GETTING TO THE DATA THAT MATTERS:

Finding the information needed for smart management and operational changes.

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and
David J. Merk, MA

Today’s home health landscape

- Extremely challenging environment
  - Great expectations – clinical, quality, customer service and financial
  - Increased transparency
  - Frequently changing regulations
  - Mounting regulatory pressures
  - Less revenue
- Never been more important for agencies to make decisions based on firm grasp of factual data
The dilemma

- Lots and lots of data
  - Posted Home Health Compare results
  - Profit Margin benchmarking
  - Patient Satisfaction measures
  - Admission and Visit records
  - Customer relationship data
  - Assessment scrubbing results
  - And the whole rest of the Medical Record!

The Solution

- Use the power of the computer for 100% review
- Make use of data you need to gather to participate in the Medicare program
- Use the small stuff to learn about the big stuff
- Go granular
- Focus on operational trends
Monitor a variety of metrics; drill to the detail to further review

- SOCs with F1 and 6+ Visits Expected
  - 12-Month Average = 13.3% (418/3132)

- Therapy Upgrades
  - 12-Month Average = 10.9% (473/4337)

- Recerts with F1 and 6+ Therapy Visits
  - 12-Month Average = 6.3% (52/832)

- LUPA Episodes
  - 12-Month Average = 13.1% (570/4337)

What data can most easily be gathered and organized?

- Oasis – skeletal clinical picture but routinely available
- Billable Visits – who did what when and for whom - directly impacts reimbursement
- Non-billable visits – may signal breakdowns in the treatment process
- Non-visit staff time
When should data be gathered?

- The earlier, the better!
  - Gather data daily to fix episodes in progress
  - Review OASIS assessments before they are finalized for submission to the state
  - Identify “at risk” patients right after admission
  - Review episodes for compliance issues before billing

How can you get access to the data?

- Reports provided by your vendor
- Generic Report Writers like Crystal Reports
- Database programs like MS Access
- Tools designed specifically for Home Health data analysis needs
Suggestions for organizing your data.

- Compare, compare, compare
- Compare one part of your agency with another to determine where improvements are needed
- Don’t ignore the “flat” lines
- Compare your performance over time on a large number of metrics to spot slips before they get out of hand
- Compare services and results from one cohort of patients to another to make sure you are matching treatment to patient needs

Using Data Wisely

- When results or metrics are obtainable via multiple programs, identify which data source is most reliable or provides the best perspective on the data and then stick with it
- Ensure your methodology and timing are consistent when running the same metrics across time points
- When data seems questionable or doesn’t match your intuition, cross check using other methods
The Process of inquiry

- “Canned” reports have limitations:
  - Rigid timeframes
  - Prescribed data elements
- Need flexibility in massaging your data:
  - Report “answers” usually raise more questions
  - Use follow-up questions to narrow your focus and anticipate decision implications
- Need quick turnaround

Comparing with other agencies: a perspective on benchmarking

- Action-oriented benchmarking: not just a grade, but a suggestion
- Micro measures as well as macro measures
- Operational measures
- Should be measures which are also readily available for the various components of your agency
- One warning: Apt to be a large number of measures to digest, but it jump-starts your improvement process
Example of operational Benchmarking

HomeHealthGold Benchmarking

Sleepy Valley Community Health Services  (123456)
Cohort: All Medicare - 12 Month Period Ending: 03/31/14 Based on 61 agencies
Risks: Lost Revenue, Underassessment, Lack of Eligibility, Treatment Planning

<table>
<thead>
<tr>
<th>Measure</th>
<th>Score</th>
<th>N</th>
<th>Rank</th>
<th>Percentile</th>
<th>Score</th>
<th>25th P</th>
<th>50th P</th>
<th>75th P</th>
<th>100th P</th>
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<tr>
<td>Average Case-Mix at SOC (with 2013 Rejected)</td>
<td>0.96</td>
<td>3.40</td>
<td>27</td>
<td>43.4</td>
<td>0.99</td>
<td>0.90</td>
<td>1.00</td>
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<td>SOCs with Clinical Domains - CL</td>
<td>47.2%</td>
<td>3.40</td>
<td>47</td>
<td>76.2 **</td>
<td>91.0</td>
<td>**</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>Average Case-Mix at Recertification (with 2013)</td>
<td>0.91</td>
<td>1.115</td>
<td>56</td>
<td>91.0</td>
<td>0.83</td>
<td>0.80</td>
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<tr>
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<td>25.0%</td>
<td>4.452</td>
<td>39</td>
<td>63.1</td>
<td>25.1%</td>
<td>25.1%</td>
<td>25.1%</td>
<td>25.1%</td>
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<tr>
<td>Average Case-Mix at End (with 2013 Rejected)</td>
<td>1.06</td>
<td>4.447</td>
<td>58</td>
<td>94.3 **</td>
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<tr>
<td>Average non-LIUPA Case-Mix at Episode End</td>
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<td>4.059</td>
<td>55</td>
<td>89.3 **</td>
<td>0.99</td>
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<tr>
<td>LIUPA Episodes</td>
<td>0.5%</td>
<td>4.417</td>
<td>7</td>
<td>10.7 **</td>
<td>15.3%</td>
<td>15.3%</td>
<td>15.3%</td>
<td>15.3%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Therapy Upgrades</td>
<td>24.1%</td>
<td>4.417</td>
<td>52</td>
<td>95.4</td>
<td>17.4%</td>
<td>17.4%</td>
<td>17.4%</td>
<td>17.4%</td>
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<td>Therapy Downgrades</td>
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<td>28</td>
<td>45.1</td>
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<td>19.1%</td>
<td>19.1%</td>
<td>19.1%</td>
<td>19.1%</td>
</tr>
<tr>
<td>Outliers</td>
<td>1.8%</td>
<td>4.417</td>
<td>29</td>
<td>46.7</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>2.0%</td>
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<tr>
<td>Readmission to Agency Which Occur Within 30</td>
<td>11.1%</td>
<td>5.340</td>
<td>59</td>
<td>95.5</td>
<td>95.4%</td>
<td>95.4%</td>
<td>95.4%</td>
<td>95.4%</td>
<td>95.4%</td>
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<tr>
<td>LIUPA Episodes in 2d or Later Episode</td>
<td>15.1%</td>
<td>1.101</td>
<td>19</td>
<td>20.5 **</td>
<td>19.5%</td>
<td>19.5%</td>
<td>19.5%</td>
<td>19.5%</td>
<td>19.5%</td>
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<tr>
<td>Starting the 5th or Later Episode</td>
<td>6.3%</td>
<td>4.455</td>
<td>31</td>
<td>50.0</td>
<td>7.0%</td>
<td>7.0%</td>
<td>7.0%</td>
<td>7.0%</td>
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</tbody>
</table>

Key Industry Challenges

- Meet Triple Aim goals for:
  - improved quality
  - improved care for populations, and
  - lower cost
- Improve compliance, avoid regulatory triggers and enhance ability to adequately respond to regulatory probes
- Identify and solidify partnerships for future growth
Aim #1 – Improve Quality

- Measured primarily as outcomes and adherence to best practice (process measures)
- Quality Improvement Process
  - Identify area(s) needing improvement
  - Set goals (benchmarking)
  - Identify action steps to meet those goals
  - Ensure you have a way to monitor results to ensure improvement is achieved long term
- Accurate, timely, easily accessed data is critical

Medication Management
OASIS Quality Improvement Project

Goal:
Take two of the lowest performing branches on the OASIS M2020 and increase non-risk adjusted scores to 60% or over in 6 month period of time. Current levels were 52% and 48%

Questions asked:
What is level of understanding of M2020
What is our process for medication reconciliation
What happens at discharge
WHAT THE DATA FOUND

Red denote Admit Nurses, Blue denotes Case Managers for the % of times they scored patients a “0” or independent in Medication management at SOC or ROC. There is significant statistical evidence that Admit nurses score people with “0” or independent in med management less often than case managers.

CLINICIAN VARIABILITY

Red denote Admit Nurses, blue denotes Case Managers. Variability does exist within all groups, with a mix of CM/Admit nurses who DO find problems at drug review. 7/12 clinicians find NO problems at review approximately 60% or more of the time. 5/12 clinicians find NO problem at review approximately 40% of the time or less.
RESULTS OF IMPROVEMENT PROJECT

OASIS Review and Case Conference

- SOC/ROC and RECERT reviewed by the Patient Care Manager each week using “The Works”
- Standardizing review tools and changing previous habits to increase efficiencies
- Reinforcing expectations of accurate OASIS completion by clinical staff
- Provide education to staff through direct input and case conference review
OASIS Review and Case Conference cont.

Golden Habits

Set Dashboard option off: Audit assessment for past 60 days - depending on the day of the week and how often you are reviewing OASIS. Always set for 4 days on Monday to capture weekend assessments.

1. View your compliance flag reports before starting your OASIS review to see if you need to look at OASIS audits prior to starting your OASIS.
2. Open the new assessments to see patients that are meeting...

For additional information contact: Jayne Broughton, 800-246-4021 or Phoebe Ralph at Home Health Gold: 201-432-5425 / phoebe@homehealthgold.com

OASIS Review and Case Conference cont.

Golden Habits

The OASIS pathway for Home Health Providers is a "26" pathway. Utilize the "26" as the framework regarding performance of the 36 OASIS-HC sections of M items making it easier to see the consistency of the items in scoring.

1. Use the printed out workshops report to review critical edits and inconsistencies and pair notes on case conference. Provide this report to your database for review and changes.
Other ways to use data to improve quality

- Evaluate individual clinicians by analyzing visit metrics to identify staff development needs
- Drill down into problematic areas such as continuity of care
- Evaluate whether a new process has resulted in better quality outcomes
- Compare teams to better understand and mitigate unique factors which result in different outcomes

Clinic Evaluations: Assessing Clinician Statistics

Skippy Hollow VNA
List of Assessments by Clinician - Assessing Clinician Statistics
Assessments with an ASSESSMENT DATE between 02/20/2014 and 03/29/2014

Assessed by ACKERMAN, ANNETIE

<table>
<thead>
<tr>
<th>Langdon Jennifer</th>
<th>36275</th>
<th>Ha-As of 03/02/2014</th>
<th>TeamPrimary: Michael / HATHWELL, RODNEY</th>
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<tr>
<td>Handelst - Helen</td>
<td>37295</td>
<td>Ha-As of 02/24/2014</td>
<td>TeamPrimary: Romand / FAWO, PAILEE</td>
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<tr>
<td>CIF2C1 (Eq.1) Cap-Mix = 3.774</td>
<td>Expected Payment = 83,604.66</td>
<td>NRD Level = 1</td>
<td>Expected TheorCmp = .994</td>
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<td>PAUL WYCKOFF</td>
<td>34454</td>
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<td>TeamPrimary: WOJ / MULKA, O'CLOONE</td>
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<td>CIF2H (Eq.1) Cap-Mix = 10.110</td>
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<td>NRD Level = 1</td>
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<tr>
<td>STILWELST FRANK</td>
<td>374 017</td>
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<td>TeamPrimary: Vining / ROY, FLORENCE</td>
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<tr>
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<td>NRD Level = 1</td>
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Summary for ACKERMAN, ANNETIE

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Value</th>
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<tr>
<td>0A - SLO MO</td>
<td>0</td>
</tr>
<tr>
<td>0B - Staff</td>
<td>0</td>
</tr>
<tr>
<td>0D - Diet</td>
<td>0</td>
</tr>
<tr>
<td>0E - Lab</td>
<td>0</td>
</tr>
<tr>
<td>0F - Ther</td>
<td>0</td>
</tr>
<tr>
<td>0G - NW</td>
<td>0</td>
</tr>
<tr>
<td>0H - Other</td>
<td>0</td>
</tr>
</tbody>
</table>

Assessment Metrics: 0A, 0B, 0D, 0E, 0F, 0G, and 0H

- 0A - Staff and NW
- 0B - Staff and NW
- 0D - Diet
- 0E - Lab
- 0F - Ther
- 0G - NW
- 0H - Other

Notes:
- 0A: 0A - Staff and NW
- 0B: 0B - Staff and NW
- 0D: 0D - Diet
- 0E: 0E - Lab
- 0F: 0F - Ther
- 0G: 0G - NW
- 0H: 0H - Other

Columns:
- 0A: 0A - Staff and NW
- 0B: 0B - Staff and NW
- 0D: 0D - Diet
- 0E: 0E - Lab
- 0F: 0F - Ther
- 0G: 0G - NW
- 0H: 0H - Other

Values:
- 0A: 0A - Staff and NW
- 0B: 0B - Staff and NW
- 0D: 0D - Diet
- 0E: 0E - Lab
- 0F: 0F - Ther
- 0G: 0G - NW
- 0H: 0H - Other

Calculations:
- 0A: 0A - Staff and NW
- 0B: 0B - Staff and NW
- 0D: 0D - Diet
- 0E: 0E - Lab
- 0F: 0F - Ther
- 0G: 0G - NW
- 0H: 0H - Other
Team Evaluations: Lots of Nurses in the home

Patients with 5 or more FLH in the home in one Month

Full Data: "Home Visits - No of Visits to QI at ctime 06/01/2012 and 03/31/2013 and THird Quarter Type - Ritual Therapy"

<table>
<thead>
<tr>
<th>Visit Number</th>
<th>Visit Date</th>
<th>Evaluator</th>
<th>Time of Day</th>
<th>Score</th>
<th>Missed</th>
<th>Late</th>
<th>Change</th>
<th>Rate</th>
<th>Notes</th>
<th>Final</th>
<th>Final</th>
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<tbody>
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<td>06 LED 1/07/2012</td>
<td>06/19/11</td>
<td>B. MILLER</td>
<td>10:30</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>85</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>06 LED 2/07/2012</td>
<td>01/19/12</td>
<td>S. FRANK</td>
<td>10:30</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>85</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06 LED 3/07/2012</td>
<td>02/19/12</td>
<td>S. FRANK</td>
<td>10:30</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>85</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>06 LED 4/07/2012</td>
<td>03/19/12</td>
<td>S. FRANK</td>
<td>10:30</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>85</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>06 LED 5/07/2012</td>
<td>04/19/12</td>
<td>S. FRANK</td>
<td>10:30</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>85</td>
<td>1</td>
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<td>Totals for Patient 6</td>
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Evaluating the effect of "wound rounds" meeting implementation

Improvement in Surgical Wound Status

<table>
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<tr>
<th>Time Frame</th>
<th>Rate</th>
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<tr>
<td>FY'12</td>
<td>81%</td>
</tr>
<tr>
<td>FY'13 - Q1 and Q2</td>
<td>79%</td>
</tr>
<tr>
<td>FY'13 - Q3 and Q4</td>
<td>85%</td>
</tr>
<tr>
<td>FY'13 Overall</td>
<td>84%</td>
</tr>
<tr>
<td>% Change FY’12 – FY’13</td>
<td>4%</td>
</tr>
<tr>
<td>% Change FY’12 – Q3&amp;4</td>
<td>5%</td>
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</table>
Example – Team Scorecard

- Volume, Financial, and Quality Domains
- Goals, 12, 6, 3, 1 month trending
- Team results and scoring
- Team trends by month
- Monthly report to Executive Team and all Clinical Teams – transparency about goals, priorities, results

Example – Team Scorecard cont.

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
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<tbody>
<tr>
<td></td>
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<td>Team Trending Scorecard</td>
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<tr>
<td>3</td>
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<td>Episode Statistics</td>
<td>Goal</td>
<td>Jun-14</td>
<td>Jul-14</td>
<td>Aug-14</td>
</tr>
<tr>
<td>4</td>
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<td># SOC</td>
<td>85</td>
<td>85</td>
<td>0</td>
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<tr>
<td>5</td>
<td></td>
<td># Recs</td>
<td>20</td>
<td>16</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
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<td># Episodes</td>
<td>112</td>
<td>101</td>
<td>0</td>
<td>0</td>
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<tr>
<td>7</td>
<td></td>
<td>All Epi Case mix at End (by visits)</td>
<td>1.03</td>
<td>0.97</td>
<td>1.00</td>
<td>0.00</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Episode Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10</td>
<td></td>
<td>Recert Rate (Recert/Adm)</td>
<td>30%</td>
<td>20.0%</td>
<td>19.8%</td>
<td>0.0%</td>
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<tr>
<td>11</td>
<td></td>
<td>LUFAs</td>
<td>5</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td></td>
<td>LUFAS Rate (LUFAS/Episodes)</td>
<td>12%</td>
<td>5.2%</td>
<td>17.8%</td>
<td>#DIV/0!</td>
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<tr>
<td>13</td>
<td></td>
<td>Outliers</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>Outlier Rate (Outlier/Epi)</td>
<td>3.0%</td>
<td>1.0%</td>
<td>1.0%</td>
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<tr>
<td>15</td>
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<td>VFE Total (Excl LUFAS)</td>
<td>15.53</td>
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<td>16</td>
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<td>0.14</td>
<td>0.65</td>
<td>0.00</td>
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<td>2.00</td>
<td>1.67</td>
<td>1.39</td>
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</table>
An example: Comparing Case Managers on a wide array of metrics

<table>
<thead>
<tr>
<th>Measure</th>
<th>Case Manager 1</th>
<th>Case Manager 2</th>
<th>Case Manager 3</th>
<th>Case Manager 4</th>
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<tbody>
<tr>
<td>Length of Stay</td>
<td>3.15</td>
<td>4.05</td>
<td>3.15</td>
<td>4.05</td>
</tr>
<tr>
<td>Percent with Discharge</td>
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<td>0.00</td>
<td>0.00</td>
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<tr>
<td>Length of Stay</td>
<td>3.15</td>
<td>4.05</td>
<td>3.15</td>
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<td>0.00</td>
<td>0.00</td>
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</table>
Aim #2: Improve Care

- Use data to ensure you are delivering the “right” care throughout the episode
- Monitor key outcomes such as hospitalization and target your at risk patients
- Leverage technology effectively
- Track and trend your agency’s key diagnoses and conditions
Potential for Hospice Care

9/18/2014

Monitoring the Episode in Progress

- ID LUPAs in progress and evaluate whether needs are being adequately addressed
- Ensure rehab projections are on track
- Prepare for recertification decisions
LUPAs – Focus on Clinical Need, Clinical Goals

- 3 Classifications:
  - Discharged by agency as a LUPA
  - Recertifications – Ongoing LUPA
  - Transferred to a facility as a LUPA

- Key Questions for all:
  - What does (or did) the patient need?
  - Did we meet clinical goals for the patient?

- Can you easily identify LUPA cases and analyze them using HHRG?

LUPAs Ending in D/C

- Was your Clinical Manager aware of the plan to D/C?
- Was case discussed in case conference or IDT
- Do you have a way to ID LUPAs in progress?
- Did visit/discipline utilization match HHRG?
- Analyze d/c disposition reasons
- Trend clinicians with LUPAs
- Trend teams/branches
- Trend referral sources, clinical liaisons
Ongoing LUPAs

- Discrete, infrequent skilled need, i.e. B12 injection, catheter change
- Long term patients, often with complex needs
- May have received therapy during past episodes – are current functional deficits addressed?
- Compare OASIS time points for changes in condition
- Ensure staff are evaluating with a fresh eye
- Rehab: Is equipment safe and up to date? Pain managed?
- SW: financial status and formal and informal supports can change over time
- HHA: use a standardized tool to ID HHA opportunities

LUPAs Ending in Transfer

- Was visit frequency and/or involved disciplines appropriate
  - Low utilization at start of episode may have contributed to transfer
- Are there trends in:
  - Diagnosis
  - Time frame in which transfer occurred
  - Facility receiving patient
  - Team / Clinician
- Access to patient information
  - Do you know what happened after the transfer
  - Method to recover referral and ensure patient returns within the episode
30 day hospitalization by cause and by facility

Telehealth – Leveraging Technology

- Can you easily identify the following:
  - Episodes with target primary diagnoses
  - “Capture” rate – patients with target dx receiving TH
- Can you compare metrics for patients with and without TH:
  - LOS
  - Recertification Rate
  - Case Mix
  - Top Diagnoses
  - Visit Utilization
  - Outcomes
- Can you quickly review existing TH census for presence of hospice flags
More Telehealth Metrics

- Telehealth Churn: Number of installs/removals per month
- Telehealth Utilization: Units “on the shelf”
- Impact of TH:
  - Financial: LUPAs, Visit Utilization, Recertifications
  - Clinical/Quality Outcomes:
    - Timeliness
    - Dyspnea
    - Medication Management
    - ED / Hospitalization

Telehealth

Side-by-Side Comparisons - Telehealth
All Tiers
All Care Managers
10/1/2013 to 12/31/2013
Current Payor/SMC

<table>
<thead>
<tr>
<th></th>
<th>Before (no Tele)</th>
<th>Telehealth</th>
<th>% of Increase</th>
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<td>Average Length of Stay</td>
<td>31.16</td>
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<tr>
<td>Average Thru Days</td>
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<td>0%</td>
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<td>Average Time On</td>
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OUTCOME AND PROGRESSION

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<th>Before (no Tele)</th>
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<th>% of Increase</th>
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<tr>
<td>Improved Air Flow Ability</td>
<td>20% of 103</td>
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<td>Reduced Anxiety</td>
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<td>10% of 103</td>
<td>-50%</td>
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<tr>
<td>Increased Physical Activity</td>
<td>20% of 103</td>
<td>10% of 103</td>
<td>-50%</td>
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<tr>
<td>Decreased Symptoms</td>
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<td>-50%</td>
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<tr>
<td>Improved Sleep Quality</td>
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<td>-50%</td>
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9/18/2014
### Analyze volume and outcomes of different conditions

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<tr>
<th>Metrics</th>
<th>All Medicare</th>
<th>CHF</th>
<th>COPD</th>
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<td>570</td>
<td>437</td>
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<td>Acuity</td>
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<td>Avg VPE</td>
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<td>Timeliness</td>
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<td>84%</td>
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<td>Imp Med Mgmt</td>
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<td>ACH</td>
<td>28%</td>
<td>39%</td>
<td>39%</td>
<td>26%</td>
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</table>

Analysis of common chronic disease diagnoses and outcomes

### Aim #3: Lower Cost

- Identify key financial metrics and provide timely feedback to teams
- Justify staffing levels as they relate to revenue, margins
- Measure and understand the key inputs related to productivity, service utilization
Financial Metrics

- Financial Profile - Click for graphs, printed report, or spreadsheet
- Financial Indicators for the 12-month Period Ending 06/30/2014
- Current Payer Mix

<table>
<thead>
<tr>
<th>Financial Indicators</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Year</th>
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<tr>
<td>SOC Case-Mix</td>
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<td>1.36</td>
<td>1.42</td>
<td>1.45</td>
<td>1.38</td>
<td>1.36</td>
<td>1.46</td>
<td>1.48</td>
<td>1.48</td>
<td>1.28</td>
<td>1.12</td>
<td>1.03</td>
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<td>7.26</td>
<td>6.62</td>
<td>6.73</td>
<td>7.36</td>
<td>7.76</td>
<td>8.40</td>
<td>8.23</td>
<td>7.55</td>
<td>6.60</td>
<td>5.84</td>
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<td>63</td>
<td>75</td>
<td>61</td>
<td>66</td>
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<td>Repeat Case-Mix</td>
<td>0.99</td>
<td>1.04</td>
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Excludes LUPAs

Weekly Team Report

North Team - Weekly Goal Worksheet

<table>
<thead>
<tr>
<th>Week Ending</th>
<th>Upvis</th>
<th># Refs</th>
<th># LUPAs</th>
<th>End CM</th>
<th>U2200</th>
<th>Upvis</th>
<th>+/- Goal</th>
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<tbody>
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<td>9-Aug</td>
<td>2</td>
<td>20.4%</td>
<td>0</td>
<td>11.0%</td>
<td>0</td>
<td>1.17</td>
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<td>22.0%</td>
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<td>0.0%</td>
<td>-1</td>
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<td>16.7%</td>
<td>-1</td>
<td>4.2%</td>
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<td>1.17</td>
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<td>30-Aug</td>
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North Team

Rolling Average (5 weeks)

<table>
<thead>
<tr>
<th>Week Ending</th>
<th>U2200</th>
<th>+/- Goal</th>
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<tbody>
<tr>
<td>9-Aug</td>
<td>32.0%</td>
<td>1.05</td>
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<td>16-Aug</td>
<td>33.8%</td>
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<td>23-Aug</td>
<td>34.8%</td>
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<td>30-Aug</td>
<td>35.3%</td>
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<td>6-Sep</td>
<td>35.3%</td>
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</table>

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<td>1.05</td>
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<tr>
<td>16-Aug</td>
<td>33.8%</td>
<td>1.06</td>
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<td>30-Aug</td>
<td>35.3%</td>
<td>1.08</td>
</tr>
<tr>
<td>6-Sep</td>
<td>35.3%</td>
<td>1.08</td>
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</table>
Study patterns of staff activity

- Look at visits per day in relation to non-visit activities
- Measure and monitor staff productivity
- Must factor in nature of caseload, other duties such as clinics, geography
# Audit service utilization

- Visit patterns for selected cohorts
- Visit use by case manager, team
- Length, time of day of visits by discipline
- Staging of visits during an episode, such as front-loading for cases with high risk of hospitalization
Compliance

- Agencies are responsible for knowing regulations, ensuring accuracy, having proper controls
- Data elements can help agencies improve compliance, identify red flags
  - Check for missing assessments
  - Scan all episodes for situations commonly focused on by post-payment audits
  - Closely examine “threshold cases” – 5-visit episodes; 20+ therapy episodes, etc.

Compliance, cont.

- Use data to identify key compliance risk areas such as
  - low HHRG
  - low utilization
  - Outliers
  - low functional scores with therapy delivery
- Use exceptions to conduct in-house pre-pay auditing to improve denial rates, prevent escalating regulatory activity
Monitoring Red Flags

- Compare different data elements gathered at the same time
- Compare data across time points
- Compare the responses of different assessors
- Compare your results with those from other agencies
- Make sure assessors are addressing scrubbing audits

Improve accuracy of data
Regulatory Reviews

- MAC Audit: Pre-payment “near LUPA”
  - Scrub cases before billing using a tool to quickly identify flagged episodes, monitor for appropriateness of care plan, potential for homebound issues
  - Monitor low-utilization episodes in progress to intervene when appropriate with increased frequency or additional disciplines

OIG

- Monitor Red Flags as identified by OIG Work Plan and agency’s experience:
  - Multi-episode cases (continuous service > 1 year)
  - High utilization, especially with low HHRG
  - Accuracy of CBSA
  - Compliance:
    - Staff licensure
    - Security of staff log ins, electronic signature verification
    - Ability to “copy forward” or “clone” documentation
OIG continued

- Compliance, cont’d
  - F2F – content, timing
  - Physicians – eligibility (NPI, PECOS)
  - Therapy reassessments
  - Billing prior to signed orders
  - Audit activity related to quality reviews

Promote your agency

- Determine who is (and isn’t) sending you patients
- Give feedback to:
  - Those who send you patients
  - Those who sign the orders
  - Those who are creating ACOs
- Back up your funding requests with data
Identify and solidify partnerships by
analyzing pay source, cost, and outcomes
by referral source

- Highlight data that is important to your referral partners:
  - Timeliness
  - Clinical Risk Measures
  - Potential for Hospice
  - 30 Day Rehospitalization

- Analyze data to show which referral sources are key accounts:
  - Pay source
  - Utilization / Cost
  - Outcomes

Studying readmissions by referral source

- Need flexibility in your reporting
- Answer the questions the ACO is asking:
  - “Readmitted within X days”
  - “those with AMI, Heart failure, Pneumonia, COPD”
- Be prepared to speak to “what went wrong” with readmitted, shared patients.
Plan for the future

- With today’s data you can:
  - Evaluate the impact of competitive threats
  - Build budgets
  - Evaluate proposed changes in reimbursement
  - Identify areas requiring concerted performance improvement initiatives

In conclusion...

- Not all data is equal
- Use knowledge of industry, agency characteristics, landscape to shape your use of data
- Be creative
- Meet today’s challenges by using your data to drive your decision-making
Presenter Contact information

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