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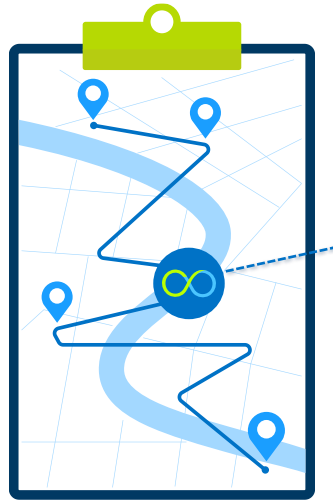
Inpatient Post-Discharge Navigation Program

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

Post-IP Navigation Program

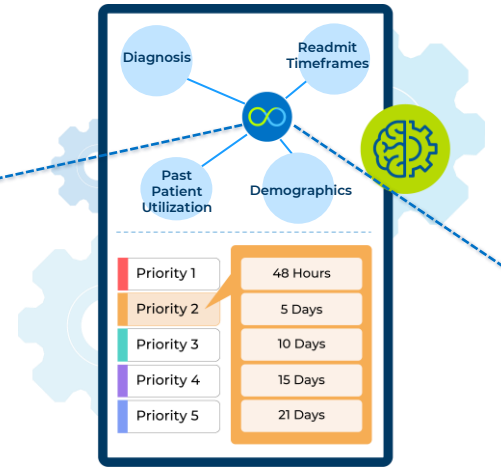
Combines AI prioritization, navigation services, and robust reporting

Readmissions program design



- Improve alignment and efficiency of current navigation and care transition resources
- Target select populations like Medicare "core 4" DRG and age 65+ IP discharges

Prioritize IP cases for smart outreach cadence



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

Personalized navigation and risk screening

- 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 granular reporting

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

Prioritize IP cases for smarter navigation

Customized outreach cadence and script for each risk segment

Using **machine learning models**, Care Continuity **scores** patients based on the likelihood of having a **post-discharge issue** and the risk of a **repeat acute event**.

Based on the patient's score, they are assigned an **outreach cadence** to **detect and escalate** issues before they lead to readmissions.

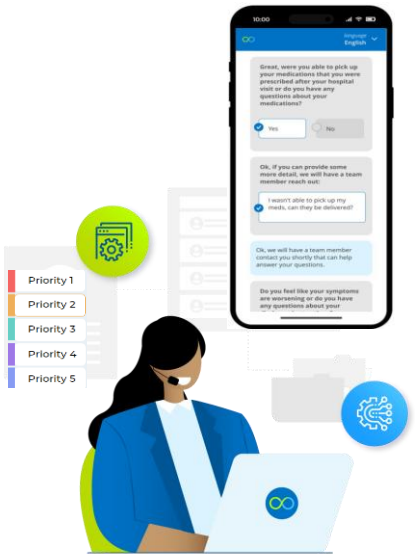
	Volume	% of Volume	Post-Discharge Issue Rate: Actual	Post-Discharge Issue Rate: Rate	Repeat Acute Care Visit: Actual	Repeat Acute Care Visit: Rate	Recommended Patient Outreach Protocols PRIORITY 2
Priority 1	89	4.9%	69	47.2%	34	38.2%	48 Hours
Priority 2	403	22.1%	105	26.1%	97	24.1%	5 Days
Priority 3	390	21.4%	62	15.9%	74	19.0%	10 Days
Priority 4	489	26.9%	40	8.2%	58	11.9%	15 Days
Priority 5	450	24.7%	21	4.7%	4	0.9%	21 Days
	1,821		**821**		**310**		

Priority 2 includes the moderate-risk patients that have a high issue rate (26.1%) and a moderate risk acute care visit rate (24.1%). These patients represent a significant opportunity to prevent readmissions.

For **Priority 2** patients, the above recommended outreach protocols are designed to engage patients post-discharge and identify patient issues before they lead to readmissions.

Navigation and Outreach Services

Care Continuity navigation team pinpoints and escalates readmission risks

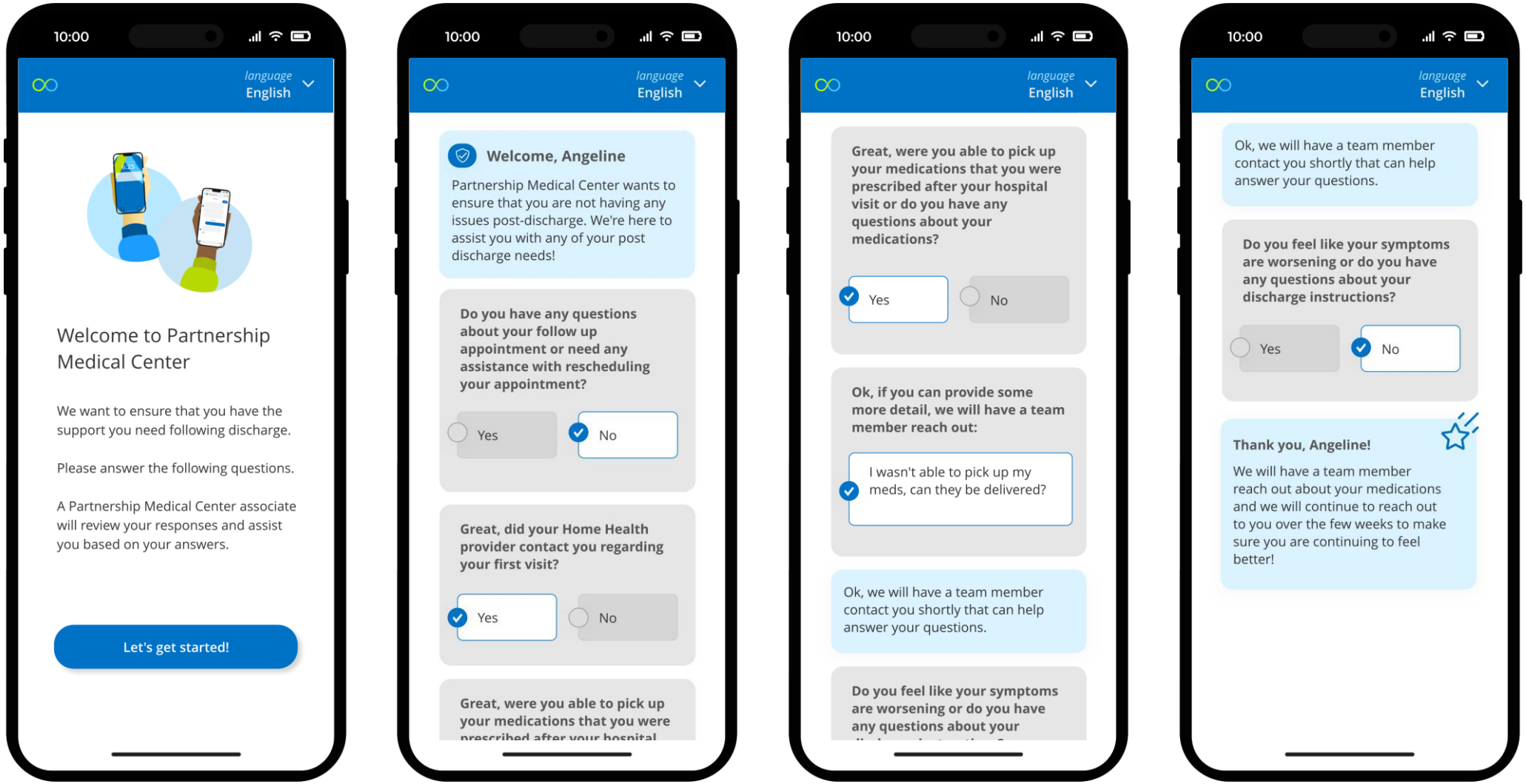


Non-clinical navigation and digital engagement

- 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 (or partner) 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.**

Inpatient readmissions program workflow

Smart navigation examples

Patient Discharge and Prioritization	Navigator Outreach	Barrier Identification, Support, and Escalation 13.4% of encounters have at least 1 documented barrier (avg 60 /mth for this population)

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

- 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

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

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.

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 this data into insights that inform process changes and new engagement approaches.

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.

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