



**M A R W O O D   G R O U P<sup>®</sup>**

# **Evaluation and Analysis of Compliance and Care Management Systems**

**Presented to:**

**Amedisys, Inc.**

September 11, 2009

*New York • Washington, D.C. • London*

**This document does not constitute an audit. Findings included in this report are based on information and documents provided by Amedisys management; Marwood Group neither tested nor validated this information. Our observations and recommendations are based solely on the information and documents presented to us.**

**This report was finalized on September 11, 2009. However, all reviews were completed prior to the departures of Amedisys Chief Operating Officer Larry Graham and Chief Information Officer Alice Ann Schwartz on September 3, 2009. Marwood Group has been assured by Amedisys General Counsel that these resignations were not a result of pending federal, state, or local investigations. This report reflects the impact of these resignations where appropriate.**



Marwood Group Advisory and its affiliated companies (Member FINRA and SIPC) is a healthcare advisory and financial services firm headquartered in New York City with additional offices in Washington, DC and London. Marwood has over 90 employees and provides services to corporations, and institutional investors.

Marwood Group Advisory LLC provides specialized analysis for corporations, financial sponsors and other investors looking to evaluate the regulatory and reimbursement framework and risks associated with making direct investments in healthcare services, life sciences, and devices.



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## I. EXECUTIVE SUMMARY

The Marwood Group was asked to provide an independent analysis of Amedisys' ("Company") corporate compliance processes, procedures, controls, clinical infrastructure, technology offerings, and future strategies. In the absence of formalized home health industry standards, Marwood conducted a review of academic research, interviewed a representative population of home health providers, and utilized its home health industry, legislative, and regulatory knowledge to measure industry standards, best practices, and leading practices according to which Company practices were evaluated.

The Marwood Group is a nationally recognized provider of strategic advisory services to for-profit and not-for-profit healthcare corporations as well as private equity investors and their portfolio companies. The Advisory Group provides customized strategic and operational consulting services across all healthcare sectors and performs proprietary due diligence of federal and state legislative, regulatory and reimbursement environments and their impact on healthcare providers and investors. Marwood's professional staff is comprised of former senior White House staff, federal agency leaders (including CMS, FDA, HHS and AHRQ) and congressional committee staff (including Senate Leadership and Finance and House Leadership and Ways & Means) members as well as former senior healthcare operators from health plans and hospitals; former employees of state agencies; and former management consultants who monitor and analyze issues related to healthcare.

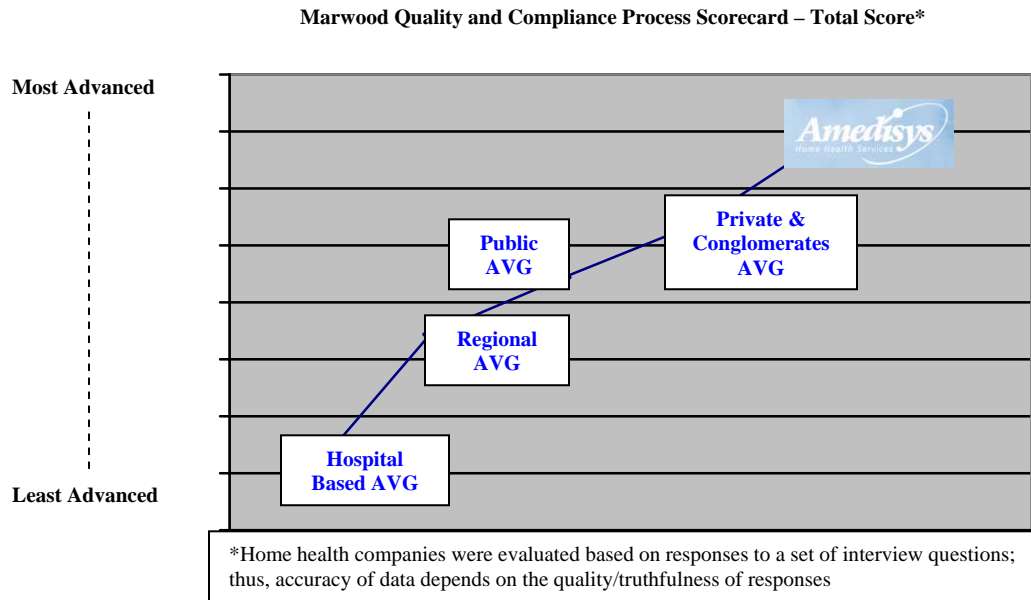
The home health industry does not have a standardized system to benchmark company compliance or quality improvement processes. Accordingly, Marwood developed a *Quality and Compliance Process Scorecard* in order to quantitatively assess organizational processes and structure. Our scorecard examines four major areas (process measures; quality improvement (including structure and initiatives); electronic data and nurse assessment; and patient satisfaction) and the elements that allow an organization to engage in best practice compliance and quality improvement processes. Each segment evaluates the necessary processes and scores current organizational processes and procedures.

Using a research member pool of senior executives, directors of quality, and quality assurance managers at corporate offices who agreed to participate in market research, Marwood arranged for phone interviews with senior management of home health companies, including the four publicly-traded home health companies, 14 large, private non-hospital home health companies with annual revenue greater than \$50 million, and four large hospital-based home health agencies. A copy of the question topics was distributed to each interviewee in advance to prepare for the call, and interviews were introduced as discussions on emerging trends in home health quality initiatives, with a focus on each organization's quality process.\*

Based on our *Quality and Compliance Process Scorecard* and information collected during our review of Company documentation and onsite interviews June 15-17, 2009, Marwood believes that, overall, Amedisys has implemented compliance and quality improvement processes that meet and/or exceed the industry average.

\* Information gathered from other home health agencies for comparative purposes was not tested or validated during the interview process. Other home health agencies did not share supporting documentation with Marwood.

In comparison to the other 17 publicly traded and Private Home Health/Conglomerate (Private) organizations evaluated by the *Marwood Quality and Compliance Process Scorecard*, Amedisys ranks sixth, with a score of 84.6 percent, in terms of its quality improvement and compliance processes. Amedisys ranks highest compared to other publicly traded companies. Scores for other home health agencies in this category range from a high score of 97 percent to a low score of 54 percent.\*



Using the survey data collected, a review of academic research, and expertise in the home health industry, Marwood established a set of industry leading practices, best practices, and industry standards in the following organizational areas: clinical quality, oversight and management infrastructure, corporate compliance, and technology.

**Industry leading practice:** an innovative practice that allows an organization to excel in the area of quality care, compliance, or patient satisfaction

**Best practice:** a practice that is recognized as showing superior results as compared to other processes and which is often used as a benchmark

**Industry standard:** the standard of practice that all providers should have implemented

Overall, Marwood believes Amedisys has implemented compliance and quality improvement processes that meet and/or exceed the industry average.

**Documentation Control Processes:**

Missing, inconsistent, or inadequate clinical documentation can lead to government recoupment of money previously paid to a provider for claims. Marwood reviewed Company documentation controls and processes, finding that the point of care system and systematic process of

\* Information gathered from other home health agencies for comparative purposes was not tested or validated during the interview process. Other home health agencies did not share supporting documentation with Marwood.

assessment review employed enables consistency and accuracy of documentation and represent best practice systems within the home health industry.

Home Health Operational Area	Type	Marwood Assessment: Research Defined Practice	Marwood Assessment: Company Practice
Documentation Control Processes: Field Clinician Coding Accuracy	Best Practice	Organization utilizes technology and/or systematic care assessments to detect inconsistencies in field clinician assessments prior to billing. Through electronic standardization, simple billing errors can be solved prior to bill submission.	Measures are built into the Company's point-of-care system to detect inconsistencies in patient assessments; data input is followed by a formal nurse review to ensure care consistency with best practices.
Documentation Control Processes: Field Clinician Coding Accuracy	Best Practice	Organization's technology infrastructure enables field clinicians and individuals reviewing claims for billing purposes access to electronic nurse assessment case data in real time.	Company utilizes a point-of-care system that allows field clinicians to directly input patient assessments and enables its team of Clinical Quality Coordinators to remotely review each assessment.

### Oversight and Management Infrastructure:

Based on documentation provided by the Company and information gained through informational interviews, Marwood believes that Amedisys has instituted an industry standard management structure which includes a corporate medical resource. The Company has also created industry best practice proprietary management reporting capabilities enabling management to closely monitor clinical quality and compliance issues. Marwood does, however, recommend the expansion of current clinician specific metrics in order to further improve nurse retention and clinical efficiency.

Home Health Operational Area	Type	Marwood Assessment: Research Defined Practice	Marwood Assessment: Company Practice
Oversight and Management Infrastructure: Centralized Medical Resource	Industry Standard	The employment of a corporate Chief Medical Officer is an important home health industry standard that enhances programs and clinical capacity.	The Company has recently hired a CMO responsible for defining clinical policy and initiatives as well as clarifying and standardizing the role of agency-specific medical directors.
Oversight and Management Infrastructure: Management Structure	Industry Standard	Organization's senior, regional, and local management goals are aligned.	The Company has instituted a system of checks and balances to ensure organizational, regional and local compliance with stated goals and requirements.
Oversight and Management Infrastructure: Management Reporting	Best Practice	Organization has the ability to electronically produce a set of metrics to be repeatedly used by management to identify potential compliance issues and improve care delivery.	The Company utilizes an automated, standardized tool (Risk Stratification Matrix) to identify those agencies which are at highest risk of regulatory non-compliance, thereby prioritizing the audits to be completed.

<b>Home Health Operational Area</b>	<b>Type</b>	<b>Marwood Assessment: Research Defined Practice</b>	<b>Marwood Assessment: Company Practice</b>
Oversight and Management Infrastructure: Management Reporting	Industry Standard	Regular internal auditing of clinical documentation to ensure compliance with minimum regulations.	Company management reviews a key statistics report each month for each agency as well as regional and corporate reports.
Oversight and Management Infrastructure: Performance Improvement Program	Best Practice	Organization has a formalized, central process improvement system coupled with an electronic system that enables each agency to track its quality improvement efforts and enables organizational management to oversee the tracking process.	The Company uses a scientific model to process improvement, allowing data driven results. Furthermore, the technological infrastructure employed allows management to continually provide feedback at both regional and corporate levels.
Oversight and Management Infrastructure: Management Reporting	Industry Standard	Regular internal auditing of clinical documentation to ensure compliance with minimum regulations.	Company management reviews a key statistics report each month for each agency as well as regional and corporate reports.
Oversight and Management Infrastructure: Performance Improvement Program	Best Practice	Organization has a formalized, central process improvement system coupled with an electronic system that enables each agency to track its quality improvement efforts and enables organizational management to oversee the tracking process.	The Company uses a scientific model to process improvement, allowing data driven results. Furthermore, the technological infrastructure employed allows management to continually provide feedback at both regional and corporate levels.
Oversight and Management Infrastructure: Performance Improvement Program	Industry Standard	Organization centralizes quality improvement initiatives across all agencies.	Each agency within the Company utilizes a quality improvement website. Regional and corporate management have remote access to assess progress at the agency level.
Oversight and Management Infrastructure: Nurse Specific Data	Industry Leading Practice	Organization employs a system of nurse specific scorecards in order to promote quality improvement and drive clinician-specific ownership of the care received by patients. (This practice is not fully implemented by the Company)	The Company uses clinician-specific outcome data in weekly care team conferences, and compiles a report which includes hospitalization trends by clinician. However, the Company compiles quality improvement data on a branch-wide level, rather than individual scorecards and does not compile and publish quality of care data on a clinician-specific level.

## Corporate Compliance

After a review of documentation provided by Amedisys, Marwood notes that the Company's corporate compliance program is Office of Inspector General (OIG) compliant.

Home Health Operational Area	Type	Marwood Assessment: Research Defined Practice	Marwood Assessment: Company Practice
Corporate Compliance	Industry Standard	Organization's corporate compliance program is compliant with OIG requirements and presented to employees in an uncomplicated, easy to understand format.	The Company's corporate compliance program employs readily discernable language and includes all of the elements required by the OIG.

## Technology and Innovative Company Initiatives

Marwood reviewed documentation and gained insight from senior management regarding the inner-workings of proprietary, innovative programs employed by the Company. Marwood notes that Amedisys has implemented home health industry leading and best practice programs aimed at increasing patient compliance with discharge instructions, increasing patient satisfaction, and increasing home health provider communication with referring physicians. Such initiatives are congruent with disease management/medical home proposals included within current health reform legislation under consideration in Congress.

Home Health Operational Area	Type	Marwood Assessment: Research Defined Practice	Marwood Assessment: Company Practice
Technology and Innovative Company Initiatives: Patient Compliance/Satisfaction Technology	Industry Leading Practice	The organizational practice of directly engaging patients post-home health discharge to increase compliance with discharge instructions represents a leading practice, as the practice aligns with current federal government initiatives regarding care management absent reimbursement for such services	Through its Encore program, nurses follow-up with discharged home health patients for a period of six months in order to enhance continuity of care and prevent costly adverse events (such as preventable re-hospitalization).
Technology and Innovative Company Initiatives: Patient Compliance/Satisfaction Technology	Best Practice	Practice of telephonic post-discharge follow-up.	Through its Encore program, the Company follows up with discharged patients by phone and collects patient satisfaction data.
Technology and Innovative Company Initiatives: Care Coordination Technology	Best Practice	Organization is able to use technology to enhance the efficiency and accuracy of information flow for both the physicians and the home health provider	The Company has developed its Mercury Doc system, which allows the home health provider to share information with the prescribing physician and enables direct physician order entry.

<b>Home Health Operational Area</b>	<b>Type</b>	<b>Marwood Assessment: Research Defined Practice</b>	<b>Marwood Assessment: Company Practice</b>
Technology and Innovative Company Initiatives: Care Coordination Technology	Best Practice	Organization's technology enables physicians to track the time spent on care plan oversight for home health patients.	The Company's Mercury Doc system assists physicians in preparing, approving, and transmitting patient care plans to the home health provider; tracking patient care vitals, progress, medication and other information; and communicating with the home health provider.
Technology and Innovative Company Initiatives: Clinical Algorithms	Industry Leading Practice	Organizational willingness to participate in the creation of models for transitional care absent reimbursement for such services.	The Company utilizes its Encore program of systematic follow-up with discharged home health, identifying patient needs leading up to and post-discharge.
Technology and Innovative Company Initiatives: Clinical Algorithms	Best Practice	Organization has developed clinical algorithms to stratify patients into corresponding pathways of care that inform field clinicians of appropriate guidelines for care.	The Company has created clinical algorithms and disease management programs outlining specific performance goals and clinical pathways for participants. The Company uses its proprietary point-of-care technology to prompt clinicians to adhere to established clinical pathways.
Technology and Innovative Company Initiatives: Clinical Algorithms	Best Practice	Organization assigns more advanced field clinicians (such as advanced practice nurses) to provide direct care for the most clinically complex, high risk patients.	The Company uses complexity of the care required as a variable in determining the appropriate type of caregiver. Advanced practice nurses are used on a consultative basis for patients with specific high-risk and complex conditions. APNs operate from remote locations, and use electronic tools to perform assessments and provide feedback to local caregivers.
Technology and Innovative Company Initiatives: Clinical Algorithms	Best Practice	Organization has developed the capability to electronically report and analyze clinical outcomes by care group.	Organization is able to electronically gather clinical outcomes data relative to each care group with the goal of enhancing quality of care received while containing the cost of care.
Technology and Innovative Company Initiatives: Clinical Algorithms	Industry Standard	Organization has stratified its home health patient population into care groups.	The Company utilizes patient data to determine the priority of specialty program and clinical algorithm development in order to segment patients into care groups.

Home Health Operational Area	Type	Marwood Assessment: Research Defined Practice	Marwood Assessment: Company Practice
Technology and Innovative Company Initiatives: Disease Management/Care Coordination	Industry Leading Practice	Organization has created programs designed to provide additional disease management support to patients during home health care episodes as well as after discharge from home care. This aligns with Congressional health reform language proposed to expand care coordination and disease management efforts.	The Company has created a patient-centered and physician-driven program (C4M) which will leverage existing reimbursement sources, while adding an un-reimbursed level of clinical oversight. Plans include using IT infrastructure and the Company's Encore program call center to control the cost of clinical oversight and care coordination.
Technology Controls	Best Practice	Organization employs technology to automatically ensure sufficient pre-billing documentation and the ability to lock down files post billing, as CMS plans to increase fraud and abuse investigations focused on billing.	The Company has implemented technology to ensure the completion of patient assessments as well as to prevent the alteration of patient records once a Quality Care Coordinator and the field clinician have approved its contents.

## II. OBJECTIVE

The Marwood Group was asked to provide an independent analysis of the Company's corporate compliance processes, procedures, controls, clinical infrastructure, and technology offerings. In addition, Marwood evaluated future Company strategies utilizing its knowledge of and forward-looking insight into the home health industry and the regulatory and legislative bodies that impact the home health space.

## III. METHODOLOGY

In order to better understand the programs and processes employed by Amedisys, Marwood conducted a series of on-site and phone interviews with the Amedisys team, followed by a review of over 11,000 pages of Company-specific documentation uploaded to the data room.

In the absence of formalized home health industry standards, Marwood conducted a review of academic research, interviewed a representative population of home health providers, and utilized its home health industry, legislative, and regulatory knowledge to measure industry standards, best practices, and leading practices according to which Company practices could be evaluated.

### A. Company-Specific Review

Marwood conducted an in-depth analysis of existing programs, procedures, processes, and controls. Analyses included a review of:

- Current and future controls intended to improve documentation, reduce risk, and enhance compliance with regulatory standards
- Organizational infrastructure with regards to coding, clinical oversight and auditing, as well as its corporate compliance program
- Existing specialty clinical programs and care algorithms
- The current technology platform for the improvement of patient care coordination

- The current technology platform for the improvement of physician care coordination
- A future chronic care program aimed at enabling higher levels of clinical oversight within a more chronic subset of patients
- Current and future controls intended to improve documentation, reduce risk, and enhance compliance with regulatory standards
- Organizational infrastructure with regards to coding, clinical oversight and auditing, as well as its corporate compliance program

Marwood reviewed documents provided by Amedisys to develop its analysis regarding the compliance, care management systems, and processes employed by the Company. (Please refer to Appendix I for a more detailed list of the corporate sources reviewed.)

Marwood conducted informational on-site interviews with the following Company leadership from June 15-17, 2009, followed by telephone interviews during the subsequent two-week period. Those interviewed were:

- Bill Borne, Chairman and Chief Executive Officer
- Larry Graham, President and Chief Operating Officer (Resigned September 3, 2009)
- Dale Redman, Chief Financial Officer
- Michael Fleming, Chief Medical Officer
- Jeffrey Jeter, Chief Compliance Officer and Corporate Counsel
- Alice Ann Schwartz, Chief Information Officer (Resigned September 3, 2009)
- Scott Ginn, Senior Vice President and Controller
- Janet Britt, Senior Vice President, Billing and Collections
- Tasha Mears, Senior Vice President, Clinical Operations
- Tom Fisher, Senior Vice President of Information Technology (Resigned July 31, 2009)
- Anne Frechette, Vice President of Disease Management
- Donna Massie, Vice President of Clinical Operations
- Martha Williams, Vice President of Training and Development
- Wanda Hull, Vice President of Specialty Programs
- Lisa Newell, Managing Director of Rehabilitation Specialty Programs
- Kimberly Marryott, Director of Corporate Rehabilitation Quality
- Diane Graham, Director of Regulatory/Clinical Service
- Iris Rancatore, Clinical Oversight Specialist

## **B. Literature Review**

The Marwood Group conducted a review of academic research in order to evaluate Company practices according to industry standards, best practices, and leading practices. Resources consulted include academic journals as well as industry-specific publications. Those referenced can be found in Appendix II.

## **C. Survey**

For purposes of this report Marwood conducted interviews with four publicly-traded home health companies, fourteen large private non-hospital home health companies with annual revenue greater than \$50 million, and four large hospital-based home health agencies. The hospital

systems surveyed included a 10+ hospital/2,000 bed system, a 7 hospital/1,500 bed system, a 4 hospital/800 bed system and a 1 hospital/250 bed system. Marwood arranged phone interviews of at least 30 minutes with a group of senior executives, directors of quality, and quality assurance managers at corporate offices from each organization. A copy of question topics was distributed to each interviewee to prepare for the call and interviews were introduced as discussions on emerging trends in home health quality initiatives, with a focus on each organization's quality process. These interviews occurred July 22-29, 2009.

#### **IV. INDUSTRY & COMPANY OVERVIEW**

Approximately 7.6 million individuals<sup>1</sup> currently receive home health care from 83,000 providers for acute illness, long-term health conditions, permanent disability, or terminal illness. The continued development of medical technologies to support in-home care, the substantial cost savings offered by keeping patients out of an institutional setting, and an increasing patient preference for care in the home have led to strong growth in the home health industry. The Center for Medicare and Medicaid Services (CMS) estimated that 2008 national home health expenditures increased by 9.1 percent over 2007, to \$64.4 billion.

The Medicare Payment Advisory Commission (MedPAC), an independent congressional agency which advises Congress on issues affecting the Medicare program, estimated Medicare home health profit margins for 2009 will continue to run in excess of 12 percent, even with the significant payment cuts promulgated by the 2008 payment revamp and MedPAC recommendations to freeze the Medicare home health market basket. This is likely due, at least in part, to the expectation that demand will grow faster than the overall market because of an aging U.S. population and an increasing prevalence of chronic and co-morbid conditions treatable at home. Thus, an increased volume of home health patients is likely to alleviate some pressure on falling profit margins caused by diminished reimbursement.

The home health industry is fragmented, comprised of several large players and a multitude of smaller, single market or regional home health agencies. Most are local or regional independently-owned agencies, visiting nurse associations or hospital-affiliated agencies. Consisting of approximately 9,800 Medicare-certified home health agencies, the home health industry's largest payer is Medicare, spending \$16.6 billion on home health care services in 2008.

The Company is one of four large, publicly traded providers of home health care in the U.S. The company's objective is to be the nation's leader in traditional homecare services, using technology and evidence-based clinical practices while leveraging its core competencies into a "comprehensive continuous chronic care management" (C4M) model. It envisions home health providers as the future center of care coordination for those requiring chronic care with a strategy that encompasses:

- Strengthening relationships between primary care and home health providers
- Increasing the utilization of technology in order to best leverage talent
- Improving outcomes and controlling costs
- Developing targeted, disease-specific programs for the elderly with multiple chronic health issues in collaboration with primary care physicians

In recent years, the Company has grown both organically and through multiple acquisitions. It experienced dramatic growth in 2008, acquiring 145 agencies and increasing net revenue by 70 percent and net income by 33 percent when compared to 2007. It has also experienced organic growth in 2008, with an increase of 11 percent in the number of internal admissions. Currently, the Company has more than 500 locations, providing services to patients in 37 states as well as the District of Columbia and Puerto Rico.

As the Company grew in size, the importance of corporate compliance and clinical quality oversight grew in tandem. In 2003, as the result of self-reported questionable conduct by the former operator of one of its agencies, the Company signed both a Settlement Agreement and a Corporate Integrity Agreement with the Office of the Inspector General (OIG) and the Department of Justice, requiring the payment of a financial settlement in the amount of \$1.2 million. The Corporate Integrity Agreement (CIA), binding for a three-year period, required that the Company maintain its existing compliance program, establish enhanced training requirements, schedule annual claims audits of the subject agency by an independent reviewer, and regularly report to the OIG. It also stipulated penalties in the event of non-compliance, including the possibility of exclusion from the Medicare program. The CIA expired in 2006, with the Company successfully fulfilling the necessary requirements. Many of the Company's efforts over the past few years have focused on improving compliance, documentation and quality; the Company has developed a point-of-care field clinician assessment technology that allows records to be instantaneously accessed and reviewed by a team of nurses specially trained in home health coding and compliance with industry regulation.

In addition, Marwood expects that in an era of budget deficits and growing healthcare expenditures, program integrity efforts will be expanded and intensified. President Obama's budget included increased funding to fight fraud and abuse. Moreover, in May 2009, his administration announced the formation of a Health and Human Services (HHS) and Department of Justice (DOJ) senior-level taskforce: the Health Care Fraud Prevention & Enforcement Action Team (HEAT). Additional fraud and abuse initiatives are included in healthcare reform legislation currently being developed in Congress.

Accordingly, Marwood placed particular emphasis on gaining an understanding of the tools and procedures the Company has in place to ensure ongoing quality of care as well as containment of potential compliance-related risks in a rapid growth environment.

In the absence of formalized home health industry standards, clinical quality, compliance, and technology adoption vary from company to company. Medicare outlines a basic set of organizational requirements that must be met to qualify as a Medicare home health care provider. Other practices and procedures employed are considered good business practices, while a select few home health organizations which strive to be industry leaders have implemented practices and procedures that improve compliance, operations, and ultimately quality of care.

## **V. DOCUMENTATION CONTROL PROCESSES**

### **A. Government Revenue Recovery Initiatives**

As part of continued federal initiatives to ensure accurate payment for appropriate care, the HHS Secretary held a demonstration project to investigate and identify over- and underpayment of Medicare claims in select geographic areas authorized by Congress in the 2003 Medicare

Modernization Act. In order to recoup overpayments, Recovery Audit Contractors (RACs) were utilized; any overpayments identified were then applied to the Medicare Trust Fund. In its July 2008 report on the demonstration project, CMS indicated that RACs corrected more than \$1.03 billion in improper Medicare payments. Four percent were underpayments requiring CMS to further compensate providers. Ninety-six percent were overpayments, which were recouped from providers.

In October 2008, CMS formalized the national roll out of the RAC program, as mandated by Congress in the Tax Relief and Health Care Act. CMS has reorganized the program into four regions, and has been adding states to the program throughout 2009. Additional initiatives are included in health care reform legislation being developed in Congress.

Inconsistency, inadequacy, or the absence of clinical documentation can lead to government recoupment of money previously paid to a provider for such claims. Amedisys has implemented and is continuing to refine a variety of documentation control initiatives to ensure the presence of clinical documentation to support claims filed.

#### **B. Documentation Control Programs and Processes: Field Clinician Assessment Coding Accuracy**

Accurate coding of claims has become increasingly important in the home health industry, as the payment methodology used by Medicare continues to evolve. Medicare, which reimburses agencies for 60-day episodes of care, accounted for 87 percent of the Company's revenue in 2008. The amount each agency is reimbursed for an episode of care is based largely on an initial patient assessment which is conducted by a registered nurse or physical therapist. Critical drivers of the reimbursement rate include diagnosis coding; the acuity and degree of services required, including therapy; and the degree of functional impairment of the patient.

In a high-growth corporate atmosphere, it is critically important that appropriate internal controls be in place to minimize compliance and quality issues. Coding of diagnoses and the completion of the Medicare patient assessment (OASIS) form are highly complex and technical in nature. During the past year, the Company has focused on centralization of the review of initial patient assessments and related coding in an effort to improve consistency, accuracy, and compliance. Currently, 206 Quality Care Coordinators review assessments for each of approximately 700 new admissions each day. These coordinators are able to view patient assessments from remote locations, utilizing an internally developed, proprietary point-of-care technology also used by its clinical employees to capture patient encounter data.

Quality Care Coordinators are registered nurses, many of whom are also certified coders. These coordinators review assessments for accuracy and consistency and act as resources for field clinicians performing assessments. In the event that a potential inconsistency or inaccuracy is noted, the Quality Care Coordinator discusses the observation with the clinician who completed the patient assessment. The clinician who completed the assessment then decides whether an inconsistency or inaccuracy exists, and makes corrections accordingly. The Company is in the process of installing technology that would allow a Quality Care Coordinator to electronically question items in a patient assessment. In addition, this technology will allow field clinicians to electronically accept or deny the change and thus bring resolution to the disputed item. In keeping with the Company's policy, no changes are made without the consent of the field

clinician. The enhanced technology will be implemented company-wide during the fourth quarter of 2009.

In addition, the point-of-care technology has further controls embedded in the assessment documentation process. For example, if a field nurse documents that a patient is taking insulin but does not document the presence of diabetes as a diagnosis, the system alerts the nurse to a possible inconsistency and does not permit further data entry until the inconsistency is resolved.

Case mix, driven to a large extent by the results of initial patient assessments, is an indicator of the intensity of care required by patients of a particular agency. A higher case mix indicates more extensive clinical needs, which can result in higher reimbursement rates. Company management regularly monitors the case mix of individual agencies as well as case mix reports on a regional and corporate level using its proprietary Risk Stratification Matrix. A high case mix places an agency into a higher risk category within the Risk Stratification Matrix. Appearance in a higher risk category leads to intensified agency oversight by regional and corporate personnel.

In addition to the point-of-care and risk stratification technologies, the Company also has implemented a compliance program that expressly prohibits up-coding of claims. Regular compliance training is required for all employees. To further ensure compliance, the Company has developed detailed flow charts that describe the flow of information related to the patient assessment process and provide ongoing education to employees involved in the process.

#### Marwood Assessment

Based on the results of Marwood's survey of home health organizations as well as the knowledge of experts in the area of home health care assessment coding accuracy, industry best practices encompass the following programmatic aspects:

- 1) Organization's technology infrastructure gives field clinicians and individuals reviewing claims for billing purposes access to electronic nurse assessment case data in real time. Electronic filing not only allows the organization an instantaneous opportunity to review the assessment, it also provides standardization across all field clinicians. Marwood understands that 14 of 18 major non-hospital based home health organizations surveyed utilize systems that allow nurses to submit assessments electronically.
- 2) Organization utilizes technology and/or systematic care assessments to detect inconsistencies in field clinician assessments prior to billing. Through electronic standardization, simple billing errors can be solved prior to bill submission. Marwood understands that 13 of 18 major non-hospital based home health organizations surveyed have implemented technology aimed at minimizing inconsistencies within field clinician assessments.

The inclusion of the programmatic aspects outlined above in the Company's system of centralized assessment evaluation and coding leads Marwood to classify this process an industry best practice in minimizing errors and enhancing the consistency of clinical information. The process by which 200 employees are kept updated regarding technical coding issues is far simpler than updating 10,000 clinicians in the field. The review of every claim by a Quality Care Coordinator also can be characterized as an industry best practice, as reviewers are able to catch inconsistencies in advance of billing. However, one risk associated with the centralization of

these functions is that field clinicians may feel that their judgment is being questioned during the assessment review process. Marwood believes that effective centralization is the balance between expected gains in efficiency and possible employee alienation; alienating field nurses, by continuously subjecting their field judgments to review by Quality Care Coordinators, could result in higher levels of nurse turnover.

Marwood understands that some other home health agencies address this issue by utilizing specific teams of admissions personnel at each branch, as opposed to completely centralized coding and assessment review teams. The Company utilizes regionally assigned Quality Care Coordinators for each branch. Because the Company is sizable and serves many small or rural markets, the centralization of the coding and assessment review functions should be an effective and efficient way to ensure accuracy and consistency.

The addition of technology that enables the electronic exchange of patient-encounter data between the field clinician and the reviewer, as well as measures built into the Company's point-of-care system to detect inconsistencies in patient assessments (followed by a formal nurse review) are consistent with industry best practices as outlined above. Electronic documentation related to the interaction between the Quality Care Coordinator and the field clinician (including a record of the filed clinician sign-off), enhances billing documentation. Marwood suggests that the verbal discussion between the field clinicians and Quality Care Coordinators continue in conjunction with electronic communications. According to documentation provided by the company, Amedisys has already outlined plans to ensure this.

The inclusion of the risk of non-compliant up-coding in the Risk Stratification Matrix regularly reviewed by the management team also represents an industry best practice utilization of technology infrastructure to further clinical compliance. The presence of direct verbiage regarding up-coding in the Corporate Compliance Program demonstrates the Company's knowledge of the importance of closely monitoring clinical quality and accurately capturing services provided.

## **VI. OVERSIGHT AND MANAGEMENT INFRASTRUCTURE**

### **A. Corporate Medical Resource**

The Company recently hired a primary care physician with more than 30 years of experience in clinical practice to assume, full-time, the newly created role of Chief Medical Officer, reporting directly to the CEO. The Chief Medical Officer has three primary areas of focus: internal clinical affairs; industry advocacy; and forging strategic partnerships with organizations.

In his work with internal clinical affairs, the Chief Medical Officer oversees the establishment of clinical policy and initiatives, ensuring the alignment of the Company strategy with that of the overall healthcare industry and related government initiatives. He also works to further define and clarify the role of local medical directors.

#### Marwood Assessment

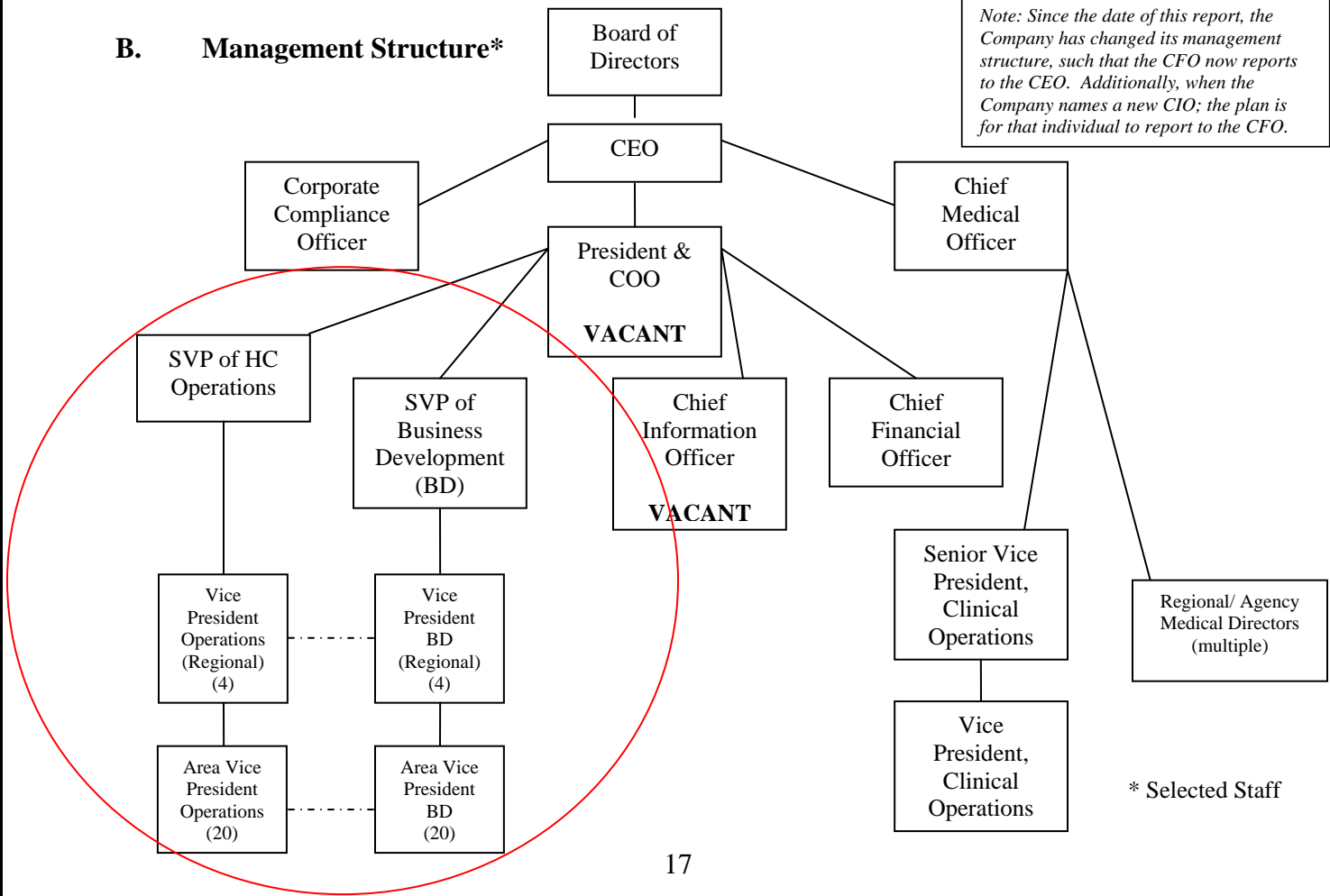
Based on a review of academic research and healthcare industry expertise in the area of home health organizational oversight, the employment of a corporate medical resource is an important industry standard.

According to a report published by the Institute of Medicine<sup>2</sup>, at least 44,000 people, and perhaps as many as 98,000, die in hospitals each year as a result of medical errors- the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim that could have been prevented. These errors are not all attributable to inpatient hospital care. One of the report's main conclusions is that the majority of medical errors do not result from individual recklessness or from the actions of a particular group. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them. One frequently cited problem is the decentralized and fragmented nature of the healthcare delivery system, including a lack of the communication necessary to ensure quality care. The need to focus on the quality of care delivered necessitates a corporate medical resource responsible for these issues; simultaneously, board members as well as senior management of healthcare organizations are placing additional importance on the role. Chief Medical Officers are medical strategists from a business perspective, responsible for putting in place programs and initiatives to ensure quality of care and patient satisfaction.

Marwood believes that the employment of a corporate Chief Medical Officer is an important home health industry standard and should further enhance the clinical capacity and programs of the Company. Standardizing the role and responsibility of all Company medical directors provides additional assurance of compliance with Company and industry regulations. The increased medical leadership and expanded capacity for physician interaction provided by the addition of this corporate executive is likely to strengthen the relationship between the Company and physicians.

**B. Management Structure\***

*Note: Since the date of this report, the Company has changed its management structure, such that the CFO now reports to the CEO. Additionally, when the Company names a new CIO; the plan is for that individual to report to the CFO.*



The Company's clinical team reports ultimately to the President and Chief Operating Officer. Operations, clinical oversight, and business development functions are strongly linked throughout the organization. Vice Presidents of Operations (who oversee clinical operations) are teamed with Vice Presidents of Business Development, and Area Vice Presidents of Operations are teamed with Area Vice Presidents of Business Development. Each Area Vice President is responsible for approximately ten agencies.

On September 3, 2009 Amedisys Chief Operations Officer and Chief Information Officer resigned effective immediately. According to Company management the strong connection between the clinical and operations teams as well as the management structure outlined above will remain unchanged. The Senior Vice President, Clinical Operations will remain closely tied to technology decisions, ensuring coordination between clinically and operationally focused portions of the company.

### Marwood Assessment

Academic research has been published regarding the alignment of senior, regional and local management goals to improve quality. According to an article published in the *Journal of Healthcare Finance*<sup>3</sup>, organizational change is possible when both senior management and local/regional managers decide that such a change is desirable. Improvement in organizational operations is a result of the alignment of local/regional and senior corporate management goals.

Accordingly, Marwood notes that the Company's clinical organizational structure is well integrated in its overall operations; business development and clinical services are partnered in order to achieve the Company's goals. The ratio of agencies to local, regional, and corporate personnel as presented to us is exactly that which would support a strong clinical organization.

## **C. Management Reports**

The Company is able to produce multiple management reports, some of which condense information from a variety of sources into a format that is readily used by the management team. One of these reports, the Risk Stratification Matrix (RSM), is prepared twice each year and displays operational, financial, and clinical indicators, helping area and corporate management teams to prioritize agencies requiring more intensive oversight. Indicators used in the RSM include operational audit reports from the prior quarter; specific variances related to the revenue cycle; employee turnover statistics; publicly reported clinical outcomes; growth in Medicare admissions; turnover in key leadership roles at the agency level; condition level survey deficiencies; focused medical review; and performance improvement compliance. Additionally, if an agency has been acquired or has started operations during the prior 12 months, it is placed into a higher risk category.

Each RSM indicator is scored based on agency performance and benchmarked internally and/or externally, as appropriate. Scores are higher for agencies which demonstrate a greater potential for operational dysfunctions. For example, an agency which receives a condition level deficiency in a regulatory survey would have four points added to its score. If an agency has employee turnover that is 20 percent higher than the Company average during the period of evaluation, two points would be added to the agency score.

Agencies which score in the highest 10 percent of the Company are subject to a Clinical Oversight Process (COP) Audit conducted by an Area Vice President. This COP audit focuses on the five most common survey deficiencies for the entire Company, as determined by the clinical leadership team. Additionally, the Area Vice President evaluates a sampling of claims billed. Agencies are required to create action plans to address any issues identified in the COP audit.

In addition to this semi-annual Risk Stratification Matrix, Company management reviews a key statistics report each month, which contains information regarding the volume of patients served as well as key financial indicators specific to Medicare, such as revenue per episode; visits per episode; percentage of low utilization payment adjustments (LUPAs) or outliers (both of which are reimbursed differently than the standard episodic rate); the case mix; and information regarding therapy utilization. Key statistic reports are produced for each agency and rolled up into area, regional, and corporate reports.

Technology used by the Company creates a daily report to assist local management teams in identifying patients who are at highest risk for emergent care or hospitalization. The system creates a risk factor analysis by compiling scores on particular OASIS measures and stratifies the patients into risk categories. The report is color-coded, with patients who fall into high or very high risk categories highlighted in red lettering. The report is used by local Directors of Operations in weekly care team conferences to prioritize care coordination and proactive intervention.

The Company also regularly produces detailed management reports to track regulatory survey results, including the dates and types of surveys; deficiencies received; whether a plan of correction has been submitted and accepted or rejected; and whether further follow up is indicated. These reports are color coded to assist the leadership team in prioritizing information. Certain deficiencies identified are tracked and trended, with results benchmarked internally as well as externally.

The point-of-care system implemented by the Company enables enhanced patient care data availability and management tracking. Within the design and implementation of these electronic medical records, Amedisys has also included controls to enhance consistency, accuracy, and completeness of patient care documentation. For example, when a plan of treatment (OASIS Form 485) is created for a new patient, a one-page pop-up document is also created which can be readily produced in the event of an audit. The document focuses on areas which are of particular importance in a claims audit such as justification of the medical necessity of care and ICD-9 coding. It also documents the reason the patient is home-bound and must receive care in the home setting rather than another setting.

The Company has established and clearly documented the process to be followed when agencies are visited by regulatory surveyors. Area and corporate personnel are notified when a surveyor arrives, and provide branch level personnel with required reports as well as any additional support that may be needed.

#### Marwood Assessment

After reviewing survey results collected in the area of home health clinical and operational oversight, regular auditing of clinical documentation represents the industry standard. Survey

results demonstrate that all 18 major non-hospital based home health organizations regularly audit clinical documentation, with 12 stating that they audit monthly and six stating quarterly. However, using an automated, standardized tool to identify those agencies at highest risk is uncommon throughout the industry.

Marwood believes that the reported metrics and their regular use by management to identify potential compliance issues and improve care delivery represent an industry best practice. The Company has succeeded in creating management tools which are concise and focused on areas of operational importance. Because of a sophisticated IT infrastructure, reports are readily available to local, area, regional and corporate personnel. Marwood understands that approximately 15 of 18 major non-hospital home health agencies surveyed are able to electronically capture data regarding the quality of home health care provided. The use of color coding to draw one's attention to higher risk operational indicators further simplifies the use of the reports.

The Company's ability to leverage its size and IT capabilities to create automated data management systems and reporting mechanisms that are accessible and easily useable by its management team represents an industry best practice. Although the RSM process is a best practice and focuses the organization on high risk entities, Marwood suggests the Company ensure that each agency is audited at least once a year. Relying purely on a data driven process could allow resourceful agencies the opportunity to manipulate the reporting structure, thus allowing them to avoid an audit. Establishing an annual audit process for all agencies could avoid this issue.

#### **D. Performance Improvement Program**

CMS, state regulatory bodies and accrediting organizations all have certain minimum performance and quality improvement requirements for home health agencies. Agencies are required to gather and report data regarding infections, complaints, incident reports, clinical documentation, and common performance indicators to be displayed on the CMS website. Agencies are also obligated to convene quarterly meetings of a quality improvement committee and to perform overall evaluations of operations on an annual basis.

The Company has created policies which clearly describe the composition and rationale of its performance improvement program; the program draws from Deming's FOCUS-PDCA model for performance improvement and is composed of a variety of activities, including adverse event monitoring; targeted outcomes; reporting of infections, incidents and complaints; satisfaction survey results; data related to patient falls; utilization review; agency specific indicators; and the annual agency evaluation. Additionally, a detailed description of its Clinical Oversight Process (COP) and clinical audit process is included within the program, as these are an important aspect of the Company's corporate compliance and performance improvement initiatives.

Information is gathered monthly at the agency level and reported to quality/performance improvement committees quarterly. These committees are divided in a manner which ensures the representation of each clinical area. In the event that an agency does not meet performance thresholds, a plan of action must be created to address any deficiencies, followed by a detailed root cause analysis. Results achieved through the plan of action are reported at the subsequent committee meeting. In order to streamline this data-gathering process and allow for remote

oversight of quality improvement efforts and results, the Company has created a performance improvement website for each of its agencies.

The Company has also implemented an additional, more stringent quarterly review called “Patient Tracer.” Management selects two patients per agency and performs home visits to observe personnel, noting either consistencies with or variance from the information and instructions documented in clinical and personnel records.

### Marwood Assessment

After reviewing academic research as well as survey responses collected in the area of home health performance improvement, both process and consistency are two key themes. Industry best practices identified include:

- 1) Organization has a formalized process improvement system such as the Institute for Healthcare Improvement recommended “Model for Improvement” which suggests the implementation of the Plan-Do-Study-Act (PDSA) cycle.<sup>4</sup> This model is a cyclical improvement tool, which places continued focus on improving processes. Central to such models is the ability to have an electronic system that enables each agency to track its quality improvement efforts as well as organizational management to oversee the process.
- 2) Organization has centralized its quality improvement initiatives across all agencies. Marwood understands that 17 of 18 major non-hospital based home health organizations surveyed centralize their quality improvement efforts.

Marwood notes that the Company’s performance improvement program meets and exceeds industry standards, focusing appropriately on high risk, high volume areas of risk. By using Deming’s PDCA model, Amedisys applies a scientific model to process improvement, which allows data driven results. The Company uses its sophisticated technological infrastructure to continually provide feedback both on the regional and corporate levels.

We believe that both the Company’s corporate office and its singular agencies have appropriate levels of oversight responsibility to minimize clinical and quality discrepancies. While the corporate office has designed the performance improvement program and provides ongoing oversight and direction, individual agencies monitor both indicators driven by the overall organization as well as those specific to the historic performance of that agency. Each agency utilizes a quality improvement website, which also allows regional and corporate management remote access to assess progress at the agency level.

### **E. Nurse Specific Data**

Amedisys currently collects particular information on a clinician-specific basis to assist with clinical management. On a daily basis, Amedisys provides each branch with a report for all current patients by clinician, measuring change in patient status from the previous day. In addition, on a monthly basis, Amedisys produces an aggregate report listing all hospitalizations by clinician for the branch. The information is reviewed daily by each local Director of Operations for real time intervention, and is distributed to the clinical staff each week during care team conferences. Reports are color coded, using red, yellow and green to illustrate decline or improvement in patient conditions and are consolidated for use by area and corporate personnel.

## Marwood Assessment

After reviewing survey results and in consultation with home health experts in the area of nurse specific data, the practice of utilizing a system of nurse specific scorecards in order to promote quality improvement and drive clinician-specific ownership of the care provided to patients represents an industry leading practice.

Marwood understands that one of the leading major non-hospital based home health organizations has developed a nurse-specific scorecard which centers around four key types of metrics: traditional outcomes measures; process-oriented quality improvement planning for specific populations of patients; patient satisfaction data, including timeliness of arrival and patient suggestions; and cost of care metrics, allowing the organization to review the type and appropriateness of visits received and the ultimate payment received.

Field clinicians document patient interactions electronically through point-of-care technology, allowing data to be accurately compiled. The organization posts this nurse-specific quality data monthly on an internal website so that field clinicians and management can monitor performance on a monthly basis. This organization communicated that field clinicians regularly visit this website as soon as data is posted each month, and that the creation of these scorecards has produced a heightened awareness of clinical quality as well as the potential for improvement. In the past, high performing field clinicians have received performance related bonuses based on their scorecard results. The organization also attributes its relatively low nurse turnover rate in recent years (15 percent or below) to this program and the transparent significance that the company places on the provision of superior patient care.

Marwood recommends that Amedisys consider expanding its current clinician-specific performance metrics. We maintain that an individual clinician scorecard program could represent a viable method for improving nurse retention and clinical efficiency, by providing timely feedback on clearly established performance expectations. Marwood understands that 11 of 18 major home health organizations surveyed collect clinical outcome data on a nurse specific level, with the vast majority sharing data collected with individual nurse clinicians on at least a quarterly basis.

It is recommended that Amedisys create a balanced scorecard for each clinician, integrating quality of care metrics as well as patient satisfaction and cost of care measurements. Such a score card could allow individual performance to be internally benchmarked against performance expectations for the local branch, area, and overall organization and could also be integrated into annual performance appraisals of clinicians. Integrating cost of care data could help to increase clinician awareness of the financial impact of their clinical decisions, while the integration of patient satisfaction data also corresponds with the Company's existing practice of gathering such information through its Encore program (See Page 24).

Research reviewed<sup>5</sup> also suggests that the only nurse retention interventions statistically significant in field clinician job satisfaction were the existence of supportive strong management, competent peers, agency support of nursing judgment, solid orientation, and support of professional nursing practices.

Marwood recommends that the Company consider the implementation of a random field clinician survey such as the Nurse Work Index-Revised (NWI-R), or other tested tool, to better understand the most valued agency traits. NWI-R is a total of 49 specific work environment traits associated with positive nurse and patient outcomes. In a recent NWI-R survey<sup>6</sup> of home care nurses throughout the U.S., the following ten factors were of high importance to respondents, in order of importance:

1. Supervisory staff that is supportive of nursing
2. Working with nurses who are clinically competent
3. Not being placed in position of having to do things that are against my nursing judgment
4. A nurse manager who is a good manager and leader
5. A good orientation program for newly employed nurses
6. Freedom to make important patient care and work decisions
7. An administration that listens and responds to employee concerns
8. Good relationships with other departments
9. The plan of care is accessible and up to date for all patients
10. Enough registered nurses on staff to provide quality patient care

## **VII. CORPORATE COMPLIANCE**

The Corporate Compliance Program maintained by the Company contains the elements established by the Office of the Inspector General in the *Federal Register*, Volume 63, No. 152, dated August 7, 1998. These elements include:

- A written Standard of Conduct for employees and directors;
- A Chief Compliance Officer who reports directly to the Chief Executive Officer and governing body;
- An effective and regular training and educational program for employees related to compliance;
- A process and mechanism for employees to report suspected misconduct without fear of recrimination (e.g., an employee hotline);
- A system to respond to allegations of misconduct;
- An ongoing system to monitor functions which are at high risk for fraud or abuse; and
- A mechanism for investigation and remediation of identified system problems, and development of policies regarding non-employment or retention of sanctioned individuals

All Amedisys employees receive training regarding the corporate compliance program, including standards of conduct, during orientation and on an annual basis. Compliance with training requirements is monitored at the corporate office, as training is completed through electronic learning centers. The Company employs a Chief Compliance Officer (CCO), reporting directly to the Chief Executive Officer, who presents a compliance report to the Board of Directors each quarter. The CCO attends all Board and audit committee meetings and has the authority to attend an executive session of the Board in the absence of the Chief Executive and Chief Operating Officers.

As part of the compliance program, an employee hotline was created for the reporting of suspected misconduct with policies in place which prohibit recrimination against employees who

report misconduct or suspected misconduct. The Corporate Compliance Plan also includes written policies which define the system used to respond to alleged misconduct.

Clinical record audits are an important component of minimizing compliance-related issues. The auditing of clinical records is overseen by a Vice President of Compliance, with a background in auditing, and performed by eight nurse auditors. Audits are completed from remote locations using the Company's point-of-care system. This allows auditors to review records without prior notice to local management teams. Each quarter, agencies are rated and audited according to risk, including complaints; results of exit interviews; internal polling; and the Risk Stratifications Matrix. Auditors are not assigned geographically or to specific agencies, and not all agencies are audited on a regular basis. Priority is given to agencies as designated by the compliance management team.

The Human Resources Department screens all involved employees for exclusion from participation in the Medicare and Medicaid programs prior to hire and on an ongoing basis thereafter. The Company has a written policy regarding non-employment and retention of sanctioned individuals. In addition, every employee leaving the Company is invited to complete an online exit interview that includes ten compliance related questions. Each month, the Human Resources Department reports the results of these interviews to the Compliance Department.

The Compliance Department employs an attorney trained to investigate potential issues and trouble areas as well as a Director of Legal Compliance responsible for ensuring compliance with HIPAA regulations when responding to outside requests for medical records.

The aforementioned compliance programs were ramped-up following the issuance of a Corporate Integrity Agreement in 2001, which has since expired. Continued compliance with all industry regulations has been made an extremely visible Company priority.

The Company's Clinical Services Department and Clinical Operations Department, comprised of 8 clinicians and 15 other non-clinical employees, play an important compliance function by training agencies concerning compliance with Company policy, Medicare Conditions of Participation, and other state and federal laws and regulations. Additionally, the Company maintains a separate Acquisition Integration team, consisting of 13 clinicians and 5 non-clinical employees, which perform this role for newly acquired agencies. This team also performs chart audits of agencies the Company proposes to acquire, as part of the Company's pre-acquisition due diligence procedures.

The Corporate Compliance Department takes an active role in evaluating potential acquisitions, and the Chief Compliance Officer has the authority to prevent an acquisition if he determines that the acquisition would put the Company at risk from a compliance perspective. For example, the Company acquired an additional home health agency, which is operating under a Corporate Integrity Agreement with the federal government which was established prior to acquisition and expires in May 2010. This Corporate Integrity Agreement was instituted to ensure compliance with government regulations related to contractual relationships with individuals and organizations able to refer business to the company. In order to ensure compliance, the Company transitioned the new home health agency's processes to their centralized contracting function, which includes leases, and requires all contracts and leases to be evaluated by the Compliance Department for reasonableness. The Compliance Department also approves all contracts with and invoices from Medical Directors; these contracts and subsequent invoices for

services provided by Medical Directors are entered into a proprietary software system which compares the charges to the contracts prior to payment of invoices and screens Medical Directors' status with the Office of the Inspector General.

### Marwood Assessment

Marwood believes that the Company's Corporate Compliance Program is comprehensive. It is written using readily discernable language and includes all of the elements suggested by the Office of the Inspector General. However, even the best compliance program is unhelpful if employees are not regularly provided with knowledge of its contents. Marwood notes that the ability to electronically track compliance with the required educational updates represents an industry best practice. The Company has effectively leveraged its size and resources to develop this tool, which is infrequently available to or utilized by smaller providers.

Centralization of contracting is also a positive programmatic element from a compliance perspective; close monitoring of Medical Director Agreements and billing is a critical function in an organization of this size. In addition to RSM-identified audits on the basis of compliance risk, Marwood also recommends that a sampling of records from every agency be audited at least once each year. However, prioritization of clinical record audits based on risk is an excellent practice to identify potential compliance concerns. Marwood understands that 12 of 18 major non-hospital home health organizations audit clinical documentation and the care that is provided monthly.

## **VIII. TECHNOLOGY AND INNOVATIVE COMPANY INITIATIVES**

### **A. Patient Compliance/Satisfaction Technology**

In October 2005, the Company launched its Encore Program, through which nurses follow up with discharged home health patients for a period of six months, with the purpose of reducing hospitalization and emergency room visits for discharged patients as well as reinforcing patient self-management of care to improve outcomes. Through Encore, patients consenting to join the program are monitored through regular telephone contact. The Company directly employs nurses to make these follow-up calls, housing a call center in its corporate headquarters. Call center employees gather self-reported health status information from patients, reinforce self-management techniques for patients, and provide assistance in coordinating healthcare services. The Company utilizes proprietary software programs to track information gathered from patients, including patient satisfaction data.

In 2007, the Company achieved a reduction in emergency room visits for patients discharged from home health. According to the Company, the percentage of patients visiting the emergency room declined from seven percent in the first quarter to 2.8 percent in the fourth quarter. The 2008 patient satisfaction data provided by the Company showed 98.1 percent of 30,801 respondents rating the quality of care received as excellent or good, and 98 percent rating the providers of care as excellent or good.

Marwood notes that the design and purpose of the Encore Program is consistent with the goals created for the Quality Improvement Organization (QIO) Program, and the Company is actively engaged in working with QIOs. The QIO Program was established through Section 1161 of the Social Security Act to improve the quality of care for beneficiaries; protect the integrity of the

Medicare Trust Fund by making sure that Medicare pays only for necessary services provided in the most economical setting; and protect beneficiaries by expeditiously addressing issues. QIOs provide support and advice to healthcare organizations which provide care to Medicare beneficiaries.

Although the Encore program has been historically utilized to support patients after discharge from home health services, a pilot study has begun to analyze its use during home health care episodes. Through telephonic health coaching, the call center will reinforce what is taught during the episode; help track physician appointments; monitor diagnostic testing values; and assist with medication and symptom management. It should be noted that no specific Medicare reimbursement category currently exists for this telephone follow up, regardless of whether a patient has been discharged from home health or is still receiving home health care. Amedisys' interest in this program is to improve the quality of care provided to the home health care population.

### Marwood Assessment

After reviewing research in the area of home health patient compliance and satisfaction, Marwood understands that 14 of 18 major non-hospital based home health organizations surveyed perform some form of follow-up with their patients post-discharge. Only seven of the 18 respondents perform this follow-up by phone, while many use a combination of phone and mailings. Follow-up seems to focus on adverse events including hospital readmissions, unplanned physician visits and falls, although some organizations also use this opportunity to collect patient satisfaction information. Thus, the practice of telephonic post-discharge follow-up represents an industry best practice.

In his *Report to Congress on the Evaluation of the Quality Improvement Organization Program for Medicare Beneficiaries for 2006*<sup>7</sup>, published in 2009, former Secretary of Health and Human Services (HHS) Michael Leavitt wrote, "For identified participant home health agencies, QIOs focus on reducing the rate of acute care hospitalizations by decreasing avoidable, unnecessary hospitalizations..." He further writes, "Identified participant home health agencies also work to...implement tele-health (tele-monitoring and phone monitoring)..." Therefore, the use of tele-health/ follow-up phone conversations to bolster patient compliance with home health discharge instructions, such as medications and physical therapy, could help to improve patient quality of life as well as decrease spending due to costly follow-up care (emergency room or acute care readmission). Marwood believes that the practice of directly engaging patients post home health discharge in order to increase compliance with discharge instructions as well as reinforce the tools provided throughout the home health care episode represents a leading practice, as the practice aligns with current federal government initiatives regarding care management absent reimbursement for such services.

Marwood believes that the Encore program represents a leading practice, as to date, comparable follow-up is not typical practice, particularly in relation to the length of follow-up, in the home health industry. The Company has made a significant investment in the Encore program, at a time when no direct Medicare reimbursement exists. In creating the Encore program, Amedisys has emphasized patient compliance and care coordination in accordance with the goals published by the U.S. Department of Health and Human Services (HHS) and has demonstrated its commitment to being a leading practice home health care provider.

Marwood also notes that the ability to gather real time patient satisfaction information as well as self-reported clinical outcomes after discharge from home health is a valuable tool, typically unavailable to home health providers. In addition, the patient satisfaction scores and diminished emergency room visits resulting from the program are superior.

We understand that a fairly analogous Agency for Healthcare Research and Quality (AHRQ) CAHPs survey is expected to be implemented in late 2009. This survey is designed to be a measure of patient experience with home health care providers and agencies, focusing on patients that receive skilled home health care services, such as physical, occupational, and speech language therapy provided by physical therapists or nurses from Medicare-certified home health agencies. CMS is projected to be the primary user of this survey; state agencies, providers, and other organizations that serve patient communities may also utilize the survey in order to make more informed decisions regarding home health providers. Accordingly, perfunctory knowledge of patient satisfaction prior to the publication of AHRQ/CAHPs survey data to be used by CMS is advantageous.

## **B. Care Coordination Technology**

The Company has developed proprietary documentation technology for physicians called Mercury Doc. Mercury Doc is a web-based system which allows physicians to access patient demographic data; create orders for care and approve/certify plans of care; view pharmacy and medication information for their patients; and access certain trended clinical data, such as vital signs. There are also plans to expand Mercury Doc's capabilities over the next four quarters to include a communication system, called "Access My Doctor," which interfaces with labs, specialists, other physician groups, and patients. No specialized computer equipment is required, and training is available at any time through a web-based learning center.

Mercury Doc also assists physicians in tracking the time spent on care plan oversight for home health patients. Physicians may bill Medicare for care plan oversight, but the documentation required is so extensive that many do not do so. Mercury Doc creates a report which physicians may use to bill Medicare.

According to Amedisys documentation, approximately 10 percent of referring physicians (5,000 physicians) use Mercury Doc, with a goal of expanding to include all referring physicians in the system. Amedisys estimates that by 2010, 20 percent of referring physicians (approximately 10,000 physicians) will utilize the system. The Company surveys physician satisfaction with Mercury Doc twice each year and updates the system based on physician feedback.

During the implementation of Mercury Doc, the Company is simultaneously implementing a process to scan paper documentation into the system for all other physicians. This will allow all data related to a case to be linked to the record and allow field staff access to this data electronically. Once this process is fully implemented, the Company will have a robust data management and compliance tool for all clinical documentation related to any case.

### Marwood Assessment

After reviewing academic research and in concert with industry expertise in the area of home health care coordination, best practices encompass the following two programmatic aspects:

- 1) Organization is able to use technology to enhance the efficiency and accuracy of information flow for both the physicians and the home health provider. According to research published by the National Conference of State Legislatures<sup>8</sup>, South Carolina has instituted a community long-term care program that incorporates an electronic system that helps to ensure patients receive quality care. Within this program, care advisors use laptop computers to input any information received from patients, family members or care providers, including patient assessment information and care plans; thus, all members of the care team can regularly access this information and cases can be reviewed to ensure that patients are receiving appropriate care. The system also generates reports that provide demographic information, utilization, and costs as well as insures appropriate access to care, care planning, and reassessment.
- 2) Organization technology enables physicians to track the time spent on care plan oversight for home health patients. Marwood understands that although physicians may bill Medicare for care plan oversight, the documentation required discourages many from doing so. This functionality incentivizes physician utilization of an electronic patient care coordination system.

The ability of a home health provider to share information with the physician who is prescribing care is critically important, and can positively impact both quality of care and regulatory compliance. The greatest benefit of this technology is its ability to enable direct physician order entry, as most home health agencies handle the communications process manually. 12 of 18 major non-hospital home health organizations can capture all patient documentation electronically. The vast majority stated they collect this data through scanning, while two stated they are using a form of physician order entry.

In addition, through Mercury Doc, physicians can access medical information related to the home health services provided. Mercury Doc is a first step in enabling the home health provider and physician to share information electronically. While physicians can order care electronically and view certain patient-specific information through Mercury Doc, it is not yet possible to view the entire medical record. The establishment of an over-arching system to integrate the entire home health clinical record with lab records and physician documentation will be important to realize the full potential of the program.

Marwood notes that the use of Mercury Doc also simplifies the process for a physician to refer cases to the Company and the care plan oversight documentation process; thus, the Company is leveraging both its sales and operations team to make Mercury Doc successful. Creation of Mercury Doc is consistent with Company strategy to build a physician-driven care model, particularly for patients who have multiple chronic health issues. If the Company is able to get the majority of its physicians on the Mercury Doc platform, it will have an advantage as it relates to compliance and administrative documentation related duties.

The Company's point-of-care system creates an electronic medical record (documentation system) for internal activities. In order to capture external documentation not provided through Mercury Doc, Marwood encourages the rollout of the documentation scanning process. The advantages of having all clinical documentation available electronically to simplify clinical and billing compliance and to increase quality improvement, as well as to provide easier access to clinical information for the field staff, are numerous and important for a robust organization.

## C. Clinical Algorithms

The Company uses patient data from both internal and external sources to determine the priority of specialty program and clinical algorithm development. Currently, 70 clinical algorithms, or pathways, are in use for common diagnoses. Based on these algorithms, 14 disease management programs are in place.

The disease management programs use clinical pathways to guide clinicians as they care for patients who have more clinically complex, costly, or common disease processes. Company best practices have been gleaned from the national healthcare delivery system as a whole, rather than strictly from home health practices. To design these programs, the Company's clinical and operations team has collaborated with external clinical sources, product vendors, and national disease-centered not-for-profit organizations.

The disease management programs currently in use are:

- *Partners in Wound Care*
- *Heart at Home*
- *Diabetes at Home*
- *Rehab Therapy at Home*
- *Orthopedic Recovery at Home*
- *Surgical Recovery at Home*
- *Behavioral Health at Home*
- *COPD at Home*
- *Stroke Recovery at Home*
- *Chronic Kidney Disease at Home*
- *Pain Management at Home*
- *Balanced for Life*
- *Wound Care – A Therapy Approach*
- Speech programs related to dysphagia and cognition

Each program outlines specific performance goals and clinical pathways for participants utilizing the Company's proprietary point-of-care technology to prompt clinician adherence with established clinical pathways. Clinical outcomes data is gathered relative to each program with the goal of enhancing quality of care received while containing the cost of care. If the Company identifies clinical pathways that require more advanced clinician support, the staff ensures that these more complex patients falling within such pathways receive the appropriate level of care.

To illustrate its comprehensive disease management programs, Amedisys has placed an emphasis on rehabilitation specialty programs. Post-discharge follow-up completed by the Company's Encore call center suggests that patient falls are a common reason for emergency room visits or re-hospitalization. In response, the Company designed the "Balanced for Life" program to help patients learn how to prevent and manage falls. The program is headed by a Specialty Program Director and supported by field clinicians with 16 hours of program-specific education. The program uses widely recognized screening tools to evaluate the risk of patient falls, including the Tinetti tool; Dynamic Gait Index; and Postural Control and Sensory Integration testing. Care and teaching protocols are based on the results of patient performance on the tests. The use of standardized testing methodologies also allows the collection of clear outcomes data; the initial outcomes data collected demonstrates clinically significant improvement for many patients, with

99.3 percent of patients demonstrating a reduction in fall risk according to Company documentation.

### Marwood Assessment

After reviewing academic research and Marwood home health survey results in the area of home health patient population management, the stratification of the patient population into care groups represents an industry standard; however, best practices in this area focus on treatment plans and outcomes measurement. Best practices include:

- 1) Organization has developed clinical algorithms in order to stratify patients into care groups with corresponding pathways of care that inform field clinicians of appropriate guidelines for care. According to research published in the *Journal for Healthcare Quality*<sup>9</sup>, a best practice in home health patient management includes screening the patient population for high-risk and disease-specific care groups that should be treated in accordance with established clinical strategies. Practices cited by the University of Pennsylvania include the creation of an interactive web-based curriculum intended to prepare field clinicians to appropriately care for patients within a given disease specific population. This information system allows for the documentation of crucial elements of the care plan and guides patient assessments, nursing interventions, and outcome measurement.
- 2) Organization assigns more advanced field clinicians (such as advanced practice nurses (APNs)) to care for the most clinically complex, high risk patients. According to studies completed by the University of Pennsylvania<sup>9</sup> and funded by the National Institute of Nursing Research, the assignment of an APN to care for high risk older adults, especially those transitioning from acute care to the home setting, improves patient outcomes and decreases cost of care.
- 3) Organization has developed the capability to electronically report and analyze clinical outcomes by care group. Marwood understands that approximately 9 of the 18 major non-hospital home health organizations surveyed have implemented a fully automated system for reporting clinical outcomes data by care group. The other organizations utilize a combination of systems which could include automated elements, spreadsheet tracking, or manual reporting.
- 4) Organizational willingness to participate in the creation of models for transitional care absent reimbursement for such services represents an industry leading practice. According to research published in the *Journal for Healthcare Quality*<sup>9</sup>, home health agencies have little motivation to adopt evidence-based best practices or improve cross-care setting communication without reimbursement for their efforts from Medicare or private payers. The study suggests that accountability follows the pattern of healthcare reimbursement and financing.

Marwood believes that the use of clinical pathways is a necessity within the home health industry, particularly in an environment of rapid growth, to ensure consistency in the way care is provided. Amedisys uses complexity of the care required as a variable in determining the appropriate type of caregiver. Research reviewed suggests that the assignment of advanced practice nurses (APNs) to particularly high risk patient populations transitioning into the home setting can improve patient outcomes as well as decrease overall costs. Amedisys uses APNs on

a consultative basis, to support local teams of caregivers. APNs are consulted for patients who have complex surgical wounds and pressure ulcers, as well as for patients who have multiple, complex chronic illnesses. In the past year, nearly 13,000 consultations were provided by APNs related to wound care issues. An additional team of APNs provides case management support to patients with chronic illnesses who are at high risk for re-hospitalization.

Amedisys leverages its technological capacity to maximize productivity of the APNs, while providing local care givers access to their specialized expertise. The use of point-of-care technology, as well as devices such as digital cameras, enables APNs to provide clinical advice and case management services from remote locations.

The Company's design of pathways and programs as well as use of proprietary technological tools to ensure compliance with clinical pathways and measure outcomes is an industry best practice. The clinical specialty programs designed by the Company are well aligned with diagnoses most prevalent among home health patients nationally, according to the National Association for Home Care's *Basic Statistics for Home Health 2008*<sup>10</sup>.

The Company's willingness to participate and partner in the creation of clinically significant, diagnosis-specific research absent additional reimbursement for care coordination or disease management demonstrates its commitment to leadership in home health care services.

#### **D. Disease Management/Care Coordination Initiative**

In early 2009, the Company wrote a white paper<sup>11</sup> describing its intention to create a specialized care program for elderly people with chronic, clinically complex conditions. According to the white paper, 66 percent of Medicare dollars are spent on people who have five or more chronic conditions, and 96 percent are spent on beneficiaries who have more than one chronic disease. With the aging of the American population, the number of Medicare beneficiaries who are chronically ill is expected to increase dramatically over the next 20 years.

The existing Medicare fee-for-service payment system and lack of standardized electronic medical records leads to fragmentation of care, particularly for beneficiaries who have multiple health problems. Such patients typically see several physicians and other healthcare providers, potentially receiving conflicting advice and prescriptions for medications which may interact poorly. Patients may be subjected to duplicate testing and procedures, and more than one-third of Medicare beneficiaries who are discharged from hospitals are readmitted within 90 days of their initial discharge. Many industry experts believe that the existing system creates relatively poor clinical outcomes at a very high cost.

In response, the Company is creating a Comprehensive Continuous Chronic Care Management (C4M) program expected to be fully implemented by Q4 2010. C4M will focus on coordinating the care of the most clinically complex elderly, using a physician-driven model of care delivery. C4M will leverage the existing home health and hospice infrastructure and benefits, complemented by enhanced technology and chronic care management, with oversight provided by advanced practice clinicians.

The existing home health and hospice benefits are structured to take an interdisciplinary approach to patient care, and regulations require the creation of a physician-approved plan of care. Care is provided by nurses; physical, speech, and occupational therapists; nursing

assistants; social workers; volunteers; and in the case of hospice, clergy. Home health and hospice workers provide support to informal caregivers in patients' homes. Home health and hospice regulations also require regular interdisciplinary team meetings to promote communication among care providers as well as consistency in care. Patient progress, medication regimens, results of diagnostic tests, and recent physician visits are all topics of discussion at these team meetings, with informal caregivers (family) present at some meetings.

In creating C4M, the Company plans to leverage its expertise in the home health and hospice models, but will use technology and advanced practice clinicians to enhance the quality and coordination of care provided; the Encore program will be expanded to provide telephonic support to patients during home health care episodes as well as after they are discharged from home care, and the Mercury Doc program will be used to support participating physicians. Remote tele-monitoring devices may also be used to track such clinical indicators as cardiac and respiratory function, blood sugar levels, and weight. Currently, the Company has several thousand tele-monitoring devices in use in a variety of markets.

In order to implement the program, the Company has created a team of nurse specialists and developed a care transition model, including best practices. Exception reports will be used to alert field clinicians to variances from established goals. Advanced practice clinicians will case manage the most complex patients, using technology to control the cost of case management.

As a first step, the Company has begun to implement its "Chronic Care Portal" segment of the C4M initiative. This program involves the use of predictive modeling to identify those home health patients at highest risk for hospitalization, and the provision of an extra layer of care to those patients based upon current evidence-based best medical practices. The program targets those diseases and health risks that most frequently affect Amedisys' sickest patients: congestive heart failure, diabetes, co-morbidities and the risk of fall.

In selecting test sites for the Chronic Care Portal program, the Company analyzed internally gathered data to select 17 providers with unusually high re-hospitalization rates. According to the Company, these test sites were launched in mid-April 2009 and will be operational for 90 days, after which 42 additional sites will be added in rolling launches. Data warehousing capabilities created for the program will enable the Company to mine provider input for outcome and cost containment research.

#### Marwood Assessment

Marwood believes that the creation of programs designed to provide added disease management support to patients during home health care episodes as well as after they are discharged from home care represents an industry leading practice. Health reform language proposed by Congress includes proposals to expand care coordination and disease management efforts. In its latest report (March 2009), MedPAC advised Congress to direct the HHS Secretary to study alternative payment strategies that drive outcome-based quality incentives, noting that CMS should implement "as soon as possible" pay-for-performance measures that penalize home health agencies with high rates of adverse events.

The current healthcare reimbursement system does not reimburse providers to coordinate care for patients not actively receiving care in an institutional setting or through a traditional program, such as home health or hospice. Providers also receive no reimbursement for developing state of

the art technology to enhance care coordination. Many healthcare programs are designed to accommodate reimbursement, rather than the desire and need of the person receiving care.

Marwood believes that the Company has designed an industry leading practice, patient-centered and physician-driven program which will leverage existing reimbursement sources, while adding an unreimbursed level of clinical oversight. The robust IT infrastructure and call center will be used to control the cost of clinical oversight and care coordination. Care must be paid in implementing the program in order for it to reach its full potential.

The creation of C4M is consistent with the Company's vision of the future. Amedisys leadership envisions the Company as the community-based coordinator of patient care in the healthcare delivery system which will be constructed through reform of the existing reimbursement structure.

### **E. Technology Controls**

Technological tools have been created to provide information to employees on an as-needed basis, and several types of controls are built into the systems. The amount of information available to employees is dependent upon the status of the employee. Reports at the agency level are available to agency employees, while area and corporate personnel have access to more extensive data.

Compliance controls are built into the systems as well. For example, only certain personnel are authorized to change visit schedules or the results of clinical evaluations. The clinical program and management reports provide assistance to the user in prioritizing information through the use of color codes. The fact that clinical records can be accessed from remote locations enhances the audit function of both the quality management and compliance departments, as auditors need not request records from local management teams. In addition, the Company has implemented technology to prevent the alteration of patient records after a Quality Care Coordinator and the field clinician have approved its contents. This feature is intended to prevent compliance-related discrepancies, such as up-coding.

Regulatory auditors often focus reviews on ensuring adequate documentation that care was provided in accordance with physician orders. Accordingly, Amedisys has implemented a frequency-based scheduling program to help ensure that care is provided within the framework ordered by the physician in the plan of treatment. The program also has controls which allow only certain employees to access and manipulate the schedule. Physician orders are required for every visit performed by a field clinician. In some instances, the number of visits provided can partially drive the amount of revenue received by a provider for an episode of care. The number of visits is determined at the start of care, and is included in the plan of treatment.

The point-of-care technology designed by Amedisys contains elements which prompt field clinicians to follow physician orders. When a patient's electronic file is opened by a clinician, pop-up reminders appear related to the plan of care, and the clinician is readily able to view physician orders. In addition, if a physician orders new medications, or changes the dose of a medication, the plan of care is automatically updated when the order is entered into the electronic documentation system.

The Company is also using point-of-care technology to enhance communication among clinical team members and to encourage loyalty among physicians who refer patients to the company. Technology is used to measure clinical outcomes, and clinical programs are created based on data mined from the systems. Technology projects are prioritized, and a clearly delineated standardized approach is used for project management. Technological tools are reevaluated on an ongoing basis and revised and updated in accordance with needs identified by users of the tools.

In addition, the Company has developed a detailed, multi-level program which should provide for complete recovery of data in the event of a disaster, estimating that data would be recovered within 24 hours.

#### Marwood Assessment

The home health industry is fragmented, consisting largely of small organizations. The Company has leveraged its size and related resources to build a sophisticated series of technological tools allowing records to be entered, evaluated, reevaluated, and finally locked to minimize quality of care and compliance issues. Using technology to automatically ensure sufficient pre-billing documentation and the ability to lock down files post-billing are industry best practices. As CMS increases fraud and abuse investigations focused on billing, a robust technological billing compliance system will become increasingly advantageous. Marwood understands that all 18 major non-hospital based home health organizations use some form of manual review for each claim prior to billing. However, 13 of these 18 rely on some form of manual process to maintain documentation integrity post-billing.

Marwood believes that the Company's ability to leverage its IT infrastructure in the performance improvement/compliance process has simplified the process of accessing and analyzing data related to performance improvement efforts. Few other organizations are able to minimize compliance related issues, such as up-coding, by locking down patient records following their final approval by a Quality Care Coordinator and the field clinician; this capability represents an industry best practice.

### **IX. FUTURE STRATEGY**

Senior leadership has a clear vision for the future of the company. They envision home health care providers as the lynchpin of the healthcare delivery system in the future, coordinating the care of chronically ill people throughout the United States. The Company has begun to pursue this strategic vision through a three-pronged approach, including a business growth strategy; clinical development strategy; and promotion of a legislative agenda.

The business growth strategy includes growth through increased market penetration in existing service areas as well as external growth through start-ups and acquisitions. The clinical development strategy encompasses strengthened relationships with physicians; the increasing use of technology to leverage talent, improve outcomes and control costs; and the development of programs which will enable the Company to care for the chronically ill elderly who consume the majority of healthcare dollars in America.

The Company supports a federal agenda that includes redesign of the Medicare home health benefit to extend care for chronically ill patients beyond the traditional reimbursement model and

promotes the role of primary care physicians, in close collaboration with home health providers, in caring for people with multiple chronic health issues. The Company's CEO is the Chairman of The Alliance For Home Health Quality and Innovation (The Alliance), a national consortium which consists of eight large home health providers, the National Association for Home Care and Hospice, and Visiting Nurse Associations of America. The Alliance designs and participates in research and quality initiatives on a national level, and collaborates to promote a pro-home health care legislative agenda.

To assist in the development and execution of Company business and federal strategies, Amedisys has created a Strategic Advisory Board comprised of experts from outside of the Company as well as members of the Company leadership team, and is in the process of further defining its role moving forward. A list of Amedisys' Strategic Advisory Board members can be found in Appendix III.

### Marwood Assessment

Marwood notes that the Company's strategic direction is consistent with the need for increased care coordination within the chronically ill patient population; its focus on this population and the expansion of the role of primary care physicians is also consistent with governmental initiatives to control healthcare costs and improve outcomes. Because the home health industry accounts for slightly over three percent of total healthcare expenditures in the United States, it may be advantageous for the Company to position itself well with primary care providers and hospitals, as they have an inevitable inclusion in any sort of medical home care coordination arrangement.

Marwood believes that the Company has created successful compliance and clinical quality improvement programs as well as superior technological tools in support of these programs, but does not appear to have a comprehensive, consistent external communications plan to promote its image within the industry and among investors and consumers. Marwood understands that approximately four of the 18 organizations surveyed disclosed publishing research to date; this represents an opportunity for the Company to publicize its innovative programs and technological advances.

Given the projected adjustments to home health industry Medicare reimbursement levels and the potential for significant changes to the healthcare system-at-large due to health reform legislation, strengthening the strategic planning process is recommended. Most of the major non-hospital home health organizations surveyed have incorporated an annual formalized strategic planning process, which includes quality improvement goals.

## **X. MARWOOD QUALITY AND COMPLIANCE PROCESS SCORECARD**

The Home Health industry currently lacks a standardized system with which to evaluate a company's quality improvement and compliance processes. This lack of clarity prompted the Marwood Group to develop the *Marwood Quality and Compliance Process Scorecard* with the goal of providing a way to evaluate and compare home health companies. In particular, we believe this scorecard is useful for evaluating a company's position relative to what Marwood believes to be "industry leading and best practices."

We note that many use the Center for Medicare and Medicaid's (CMS) Medicare Compare dataset as a rough tool for evaluating quality improvement processes; however, we do not believe it provides a true representation of an organization's quality improvement and compliance infrastructure. For instance, the Medicare Compare dataset does not measure the processes and procedures involved with quality improvement and compliance programs. In addition, the dataset tends to present a distorted view of growing companies, especially those that grow through acquisition.

Through Marwood's experience in the home health industry, its review of relevant academic literature, and extensive interviews with nationally recognized industry experts, areas of quality improvement and compliance process that are important components of a well-run home health company as well as "industry leading and best practices" were identified. These components were combined and weighted to provide criteria by which the final score was assigned.

### *Marwood Quality and Compliance Process Scorecard*

The *Marwood Quality and Compliance Process Scorecard* is composed of four major sections:

- A. Electronic Data Capture and Nurse Assessments (representing 38% of the final score)
- B. Process Measures (representing 31% of the final score)
- C. Quality Improvement: Structure and Initiatives (representing 15% of the final score)
- D. Patient Satisfaction and CAHPS (representing 15% of the final score)

As we researched the home health industry, a "lack of transparency" theme began to emerge. Unlike other healthcare providers, since care is provided in the home, it is difficult to judge quality and compliance on an individual patient level. A system which electronically captures all data related to the home health encounter begins to provide transparency to the system and minimizes the risks of fraud and abuse. Therefore the Electronic Data Capture and Nurse Assessment section, which evaluates an organization's ability to collect all data electronically, received the highest weight. The question of "how do you use your data?" is answered by the Process Measures section, which evaluates how a company uses its clinical data for quality improvement, and is therefore given the second highest weight. The Quality Improvement: Structure and Initiatives and the Patient Satisfaction and CAHPS sections evaluate how an organization implements quality goals internally, how it uses systems for compliance, and an organization's focus on third party research as well as patient relationships. These elements are important parts of a quality improvement program and are weighted equally. Additional detail can be found in Appendix IV.

Finally, the data for this scorecard was acquired by conducting a survey of home health companies, which is described in greater detail below.

### Survey Methodology

For the purposes of this report, the *Marwood Quality and Compliance Process Scorecard* evaluates the four publicly traded home health companies, 14 large private non-hospital home health companies (>\$50M annual revenue), and four large hospital-based home health agencies. The hospital systems surveyed included a 10+ hospital/2,000 bed system, a 7 hospital/1,500 bed system, a 4 hospital/800 bed system and a 1 hospital/250 bed system. Marwood arranged phone interviews with a group of senior executives, directors of quality, and quality assurance managers at corporate offices from each organization. A copy of question topics was distributed to each interviewee to prepare for the call and interviews were introduced as discussions on emerging trends in home health quality initiatives, with a focus on each organization's quality process. These interviews occurred July 22-29, 2009. Amedisys was scored using the information provided through our documentation review and our on-site visit interview process described above.

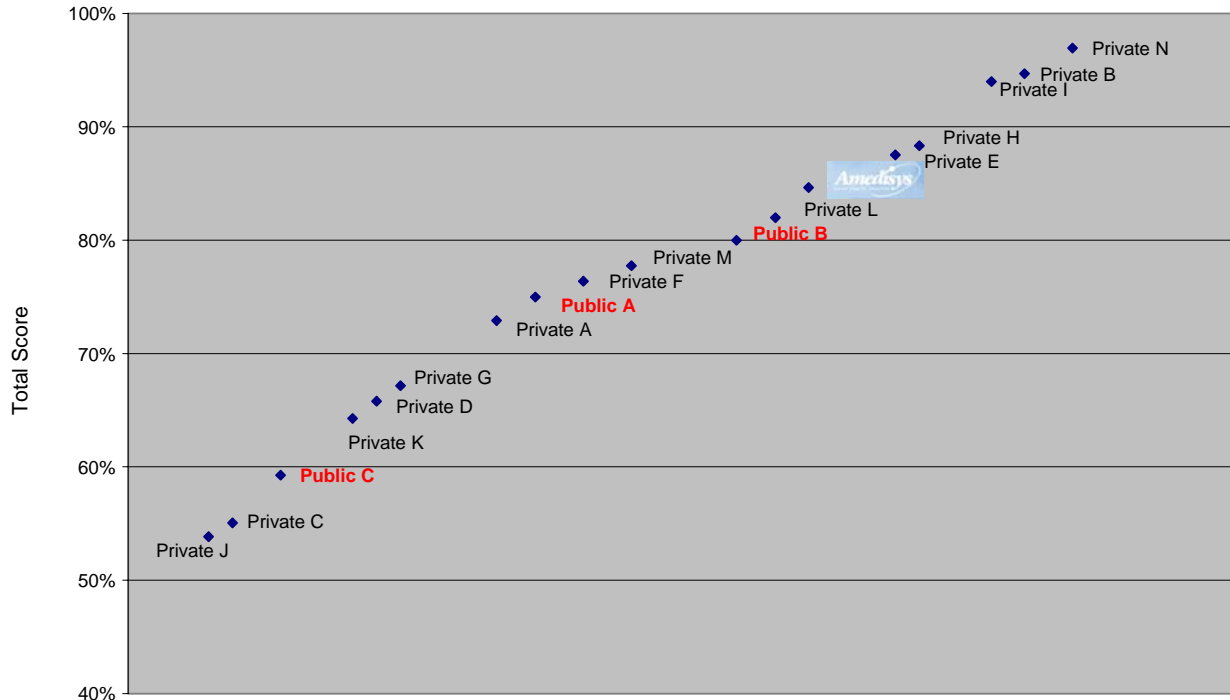
Using an Internet survey, Marwood also surveyed 167 regional home health agency quality executives and quality assurance managers regarding emerging trends in home health quality initiatives, with a focus on each organization's quality process. The Internet survey was conducted July 22-29, 2009 and utilized the same set of questions as our telephone interviews; responses directly populated a database for analysis.

Information gathered from other home health agencies for comparative purposes was not tested or validated during the interview process. Other home health agencies did not share supporting documentation with Marwood.

Detailed scorecard results can be found in Appendix V.

# Marwood Quality and Compliance Process Scorecard

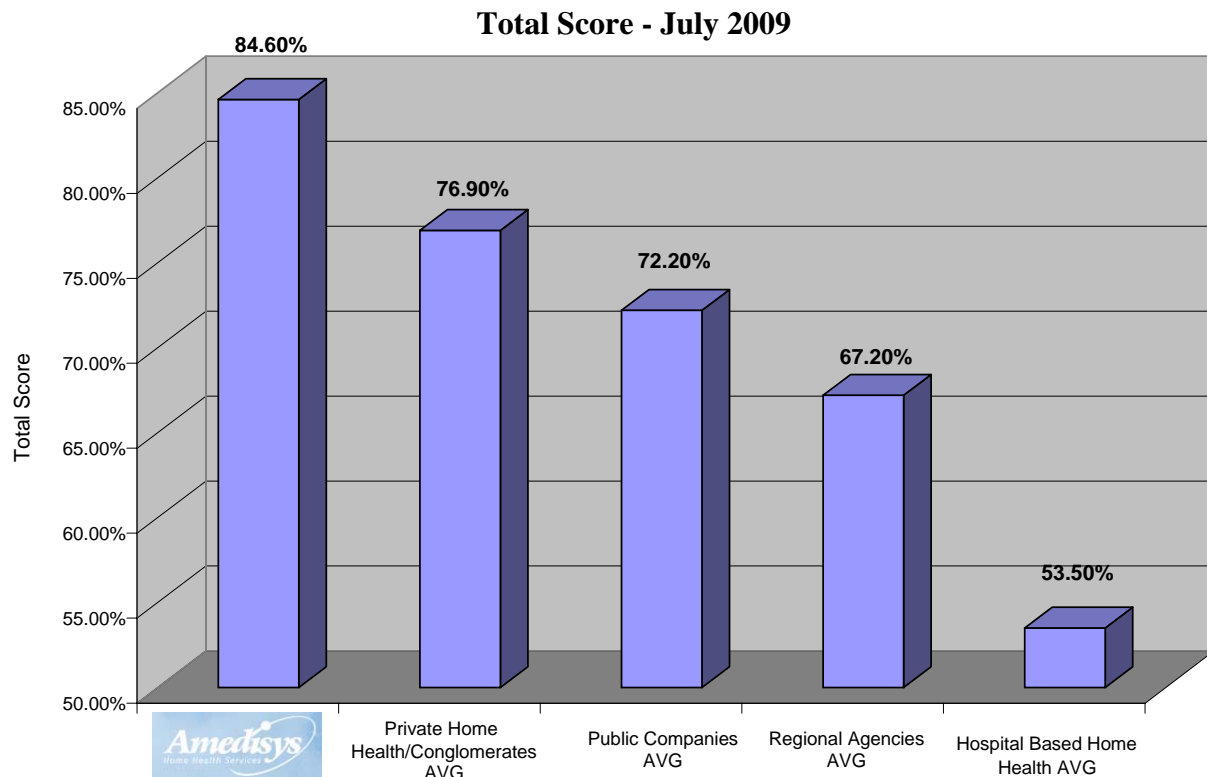
## Total Score - Top 18 Non-Hospital Agencies July 2009



In comparison to the other 17 organizations (publicly traded and Private Home Health/Conglomerates) evaluated by the *Marwood Quality and Compliance Process Scorecard*, Amedisys ranks sixth, with a score of 84.6 percent, in terms of its quality improvement and compliance processes. Amedisys ranks highest compared to other publicly traded companies. Of the 18 organizations, scores ranged from a high score of 97 percent to a low score of 54 percent. As a reference point, fulfilling the minimum requirements to be a Medicare certified Home Health agency, i.e. having a quality improvement committee, submitting OASIS data, etc., yields a total score of 21.8 percent on the Marwood scorecard.

Amedisys ranks higher than the three other public home health companies, but below five of the industry leading private home health organizations. Organizations that ranked above Amedisys have implemented full electronic documentation systems, have calculated and provided nurse specific balanced scorecards to staff, and have applied for and received third party quality awards.

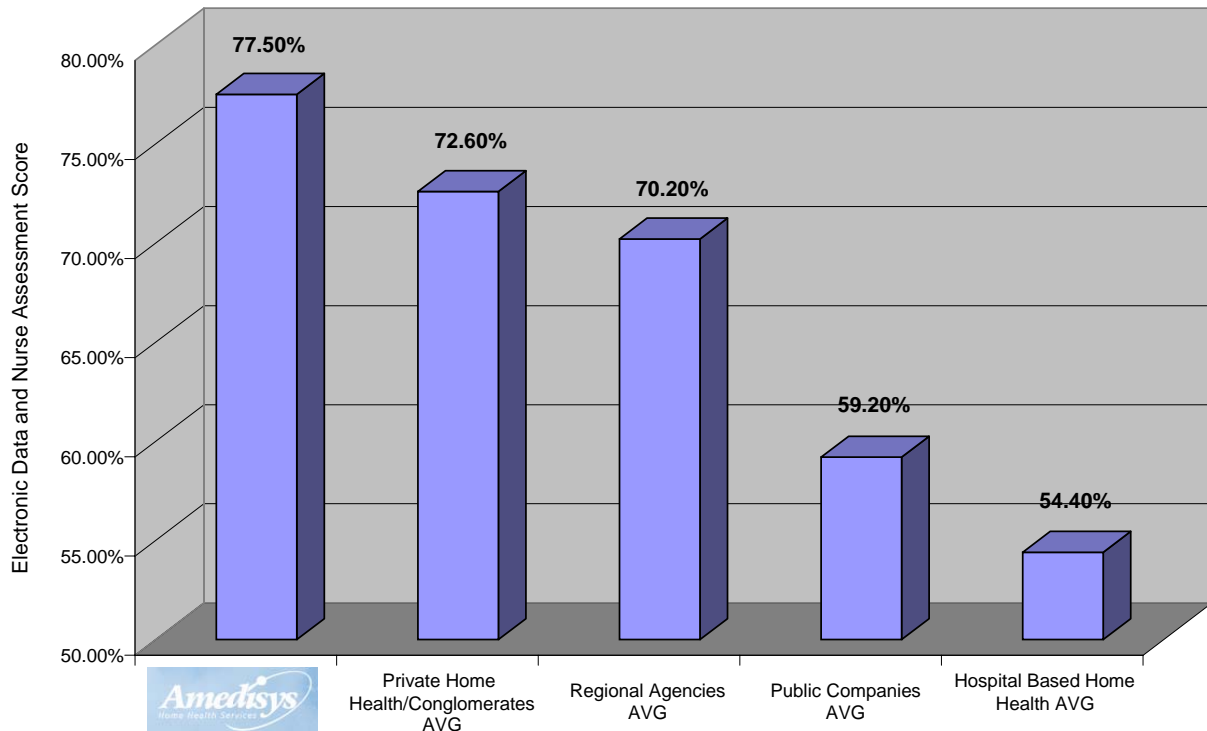
## Marwood Quality and Compliance Process Scorecard



Based on the *Marwood Quality and Compliance Process Scorecard*, Amedisys exceeds the average score across the four major agency categories with a score of 84.6%. Private home health companies and conglomerates rank second with an average score of 76.9%, while public companies and regional agencies rank third and fourth, respectively. Hospital based home health companies come in last with an average score of 53.5%, mostly due to a lack of infrastructure investment from their parent organization.

# Marwood Quality and Compliance Process Scorecard

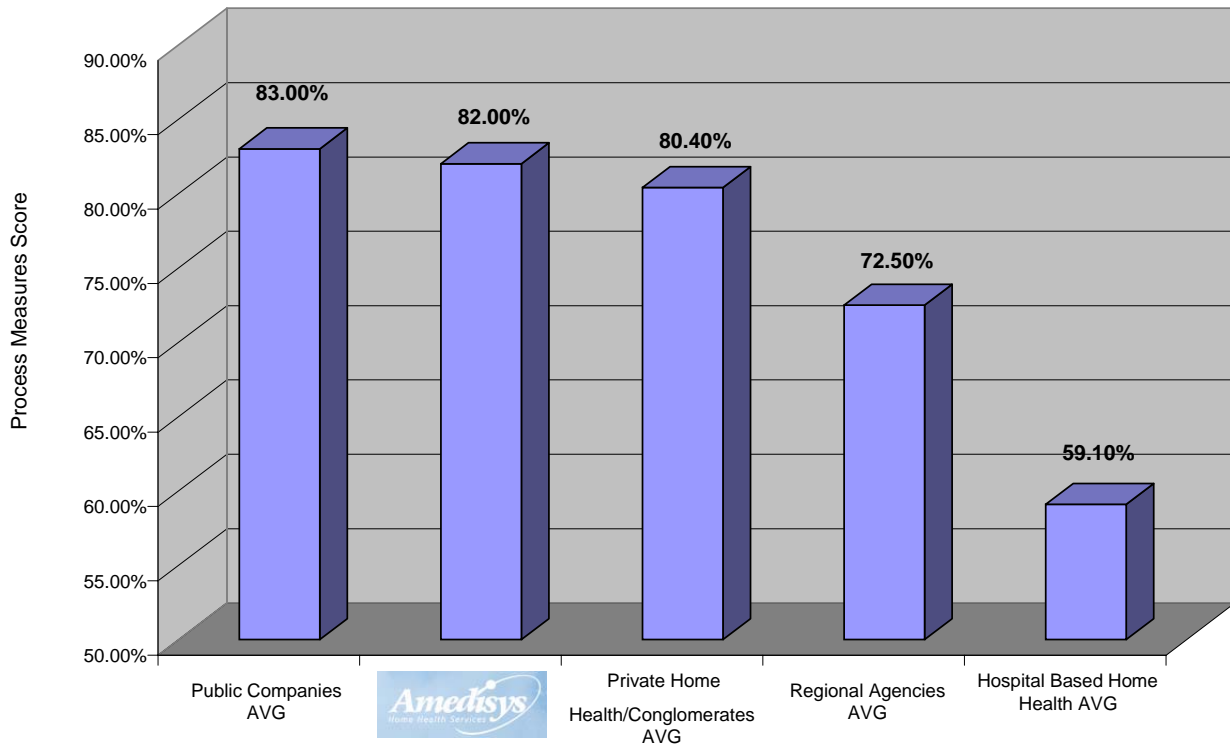
## Electronic Data and Nurse Assessments - July 2009



In the Electronic Data and Nurse Assessment section, Amedisys is the high score in the area with a score of 77.5%, with Private Home Health Conglomerates ranking second with an average score of 72.6%. Public Companies and Hospital Based Home Health agencies ranked fourth and fifth with average scores of 59.2% and 54.4% respectively. Most respondents used technology to obtain nurse assessments and automatically check those assessments for inconsistencies, however only approximately half of the organizations collected all data electronically. Most of these organizations used a scanning methodology to link clinical data to individual cases. In addition, most organizations used a combination of manual and automatic controls to ensure billing compliance, although a few had moved to a fully automated system. Amedisys' opportunity for improvement in this area, as mentioned previously in this report, is a continued rollout of the Mercury Doc system to all possible providers and full implementation of a scanning program for all other documentation.

# Marwood Quality and Compliance Process Scorecard

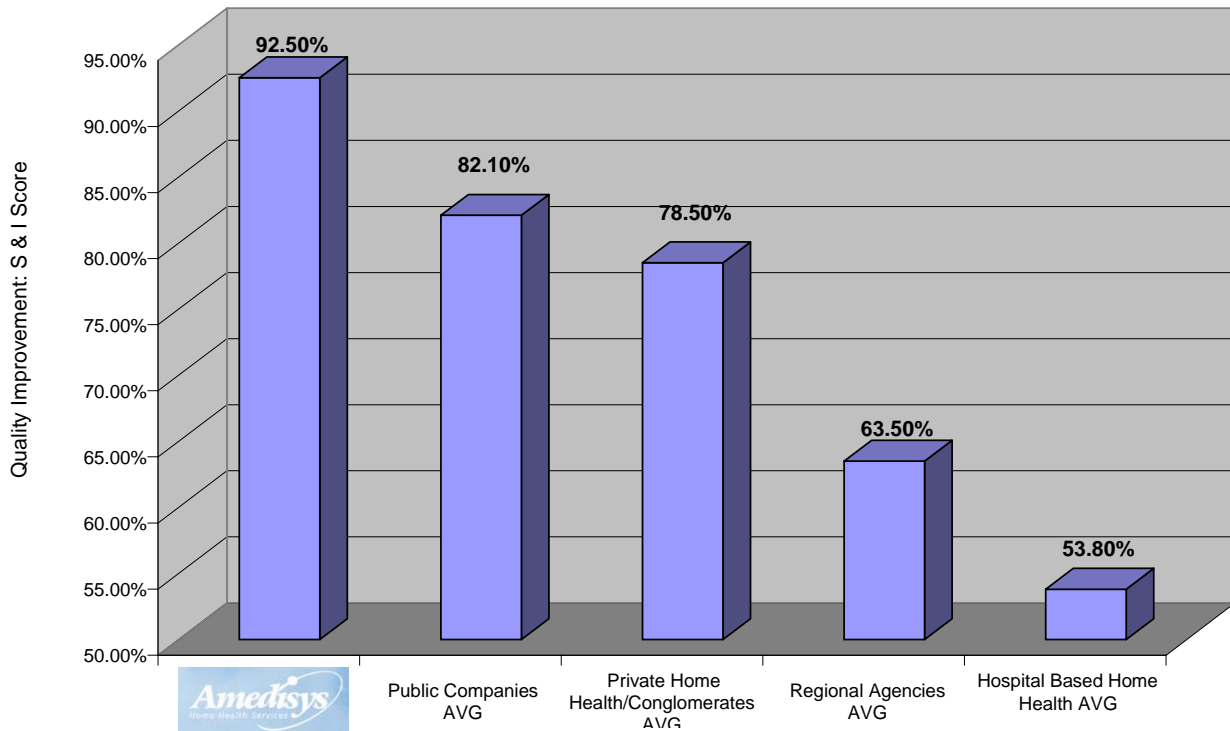
## Process Measures – July 2009



In the Process Measures section, the Amedisys score and the averages of the Public Companies and the Private Home Health/Conglomerates were close. Virtually all the organizations surveyed have systems to track quality improvement outcomes and use quality improvement teams/committees to oversee the quality improvement process. The higher scoring organizations stratify patients by diagnosis/acuity and report outcomes through technology. In addition, these organizations report and share clinical outcomes on a nurse-specific level, and when following up with patients post-discharge adverse events are tracked and trended. Amedisys scores very well in this area, with opportunity for improvement, as mentioned previously in this report, in the category of nurse-specific clinical outcome tracking.

# Marwood Quality and Compliance Process Scorecard

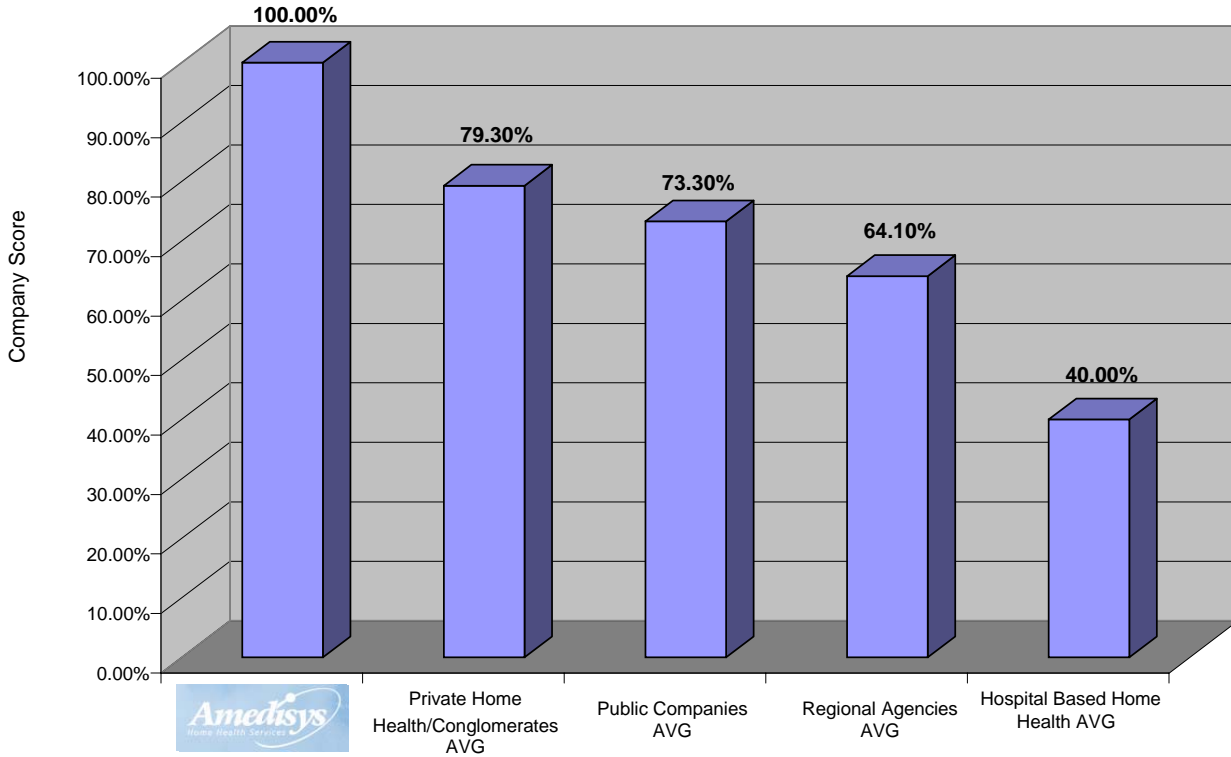
## Quality Improvement: Structure and Initiatives - July 2009



In the Quality and Improvement: Structure and Initiatives section, Amedisys scores higher than the other category averages with a score of 92.5%. Virtually all the respondents use a centralized quality improvement function, although not all of the organizations perform a formalized, corporate-wide annual strategic planning process that includes quality improvement goals. In addition, not all of the organizations were accredited and only a few have focused on third-party awards or published research. Opportunities for Company improvement in this area include focusing on the ability to publicly demonstrate superior capabilities through third-party quality awards to gain notoriety with patients and physicians.

# Marwood Quality and Compliance Process Scorecard

## Patient Satisfaction/CAHPS - July 2009



In the Patient Satisfaction/CAHPS area, Amedisys ranked first, scoring a perfect 100%. The Private Home Health/Conglomerates ranked second with a score of 79.3%. Virtually all respondents have implemented some form of patient satisfaction surveys, but very few have implemented the CAHPS system ahead of the CMS requirement as Amedisys has done. Almost all respondents implement process improvement plans if their patient satisfaction scores do not meet benchmarks. Amedisys, having already implemented an extensive patient satisfaction data system through Encore, is an industry leader in collecting patient satisfaction data.

## **XI. SUMMARY STATEMENT**

The Marwood Group was asked to provide an independent analysis of Amedisys' ("Company") corporate compliance processes, procedures, controls, clinical infrastructure, technology offerings, and future strategies. In the absence of formalized home health industry standards, Marwood conducted a review of academic research, interviewed a representative population of home health providers, and utilized its home health industry, legislative, and regulatory knowledge to measure industry standards, best practices, and leading practices according to which Company practices were evaluated.

After review of documentation provided by the Company and informational interviews with senior management, Marwood believes that Amedisys has implemented compliance and quality improvement processes that meet and exceed the industry average. The Company demonstrates industry leadership in the areas of patient compliance and satisfaction technology, having developed a program through which patients are engaged post-home health discharge to increase compliance with discharge instructions, as well as disease management and care coordination initiatives, having created programs designed to provide additional disease management support to patients during home health care episodes and post-discharge. Amedisys also employs best practices in the areas of field clinician coding and accuracy, oversight and management infrastructure, corporate compliance, and care coordination technology.

Additionally the Company has developed a strategic direction consistent with the need for increased care coordination discussed at great length throughout the healthcare reform debate. To assist in the development and execution of this strategy, Amedisys has created a Strategic Advisory Board, consisting of outside expertise as well as internal leadership (see Appendix III for biographical information), to define future Company initiatives. Given the projected adjustments to home health industry Medicare reimbursement levels and the potential for significant changes to the healthcare system-at-large due to the present comprehensive health reform legislation under Congressional consideration, Marwood recommends a focus on strategic planning.

Based on our *Quality and Compliance Process Scorecard* and information collected during our review of Company documentation and onsite interviews, Marwood believes that, overall, Amedisys has implemented compliance and quality improvement processes that meet and/or exceed the industry average.

## Works Cited

<sup>1</sup> U.S. Census Bureau estimate

<sup>2</sup> The Quality of Healthcare in America Committee of the Institute of Medicine (IOM). "To Err is Human: Building a Safer Health System." (2000): Print

<sup>3</sup> Zelman, William N., George Pink, Catherine Matthias. "Use of the balanced scorecard in health care." *Journal of Health Care Finance*. (2003)

<sup>4</sup> The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. *The New Economics for Industry, Government, and Education*. (2000): Print.

<sup>5</sup> Ellenbecker, et al., "Employer Retention Strategies and Their Effect on Nurses' Job Satisfaction and Intent to Stay," Home Health Care Services Quarterly (2007): 43-58

<sup>6</sup> Linda Flynn, "The Importance of Work, Evidence-Based," Home Healthcare Nurse (June 2005): 366-:371

<sup>7</sup> Michael Leavitt. *Report to Congress on the Evaluation of the Quality Improvement Organization Program for Medicare Beneficiaries for 2006*

<sup>8</sup> Folkemer, Donna; National Conference of State Legislatures. *Home Care Quality: Emerging State Strategies to Deliver Person-Centered Services*. Rep. no. 2006-07. Washington DC: AARP Public Policy Institute, 2006. Print.

<sup>9</sup> Naylor, Mary D. "Transitional Care: A Critical Dimension of the Home Healthcare Quality Agenda." *Journal for Healthcare Quality* 28.1 (2006): 20+. Print.

<sup>10</sup> National Association of Home Care. *Basic Statistics for Home Health 2008*

<sup>11</sup> Amedisys. *Comprehensive, Continuous Chronic Care Management in the Home*. April 2009

## Appendix I

Marwood was granted access to review documents consistent with the categories outlined below to develop its analysis regarding the compliance, care management systems, and processes employed by Amedisys.

- Corporate Compliance Program
  - Compliance Audits
  - The Amedisys Corporate Compliance Plan
  - Federal Program Participation Exclusion Checks – May 27, 2009 written by Jeffrey Jeter, Chief Compliance Officer
- Description of the compliance department's role in the integration of acquisitions
- Policy related to the of screening employees for exclusion from Medicare and Medicaid
  - Federal Program Participation Exclusion Checks on May 27, 2009 written by Jeffrey Jeter, Chief Compliance Officer
- Existing Corporate Integrity Agreement related to an acquired entity
  - Corporate Integrity Agreements – May 28, 2009 written by Jeffrey Jeter, Chief Compliance Officer
- Annual Reports for 2006, 2007 and 2008
  - 2008 Annual Report
  - @ home AMEDISYS HOME HEALTH SERVICES 2007 Annual Report
  - @ home AMEDISYS HOME HEALTH SERVICES 2006 Annual Report
- Mission Statement
  - Mission statement 06/2009
- Statement of Philosophy
  - 07/2004 Philosophy
- Company Objectives
  - 02/2002 Company Objectives
- Scope of services and hours of operation
  - Scope of Services and Hours of Operations 06/2009
- Whitepaper related to the planned comprehensive continuous chronic care management program
  - Comprehensive, Continuous Chronic Care Management in the Home, April 2009
- Various promotional materials describing programs and services
  - Home Health Services, Disease Management, Diabetes, Awareness, etc
- Corporate, regional and branch level organizational charts
  - Including compliance; growth strategies; mergers and acquisitions; clinical services; quality management and analytics; and risk management
    - Amedisys Organizational Structure – Active Subsidiaries – January 2009
    - Compliance
    - Corporate Growth Strategies
    - Mergers & Acquisitions
    - Clinical Services
    - Quality Management and Analytics
    - Risk Management
    - Executive Bios
    - Regional

- Branch: Gonzales, Hammond, Mandeville
- Documents related to quality improvement efforts
  - Including clinical oversight indicators; summary of performance improvement program; aggregate survey results, utilization review, specialty program outcomes; external benchmarking reports; trended incident reports; and the risk stratification profile
    - Performance Improvement Executive Summary - 2008
    - Satisfaction Survey Results – 30,801 responses – 1/1/08-12/31/08
    - Benchmarking tools (11)
    - Utilization Review Audit - Homecare Only (Question Level)
    - Trended Incident Report – April 7, 2009
- Description of the initial patient evaluation and coding process
- Survey performance results
  - Including survey tracking report; external benchmarking of results; and aggregate survey results for seven quarters, starting in the second quarter of 2007
    - Q4 2008 Survey Tracking (Q1-Q4 for 2007 and 2008)
    - 10 other items
- Management reports
  - Including outstanding litigation summary; report on visits per episode, episodes per patient, percentage of Low-utilization payment adjustment (LUPAs) and outliers; statement on employee turnover; therapy utilization report; missed visit report and process; and clinical outcome reports
    - Litigation Summary
    - (Visits per episode) Key Statistics 2005-2009
    - (Episodes per patient) Key Statistics 2005-2009
    - (Percentage LUPAs-Outliers) Key Statistics 2005-2009
    - (Employee Turnover) - YTD 2008
    - (Therapy Utilizations) Key Statistics 2005-2009
    - Quality Management & Analytics Outcomes Executive Summary September 2008
    - Missed Visit Process
- Information on the acquisition integration process
  - Including memo on the role of corporate compliance, and the training calendar, checklist, and outline for new entities
    - Compliance due diligence process for acquisitions – May 25, 2009 written by Jeffrey Jeter, Chief Compliance Officer and Corporate Counsel
    - Acquisition Training Calendar April 09
    - Acquisition Training Checklist December 08
- Information related to the process for adoption of new and revised policies and procedures
  - Forms/Policy Request
  - Governing Body Approval
  - Highlights of 12/2008 Revisions to Manuals (also 10/08, 4/08, 6/08, 8/08)
  - Policy and Procedure Formulation
- A description of rehabilitation specialty programs and summary of contract therapy visits
  - Contract Therapy Visits
  - Amedisys Specialty Rehab Programs

- An overview and whitepaper on the Encore program
  - Encore White Paper – March 2009
  - Encore, Integrated Care Coordination
- Overview and reports related to Mercury Doc
  - Mercury Doc, AMD – Access My Doctor
  - Key Stats, Mercury Doc Q4 Outliers Report, Mercury Doc Productivity, Bounce back Spreadsheet
- Information on clinical specialty programs, including clinical tracks in English and Spanish; educational materials; best practices; and outcomes
- Risk analysis reports
- Dashboard reports
- COGNOS exception reporting and business requirement reports
  - Business Requirements
  - Project Charter
- Minutes of meetings with clinical experts regarding specialty program development and strategy
- Detailed information related to data recovery procedures
  - Amedisys DR/BC Overview – rev April 2007
  - Disaster Recovery Purchase Orders
- Strategic advisory board meeting minutes and mission statement
  - Strategic Advisory Board Meeting Report – September 9, 2008, January 14, 2009 – January 15, 2009, June 5, 2008
  - Mission and Vision of the SAB
- A sampling of clinical audit tools which measure outcomes for high risk patient populations
  - Adverse Event – DC to Community Needing Toileting Assistance, Adverse Event – DC to community needing Wound Care, Adverse Event – DC to community with Behavior problems, Adverse Event – Development of UTI, etc
  - Utilization Review Audit Tool

## Appendix II

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### **Appendix III**

#### **Amedisys Strategic Advisory Board Members**

**Peter A. Boling, MD**

Professor of Medicine at Virginia Commonwealth University directing Geriatric programs

**L. Allen Dobson, Jr. MD, FAAFP**

Vice President for Clinical Practice Development for Carolinas Healthcare System and President of Cabarrus Family Medicine; Chairman, North Carolina Community Care Networks, Inc.

**Steven Landers, MD, MPH**

Medical Director, Home Care Services for Cleveland Clinic

**Bruce Leff, MD**

Associate Professor of Medicine at the Johns Hopkins University School of Medicine; Interim Director of the Center on Aging and Health Program in Geriatric Health Services Research

**Frank G. Opelka, MD, FACS**

Vice Chancellor for Clinical Affairs at Louisiana State University Health Sciences Center; Fellow, American College of Surgeons; Chairman, Surgical Quality Alliance

**Donald A. Storey, MD**

VP, Medical Affairs for Reach My Doctor Networks

#### **Strategic Advisory Committee Members**

**Steve Adams**

Founder and CEO of Reach My Doctor Networks (RMD Networks)

**C. Gresham Bayne**

Chief Medical Director, Janus Health, Inc.

**Claudia Campbell, PhD**

Professor, Department of Health Systems Management, School of Public Health and Tropical Medicine; Adjunct Professor, Department of Medicine, Tulane University School of Medicine

**David Kibbe, MD, MBA**

Senior Advisor for American Academy of Family Physicians and Principle at The Kibbe Group

**Vince Kuraitis JD, MBA**

Principal and founder of Better Health Technologies, LLC.

**Karl LeBlanc, MD**

Clinical Professor, Surgery – Louisiana State University

**James C. Pyles, JD**

Principal at Powers Pyles Sutter & Verville PC; Washington, DC.

**Paige Sensenbrenner, JD**

Partner, Adams and Reese

**Victor Villagra, MD**

Founder and president of Health & Technology Vector, Inc.

\* Depending on the needs of the Strategic Advisory Board and the agenda topics, the Company will invite partners/guests to join the group.

## **Appendix IV**

### **Elements of the Marwood Scorecard**

Each section is weighted within the section and is then weighted within the total scorecard:

#### **Major Area Sections:**

- Process Measures - 31% of Total Scorecard
- Quality Improvement: Structure and Initiatives – 15% of Total Scorecard
- Electronic Data Capture and Nurse Assessments – 38% of Total Scorecard
- Patient Satisfaction and CAHPS – 15% of Total Scorecard

\*Note percentages do not sum to 100 percent due to rounding.

#### **Individual Section Details:**

- Process Measures - 31% of Total Scorecard
  - Clinical Outcomes Tracking and Quality Improvement Plans – 35%
  - Patient Stratification Clinical Outcome Tracking – 21.7%
  - Nurse Specific Clinical Outcome Tracking and Turnover – 21.7%
  - Patient Follow-up Post Discharge – 21.7%
- Quality Improvement: Structure and Initiatives - 15% of Total Scorecard
  - Quality Improvement Team Structure – 40%
  - Strategic Planning and QI – 15%
  - Third Party Quality Recognition/Publications – 15%
  - QIO involvement – 15%
  - Accreditation – 10%
  - Membership Organization Activity – 5%
- Electronic Data Capture and Nurse Assessments – 38% of Total Scorecard
  - Nurse Assessments and Technology – 40%
  - Full Electronic Data Capture – 40%
  - Billing File Compliance and Technology – 20%
- Patient Satisfaction and CAHPS – 15% of Total Scorecard

## Appendix V

### Detailed Scorecard Results

Organization Type	Organization	Weighted TOTAL Score	Process Measures	Quality Improvement: Structure and Initiatives	Electronic Data and Nurse Assessments	Patient Satisfaction /CAHPS Measures
Public	Public A	75.9%	83.4	80.0	66.7	80.0
	Public B	81.4%	90.7	87.5	80.0	60.0
	Public C	59.3%	74.8	78.8	30.8	80.0
	Amedisys	84.6%	82.0	92.5	77.5	100.0
	Public A-C Average	72.2%	83.0	82.1	59.2	73.3
Private/ Conglomerates	Private/Conglomerate A	72.9%	61.3	85.0	82.5	60.0
	Private/Conglomerate B	94.7%	99.0	86.3	92.5	100.0
	Private/Conglomerate C	55.1%	55.9	72.5	45.4	60.0
	Private/Conglomerate D	65.8%	70.1	61.7	58.3	80.0
	Private/Conglomerate E	87.8%	80.2	92.5	95.0	80.0
	Private/Conglomerate F	76.4%	78.3	83.8	70.4	80.0
	Private/Conglomerate G	67.0%	86.4	83.8	39.6	80.0
	Private/Conglomerate H	88.3%	91.3	73.8	95.0	80.0
	Private/Conglomerate I	94.7%	99.0	86.3	92.5	100.0
	Private/Conglomerate J	53.8%	62.1	63.8	40.8	60.0
	Private/Conglomerate K	64.3%	73.4	83.8	42.9	80.0
	Private/Conglomerate L	81.5%	94.3	71.3	80.0	70.0
	Private/Conglomerate M	78.1%	76.8	58.8	86.3	80.0
	Private/Conglomerate N	97.0%	98.2	96.3	95.0	100.0
		Private/Conglomerate-Average	76.9%	80.4	78.5	72.6
Regional	Regional Organizations-Average	67.2%	72.5	63.5	65.8	64.1
Hospital-Based	Hospital A	43.5%	55.9	60.0	28.3	40.0
	Hospital B	64.3%	79.4	60.4	63.3	40.0
	Hospital C	63.6%	76.2	60.4	64.2	40.0
	Hospital D	42.7%	24.7	34.2	61.7	40.0
		Hospital-Based Average	53.5%	59.1	53.8	54.4