dispatchhealth®

Bringing the power of the hospital to the comfort of home

High-acuity in-home care continuum

ED substitution
Acute Care

Increase access & reduce ED utilization

ED-to-home
ED Bridge Care

Reduce observations & improve ED bounce backs

Hospital-to-home
Inpatient Bridge Care

Reduce readmissions & improve LOS/throughput

Hospital substitution
Advanced Care

"Virtual bed" Revenue & inpatient capacity creation

SNF substitution
Extended Care

Improve LOS/throughput for high risk DRGs

Providing parallel value drivers for health systems

Value based care

Increased access points

Diversion cost savings

- ED diversions
- 911 transport diversions
- Observation diversions
- Hospitalization diversions
- Readmission avoidance

Social determinants of health

Right sizing care settings

Improved patient & provider access & experience

Health system

- Patient & provider access, experience & differentiation
- ED and IP throughput & capacity creation
- ED & IP contribution margin enhancement
- Staff optimization
- Capital redirection/ investment alternative

Partnering with leading systems

The Ohio State University Wexner Medical Center

MultiCare

BON SECOURS MERCY HEALTH

AdventHealth

UCI Health

Texas Health Resources®

RUSH UNIVERSITY MEDICAL CENTER

Marshfield Clinic Health System

Billings Clinic

LEE HEALTH

INOVA

EMORY HEALTHCARE

And others...

dispatchhealth®

Driving value for our partners

Working with DispatchHealth puts the power of a complete system of in-home care at your fingertips, ready to deploy where and when you want it. Here's what we have helped our partners accomplish so far.

Medical cost savings

An estimated **$1,625** in medical cost savings for every visit that avoided an unnecessary trip to the emergency room.[1]

Medical cost savings ranges from **$5,000** to **$7,000** for every patient admitted with hospital level care in the home[2]

Since the company's inception in 2013, we have driven nearly **$1.5 billion** in total medical cost savings[3]

Reduced readmissions

41%

reduction in 30-day readmissions for patients that receive transitional care services[5]

Capacity creation

Versatile decompression and throughput option for case management teams, emergency departments, and inpatient units

Complexity of care

40%

of patients are greater than 65 years of age[8]

52%

of patients have 2 or more complex conditions, for which services are coordinated post-visit[9]

Medication reconciliation performed as on average patients have 10 existing medications each[9]

Patient satisfaction

97

average net promoter score[4]

Based on **1 million** patients treated in their home

Insight into home

Data collection and potential intervention occurs on 10 different Social Determinants of Health (SDOH) with at least one SDOH captured in roughly **40%** of patients[9]

Coordinated care

Communication and coordination with the whole care ecosystem as nearly **80%** of clinical notes transfer to an established PCP post-visit[6]

Sources:

1. DispatchHealth Analytics Medical Cost Savings – 2022, All Markets; Acute Care
2. DispatchHealth Analytics Medical Cost Savings – 2022, All Markets; Advanced Care
3. DispatchHealth Analytics Medical Cost Savings – through April 2023, All Markets; Acute Care and Advanced Care
4. Market Scorecard – 2021, All Markets, All Services
5. Health System Partner Bridge Care Case Study, March 2021
6. DispatchHealth Partner Scorecard – 2021, All Markets, All Services
7. Moving Health Home, August 2021; Methodology: Online interviews among a sample of 2200 adults. Data was weighted to approximate a target sample of adults based on gender, educational attainment, age, race, region. Results of the survey have a margin of error of +/- 2%.
8. Patient Journey: Standard Metrics ACCESS; All Markets, All Services, 2018-2021
9. Social Determinants and Medical History Dashboard – 2021, All Markets, All Services

To learn more visit DispatchHealth.com/Partners or scan the code to contact us.