NTT DATA Services

Improve Care Transition, Hospital Bed Utilization and Patient Experience

Discharge Management and Care Transition by NTT DATA

Reduce readmissions and improve care transition

More and more, hospitals are being held accountable for patient outcomes after discharge. Preventable readmissions or re-hospitalizations directly affect patient safety and outcomes, as well as hospital reimbursement and accreditation. And with manual processes and minimum resources, it can be difficult to assess and address patient needs while tracking patients after discharge.

NTT DATA Services provides end-to-end coordination of discharge management and care transition. Our services include:

- **Implementation assistance**: Building adapters for information exchange from hospital core systems to a discharge management and care transition platform. This provides a seamless experience for case managers, discharge clerks and physicians at your hospital, as well as post-acute care facilities.
- **Network creation and onboarding of facilities**: Supporting network creation and onboarding of physicians and post-acute care facilities in your area.
- **Facility identification and network maintenance**: Quickly identifying post-acute care facilities, skilled nursing facilities, home health facilities and physician practices — focusing on maintaining response times of less than 30 minutes.
- **Quality assessment**: Administering patient surveys and reporting in compliance with regulatory requirements.
- **Support**: Providing ticket management and support for technical and clinical issues.
- **Follow-up**: Maintaining post-discharge communication and arranging home visits for your hospital's healthcare team.

Key benefits:

- Accelerated placement in post-acute care facilities
- Significant reduction in time to discharge and improved utilization of hospital beds
- Enhanced customer satisfaction
- Reduced stay, readmissions and operating costs
- Enhanced revenue associated with increased or virtual capacity

This cloud-based platform utilizes a network of more than 100,000 physicians and post-acute care facilities. It includes the following components:

- **Transition**: Automates the discharge process to place patients quickly in the post-acute care facility best able to meet their clinical and non-clinical needs. Our always-on call center works with post-acute care providers to shorten response times, making it easy to place a patient in the ideal care setting — whether across the street or across the country. You have on-demand access to our all-inclusive, no-cost provider network. Our network of facilities has a provider participation rate of 85-90%. On average, the transition delivers a referral-to-response time in 30 minutes or less.
- **Sync**: Unites all members of a patient's care team, including primary care physicians, care managers, home health nurses, pharmacies and family members. It is the electronic command center to communicate the care plan, monitor the patient's path after discharge and create updates as their needs change. Sync uses robust technology backed by customer support to engage all members of a patient's care plan to reduce the risk of readmission. It monitors and automatically sends alerts to appropriate care team members when interventions or escalation of care is needed.

- **Connect**: Allows patients and families to easily see the care plan and each step they need to take after leaving your hospital — medications, follow-up appointments and physical therapy schedules, all of which can be retrieved from any online source using a secure, personal login. Vital information can be entered and reported back to the care team, such as daily blood pressure readings or changes in weight. Patients have access to condition and provider-specific educational materials to encourage patient compliance, family engagement and caregiver support.
- **Insight**: Enables you to monitor trends and outcomes, discover opportunities for improvement and determine ways to actively manage your patients and healthcare network. Insight analyzes post-acute care activities to see which facilities are readmitting patients more often and under what conditions, so care plans can be adjusted for future patients. By employing these best practices for care coordination, you can reduce the length of stay and prevent readmissions, while also promoting better outcomes and improving the patient experience.

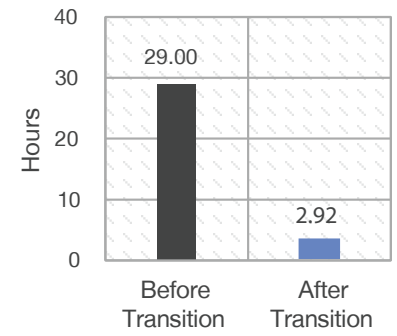
A cloud-based discharge management platform

Transition	Sync	Connect	Insight
• Ensure care transition efficiency as patients are discharged • Help reduce readmission rates • Provide access to a large networks of physicians	• Provide care path tracking, risk stratification and team communication • Manage referral process	• Encourage patient/family engagement and education • Use portal-based, multi-device access	Utilize reporting, data analytics and predictive modeling

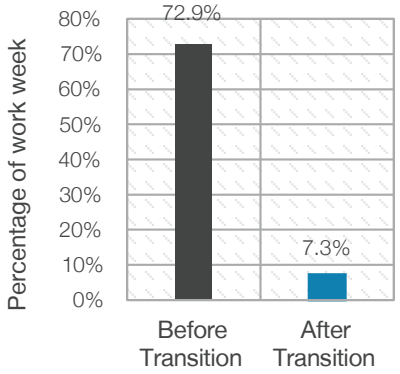
Benefits of a comprehensive discharge management solution

	Clinical benefits:	Financial benefits:
1	Accelerated placement in post-acute care: Our technology and provider engagement model accelerates referral requests and response times, reducing time to post-acute care placement and time to discharge.	Reduce operating costs associated with avoidable days: Unnecessary labor, supply and overhead expense is decreased, reducing the days of care beyond medical necessity.
2	Coordinated post-acute care: Our technology enables accurate, accelerated communication between you and post-acute care providers, ensuring patients are discharged to the facility that best fits their needs.	Decrease in length of stay: Our clients receive referral responses within an average of 30 minutes. Timely, accurate placements and strong engagement with the post-acute care facilities reduce the length of hospital stays.
3	Reduced time to discharge: On-demand access to industry-leading network of more than 100,000 post-acute care providers speeds patient placement and reduces time spent on manual processes and unnecessary rework.	Decline in readmissions: Reporting capabilities within the discharge management platform allow hospitals to track patient placement and analyze trends and outcomes to reduce readmissions from post-acute care providers.
4	Improved throughput: Timely transfer of patients to post-acute care improves patient flow and placement delays.	Boost in revenue associated with increased or virtual capacity: Our solutions improve patient throughput and create virtual capacity, which frees up beds for additional patient admissions.
5	Increased patient satisfaction: Our solution provides resources to help patients and their families locate providers that best meet their needs in their desired locations.	Increase quality of experience and support processes: We conduct patient satisfaction surveys to get the insights required to improve the overall experience and our end-to-end support model.

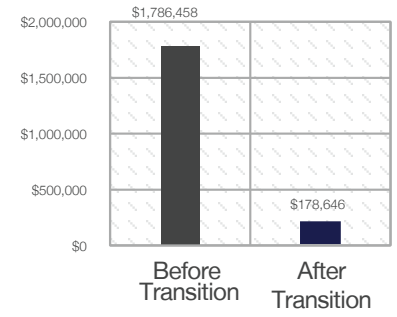
Average hours of clerical work completed by planners each week



Percentage of workload spent performing clerical tasks



Money spent annually on clerical tasks



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