Cognizant

Mini Summit 12 – Methods for Managing Post Acute Care

Ninth National Bundled Payment Summit

June 2019

Cognizant Healthcare Practice

Revenue

Up 9% 2018 vs. 2017

As of 2018

Digital

28% growth in our Digital Business

- Ranked **3rd** on the Healthcare Informatics top 100 Healthcare IT Vendors
- NCQA DM Systems Certification for **7** programs supported by CareAdvance Enterprise™
- Serving **¼** of provider population in North America
- Strong team of **35,000+** professionals - 1500+ Doctors, PhD's, Nurses, Pharmacists
- **70+** Health Systems and **300,000+** Care Providers Supported through over 400 PM/EHR Partners

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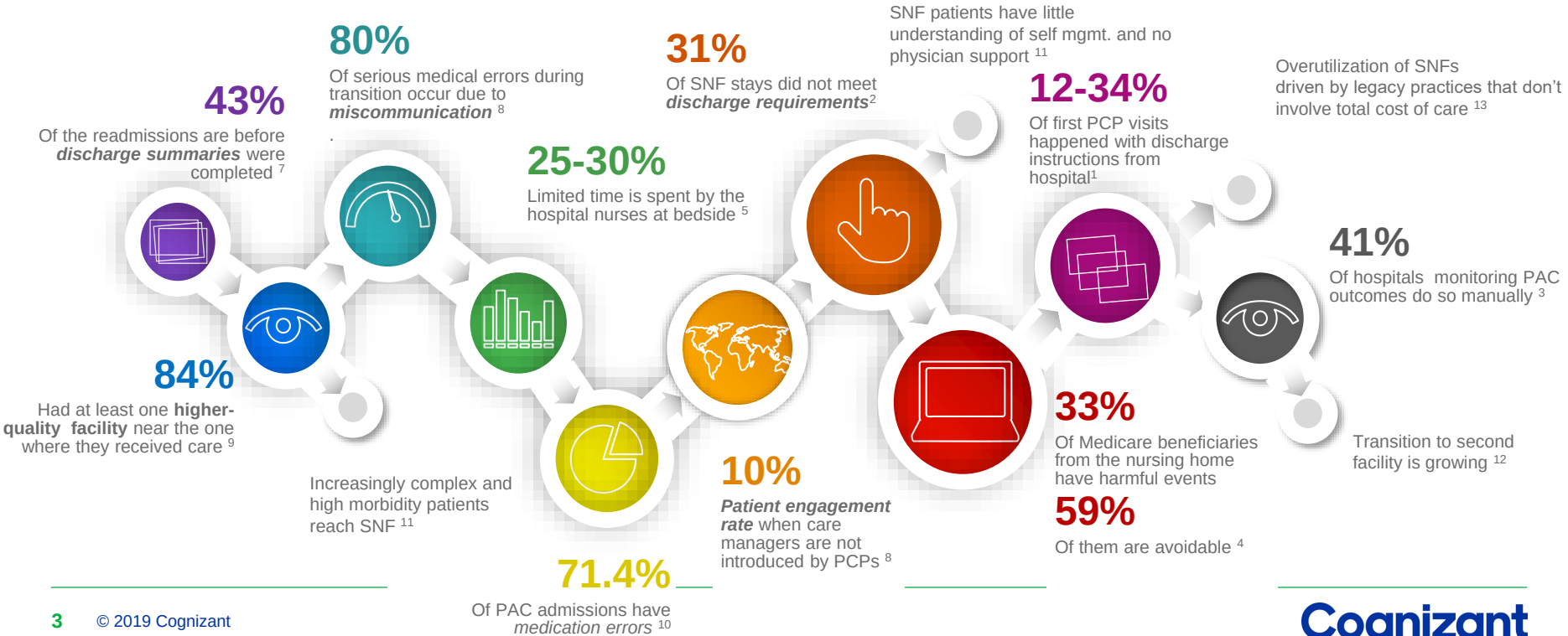
Industry Challenges

Post-acute care spending is forecast to increase from $646 billion to $1,312 billion, reflecting a compound annual growth rate of 7.3%, during the next decade[4] due to a) increased severity of patients when leaving the hospital[11]; b) perverse financial incentives of hospitals and PAC facilities; and c) a badly broken PAC system lacking standardized care, point of care decision support and timely care interventions[13].



Successful pilots from market leaders

New solution features have been proven in pilots (limited by scope) conducted by market leaders and have shown measurable results

Readmission focus

CareMore HEALTH

30 day readmissions is 40% better than national average [1]

- Extensivists link hospitalization with outpatient care
- Provide recommendations following discharge

Cleveland Clinic

Reduced 30 day readmissions from 25% to 20% [4]

- Medication accuracy with pharmacists
- Physicians guardians of patient transition

Penn Nursing

University of Pennsylvania School of Nursing

Reduce readmissions or emergency department visits [5]

- Discharge Referral Expert System for Care Transitions
- Change in characteristics of patients referred

Many examples

PAC utilization focus

Savings =2X Readmission focus savings

Saint Luke's HEALTH SYSTEM

ALOS dropped from 36-40 days to 14-19 days [3]

- RN / PT develop care protocols for PAC
- Physicians embedded to train PAC staff

PriorityHealth

15% decrease in SNF days per 1,000 & 13% reduction in PMPM costs for MA programs [2]

- NaviHealth benchmarks performance
- Embed discharge planners in hospitals

CMS

5.9% reduction in CCJR episodes where patients were discharged to PAC [6]

- Risk-stratification tools, patient education, home care supports [7]
- Influence SNF quality & cost [7]

Very nascent

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naviHealth | Guiding the Way

Methods for Managing Post-Acute Care

Karen Chambers, VP of Clinical Outcomes

naviHealth.com

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.

Disclaimer: The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document.

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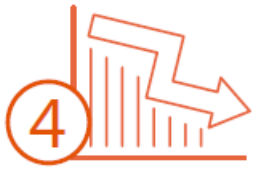
Strategies for Managing Post-Acute Care (PAC)

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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UNIVERSITY MEDICAL CENTER

LUBBOCK, TX

1 of 18 Level 1 Trauma Facilities in Texas

- Beds – 501
- Annual Admissions – 42,000+
- EC Visits – 88,000+
- Providers – 800+
- 700,000+ patients yearly in hospital and clinics
- Timothy J. Harnar Regional Burn Center
- Level 1 Trauma Certification
- Employees 4600+
- Net Patient Revenue $502M

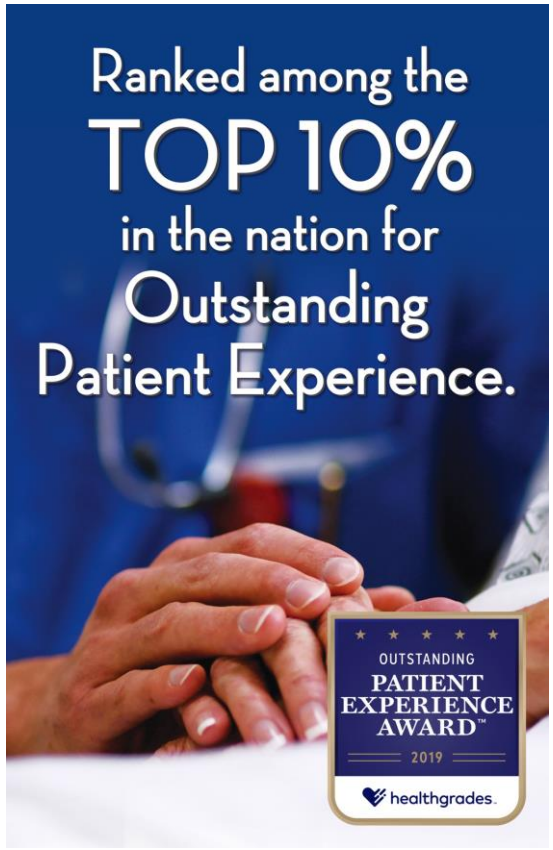
Dawn Rakiey MPT, PTA
DIRECTOR, Clinical Integration Network/ACO
2019

THE STRENGTH OF OUR CULTURE

BEST IN TEXAS
UMC: №7 & UMCP: №4

Best Companies to Work for Texas 2019

2019 Women's Choice Award®
America's 100 Best Hospitals For Patient Experience



Baby-Friendly USA
The gold standard of care

IDSA
ANTIMICROBIAL STEWARDSHIP
CENTER OF EXCELLENCE

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

HealthCare's most wired®

Service · Teamwork · Leadership

UMC HEALTH SYSTEM

SNF PREFERRED PROVIDER NETWORK

MANDATORY CRITERIA:

STAR RATING OF 3 OR ABOVE

NURSING HOME COMPARE:

% of short stay patients re-hospitalized after SNF stay
% of short stay patients who had an ER visit no hospitalization
% of short stay patients who made improvements in function
% of short stay patients with pressure ulcers that are new or worsened

SPECIFIC DATA FROM FACILITY:

ALOS

***CONTRACTS WITH SNFs FOR BED ALLOTMENT, UNFUNDED PATIENTS,ETC**

HHA PREFERRED PROVIDER NETWORK

MANDATORY CRITERIA:

STAR RATING OF 3 OR ABOVE
Monthly meetings with UMC
Accept Unfunded/Poorly Funded patients

HOME HEALTH COMPARE:

% How often patients had an ER visit without hospitalization
% How often patients had to be re-admitted to the hospital
% How often patients got better at walking/moving around
% How often patients had less pain when moving around
% Home health began in a timely manner
% Patients got better at taking medications by mouth

POST ACUTE CARE SPENDING OF TOTAL CJR EPISODES

Baseline (2014-2016)

49 %

2018

46 %

DECREASED LENGTH OF STAY IN SNF

Baseline (2014-2016)

45 Days

2018

37 Days

DECREASED HOME HEALTH COSTS

Baseline (2014-2016)

$3,600

2018

$2,203

Questions?

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