CURRENT HEALTHCARE LANDSCAPE: TRENDS

My approach to this presentation

Entrusted with your time
This will not be a commercial
Factually based; speaking to trends
Won't mention my product one time
Intended to build into you to be an even more valuable, insightful member of your VAT

Agenda

- Opening
- Healthcare Landscape
- Stakeholder perspectives on POCT
- Study review
  - -Process Improvement via POCT
  - -Utility of POCT in Triage
  - -The six key factors of optimizing processes determining cultural readiness for model POCT

IMPROVING LIVES FOR 125+ YEARS

1880s

Dr. Wallace Abbott advances the science of medications to improve accuracy and effectiveness.

1930s–1960s

Expands into vitamins and, later, infant formula, marking decades of growth in nutrition.

1970s–1980s

Creates the modern diagnostics industry with ground-breaking products.

1990s–2000s

Sharpens its focus on medical devices, to deliver unprecedented innovation.

TODAY

Abbott continues to shape new ways to bring better health to people all over the world, through diverse products and technologies.

ADDRESSING HEALTH NEEDS AT EVERY STAGE, FROM NEWBORNS TO AGING ADULTS

- Nutrition
- Diagnostics
- Medical devices
- Branded generic pharmaceuticals

Opening: Why we love POCT

- POCCs-the AMBASSADOR of the lab
- Servant leaders daily
- Often underappreciated

- When done right, it truly makes a difference
- With the right spirit, it brings out the best in people
- Good stewardship, sustainable
- Common good oriented, breaks down silos
- It's all about the patient-the central reason why we're all here
- Trends suggest that it will become the standard of care one day
- Sustains for 2 reasons:
    1) It's patient centric
    2) It's the lowest total cost of care
- Identifies the acceptor vs. the resistor cultures

Trends

DEMAND AND HEALTHCARE SPENDING CONTINUES TO INCREASE GLOBALLY

~13 Million enrolled in ACA plan

50% adults have at least one chronic disease

Chronic disease cost > 1 trillion in US spend

Most Common and Costly: (heart disease, stroke, cancer & diabetes)

Medical Errors-a leading cause of death in the US

Much of cost in hospitalizations are avoidable through better upstream primary care and prevention (education)

There is a desire to improve quality of care at a reduced cost

Resources: CMS.gov website, AHA Database., www.usnews.com

FUNDING REMAINS CONSTRAINED, SO PAYERS LOOK FOR OTHER SOLUTIONS

- Accelerate decision-making
- Reduce Total Costs
- Eliminate waste
- Optimize Processes
- Drive appropriate resource utilization

COMMON TRENDS:

Caring for patients in lower-cost peripheral settings

- Ambulatory Clinics
- Home Care Services
- Free Standing EDs & Urgent Care Clinics

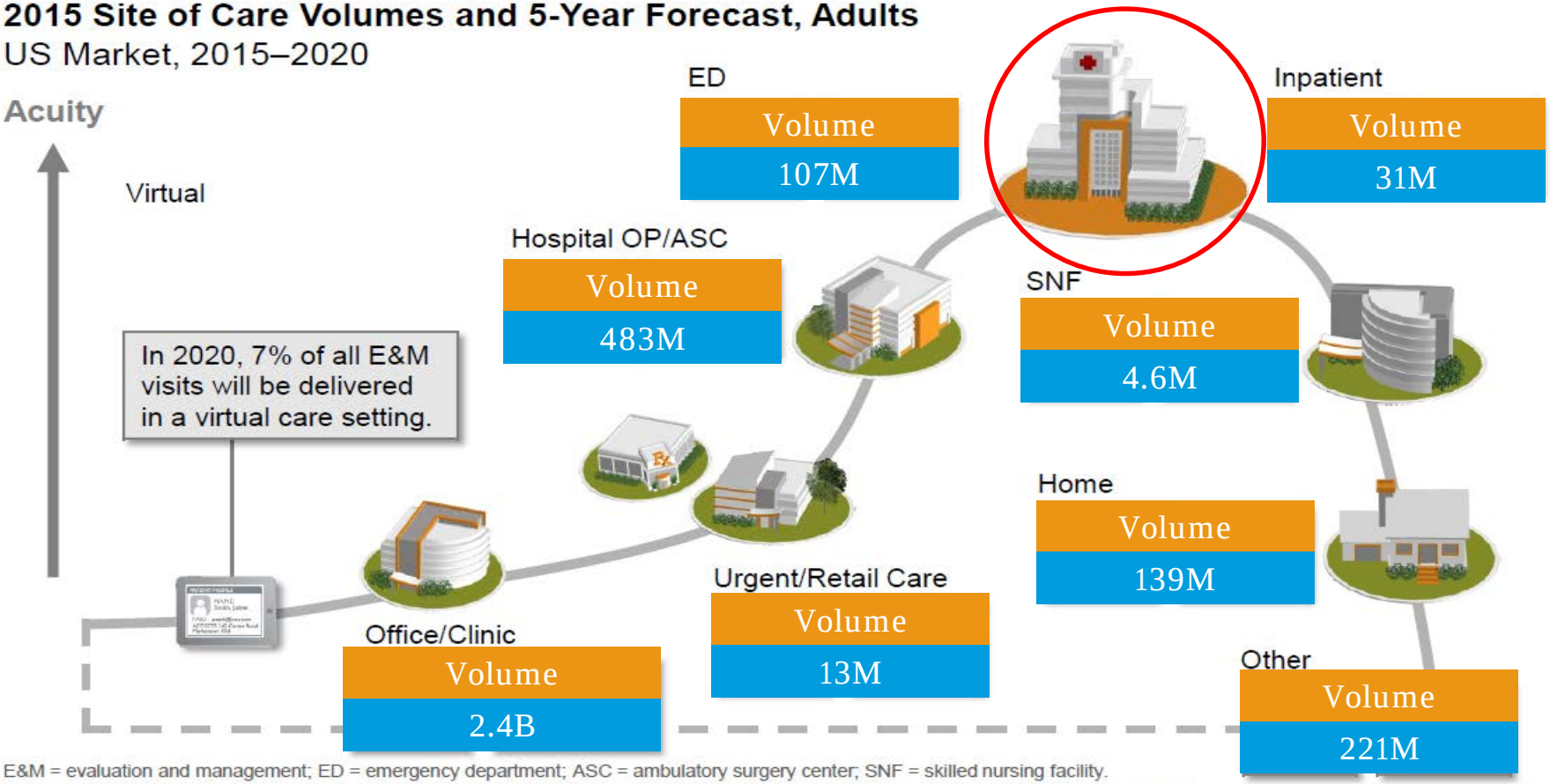
Reducing length of stay in higher-cost acute settings

Improving access to healthcare services in rural locations

A NEW ERA OF NETWORKS AND PARTNERSHIPS DEFINES THE MODERN HEALTH SYSTEM - - US MARKET 2015-2020

Utilization Growth Will Shift to Lower Acuity Care Sites

2015 Site of Care Volumes and 5-Year Forecast, Adults
US Market, 2015–2020



E&M = evaluation and management; ED = emergency department; ASC = ambulatory surgery center; SNF = skilled nursing facility.
Notes: Analysis excludes 0–17 age group. Other includes nonhospital locations such as OP rehab facilities, psychiatric centers, hospice centers, federally qualified health centers and assisted living facilities. **Sources:** Impact of Change® v15.0; NIS; PharMetrics; CMS; Sg2 Analysis, 2016.

SERVICE LINE
EMERGENCY DEPARTMENT

- ED
  - Overall 3% growth
  - 107 Million ED visits
  - ACA key goals and initiatives are driving:
    - Improve metrics
    - Improve HCAP Scores
    - Improve sepsis protocols
    - Reduce cost and standardize care
  - Decrease readmission rates
    - Focus on keeping CHF patients out of acute care setting

Based on AHA data Hospitals outside AHA excluded

SERVICE LINE
CARDIOVASCULAR CRITICAL CARE

- Cardiovascular Critical Care
  - Overall 3% growth
  - 1.03 Million in patient stays
  - 29% growth with ventricular devices and transplants
  - ACA key goals and initiatives are driving:
    - Improve metrics
    - Improve HCAP Scores
    - Improve sepsis protocols
    - Reduce cost and standardize care

Based on AHA data Hospitals outside AHA excluded

New Hospital Value – Based World

New Payment Models Are Emerging Over the next 5 years

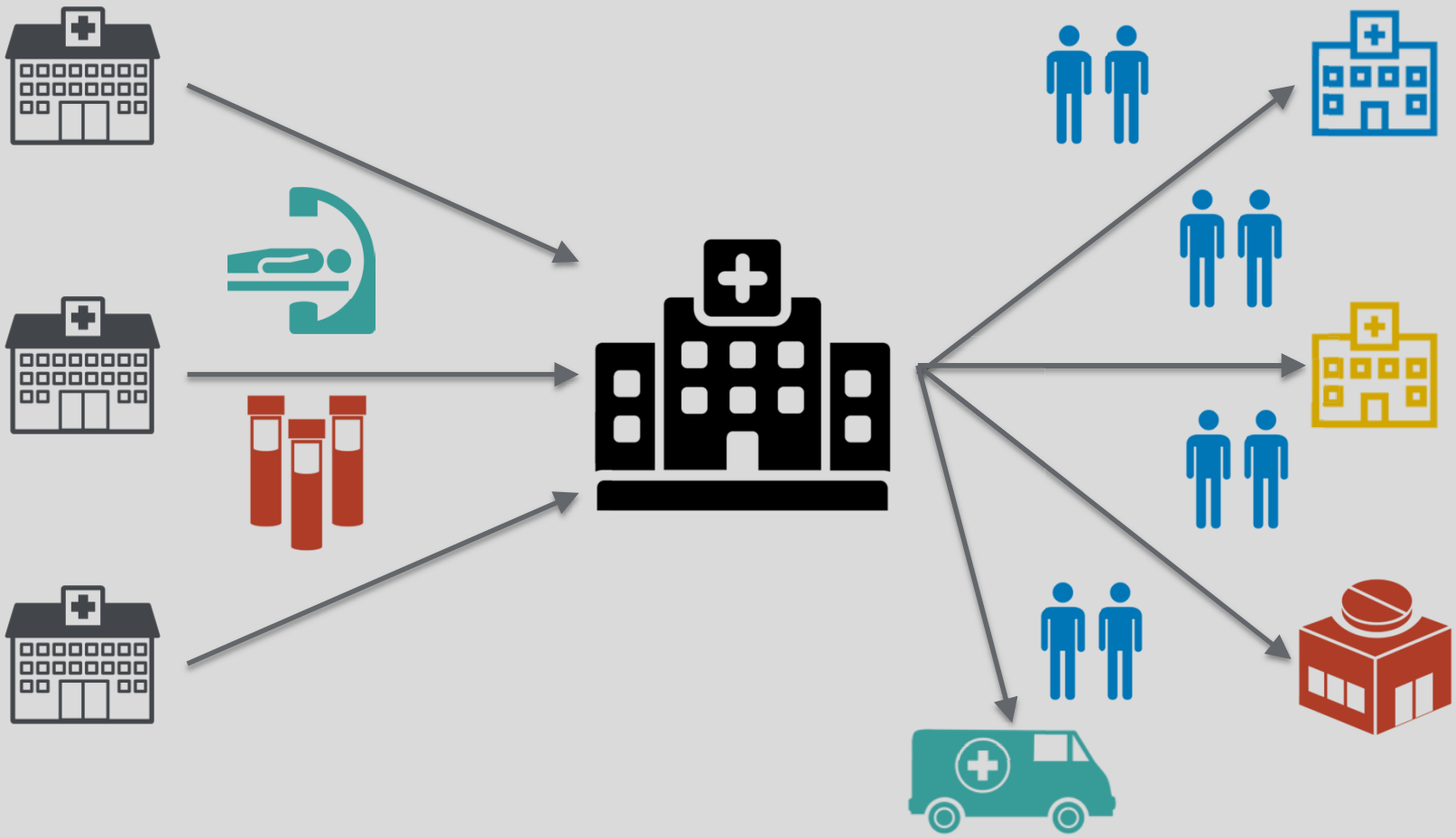
Reform Driving Alternative Care Models and Reimbursement Structures

Traditional Fee For Service → Incentive – Base Pay → Transfer of risk

Fee For Service	**Payment for services rendered**
Pay For Performance	**Payment based on improvements in cost or outcomes**
Bundled Payments	**Procedure – or condition-based bundle payments, also known as case rates, whereby a single payment is made for all services related to a specific procedure, event or condition**
Transfer of Risk	**Transfer from health insurer to provider group. Transfer of cost to either the consumer, insurance company and/or hospital system.**

Resources: Modern Healthcare. Bundled Payments Attract Providers –But will they sign? July 31, 2014. Becker's Hospital Review. New Reimbursement Models to Eclipse Fee For Service by 2020. June 11, 2014.
CMS.gov website, Optum Health

SERVICES & TESTING ARE CONSOLIDATING, AND PATIENTS ARE BEING CARED FOR PERIPHERALLY, AND STANDARDIZATION IS THE NEW TREND



NEW HOSPITAL VALUE – BASED WORLD

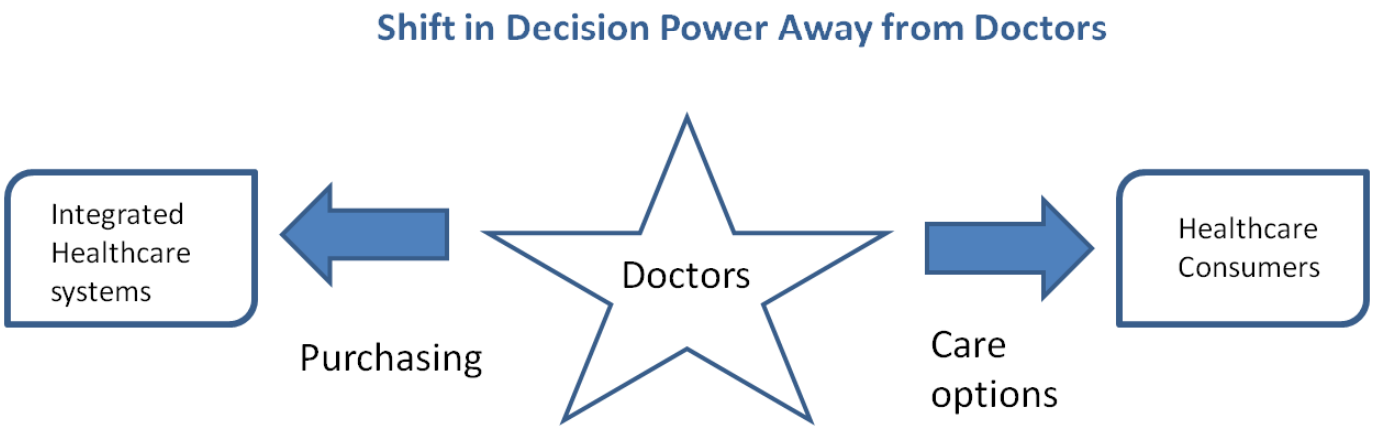
NEW PAYMENT MODELS ARE EMERGING

2. Value-based payment models are gaining traction

1. Penalties and mandates are increasingly impacting net revenue
2. Improving quality is no longer optional
3. Cost savings and efficiency improvements will be top of mind
4. Progressive systems are experimenting with different payment models
5. Physician's revenue will also start to be affected soon by value-based mandates from CMS
6. Value-focused strategies vary by market and health system 'readiness'

CMS = Centers for Medicare and Medicaid Services; FTE = full time equivalent; ED = emergency department; VBP = value based payment.

Health Care Consolidation
Doctors are no longer the primary decision makers



Physicians no longer can unilaterally make decisions. Instead, they are part of a purchasing process governed by value analysis committees. Physicians still have a key role as advocates, but many others are now involved to collectively make final purchasing decisions.

Point of Care

DELIVERING CLINICAL EVIDENCE YOU NEED TO FEEL CONFIDENT

- Accelerate decision-making
- Optimize processes
- Reduce total costs related to care
- Reduce medical record errors
- Eliminate waste
- Drive appropriate resource utilization

KEY TAKEAWAYS

- Demand and spend for healthcare is going to continue to increase
- The new hospital value based world is forcing hospitals to adopt new hospital business models
  - Fee For Service
  - Incentive Base Pay
  - Transfer of Risk
- Physicians are no longer the main influencer. Successful initiatives possess a team of supporters that include clinicians, operation managers, directors, and administration.

Stakeholder Perspectives on POCT

With POCT used appropriately, and within an optimal process, you can:

produces fast, accurate insights seamlessly to manage risk

transform the delivery of care & ***thrive*** in the changing landscape

POCT IS USED ACROSS MULTIPLE CARE SETTINGS:

- Emergency Department
- ICU
- PICU
- Cath Lab
- CVOR
- NICU
- Respiratory Therapy
- General Surgery
- Radiology
- Urgent Care Centers
- Coumadin Clinics
- Surgical Services

TRUE BENEFITS OF WITH-PATIENT TESTING

A NOTE ON QUALITY…

Above all, this is a process improvement initiative…

"To Err is Human" (IOM, Nov 1999)

- 44,000 to 98,000 deaths per year
- $17 - $29 billion in total costs to hospitals nationwide
- Other intangible errors – Loss of trust, diminished patient and staff satisfaction

Leape (2004) stated, "The key to reducing medical errors is a systems approach. The problem is not bad people—it's bad systems." *

*** Leape, L., Preventable Medical Injury A Major Public Health Issue Anesthesiology News 2004 August, 1 Volume: 30:08.**

PHYSICIAN PERSPECTIVE

IT'S INTUITIVE TO THE PHYSICIAN THAT THEY CAN INTERVENE FASTER TO THE PATIENT'S BENEFIT THE FASTER THAT LABS COME BACK AFTER ORDER

"DUE TO THE ANTICIPATED WAIT, I TYPICALLY USE LABS TO CONFIRM MY SUSPICIONS"

"WHEN I ORDER LABS IT'S BECAUSE I WANT THAT INFORMATION NOW-WE NEED INFORMATION!"

OUR SYSTEM APPROACH IS A SYSTEM/'THE WAY IT'S ALWAYS BEEN DONE' CENTRIC, NOT PATIENT CENTRIC

NURSING PERSPECTIVE (BEFORE)

WE GET ALL OF THE WORK PUT ON US

I DON'T WANT TO DO THE LAB'S JOB FOR THEM

I DON'T WANT TO DO IT-SEEMS LIKE MORE WORK

WHY CAN'T THE LAB BRING SOMEONE UP HERE?

IF YOU MAKE ME DO THIS, WHAT ARE YOU GOING TO TAKE AWAY?

HOW CAN I USE THIS TO NEGOTIATE? (UNION)

NURSING PERSPECTIVE (AFTER)

I REALIZED THAT I GAINED CONTROL OF THE CARE PROCESS

IT IMPROVED MY WORK FLOW-IT WAS LESS WORK!!

I NO LONGER HAD TO DO REDRAWS OR CALL LAB

IT MADE MY PATIENT FEEL MORE CONFIDENT

I HAD THE TIME TO EDUCATE MY PATIENT

IT WAS THE MOST PATIENT CENTRIC PROCESS

WHAT'S GOOD FOR THE PATIENT IS GOOD FOR RN'S

LAB PERSPECTIVE

NO TWO DAYS ARE THE SAME; HECTIC; OYVAY; LOVE IT!

POCT IS A LOT OF WORK! TRAINING, COMPETENCIES

GOOD FOR NICHE APPLICATIONS

LAB DIRECTOR DOESN'T ALLOCATE ENOUGH FTE TIME

RN'S CAN NEVER DO SAMPLE QUALITY LIKE THE LAB

COMPLIANCE IS SUCH A PAIN; CHASING RN'S DOWN…

ACADEMIC TRANSCRIPTS COLLECTION

COSTS TOO MUCH

Study Review

Joint Commission Paper

Journal of Emergency Medicine article

THE JOINT COMMISSION

Internal customers viewed the central laboratory's core business as laboratory information management, not laboratory testing.

TOOLS, METHODS, AND STRATEGIES

Laboratory Process Improvement Through Point-of-Care Testing

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ratory by laboratory staff. The main laboratory also had stat testing capabilities to support other hospital areas and the outpatient areas.

Conceptualizing Changes in Clinical Laboratory Services

As Clinical Laboratory Services came under increasing pressure in recent years to reduce costs, we realized we couldn't continue to cut costs without compromising the core of our operation. In the traditional cost reduction mode, we were out of options. To survive, we had to understand why people valued us from the system and customer perspective. In shifting to a value-added mode of thinking, we believed we could generate options.

Exploring the purpose of the laboratory from the perspective of the customer refocused our efforts and generated alternatives beyond just doing laboratory tests more efficiently. Several concepts emerged as useful in improving our cost performance. All these concepts reinforced how we could create value from a total system perspective.[1–5]

Focusing on the core process. We needed to understand the true purpose of our business and how we added value to the larger enterprise. This involved exploring customer requirements and being open to alternative means of meeting their needs.

Understanding the concept of cycle time. Again, from the perspective of the customer, we needed to understand the total laboratory testing process across boundaries. Intuitively, end users were convinced that they could provide better care of patients if laboratory information were made available to them more quickly. To do this, we all wanted to understand the real and perceived bottlenecks in the process and address each of them.

Mapping the process. The conceptual understanding of core processes must be translated into defined process steps to allow full analysis.

Working across boundaries. By identifying where the process crosses boundaries, opportunities for cooperating and adopting a total system perspective can lead to powerful new solutions to common problems. Tasks and responsibilities can be moved across traditional boundaries.

Creating a value-added process. Work that did not add value to the customer needed to be removed. This was done by examining each step of our testing process and determining the true value-adding components. Removing the non-value–added steps—essentially waste—became a core strategy. This not only contributed to cost reduction and improved cycle time but also eliminated unnecessary complexity and associated hand-off issues.

Taking a total cost perspective. Understanding the interaction of materials, equipment, and labor or expenses across boundaries allowed a systems view to reducing the costs of laboratory and nonlaboratory expenses.

Understanding the Core Process

Clinical Laboratory Services brought together a POCT group consisting of managers from the clinical laboratory, pathology, and hospital administration, and medical and nursing staff. Starting in January 1992, this group met monthly at minimum and often weekly to discuss how the laboratory could add value to the care process—and, more specifically, to determine whether it could recommend POCT. The caregivers told us they wanted real-time laboratory information at the patient's bedside. Although they thought our current satellite stat laboratories made laboratory information more available, it was not their vision of the ideal care process. They wanted their interactions with patients, including their need for critical laboratory information, to occur in a smooth, uninterrupted, efficient process that would optimize their ability to make care decisions. They referred to this as their *decision cycle time*, which starts when a caregiver encounters a patient with a problem, and which continues as symptoms are assessed, signs evaluated, diagnostic tests ordered and performed, and results returned and interpreted. The cycle ends when a care decision is made.

Caregivers wanted laboratory information in a fashion that would decrease this decision cycle time. They felt that the laboratory was responsible for delivering testing information in an efficient, timely, and seamless fashion both to the primary caregiver and into the system's longitudinal electronic patient care medical record. Our customers viewed our core business as laboratory information management, not laboratory testing.

By reframing the core business of the laboratory as information management directed at decreasing the decision cycle for caregivers, we now understood our role in the entire care process and how we generated value. New options opened to us. No longer were we confined in solving laboratory cost issues in terms of only the laboratory. Our solutions could extend across departmental and service boundaries and this view created options that were otherwise unavailable.

INSIGHTS GAINED FROM GLUCOSE TESTING

FIRST, THE FULL IMPACT OF THIS PROGRAM ON THE CARE OF THE PATIENTS WAS SEEN ONLY WHEN CARE PROTOCOLS WERE MODIFIED TO ALLOW THE BEDSIDE CAREGIVER TO IMMEDIATELY TREAT THE PATIENT ON THE BASIS OF LABORATORY INFORMATION.

ALSO, NURSES HAVE THE CAPACITY TO MANAGE REGULATORY AND TRAINING ISSUES AND CAN PERFORM PHLEBOTOMY, SKILLS CRITICAL TO THE SUCCESS OF THIS TYPE OF PROGRAM.

TOTAL COST PERSPECTIVE: DEVELOPING THE COMPARATIVE MODEL

A METHOD TO COMPARE THE COSTS OF DELIVERING LABORATORY INFORMATION USING POCT TECHNOLOGY VS. DELIVERING THE SAME INFORMATION BY USING TRADITIONAL LABORATORY TESTING METHODOLOGY. THE LITERATURE ON COSTS ASSOCIATED WITH POCT FOCUSED PRIMARILY ON LABORATORY SUPPLY COSTS AND NOT ALL COSTS ASSOCIATED WITH A POCT PROGRAM IN A COMPREHENSIVE FASHION.

WE AGREED THAT THIS COST COMPARISON COULD NOT BE PERFORMED IN THE ISOLATION OF THE LABORATORY AND NEEDED TO BE CUT ACROSS ADMINISTRATIVE AND FUNCTIONAL BOUNDARIES AT THE HOSPITAL SYSTEM LEVEL. IN ADDITION, WE WANTED TO SEE IF WE COULD MEASURE WHAT IMPACT THIS MODEL WOULD HAVE ON OPTIMIZING THE DECISION CYCLE TIME.

TO ASSESS THE ACTUAL COST OF THE TRADITIONAL BLOOD ANALYSIS PROCESS, EACH STEP IN THE DELIVERY PROCESS MUST BE IDENTIFIED AND DOCUMENTED.

THE END GOAL IS TO IMPROVE BOTH TOTAL COST AND DECISION CYCLE TIME.

Why Process Mapping?

Process Improvement Initiative…

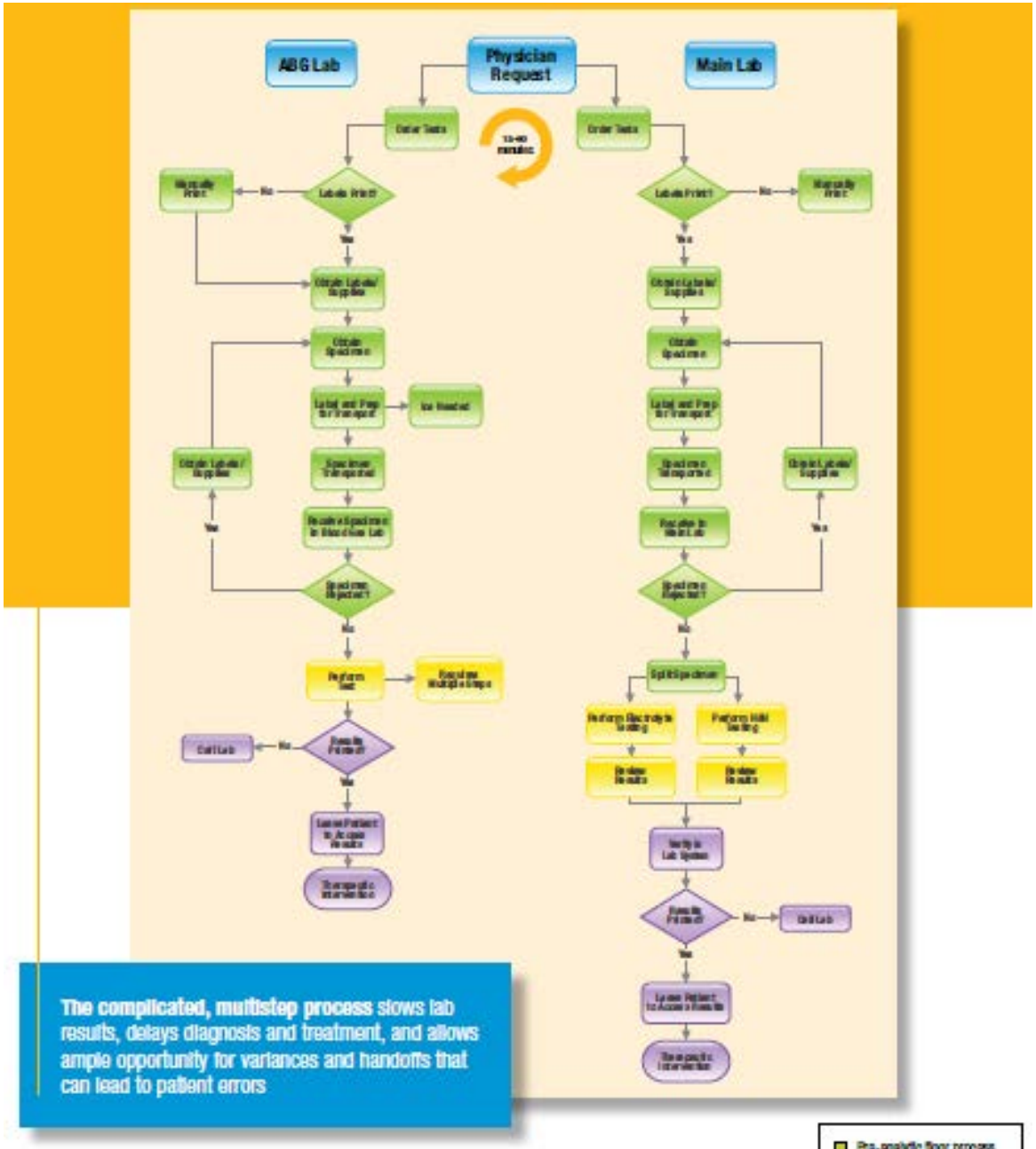
- Understand and document current process
- Analyze findings
- Process Flow
- Time studies
- Analysis of Variation (ANOVA)
- Process Cycle Efficiency (PCE)
- Financial Model

Process Improvement Initiative…

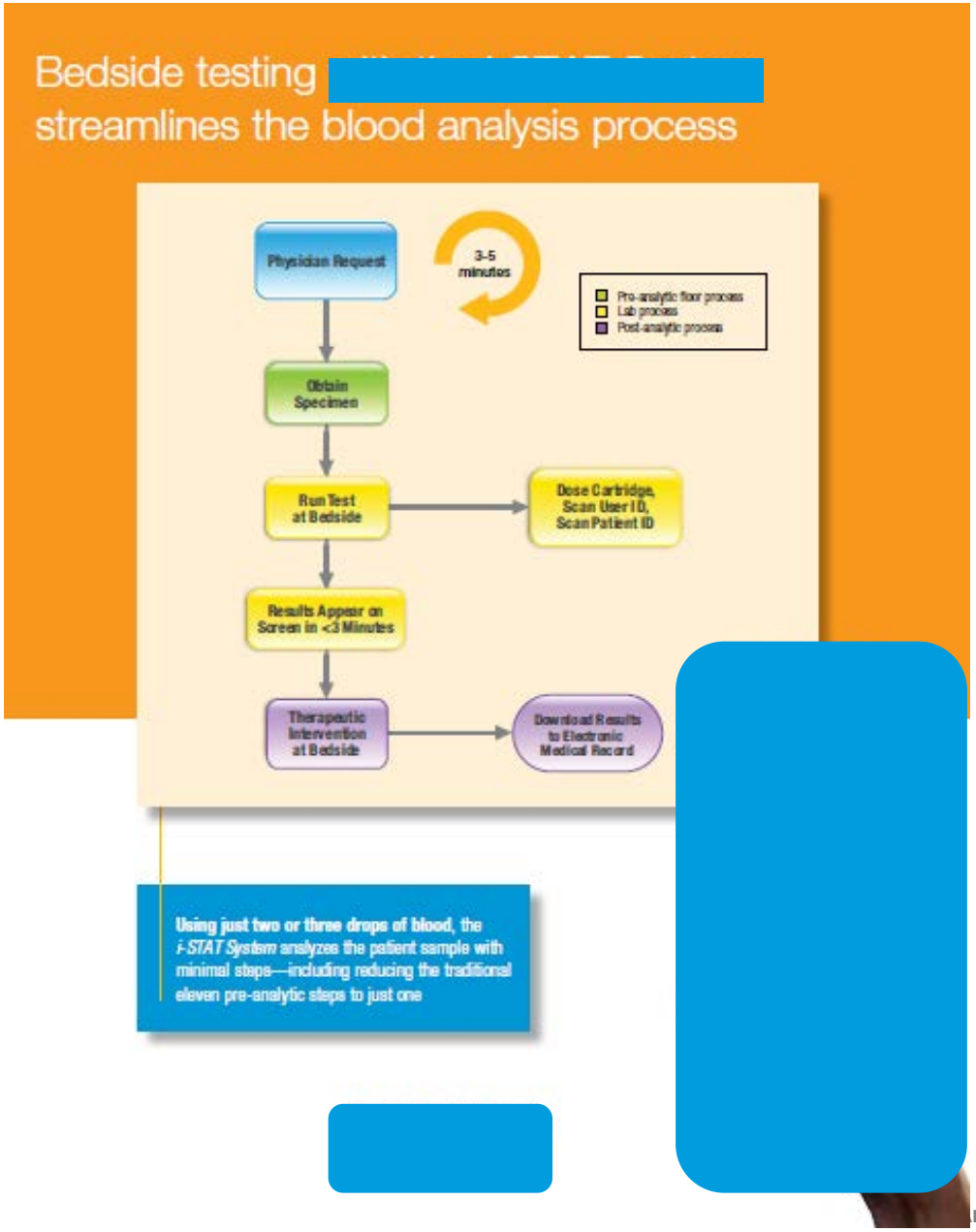
Link findings to hospital goals and initiatives…

- Patient Management
- Decrease Decision Cycle Time (DCT)
- Staff efficiencies
- Streamlining Processes
- Decrease process waste
- Reduce process variation
- Promote process standardization
- Satisfaction

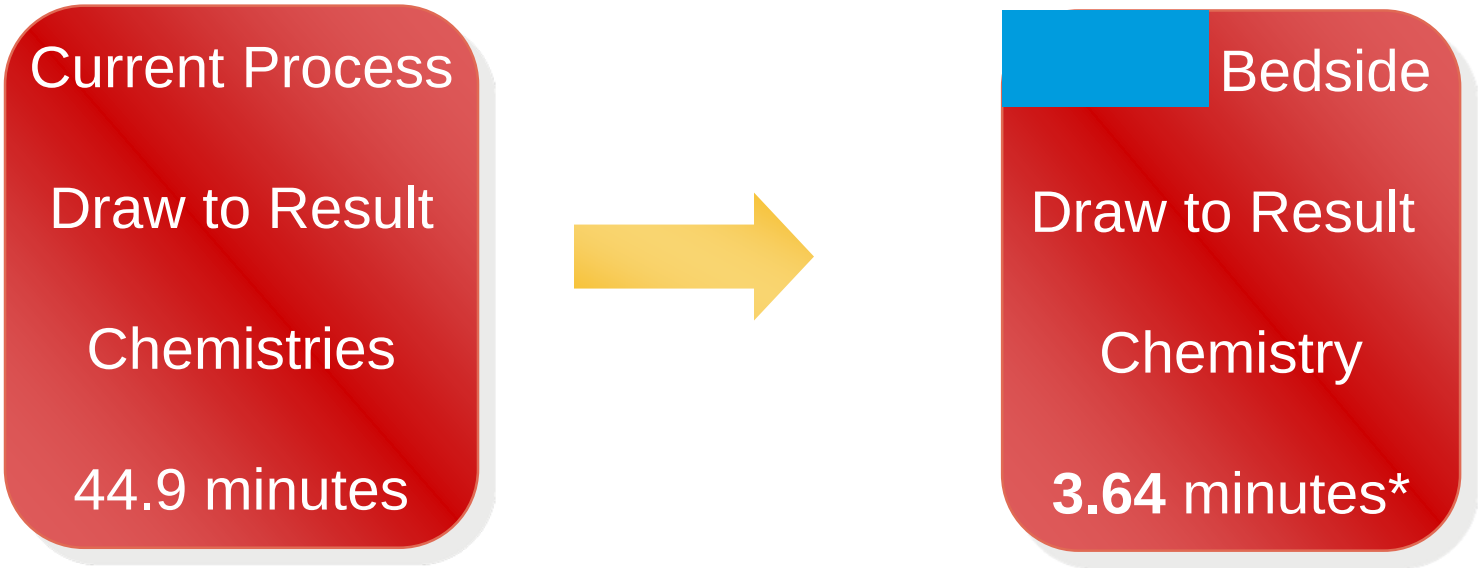
Traditional testing process



With-patient testing process



DRAW TO RESULT FOR CHEMISTRY…



- ✓ **Data Driven Decision 92% Faster**
- ✓ **Real Time Decision**
- ✓ **Better Patient Management**

030256 Rev.A 2/11

*** i-STAT time metric obtained from process observation at multiple hospitals nationwide using i-STAT for Blood Gas and Chemistry testing. Data on file**

The end goal is to improve cost and decision cycle time

Internal customers viewed the central laboratory's core business as laboratory information management, not laboratory testing.

Sustainable adaptation and growth depends on ability of health care professionals to redefine their role within the emerging system, taking an active role in shaping its final form and structure. It is a future where we must ask ourselves what are we trying to accomplish from the customer's perspective.

This was made possible by a collaborative team effort that empowered all laboratory staff to identify inefficiencies in the current process and use team building, inclusion, and consensus to develop solutions.

The purpose is to optimize decision cycle times while reducing the total cost of providing information.

Results: MDs/RNs were empowered in real time, with a **patient centric** process. Past work duties were reallocated to higher productivity tasks/endeavors.

The end goal is to improve cost and decision cycle time

RESULTS

THE IMPROVEMENTS IN THE OVERALL TAT OF TEST RESULTS HAVE AFFECTED THE DECISION CYCLE TIME OF THE CAREGIVER.

CAREGIVERS HAVE REENGINEERED THE WAY THEY ARE PROVIDING PATIENT CARE.

RN TASKS CHANGED BUT THERE WAS NO INCREASE IN WORKLOAD

LAB FTE SAW AN INCREASE IN PRODUCTIVITY

American Journal of Emergency Medicine (2013) 31, 291–296

ELSEVIER

The American Journal of Emergency Medicine

www.elsevier.com/locate/ajem

Original Contribution

Utility of point-of-care testing in ED triage☆,☆☆

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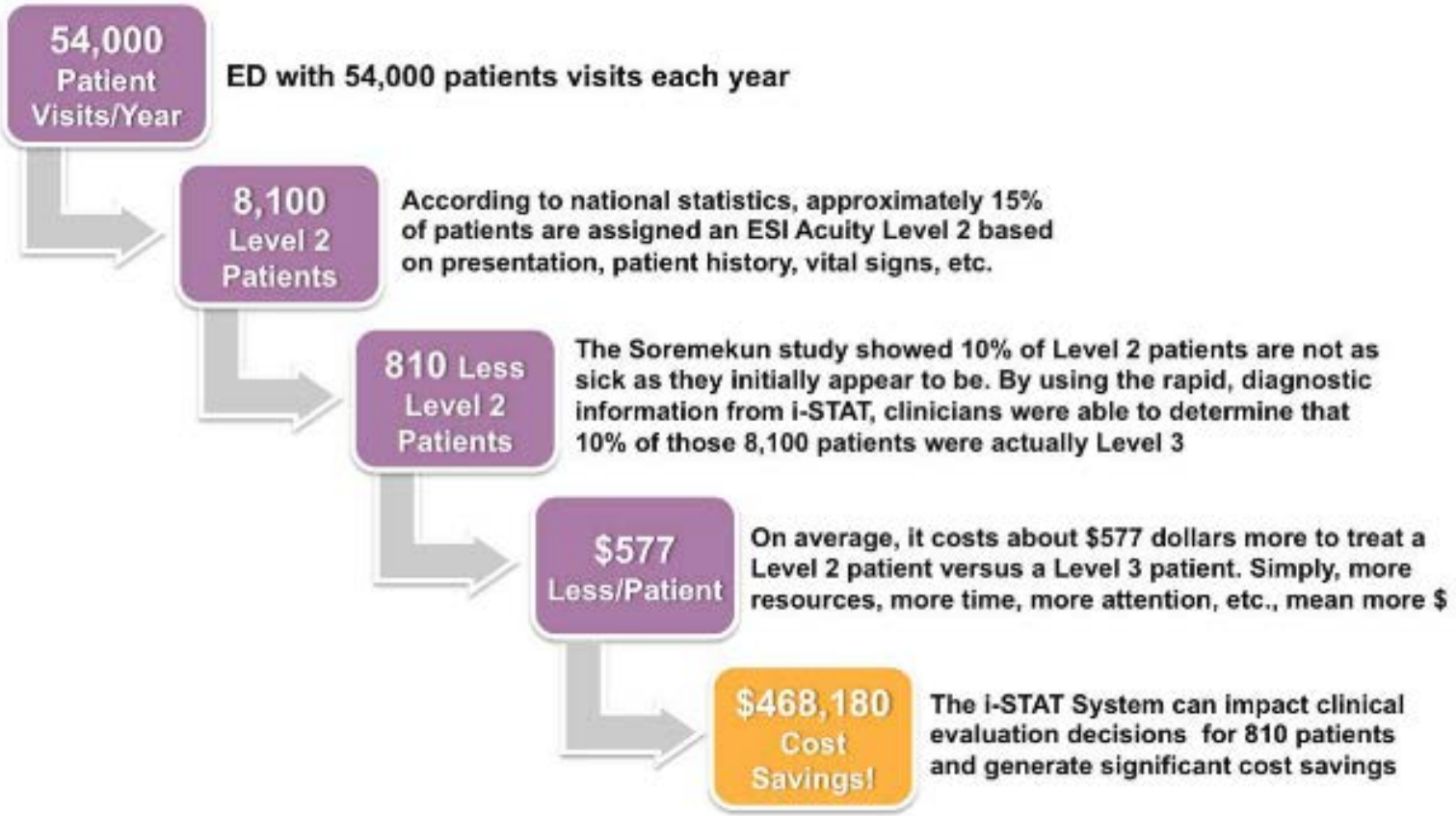
UTILITY OF POINT OF CARE TESTING IN ED TRIAGE

- **Study Goal to Determine if Improved Patient Outcomes achieved by:**
  - **lab information early in the patient experience**
  - **Optimize allocation resources to patients needing immediate care**

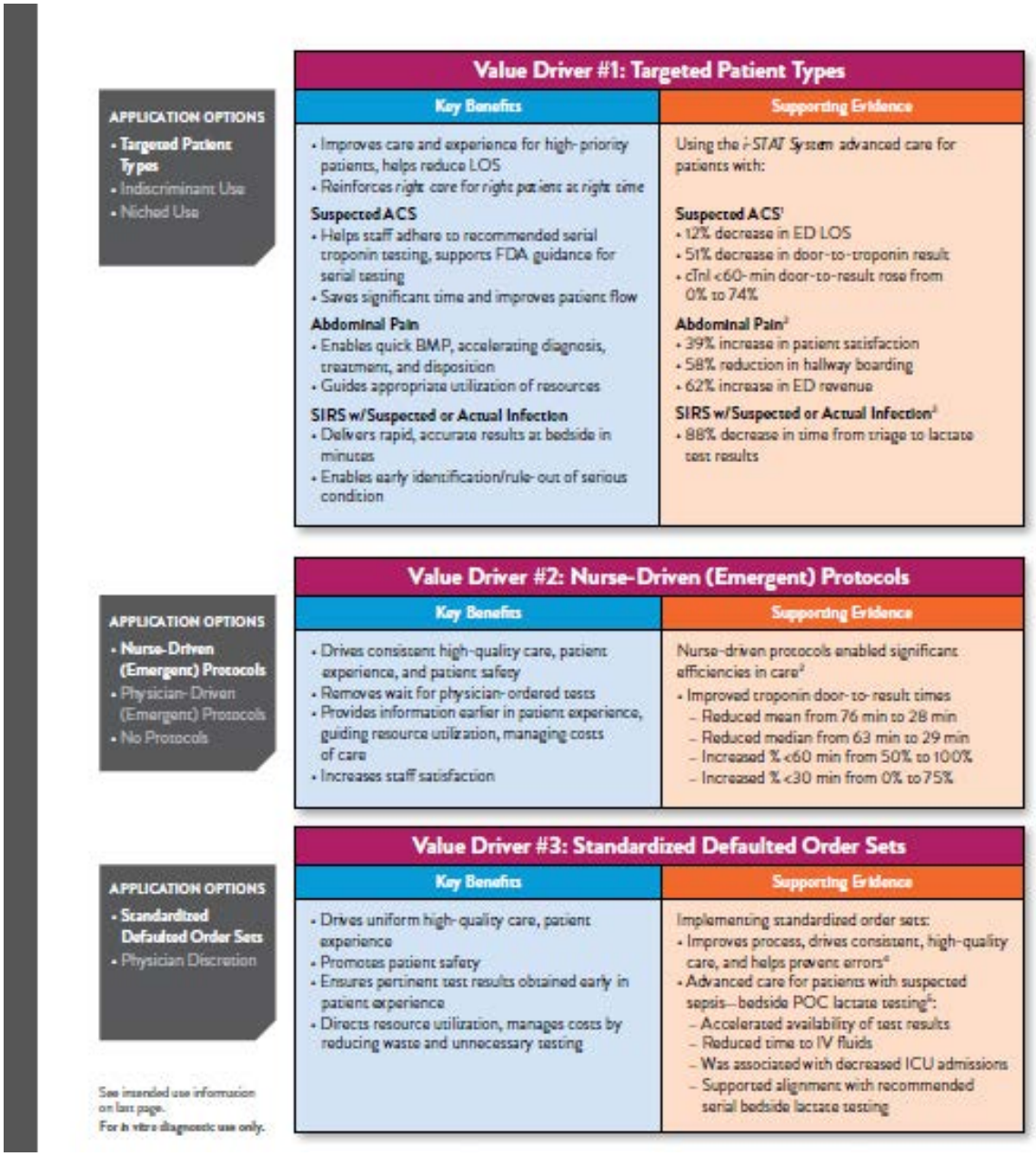
- **300 Patients presented in ED 54,000 annual visits**
- **Patient Selection Criteria**
  - **Chest Pain / SOB > 40 yrs old**
  - **Possible infection 2+ systemic inflammatory response criteria > 18 yrs old**
  - **Patients > 65 yrs with non-traumatic complaints**
- **Results: Helpful in 56% of patients**
  - **Triage level changed in 15% of patients**
    - **4% of patients increased to higher acuity levels (ESI 3 > ESI 2)**
    - **10% of patients reduced from ESI 2 to ESI 3**
  - **Modified additional care & management in 14% patients**
  - **More rapid MD evaluation in 6% of patients (possible delays in receiving medical attention vs. waiting room)**

The *Soremekun* study demonstrates that by using i-STAT early in the patient experience, clinicians can confidently deliver care based on presentation, vital signs, AND rapid diagnostic information, potentially achieving significant cost savings. Let's examine this further using an ED with 54,000 patient visits per year.



Conclusion: using appropriate POCT early in the patient experience drove a more accurate assessment of patient acuity level and better risk stratification. The authors reported a more efficient and targeted allocation of ED resources. Clinicians were able to deliver **the right care at the right time,** which can ultimately help drive down the total cost of care.

6 Key Factors that Optimize POCT


APPLICATION OPTIONS
• Targeted Patient Types
• Indiscriminant Use
• Niched Use
Value Driver #1: Targeted Patient Types
Key Benefits
• Improves care and experience for high-priority patients, helps reduce LOS
• Reinforces right care for right patient at right time
Suspected ACS
• Helps staff adhere to recommended serial troponin testing, supports FDA guidance for serial testing
• Saves significant time and improves patient flow
Abdominal Pain
• Enables quick BMP, accelerating diagnosis, treatment, and disposition
• Guides appropriate utilization of resources
SIRS w/Suspected or Actual Infection
• Delivers rapid, accurate results at bedside in minutes
• Enables early identification/rule-out of serious condition
Supporting Evidence
Using the i-STAT System advanced care for patients with:
Suspected ACS[1]
• 12% decrease in ED LOS
• 51% decrease in door-to-troponin result
• cTnI <60-min door-to-result rose from 0% to 74%
Abdominal Pain[2]
• 39% increase in patient satisfaction
• 58% reduction in hallway boarding
• 62% increase in ED revenue
SIRS w/Suspected or Actual Infection[3]
• 88% decrease in time from triage to lactate test results
APPLICATION OPTIONS
• Nurse-Driven (Emergent) Protocols
• Physician-Driven (Emergent) Protocols
• No Protocols
Value Driver #2: Nurse-Driven (Emergent) Protocols
Key Benefits
• Drives consistent high-quality care, patient experience, and patient safety
• Removes wait for physician-ordered tests
• Provides information earlier in patient experience, guiding resource utilization, managing costs of care
• Increases staff satisfaction
Supporting Evidence
Nurse-driven protocols enabled significant efficiencies in care[2]
• Improved troponin door-to-result times
– Reduced mean from 76 min to 28 min
– Reduced median from 63 min to 29 min
– Increased % <60 min from 50% to 100%
– Increased % <30 min from 0% to 75%
APPLICATION OPTIONS
• Standardized Defaulted Order Sets
• Physician Discretion
Value Driver #3: Standardized Defaulted Order Sets
Key Benefits
• Drives uniform high-quality care, patient experience
• Promotes patient safety
• Ensures pertinent test results obtained early in patient experience
• Directs resource utilization, manages costs by reducing waste and unnecessary testing
Supporting Evidence
Implementing standardized order sets:
• Improves process, drives consistent, high-quality care, and helps prevent errors[4]
• Advanced care for patients with suspected sepsis—bedside POC lactate testing[5]:
– Accelerated availability of test results
– Reduced time to IV fluids
– Was associated with decreased ICU admissions
– Supported alignment with recommended serial bedside lactate testing
See intended use information on last page.
For in vitro diagnostic use only.

APPLICATION OPTIONS
- **Nurses**
- RT/ED Technicians, Limited RN Users
- Lab Technicians, Phlebotomists

Value Driver #4: Nurses As Primary Operators

Key Benefits	Supporting Evidence
• Enables seamless, patient-centric care • Improves care team communication and satisfaction • Reinforces nurse's integral role in patient care and experience	With nurses using *i-STAT* at bedside: • Staff were highly satisfied† – Survey of nurses revealed: • 100% noted improved departmental workflow • 84% noted improved productivity • 81% noted improved communication • cTnI door-to-result times were accelerated from 123 min to 54 min *(-69 min)*[2]

APPLICATION OPTIONS
- **Bedside**
- Workstation (Near-Patient)
- Stat Lab/Central Lab

Value Driver #5: Bedside Use

Key Benefits	Supporting Evidence
• Fosters communication between clinician and patient • Improves efficiency, provides information early in patient experience • Allows nurse to educate patient on value of rapid bedside diagnostic results • Reinforces patient safety	Proximity of *i-STAT* testing to patients dramatically affects impact on efficiency of results: • Reductions in door-to-troponin result time*[2] – Bedside: reduced from 123 min to 54 min *(-69 min)* – Workstation: reduced from 99 min to 60 min *(-39 min)* – Central lab: reduced from 82 min to 64 min *(-18 min)*

APPLICATION OPTIONS
- **Wireless, Interfaced**
- Interfaced, Results Need to Download
- No Interface, Print

Value Driver #6: Wireless, Interfaced Transmission

Key Benefits	Supporting Evidence
• Uploads results from bedside—fastest delivery to full care team • Provides seamless integration into DM, EMR, tracking board • Supports better data capture/management in today's data-driven environment • Reduces risk of errors, reinforcing patient safety	Use of wireless, interfaced transmission†: • Increases operational efficiency*[3] – Reduced cTnI door-to-EMR times by 40.5% – Reduced door-to-admit decision times by 25% – Reduced door-to-discharge decision times by 12% • Aligns with Core Performance Measures (OP-12)[3]

*Data reflect a pilot study across facilities where proximity to patient was the only difference in the use of *i-STAT*.
†Data reflect impact of converting to wireless system; *i-STAT* had already been in use at this facility.

LOS=length of stay; ACS=acute coronary syndrome; BMP=basic metabolic panel; SIRS=Systemic Inflammatory Response Syndrome; ICU=Intensive Care Unit; RT=Registered Technician; RN=Registered Nurse; DM=data manager; EMR=electronic medical record.

See intended use information on last page.
For *in vitro* diagnostic use only. Not all products are available in all regions. Check with your local representative for availability in specific markets.

Key Takeaways:

To thrive in the challenging healthcare landscape, hospitals must:

- Improve the Quality of Patient Care
- Reduce the Total Cost of providing care
- Improve the Patient Experience

-Standardization of Care and protocols appear to be a trend in its early phases that looks to be sustainable

- Point of Care has a bright future!!

THANK YOU

QUESTIONS/DISCUSSION

Abbott