Scalable Discharge Clinic

Discharge Clinic Builds

BridgeCare Specialists

Company story

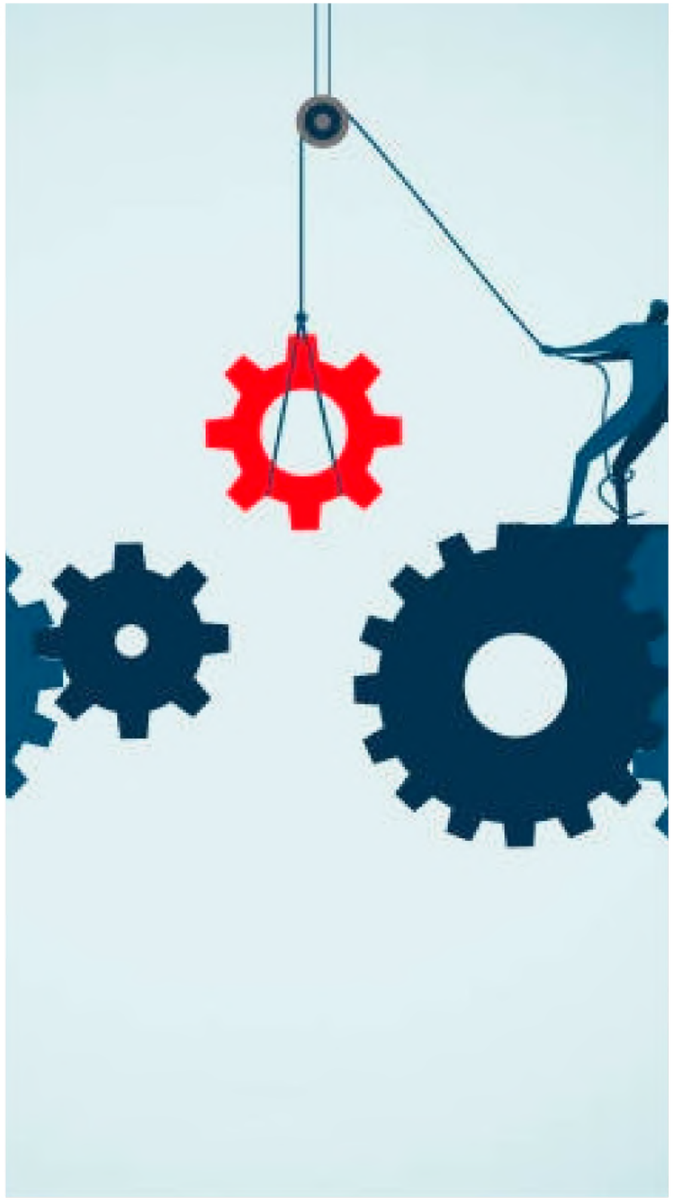
BridgeCare started in 2020 as a pilot company, using a decade of expertise in outcome-based program building. The mission of the company was twofold.

Mission:

1) reduce readmissions

2) achieve triple AIM in high-risk patients

Finding success in all measurable metrics available to the team, BridgeCare is offering its proprietary service to ACO REACHs.



Founder's story

Dr. Hershey, the founder of BridgeCare, is a visionary in the medical marketplace. Despite a humble upbringing in shelters, she leveraged her limited health literacy upon entering medical school to gain a unique perspective on the healthcare system. Over the course of ten years post-residency, she explored different aspects of the system, ascending the management hierarchy in hospitals, clinics, PACE programs, hospices, and rehabs. Drawing from her personal experiences, she adeptly addressed problems by forging connections and creating links between various healthcare entities.

BridgeCare bridges gaps in care to drive outcomes.

The problem

GAP

No provider support

Acute care
physician management

Outpatient Care
physician managment

One major problem our industry is facing

Problem

Once patients are discharged from an acute care facility, there exists a transitional period wherein they lack support from the facility they departed from or their healthcare providers in the outpatient setting.

Challenges

This situation poses a challenge for patients as they experience a lack of support and continuity of care during the transitional phase following their discharge from an acute care setting.

Impact

The high-risk Medicare population faces a readmission rate ranging from 15% to 35%. This significantly diminishes the quality of life for patients, negatively impacts overall outcomes, and contributes to increased healthcare costs.

Preventable readmissions cost the US healthcare system

$17 BILLION PER YEAR

without even including unnecessary visits to urgent care settings or emergency departments within the first 30 days following discharge.

As many as

1 in 3

Medicare patients are readmitted to a hospital within 30 days

Who is affected by this problem?

The Patient

Patients experience decreased quality of life, increased costs, decreased satisfaction, and poorer outcomes.

Care Centers

The system experiences overflow, staff fatigue, divergence, and shortages of resources.

The Payer

Cost of care rises overall. Diverted spending to avoidable situations reduce funds available for general beneficiaries

Population health

Insurance nurse calls

Analytics

Hasn’t this problem been addressed already?

CCM

Case managers

Automated outreach

RPM

Discharge services

Previous attempts to solve the problem

Current market offerings have made strides in reducing readmissions. However, their effectiveness is limited. Without direct provider participation, all the services could only achieve a certain level of success. To truly address the issue of readmissions comprehensively, the active engagement and guidance of providers trained in hospital prevention programs and outpatient services are vital.

Hospital owned discharge clinics

There are limited existing services for post-discharge care, and those that do exist face financial challenges arising from high rates of patient no-shows and the cost of clinician time. Moreover, returning to a medical environment is often one of the least desirable things for patients after being discharged from an acute care setting. Many patients are still in a weakened or ill state, making travel burdensome or impractical. Additionally, the expenses associated with operating a brick-and-mortar discharge clinic can present a barrier to providing effective care that leads to significant outcomes.

Case Managers and Nurses

While case managers and nurses offered by hospitals, insurance providers, outpatient clinics, and Transitional Care companies offer valuable services, they lack the authority to make changes to medication regimens, issue orders, or provide clinical treatment for health issues in a home setting.

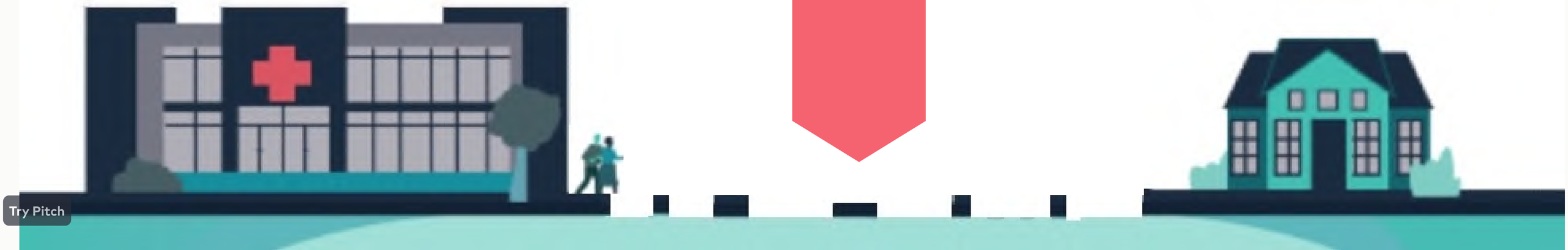
Market Landscape

FRAGMENTED

Acute care
physician management

Current supports

Outpatient Care
physician managment



Why now?

The timing is ideal for the emergence of unique solutions in the value-based marketplace. These solutions must address patient needs when it's needed, enhance care delivery, and align with the evolving healthcare reimbursement landscape.

Advancements in technology and patient-focused care have allowed the market to address needs creatively while keeping costs in perspective.

The solution

BridgeCare Specialists

Hospital Prevention Program (HPP)

Efficient | Evidence-Based | Outcome-Driven

Hospital Prevention Program (HPP)

Goal: Reduce re-admissions & achieve triple AIM

Our mission is to go above and beyond typical doctor's visits by providing patients with treatment alternatives. Our team proactively addresses issues, meeting the needs that cause re-admissions, not just the diagnosis needs, while collaborating with staff to create effective solutions. Furthermore, we are continuously looking into new community options and service possibilities that can enhance patient care. Our unwavering dedication to providing comprehensive and effective healthcare services to patients is our ultimate goal.

Hospital Prevention

requires a unique un-learning of the system, while embracing evidence-based alternative options.

This is not taught in current medical curriculum.

Provider driven, patient focused unique solutions

The Hospital Prevention Program (HPP) is established through specialized home health and transitional service providers.

HHP Home Health

Home health groups with record of delivering high star rated services are trained specifically in HPP and partnering with HHP Providers.

HPP Community Provider

These providers are vailable for appts virtually, in-person, and as needed. Visits are available same day.

Centralized managment and oversight

Driving Q/I, metrics, and cost analysis, a medical director trained in HPP is available for advanced consultation.

Provider driven, patient focused unique solutions

Hospital Prevention Program (HPP)

Different way to think

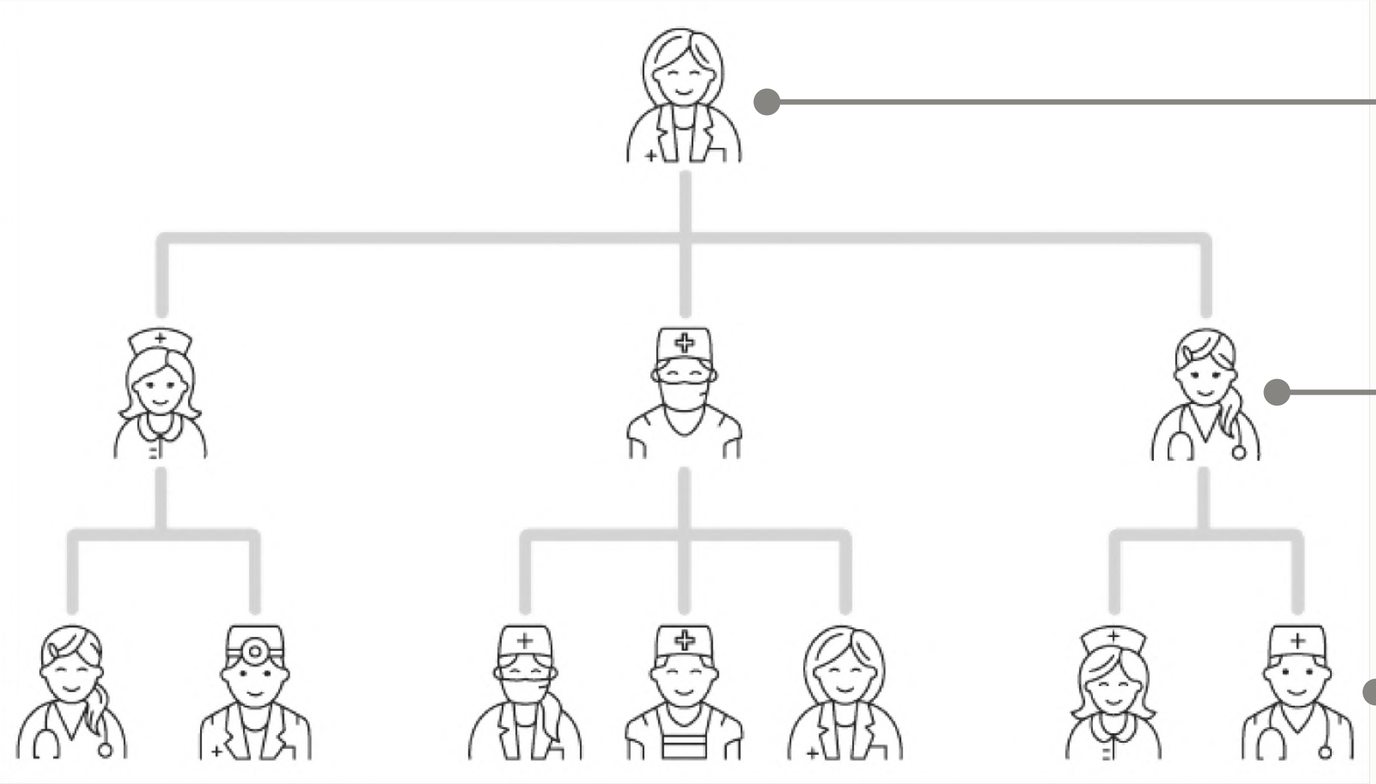
Different options to consider

Different partnerships fostered

Different way to teach patients and family

Different focus of care

HHP General Layout



Medical directors (MD, DO) - $$$

available for consultation for complicated patients, driving quality metrics, and clinical education specific to HPP

Community-based providers (NP, PA)- $$,

available for virtual or in-person appointments for 60 days post-acute discharge

High-quality home health caregivers (RN, LPN)- $

regularly sees patients and reports any non/clinical concerns that may increase hospitalization risk back to Providers

HPP Services

Helping reduce re-admission (A), acute LOS (L), and avoidable rehab stays (R)

A	Managing medications and refilling prescriptions	Signing orders and ordering medical equipment (if needed)	*A, L, R*
A, L, R	Managing home IV antibiotics	Health coaching and education for patients and families	*A*
A	Care coordination with specialists	Aiding wound care	*A, L, R*
A, R	Reviewing labs, tests, and treatment plans	Aiding home care and other post-acute providers	*A, L, R*

Example

"I'm with the patient with CHF. I'm worried they are getting fluid-overloaded compared to last week. It hasn't started to affect their breathing yet, but they've gained weight and their legs are very swollen."

HPP Trained Home Care Nurse

HPP Provider

"Thanks for jumping on a video call. I agree, let's try to prevent the excess fluid from going to their lungs. I'll send a 5-day diuretic burst script to the pharmacy. Can you show them how to limit their water as per the HPP program education? Also, I'd like to approve another home visit for tomorrow to check on the patient again."

Model Options

HHP Community Based Provider	HHP Centralized Virtual Provider	Train existing PCP on HHP
Knows services and community culture best. Can connect with patients in person and virtually. In-person services allow for wound care services in the home.	Geographic pods created in a centralized location with patients distributed according to needs	Allows for a more streamlined continuum of care but is dependent on the availability of staff/providers. Home visits possibility is dependent on structuring.
best for high-population areas, high risk/cost areas	best for pilot start and low-population areas	best for patients resistant to seeing new providers

HPP trained Community Home Cares

HHP Providers Services

Available • Cost effective • Flexible • Reliable • Real-time • Scalable

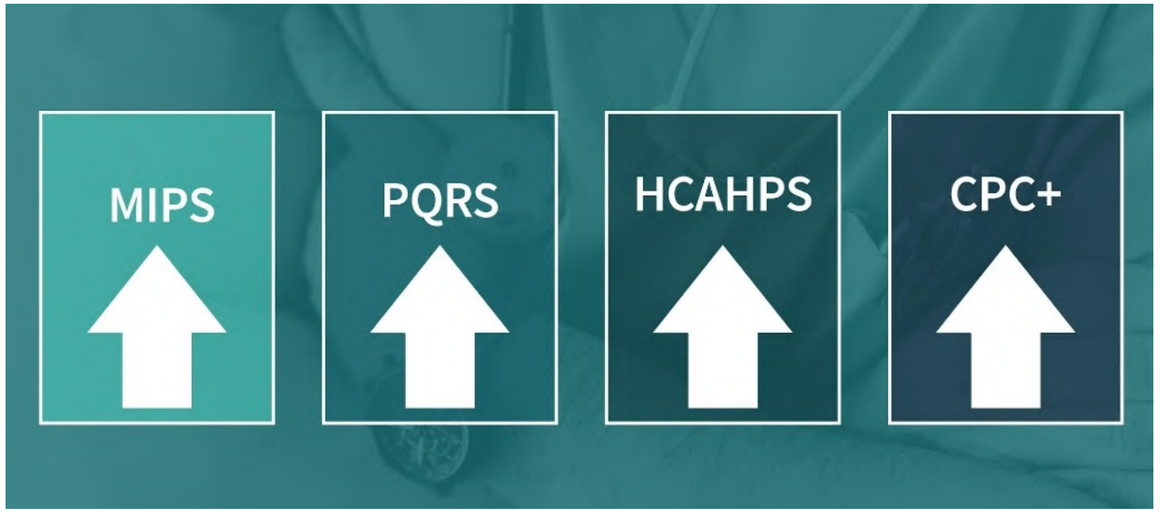
Complete

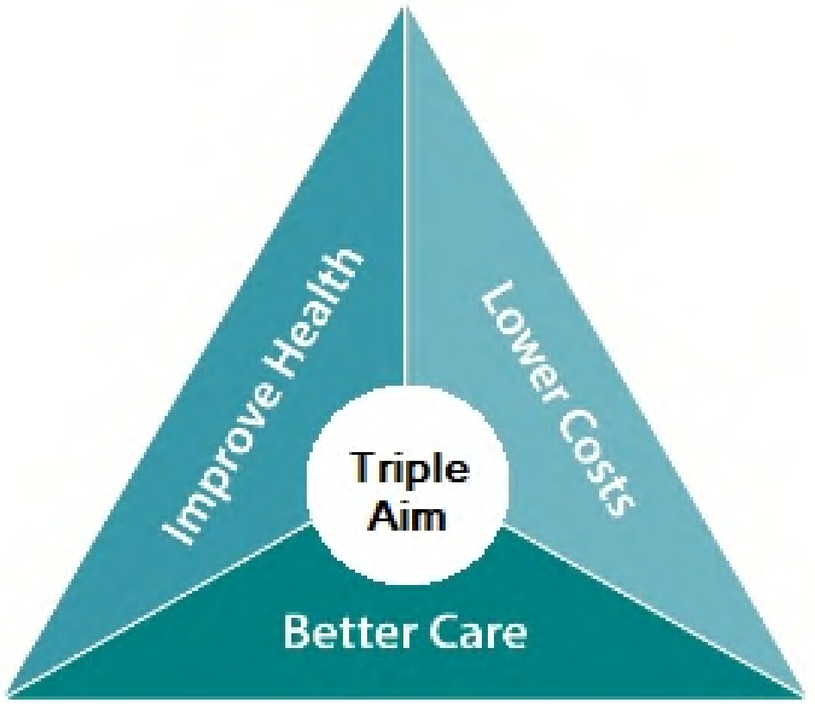
Acute care
physician management

Hospital Prevention Program

Outpatient Care
physician managment

Value Proposition





Improved Quality, Higher Satisfaction, Significant Savings

Next step

BridgeCare can either provide the services of a Discharge Clinic under BridgeCare, serve as an extenstion of your team, or help you build your own program.

BridgeCare is available to train existing providers or provide trained providers to cover the continuum of care gap starting from day 0 to day 60 from discharge. We remain accountable for results under each option.

* Timeing of results are dependent on a number of factors including provider/staff availability, level of experience in Hospital at Home programs, and ease of adoption