THE POWER OF ONE -

Effective Care Transitions

ACO Expo / Ft Lauderdale, FL
January 15, 2015

Kindred Healthcare
Dedicated to Hope, Healing and Recovery
The Nation’s Leading Provider of Post-Acute Care

The Nation’s Largest, Fully Diversified Post-Acute and Rehabilitation Care Provider

Providing Integrated Post-Acute Care in Local Communities

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.

Kindred is 63,300 dedicated employees taking care of 62,600 patients and residents every day in over 2,200 locations in 47 states.

Our Management Philosophy
At Kindred, we believe that if we focus on our people, on quality and customer service, our business results will follow.
What is a Transitional Care Hospital?

Kindred Hospitals are transitional care hospitals.

Transitional care hospitals are:

• Licensed as acute care or specialty hospitals
• Certified by Medicare as long-term care hospitals
• Reimbursed by Medicare under a PPS/DRG system
• The Joint Commission is the accrediting agency for transitional care hospitals
TRANSITIONAL CARE HOSPITALS

- 10 sites of service in Florida
- 5 sites of service in south Florida
What Do Transitional Care Hospitals Provide?

• Aggressive, specialized interdisciplinary care to medically complex patients who require extended recovery time.
• 24-hour physician support and the ancillary services found at an acute care hospital, including laboratory, radiology, operating or procedure rooms, high acuity units, special care or intensive care units (ICUs) and telemetry units.
• Care for very ill patients with few care options left; they come to us because they require the aggressive, specialized care and prolonged recovery and are unable to recover completely in the short-term setting.
Who are LTAC patients?

The majority of our patients are admitted after a stay in a short term hospital, often from intensive care and step-down units. Kindred Hospitals specialize in caring for patients with:

- an average length of stay of 25-30 days
- three to six concurrent active diagnoses and an acute episode on top of several chronic illnesses and co-morbidities that cannot be treated effectively at an alternative level of care
- multiple acute complexities as determined by a physician assessment and subsequent documentation requiring daily physician intervention
Common Misconceptions

Transitional care hospitals are not:

chronic care
skilled nursing facilities
acute rehab facilities
short-term acute care hospitals
LTAC patients have at least 20 Diagnoses with similar Apache scores to ICU patients

![Graph showing Apache III scores distribution by facility.]

**APACHE III**

- **Mean**: 41.64
- **Median**: 41.89
- **Mode**: 44.22
- **Stdev**: 5.36
- **Min**: 28.90
- **Max**: 54.42

**Count of Kindred Transitional Care Hospitals:**

- **Kindred Patients**: 42
- **STAC ICU Patients**: 45
Why Post-Acute Care is an Important Part of the Evolving Healthcare Marketplace

Demographics and Demand for Post-Acute Services are Growing

- Aging Demographics
- Post-Acute Utilization
- Increasing Incidence of Chronic Disease
- Imperative to get Patients Home More Quickly and to Coordinate Delivery of Post-Acute Care Services

Post-Acute Care is a Critical Part of Quality Improvement and Patient-Centered Care

- Customer Satisfaction
- Quality Outcomes
- Care Coordination across Sites of Care
- Reduce Hospital Readmissions
- Establish Provider Networks to Support a Continuum of Care

Post-Acute Care Can Help Reduce Costs in a Rapidly Changing Payment Environment

- Value-Based Purchasing
- Readmission Penalties
- Episodic / Bundled Payment
- “Accountable Care” and Risk Payments
For more information, visit www.kindred.com.
Home Health - A Valuable Clinical Resource

ACO Expo / Ft Lauderdale, FL
January 15, 2015

An Affiliate of

Senior Home Care
An Affiliate of Kindred at Home

An Affiliate of

Kindred at Home
Kindred At Home Vision, Mission and Goals

Our Vision
To be the provider of choice for delivering care in the home, leading on quality, efficiency and growth.

Our Goals
- Deliver exceptional patient care and outcomes through highly skilled, compassionate clinicians, leading practice standards and new services.
- Achieve operating consistency and the highest level of field support, through best practice processes, training and information sharing.
- Serve more patients and touch more lives, bringing hope, comfort and recovery to patients and their families.

Our Mission
To help patients remain at home and in their own communities, surrounded by friends and family, while receiving the highest-quality, most compassionate home-based care possible.

Senior Home Care
An Affiliate of Kindred at Home

Mission, Goals and Values
Senior Home Care, an Affiliate of Kindred at Home offers **State-Wide** Home Health Coverage
Kindred and Silver State ACO

KINDRED BECOMES STRATEGIC PARTNER AND OWNER IN ACCOUNTABLE CARE ORGANIZATION IN LAS VEGAS, NEVADA

- Silver State has secured the participation of approximately 150 primary care physicians and other healthcare providers covering more than 10,000 lives. An ACO is formed by groups of doctors, hospitals, and other healthcare providers to deliver coordinated high-quality care to their Medicare patients.

- Silver State will partner with Kindred’s Care Management Division to more effectively manage the patients’ experience across the entire episode of care through a population health model.

Press Release May 5, 2014:
www.kindredhealthcare.com/integrated-care-markets/las-vegas/las-vegas-aco/
Creating Value for the Patient and the Referral Source

- Reduce Avoidable Re-Hospitalizations
- Better Patient Outcomes
- Improve Patient Satisfaction
- Enhanced Communication with multiple providers

Home Health – A Valuable Post-Acute Partner
Clinical Services available with Senior Home Care

- Transitional Care for High Risk Patients
- Behavioral Health
- Balance/ Fall Prevention Program
- Diabetes Mgmt
- Wound Care & Mgmt
- Movement Re-Training/ Neurology
- Lymphedema Treatments
- In-home infusion
- Physician Portal for immediate access to EMR

BRINGING COMPASSIONATE CARE HOME
Your Focus is Our Focus at Senior Home Care

Better Patient Outcomes

Patient-Centered Care

Improved Patient Satisfaction

At Reduced Cost
Evidence-Based / Patient-Centered Care

- Prompt in-home assessments following referral
- Holistic approach to total-person care
  - Medication reconciliation in home
  - Family dynamics accounted for when educating
- Use of Patient Educational materials (Lippincott)
  - Accounting for patient literacy
  - Red Flags or Zone Tools for symptom recognition
- 24/7 clinical coverage
- Linkage to Community Resources when needed
- Coordination with other providers
Education on Physician & Staff on Medicare Billing Opportunities

• Care Transitions Management Billing
  – Inception 1/1/13
  – For Moderate or High Risk patients
  – Covers initial 30 day period following Acute hospital or skilled facility stay

• Home Health Certification or Recertification billing

• (new) Complex Care Mgmt
  – Per Beneficiary/Per Month
  – Reimbursement for oversight of patients with chronic condition (does not require MD office visit)
# Easy Referral Process

<table>
<thead>
<tr>
<th>From a Hospital</th>
<th>• <em>Order Senior Home Care</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>From Physician Office</td>
<td>• <em>Call your local Senior Home Care Office</em></td>
</tr>
<tr>
<td>From ALF/SNF</td>
<td>• <em>Write order for Senior Home Care</em></td>
</tr>
</tbody>
</table>
Mick Nemet
AVP/Sales for Florida
Mick.Nemet@SeniorHomeCare.net
305.900.8976