Joan

“The rehab staff at ManorCare Health Services - Ruxton is very dedicated, professional, concerned and caring. Everything has been great and a wonderful experience. I enjoyed socializing with the other patients and staff, who were very friendly. They really know how to spoil me here, and I will miss it when I go home.”
We are HCR ManorCare

- Quality caring provided by more than 55,000 employees through more than 500 locations in 32 states
- One of the largest providers of post-hospital skilled nursing and rehabilitation through more than 275 centers, most of which provide care under the respected names of Heartland and ManorCare Health Services
- With rehabilitation outcomes for Medicare patients comparable to and often exceeding those of independent rehabilitation facilities
- The third largest U.S. provider of hospice care in over 100 markets under the Heartland name
- A leading U.S. provider of home health care under the Heartland name
- A leading provider of Alzheimer's/dementia care through more than 50 Arden Courts memory care communities and in many of our skilled nursing centers
- Rehabilitation also provided in 50 outpatient clinics, primarily under the Heartland name
of our rehabilitation admissions are discharged home, with the majority of the others deciding that they need the 24/7 care of long-term skilled nursing services.

Lou

“I had my left knee replacement surgery in May 2011. Since everything went perfectly well, when I decided to have right knee replacement surgery, I used the same orthopedic surgeon, the same hospital and the same rehabilitation center, ManorCare Health Services - West Palm Beach. Once again, the ManorCare team met my expectations. They were able to get me walking normally again in a relatively short period of time. Thank God such places were available for me to get my life back to normal.”
Skilled Nursing and Assisted Living Centers

Home Health Care and Hospice Agencies
Bridging the Gap from Hospital to Home
A Skilled Nursing and Rehabilitation Story

It wasn’t as if I was unfamiliar with a trip to the hospital. My history of heart issues had often required a visit there. But I still had difficulty admitting to myself that it was time to get my knee replaced. I had been having a little difficulty getting around for several years, but my husband and I still were regularly taking our dogs out to the state park for long walks. It wasn’t a pain-free experience, but it was tolerable, or maybe I was just getting used to it.

But then one day, one of our dogs saw something in the brush, and a hard pull on the leash had me on the ground. There were bumps and bruises, but what had my attention was the excruciating knee pain. And it didn’t go away. I probably should have had my husband take me to the emergency room, but as circumstance would have it, I already had an appointment scheduled the next day with my orthopedic specialist for a periodic cortisone shot.

The appointment was short. A look at an updated x-ray and consultation on my pain indicated the knee was only going to get worse, and continued cortisone shots would not be the answer. Surgery was scheduled and was successfully completed.

Even prior to the surgery, I was thinking about post-surgical care, because my doctor said I would need care and rehab following my short hospital stay. I was leaning toward a Heartland Health Care Center. It wasn’t the closest center to where I lived, nor the newest. But a close friend had completed his rehab there and thought they had done an excellent job of preparing him to return home and to life before his hip replacement. At 75, he was also about my age.

I was a little concerned about my history of congestive heart failure and other medical issues that could

Post-Hospital Rehabilitation

More than 160,000 patients annually choose us for their post-hospital rehabilitation care. Patients are leaving the hospital earlier and sicker than in the past. It’s critical that these patients choose the post-hospital provider that is experienced in providing the services they need to get back home and back to their lives.

In 2014, we treated the following number of patients:

- 43,257 Orthopedic
- 12,105 Stroke and Neurological
- 23,885 Cardiac
- 5,004 Oncology
- 12,751 Pulmonary
MedBridge – Specialized Care for Our Short-Stay Patients

MedBridge is a distinct post-hospital unit within many of our skilled nursing and rehabilitation centers that has been specially designed for shorter-stay patients who still require intensive medical and rehabilitation care after their time in the hospital. These are patients who have experienced issues such as an orthopedic injury or replacement, a stroke or other neurological concern, a cardiac complication, a chronic disease, a pulmonary problem or cancer. MedBridge provides a bridge to take them safely and confidently from the hospital to home. An interdisciplinary team of therapists works with attending physicians, nurse practitioners and specialty physicians to deliver post-hospital services focused on maximizing individual patient goals. Our centers are required to earn a MedBridge certification and the right to use the name. MedBridge provides a post-hospital level of care focused on returning patients to a normal and productive lifestyle. In 2015, we are celebrating the opening of our 100th MedBridge center.

complicate my stay. My doctor helped to alleviate my concerns. As it turned out, he and his practice partners had referred several patients with multiple medical issues to the Heartland center specifically because of its ability to deal with medically complex patients who also needed intensive rehabilitation.

My fears were further allayed when a nurse liaison representing the Heartland center met with me in the hospital following my surgery. She told me about the team approach to care delivery and focus on total joint recovery in the center's MedBridge unit. She went over everything else I could expect from the licensed professional staff to state-of-the-art rehab equipment to home-style meals. Most important, she provided me with data on the rehab team's outcomes success, which gave me a lot of confidence that I would be returning home and getting back to my life.

I won't pretend I was looking forward to a stay in a rehab center, but from the moment I arrived, I felt welcomed. A plan of care was prepared that involved me, my doctor and the center's interdisciplinary team. We set goals that I admit made me a little apprehensive, but at the end of those goals, I could see myself at home. Mike, the physical therapist who had primary responsibility for my rehabilitation, was engaging and friendly but also firm. He let me know when he thought I was “dogging” it and didn't hesitate to remind me of our agreed-upon goals. Most important, he was encouraging, and it seemed as if each day we celebrated some small success. Connie, an occupational therapist, worked with me on mobility and helping me get used to doing my normal daily activities with my new knee.

I didn't have any serious flare-ups with my heart while I was at the Heartland center, but I was thankful for Gail, the nurse practitioner. I wasn't at the center even 24 hours when she came in and gave me a complete assessment. I began a preventative program that helps people such as me with cardiac issues to decrease the risk of falls and assist with other debilities such as osteoporosis. My doctor couldn't visit me every day, so it was comforting that Gail was there and stopped in to see
“My experience at MedBridge at ManorCare Health Services - Elk Grove Village was marvelous. I felt like the time went by fast because I was not only doing therapy, but also enjoying the people I was working with. My nursing staff was also excellent. They were always there to help me. The most important thing to me about my time here was learning how to do things for myself so that when I got home, I would have a better quality of life than I did before my surgery. I feel like I achieved my goal at ManorCare - Elk Grove Village and would recommend this place to any of my friends or family in need of rehabilitation.”
Choosing the Right Provider

HCR ManorCare has raised the bar for aggressive, short-term, expert, compliant and outcomes-focused rehabilitation – with an impressive track record of success in achieving necessary results for our patients and their families. We believe to ensure effective medical care and rehabilitation, it takes an experienced leader who can work collaboratively with the patient, the acute care team and the health care plan to provide state-of-the-art quality of care that is proven to lead to a safe and productive discharge back to the community. Further, we believe it is vital for patients and their families, as well as those who refer patients, to examine evidence of a post-acute care provider’s outcomes success before deciding whom to trust. Patients and their families need this data in choosing the best provider to achieve their care goals and a return to their lives.

Alfredo

“...I feel that I made great progress during my stay at MedBridge at ManorCare Health Services - Naperville. The nursing team at the facility is very nice, capable and skilled. My therapy was also very good; my team was always supportive and encouraging. I am glad I chose ManorCare for my rehabilitation treatment. I did not expect that my tracheotomy tube would be removed in such a short time. I can’t wait to go home and taste my wife’s home-cooked food again.”
The Role of the Nurse Practitioner

Nurse practitioners provide comprehensive evaluations of new admissions either prior to or following the initial assessment by the patient’s attending physician. To foster improved processes of our centers with nurse practitioners, at least 70 percent of new admissions must be seen by a nurse practitioner within 48 hours of admission, with frequent follow-ups during the first days and weeks of the patients’ stay as their conditions indicate and as is medically necessary. Additionally, if a patient has a primary diagnosis on admission of congestive heart failure, acute myocardial infarction or pneumonia, he or she can expect to be seen daily for seven days and then a minimum of weekly thereafter for the first 30 days. High-acuity centers with medical practice nurse practitioners are successfully managing complex cases by reducing preventable and unnecessary readmissions to the hospital.

82% of our patients complete their rehab treatment without returning to the hospital.
Over the past three years, we invested nearly $300 million in new construction, renovation and expansion of existing facilities, new equipment and information technology. Four new skilled nursing and rehabilitation centers were opened, and one skilled nursing center and one memory care community are under construction. Seventeen expansions were completed and four are under way to add short-term stay beds and enhance rehab therapy areas. Over 450 renovations, each at a cost of more than $50,000, were completed.
HCR ManorCare has significantly more admissions per month than a peer group of for-profit nursing centers and significantly more admissions per deficiency.

### Ratio of Admissions per Month to Deficiencies

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admissions per one deficiency</td>
<td>Admissions per one G-tag</td>
</tr>
<tr>
<td>HCR ManorCare</td>
<td>34.0</td>
<td>5.64</td>
</tr>
<tr>
<td>PointRight For-Profit 50*</td>
<td>16.1</td>
<td>2.54</td>
</tr>
</tbody>
</table>

HCR ManorCare has significantly more admissions per month than a peer group of for-profit nursing centers and significantly more admissions per deficiency.

* 50 for-profit nursing companies tracked by PointRight

---

**Average Length of Stay in Days**

- Insurance/Managed Care: 23.9
- Medicare: 35.1
- Hospice: 67.5
- Private Pay: 76.4
- Veterans Administration: 94.5
- Medicaid: 263.2

On average in 2014, the Medicare and managed care patients in our skilled nursing and rehabilitation centers returned to the community in less than 36 days.

**Percent of Medicare Patients Receiving Therapy**

- Any Therapy: 97.9%
- Physical Therapy: 96.4%
- Occupational Therapy: 96.0%
- Speech Therapy: 36.1%

Almost all of our skilled nursing and rehabilitation center Medicare patients received at least one form of rehabilitation therapy in 2014.

**Residence Prior to Admission to HCR ManorCare**

- Acute Care Hospital: 88.8%
- Nursing Home: 3.5%
- Home: 2.9%
- Other: 4.8%

Nearly 90 percent of our skilled nursing and rehabilitation center patients came to us from the hospital in 2014.

**Nearly 80%**

Nearly 80% of patients reported that after discharge they felt prepared to manage their care “quite a lot” or “completely.”
Quality Care Reflected in Satisfaction Surveys

Collecting and using patient satisfaction survey data is an important part of our process for ensuring that patients feel that they have received the care they expected. As a member of the American Health Care Association, HCR ManorCare participates in a regular independent customer satisfaction survey. We are proud to report that results from these surveys show high levels of satisfaction. In 2014, over 25,000 discharged patients from our skilled nursing and rehabilitation centers returned surveys, which has helped us create a good gauge of patient satisfaction.

Caring for Those Who Make Our Center Their Home

While short-stay patients in need of intensive rehabilitation are an increasing percentage of those we care for, we also continue to care for a medically complex, functionally limited and/or cognitively impaired longer-stay population. Many enter a nursing center as their care needs go beyond their ability to stay in their homes. Others enter because their frailty and need for around-the-clock, comprehensive care can best be met in a professional care setting. Community-based services are enabling people to stay longer in their homes or assisted living residences, and this means by the time they do come to our skilled nursing centers, they are in need of more intensive care than this population required 10 to 15 years ago. Nearly half are taking nine or more medications.

These residents come from the hospital, home and other community residences and need assistance in performing activities of daily living, such as walking, eating and bathing. Much like short-term patients, they receive physical, occupational and speech therapies to keep their functional level at as high a level as possible. They may also require pain management, medication management, wound care, and counseling and social services. Some short-term patients may become long-term residents. After receiving the rehabilitation and other care required, it’s often determined that the patient is not going to progress to the point where he or she can return to the community. He or she needs a level of care that cannot be safely provided at home.

Marian

“I was living at home independently until I became ill and was admitted into the hospital with respiratory complications. I was weak, tired and anxious – more like panicked. I knew I wasn’t ready to be discharged home yet, so I chose MedBridge at Heartland of Oregon. I had an immediate sense that I was going to be well taken care of. Everyone here is so willing to help, and the respiratory program is exceptional. With my goal to be discharged back home, I knew Heartland was the perfect fit for me. With the programming and education I have gained at Heartland, I feel confident I will be able to take care of myself at the time of discharge.”
95% of patients reported being satisfied with the encouragement their therapist provided to help them meet their individual rehabilitation goals.

Theodore

“I was stuck in my hospital bed for five months. I was so weak, I couldn’t do anything for myself. The clinical staff and expert therapy team at ManorCare Health Services – Kenosha worked together to ensure I got stronger. I’m on top of the world now! ManorCare is a very special place for me, full of very special people. I feel confident and secure about returning home and am looking forward to continuing outpatient therapy at ManorCare.”

92% of patients rated the respect shown them by therapists and nurses as “Excellent” or “Good.”
We believe that our mission is to enrich lives. That begins with every life we encounter – our employees, our patients and those who love and care for them, the communities in which we operate, our stakeholders and those who are yet to become our customers.
The Heartland Hospice Interdisciplinary Team (IDT)

Patients with heart failure and other chronic diseases benefit most with care from the entire interdisciplinary team. This necessitates employing specialized professionals to efficiently guide patient care throughout the episode of the illness. At least four core team members develop and implement the initial plan of care. Each patient is discussed at an IDT meeting every two weeks. The physician’s role is essential in providing the medical perspective to negotiate the plan of care in keeping with the patient’s and family’s wishes. The physician also collaborates with the other members of the team in developing mutually agreed-upon plans of action.

A Hospice Care Story

My husband, Mark, died a little over a year ago from end-stage congestive heart failure that he fought for six years. Mark was a 65-year-old elementary school teacher who was first diagnosed with heart failure following a heart attack. Initially, treatment was mainly medications and fluid restriction. But Mark’s biggest problem in coping with his illness was sticking to his medications. As he was still actively teaching, he found it difficult to take his water pills because it meant he would have to use the bathroom frequently, and this interfered with his being in the classroom. Mark had always led an active life, and his love for teaching made it hard for him to comply with his therapy.

“Why won’t you listen to the doctors and do what you’re supposed to do?” I pleaded with him.

“I don’t like how the medications make me feel, and it’s depressing to be sick all the time,” Mark replied.

Eventually, he stopped taking his medications and stopped seeing his cardiologist. As time went on, Mark began to have more problems. In the beginning, he felt tired all the time, along with experiencing shortness of breath and swelling of his legs. One night, I was awakened by Mark gasping for air, and I called 911. He was admitted to the hospital, and we learned that his heart failure had progressed to a stage III, coupled with kidney failure. Mark’s health began to decline rapidly. He could no longer work and needed my help with bathing, dressing and other activities we often take for granted when we are healthy.

During his fourth hospital admission in three months, he had severe shortness of breath, low blood pressure, nausea and acute renal failure. He was started on IV medication to correct his low blood pressure, but when the cardiologist tried to wean him off that medication,

Heartland Hospice gave care to my aunt in Santa Clara, California for 10 months. I would like to tell you how much we appreciate the professionalism and the care my aunt received.

The Heartland Hospice Interdisciplinary Team (IDT)

Patients with heart failure and other chronic diseases benefit most with care from the entire interdisciplinary team. This necessitates employing specialized professionals to efficiently guide patient care throughout the episode of the illness. At least four core team members develop and implement the initial plan of care. Each patient is discussed at an IDT meeting every two weeks. The physician’s role is essential in providing the medical perspective to negotiate the plan of care in keeping with the patient’s and family’s wishes. The physician also collaborates with the other members of the team in developing mutually agreed-upon plans of action.
Nurse

The registered nurse has experience in physical assessment, pain and symptom management. In this role, the nurse coordinates care so the patient and family can receive needed supplies, treatments and interventions to alleviate physical, psychological, social and spiritual pain. She/he works closely with the physician and the interdisciplinary team to meet complex patient needs to promote quality care.

his symptoms returned. The cardiologist suggested he be seen by the heart transplant team for either a transplant or an invasive therapy using a mechanical heart pump, which might improve his quality of life and chances of survival.

I was feeling overwhelmed and scared. Mark was getting excellent medical care, but we both needed more. You see, while my husband and I were close, we didn’t share with each other how we were feeling or what we thought we should do as Mark’s illness progressed. Mark was a private person and only communicated things in bits and pieces. I didn’t want to create more stress and discomfort for him by telling him about my fears. Maybe we were trying to protect each other from additional pain.

I remember our doctor mentioning Heartland Hospice during one of our visits. “Mark isn’t ready yet, but remember, when you need additional emotional and spiritual support, Heartland is available.”

His words came back to me as I watched my husband’s health fade. I knew we had used all the coping tools in our toolbox and now needed the reinforcement and help of others. I called Heartland Hospice to learn about hospice care. Within a couple hours, a Heartland team member came to our home to speak with us. She was a social worker and took time to answer all of our questions and concerns. During the course of our conversation, it became clear that Mark could benefit from hospice, but he was hesitant.

“I don’t want to feel like I’m giving up,” he said.

The social worker nodded her head and said exactly what he needed to hear. “Mark, you aren’t giving up. It is extremely courageous to admit you need help. We want to help you live your life to its fullest for the time you have remaining.” Tearfully, Mark agreed to receive the gift being offered.

Social Worker

The medical social worker has five critical aspects in the support he/she offers:

1. Assess the psychosocial and cultural needs of patient and loved ones.
2. Educate in regards to resources available and relevant topics related to illness.
3. Advocate on behalf of the patient and loved ones to the interdisciplinary team, local and state programs, and care facilities.
4. Facilitate important conversations with the patient, loved ones and community partners in care.
5. Provide interventions as needed to assist the patient and loved ones in attaining their goals.

The social worker participates in interdisciplinary team meetings to communicate identified patient and family needs as an integral component to the plan of care.

We had Heartland Hospice in Shawnee, Oklahoma and could not have been more pleased. They were professional, they were personable. It was absolutely wonderful. I would be willing to write or document or recommend. Anything I can do to make sure this agency receives credit and gratitude from our family. They went significantly above and beyond.
That same day, the nurse came and helped us understand the support we would receive for Mark’s physical needs. The nurse asked a lot of questions and answered ours. He helped me organize and understand Mark’s medications. He asked Mark if he wanted a nurse’s aide to come and help him with bathing and dressing. Mark wasn’t ready for that yet, but it was such a relief to know that when the time came, that kind of service was available.

In the days that followed, we met several new people. The social worker returned and helped us have conversations that were hard to get started on our own. What funeral home would we use? Is there unfinished business that Mark would like to take care of? Another member of the Heartland team, a spiritual care coordinator, came for a visit. We were both uncertain how this would turn out. Mark and I did not have a church affiliation but became more interested in spiritual things as his illness progressed. She had a calming presence and wanted to know about our hopes and fears and what was meaningful to us and gave us purpose. Mark talked with her about his love for being in the woods. When he was having a good day, they would sit outside and stare into the forest behind our home while they talked. Mark always seemed happier after those visits.

On behalf of my entire family, I would like to express our sincere thanks for the exemplary care given to my mother. The Allentown Heartland Hospice team worked together to manage her care with excellent physical symptom management, along with spiritual and emotional support for her and my family.

Spiritual Care Coordinator
A spiritual care coordinator (SCC) humbly enters the life of a patient and his/her loved ones with an open mind. The SCC offers compassion, understanding and acceptance of diverse religious and spiritual beliefs. Our patients and families are accompanied every step of their journey and encouraged to explore issues of faith, peace, transcendence, strength, meaning, hope and purpose. An SCC can also make connections with leaders of faith communities on behalf of the patient and facilitate the patient being served by his/her specific denomination or faith fellowship. Upon request, an SCC can participate in a patient’s memorial service or funeral when the time comes.

Bereavement Coordinator
Chronic and terminal illnesses bring about multiple and ongoing losses for patients and their loved ones. Because of this, Heartland is committed to providing grief and loss support from the time of admission through 13 months following the death of the patient. The bereavement coordinator will assess the bereaved for complicated or prolonged grief and develop a plan of care appropriate for each person. Heartland’s bereavement program is committed to supporting our patients, families and communities through programs such as Journey of the Heart, a support group of caregivers of dementia/Alzheimer’s disease patients, and In Your Own Words: Writing for Reflection, Remembrance and Renewal, a restorative writing program for anyone who has suffered a loss.
As Mark’s health deteriorated, I became fearful and stressed. The social worker asked if I would like to have a visit from the bereavement coordinator. I was so focused on caring for Mark, I didn’t think of addressing my own needs. The bereavement coordinator and I became fast friends. It was a relief to know that she and I would continue our relationship even after Mark was gone; I wasn’t going to be left alone. She also helped me see the wisdom in accepting a volunteer to come in and visit with Mark so I could get out and run errands.

The day came too quickly for Mark to leave me, but the support of the Heartland team was all around me. The gifted hospice team of professionals walked the eight-month journey with my family and me until Mark’s death. Mark and I had the courage to explore the reality of his health, but we didn’t have the knowledge or skills to know where to begin. Heartland helped us understand Mark’s complex medical needs and prognosis. They made it clear to Mark that he was in control of his own life until the very end. You’ve heard it said, “It takes a village to raise a child.” Well, I think it takes a village to help someone die, and Heartland was our village.

I’m just calling to let you know that this was the best care for any patient that I have ever known. Heartland Hospice Services in Richmond, Virginia is so knowledgeable with care for people. You taught me so much. From the deepest part of my heart, I truly do thank you.

Home Health Aide

Home health aides are one of the most valued services provided by hospice. The home health aides are essential in meeting the patient’s personal care needs. Because they are in the patient’s place of residence more frequently than other members of the team, they often become aware of the patient’s deepest emotional and spiritual needs and communicate this to the RN for care plan coordination. As a part of the hospice team in supporting the patient’s goals, the home health aide creates a positive difference in the care provided.
My mom has been receiving home care from Heartland in Myrtle Beach since mid-February, and we couldn’t be more pleased! She resides in assisted living and with Heartland’s help was able to return after breaking her leg and numerous complications. We feel so lucky to have crossed paths with your wonderful folks. Thank you for the way you have enriched my mom’s life…and mine!

Nurse Practitioner

The hospice nurse practitioner is employed by Heartland Hospice Services and works under a collaborative agreement with the hospice medical director and/or team physician(s) to provide clinical expertise, consistent care and accountability. The nurse practitioner provides face-to-face hospice assessments for the Heartland Hospice Services agency and communicates his/her findings with the certifying physician. To foster improved processes at our agencies, we have established thresholds for medical practice nurse practitioners to ensure timely review and evaluation of medical treatment plans, diagnostic tests, lab results, medication lists and goals of care for assigned patients.
Memory Care

We know. We understand.
We can help.

93% of the families of residents rated their overall satisfaction with Arden Courts centers as “Excellent” or “Good.”
It was an agonizing decision. No one likes the idea of putting a parent in the care of others. But what could I do? I had a job. I had a family. I couldn’t devote 24 hours a day, every day, to caring for my father. Even if I had the skills and training to do so (which I don’t), the responsibility was physically (and emotionally) impossible.

When my mother died, my dad was 77 years old. He lived about 800 miles away from me and my family, but that was OK, because he was fine taking care of himself. But then we noticed how he began to repeat things, sometimes in the same conversation. Then he began having trouble keeping up with his bills. Twice he found himself locked out of his house. He wanted to remain on his own, but he agreed to move near us. We found a senior living center where he would have his own small apartment with a kitchenette, but he could also enjoy facility activities and take part in meals in the facility’s main dining area.

At first, it was like going back in time, as I got to spend some wonderful days with my dad, times that I had missed out on since we had moved away. He especially enjoyed being with his two grandkids, and they enjoyed it, as well. But then things started to change. My dad would wake up in the middle of the night thinking it was breakfast time. He told me people were coming into his apartment and taking things. He couldn’t remember appointments, even when I left notes for him. He started feeling depressed and was losing weight. Then he began to turn on me, accusing me of stealing from him.

Making the Care Decision

The team at our Arden Courts memory care communities knows the emotional commitment and critical decisions that families must manage as dementia progresses and greater loss occurs. Making an informed care decision includes understanding changes, safety risks and determining the right time to choose a protected and safe environment. Waiting until a crisis such as leaving on a stove, wandering away from home, a car accident, setting the microwave on too long and an inability to dial 911 can result in heartbreak and misfortune for the individual with memory loss and for family members seeking to allow independence when what’s needed is a protected environment.
The Arden Courts Experience

Memory care is all we do at Arden Courts, and programs have been developed to maximize each resident’s remaining skills and abilities to enhance their sense of independence and increase their self-esteem. We have found that when structuring the day for someone living with dementia, programs must be based on that individual’s interests, hobbies and habits, which have been formed over a lifetime. One size programming does not fit all. Through the tens of thousands of individuals with this disease that we have cared for in our communities throughout these two decades, we have found that effective programs rely on activities that are created and adjusted to individual needs and functional ability.

Soon, management at my dad’s facility said he had progressed beyond what they could offer there. But I was not ready to accept that he needed supervised 24-hour care, and thus began an odyssey covering five more facilities, trying to find one suited to his needs. I can only describe this odyssey as nightmarish. I found that a residential, home-like setting doesn’t mean they know anything about treating dementia. I found that medication was a common way to keep residents “under control.” I found that when someone has sunk as far into dementia as my dad, you have to find a community where all they do is memory care. That was when I found Arden Courts.

My dad’s stay at an Arden Courts memory care community began with a meeting to talk about his condition. He was overmedicated from his last couple facilities, but staff at Arden Courts thought it important to stay the course for the first 30 days so he could better adjust to his new environment. After that, they would work on reducing use of medications and eliminating them where possible. I also learned in our discussion about my dad that every Arden Courts employee gets eight hours of dementia training when hired and four hours annually thereafter. Other programs, such as the Circle of Care, also provide training for employees’ interactions with residents – and one another. Managers are on duty on weekends and holidays. Care is everyone’s responsibility, and everyone is engaged in residents’ service plans.

A year ago when we realized that my mom could no longer care for my dad at home, we began the difficult search of finding a place for him to call home. Nowhere felt quite right until we found Arden Courts of Fort Myers. If we had to call Arden Courts with any questions, big or small, someone was always available to help. My dad went on several outings, which he enjoyed, and as a family we also participated and enjoyed several family events. We would recommend Arden Courts to anyone needing memory care for a loved one.
By the time he moved to Arden Courts, my dad was not as communicative and sometimes seemed almost robot-like, showing little emotion. But slowly things began to change. Set schedules and routines, balanced food and nutrition throughout the day, weaning him off unnecessary medications, and the programs and activities at the community started to bring my dad “back.” Twenty years of experience have developed programs at Arden Courts that maximize each resident’s remaining skills and abilities. There are programs for groups of residents, for individuals and for residents with advanced dementia who no longer can benefit from the traditional programs. My dad thrives in a group of residents who share his love of the outdoors in general and fishing in particular. I have heard him share more than one “whopper” of a story. There always seems to be something going on, and even at this level of dementia, the security of the Arden Courts environment allows residents the freedom to roam and explore throughout the community, including the outdoors when weather permits.

I had been told early in my quest for living arrangements for my dad that if I was to survive emotionally my dad’s slipping into dementia, I needed to join a support group. The executive director of my dad’s Arden Courts leads such a group once a month. We talk about the progression of the disease and how it affects family members, in addition to our loved one. Guest speakers lead discussions on care issues. I have made friends through this group that I expect will remain friends even after my dad passes. I can’t minimize the support of my husband and my kids. This hasn’t been easy for them either, and they have always been by my side, walking this journey.

My family member was a resident at the Arden Courts in Sterling Heights, Michigan. The level of care that he received was truly extraordinary. This has meant so much to me and my entire family. We live in Massachusetts and could not be there as much as we would have liked, but no matter when we came and how long we stayed, the staff on duty was cheerful and responsive. It struck me that he was truly part of a family at Arden Courts. The staff has such patience, and I feel that they truly understood this man and provided a level of care that even we could not. Thank you to the entire staff for this care.

Arden Courts Individual Pursuits

Individual Pursuits benefit residents who do not like or are cognitively unable to participate in structured group programs. Individual pursuits are arranged by programming staff and staged so that an individual is prompted to participate in such activities as leisurely outdoor strolls, pruning plants, sanding wood or working on a word game.

Arden Courts Engagement Therapy Treatment®

Engagement Therapy Treatment is an exclusive, trademarked Arden Courts program that provides an opportunity for residents with similar functional and cognitive abilities to socialize and share with others in a group setting. Sharing involves subjects such as art appreciation, poetry, food creations and craft projects. It is a way to enjoy times together, sharing past memories and discussions of the present in a small, structured group setting that nurtures communication and friendships.
94% of the families of residents rated the safety of our Arden Courts centers as “Excellent” or “Good.”

94% of the families of Arden Courts residents rated the respect shown them by staff as “Excellent” or “Good.”

96% of the families of Arden Courts residents rated the respect shown them by staff as “Excellent” or “Good.”

I would like to tell you how impressed and amazed I am with the staff, the quality of care and cleanliness at the Arden Courts in Palos Heights, Illinois. I can’t tell you enough what an amazing staff you have and what a wonderful facility. It is a gem in a world of mediocre and some even bad facilities we looked at for memory care. I highly recommend Arden Courts in Palos Heights to everyone I know looking for memory care. We couldn’t be happier knowing my dad is in such good hands.

Arden Courts Lifestyle Programming

Lifestyle Programming (similar to Engagement Therapy Treatment in that it involves interaction with others) is designed and developed to include physical, spiritual, musical, social, intellectual and creative programs that encourage interaction in an open community setting based on the residents’ interests, hobbies and routines, and to the extent that is reasonable and meaningful to them. One result of the programming is that it provides meaningful moments and stimulates friendships among participants.
The support group and the Arden Courts staff have been especially important as my dad enters a world where I am a stranger. The first time he didn’t recognize me was tearful. The first time he told me he didn’t have any children was agonizing. But I’ve learned to enter his world and play whatever role allows me to spend time with him. The now fleeting times when he’s back in my world are a bonus. My dad knows when I’m there, but doesn’t know when I’m not, and this helps me with my peace of mind.

I visit my dad several days a week, although the visits have become shorter and less frequent. I need to see him, but when I see the great care he is getting, his interaction with other residents, how absorbed he gets in activities, I want to minimize the disruption to his world. And when there are days that aren’t going real smoothly, I can always count on staff to call me. What I appreciate even more is the call I get telling me about something warm and nice that happened with my dad or receiving photographs of him enjoying programs, entertainers and events with his new friends. That always brings a smile and is part of the support that gets me through the day.

The journey continues for my dad, my family and me, and I am thankful that I have the Arden Courts staff and their singular focus on memory care with us on this journey.

I can’t give enough praise to the staff who work here for their patience, understanding and caring ways shown to residents and families at Arden Courts of Seminole. I am so pleased that I have my mother in this facility. Everyone has been so pleasant to deal with and talk to. Every time I enter this assisted living facility, I am greeted with a smile and a hello. This facility is like a family. I just can’t say enough good things about the staff that works here.

Arden Courts Namaste Care Program

Arden Courts was the first national company to use the Namaste Care Program. Namaste is a Hindu term meaning “honoring the spirit within.” It is used most effectively with individuals with advanced dementia when verbal communication is limited due to the disease process, and touch becomes the meaningful language to demonstrate care, concern and love. Namaste Care nurtures and stimulates the senses using assistance such as scents of lavender, soft music, nature scenes, warmth, touch and hydration. It results in a state of peacefulness that cannot be reached by many late-stage dementia residents through other programs.
Experience Makes a Difference

Reducing Hospital Readmissions – Successful Transition of Care

Because discharged patients are leaving the hospital much sooner than in the past, they are more likely to be readmitted to the hospital due to lingering or new medical complications. The cost of these readmissions is prohibitive to the health care system and a target of government agencies to remove cost from the system. Just as important, once patients are released from the hospital, they don’t want to go back. HCR ManorCare is working closely with its hospital referral sources to help ensure there is a smooth transition from hospital to our centers so that when patients leave the hospital, they do not return.

A successful and safe outcome begins with a comprehensive assessment and development of a patient-specific plan of care. Education and counseling target individual and family concerns. Frequent meetings that include the patient, family and staff help ensure we are meeting patient needs, addressing any concerns and working toward patient goals. Challenges of home and community life after discharge are also addressed, which includes follow-up to ensure the patients’ well-being.

Communication is especially critical to decreasing rehospitalizations within the first 30 days of a patient’s stay in the post-hospital care setting. Evidence-based medicine indicates that the communication of specific and focused patient information can reduce those “bounce-backs” which occur in the first 24 to 48 hours. The medical literature indicates that patients seen within the first 72 hours of hospital discharge by a medical practitioner have a decreased risk of readmission. HCR ManorCare supports timely and frequent visits by a physician and/or a nurse practitioner as deemed medically necessary, particularly during the first three to seven days of a patient’s stay. HCR ManorCare has also developed an evidence-based toolbox for medical practitioners and clinicians as a guide for addressing patients with diagnoses that place them at higher risk for rehospitalization, such as congestive heart failure, acute myocardial infarction, stroke, COPD and pneumonia.

We continue to provide a series of educational programs to train nurses and nursing assistants in the early warning signs for care conditions that have been identified as reasons for rehospitalizations. This educational initiative is designed for everyday use and instructs the clinical teams in providing appropriate interventions for these specific care conditions. Missed communications are a primary cause of rehospitalizations that occur between day 8 and day 30 after discharge. Our educational initiatives have reduced rehospitalizations in this time period by as much as 20 percent.

Advanced Disease Management

Heartland Care Partners is a provider of short- and long-term health care with a particular emphasis on effectively treating medically complex patients. Oftentimes, patients could benefit from a higher level of consultation, management and involvement than they are receiving in their current setting. Heartland Advanced Disease Management is an established and rapidly growing program under the direction of Heartland Care Partners to provide patients with advanced disease and pain management when they are chronically ill but not quite ready or appropriate for hospice or dedicated end-of-life services. It provides consultation designed to help minimize the impact of a patient’s advanced disease by educating and making recommendations to physicians, patients and families regarding pain and symptom management and providing helpful information for complex health care decisions.
HCR ManorCare Independent Advisory Committee on Quality

In 2008, HCR ManorCare created an Independent Advisory Committee on Quality to provide advice and recommendations to the company’s Board of Directors on ways to measure, maintain and improve quality of care for HCR ManorCare patients and residents. The distinguished three-person panel is composed of Vincent Mor, Ph.D., Professor of Medical Science in the Department of Health Services, Policy & Practice at the Warren Alpert Medical School, Brown University; Robyn Stone, Dr.P.H., Executive Director of the Institute for the Future of Aging Services and Senior Vice President of Research for LeadingAge; and Gail Wilensky, Ph.D., Economist and Senior Fellow at Project HOPE.

The Independent Advisory Committee on Quality meets several times a year. During 2014, the committee focused on the continued integration of medical and nursing services as it relates to palliative care, expanded use of post-acute care hospitalists to reduce rehospitalization and ongoing enhancement of the electronic medical record. The committee noted the continued improvement in both quality and regulatory outcomes during the year.
Partnerships to Improve the Post-Hospital Care Experience

HCR ManorCare is collaborating with referral sources, health care insurers, health care systems and others in the health care field to find ways to improve the quality and delivery of health care. Through partnerships with world class health care companies, our goals are to achieve improved patient outcomes, improved transitions between acute and post-acute settings, and, ultimately, to enhance the patient experience. Here is an example of one of these partnerships.

Kaiser Permanente and HCR ManorCare have had a long-standing, successful collaboration, one which shares a common vision – to deliver coordinated, comprehensive health care that keeps patients as healthy as possible. As part of Kaiser’s select network of highest-performing facilities, the ManorCare Health Services Wheaton, Maryland skilled nursing and rehabilitation center has a wing dedicated to Kaiser patients. This provides greater efficiency and improved continuity of care.

The Wheaton center houses an onsite office suite for Kaiser physicians, case managers and social workers, allowing for close communications and routine open dialog as it relates to the care plan and transitions for patients. But beyond physical proximity, it is about the collaborative relationship that the Kaiser and Wheaton teams have built over the course of the past 20 years.

The combination of a good data environment, strong end-to-end processes, clear communications and a patient-centric focus creates integrated care. Ultimately, it is this deep level of commitment to the partnership that has enabled the relationship to find efficiencies that reduce costs, improve or maintain quality and promote innovation.

In October 2014, Wheaton and Kaiser entered into an innovative episodic payment arrangement. The “episode payment” is a single price for all of the services needed by a patient for an entire episode of care (i.e., all of the inpatient care they would need at the Wheaton facility). This episode payment system changes the focus from the daily measurement of nursing and therapy care to the management of the patient’s total condition and keeps the patient’s rehabilitation goal as the driving force for his or her care across the “episode” of the stay in the post-acute center. This new method of managing care gives us the flexibility to decide what services should be delivered and to deliver them in an efficient and effective manner. At the same time, clinical outcomes, customer service and, in particular, hospital readmissions have been maintained or improved. The three-month rolling rehospitalization rate is approximately 11.5 percent.
Growing Leaders from Within

At HCR ManorCare, we have a tradition of providing experiences for employees to help with their job satisfaction and to assist their growth into more responsible positions. This has led to long-tenured employees.

- Over 7,500 employees have 10 years or more of service.
- Almost 2,000 have 20 years or more of service.
- Over 500 have 30 years or more of service.
- 32 remarkably have 40 years or more of service.

These experiences can also put employees on a track to achieve a leadership role in our company. All of our Vice Presidents/General Managers with operations responsibility have been promoted from within the company, and all have at least 20 years of service. Together, their experience with our company totals nearly 175 years.

**John Graham, VP/General Manager, Assisted Living Division**

Joined our company in 1987 and was named Marketing Projects Coordinator in 1988. He served as an Assistant Administrator of a Wisconsin skilled nursing center in 1989, and advanced to Manager of Planning in 1990. He held a series of jobs in operations support and product development before advancing to Assistant Vice President, Director of Planning and Corporate Marketing in 1996. A year later, he was named Assistant Vice President/General Manager of Ancillary Businesses. In 1998, he was named Vice President, Director of Rehabilitation Services, and in 2000 also became General Manager of the West Division. Named Vice President/General Manager of the Eastern Division in 2002 and Group Vice President, Hospice and Home Health Care in 2005. Named to his current position in 2008.

**Alan Hash, VP/General Manager, West Division**

Joined the company in 1990 as Area Controller for several of our skilled nursing centers. In 1993, he was promoted to Regional Controller with responsibility for 15 centers. In 1996, he was promoted to District Director of Finance/Administration for three Midwest states, and in 1998 was promoted to National Director of Collections. Later that year, he was named Senior Financial Services Consultant with responsibility for business office functions for 90 centers in the Midwest. In 2001, he was promoted to Director of Collections, and was named Regional Director of Operations in 2002. In 2008, he was elected to his current position.

**Lynn Hood, VP/General Manager, Atlantic Coastal Division**

Joined our company in 1991 as Administrator of a skilled nursing center in Florida after several years in various positions with another nursing center in Connecticut. She advanced to Senior Administrator in 1994, and in 1995 was named Regional Director of Operations for a group of company nursing centers in Florida. She held this position until being named Assistant Vice President/General Manager of our company’s South-West Division in 2004. In 2006, she was named Vice President/General Manager of the newly formed South Division, which was later expanded into the Atlantic Coastal Division, for which she now has responsibility.
Sue Morey, VP/General Manager, Eastern Division
Joined our company in 1984 as Director of Physical Therapy at a Pennsylvania skilled nursing center and advanced to Division Physical Therapist in 1988. She was named Division Rehabilitation Director in 1994 and Regional Director of Operations in 1997. She advanced to Assistant Vice President/General Manager for the Eastern Division in 2001, and was elected to her current position in 2005. She served in the health care industry for 10 years prior to joining HCR ManorCare.

Linda Neumann, VP/General Manager, Great Lakes Division
Joined our company in 1990 as an RN Nurse Supervisor, and in 1993 was promoted to Director of Nursing for a Michigan skilled nursing center. In 1994, she advanced to the position of Professional Service Consultant for the Midwest Division, and two years later was promoted to Director of Clinical Services for the Central and Midwest Divisions. She was Director of Quality Process beginning in 1999, a position she held until being named Regional Director of Operations in the Midwest Division in 2000. She was named Assistant Vice President of the Central Division in 2007 and elected to her current position in 2008.

David Parker, VP/General Manager, Central Division
Joined our company in 1995 as Administrator of a Maryland skilled nursing center. He advanced to Senior Administrator a year later, and in 1997 was named Regional Director of Operations for a group of company nursing centers in Ohio. He held this position until 2003 when he was named Assistant Vice President/Assistant General Manager of HCR ManorCare’s Central Division. In 2007, he was appointed Vice President/General Manager of the company’s Mid-Atlantic Division, a position he held until his current one, which he assumed in 2011. He served in the health care industry for six years prior to joining HCR ManorCare.

Mike Reed, VP/General Manager, Heartland Home Health Care and Hospice
Joined our company in 1986 as a Regional Marketing Manager in the Chicago market. He moved to operations as a Regional Director of Operations for a group of skilled nursing centers in 1988, and became Vice President/General Manager of a skilled nursing division in 1990. He was named Vice President/General Manager of Assisted Living, became Vice President/General Manager of skilled nursing locations in Maryland and Virginia, and then was named Vice President of Sales. After an absence, he returned as Vice President/General Manager, Assisted Living Division. He was named to his current position in 2008.

The other officers in our company have a very similar history. They average nearly 20 years of seniority and more than 375 years of combined service. Almost all of them have held multiple positions within our company and have been promoted into several roles of increasing responsibility to reach their current leadership positions.
The Hug Fund, a non-profit charity, is a partnership of HCR ManorCare employees helping their fellow employees who have experienced a catastrophic event causing financial hardship. The fund provides financial assistance to employees who are unable to meet their urgent need. Through the financial support of HCR ManorCare employees, the Hug Fund is able to offer hope and peace of mind for our employees across the nation.

An Employee’s Experience Defines the Hug Fund

When I was looking for a job, one of the things that drew me to HCR ManorCare was that this company has a good understanding of how important it is for employees to feel cared for and supported. As a Human Resources Manager, I truly believe that if you value and care for your employees, your employees will provide excellent care for their patients. It’s extraordinary to work for a company where not only does the company value its employees, but these same employees value and care for one another.

The Hug Fund program is strong evidence of employees caring for one another. It’s not just words; it’s compassion in action. In my job, I am a liaison between staff and the Hug Fund. Many times when a co-worker falls upon hard times related to a sick child or death of a spouse, the rest of us respond by taking up a collection of money. The Hug Fund does this, but on a much larger scale.

It never occurred to me that I would someday be in a situation where I would need help. For more than three years, I told others about the Hug Fund and provided guidance on whether or not employees met the conditions to qualify for grants. But I found it difficult to apply for myself. I wanted to be the giver, not the receiver. But after a double mastectomy, radiation and chemotherapy, I was out of sick days and vacation days and had negative balances in my checking and savings accounts. With trepidation and, frankly, a little embarrassment, I applied for a Hug Fund grant. The Hug Fund staff helped me through the process and within about two weeks I was awarded a grant that paid my household bills and helped me get back on track financially until I could return to work.

My experience as a grant recipient has made me a better employee. I’m more compassionate and less quick to make snap judgments. Everyone has a story, and we should always proceed cautiously and compassionately in the presence of our work family. We should be feeling proud that through the Hug Fund, we are able to care for one another in times of tragedy and sickness. I know that many of my co-workers donate to the Hug Fund and their hearts are big. To say I am grateful is an understatement. Hundreds of grants are awarded each year to employees who, like me, feel panicked, desperate and defeated by an unexpected catastrophic event in their lives. The Hug Fund brings comfort and relief.
The Heartland Hospice Memorial Fund, a non-profit charity, believes that people who are at the end of their lives should be able to focus on enjoying time with their family and friends, cherishing their last days and making lasting memories. But financial stressors due to a terminal diagnosis often complicate the end-of-life journey, leaving little time for families and friends to focus on this important time with the patient. The fund can relieve the financial pressures experienced by patients and their families coping with terminal illness and its aftermath by providing financial assistance with the daily expenses of everyday life.

The Experience of a Hospice Patient’s Family Defines the Heartland Hospice Memorial Fund

Quitting my job to be with my mom was a no-brainer. It wasn’t a choice but more of a natural and instinctual action. My main focus was on keeping her comfortable, pain-free and never feeling as if she was alone. I knew that I could one day return to my job as a registered nurse, and I thought my family could cut back on expenses, live a little leaner and get by on just my husband’s income. We were fine for a while, relying on savings and cutting back, but as time went on, we found it very difficult and then impossible to pay our bills without my income.

My time with my mom during the months before she passed was invaluable to me. Heartland Hospice staff kept her comfortable, and her mind was good, so we were blessed with many hours of family time. My mom told me over and over that she wasn’t afraid, wasn’t in pain, and that she could feel our love. She bonded with the Heartland Hospice staff and formed friendships that touched us all.

It became necessary for my husband to take time off from work to help me care for my mom, which was another blow to our financial situation. The time I spent with my mom was clouded by my worries about paying our mortgage and buying groceries. The Heartland Hospice social worker told me about the Heartland Hospice Memorial Fund and how the fund could help us pay for some of the things that were causing me stress. She was true to her word. We were given a grant to pay our mortgage for two months. That grant didn’t just keep a roof over our heads; it provided peace of mind and afforded the opportunity for me to care for and love my mom through her last days.

Each year on my mom’s birthday, we give a gift of money to the Heartland Hospice Memorial Fund. We do this not only to honor and celebrate her life and the wonderful care she received, but also to make sure that people just like us, who want and need to be with their loved ones as they approach death, can do so unencumbered by bills and money worries.