The Perfect Storm: A Distinguished Post-Acute Rehabilitation Program

(Session # W25)
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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

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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?

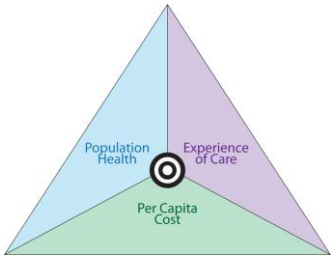
Specialty Program Development

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

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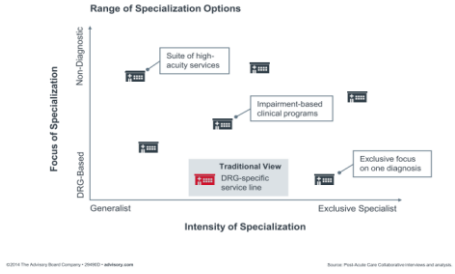
SWOT Analysis

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



Market Analysis

Utilize existing resources to help you

- Your State Healthcare Association https://www.ohca.org/
- CMS http://innovation.cms.gov/initiatives/
- Advisory Board http://www.advisory.com/
- NaviHealth http://navihealth.us/
- Remedy Partners https://www.remedypartners.com/

Sample Market Analysis

Memphis Jewish Home 2015

Memphis Jewish HOME&REHAB

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 report 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

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

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

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

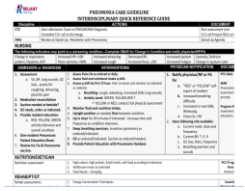
Program Development

Aligning your program needs
- It doesn't have to be difficult, just different!

Implementation
- Staff
- Competency/Training
- Equipment
- Environment
- Outcomes

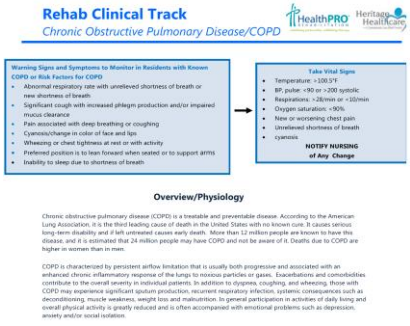
Re-evaluation and Revisions

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

Warning Signs and Symptoms to Monitor in Residents with Known COPD or Risk Factors for COPD

- Abnormal respiratory rate with unrelieved shortness of breath or new shortness of breath
- Significant cough with increased phlegm production and/or impaired mucus clearance
- Pain associated with deep breathing or coughing
- Cyanosis/change in color of face and lips
- Wheezing or chest tightness at rest or with activity
- Preferred position is to lean forward when seated or to support arms
- Inability to sleep due to shortness of breath

Take Vital Signs

- Temperature: >100.5°F
- BP, pulse: <90 or >200 systolic
- Respirations: >28/min or <10/min
- Oxygen saturation: <90%
- New or worsening chest pain
- Unrelieved shortness of breath
- cyanosis

NOTIFY NURSING of Any Change

Overview/Physiology

Chronic obstructive pulmonary disease (COPD) is a treatable and preventable disease. According to the American Lung Association, it is the third leading cause of death in the United States with no known cure. It causes serious long-term disability and if left untreated causes early death. More than 12 million people are known to have this disease, and it is estimated that 24 million people may have COPD and not be aware of it. Deaths due to COPD are higher in women than in men.

COPD is characterized by persistent airflow limitation that is usually both progressive and associated with an enhanced chronic inflammatory response of the lungs to noxious particles or gases. Exacerbations and comorbidities contribute to the overall severity in individual patients. In addition to dyspnea, coughing, and wheezing, those with COPD may experience significant sputum production, recurrent respiratory infection, systemic consequences such as deconditioning, muscle weakness, weight loss and malnutrition. In general participation in activities of daily living and overall physical activity is greatly reduced and is often accompanied with emotional problems such as depression, anxiety and/or social isolation.

Sample Rehab Track

Stages of COPD: The progression of COPD is determined by the GOLD staging system. Gold stands for the Global Initiative for Chronic Obstructive Pulmonary Disease established by the National Institute of Health. These stages are confirmed by spirometric results which are based on the ratio of forced vital capacity (FVC) and forced expiratory volume (FEV1).

- **Stage I:** FEV1 is at least 80% normal. Mild airflow limitation and sometimes, but not always, chronic cough and sputum production. At this stage the individual may or may not be aware of abnormal lung function.
- **Stage II:** FEV1 is between 50% and 80% of normal. Worsening airflow limitation with shortness of breath, typically developing on exertion. This is the stage at which patients typically seek medical attention because of chronic respiratory symptoms or an exacerbation of the disease.
- **Stage III:** FEV1 is between 30% and 50% of normal. Further worsening of airflow limitation with greater shortness of breath. Reduced exercise capacity, and repeated exacerbations which have an impact on patient's quality of life.
- **Stage IV:** FEV1 is less than 30% of normal; or FEV1 is less than 50% of normal *and* chronic respiratory failure is present. Requires chronic oxygen therapy. Quality of life is very appreciably impaired.

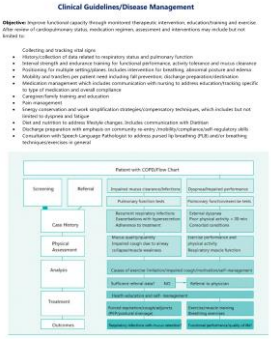
Sample Rehab Track

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 capillary bed.
- **Spirometry Tests:** Used to assess lung function. Often used to evaluate a person with a chronic cough, sputum production, and a history of COPD. Measured by 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 the measurements depends on age, height, gender and race. This is known as the predicted value.
- **Medication:** Pharmacologic treatment is used with COPD to control/manage, reduce the frequency and severity of exacerbations and prevent symptoms. This often assists in improving exercise tolerance and overall health status. Understanding the type of medication used in each individual case is important due to the short and long acting agents of each. This significantly impacts the management of the disease, ultimately attributing to the outcome of rehabilitation and safe transition.
- **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/or 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/Disease Management



Sample Rehab Track

Applicable/Techniques and Tools

- **Discipline specific evaluation**
- **Full set of vitals**
- **Cognitive and/or communication evaluations**
- **Berg Balance Scale/Tinetti Balance Assessment Tool**
- **Borg Rating of Perceived Exertion Scale which may include dyspnea scale**
- **6-minute walking test**
- **Swallowing/Cough Assessment**
- **Breathing/relaxation techniques**
- **Treatment modalities to address mucus clearance**
- **Measurable pain scale**
- **Tracking tools/logs/charts specific to medication management**
- **Tracking tools/logs/charts specific to diet, nutrition and meal prep**
- **Energy conservation/work simplification specific to activities of daily living**
- **Adaptive equipment/DME evaluation**
- **HEP specific to patient**
- **Home evaluation which may include safety related to long term oxygen therapy and overall home management**
- **Patient education with return demonstration including caregivers/family**
- **Discharge readiness checklists for community re-entry and disease management**
- **Standardized depression and/or anxiety scale**

Results: How do I compare?

OHIO			
Facility Characteristics		**Patient Characteristics**	
Nursing Facilities	957	Total Patients Served	193,000
		# Admissions	144,000
Total Employees (FTE)	99,509	% with Medicare FFS as Payer	66%
All Direct Care Staff (FTE)	56,360	Average Age	76.3
Registered Nurses (FTE)	6,762	Average ADL Dependence*	4.5
Licensed Practical Nurse (FTE)	13,802	Rehospitalization rate	17.5%
Aides (FTE)	35,796	Discharge to Community rate	59.5%
Average Bed Size	95.8	# Long Stay Resident (≥ 1 yr)	50,000
Average Daily Census	80.6	% with Medicaid as Current Payer	63.1%
Four or Five Star	43.4%	Average Age	78.4
		Average ADL Dependence*	4.5
		% with Dementia	58%

UNITED STATES			
Facility Characteristics		**Patient Characteristics**	
Nursing Facilities	15,666	Total Patients Served	3,363,000
		# Admissions	2,513,000
Total Employees (FTE)	1,813,499	% with Medicare FFS as Payer	64%
All Direct Care Staff (FTE)	1,022,416	Average Age	77.7
Registered Nurses (FTE)	124,565	Average ADL Dependence*	4.5
Licensed Practical Nurse (FTE)	227,956	Rehospitalization rate	17.5%
Aides (FTE)	669,895	Discharge to Community rate	58.0%
Average Bed Size	109.0	# Long Stay Resident (≥ 1 yr)	851,000
Average Daily Census	87.6	% with Medicaid as Current Payer	63.1%
Four or Five Star	50.6%	Average Age	79.3
		Average ADL Dependence*	4.3
		% with Dementia	61%

Outcomes

Measuring your Success

What are outcomes?

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

Sector	Report Standardized Patient Assessments	Report Additional Quality Measures	Report Resource Use Measures
LTACH	Oct. 1, 2018	Oct. 1, 2016 (skin integrity, major falls); Oct. 1, 2018 (functional status, medication reconciliation, transfer of health information)	Oct. 1, 2016
IRF	Oct. 1, 2018	Oct. 1, 2016 (functional status, skin integrity, major falls); Oct. 1, 2018 (medication reconciliation, transfer of health information)	Oct. 1, 2016
SNF	Oct. 1, 2018	Oct. 1, 2016 (functional status, skin integrity, major falls); Oct. 1, 2018 (medication reconciliation, transfer of health information)	Oct. 1, 2016
HHA	Jan. 1, 2019	Jan. 1, 2017 (skin integrity, medication reconciliation); Jan. 1, 2019 (functional status, major falls, transfer of health information)	Jan. 1, 2017

Using your data effectively: Score Cards

Heritage HealthCare | HealthPRO Heritage

Utilization and Efficiency	Data Source	Benchmark	Q1	Q2
Avg LOS (dc)				
staff hours/patient				
conversion rates				
Care Experience				
overall client satisfaction				
Cost Data				
cost/unit				
cost/episode				
Clinical Outcomes				
CMS 5 star rating				
readmission rate (24 hr/30 day)-all cause	admissions			
AMI	admissions			
HF	admissions			
PN	admissions			
COPD	admissions			
THR	admissions			
TKR	admissions			
Discharge to Community				
moderate to severe pain	Casper			
fall rate	Casper			
infection rate	Casper			
mortality rate	Casper			
Functional Outcome Measures				
LOS DC				
LOS/dc				
FIM change by dc				

State- of- the - Art Technology	
EMR	
Interfacing capabilities	
Readmission Reduction Program	
program standard	
measureable outcomes by hospital referral source	
% of f/u MD visit within X days of d/c	
% of patients referred to home care services	
% of patients referred to outpatient therapy	
Scope of Services/PAC Programs	
admissions process/pathway	
Care transitions program	
Liaisons	
NP coverage	
medication reconciliation process	
lab's	
IV's	
radiology	
special service 1	
special service 2	

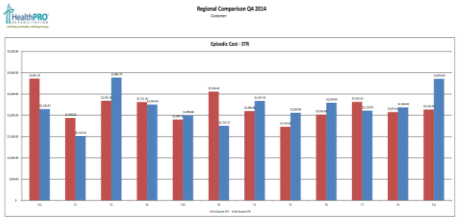
Outcomes: More than Re-hospitalization Rate!

– 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

VAN DYK HEALTH CARE AT MONTCLAIR
We care.

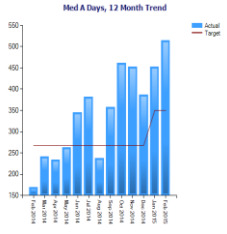
Specialty Program Details

- 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 nce

Program details

- Jewish Home LifeCare Manhattan division, a165 year old, 514 bed, non-profit in Metropolitan New York City sought to expand their clinical excellence though 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)

	Admissions (n)	0-3 day Readmissions (n)	0-3 Day Readmission Rate	0-30 day Readmissions (n)	0-30 Day Readmission Rate	JHL 30-Day Readmission Rate 2014
Overall	**254**	**10**	**3.6%**	**56**	**20.2%**	**14.3% (Manhattan only)**
Mt. Sinai Medical Center	62	3	4.8%	17	**25.8%**	24.1%
NYU Langone	51	1	1.96%	7	**13.9%**	15.6%
Mt. Sinai St. Luke's	43	2	4.65%	13	**25.6%**	14.5%
Lenox Hill	29	1	3.4%	5	**17.2%**	10.9%
Beth Israel Medical Center	15	1	6.6%	4	**26.6%**	5.3%
NYP Cornell	13	0	0%	1	**14.3%**	16.24%
Mt. Sinai Roosevelt	10	0	0%	2	**20.0%**	6.7%
NYP Columbia	10	0	0%	1	**10%**	6.3%
Harlem	4	2	50%	4	**75.0%**	1%
Brookdale	2	0	0	1	**50.0%**	0.3%
Veteran's Administration	2	0	0%	1	**50.0%**	2.5%
Montefiore Medical Center	3	0	0%	0	**0.0%**	0.7%
Hospital For Special Surgery	2	0	0%	0	**0.0%**	0.7%
Other Hospitals	8	0	0%	0	**0.0%**	3.2%

Results- 30 day specific re-hospitalization rates

	Admissions (n)	0-3 day Readmissions (n)	0-3 Day Readmission Rate	0-30 day Readmissions (n)	All Cause 0-30 Day Readmission Rate	Heart Failure 0-30 Day Readmission Rate	Pneumonia 0-30 Day Readmission Rate	COPD Readmission Rate
Overall	**254**	**9**	**3.5%**	**52**	**20.5%**	**3.5% (n=9)**	**3.33% (n=4)**	**3.3% (n=4)**
Mt. Sinai Medical Center	62	3	4.8%	17	25.8%	28%	3.2%	0%
NYU Langone	51	1	1.96%	7	13.9%	6.5%	0%	4.0%
Mt. Sinai St. Luke's	43	2	4.65%	13	25.6%	28%	4.6%	0%
Lenox Hill	29	1	3.4%	5	17.2%	3.1%	0%	7.0%
Beth Israel Medical Center	15	1	6.6%	4	26.6%	3.1%	0%	0%
NYP Cornell	14	0	0%	1	14.3%	0%	0%	0%
Mt. Sinai Roosevelt	10	0	0%	2	20.0%	6.5%	0%	0%
NYP Columbia	10	0	0%	1	10%	3.1%	0%	0%
Harlem	4	2	50%	4	75.0%	12.5%	0%	0%
Brookdale	2	0	0%	1	50.0%	3.1%	0%	0%
Veteran's Administration	2	0	0%	1	50.0%	0%	0%	0%
Montefiore Medical Center	3	0	0%	0	0%	0%	0%	0%
Hospital for Special Surgery	2	0	0%	0	0%	0%	0%	0%
Other Hospitals	8	0	0%	0	0%	0%	0%	0%

Results LOS by Diagnosis

Primary Diagnosis (ICD-9 Code)	Number	%	Mean Length of Stay (days)
Heart Failure (428.0)	68	27%	21 days
Hypertension (401.9)	31	12%	25 days
Atrial Fibrillation (427.31)	24	9%	21 days
Pneumonia (486)	23	9%	25 days
Chronic Airway Obstruction (496)	17	7%	17 days
Overall Cardiac Rehab Program			**22 days**

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

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