4%	10,543	8.5%	8,676	4.5%	9,168	3.7%
12 Visits	9,959	10.1%	11,414	9.2%	8,805	4.6%	9,826	3.9%
13 Visits	5,986	6.0%	7,502	6.0%	8,476	4.4%	9,660	3.9%
14 Visits	4,532	4.6%	5,782	4.6%	10,761	5.6%	12,496	5.0%
15 Visits	4,010	4.0%	5,142	4.1%	9,890	5.2%	12,153	4.9%
16 Visits	3,706	3.7%	5,122	4.1%	9,621	5.0%	12,731	5.1%
17 Visits	3,172	3.2%	4,416	3.5%	7,641	4.0%	10,584	4.2%
18 Visits	2,247	2.3%	3,302	2.7%	5,388	2.8%	7,685	3.1%
19 Visits	1,599	1.6%	2,110	1.7%	3,575	1.9%	5,406	2.2%
20 Visits	1,299	1.3%	1,734	1.4%	3,479	1.8%	5,414	2.2%
21 Visits	1,080	1.1%	1,428	1.1%	3,160	1.7%	5,115	2.0%
22 Visits	856	0.9%	1,161	0.9%	2,678	1.4%	4,664	1.9%
23 Visits	699	0.7%	1,047	0.8%	2,346	1.2%	3,992	1.6%
24 Visits	606	0.6%	834	0.7%	2,052	1.1%	3,668	1.5%
25 Visits	458	0.5%	703	0.6%	1,717	0.9%	3,174	1.3%
26 Visits	429	0.4%	596	0.5%	1,506	0.8%	2,795	1.1%
27 Visits	330	0.3%	433	0.3%	1,146	0.6%	2,403	1.0%
28 Visits	244	0.2%	355	0.3%	1,006	0.5%	2,243	0.9%
29 Visits	227	0.2%	335	0.3%	909	0.5%	2,026	0.8%
30 Visits	217	0.2%	309	0.2%	771	0.4%	1,897	0.8%
Totals	**98,075**	**99.0%**	**123,031**	**98.8%**	**186,862**	**97.9%**	**239,541**	**95.8%**

Note: The 2008 column does not include information regarding approximately 17,260 episodes, related to Amedisys' 2008 acquisition of TLC Health Care, that did not transfer to the Amedisys system from the legacy TLC system.

Amedisys, Inc.
Senate Finance Comittee Request
Response #2

Average OASIS Scores

Activities of Daily Living by Year

	Year			
	2006	2007	2008	2009
Therapy Episodes - Average Score				
OASIS M0520 - Urinary Incontinence	0.498	0.523	0.529	0.534
OASIS M0530 - Urinary Incontinence	1.575	1.584	1.583	1.682
OASIS M0540 - Bowel Incontinence	0.378	0.398	0.410	0.409
OASIS M0640 - Grooming	1.296	1.456	1.449	1.436
OASIS M0650 - Upper Dressing	1.492	1.608	1.574	1.552
OASIS M0660 - Lower Dressing	1.805	1.891	1.836	1.809
OASIS M0670 - Bathing	2.970	3.055	3.010	2.957
OASIS M0680 - Toileting	1.307	1.418	1.367	1.303
OASIS M0690 - Transferring	1.470	1.505	1.436	1.379
OASIS M0700 - Ambulation	1.762	1.839	1.784	1.739
OASIS M0710 - Feeding	0.705	0.745	0.725	0.722

Note 1: The table above contains the average Activities of Daily Living scores from the Start of Care OASIS Assessment for patients receiving Therapy Visits during an episode of care listed in request #2.

Note 2: The data above does not include certain 2008 OASIS Assessments, related to Amedisys' 2008 acquisition of TLC Home Health Care, that did not transfer to the Amedisys system from the legacy TLC system. Based upon admission data that remained on the legacy system, we estimate that approximately 10,000 TLC OASIS Assessments are not included in this analysis.

Footnote 19

Amedisys, Inc.
Senate Finance Comittee Request
Response #3 (a,b,c)

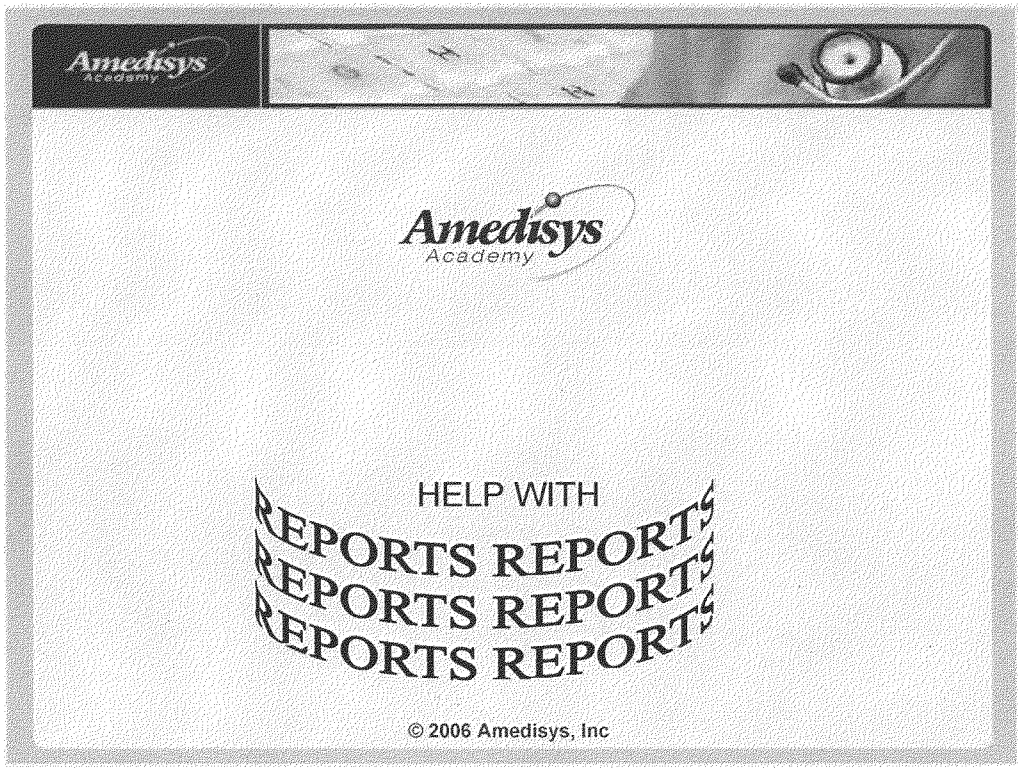
Medicare Reimbursement

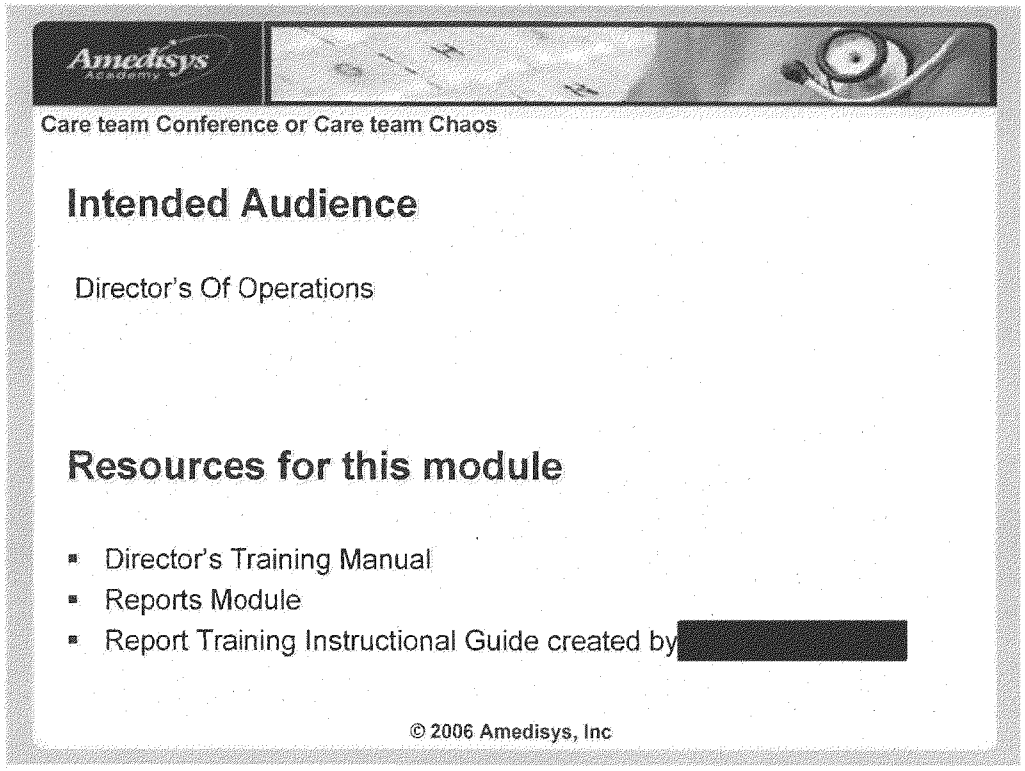
by Year

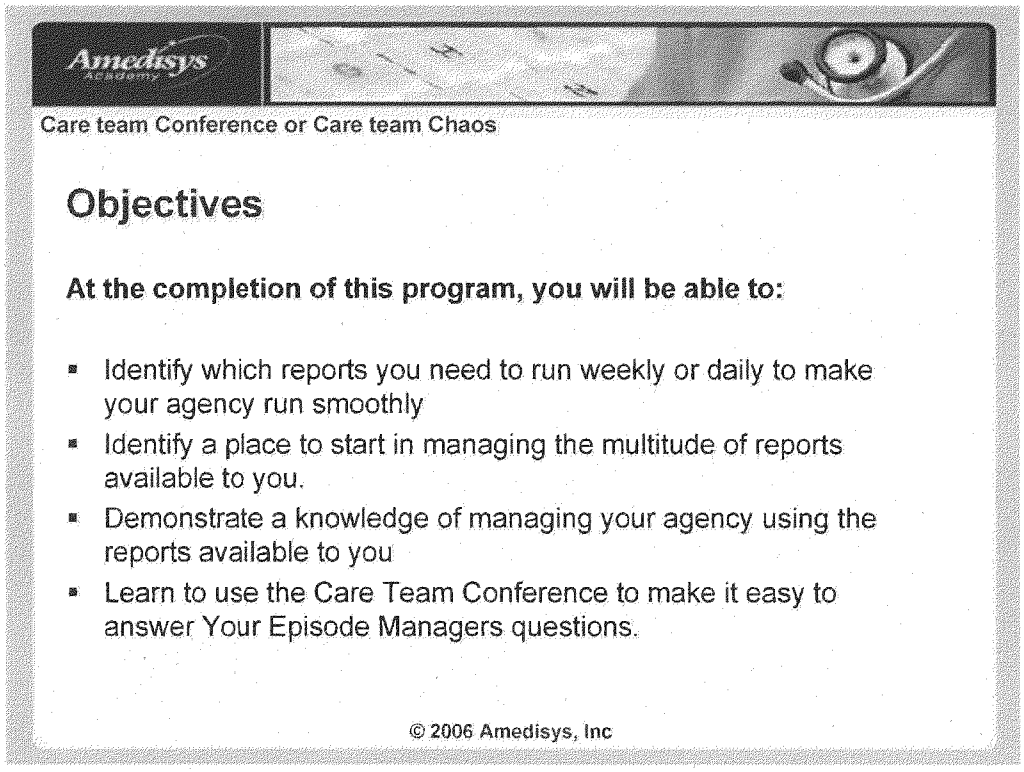
	Year			
	2006	**2007**	**2008**	**2009**
Request #3 - by Question				
3a - Medicare Home Health Patients - Therapy	79,886	96,542	144,579	184,635
3b - Medicare Reimbursement - Episodes with Therapy Reimbursement.	$ 255,955,854	$ 320,581,498	$ 607,735,682	$ 878,535,009
3c - Medicare Reimbursement - All Episodes	$ 460,414,462	$ 575,516,279	$ 921,645,588	$1,229,755,214

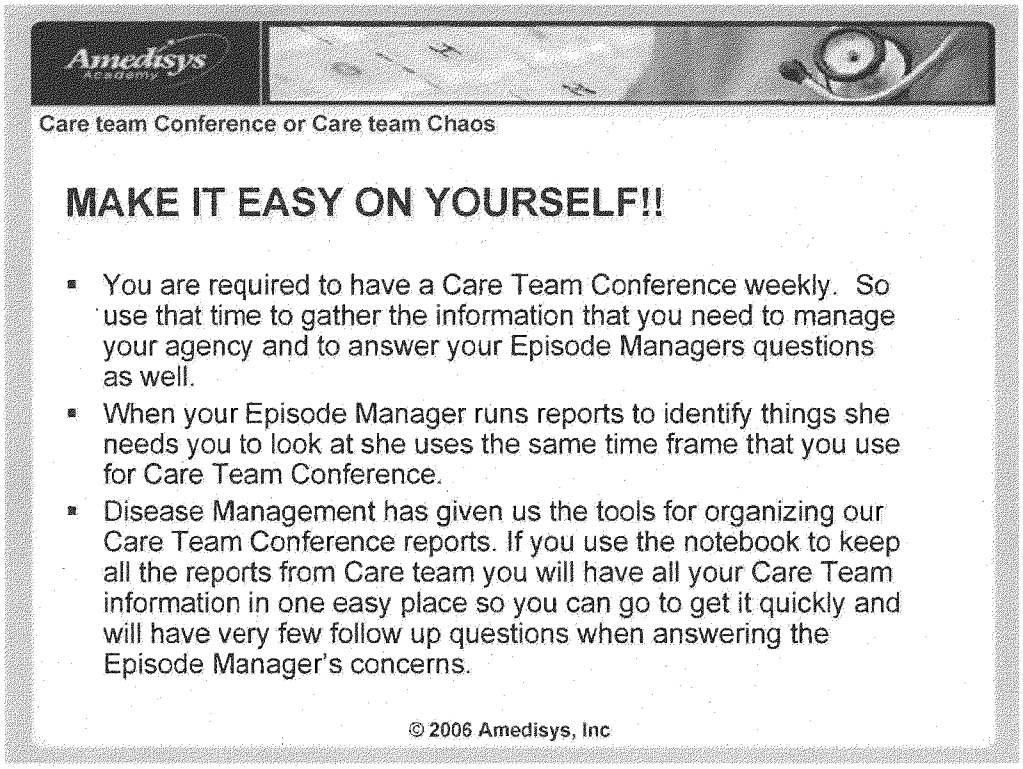
Note: The 2008 column does not include information regarding approximately 17,260 episodes, related to Amedisys' 2008 acquisition of TLC Health Care, that did not transfer to the Amedisys system from the legacy TLC system.

Footnote 21, 22



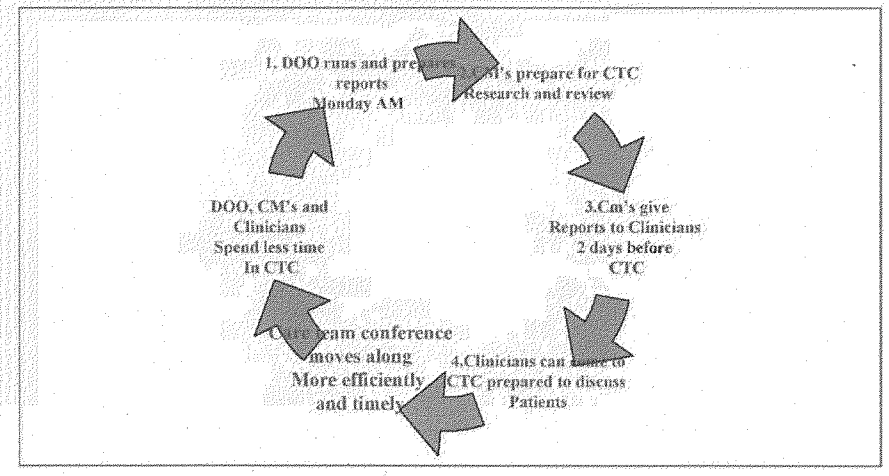






Care team Conference or Care team Chaos

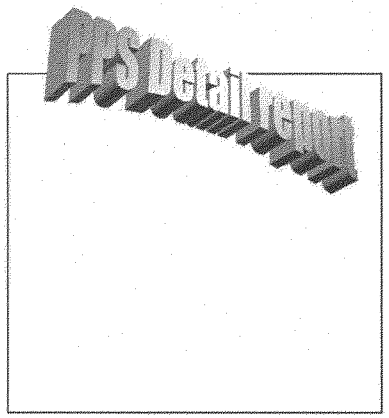
Preparation is the Key!!



Care team Conference or Care team Chaos

PPS Detail report
DOO manual page 57

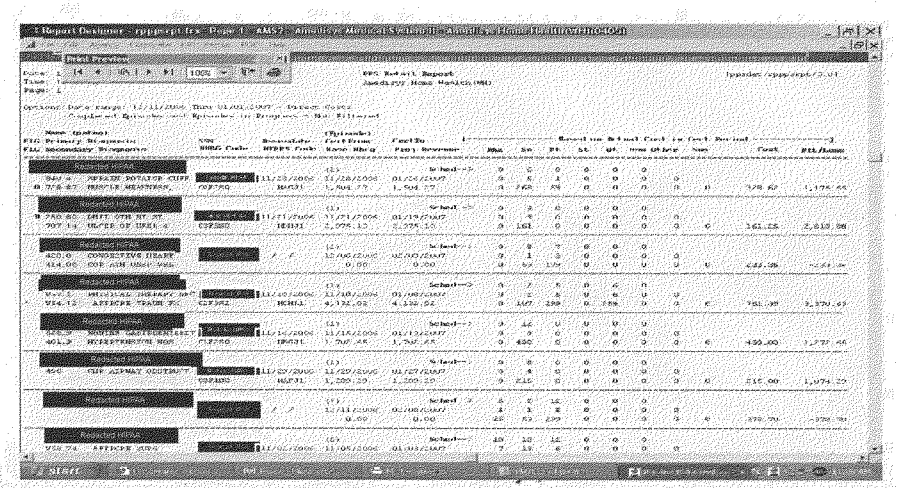
- Gives the most information in one report
- Patient name and MR#
- Primary and secondary Dx
- Both HHRG and HIPPS codes
- Certification Dates
- Revenue info
- Numbers of visits scheduled and actual by discipline
- Use this report to prepare for Care team Conference
- This report can support other reports

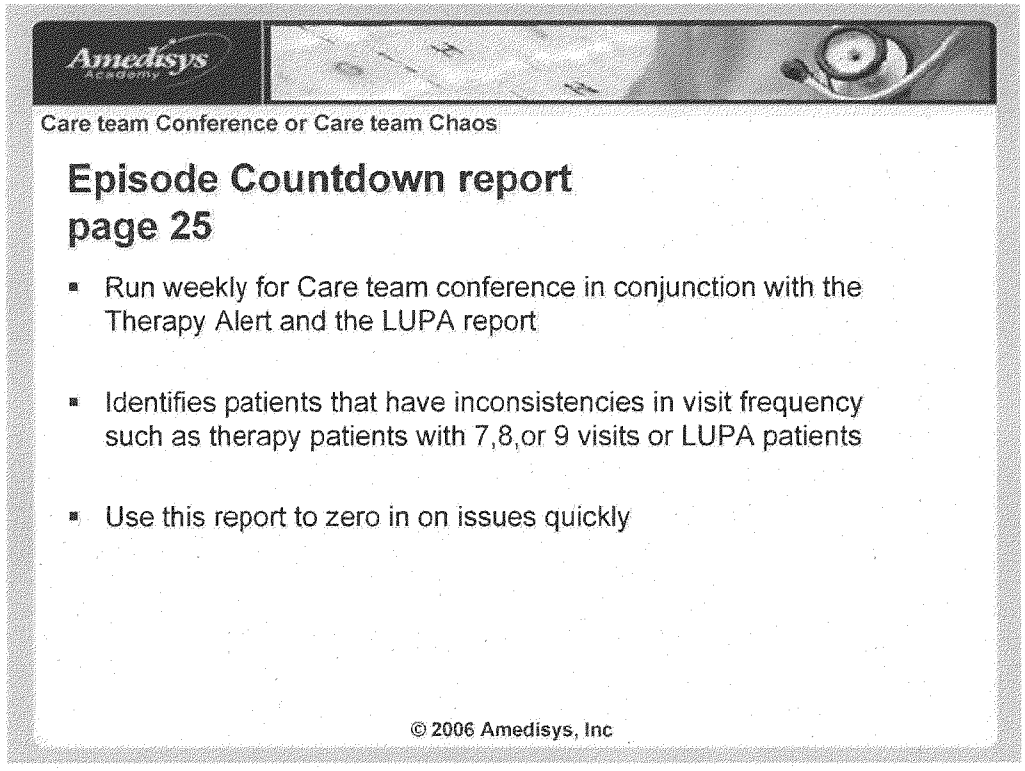


Amedisys

Care team Conference or Care team Chaos

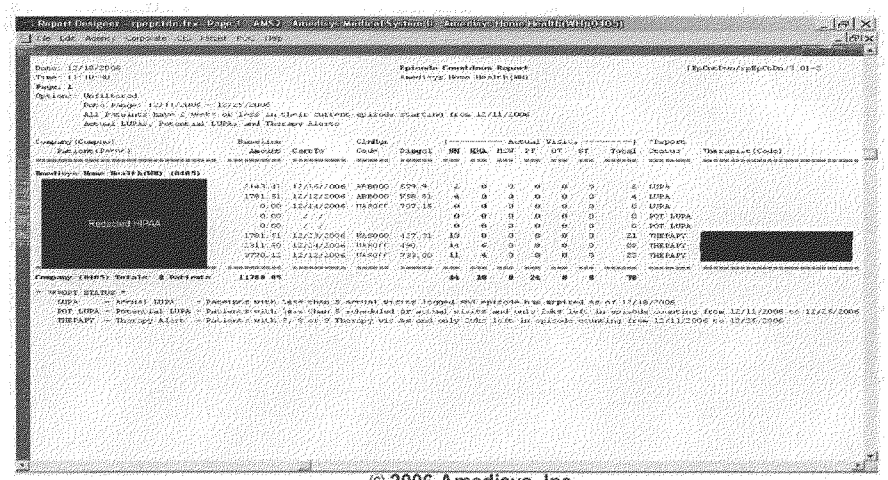
PPS Detail Report

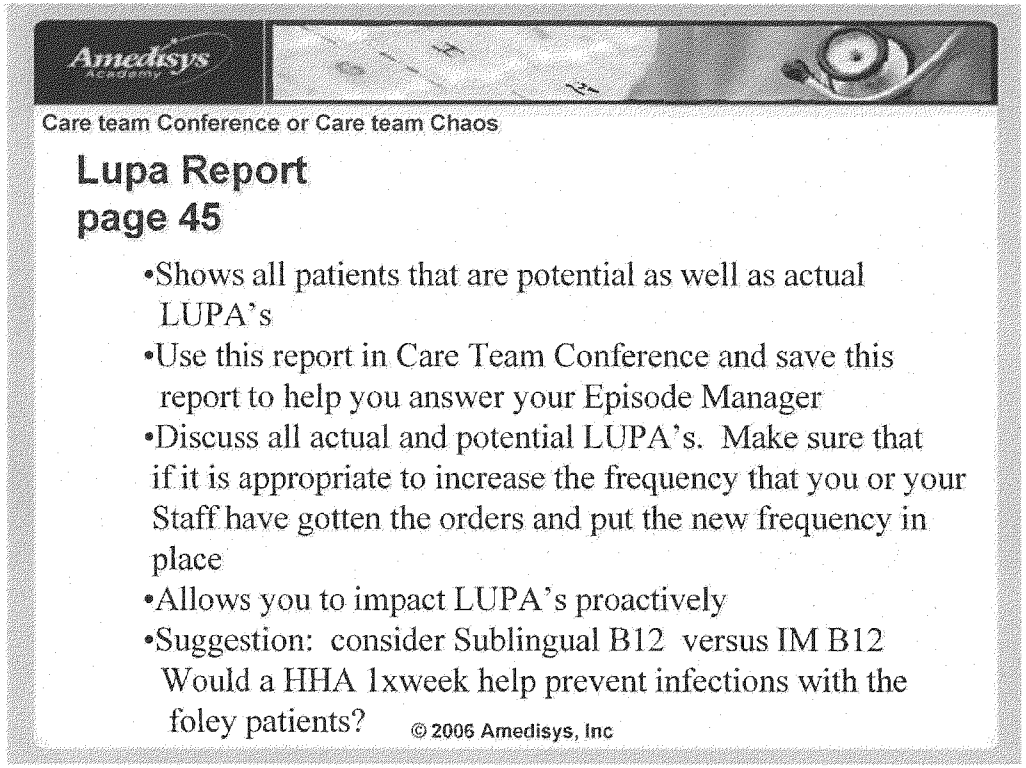




Care team Conference or Care team Chaos

Episode Countdown Report

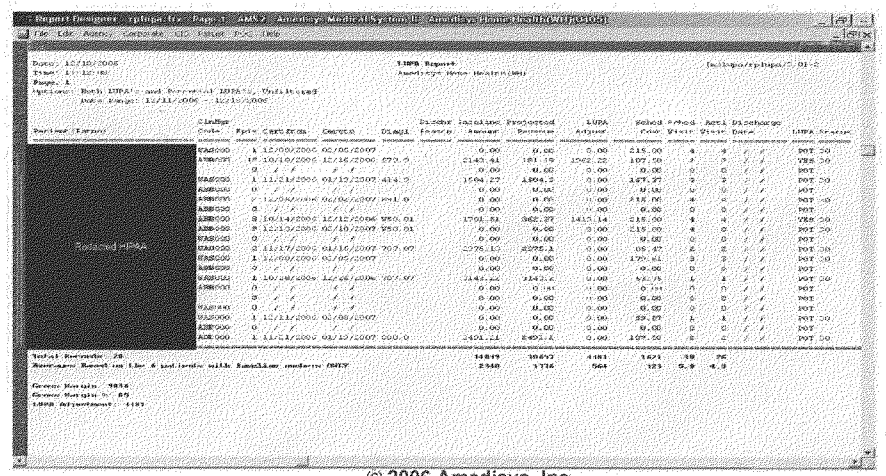


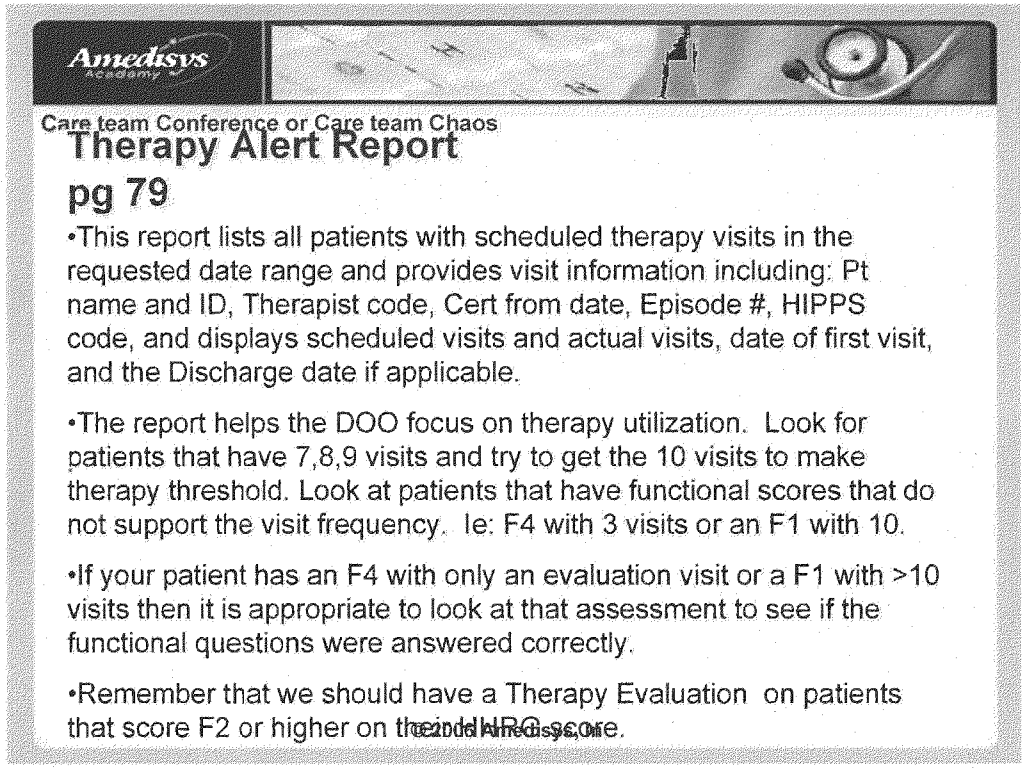


Amedisys Academy

Care team Conference or Care team Chaos

LUPA report

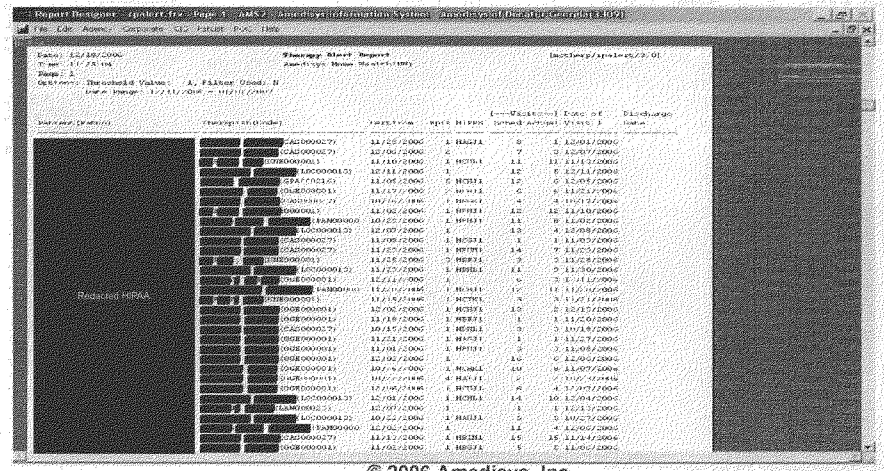


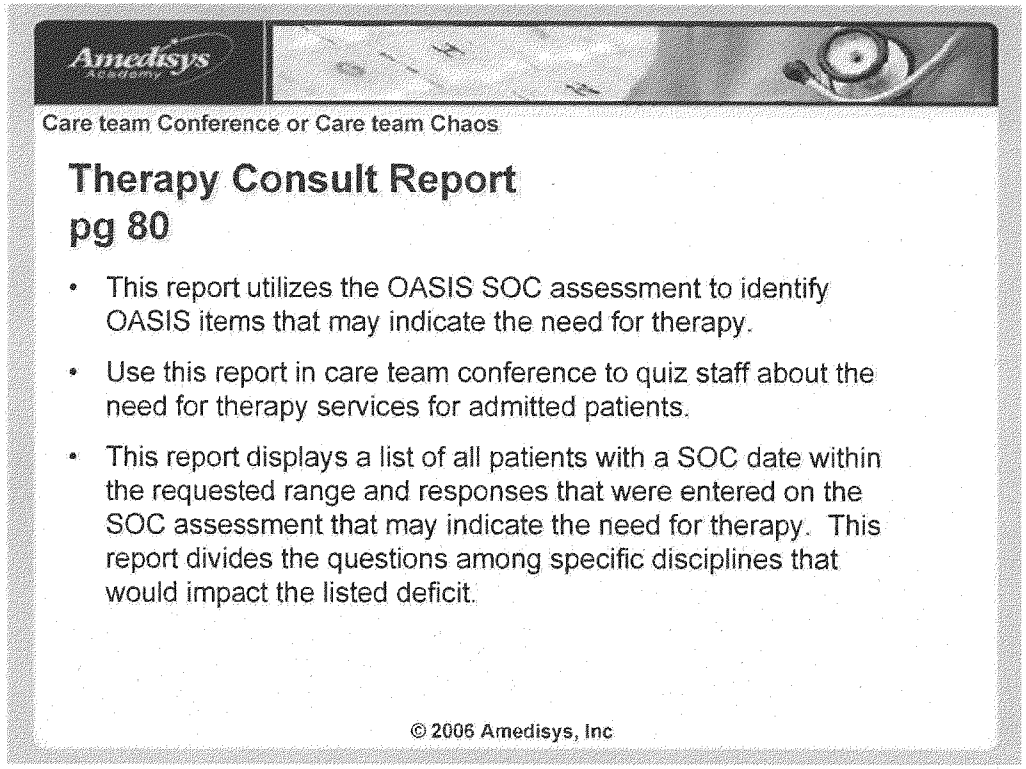


Amedisys Academy

Care team Conference or Care team Chaos

Therapy Alert Report

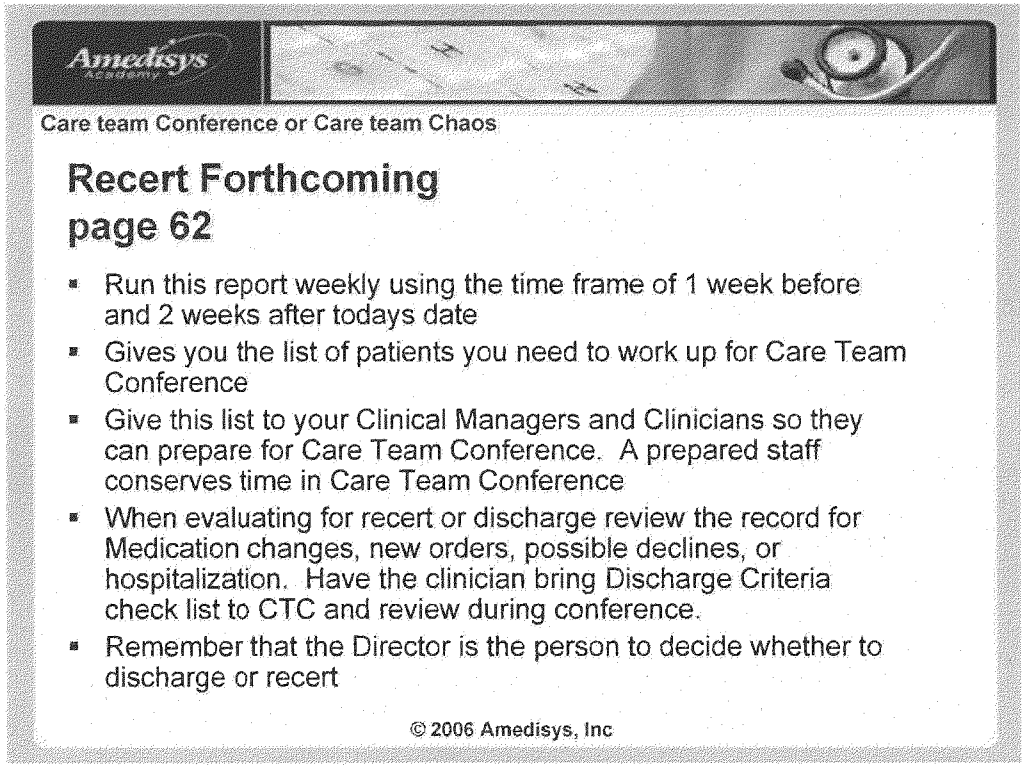


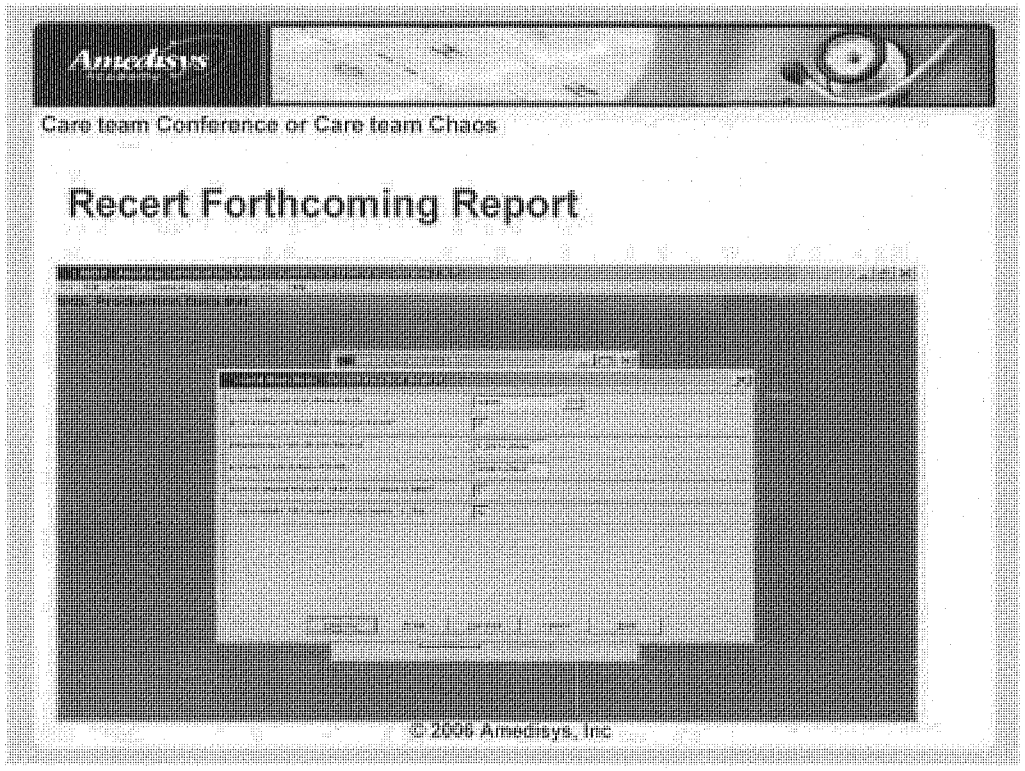


Amedisys Academy

Care team Conference or Care team Chaos

Therapy Consult Report

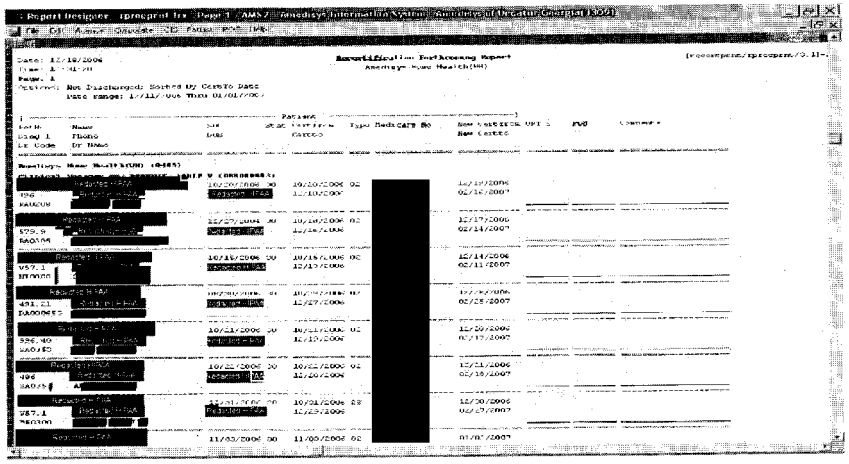


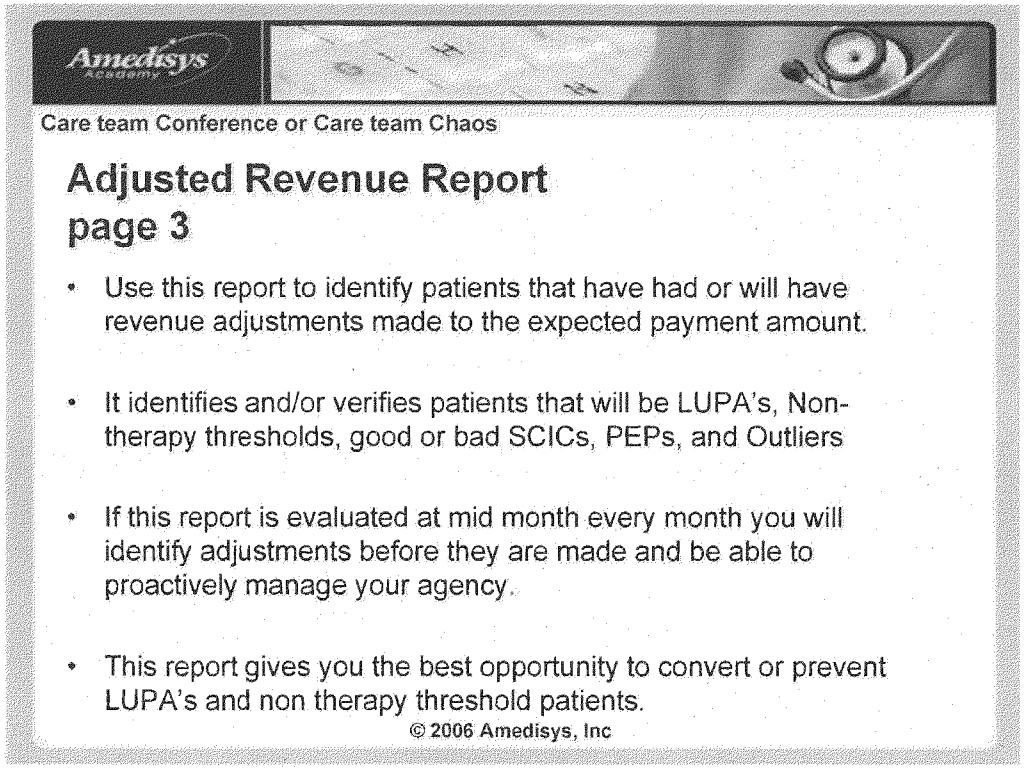


Amedisys

Care team Conference or Care team Chaos

Recert Forthcoming

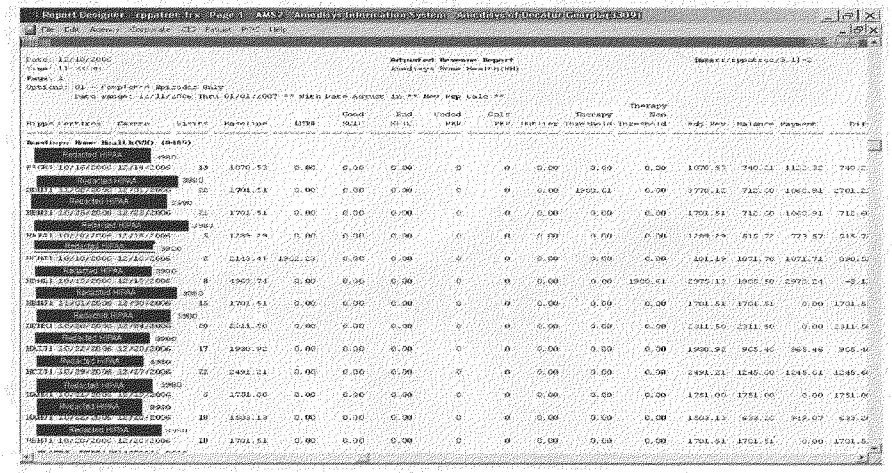


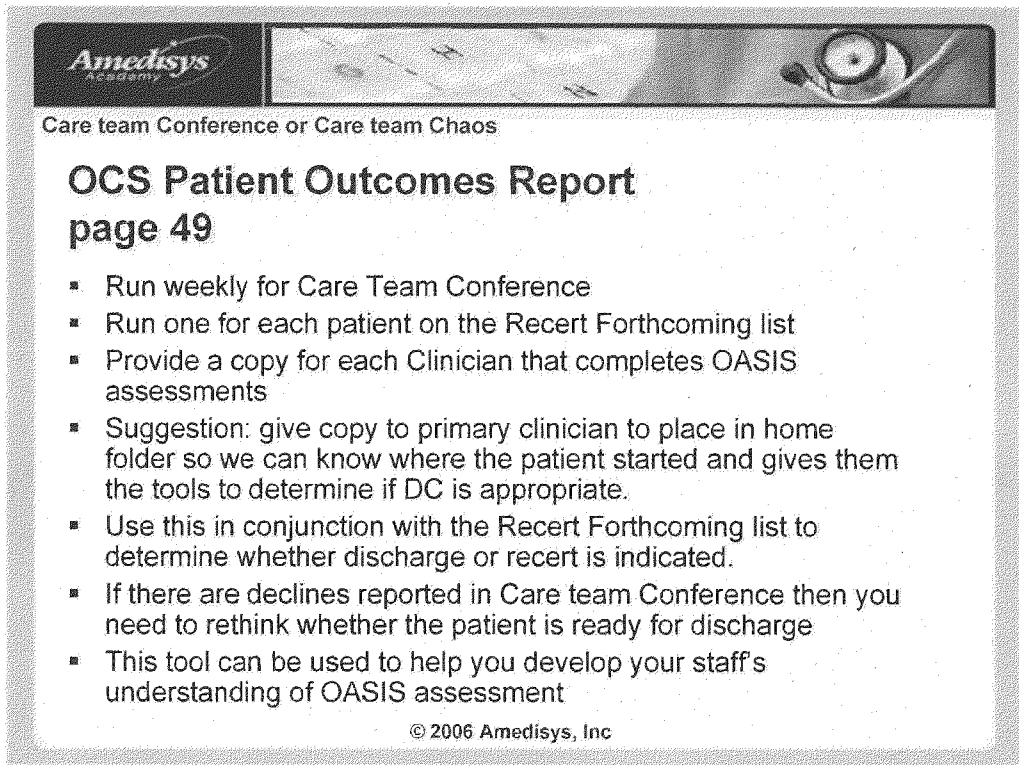


Amedisys Academy

Care team Conference or Care team Chaos

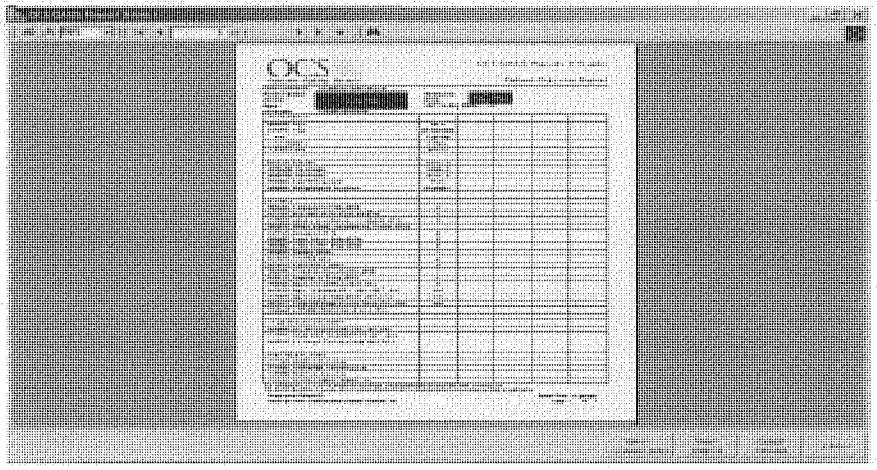
Adjusted Revenue Report

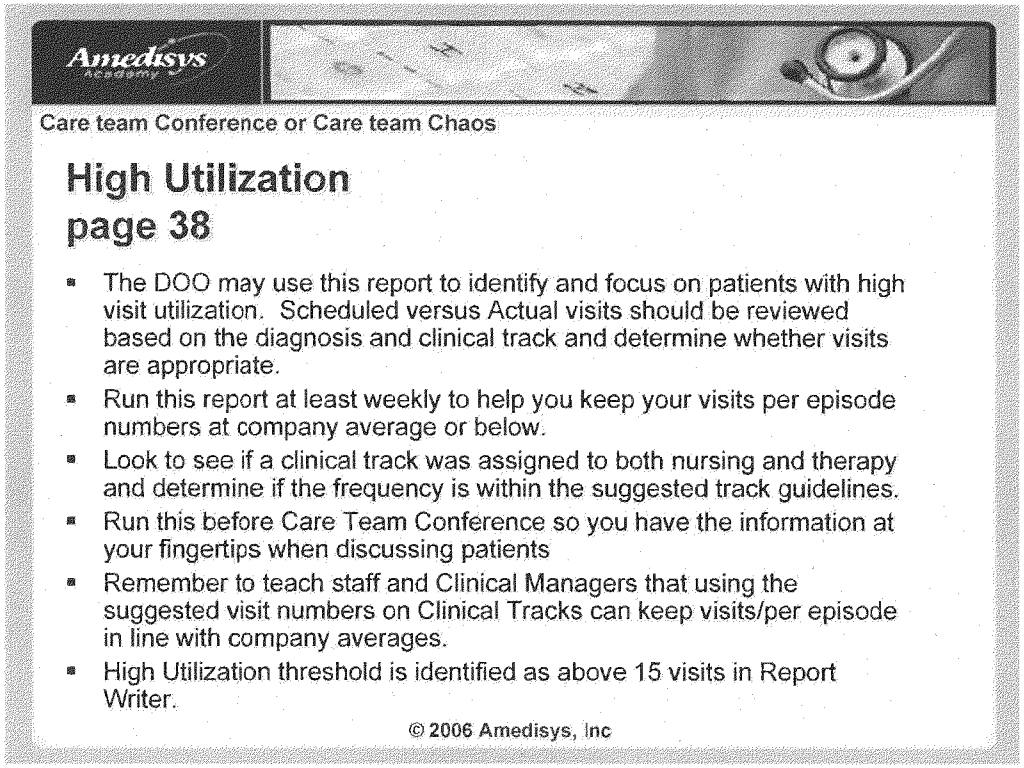


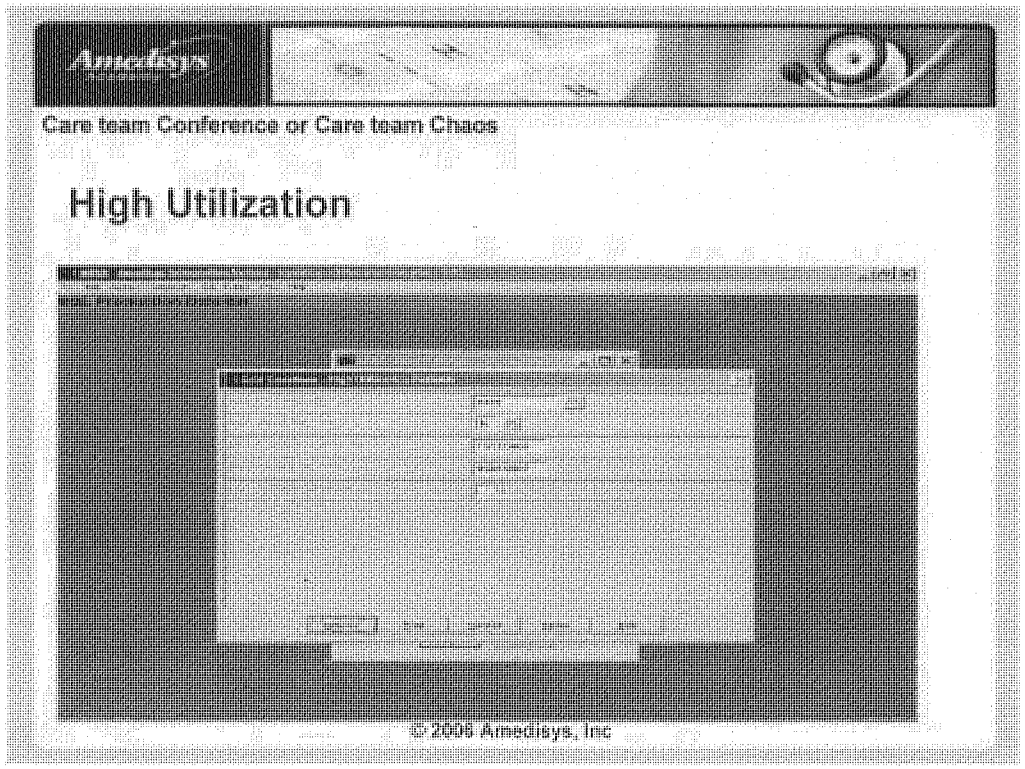


Care team Conference or Care team Chaos

OCS Report-Patient Outcomes Report







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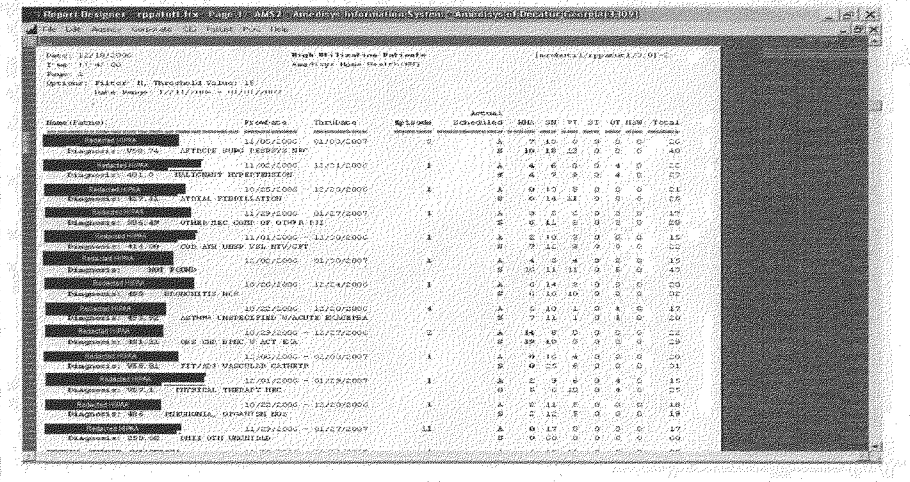
High Utilization Report



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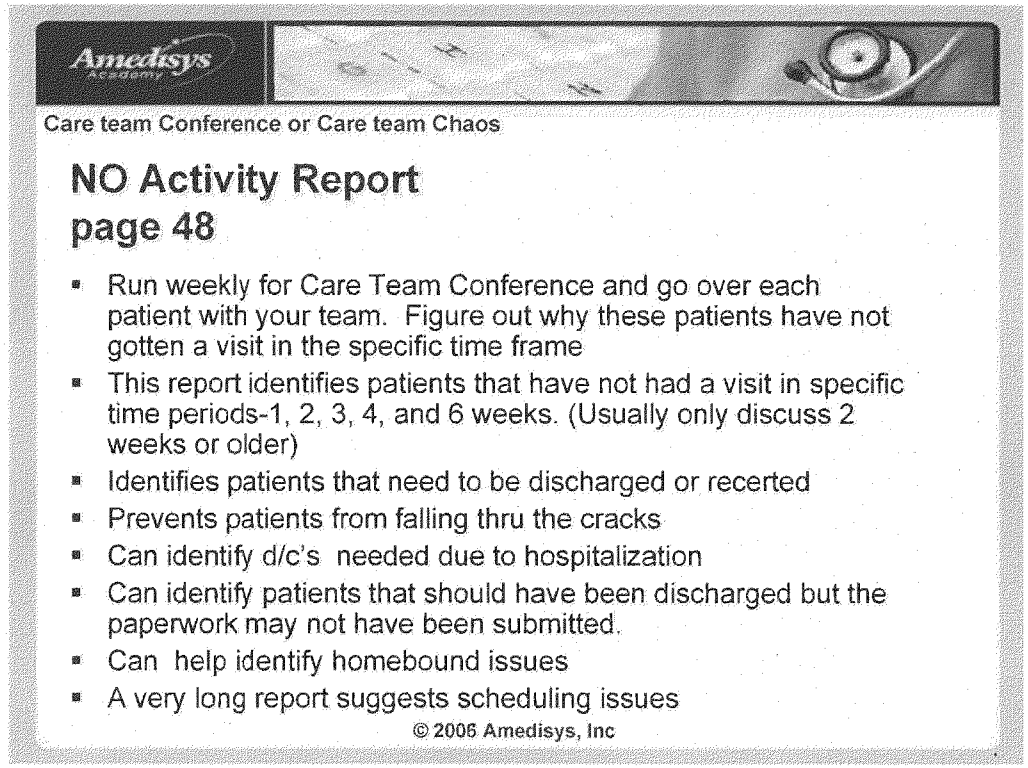

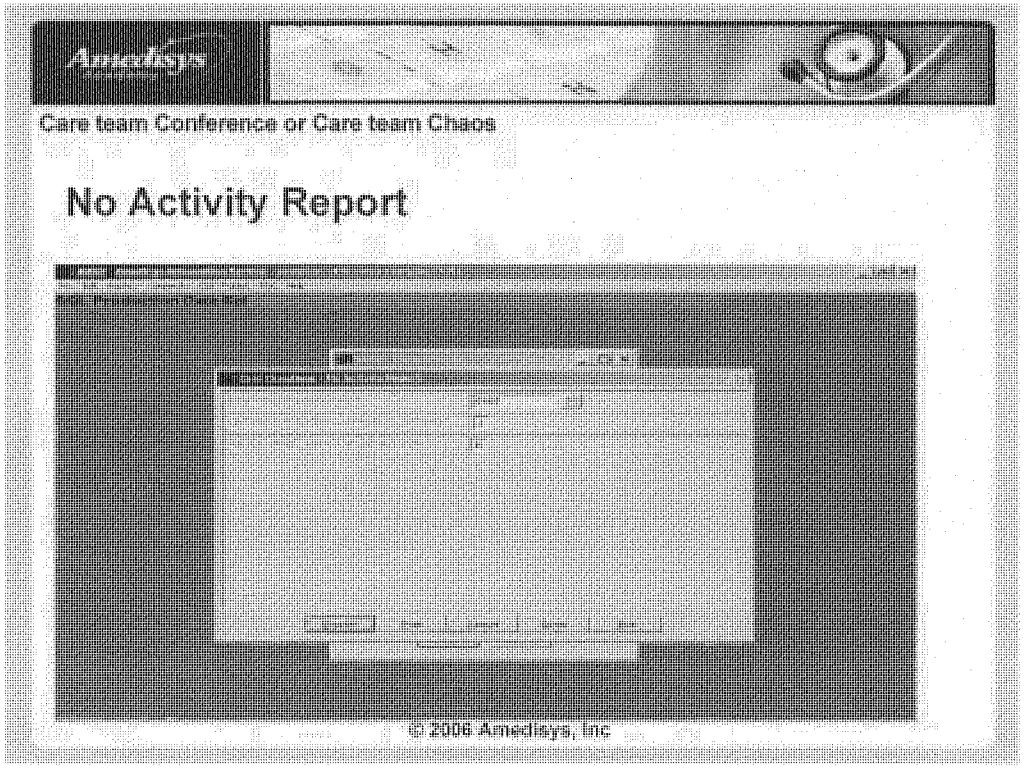

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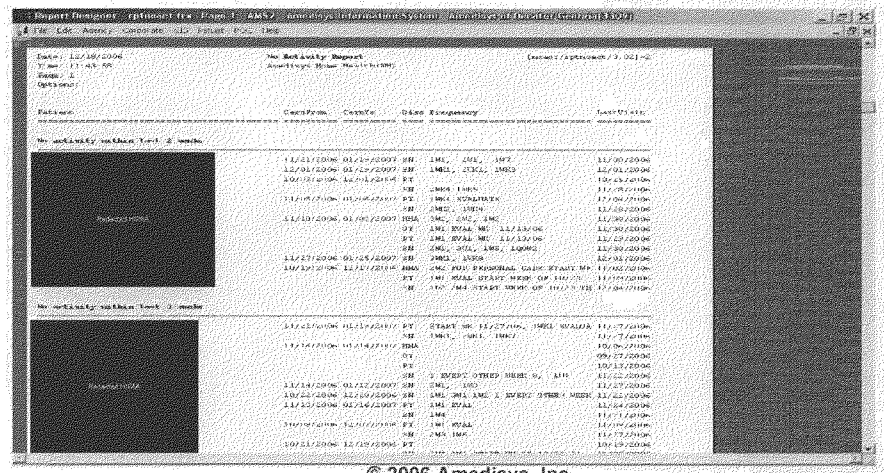
Care team Conference or Care team Chaos

No Activity Report



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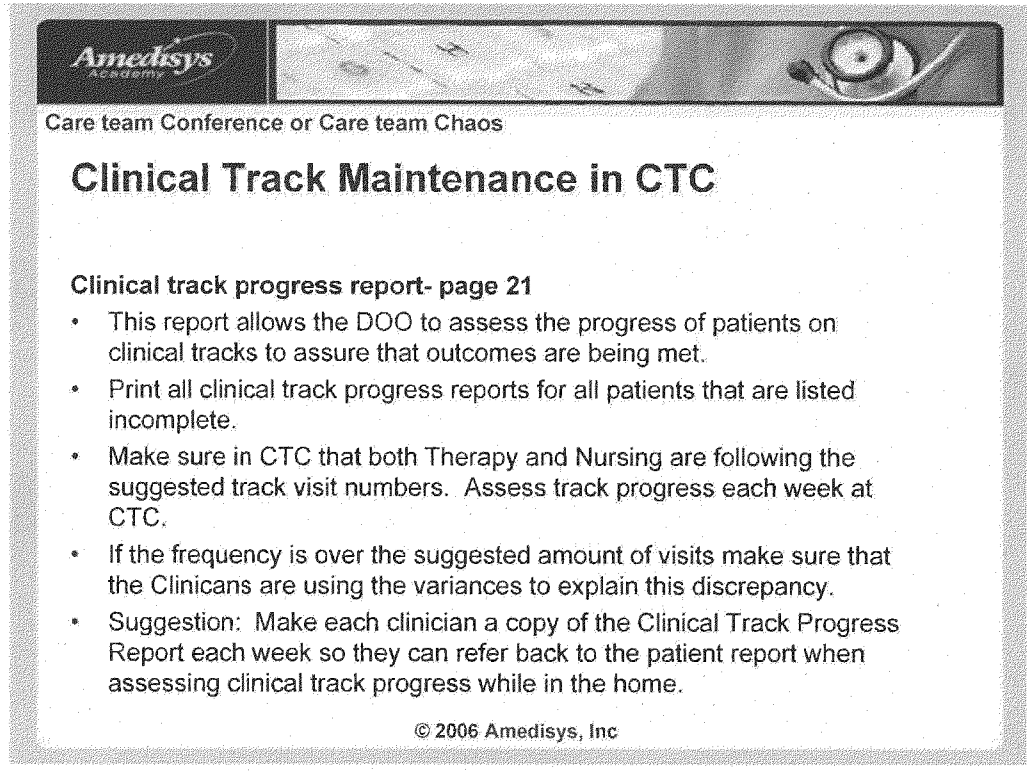
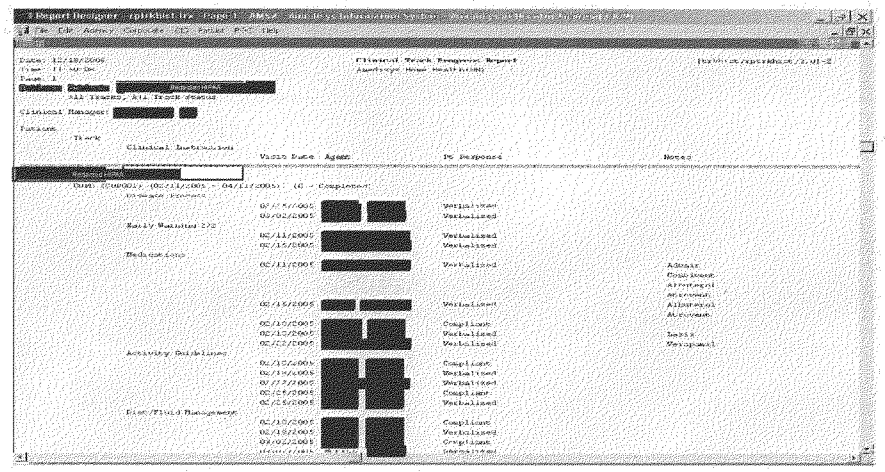
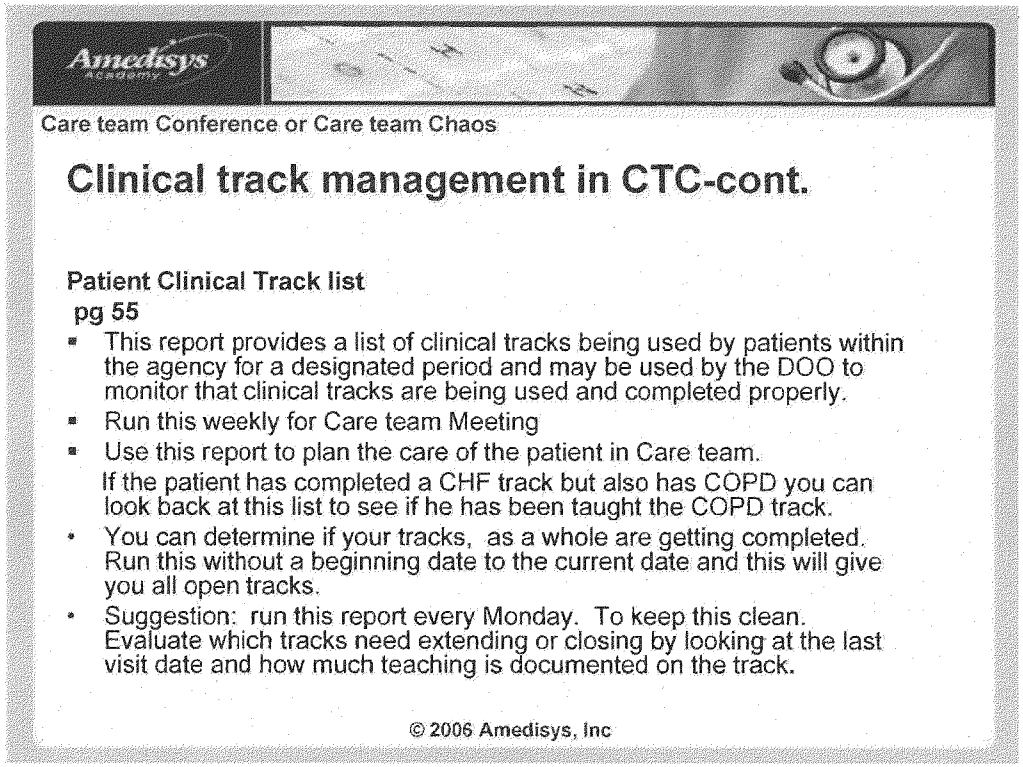
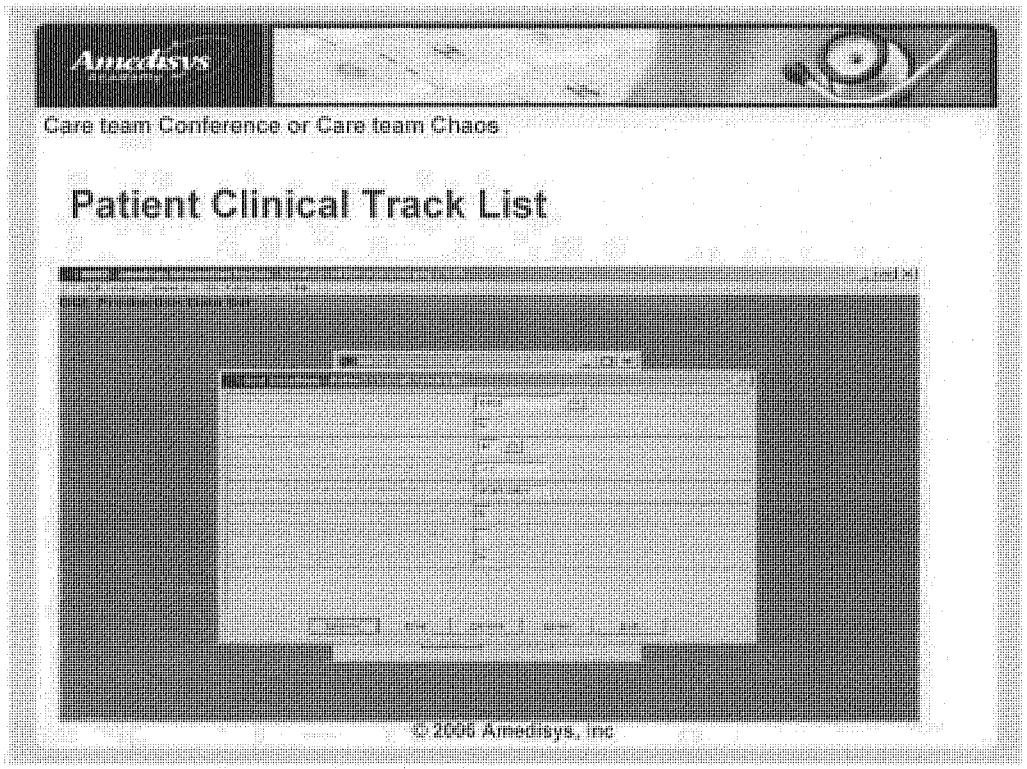


Care team Conference or Care team Chaos

Clinical Track Progress Reports







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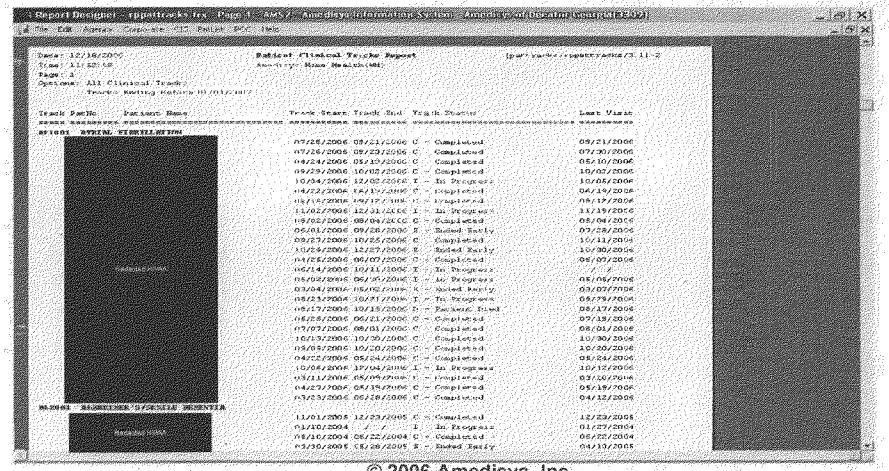
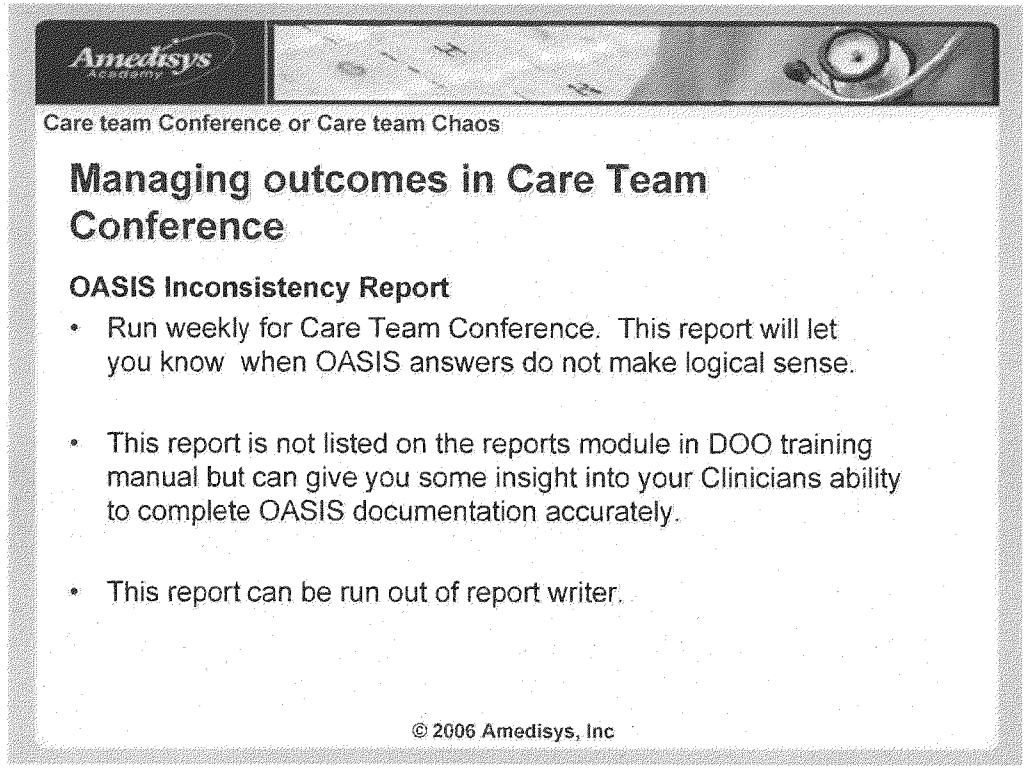
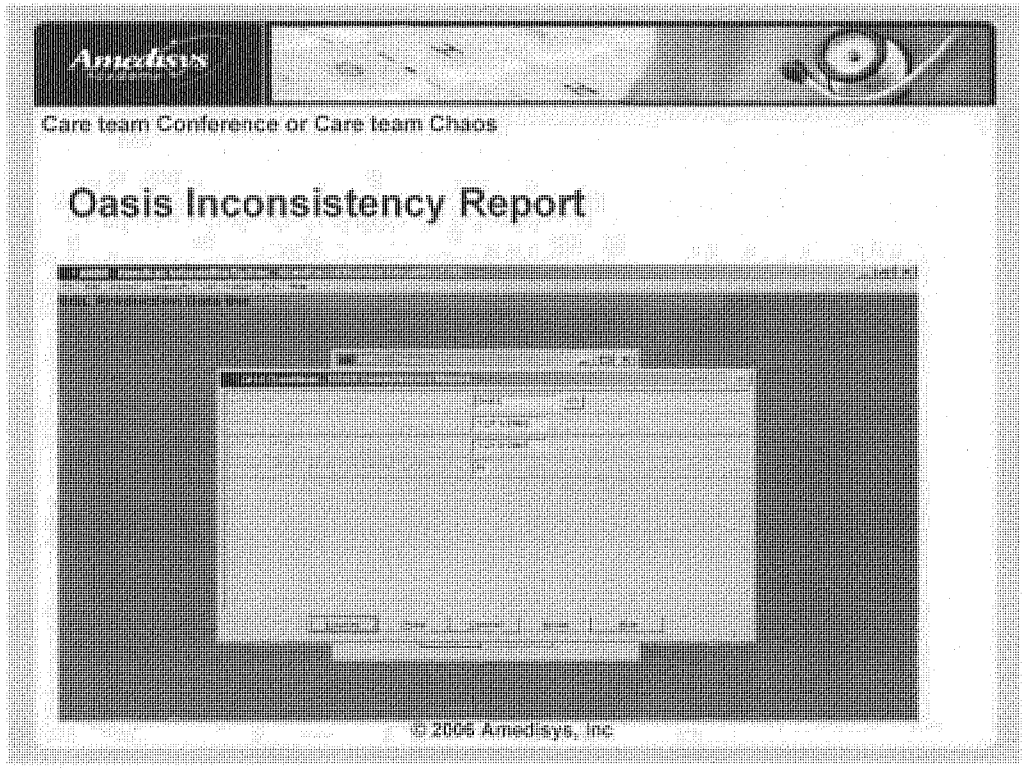
Care team Conference or Care team Chaos

Patient Clinical Track List







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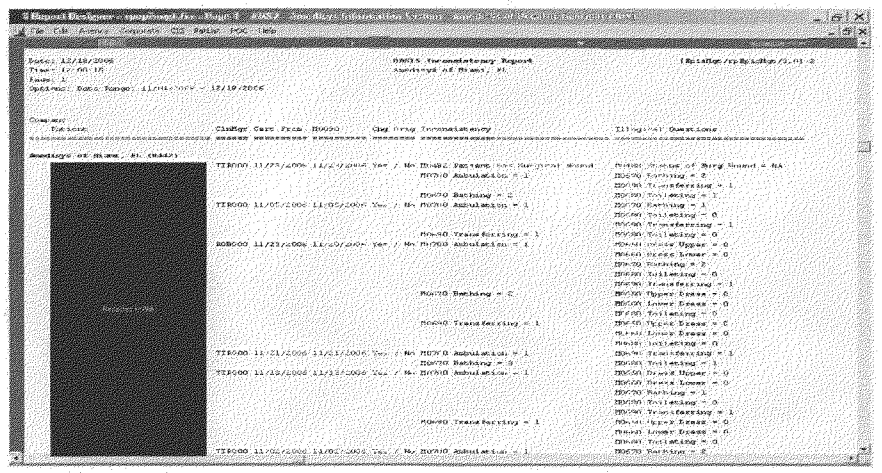
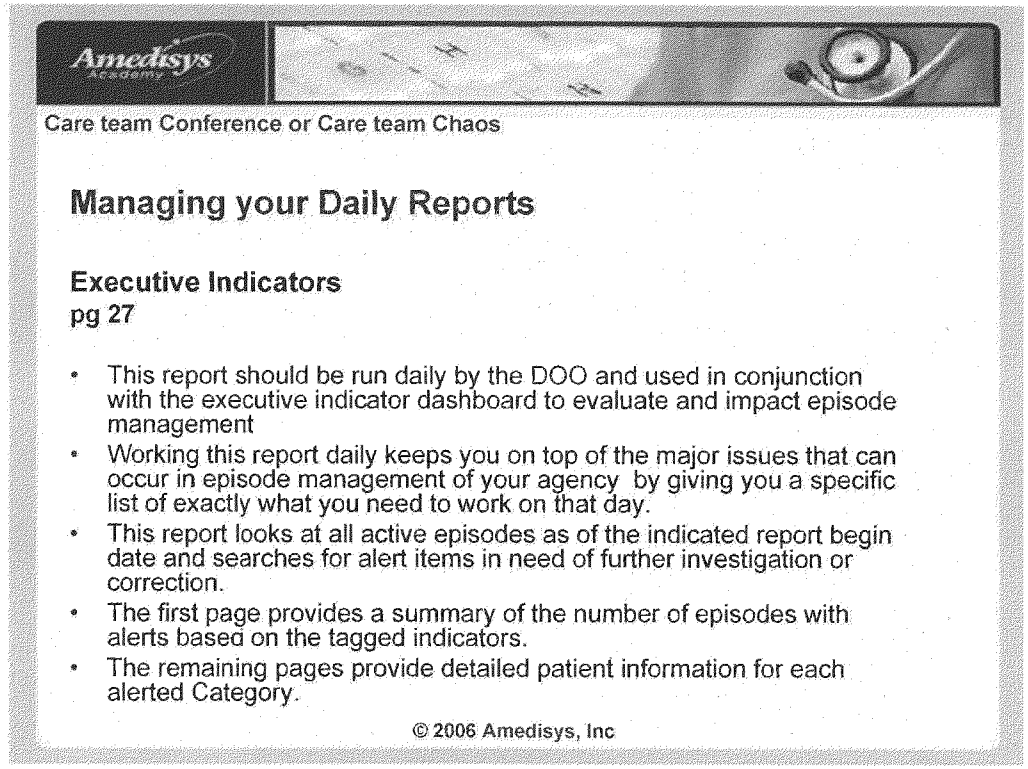
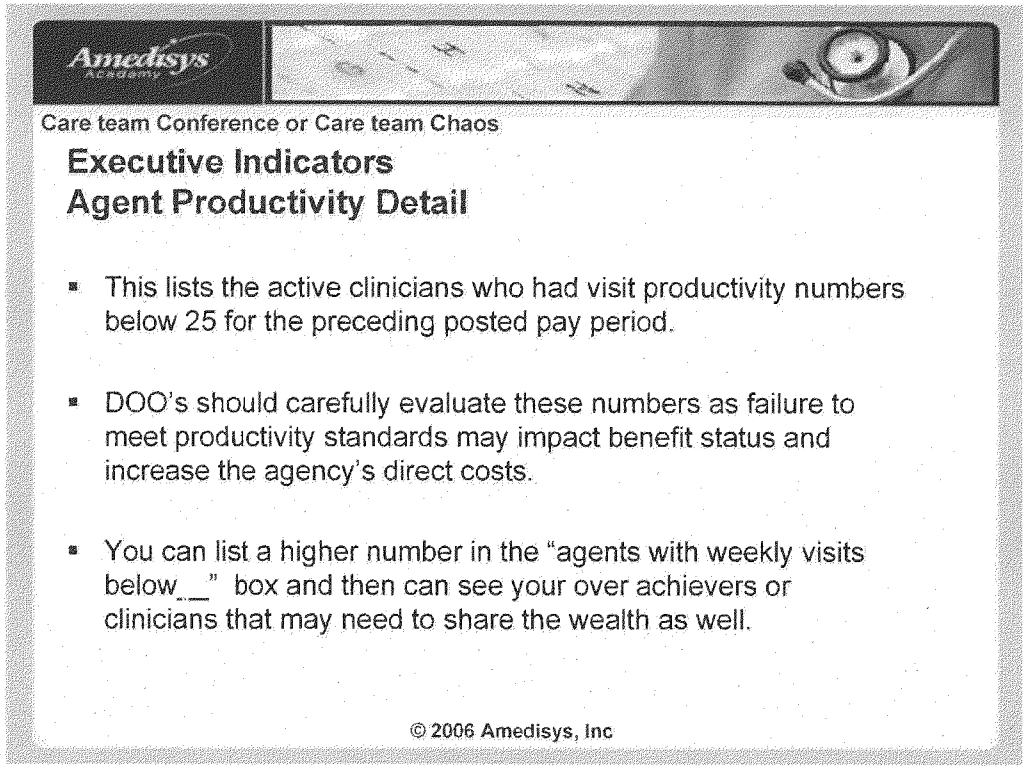
Care team Conference or Care team Chaos

Oasis Inconsistency Report

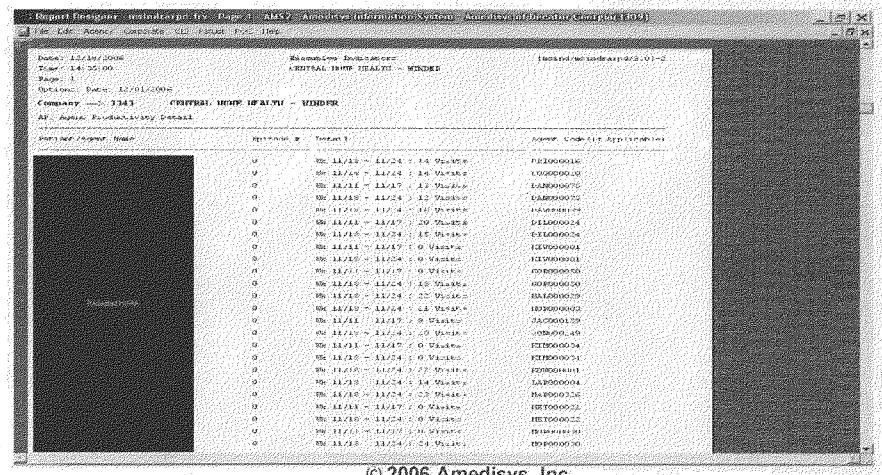


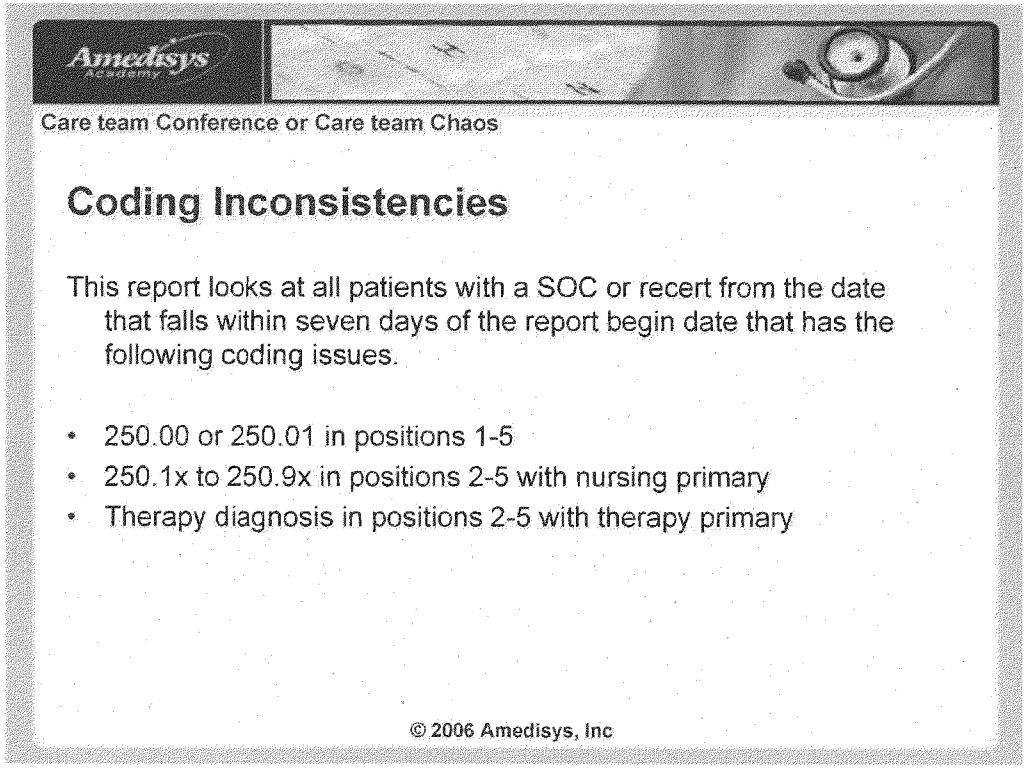




Care team Conference or Care team Chaos

Agent Productivity report





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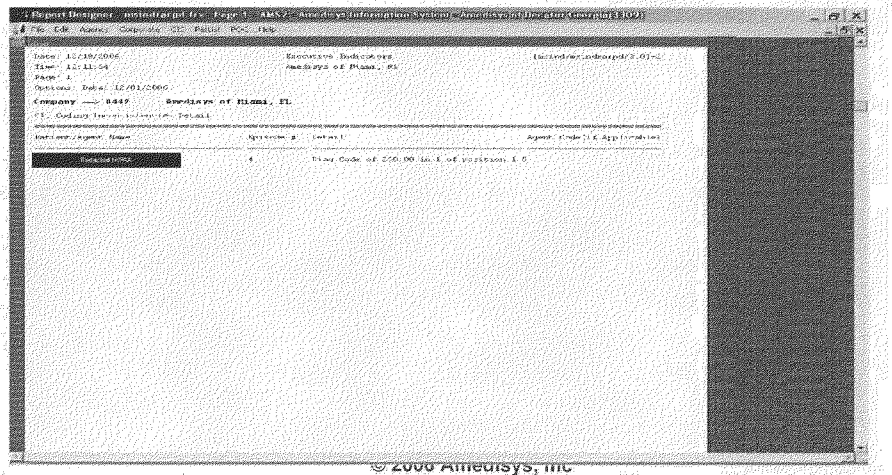
Care team Conference or Care team Chaos

Coding inconsistencies detail



Executive Indicators, cont.

Recert Inconsistencies Detail

- Looks at active assessments with a cert from within 7 days of the report begin date that have had an improvement from the previous assessment yet have equal or more visits than the previous episode.

- To manage this list the DOO needs to validate that the patient has indeed improved. If so then why did the frequency need to increase? If not then Clinician needs to correct the OASIS to clearly describe the patient.

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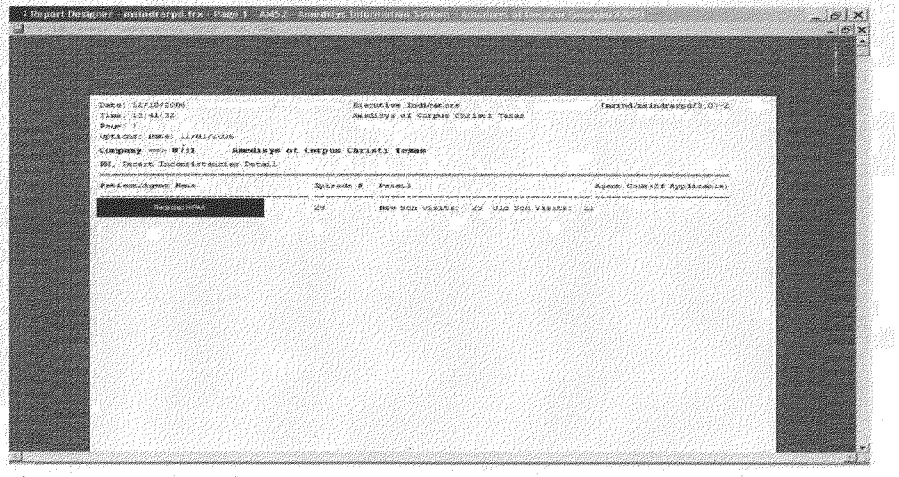
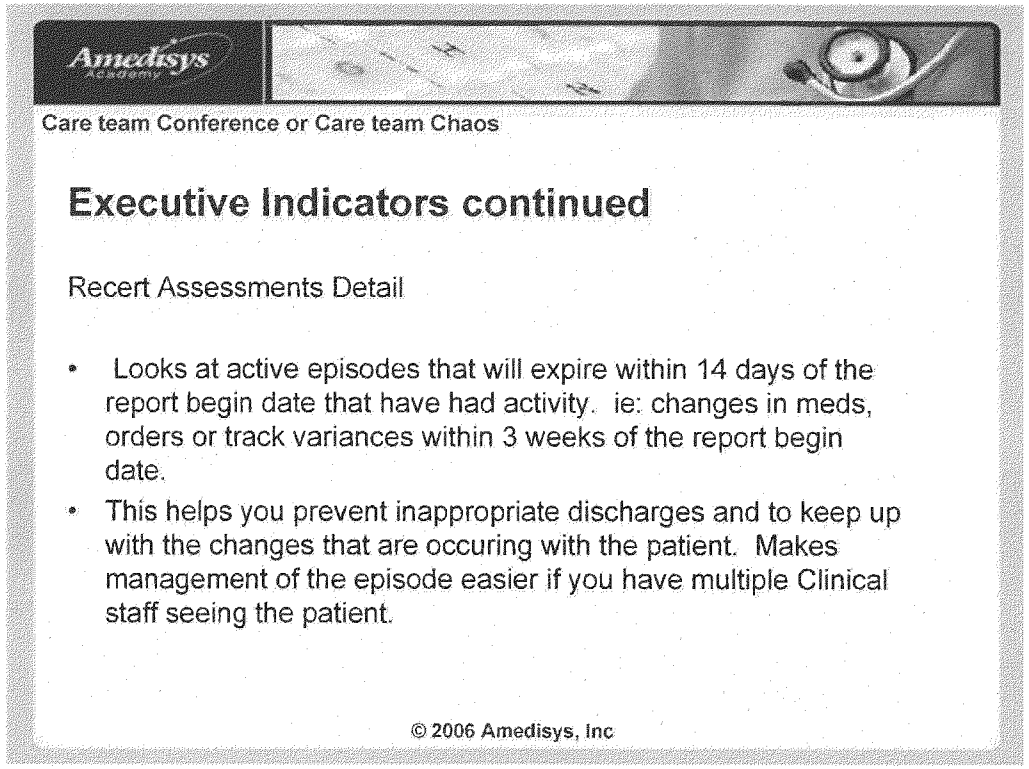
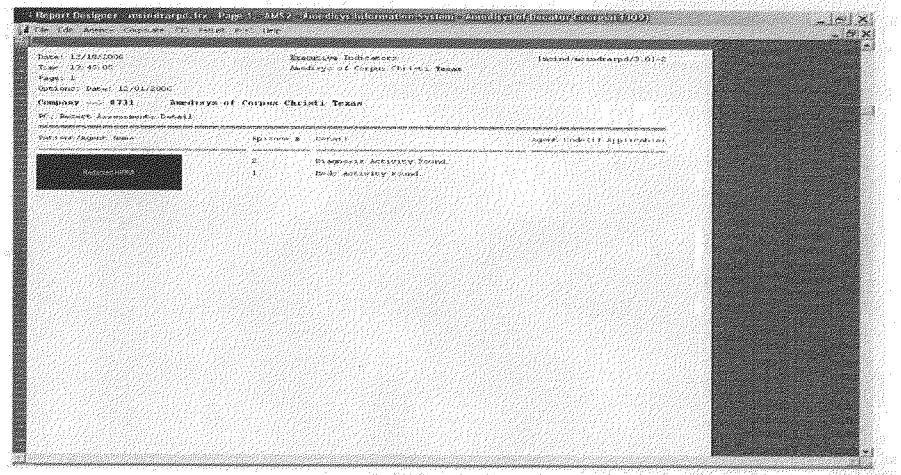
Recert Inconsistencies

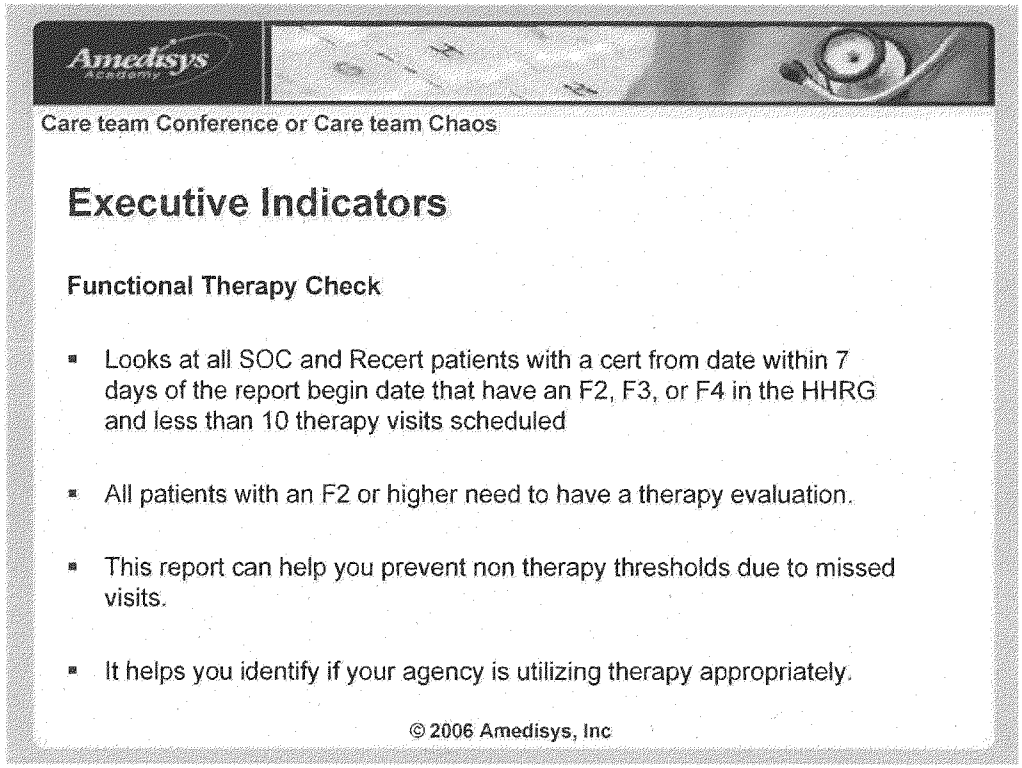




Care team Conference or Care team Chaos

Recert Assessments detail





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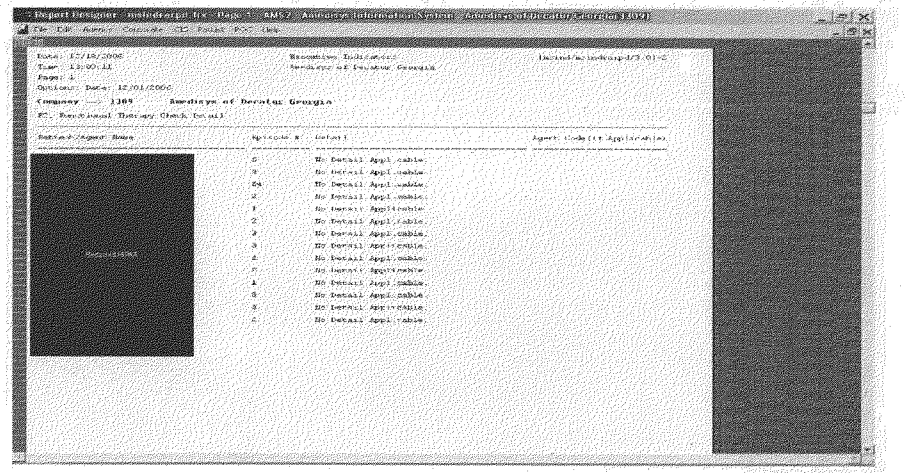
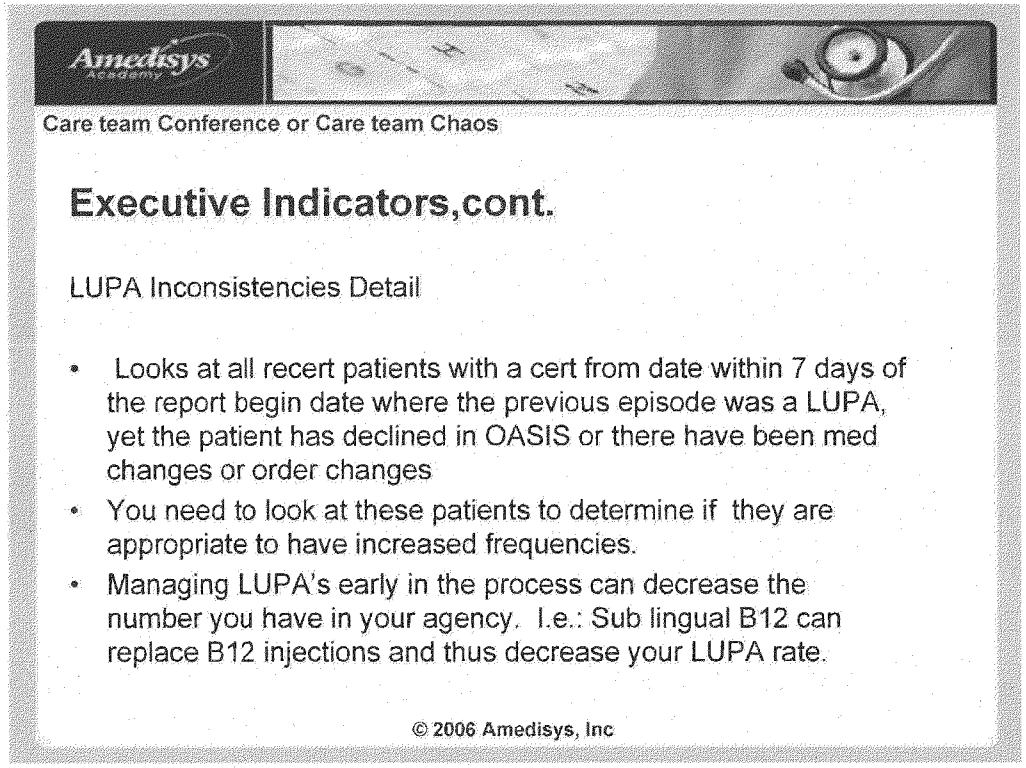
Functional Therapy check





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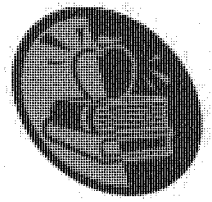
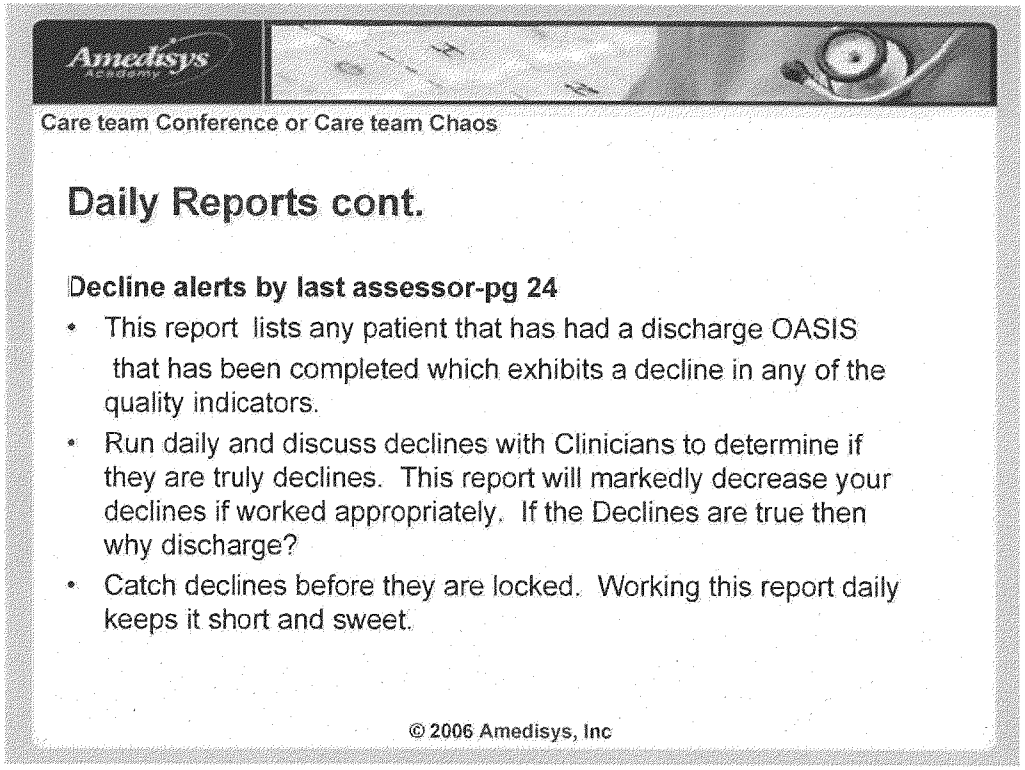
Care team Conference or Care team Chaos

LUPA Inconsistencies

Executive Indicators cont.

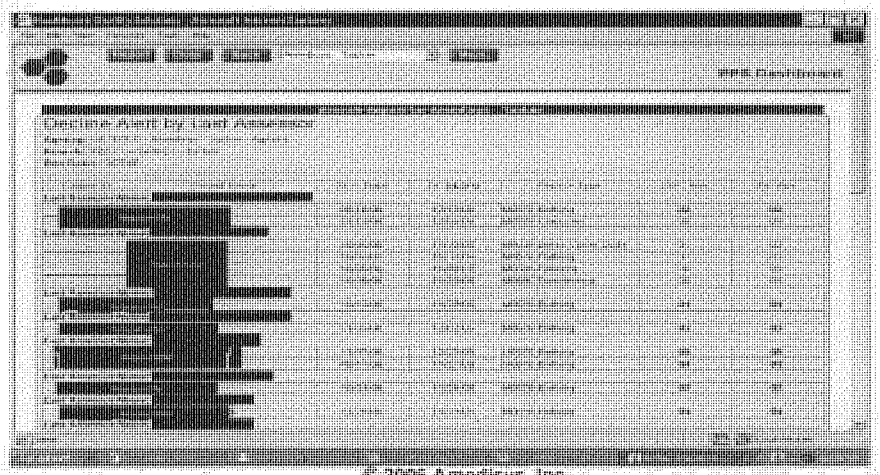
- As you can see the executive Indicators can keep you on top of a major portion of your agency needs.
- An apple a day may keep the Doctor away but working this report daily will keep the Episode Manager away.

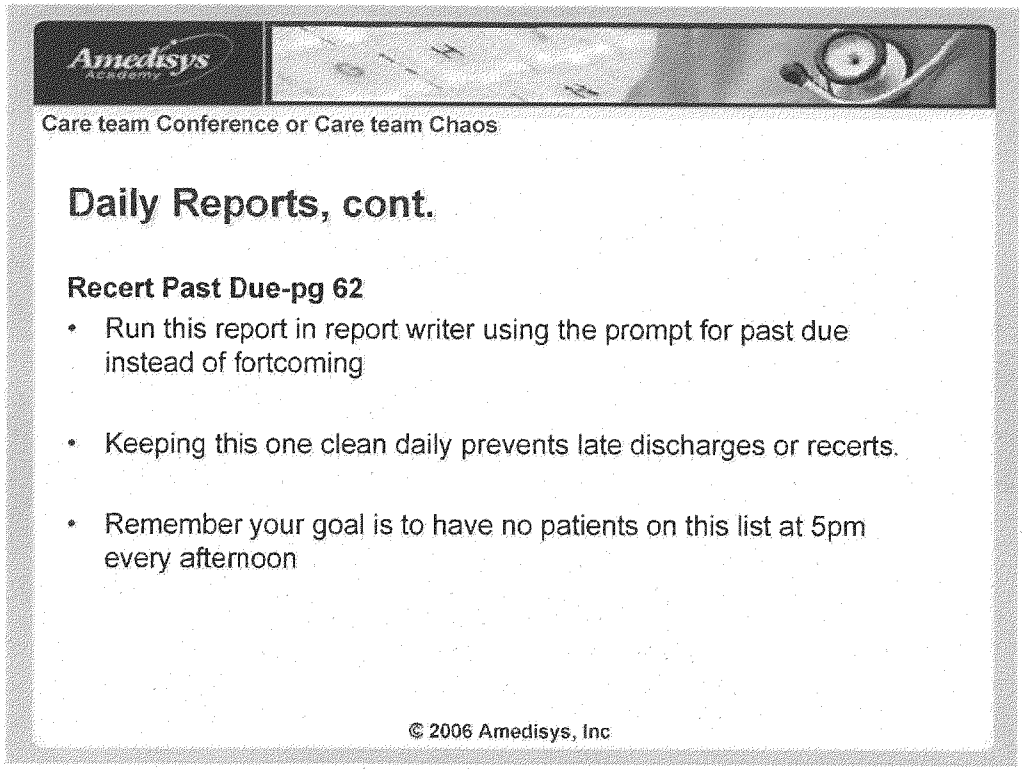


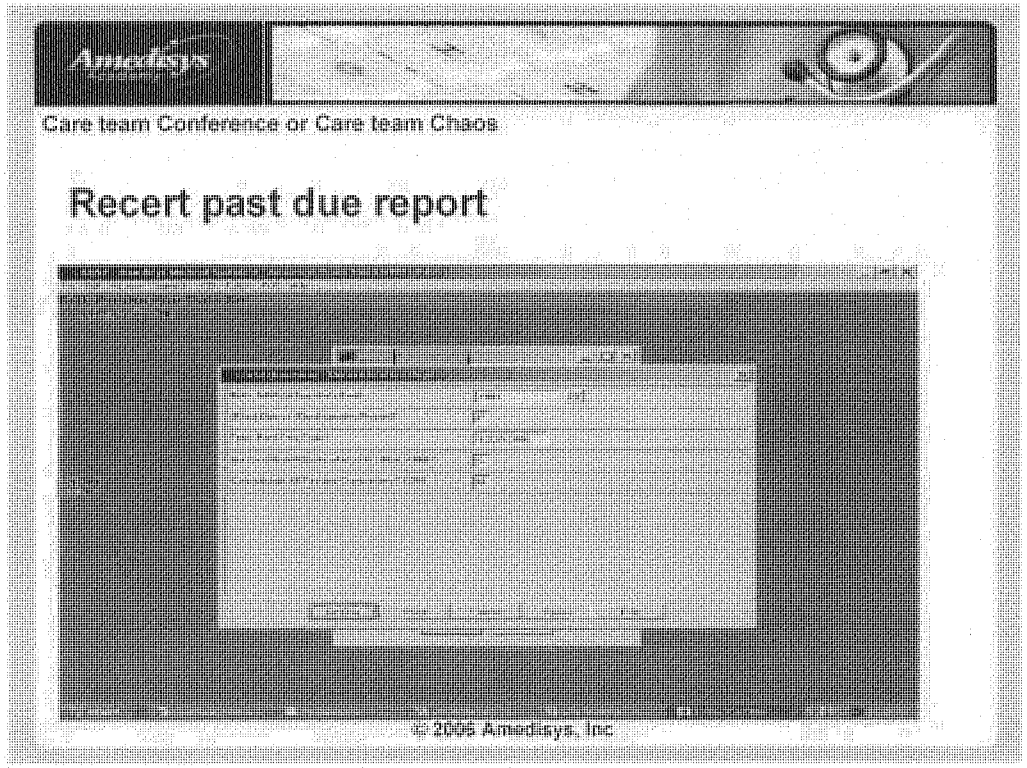


Care team Conference or Care team Chaos

Decline alerts by last assessor







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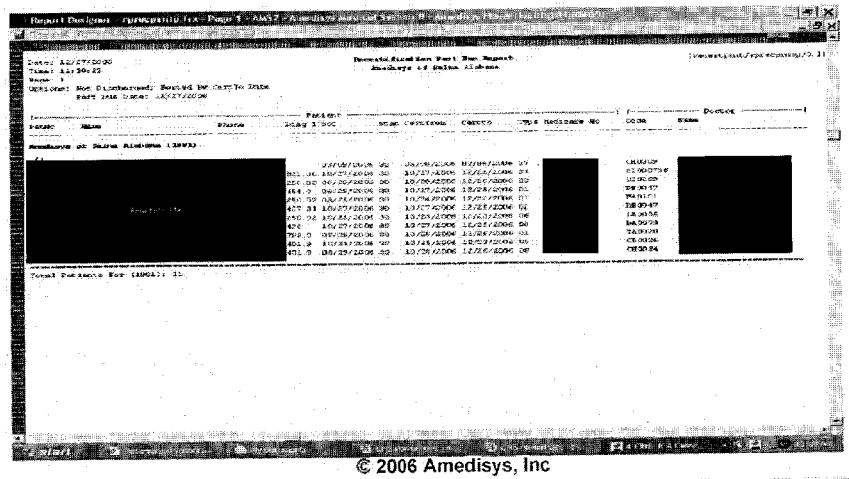
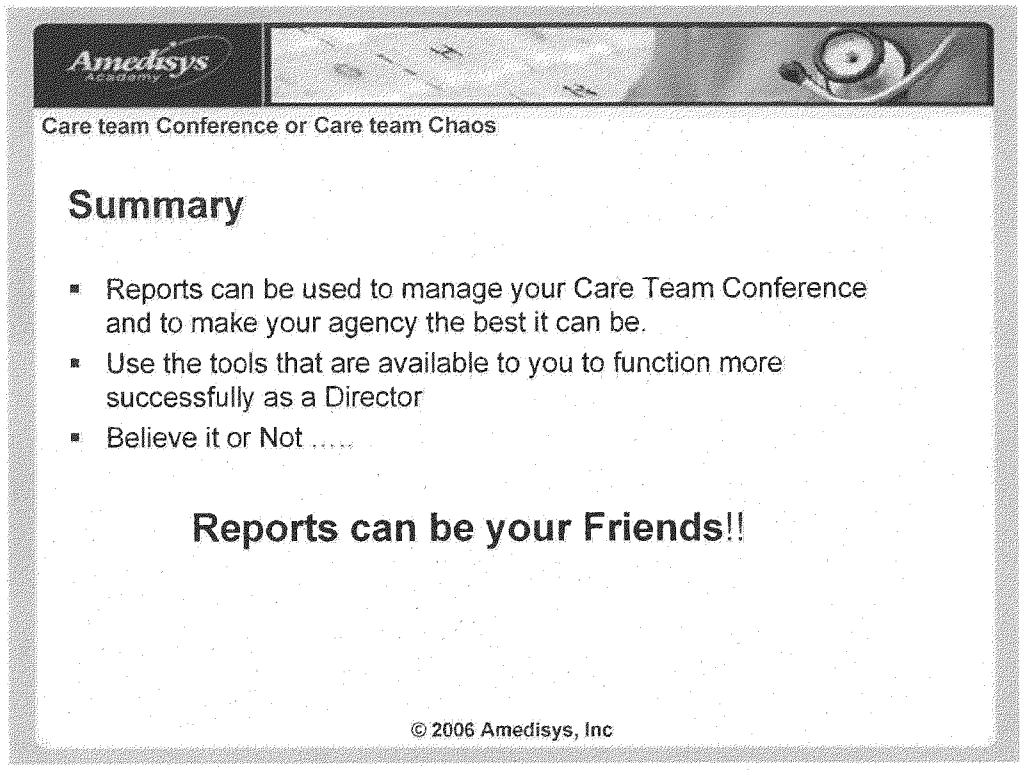
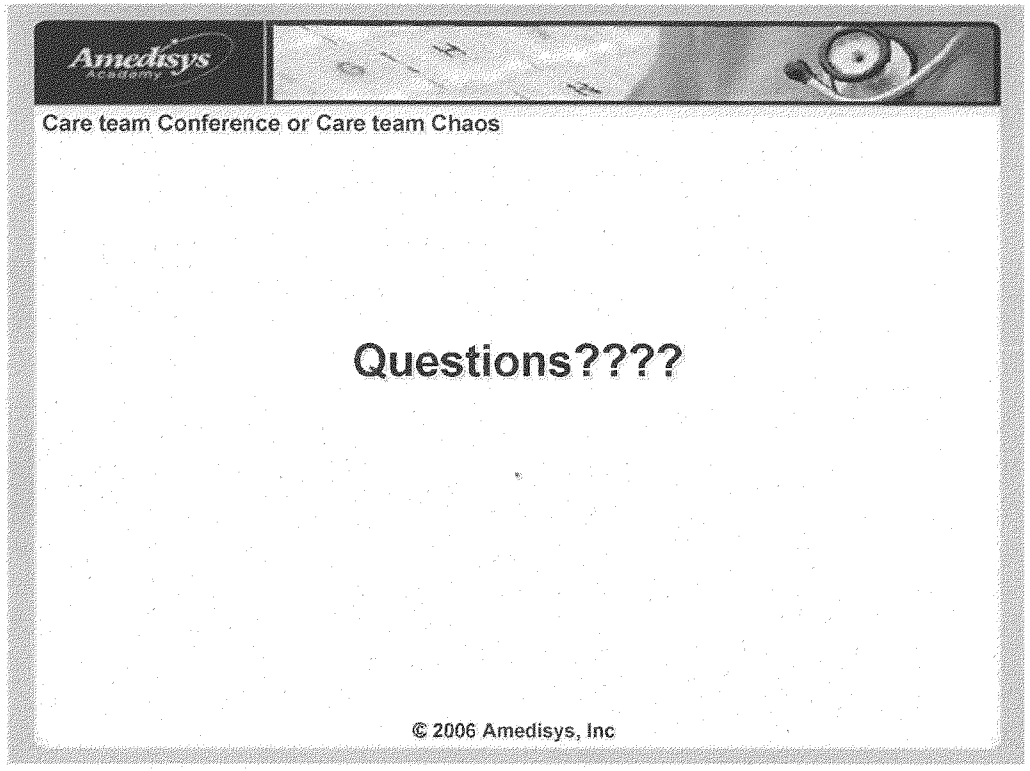
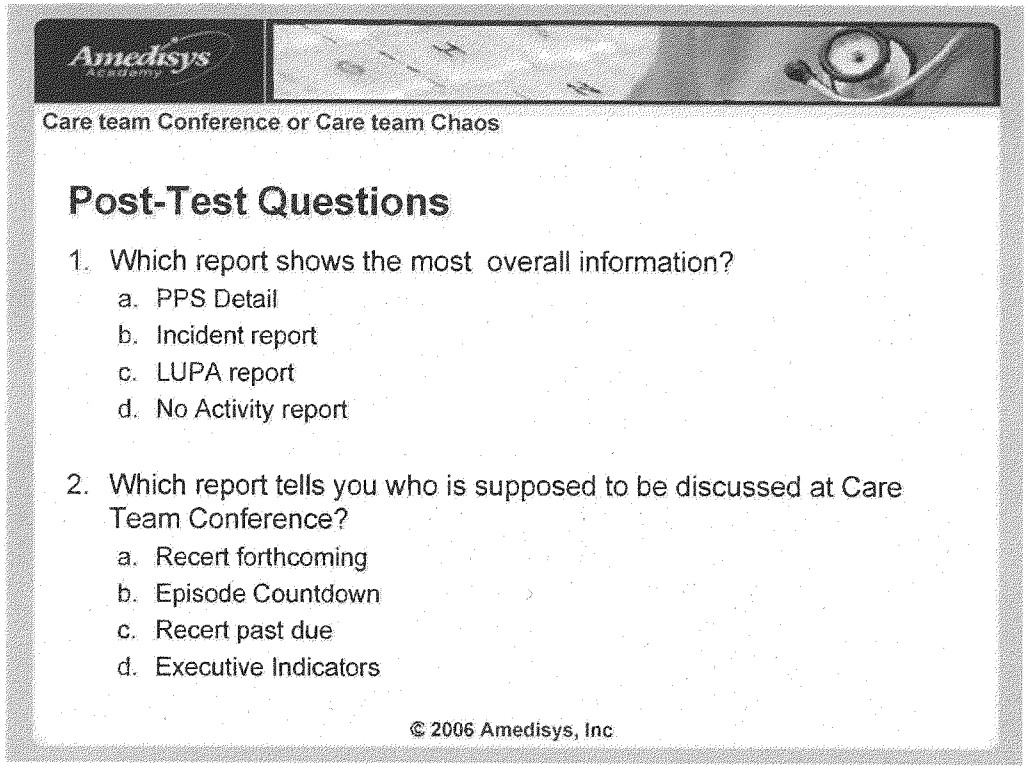
Care team Conference or Care team Chaos

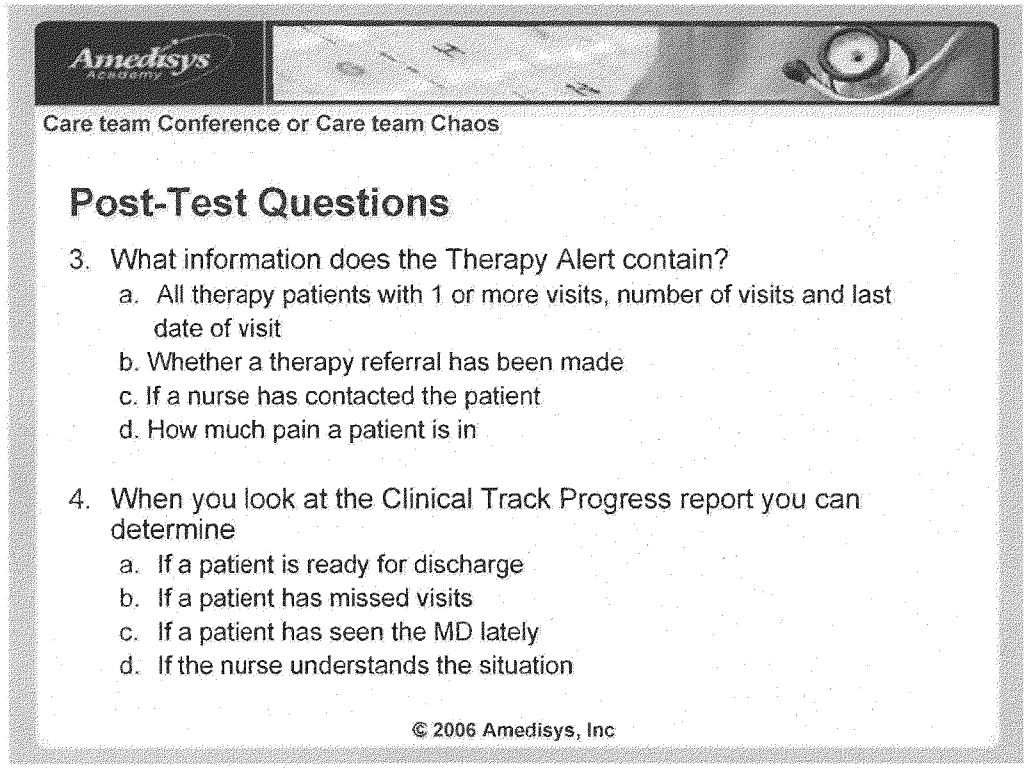
Recert past due

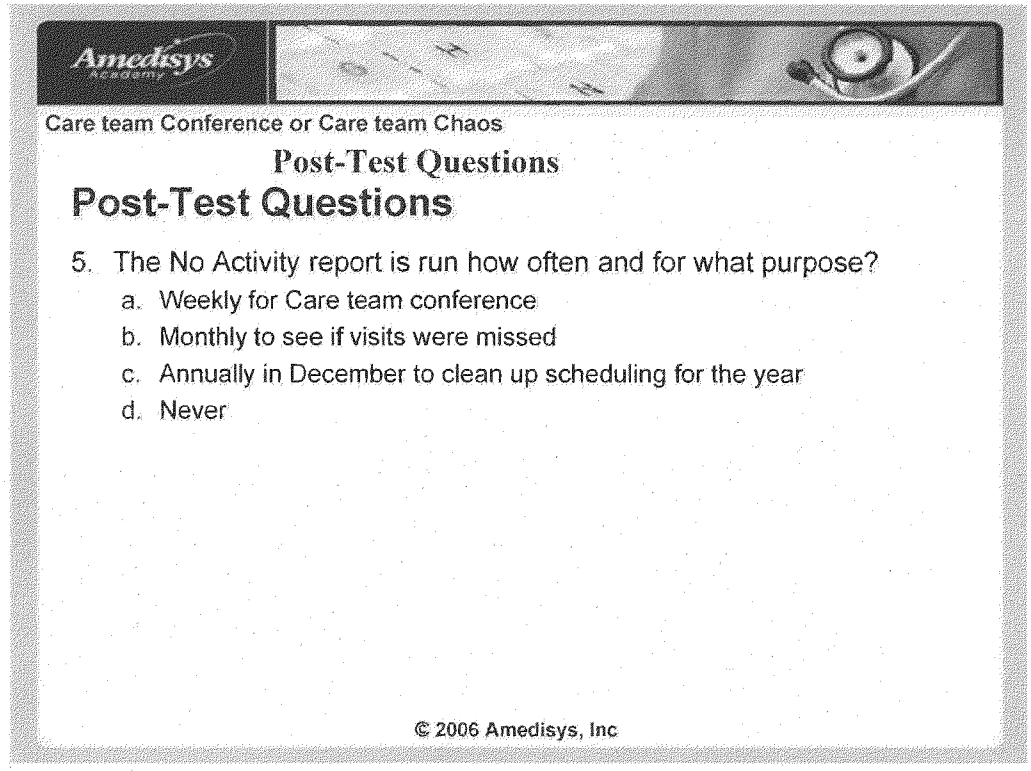


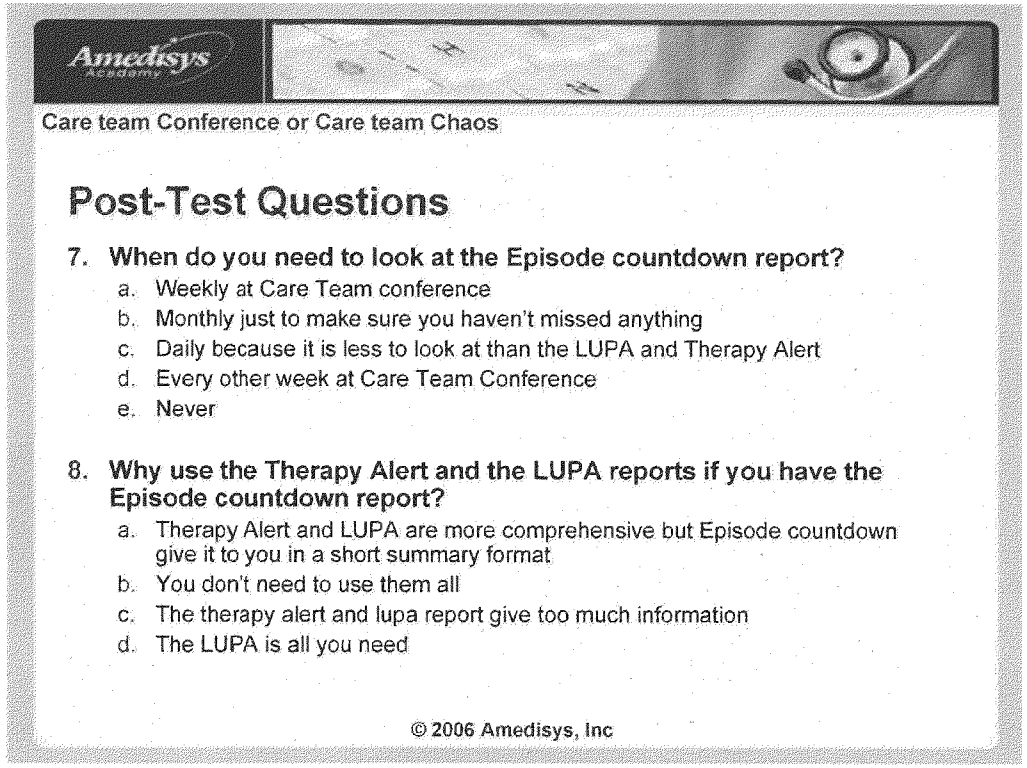


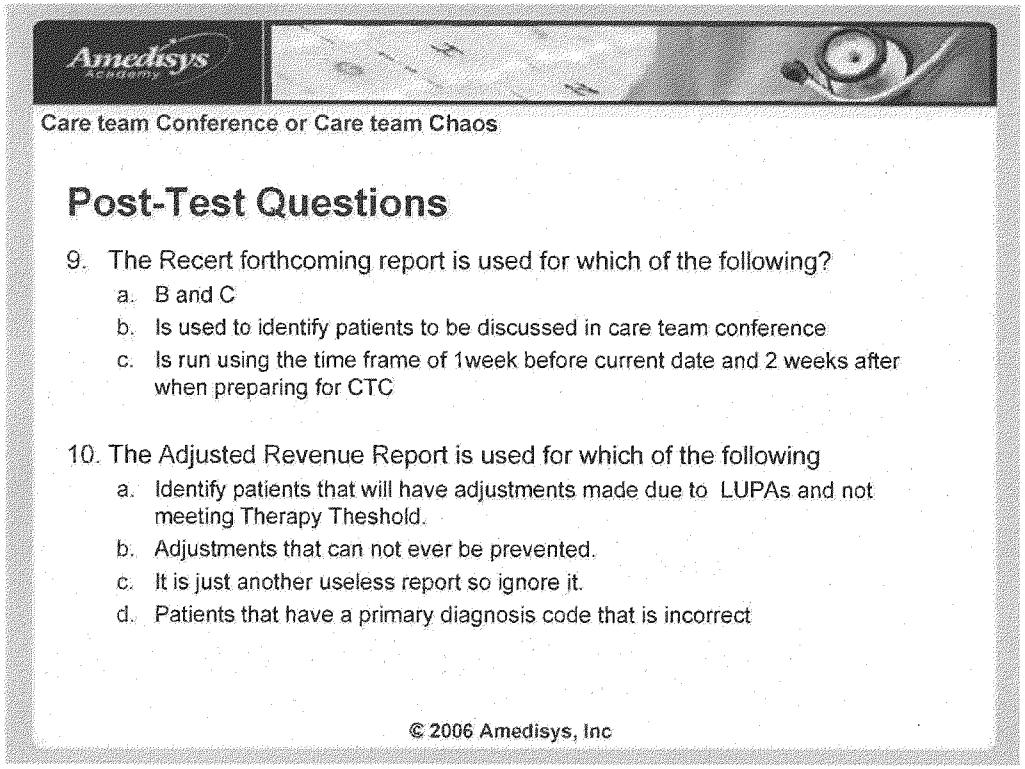


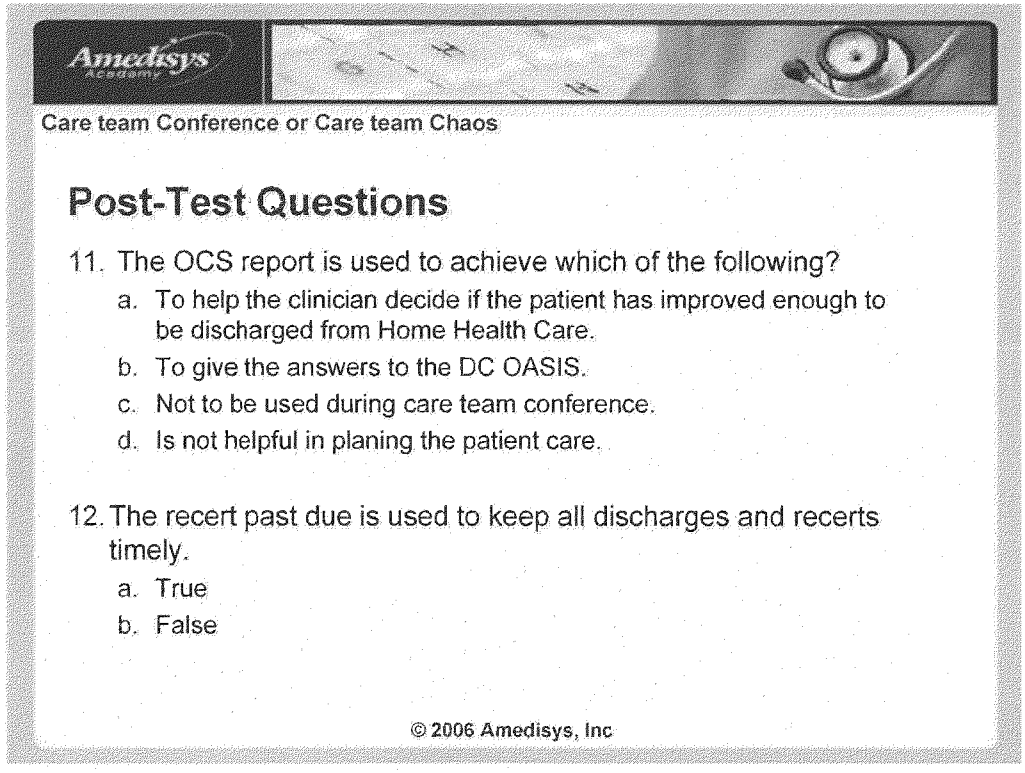


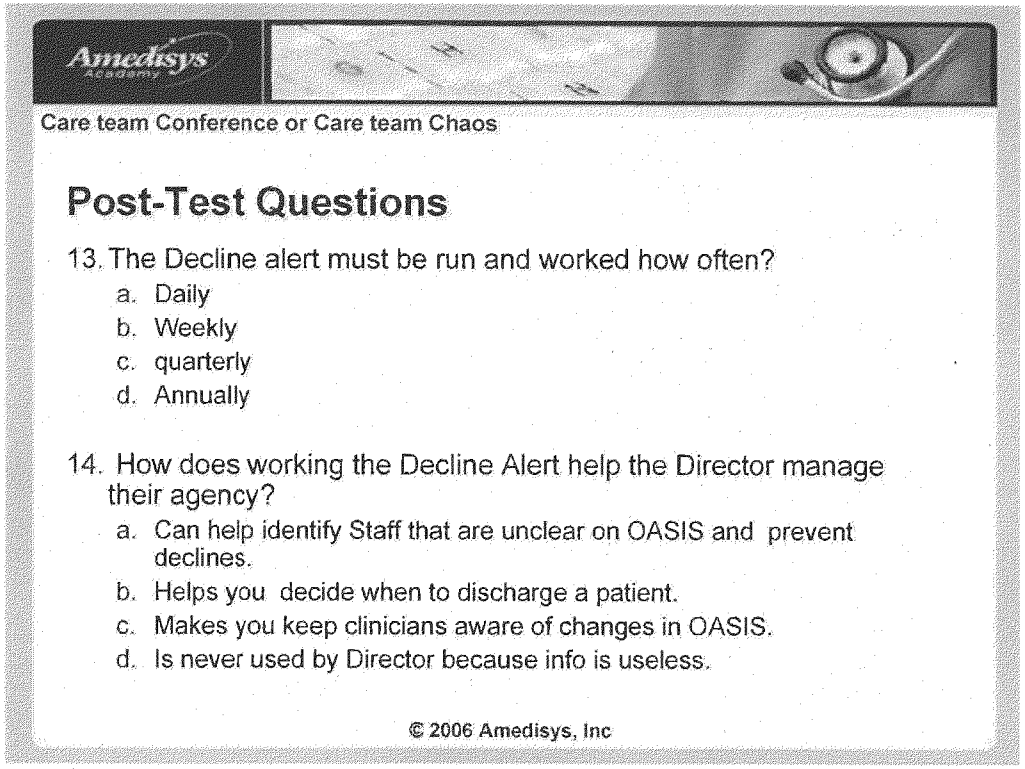


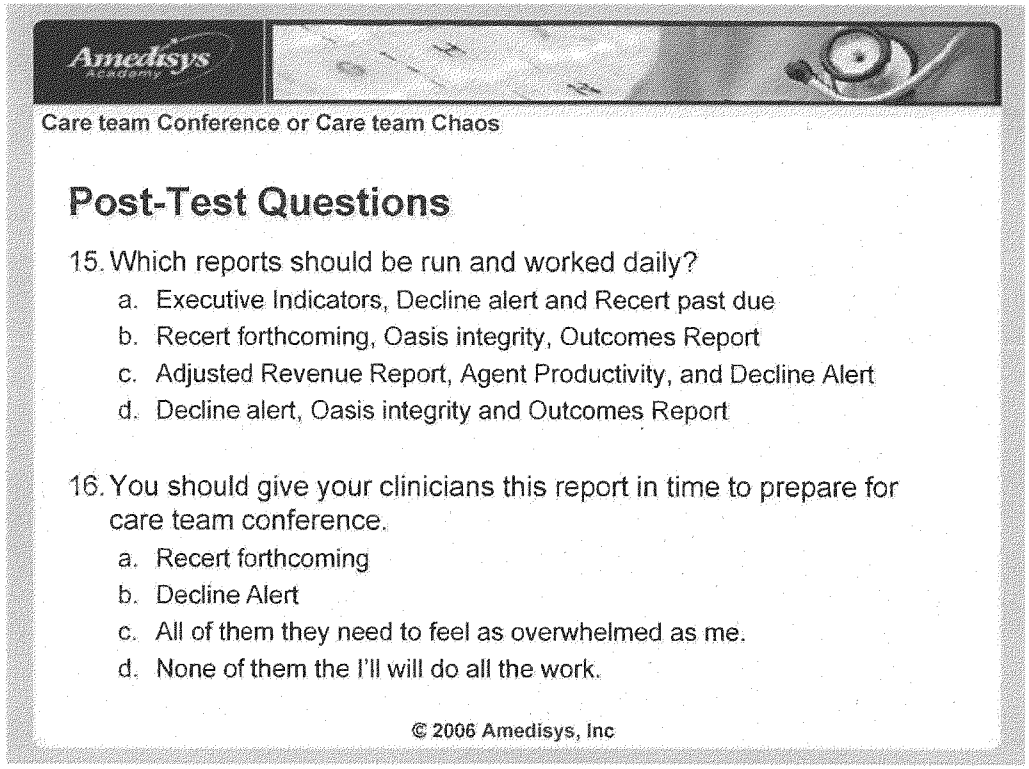


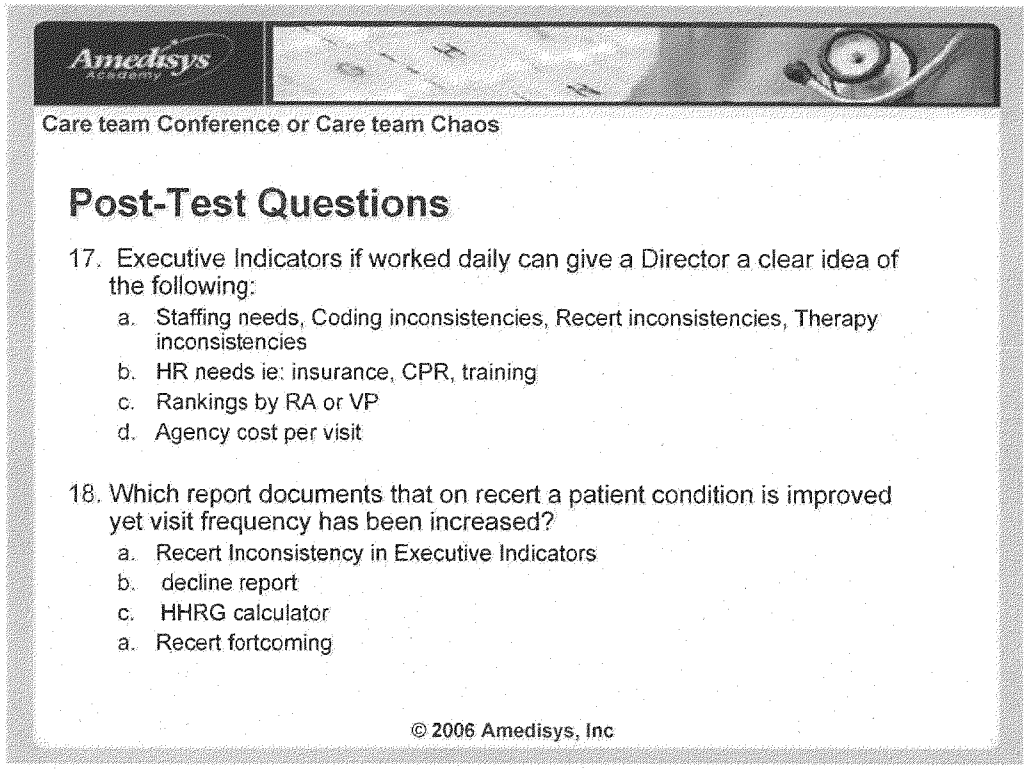


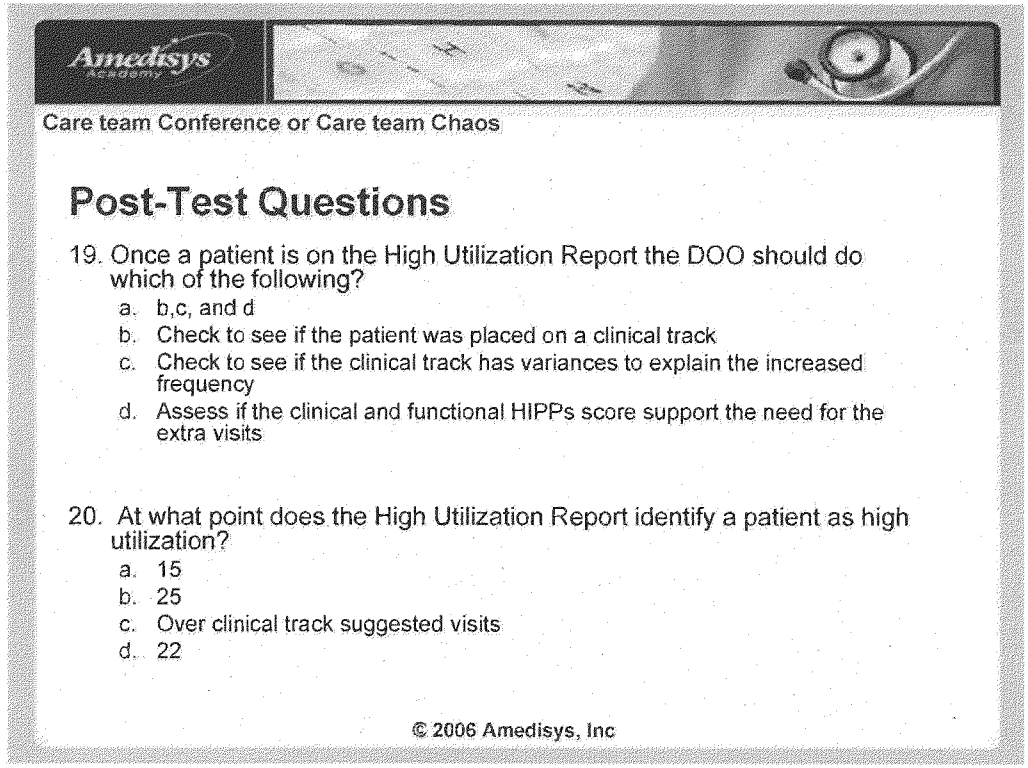




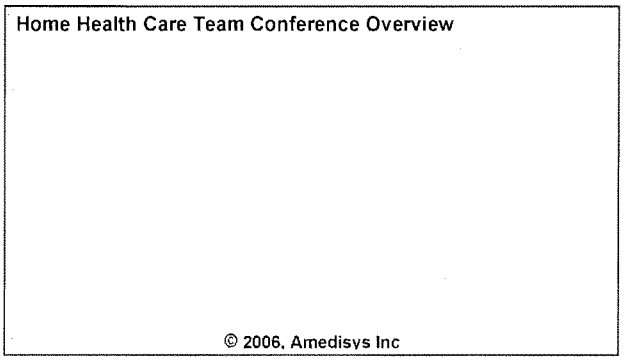








Footnote 24


Home Health Care Team Conference Overview
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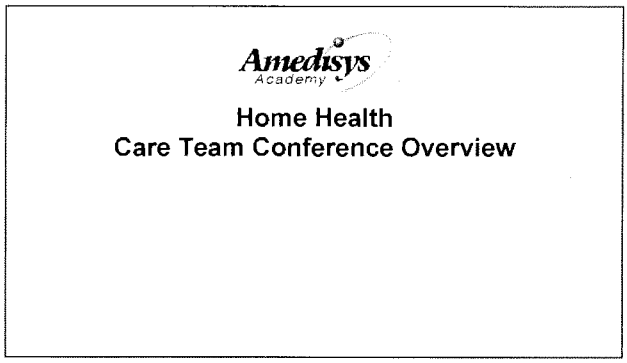
Title (add graphics) 700 pixels



Stream 1

Welcome to the computer-based training program that provides and overview on the weekly home health care team conference.

This program is intended for home health agency directors, clinical managers, and clinical manager assistants. Successful completion of this course requires that the full course be viewed and the post-test be passed with a score of 80 percent or greater. You may direct feedback or questions to your Regional Director of Clinical Operations. To navigate through this course, click the navigation buttons located in the right lower corner of the screen. You will know it is time to progress to the next screen when the right arrow begins flashing white.

Instructions and Navigation (700 pixels)

Home Health Care Team Conference Overview

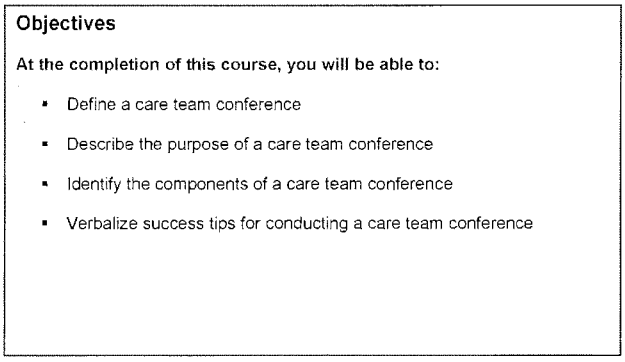
Target Audience: Home Health Directors, Clinical Managers, Clinicians

Course Completion: Full course plus post-test score of 80% or greater

Feedback or Questions: Regional Director of Clinical Operations

Navigating Through Course: Right lower corner of screen

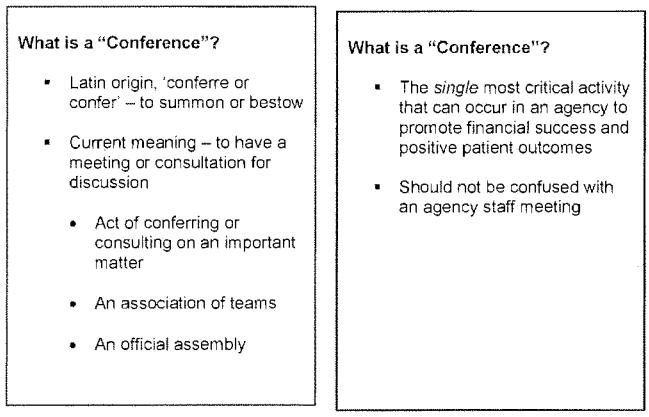
Objectives (700 pixels)



Stream 2: Objectives

At the completion of this program, you will be able to define a care team conference, describe the purpose of a care team conference, identify the components of a care team conference, and verbalize success tips for effectively conducting a care team conference

Stream 3: Defining Care Team Conference



The word conference dates back to the early 1400s and is of Latin origin coming from the word conferre or confer, which means to summon or bestow. Its current meaning is to have a meeting or consultation for discussion. Other components of the definition include the act of conferring or consulting on an important matter, an association of teams, and an official assembly.

Stream 4: Purpose of Care Team Conference

Purpose of Care Team Conference:

- Required in most healthcare settings
- Federally mandated under the Home Health **Conditions of Participation**

Purpose of Care Team Conference:

- **484.14 (g) Standard:** Coordination of Patient Services
  - **G143:** All personnel furnishing services maintain liaison to ensure their efforts are coordinated and support the objectives outlined in the plan of care
  - **G144:** The clinical record or minutes of care conference establish that effective interchange, reporting and coordination of patient care does occur
  - **G145:** A written summary report for each patient is sent to the attending physician at least every 60 days

Why is there such an emphasis on care team conferences in home care? Actually these types of conferences are not unique to home care. They are also required in almost all other health care settings as well. In acute care settings such as hospitals, nurses meet between shifts to discuss patient goals and discharge planning. Nurses round with physicians to discuss each patient's progress and needs. And therapists meet with floor nurses to discuss the patient's progress toward rehab goals. These discussions are not just pivotal to inpatient settings. They are also just as important, if not more so, in the home setting.

The federally mandated Home Health Conditions of Participation require that agencies demonstrate ongoing care coordination through care team conferences. Standard 484.14 G Coordination of Patient Services states that all personnel furnishing services must maintain liaison to ensure their efforts are coordinated and support the objectives outlined in the plan of care. The clinical record or minutes of care conference must establish that effective interchange, reporting and coordination of patient care does occur. And a written summary report for each patient is required to be sent to the attending physician at least every 60 days.

Stream 5: Participants

Care Team Conference Participants:

- The Director of Operations (DOO) is responsible and accountable for preparing, coordinating, and facilitating each week's care team conference
- The DOO will be present at each team conference and supervise the conference activities
- Participants:
  - DOO
  - Clinical Manager (by team)
  - Clinical Manager Assistant (if applicable)
  - Case Managers or Primary Clinicians (by team)
  - Full time Clinicians (by team)
  - Program Manager
  - Medical Social Worker
  - Home Health Aides (by team)

The Director of Operations of each agency is responsible and accountable for preparing, coordinating, and facilitating each week's care team conference. Although components of the conference may be delegated to other members of the team, the D O O is required to be present at each care team conference and supervise conference activities.

Participants that should be present at the conference include the D O O, Clinical Manager of the team being discussed, the Clinical Manager Assistant, if applicable, Case Managers or Primary Clinicians of the team being discussed, and full time clinicians, Program Managers, Medical Social Workers and Home Health Aides caring for patients in the team being discussed.

~~Dora is the DOO of a very large agency. She has 3 clinical managers overseeing multi-disciplinary teams within the office. Dora has set up a care team structure where each Clinical Manager facilitates individual care team conferences and then Dora meets with just the Clinical Managers on Friday to receive a summary of each meeting.~~

~~Do you agree that this is an effective way to manage care team conferences in large agencies (yes or no)?~~

~~Yes –~~

~~Although DOOs of larger agencies may have a greater challenge managing care team conferences, it is still a priority that the DOO facilitate care team conferences. Clinical Managers should play an active role in participating and presenting key information, but this should be done under the direction of the DOO. Larger agencies often manage care team conferences more efficiently by separating them into smaller subsets, but the DOO should still participate in each conference.~~

~~No –~~

~~You are correct. Although DOOs of larger agencies may have a greater challenge managing care team conferences, it is still a priority that the DOO facilitate care team conferences. Clinical Managers should play an active role in participating and presenting key information, but this should be done under the direction of the DOO. Larger agencies often manage care team conferences more efficiently by separating them into smaller subsets, but the DOO should still participate in each conference.~~

Stream 6: Ground Rules

Care Team Conference Ground Rules:

- Held weekly
- Have multidisciplinary representation (required by federal guidelines and Amedisys policy)
- Limit to 1 hour in duration
- Keep focus on the team conference agenda
- Demonstrate conference importance by honoring the scheduled date as well as the start and end time for the meetings
- Hold required participants accountable for attending and being prepared

Care team conferences are required to be held weekly and must have multidisciplinary representation in order to comply with federal guidelines and Amedisys policy. It is recommended that the conference be limited to 1 hour in duration to allow for an efficient and effective team meeting. The D O O should make it a priority to not allow outside distractions and other matters to take the focus away from the team conference agenda.

The D O O can show the team the priority and value of the conference by honoring the scheduled date as well as the start and end time for the meetings. If a meeting must be cancelled, ample notice should be given to ALL staff and the rescheduled date and time communicated promptly. The D O O should hold required participants accountable for attending and for being prepared to discuss their patients at the conference.

Stream 7: Care Team Conference Binder

Care Team Conference Binder:

- Used to organize reports and discussion points for the conference
- Divided into 12 monthly tabs
- Binder contents:
  - Agenda
  - Meeting minutes
  - Reports used to conduct conference
  - Conference notes

The D O O should create an annual Care Team Conference binder that will be used to organize reports and discussion points for the conference. In addition to using the binder to house reports that will be used to prepare and facilitate the meeting, the binder will also contain documentation that validates what was discussed at the conference.

The binder should be divided into 12 sections using Monthly tab dividers. Items that go into the binder include the care team conference agenda, meeting minutes, any reports used to conduct the conference, and notes taken during the conference.

Stream 8: Care Team Conference Agenda

Care Team Conference Agenda:

- Having a consistent agenda that is followed each week will guide the conference, keep participants on track and assure that critical elements are addressed.

Care Team Conference Agenda:

- Agenda items should include:
  - New admissions
  - Upcoming recertifications
  - Discharges (unplanned and upcoming)
  - Clinical Track Progress Report
  - Hospitalization / Emergent Care cases
  - Complex wound patients
  - High utilization / Complex cases / Multi-Disciplinary
  - Therapy utilization
  - High Priority Patient Events / Episode Management Alerts
  - "Clean Sweep"

Planned and structured care team conferences provide an opportunity for patients to be evaluated from the point of admission, throughout their care, and when a decision is made to recertify or discharge the patient. Having a consistent agenda that is followed each week will guide the conference, keep participants on track and assure that critical elements are addressed. The following topics are important agenda items for the weekly Care Team Conference.

New Admissions during the past week, patients up for recertification in the next week, unplanned discharges during the past week as well as planned discharges during the next week, a review of the Clinical Track Progress Report particularly as it relates to patients scheduled for discharge, patients hospitalized or needing emergent care during the past week, current patients with complex wounds, complex cases, including high utilization patients and multi-disciplinary patients, therapy utilization focusing on therapy need as it relates to the patient's functional assessment score, High Priority Patient Events and patients with episode management alerts, and a clean sweep, which is a clean up by the D O O of outstanding issues. Examples might include updating E P C codes based on patients with discussed status changes, a review of O C S data and other report findings that need further discussion.

Click the Care Team Conference Agenda graphic on this screen to download a copy of an agenda template. Once the file has been opened on your computer, you may click File and Save As to save the Word document on your hard drive where you may print or revise the template for use during future care team conferences.

Stream 9: Achieving Success

Achieving Success:

- Process can be effectively managed through preparation and a disciplined approach focused on the agenda
- Executive Indicators that are worked daily provide most needed resources
- Clinicians should come prepared with required information
- Clinicians are responsible for documenting care coordination details

We will now take a closer look at each agenda topic area and stress points that should be addressed by the D O O during the weekly care team conference. When first beginning this process, managing the meeting and associated information may seem daunting. With preparation and a disciplined approach focused on the agenda, the process can be effectively managed. Remember, that a well-orchestrated care team conference will provide the D O O with the necessary information to achieve top-level clinical and financial outcomes. Since the D O O works executive indicator reports daily, most of the preparation work will already have been completed. In addition, staff present at the conference should be held accountable for coming to the meeting with the necessary patient information. As patients are discussed in the conference, the primary clinician should document the details using the case conference report or the handwritten clinical conference note generated from the Clinical Manager dashboard. This documentation is necessary to demonstrate that care coordination has taken place. The note should then be signed by the appropriate team members and placed in the patient's clinical record.

Click the Care Team Conference Reports button to download and print a summary of resources that the D O O can use to investigate patients scheduled for conference. Not all resources may be necessary and others not listed may prove to be valuable. The intent is for the process to be patient rather than report-focused.

Stream 10: Admissions

New Admissions:

- New admissions since last conference
- Clinical manager and primary clinician should come prepared to discuss each patient
  - Plan of care
  - Interdisciplinary needs
  - Complex issues that affect care coordination
- Review referral orders and patient needs to assure they are implemented on plan of care

New Admissions:

- Preparation:
  - Have list of new admissions (AMS2 Patient Filter report; referral log)
  - Reports:
    - **Schedule Utilization Report** for clinical track information
    - **PPS Detail Report** for episode details

New Admissions:

- Examples of Questions:
  - What is the primary diagnosis?
  - Which discipline will have the greatest intensity and does it have a corresponding principle diagnosis to support it?
  - What is the disease management program and clinical track being used?
  - What is a brief history of the patient's condition?
  - What is the patient's history of emergent care use?
  - What is the patient's functional status based on the HHRG Functional score and does this functional status support the therapy and home health aide orders?

New Admissions:

- Examples of Questions:
  - Is there a resource that could help manage the patient's care?
  - If the patient is receiving a home health aide, is occupational therapy consulted?
  - Is the frequency and duration realistic to the patient's needs as identified on the comprehensive assessment and does it correlate to the clinical track guidelines?
  - If the patient is getting daily visits, is there an end point?
  - Has the assessment been processed in the Clinical Manager Dashboard?

New Admissions:

- Spending extra time reviewing patients at the time of admission will often prevent care problems from occurring during the episode

New admissions that have occurred since the last conference should be discussed during care team conference. The clinical manager and primary clinician should be prepared to discuss each patient, including the plan of care, interdisciplinary needs, and complex issues that affect care coordination in need of being resolved. This is a good time to review the initial referral orders to ensure they have been implemented on the plan of care.

To prepare for this discussion, the D O O should have a list of new admissions available to assure they are all discussed. The A M S 2 Patient Filter report filtered based on start of care date can provide all patients admitted during the past week. In addition, the agency's referral log can provide valuable information about patients whose admission has not yet been processed in the system or patients who were not admitted for further investigation.

As patients are discussed, the D O O should quiz the clinical manager and primary clinician to verify that the patient was appropriately placed on a clinical track. The Schedule Utilization Report sorted by admit agent or clinical manager provides clinical track information. Having a copy of the P P S Detail Report will provide valuable episode information including episode flags or alerts and revenue details, such as potential LUPAs. This report also provides information on the number of disciplines scheduled and the patient's H H R G score allowing the D O O to validate with the team whether services have been ordered appropriately. The D O O can use this report to validate that admissions have been processed in the system timely as the Cost and Profit and Loss columns remain at 0 until the patient's file has been imported into A M S 2 after the OASIS and 485 have been reviewed.

Examples of questions that the D O O may ask to gain better knowledge of each new admission to assure each is being effectively managed include

What is the primary diagnosis?

Which discipline will have the greatest intensity and does it have a corresponding principle diagnosis to support it?

What is the disease management program and clinical track being used?

What is a brief history of the patient's condition?

What is the patient's history of emergent care use? If high, the D O O may want to place the patient on an alert status for closer follow up, including Friday Calls.

What is the patient's functional status based on the H H R G Functional score and does this functional score support the therapy and home health aide orders?

Is there a resource that could help manage the patient's care, such as telemedicine for wounds, a program manager, medical social worker for long-range planning, other

experienced staff for unique problems, or physical or occupational therapy for functional deficits?

If the patient is receiving a home health aide, is occupational therapy consulted?

Is the frequency and duration realistic to the patient's needs as identified on the comprehensive assessment and does it correlate to the clinical track guidelines?

If the patient is getting daily visits, is there an end point?

And has the assessment been processed in the Clinical Manager Dashboard?

Spending extra time reviewing patients at the time of admission will often prevent care problems from occurring during the episode.

Stream 11: Recertifications

Recertifications:

- Discuss patients up for recertification in the next 2 to 3 weeks
- Prepare by running the **Recertification Report** (AMS2, Report Writer)
  - Recert Forthcoming
  - Recert Past Due
- Evaluate **Clinical Track Progress Report** for successful completion of clinical tracks

Recertifications:

- Examples of Questions:
  - Is the patient going to be recerted and for what reason?
  - Is the patient in the hospital during the recert window?
  - Does the patient have any new or changed medications?
  - Has the patient had any new treatment orders?
  - Has the patient met all outcomes on the clinical track?
  - Is the clinical track complete?

Recertifications:

- Examples of Questions:
  - Are there any variances on the clinical track and, if so, what can be done to correct them?
  - Has there been any emergent care or acute care admissions?
  - Does the patient still have a home health aide?
  - Does the patient have any new rehab needs?
  - Does the patient need any additional resources?
  - Is the patient still homebound?

Recertifications:

- These questions should guide the DOO in evaluating whether the patient has continued needs for home care, at which point, recertification would be supported

Patients who are up for recertification within the upcoming two to three weeks should also be discussed during care team conference. To prepare for this review, the D O O should run the Recertification report from A M S 2 Report Writer. This report should be filtered as a Recert Forthcoming report with the beginning and ending dates set 7 to 21 days in the future to generate a list of patients with a cert to date expiring during that time. Once again, it is important for the clinical manager and primary clinician to come prepared to discuss patients listed on the recert forthcoming report, so providing them a list of patients ahead of schedule is essential.

The D O O should also run the Recertification Report as Recert Past Due with the cert to date the same date as the case conference to evaluate active patients who have not been discharged and whose certification period has expired. This is done to verify that there are no active patients who were not recertified in the required 5 day window. Any identified late recerts should have an action plan established with the primary clinician for getting the recertification documentation submitted to the office as quickly as possible. Patients who will not be recertified should have associated discharge documentation completed as appropriate.

All patients up for recertification should be evaluated on the Clinical Track Progress report to assure that all clinical track teaching has been completed.

Important questions to ask during recertification part of the care team conference include

Is the patient going to be recerted and for what reason?

Is the patient in the hospital during the recert window? Clinicians should be directed that if the patient is in the hospital and comes home in the 5 day recert window, a Resumption of Care OASIS assessment should be completed, including all 485 locators. The Follow-up Recertification OASIS assessment is not necessary. A physician order must also be written to cover the time frame from the resumption of care date through the end of episode. If the patient comes home on Day 60, the patient must be discharged and readmitted with a new start of care assessment, unless the patient must be seen on Day 60 for a specific treatment ordered by the physician, such as infusion, wound care, or tube feeding teaching, at which point a resumption of care assessment should be completed, including all 485 locators. The clinician should be directed that a new start of care assessment must be completed for all patients discharged on day 61 or later.

Does the patient have any new or changed medications? If so, consider recertification.

Has the patient had any new treatment orders? If so, consider recertification.

Has the patient met all outcomes on the clinical track?

Is the clinical track complete?

Are there any variances on the clinical track and, if so, what can be done to correct them?

Has there been any emergent care or acute care admissions? If so consider recertification.

Does the patient still have a home health aide? If so, does the functional needs of the patient match the intensity of home health aide services? Consider reducing services as the patient's functional status improves. Consider occupational therapy services for patients with no improvement.

Does the patient have any new rehab needs?

Does the patient need any additional resources?

Is the patient still homebound?

These questions should guide the D O O in evaluating whether the patient has continued needs for home care, at which point, recertification would be supported.

Stream 12: Discharges

Discharges:

- All upcoming *planned* discharges that are scheduled to occur 2 to 3 weeks out should be discussed during care team conference
- The **Discharge Criteria Checklist** drives discussion and is used to assess the patient's readiness for discharge
- Evaluate the **Clinical Track Progress Report** to assure all clinical tracks have been completed prior to discharge
- Review *unplanned* discharges that occurred during the past week

Discharges:

- Examples of Questions:
  - Has the Discharge Criteria Checklist been reviewed and does it support discharge?
  - Is the patient being discharged needing wound care, toileting assistance or having behavioral problems? These might lead to tier 2 adverse events
  - Is the clinical track complete and have all outcomes been met?
  - Has the patient's OASIS outcomes improved since admission?
  - Have there been any new or changed medications? If so, consider postponing discharge.

Discharges:

- Examples of Questions 2:
  - Has the patient had any new treatment orders? If so, consider postponing discharge.
  - Has there been an emergency room or acute care visit?
  - Are there continued skilled needs or any other continuing needs?
  - Is the patient still homebound?
  - Has discharge planning taken place and been communicated and documented?

Discharges:

- Examples of Questions 3:
  - Are all disciplines aware of the pending discharge? If a home health aide or medical social worker is still visiting, is there a plan to stop them prior to the discharge visit?
  - If this is only a discipline discharge, which skilled service will supervise the home health aide?
  - Are there any community resources that need to be coordinated?
  - Are the patient and family aware of the discharge?
  - Has the physician been notified of the discharge and is this documented? If needed, has an order been obtained?

Discharges:

The DOO should use this part of the conference to assess for issues that might signal that a patient is not appropriate for discharge, such as a patient who has not achieved optimal outcomes, a patient who is at risk for exacerbation or hospital readmission, or a patient whose clinical track has not been completed

A discussion on upcoming discharges is one of the most important agenda items for Care Team Conference. Assuring that patients are ready for discharge is critical to achieving positive outcomes for the agency and, more importantly, the patient. All upcoming discharges that are planned to occur 2 to 3 weeks out should be discussed during each conference.

The Amedisys Discharge Criteria Checklist is the tool that should drive the discussion and is used to assess the patient's readiness for discharge. The checklist addresses such subjects as whether the patient has experienced emergent care or acute care hospitalization during the episode, whether the patient is prescribed a high number of medications that would likely require additional teaching or follow up, whether the patient had any status or order changes during the previous 3 weeks that would require additional skilled observation, and whether there are additional high risk situations going on with the patient that should delay discharge. Clinical points and questions to consider are located on the bottom of the form to support the best decision related to discharge. This tool should be completed by the primary clinician, in consultation with the clinical manager, prior to the care team conference and should be brought to the meeting to guide the discussion.

The Clinical Track Progress Report should also be printed for each scheduled discharge and reviewed during the conference to assure that all clinical track teaching has been completed.

In addition to planned upcoming discharges, unplanned discharges that occurred during the past week should also be addressed during the care team conference to assure that

proper actions have been taken to secure the patient's clinical record contents and tie up any loose ends. The D O O should use this as an opportunity to identify situations where unplanned discharges occurred that could have been better planned.

Questions that may be asked during this part of the care team conference include

Has the Discharge Criteria Checklist been reviewed and does it support discharge?

Is the patient being discharged needing wound care, toileting assistance or having behavioral problems? These might lead to tier 2 adverse events

Is the clinical track complete and have all outcomes been met?

Has the patient's OASIS outcomes improved since admission?

Have there been any new or changed medications? If so, consider postponing discharge.

Has the patient had any new treatment orders? If so, consider postponing discharge.

Has there been an emergency room or acute care visit?

Are there continued skilled needs or any other continuing needs?

Is the patient still homebound?

Has discharge planning taken place and been communicated and documented?

Are all disciplines aware of the pending discharge? If a home health aide or medical social worker is still visiting, is there a plan to stop them prior to the discharge visit?

If this is only a discipline discharge, which skilled service will supervise the home health aide?

Are there any community resources that need to be coordinated?

Are the patient and family aware of the discharge?

Has the physician been notified of the discharge and is this documented? If needed, has an order been obtained?

The D O O should use this part of the conference to assess for issues that might signal that a patient is not appropriate for discharge, such as a patient who has not achieved optimal outcomes, a patient who is at risk for exacerbation or hospital readmission, or a patient whose clinical track has not been completed.

Stream 13: Clinical Track Progress Report

Clinical Track Progress Report:

- All patients to be discussed should have a Clinical Track Progress Report printed and reviewed
- Best to assign one clinician from each team to review components as patients are discussed
- **Before a patient is recertified or discharged, the clinical track must be complete**

In preparation for each care team conference, all patients to be discussed should have a clinical track progress report printed from A M S 2 Report Writer. This process works best if the D O O designates a clinician on each team to review the patient specific teaching elements listed on the clinical track progress report as patients are discussed and report the status of the track to the team. Before a patient is recertified or discharged, the clinical track must be complete.

Stream 14: Hospitalizations and Emergent Care

Hospitalizations and Emergent Care:

- Involve all team members in discussion of patients hospitalized or needing emergent care
- Involve Account Executive or Account Manager in liaison activities while patient is in hospital
- Investigate the cause of hospitalization and begin developing post-resumption care plan to reduce future re-hospitalization
- Patients needing emergent care should be placed on an elevated monitoring status to prepare for and guard against future acute care needs

Hospitalizations and Emergent Care:

- Examples of Questions:
  - What was the reason for hospitalization or emergent care?
  - Are all clinicians involved in the patient's care aware of the hospitalization?
  - Has the account executive or account manager been notified of the hospitalization?
  - Were there any missed home care visits prior to the hospitalization or emergent care?
  - Did the patient have any order or medication changes prior to hospitalization or emergent care?

Hospitalizations and Emergent Care:

- Examples of Questions 2:
  - Did the patient contact the home health agency prior to seeking hospitalization or emergent care?
  - Could any home care actions have prevented or reduced the chance that the patient would have needed hospitalization or emergent care?
  - Will the patient have any special post-resumption needs for which the team should begin preparing?

Hospitalizations and Emergent Care:

Discussing these patients during care team conference has several purposes.

1. To be prepared to effectively resume care once the patient comes home
2. To have the liaison business development team on hand in the acute care setting to facilitate resumption of care and the required care communication needs
3. To provide learning opportunities for the team to reduce the chance that the patient will require emergent care in the future.

Patients who have been hospitalized or have received emergent care in the past week should be included in the care team agenda. The primary clinician and clinical manager should come to the conference prepared to discuss these patients. All team members involved in the care of hospitalized patients should be involved at this time with planning and preparation for resuming care. In addition, appropriate business development employees, such as account executives and account managers should be involved to monitor the patient while in the hospital. D O Os should quiz the primary clinician on the cause of hospitalization and any risk factors that can be added to the patient's post-resumption care plan that could reduce the incidence of re-hospitalization in the future.

Patients who have received emergent care in the past week should be placed on an elevated monitoring status to prepare for and guard against future acute care needs.

The Hospitalized Patient Report from A M S 2 Report Writer may be run to provide a list of patients hospitalized, however, this report does not include all emergent care.

Questions that may be asked during this part of the conference include

What was the reason for hospitalization or emergent care?

Are all clinicians involved in the patient's care aware of the hospitalization?

Has the account executive or account manager been notified of the hospitalization?

Were there any missed home care visits prior to the hospitalization or emergent care?

Did the patient have any order or medication changes prior to hospitalization or emergent care?

Did the patient contact the home health agency prior to seeking hospitalization or emergent care?

Could any home care actions have prevented or reduced the chance that the patient would have needed hospitalization or emergent care?

Will the patient have any special post-resumption needs for which the team should begin preparing?

Discussing these patients during care team conference has several purposes. The first is to be prepared to effectively resume care once the patient comes home. The second is to have the liaison business development team on hand in the acute care setting to facilitate resumption of care and the required care communication needs. And third these conversations provide learning opportunities for the team to reduce the chance that the patient will require emergent care in the future.

Stream 15: Complex wound patients

Complex Wound Patients:

- Discussed to assure that optimal wound management is occurring and that available company wound expertise and resources are being used
- PPS Detail Report and Supply Exception Report are good resources for this part of the conference

Complex Wound Patients:

- Examples of Questions:
  - What is the status of the wound and is there progression in wound healing?
  - What is the current wound treatment and orders?
  - When was the last time the treatment was changed?
  - Has the Telemedicine Wound specialist been consulted in the care of the patient and, if so, what recommendations were made? Were these recommendations implemented?

Complex Wound Patients:

- Examples of Questions:
  - When was the last wound photograph taken? Have wound photos been filed in the patient's clinical record. Have requested photos been sent to the Telemedicine Wound Specialist?
  - Has a nutritional assessment been done and nutritional interventions implemented?
  - Has the patient had any recent labs to assess nutritional status?
  - Has the patient been screened for appropriate bedding and an alternative surface for pressure relief?

Complex Wound Patients:

As the DOO reviews these patients, it is important to assess that the patient is being managed holistically to effectively impact as many risk factors as possible to promote wound healing.

In addition, the DOO should validate that all available resources are being utilized to manage the patient, including the Telemedicine Wound department.

Patients with complex wounds are often clinical challenges for the agency and should be discussed during the care team conference. It is important that these patients be closely managed to assure that optimal wound management is occurring and that available company wound expertise and resources are being used. Primary clinicians caring for patients with complex wounds should come to the conference prepared to discuss these patients.

The P P S Detail Report from A M S 2 Report Writer filtered for active patients with top wound diagnoses is an effective resource for this part of the conference and allows the D O O to evaluate costs versus revenue. The Supply Exception Report from A M S 2 Report Writer filtered for active patients with top wound diagnoses may also be used to evaluate supply utilization.

Questions that may be asked by the D O O during this part of the conference to facilitate the discussion include

What is the status of the wound and is there progression in wound healing?

What is the current wound treatment and orders?

When was the last time the treatment was changed?

Has the Telemedicine Wound specialist been consulted in the care of the patient and, if so, what recommendations were made? Were these recommendations implemented?

When was the last wound photograph taken? Have wound photos been filed in the patient's clinical record. Have requested photos been sent to the Telemedicine Wound Specialist?

Has a nutritional assessment been done and nutritional interventions implemented?

Has the patient had any recent labs to assess nutritional status?

Has the patient been screened for appropriate bedding and an alternative surface for pressure relief?

As the D O O reviews these patients, it is important to assess that the patient is being managed holistically to effectively impact as many risk factors as possible to promote wound healing. In addition, the D O O should validate that all available resources are being utilized to manage the patient, including the Telemedicine wound department.

Stream 16: Multi-Disciplinary / High utilization / Complex cases

Multidisciplinary / High Utilization / Complex Cases:

- One of the primary purposes of the care team conference is to assure that multiple clinicians caring for a patient are doing an effective job coordinating care
- Care team conference provides an excellent opportunity to assure that multi-disciplinary cases are effectively working together to achieve the best patient outcomes and resource utilization
- The PPS Detail Report provides episode summary details including disciplines ordered for each patient as well as associated revenue and costs

Multidisciplinary / High Utilization / Complex Cases:

- Examples of Questions:
  - Are the ordered services congruent with the patient's assessment results?
  - Are the patient's assessment results accurately capturing the patient's home care needs?
  - As the patient's clinical and functional outcomes improve, is utilization being modified appropriately?
  - Is the patient being managed holistically so all risk factors are incorporated into the care plan?
  - Are there any family or community resources that can be brought in to support the care plan?

Multidisciplinary / High Utilization / Complex Cases:

In addition to using the care team conference as a means to assure that all disciplines are fully incorporated into an all-encompassing care plan, the DOO should also assure that this care coordination is documented and present in the clinical record

Lack of documentation that care coordination is effectively taking place is one of the most often-cited survey deficiencies

A well-documented care team conference is a valuable mechanism that can be used to validate that this required care component is occurring

One of the primary purposes of the care team conference is to assure that multiple clinicians caring for a patient are doing an effective job coordinating care. While coordination of care often occurs informally outside of the team conference, the actual conference provides an excellent opportunity to assure that multi-disciplinary cases are effectively working together to achieve the best patient outcomes and resource utilization. Often multidisciplinary cases are also patients that have high resource utilization and are complex cases that require close monitoring. The primary clinician, clinical manager and other clinicians caring for the patient should come to the conference prepared to discuss these patients.

The P P S Detail Report printed from A M S 2 Report Writer provides episode summary details including disciplines ordered for each patient as well as associated revenue and costs.

Questions that may be asked by the D O O during this part of the conference include

Are the ordered services congruent with the patient's assessment results?

Are the patient's assessment results accurately capturing the patient's home care needs?

As the patient's clinical and functional outcomes improve, is utilization being modified appropriately?

Is the patient being managed holistically so all risk factors are incorporated into the care plan?

Are there any family or community resources that can be brought in to support the care plan?

In addition to using the care team conference as a means to assure that all disciplines are fully incorporated into an all-encompassing care plan, the D O O should also assure that this care coordination is documented and present in the clinical record. Lack of documentation that care coordination is effectively taking place is one of the most often cited survey deficiencies. A well-documented care team conference is a valuable mechanism that can be used to validate that this required care component is occurring.

Stream 17: Therapy utilization

Therapy Utilization:

- Therapy services are typically resource-intensive
- Therapy services can significantly impact the episode payment
- Therapy utilization should largely correlate with the patient's functional needs as captured on the OASIS assessment
- Executive Indicators and Therapy Alert Report alert the DOO when discrepancies exist between the functional assessment score and the ordered therapy services

Therapy Utilization:

- Examples of Questions:
  - What is the patient's rehab potential?
  - Does the patient have any balance issues that might create a high risk for falls?
  - How does the patient's functional HHRG score relate to the established care plan?
  - Is the patient appropriate for other therapy services or disciplines?
  - Have any missed visits occurred that might impact achieving the established care plan and visit threshold? If so, are there plans to make up these visits?

Therapy Utilization:

Effectively utilizing therapy services in home care increases the opportunity of improved patient outcomes, reduces the incidence of re-hospitalization due to falls or injuries, and allows the patient to achieve independence more quickly

Patients receiving physical, occupational and or speech therapy often pose a special management challenge in that these patients are typically resource intensive. In addition, therapy patients must be assessed accurately since the results can significantly impact the episode payment related to the service utilization domain should the patient receive 10 or more therapy visits. Therapy utilization should largely correlate with the patient's functional needs as captured on the OASIS comprehensive assessment.

The Executive Indicators, worked on a daily basis, alert the D O O when discrepancies exist between a patient's functional assessment score and the actual therapy services ordered. During care team conference, the team should further discuss any alerts identified as well as the utilization of therapy patients in general.

The Therapy Alert Report printed from A M S Report Writer may be used to focus further on these patients. The D O O should discuss the therapy patients listed on the report that are close to the 10-visit threshold to identify whether or not the treatment plans are appropriate and to assess the status of meeting the threshold.

Questions that may be asked during this part of the conference include

What is the patient's rehab potential?

Does the patient have any balance issues that might create a high risk for falls?

How does the patient's functional H H R G score relate to the established care plan?

Is the patient appropriate for other therapy services or disciplines?

Have any missed visits occurred that might impact achieving the established care plan and visit threshold? If so, are there plans to make up these visits?

Effectively utilizing therapy services in home care increases the opportunity of improved patient outcomes, reduces the incidence of re-hospitalization due to falls or injuries, and allows the patient to achieve independence more quickly.

Stream 18: High Priority Patient Events / Episode Management Alerts

High Priority Patient Events / Episode Management Alerts:

- The DOO should use the care team conference to tie up loose ends related to **High Priority Patient Events** and **Episode Management alerts**
- **High Priority Patient Events** should be evaluated for the need to intensify home care services to decrease the likelihood that the patient will require emergent care or re-hospitalization
- **Episode Management alerts** focus on LUPAs and therapy patients with 7-9 visits

High Priority Patient Events / Episode Management Alerts:

- Examples of Questions:
  - How has the patient's assessment changed?
  - Would the patient benefit from a change in the treatment plan or additional services based on the change in condition?
  - Should this patient be placed on high risk monitoring to decrease the chance of emergent care or re-hospitalization, such as being included on the Friday call list?

High Priority...

If High Priority Patient Events and Executive Indicators are worked daily, little discussion time will be needed during this part of the conference

The D O O should use the care team conference to tie up loose ends related to High Priority Patient Events and Episode Management alerts.

High Priority Patient Events are worked on a daily basis by the clinical manager as part of the Clinical Manager Dashboard and involve abnormal clinical assessment findings that have been documented by the clinician within the P O C application. Many times the triggers indicate a change between two assessment results, such as a weight gain in a congestive heart failure patient. These patients should be evaluated for the need to intensify home care services to decrease the likelihood that the patient will require emergent care or re-hospitalization.

The Episode Countdown report printed from A M S 2 Report Writer includes actual or potential patients with less than 5 visits for the episode, indicating they may fall under the Low Utilization Payment Adjustment or LUPA. D O Os should quiz clinicians to determine if any changes in the patient's status have occurred that might allow for justifiably increasing the episode visits. This report also lists therapy patients with 7 to 9 visits, indicating they are close to meeting the 10-visit threshold.

The D O O should also use this part of the conference to discuss other unresolved episode management issues, such as OASIS and coding inconsistencies as well as observed trends seen within the agency.

Questions that may be asked during this part of the conference include:

How has the patient's assessment changed?

Would the patient benefit from a change in the treatment plan or additional services based on the change in condition?

Should this patient be placed on high risk monitoring to decrease the chance of emergent care or re-hospitalization, such as being included on the Friday call list?

It is important to note that if the High Priority Patient Events and Executive Indicators are worked daily, little discussion time will be needed during this part of the conference.

Stream 19: "Clean Sweep"

"Clean Sweep":

The final portion of the care team conference involves performing a clean sweep where any unresolved issues that have not been previously included get discussed.

Topics that are often included in the clean sweep include:

- Coding inconsistencies
- Scheduling issues
- Identified trends

"Clean Sweep":

The DOO may also effectively use this part of the conference to focus on staff teaching topics that will promote more effective patient and visit management.

A DOO who focuses more on increasing the knowledge of team members instead of merely corrected performance issues will have much greater outcomes in the long run. Successful DOOs look for performance trends and use those opportunities to educate team members so they become part of the solution.

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Stream 20: Tips for Success

Tips for Success:

Because effectively run case conferences are probably the single most critical activity that can occur in an agency to promote financial success and positive patient outcomes, DOOs should make them a consistent priority in the agency.

The following tips are important for success...

Tips for Success:

- Notify your staff well in advance of the care team conference schedule, including the date, time, and place. Be consistent with the conference schedule so employees develop positive attendance habits.
- Avoid canceling the conference at the last minute, except under a true emergency. Canceling due to staffing issues or other priorities lessens the perceived significance of the conference.
- Start on time and end on time so team members develop trust in your commitment to the conference and their time.
- Come to the conference prepared and organized as a courtesy and sign of respect to team members.
- Stick to the agenda and refrain from distractions that add to the length of the meeting. Avoid discussing non-conference issues during the meeting.

Tips for Success:

- Keep the conference positive.
- Hold staff accountable for their own conference preparation.
- Refrain from conducting staff counseling sessions during the conference. Accountability or other performance issues should be managed in a private coaching session.
- Maintain open lines of communication. Lead the conference with open-ended questions that allow team members to supply critical information and positive input.
- Avoid leading a conference that focuses on reports instead of the patient. Reports should provide only one component of the information discussed and should support, not control the team's discussion.

Tips for Success:

By leading an organized care team conference, team members will value and learn from the process. Ultimately the meeting will achieve the desired outcomes. Well-orchestrated care team conferences not only benefit the agency's patients, but they also build a solid team that works in sync together to improve the agency's communication, processes and results.

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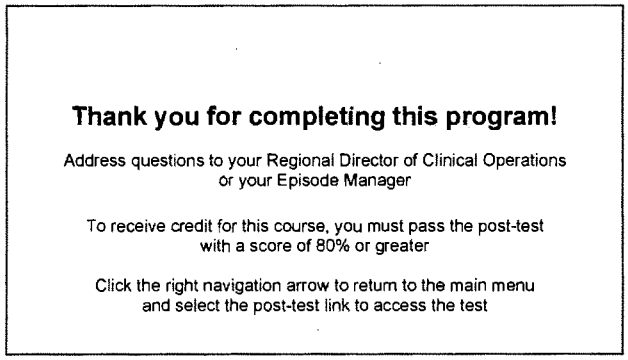
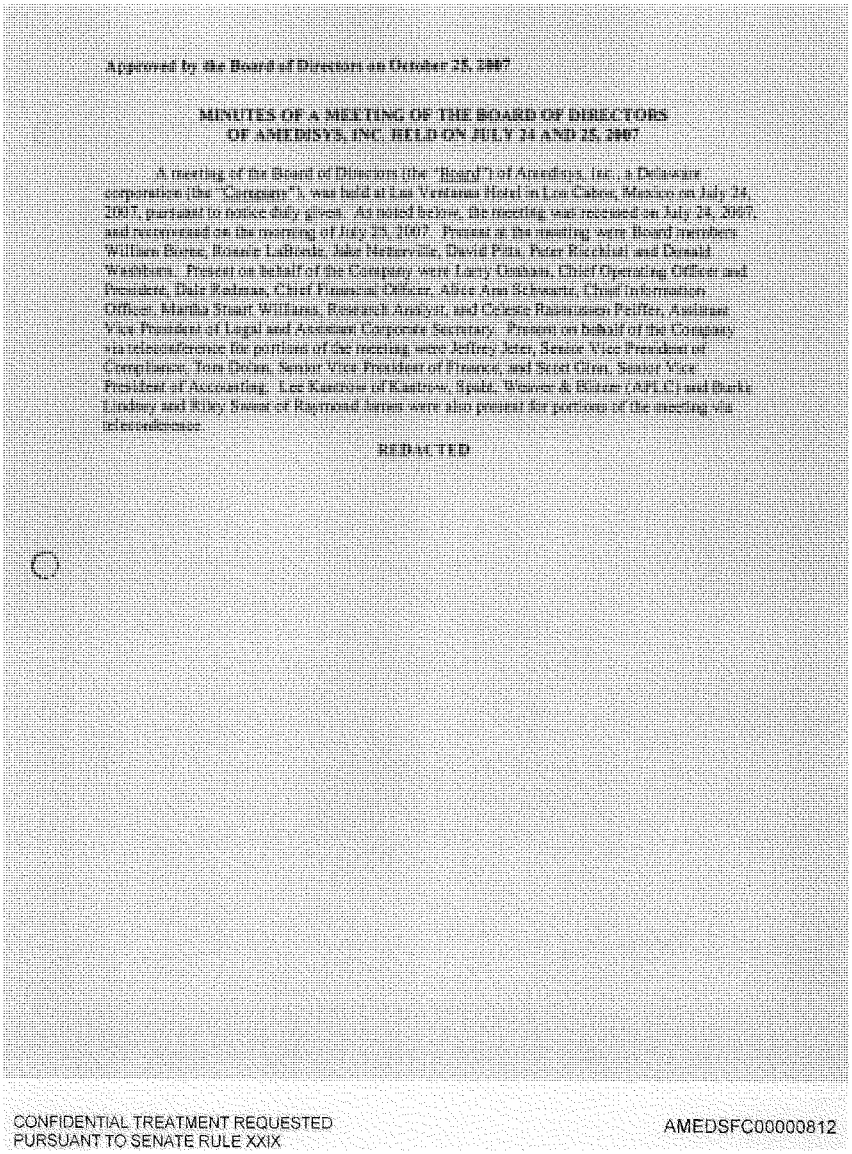
Steam 21: Conclusion



Thank you for completing this program. We hope this information has provided you with valuable information on organizing and facilitating care team conferences in your agency. Please address questions to your Regional Director of Clinical Operations or your Episode Manager.

To receive credit for this course, you must pass the post-test with a score of 80 percent or greater. Click the right navigation arrow to return to the main menu and select the post-test link to access the test.

Footnote 25, 26



Approved by the Board of Directors on October 25, 2007

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS OF AMEDISYS, INC. HELD ON JULY 24 AND 25, 2007

A meeting of the Board of Directors (the "Board") of Amedisys, Inc., a Delaware corporation (the "Company"), was held at Las Ventanas Hotel in Los Cabos, Mexico on July 24, 2007, pursuant to notice duly given. As noted below, the meeting was recessed on July 24, 2007, and reconvened on the morning of July 25, 2007. Present at the meeting were Board members William Borne, Ronnie LaBrum, Jake Netterville, David Pitts, Peter Ricchiuti and Donald Washburn. Present on behalf of the Company were Larry Graham, Chief Operating Officer and President, Dale Redman, Chief Financial Officer, Alice Ann Schwartz, Chief Information Officer, Martha Stuart Williams, Research Analyst, and Celeste Rasmussen Peiffer, Assistant Vice President of Legal and Assistant Corporate Secretary. Present on behalf of the Company via teleconference for portions of the meeting were Jeffrey Jeter, Senior Vice President of Compliance, Tom Dolan, Senior Vice President of Finance, and Scott Ginn, Senior Vice President of Accounting. Lee Kantrow of Kantrow, Spaht, Weaver & Blitzer (APLC) and Burke Lindsey and Riley Sweet of Raymond James were also present for portions of the meeting via teleconference.

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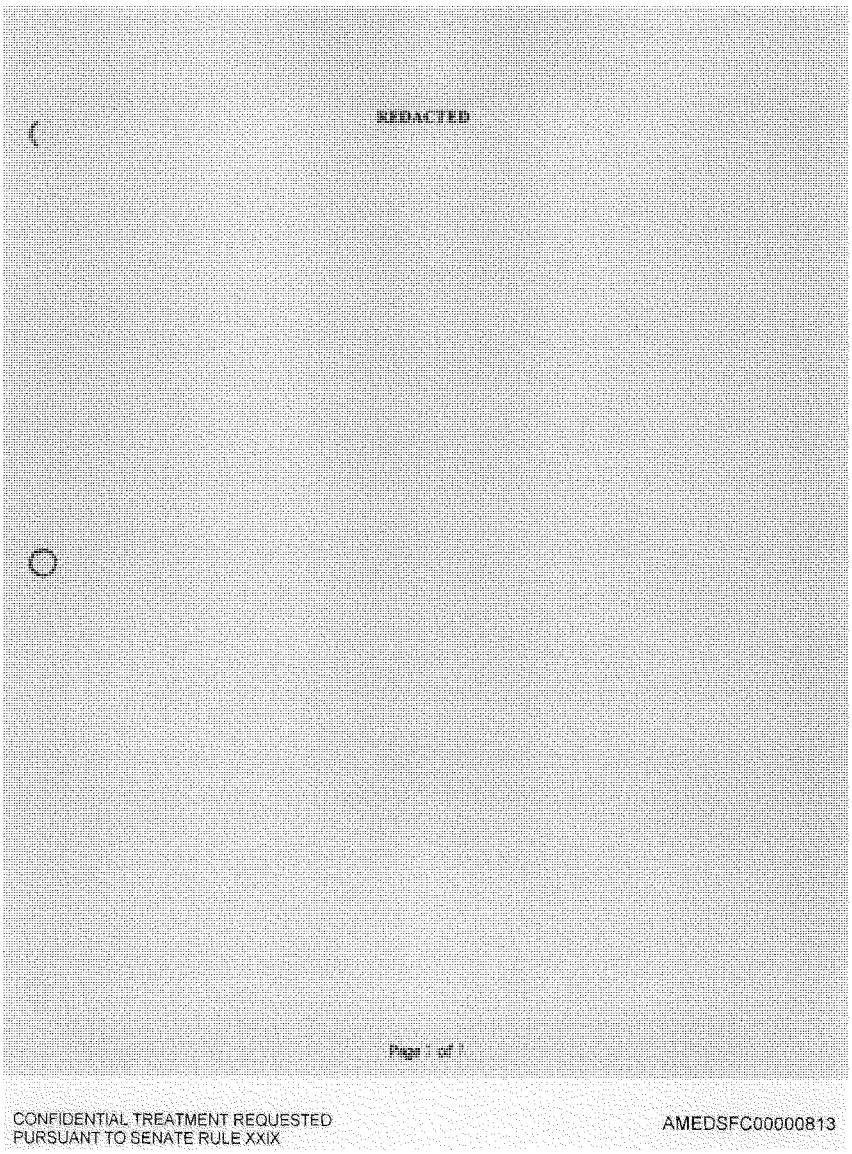
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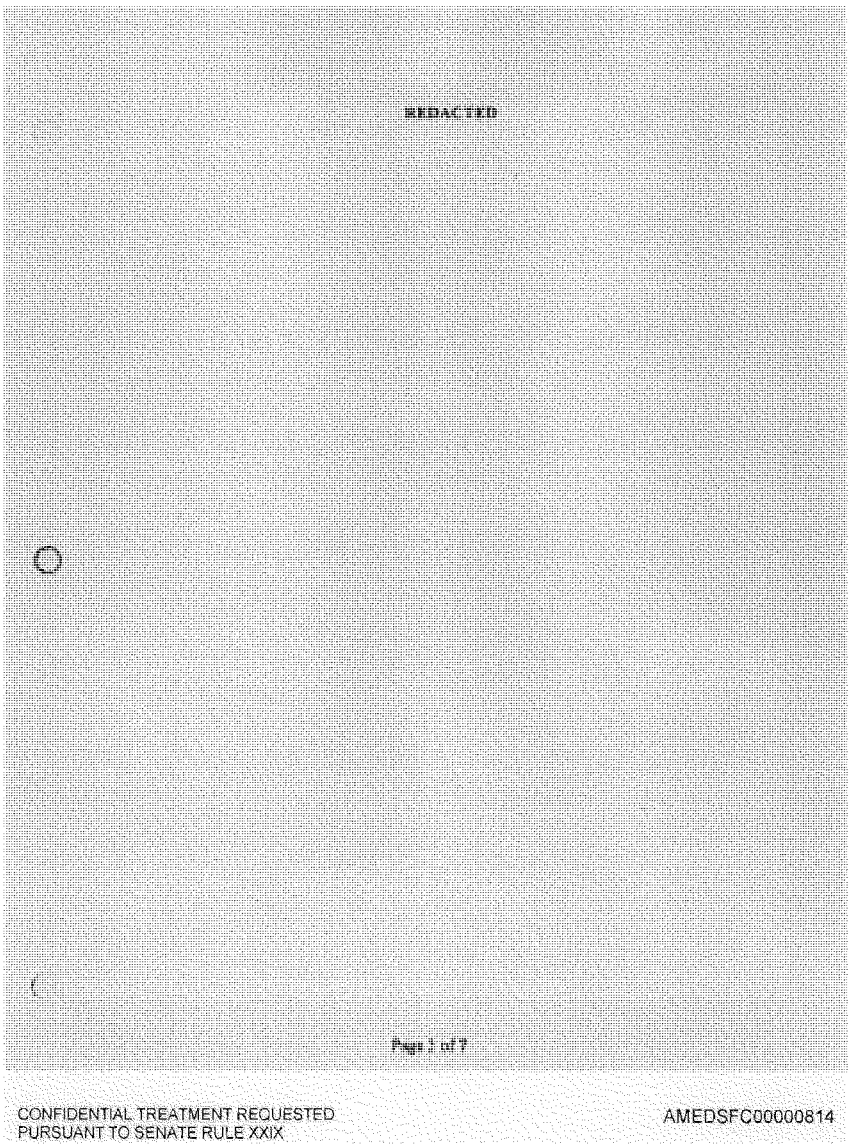

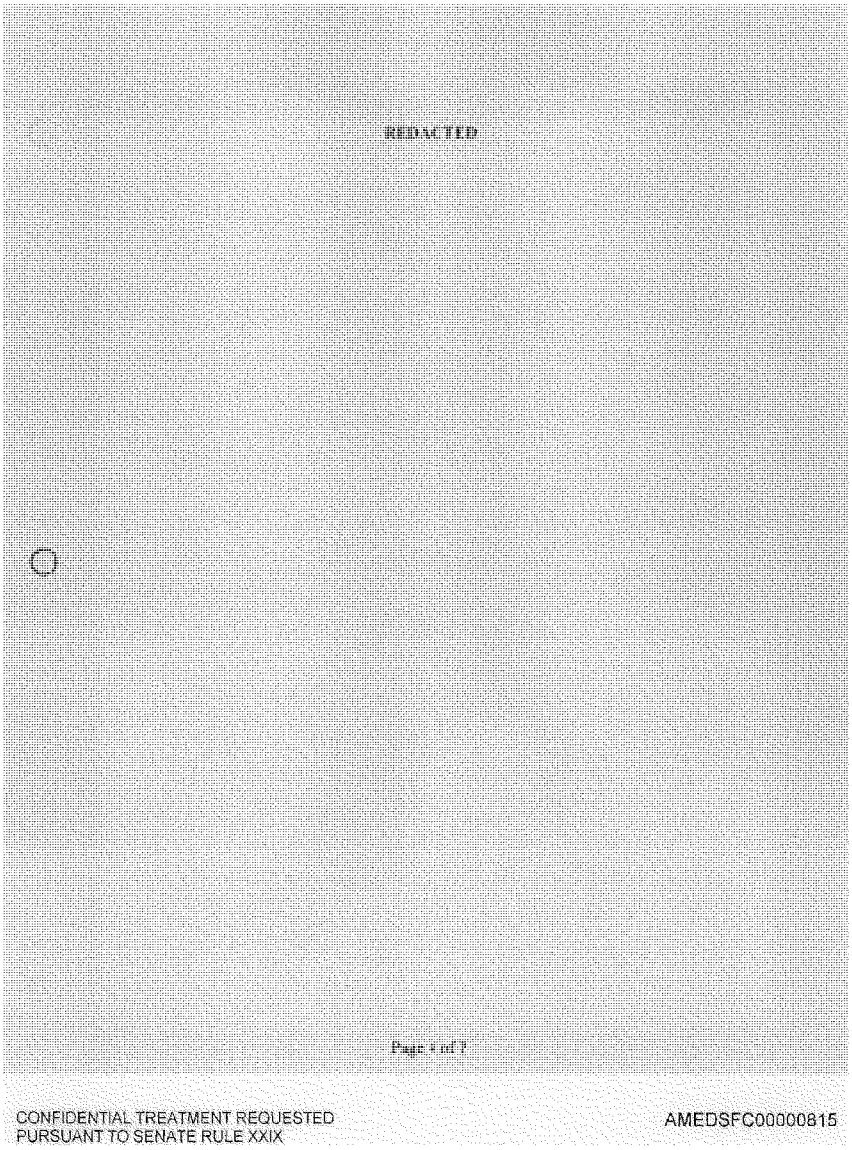

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Ms. Schwartz addressed the "case mix adjustment" rules recently proposed by the Centers for Medicare and Medicaid Services ("CMS") and informed the Board that the Company had formed a committee called the "A-Team" whose specific purpose was to develop strategic clinical programs and cost-cutting/efficiency measures to address the proposed case mix refinement. She noted that this committee was meeting on a bi-monthly basis. During her presentation, Ms. Schwartz responded to various questions from the Board members.

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Page 7 of 7

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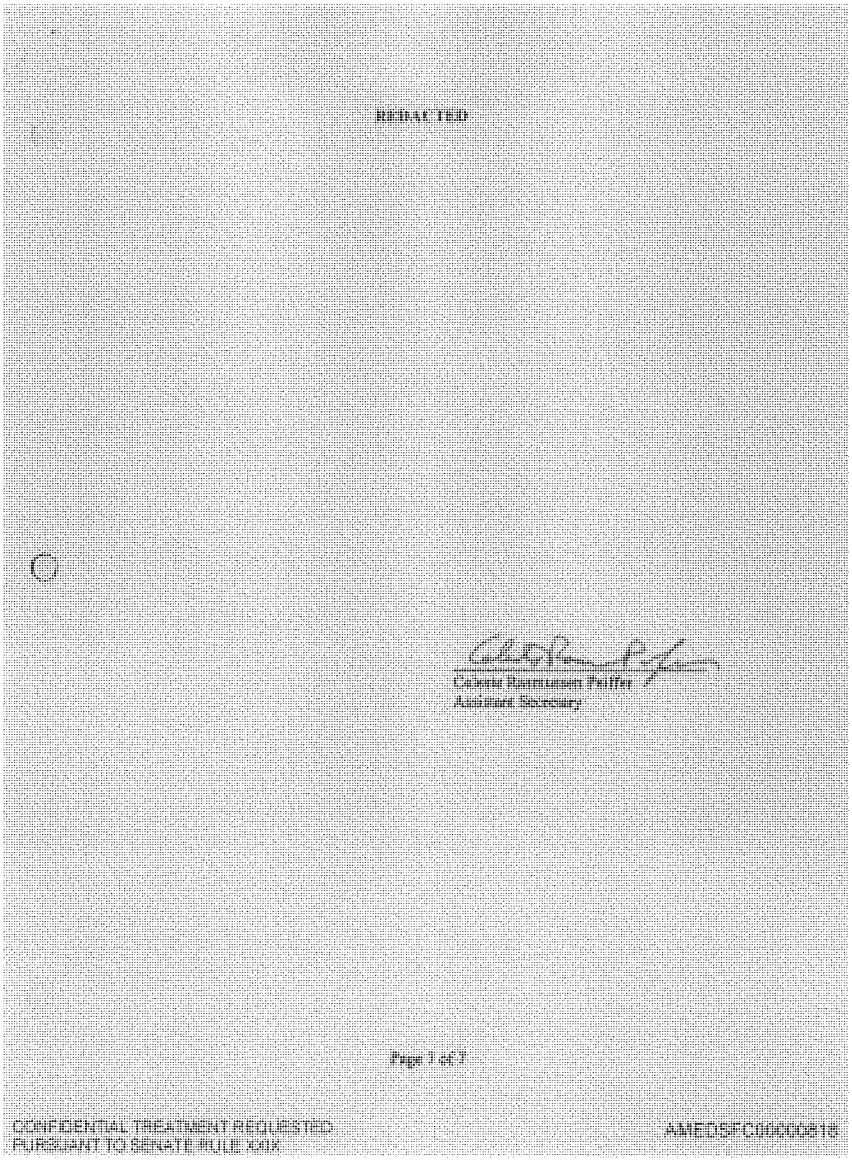

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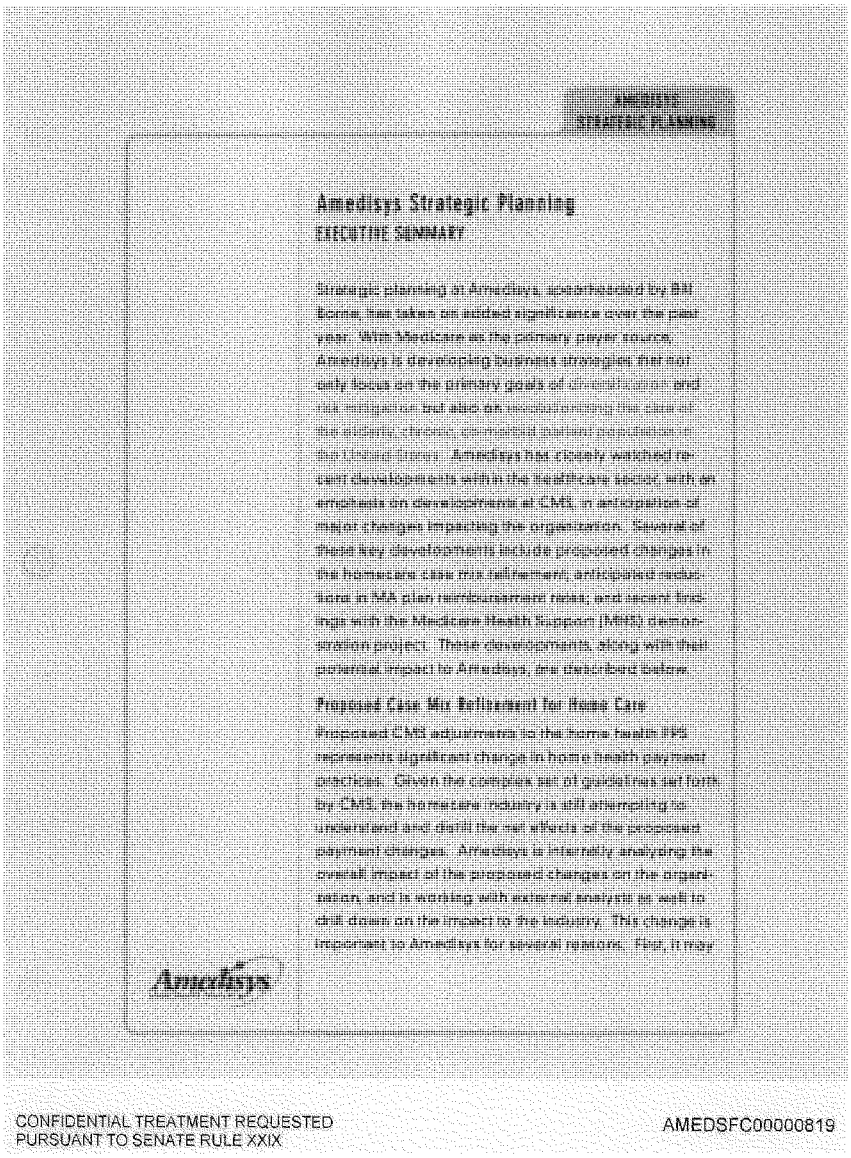
Colleen Patrumonn Peiffer
Assistant Secretary



AMEDISYS
STRATEGIC PLANNING

Amedisys Strategic Planning

EXECUTIVE SUMMARY

Strategic planning at Amedisys, spearheaded by Bill Borne, has taken on added significance over the past year. With Medicare as the primary payer source, Amedisys is developing business strategies that not only focus on the primary goals of [illegible] and risk mitigation but also on accommodating the ease of the patient, chronic, co-morbid patient population in the United States. Amedisys has closely watched recent developments within the healthcare sector, with an emphasis on developments at CMS, in anticipation of major changes impacting the organization. Several of these key developments include proposed changes in the homecare case mix refinement; anticipated reductions in MA plan reimbursement rates; and recent findings with the Medicare Health Support (MHS) demonstration project. These developments, along with their potential impact to Amedisys, are described below.

Proposed Case Mix Refinement for Home Care

Proposed CMS adjustments to the home health PPS represents significant change in home health payment practices. Given the complex set of guidelines set forth by CMS, the homecare industry is still attempting to understand and distill the net effects of the proposed payment changes. Amedisys is internally analyzing the overall impact of the proposed changes on the organization, and is working with external analysts as well to drill down on the impact to the industry. This change is important to Amedisys for several reasons. First, it may

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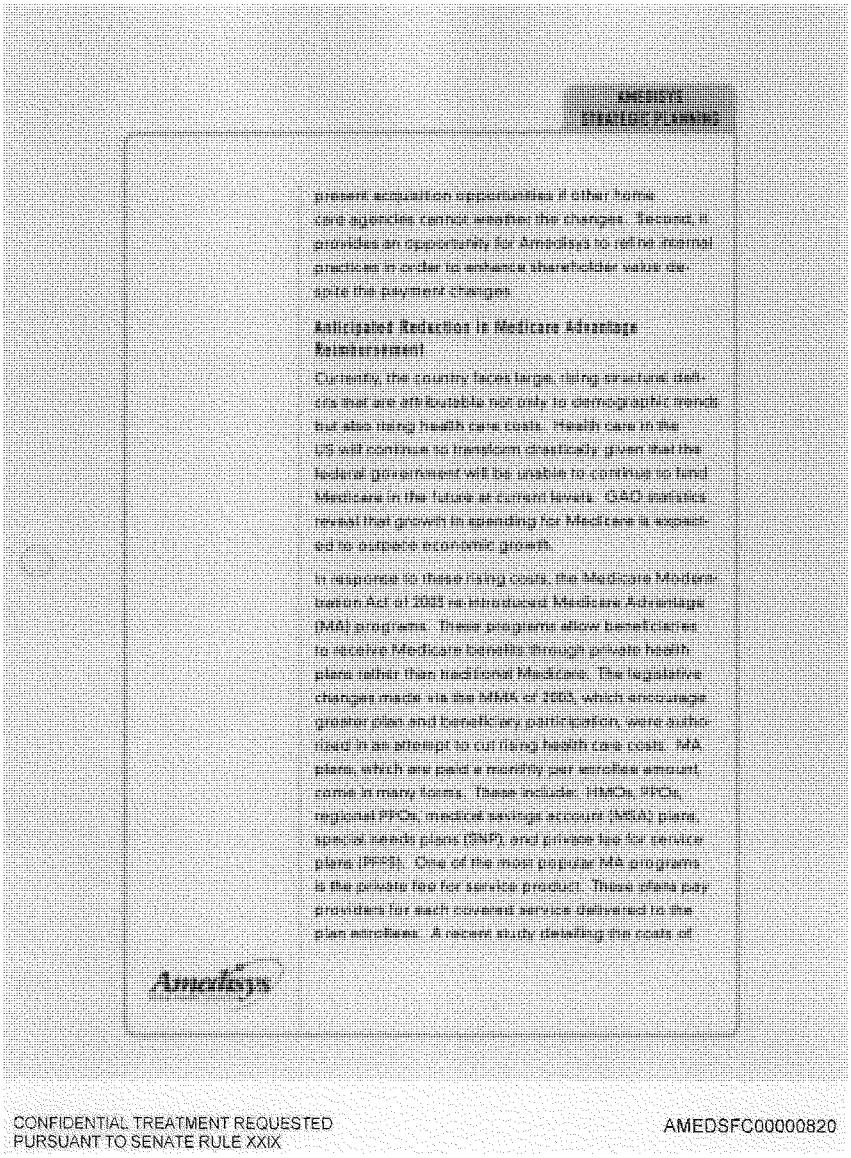
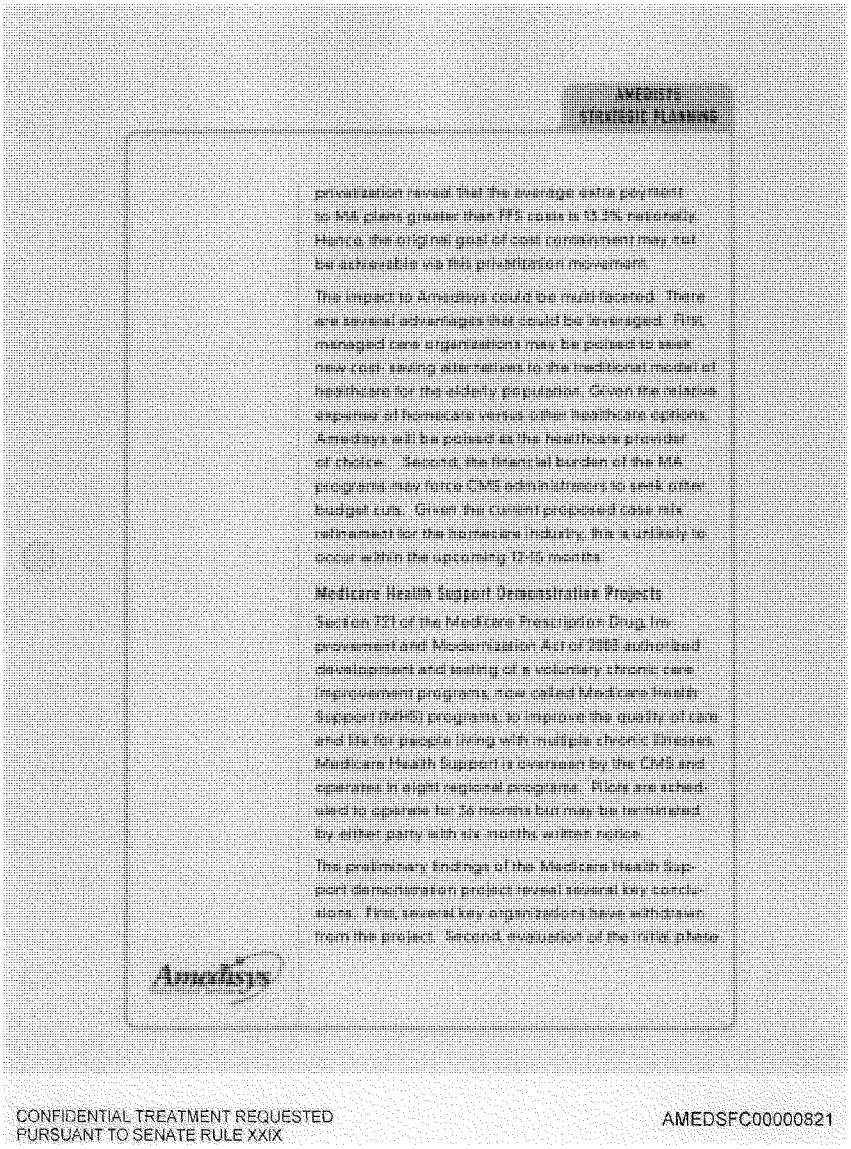


present acquisition opportunities if other home care agencies cannot weather the changes. Second, it provides an opportunity for Amedisys to refine internal practices in order to enhance shareholder value despite the payment changes.

Anticipated Reduction in Medicare Advantage Reimbursement

Currently, the country faces large, rising structural deficits that are attributable not only to demographic trends but also rising health care costs. Health care in the US will continue to transform drastically given that the federal government will be unable to continue to fund Medicare in the future at current levels. GAO statistics reveal that growth in spending for Medicare is expected to outpace economic growth.

In response to these rising costs, the Medicare Modernization Act of 2003 re-introduced Medicare Advantage (MA) programs. These programs allow beneficiaries to receive Medicare benefits through private health plans rather than traditional Medicare. The legislative changes made via the MMA of 2003, which encourage greater plan and beneficiary participation, were authorized in an attempt to cut rising health care costs. MA plans, which are paid a monthly per enrollee amount, come in many forms. These include: HMOs, PPOs, regional PPOs, medical savings account (MSA) plans, special needs plans (SNP), and private fee for service plans (PFFS). One of the most popular MA programs is the private fee for service product. These plans pay providers for each covered service delivered to the plan enrollees. A recent study detailing the costs of



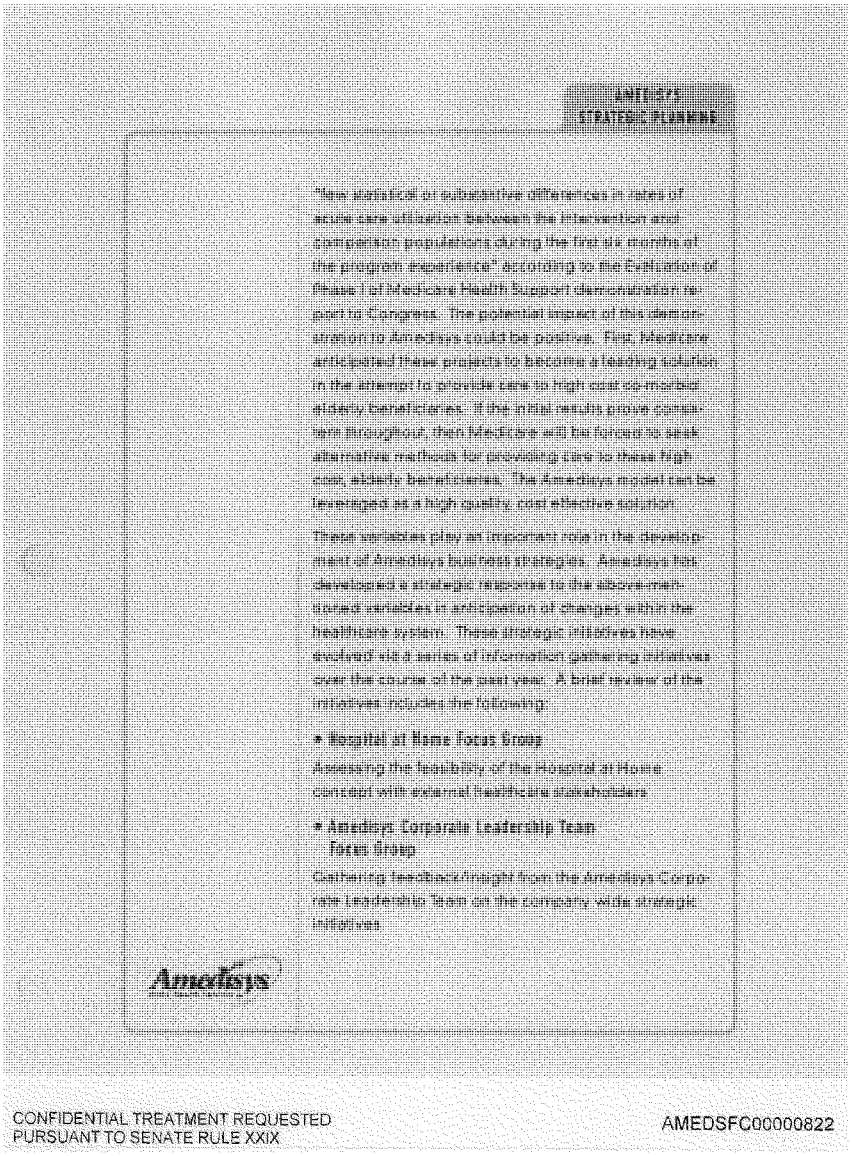
privatization reveal that the average extra payment to MA plans greater than FFS costs is 13.3% nationally. Hence, the original goal of cost containment may not be achievable via this privatization movement.

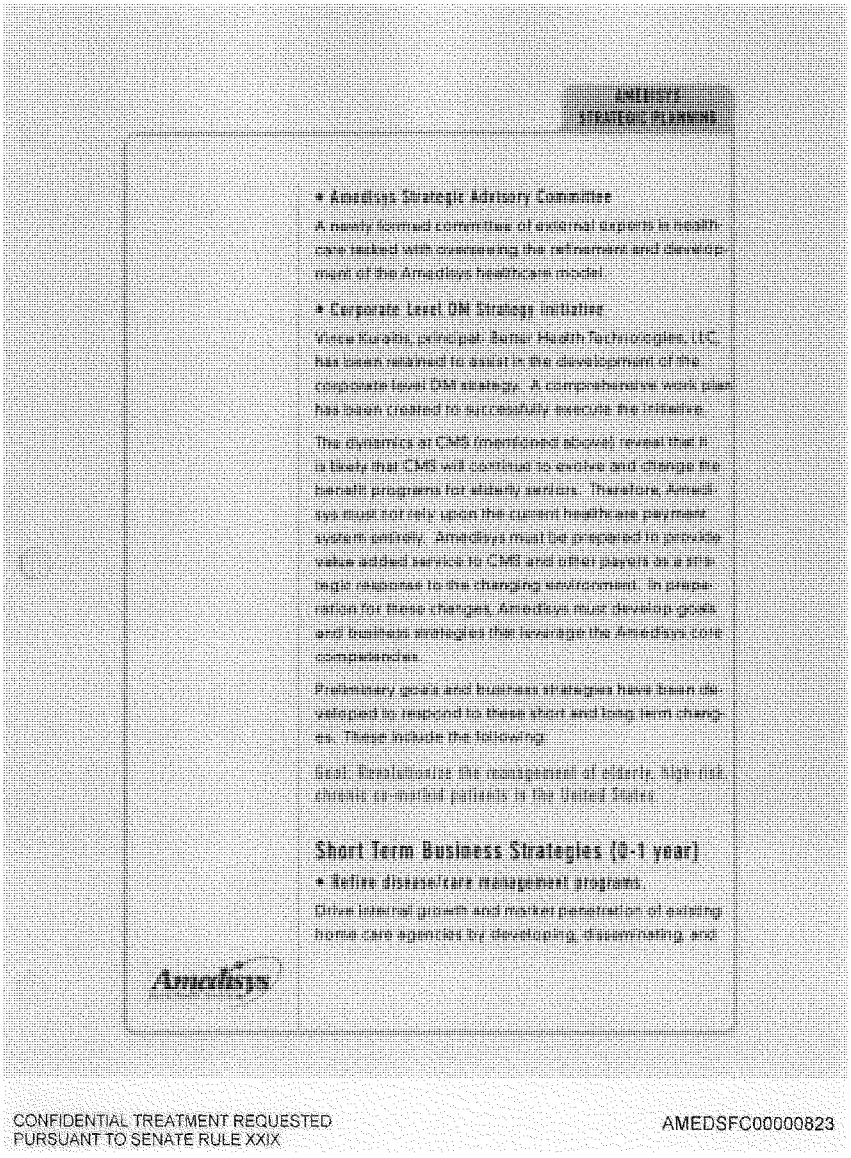
The impact to Amedisys could be multi-faceted. There are several advantages that could be leveraged. First, managed care organizations may be poised to seek new cost-saving alternatives to the traditional model of healthcare for the elderly population. Given the relative expense of homecare versus other healthcare options, Amedisys will be poised as the healthcare provider of choice. Second, the financial burden of the MA programs may force CMS administrators to seek other budget cuts. Given the current proposed case mix refinement for the homecare industry, this is unlikely to occur within the upcoming 12-18 months.

Medicare Health Support Demonstration Projects

Section 721 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 authorized development and testing of a voluntary chronic care improvement programs, now called Medicare Health Support (MHS) programs, to improve the quality of care and life for people living with multiple chronic illnesses. Medicare Health Support is overseen by the CMS and operates in eight regional programs. Pilots are scheduled to operate for 36 months but may be terminated by either party with six months written notice.

The preliminary findings of the Medicare Health Support demonstration project reveal several key conclusions. First, several key organizations have withdrawn from the project. Second, evaluation of the initial phase





• Amedisys Strategic Advisory Committee

A newly formed committee of external experts in healthcare tasked with overseeing the refinement and development of the Amedisys healthcare model

• Corporate Level DM Strategy Initiative

Vince Kuraitis, principal, Barker Health Technologies, LLC, has been retained to assist in the development of the corporate level DM strategy. A comprehensive work plan has been created to successfully execute the initiative.

The dynamics at CMS (mentioned above) reveal that it is likely that CMS will continue to evolve and change the benefit programs for elderly seniors. Therefore, Amedisys must not rely upon the current healthcare payment system entirely. Amedisys must be prepared to provide value added service to CMS and other payers as a strategic response to the changing environment. In preparation for these changes, Amedisys must develop goals and business strategies that leverage the Amedisys core competencies.

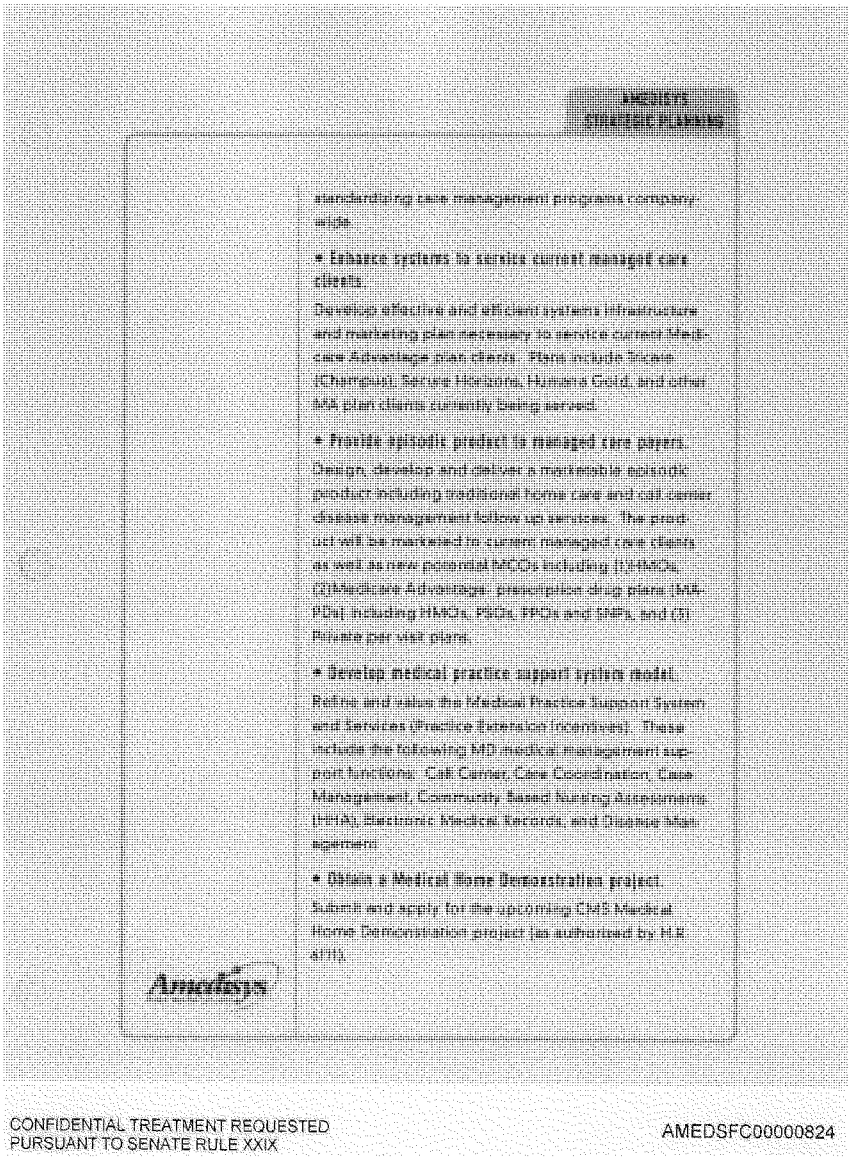
Preliminary goals and business strategies have been developed to respond to these short and long term changes. These include the following:

Goal: Revolutionize the management of elderly, high risk, chronic co-morbid patients in the United States.

Short Term Business Strategies (0-1 year)

• Refine disease/care management programs.

Drive internal growth and market penetration of existing home care agencies by developing, disseminating, and


standardizing care management programs company-wide.
• Enhance systems to service current managed care clients.
Develop effective and efficient systems infrastructure and marketing plan necessary to service current Medicare Advantage plan clients. Plans include Tricare (Champion), Senior Horizons, Humana Gold, and other MA plan clients currently being served.
• Provide episodic product to managed care payers.
Design, develop and deliver a marketable episodic product including traditional home care and call center disease management follow up services. The product will be marketed to current managed care clients as well as new potential MCOs including (1)HMOs, (2)Medicare Advantage prescription drug plans (MA-PDs) including HMOs, PSOs, PPOs and PFFs, and (3) Private pay visit plans.
• Develop medical practice support system model.
Refine and value the Medical Practice Support System and Services (Practice Extension Incentives). These include the following MD medical management support functions: Call Center, Care Coordination, Case Management, Community Based Nursing Assessments (HHA), Electronic Medical Records, and Disease Management.
• Obtain a Medical Home Demonstration project.
Submit and apply for the upcoming CMS Medical Home Demonstration project (as authorized by H.R. 6111).
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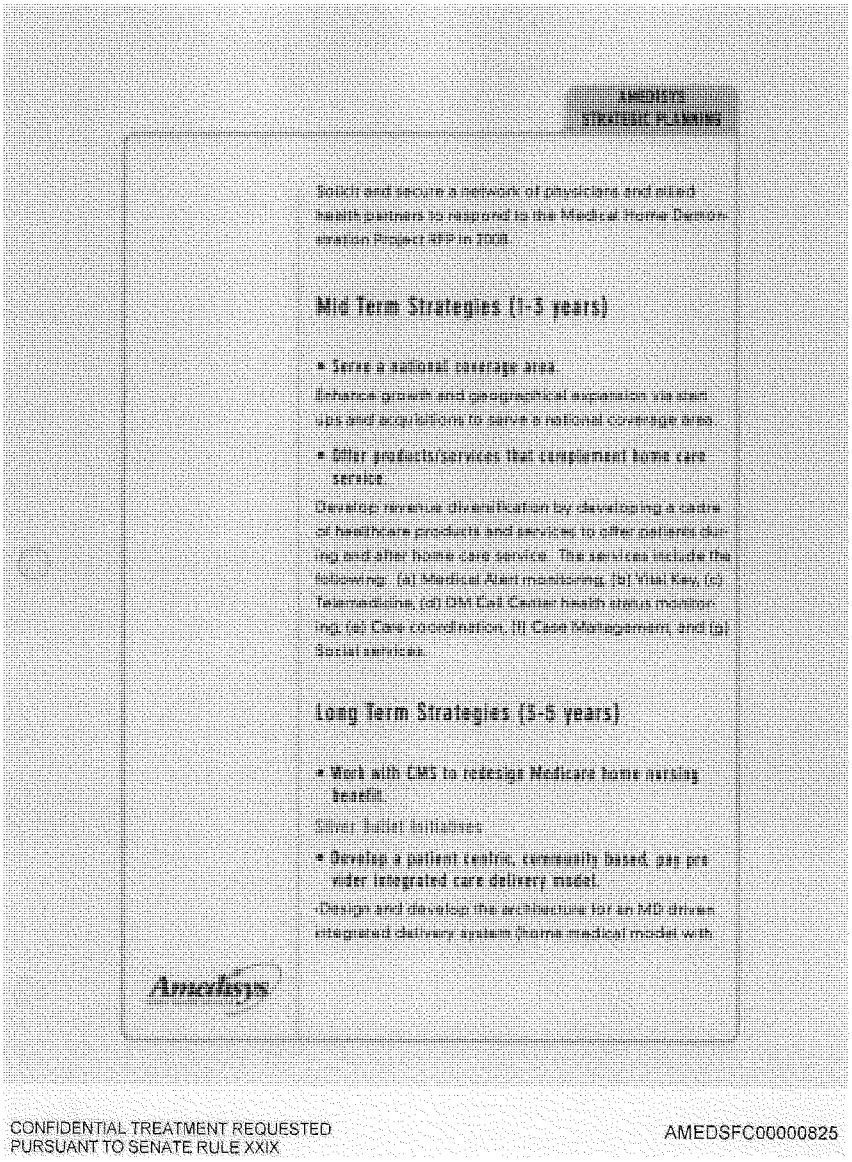

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Solicit and secure a network of physicians and allied health partners to respond to the Medical Home Demonstration Project RFP in 2008.

Mid Term Strategies (1-3 years)

- **Serve a national coverage area.**

Enhance growth and geographical expansion via start-ups and acquisitions to serve a national coverage area.

- **Offer products/services that complement home care service.**

Develop revenue diversification by developing a cadre of healthcare products and services to offer patients during and after home care service. The services include the following: (a) Medical Alert monitoring, (b) Vital Key, (c) Telemedicine, (d) DM Call Center health status monitoring, (e) Care coordination, (f) Case Management, and (g) Social services.

Long Term Strategies (3-5 years)

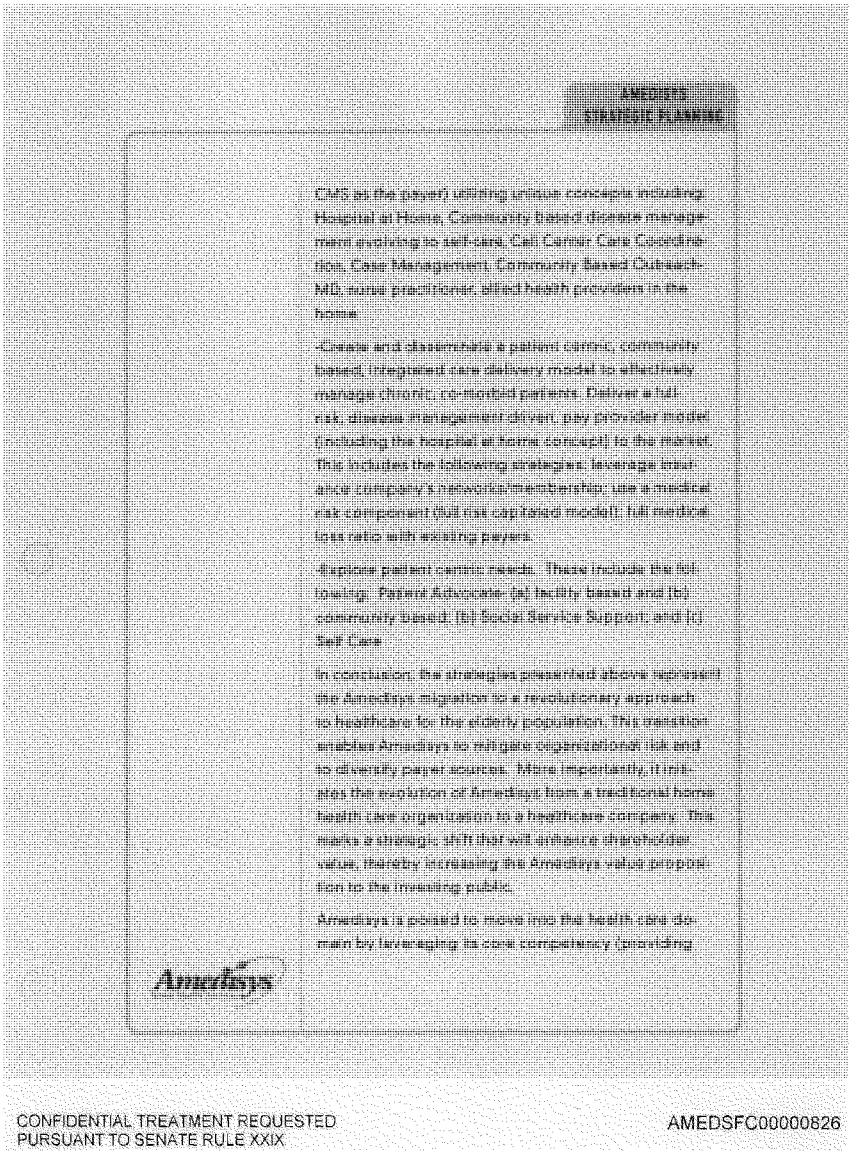
- **Work with CMS to redesign Medicare home nursing benefit.**

Silver Bullet Initiatives

- **Develop a patient centric, community based, pay provider integrated care delivery model.**

Design and develop the architecture for an MD driven integrated delivery system (home medical model with

Amedisys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CMS as the payer) utilizing unique concepts including Hospital at Home, Community based disease management evolving to self-care, Call Center Care Coordination, Case Management, Community Based Outreach-MD, nurse practitioner, allied health providers in the home.
-Create and disseminate a patient centric, community based, integrated care delivery model to effectively manage chronic, co-morbid patients. Deliver a full-risk, disease management driven, pay provider model (including the hospital at home concept) to the market. This includes the following strategies: leverage insurance company's networks/membership; use a medical risk component (full risk capitated model); full medical loss ratio with existing payers.
-Explore patient centric needs. These include the following: Patient Advocate- (a) facility based and (b) community based; (b) Social Service Support; and (c) Self Care.
In conclusion, the strategies presented above represent the Amedisys migration to a revolutionary approach to healthcare for the elderly population. This transition enables Amedisys to mitigate organizational risk and to diversify payer sources. More importantly, it increases the evolution of Amedisys from a traditional home health care organization to a healthcare company. This marks a strategic shift that will enhance shareholder value, thereby increasing the Amedisys value proposition to the investing public.
Amedisys is poised to move into the health care domain by leveraging its core competency (providing
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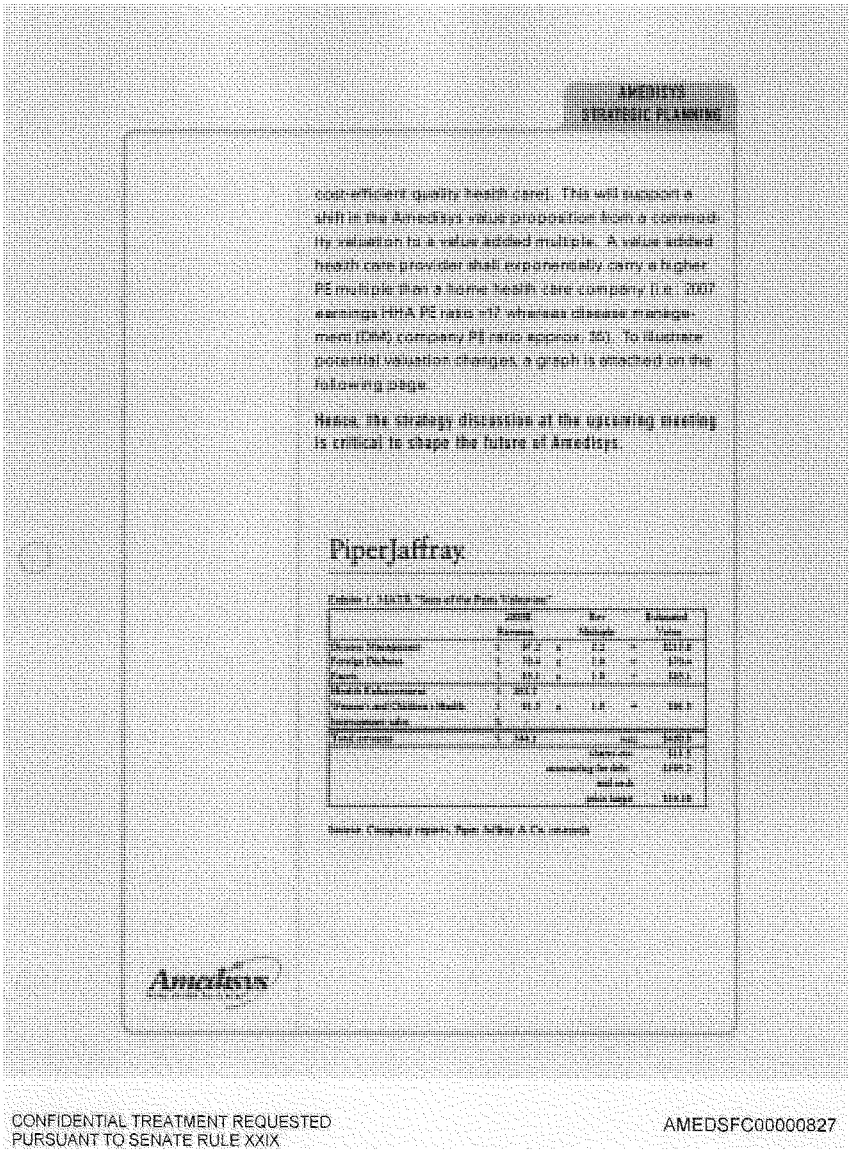

AMEDISYS
STRATEGIC PLANNING

cost-efficient quality health care). This will support a shift in the Amedisys value proposition from a commodity valuation to a value added multiple. A value added health care provider shall exponentially carry a higher PE multiple than a home health care company (i.e., 2007 earnings HHA PE ratio =17 whereas disease management (DM) company PE ratio approx. 35). To illustrate potential valuation changes, a graph is attached on the following page.

Hence, the strategy discussion at the upcoming meeting is critical to shape the future of Amedisys.

PiperJaffray

Amedisys

Approved by the Board of Directors on December 13, 2007

MINUTES OF A MEETING OF THE BOARD OF DIRECTORS OF AMEDISYS, INC. HELD ON OCTOBER 25, 2007

A meeting of the Board of Directors (the "Board") of Amedisys, Inc., a Delaware corporation (the "Company"), was held at the Company's corporate headquarters in Baton Rouge, Louisiana on October 25, 2007, pursuant to notice duly given. Present at the meeting were Board members William Borne, Bonnie Lalleuda, Jake Netterville, David Pitts, Peter Ricchiuti and Donald Washburn. Present on behalf of the Company were Larry Graham, Chief Operating Officer and President, Dale Redman, Chief Financial Officer, Alice Ann Schwartz, Chief Information Officer, Jeffrey Jeter, Senior Vice President of Compliance, Tom Dolan, Senior Vice President of Finance, Scott Ginn, Senior Vice President of Accounting, and Calvin Peiffer, Assistant Vice President of Legal and Assistant Corporate Secretary. Present for a portion of the meeting was Michael Allison, Vice President of Network Administration.

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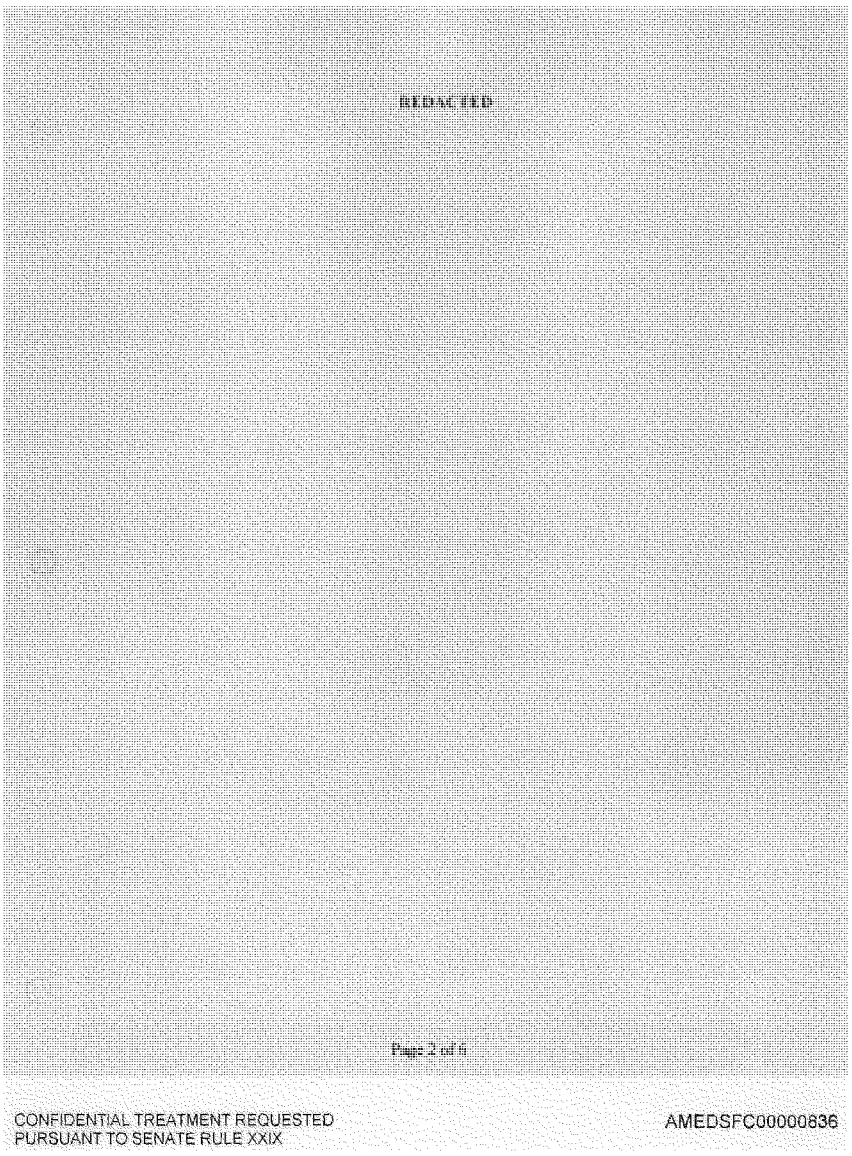

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Ms. Schwartz updated the Board regarding the impact of the "case mix adjustment" rules recently adopted by the Centers for Medicare and Medicaid Services ("CMS") on the Company's "Case Mix Refinement Plan." She noted that the Case Mix Refinement Plan is designed to promote (i) data consistency automation strategies, (ii) defined cost-cutting efficiency measures and (iii) defined strategic clinical programs. She also outlined (x) the impact on the Company's revenue of the new CMS rules that they been in effect in prior fiscal periods, and (y) the impact on revenue for various fiscal periods of processing (1) data consistency/automation, (2) certain other cost cutting efficiency measures (including Briggs forms conversion, OASIS transmission automation, certain in-house Sarbanes-Oxley audit savings and other possible collection efficiencies) and (3) certain defined clinical programs (including the Company's wound-care program, Balance for Life campaign and cardiac rehab program). Ms. Schwartz also noted that the Company's paper forms vendor, Briggs, had sued the Company for copyright infringement, alleging that certain survey forms appearing on the Company's electronic Point of Care system were duplicative of their forms. The Secretary recorded the portion of the meeting relating to this suit in a confidential excerpt of these minutes. During her presentation, Ms. Schwartz responded to various questions from the Board members.

REDACTED

Page of 3

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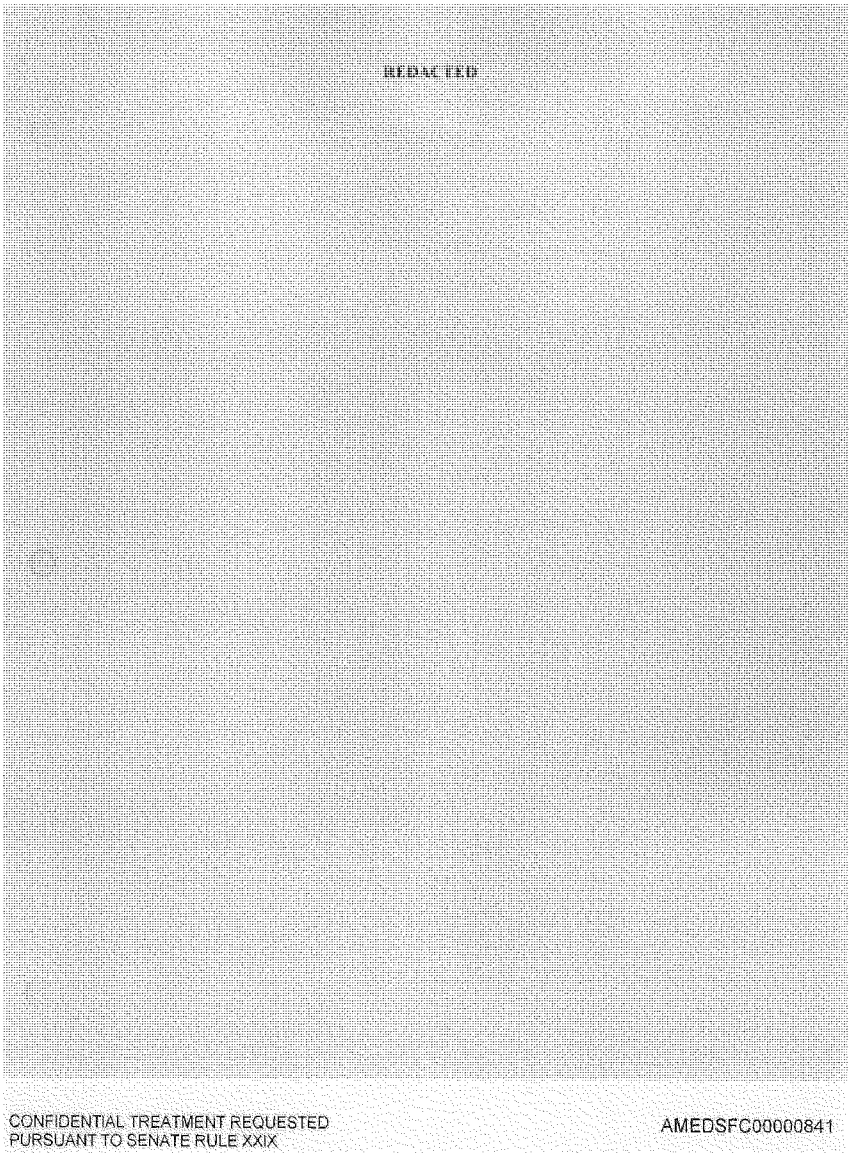
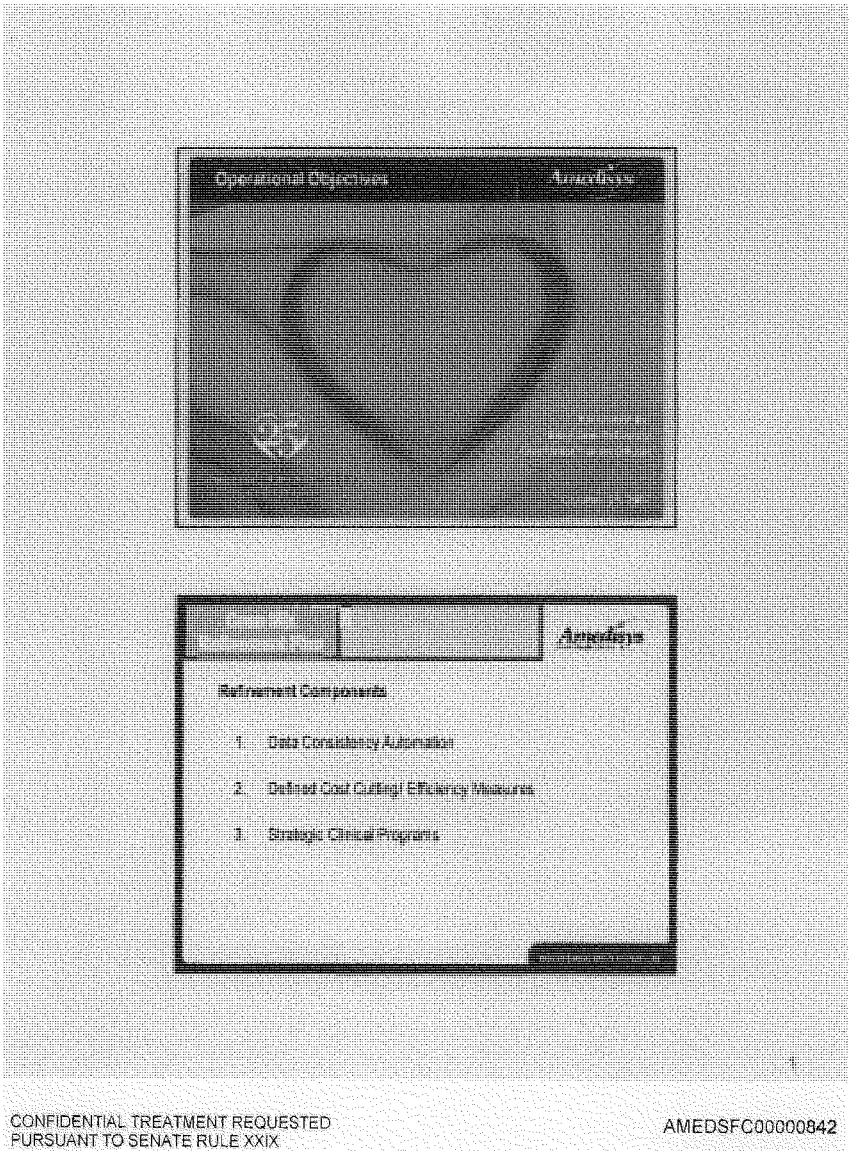
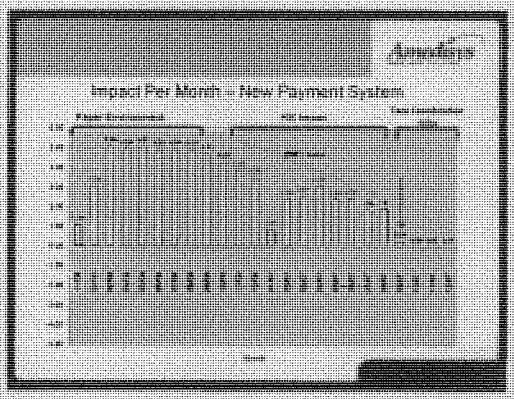
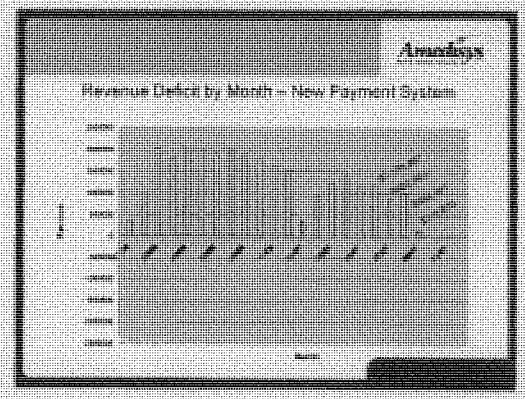
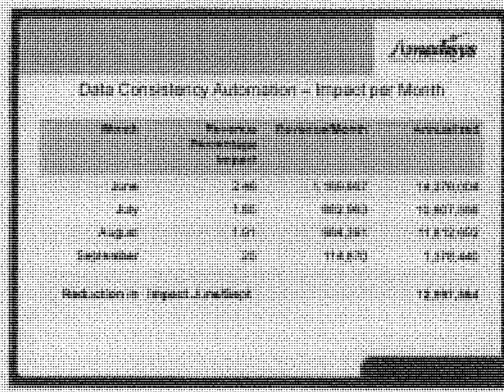
Celeste Rasmussen Peiffer
Assistant Secretary

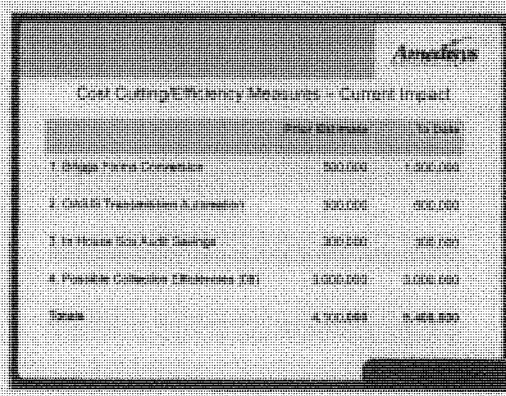


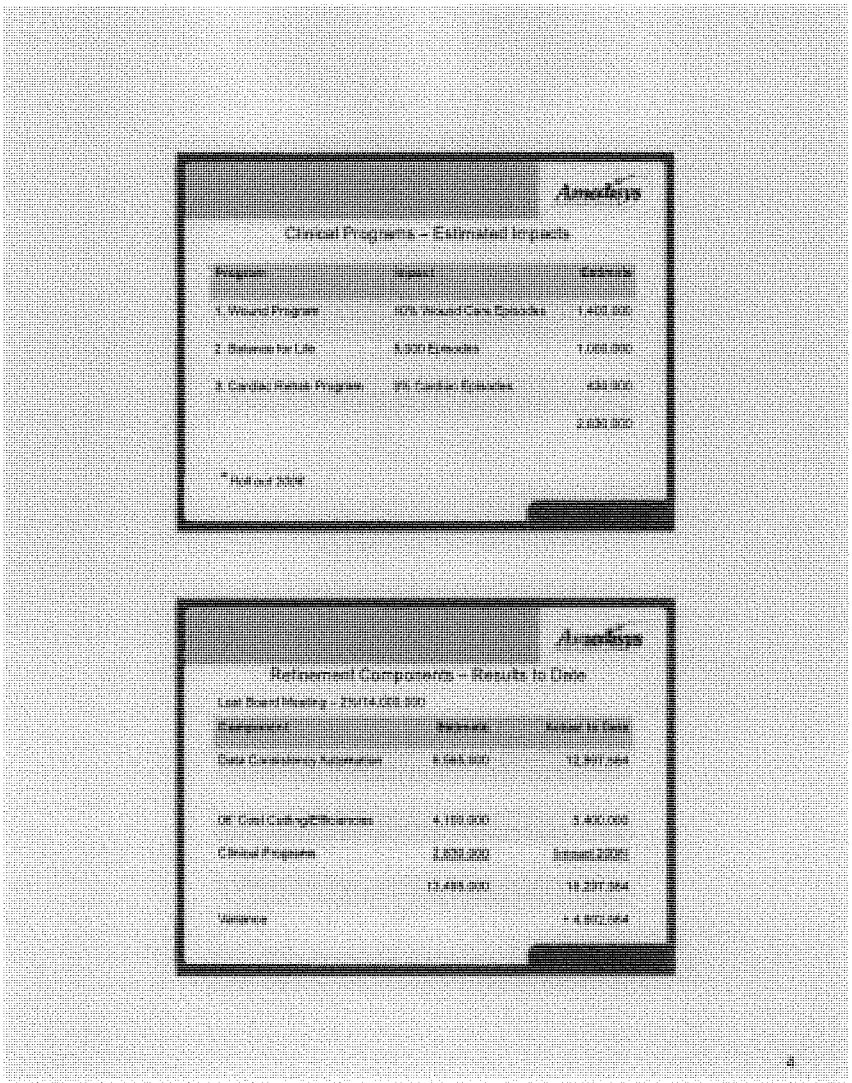












Footnote 27, 28, 30

From: Patti Waller
Sent: Friday, June 08, 2007 11:19 AM
To: ~Regional Administrators; ~Business Development RDBD; ~VP Operations; Esther Lee; Ed Sims
CC: Jill Cannon; William Mayes; Bari Dees; Peggy Hill; Alice Schwartz; Larry Graham
Subject: Conference Call
Attachments: Data Mining Strategies Handout (2).doc; AmedPPSstrategies.doc; Proposed PPS changes compared to current PPS.doc

Hello Everyone,

Jill, William and I would like to have a brief conference call to discuss the newly proposed PPS regs. and the efforts taking place to prepare our company for continued success once the new regs are implemented in January 2008. The call will take place on Wednesday June 13th at 2:00 p.m. EST. The call in number is as follows:

[redacted] participant code [redacted]#

Attached you will see a comparison of the proposed PPS changes compared to the current PPS that was published in the May 7th issue of Home Health Line. I have also included a list of projects and project leaders that are taking place within our company. One other attachment is information regarding the data the company is assessing that will allow us to determine the strategies our company is and will be implementing for success under the new regulations.

If you are not able to attend this call, please identify a person who can update you on the information we will going over. This will be very brief……we just want to make sure everyone is kept in the loop as to where we are heading as an organization.

Data Inconsistencies	*# Episodes*	*Added Revenue*	*POC Strategy*
Wound indicated on OASIS (with no supporting diagnosis	15,740	$940,000	Immediate POC enhancement to capture wound diagnosis
Patients on Diabetes medication(s) without diagnosis	8840	$1,200,000	Immediate POC enhancement to capture diagnosis. Edit will increase revenue in current model
Patients on medication to treat Cancer (Antineoplastic Agent) without diagnosis	7644	$998,000 *(as secondary diagnosis)*	Immediate POC enhancement to capture diagnosis
Inhaler indicated on OASIS (M0790) without pulmonary diagnosis (COPD)	15604	$750,000	Immediate POC enhancement to capture diagnosis
Patients on medications commonly used to treat Heart Disease or HTN w/o diagnosis	32423	$1,600,000	Immediate POC enhancement to capture diagnosis
V57 as Primary Dx with <6 Therapy visits & F2/F3 case mix	F2=4392 F3=2475	$360,000 *(adding 6 visits)*	AMS2 report to identify and track F2F3 episodes where therapy visits are <6 Rehab tracks based on clinical and functional domains / goal driven
All episodes with F2/F3 case mix without therapy services	6249	$715,000 *(adding 6 visits)*	AMS3 report to identify and track F2F3 episodes where there are no therapy visits Integration of rehab and clinical tracks for multidisciplinary approach
Other	*# Episodes*	*Added Revenue*	*New Program*
PT replaces SN visits in wound care episodes w/o therapy	6292	$1,400,000	PT Wound Care Specialty Program Currently evaluating state practice acts, selection and training of PTs in each market to assume wound care treatment, utilizing career ladders
Add Therapy to CHF patients with F2F3 score w/o therapy	8809	$ 430,000	Rehab @ Home with clinical diagnoses integration, # visits based on HHRG scores
Totals		8.4 Million	

Higher Profit Medical Diagnoses (V57 group omitted)	*Avg Profit/ Episode*	*DM Program and Business Development Strategy*
Neuro 3 – CVA/Stroke/TIA	$2,318	**New Programs:**
Ortho 2 – Muscle Disease	$2097	a. **Rehab @ Home (Ortho 2) - July 13, 2007**
Skin 2 – Ulcers and other Skin Conditions	$1877	b. **Dysphagia, E-stim, Infrared Light Therapy – July 30, 2007**
Skin 1 – Open Wound of Lower Limb	$1754	c. **Progressive Neuro Program – August 15, 2007**
Diabetes	$1745	**Update & Re-Launch the following DM programs** d. **Stroke Recovery @ Home (Neuro 3). July 30, 2007**
Traumatic wound, burns and post-op complications	$1678	e. **Heart @ Home – August 15, 2007** f. **Behavioral Health @ Home (psych nurse required) – August 30, 2007**
Skin 2 – Cellulitis / abscess	$1561	g. **Partners in Woundcare (Skin 1, Skin 2) - September 17, 2007**
Varicosities of the lower extremities	$1557	h. **Diabetes @ Home – October 15, 2007**

Hypertension	$1540	
Psych 1	$15117	

VP/RA/RDBD
Conference Call
June 13, 2007 2:00 p.m. EST / 1:00 p.m. CST

Items To Discuss

Proposed PPS Changes

Project Overview

1. Point of Care – strategy - Project Leader – Sherry Dukes

   Edits to ensure data consistency and proper diagnosis tracking in the POC system

   Education of staff with POC edits, OASIS and coding

2. Contracting – strategy – Project Leader – Francis Mayer

   Maintaining efficiency and monitoring contract Performance

3. Technology – strategy – Project Leader – Michael Allison

   OASIS transmission internally

   Evaluate payor verification outsource

4. Clinical Development – strategy – Project Leader – Anne Frechette

   Operational roll out plan…Clinical programs
   - DM
   - Case mix strategies
   - Centers of Clinical Excellence
   - Scheduling to the lowest discipline – to include LPN
     - Competency testing and training modules

   Data Mining of most profitable/ least profitable diagnoses and the financial impact

Clinical Development Continued

Develop an infrastructure to track monthly percentage growth in desirable cases

Recommendations of new programs with conceptual framework submitted based on analysis / data mining.

5. Information Technology – strategy – Project Leader – Dana Voss

Care to the lowest discipline is being designed to be a tool for Directors. The report will allow the agency to see the financial impact of using a lower cost discipline versus a higher cost discipline.

Identifying top reasons for claim errors for Private payers . Enhance absent data check, implement user-definable edits
Electronic Remittance advises for the top 12 payers
Automate the posting of the ERAs
GPS mileage in POC

6. Sales Marketing – strategy – Project Leader – William Mayes

Developing a strategic sales focus upon preferred patient mix

Footnote 29

From: Wanda Hull
Sent: Saturday, August 11, 2007 11:29 AM
To: Jill Cannon
Subject:
Attachments: VP RTeam Training Therapy Initiatives.ppt

Jill, I sent this presentation to Joy to send to the appropriate person to load for next week but I make a few revisions and wanted to be sure the updated version got to the right person.

I will be presenting and David and Lisa will be available for the Question portion.

Thanks and I look forward to seeing you next week.

Wanda

Therapy and Specialty Program Initiatives

VP/RA/RDBD Education

Case Mix Weight Refinement - Initiatives

- Wound Care – A Therapy Approach
- COPD/CHF – Therapy Model
- Revise Geriatric Model to include Diabetes, Incontinence, etc.
- Triggers on Oasis for appropriate utilization of PT,OT, SLP
- Revision of Therapy Clinical Tracks – Learn Center Module
- Revision of Marketing Materials and Patient Education Packets to match clinical tracks

Wound Care – A Therapy Approach
Selection Criteria

- Must be State-Approved for PT wound care
- Physical Therapists (No PTA's or OT's)
- PT must be willing to complete:
  - Required Learn Center Training Modules
  - Attend 2 day credentialing course
  - Skills Validation
  - Oversight of coding and documentation
  - Market specific incentive for advance skills

Wound Care – A Therapy Approach

- Extensive Clinical Training
- Added Modalities for Improved Outcomes
  - Infrared Light Therapy
  - E-Stim
  - Ultrasound
- Specialty Director responsible for Clinical Integrity and Financial Success in BFL Locations
- All other markets will role under "Go Live Model" - RA/RDBD monitoring Clinical and Financial Success

Neuropathic Ulcers – Therapy Approach

- Testing LOPS
- Appropriate Modalities
- Pressure Relief with Appropriate Orthotics and Footwear
- Manage Wound
- Sensory Integration (BFL)

Pressure Ulcers – Therapy Approach

- Evaluate for Root Cause:
  - friction, shear, pressure, contracture, etc.
- Appropriate Positioning and Pressure Reduction (bed/wc)
- Oral Intake
- Manage Wound (debridement) and Pain
- Appropriate Modalities
- Functional Mobility

Surgical Wound – Therapy Approach

- Staple/Suture Removal
- Wound Management
- Appropriate Modalities
- Functional Mobility

Venous Insufficiency – Therapy Approach

- Edema Control
- Compression Therapy
- Manage Wound
- Appropriate Modalities
- Functional Mobility – (BFL)

Arterial Insufficiency – Therapy Approach

- Improve Circulation
- Appropriate Modalities
- Manage Wound
- Pain Control
- Functional Mobility

Wound Care – A Therapy Approach

- Identify 2+ PT's to go through training
  - PT's who have experience or certified in wound care
  - PT's interested in becoming credentialed in wound care – Internal Training
  - RECRUIT – Contact Roxane Johnson for targeted plan – do not swap business lines but prepare to take all business opportunities
- Goal: Convert at least 10% of nursing only wound care cases to therapy.

Wound Care – A Therapy Approach

Financial Impact

Case 1

- Diagnosis:
  - Diabetes
  - Skin 2 – Ulcers
  - Gait Abnormality
  - HTN
  - Pulmonary
- 25 Nursing Visits
- 1 PT Visit
- 1st Episode

Case 1

- 2007
  - Reimbursement $2,257.36
  - Cost $2,489.50
    - $232.14
- 2008
  - Reimbursement $2,505.98 RN only
  - Reimbursement $5,807.81 14 PT + 12 RN
  - Reimbursement $7,688.80 20 PT + 6 RN

Case 2

- Diagnosis:
  - Leg Vericosity with Ulcers
  - Fitting Urinary Device
  - Urinary Incontinence
  - Neuro 3
  - Diabetes
- 26 Nursing Visits
- 15th Episode

Case 2

- 2007
  - Reimbursement $2,135.81
  - Cost $2,362.81
  - $226.76

2008
- Reimbursement $2,908.13 RN only
- Reimbursement $6,236.39 14 PT + 12 RN
- Reimbursement $7,688.80 20 PT + 6 RN

Wound Care – A Therapy Approach

- Trainings start in October
- E-mail names of PT's to Wanda Hull

COPD/CHF – Therapy Model

- Launching October 1, 2007
- Multi-discipline approach – PT, OT and SLP
- Standardized Testing to determine patient specific needs
- Learn Center Module - all therapists
- POC Edits for 2008 – Trigger appropriate therapy evaluations

Data Mining Results

2006 Database Analysis – Adding Therapy to existing programs

Adding Therapy	# Episodes
PT replaces SN visits in wound care episodes w/o therapy	6292
Add Therapy to CHF patients with F2F3 score w/o therapy	8809

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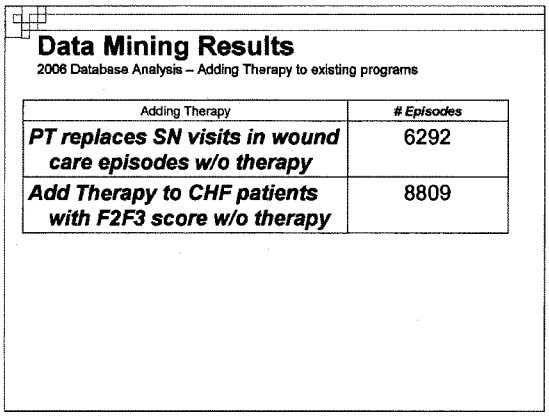


We then looked at the impact of adding therapy to these programs (see slide)

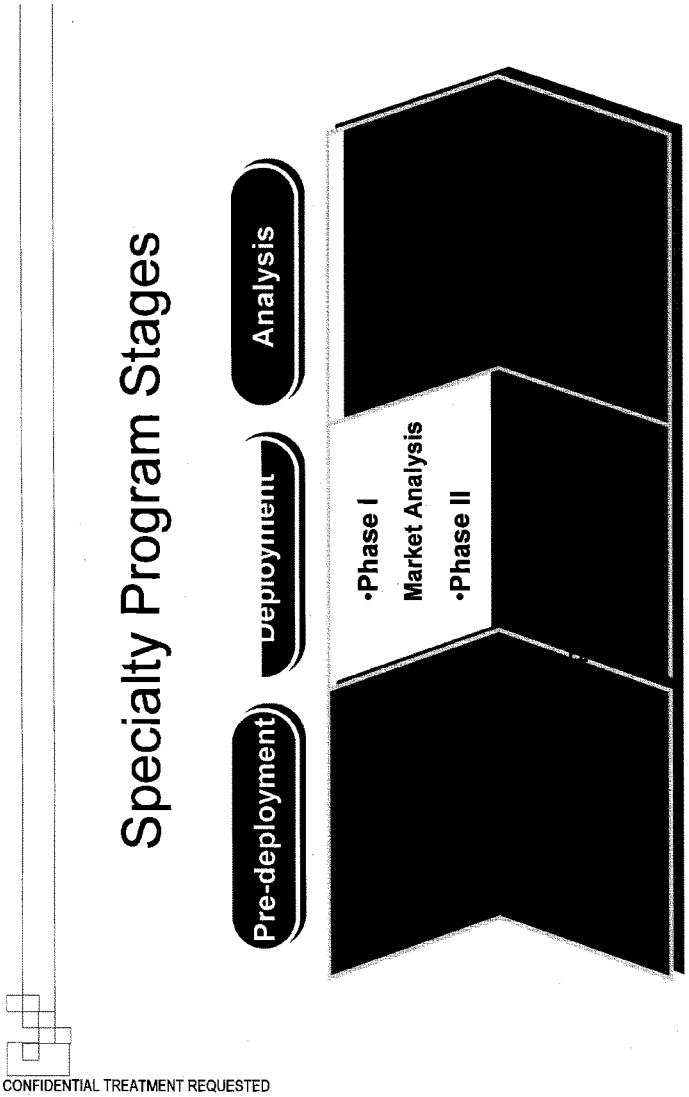
If we replaced SN visits with PT in 10% if the wound care episodes ...6292 episodes resulting in 1.4 million dollars to the company.

If we added only 6 Therapy visits to 3% of CHF patients who are F2F3 but received no therapy - 8809 episodes, net to company almost half a million.

Imagine what the revenue for the agencies will be!!

Specialty Programs

- A Program with Advanced Training to Acquire a Skill Set that is Above and Beyond the Traditional Homecare Delivery Model
- Incorporates Evidence Based Practice
- Collects Publishable Clinical Outcomes
- Clinically Driven and Therapy Led



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Specialty Programs require "Commitment"

- **Market Analysis**
  - Operational Stability
  - Pre-launch Financial Analysis
  - Capacity
- **Investment in a Specialty Director** with high clinical, operational, business development and leadership skills
  - Responsibility for Clinical Integrity
  - Accountable for operationalizing program with branch leadership
  - Meeting "Benchmarks" and Financial Proforma for the program
- **Operational Tenets**
  - Coding Guidelines
  - Program Tracking and Outcome Tools
  - Analysis of Key Reports
- **Business Development**
  - Develops Market Growth Plan
  - Partners with Business Development for clinical sell

Specialty Programs - Our Beginning at Amedisys

- **Balanced For Life** – A comprehensive approach to the assessment and treatment of the geriatric patient with an emphasis on balance dysfunction.
- 21 Locations participated in beta project for 2 Quarters.
- 1400 Admits
- Average HHRG – $4,100
- Projected HHRG 2008 - $4,700 (Increased with OT utilization)

Success Stories - BFL

- ALF in Augusta, GA with a fall rate of 63%
  - Residents identified for fall risk
    - 30 referrals for BLF
  - Staff in services on falls reduction strategies
  - Program Director became a member of their fall risk reduction committee
  - At the end of Q1, the facility had reduced their falls from **63% to 18%. (Goal was 19%)**

Success Story - BFL

- 90 year old with vestibular basilar insufficiency
  - Bed bound because of Dizziness
  - Slow consistent therapy
  - In the dining room eating and playing Bingo
  - Came to a marketing presentation with us to talk to the group

Dysphagia Initiatives

- David Hutchings – Corp. Speech Program Manager
- "Hybrid Specialty" – monitored by SD or Lead SLP
- Internal credentialed training on Dysphagia with E-Stim
- Operational Deployment
  - "Policies and Procedures"

    Admission and Financial "Benchmarks" for Full Time SLP's
- Clinical Deployment
  - 3 Revised Dysphagia Clinical Tracks
    Documentation Guidelines

Success in 2008

- Multi-disciplined Approach
- Continuous Recruitment Activities
- Retention is CRITICAL

Footnote 31

From: Misty Purdom [redacted]
Sent: Thursday, August 02, 2007 8:10 AM
To: ~Directors of Office Operations; ~Clinical Managers; ~Regional Administrators; ~Business Development RDBD; ~Episode Management; ~Clinical Operations; ~VP Operations; ~SVP Operations
CC: Larry Graham; Alice Schwartz; Jami Henzen; Anne Frechette; Victoria Johnson; Holly Summers
Subject: Conference Call with Larry Graham - August 2nd at 10 am Central/11 am Eastern - HANDOUTS!
Attachments: Case Mix Strategy Handouts.pdf

Importance: High

Please find attached the handouts for today's conference call. Thank you!

From: Misty Purdom
Sent: Monday, July 30, 2007 3:04 PM
To: ~Directors of Office Operations; ~Clinical Managers; ~Regional Administrators; ~Business Development RDBD; ~Episode Management; ~Clinical Operations; ~VP Operations; ~SVP Operations
Cc: Larry Graham; Alice Schwartz; Jami Henzen; Anne Frechette
Subject: Conference Call with Larry Graham - August 2nd at 10 am Central/11 am Eastern

There will be a conference call on **Thursday, August 2nd at 10:00 am Central/11:00 am Eastern** to discuss Case Mix refinement.

The dial in number is [redacted] and the conference ID number is [redacted].

The call will begin promptly, so please dial in 5 to10 minutes in advance.

We have a limited number of lines, so please try, and dial in from an agency using a speaker phone.

On Wednesday, August 1st we will send out attachments regarding this conference call.

Attendees
Directors of Operations
Clinical Managers
Regional Administrators
Regional Directors of Business Development
Episode Management
Clinical Operations
Vice Presidents of Operations/Business Development
Senior Vice Presidents of Operations/Business Development

Misty Purdom
Amedisys, Inc.
5959 S. Sherwood Forest Blvd.
Baton Rouge, LA 70816
Phone: [redacted]
Fax: [redacted]

2008 PPS Case Mix Changes

Operational Overview

Company Conference Call
August 2, 2007

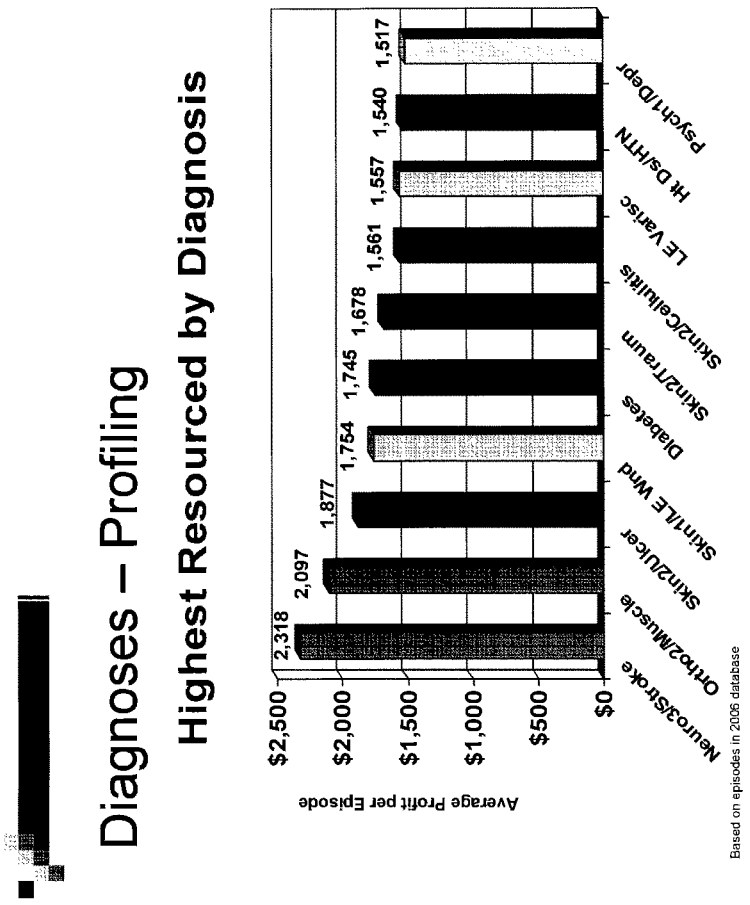
- Agenda
  - Overview of PPS Case Mix Adjustments
  - Resource Changes
    - Most Resourced Diagnoses
    - Least Resourced Diagnoses
  - Point of Care Data Consistency Automation
  - Staffing to Lowest Discipline Roll Out
  - Roll-out Schedule of Key Initiatives

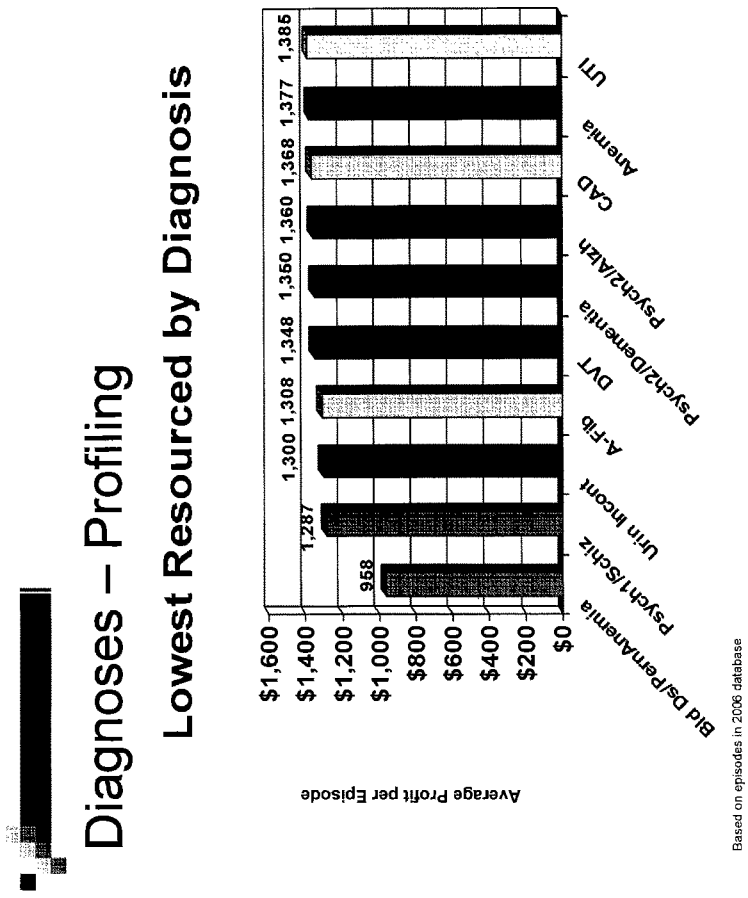
PPS Case Mix and Therapy Adjustment Overview

	Existing HHPPS	*Proposed Rule*
Case Mix regression Model	80 case-mix resource groups	153 case-mix resource groups
	Single therapy threshold at 10 therapy visits	Therapy threshold at 6, 14 and 20 visits; 6 additional service utilization levels added to the model to account for visits performed between threshold
	Increase in payment for delivering at least 10 therapy visits in an episode	Gradual increase in payment between 1st and 3rd therapy thresholds
	No accounting for timing of episodes	Accounts for early episodes (1st or 2nd episode) and later episodes (3rd or subsequent episodes), regardless whether the same home health agency provided the entire series of episodes
	Single equation model for weight calculation, with single therapy threshold	Four equation model for weight calculation: <14 therapy visits in early episode; ≥14 therapy visits in early episode < 14 therapy visits in later episode; ≥14 therapy visits in later episode
Case-Mix Model Variables	Scores not given for infected surgical wounds, abscesses, chronic ulcers and gangrene	Includes scores for infected surgical wounds abscesses, chronic ulcers and gangrene
	No GI, pulmonary, cardiac, cancer, blood disorders or affective and other psychoses diagnosis groups included	Added GI, pulmonary, cardiac, cancer blood disorders, and effective and other psychoses diagnosis groups
	Points not given for secondary diagnoses	Points assigned for some secondary diagnoses
	Points not given for combinations of conditions in the same episode	Points assigned for some combinations of Conditions in the same episode
	M0175 & M0810 included, M0470, M0520, & M0800 not included	Excluded M0175 & M0810, M0470, M0520 & M0800 are added

PPS Case Mix and Therapy Adjustment Overview

	Existing HHPPS	*Proposed Rule*
60 day Episode Rate	$2339.00	Episodes beginning in CY 2007 & ending in CY 2008 = $2,355.96 Episodes beginning & ending in CY2008 = $2300.60 followed by 3 consecutive years of 2.75% payment reductions 2.9% market basket increase for CY 2008
Non-routine supplies (NSR)	Reimbursed $49.62 for all episodes, bundled in the episodic rate, updated annually	Payment related to 5 NSR severity groups ranging from $12.96 to $367.34
LUPA	No additional payment for LUPA episodes	Additional $92.63 flat payment if patient's first episode is a LUPA
SCIC	Required to be billed if indicative of an unanticipated improvement in patient condition	Eliminated
Quality data Reporting	10 measures of quality	12 measures of quality Added: Urgent/Emergent Care for Wound Infections Improvement in Status of Surgical Wounds


Diagnoses – Profiling
Highest Resourced by Diagnosis
Average Profit per Episode
$2,500
$2,000
$1,500
$1,000
$500
$0
2,318
2,097
1,877
1,754
1,745
1,678
1,561
1,557
1,540
1,517
Neuro3/Stroke
Ortho2/Muscle
Skin2/Ulcer
Skin1/LE Wnd
Diabetes
Skin2/Traum
Skin2/Cellulitis
LE Varisc
Ht Ds/HTN
Psych1/Depr
Based on episodes in 2006 database



Data Mining Results

2006 Database Analysis

Data Inconsistencies	# Episodes
Wound indicated on OASIS with no supporting diagnosis (MO450) Pressure Ulcers (MO476) Stasis Ulcers	12529 3211
Patients on Diabetes medication(s) without diagnosis	8840
Patients on medication to treat Cancer (Antineoplastic Agent) without diagnosis	7644
Inhaler indicated on OASIS (MO790) without pulmonary diagnosis (COPD)	15604
Patients on medications used to treat Heart Disease or HTN without diagnosis	32423
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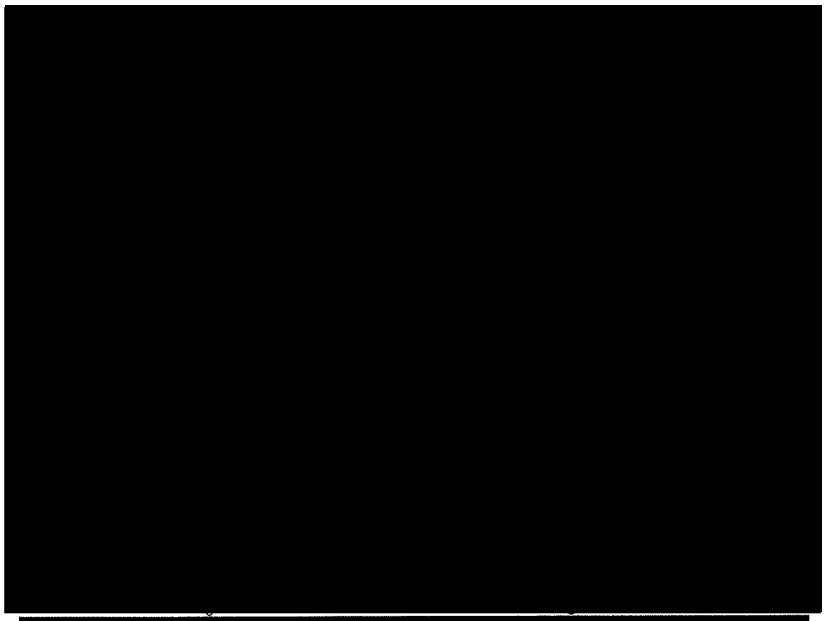
All episodes with F2/F3 case mix without therapy services	6249



STAFFING TO LOWEST DISCIPLINE

Phase 1: Administrative Report for directors, as well as other administrative staff, to capture financial impact of utilizing lower discipline (SN, PT, OT) to perform routine visits and monitor the agencies' adherence to scheduling routine visits to the lowest discipline

Two (2) Versions:

1. **Detailed:** (Patient data, printed weekly, for previous week, by DOO/CM)
2. **Admin:** (Agency data, printed monthly and as needed by DOO, RA, VP & SVP)

Data captured on the reports:

- Total Visit Count per discipline. Example: Total SN Visits
- # of Visits that require the higher discipline
  Example: Total visits, based on service code, that require a RN to perform the visit.
- # of Regular Visits per each discipline
  Example: visits that can be performed by both RN's and LPN's (SN Visits minus RN Required Visits.
- The number of Regular Visits performed by the lower discipline
  Example: # of Regular visits performed by a LPN.
- The number of Regular Visits performed by the higher discipline
  Example: # of Regular visits performed by a RN.
- Recommended # of visits per higher and lower discipline(s)
- Actual staffing cost versus recommended staffing cost *(Note: Discipline cost will be calculated by computing the average default payroll rate by location by title (i.e. the cost of an LPN visit will be the average of the default payroll rates for all LPN's in that location).*
- Potential Savings

Admin Version captures the additional information:

- LPN % - The percentage of Regular SN Visits performed by an LPN.
- RN % - The percentage of Regular SN Visits performed by an RN.
- SN Visit Count – The total number of SN visits.

[illegible] **Care to Lowest Discipline Report** [illegible]

[illegible]

[illegible] Date Range: [illegible]

Report by scheduled visits, sorted by patient

Page 1 of 1

Amedisys of [redacted]

	Actual	Optimal	Avg. Rate	Actual Cost	Optimal Cost		
RN visits:	505 (84%)	169 (28%)	$ 28.38	$ 14333.58	$ 4796.78		
LPN visits:	96 (16%)	432 (72%)	$ 18.00	$ 1728.00	$ 7776.00		
PT visits:	349 (83%)	44 (10%)	$ 49.08	$ 17130.08	$ 2159.67		
PTA visits:	73 (17%)	378 (90%)	$ 34.08	$ 2488.08	$ 12883.50		
OT visits:	108 (100%)	20 (19%)	$ 46.00	$ 4968.00	$ 920.00		
OTA visits:	0 (0%)	88 (81%)	$ 36.50	$ 0.00	$ 3212.00		
				$ 40647.75	$ 31747.95	Savings: $	8899.80 (22%)

	Actual Cost	Optimal Cost		
TOTAL:	**$ 40647.75**	**$ 31747.95**	**Savings: $**	8899.80 (22%)

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEDSFC00064393

Case Mix Refinement Strategy

Key Operational Initiatives

Initiatives

1. Point of Care Documentation Consistency Automation
2. Lowest Discipline Staffing Reporting
3. Growth of Focused DM Programs in 2008
4. MapQuest Mileage Technology

Goals

1. Fully implement POC Data Consistency Edits
2. Fully operationalize Staffing to Lowest Discipline
3. Grow strategic clinical programs
4. Fully implement MapQuest Mileage Initiative

	August 2007	September 2007	October 2007	November 2007	December 2007
Automation / Centralization	▪Point of Care Edits - 8/21 ▪Lowest Discipline Staffing Report – 8/21	Report Inspection and Tracking ▪POC Edits ▪Lowest Discipline Staffing	Report Inspection and Tracking ▪POC Edits ▪Lowest Discipline Staffing	Report Inspection and Tracking ▪POC Edits ▪Lowest Discipline Staffing	MapQuest Mileage Technology rollout by 12/31
Clinical Programs	▪Introduction of credentialed Learn Center Model: 8/13 ▪Selection of Site: Multidisciplinary DM (MDM) Programs by Go-Live Committee: 8/31	▪New Therapy Clinical Tracks rollout: 9/15	Program Go-Live: ▪MDM Heart @Home: 10/1 ▪Therapy Wound Program: 10/15	Program Go-Live: ▪MDM Diabetes@Home: 11/1 ▪MDM Stroke Recovery @Home: 11/15	
Education / Training	▪Patti Waller's Region: 8/6 – 8/10 VP/RA/RDBD ▪Jill Cannon's Region 8/15: VP/RA/RDBD ▪Companywide DOO/CM Training 8/13–8/17: POC, Lowest Discipline	▪Site credentialing for MDM Heart @Home: 9/1 – 10/1 ▪Site credentialing for Therapy Wound Program: 9/15 – 10/15	▪Site credentialing for MDM Diabetes@Home: 10/1 – 11/1 ▪Site credentialing for MDM Stroke Recovery @Home: 10/15 – 11/15	Coding / OASIS Update Training: 11/16 – 11/30	▪MapQuest Mileage Technology education upon release

Case Mix Refinement Strategy
August Goals

1. All VP/RA/RDBD teams educated on upcoming enhancements (8/6 – 8/15)
2. All DOOs/CMs trained on upcoming enhancements (8/13 – 8/17)
3. Consistency edits release (8/21)
4. Staffing to Lowest Discipline release (8/21)
5. RA/RDBD teams select their primary MDM program for growth (8/23)

Footnote 32

From: Wanda Hull [redacted]
Sent: Wednesday, September 26, 2007 5:54 PM
To: ~Directors of Office Operations
CC: Lisa Newell; Luzelle Havenga; Diane Walton; Jerri Drain; Bobbie Stallings
Subject: Therapy Wound Care
Attachments: Wound Therapy Initiatives .ppt

Wound Care – A Therapy Approach – Introductory Call

Purpose: Introduce the therapy wound care initiative and answer questions regarding operational integration

Make-Up Call

Participants Required: DOO's that have therapists in scheduled trainings for 2007

Participants Optional: DOO's that may have therapists participating in 2008 or want to be included in the "Targeted Recruitment Campaign"

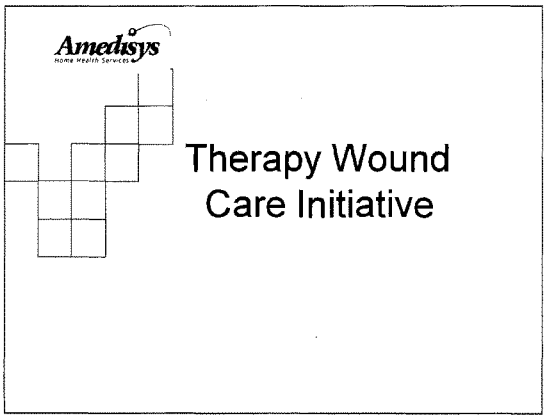
Call in #: [redacted] ***Participant Code:*** [redacted]

Call Times and Dates: ***Thursday Oct. 4th at 8:30 AM Central***

Please print the attachments prior to joining a call and thanks for your time and support of this exciting initiative for Amedis

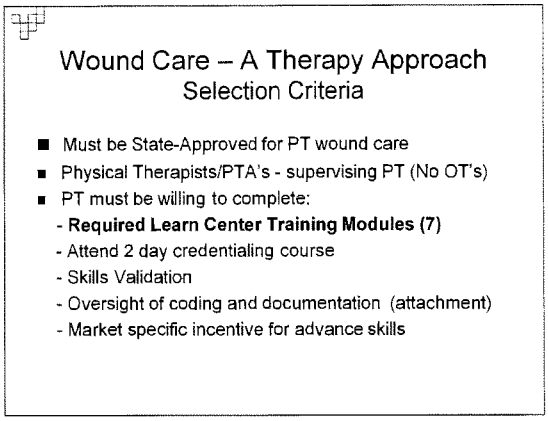
Wanda Hull
Corp. Rehab Specialty Director
Cell: [redacted]
Treo: [redacted]

Therapy Wound Care Initiative



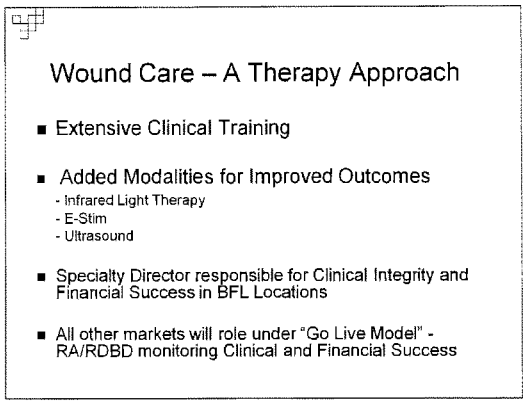
Wound Care – A Therapy Approach
Selection Criteria

- Must be State-Approved for PT wound care
- Physical Therapists/PTA's - supervising PT (No OT's)
- PT must be willing to complete:
  - **Required Learn Center Training Modules (7)**
  - Attend 2 day credentialing course
  - Skills Validation
  - Oversight of coding and documentation (attachment)
  - Market specific incentive for advance skills



Wound Care – A Therapy Approach

- Extensive Clinical Training
- Added Modalities for Improved Outcomes
  - Infrared Light Therapy
  - E-Stim
  - Ultrasound
- Specialty Director responsible for Clinical Integrity and Financial Success in BFL Locations
- All other markets will role under "Go Live Model" - RA/RDBD monitoring Clinical and Financial Success



Wound Care – A Therapy Approach Implementation Strategy

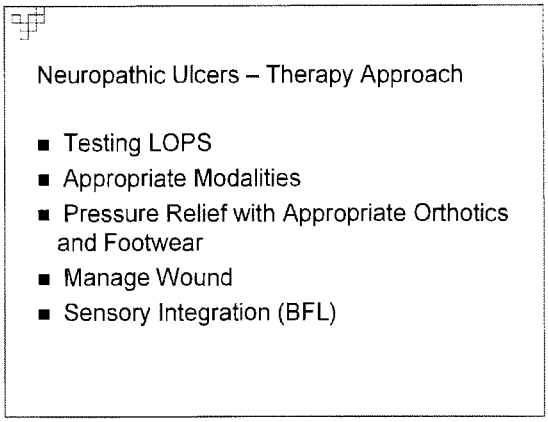
- Multi-disciplined Approach – PT may carry some of the wound care cases (Diabetes, Pressure Ulcers, etc.) with nursing supporting for co-morbidities
- Improved Patient Outcomes
- PT's/PTA's will be doing wound management and traditional therapy during the visit
- Contact RA's regarding incentive pay for therapists participating in wound care initiative

Wound Care – A Therapy Approach Implementation Strategy

- Multi-disciplined Approach – PT may carry some of the wound care cases (Diabetes, Pressure Ulcers, etc.) with nursing supporting for co-morbidities
- Improved Patient Outcomes
- PT's/PTA's will be doing wound management and traditional therapy during the visit
- Contact RA's regarding incentive pay for therapists participating in wound care initiative

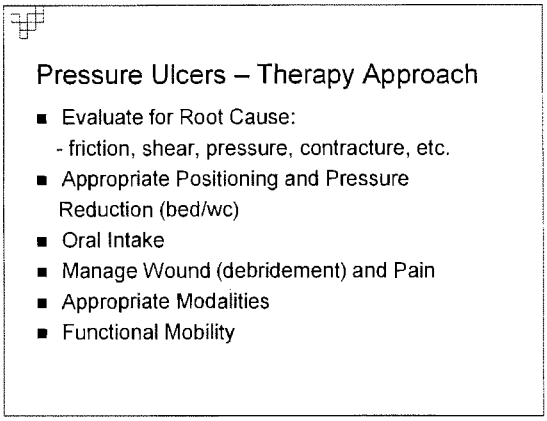
Neuropathic Ulcers – Therapy Approach

- Testing LOPS
- Appropriate Modalities
- Pressure Relief with Appropriate Orthotics and Footwear
- Manage Wound
- Sensory Integration (BFL)



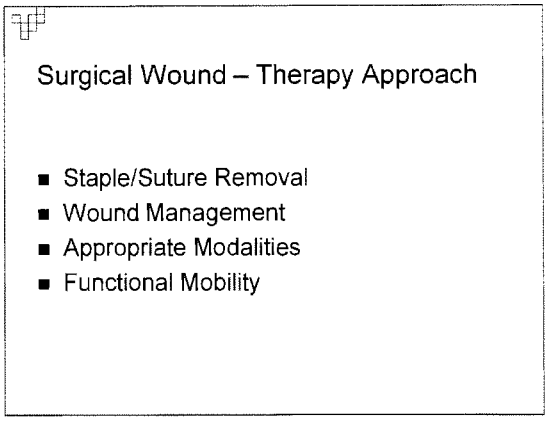
Pressure Ulcers – Therapy Approach

- Evaluate for Root Cause:
  - friction, shear, pressure, contracture, etc.
- Appropriate Positioning and Pressure Reduction (bed/wc)
- Oral Intake
- Manage Wound (debridement) and Pain
- Appropriate Modalities
- Functional Mobility



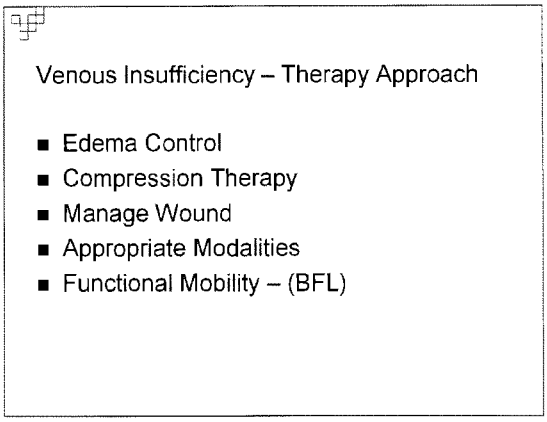
Surgical Wound – Therapy Approach

- Staple/Suture Removal
- Wound Management
- Appropriate Modalities
- Functional Mobility



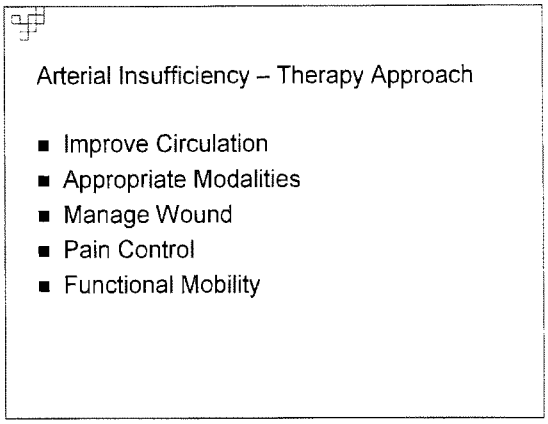
Venous Insufficiency – Therapy Approach

- Edema Control
- Compression Therapy
- Manage Wound
- Appropriate Modalities
- Functional Mobility – (BFL)



Arterial Insufficiency – Therapy Approach

- Improve Circulation
- Appropriate Modalities
- Manage Wound
- Pain Control
- Functional Mobility



Wound Care – A Therapy Approach

- Identify 2+ PT's to go through training
  - PT's who have experience or certified in wound care
  - PT's interested in becoming credentialed in wound care – Internal Training
  - RECRUIT – Contact Wanda Hull for targeted plan – do not swap business lines but prepare to take all business opportunities

Wound Care – A Therapy Approach

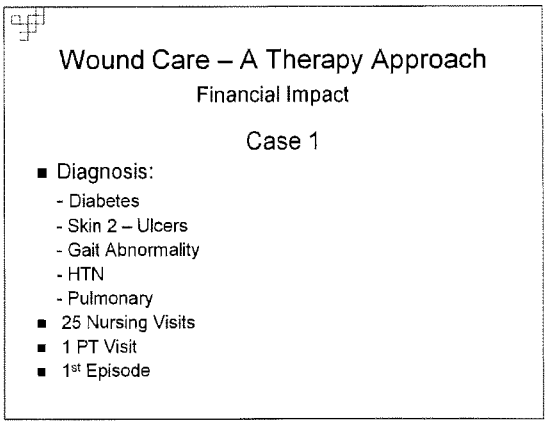
- Identify 2+ PT's to go through training
  - PT's who have experience or certified in wound care
  - PT's interested in becoming credentialed in wound care – Internal Training
  - RECRUIT – Contact Wanda Hull for targeted plan – do not swap business lines but prepare to take all business opportunities

Wound Care – A Therapy Approach

Financial Impact

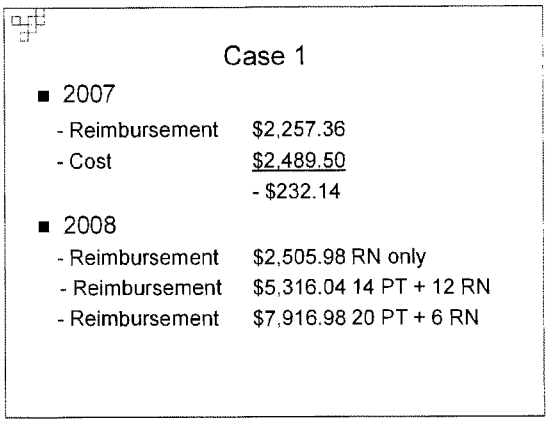
Case 1

- Diagnosis:
  - Diabetes
  - Skin 2 – Ulcers
  - Gait Abnormality
  - HTN
  - Pulmonary
- 25 Nursing Visits
- 1 PT Visit
- 1st Episode



Case 1

- 2007
  - Reimbursement $2,257.36
  - Cost $2,489.50
  - $232.14
- 2008
  - Reimbursement $2,505.98 RN only
  - Reimbursement $5,316.04 14 PT + 12 RN
  - Reimbursement $7,916.98 20 PT + 6 RN



Case 2

- Diagnosis:
  - Leg Vericosity with Ulcers
  - Fitting Urinary Device
  - Urinary Incontinence
  - Neuro 3
  - Diabetes
- 26 Nursing Visits
- 15th Episode

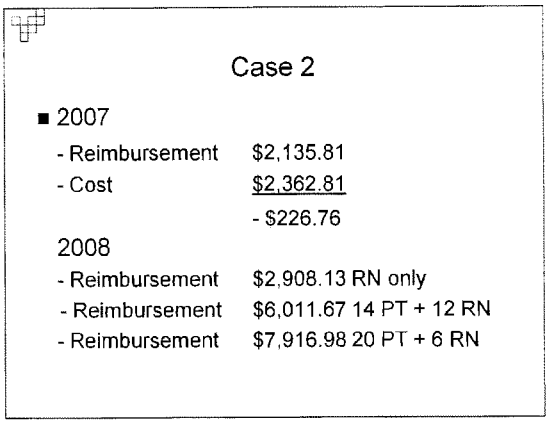
Case 2

- Diagnosis:
  - Leg Vericosity with Ulcers
  - Fitting Urinary Device
  - Urinary Incontinence
  - Neuro 3
  - Diabetes
- 26 Nursing Visits
- 15th Episode

Case 2

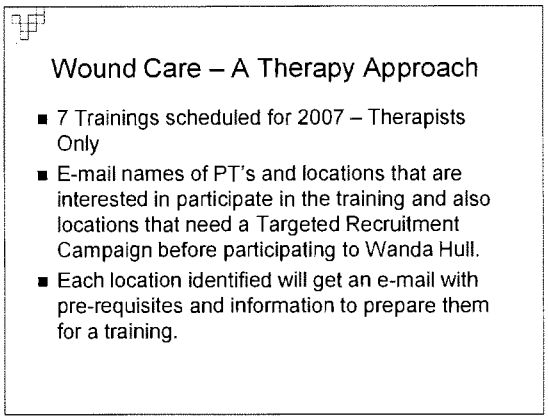
- 2007
  - Reimbursement $2,135.81
  - Cost $2,362.81
  - $226.76

- 2008
  - Reimbursement $2,908.13 RN only
  - Reimbursement $6,011.67 14 PT + 12 RN
  - Reimbursement $7,916.98 20 PT + 6 RN



Wound Care – A Therapy Approach

- 7 Trainings scheduled for 2007 – Therapists Only
- E-mail names of PT's and locations that are interested in participate in the training and also locations that need a Targeted Recruitment Campaign before participating to Wanda Hull.
- Each location identified will get an e-mail with pre-requisites and information to prepare them for a training.



Footnote 33

From: Donnie Hernandez [redacted]
Sent: Friday, December 14, 2007 12:49 PM
To: Andre' Hill; Anne Frechette; Cheryl Lacey; Cindy Phillips; Dana Voss; Donna Massie; Elizabeth Robinson; Francis Mayer; Janet Britt; Jeremy Rogers; Jill Cannon; Kirk Thevis; Kristopher Miller; Lisa Newell; Lu Post; Martha Williams; Melissa Geci; Michael Allison; Michelle Quigley; Mike Ginn; Mike Hamilton; Pamela Huffman; Patti Waller; Pete Hartley; Scott Ginn; Shannen Rouse; Sherry Dukes; Tasha Mears; Teresa Ledgerwood; TeRonna Hall; Tom Dolan; Wanda Hull; William Mayes
CC: Alice Schwartz
Subject: FW: A-Team Case Mix Committee
Attachments: Action Items 12 7 07.xlsx

Attached please find the action items from the last meeting on 12-07-07.

Please send me any updates to these action items by Wednesday of next week.

Thanks!

Donnie Hernandez
Executive Assistant to Alice Ann Schwartz
Amedisys, Inc.
5959 S. Sherwood Forest Blvd.
Baton Rouge, LA 70816
Phone: [redacted] Ext. [redacted]

Case Mix (A-Team) Committee
October 26, 2007

	A	B	C	D	E	F	G
1	Action Item Owner	Action Item	Strategy	Misc.		Action Items	Completion Date
2	Anno Frechette	Clinical Development	Strategy: Recommendations for New Programs with conceptual framework submitted based upon analysis/data mining		3.	New program framework development	Complete
3	Anne Frechette	Clinical Development	Strategy: Recommendations for New Programs with conceptual framework submitted based upon analysis/data mining		2.	New program development brainstorming	Complete
4	Anno Frechette	Clinical Development	Strategy: Recommendations for New Programs with conceptual framework submitted based upon analysis/data mining		1.	Completion of data mining (see action plan)	Complete
5	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		3.	SVP/VP/RA/RD/RD conference call to introduce top level case mix strategy concepts	Complete
6	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		4.	Meeting with SVPs and DM to make recommendations for Centers of Clinical Excellence selection criteria	Complete
7	Anno Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		1.	Preliminary dissemination of data mining results (see action plan)	Complete
8	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		5.	Recommendations to CRO for updating CCE	Complete
9	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		2.	Further dissemination of data mining results	Completed
10	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		13.	Development of new programs based on data mining and agency results	On-Going
11	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		14.	Development of participation in DM program strategy & feedback	Completed
12	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		11	Submission of growth plan & implementation date per site	9/5/2007 - completed
13	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		10	Establish on-going DM Go-Live Committee meetings to discuss deployed sites, upcoming sites & growth by discharge	Next meeting Mid-Dec
14	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Clinical Programs		7	Marketing Dept. to develop internal/ external collaterals and program completion recognition rewards	9/1-11/15/07

Case Mix (A-Team) Committee
October 26, 2007

	H	I
1	**Person Responsible**	**Comments**
2	Anne Frechette Michelle Quigley Wanda Hull Lisa Newell, Lu Post	Submitted to A-Team & SVP/VP 6/27& 6/28
3	Anne Frechette Michelle Quigley Wanda Hull Lisa Newell	Will be integrating therapy into CHF program
4	Pete Hartley Anne Frechette	Results at meeting
5	SVPs Anne Frechette	Meeting held 6/27 & 6/28.
6	SVPs, Anne Frechette, Michelle Quigley, Lu Post	Meeting held 6/27 & 6/28.
7	Pete Hartley Anne Frechette	Presented at A-Team meeting
8	Anne Frechette	
9	Pete Hartley Anne Frechette	
10	Anne Frechette, Pete Hartley, Anita Saturley	Focused DM Program launches in progress. Chronic Care Coordination Model in development Risk-stratified, centralized, standardized evidence-based care delivery system. Integration of intra-episodic Call Center, advanced medication management program leveraging pharmacy partner, standardized protocols of care management. Recruitment in progress for Director of Cardiopulmonary Services to lead telehealth initiative and develop / implement high risk portals. Aggressive BFL and multi-desciplinary therapy program launches in 2008.
11	SVPs, VPs, RAs, RDBDs, T&D, DM Dept. to assist	Key DOO feedback and recommendations
12	RA RDBD	Completed AVP submission of agency program selection. One-on-one calls completed with VPs 9/7/07.
13	Ops, DM, Bus. Dev.	[redacted] Go-Live Committee Meeting rescheduled for Dec 17.
14	Holly Summers, Ace Bourgeois, Patty Graham, Anne Frechette	Meeting held with Anne, Kaci, Kim, Ace, Holly 12/3. Lapel Pins purchased, Vendor will mail to DOO for distribution. Collateral updates complete. Development of COGNOS report for identifying individuals and agencies. Certificates for site credentialing development by Marketing.

Case Mix (A-Team) Committee
October 26, 2007

	A	B	C	D	E	F	G
15	Anne Frechette	Clinical Development	*Strategy:* Operational roll out plan - Clinical Programs		9.	Completion of DM operations pre-requisite modules and migration to i.team Center	complete
16	Anne Frechette	Clinical Development	*Strategy:* Operational roll out plan - Clinical Programs		8.	Completion of Learn Center credentialing DM programs	8/7/07 - 12/30/07
17	Anne Frechette	Clinical Development	*Strategy:* Operational roll out plan - Clinical Programs		12.	Focused/Strategic deployment/re-deployment of DM program that drives internal growth (Diabetes, Heart@Home, Wound Care - a Thought Approach, Stroke Recovery@Home)	9/1/07 - 11/15/07
18	Anne Frechette	Clinical Development	*Strategy:* Infrastructure to track monthly percentage growth in desirable cases		2.	Integration of key strategies into POC enhancements	Complete
19	Anne Frechette	Clinical Development	*Strategy:* Infrastructure to track monthly percentage growth in desirable cases		3.	SVP conference call to discuss analysis focus and metrics to be monitored	Complete
20	Anne Frechette	Clinical Development	*Strategy:* Infrastructure to track monthly percentage growth in desirable cases		5.	Additional tracking mechanisms developed as new queries are run and POC is updated	On-Going
21	Anne Frechette	Clinical Development	*Strategy:* Infrastructure to track monthly percentage growth in desirable cases		1.	Develop desired queries needed to track agency/regional/company progress monthly and integrate into top level reports	12/10/2007
22	Anne Frechette	Clinical Development	*Strategy:* Operational roll out plan - Staffing to Lowest Discipline		3.	Completion of beta, recommendations for staffing model	Complete
23	Anne Frechette	Clinical Development	*Strategy:* Operational roll out plan - Staffing to Lowest Discipline		5.	Focus Group organization to develop case management/team model, staffing and reimbursement recommendations	Complete
24	Anne Frechette	Clinical Development	*Strategy:* Operational roll out plan - Staffing to Lowest Discipline		10.	Monthly report monitoring for agency adherence and progress	On-Going
25	Anne Frechette	Clinical Development	*Strategy:* Operational roll out plan - Staffing to Lowest Discipline		4.	Dissemination to SVPs	Complete
26	Anne Frechette	Clinical Development	*Strategy:* Operational roll out plan - Staffing to Lowest Discipline		8	Develop and finalize staffing and reimbursement model/communication with VPs/RAs/DOOs	Complete
27	Anne Frechette	Clinical Development	*Strategy:* Operational roll out plan - Staffing to Lowest Discipline		1.	SVP/VP/RA/RDBD conference call to introduce concept	Complete

Case Mix (A-Team) Committee
October 26, 2007

	H	I
15	Lu Post, Anne Frechette, Michelle Quigley	Pre-requisite modules on learn center
		Site credentialing continues. Launch schedules:
	Holly Summers, Anne Frechette, Lynn Kish	Therapy Wound 9/17/07, Cardiac 9/24 Diabetes 10/15/07, Stroke 11/2/07 All clinician modules available on Learn Center, Stroke Recovery @ Home sales module currently being created
16		
	Ops, DM, Bus. Dev., Marketing, T&D	SOLUVE DATES: Therapy Wound - staggered 10/29, 11/28, 1/7 depending on training complex rollout Cardiac 10/22/07, Diabetes 11/16, Stroke 12/3 Credentialing reports / DM Program updates sent weekly via specific agency distribution lists Tracking mechanism for Therapy Wound in development - hybrid Learn Center and On-site advanced training
17		
	Pete H., Dana V., Carol B, Sherry D., Coders, Lu P., Michelle Q., Anne F.	List provided to IT
18		
	Anne Frechette Jill Cannon Walter Patti	Meeting held 6/27 & 6/28.
19		
	Anne Frechette, Tasha Mears, Wendy Melancon, Todd Fontenot	Process development for baseline numbers pre-Go-Live dates per diagnosis to track growth and ACH.
20		
	Anne Frechette, Tasha Mears, Wendy Melancon, Todd Fontenot	LearnCenter tracking credentialing, report in refinement by Kim Austin. Development of baseline DM admissions report in progress, logic finalized to capture appropriate / relevant diagnoses with Tasha, Wendy, Todd and Anne.
21		
	Anne Frechette, Michelle Quigley, Dana Voss	Phase 1 Report recommendations submitted to IT
22		
	Lu Post SVPs	Virtual focus group of (25) completed on 7/30/07; developing draft model
23		
	SVPs, RAs, DOOs, and DM dept. to assist	COGNOS report in development for DOOs, AVPs, VPs, SVPs. Monthly updates to be disseminated, quarterly report shared at next Go-Live meeting in April 08
24		
25	Anne Frechette	Company Conf Call scheduled 8/2
	SVPs	Completed, communicated per STLD task force
26		
	SVPs Anne Frechette	Compnay Conf Call scheduled 8/2
27		

Case Mix (A-Team) Committee
October 26, 2007

	A	B	C	D	E	F	G
28	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		2.	Notify HR/Recruiting to begin making recommendations to DOOs for new clinical hires at lower disciplines	10/11/2007
29	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on- line. Physical Assessment: Cardiac, Pulmonary, Endocrine, Integumentalary and Pain.	Complete
30	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line	Complete
31	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line. Wound Care in Home Care (CBTs).	Complete
32	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line	Complete
33	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line	Complete
34	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line	Complete
35	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line. Physical Assessment: Gastrointestina.	Complete
36	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line	Complete
37	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line	Complete
38	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line. Physical Assessment: Neurologic.	Complete
39	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line	Complete
40	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line	Complete

Case Mix (A-Team) Committee
October 26, 2007

	H		I
28	Anne Frechette Phillips Cindy		Development of coursework based on state practice acts completed for approval process by HR. Licensure / state regs completed, scope of practice for LPN calls to boards of nursing completed. Sent to Donna Massie for review and dissemination to field
29	Lu Post		Cardiac – Heart @ Home M_3, Pulmonary – Heart @ Home M_3, Endocrine – Diabetes @ Home M_3, Integumentatary – Partners HC101, Pain Mgt @ Home Pain –
30	Lu Post		Urinary Catheter Insertion in Home Care CBT
31	Lu Post Cairns Ronda Diane Walton		WC 101 Intro to WC Lower Extremity Ulcers Pressure Ulcers
32	Vicki Johnson		Home Infusion Therapy - CBT
33	Lu Post		Tracheostomy Care in Home Care CBT
34	Vicki Johnson		Dosage Calculations and Drip Rates
35	Vicki Johnson		Gastrointestinal
36	Lu Post		Writing Effective Verbal Orders in HC
37	Ronda Cairns		Venipunctures in Home Care
38	Vicki Johnson		Neurologic – Stroke @ Home M_3
39	Ronda Cairns Diane Walton		Colostomy and Ostomy Care
40	Vicki Johnson		Tube Feedings in Home Care CBT

Case Mix (A-Team) Committee
October 26, 2007

	A	B	C	D	E	F	G
41	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		7.	LPN competency testing and training modules, identify skill gaps and track on-line	12/15/2007
42	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		8.	Operations education development and migration to Learn Center	8-14-07
43	Anne Frechette	Clinical Development	Strategy: Operational roll out plan - Staffing to Lowest Discipline		9.	Launch company wide	9-15-07
44	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		1.	Wound patient analysis - Missing code financial impact	Complete
45	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		2.	Stratification of most commonly appearing diagnoses groups in patients current case load (30)	Complete
46	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		3.	Stratification of patient diagnoses by most profitable and least profitable (in top 30)	Complete
47	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		4.	Data mining for impact of POC system enhancements in most frequent diagnoses	Complete
48	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		5.	Drill down on all pertinent diagnoses groups, identify dollar impact with POC edits	Complete
49	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		6	Evaluation of current patients served with Y-2F3 scoring without therapy	Complete
50	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		7.	Quantify impact of introducing (3) levels of therapy	Complete
51	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		8.	Complete data mining for lost opportunities, migration of loss, and other anticipated scenarios of financial impact	Complete
52	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		8.	Complete data mining for lost opportunities, migration of loss, and other anticipated scenarios of financial impact	Complete
53	Anne Frechette	Clinical Development	Strategy: Data Mining of Most Profitable/Least Profitable Diagnosis		8.	Complete data mining for lost opportunities, migration of loss, and other anticipated scenarios of financial impact	Complete
54	Dana Voss	Information Technology	Strategy: Identify top reasons for claim errors for Private Payors. Enhance the Absent Data check, implement user-definable edits.		1.	Finalize listing of top reasons for errors by Payor	Complete
55	Dana Voss	Information Technology	Strategy: Identify top reasons for claim errors for Private Payors. Enhance the Absent Data check, implement user-definable edits.		2.	Gather requirements	Complete

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	H	
41	Lu Post	Communicating Effectively with Physicians using SBAR
42	Lu Post, Anne Frechette, Michelle Quigley	Ops Training on Report held week on 8/13
43	SVPs Other depts. as directed	Report released 8/28/07 First draft of model in review
44	Pete Hartley Alice Ann Schwartz	
45	Pete Hartley Anne Frechette	
46	Pete Hartley Anne Frechette	
47		
48	Pete Hartley Anne Frechette	
49	Pete Hartley Anne Frechette	
50	Pete Hartley Anne Frechette	
51	Pete Hartley Anne Frechette	
52	Pete Hartley Anne Frechette	
53	Pete Hartley Anne Frechette	
54	Jeremy Rogers	
55	Brannon Byrd Dana Voss Jeremy Rogers	We will split the project into (2) phases. This is complete for phase (1).

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	A	B	C	D	E	F	G
56	Dana Voss	Information Technology	Strategy: Identify top reasons for claim errors for Private Payors. Enhance the Absent Data check, implement user-definable edits.		3.	Phase 1 (Top 7 reasons for denials)	Complete - Released on 8/28/07
57	Dana Voss	Information Technology	Strategy: Identify top reasons for claim errors for Private Payors. Enhance the Absent Data check, implement user-definable edits.		4.	Gather requirements for Phase 2	In progress
58	Dana Voss	Information Technology	Strategy: Identify top reasons for claim errors for Private Payors. Enhance the Absent Data check, implement user-definable edits.		4.	Phase 2 (Next major 5-10 reasons for denials)	Q4 07
59	Dana Voss	Information Technology	Strategy: Identify top reasons for claim errors for Private Payors. Enhance the Absent Data check, implement user-definable edits.		4.	Phase 3 (F757, SysAuth removed after 2 weeks, F913, EMC errors looked down in CIS)	Jan. 2008
60	Dana Voss	Information Technology	Strategy: The Care to Lowest Discipline Report is being designed to be a tool for directors, as well as other administrative staff, to monitor the agencies adherence to scheduling recommendations by service code. The report will promote an agency's progress toward the corporate initiative of staffing to the lowest discipline. It will also allow an agency to see the financial impact of using a lower cost discipline versus a higher cost discipline.		1.	Define & finalize strategy	Complete
61	Dana Voss	Information Technology	Strategy: The Care to Lowest Discipline Report is being designed to be a tool for directors, as well as other administrative staff, to monitor the agencies adherence to scheduling recommendations by service code. The report will promote an agency's progress toward the corporate initiative of staffing to the lowest discipline. It will also allow an agency to see the financial impact of using a lower cost discipline versus a higher cost discipline.		2.	Complete Design & Documentation	Complete
62	Dana Voss	Information Technology	Strategy: The Care to Lowest Discipline Report is being designed to be a tool for directors, as well as other administrative staff, to monitor the agencies adherence to scheduling recommendations by service code. The report will promote an agency's progress toward the corporate initiative of staffing to the lowest discipline. It will also allow an agency to see the financial impact of using a lower cost discipline versus a higher cost discipline.		3.	Programming of Care to Lowest Discipline	Complete

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		H	
56	Brannon Byrd Voss Rogers Dana Jeremy		1. Set place of service to 12 2. Remove occurrence code of 27 for HH claims 3. Do not allow invalid group #s on P's insurance screen or in CIS 4. Do not allow invalid cond. codes on UB92 screen 5. Medicaid, Private, & Private PPS claims-set admit type to 3 6. include admit source & type in 837 file 7. Physician info. in 837 file
57	Jim Young Dana Voss Jeremy Rogers		
58	Jim Young Dana Voss Jeremy Rogers		Released in 8.0 on 10/12: F644: Prevent duplicate doctors from being entered F705: lock down the recall button and EMC send button on the ledger tab in Pats to prevent the agencies from using them To be released in 8.0 on 12/17: F756: add MA Term Date to pertinent datas screen
59	Brannon Byrd Dana Voss Jeremy Rogers		To be released in 9.0, Jan 2008: F757: SysAuth removed after 2 weeks F913: EMC errors locked down in CIS
60	Brannon Byrd Voss Dana		
61	Brannon Byrd Voss Dana		
62	Brannon Byrd Voss Dana		Completed on 7-20.

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	A	B	C	D	E	F	G
63	Dana Voss	Information Technology	Strategy: The Care to Lowest Discipline Report is being designed to be a tool for directors, as well as other administrative staff, to monitor the agencies adherence to scheduling recommendations by service code. The report will promote an agency's progress toward the corporate initiative of staffing to the lowest discipline. It will also allow an agency to see the financial impact of using a lower cost discipline versus a higher cost discipline.		4.	Testing	Complete
64	Dana Voss	Information Technology	Strategy: The Care to Lowest Discipline Report is being designed to be a tool for directors, as well as other administrative staff, to monitor the agencies adherence to scheduling recommendations by service code. The report will promote an agency's progress toward the corporate initiative of staffing to the lowest discipline. It will also allow an agency to see the financial impact of using a lower cost discipline versus a higher cost discipline.		5.	Training & Communication	Complete
65	Dana Voss	Information Technology	Strategy: The Care to Lowest Discipline Report is being designed to be a tool for directors, as well as other administrative staff, to monitor the agencies adherence to scheduling recommendations by service code. The report will promote an agency's progress toward the corporate initiative of staffing to the lowest discipline. It will also allow an agency to see the financial impact of using a lower cost discipline versus a higher cost discipline.		6.	Release	Complete
66	Dana Voss	Information Technology	Strategy: Receive electronic RAs via Per Se for the top 12 Private Payors. Automate the posting of the ERAs for the top Private Payors in AMS2.		3.	Complete automation of cash posting in AMS2 for those Private & PPS payors currently enrolled with Per Se	11/15/2007
67	Dana Voss	Information Technology	Strategy: Receive electronic RAs via Per Se for the top 12 Private Payors. Automate the posting of the ERAs for the top Private Payors in AMS2.		3.	Phase 2: Complete automation of cash posting in AMS2 for the remaining top (10) Private payors and top (10) PPS payors	12/31/2007
68	Dana Voss	Information Technology	Strategy: Receive electronic RAs via Per Se for the top 12 Private Payors. Automate the posting of the ERAs for the top Private Payors in AMS2.		3.	Phase 2: additional functionality	Feb. 2008
69	Dana Voss	Information Technology	Strategy: POC Edits Phase 2		3.	Programming, Testing & release	12/17/2007
70	Dana Voss	Information Technology	Strategy: Case Mix Programming in AMS2 & POC		3.	Core functionality programming changes	11/2/2007
71	Dana Voss	Information Technology	Strategy: Case Mix Programming in AMS2 & POC		3.	Business unit Testing sign-offs	12/14/2007
72	Francis Mayer	Contracting	Strategy: Maintaining efficiency and monitoring contract performance.		1.	Hire Director of Managed Care	Complete
73	Francis Mayer	Contracting	Strategy: Maintaining efficiency and monitoring contract performance.		6.	Review all POC processes & adjust as necessary to be completely different from Briggs forms	Complete

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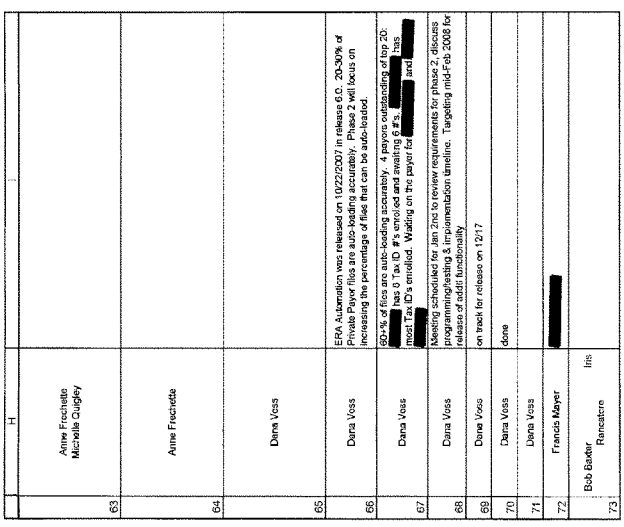

	H	
63	Anne Frechette Michelle Quigley	
64	Anne Frechette	
65	Dana Voss	
66	Dana Voss	ERA Automation was released on 10/22/2007 in release 6.0. 20-30% of Private Payer files are auto-loading accurately. Phase 2 will focus on increasing the percentage of files that can be auto-loaded.
67	Dana Voss	60+% of files are auto-loading accurately. 4 payors outstanding of top 20: [redacted] has 0 Tax ID #'s enrolled and awaiting #'s, [redacted] has most Tax ID's enrolled. Waiting on the payer for [redacted] and [redacted]
68	Dana Voss	Meeting scheduled for Jan 2nd to review requirements for phase 2, discuss programming/testing & implementation timeline. Targeting mid-Feb 2008 for release of addtl functionality
69	Dana Voss	on track for release on 12/17
70	Dana Voss	done
71	Dana Voss	
72	Francis Mayer	[redacted]
73	Bob Baxter Iris Rancatore	

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	A	B	C	D	E	F	G
74	Francis Mayer	Contracting	Strategy: Maintaining efficiency and monitoring contract performance.		9.	[redacted]	8-1-07
75	Francis Mayer	Contracting	Strategy: Maintaining efficiency and monitoring contract performance.		5.	[redacted]	Complete
76	Francis Mayer	Contracting	Strategy: Maintaining efficiency and monitoring contract performance.		6.	[redacted]	Complete
77	Francis Mayer	Contracting	Strategy: Maintaining efficiency and monitoring contract performance.	Develop Supply Protocols	Complete	Andre' Hill Francis Mayer	Wound product algorithms complete, submit to IT by 12/10
78	Francis Mayer	Contracting	Strategy: Maintaining efficiency and monitoring contract performance.		3.	Train Managed Care staff on Admissions Source Summary Report	Complete
79	Francis Mayer	Contracting	Strategy: Maintaining efficiency and monitoring contract performance.		4.	Develop Supply Protocols	11/1/2007
80	Jeremy Rogers	Private Collection	Strategy: Implement clean claim project. 365 day write off policy. Dedicated MA collection sub-team. Lag analysis proving reduced reserve need to 2% by Jan. 2008. Top payor visit project. Implement denial management system coming from private electronic RAs.		5.	Top Payor visit project	10/15/2007
81	Jeremy Rogers	Private Collection	Strategy: Implement clean claim project. 365 day write off policy. Dedicated MA collection sub-team. Lag analysis proving reduced reserve need to 2% by Jan. 2008. Top payor visit project. Implement denial management system coming from private electronic RAs.		6.	Implement denial management system	Complete
82	Jeremy Rogers	Private Collection	Strategy: Implement clean claim project. 365 day write off policy. Dedicated MA collection sub-team. Lag analysis proving reduced reserve need to 2% by Jan. 2008. Top payor visit project. Implement denial management system coming from private electronic RAs.		4.	Lag analysis proving reduced reserve need to 2% by January 2008	1-1-08
83	Jeremy Rogers	Private Collection	Strategy: Implement clean claim project. 365 day write off policy. Dedicated MA collection sub-team. Lag analysis proving reduced reserve need to 2% by Jan. 2008. Top payor visit project. Implement denial management system coming from private electronic RAs.		2.	365 day write off policy implementation -Review with Medicare weekly rep issues for accounts over 365 -Submit report detailing results of McBee's findings in addition to our plan for implementing corrective measures to prevent issues from re-occurring	Complete

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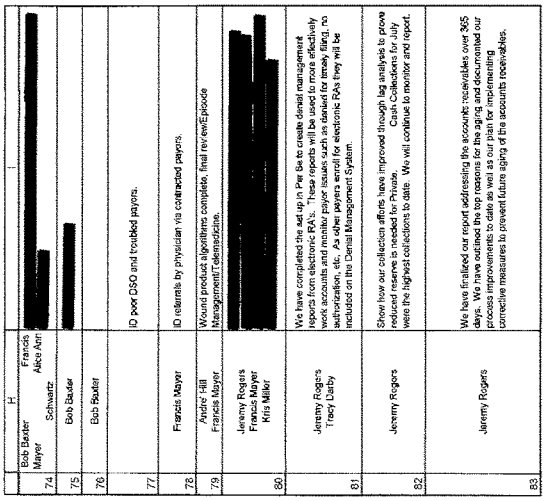

	H	I
74	Bob Baxter Mayer Francis Alice Ann Schwartz	
75	Bob Baxter	
76	Bob Baxter	
77		ID poor DSO and troubled payors.
78	Francis Mayer	ID referrals by physician via contracted payors.
79	Andre' Hill Francis Mayer	Wound product algorithms complete, final review/Episode Management/Telemedicine.
80	Jeremy Rogers Francis Mayer Kris Miller	
81	Jeremy Rogers Tracy Darby	We have completed the set up in Per Se to create denial management reports from electronic RA's. These reports will be used to more effectively work accounts and monitor payor issues such as denied for timely filing, no authorization, etc. As other payers enroll for electronic RAs they will be included on the Denial Management System.
82	Jeremy Rogers	Show how our collection efforts have improved through lag analysis to prove reduced reserve is needed for Private. Cash Collections for July were the highest collections to date. We will continue to monitor and report.
83	Jeremy Rogers	We have finalized our report addressing the accounts receivables over 365 days. We have outlined the top reasons for the aging and documented our process improvements to date as well as our plan for implementing corrective measures to prevent future aging of the accounts receivables.

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	A	B	C	D	E	F	G
84	Jeremy Rogers	Private Collection	Strategy: Implement clean claim project. 365 day write off policy. Dedicated MA collection sub-team. Lag analysis proving reduced reserve need to 2% by Jan. 2008. Top payor visit project. Implement denial management system coming from private electronic RAs.		1.	Implement Clean Claim Project -Identify top reasons for claim errors in Per Se Work with programming to 'lock down' top reasons for claim errors in CIS -Identify top reasons per payor for claim errors from clearinghouse using 277 reports -Enroll top 15 payors for electronic billing Begin submitting all claims from AMS2 through Per Se	10/31/2007
85	Jeremy Rogers	Private Collection	Strategy: Implement clean claim project. 365 day write off policy. Dedicated MA collection sub-team. Lag analysis proving reduced reserve need to 2% by Jan. 2008. Top payor visit project. Implement denial management system coming from private electronic RAs.		3.	Dedicated MA Collection Team -Tiffany Riddle, Susan Shields, and Patricia Broussard will be on the MA Team -Focus group to bill and collect PPS payors Develop guidelines for follow up on payors who do not adhere to PPS payment agreements	Complete
86	Michael Allison	Information Technology	Strategy: OASIS Transmission internally. Evaluate payor verification outsource.	Revenue Recovery	4.	Define SLA and baseline operations	Complete
87	Michael Allison	Information Technology	Strategy: OASIS Transmission internally. Evaluate payor verification outsource.	Revenue Recovery	2.	Draft processes and procedures	Complete
88	Michael Allison	Information Technology	Strategy: OASIS Transmission internally. Evaluate payor verification outsource.	Revenue Recovery	3.	Implement call monitoring processes	Complete
89	Michael Allison	Information Technology	Strategy: OASIS Transmission internally. Evaluate payor verification outsource.	Revenue Recovery	1.	Evaluate staffing model	Complete
90	Michael Allison	Information Technology	Strategy: OASIS Transmission internally. Evaluate payor verification outsource.	Oasis Transfer	7.	Evaluate outsourcing to overseas	Complete
91	Michael Allison	Information Technology	Strategy: OASIS Transmission internally. Evaluate payor verification outsource.	Oasis Transfer	5.	Travel to HSS to review transfer procedures	Complete
92	Michael Allison	Information Technology	Strategy: OASIS Transmission internally. Evaluate payor verification outsource.	Oasis Transfer	6.	Create an OASIS technology team	Complete
93	Michael Allison	Information Technology	Strategy: OASIS Transmission internally. Evaluate payor verification outsource.			Baseline New broadband Tech.	Complete
94	Pete Hartley	Information Technology	Strategy: GPS mileage in POC. Data mining of most profitable/least profitable diagnoses. Infrastructure to track monthly percentage growth in desirable cases.		1.	POC Mapping Software	10-07 thru 12-07

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	H	I
84	Jeremy Rogers Allison Speaks Tracy Darby	Completed Phase 1 of the Clean Claim Project. Started Phase 2 of Clean Claim project. Focus is on tracking down frequent errors using absent data checks
85	MA Team Jeremy Rogers	We have identified Tiffany Riddle, Susan Shields, and Patricia Broussard for our MA Collection Team. This group will be focused on billing and collecting on PPS Claims. We will also provide education and process for communicating those payers which are not adhering to PPS payment guidelines. We are focused on accurate and timely claim submission, follow up of accounts, and analysis of PPS payments.
86	Michael Allison Pat Jones	
87	Michael Allison Pat Jones	
88	Michael Allison Pat Jones	300% increase in performance with 50% reduction in staff
89	Michael Allison Pat Jones	PV Manager has been working on truing up job descriptions and finalizing restructure of team leaders and managers. Has begun working with Pre Se on automated Private verifications / identifying eligible payors
90	Michael Allison	[redacted]
91	Michael Allison	
92	Michael Allison	This team will look at existing technologies to see if any combination can yield efficiencies to reduce operational expenses.
93	Michael Allison	Finalizing Casper report requirements with LAW, Donna M., Allen, and Sherry. Have one outstanding programming issue that is preventing us from bringing the process inhouse. Staffing model has been developed and waiting for Senior Management Approval
94	Pete Hartley	[redacted]

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	A	B	C	D	E	F	G
95	Pete Hartley	Information Technology	Strategy: GPS mileage in POC. Data mining of most profitable/least profitable diagnoses. Infrastructure to track monthly percentage growth in desirable cases.		3.	Infrastructure to measure growth of desirable cases	Complete
96	Pete Hartley	Information Technology	Strategy: GPS mileage in POC. Data mining of most profitable/least profitable diagnoses. Infrastructure to track monthly percentage growth in desirable cases.		2.	Data Mining of Most/Least profitable diagnosis	Complete
97	Sherry Dukes	Point of Care	Strategy: Edits to ensure data consistency and proper diagnosis tracking in the POC system. Education of staff with POC edits, OASIS, and Coding.		3.	Education to field staff on POC edits/ OASIS ready for release (live sessions)	Complete
98	Sherry Dukes	Coding	Strategy: Edits to ensure data consistency and proper diagnosis tracking in the POC system. Education of staff with POC edits, OASIS, and Coding.		5.	Coding education complete for release (live sessions)	12/10/2007
99	Sherry Dukes	Point of Care	Strategy: Edits to ensure data consistency and proper diagnosis tracking in the POC system. Education of staff with POC edits, OASIS, and Coding.		4.	Education to field staff on POC edits/ OASIS ready for release on Learn Center	complete
100	Sherry Dukes	Coding	Strategy: Edits to ensure data consistency and proper diagnosis tracking in the POC system. Education of staff with POC edits, OASIS, and Coding.		6.	Coding education complete for release on Learn Center	1/30/2008
101	Sherry Dukes	Point of Care	Strategy: Edits to ensure data consistency and proper diagnosis tracking in the POC system. Education of staff with POC edits, OASIS, and Coding.		2.	Phase I POC edits in system	Complete
102	Sherry Dukes	Point of Care	Strategy: Edits to ensure data consistency and proper diagnosis tracking in the POC system. Education of staff with POC edits, OASIS, and Coding.		1.	Phase I POC edits list completed	Complete
103	Sherry Dukes	Point of Care	Strategy: Edits to ensure data consistency and proper diagnosis tracking in the POC system. Education of staff with POC edits, OASIS, and Coding.			Phase II POC edits list completed	complete
104	Sherry Dukes	Point of Care	Strategy: Edits to ensure data consistency and proper diagnosis tracking in the POC system. Education of staff with POC edits, OASIS, and Coding.		2.	Phase II POC edits in system	12/30/2007
105	Sherry Dukes	CM Centralization	Strategy: Centralize admissions plan reviews and booking			Beta Testing of 4 Oklahoma sites	In progress
106	Sherry Dukes	Education	Strategy: Create education for all levels of staff, VP, AVP, DOO, Clinical Managers and Field staff on PPS definement			Live Centra calls	complete
107	Sherry Dukes	Real Time Mgmt	Strategy: Use data warehouse to pull real time data on agencies for wounds, lupa, therapy, oasis, recerts, utilization, outcomes, coding			Reports created in cognos and ready for use.	complete
108	William Meyers	Sales Marketing	Strategy: Develop strategic sales focus centered upon preferred patient mix.		1.	Identify each diagnosis that will impact higher reimbursement x patient type: -Develop sales message to each diagnosis/ patient type -Develop company wide education plan on each focus diagnosis/ communication plan on the education/ message	Complete

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	H	I
95	Pete Hartley	Desirable cases need to be defined. As they are, a baseline of the episode characteristic will be performed. Queries will be created to measure the number of episodes under care. The queries will be turned into reports and added to report writer in AMS2.
96	Pete Hartley	Additional analysis will be done as required.
97	Sherry Dukes	
98	Jamie Seghers	
99	Lu Post/ Sherry Dukes	
100	Lu Post	content from Tasha
101	Brannon Byrd	
102	Sherry Dukes	Complete list of final edits to be added to POC with all prompts included in detail
103	Sherry Dukes	Complete list of final edits to be added to POC with all prompts included in detail
104	Brannon Byrd	
105	Sherry Dukes	Roll out to begin 2/1/08 for the remainder of Cheryl Lacey's region
106	TaRonna Hall	36 Central Calls scheduled in the month of November for staff; make up calls will be in December.
107	Hsin-Chih, TaRonna Hall, Wendy Meadows, Sherry Dukes, Jamie Seghers, Diane Walton	Therapy, wounds, coding, oasis ready 9/1/07. Others will be released thru out Sept with all be live by 10/1/07.
108	William Mayes Ed, Esther, Lynn, Patty Graham Jill Cannon Patti Weller	Work with Alice Ann to get data. Will want to have a dashboard report that can be used for all departments to review PPS. Diagnoses identified. Working on training courses now and developing implementation strategy now. All education is to be done by Sept. Will be multiple layer strategy on line education, citrix calls, and live regional meetings.

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	A	B	C	D	E	F	G
109	William Mayes	Sales Marketing	Strategy: Develop strategic sales focus centered upon preferred patient mix.		3.	Review with Marketing current sales collaterals: - Do we need to implement new collateral? We need to emphasize the picture of difficult patients/co-morbities/chronic patients with acute exacerbations -Look at developing marketing campaigns/contests around this emphasis	Sales Coll review Complete A sls slick specific to new DM diagnosis is being worked on by mkting and will have it w/n few wks for review
110	William Mayes	Sales Marketing	Strategy: Develop strategic sales focus centered upon preferred patient mix.		4.	Review each agency/sales territory market analysis to make sure it is current and up to date	On going and being monitored on a weekly basis by AVP of BD
111	William Mayes	Sales Marketing	Strategy: Develop strategic sales focus centered upon preferred patient mix.		2.	Review sales knowledge of each diagnosis: - Develop a training schedule to ensure sales force is knowledgeable of patient types/ DM programs and can discuss with patient -Develop training schedule to make sure sales force can develop a proper focus on DM programs/ patient types in territories	Ongoing and being monitored and managed to now
112	William Mayes	Sales Marketing	Strategy: Develop strategic sales focus centered upon preferred patient mix.		5.	Review all market plans to identify KEY strategic markets/accounts to target in the campaign: -Identify the KEY accounts x territory (doctors, hospitals,SLFs) - Develop a call reach and frequency x target accounts (for tagged diagnoses) -Develop a mgmt. metric to monitor/track/manage to this strategy	Ongoing and developing the plans as we speak

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	H		I
109	William Mayes Esther, Lynn, Graham, Carroll Cannon Waller Ed, Patty Kim Jill Patti		We have great collaterals now . I feel that we just need to work on a stick that outlines the top diagnoses and highlights what those patients look like. In action phase now. We have trained the training modules for the DM programs and they are now with Pamela to be dropped into web based learning centre modules. Each sales person will take the online class then take a test on the module for core competency.
110	RDBDs VP Operations VPs of BD RAs		This is a core metric now being measured weekly. It shouldn't be difficult to do. In check off phase.
111	RDBDs Operations William Mayes Ed, Esther Jill Cannon Patti Waller VP		RDBDs will begin managing to this once key diagnoses are identified. Will begin implementing to entire sales team through meetings/conference calls/Centra. On-Going now and training sessions are in the planning stage.
112	RDBDs VP Operations Reps VP's of BD Sales Reps. William Mayes		We will require the sales team to break down business plan. We already have a core metric template in place. All we have to do is add these points to it and manage the RDBDs to the additions.

Footnote 34

From: Jami Henzen
Sent: Thursday, August 30, 2007 5:19 PM
To: William Mayes; Jill Cannon; Patti Waller; Anne Frechette; Donna Massie; Michelle Quigley; Sherry Dukes; TeRonna Hall; Lu Post; Pete Hartley; Dana Voss; Michael Allison; Jeremy Rogers; Shannen Rouse; Francis Mayer; Scott Ginn; Martha Williams; Kristopher Miller; Cindy Phillips; Melissa Geci; Mike Ginn; Mike Hamilton; Elizabeth Robinson; Teresa Ledgerwood; Cheryl Lacey; Pamela Huffman; Wanda Hull; Lisa Newell; Tom Dolan
CC: Alice Schwartz; Peggy Hill; Bill Borne; Dale Redman; Bari Dees; Dara Modupe; Holli Kliebert; Donnice Long; Trina Johnson; Lorraine Bossier; Stephanie Lauve; Lori Gauthier
Subject: A-Team Case Mix Committee
Attachments: Bad Debt Expense Review.xls; Therapy Initiatives Update.doc; Action Items.08.31.07.xls

Importance: High

This is just a reminder of the A-Team Case Mix Committee Conference Call scheduled for tomorrow, August 31st at 9:00a.m. C.S.T./ 10:00a.m. E.S.T.

Conference Call #: [redacted]

Participant Code: [redacted]

Please print the attached documents for the call.

Thanks,
Jami Henzen
Admin. Asst. CIO
Amedisys, Inc.
O- [redacted] ***ext.*** [redacted]
F- [redacted]
C- [redacted]
"A true friend is someone who reaches for your hand and touches your heart."

Therapy Initiatives Update

- ***Wound Care – A Therapy Approach***
  - Sept. 15th-16th – first training to Specialty Locations
  - Oct. – Dec. 2007 – We have 5 additional trainings scheduled for 2007 in Atlanta.
  - Anticipate 1 Training per Month in 2008
  - 7 Learn Center Modules – Pre-requisites to attend course
  - Under "Go Live" Model for Oversight
  - 123 Locations Responded to Date for Participation
  - 248 Therapists Registered for Course
  - Trainers: Telemedicine Team, Specialty Team
  - ConvaTec will be providing support for Products Lab, Wound Algorithms, Formulary and Skills Check-offs.

- ***Balanced For Life***
  - 22 Locations Launched
  - Approx. 1400 Admits by the end of Q2
  - 2007 – Average HHRG was $4,100
  - 2008 – Projected HHRG is $4,700 (Higher with OT added to BFL)
  - POC Triggers with New Falls Risk Assessment in Oasis SOC
  - Aggressive Strategy for Atlanta BFL – Started first of August with Specialty Director search for 9 Directors to cover 19 locations. 6 high talent therapists have been identified and offers made to 4. Plan to launch the branches and train the therapists in October with a full blown Blitz of the market in November.

Footnote 35

REHAB CLINICAL TRACK OPTIONS

Rehab Program: JOINT RECOVERY AT HOME

Track Name	Track Code	Recommended Visits
Joint Recovery - Hip - Short Stay1	HIP001	6 PT
Joint Recovery - Hip - Short Stay2	HIP002	3 PT + 3 OT
Joint Recovery - Hip - Advanced Care1	HIP003	12 PT
Joint Recovery - Hip - Advanced Care2	HIP004	8 PT + 4 OT
Joint Recovery - Knee - Short Stay1	KNE001	6 PT
Joint Recovery - Knee - Short Stay2	KNE002	3 PT + 3 OT
Joint Recovery - Knee - Advanced Care1	KNE003	12 PT
Joint Recovery - Knee - Advanced Care2	KNE004	8 PT + 4 OT

Rehab Program - BETTER BALANCE AT HOME

Track Name	Track Code	Recommended Visits
Better Balance - Short Stay1	BAL001	3 PT (SN also in home)
Better Balance - Short Stay2	BAL002	5 PT
Better Balance - Advanced Care1	BAL003	12 PT
Better Balance - Advanced Care2	BAL004	8 PT + 4 OT

Rehab Program - BETTER STRENGTH AT HOME

Track Name	Track Code	Recommended Visits
Better Strength - Short Stay1	STR001	3 PT (SN also in home)
Better Strength - Short Stay2	STR002	5 PT
Better Strength - Advanced Care1	STR003	12 PT
Better Strength - Advanced Care2	STR004	8 PT + 4 OT

8/04

"STROKE RECOVERY AT HOME"
CLINICAL TRACK FOR THERAPY

Guidelines	Information
Outcomes Assessment Tool **The Carr/Shepherd assessment should be used periodically and at discharge to gauge patient progress.** **Assess patient's multi-disciplinary needs in setting up the treatment plan.**	**Based on Carr/Shepherd Assessment Scoring indication:** Severe stroke Moderate stroke Mild stroke Carr/ Shepherd Assessment tool located in Stroke Recovery at Home Workbook
Visit Frequency **(Combined PT, OT, and SLP)**	Severe stroke - 3 x week Moderate stroke – 2-3 x week Mild stroke – 1-2 x week
Visit Duration **(Combined PT, OT and SLP) Decrease frequency of visits as patient progresses.**	Severe stroke – up to 8 weeks Moderate stroke – up to 8 weeks Mild stroke – up to 6 weeks
Therapeutic Exercises and Education	Refer to Stroke Recovery at Home Workbook, which is a tool to help you design an exercise program. It contains educational material and illustrated exercises for patients with severe, moderate, or mild conditions. In addition to these, use your creativity and experience to expand on these basic exercises.
Rehab Goals **Coordinate Physical and Occupational Therapy Goals (sample goals)**	**Severe stroke –** 1. Indep bed mobility 2. Indep bedside sitting 3. Basic transfers 4. Basic arm/hand movements **Moderate stroke –** 1. Indep sitting activities 2. Indep sit/stand/sit 3. Amb w/ assist w/ even LE WB 4. Active forward reaching in sitting 5. Simple grasping **Mild stroke -** 1. Indep amb w/ direction changes, no device. 2. Indep on steps w/ device or rail. 3. Fine motor grasping with grooming, bathing, dressing, and feeding.
Speech therapy goals (sample goals)	1. Re-establish fundamentals of language. 2. Regain communication skills. 3. Improve swallowing. 4. Improve speech, voice quality.
Discharge Planning	Discharge when: Goals have been achieved, pt/cg independent with home exercises, or if pt has reached plateau and is no longer making progress, no longer homebound.

CVA CLINICAL TRACK OPTIONS

Rehab Program: STROKE RECOVERY AT HOME

Track Name	Track Code	Recommended Visits
Stroke Recovery – Severe – PT Only	CVA 002	16 PT
Stroke Recovery – Severe – Multi-Discipline 1	CVA 003	10 PT + 6 OT
Stroke Recovery – Severe – Multi-Discipline 2	CVA 004	6 PT + 6 OT + 4 ST
Stroke Recovery – Moderate – PT Only	CVA 005	14 PT
Stroke Recovery – Moderate – Multi-Discipline 1	CVA 006	8 PT + 6 OT
Stroke Recovery – Moderate – Multi-Discipline 2	CVA 007	6 PT + 6 OT + 4 ST
Stroke Recovery – Mild – PT Only	CVA 008	12 PT
Stroke Recovery – Mild – Multi-Discipline 1	CVA 009	6 PT + 6 OT
Stroke Recovery – Mild – Multi-Discipline 2	CVA 010	6 PT + 4 OT +4 ST

DSM DEV 08/05

Amedisys Physical Therapy Exercise and Tracking Log

Patient name _____ ID # _____ Diagnosis _____

Therapist _____ initials ____ Limiting factors _____ Physician _____

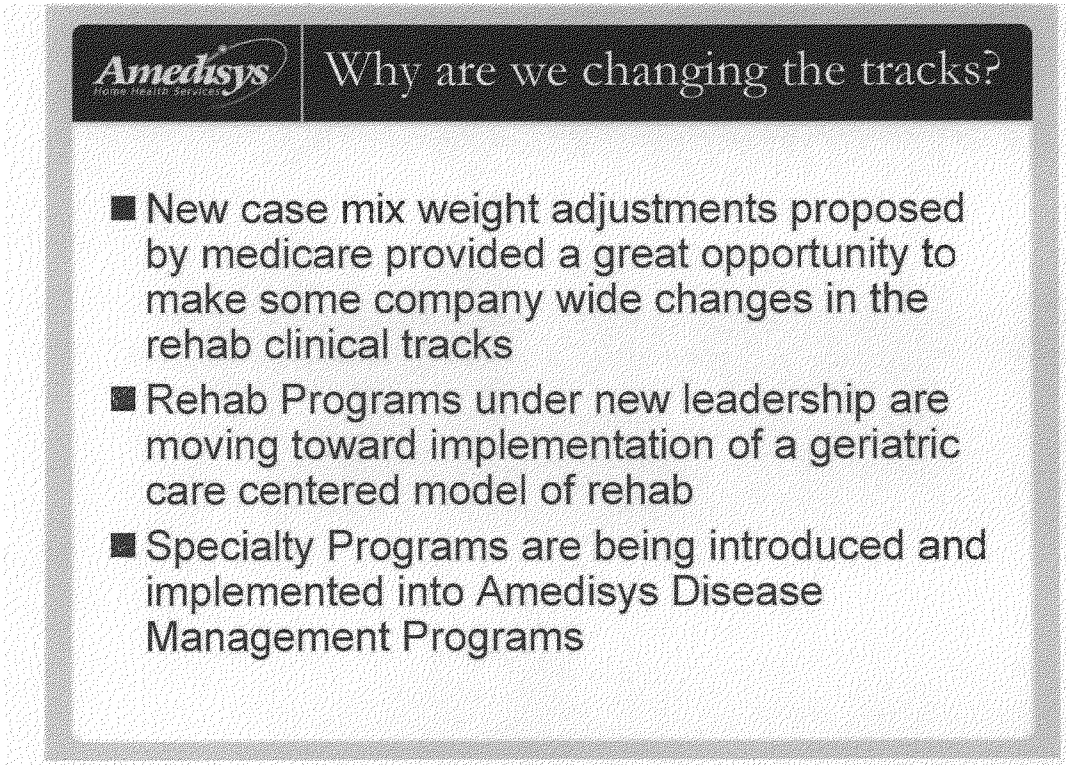
Date													
Example	10 10x1	12 12x1	14 14x1	10 10x2	12 12x2	14 14x2	10 10x3	12 12x3	14 14x3	10 10x4	12 12x4	14 14x4	
Totals													
Ambulation (feet or minutes) Goal: 10 minutes nonstop													
Device for Amb													
ROM													
Pain													
Tinetti Balance scores (max 28)													
PT Initials													

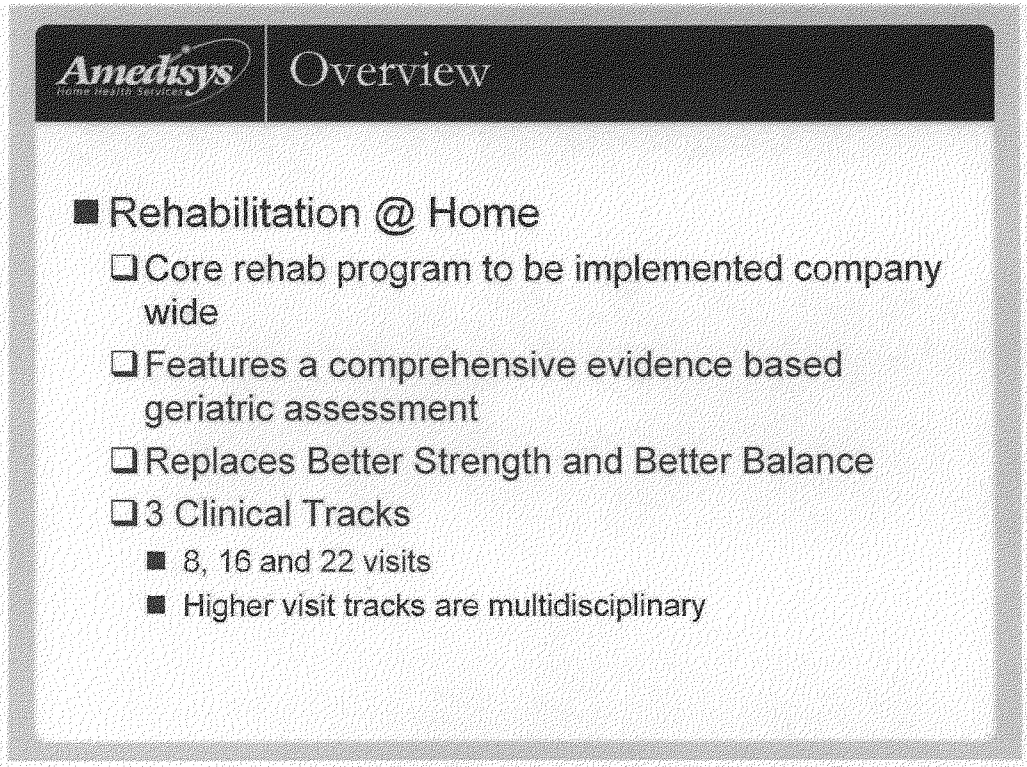
Number of reps x color of T-band (no T-band = 1, yellow = 2, red = 3, green = 4)
Sit to stand: Pulling on sink = **1**, using BOTH armrests from straight chair = **2**, using ONE armrests from straight chair = **3**, using no armrests = **4**

Correspondence with Physician

Footnote 36

Amedisys
Amedisys Rehabilitation
2007-2008
CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO RHODE RULE XXX
AMED-SR-0000184

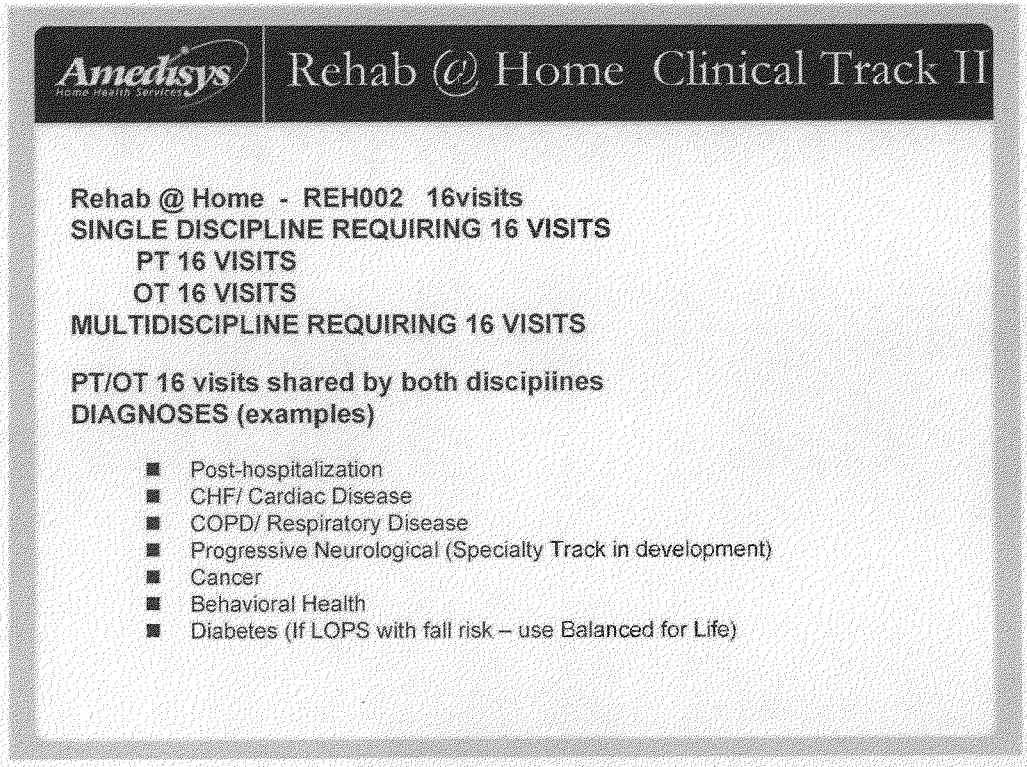




Rehab @ Home Clinical Track I

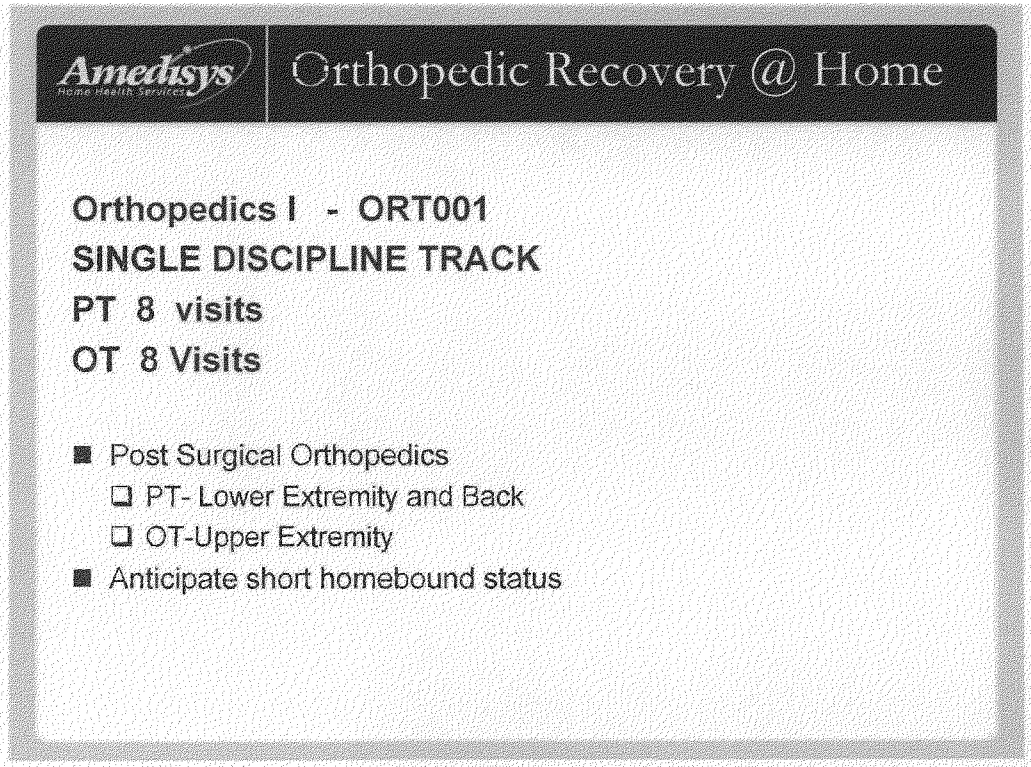
- **Rehab @ Home - REH001 8 visits***
- **SINGLE DISCIPLINE TRACK**
  - **PT 8 visits**
  - **OT 8 visits**
- Anticipate quick recovery and short homebound status or guarded rehab potential
- DIAGNOSES (examples)
  - Post – Hospital (De-conditioned)
  - Pneumonia
  - Stable CHF, COPD, HTN, etc.
  - Behavioral Health

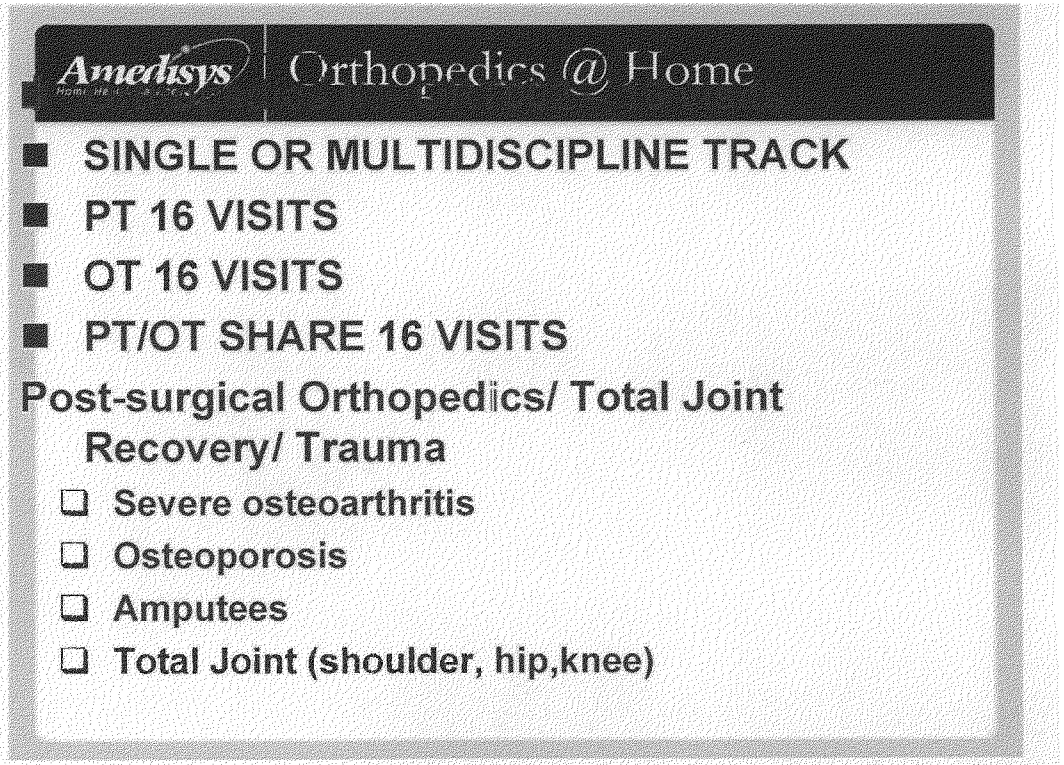
*visit numbers are guidelines. Care plans are made patient specific and appropriate to the needs of that patient

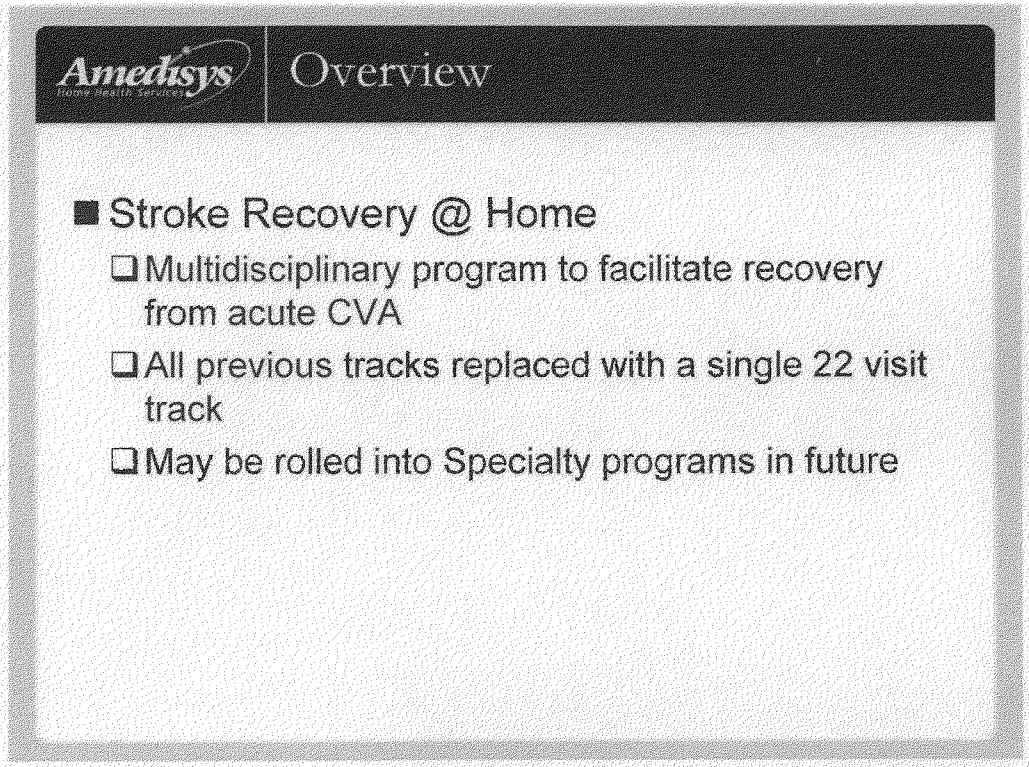


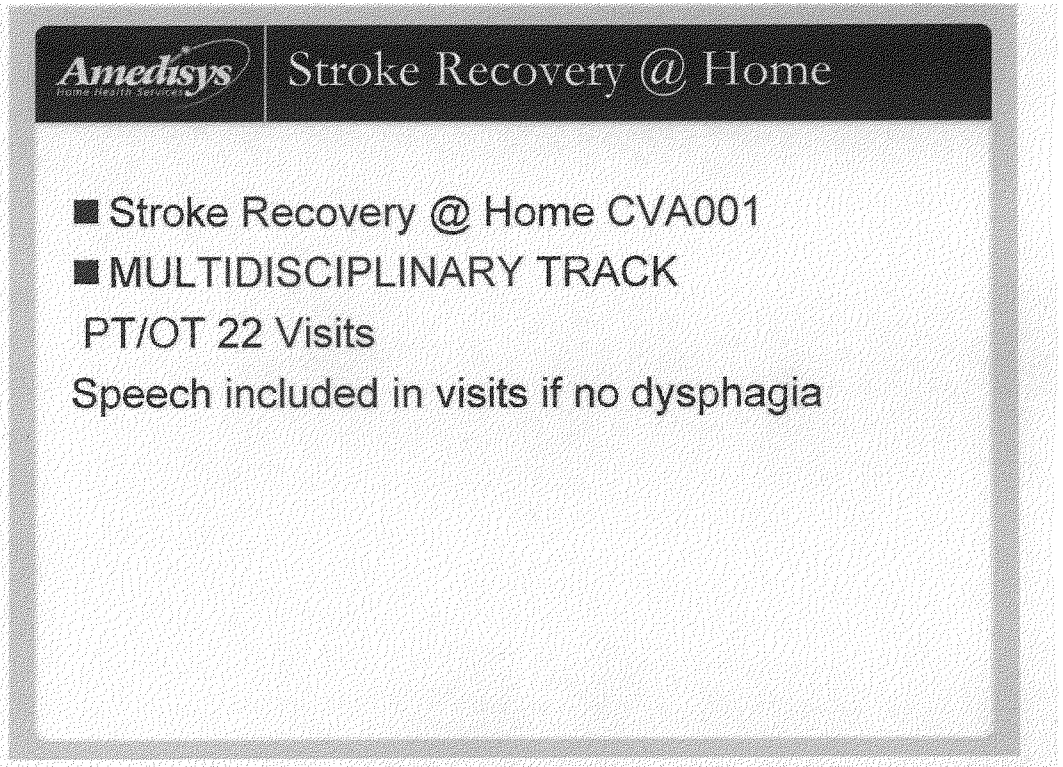
Overview

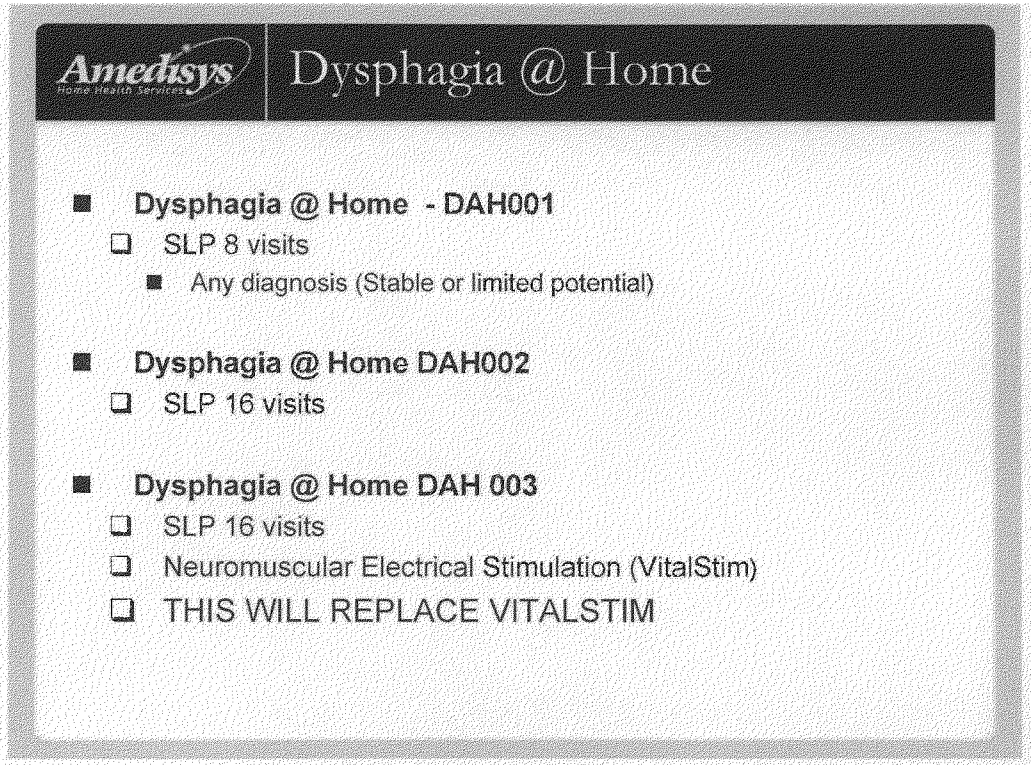
- Orthopedic Recovery @ Home
  - Orthopedic clinical program with focus on pain management and manual therapy to return functional ROM, strength and mobility
  - Replaces Total Joint Recovery @ Home
  - 2 Clinical Tracks
    - 8 visits and 16 visits
    - Patients with co-morbid conditions and multidisciplinary needs requiring more visits would use Rehab @ Home for 22 visits

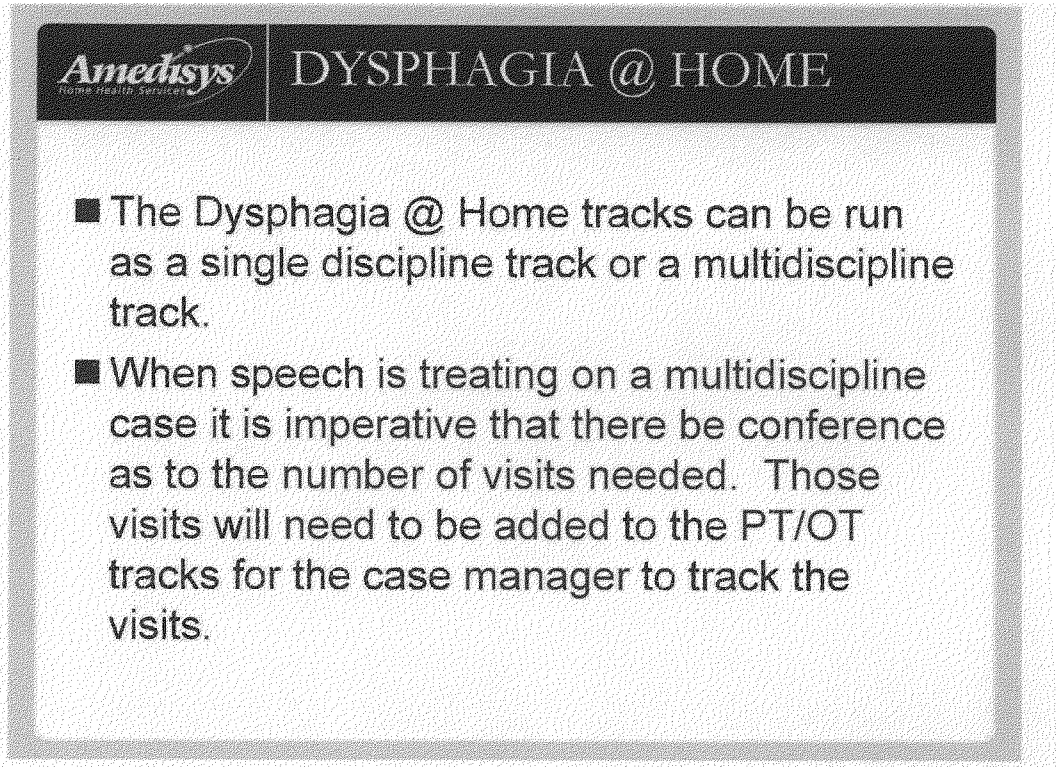


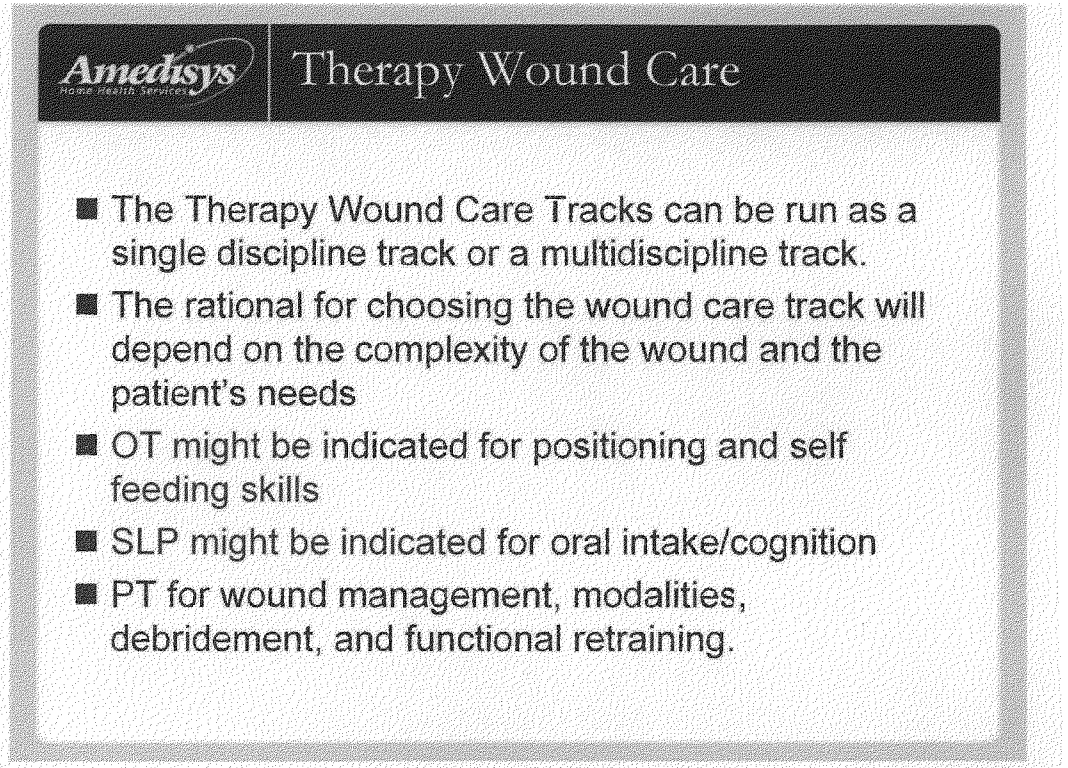


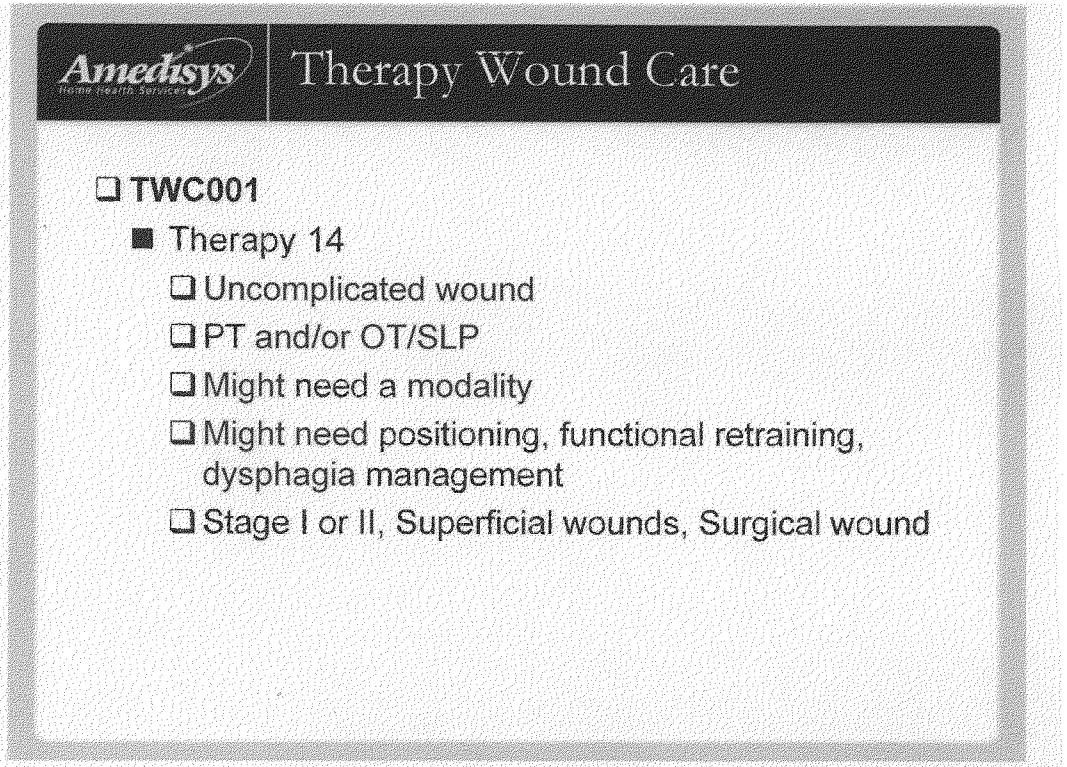


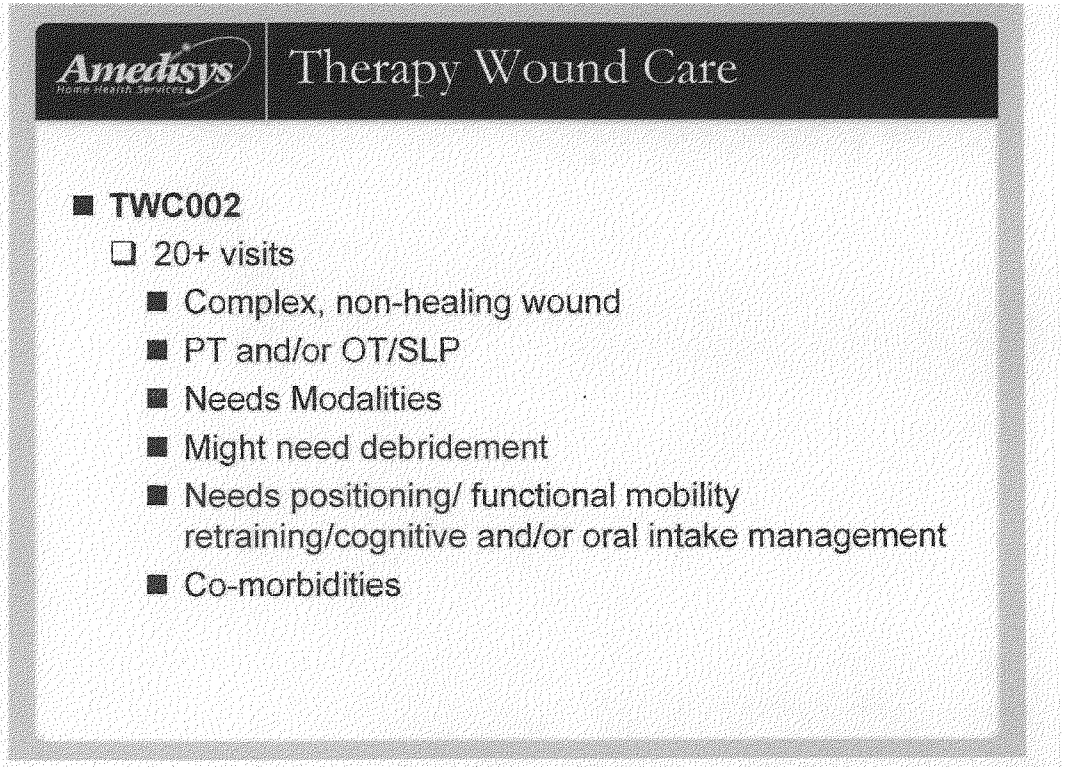


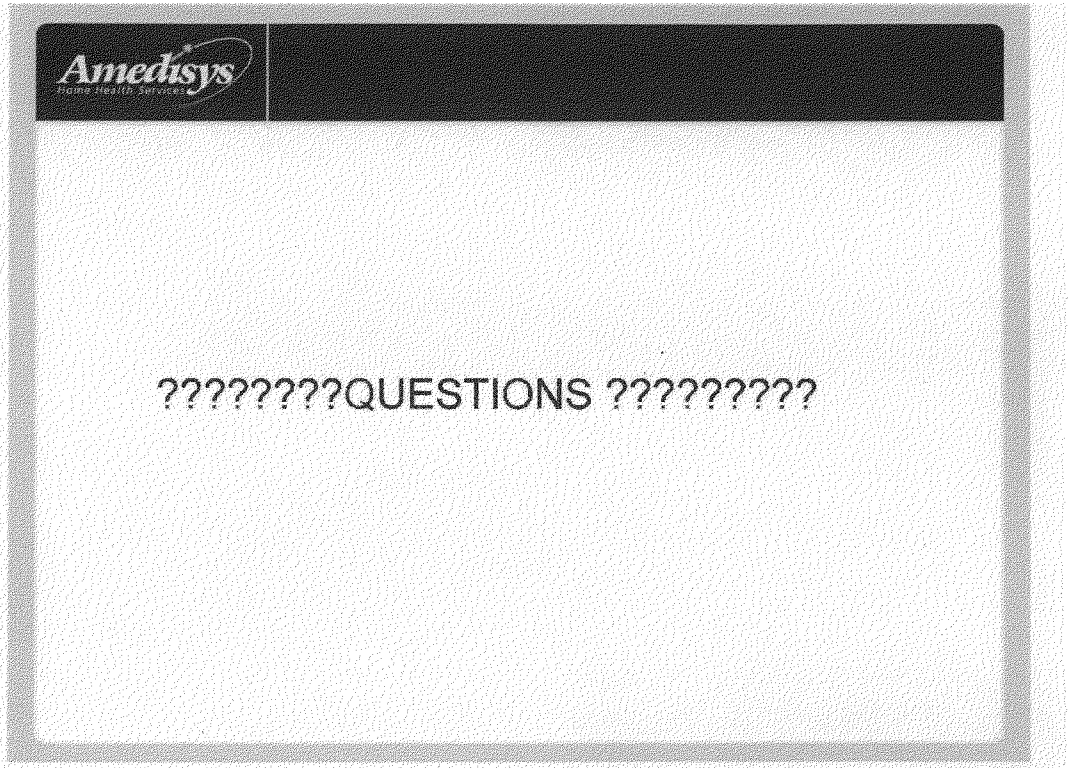












Footnote 37

Disease Management: Clinical Track Selection Sheet

Patient Name: _____
Cert/Recert Period: _____

Clinician Selection Track: _____
CIRCLE THE **CODE** FOR SELECTED CLINICAL TRACK

TRACK	CODE	# OF VSTS
Rehab Specialty Programs Requires Special Training to Use		
Balance for Life		
Balance for Life (PT/OT)	BFL001	14 or ___
Balance for Life with Decond (PT/OT)	BFL002	22 or ___
Balance for Life with Anodyne (PT/OT)	BFL003	22 or ___
Behavioral Health @ Home		
Alzheimers; Senile Dementia	ALZ001	8 or ___
Anxiety	ANX001	10 or ___
Bi Polar Disorder	BIP001	10 or ___
Depression	DEP001	12 or ___
Schizophrenia	SCH001	12 or ___
Chronic Kidney Disease @ Home		
Chronic Kidney Disease	CKD001	8 or ___
COPD @ Home		
Chronic Obs. Pulm Disease	COP001	8 or ___
Diabetes @ Home		
Diabetes Type 1 or Type II	DIA001	8 or ___
Diabetes (ADA Program: SN)	DIA002	6 or ___
Diabetes Survival Skills	DIA003	4 or ___
Dysphagia @ Home		
Dysphagia at Home (SLP)	DAH001	6 or ___
Dysphagia at Home (SLP,PT,OT)	DAH002	14-20 or ___
Dysphagia at Home with NMES (SLP)	DAH003	14 or ___
Heart @ Home		
Atrial Fibrillation	AFL001	6 or ___
Congestive Heart Failure	CHF001	12 or ___
Coronary Artery Disease	CAD001	10 or ___
Coronary Artery Bypass Graft	COR001	10 or ___
Heart Transplant	HEA001	8 or ___
Heart Transplant w/Infusion	HEA002	12 or ___
Hypertension	HYP001	12 or ___
Intropic Infusion	INO001	15 or ___
Myocardial Infarction	MYO001	10 or ___
Other Medical Conditions		
Anemia	ANE001	5 or ___
Anemia with Injection	ANE002	7 or ___
Anti-Coagulant Therapy	ANC001	4 or ___
Cellulitis	CEL001	6 or ___
Cellulitis with Infusion	CEL002	10 or ___
Deep Vein Thrombosis	DVT001	9 or ___
Diverticuler Disease	DIV001	6 or ___
Dyspnea	DYS001	6 or ___
Fluid and Electrolyte Imbalance	FLU001	5 or ___
Fractures	FRA001	4 or ___
Malabsorption Syndrome	MAL001	6 or ___
Malabsorption w/Injection	MAL002	8 or ___
Malabsorption w/Infusion	MAL003	10 or ___
Malabsorption tube feeding	MAL004	8 or ___
Multiples Sclerosis	MUL001	7 or ___
Neoplasm, Malignant	NEO001	7 or ___
Osteoarthritis	OST001	4 or ___
Osteoporosis	OST002	6 or ___
Parkinson's DX	PAR001	8 or ___
Peripheral Arterial Disease	PER001	5 or ___
Pneumonia	PNE001	6 or ___
Urinary Incontience/UTI Prevention	URI001	5 or ___
Urinary Retention w/Catheter	URI002	7 or ___
Urinary Incontinence w/indwelling Cath	URI003	7 or ___
Varicose Veins	VAR001	6 or ___

TRACK	CODE	# OF VSTS
Orthopedics @ Home		
Orthopedics I (PT)	ORT001	8 or ___
Orthopedics II (PT/OT)	ORT002	16 or ___
Total Hip (SN Only)	THR001	4 or ___
Total Knee (SN Only)	TKR001	4 or ___
Pain Management @ Home		
Pain	PAI001	6 or ___
Rehab @ Home		
Geriatric Rehab Patients	REH001	8 or ___
Geriatric Moderate/High/Acuity (PT/OT)	REH002	16 or ___
Geriatric Moderate/High Acuity (PT/OT/ST)	REH003	22 or ___
Stroke Recovery @ Home		
CVA (SN Only)	CVA001	6 or ___
Stroke Rehab Multi-Disciplined (PT/OT/SLP)	CVA002	22 or ___
Surgical Recovery @ Home		
Operative	OPER01	8 or ___
Wound & Skin Care		
Burn: Massive Tissue Loss	BUR001	8 or ___
Pressure Ulcer	PRE001	16 or ___
Surgical Wound: (Closed/Uncomplicated)	SUR001	8 or ___
Surgical Wound: (Open/Dehisced)	SUR002	12 or ___
Venous Statis Ulcer	VAS002	12 or ___
Arterial Wound	VAS003	12 or ___
Neuropathic/Diabetic Ulcer	VAS004	12 or ___
Rehab Specialty Programs Requires Special Training to Use		
Therapy Wound Care I (PT/OT/ST)	TWC001	14 or ___
Therapy Wound Care II (PT/OT/ST)	TWC002	20 + or ___
Telehealth (CV) Specialty Program Requires Permission to Use		
Telehealth (CV)	TEL001	7 or ___
SPECIALTY PROGRAMS MUST BE TRAINED OR PICK TO USE		
Balance for Life (PT/OT)	BFL001	14 or ___
Balance for Life with Decond (PT/OT)	BFL002	22 or ___
Balance for Life with Anodyne (PT/OT)	BFL003	14 or ___
Therapy Wound Care I (PT/OT/ST)	TWC001	14 or ___
Therapy Wound Care II (PT/OT/ST)	TWC002	20 + or ___
Telehealth (CV)	TEL001	7 or ___

Clinical Manager Review: Number of vists ordered for this episode

SN _____ PT _____ OT _____ ST _____ HHA _____

Visits Ordered are greater than # of Visits on the selected Tracks: **YES/NO**

If Yes, Clinical Manager must sign here for approval: _____

MSW _____ Total: _____

Footnote 38

BIG BOOM! BIG BANG!

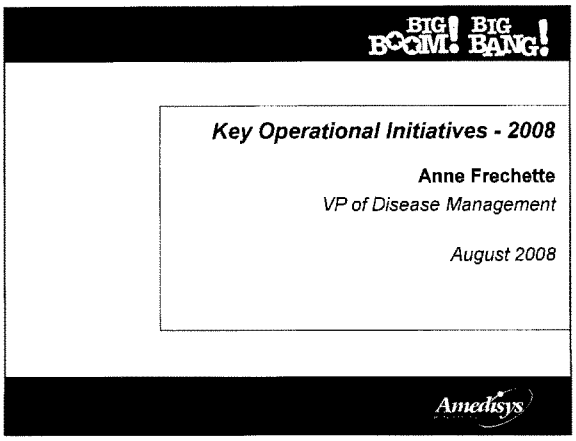
Key Operational Initiatives - 2008

Anne Frechette

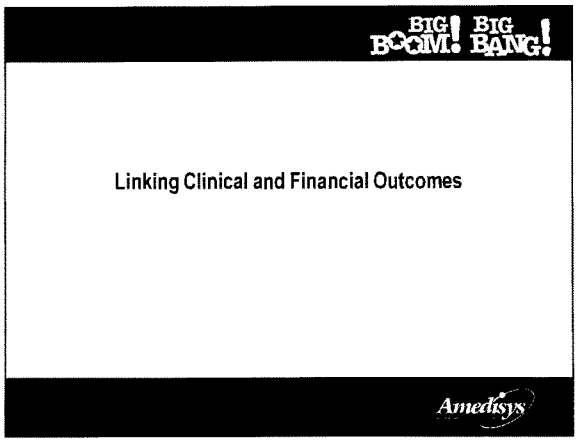
VP of Disease Management

August 2008

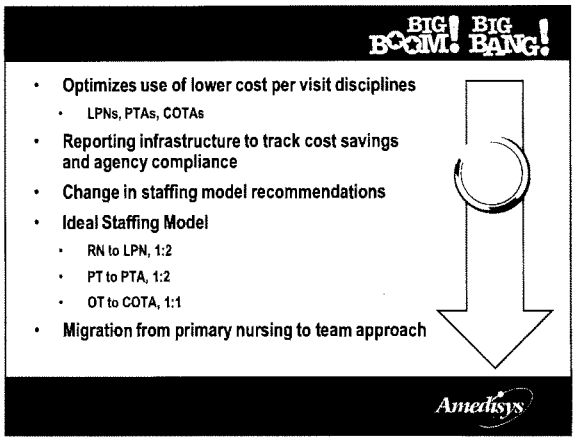
Amedisys



Linking Clinical and Financial Outcomes



- Optimizes use of lower cost per visit disciplines
  - LPNs, PTAs, COTAs
- Reporting infrastructure to track cost savings and agency compliance
- Change in staffing model recommendations
- Ideal Staffing Model
  - RN to LPN, 1:2
  - PT to PTA, 1:2
  - OT to COTA, 1:1
- Migration from primary nursing to team approach



Targeted Discipline Scheduling…what is it? The Right Care to the Right Patient by the Right Clinician.

Rolling back to the dawn of PPS…when Medicare changed their reimbursement to the PPS model, we were given the OASIS assessment, which could only be done by an RN. The result was that RNs drove the home care delivery system.

Rolling Forward…in today's system, we have sicker patients, older patients, and Medicare continues to change their reimbursement.

Amedisys is committed to quality care and outcomes, while maintaining attention to our bottom line. The Best Way to move forward in this environment is a new clinical initiative that involves a Team Approach.

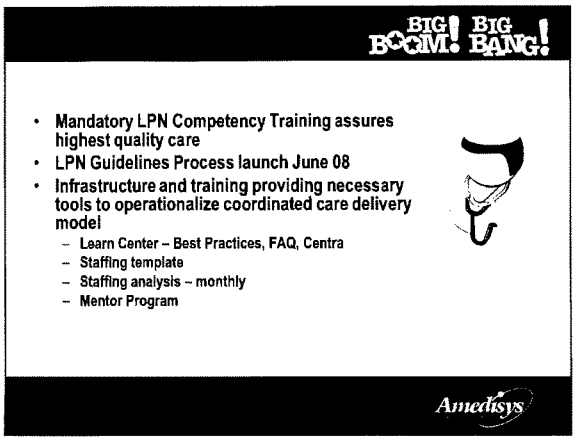
In our current system of primary care from the RN, who has their own set of patients, traditionally has had control of scheduling, did all the visits, and decided when to discharge, many times without anyone else familiar with the patient's true clinical needs.

This clinical initiative moves that primary RN to a coordinated care model, using All Members of the clinical team…the RN, LPN, therapists and therapy aides.

BIG! BIG BOOM! BANG!

- **Mandatory LPN Competency Training assures highest quality care**
- **LPN Guidelines Process launch June 08**
- **Infrastructure and training providing necessary tools to operationalize coordinated care delivery model**
  - **Learn Center – Best Practices, FAQ, Centra**
  - **Staffing template**
  - **Staffing analysis – monthly**
  - **Mentor Program**

Amedisys



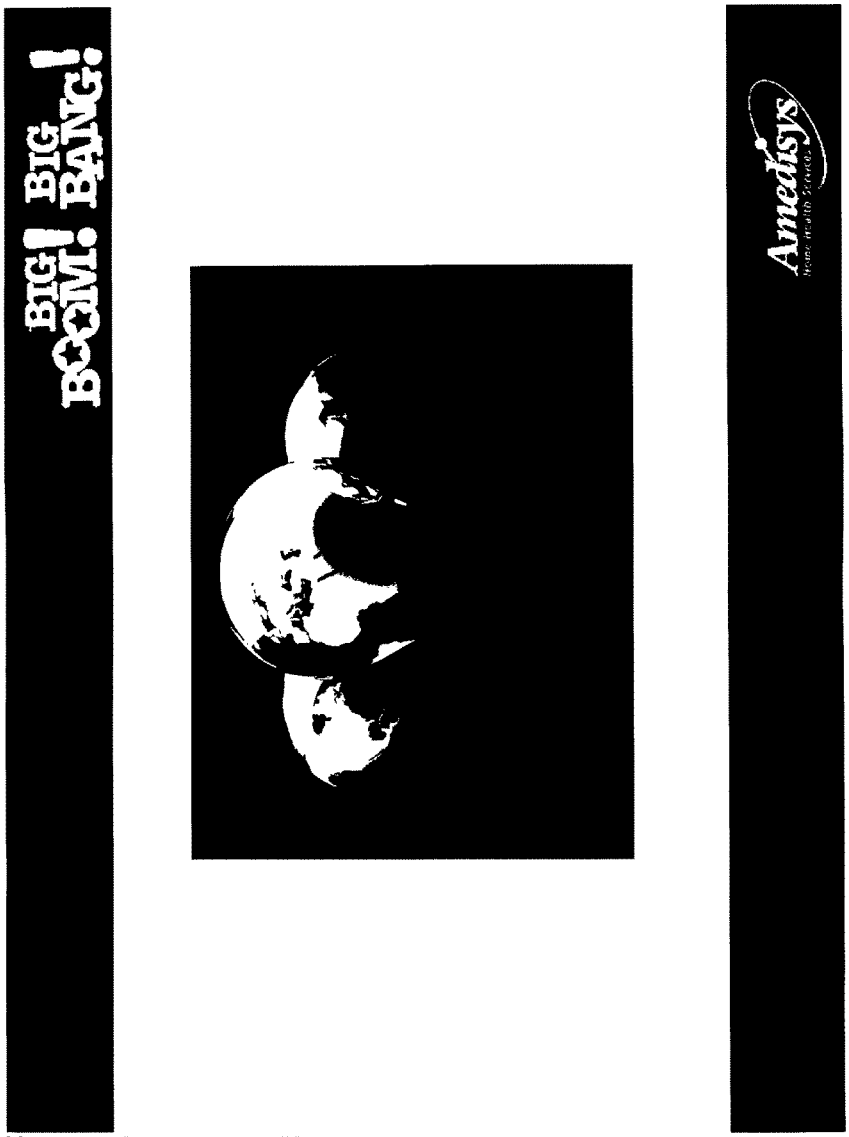
We put forth significant effort over the past 2 years in developing this clinical program. We know the success of this initiative rests on 3 things
1.Education
2.Training
3.Validation of skills

Let's talk about education

In Quarter 4 of 2007, Advanced credentialed clinical training programs were developed, aligned with the most prevalent diagnoses in our population, specifically Wound, Cardiac, Diabetes and Stroke and launched in our on-line learning application. In order to be credentialed in one of these programs, clinicians complete a series of courses (3-5) and, with 80% pass scores, receive CEUs and credentialing recognition by way of a lapel pin. To date, we've sent out over 10,000 pins. 10,000 of these credentialed courses have been completed and they are not easy courses!

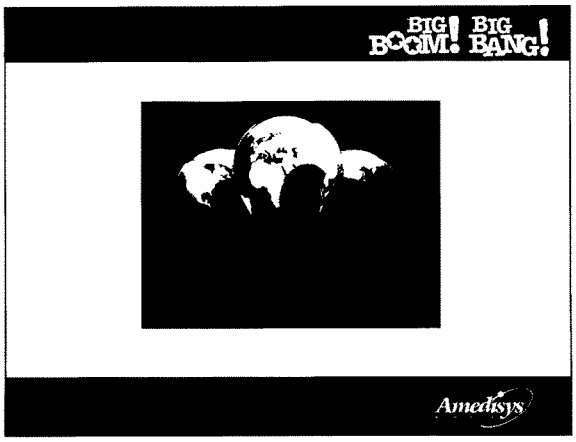
Training. Our next step in assuring consistent quality was to develop and implement core competency training MANDATORY for ALL of our nurses upon hire and require annual renewal. This ensures there is a required level of expertise for ALL nurses, but especially critical for LPNs. These courses are a condition of employment – there are 9 of them; some are Low Tech but critical for survey success, but include highly technical courses on advanced wound care, IV management and phlebotomy skills.

Finally, we understood it was critical to validate the technical skills, so all of



CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEDSFC00066786



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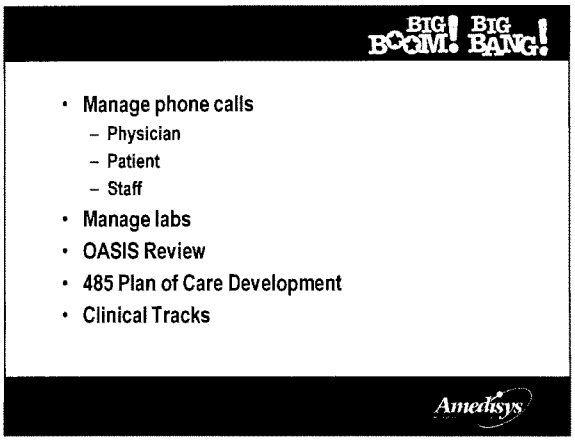

These are current agency clinical manager tasks (at a minimum). The reality of managing a team of patients is that all of these tasks take priority over the processing of paperwork (OASIS and 485's).

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

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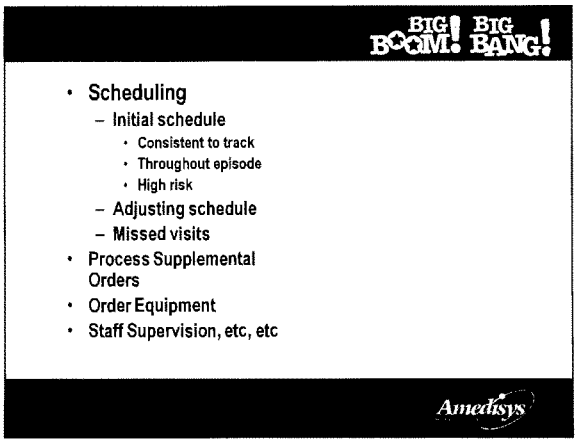
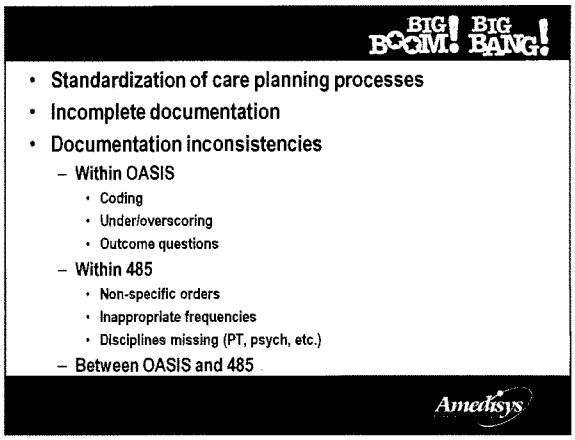


These are current agency clinical manager tasks (at a minimum). The reality of managing a team of patients is that all of these tasks take priority over the processing of paperwork (OASIS and 485's).

BIG BOOM! BIG BANG!

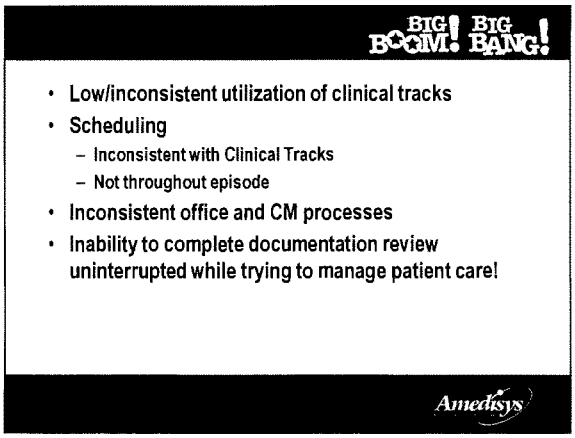
- Standardization of care planning processes
- Incomplete documentation
- Documentation inconsistencies
  - Within OASIS
    - Coding
    - Under/overscoring
    - Outcome questions
  - Within 485
    - Non-specific orders
    - Inappropriate frequencies
    - Disciplines missing (PT, psych, etc.)
  - Between OASIS and 485



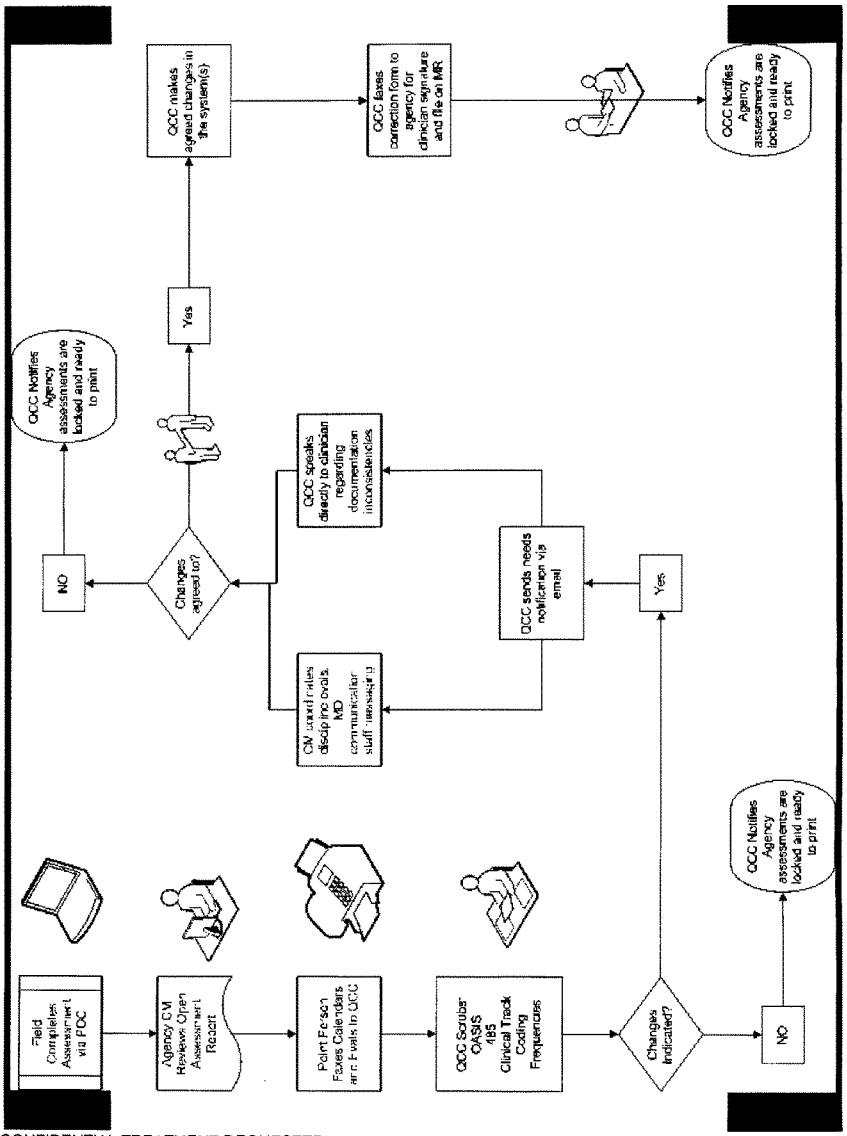
These are just some of the challenges Clinical managers face on a day to day basis trying to manage a team of patients.

BIG BOOM! BIG BANG!

- Low/inconsistent utilization of clinical tracks
- Scheduling
  - Inconsistent with Clinical Tracks
  - Not throughout episode
- Inconsistent office and CM processes
- Inability to complete documentation review uninterrupted while trying to manage patient care!



These are just some of the challenges Clinical managers face on a day to day basis trying to manage a team of patients.



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PURSUANT TO SENATE RULE XXIX

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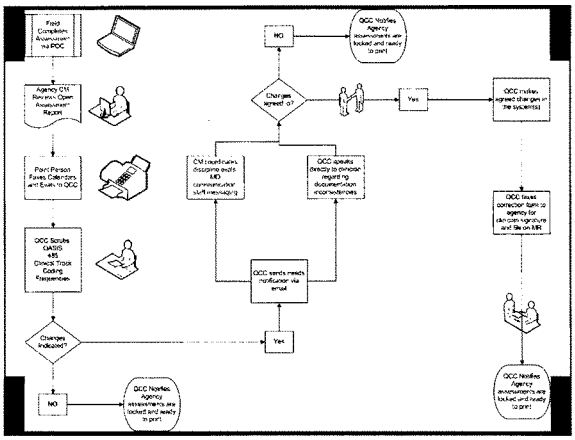

This is a diagram of the typical processing of OASIS and 485 plan of care development. Everything highlighted in yellow are the tasks the QCC will segment off of the agency clinical manager.

BIG BOOM! BIG BANG!

- Improve quality of OASIS documentation
- Improve 485 development
- Improve care coordination
- Standardization of processes
- Scheduling according to orders
- Improve compliance with scheduling according to clinical tracks

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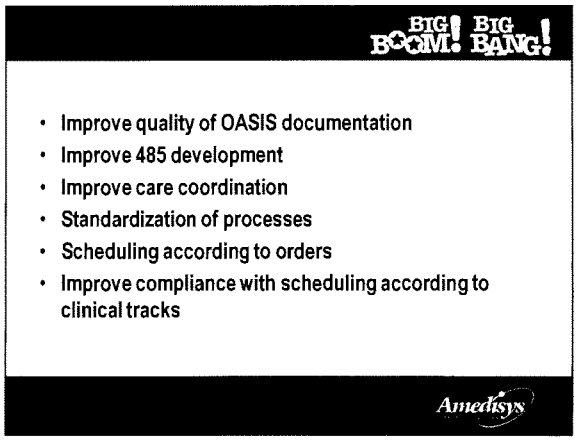
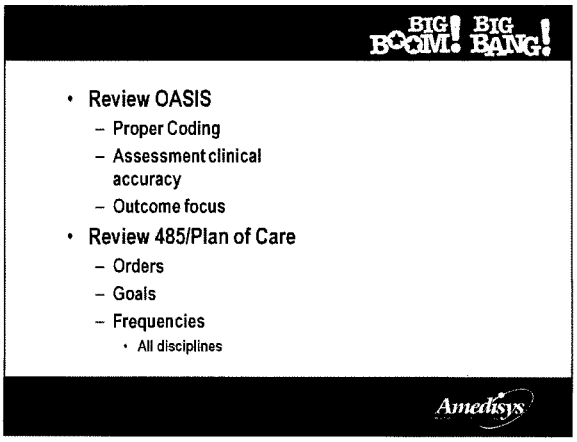


By taking the "transaction processing" away from the day to day responsibilities of the agency clinical managers, we are able to improve these goals.



QCC's process all admits, recerts, and resumptions.

BIG BOOM! BIG BANG!

- Assign Clinical Tracks
- Review Schedule
  - Consistent with track
  - Throughout episode
  - High risk scheduling
- Auto forward wound care evaluations
- Corrects agreed changes

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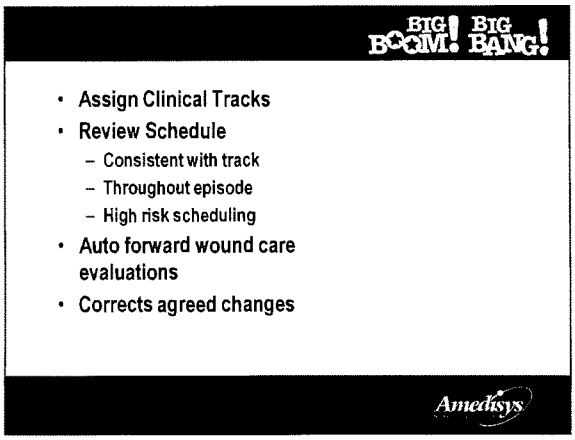

QCC's process all admits, recerts, and resumptions.

BIG BOOM! BIG BANG!

- Agency Contact Person to Notify of Locks
- Point Person for Schedules
- Point Person for Calendars
- Point Person for Therapy evals if not done on POC
- Point Person for Entering Episode Dates in AMS2
- Point Person for OASIS correction forms
- List of clinician contact info

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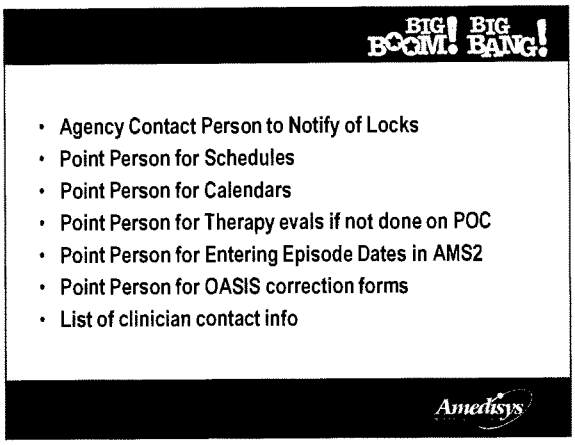

Status of receiving this information?

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

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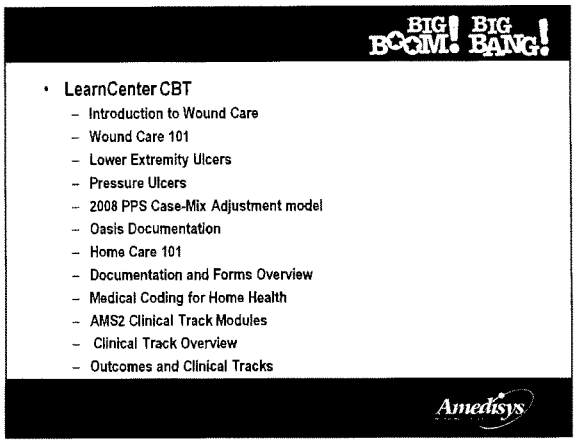
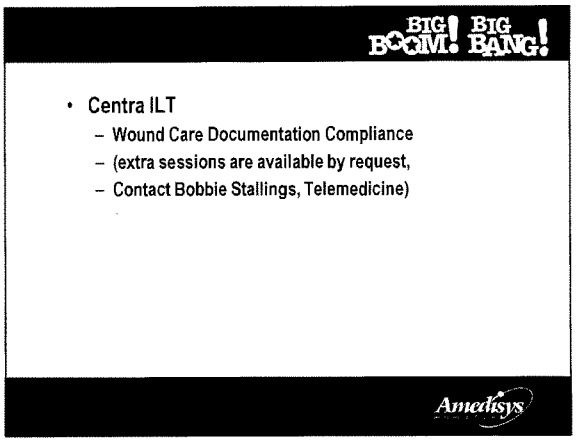


These are the basic learn center courses that all OASIS assessing field staff should perform prior to the roll out of QCC in your region. These are mandatory trainings, that are already a part of field clinicians' curriculum. If they have not completed within 6 months of QCC go live, they must take and/or repeat.

BIG! BOOM! BIG BANG!

- Centra ILT
  - Wound Care Documentation Compliance
  - (extra sessions are available by request,
  - Contact Bobbie Stallings, Telemedicine)

Amedisys



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BIG BOOM! BIG BANG!

- Clinical Staff Education Pre-go live
  - Overall concept of QCC
  - Documentation, OASIS, Clinical Tracks, etc.
- Timeliness of documentation to QCC
  - Assessment transfers
  - Schedules
- Responsiveness of staff to inquiries
  - Best practice is for QCC to have direct clinician access
  - Need to educate and establish expectations
  - 48 hr response

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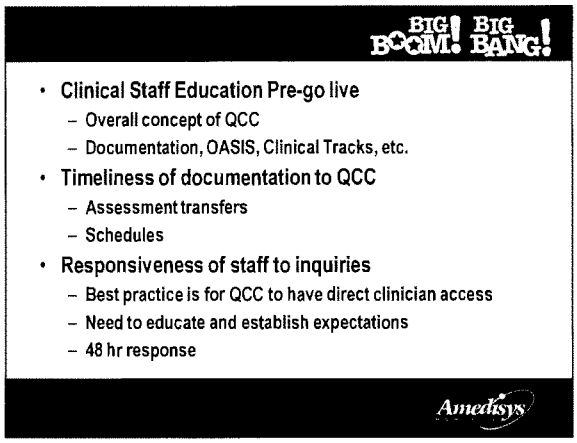
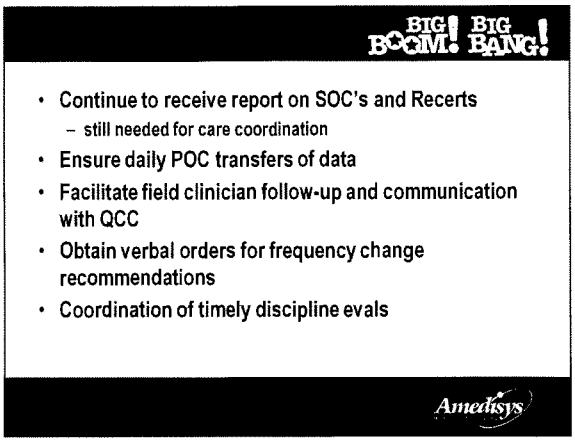


These are lessons learned from the beta and current live sites that will make the transition easier on the agency.

BIG BOOM! BIG BANG!

- Continue to receive report on SOC's and Recerts
  - still needed for care coordination
- Ensure daily POC transfers of data
- Facilitate field clinician follow-up and communication with QCC
- Obtain verbal orders for frequency change recommendations
- Coordination of timely discipline evals

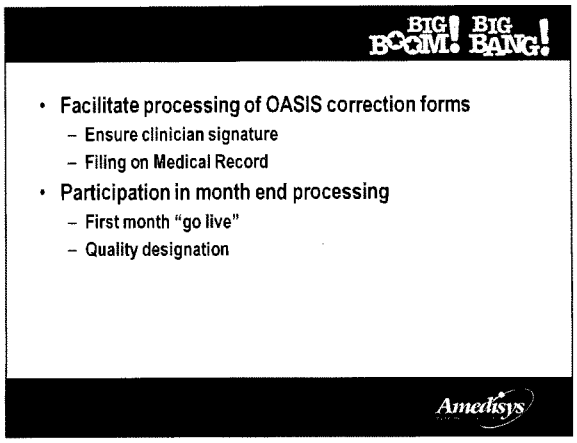


The clinical manager in the agency managing patient care, still has some responsibilities to ensure it is possible for the QCC to process OASIS and 485's in a timely manner and continue to ensure quality care coordination. Quality designation refers to the late clinician transfers at month end. If clinicians continue to transfer assessments late at month end, the agency will be responsible for processing these.

BIG BOOM! BIG BANG!

- Facilitate processing of OASIS correction forms
  - Ensure clinician signature
  - Filing on Medical Record
- Participation in month end processing
  - First month "go live"
  - Quality designation

Amedisys Home Health Services



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BIG BOOM! BIG BANG!

- Fax scheduling calendar to QCC upon receipt
- If PT/OT/ST eval is ordered: write "eval scheduled on:_____" onto the calendar before faxing it to QCC
- Ensure timely transmissions

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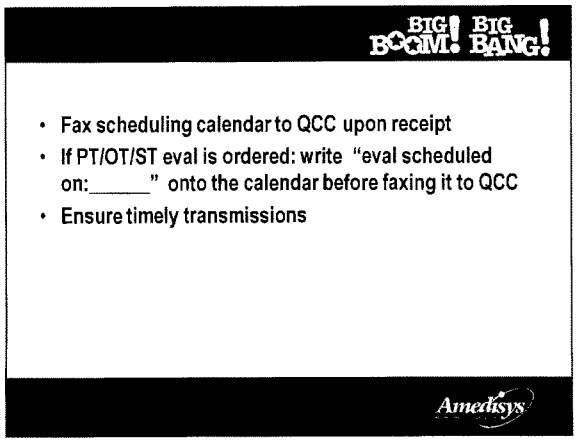

BIG BOOM! BIG BANG!

- **Ensure staff training (current and new)**
  - Learn center modules
  - QCC process
    - Who is this person?
    - Why are they calling me?
- **Ensure daily transfers**
- **Ensure field clinician follow-up and communication with QCC**

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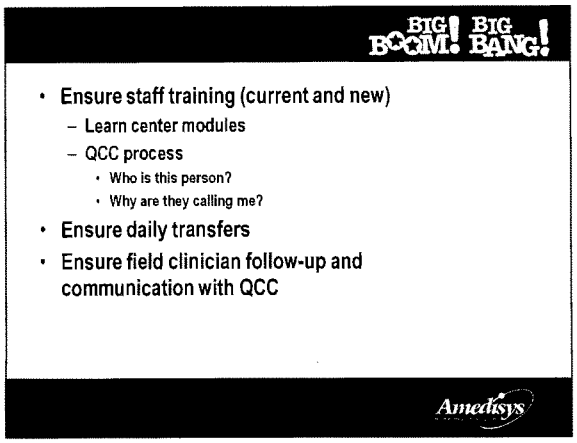

Give example of how we are going to communicate when we have staff management issues:

How will we let the DOO know?

What are the expectations?

Chronic uoncompliance issues.

How will we communicate trends to them.....QCC spreadsheet

BIG BOOM! BIG BANG!

- "Team with the QCC"
- Address staff management issues
- Work 485's locked with quality issues
- Promote comprehensive care plan development (quality documentation)
  - QCC does not create entire care plan from scratch

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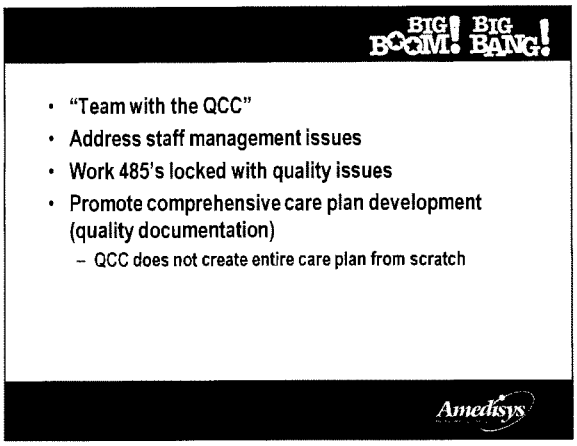

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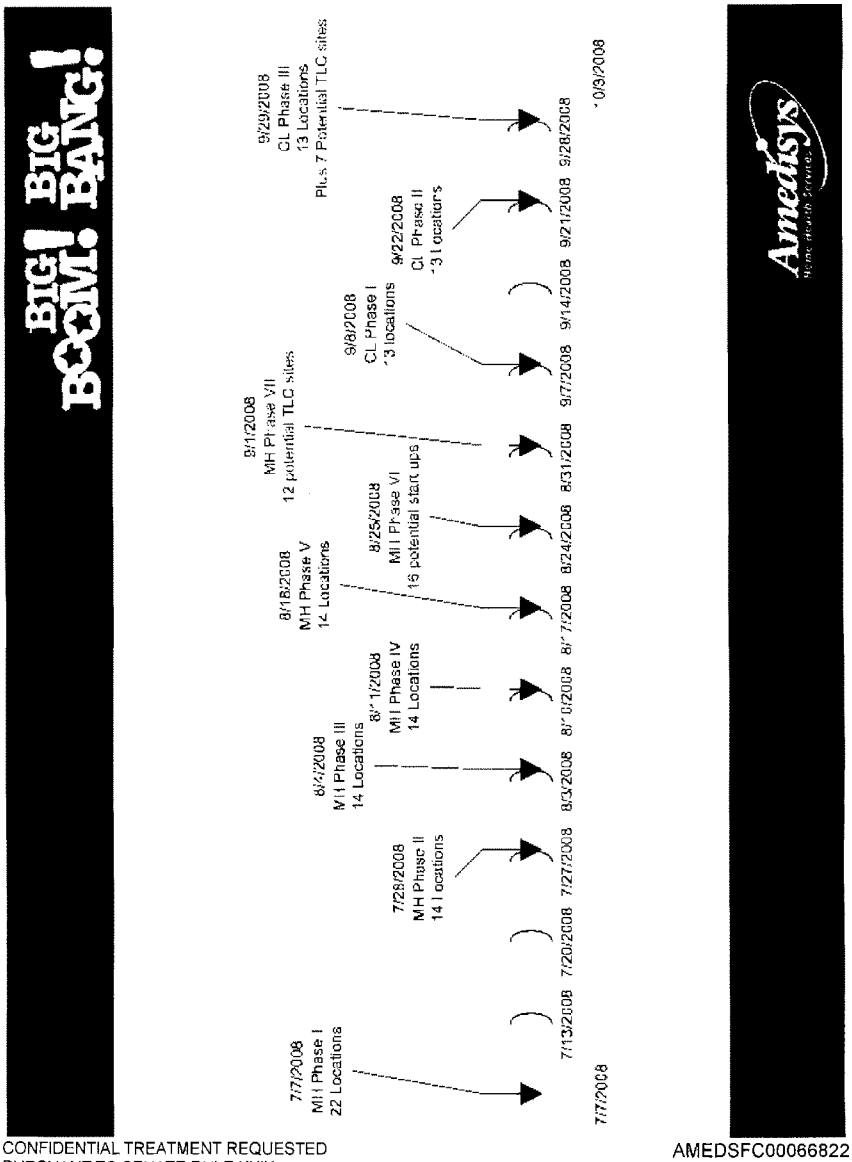

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

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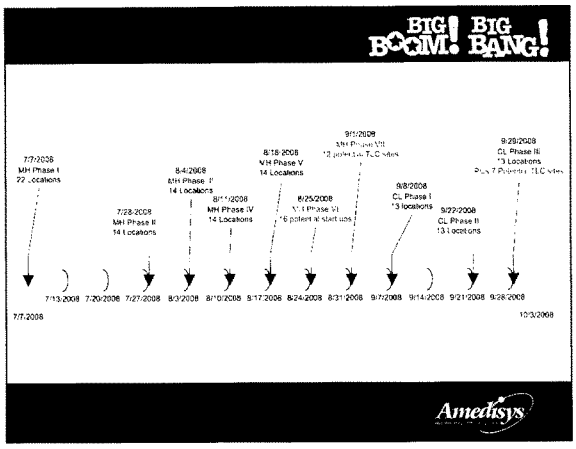
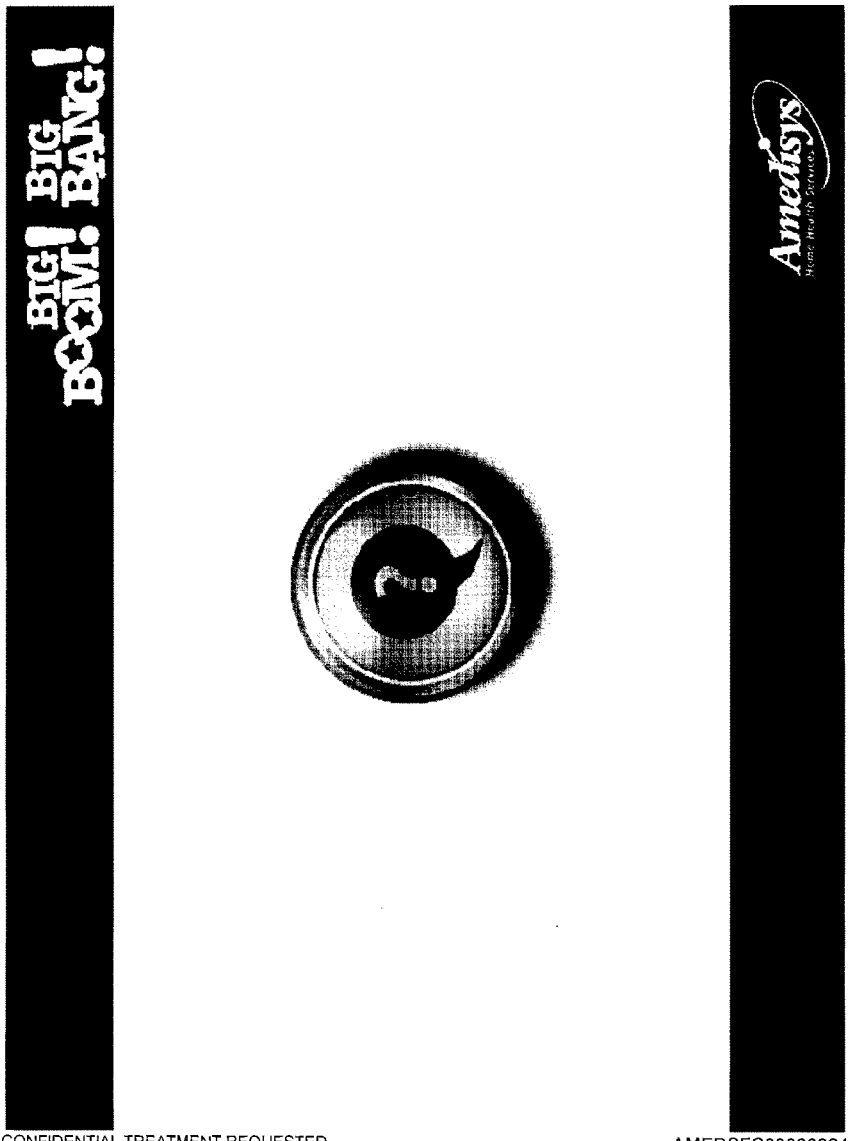


This is the tentative roll out schedule for Q3 2008. Entire companywide roll-out is expected by the end of 2Q 2009. For questions about your agency's roll-out date, forward them to Robin Landry. [redacted]



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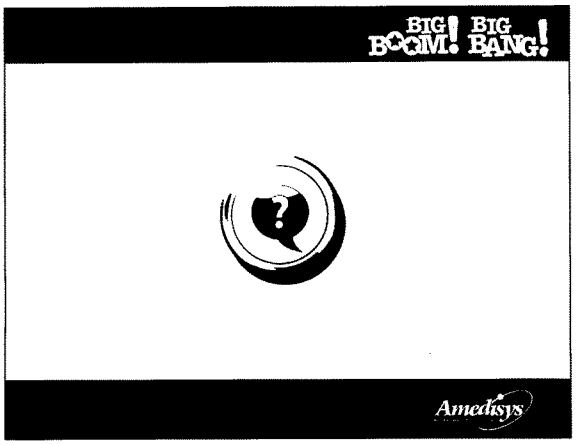


BIG BOOM! BIG BANG!

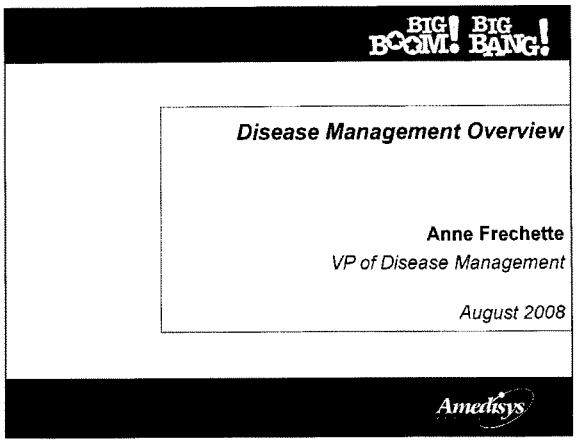
Disease Management Overview

Anne Frechette

VP of Disease Management

August 2008

Amedisys Home Health Services



BIG BOOM! BIG BANG!

- Revolutionary changes/systems
- Increasing demands for cost containment
- Increasing demands for proof of quality
- Technological advances
- Advancing health promotion, prevention and treatment

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BIG BOOM! BIG BANG!

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BIG BOOM! BIG BANG!

- Our population is growing….Baby Boomers are entering the Senior Population
- We are living longer
- There are more co-morbidities
- One in three to four patients goes back into the hospital after discharge

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BIG! BIG BOOM! BIG BANG!

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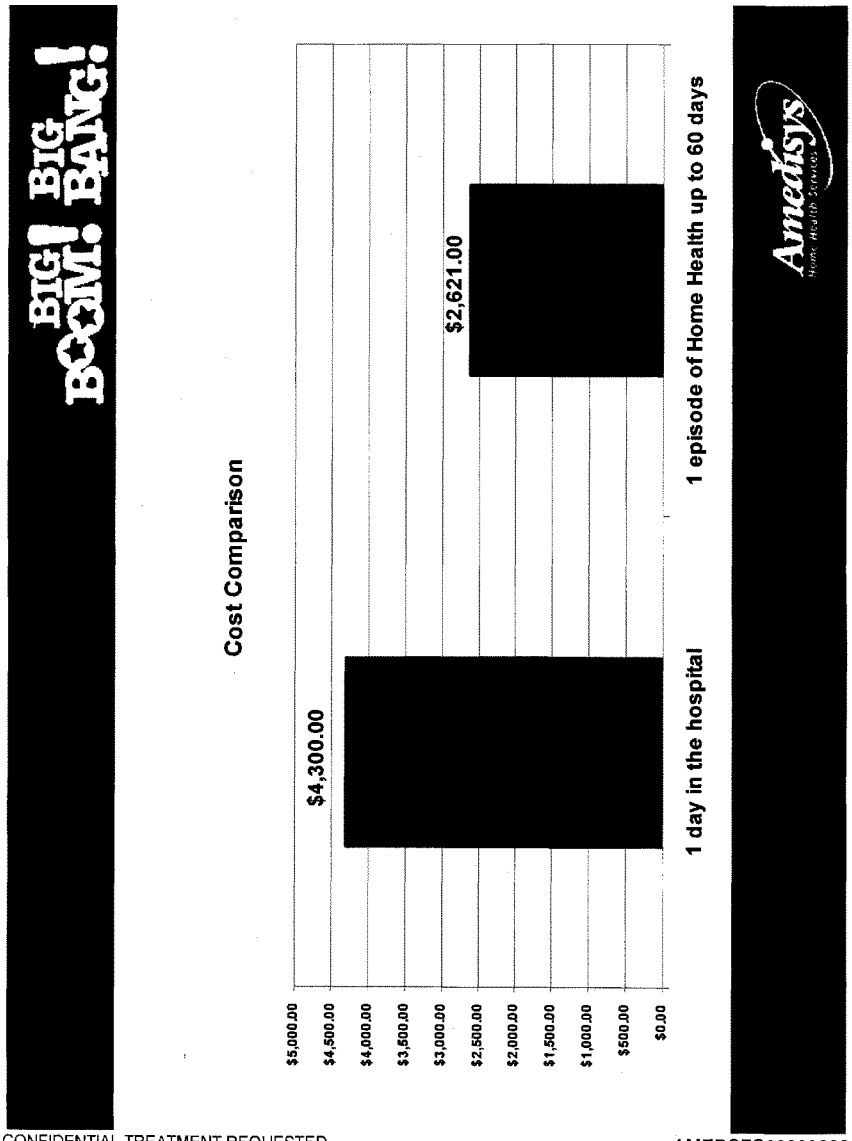

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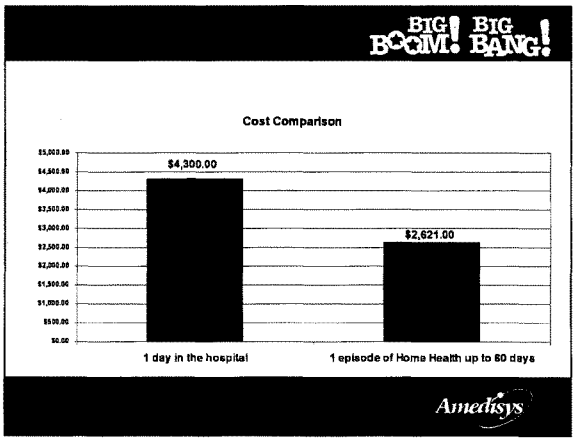

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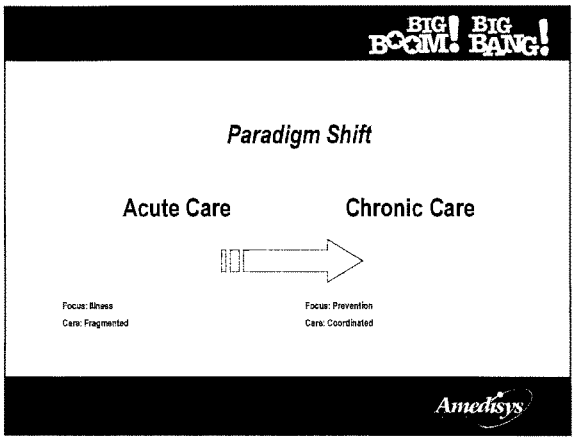

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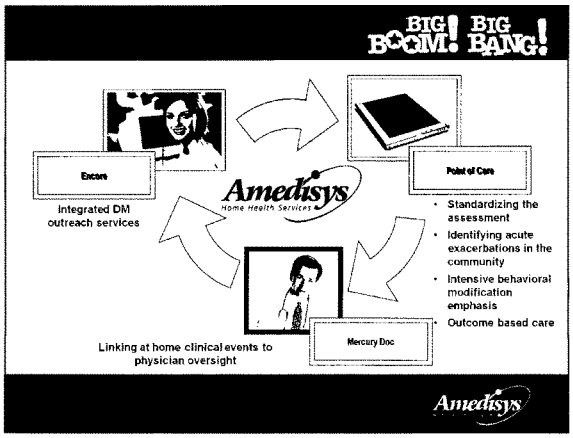

BIG BOOM! BIG BANG!

A series of processes and services, that are coordinated into disease programs designed to:

- Manage high-risk diagnoses/disease processes
- Improve patient care
- Promote wellness
- Improve outcomes
- Manage costs

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CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEDSFC00066838

BIG! BIG BOOM! BANG!

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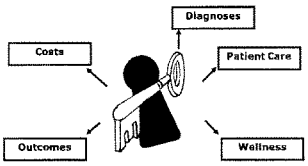

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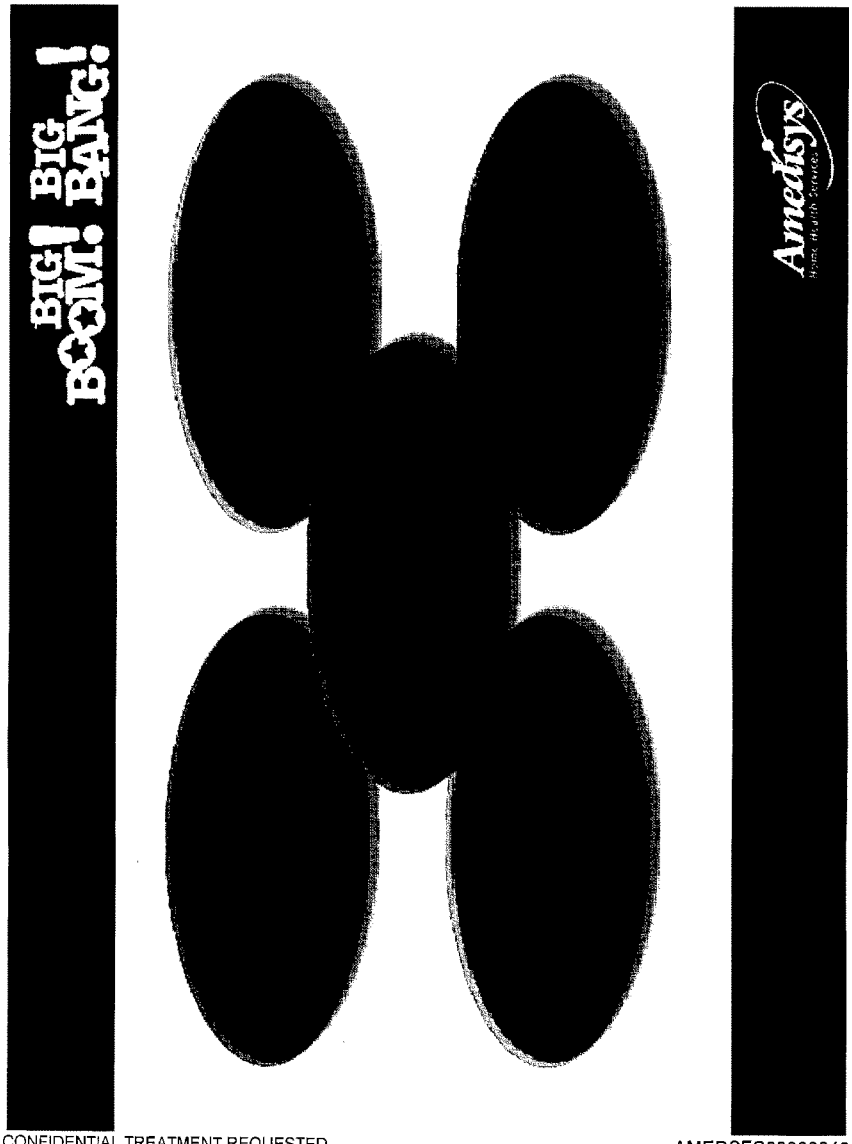

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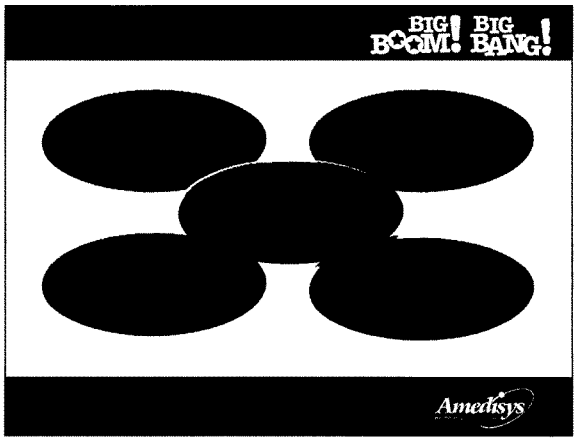


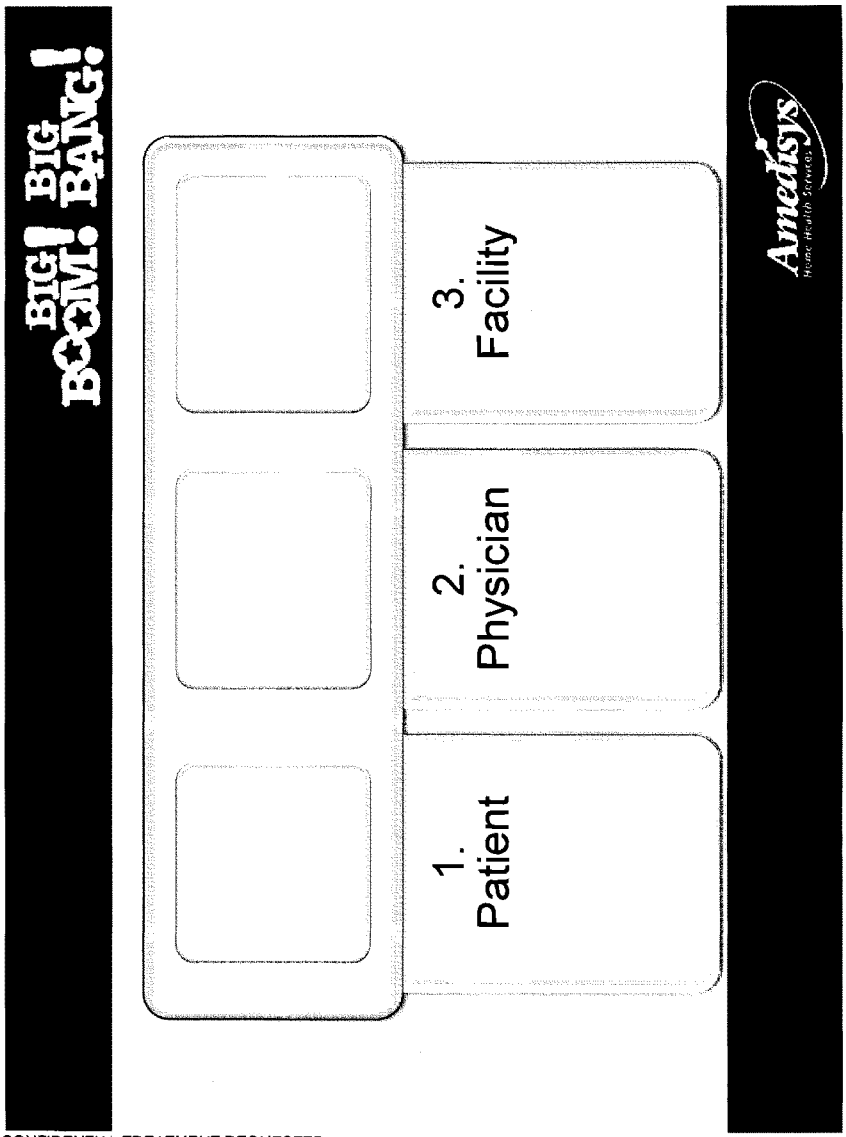
Review slide – start with physician involvement at the corporate and local level…education development based on national standards and evidenced based practice…ongoing evaluation for quality improvement…vigilant outcomes monitoring…resulting in consistent comprehensive patient and caregiver education in an adult education model.

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEDSFC00066842

Amedisys programs based on national standards and documented research.

- –AHRQ: Agency for Healthcare Research and Quality
- –American Association of Wound, Ostomy, and Continence Nurses
- –American Association of Cardiovascular and Pulmonary Rehabilitation
- –American Heart Association
- –American Diabetes Association
- –American Lung Association
- –American Psychiatric Association
- –American Physical Therapy Association
- –JCAHO
- –American Thoracic Society



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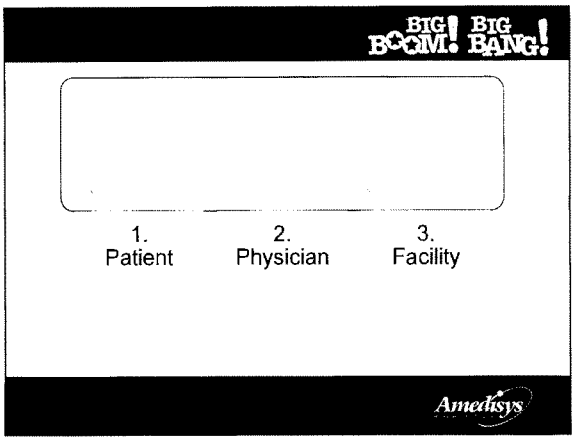

Review slide

BIG BOOM! BIG BANG!

- Care consistency
- Focus on self-management/ education
- Early warning signs/ symptom recognition
- Improved functioning at home
- ↓ ER visits/↓ hospitalizations/↑ quality of life

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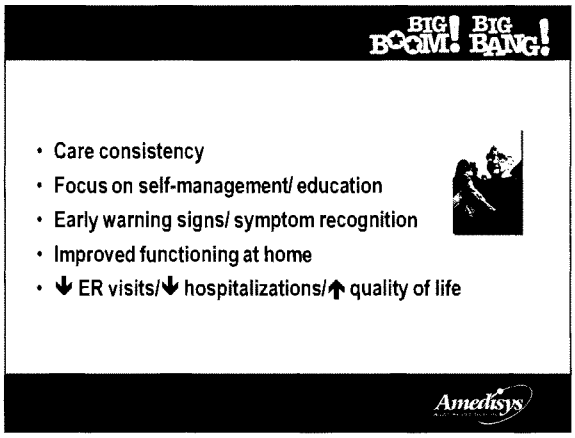
Home Health Services



Review slide

BIG BOOM! BIG BANG!

- Streamlined communication
- Consistent treatment protocols / procedures
- Early warning signs / symptom management
- Clinical outcome results for MD's patients
- Physician involvement – DM / Quality
- Be the "eyes – ears" for patients with chronic diseases

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Home Health Services

BIG BOOM! BIG BANG!

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Focus on partnering or complementing their practice with MD to care for patient.

BIG BOOM! BIG BANG!

- Inpatient PPS challenges
- "Transition without abandonment"
- Facility / Hospital → Disease Management Program
- Reduced re-hospitalizations in 24 hours
- Improved utilization of emergency room

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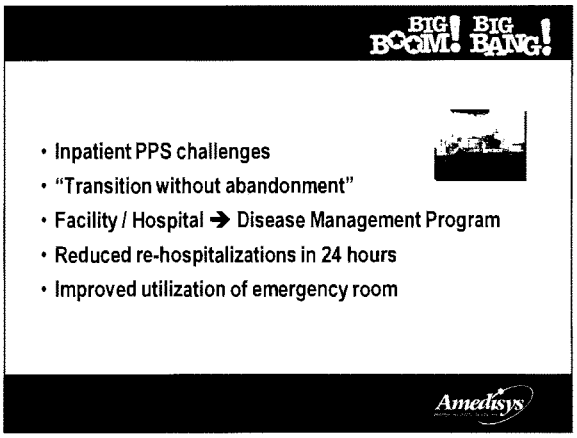
Home Health Services



Review slide

Facilities have PPS challenges just as the home care industry. Working with facilities, we can encourage them to discharge their patients home to us with our DM programs. Facilities can transition patients home without fear of abandoning them when they discharge them to us.

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

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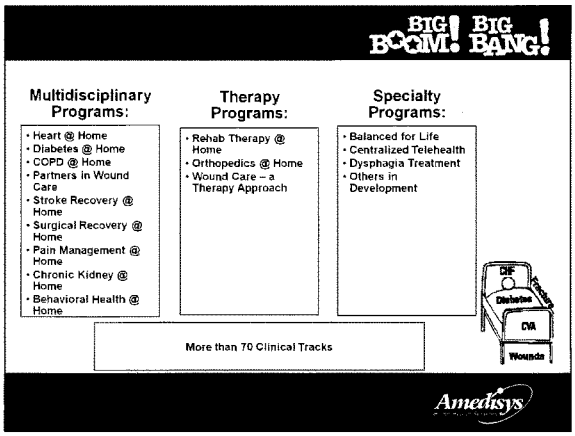
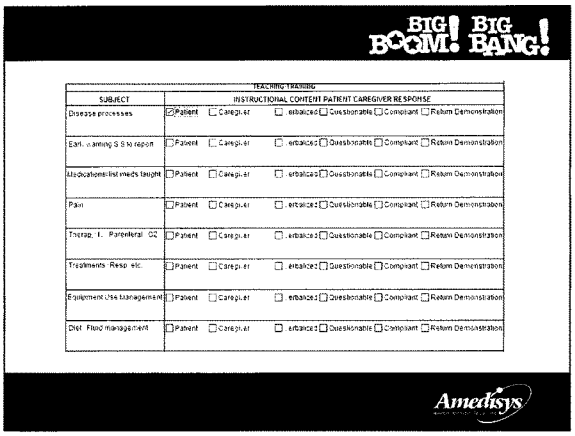


TEACHING/TRAINING

SUBJECT	INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE		
Disease processes	☑ Patient	☐ Caregiver	☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Early warning S/S to report	☐ Patient	☐ Caregiver	☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Medications/list meds taught:	☐ Patient	☐ Caregiver	☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Pain	☐ Patient	☐ Caregiver	☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Therapy: IV / Parenteral / O2	☐ Patient	☐ Caregiver	☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Treatments (Resp. etc:	☐ Patient	☐ Caregiver	☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Equipment Use/Management	☐ Patient	☐ Caregiver	☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration
Diet / Fluid management	☐ Patient	☐ Caregiver	☐ Verbalized ☐ Questionable ☐ Compliant ☐ Return Demonstration

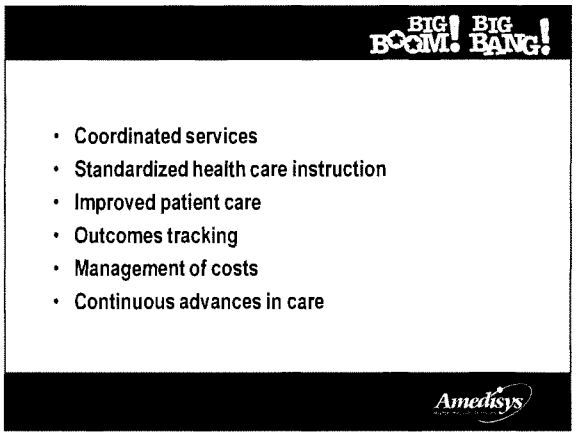


This is an example of our automated Disease Management Teaching documentation. Not only does documentation include WHAT was taught, but we are also able to track and report the patient/caregiver response to the teaching and whether or not they are compliant with the behavior modification. These key elements are based on national standards of care, and are routinely aggregated as Disease Management outcomes.

BIG BOOM! BIG BANG!

- Coordinated services
- Standardized health care instruction
- Improved patient care
- Outcomes tracking
- Management of costs
- Continuous advances in care

Amedisys Home Health Services

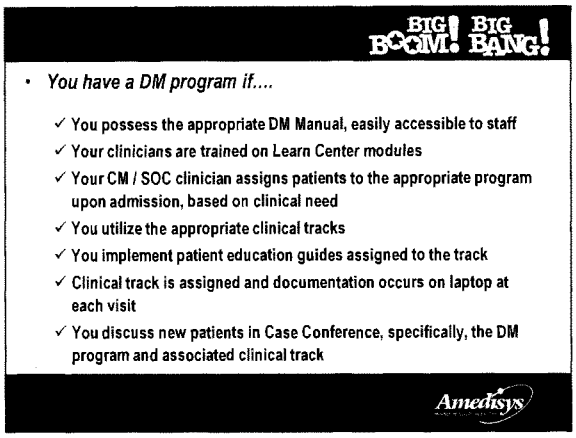


Amedisys leads the industry with their standardized DM program model. Here is a review of what differentiates us from the rest....

BIG BOOM! BIG BANG!

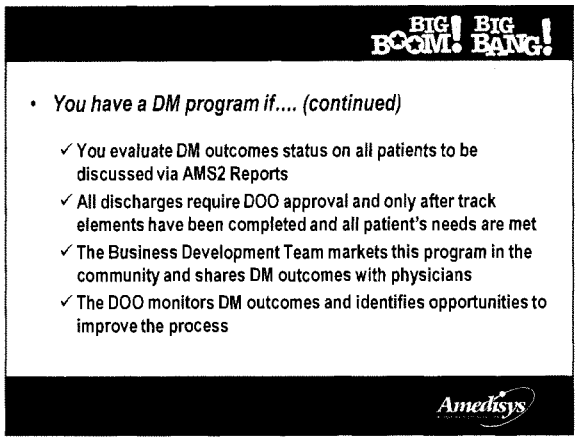
- *You have a DM program if….*
  - ✓ You possess the appropriate DM Manual, easily accessible to staff
  - ✓ Your clinicians are trained on Learn Center modules
  - ✓ Your CM / SOC clinician assigns patients to the appropriate program upon admission, based on clinical need
  - ✓ You utilize the appropriate clinical tracks
  - ✓ You implement patient education guides assigned to the track
  - ✓ Clinical track is assigned and documentation occurs on laptop at each visit
  - ✓ You discuss new patients in Case Conference, specifically, the DM program and associated clinical track

Amedisys Home Health Services



This is how you know if you have a DM program in your agency. First, implement the use of clinical tracks and training materials and build your programs from that foundation. All clinicians do not have to be credentialed for a standard DM program to be implemented – it needs to be a market need, clinical competency, and an infrastructure to gather outcomes data and share with physicians.

- *You have a DM program if.... (continued)*
  - ✓ You evaluate DM outcomes status on all patients to be discussed via AMS2 Reports
  - ✓ All discharges require DOO approval and only after track elements have been completed and all patient's needs are met
  - ✓ The Business Development Team markets this program in the community and shares DM outcomes with physicians
  - ✓ The DOO monitors DM outcomes and identifies opportunities to improve the process



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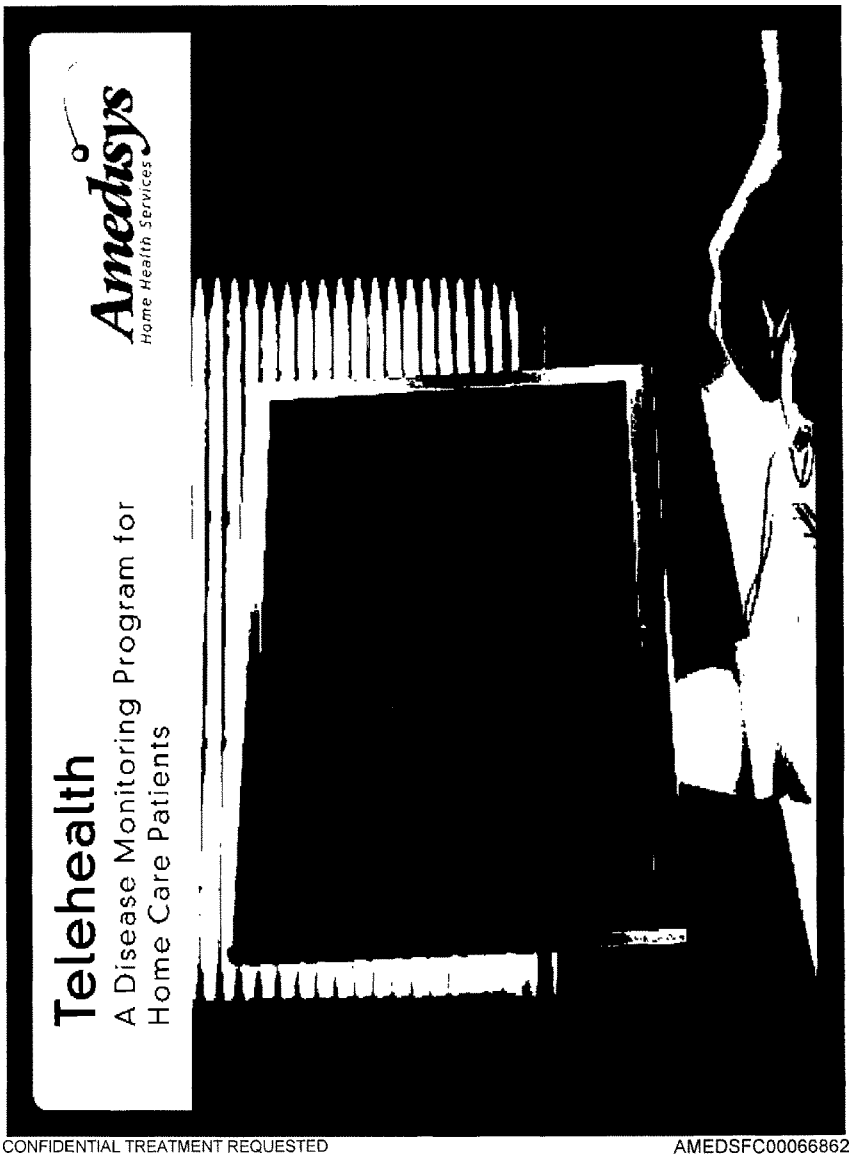

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

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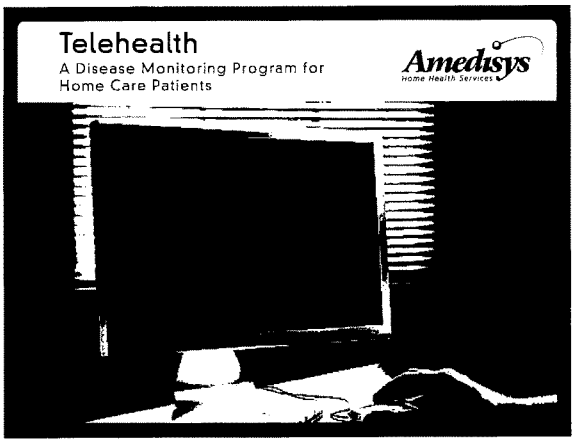
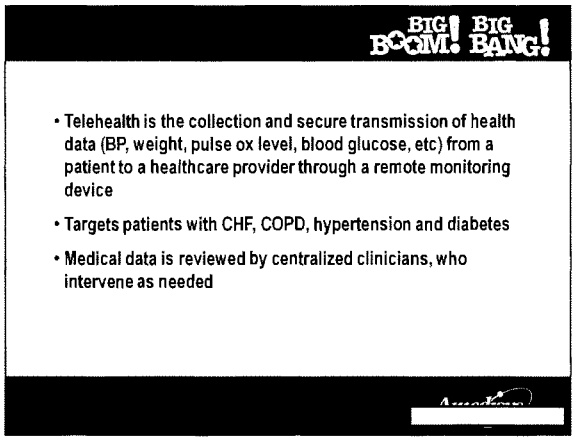
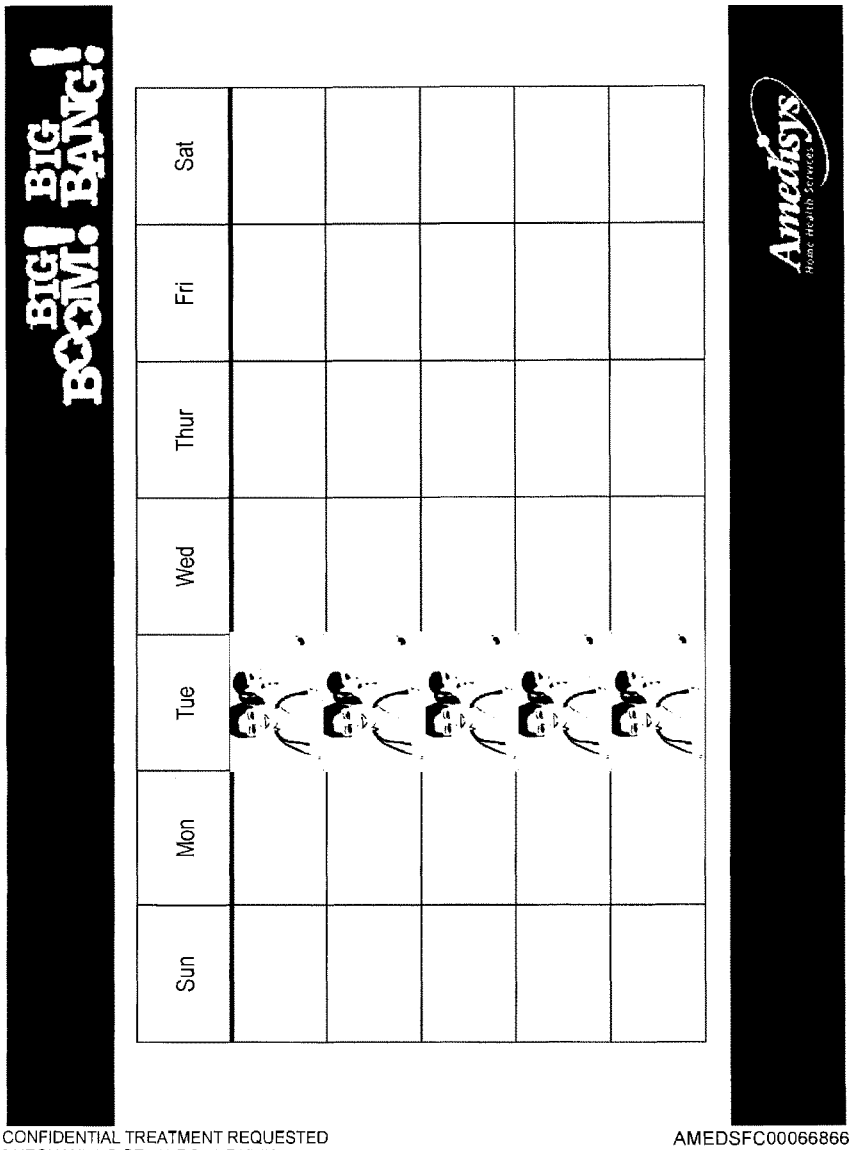


- Telehealth is the collection and secure transmission of health data (BP, weight, pulse ox level, blood glucose, etc) from a patient to a healthcare provider through a remote monitoring device
- Targets patients with CHF, COPD, hypertension and diabetes
- Medical data is reviewed by centralized clinicians, who intervene as needed



I'm certain you know what telehealth remote monitoring is but there are some key differentiators – we have designated remote, centralized telehealth nurses and are piloting multiple monitors / products across the nation. Roughly 2,000 monitors deployed, 800 monitored centrally, others are on a local monitoring system (mostly through acquisition) but their quality and outcomes are monitored by our DM Department centrally.



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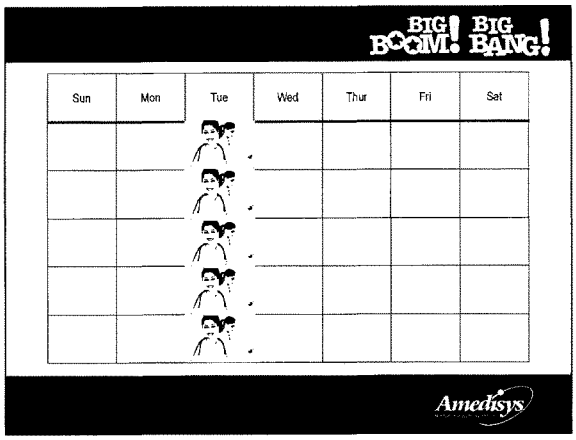

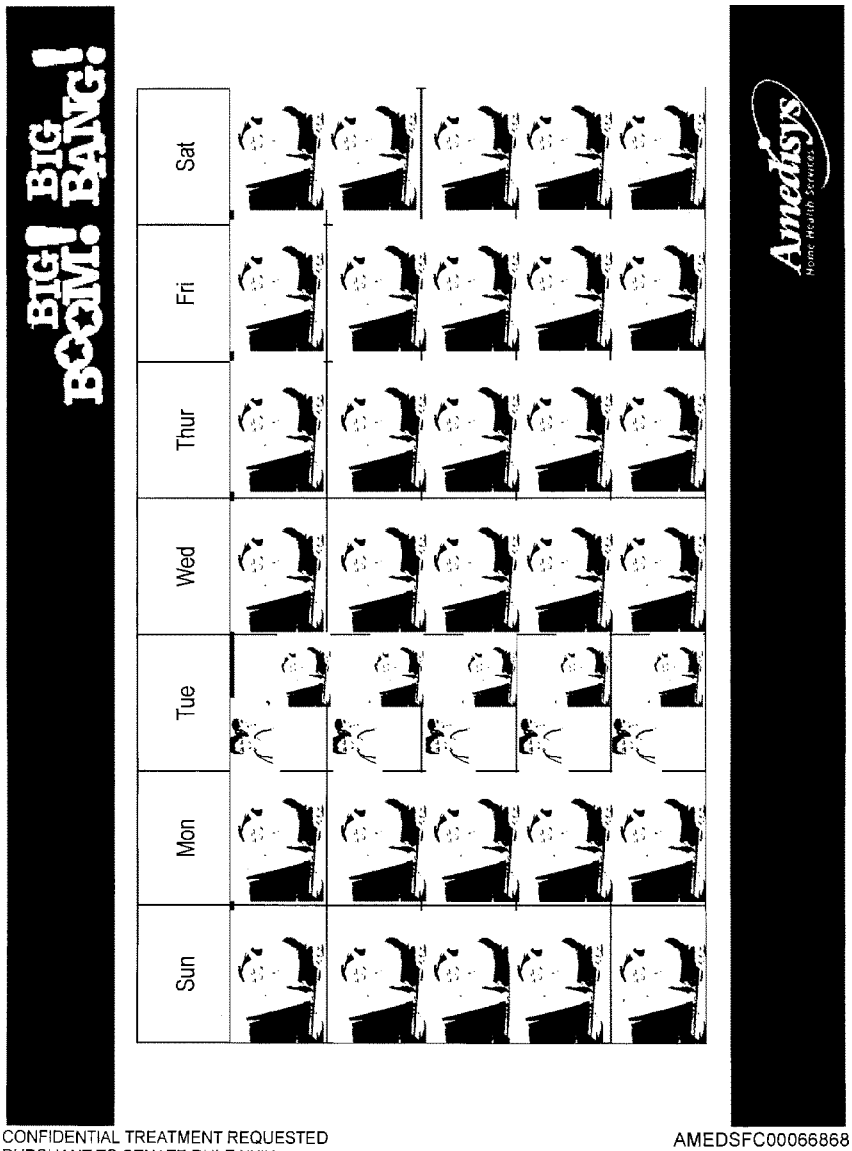

CONFIDENTIAL TREATMENT REQUESTED
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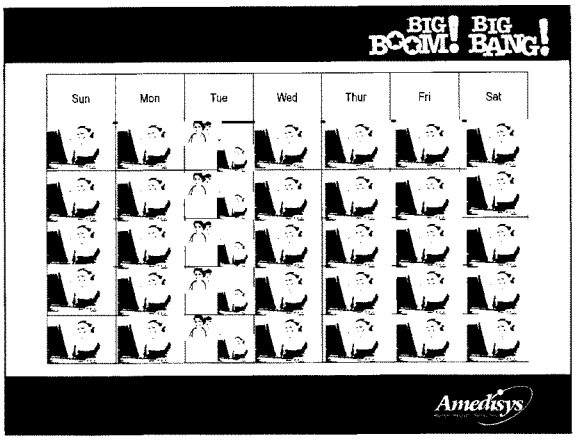


BIG! BIG BOOM! BANG!

Agencies selected by key metrics demonstrating operational readiness

- *Performance offsets non-reimbursed cost*

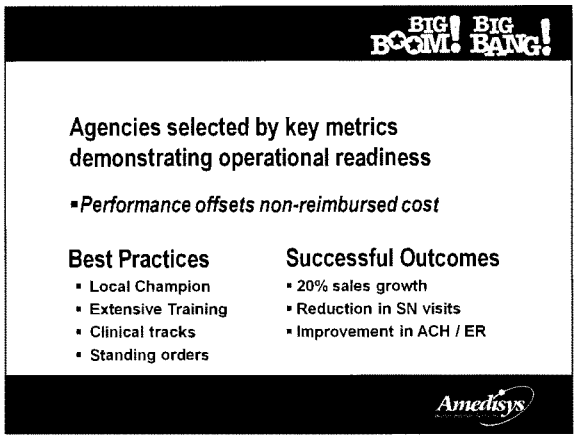
Best Practices

- Local Champion
- Extensive Training
- Clinical tracks
- Standing orders

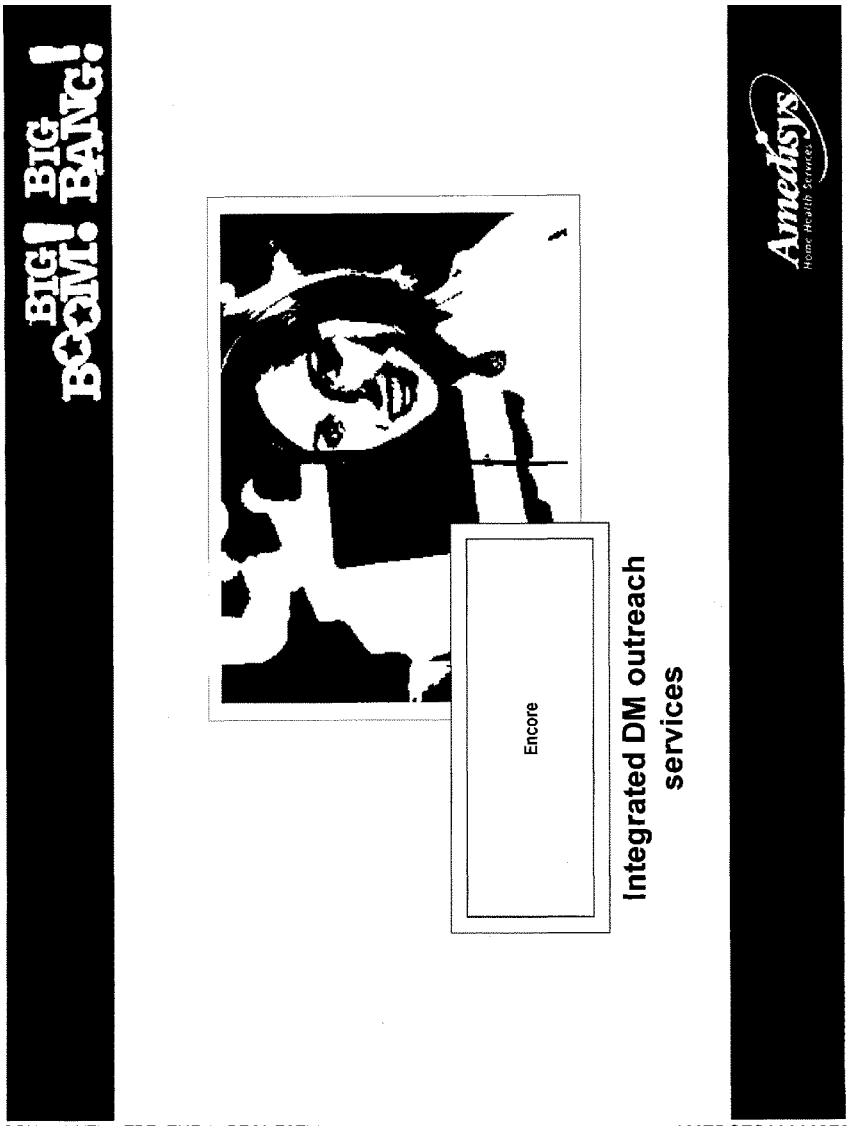
Successful Outcomes

- 20% sales growth
- Reduction in SN visits
- Improvement in ACH / ER

Amedisys Home Health Services



Currently evaluating multiple vendors / applications in preparation for a national launch. Some markets have local monitoring (per acquisition) and, although the DM Dept is not directly involved with the operations, we are monitoring their outcomes.



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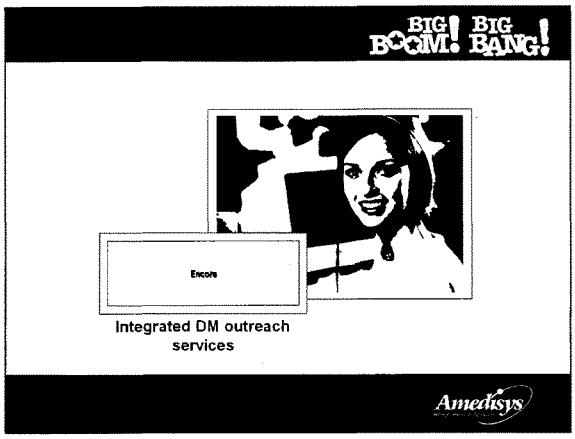

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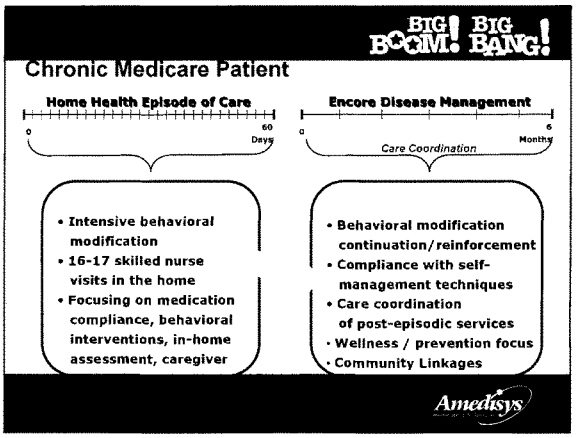
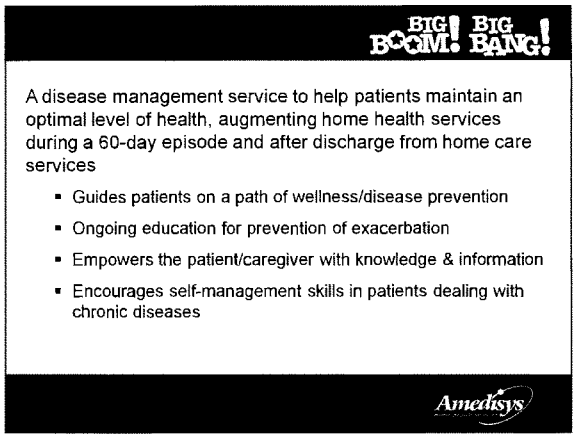


BIG BOOM! BIG BANG!

A disease management service to help patients maintain an optimal level of health, augmenting home health services during a 60-day episode and after discharge from home care services

- Guides patients on a path of wellness/disease prevention
- Ongoing education for prevention of exacerbation
- Empowers the patient/caregiver with knowledge & information
- Encourages self-management skills in patients dealing with chronic diseases

Amedisys Home Health Services



The definition of Encore .... A repeat performance

Encore is an extension of the exceptional services *already* provided by our home care agencies.

We contact Medicare & Medicaid Patients upon discharge from home health services

•Ensure that your patients are maintaining a successful & independent lifestyle

•Provide ongoing education & support by coordinating their healthcare needs

•Continue the patient relationship

We want to ensure that our patients are patient's for life!

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

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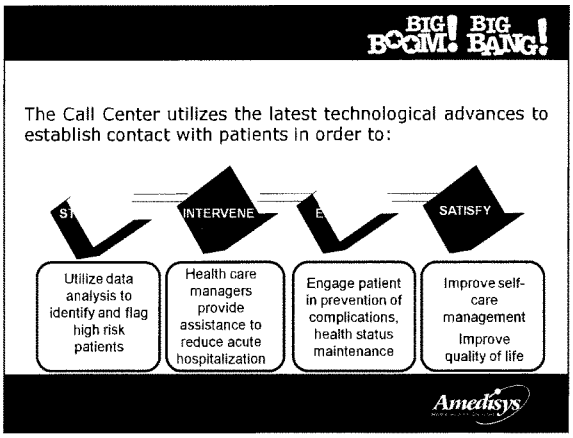


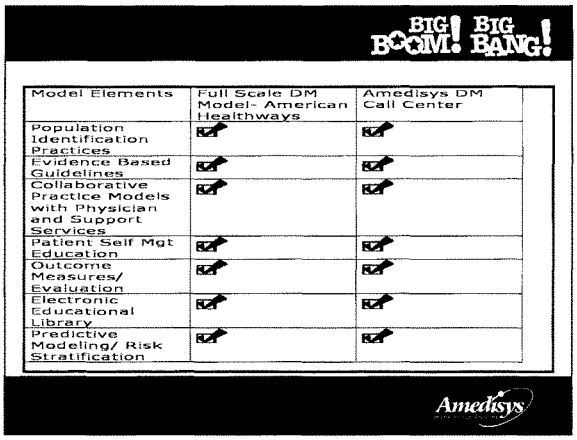
Our objective is to utilize the latest technology to

•STRATIFY patient elements to identify high risk patients

•Utilize health car managers to provide INTERVENTION based on each individual patient's health and emotional status.

•ENGAGE patients and caregivers by providing consistent health education material

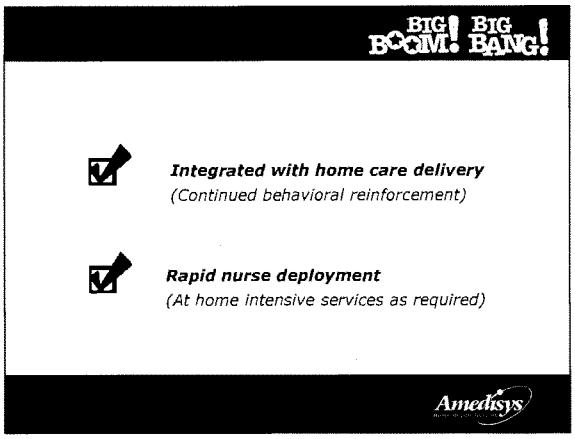
•SATISFY our patients, caregivers and physicians by promoting self care management skills and improving quality of life.



BIG BOOM! BIG BANG!

- ***Integrated with home care delivery***
  (Continued behavioral reinforcement)
- ***Rapid nurse deployment***
  (At home intensive services as required)

Amedisys Home Health Services



Encore's disease management call center has key differentiators from traditional Disease Mgmt Call Centers that set us apart from our competition.

BIG BOOM! BIG BANG!

- Engage with chronically ill patients; maintain a partnership to ensure adherence to appropriate treatment regime.
- Provide monitoring and proactive intervention to improve/maintain patient's health status.
- Trend reduction in hospital admission rate of patients discharged from home care services.

Amedisys
Home Health Services

BIG BOOM! BIG BANG!

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CONFIDENTIAL TREATMENT REQUESTED
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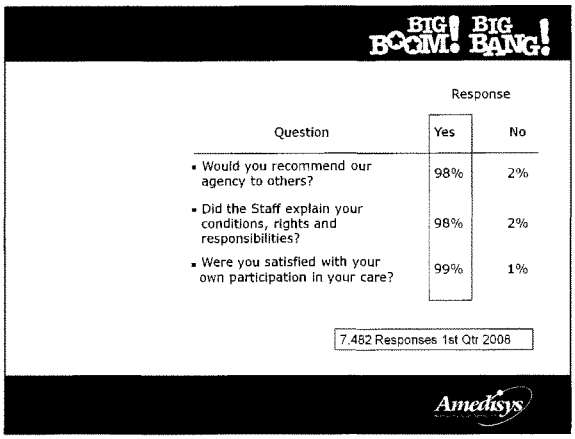
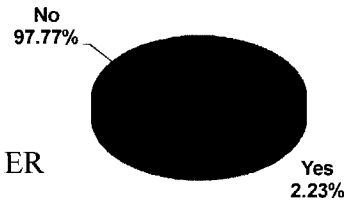


BIG! BIG BOOM! BANG!

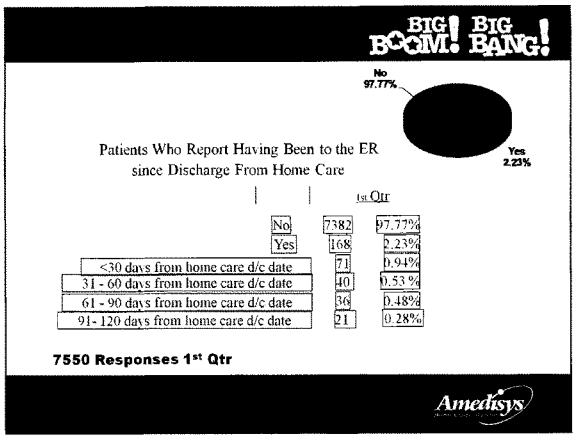


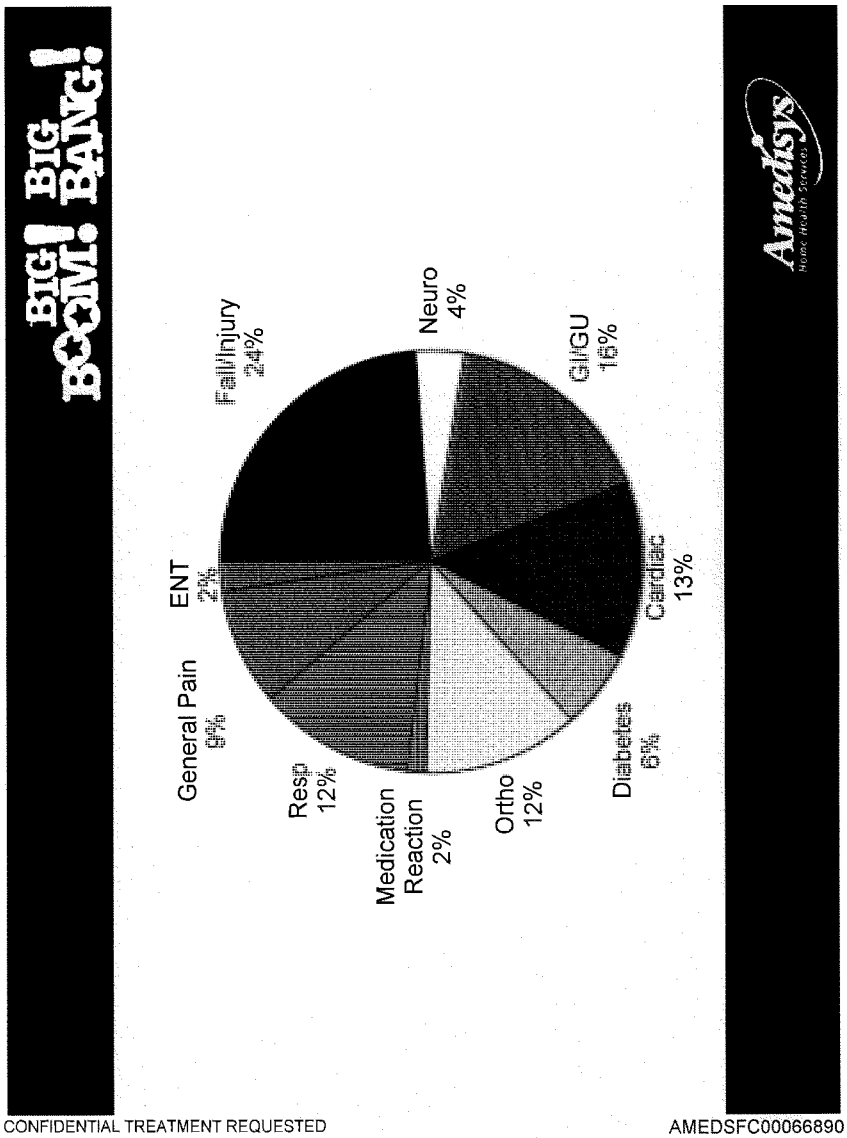
Patients Who Report Having Been to the ER since Discharge From Home Care

	1st Qtr	
No	7382	97.77%
Yes	168	2.23%
<30 days from home care d/c date	71	0.94%
31 - 60 days from home care d/c date	40	0.53 %
61 - 90 days from home care d/c date	36	0.48%
91- 120 days from home care d/c date	21	0.28%

7550 Responses 1st Qtr

Amedisys Home Health Services





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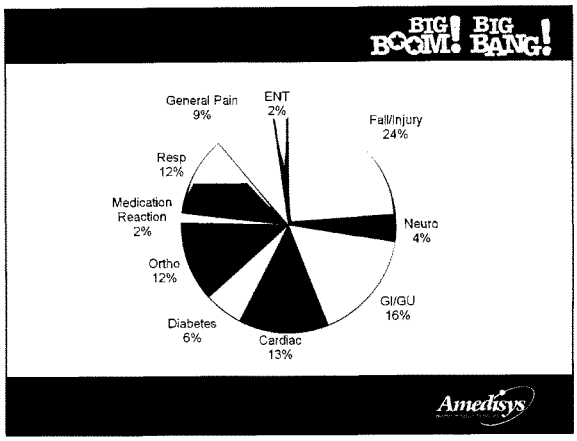

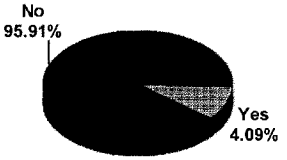

Patients Who Report Having Been Admitted to the Hospital since Discharge From Home Care

		1st Qtr
No	7241	95.91%
Yes	309	4.09%
<30 days from home care d/c date	121	1.60%
31 - 60 days from home care d/c date	88	1.17%
61 - 90 days from home care d/c date	47	0.62%
91 - 120 days from home care d/c date	53	0.70%

7550 Responses 1st Qtr

BIG BOOM! BIG BANG!

Patients Who Report Having Been Admitted to the Hospital since Discharge From Home Care

		1st Qtr
No	7241	95.91%
Yes	309	4.09%
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7550 Responses 1st Qtr

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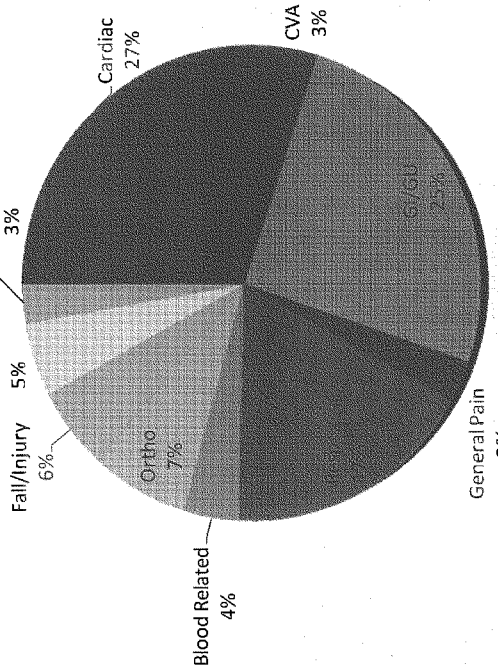
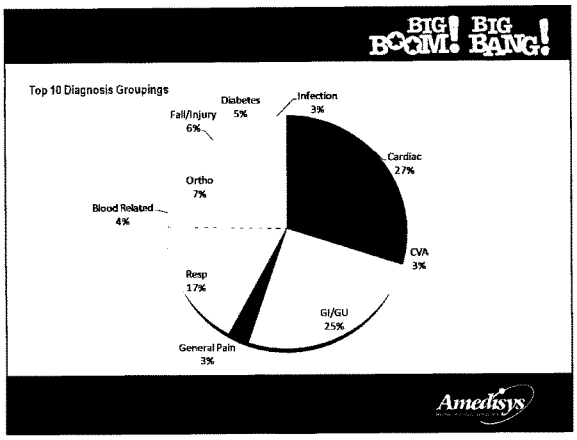
BIG BOOM! BIG BANG!



Amedisys Home Health Services



BIG BOOM! BIG BANG!

External Benchmarks

Most recent information reveals readmission rates are 12% to 14% on average per admission.

< 30 Days	4.7% - 6.2%
31-60 Days	8.1% - 10.7%
61-90 Days	6.5% - 12.8%
91+ Days	8.2% - 14.1%

Sources:
1. Dept. of Health and Human Services – Office of Inspector General 2000, 2002, 2004, 2005
2. 2002 NHS Trust Plan and Report
3. 2004 Institute for Healthcare Improvement
4. Health Care Cost Containment Council 2005

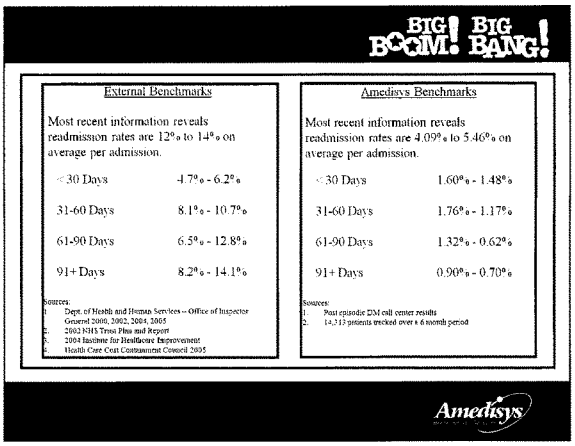
Amedisys Benchmarks

Most recent information reveals readmission rates are 4.09% to 5.46% on average per admission.

< 30 Days	1.60% - 1.48%
31-60 Days	1.76% - 1.17%
61-90 Days	1.32% - 0.62%
91+ Days	0.90% - 0.70%

Sources:
1. Post episodic DM call center results
2. 14,313 patients tracked over a 6 month period

Amedisys
Home Health Services



BIG BOOM! BIG BANG!

- To evaluate satisfaction with home health services
- To reduce post-discharge acute care hospitalizations
- To measure and report outcomes
- Build lifelong relationships

Amedisys
Home Health Services

BIG! BIG BOOM! BIG BANG!

- To evaluate satisfaction with home health services
- To reduce post-discharge acute care hospitalizations
- To measure and report outcomes
- Build lifelong relationships

Amedisys

Footnote 39

From: Robin Landry [redacted]
Sent: Friday, December 26, 2008 9:26 AM
To: ~Mentor4335; ~St.Augustine0469; ~BocaRaton0466; ~Piedmont1310; ~Fredericksburg1716; ~PoplarBluff1309; ~SanAntonioHH0748; ~Chicago2411; ~Camden2216; ~Daytona5449; ~Trenton3344; ~LakeForest3503; ~Alexandria1210; ~Elizabethtown2155; ~OakHill3002; ~Riverton0201; ~Jasper3329; ~Vicksburg1406; ~New Hope1017; ~Hiltonhead2210; ~Newnan3356; ~Jackson1408; ~FortPayne1029; ~Greenville2223; ~LaGrange3346; ~Opelousas1292; ~Thomasville1020; ~Hinsdale2401; ~Cincinnati4334; ~Dyersburg5508; ~Glasgow2153; ~Riverside3505; ~MountPleasant2209; ~Jacksonville0467; ~Demopolis1002; ~PortOrange0468; ~Parkersburg3015; ~Columbus3348; ~Sumter2214; ~Selma1001; ~Northlake8317; ~Conway2222; ~Stockbridge3350; ~Augusta3340; Susan Goff; Pamela Arnold; Pam Nary; Jill Stahl; Rita Pridemore; Cindy Ritchie; Yvonne Hines; Deanna Wildes; Jenice Carrick; Deborah Griffin; Brenda Dile; Donna Smith; Kimberley Boyd; Linda Tronco; Chris Roller; Teresa Mills; Robert Weger; Patti Von Riesen; Kim Wilson; Sheryl Holdren; Teresa Ledgerwood; Cheryl Lacey; Dan Cundiff; Mike Hamilton; Mike Ginn; Elizabeth Robinson; Tasha Mears
Subject: 1/5/09 QCC roll out conference call
Attachments: Remote Quality Care Coordinators DOO_CM presentation for Oct roll out.ppt

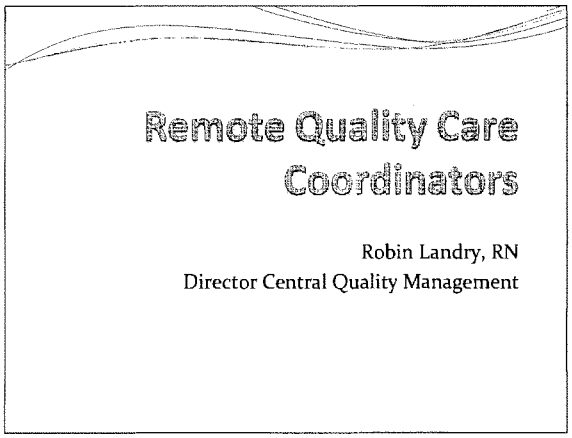
When: Tuesday, December 30, 2008 11:00 AM-12:00 PM (GMT-06:00) Central Time (US & Canada).

~~*~*~*~*~*~*~*~*~*

<<Remote Quality Care Coordinators DOO_CM presentation for Oct roll out.ppt>> **Please call [redacted] code [redacted] at 1100 central standard time!**

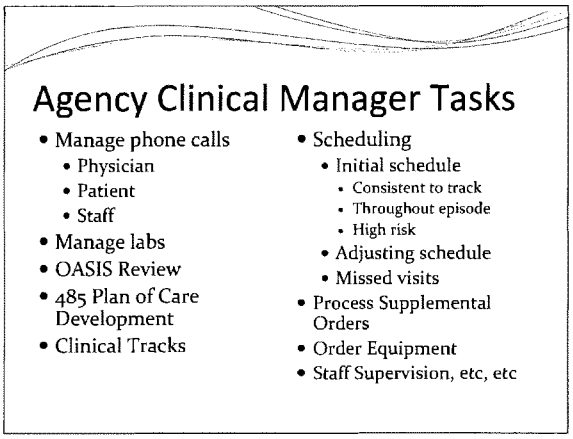
Remote Quality Care Coordinators

Robin Landry, RN
Director Central Quality Management



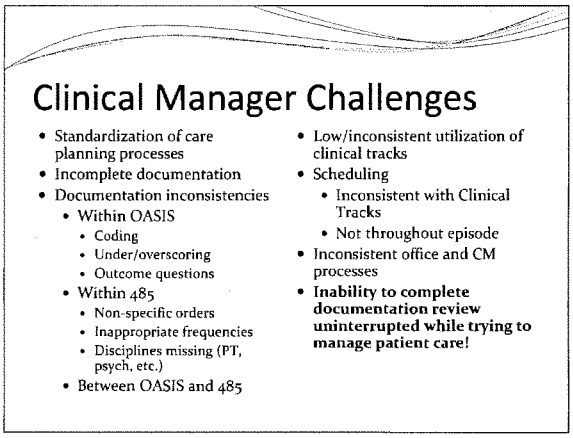
Agency Clinical Manager Tasks

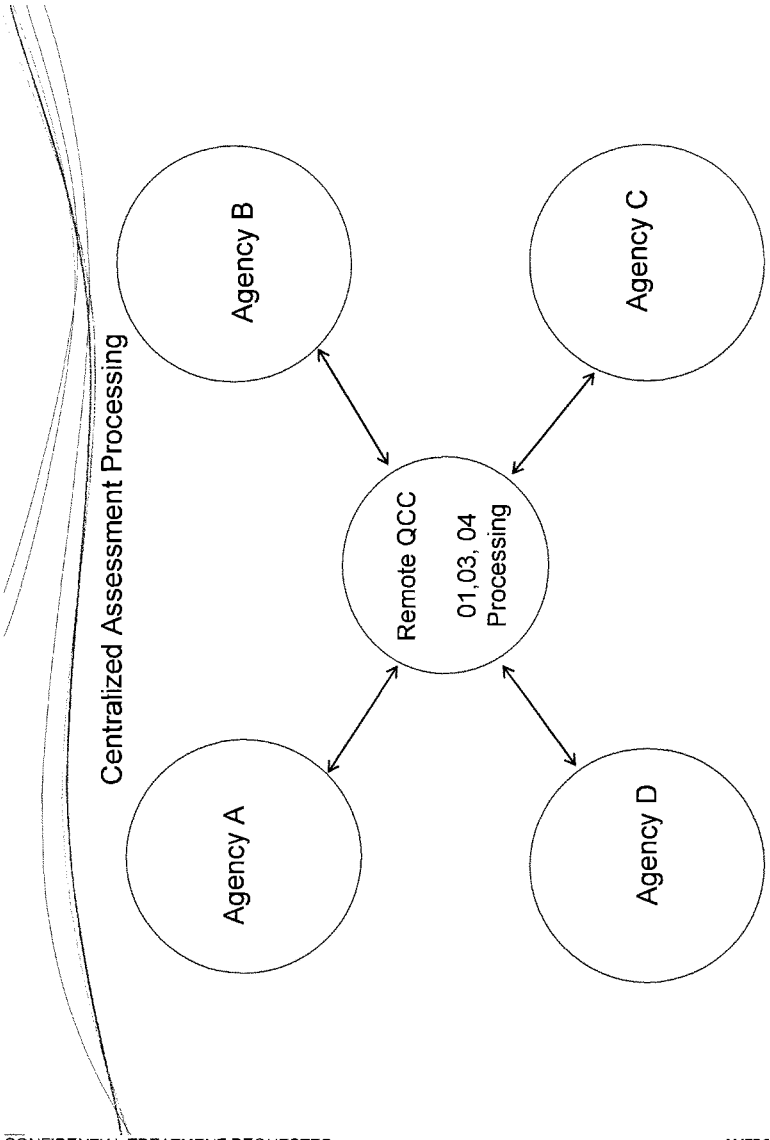
- Manage phone calls
  - Physician
  - Patient
  - Staff
- Manage labs
- OASIS Review
- 485 Plan of Care Development
- Clinical Tracks
- Scheduling
  - Initial schedule
    - Consistent to track
    - Throughout episode
    - High risk
  - Adjusting schedule
    - Missed visits
- Process Supplemental Orders
- Order Equipment
- Staff Supervision, etc, etc



Clinical Manager Challenges

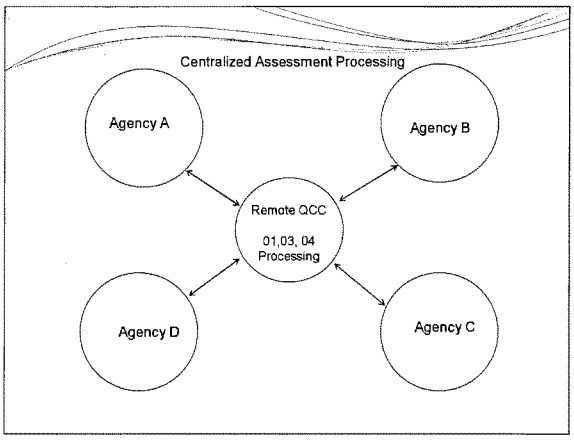
- Standardization of care planning processes
- Incomplete documentation
- Documentation inconsistencies
  - Within OASIS
    - Coding
    - Under/overscoring
    - Outcome questions
  - Within 485
    - Non-specific orders
    - Inappropriate frequencies
    - Disciplines missing (PT, psych, etc.)
  - Between OASIS and 485
- Low/inconsistent utilization of clinical tracks
- Scheduling
  - Inconsistent with Clinical Tracks
  - Not throughout episode
- Inconsistent office and CM processes
- **Inability to complete documentation review uninterrupted while trying to manage patient care!**





CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEDSFC00064477

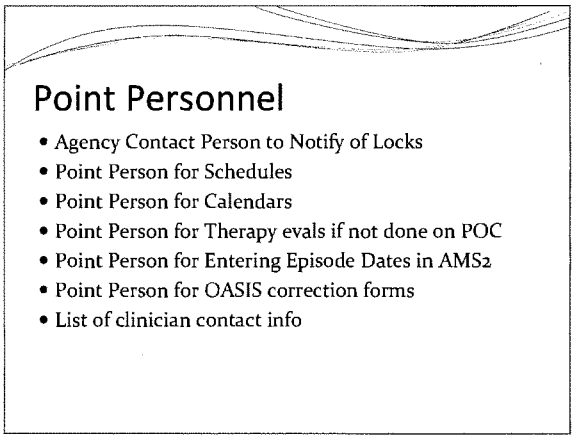


Goal(s) of centralization

- Improve quality of OASIS documentation
- Improve 485 development
- Improve care coordination
- Standardization of processes
- Scheduling according to orders
- Improve compliance with scheduling according to clinical tracks

Point Personnel

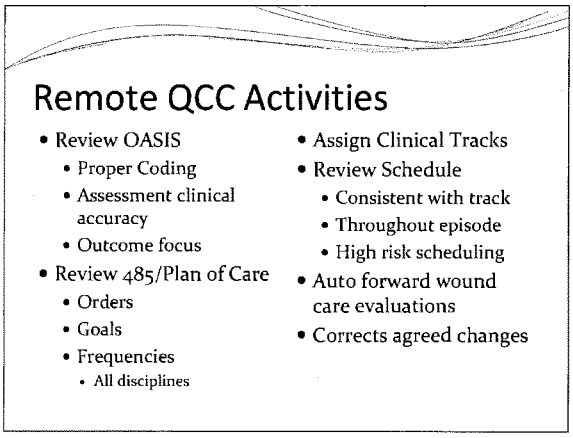
- Agency Contact Person to Notify of Locks
- Point Person for Schedules
- Point Person for Calendars
- Point Person for Therapy evals if not done on POC
- Point Person for Entering Episode Dates in AMS2
- Point Person for OASIS correction forms
- List of clinician contact info

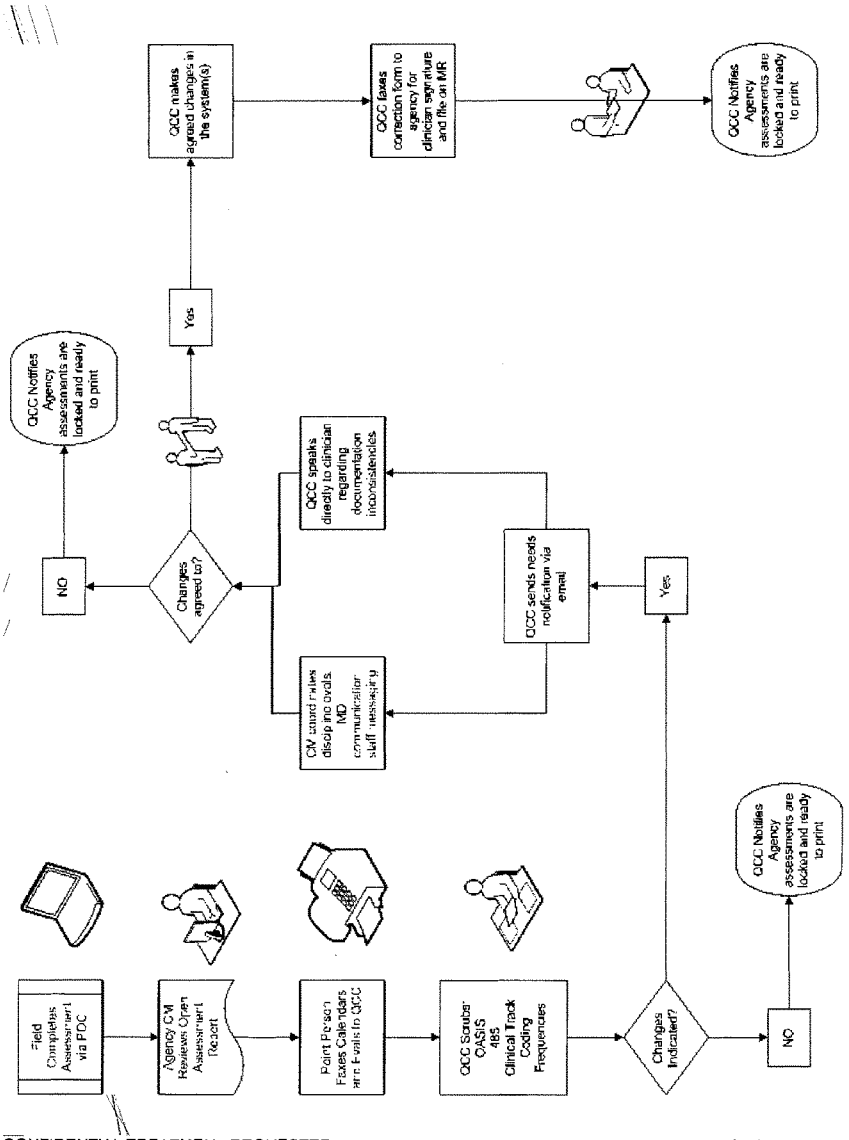


Status of receiving this information?

Remote QCC Activities

- Review OASIS
  - Proper Coding
  - Assessment clinical accuracy
  - Outcome focus
- Review 485/Plan of Care
  - Orders
  - Goals
  - Frequencies
    - All disciplines
- Assign Clinical Tracks
- Review Schedule
  - Consistent with track
  - Throughout episode
  - High risk scheduling
- Auto forward wound care evaluations
- Corrects agreed changes





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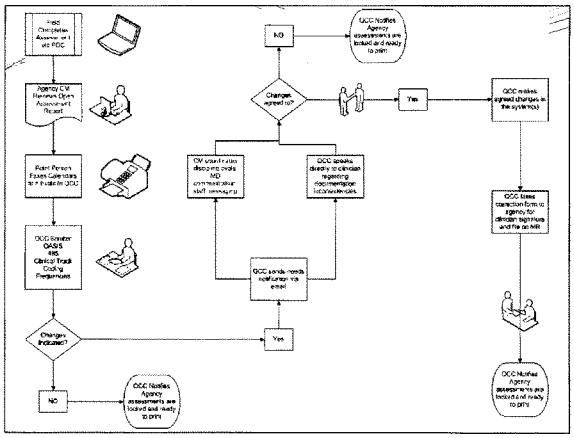
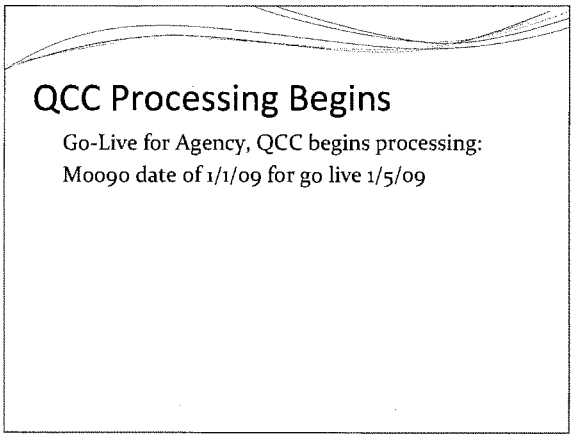


QCC Processing Begins

Go-Live for Agency, QCC begins processing:

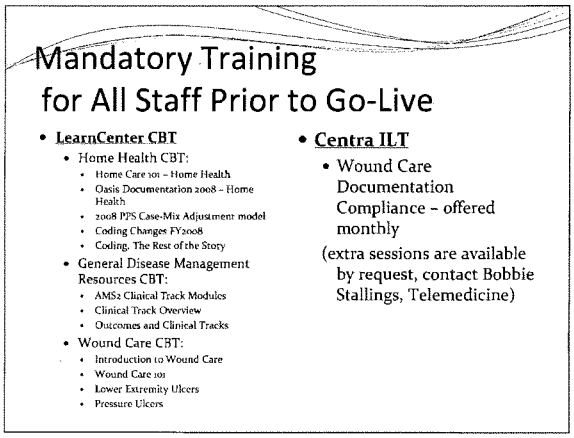
M0090 date of 1/1/09 for go live 1/5/09



Mandatory Training for All Staff Prior to Go-Live

- **LearnCenter CBT**
  - Home Health CBT:
    - Home Care 101 – Home Health
    - Oasis Documentation 2008 – Home Health
    - 2008 PPS Case-Mix Adjustment model
    - Coding Changes FY2008
    - Coding, The Rest of the Story
  - General Disease Management Resources CBT:
    - AMS2 Clinical Track Modules
    - Clinical Track Overview
    - Outcomes and Clinical Tracks
  - Wound Care CBT:
    - Introduction to Wound Care
    - Wound Care 101
    - Lower Extremity Ulcers
    - Pressure Ulcers
- **Centra ILT**
  - Wound Care Documentation Compliance – offered monthly

(extra sessions are available by request, contact [redacted], Telemedicine)



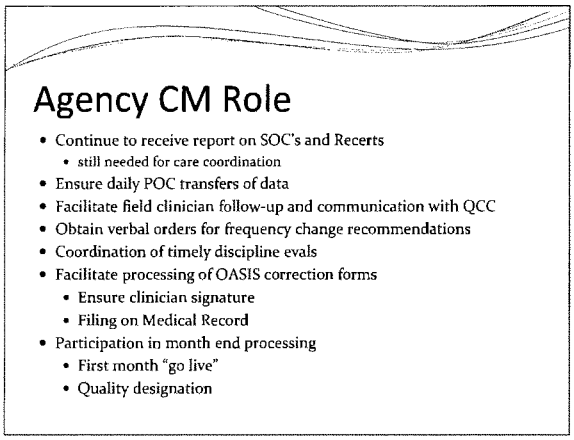
Distribute copy of agents that have taken courses from Holly. If they have staff that haven't completed these, that needs to be a priority and they need to give you a completion status update by end of next week.

Beta Lessons Learned

- Clinical Staff Education Pre-go live
  - Overall concept of QCC
  - Documentation, OASIS, Clinical Tracks, etc.
- Timeliness of documentation to QCC
  - Assessment transfers by 1000 day after visit
  - Schedules plugged into system, calendar faxed to QCC by next business day
- Responsiveness of staff to inquiries
  - Best practice is for QCC to have direct clinician access
  - Need to educate and establish expectations
  - 48 hr response time necessary for timely processing

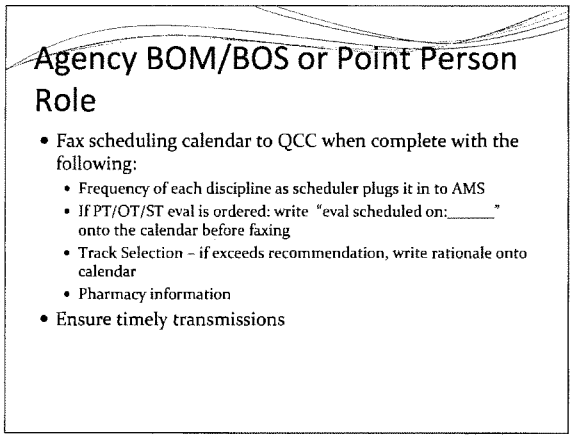
Agency CM Role

- Continue to receive report on SOC's and Recerts
  - still needed for care coordination
- Ensure daily POC transfers of data
- Facilitate field clinician follow-up and communication with QCC
- Obtain verbal orders for frequency change recommendations
- Coordination of timely discipline evals
- Facilitate processing of OASIS correction forms
  - Ensure clinician signature
  - Filing on Medical Record
- Participation in month end processing
  - First month "go live"
  - Quality designation



Agency BOM/BOS or Point Person Role

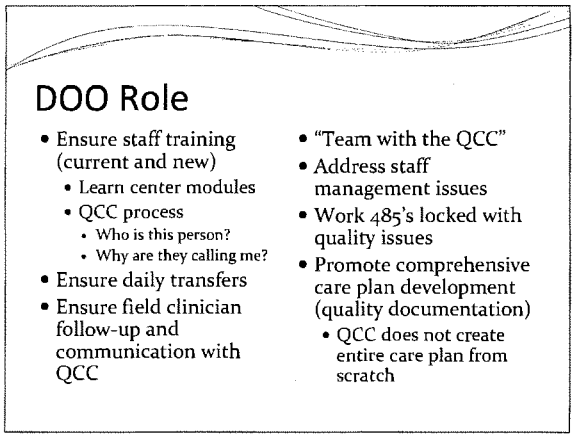
- Fax scheduling calendar to QCC when complete with the following:
  - Frequency of each discipline as scheduler plugs it in to AMS
  - If PT/OT/ST eval is ordered: write "eval scheduled on:_____" onto the calendar before faxing
  - Track Selection – if exceeds recommendation, write rationale onto calendar
  - Pharmacy information
- Ensure timely transmissions



Frequency - (Not necessarily what clinician writes - She will have adjusted it to "fit" the 9 weeks prior to sending to QCC) Track selection - (CM is to get report and help choose track for what is driving the care) If # of visits exceeds track recommendations Clinical rational for this needs to be written on calendar. Pharmacy (many are getting lost in transmission and time is lost tracking this down)

DOO Role

- Ensure staff training (current and new)
  - Learn center modules
  - QCC process
    - Who is this person?
    - Why are they calling me?
- Ensure daily transfers
- Ensure field clinician follow-up and communication with QCC
- "Team with the QCC"
- Address staff management issues
- Work 485's locked with quality issues
- Promote comprehensive care plan development (quality documentation)
  - QCC does not create entire care plan from scratch



Give example of how we are going to communicate when we have staff management issues:
How will we let the DOO know?
What are the expectations?
Chronic noncompliance issues.
How will we communicate trends to them.....QCC spreadsheet

Next Steps

- Determining remaining agencies to go live next
- Agencies that go live in the same month participate in month end processing for that first month
- Compliance with processes needs to be emphasized with all staff
- Follow-up DOO/CM conference call will be monthly
- Distribute QCC contact information to DOO's/CM's prior to going live
- Agency to distribute agency contact information to QCC

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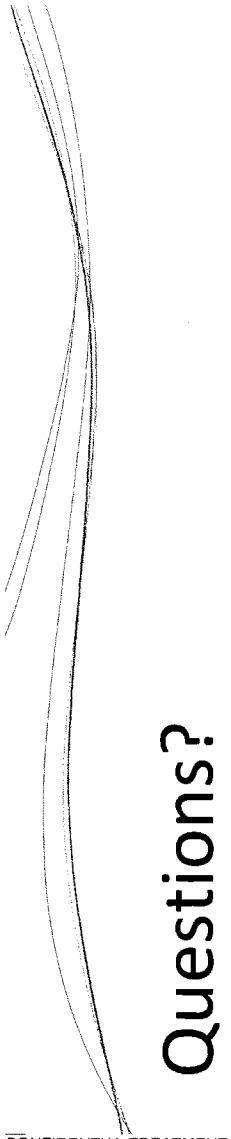


Footnote 40

From: Tasha Mears [redacted]
Sent: Monday, February 25, 2008 7:04 PM
To: ~Directors of Office Operations; ~VP Operations; ~Regional Administrators; ~SVP Operations; ~Episode Management
CC: Larry Graham; Andy Davis; Wanda Hull
Subject: Therapy Management in 2008
Attachments: Therapy_Bucket_Graph.xlsx; Therapy_Bucket_Report.xlsx; Therapy_Bucket_Graph 2003 v.xls; Therapy_Bucket_Report 2003 v.xls

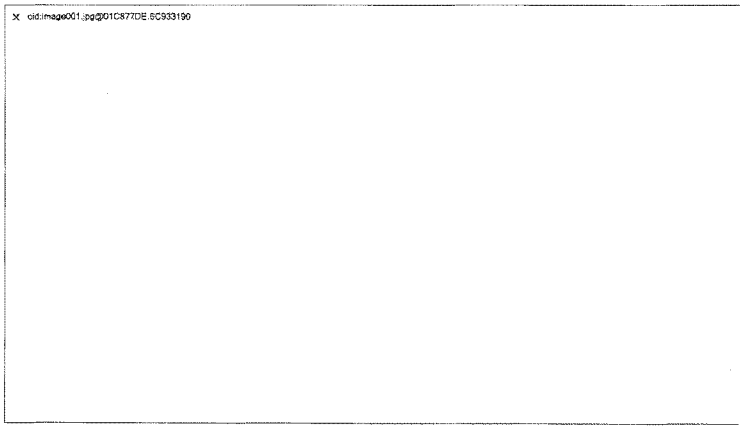
All~

In 2007 there were only 2 categories (buckets) of therapy visits, less than 10 total therapy visits and 10 or more therapy visits. In the 2008 Case Mix environment, CMS recognizes that certain patients require more ranges of therapy visits than just the two 2007 categories.

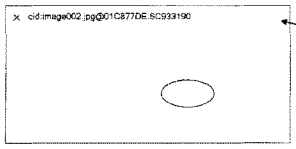
There are now NINE different categories of therapy visits (buckets):

0-5	**14-15**
6	**16-17**
7-9	**18-19**
10	**20 and higher**
11-13	

Below you will see a graph that shows the company wide differences in reimbursement in 2008 versus 2007 based on the total therapy visits per episode. 2007 is the red bar, and 2008 is the blue bar.



Below is a chart that also shows the changes in revenue per episode, moving from "bucket" to "bucket" in 2008. For example, moving from 11-13 visits to 14-15 visits, increases $813.13 per episode in 2008 (increased $34.38 in 2007).



This graph and chart is attached (Therapy Bucket Graph), along with the AGENCY THERAPY BUCKET REPORT, 2/1 through 2/22/08. (2003 v means Microsoft Office 2003)

This report ranks individual agencies, AVP's and VP's by 14+ total therapy visits per episode, and shows how many episodes are in each therapy "bucket".

Therapy services should be consistent with the functional level of the patient, and the Quality Managers are sending out reports weekly to every agency to request responses and ensure care coordination about:

1. **Therapy Scheduling Inconsistencies = the number of therapy visits scheduled is NOT consistent with the OASIS documentation**
2. **Therapy Countdown Inconsistencies = the episode has not ended, and the therapy visits provided is NOT consistent with what was planned for the patient**
3. **Therapy Evaluation Inconsistencies = the patient has a functional score that would indicate an evaluation for therapy, and does not have one scheduled**

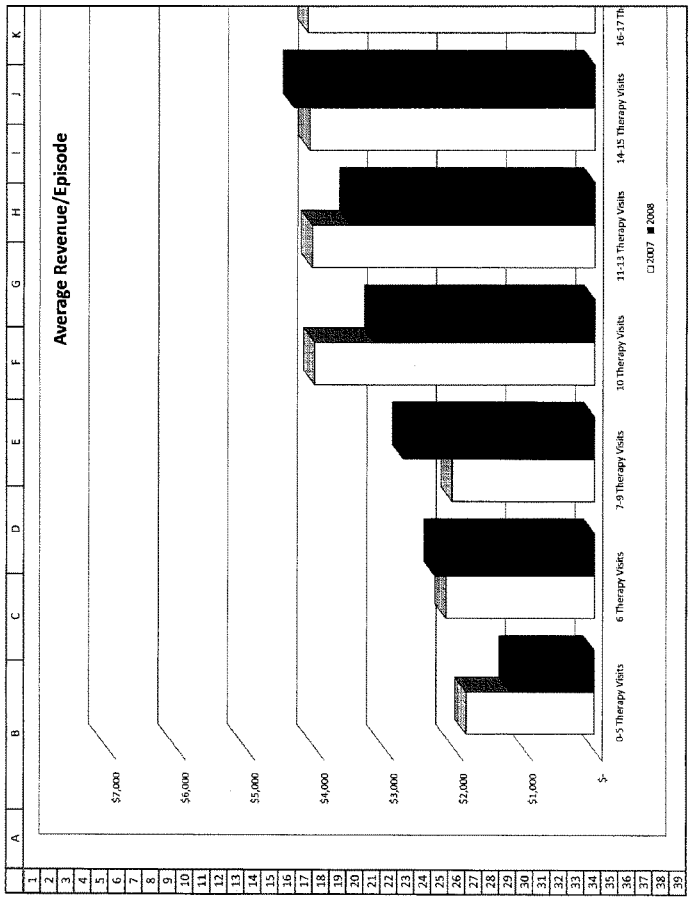
It is very important that we are clinically consistent with evaluating our patients for appropriateness for rehabilitative services, and provide the level of services that is indicated and planned for our patients.

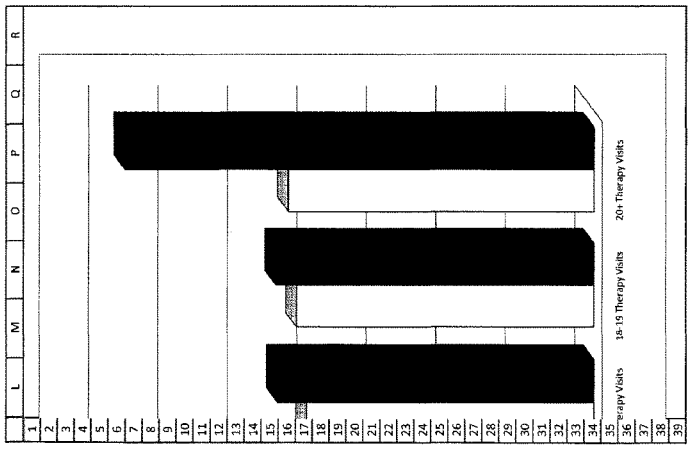
There will be Centra training sessions with the AVP's and VP's to further review these reports in detail.

If you have specific questions about your agency's data in the Therapy Bucket Report, please email Andy Davis in my department.

Thanks,

Tasha M. Mears, RN, BSN
VP Quality Management and Analytics
Direct: [redacted]
Fax: [redacted]





	A	B	C	D	E	F	G	H	I	J	K
40											
41			AVERAGE REVENUE		INCREASE/						
42		TOTAL THERAPY VISITS	2007	2008	(DECREASE)						
43		0-5 Therapy Visits	$ 1,840.66	$ 1,206.73	$ (633.94)						
44		6 Therapy Visits	$ 2,131.51	$ 2,290.41	$ 158.90						
45		7-9 Therapy Visits	$ 2,045.51	$ 2,748.82	$ 703.31						
46		10 Therapy Visits	$ 4,032.79	$ 3,152.96	$ (879.83)						
47		11-13 Therapy Visits	$ 4,070.03	$ 3,518.53	$ (551.50)						
48		14-15 Therapy Visits	$ 4,104.41	$ 4,331.66	$ 227.25						
49		16-17 Therapy Visits	$ 4,134.09	$ 4,555.45	$ 421.36						
50		18-19 Therapy Visits	$ 4,277.46	$ 4,577.01	$ 299.56						
		20+ Therapy Visits	$ 4,401.14	$ 6,750.23	$ 2,349.08						

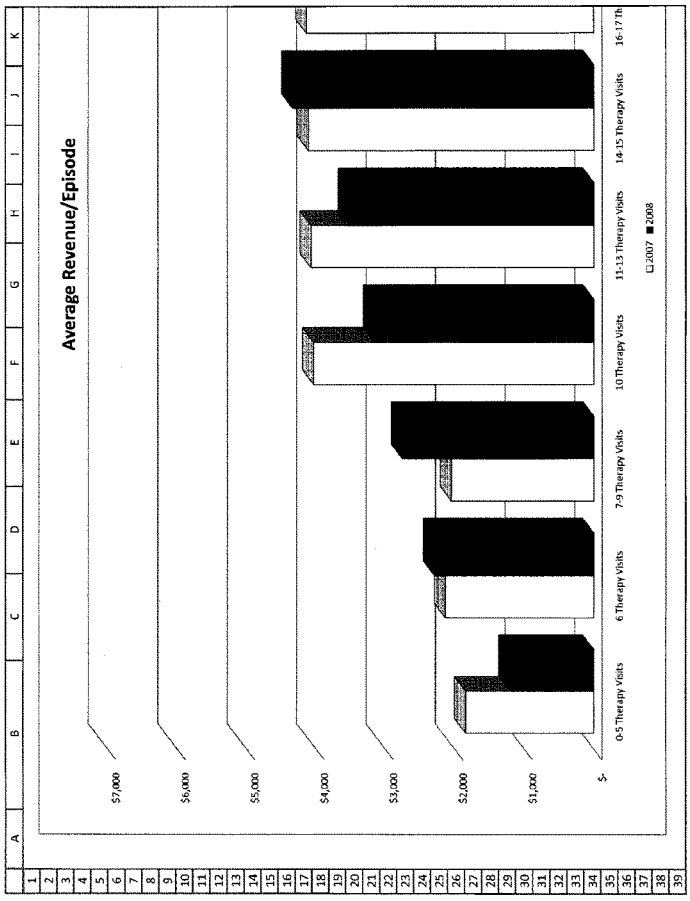
	A	B	C	D	E	F	G
1		All Episodes				14+ Therapy Visits	
2	VP	EPISODES	% of EPISODES	REV/EPISODE	RANK	EPISODES	% of EPISODES
3	Mike Hamilton	3,086	100.00%	$ 2,712.86	1	769	24.92%
4	Cheryl Lacey	1,390	100.00%	$ 2,672.24	2	265	19.06%
5	Elizabeth Robinson	2,619	100.00%	$ 2,704.64	3	494	18.86%
6	Teresa Ledgerwood	1,652	100.00%	$ 2,460.90	4	297	17.98%
7	Vonnie Fox	272	100.00%	$ 2,601.67	5	47	17.28%
8	Dan Cundiff	1,070	100.00%	$ 2,550.60	6	172	16.07%
9	Mike Ginn	3,076	100.00%	$ 2,391.14	7	430	13.98%
10	N/A	55	100.00%	$ 2,334.15	8	6	10.91%
11	TOTAL	13,220	100.00%	$ 2,583.62	--	2,480	18.76%

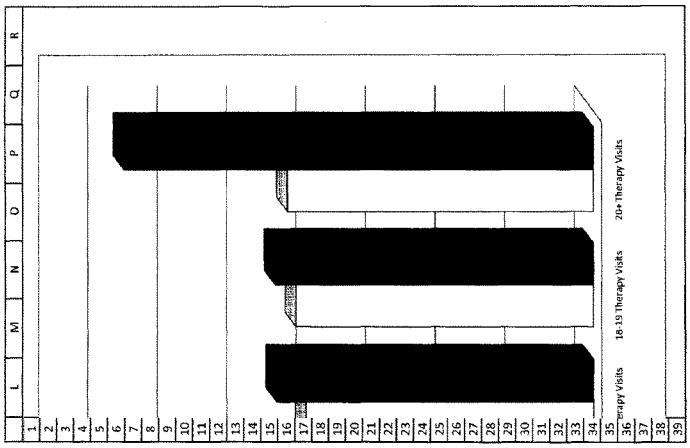
	H	I	J	K	L	M	N
1			20+ Therapy Visits			18-19 Therapy Visits	
2	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE
3	$ 4,184.82	200	6.48%	$ 4,390.87	105	3.40%	$ 4,274.01
4	$ 4,408.70	75	5.40%	$ 4,499.97	36	2.59%	$ 4,797.22
5	$ 4,392.37	163	6.22%	$ 4,569.80	70	2.67%	$ 4,367.00
6	$ 4,216.51	84	5.08%	$ 4,542.58	40	2.42%	$ 4,052.90
7	$ 4,626.47	16	5.88%	$ 4,935.26	8	2.94%	$ 4,666.26
8	$ 4,323.25	42	3.93%	$ 4,459.42	25	2.34%	$ 4,157.62
9	$ 4,056.68	125	4.06%	$ 4,273.11	50	1.63%	$ 4,071.90
10	$ 4,388.70	1	1.82%	$ 4,618.93	1	1.82%	$ 3,897.97
11	$ 4,250.13	706	5.34%	$ 4,457.71	335	2.53%	$ 4,292.66

	O	P		Q	R	S		T	U
1		16-17 Therapy Visits			14-15 Therapy Visits				
2	EPISODES	% of EPISODES		REV/EPISODE	EPISODES	% of EPISODES		REV/EPISODE	EPISODES
3	213	6.90%	$	4,141.53	251	8.13%	$	4,020.05	356
4	70	5.04%	$	4,250.34	84	6.04%	$	4,292.68	143
5	99	3.78%	$	4,328.72	162	6.19%	$	4,263.70	252
6	89	5.39%	$	4,087.50	84	5.08%	$	4,105.05	155
7	10	3.68%	$	4,364.24	13	4.78%	$	4,423.64	26
8	47	4.39%	$	4,324.71	58	5.42%	$	4,294.84	117
9	107	3.48%	$	3,930.94	148	4.81%	$	3,959.66	356
10	1	1.82%	$	4,091.85	3	5.45%	$	4,574.48	4
11	636	4.81%	$	4,156.61	803	6.07%	$	4,123.94	1,409

	V	W	X	Y	Z	AA	AB
1	11-13 Therapy Visits		10 Therapy Visits			7-9 Therapy Visits	
2	% of EPISODES	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE	EPISODES	% of EPISODES
3	11.54%	$ 3,964.49	111	3.60%	$ 3,907.04	208	6.74%
4	10.29%	$ 4,066.87	54	3.88%	$ 4,029.98	83	5.97%
5	9.62%	$ 4,210.99	84	3.21%	$ 3,954.16	172	6.57%
6	9.38%	$ 3,981.98	65	3.93%	$ 3,784.44	133	8.05%
7	9.56%	$ 4,107.72	7	2.57%	$ 4,092.67	16	5.88%
8	10.93%	$ 4,098.27	47	4.39%	$ 3,995.95	79	7.38%
9	11.57%	$ 3,844.49	121	3.93%	$ 3,763.60	180	5.85%
10	7.27%	$ 3,669.54	2	3.64%	$ 4,204.16	10	18.18%
11	**10.66%**	**$ 4,003.49**	**491**	**3.71%**	**$ 3,889.43**	**881**	**6.66%**

	AC	AD	AE	AF	AG	AH	AI
1			6 Therapy Visits			0-5 Therapy Visits	
2	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE
3	$ 2,307.05	72	2.33%	$ 2,282.34	1,570	50.87%	$ 1,697.16
4	$ 2,207.21	20	1.44%	$ 2,253.15	825	59.35%	$ 1,840.81
5	$ 2,293.54	65	2.48%	$ 2,177.44	1,552	59.26%	$ 1,922.87
6	$ 2,275.00	66	4.00%	$ 2,238.06	936	56.66%	$ 1,602.16
7	$ 2,569.87	12	4.41%	$ 2,420.46	164	60.29%	$ 1,735.35
8	$ 2,223.71	45	4.21%	$ 2,165.90	610	57.01%	$ 1,713.27
9	$ 2,090.70	58	1.89%	$ 1,980.17	1,931	62.78%	$ 1,706.65
10	$ 2,608.48	1	1.82%	$ 2,127.49	32	58.18%	$ 1,585.86
11	$ 2,246.69	339	2.56%	$ 2,189.16	7,620	57.64%	$ 1,751.06





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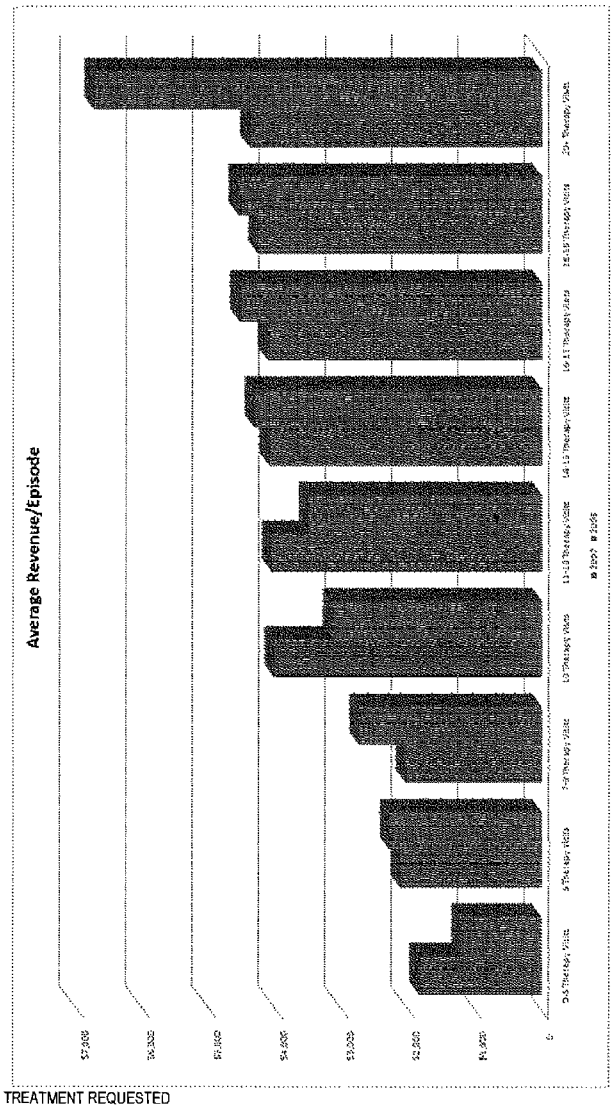
	H	I	J	K	L	M	N
1		20+ Therapy Visits			18-19 Therapy Visits		
2	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE
3	$ 4,184.82	200	6.48%	$ 4,390.87	105	3.40%	$ 4,274.01
4	$ 4,408.70	75	5.40%	$ 4,499.97	36	2.59%	$ 4,797.22
5	$ 4,392.37	163	6.22%	$ 4,569.80	70	2.67%	$ 4,367.00
6	$ 4,216.51	84	5.08%	$ 4,542.58	40	2.42%	$ 4,052.90
7	$ 4,626.47	16	5.88%	$ 4,935.26	8	2.94%	$ 4,666.26
8	$ 4,323.25	42	3.93%	$ 4,459.42	25	2.34%	$ 4,157.62
9	$ 4,056.68	125	4.06%	$ 4,273.11	50	1.63%	$ 4,071.90
10	$ 4,388.70	1	1.82%	$ 4,618.93	1	1.82%	$ 3,897.97
11	**$ 4,250.13**	**706**	**5.34%**	**$ 4,457.71**	**335**	**2.53%**	**$ 4,292.66**

	O	P	Q	R	S	T	U
1	16-17 Therapy Visits			14-15 Therapy Visits			
2	EPISODES	% of EPISODES	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE	EPISODES
3	213	6.90%	$ 4,141.53	251	8.13%	$ 4,020.05	356
4	70	5.04%	$ 4,250.34	84	6.04%	$ 4,292.68	143
5	99	3.78%	$ 4,328.72	162	6.19%	$ 4,263.70	252
6	89	5.39%	$ 4,087.50	84	5.08%	$ 4,105.05	155
7	10	3.68%	$ 4,364.24	13	4.78%	$ 4,423.64	26
8	47	4.39%	$ 4,324.71	58	5.42%	$ 4,294.84	117
9	107	3.48%	$ 3,930.94	148	4.81%	$ 3,959.66	356
10	1	1.82%	$ 4,091.85	3	5.45%	$ 4,574.48	4
11	636	4.81%	$ 4,156.61	803	6.07%	$ 4,123.94	1,409

	V	W	X	Y	Z	AA	AB
1	11-13 Therapy Visits			10 Therapy Visits			7-9 Therapy Visits
2	% of EPISODES	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE	EPISODES	% of EPISODES
3	11.54%	$ 3,964.49	111	3.60%	$ 3,907.04	208	6.74%
4	10.29%	$ 4,066.87	54	3.88%	$ 4,029.98	83	5.97%
5	9.62%	$ 4,210.99	84	3.21%	$ 3,954.16	172	6.57%
6	9.38%	$ 3,981.98	65	3.93%	$ 3,784.44	133	8.05%
7	9.56%	$ 4,107.72	7	2.57%	$ 4,092.67	16	5.88%
8	10.93%	$ 4,098.27	47	4.39%	$ 3,995.95	79	7.38%
9	11.57%	$ 3,844.49	121	3.93%	$ 3,763.69	180	5.85%
10	7.27%	$ 3,669.54	2	3.64%	$ 4,204.16	10	18.18%
11	**10.66%**	**$ 4,003.49**	**491**	**3.71%**	**$ 3,889.43**	**881**	**6.66%**

	AC	AD	AE	AF	AG	AH	AI
1			6 Therapy Visits			0-5 Therapy Visits	
2	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE	EPISODES	% of EPISODES	REV/EPISODE
3	$ 2,307.05	72	2.33%	$ 2,282.34	1,570	50.87%	$ 1,697.16
4	$ 2,207.21	20	1.44%	$ 2,253.15	825	59.35%	$ 1,840.81
5	$ 2,293.54	65	2.48%	$ 2,177.44	1,552	59.26%	$ 1,922.87
6	$ 2,275.00	66	4.00%	$ 2,238.06	936	56.66%	$ 1,602.16
7	$ 2,569.87	12	4.41%	$ 2,420.46	164	60.29%	$ 1,735.35
8	$ 2,223.71	45	4.21%	$ 2,165.90	610	57.01%	$ 1,713.27
9	$ 2,090.70	58	1.89%	$ 1,980.17	1,931	62.78%	$ 1,706.65
10	$ 2,608.48	1	1.82%	$ 2,127.49	32	58.18%	$ 1,585.86
11	**$ 2,246.69**	**339**	**2.56%**	**$ 2,189.16**	**7,620**	**57.64%**	**$ 1,751.06**



Footnote 41

From: Teresa Mills
Sent: Tuesday, February 26, 2008 2:13 PM
To: Patti Waller
Subject: FW: Utilization of the New Therapy Clinical Tracks

Patti,
I forgot to copy you on this email I sent to my region on 2008 Therapy Management. teresa

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From: Teresa Mills
Sent: Tuesday, February 26, 2008 2:08 PM
To: Pam Morgan; Traci Ferguson; Paula McCarty; Teresa Turner; Kristi Bentley; Patti McCarver; Heather Drake; Mechelle Harvey; Cynthia Underwood; Brenda Driver; Shirley Barber; Julie Sutphin; Todd Miller; Heather Mackrell
Cc: Mike Ginn; Pamela Arnold
Subject: Utilization of the New Therapy Clinical Tracks

Good Afternoon All,

Hopefully by now you have reviewed your agency's rankings in relation to the email Tasha Mears sent last night on Therapy Management 2008. It is imperative that we are compliant with the clinical tracks for Rehab that were made available to your agency December 2007. After reviewing each of the agencies Episode Statistics for Feb.1 thru today it is evident that we as a region are not following the established guidelines for clinical management of therapy utilization. 65 percent or greater of your episodes that have ended this month fell under the 2008 PPS rules and discovery is that most of your episodes have fallen into the Grouping Step 1 or Grouping Step 3 with 0-13 therapy visits. The Rehab Clinical Traction Options selection sheet is based on the therapist's assessment of the geriatric rehab patient with attention to the clinical and functional scoring established on the evaluation . There are only 3 of the 14 Therapy Tracks that have less than 14 visits to be scheduled ---they are Rehab at Home—001 for C1F1-8 visits recommended, Dysphagia at Home -001 for C2-3 F2-3 for 8 SLP visits, and Orthopedics I -001 for C1-2 F1 for 8 PT visits. Most patients in this clinical and functional status would not be a patient in home health for any length of time. Most of your patients fall into a C2F2-3 status or greater and would more appropriately be placed on the other tracks having 14-22 visit options and are based on Clinical 2-3 and Functional 2-3 scoring on the OASIS. This is your guideline and the Clinical Managers are to work with the therapists to obtain the accurate track selection------do not use any of the old therapy tracks.

Please review the Home Health Line dated February 18, 2008 as it will greatly assist you and your staff in understanding the 08 PPS coding. An example stated was: A look at the answer to OASIS MO390 (vision), might reveal that the patient has low vision. Code that correctly and you could gain an extra three clinical domain points and upwards of $380.28 for some patients. If your agency manages 1,000 episodes a year with a quarter of them involving patients with hypertension and low vision, there could be as much as $95,000.00 in annual revenue at stake per Home Health Line. I believe these two diagnosis fit many of the patients at your agencies. Again, review the article, share it with your team and put into place the items reviewed today. Thank you for your prompt attention to this matter.

Teresa B. Mills, RN,BSN/AVP of Operations North Alabama

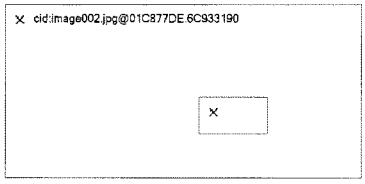
Footnote 42

From: Dan Cundiff
Sent: Wednesday, February 27, 2008 6:40 AM
To: Sarah Zimmerman; Susan Goff; Jenice Carrick; Donna Merritt; Denise Earnshaw
CC: Patti Waller; Esther Lee
Subject: January

Team, we are beginning to get an analysis of our January. Here are the simple conclusions:

-LUPA's killed us. In a month when rev/episode dropped, this was a double hammer

-Therapies met also dropped for the company....and for virtually everyone in Florida. We need to work immediately to adjust our "10 therapy threshold" mindset. See the e mail from Tasha yesterday. At 10, our episode value drops by over 880.00. 14-15 is where we need to be...and yes, I understand that our visits per episode will go up....but I would rather be profitable than have a low visits/episode. At 7-9 we have upside, but the overall episode value is less than I would like to see for cases involving therapies. If we continue to drive meeting 10 therapies.....we will be cooked. 11-13 as well.



This column shows the difference between 2007 and 2008

Lastly, we are under budget on admits. Our cost structure cannot support our revenue. If we do not have an acceptable Feb. we will have to make some tough decisions...and it is just easier to grow a business!

Pls address these items immediately. THANK YOU.

Dan Cundiff

VP, Florida Operations
[redacted]

Clinical Excellence is Job One!

Footnote 43

From: Dan Cundiff
Sent: Friday, February 29, 2008 11:38 AM
To: Donna Merritt; Susan Goff; Sarah Zimmerman; Jenice Carrick; Denise Earnshaw
CC: Patti Waller
Subject: episode follow up

Thank you for taking part on our call this morning.

Team, at the risk of being over bearing!!!!! Pls forward this to your DOO's.

Our single largest loss in January, was an almost state wide reduction in episode values....with the exception of just a couple of agencies.

This was driven by a change in therapy threshold met. We still drove to a 10 therapy threshold.....and thus, our values per episode were HAMMERED. We must stop thinking that 10 therapies maximizes our reimbursement.

The new upper level threshold is now 14 therapy visits. **When clinically appropriate**, lets drive to that number. From 10-13 visits, we become significantly less profitable..to the tune of an 800.00+ negative adjustment from 2007 rates.

Falling in the 10-13 range without a solid set of reasons is real shame, and the only acceptable reason is that it was absolutely the best thing for the patient. I will never...NEVER argue that point, but I would also suggest, that in most cases, patients benefit from additional therapy beyond 10-13 visits.

Let's get with the newer reimbursement schedule.....improve our outcomes by more therapy patient contact....and win all around. Lastly, let's not be overly concerned about visits per episode ....until we maximize our revenue opportunities..when supported by clinical standards.

Thank you.

Dan

Dan Cundiff
VP Operations
Florida, Puerto Rico
[redacted]

Clinical Excellence is JOB One

Footnote 44

From: Mike Hamilton
Sent: Monday, March 10, 2008 1:53 PM
To: Jill Cannon; William Mayes
Subject: FW: Financial Action Plans
Attachments: Wentzville.docx; Fort Wayne.docx; Hillsboro.docx; Indy.docx; Muncie.docx; St. Louis.docx

Since most of these sites are fairly new to Melissa I went ahead and asked her to prepare an action plan for them. She worked with Mary Jane and both are in agreement with the action items outlined for each office.

If you have any questions or if you would like to add or delete anything please let me know.

Thanks,

Mike Hamilton
VP of Operations
12682

From: Melissa Adams
Sent: Thursday, March 06, 2008 1:26 PM
To: Mike Hamilton
Subject: Financial Action Plans

Here you go. Let me know if these are adequate or if I need to add anything.

Melissa Adams, RN
Area Vice President of Operations
[redacted]
St. Louis, MO 63127
[redacted] Fax
[redacted] Cell

Wentzville 1305 — **ACTION PLAN FOR** — **DATE: MARCH 5, 2008**

AREA IDENTIFIED FOR IMPROVEMENT	ACTION ITEM(S) TO COMPLETE PROJECT	RESPONSIBLE PARTY	DATE COMPLETED	FOLLOW UP
The Wentzville office technically opened in Aug 2007, however we did not have any DOO or clinical staff until October 2007. Shortly after opening the AE resigned before Christmas. Presently we have an AE from our Belleville IL office covering 2 ½ days per week. Agency does not have any rehab. Staff and are presently using contract therapy. Looking at the financials the primary issues I have identified: Must increase admissions, increasing the revenue. Rev/Episdoe is low due to the under utilization of therapy. All therapy visits in Jan. were in the 5-6 bucket. Recerts are actually very good when you look at how long these patients have been on service, most of them are in their first episode. M/Core Adm ACTUAL 4 BUDGET 17 Rev/Episode $1619 $2712 Recert 4				
Need FT AE	Work with recruitment department to identify and hire an AE	Melissa Adams AVP Ops and Mary Jane Hagar AVP BD	03/31/08	
Optimize usage of available DM programs to increase admissions.	1. Work with DOO's from the Hillsboro and St. Louis offices to share the hiring of a FT ST to introduce the Dysphagia Program. 2. Work with David Hutchings to optimize our usage and marketing of this program. 3. Presently working with Wanda Hull to introduce the Balance for Life program in the area, which should occur the second quarter.	1. Denise O'Malley DOO 1302 2 & 3 DOO's from 1301, 1302 & 1305	1 & 2 4/15/08 3 2nd quarter	
Increase Revenue per episode via episode management from $1619 to $2500.	1. Work with DOO to understand the new case mix. 2. Identify patients with rehab needs and optimize their usage. 3. Work with DOO to insure usage of clinical tracks. Both	Melissa Adams AVP OP	3/15/08	

	Nursing and Rehab.				
Increase M/Care admissions from 25% of budget to 75% of budget. Increase to 40% by end of March, 50% by end of April, 65% by the end of May and 75% by the end of June.	Same as all of above 1. Belleville AE will continue to cover 2 ½ days per month until FT AE is obtained. 2. DOO will assist with follow-up marketing calls once FT field RN is hired and trained.	Melissa Adams AVP OP & Jeanne Rotunda DOO	6/30/08		

Wentzville 1305 — **ACTION PLAN FOR** — **DATE: MARCH 5, 2008**

AREA IDENTIFIED FOR IMPROVEMENT	ACTION ITEM(S) TO COMPLETE PROJECT	RESPONSIBLE PARTY	DATE COMPLETED	FOLLOW UP
The Wentzville office technically opened in Aug 2007, however we did not have any DOO or clinical staff until October 2007. Shortly after opening the AE resigned before Christmas. Presently we have an AE from our Belleville IL office covering 2 ½ days per week. Agency does not have any rehab. Staff and are presently using contract therapy. Looking at the financials the primary issues I have identified. Must increase admissions, increasing the revenue. Rev/Episdoe is low due to the under utilization of therapy. All therapy visits in Jan. were in the 5-6 bucket. Rccerts are actually very good when you look at how long these patients have been on service, most of them are in their first episode. ACTUAL BUDGET M/Care Adm 4 17 Rev/Episode $1619 $2712 Recert 4				
Need FT AE	Work with recruitment department to identify and hire an AE	Melissa Adams AVP Ops and Mary Jane Hagar AVP BD	03/31/08	
Optimize usage of available DM programs to increase admissions.	1. Work with DOO's from the Hillsboro and St. Louis offices to share the hiring of a FT ST to introduce the Dysphagia Program. 2. Work with David Hutchings to optimize our usage and marketing of this program. 3. Presently working with Wanda Hull to introduce the Balance for Life program in the area, which should occur the second quarter.	1. Denise O'Malley DOO 1302 2 & 3 DOO's from 1301, 1302 & 1305	1 & 2 4/15/08 3 2nd quarter	
Increase Revenue per episode via episode management from $1619 to $2500.	1. Work with DOO to understand the new case mix. 2. Identify patients with rehab needs and optimize their usage. 3. Work with DOO to insure usage of clinical tracks. Both	Melissa Adams AVP OP	3/15/08	

Increase M/Care admissions from 25% of budget to 75% of budget. Increase to 40% by end of March, 50% by end of April, 65% by the end of May and 75% by the end of June.	Nursing and Rehab. Same as all of above 1. Belleville AE will continue to cover 2 ½ days per month until FT AE is obtained. 2. DOO will assist with follow-up marketing calls once FT field RN is hired and trained.	Melissa Adams AVP OP & Jeanne Rotunda DOO	6/30/08	

Fort Wayne 1823 — **ACTION PLAN FOR** — **DATE: MARCH 6, 2008**

AREA IDENTIFIED FOR IMPROVEMENT	ACTION ITEM(S) TO COMPLETE PROJECT	RESPONSIBLE PARTY	DATE COMPLETED	FOLLOW UP
I took this branch over the end of Sept. 2007, when the DOO left. There was absolutely no office staff or a AE. Presently we have a new DOO, BOM and AE. The AE has failed bring in new referral sources. Her 90 day has been extended and will be put on a PIP April 1st if no improvement by the end of March. We are presently recruiting a new AE in order to be proactive with this situation. Analysis of Financials: Must increase admissions this will bring up the GM, NPO and decrease the G&A. Revenue per episode could be increased by better utilizing therapy 50% of their therapy was in the 11-13 range the other 50% was in the 6 range. Need to increase recert to a minimum of 50% of census. ACTUAL BUDGET McCare Adm 5 29 Rev/Episode $2714 $2567 Recert 3 Census 16	1. Entire clinical staff and AE will be doing an ALF/SNF Blitz in 2 weeks, to try and increase this part of the market 2. AVP BD will be spending time at the branch and working with the AE in April. 3. AE to concentrate marketing efforts to promote Therapy Wound Care. 4. Hire and train an additional AE. 5. Continue to monitor AE's productivity and address as necessary.	1 DOO, AE & clinical staff 2, 4 & 5 AVP BD – Mary Jane Hagar 3 AE Diane Whisler	1, 2, 3, & 5 3/30/08 4 4/15/08	
Increase Rev/Episode and Recert.	1. DOO will monitor therapy utilization and ensure therapists are utilizing the therapy tracks. 2. DOO will continue to monitor discharges via the DC Checklist, identifying patients that could be recerted. 3. DOO will ensure that all clinical staff are utilizing the clinical tracks and monitor visit utilization.	DOO and AVP OP	Ongoing	

Hillsboro 1301 — **ACTION PLAN FOR** — **DATE: MARCH 6, 2008**

AREA IDENTIFIED FOR IMPROVEMENT	ACTION ITEM(S) TO COMPLETE PROJECT	RESPONSIBLE PARTY	DATE COMPLETED	FOLLOW UP
Hillsboro is in a rural setting. The hospital home health has a majority of the market The AE is strong and they have a strong office staff. Financial Analysis: Need to get Medicare admissions over their budget. G&A is high due to having to salary field staff to cover a large rural area and trying to get a Psych program off the ground. Recert are low, need to increase. Rev/Episode could be higher with better utilization of therapy. They have a therapist cert. in wound care which they are not presently using. Avg visits per episode is high which would not be bad if this was therapy, but it is not. They have 62% of therapy in the below 10 visits. ACTUAL BUDGET McCare Adm 22 24 Recert 6 Rev/Episode $2713 Avg Visit/Episode 19.48 16.5				
Increase Medicare Admissions and Recert	1. Wound Care Blitz scheduled mid March. 2. DOO will insure that all staff has completed the required wound care training. 3. DOO will monitor proper utilization of therapy wound care. 4. DOO and CM will review and authorize all discharges using the DC Criteria Checklist. 5. DOO and AE will plan an ALF/SNF Blitz the beginning of April.	1 DOO's 1301 & 1302 and all AE's 2 DOO 3&4 DOO & CM 5 DOO & AE	1 3/15/08 2 3/15/08 3&4 Ongoing 5 4/10/08	
Increase Revenue per Episode	1. DOO and CM will implement the therapy wound care and ensure proper utilization of therapy wound care. 2. DOO will monitor therapy usage during Care Team. 3. DOO and CM will monitor the utilization of clinical tracks using the allotted visit numbers. 4. DOO and CM will monitor the utilization of the Rehab. Tracks using the allotted visit numbers.	DOO & CM	3/10/08	

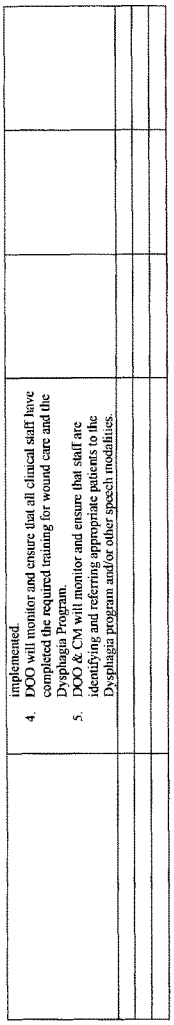
Indianapolis 1820	ACTION PLAN FOR	DATE: MARCH 6, 2008			
AREA IDENTIFIED FOR IMPROVEMENT	ACTION ITEM(S) TO COMPLETE PROJECT	RESPONSIBLE PARTY	DATE COMPLETED	FOLLOW UP
Indianapolis I took over in Oct 2007. We have had a major clean-up in this office. We just recently hired a DOO and a FT RN in Jan. Prior to this we did not even have an RN for the location. The BOM is on a PIP. Due to the billing compliance and regulatory issues we discovered we terminated our relationship with a sub-contract group we were working with in an ALF. This referral source was 90% of the branches business. Operationally the branch is doing better. SYS holds and AR is decreasing. Daily Billing is being managed by the BOM. We have a very strong AE and clinical staff. The therapist is becoming Wound certified in March. Financial Analysis: Branch meeting M/Care admissions but this will need to be much higher in order for this branch to be profitable. Rev/Episode is extremely high but this will drastically decrease in Feb. due to the subcontractor over utilization in the above ALF. We will try and make this up by implementing the Therapy Wound Care program. Recert are very low, but the census of 36 is not a true reflection due to the subcontract group not turning in DC paperwork for 30-45 days late. Avg. Visits/Episode is high also due to the sub-contract group over utilization. ACTUAL BUDGET M/Care Adm 9 9 Rev/episode $3337 $3082 Avg Visit/Episode 21.62 16.50 Recert 2 11				
Increase Medicare Admissions & Recert.	1. Schedule Wound Care Blitz. 2. DOO will insure that all staff has completed the	1 & 5 DOO & AE	1 3/15/08	

	3. DOO will monitor proper utilization of therapy wound care. 4. DOO will review and authorize all discharges using the DC Criteria Checklist. 5. DOO and AE will plan an ALF/SNF Blitz the beginning of April.	2-4 DOO	2-4 On-going 5 3/30/08	
Maintain Revenue/Episode at over $3000	1. DOO and will implement the therapy wound care and ensure proper utilization of therapy wound care. 2. DOO will monitor therapy usage during Care Team. 3. DOO will monitor the utilization of clinical tracks using the allotted visit numbers. 4. DOO will monitor the utilization of the Rehab. Tracks using the allotted visit numbers.	DOO	1 3/30/08 2-4 On-going	
Decrease Avg visits/Episode	1. DOO will ensure that all patients are put on the appropriate clinical track and visit recommendations are followed. 2. DOO will ensure that all rehab patients are put on appropriate Rehab. Track and visit recommendations are followed.	DOO	On-going	

Muncie 1826	ACTION PLAN FOR		DATE: MARCH 6, 2008		
AREA IDENTIFIED FOR IMPROVEMENT	ACTION ITEM(S) TO COMPLETE PROJECT	RESPONSIBLE PARTY	DATE COMPLETED	FOLLOW UP
This is a new start-up which opened the very end of Aug. 2007. We have had a serious Therapy recruitment crisis in this area. They have no therapist (employees or sub-contract), even after mailers, running numerous ads, working with Amica. The agency continues to turn down referrals requiring therapy, drastically effecting their admission numbers. They have called every outpatient rehab. In the area, trying to get a sub-contractor without any success. After analyzing the financials: Revenue will have to be increased in order to see any change in the agency. The Rev/Episode is actually pretty high considering therapy is not involved. They have some wounds with copious amounts of drainage requiring frequent dressing changes which is effecting their visits/episode. The key factor in this agency will be getting therapy services, which will increase admissions and affect the rev/episode. GM will go up and G&A will go down once revenue is increased. ACTUAL BUDGET M/Care Adm 6 19 Rev/Episode $2272 $2711 Avg. Visit/Episode 23.50 16.50				
Hire PT and OT	1. Continue to work with Amedisys Recruiter. 2. Continue to have bi-weekly recruitment meetings with Amedisys recruiter, AVP of Ops and VP 3. Continue to work with therapist at sister agencies requesting recruitment help. 4. Continue to have all employees (especially AE) to try and identify potential applicants in the community. 5. Continue to work with Amica. 6. Continue to work with an outside recruiter.	DOO, AVP Ops, VP & Recruiter	On-going	
Maximize marketing efforts in area's that may not require therapy.	AE to concentrate marketing wound care and Diabetic care that may not require therapy.	Tammy tweedy DOO & Lissa Wright AE	On-going	

Increase Recert to at least 50%	DOO will monitor all discharges using DC Criteria Checklist.	Tammy Tweedy DOO	Ongoing	

St. Louis 1302	Action Plan for		Date: March 6, 2008		
Area Identified for Improvement	Action Item(s) to Complete Project	Responsible Party	Date Completed	Follow Up
St. Louis is improving. They have a strong DOO and office staff. 1 strong AE, 1 medium AE and another AE who will be put on a PIP if there is not a great improvement by the end of March. Financial Analysis: The LUPA's and Therapy adjustments really hurt this branch in Jan. a total of $23600 in adjustments came off of their Revenue. If this had not occurred this branch would have been in the green. The LUPA's were primarily ACF admissions, 1 foley cath care and 2 patients refusing services. The therapy was pretty much the same, we were unable to identify any trends that we could correct in this area. It was just an unfortunate month. Rev/Episode can be increased with better utilization of therapy, 55% were below 10 visits. Medicare admissions were at 76%, need to increase.					
Increase Medicare Admissions	1. Wound Care Blitz scheduled 3/10/08 2. ST has been hired, working with AE's, DOO, Clinical staff and David Hutchings to increase ST utilizing the Dysphagia program. 3. Balance For Life implementation scheduled for 2nd Quarter 4. Put AE on PIP if productivity does not increase by the end of March.	1&2 DOO, AE 3 DOO, AVP OP and Wanda Hull 4 AVP of OP & BD	1 3/10/08 2 4/1/08 3 6/30/08 4 3/30/08	
Increase Recert.	1. All DC will be authorized by DOO using DC Criteria Checklist. 2. All Recert and DC will be discussed at Care Team Weekly.	DOO & CM	On-going	
Increase Therapy Utilization	1. DOO and CM will monitor therapy utilization during Care Team weekly. 2. DOO will ensure that all therapists are using the Rehab. Tracks using recommended visits. 3. DOO and CM will ensure that Therapy Wound Care patients are identified and their care via a therapist is	DOO & CM	3/30/08	



implemented.
4. DOO will monitor and ensure that all clinical staff have completed the required training for wound care and the Dysphagia Program.
5. DOO & CM will monitor and ensure that staff are identifying and referring appropriate patients to the Dysphagia program and/or other speech modalities.

Footnote 45, 46

# of Therapy Visits	2006 #	2006 %	2007 #	2007 %	2008 #	2008 %	2009 #	2009 %
1	7,435	6.9%	10,561	8.1%	9,186	6.5%	8,333	5.2%
2	4,264	4.0%	4,946	3.8%	4,996	3.5%	5,426	3.4%
3	4,046	3.8%	4,746	3.6%	4,685	3.3%	4,630	2.9%
4	4,308	4.0%	5,060	3.9%	5,123	3.6%	5,027	3.2%
5	5,421	5.1%	6,467	4.9%	5,930	4.2%	5,773	3.6%
6	7,046	6.6%	8,589	6.5%	8,568	6.1%	7,575	4.8%
7	5,257	4.9%	6,255	4.8%	7,800	5.5%	8,098	5.1%
8	4,267	4.0%	5,222	4.0%	7,578	5.4%	8,249	5.2%
9	4,189	3.9%	4,722	3.6%	7,324	5.2%	7,918	5.0%
10	8,712	8.1%	10,120	7.7%	8,255	5.8%	8,696	5.5%
11	8,444	7.9%	10,384	7.9%	8,647	6.1%	9,077	5.7%
12	10,604	9.9%	12,649	9.6%	10,819	7.7%	10,404	6.6%
13	5,505	5.1%	7,077	5.4%	7,128	5.0%	8,231	5.2%
14	4,230	3.9%	5,242	4.0%	6,805	4.8%	7,970	5.0%
15	3,609	3.4%	4,572	3.5%	5,666	4.0%	7,037	4.4%
16	3,364	3.1%	4,384	3.3%	5,034	3.6%	6,305	4.0%
17	2,977	2.8%	3,624	2.8%	4,403	3.1%	5,772	3.6%
18	2,476	2.3%	3,209	2.4%	3,845	2.7%	5,115	3.2%
19	1,999	1.9%	2,403	1.8%	3,149	2.2%	4,328	2.7%
20	1,673	1.6%	2,130	1.6%	2,967	2.1%	4,066	2.6%
21	1,415	1.3%	1,701	1.3%	2,473	1.8%	3,561	2.2%
22	1,177	1.1%	1,366	1.0%	2,015	1.4%	3,062	1.9%
23	998	0.9%	1,178	0.9%	1,743	1.2%	2,547	1.6%
24	913	0.9%	1,055	0.8%	1,556	1.1%	2,479	1.6%
25	712	0.7%	932	0.7%	1,322	0.9%	2,224	1.4%
26	651	0.6%	722	0.6%	1,148	0.8%	1,804	1.1%
27	519	0.5%	549	0.4%	908	0.6%	1,519	1.0%
28	399	0.4%	496	0.4%	797	0.6%	1,361	0.9%
29	381	0.4%	406	0.3%	672	0.5%	1,141	0.7%
30	305	0.3%	403	0.3%	661	0.5%	1,044	0.7%
Total	107,296	100.0%	131,169	100.0%	141,202	100.0%	158,772	100.0%

* This info includes data from Gentiva systems and post-acquisition data from acquired systems.

Between 2006 & 2009, Gentiva saw a 34% increase in Medicare episodes, while therapy episodes increased 48%. One reason for the additional growth is the continued expansion of our clinical treatment planning for rehabilitation patients through our Specialty programs. These programs have been developed from the latest clinical evidence in healthcare and are designed to treat significant health issues facing older Americans, such as vestibular balance, joint replacement, and the effects of neurological injuries. Over this period, 308 programs were introduced in 218 locations nationwide. Therapy episodes treated within our Specialty programs comprised only 14% of all episodes in 2006 but accounted for 27% in 2009. As a percentage of therapy episodes, Specialties grew from 25% to 35% during the same period.

* All mention of "episodes" refers to Medicare-reimbursed episodes only.
* All mention of "therapy episodes" refers to Medicare-reimbursed episodes with 1-30 therapy visits only.
* For further detail of the clinical breakdown of our Specialty programs, please see the answer to #5.

Footnote 47

	2006	2007	2008	2009
a Therapy Patients	71,048	94,918	123,440	143,860
Episodes Qualifying for Additional Payments	41,896	62,281	110,932	136,104
b Reimbursement from Episodes Qualifying for Additional Payments	$179,065,481	$272,826,363	$467,346,781	$606,921,660
c Total Medicare Reimbursement	$298,314,104	$436,824,896	$617,046,385	$773,673,026

* This info does not include post-acquisition data from acquired systems.

Footnote 49

From: Sender, Susan
Sent: Friday, January 05, 2007 02:26 PM
To: Benner, Mara; Malone, Ron; Strange, Tony
CC: Ballew, Brandon; Teenier, Pamela
Subject: RE: PPS Refinements Proposed Regulations

FYI - we also have an internal group (including Teenier, Gold, Peirce, and Tumolo) crunching utilization and outcomes data to determine whether revisions to our therapy protocols are clinically defensible.

Susan Sender
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-----Original Message-----
From: Benner, Mara
Sent: Friday, January 05, 2007 9:20 AM
To: Malone, Ron; Strange, Tony
Cc: Ballew, Brandon; Sender, Susan; Teenier, Pamela
Subject: PPS Refinements Proposed Regulations

Hi Ron and Tony,

FYI --- We are waiting on the release by CMS of the PPS refinements proposed regulations that will include the three new therapy thresholds along with case mix changes. The proposed regulation is expected out sometime this month. CMS usually releases regulations around the 15th and last of the month, however, CMS officials are implying that it could be released at any time. I will be carefully watching for it. (And while they have been stating January, if they don't get all of the approvals, this could slip into February.)

At the same time, CMS officials also stated yesterday that investors and others are anxious to see the proposed regulation. (But that no one will receive it earlier than its public release.)

I plan to have the proposed regulation reviewed internally by Brandon Ballew, Susan Sender and Pamela Teenier (Pamela served on the Technical Expert Panel at CMS.) Then provide you with a quick analysis. Is there anything else that you may need?

At this time, the PPS refinements are not expected to be implemented until at the earliest January 2008.

Mara

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Footnote 50

	A	B	C	D	E	F	G	H	I
1	Gentiva Health Services								
2	Changes in Profitablity due to Proposed Changes in Therapy Reimbursement								
3	Episodes Ending July 1- December 31, 2006								
4									
5									
6	Total Episodes							82,711	100%
7	Episodes including therapy visits							50,795	61%
8	Episodes including 10 or more therapy visits							30,157	36%
9									
10									
11	Assumptions -								
12	Current Reimbursement for 10 or more therapy visits - $1500								
13									
14	Proposed Reimbursement for 6 visits -$400; 7-13 visits - $40 per visit; 14 visits - $900; 15-19 visits - $30 per visit; 20 visits - $190								
15									
16	1st Scenario								
17	Actual visits from episodes is used in calculation								
18	No changes in costs related to changes in reimbursment amounts								
19									
20	Expected Reimbursement under Current Therapy Guidelines							$ 235,760,172	
21	Expected Reimbursement under Proposed Therapy Guidelines							$ 230,789,362	
22	Increase/(Decrease) in Expected Reimbursement							$ (4,970,810)	
23	Additional Direct Cost							$ -	
24	Increase/(Decrease) in EBITDA							$ (4,970,810)	
25									
26									
27	2nd Scenario								
28	Therapy visits provided increased 2 to 4 visits to reach 6 and 14 visit plateaus								
29	Direct cost added for additional visits at $65 per visit								
30									
31	Expected Reimbursement under Current Therapy Guidelines							$ 235,760,172	
32	Expected Reimbursement under Proposed Therapy Guidelines							$ 247,153,522	
33	Increase/(Decrease) in Expected Reimbursement							$ 11,393,350	
34	Additional Direct Cost							$ (2,992,470)	
35	Increase/(Decrease) in EBITDA							$ 8,400,880	

Footnote 51, 54, 55

From: Ballew, Brandon
Sent: Wednesday, June 02, 2010 02:31 PM
To: Ballew, Brandon; Carter, Bruce; Aurelio, John; Jalwan, Mary; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Erickson, Julie; Carpenter, Lisa; Mahoney, Darlene; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa; Simpson, Edwina; Klimo, Dianne; Donahue, Marion; Hodges, Ann; Maddox, Daniel; Brunson, Robert; Moore, Geri; Miller, Mitzi; Kisluk, Jennifer; Bell, Joe; MacInnis, Christopher
CC: Norlander, John; Cavanaugh, Pete; Gregory, Lee; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven; Spencer, Genia; Erhardt, Joshua; Slusser, Eric
Subject: RE: 2010 KIR Regional Rankings
Attachments: Regional Ranking April 2010.xls

April is closed and behind us. May is not far behind. We are 30 days away from the end of Q2, and things could be looking better. The race is getting closer for #1. Congrats to the new team of Chris and Joe for making a move this month. I keep hearing that the South will rise again?

Overall, we need a VERY STRONG JUNE to help close out the quarter. April and May were not what we expected or have seen in the past. All hands on deck!

ONLY 30 DAYS LEFT!

REGIONRVP OPSRVP SALESWeighted AVGPrev Avg
CarolinasTeresa GregorySusan Benoit2.011.96
Mid-AtlanticMonica HullingerRob Little2.362.46
WestJohn AurelioMark Hunt3.593.29
Mid AmericaBruce CarterGordon Thoennes3.773.88
SouthChris MacInnisJoe Bell4.804.89
NortheastOPENJohn Ellis4.804.92
FloridaMary JalwanBob Brunson4.924.69

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From: Ballew, Brandon
Sent: Wednesday, May 05, 2010 1:21 PM
To: Ballew, Brandon; Carter, Bruce; Aurelio, John; Jalwan, Mary; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Erickson, Julie; Carpenter, Lisa; Mahoney, Darlene; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa; Simpson, Edwina; Klimo, Dianne; Donahue, Marion; Hodges, Ann; Maddox, Daniel; Brunson, Robert; Moore, Geri; Miller, Mitzi; Kisluk, Jennifer; Bell, Joe; MacInnis, Christopher
Cc: Norlander, John; Cavanaugh, Pete; Gregory, Lee; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven; Spencer, Genia; Erhardt, Joshua; Slusser, Eric
Subject: 2010 KIR Regional Rankings

Happy New Year.

As we close the first quarter, we get our first look at the 2010 Rankings. We have some added changes this year to enhance the process. Many of the metrics are the same, however, they are now weighted between comparison to one another as well as compared to how your region is performing to

plan. For example, one metric is Gross Margin %. On a current run rate basis, Mid Atlantic is performing the best with a GM of 55.7%, however, they are only 98% of their budgeted GM %, which puts them in 4th for that piece. Combined together, the Mid Atlantic group is #2 in GM % compared to the other regions.

There is a grid below that illustrates the metrics and their calculations.

Congratulations to the #1 ranked……..KILLER BEES!!!

REGIONRVP OPSRVP SALESWeighted AVGPrev Avg
CarolinasTeresa GregorySusan Benoit1.962.01
Mid-AtlanticMonica HullingerRob Little2.462.86
WestJohn AurelioMark Hunt3.293.29
Mid AmericaBruce CarterGordon Thoennes3.884.43
FloridaMary JalwanBob Brunson4.654.60
SouthChris MacInnisJoe Bell4.895.01
NortheastOPENOPEN4.954.48

I imagine the Spider Monkeys may have something to say about that after April…..

Criteria
Gross Margin % 50% on current 4 month trend and 50% on YTD compared to budget
EBITDA % 4 month average
PPS Mix 4 month average
PPS Admits to Budget50% on raw number to budget and 50% on % to budget
PPS Case Mix 50% on current 4 month trend and 50% on YTD compared to budget
PPS Recert % 50% on current 4 month trend and 50% on YTD compared to budget
Days to RAP 4 month average
Cost Per Visit 50% on current 4 month trend and 50% on YTD compared to budget
Visits Per Episode4 month average
% Therapy > 20 4 month average
% Therapy <7 4 month average
Operating Exp % 50% on current 4 month trend and 50% on YTD compared to budget
PPS Admits per Sales FTE33% on 4 month average, 33% on YTD to budget, 33% on YTD FTEs to budget
FT Clincial Turnover4 month average
Cash Lag 60 4 month average
EBITDA to Budget33% on raw number, 33% on raw number to budget, 33% on % to budget
Conditional Level SurveyYTD count
Clinical Score YTD Clincial Audit Score + YTD Home Visit Score + YTD Customer Sat Score
Spec MCR Admits To Plan20% on PPS admits to budget for each program
PPS Revenue to Budget50% on raw number to budget and 50% on % to budget
Less than 10% % of branches Orange or Red

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From: Ballew, Brandon
Sent: Friday, January 29, 2010 6:35 PM
To: Ballew, Brandon; Carter, Bruce; Aurelic, John; Jalwan, Mary; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Carpenter, Lisa; Mahoney, Darlene; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa; Simpson, Edwina; Klimo, Dianne; Donahue, Marion; Hodges, Ann; Maddox, Daniel; Brunson, Robert; Moore, Geri; Miller, Mitzi; Brown, Shawn; Kisluk, Jennifer; Buchanan, Kent
Cc: Norlander, John; Cavanaugh, Pete; Gregory, Lee; Gieringer, David; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven; Spencer, Genia; Erhardt, Joshua; Slusser, Eric
Subject: KIR Regional Rankings through December 2009

Great to see everyone this week. Here are the final 2009 rankings. Congrats to the Spider Monkeys!

1. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales
2.27 SPIDER MONKEYS
2. Carolina Jeff Shaner Theresa Gregory Interim RVP Ops, Susan Benoit
RVP Sales 2.64 Killer Bees
3. West David Causby John Aurelio RVP Ops, Mark Hunt RVP Sales
3.62 Mustangs
4. Florida David Causby Mary Jalwan RVP Ops, Bob Brunson RVP Sales
4.12 Barracudas
5. Northeast Jeff Shaner Open RVP Ops, Shawn Brown RVP Sales
4.35 Yankees
6. Mid America Jeff Shaner Bruce Carter RVP Cps, Gordon Thoennes RVP Sales
5.08 Wildcats
7. South David Causby Open RVP Ops, Open RVP Sales
5.31 Tornados

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Great healthcare has come homeSM
From: Ballew, Brandon
Sent: Friday, December 11, 2009 11:29 AM
To: Ballew, Brandon; Carter, Bruce; Aurelio, John; Jalwan, Mary; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Carpenter, Lisa; Mahoney, Darlene; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa; Simpson, Edwina; Klimo, Dianne; Donahue, Marion; Hodges, Ann; Maddox, Daniel; Brunson, Robert; Moore, Geri; Miller, Mitzi; Brown, Shawn; Kisluk, Jennifer; Buchanan, Kent
Cc: Norlander, John; Cavanaugh, Pete; Gregory, Lee; Gieringer, David; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven; Spencer, Genia; Erhardt, Joshua; Slusser, Eric
Subject: KIR Regional Rankings through October 2009

We have been working on improving the automation of the reports and took some additional time to get some of the bugs worked out. So while we missed September, attached is the October results

1. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales
1.95 SPIDER MONKEYS
2. Carolina Jeff Shaner Theresa Gregory Interim RVP Ops, Susan Benoit
RVP Sales 2.81 Killer Bees
3. West David Causby John Aurelio RVP Ops, Mark Hunt RVP Sales
3.40 Mustangs
4. Florida David Causby Mary Jalwan RVP Ops, Bob Brunson RVP Sales
3.53 Barracudas
5. Northeast Jeff Shaner Open RVP Ops, Shawn Brown RVP Sales
4.25 Yankees
6. South David Causby Open RVP Ops, Open RVP Sales
4.68 Tornados
7. Mid America Jeff Shaner Bruce Carter RVP Cps, Gordon Thoennes RVP Sales
4.97 Wildcats

Congrats to the West team for moving back into third place. Only two months to go until the year end numbers are finalized. The ribbon is in plain sight, who has the speed to get their first!

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Great healthcare has come homeSM
From: Ballew, Brandon
Sent: Monday, September 21, 2009 10:40 AM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa; Simpson, Edwina; Klimo, Dianne; Donahue, Marion; Hodges, Ann; Maddox, Daniel; Brunson, Robert; Moore, Geri; Miller, Mitzi; Brown, Shawn
Cc: Norlander, John; Cavanaugh, Pete; Gregory, Lee; Gieringer, David; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven; Spencer, Genia; Erhardt, Joshua
Subject: KIR Rankings through August 2009

August is in. It was not a pretty month. One of the lowest results on multiple fronts, from admits to plan to EBITDA and EBITDA %. We have had some movement in the rankings as the South has moved up from the bottom. The fourth quarter will be here in a couple of days, not weeks. We have some significant ground to make up from the summer slow down. It's time to kick it up a notch.

1. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales
2.03 SPIDER MONKEYS
2. Carolina Jeff Shaner Theresa Gregory Interim RVP Ops, Susan Benoit RVP Sales
2.77 Killer Bees
3. Florida David Causby Mary Jalwan RVP Ops, Bob Brunson RVP Sales
3.61 Barracudas
4. West David Causby John Aurelio RVP Ops, Mark Hunt RVP Sales
3.89 Mustangs
5. Northeast Jeff Shaner Dan Locker RVP Ops, Shawn Brown RVP Sales
4.69 Yankees
6. South David Causby Open RVP Ops, Bob Garvin RVP Sales
5.12 Tornados
7. Mid America Jeff Shaner Bruce Carter RVP Ops, Gordon Thoennes RVP Sales
5.20 Wildcats

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Great healthcare has come homeSM

From: Ballew, Brandon
Sent: Monday, August 31, 2009 12:19 PM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa; Simpson, Edwina; Klimo, Dianne; Donahue, Marion; Hodges, Ann; Maddox, Daniel; Brunson, Robert; Moore, Geri; Miller, Mitzi
Cc: Norlander, John; Cavanaugh, Pete; Gregory, Lee; Gieringer, David; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven; Spencer, Genia; Erhardt, Joshua
Subject: UPDATED KIR Rankings through July 2009

There was an error on the admit sort. I apologize to the Florida region.

1. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales
2.08 SPIDER MONKEYS
2. Carolina Jeff Shaner Theresa Gregory Interim RVP Ops, Susan Benoit
RVP Sales 2.72 Killer Bees
3. Florida David Causby Mary Jalwan RVP Ops, Bob Brunson RVP Sales
3.62 Barracudas
4. West David Causby John Aurelio RVP Ops, Mark Hunt RVP Sales
3.77 Mustangs
5. Northeast Jeff Shaner Open RVP Ops, Shawn Brown RVP Sales
4.92 Yankees
6. Mid America Jeff Shaner Bruce Carter RVP Ops, Gordon Thoennes Interim RVP
Sales 5.12 Wildcats
7. South Jeff Shaner Open RVP Ops, Bob Garvin RVP Sales
5.31 Tornados

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Great healthcare has come homeSM

From: Ballew, Brandon
Sent: Monday, August 31, 2009 11:31 AM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa; Simpson, Edwina; Klimo, Dianne; Donahue, Marion; Hodges, Ann; Maddox, Daniel; Brunson, Robert; Moore, Geri; Miller, Mitzi
Cc: Norlander, John; Cavanaugh, Pete; Gregory, Lee; Gieringer, David; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven; Spencer, Genia
Subject: KIR Rankings through July 2009

As we begin the second half of the year, we seem to have tripped a little in July. For the first month in awhile, we missed our budget. Between a sloppy close, slower admissions, and THREE conditional level surveys, July is a month to forget. Here's to knowing August will be better!

1. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales
2.22 SPIDER MONKEYS
2. Carolina Jeff Shaner Theresa Gregory Interim RVP Ops, Susan Benoit
RVP Sales 2.99 Killer Bees
3. West David Causby John Aurelio RVP Ops, Mark Hunt RVP Sales
3.64 Mustangs
4. Florida David Causby Mary Jalwan RVP Ops, Bob Brunson RVP Sales
4.03 Barracudas
5. Northeast Jeff Shaner Open RVP Ops, Shawn Brown RVP Sales
4.65 Yankees
6. Mid America Jeff Shaner Bruce Carter RVP Ops, Gordon Thoennes Interim RVP
Sales 4.72 Wildcats
7. South Jeff Shaner Open RVP Ops, Bob Garvin RVP Sales
5.31 Tornados

Those conditional level surveys have made a big difference on the rankings, the Carolina's were much closer to #1 and Mid America was in Fourth place prior to scoring the surveys.

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From: Ballew, Brandon
Sent: Friday, July 24, 2009 4:28 PM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa; Simpson, Edwina; Klimo, Dianne; Donahue, Marion; Hodges, Ann; Maddox, Daniel; Brunson, Robert; Moore, Geri; Miller, Mitzi
Cc: Norlander, John; Cavanaugh, Pete; Gregory, Lee; Gieringer, David; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven; Spencer, Genia
Subject: KIR Rankings through June 2009

What a great first half of 2009! Congrats to everyone on a wonderful Q2!

We had a little change in the top half of the rankings, as the Killer Bees are getting tired of seeing those Monkeys up top. They'll have to stare up for one more week but in second position this time. Congrats Carolina team!

1. Mid Atlantic	Jeff Shaner	Monica Hullinger RVP Ops, Rob Little RVP Sales	
	2.43	SPIDER MONKEYS	
2. Carolina	Jeff Shaner	Theresa Gregory Interim RVP Ops, Susan Benoit RVP Sales	
	3.08	Killer Bees	
3. West	David Causby	John Aurelio RVP Ops, Mark Hunt RVP Sales	
	3.23	Mustangs	
4. Florida	David Causby	Mary Jalwan RVP Ops, Bob Brunson RVP Sales	
	4.41	Barracudas	
5. South	David Causby	Open RVP Ops, Bob Garvin RVP Sales	
	5.18	Tornados	
6. Mid America	Jeff Shaner	Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales	
	5.23	Wildcats	
7. South Central	David Causby	John Aurelio RVP Ops, Duane Neel RVP Sales	
	5.57	???	
8. Northeast	Jeff Shaner	Dan Locker RVP Ops, Open RVP Sales	
	5.74	Yankees	

The summer months tend to separate the winners from the los…not winners. Wonder what the other groups are doing to get ahead?

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From: Ballew, Brandon
Sent: Thursday, July 02, 2009 10:32 AM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch,

Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa; Simpson, Edwina; Klimo, Dianne; Donahue, Marion; Hodges, Ann; Maddox, Daniel; Brunson, Robert; Moore, Geri; Miller, Mitzi
Cc: Norlander, John; Cavanaugh, Pete; Gregory, Lee; Gieringer, David; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven; Spencer, Genia
Subject: KIR Rankings through May 2009

Q2 is in the books! This is still a look back to May. There was a softer close than normal in the month of May leading to a step back in overall performance. We were consistent across the country as the ranking have not changed since April.

1. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales
2.26 SPIDER MONKEYS
2. West David Causby John Aurelio Interim RVP Ops, Mark Hunt RVP Sales
2.91 Mustangs
3. Carolina Jeff Shaner Theresa Gregory Interim RVP Ops, Susan Benoit RVP Sales
3.23 Killer Bees
4. Florida David Causby Mary Jalwan RVP Ops, Bob Brunson RVP Sales
4.11 Barracudas
5. South David Causby Open RVP Ops, Bob Garvin RVP Sales
5.15 Tornados
6. Mid America Jeff Shaner Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales
5.59 Wildcats
7. Northeast Jeff Shaner Dan Locker RVP Ops, Open RVP Sales
5.88 ???
8. South Central David Causby John Aurelio RVP Ops, Duane Neel RVP Sales
6.00 ???

The race is getting a little closer, but as Monica always says "NO ONE can catch a Spider Monkey!" I always thought that Mustangs were fast, but I guess only time will tell.

On a side note, congratulations on a great June close! It was a tough week with many competing priorities and you and your folks got it all done! Very impressive!

Happy 4th to everyone and a special thank you to all the men and women and their families who provide the independence we are celebrating this weekend!

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From: Ballew, Brandon
Sent: Wednesday, May 27, 2009 6:12 PM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Neel, Duane; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Hand, Candy; Chartier, Todd; Martin, Joyce; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa
Cc: Norlander, John; Cavanaugh, Pete; Walters, Brett; Gregory, Lee; Gieringer, David; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven
Subject: KIR Rankings through April 2009

Q2 has begun. Everyone picked their game up in April as scores continue to improve. Who has what it takes to continue the move up in the upcoming summer months?

1. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales
2.31 SPIDER MONKEYS
2. West David Causby John Aurelio Interim RVP Ops, Mark Hunt RVP Sales
3.07 ???
3. Carolina Jeff Shaner Theresa Gregory Interim RVP Ops, Susan Benoit
RVP Sales 3.23 Killer Bees
4. Florida David Causby Mary Jalwan RVP Ops, Open RVP Sales
3.78 Barracudas
5. South David Causby Open RVP Ops, Bob Garvin RVP Sales
5.18 Tornados
6. Mid America Jeff Shaner Bruce Carter RVP Ops, Gordon Thoennes Interim RVP
Sales 5.76 Wildcats
7. Northeast Jeff Shaner Dan Locker RVP Ops, Open RVP Sales
5.82 ???
8. South Central David Causby John Aurelio RVP Ops, Duane Neel RVP Sales
5.92 ???

The Killer Bees have guaranteed that whatever is out West will not be in their way for long. They have a taste for victory, served best with a side of Spider Monkey…

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From: Ballew, Brandon
Sent: Wednesday, April 22, 2009 6:05 PM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Neel, Duane; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Brickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Hand, Candy; Chartier, Todd; Martin, Joyce; Crum, Kimberly; Kinsella, Donna; Gregory, Teresa
Cc: Norlander, John; Cavanaugh, Pete; Walters, Brett; Gregory, Lee; Gieringer, David; Rauch, Andrew; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen; Allred, Steven
Subject: KIR Rankings through March 2009

With Q1 in the books, the race is getting interesting. Mid Atlantic appears to be pulling away from the pack right now. The race between 2-4 is very close, with a new runner up....congrats on a great quarter West team! Watch out for the Florida Lame Ducks (that's the name that the Spider Monkeys use anyway), they are making a serious run at the top spot!

1. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales
2.47
2. West David Causby Open RVP Ops, Mark Hunt RVP Sales
3.16
3. Carolina Jeff Shaner Theresa Gregory Interim RVP Ops, Susan Benoit
RVP Sales 3.30
4. Florida David Causby Mary Jalwan RVP Ops, Open RVP Sales
3.43
5. South David Causby Open RVP Ops, Bob Garvin RVP Sales
4.97
6. Northeast Jeff Shaner Dan Locker RVP Ops, Open RVP Sales
5.46
7. Mid America Jeff Shaner Bruce Carter RVP Ops, Gordon Thoennes Interim RVP
Sales 5.65
8. South Central David Causby John Aurelio RVP Ops, Duane Neel RVP Sales
5.91

Good luck to all in April!

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From: Ballew, Brandon
Sent: Thursday, March 26, 2009 2:36 PM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Neel, Duane; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Russo, Bryan; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Hand, Candy; Chartier, Todd; Martin, Joyce; Crum, Kimberly; Kinsella, Donna
Cc: Norlander, John; Cavanaugh, Pete; Walters, Brett; Gregory, Lee; Gieringer, David; Printz, Ann; Rauch, Andrew; Fox, Mary; Grieco, Michael; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen
Subject: RE: KIR Rankings through February 2009
MY APOLOGIES.

There was an error on the PPS admits to budget calculation (thanks John N). The ranking were changed slightly only effecting 2 places, #1 and #2. They are now reversed as the Mid Atlantic region is #1 and Carolinas are #2.

1. Mid Atlantic	Jeff Shaner 2.73	Monica Hullinger RVP Ops, Rob Little RVP Sales	
2. Carolina	Jeff Shaner 2.70	Open RVP Ops, Susan Benoit RVP Sales	
3. Florida	David Causby 3.53	Mary Jalwan RVP Ops, Open RVP Sales	
4. West	David Causby 3.69	Open RVP Ops, Mark Hunt RVP Sales	
5. South	David Causby 5.12	Open RVP Ops, Bob Garvin RVP Sales	
6. Northeast	Jeff Shaner 5.47	Dan Locker RVP Ops, Bryan Russo RVP Sales	
7. Mid America Sales	Jeff Shaner 5.61	Bruce Carter RVP Ops, Gordon Thoennes Interim RVP	
8. South Central	David Causby 5.65	John Aurelio RVP Ops, Duane Neel RVP Sales	

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From: Ballew, Brandon
Sent: Thursday, March 26, 2009 12:34 PM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Neel, Duane; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Russo, Bryan; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Hand, Candy; Chartier,

Todd; Martin, Joyce; Crum, Kimberly; Kinsella, Donna
Cc: Norlander, John; Cavanaugh, Pete; Walters, Brett; Gregory, Lee; Gieringer, David; Printz, Ann; Rauch, Andrew; Fox, Mary; Grieco, Michael; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen
Subject: KIR Rankings through February 2009
Welcome to 2009. We have reviewed the 2008 criteria and made some minor changes for 2009.

Added:
- Conditional Level Surveys
- Staffing : the sum of the Full Time Turnover, the Admin Turnover, and the change in the capacity for SN and PT
- Cost Per Visit
- Days to RAP

Removed:
- Non Admit %
- GP non Medicare
- Medicare Adj %

For 2009, the results are as follows:

1. Carolina	Jeff Shaner	2.85	Open RVP Ops, Susan Benoit RVP Sales
2. Mid Atlantic	Jeff Shaner	2.86	Monica Hullinger RVP Ops, Rob Little RVP Sales
3. Florida	David Causby	3.32	Mary Jalwan RVP Ops, Open RVP Sales
4. West	David Causby	3.69	Open RVP Ops, Mark Hunt RVP Sales
5. South	David Causby	5.12	Open RVP Ops, Bob Garvin RVP Sales
6. Northeast	Jeff Shaner	5.41	Dan Locker RVP Ops, Bryan Russo RVP Sales
7. Mid America	Jeff Shaner	5.61	Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales
8. South Central	David Causby	5.72	John Aurelio RVP Ops, Duane Neel RVP Sales

Congratulations to the Carolina team!
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From: Ballew, Brandon
Sent: Tuesday, February 10, 2009 6:27 PM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Neel, Duane; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Russo, Bryan; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovatc, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Rearden, Bruce; Mickholtzick, David; Hand, Candy; Chartier, Todd; Martin, Joyce
Cc: Norlander, John; Cavanaugh, Pete; Walters, Brett; Gregory, Lee; Gieringer, David; Printz, Ann; Rauch, Andrew; Fox, Mary; Grieco, Michael; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Blevins, Teri; Shanahan, Kathleen
Subject: KIR Rankings through December 2008
What a year! and what a great race for first place!

1. Carolina	Jeff Shaner	2.96	Open RVP Ops, Susan Benoit RVP Sales
2. Mid Atlantic	Jeff Shaner		Monica Hullinger RVP Ops, Rob Little RVP Sales

3.00
3. West David Causby Open RVP Ops, Mark Hunt RVP Sales
4.49
4. Mid America Jeff Shaner Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales 4.82
5. Florida David Causby Open RVP Ops, Mary Jawlan RVP Sales
5.08
6. Northeast Jeff Shaner Dan Locker RVP Ops, Bryan Russo RVP Sales
5.13
7. South Central David Causby John Aurelio RVP Ops, Duane Neel RVP Sales
5.18
8. South David Causby Open RVP Ops, Bob Garvin RVP Sales
5.27

Congratulations to Susan and Adam on a great year!!
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From: Ballew, Brandon
Sent: Tuesday, January 06, 2009 7:03 PM
To: Ballew, Brandon; Locker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Neel, Duane; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Russo, Bryan; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Riggs, Cecille; Lovato, Michele; Sylvestre, Trevor; Nankee, Richard; Jones, Susan; Brooks, Adam; Nordman, Derek; Reardon, Bruce; Mickholtzick, David; Hand, Candy; Chartier, Todd; Martin, Joyce
Cc: Norlander, John; Cavanaugh, Pete; Walters, Brett; Gregory, Lee; Gieringer, David; Printz, Ann; Rauch, Andrew; Fox, Mary; Grieco, Michael; Potapchuk, John; Camperlengo, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Shaner, Jeff; Shoemaker, Paula; Strange, Tony; Landry, Beth; Blevins, Teri; Shanahan, Kathleen
Subject: KIR Rankings through November 2008
Well guess who had enough of being in 2nd place.....

1. Carolina Jeff Shaner Open RVP Ops, Susan Benoit RVP Sales
2.96
2. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales
3.30
3. West David Causby Open RVP Ops, Mark Hunt RVP Sales
4.24
4. Mid America Jeff Shaner Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales 4.93 watch out for South Central!
5. South Central David Causby John Aurelio RVP Ops, Duane Neel RVP Sales
4.99
6. South David Causby Open RVP Ops, Bob Garvin RVP Sales
5.06
7. Florida David Causby Open RVP Ops, Mary Jalwan RVP Sales
5.21
8. Northeast Jeff Shaner Dan Locker RVP Ops, Bryan Russo RVP Sales
5.32

Only one more month to go! Who will come out on top???
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From: Ballew, Brandon
Sent: Thursday, December 11, 2008 10:15 AM
To: Ballew, Brandon; Locker, Dan; Young, Mike (VP of Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Landry, Beth; Neel, Duane; Shanahan, Kathleen; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Russo, Bryan; Hunt, Mark; Blevins, Teri
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Nankee, Richard; Walters, Brett; Gregory, Lee; Gieringer, David; Printz, Ann; Rauch, Andrew; Fox, Mary; Andrews, Jim; McDonald, Aimee; Grieco, Michael; Potapchuk, John
Subject: KIR Rankings through October 2008
We had a very good close for October, which allowed us to accurately record all of your hard work! Congrats to the teams on continued success in 2009.

At the top, Mid Atlantic has INcreased their lead on the Carolina region.

1. Mid Atlantic Jeff Shaner Monica Hullinger RVP Ops, Rob Little RVP Sales 2.90
2. Carolina Jeff Shaner Open RVP Ops, Susan Benoit RVP Sales 3.17
3. West David Causby Open RVP Ops, Mark Hunt RVP Sales 4.18
4. Mid America Jeff Shaner Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales 4.87
5. South Jeff Shaner Jorie Jacobs Interim RVP Ops, Bob Garvin RVP Sales 5.10 WOW what a move!
6. South Central David Causby John Aurelio RVP Ops, Duane Neel RVP Sales 5.18
7. Northeast Jeff Shaner Dan Locker RVP Ops, Bryan Russo RVP Sales 4.93
8. Florida David Causby Open RVP Ops, Mary Jawlan RVP Sales 5.35

What a close race! All groups are moving significantly based on recent performance.

Overall we continue on executing strong business fundamentals in managing our business. We continue to make good sound decisions and are seeing the benefits. Gross and EBITDA margins continue to increase as we focus are efforts on our senior population, PPS% is above 63%, with appropriate increases in CMW (1.50) and recertifications (31.2%), leading to strong clinical performance, and most importantly, doing the right thing for the patients we are taking care of. As we continue to focus on productivity, we are seeing a decline in our CPV ($61.49), with increasing productivity from SN (61.5%) and PT (75.7%). Our cash has been lagging some this year, and an increased focus on cash collections is needed (specifically in final claim management). We did have another month above 100%, but are still only at 97.5% YTD.

Only 2 months left! I know everyone is committed to closing out a great (not good) year!

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From: Ballew, Brandon
Sent: Thursday, November 20, 2008 6:34 PM
To: Ballew, Brandon; Locker, Dan; Young, Mike (VP of Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Landry, Beth; Neel, Duane; Shanahan, Kathleen; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Russo, Bryan; Hunt, Mark; Blevins, Teri
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Nankee, Richard; Walters, Brett; Gregory, Lee; Gieringer, David; Printz, Ann; Rauch, Andrew; Fox, Mary; Andrews, Jim; McDonald, Aimee; Grieco, Michael; Potapchuk, John

Subject: KIR Rankings through September 2008
Sorry for the delay.

What a great quarter for Gentiva! All the hard work and dedication is paying off! You and your teams have taken Gentiva to a new level.

We have a change at the top this week....

1. Mid Atlantic	Jeff Shaner 3.13	Monica Hullinger RVP Ops, Rob Little RVP Sales	
2. Carolina	Jeff Shaner 3.23	Open RVP Ops, Susan Benoit RVP Sales	will they stand for being #2?
3. West	David Causby 4.06	Open RVP Ops, Mark Hunt RVP Sales	
4. Northeast	Jeff Shaner 4.93	Dan Locker RVP Ops, Bryan Russo RVP Sales	
5. Mid America	Jeff Shaner	Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales	4.94 .01 from moving ahead of the Northeast
6. South Central	David Causby 5.01	John Aurelio RVP Ops, Duane Neel RVP Sales	
7. Florida	David Causby 5.30	Open Interim RVP Ops, Mary Jawlan RVP Sales	
8. South	David Causby 5.41	Jorie Jacobs Interim RVP Ops, Bob Garvin RVP Sales	

As you can see the races have all tightened. The spread from 1 - 8 has narrowed. There are three months to go, who will come out on top???

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From: Ballew, Brandon
Sent: Tuesday, September 30, 2008 4:26 PM
To: Ballew, Brandon; Locker, Dan; Young, Mike (VP of Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Landry, Beth; Neel, Duane; Shanahan, Kathleen; Benoit, Susan; Thoennes, Gordon; Hullinger, Monica; Little, Rob; Russo, Bryan; Hunt, Mark; Blevins, Teri
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Nankee, Richard; Walters, Brett; Gregory, Lee; Gieringer, David; Printz, Ann; Rauch, Andrew; Fox, Mary; Andrews, Jim; McDonald, Aimee; Grieco, Michael; Potapchuk, John
Subject: KIR Rankings through August 2008
Attached is the June rankings. We see the race getting tighter as the year progresses, looks like Mid America and the Northeast have a good battle going. The year is getting closer to being finished. Who can push to the finish line??

1. Carolina	Jeff Shaner 2.77	Open RVP Ops, Susan Benoit RVP Sales	
2. Mid Atlantic	Jeff Shaner 3.08	Monica Hullinger Interim RVP Ops, Rob Little RVP Sales	getting closer to #1
3. West	David Causby 3.73	Open RVP Ops, Mark Hunt RVP Sales	
4. Northeast	Jeff Shaner 4.90	Dan Locker RVP Ops, Bryan Russo RVP Sales	
5. Mid America	Jeff Shaner	Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales	4.97 can Mid America reclaim the 3rd spot?
6. South Central	David Causby 5.21	John Aurelio RVP Ops, Duane Neel RVP Sales	
7. South	David Causby 5.65	Jorie Jacobs Interim RVP Ops, Bob Garvin RVP Sales	
8. Florida	David Causby 5.68	Open RVP Ops, Mary Jalwan RVP Sales	

Overall Home Health posted a strong August month! Congratulations to all for a job well done during, what has been historically, a slower time of year. Our Medicare patients served % climbed above 58% for the first time! Case Mix weight, Medicare admissions and recertifications continue to improve, a positive sign reaffirming our continued commitment to superior patient care management. The Safe Strides admissions continue to post impressive growth figures, helping to drive through the summer months. Our cash collections have slipped for the past few months, reminding us of the importance to focusing on great billing practices! I am sure that number will rebound in the coming months.

We are closing the 3rd quarter this week! So please help inspect that everything that should be will be in for a crisp clean quarter!

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From: Ballew, Brandon
Sent: Friday, August 01, 2008 2:15 PM
To: Ballew, Brandon; Locker, Dan; Young, Mike (VP of Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Landry, Beth; Neel, Duane; Shanahan, Kathleen; Benoit, Susan; Thoennes, Gordon
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Nankee, Richard; Walters, Brett; Gregory, Lee
Subject: KIR Rankings through June 2008
Attached is the June rankings. We see the race getting tighter as the year progresses, but no change in the rankings from May.

1. Carolina Region - Jeff Shaner - Open RVP Ops, Susan Benoit RVP Sales
2.98
2. Mid Atlantic Region - Jeff Shaner - Open RVP Ops, Open RVP Sales
3.42
3. West Region - David Causby - Open RVP Ops, Open RVP Sales
3.93

4. Mid America Region - Jeff Shaner - Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales
4.13
5. Northeast Region - Jeff Shaner - Dan Locker RVP Ops, OPEN RVP Sales
4.89
6. Florida Region - David Causby - Open RVP Ops, Mary Jalwan RVP Sales
5.34
7. South Central Region - David Causby - John Aurelio RVP Ops, Duane Neel RVP Sales
5.45
8. South Region - David Causby - Open RVP Ops, Bob Garvin RVP Sales
5.09

Overall in Home Health, we finished the quarter on a very positive note. The revenue growth continues to remain strong, with improvements in gross margin adding tot he bottom line. While operating expenses had begun to climb, we did see a flattening of these costs, which should allow us to leverage even more of the revenue growth in future quarters! Most metrics continue positive movement, with some expectations. Recertification rates are beginning to fall and VPE continues to climb, questioning our execution on patient care management. Our full time and admin turnover are also starting to rise, something to watch over the next month or so. All in all, a very solid quarter.

As we enter the 3rd quarter, I would like to reemphasize the importance of growing episodes (admits and recerts) through this historic slower period. All of the room we can make up here in this quarter, makes the fourth quarter all that much less imposing. Back to back solid quarters go along way in building value for Gentiva's employees!

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Great healthcare has come homeSM

From: Ballew, Brandon
Sent: Tuesday, May 27, 2008 7:10 PM
To: Ballew, Brandon; Locker, Dan; Young, Mike (VP of Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Landry, Beth; Neel, Duane; Weston, Damien; Shanahan, Kathleen; Benoit, Susan; Thoennes, Gordon
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Nankee, Richard; Wang, Shirley; Walters, Brett; Gregory, Lee
Subject: KIR Rankings through April 2008
Attached is the April ranking report. I want to apologize for not sending out a March report. March was significantly delayed due to late entries surrounding the end of the quarter, as well as a needed update to the KIR hierarchy that was missing some new cost centers for 2008. Here are the rankings

1. Carolina Region - Jeff Shaner - Open RVP Ops, Susan Benoit RVP Sales
2.77
2. Mid Atlantic Region - Jeff Shaner - Open RVP Ops, Open RVP Sales
3.65 up from 3rd!
3. West Region - David Causby - Open RVP Ops, Damien Weston RVP Sales
3.94
4. Mid America Region - Jeff Shaner - Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales
4.54
5. Northeast Region - Jeff Shaner - Dan Locker RVP Ops, OPEN RVP Sales
4.75
6. Florida Region - David Causby - Open RVP Ops, Mary Jalwan RVP Sales
4.99
7. South Central Region - David Causby - John Aurelio RVP Ops, Duane Neel RVP Sales
5.45
8. South Region - David Causby - Open RVP Ops, Bob Garvin RVP Sales
5.61

In April, we saw continued improvement in operations as evident from March. Keep in mind, April is now a 5 week month, as we have now switched to the 5-4-4 calendar. Our overall Medicare mix continued to climb up, to just under 57% as a % of patients served. Most other metrics continued to follow suit, with slight improvements across the board. We are still over 2,600 admits behind our medicare admit target. However, we are significantly over in our MMA PPS plan to make up the majority of this difference. While we are moving in the right direction, we have still not made up for the January and February short fall, and remain behind plan for the year.

May does appear to be a more modest budget month, so I am hoping we can make a big move this month. Only time and a good clean close will tell.

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From: Ballew, Brandon
Sent: Monday, March 24, 2008 6:55 PM
To: Ballew, Brandon; Locker, Dan; Young, Mike (VP of Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Sender, Susan; Landry, Beth; Neel, Duane; Weston, Damien; Shanahan, Kathleen; Biondello, Frank; Thoennes, Gordon
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Williams, Amanda; Nankee, Richard; Wang, Shirley; Walters, Brett
Subject: KIR Rankings through February 2008
Attached is the first regional ranking of 2008! We were waiting for the dust to settle on 2007 and get the new regional structure in place. You will notice a few changes to the rankings for this

year:
1. new regional structure - to include the new regions after breaking up the Southeast and Southern regions
2. 4 new metrics added,
        1. Medicare adj % - Medicare adjustments for three months lagged three months as a % of revenue
        2.clinical scoring (a composite of the Internal Home Visit and Clinical Audit scores + the customer service scores + the OBQI ACH score) max 4.0,
        3. specialty admits - % variance to budget YTD for each program ranked and totaled
        4. Medicare Revenue YTD versus budget

Let the betting begin!

1. Carolina Region - Jeff Shaner - Open RVP Ops, Open RVP Sales
                2.55
2. West Region - David Causby - Open RVP Ops, Damien Weston RVP Sales
          3.97
3. Mid Atlantic Region - Jeff Shaner - Open RVP Ops, Open RVP Sales
                  4.10
4. South Central Region - David Causby - John Aurelio RVP Ops, Duane Neel RVP Sales
    4.73
5. Northeast Region - Jeff Shaner - Dan Locker RVP Ops, Frank Biondello RVP Sales
          4.80
6. Florida Region - David Causby - Open RVP Ops, Mary Jalwan RVP Sales
                5.15
7. Mid America Region - Jeff Shaner - Bruce Carter RVP Ops, Gordon Thoennes Interim RVP Sales
5.30
8. South Region - David Causby - Open RVP Ops, Bob Garvin RVP Sales
                5.39

Overall, to start the year, the Home Health division is off to an apprehensive start. While we have grown qualified admissions, we are still behind plan YTD 5% or 1,266 admits. This is offset somewhat by continued improvement in patient care management, as recertifications are ahead of plan by about 500 patients. While February was a good month, we did not make up for the slow start in January. This may be in paperwork issues stemming from conversion of billing platforms and the new PPS refinements. I am anticipating this to be cleaned up for March, to ensure a great close for the 1st quarter. While we are moving up the hill, that hill will continue to grow over the next couple of months (keep in mind April is a 5 week month). No rest for the weary!
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From: Ballew, Brandon
Sent: Friday, December 28, 2007 1:33 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike (VP of Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Sender, Susan; Landry, Beth; Neel, Duane; Weston, Damien; Shanahan, Kathleen
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Williams, Amanda; Nankee, Richard; Wang, Shirley; Walters, Brett
Subject: KIR Rankings through November
A disappointing November is in the books. I'm not sure what happened given the strong end of October, but it appears the Holiday gave us some paperwork issues. The finish line is straight ahead any only a couple feet away. We are out of months to "catch up" on for this year, so please reinforce how to inspect your clean December close.

The race has tightened up. Only .04 points are between 1st and 2nd. It may be a photo finish!

Rankings are as follows:
1. Southern   Shaner/Garvin   2.48
2. West   Causby / Weston   2.52
3. Mid America   Carter / Jalwan   3.39
4. Southeast   Shoemaker / Young   3.43

5. Northeast Locker / Biodello 4.48
6. South Central Aureilo / Neel 4.65

Overall we had a lack luster financial performance in what is generally a very good month for Home Care. Revenues were down from their current run rate in all groups (Medicare, nonMedicare, and private duty). Despite the decrease in revenue, direct costs were well above there past 13 week run rate as well. So we are paying people more to do less work? On top of this, operating costs continue to climb, up 700K over the last 13 week run rate. All of this has led to the lowest earnings month of the year.
Our stats tell a little different picture, as we have seen an increase in admissions (11,605), 2% over the previous 13 week average (but down from October - 11,755). Recertifications did slip pretty good this month (4,535), down 7% from our 13 week run rate (4,914). adjustments and Case mix held fairly steady.

Let's close it out on a positive note! Have a Happy New Year!
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From: Ballew, Brandon
Sent: Tuesday, November 27, 2007 6:31 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike (VP of Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Sender, Susan; Landry, Beth; Neel, Duane; Weston, Damien
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Williams, Amanda; Nankee, Richard
Subject: RE: KIR Rankings through October
Pardon the resend, the Northeast is ranked 5 not 6

4 weeks down, 9 to go. 2008 will be in here in a few short weeks. We are starting to pickup some momentum from the slow summer, but not at a budgeted pace. The race continues to remain close with only .09 separating 1st and second. We also have some movement in the final 4 places as well. Congrats to Mid America and the Northeast for moving up a spot this month!

Rankings are as follows:
1. Southern Shaner/Garvin 2.48
2. West Causby / Weston 2.57
3. Mid America Carter / Jalwan 3.39
4. Southeast Shoemaker / Young 3.41
5. Northeast Locker / Biodello 4.52
6. South Central Aureilo / Neel 4.57

Overall, medicare admits we up nicely this month (11,762) about 6% from the previous 3 month average. We continue to see improved patient care management as recertification's have grown to 32.6% compared to only 29.0% three months ago, equating to an increase of 9% over the past 3 month average. Even with this growth in recerts, we are maintaining our case mix (1.42) and reducing our VPEs (16.6)! Operating expenses are starting creep up over the past couple of months, almost 200K per month! Gross margins are also experiencing a continued pressure.

I hope everyone enjoyed the turkey. Let me know if you have any questions or concerns, thanks.
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From: Ballew, Brandon
Sent: Monday, October 29, 2007 6:56 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike (VP of Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Sender, Susan; Landry, Beth; Neel, Duane
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Williams, Amanda
Subject: KIR Rankings through September
The 3rd quarter is in, with some mixed results. Overall we had a good quarter compared to our Q3 of last year, but continue to lag behind in our budgeted expectations. This month proved to be a very interesting race for the tape (year end for 2007) as well. We have a tie between BOTH 1st and 2nd, as well as 3rd and 4th.

Rankings are as follows:

1. Southern	Shaner/Garvin	2.56
1. West	Causby / Weston	2.56
3. Southeast	Shoemaker / Young	3.44
3. Mid America	Carter / Jalwan	3.44
5. South Central	Aurello / Neel	4.24
6. Northeast	Locker / Biodello	4.76

Looks like the "drafting" is over and it's time to see who can put their foot on the gas to get across the finish line!

Overall, we continue to grow our Medicare patients served (as a % of total patients) to 55.7% as well as in total. Admissions were actually slightly down as compared to August (4 weeks) about 200 admits. While overall financial performance is increasing, we are not yet at the need Q4 run rate. It's time to get moving folks!

Let me know if you have any questions or concerns, thanks.
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From: Ballew, Brandon
Sent: Friday, September 21, 2007 4:39 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike (RVP Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Sender, Susan; Landry, Beth; Neel, Duane
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Williams, Amanda
Subject: KIR Rankings through August
8 down 4 to go. August is in the books. We held steady for the month compared to a weaker budget but did not make up any ground from our July miss. We are going to need to great September to close the quarter on a high note. This is not going to be easy as the budget really starts to ramp up from a % standpoint.

Overall Rankings:

Southern	Shaner / Garvin	2.35
West	Causby / Weston	2.50
Southeast	Shoemaker / Young	3.46
MidAmerica	Carter / Jalwan	3.50
South Central	Aurelio / Neel	4.37
Northeast	Locker / Biondello	4.81

Our medicare mix has continued its flat line for the past 4 months at 55%. We are starting to see a pickup in the recert rate, moving up to 30.8% in August (27.7% in May). Our non Medicare business is starting to grow as well (126K August visits compared to 122K May even 121K in January). This may explain part of the variance to plan from a % standpoint. We are 4.6% ahead of our non Medicare revenue budget but -1.3% behind the Medicare side. While we've made up some of that difference at the operating and regional expense lines, this variance seems to be growing.

Q4 starts in a week!

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From: Ballew, Brandon
Sent: Monday, August 20, 2007 9:40 AM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike (RVP Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Sender, Susan; Landry, Beth; Neel, Duane
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Williams, Amanda
Subject: KIR Rankings through July

After two solid quarters, we have slipped back some in July. The July 4th holiday had a significant impact to our business (please keep that in mind for the upcoming Labor day holiday). Overall, every region struggled with July. The good news is, we have seen some bounce back toward the end of July / beginning of August. We need that momentum to continue.

Through July, the rankings are as follows:

Southern	Shaner / Garvin
West	Causby / Weston
Southeast	Shoemaker / Young
MidAmerica	Carter / Jalwan
South Central	Aurelio / Neel
Northeast	Locker / Biondello

Our Medicare mix continues to improve, but we are seeing a decline in overall gross margins? Cost per visit (64.07) and VPE (17.7) continue to climb. Medicare admissions also continue to lag over the past few months, under 11,000 (10,714) for the first time all year. Case mix held for July as compared to June (1.41), but is down from April (1.42) and May (1.43). Keep in mind, every .01 change in case mix equates to approximately $350,000 in revenue / gross margin / and EBITDA.

We need some strong momentum over the next couple of months. We are getting close to the finish line without much room to spare. July slowed us down even further. Let's buck the trend in August and get the sprinting shoes on.

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From: Ballew, Brandon
Sent: Wednesday, July 25, 2007 11:33 AM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike (RVP Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Sender, Susan; Landry, Beth; Neel, Duane
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor; Williams, Amanda
Subject: KIR Rankings through June

We are half way to the end of 2007. Second half results are in! Congratulations on a good quarter but an even stronger 1st half. Overall, we had a good second quarter and have made significant improvement during our 1st full twelve month period after the merger of the two organizations. The new Gentiva looks great!

There is some concern, as June was not a very strong month. We seem to have lost some momentum gained in the first quarter and are sliding into the 2nd half of the year. We all have very strong

4th quarter results and need to get focused on regaining that momentum!

Through June, the rankings are as follows:

Southern	Shaner / Garvin
West	Causby / Open
Southeast	Shoemaker / Young
MidAmerica	Carter / Jalwan
South Central	Aurelio / Neel
Northeast	Locker / Biondello

We continue to lag behind in our Medicare admission goals, down -5% YTD. June was also a month of set backs in several metric, case mix fell to 1.40 from 1.42, and VPE climbed to 17.8 from 17.5.

Kudos to all the regions for having a clean close!! Please let all involved know how much we appreciate their efforts in getting all paperwork in timely.

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From: Ballew, Brandon
Sent: Wednesday, June 20, 2007 4:30 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike (RVP Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Sender, Susan; Landry, Beth; Neel, Duane
Cc: Lovato, Michele; Norlander, John; Cavanaugh, Pete; Sylvestre, Trevor
Subject: KIR Rankings through May

May is in the books. It was a decent month but our weaknesses are growing and strengths fading. We had a rough close due to a couple of factors; a. Memorial Day holiday being on the system close week and back office unity conversions in the Southern region. This led to some areas being significantly impact for the month. Important to note, the same thing will be going on for June - compounded because June is a Quarter end close month! July 4th falls on the Wednesday of the system close week, please get ahead of the holiday to address any admin coverage. The Southern and Southeast regions will also continue to go through system conversions this month. PLEASE INSPECT that your paperwork is getting recorded appropriately! I'll get off the soap box now.

On to May. Medicare admissions were flat to April and continue to lag behind our budgeted targets. We are seeing an increase in patients served due to patient care management! Our Medicare mix climbed again to a new record of 55% (of patients served, 68% of revenue)! Case mix continues to remain strong, however Visits per Episode (VPE) continues to hover above budget at 17.5 in May. Our non Medicare business continues to improve with fewer patients receiving greater reimbursement per visit, over $90 per visit this month. With our continued move to Medicare census, we are not seeing the corresponding decreases in operating expenses. We are took care of 500 less patients this month as compared to February, but have seen our operating expenses increase over $250,000 per month. This is further reinforced as our FTE to patient served has decreased from 26 (February) to 25 (May).

All this led to an overall weaker month at 14.1% EBITDA.

The overall rankings are as follows:

Southern	Shaner / Garvin
West	Causby / Open
Southeast	Shoemaker / Young
MidAmerica	Carter / Jalwan
South Central	Aurelio / Neel
Northeast	Locker / Biondello

Please review and let me know if you have any questions, thanks.

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From: Ballew, Brandon
Sent: Thursday, May 17, 2007 11:54 AM
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Cc: Lovato, Michele; Markus, Ann; Norlander, John; Southerland, Perri; Cavanaugh, Pete; Sylvestre, Trevor
Subject: KIR Rankings through April

April has closed and our admission shortage is starting to catch up with us. Overall it was a good month, but as we have been stepping up the bar, this is a step backwards. Home Health missed it's plan for the first time this year. The rankings are as follows:

Southern
West
Mid America - tie for 3rd
Southeast - tie for 3rd
South Central
Northeast

The Southern and West regions are separating themselves from the pack and continue to set the bar very high! Congrats to those teams!

Overall we continue to see an increase in Medicare payer mix, up to 54.8% from 52.3% in January. Medicare admissions continue to lag to our plan, behind 1,786 (-3.5%) for the year. For the year we are still ahead of plan for revenue as recerts and case mix remain strong. We did miss in April however, primarily due to admissions. We also saw nice movement in the turnover numbers this month from January, clinical full time turnover is at 18.2%, ahead of our 20% goal and down from 24% in January! Our ACH continue to remain strong at 20.5%!
Let's get the foot on the gas and fight off the summer lull!

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From: Ballew, Brandon
Sent: Monday, April 23, 2007 5:45 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike (RVP Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Sender, Susan; Landry, Beth; Nixon, Robert
Cc: Lovato, Michele; Markus, Ann; Norlander, John; Southerland, Perri; Cavanaugh, Pete
Subject: KIR Rankings through March

Q1 is in the books! With a great February in, March came in even stronger! Every individual region EXCEEDED BUDGET in March!

The Regional rankings are as follows:
Southern
West
Southeast
Mid America
South Central
Northeast

The race continues to tighten as there is only one weighted average point between 1st and 4th place.

Overall, Home Health continues to make great improvements in overall Medicare Management. The Medicare % for patients served continues to climb at another all time high of 54.2% in March. While admissions continue to grow, they are lagging to our budget by 3%. This has been more than offset by a 4% increase in the number of recerts and a .01 point increase in case mix (1.40 actual vs 1.39 budget). All this equates to Medicare revenue ahead of plan by 4.3% in Q1! The improved Medicare management is starting to show a decrease in overall Medicare adjustments down .5% to 16.1% for the 4th quarter of 2006. VPE continues to creep up over the past 3 months, now at 17.8 versus 17.0 in January.

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From: Ballew, Brandon
Sent: Thursday, March 15, 2007 7:36 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike (RVP Sales); Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Sender, Susan
Cc: .FINANCE HOME HEALTH
Subject: KIR Rankings through February
Congratulations on a great February! Attached are the February rankings for all the regions.
The Region order is:
Southern
West - a new #2
Southeast
Mid America
South Central
Northeast

For February, the Medicare mix continues to grow (53.6 % FEB versus 51.3 % DEC), 5th consecutive month over 50%! Recert % (30.5%) has picked up momentum as patient care management focus increases. Recertification numbers are up 9.1% (733) from the YTD budget. The decreasing case mix trend has reversed and picked up steam in 2007 (Feb at 1.40 to Dec 1.37). VPE remained flat to down at 17.3. Medicare admissions numbers are off budget -5.6% (-1,331) overall, however specialty admissions are ahead of budget by 351.

One change to the 2007 ranking, is the exclusion of the Private Duty GP and addition of the EBITDA YTD to Budget category.

Due to issues with the January results and a delay in the KIR update, there will not be a January ranking. I am currently working on an Area ranking report to be distributed soon.

Please review and let me know if you have any questions, thanks.

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From: Ballew, Brandon
Sent: Wednesday, January 24, 2007 5:14 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike; Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug;

Wilson, Doug; Sender, Susan
Cc: .FINANCE HOME HEALTH
Subject: KIR Rankings through December
Attached are the December rankings for all the regions.
The Region order is:
Southern
Southeast
Mid America back in 3rd
West
Northeast
South Central

For December, the Medicare mix continues to grow (51.3 % DEC versus 49. 2 % SEP), 3rd consecutive month over 50%! Recert % (27 .7%) has leveled off and we are starting to see a trend of decreasing case mix (Dec 1.37 to Sep1.39). VPE remained flat to down at 17.6. Medicare admissions numbers were down from the previous month, but considering the holidays, December continued the strong momentum into January. A reduced cost per visit and clinical turnover contributed to a strong gross margin of 52%!

With the continued momentum and movement toward profitability, nursing operations recorded the highest EBITDA of the year at 16.2%!

You will notice a couple of changes in the rankings, we've added clinical full time turnover as a measurement and Medicare cash lag 60. Accordingly, we've removed days to RAP and days to FINAL.

Please review and let me know if you have any questions, thanks.

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From: Ballew, Brandon
Sent: Wednesday, November 22, 2006 3:20 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike; Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug; Wilson, Doug
Cc: .FINANCE HOME HEALTH
Subject: KIR Rankings through October
Happy Turkey day to all!

Attached are the October rankings for all the regions.

The order is:
Southeast II or Southern Region
Southeast I
West - up one more spot!
Mid America
Northeast
South Central

For October, the Medicare mix continues to grow (49.0% versus 48.2% average), 1st month over 50%! We are still seeing an increase in the recert % (28.5%) without a decrease in case mix (1.39). VPE moved down slightly after a two month increase to 17.5. Something to monitor during the implementation of Patient Care Management. Overall admissions numbers remain flat from the previous months entering the fourth quarter. However, in the first two weeks of November we are beginning to see a nice up tick in Medicare Admissions. I've also attached the weekly admission report.

Mid America is leading the way in the Q4 SPIF, at about 98%, with the West on their tail!
Weather today: Saint Thomas 85 and sunny feels like 90
Newark, NJ 46 and cloudy feels like 40

Please review and let me know if you have any questions, thanks.

Brandon Ballew
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Great healthcare has come homeSM

From: Ballew, Brandon
Sent: Tuesday, October 24, 2006 6:47 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike; Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug
Cc: Short, Mark; Norlander, John; Southerland, Perri; Accurso, Joseph; Copeland, Jeff; 'Mary Wollstein'
Subject: KIR Rankings through September
Attached are the September rankings for all the regions.

The order is:
Southeast II or Southern Region
Southeast I
Mid America
West
Northeast
South Central

There are a few new changes to the rankings this month.
1. the non admits are now for only Medicare and do not include the non Medicare non admits (due to the fact ALL referrals are coded to the correct payer now)
2. an additional section for Private Duty GP has been added into the overall rankings
3. a weighting has been added to the different sections. you'll notice a number of 1-5 (5 being the heaviest weighting) above the criteria

For September, the Medicare mix continues to grow (48.2% versus 47.7% average). We are still seeing an increase in the recert % (28.1%) without a decrease in case mix (1.38). VPE is showing a slight up tick (17.8 in Sept versus 17.4 average) over the past couple of months. Something to monitor during the implementation of Patient Care Management. Overall admissions numbers remain flat from the previous months entering the fourth quarter.

Weather today: Saint Thomas 85 and sunny
Newark, NJ 47 and cloudy

Please review and let me know if you have any questions, thanks.

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From: Ballew, Brandon
Sent: Thursday, September 21, 2006 7:29 PM
To: Ballew, Brandon; Locker, Dan; Biondello, Frank; Young, Mike; Shoemaker, Paula; Causby, David; Shaner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jalwan, Mary; Strange, Tony; Caddell, Doug
Cc: Short, Mark; Gregory, Debbie; Southerland, Perri; Accurso, Joseph; Copeland, Jeff
Subject: KIR Rankings through August
Attached are the region rankings for the four months ended in August. In the overall rankings, the Southeast 2 region is leading the way.

SE 2

SE 1
Northeast
Mid America
West
South Central

Overall, earnings have increased over July by about 2 points. Medicare mix is climbing, up a point to 49% in August. Recerts continue to climb (28.6%) without a down tick in Case Mix (1.39). Non Admits are slightly up from July, coming in at an average of 23.2%, 15.4% is Medicare. Please review and let me know if you have any questions, thanks.

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Footnote 52, 57, 58

Response to June 17, 2011 SFC Set of Supplemental Questions

We are writing to respond to the questions that you posed to us in your electronic mail to me of June 17, 2011. The information contained below is considered proprietary and confidential and would not be releasable under the Freedom of Information Act (*see* 5 U.S.C. § 552(b)(4)). Accordingly, we request that the information below not be publicly disclosed.

Question 1. Please list all 21 metrics used to gauge the key indicator report, along with their corresponding weights on the 1-5 scale as described in your 6/12/2011 response to the Committee.

Response The following metrics and their respective weights are currently used by the Company:

	Factors	**Weight**
1	Gross Margin	5
2	EBITA	5
3	Medicare Mix	3
4	Medicare Admits to Budget	5
5	Medicare Case Mix	4
6	Medicare Recertifications	4
7	Days to RAP	4
8	Cost per Visit	3
9	Visits per episodes	3
10	% Therapy >20	3
11	% Therapy < 7	3
12	Operating Expense	4
13	M Admits per Sales FTE	4
14	FTE Clinical Turnover	4
15	Cash Lag 60	3
16	EBITDA to Budget	5
17	Conditional Level Survey	5
18	Clinical Scores	4
19	Specialty Admits to Plan	4
20	Medicare revenue to Budget	5
21	Red/Orange Zone Branches	3

Question **a.** Please note which if any of the weight values of the 21 metrics were changed from 2007 through the present. Please note the specific numerical change in value and the date they were changed.

Response None of the weights has changed. However, for CY 2010, three new factors were added as follows: (i) % Therapy >20 (item 10); (ii) % Therapy < 7 (item 11); and (iii) Red/Orange Zone Branches (item 21). These three were not used in evaluations for CY 2007-2009 so during these three years, they were not a factor.

Question **b.** Please note specifically any of the metrics that would be influenced by an increase in therapy visits or revenue derived from therapy visits. Please note how each metric would be influenced.

Response Metrics 10 and 11, which had no weight in 2007-2009. These two metrics which became operational for CY 2010 have a statistical effect of approximately 7% of the weighted metrics.

Question **c.** Please note any metrics that were added or removed from the key indicator report metrics from 2007 through the present.

Response As noted above, for CY 2010, three new factors were added as follows: (i) % Therapy >20 (item 10); (ii) % Therapy < 7 (item 11); and (iii) Red/Orange Zone Branches (item 21). These three were not used in evaluations for CY 2007-2009 so during these three years, they were not a factor.

Question **2.** Please note the total amount of money paid out in bonuses associated with the KIR report's results from 2007 through the present.

Response Bonuses in the aggregate based on the evaluation factors noted above were as follows:

2010	$49,000
2009	$70,000
2008	$36,000
2007	$161,811

Footnote 53

From: Cavanaugh, Pete
Sent: Monday, February 16, 2009 04:49 PM
To: Shaner, Jeff; Causby, David
CC: Ballew, Brandon; Norlander, John
Subject: AVP Rankings

Hi Dave, and Jeff,
John and I spoke with Brandon last week about the AVP rankings and here is how it shook out
Current metrics that won't change:
EBITDA to Budget YTD
Case Mix Avg over the last 4 Months
Recert % average over the last 4 months
Acute Care Hosp Rate YTD
Home Visit Score YTD
FT Clinical Turnover rate over last 4 months
EBITDA % over the last 4 months
Gross Margin % over the last 4 months
Total Revenue to Budget YTD
Operating Expense % average for last 4 months

Metrics that will change
Medicare Revenue to Budget YTD changes to PPS Revenue
Medicare Admits to Budget YTD changes to PPS Admits
Medicare Admits/FTE average for last 4 months changes to PPS Admits
Pts Svd / Admin FTE avg over the last 4 months - will eliminate the Private Duty patients from the calculation

Metrics that will be eliminated
VPE over the last 4 months - runs counter to our initiative to increase PT
Medicare Non Admit % avg over the last 4 months
Rev per Visit average over last 4 months

New Metrics added to the ranking
Add Days to RAP
Cash Lag
Clinical Documentation Score
Admin Turnover Rate
% PPV Utilization
Number of Red or Orange branches - based on a report finance will be completing for January
Weekly Clean close - based on area overall and will be a report that John and I will work out

We will also subtract 2 points from the overall score for having a conditional level deficiency. This will take a first place area and drop them down approximately 5 spots. If they are clicking on all other cylinders they still stay in the top 10, but they cannot be considered the best area in the company if they had a conditional level deficiency.

Let me know if you'd like to make any other changes. Also, would you like to draft a communication to the field on this, or should we just forward this email on to them? Thanks,
Pete

Peter M Cavanaugh
AVP Financial Operations
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Footnote 56

ITEMS 1 and 2

We have evaluated this information as follows: Items GEN 013823 and GEN 014163 were created by Gentiva Health Services' Finance Department prior to the implementation of the January 1, 2008 rate changes. These analyses were prepared in late 2007 and were attempting to look at the potential impact the new rules may have on our historical patient population. This is the type of financial impact analysis that companies would typically undertake in the regular course of business.

As included in other materials we provided, in 2002 the Company commenced the roll out of a number of therapy related programs (such as Gentiva Orthopedics and Safe Strides). Members of the Finance Department ran a number of "what if" scenarios to determine potential effects of the upcoming PPS changes. This is fairly routine, as the Finance Department regularly prepares scenarios for senior management on a host of items including potential affects of increased fuel costs, increased caregiver hourly rates, changes in business mix, the results of potential acquisitions, etc. Anything that might have a significant impact on the business is run through a series of "what ifs," as anything less would be imprudent of a company that is required to report its results publicly. The results of these "what ifs" were not shared with the Company at large (marketing, sales, clinical, etc.) and were not used to define Gentiva's operations. There was no directive to the field to follow any "what if" scenario or change any utilization at all.

ITEM 3

We have evaluated this information as follows: Item 3 refers to the KIR (Key Indicator Report) regional ranking report. This is a report, created by the Finance Department, compares Gentiva's operations in different regions as a function of twenty-one criteria, e.g., clinical, operational, human resources metrics (turnover). As a national company, we constantly monitor the efficiency, overhead costs and productivity of our workforce as part of routine management oversight. For example, the Northeast is heavily laden with non-Medicare, non-skilled personal care business, while there is less of that type of business in the Southeast. The 21 categories are used to gauge how effective each region is compared to their peers and are measured on a sliding scale. The metrics are weighted (1-5 with 1 the lowest weight and 5 the highest weight) based on their objectiveness-- the more objective a criteria, the higher the weighting. For example, whether a region receives a conditional deficiency, that fact is very objective; a region receives them or not. Therefore, the Finance Department determined that that criterion should be given a "5" weighting. Other metrics which are more subjective would be given less weight.

Each geographic region has certain characteristics as noted above, so the Finance Department determined that a review of the weighted average of all 21 measures was needed to get a sense of overall performance. This report is run monthly and published to the field to see

where they rate against their peers. At the end of the year, the winner is recognized at a national kickoff meeting held in January of the following year and awarded a trophy and small cash award. In 2010, six cash awards were given to the regional team with the highest overall weighted ranking ($3,500 for each award) and four awards were given to the top Area Vice Presidents of Sales and Operations with the highest rankings ($7,000 for each award) or a total of 10 awards out of an employee base of more than 11,500.

ITEM 4

We have evaluated the information in the email. In E-GEN 024516, Mr. Cavanaugh, an AVP for Financial Operations, was responding to a question from the Company's CEO, Tony Strange, regarding the financial impact of various operational changes being implemented by Gentiva, *e.g.*, roll-out of specialty programs, new training programs, new treatment protocols, as a function of utilization. In particular, this analytical exercise was aimed at ascertaining the impact of these operational changes on costs and revenues under both the current utilization model and a one percent (1%) increase in that utilization. Here, Mr. Cavanaugh was attempting to ascertain the economic impact from a purely financial standpoint of rising costs coupled with an increased utilization, but no increase in reimbursement.

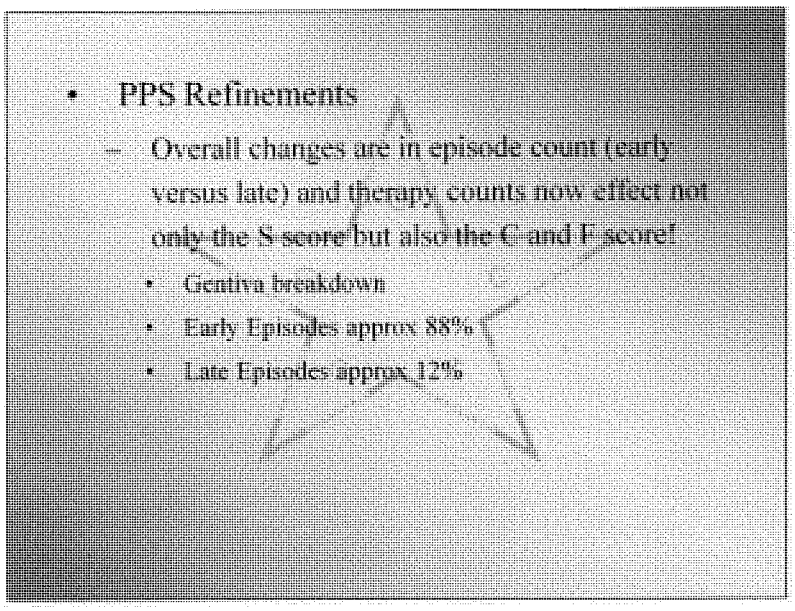
This is the form of analysis that all businesses run, especially where there are many factors that affect costs and revenues. In that regard, businesses must be prepared to assess the possible outcomes associated with operational, legal and regulatory changes (such as face-to-face) in their sector. Mr. Strange requests similar analyses with respect to many other factors including the financial impact of rising fuel costs or reductions in payment rates when CMS publishes its proposed rate cuts. And when the Senate Finance Committee proposed its outlier caps, Mr. Strange directed the Finance Department to conduct a similar analysis to determine the impact these caps would have on Gentiva's revenues. Similarly, no directive was sent to the field to stop serving patients whose needs might be impacted by these caps, as the needs of our patients and physician orders determine appropriate utilization.

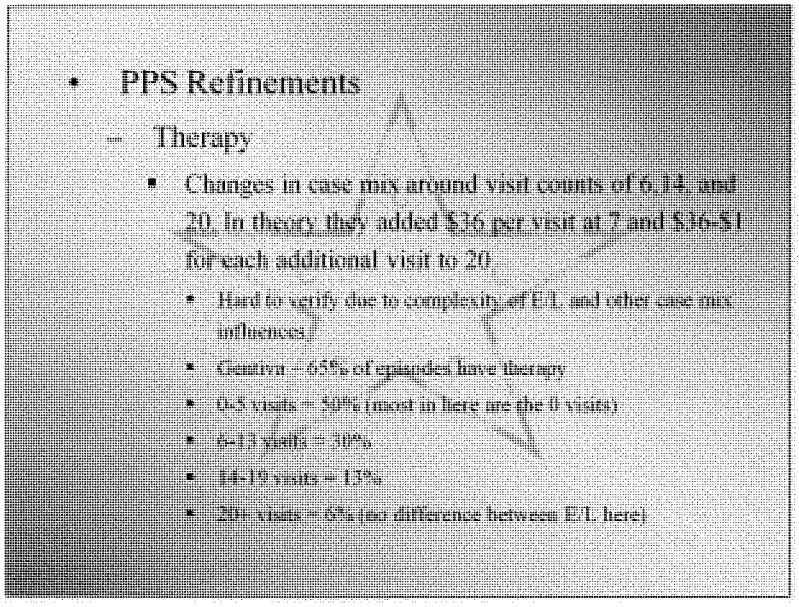
These activities are done as standard business analyses and are the types of prudent analyses that are done in the regular course of business. This analysis was kept within the Finance Department and we can find no indication that any executive, including Mr. Strange and Mr. Cavanaugh, used the analysis discussed in 024516 to direct that utilization be increased.

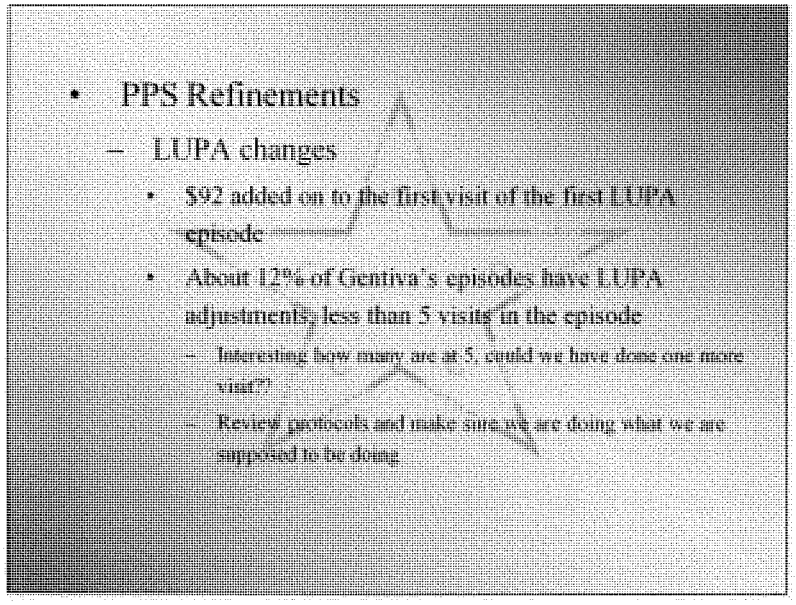
Footnote 59

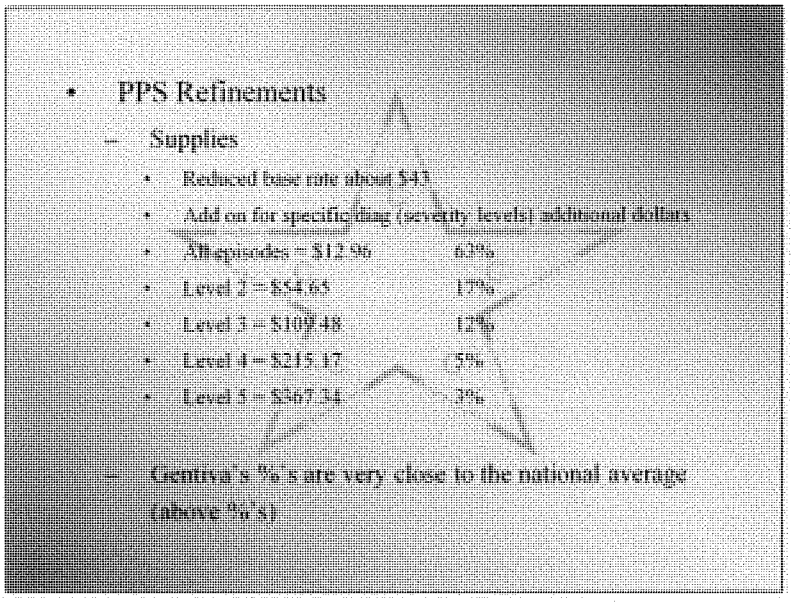
PPS Refinements

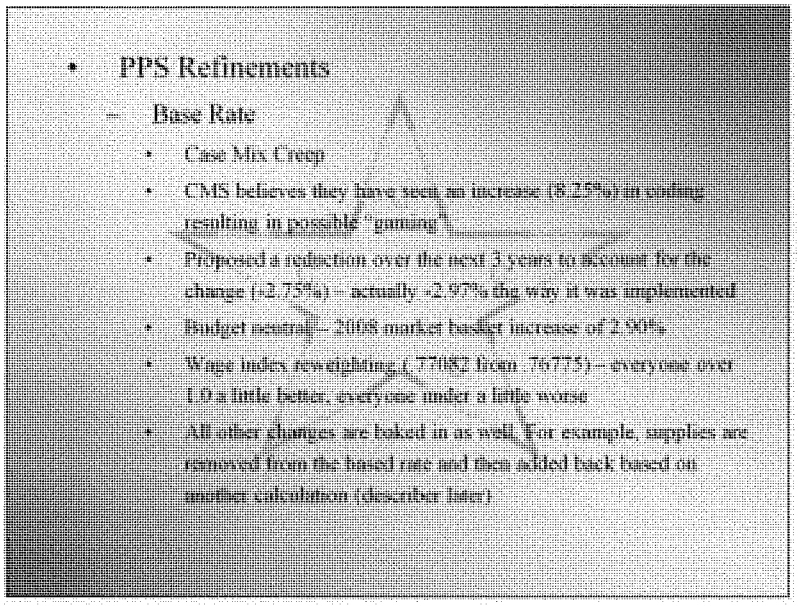
- Major overhaul of PPS system
  - Complete rescoring of the OASIS
    - Old and new are in no way comparable
  - Budget neutral impact?
  - Current team analyzing all OASIS scores from Q2 2006 to Q1 2007 – 138,000 episodes from 4 different systems
  - Another updated review of Q1 data with all completed episodes – about 37K episodes

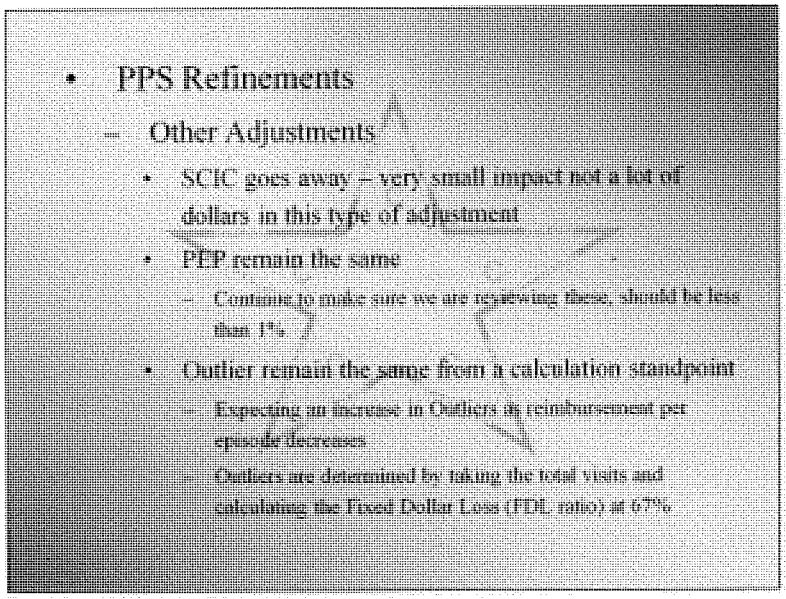


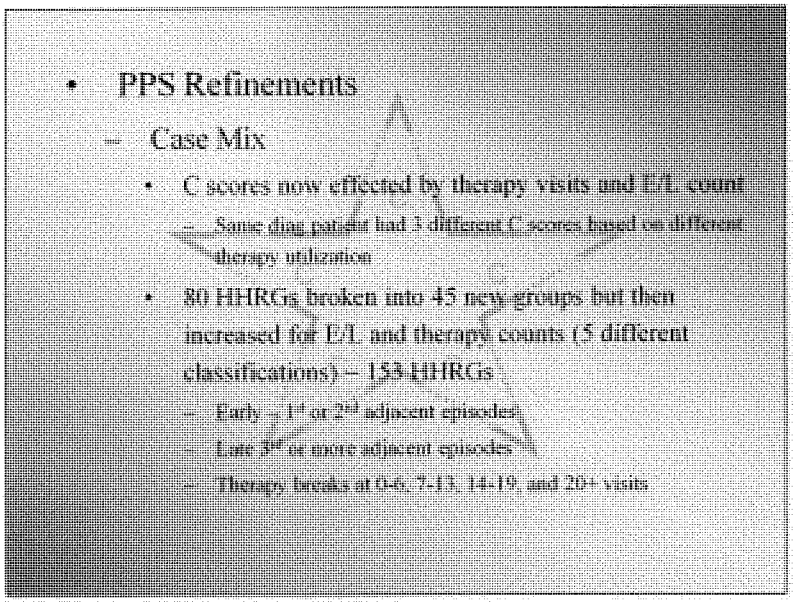











• PPS Refinements
– Case Mix
• C scores now effected by therapy visits and E/L count
– Same diag patient had 3 different C scores based on different therapy utilization
• 80 HHRGs broken into 45 new groups but then increased for E/L and therapy counts (5 different classifications) – 153 HHRGs
– Early – 1st or 2nd adjacent episodes
– Late 3rd or more adjacent episodes
– Therapy breaks at 0-6, 7-13, 14-19, and 20+ visits

8

- PPS Refinements
  - Case Mix
    - The OASIS is the same (kind of) but the number of points scored are very different
      - Secondary Diag now counted
      - M0825 is not yes or no, now anticipated visits
        - This means therapy adjustments are now baked into the case mix – today's 1.41 is before therapy; tomorrow's case mix will be net of these adjustments

9

- PPS Refinements
  - Clear as mud
  - Patient Care Management is rewarded
  - Clinical Documentation is VERY important
  - Do the right thing for the patient!!
  - Be sensitive, we don't know the impact of our possible behavioral changes to the refinements, we only know how our historical behavior would have been recorded

Footnote 60

From: Southerland, Perri
Sent: Friday, September 07, 2007 02:49 AM
To: Strange, Tony
CC: Wollstein, Mary; Ballew, Brandon
Subject: PPS refinements - Therapy analysis
Attachments: Therapy Analysis.xls

Hi Tony,

I have attached some analyses of the therapy episodes for Q1 of 2007. As we discussed on Tuesday, the average therapy visits for "nonSpecialty" episodes is comparable to the Gentiva Orthopedics program. This is the first summary included in the attachment.

I also summarized all nonLUPA episodes by the therapy groups that make up the S scores in reimbursement. For each increase in S score (or therapy bucket), the reimbursement increases between about $350 to $550. In the analysis, I increased the therapy visits by an average of two visits to determine the additional revenue from moving to the next highest therapy bucket. The lowest episodes that I added the two visits to were 4 therapy visits, since 3 visits to 5 visits would not increase reimbursement.

The third analysis is based on a point that Mary brought up in our meeting. She reported on episodes with high therapy visits, but the functional score was low. I calculated the inverse. Functional scores were high, F2 or F3, but no therapy was provided to these patients. I calculated the additional revenue if 6 therapy visits were provided to these patients with the high functional scores.

In all cases, I calculated the additional revenue on 100% of the episodes changing in the analysis. All the revenue increases are for 1 quarter only.

In summary, increasing therapy visits by an average of 2 visits per episode will increase revenue by approximately $350 to $550 per episode. Adding therapy services (6 visits) to patients with high functional needs will increase revenue by about $700 per episode. Costs will need to be controlled on these episodes (swap nursing for therapy visits), or profitability will decrease.

I hope the worksheets are self explanatory, but give me a call if further explanations are needed.

Perri

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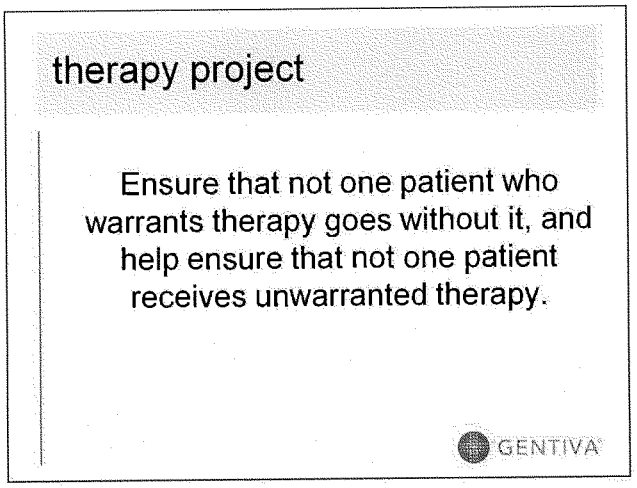
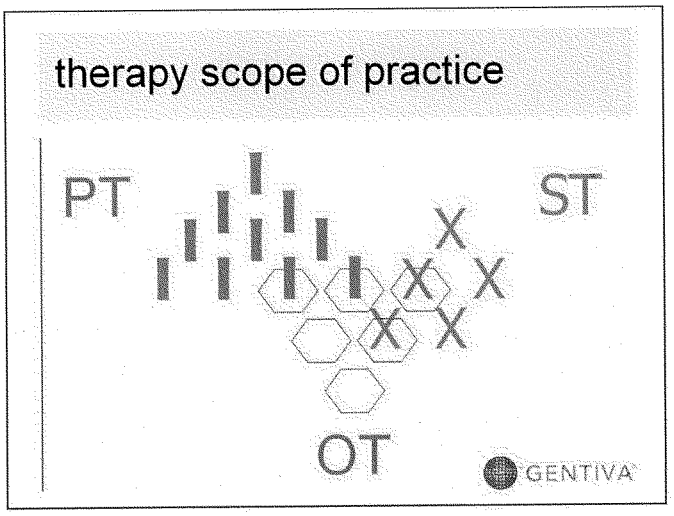
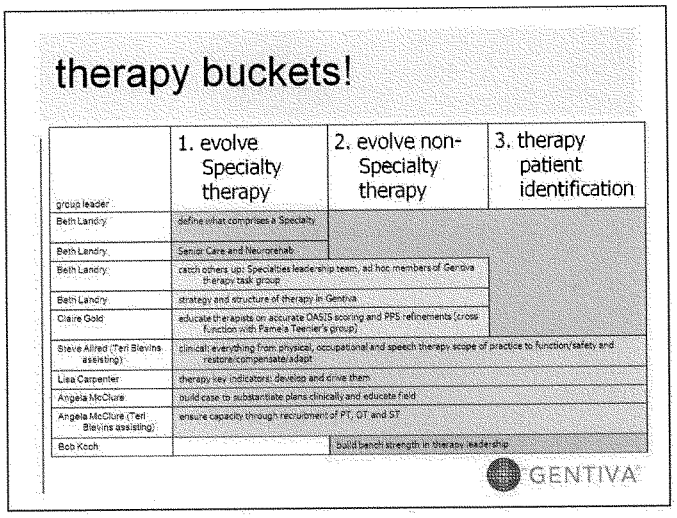
Footnote 61



see overall project assumptions, benefits, challenges.





therapy buckets!

group leader	1. evolve Specialty therapy	2. evolve non-Specialty therapy	3. therapy patient identification
Beth Landry	define what comprises a Specialty		
Beth Landry	Senior Care and Neurorehab		
Beth Landry	catch others up: Specialties leadership team, ad hoc members of Gentiva therapy task group		
Beth Landry	strategy and structure of therapy in Gentiva		
Claire Gold	educate therapists on accurate OASIS scoring and PPS refinements (cross function with Pamela Teenier's group)		
Steve Allred (Teri Blevins assisting)	clinical: everything from physical, occupational and speech therapy, scope of practice to function/safety and restore/compensate/adapt		
Lisa Carpenter	therapy key indicators: develop and drive them		
Angela McClure	build case to substantiate plans clinically and educate field		
Angela McClure (Teri Blevins assisting)	ensure capacity through recruitment of PT, OT and ST		
Bob Koch		build bench strength in therapy leadership	

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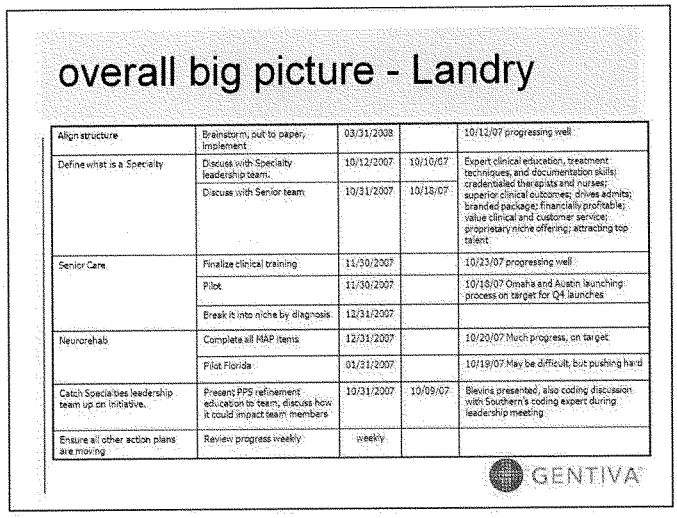

overall big picture - Landry

Align structure	Brainstorm, put to paper, implement	03/31/2008		10/12/07 progressing well
Define what is a Specialty	Discuss with Specialty leadership team.	10/12/2007	10/10/07	Expert clinical education, treatment techniques, and documentation skills; credentialed therapists and nurses; superior clinical outcomes; drives admits; branded package; financially profitable; value clinical and customer service; proprietary niche offering; attracting top talent
	Discuss with Senior team	10/31/2007	10/18/07	
Senior Care	Finalize clinical training	11/30/2007		10/23/07 progressing well
	Pilot	11/30/2007		10/18/07 Omaha and Austin launching; process on target for Q4 launches
	Break it into niche by diagnosis	12/31/2007		
Neurorehab	Complete all MAP items	12/31/2007		10/20/07 Much progress, on target
	Pilot Florida	01/31/2007		10/19/07 May be difficult, but pushing hard
Catch Specialties leadership team up on initiative.	Present PPS refinement education to team, discuss how it could impact team members	10/31/2007	10/09/07	Blevins presented, also coding discussion with Southern's coding expert during leadership meeting
Ensure all other action plans are moving	Review progress weekly	weekly		

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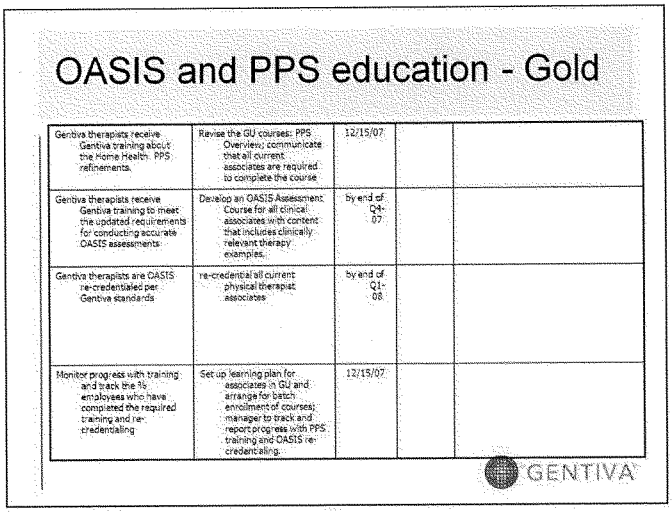

OASIS and PPS education - Gold

Gentiva therapists receive Gentiva training about the Home Health PPS refinements.	Revise the GU courses: PPS Overview; communicate that all current associates are required to complete the course	12/15/07		
Gentiva therapists receive Gentiva training to meet the updated requirements for conducting accurate OASIS assessments.	Develop an OASIS Assessment Course for all clinical associates with content that includes clinically relevant therapy examples.	by end of Q4-07		
Gentiva therapists are OASIS re-credentialed per Gentiva standards	re-credential all current physical therapist associates	by end of Q1-08		
Monitor progress with training and track the % employees who have completed the required training and re-credentialing	Set up learning plan for associates in GU and arrange for batch enrollment of courses; manager to track and report progress with PPS training and OASIS re-credentialing.	12/15/07		

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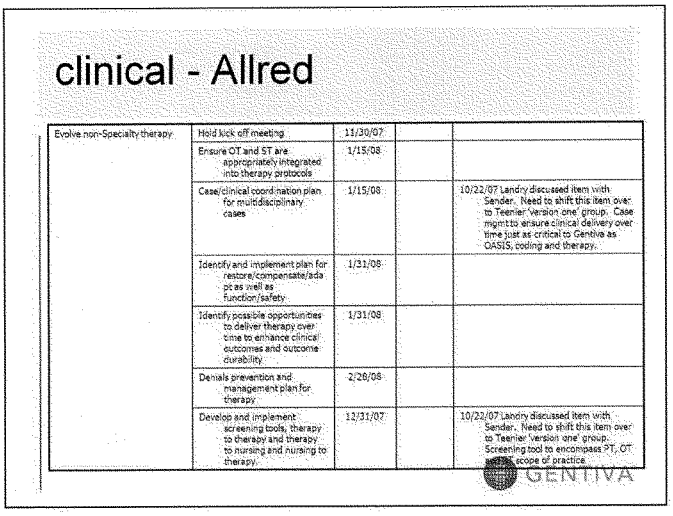
clinical - Allred

Evolve Specialties clinically	Hold kick off meeting	10/31/07	n/a	10/23/07 Landry discussed with Sender re-aligning groups. Version one of clinical initiative to be lead by Teenier with strong participation from Allred on all therapy clinical items. Goal is to respond to critical PPS items, to be complete by 12/31/07. Version two of clinical initiative to be lead by Allred with strong participation from Sender's group, goal is to evolve therapy to include OT and ST where applicable to drive clinical outcomes.
	Hire OT and ST	10/27/07		
	Review PT, OT and ST scope of practice; identify items that would strengthen clinical offering	11/5/07		
	Ensure OT and ST are appropriately integrated into Specialty protocols	11/30/07		
	Identify possible opportunities to deliver therapy over time to enhance clinical outcomes and outcome durability	11/30/07		
	Denials prevention and management plan for Specialties	12/15/07		GENTIVA



clinical - Allred

Evolve non-Specialty therapy	Hold kick off meeting	11/30/07		
	Ensure OT and ST are appropriately integrated into therapy protocols	1/15/08		
	Case/clinical coordination plan for multidisciplinary cases	1/15/08		10/22/07 Landry discussed item with Sender. Need to shift this item over to Teenier 'version one' group. Case mgmt to ensure clinical delivery over time just as critical to Centiva as OASIS, coding and therapy.
	Identify and implement plan for restore/compensate/adapt as well as function/safety	1/31/08		
	Identify possible opportunities to deliver therapy over time to enhance clinical outcomes and outcome durability	1/31/08		
	Denials prevention and management plan for therapy	2/28/08		
	Develop and implement screening tools, therapy to therapy and therapy to nursing and nursing to therapy.	12/31/07		10/22/07 Landry discussed item with Sender. Need to shift this item over to Teenier 'version one' group. Screening tool to encompass PT, OT scope of practice

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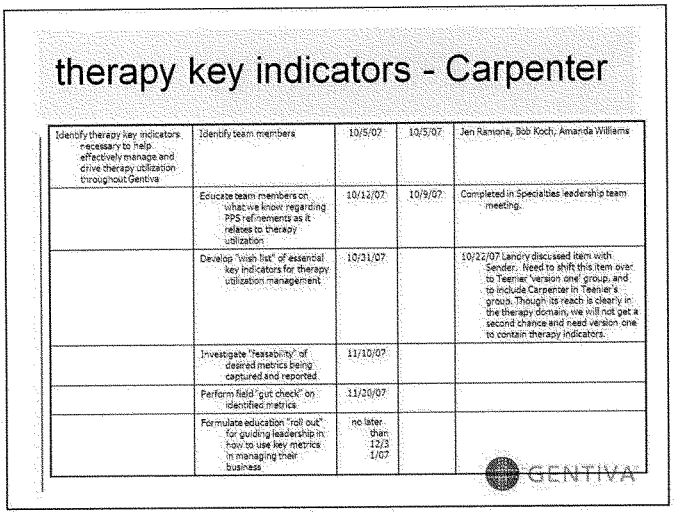

therapy key indicators - Carpenter

Identify therapy key indicators necessary to help effectively manage and drive therapy utilization throughout Gentiva	Identify team members	10/5/07	10/5/07	Jen Ramone, Bob Koch, Amanda Williams
	Educate team members on what we know regarding PPS refinements as it relates to therapy utilization	10/12/07	10/9/07	Completed in Specialties leadership team meeting.
	Develop "wish list" of essential key indicators for therapy utilization management	10/31/07		10/22/07 Landry discussed item with Sender. Need to shift this item over to Teenier 'version one' group, and to include Carpenter in Teenier's group. Though its reach is clearly in the therapy domain, we will not get a second chance and need version one to contain therapy indicators.
	Investigate "feasability" of desired metrics being captured and reported.	11/10/07		
	Perform field "gut check" on identified metrics	11/30/07		
	Formulate education "roll out" for guiding leadership in how to use key metrics in managing their business	no later than 12/3 1/07		

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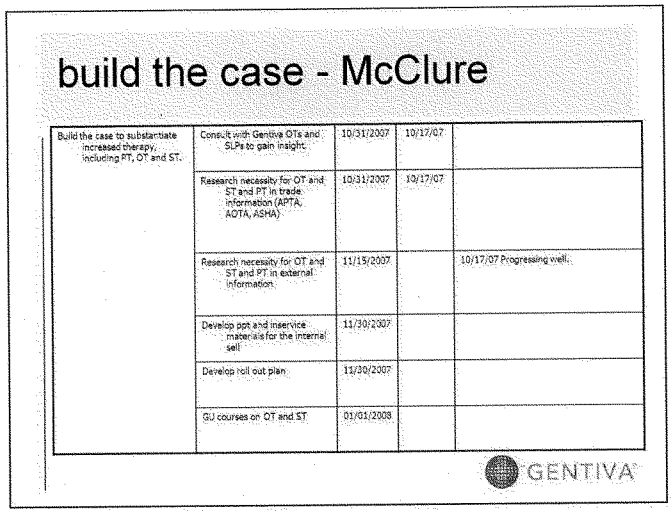
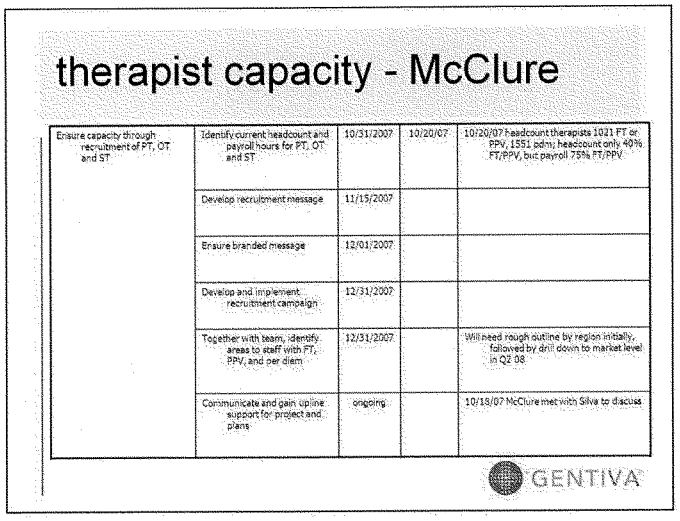


build the case - McClure

Build the case to substantiate increased therapy, including PT, OT and ST.	Consult with Gentiva OTs and SLPs to gain insight	10/31/2007	10/17/07	
	Research necessity for OT and ST and PT in trade information (APTA, AOTA, ASHA)	10/31/2007	10/17/07	
	Research necessity for OT and ST and PT in external information	11/15/2007		10/17/07 Progressing well.
	Develop opt and inservice materials for the internal sell	11/30/2007		
	Develop roll out plan	11/30/2007		
	GU courses on OT and ST	01/01/2008		

GENTIVA



therapist capacity - McClure

Ensure capacity through recruitment of PT, OT and ST	Identify current headcount and payroll hours for PT, OT and ST	10/31/2007	10/20/07	10/20/07 headcount therapists 1021 FT or PPV, 1551 pdm; headcount only 40% FT/PPV, but payroll 75% FT/PPV
	Develop recruitment message	11/15/2007		
	Ensure branded message	12/01/2007		
	Develop and implement recruitment campaign	12/31/2007		
	Together with team, identify areas to staff with FT, PPV, and per diem	12/31/2007		Will need rough outline by region initially, followed by drill down to market level in Q2 08
	Communicate and gain upline support for project and plans	ongoing		10/18/07 McClure met with Silva to discuss

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11

build bench strength - Koch

Build bench strength	Gather names for bull pen	10/31/2007		10/23/07 List has 13; still building it.
	Build/find leadership training	11/10/2007		
	Build/find clinical training	11/30/2007		
	Build/find operational training	12/15/2007		
	Build/find sales training	12/31/2007		
	Communicate with ops and sales about initiative	11/30/2007		
	Train in class sessions via web conference	01/31/2008		
	Evaluate effectiveness through survey monkey.	12/07/2007		

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12

Footnote 62, 63

From: Norlander, John
Sent: Monday, September 29, 2008 06:49 PM
To: Cavanaugh, Pete; Ballew, Brandon
Subject: RE: PPS Therapy Impact Analysis

I think we need to all get on the same page.

Andrew can work with the PPS Files to see if we move 1% of <7 visits and see the last 6 months impact by Region - Net Revenue, Gross Margin and EBITDA.

Andrew and I looked at the Northeast on Friday - the upside was $48k in EBITDA.

I have a conference call at 3pm EST. Can we discuss live tomorrow?

JN

John N. Norlander
Area Vice President of Finance
Gentiva®
[redacted]
Atlanta, GA 30339
Office: [redacted]
Cell: [redacted]
Fax: [redacted]

From: Cavanaugh, Pete
Sent: Monday, September 29, 2008 2:43 PM
To: Ballew, Brandon; Norlander, John
Subject: RE: PPS Therapy Impact Analysis

Do you have any other PPS data that you would like to review? I was trying to get back to Tony's question on what 1% movement in the therapy utilization would mean…

Peter M Cavanaugh
AVP Financial Operations
Gentiva® Health Services
[redacted] KS 66213
[redacted]
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From: Ballew, Brandon
Sent: Monday, September 29, 2008 1:40 PM
To: Cavanaugh, Pete; Wang, Shirley
Cc: Norlander, John
Subject: RE: PPS Therapy Impact Analysis

this is something that Pam put together with that analysis

Brandon Ballew
Vice President of Finance
Gentiva®
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Fax: [redacted]
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From: Cavanaugh, Pete
Sent: Monday, September 29, 2008 2:38 PM
To: Wang, Shirley
Cc: Ballew, Brandon; Norlander, John
Subject: PPS Therapy Impact Analysis
Hi Shirley,
Can you please go through the 2008 PPS file and tell me the total number of episodes that had at least 1 therapy visit (total therapy, not just PT), but less than 7? I'd like to know what overall impact we'll get if we push for an increase in therapy, so all of those episodes times $70 would equal the cost of increasing the utilization. Then take the count of the number of episodes with 5 visits times $480, and the number of episodes with 6 visits and multiply times $500. That will get the revenue impact. Thanks,
Pete

Peter M Cavanaugh
AVP Financial Operations
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Footnote 64

From: Weaver, Charlotte
Sent: Wednesday, January 07, 2009 06:49 PM
To: Landry, Beth; Strange, Tony
Subject: RE:

Beth,
A couple of points.

I do understand from Tony and Ron that you provided leadership support for the Regional Directors as a "temporary" assignment due to lacking anyone else who could step in until we got our organizational structure defined.

The best that I can understand folks' perspectives on your assignment and handoff points, was that you were given the task to develop tools, metrics etc for engaging therapies more broadly in non-specialities; operations did a 2-part pt. management assignment which was to target getting more standardization across Gentiva/Healthfield's LOS practices…., and the 2nd part addressed getting more therapy visits in an episode of care. From their perspective they owned what they were doing to make these changes happen in operations….and they weren't thinking of stealing your thunder.

I can talk to you about this more at a later time. I think it important that you take away some learning points from this that should be in the skill set of a Vice President. I'm struggling with this cold at the moment, so need to leave the office now. But will look to catch up with you later this week so we can discuss this and hopefully get this behind you and focusing on future.

Charlotte

Charlotte Weaver RN, PhD
Sr.VP & Chief Clinical Officer
Gentiva® Health Services
[redacted] Atlanta, GA 30339
Tel: [redacted]
Fax: [redacted]
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From: Landry, Beth
Sent: Wednesday, January 07, 2009 1:00 PM
To: Weaver, Charlotte; Strange, Tony
Subject:

Charlotte,
When we met Monday, several times you commented that my team should have known to develop things then let them be implemented elsewhere. Obviously it confused me Monday and I questioned it several times, and continues to nag at me.

For the past two and a half years I have had two teams. One team (national team, straight line to me) is responsible to develop items with some help from regionals, launch, then support regions peripherally. The other team (regional specialty/rehab directors, dotted line to me) is responsible to drive same store growth and keep them special following launch with some help from national team. Our org charts have been utilized at all levels in the organization along with descriptions of what each team does for several years. This has been extremely successful and to my knowledge has never changed.

It appears that your understanding is different, almost as though I am only responsible for the national team and the national team is only responsible to develop and not implement. Almost as though the regionals have been cut off, again not my understanding. The regionals have been very clear that they need support from the national team following launches. While the regionals 'own' it and have ultimate responsibility, they simply utilized the national team to help get results. Additionally, the regionals have relied on my support for the past 15 months to identify and drive rehab metrics.

It had always been the plan - documented and communicated over and over at many levels - that the rehab initiative would follow the same pattern. It would be developed and implemented by a cross sectional team consisting of some national team members, some regional team members, some field members, Claire and Teri with support from Ben and Pamela.

The documentation reviewed Monday demonstrates that I consistently communicated, collaborated, set up a roll out plan together with clinical counterparts - only to have the plan cut out from under me with zero communication. And the best part is that I took a bullet from trying desperately to do the right thing.

Either my job had changed and I was not aware of it, or we have a mixed up understanding.

I don't even care how it is moving forward - no problem being gumby and aligning. I care very much to have my name and reputation cleared and to have a clear position to thrive in.

Thoughts??

Beth Landry
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Footnote 65

From: [redacted]
Sent: Monday, May 03, 2010 03:26 PM
To: Strange, Tony
Subject: Parting comments

Dear Tony,

As I prepare to leave after 6 years with Gentiva, I would like to share some of my thoughts and concerns. As I wasn't sure who to send these on to and you always sated you wanted to hear from us, I am addressing them to you.

When I came to Gentiva six years ago, I felt I had found a company that combined the benefits of a large company with clout to make a difference with the home health arena with the benefits of a small company that cared about its employees and the area in which they worked. I had been doing the Gentiva Orthopedics model long before Gentiva dreamed of it, connecting with the leading surgeon in our area and developing a plan for immediate post op d/c to home and intense in home rehab. Joining with Gentiva gave me the opportunity to build an outstanding team and really expand what I had dreamt of doing.

Unfortunately I have seen many changes with Gentiva in the last few years. I see the push to treat by metrics not by what the patients need. I see dropping insurance companies because they don't pay well enough. What this is doing is making Gentiva look like cherry pickers and instead of saying all patients will get the best care, Gentiva is saying only those who will pay us well will get good care. This is discrimination in the worse sense in my book and I am not comfortable with it. I understand the need to make a profit and keep the company solvent but I don't think this is a good way to do it. Treating by numbers is also making the clinicians feel their professional judgment is being questioned. Again, not sitting on plateaus is understandable but pushing to thresholds based on what their diagnosis is, not by what the patient needs is just wrong.

I also feel the push to the pay per visit is wrong for the full time clinicians. To offer the 32 hour spot for people who don't want to work full time and to give them full benefits was very generous. To put all the dedicated clinicians who want full time into a pay per visit environment is just not a good idea. It is telling them that they are only worth something if they are always busy. On the occasion the census drops, we are telling them they either have to use their PTO, which cuts into their ability to take time off with their family or have time for illness available if needed, or they have to take a cut in pay. This is a pretty nasty way to treat dedicated, hard working clinicians.

I feel that Gentiva has become the large corporation that is only concerned with the bottom line and not with the people who make it what it is. As such, I am going to pursue other interests and challenges as I am not comfortable working in this environment.

I wish you well with the future.

Sincerely,
[redacted]

[redacted] PT
Orthopedics Director
Gentiva®
[redacted]
Fax: [redacted]
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Footnote 66

	A	B	C	D	E
1	Data analysis was performed on episodes ending for Q1 of 2007 from all systems. Total episodes analyzed were				
2	42,228. The results are as follows:				
3					
4					
5	Total Revenue for 2007 (Net LUPA, Therapy, and including Outliers)				
6	Total Revenue for 2008 (Net LUPA, Therapy, NRS and including Outliers)				
7	Difference				
8	% Inc (Decrease)				
9	***Note: The change in the revenue from the proposed to the final is primarily due to the change in the case mix weight***				
10					
11					
12	**Potential for Revenue Increase:**				
13	Specialty Programs (Orthopedics) increasing visits				
14	LUPAs in Initial Episodes				
15	LUPAs (Recerts) with 4 visits				
16	F Scoring Changes on Patients with Therapy				
17					

	F	G	H	I
1				
2				
3				
4				
5		114,035,067		
6		112,525,420		
7		(1,509,647)		
8		-1.34%		
9				
10				
11				
12				
13		2,774,572		
14		1,086,181		
15		705,081		
16		1,110,713		
17		5,676,547		4.98%

	A	B	C	D	E	F	G	H
1	Rev by Territory		2007	2008	Difference	%	# of Episodes	
2	T01	Locker	8,488,139	8,159,099	(329,040)	-3.9%	2,802	
3	T04	Carter	7,324,726	7,084,569	(240,157)	-3.3%	2,289	
4	T05	Shoemaker	37,113,514	36,232,015	(881,499)	-2.4%	14,160	
5	T06	Aurelio	3,982,504	3,978,219	(4,285)	-0.1%	1,444	
6	T07	Shaner	39,795,251	39,908,980	113,729	0.3%	16,140	
7	T08	Causby	17,330,933	17,162,539	(168,394)	-1.0%	5,393	
8			**114,035,067**	**112,525,420**	**(1,509,647)**	**-1.3%**	**42,228**	
9	***Note: The revenue includes LUPA, Non LUPA, NRS, and Outliers***							
10								
11								
12	Change in Case Mix and Wage Index		Avg CM 2007 (No LUPAs)	Avg CM 2008 (No LUPAs)	% Change	Avg Wage Index 2007	Avg Wage Index 2008	% Change
13	T01	Locker	1.32	1.28	-3.3%	1.0490	1.0524	0.32%
14	T04	Carter	1.52	1.49	-1.9%	0.9725	0.9716	-0.09%
15	T05	Shoemaker	1.36	1.35	-0.8%	0.8652	0.8589	-0.73%
16	T06	Aurelio	1.39	1.40	0.9%	0.8802	0.8783	-0.22%
17	T07	Shaner	1.31	1.33	1.1%	0.9086	0.9094	0.09%
18	T08	Causby	1.45	1.44	-0.5%	1.0778	1.0878	0.93%
19			**1.36**	**1.36**				

	A	B	C	D	E	F	G	H	I
1	Specialty Program	Case Mix Weight 2007	Case Mix Weight 2008	% Change In CMW	Gross HHRG 2007	HHRG + NRS 2008	% Change in Revenue	GP% Standard Cost	Therapy Visits
2	Cardio	1.21	1.30	9%	2,690.49	2,819.29	6%	58%	7
3	Ortho	1.65	1.51	-6%	3,791.63	3,414.10	-8%	71%	11
4	Safe Strides	1.71	1.73	2%	3,909.57	3,876.39	0%	69%	13
5									
6									
7									
8									
9	Speciality Program Ortho (Change in Revenue by Increasing Therapy Visits to 14)		Change in Case Mix Weight 2008	% Change In CMW	Change in HHRG + NRS 2008	% Change in Revenue	Change in GP% Standard Cost	Total HHRG+NRS Revenue	Episode Count
10	T01	Locker	0.4465	33%	1,081	35%	-3%	286,468	265
11	T04	Carter	0.4482	34%	970	33%	-8%	281,436	290
12	T05	Shoemaker	0.4144	31%	915	31%	-1%	490,307	536
13	T06	Aurelio	0.3188	24%	712	24%	1%	12,812	18
14	T07	Shaner	0.5342	41%	1,125	39%	-4%	888,765	790
15	T08	Causby	0.5092	40%	1,156	37%	-2%	814,783	705
16								2,774,572	2,604
17	*Note: These episodes are from the Unity system only*								

	J	K	L
1	Total Visits	Total HHRG+NRS Revenue	Episode Count
2	20	2,263,887	803
3	16	11,611,360	3401
4	20	12,199,003	3147
5		26,074,250	7,353
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

	A	B	C	D
1	An analysis was done of the LUPA episodes that had 4 billable visits and then this data was separated into first episodes			
2	(new admits) and recert episodes.			
3				
4	The assumption is to add 1 additional visit to these episodes. The calculation was made by taking the full HHRG			
5	amount on these patients and subtracting the LUPA reimbursement.			
6				
7	The LUPA episodes in the entire database is 5,172 or 12% of the total episodes.			
8				
9	The % of total episodes of 4 visit LUPAs is 3%.			
10				
11				
12	LUPA Additional Revenue (5th Visit)		First Episode	Recert Episode
13	T01	Locker	63,221	39,485
14	T04	Carter	59,408	19,462
15	T05	Shoemaker	293,609	185,250
16	T06	Aurelio	14,676	26,588
17	T07	Shaner	455,544	371,845
18	T08	Causby	199,723	62,451
19			1,086,181	705,081

	E	F	G	H
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12	Total	# of First Episodes	# of Recert Episodes	Rev per visit for 5th Visit
13	102,706	40	25	1,580
14	78,870	45	12	1,384
15	478,859	230	148	1,267
16	41,264	13	20	1,250
17	827,389	361	279	1,293
18	262,174	135	35	1,542
19	**1,791,262**	**824**	**519**	1,334

	A	B	C	D
1	An analysis was done of the patients that have the lowest functional dimension score (F1) but received 6 or more therapy visits.			
2				
3	The assumption is that a patient that requires 6 or more therapy visits would not fall into the lowest functional dimension			
4	on the OASIS scoring. The analysis below moves this population of patients from the lowest function dimension score (F1)			
5	to the next function dimension score (F2) and multiplying these episodes by the regression coefficient table (Table 4)			
6	published in the final rules.			
7				
8	The amounts have not been wage index adjusted.			
9				
10	F Score Changes with Therapy		Revenue Increase	# Of Episodes
11	T01	Locker	60,281	274
12	T04	Carter	90,254	471
13	T05	Shoemaker	367,605	1,562
14	T06	Aurelio	40,668	170
15	T07	Shaner	371,661	1,548
16	T08	Causby	180,245	776
17			**1,110,714**	**4,821**

	A	B	C	D	E	F	G	H	I
1	Outlier Summary		# of Episodes	Case Mix Weight 2008	Gross HHRG	NRS Amount	Outlier Payment	GP % Standard Cost	Total Visits
2	T01	Locker	108	1.04	2,535	93	2,558	-5%	77
3	T04	Carter	28	1.07	2,354	136	1,476	-11%	76
4	T05	Shoemaker	148	1.07	2,203	111	1,575	-4%	67
5	T06	Aurelio	36	1.12	2,307	128	1,929	1%	75
6	T07	Shaner	144	1.06	2,239	104	2,028	-4%	71
7	T08	Causby	26	1.05	2,402	121	1,147	-12%	69
8			**505**	**1.06**	**2,315**	**108**	**1,907**	**-5%**	72

	A
1	Gentiva PPS Refinement Project
2	
3	Project Scope: To prepare the home health division to accommodate the Medicare PPS changes that take effect on 01/01/2008.
4	
5	Project Leads:
6	
7	Group Leaders
8	Accounting
9	
10	Clinical
11	
12	Departmental Awareness
13	
14	FSU
15	
16	Finance
17	
18	TSG
19	
20	
21	
22	Leadership Tasks
23	Accounting
24	
25	
26	
27	Clinical
28	
29	
30	Departmental Awareness
31	
32	
33	
34	
35	
36	Finance
37	
38	
39	
40	
41	FSU
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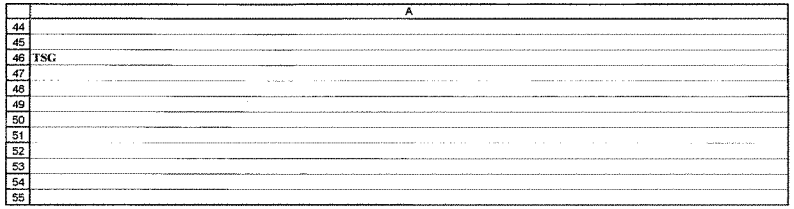
43	

	B
1	
2	
3	
4	
5	Perri Southerland & Mary Wollstein
6	
7	
8	Ann Printz
9	
10	Pamela Teenier
11	
12	Tony Strange
13	
14	Jim Andrews
15	
16	Brandon Ballew
17	
18	Mike Carbery
19	Louise Scafati
20	
21	
22	
23	Revenue Recognition (related to adjustments from the new OASIS questions)
24	Changes to SOI (if warranted)
25	Communication to Internal Audit in conjunction with Finance
26	
27	OASIS Education and Training (New Forms and accurate recording of information)
28	Revised Clinical Protocols (if warranted)
29	
30	Executive Leadership
31	Sales
32	RVPs
33	Legal
34	Compliance
35	
36	Budgets
37	WKI
38	Communication to Internal Audit in conjunction with Accounting
39	Specialty Group
40	
41	Prepare and Educate FSUs on Changes and any impact to current processes
42	Participate with the TSG group for development and UAT
43	Liaison for Gentiva Consulting relating to billing changes



	B
44	Determine if all Non Medicare PPS Payors will follow the new guidelines
45	
46	Unity
47	Homesys
48	H.E.A.T.
49	Lifesmart
50	PtCT
51	Haven Software (transmission of OASIS)
52	Mev/Merv enhancements
53	B1 File
54	
55	

Footnote 67

From: Landry, Beth
Sent: Monday, August 04, 2008 02:17 PM
To: Causby, David; Shaner, Jeff
CC: Strange, Tony; Ballew, Brandon
Subject: RE: Specialties growth

More recommendations:
* with Causby/Shaner identify 15 -20 total locations for Neurorehab and Senior Health, load them into pipeline; recruit for director, launch in order of hires (currently hiring director is the thing that most often holds up launches)
* implement delist and/or relaunch cost to locations
* budget launches at location level for Q1 and Q2
* budget launches at region level for Q3 and Q4 to keep pressure on
* exposure and visibility - announce launches on Friday ring the bell call?

Other related info:
* national team to do site visits to locations in SBAP to prime the pump and get them ready
* we have completely shifted the national team to launch, keep their Specialty current and cutting edge, external visibility, and with remainder of time site visits as requested by regions; this means that we have moved away from dual accountability for same store growth; complete ownership now shifted to regionals; this makes it even more imperative that regions fill and drive the pipeline, to accomplish this we need RVPs, Jeff/Dave/Mike to drive expectations

Looking forward to it.

Beth Landry
vice president
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-----Original Message-----
From: Landry, Beth
Sent: Wednesday, July 30, 2008 4:06 PM
To: Strange, Tony; Causby, David; Shaner, Jeff
Subject: RE: Specialties growth

Lots thinking about this. Believe actions should be:
* visibility and accountability - at any ops review at any level, include discussion of Specialty actual to budget, discusion of pipeline for all Specialties, where they are in process, expectations for launches and new Specialties. Without full KIR info and without incenties tied, difficult to push importance but need to make it happen and permeate the organization.
* through direct report line mgmt - Specialties can support and help drive it, and yet the message needs to be loud and clear through Ron, Tony, Dave/Jeff and RVPs to their direct report Reg Rehab Directors.

Thoughts?

Beth Landry
[redacted]
Atlanta, GA 30339
[redacted]

-----Original Message-----
From: Strange, Tony <[redacted]>
Sent: Tuesday, July 29, 2008 11:47 AM
To: Causby, David <[redacted]>; Shaner, Jeff <[redacted]>
Cc: Landry, Beth <[redacted]>
Subject: FW: Specialties growth

I agree with Ron. Amedisys is on our heals related to growth in Specialties. I want to see us kick it up a notch related to launches. Especially, in the programs that drive high % Medicare growth. I have yet to see the pipe line for the remainder of the year especially Neuro and Sr Health. I expect the pipeline to be full between now and year end. If we don't make these investments right now we will not hit our growth numbers in 09. Beth, please provide me with the "full" pipeline throughout the remainder of 08 no later that 8/7. David and Jeff, please be sure these plans are well thought out and executable. In addition, please make it part of our strategy to review all existing programs that are not performing and either have a plan to address performance or re allocate the resources.

Thanks.
Tony

From: Malone, Ron
Sent: Tuesday, July 29, 2000 10:50 AM
To: Causby, David; Landry, Beth; Shaner, Jeff
Cc: Strange, Tony
Subject: Specialties growth
Importance: High

You may want to listen to the replay of the Amedisys earnings call wherein they discuss an aggressive rollout schedule for their specialty division. While we were clearly first to market that doesn't mean much if someone beats us to a local market with their rollout. I urge you to take them seriously.

Footnote 68

1. Therapy Episode Distribution	2006		2007		2008		2009	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Number of therapy episodes that received:								
1 visit	1,297	8.5%	2,520	9.6%	3,920	9.2%	4,502	8.0%
2 visits	574	3.8%	1,041	4.0%	1,573	3.7%	1,907	3.4%
3 visits	467	3.1%	862	3.3%	1,288	3.0%	1,458	2.6%
4 visits	412	2.7%	834	3.2%	1,150	2.7%	1,538	2.7%
5 visits	369	2.4%	693	2.7%	1,174	2.8%	1,604	2.8%
6 visits	318	2.1%	641	2.5%	2,367	5.5%	3,066	5.4%
7 visits	267	1.7%	493	1.9%	2,140	5.0%	3,218	5.7%
8 visits	236	1.5%	481	1.8%	1,928	4.5%	3,013	5.3%
9 visits	305	2.0%	682	2.6%	1,739	4.1%	2,513	4.5%
10 visits	3,196	20.9%	5,381	20.6%	2,945	6.9%	2,972	5.3%
11 visits	1,969	12.9%	3,178	12.2%	2,704	6.3%	2,962	5.3%
12 visits	1,905	12.4%	2,845	10.9%	2,548	6.0%	3,141	5.6%
13 visits	1,142	7.5%	1,826	7.0%	2,111	4.9%	2,691	4.8%
14 visits	751	4.9%	1,193	4.6%	3,403	8.0%	3,976	7.1%
15 visits	462	3.0%	802	3.1%	2,178	5.1%	2,797	5.0%
16 visits	370	2.4%	652	2.5%	2,104	4.9%	2,760	4.9%
17 visits	289	1.9%	539	2.1%	1,517	3.6%	2,259	4.0%
18 visits	229	1.5%	366	1.4%	1,115	2.6%	1,712	3.0%
19 visits	162	1.1%	233	0.9%	667	1.6%	1,181	2.1%
20 visits	116	0.8%	189	0.7%	893	2.1%	1,297	2.3%
21 visits	106	0.7%	143	0.5%	643	1.5%	1,041	1.8%
22 visits	75	0.5%	119	0.5%	512	1.2%	823	1.5%
23 visits	53	0.3%	78	0.3%	407	1.0%	664	1.2%
24 visits	52	0.3%	74	0.3%	316	0.7%	541	1.0%
25 visits	23	0.2%	50	0.2%	234	0.5%	450	0.8%
26 visits	19	0.1%	49	0.2%	229	0.5%	411	0.7%
27 visits	26	0.2%	33	0.1%	154	0.4%	300	0.5%
28 visits	19	0.1%	31	0.1%	110	0.3%	248	0.4%
29 visits	15	0.1%	24	0.1%	94	0.2%	194	0.3%
30 visits	11	0.1%	16	0.1%	86	0.2%	141	0.3%
More than 30 visits	68	0.4%	79	0.3%	437	1.0%	953	1.7%
Total:	15,303	100.0%	26,147	100.0%	42,686	100.0%	56,333	100.0%

Footnote 69

3.a. Therapy Patient Count:	2006	2007	2008	2009
Unduplicated count of Medicare pts receiving therapy:	12,693	21,334	35,271	48,028

3.b. Therapy Episode Reimbursement:	2006	2007	2008	2009
Total Medicare reimbursement for episodes that qualified for additional payments due to therapy visits provided[1]:	$42,530,496	$70,846,023	$132,184,654	$184,571,930

Notes

[1] Includes all episodic reimbursement for episodes with ten or greater therapy visits in 2006-2007. For 2008-2009, all episodic reimbursement was included for episodes with six or greater therapy visits.

3.c. Total Medicare Reimbursement:	2006	2007	2008	2009
Total Medicare reimbursement for the company	$128,886,698	$191,073,709	$263,328,055	$366,673,596

Footnote 71

From: Barbara Goodman
Sent: Wednesday, January 30, 2008 9:24 PM
To: Patty Stonecypher; Angie Begnaud
Cc: Chris Stagg; Kendra Case; Jenny Minvielle
Subject: Re: Fw: Low vision

Patty,
Great question and on the table to be looked at.
Most of our programs (low vision, Pelvic Floor) called for 10 visit because it was at that threshold that we actually made additional revenue for therapy.
We are in the process of looking at all of these programs.
The breakdown of therapy visits, I have attached. We get no additional revenue until we hit 6 visits.
I can't make the decision whether or not to supply the patient with supplies if < 10 visits now, but my gut feeling is that if the pt gets 6 or > visits some portion if not all the supplies would be approved.
I will bring this up at the DVP meeting next time we meet - scheduled for Monday unless they cancel it due to Mardi Gras
Will let you know as soon as I find out.
BG

Barbara Goodman
RN, MSN, CHCE, HCS-D, COS-C / Vice-President of Quality and Performance Improvement

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Phone: [redacted] | Fax: [redacted] | [redacted]
Email: [redacted]

Patty Stonecypher/LAHCG

01/30/2008 04:49 PM

To

Barbara Goodman/LAHCG

cc

Chris Stagg/LAHCG

Subject
Fw: Low vision

Barbara

I think from the questions introduced by the Ky Sales team, it is basically this: Previously, in order for the patient to be eligible for the $150 in adaptive equipment through the Low Vision Program, there had to be a total of 10 visits. Now with the changes in PPS, the total number of visits does not come to 10 therefore the patients are not eligible for the equipment. They are asking if something can be done to change the policy so that if patients get fewer than 10 visits, the $150 can be adjusted in order to assist our patients in getting some money toward equipment. (If you can't tell by now, the Low Vision Program is a huge hit here in KY. We even got an emergency CON in one of our counties based on physicians who wanted their patients to benefit from this program.
Thanks
Patty

Patty Stonecypher
Director of Sales
[redacted]
Somerset, KY 42503 US

Phone: [redacted] | Fax: [redacted]
Email: [redacted]

----- Forwarded by Patty Stonecypher/LAHCG on 01/30/2008 05:43 PM -----

Kendra Case [redacted]

01/30/2008 04:44 PM

To

Barbara Goodman [redacted]
cc
Shelia Heflin [redacted], Patty Stonecypher [redacted]

Subject
FW: Low vision

Barbara - Can you please help out Sheila with her question below? I am still just not sure how to respond to these questions.

Thanks.

Kendra Case
RN, BSN, CPHRM, CRM
Vice President, Education & Risk Management

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Lafayette, La 70503 US
Phone: [redacted] | Fax: [redacted]
Cell: [redacted]
Email: [redacted]

From: Jenny Minvielle
Sent: Thursday, January 24, 2008 12:45 PM
To: Kendra Case
Subject: Fw: Low vision

Kendra -

Here is another email about the Low vision program. Can you answer this question also?

Thanks,
Jenny

Jenny Minvielle
LHC Group
[redacted]

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----- Forwarded by Jenny Minvielle/LAHCG on 01/24/2008 12:44 PM -----

Patty Stonecypher/LAHCG

01/14/2008 10:55 AM

To

Jenny Minvielle/LAHCG

cc

Subject

Fw: Low vision

Jenny

Another email regarding the $150 for supplies to the Low Vision patients. Just let me know your thoughts?

Thanks

Patty

Patty Stonecypher
Director of Sales
Lifeline Healthcare of Pulaski
[redacted]
Somerset, KY 42503 US

Phone: [redacted] Fax: [redacted]
Email: [redacted]

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----- Forwarded by Patty Stonecypher/LAHCG on 01/14/2008 11:54 AM -----

Shelia Heflin/LAHCG

01/14/2008 10:32 AM

To [redacted]

cc [redacted]

Subject Low vision

Patty,

Beginning Jan 1st, the therapy might be changed to different numbers, say 7 needed for certain dx., 5 for others. Did this happen?

If so, on the low vision, it is very difficult to do 10 visits with most of these pts., Our therapist said 5 would be excellent. Then maybe we could provide them with $100.00 of vision supplies and come out ok.

Our Dr. Naser is very willing to work with us on this, but we have only been able to make the 10 visits on 1 pt. so far.

This could be a wonderful opportunity,

Please let me know if you have heard anything about the decreased visit requirement.

Thanks,

Shelia

Shelia Heflin
Lifeline Health Care of McCreary
[redacted]
Whitley City, KY 42653 US

Phone: [redacted] | Fax: [redacted]
Email: [redacted]

Footnote 72

From: Liz Regard
Sent: Wednesday, June 13, 2007 11:47 AM
To: Rocky Goodwin/LAHCG
Subject: Fw: Therapy assistance

see below
cindy keeton
[redacted]
Your secretay
Liz
(what is keeping you occupied lately. just joking!)

Liz Regard
Area Manager
LHC Group
Phone [redacted]
Email: [redacted]

----- Forwarded by Liz Regard/LAHCG on 06/13/2007 10:45 AM -----

Cindy Keeton/LAHCG
06/05/2007 10:15 AM
To Liz Regard/LAHCG
cc Liz Starr/LAHCG@LAHCG, Sonya Owens/LAHCG@LAHCG
Subject Therapy assistance

Hey Liz,
On conference yest with Liz Starr, we discussed an issue that I am experiencing with one of the Brandon location therapist. She was a PT instructor at a local university here that wanted a change a year ago. She started with us as a field therapist. Throughout her time here it has been a constant battle with her regarding the 10 visit threshold. She even bucks when a MD orders a specific frequency and if she feels they do not need it then she refuses. She also sets frequencies based on territory and the home enviroment. If she feels that the pt is out of her territory then she sets frequencies of < 4 visits. The other therapist here do not want mentor her due to that fact that she taught all of them. You can see that I have an unusual situation in getting this employee educated on home health therapy as related to hospital. It was suggested that you might have a therapist that would be willing to come here and work with her. I think the name Rocky was mentioned. Please let me know your thoughts.
thanks ck

Cindy Keeton, RN,BSN

Regional Manager
Mississippi HomeCare of Jackson, L.L.C. Brandon, Jackson, Yazoo City, Madison and Hazlehurst
[redacted]
Jackson, MS 39202 US

Phone: [redacted] | Fax: [redacted]
(c) [redacted]
Email: [redacted]

Footnote 73

From: Liz Regard
Sent: Sunday, July 08, 2007 9:40 PM
To: Rocky Goodwin/LAHCG
Subject: Re: My visit to Princeton

Perfect!!!
Don't know why I feel like I have to give you hints!!

Liz Regard
Area Manager
LHC Group
Phone [redacted]
Email: [redacted]

Rocky Goodwin/LAHCG
07/08/2007 07:30 PM
To Thressa Guchereau/LAHCG
cc John Indest/LAHCG, Pam Bridges/LAHCG, Pat Derouen/LAHCG, Liz Regard/LAHCG, Lynda Downard/LAHCG
Subject My visit to Princeton

Thressa,
I want to thank you for the opportunity to help in Princeton. I feel that my visit was productive. [redacted] is an excellent PT and is excited about the profession and Home Health. He was very receptive to my ideas. Let me go over, briefly, what I tried to convey.
1) Therapy visit thresholds. I explained that 10 visits is not etched in stone but that 5-9 visits is a killer. He voiced knowledge of the threshold concept and the bell curve. I explained the background of the 10 visit concept and the financials involved. He seemed to be more convinced with this background.
2) I left him a copy of the old LTR calendar/visit log that we used to use. He was receptive to this and embraced it as a tool to manage his schedule more effectively. He will probably adapt it some; I encouraged him to do so.
3) I gave him several pointers as to how to "finish out" a therapy episode where only 6-9 visits are on the book and he needs something else to do to get to 10 visits. There are several old tricks up my sleeve that I told him about from a clinical standpoint that he should feel better about using to get to the 10 visits.
4) He was told to involve OT more in the completion of a cert period to reach the threshold. He had not necessarily done so in the past.
5) I also showed him how I actually use my own schedule book and how I keep track of

visits made. Again, he liked this. In this area, I also demonstrated how I empower my PTA's to keep track of supervisory visits.
6) [redacted] could benefit as well from moving toward making out his own schedule instead of bogging himself and team leaders down on a daily basis with this.

I was also able to give [redacted] a few pointers in the clinical aspect of seeing patients. He is eager for this. I pointed out several Continuing Education courses that I have been to that are Home Health specific. He is craving this type of information.

I feel also that the Princeton office could benefit from the use of an Occupational Therapist with more of a dedication to Home Health. The OT that is available now sounds like a remarkable lady but her full time attention is in a rehab setting, thus a lot of her referrals are one and two visit episodes. I know that OT's are hard to find, but they are out there. [redacted] could benefit from coordinating with one on a regular basis. I explained how I am able to do this.

Fine tuning seems to be the only need here. I hope that I have helped. I made a concentrated effort to not focus on the financial aspect of all of this too much, but reminded [redacted] that PCH has to function in the black for his own benefit. He knew this. It was also reinforced that CMS will probably change all of this in January. I look forward to being available to train therapists once we all know which way the ball bounces.

I enjoy this type of work and welcome the chance to do so in the future and would love to be available to be in on the ground floor of a start up situation. I feel that my effectiveness would be greater if able to do so. Thanks again, Thressa.
Rocky Goodwin, PT

Footnote 74, 75

From: Liz Regard
Sent: Monday, October 01, 2007 4:29 PM
To: Jessica VanBuskirk/LAHCG
Subject: Therapy in the new system- Need RESOURCES please

Jessica,
In reviewing budgets with Pat Derouen last Thursday, we noted the anticipated drop in reimbursement for the Hot Springs office for 2008 due to their large percentage of Ortho patients that they have served in the past requiring usually a max of 10 visits.

Pat said that he thought that Tasha had information that would tell us the types of patients that Medicare would see justification for 6 therapy visits, 14 therapy visits, etc.
This is hard to put into words but basically, should CMS audit a chart next year of a patient with greater than 14 visits, what type of patient would they be expecting to find.
Same thing with 6 therapy visits.
Same thing with 20 therapy visits.

I know that much of this depends on documentation of "need, progress, etc and also what the HIM11 states related to what each service should be providing, etc.
But where would we go to find the best information on how they are viewing Maintenance therapy , etc.
I am trying to get Rocky Goodwin PT in Shreveport who assists the start up team occasionally in an education role in our region.
I see this so badly needed for training/transitioning of the different offices in relation to therapy in the new payment system.

Rocky will read if I give him something.!!

Liz Regard
Area Manager
LHC Group
Phone [redacted]
Email: [redacted]

Footnote 76

From: Don Stelly
Sent: Saturday, September 22, 2007 7:40 AM
To: Liz Starr
Subject: Re: Thoughts on PPS changes

Liz,

You are hitting on all cylinders right now!

I really need to sit with you and tap your brain. I think you will be an integral part of this education process going forward...

Thanks

Don Stelly
Senior Vice President - Operations
LHC Group
[redacted]
Lafayette, La 70503 US

Phone: [redacted] | Fax: [redacted]
Email: [redacted]

Liz Starr/LAHCG

09/21/2007 04:05 PM

To

Don Stelly/LAHCG@LAHCG

cc

Subject

Thoughts on PPS changes

Don

I spent time this past week preparing for the SVP mtg and really got excited with the material. There are many ways on how we can progress successfully.

It feels like 2000, my brain is on fire with ideas and the exciting things is that our upper mgmt team is all feeling the same way. We are up for the challenge and ready to start absorbing data to develop our approach.

Just a few thoughts:

1. Development of an electronic or "excel" tool based on Table 2A to identify clinical pathways for the HHRG - this will help with determination of SVP points allotted per HHRG. I have some ideas and will put them together. Once we finish the dashboard audio conference, the team in that conference could stay for brainstorming - JUST A RECOMMENDATION. The logic behind this table will be able to be configured in a way that would allow a "click touch" to easily select items and remove items to determine the best course of action for patient care services and ensuring availability of financial resources.

2. Identification of high reimbursement patients and:

a. How our current programs currently fit into these cases (specific pathway for each therapy program we currently have in place)

b. What revisions we want to make to our current programs to assure adequate reimbursement for resources utilized in the program

c. Development of new therapy programs that will now be VERY financially sound but would not have been in the past PPS reimbursement program.

Some of the programs we did not move forward with in the past are now going to be "Winners"

3. MO826 - Financially - we will need to increase our reserves due to anticipated increase to revenue adjustments related to * of inaccuracy of therapy visit # anticipated by the RN. Our RNs will not be as accurate on a percentile average when trying to identify services needed upon admit. Of course, education will help with improvement of accuracy related to this and perhaps a review of our process for revisions is warranted to ensure process limits controllable inaccuracies expected - the tool mentioned in #1 above would be a great way to identify corrections to MO826 before we complete the admit review.

4. Development of pathways - including the specifics required to place the person on each pathway - following our user friendly disease mgmt approach as the format

ie...HHRG of X = SVPs (base on care required)
Identify the Requirements: Injectables((X SN visits), teaching of _____, therapy for _____(x # vs) and anticipate LOS _____ (develop each pathway geared toward the anticipated LOS with a pathway for each episode anticipated). This would assist in appropriate continuation of care.

*note- this is hard to explain via email

5.Redirecting Marketing Efforts - this is where the data you requested from me related to HHRG and dx will help.

6. Audit Tool for OASIS accuracy - SHP is our current program but we need to evaluate the logic written for the 08 revisions. This needs to happen now so we can get them to implement the necessary changes needed by 1-1-08

7. Heavy Education to our Case Mgmt Team - as this will be the checking point for accuracy of OASIS and they need to understand the points of consideration

8.Concern area - noted that there will be a 2% reduction for failure to report OASIS July 2006 - June 2007. This may impact us with the recent discovery of OASIS not submitted on our MCR HMO claims. I believe this will be able to be battled but we just need to recognize the potential impact and confirm that this will not effect us or if we are required to act to prevent from being effected. We need to identify how many this impacts, the sites, prepare a comparative analysis on the % submitted versus the nominal 8 not submitted, a white paper on our position including reasons and determine how we will proceed with our approach to each state OASIS coordinator and CMS on consideration to be removed from the 2% reduction related to OASIS not submitted (simply a computer glitch but we need to be pro-active to prevent the reimbursement reduction if this situation could fall into this category).

9. Naturally revisit our current dashboard and revise accordingly.

These are just a few initial thoughts. This it why I kept waiting to get time for review and get my head wrapped around it. Now that I have finally read the material, get ready. It's like trying to solve a jigsaw, mathematical and logic puzzle all at once!

Also, I learned that the case mix creep is an administrative adjustment, which means the president does not require congressional approval. This can be done as an "executive" decision under the administrative branch that reports directly to the president. This creep needs to be brought up by home health lobbyist - they are not basing this creep on a large percent of educational improvement resulting in increased accuracy on the OASIS causing the increase. Anyway, I know our team is probably all over this.

In conversation this week, we talked about how fast we are moving. However, I did not expound on agreeing with you that we need a fast pace right now and all of the changes have been VERY GOOD! A few things still needed and I have no doubt you will be challenging us to identify them, if you have not already identified them yourself, as well as contributing on how to overcome and address pro-actively.

Have an enjoyable weekend
Liz

Liz Starr, RN, BSN, COS-C
Division Vice President / Home Based Operations
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Footnote 77, 97

From: keith myers
Sent: Friday, April 04, 2008 6:38 AM
To: Kevin Cragar
Cc: area sales managers; Scott Tobey; Don Stelly; George Wyatt; SMT; Vice Presidents; Jessica VanBuskirk; State Directors
Subject: RE: New Reimbursement
Attachments: oledata.mso

It's all in the therapy Kevin. Episodes in the 0-5 therapy buckets have been hit the worst. We have over 70% of episodes in the 0-5 bucket since January 1, 2008. We are looking at freestanding agencies in business development that are doing much better than we are with regard to2008 case mix and most of them actually have a pick up under the new rule. The key is that they have less than 50% of their episodes in the 0-5 therapy buckets. We took a financial hit for any therapy provide below 10 visits in the past, but under the new system an episode with 6 therapy visits is better than episode with 0-5 therapy visits. The new "10 visit threshold" is actually 6 visits on the low side and 20 visits on the high side. In other words, once you get to 6 visits, the more therapy visits provided the better, up to 20 visits. We need to move episodes out of the 0-5 buckets and up to the 6 and 7-9 buckets on the low end, and look for higher therapy need cases on the high end.

I think our sales people should be working closely with operations to recruit and employee more PT's, PTA's, OT's, and COTA's. Sales incentives are driven by admissions X case mix, and the only way to get case mix up is to increase therapy utilization. We need to look for opportunities especially within the OT area, i.e. low vision, etc.

Take a look at the chart below. This shows you how much of an impact therapy has on case mix, and case mix is what determines revenue.

Total Therapy Visits	Average Case Mix	% of All Episodes
20+	3.05	2.6%
18-19	2.36	1.3%
16-17	2.22	3.1%
14-15	2.08	7.4%
11-13	1.77	6.1%
10	1.60	2.9%
7-9	1.38	4.1%
6	1.17	2.2%
0-5	0.86	70.4%

Keith Myers
Chairman / CEO
LHC Group
420 W. Pinhook Rd. A
Lafayette, LA 70503 US

Executive Assistant: Judy Simien
Phone: [redacted] Ext [redacted] | Fax: [redacted]
Email: [redacted]

From: Kevin Cragar
Sent: Thursday, April 03, 2008 8:49 PM
To: keith myers
Subject: New Reimbursement

Keith,

Under the new Medicare reimbursement. What areas should we be putting most of our efforts toward from a sales perspective. I know therapy, what other areas???

Thanks,

Kevin

Kevin Cragar
Area Sales Manager
LHC Group
[redacted]
Fayetteville, AR 72701 US

Phone: [redacted] | Fax: [redacted]
Cell [redacted]
Email: [redacted]

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Footnote 78

From: Angie Begnaud
Sent: Friday, January 18, 2008 10:11 AM
To: elizabeth weldon <[redacted]>
Cc: [redacted]
Subject: Re: PT

Beth,
Definitely not!!!!!!!! We want to do more therapy visits. The point was made by Johnny that we still see our agencies doing only 10-12 visits, when in fact some of these patients we could be doing 14-20 visits if needed. They misunderstood what was being said.

Kim,
Please make sure that all staff understand this.

Thanks,
Angie

Angie Begnaud
Division Vice President, Central Division

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Email: [redacted]

elizabeth weldon <[redacted]>
01/18/2008 08:26 AM
To Angie Begnaud <[redacted]>
cc
Subject PT

Different nurses that heard the in-service yesterday said that we are to do no more than 6 PT visits. I was under the impression from the meeting and reading the regs that you got more reimbursement for increased visits. I need to know ASAP the answer because if we are to stop at 6 we are definitely doing things wrong and hiring a full time OT might not be in the best interest if 6 total therapy visits is all that we are to be allowed. Please advise. Thanks!! Beth

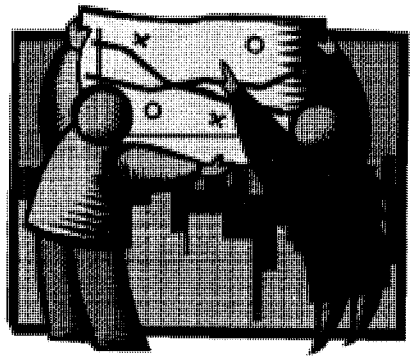
Footnote 79

Therapy Practice in the Refined PPS Environment: Challenges and Opportunities

Cindy Krafft MS PT, COS-C
Consultant & Educator
Vice President / Program Chair
Home Health Section APTA

633

Strategies???



- Be cautious of any deliberate plan to alter therapy practice patterns in response to a threshold change.
- Shifts in practice in order to maximize revenue may draw unwanted attention from Medicare and are NOT recommended.

Footnote 81

From: Angie Begnaud
Sent: Wednesday, April 02, 2008 4:43 PM
To: Pam Wigglesworth
Subject: missed conference call

Pam,

I am emailing the information that you missed from the conference call at 2:00pm with Don. Basically the call was one to stress the urgency of the problem with LUPAs and downgrades, and also the need for our DONs to communicate with the therapists the problem with projecting visits and not completing them. The therapist also need to look at increasing the number of therapy visits if warranted to move these patients into the higher therapy buckets. In looking at all 2008 episodes, the company has a 10% LUPA rate and a 10% therapy downgrade rate for a 20% adjustment rate. Don has asked for us to have all hands on deck to look at all open episodes. He also asked that all DONs and BMs report to the state director weekly on the number of LUPAs and downgrades. The last thing that he requested was that by the end of this week, all DONs and BMs call all of the therapists that do work for them to re-educate them on the final rule and to stress the urgency of not having the downgrades, and the need to really provide the amount of therapy visits necessary to move those patients into the higher buckets. Presently on our RAP claims, 47% of our therapy patients are receiving 0-5 therapy visits. This cannot continue to happen and the therapists need to get back with the agency asap after evaluation to let them know how many therapy visits they will be doing. Please let me know if you have any questions.

Thanks,

Angie

Footnote 82

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From: Lana Smith
Sent: Thursday, October 22, 2009 2:47 PM
To: Carolyn Cole
Cc: Pam Barnett
Subject: financials

Carolyn,
Considerations to get more profitable:

Would you be able to increase therapy utilization in improve case mix and Op Margin?
Both of these would improved financials.
Also many episodes have a high utilization rate so if one visit can be trimmed this would help the overall SVPs Positive adjustments need to be 2-3 times greater than negative adjustments LUPA rate too high today Check M0826 projections vs. what is scheduled

Thanks'

Lana Smith, RN, BSN
Kentucky State Director of Operations
LHC Group
[redacted]
Lexington, Ky. 40509
Phone: [redacted]
Fax #: [redacted]
Cell #: [redacted]
Email: [redacted] <mailto[redacted]

Footnote 83

.

From: Kim Bradberry
Sent: Friday, April 18, 2008 5:04 PM
To: denise hopkins; Melanie Rickman; debbie isbell; Donna Fleenor; angela todd; Sarah Eason; Cindy Cooper; elizabeth weldon
Cc: Susan Sylvester; Paula White
Subject: FW: Therapy Educational WebEx

Importance: High

Attachments: Therapy and The Final Rule.ppt


Therapy and The Final Rule.ppt...

All,
Please be sure your entire therapy staffs have this Web X info so that they may attend. It is MANDATORY for them, as you can see below.

Also, your team leaders, team leader assists (your call), PIs, you, and me....we are all invited!!

In looking at SVP tools for each W TN office yesterday, the greatest % of visits are in the dreaded 0-5 bucket for each office.

Let's all make a point of attending this, so that we can get the higher paying buckets FULL...we want to be able to say our "20+ buckets runneth over"! :-)

Thanks for facilitating!
Kim Bradberry, RN
DON/Admin

Extendicare Home Health of West/Western TN
[redacted]
Union City, TN 38261
[redacted]
Fax [redacted]
[redacted]

From: Jessica VanBuskirk
Sent: Thursday, April 17, 2008 1:32 PM
To: DONs; State Directors; Performance Improvement; Care Management; Branch Managers
Subject: Therapy Educational WebEx

Therapy in the PPS Final Rule

WebEx Teleconference

Two offerings of the Call will be Given:

Tuesday April 22nd 1:00pm CST

Thursday April 24th 9:00am CST

Call In Number [redacted]

Participant [redacted]

It is mandatory for ALL therapists to attend this call!

Also invited are DON's, Branch Managers, Team Leaders and PI.

Attached is a flyer with all of the WebEx information. Please print off and give a copy to all of your therapists.

If you have any questions, please let me know.

Jessica Van Buskirk

Director of Care Management

LHC Group

http://www.lhcgroup.com/ <http://www.lhcgroup.com/>

[redacted]

Lafayette, La 70503 US

Phone: [redacted] | Fax: [redacted]

Cell: [redacted]

Email: [redacted] <mailto:[redacted]>

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Footnote 84, 85, 86

From: Susan Sylvester
Sent: Tuesday, April 08, 2008 1:23 PM
To: pam harris
Subject: RE: Therapy

Sounds as if you had a good conversation. Frankly, I am very glad to hear that Sally was receptive. I was concerned about her 'take' on this. In order to be successful with this, the therapists must buy in.

Thanks,
Susan Sylvester, RN

University of Tennessee Home Care Services [redacted] Knoxville, TN [redacted] office [redacted] fax _____

From: pam harris
Sent: Tuesday, April 08, 2008 11:29 AM
To: Susan Sylvester
Subject: RE: Therapy

Susan,

I just had a discussion with Sally regarding Therapy untilization, downcodes, front loading of visits, etc. She was suprisingly receptive. I reveiwed the case mix impact with her and our therapy bucket of 0-5 visits that a vast majority of our patients fall into. She agrees to frontloading as well as going back after a couple of week to see if patients are following their exercise program or are functionally declining, in an attempt to raise the number of visits.

I also informed her of the upcoming Web Ex for the company's therapists that we were notified of this morning.

Weekly in our Interdisciplinary Meeting, Sally and I will review therapy utilization numbers, potential problem issues (downcodes, Lupas, etc.) together setting a plan to fix and adjustment accordingly. I have instructed her to call me immediately if a patient refuses visits or potentially could be a problem in completing set vists, which she agreed to do.

The Team Leaders and RN's are evaluating all patients (especially Recerts, ROC and SOC's) for the need for a therapy referral. All falls are immediately referred.

I think I covered all the bases..if not let me know.

Thanks,
Pam

Pamela Harris, RN
DON / Branch Manager
Lifeline Home Health Care of Springfield
[redacted]
Springfield, TN 37172

[redacted] (Office)
(Fax)

From: Susan Sylvester
Sent: Tuesday, April 08, 2008 9:04 AM
To: Deborah Kirkland; pam harris; Kim Bradberry
Subject: Therapy

All,

When speaking with your therapists about downcodes, please discuss front loading of visits. It appears that many of the patients begin to improve and decide to refuse the remainder of their therapy, go to outpatient, or are rehospitalized. The more therapy visits we've gotten in before that happens, the better off we are, as well as the patient. Obviously our goal is to improve the patient's overall condition and functionality, however if we are providing 5 therapy visits or less, we have incurred all of the expense of the therapy without any of the reimbursement. If the visits are frontloaded, ie 3w4, 2w4, 1w1, we may be able to get in enough visits early enough to complete (or nearly complete) our plan of care.

Please let me know should you have questions. I realize there have been many discussions/emails about downcodes, LUPA's and therapy utilization over the past week or so. This is a MAJOR push for Sr. Management at this time, as well as for all of us, in order to continue to operate successfully.

Thanks,
Susan Sylvester, RN

University of Tennessee Home Care Services [redacted] Knoxville, TN 37919 [redacted] office [redacted] fax

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Footnote 87

From: Melissa Ayers
Sent: Monday, October 20, 2008 7:55 AM
To: Becky McCoy
Cc: addie Davis
Subject: RE: Weekly Case Mix report (10/14/2008)

Becky,
We have new staff RN's, which now has an understanding of the case mix and Oasis. Kelly now has an understanding of the therapy buckets. He now places his patient's in 6, 10 or 14 visit ranges.
Also the lag time with data entry, I can look at the bends and know our case mix and SVP numbers will be down. As soon as data entry is caught up the numbers go up. Teena is working with the clerical staff, things are still slow but moving better.
Today's Case mix is 1.237 Initial rap is 1.21, Initial to final is +1.4%.
We also check the Oasis and make corrections with staff as well as outcome support team. Also we had 10 lupa's which I went over and over there was nothing I could do to change this.

Melissa Ayers RN, BSN
Branch Manager
[redacted]
Harrisville WV 26362
Phone: [redacted]
Fax: [redacted]
Toll Free: [redacted]

From: Becky McCoy
Sent: Friday, October 17, 2008 1:01 PM
To: Melissa Ayers
Cc: addie Davis
Subject: FW: Weekly Case Mix report (10/14/2008)

Addie, Missy,
Please view the Harrisville case mix and identify what is happening.
Please respond by Tuesday at 2:00 .
Thanks,
Becky McCoy
State Director Ohio/ Western WV

[redacted]
Parkersburg, WV 26101
Telephone [redacted], Fax [redacted], Cell [redacted] e-mail [redacted] <mailto:[redacted]>

From: Joe Dobbs
Sent: Tuesday, October 14, 2008 4:21 PM
To: stats distribution
Cc: Joe Dobbs
Subject: Weekly Case Mix report (10/14/2008)

This report includes episodes start dates 08/16/08 through 10/14/08.

Updated budgeted amounts for 4Q-2008.

New column descriptions:

1. Initial Case Mix (RAP) - Case mix as determined by HHRG at episode start.
2. Adjusted Case Mix (Final) - Case mix after any necessary adjustments for therapy, LUPA, Outlier.
3. % Initial to Final - Percentage of increase or decrease in initial to final case mix weight.
4. Q4 2008 Budgeted Case Mix - Budgeted amounts by location updated for 4th quarter of 2008.
5. % Final to Budget - Percentage of difference in adjusted and budgeted case mix weight.

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Footnote 88

From: Katy LaBauve
Sent: Wednesday, July 08, 2009 12:32 PM
To: Kimberly Gordon
Subject: Therapy buckets

You have 20% in the 7-9 therapy bucket range. Please get with therapists and have them reeval those to see if any can or need to be bumped up please

Footnote 89

From: Jeannie Duckett
Sent: Wednesday, December 02, 2009 1:47 PM
To: Ammy Lee
Subject: RE: Weekly report for 12-1-09

No I did not will discuss with therapy.
Thanks

Jeannie Duckett, RN
DON/Branch Manager, LHC Group
Medical Centers Home Care
[redacted]
Office: [redacted] Fax: [redacted] Cell: [redacted]

"In the Middle of Difficulty lies Opportunity"
Albert Einstein

From: Ammy Lee
Sent: Wednesday, December 02, 2009 12:27 PM
To: Jeannie Duckett
Subject: RE: Weekly report for 12-1-09

Thanks Jeannie, good report and agency doing well.....

Some comments:
- I see 19 patients in the 12-14 therapy bucket. Were you aware that there is an 18% difference in revenue between this bucket and the next highest one (15-16)?
- I have emailed Shelley about the marketing issues

Ammy
-

LHC GROUP

Ammy Lee

Division Vice President Home Based Operations
[redacted]
Lafayette, LA 70503
[redacted]
Fax: [redacted]
Cell: [redacted]
[redacted]

From: Jeannie Duckett
Sent: Wednesday, December 02, 2009 12:15 PM
To: Ammy Lee
Subject: RE: Weekly report for 12-1-09

I guess that would be helpful, sorry.

Jeannie Duckett, RN
DON/Branch Manager, LHC Group
Medical Centers Home Care
[redacted] Guntersville, AL 35976
Office: [redacted] Fax: [redacted] Cell: [redacted]
[redacted]

"In the Middle of Difficulty lies Opportunity"
Albert Einstein

From: Ammy Lee
Sent: Wednesday, December 02, 2009 12:13 PM
To: Jeannie Duckett
Subject: RE: Weekly report for 12-1-09

Attachment?

Ammy Lee
Division Vice President Home Based Operations
[redacted]

Lafayette, LA 70503
[redacted]
Fax [redacted]
Cell [redacted]
[redacted]

From: Jeannie Duckett
Sent: Wednesday, December 02, 2009 11:44 AM
To: Ammy Lee
Subject: Weekly report for 12-1-09

Please critique me on this if it is not the information you need/asked for or too much. I do like the format though, easier to interpret.

Thanks

Jeannie Duckett, RN
DON/Branch Manager, LHC Group
Medical Centers Home Care
[redacted] Guntersville, AL 35976
Office: [redacted] Fax: [redacted] Cell: [redacted]
[redacted]

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Albert Einstein

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Footnote 90

Request #1: For each calendar year from 2006 through 2009, provide data showing the distribution in one therapy visit intervals from 1 to 30 of therapy visits for therapy episodes (episodes which include at least one therapy visit) by both number and percentage. The information is for Medicare episodes only.

Medicare Episodes by number	Number of Episodes				Percent of Episodes with Therapy				Percent of Total Episodes			
of Therapy Visits	2006	2007	2008	2009	2006	2007	2008	2009	2006	2007	2008	2009
0	7,869	13,459	21,204	30,267					40.5%	41.9%	42.1%	41.4%
1	846	1,332	2,136	3,130	7.3%	7.1%	7.3%	7.3%	4.4%	4.1%	4.2%	4.3%
2	598	865	1,199	1,861	5.2%	4.6%	4.1%	4.3%	3.1%	2.7%	2.4%	2.5%
3	529	713	1,080	1,615	4.6%	3.8%	3.7%	3.8%	2.7%	2.2%	2.1%	2.2%
4	573	828	1,195	1,648	5.0%	4.4%	4.1%	3.9%	3.0%	2.6%	2.4%	2.3%
5	656	929	1,262	1,674	5.7%	5.0%	4.3%	3.9%	3.4%	2.9%	2.5%	2.3%
6	642	838	1,759	2,358	5.6%	4.5%	6.0%	5.5%	3.3%	2.6%	3.5%	3.2%
7	494	686	1,885	2,730	4.3%	3.7%	6.5%	6.4%	2.5%	2.1%	3.7%	3.7%
8	466	566	1,569	2,305	4.0%	3.0%	5.4%	5.4%	2.4%	1.8%	3.1%	3.2%
9	432	589	1,320	1,991	3.7%	3.2%	4.5%	4.7%	2.2%	1.8%	2.6%	2.7%
10	970	1,754	1,514	1,887	8.4%	9.4%	5.2%	4.4%	5.0%	5.5%	3.0%	2.6%
11	875	1,586	1,364	1,738	7.6%	8.5%	4.7%	4.1%	4.5%	4.9%	2.7%	2.4%
12	758	1,614	1,442	1,785	6.6%	8.7%	4.9%	4.2%	3.9%	5.0%	2.9%	2.4%
13	598	1,070	1,311	1,840	5.2%	5.7%	4.5%	4.3%	3.1%	3.3%	2.6%	2.5%
14	521	864	1,773	2,815	4.5%	4.6%	6.1%	6.6%	2.7%	2.7%	3.5%	3.9%
15	378	680	1,335	1,859	3.3%	3.6%	4.6%	4.3%	1.9%	2.1%	2.6%	2.5%
16	368	616	1,139	1,574	3.2%	3.3%	3.9%	3.7%	1.9%	1.9%	2.3%	2.2%
17	336	581	897	1,387	2.9%	3.1%	3.1%	3.2%	1.7%	1.8%	1.8%	1.9%
18	255	452	725	1,108	2.2%	2.4%	2.5%	2.6%	1.3%	1.4%	1.4%	1.5%
19	201	379	540	803	1.7%	2.0%	1.9%	1.9%	1.0%	1.2%	1.1%	1.1%
20	166	283	710	1,043	1.4%	1.5%	2.4%	2.4%	0.9%	0.9%	1.4%	1.4%
21	164	244	521	849	1.4%	1.3%	1.8%	2.0%	0.8%	0.8%	1.0%	1.2%
22	115	180	413	718	1.0%	1.0%	1.4%	1.7%	0.6%	0.6%	0.8%	1.0%
23	99	187	338	602	0.9%	1.0%	1.2%	1.4%	0.5%	0.6%	0.7%	0.8%
24	77	168	330	554	0.7%	0.9%	1.1%	1.3%	0.4%	0.5%	0.7%	0.8%
25	76	121	274	477	0.7%	0.6%	0.9%	1.1%	0.4%	0.4%	0.5%	0.7%
26	58	95	205	365	0.5%	0.5%	0.7%	0.9%	0.3%	0.3%	0.4%	0.5%
27	41	74	142	312	0.4%	0.4%	0.5%	0.7%	0.2%	0.2%	0.3%	0.4%
28	42	67	128	274	0.4%	0.4%	0.4%	0.6%	0.2%	0.2%	0.3%	0.4%
29	70	76	187	437	0.6%	0.4%	0.6%	1.0%	0.4%	0.2%	0.4%	0.6%
30 or more	139	216	486	1,058	1.2%	1.2%	1.7%	2.5%	0.7%	0.7%	1.0%	1.4%
Total	19,412	32,112	50,383	73,064	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Excluding Zero Therapy Episodes	11,543	18,653	29,179	42,797								
Episodes By Range of Therapy Visits	2006	2007	2008	2009	2006	2007	2008	2009	2006	2007	2008	2009
0	7,869	13,459	21,204	30,267					40.5%	41.9%	42.1%	41.4%
1-5	3,202	4,667	6,872	9,928	27.7%	25.0%	23.6%	23.2%	16.5%	14.5%	13.6%	13.6%
6-9	2,034	2,679	6,533	9,384	17.6%	14.4%	22.4%	21.9%	10.5%	8.3%	13.0%	12.8%
10-13	3,201	6,024	5,631	7,250	27.7%	32.3%	19.3%	16.9%	16.5%	18.8%	11.2%	9.9%
14-19	2,059	3,572	6,409	9,546	17.8%	19.1%	22.0%	22.3%	10.6%	11.1%	12.7%	13.1%
20+	1,047	1,711	3,734	6,689	9.1%	9.2%	12.8%	15.6%	5.4%	5.3%	7.4%	9.2%
	19,412	32,112	50,383	73,064	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Episodes with 0-5 therapy visits	11,071	18,126	28,076	40,195	27.7%	25.0%	23.6%	23.2%	57.0%	56.4%	55.7%	55.0%
Episodes at 10 or more Therapy Visits	6,307	11,307	15,774	23,485	54.6%	60.6%	54.1%	54.9%	32.5%	35.2%	31.3%	32.1%
Episodes with Therapy Visits at Exact Thresholds												
6	642	838	1,759	2,358	5.6%	4.5%	6.0%	5.5%	3.3%	2.6%	3.5%	3.2%
10	970	1,754	1,514	1,887	8.4%	9.4%	5.2%	4.4%	5.0%	5.5%	3.0%	2.6%
14	521	864	1,773	2,815	4.5%	4.6%	6.1%	6.6%	2.7%	2.7%	3.5%	3.9%
20	166	283	710	1,043	1.4%	1.5%	2.4%	2.4%	0.9%	0.9%	1.4%	1.4%
	2,299	3,739	5,756	8,103	19.9%	20.0%	19.7%	18.9%	11.8%	11.6%	11.4%	11.1%
Episodes NOT at a Therapy Threshold	17,113	28,373	44,627	64,961	80.1%	80.0%	80.3%	81.1%	88.2%	88.4%	88.6%	88.9%

In order to provide a comprehensive look at the patients we are treating, the table above also includes information on those patients who did not receive any therapy. Note that 88% of our episodes were not at a therapy payment threshold while 80% of our therapy episodes were not at a payment threshold, while well over 50% of our episodes generate no incremental therapy reimbursement in all four years.

Request #2: For each calendar year from 2006 through 2009, provide data showing the average score at admission for Medicare patients that received therapy visits for each one of the following activities of daily living as reported in the Outcomes and Assessment Information Set (OASIS): (a) Walking/Ambulation; (b) Hygiene; (c) Continence; (d) Dressing; (e) Eating; (f) Toileting; and (g) Transferring.

In order to provide a comprehensive look at our patients, we have included information related to their OASIS scores upon discharge so that you can see their improvement during the course of treatment.

	Average Scores on Admission				Average Scores on Discharge				Percent Improvement			
OASIS Question	2006	2007	2008	2009	2006	2007	2008	2009	2006	2007	2008	2009
M0700 Average (Walking)	1.433	1.476	1.506	1.543	1.021	1.048	1.063	1.076	29%	29%	29%	30%
M0640 Average (Hygiene)	0.866	0.902	0.994	1.062	0.348	0.351	0.398	0.427	60%	61%	60%	60%
M0670 Average (Hygiene)	2.610	2.622	2.628	2.636	1.524	1.550	1.639	1.644	42%	41%	38%	38%
M0520 Average (Continence)	0.425	0.521	0.559	0.559	0.229	0.315	0.403	0.409	46%	40%	28%	27%
M0540 Average (Continence)	0.272	0.316	0.343	0.330	0.155	0.181	0.196	0.202	43%	43%	43%	39%
M0650 Average (Dressing)	1.085	1.135	1.207	1.262	0.464	0.500	0.585	0.624	57%	56%	52%	51%
M0660 Average (Dressing)	1.507	1.510	1.576	1.617	0.645	0.687	0.774	0.807	57%	54%	51%	50%
M0710 Average (Eating)	0.406	0.452	0.480	0.505	0.181	0.199	0.213	0.216	55%	56%	56%	57%
M0720 Average (Eating)	1.090	1.130	1.146	1.160	0.486	0.519	0.557	0.561	55%	54%	51%	52%
M0680 Average (Toileting)	0.641	0.694	0.730	0.740	0.270	0.312	0.364	0.365	58%	55%	50%	51%
M0690 Average (Transferring)	1.102	1.131	1.142	1.160	0.551	0.621	0.701	0.718	50%	45%	39%	38%

Higher scores indicate higher patient needs. Lower average scores on discharge mean our patients' conditions improved. The percent improvement is calculated as the difference in the average score from admission to discharge divided by the average score on admission.

Note that our patients show significant improvement in all categories and across all years.

Footnote 91

Request #3: For each calendar year from 2006 through 2009, provide:

a. The total number of Medicare home health patients that received therapy visits from your company for that year;
b. The total amount of Medicare reimbursement your company received for home health episodes that qualified for additional payments because of therapy visits provided; and
c. The total amount of Medicare reimbursement your company received

	2006	2007	2008	2009
PATIENTS RECEIVING THERAPY				
Patients Receiving Care	10,004	15,610	22,534	30,249
Reimbursement:				
Base episodic amount	23,219,069	39,565,828	57,239,602	84,477,825
Incremental reimbursement for therapy	13,012,711	24,133,838	50,653,770	81,011,884
Total Reimbursement	36,231,780	63,699,666	107,893,372	165,489,710
ALL PATIENTS				
Patients Receiving Care	15,022	23,968	32,615	41,596
Reimbursement:				
Base episodic amount	35,193,944	62,005,129	93,748,106	136,999,698
Incremental reimbursement for therapy	13,012,711	24,133,838	50,653,770	81,011,884
Total Reimbursement	48,206,655	86,138,967	144,401,877	218,011,583

Incremental reimbursement for therapy is calculated on an episode by episode basis as the amount of additional reimbursement over the base episodic payment that the Company receives as specific reimbursement for therapy visit thresholds.

Note that for the inquiry period incremental reimbursement for therapy ranged from 27% to 37% of the Company's total Medicare reimbursement and reimbursement not related to therapy ranged from 53% to 63%.

Footnote 98

[redacted]

From: keith myers
Sent: Friday, May 29, 2009 11:32
To: 'William Simione Jr.'; Bill Borne [redacted]; Steve Guenthner; WilliamYarmuth[redacted]; williamyarmuth[redacted]; Val Halamandaris ; Bill Dombi; Jeffrey Kincheloe; Colin Roskey ([redacted]; Baiada, Mark; Chris MacInnis; Tony Strange; 'Malone, Ron'; Amanda Twiss
Subject: OCS - HHRG Margins by Therapy Utilization

Please find the attached data from OCS (National HHRG Analysis)

I've summarized the data by therapy bucket for our discussions. I think we can safely say that higher therapy utilization results in higher absolute margins and higher margins as a percentage of revenue under the current case mix weights.

Yesterday I had the opportunity to meet with a group of physicians who were voicing some of the same concerns we have about Medicare cuts.
Within physician reimbursement, they felt strongly that across the board cuts were not the answer. They pointed out to me that the highest Medicare physician fee schedule margins were in orthopedic cases, specifically total knees and total hips. They argued that across the board cuts would put many primary care physicians and other specialist at low to no margins, while ortho's performing total knees and total hips would still have attractive margins. This was the first time I had heard this from a physicians perspective. I have not verified this independently, but if it's the case, it seems that the current reimbursement methodology on the physician side has the same disproportionate margin distribution.

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No. Therapy Visits	Avg. Reim.	Avg. Cost	Avg. Margin Per Episode	Avg. % Margin Per Episode
0-5	$ 1,900	$ 1,521	$378.53	19.93%
6	$ 2,617	$ 2,084	$532.31	20.34%
7-9	$ 3,057	$ 2,377	$680.67	22.26%
10	$ 3,493	$ 2,671	$821.41	23.52%
11-13	$ 3,831	$ 2,944	$886.35	23.14%
14-15	$ 4,418	$ 3,183	$1,234.22	27.94%
16-17	$ 4,725	$ 3,424	$1,301.50	27.54%
18-19	$ 5,091	$ 3,767	$1,324.02	26.01%
20+	$ 6,540	$ 4,648	$1,892.47	28.94%

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