naviHealth | Guiding the Way

Methods for Managing Post-Acute Care

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About naviHealth

19 Years

Experience in discharge management

Manage care transitions for

875+ Acute hospitals

12K+ PAC facilities

25% of all nationwide acute discharges move across our networks

$350 MILLION in unnecessary costs removed from the healthcare system annually

20% generated in savings and reduced medical expenses for health plan partners

Providing services for the BPCI Advanced initiative in

22 STATES

>150 HOSPITALS across **12 health systems**

~3.5 MILLION Medicare Advantage and ACO member lives under PAC management

>100K BPCI Advanced episodes of care managed annually

CLINICAL IMPACT

8% average BPCI savings per episode vs. historical baseline

* Figures based on Monthly CMS Claims, Q1&Q2 2016 results for 2017 Phase II (at-risk) episodes annualized. Financials based on experience, and results in managing episodes in partnership with health systems as an Awardee Convener in the inaugural Bundled Payments for Care Improvement initiative.

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Strategies for Managing Post-Acute Care (PAC)

Determining Appropriate PAC Level of Care

Forming and Managing High-Quality PAC Networks

Optimizing SNF Utilization

Reducing Readmissions

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1

Determining appropriate PAC level of care

Determining the appropriate PAC setting is the first step in ensuring successful outcomes

- **Clinical decision support technology** to support decision-making, develop personalized PAC care plans for each patient and to seamlessly integrate assessments into workflow

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2

Forming and managing high-quality PAC networks

Increase use of high-quality providers

- **A data-driven approach** to form networks based on quality, and common evaluation metrics must be articulated and established
- Support the patient and family and provide information that allows them to make **informed decisions**

3

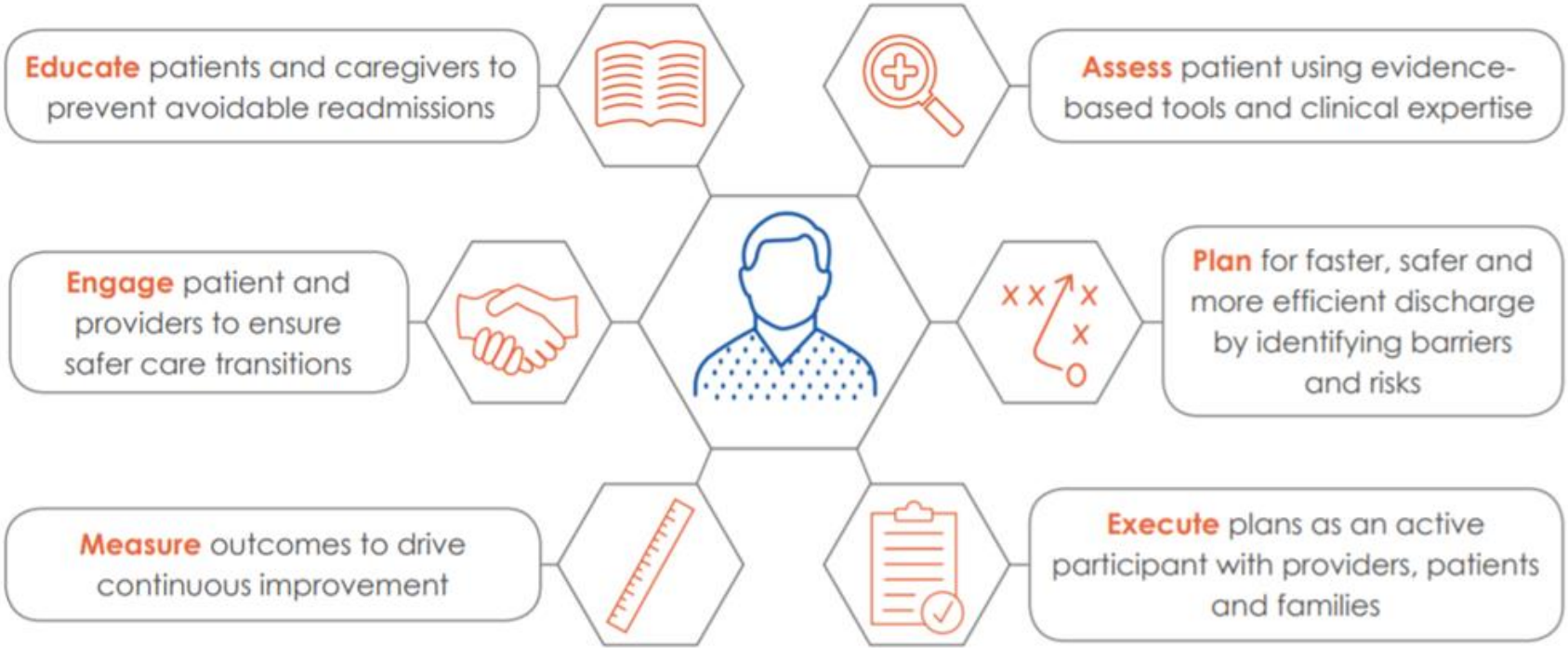
Appropriate PAC Utilization

- Combining clinical decision support technology, clinical expertise and engagement in the PAC setting **while monitoring the patient's recovery progress**
- Expediting safe transitions home when target functional gains are achieved and medical needs are met
  - Early alignment by the interdisciplinary provider team, patient, family/caregiver on anticipated length of stay and non-skilled caregiver needs post- discharge
  - Early identification of barriers to discharge and working collaboratively toward resolution

4 Reducing Readmissions

- Lack of patient engagement, information and education on burden of care post-discharge, and inadequate patient self-management skills can lead to high readmissions and should be addressed prior to the patient's transition
  - Hardwiring **seamless and 'warm' transitions of care** to connect patients with their community and community resources, as well as existing care management programs (e.g., home-based primary care, palliative care, etc.)
  - Setting expectations with patients and families on the recovery process and needs to set the patient up for success

Keeping Patient at the Center of Care



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