GEDC and West Health welcome you

GEDC | THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

GARY & MARY westhealth™ institute

GED Health Care System Roundtable #9

Census Management: Across and Within Systems

Tuesday, May 30th, 2023

Visit the GEDC Healthcare System Landing Page for additional resources:
https://gedcollaborative.com/hcs-roundtable/

GEDC | THE GERIATRIC EMERGENCY DEPARTMENT COLLABORATIVE

EDUCATE IMPLEMENT EVALUATE

OUR FACULTY IN ATTENDANCE

Kevin Biese, MD, MAT
Emergency Physician
UNC

Ula Hwang, MD, MPH
Professor of Emergency Medicine
Yale New Haven

Aaron Malsch, MSN, GCNS-BC
Senior Services Program Coordinator
Advocate Aurora Health

Laura Stabler, MPH
GEDC Program Director

Michael Malone, MD
Geriatrician
Advocate Aurora Health

Conor Sullivan, B-Med Sc
GEDC Program Manager

Our Mission

We bring best practice into action.

We transform and evaluate interdisciplinary best practice in geriatric emergency medicine, and then build and distribute practical, evidence-based clinical curriculum and quality improvement tools that support sustainable, quality care for older adults.

westhealth

Zia Agha, MD
Chief Medical Officer and Executive Vice President

Jon Zifferblatt, MD, MPH, MBA
Executive Vice President, Strategy and Successful Aging

Renee Tyska, RN, BSN
Director of Clinical West Health

Emily Weaver, PhD
Principal Investigator

Kaylee Knowles, MSc
Program and Partnerships Manager

Our Mission

We are dedicated to lowering healthcare costs to enable seniors to successfully age in place with access to high-quality, affordable health and support services that preserve and protect their dignity, quality of life and independence.

Meet the Team

West Health GED Team

Clinical Director: Renee Tyska, RN, BSN

Principal Investigator: Emily Weaver, PhD

Data Analyst: Hussein Elamin

Research Analyst: Evelyn Brady, BS

Program and Partnerships Manager: Kaylee Knowles, MS, MCHES

Program Manager: Courtney Enge, MBA, MPH

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

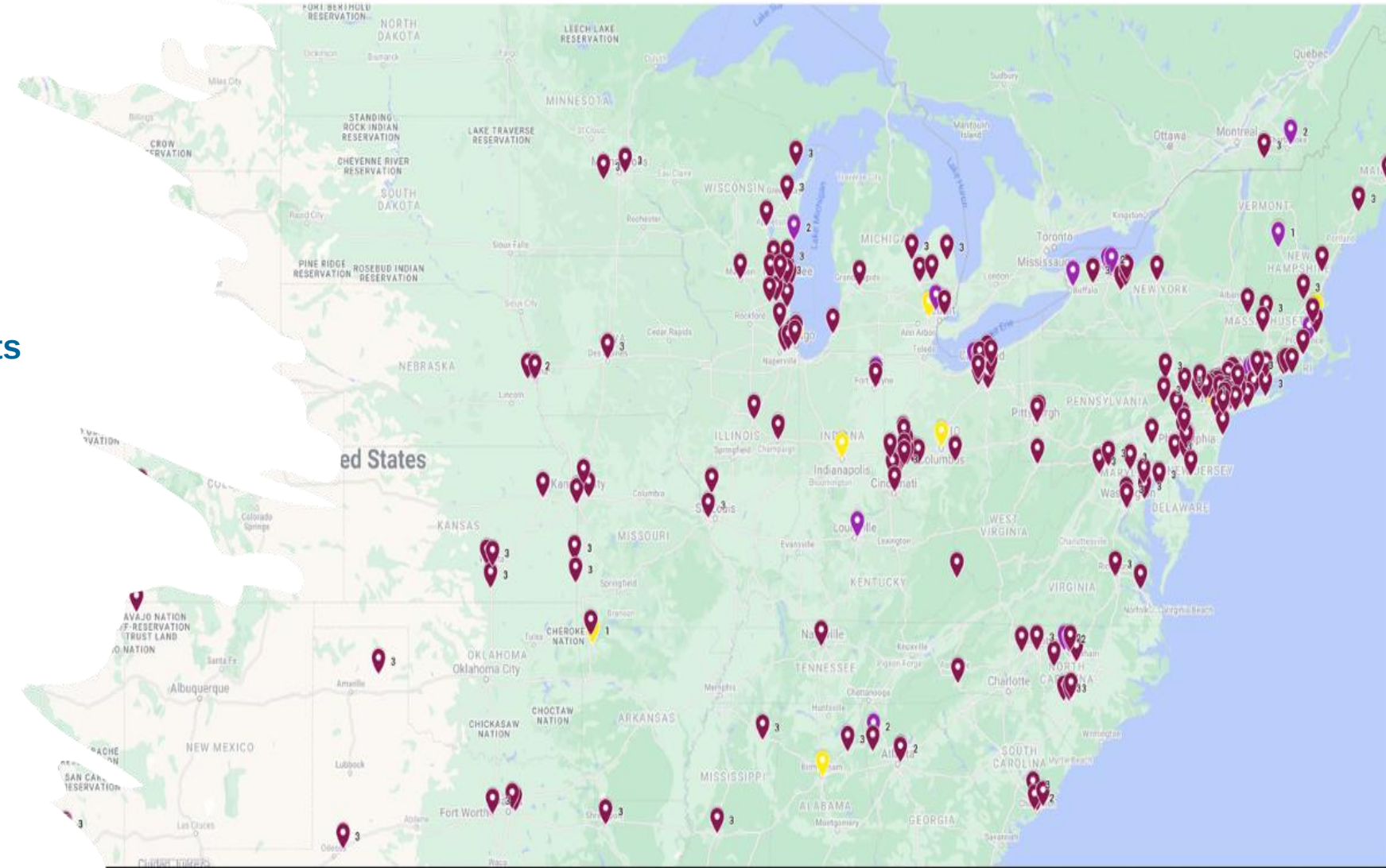
ACEP Geriatric Emergency Department Accreditation

The GEDA Team

Nicole Tidwell
Sr. Program Manager

Amber Hartman
Rural & Special Projects

Bonita Marek
Project Administrator



Evolving the Standard of Care
The Role of Geriatric Emergency Departments

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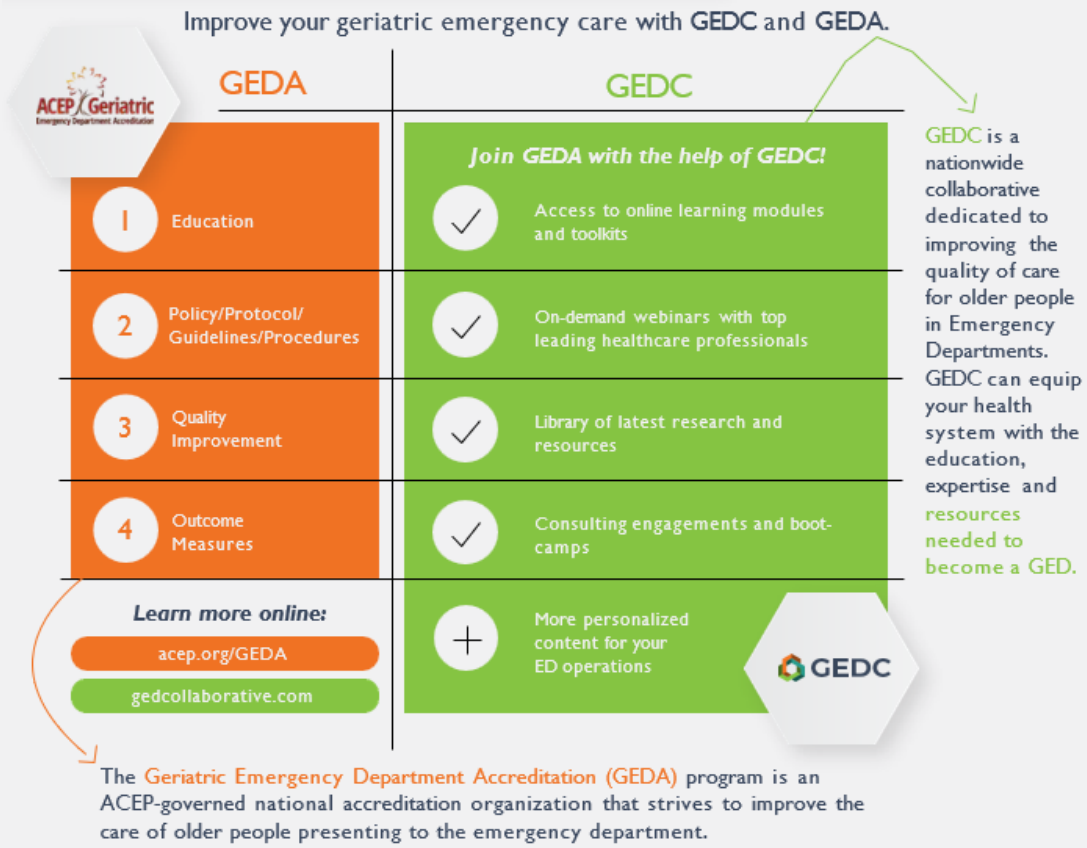

Why GEDs?

Lower return visits

Recent data affirms that readmissions, as well as returns to the emergency department for high-risk populations are lower in communities with GEDs.

Greater market share

GEDs enable health systems demonstrate their commitment to excellent care to the community, while also allowing emergency departments to better manage existing patients to create space for patients needing a high level of care.

Improved patient experience

According to emerging research, older adult patients who receive comprehensive geriatric assessment and enhanced transition of care services report higher patient satisfaction.

Better census managment

Studies demonstrate that hospitals with GEDs have up to 16% fewer hospital admissions and a decreased inpatient length-of-stay for admitted older patients.

Higher staff morale

GEDs help staff know that they are doing an excellent job caring for their patients.

GEDC/West Health

Health Care System Roundtable Goals

Connection

Exchange among Health Care Systems leading the country in Geriatric Emergency Care

Collaboration

Identify ways each of your teams can support the others in their Quality Improvement Initiatives

Dissemination

Explore opportunities to share Roundtable insights with other health systems interested in GEDs

Direction

Identify major trends and topics to help lead change across health systems

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ROUNDTABLE AGENDA: Census Management

GED Healthcare System Roundtable

Census Management

Tuesday, May 30th, 2023

1:00-2:30 PM EST

I. **1:00 — 1:05 | Session Introduction** *(5 minutes) – **Conor***
- Welcome and Roundtable Agenda
- West Health welcome – (Renee)

II. **1:05 — 1:10 | Kevin's Welcome and Remarks** *(5 mins)* **– *Kevin***
- Overview of Census Management
- Roundtable Panelist Intro

Census Management and the GED

III. **1:10—1:55 | Panelist Discussion** *(45 mins) – **Kevin***

- Ula Hwang and Scott Dresden (GEDIWISE) ⬇ Unnecessary Admissions
- Lauren Cameron-Comasco ⬇ LOS
- Aaron Malsch, Suzie Ryer, AAH team ⬇ Re-Admissions

VI. **1:55 – 2:25 | Roundtable Discussion** (*30 minutes*) **–** Q&A with HSR members

VII. **2:25 – 2:30 | CMS Reminder and Closing Remarks** *(5 minutes)* – Kevin Biese
- Session Topic Debrief / Reflections
- Identify next topics for 2023

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Get The Most Out of This Roundtable

Many Ways to Participate

Use the Zoom Chat Function

Post questions, reply to colleagues, and be active in our discussion.

Share your Experience

We can all learn from one another's unique experiences – from what works, and what doesn't. Don't be shy.

Become a GEDC Member

gedcollaborative.com

Membership

GEDC Members work together to transform ED care of older adults; catalyze action at local and national levels to support these care transformations; and evaluate the impact of these new models of care for older people.

https://gedcollaborative.com/membership/application/

Join the GEDC

- Make your plan to become a GED
- Access to GEDC Community
- Participate in consulting services
- Access to education tools
- Implementation tools and training
- Evaluation resources

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Overview of Census Management:

What is it and why it's important?

Kevin Biese, MD, MAT
GEDC Co-PI
UNC

GEDC

Today's Roundtable Panelist Presentations:


Building the Case for Geriatric EDs

Impact of a GED on Hospital Length of Stay


Census Management and the GED

GEDC

Building the Case for Geriatric EDs

Ula Hwang, MD, MPH
Professor of Emergency Medicine
Yale School of Medicine

Scott M. Dresden, MD, MS, FACEP
Director, Geriatric Emergency Department Innovations (GEDI)
Associate Professor
Northwestern University

Yale SCHOOL OF MEDICINE

YaleNewHavenHealth

Northwestern Medicine®

GEDI WISE

- **WHERE**

  Paterson, NJ — Chicago, IL — New York, NY

  St Joseph's Regional Medical Center — Northwestern Memorial Hospital — Mount Sinai Hospital

- **WHO** 50,000+ Medicare beneficiaries (65+ aged patients) at the 3 sites
- **WHEN** July 1, 2012 – June 30, 2016
- **WHAT**
  - ED-based Interdisciplinary GED staff trained to deliver quality improvement initiatives (ED physicians and nurses, Transitional Care Nurses, Social Workers, Case Managers, Pharmacists, Geriatricians, PT/OT)
  - Comprehensive geriatric, emergency-care specific assessments.
  - Treatment initiated based on needs during GEDI WISE assessments
- ***NOT*** a RCT

Top 10 Interventions by the GEDI WISE team

1. Risk assessment for adverse outcomes from the ED.
2. Risk assessments for *cognitive impairment and delirium*.
3. Risk assessments and interventions to decrease *falls and improve mobility*, consult or refer to physical therapy when appropriate.
4. *Functional assessments*, consult or refer to occupational therapy when appropriate.
5. Evaluation of polypharmacy and *potentially inappropriate medication* use, consult ED pharmacist when appropriate.
6. Coordination for *direct admission from ED to skilled nursing facilities* or subacute rehabilitation.
7. *Transportation coordination* to and from ED to home.
8. *Coordination of care transitions* with outpatient evaluation and initiating referrals with home care agencies to ensure home safety for discharged patients.
9. *Goals of care*, advanced care planning discussions with palliative care.
10. *Follow-up calls* for discharged patients.

Geriatric Emergency Department Innovations: Transitional Care Nurses and Hospital Use

Ula Hwang, MD, MPH,[*†‡] *Scott M.Dresden, MD, MS,*[§] *Mark S. Rosenberg, DO, MBA,*[¶] *Melissa M. Garrido, PhD,*[†‡] *George Loo, MPA, MPH, DrPh,*[*] *Jeremy Sze, BS,*[*] *Stephanie Gravenor, MBA,*[§] *D. Mark Courtney, MD,*[§] *Raymond Kang, MA,*[**] *Carolyn W. Zhu, PhD,*[†‡] *Carmen Vargas-Torres, MA,*[*] *Corita R. Grudzen, MD, MSHS,*[††] *and Lynne D. Richardson, MD,*[*‡‡] *The GEDI WISE Investigators*

Journal of the American Geriatrics Society 2018

- Design: Observational, 3 GEDI WISE EDs from 1/2013 – 6/2015
- Subjects: Unique ED patients, aged 65+, ESI>1
- Analyses: Entropy balancing comparison vs. ***TCN group*** (selection bias), adjusted logistic regression models
- Results:
  - 52,287 unique patients with ESI >1 made 120,221 visits
  - 10% seen by TCN (10% MSMC, 12% NMH, 9% SJRMC)

Entropy Balancing by site

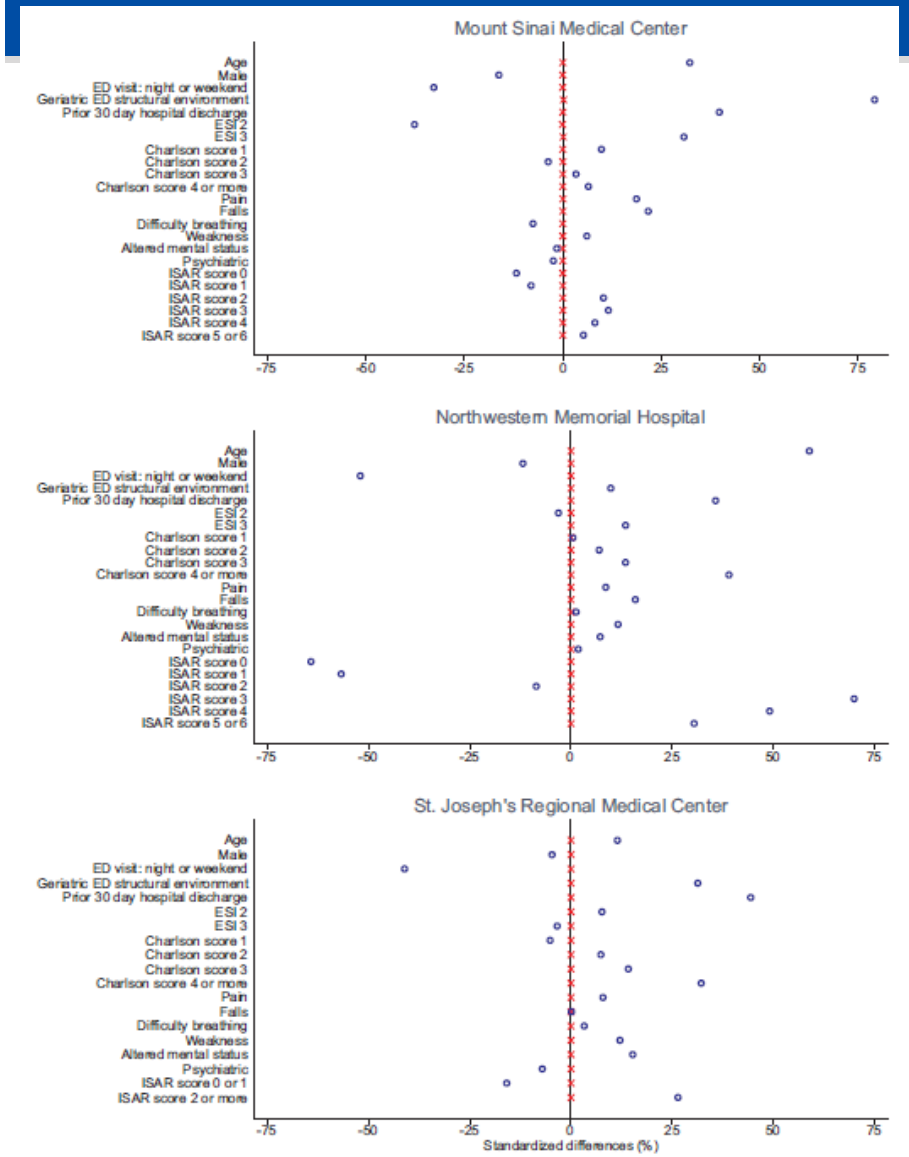


Table 3. Percentage Change in Day 0 Inpatient Admissions, Discharges with Subsequent 72-Hour Emergency Department (ED) Visits from Multinomial Logistic Model, and Any Admission in the 30 Days After ED Discharge Associated with Transitional Care Nurse (TCN) Intervention from Logistic Model

Outcome (Reference Discharged with No Repeat 72-Hour ED Visit[a])	Mount Sinai Medical Center	Northwestern Memorial Hospital	St. Joseph's Regional Medical Center
	Effect of TCN vs Control (95% Confidence Interval)		
Inpatient admission (Day 0)[a]	−9.90 (−12.31 to −7.47)	−16.46 (−18.68 to −14.24)	−4.72 (−7.47 to −1.98)
Discharged with subsequent 72-hour ED visit[a]	1.49 (0.65–2.33)	1.38 (0.65–2.12)	0.37 (−0.53–1.28)
Any inpatient admission (Day 0–30)[b]	−7.79 (−10.33 to −5.25)	−13.82 (−16.07 to −11.58)	−1.38 (−4.04–1.27)

Results obtained from [a]multinomial logistic regression models or [b]logistic regression models, which were adjusted for age; sex; index ED visit at night (9:00 p.m. to 9:00 a.m.) or during the weekend; Emergency Severity Index; use of a geriatric ED structural environment during the index ED visit; discharge from a hospital admission in the prior 30 days; Charlson Comorbidity Index score; chief complaint related to pain, falls, difficulty breathing, weakness, altered mental status, psychiatric; Identification of Senior At Risk score.

ORIGINAL CONTRIBUTION

Geriatric Emergency Department Innovations: The Impact of Transitional Care Nurses on 30-day Readmissions for Older Adults

Scott M. Dresden, MD, MS[1,2], Ula Hwang, MD, MPH[3,4], Melissa M. Garrido, PhD[5], Jeremy Sze[3], Raymond Kang, MA[2], Carmen Vargas-Torres, MA[3], D. Mark Courtney, MD, MSCI[1], George Loo, MPA, MPH, DrPH[3,6], Mark Rosenberg, DO, MBA[7], and Lynne Richardson, MD[3,6]

Academic Emergency Medicine 2020

- Design: Observational, 3 GEDI WISE EDs from 1/2013 – 6/2015
- Subjects: Unique ED patients, aged 65+, ESI>1
- Analyses: Entropy balancing comparison vs. ***TCN group*** (selection bias), adjusted logistic regression models
- Results:
  - (52,287 unique patient ED visits;)
  - 6,838 (12%) occurred within 30D of prior hospital discharge.
  - 9% seen by TCN (7% MSMC, 13% NMH, 7% SJRMC)

Entropy Balancing by site

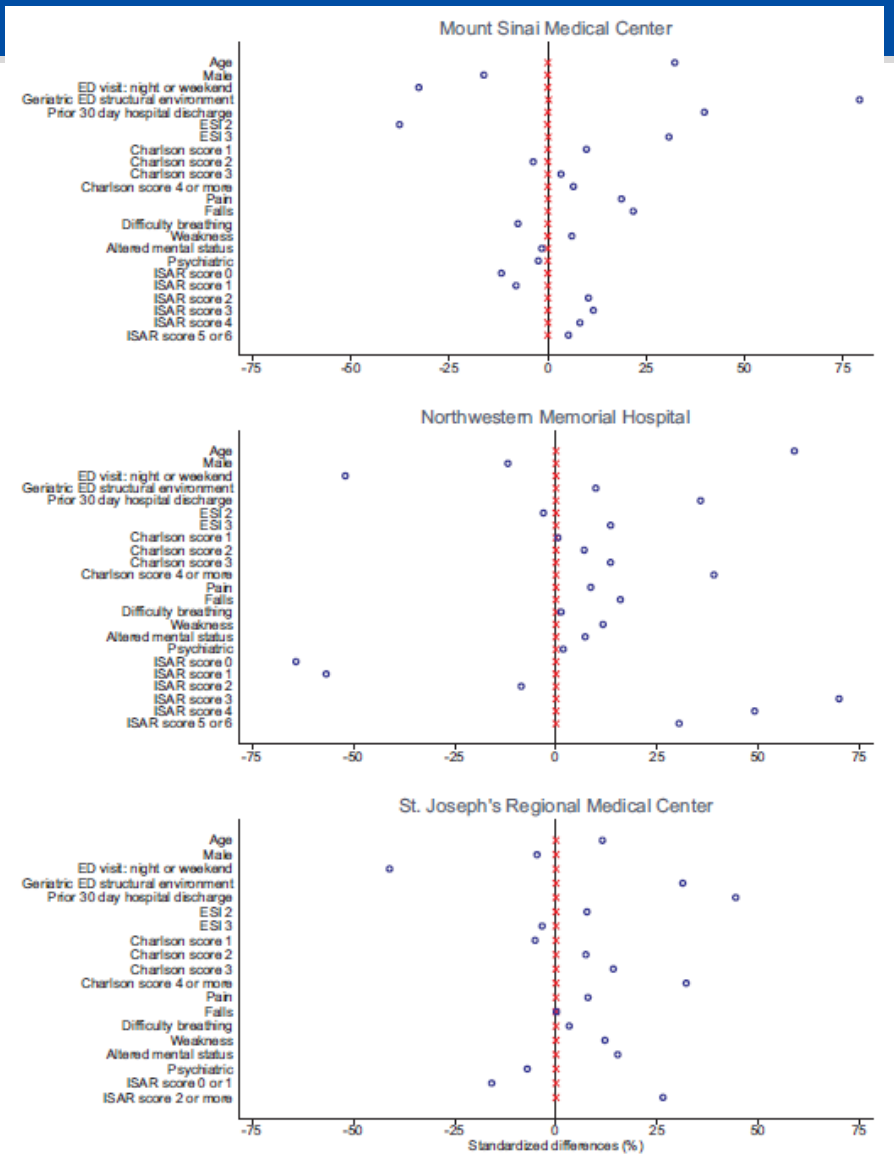


Table 3
Weighted Multivariable Regressions of TCN Intervention and Readmission Outcomes by Site

	Mount Sinai Medical Center (n = 2,340)	Northwestern Memorial Hospital (n = 2,333)	St. Joseph's Regional Medical Center (n = 2,165)
Multinomial logistic regression, AIE of TCN vs. comparison, percentage point difference (95% CI)			
Readmission during ED visit	–10.1 (–18.5 to –2.7)*	–17.3 (–23.1 to –11.5)*	–2.5 (–10.5 to 5.5)
Discharge during ED visit, but subsequently readmitted within 30 days of previous admission	4.8 (0.4 to 9.2)*	1.1 (–1.8 to 4.0)	3.0 (–1.6 to 7.5)
Discharged from ED visit and never readmitted	Reference	Reference	Reference
Logistic Regression, AIE of TCN vs. Comparison, Percentage Point Difference (95% CI)			
Readmission during or after index ED visit within 30 days of previous admission	5.6 (–13.1 to 1.8)	–16.2 (–22.0 to –10.3)*	0.5 (–7.2 to 8.2)

AIE = average incremental effect; TCN = transitional care nurse.
Multinomial logistic regression comparing TCN group and comparison group with resultant AIE of the TCN intervention on readmission during the index ED visit (primary outcome), discharge from the ED with subsequent admission within 30 days of prior admission, or discharge from the ED without subsequent readmission.
Logistic regression comparing TCN group with comparison group and resultant AIE of any readmission during or after index ED visit occurring within 30 days of prior hospitalization.
*$p < 0.05$.

Replicating: GEMS at SRC & YSC (10/21 – 12/22)

"Identifying your champion partners"

James Lai, MD, MHs, MSc
Associate Chief of Clinical Affairs, Geriatrics
Medical Director Verdi 4W
Firm Chief, Cooney Service

Pamela Martin, FNP-BC, APRN, GS-C
Geriatric Emergency Medicine Specialist, Lead Geriatric ED Collaborative Core Faculty

Sarah Palleschi, PA-C
Geriatric Emergency Medicine Specialist

Impact of a GED on Hospital Length of Stay

Lauren Cameron Comasco, MD

Assistant Professor, Emergency Medicine, OUWB School of Medicine

Geriatric Emergency Medicine Fellowship Director

Director Danto Family Geriatric Emergency Medicine Program

Beaumont Health, Royal Oak

Beaumont's Population

- Suburban, Level 1 Trauma center
- Number of beds in the ED: 150+
- Volume: 120,000 patients annually (2022)
- Percentage 65+: 30%
- Admission rate 65+: 69%
- Level 2 Geriatric Emergency Department

Beaumont Geriatric Emergency Medicine

- Model: Advanced Practice Provider, Occupational Therapy, Care Management
- Community dwelling patients ≥65yo are screened for risk of functional decline
  - ➡ If screened positive, patients are evaluated for: cognition, falls risk, delirium
    - ➡ If positive for falls risk or potential cognitive impairment, Occupational Therapy and Care Management consulted

Outcomes

Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: www.elsevier.com/locate/ajem

Implementation of a geriatric emergency medicine assessment team decreases hospital length of stay

Sarah E. Keene, MD, PhD [a], Lauren Cameron-Comasco, MD [a,b,*]

[a] Department of Emergency Medicine, Beaumont Health System, 3601 W. 13 Mile Rd, Royal Oak, MI 48073, USA
[b] Oakland University William Beaumont School of Medicine, 586 Pioneer Dr, Rochester, MI 48309, USA

Findings:

- Assessed patients more likely to be discharged from the ED (54% vs 29%, OR 2.06)
- The mean hospital LOS was **25h less** in assessed patients (4.50 vs 5.54 days, $p < 0.01$)
- The reduction in hospital LOS resulted in an estimated savings of **$1.7 million** per year using the national average cost for 24h of inpatient care

OU WB School of MEDICINE
OAKLAND UNIVERSITY WILLIAM BEAUMONT

Beaumont

What is contributing to the decrease in LOS?

- Our Geriatric ED recognizes those who will benefit from inpatient care & initiates safe discharge planning upon initial assessment in the ED
- Occupational Therapy in the ED:
  - Those evaluated by OT in the ED, admitted, and ultimately discharged to SAR: 6.89d vs 9.49d (**62h** shorter length of stay)
  - **12h decrease** in hospital LOS (2.49d v 3.01d) if OT ordered and completed in the ED vs ordered and not completed

Questions?

GEDC Healthcare System Roundtable Census Management and the GED

AAH Geriatric Emergency Department

May 30th, 2023

Aaron Malsch MS, RN, GCNS-BC

Suzie Ryer DPT, GCS, CEEAA

Chris Rubach, MBA, PMP

Advocate Health Care | Aurora Health Care

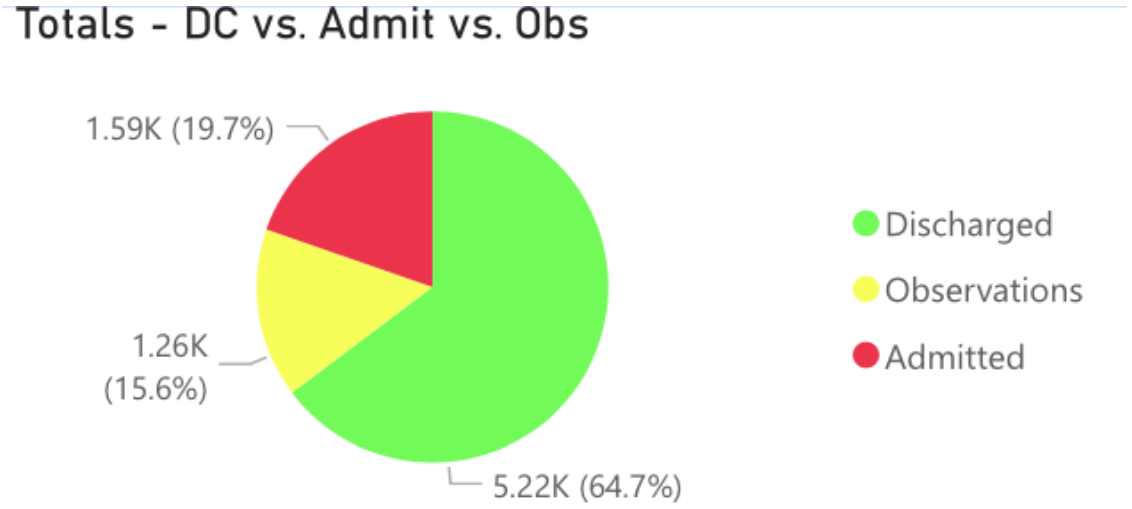
Now part of ADVOCATEHEALTH

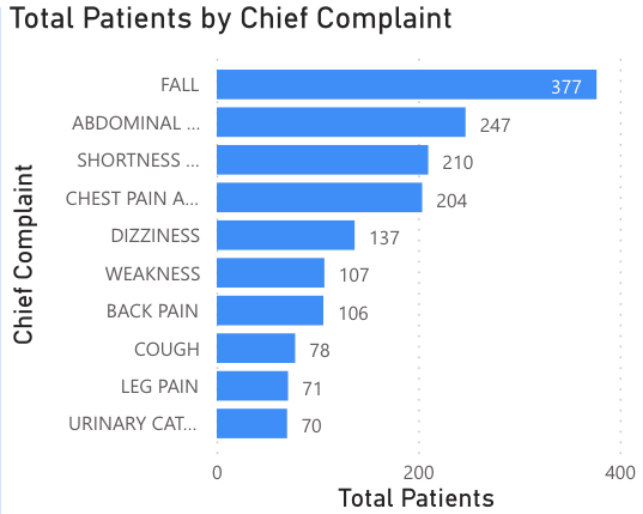
Purpose of Geriatric ED

- Identify unique challenges encountered by older adults in the ED setting (EBP protocols)
  - Screening, Assessment, Intervention in ED ← RN performing ISAR & Communicates risk to MD and RN CM
- Coordinate post-ED care transitions and follow up care for vulnerable older adults
  - Promote Post-ED Service-to Orders (STO) ← MD orders post-ED services & RN CM executes orders
- Promote best outcomes for patients including avoiding unnecessary admissions and reduce revisits
  - Reduce ED revisit & Hospital Admissions ← Patients are more successful in their homes & Cost Reduction to AAH

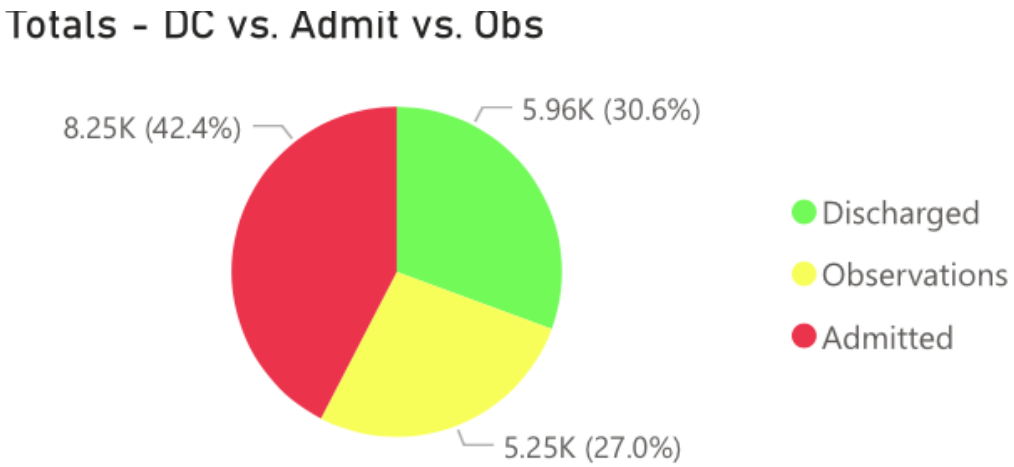
AAH Geri ED Key Metrics

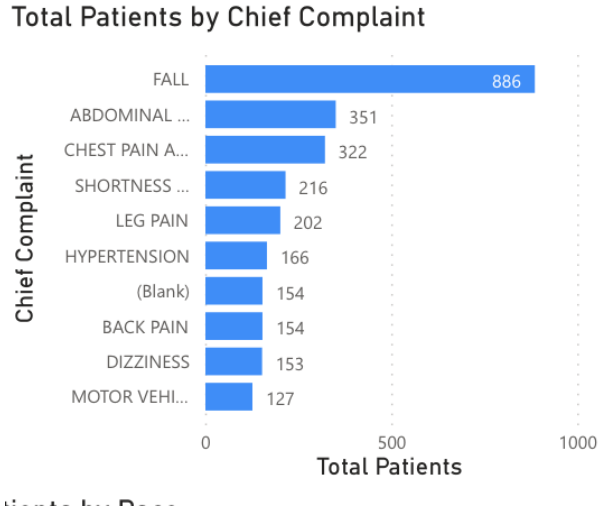
Site A:





Site B:





AAH Geri ED Key Metrics

Balancing act between Dispo, LOS, 30day, Post ED Service, and Visit Closure/Capture rate

3487
Total Patients

23.7%
30 Day Returns

348
Service To, Totals

123
Service to OP PT

145.00
Median LOS, mins.

7.9%
72 Hr Returns

9.5%
Service To, %

30.9%
PT Capture

Assigned Nurse	TUGs	Fallers	TUG, %	Mobility, %
SCHULTZ, DAVID J	3	5	60.0%	80.0%
COMISKEY, SAMANTHA J	5	9	55.6%	33.3%
HOLL, MORGAN E	4	8	50.0%	50.0%
JOHNSON, AMY	7	14	50.0%	57.1%
MYERS, JANE M	1	2	50.0%	0.0%
SONNENBERG, SYDNEY E	1	2	50.0%	100.0%
Total	**445**	**19297**	**2.3%**	**45.8%**

MD	Service To	Fallers	TUGs	PT Consults
LAURENT, ROSS	8	63	22	3
BRUCE, DINA	8	65	18	12
SPYCHALLA, ZECHARIAH D	14	51	18	2
KNAPP, PAUL A	11	70	16	16
POLGLAZE, KEVIN L	10	50	14	6
GALE, DANIEL S	10	58	13	10
Total	**917**	**17531**	**342**	**1381**

AAH Geri ED Research

Received: 29 June 2022 | Revised: 13 October 2022 | Accepted: 3 November 2022

DOI: 10.1111/jgs.18137

CLINICAL INVESTIGATION

Journal of the American Geriatrics Society

Association of Geriatric Emergency Department post-discharge referral order and follow-up with healthcare utilization

Michelle Simpson PhD, RN[1] | Clinton Sergi PhD[1] | Aaron Malsch MSN, RN[2] | Suzanne Ryer DPT[2] | Christopher Rubach MBA[2] | Maharaj Singh PhD[1]

https://onlinelibrary.wiley.com/share/author/ZDHEWIEIKIEMUWUPPYPK?target=10.1111/jgs.18137

Falls and Mobility Protocol

Why have a protocol for falls?

- ***#1 diagnosis amongst older adult ED visits in system and ED high utilizers***
- Focus on discharging “fallers” with high risk of future falls/ ED revisit
- Provide minimal yet effective interventions in ED
- ***Focus on prompt connection to post-ED follow up care***
- Avoid unnecessary admissions and revisits

Components:

- Evaluate contributing factors to fall including mobility
- Early activation of PT Evaluation for older adults who have fallen
- Connection to follow up care including primary care, therapy, and community fall prevention programs

AMCO Falls Outcomes

AMCO fall patient outcomes 2020 - 2022

STO: Service-to Orders (PCP, Homecare, Palliative, PT Cx, OP PT)

High Risk Population (>65 years old, discharged, Chief Complaint of Fall

Comparison: 2020 - 2022 STO Rate and 30day ED revisit

Summary: Significant Practice Change (500% rate increase in STO) & 27% reduction in 30day return & lower LOS by 37 minutes vs system average

2020 Fallen Pts

n= 326

4.3% received STO

n=65

27.6% 30 Day revisit

In 2020, only 4.3% of patients received a post ED order

In 2022, 26.3% of patients received a post ED order

511% INCREASE!

27% Reduction in ED revisits!!

27.4% vs 20.1%

2022 Fallen Pts

n= 418

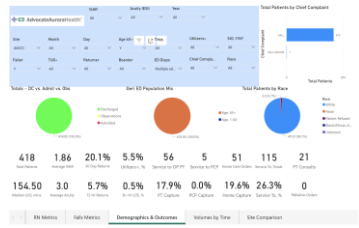
26.3% received STO

n=115

20.1% 30 Day revisits

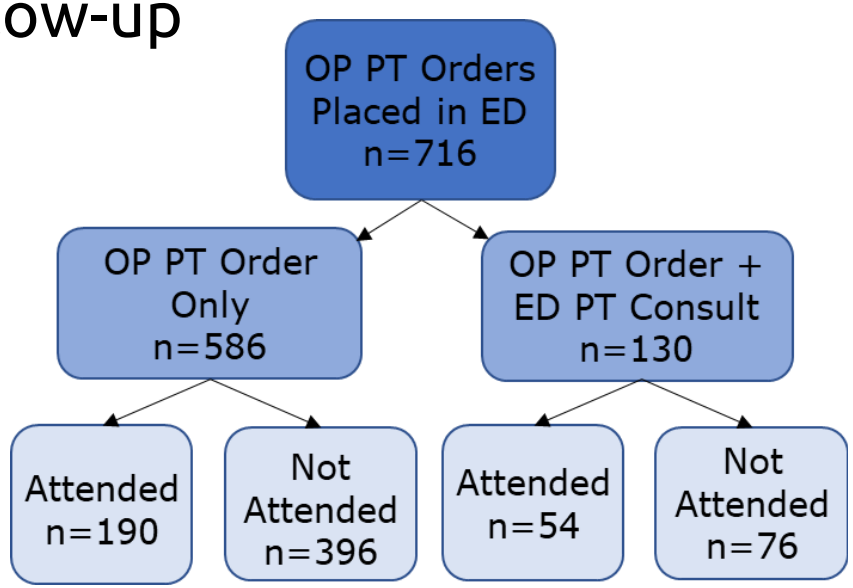
154 min LOS

(System 191 min LOS)



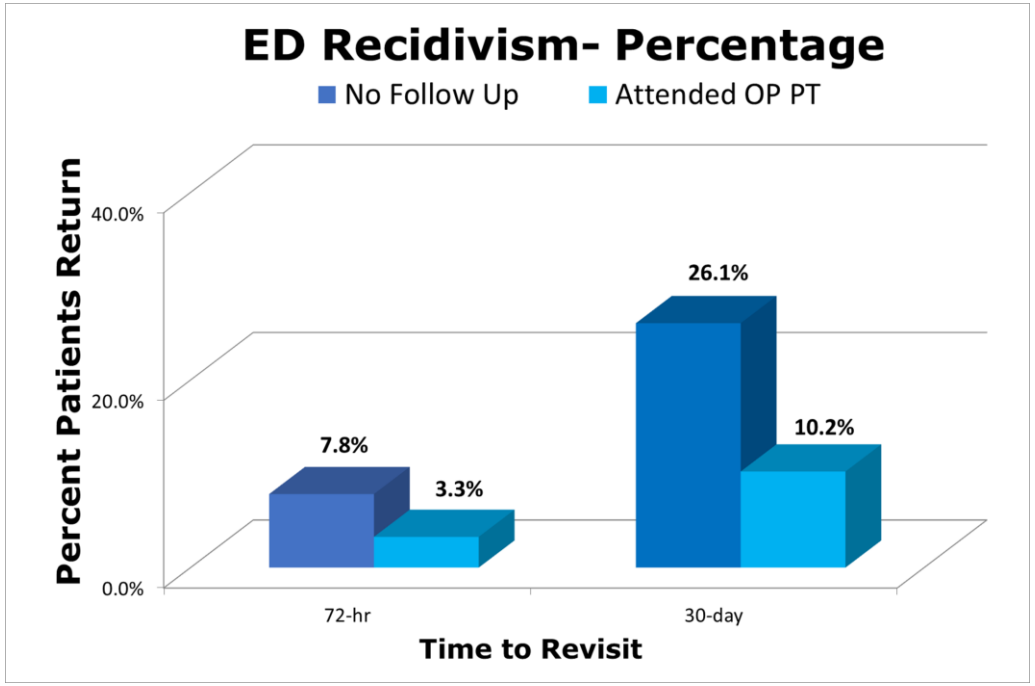
Service to PT from ED

- Data collected retrospectively from 15 EDs
- Interventions: Attended OP PT and PT in ED
- Outcomes: All cause revisits 72 hrs and 30 days
- Older adults who attended OP PT after ED visit were less likely to return
- Patients who received ED PT more likely to attend follow-up



	Not Attended (NA) n= 472	Attended (AP) n=244	Stats
72-hour revisit	7.0% n=37	3.1%* n=8	z=2.24 p=0.03
30-day revisit	26.1% n=123	10.2%* n=25	z= 4.26 p<0.001

*p<0.05



Questions?

Roundtable Discussion

Enable your video, ask questions and share your experiences

GEDC

Roundtable Discussion

Topics for Discussion:

1. Does your leadership understand the value of this work in their census management? What would help them better understand?
2. Any data you have on the impact of census management in your system
3. What information would be most valuable to learn from or share with your Roundtable colleagues?

Other items to consider:

A. Larger strategy for bringing in Non-GED systems (get advice from Roundtable members?)
B. Needs analysis 2023

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Call to Action

CMS Proposed Rule: Public Comment Invited on Two Geriatrics Hospital Measures

CMS Link:
https://www.johnahartford.org/dissemination-center/view/cms-proposed-rule-public-comments-invited-on-two-geriatrics-hospital-measures

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THANK YOU ROUNDTABLE MEMBERS!

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EDUCATE IMPLEMENT EVALUATE

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UPCOMING:

GED Health Care System Roundtable 2023

Dates and Topics, TBD, 2023

Visit the GEDC Healthcare System Landing Page for additional resources:
https://gedcollaborative.com/hcs-roundtable/

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Healthcare System Roundtable

Appendix Slides

Visit the GEDC Healthcare System Landing Page for additional resources:
https://gedcollaborative.com/hcs-roundtable/

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GED Dashboard

JUHI ISRANI, MS
DATA SCIENCE MANAGER AT WEST HEALTH INSTITUTE

MICHAEL SCHERER

EMILY WEAVER, PHD

westhealth

University Health Network (UHN)

2

EMERGENCY DEPARTMENTS

2 EDs total: TGH & TWH (Toronto, Ontario)

2 EDs in GEDC: TGH & TWH (Toronto, Ontario)

32K

OLDER ADULTS SERVED

TGH: 14,548 (26%)

TWH: 17,646 (27%)

TEAM MEMBERS

- Dr. Tessa Ringer, Medical Director & MD Champion

We are interested in:

How to generate buy-in across a health system and implement new protocols into practice

Use of IT system (particularly Epic) to support GEDs and track processes and outcomes

Yale New Haven Health (YNHH)

Yale NewHaven Health

9

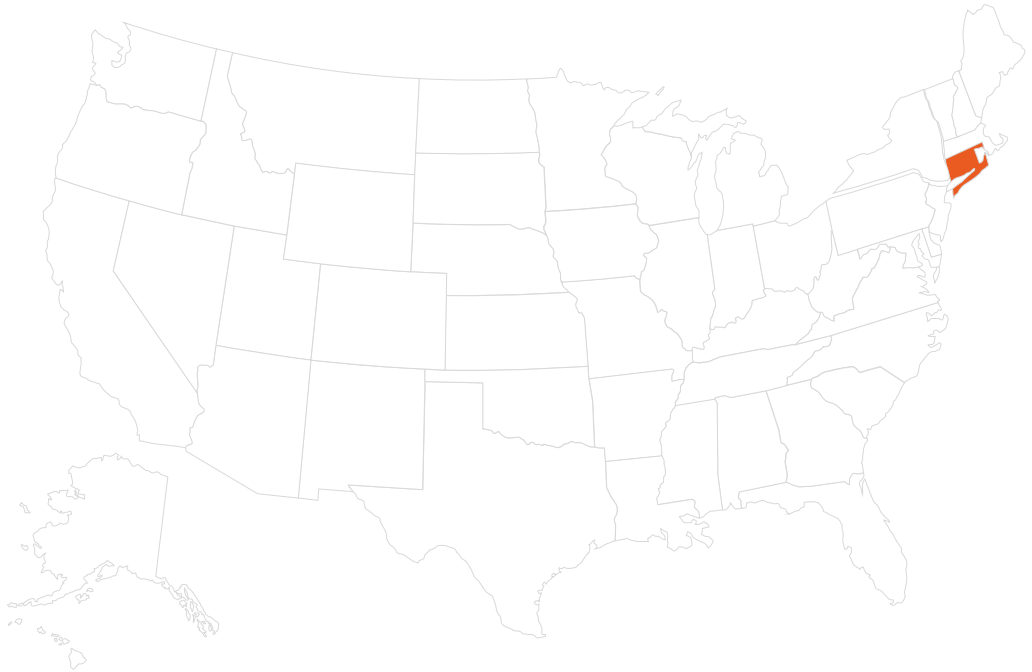
EMERGENCY DEPARTMENTS

9 care delivery networks including 2 free standing EDs

CT and RI

103K

OLDER ADULTS SERVED



TEAM MEMBERS

- Mark Sevilla, VP Behavioral and Emergency Services (YNHH)
- Peggy Parniawski, Executive Director, Milford Hospital
- Ula Hwang, MD Emergency Medicine (YNHH)
- James Lai, MD Geriatrics (YNHH)
- Pamela Martin, GEMS APRN (YNHH)
- Sarah Palleschi, GEMS PA (YNHH)
- Theresa Aversa, RN (manager) (YNHH)
- Corinna Clark, Rehab Services (YNHH)
- Judy Tripodi and Brittany Palladino, YNHH Case Management
- Myla Anderson, Pharmacy (YNHH)
- Geriatric ED Nurse and Physician Champions at each care delivery network

We are interested in:

Challenges faced when bringing multiple centers on board simultaneously.

Standardization of policies across care delivery networks.

GEDC

Prime Healthcare

45

EMERGENCY DEPARTMENTS

14 States

500K+

OLDER ADULTS SERVED

600 Communities

8,708 Licensed Beds

TEAM MEMBERS

50,000 staff and physicians

Prime Healthcare

3480 East Guasti Road
Ontario, CA 91761
909-235-4400 | www.primehealthcare.com

At Prime Healthcare, we care deeply about patients and their communities. Since the acquisition and transformation of our first hospital in 2001, we have saved and improved hospitals across the nation while providing compassionate, nationally recognized quality care. Founded by Dr. Prem Reddy, Prime Healthcare has grown to be among the largest health systems in the nation. As we continue to fulfill our mission of ensuring health equity and delivering clinically excellent, value-based care, we remain committed to delivering an exceptional patient experience and creating a legacy that will improve healthcare for all.

Facts

Hospitals saved	45
States with hospitals	14
Not-for-profit hospitals	14
Patient visits annually	2.6 million
Communities served	600
Staff and physicians	50,000
Licensed beds	8,708
Charitable contributions since 2010	$9 billion

- Prime Healthcare has ranked among the Top 10 health systems in the nation, and was the only health system recognized with the prestigious 2021 John M. Eisenberg Patient Safety and Quality Award for addressing social determinants of health.
- Prime Healthcare ranks among the top 10 health systems in the nation for social responsibility and cost efficiency, according to the Lown Institute.

We are interested in:

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