STAFF REPORT ON HOME HEALTH AND THE MEDICARE THERAPY THRESHOLD

PREPARED BY THE STAFF OF THE
COMMITTEE ON FINANCE
UNITED STATES SENATE

SEPTEMBER 2011

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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.²

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.

• 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.
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.
Figure 1: Pre-2008 OASIS calculation for HHRG

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

### Clinical
- Add the scores from each of these factors:
  - Primary home care diagnosis
  - IV/Infusion or parenteral/enteral therapy
  - Vision limitation
  - Wound/lesion
  - Multiple pressure ulcers
  - Most problematic pressure ulcer stage

### Functional
- Add the scores from each of these factors:
  - Dressing
  - Bathing
  - Toileting
  - Transferring
  - Locomotion

### Service utilization
- Add the scores from each of these factors:
  - No hospital discharge past 14 days
  - IRF/SNF discharge past 14 days
  - 10 or more therapy visits

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.” 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

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

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-

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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.\textsuperscript{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.\textsuperscript{8}

CMS noted similar results, finding the threshold system “might have distorted service delivery patterns.”\textsuperscript{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.\textsuperscript{10}

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

![Graph showing distribution of therapy visits](image)

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

\textsuperscript{7}Id. 41148.
\textsuperscript{8}MedPAC, “Report to Congress,” March 2011.
\textsuperscript{10}Id.
in 2007, to take effect in 2008. 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.

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. 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**

<table>
<thead>
<tr>
<th>Number of Therapy Visits</th>
<th>Payment Amount</th>
<th>Percentage Increase</th>
<th>Number of Therapy Visits</th>
<th>Payment Amount</th>
<th>Percentage Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$1,544.03</td>
<td></td>
<td>16</td>
<td>$5,010.47</td>
<td>6.48%</td>
</tr>
<tr>
<td>2</td>
<td>$1,639.59</td>
<td>6.19%</td>
<td>17</td>
<td>$4,947.58</td>
<td>-1.26%</td>
</tr>
<tr>
<td>3</td>
<td>$1,742.85</td>
<td>6.30%</td>
<td>18</td>
<td>$5,275.00</td>
<td>6.62%</td>
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<td>4</td>
<td>$1,803.85</td>
<td>3.50%</td>
<td>19</td>
<td>$5,276.52</td>
<td>0.03%</td>
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<td>5</td>
<td>$1,925.24</td>
<td>6.73%</td>
<td>20</td>
<td>$6,809.22</td>
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<td>6</td>
<td>$2,546.26</td>
<td>32.26%</td>
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<td>$6,834.21</td>
<td>0.37%</td>
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<td>7</td>
<td>$3,012.44</td>
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<td>22</td>
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<td>23</td>
<td>$6,841.38</td>
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<td>9</td>
<td>$3,023.28</td>
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<td>$6,888.63</td>
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<td>10</td>
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<td>$6,926.49</td>
<td>-0.93%</td>
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</tbody>
</table>

*Source: CMS*

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11[^11]

12[^12]

13[^13]
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.

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.
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

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

16 Id.
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."\textsuperscript{17}

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

\textit{Source: CMS}

\textbf{Amedisys}

\textsuperscript{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.\textsuperscript{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

\textsuperscript{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.\textsuperscript{19} Medicare reimbursements consisted of 88 percent of Amedisys’s revenue in 2009.\textsuperscript{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.”\textsuperscript{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.”\textsuperscript{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.”\textsuperscript{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?”\textsuperscript{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.”\textsuperscript{25}
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.”

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.”

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.”

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!”

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.”

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.

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
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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33 A-Team Case Mix Committee Action Items, December 2007, AMEDSFC00070083—AMEDSFC00070103, *AMEDSFC00070085.
35 Amedisys Rehab Clinical Track Options, AMEDSFC00001347—AMEDSFC00001350, *AMEDSFC00001347.
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:
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-
The percentage 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.\textsuperscript{46}

\textbf{Figure 12: Gentiva Distribution of Episodes with Therapy Visits, 2007 vs. 2008}

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

\textsuperscript{46}Id.
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. Medicare reimbursements consisted of 82 percent of Gentiva’s revenue in 2009.

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.”

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.”

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-
Atlantic “Spider Monkeys” and the Carolina “Killer Bees.” Teams were then ranked based on a list of 21 individual, weighted metrics primarily designed to maximize profits. 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].” The company later indicated that this metric was not eliminated from the KIR reports.

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?” First place teams also received a monetary bonus during an annual company meeting. In 2007, KIR bonuses totaled $161,811.

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. 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??”

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.”

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

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.”
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.”

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.”

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.”

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.

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.”

**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.

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

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.”

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

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° LHC Group Medicare Reimbursement, LHCGROUP_000000003, LHCGROUP_000000004.
°°° 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."

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.” 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. 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.”

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.”

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...
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.  

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.”

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.”

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.

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.
78 E-mail from Division Vice President Angie Begnaud, January 18, 2008, LHCGroup 00047210—LHCGROUP 00047230.
79 Therapy Practice in the Refined PPS Environment: Challenges and Opportunities, LHCGroup 00047210, LHCGROUP 00047230, LHCGROUP 00047230.
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, LHCGROUP_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.”

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.”

A July 8, 2009 e-mail from LHC employee Katy LaBauve 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.”

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)?”

**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.

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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
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. Medicare reimbursements consisted of 77 percent of Almost Family’s revenue in 2009.

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. 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-

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91 Almost Family Letter, Medicare Reimbursements.
92 Almost Family Annual Report 2010, page 6, [http://almostfamily.ir.edgar-online.com/EFXL.dll/EDGARpro.dll/FetchFilingCONVPDF!/SessionID=a7fjF5M1mZmg98&ID=7757385](http://almostfamily.ir.edgar-online.com/EFXL.dll/EDGARpro.dll/FetchFilingCONVPDF!/SessionID=a7fjF5M1mZmg98&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.  

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.” 

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. 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.

---

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.
96 Id.
97 E-mail from Chairman and CEO Keith Myers, LHC Group, April 4, 2008, LHCGroup _00048299—LHCGROUP _00048300, *LHCGroup _00048299.
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.” This e-mail was based on an additional chart circulated at LHC Group that analyzed the payment changes made by CMS.

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. 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.

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-
hance quality of care.\textsuperscript{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.

\textsuperscript{101} Patient Protection and Affordable Care Act, Pub L. no. 111–148, § 3023, 124 Stat 401 (2010).

\textsuperscript{102} Patient Protection and Affordable Care Act, § 3021, 124 Stat 389.
APPENDIX

SELECT DOCUMENTS CITED IN THIS REPORT
Footnote 18
<table>
<thead>
<tr>
<th>Therapy Visit Category</th>
<th>Year 2006 Episode Count</th>
<th>% Therapy</th>
<th>Year 2007 Episode Count</th>
<th>% Therapy</th>
<th>Year 2008 Episode Count</th>
<th>% Therapy</th>
<th>Year 2009 Episode Count</th>
<th>% Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Visit</td>
<td>8,982</td>
<td>8.0%</td>
<td>10,029</td>
<td>8.9%</td>
<td>10,945</td>
<td>8.7%</td>
<td>11,231</td>
<td>8.9%</td>
</tr>
<tr>
<td>2 Visits</td>
<td>4,356</td>
<td>4.3%</td>
<td>5,265</td>
<td>4.2%</td>
<td>5,361</td>
<td>4.3%</td>
<td>10,620</td>
<td>7.9%</td>
</tr>
<tr>
<td>3 Visits</td>
<td>3,435</td>
<td>3.4%</td>
<td>4,116</td>
<td>3.2%</td>
<td>5,759</td>
<td>4.5%</td>
<td>8,077</td>
<td>6.1%</td>
</tr>
<tr>
<td>4 Visits</td>
<td>3,199</td>
<td>3.2%</td>
<td>4,513</td>
<td>3.6%</td>
<td>6,870</td>
<td>5.1%</td>
<td>8,149</td>
<td>6.1%</td>
</tr>
<tr>
<td>5 Visits</td>
<td>4,558</td>
<td>4.6%</td>
<td>5,649</td>
<td>4.5%</td>
<td>7,405</td>
<td>5.5%</td>
<td>9,215</td>
<td>6.6%</td>
</tr>
<tr>
<td>6 Visits</td>
<td>4,247</td>
<td>4.3%</td>
<td>5,843</td>
<td>4.5%</td>
<td>9,834</td>
<td>7.3%</td>
<td>11,715</td>
<td>8.0%</td>
</tr>
<tr>
<td>7 Visits</td>
<td>3,012</td>
<td>3.0%</td>
<td>4,077</td>
<td>3.3%</td>
<td>9,182</td>
<td>6.8%</td>
<td>10,952</td>
<td>8.2%</td>
</tr>
<tr>
<td>8 Visits</td>
<td>2,413</td>
<td>2.4%</td>
<td>3,609</td>
<td>2.9%</td>
<td>9,769</td>
<td>7.1%</td>
<td>12,496</td>
<td>9.1%</td>
</tr>
<tr>
<td>9 Visits</td>
<td>2,513</td>
<td>2.5%</td>
<td>6,085</td>
<td>5.0%</td>
<td>8,573</td>
<td>6.6%</td>
<td>13,173</td>
<td>9.2%</td>
</tr>
<tr>
<td>10 Visits</td>
<td>10,441</td>
<td>10.3%</td>
<td>11,149</td>
<td>9.0%</td>
<td>9,939</td>
<td>7.4%</td>
<td>9,834</td>
<td>7.4%</td>
</tr>
<tr>
<td>11 Visits</td>
<td>9,314</td>
<td>9.3%</td>
<td>10,482</td>
<td>8.5%</td>
<td>8,576</td>
<td>6.5%</td>
<td>9,168</td>
<td>6.7%</td>
</tr>
<tr>
<td>12 Visits</td>
<td>6,919</td>
<td>6.9%</td>
<td>12,454</td>
<td>10.2%</td>
<td>8,859</td>
<td>6.9%</td>
<td>9,830</td>
<td>7.3%</td>
</tr>
<tr>
<td>13 Visits</td>
<td>5,981</td>
<td>5.9%</td>
<td>7,502</td>
<td>6.0%</td>
<td>8,470</td>
<td>6.4%</td>
<td>9,650</td>
<td>6.8%</td>
</tr>
<tr>
<td>14 Visits</td>
<td>4,552</td>
<td>4.5%</td>
<td>7,862</td>
<td>6.0%</td>
<td>10,161</td>
<td>7.6%</td>
<td>12,496</td>
<td>9.1%</td>
</tr>
<tr>
<td>15 Visits</td>
<td>4,010</td>
<td>4.0%</td>
<td>5,147</td>
<td>4.1%</td>
<td>9,980</td>
<td>7.1%</td>
<td>12,155</td>
<td>8.9%</td>
</tr>
<tr>
<td>16 Visits</td>
<td>3,701</td>
<td>3.7%</td>
<td>5,122</td>
<td>4.1%</td>
<td>9,621</td>
<td>7.0%</td>
<td>12,731</td>
<td>9.4%</td>
</tr>
<tr>
<td>17 Visits</td>
<td>3,182</td>
<td>3.2%</td>
<td>4,476</td>
<td>3.5%</td>
<td>7,641</td>
<td>5.9%</td>
<td>10,584</td>
<td>7.9%</td>
</tr>
<tr>
<td>18 Visits</td>
<td>2,247</td>
<td>2.2%</td>
<td>3,352</td>
<td>2.7%</td>
<td>5,388</td>
<td>4.1%</td>
<td>7,885</td>
<td>5.7%</td>
</tr>
<tr>
<td>19 Visits</td>
<td>1,559</td>
<td>1.5%</td>
<td>2,120</td>
<td>1.7%</td>
<td>3,670</td>
<td>2.7%</td>
<td>5,409</td>
<td>3.9%</td>
</tr>
<tr>
<td>20 Visits</td>
<td>1,209</td>
<td>1.2%</td>
<td>1,724</td>
<td>1.4%</td>
<td>3,479</td>
<td>2.6%</td>
<td>5,615</td>
<td>4.1%</td>
</tr>
<tr>
<td>21 Visits</td>
<td>1,085</td>
<td>1.1%</td>
<td>1,438</td>
<td>1.2%</td>
<td>3,100</td>
<td>2.3%</td>
<td>5,215</td>
<td>3.8%</td>
</tr>
<tr>
<td>22 Visits</td>
<td>856</td>
<td>0.8%</td>
<td>1,141</td>
<td>0.9%</td>
<td>2,638</td>
<td>2.0%</td>
<td>4,854</td>
<td>3.4%</td>
</tr>
<tr>
<td>23 Visits</td>
<td>693</td>
<td>0.7%</td>
<td>1,047</td>
<td>0.8%</td>
<td>2,149</td>
<td>1.6%</td>
<td>3,932</td>
<td>2.8%</td>
</tr>
<tr>
<td>24 Visits</td>
<td>506</td>
<td>0.5%</td>
<td>834</td>
<td>0.7%</td>
<td>2,052</td>
<td>1.5%</td>
<td>3,869</td>
<td>2.9%</td>
</tr>
<tr>
<td>25 Visits</td>
<td>416</td>
<td>0.4%</td>
<td>703</td>
<td>0.6%</td>
<td>1,717</td>
<td>1.2%</td>
<td>3,174</td>
<td>2.3%</td>
</tr>
<tr>
<td>26 Visits</td>
<td>429</td>
<td>0.4%</td>
<td>596</td>
<td>0.5%</td>
<td>1,906</td>
<td>1.4%</td>
<td>2,795</td>
<td>2.0%</td>
</tr>
<tr>
<td>27 Visits</td>
<td>330</td>
<td>0.3%</td>
<td>463</td>
<td>0.4%</td>
<td>1,546</td>
<td>1.1%</td>
<td>2,403</td>
<td>1.7%</td>
</tr>
<tr>
<td>28 Visits</td>
<td>244</td>
<td>0.2%</td>
<td>355</td>
<td>0.3%</td>
<td>1,908</td>
<td>1.4%</td>
<td>2,243</td>
<td>1.6%</td>
</tr>
<tr>
<td>29 Visits</td>
<td>227</td>
<td>0.2%</td>
<td>335</td>
<td>0.3%</td>
<td>942</td>
<td>0.7%</td>
<td>2,056</td>
<td>1.5%</td>
</tr>
<tr>
<td>30 Visits</td>
<td>207</td>
<td>0.2%</td>
<td>205</td>
<td>0.2%</td>
<td>771</td>
<td>0.6%</td>
<td>1,027</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

| Total                  | 29,075                | 99.0%     | 122,031               | 99.8%     | 186,662                | 97.9%     | 239,541                | 95.9%     |

Note: The 2008 column does not include information regarding approximately 17,240 episodes, related to Amedes' 2008 acquisition of TLC Health Care, that did not transfer to the Amedes system from the legacy TLC system.
## Average OASIS Scores

### Activities of Daily Living by Year

<table>
<thead>
<tr>
<th>Year</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapy Episodes - Average Score</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OASIS M0520 - Urinary Incontinence</td>
<td>0.498</td>
<td>0.523</td>
<td>0.529</td>
<td>0.534</td>
</tr>
<tr>
<td>OASIS M0530 - Urinary Incontinence</td>
<td>1.575</td>
<td>1.584</td>
<td>1.583</td>
<td>1.682</td>
</tr>
<tr>
<td>OASIS M0540 - Bowel Incontinence</td>
<td>0.379</td>
<td>0.398</td>
<td>0.410</td>
<td>0.409</td>
</tr>
<tr>
<td>OASIS M0640 - Grooming</td>
<td>1.296</td>
<td>1.456</td>
<td>1.449</td>
<td>1.436</td>
</tr>
<tr>
<td>OASIS M0650 - Upper Dressing</td>
<td>1.492</td>
<td>1.608</td>
<td>1.574</td>
<td>1.552</td>
</tr>
<tr>
<td>OASIS M0660 - Lower Dressing</td>
<td>1.805</td>
<td>1.891</td>
<td>1.836</td>
<td>1.809</td>
</tr>
<tr>
<td>OASIS M0670 - Bathing</td>
<td>2.970</td>
<td>3.055</td>
<td>3.010</td>
<td>2.957</td>
</tr>
<tr>
<td>OASIS M0680 - Toileting</td>
<td>1.307</td>
<td>1.418</td>
<td>1.267</td>
<td>1.303</td>
</tr>
<tr>
<td>OASIS M0690 - Transferring</td>
<td>1.470</td>
<td>1.585</td>
<td>1.436</td>
<td>1.379</td>
</tr>
<tr>
<td>OASIS M0700 - Ambulation</td>
<td>1.762</td>
<td>1.839</td>
<td>1.784</td>
<td>1.739</td>
</tr>
<tr>
<td>OASIS M0710 - Feeding</td>
<td>0.705</td>
<td>0.745</td>
<td>0.725</td>
<td>0.722</td>
</tr>
</tbody>
</table>

**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 30,000 TLC OASIS Assessments are not included in this analysis.
Footnote 19
## Medicare Reimbursement

### by Year

<table>
<thead>
<tr>
<th>Request #3 - by Question</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a - Medicare Home Health Patients - Therapy</td>
<td>79,886</td>
<td>96,542</td>
<td>144,574</td>
<td>184,635</td>
</tr>
<tr>
<td>3b - Medicare Reimbursement - Episodes with Therapy Reimbursement</td>
<td>$255,955,854</td>
<td>$220,581,498</td>
<td>$607,735,682</td>
<td>$878,535,069</td>
</tr>
<tr>
<td>3c - Medicare Reimbursement - All Episodes</td>
<td>$460,414,462</td>
<td>$575,516,279</td>
<td>$921,645,988</td>
<td>$1,229,755,214</td>
</tr>
</tbody>
</table>

*Note: The 2008 column does not include information regarding approximately 17,258 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
Objectives

At the completion of this program, you will be able to:

- Identify which reports you need to run weekly or daily to make your agency run smoothly.
- Identify a place to start in managing the multitude of reports available to you.
- Demonstrate a knowledge of managing your agency using the reports available to you.
- Learn to use the Care Team Conference to make it easy to answer Your Episode Managers questions.
MAKE IT EASY ON YOURSELF!!

- You are required to have a Care Team Conference weekly. So use that time to gather the information that you need to manage your agency and to answer your Episode Managers questions as well.
- When your Episode Manager runs reports to identify things she needs you to look at she uses the same time frame that you use for Care Team Conference.
- Disease Management has given us the tools for organizing our Care Team Conference reports. If you use the notebook to keep all the reports from Care team you will have all your Care Team information in one easy place so you can go to get it quickly and will have very few follow up questions when answering the Episode Manager’s concerns.
Preparation is the Key!!

1. DOO runs and provides reports Monday AM

DOO, CM's and Clinicians
Spend less time in CTC

Clinicians can cover 2 days before CTC

Team conference moves along
More efficiently and timely

Clinicians can discuss Patients

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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

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Episode Countdown report
page 25

- Run weekly for Care team conference in conjunction with the Therapy Alert and the LUPA report
- Identifies patients that have inconsistencies in visit frequency such as therapy patients with 7, 8, or 9 visits or LUPA patients
- Use this report to zero in on issues quickly
Lupa Report

page 45

- Shows all patients that are potential as well as actual LUPA’s
- Use this report in Care Team Conference and save this report to help you answer your Episode Manager
- Discuss all actual and potential LUPA’s. Make sure that if it is appropriate to increase the frequency that you or your staff have gotten the orders and put the new frequency in place
- Allows you to impact LUPA’s proactively
- Suggestion: consider Sublingual B12 versus IM B12 Would a HHA 1xweek help prevent infections with the foley patients?

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Care team Conference or Care team Chaos

Therapy Alert Report
pg 79

• This report lists all patients with scheduled therapy visits in the requested date range and provides visit information including: Pt name and ID, Therapist code, Cert from date, Episode #, HIPPS code, and displays scheduled visits and actual visits, date of first visit, and the Discharge date if applicable.

• The report helps the DOO focus on therapy utilization. Look for patients that have 7,8,9 visits and try to get the 10 visits to make therapy threshold. Look at patients that have functional scores that do not support the visit frequency. I.e: F4 with 3 visits or an F1 with 10.

• If your patient has an F4 with only an evaluation visit or a F1 with >10 visits then it is appropriate to look at that assessment to see if the functional questions were answered correctly.

• Remember that we should have a Therapy Evaluation on patients that score F2 or higher on the FES score.
Care team Conference or Care team Chaos

Therapy Consult Report
pg 80

- This report utilizes the OASIS SOC assessment to identify OASIS items that may indicate the need for therapy.
- Use this report in care team conference to quiz staff about the need for therapy services for admitted patients.
- This report displays a list of all patients with a SOC date within the requested range and responses that were entered on the SOC assessment that may indicate the need for therapy. This report divides the questions among specific disciplines that would impact the listed deficit.

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Recert Forthcoming
page 62

- Run this report weekly using the time frame of 1 week before and 2 weeks after today's date
- Gives you the list of patients you need to work up for Care Team Conference
- Give this list to your Clinical Managers and Clinicians so they can prepare for Care Team Conference. A prepared staff conserves time in Care Team Conference
- When evaluating for recert or discharge review the record for Medication changes, new orders, possible declines, or hospitalization. Have the clinician bring Discharge Criteria check list to CTC and review during conference.
- Remember that the Director is the person to decide whether to discharge or recert

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Adjusted Revenue Report

page 3

- Use this report to identify patients that have had or will have revenue adjustments made to the expected payment amount.

- It identifies and/or verifies patients that will be LUPA's, Non-therapy thresholds, good or bad SCICs, PEPs, and Outliers

- If this report is evaluated at mid month every month you will identify adjustments before they are made and be able to proactively manage your agency.

- This report gives you the best opportunity to convert or prevent LUPA's and non therapy threshold patients.

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OCS Patient Outcomes Report
page 49

- Run weekly for Care Team Conference
- Run one for each patient on the Recert Forthcoming list
- Provide a copy for each Clinician that completes OASIS assessments
- Suggestion: give copy to primary clinician to place in home folder so we can know where the patient started and gives them the tools to determine if DC is appropriate.
- Use this in conjunction with the Recert Forthcoming list to determine whether discharge or recert is indicated.
- If there are declines reported in Care team Conference then you need to rethink whether the patient is ready for discharge
- This tool can be used to help you develop your staff's understanding of OASIS assessment

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High Utilization
page 38

- The DOO may use this report to identify and focus on patients with high visit utilization. Scheduled versus Actual visits should be reviewed based on the diagnosis and clinical track and determine whether visits are appropriate.
- Run this report at least weekly to help you keep your visits per episode numbers at company average or below.
- Look to see if a clinical track was assigned to both nursing and therapy and determine if the frequency is within the suggested track guidelines.
- Run this before Care Team Conference so you have the information at your fingertips when discussing patients
- Remember to teach staff and Clinical Managers that using the suggested visit numbers on Clinical Tracks can keep visits/per episode in line with company averages.
- High Utilization threshold is identified as above 15 visits in Report Writer.

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NO Activity Report

page 48

- Run weekly for Care Team Conference and go over each patient with your team. Figure out why these patients have not gotten a visit in the specific time frame
- This report identifies patients that have not had a visit in specific time periods-1, 2, 3, 4, and 6 weeks. (Usually only discuss 2 weeks or older)
- Identifies patients that need to be discharged or recerted
- Prevents patients from falling thru the cracks
- Can identify d/c's needed due to hospitalization
- Can identify patients that should have been discharged but the paperwork may not have been submitted.
- Can help identify homebound issues
- A very long report suggests scheduling issues

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Clinical Track Maintenance in CTC

Clinical track progress report- page 21

- This report allows the DOO to assess the progress of patients on clinical tracks to assure that outcomes are being met.
- Print all clinical track progress reports for all patients that are listed incomplete.
- Make sure in CTC that both Therapy and Nursing are following the suggested track visit numbers. Assess track progress each week at CTC.
- If the frequency is over the suggested amount of visits make sure that the Clinicians are using the variances to explain this discrepancy.
- Suggestion: Make each clinician a copy of the Clinical Track Progress Report each week so they can refer back to the patient report when assessing clinical track progress while in the home.

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Managing outcomes in Care Team Conference

OASIS Inconsistency Report

- Run weekly for Care Team Conference. This report will let you know when OASIS answers do not make logical sense.

- This report is not listed on the reports module in DOO training manual but can give you some insight into your Clinicians ability to complete OASIS documentation accurately.

- This report can be run out of report writer.
Managing your Daily Reports

Executive Indicators

pg 27

- This report should be run daily by the DOO and used in conjunction with the executive indicator dashboard to evaluate and impact episode management.
- Working this report daily keeps you on top of the major issues that can occur in episode management of your agency by giving you a specific list of exactly what you need to work on that day.
- This report looks at all active episodes as of the indicated report begin date and searches for alert items in need of further investigation or correction.
- The first page provides a summary of the number of episodes with alerts based on the tagged indicators.
- The remaining pages provide detailed patient information for each alerted Category.

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Care team Conference or Care team Chaos

Executive Indicators
Agent Productivity Detail

- This lists the active clinicians who had visit productivity numbers below 25 for the preceding posted pay period.

- DOO's should carefully evaluate these numbers as failure to meet productivity standards may impact benefit status and increase the agency's direct costs.

- You can list a higher number in the "agents with weekly visits below__" box and then can see your over achievers or clinicians that may need to share the wealth as well.
Coding Inconsistencies

This report looks at all patients with a SOC or recert from the date that falls within seven days of the report begin date that has the following coding issues.

- 250.00 or 250.01 in positions 1-5
- 250.1x to 250.9x in positions 2-5 with nursing primary
- Therapy diagnosis in positions 2-5 with therapy primary

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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.
Executive Indicators continued

Recert Assessments Detail

• Looks at active episodes that will expire within 14 days of the report begin date that have had activity. i.e. changes in meds, orders or track variances within 3 weeks of the report begin date.
• This helps you prevent inappropriate discharges and to keep up with the changes that are occurring with the patient. Makes management of the episode easier if you have multiple Clinical staff seeing the patient.
Executive Indicators

Functional Therapy Check

- Looks at all SOC and Recert patients with a cert from date within 7 days of the report begin date that have an F2, F3, or F4 in the HHRG and less than 10 therapy visits scheduled

- All patients with an F2 or higher need to have a therapy evaluation.

- This report can help you prevent non therapy thresholds due to missed visits.

- It helps you identify if your agency is utilizing therapy appropriately.

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Executive Indicators, cont.

LUPA Inconsistencies Detail

- Looks at all recent patients with a cert from date within 7 days of the report begin date where the previous episode was a LUPA, yet the patient has declined in OASIS or there have been med changes or order changes
- You need to look at these patients to determine if they are appropriate to have increased frequencies.
- Managing LUPA’s early in the process can decrease the number you have in your agency. I.e.: Sub lingual B12 can replace B12 injections and thus decrease your LUPA rate.

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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.
Daily Reports cont.

Decline alerts by last assessor-pg 24
- This report lists any patient that has had a discharge OASIS that has been completed which exhibits a decline in any of the quality indicators.
- Run daily and discuss declines with Clinicians to determine if they are truly declines. This report will markedly decrease your declines if worked appropriately. If the Declines are true then why discharge?
- Catch declines before they are locked. Working this report daily keeps it short and sweet.

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Daily Reports, cont.

Recent Past Due-pg 62

- Run this report in report writer using the prompt for past due instead of forthcoming

- Keeping this one clean daily prevents late discharges or recerts.

- Remember your goal is to have no patients on this list at 5pm every afternoon

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Recert past due report
Care team Conference or Care team Chaos

Summary

- Reports can be used to manage your Care Team Conference and to make your agency the best it can be.
- Use the tools that are available to you to function more successfully as a Director.
- Believe it or Not ....

Reports can be your Friends!!

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Care team Conference or Care team Chaos

Questions????

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Post-Test Questions

1. Which report shows the most overall information?
   a. PPS Detail
   b. Incident report
   c. LUPA report
   d. No Activity report

2. Which report tells you who is supposed to be discussed at Care Team Conference?
   a. Recert forthcoming
   b. Episode Countdown
   c. Recert past due
   d. Executive Indicators

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Post-Test Questions

3. What information does the Therapy Alert contain?
   a. All therapy patients with 1 or more visits, number of visits and last date of visit
   b. Whether a therapy referral has been made
   c. If a nurse has contacted the patient
   d. How much pain a patient is in

4. When you look at the Clinical Track Progress report you can determine
   a. If a patient is ready for discharge
   b. If a patient has missed visits
   c. If a patient has seen the MD lately
   d. If the nurse understands the situation
Post-Test Questions

5. The No Activity report is run how often and for what purpose?
   a. Weekly for Care team conference
   b. Monthly to see if visits were missed
   c. Annually in December to clean up scheduling for the year
   d. Never
Post-Test Questions

7. When do you need to look at the Episode countdown report?
   a. Weekly at Care Team conference
   b. Monthly just to make sure you haven't missed anything
   c. Daily because it is less to look at than the LUPA and Therapy Alert
   d. Every other week at Care Team Conference
   e. Never

8. Why use the Therapy Alert and the LUPA reports if you have the Episode countdown report?
   a. Therapy Alert and LUPA are more comprehensive but Episode countdown give it to you in a short summary format
   b. You don't need to use them all
   c. The therapy alert and lupa report give too much information
   d. The LUPA is all you need

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Post-Test Questions

9. The Recert forthcoming report is used for which of the following?
   a. B and C
   b. Is used to identify patients to be discussed in care team conference
   c. Is run using the time frame of 1 week before current date and 2 weeks after
      when preparing for CTC

10. The Adjusted Revenue Report is used for which of the following
    a. Identify patients that will have adjustments made due to LUPAs and not
       meeting Therapy Threshold.
    b. Adjustments that can not ever be prevented.
    c. It is just another useless report so ignore it.
    d. Patients that have a primary diagnosis code that is incorrect
Post-Test Questions

11. The OCS report is used to achieve which of the following?
   a. To help the clinician decide if the patient has improved enough to be discharged from Home Health Care.
   b. To give the answers to the DC OASIS.
   c. Not to be used during care team conference.
   d. Is not helpful in planning the patient care.

12. The recent past due is used to keep all discharges and recerts timely.
   a. True
   b. False
Post-Test Questions

13. The Decline alert must be run and worked how often?
   a. Daily
   b. Weekly
   c. Quarterly
   d. Annually

14. How does working the Decline Alert help the Director manage their agency?
   a. Can help identify Staff that are unclear on OASIS and prevent declines.
   b. Helps you decide when to discharge a patient.
   c. Makes you keep clinicians aware of changes in OASIS.
   d. Is never used by Director because info is useless.
Post-Test Questions

15. Which reports should be run and worked daily?
   a. Executive Indicators, Decline alert and Recert past due
   b. Recert forthcoming, Oasis integrity, Outcomes Report
   c. Adjusted Revenue Report, Agent Productivity, and Decline Alert
   d. Decline alert, Oasis integrity and Outcomes Report

16. You should give your clinicians this report in time to prepare for care team conference.
   a. Recert forthcoming
   b. Decline Alert
   c. All of them they need to feel as overwhelmed as me.
   d. None of them the I'll will do all the work.

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Care team Conference or Care team Chaos

Post-Test Questions

17. Executive Indicators if worked daily can give a Director a clear idea of the following:
   a. Staffing needs, Coding inconsistencies, Recert inconsistencies, Therapy inconsistencies
   b. HR needs ie: insurance, CPR, training
   c. Rankings by RA or VP
   d. Agency cost per visit

18. Which report documents that on recert a patient condition is improved yet visit frequency has been increased?
   a. Recert Inconsistency in Executive Indicators
   b. decline report
   c. HHRG calculator
   a. Recert forthcoming

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Post-Test Questions

19. Once a patient is on the High Utilization Report the DOO should do which of the following?
   a. b, c, and d
   b. Check to see if the patient was placed on a clinical track
   c. Check to see if the clinical track has variances to explain the increased frequency
   d. Assess if the clinical and functional HIPPs score support the need for the extra visits

20. At what point does the High Utilization Report identify a patient as high utilization?
   a. 15
   b. 25
   c. Over clinical track suggested visits
   d. 22
Footnote 24
Home Health Care Team Conference Overview

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Home Health
Care Team Conference Overview

Stream 1

Welcome to the computer-based training program that provides an 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.
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)

Objectives

At the completion of this course, 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
- Verbalize success tips for conducting a care team conference

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

What is a "Conference"?

- Latin origin: 'conferre or confer' — to summon or bestow
- Current meaning — to have a meeting or consultation for discussion
- Act of conferring or consulting on an important matter
- An association of teams
- An official assembly

What is a "Conference"?

- The single most critical activity that can occur in an agency to promote financial success and positive patient outcomes
- Should not be confused with an agency staff meeting

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.
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.
## 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 DOO is required to be present at each care team conference and supervise conference activities.

Participants that should be present at the conference include the DOO, 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 each Clinical Manager 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 teams 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.
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.

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PURSUANT TO SENATE RULE XXIX

AMEDSFC00001563
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.
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 Risk 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.
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 with 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 clinicians should document the details using the care 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 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.
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 NHIRD 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?

- 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 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 close follow up, including Friday Calls.
What is the patient's functional status based on the 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 care 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 recert 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 ensure 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 recertified 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 infusions, 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?
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 DOO 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 AMS 2 Report Writer. This process works best if the DOO 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. The team should quiz the primary clinicians 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 AM 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 with 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 Telmedicline 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 Telmedicline 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 beding 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 Telmedicline wound department.
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-ensnapping 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 multi-disciplinary 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 DOO during this part of the conference include:

- Are the ordered services component 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 DOO should also assure that 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.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.
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 this 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 POC 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.
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, and trends that have been identified. The D O O 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 D O O who focuses more on increasing the knowledge of team members instead of merely correcting performance issues will have much greater outcomes in the long run. Successful D O Os look for performance trends and use those opportunities to educate team members so they become part of the solution.
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...

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**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.
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, DOs should make them a consistent priority in the agency. The following tips are important for success.

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Thank you for completing this program!
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% or greater.
Click the right navigation arrow to return to the main menu and select the post-test link to access the test.

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
MINUTES OF A MEETING OF THE BOARD OF DIRECTORS
OF AMERICAN, INC. HELD ON JULY 26, 2007

A meeting of the Board of Directors of the "Company", a Delaware corporation (the "Corporation"), was held at 1 East Van Buren Street, Chicago, Illinois on July 26, 2007, pursuant to notice duly given. As noted below, the meeting was reconvened on July 26, 2007, and reconvened on the morning of July 26, 2007. Pursuant to the meeting were Board members:

William Bower, Robert Lubell, Jack Miskovich, David Pila, Peter Blockson, and Donald Nishihara. Present on behalf of the Company were Carl O'Hara, Chief Operating Officer and President, Dan Bokan, Chief Financial Officer, Artie Ellis, Chief Financial Officer, Marina Sartz, William Rogers, Joseph Andreadis, and Cherie Fabian, as well as the President of Legal and Corporate Secretary, representing the Board of the Company.

The minutes for portions of the meeting were Jeffrey Kri, Senior Vice President of

CFO's Office, Jon Dolen, Senior Vice President of Finance, and Kent Cowen, Senior Vice President of Accounting. Lee Klein of Boulder, Jared White, and Bruce E. Edelman, Chief Executive Officer, and Mary Beth FrAncese, Chief Financial Officer, also participated for portions of the meeting.

RESOLVED:

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEDFCG00000812
Mr. Schwartz addressed the "bare facts" regarding the vote recently approved by the Council for American and Medical Services (CAMS) and informed the Board that the Company had formed a committee called the "A Team" which had been formed to address the proposal and conduct research. He noted that this committee was meeting on a bi-weekly basis. During her presentation, Ms. Robinson responded to various questions from the Board members.
The relationship between the health care and \,

occupational populations among the diverse members \,

of the health care industry. According to the Council of \,

Medical simulator for patients who have \,

attended a course designed to improve \,

their skills in managing complicated medical cases. \,

The major goal of this course is to prepare \,

physicians, nurses, and other health care providers \,

for the critical decision-making processes involved in \,

managing complex medical situations. The course \,

covers a wide range of topics, including medical \,

diagnosis, treatment options, and ethical considerations. \,

Participants in the course learn through interactive \,

scenarios that simulate real-world situations. The \,

course is designed to enhance \,

participants' ability to make informed decisions and \,

address challenging medical issues effectively. \,

The Council of \,

Medical simulators is committed to improving \,

the quality of medical care by providing \,

effective training programs for health care providers.
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Amedsys Strategic Advisory Committee

A newly formed committee of national experts in health care will be working hand in hand with the founders and developers of the Amedsys healthcare model.

Corporate Level OK Strategy Initiative

Key Strategy: Principle - Amedsys OK Engines. The OK engines have been designed to align the development of the corporate level OK engines. A comprehensive OK plan has been created to successfully execute this initiative.

The dynamics of OKS mentioned above reveal that it is likely that OKS will continue to evolve and change the health programs for all entities. Therefore, Amedsys needs to stay on the cutting edge of health care payment systems continually. Amedsys OKs may be configured to provide an additional service to OIS and other systems on an as-needed basis in the changing environment. In particular, for those changing, Amedsys must develop goals and business strategies that leverage the Amedsys core competencies.

Preliminary numbers and business models have been developed to assess short and long-term changes. Please include the following:

1. Two strategies for the management of additional high-cost claims on existing platforms in the United Sates.

2. Short Term Business Strategies (2-1 year):
   - Develop infrastructure management programs.

- Amedsys is a leading provider of healthcare management solutions.
- Enhance systems to serve current managed care clients.
- Develop effective and efficient systems infrastructure and marketing plans necessary to sustain client growth.
- Enhance case management. Plan models include: Enhanced Primary Services, Personal Health, and other.
- Enhance patient portal.
- Provide electronic referrals.
- Develop, implement and deliver a manageable, scalable product including national healthcare and care delivery management following up services. The product will be marketed to current managed care clients as well as new potential MCOs including FMCOs. Product will include: Imaging, Billing, IT/IS, and HIPAA.
- Improve patient portal.
- Develop medical practice support system model.
- Refine and transfer the Medical Practice Transition System and Electronic Physician Information Resources. These include the following MCO medical management support functions: Call Center, Care Coordinators, Case Management, Community Based Health Administrators, Practice, Revenue Cycle, and Access tools.
- Obtain a Medical Home Demonstration project.
- Refine and adjust for the upcoming CMS National Home Demonstration project as submitted by the HIPAA.

CONFIDENTIAL TREATMENT REQUESTED
Pursuant to Senate Rule XXIX
Mid Term Strategies (1-3 years)

- Serve a national coverage area
- Enhance group and subpopulations of population to meet needs and expectations to serve a national coverage area
- Offer products/services that complement home care service
- Develop new or redraft regulations by developing a network of healthcare providers and services to offer patient care and home care services. The services include the following: (a) Medical Alert monitoring, (b) Telehealth, (c) Telemental Health, (d) Ambulatory health management, (e) Case coordination, (f) Care Management, and (g) Social services.

Long Term Strategies (5-6 years)

- Work with CMS to redesign Medicare home nursing benefits
- User-based innovation
- Develop a patient-centric, community-based, payer-driven integrated care delivery model.
- Design and deliver a framework for an HCT driven integrated delivery system (SDM) model with...
In conclusion, the strategies outlined above represent a new era of health care delivery. These initiatives will lead to improved health outcomes, increased efficiency, and reduced costs. By leveraging the strengths of each component, we can create a comprehensive, integrated system that improves health care delivery and outcomes for all patients.

Amexsys
Piper Jaffray

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Source: Company report, Piper Jaffray & Co., Research

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEOFSO00000827
MINUTES OF A MEETING OF THE BOARD OF DIRECTORS
OF AMERIFLEX, INC. HELD ON OCTOBER 21, 2007

A meeting of the Board of Directors of the "Company," a Delaware corporation, was held on October 21, 2007, at 10000 Tabor, at the Company's corporate headquarters in Boston, Massachusetts. The purpose of the meeting was to approve the minutes of the preceding Board meeting held on September 24, 2007.

Present at the meeting were Board members William Bonk, William LeBlanc, and Robert L. Murray. Also in attendance were Marcia J. Patterson, Chief Financial Officer; James W. Armbrust, Chief Executive Officer; and James B. Bower, General Counsel. The meeting was called to order by Chairman William Bonk, with Marcia J. Patterson, Chief Financial Officer, presiding.

The minutes of the preceding Board meeting were reviewed and approved. There were no new business items. The meeting adjourned.

RESOLVED

[Signatures]

[Seal]

[Seal]

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Approved by the Board of Directors on December 13, 2007

[Signature]

[Signature]

[Signature]

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEDSFC00000835
Ms. Schwartz updated the Board regarding the impact of the "take rate adjustment" recently implemented by the Centers for Medicaid and Medicare Services ("CMS") on the Company's Medicare Advantage enrollment and related revenue. She noted that the Company's Medicare Advantage enrollment increased due to the implementation of this adjustment. Ms. Schwartz also discussed the impact on the Company's overall operations and financial performance. She highlighted the Company's efforts to mitigate the impact of the adjustment and its impact on the Company's revenue and profitability. Ms. Schwartz concluded by expressing the Company's commitment to maintaining its Medicare Advantage program and its focus on improving the overall customer experience.
### Data Consistency Automation - Impact per Month

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### Cost Cutting Efficiency Measures - Current Impact

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</thead>
<tbody>
<tr>
<td>1. Change History Errors</td>
<td>50.00</td>
</tr>
<tr>
<td>2. Define Transactions</td>
<td>100.00</td>
</tr>
<tr>
<td>3. Define Transactions</td>
<td>150.00</td>
</tr>
<tr>
<td>4. Process Collected</td>
<td>200.00</td>
</tr>
<tr>
<td>5. Process Collected</td>
<td>300.00</td>
</tr>
<tr>
<td>Total</td>
<td>700.00</td>
</tr>
</tbody>
</table>

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XIX

AMEDSF000000844
### Clinical Programs - Estimated Impact

<table>
<thead>
<tr>
<th>Program</th>
<th>Initial Funding</th>
<th>Estimated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Care Program</td>
<td>1,000,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Family Support Program</td>
<td>5,000,000</td>
<td>6,000,000</td>
</tr>
<tr>
<td>Elderly Care Program</td>
<td>2,000,000</td>
<td>2,500,000</td>
</tr>
<tr>
<td>Mental Health Program</td>
<td>3,000,000</td>
<td>3,500,000</td>
</tr>
<tr>
<td>Substance Abuse Program</td>
<td>1,000,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Substance Abuse Education</td>
<td>500,000</td>
<td>750,000</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td>1,000,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Other Programs</td>
<td>2,000,000</td>
<td>2,500,000</td>
</tr>
</tbody>
</table>

### Alternative Programs - Estimated Impact

<table>
<thead>
<tr>
<th>Program</th>
<th>Initial Funding</th>
<th>Estimated Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>df Care Comprehension</td>
<td>1,000,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>df Care Treatment</td>
<td>2,000,000</td>
<td>2,500,000</td>
</tr>
<tr>
<td>df Care Programs</td>
<td>1,000,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>df Care Education</td>
<td>500,000</td>
<td>750,000</td>
</tr>
<tr>
<td>df Care Treatment</td>
<td>1,000,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Other Programs</td>
<td>2,000,000</td>
<td>2,500,000</td>
</tr>
</tbody>
</table>
Footnote 27, 28, 30
From: Pat Waller
Sent: Friday, June 29, 2007 11:19 AM
To: Regional Administrators; Business Development/Operations; VP Operations; Esther Lee; Fred Simms
CC: Jill Cannon; William Meyers; Barbi Deen; Peggy Hill; Alice Schwartz; Larry Graham
Subject: Conference Call
Attachments: Data Mining Strategies Handout (2).doc, AmedIPSStrategies.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 reg, and the efforts taking place to prepare our company for continued success once the new reg is 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]

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 to 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.

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXX

AMEDFC20006904
<table>
<thead>
<tr>
<th>Date Ins satisfactory</th>
<th># Episodes</th>
<th>Added Revenue</th>
<th>POC Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound diagnosted on GASS without supporting diagnosis</td>
<td>15,760</td>
<td>$391,000</td>
<td>Immediate POC enhancement to capture wound diagnosis</td>
</tr>
<tr>
<td>Patients on diabetes medication without diagnosis</td>
<td>884</td>
<td>$1,200,000</td>
<td>Immediate POC enhancement to capture diagnosis. Will increase revenue in current model</td>
</tr>
<tr>
<td>Patients on medication for treatment of cancer without diagnosis</td>
<td>764</td>
<td>$598,000</td>
<td>Immediate POC enhancement to capture diagnosis.</td>
</tr>
<tr>
<td>Thalidomide indicated on GASS/RevMed without pulmonary diagnosis (0.995)</td>
<td>13564</td>
<td>$730,000</td>
<td>Immediate POC enhancement to capture diagnosis</td>
</tr>
<tr>
<td>Patients on medications commonly used to treat heart disease or H19 with diagnosis</td>
<td>3243</td>
<td>$1,200,000</td>
<td>Immediate POC enhancement to capture diagnosis</td>
</tr>
<tr>
<td>F77 on Primary 30x with &lt;6 Therapy visits &amp; F2:331 case mix</td>
<td>30472</td>
<td>$500,000</td>
<td>AMBS report to identify and track F2F episodes where therapy visits are &lt;6. Rehab tracks based on clinical and functional domains / goal directs</td>
</tr>
<tr>
<td>All episodes with F2:331 case mix without therapy services</td>
<td>5248</td>
<td>$715,000</td>
<td>AMBS report to identify and track F2F episodes where there are no therapy visits. Integration of rehab and clinical tracks for interdisciplinary approach.</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PT replaces SW visits in wound care episodes with therapy</td>
<td>4292</td>
<td>$1,400,000</td>
<td>PT Wound Care Specialty Program. Currently evaluating state practice acts, selection and training of PTs in each market to assume wound care treatment, utilizing care managers.</td>
</tr>
<tr>
<td>Add Therapy to CHF patients with F2F3 case mix with therapy</td>
<td>4200</td>
<td>$450,000</td>
<td>Rehab @ Home with clinical diagnosis integration. 4 visits based on H10G scores</td>
</tr>
<tr>
<td>Totals</td>
<td>84 Million</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Higher Profit Medical Diagnoses (ICD progr. oriented)</th>
<th>Avg Profit / Episode</th>
<th>DM Program and Business Development Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuro 2 - CVA/Stroke/TEA</td>
<td>$2,518</td>
<td>New Programs:</td>
</tr>
<tr>
<td>Ortho 2 - Muscle Disease</td>
<td>$2,017</td>
<td>a. Rehab at Home (Ortho 2) - July 13, 2007</td>
</tr>
<tr>
<td>Skin 2 - Ulcers and other Skin Conditions</td>
<td>$1,877</td>
<td>b. Dysphagia, E-soins, Infrared Light Therapy – July 30, 2007</td>
</tr>
<tr>
<td>Skin 1 – Open Wound of Lower Limb</td>
<td>$1,751</td>
<td>c. Progressive Neuro Program – August 15, 2007</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$1,725</td>
<td>Update &amp; Re-Launch the following DM programs</td>
</tr>
<tr>
<td>Traumatic wound, burn and post-op complications</td>
<td>$1,410</td>
<td>d. Stroke Recovery @ Home (Neuro 3). July 30, 2007</td>
</tr>
<tr>
<td>Skin 1 – Cetuhab / Infections</td>
<td>$1,343</td>
<td>e. Heart @ Home – August 15, 2007</td>
</tr>
<tr>
<td>Varicosities of the lower extremities</td>
<td>$1,337</td>
<td>f. Behavioral Health @ Home (post narc required) – August 15, 2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>g. Partners in Woundcare (Skin 1, Skin 2) - September 17, 2007</td>
</tr>
<tr>
<td></td>
<td></td>
<td>h. Diabetes @ Home – October 15, 2007</td>
</tr>
</tbody>
</table>
VP/RA/RDDD
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 payer verification outsource

4. Clinical Development – strategy – Project Leader – Arne Freehette
   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 advices for the top 12 payers

Automate the posting of the BRAs

GPS mileage in POC


Developing a strategic sales focus upon preferred patient mix
Footnote 29
From: Wanda Hull
Sent: Saturday, August 11, 2007 11:29 AM
To: Jill Cameron
Subject: Attachment: VP KTeam Training Therapy Initiatives.ppt

Jill, I sent this presentation to you 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
<table>
<thead>
<tr>
<th>Case</th>
<th>Year</th>
<th>Reimbursement</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2007</td>
<td>$2,577.36</td>
<td>$2,489.50</td>
</tr>
<tr>
<td></td>
<td>2008</td>
<td>$5,807.81</td>
<td>$7,688.80</td>
</tr>
</tbody>
</table>

- Reimbursement only
- 14 PT + 12 RN
- 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

<table>
<thead>
<tr>
<th>Adding Therapy</th>
<th># Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>PT replaces SN visits in wound care episodes w/o therapy</em></td>
<td>6292</td>
</tr>
<tr>
<td><em>Add Therapy to CHF patients with F2F3 score w/o therapy</em></td>
<td>8809</td>
</tr>
</tbody>
</table>
### Data Mining Results

<table>
<thead>
<tr>
<th>Adding Therapy</th>
<th># Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT replaces SN visits in wound care episodes w/o therapy</td>
<td>6292</td>
</tr>
<tr>
<td>Add Therapy to CHF patients with F2F3 score w/o therapy</td>
<td>8809</td>
</tr>
</tbody>
</table>

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
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
Questions??
Footnote 31
From: Misty Purdon [REDACTED]
Sent: Thursday, August 02, 2007 8:10 AM
To: [REDACTED] - Clinical Operations; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]
CC: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]
Attachments: Case Mix Strategy Handouts.pdf
Importance: High

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

From: Misty Purdon
Sent: Monday, July 30, 2007 3:04 PM
To: [REDACTED] - Clinical Operations; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]
CC: [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]; [REDACTED]
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 to 10 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 Purdon
Amedisys, Inc.
5959 S. Sherwood Forest Blvd.
Baton Rouge, LA 70816
Phone: [REDACTED]
Fax: [REDACTED]

*** NOTICE:*** The attached information is intended for the personal use of the intended recipient and is not to be copied, reproduced or distributed without written consent of Amedisys, Inc. If you have received this communication in error, please notify us immediately and delete this communication.

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Pursuant to Senate Rule XXIX

AMEDSF00064385
## PPS Case Mix and Therapy Adjustment Overview

### Existing HHPPS

<table>
<thead>
<tr>
<th>Case-Mix Model</th>
<th>Existing HHPPS</th>
<th>Proposed Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 case-mix resource groups</td>
<td>153 case-mix resource groups</td>
<td></td>
</tr>
<tr>
<td>Single therapy threshold at 10 therapy visits</td>
<td>Therapy threshold at 5, 14 and 20 visits. 6 additional service utilization levels added to the model to account for visits performed between thresholds</td>
<td></td>
</tr>
<tr>
<td>Increase in payment for delivering at least 10 therapy visits in an episode</td>
<td>Gradual increase in payment between 1st and 3rd therapy thresholds</td>
<td></td>
</tr>
<tr>
<td>No accounting for timing of episodes</td>
<td>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</td>
<td></td>
</tr>
</tbody>
</table>
| 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

<table>
<thead>
<tr>
<th></th>
<th>Existing HHPPS</th>
<th>Proposed Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scores not given for infected surgical wounds, abscesses, chronic ulcers and gangrene</td>
<td>Includes scores for infected surgical wounds, abscesses, chronic ulcers and gangrene</td>
<td></td>
</tr>
<tr>
<td>No GI, pulmonary, cardiac, cancer, blood disorders or effective and other psychoses diagnosis groups included</td>
<td>Added GI, pulmonary, cardiac, cancer blood disorders, and effective and other psychoses diagnosis groups</td>
<td></td>
</tr>
<tr>
<td>Points not given for secondary diagnoses</td>
<td>Points assigned for some secondary diagnoses</td>
<td></td>
</tr>
<tr>
<td>Points not given for combinations of conditions in the same episode</td>
<td>Points assigned for some combinations of conditions in the same episode</td>
<td></td>
</tr>
<tr>
<td>M0175 &amp; M0610 included; M0470, M0520, &amp; M0800 not included</td>
<td>Excluded M0175 &amp; M0610, M0470, M0520 &amp; M0800 are added</td>
<td></td>
</tr>
</tbody>
</table>
# PPS Case Mix and Therapy Adjustment Overview

<table>
<thead>
<tr>
<th></th>
<th>Existing HHPPS</th>
<th>Proposed Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 day Episode Rate</td>
<td>$2339.00</td>
<td>Episodes beginning in CY 2007 &amp; ending in CY 2008 = $2,335.98</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Episodes beginning &amp; ending in CY 2008 = $2,330.60 followed by 3 consecutive years of 2.75% payment reductions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.9% market basket increase for CY 2008</td>
</tr>
<tr>
<td>Non-routine supplies (NSR)</td>
<td>Reimbursed $46.62 for all episodes, bundled in the episodic rate, updated annually</td>
<td>Payment related to 5 NSR severity groups ranging from $12.95 to $367.34</td>
</tr>
<tr>
<td>LUPA</td>
<td>No additional payment for LUPA episodes</td>
<td>Additional $92.63 flat payment if patient's first episode is a LUPA</td>
</tr>
<tr>
<td>SCIC</td>
<td>Required to be billed if indicative of an unanticipated improvement in patient condition</td>
<td>Eliminated</td>
</tr>
<tr>
<td>Quality data Reporting</td>
<td>10 measures of quality</td>
<td>12 measures of quality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Added: Urgent/Emergent Care for Wound Infections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement in Status of Surgical Wounds</td>
</tr>
</tbody>
</table>
Diagnoses – Profiling

Highest Resourced by Diagnosis

Average Profit per Episode

- Neuro2Stroke
- Ortho/Muscle
- Skin2Oulcer
- Skin/IL/E.Wnd
- Diabetes
- Skin/2Trauma
- Skin2Cellulite
- LE Varic
- HA DML/HTN
- Psych/HOSP

Based on episodes in 2006 database
Diagnoses – Profiling

Lowest Resourced by Diagnosis

Average Profit per Episode

Based on episodes in 2006 database
## Data Mining Results

2006 Database Analysis

<table>
<thead>
<tr>
<th>Data Inconsistencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wound indicated on OASIS with no supporting diagnosis (MO450) Pressure Ulcers (MO476) Stasis Ulcers</strong></td>
</tr>
<tr>
<td><strong>Patients on Diabetes medication(s) without diagnosis</strong></td>
</tr>
<tr>
<td><strong>Patients on medication to treat Cancer (Antineoplastic Agent) without diagnosis</strong></td>
</tr>
<tr>
<td><strong>Inhaler indicated on OASIS (MO790) without pulmonary diagnosis (COPD)</strong></td>
</tr>
<tr>
<td><strong>Patients on medications used to treat Heart Disease or HTN without diagnosis</strong></td>
</tr>
<tr>
<td><strong>V57 as Primary Dx with &lt;6 Therapy visits &amp; F2/F3 case mix</strong></td>
</tr>
<tr>
<td><strong>All episodes with F2/F3 case mix without therapy services</strong></td>
</tr>
</tbody>
</table>
STAFFING TO LOWEST DISCIPLINE

Phase I: 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 DCEO/CM.)
2. Admin.: (Agency data, printed monthly and as needed by DCO, RA, VP & SVP.)

Data captured on the report:

- Total Visit Count per discipline. Example: Total SN Visits
- # of Visits that require the higher discipline
- # 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 an 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 and 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.
# Case Mix Refinement Strategy

## Key Operational Initiatives

<table>
<thead>
<tr>
<th>Initiatives</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Point of Care Documentation Consistency Automation</td>
<td>1. Fully implement POC Data Consistency Edits</td>
</tr>
<tr>
<td>2. Lowest Discipline Staffing Reporting</td>
<td>2. Fully operationalize Staffing to Lowest Discipline</td>
</tr>
<tr>
<td>4. MapQuest Mileage Technology</td>
<td>4. Fully implement MapQuest Mileage Initiative</td>
</tr>
</tbody>
</table>

## Automation / Centralization

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Point of Care Edits - 6/21</td>
<td>- Report Inspection and Tracking</td>
<td>- Report Inspection and Tracking</td>
<td>- Report Inspection and Tracking</td>
<td>MapQuest Mileage Technology rollout by 12/31</td>
</tr>
<tr>
<td>- Lowest Discipline Staffing Report - 6/21</td>
<td>- POC Edits</td>
<td>- POC Edits</td>
<td>- POC Edits</td>
<td>- POC Edits</td>
</tr>
<tr>
<td>- Lowest Discipline Staffing</td>
<td>- Lowest Discipline Staffing</td>
<td>- Lowest Discipline Staffing</td>
<td>- Lowest Discipline Staffing</td>
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</tr>
</tbody>
</table>

## Clinical Programs

<table>
<thead>
<tr>
<th>Introduction of clinicalized Lean Center Model 8/15</th>
<th>New Therapy Clinical Tracks rollout 8/16</th>
<th>Program Go-Live:</th>
<th>Program Go-Live:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Implementation of Single Multidisciplinary DM (MDM) Programs by Go-Live:</td>
<td></td>
<td>MDM</td>
<td>MDM</td>
</tr>
<tr>
<td>- Outpatient Wound MDM</td>
<td></td>
<td>Wound</td>
<td>Clinical</td>
</tr>
<tr>
<td>- Therapy Wound Program: 10/15</td>
<td></td>
<td>Stroke Recovery</td>
<td>Program:</td>
</tr>
<tr>
<td>- Stroke Recovery Program</td>
<td></td>
<td>11/15</td>
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</tr>
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</table>

## Education / Training

<table>
<thead>
<tr>
<th>Pathway's Region: 6/8 - 6/10</th>
<th>Site credentialing for MDM @ Home: 10/1</th>
<th>Coding / OASIS Update Training:</th>
<th>MapQuest Mileage Technology education upon release</th>
</tr>
</thead>
</table>
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
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 training 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 Manager
Cell: [REDACTED]
Therapy Wound Care Initiative

Amersys

Home Health Services

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEDSF00070247
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

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

- 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)
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
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
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)
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
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
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

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>2007</td>
<td>Reimbursement</td>
<td>$2,257.36</td>
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<tr>
<td></td>
<td>Cost</td>
<td>$2,489.50</td>
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<tr>
<td></td>
<td></td>
<td>-$232.14</td>
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<tr>
<td>2008</td>
<td>Reimbursement</td>
<td>$2,505.98 RN only</td>
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<tr>
<td></td>
<td>Reimbursement</td>
<td>$5,316.04 14 PT + 12 RN</td>
</tr>
<tr>
<td></td>
<td>Reimbursement</td>
<td>$7,916.98 20 PT + 6 RN</td>
</tr>
</tbody>
</table>
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 Varicosity 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
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.
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
Sent: Friday, December 14, 2007 12:49 PM
To: Andrew Hill, Anne Fromette, Cheryl Laizey, Cindy Phillips, Donna Voss; Donna Maxie; Elizabeth Robinson; Francis Mayer; Janet Britt; Jeremy Rogers; Jill Cannon; Kirk Tewes; Kristopher Miller; Lisa Newell; Lu Post; Martha Williams; Melissa Geid; Michael Allison; Michelle Quigley; Mike Glenn; Mike Hamilton; Pamela Huffman; Patti Walker; Pete Hartley; Scott Green; Sherri Rose; Sherry Bokes; Tasha Means; Teresa Ledgerwood; TelReona Hall; Tom Dolan; Wanda Hull; William Mayes
CC: Alice Schwartz
Subject: PW: Action Items 12-7-07.xlsx
Attachment: 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
Amedius, Inc.
5939 S. Sherwood Forest Blvd.
Baton Rouge, LA 70808
Phone: [redacted]

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AM025F000070083
<table>
<thead>
<tr>
<th>No.</th>
<th>Pursen Responsible</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anne Prochaleck</td>
<td>Participated in conference call with Liza Nehrstedt, CCMFA.</td>
</tr>
<tr>
<td>2</td>
<td>Anne Prochaleck</td>
<td>Submitted to A Team: 2011-11-28-0627.105.0989.098.0968.098.098</td>
</tr>
<tr>
<td>3</td>
<td>Anne Prochaleck</td>
<td>Michele Dugan and Lisa Nehrstedt met with Liza Nehrstedt.</td>
</tr>
<tr>
<td>4</td>
<td>Anne Prochaleck</td>
<td>Results of meeting.</td>
</tr>
<tr>
<td>5</td>
<td>Anne Prochaleck</td>
<td>Meeting held 8/27/11.</td>
</tr>
<tr>
<td>6</td>
<td>Anne Prochaleck</td>
<td>Michele Dugan and Liza Nehrstedt met to discuss.</td>
</tr>
<tr>
<td>7</td>
<td>Pat Herley</td>
<td>Presented at A Team meeting.</td>
</tr>
<tr>
<td>8</td>
<td>Anne Prochaleck</td>
<td>Meeting held 8/27/11.</td>
</tr>
</tbody>
</table>

For each issue, the responsible parties and the outcomes of meetings are listed. The comments section provides details on the progress and discussions held.
<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Operational road map - Clinical Programs</td>
<td>9</td>
<td>Completion of clinical capacity plan and integration into CCOs Complete</td>
</tr>
<tr>
<td>18</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Operational road map - Clinical Programs</td>
<td>6</td>
<td>Completion of Stage 1 GDO underwriting 2022 programs 07/22 - 12/30/22</td>
</tr>
<tr>
<td>17</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Operational road map - Clinical Programs</td>
<td>12</td>
<td>Forecast/Strategic Implementation Department of Attraction that drives internal growth (Health, Human Services, Mental Health, a new Treatment Mirroring Program) 01/01/23 - 11/30/23</td>
</tr>
<tr>
<td>10</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Introduction to track monthly percentage growth in accessible areas</td>
<td>2</td>
<td>Integration of key strategies into PQI initiatives Complete</td>
</tr>
<tr>
<td>19</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Introduction to track monthly percentage growth in accessible areas</td>
<td>3</td>
<td>PQI outcomes add to clinical strategy in order and metrics to be completed Complete</td>
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<tr>
<td>20</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Introduction to track monthly percentage growth in accessible areas</td>
<td>5</td>
<td>Additional tracking mechanisms developed as review options are not and Do-Going</td>
</tr>
<tr>
<td>21</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Introduction to track monthly percentage growth in accessible areas</td>
<td>1</td>
<td>Develop strategic operational plan to track performance/programmes and target metrics in specific areas 02/01/21</td>
</tr>
<tr>
<td>22</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Operational road map - staffing in lower directive</td>
<td>3</td>
<td>Completion of all, acceptance and implementation of staffing model Complete</td>
</tr>
<tr>
<td>23</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Operational road map - staffing in lower directive</td>
<td>5</td>
<td>Focus Group operational road map - PQI objectives and metrics Complete</td>
</tr>
<tr>
<td>24</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Operational road map - staffing in lower directive</td>
<td>10</td>
<td>Monthly report monitoring for agency adherence and progress Do-Going</td>
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<tr>
<td>26</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Operational road map - staffing in lower directive</td>
<td>4</td>
<td>Development of staff Complete</td>
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<tr>
<td>27</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Operational road map - staffing in lower directive</td>
<td>8</td>
<td>Develop and analyze staffing and to implement the staff model with specific goals Complete</td>
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<tr>
<td>28</td>
<td>Acoma Pueblo</td>
<td>Clinical Development</td>
<td>Strategic Operational road map - staffing in lower directive</td>
<td>1</td>
<td>EPA/HRD/CMC conference call to establish outcomes Complete</td>
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<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
<td></td>
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</tr>
<tr>
<td>20</td>
<td>Aroa-Faiva</td>
<td>Clinical Development</td>
<td>Strategy: Operational Plan 1 - Staffing in Linear Accelerator</td>
<td>2.</td>
<td>Feeds improvements to improve making recommendations to DOAA for new clinical areas to lower occasions</td>
</tr>
<tr>
<td>21</td>
<td>Aroa-Faiva</td>
<td>Clinical Development</td>
<td>Strategy: Operational Plan 2 - Staffing in Linear Accelerator</td>
<td>7.</td>
<td>Linac and time division, identify skill gaps and level of care, physical assessment, dose allocation for each patient, clinical care, training, and education.</td>
</tr>
<tr>
<td>22</td>
<td>Aroa-Faiva</td>
<td>Clinical Development</td>
<td>Strategy: Operational Plan 3 - Staffing in Linear Accelerator</td>
<td>1.</td>
<td>Linac and time division, identify skill gaps and level of care, physical assessment, dose allocation for each patient, clinical care, training, and education.</td>
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<tr>
<td>23</td>
<td>Aroa-Faiva</td>
<td>Clinical Development</td>
<td>Strategy: Operational Plan 4 - Staffing in Linear Accelerator</td>
<td>7.</td>
<td>Linac and time division, identify skill gaps and level of care, physical assessment, dose allocation for each patient, clinical care, training, and education.</td>
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<tr>
<td>24</td>
<td>Aroa-Faiva</td>
<td>Clinical Development</td>
<td>Strategy: Operational Plan 5 - Staffing in Linear Accelerator</td>
<td>7.</td>
<td>Linac and time division, identify skill gaps and level of care, physical assessment, dose allocation for each patient, clinical care, training, and education.</td>
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<tr>
<td>25</td>
<td>Aroa-Faiva</td>
<td>Clinical Development</td>
<td>Strategy: Operational Plan 6 - Staffing in Linear Accelerator</td>
<td>7.</td>
<td>Linac and time division, identify skill gaps and level of care, physical assessment, dose allocation for each patient, clinical care, training, and education.</td>
</tr>
<tr>
<td>26</td>
<td>Aroa-Faiva</td>
<td>Clinical Development</td>
<td>Strategy: Operational Plan 7 - Staffing in Linear Accelerator</td>
<td>7.</td>
<td>Linac and time division, identify skill gaps and level of care, physical assessment, dose allocation for each patient, clinical care, training, and education.</td>
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<tr>
<td>27</td>
<td>Aroa-Faiva</td>
<td>Clinical Development</td>
<td>Strategy: Operational Plan 8 - Staffing in Linear Accelerator</td>
<td>7.</td>
<td>Linac and time division, identify skill gaps and level of care, physical assessment, dose allocation for each patient, clinical care, training, and education.</td>
</tr>
<tr>
<td>Time</td>
<td>Action</td>
<td>Client</td>
<td>Notes</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>Meet</td>
<td>Laura</td>
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</tr>
<tr>
<td>02</td>
<td>Meet</td>
<td>Laura</td>
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<td>03</td>
<td>Meet</td>
<td>Laura</td>
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<tr>
<td>09</td>
<td>Meet</td>
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Note: Action and meeting notes are placeholders for actual content.
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<td>Strategy: Operational roll-out plan - Staffing in Local Esplanade</td>
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<td>LRF completion testing and training initiation, identity and access plan back up</td>
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<td>Operations documentation and training to local Center</td>
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<td>Evaluation of current patient served with 12/3 scoring analysis of strategy</td>
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<td>Complete testing for tool utilization, regulation of cases and other indicated scenarios of financial impact</td>
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<td>Strategy: Identify top reasons for claim errors for State Payers, enhance the current data checks, implement user defined edits</td>
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<td>Present list of major errors for errors by payer</td>
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<td>Strategy: Identify top reasons for claim errors for State Payers, enhance the current data checks, implement user defined edits</td>
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| 58   | Lo Paul  
Commenting Effectively with Physicians using SBAR  |
| 59   | Lo Paul, Marc Fischetti,  
Midnight Dupuy  
OAS Training on Report Card on 9/12  
Evals  
Other duties as directed  
Report released 8/2007 Final draft of needed in revision  
Pete Harley  
Alex A. Schwartz  |
| 60   | Pete Harley  
Marc Fischetti  |
| 61   | Pete Harley  
Marc Fischetti  |
| 62   | Pete Harley  
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| 71   | Pete Harley  
Marc Fischetti  |
| 72   | Pete Harley  
Marc Fischetti  |
| 73   | Jeremy Rogan  |

**SHEET DATA**  
Dennis Smith  
Date of Jonny  
We will split the project into 2 phases. This is complete for phase 1.

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Dennis Smith  
Date of Jonny  
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<td>Identify top three reasons for customer service for Private Papers; enhance the paperless office, streamlining user-acceptable sales, 3.</td>
<td>Phase 1 (Top 2 reasons for details)</td>
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<td>Identify top three reasons for customer service for Private Papers; enhance the paperless office, streamlining user-acceptable sales, 4.</td>
<td>Gather requirements for Phase 2</td>
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<td>Phase 2 (Next major 5-11 regions for details)</td>
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<td>Strategy: The Class Voss Information Technology is being designed to be a tool for clinicians, as well as other administrative staff, to promote the patients adherence to scheduling recommendations by service code. This report will promote an agency's progress toward the complete inclusion of scheduling in the lower discipline. It will also show an agency the financial impact of not using a cost/benefit tool. It will be higher cost/benefit ratio.</td>
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Case Mix (A-Tennis Committee)
October 29, 2007

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**Case Mix IA Target Committee**
October 26, 2007

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<td>Jeremy Rogers</td>
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*Case Mix-0-Tenui Committee October 28, 2007*
Case No. A-Team Committee
October 30, 2017

Jeremy Rogers

We have completed the set up in the SIs to create dual management reports from selections, RIA. These reports will be used to more effectively work accounts and monitor point issues such as denial for these. We've also completed the test run of the new system where they will be included on the Closed Management System.

Jeremy Rogers

Show how our collection efforts have improved through lag analysis to prove reduced reserves or needed for Periods.

Cash Collections for July were the highest collectors to date. We will continue to monitor and report.

Jeremy Rogers

We have finalized our report addressing the accounts receivables over 155 days. We have gathered the top 100 for the aging and documented our progress requirements to date as well as our plans for improving collection rates.

Jeremy Rogers
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| 04 | Jeremy Rogers | Private Collection | Implement clean claim project: 165-day rule all payors - [Details] | 1. Implement Clear Claim Project - Identify key reasons for claim denials, with programming to reduce claim denials. 
2. Implement 45-day rule for claims. 
3. Implement 90-day rule for claims. 
4. Implement 135-day rule for claims. | 12/31/2007 |
| 08 | Jeremy Rogers | Private Collection | Implement clean claim project: 165-day rule all payors - [Details] | 1. Implement Clear Claim Project - Identify key reasons for claim denials, with programming to reduce claim denials. 
2. Implement 45-day rule for claims. 
3. Implement 90-day rule for claims. 
4. Implement 135-day rule for claims. | Complete |
<p>| 09 | Michael Allen | Information Technology | Strategy: CDS/ISMS - Transmission Int. | Days Transfer | 7. Evaluate outgoing to increase | Complete |
| 09 | Michael Allen | Information Technology | Strategy: CDS/ISMS - Transmission Int. | Days Transfer | Base endband tools | Complete |
| 09 | Pete Harley | Information Technology | Strategy: CDS/ISMS - DFC. | POC Mastering Software | 1. POC Mastering Software | 10/07 Rev. 12/07 |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pete Hardin</td>
<td>Charles needs your help. He thinks he has a baseline for the current quarters.</td>
</tr>
<tr>
<td>Sherry Dulles</td>
<td>Added an analysis to the POC for the next quarter.</td>
</tr>
<tr>
<td>Jamie S rather</td>
<td>kontakt from Tonya.</td>
</tr>
<tr>
<td>Swayne Byrd</td>
<td>A list of all the meetings with all the meetings included in the plan.</td>
</tr>
<tr>
<td>Sherry Dulles</td>
<td>Completed all these tasks to be added to the POC for the next quarter.</td>
</tr>
<tr>
<td>Swayne Byrd</td>
<td>Sherry Dulles</td>
</tr>
<tr>
<td>Swayne Byrd</td>
<td>Sherry Dulles</td>
</tr>
<tr>
<td>Taffonna Had</td>
<td>Bill audits begin 3-15 for the remainder of the quarter.</td>
</tr>
<tr>
<td>Helen, Taffonna Had, Sherry Dulles, Jamie S rather, Swayne Byrd, Claire Webber</td>
<td>Therapy, counseling, coding, audit reply 9/1/07. Others will be released this week. All sick with be paid by 10/1/07.</td>
</tr>
<tr>
<td>William Meyers, Milton Lyman, Charles Cohen, Evan White</td>
<td>Work is due on 3/15. No additional comments.</td>
</tr>
</tbody>
</table>
VerDate Nov 24 2008

16:35 Sep 29, 2011

Jkt 000000

PO 00000

Frm 00291

Fmt 6621

Sfmt 6621

R:\DOCS\68404.000

TIMD

68404.253

285


Footnote 34
From: Jami Henzen
Sent: Thursday, August 30, 2007 5:19 PM
To: William Mayers, Jill Cannon, Pati Walter, Anne Frechette, Donna Massie, Michelle Quigley, Sherry Dukes, Telonna Hall, Lu Post, Pete Hurley, Dana Voss, Michael Allison, Jeremy Rogers, Shannon Rous, Francis Mayers, Scott Ginn, Martha Williams, Christopher Miller, Cindy Phillips, Melissa Geis, Mike Ginn, Mike Hamilton, Elizabeth Robinson, Trena Leightywood, Cheryl Lacy, Pamela Huffman, Wanda Hull, Lisa Newell, Tom Delan
CC: Alice Schwartz, Peggy Hill, Bill Boras, Dale Redman, Rach Dee, Dara Medupe, Hollie Kliebert, Donnice Long, Trina Johnson, Lorraine Bosuer, Stephanie La awe, Lori Gaulter
Subject: A-Team Case Mix Committee
Attachments: Bud Delo 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. CEO
Amedisys, Inc.

*"A true friend is someone who reaches for your hand and touches your heart."*
Therapy Initiatives Update

- Wound Care – A Therapy Approach
  - Sept, 15th, 2006 – 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 HRRG was $4,100
  - 2008 – Projected HRRG is $4,700 (Higher with GF added to HFL)
  - POC Triggers with New Falls Risk Assessment in Oasis SOC
  - Aggressive Strategy for Atlanta HFL – Started first of August with Specialty Director search for 9 Directors to cover 10 locations. 6 high talent therapists have been identified and offers made to 4. Plans 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

<table>
<thead>
<tr>
<th>Track Name</th>
<th>Track Code</th>
<th>Recommended Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Recovery - Hip - Short Stay1</td>
<td>HIP001</td>
<td>6 PT</td>
</tr>
<tr>
<td>Joint Recovery - Hip - Short Stay2</td>
<td>HIP002</td>
<td>3 PT + 3 OT</td>
</tr>
<tr>
<td>Joint Recovery - Hip - Advanced Care1</td>
<td>HIP003</td>
<td>12 PT</td>
</tr>
<tr>
<td>Joint Recovery - Hip - Advanced Care2</td>
<td>HIP004</td>
<td>8 PT + 4 OT</td>
</tr>
<tr>
<td>Joint Recovery - Knee - Short Stay1</td>
<td>KNE001</td>
<td>6 PT</td>
</tr>
<tr>
<td>Joint Recovery - Knee - Short Stay2</td>
<td>KNE002</td>
<td>3 PT + 3 OT</td>
</tr>
<tr>
<td>Joint Recovery - Knee - Advanced Care1</td>
<td>KNE003</td>
<td>12 PT</td>
</tr>
<tr>
<td>Joint Recovery - Knee - Advanced Care2</td>
<td>KNE004</td>
<td>8 PT + 4 OT</td>
</tr>
</tbody>
</table>

## Rehab Program - BETTER BALANCE AT HOME

<table>
<thead>
<tr>
<th>Track Name</th>
<th>Track Code</th>
<th>Recommended Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Balance - Short Stay1</td>
<td>BAL001</td>
<td>3 PT (SN also in home)</td>
</tr>
<tr>
<td>Better Balance - Short Stay2</td>
<td>BAL002</td>
<td>5 PT</td>
</tr>
<tr>
<td>Better Balance - Advanced Care1</td>
<td>BAL003</td>
<td>12 PT</td>
</tr>
<tr>
<td>Better Balance - Advanced Care2</td>
<td>BAL004</td>
<td>8 PT + 4 OT</td>
</tr>
</tbody>
</table>

## Rehab Program - BETTER STRENGTH AT HOME

<table>
<thead>
<tr>
<th>Track Name</th>
<th>Track Code</th>
<th>Recommended Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Strength - Short Stay1</td>
<td>STR001</td>
<td>3 PT (SN also in home)</td>
</tr>
<tr>
<td>Better Strength - Short Stay2</td>
<td>STR002</td>
<td>5 PT</td>
</tr>
<tr>
<td>Better Strength - Advanced Care1</td>
<td>STR003</td>
<td>12 PT</td>
</tr>
<tr>
<td>Better Strength - Advanced Care2</td>
<td>STR004</td>
<td>8 PT + 4 OT</td>
</tr>
</tbody>
</table>
## “STROKE RECOVERY AT HOME” CLINICAL TRACK FOR THERAPY

<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcomes Assessment Tool</strong></td>
<td>Based on Carr/Shepherd Assessment Scoring indications:</td>
</tr>
<tr>
<td>The Carr/Shepherd assessment should be used periodically and at discharge to gauge patient progress.</td>
<td>Severe stroke: Moderate stroke: Mild stroke: Carr/Shepherd Assessment tool located in Stroke Recovery at Home Workbook</td>
</tr>
<tr>
<td>Assess patient’s multi-disciplinary needs in setting up the treatment plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Visit Frequency (Combined PT, OT, and SLP)</strong></td>
<td>Severe stroke - 3 x week</td>
</tr>
<tr>
<td></td>
<td>Mild stroke - 1-2 x week</td>
</tr>
<tr>
<td><strong>Visit Duration (Combined PT, OT and SLP): Decrease frequency of visits as patient progresses.</strong></td>
<td>Seven stroke – up to 8 weeks</td>
</tr>
<tr>
<td></td>
<td>Mild stroke – up to 8 weeks</td>
</tr>
<tr>
<td><strong>Therapeutic Exercises and Education</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Rehab Goals</strong></td>
<td>Severe stroke – 1. Indep bed mobility 2. Indep beside sitting 3. Basic transfers 4. Basic arm/hand movements</td>
</tr>
<tr>
<td><strong>Coordinate Physical and Occupational Therapy Goals (sample goals)</strong></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Mild stroke: 1. Indep amb w/ direction changes, no devices 2. Indep on steps w/ device or rail 3. Fine motor grasping with grooming, bathing, dressing, and feeding.</td>
</tr>
<tr>
<td><strong>Discharge Planning</strong></td>
<td>Discharge when: Goals have been achieved/pat independent with home exercises, or if pt has reached plateau and is no longer making progress, no longer homebound.</td>
</tr>
</tbody>
</table>
### CVA Clinical Track Options

**Rehab Program: Stroke Recovery at Home**

<table>
<thead>
<tr>
<th>Track Name</th>
<th>Track Code</th>
<th>Recommended Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke Recovery – Severe – PT Only</td>
<td>CVA 002</td>
<td>15 PT</td>
</tr>
<tr>
<td>Stroke Recovery – Severe – Multi-Discipline 1</td>
<td>CVA 003</td>
<td>10 PT + 6 OT + 4 ST</td>
</tr>
<tr>
<td>Stroke Recovery – Severe – Multi-Discipline 2</td>
<td>CVA 004</td>
<td>6 PT + 6 OT + 4 ST</td>
</tr>
<tr>
<td>Stroke Recovery – Moderate – PT Only</td>
<td>CVA 005</td>
<td>14 PT</td>
</tr>
<tr>
<td>Stroke Recovery – Moderate – Multi-Discipline 1</td>
<td>CVA 006</td>
<td>8 PT + 6 OT</td>
</tr>
<tr>
<td>Stroke Recovery – Moderate – Multi-Discipline 2</td>
<td>CVA 007</td>
<td>6 PT + 6 OT + 4 ST</td>
</tr>
<tr>
<td>Stroke Recovery – Mild – PT Only</td>
<td>CVA 008</td>
<td>12 PT</td>
</tr>
<tr>
<td>Stroke Recovery – Mild – Multi-Discipline 1</td>
<td>CVA 009</td>
<td>6 PT + 6 OT</td>
</tr>
<tr>
<td>Stroke Recovery – Mild – Multi-Discipline 2</td>
<td>CVA 010</td>
<td>6 PT + 4 OT + 4 ST</td>
</tr>
</tbody>
</table>
# Amedisys Physical Therapy Exercise and Tracking Log

<table>
<thead>
<tr>
<th>Date</th>
<th>Example</th>
<th>10</th>
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<th>14</th>
<th>10</th>
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<tr>
<td>Totals</td>
<td>Ambulation</td>
<td>(no or reason)</td>
<td>(no or reason)</td>
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<tr>
<td></td>
<td>Device for Amb</td>
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<tr>
<td></td>
<td>Pain</td>
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<tr>
<td></td>
<td>Tinetti Balance Score (max 20)</td>
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<tr>
<td></td>
<td>PT Initials</td>
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</tr>
</tbody>
</table>

Number of reps x color of T-band (no T-band = 1, yellow = 2, red = 3, green = 4)  
Sit to stand: Pulling on side = 1, using both arms from straight chair = 2, using one arm from straight chair = 3, using no assistance = 4
Footnote 36
Why are we changing the tracks?

- New case mix weight adjustments proposed by Medicare provided a great opportunity to make some company-wide changes in the rehab clinical tracks.
- Rehab Programs under new leadership are moving toward implementation of a geriatric care-centered model of rehab.
- Specialty Programs are being introduced and implemented into Amedisys Disease Management Programs.
Rehabilitation @ Home

- Core rehab program to be implemented company wide
- Features a comprehensive evidence based geriatric assessment
- Replaces Better Strength and Better Balance
- 3 Clinical Tracks
  - 8, 16 and 22 visits
  - Higher visit tracks are multidisciplinary
Rehab @ Home Clinical Track 1

- 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.
Rehab @ Home - REH002 16 visits
SINGLE DISCIPLINE REQUIRING 16 VISITS
PT 16 VISITS
OT 16 VISITS
MULTIDISCIPLINE REQUIRING 16 VISITS
PT/OT 16 visits shared by both disciplines
DIAGNOSES (examples)
- Post-hospitalization
- CHF/ Cardiac Disease
- COPD/ Respiratory Disease
- Progressive Neurological (Specialty Track in development)
- Cancer
- Behavioral Health
- Diabetes (If LOPS with fall risk – use Balanced for Life)
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
Orthopedics I - ORT001
SINGLE DISCIPLINE TRACK
PT 8 visits
OT 8 visits

- Post Surgical Orthopedics
- PT - Lower Extremity and Back
- OT - Upper Extremity
- Anticipate short homebound status
SINGLE OR MULTIDISCIPLINE TRACK
PT 16 VISITS
OT 16 VISITS
PT/OT SHARE 16 VISITS
Post-surgical Orthopedics/ Total Joint Recovery/ Trauma
- Severe osteoarthritis
- Osteoporosis
- Amputees
- Total Joint (shoulder, hip, knee)
Stroke Recovery @ Home
- Multidisciplinary program to facilitate recovery from acute CVA
- All previous tracks replaced with a single 22 visit track
- May be rolled into Specialty programs in future
Stroke Recovery @ Home CVA001
MULTIDISCIPLINARY TRACK
PT/OT 22 Visits
Speech included in visits if no dysphagia
Dysphagia @ Home - DAH001
- SLP 8 visits
- Any diagnosis (Stable or limited potential)

Dysphagia @ Home DAH002
- SLP 16 visits

Dysphagia @ Home DAH 003
- SLP 16 visits
- Neuroromuscular Electrical Stimulation (VitalStim)

THIS WILL REPLACE VITALSTIM
The Dysphagia @ Home tracks can be run as a single discipline track or a multidiscipline track.

When speech is treating on a multidiscipline case it is imperative that there be conference as to the number of visits needed. Those visits will need to be added to the PT/OT tracks for the case manager to track the visits.
The Therapy Wound Care Tracks can be run as a single discipline track or a multidiscipline track.

The rational for choosing the wound care track will depend on the complexity of the wound and the patient’s needs.

OT might be indicated for positioning and self feeding skills.

SLP might be indicated for oral intake/cognition.

PT for wound management, modalities, debridement, and functional retraining.
- **TWC001**
  - Therapy 14
    - Uncomplicated wound
    - PT and/or OT/SLP
    - Might need a modality
    - Might need positioning, functional retraining, dysphagia management
    - Stage I or II, Superficial wounds, Surgical wound
TWC002

- 20+ visits
  - Complex, non-healing wound
  - PT and/or OT/SLP
  - Needs Modalities
  - Might need debridement
  - Needs positioning/functional mobility
  - retraining/cognitive and/or oral intake management
  - Co-morbidities
Footnote 37
# Disease Management: Clinical Track Selection Sheet

| Patient Name: | | | |
| Get/Release Period: | | | |
| | | | |

<table>
<thead>
<tr>
<th>Clinical Track Selection</th>
<th>Code</th>
<th># of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

## Conditions

### Current Disease Status

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
<th># of Visits</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

### Chronic Disease Status

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
<th># of Visits</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### Contact Information

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone</th>
<th>Email</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

---

**Clinical Manager Review:**

Number of visits ordered for this episode: ___

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

If YES, Clinical Manager must sign here for approval: ___

Well: ___

Total: ___

---

**CONFIDENTIAL TREATMENT REQUESTED**

**PURSUANT TO SENATE RULE XXIX**

**AMEDSFC00001935**
Footnote 38
Key Operational Initiatives - 2008

Anne Frechette
VP of Disease Management

August 2008
Key Operational Initiatives - 2008

Anne Frechette
VP of Disease Management

August 2008
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.
• 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
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 credentials; recognition by way of a lapel pin. To date, we’ve sent out over 10,000 pins. 10,000 of these credentialled 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
- Manage phone calls
  - Physician
  - Patient
  - Staff
- Manage labs
- OASIS Review
- 485 Plan of Care Development
- Clinical Tracks
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).
• Scheduling
  – Initial schedule
    • Consistent to track
    • Throughout episode
    • High risk
  – Adjusting schedule
  – Missed visits
• Process Supplemental Orders
• Order Equipment
• Staff Supervision, etc, etc
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).
- 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
• Standardization of care planning processes
• Incomplete documentation
• Documentation inconsistencies
  – Within OASIS
    • Coding
    • Under/over-scoring
    • 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.
• 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.
This is a diagram of the typical processing of OASIS and 485 plans of care development. Everything highlighted in yellow are the tasks the QCC will segment off of the agency clinical manager.
- 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
• 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

By taking the “transaction processing” away from the day to day responsibilities of the agency clinical managers, we are able to improve these goals.
• Review OASIS
  – Proper Coding
  – Assessment clinical accuracy
  – Outcome focus

• Review 485/Plan of Care
  – Orders
  – Goals
  – Frequencies
    • All disciplines
QCC's process all admits, recerts, and resumptions.
- Assign Clinical Tracks
- Review Schedule
  - Consistent with track
  - Throughout episode
  - High risk scheduling
- Auto forward wound care evaluations
- Corrects agreed changes
QCC's process all admits, recerts, and resumptions.
- 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
- 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?
- LearnCenter CBT
  - Introduction to Wound Care
  - Wound Care 101
  - Lower Extremity Ulcers
  - Pressure Ulcers
  - 2008 PPS Case-Mix Adjustment model
  - Oasis Documentation
  - Home Care 101
  - Documentation and Forms Overview
  - Medical Coding for Home Health
  - AMS2 Clinical Track Modules
  - Clinical Track Overview
  - Outcomes and Clinical Tracks
LearnCenter CBT
- Introduction to Wound Care
- Wound Care 101
- Lower Extremity Ulcers
- Pressure Ulcers
- 2008 PPS Cas-mix Adjustment model
- Oasis Documentation
- Home Care 101
- Documentation and Forms Overview
- Medical Coding for Home Health
- AMH2 Clinical Track Modules
- Clinical Track Overview
- Outcomes and Clinical Tracks

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.
• Centra ILT
  - Wound Care Documentation Compliance
  - (extra sessions are available by request,
  - Contact Bobbie Stallings, Telemedicine)
- Centra ILT
  - Wound Care Documentation Compliance
  - (extra sessions are available by request,
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These are the basic lean 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.
- 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
- 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

These are lessons learned from the beta and current live sites that will make the transition easier on the agency.
- 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
• 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.
- Facilitate processing of OASIS correction forms
  - Ensure clinician signature
  - Filing on Medical Record
- Participation in month end processing
  - First month "go live"
  - Quality designation
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 those.
- 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
- 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
• 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
- 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

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
• "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
• “Team with the QCC”
• Address staff management issues
• Work 485’s locked with quality issues
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  – 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
This is the tentative roll out schedule for Q3 2008. Entire companywide roll-out is expected by the end of 3Q 2009. For questions about your agency's roll-out date, forward them to Robin Landry.
Disease Management Overview

Anne Frechette
VP of Disease Management

August 2008
Disease Management Overview

Anne Frechette
VP of Disease Management

August 2008
- Revolutionary changes/systems
- Increasing demands for cost containment
- Increasing demands for proof of quality
- Technological advances
- Advancing health promotion, prevention and treatment
- Revolutionary changes/systems
- Increasing demands for cost containment
- Increasing demands for proof of quality
- Technological advances
- Advancing health promotion, prevention and treatment
- 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
• 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
Paradigm Shift

Acute Care

Focus: Illness
Care: Fragmented

Chronic Care

Focus: Prevention
Care: Coordinated
Paradigm Shift

Acute Care  Chronic Care

Focal Roles  Focal Promotion
Cares Fragmented  Cares Coordinated
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
A series of processes and services, that are coordinated into disease programs designed to:

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[Diagram of processes and outcomes]
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.
Based on national standards and documented research

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

Joint Commission

American Physical Therapy Association

American Thoracic Society

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

Review slide
• 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
- Streamlined communication
- Consistent treatment protocols / procedures
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- Physician involvement - DM / Quality
- Be the "eyes - ears" for patients with chronic diseases
- Inpatient PPS challenges
- "Transition without abandonment"
- Facility / Hospital → Disease Management Program
- Reduced re-hospitalizations in 24 hours
- Improved utilization of emergency room
Inpatient PPS challenges
"Transition without abandonment"
Facility / Hospital ➜ Disease Management Program
Reduced re-hospitalizations in 24 hours
Improved utilization of emergency room

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.
**Multidisciplinary Programs:**
- Heart @ Home
- Diabetes @ Home
- COPD @ Home
- Partners in Wound Care
- Stroke Recovery @ Home
- Surgical Recovery @ Home
- Pain Management @ Home
- Chronic Kidney @ Home
- Behavioral Health @ Home

**Therapy Programs:**
- Rehab Therapy @ Home
- Orthopedics @ Home
- Wound Care – a Therapy Approach

**Specialty Programs:**
- Balanced for Life
- Centralized Telehealth
- Dysphagia Treatment
- Others in Development

More than 70 Clinical Tracks
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>INSTRUCTIONAL CONTENT/PATIENT/CAREGIVER RESPONSE</th>
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<tbody>
<tr>
<td>Extensive processes</td>
<td>Patient</td>
</tr>
<tr>
<td>Early warning S.O.S to report</td>
<td>Patient</td>
</tr>
<tr>
<td>Medications list meds taught</td>
<td>Patient</td>
</tr>
<tr>
<td>Pain</td>
<td>Patient</td>
</tr>
<tr>
<td>Therapy: IV, Parenteral, IV</td>
<td>Patient</td>
</tr>
<tr>
<td>Treatments (Resp. etc.)</td>
<td>Patient</td>
</tr>
<tr>
<td>Equipment Use/Management</td>
<td>Patient</td>
</tr>
<tr>
<td>O&amp;T Fluid management</td>
<td>Patient</td>
</tr>
</tbody>
</table>
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.
- Coordinated services
- Standardized health care instruction
- Improved patient care
- Outcomes tracking
- Management of costs
- Continuous advances in care
Amedisys leads the industry with their standardized DM program model. Here is a review of what differentiates us from the rest.
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
You have a DM program if...

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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
• You have a DM program if.... (continued)

✓ You evaluate DM outcomes status on all patients to be discussed via AMIS2 Reports
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Telehealth
A Disease Monitoring Program for Home Care Patients
Telehealth
A Disease Monitoring Program for
Home Care Patients
• 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
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.
<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
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</tbody>
</table>
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
### Agencies selected by key metrics demonstrating operational readiness

- *Performance offsets non-reimbursed cost*

<table>
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<th>Successful Outcomes</th>
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<tr>
<td>Clinical tracks</td>
<td>Improvement in ACH / ER</td>
</tr>
<tr>
<td>Standing orders</td>
<td></td>
</tr>
</tbody>
</table>

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.
Chronic Medicare Patient

Home Health Episode of Care

- Intensive behavioral modification
- 16-17 skilled nurse visits in the home
- Focusing on medication compliance, behavioral interventions, in-home assessment, caregiver

Encore Disease Management

- Behavioral modification continuation/reinforcement
- Compliance with self-management techniques
- Care coordination of post-episodic services
- Wellness / prevention focus
- Community Linkages

Amedisys
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
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

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- Empowers the patient/caregiver with knowledge & information
- Encourages self-management skills in patients dealing with chronic diseases

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!
The Call Center utilizes the latest technological advances to establish contact with patients in order to:

- **Stratify**: Utilize data analysis to identify and flag high risk patients
- **Intervene**: Health care managers provide assistance to reduce acute hospitalization
- **Engage**: Engage patient in prevention of complications, health status maintenance
- **Satisfy**: Improve self-care management, improve quality of life
The Call Center utilizes the latest technological advances to establish contact with patients in order to:

- Utilize data analysis to identify and flag high risk patients
- Health care managers provide assistance to reduce acute hospitalization
- Engage patients in prevention of complications, health status maintenance
- Improve self-care management, improve quality of life

Our objective is to utilize the latest technology to

- STRATIFY patient elements to identify high risk patients
- Utilize health care 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.
<table>
<thead>
<tr>
<th>Model Elements</th>
<th>Full Scale DM Model- American Healthcare</th>
<th>Amedsys DM Call Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Identification Practices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence Based</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaborative</td>
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</tr>
<tr>
<td>Protocol Based Collaborative</td>
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<tr>
<td>PCC with Physician and Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient and Staff Education</td>
<td></td>
<td></td>
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<tr>
<td>Outcome Measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational Materials</td>
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<td></td>
</tr>
<tr>
<td>Literature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Predictive Modeling/ Risk Stratification</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Integrated with home care delivery
(Continued behavioral reinforcement)

Rapid nurse deployment
(At home intensive services as required)
Encore's disease management call center has key differentiators from traditional Disease Mgmt Call Centers that set us apart from our competition.
- 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.
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<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you recommend our agency to others?</td>
<td>98%</td>
<td>2%</td>
</tr>
<tr>
<td>Did the Staff explain your conditions, rights and responsibilities?</td>
<td>98%</td>
<td>2%</td>
</tr>
<tr>
<td>Were you satisfied with your own participation in your care?</td>
<td>99%</td>
<td>1%</td>
</tr>
</tbody>
</table>

7,482 Responses 1st Qtr 2008
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
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<td>1%</td>
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</table>

7-482 Responses 1st Qtr 2008
Patients Who Report Having Been to the ER since Discharge From Home Care

<table>
<thead>
<tr>
<th></th>
<th>1st Qtr</th>
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<tr>
<td><strong>No</strong></td>
<td>7382</td>
</tr>
<tr>
<td><strong>Yes</strong></td>
<td>168</td>
</tr>
<tr>
<td>&lt;30 days from home care d/c date</td>
<td>71</td>
</tr>
<tr>
<td>31 - 60 days from home care d/c date</td>
<td>40</td>
</tr>
<tr>
<td>61 - 90 days from home care d/c date</td>
<td>36</td>
</tr>
<tr>
<td>91-120 days from home care d/c date</td>
<td>21</td>
</tr>
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</table>

7550 Responses 1st Qtr
### Patients Who Report Having Been to the ER Since Discharge From Home Care

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
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</thead>
<tbody>
<tr>
<td>&lt;31 days from home care 4/4 date</td>
<td>71</td>
<td>342</td>
</tr>
<tr>
<td>31-60 days from home care 4/4 date</td>
<td>44</td>
<td>287</td>
</tr>
<tr>
<td>61-90 days from home care 4/4 date</td>
<td>43</td>
<td>276</td>
</tr>
<tr>
<td>91-120 days from home care 4/4 date</td>
<td>24</td>
<td>160</td>
</tr>
</tbody>
</table>

7550 Responses 1st Qtr
Patients Who Report Having Been Admitted to the
Hospital since Discharge From Home Care

<table>
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<tr>
<th></th>
<th>1st Qtr</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>7241</td>
</tr>
<tr>
<td>Yes</td>
<td>309</td>
</tr>
<tr>
<td>&lt;30 days from home care d/c date</td>
<td>121</td>
</tr>
<tr>
<td>31 - 60 days from home care d/c date</td>
<td>88</td>
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<tr>
<td>61 - 90 days from home care d/c date</td>
<td>47</td>
</tr>
<tr>
<td>91 - 120 days from home care d/c date</td>
<td>53</td>
</tr>
</tbody>
</table>
Patients Who Report Having Been Admitted to the Hospital since Discharge From Home Care

<table>
<thead>
<tr>
<th>Interval</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 days from home care discharge</td>
<td>121</td>
<td>7241</td>
</tr>
<tr>
<td>31 - 60 days from home care discharge</td>
<td>47</td>
<td>88</td>
</tr>
<tr>
<td>61 - 90 days from home care discharge</td>
<td>55</td>
<td>35</td>
</tr>
<tr>
<td>91 - 120 days from home care discharge</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

7550 Responses 1st Qtr
Top 10 Diagnosis Groupings

- Cardiac: 27%
- Blood Related: 4%
- General Pain: 3%
- CVA: 3%
- Diabetes: 5%
- Fall/Injury: 6%
- Ortho: 7%
- Infection: 3%
<table>
<thead>
<tr>
<th>External Benchmarks</th>
<th>Amedisys Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most recent information reveals readmission rates are 12% to 14% on average per admission.</td>
<td>Most recent information reveals readmission rates are 4.09% to 5.46% on average per admission.</td>
</tr>
<tr>
<td><strong>&lt; 30 Days</strong></td>
<td><strong>&lt; 30 Days</strong></td>
</tr>
<tr>
<td>4.7% - 6.2%</td>
<td>1.60% - 1.48%</td>
</tr>
<tr>
<td><strong>31-60 Days</strong></td>
<td><strong>31-60 Days</strong></td>
</tr>
<tr>
<td>8.1% - 10.7%</td>
<td>1.76% - 1.17%</td>
</tr>
<tr>
<td><strong>61-90 Days</strong></td>
<td><strong>61-90 Days</strong></td>
</tr>
<tr>
<td>6.5% - 12.8%</td>
<td>1.32% - 0.62%</td>
</tr>
<tr>
<td><strong>91+ Days</strong></td>
<td><strong>91+ Days</strong></td>
</tr>
<tr>
<td>8.2% - 14.1%</td>
<td>0.90% - 0.70%</td>
</tr>
</tbody>
</table>

Sources:
2. 2002 NHS Trust Plan and Report
3. 2004 Institute for Healthcare Improvement
4. Health Care Cost Containment Council 2005

1. Post-acute inpatient stays
2. 14,315 patients tracked over a 6 month period
### Essential Data

#### Most recent information results on admission: labor per 25s to 1/2 cm average per admission:

<table>
<thead>
<tr>
<th>Days</th>
<th>Days</th>
<th>Days</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>4.7%</td>
<td>6.2%</td>
<td>4.7%</td>
</tr>
<tr>
<td>31-60</td>
<td>8.1%</td>
<td>10.7%</td>
<td>8.1%</td>
</tr>
<tr>
<td>61-90</td>
<td>6.3%</td>
<td>12.8%</td>
<td>6.3%</td>
</tr>
<tr>
<td>91+</td>
<td>8.2%</td>
<td>14.1%</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

**Notes:**
- Data on fertility and change from 1996 - Office of Women's
- Data on fertility and change from 1996 - Office of Women's
- Data on fertility and change from 1996 - Office of Women's

### Anechoic Echo Logo

#### Most recent information results on admission: labor per 25s to 1/2 cm average per admission:

<table>
<thead>
<tr>
<th>Days</th>
<th>Days</th>
<th>Days</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>1.6%</td>
<td>1.4%</td>
<td>1.6%</td>
</tr>
<tr>
<td>31-60</td>
<td>1.5%</td>
<td>1.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>61-90</td>
<td>1.4%</td>
<td>0.5%</td>
<td>1.4%</td>
</tr>
<tr>
<td>91+</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

**Notes:**
- Data on fertility and change from 1996 - Office of Women's
- Data on fertility and change from 1996 - Office of Women's
• To evaluate satisfaction with home health services
• To reduce post-discharge acute care hospitalizations
• To measure and report outcomes
• Build lifelong relationships
- To evaluate satisfaction with home health services
- To reduce post-discharge acute care hospitalizations
- To measure and report outcomes
- Build lifelong relationships
Footnote 39
From: Robin Landry
Subject: 1/500 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!

CONFIDENTIAL TREATMENT REQUESTED
PURSUANT TO SENATE RULE XXIX

AMEDSF000064470
Remote Quality Care Coordinators

Robin Landry, RN
Director Central Quality Management
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
### Agency Clinical Manager Tasks

- Manage phone calls
  - Physician
  - Patient
  - Staff
- Manage labs
- OASIS Review
- 48s 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!
Clinical Manager Challenges

- Standardization of care planning processes
- Incomplete documentation
- Documentation inconsistencies
  - Within OASIS
    - Coding
    - Under/over-scoring
    - 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!
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
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 AMS
- 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
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
QCC Processing Begins

Go-Live for Agency, QCC begins processing:
M0090 date of 1/1/09 for go live 1/5/09
QCC Processing Begins

Go-Live for Agency, QCC begins processing:
Moo90 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)
Mandatory Training for All Staff Prior to Go-Live

- LeasaCenter CRT
  - Home Health CRT:
    - Home Care vs. Home Health
    - Case Management and Home Hospital
    - Joint RSU Case Mix Adjustment model
    - Coding: Disease Process
    - Coding: The Bill for the Story

- General Disease Management Resources CRT:
  - AMDa CD/Track Module
  - Clinical Track Overview
  - Outcomes and Clinical Trends

- Wound Care CRT:
  - Introduction to Wound Care
  - Wound Care Overview
  - Pressure Ulcers

- Contra IIT
  - Wound Care Documentation
  - Compliance - offered monthly
  - (extra sessions are available by request, contact John Stallings, 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 CM Role

- Continue to receive report on SOC's and Recerts
- still needed for care coordination
- Ensure daily POC transfers of data
- Facilitate field clinic follow-up and communication with QCC
- Obtain verbal orders for frequency change recommendations
- Coordination of timely discipline evils
- 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
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
  - IFT/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
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
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
Footnote 40
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 5/6 different categories of therapy visits (buckets):

<table>
<thead>
<tr>
<th>Number of Visits</th>
<th>Bucket</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>0-5</td>
</tr>
<tr>
<td>6</td>
<td>6-17</td>
</tr>
<tr>
<td>7-9</td>
<td>18-19</td>
</tr>
<tr>
<td>10</td>
<td>20 and higher</td>
</tr>
</tbody>
</table>

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 12-18 visits to 14-15 visits, increases $335.13 per episode in 2008 (increased $84.38 in 2007).
This graph and chart is attached (Therapy Bucket Graph), along with the AGENCY THERAPY BUCKET REPORT, 2/1 through 2/12/08. (2008 = means Microsoft Office 2008)

This report ranks individual agencies, AVP's and VIP'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 CASIS documentation
2. Therapy Start/End 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 Centro training sessions with the AVP's and VIP's to further review these reports in detail.

If you have specific question about your agency's data in the Therapy Bucket Report, please email daily fixes in my department.

Thanks,

[Signature]

[Title]

[Department]

[Phone]

[Email]

**NOTE**: The attached communication contains proprietary and confidential information. If you are not the intended recipient, DO NOT read, copy, or distribute this communication. This communication was created with the knowledge and approval of the Centro organization. The Centro organization is not responsible for the security of any data which you may be given in this communication. If you do not wish to receive this type of communication, please notify Centro or ask your manager if you have received this type of communication in error. **CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO SENATE RULE XXIX**
<table>
<thead>
<tr>
<th></th>
<th>O</th>
<th>P</th>
<th>Q</th>
<th>R</th>
<th>S</th>
<th>T</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>213</td>
<td>6.90%</td>
<td>4,141.87</td>
<td>253</td>
<td>8.13%</td>
<td>4,032.01</td>
<td>356</td>
</tr>
<tr>
<td>2</td>
<td>70</td>
<td>0.04%</td>
<td>4,250.94</td>
<td>84</td>
<td>0.04%</td>
<td>4,292.68</td>
<td>463</td>
</tr>
<tr>
<td>3</td>
<td>86</td>
<td>0.03%</td>
<td>4,128.72</td>
<td>86</td>
<td>0.03%</td>
<td>4,283.75</td>
<td>352</td>
</tr>
<tr>
<td>4</td>
<td>89</td>
<td>0.03%</td>
<td>4,087.50</td>
<td>84</td>
<td>0.03%</td>
<td>4,105.05</td>
<td>455</td>
</tr>
<tr>
<td>5</td>
<td>88</td>
<td>0.03%</td>
<td>4,264.24</td>
<td>12</td>
<td>0.02%</td>
<td>4,125.54</td>
<td>26</td>
</tr>
<tr>
<td>6</td>
<td>47</td>
<td>0.03%</td>
<td>4,324.73</td>
<td>56</td>
<td>0.03%</td>
<td>4,298.84</td>
<td>217</td>
</tr>
<tr>
<td>7</td>
<td>107</td>
<td>0.04%</td>
<td>3,180.94</td>
<td>140</td>
<td>0.04%</td>
<td>3,950.66</td>
<td>266</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>0.02%</td>
<td>4,091.55</td>
<td>5</td>
<td>0.02%</td>
<td>4,176.40</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>636</td>
<td>4.81%</td>
<td>4,158.61</td>
<td>263</td>
<td>0.06%</td>
<td>4,123.94</td>
<td>3,409</td>
</tr>
</tbody>
</table>

Page 3 of 5
<table>
<thead>
<tr>
<th></th>
<th>11-13 Therapy Visits</th>
<th>10 Therapy Visits</th>
<th>7-9 Therapy Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of EPISODES</td>
<td>REV/EPISODE</td>
<td>% of EPISODES</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>11.50%</td>
<td>3,964.49</td>
<td>11%</td>
</tr>
<tr>
<td>4</td>
<td>10.05%</td>
<td>4,066.47</td>
<td>54%</td>
</tr>
<tr>
<td>5</td>
<td>9.67%</td>
<td>4,210.39</td>
<td>84%</td>
</tr>
<tr>
<td>6</td>
<td>9.38%</td>
<td>3,981.38</td>
<td>65%</td>
</tr>
<tr>
<td>7</td>
<td>9.66%</td>
<td>4,352.72</td>
<td>26%</td>
</tr>
<tr>
<td>8</td>
<td>10.59%</td>
<td>4,099.57</td>
<td>41%</td>
</tr>
<tr>
<td>9</td>
<td>13.15%</td>
<td>3,844.85</td>
<td>121</td>
</tr>
<tr>
<td>10</td>
<td>7.77%</td>
<td>3,607.54</td>
<td>27%</td>
</tr>
<tr>
<td>11</td>
<td>10.66%</td>
<td>4,003.49</td>
<td>431</td>
</tr>
</tbody>
</table>

Page 6 of 5
<table>
<thead>
<tr>
<th></th>
<th>AC</th>
<th>AD</th>
<th>AE</th>
<th>AF</th>
<th>AG</th>
<th>AH</th>
<th>AN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>REV/EPISODE</td>
<td>EPISODES</td>
<td>% of EPISODES</td>
<td>REV/EPISODE</td>
<td>EPISODES</td>
<td>% of EPISODES</td>
<td>REV/EPISODE</td>
</tr>
<tr>
<td>3</td>
<td>$2,393.85</td>
<td>72</td>
<td>2.33%</td>
<td>$2,282.34</td>
<td>1,570</td>
<td>50.8%</td>
<td>$1,697.15</td>
</tr>
<tr>
<td>4</td>
<td>$2,287.21</td>
<td>76</td>
<td>1.44%</td>
<td>$2,213.35</td>
<td>835</td>
<td>30.5%</td>
<td>$1,840.81</td>
</tr>
<tr>
<td>5</td>
<td>$2,392.80</td>
<td>69</td>
<td>2.48%</td>
<td>$2,277.94</td>
<td>1,552</td>
<td>50.3%</td>
<td>$1,727.97</td>
</tr>
<tr>
<td>6</td>
<td>$2,275.08</td>
<td>60</td>
<td>4.02%</td>
<td>$2,235.06</td>
<td>936</td>
<td>56.6%</td>
<td>$1,602.15</td>
</tr>
<tr>
<td>7</td>
<td>$2,569.87</td>
<td>17</td>
<td>4.41%</td>
<td>$2,425.46</td>
<td>164</td>
<td>60.2%</td>
<td>$1,731.05</td>
</tr>
<tr>
<td>8</td>
<td>$2,217.75</td>
<td>40</td>
<td>4.03%</td>
<td>$2,265.90</td>
<td>610</td>
<td>57.4%</td>
<td>$1,973.77</td>
</tr>
<tr>
<td>9</td>
<td>$2,546.70</td>
<td>58</td>
<td>1.89%</td>
<td>$1,583.17</td>
<td>1,381</td>
<td>62.78%</td>
<td>$3,706.03</td>
</tr>
<tr>
<td>10</td>
<td>$2,608.98</td>
<td>1</td>
<td>5.43%</td>
<td>$2,237.40</td>
<td>32</td>
<td>58.10%</td>
<td>$1,380.36</td>
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<td>11</td>
<td>$2,486.69</td>
<td>339</td>
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<td>$2,488.35</td>
<td>7,680</td>
<td>57.64%</td>
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<td>Year</td>
<td>All Employees</td>
<td>Non-Union</td>
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<tr>
<td>2022</td>
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<td>2020</td>
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<td>160,000</td>
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</table>

Note: The table above shows the number of employees, non-union, union, and total for the years 2022, 2021, and 2020.
Footnote 41
From: Teresa Mills
Sent: Tuesday, February 26, 2008 2:13 PM
To: Patti Walker
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

From: Teresa Mills
Sent: Tuesday, February 26, 2008 2:08 PM
To: Pam Huggen; Traci Ferguson; Paula McCarthy; Teresa Turner; Kristi Bentley; Patti McFadden; Heather Drake; Mechelle Harvey; Cynthia Underwood; Brenda Diver; Shirley Barber; Julie Sulphen; Todd Miller; Heather Marshall
Cc: Mills Gina; 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 Means 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 then 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 fall 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 CIF 3-8 visits recommended, Dynahap at Home—001 for CIF 3-7 F 3 for 8 SL visits, and Orthopedics 1-001 for CIF 2 F 2 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 CIF 2-3 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 OAMS. 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 User dated February 18, 2008 and it will greatly assist you and your staff in understanding the OAH PPS rules. An example stated was: A look at the answer to OAH5:503:940 (vision), might reveal that the patient has low vision. Code that correctly and you could gain an extra three clinical domain points upwards of $380.28 for some patients. If your agency manages 1,000 episodes a year with a quarter of them involving patients with hypotension and low vision, there could be as much as $55,000.00 in annual revenue at stake per Home Health User. I believe these two diagnoses 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

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Pursuant to Senate Rule XCVI

AMEGRF/20002120
Footnote 42
From: Dan Cundiff  
Sent: Wednesday, February 27, 2008 6:40 AM  
To: Sarah Zimmerman, Susan Goff, Jessica Carrick, Donna Merritt, Denise Fairhaw  
CC: Patti Walker, Esther Lee  
Subject: January  

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

-LUPA is killing us. In a month when revi/epidrop dropped, this was a double whammy.

-Therapeutics 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 email from Tatha yesterday. At 10, our episode value drops by over 80% or 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 visit/episode. At 7-8 we have usable, 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.

Lastly, we are under budget on admits. Our cost structure cannot support our revenue. If we don't have an acceptable P&I we will have to make some tough decisions... and it is just easier to grow a business.

Please address these items immediately. THANK YOU.

Dan Cundiff  

VP, Florida Operations  

Clinical Excellence is Job One!
Footnote 43
From: Dan Cundiff
Sent: Friday, February 29, 2008 11:38 AM
To: Donna Moretti, Susan Griff, Sarah Zimmerman, Jenice Carrick, Denise Earnshaw
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 18 therapy visits. When clinically appropriate, lets drive to that number. From 10-13 visits, we become significantly less profitable...to the tune of an $80.00+ negative adjustment from 2007 rates.

Falling in the 10-13 range without a valid 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

Clinical Excellence is JOB One
Footnote 44
From: Mike Hamilton  
Sent: Monday, March 10, 2008 1:53 PM  
To: Jill Cassie, William Mays  
Subject: FW: Financial Action Plans  
Attachments: Wentzville.doc, Fort Wayne.doc, Hillsboro.doc, Indy.doc, Muncie.doc, St. Louis.doc  

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  

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  

CONFIDENTIAL TREATMENT REQUESTED  
PURSUANT TO SENATE RULE XXIX  

AMEISFC00053356
<table>
<thead>
<tr>
<th>Area Identified for Improvement</th>
<th>Action Plan(s) to Complete Project</th>
<th>Responsible Party</th>
<th>Date Completed</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Westville office technically opened in Aug 2007, however we did not have any DOO or clinical staff until October 2007. Shortly after opening the AE reported before Christmas. Presently we have an AE from our Bellevue Office covering 2/3 days per week. Agency does not have any rehab staff and are presently using contract therapy.</td>
<td>Looking at the statistics for primary issues I have identified: Most increase admissions, increasing the revenue.</td>
<td>Actual Budget</td>
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<tr>
<td>McCain Atkins</td>
<td>4/13/08</td>
<td>557.5</td>
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<tr>
<td>Re-Employ</td>
<td>4</td>
<td></td>
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<tr>
<td>Need FT AE</td>
<td>Work with recruitment department to identify and hire an AE</td>
<td>Melissa Adams AVP Ops and Mary Janeugar AVP BD</td>
<td>6/3/09</td>
<td></td>
</tr>
<tr>
<td>Optimize usage of available DM programs to increase admissions.</td>
<td>1. Work with DOO’s from the Hillmen and St. Louis offices to share the benefits of a FT ST to introduce the Dysphagia Program. 2. Work with David Kozub to optimize our intake and marketing of this program. 3. Presently working with Woods Hall to introduce the Balance for Life program in the area, which should occur the second quarter.</td>
<td>1. Denise O’Malley DOO 1/3, 2 &amp; 4 2. 1 DOO’s from 1/06 3. 1/02 &amp; 1/05 3/15/08</td>
<td>1 &amp; 2 4/15/08 2 7th quarter</td>
<td></td>
</tr>
<tr>
<td>Increase Revenue per episode via episode management from $16.19 to $24.00.</td>
<td>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 ensure usage of clinical tools.</td>
<td>Melissa Adams AVP OP</td>
<td>3/15/08</td>
<td></td>
</tr>
</tbody>
</table>
| Increase MCCare admissions from 25% of budget to 75% of budget. Increase to 40% by end of March, 50% by end of April, 60% by end of May and 75% by the end of June. | Same as all of above:  
1. Belleville AE will continue to cover 2 1/2 days per month until PT AE is obtained.  
2. DOO will assist with follow-up marketing calls once PT field RN is hired and trained. | Melona Adams  
AVP OP & Inpatient Services DOO | 6/30/11 |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Area Identified for Improvement</td>
<td>Action Items to Complete Project</td>
<td>Responsible Party</td>
<td>Date Completed</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td>Wentzville 1305</td>
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<tr>
<td></td>
<td>Actual Budget</td>
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<tr>
<td></td>
<td>Actual $1639</td>
<td>Budget $2712</td>
<td></td>
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<tr>
<td></td>
<td>Need PT AE</td>
<td></td>
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<tr>
<td></td>
<td>Work with recruitment department to identify and hire an AE</td>
<td>Melissa Adams, AYP Ops, and Mary, Izzo, IHP, IHP, IHP</td>
<td>03/01/08</td>
</tr>
<tr>
<td></td>
<td>Optimize usage of available DM programs to increase admissions.</td>
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<tr>
<td></td>
<td>1. Work with DOO's from the Hillburn and St. Louis offices to share the lessons of a PT 55 to introduce the Dysphagia Program.</td>
<td>Denise O'Neilley, DOO 1802, 2 &amp; 3 DOO, from 1305</td>
<td>1 &amp; 2/4/15</td>
</tr>
<tr>
<td></td>
<td>2. Work with David Leckie in marketing of this program.</td>
<td></td>
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<tr>
<td></td>
<td>3. Presently working with Wanda Hall to introduce the patient experience program in the area, which would occur in the second quarter.</td>
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<tr>
<td></td>
<td>Increase Revenue per episode via episode management from $1615 to $2500.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Work with DOO to understand the new-care model.</td>
<td>Melissa Adams, AYP Ops</td>
<td>3/13/08</td>
</tr>
<tr>
<td></td>
<td>2. Identify patients with rehab needs and optimize their usage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Work with DOO to increase usage of existing tools.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Admissions</td>
<td>Same as all of above 1. Referral AE will continue to cover 2 1/2 days per month until PT AE is obtained. 2. DOO will assist with follow-up marketing calls once PT field RN is hired and trained.</td>
<td>Melissa Adams, AVP OP &amp; Joanne Rotunda DOO</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Increase private admissions from 25% of budget to 75% of budget. Increase to 49% by end of March, 50% by end of April, 55% by end of May, and 75% by the end of June.</td>
<td></td>
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**CONFIDENTIAL TREATMENT REQUESTED**

**MEDICAL, DRG, PPS DATA**
### Action Plan for March 6, 2010

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<thead>
<tr>
<th>Area Identified for Improvement</th>
<th>Action Item(s) to Complete Project</th>
<th>Responsible Party</th>
<th>Date Completed</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>I took this branch over the end of Sept. 2007/when the 3000 left. There was absolutely no office staff on a AE. Presently we have a new DOO, BSM 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 as order to be proactive with this situation. Analysis of Financials: More increase admissions this will bring up the GM, NEP and decrease the G&amp;A. Revenue per episode could be increased by better utilizing therapy 10% of therapy in the 11-13 range the other 90% will in the 6 range. Need to increase census to a minimum of 30% of census.</td>
<td>1. Entire clinical staff and All will be doing an AE/SNF Blitz in 2 weeks. The AE can brainstorm these for the entire</td>
<td>1 DOO, AE &amp; clinical staff</td>
<td>1, 2, 3, 4, &amp; 5</td>
<td>3/30/11</td>
</tr>
<tr>
<td>Increase Medicare admissions 2. AVP ID will be spending time at the branch and working with the AE in April. 3. AE to concentrate tracking efforts to promote Therapy Wound Care. 4. Hire and train an additional AE. 5. Continue to monitor AE's productivity and address as necessary.</td>
<td></td>
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</tr>
<tr>
<td>Increase Rec-Episode and Recert. 1. DOO will monitor therapy utilization and ensure therapies are utilizing the therapy trucks. 2. DOO will continue to monitor discharges via the DC Checklist, identifying patterns that could be improved. 3. DOO will ensure that all clinical staff are utilizing the clinical trucks and monitor visits utilization.</td>
<td></td>
<td>DOO and AVP OP</td>
<td>Ongoing</td>
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### Hillsboro 1302

**Action Plan for**

**DATE: March 6, 2008**

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<th>Responsible Party</th>
<th>Date Completed</th>
<th>Follow Up</th>
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</thead>
<tbody>
<tr>
<td>Hillsboro is in a state of crisis. The hospital</td>
<td>1. Wound Care Blitz scheduled and March</td>
<td>501</td>
<td>3/15/08</td>
<td>3/15/08</td>
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<tr>
<td>Financial Analysis:</td>
<td>2. DOO will ensure that all staff has completed the</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
</tr>
<tr>
<td>Need to get Medicare admissions over their</td>
<td>3. DOO will monitor proper utilization of therapy wound</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
</tr>
<tr>
<td>budget 2.5% is high due to having in salary</td>
<td>care.</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
</tr>
<tr>
<td>2.5% and to cover multiple lots and</td>
<td>4. DOO and CM will review and authorize all discharges</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
</tr>
<tr>
<td>trying to get a Psych program off the ground.</td>
<td>using the DC Criteria Checklist.</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
</tr>
<tr>
<td>Racial cases are low, need to increase. Real episodes could be higher with better utilization of therapy. They have a therapy cart, in wound care which they are not properly using. Avg. visits per episode is high which would be bad if this was therapy, but it is not. They have 0.2% of therapy in the below 15 visits.</td>
<td>5. DOO and AE will plan an AEP/ISNFT Blitz the beginning of April.</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
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<table>
<thead>
<tr>
<th>Increase Medicare Admissions and Revenue</th>
<th>1. DOO and CM will implement the therapy wound care and ensure proper utilization of therapy wound care.</th>
<th>501</th>
<th>3/15/08</th>
<th>3/15/08</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>2. DOO will monitor therapy usage during Care Team.</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
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<tr>
<td></td>
<td>3. DOO and CM will monitor the utilization of clinical tools using the allocated visit numbers.</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
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<tr>
<td></td>
<td>4. DOO and CM will monitor the utilization of the Rehab Tools using the allocated visit numbers.</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
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</table>

<table>
<thead>
<tr>
<th>Increase Revenue per Episode</th>
<th>1. DOO and CM</th>
<th>501</th>
<th>3/15/08</th>
<th>3/15/08</th>
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<tbody>
<tr>
<td></td>
<td>2. DOO</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
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<tr>
<td></td>
<td>3. DOO and CM</td>
<td></td>
<td>3/15/08</td>
<td>3/15/08</td>
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**ACTUAL / BUDGET**

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<tr>
<th>McClellan Alloc</th>
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<td>22</td>
<td>24</td>
<td>22</td>
<td>-4</td>
</tr>
<tr>
<td>8</td>
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<td>9</td>
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<tr>
<td>125</td>
<td>126</td>
<td>125</td>
<td>-1</td>
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<tr>
<td>Avg Var/Episode</td>
<td>10.0%</td>
<td>10.0%</td>
<td>0%</td>
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</tbody>
</table>
Indianapolis 1020

<table>
<thead>
<tr>
<th>AREA IDENTIFIED FOR IMPROVEMENT</th>
<th>ACTION ITEM(S) TO COMPLETE PROJECT</th>
<th>RESPONSIBLE PARTY</th>
<th>DATE COMPLETED</th>
<th>FOLLOW UP</th>
</tr>
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<tbody>
<tr>
<td>Indianapolis 1 in Oct 2007. We</td>
<td>Complete project</td>
<td></td>
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<tr>
<td>have had a major clean-up in</td>
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<tr>
<td>this office. We just recently</td>
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<td>had a DOO and a FT RN in</td>
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<tr>
<td>this. Prior to this we did not</td>
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<tr>
<td>even have an RN for the location. The Hom is on a PEP. Due to the</td>
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<tr>
<td>billing compliance and regulatory issues we discovered we terminated our</td>
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<td>relationship with a sub-contract group whose working with in an ALF. This</td>
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<tr>
<td>referral source was 50% of the branch's business. Occasionally the branch is</td>
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<tr>
<td>doing better, SY5 adds and AR is decreasing. Daily billing is being managed</td>
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<tr>
<td>by the ROM. We have a very strong AE and clinical staff. The branch is</td>
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<tr>
<td>becoming Wound certified at March. Financial Analysis: Branch meeting McCare 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. Risks are very low, but the causes of 36 is not a true reflection due to the subcontractor group not turning in DC paperwork for 30-45 days after. Avg. Visits/Episode is high due to the subcontractor group's utilization.</td>
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<table>
<thead>
<tr>
<th>ACTUAL</th>
<th>BUDGET</th>
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</table>

1. Schedule Wound Care Biz
2. DOO will ensure all staff has completed the
1 1/3/2008
| Maintain Revenue/Episode at over $1000 | 1. DOO will implement the therapy wound care plan and monitor the improvement of therapy wound care.
2. DOO will monitor therapy usage during Care Team.
3. DOO will monitor the utilization of clinical tools using the allocated visit numbers.
4. DOO will monitor the utilization of the Rehab. Tracks and track the allocated visit numbers. | 2-4 DOO | 2-4 Ongoing | 5/31/09 |
|--------------------------------------|-------------------------------------------------------------------------------------------------|--------|------------|--------|
| Decrease Avg visits/Episode          | 1. DOO will ensure that all patients are put on the appropriate clinical tools and visit recommendations are followed.
2. DOO will ensure that all rehab patients are put on appropriate Rehab. Tracks and visit recommendations are followed. | DOO    | Ongoing    |        |
<table>
<thead>
<tr>
<th>Action Type(s) to Complete Project</th>
<th>Responsibility Party</th>
<th>Date Completed</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a new start up which opened the very end of Aug. 30th. We have had a serious</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Therapy recruitment crisis in this area. They have no therapists (employed or sub-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>contracted), even after making numerous ads, working with Amolex. The agency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>continues to turn down referrals requiring therapy, despite offering their</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>admission matrices. They have called every outpatient rehab. In the area, trying to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>get a sub-contractor without any success.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After analyzing the financials, revenues will have to be increased in order to see any | | | |
change in the agency. The non-operate is actually pretty high considering therapy is | | | |
not involved. They have some wards with copious amounts of drainage requiring | | | |
frequent dressing change which is effecting their visit rates. The key factor in this | | | |
agency will be getting therapy services, which will increase admissions and effect | | | |
the revenue. GM will go up and Q&A will go down as revenue is increased. |

<table>
<thead>
<tr>
<th>ACTUAL</th>
<th>BUDGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCA/CAI</td>
<td>0</td>
</tr>
<tr>
<td>New Episode</td>
<td>8277</td>
</tr>
<tr>
<td>Avg. Visit Episode</td>
<td>23.90</td>
</tr>
</tbody>
</table>

**Tile PT and OT**

- 1. Continue to work with Amolex's recruiters.
- 2. Continue to have bi-weekly recruitment meetings with Amolex recruiters, AVP of Ops and VP.
- 3. Continue to work with therapists at sister agencies requesting recruitment help.
- 4. Continue to have all employees (especially AE) try to identify potential candidates in the community.
- 5. Continue to work with Amolex.
- 6. Continue to work with outside vendor.

**Maximize marketing efforts in area's that may not require therapy.**

- All to concentrate marketing wound care and Diabetic care that may not require therapy.

**Timely**

- Budget, DOO & Lisa
- Ongoing
<table>
<thead>
<tr>
<th>Area Identified for Improvement</th>
<th>Action Plan(s) to Complete Project</th>
<th>Responsible Party</th>
<th>Date Completed</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Louis is improving. They have a strong DOO, 1000 and office staff, 1 strong AE.</td>
<td>Increase Medicare Admissions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Wound Care Report scheduled by DOO.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. ST has been hired, working with AE, DOO, Clinical staff and David Gundlings to increase ST utilizing the Dysphagia program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Palmae Pro Lift implementation scheduled for 7th Quarter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Put AE on PFP if productivity does not increase by the end of March</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase Reuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. ATEC will be authorized by DOO using UC Criteria Checklist.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. All Reuse and DC will be discussed at Care Team Weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase Therapy Utilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. DOO and CM will monitor therapy utilization during Care Team weekly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. DOO will ensure that all therapists are using the Nobo Tracks using recommended visits.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. DOO and CM will ensure that Therapy Wound Care patients are identified and their care via therapy is</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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-related services.

6. DOO will be responsible for ensuring that all staff are fully trained on the use of the Dysphagia program and relevant equipment.
Footnote 45, 46
<table>
<thead>
<tr>
<th># of Therapy Visits</th>
<th>2006 n</th>
<th>2007 n</th>
<th>2008 n</th>
<th>2009 n</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7,435</td>
<td>7,486</td>
<td>9,774</td>
<td>9,333</td>
</tr>
<tr>
<td>2</td>
<td>4,264</td>
<td>4,376</td>
<td>5,496</td>
<td>5,268</td>
</tr>
<tr>
<td>3</td>
<td>4,264</td>
<td>4,264</td>
<td>5,268</td>
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<tr>
<td>4</td>
<td>4,264</td>
<td>4,264</td>
<td>5,268</td>
<td>5,268</td>
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<tr>
<td>5</td>
<td>5,268</td>
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<td>5,268</td>
<td>5,268</td>
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<tr>
<td>7</td>
<td>5,268</td>
<td>5,268</td>
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<td>8</td>
<td>5,268</td>
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</tr>
<tr>
<td>9</td>
<td>5,268</td>
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<tr>
<td>10</td>
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<tr>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Total</td>
<td>107,296</td>
<td>107,296</td>
<td>107,296</td>
<td>107,296</td>
</tr>
</tbody>
</table>

* This % includes data from Geviva systems and post-acquisition data from acquired systems.

Between 2006 & 2009, Geviva 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 the years, all 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-numbered episodes only.
* All mention of "therapy episodes" refers to Medicare-numbered episodes with 1-30 therapy visits only.
* For further detail of the clinical breakdown of our Specialty programs, please see the answer to Q5.
Footnote 47
<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Therapy Patients</td>
<td>71,048</td>
<td>94,918</td>
<td>123,440</td>
<td>143,860</td>
</tr>
<tr>
<td>Episodes Qualifying for Additional Payments</td>
<td>41,896</td>
<td>62,281</td>
<td>110,932</td>
<td>136,164</td>
</tr>
<tr>
<td>b Reimbursement from Episodes Qualifying for Additional Payments</td>
<td>$179,065,481</td>
<td>$272,326,363</td>
<td>$467,346,781</td>
<td>$606,921,660</td>
</tr>
<tr>
<td>c Total Medicare Reimbursement</td>
<td>$298,314,104</td>
<td>$436,824,896</td>
<td>$617,046,385</td>
<td>$773,673,020</td>
</tr>
</tbody>
</table>

* This info does not include post-acquisition data from acquired systems.
Footnote 49
FYI -- we also have an internal group (including Teiller, Gold, Feirce, and Tuzio) crunching utilization and outcomes data to determine whether revisions to our therapy protocols are clinically defensible.

Susan Sender
Vice President & Chief Clinical Executive
SUNY Upstate Health Services
Syracuse, NY (315) 470-6743
tel: 
fax: 
http://www.sunyupstate.com
Great healthcare has case burden

-----Original Message-----
From: Bennor, Marc
To: Teiller, Brandon Sender, Susan Tuzio, Pamela
Cc: Yallow, Brandon Sender, Susan Tweeter, 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 abating 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 Teiller, Susan Sender and Pamela Tweeter (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.

Marc
Marc Bennor
Vice President, Government Affairs
SUNY Upstate Health Services
Alexandria, Va 22314
tel: 
fax: 
http://www.sunyupstate.com
Great healthcare has case burden

E-GEN 079938
Confidential Commercial and Financial Information
Footnote 50
Footnote 51, 54, 55
April is closed and behind us. May is not far behind. We are 30 days away from the end of Q1, and things could be looking better. The race is getting closer for #1. Complete the new task of Christ and Joe for making a move this month. I keep hearing that the south will rise again.

Overall, we need a VERY STRONG Q2 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!

REGIONAVP: DEREK SALLEY: Weighted ANDREW MEN

Activity: Price, Size, Volume, and Trend.

Brandon Ballow
Vice President of Finance and Investor Relations

Investor Relations

Atlanta, GA 30339

From: Ballow, Brandon
Sent: Wednesday, May 05, 2010 1:11 PM
To: Ballow, Brandon; Carter, Rocco; Auer, John; Jarrard, Mary; Bento, Susan; Thomsen, Gordon; Hubinger, Monica; Little, Rob; Hunt, Mark; Schwartz, Catherine; Erikson, Julie; Carpenter, Luke; Mahoney, Darlene; Rizzo, Cecilia; Levine, Michelle; Sylverton, Trevor; Namke, Richard; Brooks, Adam; Nordman, Derek; Page, Stephen; Chappell, Bruce; Michalski, David; Cum, Kimberly; Rinaldi, Donna; Gregory, Terrie; Sprung, Edward, Kimm, Sharron, McVay, Carol; Keene, Andrew; Stackhouse, John; Camperen, John; Paiz, Stephen; Wexler, Charlotte; Young, Miller (VP of Sales); Cusack, David; Shana, Jeff; Shemak, Paul; Strong, Terry; Bowers, Tim; Sharer, Kathleen; Alford, Steven; Spencer, Greg; Effordt, Joshua; Slusser, Brian

Subject: 2010 Q2 Regional Rankings

FYI: 2010 Q2 Regional Rankings

Regional Ranking April 2010.xls

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

E-GEN 024576

Confidential Commercial and Financial Information
plan. For example, one metric is Gross Margin %. On a current run rate basis, Mid Atlantic is performing the best with a GM of 58.7%, however, they are only 50% of their budgeted GM %, which puts them in 4th for that metric. 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... MILLER REED!!!

DEI148452 DEI148452 SALESWAverage AVG Prev Avg
Carolina/Texas Gregory/Susan Benoit, 946.51
Mid Atlantic/Mesa Hollinger/Dee 632.46
West Coast Aurel/$Mark Mant3.23/29
Mid America/Theodore Robinson 354.63
Florida/Mary Clemens/Bruce 693.40
Southeast/McMasters/Bella 635.21
Northwest/Dee Weihenmeyer 594.48

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

Criteria
Gross Margin % 55% on current 4 month trend and 50% on YTD compared to budget

\[ \text{REVENUE} \times \text{Gross Margin} \]

\[ \text{REV} \times \text{GM} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

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\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

\[ \% \text{Actual} \text{Gross Margin} \text{%} \text{Actual} \text{Gross Margin} \text{%} \text{Budget} \]

Brandon Ballew
Vice President of Finance and Investor Relations
Genting Health Services

Atlanta, GA 30339

Fax: 404-596-2223

From: ballew, brandon
Sent: Friday, January 29, 2010 6:19 PM
To: dawson, brandon; carter, bryan; ballew, brandon; john; jellett; mary; benoit; susan; thommes, gordon; holinger, monika little; rob hum; mark schwartz, catherine wood; ron; erickson, dave; carpenter, linda; mckinney, debbie; mccaig; cecilia lovejoy, michelle; gillette, trevor; ralston, richard; muen, dana; brooks, adrian; hokman, davey; severd, brendy; mckintosh, david; trim, tepcer. morgan, toby; gregory, teresa; simpson, david; riem, diane; nonhav, marrie; budgets, ang; wood, denise; stinnes, robert; moore, gail; miller, matt; benson, sara; willie, jennifer; zuhman, robi;

Carolina/Georgia

Carolina/Georgia Thursday, January 28, 2010 7:32 PM

CC: brandon, brandon; carter, bryan; ballew, brandon; john; jellett; mary; benoit; susan; thommes, gordon; holinger, monika little; rob hum; mark schwartz, catherine wood; ron; erickson, dave; carpenter, linda; mckinney, debbie; mccaig; cecilia lovejoy, michelle; gillette, trevor; ralston, richard; muen, dana; brooks, adrian; hokman, davey; severd, brendy; mckintosh, david; trim, tepcer. morgan, toby; gregory, teresa; simpson, david; riem, diane; nonhav, marrie; budgets, ang; wood, denise; stinnes, robert; moore, gail; miller, matt; benson, sara; willie, jennifer; zuhman, robi; gregg, keith

Subject: K6 Regional Rankings Through December 2009

E-GEN 024577

Confidential Commercial and Financial Information
Great to see everyone this week. Here are the final 2009 rankings. Congrats to the Spider Monkeys!

<table>
<thead>
<tr>
<th>Region</th>
<th>Name</th>
<th>RVP Ops</th>
<th>Sales Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid Atlantic</td>
<td>Jeff Shaver</td>
<td>Monica Hullinger</td>
<td>1.95</td>
</tr>
<tr>
<td>Carolina</td>
<td>Jeff Shaver</td>
<td>Theresa Gregory Interlin RVP Ops</td>
<td>2.01</td>
</tr>
<tr>
<td>West</td>
<td>David Cady</td>
<td>John Aurelio RVP Ops</td>
<td>1.98</td>
</tr>
<tr>
<td>Florida</td>
<td>David Cady</td>
<td>Mary Jalain RVP Ops</td>
<td>1.93</td>
</tr>
<tr>
<td>Midwest</td>
<td>Jeff Shaver</td>
<td>Open RVP Ops</td>
<td>1.95</td>
</tr>
<tr>
<td>East</td>
<td>Jeff Shaver</td>
<td>Open RVP Ops</td>
<td>1.95</td>
</tr>
</tbody>
</table>

Brandon Ballow
General Manager, Investor Relations

Atlanta, GA 30339

E-GEN 024578

Confidential Commercial and Financial Information
August is in. It was not a pretty month. One of the lowest results on multiple fronts, from admits to plan to be at HITHC 4. We have had some movement in the rankings as the South has gained 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 Shamah
   Monica Wallinger MVP Ops, Bob Little MVP Sales

2. Carolina
   Jeff Shamah
   2.77
   Theresa Gregory Interim MVP Ops, Susan Bennett
   Miller Hess

3. Florida
   David Casey
   3.53
   Mary J. Allen MVP Ops, Bob Arison MVP Sales
   Battlefields

4. West
   David Casey
   3.69
   John Auriello MVP Ops, Mark Hant MVP Sales
   Mustangs

5. Northeast
   Jeff Shamah
   4.45
   Dan Linker MVP Ops, Shawn Brown MVP Sales
   Thunder

6. South
   David Casey
   5.12
   Open MVP Ops, Bob Garin MVP Sales
   Buccaneers

7. Mid America
   Jeff Shamah
   5.29
   Bruce Carter MVP Ops, Gordon Thorne MVP Sales
   Wildcats

Brandon Bixler
greaterhealthservices@tivo.com
Vice President F&O, Investor Relations

SR: 10-10389
IR: 20-42602
Fax:

www.greaterhealth.com
Great healthcare has come home!
<table>
<thead>
<tr>
<th>Region</th>
<th>Representative</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwest Atlantic</td>
<td>Jeff Shaner</td>
<td>Monica Kullinger MVP Ops, Rob Little MVP Sales</td>
</tr>
<tr>
<td>Southeast</td>
<td>Jeff Shaner</td>
<td>breeder moments</td>
</tr>
<tr>
<td>Carolinas</td>
<td>Jeff Shaner</td>
<td>Theresa Gregory Interim MVP Ops, Susan Bannett</td>
</tr>
<tr>
<td>MVP Sales</td>
<td>2.72</td>
<td>Miller (be)</td>
</tr>
<tr>
<td>Florida</td>
<td>David Caudby</td>
<td>3.62</td>
</tr>
<tr>
<td>West</td>
<td>David Caudby</td>
<td>3.77</td>
</tr>
<tr>
<td>Northeast</td>
<td>Jeff Shaner</td>
<td>4.32</td>
</tr>
<tr>
<td>Midwest America</td>
<td>Jeff Shaner</td>
<td>Wildcat</td>
</tr>
<tr>
<td>MVP Sales</td>
<td>5.25</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>Jeff Shaner</td>
<td>5.31</td>
</tr>
</tbody>
</table>

Brandon Bellow  
Genentech Health Services (GTHS)  
Vice President of Finance, Investor Relations  

Atlanta, GA 30303  
IR @ direct1:  
Fax: www.genentech.com  

Great healthcare has come home!  

From: Bellow, Brandon  
Sent: Monday, August 11, 2011 11:13 AM  
To: Bellow, Brandon; Gruber, David; Carter, Bruce; Aurelio, John; Jalewo, Mary; Benoit, Dale; Thompson, Gordon; Kullinger, Monica; Little, Bob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Knuckles, Rolly; Thompson, Donna; Carpenter, Lisa; Mahney, Delene; Narr, Jeff; Riopre, Cecile;蠖dias, Alphonso; Denham, Adam; Nordman, Dave; Newsom, Bruce; McCollum, Susan; Craig, Kimberly; Dunham, Donald; Slobog, Teresa; Carpenter, John; RAILY, Stephen; Weaver, Patricia; Young, William; YP of Sales; Caudby, David; Shaner, Jeff; Shoemaker, Paula; Strong, Tony; Levin, Yehli; Machina, Matthew; Allred, Steven  
Subject: Kirk 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 clone, slower admissions, and TORME conditional level surveys, July is a month to forget. Here’s to August being better!  

<table>
<thead>
<tr>
<th>Region</th>
<th>Representative</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
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<td>David Caudby</td>
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<td>3.77</td>
</tr>
<tr>
<td>Northeast</td>
<td>Jeff Shaner</td>
<td>4.32</td>
</tr>
<tr>
<td>Midwest America</td>
<td>Jeff Shaner</td>
<td>Wildcat</td>
</tr>
<tr>
<td>MVP Sales</td>
<td>5.25</td>
<td></td>
</tr>
<tr>
<td>South</td>
<td>Jeff Shaner</td>
<td>5.31</td>
</tr>
</tbody>
</table>

Those conditional level surveys have made a big difference on the rankings, the Carolinas were much closer to #1 and Midwest America was in fourth place prior to souring the surveys.  

Brandon Bellow  
Genentech Health Services (GTHS)  
Vice President of Finance, Investor Relations  

F-GEN 024580  
Confidential Commercial and Financial Information
From: Ballow, Brandon
Sent: Friday, July 31, 2009 4:39 PM
To: Ballow, Brandon; Locker, Dan; Davis, Bob; Carter, Bruce; Ausilio, John; Selwan, Mary; Benoit, Susan; Thenen, Gordon; Mullinger, Monique; Little, Rob; Hunt, Mark; Schwartz, Catherine; Koch, Robert; Erickson, Bruce; Thomas, Susan; Campbell, Lisa; Mahoney, Darlene; Bari, Jeff; Rogers, Cecille; Conover, Michele; Sylvester, Trevor; Nanke, Richard; Jones, Susan; Brooks, Adam; Northam, Terry; Meck, Ron; Parks, Michael; Dalzell, Sandy; Club, Kimberly; Kimmins, Susan; Gregory, Teresa; Gregson, Edwin; Kirlin, Daniel; Donahue, Marion; Hodge, John; Maddox, Daniel; Johnson, Robert; Major, David; Miller, Mike; Co: Boskovich, John; Cannavaghi, Peter; Gregory, Lee; Sieringer, David; Masco, Andrew; Foglebach, John; Campbell, John; Page, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Cauboy, David; Shiner, Jeff; Shoemaker, Paul; Strange, Tony; Levine, Peter; Shasham, Kathleen; Allred, Steven; Sponza, Georgia
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 these messages go up top, they’ll have to start up for one more week but in second position this time. Congrats Carolina teens!

1. Mid Atlantic
   Jeff Shiner
   Monica Mullinger MVP Op, Bob Little MVP Sales
   Panthers Moments
   2.03

2. Carolina
   Jeff Shiner
   Susan Dannit MVP Sale
   2.43

3. West
   David Cauboy
   Mary Selwan MVP Op, Bob Bruson MVP Sales
   2.33

4. Florida
   David Cauboy
   1.41

5. South
   David Cauboy
   1.38

6. Mid America
   Jeff Shiner
   Bruce Carter MVP Op, Gordon O’Hara MVP Sales
   2.53

7. South Central
   David Cauboy
   1.13

8. Northeast
   Jeff Shiner
   Dan Locke MVP Op, Open MVP Sales
   1.74

The summer months tend to separate the winners from the losers. Wonder what the other groups are doing to get ahead?

Brandon Ballow
Centena Health Services (CTIV)
Vice President of Finance, Investor Relations

Confidential Commercial and Financial Information

E-GEN 024581
Robert: Ireland, Julia; Thomas, Susan; Carpenter, Lisa; Mahoney, Glad; Bit, Jeff; Riggs, Occle, Lovell, Michelle; Sylvestri, Trevor; Nakay, Richard; Jones, Susan; Novak, Adam; Redman, Derek; Keardon, Bruce; Michotolitch, David; Crow, Kimberly; Kimball, Denise; Grayboy, Texas; Angers, Edgins, Elmo; Evans, Donahoe, Manon; Rodgers, Adam; Handlin, Daniel; Barlow, Robert; Minor, Geri; Miller, Matt

cce: Nilander, John; Cerveny, Pete; Gregory, Lee; Gierlinger, David; Bauch, Andrew; Etchey, John; Casper, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Sharer, Jeff; Shuman, Paul; Strange, Tony; Riebe, Jeff; Shaw, Kathleen; Slezak, Steven; Spero, Denis

Subject: KTV Rankings through May 2009

Q1 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 earnings have not changed since April.

| 1. Midwest | Jeff Sharer | 2.62 | Monico Mullinger MVP Ops, Rob Little MVP Sales |
| 2. West | David Casady | 1.81 | John Aurelio Interim MVP Ops, Mark Hunt MVP Sales |
| 3. Carolina | Jeff Ham | 1.53 | Hines Gregory Interim MVP Ops, Susan Sennit |
| 4. Florida | David Casady | 1.41 | Mary Palman MVP Ops, Bob Branson MVP Sales |
| 5. South | David Casady | 1.15 | Open MVP Ops, Bob Gorczynski MVP Sales |
| 6. Midwest | Jeff Sharer | 1.15 | Bruce Coller MVP Ops, Gordon Thomsen Interim MVP Sales |
| 7. South Central | David Casady | 0.85 | Dan Locker MVP Ops, Open MVP Sales |

The case is getting a little closer, but as Melvin always says "NO ONE can catch 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 all did 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!

Brandon Beall
Centrec Health Services, Inc.
Vice President of Finance, Investor Relations

Atlanta, GA 30319
IR: beall@centrec.com
direct: 770-926-4000
fax: 770-926-4001

[Website: www.centrec.com]

Great healthcare has come home!

From: Beall, Brandon
Sent: Wednesday, May 27, 2009 6:42 PM
To: Beall, Brandon; Lock, Dan; Carter, Bruce; Assel, John; Julin, Mary; Neal, David; Sennit, Susan; Thomsen, Gordon; Mullinger, Monica; Little, Rob; Bart, Mike; Schwartz, Catherine; Koch, Robert; Ireland, Julia; Thomas, Susan; Carpenter, Lisa; Mahoney, Glad; Bit, Jeff; Riggs, Occle; Lovell, Michelle; Sylvestri, Trevor; Nakay, Richard; Jones, Susan; Novak, Adam; Redman, Derek; Keardon, Bruce; Michotolitch, David; Crow, Kimberly; Kimball, Denise; Grayboy, Texas; Angers, Edgins, Elmo; Evans, Donahoe, Manon; Rodgers, Adam; Handlin, Daniel; Barlow, Robert; Minor, Geri; Miller, Matt
Cc: Nilander, John; Cerveny, Pete; Gregory, Lee; Gierlinger, David; Bauch, Andrew; Etchey, John; Casper, John; Paige, Stephen; Weaver, Charlotte; Young, Mike (VP of Sales); Causby, David; Sharer, Jeff; Shuman, Paul; Strange, Tony; Riebe, Jeff; Shaw, Kathleen; Slezak, Steven

Subject: KTV Rankings through April 2009

Q1 had length. 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?

E-GEN 024582
Confidential Commercial and Financial Information
1. Mid Atlantic  Jeff Shaver  1.31  
   Monica Mullinger MVP Ops. Rob Little MVP Sales
   AYEZER MOMENTS
2. West        David Cauby  3.37
   John Aurelio Interim MVP Ops. Mark Hunt MVP Sales
3. Carolina    Jeff Shaver  3.13
   Theresa Gregory Interim MVP Ops. Susan Benoit
   MVP Sales
4. Florida     David Cauby  2.70
   Mary Jelwan MVP Ops. Open MVP Sales
   Barristers
5. South       David Cauby  2.18
   Open MVP Ops. Rob Garvin MVP Sales
   Torrando
6. Mid America Jeff Shaver  1.76
   Bruce Carter MVP Ops. Gordon Thoenes Interim MVP
   Sales
7. Northeast   Jeff Shaver  5.62
   Dan Locker MVP Ops. Open MVP Sales
777
8. South Central David Cauby  7.92
   John Aurelio MVP Ops. Duane Neel MVP Sales
777

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.

Brandon Ballam
Vice President of Finance, IR
Atlanite, OR 90333
Investor Relations
Fax: 
WWW.JEETLINE.COM
Great healthcare has come home

From Ballam, Brandon
Sent: Monday, April 22, 2009 6:05 PM
To: Ballam, Brandon; Lisker, Dan; Garvin, Bob; Carter, Bruce; Aurelio, John; Jelwan, Mary; Beel, Dan; Benoit, Susan; Thomas, Gerard; Mullinger, Monica; Little, Rob; Hunt, Mark; Schwerdt, Catherine; Koch, Robert; Erickson, Julie; Thomas, Owen; Carpenter, Lisa; Mahoney, Darlene; Barr, Jeff; Maggs, Gerald; Gortler, Michele; Appelgetter, Trevor; Kalsbe, Michael; Jones, Susan; Brooks, Adam; Brandt, David; Miranda, Bruce; Mosbacher, David; Bane, Candy; Chartier, Todd; Martin, Ted; Nelson, Michael; Radtke, Tiger; Qi, Qian; Ko, Tim; Markovitz, Ron; Stowe, Cara; Strimple, Tony; Stross, Peter; Vample, Tad; Wurden, John; Yang, Yung
Cc: Horlacher, John; Cunick, Paul; Beans, Greg; Gregory, Lee; Gieringer, David; Haas, Andrew; 
Mesum, John; Cochrane, Steve; Bood, Mike (VP of Sales); Caruso, David Shaver; Jeff; Shaver, David; 
Wu, Lin; Cheung, Allen; Airey, John; Ramism, Mike; Davis, Tom; Fowles, Karl; Fisher, Kevin; 
Vandor, Sarah; Helford, Kevin; Imagawa, Ken; Johnson, John; Kikuta, Jil; Green, Stuart; 
Korf, Rick; Schmitt, Bill; Hink, Scott; Davis, Mark; Farber, Alan; Venable, Charles; 
Kirby, Steven; Seidman, Jon; Scudder, Matt; Doel, Kevin; Mangan, John; 
Subject: ERP Rankings through March 2009

With Qi in the house, the race is getting interesting. Mid Atlantic appears to be pulling away from the pack right now. The race between 2-8 is very close. With a new name Ops...it seems to me a great
quarter West teams! Watch out for the Florida team Dudes (that's the name that the Spider Monkeys use
everyday), they are making a serious run at the top spot!

1. Mid Atlantic  Jeff Shaver  2.41
   Monica Mullinger MVP Ops. Rob Little MVP Sales
2. West        David Cauby  3.16
   Open MVP Ops. Mark Hunt MVP Sales
3. Carolina    Jeff Shaver  3.32
   Theresa Gregory Interim MVP Ops. Susan Benoit
   MVP Sales
4. Florida     David Cauby  5.43
   Mary Jelwan MVP Ops. Open MVP Sales
   Barristers
5. South       Jeff Shaver  4.97
   Open MVP Ops. Rob Garvin MVP Sales
   Torrando
6. Northeast   Jeff Shaver  5.06
   Dan Locker MVP Ops. Open MVP Sales
7. Mid America Jeff Shaver  5.62
   Bruce Carter MVP Ops. Gordon Thoenes Interim MVP
   Sales
8. South Central David Cauby  5.91
   John Aurelio MVP Ops. Duane Neel MVP Sales

Good luck to all in April!

E-GEN 024583
Confidential Commercial and Financial Information
Brandon Bellow  
Vice President of Finance  
Gentiva

Tel:  
Fax:  
http://www.gentiva.com

Great healthcare has come home

From: Bellow, Brandon  
Sent: Thursday, March 24, 2009 2:36 PM  
To: Bellow, Brandon; Locker, Dan; Garvin, Rob; Carter, Bruce; Aucello, John; Jailwan, Mary; Neel, Dianne; Hensley, Susan; Thommes, Gordon; Mullinger, Nhung; Little, Bob; Russo, Bryan; Hunt, Mark; Schwartz, Catherine; Rush, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mehmney, Leslie; Deitz, Jeff; Higgins, Cecilia; Lovecchio, Michael; Sylvain, Trev; Hanke, Richard; Jones, Susan; Brown, Adam; Herndon, Derek; Reardon, Dave; Minichillo, David; Hahn, Candy; Chartier, Ted; Martin, Joyce; Crow, Rishley; Kinsella, Donna  
Cc: Stradling; John; Cavanaugh, Dave; Walters, Brent; Gregory, Lew; Geringer, David; Snider, Ann; Bean; Andrews, Bob; Grieve, Michael; Potemkin, John; Cremerslag, John; Page, Stephen; Weaver, Chuck; Young, Mike; Ivy, Don; [D] Casey, David; Shames, Jeff; Shomaker, Paul; Strange, Tony; Dzienko, Tim; Mahan, Kathleen  
Subject: RVP MVP Rankings through February 2009  

There was an error on the RVP MVP calculations (thanks to John W). The ranking were changed slightly, only affecting 2 places. #1 and #2. They are now reversed as the Mid Atlantic region is #1 and Carolinas are #2.

1. Mid Atlantic  
   Jeff Aucello  
   2.73  
   Monica Mullinger MVP Opes, Rob Little MVP Sales

2. Carolina  
   Jeff Shames  
   2.70  
   Open MVP Opes, Susan Benoit MVP Sales

3. Florida  
   David Casey  
   3.53  
   Mary Jailwan MVP Opes, Open MVP Sales

4. West  
   Dave Clark  
   3.49  
   Open MVP Opes, Mark Hunt MVP Sales

5. South  
   David Casey  
   3.12  
   Open MVP Opes, Rob Garvin MVP Sales

6. Northeast  
   Jeff Shames  
   3.47  
   Don Locke MVP Opes, Brian Musso MVP Sales

7. Mid Atlantic  
   Jeff Aucello  
   3.91  
   Brown Carter MVP Opes, Gordon Thommes, Interim MVP

8. South Central  
   David Casey  
   5.65  
   John Aucello MVP Opes, Susan Neel MVP Sales

Brandon Bellow  
Vice President of Finance  
Gentiva

Tel:  
Fax:  
http://www.gentiva.com

Great healthcare has come home

From: Bellow, Brandon  
Sent: Thursday, March 24, 2009 17:34 PM  
To: Bellow, Brandon; Locker, Dan; Garvin, Rob; Carter, Bruce; Aucello, John; Jailwan, Mary; Neel, Dianne; Hensley, Susan; Thommes, Gordon; Mullinger, Nhung; Little, Bob; Russo, Bryan; Hunt, Mark; Schwartz, Catherine; Rush, Robert; Erickson, Julie; Thomas, Susan; Carpenter, Lisa; Mehmney, Leslie; Deitz, Jeff; Higgins, Cecilia; Lovecchio, Michael; Sylvain, Trev; Hanke, Richard; Jones, Susan; Brown, Adam; Herndon, Derek; Reardon, Dave; Minichillo, David; Hahn, Candy; Chartier, Ted; Martin, Joyce; Crow, Rishley; Kinsella, Donna; Stradling; John; Cavanaugh, Dave; Walters, Brent; Gregory, Lew; Geringer, David; Snider, Ann; Bean; Andrews, Bob; Grieve, Michael; Potemkin, John; Cremerslag, John; Page, Stephen; Weaver, Chuck; Young, Mike; Ivy, Don; [D] Casey, David; Shames, Jeff; Shomaker, Paul; Strange, Tony; Dzienko, Tim; Mahan, Kathleen

E-GEN.024584  
Confidential Commercial and Financial Information
Welcome to FY09. We have reviewed the FY08 criteria and made some minor changes for FY09.

For FY09, the results are as follows:

1. Carolina    Jeff Shane: 2.65
                Open MFP Ops, Susan Dennis MFP Sales

2. Mid Atlantic Jeff Shane: 2.66
                Monica Hallinger MFP Ops, Rob Little MFP Sales

3. Florida      David Caudby: 3.32
                Mary Selwan MFP Ops, Open MFP Sales

4. West         David Caudby: 1.69
                Open MFP Ops, Mark Hunt MFP Sales

5. South        David Caudby: 5.12
                Open MFP Ops, Rob Garrison MFP Sales

6. Northeast    Jeff Shane: 3.61
                Dan Lecker MFP Ops, Bryan Ross MFP Sales

7. Mid America  Jeff Shane: 5.6
                Bruce Carter MFP Ops, Jordan Thompson Interim MFP Sales

8. South Central David Caudby: 5.12
                John Aurelio MFP Ops, Diane New MFP Sales

Congratulations to the Carolina Lean Team!
Brandon Baker
Vice President of Finance

Tel: 770-222-1234
Fax: 770-222-1234
E-mail: brandon.baker@mix.com

From: Baker, Brandon
Sent: Tuesday, February 10, 2009 6:27 PM
To: Brandenburg, Rebecca; Barron, Rob; Carter, Bruce; Aurelio, John; Selwan, Mary; New; Durbin, Sondra; Johnson, John; Anderson, Paul; Taylor, Scott; Becker, Charles
Subject: EGEN 024585

What a year! What a great race for first place!

1. Carolina    Jeff Shane: 2.95
                Open MFP Ops, Susan Dennis MFP Sales

2. Mid Atlantic Jeff Shane: 2.95
                Monica Hallinger MFP Ops, Rob Little MFP Sales

E-GEN 024585
Confidential Commercial and Financial Information
527

3. West
David Cauby 4.19
Open RVP Ops, Mark Hunt RVP Sales

4. Mid America
Jeff Shane 4.82
Bruce Carter RVP Ops, Gordon Theobalds Interim RVP Sales

5. Florida
David Cauby 5.09
Open RVP Ops, Mary Juehn RVP Sales

6. Midwest
Jeff Shane 5.13
Dan Locker RVP Ops, Bryan Russo RVP Sales

7. South Central
David Cauby 5.18
John Aurelio RVP Ops, Diane Heel RVP Sales

8. South
David Cauby 5.27
Open RVP Ops, Bob Garvin RVP Sales

Congratulations to Susan and Adam on a great year!!
Brandon Salwen
Vice President of Finance

Tel: http://www.gentiva.com
Fax: Atlanta, GA, 30339

From: Salwen, Brandon
Sent: Tuesday, January 06, 2009 11:03 PM

To: Slawski, Brandon; Soley, Bob; Duron; Carter, Bruce; Hurlin; John; Juehn, Mary; Heel, Dan; Locker, Dan; Russo, Bryan; Shane, Jeff; Shane, Susan; Cauby, David; Theobalds, Gordon; Littile, Monica; Banos, Raul; Murphy, Matt; Marsh, David; Fosch, Robert; Grifal, Julie; Theobalds, Gordon; Carpenter, Lisa; McNamara, Carlene; Rigg, Jeff; Lorr, Celatoria; Gilello, Michael; Sylvester, Irene; Barnett, Richard; Jones, Colleen; Corso, Adam; Blond, Betty; Shoemaker, Bruce; Machinist, David; Mandy, Candy; Chadders; Mcin; Joyce

Subject: Great healthcare has come home!

Well guess who had enough of being in 2nd place.....

1. Carolinas
Jeff Shane 2.76
Open RVP Ops, Susan Bensisl RVP Sales

2. Mid Atlantic
Jeff Shane 3.30
Monica Mullinger RVP Ops, Rob Little RVP Sales

3. West
David Cauby 4.28
Open RVP Ops, Mark Hunt RVP Sales

4. Mid America
Jeff Shane 4.99
Bruce Carter RVP Ops, Gordon Theobalds Interim RVP Sales

5. South Central
David Cauby 5.06
John Aurelio RVP Ops, Diane Heel RVP Sales

6. South
David Cauby 5.18
Open RVP Ops, Bob Garvin RVP Sales

7. Florida
David Cauby 5.21
Open RVP Ops, Mary Juehn RVP Sales

8. Northeast
Jeff Shane 3.22
Dan Locker RVP Ops, Bryan Russo RVP Sales

Only one more month to go! Who will come out on top??
Brandon Salwen
Vice President of Finance

Tel: http://www.gentiva.com
Fax: Atlanta, GA, 30339

Confidential Commercial and Financial Information

E-GEN 024586
From: Hallow, Brandon  
Date: Thursday, January 11, 2008 10:35 AM  
To: Hallow, Brandon Locker, Dan Young, Mike O'F Sullivan, Shewaker, Paula County, David County, Jeff Davison, Rob Carter, Stephen Amiel, John Alman, Mary Alman, Tony Amery, Beth Heel, Susan, Shiloh, Matthew Becciu, Susan Thomas, Gordon Sullivan, Mike Little, Rob Huse, Ray Huse, Matt Stevens, Ted  
Cc: Lovejoy, Michelle Meierland, John Cavanaugh, Peter Sylvester, Trevor Nysted, Richard Walters, Bethie Gregory, Lee Belling, David Print, Rob Heu, Andrew Fox, Mary Andrews, Jim McDonald, Alene Gries, Michael Hotschuh, John  
Subject: KIA Rankings through October 2008

We had a very good close for October, which allowed us to accurately record all of your hard work and progress on continued success in 2009.

At the top, HD Atlantic has increased their lead on the Carolina region.

<table>
<thead>
<tr>
<th>Region</th>
<th>Sales Rep</th>
<th>Sales</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mid Atlantic</td>
<td>Jeff Shafter</td>
<td>7,391</td>
</tr>
<tr>
<td>2. Carolina</td>
<td>Jeff Shafter</td>
<td>7,067</td>
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<tr>
<td>3. East</td>
<td>David Caaby</td>
<td>4,188</td>
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<tr>
<td>4. Mid America</td>
<td>Jeff Shafter</td>
<td>2,878</td>
</tr>
<tr>
<td>5. South</td>
<td>Jeff Shafter</td>
<td>1,378</td>
</tr>
<tr>
<td>6. South Central</td>
<td>David Caaby</td>
<td>8,391</td>
</tr>
<tr>
<td>7. Northeast</td>
<td>Jeff Shafter</td>
<td>1,378</td>
</tr>
<tr>
<td>8. Florida</td>
<td>David Caaby</td>
<td>6,391</td>
</tr>
</tbody>
</table>

What a close race! All groups are moving significantly based on recent performance.

Overall, we continue to execute 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 on efforts to control our population. This has led to more consistent increases in OPE (1.26) and reclassification (31.12%), 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 ($81.49), with increasing productivity from BH ($5.54) and PT ($7.71). Our cash has been lagging since this year, and an increased focus on cash collections is needed specifically in final claim management. We have another month ahead, so we are still only at 57.15%.

Only 2 months left! I know everyone is committed to closing out a great (not good) year!

Brandon Hallow  
Vice President of Finance

Tel:  
Fax:

http://www.gdnlive.com

Great healthcare has come out of

From: Hallow, Brandon  
Date: Thursday, November 23, 2008 6:34 PM  
To: Hallow, Brandon Locker, Dan Young, Mike O'F Sullivan, Shewaker, Paula County, David County, Jeff Davison, Rob Carter, Stephen Amiel, John Alman, Mary Alman, Tony Amery, Beth Heel, Susan, Shiloh, Matthew Becciu, Susan Thomas, Gordon Sullivan, Mike Little, Rob Huse, Ray Huse, Matt Stevens, Ted  
Cc: Lovejoy, Michelle Meierland, John Cavanaugh, Peter Sylvester, Trevor Nysted, Richard Walters, Bethie Gregory, Lee Belling, David Print, Rob Heu, Andrew Fox, Mary Andrews, Jim McDonald, Alene Gries, Michael Hotschuh, John  
Subject: Confidential Commercial and Financial Information

E-GEN 024587
Subject: Mid Rankings through September 2009
Sorry for the delay.

What a great quarter for Genstar! All the hard work and dedication is paying off! You and your teams have taken Genstar to a new level.

We have a change at the top this week....

1. Mid Atlantic 3.15
   Jeff Sharer
   Monica Mullinger MVP Ops, Rob Little MVP Sales

2. Carolina 3.23
   Jeff Sharer
   Open MVP Ops. Susan Bennett MVP Sales

3. West 4.06
   David Cassady
   Will they stand for being #2?
   Open MVP Ops, Mark Hunt MVP Sales

4. Northeast 4.92
   Jeff Sharer
   Dan Locker MVP Ops, Bryan Russo MVP Sales

5. Mid America 5.94
   Bruce Carter MVP Ops, Gordon Thomas MVP Sales
   0.81 from moving ahead of the Northeast

6. South Central 5.01
   David Cassady
   John Aurelio MVP Ops, Suave Neal MVP Sales

7. Florida 5.10
   David Cassady
   Open MVP Ops, Mary Jacoby MVP Sales

8. South 5.41
   David Cassady
   Josie Jacobs Interim MVP Ops, Bob Garvin MVP Sales

As you can see the races have all tightened. The spread from 1 - 8 has narrowed. There are three rounds to go, who will come out on top???

Brandon Ballew
Vice President of Finance

Fax: http://www.genstar.com
Great healthcare has come home2M

From: Ballew, Brandon
Sent: Tuesday, September 20, 2009 4:26 PM
To: Ballew, Brandon; Locke, Darren; Young, Mike (VP of Sales); Shoemaker, Paul; Truly, David; Sharer, Jeff; Barrown, Bob; Carter, Bruce; Rulino, John; Heelan, Mary; Strayer, Tony; Landry, Beth; Heelan, Susan; Shamahan, Kathleen; Boucher, Susan; Thomas, Gordon; Mullinger, Monica; Little, Bob; Russo, Bryan; Hunt, Mark; Bivens, Ted
Cc: Luroe, Michelle; Voklander, John; Cavanagh, Peter; Sylvestre, Trevor; Mackie, Richard; Walters, Brett; Gregory, Lee; Gieringel, David; Frizzi, Ron; Neuch, Andrew; Yax, Mary; Andrews, Jim; McDowell, Almer; Gecio, Michael; Potanchuk, John
Subject: Mid Rankings through August 2009

Attached is the June rankings. We see the races 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 2.17
   Open MVP Ops. Susan Bennett MVP Sales

2. Mid Atlantic 3.08
   Monica Mullinger Interim MVP Ops, Rob Little MVP Sales
   Getting closer to #1

3. West 1.73
   David Cassady
   Open MVP Ops, Mark Hunt MVP Sales

4. Northeast 2.89
   Jeff Sharer
   Dan Locker MVP Ops, Bryan Russo MVP Sales

5. Mid America 1.97
   Bruce Carter MVP Ops, Gordon Thomas Interim MVP
   Can Mid America reclaim the #2 spot?

6. South Central 1.11
   David Cassady
   John Aurelio MVP Ops, Suave Neal MVP Sales

7. South 3.68
   Josie Jacobs Interim MVP Ops, Bob Garvin MVP Sales

8. Florida 5.68
   David Cassady

E-GEN 024588
Confidential Commercial and Financial Information
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. Out Medicare patients dropped 5% overall above the same period last year. The first two weeks of September have shown continued improvement in the inpatient census management. The Left Strokes admissions continue to post impressive growth figures, helping to drive through the summer months. Our cash collections have improved for the past few months, reminding us of the importance of 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!

Brandon Ballew
Vice President of Finance

Atlanta, Ga. 30339

Tel: [Redacted]
Fax: [Redacted]
http://www.genlive.com

Great healthcare has done home!

From: Ballew, Brandon
Sent: Friday, August 31, 2008 2:15 PM
To: Ballew, Brandon, Locker, Dan, Young, Mike (VP of Sales); Shoreman, Paula; Caudby, David; Shearer, Jeff; Whelan, Bob; Carter, Bruce; Koehler, John; Jainan, Mary; Strange, Tony; Landry, Behr; Deel, Bruce; Shabah, Kathleen; Nebbe, Susan; Thompson, Gordon; Couch, Toran; Robinson, Zacharias; John; Cavagnagh, Peter; Sylvester, Trevor; Rankoe, Richard; Walters, Brett; Gregory, Lee
Cc:
Attachments: [Redacted]

Subject: [Redacted] through June 2008

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 ending at 60.1%. Despite the drop in revenue growth, we still met our annual revenue targets. We are working closely with our providers to ensure that our patients receive the best possible care.

As we enter the 3rd quarter, we would like to emphasize the importance of planning and executing our strategies to meet our goals. Our focus will be on expanding our market share and improving our patient satisfaction rates. We also plan to continue our efforts in reducing our operating expenses to ensure our financial stability.

Brandon Ballew
Vice President of Finance

Atlanta, Ga. 30339

Tel: [Redacted]

Confidential Commercial and Financial Information
Great Healthcare has come home

From: Ballew, Brandon
Sent: Tuesday, May 27, 2008 1:10 PM
To: Ballew, Brandon; Locker, Dan; Young, Mike (VP of Sales); Shoemaker, Paula; Caushay, David; Shaner, Jeff; Gurvin, Rob; Carter, Bruce; Persignol, John; Dalbase, Mary; Strange, Tony; Landry, Beth; Neel, Duane; Weston, Damon; Sharman, Kathleen; Bennett, Susan; Thoene, Gordon
Cc: Lewitt, Michael; Martin, John; Coleman, Peter; Sylvester, Trevor; Nance, Richard; Wang, Shirley; walkers, Brett; Gregory, Lee
Subject: 4th 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 KPI hierarchy that was missing some new cost centers for 2008. Here are the rankings:

1. Carolina Region - Jeff Shaner - Open MVP Ops, Susan Bennett MVP Sales 2.70
2. Mid Atlantic Region - Jeff Shaner - Open MVP Ops, Open MVP Sales 3.65 (UP FROM 3rd)
3. West Region - David Caushay - Open MVP Ops, Damon Weston MVP Sales 3.94
4. Mid America Region - Jeff Shaner - Bruce Carter MVP Ops, Gordon Thoene Interim MVP Sales 4.55
5. Northeast Region - Jeff Shaner - Dan Locker MVP Ops, Open MVP Sales 4.75
6. Florida Region - David Caushay - Open MVP Ops, Mary Dalbase MVP Sales 4.89
7. South Central Region - David Caushay - John Auvello MVP Ops, Duane Neel MVP Sales 5.07
8. South Region - David Caushay - Open MVP Ops, Rob Gurvin MVP Sales 5.01

In April, we saw continued improvement in operations as evident from March. Keep in mind, April is only 5 weeks, as we have now switched to the 1-4Q calendar. Our overall metrics are continued to climb up, to just under 5% as a % of patients served. Most other metrics continued to follow suit, with slight improvements upon the month. We are still over 2,000 days before our Medicare about target. However, we are significantly over our 90 day MSS plan to date of the majority of those differences. While we are moving in the right direction, we are still not making the planned 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.

Brandon Ballew
Vice President of Finance
atlanta, ga 30339

Fax: http://www.pentium.com

Great healthcare has come home

From: Ballew, Brandon
Sent: Monday, March 24, 2008 6:56 PM
To: Ballew, Brandon; Locker, Dan; Young, Mike (VP of Sales); Shoemaker, Paula; Caushay, David; Shaner, Jeff; Gurvin, Rob; Carter, Bruce; Persignol, John; Dalbase, Mary; Strange, Tony; Landry, Beth; Neel, Duane; Weston, Damon; Sharman, Kathleen; Bennett, Susan; Thoene, Gordon
Cc: Lewitt, Michael; Martin, John; Coleman, Peter; Sylvester, Trevor; Nance, Richard; Wang, Shirley; walkers, Brett; Gregory, Lee
Subject: 1ST Rankings through February 2008

Attached are the first regional ranking of 2008! We are waiting for the data to settle out 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 entities added.
   1. Medicare ACH - Medicare adjustments for three months lagged three months as a % of revenue
   2. Clinical scoring (a composite of the Internal Revenue and Clinical Audit scores - the customer service scores - the average ACH score) was 4.0
   3. Specialty aduts - 9 variance to budget YTD for each program ranked and totaled
   4. Medicare Revenue YTD versus budget

Let the betting begin!
1. Caroline Region - Jeff Elsen - Open RVF Ops, Open RVF Sales
   4.14
2. West Region - David Kasy - Open RVF Ops, Daniel Weston RVF Sales
   4.10
3. Mid Atlantic Region - Jeff Elsen - Open RVF Ops, Open RVF Sales
   4.10
4. South Central Region - David Kasy - John Auclair RVF Ops, Duane New RVF Sales
   4.10
5. Northeast Region - Jeff Elsen - Dan Locke RVF Ops, Frank Bianchello RVF Sales
   4.05
6. Florida Region - David Kasy - Open RVF Ops, Mary Jaykun RVF Sales
   4.05
7. Mid America Region - Jeff Elsen - Bruce Carter RVF Ops, Gordon Thomson Interim RVF Sales
   4.03
8. South Region - David Kasy - Open RVF Ops, Rob Sarvin RVF Sales
   3.95

Overall, to start the year, the Home Health division is off to an aggressive start. While we have
100% of qualified submissions, we are still behind plan YTD 5% or 1,286 aduts. This is offset somewhat
by continued improvement in patient care management, as reclassifications are ahead of plan by about
50%. 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 RVF
rollouts. I am anticipating this to be cleaned up for March, to assure 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). So feast for the weary!

Brandon Rallaw
Vice President of Finance
Tel: xxx
Fax: xxx
Email: xxx

Great healthcare has come home

From: Ballew, Brandon
To: Ballew, Brandon; Locker, Dan; Bredinello, Frank; Young, Mike (VP of Sales); Shoemaker, Paula;
Casby, David; Shaker, Jeff; Garvine, Bob; Carter, Bruce; Auclair, John; Vajani, Mary; Dietz, Tony;
Caldwell, Doug Bredinello, Susan; Sandvik, Beth; New, Duane; Weston, Samuel; Shaker, Jeff;
Carter, Bob; Garvine, Bob; Auclair, John; Vajani, Mary; Dietz, Tony; Caldwell, Doug;
Subject: RPM Rankings through November

Disappointing November is in the books. I'm not sure what happened given the strong end of
October, but it appears the holidays gave us some paperclip losses. The finish line is straight ahead
there's only a couple feet away. We are not out of months to "catch up" on for this year, so please
reinforce how to impact your close December closer.

The race has tightened up. Only .04 points are between 1st and 2nd. It may be a photo finish!

Rankings are as follows:
1. Southeast Shaker/Garvine 2.08
2. West Casby / Weston 2.62
3. Midwest Cortez / Vajani 3.13
4. Southeast Shoemaker / Young 3.43

E-GEN 024591
Confidential Commercial and Financial Information
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 their 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 73% over the last 13 week run rate.  All of this has led to the lowest earnings month of the year.

Our rates tell a little different picture, as we have seen an increase in submissions (11,665), 3% over the previous 13 week average (put down from October - 11,705).  Recertifications did slip pretty good this month (4,331); down 15% from our 13 week run rate (4,414).  Adjustments and case mix held fairly steady.

Let’s close it out on a positive note!  Have a Happy New Year!

Brandon Ballow
Vice President of Finance

email

uri

http://www.penliva.com

Great healthcare has come home2M

From: Ballow, Brandon
Sent: Thursday, November 27, 2008 6:31 PM
To: Ballow, Brandon; Becker; Frank; Young, Mite [FV of Safei]; Hoensker, Paula; Raskin, David; Sharp, Jeff; Gaskins, Rob; Carter, Bruce; Rasmussen, John; Jones, Mary; Strange, Tony; Cullipher, Doug; Sherry, Susan; Lenegy, Seth; Meek; Weston, D. Max
Cc: Lavelle, Michael; Ullman, John; Coe; Law; Michael; Sylwester, Trevor; Williams, Randi; Winkes, Darrell

Subject: RE: NTR Rankings through October

Barden the second, the Northeast is ranked 8 out 8.

4 weeks down, 9 to go. 2009 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 6 of 13 separating 1st and 2nd. We also have some movement in the final 4 places as well.

Congrats to Ms. America and the Northeast for moving up a spot this month!

Ranks are as follows:

1. Southern
2. West
3. Mid America
4. Southeast
5. Northeast
6. South Central

Overall, Medicare admits are up nicely this month (11,762) about 6% from the previous 3 month average. We continue to see improved patient care management as recertificates have grown to 32.4% compared to only 25.3% three months ago, equating to an increase of 7% over the last 3 month average. Even with this growth in recerts, we are maintaining our case mix (1.42) and reducing our VEX (16.5%). Operating expenses are starting creep up over the past couple of months, almost $5000 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.

Brandon Ballow
Vice President of Finance

email

uri

http://www.penliva.com

Great healthcare has come home2M
FROM: Ballew, Brandon  
Sent: Monday, October 29, 2007 6:16 PM  
To: Ballew, Brandon; Luxner, Dan; Biondiolli, Frank; Young, Mike (VP of Sales); Showmaker, Paula; Kaspar, David; Skinner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jamshid, Mary; Sizemore, Tony; Caswell, Doug; Sonder, Mark; Laddry, Jeff; Neal, Duke  
Cc: Lovejoy, Nathaniel; Walander, Pablo; Cavanaugh, Peter; Sylvester, Trevor; Williams, Amanda  
Subject: Q3 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 quarter proved to be a very interesting race for the top (year end for 2007) as well. We have a tie between SOUT and SOH, all as well as 2nd and 4th.

Rankings are as follows:

1. Southern Showmer/Garvin  2.56
2. West Kaspar/Vestcom  2.54
3. Southeast Showmaker/Young  2.41
4. Mid America Carter/Aurelio  2.44
5. South Central Aurelio/Neal  2.42
6. Northeast Lecker/Biondiolli  2.41

Looks like the “drafting” is over and it’s time to see who can put their feet on the gas to get across the finish line!

Overall, we continue to grow our Medicare patients served (as a % of total patients) to 35.7% as well as in total. Ablations were actually slightly down as compared to August (6 weeks) about 200 within. While overall financial performance is increasing, we are not yet at the need of run rate. It’s time to get moving folks!

Let me know if you have any questions or concerns, thanks.

Brandon Ballew  
Vice President of Finance  

Fax: 678-323-0158  
http://www.jenfala.com  
Great healthcare has come homeSM

---

FROM: Ballew, Brandon  
Sent: Friday, September 21, 2007 4:30 PM  
To: Ballew, Brandon; Luxner, Dan; Biondiolli, Frank; Young, Mike (VP of Sales); Showmaker, Paula; Kaspar, David; Skinner, Jeff; Garvin, Bob; Carter, Bruce; Aurelio, John; Jamshid, Mary; Sizemore, Tony; Caswell, Doug; Sonder, Mark; Laddry, Jeff; Neal, Duke  
Cc: Lovejoy, Nathaniel; Walander, Pablo; Cavanaugh, Peter; Sylvester, Trevor; Williams, Amanda  
Subject: Q3 Rankings through August

5 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 hard standpoint.

Overall Rankings:

Southern Showmer / Garvin  2.31
West Kaspar / Vestcom  1.50
Southwest Showmaker / Young  1.46
MidAmerica Carter / Aurelio  2.10
South Central Aurelio / Neal  1.37
Northeast Lecker / Biondiolli  2.11

Our Medicare mix has continued its flat line for the past 4 months at 55%. We are starting to see a pickup in the recent rate, moving up to 30.8% in August (27.7% in May). Our non Medicare business is starting to grow as well. 1175 August weeks compared to 1055 May even 1265 in January. This may explain part of the variance to plan from a hard standpoint. We are 4.5% ahead of our non Medicare revenue budget but -1.1% behind the Medicare side. While we’ve made up some of that difference at the operating and regional expense lines, this variance needs to be growing.

Q4 starts in a week!

E-GEN-024593  
Confidential Commercial and Financial Information
Brandon Ballew
Vice President of Finance

Tel:  
Fax: http://www.pensieve.com
Great Healthcare has come home

From: Ballew, Brandon
Sent: Monday, August 20, 2007 9:10 AM
To: Ballew, Brandon; Lohrer, Dan; Biondello, Frank; Young, Mike (HVP Sales); Shoemaker, Paula;
Casby, David; Shaver, Jeff; Servin, Rob; Carter, Bruce; Aurelio, John; Zelman, Mary; Strange, Tony;
Cade, Doug; Smothers, Susan; Landry, Ruby; Neel, Duane
Cc: Lowery, Michelle; Vinsel, John; Cavanaugh, Peter; Sylvester, Trevor; Williams, Amanda
Subject: ECA 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
Shearer / Servin

West
Casby / Young

Midwest
Carter / Zelman

South Central
Aurelio / Neel

Northeast
Lowery / Biondello

Our Medicare mix continues to improve, but we are seeing a decline in overall gross margin. Cost
growth for P&L: [Data not visible] and VME: [Data not visible] 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 [Data not visible], but is down from April [Data not visible] and May [Data not visible]. Keep in mind, every .5%
change in case mix equates to approximately $100,000 in revenue / gross margin / and HEDIS.

We need some strong momentum over the next couple of months. We are getting close to the finish line
without much room in spare. July showed us down even further. Let’s buck the trend in August and get
the spurring shows up.

Brandon Ballew
Vice President of Finance

Tel:  
Fax: http://www.pensieve.com
Great Healthcare has come home

From: Ballew, Brandon
Sent: Wednesday, July 25, 2007 11:23 AM
To: Ballew, Brandon; Lohrer, Dan; Biondello, Frank; Young, Mike (HVP Sales); Shoemaker, Paula;
Casby, David; Shaver, Jeff; Servin, Rob; Carter, Bruce; Aurelio, John; Zelman, Mary; Strange, Tony;
Cade, Doug; Smothers, Susan; Landry, Ruby; Neel, Duane
Cc: Lowery, Michelle; Vinsel, John; Cavanaugh, Peter; Sylvester, Trevor; Williams, Amanda
Subject: ECA 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 2nd half. Overall, we had a good second quarter and have made significant
improvement during our first full twelve month period after the merger of the two organizations. The
new venture 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 repairing that moment!

Through June, the rankings are as follows:

<table>
<thead>
<tr>
<th>Region</th>
<th>Cheeks / Devlin</th>
<th>West</th>
<th>Northeast</th>
<th>Southeast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern</td>
<td>Cheeks / Devlin</td>
<td>West</td>
<td>Southeast</td>
<td>Southeast</td>
</tr>
<tr>
<td>West</td>
<td>Cheeks / Devlin</td>
<td>West</td>
<td>Southeast</td>
<td>Southeast</td>
</tr>
<tr>
<td>Northeast</td>
<td>Cheeks / Devlin</td>
<td>West</td>
<td>Southeast</td>
<td>Southeast</td>
</tr>
</tbody>
</table>

We continue to lag behind in our Medicare admission goals, down ~5% YTD. June was also a month of net losses in several metrics, case mix fell to 1.45 from 1.42, and VPE climbed to 17.8 from 17.0.

Rude 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.

Brandon Ballew
Vice President of Finance

---

From: Ballew, Brandon
Sent: Wednesday, June 20, 2007 6:35 PM
To: Ballew, Brandon; leker, Dan; Blandello, Frank; Young, Mike (VP Sales); Sheehy, Paula; Caussy, David; Shanes, Jeff; Gavron, Rob; Carter, Bruce; Rusell, John; Jablan, Mary; Strange, Tony; Chadwell, Doug; Sender, Dub; Landry, Bob; Meel, Ruven
CC: Leuto Jr., Michael; Bolander, John; Zwach, Peter; Sylvester, Trevor
Subject: MCR 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: k. Memorial lay holding being on the system close week and lack of office unity conversions in the Southern region. This led to some areas being significantly impact to the month. Important to note, the same thing will be going on Oct June - compounded because June is a Quarter and close month! July 6th falls on the Wednesday of the system close week, please get ahead of the holiday to address any write coverage. The Southern and Southeast regions will also continue to go through system conversions this month. PLEASE REQUEST that your paperwork is getting received appropriately! I’ll get all the soap box now.

On to May. Medicare admissions were Eliz 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 also showed up a couple of 5% (of patients served, 6% of revenue) but our mix continues to remain strong. However, visits per Episode (VPE) continues to honor above budget at 17.5 in May. Our non-Medicare business continues to improving with fewer patients receiving greater reimbursement per visit, over $90 per visit this month. With our continued move to Medicare-centric, we are not seeing the corresponding decreases in operating expenses. We are out pace of 500 less patients this month as compared to February, but have seen our operating expenses increase over $750,000 per month. This is further reinforced in our VPE to patient served has increased from 06 (February) to 05 (May).

All this led to an overall weaker month at 14.16 STRIATA.

The overall rankings are as follows:

<table>
<thead>
<tr>
<th>Region</th>
<th>Cheeks / Devlin</th>
<th>West</th>
<th>Northeast</th>
<th>Southeast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern</td>
<td>Cheeks / Devlin</td>
<td>West</td>
<td>Northeast</td>
<td>Southeast</td>
</tr>
<tr>
<td>West</td>
<td>Cheeks / Devlin</td>
<td>West</td>
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<td>Southeast</td>
</tr>
<tr>
<td>Northeast</td>
<td>Cheeks / Devlin</td>
<td>West</td>
<td>Southeast</td>
<td>Southeast</td>
</tr>
</tbody>
</table>

Please review and let me know if you have any questions, thanks.

Brandon Ballew
Vice President of Finance

---

Confidential Commercial and Financial Information
From: Mallow, Brandon
Sent: Thursday, May 11, 2007 11:14 AM
To: Malow, Brandon; Locke, Dan; Monello, Frank; Young, Mike [MVP Sales]; Shumaker, Reila;
Casby, David; Shaw, Jeff; Ollivin, Bob; Carter, Bruce; Austin, John; Albuch, Mary; Stappo, Doug;
Cafarelli, Doug; Senders, Susan; Laddby, Reth; Meel, Rob
Cc: Lovero, Michelle; Markes, Ann; McLaughlin, John; Southerland, Perri; Cavanaugh, Pete; Sylvester, Terry
Subject: XIR 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. Hush Health missed it’s plan for the first time this year. The rankings are as follows:

Southern
West
MG America - tie for 1st
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 34.4% from 32.3% in January. Medicare admissions continue to lag our plan, behind 1,786 (+3.5%) for the year. For the year we are still ahead of plan for revenue as receipts and case mix remain strong. We did finish in April however, primarily due to admissions. We also saw nice movement in the turnover numbers this month from January. Overall full time turnover is at 19.2%, ahead of our 20% goal and down from 24% in January! Our ACR continue to remain strong at 20.5%!

Let’s get the focus on the gas and light dollars the summer lail!

Brandon Mallow
Vice President of Finance

Tel: [redacted]
Fax: [redacted]
http://www.mallow.com

Great healthcare has come home

From: Mallow, Brandon
Sent: Monday, April 30, 2007 5:45 PM
To: Malow, Brandon; Locke, Dan; Monello, Frank; Young, Mike [MVP Sales]; Shumaker, Reila;
Casby, David; Shaw, Jeff; Ollivin, Bob; Carter, Bruce; Austin, John; Albuch, Mary; Stappo, Doug;
Cafarelli, Doug; Senders, Susan; Laddby, Reth; Meel, Rob
Cc: Lovero, Michelle; Markes, Ann; McLaughlin, John; Southerland, Perri; Cavanaugh, Pete; Sylvester, Terry
Subject: XIR Rankings through March/Q1

Qu is it in the books? With a great February in, March came in even stronger! Every individual region SUCCEEDED BUDGET in March!

The regional rankings are as follows:
Southern
West
Northeast
South Central
MG America

The race continues to tighten as there is only one weighted average point between 1st and 6th place.

E-GEN 024596
Confidential Commercial and Financial Information
Overall, Blue Health continues to make great improvements in overall Medicare Management. The Medicare 90% pass rates have continued to climb at nearly an 8% bump in March. While admissions continue to grow, they are lagging to our budget by 2%. This has been more than offset by a 4% increase in the number of patients and a 0.5 point increase in our OOP rate. We have met our 4th quarter of 2009. VFM continues to creep up over the past 3 months, now at 17.6 versus 16.3 in January.

Brandon Ballow  
Vice President of Finance

Atlanta, GA 30339

Tel:  
Fax:  
http://www.geminate.com

Great healthcare has come home NM

From: Ballow, Brandon  
Sent: Thursday, March 19, 2007 7:38 AM  
To: Ballow, Brandon; Locker, Dan; Randello, Frank; Young, Mike [VP of Sales]; Showmaker, Randall; Cuskey, David; Shain, Jeff; Garvin, Bob; Carter, Bruce; Anselino, John; Salam, Mary; Strange, Tony; Caddell, Doug; Zanders, Susan

Subject: Kristin Haring through February  

Congratulations on a great February! Attached are the February rankings for all the regions. The region order has changed. Midwest – a new #1  

For February, the Medicare mix continues to grow (53.6% PEP versus 51.9% OOP). Inpatient admissions have grown for February and the YTD has increased. Recertification numbers are up by 5.1% (731) from the YTD budget. The decreasing trend in the number of patients and a 0.5 point increase in our OOP rate. VFM continued flat to down at 17.2. Medicare admissions numbers are off budget -5.6% (-1,231) overall, however specialty admissions are ahead of budget by 5%.

One change to the YTD ranking, is the exclusion of the Private Duty GP and addition of the NICU YTD to the budget category.

Due to issues with the causality results and a delay in the NMR update, there will be no January releases as we are currently working on an April ranking report to be distributed soon.

Please review and let me know if you have any questions. Thanks.

Brandon Ballow  
Vice President of Finance

Atlanta, GA 30339

Tel:  
Fax:  
http://www.geminate.com

Great healthcare has come home NM

From: Ballow, Brandon  
Sent: Wednesday, January 24, 2007 5:14 PM  
To: Ballow, Brandon; Locker, Dan; Randello, Frank; Young, Mike; Showmaker, Randall; Cuskey, David; Shain, Jeff; Garvin, Bob; Carter, Bruce; Anselino, John; Salam, Mary; Strange, Tony; Caddell, Doug; Zanders, Susan

Tel:  
Fax:  
http://www.geminate.com

E-GEN 024597

Confidential Commercial and Financial Information
Wilson, Doug: Sender: Susan
Co.: FINANCE HOME HEALTH
Subject: KTR Rankings through December
Attached are the December rankings for all the regions.
The region order is:
Southern
South Central
Mid America back in 3rd
West
Northeast

For December, the Medicare mix continues to grow (51.3% versus 49.2% in the third consecutive month over 50%). Report % (27.9%) has leveled off and we are starting to see a trend of decreasing case mix (Dec 1.37 to Sep 1.39). VPK remained flat to down at 11.5. 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 145.

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 SAP and days to PTEAR.

Please review and let me know if you have any questions. Thanks.

Brandon Hallow
Vice President of Finance

[Contact Information]

Great Healthcare has come homeTN

From: Hallow, Brandon
Sent: Wednesday, November 22, 2006 3:35 PM
To: Hallow, Brandon; Becker, Dan; Blondello, Franco; Young, Mike; Showalter, Paul; Cuddy, David; Xie, Jerry; Verdin, Bob; Carter, Bruce; Aurelio, John; Salzman, Mary; Strange, Tony; Cassell, Doug; Wilson, Doug
Co.: FINANCE HOME HEALTH
Subject: KTR Rankings through October

Attached are the October rankings for all the regions.
The region order is:
Southern 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 report % (25.9%) without a decrease in case mix (1.33). VPK moved down slightly after a two month increase to 11.5. Something to monitor during the implementation of Patient Care Management. Overall admissions numbers remain flat from the previous month entering the fourth quarter. However, in the first two weeks of November we are beginning to see a spike up tick in Medicare Admissions. I’ve also attached the weekly admissions report.

Mid America is leading the way in the Q4 S2IR, at about 58%, with the West on their tail.

Weather today: Saint Thomas 85 and sunny feels like 95
Minneapolis, MN 46 and cloudy feels like 40

Please review and let me know if you have any questions. Thanks.

E-GEN 024598
Confidential Commercial and Financial Information
From: Hallew, Brandon
Sent: Tuesday, October 24, 2006 6:47 PM
To: Hallew, Brandon; Loker, Dan; Blumelle, Frank; Young, Mike; Shoemaker, Paul; Casady, David; Shaker, Jeff; Davison, Rob; Carter, Bruce; Burello, John; Jaw, Tony; Campbell, Doug; Conley, Matt; Hesler, Mary; Hatfield, John; Southland, Matt; Alcayde, Joseph; Copeland, Jeff; Mary Wollstein
Subject: RTH Rankings through September

Attached are the September rankings for all regions.

The order is:
Southeast 1
Southeast 2
Midwest
West
South Central

There are a few new changes to the rankings this month.

1. The top 10 lists are now for only Medicare and do not include the non-Medicare non admits (due to increased inpatient dollars)$
2. A new section for Private Duty has been added to the overall rankings
3. A weighting has been added to the different sections. You will notice a number of 1-5 ($ being the heaviest weighting) above the criteria.

For September, the Medicare mix continues to grow (48.3% versus 47.7% average). We are still seeing an increase in the present 9 (22.1%) without a decrease in the mix (13.9%). VHC is showing a slight up tick (17.6 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 5 and sunny
Bridgeport, CT 47 and cloudy

Please review and let me know if you have any questions, thanks.

Brandon Hallew

From: Hallew, Brandon
Sent: Thursday, September 21, 2006 7:29 PM
To: Hallew, Brandon; Loker, Dan; Blumelle, Frank; Young, Mike; Shoemaker, Paul; Casady, David; Shaker, Jeff; Davison, Rob; Carter, Bruce; Burello, John; Jaw, Tony; Campbell, Doug; Conley, Matt; Hesler, Mary; Hatfield, John; Southland, Matt; Alcayde, Joseph; Copeland, Jeff
Subject: RTH 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.

SS 2
Overall, earnings have increased over July by about 2 points. Medicare Mix is climbing, up a point to 4% in August. Payers continue to claim 22.6% without a down tick in Case Mix (1.2%). Non-
Adults are slightly up from July, coming in at an average of 23.8%. 15.4% in Medicare. Please review
and let me know if you have any questions, thanks.

Brandon Ballou
Vice President of Finance
phone: [redacted]
Atlanta, GA 30339
fax: [redacted]
http://www.gentiva.com
Great healthcare has come home

E-GEN 024600
Confidential Commercial and Financial Information
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:

<table>
<thead>
<tr>
<th>Factors</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Gross Margin</td>
<td>5</td>
</tr>
<tr>
<td>2 EBITA</td>
<td>5</td>
</tr>
<tr>
<td>3 Medicare Mix</td>
<td>3</td>
</tr>
<tr>
<td>4 Medicare Admits to Budget</td>
<td>5</td>
</tr>
<tr>
<td>5 Medicare Case Mix</td>
<td>4</td>
</tr>
<tr>
<td>6 Medicare Recertifications</td>
<td>4</td>
</tr>
<tr>
<td>7 Days to RAP</td>
<td>4</td>
</tr>
<tr>
<td>8 Cost per Visit</td>
<td>3</td>
</tr>
<tr>
<td>9 Visits per episodes</td>
<td>3</td>
</tr>
<tr>
<td>10 % Therapy &gt;20</td>
<td>3</td>
</tr>
<tr>
<td>11 % Therapy &lt; 20</td>
<td>3</td>
</tr>
<tr>
<td>12 Operating Expense</td>
<td>4</td>
</tr>
<tr>
<td>13 M Admits per Sales FTE</td>
<td>4</td>
</tr>
<tr>
<td>14 FTE Clinical Turnover</td>
<td>4</td>
</tr>
<tr>
<td>15 Cash Lag 60</td>
<td>3</td>
</tr>
<tr>
<td>16 EBITDA to Budget</td>
<td>5</td>
</tr>
<tr>
<td>17 Conditional Level Survey</td>
<td>5</td>
</tr>
<tr>
<td>18 Clinical Scores</td>
<td>4</td>
</tr>
<tr>
<td>19 Specialty Admits to Plan</td>
<td>4</td>
</tr>
<tr>
<td>20 Medicare revenue to Budget</td>
<td>5</td>
</tr>
<tr>
<td>21 Red/Orange Zone Branches</td>
<td>3</td>
</tr>
</tbody>
</table>

**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.

06/24/2011 Confidential Commercial and Financial Information GEN 000003
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:

<table>
<thead>
<tr>
<th>Year</th>
<th>Bonus Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$49,000</td>
</tr>
<tr>
<td>2009</td>
<td>$70,000</td>
</tr>
<tr>
<td>2008</td>
<td>$36,000</td>
</tr>
<tr>
<td>2007</td>
<td>$161,811</td>
</tr>
</tbody>
</table>
Footnote 53
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:
- ER/DA to Budget TTD
- Case Mix Avg over the last 4 months
- Acute Care Read Rate TTD
- Home Visit Score TTD
- FT Clinical Turnover rate over last 4 months
- ER/DA TTD over the last 4 months
- Gross Margin 1 over the last 4 months
- Total Revenue to Budget TTD
- Operating Expense 1 average for last 4 months

Metrics that will change:
- Medicare Revenue to Budget TTD changes to 995 Revenue
- Medicare Admits to Budget TTD changes to 995 Admits
- Medicare Admits/TTD average for last 4 months changes to 995 Admits
- PIVS/DVS: Adam PFE avg over the last 4 months - will eliminate the Private Duty patients from the calculation

Metrics that will be eliminated:
- AVP over the last 4 months - runs counter to our initiative to increase PT
- Medicare Non Admit 1 avg over the last 4 months
- AVP per Visit average over last 4 months

New Metrics added to the ranking:
- Adh Days to SAP
- Clinical Documentation Score
- AE/DU Turnover Rate
- APP 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 1 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 staff on this, or should we just forward this email on to them? Thanks,

Peter M Cavasquah
AVP Financial Operations
http://www.gentiva.com

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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 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 - 158,000 episodes from 4 different systems
- Another updated review of Q1 data with all completed episodes - about 37K episodes
• PPS Refinements
  - Overall changes are in episode count (early versus late) and therapy counts now affect not only the S score but also the G and F score!
  - Gentiva breakdown
    - Early Episodes approx. 88%
    - Late Episodes approx. 12%
• PPS Refinements
  • Therapy
    • Changes in case mix around visit counts of 5, 14, and 20. In theory, they added $36 per visit at 7 and $36 per visit for each additional visit to 20.
    • Hard to specify due to complexity of CPT, and other case mix influences.
    • Caucasian = 65% of samples have therapy.
    • 0-5 years = 50% (most in here are the 0 visits)
    • 5-15 years = 20%
    • 15+ years = 10%
    • 20+ visits = 5% (no difference between E/T, here)
• PPS Refinements
  
  — LUPA changes
    • $92 added on to the first visit of the first LUPA
      episode
    • About 12% of Gentiva's episodes have LUPA
      adjustment of less than 3 visits in the episode.
      Interesting, how many are at 3; could we have done one more
      visit?
    • Review protocols and make sure we are doing what we are
      supposed to be doing.
• PPS Refinements
  
  • Supplies
    - Reduced base rate about 5%
    - Add-on for specialization (severity levels) additional details
      - All episodes $12,96 5%
      - Level 2 $8,54 17%
      - Level 3 $10,94 17%
      - Level 4 $21,5.3 15%
      - Level 5 $8,47 20%

  Greetings 5% are very close to the national average
• PPS Refinements
  • Base Rate
  • Case Mix weights
  • CMS believes they have a significant increase (2.5%) in cost, resulting in possible "gaming"
  • Proposed a reduction over the next 5 years to account for the change (1.75%) — actually, -2.50%
  • the way it was implemented
  • Budget neutrality — 2008 market basket increase of 1.50%
  • Wage index reweighting, 771542 from 1.6775 — everyone over $1 a little better, everyone under a little worse
  • All other changes are baked in as well. For example, supplies are removed from the base rate and then added back based on another calculation (distributor later)
• **PPS Refinements**
  - **Other Adjustments**
    - SCIC goes away - very small impact not a lot of dollars in this type of adjustment
    - PEP remain the same
      - Continue to make sure we are head-to-head, these should be less
    - Outlier remain the same from a calculation standpoint
      - Expect an increase in Outliers in reimbursement per episode frequency
      - Outliers are determined by taking the total visits and calculating the Fixed Dollar Loss (FDL ratio) at 97%
• PPS Refinements
  
  - Case Mix
  
  • C scores now affected by therapy visits and E/L count
    • Some data points had 2 different C scores based on different
      therapy utilization
  
  • 80 HHRRs broken into 45 new groups and then
    increased for E/L and therapy counts (5 different
    classifications) — 155 HHRRs
      - Each = 1st or 2nd adjacent episode
      - Three or more adjacent episodes
      - Therapy scores 0, 3, 7, 13, 19, and 20 visits
PPS Refinements

Case Mix

- The GOSIS is the same (kind of) but the number of points scored are very different.
- Secondary Drug now counted
- MOS25 is not yes or no, now anticipated visits

This means therapy adjustments are now factored into the case mix - today vs. 1 AE before therapy, tomorrow vs. case mix, will be set of these adjustments.
- 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
Hi Tony,

I have attached some analyses of the therapy episodes for Q1 of 2007. As we discussed on Tuesday, the average therapy visit for "noncritical" episodes is comparable to the Gentiva Orthopedics program. This is the first summary included in the attachment.

I also summarized all nonOPA episodes by the therapy groups that make up the 3 scores in reimbursement. For each increase in 2 score (2 therapy bucket), the reimbursement increases between about $350 to $450. In the analysis, I increased the therapy visits by an average of 2 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 10% of the episodes changing in the analysis. All the revenue increases are for Q3 quarter only.

In summary, increasing therapy visits by an average of 2 visits per episode will increase revenue by approximately $350 to $450 per episode. Adding therapy services (6 visits) to patients with high functional needs will increase revenue by about $200 per episode. If the visits are to be controlled on these episodes (e.g., pain nursing for therapy visits), the profitability will decrease.

I hope the worksheets are self-explanatory, but give me a call if further explanations are needed.

Perri

Ferris Sutherland
Finance Department
Gentiva Healthcare Services
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Fax: [redacted]
http://www.gentiva.com
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E-GEN 025083
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Footnote 61
therapy project

Ensure that not one patient who warrants therapy goes without it, and help ensure that not one patient receives unwarranted therapy.

see overall project assumptions, benefits, challenges.
therapy buckets!

<table>
<thead>
<tr>
<th>1. evolve Specialty therapy</th>
<th>2. evolve non-Specialty therapy</th>
<th>3. therapy patient identification</th>
</tr>
</thead>
<tbody>
<tr>
<td>group leader:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abc. L.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Def. L.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. L.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. L.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. L.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Group Leader: Abc. L.**
- Participates in group activities.
- Provides guidance to other staff members.
- Facilitates communication among team members.

**Group Leader: Def. L.**
- Manages daily operations.
- Coordinates with other departments.
- Coordinates with other group leaders.

**Group Leader: G. L.**
- Manages daily operations.
- Coordinates with other departments.
- Coordinates with other group leaders.

**Group Leader: H. L.**
- Manages daily operations.
- Coordinates with other departments.
- Coordinates with other group leaders.

**Group Leader: I. L.**
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- Coordinates with other departments.
- Coordinates with other group leaders.

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- Manages daily operations.
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- Manages daily operations.
- Coordinates with other departments.
- Coordinates with other group leaders.

**Group Leader: H. L.**
- Manages daily operations.
- Coordinates with other departments.
- Coordinates with other group leaders.

**Group Leader: I. L.**
- Manages daily operations.
- Coordinates with other departments.
- Coordinates with other group leaders.
overall big picture - Landry

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Task Description</th>
<th>Date</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>Course with Specialty team</td>
<td>02/12/2014</td>
<td>Aug 15th, 10am meeting</td>
</tr>
<tr>
<td>Medical Device</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Care</td>
<td>Final audit meeting</td>
<td>11/09/2017</td>
<td>10/32/17, presentation will</td>
</tr>
<tr>
<td>Network</td>
<td>Complete all HIPAA forms</td>
<td>12/10/2017</td>
<td>10/25/17, first approval, on review</td>
</tr>
<tr>
<td>Facility</td>
<td>Complete all equipment</td>
<td>01/16/2018</td>
<td>10/19/17, first approval, on review</td>
</tr>
<tr>
<td>Field Services</td>
<td>Plan all on-site training,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure other active project</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

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## OASIS and PPS education - Gold

<table>
<thead>
<tr>
<th>Action/Timeline</th>
<th>Details</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OASIS Timelines</strong></td>
<td>Review OASIS guidelines and procedures.</td>
<td>1/1/2011</td>
<td>1/31/2011</td>
</tr>
<tr>
<td></td>
<td>Develop OASIS timelines and procedures for conducting OASIS assessments.</td>
<td>By end of Q1 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review OASIS assessments and case examples.</td>
<td>By end of Q1 2011</td>
<td></td>
</tr>
</tbody>
</table>

**Gentiva Timelines**

- Develop and implement a model OASIS assessment for patients with complex needs and transitional care pathways.
- Implement OASIS assessment training and certification by all clinical and nursing staff.

**Training and Education**

- Conduct an ongoing education and training program for all staff to ensure proficiency in OASIS assessment and documentation.
- Monitor progress and adjust training as necessary.

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- GEN 013804
<table>
<thead>
<tr>
<th>Topic</th>
<th>Due Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team meeting</td>
<td>12/10/07</td>
<td>(No description provided)</td>
</tr>
<tr>
<td>Ensure all TA are adequately trained</td>
<td>1/18/08</td>
<td>(No description provided)</td>
</tr>
<tr>
<td>CMO and HD are prepared and trained for multidisciplinary cases</td>
<td>2/25/08</td>
<td>(No description provided)</td>
</tr>
<tr>
<td>Identify and implement key performance indicators</td>
<td>1/21/08</td>
<td>(No description provided)</td>
</tr>
<tr>
<td>Identify key programs to include in the plan</td>
<td>1/21/08</td>
<td>(No description provided)</td>
</tr>
<tr>
<td>Develop and implement a robust plan</td>
<td>1/21/07</td>
<td>(No description provided)</td>
</tr>
</tbody>
</table>
# Therapy Key Indicators - Carpenter

<table>
<thead>
<tr>
<th>Specific therapy key indicator</th>
<th>Description</th>
<th>12/31/07</th>
<th>12/31/08</th>
<th>12/31/09</th>
<th>12/31/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in patient's condition</td>
<td>Patient's condition improved significantly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effectiveness of therapy</td>
<td>Patient's condition improving steadily</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with therapy regimen</td>
<td>Patient adhered to therapy regimen effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- 12/31/07: Patient's condition was assessed as mild.
- 12/31/08: Significant improvement noted.
- 12/31/09: Patient continued to improve, but some challenges remain.
- 12/31/10: Therapy regimen adjusted based on patient's response.

---

**Confidential Commercial and Financial Information**

GEN 013807
## Build the Case - McClure

<table>
<thead>
<tr>
<th>Task</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect off-price Info and BPA in gaining height.</td>
<td>10/11/2007</td>
<td>10/12/07</td>
</tr>
<tr>
<td>Research avenues for GT and PT to trade in gaining height</td>
<td>10/11/2007</td>
<td>10/12/07</td>
</tr>
<tr>
<td>Research avenues for GT and PT to trade in gaining height</td>
<td>11/13/2007</td>
<td>11/13/07</td>
</tr>
<tr>
<td>Develop GT and take over marketing to the maximal sell</td>
<td>11/20/2007</td>
<td>11/20/07</td>
</tr>
<tr>
<td>Develop GT solution</td>
<td>11/24/2007</td>
<td>11/24/07</td>
</tr>
<tr>
<td>50 shares of GT and PT</td>
<td>01/01/2008</td>
<td>01/01/08</td>
</tr>
<tr>
<td>Task Description</td>
<td>Completion Date</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>Develop recruitment message</td>
<td>12/15/2007</td>
<td></td>
</tr>
<tr>
<td>Email broadcast message</td>
<td>12/10/2007</td>
<td></td>
</tr>
<tr>
<td>Develop and maintain recruitment campaign</td>
<td>12/15/2007</td>
<td></td>
</tr>
<tr>
<td>Together with team, identify, prepare, launch campaign</td>
<td>12/15/2007</td>
<td></td>
</tr>
<tr>
<td>Communicate and gain active support for projected plans</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*GENTIVA*
### Build Bench Strength - Koch

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leader Training</td>
<td>04/20/2007</td>
<td>04/20/2007</td>
</tr>
<tr>
<td>Build/Prep leadership training</td>
<td>11/24/2007</td>
<td></td>
</tr>
<tr>
<td>Build/Prep clinical training</td>
<td>11/24/2007</td>
<td></td>
</tr>
<tr>
<td>Build/Prep operational training</td>
<td>12/15/2007</td>
<td></td>
</tr>
<tr>
<td>Build/Prep sales training</td>
<td>12/20/2007</td>
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<tr>
<td>Communicate risks and solutions</td>
<td>11/20/2007</td>
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<tr>
<td>Train on risks, solutions, and</td>
<td>10/31/2008</td>
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<tr>
<td>conference</td>
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<tr>
<td>Evaluate effectiveness through</td>
<td>11/07/2007</td>
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<td>reviews and feedback</td>
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*Confidential Commercial and Financial Information*
Footnote 62, 63
From: Not Listed
Sent: Monday, September 28, 2009 6:49 PM
To: Cavanaugh, Pete; Ballew, Brandon
Cc: Not Listed
Subject: RE: PPS Therapy Impact Analysis

I think we need to get all of that on the same page.

Andrew can work with the PPS files to see if we move 1% of C7 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 $49k in EBITDA.

I have a conference call at 3pm EST. Can we discuss live tomorrow?

JN

John W. Norlander
Area Vice President of Finance
Comstock
Atlanta, GA 30339
Office: 
Cell: 
Fax: 

From: Cavanaugh, Pete
Sent: Monday, September 29, 2009 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 % movement in the therapy utilization would mean.

Peter M. Cavanaugh
AVP Financial Operations
Comstock Health Services
Atlanta, GA 30339
http://www.comstock.com
Great healthcare has come home

From: Ballew, Brandon
Sent: Monday, September 29, 2009 1:40 PM
To: Cavanaugh, Pete; Wang, Shirley
Cc: Norlander, John
Subject: RE: PPS Therapy Impact Analysis

This is something that I put together with that analysis.

Brandon Ballew
Vice President of Finance
Comstock
Atlanta, GA 30339
Tel: 
Fax: 
http://www.comstock.com
Great healthcare has come home

E-GEN 024516
Confidential Commercial and Financial Information
From: Cavanaugh, Pete  
Sent: Monday, September 23, 2008 2:30 AM  
To: Wang, Slikley  
CC: Bellone, Bernadine; Norlander, John  
Subject: PRT Therapy Impact Analysis  
Hi Slikley,  
Can you please go through the 2009 PRT file and tell us the total number of episodes that had at least 1 therapy visit at total therapy, not just P7, but also less than P7. 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 $80, and the number of episodes with 6 visits and multiply times $100. That will get the revenue impact. Thanks.  
Best,  
Pete  
Peter M. Cavanaugh  
AVP Financial Operations  
Community Health Services  
http://www.genlive.com  
Great healthcare has come homeSH  

E-GEN.024517  
Confidential Commercial and Financial Information
Footnote 64
Beth,

A couple 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-specialties. operations did a 2-part gt. management assignment which was to target getting more standardization across CERT/indexHealth's 160+ 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
National Health Services
Atlanta, GA 30339
Tel: 404-574-1102
Fax: 404-574-1117
http://www.jmpchealthcare.com
Great healthcare has come homeSM

From: Landry, Beth
Sent: Wednesday, January 07, 2009 1:00 PM
To: Weaver, Charlotte; Strange, Tony
Subject: Charlotte

Charlotte

When we met Monday, several items you commented that my team should have known to develop things that lets them be implemented elsewhere. Obviously it confused me Monday and I questioned it several times, and continued 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 ideas with some help from regions, launch, then support regions periodically. The other team (regional specialty/regional director) asked line to me is responsible to drive same store growth and keep them special following launch with some help from national team. Our promise 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 get implement. Almost as though the regions have their own team to help get results. Additionally, the regions have relied on my support for the past 15 months to identify and drive rehab metrics.

E-GEN 028021
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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, each field manager, regionals and field with support from Bob 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 put out of my hands with zero communication. And the best part is that I was 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 petty 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
vice president

building secondary and rehab without walls

Atlanta, Georgia 30335

tel: 1234

fax: 1234

http://www.benevita.com

Great healthcare has come home2M

E-GEN 028022

Confidential Commercial and Financial Information
Footnote 65
Dear Tony,

As I prepare to leave after 6 years with Gentiva, I would like to share some of my thoughts and observations. As I wasn’t sure who to send these on to and you always asked 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 the ability 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 same type of work for many years before Gentiva was formed and it, connecting with five leading physicians in our area and developing a plan for immediate post op dc to home and infus to home rehab. Joining with Gentiva gave me an opportunity to build an outstanding team and really repay what I had dreamed of doing.

Unfortunately, I have seen many changes with Gentiva in the last few years. I see the push to treat by numbers not by what the patient needs. I see dropping insurance companies because they don’t pay well enough. What this is doing is making Gentiva look like a churning machine and instead of caring for all patients willing to treat, Gentiva is saying only those who will pay us well will get good care. This is discrimination in the worst sense. I 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 patients is understandable but pushing to throwouts 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 pull 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 leave work for illness available if needed, or they have to take a cut in pay. This is a very nasty way to treat dedicated, hard working clinicians.

I feel that Gentiva has become a 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 in the future.

Sincerely,

[Signature]

Orthopedics Director

[Contact Information]

Great healthcare has come how SH

E-GEN 034749
Confidential Commercial and Financial Information
Footnote 66
<table>
<thead>
<tr>
<th></th>
<th>Rev by Territory</th>
<th>2007</th>
<th>2008</th>
<th>Difference</th>
<th>%</th>
<th># of Periods</th>
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<td>1</td>
<td>Total</td>
<td>8,486,139</td>
<td>9,158,368</td>
<td>-672,229</td>
<td>-7.0%</td>
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<td>2</td>
<td>Total</td>
<td>7,501,728</td>
<td>7,688,750</td>
<td>-186,022</td>
<td>-2.5%</td>
<td>2,589</td>
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<tr>
<td>3</td>
<td>Total</td>
<td>6,958,618</td>
<td>7,070,242</td>
<td>-211,624</td>
<td>-3.0%</td>
<td>3,208</td>
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<td>4</td>
<td>Total</td>
<td>10,982,014</td>
<td>10,762,145</td>
<td>219,869</td>
<td>1.6%</td>
<td>1,466</td>
</tr>
<tr>
<td>5</td>
<td>Total</td>
<td>20,245,221</td>
<td>20,471,588</td>
<td>-226,367</td>
<td>-1.1%</td>
<td>6,540</td>
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<tr>
<td>6</td>
<td>Total</td>
<td>52,386,351</td>
<td>54,106,666</td>
<td>-1,720,315</td>
<td>0.0%</td>
<td>6,140</td>
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<tr>
<td>7</td>
<td>Total</td>
<td>115,955,867</td>
<td>119,552,043</td>
<td>-3,596,176</td>
<td>-3.0%</td>
<td>45,289</td>
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</table>

**5. Note:** The revenue includes LUPA, Los LUPA, MEX, and Others.

<table>
<thead>
<tr>
<th></th>
<th>Change in Case Mix and Wage Index</th>
<th>Avg CM 2007 (No LUPA)</th>
<th>Avg CM 2008 (No LUPA)</th>
<th>% Change</th>
<th>Avg Wage Index 2007</th>
<th>Avg Wage Index 2008</th>
<th>% Change</th>
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</thead>
<tbody>
<tr>
<td>11</td>
<td>Total</td>
<td>1.32</td>
<td>1.39</td>
<td>+5.1%</td>
<td>1.095</td>
<td>1.082</td>
<td>-1.1%</td>
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<td>12</td>
<td>Total</td>
<td>1.52</td>
<td>1.48</td>
<td>-1.3%</td>
<td>0.9716</td>
<td>0.9770</td>
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<td>13</td>
<td>Total</td>
<td>1.38</td>
<td>1.35</td>
<td>-2.2%</td>
<td>0.8987</td>
<td>0.9169</td>
<td>-1.9%</td>
</tr>
<tr>
<td>14</td>
<td>Total</td>
<td>1.59</td>
<td>1.44</td>
<td>-9.3%</td>
<td>0.8532</td>
<td>0.9783</td>
<td>-13.0%</td>
</tr>
<tr>
<td>15</td>
<td>Total</td>
<td>1.53</td>
<td>1.37</td>
<td>-11.6%</td>
<td>0.9094</td>
<td>0.9304</td>
<td>-2.6%</td>
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<tr>
<td>16</td>
<td>Total</td>
<td>1.36</td>
<td>1.36</td>
<td>0.0%</td>
<td>1.0778</td>
<td>1.0778</td>
<td>0.0%</td>
</tr>
<tr>
<td>17</td>
<td>Total</td>
<td>1.38</td>
<td>1.50</td>
<td>+8.7%</td>
<td>1.0687</td>
<td>1.0878</td>
<td>-1.7%</td>
</tr>
<tr>
<td>Specialty Program</td>
<td>Case Mix Weight 2007</td>
<td>Case Mix Weight 2008</td>
<td>% Change in CMW</td>
<td>Gross HH60 2007</td>
<td>HH60 + MSIS 2006</td>
<td>% Change in Revenue</td>
<td>GP$ Standard Cost</td>
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</tr>
<tr>
<td>Cardis</td>
<td>1.11</td>
<td>1.30</td>
<td>+2%</td>
<td>2,020.45</td>
<td>3,010.29</td>
<td>+8%</td>
<td>59%</td>
</tr>
<tr>
<td>Ortho</td>
<td>1.25</td>
<td>1.25</td>
<td>+0%</td>
<td>2,794.85</td>
<td>3,844.10</td>
<td>+3%</td>
<td>77%</td>
</tr>
<tr>
<td>Pain</td>
<td>1.72</td>
<td>1.72</td>
<td>+0%</td>
<td>1,282.97</td>
<td>1,296.97</td>
<td>+1%</td>
<td>63%</td>
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</table>

Change in Therapy Visits by Increasing Therapy Visits to 10

<table>
<thead>
<tr>
<th>Specialty Program</th>
<th>Case Mix Weight 2007</th>
<th>Case Mix Weight 2008</th>
<th>% Change in CMW</th>
<th>Gross HH60 + MSIS 2006</th>
<th>% Change in Revenue</th>
<th>Total HH60/MSIS Revenue</th>
<th>Episode Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>T01</td>
<td>0.440</td>
<td>0.640</td>
<td>+22%</td>
<td>1,281</td>
<td>+20%</td>
<td>286,446</td>
<td>250</td>
</tr>
<tr>
<td>T04</td>
<td>0.467</td>
<td>0.640</td>
<td>+34%</td>
<td>370</td>
<td>+33%</td>
<td>371,406</td>
<td>250</td>
</tr>
<tr>
<td>T03</td>
<td>0.444</td>
<td>0.640</td>
<td>+22%</td>
<td>1,281</td>
<td>+20%</td>
<td>286,446</td>
<td>250</td>
</tr>
<tr>
<td>T06</td>
<td>0.313</td>
<td>0.741</td>
<td>+12%</td>
<td>372</td>
<td>+24%</td>
<td>382,813</td>
<td>250</td>
</tr>
<tr>
<td>T07</td>
<td>0.569</td>
<td>0.741</td>
<td>+12%</td>
<td>372</td>
<td>+24%</td>
<td>382,813</td>
<td>250</td>
</tr>
<tr>
<td>T05</td>
<td>0.505</td>
<td>0.741</td>
<td>+12%</td>
<td>372</td>
<td>+24%</td>
<td>382,813</td>
<td>250</td>
</tr>
</tbody>
</table>

Note: These estimates are from the clinical system only.
A  B  C  D
1. An analysis was done of the LUPA episodes that had 6 totable visits and then this data was separated into first episodes
2. A mean visit(s) and recent episodes
3. The assumption is to add 1 additional visit to these episodes.  The calculation was made by taking the full WRRS
4. Amount on these patients and subtracting the LUPA reimbursement.
5. The LUPA episodes in the entire database is 5.17% or 12% of the total episodes.
6. The % of total episodes of 6 visit LUPA is 9%.

<table>
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<tr>
<th>LUPA Additional Revenue (6th Visit)</th>
<th>First Episode</th>
<th>Recent Episode</th>
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<tbody>
<tr>
<td>1.01</td>
<td>65,322</td>
<td>70,480</td>
</tr>
<tr>
<td>1.10</td>
<td>59,888</td>
<td>70,962</td>
</tr>
<tr>
<td>1.16</td>
<td>203,889</td>
<td>109,250</td>
</tr>
<tr>
<td>1.17</td>
<td>14,379</td>
<td>28,589</td>
</tr>
<tr>
<td>2.10</td>
<td>215,544</td>
<td>373,847</td>
</tr>
<tr>
<td>3.10</td>
<td>139,723</td>
<td>62,451</td>
</tr>
<tr>
<td>5.8</td>
<td>1,088,181</td>
<td>768,881</td>
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Confidential Commercial
and Financial Information

GEN 014173
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<table>
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<tr>
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<tbody>
<tr>
<td>41</td>
<td>Determine if all Non-Modifier PFS Firms will follow the new guidelines</td>
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<tr>
<td>42</td>
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<td>48</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td></td>
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<tr>
<td>50</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td></td>
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<td>53</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td></td>
</tr>
</tbody>
</table>

Confidential Commercial and Financial Information
Footnote 67
Hair recommendations:
* With Causty/Shamer identity 15-20 total locations for Neurorehab and Senior Health, load them into pipelines except for director, launch in order of lowest currently hiring director is the thing that most often holds up launch
* Implement (what and) or research cost to locations
* Budget launches at location level (Q1 and Q2)
* Budget launches at region level (Q3 and Q4) to keep pressure on

Other related info:
* National team to do site visits to locations in Q1 to prime the pump and get them ready
* We have completely shifted the national team to launch, keep their specialized current and cutting edge, external visibility, and with remainder of site visits as requested by regions; this means that we have moved away from dual accountability for site growth: complete ownership now shifted to regionals; this makes it even more imperative that regions fill and drive the pipeline, to accomplish that we need RVs, J&J/CA/PMs to drive expectations looking forward to it.

Nath Leuty
vice president
sending specialties and rehab without walls

Atlanta, Georgia 30313

tel: [Redacted]
fax: [Redacted]

http://www.pmdeva.com

Great healthcare has one name: PM

-----Original Message-----
From: Lendy, Ruth
Sent: Wednesday, July 29, 2009 4:04 PM
To: Strange, Tony; Causty, David; Shamer, Jeff
Subject: RE: Specialties growth

Thoughts on specialties growth:

Let's thinking about this. Believe actions should be:
* Visibility and accountability - at any ops review at any level, include discussion of specialty growth and go to budget, discussion of pipeline for all specialties, where they are in progress, expectations for launches and new specialties. Without full R1 info and without specialties tied, difficult to gain importance and need to make it happen and permeate the organization.
* Through direct report line mgmt - specialties can support and help drive it and get the message across to local and client through Mon, Tony, David/ Jeff and PMs to their direct reports. Reg Rehab.

Thoughts

Nath Leuty

-----Original Message-----
From: Strange, Tony
Sent: Tuesday, July 28, 2009 1:47 AM
To: Causty, David; Shamer, Jeff
Cc: Lendy, Ruth
Subject: PM, specialties updates

I agree with Ruth. Seedlings is do our brands related to growth in specialties. We want to see if we can kick it up a notch related to launches. Especially, in the program that drive high D Medicare growth. I have yet to see the pipeline for two regions of the year especially Brain and Ortho. I expect the pipeline to be full between now and year end. If we don't make these investments right now we will hit our growth targets. We need to grow our specialties in Q3, Q4, please provide me with the "fall" pipeline throughout the remainder of Q3 up later that 8/7. David and Jeff, please be sure these plans are well thought out and get 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 reallocate the resources.

Thanks,
Tony

E-GEN 037384
Confidential Commercial and Financial Information
You may want to listen to the replay of the Zeevex 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
<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 visit</td>
<td>1,297</td>
<td>8.5%</td>
<td>2,020</td>
<td>9.6%</td>
<td>3,202</td>
<td>9.2%</td>
<td>4,503</td>
<td>8.0%</td>
</tr>
<tr>
<td>2 visits</td>
<td>574</td>
<td>3.8%</td>
<td>1,041</td>
<td>4.0%</td>
<td>1,573</td>
<td>3.7%</td>
<td>1,907</td>
<td>3.4%</td>
</tr>
<tr>
<td>3 visits</td>
<td>487</td>
<td>3.1%</td>
<td>862</td>
<td>3.3%</td>
<td>1,288</td>
<td>3.9%</td>
<td>1,458</td>
<td>2.6%</td>
</tr>
<tr>
<td>4 visits</td>
<td>412</td>
<td>2.7%</td>
<td>834</td>
<td>3.2%</td>
<td>1,150</td>
<td>2.7%</td>
<td>1,538</td>
<td>2.7%</td>
</tr>
<tr>
<td>5 visits</td>
<td>369</td>
<td>2.4%</td>
<td>693</td>
<td>2.7%</td>
<td>1,174</td>
<td>2.8%</td>
<td>1,604</td>
<td>2.8%</td>
</tr>
<tr>
<td>6 visits</td>
<td>318</td>
<td>2.1%</td>
<td>641</td>
<td>2.5%</td>
<td>2,367</td>
<td>5.5%</td>
<td>3,066</td>
<td>5.4%</td>
</tr>
<tr>
<td>7 visits</td>
<td>267</td>
<td>1.7%</td>
<td>483</td>
<td>1.9%</td>
<td>2,140</td>
<td>5.5%</td>
<td>3,218</td>
<td>5.7%</td>
</tr>
<tr>
<td>8 visits</td>
<td>236</td>
<td>1.5%</td>
<td>481</td>
<td>1.8%</td>
<td>1,928</td>
<td>4.5%</td>
<td>3,013</td>
<td>5.3%</td>
</tr>
<tr>
<td>9 visits</td>
<td>305</td>
<td>2.0%</td>
<td>692</td>
<td>2.6%</td>
<td>1,739</td>
<td>4.1%</td>
<td>2,513</td>
<td>4.5%</td>
</tr>
<tr>
<td>10 visits</td>
<td>3,196</td>
<td>20.9%</td>
<td>5,381</td>
<td>20.6%</td>
<td>2,945</td>
<td>6.9%</td>
<td>2,972</td>
<td>5.3%</td>
</tr>
<tr>
<td>11 visits</td>
<td>1,908</td>
<td>12.9%</td>
<td>3,178</td>
<td>12.2%</td>
<td>2,704</td>
<td>6.3%</td>
<td>2,962</td>
<td>5.3%</td>
</tr>
<tr>
<td>12 visits</td>
<td>1,906</td>
<td>12.4%</td>
<td>2,945</td>
<td>10.9%</td>
<td>2,548</td>
<td>6.0%</td>
<td>3,141</td>
<td>5.6%</td>
</tr>
<tr>
<td>13 visits</td>
<td>1,142</td>
<td>7.5%</td>
<td>1,826</td>
<td>7.0%</td>
<td>2,111</td>
<td>4.9%</td>
<td>2,691</td>
<td>4.8%</td>
</tr>
<tr>
<td>14 visits</td>
<td>751</td>
<td>4.9%</td>
<td>1,193</td>
<td>4.6%</td>
<td>3,403</td>
<td>8.0%</td>
<td>3,976</td>
<td>7.1%</td>
</tr>
<tr>
<td>15 visits</td>
<td>462</td>
<td>3.0%</td>
<td>802</td>
<td>3.1%</td>
<td>2,178</td>
<td>5.1%</td>
<td>2,797</td>
<td>5.0%</td>
</tr>
<tr>
<td>16 visits</td>
<td>370</td>
<td>2.4%</td>
<td>652</td>
<td>2.5%</td>
<td>2,104</td>
<td>4.9%</td>
<td>2,760</td>
<td>4.9%</td>
</tr>
<tr>
<td>17 visits</td>
<td>289</td>
<td>1.9%</td>
<td>539</td>
<td>2.1%</td>
<td>1,517</td>
<td>3.6%</td>
<td>2,259</td>
<td>4.0%</td>
</tr>
<tr>
<td>18 visits</td>
<td>228</td>
<td>1.5%</td>
<td>366</td>
<td>1.4%</td>
<td>1,115</td>
<td>2.6%</td>
<td>1,712</td>
<td>3.0%</td>
</tr>
<tr>
<td>19 visits</td>
<td>162</td>
<td>1.1%</td>
<td>233</td>
<td>0.9%</td>
<td>667</td>
<td>1.6%</td>
<td>1,181</td>
<td>2.1%</td>
</tr>
<tr>
<td>20 visits</td>
<td>116</td>
<td>0.8%</td>
<td>189</td>
<td>0.7%</td>
<td>893</td>
<td>2.1%</td>
<td>1,297</td>
<td>2.3%</td>
</tr>
<tr>
<td>21 visits</td>
<td>106</td>
<td>0.7%</td>
<td>143</td>
<td>0.5%</td>
<td>643</td>
<td>1.5%</td>
<td>1,041</td>
<td>1.8%</td>
</tr>
<tr>
<td>22 visits</td>
<td>75</td>
<td>0.5%</td>
<td>119</td>
<td>0.5%</td>
<td>512</td>
<td>1.2%</td>
<td>823</td>
<td>1.5%</td>
</tr>
<tr>
<td>23 visits</td>
<td>53</td>
<td>0.3%</td>
<td>78</td>
<td>0.3%</td>
<td>407</td>
<td>1.0%</td>
<td>664</td>
<td>1.2%</td>
</tr>
<tr>
<td>24 visits</td>
<td>52</td>
<td>0.3%</td>
<td>74</td>
<td>0.3%</td>
<td>316</td>
<td>0.7%</td>
<td>541</td>
<td>1.0%</td>
</tr>
<tr>
<td>25 visits</td>
<td>23</td>
<td>0.2%</td>
<td>50</td>
<td>0.2%</td>
<td>234</td>
<td>0.5%</td>
<td>450</td>
<td>0.8%</td>
</tr>
<tr>
<td>26 visits</td>
<td>19</td>
<td>0.1%</td>
<td>49</td>
<td>0.2%</td>
<td>229</td>
<td>0.5%</td>
<td>411</td>
<td>0.7%</td>
</tr>
<tr>
<td>27 visits</td>
<td>26</td>
<td>0.2%</td>
<td>33</td>
<td>0.1%</td>
<td>154</td>
<td>0.4%</td>
<td>300</td>
<td>0.5%</td>
</tr>
<tr>
<td>28 visits</td>
<td>19</td>
<td>0.1%</td>
<td>31</td>
<td>0.1%</td>
<td>110</td>
<td>0.3%</td>
<td>248</td>
<td>0.4%</td>
</tr>
<tr>
<td>29 visits</td>
<td>15</td>
<td>0.1%</td>
<td>24</td>
<td>0.1%</td>
<td>94</td>
<td>0.2%</td>
<td>194</td>
<td>0.3%</td>
</tr>
<tr>
<td>30 visits</td>
<td>11</td>
<td>0.1%</td>
<td>16</td>
<td>0.1%</td>
<td>86</td>
<td>0.2%</td>
<td>141</td>
<td>0.3%</td>
</tr>
<tr>
<td>More than 30 visits</td>
<td>68</td>
<td>0.4%</td>
<td>79</td>
<td>0.3%</td>
<td>437</td>
<td>1.0%</td>
<td>933</td>
<td>1.7%</td>
</tr>
<tr>
<td>Total</td>
<td>15,303</td>
<td>100.0%</td>
<td>26,147</td>
<td>100.0%</td>
<td>42,666</td>
<td>100.0%</td>
<td>56,333</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Footnote 69
### Therapy Patient Count:

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unduplicated count of Medicare pts receiving therapy</td>
<td>12,693</td>
<td>21,334</td>
<td>35,271</td>
<td>48,028</td>
</tr>
</tbody>
</table>

### Therapy Episode Reimbursement:

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicare reimbursement for episodes that qualified for additional payments due to therapy visits provided</td>
<td>$42,530,498</td>
<td>$70,846,029</td>
<td>$132,184,654</td>
<td>$184,571,630</td>
</tr>
</tbody>
</table>

**Note:**

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.
<table>
<thead>
<tr>
<th>3.c. Total Medicare Reimbursement:</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicare reimbursement for the company</td>
<td>$178,886,698</td>
<td>$191,073,709</td>
<td>$263,328,055</td>
<td>$366,673,556</td>
</tr>
</tbody>
</table>
Footnote 71
Patty,

Great question and on the table to be looked at.

Most of our programs (low vision, Pelvic Floor) called for 10 visits because it was at that threshold that we actually made additional revenue for therapy.

We are in the process of looking at all of those 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 7 visits some portion if not all the supplies would be approved.

I will bring this up at the QVP 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.

BC

Barbara Goodman
RN, MSN, CHCE, MCHS-CL, COS-C / Vice-President of Quality and Performance Improvement
LHC Group

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Patty Stonewyser/LHC
01/30/2008 04:49 PM

To

cc

CONFIDENTIAL
Subject: For: Low vision

I think from the questions introduced by the My 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 count 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 NY. We even got an emergency DMB in one of
our counties based on physicians who wanted their patients to benefit from this program.

Thanks
Patty

---

Patty Stonecipher
Director of Sales
Somerset, KY 42503 US

Phone: | Fax: |
Email: 

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--- Forwarded by Patty Stonecipher/LHCG on 03/30/2008 05:43 PM ---

Mendra Case
01/30/2008 04:41 PM

To

CONFIDENTIAL

LHCGROUP_00007024
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 Casa
RN, BSN, CPHRM, CRM
Vice President, Education & Risk Management

LHC Group
http://www.lhgroup.com/

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FROM: Jenny Minvielle
Sent: Thursday, January 24, 2008 12:45 PM
To: Kendra Casa
Subject: Ft Low vision

Kendra -

Here is another email about the Low Vision program. Can you answer this question also?

Thanks,

Jenny

Jenny Minvielle
LHC Group
610

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----- Forwarded by Jenny Minvielle/LHCG on 01/14/2008 12:44 PM
-----

Patty Stonecyper/LHCG
01/14/2008 12:55 AM

To

Jenny Minvielle/LHCG

cc

Subject

FW: low vision

Jenny

Another email regarding the 6100 for supplies to the Low Vision
patients. Just let me know your thoughts?
Thanks
Patty

Patty Stonecyper
Director of Sales
Lifespan Healthcare of Pulaski
BOWERSVT, KY 4203 US

Phone: [redacted]
Email: [redacted]

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CONFIDENTIAL LHCGROUP_00007626
To

cc

Subject

Low vision

Patty,

Beginning Jan 1st, the therapy might be changed to different numbers, say 1 needed for certain pts., 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. Kasee 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.
Footnote 72
From: Liz Regard
Sent: Wednesday, June 13, 2007 11:47 AM
To: Rocky Goodale/LHCG
Subject: Therapy assistance

see below
Cindy Keeton
Your secretary
Liz
(what is keeping you occupied lately, just joking!)

Liz Regard
Area Manager
LH Group

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----- Forwarded by Liz Regard/LHCG on 06/13/2007 10:45 AM -----

Cindy Keeton/LHCG
60/05/2007 10:15 AM
To: Liz Regard/LHCG
cc: Liz Starr/LHCG, Sonya Owens/LHCG@LHCG
Subject: Therapy assistance

May 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 30 visit threshold. She even bunks when a MD orders a specific frequency and if she feels they do not need it then she refuses. She also sets frequency based on territory and home environment. 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
cindy Keeton, RN, BSN
Regional Manager
Mississippi HomeCare of Jackson, L.I.C. Brandon, Jackson, Yazoo City, Madison and
Walthall Counties
Jackson, MS 39201 US
Phone: [redacted] Fax: [redacted]
Email: [redacted]

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Footnote 73
From: Liz Regard
Sent: Sunday, July 08, 2007 9:40 PM
To: Rocky Goodwin/LAHCG
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:
Email: [REDACTED]

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Rocky Goodwin/LAHCG
07/08/2007 07:10 PM
To: Thresa Ducheneau/LAHCG
cc: John Cesta/LAHCG, Pam Bridges/LAHCG, Pat Berown/LAHCG, Liz Regard/LAHCG, Lynda Comard/LAHCG
Subject: My visit to Princeton

Thresa,

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 8-9 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 FTC’s to keep track of supervisory visits.

e)  I could benefit as well from moving toward making out his own schedule instead of logging himself and team leaders down on a daily basis with this.

I was also able to give 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. I 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 that NO- has to function in the black for his own benefit. He knows 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.

Nicky Goodwin, MFT
Footnote 74, 75
From: Liz Regard
Sent: Monday, October 01, 2007 4:29 PM
To: Jessica VanBuskirk/AHCGS
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 mix of 28 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, 16 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 34 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 HIMIS 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 as badly needed for training/transferring 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]

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Footnote 76
From: Don Stelly  
Sent: Saturday, September 22, 2007 7:49 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  
Lafayette, La 70503 US  

Phone:  
Fax:  
Email:  

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Liz Starr/LAHCS  
09/21/2007 04:05 PM  

To: Don Stelly/LAHCS  
cc:  
Subject: Thoughts on PPS changes  

CONFIDENTIAL  
LHC GROUP 00020460
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 the 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 HERO - this will help with determination of SVP points allotted per HERO. 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 - STAY A MEETING. 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 seen 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. MEDIC - Financially - we will need to increase our reserves due to anticipated increase in 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 admittance. 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 reported - the loss mentioned in $ above would be a great way to identify corrections to MEDIC 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:
   - Patient of X - SVP mtg (base on core required)
   - Identify the requirements: Inj/Inf (X SM visits, teaching of ___, therapy for ___ (X # wk) 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 provided from me related to HRIS and DM will help.

6. Audit Tool for OASIS accuracy – SEP is our current program but we need to evaluate the logic written for the DRF decisions. This needs to happen soon so we can get them to implement the necessary changes needed by 1-1-09.

7. Heavy Education to our Case Mgmt Team – as this will be the new training for accuracy of OASIS and they need to understand the points of consideration.

8. Concerns 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 MBR and MO claims. I believe this will be able to be addressed but we just need to recognize the potential impact and confirm that this will not affect us or if we are required to act to prevent from being affected. We need to identify how many cases this impacts, then assess a comparison analysis on the number submitted versus the nominal 6 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 proactive 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 is why I kept waiting to get time to 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 in 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 some health lobbyists – they are not seeing this creep as a large percent of educational improvement swelling 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 expand 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 proactively.

Have an enjoyable weekend

Liz

Liz Starr, RN, MS, CGC-C
Division Vice President / Home Based Operations
LHC Group
tel: [Redacted]
Fax: [Redacted]
http://www.lhcgroup.com/

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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 free-standing 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 volume 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 5 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 employ more PT's, PTA's, OT's, and COTA's. Sales incentives are driven by admissions K case mix, and the only way to get case mix up is to increase therapy utilization. We need to look for opportunities espactively within the OT arena, 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.

<table>
<thead>
<tr>
<th>Total Therapy Visits</th>
<th>Average Case Mix</th>
<th>% of All Episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20+</td>
<td>3.05</td>
<td>2.6%</td>
</tr>
<tr>
<td>18-19</td>
<td>2.36</td>
<td>1.9%</td>
</tr>
<tr>
<td>16-17</td>
<td>2.27</td>
<td>1.8%</td>
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<tr>
<td>14-15</td>
<td>2.08</td>
<td>1.6%</td>
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<tr>
<td>12-13</td>
<td>1.77</td>
<td>1.4%</td>
</tr>
<tr>
<td>10</td>
<td>1.60</td>
<td>1.3%</td>
</tr>
<tr>
<td>8-9</td>
<td>1.38</td>
<td>1.1%</td>
</tr>
<tr>
<td>6</td>
<td>1.17</td>
<td>0.9%</td>
</tr>
<tr>
<td>0-5</td>
<td>0.86</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

Keith Myers
Chairman / CEO
LHC Group
60 W. Street Blvd. A
Lakeview, LA 70031-15

From: Kevin Cragar
Sent: Thursday, April 03, 2008 8:49 PM
To: keith myers
Subject: New Reimbursement

CONFIDENTIAL
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 Craig
Area Sales Manager
LHC Group
Fayetteville, AR 72701 US

Phone:
Fax:
Email:

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CONFIDENTIAL
LHCGROUP_00046500
Footnote 78
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

LHC Group

www.LHCgroup.com

LaFayette, LA 70501 US

Phone: [Redacted] | Fax: [Redacted]

Email: [Redacted]

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elizabeth.waldon@lhcgroup.com

01/18/2008 08:28 AM

To: Angie Begnaud

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 the answer because if we are to stop at 6 we are definitely doing things wrong and hiring a full time PT might not be in the best interest if 6 total therapy visits is all that we are to be allowed. Please advise. Thanks! Beth
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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
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 Belnavid
Sent: Wednesday, April 22, 2009 4:43 PM
To: Pam Wigleworth
Subject: missed conference call

Pam,

I am emailing the information that you missed from the conference call at 3:10pm with Don. Basically the call was one to stress the urgency of the problem with L/HAs and downgrades, and also the need for our DOHs 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 it warranted to move these patients into the higher therapy buckets. In looking at all 2008 episodes, the company has a 10% L/HA 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. We also asked that all DOHs and RNs report to the state director weekly on the number of L/HAs and downgrades. The last thing that he requested was that by the end of this week, all DOHs and RNs 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 HAP claims, 4/4 of our therapy patients are receiving 0-1 therapy visits. This cannot continue to happen and the therapists need to get back with the agency soon 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
Caryl, 
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 as if each visit can be trimmed this would 
help the overall ADR. Positive adjustments need to be 2-3 times greater than negative 
adjustments. LPHA rate too high today Check MOB projections vs. what is scheduled 
Thanks.'

Lana Smith, RN, BSN 
Kentucky State Director of Operations 
LHC Group 
Lexington, Ky. 40504 
Phone: 
Fax #: 
Cell #: 
Email: 

CONFIDENTIAL
Footnote 83
From: Kim Bradberry
Sent: Friday, April 18, 2008 5:04 PM
To: denise hopkins; Melanie Rickman; debbie isbell; Donna Pleenor; angela todd; Sarah Eisen;
CC: Cindy Cooper; Elizabeth winton
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 assistants (your call), PIs, you, and me...we are all invited!!

In looking at MVP tools for each TN office yesterday, the greatest % of visits are in the dreaded 0-4 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 FL

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
Participant

It is mandatory for ALL therapists to attend this call!
Also invited are RN’s, Transplant Managers, Team Leaders and PI.

Attached is a flyer with all of the Wadax 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 Case Management

LHC Group


[Redacted]

Lafayette, La 70503 US

Phone: [Redacted] | Fax: [Redacted]

Cell: [Redacted]

Email: [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
Knoxville, TN

From: Pam Harris  
Sent: Tuesday, April 08, 2008 11:25 AM  
To: Susan Sylvester  
Subject: RE: Therapy

Susan,

I just had a discussion with Sally regarding Therapy utilization, downcodes, front loading of visits, etc. She was surprisingly receptive. I reviewed the case mix impact with her and our therapy bucket of 5-3 visits that a vast majority of our patients fall into. She agrees to front loading as well as going back after a couple of weeks 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 areas (downcodes, lops, etc.) together setting a plan to fix and adjust accordingly. I have instructed her to call me immediately if a patient refuses visits or potentially could be a problem in completing all visits, which she agreed to do.

The Team Leaders and RN’s are evaluating all patients (especially Recs 2, 3C and 3D) 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  
IDC / Branch Manager  
Lifeline Home Health Care of Springfield  
Springfield, TN 37172

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LHCGROUP_00014716
When speaking with your therapists about discharges, please discuss front loading of visits. It appears that many of the patients begin to improve and decide to reduce 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 front-loaded, ie 4w, 2w, 1w, 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 discharges, EDPA’s and therapy utilization over the past week or so. This is a MAJOR push for PT. 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 37917

[Redacted]

[Redacted]

CONFIDENTIAL

[Redacted]

LHCGROUP_0014717
Footnote 87
From: Melissa Ayers
Sent: Monday, October 20, 2008 7:55 AM
To: Becky McCoy
Cc: NW 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. We now place his patient’s in 6, 10 or 14 visit ranges. Also the lag time with data entry, I can look at the benefit and know our case mix and 2VP numbers will be down. As soon as data entry is caught up the numbers go up. Teens is working with the clerical staff, things are still slow but moving better.

Today’s Case mix is 1.21! Initial sap is 1.21, Initial to final is 41.44.

We also check the Oasis and make corrections with staff as well as outcome support team.

Also we had 10 IgAs which I went over and over there was nothing I could do to change this.

Melissa Ayers RN, BSN
Nurse Manager
Harrisonville 3020
Fax:

From: Becky McCoy
Sent: Friday, October 17, 2008 1:01 PM
To: Melissa Ayers
Cc: adeline Davis
Subject: FW: Weekly Case Mix report (10/14/2008)

Addie, Misary,

Please review the Harrisonville case mix and identify what is happening.
Please respond by Tuesday at 2:00.

Thanks,

Becky McCoy
State Director Ohio/ Western KY

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 episc推崇 start dates 08/16/08 through 10/16/08.

Updated budgeted amounts for 4Q-2008.

New column descriptions:
1. Initial Case Mix (KAP) - Case mix as determined by DHHS at episode start.
2. Adjusted Case Mix (Final) - Case mix after any necessary adjustments for therapy, LUPA, outliers.
3. Initial to Final - Percentage of increase or decrease in initial to final case mix weight.
5. Final to Budget - Percentage of difference in adjusted and budgeted case mix weight.

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CONFIDENTIAL LMCGROUP_00040049
Footnote 88
From: Katy LaRue
Sent: Wednesday, July 08, 2009 12:21 PM
To: Kimberly Gordon
Subject: Therapy buckets

You have 20% in the 7-9 therapy bucket range. Please get with therapists and have them reevaluate 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: Amy Lee
Subject: RE: Weekly report for 12-1-09

Hi I did not will discuss with therapy. 
Thanks

Jeannie Duckett, RN
DOM/Teleph Manager, LHC Group
Medical Centers Home Care

"In the Middle of Difficulty lies Opportunity"
Albert Einstein

From: Amy Lee
Sent: Yesterday, 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 Shelby about the marketing issues

Amy

Amy Lee

CONFIDENTIAL LHC GROUP_00040771
From: Jeannie Duckett
Sent: Wednesday, December 02, 2009 12:15 PM
To: Amy 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
Lafayette, LA 70503

"In the Middle of Difficulty lies Opportunity"
(Albert Einstein)
From: Jeannie Duckett  
Sent: Wednesday, December 01, 2009 11:44 AM  
To: Jimmy 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  
Medicare Centers Home Care  
Office:  
Fax:  
Cell:  

"In the Middle of Difficulty lies Opportunity"  
Abert Edstrum
Footnote 90
### Table: Distribution of Therapy Visits

<table>
<thead>
<tr>
<th>Week of Therapy</th>
<th>Number of Visits</th>
<th>Percent of Visits with Therapy</th>
<th>Percent of Total Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>845</td>
<td>1,352</td>
<td>2,126</td>
</tr>
<tr>
<td>2</td>
<td>596</td>
<td>1,199</td>
<td>1,850</td>
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<tr>
<td>3</td>
<td>529</td>
<td>1,080</td>
<td>1,658</td>
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<td>935</td>
<td>1,515</td>
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<td>451</td>
<td>888</td>
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<td>502</td>
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<td>1,780</td>
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<td>2,316</td>
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<td>836</td>
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<td>824</td>
<td>1,399</td>
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<td>15</td>
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<td>16</td>
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<td>855</td>
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<td>854</td>
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<td>1,323</td>
<td>2,181</td>
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<tr>
<td>25</td>
<td>858</td>
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<tr>
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<td>858</td>
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</tr>
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</table>

<table>
<thead>
<tr>
<th>Total Including Zero Therapy</th>
<th>11,543</th>
<th>18,615</th>
<th>29,279</th>
<th>43,297</th>
</tr>
</thead>
</table>

### Table: Breakdown by Week of Therapy

<table>
<thead>
<tr>
<th>Week of Therapy</th>
<th>Number of Visits</th>
<th>Percent of Visits with Therapy</th>
<th>Percent of Total Visits</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>845</td>
<td>1,352</td>
<td>2,126</td>
</tr>
<tr>
<td>2</td>
<td>596</td>
<td>1,199</td>
<td>1,850</td>
</tr>
<tr>
<td>3</td>
<td>529</td>
<td>1,080</td>
<td>1,658</td>
</tr>
<tr>
<td>4</td>
<td>475</td>
<td>935</td>
<td>1,515</td>
</tr>
<tr>
<td>5</td>
<td>451</td>
<td>888</td>
<td>1,473</td>
</tr>
<tr>
<td>6</td>
<td>502</td>
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<td>1,606</td>
</tr>
<tr>
<td>7</td>
<td>598</td>
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<tr>
<td>8</td>
<td>858</td>
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</tr>
<tr>
<td>9</td>
<td>801</td>
<td>1,401</td>
<td>2,202</td>
</tr>
<tr>
<td>10</td>
<td>810</td>
<td>1,421</td>
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</tr>
<tr>
<td>11</td>
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<th>43,297</th>
</tr>
</thead>
</table>

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 85% of our episodes were not at a therapy payment threshold while 85% 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.

<table>
<thead>
<tr>
<th>OASIS Question</th>
<th>Average Scores on Admission</th>
<th>Average Scores on Discharge</th>
<th>Percent Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0700 Average (Walking)</td>
<td>1.433</td>
<td>1.475</td>
<td>1.506</td>
</tr>
<tr>
<td>M0400 Average (Hygiene)</td>
<td>0.866</td>
<td>0.902</td>
<td>0.994</td>
</tr>
<tr>
<td>M0670 Average (Hygiene)</td>
<td>2.610</td>
<td>2.622</td>
<td>2.628</td>
</tr>
<tr>
<td>M0520 Average (Continence)</td>
<td>0.425</td>
<td>0.521</td>
<td>0.559</td>
</tr>
<tr>
<td>M0540 Average (Continence)</td>
<td>0.272</td>
<td>0.316</td>
<td>0.343</td>
</tr>
<tr>
<td>M0610 Average (Dressing)</td>
<td>1.085</td>
<td>1.135</td>
<td>1.207</td>
</tr>
<tr>
<td>M0600 Average (Dressing)</td>
<td>1.570</td>
<td>1.510</td>
<td>1.576</td>
</tr>
<tr>
<td>M0710 Average (Eating)</td>
<td>0.406</td>
<td>0.452</td>
<td>0.480</td>
</tr>
<tr>
<td>M0720 Average (Eating)</td>
<td>0.190</td>
<td>0.138</td>
<td>0.146</td>
</tr>
<tr>
<td>M0680 Average (Toileting)</td>
<td>0.641</td>
<td>0.694</td>
<td>0.710</td>
</tr>
<tr>
<td>M0690 Average (Transferring)</td>
<td>1.102</td>
<td>1.131</td>
<td>1.142</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENTS RECEIVING THERAPY</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Patients Receiving Care</td>
<td>10,004</td>
<td>15,610</td>
<td>22,534</td>
<td>30,249</td>
</tr>
<tr>
<td>Reimbursement:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base episodic amount</td>
<td>23,219,069</td>
<td>39,565,828</td>
<td>57,219,602</td>
<td>84,477,825</td>
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<tr>
<td>Incremental reimbursement for therapy</td>
<td>13,012,711</td>
<td>24,133,838</td>
<td>56,653,770</td>
<td>81,011,884</td>
</tr>
<tr>
<td>Total Reimbursement</td>
<td>36,231,780</td>
<td>63,699,666</td>
<td>107,893,372</td>
<td>165,489,710</td>
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<tr>
<td><strong>ALL PATIENTS</strong></td>
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<tr>
<td>Patients Receiving Care</td>
<td>15,022</td>
<td>23,968</td>
<td>32,615</td>
<td>41,596</td>
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<tr>
<td>Reimbursement:</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base episodic amount</td>
<td>35,193,944</td>
<td>62,055,129</td>
<td>93,748,106</td>
<td>136,999,678</td>
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<tr>
<td>Incremental reimbursement for therapy</td>
<td>13,012,711</td>
<td>24,133,838</td>
<td>56,653,770</td>
<td>81,011,884</td>
</tr>
<tr>
<td>Total Reimbursement</td>
<td>48,206,655</td>
<td>86,188,967</td>
<td>150,401,877</td>
<td>218,011,563</td>
</tr>
</tbody>
</table>

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
Please find the attached data from OCC (National HRRG 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 test 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 specialists 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 physician 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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Keith Myers
LHC Group
Lafayette, LA 70503 US

Executive Assistant: Judy Simon

Phone: [redacted] Ext. 11 Fax: [redacted]
E Mail: [redacted]

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<td>0.5</td>
<td>$1,980</td>
<td>$2,617</td>
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<tr>
<td>7.9</td>
<td>$3,657</td>
<td>$5,671</td>
<td>$1,994.14</td>
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<tr>
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<td>$7,294</td>
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<tr>
<td>11.13</td>
<td>$4,918</td>
<td>$7,344</td>
<td>$2,426.22</td>
<td>27.94%</td>
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<tr>
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<td>16.17</td>
<td>$5,801</td>
<td>$7,767</td>
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<tr>
<td>18.19</td>
<td>$6,541</td>
<td>$8,294.47</td>
<td>$1,753.26</td>
<td>20.94%</td>
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<tr>
<td>20+</td>
<td>$6,541</td>
<td>$8,294.47</td>
<td>$1,753.26</td>
<td>20.94%</td>
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</tbody>
</table>