High Quality Care and Excellent Financial Outcomes

Should be Every Agency’s Goal!

- 2016 begins the Era of Value Based Purchasing
- CMS publication of the 5 Star Rankings – July 1st!
  - Outcomes...then HH CAHPS!
    - Where will you rank?
  - How has the Case Weight reductions affected your revenue and you bottom line?
    - The therapy case weight value decrease after visit 13
    - The loss of clinical points for certain diagnoses, etc.
- Have you had Increases in Direct costs?
  - Salaries & hourly rates and premium-based fringes, productivity and case capacity issues, etc.
Clinical Outcomes are Challenged!
The Issues

Where Does Your Agency Stand?

Clinical Outcomes are challenged! The Issues are:

- Inadequate OASIS education and training with little re-education, including new hires.
  - Many agencies sent 1 or 2 RNs to a training session for the purpose of then training the rest of the staff!
- Poor ADL assessment skills of RNs. Lack of education and training from PTs/OTs
  - Measured outcomes don’t match actual achievements!
- OASIS reviewers:
  - Make the corrections, not the Clinician!
  - Don’t really review Discharge OASIS!
  - If a “Data Scrubber” is used, not all inconsistencies are resolved before submission!
Where Does Your Agency Stand?

Clinical Outcomes are challenged! The Issues are:
- OASIS reviewers (cont’d):
  - Many are the supervisors, who then don’t have the time to supervise!
  - Many are not COS-C for OASIS C-
- Use of Admission RNs for efficiency that:
  - Treat the patient being admitted as a task
  - OASIS is pretty much “cookie-cutter”
  - That do 2 visits a day (very expensive)
  - Creates a lack of consistency and continuity of care negatively affecting HH-CAHP scores!

Where Does Your Agency Stand?

Clinical Outcomes are challenged! The Issues are:
- RN (primary clinician) doing the 1st follow-up visit sees the patient differently and generates change orders.
  - May be the 1st of many RNs, depending on the staffing!
- Visit Nurse model increases visits and lack of consistency and continuity of care negatively affects patient satisfaction.
  - Who owns the patient?
  - Requires scheduler(s) to fill care plan frequencies! Costly!
  - LPNs/LVNs are a false economy! Get what you pay for!
Where Does Your Agency Stand?

Clinical Outcomes are challenged! The Issues are:

- The Admitting Clinicians or their Supervisor(s) are doing the coding.
  - Probably not Certified Coders
  - Greatly increases the Admission documentation time
  - Negatively affects OASIS clinical scoring and case weights

Where Does Your Agency Stand?

Clinical Outcomes are challenged! The Issues are:

- Clinical Case Conferences only address those patients with issues, recert decisions and sometimes new patients!
  - Held weekly in the office with all RNs and others present.
- Most Patients never discussed!
  - Supervisors not informed of patients’ progress towards outcomes
- Lack of oversight of patient care plan development
  - Appropriate visit frequencies and durations.
Where Does Your Agency Stand?

Financial Outcomes are challenged! The Issues are:
- Clinical field staff productivity is often overstated because visit points (visits weights) are often over valued.
- Clinical field staff cases managed is often below capacity.
- Lack of incentives for clinical field staff - visit productivity, cases managed and outcomes/HH-CAHPS achieved.
- Maintaining a “Supply Closet” forces office visits to pick-up supplies, costing a visit each time.
- Direct costs per visit by discipline not monitored monthly and year to date.
- Average visits per discipline per episode by diagnosis not monitored.

Clinical Outcomes are challenged!
Solutions
The Clinical Model

- Primary Care Case Management
  - Clinician manages 20 – 25 patients...depends on acuity.
  - Effective use of Telehealth increases capacity
  - Responsible for entire episode of care
  - Oversight and communication with other disciplines
  - Responsible for patient case conferencing
  - Responsible for outcomes

- Appropriate Supervision
  - Supervision – primary responsibility
  - Ability to enforce process and policy for productivity, OASIS corrections, appropriate care delivery
  - Case conferencing with Primary Care Clinicians

The Clinical Model

- Productivity expectations
  - SN - Minimum average of 5 actual visits per day – 6.25 – 6.50 weighted visits
  - PT – Minimum average of 6.0 actual visits per day – 6.75 weighted visits
  - Supervisor/Manager – 1 per 7-9 FTEs (depends on function)
    - Maximum 10 individuals
  - OASIS Reviewer – w/data manager - 75 - 85 patients

- Adequate OASIS review process
  - Real-time “Data Scrubber” to decrease review time and increase accuracy
The Visit Weights

Visit weighting – Based the Requirements and Complexities of completing OASIS C-1

- Admission (evaluation) visit 1.90
- Non-OASIS Evaluation Visit 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

Visit Weight – Time Equivalents
Based upon OASIS C-1

<table>
<thead>
<tr>
<th>Visits /Day</th>
<th>Follow-up</th>
<th>Admission</th>
<th>Resumption</th>
<th>Recert.</th>
<th>Discharge</th>
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<tr>
<td>5.00</td>
<td>1.00</td>
<td>1.90</td>
<td>1.30</td>
<td>1.20</td>
<td>1.25</td>
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<tr>
<td></td>
<td>96 minutes</td>
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<td>5.25</td>
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<td>5.75</td>
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<td>1 hr 20 min</td>
<td>2 hrs 32 min</td>
<td>1 hr 44 min</td>
<td>1 hr 36 min</td>
<td>1 hr 40 min</td>
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</table>

All times include hands-on, documentation, travel, conference and case management time
The Case Conference Model

Case Conference Model via Telephone

- Between the Primary Care Clinician and their Supervisor
  - Primary Care Clinician responsible with communication and oversight of all involved disciplines

- Every Patient...Every 14 days!
  - Controls the Episode Visits
    - Reviews prior 14 days utilization and outcome achievement
    - Plans next 14 days utilization and outcome goals

- Supervisor knowledgeable about all their clinicians’ patients....No Surprises!

The Primary Care Case Manager

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
HOMECARE OF HOLLAND HOME

AGENCY CASE STUDY

CAROLYN FLIETSTRA, BSN, RN
VICE PRESIDENT – HOME & COMMUNITY BASED SERVICES

Overview of Agency

- Not for profit subsidiary of Holland Home, a faith based continuing care retirement community provider
- Certified home health agency has average daily census of 260
- 6 county service area
Agency Management Structure

- Administrator
- Clinical Managers
  - Rehabilitation and Outpatient Therapy
  - Medical-Surgical
  - Mental Health
- Quality Review RNs
- Quality Assurance Performance Improvement (QAPI) Manager

Field Clinician Structure

- Primary Case Management
  - RNs and therapists admit their own patients
  - Case manager provides most/all of the OASIS visits
  - Therapy only admissions admitted by PT or SLP
- High utilization of technology for efficiency
  - EMR, remote access with or without internet, PDFs attached (e-forms in process)
  - iPhones, including internet hot spot and scanner
  - Portable printers
- Patient home delivered supplies with interface
Quality Review Department

- Staffed by Quality Review RNs
  - Responsible for OASIS and other documentation review and related diagnosis coding for selected visit types
  - Experienced in home health and program
  - ICD-9 and ICD-10 HCS-D certified
  - OASIS certified
  - Primary and back up specialization in cases reviewed
  - Role is education, not management

Quality Review Department, cont’d.

- High utilization of data scrubbing software
  - Electronic medical record software
    - Assessment validation
  - 3rd party scrubbing software
    - Internal OASIS inconsistencies
    - Assessment- Diagnosis inconsistencies
    - Clinical alerts
    - Tracking changes in quality review
Field Clinician Quality Development

- OASIS training (OASIS walk)
- OASIS competency testing
- End user corrections
- Case Conferencing model
- Program manager oversight
- Quality bonus program
- Continuous feedback and outcomes shared

Quality Review Process

1. 3rd party data sweep after admission synched
2. Other disciplines evaluate and collaborate
3. Admit clinician corrects based on collaboration
4. Initial quality review in office
5. Admit clinician addresses inconsistencies, queries physician as needed for additional coding detail
6. Final quality review in office, includes confirmation of coding and sequencing
7. 3rd party data sweep to identify any remaining inconsistencies ("resolved")
8. Clinical manager reviews outcomes at transfer or discharge, educates as needed
9. High level agency trends review and report process
### Proposed QAPI in Practice

<table>
<thead>
<tr>
<th>Proposed Rule: QAPI</th>
<th>HomeCare of Holland Home current practice</th>
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</table>
| **Activities to focus on high risk, high volume, or problem prone areas of service** | • Review areas related to pt injury: Potentially Avoidable Events (PAEs): emergent care for falls, wounds, med SE, increased pressure ulcers.  
• Trend to identify changes from norm, review literature, regulations and standards to improve selected areas. |
| **And to consider the incidence, prevalence, and severity of problems in those areas** | • Track each area quarterly  
• Perform root cause analysis (RCA) on each event to determine preventability |
| **We also propose that the HHA immediately correct any identified problems that directly or potentially threatens the health and safety of patients** | • PAEs reviewed daily. Staff counseling for any divergence from best practice.  
• Trends and process issues are addressed in weekly Quality /Management meetings, implemented in next staff meetings. |

### Proposed QAPI in Practice

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</table>
| **Additionally, the HHA’s QAPI activities would have to track incidents and adverse patient events, as well as analyze those events, so that preventive actions and mechanisms could be implemented by the HHA.** | • Individual events: individual staff coaching. Examples: Process non-compliance, adverse events.  
• Trends: group education. Examples: inclusion in programs (PC), referrals from certain sources, alerts from OASIS software, deficiencies in best practices (SBAR, timely advance care planning) |
| **We also propose that after steps have been taken to improve an area of concern, the HHA would continue to monitor the area in order to assure that improvements were sustained over time.** | • Annual QAPI calendar: frequency of all monitoring activities, OASIS staff education for the past 18 months.  
• Quarterly results review: QAPI Committee, Professional Advisory Committee, Quality Committee of the Board. |
Proposed QAPI in Practice

### Proposed Rule: QAPI

| HHAs would be able to utilize data for the OASIS data set through the risk-adjusted outcome-based quality improvement (OBQI), outcome-based quality management (OBQM), and process-based quality improvement (PBQI) reports. |

- Complete Quality Package (from the CASPER site) quarterly review: by Quality team, QAPI Committee.
- Summary quarterly review: Quality Committee of the Board.

### HomeCare of Holland Home current practice

| Infection Control: We propose that in CFR 484.70(a) that HHAs follow infection prevention and control best practices, which include the use of standard precautions, to curb the spread of disease. Reporting (per State regs) Prevention Control and Education (1) Protect the patient; (2) protect the health care worker (and others in the healthcare environment); and (3) accomplish the previous 2 goals in a manner that is timely, efficient, and cost effective whenever possible |

- Infection Control Plans for TB, Blood-borne pathogens, and general (long standing)
- Ebola plan (2014)
- Missouri Infection Surveillance Program process (surveillance and trending of Foley infections)
- Infection control info reported quarterly to the Quality Committee of the Board.

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### Outcomes 2011

**Real-Time Home Health Compare**

<table>
<thead>
<tr>
<th>Managing Daily Activities</th>
<th>Actual</th>
<th>CMS</th>
<th>Risk Adj</th>
<th>State (MI)</th>
<th>CMS</th>
<th>SHP</th>
<th>National</th>
<th>CMS</th>
<th>SHP</th>
<th>Your % Rank</th>
<th>CMS</th>
<th>SHP</th>
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<tbody>
<tr>
<td>Improvement in Ambulation</td>
<td>55.2%</td>
<td>52%</td>
<td>60.7%</td>
<td>56%</td>
<td>60.3%</td>
<td>59%</td>
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<td>57.3%</td>
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<td>63.6%</td>
<td>67%</td>
<td>67.3%</td>
<td>66%</td>
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<td>49.8%</td>
<td>43.6%</td>
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<table>
<thead>
<tr>
<th>Managing Pain and Treating Symptoms</th>
<th>Actual</th>
<th>CMS</th>
<th>Risk Adj</th>
<th>State (MI)</th>
<th>CMS</th>
<th>SHP</th>
<th>National</th>
<th>CMS</th>
<th>SHP</th>
<th>Your % Rank</th>
<th>CMS</th>
<th>SHP</th>
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<tr>
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<td>99%</td>
<td>99.4%</td>
<td>95%</td>
<td>99.4%</td>
<td>95%</td>
<td>99.5%</td>
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<td>99.5%</td>
<td>62.8%</td>
<td>64.5%</td>
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<tr>
<td>Pain Interventions in Short Term EOC</td>
<td>100.0%</td>
<td>100%</td>
<td>100.0%</td>
<td>90%</td>
<td>90.0%</td>
<td>97%</td>
<td>97.9%</td>
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<td>54.4%</td>
<td>43.6%</td>
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<td>Pain Interventions in Short Term EOC</td>
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<td>62.2%</td>
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<th>Treating Wounds/Preventing Pressure Sores</th>
<th>Actual</th>
<th>CMS</th>
<th>Risk Adj</th>
<th>State (MI)</th>
<th>CMS</th>
<th>SHP</th>
<th>National</th>
<th>CMS</th>
<th>SHP</th>
<th>Your % Rank</th>
<th>CMS</th>
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<td>92%</td>
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<td>86%</td>
<td>88.6%</td>
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<td>88.2%</td>
<td>85%</td>
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## Outcomes 2014

### Managing Daily Activities

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<th>CMS Adjusted</th>
<th>State (MS)</th>
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<td>80.3%</td>
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<td>76.8%</td>
<td>83%</td>
<td>71.1%</td>
<td>80.3%</td>
<td>67.4%</td>
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<td>3. Improvement in Bathing</td>
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<td>52.9%</td>
<td>56%</td>
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### Managing Pain and Treating Symptoms

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<td>5. Pain Interventions</td>
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<td>96%</td>
<td>90%</td>
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<td>8. Improvement in Depression</td>
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### Treating Wounds/Preventing Pressure Sores

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<th>State (MS)</th>
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<th>CMS Adjusted</th>
<th>Your % Rank</th>
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<tr>
<td>9. Improvement in Status of Surgical Wound</td>
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<td>93%</td>
<td>90%</td>
<td>93%</td>
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<td>90%</td>
<td>99%</td>
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<td>90%</td>
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<td>99%</td>
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<td>90%</td>
<td>99%</td>
<td>99.9%</td>
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## Outcomes 2011

### Preventing Harm

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<thead>
<tr>
<th>Activity</th>
<th>Your 2011</th>
<th>CMS Adjusted</th>
<th>State (MS)</th>
<th>CMS Adjusted</th>
<th>National</th>
<th>CMS Adjusted</th>
<th>Your % Rank</th>
<th>CMS Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Timely Initiation of Care</td>
<td>96.9%</td>
<td>97%</td>
<td>89%</td>
<td>92%</td>
<td>90%</td>
<td>92%</td>
<td>81.0%</td>
<td>76.7%</td>
</tr>
<tr>
<td>14. Drug Education All Leads</td>
<td>97.4%</td>
<td>97%</td>
<td>91%</td>
<td>96%</td>
<td>91%</td>
<td>96%</td>
<td>86.6%</td>
<td>76.7%</td>
</tr>
<tr>
<td>15. Improvement in Management of Oral Meds</td>
<td>95%</td>
<td>64%</td>
<td>93%</td>
<td>52%</td>
<td>90%</td>
<td>49%</td>
<td>85.5%</td>
<td>76.7%</td>
</tr>
<tr>
<td>16. Fall Risk Assessment Conducted</td>
<td>94%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
<td>85.7%</td>
<td>76.7%</td>
</tr>
<tr>
<td>17. Depression Assessment Conducted</td>
<td>99%</td>
<td>99%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95.7%</td>
<td>76.7%</td>
</tr>
<tr>
<td>18. Flu Vaccine Received - Current Season</td>
<td>83%</td>
<td>83%</td>
<td>90%</td>
<td>80%</td>
<td>90%</td>
<td>80%</td>
<td>87.2%</td>
<td>69.7%</td>
</tr>
<tr>
<td>19. IPV Received - Ever</td>
<td>81%</td>
<td>82%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>76.4%</td>
<td>69.7%</td>
</tr>
<tr>
<td>20. Diabetic Foot Care &amp; Education in Short Term EOC</td>
<td>95.0%</td>
<td>99%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>94.2%</td>
<td>74.9%</td>
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</tbody>
</table>

### Preventing Unplanned Hospital Care

<table>
<thead>
<tr>
<th>Activity</th>
<th>Your 2011</th>
<th>CMS Adjusted</th>
<th>State (MS)</th>
<th>CMS Adjusted</th>
<th>National</th>
<th>CMS Adjusted</th>
<th>Your % Rank</th>
<th>CMS Adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. 30-Day Emergency Care without Hospitalizations</td>
<td>13.4%</td>
<td>16.9%</td>
<td>17.1%</td>
<td>16.1%</td>
<td>16.1%</td>
<td>16.1%</td>
<td>9.4%</td>
<td>13.4%</td>
</tr>
<tr>
<td>22. 30-Day Hospitalizations</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
</tbody>
</table>

Note: In this section, lower scores are better.
Outcomes 2014

Preventing Harm

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Actual</th>
<th>You CMS</th>
<th>Risk Adj</th>
<th>State (MI) CMS</th>
<th>SHP</th>
<th>National CMS</th>
<th>SHP</th>
<th>Your % Rank CMS</th>
<th>SHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>13 Timely Initiation of Care</td>
<td>96.2%</td>
<td>99%</td>
<td>96.6%</td>
<td>95.0%</td>
<td>92%</td>
<td>92.0%</td>
<td>94.4%</td>
<td>94.4%</td>
<td>36.4%</td>
</tr>
<tr>
<td>14 Drug Education All Meds</td>
<td>96.0%</td>
<td>99%</td>
<td>96.0%</td>
<td>95.0%</td>
<td>93%</td>
<td>92.0%</td>
<td>94.4%</td>
<td>94.4%</td>
<td>84.7%</td>
</tr>
<tr>
<td>15 Improvement in Management of Oral Meds</td>
<td>62.2%</td>
<td>68%</td>
<td>68.2%</td>
<td>56%</td>
<td>58.0%</td>
<td>53%</td>
<td>56.2%</td>
<td>92.7%</td>
<td>92.5%</td>
</tr>
<tr>
<td>16 Fall Risk Assessment Conducted</td>
<td>90.8%</td>
<td>100%</td>
<td>97.8%</td>
<td>98.0%</td>
<td>98.2%</td>
<td>98.2%</td>
<td>99.0%</td>
<td>99.0%</td>
<td>92.7%</td>
</tr>
<tr>
<td>17 Depression Assessment Conducted</td>
<td>90.0%</td>
<td>100%</td>
<td>98%</td>
<td>98.7%</td>
<td>98%</td>
<td>98.2%</td>
<td>99.0%</td>
<td>99.0%</td>
<td>92.7%</td>
</tr>
<tr>
<td>18 Pneumococcal Vaccine Received - Current Season</td>
<td>87.3%</td>
<td>97%</td>
<td>74%</td>
<td>76.5%</td>
<td>73%</td>
<td>75.9%</td>
<td>81.1%</td>
<td>80.8%</td>
<td>64.2%</td>
</tr>
<tr>
<td>19 Pneumococcal Vaccine Received - Ever</td>
<td>91.6%</td>
<td>92%</td>
<td>73%</td>
<td>77.2%</td>
<td>73%</td>
<td>75.9%</td>
<td>81.1%</td>
<td>80.8%</td>
<td>64.2%</td>
</tr>
<tr>
<td>20 Diabetic Foot Care &amp; Education</td>
<td>98.1%</td>
<td>99%</td>
<td>98%</td>
<td>97.2%</td>
<td>98%</td>
<td>95.9%</td>
<td>72.8%</td>
<td>83.4%</td>
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</table>

Preventing Unplanned Hospital Care

<table>
<thead>
<tr>
<th>SOC</th>
<th>Actual CMS</th>
<th>Projected CMS</th>
<th>State (MI) CMS</th>
<th>SHP</th>
<th>National CMS</th>
<th>SHP</th>
<th>Your % Rank CMS</th>
<th>SHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 30-Day Emergency Care without Hospitalizations</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
<td>53.7%</td>
<td>53.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 30-Day Hospitalizations</td>
<td>13.1%</td>
<td>15%</td>
<td>15.5%</td>
<td>16%</td>
<td>15.7%</td>
<td>16%</td>
<td>14.7%</td>
<td>53.7%</td>
</tr>
</tbody>
</table>

Cost Considerations

- Control at the clinician level by:
  - manager case conferencing
  - appropriate compensation model (*Incentive Based, including Accumulated Visit Weights, Number of Cases Managed, and Outcomes*)
  - ensure remote access to information, supplies

- Monitor at the agency level by:
  - direct cost per visit analysis
  - indirect cost per visit analysis, including supplies and administration
  - agency visits per episode by discipline comparison
Cost Metrics

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN Direct Cost/Visit</td>
<td>$107.08</td>
<td>$93.40</td>
</tr>
<tr>
<td>PT Direct Cost/Visit</td>
<td>$94.02</td>
<td>$92.30</td>
</tr>
<tr>
<td>OT Direct Cost/Visit</td>
<td>$78.98</td>
<td>$82.95</td>
</tr>
<tr>
<td>Indirect Cost/Visit</td>
<td>$52.45</td>
<td>$47.01</td>
</tr>
<tr>
<td>Total Cost/Visit</td>
<td>$156.41</td>
<td>$139.45</td>
</tr>
</tbody>
</table>

Revenue Considerations

Based on accurate assessment of each patient

- Monitored through key performance indicators compared to benchmarked group
  - LUPAs, Downcodes, Outliers
  - Case mix weight
  - Average revenue per episode
Revenue Metrics

<table>
<thead>
<tr>
<th>Revenue Metrics</th>
<th>2011</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Downcodes HC of HH</td>
<td>14.6%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Downcodes MI</td>
<td>16.3%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Downcodes US</td>
<td>14.8%</td>
<td>15.3%</td>
</tr>
<tr>
<td>LUPA HC of HH</td>
<td>11.4%</td>
<td>11.5%</td>
</tr>
<tr>
<td>LUPA MI</td>
<td>13.1%</td>
<td>12.1%</td>
</tr>
<tr>
<td>LUPA US</td>
<td>11.5%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Case wt HC of HH</td>
<td>1.27</td>
<td>1.07</td>
</tr>
<tr>
<td>Case wt MI</td>
<td>1.32</td>
<td>1.03</td>
</tr>
<tr>
<td>Case wt US</td>
<td>1.27</td>
<td>1.00</td>
</tr>
<tr>
<td>Avg rev ep HC of HH</td>
<td>$2,450</td>
<td>$2,646</td>
</tr>
<tr>
<td>Avg rev ep MI</td>
<td>$2,562</td>
<td>$2,529</td>
</tr>
<tr>
<td>Avg rev ep US</td>
<td>$2,830</td>
<td>$2,700</td>
</tr>
</tbody>
</table>

CMS 5 Star Rating

Home Health Star Rating
Provider Preview Report
Based on completed quality episodes with end-of-care OASIS assessment data from January 1, 2014 through December 31, 2014 and claims data with through dates from October 1, 2013 through September 30, 2014

Rating for Homecare Of Holland Home
Grand Rapids, Michigan
Overall Star Rating
**** (4.5 stars)
Conclusions

- These Results are Not Unique to the Agency
- Primary Care Clinicians own their Patients
  - Responsibility and Accountability
  - Supervisors that actually supervise
- Quality process and Clinical Team Improved
good scores to great scores!
- Very Positive Financial Results after Re-basing!
- Q&A

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Holland Home
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Email: carolyn.flietstra@hollandhome.org