How healthcare reform opens new doors to senior living

Opportunities await senior living providers who offer viable solutions to hospital readmissions challenges, according to these forward-looking thought leaders

by Kay Van Norman, MS, and Khristine Rogers, BA

The Affordable Care Act, signed into law in March 2010, signals sweeping changes to healthcare in the United States. But what does this legislation mean for those who support older-adult health and well-being? Are there opportunities to expand services and partnerships, or rework existing ones, to improve customer health and quality of life as well as organizational bottom lines? In this article, two active-aging thought leaders present their vision of opportunities for senior living providers in the area of hospital readmissions.

For the past 15 years, the senior living industry has been steadily building quality metrics around the concepts of healthy lifestyles, prevention, and the social model of care. Progressive companies have made significant long-term

Continued on page 26

How healthcare reform opens new doors to senior living

Continued from page 24

investments in wellness centers, comprehensive whole-person wellness initiatives, and brand strategies embracing social connection, empowerment and well-being. Now, because of the Affordable Care Act, the senior living industry in the United States is ideally positioned to leverage these investments by offering integrated prevention strategies and wellness solutions to healthcare systems and consumers.

This article focuses on strategies assisted living can use to grow business without joining an Accountable Care Organization (ACO), and without changing acuity guidelines or the private-pay structure of the senior living industry. We believe that new independent and assisted living hybrids can also leverage the Accountable Care environment as they enter the marketplace seeking to reposition their value proposition to consumers. The rehabilitation industry has an equally great opportunity in this new environment, but that discussion is outside the scope of this article.

In brief, the Affordable Care Act includes a federal mandate to reduce costs for Medicare, the US national health insurance program for adults ages 65 and older, by focusing on quality metrics and outcomes rather than fees for services. Healthcare systems are challenged to reduce costs, improve quality outcomes, and improve the consumer's perception of, and satisfaction with, healthcare. If they fail to meet quality benchmarks, they are financially penalized. For example, on October 1, 2012, the Hospital Readmissions Reduction Program (within the Affordable Care Act) began penalizing hospitals for avoidable readmissions within 30 days of initial hospitalization for three "penalty diagnoses": heart failure, pneumonia and heart attack.[1] More penalty diagnoses are in the queue. And while hospitals already work with post-acute care partners such as skilled nursing centers, they are now incentivized to seek additional partners who can interrupt the costly hospital readmission cycle *and* help keep older adults out of hospital in the first place.

We believe senior living providers can increase professional referrals from healthcare systems by delivering cost savings and quality improvement, including:

- wellness strategies to prevent hospital admissions
- recovery support to prevent readmissions
- care coordination
- better customer/resident experiences

Providers can demonstrate their core competencies in these areas with already established wellness "best practices," quality metrics around social support and engagement, and customer service and satisfaction benchmarks.

To maximize opportunities, however, senior living must learn the language of Accountable Care. Providers must also track results and frame existing strategies with outcomes data, match existing internal quality metrics to healthcare needs, and essentially "double down" on prevention, wellness and the social model of care.

The senior-living business opportunity

Accountable Care calls on acute and post-acute care providers to optimize health outcomes and reduce spending in a data-driven environment. It's up to senior living providers to effectively educate the care continuum on the viability of senior living as a post-acute *recovery* option.

The drive to reduce avoidable hospital readmissions creates specific business growth opportunities for senior living. These include:

- increased professional referrals as senior living recasts capabilities to hospitals, physicians and post-acute providers (i.e., skilled nursing and rehabilitation centers)
- increased sales by leveraging the advantages of senior living's wellness and social model as a better "recovery" alternative to returning home
- return on wellness capital investments, and ongoing investments in wellness programs and staffing
- increased occupancy, length of stay, and revenue as short-term transition stays convert to long-term move-ins

Increase professional referrals

We believe Accountable Care creates a new selling environment that will help senior living generate more referrals from medical professionals. Hospitals and healthcare professionals have a financial incentive to consider new post-acute recovery partners who can offer innovative solutions to reduce both hospital admissions and readmissions. As a result, senior living providers can become desirable business partners by leveraging their current acuity guidelines for assisted-living support, and framing complete (and immediate) solutions based on strategies they already employ. However, sales success will depend on your ability to offer solutions backed by outcomes and healthcare system needs. Start by knowing your referring hospital's readmissions data as well as your own. You can research the 30-day readmissions rates for hospitals across the US at www.medicare.gov/hospitalcompare. Then use the research outcomes related to the goals of the Affordable Care Act and your own community's outcomes stories to package and sell solutions to a referring hospital's penalty risks.

Tell the senior living story

Even before you have community-based outcomes, you can tell the senior living story with industry data and evidence-based outcomes. For example, chronic

Continued on page 28

How healthcare reform opens new doors to senior living

Continued from page 26

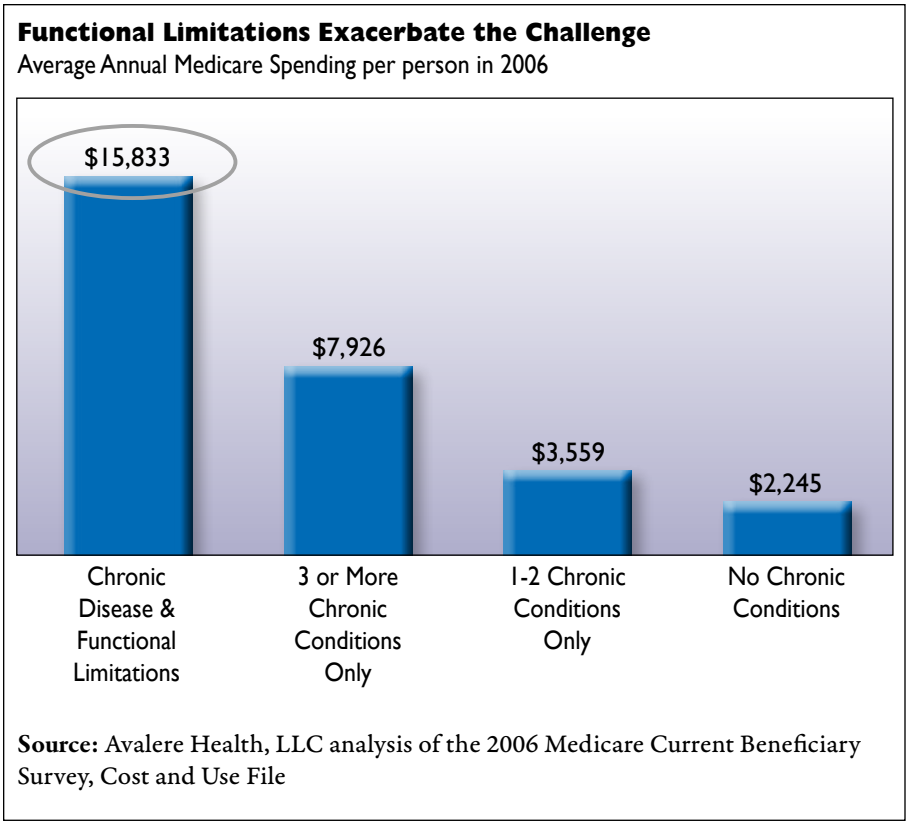


Figure 1. Functional Limitations Exacerbate the Challenge.

disease and the inability to perform activities of daily living (ADL) are two factors that drive hospital readmissions and healthcare costs. Figure 1 on this page illustrates how Medicare expenditures increase significantly when a person is challenged with a chronic condition, and costs grow steadily with each additional chronic condition. Costs more than double when a person has both chronic conditions and functional limitations.

Senior living providers have done an outstanding job creating healthy lifestyle environments to help prevent and manage chronic conditions. They are also experts at providing support for instrumental and basic ADL. And research demonstrates that senior living can play a role in reducing healthcare costs for individuals with moderate to severe disabilities (see Figure 2 on page 29).

You can quickly translate these core competencies into language that resonates with healthcare professionals by describing how senior living can reduce healthcare costs related to chronic disease and ADL needs. Supporting these claims with compelling research can help you build meaningful relationships with referral networks and craft strategies to "sell against home" (see page 30 for information).

For example, De Palma et al.[2] found that one in four Medicare patients returns home with unmet ADL needs for new or existing ADL disabilities, and unmet ADL needs significantly increase risks for hospital readmission. Research also shows that living alone, having unmet functional needs, lacking self-management skills, or having limited education was associated with an increased likelihood of early readmissions.[3] Finally, community-based frail older adults, burdened with complex medical and social needs, are at great risk for preventable rapid rehospitalizations.[4]

Frame solutions

The senior living model offers solutions to other factors driving hospital readmissions from patients discharged to home. These factors include lack of transportation to follow-up appointments, failure to understand and/or follow care plans, and lack of medication reconciliation and management.

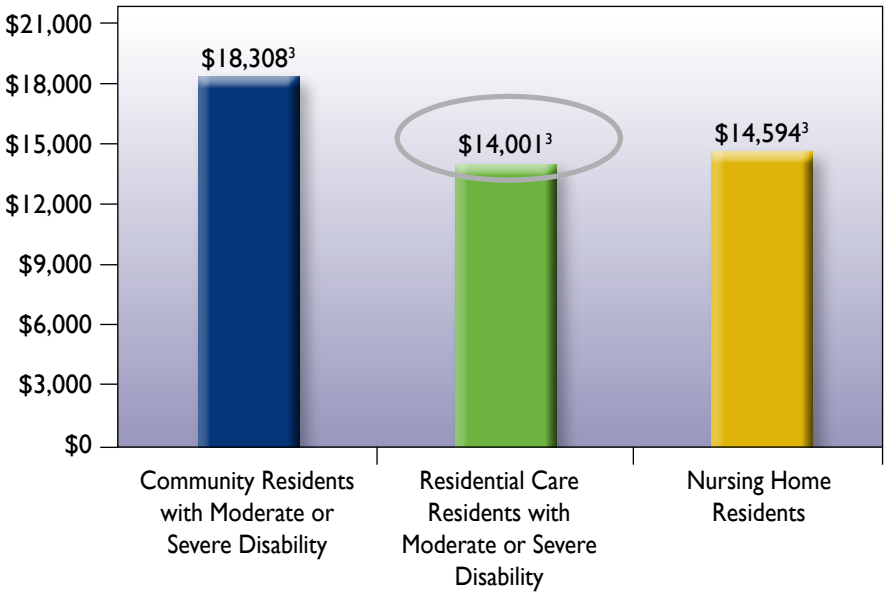
Medication mismanagement poses one of the greatest hospital readmission threats for patients who discharge to home without care support.[1] Medicare patients typically are taking multiple medications when they admit to the hospital, where new medications are often added and changes made to existing prescriptions. This can leave individuals understandably confused about what medications they should continue to take when they leave the hospital, especially when no one takes responsibility for medication reconciliation and management.

Another factor in rapid hospital readmissions for Medicare patients discharged to home is a change in health status that goes undetected until it's too late to prevent readmission.[4] Senior living providers can hone their current transitional care strategies to quickly identify and report changes in health status for rapid intervention.

Consider, for example, the Stop and Watch Tool employed in Brookdale Senior Living's CMS Health Innovations Challenge Grant[5] (also see the sidebar on page 30). Stop and Watch is a component of INTERACT [Interventions to Reduce Acute Care Transfers], a comprehensive quality improvement program created by geriatrician Joseph Ouslander, MD, and colleagues. The Stop and Watch component encour-

Senior Living: Part of the Solution

Total Per Capita Medicare Spending For Beneficiaries with Disabilities, by Residence Setting, 2006



1 Seniors with moderate or severe disability includes community residents and residential care residents with 2 or more Activities of Daily Living (ADL) needs and all nursing home residents. N= 1,161,759 community residents with 2+ADLs, 202,161 residential care residents with 2+ ADLs, 817,954 nursing home residents, and 24,553,318 community and residential care residents with no disabilities. Excludes beneficiaries who died in 2006.

2 Includes spending on inpatient hospital, outpatient hospital, physician, emergency department, skilled nursing facility, home health, and hospice. Excludes prescription drugs, DME, and miscellaneous Medicare spending.

3 The differences in spending between all 3 residence settings are statistically significant at the p = 0.05 level.

Source: The Scan Foundation and Avalere Health

Figure 2. Senior Living: Part of the Solution.

ages all staff (clinical and nonclinical) to report even subtle changes in health status or behavior with a simple observational reporting tool. This strategy gives all staff encouragement, support, and a simple *method* to report perceived changes in resident status, resulting in rapid intervention in health changes.

Kevin O'Neil, MD, Brookdale's chief medical officer, identifies another benefit of the Stop and Watch tool. The reporting staff member receives follow-up validation, clear acknowledgement of how important nonclinical staff observations are to resident well-being. "This simple thing can improve staff self-efficacy and sense of value," he notes. Considering the high rate and cost of staff turnover in senior living, improving staff satisfaction is an important staff retention bonus.

Jamie Huysman, PsyD, LCSW, vice president of WellMed Medical Management, reinforces the role nonclinical partners can play in reducing avoidable hospital admissions and readmissions. He observes that, in the past, healthcare teams would attempt to solve care transition problems alone, even though underlying issues such as self-perceptions, lack of social support or depression could be primary drivers. Now, healthcare has a financial incentive to engage social service and allied health professional networks, skilled in care coordination and client evaluation from a "whole person" perspective, to help identify and implement post-discharge compliance strategies. He describes these professionals as "more relevant than ever" in this new healthcare environment.

Community-based multidisciplinary teams are rising to the challenge. For example, Huysman describes a proposed Care Transitions Pilot Program currently being designed by WellMed and Your Aging Resource Center (Florida's Area Agency on Aging of Palm Beach and the Treasure Coast) that will focus on hospital discharge and post-acute care follow-up, care transition coordination, and community-based social service coordination.

Senior living can act to strengthen relationships with social services and allied health professionals. First, providers must clearly understand and embrace their own core competencies; and, second, they must ensure these networks understand how senior living can both support transitional care needs and optimize health recovery for private-pay clients.

Short-term stays: offering a complete solution

As senior living providers already offer solutions to many hospital readmission challenges, there is an immediate opportunity to translate existing short-term

Continued on page 30

How healthcare reform opens new doors to senior living

Continued from page 29

Brookdale Senior Living: highlights of post-acute care strategies

Brookdale's Bridges™ program impact (2009–2011)

- Significantly reduced 30-day hospital readmissions.
- Enhanced resident care planning across care continuum.
- Improved customer satisfaction.
- Increased hospital referrals.

Brookdale's CMS Health Innovations Challenge Grant

- Three-year, US$7.3-million grant (2012) to University of North Texas Health Sciences Center, partnering with Brookdale.
- Revise and implement INTERACT II, a comprehensive quality improvement approach to reduce hospital readmissions.
- Electronic medical records and sharing.
- Clinical nurse leaders will act as program managers and train care transition nurses and other staff.
- Twenty-seven communities in Florida and Texas, with intent to expand to all Brookdale locations.
- Expected savings of more than US$9 million.

stay options into post-acute stays. Consider how to package and articulate what you're already doing into a complete post-acute recovery stay solution. Examples include care transitions, medication management, ADL support, nutritional support, healthy lifestyle support, transportation to appointments, and care coordination and communication. (See "30-Day Post-Acute Recovery Stay" on page 32.)

This is not about senior living trying to replicate or compete with skilled nursing. In fact, it's just the opposite. Senior living can increase referrals from health professionals and systems (including skilled nursing) by providing an optimal environment and maximum support for the fullest recovery possible from a health crisis. And, as a private-pay industry, senior living can offer solutions without competing for Medicare dollars.

Selling against home

Continuing to live at home is consistently identified as the number one competitor of senior living. In this new business environment, senior living has a unique opportunity to demonstrate how it can be a more effective wellness recovery option than returning home after a hospital stay. Customers not only have the opportunity to regain their prehospitalization health status, but they also gain the tools and support to get stronger and healthier than they were *before* hospitalization.

Spotlight recovery

According to Brookdale's Dr. O'Neil, a hospitalization can be an "index event" to motivate changes in health behavior. Many patients leave the hospital with a renewed sense of urgency to improve health, but without targeted behavior change support, they rapidly return to old lifestyle habits. Senior living can leverage its wellness environments to educate patients about, and actively support, guided self-responsibility for health as a key advantage to their short-term recovery stays.

Trial stay residents who experience a socially engaged, whole-person wellness environment during a short-term recovery stay in senior living often chose to move in versus return to home. Short-term recovery stays are a prime opportunity to *demonstrate* the common senior living promise of optimizing independence and quality of life, and to become a premium recovery option in the minds of healthcare providers and consumers alike.

Leverage the social model

Senior living does a good job of showcasing the social model of care as an intervention to social isolation and loneliness. In this new environment, however, providers must actively link this model to interrupting the hospital readmission cycle, and preventing hospital admissions in the first place.

Showcase the value of the social model of care, compared to home discharge, by weaving research outcomes on engagement, social support and loneliness into the sales narrative. For example, engagement in life has long been identified as central to successful aging, and research now documents the health risks of disengagement, isolation and loneliness.[6] One recent study conducted in Amsterdam with older adults living outside a long-term care setting found that feelings of loneliness increased the odds of an individual developing dementia by 64%.[7] In addition, Perissinotto et al.[8] recently concluded that among participants older than 60 years, loneliness was a predictor of functional decline and death. Lonely individuals were more likely to experience decline in ADL; develop difficulties with upper-extremity tasks; experience decline in mobility; and have difficulty climbing stairs. We believe the growing body of research demonstrating that loneliness can be as detrimental to health outcomes as chronic conditions, strongly positions senior living as a viable alternative to returning home after a hospitalization.

Leverage wellness investments

Research linking ADL deficits with hospital readmissions is only a small portion of the extensive research showing how physical activity improves health outcomes. This is where independent living can shine. Many operators have invested in resistance and cardiovascular equipment and training programs. Compelling research proves that physical frailty

Continued on page 32

How healthcare reform opens new doors to senior living

Continued from page 30

can be prevented and even reversed with quality resistance-training programs,[9] while both cardio and resistance training improve heart health, functional ability, depression, and chronic disease prevention and management.[10] Healthcare reform has created the perfect platform for senior living to showcase its capital investments in wellness centers and equipment, as well as ongoing programming and staffing of supervised exercise opportunities.

30-Day Post-Acute Recovery Stay

Transition and care plan implementation and follow-up

- ☐ Medication reconciliation and management
- ☐ Basic and instrumental activities of daily living support
- ☐ Health status communication and reporting
- ☐ Healthy meals and nutritional support
- ☐ Transportation services
- ☐ Evidence-based prevention and intervention tools (supervised exercise, fall prevention, chronic disease self-management, etc.)
- ☐ Opportunity-rich wellness environment
- ☐ On-site rehabilitation services (if available)

Immersion in a culture of shared responsibility for health

- ☐ Staff/residents as partners in recovery
- ☐ Social engagement and support
- ☐ Optimize functional independence
- ☐ Counseling and support regarding healthy lifestyles
- ☐ Engagement coaching

Leveraging investments in exercise and wellness initiatives offers two distinct opportunities for senior living:

- gathering data and speaking in outcomes language to healthcare systems about your prevention and health improvement solutions
- recasting senior living as a "wellness" living option in the minds of the broader community and older adults who may believe that staying home is their best chance for independence

In fact, according to Dr. O'Neil, even many physicians do not clearly understand the difference between senior living products—skilled versus assisted and independent living. The reality is, regardless of all the messaging about independent living being the "active living" option, most people still lump senior living into one category: nursing homes. We believe that healthcare providers now have an incentive to examine different senior living capabilities. And senior living has a prime opportunity to clearly differentiate its options in the minds of both healthcare providers and consumers.

Industry challenges

A key challenge for senior living is becoming fluent in outcomes, the language of Accountable Care. But the good news is you can start by leveraging industry data and outcomes from evidence-based programs while creating your own community's outcomes process.

Prove it with data

In our experience, many providers employ evidence-based strategies that already have outcomes measures and data (e.g., Stanford University's Chronic Disease Self-Management Program, FallProof from California State University, Fullerton's Center for Successful Aging). If you have supervised exercise programs, you have an outcomes story to tell based on volumes of research linking physical activity to positive health outcomes. These evidence-based programs can become your initial point of difference when meeting with professional referral networks, while you become proficient at collecting outcomes of your own.

Outcomes are available within any senior living community, even if they are not currently well organized or easily accessible. For example, incidents like falls and hospitalizations are carefully reported and documented. That data can be assimilated to start building your outcomes story. Don't let gaps in data tracking intimidate you; start with what you have and coordinate with your company's information systems (IS) and technology resources to clarify what needs to be measured. Communicate specific data gaps to your IS team so you can plan how to capture the outcomes that are meaningful to your referring professionals.

Operationalize it

Product positioning in this new environment requires a coordinated approach between three key areas in senior living:

- operations
- functional groups, including care, wellness, resident engagement and programming, and culinary
- sales and marketing

Senior living providers possess the capabilities and skills to package, leverage and sell programs as viable solutions to hospital readmissions challenges. But strategic alliance development takes time and focus, and very few companies have an executive-level position structured to focus on emerging business opportunities that have no clear industry blueprint.

According to Kelly Stranburg, who spearheaded Senior Living Communities' 2012 Assisted Living Federation of

Continued on page 34

How healthcare reform opens new doors to senior living

Continued from page 32

Accountable Care Primer

1. Key business growth opportunities
- Leveraging core competencies/investments.
- Senior living as preferred alternative to home discharge.
- Changing perceptions of senior living.

2. Learn healthcare language and challenges
- Know top 5 discharge diagnoses, referral patterns, and readmission rates by diagnosis.
- Know healthcare "dashboard" of quality metrics.
- Articulate how you can impact outcomes.

3. Define and articulate complete solutions
- Link your quality benchmarks with hospital dashboard metrics.
- Show how you can prevent hospital admissions and interrupt the readmission cycle.
- Frame your solutions with research outcomes.

4. Communicate/coordinate/collaborate
- Executive-level collaboration to assess opportunities in your market.
- Seek quick-to-market solutions that leverage core competencies like care transitions and short-term stays.
- Targeted sales and marketing strategies to optimize this window of opportunity.

kayvn@kayvannorman.com and khristinerogers@gmail.com

America Best of the Best Award: "We need to change our thinking and approaches to how we package, market and sell our services, yet the volume of daily senior-living operational demands makes it difficult to proactively respond to industry shifts like Accountable Care. Everyone's plate is so full that it can be difficult to identify who should be responsible for leading strategies and programs that position senior living as a solution to reducing avoidable hospital readmissions."

It's easy to understand, in light of operational realities, why industry shifts such as those related to the Affordable Care Act are often tabled until opting out is no longer an option. An alternative to watching from the sidelines is to act now to leverage return on investments that have already been made. "Anyone can do this without overhauling acuity guidelines and operational practices," Stranburg adds, "but it takes leadership to thrive in this new business environment."

Dr. O'Neil also emphasizes that executive team buy-in and leadership are critical for strategies to be successful. Brookdale identifies both a champion and cochampion for its Post Acute Care (PAC) teams to ensure strategic forward momentum and establish consistent interactions with healthcare systems.

Consider what short-term investments need to be made to create or "free up" an executive-level champion for your strategies. Also consider the opportunity costs of allowing it to languish on already full plates. The "Accountable Care Primer" on this page outlines a starting point for discussing who could emerge as your organization's champion, and how to support integrated implementation.

A golden opportunity

Senior living companies can provide premium hospital readmissions solutions by leveraging their expertise in ADL support, chronic disease management, customer service/satisfaction, the social model of care, and investments they've already made in wellness programs, equipment and initiatives. This opportunity *doesn't* require a change in either the existing assisted-living acuity guidelines or the private-pay model of senior living.

Healthcare professionals seek strategic partners to decrease hospital admissions and readmissions, driving opportunities for collaboration across the care continuum. This creates a new selling environment for senior living that can significantly increase professional referrals, and offer an immediate opportunity to package and sell short-term transition stays as a preferred option to discharging to home.

We believe that provisions in the Affordable Care Act create a new revenue-stream opportunity for senior living providers who bring to market outcomes-based solutions that help reduce avoidable hospital readmissions. Providers who want to enhance their business growth in 2013 can recast their image and expand their role as a post-acute care partner to the healthcare community and consumers. There is no blueprint for the senior living industry to follow. But opportunities and resources abound to lead with innovation. Perhaps the single most important first step in seizing this business opportunity is to identify who will own and champion your interdisciplinary strategy, and what external support they may need to succeed.

Senior living providers who master complete solutions for reducing avoidable hospital readmissions have a golden opportunity to showcase the wellness expertise of senior living, and leverage valuable strategic alliances in today's business environment. Quick-to-market action in the first and second fiscal quarters of 2013 promises enhanced sales, revenue growth, and competitive advan-

Senior living companies can provide premium hospital readmissions solutions by leveraging their expertise

tage in an industry that is already trending occupancy growth.[11]

Kay Van Norman is an internationally known author, speaker and consultant. With over 24 years' experience in healthy aging, she has been a visionary and agent of change in multiple industries, guiding both national and international organizations through strategies to help change the way people view and experience aging. Founder and president of Brilliant Aging, Van Norman is committed to promoting lifelong vitality, and translating active aging's global momentum into business growth opportunities for diverse industries. She can be contacted at www.kayvannorman.com.

Khristine Rogers is a senior living executive with 23 years' experience in all aspects of operations and delivering private-pay sales results. She is highly skilled at identifying active-aging trends that create new business for the senior living and healthcare industries. She is the founder of Get Booming, LLC, a firm that provides Virtual Vice President leadership and quick-to-market solutions for high-impact business growth opportunities, including Accountable Care and post-acute strategic alliances. Rogers can be contacted at khristinerogers@gmail.com.

References

1. Stone, J., & Hoffman, G. J. (2010). *Medicare Hospital Readmission: Issues, Policy Options and PPACA.* Congressional Research Service Report for Congress R40972. Retrieved from http://www.ncsl.org/documents/health/Medicare_Hospital_Readmissions_and_PPACA.pdf.
2. DePalma, G., Xu, H., Covinsky, K. E., et al. (2012). Hospital Readmission Among Older Adults Who Return Home With Unmet Need for ADL Disability. *The Gerontologist,* doi: 10.1093/geront/gns103.
3. Arbaje, A. I., Wolff, J. L., Yu, Q., et al. (2008). Postdischarge Environmental and Socioeconomic Factors and the Likelihood of Early Hospital Readmission Among Community-Dwelling Medicare Beneficiaries, p. 501. *The Gerontologist, (48)*4, 495–504.
4. Golden, A. G., Tewary, S., Dang, S., & Roos, B. A. (2010). Care Management's Challenges and Opportunities to Reduce the Rapid Rehospitalization of Frail Community-Dwelling Older Adults. *The Gerontologist, (50)*4, 451–458.
5. Centers for Medicare and Medicaid Services, United States Department of Health and Human Services. Health Care Innovations Awards: Texas. Available at http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Texas.html.
6. Rowe, J. W., & Kahn, R. L. (1997). Successful Aging. *The Gerontologist, 37*(4), 433–440.
7. Holwerda, T. J., Deeg, D. J. H., Beekman, A. T. F., et al. (2012). Feelings of Loneliness, but Not Social Isolation, Predict Dementia Onset: Results from the Amsterdam Study of the Elderly (AMSTEL). *Journal of Neurology, Neurosurgery and Psychiatry,* doi:10.1136/jnnp-2012-302755.
8. Perissinotto, C. M., Stijacic Cenzer, I., & Covinsky, K. E. (2012). Loneliness in Older Persons: A Predictor of Functional Decline and Death. *Archives of Internal Medicine, 172*(14), 1078–1084; doi:10.1001/archinternmed.2012.1993.
9. Hurley, B. F., & Roth, S. M. (2000). Strength Training in the Elderly: Effects on Risk Factors for Age-Related Diseases. *Sports Medicine, 30*(4), 249–268.
10. Van Norman, K. A. (2010). *Exercise and Wellness for Older Adults: Practical Programming Strategies* (second edition). Champaign IL: Human Kinetics Publishers.
11. National Investment Center for the Seniors Housing and Care Industry (NIC). Available at http://www.nic.org.

Glossary

Accountable Care Organization (ACO): A healthcare organization that ties Medicare and Medicaid provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

Acuity guidelines: A provider's licensed and established care capabilities.

Acute care provider: A provider of short-term medical treatment, usually in a hospital, for patients who have an acute illness or injury or are recovering from surgery.

Care continuum: An integrated system of healthcare and supportive services spanning all levels and intensity of care.

Healthcare systems: The organization of people, institutions and resources to deliver healthcare services to meet the health needs of target populations.

Hybrid providers: A senior living product that combines service elements from two different models, such as independent and assisted living.

Post-acute care provider: A provider that supports an individual's continued recovery from illness or management of a chronic illness or disability after hospitalization.