Welcome to TriHealth

HIMSS
Nicholas E. Davies
Award of Excellence
Case Studies
August 1, 2018





TriHealth At A Glance

- Four acute-care hospitals with 900 adultstaffed beds
- One short-stay surgical hospital
- Three free-standing outpatient surgery centers
- Over 140 outpatient service locations
- Over 150 physician practice locations
- Over 850 employed physicians
- Over 1₁800 physicians on medical staff
- Over 12,000 employees





TriHealth Awards for Clinical Quality Technical Excellence and Employee Engagement























TriHealth Awards for Clinical Quality Technical Excellence and Employee Engagement



Healthcare Information and Management System Society (HIMSS) Analytics Electronic Medical Record (EHR) Adoption Model Stage 7 Awarded to TriHealth July 2014

TriHealth successfully recertified as HIMSS Stage 7 in December 2017



Advanced Quality Outcomes

Presented by:
Lori Baker, MSOL, MSW, LSW
Director Senior Services and Post-Acute
Network
Martha Tillson, R.N., BSN, Manager
Application Solution Center
Barb Dam, R.N., BSN Nurse Liaison for
Post Acute



Local Problem



Over 125 SNF in Cinti market, TriHealth does not own any SNF

Collaborate with highest quality local SNF to achieve triple aim

Capture data was manual in the beginning which was time consuming





Local Problem



Historically data was based on perceived quality and we have moved to actual quality

We wanted to educate patients and team members throughout organization about value of network that was based on quality that was objective

An automated system was needed to track quality to develop and maintain a post-acute preferred provider network









Where We Started

	Jan - Dec 2015
D ischarges to Preferred Providers	unknow n
Post Acute Spend	\$703/m em ber
SNF Expenditure	\$ 17,575,000.00
FTE Expense	\$31 , 250



Update Colorectal as the Perferred Service Line to font 26 to match the other heading. Smith, Diana (Trihealth), 7/22/2018DLS1





AQO measures quality in post-acute for the management and determination of the preferred provider network that is based on objective quality data by:

✓Monthly onsite contact with SNF and Educational Programming to share best practice every 6-9 weeks- attended by nursing leaders at SNF. Video-taped for education of all team members a SNF

√Open discussions with all members of the treatment team to share data to improve network utilization

✓AQO Monthly Meetings with SNF and HC to share best practice communicate efforts, and share overall outcomes of the data

✓ Documentation within EPIC of quality metrics by disease for all patients discharged from TriHealth to SNF or HE_data_____

Workflow and Solution Design

Governance

Implementation



- Multi-disciplinary team leverage physician leadership team
- Matrixed partnership with clear goals and objectives for the program

• Guiding principles to leverage core systems

- Standardized documentation
- Scalable architecture
- Discrete data for reporting quality and compliance

Solution Design

Logistics

- Training and support
- Report cards for communicating performance

Barriers and **Challenges**

> Legal barriers: **HIPPA** requirements

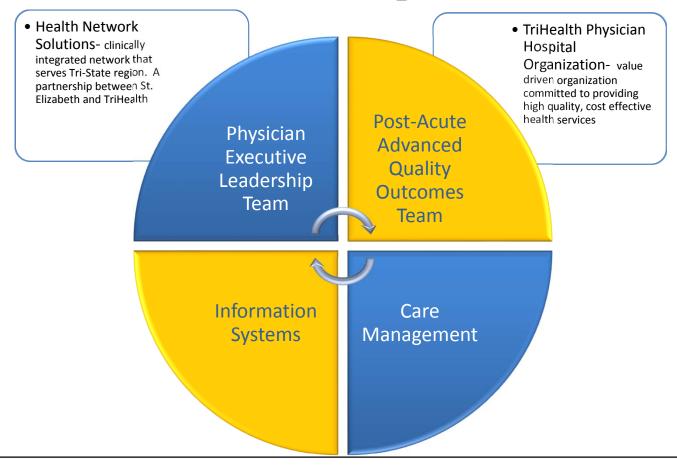
- High turnover at **SNFs**
- Connectivity to TH **EMR**





Importance of Team in Decision Making





Multiple Teams work together for the development and ongoing management of the TriHealth Preferred Provider Network





Intended Project Outcomes



- Increase communication with SNFs and Home Care partners
- Increase documentation compliance
- Decrease readmissions from SNFs
- Improve utilization of preferred partners who demonstrate better quality outcomes
- Increase shared savings

Move from an environment of perceived quality to data driven quality performance for our patients





Process for Workflow Developm



Review existing workflows with SME

Create mechanism to restrict patient access

Create discrete documentation tools

Determine mechanism for login to TH Epic

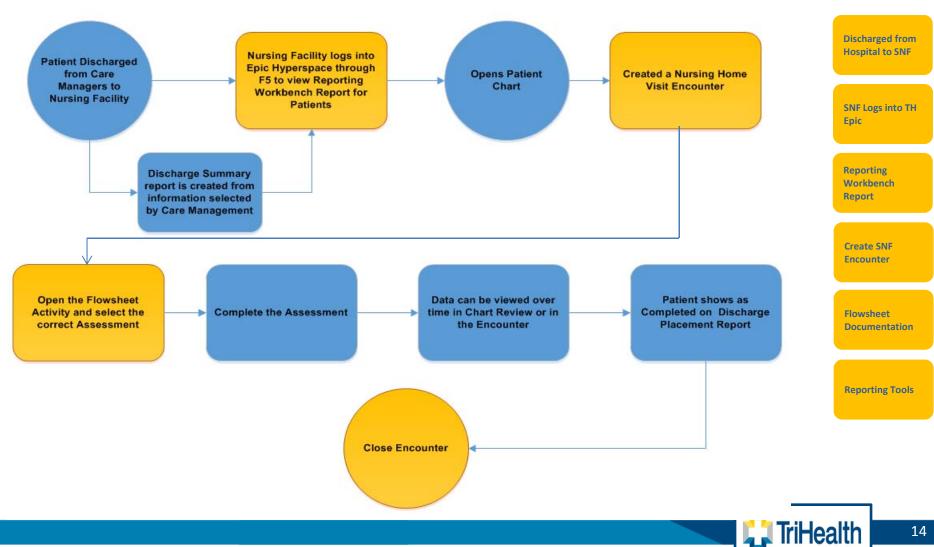
Workgroup utilized to:

- Validate content
- Review and approve workflows
- Establish metrics of success.
- Communication of workflow and expectations to SNF



Clinical Workflow



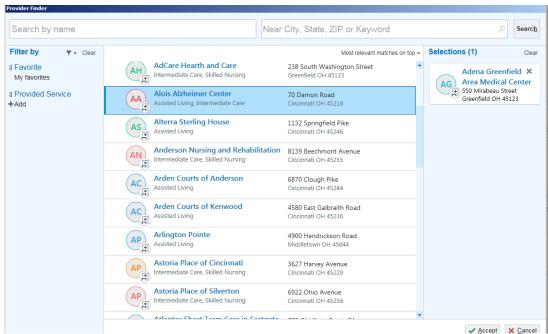




Clinical Workflow - Social Worker/Care M



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Discharge Planning					
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	☐ Independent Livi	in Homeless	Group Home	Hotel	Acute Rehab
Has Patient Resided in ECF, LTAC, SNF, Nursing Home or Rehab Hospital in Past 3 Months?	Ves No ✓ Discharge Plannii Provider F				



Discharged from Hospital to SNF

SNF Logs into TH Epic

Reporting Workbench Report

Create SNF Encounter

Flowsheet Documentation



IT Helps Make Documentation as easy



Discharged from Hospital to SNF

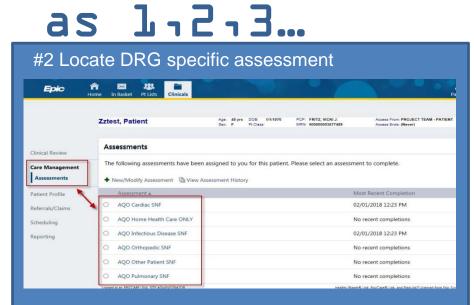
SNF Logs into TH

Reporting Workbench Report

Create SNF Encounter

Flowsheet Documentation





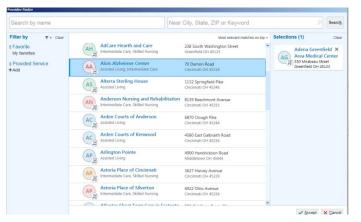
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Clinical Workflow - Skilled Nursing Faci





Solution design:

Social Worker selected facility at discharge establishing patient

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Discharged from Hospital to SNF

SNF Logs into TH Epic

Reporting Workbench Report

Create SNF Encounter

Flowsheet Documentation



New Encounter for Zztest, Ago

3/22/2016

Nursing Home Visit

PCP, PENDING ONLY

TH DOVERWOOD SNF

Accept

Date:

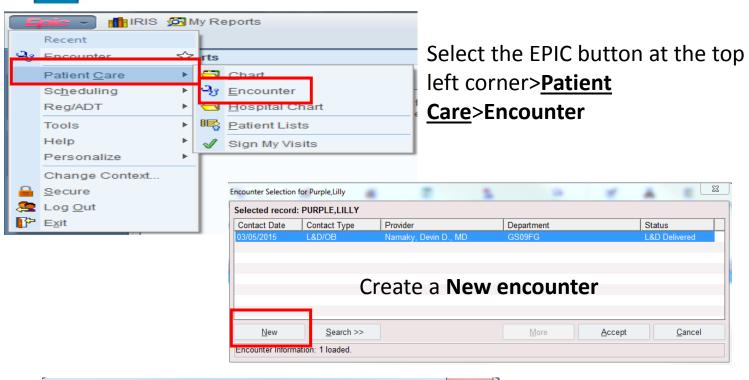
Type:

Provider:

Department:

Clinical Workflow - Skilled Nursing Faci





PCP

Cancel

•

Select Nursing home visit as type. Facility name will appear in the department field

Discharged from Hospital to SNF

SNF Logs into TH Epic

Reporting Workbench Report

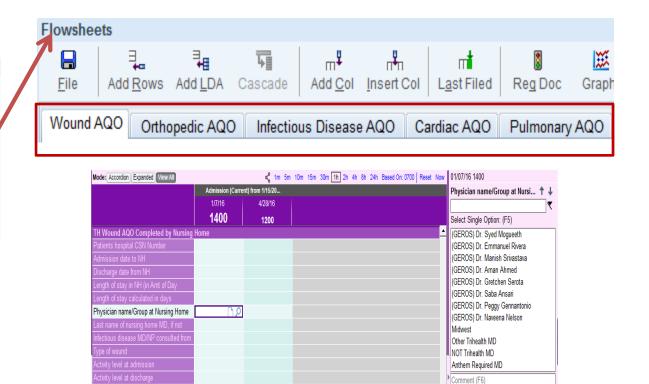
Create SNF Encounter

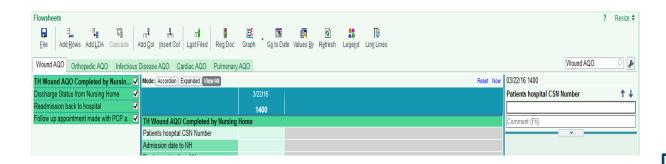
Flowsheet Documentation

Clinical Workflow - Skilled Nursing Faci















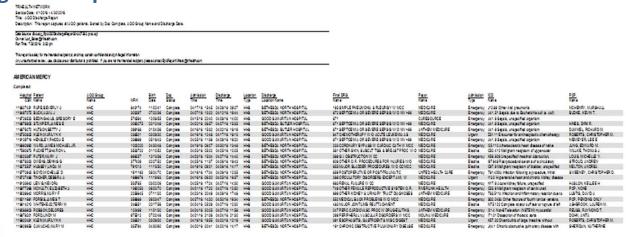
Clinical Workflow - Skilled Nursing Facility



Emailed Excel Report

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Epic Integrated Report



Discharged from Hospital to SNF

SNF Logs into TH Epic

Reporting Workbench Report

Create SNF Encounter

Flowsheet Documentation



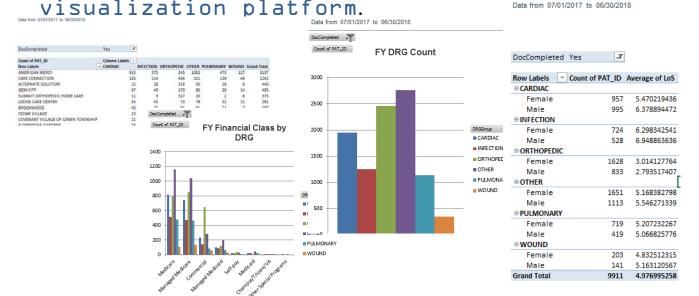


Clinical Workflow - Skilled Nursing Faci



Advanced Analytics

- Over 356 discrete data points available.
- Single report combines both hospital and SNF/HC data.
- Refreshes daily.
- Can pull data from any date range.
- Can be displayed in nearly any visualization platform.



Discharged from Hospital to SNF

SNF Logs into TH Epic

Reporting Workbench Report

Create SNF Encounter

Flowsheet Documentation





EpicCare Link Login Requ<mark>it Tools</mark>



- The SNFs fill out a Login Request form. They either get this on the EpicCare Link website or we email them a blank copy.
- Form is completed and faxed back or securely emailed
- Identity Management team builds EMP record
- EpicCare Link team adds in Site Specifical Site Reports into Epic and activates record in PRD
- EpicCare Link contacts user with login information
- Users login using dual authentication through



EpicCare Link Site Verification



- Every AQO site has a Site Administrator that can deactivate users at any time
- Per our Security Policy every year the Site
 Administrators are required to verify all users at their site
 Site verification is due. Please verify the list of users is accurate.

Verify Now Verify Later

- Once AQO site is verified it falls off our report to follow up on requirement.
- If requirement is not met after 30 days than all access at site is eliminated.
- In addition, site administrators notify our Information Systems Service Center to terminate team



How is the Preferred Provider Network Determined?







Submitted Quality Data thru AQO •Source: Epic-SNF Scorecard results of disease specific quality measures/utilization •Source: Epic-SNF Length of Stay in SNF •Source: Claims data, Epic-SNF Direct readmission rate/ED (30 days) •Source: Epic-SNF CMS CJR Navigant Data •Source: Claims data CMS MSSP HSN Data Source: Claims data/all diagnoses Geographic areas •Source: Network adequacy IBM Modeler High Risk for Readmission •Source: Epic TriHealth



Sharing Performance SNF and HC



	OTHER Advance Q	uality Out	tcome Sco	recard				
	Goal of SNF vs. the SNF in Region	Project Status	Score	Total Points for SNF (based on points possible)	Points Possible	Comparison SNF in Region	Overall Scores of Collected TriHealth Data from SNF	
Total % of OTHER Readmissions to Any Hospital (Defined as patient had primary diagnosis of ortho DRG. Then readmitted to ANY hospital for ANY reason within 30 Days of the Ortho original DRG (Based on EPIC documentation from SNF)	Goal to be Lower		5%	5	5	18.55%	22.95%	
# ED visits (counted as patient was sent to ED and RETURNED to SNF same day)(Based on EPIC documentation from SNF)	Goal to be Lower		0%	3	3	4.03%	5.46%	
Average Length of Stay all OTHER (Based on EPIC documentation from SNF)	Goal to be Lower		15.72	5	5	17.6	18.35	
HSN CMS Data (July 2016- June 2017) ALL Patient LOS	Goal to be Lower		16.30	4	4	20.00	20.00	
HSN CMS Data (July 2016- June 2017) ALL Patient Total Cost	Goal to be Lower		\$7,302.01	4	4	\$9,378.00	\$9,378.00	
HSN CMS Data (July 2016- June 2017) ALL Patient ED Visits (30 Days)	Goal to be Lower		3.57%	4	4	7.19%	7.19%	
HSN CMS Data (July 2016- June 2017) ALL Patient Readmission IN-DIRECT (during 30 day episode)	Goal to be Lower		10.71%	4	4	14.36%	14.36%	
% of TriHealth/ GEROS as Primary Care In SNF	Goal to be Higher		55%	0	3	77.6%	75.07%	Γ
Total # Transfer at Admission	Goal to be Higher		6.1	0	1	6.02	6.22	L
Total # Transfer at Discharge			4.1					
Total Change in Transfer	Goal to be Higher		2	0	1	2.1	1.87	
Endurance/Activity Level at Admission	Goal to be Higher		5.95	1	1	5.95	6.27	
Endurance/Activity Level at Discharge			4					L
Total Change in Activity	Goal to be Higher		1.95	0	1	2.07	1.86	
Bisphosphonate Medications - Patient would benefit and med NOT started/ Pt Not on med			nla					
Average UTI	Goal to be Lower		5%	1	1	7.26%	11.54%	
Average Fall Score	Goal to be Lower		35%	0	1	19.20%	18.07%	
Management of Pain	Goal to be Higher		1.05	1	1	0.76	0.61	
Utilization of Preferred Providers for Home Care	Goal to be Higher		75%	0	3	80.00%	37.48%	
PCP Appointment Made Prior to Discharge	Goal to be Higher		100%	2	2	77.78%	78.36%	
Based on IBM Readmission Modeler, $\%$ of patients that were high risk for readmission.	Goal to be Higher		7.59%	0	2	15.82%	15.82%	
Total Points				34	46			
Project Statu	s Indicator Key							Г
	Above the averag							
	At average for rep							
	Below average for	r reportin	g SNF					

- On a Yearly Basis and Quality and Utilization data is shared with the SNF and HC.
- Comparison data is also shared to understand where there are opportunities to improve and where

they are
Datatperforming
repented in their
• Marketd HC in
TriHealth EMR/

EPIC

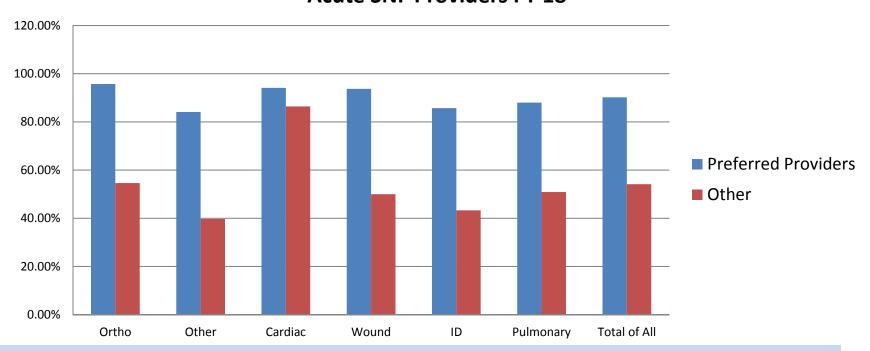


data





Documentation Completion Rate by Diagnosis Category for Post-Acute SNF Providers FY 18



Post-acute Providers submit quality and utilization documentation within EPIC by disease category through secure web-based portal. **Preferred provider data demonstrates more engaged participation**

Source: EPIC

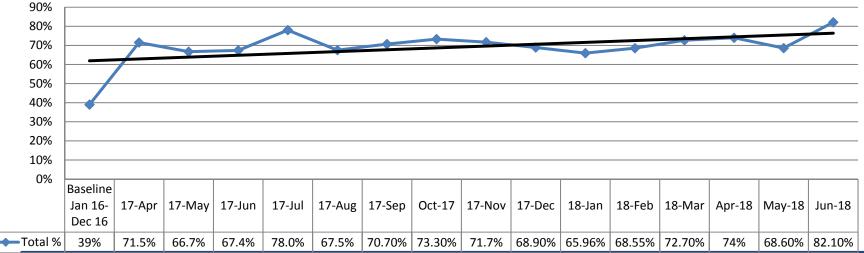




Utilization of SNF Preferred Provider Network







- 1. Developing educational document of value of preferred providers
- 2. Having CM document why network not selected- to ensure we are meeting community needs and that SNF Preferred Providers are taking all patients
- 3. Educating all areas about the performance of the



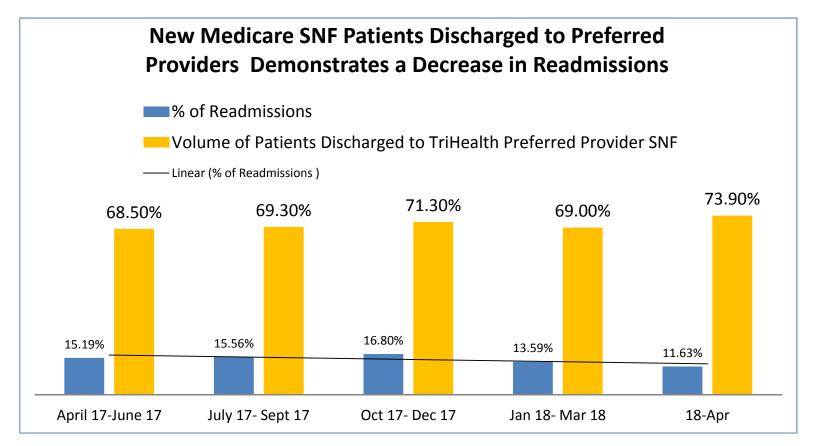


Decreasing Readmissions As the % of patients discharged to Preferred Provider SNF Increased,



TriHealth

As the % of patients discharged to Preferred Provider SNF Increased, Readmission Rates decreased Data Source: EPIC data warehouse



Our Preferred Providers had a 8.7% lower readmission rate than the CMS National Average demonstrating lower than the National Average readmission costs

Patient educational Tool – The Why

Striked nursing facilities designated as Centers of Advanced Quality Outcomes demonstrated lower rates of infection as compared to other facilities along with the following

 Medical condition
 Length of stay
 Readmission rates

 Orthopedics
 1.8 days shorter
 5.75% lower

 Pulmonary
 0.9 days shorter
 9.86% lower

 Advanced wound care
 0.3 days shorter
 18.56% lower

 ardiac
 3.3 day shorter
 4.95% lower

Results a red on data collected during 2017-2018.

Let's prepare you for your short stay in skilled nursing care:

You are getting stronger and your goal is to get back to your prior functioning as soon as possible. That is our goal for you too! There are some differences between hospital and skilled nursing care that include:

- You can expect to do more activities on your own.
- You will have less team members assisting you with your daily routine (remember you are getting stronger and this is GOOD! It will help get you back to your routine sooner).
- Doctors are available but not in the facility at all times. Your treatment team will ensure
 they are kept informed and reached, when needed. Changes in your condition will be
 promptly reported to your doctor. Many conditions can be treated right in the skilled
 facility without the need to transfer to the hospital.
- How long you will stay will depend on your personal progress and goals that are set by the treatment team.

What to bring:

- Three to five (3-5) sets of clothes (shorts/pants, shirts, undergarments, gymishoes, socks)
- Any equipment you used prior to your hospital stay (cane, walker, wheel chair)
- · Copies of Health Care Power of Attorney, Insurance Cards
- Glasses, hearing aids, cell phone/IPad

Inpatient care coordinators

Bethesda Butler Hospital 513 893 8095

Bethesda North Hospital 513 865 1122

Good Samaritan Hospital 513 862 2567

Mc Outlough - Hyde Memorial Hospital | TriHealth 513 524 5492

TriHealth Evendale Hospital 513 853 1868



TriHealth.com



Let's get you back to your daily routine.

Together, we'll work to improve your health.

The road to recovery doesn't have to be traveled alone. TriHealth Institute specialists, hospitalists, geriatric physicians in post-acute and primary care physicians, in collaboration with other medical professionals within TriHealth, developed the Advanced Quality Outcomes Program to measure quality care in skilled nursing facilities in the followings pecialties:

- Orthopedics:
- · Pulmorary
- Advanced wound care
- + Cardiac
- + Infectious disease

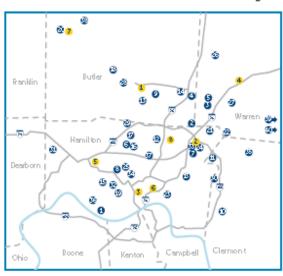
Pacilities designated as Centers of Advanced Quality Outcomes have to meet strict standards of care including:

- Centers for Medicare and Medicaid (CMS) star rating of 3 or above
- · Reduced patient readmission rates
- Improved patient recovery.
- Low rate of infection

Educating Patients about preferred providers

Centers of Advanced Quality Outcomes

Post-acute Network for Skilled Nursing Facilities



- 1) Beithesda Blutler Hospital
- Beithesda North Hospital
- Good Samaritan Hospital
- 🐠 Beithesda Arrow Springs
- Good Samaritan Western Ridge
- 🏮 TriHealth Rehabilitation Hospital
- McCullough-Hyde Memorial Hospital | Tri Health
- 8 TriHealth Evendale Hospital

KEY

- Al: Aetha Medicare Advantage
- B: Anthem Medicare Advantage
- C: Humana Medicare Advantage
- D: Molina
- E: UnitedHealthcare Medicare Advantage
- F: CareSource

Butler County (OH)

- Ohesterwood Village 8073 TylersvilleRoed West Chester, OH 45069 51 3777 1400 A BC D E
- O Dovenwood Village 4195Hamilton-Mason Road Hamilton, OH45011 51,3888,2866 BC D E
- Heritagespring of West Chester 7235Horksgepring Drive West Chester, OH 45069 SL 37 29 5777 24 Hour AdmissionLine SL3 337 5460 BC DE
- 3 James towne 1571 Main Street Hamilton, OH45013 5157854800 D F

- The Knots of Oxford
 6727 Contrers Road
 Oxford OH 45056
 5135247990
 A B C D E
- Residence at Huntington Columb 350 Hancock Avenue Hamilton, CH 45011 513 663 4216 BC DE F
- Tri County Extended Care 5300 Camelot Dr Fair field. OH 45014 513 #25 #3100 A B C D E F
- Woodland Country Manor 4166 Somerville Road Somerville, OH45064 513 52344449

Clermont County (OH)

- Eastgales pring of Clincinna ti 4400 Glen Este With annexille Road Cindinna 8, 0H 45345 513 752 3710 24 Hour Admission Line 9,3543 8810 B C D E
- 409 WardsCorner Road Loveland OH4 940 513 6301140 A BC D E F
- SEM Haven 225 Cleveland Avenue Milford, OH4 \$1 50 \$13 34 81 270 C D
- Veine tians Gardens 1650 SateRoute 28 Loveland OH4 940 513 722 0700 AC DEF

Clinton County (OH)

Laurels of Blanchester
 839 Cherry 9:
 Blanchester, OH 45107
 937 7834911
 A B C D E F

Hamilton County (OH)

- Bayley
 990 Bayley Drive
 Cindmat . OH 45253
 \$13 347 5500
 ## C D E
- Brookwood Retirement 12:00 ReadHartman Highway Cindinnati, OH 45341 513 605 2000 A B D E F
- Christian Village at Mit. Healthy 9097 Hamilton Avenue Cindinest. OH 45231 913 931 9000 C. D.
- Ocur tyard at Seasons 7100 Dearwester Drive Cindinneti. OH 45296 513 364 727 3 A.C. D.E.
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- (2) Glendale Place Nursing & Rehab Center 779 Gendale Milford Road Cindrast. OH 452L5 S13 771 1779 0 BC DE
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- The Home at Hearths tone 9029 Hamilton Avenue Cindmati. OH 45251 913 921 2700 C D E F

- 464 SpringdaleRoad Choinnest, OH4 5251 513741 4888 A B C D E F
- Judson Care Center 2575 Harrison Avenue Chrismelli OH4 5211 513662 5880 C. D.E.F.
- Lodge Nursing & Rehab Center 9570 Union Camatary Road Loveland CH45340 535677 4900 Hour Admission Line 513 9266 957 A BC D E
- Marjorie P. Lee Community 3550 Shaw Avenue Cincinnati, 0H4 508 513 553 9014 0 RC DEF
- MeadowbrookCare Center 82t1 Weller Road Circinna6, 0H4 5242 513489 2444 A C DE
- Ohio Living Llanfair 1701 Banair Avenue Choinnati, OH4 5224 513681 4230 R D F
- Sanctuary Pointe Nursing & Rehab Center 11:91 Hamilton Avenue Chairnest, OH4 5231 51:364 87000 A B D E
- Shawneespring of Harrison 10111 Smoreon Road Harrison, OH 490 90 513 967 7780 34 Hour Admission Line 51 3 314 4064 BC DE
- Terrace View Gardens 5904 North Band Road Cincinnati, 0H4 521 515481 2201 C D E F
- Twin Lakes at Montgomery 9840 Montgomery Road Cincinneti, OH4 5842 515 247 1 300 A D

- Twin Towers

 5345 Hamilton Avenue
 Cincinnati OH 45234
 513 853 2000
 0 C D F F
- Wells pring Health Center
 8000 Evergreen Ridge Dr
 Gindnraß, OH 452,5
 513 655 5384
 0 C E
- Western Hills Retirement Village 6210 ClovesWarsaw Pike Cinchnatt CH 45233 33 941 0039 A B C D E

Highland County (OH)

Daure's of Hillsboro
175 Chilliothe Ave
Hillsboro, OH 49, 33
937, 393,1925
A B C D E F

Warren County (OH)

- Sector Village 5467 Codor Village Drive Mason, OH 45040 513 754 3100 A BC D E
- S Christian Village at Mason 411 Western Row Road Cincinnati OH 45040 513 398 1496
- Lovetand Health Care Center
 Sti North Second Street
 Loveland OH 49.40
 states second
 D E F
- Otterbein Lebanon SSS North SateRoute 741 Lebanon OH 450 35 S13 932 2020 BC D F
- Otterbein Maineville 201 Marge Schott Way Maineville OH 45029 513 583 5161 A B D F





Type Provider	Bisphosphonates needed and not started (goal lower) (source: EPIC)	Fall Prevention (goal lower) (Source: EPIC)	Falls tx to hospital for treatment (goal lower) (source: EPIC)	Readmission rate (source: HSN MSSP Data 30 day readmission)
Preferred Provider	6.3%	9.2% falls	1%	12.8%
Other	13.9%	12.2% falls	4%	14.72%

Additional Metrics collected from EPIC on Preferred Providers:

- ✓ SNF preferred providers managed pain significantly better than others
- ✓ Avg. of 73% of time MD appointment made prior to d/c from SNF
- ✓ 33.4% better management of pain

Source: EPIC

7/1/17-3/30/18





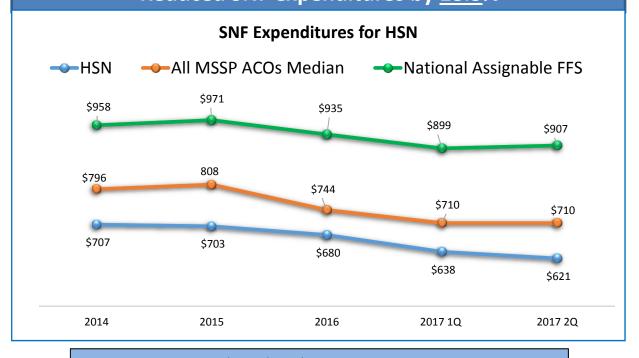
Performance of Demonstrated Post-Acute Results



2016 SHARED SAVINGS PARTICIPANTS

In 2016, 134 (31%) ACOs achieved shared savings.

* Reduced SNF expenditures by 18.3% *





- ✓ Post acute spend
 CY 2015 \$703
 CY 2016 \$680
 CY 2017 Q2 \$621
 Savings \$1,757,000
- ✓ SNF total cost decreased to almost \$300 per member compared to CMS

Source: HSN 2017 Final Benchmark Report Note: the All MSSP ACO trend is $\underline{\text{median}}$.

*between benchmark year #3 (BY3) and performance year 2016 (PY16).





Overall Project Outcomes



	Jan- Dec 2015	Jan- Dec 2016	Jan- June 2017
Discharges to Preferred Provider SNF	unknown	39%	82%
Post-Acute Spend	\$703 / member	\$680/ member	\$621/ member
SNF Expenditure	\$17,575,000	\$17, 050,000 (svg \$525,00 from 2015)	\$15,525,000 (svg \$1, 525,000 from 2016)
FTE Expense	\$31,250	\$15, 625	\$0



2 Year Soft & Hard ROI for AQO



Reduced SNF Expenditure \$2,050,000

Reduced Labor Expense \$46,875

Reduced Readmissions
7%
Cost Avoidance*
\$481,248

Total ROI \$2,578,123

**TH average cost per readmission/all readmissions SOURCE: TH Decision Support Financial Data Warehouse





Keys to Success



At TriHealth, there is a strong culture of partnership between all team members. The ability to work successfully in complex multidisciplinary teams by valuing everyone's contribution is critical to the success our initiatives

Culture of Partnership

At TriHealth, Information
System is considered part of
the care team. There is a
close relationship between In
and Clinical Operations

Information Systems is part of the Care Team Keys to Success Collaboration, on-going education, regular communication and a spirit of true partnership with the SNFs for improved care for our patients is paramount

Partnership SNF





Lessons Learned



- Explain the why of the value of the network to the entire organization involving all stakeholders to achieve strong results
- Continual process improvement is critical to success
- Meet in person with inpatient care management monthly for ongoing opportunities to improve results and share wins.
- Measure and report outcomes to the entire organization monthly including wins and opportunities to move results
- Quarterly share with each SNF/HC their performance and comparison data of the top performers to push all SNF/HC to improve utilization and quality and have monthly meetings to engage/ inform SNF/ HC
- Meet regularly with Preferred Providers to show successes and opportunities to improve. This is very helpful is driving performance of our SNFs
- We realized from SNFs that we needed to do internal education about what each SNF could/could not do- Don t



What's Next



TriHealth

Data Analytics

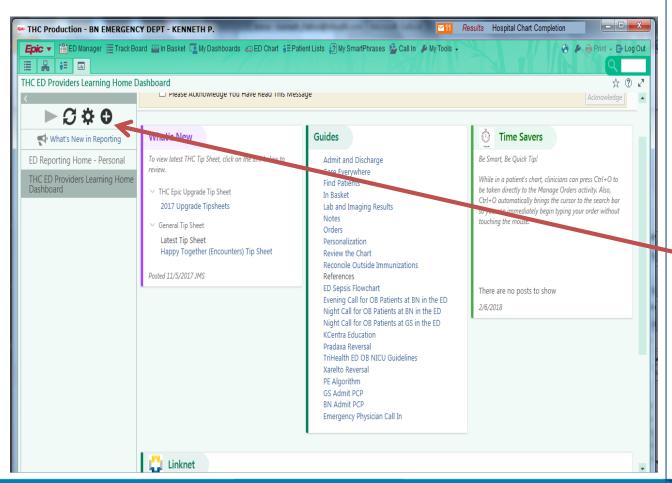
 Claims data into Caboodle will allow us to automate the generation of annual quality report cards

Continue Education Programs

- RN visits SNF and HC meeting with key clinical team members to
 - Communicate and enhance best practices
 - Clinical education to decrease readmissions/ED visits
- Educational programs ¬ organize¬
 coordinate¬ arrange video¬ speaker set μp

Improving Care and Reducing Avoidable SNF Admissions/Readmissions





Problem: During a recent ED Education between TH ED and SNF it was discovered that there was an opportunity to improve communication and knowledge of TH Team members about SNF capabilities

Solution:

- Task force of ED nurses, doctors, AQO Nurse, and SNF representatives to find better ways to communicate
- Educational tool created to be loaded to ED dashboard about SNF capabilities by location

Next Steps:

 IMPACT transfer document to align all SNF to using same information when transferring patients to TH



AQO Recognition



- Winner QSS Mission Award for post-acute
- Nomination for the Dr. Richard Smith Leadership in Quality Award (Health Collaborative)





Wrap Up



Problem

No affiliated SNF
Population Health - VBC
Need to lower cost/improve quality
Perceived quality
Vs. Data driven qualit

Design

Leverage core systems
Control patient access
Clinical end user
involvement
Strong clinical governa



IT Tools

Identify patient population at discharge
Reporting Workbench Access
Standardized & discrete documentation
Reporting



<u>Value</u>

Reduced Readmissions
Reduced SNF Spend
Improved Quality Outcomes
Reduced cost for manual
entry





