2013 NAHC Annual Meeting

2014 A Watershed Year! What Does it Hold for You?

Presented by: Lynda Laff, Pat Laff

How Did We Get Here?

- Escalating health care costs – all sectors of the delivery system
- CMS identified home care “behavioral changes” to influence payment
- Practice variation among providers
- Potentially avoidable events did not decrease
- Slow outcomes improvement
- Continued re-hospitalization
2014 CMS HHPPS Proposed Rule

- HHPPS “overvalues therapy and undervalues non therapy services”
- Re-basing will re-set payment rates to = an average case weight of 1.00
- Revision of payment rates designed to “discourage overutilization of therapy”

2014 CMS HHPPS Proposed Rule

- Removal of 170 Diagnosis codes
  - Acute care codes
    - Codes with initial encounter extensions
    - Codes that require no intervention from HH
    - Codes with no impact on HH care plan
    - Codes requiring no additional resource utilization from HH
    - Non specific codes – clinician should have been able to identify more specific code based on assessment
2014 CMS HHPPS Proposed Rule

- Implementation of ICD-10 October 1, 2014
- Must comply with coding conventions
- Cannot use several dementia codes as primary diagnosis
- Coding errors will be returned to provider beginning October 1, 2014
- Will no longer report diagnosis payment codes

2014 Value Based Purchasing

- Elimination of stratification of process measures
- Reduces process measure reporting from 45 to 27 measures
- Continued requirement for reporting for 2% APU
  - Patient outcomes measures
  - Process measures
  - HHCAHPS
2014 PPS Proposed Rule

- Adoption of re-hospitalization measures measuring only patients with hospitalization within 5 days prior to HH admission - 2015
  - Re-hospitalization during first 30 days of home care after a hospital stay
  - Emergency department use without hospital admission within first 30 days of home care

Circle Your Wagons.... and Manage Smarter

- Manage costs
  - Know what it costs to provide services — by discipline
  - Knowledgeable financial accounting
- Pay for what your clinicians do- not how long it takes them to do it!!!
  - Must have experienced clinical management and oversight processes in place
  - Per visit case management incentive compensation
  - No one will turn down admissions.....
Manage Smarter

- Manage clinical operations
  - Right people in right positions
  - Manage utilization of resources with one-on-one case conferencing
  - Does not mean automatic staff and resource cuts!!!
  - Adequate clinical oversight of care delivery
    - Patient Care is what you provide and get paid for - do it right!
    - Validate care appropriateness with one-on-one case conferences - Ask the RIGHT QUESTIONS

Manage Smarter

- Create appropriate efficiencies
- Right number and type of employees
- Prevent redundancy and unnecessary hand-offs
  - Duplication of data entry?
  - Multiple reviews by multiple staff?
- Promote standardization for entire agency
  - Number of patients managed by case managers
  - Productivity expectations
  - Documentation submission timelines
  - Best practice protocols
  - Requirements for OASIS corrections – same for every clinician
Is Profitability Possible?

- Implement and integrate Tele-health
  - ↑ focus on preventing re-hospitalization and emergent care
  - ↑ focus on timely intervention and preventing Potentially Avoidable Events
  - ↑ efficiency by increasing case capacity of case managers
  - ↓ unnecessary visit utilization

Is Profitability Possible?

- Review payer mix
  - % of Medicare
  - % Managed Medicare
  - % Insurance
    - Episodic versus reduced contracted rates
- Define your referral “triage” strategy
  - All referrals are not created equal
  - Criteria for admission – are they a “mission” or part of a “strategy”?
- Review contract rates
  - More of a loss – is... just...more loss!
Realistic Expectations

- Number of visits per day is dependent upon your clinical model;
  - Do your field nurses case manage a census of patients’
  - If so – is the number consistent among your staff?
  - Do you have admission nurses?
  - Do you use a point of care documentation system?
  - How many miles does a clinician average per day/week?
  - How are they compensated?
  - How often are patient care plans actually discussed in a case conference’?

Evaluate Your Agency

- Review work processes
  - Objective review from intake to submission of RAP & EOE
    - Review how patients are referred, accepted, assigned and admitted
  - OASIS review process
    - Who reviews the OASIS?
    - Is that a primary function?
    - Is that individual qualified? - is there an RN COS-C in the house??
    - Do you have a coder(s)?
    - Manual review or Data Scrubber?
Evaluate Your Agency

- Corrections versus consequence....How are OASIS errors corrected?
  - Stop supervisory “fixing”
  - Teach, re-teach then....
  - Eliminate “warm body syndrome”
  - Eliminate poor performers
- What is the process for insuring the F2F is adequate?
- What is the process for order tracking and bill submission?

Focus on “Bottlenecks”- they are Sx

- Scheduling.....is it the IT system???
- Documentation submission timeliness
- MD signatures for POC & interim orders

Review Data

- What data do you review routinely?
  - Number of ACTIVE patients on your census list
  - “Clean” census list
  - All discharges removed at least weekly
  - Identify why “old” patients remain – someone is not “managing” well...
  - Expectations for staff productivity
  - Visits per day, per week
Key Indicators

- Productivity by discipline
  - Actual # of patients visited (not weighted)
- Cases/patients (not visits) managed per Clinician
  - Goal of 20 – 25 (without telehealth)
  - Goal of 25–30 (with telehealth)
- Number of OASIS Errors by Clinician
  - You cannot afford repeated errors!
    - Reinforce correction process – if you fix it – no one benefits

What Does Your Data Say About You?

- Check for “symptoms” of inefficiency and inadequate clinical management -
  - High average SN utilization or...
  - Very low average SN utilization
  - ↑ referrals not admitted
    - Inadequate staffing
    - Admission nurses
  - Patients not receiving timely and/or necessary visits?
    - Low score on timely initiation of care (HHC)
    - SN visits averaging < 6 per patient per episode (without adequate tele-monitoring and/or telephony?)
    - ↓ Patient satisfaction scores
    - ↑ re-hospitalizations, patient declines, poor outcomes
    - ↑ LUPA rate
What Does Your Data Say About You?

- PT visits averaging > 4 per patient per episode?
  - Watch for therapy “Red Flags” - high therapy utilization, therapy “clusters”
  - PT visits averaging <3 per patient episode + ↑LUPA rate?
  - PTs may be “managing” schedules - not patient care

You May Be At Risk If....

- Agency evaluation indicates -
  - ↑OASIS item inconsistencies/errors continue over time
  - Large variance in SOC/EOE
    - Check process for collaboration between SN and therapists
  - DX Coding errors
    - Dx listed but not addressed in POC
  - Very low average EOE case weight - 1.100
  - High LUPA rate – over 12%
    - Check marketing incentives....are you receiving the RIGHT referrals?
    - Are PT “managing” their schedules instead of patient care needs?
You May Be At Risk If....

- Agency evaluation indicates – (Medicare)
  - Higher than average therapy utilization
  - LOS average ↑60 days / multiple re-certifications
    - Are your patients really “sicker”?
    - Multiple re-certifications per patient with “rotating primary DX”
  - Skilled service provided to large % of patients is “Observation & Assessment”
  - LOS average less than 35 days and re-hospitalization rate > state & national averages.

Benchmarks

- Productivity expectations -
  - SN - Minimum average of 5 actual visits per day – 6 – 6.25 weighted visits
  - PT – Minimum average of 6 actual visits per day – 6.5 – 7 weighted visits
  - Supervisor/Manager – 1 per 8-10 FTEs (depends on function)
  - OASIS Reviewer (not Dx coder!) – w/data manager - 75 - 85 patients
  - Dx Coding Specialist – 20 – 25 admissions per day (with scrubber – coding alerts)
Benchmarks

- Case Weight
  - Case weight variance – SOC to EOE average variance not more than 2-3%
  - EOE case weight - (NOT SOC) is the case weight to “hang your hat on”
- % of re-certifications and LOS
  - National average LOS = 43 – 48 days
  - Worry if you have a LOS over 60 days!
  - Worry if you have LOS under 35 days!
- Visit Utilization Averages
  - Ratio nursing/therapy - shoot for 5-7 SN vs. 3-4 therapy
  - Worry if your SN average is less than 5 over 9
  - Worry if your therapy average (all patients) is less than 3 or over 4

Benchmarks

- Average visits per episode
  - Worry if average total visits per episode is over 17
  - Be aware that it must be improved if average IS 17
- Actual Revenue versus Anticipated Revenues
  - Downcodes
  - Actual revenue = EOE
- Timeliness of RAP Submission
  - Set a standard of 7-10 days
- % of Therapy Visits per Threshold
  - Look for therapy threshold “clusters” (will likely disappear in 2014)
Strategies to Diversify Revenue

- Clinical Care Transitions Coordinator position to triage referrals/admissions
  - Work with intake and clinical managers
  - Organize by payer, type of service and date for admission

- More and different types of patients referred due to VBP
  - ↑ Hospital recidivists
    - Watch for known non-compliance
    - Lack of necessary resources in the home
    - Psychiatrically impaired patients

Diversify Revenue

- Create a Care Transitions Program for Pure transitions patients – not Medicare eligible
  - May not be homebound
  - May not have Medicare benefits
  - May not meet Medicare qualifying criteria
  - Always validate the criteria before enrollment!

- Create a separate “transitions” service/program within your organization
  - Must have a written agreement with hospital or Accountable Care Organization (ACO)
  - Include written purpose and scope of transitions program
  - Define specific responsibilities of both the hospital or ACO and the agency
Transitions in Care

- Identify patient enrollment exclusions:
  - Strong history of non-compliance with meds, diet and physician appointments
  - Evidence of unsafe/inadequate home environment – patient not safe at home

- Attending physician must agree to manage the patient care with shared goals:
  - To maintain and improve patients health
  - To prevent unnecessary re-hospitalizations and emergency room visits
  - To provide patient education and support/mentoring regarding symptom and medication management
  - To promote compliance with appropriate disease management principles
  - Teach self care and independence to patients and families/caregivers

Transitions in Care

- Clarify basic requirements of participation in the transitions program
  - Physician participation and buy-in
    - MD orders required
  - Clients must be willing and able to participate
  - Specify inclusion of Tele-monitoring or Telephone contact
  - Frequency and type of contact – focus of care is “contact” not in-home visit
    - Specify (few) circumstances that may require in-home visit
    - Patient/client education materials/teaching/follow-up

- Agreement must specify that the program is for a minimum patient service period of 35 days from hospital discharge at no charge to the patient
Care Transitions
Nursing Assessment Visit

- Non-OASIS clinical assessment RN visit
  - Complete necessary intake and clinical assessment information to manage (and monitor) the patient
  - Identify social service needs and safety issues that may require a PT, OT or Social Work evaluation
  - Reconcile Medications
  - Schedule a physician follow-up appointment if not already scheduled
  - Verify vital sign parameters and when to notify physician
  - Review disease management education with patient/client
  - Reaffirm willingness of patient/client to participate in program

Remote Monitoring

- Tele-monitoring
  - Monitor vital signs via tele-monitoring system
    - Establish routine telephone contact with patient and attending physician
    - Establish physician vital sign parameters
    - **Follow-up visit(s) not anticipated** unless specifically ordered by attending physician and included in written contract

- Telephony
  - Establish routine telephone contact with patient/client
  - Establish appropriate frequency for contacts
  - Set goals for each call
  - May include teaching patient to take, record and report vital signs daily
  - Identification of other signs or symptoms indicating a potential problem
  - Review medications, response and potential side effects
  - **Follow-up visit(s) not anticipated** unless specifically ordered by attending physician and included in written contract
Proposed HHPPS 2014 and Beyond

- A comparison of the estimated base rates for 2013 and 2014 before the rebasing recalibration of 26.02%, the reduction appears to be 3.49%
  - Plan on the Reduction
  - Being close to 3.49%
  - Don’t Forget the 2% Sequestration
- Additional 3.5% reductions for the following 3 years
- The rates are subject to upward change based upon 2012 MCR data as it is accumulated and analyzed
Proposed
HHPPS 2014 and Beyond

- NAHC analysis of filed Medicare Cost Reports with the highest margins revealed:
  - They didn’t have the case weights or revenue per episode!
  - They were organizations with lower costs per episode because they had lower direct and total costs per visit by discipline!
  - They were organizations with NRS revenues in line with their costs!

Where do you stand?

Achieving
Positive Financial Outcomes

Let’s talk about controlling costs....

- Direct Cost per Visit by Discipline
  - Compensation methodology and incentives
  - Productivity and efficiency of staff
  - Case Capacity
  - Outcome achievement
- Consider a Weekender Program!
- Appropriate utilization of services and supplies
  - Frequencies and durations
  - Provision of supplies
- Clinical oversight
Achieving Positive Financial Outcomes

- **Gross profit issues – Control the Direct Cost/Visit & NRS**
  - Direct Costs are the majority of agency’s total operating expenses
  - The majority of the direct cost/visit is compensation and related taxes (staff and direct supervision)
  - The cost/visit of premium-based fringes is directly proportional to visits made
  - The cost of mileage/auto reimbursement is directly related to geographically sequential patient scheduling, the size of the territory and a global vision of the entire week
  - An agency specific formulary and trunk supply protocol, electronic ordering with independent oversight and patient specific direct delivery reduces costs and increases productivity

Achieving Positive Financial Outcomes

- **Gross profit issues – Revenue and Productivity**
  - Admitting clinicians coding OASIS is a false economy
    - Severe productivity - one follow-up visit for each admission
    - Challenges coding conventions, proper sequencing and case weight values, reducing Episode and NRS revenue
  - Resolution of OASES inconsistencies for all admissions and discharges identified by scrubber software before submission
    - Identified by quality staff, but resolved by primary care case manager
  - Use of Part-time staff can also be a false economy
Weekender Program

- Begins Friday at noon..ends Monday at noon
  - Friday admissions – patients with weekend follow-up visits
  - Monday morning conference call with weekday RNs
- Converts Agency from 5 days/ week plus weekends to 7 days/week
- Frequencies spread over 7 days, not just 5 days
- Do all weekend visits
- Takes weekend on-call
- Eliminates weekday staff weekend rotation and compensatory time

Weekender Program

- Shares case management responsibilities with weekday RN – patients with weekend frequencies
- Weekend differentials apply
- Considered full-time for Fringe Benefits
Achieving Positive Financial Outcomes

Who owns the patient?

- Using a combination of Admission and Visit RNs/LPNs challenges both good clinical and financial outcomes
  - Lacks care consistency and continuity
  - Limited, if any, patient care oversight
  - Cause of patient dissatisfaction

- Primary Care Case Management achieves the desired patient care outcome goals and is the best approach towards best financial outcomes
  - Integrates with an incentive compensation for both the field clinician and their immediate supervisor!

Achieving Positive Financial Outcomes

- Align Clinical and Case Conference Models with Compensation!
- Incentive Compensation...
  - Determines ownership of the patient, resource utilization and care oversight and outcomes achieved
  - Matches clinician responsibilities and achievements
    - Not based upon the length of time or just a fixed salary to accomplish their patient needs
  - Reinforces consistency and continuity of patient care
  - Reduces the direct cost of care for those disciplines
Achieving Positive Financial Outcomes

Key Ingredients!

- Effective Clinical Management (Supervisory) staff
- Primary Case Management
- Case Conference Model – Controls visit utilization
  - Every Patient...Every 14 days from SOC date!
  - Reviews prior 14 days utilization and outcome achievement
  - Plans next 14 days utilization and outcome goals
- Tools for efficiency
  - Laptops with power cords to car power source and air-cards
  - Smart cell phones
  - Patient specific electronic ordering and delivery of NRS

Achieving Positive Financial Outcomes

Primary Care Case Managers are responsible for the:

- Case Management of their patients
- Primary visits, including admission, resumptions and recerts, most follow-ups and the discharge.
- Achieve the desired patient outcomes and HH-CAHPs results
- Self scheduling!
  - Places responsibility where it belongs
  - Provides for more autonomy and control of clinician’s day...
  - Eliminates the cost of schedulers
Incentive Based Compensation

- Compensates the staff for what they do, not for how long it takes them!
- Rewards efficiency, productivity, capacity and clinical (HH-CAHP) outcomes achievement
- Improves team chemistry...Under-performing encouraged staff to improve or seek a successful career elsewhere
- Assures that clinicians meet or exceed individual productivity and case capacity goals
- Applies to Weekender staff

IT WORKS!

Incentive Based Compensation

- Can apply to all disciplines, depending upon patient census and discipline demand
- Exempt status does not apply to LPNs, PTAs, COTAs and HHAs (FLSA)
- Most effective for RNs, PTs and OTs
  - Supervisory responsibility
  - Visits are Unique
  - No portion of compensation is based on time (Hourly)
Visit Weights

- Visit weighting – Based the Requirements and Complexities of completing OASIS C
  - Admission (evaluation) Visit 1.90
  - Non-OASIS Evaluation Visit - mainly therapy 1.60
  - Resumption Visit 1.30
  - Recertification Visit 1.20
  - Discharge Visit 1.25
  - Follow-up Visit 1.00
  - Virtual Telephone Visit (Telehealth) 0.25

Questions Often Asked
(Visit Weight – Time Equivalents Based upon OASIS C)

<table>
<thead>
<tr>
<th>Visits /Day</th>
<th>Follow-up Value</th>
<th>Admission Value</th>
<th>Resumption Value</th>
<th>Recert. Value</th>
<th>Discharge Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.00</td>
<td>1.00 1hr 36min</td>
<td>1.90 182.4min</td>
<td>1.30 124.8min</td>
<td>1.20 115.2min</td>
<td>1.25 120.0min</td>
</tr>
<tr>
<td>5.25</td>
<td>1.00 1hr 31min</td>
<td>1.90 173.7min</td>
<td>1.30 118.9min</td>
<td>1.20 109.7min</td>
<td>1.25 114.3min</td>
</tr>
<tr>
<td>5.50</td>
<td>1.00 1hr 27min</td>
<td>1.90 165.8min</td>
<td>1.30 113.5min</td>
<td>1.20 104.7min</td>
<td>1.25 109.9min</td>
</tr>
<tr>
<td>5.75</td>
<td>1.00 1hr 23min</td>
<td>1.90 158.6min</td>
<td>1.30 108.5min</td>
<td>1.20 100.2min</td>
<td>1.25 104.4min</td>
</tr>
<tr>
<td>6.00</td>
<td>1.00 1hr 20min</td>
<td>1.90 152.0min</td>
<td>1.30 104.0min</td>
<td>1.20 96.0min</td>
<td>1.25 100.0min</td>
</tr>
</tbody>
</table>

Includes hands-on, documentation, travel, conference and case management time.
Incentive Based Compensation

- Bonus structure for Primary Care Case Managers
  - Calendar quarter or 12 week period (based upon payroll periods)
    - Accumulated Visit Weights = $ per hands-on visit for every visit
    - Total Cases Managed = % of earnings for the measured period
    - Outcomes Achieved = % of earnings for the measured period
- Bonus structure for their immediate “supervisors”
  - Same as above, plus
  - Other to address problem areas, such as
    - OASIS error rates
    - Timeliness of corrections, etc.
    - Time to RAP and EOE billing

Benefits of Incentive Compensation

- Unproductive nurses left and some didn’t have to be replaced
- New nurses oriented and trained under new program
- Improved team chemistry and morale
- Improved communication with nurses and supervisor
- Documentation is timely and better quality
- Telehealth is being used more consistently and the telephone follow up visits are visit weighted
- Improved ER and Hospital outcomes
Incentive Compensation Results

- Clinician visit productivity and case capacity increased
- Timeliness of documentation improved. For the first time anyone can remember, all nurses notes were completed within 24 hours.
- MD verbal orders and recertifications were completed on time
- Visit frequency orders were accurate
- Nurses made more visits per day and made more money
- Monitors were in patient homes and no longer on the shelves
- Individual compensation levels increased significantly

Incentive Compensation Results

- Clinicians did not complain!
- Comments:
  - “I’m really working hard”
  - “It’s difficult to get your paperwork done with this many patients, but, I’m not complaining”
  - Supervisor states nurses are content
  - No problem getting nurses to see patients on weekends!!!
  - No push back when given a new admission in their territory!
Incentive Compensation
The Results

- Direct and Total Costs per Visit substantially reduced!
- Visits per episode were effectively reduced
- Incentive compensation increased efficiency throughout the entire organization
- Quality of patient care was positively impacted
- Accounting department is able to bill timely
- Clinical staff are rewarded for their work
- Communication with clinical managers improved
- Telehealth being utilized to its fullest capabilities

Effective Episode Management

- Reduces episode cost, increases efficiency and communication, and improves clinical and financial outcomes
- Integrates:
  - Clinical Supervisory Management and Oversight
  - Primary Care Case Management
  - Goals and Performance
- Can enhance compensation and reward excellent performance
“Transitions in Care”
Price Point Development

- Visit Pricing to be developed:
  - Skilled Nursing – evaluation and follow up
  - Occupational Therapy
  - Social Work
  - Telehealth

**Calculation of cost of an evaluation and follow up nursing visit:**

Direct cost per RN visit averages $68.37 per visit overall.
Total visits were 8,157. Total direct costs were $557,723.

Here is how to isolate the cost per type of RN visit:

<table>
<thead>
<tr>
<th>Type</th>
<th>Visits</th>
<th>Ind. Visit Weight</th>
<th>Total Visit Weight</th>
<th>Follow-up</th>
<th>Direct Cost</th>
<th>Cost Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>783</td>
<td>1.90</td>
<td>1,487.70</td>
<td></td>
<td>91,110</td>
<td>$116.36</td>
</tr>
<tr>
<td>Discharges</td>
<td>500</td>
<td>1.25</td>
<td>625.00</td>
<td></td>
<td>38,277</td>
<td>$ 76.55</td>
</tr>
<tr>
<td>Recerts</td>
<td>404</td>
<td>1.20</td>
<td>484.80</td>
<td></td>
<td>29,690</td>
<td>$ 73.49</td>
</tr>
<tr>
<td>Resumption</td>
<td>131</td>
<td>1.30</td>
<td>170.30</td>
<td></td>
<td>10,430</td>
<td>$ 79.62</td>
</tr>
<tr>
<td>Follow up</td>
<td>6,339</td>
<td>1.00</td>
<td>6,339.00</td>
<td>61.24*</td>
<td>388,216</td>
<td>$ 61.24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9,106.80</td>
<td>557,723</td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>1.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$ 97.98</td>
</tr>
<tr>
<td>Telephone</td>
<td>0.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$ 15.31</td>
</tr>
</tbody>
</table>

Using 20% mark-up of the direct cost per visit to a 20% contribution margin for overhead, the visit prices would be:

- Evaluation: $117.58 up to $118.00
- Follow-up: $73.49 up to $74.00
- Telephone Visit: $18.37 up to $18.50
“Transitions in Care”
Price Point Development

Calculation of cost of an evaluation and follow up OT visit:
Direct cost per OT visit averages $92.64 per visit overall.
Total visits were 889. Total direct costs were $83,287.
Here is how to isolate the cost per type of RN visit:

<table>
<thead>
<tr>
<th>Type</th>
<th>Visits</th>
<th>Ind Visit Weight</th>
<th>Total Visit Weight</th>
<th>Ind Cost</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluations</td>
<td>201</td>
<td>1.60</td>
<td>321.60</td>
<td>$26,532</td>
<td>$132.00</td>
</tr>
<tr>
<td>Follow up</td>
<td>688</td>
<td>1.00</td>
<td>688.00</td>
<td>82.50*</td>
<td>56,755</td>
</tr>
<tr>
<td></td>
<td>889</td>
<td>1.00</td>
<td>1,009.60</td>
<td></td>
<td>$83,287</td>
</tr>
</tbody>
</table>

Using 20% mark-up of the direct cost per visit to a 20% contribution margin for overhead, the visit prices would be:
- Evaluation: $154.80 up to $155.00
- Follow-up: $99.00 up to $99.00

“Transitions in Care”
Price Point Development

Calculation of Cost for a Social Work Visit:

- Social Worker costs are generally greatly distorted:
  - Few actual visits being made
  - Most of the cost reflects non-visit indirect time
- Need to do a cost finding on actual cost per visit:
- Agency separated direct visit cost and indirect Social Worker cost!
- Total direct costs were $2,047 and there were 32 visits.
- Direct costs were $39.37 per visit.
- Using 20% mark-up of the direct cost per visit for contribution margin towards overhead, the visit prices would be $47.24 rounded up to $48.00.
“Transitions in Care”
Price Point Development

Actual costs for Telehealth monitoring:
Annual equipment depreciation and communication fees:
62 monitors @ $ 77 per month would be $57,288.

Costs of a RN to perform Central Station functions, including telephone contacts with patients and Primary Care Case Manager RNs were $7,525.

Costs of staff to clean-up and prepare equipment for new installation were $2,508.

Total costs of $67,321 divided by average number of monitors on hand, the annual cost of was $1085.82 per monitor or $ 2.9748 per calendar day.

Applying 120% of direct cost for a gross margin contribution, the daily charge is $3.57, rounded up to $3.60 per day.

---

“Transitions in Care”
Price Point Development

Recap of per visit charges:

<table>
<thead>
<tr>
<th></th>
<th>Evaluation</th>
<th>Follow-up</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>$118.00</td>
<td>$74.00</td>
<td>$18.50</td>
</tr>
<tr>
<td>OT</td>
<td>$155.00</td>
<td>$99.00</td>
<td></td>
</tr>
<tr>
<td>MSW</td>
<td>$48.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telemonitoring- per day</td>
<td>$3.60</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Cost / Benefit to the Hospital
Variation and costs of services for 35 days:

<table>
<thead>
<tr>
<th>Patient Variation</th>
<th>RN Assessment (RN Only)</th>
<th>RN Follow-up Calls</th>
<th>Social Service Visit</th>
<th>OT Evaluation</th>
<th>Tele-health Monitoring</th>
<th>Total Cost Per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN Only</td>
<td>$118</td>
<td>$74</td>
<td></td>
<td></td>
<td>(35) $126</td>
<td>$192</td>
</tr>
<tr>
<td>Monitoring</td>
<td>$118</td>
<td>$74</td>
<td></td>
<td>(35) $126</td>
<td>$387</td>
<td></td>
</tr>
<tr>
<td>OT</td>
<td>$118</td>
<td>$74</td>
<td>$155</td>
<td>(35) $126</td>
<td>$473</td>
<td></td>
</tr>
<tr>
<td>Soc. Work</td>
<td>$118</td>
<td>$74</td>
<td>$48</td>
<td>$155</td>
<td>(35) $126</td>
<td>$521</td>
</tr>
</tbody>
</table>

Cost / benefit to the hospital

- Large 500 bed teaching hospital in the Philadelphia metropolitan area
- Total of 4,627 Medicare Fee for Service discharges in fiscal year 2011
- 1,074 (23.21%) discharged patients referred to Homecare
- 1,079 (23.32%) discharged patients referred to other post acute settings
- 162 (3.50%) discharged patients expired
- 2,312 (49.97%) discharged patients not referred to any post acute settings!
- Hospital does not track its re-admission data!
- Hospital’s variable cost per Bed Day is $1,130 and likely a $1,950 total cost
- Hospital’s variable cost of an Emergency Room visit is $124.30 and likely a total cost of $214.31
- Hospital’s re-admission rate on Hospital Compare is above the national average for all reported measured diagnoses!
- Hospital’s H-CAHP scores are all below national averages!
Cost / benefit to the hospital

- Hospital's 2011 Medicare revenue was $101,000,000.
- If this was 2013, the Hospital’s 1% penalty risk is $1,010,000.
- The Vacated Days and ER visits are estimated:
  - Assuming an average of 3 re-hospitalized days for each patient and a 50% patient usage of an emergency room visit (actual data unknown)
  - Estimated variable cost:
    - 2,312 patients discharged x 23.07% readmission rate =
    - 533 patients x 10 re-hospitalized days = 2,665 days
    - @ $1,130 = $3,011,450
    - 50% of 2,312 patient admitted through ER @ 124.30 = $143,691
    - $3,155,141

Cost / Benefit to the Hospital

<table>
<thead>
<tr>
<th>Assumed cost of Vacated Days and ER Visit Costs</th>
<th>$ 3,155,141</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Services – 2,312 patients</td>
<td></td>
</tr>
<tr>
<td>30% RN only</td>
<td>694 @ $192 = $ 133,248</td>
</tr>
<tr>
<td>25% RN &amp; Monitoring</td>
<td>578 @ $387 = 223,866</td>
</tr>
<tr>
<td>20% RN, Monitoring and OT</td>
<td>462 @ $473 = 218,526</td>
</tr>
<tr>
<td>25% RN, Monitoring OT &amp; SS</td>
<td>578 @ $521 = 301,138</td>
</tr>
<tr>
<td></td>
<td><strong>876,778</strong></td>
</tr>
<tr>
<td>Net Savings to Hospital</td>
<td>$ 2,278,363</td>
</tr>
</tbody>
</table>
Hospital Readmission Study Within the 30-Day DRG Period

- Suburban-rural 109 bed Regional Medical Center in the Minneapolis Metro area
  - 179 Readmits (single and multiple) of Medicare Patients within the DRG Period resulted in 621 inpatient days for FY 2012
    - 12.35% re-admission rate (2,890 Medicare discharges)!
    - 3.47 average days per readmitted patient!
    - 82% (147) admitted through the Emergency Department
  - Loss of $1,543,185 @ $2,485 per Bed Day Cost
  - Loss of $28,077 @ $191 per Bed Day Cost
  - Only 37 of the Readmitted Patients were referred to Home Care and 3 were referred to Hospice
  - Tele-health was not available at the Hospital-based Home Health Agency

Hospital Readmission Study Within the 30-Day DRG Period

- External Review of Readmission DRGs
  - 139 Readmitted Patients (77.65%) should not have been referred to Home Care or Hospice
  - Could have been eligible for a “Transitions in Care” program
  - Potential savings of a significant portion of the $1,571,262 in vacated days cost!
Hospital Readmission Study
Within the 30-Day DRG Period

- Large Regional Medical Center in a Western State
- 680 Readmits (single and multiple) of Medicare Patients within the DRG Period resulted in 8,214 inpatient days for FY 2003
  - 23.53% re-admission rate (2,890 Medicare discharges)
  - 12.08 average days per readmitted patient
- Loss of $15,072,700 @ $1,835 per Bed Day Cost
  - Not including ER or any other Department Costs
- Only 80 of the Readmitted Patients had ever been Referred to Home Care
- Tele-health was not available at the Hospital-based Home Health Agency

Hospital Readmission Study
Within the 30-Day DRG Period

- External Review of Readmission DRGs
  - 231 Readmitted Patients (34%) should have been in Home Care
  - Only 34 of the Readmitted patient were referred to home care
  - Potential Savings to Hospital of 2,752 days (33.50%) @ $1,835 = $5,049,900
  - Additional Revenue to Home Care Agency = $482,650
    - Estimated 197 Episodes @ $2,450
Hospital Readmission Study
Within the 30-Day DRG Period

➢ External Review of Readmission DRGs
  ▪ 449 Readmitted Patients (66%) should not have been referred to Home Care
  ▪ Could have been eligible for a “Transitions in Care” program
  ▪ Potential savings of a significant portion of the $10,022,800 in vacated days cost!

Contact Information
Lynda Laff, RN, COS-C  Pat Laff, CPA
Laff Associates
Consultants in Home Care & Hospice
Phone: (843) 671-4170
Email: llaff@laffassociates.com
Email: plaff@laffassociates.com
Website: www.laffassociates.com