The Role of Percutaneous Cardiac Assist Devices in Advancing Accountable Care in High-Risk Heart Failure Patients

NAMCP Spring Forum
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Presented By:
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David Gregory, Partner, Presscott Associates (ParenteBeard)

Today’s Agenda

• Introduction to Ochsner and Presscott
• Review the burden of heart failure in the U.S.
• Discuss how percutaneous cardiac assist devices (pVADs) work
• Offer a case study to define the clinical value of pVADs in specific populations
• Explore pVAD value in a managed care and ACO context via a budget impact model
• Conclusions
Ochsner Health System

- Southeast Louisiana's largest non-profit, academic, multi-specialty, healthcare delivery system
  - 8 hospitals
  - 38 health centers
  - 860 multi-specialty physician practice
- Employs more than 13,000 employees, over 850 physicians in over 90 medical specialties and subspecialties and conducts over 300 clinical research trials annually
- Recognized as an Accountable Care Organization
  - Medicare Shared Savings Program Participant
  - Cigna Collaborative Accountable Care Organization

Ochsner Awards and Recognitions

- 2012-13 U.S. News & World Report Best Hospitals: Cardiology and Heart Surgery departments
- Only Louisiana hospital recognized by U.S. News and World Report as a “Best Hospital” across 11 specialty categories
- Healthgrades #1 ranking in Louisiana for Overall Cardiac Services, Cardiology Services and Coronary Interventional Procedures
- Consumer Choice for Healthcare in New Orleans for 16 consecutive years
- Named in 2011 Thompson Reuters as Best Hospitals in the U.S.
The Burden of Heart Failure

- More than one in three American adults have at least one type of cardiovascular disease\(^1\) and it is the leading cause of death in the U.S. for both men and women.

- Recent estimates of the total burden of cardiovascular disease equate to $312.6 billion in annual combined direct and indirect costs\(^1\).

- Heart failure is one of the main causes necessitating acute hemodynamic support.

- Acute heart failure is a leading reason for medical readmissions in the Medicare\(^2\) and commercial populations\(^3\).

- These heart failure patients typically have unstable hemodynamic profiles which have clinical and economic implications to payers and providers alike.

Impella 2.5

TandemHeart
Current Clinical Guidelines

- 2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention. JACC 2011
  - High-risk patients (section 5.6) Class IIb
  - PCI and Cardiogenic Shock (section 5.2.3) Class I

  - STEMI and Cardiogenic Shock Class IIb
  - STEMI and urgent CABG Class Ila

  - Acutely decompensated heart failure patients: Class Ila

  - Temporary mechanical support for patients with multi-organ failure: Class I

- These guidelines do not yet incorporate results from PROTECT II, USpella, or RECOVER I publications due to timing

High-Risk PCI Cases

- JP Reilly, MD, FACC, FSCAI
- John Ochsner Heart and Vascular Institute

pVad Case Studies

- 87 year old female presented to outside ER with chest pain and anterior ST elevation
- HTN, Hyper chol
- BP 180/115, Pulse 100, RR 24
- Transferred to Ochsner
- BP 100/70, Pulse 90
- CV surgery consult
- LVEF 30%
- Calcified LAD
- 3 days later
  - High-risk PCI
**PROTECT II Trial Design**

Patients Requiring Prophylactic Hemodynamic Support During Non-Emergent High-Risk PCI on Unprotected LM/Last Patent Conduit and LVEF ≤ 35% OR 3 Vessel Disease and LVEF ≤ 30%

Primary Endpoint = 30-day Composite MAE* rate

Follow-up of the Composite MAE* rate at 90 days


**Baseline Characteristics**

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>IABP (N=223)</th>
<th>Impella (N=224)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>67±11</td>
<td>68±11</td>
<td>0.4</td>
</tr>
<tr>
<td>Gender - Male</td>
<td>81.2%</td>
<td>79.5%</td>
<td>0.651</td>
</tr>
<tr>
<td>History of CHF</td>
<td>83.4%</td>
<td>91.1%</td>
<td>0.015</td>
</tr>
<tr>
<td>Current NYHA (Class III / IV)</td>
<td>54.8%</td>
<td>58.1%</td>
<td>0.5</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>50.7%</td>
<td>52.2%</td>
<td>0.7</td>
</tr>
<tr>
<td>Implantable Cardiac Defib.</td>
<td>31.1%</td>
<td>34.8%</td>
<td>0.4</td>
</tr>
<tr>
<td>Prior CABG</td>
<td>28.7%</td>
<td>38.4%</td>
<td>0.03</td>
</tr>
<tr>
<td>LVEF</td>
<td>24.1±6.3</td>
<td>23.5±6.3</td>
<td>0.3</td>
</tr>
<tr>
<td>STS Mortality Score</td>
<td>6±7</td>
<td>6±6</td>
<td>0.8</td>
</tr>
<tr>
<td>Not-Surgical Candidate</td>
<td>64.1%</td>
<td>63.4%</td>
<td>0.9</td>
</tr>
<tr>
<td>Syntax Score Pre-PCI</td>
<td>29±13</td>
<td>30±14</td>
<td>0.5</td>
</tr>
</tbody>
</table>

PROTECT II Key Clinical Findings
30-Day Intent to Treat Analysis

Abbreviations: MACCE: Major adverse cardiac and cerebrovascular event; MAE: Major adverse event.

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>IABP (n=222)</th>
<th>pVAD (n=225)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat Revascularization</td>
<td>4.1%</td>
<td>1.3%</td>
<td>0.075</td>
</tr>
<tr>
<td>MAE Rate</td>
<td>40.1%</td>
<td>35.1</td>
<td>0.277</td>
</tr>
<tr>
<td>MAE Rate Post Hospital Discharge</td>
<td>18.3%</td>
<td>9.8</td>
<td>0.01</td>
</tr>
<tr>
<td>MACCE</td>
<td>12.8%</td>
<td>7.1</td>
<td>0.047</td>
</tr>
</tbody>
</table>


PROTECT II Key Clinical Findings
90-Day Per Protocol Analysis

Abbreviations: MACCE: Major adverse cardiac and cerebrovascular event; MAE: Major adverse event.

<table>
<thead>
<tr>
<th>Adverse Event</th>
<th>IABP (n=211)</th>
<th>pVAD (n=216)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repeat Revascularization</td>
<td>12.4%</td>
<td>6.0%</td>
<td>0.024</td>
</tr>
<tr>
<td>MAE Rate</td>
<td>51.0%</td>
<td>40.0%</td>
<td>0.023</td>
</tr>
<tr>
<td>MAE Rate Post Hospital Discharge</td>
<td>18.1%</td>
<td>7.9%</td>
<td>0.002</td>
</tr>
<tr>
<td>MACCE</td>
<td>31.0%</td>
<td>21.9%</td>
<td>0.033</td>
</tr>
</tbody>
</table>

PROTECT II Major Adverse Events

Impella has 56% fewer Out-of-Hospital MAEs (p=0.002)


Significant Functional Status Improvement

Impella Reduces Readmissions for Repeat Revascularizations: PROTECT II

- Repeat Revascularization At 90 days:
  - IABP: 12%
  - Impella: 6%
  - 52% reduction, p=0.024


Impella 2.5 Real World Registry: USpella

USpella Registry: High-Risk PCI

- Retrospective multicenter study includes 175 patients supported with the Impella 2.5 at 18 centers in the U.S. and Canada
- Independent CEC for MAE adjudication (2 Cardiologists + 1 CT Surgeon)
- CEC adjudicated events per FDA Impella 2.5 trial definitions
- CoreLab for the Angiographic success and Syntax Score

Impella 2.5 used for high-risk PCI:
- Functional or Anatomical risk
- PCI = Elective (stable angina, silent ischemia)
- PCI = Urgent (unstable angina, NSTEMI)

Primary Endpoint MACE at 30 days
Follow-up to 1 year (longest available)

PCI Provided Significant Functional Status Improvement for Patients: USpella

New York Heart Association Functional Class Changes

Baseline NYHA Class Distribution

NYHA Class Distribution

Hospital Discharge

52% reduction in Class III, IV

p<0.0001


Ochsner/CIGNA CAC Partnership

Designed to align incentives:

- Focus on the Right Care
  - Safe
  - Effective
  - Timely
  - Effective
  - Patient Centric
- Optimized outcomes are rewarded
  - Quality
  - Cost-efficiency
  - Patient satisfaction
- Metrics
  - Performance Reporting
  - Patient-specific actionable information
Collaborative Accountable Rewards

• We are compared local market trends for quality and total medical cost
  – Quality measure defined by Evidence-Based Medicine (EBM) guidelines and performance
  – Total medical cost defined by PMPM improvement or deterioration compared to local market norms
• Our system is incented to identify and implement all opportunities for clinical protocol changes that can influence quality and PMPM costs
• pVADs are a great example of a technology assisting a health system to be successful in these new partnerships
  – Reduces adverse events, hospital LOS and readmission costs and offers a more cost-effective approach to high-risk heart failure patients
  – Promotes improved population health within a very sick disease cohort

pVAD Economic Overview

Cost-Effectiveness Analysis

Budget Impact Model (BIM):
  Payer Perspective

Presscott Associates
**PROTECT II Trial Design**

Patients Requiring Prophylactic Hemodynamic Support During Non-Emergent High-Risk PCI on Unprotected LM/Last Patent Conduit and LVEF ≤ 35% OR 3 Vessel Disease and LVEF ≤ 30%

**Primary Endpoint = 30-day Composite MAE* rate**

Follow-up of the Composite MAE* rate at 90 days


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**Healthcare Focus on 90-Day Outcomes**

- Impella arm of Protect II had 56% fewer Major Adverse Events (MAE) after hospital discharge (p=0.002)
- Repeat revascularizations were also lower by 52% at 90 days (p=0.024)
- Repeat revascularization impacts readmissions & patient quality of life
- Beginning in 2012, overall DRG rates for hospitals may be reduced (1%-3%) as a high readmission rate penalty*

Repeat Revascularization At 90 days

<table>
<thead>
<tr>
<th>IABP</th>
<th>pVAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.4%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

↓ 52% reduction
p=0.024

* CMS penalty = FY13 1% , FY14 2%, FY15 3%

PROTECT II Economic Study

Study Goal

• Demonstrate that reductions in major adverse events will improve quality of life and cost-effectiveness for Impella patients vs. IABP

Primary Study Objectives

• Measure and compare resource utilization during the episode of care (index admission and 90-day follow-up period)
• Determine quality of life as measured primarily by reduction in major adverse events
• Calculate incremental cost per quality-adjusted life-year (ICER)
  - Note: Contemporary studies show <$100k as acceptable U.S. threshold, older studies show <$50k as acceptable threshold.

PROTECT II Economic Study


Analytic Perspective

• Based on data from United States hospitals using 2009 U.S. dollars
• Sources and methods: MedPAR1-4, Tufts CEA Registry5-7, Seattle Heart8-9 Failure Model, Markov Modeling10-13

Patient Population

• Clinical outcomes determined from patients meeting trial criteria (N=427)
• Patient billing data includes all bills from patients with signed consent form

General Approach

• Data collected by trial coordinating academic center (HCRI) and analyzed by independent economic organization (Presscott Associates)
• Medical billing data from actual claims submitted to payers from index stay through 90 days and analysis of major adverse event reductions

Methods: Overview

Methods: Costing

- Data collected included hospital and patient bills for charges and costs, length of stay and critical care length of stay, readmissions, MAE and MACCE rates
- Itemized bills collected for all available patient data (N=263)
- Industry standard modeling utilized via patient matching with MedPAR FY09 Medicare costing database and extrapolated billing data
- Costs derived using hospital and department specific cost-to-charge ratio as filed in most recent Medicare Cost Report
- Discount rate of 3%, consistent with current guidelines

Total Days in Hospital

- Total Days in Hospital
  - Index plus 90 Days post discharge
  - 2 days less
  - 22% reduction
  - p=0.008

- Readmission Days
  - 2 days less
  - 29% reduction
  - p=0.001

* Median days in hospital; index stay through 90 days, N=427, Readmissions N=208

Hospital Resources

Index Stay In-Hospital Costs

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>IABP</td>
<td>$34k</td>
</tr>
<tr>
<td>pVAD</td>
<td>$48k</td>
</tr>
</tbody>
</table>

Readmission In-Hospital Costs

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>IABP</td>
<td>$22k</td>
</tr>
<tr>
<td>pVAD</td>
<td>$11k</td>
</tr>
</tbody>
</table>

* Includes device costs, all in-hospital days, patients N=427, readmissions N=208


Cost-Effectiveness Terminology

• **Quality-Adjusted Life Years (QALYs)**
  Combination of life expectancy and a measure of the quality of life generated by healthcare interventions.

• **Incremental Cost-Effectiveness Ratio (ICER)**
  Additional cost of one unit of outcome gained (QALY) by a healthcare intervention, when compared to the next best alternative.
  
  \[
  ICER = \frac{(\text{cost treatment A}) - (\text{cost treatment B})}{(\text{outcome treatment A}) - (\text{outcome treatment B})}
  \]

  - Outcome measured by MACCE rates
  - Lower ICER preferred over higher ratio
  - Society’s /Payer’s Willingness to Pay; U.S. ICER threshold: $100,000

### Comparative Cost-Effectiveness Studies

<table>
<thead>
<tr>
<th>Incremental cost per life year or QALY (thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
</tr>
<tr>
<td>$25</td>
</tr>
<tr>
<td>$50</td>
</tr>
<tr>
<td>$75</td>
</tr>
<tr>
<td>$100</td>
</tr>
<tr>
<td>$125</td>
</tr>
<tr>
<td>$150</td>
</tr>
<tr>
<td>$175</td>
</tr>
</tbody>
</table>

- $<100,000$ Threshold

**References:**
5. Moisi, et al. TCT, 2011 PROTECT II

### Cost-Effectiveness of Impella vs. IABP

**Graph:**
- Incremental Cost vs. Quality of Life Years
- ICER $39,389/QALY

**References:**
Cost-Effectiveness of Impella vs. IABP

Monte Carlo Simulation
ICER $39,389
CE Acceptability Curve

100% of model iterations are cost effective with $100,000 threshold
79% of model iterations are cost effective with $50,000 threshold

Summary Findings

- Protect II 90-day clinical trial results concluded the Impella demonstrated clinical advantages over the IABP in the following endpoints:
  - 22% relative reduction in overall Major Adverse Events (p=0.023)
  - 29% relative reduction in overall MACCE (p=0.033)
  - 52% relative reduction in repeat revascularization (p=0.024)
  - 56% relative reduction in Major Adverse Events post hospital discharge (p=0.002)
- There were higher costs in the Impella arm during hospital index stay, and lower costs over the IABP arm during readmissions through 90 days
- Impella meets cost-effectiveness guidelines in the United States with a projected ICER of $39,389
- Results were minimally impacted by major sensitivity analyses

Model Overview

- **Data Source:** OptumHealth, 2009 – 2011 (extended to 2012 for follow-up periods) commercial claim data set
- **Episode Length:** 12 months following index events
- **Cost Metric:** Allowed Amounts (including payer and member responsibility)
- **Cardiogenic Shock Comparators:** ECMO or LVAD vs. pVAD
- **High-Risk PCI Comparators:** IABP vs. pVAD
- **Service Types Analyzed:** Inpatient, Outpatient, ER, Professional and Pharmacy
- **HR-PCI Mortality:** IABP: 12%  pVAD: 8%
- **Cardiogenic Shock Mortality:** ECMO/LVAD: 23%  pVAD: 23%
Budget Impact Model Methods

- Data were extracted from a national commercial claims database with approximately 25 MM members
- Events were identified through coding submitted on hospital bills; a hospital admission with CS coded was the “trigger event” that precipitated a member’s entry into the study
- Members were followed for one year
- Allowed amounts were analyzed across the following categories:
  - Inpatient hospital
  - Outpatient hospital
  - Emergency room
  - Physician
  - Pharmaceuticals


Interactive Model Demonstration

Inlet Area
Budget Impact Model Demographics/Coding

- Commercial claims database membership distribution (in thousands)

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>4,860</td>
<td>4,886</td>
<td>9,746</td>
</tr>
<tr>
<td>30-49</td>
<td>3,064</td>
<td>3,831</td>
<td>7,795</td>
</tr>
<tr>
<td>50-64</td>
<td>2,654</td>
<td>2,511</td>
<td>5,175</td>
</tr>
<tr>
<td>65-79</td>
<td>746</td>
<td>777</td>
<td>1,523</td>
</tr>
<tr>
<td>80+</td>
<td>332</td>
<td>280</td>
<td>612</td>
</tr>
<tr>
<td>Total</td>
<td>12,566</td>
<td>12,285</td>
<td>24,851</td>
</tr>
</tbody>
</table>

- Index event coding logic

<table>
<thead>
<tr>
<th>High-Risk PCI</th>
<th>Procedure Definitions</th>
<th>Cardiogenic Shock</th>
<th>Diagnosis and Procedure Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>pVAD</td>
<td>00.66 (PCI) and 37.68 (pVAD)</td>
<td>CS/AMI and pVAD</td>
<td>Dx 785.51 and px 37.68</td>
</tr>
<tr>
<td>IABP</td>
<td>00.66 (PCI) and 37.61 (IABP)</td>
<td>CS/AMI and ECMO or LVAD</td>
<td>Dx 785.51 and px 37.65 or px 39.65</td>
</tr>
</tbody>
</table>

1.401.x - Essential Hypertension
427.31 - Atrial fibrillation
428.1 - Heart Failure
584.x - Acute kidney failure
414.8 - Other specified forms of chronic ischemic heart disease
250.x - Diabetes mellitus
443.x - Other peripheral vascular disease


Methods & Incidence

- Two years of data were extracted from a national commercial claims database with approximately 25 MM members (patients followed for one year)

- Allowed amounts were analyzed across the following categories
  - Inpatient hospital, outpatient hospital, emergency room, physician, pharmaceuticals (commercial only), and SNF (Medicare only)

- CS Incidence rates by cohort
  - Surgical Alternatives: 0.00282 index admits per thousand members
  - pVADs: 0.00225 index admits per thousand members
  - Overall CS incidence (regardless of intervention) is 0.0619 per 1,000 members

- High-Risk PCI rates by cohort (commercial only):
  - IABP: 0.0282 index admits per thousand members
  - pVADs: 0.00306 index admits per thousand members
  - Overall High-Risk PCI (regardless of intervention) is 0.0312 per 1,000 members

Length of Stay: Budget Impact Model

**Emergent Care Model**

- Surgical Support: 30.9 days (N=70)
- pVAD Support: 10.5 days or 34% reduction (p=0.05) (N=56)

**Non-Emergent Care Model**

- IABP Support: 11.9 days (N=700)
- pVAD Support: 9.8 days or 18% reduction (p=0.001) (N=76)

*Mean days, Index Stay
2009-2011 OptumInsight Commercial Database

Post-Index Costs: Budget Impact Model

**Emergent Care Model**

- Surgical Support: $76k
- pVAD Support: $53k or 30% reduction

**Non-Emergent Care Model**

- IABP Support: $27k
- pVAD Support: $26k or 4% reduction

* Includes device costs, all in-hospital days, outpatient, physician, emergency room, pharmacy costs

Emergent Care Budget Impact Model

Cost savings for pVADs throughout entire 12-month episode of care

Payer Allowed Amounts

<table>
<thead>
<tr>
<th>Index Admission</th>
<th>Post Index Cost</th>
<th>Total Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$76k</td>
<td>$53k</td>
<td>$341k</td>
</tr>
<tr>
<td>$458k</td>
<td>$288k</td>
<td>$533k</td>
</tr>
<tr>
<td>↓$170k or 37%</td>
<td>↓$23k or 30%</td>
<td></td>
</tr>
</tbody>
</table>

p=0.006


Non-Emergent Care Budget Impact Model

Modest Total Incremental Cost for pVADs

Payer Allowed Amounts

<table>
<thead>
<tr>
<th>Index Admission</th>
<th>Post Index Cost</th>
<th>Total Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$28k</td>
<td>$27k</td>
<td>$122k</td>
</tr>
<tr>
<td>$85k</td>
<td>$95k</td>
<td>$113k</td>
</tr>
<tr>
<td>↑$10k or 0.218</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

p=0.218

### Minimal Per Member Per Month Payer Impact

#### Emergent Care Model
Mean cost per case for 12-month EOC

- **Surgical Hemodynamic Support**
  - Pre-index Cost: $533,285, $0.07 PMPM (N=70)
  - Post-index Cost: $341,040, $0.03 PMPM (N=56)

- **pVAD Support**
  - Pre-index Cost: $112,982, $0.14 PMPM (N=700)
  - Post-index Cost: $121,602, $0.02 PMPM (N=76)

The difference in mean index cost was statistically significant. P-value=0.006.

#### Non-Emergent Care Model
Mean cost per case for 12-month EOC

The difference in mean index cost was not statistically significant. P-value=0.218.

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### Integrated Budget Impact Model
*(Based on 25MM Member Plan)*

<table>
<thead>
<tr>
<th></th>
<th>HR-PCI</th>
<th>CGS</th>
<th>NET</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Spend</strong></td>
<td>$88MM ($0.16 PMPM)</td>
<td>$56MM ($0.10 PMPM)</td>
<td></td>
</tr>
<tr>
<td><strong>Assumed Penetration Rates</strong></td>
<td>30%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td><strong>Savings</strong></td>
<td>- $1.8MM ($0.003 PMPM) + $6.7MM ($0.01 PMPM) = $4.8MM (net savings)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. From standard of care to pVAD

---

Integrated Model: “Worst Case” Scenario: 10% CGS and 80% HR-PCI (1)

<table>
<thead>
<tr>
<th>HR-PCI</th>
<th>CGS</th>
<th>NET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$10.6M</td>
<td>$6.8M</td>
</tr>
<tr>
<td>Spend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assumed Penetration Rates¹</td>
<td>80%</td>
<td>10%</td>
</tr>
<tr>
<td>Savings</td>
<td>-$581K ($0.0087 PMPM)</td>
<td>+ $160k ($0.0024 PMPM)</td>
</tr>
</tbody>
</table>

1. From standard of care to pVAD in a 3 MM plan

Integrated Budget Impact Model Conclusions

- In the CS population, current PMPM budget impact for each strategy is minimal:
  - Surgical Alternatives PMPM: $0.07
  - pVAD PMPM: $0.03
- In the HR-PCI population, current PMPM budget impact for each strategy is minimal:
  - IABP PMPM: $0.14 (due to standard of care status)
  - pVAD PMPM: $0.02
- 50% conversion of surgical hemodynamic support cases to pVAD yields a $6.7MM savings for the CS population ($0.01 PMPM); 30% conversion of IABP cases to pVAD in the HR-PCI population will cost an additional $1.8MM ($0.003 PMPM)

Joint pVAD Conclusions

• Improves clinical quality (safe and effective)
• Reduces costs and LOS, including expensive readmissions
• Improves patient outcomes and satisfaction
• “ACO friendly”
• Payers: Call us if you would like the budget impact for your plan
• Providers: We can help you do an economic assessment