SurgCare Network

We work to keep high risk patients from being readmitted to the hospital.

Company Overview:

We provide high quality follow-up care after surgery to help reduce hospital readmissions during the critical first 30 days after they have been discharged from the hospital. Our service includes home visits and telephone calls with a stable, consistent team so that we earn the patient's trust. The objective is to build on that trust to encourage frank, honest communication with the patient. If they are more truthful with us about what happening and their perception of their condition, we can help them stay out of the hospital by addressing a potential problem before it becomes a serious issue. Not every surgery and every patient have the same needs. We tailor our care to meet the needs of each physician and each patient.

Problem:

According to a study published in the New England Journal of Medicine analyzing close to 12 million Medicaid beneficiaries, nearly 20% of them who had been discharged from a hospital were re-hospitalized within 30 days. These numbers have become alarmingly high and data suggest that at least three-quarters of these cases are preventable.

Our Company's Study, Analysis and Test:

- Our 3 month study and analysis of why patients where readmitted conducted in Roseville, CA with an Orthopedic Clinic
- Test-run of 40 patients in July and August 2015.

Case Studies:

- A female was released on a Friday. Monday her left arm went numb, she telephoned her cardiologist and was connected to "on call cardiologist," who told her to go to the ER. We knew that they could preform the same test at the Urgent Care Center, so we took her there. We found out it was a medication problem, it was solved and she went home. No readmission.
- A 90 year old male was released from the hospital and contracted a urinary tract infection. He called the doctor's office about 4:00 pm and an appointment was scheduled for 2 days later. By 2:00 am he was in so much pain he called an ambulance and was taken to the hospital. If we were following him, we would have either texted or contacted his doctor or a contract staff doctor. We could have either had a face-to-face video appointment or they felt comfortable, they could have telephoned in a script. Hospital readmission would have been avoided.
- A female's daughter was her intended caregiver. The daughter had the best intentions but couldn't handle the responsibilities of her family and the care of her mother. They telephoned a skilled facility and they were told that she would need to be readmitted to the hospital for 3 days before she could be admitted into a skilled facility. We arrived and found out what was going on and immediately called the physician who was able to write the orders to get "mom" into the skilled nursing facility. Hospitalization was avoided.

How we help reduce readmission rates:

- We conduct daily home visits for the first 7 days and then we go to a combination of home visits and telephone calls.
- We provide medication review with Pharmacists and Physicians
- We work with Home Health Services
- We work with Caregiver(s)
- We provide HIPAA compliant video appointments
- We take patients to appointments when needed
- We take patients to Urgent Care when needed
- We are proactive in helping find a timely solution to problems that could otherwise result in readmission
- We listen to and build trust with the patients

How we operate:

- Day 1 Our nurse will attend the discharge to meet the patient and the caregiver(s).
- Day 2 Home visit where all the medication is documented and sent to the doctor and pharmacist for confirmation. If a problem is found, either the doctor or pharmacist will work with the patient to work it out. We have a process (patent pending) that the patient can use to manage their medication with times and doses. We go over their schedule of appointments and, if they have any questions or concerns, we notify the doctor.
- Days 3 - 7 Home visits
- Days 8 – 30 Daily calls or home visits if needed

- Our “on the ground” staff will develop a relationship with the patient and a list of specific questions for checking on a particular patient’s condition. Our questions will be tailored for the physician and the patient. If there are any indicators that the patient’s condition is not taking the expected course. Our staff member will contact our Case Manager/Nurse, who will then take over helping the patient determine the care that is needed by coordinating with the physician.

- We provide 30/45/60/90 day care plans.

Medicaid/State Savings:

Patients	SN Cost	Total Cost	Cost per Readmission	20% RR	Medicaid Cost	8% RR	Medicaid Cost	Savings	5% RR	Medicaid Cost	Savings
50	$ 1,200	$ 60,000	$ 9,500	10	$ 95,000	4	$ 38,000	$ (3,000)	3	$ 23,750	$ 11,250
100	$ 1,200	$ 120,000	$ 9,500	20	$ 190,000	8	$ 76,000	$ (6,000)	5	$ 47,500	$ 22,500
1,000	$ 1,100	$ 1,100,000	$ 9,500	200	$ 1,900,000	80	$ 760,000	$ 40,000	50	$ 475,000	$ 325,000
10,000	$ 1,000	$ 10,000,000	$ 9,500	2,000	$ 19,000,000	800	$ 7,600,000	$ 1,400,000	500	$ 4,750,000	$ 4,250,000
50,000	$ 1,000	$ 50,000,000	$ 9,500	10,000	$ 95,000,000	4,000	$ 38,000,000	$ 7,000,000	2,500	$ 23,750,000	$ 21,250,000
100,000	$ 950	$ 95,000,000	$ 9,500	20,000	$ 190,000,000	8,000	$ 76,000,000	$ 19,000,000	5,000	$ 47,500,000	$ 47,500,000

*Prices can be per patients or per service.

Additional Benefits:

These numbers do not include the savings from the education that will also help Medicaid Patients avoid future visits to the ER.