Inpatient Post-Discharge Navigation Program

Targeted navigation and analytics to address the root causes of readmission risk

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Care Continuity Solutions

Addressing What Matters Most

Access to Care | **Service Line Growth** | **Quality Improvement** | **Market Competition**

Three distinct programs, each designed to address the most pressing challenges facing health systems today. The Program differences lie in the targeted patient population and the level of outreach required to drive impact.

Post-ED Navigation Program

Post-IP Readmission Program

Specialist Referral Optimization Program

Program Outcomes

Service Line Growth	Resource Effectiveness	Risk Reduction	Quality Impacts	Actionable Insights

Healthcare Initiatives

Enhance Patient Engagement

Ensure care navigation is targeted, proactive and effective.

Streamline FFS to VBC Transition

Enable organizations to manage both payment models efficiently.

Consolidate Fragmented Solutions

Reduce complexity while increasing operational synergy.

Unlock Strategic Growth Opportunities

Integrate data, insights, and workflow automation into a single, cohesive system.

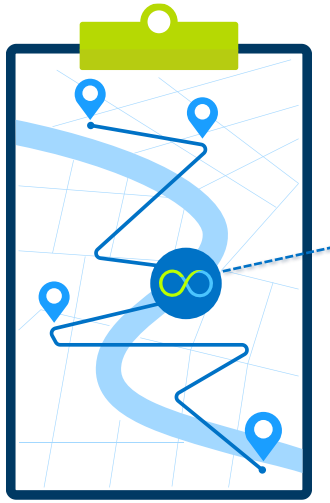
Utilize Intelligence & Infrastructure Platform

Optimize network performance at scale.

Post-IP Navigation Program

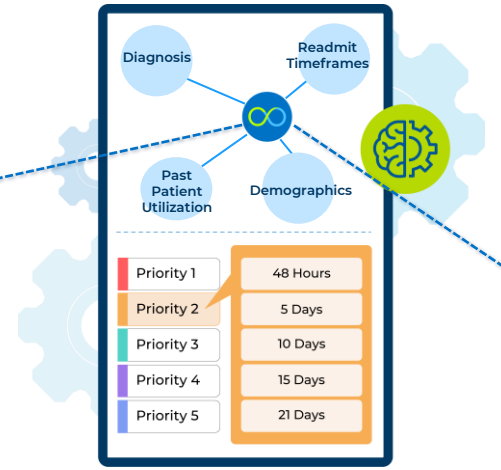
Combines AI workflow technology, navigation services, and robust reporting

Readmissions Program Design



- Improve utilization of current resources
- Integrate with existing case mgmt, population health, and medical group workflows
- Option to design an affordable "tech-only" solution workflow

AI-Driven Outreach Models



- Machine learning optimizes outreach protocol for each patient segment
- Designed to catch key patient issues prior to readmission risk

Navigation and Digital Engagement

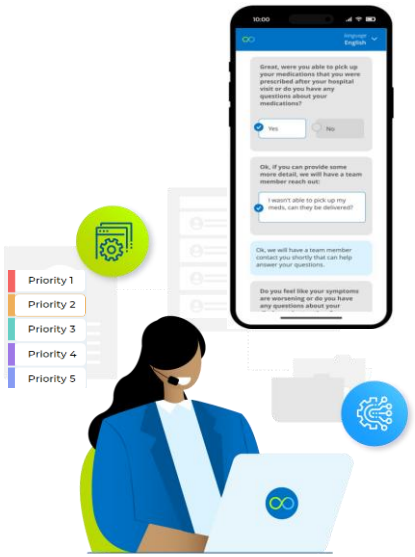
- Digital screening tools and text engagement to escalate any risk factors
- Care concierge team connects with patients to guide follow-up activities

Actionable Insights and Reporting

- Understand patient issues, questions and root causes of readmissions risk
- Continuous feedback loop to inform program design and feed the models

Navigation and Outreach Services

Utilize Care Continuity concierge team to reduce readmissions

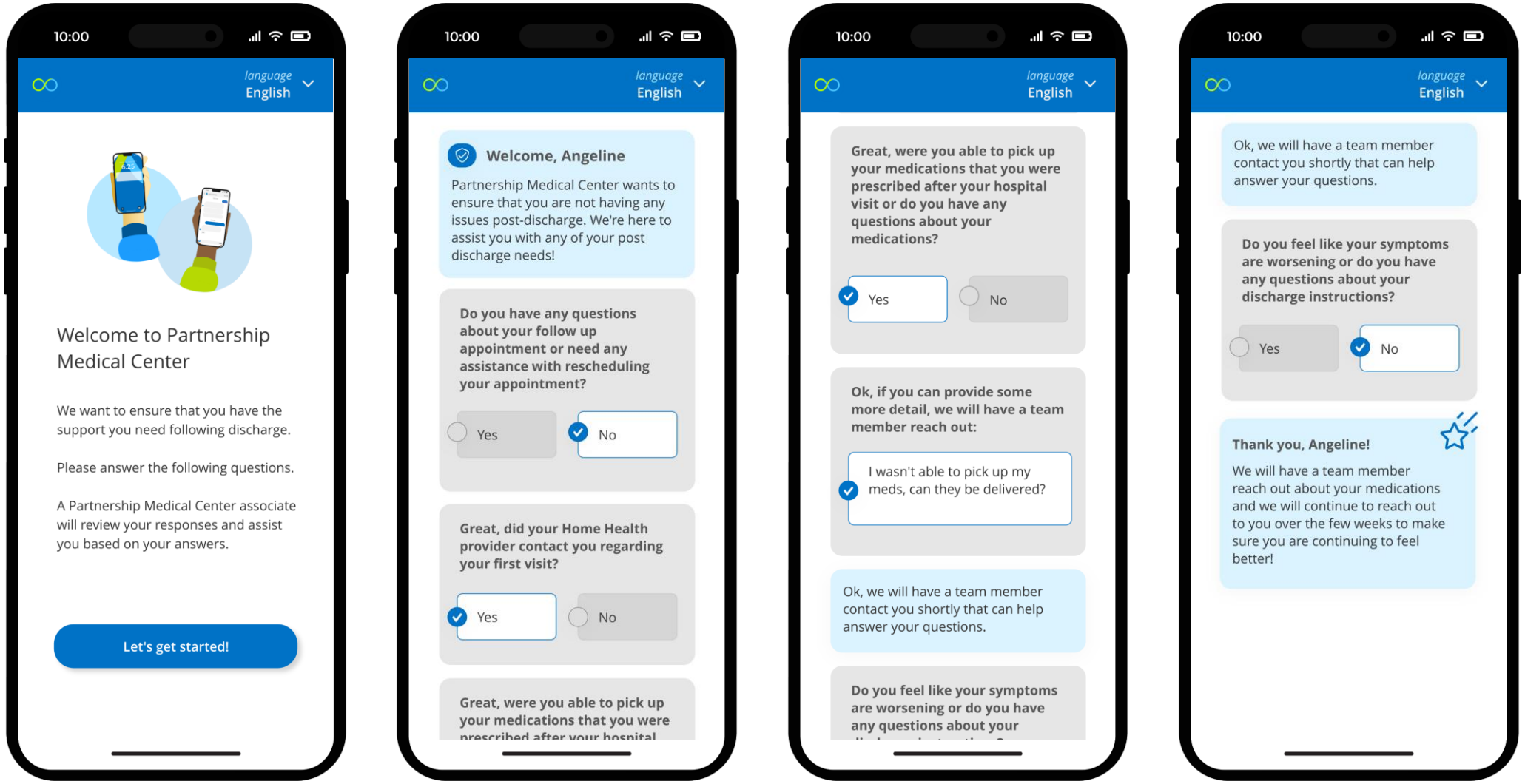


Non-clinical navigation and digital engagement

- Non-clinical navigators provide patient outreach post-discharge to identify post-discharge issues and escalate patient issues prior to a readmission.
- Navigators focus on providing a white-glove service for patients to help improve post-discharge care plan compliance and connect patients with worsening symptoms with appropriate health system resources.
- Navigators schedule post-discharge appointments and ask patients the following questions on a targeted cadence:
    1. Were you able to pick up your **medications** or do you have any questions about your medications?
    2. Did **home health** connect with you about visiting and/or did **DME** show up?
    3. Are you still able to attend your **follow-up appointment** or do you need assistance rescheduling?
    4. How are you feeling/are your **symptoms** improving?
- Depending on the escalation protocols outlined in the program design, the navigator will connect the patients to the most appropriate health system resource.

Post-discharge Virtual Engagement

Automated outreach to identify patient barriers post-discharge



Text-based outreach initiates web portal for virtual screening with **real-time automated interactions.**

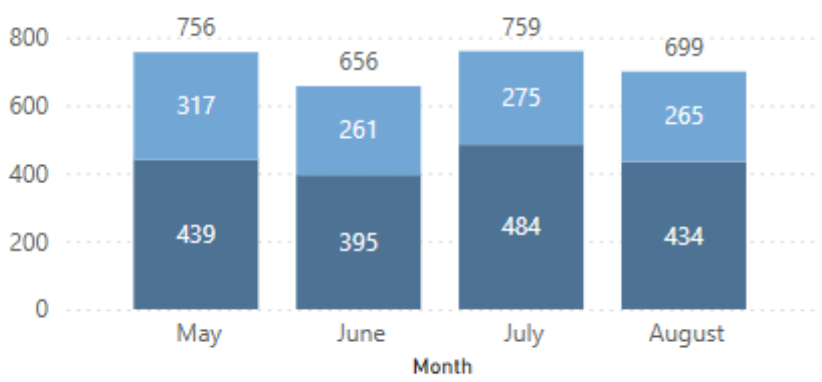
Outreach is **configured to patient's discharged needs** and designed to **identify** and **escalate patient barriers** to care before they **lead to readmissions.**

Insights & Reporting

Discharges and Appointments

DischargeDate: 5/1/2024 – 8/31/2024

Total Weekly Discharges



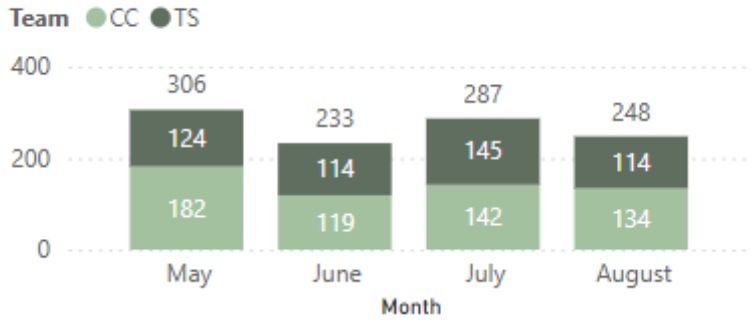
Percentage of Patients with Appointments by Group

65+ Group	All Other		Medicare ...		Total	
HasAppt	Total	%	Total	%	Total	%
⊞ No Appts	427	24%	118	11%	545	19%
⊟ Has Appts	1325	76%	1000	89%	2325	81%
After 14 Days	222	13%	16	1%	238	8%
Within 14 Days	337	19%	49	4%	386	13%
Within 7 Days	766	44%	935	84%	1701	59%
Total	1752	100%	1118	100%	2870	100%

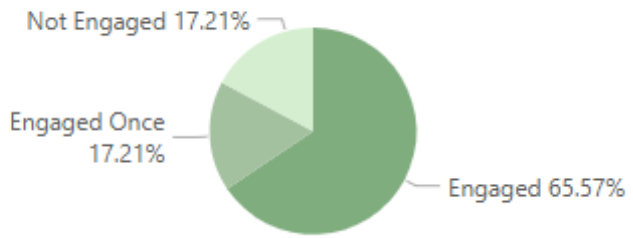
Medicare Patient Weekly Calls

TaskDateCompleted: 5/1/2024 – 8/30/2024

Medicare Patient Weekly Follow Up by Team



Patient Engagement Rate For Weekly Calls



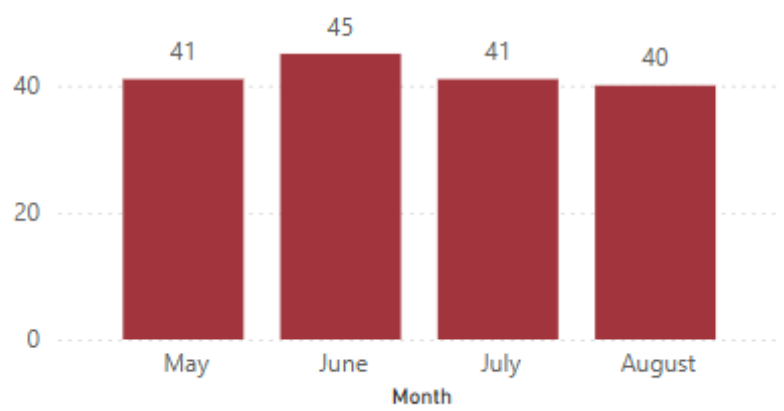
Patient Questions/Issues During Calls

Week	Symp.	Other	Meds	HH	Appt	DME	Total
8/26/24	5	5	4	2	6		12
8/19/24	5	3	2	2	2	2	10
8/12/24	3	4	2	2	3		9
8/05/24	4	3	4	1	5	1	9
Total	47	56	21	15	15	4	138

Readmissions Details

NextAdmission: 5/1/2024 – 8/31/2024

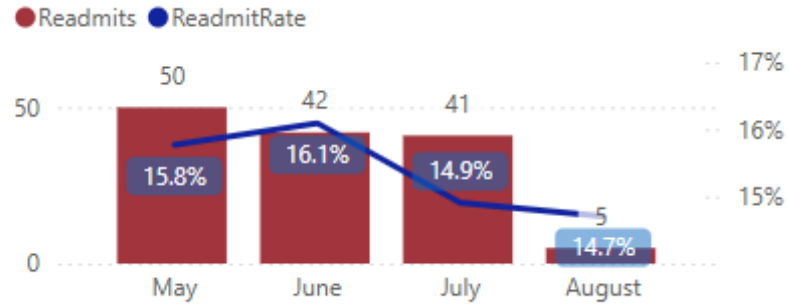
Readmits by Readmit Date



All Other
Medicare Discharges

DischargeDate: 5/1/2024 – 8/4/2024

Readmit Rate by Discharge Date



Readmissions Feedback Loop

Insights to improve program design and adjust the outreach models

Discharge Diagnosis	Total Patients
AMI	56
COPD	75
CHF	**92**
Pneumonia	16
Sepsis	60
ESRD	92

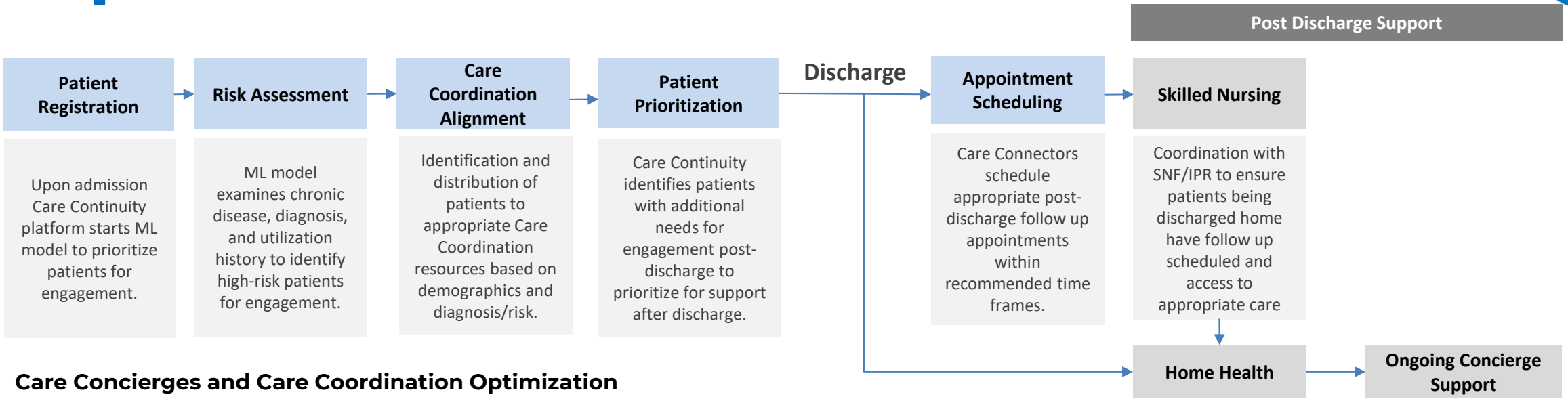
Outreach	Symptoms Worsening	Medication Issues	Appointment Issues	Home Health	DME
48 Hours	12	20	7	10	4
5 Days	5	22	12	6	3
10 Days	3	7	3	2	0
15 Days	3	16	0	7	0
21 Days	2	3	0	0	0
Total Issues	25	58	22	25	7

Readmission Rate	Median Time to Appointment	Median Time To Readmission
17.3%	11.7 Days	8.2 Days

Engaged Readmission Rate	Non-engaged Readmission Rate
13.2%	24.8%

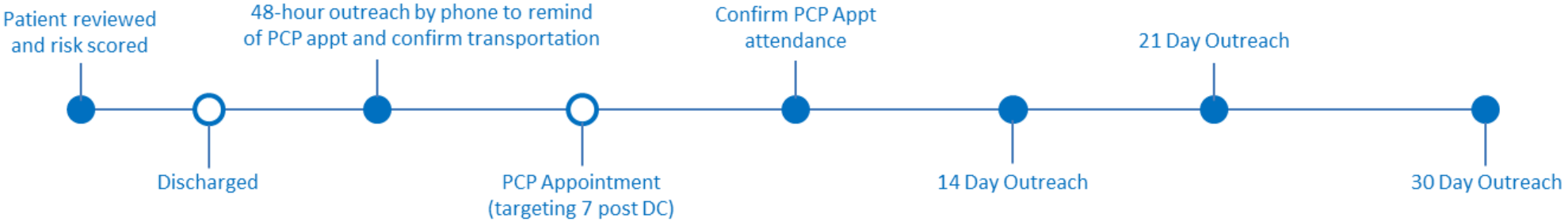
- Patient engagement reporting based on navigator outreach is used in collaboration with clinical leadership to improve resource utilization and the discharge process.
- In example above, patients with CHF that had issues at 5 days had a readmission rate of 17.3% and a median time to readmission of 8.2 days. With the high number of medication issues (42 in the first 5 days), expanded medication education at time of discharge combined with a shorter time to appt are recommended to reduce readmissions.

Inpatient Workflow – *example*



Care Concierges and Care Coordination Optimization

- Care Concierges ensure patients have increased access to care and that patients are engaged to prevent repeat acute events.
- Data-driven approach to increase transparency and alignment and to ensure patients are connected with the appropriate community resources in a timely manner
- Alignment of Telemedicine, Provider Outreach, and other Care Management resources will result in an optimized, robust readmission reduction program.



Inpatient readmissions program

Smart navigation examples

Patient Discharge and Prioritization

Patients 65+ are reviewed and prioritized to verify if they had an appointment scheduled prior to discharge. If not, a concierge reaches out to assist with getting that patient an appointment within 7 days.
Secondarily, for patients 65+ with traditional Medicare who do not have a Core 4 diagnosis (those are followed by an internal transition team) are engaged for weekly check-in calls.

Navigator Outreach

Navigator Outreach

- 48 hours
- 5 days
- 10 days
- 15 days
- 21 days

Confirm follow-up appointments and attendance, identify barriers, address issues and risks per the escalation protocol. Coordinate with case management

Barrier Identification, Support, and Escalation

13.4% of encounters have at least 1 documented barrier (avg 60 /mth for this population)

Appointment Scheduling and Follow-up Care — 22% of identified barriers

Patient doesn't have an appointment or doesn't want to go
Make appointment and stress importance of going, follow-up to confirm

DME — 6% of identified barriers

DME hasn't shown up (not covered, missing orders, patient didn't know to pick it up)

- Educate patient
- Contact DME company
- Track down orders

Home Health — 15% of identified barriers

Home Health hasn't shown up

- Look up orders, call home health agency, facilitate support, address gaps
- If no orders, contact case manager or PCP

Symptoms Worsening — 26% of identified barriers

Patient reports symptoms are getting worse
Refer patient to identified escalation resource such as

- Urgent care
- Nurseline
- PCP
- Case manager

Medication — 17% of identified barriers

Patient doesn't have medication (affordability, not aware, pharmacy doesn't have script, not covered)

- Local resources, community services for SDOH issues
- Connect with pharmacy
- Patient education and stress importance
- Contact PCP, case management, or provider

Navigation is just the beginning.

The obvious value of Care Continuity is taking on the complexity of patient navigation to improve access and throughput. The deeper impact, the real game changer, is what our clients do with the insights we surface.

Together we turn their data into smarter, faster decisions that improve patient outcomes and system performance.

Reducing Readmissions through Smarter Telemedicine

Identified 80% of telemedicine follow-ups were going uncompleted, contributing to >20% readmission in high-risk patients. We drove a vendor change and improved workflows, cutting confusion and enabling active rescheduling, turning a gap into a safety net.

Fast-Tracking Stroke Follow-Ups

Stroke patients were waiting too long for Neurology. Care Continuity built a daily stroke discharge report to prioritize urgent follow-ups - cutting appointment delays and improving recovery outcomes

Addressing Home Health Delays

Recognized consistent 48-hour+ delays in first Home Health visits. We surfaced the issue with data and helped the system reset expectations with agencies, accelerating care and reducing readmissions tied to missed visits.

Closing the Meds Gap for CHF Patients

Caught medication issues within 48 hours post-discharge, especially in CHF patients. Result: A "meds in beds" program was launched, reducing confusion and improving access before problems escalated.

Escalating to Paramedicine for Non-Responsive Patients

When nurse line interventions weren't enough. We identified patterns and added Paramedicine to the escalation path, giving vulnerable patients another layer of support before they bounce back to the ER.

Prioritizing Urology for Critical Tube/Catheter Patients

High readmissions tied to delayed follow-ups for patients with nephrostomy tubes or catheters. We used Natural Language Processing to flag these patients, fast-tracked their scheduling, and worked with Urology to add a dedicated appointment type. Result: improved care at a critical time.

Inpatient Navigation Results

Our goal is to **improve patient engagement**, **reduce repeat acute events**, and **improve alignment of post-discharge resources**. Our inpatient program focuses on a data-driven approach to navigation, ensuring patients receive the **right care at the right time**.

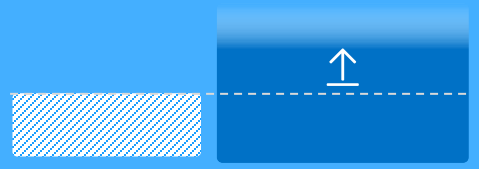
Percent of patients with follow-up appt within 7 days

75%

Targeting high risk patients for follow-up appointments within 7 days to improve transitions of care.

Average Patient Engagement Rate

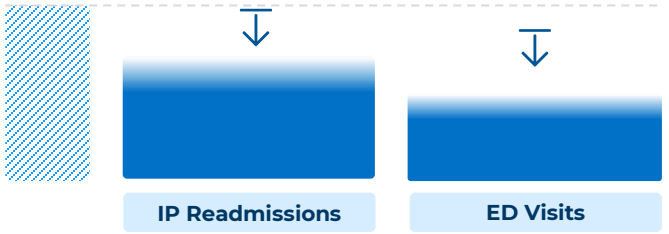
+80%



Active bi-weekly outreach to patients post-discharge to improve care plan compliance results in engagement rate above 80%

Reduction in Repeat Acute Events

-30% **-20%**



Engaged patients with follow up appointments within the appropriate time frame see an average reduction in readmissions of 30% and a reduction in preventable ED return visits of 20%