AMEDISYS HOME HEALTH RESPONSE TO STAFF'S OCTOBER 12, 2018 COMPLETENESS QUESTIONS

Part II: Consistency with Review Criteria at COMAR 10.24.01.08G(3)

Populations and Services

1. Please describe the services – if any – which you intend to provide that would augment the standard Home Health Services.

   Applicant Response: As it does in the jurisdictions it currently serves, the Applicant will provide an array of services to augment and enhance the standard Home Health Services. The services the Applicant intends to provide are generally described at pages 8-11 of the Application as part of the project description in response to Question 11, and Exhibits 3 and 4. Below the Applicant will provide additional information beyond what was provided in the Application about particular services that the Applicant will offer.

   Psychiatric services is one of the specialized services that the Applicant will provide, as it does in its current jurisdictions. The Amedisys Empowered for Life behavioral health program targets the specific and unique needs of patients with behavioral health issues. Patients with psychiatric conditions have special needs. The Applicant supports patients under psychiatric care, including care for Alzheimers and depression, among other diagnoses. Traditionally, behavioral health issues addressed at home have focused on patients with a primary diagnosis of Alzheimers, dementia or psychiatric, leaving out a third group of those with depression or anxiety disorders arising from a primary diagnosis of heart failure, diabetes, COPD or other serious disease. A primary diagnosis of such a disease may trigger depression or anxiety disorders or may be exacerbated by other more severe diagnoses, necessitating nursing care that is specific to both conditions. The Empowered for Life Program was developed as part of Amedisys' comprehensive care at home plan in order to assess and treat patients suffering from the full range of psychiatric conditions -- including those who are suffering from depression, anxiety or other disorders in tandem with a primary diagnosis of heart failure, diabetes, COPD or other serious disease.

   The Empowered for Life program uses evidence-based practices to shift the treatment model to one of patient involvement and empowerment with the goal of beginning a recovery lifestyle. The program moves beyond traditional teaching of coping skills to a model of involving the patient to identify problematic behaviors and interactions, choosing approaches to learn and incorporating these new skills through role playing and homework exercises. Whenever possible, family members and other caregivers are involved in this teaching and role modeling.

   Please refer to **Exhibit 22** for an article about the Amedisys Empowered for Life Program from the Alliance for Home Health Quality and Innovation.

In addition to the Empowered for Life program, the Applicant provides (and intends to provide in the new jurisdictions) an array of evidence-based, specialized disease management programs that provide a coordinated approach to managing overall health status for patients with chronic illnesses, designed to improve patient outcomes and contain health care costs. The programs are listed on page 9 and 10 of the Application, with additional information in Exhibit 4. These programs have in common the following characteristics and advantages:

- Improving the quality of care
- Actively engaging the patient in health promotion
- Focusing on educating the patient in self-care management
- Partnering with physicians to promote disease prevention and proactive care
- Collaborating with partners in the medical community and coordinating care across the continuum
- Applying evidence-based guidelines in patient care standards
- Measuring clinical outcomes to improve health and quality of life
- Reducing emergent care and acute care hospitalization rates
- Recognizing early warning signs and symptoms to prevent exacerbations
- Facilitating an easier transition for patients from facility to home setting

Among the specialized disease management programs to be offered is one for heart disease (Heart@home), which uses skilled nurses, therapists and other clinicians to provide at-home care for patients with heart failure, hypertension, myocardial infarction, coronary artery disease, CABG, CVA and other heart conditions. Detailed assessment and education are provided on management of medications, symptoms, mobility and other aspects of care. The program provides:

- Identification and monitoring of early warning signs to prevent exacerbation.
- Plan of care management
- Medication monitoring and management, including injections, IM and IV
- Post-surgical and post stroke care
- Wound care
- Patient and caregiver education, including education for newly diagnosed patients and self-management skills
- Therapy and rehabilitation to help patients with tasks of daily living

Another such program is the Applicant's Diabetes Disease Management Program (Diabetes@home), which was developed to provide patient management for patients with Type 1 and Type 2 Diabetes. The program utilizes diabetes clinical tracks, which focus on patient education on self-management, basic survival skills and complications associated with diabetes. Benefits to the patient and physician include:

- Maximized blood glucose control
- Recognition of early warning signs/symptoms and appropriate interventions
- Reduced need for urgent/emergent care
- Reduced hospitalization
- Improved quality of life

- Patient diaries for documentation of blood glucose, insulin administration and activities
- Educational focus on self-care management skills
- Clinical outcomes feedback
- Multidisciplinary team
- Staff credentialing and competency testing

The program is based on national standards supported by the American Diabetes Association (ADA), and helps patients understanding the importance of controlling blood glucose levels and the prevention of long term complications. Amedisys has received recognition from the ADA for its program.

Another specialized service is the Amedisys Chronic Obstructive Pulmonary Disease (COPD) Disease Management Program (also referred to as COPD@home). This program has been carefully designed to help improve the quality of life for patients living with COPD. Teaching self-management and early intervention skills are the keys to improving patients' quality of life. Through the active involvement of the patient and caregiver in the management of their disease, the treatment plan will help prevent or delay complications for those living with COPD and help the patient achieve the best possible outcome. The program uses an interdisciplinary team approach to enhance patient/caregiver's knowledge of the COPD disease process through education and improve their self-management and understanding of the disease. Like the Applicant's other specialized disease management programs, this helps to reduce emergent/urgent care visits and reduce hospitalizations and readmissions. The Applicant's skilled home care clinicians help with oxygen therapy, medication management and monitoring of vitals, all essential to managing COPD effectively.

Likewise, the Chronic Kidney Disease Management Program (Chronic Kidney Disease@home) addresses a chronic disease afflicting millions of Americans, many who are unaware they have the disease. The program provides early assessment, intervention and education on risk factors including management of high blood pressure, which is often present with CKD, diet and medication management.

The Applicant's Partners in Wound Care program recognizes that wound care is frequently complicated by multiple disease conditions. The Applicant implements the most current evidence-based practices, incorporates the most current techniques and uses the most advanced products to improve healing.

Please refer to Exhibit 4 to the Application for descriptions of additional specialized programs to be offered. Additionally, **Exhibit 23** to this filing includes some educational and marketing materials regarding some of these programs.

Financial Accessibility

2. Please report your 2017 Payor Mix as a percentage of total revenue.

Applicant Response: The table below provides the payor mix in 2017 as a percentage of total revenue. Please note that the amount of charity care is shown as revenue based on list prices.

Revenue		
Medicare	$ 11,343,380	94.44%
PPS Episodic	$ 220,066	1.83%
Private/Medicaid	$ 520,424	4.33%
Allowance for Bad Debt	$ (72,839)	-0.61%
Charity Care	$ 9,400	0.08%
Charity Care Write-offs	$ (9,400)	-0.08%
Net Patient Service Revenues	$ 12,011,031	100.00%

Fees and Time Payment Plan

3. As requested in the standard and in the guidance provided at the pre-application conference, please cite the specific language, as well as a citation of the location, from the policy which describes the clients' time payment options and mechanisms to arrange payments.

   Applicant Response: As noted in the Application (p.15), Exhibit 7 includes a clean copy of the Applicant's Charity Care Policy as well as a version with comments in the margin highlighting the time payment plan provision and other required provisions under the standard. On page 2 of the Policy, the Time Payment Plan provision is highlighted with a comment noting that this is the provision under which patients who are eligible for discounted fee care may request a time payment plan. The specific language is as follows: "A patient who qualifies for discounted fee care under this policy may request to pay billed charges over time. Amedisys requests a minimum of $25 per month with the balance being resolved within 1 year from start of care."

Financial Feasibility

4. Please provide an explanation for basis of your financial projections in Tables 3 and 4. A HHA's Projected Revenue should be based on its experience in providing HHA services to other jurisdictions it serves.

   Applicant Response: The financial projections in Tables 3 and 4 of the Application are based on the 2017 actual results of the existing operations of the Applicant in its Cambridge and Salisbury offices. Revenue projections are based upon actual revenue per admission earned in those existing locations. Visits per admission and costs related to those visits are also based on existing locations and actual visits performed and pay to clinicians for those services.

5. Table 5, "Staffing Information," reflects an increase of 8.25 staff and contractual FTEs. When will these FTE increases take place?

   Applicant Response: The Applicant intends these FTEs to commence work with the initiation of services in the new jurisdictions.

Impact

6. Please specifically address the impacts that your entering the market will have on existing HHAs' caseloads, staffing and payor mix.

   Applicant Response:

   Caseloads: The Applicant projects to serve 382 patients and 9.985 visits in Caroline, Kent and Queen Anne's Counties in its fourth year of operation (first year at projected full utilization). This projected caseload is modest and, while it would not be inconsistent with the State Health Plan' purpose of opening up these counties to additional competition from high quality HHAs, it is not expected to have a material impact on the caseload of any existing HHA.

   Several factors strongly indicate that there will be significant organic growth in utilization in these counties such that there would be little or no impact on existing HHA's caseloads. As explained in the Application, the elderly population of these counties is projected to double in size between 2010 and 2030, and grow by nearly 40% between 2020 and 2030. (See Table 20 on Application page 33). There were 33,557 total visits provided in these counties in 2014, which represented a 23% increase since 2010. Simply carrying forward that same growth rate would result in an additional 7,700 visits in 2019, and an additional 9,500 visits in those counties five years later (2024), when the Applicant will be at full utilization.

   Additionally, these counties underutilize home health services currently, and simply increasing utilization to the statewide average will increase caseloads (see Application Table 23, at page 35). Further, home health utilization can be expected to increase with the Total Cost of Care model driving care to lower cost settings while maintaining quality, as well as with advances in technology allowing more care to be safely provided in the home setting.

   Accordingly, with the organic growth in the elderly population and in utilization that is likely to occur in these counties, the project will not materially impact existing HHAs' caseloads.

   It should also be noted that, as explained in detail in the Application (at page 41), of the existing HHAs that serve in one or more of the three counties that the Applicant seeks to serve, only two of them rely on Caroline, Kent and/or Queen Anne's Counties for a substantial portion (40% or more) of their caseloads, and one of those HHAs serves other counties as well.

   Staffing: Because the Applicant is an existing HHA serving other counties on the Eastern Shore, it can use its existing staff to help serve the new counties, minimizing the number of

new staff that need to be hired. As shown on Table 5, the Applicant projects needing to hire only 6 FTEs as additional staff, including 2 administrative personnel, 3 registered nurses, 1.5 physical therapists, 0.5 occupational therapists, 0.25 speech therapists, 0.25 home health aides, and 0.25 medical social workers. The Applicant has not experienced any workforce shortages or difficulty in recruiting and retaining qualified staff in this region. Accordingly, the modest number of new staff to be hired by the Applicant (only four of which will be clinical staff) will not impact existing HHAs in these counties.

Payor Mix: As shown in the Application (at page 41), three existing HHAs derived more than a de minimus percentage of their total clients and visits from Caroline, Kent and/or Queen Anne's County in 2014 (the most recent year for which data is publicly available) – Home Call, Shore Health and Chester River. Those agencies' 2014 payor mix and the Applicant's projected payor mix (based on its payor mix in its existing jurisdictions) is as follows:

Payor	Home Call (#7066)	Shore (#7139)	Chester River (#7142)	Applicant
Medicare	93%	72%	72%	94%
Medicaid	1%	6%	2%	4%
Private insurance and other	6.9%	22%	26%	2%

Like these existing HHAs, the Applicant expects Medicare to be its largest payor source, and will serve Medicaid as well. Further, as an existing HHA with existing contracts with private insurers for the jurisdictions it currently serves, the Applicant will continue to serve privately insured patients in the new jurisdictions under those contracts The Applicant contracts with several major private payors (including Carefirst), and is always open to contracting with additional payors on commercially reasonable terms. While its projected private insurance percentage is at the lower end of the range compared to the existing HHAs serving these counties in 2014, it is important to note that the Applicant does not decline referrals of any privately insured patient unless it is not contracted with the insurer.

With the organic growth in the elderly (Medicare) population and in home health utilization that is likely to occur in these counties (as described above under Caseloads and in the Application), the Applicant projects no material impact on the other HHAs' payor mixes because of the Applicant's entry into the market.

Financial Solvency

7. Please provide specific citations and language from your more than 115 page Annual Report (Exhibits 15 and 16) that demonstrate the availability of financial resources necessary to sustain this project.

Applicant Response: As it is the most recent, the 2017 Annual Report best demonstrates the availability of financial resources necessary to sustain this project. Please refer to page 49 of

the 2017 Annual Report (Exhibit 16) which shows that Amedisys, Inc. had $86,363,000 in Cash and Cash Equivalents on hand as of 12/31/17, as well as $224,793,000 in other current assets (including Accounts Receivable). Additionally, page 50 reports Net Income for 2017 of Amedisys, Inc. of $30,301,000. Please also refer to page 28 of Exhibit 16 includes a chart that compares the outstanding debt of Amedisys, Inc. (in the amount of $88,841,000 as of 12/31/17) to assets on hand (in the amount of $813,482,000 as of 12/31/17).

Discharge Planning

8. Please provide page 1-7 of Attachment 12, Policy: AA-016 "Discharge of Patients". Be sure to include a list and a description of valid reasons to discharge or transfer patients.

Applicant Response: The Applicant regrets that an incomplete copy of its Discharge Policy was inadvertently attached to the Application. Further, the version of the Discharge Policy that was attached to the Application has been updated. Accordingly, please refer to **Exhibit 24** for the Applicant's updated, complete Discharge Policy. Under that Policy, the following reasons for discharge are provided (at pages 3-4):

The HHA may only transfer or discharge the patient from the HHA if:

A. **Acuity**:
   (1) The transfer or discharge is necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity.
   (2) The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities;
   (3) **Examples include**:
      a. *The agency can no longer provide appropriate staffing.*
      b. *The agency will no longer provide a particular service needed by patients*

B. **Payment/Eligibility**:
   (1) The patient or payer will no longer pay for the services provided by the HHA.
   (2) The patient fails to continue to meet criteria for eligibility of services established by the patient's payor sources.
   (3) **Examples include**:
      a. *Failure to comply with face-to-face and homebound requirements.*
      b. *The agency has not been/will not be compensated for care provided*
      c. *No signed orders from appropriately licensed practitioners (doctors of medicine, osteopathy or podiatry) are in effect upon which to base services.*
      d. *In the event of a natural disaster when the client's health and safety is at risk.*
      e. *If the patient is found to be ineligible for home care services, all attempts will be made by the agency to direct the individual to the appropriate community resource and notification will be made to the patient's attending physician and/or referral agency.*

C. **Goals and measurable outcomes achieved/goals met:**
   (1) The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and

goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved;

(2) And the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services;

(3) **Examples include**:

a. The goals of the patient's plan of care have been attained or are no longer attainable.

b. A caregiver has been prepared and is capable of assuming responsibility for care.

D. Patient's choice:

(1) Patient refuses services,

(2) Patient elects to be transferred or discharged;

(3) **Examples include**:

a. The patient moves to a location outside of the licensed geographic service area of the agency.

b. The patient or his/her legally authorized representative chooses another provider

c. The patient or the patient's legally authorized representative terminates services by the Agency or refuses care.

E. Discharge for cause:

(1) The patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired.

(2) **Examples include**:

a. Threats of violence or actual violence to agency staff members, and conditions in or around home, which pose safety risk to staff.

b. The patient's home environment will not support the provision of home health services.

c. There is suspected illegal activity in the patient's home. i.e. drug abuse or history of drug abuse.

d. Agency staff members are subject to sexual harassment or verbal abuse when they provide services to the patient

e. The patient cannot care for him/herself in between visits from Agency personnel and no reliable paid or voluntary primary caregiver is available to meet all of the needs of the patient between visits by Agency staff

f. The patient and/or primary caregiver are noncompliant or have a documented history of noncompliance in cooperating to attain the objectives of home care

g. Agency staff members are subject to racial discrimination when they provide services to the patient.

(3) The HHA must do the following before it discharges a patient for cause:

a. Advise the following that a discharge for cause is being considered:

i. The patient,

ii. representative (if any),

iii. the physician(s) issuing orders for the home health plan of care, and

iv. the patient's primary care practitioner or other health care professional who

will be responsible for providing care and services to the patient after discharge from the HHA (if any).

b. Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation;
c. Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and
d. Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records.

F. The patient dies; or

G. The HHA ceases to operate.

Higher levels of performance will be given preference over lower levels of performance

9. Please provide full version of your CMS "Provider Preview Reports".

Applicant Response: Please refer to **Exhibit 25** for the full version of these reports.

Proven Track Record in Serving all Payor Types, the Indigent and Low Income Persons.

10. In Table 18 of your application, which payor type accounts for charity care patients?

Applicant Response: Charity care is encompassed in the "private" category.

Proven Track Record in Providing a Comprehensive Array of Services.

11. Please provide a comprehensive listing of services offered to patients including descriptions.

Applicant Response: Please refer to **Exhibit 26** hereto for a list of the basic home health services provided by the Applicant with descriptions.

Additionally, please refer to Exhibit 4 to the Application for a comprehensive list and descriptions of the array of evidence-based, specialized disease management programs provided by the Applicant which provide a coordinated approach to managing overall health status for patients with chronic illnesses, designed to improve patient outcomes and contain health care costs. Additional information about these programs is also included in response to Question 1 above.

The Applicant's groundbreaking Empowered for Life behavioral health program, which targets the specific and unique needs of patients with behavioral health issues, is described in detail in response to Question 1 above and **Exhibit 22** hereto. The Applicant's Salisbury office has cared for 340 total patients in the Empowered for Life, COPD @ Home, Heart @ Home programs since 2017, and the Cambridge office has cared for 177 patients in these programs in that same period.

Additionally, the Applicant's Care Transitions Program to reduce avoidable hospitalizations is another important part of the comprehensive array of services offered by the Applicant. It is described at length in the Application at pages 9-10 and in Exhibit 3 to the Application.

Availability of More Cost-Effective Alternatives

12. As you did not completely answer all parts of the standard, please address the following: please provide a full description of alternative approaches to meeting the objectives that you outlined in this section. The effectiveness of each alternative should be evaluated and the cost of each alternative should be estimated.

Applicant Response: As explained in response to this Standard, the Applicant's objective is to expand its footprint in the state of Maryland in order to generate increased organic growth and enhance its recognition and stability in the Maryland market as a provider of high quality home health services. The Applicant identified the Upper Eastern Shore for this expansion due to market potential associated with its low home health utilization rate and its growing 65+ population, and also due to the limited competition that currently exists in these counties, which presents a market opportunity for high quality providers like the Applicant.

There are only two alternatives available to the Applicant to achieve the objective of expanding its home health footprint into the Upper Eastern Shore: (1) obtain a CON to expand its existing home health agency on the Eastern Shore into the Upper Eastern Shore, or (2) acquire an existing HHA serving that area. The current market price to acquire an existing agency is as much as 12 times the HHA's earnings before interest, taxes and amortization (EBITA). That assumes that there is an existing HHA on the market that is already authorized to serve these counties, and the Applicant is aware of none. (In fact, there is only one HHA that serves all three counties that the Applicant seeks to serve through this Application.) Further, the Commission has determined that there is a need for additional HHAs to serve the Upper Eastern Shore in order to provide consumers with "meaningful choices for obtaining high quality services in which one HHA or a small number of HHAs do not command overwhelming dominance." COMAR 10.24.16.03B. The only way to accomplish the Commission's objective is to authorize new high quality HHAs in the Upper Eastern Shore that meet the other requirements of the Chapter. The Applicant's acquisition of an existing HHA would not accomplish the Commission's objective of providing consumers with additional options for high quality home health care.

In contrast to purchasing an existing HHA, there is minimal expense for the Applicant to expand to the Upper Eastern Shore, as shown in CON Table 1. Further, expanding its existing HHA serving the Eastern Shore into the Upper Eastern Shore is an efficient way to accomplish the objective because the Applicant is able to operate out of its existing offices. While the project requires additional staffing, the 6 FTEs that the Applicant intends to hire is less than would be required for a new office because the Applicant can use some of its existing staff to serve the new counties. As shown in CON Table 4, the project is profitable beginning in its first year due to these efficiencies.

Accordingly, obtaining a CON to expand its existing home health agency to the Upper Eastern Shore is the most cost effective alternative. Acquiring one of the existing HHAs serving the Upper Eastern Shore would be more costly and less efficient, and would not achieve the State Health Plan objective of providing consumers in that region with additional options for high quality home health care.

Viability of the Proposal

13. Please provide an Audited Financial Statement for your specific branch of Amedisys. If this information is included in the application, then provide a citation for the specific information pertaining to your branch of Amedisys. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant.

Applicant Response: The Applicant (Amedisys Maryland, LLC d/b/a Amedisys Home Health) is a wholly owned subsidiary of Amedisys, Inc. As a publicly traded company, Amedisys, Inc.'s audited financial statements for 2016 and 2017 are part of its annual Form 10-K filed with the SEC, which are attached to the Application as Exhibit 15 and 16, respectively. Amedisys, Inc.'s audited financial statements begin on page 59 of Exhibit 15 and page 48 of Exhibit 16. The audited financial statements of Amedisys, Inc. are compiled on a consolidated basis to include all of its subsidiaries, including Amedisys Maryland, LLC, in compliance with the Sarbanes-Oxley Act of 2002 applicable to publicly traded companies. Individual subsidiaries of Amedisys, Inc. do not maintain their own financial statements.

As shown in CON Table 1, the only cost to establish the project is CON legal fees of $40,000, and an annual expense to lease minor moveable equipment of $3,000. The source of funds for the $40,000 CON expense and the $3,000 annual lease expense is documented on page 49 of Exhibit 16 to the Application (Amedisys, Inc. 2017 audited financial statement) which shows that Amedisys, Inc. had $86,363,000 in Cash and Cash Equivalents on hand as of 12/31/17, as well as $224,793,000 in other current assets (including Accounts Receivable). Additionally, page 50 reports Net Income for 2017 of Amedisys, Inc. of $30,301,000.

As shown in Table 4, this project is profitable beginning in its first year. However, should there ever be a shortfall, the Applicant is backed up by the substantial resources of its parent company (documented in its consolidated audited financial statements as described above).

14. When answering part (b.) of this Criteria you referenced CON Table 3. This Table does is not related to the question. Please provide the correct table and address the probable impact of the project on the cost of core services you provide and will provide.

Applicant Response: While the Applicant believes that Table 3 is relevant to this question because it shows the Applicant's total existing and projected expenses in providing home health services, including the proposed project, the Applicant should have also referred to Table 4, which shows the Applicant's expenses for this project only, in order to serve the

three additional counties proposed in this Application. These two tables together demonstrate the impact of the project on the Applicant's costs to provide home health services. As an existing HHA serving other counties on the Eastern Shore, the Applicant can efficiently expand to serve Caroline, Kent and Queen Anne's Counties. Similar to the response of VNA to this question in its recently approved CON application to serve the lower Eastern Shore, the impact of this project on the Applicant from a cost perspective (as shown in the Revenues and Expenses table) is almost entirely the direct labor expenses associated with the additional 6 FTEs (employees and contractual). Other expenses for this project include transportation, advertising, training, office and other supplies. As shown in Table 4, no office rental expense is associated with the project because the Applicant will operate out of its existing offices in Cambridge and Salisbury.

15. Please discuss the probable impact of the project on the cost for services provided by other home health agencies in the area. In your response, you referred to the impact on charges only.

    Applicant Response: The project will not impact on the cost of services provided by other home health agencies. As explained above, and as shown on Table 5, the Applicant projects needing to hire only 6 FTEs as additional staff (4 of which are clinical staff). The Applicant has not experienced any workforce shortages or difficulty in recruiting and retaining qualified staff in this region. Accordingly, the modest number of new staff to be hired by the Applicant to serve three additional counties (only four of which will be clinical staff) will not raise the costs of hiring qualified staff by existing HHAs in these counties.

16. What is the applicant's average turnover rate?

    Applicant Response: The Applicant has a low average turnover rate. Its trailing 120 month turnover rate is only 3.2% in the Cambridge office and 7.3% in the Salisbury office.

Impact on Existing Providers

17. Please provide source(s) and discuss logic used to make the prediction that there will be no impact on payer mix of other home health agencies.

    Applicant Response: Please refer to the Applicant's response to Question 6 (Payor Mix) above.

18. As you are an existing provider, please submit a summary description of the impact of the proposed project on the applicant's costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

    Applicant Response: As an existing HHA serving other counties on the Eastern Shore, this project would represent an efficient expansion of services to additional jurisdictions (Caroline, Kent and Queen Anne's Counties) in which the State Health Plan Chapter recognizes the need for additional competition from additional, high quality HHAs like the Applicant. As shown in the Project Budget (Table 1), there are no capital costs associated

with the project because the Applicant will operate out of its existing offices in Cambridge and Salisbury. The only startup expense is the cost of obtaining the CON. Table 1 also shows a $3,000 annual lease expense for minor moveable equipment (laptops, etc). As shown in CON Table 4 (Revenues and Expenses associated with the project), the ongoing impact of this project on the Applicant from a cost perspective is almost entirely the direct labor expenses associated with the additional 6 FTEs (employees and contractual) which are shown in CON Table 5, with small additional expenses for transportation, advertising, training, and office and other supplies. As shown in Table 4, in 2022 (the first year at full utilization), labor costs represent 90% of the total expenses associated with the project. As further shown in Table 4, this project is profitable in its first year of operation.

Part IV: Tables

Table 1

19. Please fill out Table 1 and document each of the "Sources of Funds for Project" for Section B of Table 1.

Applicant Response: Table 1 as filed with the Application contains all of the costs associated with establishing the project. There are no capital costs associated with this project. As shown in Part A of Table 1, Line c, the only "Financing Cost and Other Cash Requirements" associated with the project is CON legal fees of $40,000. The source for the $40,000 is cash, as shown on line 1 of Part B. Additionally, as shown in Part B, there is a $3,000 annual cost to lease minor moveable equipment. The source of cash for the $40,000 CON expense is documented on page 49 of the 2017 Annual Report (Exhibit 16 to the Application) which shows that Amedisys, Inc. had $86,363,000 in Cash and Cash Equivalents on hand as of 12/31/17, as well as $224,793,000 in other current assets (including Accounts Receivable). Additionally, page 50 reports Net Income for 2017 of Amedisys, Inc. of $30,301,000. Please also refer to page 28 of Exhibit 16 includes a chart that compares the outstanding debt of Amedisys, Inc. (in the amount of $88,841,000 as of 12/31/17) to assets on hand (in the amount of $813,482,000 as of 12/31/17).

Additionally, please note that the $3,000 annual expense for minor moveable equipment is an expense of the project shown in Table 4. As shown in Table 4, the project is profitable beginning in its first year, including this expense.

Table 5

20. Please specify the job classifications of "Other" employees listed on Table 5.

Applicant Response: This was an error in the Table. A revised Table 5 is attached in which these employees have been removed.

TABLE 5. STAFFING INFORMATION

Position Title	Current No. of FTEs (2017)		Change in FTEs (+/-)		Average Salary		TOTAL SALA EXPENSE (2(
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency
Administrative Personnel	15		2		78,500		1,334,500
Registered Nurse	34		3		71,112		2,631,144
Licensed Practical Nurse	1				46,410		46,410
Physical Therapist	18	2	1.5	0.5	95,000	212,550	1,852,500
Occupational Therapist	9		0.5		89,888		853,936
Speech Therapist	4		0.25		91,655		389,534
Home Health Aide	1.25		0.25		29,000		43,500
Medical Social Worker	1.25		0.25		55,700		83,550
Other (Please specify.)							-
Benefits							$1,808,769
						TOTAL	$9,043,843

$1

ARY 022)
Staff
425,100
$425,100

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to October 12, 2018 Completeness Questions are true and correct to the best of my knowledge, information and belief.

Dated: October 12, 2018

Name: Geoffrey Abraskin
Title: Vice President of Operations

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to October 12, 2018 Completeness Questions are true and correct to the best of my knowledge, information and belief.

Dated: October 12, 2018

Brenda Dile

Name: Brenda Dile

Title: Vice President Clinical Practice

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Response to October 12, 2018 Completeness Questions are true and correct to the best of my knowledge, information and belief.

Dated: October 12, 2018

Michelle B. Gee, CPA

Name: Michelle B. Gee

Title: Regional Director Financial Ops.

EXHIBIT 22

Alliance for Home Health Quality and Innovation

FACES *of* HOME HEALTH

Caring for Patients with Behavioral Health Issues at Home

With the mission of bringing the continuum of care into the home, Amedisys' Empowered for Life program targets the specific and unique needs of patients with behavioral health issues. Developed in 2010, the Empowered for Life program originated from the idea of helping all patients—recognizing behavioral health issues that often accompany primary diagnoses of Heart Failure (HF), diabetes, COPD, and more.

Behavioral issues can often occur concurrently with other medical diagnoses. Elizabeth Gregory, RN, CNS, PhD, Director of Behavioral Health at Amedisys, says behavioral health issues addressed in the home are often put into two categories—dementia and psychiatric patients—leaving a third group of those with depression and anxiety disorders without the attention they need. A primary diagnosis of, for example, heart failure or COPD, may trigger depression and anxiety disorders, or may be exacerbated by other, more severe diagnoses. Thus, the Empowered for Life program was born as part of Amedisys' comprehensive care at home plan in order to assess and treat patients suffering from the full range of psychiatric conditions. A majority of the program's patients are direct referrals from doctors who recognize psychiatric patients, or patients who are exhibiting signs of depression, anxiety, or dementia. A credentialed psychiatric nurse will then do an evaluation of the patient and report back to the doctor. Some evaluations are requested by nurses and other home health clinicians, and a referral is obtained from the physician.

Mr. John Cross is a 66 year-old Vietnam War veteran who was diagnosed with schizoaffective disorder after his third deployment. Prior to his last hospitalization, he was diagnosed with asymptomatic lung cancer and had recently lost his sight from untreated glaucoma. Following his most recent in-patient psychiatric hospital admission in January, 2014, Mr. Cross entered Ford Road Care Home, an assisted care facility, where he received six weeks of home health care from the Amedisys team.

Empowered for Life patient John Cross, pictured with his sister Ms. Shirley Nelms on the far left right, Susan Mullikin, RN of Amedisys, and Ford Care Home Operator Ms. Cornelius Rand on the far right.

Through the Empowered for Life program, Amedisys worked with Mr. Cross, his sister Shirley Nelms, and the Ford Care Home to provide Mr. Cross with occupational therapy for low vision and adaptation interventions, physical therapy for fall risk prevention, psychiatric nursing, and caregiver education in his new group home. Working together, Mr. Cross's team of skilled clinicians and caregivers helped devise a plan that directly addressed occupational needs, and has thus far prevented unnecessary rehospitalization.

Working with Patients in Assisted Care Facilities

Caring for patients like Mr. Cross with behavioral health conditions requires a strong team-based approach that includes home health professionals, caregivers (both family and formal caregivers), and physicians. Upon discharge from the hospital, Mr. Cross moved into Ford Care Home, which is run by Cornelius Rand, a care home operator with experience working with psychiatric patients. Ford helped to ease Mr. Cross's transition into a new home with the assistance of Amedisys.

Susan Mullikin, the Psychiatric Program Manager for Amedisys in West Tennessee, saw Mr. Cross for seven visits. "Initially we focused on teaching his caregiver and sister about his psychoactive medication regimen," said Mullikin. "Everyone understood what the drugs did and how we monitored effectiveness."

Over the course of his home health episode, Mr. Cross received a number of different therapies to ease his transition from the hospital to his new home and adapt to his blindness. According to Ms. Nelms, Mr. Cross is now able to put on his clothes, tie his shoes, and feel his way down the hall—all areas he struggled with after initially being discharged from the hospital. She also noted how comfortable her brother felt with the care team, and the importance of home health in easing the transition to an entirely new home.

As his family caregiver, Ms. Nelms has helped her brother at every step, working with both the care home and the home health team to help her brother continually adapt. Mullikin noted that Mr. Cross "lights up like a Christmas tree" whenever he hears his sister's name. "I try to be as much support as I can," said Ms. Nelms, who also helps her brother to obtain his Veterans Affairs system benefits.

Another important aspect of the care team was Mr. Cross's new care home. Ms. Rand touched on the relationship they developed with Amedisys, and how their team gave them the ok to call any time with questions or concerns.

"One of the things we hope to do," said Ms. Mullikin, "is give this care home setting another level of care. Instead of sending patients directly to the emergency room, they can call us. Otherwise, the only option they have is to call the police (for psychiatric incidents) or an ambulance (for medical issues)."

Tailoring Care for the Patient

Although Mr. Cross's mental health condition, Schizoaffective Disorder, is a chronic condition, his home health episode of care helped him adapt to a new home and condition, and avoid rehospitalization—an emphasis in his plan of care.

In order to best serve the patient, the home health team worked with Mr. Cross on daily tasks and functions, such as strength training, group behavior, and activities of daily living.

After Mr. Cross was diagnosed with asymptomatic lung cancer, Mr. Cross's home health care team worked with him to support his efforts to quit smoking, a difficult task for the lifelong smoker.

Ms. Mullikin spoke of the importance of building a relationship with each individual patient, especially in cases of psychiatric diagnoses. "We have a number of interventions we use, but probably the most powerful factor is the ability to build a relationship with the patient and caregivers." Ms. Mullikin also emphasized that a key factor in improving patient outcomes is having a relationship with a nurse that makes them feel safe. Coupled with the therapy interventions Mr. Cross received, the security he felt with the Amedisys team helped combat some of the symptoms associated with schizoaffective disorder, including depressed episodes, periods of manic behavior, and impaired occupational function. Treating Mr. Cross, and other behavioral health patients, requires a combination of skilled care and relationship building—a focus of the Empowered for Life program.

Despite the struggles, both his sister and Ms. Rand spoke about Mr. Cross's improvement both throughout and after his home health episode.

"Mr. Cross will always struggle with psychiatric issues," Mullikin said, referring to the diagnosis he received following his return from the war. "But he's been out of the hospital for nine months, and going from a psychiatric VA hospitalization to a new care home with the history he has is a success story for all of us."

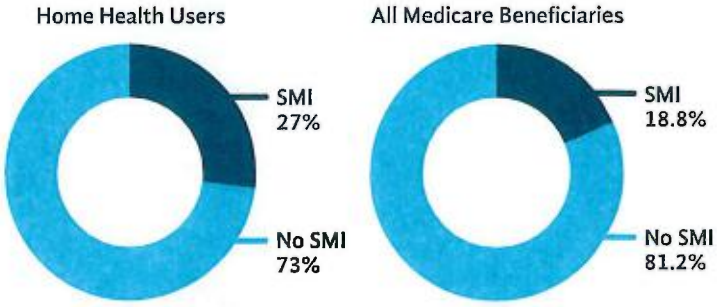
Information about Patients with Mental and Behavioral Health Issues

National trends for home health care reveal that patients receiving the Medicare home health benefit are more likely to have a severe mental illness (SMI) as compared to the general Medicare population. By way of background, SMI is defined as having depression or another mental disorder, which may include bipolar disorder, schizophrenia, and other psychoses. The following information, taken from the 2014 Home Health Chartbook, reveals basic demographic information using the 2012 Medicare claims data for the patients receiving home health care services under the Medicare program. You can find the full analysis and past years of data at http://ahhqi.org/research/home-health-chartbook.

Medicare home health care providers in the United States serve a disproportionate share of SMI patients as compared to the overall Medicare population.

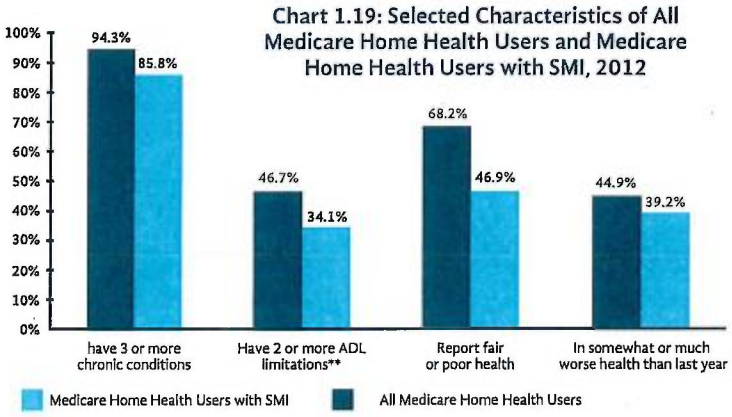
- In 2011, more than one in four, 27.0%, of home health users had a SMI (compared with 18.8% of all Medicare beneficiaries).
- Home health users with SMI tend to be sicker, with a larger proportion having multiple chronic conditions as compared with the general Medicare population. Of those Medicare home health users with SMI, 94.3% suffered from three or more chronic conditions (compared to 62.9% of all Medicare beneficiaries).

Demographics of Home Health Users by Severe Mental Illness (SMI)*



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file, 2012

* Severe mental illness (SMI) is defined as having depression or other mental disorder, including bipolar disorder, schizphrenia, and other psychoses.



Source: Avalere analysis of the Medicare Current Beneficiary Survey, Access to Care file 2012.

* Severe mental illness (SMI) is defined as having depression or another mental disorder, including bipolar disorder, schizophrenia, and other psychoses.

**ADL = Activities of daily living, such as eating, dressing, and bathing. Limitations with at least 2 ADLs is considered a measure of moderate to severe disability and is often the eligibility threshold for a nursing home level of care.

- A high proportion of home health users with SMI also tend to have low incomes. 75.8% of home health users with SMI have an income level under 200% of the Federal Poverty Level (compared to 53.1% of all Medicare beneficiaries).
- 97.2% of home health users with SMI have depression, while 21.6% of users with SMI have a mental disorder such as bipolar disorder, schizophrenia, and other psychoses.

Typical Empowered for Life Patient:

Generally, patients in the Empowered for Life program are older and have reduced abilities and a loss of independence in their homes. This leaves many feeling isolated and with reduced appetites. Patients who enter the program, according to Ms. Gregory, receive care that is tailored to not only their complete set of diagnoses, but also multiple other factors that include their environment, family situation, and socioeconomic status.

"It's a matter of getting inventive and creative and looking at what programs and services they've been involved with in the past," said Gregory. Nurses are taught to work with patients and caregivers to identify areas of need, and will work with them to ensure they get the support needed, including working with VA programs, and community-based services such as Meals on Wheels.

It's important to understand that many patients may not just be resistant or non-adherent to their plan of treatment, Gregory added. These patients may be suffering from depression, anxiety or other severe mental illness, which may be inhibiting their compliance.

"When you're depressed," she said, "Your mind functions at a slower pace; you lose interest in things, and learning is more difficult."

Due to the complexities in treating patients with severe mental illness, the Empowered for Life program includes a multidisciplinary approach. Amedisys developed their own series of training courses for nurses working within the program to prepare them to serve patients with serious mental illness. These courses are coupled with ride-alongs, teaching guides, and step-by-step lists of what to address with the patient in order to care for each patient holistically.

Importance of Programs for Behavioral Health:

Ms. Gregory expressed concerns over inaccurate portrayals of mental illness, including the perception of a highly violent population. This, she says, is not true, and in fact violent behavior is no more likely in the mental health population as in the general population. Patients with mental and behavioral health diagnoses deserve to be treated with the same dignity as any another patient population. Home health can be the "eyes and ears" within the residential environment to clue in on important factors such as family dynamics, emotional tension, living conditions, and lack of available supplies that may impact a patient's overall and mental health.

Despite the importance of clinical behavioral care in the home health setting, only 3-5% of RNs specialize in psychiatric care. Ms. Gregory said that once medical nurses see the impact of a psychiatric nurse in the care of patients, they notice a huge improvement in the patient's overall health.

Working with psychiatric patients requires coordination and communication among all members of the care team, including the patient and caregiver. Because of this, and the stability a home environment may provide, the home may serve as a key locus of care. Ms. Gregory stressed that the program is not trying to supplant the mental health space, but instead serving as a supporting partner for homebound patients with behavioral health needs.

"We need to advocate for people," she said, noting the stigma that mental health patients often face. "It's not a choice, but a brain disorder, and [mental health patients] have the same right to respectful treatment as any other patient."

EXHIBIT 23

GENERAL SURGERY

Specialized At-Home Care To Help You Manage Your Patients

COMMON HOME HEALTH CARE DIAGNOSES

- Cholecystectomy
- Urinary Diversions
- Colon Resection
- Gastric Resection
- Gastrectomy
- Hernia Repair
- Amputation
- Skin Graft/Flap
- Exploratory Surgery
- Ostomies (all types)
  - Tracheostomy
  - Gastrostomy
  - Ileostomy
  - Colostomy
  - Cystostomy
  - Enterostomy

HOME HEALTH SERVICES

Amedisys uses a comprehensive assessment and interdisciplinary approach to treat patients in their homes. All disciplines provide ongoing patient/caregiver education, using an individualized, disease-specific focus.

SKILLED NURSING

- Complete assessment and plan of care management with physician orders
- Vital signs and pulse oximetry
- Complete medication review including adherence, effectiveness of treatment, and evaluation of any adverse reactions
- Medication administration, injections-Sub Q, IM and IV
- Management of infusion pumps, implanted pumps and ports
- Ostomy, enterostomal management
- Enteral/parenteral infusion therapy
- Suprapubic catheter changes/management
- Assess nutrition and hydration status
- Assess skin integrity and circulation
- Venipuncture for lab work, as ordered
- Bowel management
- Wound assessment and dressing changes, if applicable
- Suture/staple removal, if applicable
- Pain assessment
- Depression assessment

PHYSICAL THERAPY

- Transfer training
- Gait training/mobility
- Home safety with mobility
- Strengthening and endurance training
- Fall risk/balance assessment
- Pain management
- Assistive device training
- Modalities

OCCUPATIONAL THERAPY

- Activities of daily living including:
  - Dressing
  - Bathing
  - Grooming
- Environmental modifications
- Adaptive equipment use
- Bathroom transfers and equipment
- Energy conservation
- Visual impairments and compensations
- Home safety with self-care

SPEECH THERAPY

- Communication
- Cognition
- Swallowing/dysphagia
- Voice quality
- Safety with oral medications
- Augmentative communication needs
- Weight loss due to malnutrition

PATIENT/CAREGIVER EDUCATION

- Disease process
- Medication management and teaching
- Exercise and activity guidelines
- Energy conservation
- Home safety and avoiding falls
- Smoking cessation
- Nutrition and fluid management
- Pain management
- Dressing change technique
- Equipment management

Call us to refer a patient or to schedule a consultation.

Representative Name
(615) 928-5450

amedisys

amedisys.com

WOUND CARE

Specialized At-Home Care To Help You Manage Your Patients

COMMON HOME HEALTH CARE DIAGNOSES

- Surgical
- Venous Ulcer
- Arterial Ulcer
- Trauma
- Pressure Injury
- Burns
- Diabetic Foot Ulcer/ Neuropathic

HOME HEALTH SERVICES

Amedisys takes a holistic approach to care, utilizing an interdisciplinary team that develops an individualized care plan for healing wounds, preventing future wounds and ultimately improving outcomes. Our highly trained staff follows clinical best practices, understands etiology, utilizes advanced wound care products and knows when to contact you. In addition, our staff is knowledgeable in the provision of palliative wound care and caring for wounds at the end of life.

SKILLED NURSING

- Development and implementation of an individualized plan of care
- Wound assessment and dressing changes
- Suture/staple removal
- Incisional care
- Assess nutrition and hydration status, provide instructions and refer to registered dietitian
- Complete medication review
- Assess for signs and symptoms of infection
- Assess for prevention/treatment support surfaces
- Implement support surface, contact physician for orders and instruct patients on use
- Compression therapy
- Negative pressure wound therapy
- Palliative and end-of-life wound management

SPEECH LANGUAGE PATHOLOGIST

- Assesses for recent pneumonia(s), weight loss and/or dehydration
- Assesses cognition and swallowing
- Identifies potential issues impacting wound healing and nutrition
- Determines food and drink items that are safe for intake

DIETICIAN

- Provides nutritional consult to assist with wound healing

PHYSICAL THERAPY

- Patient positioning, mobility and transfers
- Contracture management
- Strength training
- Orthotic/prosthetic needs
- Skin assessment
- Caregiver education for pressure relief schedules
- Offloading

OCCUPATIONAL THERAPY

- Recommend appropriate assistive devices
- Adapt self-care activities to maintain skin integrity
- Self-feeding skills

MEDICAL SOCIAL WORKER

- Assist patients having difficulty adhering to prescribed plan of care
- Assist patients with financial challenges that impede adequate nutrition and/or medication costs
- Aid in securing patient transportation to appointments

HOME HEALTH AIDE

- Follows the supervising clinician's plan of care for the patient
- Notifies clinician of changes noted related to the patient's integument which may include:
  - Ingrown, broken or discolored toenails
  - Cracks/fissures on heels or blisters on feet
  - Reddened areas on feet, legs and bony prominence
  - Changes in color or temperature of feet and legs
  - New open areas, injuries or rashes

PATIENT/CAREGIVER EDUCATION

- Disease process, etiology and risk factors
- Signs and symptoms of infection
- Medication management
- Nutrition for healing
- Wound healing process
- Wound products and wound care technique with step-by-step instructions
- Principles of moist wound healing
- Preventative measures
- Proper skin care
- Hand hygiene and infection control measures

Call us to refer a patient or to schedule a consultation.

amedisys
HOME HEALTH

Representative Name
(863) 680-3531

amedisys.com

ORTHOPEDICS

Specialized At-Home Care To Help You Manage Your Orthopedic Patients

COMMON HOME HEALTH CARE DIAGNOSES

Total Hip Replacement	Total Shoulder Replacement	Open Reduction Internal Fixation	Arthritis
Total Knee Replacement	Traumatic Injury/Fractures	Open Reduction External Fixation	

HOME HEALTH SERVICES

Amedisys uses a comprehensive assessment and multidisciplinary approach in treating orthopedic patients at home. All disciplines provide ongoing patient/caregiver education using an individualized, condition-specific focus.

PHYSICAL THERAPY

- Exercise guidelines
- Adherence to surgical precautions
- Balance/fall risk
- Gait training/mobility
- Range of motion
- Home safety
- Strengthening
- Pain management
- Assistive device training
- Transfer training

OCCUPATIONAL THERAPY

- Instruction on adaptive equipment
- ADL training while adhering to precautions
- Dressing
- Bathing
- Grooming
- Bathroom transfers and DME use
- Energy conservation
- Visual impairments
- Home safety

SPEECH THERAPY

- Communication
- Cognition
- Swallowing/dysphagia
- Voice quality
- Safety with oral medications
- Augmentative communication needs
- Weight loss due to malnutrition

PATIENT/CAREGIVER EDUCATION

- Management of multiple medications
- Nutrition and fluid management
- Dressing change technique and cast care
- Activity guidelines and energy conservation
- Equipment management
- Safety in the home and avoiding falls
- Emergency plan

SKILLED NURSING

- Plan of care management
- Assess skin integrity and circulation
- Assess nutrition and hydration status
- Pain assessment and management
- Complete medication review including adherence, response, signs and symptoms of toxicity
- Medication administration, injections-Sub Q, IM and IV
- Wound assessment and dressing changes
- Suture/staple removal
- Pressure ulcer wound care
- Orthopedic pin care
- Venipuncture for lab work, as ordered
- Depression assessment

Call us to refer a patient or to schedule a consultation.

Representative Name
(615) 928-5450

amedisys

amedisys.com

UROLOGY

Specialized At-Home Care To Help You Manage Your Patients

Conditions

- Bladder Disorders
- Malignant Neoplasms
- Ostomy Management
- Urinary Incontinence or Retention
- Cystectomy
- Urinary Diversions
- Pyelonephritis
- Neurogenic Bladder
- Nephrostomy
- Nephrectomy
- Prostatectomy
- TURP & Uro-lift

How We Help

Amedisys uses a comprehensive assessment and interdisciplinary approach to treat urology patients in their homes. All disciplines provide ongoing patient/caregiver education, using an individualized, disease-specific focus.

SKILLED NURSING

- Complete assessment and plan of care management with physician orders
- Complete medication review, including adherence, effectiveness of treatment and evaluation of any adverse reactions
- Vital signs and pulse oximetry
- Venipuncture for lab work, as ordered
- Urinary and fecal incontinence management
- Ostomy teaching
- Catheter changes/management
- Nutrition and hydration management
- Assess skin integrity and circulation
- Pain assessment

PHYSICAL THERAPY

- Transfer training
- Gait training
- Home safety with mobility
- Strengthening and endurance training
- Balance training
- Pain management
- Assistive device training

OCCUPATIONAL THERAPY

Activities of Daily Living including:

- Dressing
- Bathing
- Grooming
- Environmental modifications
- Adaptive equipment use
- Bathroom transfers and equipment
- Energy conservation
- Visual impairments and compensations
- Home safety with self-care

SPEECH THERAPY

- Communication
- Cognition
- Swallowing/dysphagia
- Voice quality
- Safety with oral medications
- Augmentative communication needs
- Weight loss due to malnutrition

PATIENT/CAREGIVER EDUCATION

- Disease process
- Medication management and teaching
- Signs and symptoms of exacerbation and/or complications of disease process
- Management of catheters
- Exercise and activity guidelines
- Energy conservation
- Home safety and avoiding falls
- Smoking cessation
- Nutrition and fluid management

Call us to refer a patient or to schedule a consultation.

Representative Name
(615) 928-5450

amedisys

amedisys.com

EDUCATIONAL HANDOUT

MANAGING HEART FAILURE

The heart's primary job is to pump blood throughout the body. When your heart isn't able to pump enough blood to meet the needs of your body, it's known as heart failure.

According to the Centers for Disease Control and Prevention, about 5.7 million people in the United States have heart failure. Read the following symptoms and treatment options for heart failure to learn more and prepare any questions for your doctor.

What is heart failure? The heart receives de-oxygenated blood from the body, sends it to the lungs to be re-oxygenated and then pumps the oxygenated blood throughout the body. If someone has heart failure, the heart isn't able to pump enough blood to meet the needs of the body.

What are the signs and symptoms of heart failure? If you have heart failure, daily monitoring of your body weight can help you monitor your health status. If you have any significant changes in your weight, make sure to let your healthcare provider know.

Symptoms of heart failure include:

- Fatigue
- Shortness of breath
- Swelling in feet, ankles, legs and/or stomach
- Weight gain caused by fluid retention
- Pulmonary congestion
- Coughing when lying flat preventing sleep
- Cough with frothy sputum
- Feeling like your heart is racing or the heart is beating faster

How can home health help me manage my heart failure? In collaboration with a resident's physician, Amedisys provides services while educating and empowering the patient to monitor and manage Heart Failure as independently as possible. Our goal is to reduce your symptoms of heart failure and slow its progression while improving your quality of life.

This is not intended to be a substitute for professional medical advice, diagnosis or treatment. Always seek the advice of a physician or other qualified health provider with any questions you may have regarding a medical condition.

Amedisys is a leading provider of healthcare in the home. Most patients prefer to be at home when they are managing a chronic condition like heart failure, diabetes or respiratory problems.

If you would like to learn more about Corporate, please contact:

Representative Name
(XXX) XXX-XXXX

amedisys

amedisys.com

EDUCATIONAL HANDOUT

TALK WITH YOUR DOCTOR

SUGGESTED QUESTIONS FOR YOUR DOCTOR

1. What is my risk for developing heart failure?
2. Do you have any concerns about the health of my heart?
3. What kind of exercise can I do, and for how long?
4. What are my target ranges for the following measurements? At what readings should I notify you?

MEASUREMENT	GOAL	CURRENT	NOTIFY MD
Weight			
Blood Pressure			
Pulse			
Cholesterol			

5. Do I have any dietary restrictions?
6. How much sodium should I have each day?
7. Can I drink alcohol? If yes, how much?
8. Are there any foods or supplemental vitamins/herbs that I should avoid with the types of medicines I take?
9. Do I need any routine blood tests, and if so, which ones and how often?
10. Other questions I have:

Expert At-Home Care for Your Cardiovascular Patients

One in four Medicare patients with heart failure is readmitted within 30 days[1]

Our skilled nurses, therapists and other clinicians are specialists in at-home care for patients with heart failure, hypertension, myocardial infarction, coronary artery disease, CABG, CVA and other conditions.

How Amedisys can help	Benefits of working with Amedisys
› Identification and monitoring of early warning signs to prevent exacerbation	› Easy referrals 24 hours a day, 7 days a week
› Plan of care management	› After hours and weekend care
› Medication monitoring and management, including injections, IM and IV	› Help in reducing unnecessary readmissions and emergent care visits
› Post-surgical and post-stroke care	› Care transitions program to ease the move from acute care to home
› Wound care	› Mercury Doc® online referral and patient tracking system
› Patient and care-giver education, including education for newly-diagnosed patients and self-management skills	› Collaboration and customized patient updates to ensure your plan of care is followed
› Therapy and rehabilitation to help patients with tasks of daily living	› Interdisciplinary team approach

Amedisys
Home Health Care

To learn more or refer a patient, contact your home health care specialist at:

510.732.0730

www.amedisys.com

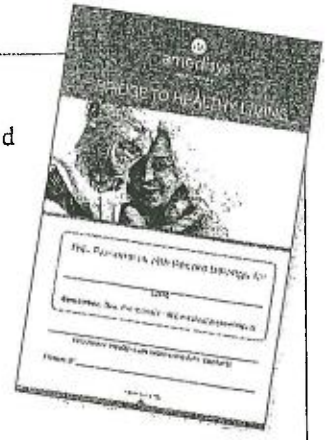
[1] Journal of the American Medical Association, January, 2012.

FL-022-HH REV 10/12

BRIDGING THE GAP FROM HOSPITAL TO HOME

CARE TRANSITIONS HELPS REDUCE UNNECESSARY HOSPITALIZATIONS

As your patients return home, our Care Transitions Program and expert nurses are there every step of the way. Through **coordination of services, an in-home risk assessment and education on self-care**, we help your patients move home safely. Together we can work to **reduce 30-day readmissions and empower patients** to take control of their own health.



Patient and Caregiver Education

Our Care Transitions Coordinators help your patients learn to self-manage symptoms and take a more active role in managing their own care. And with the help of our **Bridge to Healthy Living Guide**, your patients can:

- Track medications
- Organize health information and appointments
- Improve communication with their physician

Medication Reconciliation

Older adults over the age of 65 are twice as likely to seek emergent care for an adverse drug event and are seven times more likely to be hospitalized after an emergency visit.[1] **Preparing patients to manage medications at home** can be a key to keeping them out of the hospital.

Our Care Transitions nurses:

- Review discharge medication lists
- Communicate medication changes
- Educate patients on medication management

Follow-up Appointment Coordination

According to a recent survey, 67% of hospital executives identify lack of coordination between hospital discharge and physician follow-up as a major cause of preventable readmissions.[2] Bridging this gap, our Care Transitions nurses:

- Monitor patient care
- Call within 24-48 hours to help ensure all needs are met
- Coordinate primary care follow-up appointments 7 to 10 days from hospital discharge

[1] Medication Safety Focus. Centers for Disease Control and Prevention. Updated June 2017 | [2] Health Leaders Media/Intelligence. Readmissions Buzz Survey Results, June 2012. http://www.healthleadersmedia.com/content/281103.pdf

To learn more about our Care Transitions Program, or to make a referral, call:

Representative Name
(863) 680-3531

amedisys
HOME HEALTH

amedisys.com

MEDICATION COMPLIANCE POLYPHARMACY DRUG INTERACTIONS

FINALLY, A SOLUTION FOR PATIENTS STRUGGLING WITH AT-HOME MEDICATION MANAGEMENT.

Too often, patients don't understand how to follow through with directions when managing medications at home. This is especially true in patients with complex diagnoses or multiple medications. Our **at-home care specialists** support patients in tracking and taking prescribed medications as ordered – helping to safeguard **quality outcomes** and **avoid unnecessary rehospitalizations.**

With our in-home nursing visits, medication education and monitoring, and tools such as our *Bridge to Healthy Living Guide*, we are able to reduce the potential for adverse effects and negative drug interactions.

Specifically we can help:

- **Provide education, tools and monitoring** to help patients take medication as prescribed;
- Assist in **communication and collaboration** between you, your patient, and other health care providers;
- Establish **easy-to-follow practices** for patients and caregivers to better manage their own medications;
- **Monitor patients for drug interactions** and negative side effects;
- Help patients keep an **up-to-date record of their medications**, over-the-counter drugs and supplements to share with all of their health care providers; and
- **Identify barriers to medication compliance** – including vision and dexterity, as well as cognitive or financial issues – and **provide treatment and resources** as appropriate.

Adults over 65 are twice as likely to go to emergency departments for adverse drug events and are nearly seven times more likely to be hospitalized after an emergency visit.[1]

[1]Adults and Older Adult Adverse Drug Events. *Centers for Disease Control and Prevention*. Updated June 19, 2017.

To learn more, call your home health care representative at:

(225) 292-2031

amedisys

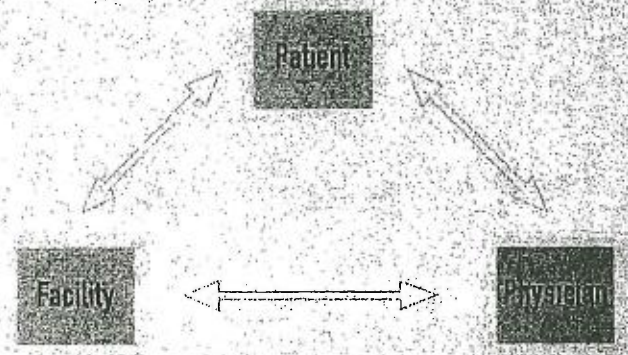
amedisys.com

ADVANTAGES:

- *Improving the quality of care*
- *Actively engaging the patient in health promotion*
- *Focusing on educating the patient in self-care management*
- *Partnering with physicians to promote disease prevention and pro-active care*
- *Collaborating with partners in the medical community; coordinating care across continuum*
- *Applying evidence-based guidelines in patient care standards*
- *Measuring clinical outcomes to improve health and quality of life*
- *Reducing emergent care and acute care hospitalization rates*
- *Recognizing early warning signs and symptoms to prevent exacerbations*
- *Facilitating an easier transition for patients from facility to home setting*
- *Setting the standard in the home care industry*

Home Health Care

Definition: A coordinated approach to managing overall health status for patients with chronic illnesses, designed to improve patient outcomes and contain health care costs.



Disease Management Programs

Behavioral Health @ Home	**Heart @ Home**	**Rehab Therapy @ Home**
	Heart Disease	*Rehabilitation*
Chronic Kidney Disease @ Home	**Orthopedic Recovery @ Home**	**Surgical Recovery @ Home**
	Rehabilitation	*Post Surgery*
COPD @ Home	**Pain Management @ Home**	**Stroke Recovery @ Home**
		Stroke
Diabetes @ Home	**Partners in Wound Care®**	**Wound Care – A Therapy Approach**
		Wound Care

Amedisys Home Health Care
510.732.0730
800.430.0095

Amedisys
Home Health Services

www.amedisys.com

@ home

Diabetes Disease Management Program

The Diabetes at Home Program was developed to provide patient management for patients with Type 1 Diabetes Mellitus and Type 2 Diabetes Mellitus.

Our Diabetes Disease Management Program utilizes diabetes clinical tracks, which focus on patient education on self-management, basic survival skills, and complications associated with diabetes.

ADVANTAGES:

- Maximized blood glucose control
- Recognition of early warning signs/symptoms and appropriate interventions
- Reduced need for urgent/emergent care
- Reduced rehospitalization
- Improved quality of life
- Patient diaries for documentation of blood glucose, insulin administration and activities
- Educational focus on self-care management skills
- Clinical outcomes feedback
- Multidisciplinary team
- Staff credentialing/competency testing

The diabetes program is based upon national standards supported by the American Diabetes Association (ADA). The program helps patients understand the importance of controlling blood glucose levels and the prevention of long-term complications.

We have received recognition from the American Diabetes Association (ADA) for our Diabetes at Home Program. All of our agencies follow this program.

Amedisys Home Health Care
510.732.0730
800.430.0095

Amedisys
Home Health Services

www.amedisys.com

2004 Rev 03-08 © AMEDISYS, INC. ALL RIGHTS RESERVED.

ADVANTAGES:

- Enhance patient / caregiver's knowledge of COPD disease process through education
- Improve patient's self-management and understanding of disease
- Improve patient's quality of life
- Reduce emergent care / urgent care visits
- Reduce hospitalizations / hospital re-admissions

- Educational focus with the patient on self-care management
- Early warning signs detection and management
- Interdisciplinary team approach
- Clinical Outcomes data feedback
- Reduction in hospitalizations / emergent care

- Increased knowledge / self-care management relating to COPD
- Improved quality of life
- Early assessment and early intervention
- Interdisciplinary team approach for treatment plan
- Reduced need for urgent / emergent care and reduced hospitalization

@ home

Chronic Obstructive Pulmonary Disease

We have developed a Chronic Obstructive Pulmonary Disease (COPD) Disease Management Program that enables us to deliver the most appropriate quality care for our patients while measuring outcomes and reducing emergent care/hospitalization rates.

This program has been carefully designed to help improve the quality of life for patients living with COPD. Teaching self-management and early intervention skills are the keys to improving patients' quality of life. Through the active involvement of the patient and caregiver in the management of their disease, the treatment plan will help prevent or delay complications for those living with COPD, and help the patient achieve the best possible outcome.

Our program follows national standards of care in accordance with the guidelines set forth by the American Thoracic Society, American Lung Association and American Nurses Association Standards of Nursing Practice.

Amedisys Home Health Care
510.732.0730
800.430.0095

Amedisys
Home Health Services

www.amedisys.com

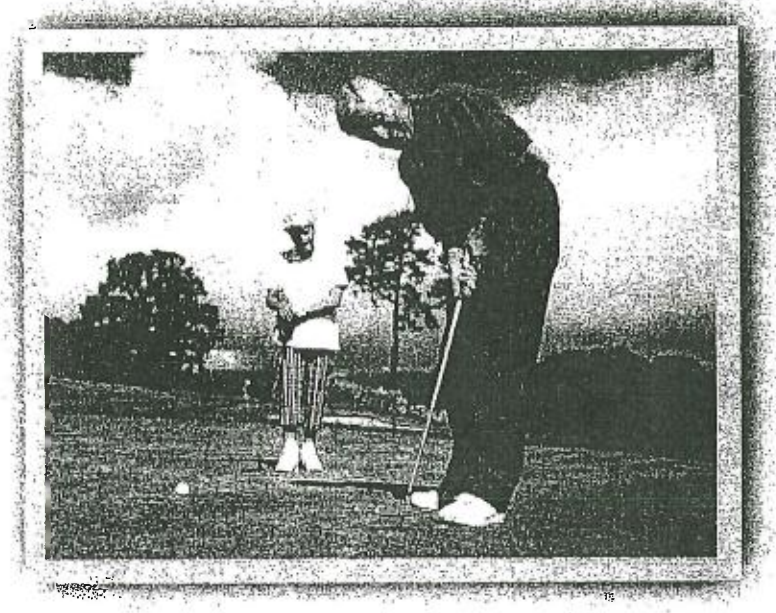
ADVANTAGES:

- A comprehensive approach with in-home therapy and nursing services providing multidisciplinary care and successful patient outcomes
- Early intervention during post-operative joint recovery to reduce complications
- Addresses the safety needs of each patient, to reduce further falls/injuries
- Regular progress reports that update the physician on patient's progress
- Customized protocol to meet individual patient and physician needs
- Improves the functional status of the patient, maximizing his or her potential in the comfort of home
- Nationally recognized home health care company with a record of excellence

Orthopedic Recovery @ home

Meeting the Special Needs of Our Orthopedic Patients

Our Orthopedic Recovery @ Home Program is at the leading edge of the home health industry. This rehabilitation program returns patients to their optimal functional status and maximizes clinical outcomes. Our customized protocols allow patients to achieve their maximum potential while recovering in the comfort of home.



The Orthopedic Recovery @ Home Program focuses on:

- Pain Management
- Manual Therapy Techniques
- Safe Independent Mobility

Who is Eligible?

All patients who require any orthopedic or post-operative, in-home care are eligible. This service allows patients to recover in the comfort of home under a supervised skilled plan of care as directed by their physician.

Amedisys Home Health Care
510.732.0730
800.430.0095

Amedisys
Home Health Services

www.amedisys.com

© AMEDISYS, INC. ALL RIGHTS RESERVED

EXHIBIT 24

Policy: AA-016	Date(s) Revised:	01/2018; 11/2018
Subject: ***Discharge of Patients***		
Applicable Service(s): Home Health	**Page:**	Page 1 of 18

PURPOSE:

- The process for discontinuing home health services will be subject to the guidelines as outlined below and as mandated by appropriate state regulatory entities.
- To have a discharge process to ensure the patient is being discharged appropriately and arrangements have been made to address any ongoing health care needs the patient may have at the time of discharge.

REGULATORY GUIDANCE:

§484.50 Condition of participation: Patient rights.

(d) Standard: Transfer and discharge. The patient and representative (if any), have a right to be informed of the HHA's policies for transfer and discharge. The HHA may only transfer or discharge the patient from the HHA if:

(1) The transfer or discharge is necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity. The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities;

(2) The patient or payer will no longer pay for the services provided by the HHA;

(3) The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services;

(4) The patient refuses services, or elects to be transferred or discharged;

(5) The HHA determines, under a policy set by the HHA for the purpose of addressing discharge for cause that meets the requirements of paragraphs (d)(5)(i) through (d)(5)(iii) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired. The HHA must do the following before it discharges a patient for cause:

(i) Advise the patient, representative (if any), the physician(s) issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered;

(ii) Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation;

(iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and

(iv) Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records;

(6) The patient dies; or

(7) The HHA ceases to operate.

§484.110 Condition of participation: Clinical records.

The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically.

(a) Standard: Contents of clinical record. The record must include:

(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician orders;

(2) All interventions, including medication administration, treatments, and services, and responses to those interventions;
(3) Goals in the patient's plans of care and the patient's progress toward achieving them;
(4) Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s);
(5) Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA; and
(6)(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or
(ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or
(iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.

Agencies must adhere to the most stringent regulations (state, federal, accreditation, professional practice, etc.); see also the state specific regulations located behind this policy for additional reference.

PROCEDURE:

1. The HHA may only transfer or discharge the patient from the HHA if:
   A. **Acuity**:
      (1) The transfer or discharge is necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity.
      (2) The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the HHA's capabilities;
      (3) **Examples include**:
         a. *The agency can no longer provide appropriate staffing.*
         b. *The agency will no longer provide a particular service needed by patients*

   B. **Payment/Eligibility**:
      (1) The patient or payer will no longer pay for the services provided by the HHA.
      (2) The patient fails to continue to meet criteria for eligibility of services established by the patient's payor sources.
      (3) **Examples include**:
         a. *Failure to comply with face-to-face and homebound requirements.*
         b. *The agency has not been/will not be compensated for care provided*
         c. *No signed orders from appropriately licensed practitioners (doctors of medicine, osteopathy or podiatry) are in effect upon which to base services.*
         d. *In the event of a natural disaster when the client's health and safety is at risk.*
         e. *If the patient is found to be ineligible for home care services, all attempts will be made by the agency to direct the individual to the appropriate community resource and notification will be made to the patient's attending physician and/or referral agency.*

C. **Goals and measurable outcomes achieved/goals met:**
   (1) The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved;
   (2) And the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services;
   (3) **Examples include**:
      a. *The goals of the patient's plan of care have been attained or are no longer attainable.*
      b. *A caregiver has been prepared and is capable of assuming responsibility for care.*

D. **Patient's choice:**
   (1) Patient refuses services,
   (2) Patient elects to be transferred or discharged;
   (3) **Examples include**:
      a. *The patient moves to a location outside of the licensed geographic service area of the agency.*
      b. *The patient or his/her legally authorized representative chooses another provider*
      c. *The patient or the patient's legally authorized representative terminates services by the Agency or refuses care.*

E. **Discharge for cause:**
   (1) The patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired.
   (2) **Examples include**:
      a. *Threats of violence or actual violence to agency staff members, and conditions in or around home, which pose safety risk to staff.*
      b. *The patient's home environment will not support the provision of home health services.*
      c. *There is suspected illegal activity in the patient's home. i.e. drug abuse or history of drug abuse.*
      d. *Agency staff members are subject to sexual harassment or verbal abuse when they provide services to the patient*
      e. *The patient cannot care for him/herself in between visits from Agency personnel and no reliable paid or voluntary primary caregiver is available to meet all of the needs of the patient between visits by Agency staff*
      f. *The patient and/or primary caregiver are noncompliant or have a documented history of noncompliance in cooperating to attain the objectives of home care*
      g. *Agency staff members are subject to racial discrimination when they provide services to the patient.*
   (3) The HHA must do the following before it discharges a patient for cause:
      a. Advise the following that a discharge for cause is being considered:
         i. The patient,
         ii. representative (if any),
         iii. the physician(s) issuing orders for the home health plan of care, and
         iv. the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any).
      b. Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation;
      c. Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and
      d. Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its clinical records.

F. The patient dies; or

G. The HHA ceases to operate.

2. The Director of Office Operations is the sole determiner of the decision to discharge the patient considering the above criteria.

3. Discharge planning will begin during the initial admission evaluation and continues throughout the length of service. The patient, or his/her representative if any, shall be informed of and participate in discharge planning.

4. The Plan of Care will identify problems and goals that need to be met for discharge. Goals and discharge planning are discussed with patient and caregiver.

5. The physician will be notified of the patient's discharge from the home health agency. Documentation of physician notification will be evident in the patient's medical record. Only when required by state regulations will a discharge order be generated.

6. When a skilled discipline discharges the patient from their service, the discipline will complete a discharge summary that will be available to the physician upon request. *Note Exceptions:*
   - When a therapist (PT, OT, ST, and MSW) completes an evaluation only, provides no subsequent therapy/care, the therapist will document communication/ notification to the physician and a discharge summary is not required.
   - When SN completes an assessment only or provides a one-time only visit (venipuncture for lab, etc.) for a patient receiving another skilled service and no subsequent Skilled Nursing services are ordered, the nurse will document communication/notification to the physician and a discharge summary is not required.

7. The discipline will also provide the patient with discharge instructions pertaining to that discipline, if applicable.

8. The clinician assigned to supervise and coordinate care for a particular patient must complete a discharge summary when services are terminated. A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge. The Discharge Summary includes:
   a. Reason for Homecare admission
   b. Summary of Care and Services provided and progress towards goals
   c. Symptoms needing continued management
   d. Instructions given to patient and family

9. A Discharge OASIS is completed within 48 hours for applicable patients.

10. The patient's discharge date is the date of discontinuation of services, patient death, transfer out of the service area or when the agency becomes aware of the discharge.

11. The discharge chart is completed and audited after the discharge date or documented discharge notification.

12. When patients already admitted to the agency meet one (1) or more of the criteria listed to discontinue services, the agency may take the following actions:
    A. Hold a case conference to determine whether to discontinue services and if so, whether immediate termination is warranted or what constitutes a reasonable notice period considering facts and circumstances relevant to individual patients and applicable state and/or federal requirements. The results of this case conference will be documented in the patient's chart, including:
        (1) The date and time of termination
        (2) The reason(s) for termination
        (3) In appropriate circumstances such as violence or an admission to an institutional provider, services may be discontinued immediately.

    B. If a decision is made to terminate services, staff will normally verbally notify non-institutionalized patients and their attending physicians at least 2 days prior to discharge of the date and time of termination of services and the reason(s) for termination within a reasonable period of time prior to discharge, or within a specified time frame according to state regulation. These verbal communications will be documented in the patient's chart. When patients who are admitted to hospitals or other institutions are discharged, the Agency will normally notify the discharge planning staff at the hospital or other institution that the patient cannot be readmitted to the agency.

    C. Verbal notification to non-institutionalized patients not in jeopardy will normally be immediately followed by written notice (Notice of Medicare Non-Coverage) Written notice will also include any additional information that may be required by state and/or federal requirements. A copy of this written notice shall be placed in the patient's chart.

    D. Agency staff will report to adult and child protective services as appropriate and in accordance with applicable requirements of state law and regulation.

13. The patient's discharge date on the Discharge Summary, and the Discharge OASIS assessment should be the date the agency becomes aware of the patient's discharge or discontinuation of services, patient death, or transfer out of service area.

Discharge Order Requirements per State

Please see the following table listing the different states and the specific requirements.
See State Specific section for regs

STATE	DC orders required if pt is discharged prior to end of episode
Alabama	No
Arkansas	No
Arizona	Yes
California	No
Connecticut	No
Delaware	No
District of Columbia	No
Florida	No
Georgia	Yes
Illinois	Yes
Indiana	No
Kansas	No
Kentucky	No
Louisiana	Yes
Maine	Yes
Maryland	No
Massachusetts	No
Minnesota	No
Mississippi	Yes

STATE	DC orders required if pt is discharged prior to end of episode
Missouri	No
New Hampshire	No
New Jersey	No
New York	No
North Carolina	No
Ohio	No
Oklahoma	No
Oregon	No
Pennsylvania	No
Rhode Island	No
South Carolina	No
Tennessee	No
Texas	No
Virginia	No
Washington	No
West Virginia	No
Wisconsin	No

State Specific Requirements

Alabama:
Discharge/ Orders/Summary: Follows Medicare Conditions of Participation

Arizona:
At the time of a Scheduled Discharge the CC must ensure a D/C plan, D/C Instructions and a D/C Summary and have available to the physician upon request. A D/C order is required for non-scheduled Discharges.

5. "Discharge summary" means a brief review of service, patient status, and reasons for discharge.

R9-10-1106. Plan of Care

C. Staff shall document, in the medical record, any verbal order for either the initiation or modification to the plan of care and shall include in the record the physician's verifying signature which shall be obtained within 30 days of the order.

R9-10-1108. Medical Records

B. Each agency shall maintain a medical record for each patient which contains the following:

13. Patient transfer or discharge plan and discharge summary.

Arkansas:
Discharge /Orders/Summary: Follows Medicare Conditions of Participation

California:
Discharge/Orders/Summary: The discharge statement shall include the date of discharge, reason for termination of services and condition upon discharge. All health records of discharged patients shall be completed within 30 days after the discharge.

(a) The agency shall establish and maintain for each patient accepted for care a health record which shall include the following information:

(9) Discharge statement. The discharge statement shall include the date of discharge, reason for termination of services, and condition upon discharge

(c) All health records of discharged patients shall be completed within 30 days after their discharge date.

(d) Health records of each discharged adult patient shall be kept for a minimum of seven years following discharge of the patient. The health record of a discharged minor shall be kept for at least one year after the minor has reached the age of 18 years and in all cases not less than seven years.

Connecticut:
Discharge/Orders/Summary: The physician must be notified each time one or more services are terminated and upon discharge. No discharge order is required.

Discharge from Service:

(A) Agency policies shall define categories for discharge of patients. These categories shall include but not be limited to:
  (i) Routine discharge--termination of service(s) when goals of care have been met and patient no longer requires home health care services;
  (ii) Emergency discharge--termination of service(s) due to the presence of safety issues which place the patient and/or agency staff in immediate jeopardy and prevent the agency from delivering home health care services;
  (iii) Premature discharge--termination of service(s) when goals of care have not been met and patient continues to require home health care services;
  (iv) Financial discharge--termination of service(s) when the patient's insurance benefits and/or financial resources have been exhausted.

(B) In the case of a routine discharge the agency shall provide:
  (i) pre-discharge planning by the primary care nurse, attending physician, or dentist and other agency staff involved in patient's care, which shall be documented in patient's clinical record;
  (ii) A procedure through which the patient's physician or dentist is notified each time one or more services are terminated, and when the patient is discharged.

(C) In the case of an emergency discharge the agency shall immediately take all measures deemed appropriate to the situation to ensure patient safety. In addition, the agency shall immediately notify the patient, the patient's physician, and any other persons or agencies involved in the provision of home health care services. Written notification of action taken, including date and reason for emergency discharge, shall be forwarded to the patient and/or family, patient's physician, and any other agencies involved in the provision of home health care services within five (5) calendar days.

(D) In the case of a premature discharge the agency shall document that prior to the decision to discharge a case review was conducted which included patient care staff, supervisory and administrative staff, patient's physician, patient and/or patient representative, and representation from any other agencies involved in the plan of care.
  (i) Decision to continue service: If the decision of the case review is to continue to provide service, a written agreement shall be developed between the agency and the patient or his/her representative to identify the responsibilities of both in the continued delivery of care for the patient. This agreement shall be signed by the agency administrator and the patient or his representative. A copy shall be placed in the patient's clinical record with copies sent to the patient and his or her physician.
  (ii) Decision to discharge from service: If the case review results in an administrative decision to discharge the patient from agency services, the administrator shall notify the patient and/or family and the patient's physician that services shall be discontinued in ten (10) days and the patient shall be discharged from the agency. Services shall continue in accordance with the patient's plan of care to ensure patient safety until the effective day of discharge. The agency shall inform the patient of other resources available to provide health care services.

(E) In the case of a financial discharge the agency shall conduct a:
  (i) Pre-termination Review: Whenever one or more home health services are to be terminated because of exhaustion of insurance benefits or financial resources, at least ten (10) days prior to such termination there shall be a review of need for continuing home health care by the patient, his family, the supervisor of clinical services, the patient's physician or dentist, primary care nurse and other staff involved in the patient's care. This determination and, when indicated, the plan developed for continuing care shall be documented in the patient's clinical record.
  (ii) Post-termination Review: The clinical records of each patient discharged because of exhaustion of insurance benefits or financial resources shall be reviewed by the professional advisory committee or the clinical record review committee at the next regularly scheduled meeting following the discharge. The committee reviewing the record shall ensure that adequate post-discharge plans have been made for any patient with continuing home health care needs.

Delaware:
Title 16, 4410 Skilled Home Health Agencies (Licensure)
6.8 Discharge
6.8.1 The patient, or her/his representative if any, shall be informed of and participate in discharge planning.
6.8.2 The home health agency shall develop a written plan of discharge which includes a summary of services provided and outlines the services needed by the patient upon discharge.

6.8.3 When discharging a patient who does not wish to be discharged, a minimum of two (2) week notice will be provided to permit the patient to obtain an alternate service provider. Exceptions to the two (2) week notice provision would include:

6.8.3.1 The discharge of patients when care goals have been met.

6.8.3.2 The discharge of patients when care needs undergo a change which necessitates transfer to a higher level of care and for whom a new discharge plan needs to be developed.

6.8.3.3 The discharge of patients when there is documented non-compliance with the plan of care or the admission agreement (including, but not limited to, nonpayment of justified charges).

6.8.3.4 The discharge of patients when activities or circumstances in the home jeopardize the welfare and safety of the home health agency caregiver.

District of Columbia:

Each home care agency shall have written policies that describe transfer, discharge, and referral criteria and procedures.

Each patient shall receive written notice of discharge or referral no less than seven (7) calendar days prior to the action. The seven (7) day written notice shall not be required, and oral notice may be given at any time, if the transfer, referral or discharge is the result of:

a) A medical or social emergency;
b) A physician's order to admit the patient to an in-patient facility;
c) A determination by the home care agency that the referral or discharge is necessary to protect the health, safety or welfare of agency staff;
d) A determination, made or concurred in by a physician, that the condition that necessitated the provision of services no longer exists; or
e) The refusal of further services by the patient or the patient's representative.

Each home care agency shall document activities related to discharge planning for each patient in the patient's record

Florida:

Discharge/Orders/ Summary: When an agency terminates services for a patient needing continuing home health care, as determined by the physician, for patients receiving care under a physician's order, or as determined by the patient or caregiver, for patients receiving care without a physician's order, a plan must be developed and a referral made by home health agency staff to another home health agency or service provider prior to termination. The patient must be notified in writing of the date of termination, the reason for termination, and the plan for continued services by the agency or service provider to which the patient has been referred.

This requirement does not apply to patients paying through personal funds or private insurance who default on their contract through non-payment. The home health agency should provide social work assistance to patients to help them determine their eligibility for assistance from government funded programs if their private funds have been depleted or will be depleted.

Georgia:

Discharge/ Orders/ Summary: Clarification from the GA DOH Jennifer Oetzel, Home Health Agency Program Manager of the Office of Regulatory Services at the Georgia Department of Human Resources: the discipline specific discharge does not need to be sent to the physician; the Agency Discharge Summary must be sent.

290-5-38-.08 (e) Coordination of Patient Services. All personnel providing services shall maintain a liaison with the Home Health Agency to assure that their efforts effectively complement one another and support the objectives outlined in the plan of treatment. The clinical record shall contain dated minutes of case conferences verifying that effective interchange, reporting, and coordinated patient evaluation does occur.

A written summary report of clinical and progress notes for each patient shall be sent to the attending physician at least every sixty (60) days and upon discharge. A copy of these reports shall become a permanent part of the patient's clinical record.
01/29/2016: Clarification from GA Nancy Holz-Scott who stated that in addition to sending the D/C summary to the physician, the Discipline D/C summary must show evidence of MD notification.

Illinois:
Section 245.200 Services – Home Health

d) Acceptance of Patients. Patient acceptance and discharge policies shall include, but not be limited to, the following:
   5) When services are to be terminated by the home health agency, the patient is to be notified three working days in advance of the date of termination, stating the reason for termination. This information shall be documented in the clinical record. When indicated, a plan shall be developed or a referral made for any continuing care.
   6) Services shall not be terminated until such time as the registered nurse, or the appropriate therapist, or both, in consultation with the patient's physician or podiatrist, deem it appropriate or arrangements are made for continuing care.

f) Consultation with the patient's physician or podiatrist on any modifications in the plan of treatment deemed necessary shall be documented, and the patient's physician's or podiatrist's signature shall be obtained within 30 days after any modification of the medical plan of treatment.

   1) The home health services team shall review the plan every 62 days, or more often if the patient's condition warrants.
   2) An updated plan of treatment shall be given to the patient's physician or podiatrist for review, for any necessary revisions, and for signature every 62 days, or more often as indicated.

h) Clinical Records
   M) A discharge summary giving a brief review of service, patient status, reason for discharge, and plans for post-discharge needs of the patient. A discharge summary may suffice as documentation to close the patient record for one-time visits and short-term or event-focused or diagnoses-focused interventions. The discharge summary need not be a separate piece of paper and may be incorporated into the routine summary of reports already furnished to the physician.

Indiana:
Discharge/Orders/Summary: The patient, the patient's legal representative or other individual responsible for the patient's care shall be given notice of discharge at least five (5) calendar days before the services are stopped. The Agency must continue, in good faith, to provide services during the 5-day period. If the Agency cannot provide such services during that period, its continuing attempts to provide services must be documented. The five (5) day period does not apply in the following circumstances:

- The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.
- The patient refuses the home health agency's services.
- The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following the discharge; or
- The patient no longer meets applicable regulatory criteria, such as lack of physician's order and the home health agency informs the patient of community resources to assist the patient following discharge.

Kansas:
Discharge/Orders/Summary: A discharge summary report is a concise statement signed by a qualified health professional, reflecting the care, treatment and response of the patient in accordance with the patient' s plan of care and the final disposition at the time of discharge.

Kentucky:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Louisiana:
Discharge/Orders/Summary: Per Marion Tate – LA Health Standards – DOH 2.22.16, "If the HHA has completed the ordered frequency – a discharge order is not necessary, however there should be documentation in the medical record of communication with the physician. If the HHA did not complete the ordered frequency for whatever reason – patient improved, patient refuses, etc., a discharge order is needed since the HHA would no longer be providing services according to the physician's plan of care.

§9123. Patient Care Standards
G. Discharge Policy and Procedures
1. The patient may be discharged from an agency when any of the following occur:
   a. the patient care goals of home care have been attained or are no longer attainable;
   b. a caregiver has been prepared and is capable of assuming responsibility for care;
   c. the patient moves from the geographic service area served by the agency;
   d. the patient and/or caregiver refuses or discontinues care;
   e. the patient and/or caregiver refuses to cooperate in attaining the objectives of home care;
   f. conditions in the home are no longer safe for the patient or agency personnel. The agency shall make every effort to satisfactorily resolve problems before discharging the patient;
   g. the patient's physician fails to renew orders for the patient;
   h. the patient, family, or third-party payor refuses to meet financial obligations to agency;
   i. the patient no longer meets the criteria for services established by the payor source;
   j. the agency is closing out a particular service or any of its services;
   k. death of the patient.
2. The agency must have discharge procedures that include, but are not limited to:
   a. notification of the patient's physician;
   b. documentation of discharge planning in the patient's record;
   c. documentation of a discharge summary in the patient's record; and
   d. forwarding of the discharge summary to the physician, if requested.
3. The following procedures shall be followed in the event of the death of a patient in the home:
   a. the proper authorities shall be notified immediately in accordance with state and local ordinances;
   b. the home health agency parent office shall be notified;
   c. the home health agency personnel in attendance shall offer whatever assistance they can to the family and others present at scene; and
   d. progress notes shall be completed in detail and must include observations of the patient, any treatment provided, individuals notified, and time of death, if established by the physician.

F. Medical Social Services
f. submit a written assessment and summary of services provided when medical social work services are discontinued, including an assessment of the patient's current status that will be retained in the patient's clinical record.
G. Nutritional Guidance Services
i. prepare a written discharge summary and ensure that a copy is retained in patient's clinical record and a copy is forwarded to the attending physician;

H. Occupational Therapy
f. when occupational therapy services are discontinued, submit a written summary of services provided, including an assessment of patient's current status, for retention in the patient's clinical record;
J. Physical Therapy.
f. when physical therapy services are discontinued, prepare a written discharge summary and ensure that a copy is retained in the patient's clinical record and a copy is forwarded to the attending physician;
M. Speech Pathology Services
f. submit a written summary of the services provided when speech therapy services are discontinued including an assessment of the patient's current status, which shall be retained in the patient's clinical record.

Maine:

7.F. **Patient/Client Records**

7.F.1. Each Home Health Care Services Provider's patient/client shall have an identifiable clinical record initiated and maintained by the Home Health Care Services Provider in accordance with accepted professional standards. Patient/client records shall contain but not be limited to:

m. Where appropriate, a dated and signed discharge summary giving a brief review of service, patient/client status, reason(s) for discharge, and plans for post-discharge needs of the patient/client;

7.G. **Patient/Client Transfer and Discharge**

7.G.1 Each Home Health Care Services Provider must have written criteria for the transfer, referral and/or discharge of patients/clients. At the time of transfer, referral and/or discharge, the patient/client must meet at least one of the following criteria. Criteria must, but are not limited to:

a. The patient's/client's welfare and/or medical needs cannot be met by the Home Health Care Services Provider,
b. The patient's/client's health and/or functional abilities have improved so that the patient/client no longer needs the services provided by the Home Health Care Services Provider, as ordered by the patient's/client's physician, with agreement from all parties involved;
c. The health and safety of individuals providing services is endangered.

7.G.2. A written notice of discharge or transfer must be sent to patients/clients at least fourteen(14)days before services are terminated. A written notification of patients/clients' appeal rights must be included in this notice and must follow State and Federal requirements. The only written exceptions to this regulation are Chapter 7.G.1.b. and Chapter 7.G.1.c.

7.G.3. Each patient's/client's clinical record must contain documentation describing the criteria that necessitated the transfer, referral and/or discharge. Documentation must include, but is not limited to:

a. Signed and dated physician's orders for transfer, referral or discharge,
b. Multidisciplinary interventions that have been tried and failed to meet the patient's needs if applicable;
c. Notation of the cessation of operation of the Home Health Care Services Provider, if applicable, and Incidents and/or circumstances where agency staffs' health and safety are endangered if applicable.

Maryland:

Discharge/Orders/Summary: Records of discharged patients must be completed no later than 30 days after the date of discharge.

Massachusetts:

Discharge /Orders/Summary: Follows Medicare Conditions of Participation

Mississippi:

130 PATIENTS' RIGHTS

130.01 General. The agency shall maintain written policies and procedures regarding the rights and responsibilities of patients. These written policies and procedures shall be established in consultation with the Professional Advisory Committee. Written policies regarding patients' rights shall be made available to patients and/or their guardian, next of kin, sponsoring agency or agencies, or lawful representative and to the public. There shall be documented evidence that the staff of the agency is trained and involved in the implementation of these policies and procedures. In-service on patient's rights and responsibilities shall be conducted annually. The patients' rights policies and procedures ensure that each patient admitted to the agency:

4. Is transferred or discharged only for medical reasons, or for his welfare, or for non-payment (except as prohibited by Titles XVIII or XIX of the Social Security Act), or on the event of an unsafe environment, or should the patient refuse treatment, and is given advance notice to ensure orderly transfer to discharge, and such actions are documented in his clinical record;

101.15 **Discharge Summary** shall mean the written report of condition of patient, services rendered, pertinent goals achieved during the entire service provided and final disposition at the time of discharge from the service.

124.01 **Manual**.

c. When services are to be terminated by the home health agency, the patient and the physician or podiatrist are to be notified in advance of the date of termination stating the reason and a plan shall be developed or a referral made for any continuing care.

d. Services shall not be terminated without an order by the physician or podiatrist in consultation with the registered nurse and/or the appropriate therapist. Except in cases of non-payment, where the specific and approved plan of care has been documented as completed, where the patient refuses treatment, in the event of an unsafe environment, or should the patient require the services beyond the capability of the agency. In any event, the physician or podiatrist shall be notified of the termination of services. Arrangements shall be made for continuing care when deemed appropriate.

Missouri:

Discharge/Orders/Summary: Follows Medicare Conditions of Participation

New Hampshire:

Discharge/Orders/Summary: Follows Medicare Conditions of Participation

New York:

Discharge/Orders/Summary: A patient may be discharged by the agency only after consultation, as appropriate, with the patient's authorized practitioner, the patient, the patient's family or informal supports, any legally designated patient representative, and any other professional personnel including any other case management entity involved in the plan of care. If the agency determines that the patient's health care needs can no longer be met safely at home, the agency must continue to provide home health services only to the extent necessary to address minimally essential patient health and safety needs until such time as an alternative placement becomes available and such placement is made or the patient or the patient's legal representative, who has the authority to make health care decisions on behalf of the patient, makes an informed choice to refuse such placement. As appropriate, the patient and family or informal supports, any legally designated patient representative and any other professional personnel including any case management entity involved, shall be fully informed of the agency's intent to discharge the patient to an alternate service, when available, and shall be consulted in the development of an interim plan of care.

North Carolina:
Discharge/Orders/Summary: A discharge summary is completed, and the physician is notified of the discharge. An advance notification to patient or responsible party of at least 48 hours is required, except in cases where the patient agrees with discharge.

Ohio:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Oklahoma:
Discharge/Orders/Summary: The physician is notified of discharge.

Oregon:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Pennsylvania:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

(b) Reasonable expectations of the home nursing care provider's or home care provider's capability to respond to the medical and nursing needs of the patient;
(c) Plan of care;
(d) Constraints imposed by limitation of services, family conditions;
(e) Community or other resources to ensure continuity of patient care; and
(f) Such other criteria as may be deemed appropriate.

(i) Discharge summaries.
16.1.1 Home nursing care provider or home care provider personnel involved in the care of patients shall participate, to the extent possible, in developing care plans. When practical, designated home nursing care provider or home care provider personnel shall complete a "Continuity of Care" form as approved by the Director for each patient who is discharged to another health care facility, such as a hospital or nursing facility, or other facility licensed under the provisions of RIGL Chapter 23-17 [Reference 1]. Said form shall be provided to the receiving facility, agency, or provider prior to, upon transfer, or discharge of the patient. (See the Department's website for the approved form: www.healthri.org).

Medical Services
21.8 Patients admitted for medical services shall be under the care of a licensed physician responsible for the development of the plan of care.
(a) A care plan prescribed by the attending physician, if appropriate, shall contain no less than the following:
(1) Pertinent diagnosis, including mental status, level of consciousness, ability to communicate including language, speech and hearing;
(2) Types of services and equipment required, frequency of visits, prognosis, rehabilitative potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures (if any), instructions for continuing care, referral or discharge; dates/times of any follow-up appointment(s), when known; and

South Carolina:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Tennessee:

Discharge/Orders/Summary: The discharge summary shall be dated and signed within 7 days of discharge. A copy of the discharge summary is available to the physician upon request. The discharge summary must include medical and health status at discharge.

For patients receiving services through the Division of Mental Retardation Services (DMRS): if the agency determines that they are no longer willing or able to provide services they must comply with the following:

1. Prior to discontinuation of authorized services, the agency will obtain approval from DMRS;
2. The agency will notify the consumer, their conservator or guardian and DMRS no less than 60 days prior to the planned discharge;
3. If the consumer or his/her representative request a hearing in accordance with T.C.A 33-1-202, the discharge will not occur prior to the final agency decision and resolution of the administrative appeal unless ordered by a court and approved by the state;
4. The agency shall continue to provide service until the consumer is provided with other services that are acceptable and appropriate quality in order to maintain the continuity of care
5. If the consumer or his/her representative request to be discharged from the agency, the agency will follow the steps outlined above and provide transfer documentation to new provider, if requested, in order to maintain continuity of care and facilitate transfer.

Texas:

§97.295 Client Transfer or Discharge Notification Requirements

(a) Except as provided in subsection (e) of this section, an agency intending to transfer or discharge a client must:

(1) Provide written notification to the client or the client's parent, family, spouse, significant other or legal representative; and

(2) Notify the client's attending physician or practitioner if he is involved in the agency's care of the client.

(b) An agency must ensure delivery of the written notification no later than five days before the date on which the client will be transferred or discharged.

(c) The agency must deliver the required notice by hand or by mail.

(d) If the agency delivers the written notice by mail:

(1) The notice must be mailed at least eight working days before the date of discharge or transfer; and

(2) The agency must speak with the client by telephone or in person to ensure the client's knowledge of the transfer or discharge at least five days before the date of discharge or transfer.

(e) An agency may transfer or discharge a client without prior notice required by subsection (b) of this section:

(1) Upon the client's request;

(2) If the client's medical needs require transfer, such as a medical emergency;

(3) In the event of a disaster when the client's health and safety is at risk in accordance with provisions of §97.256 of this chapter (relating to Emergency Preparedness Planning and Implementation);

(4) for the protection of staff or a client after the agency has made a documented reasonable effort to notify the client, the client's family and physician, and appropriate state or local authorities of the agency's concerns for staff or client safety, and in accordance with agency policy;

(5) According to physician orders; or

(6) If the client fails to pay for services, except as prohibited by federal law.

(f) An agency must keep the following in the client's file:

(1) A copy of the written notification provided to the client or the client's parent, family, spouse, significant other or legal representative;

(2) Documentation of the personal contact with the client if the required notice was delivered by mail; and

(3) Documentation that the client's attending physician or practitioner was notified of the date of discharge.

Virginia:
Discharge/Orders/Summary: In agencies licensed by the state of Virginia, the patient is assured at least 5 days written notice prior to discharge or referral in service except when a medical emergency exists, when the patient's physician orders admission to an inpatient facility, or when discharge is determined by the chief administrative officer to be necessary to protect the health and welfare of the staff member providing services. Patients will receive an oral and written explanation of the reason for discharge or referral.

12VAC5-381-10. Definitions.

"Discharge or termination summary" means a final written summary filed in a closed client record of the service delivered, goals achieved and final disposition at the time of client's discharge or termination from service.

12VAC5-381-180. Written policies and procedures.

F. Admission and discharge or termination from service policies and procedures shall include, but are not limited to:

1. Criteria for accepting clients for services offered;
2. The process for obtaining a plan of care or service;
3. Criteria for determining discharge or termination from each service and referral to other agencies or community services; and
4. Process for notifying clients of intent to discharge/terminate or refer, including:
   a. Oral and written notice and explanation of the reason for discharge/termination or referral;
   b. The name, address, telephone number and contact name at the referral organization; and
   c. Documentation in the client record of the referral or notice.

12VAC5-381-280. Client record system.

F. An accurate and complete client record shall be maintained for each client receiving services and shall include, but shall not be limited to:

8. A discharge or termination of service summary.

In addition, client records for skilled and pharmaceutical services shall include:

1. Copies of all summary reports sent to the primary care physician.

12VAC5-381-230. Client rights.

C. Written procedures to implement the policies shall ensure that each client is:

10. Given at least five days written notice when the organization determines to terminate services.

Washington:
Discharge /Orders/Summary: Follows Medicare Conditions of Participation

WAC 246-335-110
Patient/client records.
(1) The licensee must:
   (f) Upon request and according to agency policy and procedure, provide patient or client information or a summary of care when the patient or client is transferred or discharged to another agency or facility.

West Virginia:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Wisconsin:
HFS 133.09 Acceptance and discharge of patients.
(3) Discharge of patients:
a. Notice of discharge.
1. A home health agency may not discharge a patient for any reason until the agency has discussed the discharge with the patient's legal representative and the patient's attending physician or advance practice nurse prescriber, and has provided written notice to the patient or the patient's legal representative in the timelines specified in this paragraph.
2. The home health agency shall provide the written notice, except when a patient is discharged due to hospital admission that occurs near the end of a 60-day episode of treatment, required under subd. 1 to the patient or the patient's legal representative at least 10 working days in advance of discharge if the reason for discharge is any of the following:
    a. Payment has not been made for the patient's care, following a reasonable opportunity to pay any unpaid billings.
    b. The home health agency is unable to provide the care required by the patient due to a change in the patient's condition that is not an emergency.
3. The home health agency shall provide the written notice under subd. 1. to the patient or the patient's legal representative at the time of discharge if the reason for discharge is any of the following:
    a. The safety of staff is compromised, as documented by the home health agency.
    b. The attending physician orders the discharge for emergency medical reasons.
    c. The patient no longer needs home health care as determined by the attending physician.
4. The home health agency shall insert a copy of the written discharge notice in the patient's medical record.
5. The home health agency shall include in every written discharge notice to a patient's legal representative of all the following:
    a. The reason for discharge
    b. A notice of the patient's right to file a complaint with the department and the department's toll-free home health hotline telephone number and the address and telephone number and the address and telephone number of the department's division of quality assurance.

Note*: A complaint may be filed by writing the Bureau of Health Services, Division of Quality Assurance, P.O. box 2969, Madison, Wisconsin 53701-2969 or by calling the Wisconsin Home Health Hotline toll free at 1-800-642-6552.*

(b) *Discharge summary.* The home health agency shall complete a written discharge summary within 30 calendar days following discharge of a patient. The discharge summary shall include a description of the care provided and the reason for discharge. The home health agency shall place a copy of the discharge summary in the former patient's medical record. Upon request, the home health agency shall provide a copy of the discharge summary to the former patient, the patient's legal representative, the attending physician, or advanced practice nurse prescriber.

EXHIBIT 25

Home Health
Quality of Patient Care Star Rating
Provider Preview Report

This report is based on end-of-care OASIS assessments for 4/1/2017-3/31/2018 and Medicare fee-for-service claims data for 1/1/2017-12/31/2017

Rating for Amedisys Home Health (217111) Salisbury, Maryland
Quality of Patient Care Star Rating
★★★★ (4.0 stars)

The Quality of Patient Care Star Rating will be displayed on Home Health Compare (HHC) in January 2019.

About the Quality of Patient Care Star Ratings

The Quality of Patient Care Star Ratings reflect how Home Health Agencies' (HHA) scores compare with one another on measurements of their quality of patient care performance. Across the country, most agencies fall "in the middle" with 3 stars - delivering good quality of care. A Star Rating higher than 3 means that an HHA performed better than average on the measured care practices and outcomes compared to other HHAs. A Star Rating below 3 means that an HHA's performance was below average compared to other HHAs.

The Quality of Patient Care Star Ratings do not provide information on the absolute quality of care being provided. In addition, these Star Ratings are different from the consumer ratings that you see on websites or apps for products like books, restaurants, or hotels that reflect averages of consumer opinions.

CMS also publishes Patient Experience of Care Star Ratings, based on responses to the Home Health Consumer Assessment of Healthcare Providers & Systems (HHCAHPS) survey. These ratings summarize patient feedback on their experience; more information is available at
https://www.medicare.gov/HHCompare/Data/About-Star-Ratings.html

How Quality of Patient Care Star Ratings Are Calculated

Effective April 2018, the Home Health Quality of Patient Care Star Ratings are determined using eight measures of quality that are reported on the Home Health Compare website[1], listed below. To have a Star Rating, HHAs must have submitted data to calculate at least 5 of 8 measures, which are:

1. Timely Initiation of Care
2. Drug Education on all Medications Provided to Patient/Caregiver
3. Improvement in Ambulation
4. Improvement in Bed Transferring
5. Improvement in Bathing
6. Improvement in Pain Interfering With Activity
7. Improvement in Dyspnea
8. Acute Care Hospitalization During the First 60 Days of Home Health (claims-based)

---

[1] *For a measure to be reported on Home Health Compare, HHAs must have data for at least 20 complete quality episodes with end dates within the 12-month reporting period (regardless of episode start date). Completed episodes for the OASIS-based measures are paired start or resumption of care and end of care OASIS assessments.*

For all measures, except Acute Care Hospitalization, a higher measure value means a better score. For Acute Care Hospitalization, a lower measure value means a better score.

On the scorecard below, the ranges for each measure are shown in Rows 1-11. The ranges were calculated using all HHAs with available information. They are also updated each quarter. These measures are used to calculate the HHA's Star Rating using the steps below.

The Scorecard at the end of this report has your information.

Steps

1. Make Groups: For each of the 8 quality measures, all HHAs' scores are sorted low to high and divided into 10 Groups that are generally equally sized.

2. Assign Group Rating: Your HHA's score on each measure is then assigned its group location as a first rating. Each group is assigned an initial ranking from 0.5 to 5.0 in 0.5 increments.

On the scorecard, Rows 12 and 13 show your HHA's score for the 8 measures and the corresponding group rating.

3. Adjust Ratings: Ratings may need to be adjusted if your HHA's score is not statistically different from the two national middle scores of 2.5 and 3.0. CMS conducts a statistical test of the difference between your HHA's score and the middle score categories of all HHAs for each measure.[2] If the test shows your results are not different from the national middle categories in a statistically meaningful way, your initial rating is moved 0.5 closer to the middle categories of 2.5 or 3.0. The rating is moved up 0.5 if your initial rating is below 2.5, or down 0.5 if your initial rating is above 3.0.

On the scorecard, Rows 15 through 17 show the inputs and results of this test and Row 18 shows the adjusted ratings of that measure, if applicable, based on the results.

4. Get Average Adjusted Rating: To obtain one overall score for your HHA rather than scores measure-by-measure, the adjusted ratings are averaged across the 8 measures and rounded to the nearest 0.5.

On the scorecard, Rows 19 and 20 show these results for your HHA.

On the scorecard, Row 21 shows the final Star Rating. It includes one more adjustment so that ratings range from 1.0 to 5.0 in half star increments (see table below). Thus, there are 9 star categories, with 3.0 stars being the middle category.

Average Adjusted Rating Rounded	Final Quality of Patient Care Star Rating
4.5 and 5.0	★★★★★ (5.0)
4.0	★★★★½ (4.5)
3.5	★★★★ (4.0)
3.0	★★★½ (3.5)
2.5	★★★ (3.0)
2.0	★★½ (2.5)
1.5	★★ (2.0)
1.0	★½ (1.5)
0.5	★ (1.0)

[2] *The calculation uses a one-sided binomial significance test and a p-value of 0.05*

More information on how the Quality of Patient Care Star Rating is calculated can be found at http[illegible].html

If Your Quality of Patient Care Star Rating is Not Available

If your preview report states 'data not available,' this means that there were not enough events reported on Home Health Compare for more than 4 of the quality measures included in the star rating calculation. This is usually because there are fewer than 20 events for those quality measures, or that your agency has been certified/re-certified for less than six months.

Requests for a Review of Your Star Rating

If you have proof that there are errors in calculating your Quality of Patient Care Star Rating, you may request a review of your rating by submitting that proof. Requests must be submitted by October 20, 2018 to HHC_Star_Rating_Review_Requests@cms.hhs.gov. As the Conditions of Participation require accurate OASIS data collection, inaccurate OASIS data recording is not a valid reason to submit a request for review of an agency's Quality of Patient Care Star Rating.

Your request should include the following information:

- Provider name and CCN
- Provider contact person – Name, Telephone #, email address
- Measure(s) affected, if any
- Detailed reason for the request with supporting documentation (do not send identifiable patient information through email)
- Any other information to assist CMS in identifying the calculation error and determining if the error(s) have affected your Star Rating

PLEASE DO NOT SEND ANY IDENTIFIABLE PATIENT INFORMATION THROUGH EMAIL! This includes medical record numbers, dates of birth, service dates (including visit dates, admission dates, or discharge dates), or any other data items considered identifiers or Protected Health Information (PHI) under HIPAA.

You should receive a receipt of your request within 2 business days. You (or your designated point of contact) may be asked to provide more information to allow CMS to fully review your request.

If the review of your documentation against the data in the national data system confirms that a calculation error has affected the Quality of Patient Care Star Rating, you may be granted suppression of your Star Rating and any incorrect measures for one quarter. You (or your designated point of contact) will receive a final decision on your request by November 22, 2018. Please note that this is a one-time suppression for the measure.

Please note that HHAs may utilize their Review and Correct Reports to determine and amend errors in OASIS data submission in a timely manner. Review and Correct Reports, containing quality measure information at the agency level for the OASIS-based publicly reported measures, are available on demand and allow Home Health providers to obtain aggregate performance data for the past four full quarters (when data is available). These reports only contain data submitted prior to the applicable quarterly data submission deadlines and display whether the data correction period for a given CY quarter is "open" or "closed." Note that the Review and Correct Reports provide a data correction deadline for each reporting quarter. Only corrections that are made on or before the data correction deadline will be used in the calculation of the measures displayed on Home Health Compare and in the Quality of Patient Care Star Rating.

Providers can access these reports within the CMS QIES Systems for Providers webpage. This is the same webpage where providers access the link to submit their OASIS data to the QIES Assessment Submission and Processing (ASAP) system.

For More Information

Any comments, questions, and suggestions about the Quality of Patient Care Star Ratings can be submitted to: [illegible]

Calculating the Quality of Patient Care Star Rating:
[illegible] as.html

Home Health Quality Measures:
[illegible]ures.html

Home health agencies can review the OASIS Guidance Manual, Appendix F – "OASIS and Quality Improvement" for further information related to the steps toward improving their quality measures. The OASIS Guidance Manual is available at
[illegible]

Quality of Patient Care Star Rating Scorecard[1] Amedisys Home Health (217111) Salisbury, Maryland

		Measure Score Cut Points by Initial Decile Rating							
	Initial Group Rating	Measure 1. Timely Initiation of Care	Measure 2. Drug Education on all Medications[2]	Measure 3. Improvement in Ambulation	Measure 4. Improvement in Bed Transferring	Measure 5. Improvement in Bathing	Measure 6. Improvement in Pain Interfering with Activity	Measure 7. Improvement in Dyspnea	Measure 8. Acute Care Hospitalization
	0.5	0.0-82.3	0.0-91.1	0.0-55.2	0.0-51.2	0.0-54.6	0.0-52.2	0.0-46.7	19.9-100.0
	1.0	82.4-88.3	91.1-95.3	55.3-62.7	51.3-59.7	54.7-64.0	52.3-62.5	46.8-59.6	18.1-19.8
	1.5	88.4-91.7	95.4-97.0	62.8-67.7	59.8-65.8	64.1-69.1	62.6-68.8	59.7-67.0	17.0-18.0
	2.0	91.8-93.8	97.0-98.0	67.8-71.3	65.9-69.9	69.2-73.0	68.9-73.4	67.1-72.1	16.2-16.9
	2.5	93.9-95.4	98.0-98.7	71.4-73.9	70.0-73.1	73.1-76.1	73.5-77.1	72.2-76.0	15.4-16.1
	3.0	95.5-96.7	98.7-99.2	74.0-76.2	73.2-75.6	76.2-79.0	77.2-80.7	76.1-79.2	14.6-15.3
	3.5	96.8-97.6	99.2-99.6	76.3-78.9	75.7-78.2	79.1-81.8	80.8-84.4	79.3-82.1	13.6-14.5
	4.0	97.7-98.5	99.6-99.9	79.0-81.9	78.3-81.1	81.9-85.1	84.5-88.3	82.2-85.3	12.4-13.5
	4.5	98.6-99.3	100.0-100.0	82.0-86.5	81.2-85.8	85.2-89.9	88.4-93.6	85.4-89.4	10.5-12.3
	5.0	99.4-100.0	100.0-100.0	86.6-100.0	85.9-100.0	90.0-100.0	93.7-100.0	89.5-100.0	0.0-10.4
12	Your HHA Score	98.0	100.0	75.6	78.9	81.1	83.4	82.3	16.1
13	Your Initial Group Rating	4.0	4.5	3.0	4.0	3.5	3.5	4.0	2.5
14	Your Number of Cases (N)	3,269	3,193	2,363	2,348	2,374	1,805	1,732	2,041
15	National (All HHA) Middle Score	95.5	98.9	74.0	73.2	76.1	77.1	76.0	15.4
16	Your Statistical Test Probability Value (p-value)	0.000	0.000	0.037	0.000	0.000	0.000	0.000	0.192
17	Your Statistical Test Results (Is the p-value < 0.050?)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	Your HHA Adjusted Group Rating	4.0	4.5	3.0	4.0	3.5	3.5	4.0	2.5

19	Your Average Adjusted Rating	3.6
20	Your Average Adjusted Rating Rounded	3.5
21	**Your Quality of Patient Care Star Rating (1.0 to 5.0)**	★★★★ **(4.0 stars)**

---

[1] *OASIS data from April 1, 2017 to March 31, 2018; claims data from January 1, 2017 to December 31, 2017.*

[2] *Initial decile cut points for this measure were determined using two decimal places based on OASIS data from October 1, 2016 to September 30, 2017. For display purposes, cut points were rounded to one decimal place.*

Home Health
Quality of Patient Care Star Rating
Provider Preview Report

This report is based on Medicare fee-for-service claims data and end-of-care OASIS assessments for 1/1/2017-12/31/2017

Rating for Amedisys Home Health (217111) Salisbury, Maryland
Quality of Patient Care Star Rating
★★★★½ (4.5 stars)

The Quality of Patient Care Star Rating will be displayed on Home Health Compare (HHC) in October 2018.

About the Quality of Patient Care Star Ratings

The Quality of Patient Care Star Ratings reflect how Home Health Agencies' (HHA) scores compare with one another on measurements of their quality of patient care performance. Across the country, most agencies fall "in the middle" with 3 stars - delivering good quality of care. A Star Rating higher than 3 means that an HHA performed better than average on the measured care practices and outcomes compared to other HHAs. A Star Rating below 3 means that an HHA's performance was below average compared to other HHAs.

The Quality of Patient Care Star Ratings do not provide information on the absolute quality of care being provided. In addition, these Star Ratings are different from the consumer ratings that you see on websites or apps for products like books, restaurants, or hotels that reflect averages of consumer opinions.

CMS also publishes Patient Experience of Care Star ratings, based on responses to the Home Health Consumer Assessment of Healthcare Providers & Systems (HHCAHPS) survey. These ratings summarize patient feedback on their experience; more information is available at

How Quality of Patient Care Star Ratings Are Calculated

Effective April 2018, the Home Health Quality of Patient Care Star Ratings are determined using eight measures of quality that are reported on the Home Health Compare website[1], listed below. To have a Star Rating, HHAs must have submitted data to calculate at least 5 of 8 measures, which are:

1. Timely Start of Care
2. Drug Education on all Medications Provided to Patient/Caregiver
3. Improvement in Ambulation
4. Improvement in Bed Transferring
5. Improvement in Bathing
6. Improvement in Pain Interfering With Activity
7. Improvement in Shortness of Breath
8. Acute Care Hospitalization

---

[1] *For a measure to be reported on Home Health Compare, HHAs must have data for at least 20 complete quality episodes with end dates within the 12-month reporting period (regardless of episode start date). Completed episodes are paired start or resumption of care and end of care OASIS assessments.*

For all measures, except acute care hospitalization, a higher measure value means a better score. For acute care hospitalization, a lower measure value means a better score.

On the scorecard, the ranges for each measure are shown in Rows 1-11. The ranges were calculated using all HHAs with available information. They are also updated each quarter. These measures are used to calculate the HHA's Star Rating using the steps below.

The Scorecard at the end of this report has your information.

Steps

1. Make Groups: For each of the 8 quality measures, all HHAs' scores are sorted low to high and divided into 10 Groups that are generally equally sized.

2. Assign Group Rating: Your HHA's score on each measure is then assigned its group location as a first rating. Each group is assigned an initial ranking from 0.5 to 5.0 in 0.5 increments.

On the scorecard, Rows 12 and 13 show your HHA's score for the 8 measures and the corresponding group rating.

3. Adjust Ratings: Ratings may need to be adjusted if your HHA's score is not statistically different from the two national middle scores of 2.5 and 3.0. CMS conducts a statistical test of the difference between your HHA's score and the middle score categories of all HHAs for each measure.[2] If the test shows your results are not different from the national middle categories in a statistically meaningful way, your initial rating is moved 0.5 closer to the middle categories of 2.5 or 3.0. The rating is moved up 0.5 if your initial rating is below 2.5, or down 0.5 if your initial rating is above 3.0.

On the scorecard, Rows 15 through 17 show the inputs and results of this test and Row 18 shows the adjusted ratings of that measure, if applicable, based on the results.

4. Get Average Adjusted Rating: To obtain one overall score for your HHA rather than scores measure-by-measure, the adjusted ratings are averaged across the 8 measures and rounded to the nearest 0.5.

On the scorecard, Rows 19 and 20 show these results for your HHA.

On the scorecard, Row 21 shows the final Star Rating. It includes one more adjustment so that ratings range from 1.0 to 5.0 in half star increments (see table below). Thus, there are 9 star categories, with 3.0 stars being the middle category.

Average Adjusted Rating Rounded	Final Quality of Patient Care Star Rating
4.5 and 5.0	★★★★★ (5.0)
4.0	★★★★½ (4.5)
3.5	★★★★ (4.0)
3.0	★★★½ (3.5)
2.5	★★★ (3.0)
2.0	★★½ (2.5)
1.5	★★ (2.0)
1.0	★½ (1.5)
0.5	★ (1.0)

[2] *The calculation uses a one-sided binomial significance test and a p-value of 0.05*

More information on how the Quality of Patient Care Star Rating is calculated can be found at [illegible].html

If Your Quality of Patient Care Star Rating is Not Available

If your preview report states 'data not available,' this means that there were not enough events reported on Home Health Compare for more than 4 of the quality measures included in the star rating calculation. This is usually because there are fewer than 20 events for those quality measures, or that your agency has been certified/re-certified for less than six months.

Requests for a Review of Your Star Rating

If you have proof that errors in data submitted to CMS may have resulted in an incorrect Quality of Patient Care Star Rating, you may request a review of your rating by submitting that proof along with a plan describing how you will correct errors. Requests must be submitted by July 23, 2018 to [illegible]. This request must include a plan that documents how you will correct all data errors in the QIES system by August 15, 2018. Note that under Review and Correct processes, only corrected assessments with effective dates in the next quarter may be incorporated in the following HHC refresh. All other data are frozen.

Your request should include the following information:

- Provider name and CCN
- Provider contact person – Name, Telephone #, email address
- Measure(s) affected
- Type of data error (Inaccurate or missing assessments)
- Date range for data errors
- Volume (number of episodes affected)
- Describe the error in detail to allow evaluation of its possible impact on the Star Ratings, such as what values were reported and what values SHOULD HAVE BEEN reported. For example, "All of our 100 episodes during the period were incorrectly picked up by our data system and reported as "0" on (M2015) Patient/Caregiver Drug Education Intervention, when 95 were assessed as "1".
- Plan for submitting missing or corrected assessments by August 15, 2018
- Any other information to assist CMS in determining if the data errors have affected your Star Rating.

As the Conditions of Participation require accurate OASIS data collection, inaccurate OASIS data recording is not a valid reason to submit a request for suppression of an agency's Quality of Patient Care Star Rating.

PLEASE DO NOT SEND ANY IDENTIFIABLE PATIENT INFORMATION THROUGH EMAIL! This includes medical record numbers, dates of birth, service dates (including visit dates, admission dates, or discharge dates), or any other data items considered identifiers or Protected Health Information (PHI) under HIPAA.

You should receive a receipt of your request within 2 business days. You (or your designated point of contact) may be asked to provide more information to allow CMS to fully review your request.

If the review of your documentation against the data in the national data system confirms that the mistake has affected the Quality of Patient Care Star Rating and you have presented an acceptable correction plan, you may be granted suppression of your Star Rating and any incorrect measures for one quarter while corrections are made. You (or your designated point of contact) will receive a final decision on your request by August 24, 2018. Please note that this is a one-time suppression for the measure and the type of error identified.

Please note that HHAs may utilize their Review and Correct Reports to determine and amend errors in OASIS data submission in a timely manner. Review and Correct reports contain quality measure information at the agency level, are available on demand and allow Home Health providers to obtain aggregate performance for the past four full quarters (when data is available). These reports only contain data submitted prior to the applicable quarterly data submission deadlines and display whether the data correction period for a given CY quarter is "open" or "closed."

Providers can access these reports within the CMS QIES Systems for Providers webpage. This is the same webpage where providers access the link to submit their OASIS data to the QIES Assessment Submission and Processing (ASAP) system.

For More Information

Any comments, questions, and suggestions about the Quality of Patient Care Star Ratings can be submitted to: HomeHealthQualityQuestions@cms.hhs.gov

Calculating the Quality of Patient Care Star Rating:
http://www.cms.gov/HomeHealthQualityInits/Downloads/HHQIStarRatings.html

Home Health Quality Measures:
http://www.cms.gov/HomeHealthQualityInits/HHQualityMeasures.html

Home health agencies can review the OASIS Guidance Manual, Appendix F – "OASIS and Quality Improvement" for further information related to the steps toward improving their quality measures. The OASIS Guidance Manual is available at
http://www.cms.gov/OASIS/06_HomeHealthQualityInitiativeGeneralInformation.asp#TopOfPage

Quality of Patient Care Star Rating Scorecard[1] Amedisys Home Health (217111) Salisbury, Maryland

		Measure Score Cut Points by Initial Decile Rating							
	Initial Group Rating	Measure 1. Timely initiation of care	Measure 2. Drug education on all medications[2]	Measure 3. Improvement in ambulation	Measure 4. Improvement in bed transferring	Measure 5. Improvement in bathing	Measure 6. Improvement in pain interfering with activity	Measure 7. Improvement in shortness of breath	Measure 8. Acute care hospitalization
2	0.5	0.0-81.9	0.0-91.1	0.0-54.1	0.0-49.7	0.0-53.5	0.0-51.5	0.0-45.7	19.9-100.0
3	1.0	82.0-88.1	91.1-95.3	54.2-62.1	49.8-58.4	53.6-63.2	51.6-61.8	45.8-58.7	18.1-19.8
4	1.5	88.2-91.4	95.4-97.0	62.2-66.8	58.5-64.2	63.3-68.5	61.9-68.1	58.8-65.9	17.0-18.0
5	2.0	91.5-93.6	97.0-98.0	66.9-70.3	64.3-68.6	68.6-72.2	68.2-72.6	66.0-71.1	16.2-16.9
6	2.5	93.7-95.1	98.0-98.7	70.4-73.1	68.7-71.9	72.3-75.4	72.7-76.4	71.2-75.1	15.4-16.1
7	3.0	95.2-96.4	98.7-99.2	73.2-75.6	72.0-74.5	75.5-78.4	76.5-80.1	75.2-78.4	14.6-15.3
8	3.5	96.5-97.4	99.2-99.6	75.7-78.0	74.6-77.1	78.5-81.2	80.2-83.9	78.5-81.6	13.6-14.5
9	4.0	97.5-98.3	99.6-99.9	78.1-81.0	77.2-80.2	81.3-84.5	84.0-88.0	81.7-84.7	12.3-13.5
10	4.5	98.4-99.2	100.0-100.0	81.1-85.9	80.3-84.8	84.6-89.4	88.1-93.7	84.8-89.0	10.5-12.2
11	5.0	99.3-100.0	100.0-100.0	86.0-100.0	84.9-100.0	89.5-100.0	93.8-100.0	89.1-100.0	0.0-10.4
12	Your HHA Score	97.6	100.0	76.3	79.5	81.6	83.8	83.2	16.1
13	Your Initial Group Rating	4.0	5.0	3.5	4.0	4.0	3.5	4.0	2.5
14	Your Number of Cases (N)	3,254	3,196	2,445	2,431	2,457	1,807	1,777	2,041
15	National (All HHA) Middle Score	95.2	98.8	73.2	71.9	75.5	76.5	75.2	15.4
16	Your Statistical Test Probability Value (p-value)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.192
17	Your Statistical Test Results (Is the p-value < 0.050?)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
18	Your HHA Adjusted Group Rating	4.0	5.0	3.5	4.0	4.0	3.5	4.0	2.5

19	Your Average Adjusted Rating	3.8
20	Your Average Adjusted Rating Rounded	4.0
21	**Your Quality of Patient Care Star Rating (1.0 to 5.0)**	★★★★½ (4.5 stars)

[1] *OASIS and claims data from January 1, 2017 to December 31, 2017*

[2] *Initial decile cut points for this measure were determined using two decimal places based on OASIS data from October 1, 2016 to September 30, 2017. For display purposes, cut points were rounded to one decimal place.*

Home Health
Quality of Patient Care Star Rating
Provider Preview Report

This report is based on Medicare fee-for-service claims data and end-of-care OASIS assessments for 10/1/2016-9/30/2017

Rating for Amedisys Home Health (217111) Salisbury, Maryland
Quality of Patient Care Star Rating
★★★★ (4.0 stars)

The Quality of Patient Care Star Rating will be displayed on Home Health Compare (HHC) in July 2018.

About the Quality of Patient Care Star Ratings

The Quality of Patient Care Star Ratings reflect how Home Health Agencies' (HHA) scores compare with one another on measurements of their quality of patient care performance. Across the country, most agencies fall "in the middle" with 3 stars - delivering good quality of care. A Star Rating higher than 3 means that an HHA performed better than average on the measured care practices and outcomes compared to other HHAs. A Star Rating below 3 means that an HHA's performance was below average compared to other HHAs.

The Quality of Patient Care Star Ratings do not provide information on the absolute quality of care being provided. In addition, these Star Ratings are different from the consumer ratings that you see on websites or apps for products like books, restaurants, or hotels that reflect averages of consumer opinions.

CMS also publishes Patient Experience of Care Star ratings, based on responses to the Home Health Consumer Assessment of Healthcare Providers & Systems (HHCAHPS) survey. These ratings summarize patient feedback on their experience; more information is available at
https://www.medicare.gov/HomeHealthCompare/About/HHCAHPS-Star-Ratings.html

How Quality of Patient Care Star Ratings Are Calculated

Effective April 2018, the Home Health Quality of Patient Care Star Ratings are determined using eight measures of quality that are reported on the Home Health Compare website[1], listed below. To have a Star Rating, HHAs must have submitted data to calculate at least 5 of 8 measures, which are:

1. Timely Start of Care
2. Drug Education on all Medications Provided to Patient/Caregiver
3. Improvement in Ambulation
4. Improvement in Bed Transferring
5. Improvement in Bathing
6. Improvement in Pain Interfering With Activity
7. Improvement in Shortness of Breath
8. Acute Care Hospitalization

---

[1] *For a measure to be reported on Home Health Compare, HHAs must have data for at least 20 complete quality episodes with end dates within the 12-month reporting period (regardless of episode start date). Completed episodes are paired start or resumption of care and end of care OASIS assessments.*

For all measures, except acute care hospitalization, a higher measure value means a better score. For acute care hospitalization, a lower measure value means a better score.

On the scorecard, the ranges for each measure are shown in Rows 1-11. The ranges were calculated using all HHAs with available information. They are also updated each quarter. These measures are used to calculate the HHA's Star Rating using the steps below.

The Scorecard at the end of this report has your information.

Steps

1. Make Groups: For each of the 8 quality measures, all HHAs' scores are sorted low to high and divided into 10 Groups that are generally equally sized.

2. Assign Group Rating: Your HHA's score on each measure is then assigned its group location as a first rating. Each group is assigned an initial ranking from 0.5 to 5.0 in 0.5 increments.

On the scorecard, Rows 12 and 13 show your HHA's score for the 8 measures and the corresponding group rating.

3. Adjust Ratings: Ratings may need to be adjusted if your HHA's score is not statistically different from the two national middle scores of 2.5 and 3.0. CMS conducts a statistical test of the difference between your HHA's score and the middle score categories of all HHAs for each measure.[2] If the test shows your results are not different from the national middle categories in a statistically meaningful way, your initial rating is moved 0.5 closer to the middle categories of 2.5 or 3.0. The rating is moved up 0.5 if your initial rating is below 2.5, or down 0.5 if your initial rating is above 3.0.

On the scorecard, Rows 15 through 17 show the inputs and results of this test and Row 18 shows the adjusted ratings of that measure, if applicable, based on the results.

4. Get Average Adjusted Rating: To obtain one overall score for your HHA rather than scores measure-by-measure, the adjusted ratings are averaged across the 8 measures and rounded to the nearest 0.5.

On the scorecard, Rows 19 and 20 show these results for your HHA.

On the scorecard, Row 21 shows the final Star Rating. It includes one more adjustment so that ratings range from 1.0 to 5.0 in half star increments (see table below). Thus, there are 9 star categories, with 3.0 stars being the middle category.

Average Adjusted Rating Rounded	Final Quality of Patient Care Star Rating
4.5 and 5.0	★★★★★ (5.0)
4.0	★★★★½ (4.5)
3.5	★★★★ (4.0)
3.0	★★★½ (3.5)
2.5	★★★ (3.0)
2.0	★★½ (2.5)
1.5	★★ (2.0)
1.0	★½ (1.5)
0.5	★ (1.0)

[2] *The calculation uses a one-sided binomial significance test and a p-value of 0.05*

More information on how the Quality of Patient Care Star Rating is calculated can be found at http://www.cms.gov/Outcome-Assessment-Information-Set/Downloads/HHCHealthStarRatings.html

If Your Quality of Patient Care Star Rating is Not Available

If your preview report states 'data not available,' this means that there were not enough events reported on Home Health Compare for more than 4 of the quality measures included in the star rating calculation. This is usually because there are fewer than 20 events for those quality measures, or that your agency has been certified/re-certified for less than six months.

Requests for a Review of Your Star Rating

If you have proof that errors in data submitted to CMS may have resulted in an incorrect Quality of Patient Care Star Rating, you may request a review of your rating by submitting that proof along with a plan describing how you will correct errors. Requests must be submitted by April 23, 2018 to HHC Star Ratings Review Request@cms.hhs.gov. This request must include a plan that documents how you will correct all data errors in the QIES system by May 15, 2018. Note that under Review and Correct processes, only corrected assessments with effective dates in the latest quarter of the current reporting period will be incorporated in the following HHC refresh. All other data are frozen.

Your request should include the following information:

- Provider name and CCN
- Provider contact person – Name, Telephone #, email address
- Measure(s) affected
- Type of data error (inaccurate or missing assessments)
- Date range for data errors
- Volume (number of episodes affected)
- Describe the error in detail to allow evaluation of its possible impact on the Star Ratings, such as what values were reported and what values SHOULD HAVE BEEN reported. For example, "All of our 100 episodes during the period were incorrectly picked up by our data system and reported as "0" on (M2015) Patient/Caregiver Drug Education Intervention, when 95 were assessed as "1".
- Plan for submitting missing or corrected assessments by May 15, 2018
- Any other information to assist CMS in determining if the data errors have affected your Star Rating.

As the Conditions of Participation require accurate OASIS data collection, inaccurate OASIS data recording is not a valid reason to submit a request for suppression of an agency's Quality of Patient Care Star Rating.

PLEASE DO NOT SEND ANY IDENTIFIABLE PATIENT INFORMATION THROUGH EMAIL! This includes medical record numbers, dates of birth, service dates (including visit dates, admission dates, or discharge dates), or any other data items considered identifiers or Protected Health Information (PHI) under HIPAA.

You should receive a receipt of your request within 2 business days. You (or your designated point of contact) may be asked to provide more information to allow CMS to fully review your request.

If the review of your documentation against the data in the national data system confirms that the mistake has affected the Quality of Patient Care Star Rating and you have presented an acceptable correction plan, you may be granted suppression of your Star Rating and any incorrect measures for one quarter while corrections are made. You (or your designated point of contact) will receive a final decision on your request by May 25, 2018. Please note that this is a one-time suppression for the measure and the type of error identified.

Please note that HHAs may utilize their Review and Correct Reports to determine and amend errors in OASIS data submission in a timely manner. Review and Correct reports contain quality measure information at the agency level, are available on demand and allow Home Health providers to obtain aggregate performance for the past four full quarters (when data is available). These reports only contain data submitted prior to the applicable quarterly data submission deadlines and display whether the data correction period for a given CY quarter is "open" or "closed."

Providers can access these reports within the CMS QIES Systems for Providers webpage. This is the same webpage where providers access the link to submit their OASIS data to the QIES Assessment Submission and Processing (ASAP) system.

For More Information

Any comments, questions, and suggestions about the Quality of Patient Care Star Ratings can be submitted to:

Calculating the Quality of Patient Care Star Rating:

Home Health Quality Measures:

Home health agencies can review the OASIS Guidance Manual, Appendix F – "OASIS and Quality Improvement" for further information related to the steps toward improving their quality measures. The OASIS Guidance Manual is available at

Quality of Patient Care Star Rating Scorecard[1] Amedisys Home Health (217111) Salisbury, Maryland

		Measure Score Cut Points by Initial Decile Rating							
	Initial Group Rating	Measure 1. Timely initiation of care	Measure 2. Drug education on all medications[2]	Measure 3. Improvement in ambulation	Measure 4. Improvement in bed transferring	Measure 5. Improvement in bathing	Measure 6. Improvement in pain interfering with activity	Measure 7. Improvement in shortness of breath	Measure 8. Acute care hospitalization
	0.5	0.0-81.8	0.0-91.1	0.0-53.5	0.0-48.2	0.0-53.4	0.0-50.5	0.0-44.1	19.8-100.0
	1.0	81.9-87.9	91.1-95.3	53.6-61.4	48.3-56.9	53.5-62.7	50.6-61.0	44.2-58.0	18.1-19.7
	1.5	88.0-91.2	95.4-97.0	61.5-66.2	57.0-62.6	62.8-68.0	61.1-67.2	58.1-64.9	17.1-18.0
	2.0	91.3-93.4	97.0-98.0	66.3-69.6	62.7-66.8	68.1-71.7	67.3-71.7	65.0-70.2	16.2-17.0
	2.5	93.5-95.1	98.0-98.7	69.7-72.4	66.9-70.3	71.8-74.7	71.8-75.5	70.3-74.2	15.4-16.1
	3.0	95.2-96.3	98.7-99.2	72.5-74.7	70.4-73.1	74.8-77.6	75.6-79.2	74.3-77.5	14.5-15.3
	3.5	96.4-97.3	99.2-99.6	74.8-77.2	73.2-75.6	77.7-80.5	79.3-83.3	77.6-80.6	13.6-14.4
	4.0	97.4-98.3	99.6-99.9	77.3-80.2	75.7-78.9	80.6-83.8	83.4-87.6	80.7-84.1	12.4-13.5
	4.5	98.4-99.1	100.0-100.0	80.3-85.2	79.0-83.4	83.9-88.7	87.7-93.7	84.2-88.4	10.6-12.3
	5.0	99.2-100.0	100.0-100.0	85.3-100.0	83.5-100.0	88.8-100.0	93.8-100.0	88.5-100.0	0.0-10.5
12	Your HHA Score	96.9	99.9	76.6	78.7	82.1	82.8	83.0	16.5
13	Your Initial Group Rating	3.5	4.0	3.5	4.0	4.0	3.5	4.0	2.0
14	Your Number of Cases (N)	3,237	3,194	2,415	2,400	2,428	1,746	1,774	2,019
15	National (All HHA) Middle Score	95.1	98.7	72.4	70.3	74.8	75.6	74.3	15.3
16	Your Statistical Test Probability Value (p-value)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.082
17	Your Statistical Test Results (Is the p-value < 0.050?)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	Your HHA Adjusted Group Rating	3.5	4.0	3.5	4.0	4.0	3.5	4.0	2.5

19	Your Average Adjusted Rating	3.6
20	Your Average Adjusted Rating Rounded	3.5
21	**Your Quality of Patient Care Star Rating (1.0 to 5.0)**	**★★★★ (4.0 stars)**

[1] *OASIS and claims data from October 1, 2016 to September 30, 2017*

[2] *Initial decile cut points and assignments for this measure were determined using two decimal places. For display purposes, cut points were rounded to one decimal place.*

EXHIBIT 26

amedisys

Skilled Services provided Cambridge/Salisbury MD

Skilled Nursing- RN/LPN

- Wound care
- Heart Failure
- Chronic Obstructive Pulmonary Disease
- Medication Management
- IV management
- G/J-Tube management
- Chest tube management
- Surgical aftercare
- Trach care
- Plan of Care management
- Pain assessment
- Nutrition assessment and management

Psychiatric Nursing/RN

- Dementia/Alzheimer's Management
- Medication Management
- Behavioral Modification Interventions
- Management of other psychiatric and mood related disorders
- Community resource identification

Physical Therapy- PT/ PTA

- Fall Reduction and Prevention Program
- Home Safety
- Orthopedic Surgical Aftercare
- Anodyne therapy
- Ultrasound
- Gait training
- Strength and endurance training
- Assistive device training
- Transfer Training
- Other modalities as appropriate

amedisys
HOME HEALTH

Occupational Therapy- OT/COTA

- Fall Prevention and Reduction
- Home Safety
- Activities of Daily Living
- Energy Conservation/Work simplification
- Cognitive and Social Skills
- Functional Mobility
- Other modalities as appropriate

Speech Language Pathology- CCC-SLP

- Enhance communication skills
- Address Cognition
- Swallowing disorders and dysphagia
- Voice Quality
- Safety with oral medications
- Augmentive Communication needs
- Weight loss due to malnutrition
- Swallowing and breathing coordination in late stage COPD/CHF

Medical Social Work- MSW

- Assist with Community resources
- Assess support systems
- Facility placement
- Safety issues
- Transportation issues
- Medication resources
- Insurance resources
- Short term counseling patient/family

Care Transitions Coordination- Care Transitions Coordinators CTC

- Patient and caregiver education bedside
- Disease process education
- Review discharge medication lists

- Review discharge needs
- Organize health information and follow up appointments
- Call within 24-48 hrs to ensure needs are met
- Coordinate primary care follow up within 7-10 days from discharge
- Coordinate with discharge planners and physicians