Accountable Care Organizations

“Voluntary groups of physicians, hospitals, and other health care providers that are willing to assume responsibility for the care of a clearly defined population of Medicare beneficiaries attributed to them on the basis of patients’ use of primary care services.

If an ACO succeeds in both delivering high-quality care or improving care and reducing the cost of that care below what would otherwise have been expected, it will share in the savings it achieves for Medicare.”

The New England Journal of Medicine (NEJM), October 20, 2011
Making Good on ACOs’ Promise – The Final Rule for the Medicare Shared Savings Program
Donald M. Berwick MD, Administrator, CMS
Perspective – Final Rule for Medicare Shared Savings Program
The New England Journal of Medicine

“We believe that today’s ACO rule is the next step in our shared commitment to a better, more lasting health care system. We look forward to being a trusted partner in our nation’s journey toward patient-centered, coordinated care.”

Donald M. Berwick MD, Administrator, CMS
The New England Journal of Medicine (NEJM), October 20, 2011
Making Good on ACOs’ Promise – The Final Rule for the Medicare Shared Savings Program

Key Principles of Accountable Care
The Brookings Institution

<table>
<thead>
<tr>
<th>Underlying Causes of Poor Performance</th>
<th>Principles of Accountable Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of clarity about aims, and about whose perspectives are most relevant.</td>
<td>Clear aims: better overall health through higher-quality care and lower costs with a focus on patients.</td>
</tr>
<tr>
<td>Providers are fragmented and unable to coordinate care well; providers accept responsibility only for what they directly control.</td>
<td>Establish provider organizations accountable for achieving better results for all of their patients at a lower cost.</td>
</tr>
<tr>
<td>Payment system drives fragmentation, rewards unnecessary care, and penalizes care coordination and overall efficiency.</td>
<td>Align financial, regulatory, and professional incentives with the aims of better health through higher-quality care, lower costs.</td>
</tr>
<tr>
<td>Inadequate information to support provider and patient confidence about the value of reforms.</td>
<td>Valid, meaningful performance measures that support provider accountability for aims and support informed and confident patient care choices.</td>
</tr>
</tbody>
</table>

Copyright 2011 © The Brookings Institution
Despite uncertainty over how the Supreme Court will rule on the health law, a key provision intended to help transform the delivery of care is moving ahead.

27 health systems have been selected to participate in Medicare’s Shared Savings Program, which offers financial incentives for physicians, hospitals and other health care providers to team up in “accountable care organizations.”

Instead of getting paid for each service ACOs reward providers that are able to manage chronic disease and meet certain quality measures, including reducing hospital admissions and emergency room visits. If they improve care while restraining costs, the systems can share in the savings.
ACOs Potential Impact on SNF Quality

1 Transparency
   - Might as well adjust to the fact that entities, other than surveyors, will be more interested in what we are doing

2 ACO or Market Level Outcomes
   - Coordinated, efficient, error free “transitions of care”
   - Length of Stay
   - Functional rehabilitation progress
   - Re-hospitalization rates
   - Patient and Family Satisfaction

3 Regulatory Level Outcomes
   - Clinical QMs (falls, pressure sores, infection, restraints, pain, psychotropic meds, etc)
   - Pharmacy error rates and Safety
   - Annual and Complaint Survey compliance

ACOs Potential Impact on SNF Quality

• Transparency
   - Entities (other than surveyors) will be more interested in what we are doing and generally “in our business”
   - ACO clinicians and physicians will likely have greater involvement in what happens to “their” patients when they enter our facilities
   - ACOs will have a vested interest in our ability to improve quality and reduce cost and they will insist on ways to measure both
   - We (read OUR CLINICIANS) will need to be conversant with the status of our patients/residents in terms of clinical complexity, rehab potential, discharge potential and hospitalization risk and we (read OUR CLINICIANS) will need to dialogue with external clinicians in regard to case specific situations and aggregate outcome data
     • Will we have the in-house physician and nursing talent to dialogue with their ACO peers?
     • Will the ACO insist on placing their physicians in our SNFs?
Existing MCO relationships may be a “window” to an ACO future?

*Kaiser and Health Care Partners* examples:

- Guidelines and Pathways for such things as transfer readiness, clinical treatment and rehab goals, length of stay and discharge preparation
- Daily Medical Management - Physician presence mandatory – they place their docs in our SNFs
- Weekly Clinical Meetings and Case Management
- Quarterly Joint Operating Committees (JOC)
- Robust Performance Improvement (PI) process on Quality Measures including Re-hospitalization reviews
- Make suggestions about décor, food, room assignments, staffing, etc.

Who are our SNF Patients?

And why is this important
Tremendous Opportunities Exist to Better Manage Patients Discharged from Acute Care Hospitals

Medicare Patients’ Use of Post-Acute Services Throughout an “Episode of Care” [1]

**Intensity of Service**

<table>
<thead>
<tr>
<th>Category</th>
<th>Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHORT-TERM ACUTE CARE HOSPITALS</td>
<td>2%</td>
</tr>
<tr>
<td>LONG-TERM ACUTE CARE HOSPITALS</td>
<td>10%</td>
</tr>
<tr>
<td>INPATIENT REHAB</td>
<td>41%</td>
</tr>
<tr>
<td>SKILLED NURSING FACILITIES</td>
<td>9%</td>
</tr>
<tr>
<td>OUTPATIENT REHAB</td>
<td>21%</td>
</tr>
<tr>
<td>HOME HEALTH CARE</td>
<td>61%</td>
</tr>
</tbody>
</table>

Patients’ first site of discharge after acute care hospital stay
Patients’ use of site during 90 day episode

35% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care

* 52% of the 35% are admitted to SNFs within 90 days *


---

SNF Patients

Percent of Total Medicare Discharges to SNFs from Short-Term Acute Care Hospitals FY 2006

STAC Patient Type

- Orthopedics
- Pulmonology
- Medicine
- Cardiology
- Infectious Disease
- Neurology
- General Surgery
- Urology
- Skin & Wound
- Chest Surgery
- Psychiatry
- Rehab & Aftercare
- Ventilator
- Vascular Surgery
- Neurosurgery
- Trauma & Wound
- Head & Neck
- Oth-Gyn

20.1% of SNF admissions from STAC had an Ortho DRG in STAC.
The APR-DRG system classifies patients by severity of illness, physiologic decompensation or organ system loss of function. The four SOI levels 1 to 4 indicate 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

<table>
<thead>
<tr>
<th>Nursing Center</th>
<th># of Beds</th>
<th>DC Expire</th>
<th>DC Hospital</th>
<th>DC Home</th>
<th>Total Nursing &amp; Therapy PPD</th>
<th>Annual Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>126</td>
<td>64%</td>
<td>8%</td>
<td>13%</td>
<td>3.72</td>
<td>Def FREE</td>
</tr>
<tr>
<td>B</td>
<td>120</td>
<td>9%</td>
<td>16%</td>
<td>67%</td>
<td>4.97</td>
<td>State Avg</td>
</tr>
</tbody>
</table>

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

## A Tale of Two Nursing Centers
### The Rest of the Story

<table>
<thead>
<tr>
<th>Center Name</th>
<th>DC Home</th>
<th>DC Hospital</th>
<th>DC Other</th>
<th>DC Nur Cen</th>
<th>DC Expire</th>
<th>DC Total</th>
<th>Nrsg &amp; Ther PPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>16</td>
<td>10</td>
<td>18</td>
<td>1</td>
<td>80</td>
<td>126</td>
<td>3.72</td>
</tr>
<tr>
<td></td>
<td>13%</td>
<td>8%</td>
<td>64%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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

<table>
<thead>
<tr>
<th>Center Name</th>
<th>DC Home</th>
<th>DC Hospital</th>
<th>DC Other</th>
<th>DC Nur Cen</th>
<th>DC Expire</th>
<th>DC Total</th>
<th>Nrs &amp; Ther PPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>1222</td>
<td>296</td>
<td>82</td>
<td>60</td>
<td>159</td>
<td>1819</td>
<td>4.97</td>
</tr>
<tr>
<td></td>
<td>67%</td>
<td>16%</td>
<td></td>
<td></td>
<td>9%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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
- Very Good care, but surveys are challenging due to patient volume and clinical complexity issues
- This is where you want to be for short stay, medical recovery and rehabilitation

Hospital Readmissions

- 20% of Medicare beneficiaries discharged from the hospital are readmitted within 30 days
- 90% are unplanned readmissions
  - $12 billion annually
- Patient Protection and Affordable Care Act
  - Starting October 1, 2012, reduce Medicare DRG payments to hospitals with higher than expected readmissions for specified conditions
  - Hospitals could have as much as $3 billion at risk annually under the ACA readmissions reduction program
ACOs and SNF RE-HOSPITALIZATIONS

“With the rising rate of hospital discharges to SNFs and the increasing complexity of SNF admissions, readmissions to hospital from nursing homes is a major issue for hospitals. The result is that preventing hospital readmissions is becoming a major focus of nursing home performance efforts...

Nursing homes that choose to compete for higher reimbursed Medicare patients and participate in Accountable Care Organizations (ACOs) will be compelled to demonstrate their performance in this regard.”

AHCA / Alliance
2011 Annual Quality Report

ACOs may increasingly depend on Rehospitalization rates as a “proxy” for Clinical Quality of Care

• Complex discussion in the SNF setting
  – Patient Population (comorbidities and complications)
  – Physician involvement and availability
  – Diagnostic testing availability (lab, x-ray, etc)
  – Pharmacy availability & medication management (meds, IVs)
  – Nursing assessment skills
  – Programmatic 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
Re-hospitalization Rates for Short-stay Nursing Facility Patients, by State

Figure 3: Frequency of Rehospitalization of Short-Stay Nursing Home Residents, by State, 2006

The period of time immediately following the hospitalization is when the patient is at highest risk for re-hospitalization.

Andrew Kramer, MD, CEO, Providigm LLC
We (the SNF Industry) should care greatly about Risk Adjustment

- Not all patients/residents have the same risk for a potentially avoidable hospitalization
- To compare rates across SNFs (or other PAC settings) risk adjustment is essential
- To track or monitor trends over time in a SNF (or other PAC settings) risk adjustment is essential
- Risk adjustment models can identify residents at highest risk for potentially avoidable hospitalizations

CMS developing a “Risk Adjusted” Rehospitalization Quality Measure for SNFs - “Potentially avoidable”

Overall Readmission Pattern by PAC Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Total PAC Episodes with within 30 days of Anchor STACH</th>
<th>Total # of Re-hospitalizations</th>
<th>% Re-hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTACH</td>
<td>121,892</td>
<td>10,989</td>
<td>9.0%</td>
</tr>
<tr>
<td>IRF</td>
<td>305,329</td>
<td>30,381</td>
<td>10.0%</td>
</tr>
<tr>
<td>Home Health</td>
<td>1,725,155</td>
<td>187,898</td>
<td>10.9%</td>
</tr>
<tr>
<td>SNF</td>
<td>1,977,864</td>
<td>333,678</td>
<td>16.9%</td>
</tr>
<tr>
<td>Community</td>
<td>5,325,852</td>
<td>938,919</td>
<td>17.6%</td>
</tr>
<tr>
<td>Hospice</td>
<td>396,343</td>
<td>6308</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

The Moran Group
Source: CMS LDS Standard Analytical Files, 2009 Date Files – Hospitalizations with admission dates after 1-5-2009 and discharge dates on or before 11-1-2011
Heart Failure Readmission Pattern by PAC Site

<table>
<thead>
<tr>
<th>Site</th>
<th>Total PAC Episodes with within 30 days of Anchor STACH</th>
<th>Total # of Re-hospitalizations</th>
<th>% Re-hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTACH</td>
<td>4298</td>
<td>305</td>
<td>7.1%</td>
</tr>
<tr>
<td>IRF</td>
<td>6256</td>
<td>807</td>
<td>12.9%</td>
</tr>
<tr>
<td>Home Health</td>
<td>90,639</td>
<td>14,641</td>
<td>16.2%</td>
</tr>
<tr>
<td>SNF</td>
<td>100,748</td>
<td>21,208</td>
<td>21.1%</td>
</tr>
<tr>
<td>Community</td>
<td>248,337</td>
<td>68,623</td>
<td>27.6%</td>
</tr>
<tr>
<td>Hospice</td>
<td>29,836</td>
<td>563</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

The Moran Group
Source: CMS LDS Standard Analytical Files, 2009 Date Files – Hospitalizations with admission dates after 1-5-2009 and discharge dates on or before 11-1-2011

MCO Re-hospitalization Story

- The Kaiser network in Southern California
- JOC Meeting in Kindred SNF - 2009
- Kaiser doc proudly shares internal Re-hospitalization report:
  - Six months of data on rates of re-hospitalization from SNF to STACH for Kaiser members only
  - Captured Re-hospitalization rates at 3 days, 7 days, and 30 days
  - In that six month period, 110 SNFs sent 7000 patients back to the hospital
  - Re-hospitalization rates varied from 8% to 60%
  - Do the math !!!!
What is a Quality Admission from ACO point of view?

- Communication with referral Center to coordinate patient’s medication, treatment, equipment needs and treatment goals
- RN and physicians available to “catch” the patient (assessment, condition, prognosis, meds, treatments, advance directives, family expectations, etc)
- Therapy availability seven days a week
- Discharge planning begins early with focus on reduced length of stay
- RNs and physicians identify and respond quickly to “changes in condition” to reduce morbidity and re-hospitalization rates
- Smooth transition to home or next site of care
- Patient and family satisfaction

Pioneer ACO: Provider Minimum Expectations Example

- MDs and APCs will either be employed by a group participating in the ACO or will be identified as a “preferred” attending clinician. Both groups will be asked to comply with a set of minimum expectations:
  - Legible discharge summary will be completed within 24 Hours of discharge and sent to ACO Medical Records for scanning into EMR
  - The Discharge summary will follow a predetermined template
    - Complete discharge med list (including pertinent changes and reasons), physical exam changes, pending labs, code status, advance directive status and follow-up plan
  - 24/7 coverage by clinicians who have experience managing patients in the SNF setting who will respond in a timely manner
  - Timely (same day) communication to PCP if unexpected change in patient status occurs
  - Newly admitted patients seen with in 48 hours by physician
  - Use of ACO preferred vendors
  - Will participate in team meetings and family meetings as necessary
  - Will participate in quality and INTERACT or other related readmission reviews
  - Comply with all payer minimum requirements
  - Will review the patients discharge/follow up needs and ensure that follow up care is appropriate and returned to ACO PCP.
Pioneer ACO: Facility Minimum Expectations Example

- Stable staff turnover; minimal use of agency; nursing supervisor on evening and night shifts
- High Quality Mental Health coverage available 7 days per week by phone and see patients within 2 – 3 days for consultation
- Provider credentialing needs to be timely and well communicated
- Same day admission screens and able to accept patient until 9 PM 7 days a week
- Able to accept direct admits from home/ER/clinician office
- Suitable work space for MD and APCs with computer access; internet access; facility PCs permit download of Citrix to enable remote access to Epic
- Facility meets patient expectations regarding food, cleanliness and environment
- Facility meets patient expectations regarding food, cleanliness and environment
- DME is in the patients room prior to arrival when appropriate
- INTERACT (or comparable tool) is utilized and quarterly reports sent to ACO
- Established day/time for team meetings for ACO patients
- Therapies are provided as ordered at least six days/wk. If patient arrives before 2PM, assessment and initial evaluation must be completed and documented on the day of admission
- STAT Radiology, Labs obtained and resulted within 5 hours and prescriptions delivered within 6 hours
- Patients are surveyed regarding their satisfaction and results shared with ACO and have target > 90th percentile
- Patients receive typed list of medications upon discharge, med changes are highlighted and explained
- Adherence to discharge planning checklist

AHCA Quality Initiative
The Goals

- Safely Reduce Hospital Readmissions
- Increase Staff Stability
- Increase Customer Satisfaction
- Safely Reduce the Off-Label Use of Antipsychotics
Kindred Healthcare

$6 billion\(^{(2)}\)
consolidated revenues

2,200\(^{(3)}\)
sites of service,
452 facilities
in 46 states

53,500\(^{(3)}\)
patients and
residents per day

77,800\(^{(3)}\)
dedicated employees,
making Kindred
a top-150 private
employer in
the U.S.\(^{(4)}\)

(1) Ranking based on revenues.
(2) Pro forma revenues for the year ended December 31, 2011 (before
intercompany eliminations).
(3) As of December 31, 2011.
(4) Ranking provided by TMP, Inc.

Kindred’s Service Lines

HOSPITAL
Long-term Acute Care Hospitals
Inpatient Rehabilitation Hospitals

$2.5 billion revenues\(^{(1)}\)
• Largest operator in U.S.\(^{(2)}\)
• 121 LTAC hospitals
8,597 licensed beds\(^{(3)}\)
• 5 IRFs
183 licensed beds\(^{(3)}\)

NURSING CENTER
Nursing and Rehabilitation Centers

$2.3 billion revenues\(^{(1)}\)
• Fourth largest nursing center operator in U.S.\(^{(2)}\)
• 224 nursing centers
27,148 licensed beds\(^{(3)}\)
• 6 assisted living facilities
413 licensed beds\(^{(3)}\)

REHABILITATION SERVICES
RehabCare

$1.0 billion revenues\(^{(1)}\)
• Largest contract therapy
company in U.S.\(^{(2)}\)
• 2,139 sites of service
served through 8,750 therapists\(^{(3)}\)
• 102 hospital-based
acute rehabilitation units\(^{(3)}\)

HOMECARE & HOSPICE
PeopleFirst

$106 million
annualized revenues\(^{(4)}\)
• 51 sites of service\(^{(2)}\)
• 2,100 employees
serving 4,800 patients
on a daily basis\(^{(1)}\)

(1) Revenues for the year ended December 31, 2011
(divisional revenues before intercompany eliminations).
(2) Ranking based on number of facilities.
(3) As of December 31, 2011.
(4) Annualized based on revenues for the three months ended December 31, 2011 (divisional revenues before intercompany eliminations) plus annualized revenues for the Synergy acquisition.
What is the optimal PAC setting for patient placement - Figuring it all out

- Care PRD demonstration project (Uniform Patient Assessment) is working its way through CMS
- At Kindred, we needed a common language and set of definitions to manage referrals and transitions of care
- Began crafting internal language in 2007 via work of Clinical Excellence and Service Line Strategic Planning Committee
- Not an easy task

<table>
<thead>
<tr>
<th>SERVICE LINE SETTING</th>
<th>KINDRED NAME</th>
<th>LONG TERM ACUTE CARE</th>
<th>TRANSITIONAL / SUBACUTE CARE</th>
<th>LONG TERM CHRONIC CARE</th>
<th>DEMENTIA CARE</th>
<th>HOSPICE &amp; PALLIATIVE CARE</th>
<th>OUTPATIENT SERVICES</th>
<th>HOME HEALTH SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Type</td>
<td></td>
<td>Hospital</td>
<td>Nursing &amp; Rehab Center</td>
<td>Hospital and Nursing &amp; Rehab Center</td>
<td>Secured Units in Nursing &amp; Rehab Center</td>
<td>Hospital, Nursing &amp; Rehab Center</td>
<td>Hospital or Nursing &amp; Rehab Center</td>
<td>Community</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Type</td>
<td></td>
<td>Multiple concurrent, acute and/or unstable diseases or overall medical complexity requiring daily physician management and intensive nursing services. (e.g. Vent Patients, Compares, Wound Care, Post surgical complications, etc.)</td>
<td>Clinically complex, but generally stable OR Rehabilitation and recovery from an acute illness or exacerbation of a chronic illness requiring enhanced skilled nursing competencies, therapy interventions and clinical management. (e.g. Recovery from acute Cardiac or Respiratory events or exacerbations, Status post surgery, stroke, fracture, wound, etc.)</td>
<td>Primarily support and supervision of individuals with stable functional, cognitive, or behavioral impairments and/or chronic illness and dysfunction. Emphasis on dignity, socialization and preserving function. Residents generally require months or years of care</td>
<td>Specialized Dementia care, programs and activities offered in a secure, structured environment to emphasize remaining abilities and quality of life, plus routine ADL care</td>
<td>Palliative care and end of life Hospice care with appropriate Psychosocial, Spiritual, ADL support and Pain management. (e.g. Cancer, late stage congestive heart failure and respiratory failure, end stage Alzheimers, etc.)</td>
<td>Primarily rehab provided to patients no longer needing inpatient care for chronic illness or acute event (CVA, fracture, wound, etc.)</td>
<td>Primarily nursing or therapy oversight of individuals able to remain at home or other supervised congregate living arrangement, but requiring nursing or therapy interventions and/or supervision.</td>
</tr>
</tbody>
</table>

* Transitional / Subacute Care CENTERS and Transitional / Subacute Care UNITS are differentiated primarily by “short stay” census in the Center and certain clinical criteria. TCCs will have a minimum short stay ADC of 50 or greater. Short stay = Medicare and Managed Care ADC.
## Kindred Healthcare: Service Line Offerings - Parameters

<table>
<thead>
<tr>
<th>SERVICE LINE SETTING</th>
<th>KINDRED NAME</th>
<th>LONG TERM ACUTE CARE</th>
<th>TRANSITIONAL / SUBACUTE CARE</th>
<th>LONG TERM CHRONIC CARE</th>
<th>DEMENTIA CARE</th>
<th>HOSPICE &amp; Palliative Care</th>
<th>OUTPATIENT SERVICES</th>
<th>HOME HEALTH SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td>Nurse Hours</td>
<td>7.0 – 9.0 PPD</td>
<td>Nurse Hours 3.4 – 5.5 PPD</td>
<td>Nurse Hours 2.9 - 3.4 PPD</td>
<td>Nurse Hours 2.9 - 3.4 PPD</td>
<td>Nurse Hours 2.9 - 3.4 PPD</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Staffing</td>
<td>Resp Hours</td>
<td>1 – 2 PPD</td>
<td>“Activities” Offered 3 to 4 hours/day</td>
<td>“Activities” Offered 4 to 5 hours/day</td>
<td>“Activities” Offered 4 to 5 hours/day</td>
<td>“Activities” Offered 4 to 5 hours/day</td>
<td>Up to 5 X/week</td>
<td>Up to 7 X/week</td>
</tr>
<tr>
<td>Rehab Services</td>
<td>Nurse Hours</td>
<td>Up to 2 hours/day</td>
<td>Up to 1 PPD</td>
<td>Up to 1 hour/day</td>
<td>Up to 1 hour/day</td>
<td>Up to 1 hour/day</td>
<td>As Medically Necessary</td>
<td>As Medically Necessary</td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>On Site x-ray</td>
<td>On or Off Site Lab, x-ray and RX</td>
<td>Off Site Lab, RX Mobile x-ray</td>
<td>Off Site Lab, RX Mobile x-ray</td>
<td>Spiritual, Bereavement Counseling</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Admission Hours</td>
<td>24/7</td>
<td>24/7</td>
<td>As scheduled</td>
<td>As scheduled</td>
<td>As scheduled</td>
<td>9 AM to 5 PM</td>
<td>As scheduled</td>
<td></td>
</tr>
<tr>
<td>Reimburse PPD**</td>
<td>$850 - $2200</td>
<td>250 - $1000</td>
<td>$150 - $250</td>
<td>$150 - $250</td>
<td>$150 - $250</td>
<td>Physician Fee Schedule Payment</td>
<td>Physician Fee Schedule Payment</td>
<td></td>
</tr>
</tbody>
</table>

* Transitional / Subacute Care CENTERS and Transitional / Subacute Care UNITS are differentiated primarily by “short stay” census in the Center and certain clinical criteria. Transitional Care CENTERS will have a minimum short stay ADC of 50 or greater. Short stay = Medicare and Managed Care ADC.

** Inclusive of Managed Care contract Rates and Medicare

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### Transparency in Outcome Metrics at Kindred

**Five Consecutive Years of Publicly Reported Outcomes**
Nursing Center Division
Annual Survey Outcome Metrics

Deficiency Free Surveys

<table>
<thead>
<tr>
<th>Kindred</th>
<th>Nation</th>
<th>For Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.23%</td>
<td>9.28%</td>
<td>11.36%</td>
</tr>
</tbody>
</table>

Higher Scope & Severity Surveys

<table>
<thead>
<tr>
<th>Kindred</th>
<th>Nation</th>
<th>For Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>26.07%</td>
<td>26.57%</td>
<td>26.11%</td>
</tr>
</tbody>
</table>

Aggregate portfolio data as of Dec 31, 2011

Nursing Center Division
% of Annual Surveys with Higher Scope and Severity Tags

<table>
<thead>
<tr>
<th>April 2005 to Jun 2006</th>
<th>Oct 2010 to Dec 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.0%</td>
<td>24.0%</td>
</tr>
<tr>
<td>18.0%</td>
<td>26.0%</td>
</tr>
<tr>
<td>20.0%</td>
<td>28.0%</td>
</tr>
<tr>
<td>22.0%</td>
<td>30.0%</td>
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<tr>
<td>24.0%</td>
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<td>26.0%</td>
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<tr>
<td>28.0%</td>
<td></td>
</tr>
<tr>
<td>30.0%</td>
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</tr>
</tbody>
</table>
Nursing Center Division
AHCA Quality Awards

> 90% of Nursing Center Division Facilities have achieved Bronze Awards since 2003

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

Nursing Center Division
Resident and Family Satisfaction Survey

Would you recommend this Facility?

Percent Excellent & Good Responses on My InnerView Surveys

2006 2007 2008 2009 2010 2011
80.0% 82.0% 85.0% 86.0% 87.0% 88.0%
Do you have a physician strategy?

Considerations:
- Do you view physicians as customers?
- Credentialing
- Privileging
- Open Vs Closed Medical Staff
- Organized Medical Staff
  - Bylaws and Committee structure

Expectations:
- Presence in Facility?
- Rounding with nursing staff?
- Meeting with facility leadership?
- Education and In-services?
- Time lapse until new admissions are seen?
- Family conferences?
- Feedback to Facility leadership?
- Utilization (pharmacy, ancillaries, rehab, etc.)?

Do you consider physicians to be customers?

- Improve physicians ability to be efficient and productive in your facility
  - Work space, phone and computer access, privacy
  - Nursing assistance with patients and charts
  - Consistency of care and communication
  - Productive, interesting & efficient PI meetings
- Offer accurate, complete & concise reporting
  - “Nursing 101” - V/S, CC or SS, appropriate history, Meds and allergies, chart available, call back protocol
- Monthly formal meeting with ED & DNS
  - Voice in hiring of key personnel, equipment needs
  - Consider informal contacts/activities with medical director e.g. fund raising, holiday activities

Do you KNOW what your physicians are thinking?
The overall evaluation of practicing at Kindred Nursing Centers is 4.06 with 76.8% favorable; among the higher rated items – highly correlated with nursing assistance and consistency of medical care.
Physician Satisfaction Trend

Rehabilitation Therapy
Outcome Metrics by Diagnosis
**Transitional Care Strategy**

- Attention to Nurse Staffing and nurse ratios
- Focus on enhanced physician coverage and specialty Medical Directors where applicable
- Development of enhanced Clinical Programs
- EMR Linkages to hospital systems, labs, pharmacy, physicians
- Review of clinical equipment needs
- Focus on therapy services, including respiratory therapy where appropriate
- Review of physical plant and amenities
- Tracking of outcomes

---

**Transitional / Subacute Care**

**Kindred Strategy & Roadmap**

**Skilled Nursing Facility**
- **Transitional Care Center**
  - TCC: > 50 SS ADC
  - Center has achieved at least 50 short stay ADC AND Market capable / Center prepared to accept 70% short stay
- **Transitional Care Unit**
  - PTCU: 40 to 50 SS ADC
  - STCU: 20 to 40 SS ADC
  - Center has achieved at least 20 short stay ADC AND has a dedicated Unit of short stay rooms with adjacent Nursing station
- Short Stay patients scattered throughout Center

**Long Term Acute Care Hospital**
- LTACH
  - Situational Analysis Indicates Need
  - Local Collaboration strong
  - SNF education & understanding
- **Subacute Care Unit**
  - within LTACH

Short Stay (SS) = Medicare and Managed Care admissions. All Kindred Centers utilize our standardized Clinical P & Ps.
Strategy Success
Critical Outcomes by Facility Category
All Payors - Full Year 2011

Patient Volume - Annual Discharges / Fac

ALOS in Days

Functional Outcome Improvement - Adm to DC

Discharge to HOME

ACO - Future SNF Value Proposition

- % Increase Medicare Case Mix Index
- % Increase in Patients Discharged Home
- % Decrease in Average Length of Stay
- % Decrease in 30-day Re-Hospitalization rates
- % Increase in Customer Satisfaction Scores
ACO Conclusion

• More transparency will be the norm and tracking Quality Outcome metrics will be imperative
• More external interest and involvement in our Centers
  – Admission and Discharge Volume will increase and the process must become more efficient, seamless and error-free
  – Length of Stay will be expected to decrease
  – Patient access to RNs and Physicians will be expected to increase
  – Patient access to Rehab will be expected to increase
  – Re-hospitalizations will be expected to decrease
  – EMR linkages will become the expectation
  – ACO Clinicians will expect to meet and dialogue with SNF Clinicians in regard to the achievement of defined outcome metrics and mutual goals
  – Solid regulatory compliance will be the expectation