naviHealth essentialINSIGHTS

Going Beyond the Call

Success stories from Patient Navigators

Introduction

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Helping people manage difficult situations is a life-long passion that I have dedicated over 20 years to, with an emphasis on developing home-based programs that provide valuable support during the post-discharge recovery period. Trying to coordinate health care needs is daunting for anyone; however, this can be particularly challenging for seniors when discharging home after an unplanned hospitalization or stay at a skilled nursing facility.

The naviHealth Patient Navigation solution is purposefully designed to solve for social need gaps, promote physician-directed discharge orders and address health disparities. Our non-clinical solution pairs seniors and their caregivers with an experienced Navigator who serves as their health care "quarterback" and advocate when it matters most. The following is a collection of inspirational "success" stories demonstrating the positive impact and value this program brings as our Navigators prioritize seniors' needs through individualized support and connection to clinical and community resources.

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Injecting High Savings

Who is the patient?

The patient is a 68-year-old female who was admitted to an acute facility for acute respiratory failure with hypoxia. Recently, she was diagnosed with osteoporosis while also managing a pulmonary disease and chronic pain. After a seven-day stay in the hospital, the patient was discharged to home with self-care.

What did we learn?

The patient said that her and her spouse can manage her own health care related needs. Because of the patient's independence, it took her a little time to warm up to the naviHealth Patient Navigator's offer of support during the post-discharge Welcome Call. Despite the hesitation from the patient, the Patient Navigator persisted, eventually gaining the trust of when the patient. Eventually, the patient admitted to struggling with her stressful situation and her newly ordered medication.

The patient explained that she received orders for a new medication for her newly diagnosed osteoporosis. When the patient initially spoke with her insurer about the medication, she was told that the first 36 injections would cost $1,000 each. The patient told her Patient Navigator that she could not afford the out-of-pocket cost.

What did we do?

The Patient Navigator called the drug manufacturing company's assistance program to see if the patient could quality for any assistance. Unfortunately, the patient did not qualify because the patient had medical insurance.

Going back to the drawing board, the Patient Navigator went on a hunt for another option to help with the expensive cost of the medication. The Patient Navigator found a program called Lilly Cares Foundation, a non-profit organization which provides ordered Lilly medications at no additional cost to qualifying patients, even if a patient has medical insurance.

With the patient being in a weakened physical state, she did not have the energy or bandwidth to fill out her part of the application. With permission from the patient, the Patient Navigator worked closely with the patient's spouse to get the application emailed over to them, completed, and returned on time to Lilly Cares Foundation. Concurrently, while working with the patient's spouse to get the application filled out, the Patient Navigator engaged the patient's Primary Care Physician (PCP) to complete the second half of the application.

What was the outcome?

Coordinating with the patient's PCP while simultaneously having the patients spouse expedite filling out the patient's application, was no easy feat. Persistence was key and fruitful, as the Patient Navigator was able to successfully get the patient's application finalized and submitted to the foundation. Thankfully, their application review process was only three-business days and the patient was approved right away. Most significantly, the patient was approved for the medication at no cost for the rest of the year. The patient received her first delivery just days later.

As a result of the naviHealth Patient Navigator addressing the cost barrier, the patient was spared a $36,000 out-of-pocket cost. Now that the patient has access to the lifesaving medication she needs, she has been able to focus on her recovery and regaining her strength in the comfort of her home.

A concerning state of affairs

- **37% of seniors** are concerned they will not be able to pay for needed health care services in the next year.[1]
- **45% of adults aged 50 to 64** report the same concern level.[1]

[1]https://news.gallup.com/poll/393494/older-adults-sacrificing-basic-needs-due-%20healthcare-costs.aspx)

Twists and Turns for a Trilogy Machine

Who is the patient?

The patient is a 76-year-old female who has had three hospitalizations over the course of a few months, all related to respiratory issues with intubations. She has a history of chronic weakness, hypertension, COPD and other comorbidities. She was discharged home with instructions to follow up with specialists.

What did we learn?

During the scheduled post-discharge Welcome Call, the Patient Navigator reviewed the patient's discharge orders with her. The patient confirmed that her daughter had already scheduled both specialists appointments but not a follow-up with her primary care provider (PCP). The patient questioned the need to see her PCP, to which the Patient Navigator was able to provide education regarding the importance of the PCP reviewing the discharge orders and newly prescribed medications. The patient confirmed understanding and gave verbal permission for the Patient Navigator to contact her daughter to schedule the appointment. The Navigator also learned that orders and supporting documents indicating the need for a BiPAP were in the process of being sent to the provider and that a sleep study would be required as a part of completing the order.

What did we do?

During several subsequent Wellness Checks, the Patient Navigator communicated directly with the patient's daughter. The daughter expressed frustration at the length of time it was taking the specialist to send the documentation and have the sleep study scheduled. During this time, the patient unfortunately learned that the sleep study appointments were unavailable for months, so the Patient Navigator proactively worked with the pulmonologist's office and the provider to ensure all supporting documents were in order prior to the sleep study appointment.

In reviewing the documentation, providers suggested a Trilogy machine instead of a sleep study. After exhaustive efforts to expedite the authorization for the machine, the patient was unfortunately readmitted to the hospital. During the hospitalization, the patient's daughter, a hospital social worker, and a Patient Navigator collaborated to ensure the patient's next post-discharge recovery phase would be successful. A decision was made to process the Trilogy order through a company at which the patient was already established. The Patient Navigator contacted the patient's insurance company to report claims and request authorization that the Trilogy machine be expedited, as the patient was stable for discharge. But, the hospital was not comfortable in discharging the patient home without the machine due to the recent readmissions, and would not do so until the Trilogy machine was ordered and a delivery date set.

While the patient was still hospitalized, the Patient Navigator received a call from the daughter requesting assistance because the patient was demanding to leave the hospital AMA. The daughter shared that the patient had grown to trust the Navigator. After hearing out the patient's concerns, the Navigator expressed empathy and understanding about the situation, but also explained the added barriers leaving the hospital AMA could cause. The Navigator explained that waiting for the Trilogy machine was the best step, as being home without it is what led the patient to be in the hospital in the first place. Thankfully, the Patient Navigator was able to convince the patient to remain in the hospital until authorizations were complete and the physician felt she was ready to safely discharge home.

What was the outcome?

The patient was successfully discharged from the hospital, with a Trilogy machine being delivered the next day. The daughter expressed appreciation to the Patient Navigator for the hard work and guidance to assist when her mother did not want to stay in the hospital. The patient's daughter reports that her mother is doing well since discharge and has neither had any further complications related to respiratory issues nor any readmissions.

Creative Problem Solving for the Win

Who is the patient?

A 65-year-old female was discharged from a skilled nursing facility (SNF) after an emergent admission to heal an inflammatory infection of the hip. The patient's discharge orders included a bariatric commode, home health and follow up with her primary care provider (PCP).

What did we learn?

During the post-discharge Welcome Call, the patient disclosed feeling upset because the SNF ordered her a bariatric commode, but, once she was home, learned that it had been denied by insurance. The patient stated that she really needed the commode and didn't know what to do to get it approved. The patient also said that she was feeling overwhelmed about making all of her necessary appointments: home health services, PCP and specialists.

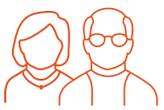
What did we do?

The naviHealth Patient Navigator placed several outreaches to look into about the denial of the commode and learned it was due to a lack of supporting documentation, which required an appeal process. The Patient Navigator informed the patient that she would need to initiate the appeal due to the denial and offered to assist her with the process. The patient declined, stating she didn't have the energy to deal. Knowing that the patient needed the commode, the Patient Navigator acted by looking into community-based resource options. The Patient Navigator was successful in finding a local commode closet that had the bariatric commode, and they would loan it to the patient for however long she needed it. In the meantime, the Patient Navigator scheduled the patient's home health services, PCP and specialists appointments.

What was the outcome?

The Patient Navigator's creative problem solving helped the patient get a bariatric commode at no cost and effort to the patient. The patient's home health services were set up, she attended all of her follow up appointments, and she no longer felt overwhelmed. The patient did not readmit during the 30-day recovery period and was extremely grateful and appreciative for the support she received.

2022 Across all clients



20,114

Lives touched (Engaged)

Patients across

34 states

9,641

SDoH Interventions

Coordinating Care to Support the Caregiver

Who is the patient?

An 82-year-old male discharged from a skilled nursing facility (SNF) after an emergent admission for a severe stroke. After a 14-day SNF stay, the patient was discharged with home health care (HHC) and orders to follow up with specialist providers.

What did we learn?

During the post-discharge Welcome Call, the patient gave permission to speak with his daughter since they were coordinating all of his care. The daughter stated that both her father and family were experiencing a huge adjustment since he was discharged to home, as her father was very independent prior to his stroke. She further shared that on the day of his stroke, he had been driving his tractor on the family farm; now, just weeks later, he was blind and in need of 24/7 care. The daughter reported needing to find a neurologist and an ophthalmologist, as well as figure out HHC because her father had to move into an assisted living facility (ALF) versus living at home. She stated that her father had already attended an appointment with the primary care physician (PCP) on staff, who plans to utilize the HHC available through the facility; however, she was not sure if this particular HHC was the best option for her father. Lastly, the daughter stated that she would be meeting with the ALF HHC nurse to determine the best plan of care and assess if they would meet her communication and quality expectations.

What did we do?

The naviHealth Patient Navigator immediately went to work to get the daughter a list of in-network neurologists and ophthalmologists near her the ALF, all of which were emailed to the daughter. During the first Wellness Check, the daughter asked for assistance in scheduling the specialists appointments and in finding out if her father was scheduled to receive therapy from the facility's HHC, since she had not yet heard anything. After calling four separate ophthalmologist practices, the Patient Navigator was able to finally find one that could address the patient's specific needs and had an open appointment within two weeks. The navigator was also successful in finding a neurologist appointment within three days and outreached to the daughter to inform her of these appointments and provided instructions per the practice staff regarding the patient information she needed to bring. Since one request from the staff was to bring medical records, the daughter asked for assistance in obtaining the records and having them sent to the doctors.

During this same call, the daughter also asked many questions about the facility PCP, including if he was an in-network provider. The Patient Navigator said she would find out and share the information with the daughter. When outreaching to the HHC the next day, the nurse confirmed that she had met with the daughter to discuss the patient's plan of care. The nurse stated that hospice was offered as an alternative; however, the daughter said she wanted to wait to get the opinions from both specialists prior to deciding. The HHC nurse said she would be in contact with the Patient Navigator should any changes to the plan of care occur. Lastly, the Patient Navigator confirmed with the practice that the patient has attended his scheduled PCP visit and had another upcoming appointment that same week.

What was the outcome?

This patient did not readmit to the hospital during the 30-day post-discharge recovery period. The Patient Navigator was able to get the patient scheduled with his neurologist just one week later and learned the family decided to move forward with HHC based on how well that appointment went. The Patient Navigator worked with the ALF to get the referral submitted for HHC and those services were to be started later that week. The patient also saw his new ophthalmologist and his eyes appeared physically healthy. He was referred for eye rehabilitation with the hopes of regaining some sight since the vision loss was due a connection issue between his brain and eyes from the stroke. The patient's daughter really appreciated having the Patient Navigator assist her with all the care coordination her father needed; expressing that the help allowed her more time to emotionally support her dad in adapting to his new normal at the ALF.

More Than a Follow-up Call

Who is the patient?

A 69-year-old female was discharged from a skilled nursing facility (SNF) after an emergent admission for a degenerative spinal condition that required back surgery. The patient also has a history of asthma, hypertension and other comorbidities. Prior to her admission to the SNF, the patient was diagnosed with COVID, resulting in a longer stay. After 21-days at the SNF, the patient discharged to home with home health care (HHC) and orders to follow-up with a primary care physician (PCP) and specialists.

What did we learn?

The Patient Navigator left several voicemails for the patient to conduct the scheduled post-discharge Welcome Call. After many unsuccessful attempts, a message was also left for the patient's daughter as a means to engage with the patient. When the Patient Navigator outreached the following day, the patient answered the call, sharing that her daughter had encouraged her to do so based on the voicemail we left about our services and the assistance we can provide. The patient disclosed that she had 97 voicemails stored on her phone and the call from naviHealth was lost in that mess. When the Patient Navigator inquired about the status of her HHC, she said they may have called and left voicemails as well; however, she has not yet talked to them. When the Patient Navigator offered to schedule the HHC service, the patient agreed.

After thoroughly reviewing the discharge orders and noting the need for PCP and specialists follow-up appointments, the patient stated they were already scheduled. The patient further confirmed that she had all her DME, which included a wheelchair, walker, shower chair, and a hospital bed. During the next telephonic Wellness Check, the patient disclosed being on a limited income and stated she was struggling to pay for medication, food and incontinence supplies. She also lacked transportation and wanted to find a reliable solution since she felt like she was imposing on her family for rides.

What did we do?

The Patient Navigator called the HHC provider who confirmed leaving several voicemails for the patient with no return calls to-date. After explaining the patient was overwhelmed with voicemails, the Patient Navigator initiated scheduling the appointment on the patient's behalf.

The Patient Navigator coordinated Meals on Wheels food delivery to address the patient's food insecurity. The Patient Navigator also provided the patient with a coupon for discounted medications and connected the patient with a community resource for free incontinence supplies. In addition, the Patient Navigator provided her with the training and education she needed to utilize Senior Alliance Transportation Services. This service eliminated the patient's need to coordinate with her family for transportation to appointments, hence giving her a greater sense of independence. This door-to-door service put her family's mind at ease knowing their mother could safely navigate to her medical appointments.

What was the outcome?

The patient was happy to report that she liked her HHC provider and was working on OT and PT services. The Patient Navigator confirmed that the patient attended her follow up specialists appointments and her neurosurgeon fitted her with a brace for her drop foot. The patient refilled a prescribed medication utilizing her coupon, which saved her $70. The patient's daughter scheduled a reoccurring pick-up time for her incontinence supplies so her mother would never be without this necessary item. During the Closing Call, the patient reported having another PCP appointment scheduled for which she coordinated her own transportation with Senior Alliance Services, thanks to the support from the Patient Navigator. The patient, who did not readmit during the 30-day post-discharge risk-period, expressed being impressed with and thankful for the naviHealth services.

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