The Perfect Storm:
A Distinguished Post-Acute Rehabilitation Program
(Session # W25)
Wednesday April 29th, 2:30-4:30
Presented by:
Hilary Forman PT, RAC-CT
Senior Vice President of Clinical Strategies
Leigh Ann Frick, PT, MBA
Chief Clinical Officer

What we will cover today
• Clinical pathway – Different sites/ different needs: finding common ground, understanding your referral source(s)
• Developing a successful post acute rehab program- a tiered approach to services & cost effective strategies without compromising patient care in an increasingly acute market
• Utilizing outcomes data to measure success- What, when & how to measure, sharing data to strengthen relationships and optimize referrals
• The fiscal benefits including findings of internal and external case studies
• Marketing strategies; take what you have learned and implement immediately
• Questions

Introduction
• Post Acute Care is not a commodity
• What are you “marketing”?  
  – Quality care?  
  – Rehab?  
  – Dementia Unit?  
• What are your competitors selling?  
• What do your referral sources NEED?  
• How can you meet that need?
Specialty Program Development

Niche Practices

What is your goal?

To improve your Clinical Capabilities/Value?
To improve Census/Payer mix?
To attract New Payers?
To become part of a Healthcare network?
To create long lasting Community Partnerships?
To create a New Program?
To create a New Revenue Stream?
All of the Above?

The IHI “Triple Aim”
Finding your path
How to create your niche in a network

Current Opportunities:
- ACO Partnerships
- Bundled Payment (BCPI) Network
- Expanding Managed Care Networks
- Care Transition Focus
- New Program Demonstration Projects
- Specialty Clinical Programs and Pathways

Putting together the plan

1. Personal Identification/SWOT analysis
   1. Data collection
   2. Affects on your payment structure- short and long term
   3. Clinical capabilities
   4. Environmental impacts
2. Market Analysis
   1. Referral Sources- understand their direction and motivators
   2. Competitors- know what programs and relationships are already established
3. Research and Team Review
   1. Must be staff adopted and staff driven
4. Implementation/Execution
   1. Timelines
   2. Accessibility
5. Evaluation and Analysis
   1. Quality initiative impacts

SWOT Analysis

Considerations:
- Current Resources
- Facility/Company Mission
- Market Dynamics and Local Competition
- Current and Potential Referral Sources
- Clinical Complexities/Skills Inventory
- Staffing changes/needs
- Payer Impact or Expectations
- EMR use/integration
Marketplace Trends

![Diagram showing range of specialization options.]

Market Analysis

Utilize existing resources to help you
- Your State Healthcare Association [https://www.ohca.org/](https://www.ohca.org/)
- NaviHealth [http://navihealth.us/](http://navihealth.us/)
- Remedy Partners [https://www.remedypartners.com/](https://www.remedypartners.com/)

Sample Market Analysis

Memphis Jewish Home 2015

![Sample Market Analysis Image]
Memphis Jewish Home

Memphis Jewish Home is a freestanding, suburban SNF, not-for-profit facility, 160 beds, no current specialty niche program/marketing, high end acuity and amenities available.

Local Hospital Market: 3 Major Medical Centers
Hospital 1- Largest Medicare market share in Shelby County. BCPI model 2 bundling 48 diagnosis via Navihealth, decreasing hospital readmission penalties x 2 years.
Hospital 2- 2nd largest Medicare market share. No current innovation models, 0% hospital readmission penalties for previous year data
Hospital 3- No current innovation models posted, high re-hospitalization penalties for previous year data

Source data 2015 Advisory board reports using Medicare Standard Analytics file CY 2013, CMS innovation website

Analysis

• Memphis Jewish Home currently ranked 6th SNF in the county in terms of Medicare total encounters
• Demonstrates 2nd and 3rd lowest re-hospitalization rates to top 2 referring hospitals at 15-18% average
• Currently demonstrates lower re-hospitalization rates than top 2 competing facilities
• Currently accepting high acuity medical patients
• Current payer mix 75% Medicare, 25% Managed Care
• Non discrete rehab unit
• Have only unit in the county with piped in oxygen supply

Recommendations

• Primary opportunity- upstream partnerships with hospitals
  – Hospital 1- specialty program in one of the potentially bundled areas, joint clinical pathways, focus on efficient care transitions
  – Hospital 2- leverage specialty program designed for hospital 1 as a model for clinical excellence and efficiency
  – Hospital 3- provide assistance in clinical programming and care transitions to assist with decreasing hospital LOS and re-hospitalization penalties
• Secondary opportunity- downstream partnership with home care and community groups to excel in care transitions considering up to 90 day episode

Source data 2015 Advisory board reports using Medicare Standard Analytics file CY 2013, CMS innovation website
Specialty Niche Programs

What makes a program a “Specialty”?

1. Has Brand Recognition - in the facility, community and among referral sources
2. Has Dedicated Resources - dedicated staff, training, technology
3. Has Proven Clinical Competence/Excellent Outcomes - all data and outcomes prove the program is success (clinical, QA and financial)

Evidenced Based Practice

• What is Evidence Based Practice?
  - Not only answers the question “what treatments work”, but also addresses for whom and under what conditions!
• Why is it important?
  - Efficiency
  - Efficacy
  - Value
  - Experience

Program Development

Aligning your program needs
• It doesn’t have to be difficult, just different!
Implementation
• Staff
• Competency/Training
• Equipment
• Environment
• Outcomes
Re-evaluation and Revisions
Sample Clinical pathway

• Commercial post acute provider with 22 post acute facilities across 3 major market places in PA.
• Adopted model of evidenced based clinical programming with focus on discharge readiness and care transitions.
• Created 6 initial clinical pathways across both impairment and diagnostic areas.

Sample Rehab Track

Rehab Clinical Track
Chronic Obstructive Pulmonary Disease/COPD

Overview/Physiology
COPD is characterized by persistent airflow limitation that usually, but not always, is accompanied by an increased rate of sputum production. It is a progressive, disabling disease that progressively reduces life expectancy.

Sample Rehab Track

Stages of COPD: The progression of COPD is determined by the FEV1/FVC ratio. Full stands for the Global Initiative for Chronic Obstructive Lung Disease (GOLD) classification. FEV1 is the forced expiratory volume in one second and FVC is the forced vital capacity.

- Stage I: FEV1 is less than 80% of predicted. Airflow limitation is present, but no symptoms or chronic bronchitis.
- Stage II: FEV1 is between 50% and 80% of predicted. Airflow limitation is present, and there are symptoms of chronic bronchitis or a partial exacerbation of the disease.
- Stage III: FEV1 is between 30% and 50% of predicted. Further worsening of airflow limitation with greater shortness of breath.
- Stage IV: FEV1 is less than 30% of predicted. Characterized by severe airflow limitation and chronic respiratory failure in patients with chronic obstructive lung disease. After chronic oxygen therapy, quality of life is very significantly impaired.
Sample Rehab Track

Key Points

- **Pulmonary Function Tests (PFTs)** are an important tool in the investigation and monitoring of patients with respiratory pathology. They provide important information relating to the large and small airways, the pulmonary parenchyma, and the size and integrity of the pulmonary capillaries.

- **Spirometry Tests**: Used to assess lung function. Often used to evaluate persons with chronic cough, asthma, emphysema, or a history of COPD. It measures forced expiratory volume in one second (FEV1), and the amount of air breathed out as forcefully as possible in one second. The FEV1 value determines the severity of COPD. The normal value of each of these measurements depends on age, height, gender and race.

- **Medication**: Pharmacologic treatment is used with COPD to control/manage, reduce the frequency and severity of exacerbations and prevent symptoms. This often includes inhaled corticosteroids for COPD and may be used in conjunction with other medications like bronchodilators, anticholinergics, and antibiotics.

- **Pulmonary Rehabilitation**: Suggested for Stage II COPD. The suggested length of the program is generally six weeks, however, the longer the program, the more effective the results.

- **Oxygen Management**: The long-term management of oxygen (15 hours per day) to patients with chronic respiratory failure has been shown to increase survival. Long-term oxygen therapy is introduced in severe COPD, or patients with pulmonary hypertension, and for peripheral edema secondary to congestive heart failure.

- **Dyspnea**: One of the hallmark symptoms of COPD, and the most frightening. Commonly known as shortness of breath, a symptom limiting exercise capacity. Dyspnea characterizes a subjective experience of breathing discomfort that consists of qualitatively distinct sensations that vary in intensity.

---

Sample Rehab Track

Clinical Guidelines/Neuromuscular Management

- Neurocognitive evaluation and muscle strength testing
- Functional capacity testing
- Gait analysis
- Balance and coordination assessments
- Dyshesion, dysmetria, and dysdiadochokinesia
- Motor unit recruitment
- Modulation of breathing
- Breathing retraining techniques
- Tolerance to tasks to address muscle weakness
- Measurable gait score
- Training of locomotion to improve endurance and gait stability
- Training of balance to improve postural stability
- Training of breathing to improve respiratory muscle strength
- Training of energy utilization
- Training of endurance and functional capacity
- Training of attention and cognitive function
- Training of depression and anxiety
- Training of self-care
- Training of family and social support
- Training of home management
- Training of employment and work simulation
- Training of community and leisure activities
- Training of communication
- Training of emotional support
- Training of physical activity
- Training of exercise
- Training of nutrition
- Training of occupational therapy
- Training of speech therapy
- Training of speech pathology
- Training of social services
- Training of vocational rehabilitation
- Training of physical therapy
- Training of occupational therapy
- Training of speech therapy
- Training of social services
- Training of vocational rehabilitation
- Training of physical therapy
- Training of occupational therapy
- Training of speech therapy
- Training of social services
- Training of vocational rehabilitation

Applicable/Techniques and Tools

- Discipline specific evaluation
- Full set of data
- Cognitive and communication evaluation
- Berg Balance Scale/Todile Balance Assessment Tool
- Bong Balloon Test/Postural Balance Assessment Tool
- Balance testing
- Posture assessment
- Breathing dysfunction assessment
- Breathing retraining techniques
- Tolerance to tasks to address muscle weakness
- Measurable gait score
- Training of locomotion to improve endurance and gait stability
- Training of balance to improve postural stability
- Training of breathing to improve respiratory muscle strength
- Training of energy utilization
- Training of endurance and functional capacity
- Training of attention and cognitive function
- Training of depression and anxiety
- Training of self-care
- Training of family and social support
- Training of home management
- Training of employment and work simulation
- Training of community and leisure activities
- Training of communication
- Training of emotional support
- Training of physical activity
- Training of exercise
- Training of nutrition
- Training of occupational therapy
- Training of speech therapy
- Training of social services
- Training of vocational rehabilitation
- Training of physical therapy
- Training of occupational therapy
- Training of speech therapy
- Training of social services
- Training of vocational rehabilitation
- Training of physical therapy
- Training of occupational therapy
- Training of speech therapy
- Training of social services
- Training of vocational rehabilitation
- Training of physical therapy
- Training of occupational therapy
- Training of speech therapy
- Training of social services
- Training of vocational rehabilitation
## Results: How do I compare?

<table>
<thead>
<tr>
<th>Facility Characteristics</th>
<th>Patient Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facilities</td>
<td>961</td>
</tr>
<tr>
<td>Total Full-Time (FTE)</td>
<td>145.000</td>
</tr>
<tr>
<td>All Direct Care FTE (FTE)</td>
<td>145.000</td>
</tr>
<tr>
<td>Total Patient NURSES</td>
<td>145.000</td>
</tr>
<tr>
<td>Weighted Ratio (FTE)</td>
<td>1.26</td>
</tr>
<tr>
<td>Average Patient Acuity</td>
<td>82.5</td>
</tr>
<tr>
<td>% With NH Services</td>
<td>17.4%</td>
</tr>
<tr>
<td>Average HH Services (%)</td>
<td>64.0%</td>
</tr>
<tr>
<td>Average Community (%)</td>
<td>35.0%</td>
</tr>
<tr>
<td>Average Resident (%)</td>
<td>75.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measuring your Success</td>
</tr>
<tr>
<td>Patient satisfaction</td>
</tr>
<tr>
<td>Cost containment</td>
</tr>
<tr>
<td>Transfer to LTC</td>
</tr>
<tr>
<td>Autonomy</td>
</tr>
</tbody>
</table>

## Outcomes

### What are outcomes?

- Increased autonomy
- Lower level of care
- Decrease in cost of care
- Decrease in length of stay
- Increased discharge to home
- Decrease in fall rate
- Increased patient satisfaction
- Transfer to LTC
- Management of chronic medical conditions

4/7/2015
Outcome Categories

Financial
Clinical
Demographic
Quality Assurance

Who wants/Needs outcomes?

- Patients
- Doctors
- Family members
- Administrators
- Executive Directors
- Corporate
- Hospitals/referral sources
- CMS
- Clinicians
- Congress
- Payers
- Marketing department

Improving Medicare Post-Acute Care Transformation Act (IMPACT Act)

- This is being compared to OBRA ‘87 and the BBA ‘97 as far as significance in the PAC marketplace.
- It was introduced June 26, 2014 and signed by President Obama on October 6, 2014...in Congressional time that is FAST!
- Three components:
  - Reporting of standardized patient assessments (data)
  - Reporting of additional Quality Measures
  - Report Resource Use Measures
Standardized Data

- Institutes major changes in reporting requirements for all PAC providers
- Will require PAC providers to report standardized patient data:
  - Functional status
  - Cognitive function and mental status
  - Special services
  - Medical condition and impairments
  - Prior functional levels
  - Other categories as determined by the Secretary
- Could lead to a Part A prospective payment system across PAC providers in five years

Standardized Data

Why standardize data across PAC settings?

- Enable Congress and CMS to compare services across PAC settings
  - Complexity
  - Outcomes
  - Costs
- As a predicate for PAC payment reform.
  - CMS’ concern - the different types of PAC providers frequently provide similar services to similar patients, but payment can vary significantly.
  - Each silo’s patient assessment tool uses different definitions, scales, time periods, and method of assessment.
- Standardization may enable policymakers to develop a payment system that cuts across all PAC settings.

Quality Measures

- SNFs, IRFs, LTCHs must begin reporting on quality measures by October 1, 2016, and by January 2017 for HHAs.
- At a minimum, must contain the following quality domains:
  - **Functional status and changes in function**
  - Skin integrity and changes in skin integrity
  - Medication reconciliation
  - Incidence of major falls
  - Patient preferences
Resource Use Measures

- By October 1, 2016, Secretary shall specify "resource use" reporting requirements.
  - Medicare spending per beneficiary
  - Discharge to community
  - Hospitalization rates of potentially preventable readmissions

Timeline by Setting and Requirement

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LTACH</td>
<td>Oct. 1, 2016</td>
<td>Oct. 1, 2018 (skin integrity, major falls)</td>
<td>Oct. 1, 2018</td>
</tr>
<tr>
<td>IRF</td>
<td>Oct. 1, 2018</td>
<td>Oct. 1, 2018 (functional status, skin integrity, major falls)</td>
<td>Oct. 1, 2018</td>
</tr>
<tr>
<td>SNF</td>
<td>Oct. 1, 2018</td>
<td>Oct. 1, 2018 (skin integrity, major falls)</td>
<td>Oct. 1, 2018</td>
</tr>
</tbody>
</table>

Using your data effectively: Score Cards
Outcomes: More than Re-hospitalization Rate!

- The set expectations are re-hospitalization rates by diagnosis, quality measure based scorecards and a 24 hour a day intake.

The new areas to focus

- Percent of patients discharging home
  - Percentage home care referrals
- Average length of stay by diagnosis for both SNF and HH
- Therapy intensity (minutes/week) and cost
- Functional Changes
- Control group/peer benchmarking/national standards
- Cost/episode by diagnostic group
- Use of evidenced based guidelines and protocols

Using your data in partnerships

Case Studies- Census Development

Internal Program development
Advanced Pulmonary Program

[Graph Image]
Specialty Program Details

- Van Dyk Montclair - a 70 bed, family owned, SNF located in affluent northern NJ launched a in house Respiratory Therapy Program aimed at improving clinical excellence, decreasing hospitalizations and attracting increased referrals.
- Local Market Dynamics - Multiple ACOs, 3 convening organizations working with both Model 2 & 3 bundlers, 2 Major competing and expanding hospital networks, Large contract therapy market.
- Market Opportunity identified as Pulmonary care

Development and Execution

- Partnered with turn key respiratory therapy company to assist in placement of PT pulmonologist and FT respiratory therapist.
- Respiratory therapist services provided 5 days per week.
- Implemented evidenced based guidelines and protocols, GOLD guidelines for Nursing, Respiratory and Rehab.
- Expanded documentation in EMR to capture more relevant assessments and documentation
- Rehab implementation of related Rehab Tracks and specific outcomes tracking for program

1 Year average Results

- 305% increase in Medicare A Rehab days
- 307% increase in Medicare A Rehab Revenues
- Reduced hospitalization rate from average of 20% to 11%
- Managed care growth in addition to this growth measuring at 15% and climbing
Case Studies - External Outreach

External Program Development
For Jewish Home LifeCare Manhattan division, a 165 year old, 514 bed, non-profit in Metropolitan New York City sought to expand their clinical excellence through partnerships in the creation of multiple co-branded units with large, expanding hospital networks.

For one unit, JHL partnered with a major medical center to develop a post-acute cardiac rehabilitation program that included telemetry monitoring.

Program details

- Jewish Home LifeCare Manhattan division, an 165 year old, 514 bed, non-profit in Metropolitan New York City sought to expand their clinical excellence through partnerships in the creation of multiple co-branded units with large, expanding hospital networks.
- For one unit, JHL partnered with a major medical center to develop a post-acute cardiac rehabilitation program that included telemetry monitoring.

Detailed Plan

- Relationship Development
  - Business Development engages key constituents to determine needs
- Opportunity Identification
  - Strategic Planning Discussions to Identify Existing Clinical Service Lines
  - What are the unmet market demands?
  - Ask not what your partner can do for you – Ask what you can do for your partner
- Return on Investment
  - Cost of Opportunity
  - Expected Volume
- Definition of Program
  - SWOT Analysis of existing resources including skill sets
  - Identification of Best Practices and Clinical Guidelines
Rehab Program Expectations

- Correctly categorize the patients by tier and expected discharge outcome
- Manage LOS and treatment minutes/levels to meet the patient’s medical/clinical needs
- Completely prepare patient for discharge to community
  - Comprehensive education and functional programming
  - Proven and tracked Clinical and Functional Outcomes
  - Track number of tier changes and reasons
  - Advanced safe transition protocols including medication management, home evaluations and safety education

Detailed Plan Continued

- Development of operational readiness
  - Recruitment of Key Staff
  - Clinical Training
  - Development of Policies/Procedures
- Take this time to re-look at your facility meeting schedules
- Capital Improvements
  - CON
- Pilot Program started April 2013
- Expansion unit (26 to 38 beds) started March 2015

Results - 30-Day Hospital Readmission Rates
(May 2014-December 2014)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>3.4%</td>
<td>3.5%</td>
<td>3.6%</td>
<td>3.7%</td>
<td>3.8%</td>
<td>3.9%</td>
<td>4.0%</td>
<td>4.1%</td>
<td>4.2%</td>
<td>4.3%</td>
<td>4.4%</td>
<td>4.5%</td>
<td>4.6%</td>
<td>4.7%</td>
<td>4.8%</td>
<td>4.9%</td>
<td>5.0%</td>
<td>5.1%</td>
<td>5.2%</td>
<td>5.3%</td>
<td>5.4%</td>
<td>5.5%</td>
<td>5.6%</td>
<td>5.7%</td>
<td>5.8%</td>
<td>5.9%</td>
<td>6.0%</td>
<td>6.1%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>
Results - 30 day specific re-hospitalization rates

<table>
<thead>
<tr>
<th>Admission (1)</th>
<th>30 Day Readmission (%)</th>
<th>90 Day Readmission (%)</th>
<th>180 Day Readmission (%)</th>
<th>All Cause Readmission (%)</th>
<th>Heart Failure (%)</th>
<th>Respiratory (%)</th>
<th>Infection (%)</th>
<th>Vascular (%)</th>
<th>All Other (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>214</td>
<td>3.3%</td>
<td>12</td>
<td>29.5%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>1.6%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Acute Heart Failure</td>
<td>54</td>
<td>4.8%</td>
<td>17</td>
<td>33.3%</td>
<td>4.8%</td>
<td>3.3%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Sickle Cell Disease</td>
<td>81</td>
<td>4.5%</td>
<td>12</td>
<td>33.3%</td>
<td>4.5%</td>
<td>3.3%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary</td>
<td>99</td>
<td>3.0%</td>
<td>6</td>
<td>17.2%</td>
<td>3.0%</td>
<td>1.6%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Stroke</td>
<td>60</td>
<td>4.6%</td>
<td>3</td>
<td>16.6%</td>
<td>4.6%</td>
<td>3.3%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Diabetic Nephropathy</td>
<td>11</td>
<td>5.0%</td>
<td>3</td>
<td>20.0%</td>
<td>5.0%</td>
<td>3.3%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Sjogren's Syndrome</td>
<td>35</td>
<td>4.0%</td>
<td>2</td>
<td>10.0%</td>
<td>4.0%</td>
<td>3.3%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>68</td>
<td>27%</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>35</td>
<td>12%</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>28</td>
<td>9%</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>23</td>
<td>9%</td>
<td>26</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive Displasia</td>
<td>17</td>
<td>7%</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Cardiac Rehab Program</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Results LOS by Diagnosis

<table>
<thead>
<tr>
<th>Primary Diagnosis (ICD-9 Code)</th>
<th>Number</th>
<th>%</th>
<th>Mean Length of Stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure (416.0)</td>
<td>68</td>
<td>27%</td>
<td>21 days</td>
</tr>
<tr>
<td>Hypertension (401.9)</td>
<td>35</td>
<td>12%</td>
<td>25 days</td>
</tr>
<tr>
<td>Atrial Fibrillation (427.31)</td>
<td>28</td>
<td>9%</td>
<td>21 days</td>
</tr>
<tr>
<td>Pneumonia (486)</td>
<td>23</td>
<td>9%</td>
<td>26 days</td>
</tr>
<tr>
<td>Chronic Obstructive Displasia</td>
<td>17</td>
<td>7%</td>
<td>17 days</td>
</tr>
<tr>
<td>Overall Cardiac Rehab Program</td>
<td>22</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Marketing your program

Start with the end in mind
Market strategies

Identify targets based on market analysis, ACO/bundled payment activity, re-hospitalization rates
Unique selling proposition...be able to articulate what differentiates you!
Demonstrate an understanding of the payment environment; how you can be a strategic partner to your referral sources
Demonstrate service delivery that is high in quality, customer satisfaction and cost containment! Data doesn’t lie!

Using your Data/Outcomes

– Internal process direction
– Introductions to hospital partners
– Expansion of hospital partnerships
  • Shared/Co-branded units in SNF
  • Develop or expand a network
– Introductions/expectations for downstream partners
– Physician discussions for specialty programs
  • Specialty units with increased MD presence

What you can do today

• Communicate to your team; the times are changing!
• Complete a market analysis
• Talk to your therapists/rehab partner
• Gather your stats; re-hospitalization rates; LOS, functional outcomes
• Identify niche/program
• Set up conversations with providers both up and downstream
Questions?

Contact Information

• Hilary Forman
  – hforman@healthpro-rehab.com
• Leigh Ann Frick
  – lfrick@heritage-healthcare.com