Making Your Case: Using Data Systems to Capture Outcomes

2011 National Skilled Nursing Investment Forum

Panelists

- **Andrew Kramer, MD**, Chief Executive Officer, Nursing Home Quality LLC & Professor Emeritus of Medicine, University of Colorado at Denver
- **Lane Bowen**, EVP & President Nursing Center Division, Kindred Healthcare
- **Jeffery S. Lemon, FACHE**, Vice President, Post Acute Care Spectrum Health Hospital Group & President, Spectrum Health Continuing Care

Evolving Role of Quality Assessment and Outcome Assessment in Post-Acute Care

Andrew Kramer, MD
Chief Executive Officer, Nursing Home Quality, LLC
Professor Emeritus of Medicine,
University of Colorado at Denver

Trends in Post-Acute Care
and Quality Assessment

Trends in Nursing Home Case Mix

Nursing home case mix has intensified since Hospital PPS (1983) and the trend continues

	Pre-PPS(1982)	Post –PPS(1986)
New admissions (Medicare)		
Tube feeding	20.9%	28.6%
UTI	6.7	13.1
Oxygen	6.1	14.3
Long-stay		
Incontinence Urine	35.0	48.2
Incontinence Bowel	34.7	51.9
Confused/disoriented	33.0	39.2
Number of ADL dependencies (0-6)	3.2	4.2

Shaughnessy and Kramer, "The Increased Needs of Patients in Nursing Homes and Patients Receiving Home Health Care." NEJM 1990

Nursing Facility Rehabilitation

SNFs offer a cost-effective rehabilitation setting for the right patients and with proper attention to quality of rehabilitation care

- Equally effective and lower cost than acute rehabilitation for some conditions (e.g. major joint fracture and repair)
- More complex rehabilitation conditions (e.g. stroke) require more intensive rehabilitation
- 3 out of 4 patients admitted to SNF receive rehabilitation services
- Variability in quality of rehabilitation care and effectiveness across SNFs (e.g. based on rehabilitation care volume)

Kramer, et al, "Outcomes and Costs after Hip Fractures and Stroke: A Comparison of Rehabilitation Settings." JAMA, 1997

Kramer, et al, "A Study of Stroke Post-Acute Care and Outcomes: Final Report." Washington, DC 2006

Epstein A and Kramer A. "Levels of Rehabilitative Care and Patient Triage." Demos Medical Publishing. 2009

Resident – Centered Care

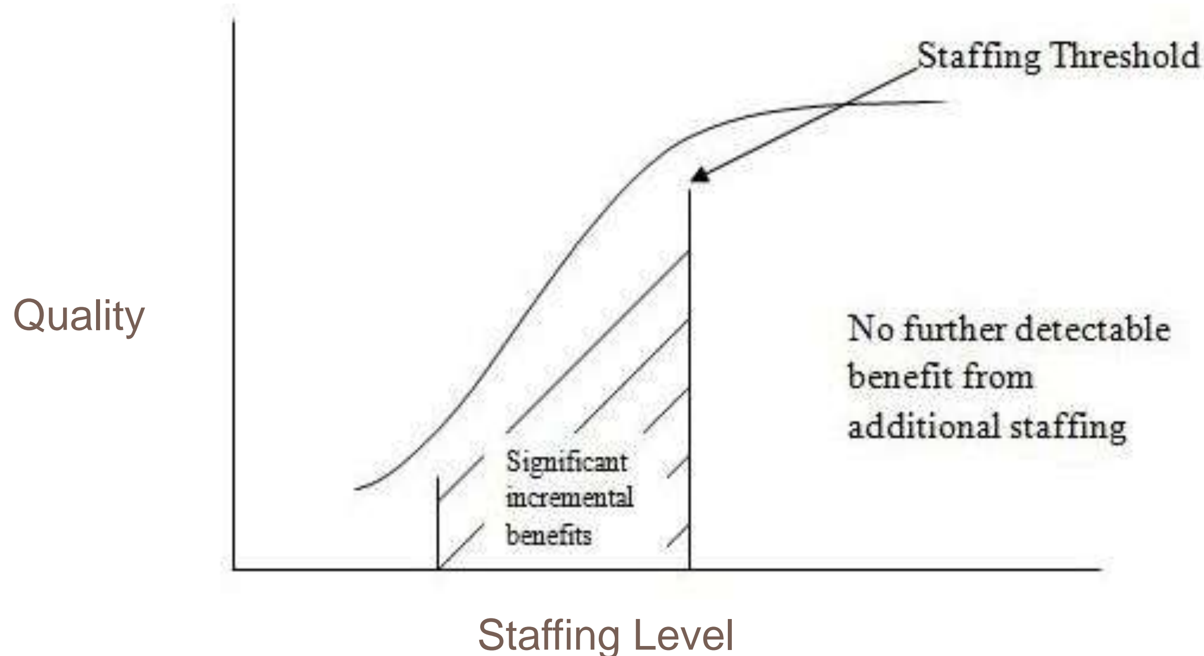
The resident's perspective is the most important perspective

- Residents can tell us a great deal about the quality of their care and life, if we listen and/or observe
- Their perceptions are the realities we must address, even in measuring and treating functional disability
- Satisfaction is not the same as quality of life
- The way you ask the question matters

Kramer AM. "Rehabilitation Care and Outcomes from the Patient's Perspective." Medical Care 1997

Staffing and its Relationship to Quality

Increased staffing, particularly RN and licensed staff, is associated with improved quality up to a threshold, and staff turnover is even more strongly associated



Kramer AM, Fish R. "The Relationship Between Nurse Staffing Levels and the Quality of Nursing Home Care." Cambridge, MA 2001

Kramer, et al, "Relationship Between Staffing Measures and Community Discharge, Rehospitalization, and Post-Acute Care Quality Measures for Short-Stay Residents." Denver, CO 2008

Kramer, et al, "Relationship Between Staffing Measures and Outcome Quality Measures for Long-Stay Residents." Denver, CO 2008

Enhancing Physician Care

Physician care can have a significant impact on quality of nursing home care

- Advanced Practice Nurses (e.g. GNPs) aiding physicians in nursing homes have repeatedly been shown to enhance overall quality of care
- Closed staffing models resulted in more on-site time, faster emergency response, and greater accountability
- Nursing home specialist MDs had enhanced clinical outcomes, reduced hospitalizations, and improved satisfaction
- Systems that increase efficiency of communication and information exchange enhance MD care

Levy CR, Kramer AM. "Physician Practice Patterns in Nursing Homes." The Long-Term Care Interface 2005

Levy C, Palat ST, Kramer, AM. "Physician Practice Patterns in Nursing Homes." Journal of the American Medical Directors Association 2007

Care Transitions

Quality of care often breaks down during transitions between settings

- 40% of Medicare hospital discharges had at least 1 additional transition within 30 days of hospital discharge
- Of those discharged to institutional rehab, 91% had 1 or more additional transfers and 16% had 4 or more
- Lack of essential information is a major cause of failed transitions
- Initiatives are underway to provide uniform information at discharge

Ma, et al, "Quantifying Post-Hospital Care Transitions in Older Patients." JAMDA 2004

Coleman, et al, "Posthospital Care Transitions: Patterns, Complications, and Risk Identification." Health Services Research 2004

Kramer, et al, "Uniform Patient Assessment for Post Acute Care: Final Report," Aurora, CO 2006

Palliative Care

Palliative care in Nursing Homes in need of improvement and quality interventions can improve outcomes

- 1 out of 3 Medicare admissions who died within 30 days of being discharged to a SNF, died in the hospital
- 1 out of 4 died within 24 hours of transfer
- Large variation in advanced planning, DNR, and DNH orders
- Making Advanced Planning a Priority (MAPP) intervention reduced hospitalization at end of life from 48% to 9% in one facility

Levy, et al, "Site of Death in the Hospital Versus Nursing Home of Medicare Skilled Nursing Facility Residents Admitted Under Medicare's Part A Benefit." JAGS 2004

Levy, et al, "Do-Not-Resuscitate and Do-Not-Hospitalize Directives of Persons Admitted to Skilled Nursing Facilities Under the Medicare Benefit." JAGS 2005

Levy, et al, "Improving End-of-Life Outcomes in Nursing Homes by Targeting Residents at High-Risk Mortality for Palliative Care: Program Description and Evaluation." J Palliative Med. 2008

Health Information Technology

Health IT is underutilized in nursing homes, particularly in the areas of quality assessment and monitoring

- While Health IT holds promise, it is not a panacea for post-acute and long-term care
- Development of quality assurance/performance improvement functionality lags behind
- Existing quality systems are often underutilized

Kramer, et al, Case Studies of of Electronic Health Records in Post-Acute and Long-Term Care. Denver, CO 2004

Kramer, et al, Understanding the Costs and Benefits of Health Information Technology in Nursing Homes and Home Health Agencies. Aurora, CO 2009

Nursing Home Survey and Enforcement

<u>Transformation of the traditional nursing home survey process is necessary to advance quality of care</u>

- The Quality Indicator Survey (QIS) is currently being implemented by CMS (22 states as of this month)
- QIS provides consistency through a more scientifically based and explicit review process
- Greater reliance is placed on information from residents and family regarding both quality of life and quality of care
- Includes an Admission Sample with quality indicators for post-acute patients

Kramer, et al, <u>Pilot Test of a Staged Quality of Care Survey Using Quality Indicator Profiles</u>, Denver, CO 1995

Kramer, et al, "Analysis of the Validity of Quality of Care Determinations." Bethesda, MD 1996

Kramer, et al, "Evaluating the Use of Quality Indicators in the Long-Term Care Process: Final Report" Raleigh, NC 2005

Greater Emphasis on Quality Assurance/Performance Improvement

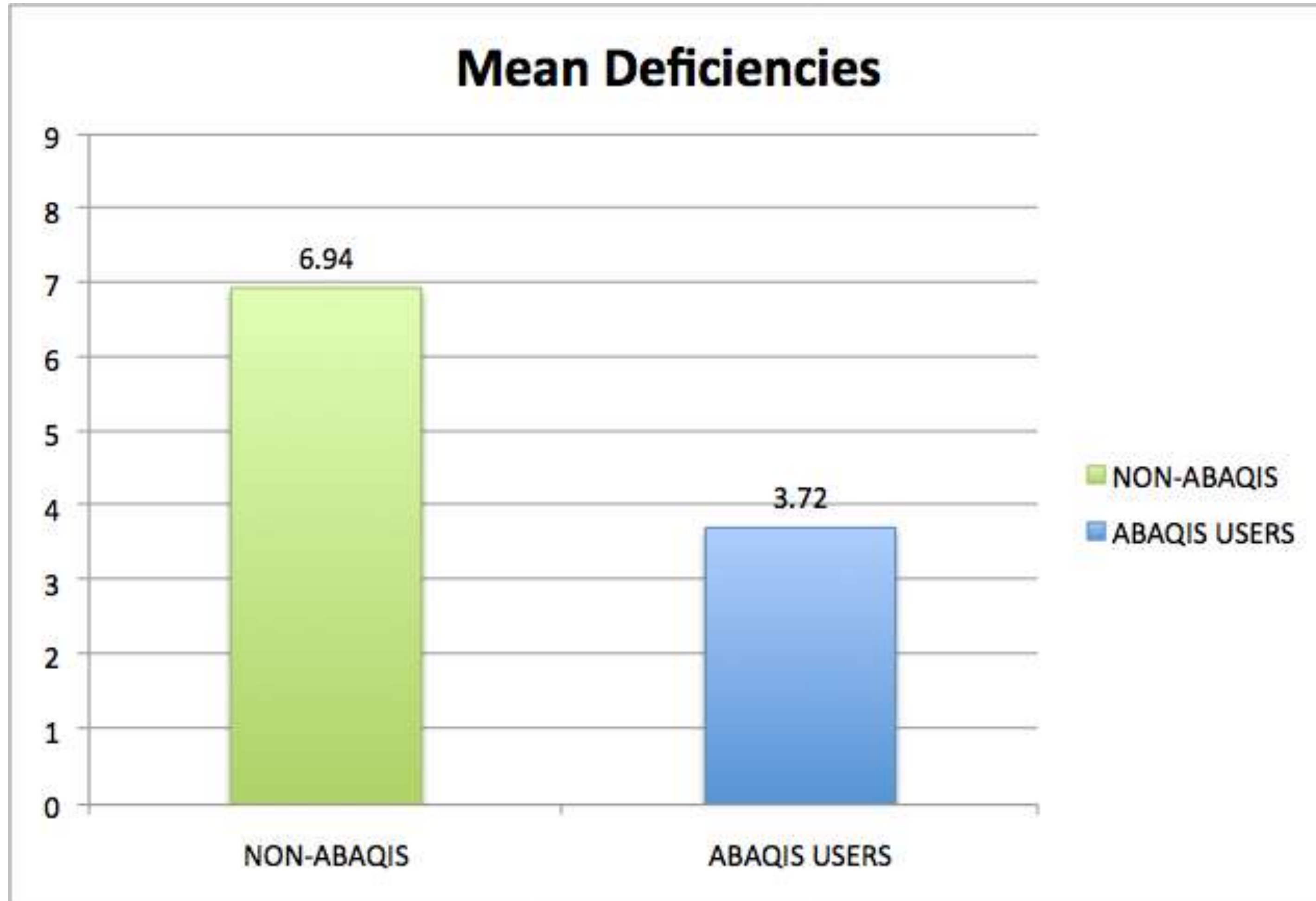
Assuring and/or improving quality requires valid metrics, good data, and a proactive systematic approach

- New QAPI regulations emphasized by CMS in all care sectors
- In home health care, CQI resulted in reduced hospitalizations and improved functional/health outcomes across 73 agencies and over 250,000 patients
- In nursing homes, continuous quality improvement using abaqis system associated with improved survey result

Berwick, Godrey, Roessner, Curing Health Care, New Strategies for Quality Improvement, 1990

Shaughnessy, et al, "Improving Patient Outcomes of Home Health Care: Findings from Two Demonstration Trials of Outcome-Based Quality Improvement." JAGS 2002

Using abaqis QA System Leads to Improved Survey Results



Rehospitalization

Rehospitalization

Potentially avoidable hospitalizations of both short-term and long-term nursing home residents is a critical outcome indicator

- Must be properly risk adjusted
- Regulatory Pressure on Hospitals due to PPACA
- Central to Value-Based Purchasing because of obvious cost implications
- Current QA data and tools lacking

Kramer, et al, "Understanding Temporal Changes in and Factors Associated with SNF Rates of Community Discharge and Rehospitalization." Washington DC, 2007

Which Hospitalizations?

- All Hospital Admissions from Nursing Homes
- Potentially Avoidable Hospital Admissions from Nursing Homes
- Preventable Hospital Admissions from Nursing Homes

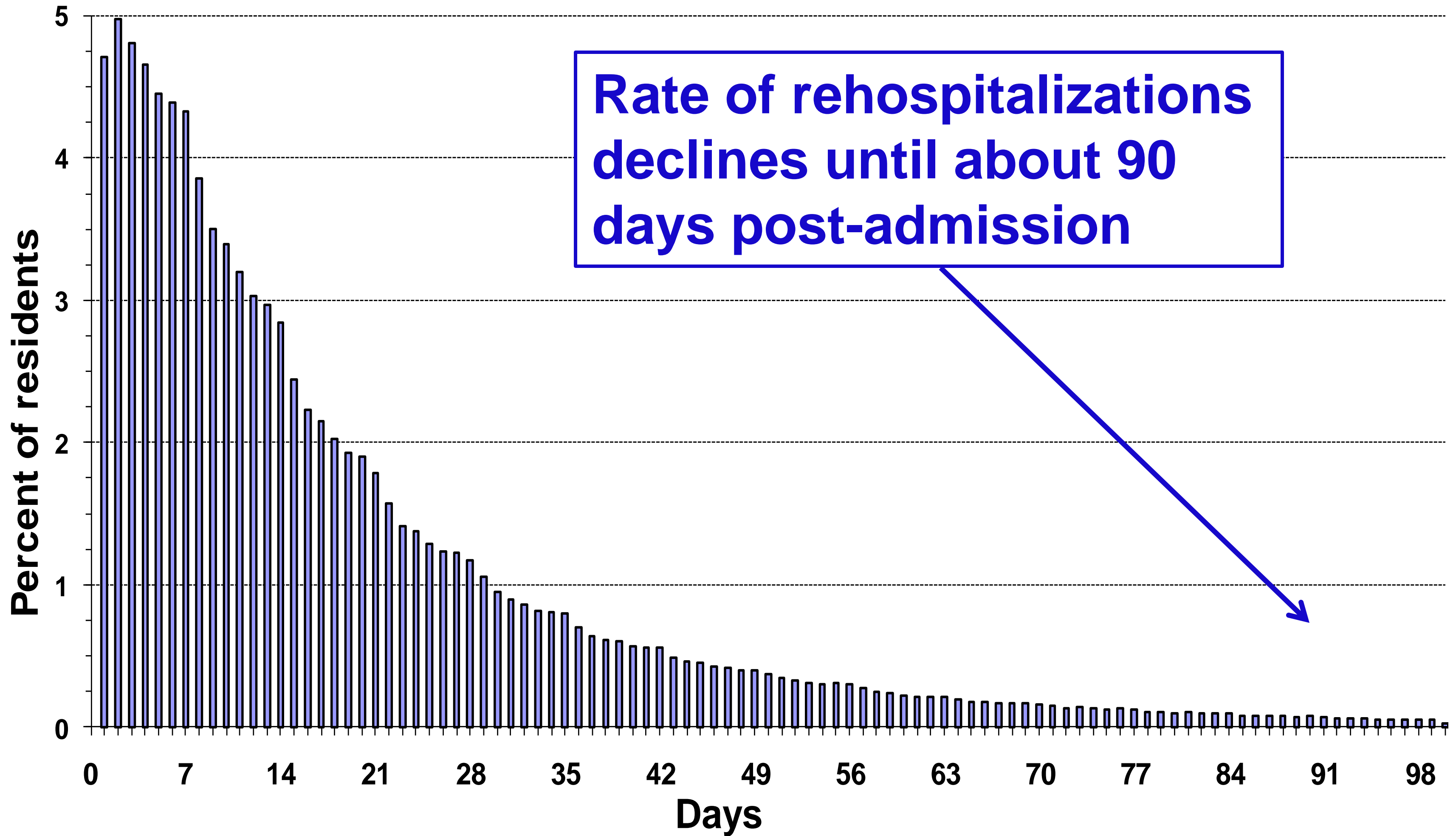
Defining Potentially Avoidable Hospitalizations

- Diagnoses where there is a larger portion of preventable hospitalizations than there is across all diagnoses
- Diagnoses where there is some type of care that a nursing home can provide that will reduce the number of hospitalizations

Which Diagnoses?

- Percent of SNF Admissions Hospitalized in 30 days for any reason: 17.7
- Percent of SNF Admissions Hospitalized for any of five conditions below: 13.9
    1. CHF 7.9
    2. Electrolyte imbalance 6.8
    3. Respiratory infection 4.6
    4. Sepsis 2.4
    5. UTI 4.7

SNF Days until Rehospitalization



Short-Stay Hospitalization Definition

Numerator: Number of short stays ending in a hospitalization for a potentially avoidable cause.

Denominator: Total number of short nursing home stays, defined as a 90-day stay ending in hospitalization or discharge to another setting.

Long-Stay Hospitalization Definition

Numerator: Number of hospitalizations for a potentially avoidable cause (including anemia) occurring while resident is a long-stay resident of the nursing home.

Denominator: Total number of resident days (in hundreds) summed across all long-stay episodes (>90 days) during the reporting period.

Risk Adjustment

- Not all residents have the same risk for a potentially avoidable hospitalization
- To compare rates across nursing homes risk adjustment is essential
- To track or monitor trends over time in a nursing home risk adjustment is essential
- Risk adjustment models can identify residents at highest risk for potentially avoidable hospitalizations

Important Risk Adjusters

- Comorbidity Index (e.g. Derived from Claims)
- Function (e.g. Barthel Index)
- Pressure Ulcers
- Tube Feeding
- Admission conditions (e.g. CHF, UTI)
- Geography- (e.g. Dartmouth Atlas market area rates)

Factors Associated with Hospitalization

- Nurse Staffing: Levels, turnover, tenure–RN in particular
- MD and GNP care
- Hospital-Based vs Freestanding organization
- Temporal Trends
- Geography
- Advanced Care Planning and Palliative Care

A New Era of Quality Assurance
in Post-Acute and Long-Term
Care: The Opportunity

Three Principles

- Alignment of a new definition for quality
- Rigorous development of quality measures
- Advanced data collection and analysis technology

Alignment of the Definition of Quality

- Aligned among regulators, consumers, and providers
- All-encompassing definition of quality
- Resident-centered
- Absolute versus relative quality

Rigorous Development of Measures

- Based in clinical science
- With improved psychometric properties
- Valid - measure what they are meant to measure
- Adequately risk adjusted

- HIT offers new possibilities
- Real time data
- Interoperability

"Opportunity is missed by most people because it is dressed in overalls and looks like work"

- Thomas Edison

Kindred Healthcare

Objectives

- Appreciate dynamics of patient flow between health care sites of service
- Specifically understand the impact of these trends upon SNFs and the significant variation in patient population among SNFs
- Discuss what has been done by industry leaders to date and why certain metrics need to be measured in the future
- Appreciate why certain outcome metrics are important to conduct business successfully in the future, both internally and externally

Kindred - Largest Diversified Post-Acute Provider In The United States[1]

$4.3 billion[2]
consolidated revenues

621[3]
sites of service, **305** facilities in **41** states

32,000[3]
patients and residents per day

54,100[3]
dedicated employees, making Kindred a top-200 private employer in the U.S.[4]

(1) Ranking based on revenues.
(2) Revenues for the fiscal year ended December 31, 2009.
(3) As of December 31, 2009.
(4) Ranking provided by TMP, Inc.

Three Main Business Lines

HOSPITAL
Long-term Acute Care Hospitals

$1.9 billion revenues[(1)]

- Largest operator in U.S. [(2)]
- 83 hospitals with 6,580 licensed beds

SKILLED NURSING
Nursing and Rehabilitation Centers

$2.2 billion revenues[(1)]

- Second largest nursing center operator in U.S. [(2)]
- 222 nursing centers with 27,196 licensed beds
- 6 assisted living residences with 327 licensed beds

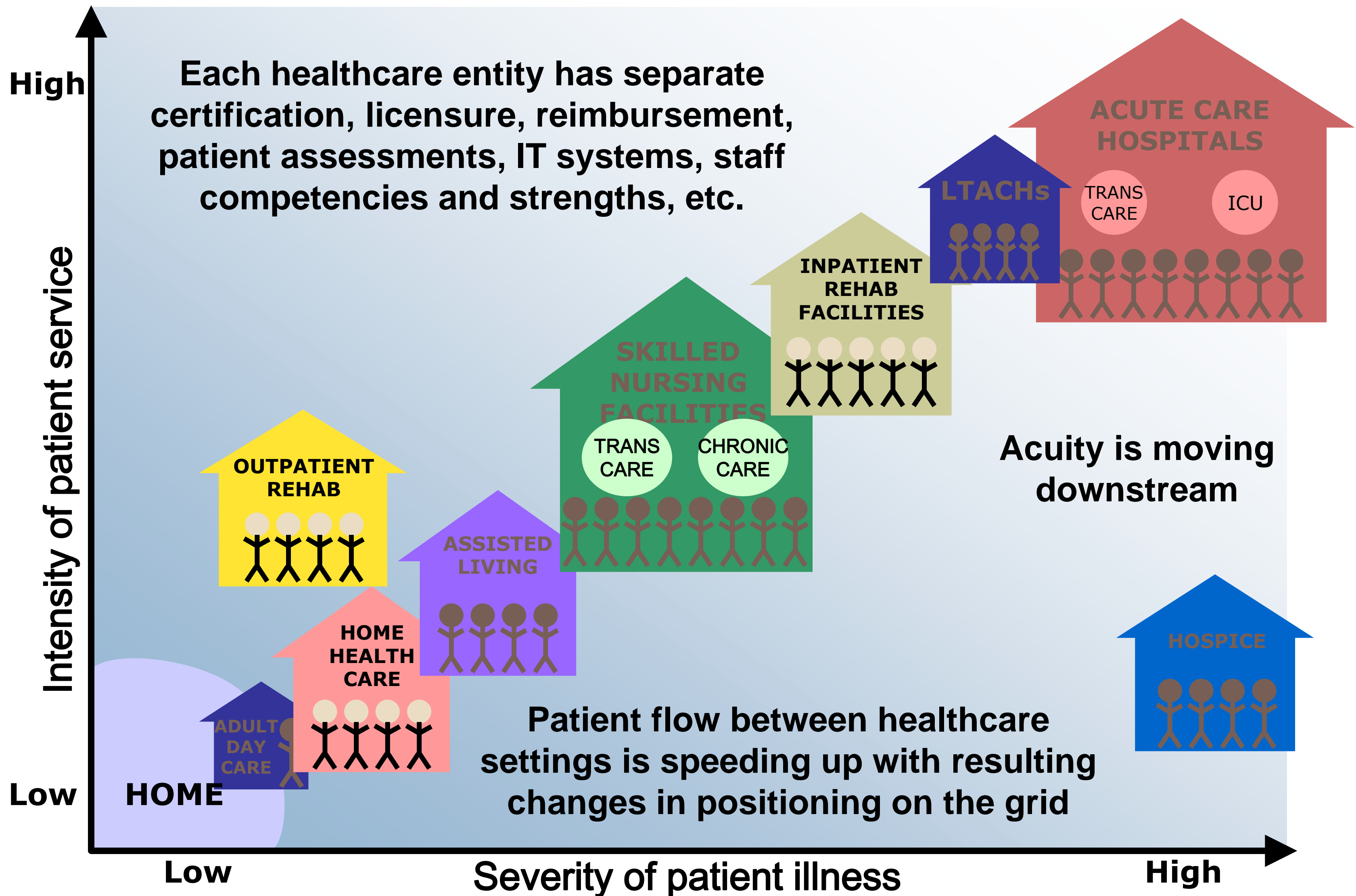
REHABILITATION
People*first* Rehabilitation Services

$475 million revenues[(1)]

- Second largest contract therapy company in U.S.[(2)]
- 316 external locations served through 5,000 therapists and 8,400 total employees

(1) Revenues for the fiscal year ended December 31, 2009 (divisional revenues before intercompany eliminations).
(2) Ranking based on revenues.

The Continuum of Healthcare Sites of Service



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Where are STACH Patients Going?
And Why, When and How Many are coming back??

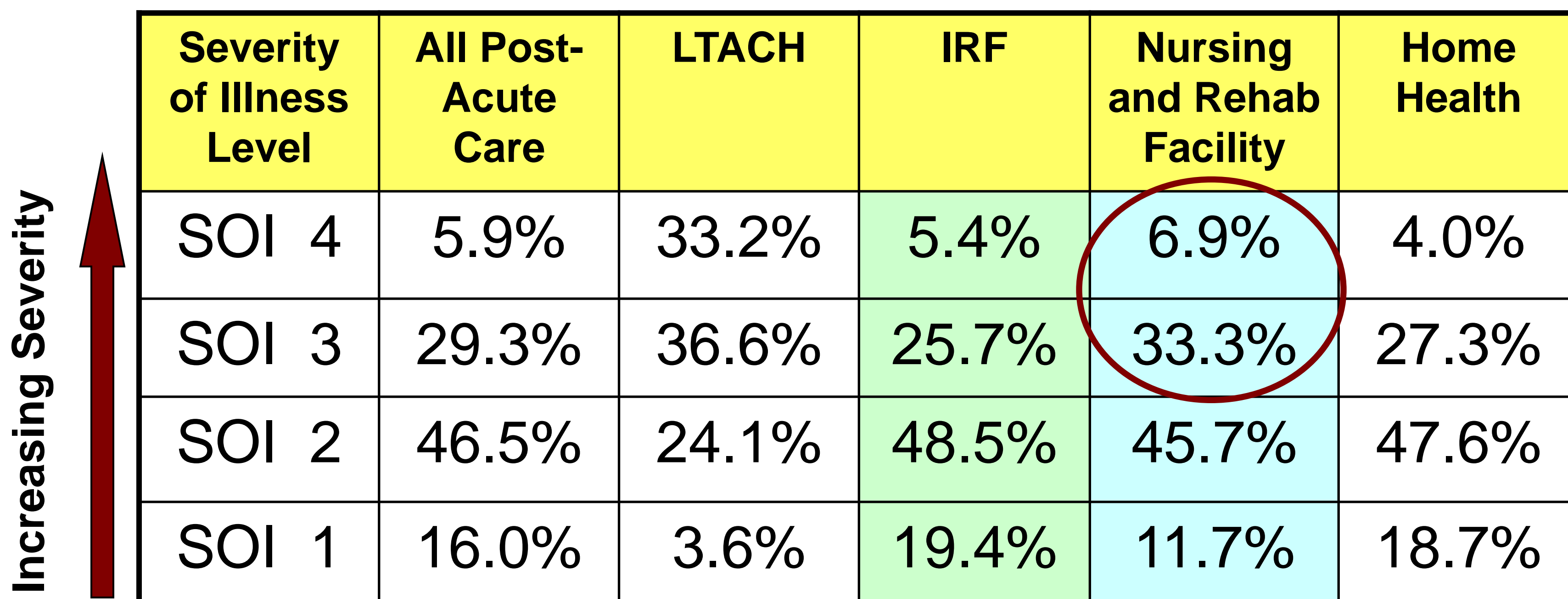
DRG Reimbursement and Managed Care Payors driving shorter STACH LOS

(resulting in "Quicker, Sicker Discharges")

- **Long Term Acute Care Hospitals (LTACH)**
  - Moratorium on growth & need for ADM criteria
- **Inpatient Rehab Facilities (IRF)**
  - 75% rule (frozen at 60%) moving patients away from IRF
- **Skilled Nursing Facilities (SNF)**
  - New RUG IV reimbursement allows for continued advancement in caring for more medically complex and short stay rehabilitation patients
- **Assisted Living Facilities (ALF)**
  - Focused primarily on a social model with amenities, more personal living space
- **Home and Community Based Services (HCBS)**
  - State Medicaid waivers will drive lower acuity to ALF and HCBS
- **Home**
  - People desire to age in place in the least restrictive environment, if possible

Severity of Illness Scores by PAC Setting

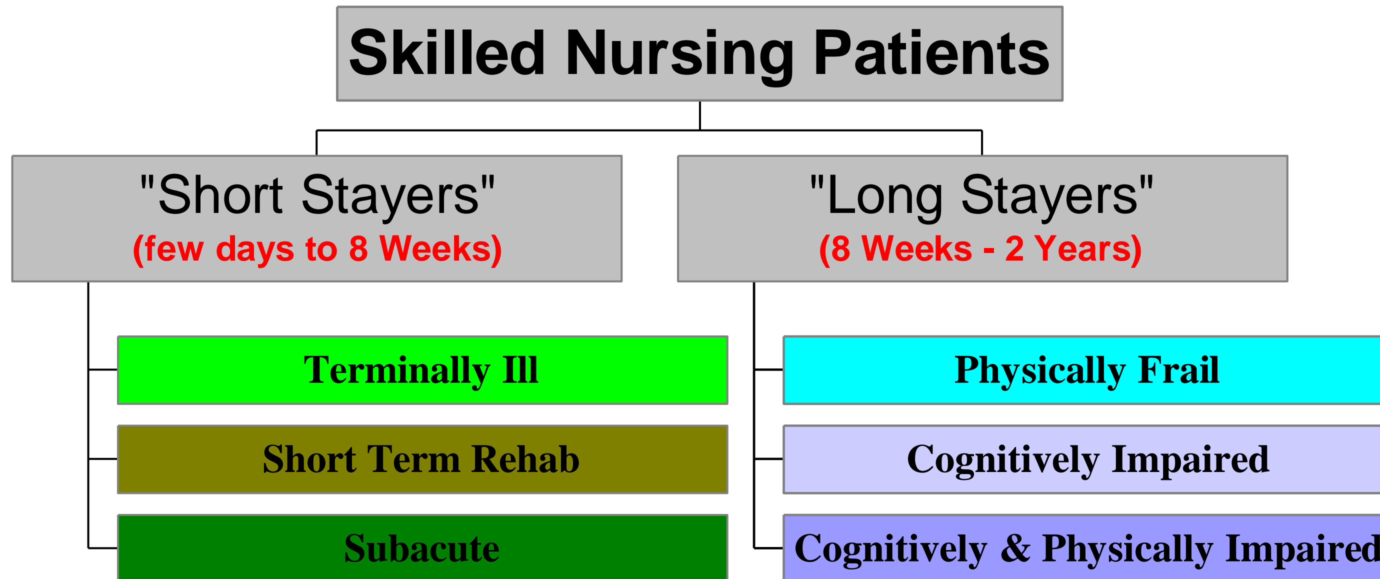
Nursing and Rehabilitation Facilities Treat a Large Share of High-severity Patients



Severity of Illness Level	All Post-Acute Care	LTACH	IRF	Nursing and Rehab Facility	Home Health
SOI 4	5.9%	33.2%	5.4%	6.9%	4.0%
SOI 3	29.3%	36.6%	25.7%	33.3%	27.3%
SOI 2	46.5%	24.1%	48.5%	45.7%	47.6%
SOI 1	16.0%	3.6%	19.4%	11.7%	18.7%

Severity of illness (SOI) was measured during the hospital stay, before the patient was discharged to the post-acute setting. The all patient refined diagnosis-related group (APR-DRG) classification system was used to first classify patients into a disease category; within that category, the APR-DRG system classifies patients by severity of illness, which refers to the extent of physiologic decompensation or organ system loss of function The four severity of illness subclasses are numbered sequentially from 1 to 4 indicating respectively, minor, moderate, major, or extreme severity of illness. Source: RTI International, March 2008

Basic Profile of Skilled Nursing & Rehabilitation Center Patients / Residents



Different subgroups have differing priorities, needs and discharge potential. Anticipate growth in the Short Stay or Transitional Care population and shrinkage in Long Stay or Chronic Care Resident population. However, **this trend is not occurring at the same rate across geographic regions nor among facilities in the same markets.**

Tale of Two Nursing Centers

Nursing Center	# of Beds	DC Expire	DC Hospital	DC Home	Total Nursing & Therapy PPD	Last three Annual Surveys
A	**126**	**64%**	**8%**	**13%**	**3.72**	**Def FREE**
B	**120**	**9%**	**20%**	**67%**	**4.97**	↑ **State Avg**

Two Skilled Nursing Centers of similar size, but with very different metrics… Why?

A Tale of Two Nursing Centers

The Rest of the Story

Center Name	DC Home	DC Hospital	DC Other	DC Nur Cen	DC Expire	DC Total	Nrsg & Ther PPD
A	16 13%	10 8%	18	1	80 64%	126	3.72

Center A – Boston suburb:

- Alzheimer's Care Center caring exclusively for Long Stay Residents
- Consumer Reports Recommend List
- Last three annual surveys were Deficiency Free (10 of last 12 Deficiency Free)
- AHCA Bronze and Silver Quality Award recipient
- Robust restorative nursing program
- Very Strong Social Services and nutrition services
- Moderate size therapy staff, no Respiratory Therapy
- This is where you want to be for long stay Alzheimer's Care

A Tale of Two Nursing Centers

The Rest of the Story

Center Name	DC Home	DC Hospital	DC Other	DC Nur Cen	DC Expire	DC Total	Nrsg & Ther PPD
B	1222 67%	363 20%	32	43	159 9%	1819	4.97

Center B – Greater Los Angeles area:

- Located on hospital campus
- Heavy Managed Care volume of higher acuity short stay patients
- Doctors & NPs round in Center daily
- Robust therapy services including Respiratory therapy
- Center discharges about 100 patients to HOME per month
- Good care, but average survey compliance, likely due to patient volume and clinical complexity issues
- This is where you want to be for short stay, medical recovery and rehabilitation

Rehospitalizations

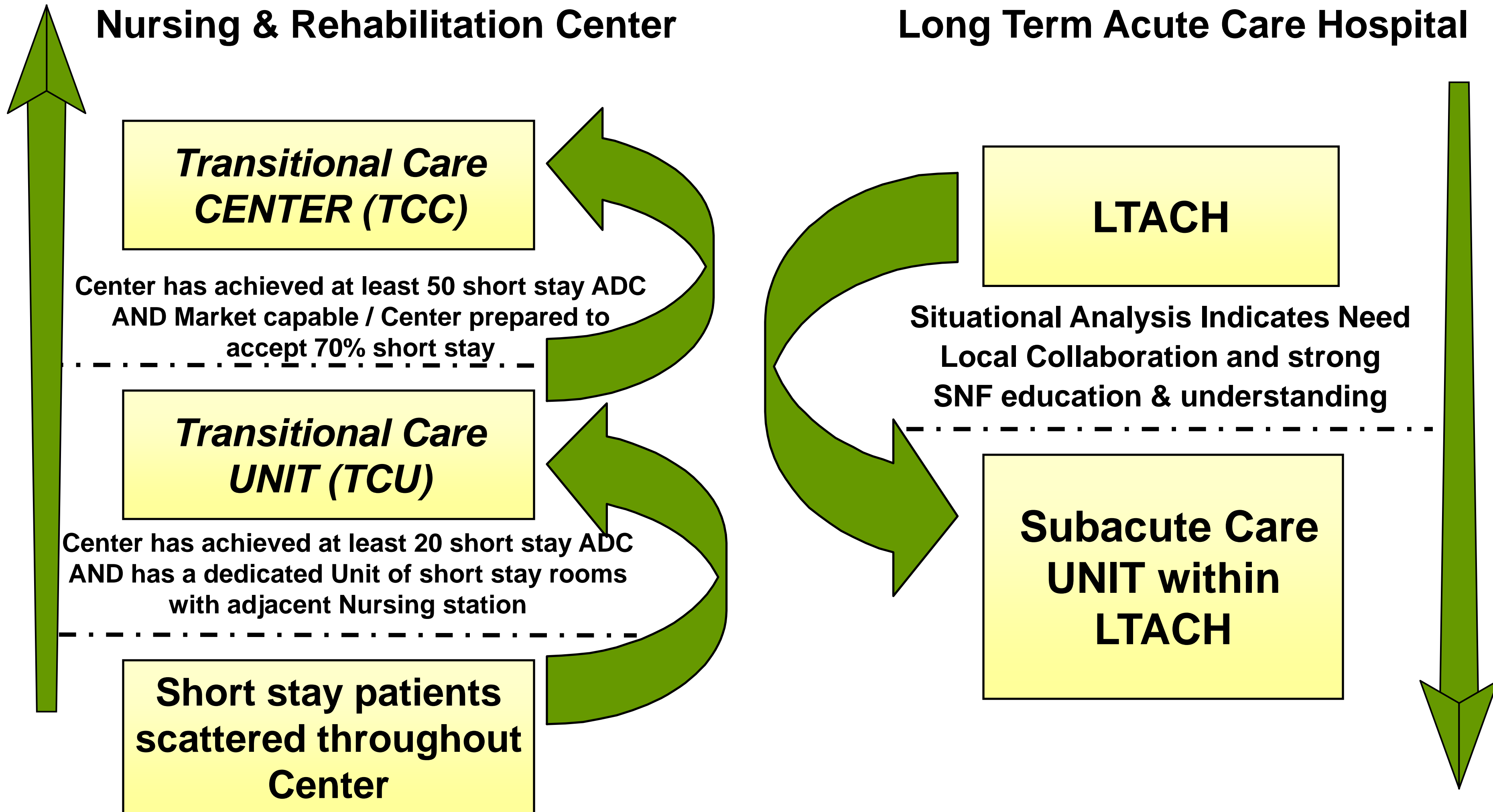
- **CMS developing a Rehospitalization Quality Indicator for SNFs - "Potentially avoidable"**
- **Complex discussion in the SNF setting**
  - Physician involvement and availability
  - Diagnostic testing availability (lab, x-ray, etc)
  - Pharmacy availability & medication management (meds, IVs)
  - Nursing assessment skills
  - Clinical competencies of SNF
  - Nurse / physician communication and understanding
  - Advance Directives, Surrogate Decision making, End-of-Life planning
  - Family expectations
  - Transition issues – accurate transfer data and medical info, continuity of care

Rehospitalization Efforts at Kindred

- We are tracking hospitalization rates in short stay and long stay population
  - Within 30 days of admission and total
  - Weekday vs. weekend
  - Relationship to case mix index and Nurse staffing
- We are using INTERACT
  - **Inte**rventions to **R**educe **A**cute **C**are **T**ransfers
    - Communication tools (e.g. SBAR)
      - Nurse / Nurse; Nurse / Doctor; SNF capabilities; Transfer protocols
    - Symptom assessment and Care Path
      - CHF, UTI, Dehydration, Respiratory illness, Mental status change, Fever
    - Advance Care Planning Tools
      - Palliative care, Hospice, Family Education, Comfort and Quality

Transitional / Subacute Care

An organized and systematic approach



Short Stay = Medicare and Managed Care admissions. All Kindred Centers utilize our standardized Clinical P & Ps

Transitional / Subacute Care Strategies

- Clinical Program Development that meets a growing need for patients discharged from Hospitals, but requiring continued medical management and/or rehabilitation for a short time (weeks) before returning to the community
  - Cardiac
  - Respiratory
  - Ortho Rehab
  - Stroke Rehab
  - Wound Care
- Focus on
  - Enhanced staffing (e.g. weekend RN supervisors, PM shift, etc.)
  - Nursing competencies
  - Rehab outcomes
  - Upgraded or additional Equipment
  - Physician involvement and Medical Advisory Boards
  - Joint Operating Committees with MCOs and Hospitals
    - Review clinical and operational outcome metrics

Important Outcome
Metrics to Manage an
Evolving SNF Business

Transparency in Outcome Metrics at Kindred

Four Consecutive Years of Publicly Reported Outcomes

BALANCED SCORECARD

Kindred Nursing Center Division – DRAFT 2011

EBITDARM

30%

People	Quality & Service	Growth	Efficiency	Capital	Organizational Excellence
10%	15%	15%	10%	10%	10%
Employee Turnover %	Average Deficiency Index	Revenue PPD	Nursing Hours PPD	A/R Days	ADR Acceptance %
24/7 RN Coverage	Clearing Tags on First Follow-up	Total Patient Revenue	Total Ancillary Expense PPD		Consistent Assignment (Staffing)
	Customer Service Satisfaction %		Total Controllable Expense PPD		

People	Quality & Service	Growth	Efficiency	Capital	Organizational Excellence
ED Turnover %	Discharge to Hospital %	Average Daily Census	Total Labor Hours PPD	Bad Debt (% of Rev)	Angel Care Program (% Told)
DNS Turnover %	Discharge to Hospital < 30 days	Medicare ADC	Average Wage Rates		
Nursing Turnover %	Discharge to Home %	Managed Care ADC	Overtime & Contract Labor (% of Total)		
Employee Retention	Implementation of Abaqis	M^2 Admissions	Workers Comp. Claims Frequency		
Employee Satisfaction	CMS 5 - Star Rating - Overall Score	Rehab RUGS Distribution %			
		Managed Care & Medicare Mix %			
		Quality Mix %			

Legend

New Scorecard Measure

New STIC Measure

BALANCED SCORECARD

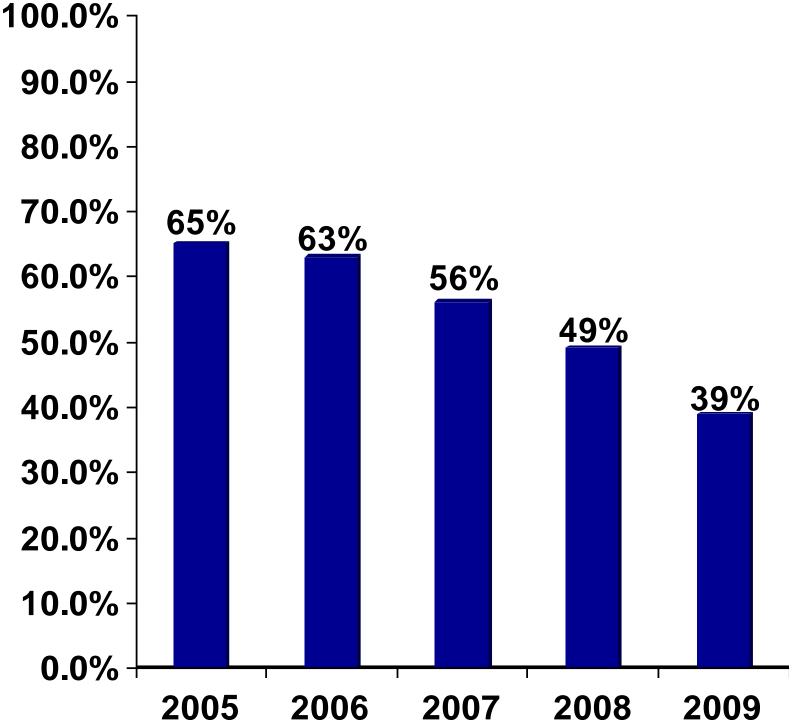
Kindred Nursing Center Division – 2009 YTD RESULTS

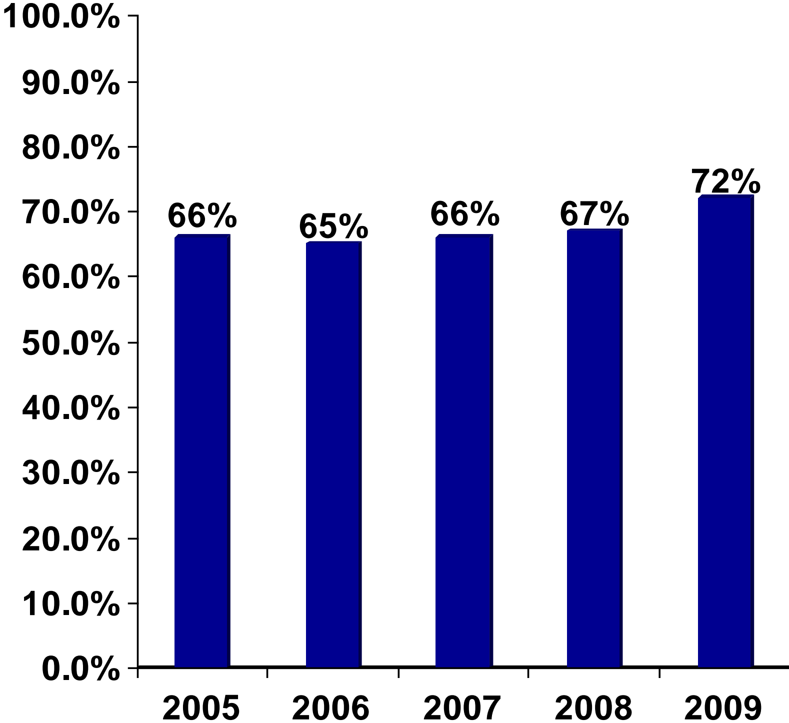
Operating Income

People	Quality & Service	Growth	Efficiency	Capital	Organizational Excellence
Employee Turnover	Average Deficiency Index	Average Daily Census	Nursing Hours PPD	A/R Days	ADR Acceptance
24/7 RN Coverage	Clearing Tags on First Follow-up	Quality Mix			Consistent Staffing Assignments
	Customer Service Satisfaction				
ED Turnover	Discharge to Hospital	M^2 Admissions	Total Labor Hours PPD	Bad Debt	Angel Care
DNS Turnover	Discharge to Home	Revenue PPD	Total Ancillary Expense PPD		Falling Stars
Nursing Turnover	Clinical Indicators	Rehab RUG Distribution	Total Controllable Expense PPD		
Employee Retention	Clinical Quality Review Score		Average Wage Rate		
Employee Satisfaction			Overtime & Contract Labor		

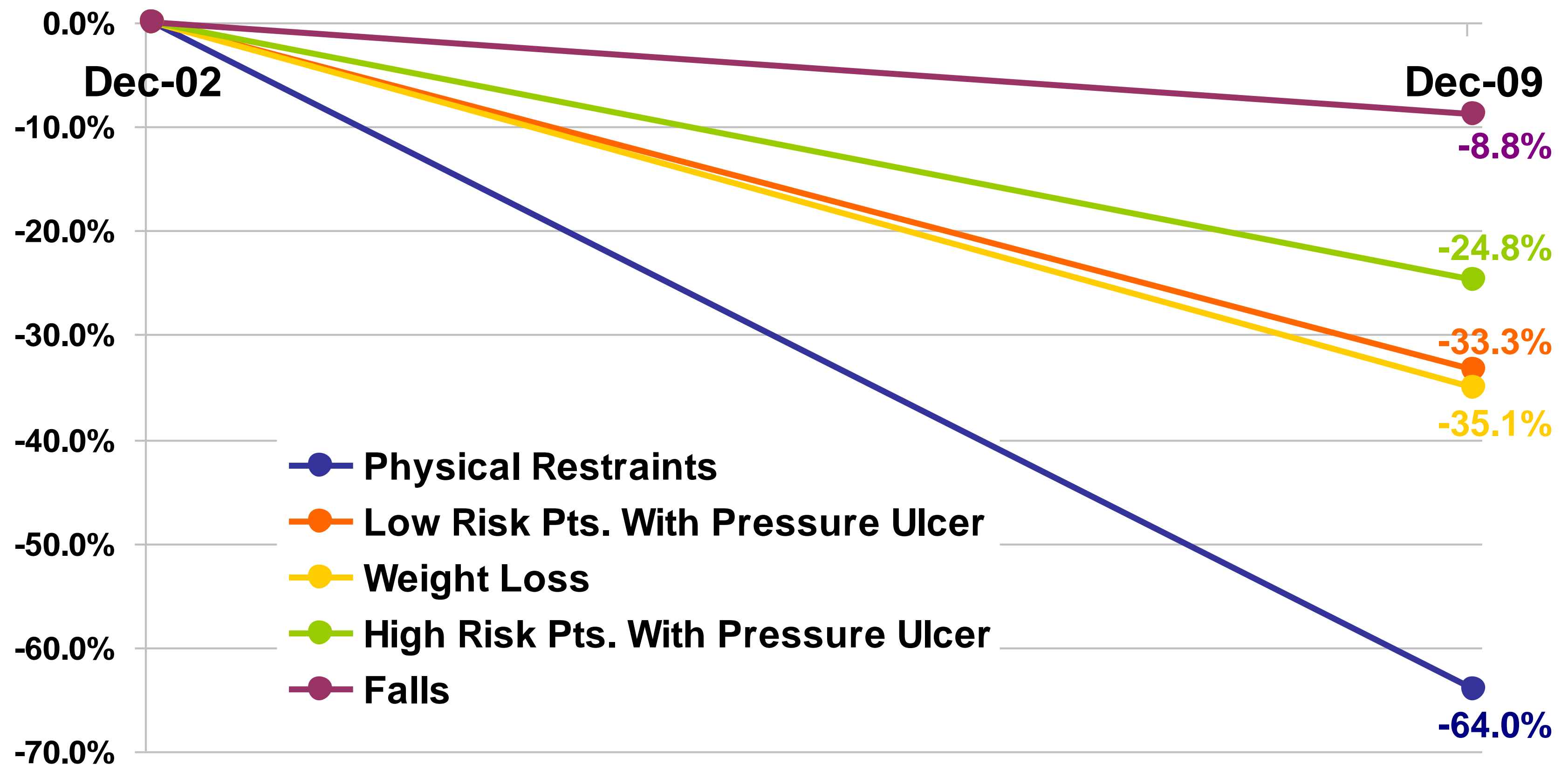
Legend: Maximum Achieved; Between Maximum & Target; Between Target & Minimum; Below Minimum

Staff Turnover and Retention





Improved Quality Indicators

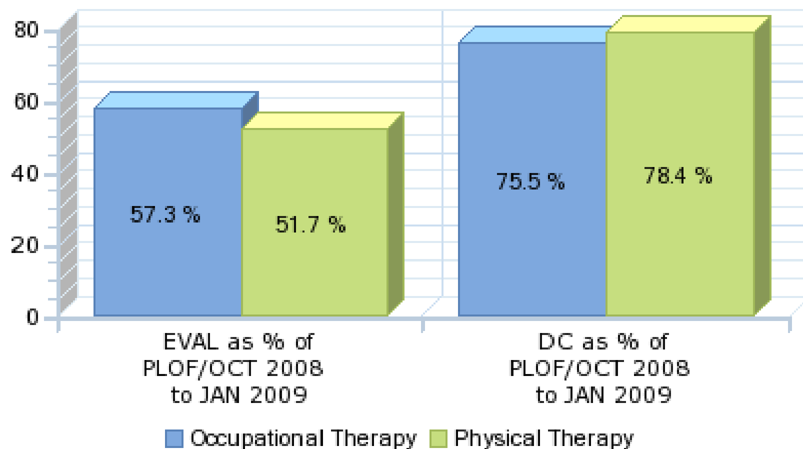


Rehabilitation Therapy

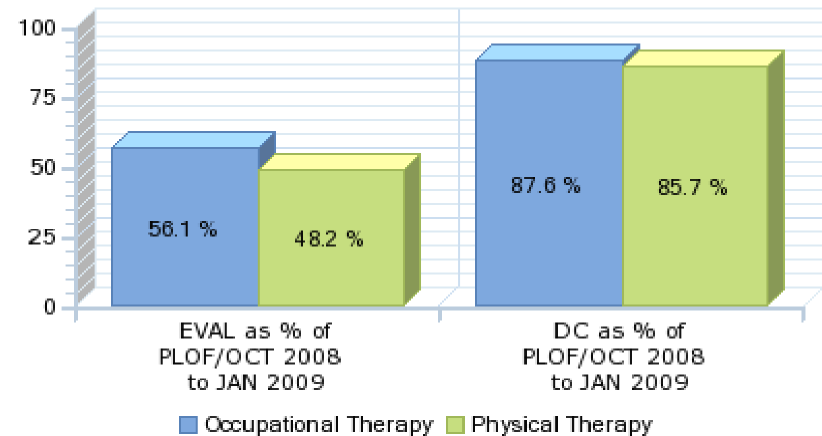
Outcome Metrics

Functional Outcome Measures (FOM)

All PeopleFirst Rehab Contracts

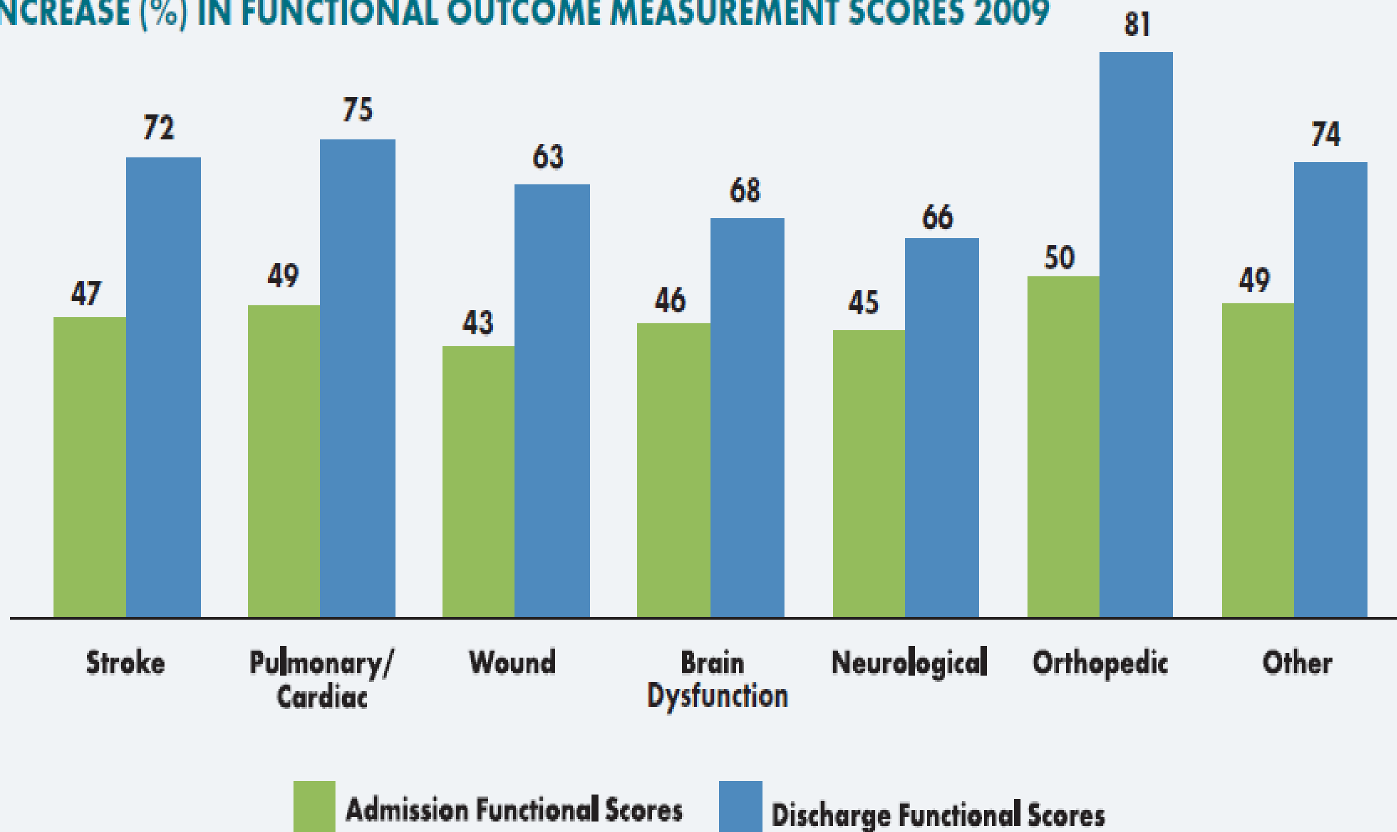


Harrison Healthcare Center

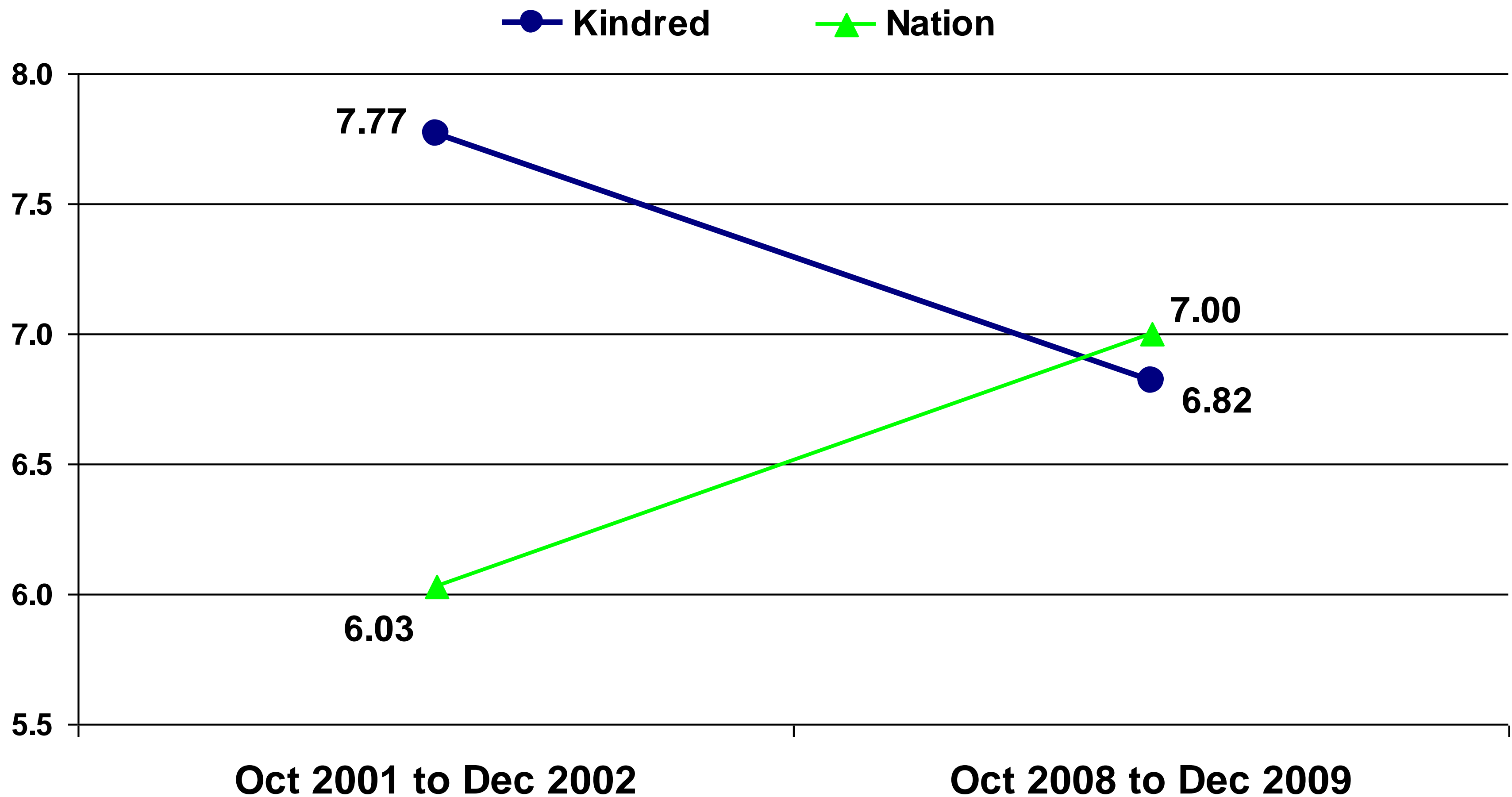


Admission (Prior Level of Function) FOM VS Discharge FOM scores for Physical and Occupational Therapy

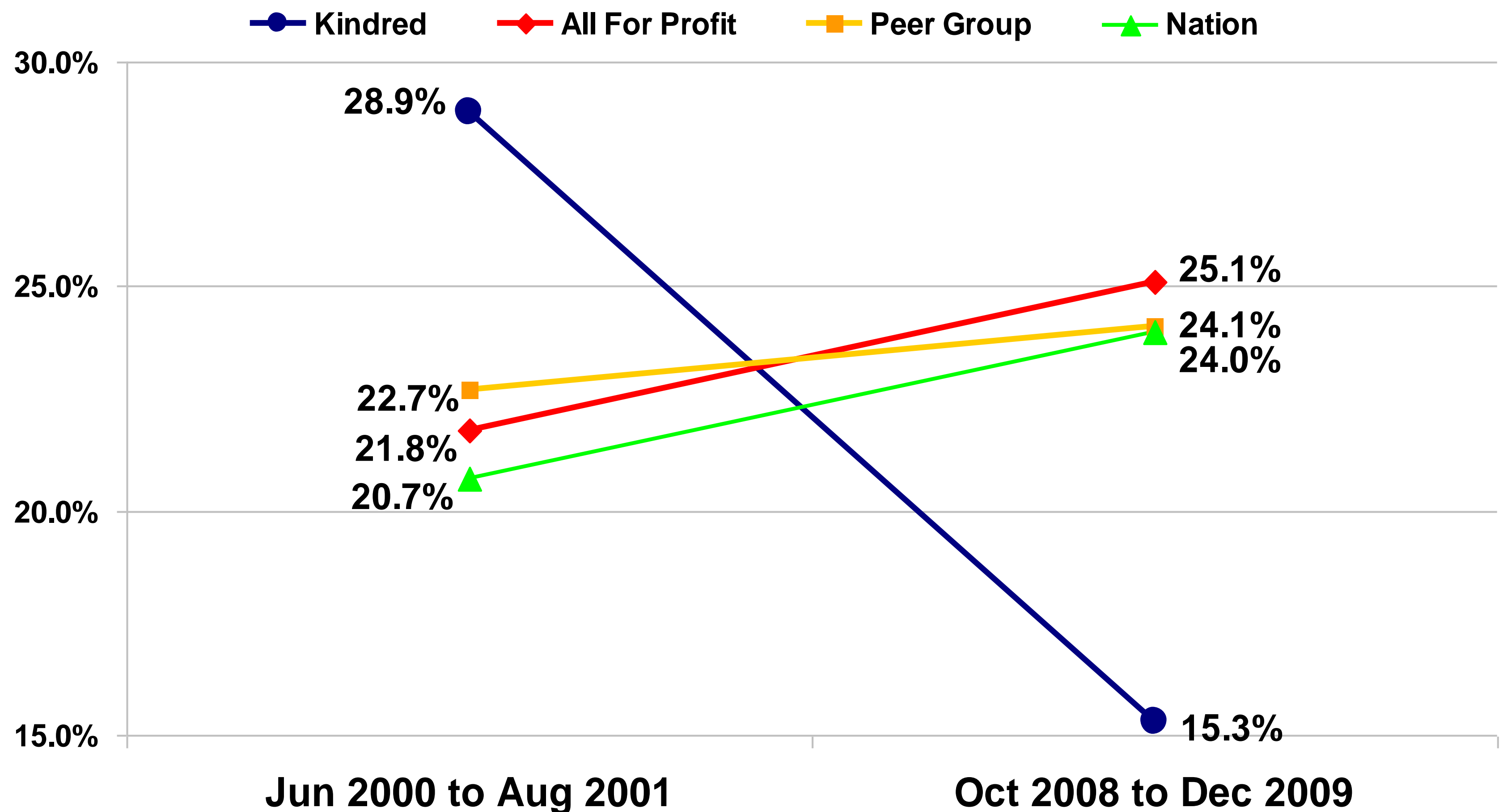
Rehabilitation Therapy
Outcome Metrics by Diagnosis



Average Number of Deficiencies per Annual Survey



Improvement in % of Annual Surveys with Higher Scope and Severity Tags (F H I J K L)

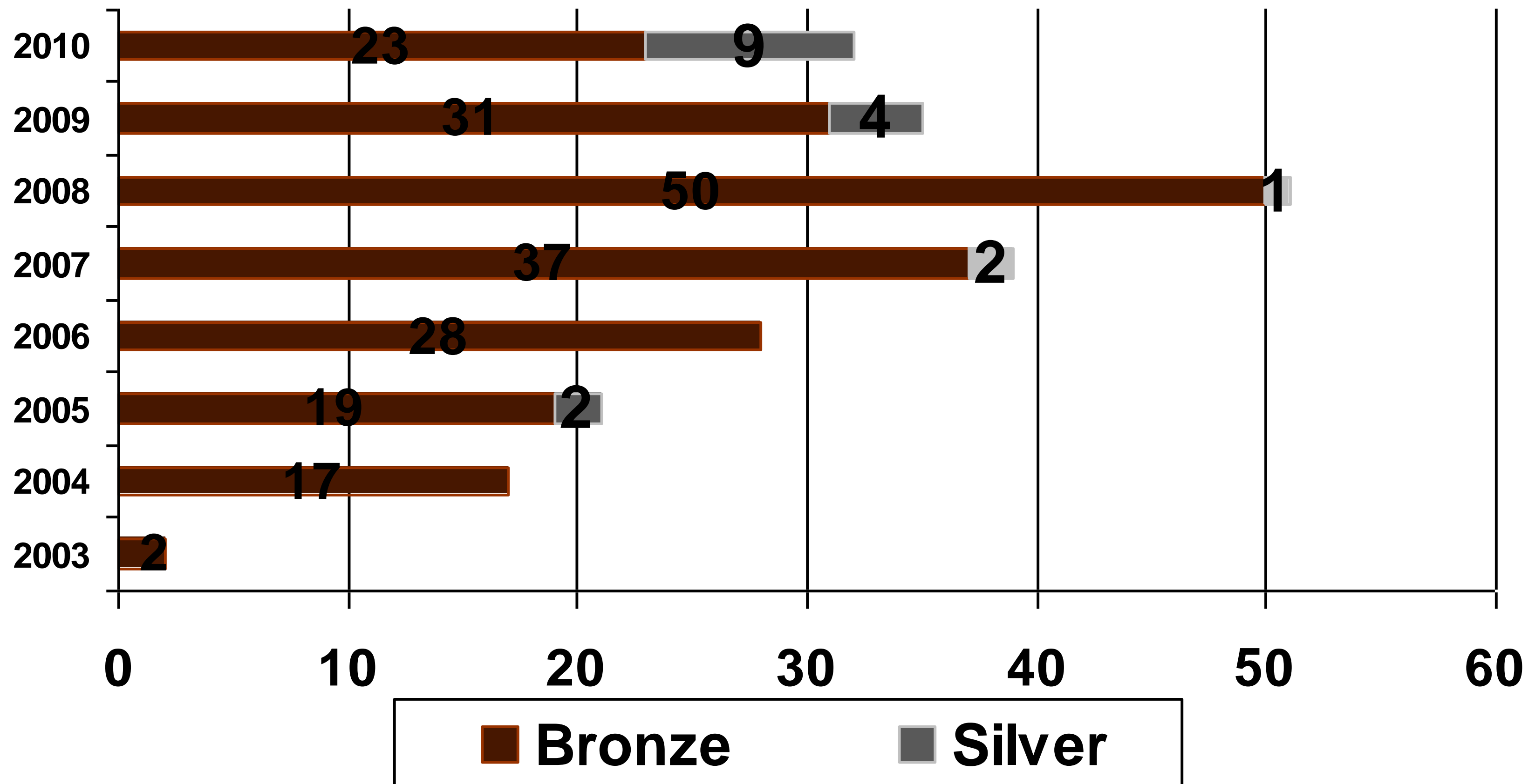


Each data point represents the most recent Standard Survey for all Centers in Kindred (n = 222), Peer Group (n = 2073) For Profit (n = 10,648), Nation (n = 15,719) as of December 31, 2009; Not same store comparisons (Kindred Continuing OPS for most recent data); Higher Scope and Severity = Tag Level F, H, I, J, K, L

AHCA Quality Awards

(American Health Care Association)

88.4% of Nursing Center Division Facilities have achieved Bronze Awards since 2003

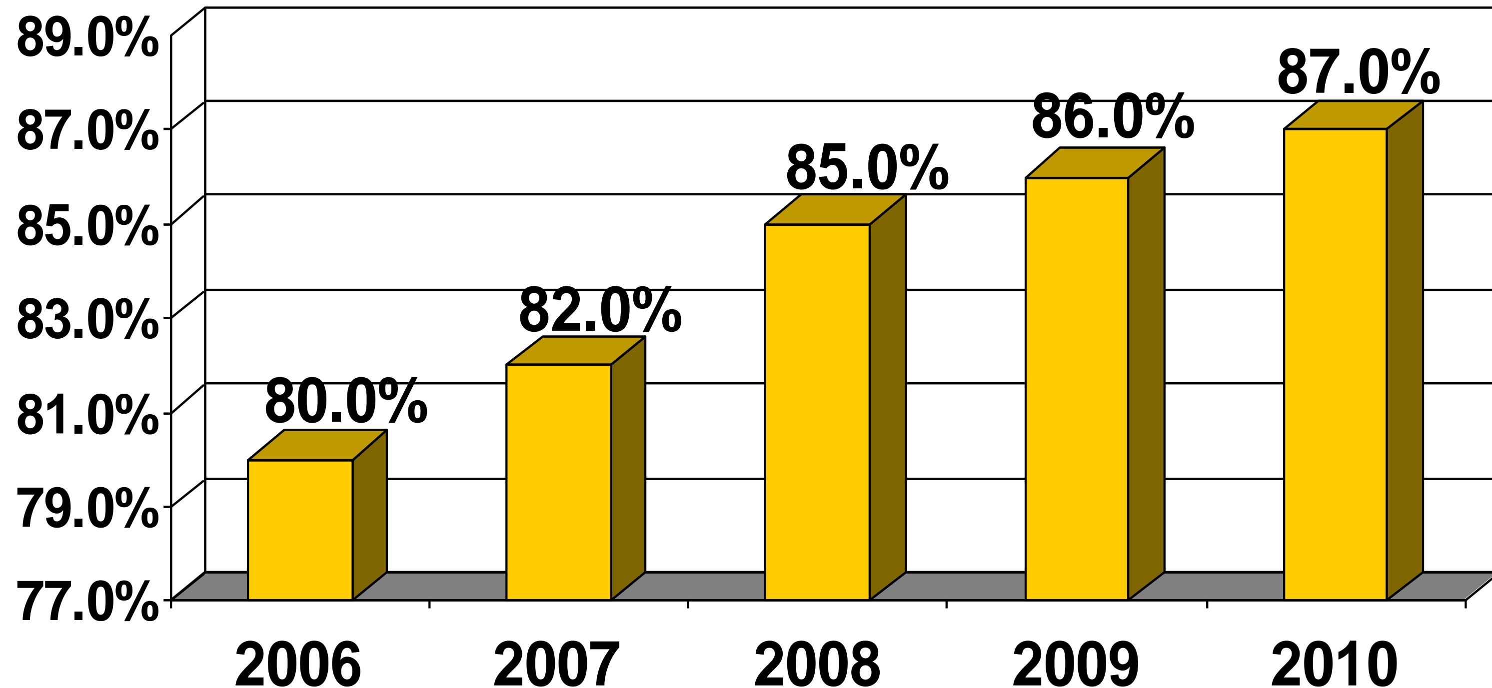


Represents awards earned during each calendar year and does not account for divestitures

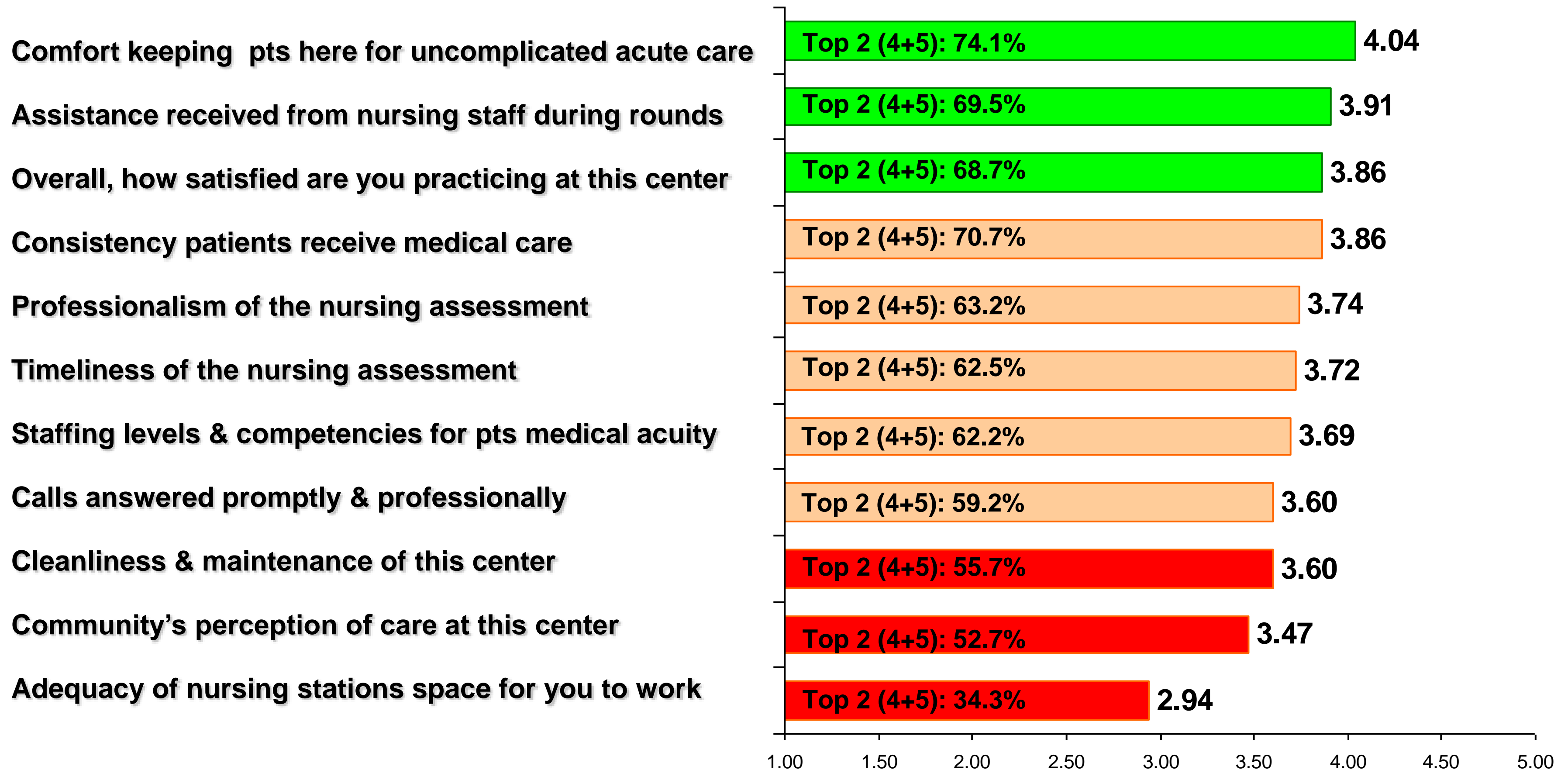
Service Excellence

Resident and Family Satisfaction Survey

Would you recommend this Facility?



Service Excellence
Physician Satisfaction Survey 2010

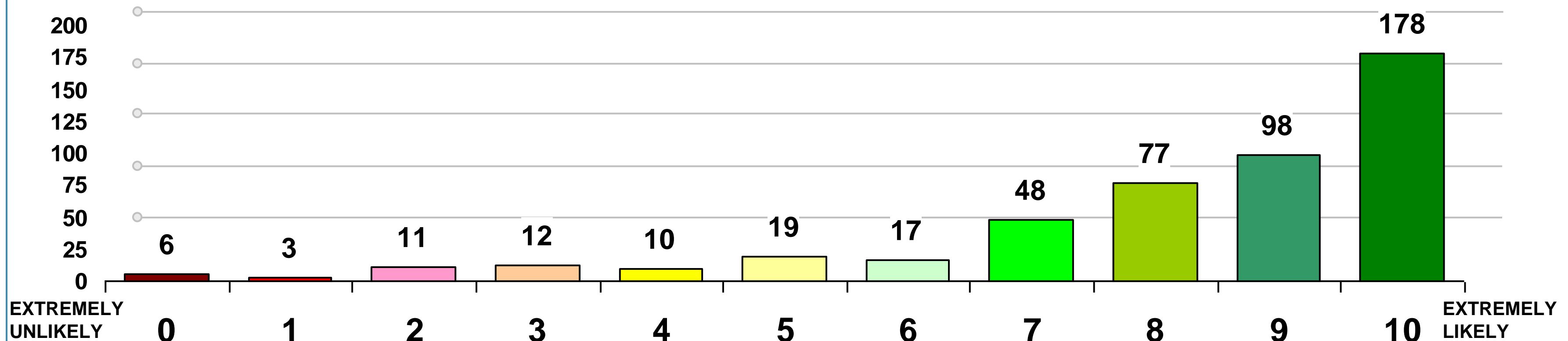


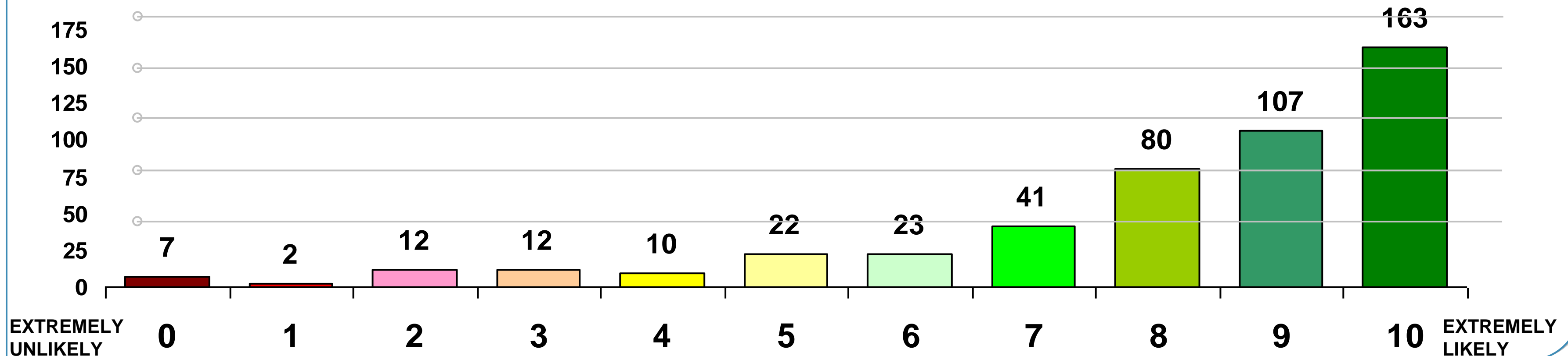
- **The overall evaluation of practicing at Kindred Nursing Centers is 3.86 with 68.7% favorable; among the higher rated items.**

Service Excellence

Physician Satisfaction Survey 2010

On a scale of 0 to 10, where 0 is "extremely unlikely" and 10 is "extremely likely"…





Summary

- Preparing for an evolving PAC world requires a systematic approach focused on enhancing clinical capabilities, physician engagement and developing Managed Care and Hospital relationships based on establishing AND articulating the "Value Proposition".

- The "Value Proposition" must be based on transparent Outcome Metrics that can be shared with patients and families, physicians, hospitals, MCOs, our own SNFs and the community at large. Clinical outcome metrics are imperative and best shared in a structured setting such as a Joint Operating Committee (hospitals / MCOs) or Medical Advisory Board (medical community).

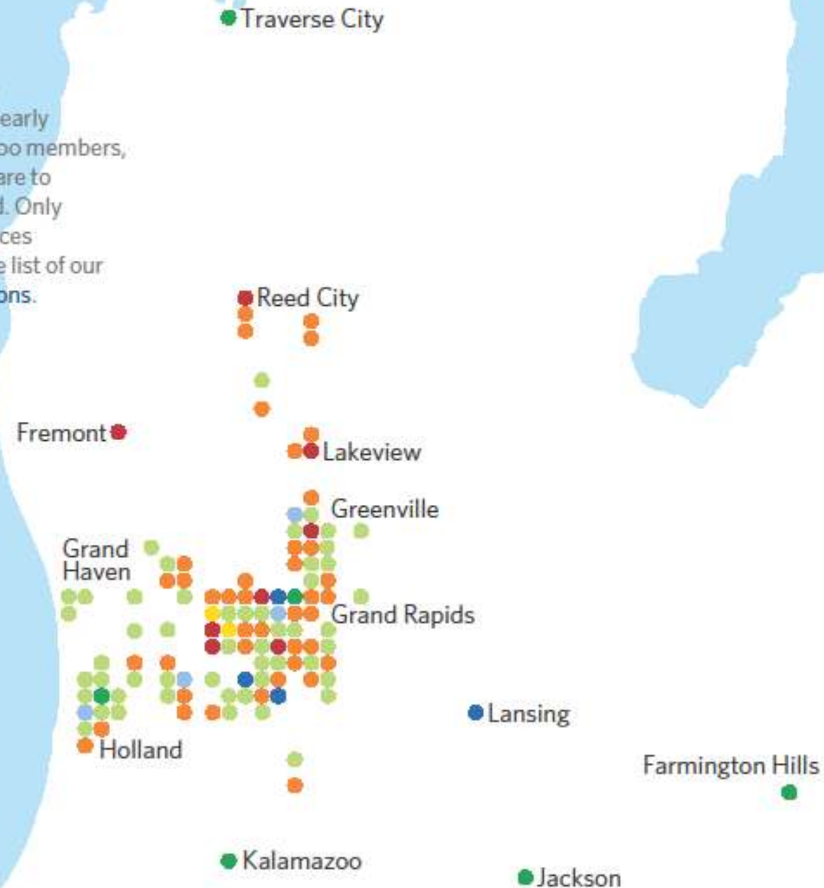
Spectrum Health

Jeffery S. Lemon, FACHE

Vice president, Post Acute Care Spectrum Health Hospital Group

President, Spectrum Health Continuing Care

Spectrum Health



Spectrum Health - Highlights

- 2,000 acute care beds
- 65,000 discharges annually
- Quaternary Medical Center
- Level One Trauma Center
- Heart Transplantation Center
- Cardiology, Cancer, Orthopaedics Centers of Excellence
- Top Ten Integrated Delivery System-2010
- Hospice and Palliative Care
- Special Care Hospital (LTACH)
- Visiting Nurse Association
- Infusion Pharmacy Services
- Rehab and Nursing Centers
- Neuro-Rehabilitation Services
- Home Medical Equipment
- Inpatient Rehabilitation Unit (July 2011)

First, the good news.

Hospitals have (re)discovered post acute care.

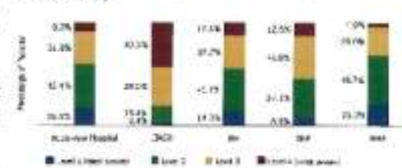
Awareness and Recognition

"Policymakers and health care providers increasingly recognize that coordination between acute care hospitals and post-acute providers is essential to improving the overall quality of care and reducing health spending."

Rich Umbdenstock, President and CEO
American Hospital Association

Maximizing the Value of Post-acute Care

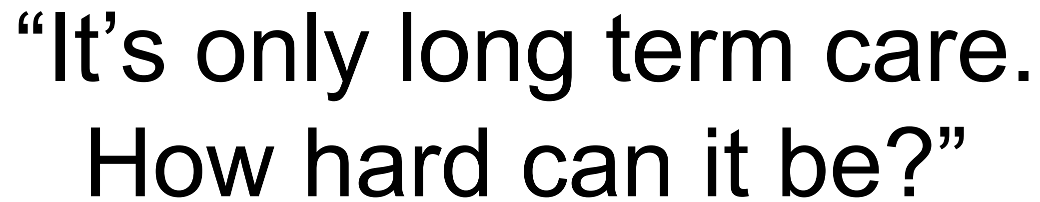
Patient severity of illness varies by PAC setting.



The number of facilities and patient volume differ by PAC setting.

Now, the bad news.

Hospitals have (re)discovered post acute care.



Anonymous Hospital CFO

Reading Tea Leaves: Hospitals

- Moving from venue-based discharge to care management via an integrated continuum (time, space, and profession)

- Enhanced clinical integration in support of emerging models of care delivery will require significant investments in time, energy, talent, and money

Reading Tea Leaves: Hospitals

- Avoidable rehospitalizations along with migration from fee-for-service to bundled payment will require risk-based arrangements and new partnerships
- “Post Acute Medicine” emerging as a distinct medical specialty with physician authorship of clinical pathways required
- Medicare as a profit-center

What Hospitals Want - For Now

- Quality Dashboards
  - ER visits and rehospitalizations
  - Planned
  - Unplanned
    - Avoidable
    - Unavoidable
      - By Diagnosis with Reason Code
      - Trended over time
- M&M review on every event deemed “avoidable”

What Hospitals Want - For Now

- Criteria to assess post acute providers and future partners
  - Clinical Outcomes
  - Geographic Coverage
  - Clinical Depth
  - Financial Strength
  - Intellectual Capital
  - Continuum Capable

- All parties must acquire the organizational aptitude needed to partner around a diverse portfolio of “non-traditional” businesses

"Everybody has a plan until they get punched in the mouth."

Mike Tyson

Q&A