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# Care Navigator



## An Integrated Solution for Post-Discharge Communication

Post-discharge communications play a critical role in a patient's healthcare journey, ensuring they continue to recover effectively after being discharged by their care team. For many hospitals, post-discharge engagement is limited to a nurse phone call, which is manual, difficult to staff, and worst of all, ineffective at reaching patients.

The consequence? Patients are slipping through the cracks. This is not only problematic for health outcomes but can also lead to increases in readmissions, lower HCAHPS scores and financial penalties. The reality is that U.S. hospitals experience an average 15 percent readmission rate[1], costing Medicare an estimated $26 billion annually.[2] Hospitals performing poorly in the Medicare Hospital Readmission Reduction Program ("HRRP") can be penalized up to 3% of overall Medicare revenue.

## Bridge the Gap Between Hospital and Follow-Up Care

Introducing Artera Care Navigator, a flexible solution designed to improve post-discharge workflows for nurses and care coordinators, enhance patient outcomes, reduce readmissions and streamline your follow-up communication.

## Versatile Applications

**Post-Discharge Follow-Up**
Engage patients to ensure compliance with care plans and check health status

**Collaborative Inbox**
Enable staff to view all messages across team to monitor patients and address inbound questions timely

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**Prep for Imaging, Labs & Procedures**
Deliver crucial reminders to patients ahead of high-stakes visits, like preparing for a procedure or imaging appointment

**Outcomes, Compliance, & Adherence**
Build patient communication journeys around chronic conditions and complex procedures

[1] Definitive Healthcare. (2024, May 10). Average Hospital readmission rate by State. https://www.definitivehc.com/resources/healthcare-insights/average-hospital-readmission-state
[2] Elfin, D. (2019, June 26). Ma patients' readmission rates higher than traditional Medicare, study finds. Healthcare Dive. https://www.healthcaredive.com/news/ma-patients-readmission-rates-higher-than-traditional-medicare-study-find/557694/

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# Empower Your Care Teams With Artera Care Navigator

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Care Navigator

**Post-Discharge Workflows**
Multi-step workflows that empower staff to better manage outreach by building multiple trigger points for content and conversations.

**Collaborative Inbox**
Shared inbox across staff to track and manage post-discharge communication efforts across all patients, improving response rates and staff efficiency.

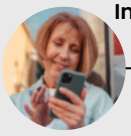
**Reporting Analytics**
Artera provides full post-discharge communication reporting from communication history to patient outcomes, creating a clear view of the success of your organization's Care Navigator program.

**Discover the Impact of Artera Care Navigator**

- Reduce readmissions and revisit rates
- Generate time savings for care managers
- Improve patient satisfaction and HCAHPS scores
- Improve health outcomes

## 30-Day Post-Discharge Sample Flow

1. **Strategically time your outreach to patients based on proven cadences and messaging**
2. **Tag relevant specialty teams for care team collaboration when triggered**
3. **Automatically engage with patients based on events and /or patient responses**



Initial Post-Discharge Outreach
Day 1 Post-Discharge Outreach
Day 3 Post-Discharge Outreach
Day 7 Post-Discharge Outreach
Day 14 Post-Discharge Outreach & Specialist Consult
No Show Follow-up
Day 21 Post-Discharge Outreach

## Proven Results

A study, authored by Houston Methodist and published in The British Medical Journal, highlights the effectiveness of post-discharge text messaging with Artera Care Navigator. The 5-month study, including 79,000 patients, explored the effectiveness of Artera's Care Navigator solution on key discharge-related outcomes. Read the full study here.

Communicate with patients post-discharge to create a "high touch" patient experience, reducing readmissions and boosting HCAHPS.

## Key Findings

Among Engaged Patients (patients who responded with 3 or more messages)

| 2-5 Higher | 10 staff | 20% | 27% | 29% |
|---|---|---|---|---|
| HCAHPS Scores | to support 7 hospitals | fewer visit rates | less likely to be readmitted | fewer readmissions |

**Ready to bridge the gap between hospital care and post-discharge follow-up care?**
See how Artera Care Navigator can help. Talk to our team about Artera Care Navigator or visit https://artera.io/care-navigator/.

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