Kansas Home Care & Hospice Association Spring Conference

Driving Results℠

KHCHA
Caring for Kansans at Home

Simione Healthcare Consultants advances quality and cost efficiency, providing reliable experts, technology and tools to grow and improve home- and community-based services.

Presenter:
Julia Maroney, Director
Rob Simione, Director

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Home Care Landscape

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Regulation

- Increase in Regulation
  - Pre Claim Review
  - F2F Requirement
  - State and Federal Audits
  - ICD 10

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Medicare Reimbursement

- Decrease in Reimbursement
  - Sequestration
  - Patient Driven Grouper Model
  - Case Mix Creep
  - Value Based Purchasing

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- Accountable Care Organizations
  - Hospital Systems
  - Physician Groups
  - Payers - Aetna, Humana, Blue Cross
- Collaboration Among Post Acute Players
- Integrated Healthcare
- Quality, Quality, Quality
- Consolidation/Mergers

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Home Care Value

Value to Hospitals & Payers

- Provide Quality Care in a low cost setting
- Prevent avoidable rehospitalizations
- Population Health Management

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Strategic Initiatives

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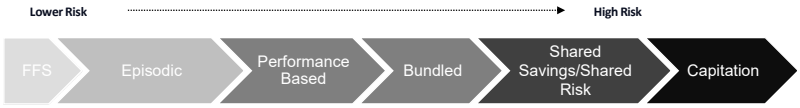
Risk Based Contracting Overview

- Major Focus
  - Moving Care from FFS to Value
  - Pay for Performance Initiative
  - Alternative Models



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Risk Based Contracting Overview

- Triple AIM
  - Improving the patient's experience of care
  - Improving the health of the population
  - Reducing the per capita cost of care for the population

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Risk Based Contracting Overview

- Payments tied to Quality or Value through alternative payment models
  - 30% by end of 2016
  - 50% by end of 2018
  - Overall Goal 85%

  - Source: HHS Secretary Sylvia M. Burwell

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Case Management Model

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Case Management Model

Trends:

- Focus on visits
  - Impacting outcomes – patient satisfaction
  - Productivity focus
  - Scheduler driving the business
  - Impact to continuity
- Not using nursing staff to the Top of their License
  - Retention
  - Satisfaction

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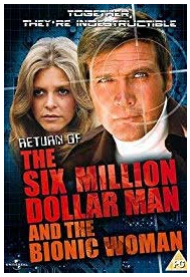
Why change?

Why need to change?

- Need to do more – Better and Faster
- Patients are more complex
- Outcome improvement Vital
  - VBP
  - Star Ratings
- PDGM
  - LUPA
  - UM



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Structure Case Management Model

- Team size based on Census – Clinical Manager

POSITION	PRIMARY RESPONSIBILITIES	METRIC
Clinical Supervisor/Manager	Direct clinical supervision of team, in home supervision of staff, productivity oversight, communicates with patient/family and MD.	1/150 – 175 Team census
Team Assistant (clerical)	General clerical support to Clinical Supervisor/Manager; processes required documentation and work flow, including patient care scheduling.	1/Team

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What is Case Management?

- Collaborative process to assess, plan, implement, coordinate, monitor and evaluate options and services to meet the patient's health needs.
- An entire interdisciplinary team working toward collaborative goals determined by the patient, family and healthcare team.
- Management of a team of patients by the Clinical Manager and individual caseloads by the Primary Case Manager (Primary Care Clinician).

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What is Case Management?

- Case management includes assessment, planning, facilitation, care coordination, evaluation, and advocacy.
- Good case management supports patient self-management and continuity of care.
- Continuity of care contributes to a good patient experience.

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Case Management

- Begins at time of referral and continues through discharge.
- Responsibility of entire team.
- Each team member plays integral role:
  - Achieve highest quality.
  - Best clinical outcome.
  - Highest patient/family satisfaction.
  - Efficient use of resources.

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Benefits of Case Management

- Patient and Family Centered Care
  - Core concepts are central to care/case management:
    - Patient centric care.
    - Dignity and respect.
      - Active listening-respect patient/family goals.
    - Information sharing
      - Timely and meaningful sharing of information between team members and practitioners.
    - Participation
      - Patients/families are encouraged/supported in participating in decision making and care planning.
    - Collaboration
      - Patient/family centered care drives implementation of programs, care delivery methods, education/training.
- Improved visit utilization/episode management.

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Impact on Outcomes

- Improved Publicly Reported Outcomes
  - Increased OASIS accuracy.
- HH and Hospice CAHPS-Patient Experience
  - Knowledge of the patient/family goals for care.
  - Collaborative reinforcement of key items.
  - Knowledge of care plan and responsiveness to care needs and status changes.
- Staff Experience
  - Retain and support employees
    - New Employee.
    - Preceptors
    - Clinical Managers.
  - Reduce turnover.

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Clinical Manager Role

- Oversees interdisciplinary Team
  - Direct Clinical Supervision
  - In-home competency assessments
  - Review of the Plan of Care
    - Care approach
    - Utilization
    - Outcome focused
  - Productivity
  - Case Load Management
    - Reviews cases with individual clinician
  - Facilitates interdisciplinary communication
    - Leads team discussion

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A Word – Clinical Manager Role

Clinical Manager Role is Key to Success

They are in control

- Key to Financial Success
  - Productivity
  - Utilization
  - Coding/OASIS
  - Staff Retention
  - Clinical Skills
- Need training and support
  - Good Nurse/Clinician does not always equate to good manager
- Skill Development and Refinement
  - Management and Supervision – (on-going)
  - Financial
    - Payment Models
    - Actions = Financial Impact

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Case Management Objectives

- Deliver *goal-driven* versus *task oriented* care
  - Focusing on moving patient to an outcome
  - Change from managing visits to managing Pt.
- Ongoing communication between the team that is consistently documented
- Follow up and resolve identified patient problems
  - Contacting the MD when needed
  - Changing the POC when needed

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Components

- Teams
  - 150-175 patients
- Case Managers (RNs and PTs)
  - Best clinicians
  - Lower visit expectation
  - Full-time
- Visit clinicians
  - RNs, LPNs
  - PTAs, COTAs
  - Full-time, part-time, per visit
  - Higher visit expectation than case managers
- "Care Pods"
  - Nurses, therapists, aides

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Team Staffing Structure

- RN Case Manager – 1 to 20/25 patients
  - *PT Case Manager – Therapy only cases- doing OASIS
  - Full time
  - Approximately 70% of staffing complement
- Flexible staffing
  - Approximately 30% staffing complement
  - RN Visit nurses – non-case manager
    - Per diem
    - New nurses
  - LPN/PTAs
  - Per Diem
- Continuity
  - Pods/Care Pairs
  - Geographic team within team
    - RN Case Manager with consistent Flex Staff

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Case Manager Role

- Professionally accountable and responsible for the patients' continuity of care.
- Establishes therapeutic relationship with an individual patient/patient's family.
  - →In effect for the patient's entire length of stay
  - →Case Manager is responsible for decision making
- Identifies the patient's unique health needs and priorities, establishes an individualized plan of care, and communicates that plan to other members of the team.

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Case Manager Skills

- Skilled communicator
- Skilled clinician
- Critical thinker
- Skilled in patient assessments
- Knowledgeable in OASIS & Coding
- Utilizes sound judgment
- Skilled in documentation
- Understands the concepts of episode management
- Self directed and innovative
- Effective decision maker
- Organized
- Excellent time management skills
- Empowered and accountable

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Case Manager Responsibilities

- Coordinate daily schedule of assigned patients with Scheduler
- Review visit frequency and length of time patient is on service
- Establish Plan of Care and oversight that plan is being followed, updated, etc.
- Review wound measurements weekly
- Complete Transfer OASIS when patient admitted to hospital
- Review labs of assigned patients
- Coordinate care with visit staff (Nurses, PTs, OTs, STs, HHA, MSW)
- Coordinate care with physicians, outside case managers, etc.

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Case Manager Responsibilities

- Review profit/loss report with Clinical Manager
- Monitor HHA supervisory visits every 14 days
- Monitor patients with home telemonitoring
- Complete Recert POC/ OASIS with visit
- Complete 2nd visit for patients if not admitting clinician

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Case Manager Delegation

- Case Managers delegate to their team/POD
  - Established plans of care
  - Reinforce the plan of care determined by the case manager
- Delegate treatments
  - Follow-up assessments/observations
  - Teaching/training activities
- Case managers see patients with clinical changes
  - New patients
  - Declining or recently hospitalized
  - Complexity drives decision-making

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Case Management Process

Patient Acuity & Hand-off to Team Clinicians

The CM is captain of patient care team. With an established Plan of Care, the CM can assign a stabilized patient to a Visit Clinician at appropriate times to an appropriate level of clinical skill.

Patient Acuity Guide

Acuity Level	Description	Minimum Staff Level Requirement
1	♦ Routine visit ♦ Stable but unpredictable condition ♦ Home environment adequate ♦ Care plan complete with revisions prn ♦ Education of patient/caregiver in progress	Visit Clinician RN/LPN Case Manager makes periodic visits to reassess
2	♦ ROC[1] or recertification ♦ Unstable condition requiring complex assessment & treatment changes ♦ Unstable home environment ♦ Multiple wounds (3 - 5) ♦ New IV requiring start, teaching & complex monitoring ♦ Stable cardiac but with complex care (i.e. LVAD)	Visit Clinician RN Case Manager makes periodic visits to reassess
3	♦ SOC[1] ♦ Complex treatments requiring assessment, care & treatment changes ♦ Unstable/unsafe home environment ♦ Multiple wounds (> 5)[2] ♦ IV care requiring onsite monitoring over 1.5 hours ♦ Unstable cardiac requiring complex assessment, coordination & treatment changes	Case Manager

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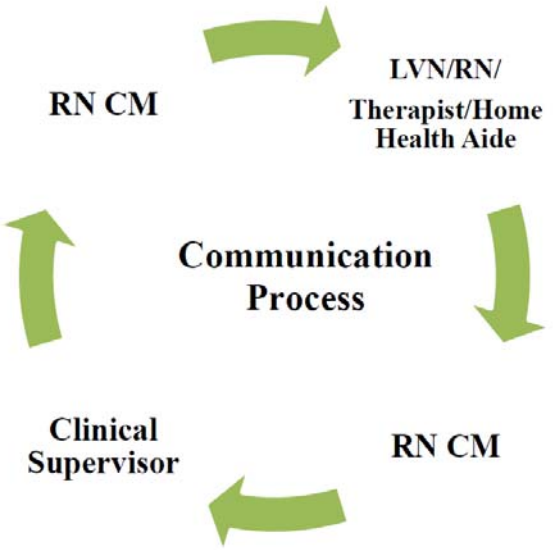
Case Manager Communication



Case Manager – Care Coordination

- Coordinate services to the patient
  - Consider patient's risk for re-hospitalization
  - Coordinate services to meet the intensive patient needs
    - Each visit – each discipline – needs to play a role with the patient – building off the plan of care
  - Coordinate the use of home telemonitoring
    - Ensure integrated into the overall plan
    - Follow-up with the patient/family for use
    - Use data for care plan changes/approaches
- Engage the patient and family
  - Goals of care

Productivity in the Case Management Model

- Case managers should have lower productivity expectations than visit nurses
  - Need time for case management activities
  - Complexities
  - OASIS

Position	Productivity
RN Case Manager	4 visits a day
LPN or non-case managing RN	5.5 to 6 visits a day

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Productivity in the Case Management Model

- A word….
  - More and faster is not always better
  - Balance efficiencies with outcomes
  - Clinicians need the time available to make visits
    - Manage meetings
    - In-services/Training
  - Clinical documentation requirements
    - Ensure processes are streamlined
    - Utilize EHR Systems

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Scheduling in a Case Management Model

- Case Manager
  - Delegates visits to team
  - Plan for week ahead – assigning visits to team LPN
  - Thursday – schedule completed for week ahead
  - Plan to leave room for admissions; unplanned visits to pts with changes
  - Consider utilization balance patient needs and *effective* use of visits

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Case Conferencing in a Case Management Model

Preparation for Case Conference

1. Review the patient record for any new or changed medications (including over the counter medications).
2. Review for any new or change in symptoms.
3. Review for any new or exacerbated diagnoses
- Hospitalization risks
4. Change in care giver or status.
5. Change in living environment.
6. Patient has a Primary Care Physician (PCP) identified.
7. HHA supervisory visits are completed per agency guidelines (every 2 weeks).

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Case Conferencing in a Case Management Model

Discussion during Case Conference

1. Patient goals
2. Anticipated length of service
3. Current assessment and problems
   - Risks
   - New or changed treatments
4. Any barriers to care
5. Team goals and implementation strategies
6. Plan for discharge

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Training and Education in a Case Management Model

- RN's are not natural born case managers…..
  - Job descriptions
  - Role expectations and activities
  - Competencies
    - Clinical
    - Organizational
    - Patient Outcome Management
  - Payment models
    - PPS
    - PDGM
    - Managed care
  - Resources
    - Community
    - Agency
  - On-going training

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Implementing a Case Management Model

- Role changes and training
- Staffing
  - Case Managers
  - Visit Clinicians
- Geographic Teams
  - Assigned care pairs
- Interdisciplinary Teams
- Case Conferencing
- Management of Outcomes and KPIS

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Key Concepts for Case Management/Clinical Operations

- OASIS Data Accuracy.
- Clinical Management Structure
  - Maximize operational efficiencies.
  - Identification of high risk areas (clinical/ops).
  - Communication/Case Conferencing.
- Episode Management
  - Clinical outcomes.
  - Financial outcomes.
- Disease Management
  - High risk hospitalization.
  - High cost/high utilization.
  - Use of Best Practice Interventions.
- Utilize agency reports to facilitate service delivery optimization/episode management/outcomes monitoring.

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Critical Success Factors in a Case Management Model

- Trust between clinicians
- Seamless, consistent and timely communication between clinicians
- Continuity of staff within a team/pod
- Management information and oversight
  - Patient satisfaction
  - Continuity
  - Case loads
  - Productivity
  - Visits per episode/LOS
  - Outcomes

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Financial Benchmarking for Home Health

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- Data needs to be used to:
  - Quality measures tied to reimbursement.
  - Growth in terms of current market share and future expansion.
  - How to be cost efficient while achieving quality goals and maximizing reimbursement.
  - How to set up staffing to deliver quality care, cost efficient operations and collect cash!
- Where do I stand today and how can I improve tomorrow?

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- The movement into new payment models means clinical and financial data must be available.
- Financial Data should be easily accessible and broken out.
  - General Ledger
  - Payroll Software
- Direct Cost by Discipline should be broken out
- Direct Cost by Type (Salary, Benefits, Contract, Mileage)
- Identify Critical Financial KPI Indicators
  - Keep it Simple
  - Focus on Revenue & Cost Drivers
- Automate your reports
- Compare to Benchmark Data

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- Focused and specific
  - Include the Revenue and Cost Metrics with Goals and/or Benchmarks Consolidated
  - Include revenue and cost drivers to meet the goals and benchmarks
  - Quick to interpret performance
- Regular and frequent
  - Early alert system
  - Monitor progress

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- What information is included?
  - What will inform the conversation?
  - What noise can and should be eliminated?
- What is the appropriate frame of reference? How is it presented?
  - Quick interpretation vs. thorough numbers
  - Tips:
    - Graphical where appropriate
    - Management by exception
    - Integrated information

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Know Thy Audience!

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- What are benchmarks:
  - Comparisons: performance into perspective
  - External or internal, based on purpose/need
    - Examples of external include national, state, median, top performers
    - Examples of internal include past performance, desired targets, subsets within your organization (by location, payer, team, diagnostic group, referral, as a few options)
  - Most appropriate for the purpose?

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- Benchmarks are often the average or median

  Are you happy being in the middle?
- Goal should be top 25%
- And/or situationally appropriate

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- **Benchmark Sources:**
  - CMS Cost Report Database; CMS Claims Database
  - CMS Quality Measures
  - National/State Surveys
  - NAHC Salary and Benefit
  - NHPCO National Data Set / Annual Summary of Hospice Care
  - Private Duty Benchmarking Reports
  - Benchmarking Software
    - Deyta, SHP, Ability, MVI, Simione Financial Monitor, viaDirect. Excel
  - State Association Surveys

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- Overall Gross Margin – 41%
  - Direct Payer Revenue minus Direct Service Cost
  - Everyone Drives Gross Margin
    - Clinical – Revenue and Cost
    - Finance – Cost Containment
    - Operation – Cost Efficiencies
    - Marketing/Intake – Revenue
    - Billing – Collection

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Data Source: Simione Financial Monitor December 2018

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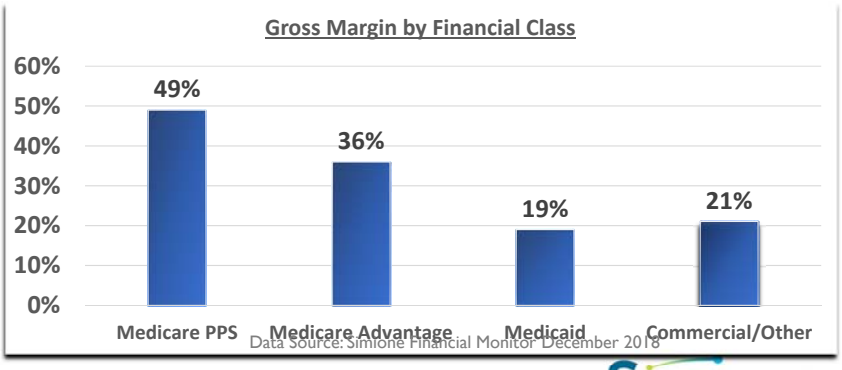
Gross Margin by Payer



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Data Source: Simione Financial Monitor December 2018

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- Payer Mix
  - What payer mix do I need to obtain to remain profitable?
  - What is my break even in terms of patient/visits for managed care fee for service contracts?
  - Is there opportunity to pursue non fee for service contracts:
    - Risk based contracts
    - Capitated rates

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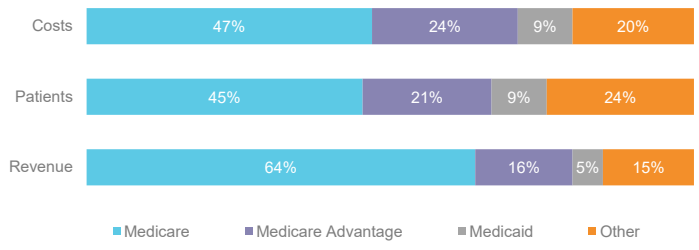
Payer Mix



Data Source: Simione Financial Monitor December 2018

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- Threats:
  - Shrinking Medicare Gross Margins
    - 2012 – 52%
    - 2018 – 49%
  - Increased losses for non Medicare Payers
    - 2012 – 30% Commercial/Managed Care
    - 2018 – 21% Commercial/Managed Care
  - Expansion of non Medicare Payers
    - 2012 – 25% of Revenue
    - 2018 – 36% of Revenue
  - Increase in Nursing Direct Cost Per Visit
    - 2012 - $89
    - 2018 - $104

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Data Source: Simione Financial Monitor December 2018

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- First step: What drives my top line?
  - Admissions
  - Capture Rate
  - Payer Mix
  - Case Weight Mix
  - Patient Acuity
  - Coding
  - Collections
  - Operational Workflow

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- Who are my referral sources and what is my market share?
  - Where is their opportunity (new or current referral source)?
  - Do I have a foundation in my current market before I expand?
  - Is my market utilizing Homecare?
- Understand referral sources:
  - Referrals by payer
  - Referrals by diagnosis
- What percentage of my referrals are admitted?

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- Market share data (Medicare Claims Data from viaDirect)
  - National - 19% Hospital discharges are going to Home Health
  - National - 44% Hospital discharges Home with no services
- Referral to Admission Conversion Ratio
  - 75% (Simione Financial Monitor)
- Admission Distribution (Simione Financial Monitor)
  - Hospitals – 64%
  - Physicians – 19%
  - SNF –12%
  - Other – 5%

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Data Source: Simione Financial Monitor December 2018

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- Know where you stand:
  - Quality Scores
  - Rehospitalization
  - Utilization
  - Patient Satisfaction
  - Payer Break Even
- Know the information by:
  - Diagnosis
  - Referral Source
  - Payer

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Clinical Measures

- Are you maximizing your revenue based on your patients?
  - Validate your clinical documentation and scoring to ensure your are maximizing the HHRG based on the patient's acuity.
- Are you outsourcing? What option would be most cost effective and have the greatest return?
- What is your readmission rate?
- Therapy up coding vs down coding?
- Are you avoiding LUPAs?
- How are you prepared for the Grouper Model?

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Medicare Statistics

- Case Weight Mix – 1.027
- Reimbursement per Episode - $2,625
- Readmission Percentage – 21%
- Percentage of Total Episodes
  - Therapy Up Code – 9%
  - Therapy Down Code – 24%
  - LUPA % - 11.1%

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Data Source: Simione Financial Monitor December 2018

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- Step 2 Creating Direct Cost Efficiencies:
  - Staffing Model
  - Productivity
  - Visit Utilization
  - Patient Acuity
  - Benefits
  - Vendor Staff Expenses
  - Mileage/Geography
  - Supplies Management

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Staffing Model

- Salary Staff
  - Advantages:
    - More control over staff's performance and schedule.
    - Staff is held accountable to the agency.
    - Easier to manage utilization and quality.
  - Disadvantages
    - No incentive for the staff to do more visits and meet productivity goals.
- Per Visit Staff
  - Advantages:
    - Incentive staff to make productivity goals.
    - Cost savings (only paying for visit and productive time, less benefits)
  - Disadvantages:
    - Quantity over Quality
    - Increase in visit utilization, less margin per episode/case
    - May have other jobs/responsibilities

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Staffing Model

- Vendor Staff
  - Advantage:
    - Paid on a per visit basis
    - Ability to accept overflow patients from referral sources
    - No benefit costs
  - Disadvantage:
    - Staff may have other jobs/priorities
    - Quantity over Quality
    - Less control over education and training

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Staffing Model

- Best Practice Staffing Model 70/30 Salary/Per Diem
  - Provides controllable salary staff and allows for flexibility for patient overflow.
  - Ability to train and educate staff to meet quality based payment model.
  - Manage productivity and visit utilization.
- Provide incentive to staff around quality and documentation while maintaining budgeted visit goals.
  - Quality has a direct impact on revenue..
  - Documentation impacts collections.

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Discipline	Direct Cost Per Visit
Skilled Nurse	$104
Physical Therapy	$106
Occupational Therapy	$98
Speech Therapy	$127
Medical Social Worker	$169
Home Health Aide	$44

Data Source: Simione Financial Monitor December 2018

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Discipline	Salaries	Taxes & Benefits	Contract Services	Transportation
SN	74%	18%	3%	5%
PT	73%	18%	6%	3%
OT	76%	18%	3%	3%
ST	74%	18%	3%	5%
MSW	63%	15%	18%	4%
HHA	47%	11%	35%	7%

Data Source: Simione Financial Monitor December 2018

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Productivity

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Productivity

Productivity

	Week 1	Week 2	Week 3	Week4
1	2.9	3.0	3.2	3.2
2	3.7	4.2	4.9	3.5
3	2.9	4.5	3.2	4.3
4	1.5	2.9	3.1	2.7
5	3.4	2.5	2	4.8
6	3.7	2.5	2.8	3.5
7	3.9	3.6	4.0	4.4
8	1.4	1.5	1.7	2.1
9	3.2	3.4	3.9	3.8
10	2.7	1.2	2.2	2.1
Totals	**2.9**	**2.9**	**3.1**	**3.4**

Under Productive Visits

Week 1	Week 2	Week 3	Week4
2.1	2.0	1.0	1.0
1.3	0.0	0.1	1.5
2.1	0.5	1.0	0.7
3.5	2.1	1.9	2.3
1.6	2.5	1.8	0.2
1.3	2.5	2.2	1.5
1.1	1.4	1.0	0.4
1.6	1.5	1.3	2.9
1.0	1.6	1.1	1.2
2.3	1.0	2.0	2.9
2.1	2.1	1.9	1.6

Productivity Cost

Week 1	Week 2	Week 3	Week4	Annualized
$ 332.00	$ 840.00	$ 756.00	$ 756.00	$ 30,801.3
$ 546.00	$ 336.00	$ 42.00	$ 630.00	$ 10,643.1
$ 332.00	$ 210.00	$ 756.00	$ 294.00	$ 25,704.3
$ 1,470.00	$ 332.00	$ 790.00	$ 966.00	$ 49,392.3
$ 672.00	$ 1,050.00	$ 1,260.00	$ 84.00	$ 36,792.3
$ 546.00	$ 1,050.00	$ 924.00	$ 630.00	$ 37,800.3
$ 462.00	$ 630.00	$ 420.00	$ 252.00	$ 20,664.3
$ 1,512.00	$ 1,470.00	$ 1,134.00	$ 1,260.00	$ 47,812.3
$ 756.00	$ 672.00	$ 462.00	$ 504.00	$ 20,724.3
$ 966.00	$ 1,596.00	$ 1,176.00	$ 1,260.00	$ 59,472.3
$ 8,694.00	$ 8,694.00	$ 7,980.00	$ 8,652.00	$ 383,040.3

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Productivity

- Provide realistic goals based on
  - Type of visits SOC vs Routine
  - Geography/Mileage
  - Patient Diagnosis
  - Staffing
  - Financial Success
- Keep field staff updated on financial success!

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Productivity

- Clinicians roles and responsibility:
- Ensure that quality care is coordinated within patients to achieve positive outcomes.
- Documentation of all patient activities and outcomes for patients.
- Asking a clinician to do to much makes the productivity goals unrealistic!

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- What are the pitfalls of increasing productivity?
  - Incentives which reward the number of visits without considering outcomes
  - Cutting corners on patient care
  - Increased need for care
  - Readmissions to home care
  - Re-hospitalizations
  - Emergency room visits
  - Late documentation and unclosed visits
  - Impact on patient or consumer satisfaction

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Discipline	Productivity Visits Per Day
RN Case Manager	4 to 4.5
Visit Nurse	5 to 6
PT (SOC & Supervising PTAs)	4 to 5
Visit PT and PTA	5 to 6
Occupational Therapy	5
Speech Therapy	4
Medical Social Worker	3.6
Home Health Aide	5

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Data Source: Simione Financial Monitor December 2018

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Home Health Staffing Direct Care Staffing

- 20-25 patients per RN Case Manager.
- 20-25 patients per Therapy Case Manager (therapy only cases and if therapist perform Oasis visits)
- 70% Full Time / 30% per visit

74

Data Source: Simione Financial Monitor December 2018

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Home Health Visit Utilization

- Reimbursement based on:
  - Quality/Value/Outcome
  - Diagnosis/Patient Condition
  - Risk Sharing
- Must measure visit utilization to meet the reimbursement goals while managing the margin of the case.
  - Managing the transition of the patient from inpatient setting to the home
  - Front loading visits to improve the outcome of the patient
  - Developing best practice care plans to improve outcomes
  - Care Teams with multiple disciplines
  - Monitoring visit and scheduling
  - Identifying potential LUPA Episodes

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Medicare Visits Per Episode

- All Episodes
  - Nursing – 6.9
  - Therapy – 7.0
  - Social Worker – 0.2
  - Home Health Aide – 1.2
  - Total = 15.3 visits

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Data Source: Simione Financial Monitor December 2018

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Visits per Patient by Payer

Discipline	Medicare	Medicare Advantage	Medicaid	Other
Nursing	6.2	6.0	5.5	5.2
Therapy	6.1	6.1	2.9	4.9
Medical Social Worker	.2	.2	.1	.1
Home Health Aide	1.1	1.0	.3	.4

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Data Source: Simione Financial Monitor December 2018

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- Mileage Costs
  - Cost Per Visit - $4.25
  - Scheduling
  - Care Teams
  - Tracking Software
  - Fleet service
- Supply
  - Billable Supplies - $1.85 per visit
  - Nonbillable Supplies - $1.02 per visit
  - Review of Formulary
  - Dropship supplies
  - Supply Management Inventory
  - Monitoring billable/non billable supply charges
  - Send RFP 2-3 years

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Data Source: Simione Financial Monitor December 2018

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Integration of Back Office Operations and Clinical Technology

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- Must look at the whole picture when reviewing back office operations and costs:
  - The cost compared to the benchmark
  - The performance of the department
  - The affect on incoming revenue
  - Staffing of the organization (overworked staff = cash flow and compliance issues)
  - The strategic growth plan

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- People
- Process
- Technology

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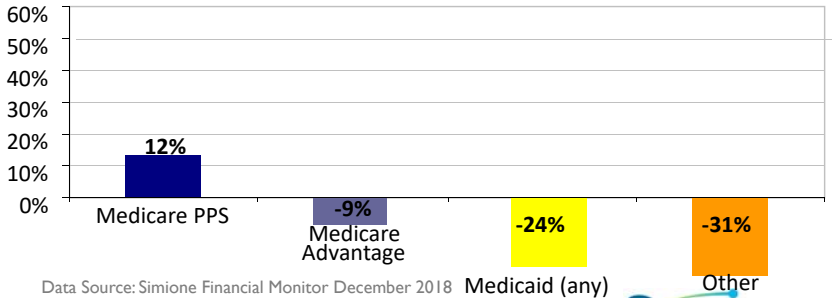
- National – Overall – 2.5%
- By Payer:



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Data Source: Simione Financial Monitor December 2018

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- Back Office Costs for the Organization
  - Measure as % of Revenue
    - As you grow your revenue you will need additional staff in areas to ensure quality care and operational efficiencies.
  - Where can technology decrease cost and optimize operations?
  - Review all expenses
    - Rent, Utilities, Office Supplies

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- Employee Costs
  - Measure cost by department:
    - Where are resources needed?
    - Where are there opportunities for operational efficiencies?
      - Let staff generate idea
    - Where do employee's feel as though they can add the most value?
    - Do you have succession planning for key management positions?
    - Communicate results.

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- Centralize departments for multi location providers:
  - Create best practices within the organization
  - Consistency of communication and processes from back office to clinical operations.
  - Reduction in cost.
  - Outsourcing opportunities.
- Single location providers:
  - Opportunity to provide management services to other providers?
    - Do I have the bandwidth?
    - Is this an opportunity for revenue?
    - Am I sharing too much?
  - Outsourcing opportunities?

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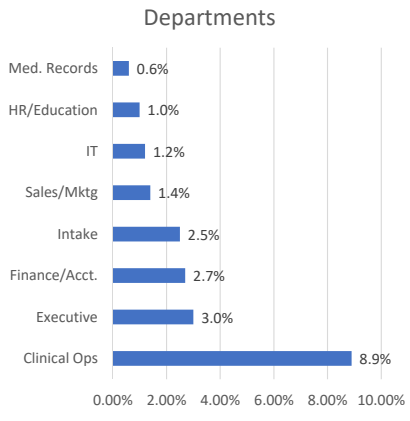
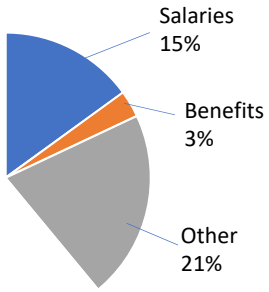
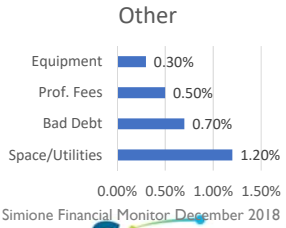
All Costs as % of Revenue







Data Source: Simione Financial Monitor December 2018

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Executive Team

- CEO, CFO, CIO, COO
- Provide Leadership and Direction
  - Communication between departments
  - Sets the tone for the culture of the organization
  - Ensure agency meets all quality, financial and operational goals.
  - Strategize priorities based on opportunities

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Marketing Department

- Hold Marketers/Liaisons accountable for admission NOT referrals
  - 20-25 referrals per week = 15 to admissions
- Educate your marketing team on the importance of Medicare admissions compared to Managed Care/Medicaid
- Utilize market data for opportunities (claims and payer data)
- Review your Advertising Campaigns – do they generate business?
- Review any Marketing cuts and their impact on revenue.
- Utilize CRM to track Marketing Activity

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Intake Department

- Important to move patient from referral to admitted status to schedule SOC visit.
- Customer Services Specialist
  - Receives referral from phone, fax, email then enters data into EMR and hands off to referral management specialist.
  - 15-20 referrals per day.
- Referral Management Specialist
  - Owns referral from receipt to admitted status.
  - 10 to 12 referrals per day.
  - 4 to 6 hours from receipt to handoff to admission nurse.
- Clinical Referral Specialist owns complex referrals – 6 to 8 referrals per day.
- Insurance Verification Coordinator
  - 1 FTE – 80 -110 Medicare referrals or 15-20 Commercial referrals per day

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Finance Department

- Provides necessary functions for billing (verification, authorization, billing)
- Provides financial oversight and review (Finance Director)
- Provides Accounting functions (Payroll, Accounts Payable, Staff Accountant)

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Finance Department

- Billing Department
  - Medicare Monthly Revenue of 1.5 million per Medicare biller.
  - Medicaid Monthly Revenue of 125 K per Medicaid biller
  - Commercial/Managed Care of 500 K per Managed Care/Commercial Biller.
- Authorization Verification Coordinator
  - 1 FTE for every 200 to 300 patients
- 1 Staff Accountant FTE per 500-750 patients.
- 1 Payroll FTE per 500-750 patients
- 1 Accounts Payable FTE 500 -750 per patients.

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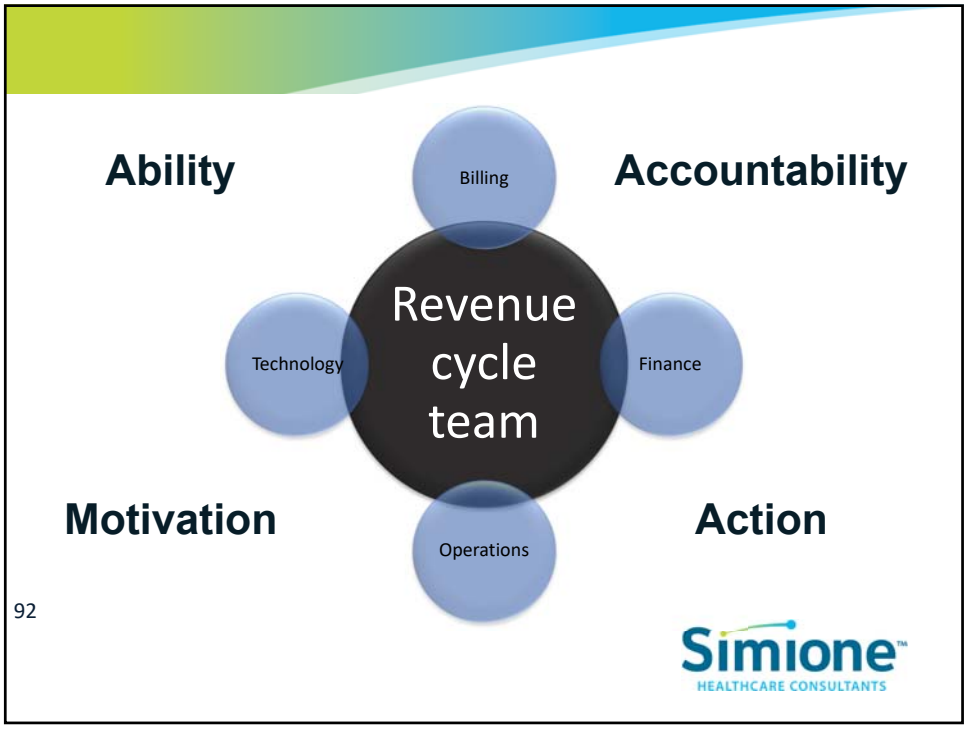

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Home Health Revenue Cycle Key Performance Metrics			
Metric	**Poor**	**Average**	**Best**
Medicare days in AR	65 days or more	55 days	45 days or less
Non-Medicare days in AR	75 days or more	65 days	55 days or less
Total days in AR	70 days or more	60 days	50 days or less

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Clinical Supervision/Support QI

- Maximize clinicians value in terms of quality, documentation and productivity:
  - Quality
    - Education & Training
    - Reports and Alerts
  - Documentation
    - Regulatory and Compliance updates
    - Education around Oasis
  - Scheduling
    - Geography, SOC vs Routine, Team Structure

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Clinical Supervision/Support QI

- 150 -175 patients per Clinical Supervision (Team)
- 20-25 patients per RN Case Manager
- 1 Clerical Clinical Assistant per Team
- 1 to 2 Clinical Navigators per Team
- Outsource coding function?
  - Coder -1 FTE per 90 to 100
  - Utilization Oasis Review Nurse - 1 FTE per 50-60

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HR Department

- Staffing
- Recruiting
- Healthcare Benefits
- Employee onboarding/training

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Information Technology

Total IT Cost as a % of Revenue	Average Gross Margin
4% or More	33%
2.5% to 4%	36%
1.0 to 2.5%	40%
Less than 1%	38%

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Data Source: Simione Financial Monitor December 2018

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IT Responsibilities

- Field Staff Training
- Remote EMR updates
- HIPPA secure messaging
- WiFi Hot Spots, Tethering devices
- Updated Hardware and cell phones
- Outsource IT support via phone or online
- Provide back up laptops
- Clinical super users may carry less of a case load.
- DME/Supply Ordering
- Mileage Software.

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IT Responsibilities

- Patient portals
- Data and analytics
- Research of new devices, software and applications.

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IT Staffing

- Clinical Informatics
  - Provides clinician with training and education around EMR.
  - IT support on any clinical related matters.
  - Part of all EMR testing and updates to ensure compliance.
  - Liaison between field staff and EMR.
- IT Support
  - Supports IT hardware and software both for clinicians and back office.
  - Responsible for IT security around HIPPA regulations.
  - Involved in purchasing process for devices, software and communication plans.
- Data Analytics
  - Responsible for reporting and communication of results to various departments.

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Telehealth

- Advantages:
  - Reduction in utilization costs.
  - Ability to monitor patients on an ongoing basis even when the Home Health criteria are not met.
  - Provide patient education around their diagnosis.
  - Access for PCP, Nurse, and Family remotely.
- Disadvantages:
  - Cost with no reimbursement
- What is the ROI?

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Other Cost Strategies

- Bad Debt
  - Review bad debt sign off process.
  - Review bad debt by reason, where is their opportunities to improve collections.
- Space Occupancy
  - Own, Rent?
  - Mobile work force
  - Utility contracts
- Professional Fees
  - RFP 2-3 years
- Equipment
  - Review purchase sign off process
  - Lease or Own?
  - Maintenance contracts

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Other Costs

- Development and Fundraising - .35%
- Liability Insurance – .25%
- Interest Expense – .23%
- All Other Admin – 1.6%
- Home Office – 17% (Hospital or Management Fees)

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Data Source: Simione Financial Monitor December 2018

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Revenue Drivers	Direct Expense Drivers

• Medicare : Admissions
  • Number of episodes
  • Types of Episodes
  • LUPAs & Outliers
  • Re-Certs
  • Case Mix Weight
  • Sequestration
• Medicare Advantage
  • Admissions
  • Number of episodes
• Medicaid
  • Admissions
  • Visits per admission/patient
• Commercial
  • Admissions
  • Visits per admission/patient
	• Gross margin percentage
	• Salaries
	  • Visits per episode by discipline
	  • Direct cost per visit
	  • Productivity by discipline (un-weighted)
	  • Days available to visit
	  • Number of patients per case manager
	  • Patients per team
	  • Average Length of Stay
	• Mileage or Transportation
	  • Average miles per visit
	• Medical supply
	  • Cost per patient or day
	  • Number of supplies ordered off formulary

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Clinical Data/KPIs

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Why Key Indicators

- Where do I stand?
  - Compared to plan/budget
  - Compared to state/regional/national norms
- What do I need to change?
  - Prioritization – key indicators to financial performance
  - Actions – to move the indicator in a positive direction
- Am I generating a positive bottom line?
  - How can I grow?
  - What are my opportunities?
- Am I operating at a loss?
  - Where are my problem areas?

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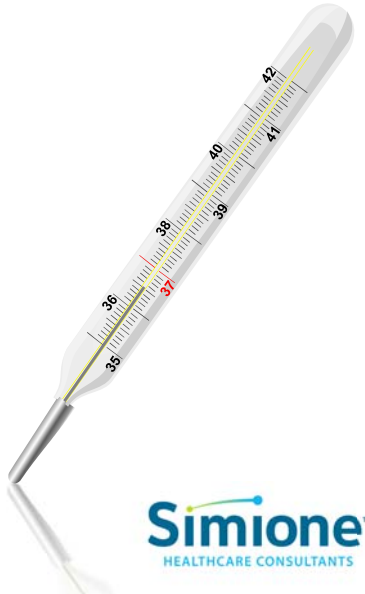
HOME HEALTH KEY PERFORMANCE INDICATORS

Limitations of Performance Data

A thermometer reading would have little value as a measure to your health **if you didn't know 98.6 is the normal temperature**

- Deluged with data without meaning
- Data without context is just a bunch of numbers



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Clinical Concerns

- What do Clinical Managers worry about? Why?
  - What does my staff schedule look like?
    - Are there patients with urgent needs?
    - Are staff prepared/skilled to provide the needed care?
    - Are there any call outs? Are there enough staff to cover admissions?
    - Is there Per Diem staff availability?
    - Am I overstaffed? Do I need to send anyone home?

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Clinical Concerns

- What is the census this morning?
  - Admissions – actual and pending
    - New Start of Care & Assessment visits
    - Recertifications
  - Home Health: Discharges
- What are the work queues looking like?
  - Do we have back ups in OASIS reviews?
  - Are there staff I need to follow-up with?

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Clinical and Operational KPIs

- **What does my patient population look like?**
  - Where are my referrals coming from, how is it impacting our outcomes?
  - Will I have to change marketing practices with PDGM?
    - What does that look like?
  - Do I need to meet with marketing to communicate the impact a change in referral patterns?
    - Are we making enough of an impact to patient outcomes to market to our referral sources?

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Clinical and Operational KPIs

- **Do I have any compliance worries?**
  - Is my staff documentation being completed timely?
  - Are there issues with the technology?
  - Does the documentation support eligibility?
  - Do I have any ADRs? Are we responding timely?
  - Are the pre-bill audits reviewing all physician orders, F2F, and OASIS submission? Are supplies tracked properly?
  - Are we prepared if a surveyor walks in the door?

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Key Measures – Patient Populations

- Census
  - Referrals by source
    - % of referrals from hospitals, MDs, SNFs
  - Admissions
    - New patients to census
  - Pending Admissions
    - Reasons why pending
    - Follow-up being completed
  - Referrals to Admission Conversion Ratios
    - Benchmark for Home Health is 85%
  - Not taken under care (NTUC)
    - Reasons not admitted
    - Track by admitting clinician

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Key Measures – Patient Populations

- Discharges
  - Discharge reasons
- Transfers
  - Re-hospitalizations
- Patients by Diagnosis
  - Opportunities for programs
    - CHF/COPD etc.
  - Need for staff training

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Key Measures - Staffing

- Staffing Ratios
  - Clinician caseloads
  - Schedules
- Patient acuity
  - Case Mix
- Clinician productivity per discipline
  - Time Available to Visit
- Overtime utilization

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Key Measures - Utilization

- Visits per Day/Episode
  - By Discipline
  - By Payer
- Therapy utilization
- LUPAs
  - % per agency
  - Team
  - Clinician trends
- Medicare episodes
  - Initial, subsequent
  - SOC, Re-certs
- Supply utilization and cost

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Key Measures – Documentation Completion

- Clinical Documentation
  - Documentation completion
  - Timeliness
- Physician document tracking
  - Outstanding documentation

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Key Measures – Patient Outcomes

- Quality Outcomes
  - The most successful organizations have a positive bottom line and satisfied customers.
  - Balance of clinical and financial outcomes
  - Benchmark your quality scores to ensure you are in compliance and have high patient satisfaction scores
  - Without quality care you risk losing patients, compliance penalties and audits
  - The negative impact is an increase in your costs while lowering your revenue!
- Patient Outcomes
  - Acute Care Hospitalization/ED visits
  - Other QI Priorities

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Key Measures – Patient Outcomes

- Process Measures
- OASIS Submission Thresholds
- Potentially Avoidable Events
- Patient Complaints
- Case Mix Weight
- LUPAs
- PEPs
- Outliers
- HHCAHPs
- PEPPER Reports

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Comparing & Benchmarking

- Sources
  - CASPER Reports
  - Home Health Compare
  - Benchmarking services
    - SHP, Deyta, SFM,

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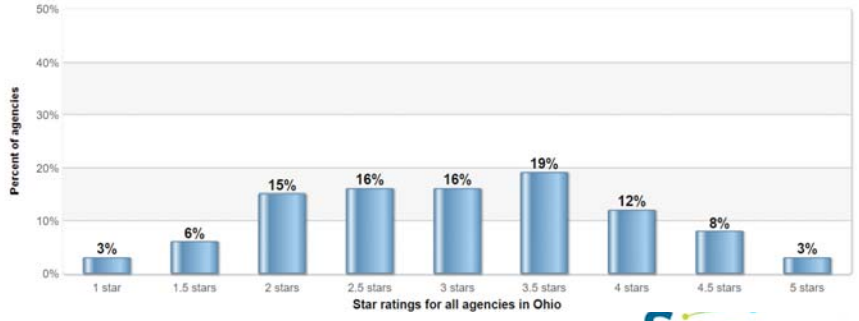
Home Health Compare

Compare your agencies to state and national results

This shows you how the quality of patient care star ratings for the agencies you selected compare to the star ratings for all home health agencies in **Ohio**.

AMERICAN NURSING CARE (3.5 stars)
AMERICARE HOME HEALTH OF DEFIANCE (4.5 stars)



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Casper Report

	HHA Obs	HHA Prior Obs[1]	Nat'l Obs
Multiple hospitalizations (%)	39.58%	40.00%	32.25%
History of falls (%)	31.25%	46.67%	33.06%
5 or more medications (%)	81.25%	88.89%	92.07% *
Frailty factors (%)	66.67%	84.44%	46.00% *
Other (%)	68.75%	60.00%	53.27%
None (%)	2.08%	0.00%	1.62%
Overall Status			
Overall Status (0-3)	1.40	1.11	1.43
Unknown / Unclear (%)	0.00%	0.00%	0.13%
Other Risk Factors			
Smoking (%)	16.67%	28.89%	23.52%
Obesity (%)	12.50%	13.33%	28.04%
Alcohol dependency (%)	0.00%	4.44%	3.80%
Drug dependency (%)	0.00%	2.22%	1.82%
None (%)	75.00%	57.78%	53.81% *
Body Mass Index			
Low Body Mass Index (%)	20.45%	7.50%	6.15% **

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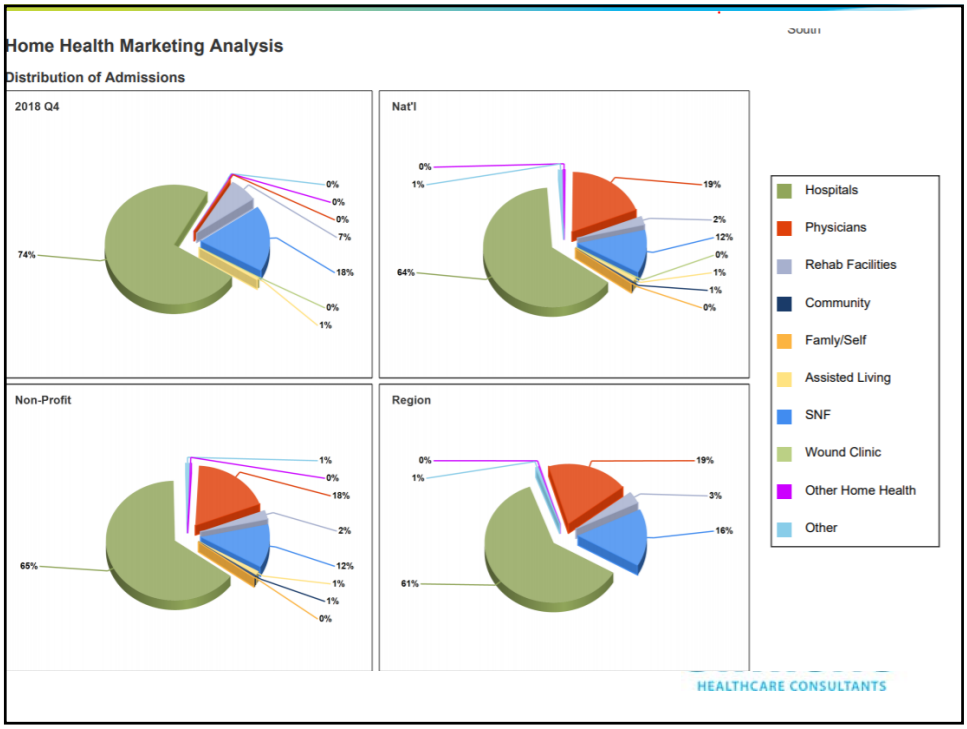

Keeping it Real

- Monitor what aligns with key organizational goals
  - Keep an eye on key indicators
  - Drill down when out of line to benchmarks or past performance
    - To understand the cause of the variations

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Operationalizing Your Data to Drive Clinical Outcomes & Financial Performance

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Data, Data, Data!

- Quality data must be collected for an agency to understand what needs to be done strategically to meet its revenue goals.
- Financial data must be collected to better understand how to cost an episode of care for a patient to meet the profitability goals.
- Set your agency up for success!

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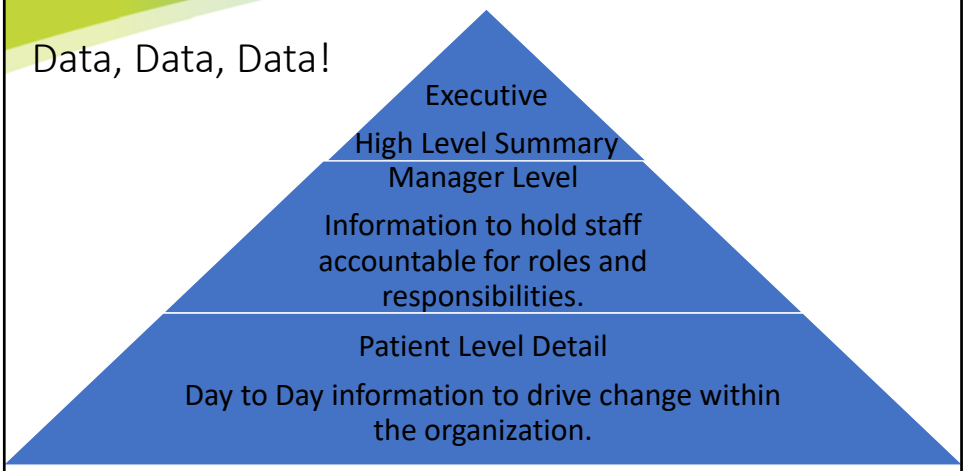
Data, Data, Data!



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Internal Agency Data

- Measure
  - Clinical Outcomes
  - Clinical Operations
  - AR/Revenue Cycle
  - Financial Profitability
  - Patient Demographics
- Tools
  - Electronic Medical Records
  - Accounting Software
  - Business Intelligence Tools (Tableu, Microstrategy)
  - Care Management Platforms (ClinLogica)

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Agency A - Profile

- 75 years in home health
- 800 patient census
- 3.5 Star Rating
- Operates in a state with HIE (Health Information Exchange)
- 60% of payments are value based
- Clinicians are paid on a per visit model
- Agency has an associated Hospice

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Agency A - Profile

- Productivity is 6 visits per day.
- 50 patients per Case Manager.
- Supervisors focused on reviewing documentation, no value add in reviewing outcomes.
- Separate staff for Start of Care visits.
- 9 Nursing visit per Medicare episode.
- 2.5 Therapy visits per Medicare episode.
- Case weight mix of .8 but have high acuity patients.
- 75% of OASIS review is outsourced.

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SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
• 75 years in business • 800 patient census • Profitable • Strong Leadership team • Lower re-hospitalization rate than local hospital based Home Care. • Operates in a state with an HIE (Health Information Exchange)	• Slight loss from VBP in 2017 • IT staff of 2 FTE's with focus on support • Separate EMR and telephony systems • Finance Team has minimal homecare experience • Supervisors focused on reviewing documentation, not reviewing outcomes. • Few clinicians with focused expertise on disease management, most are generalist.	• Most of staff are generalists • 3.5 STAR rating • Capturing 10% of the market's referrals • Key business strategy is to reduce hospitalizations for CHF patients • 1 clinical informatics person • Executive Team approached about Risk Based Payment Model • Hospital has an RFP for Palliative Care	• Highly competitive staffing market • Underutilized telehealth system that does not interface with EMR • Network hospital utilizes a different telehealth system • Hospital has a Population Health Management System with no integration

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Business Strategy

- Align data and operations to local Hospital key initiatives.
  - Provide a reduction in rehospitalization.
  - Provide patients with quality outcomes compared to competitors.
  - Utilize non traditional Home Care services.
  - Develop strategic payment models to care for patients.
- Create a clinician payment model aligned with the agency's compensation strategy.
- Development staffing model that ensures case management of the patient.
- To be on the upside of value based purchasing.
- Improve Medicare case weight mix to align with patient acuity.

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Strategic Plan

- Utilize market data to better understand opportunities:
  - What is the current opportunity with market hospital systems, physician groups, skilled nursing facilities?
  - What type of patient diagnosis make up most of their discharges to Home Care?
  - Are referral partners part of any bundled or quality based payment models?
- Based on the current staffing and expertise what opportunity can be a quick win? What opportunity may need time to develop?
- What opportunity could provide additional revenue streams without incurring high costs?
- How can I use technology to increase efficiency and provide better feedback to my agency?

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Strategic Plan

- What improvements/changes does my agency need to make to ensure a successful plan? (Quality, Staffing, Education, Financial)
- How much would these improvements cost? Are they greater than or less than the additional revenue stream?
- How can I use technology to increase efficiency and provide better feedback to my agency?
- What type of data do I need to measure my success? Who is the data shared within the organization? How can leadership and staff be held accountable.

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Hands On Data

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What Data should drive Analytics?

- General Data
  - Because it is Mandated
    - I.e. OASIS, Cost Reports
  - Because it affects Revenue
    - Payroll, G/L, Visit Orders
- Population Related Data
  - Because it is Required
    - QAPI
  - Because it improves Outcomes
    - Five-Star, HF/COPD, etc.
- Other
  - Because it is how a partner is measured
    - HEDIS, PQRS, MIPS/MACRA

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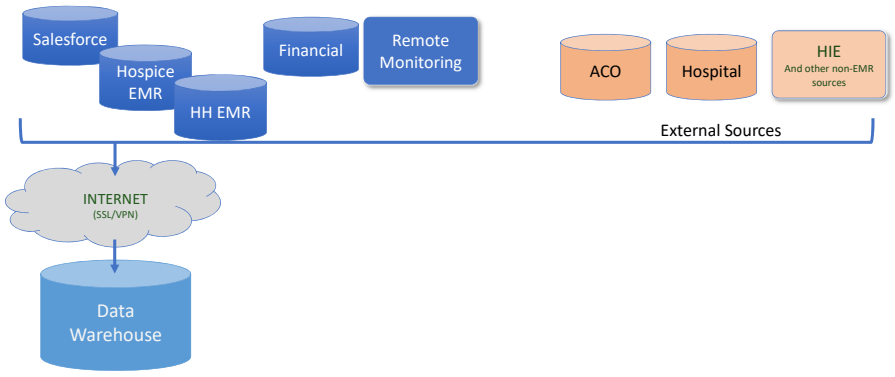
Data Consolidation Improves Accuracy



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Using Data to Align Revenue / Salary Models

Agency - Shifting Revenue Focus

- Revenue linked to Outcomes
- Reduce LOS
- Reduce Visits / Episode
- Front-load

Employee reward by Productivity

- Paid by visit
- Coordination of care not priority
  - Large case loads
  - Coordination is time consuming

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Pure PRODUCTIVITY Measures
De-incentivize Outcome-based Care

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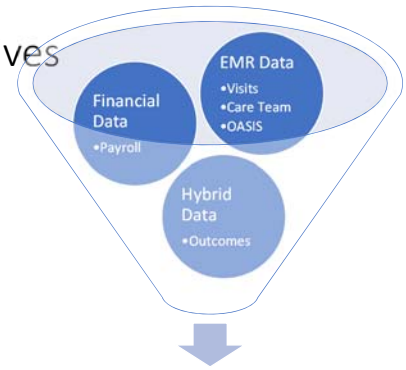
Different Incentives Different Result

EMR Data
- Visits
  - Who
  - When
  - Average / clinician / week / episode
  - # of different clinicians / discipline
- Care Team
  - Does Clinician tend to work with PT/OT
- OASIS
  - Clinicians avg CMI vs others
  - Clinicians typical answers vs others
  - Percent of Pts Where Meds are not fully taught
- Other
  - Percent of pts that are re-certified
  - Average LOS



Outcome weighted Productivity

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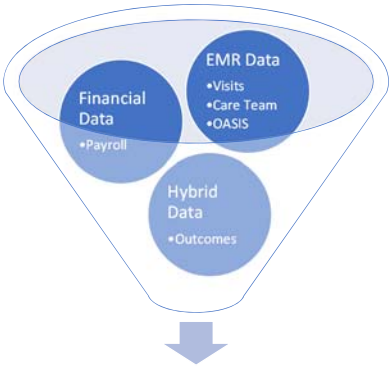
Different Incentives Different Result

Financial Data

- Payroll
  - Salary
    - Average by Discipline
    - Specific
  - Incentives
  - Overtime
- Claims
  - 60 Day
  - Other



Outcome weighted Productivity

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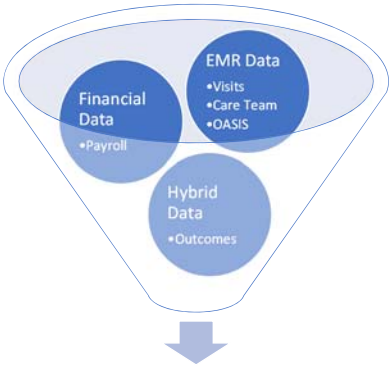
Different Incentives Different Result

Outcome Data

- ER Rate
  - By Disease/Issue (HF, COPD, Falls)
  - When (1st 15d, 2nd 15d, etc.)
- Hospitalization Rate
  - By Disease/Issue (HF, COPD, Falls)
  - When (1st 15d, 2nd 15d, etc.)
- Vaccination Rate
  - FLU
  - PNU
- ADL Improvement Rate



Outcome weighted Productivity

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Risk Stratification using Data

Risk Stratification is the process of using data to identify the most likely patients to have a specific risk, so resources can be focused where it may have the largest impact.

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Risk Stratification using Data

Risk Stratification is the process of using data to identify the most likely patients to have a specific risk, so resources can be focused where it may have the largest impact.

Good

- Helps Identify patient(s) to focus on
  - Emotionless
  - Repeatable
- Can pick up subtle clues that can be easily missed
  - Not dependent on Clinical Experience

Concerns

- Works well on stable patients
  - *No clinical changes*
- False Negatives vs False Positives
  - *False Positive*
    - *Easily screened Out*
    - *What is False Positive Rate?*
  - *False Negative*
    - *Assumes Screen is Perfect*
    - *Might have picked it up if no algorithmic screen. Now ignored*
    - *What is False negative Rate?*

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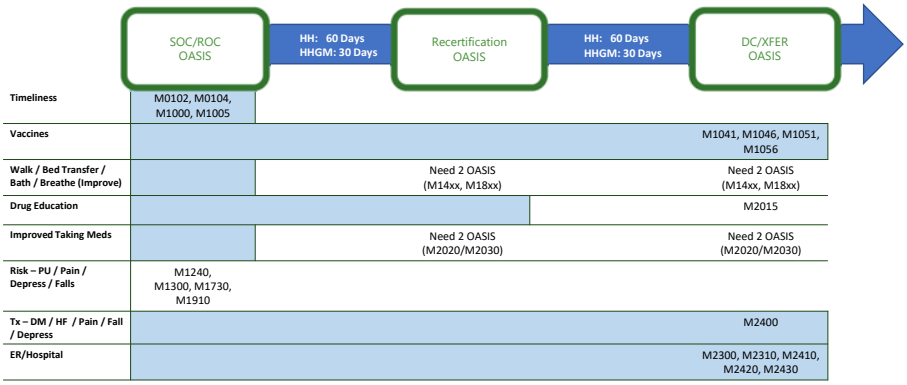
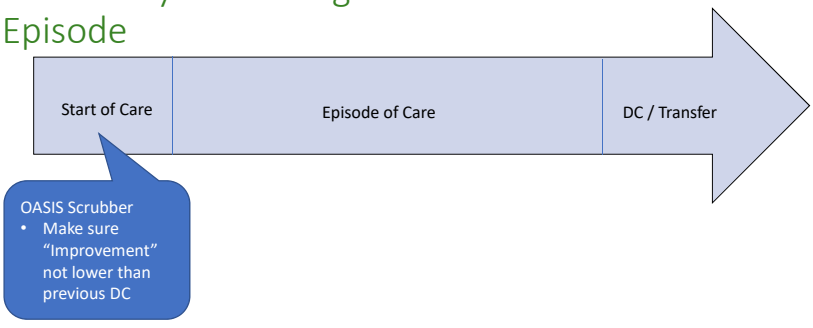
Problem: Majority of Outcomes ***AFTER*** D/C



Timeliness	M0102, M0104, M1000, M1005		
Vaccines			M1041, M1046, M1051, M1056
Walk / Bed Transfer / Bath / Breathe (Improve)		Need 2 OASIS (M14xx, M18xx)	Need 2 OASIS (M14xx, M18xx)
Drug Education			M2015
Improved Taking Meds		Need 2 OASIS (M2020/M2030)	Need 2 OASIS (M2020/M2030)
Risk – PU / Pain / Depress / Falls	M1240, M1300, M1730, M1910		
Tx – DM / HF / Pain / Fall / Depress			M2400
ER/Hospital			M2300, M2310, M2410, M2420, M2430

Data Analytics Throughout the Episode



OASIS Scrubber
- Make sure "Improvement" not lower than previous DC

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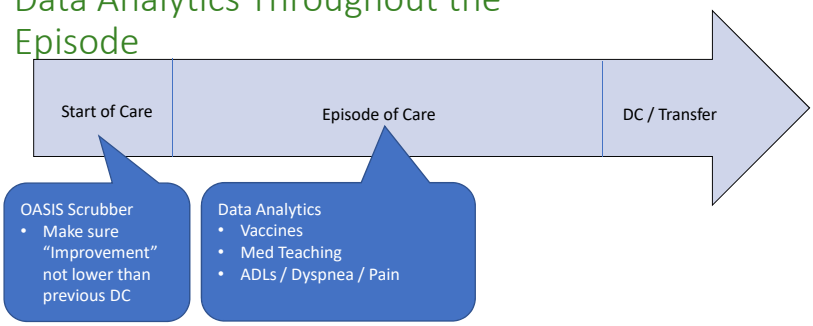
Data Analytics Throughout the Episode



OASIS Scrubber
- Make sure "Improvement" not lower than previous DC

Data Analytics
- Vaccines
- Med Teaching
- ADLs / Dyspnea / Pain

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Data Analytics Throughout the Episode

OASIS Scrubber
- Make sure "Improvement" not lower than previous DC

Data Analytics
- Vaccines
- Med Teaching
- ADLs / Dyspnea / Pain

Data Analytics:
- **Validation against clinical documentation**

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Reactive to Proactive to Affect Change

Example: **HHCHAPS**

- Collected post D/C
  - By law
  - Anonymous
  - Does not enable any specific actions
- Real-time "Customer" surveys
  - Voluntary
  - Non-anonymous
  - Every visit, weekly, monthly
  - Tie back to outcomes, clinicians
  - React to issues mid-episode

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Agency Capability – KPIs related to Outcomes

- Low CMI
  - Employee?
  - Referral Source
- Timeliness
  - MD - always request next day?
- Hospitalization Risk
  - What areas are worse than others
- Disease Management Outcomes
  - Does MD support orders that allows success?

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Agency Capability – KPIs – Related To Revenue

- Garbage In / Garbage Out
  - Outcome-based Revenue not synchronized with Episode Margin
  - Average vs Specific costs
- Who you Measure - Outcomes - need to be cut by who you sell to
  - Payer
  - Referral Source
- How your KPIs compare against "Partner's" KPIs
  - Insurers
    - HEDIS
  - Physicians
    - MIPS/MACRA
    - PQRS

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Metrics need to Follow the Dollars

METRIC	Home Health Compare	Five Star (National)	VBP (State)	ACO
PROCESS				
Timeliness	●	●		●
Drug Education	●	●	●	
Influenza	●	●	●	●
PNU			●	
Care Mgmt Types/Sources			●	
Screen Risk of Fall	●			●
Screen Depression	●			●
Screen Pain	●			
Screen PU	●			
Screen BMI				●
Screen Smoking				●
Screen HBP				●
Screen Colorectal				●
Screen Breast Cancer				●
Diabetic Foot Care	●			
Treated Pain	●			
Treated HF	●			
PU in Care Plan	●			
Treatment to prevent PU	●			
Med Reconciliation				●

OUTCOMES				
Ambulation	●	●	●	
Bed Xfer	●	●	●	
Bathing	●	●	●	
Pain/Activity	●	●	●	
Dyspnea	●	●	●	
Wound	●			
Community D/C			●	
Improve Mgmt Oral Meds	●		●	
Prior Func ADL/IADL			●	
HBP: Therapy				●
CVD: Statin Therapy				●
IVD: Aspirin/Thromoboltic				
HF: Beta Blocker				
CAD: Ace/Arb				
DM				
A1C				●
Eye Exam				●
ED Use	●	●	●	
HF				●
COPD				●
Readmission				●
SNF 30d				●
Depression				
Hospitalization	●	●		
DM				●
HF				●
Multiple CC				
Communication	●		●	●
Specific Care Issues	●		●	
Recommend?	●		●	
Care of Pts	●		●	●

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KPI's - QAPI vs Operations vs Disease Mgmt..

ALL

- Hospitalization rate first 15d post discharge
- Careful what population you use as the denominator

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KPI's - QAPI vs Operations vs Disease Mgmt..

ALL

COPD

- Hospitalization rate first 15d post discharge
- Careful what population you use as the denominator

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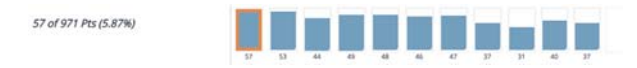
KPI's - QAPI vs Operations vs Disease Mgmt.

ALL



COPD

PNU

- Hospitalization rate first 15d post discharge
- Careful what population you use as the denominator

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Operationalizing

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Using & Interpreting Data to Improve Operational and Clinical Performance

- Volumes of data available
  - EMR systems
  - External reports
  - OASIS data
- Data = value
  - Define and measure performance
    - Define the data needed
  - Analyze the causes of variation
  - Develop solutions and strategies to resolve the problems
    - Able to focus on correcting the right problems

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Using Data to Define and Analyze

- Questions to ask of our data = what is it we need to know?
  - Opportunity to work with the hospital
    - How is their re-admission performance?
      - How does our agency impact this volume?
      - Specifically perform to assist to mutual goals of re-admission.
    - How does our agency perform for this hospital's discharges?
      - Are we getting the volume of referrals we should?
        - How easy are we to refer to?
      - How does our care model impact care?
        - Prevent re-hospitalizations?
        - Is our staffing model promoting care management and improving outcomes?

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Using Data to Define and Analyze

- How is their re-admission performance?
  - Source data from the hospital
    - https://data.medicare.gov/data/hospital-compare
      - AMI
      - HF
      - Pneumonia
      - COPD
      - Joint Replacement
      - CABG
- How does our agency perform for this hospital's discharges?
  - Specifically our performance on these indicators
  - Does the hospital refer enough of the patients to home care to benefit from the services?
    - Approximately 20% of all hospital discharges should require Home Health
      - Hospital data of referrals to home health (all providers, by primary diagnosis*)
      - * May want to expand on the diagnoses to capture the true picture of patients (many with multiple co-morbidities)

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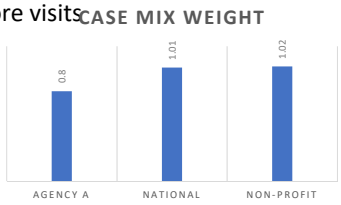
Using Data – Analyze Service Delivery

- How does our care model impact care?
  - High productivity but high caseloads of 50
    - Industry standard is 20 to 25
    - Pay model provides incentive to have more visits
      - Length of Visits
    - Episode Management
      - Case weights lower than average
        - Reported higher acuity patients



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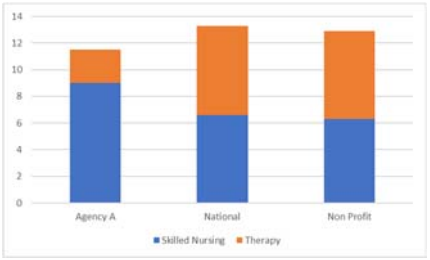
Using Data – Analyzing Service Delivery

- Continuity and care plan follow through
  - Admission model
  - 9 Nursing visits in an episode
  - Therapy Utilization lower than national at 2.5
- Salary model
  - Incentive for more visits
  - Misaligned incentives



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Using Data – Analyze the Service Delivery

- Patient outcome focus
  - Clinical manager model not focusing on outcomes
  - VBP purchasing miss
  - Star rating
- OASIS Accuracy
  - Outsourcing 75%
    - Processes to manage
    - Utilization of system

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Implementing Change

- Care Model Delivery change
  - Reduction of case loads
  - Creation of Team Based Care
    - Care pods
    - Continuity
  - Re-alignment of Incentives salary model
    - Incentives for care outcomes
    - Incentives for productivity expectation
  - Education & Specialization
    - Disease management
    - Care navigators
- Staff training
    - Accuracy
    - Consistent periodic re-training to ensure consistency
    - On-going OASIS training

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Agency Capability & Outcomes

- Capable partner
  - Reduce risk
  - Manage patients in the least costly setting
  - Demonstrate Outcomes
    - Risk Based contracts
    - Acute care referral partners
- Payer success
  - VBP
    - Enhance Clinical outcomes
    - Ensure OASIS Accuracy
- Data availability
  - Harvesting data
    - EMR
    - External Data Source
  - Knowledge is power

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Takeaways

- Ensure that data that is collected will provide agencies with the road map to reach their strategic goals.
- Data should be presented both internally for performance and used externally as a tool to position the agency within the market.
  - Data and metrics should promote value and cost savings to referral partners.
- All targets should be based on historical performance and industry benchmarks.
- Data should be used for expansion, diversification and improvement in service delivery. Think outside of the box!

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Driving Results

Rob Simione, Director robsimione@Simione.com

Julia Maroney, Managing Director jmaroney@Simione.com

800.949.0388 | Simione.com

Corporate Headquarters
4130 Whitney Avenue
Hamden, CT 06518

California Office
50 Professional Center Drive, Suite 200
Rohnert Park, CA 94928

Massachusetts Office
54 Main Street, Unit 3
Sturbridge, MA 01566

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