Understanding the Dynamics of a Preferred Network Development

HDG National Summit

Brent T. Feorene, Vice President, Integrative Delivery Models

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Lynn C. Jones, President, Christiana Care Visiting Nurse Association

Drew Sheinen, Vice President, Network Strategy and Development, Kindred Healthcare
The Case for Building a SNF Network

Affordable Care Act creating a shifting landscape toward value-based care and mandates managing patient populations across entire care continuum, prompting hospitals to work more closely with post-acute providers; hospitals face Medicare penalties for high readmission rates.

Establishing narrow networks of post-acute partners can encourage providers to improve quality of care.

Tactics for improving care between acute and post-acute partners include “warm handoffs” that involve actual conversations, not just the exchange of paperwork, between clinicians on both sites.

New staffing models, including the use of SNFists and nurse care navigators, are gaining ground.
Acute/Post-acute Interface Is Rapidly Evolving

43%
- 43% of Medicare patients discharged to some form of post-acute care (PAC) (MedPAC testimony, 2013)
- Bulk of these directed to skilled nursing facilities (SNFs) or home health agencies (HHAs)

73%
- At 73%, post-acute represents greatest area of variability in health spending (Institute of Medicine study, October 2013)

SNFs
- SNFs are essential component of PAC continuum—managing patients for short- and long-term time frames
Post-acute Cost and Quality Control Attributed to ACO Savings

• **Banner Health Network** (BHN), a Pioneer ACO, accounted for $29 million in savings; **Montefiore** ACO saved $18 million

• Officials at both organizations said performance was boosted by attention to PAC costs and quality

• BHN’s ACO developed preferred network of SNFs and recommends those facilities to patients, vetting local SNFs with questions on quality and culture

• PAC improvement was significant contributor to the ACO’s results, according to Shaun Anand, BHN chief medical officer

• Montefiore ACO worked with SNFs to avoid hospitalization, where possible, by finding alternatives for services that could be delivered elsewhere, such as blood transfusions
Value-Based Movement: Redefining the Value Statement

Offering an Integrated Solution to Population Health Management

- Medical care delivery in patient’s residence
- Providing skilled care in patient’s residence
- Alternative for follow-up visit to busy PCP office with access and scope limitations
- Offering ED physicians clinically appropriate options to inpatient admission
- Integrated, collaborative care in a SNF using physicians and advanced practice providers
- Offering a high-quality, lower-cost alternative to SNF

Acute Care

- Medical House Calls
- ED Diversion
- Home Care
- Care Transitions
- SNF
- ALF
- Complex Care Clinic
- Psycho-social Support

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Costs Vary by Initial Post-acute Setting

Average Medicare Episode Payment for MS-DRG 291 (CHF) by First-PAC-Setting for 30-day Fixed-length Episodes (2007–2009)

<table>
<thead>
<tr>
<th>Setting</th>
<th>Average Medicare Episode Payment</th>
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</thead>
<tbody>
<tr>
<td>HHA</td>
<td>$13,470</td>
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<tr>
<td>SNF</td>
<td>$20,318</td>
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<tr>
<td>IRF</td>
<td>$33,295</td>
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<tr>
<td>LTCH</td>
<td>$45,293</td>
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<tr>
<td>STACH</td>
<td>$23,679</td>
</tr>
<tr>
<td>Community</td>
<td>$12,388</td>
</tr>
</tbody>
</table>

Overall Average = $14,928

Notes: Dobson | DaVanzo analysis of research-identifiable 5% SAF for all sites of service, 2007–2009, wage index adjusted by setting and geographic region, and standardized to 2009 dollars

Value- and Outcome-Based Payment Growth

Health & Human Services set goals for Medicare fee-for-service (FFS) payments linked to quality and alternative payment models in 2016 and 2018 targets

Health Care Transformation Task Force

Several of nation’s largest health care systems and payers, joined by purchasers and patient stakeholders, have committed 75% of their business into value-based arrangements by 2020

Source: http://www.hcttf.org, accessed 2/10/16

Source:
Shifting Sands of Hospital Value-Based Purchasing

Difference Between 2015 and 2016 Weights
Moving from Process to Outcomes

- **Efficiency Measures**
  - 2016: 25%
  - 2015: 20%

- **Clinical Process of Care Measures**
  - 2016: 10%
  - 2015: 20%

- **Patient Experience of Care Measures (HCAHPS)**
  - 2016: 25%
  - 2015: 30%

- **Outcomes Measures**
  - 2016: 40%
  - 2015: 30%
Medicare Spending per Beneficiary (MSPB)

• Medicare’s measure of hospital financial efficiency

• Average Medicare episode spend (Part A & Part B) for a hospital patient compared to a risk-adjusted national average

• Medicare spending episode includes:
  – 3 days prior to hospital admission
  – Acute care stay
  – 30 days post acute stay

• MSPB requires hospital systems to understand PAC providers’ costs and outcomes:
  – Readmission rates
  – Cost of care
  – Length of stay
  – Medical necessity of placement
Post-acute Care Plays a Key Role in MSPB

- Skilled Nursing: 41%
- Home Health: 37%
- Acute Rehab: 10%
- Outpatient: 9%
- LTACH: 2%

With the bulk of post-hospital patients, SNF & HHA represent key settings for controlling total costs and managing outcomes.

Health systems often have limited control of costs and outcomes sent to non-affiliated post-acute settings.

Source: MedPAC Testimony, 2013
2022 Goal: Minimum 50% of Total Medicare PAC Provider Payments Bundled

Reduce Spend by -2.85%

- 2013: BPCI Voluntary Pilot Began
- 2015: Second Round of BPCI
- 2016: Mandatory Geographic Ortho Bundling
- 2018: All Post-acute Care Providers

Source: Budget of the United States Government, FY 2016; http://www.whitehouse.gov/omb/budget

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Medicare Bundled Payments for Care Improvement (BPCI) Demonstration

<table>
<thead>
<tr>
<th>Types of Services Included in Bundle</th>
<th>Model 1 Acute Hospital Stay Only</th>
<th>Model 2 Acute Hospital + Post-Acute</th>
<th>Model 3 Post-Acute Care Only</th>
<th>Model 4 Acute Hospital Stay + Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital and physician services</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
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<tr>
<td>Related post-acute care services</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
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<tr>
<td>Related readmissions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Other services defined in the bundle (Medicare Parts A &amp; B)</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Target to Performance Payment</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
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</table>
PAC Network

Hospital ACO/MCO

Tiered Membership

Contracted Vendors

PACN Patient Intake/Management

SNF → Home Care → Hospice

Patient Residence
Four Essentials of PACN Relationships

- Standardization of referral protocols ensures rapid placement of patients in appropriate PAC settings
- PAC facilities must regularly report quality metrics to ensure continued eligibility in affiliation networks
- Acceptance tracking generates data for future conversations between hospitals and PAC facilities
- Attendance at ongoing meetings in conjunction with reactive communication is a necessity

Standardized Referral Protocols

Patient Acceptance Tracking

Clinical Quality Reporting

Require Ongoing Communication
Post-Acute Medicine

- Medical model not bound by traditional delivery locales or roles
- Certain population segments require medical care outside of acute and ambulatory settings
- Focus on timely access and collaborative, team-based care to achieve success in a future defined by value
- Post-acute medicine delivers care in patient-centered health home model, integrating and collaborating with other health care and community-based services
SNFists: Complex Discussion in SNF Setting

- Physician involvement and availability
  - One study indicated average number of combined visits per month was only 0.83 in FFS setting
- Diagnostic testing availability
- Nursing assessment skills
- Clinical competencies of staff
- 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
Clinical Model Results

Source: IPC Analysis 2012
A “Health Care Neighborhood”
For Those with Advanced and Chronic Illness

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Complex Care Clinic</th>
<th>Home Care, Private Duty &amp; DME</th>
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<tbody>
<tr>
<td>Adult Day Care</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Skilled Nursing Facility</th>
<th>Patient-Centered Health Care Neighborhood</th>
<th>Palliative Care Clinic/Hospice</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Telemedicine/Telemonitoring</th>
<th>Geriatric Assessment &amp; Consultation</th>
<th>Area Agency on Aging &amp; Other Community Agencies</th>
</tr>
</thead>
</table>

House Calls
Preferred Network Development

PETER A. BOLING, MD
PROFESSOR AND CHAIR, DIVISION OF GERIATRIC MEDICINE
VIRGINIA COMMONWEALTH UNIVERSITY
Post-acute network development: Why?

**Fiscal pressures:** readmission penalty, bundles, MCOs and ACOs, public reporting

**Quality:** patient and family satisfaction
Usual “continuum of care”

- Navigators
- Hospital
- Hospice
- Nursing Facility
- Assisted Living
- Memory Care
- Medical Offices
- Home Medical Care
- Home Health Agency
- Social Services
- Personal Care
- DME
VCU Medical Center

- 750 beds; 33,000 annual discharges
- Safety net facility with corresponding payer mix
- Level 1 Trauma Center
- NCI designated Cancer Center
- Various transplants, advanced cardiac surgery
- Medicare DRG weight 2.15 and rising
- Affiliated 150-bed hospital 75 miles away with associated 160-bed nursing home and home health agency
- We do not “own” local Richmond assets in the usual continuum of care
# VCU Medical Center Post-acute Referrals

<table>
<thead>
<tr>
<th>Post-acute Discharges</th>
<th>12 Months</th>
<th>Column %</th>
<th>Per Day (254 days/year)</th>
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</thead>
<tbody>
<tr>
<td>Home Health Agency</td>
<td>5,768</td>
<td>66%</td>
<td>22.7</td>
</tr>
<tr>
<td>LTACH</td>
<td>114</td>
<td>1%</td>
<td>0.4</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>1,668</td>
<td>19%</td>
<td>6.6</td>
</tr>
<tr>
<td>Acute Care Hospital</td>
<td>184</td>
<td>2%</td>
<td>0.7</td>
</tr>
<tr>
<td>Inpatient Rehab Facility</td>
<td>622</td>
<td>7%</td>
<td>2.4</td>
</tr>
<tr>
<td>Hospice</td>
<td>432</td>
<td>5%</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>8,788</strong></td>
<td><strong>100%</strong></td>
<td><strong>34.6</strong></td>
</tr>
</tbody>
</table>
Post-acute network planning options, critical decisions 1

**Buy**
- Expensive, have more control

**Build**
- Expensive, have more control, also more operational responsibility

**Affiliate**
- Varying degrees of investment and control depending on nature of affiliation contract
- Least restrictive is preferred referral network with no financial relationship
Post-acute network options, environmental scan, provider capacity

- Home health agencies
- Hospices
- IRF
- NH
  - Geography – where are they in relation to where families live
  - Quality –
    - Web data CMS website
    - “Smell” test – families will visit facilities
    - Local reputation, rumors from friends, anecdotes, personal experiences
- ALFs
  - Memory Care units

What is the extent of potential affiliates’ existing linkages to competing health systems and are they truly exclusive or appear so by historical tendency?
Post-acute network planning 2, local environment, financial scan

• Competition by other health systems

• Penetration of managed care and other new financing mechanisms
  ◦ Medicare/Medicaid Duals MCOs
  ◦ MA plans
  ◦ SNPs
  ◦ ACOs
  ◦ Bundles

• Also, extent of state (Medicaid) investment in community LTC (personal care) as contrasted with institutional care—more options in community will decrease need for NH beds
Planning post-acute care: What are your own characteristics?

- Volume of discharges
- Payer mix
- Clinical profile that may need post-acute care—examples: tracheostomies, advanced cardiac care, LVADs, IV infusions, wound care, etc.
- Referral patterns to post-acute care settings
  - How many patients and what type
    - Rehab needs (technically complex vs. generic); this impacts choice of partners and capacity
  - Is your payer mix and patient population attractive to post-acute providers?
  - Is your organization committed to having a strong extended care network:
    - What sort of relationships do you have in the community?
    - Is your organization operationally prepared to interface with and manage the continuum relationships?
Identifying potential partners

- Review partners’ capacity (volume)
- Identify geographic location and coverage
- Determine extent to which referral and clinical relationships already exist
- Ask about their interest and constraints; this is a detailed exploration
  - Survey
    - Capacity
    - Size
    - Technical skills
    - Payer mix
    - Quality measures
    - IT systems
Finances and contracting

• Will there be money involved?
• Solicitation for interest in network must comply with fair business practices
• Careful attention to Stark rules, particularly if referring not owning
• Develop standard contract
  ◦ Contract payments for uninsured patients from VCUHS
    ◦ Based on Medicare RUGS, HHRGs
  ◦ Bundles
  ◦ MCO agreements, other risk contracts, e.g., PACE, SNP
  ◦ ACO shared savings payments
  ◦ Pay attention to risk adjustment, and timely access to cost and service use data
Interface planning

• Will your system’s own providers follow your patients during post-acute care?

• IT
  ◦ Most post-acute providers and systems’ records are computerized
  ◦ How well do their systems and your systems interface, share documents, data?

• Patient identification, selection, referral

• Bi-directional handoffs:
  ◦ Hospital to post-acute
  ◦ Post-acute to hospital
    ◦ Processes
    ◦ Quality
Network interface management

• Clinical coordinator is needed (nurse)
• Physician leadership is important
• Clinical management infrastructure inside hospital when things do not go as planned
• Integration of network with strategic planning by senior leadership at hospital/health system
• Create Joint Operating Committee (JOC) that meets regularly
  ◦ Health system and external partners by type (HHA, SNF)
  ◦ OK to have competitors in the same room—strengthens process
  ◦ Data driven
Metrics and things to discuss at JOC

• Volume and type of referrals to each provider in network
• Timeliness of post-acute response by network
• Process problems in bi-directional communication
  ◦ Quality and timing of information
  ◦ Implementation of care plan generated by hospital and as revised during the process of care
• Outcomes of interest to both parties
  ◦ Early, preventable hospital readmissions
  ◦ ED visits
  ◦ Customer satisfaction
  ◦ Provider satisfaction
Clinical operations in your health system

• How well articulated is the discharge and continuing care plan?
• Does some one person or office “own” the responsibility?
• Does everyone know who that is, and has that office/person accepted the responsibility?
• Is there an effective action arm when care plans need to change after hospital discharge or help is needed later in course of care?
• Are follow-up plans carried out reliably in the post-acute network provider settings?
• Are there clinical care process problems being reported during post-acute care by either party?
What VCUHS is doing

• Affiliation agreements
• DME network with 1 preferred partner
• HHA network with 3 preferred partners (18 months)
• Hospice network with 2 preferred partners (6 months)
• Nursing home network under development with 14 preferred partners (forming)
  ◦ Geography
  ◦ Quality
  ◦ Distribute the uninsured, socially complex contract patients
• Nursing facility attending service to manage clinical complexity, facilitate continuing care, reduce unplanned returns to hospital
Other opportunities

- Independence at Home (IAH), shared savings program
- Required quality measures regulate access to shared savings
- 3-year demo with 2-year bipartisan legislative extension 2016–2018
- 15 sites, house calls team as medical home
- Voluntary enrollment; no beneficiary constraints
- Beneficiary eligibility:
  - Medicare A and B
  - Hospitalization
  - Use of post-acute care
  - 2 or more ADL dependencies
  - 2 or more serious chronic illnesses
IAH preliminary results

- 8,000+ beneficiaries, avg. HCC > 3.5, average annual cost >$50,000
- Demo Year 1 Medicare A+B savings of $25 million
- Year 2 and 3 results not yet available; demo evaluation in progress
- Medicare A+B savings of 7.7% across all sites
  - 17% across 9 sites that exceeded 5% mandatory minimum savings and qualified for shared savings
- Highest percentage reduction in expected Medicare A+B cost at any one site was 32%
- High quality measure attainment
Understanding the Dynamics of a Preferred Network Development

Lynn C. Jones, FACHE
President, Christiana Care VNA
SVP, Post Acute Care
The Christiana Care Way

We serve our neighbors as respectful, expert, caring partners in their health. We do this by creating innovative, effective, affordable systems of care that our neighbors value.
• **Delaware’s largest private employer**
  - More than 11,000 employees

• **Major teaching hospital with four campuses**
  - Largest teaching affiliate hospital for Sidney Kimmel Medical College at Thomas
  - Jefferson University, training more than 280 residents and fellows annually

• **Christiana Care Quality Partners**
  - More than 2,370 providers participate in clinically integrated network

• **Net operating revenue of $1.66 billion in FY 2015**
• Primary Care Office Visits: 227,295
• Home Health Care Visits: 308,096
• Admissions: 53,072
  – 21st in the nation
• Surgeries: 38,712
  – 29th in the nation
• ED Visits: 187,317
  – 21st in the nation
• Births: 6,469
  – 32nd in the nation
<table>
<thead>
<tr>
<th>Service</th>
<th>Ownership</th>
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<tbody>
<tr>
<td>Home Health</td>
<td>Own</td>
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<tr>
<td>Inpatient Rehab Facility (IRF)</td>
<td>Own</td>
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<tr>
<td>Hospice</td>
<td>In Process</td>
</tr>
<tr>
<td>SNF/LTACH</td>
<td>Partner</td>
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</table>
CCHS SNF Network Development Steps

1. “Multipronged” outreach
2. Initial focus with high-volume partners
3. Dialogue; listening; learning; relationship building
4. All welcome to participate (maintain choice)
5. Measure performance together
6. Continue to develop/refine SNF & HHA protocols
7. Prepare for patient “informed choice”
Population Health Initiatives CCHS Is Involved With

- 7 BPCI Model 2 bundles
- Independence at Home
- ACO shared savings
- Medicaid risk partnership with Highmark
Key Initiatives in Post Acute

- Transitional Care Consortium
- Communitywide consortium of all providers & others (QIO, State licensure, transport companies, hospitalists, etc.)
- Care Transitions Improvement
Post Acute Leadership Council

- Internal education bimonthly
- Idea generation
- Bringing together Post Acute/ACO/Case Management/Medical Group/Acute Care
SNF Partners Council

- Smaller group of high-volume SNFs
- Define & monitor quality together
- Collaborative program development
- Relationship building
Delaware Healthcare Association Post Acute Council

- All health systems in DE
- Focus is electronic transfer of care transition info
A few examples of our work…
BPCI Joint Replacement Care Redesign

Pre-op

Care Link Risk stratification
Care Link Discharge Planning

In-hospital, post-op

Clinical Pathways
OR Supply cost reduction opportunities

Post-acute

Care Link Support for patient
Care Link Coordination with post-acute providers
BPCI Joint Replacement Results (first 6 months)

- % Admitted to SNF: 30% (Group A), 20% (Group B)
- 30-day Readmission Rate: 5.3% (Group A), 3.8% (Group B)
- Patient Experience: 91% (Group A), 93% (Group B)
- Homecare “days to outpatient”: 15 d (Group A), 10 d (Group B)
## SNF Quality Dashboard

### 1. Star Ratings (Dec-15)
- **Quality Measure Rating**: 5 stars
- **RN Staff Rating**: 5 stars
- **Health Inspection Rating**: 5 stars

### Overall Star Rating Trends

### Quality Measures
- **Percent of Short Stay Residents Who New Received an Antipsychotic Medication**
  - Q1-14: 1.3%
  - Q1-15: 1.3%
  - Q2-15: 2.8%
  - Q3-15: 1.8%
  - Q4-15: 2.5%
- **Percent of Short Stay Residents Who Self Report Moderate to Severe Pain**
  - Q1-14: 20.9%
  - Q1-15: 19.9%
  - Q2-15: 18.2%
  - Q3-15: 17.6%
  - Q4-15: 17.6%
- **Percent of Short Stay Residents With Pressure Ulcers That Are New or Worsened**
  - Q1-14: 0.6%
  - Q1-15: 0.4%
  - Q2-15: 0.6%
  - Q3-15: 0.5%
  - Q4-15: 0.8%

### 2. Patient Satisfaction/Experience
- **Facility Reported**: 80%
- **Benchmark**: 82%

### 3. CareLink "Culture of Collaboration" Score: 9

**Comments:**
- Easy working and communicating with the facility

### 4. Readmissions - Bundle (Jan-Nov 2015)
- **# Referrals**: 76, 492, 589, 891
- **# 7-Day**: 3, 25, 39, 37
- **# 30-Day**: 7, 72, 90, 87
- **# 60-Day**: 7, 72, 90, 87

### 5. Length of Stay (days)
- **CFH**: xx, xx, xx
- **Joint Replacement**: xx, xx
- **Stroke**: xx, xx
- **SNF Overall**: xx, xx
- **SNF "Falls Overall"**: xx, xx
- **DE Benchmark**: xx, xx

Data sources:
- CMS Nursing Compare
- ChristianaCare Facility

Bundles: CARE, CAMS, CHF, Joint, Limbar, Stroke and Value

For questions and feedbacks:
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  - 302-225-5283
  - lynn.jones@christianacare.org
- Sherry Hauman, Director PHSS
  - 302-225-6218
  - sherry.hauman@christianacare.org

Please turn page over for facility specific information
# Care Link & SNF Case Management

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Facility</th>
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<tbody>
<tr>
<td>Monday</td>
<td>-</td>
<td>Health South</td>
</tr>
<tr>
<td>Tuesday</td>
<td>10:00</td>
<td>Shipley Manor</td>
</tr>
<tr>
<td>Tuesday</td>
<td>10:30</td>
<td>Churchman’s</td>
</tr>
<tr>
<td>Tuesday</td>
<td>1:00</td>
<td>Cadia Silverside</td>
</tr>
<tr>
<td>Tuesday</td>
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<td>Cadia Broadmeadow</td>
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<tr>
<td>Wednesday</td>
<td>9:30</td>
<td>Hillside</td>
</tr>
<tr>
<td>Wednesday</td>
<td>10:30</td>
<td>Cadia Pike Creek</td>
</tr>
<tr>
<td>Wednesday</td>
<td>11:00</td>
<td>New Castle Health &amp; Rehab</td>
</tr>
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<td>Wednesday</td>
<td>1:00 pm</td>
<td>Manor Care Pike Creek</td>
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<td>Regal Heights</td>
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<td>Regency</td>
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<td>Brackenville</td>
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<tr>
<td>Thursday</td>
<td>11:30</td>
<td>Manor Care Wilmington/Foulk Road</td>
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Health South Call Case Managers

SNF Call Schedule
# SNF HF Telemonitoring Program

30-Day Readmission Rate for HF Patients

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>2015–2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.5%</td>
<td>14.4%</td>
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</table>
Community
30-day
Readmission Rate Trending
Shaping the Future of Care for an Aging America

Understanding the Dynamics of a Preferred Network Development

February 23, 2016
Our Mission

Kindred's mission is to promote healing, provide hope, preserve dignity and produce value for each patient, resident, family member, customer, employee and shareholder we serve.

Our Management Philosophy

Kindred’s management philosophy is to focus on our people, on quality and customer service and our business results will follow.

Kindred Is One of the Leading Providers of Rehabilitation and Post-Acute Care in the United States

Kindred is
102,200
Dedicated teammates taking care of more than
1,070,000
Patients and residents in
2,723
locations in
47
States

As of September 30, 2015.
Kindred Has Built a Solid Platform and Has Transformed Its Business Mix for Integrated Care and Population Health

Revenue Mix

YESTERDAY (2010)

Hospitals: 47%
Nursing Centers: 42%
Rehab: 14%
Kindred at Home: 11%

TODAY (2015)

Hospitals: 21%
Nursing Centers: 33%
Rehab: 14%
Kindred at Home: 32%

Transitional Care Hospitals
Rehabilitation Services
Sub-Acute & Skilled Nursing
Home Health, Hospice, Community Care & Home Based Primary Care
Kindred’s Evolving Value Proposition

Currently, Kindred…

– Is the largest and most diversified post acute provider in the country
– Has a proven track record of operational expertise and success across post acute care settings
– Implements national programs based on proven clinical pathways to drive quality and efficiency

Moving forward, Kindred is…

– Increasing its accountability for quality and efficiency through value-based contracts
– Developing comprehensive care management and network management capabilities
– Driving improved outcomes through post acute care placement expertise
– Enhancing the patient experience through end-to-end population health management solutions
Care Management

Delivering coordinated activities that prioritize patient preference, across care settings from wellness to illness to baseline health, that result in optimal resource utilization, clinical outcomes and care delivery.

Kindred’s Care Management services are designed to be more integrated and place more emphasis on member activation, a coordinated experience, and insightful analytics to meet evolving segment needs.
Cultivating and Managing a Network

What does the population need?
- Coordinated care management
- Comprehensive delivery system guidance
- Education

What partners does the network serve?
- ACOs
- Commercial payers
- Employers
- Government payers
- Health systems

How are network providers chosen?
- Capacity
- Clinical integration
- Data sharing
- Geographic adequacy
- Payer mix
- Quality ratings
- Service line offerings

What is the contracting strategy?
- High performance networks
- Pay for Performance
- Shared savings/risk
- Capitation
- Delegation

Network Management
- Scope of managed population
- Catchment area planning
- Clinical performance reviews
- Financial results
- Improvement plans for sub-standard performance
The Importance of SNFs in Network Considerations

Health System Case Study

2014 Medicare & Medicare Advantage Discharges

- Long Term Acute Care Hospital (LTACH) 2%
- Inpatient Rehab Facility (IRF) 4%
- Skilled Nursing (SNF) 18%
- Home Health 17%
- Hospice 2%
- Home 50%
- Other 7%

Post Acute Discharge Distribution

- 1 LTACH receives 84% of Health System's LTACH volume
- 2 LTACHs
- 2 IRFs/Rehab Units receive 94.8% of rehab volume
- 3 IRFs
- 21 SNFs receive 70% of SNF volume
- These 21 SNFs have 1,729 beds, ~2x more SNF beds than health system needs in its network
- 43 SNFs
- 6 Home Health Agencies receive 70% of home health volume
- 15 Home Health Agencies
- 4 Hospice Agencies receive 70% of hospice volume
- 9 Hospice Agencies

Source: 2014 MedPAR data
1) Assuming an occupancy rate of 85%, and assuming 50% of occupied beds could be dedicated 100% to health system volume
HOSPITALITY

STEWARDSHIP

INTEGRITY

RESPECT

HUMOR