Kindred Healthcare & GENTIVA

Better Together Feb ...

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EXHIBIT R - Postacute Care
Document consists of 7 pages.
Entire exhibit provided.
Meeting Date: 02-17-16

Kindred at Home

Home Health Care Overview and Our Role in Post Acute Services

A health service provided in the patient's place of residence for the purpose of promoting, maintaining, restoring health and/or minimizing the effects of illness and disability.

- Patients 65-74 years; majority of patients utilizing home health:
  - Skilled nursing services (84%) **Gentiva Reno Area** (90%)
  - Physical Therapy (40%) **Gentiva Reno Area** (75%)
  - Occupational Therapy (14%) **Gentiva Reno Area** (51%)
  - Speech Therapy **Gentiva Reno Area** (9%)
  - Home Health Aide (37%) **Gentiva Reno Area** (13%)
  - Social Worker **Gentiva Reno Area** (10%)

- Care is initiated by Physicians with continual involvement throughout the episode of care (60 days)
- Medicare Certified Agency
- Work Closely with Hospitals, Skilled Nursing Facilities, Rehabilitation Hospitals, Long Term Acute Care Hospitals, Hospice, and Doctor offices
- In the state of Nevada we have 5 offices-**Reno**, **Carson**, **Fernley**, Las Vegas, and Mesquite. 145 Home Health agencies in the state of Nevada

2014 CMS Hospital Medicare Discharge Data to Post Acute

(Home Health, Skilled Nursing Facilities, Hospice, Inpatient Rehab, Long Term Acute Care)

Las Vegas (29 Hospitals)

2014 Medicare Cases – 77,331

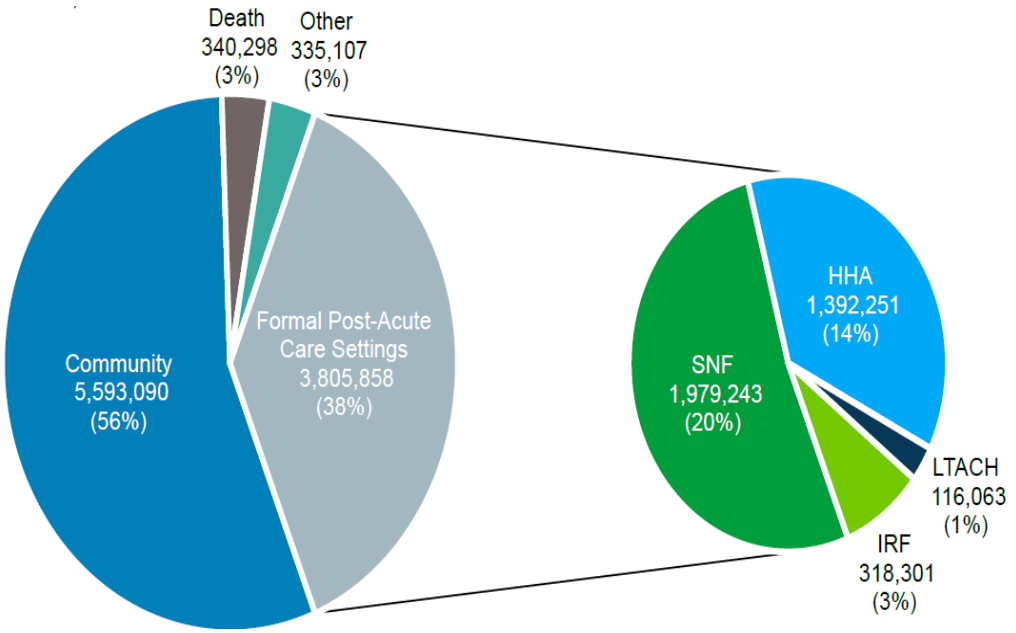
- 19.5% to Home Health
- 11.4% to Skilled nursing Facilities
- 1.1% to hospice home
- 2.2% to hospice facilities
- Payment per day all cases $1,405
- Home Health $3,000-$5,000/60-day episode

Reno (17 Hospitals)

2014 Medicare Cases – 30,048

- 13.6% to home
- 16.2% to skilled nursing facilities
- 1.4% to Hospice home
- .1% to hospice facility
- Avg. payment/day all cases $1,898
- Home Health $3,000-$5,000/60-day episode

Source: 2014 CMS MedPar for hospital payments
And discharges. Data collected 7/1/2011-6/30/2014



Source: Avalere Health, LLC analysis of Medicare Standard Analytic Files, 2013.
Hospital: Short-Term Acute Care Hospital (STACH).
Community: Discharges to the community without skilled home health care; includes individuals living at home, assisted living facilities, and
retirement communities.
Formal Post-Acute Care Settings: Settings designated as post-acute care by Medicare. Includes skilled nursing facilities (SNF),
home health agencies (HHA), inpatient rehabilitation facilities (IRF), and long-term acute care hospitals (LTACH).
Other: Hospice, a different Inpatient Hospital, or other Inpatient Hospitals such as Inpatient Psychiatric Facilities

Home Health Compare
CMS Publically Reported Data

This information comes from Medicare claims for patients beginning home health care between **April 1, 2014 - March 31, 2015**

<u>30 Day Hospital Readmissions</u>

Gentiva Health Services 15.8%

Nevada Average 15.2%

National Average 16.0%

Medicare.gov

Home Health Compare

Outcomes: Readmissions Among Post-Acute Care Users

Table 7.1: 30-day Readmission Rates for Top 20 Most Common MS-DRGs Discharged from Hospital to Selected Post-Acute Care (PAC) Settings, by Setting, 2013

MS-DRG	% of Home Health Users Readmitted Within 30 Days	% of SNF Users Readmitted Within 30 Days
Major joint replacement or reattachment of lower extremity w/o mcc	3.59%	6.97%
Septicemia or severe sepsis w/o mv 96+ hours w mcc	21.37%	22.74%
Heart failure & shock w mcc	24.77%	25.66%
Heart failure & shock w cc	23.86%	23.28%
Kidney & urinary tract infections w/o mcc	18.51%	14.21%
Hip & femur procedures except major joint w cc	8.03%	11.64%
Intracranial hemorrhage or cerebral infarction w cc	12.39%	14.64%
Simple pneumonia & pleurisy w cc	16.93%	16.42%
Renal failure w cc	22.78%	19.47%
Simple pneumonia & pleurisy w mcc	20.40%	21.88%
Septicemia or severe sepsis w/o mv 96+ hours w/o mcc	16.21%	16.77%
Chronic obstructive pulmonary disease w mcc	22.30%	23.77%
Cellulitis w/o mcc	14.00%	13.88%
Renal failure w mcc	25.19%	24.02%
Misc disorders of nutrition, metabolism, fluids/electrolytes w/o mcc	21.16%	15.67%
Kidney & urinary tract infections w mcc	21.10%	17.66%
Pulmonary edema & respiratory failure	22.26%	25.75%
Chronic obstructive pulmonary disease w cc	22.20%	20.83%
Esophagitis, gastroent & misc digest disorders w/o mcc	19.71%	16.68%
G.I. hemorrhage w cc	18.58%	17.99%
Average Rate Across All MS-DRGs	16.92%	17.49%

Source: Avalere Health, LLC, analysis of Medicare Standard Analytic Files, 2013.
*Analysis includes Medicare Part A claims only.
Note: CC is complication or comorbidity. MCC is major complication or comorbidity.
SNF: Skilled Nursing Facilities

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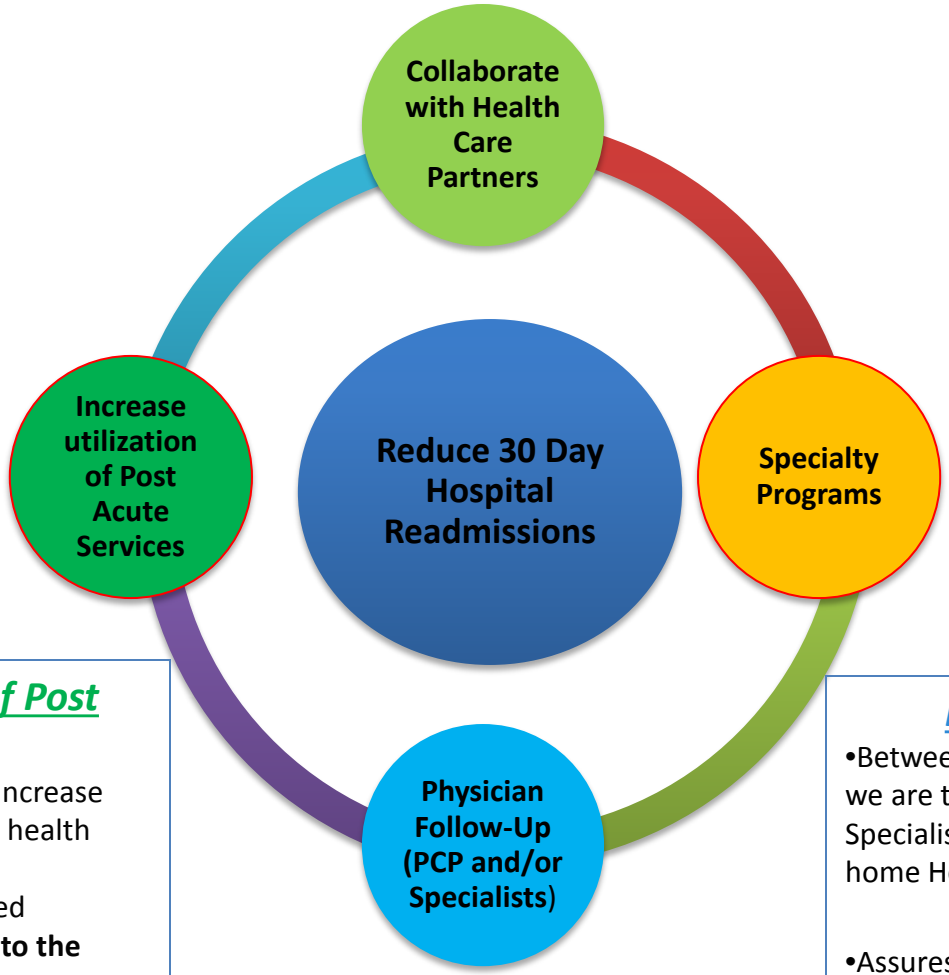
Quality Metric-Gentiva's Specific Role
30-Day Hospital Readmissions

Collaboration with HealthCare partners
- Educating MD's – ER, PCP's, Specialists
- Monthly meetings to discuss best practices with SNF & Hospitals
- Involvement with ACO's Accountable Care Organizations- improve quality care to patients and decreasing cost of care through better collaboration



Gentiva Specialty Programs-
- Safe Strides- fall risk
- Low vision- visually impaired
- Cardiac Program
- LSVT-Parkinson's
- Joint Replacement Program
- Transitional Care
- Home Health Specialists

Increase utilization of Post Acute Services
- Home Health is under utilized- Increase education of services offered to health care professionals
- Acquisition of Gentiva by Kindred
- **Expanded our coverage area into the rural locations**

Physician Follow-Up
- Between Hospitalist and PCP/Specialist – we are the facilitators-Home Health Specialists notify MD's of transition to home Health from hospital/SNF

Follow up MD appt
- Assures patient keeps post hosp MD appt

Kindred at Home

Key Clinical Quality Metrics

- **Governmental**:
  - CMS Quality Measures
  - CMS Star Quality Rating System (new in 2015)
  - Hospitalization and Rehospitalization rates
  - Patient experience surveys – Home Health Consumer Assessment of Health Care Providers and Systems (HH-CAHPS)
  - State Survey Process
- **Internal**:
  - KAH uses a quality data vendor – Strategic Healthcare Partners (SHP) – to benchmark against industry peers:
    - Star Quality: Rehospitalization, Pain, Ambulation, etc.
    - Core KND Quality: Falls, Wounds, Infections, Medications
  - Internal Audit Process for measures of branch stability (quality, people, process, documentation and compliance)