HOSPITAL TO HOME BRIDGE PROGRAM

Statistics

- Medicare national 30 day rehospitalization rate at **20%**
- Medicare national 90 day rehospitalization rate at **34%**
- Patient discharged from hospital without services had a **62%** readmission rate
- Average patient has **5** additional medications as part of their regimen In the hospital
- Chronic illnesses account for **84%** of all healthcare spending
- Avoidable readmissions make up **14%** of hospitalization
- More than **$17 Billion** spent annually on avoidable hospital readmissions

Services

- Bridging hospital core measures and disease process and management In the home setting
- Implement clinical pathways in a home health care approach in order to provide standardized care plans for achieving desired outcomes and reducing re-hospitalization
- Core measures: CHF, COPD, Pneumonia, Myocardial Infarction, Post Surgical Complication, and OM
- Collaborative relationships with other health care providers in the community in order to customize patient's needs (IV Infusion, DME, Physician House Call) at home.

Objective

- Improve patient outcomes and quality of life
- Implementation of an evidence·based condition-specific, and timely care program to empower patient and their caregivers on illness management
- Assist hospital and other healthcare providers in coordination of patient's needs for discharging to home setting. Bui lding better interfaces within the community
- Bridging hospital based core measures to home health based core measures
- Enhancing patients's quality of life and reducing negative outcomes such as undue hospital readmission, medication adverse reaction, falls, etc.

Solution

Provide seamless continuum of care and avoid unnecessary rehospitalization through the use of Hospital to Home Bridge Program

899 Presidential Dr. | Suite 117 I Richardson, TX 75081 | 214.363.2559 | www.allyhh.com