Deliver tried-and-true cardiac care at scale.

Empowering skilled nursing facilities everywhere.

providerloop

Scaling quality, delivering care, supporting communities.

SERVICES OF ProviderLoop

Basic

- Provide remote Ai assisted management of cardiac patients
- Predictive analytics to identify patients at risk for readmits
- Automated order sets and patient reminders for critical functions
- Compliance module to ensure that patients receive guideline therapies

Premium

- Training for providers
- Advanced protocol implementation for IV diuretics, Inotropes and LVADS
- Video visits / RPM /CCM
- Dedicated Board certified Cardiologist
- Weekly management call to review patients with Board certified Cardiologist

ProviderLoop Results

CARDIAC Failure

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Nursing Home Readmissions Reduced Using a Novel Heart Failure Protocol

Noah Moss, Rekha Bhandari, Jeffrey Bander

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DOI: http://dx.doi.org/10.1016/j.cardfail.2015.06.191

Abstract | Full Text

Congestive Heart Failure (CHF) is among the leading cause for hospital readmissions. Discharge to Skilled Nurse Facility (SNF) occurs in approximately 1 in 5 Medicare beneficiaries after hospitalizations for CHF. Among these patients 23.5% are readmitted to acute hospitals within 30 days. CHF readmissions worsen patient outcomes and are very costly. Increasing onsite physician involvement is often not realistic given existing financial constraints on these institutions.

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Hospital Readmission reduced

4x

to 8%

30 day CHF readmit

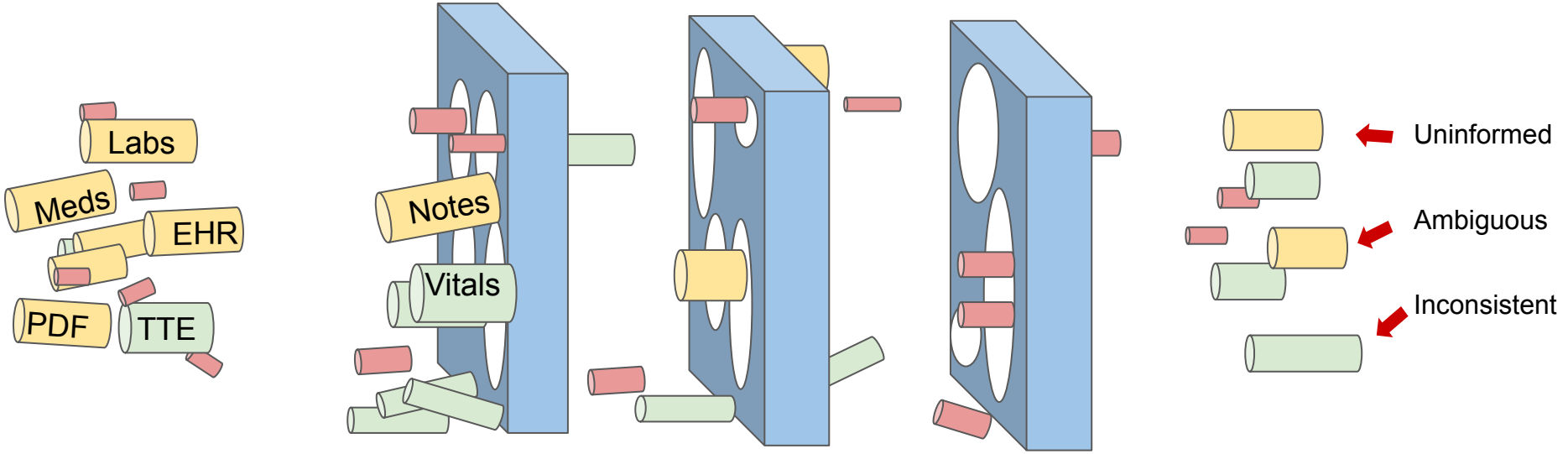
15% → 4.3%

after 6 months

* Pilot study after starting program

Key Challenges to Scaling Quality Cardiac Care

Data Overload + Missing Expert Support → **Poor Care Plans**



Swiss Cheese Model

Aligned Solution to AHA Guidelines

AHA Guidelines

- Standardization of Care
- Enhanced Education & Training
- Comprehensive Care Coordination
- Performance Measurement & Quality Improvement
- Patient-Centered Focus

Value Added

- ➔ Ensure evidence-based care to reduce $70B costs and improve outcomes for 8.7M HF patients by 2030.
- ➔ Equip SNF staff with proven strategies to reduce HF readmissions and Medicare rehospitalizations.
- ➔ Streamline transitions for 1 in 5 HF patients discharged to SNFs with diet, exercise, and GDMT.
- ➔ Optimize care to meet ACA benchmarks, reduce HF hospitalization costs, and improve patient satisfaction.
- ➔ Tailor care with diet, exercise, and follow-ups, aligning SNFs with AHA standards for holistic cardiac care.

Behind the Scenes

- Aigentic AI system Monitering 500+ CHF pts across 10 NH site
- Validated Expert Cardio Clinical Decision Support
- Care plan generation
- Real time clinical intervention tool