

Readmissions. Solved at Scale.



CareFlow Pulse

The Hospital Readmissions Reduction Program (HRRP) imposes a significant financial burden.

\$528 Million

The total value of HRRP penalties cost U.S. hospitals in a single year (2017).

79% of all acute care hospitals in the U.S. were penalized.

Source: The Hospital Readmissions Reduction Program – Learning from Failure of a Healthcare Policy - PMC

Nearly 1 in 5 Medicare Patients Return to the Hospital Within 30 Days



~20% of Medicare beneficiaries are readmitted within 30 days of discharge.



GAPS IN CARE: A readmission indicates potential gaps in quality of care and patient education.



30 DAYS: The post-discharge period is critical and highly vulnerable for patients.



Up to 27% of these readmissions are considered potentially preventable.

The Transition from Hospital to Home is Riddled with Gaps



Information Lost in Transit:
Only 12% to 34% of discharge summaries reach primary care providers by the time of the first follow-up appointment.

Follow-Up is Dangerously Inconsistent:
Only half of Medicare beneficiaries who were readmitted within 30 days had a follow-up visit with a clinician.

Medication Errors are Common:
Approximately 20% of patients experience adverse events after discharge, with medication-related issues being the most common.

The Acknowledged Gold Standard: The AHRQ Re-Engineered Discharge (RED) Toolkit.



- Developed by Boston University Medical Center and promoted by the AHRQ to improve discharge processes and reduce readmissions.
- A comprehensive set of 12 mutually reinforcing actions to ensure a smooth and effective transition.
- **Proven Impact***: Research showed the RED was effective at reducing readmissions and post-hospital emergency department (ED) visits.

“The RED has shown significant effects in a randomized controlled trial.”
Inter Regular

At the Heart of the RED Toolkit: The Post-Discharge Follow-up Call.



"The postdischarge followup phone call, the 12th component of the RED, is an essential part of supporting the patient from the time of discharge until his or her first appointment for followup care."

- Review the patient's Health Status.
- Check understanding of Medicines.
- Confirm upcoming Appointments.
- Address any problems and reinforce the plan for what to do if an issue arises.

The Manual Process is Overwhelmed, Inefficient, and Reactive.



Today's system forces our best clinical experts to perform routine, low-value tasks instead of focusing where they are needed most.

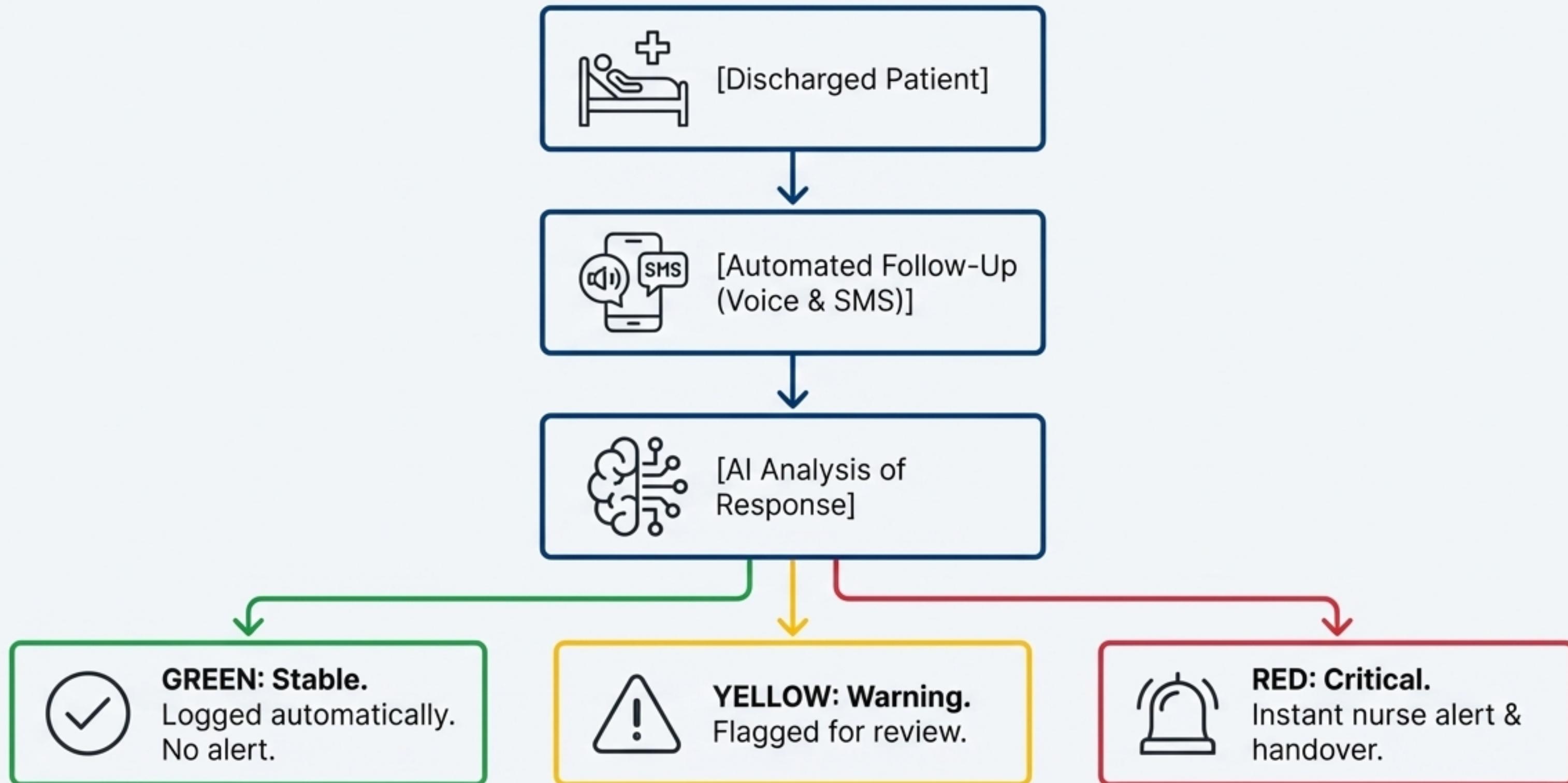
Introducing CareFlow Pulse

Your Intelligent Assistant for Proactive Post-Hospitalization Care.

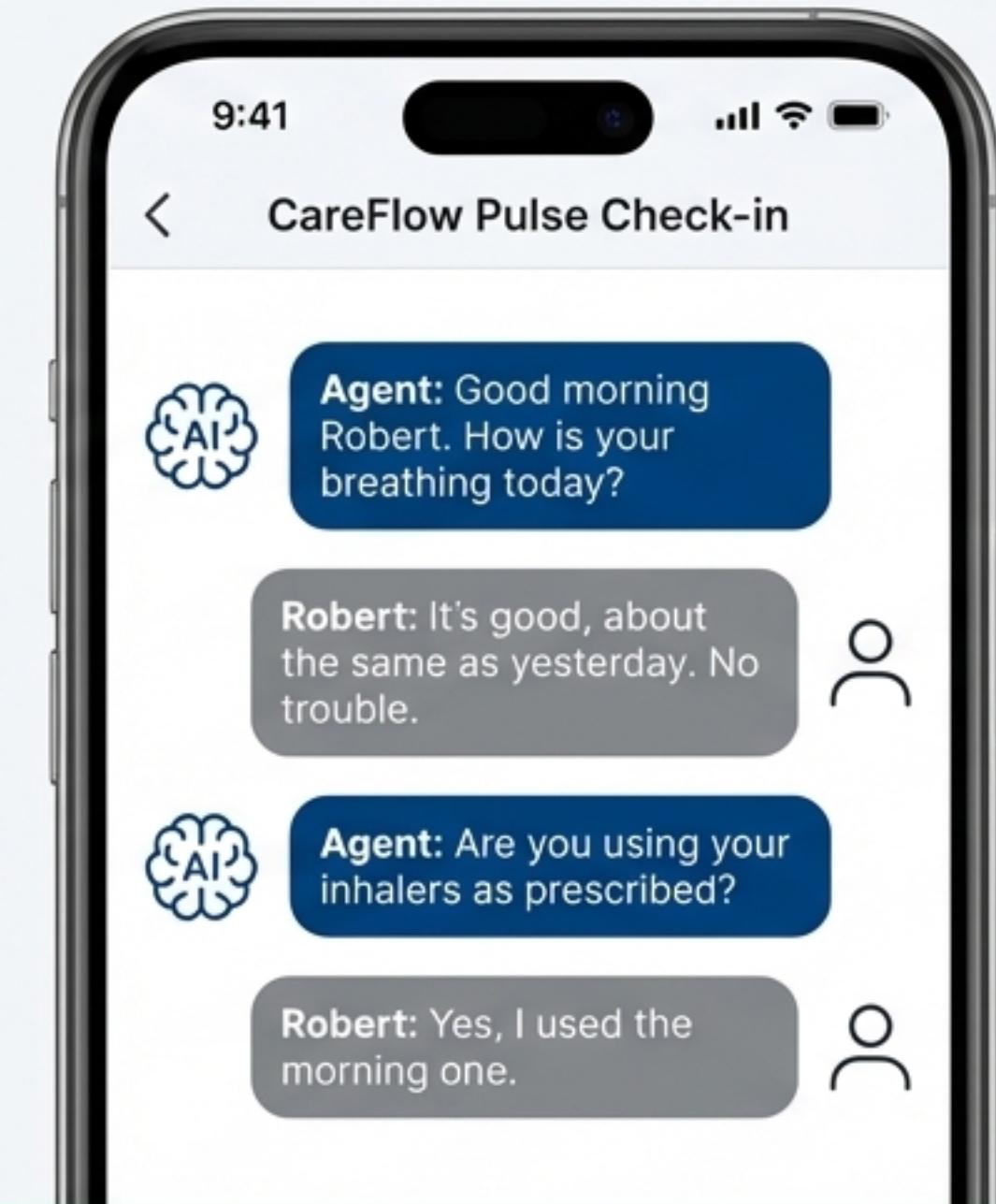
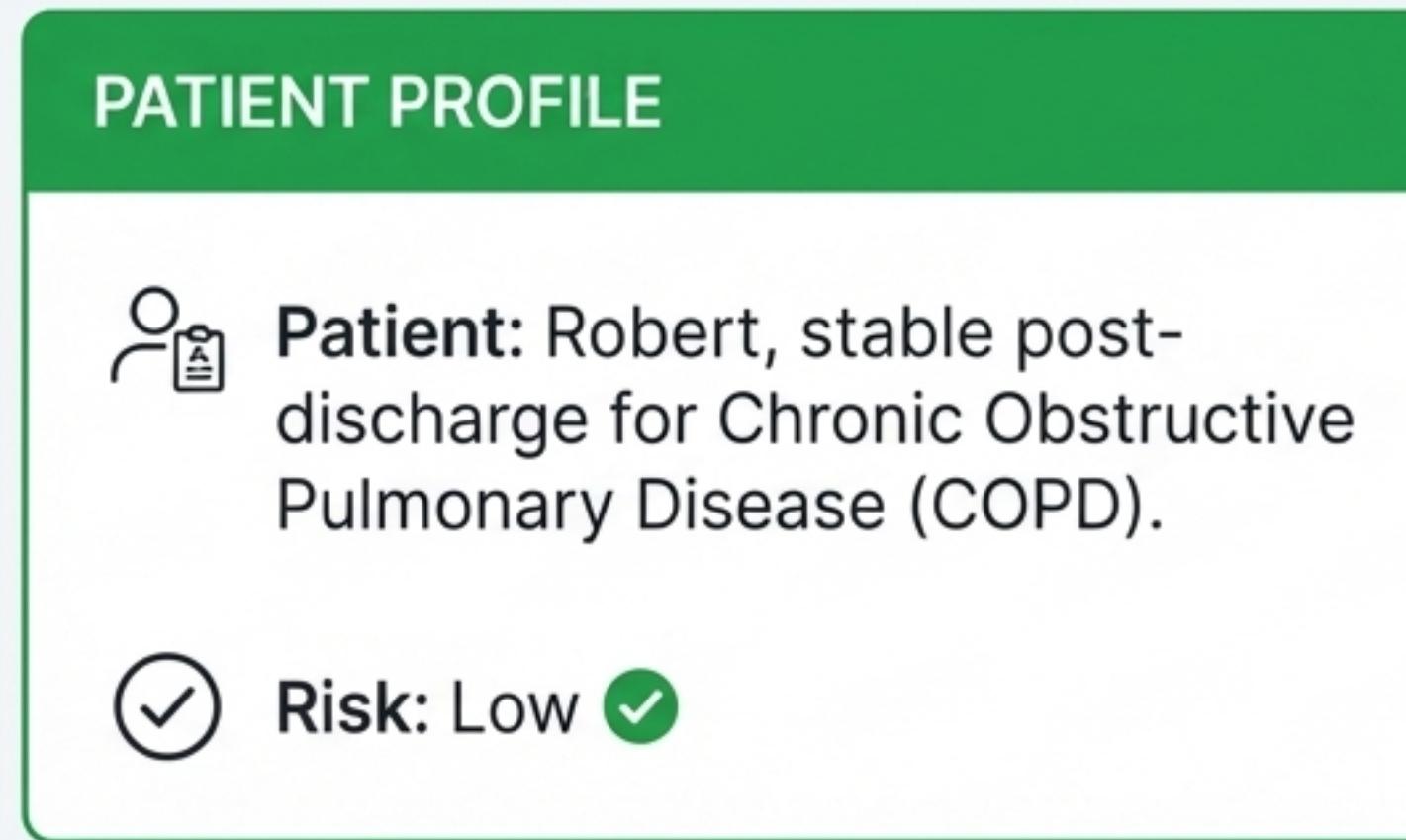


Our Mission: To **break the cycle of hospital readmissions** by automating routine patient follow-ups and **intelligently triaging alerts**, ensuring that human expertise is applied precisely where it is needed most.

Automating the Routine, Escalating the Critical.

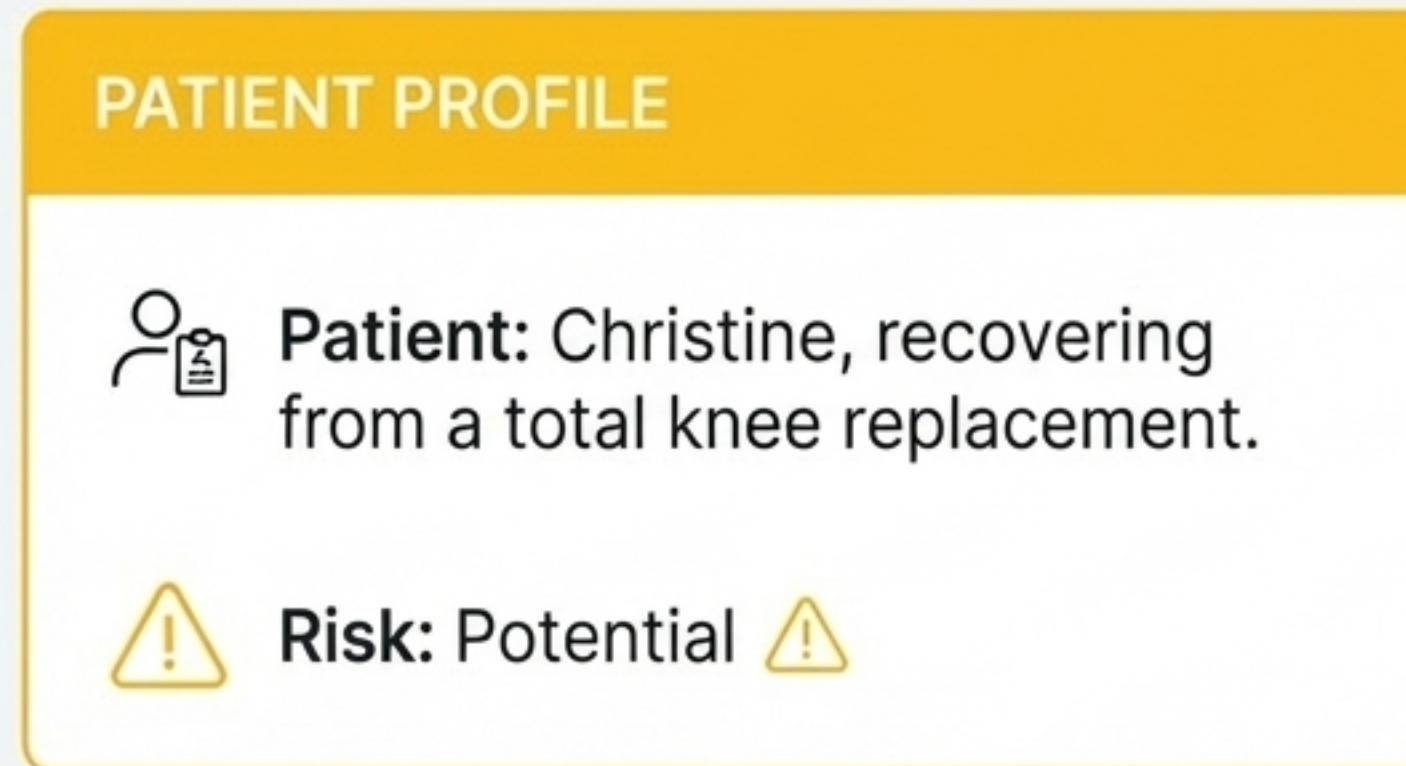


The 'Green Path': Automated Peace of Mind for Robert



✓ **The system classifies the interaction as 'GREEN'.**
Nurse Sarah sees the successful check-in on her dashboard without ever being interrupted.

The 'Yellow Path': Verifying Understanding for Christine.



The system detects confusion, provides the correct information, and sets the risk level to 'YELLOW'.



An alert is created: 'Patient confusion regarding meds and appointment. Re-education provided, but verify understanding.'

Nurse Sarah receives the alert and makes a personal call to ensure comprehension.

The “Red Path”: A Critical Alert for Maria.

Patient Profile

Patient: Maria, post-discharge for Congestive Heart Failure (CHF).

Risk: High 



The system identifies CHF red flags (Weight gain >3lbs, Dyspnea, Edema) and creates a “RED” alert. The dashboard flashes: “CRITICAL: Signals of decompensation.” Nurse Sarah is engaged in seconds to intervene.

Enterprise-Ready and HIPAA Compliant



Access Control (The Fortress)

Strict Row-Level Security via Firestore Rules. Users can ONLY access patients belonging to their `hospitalId`.



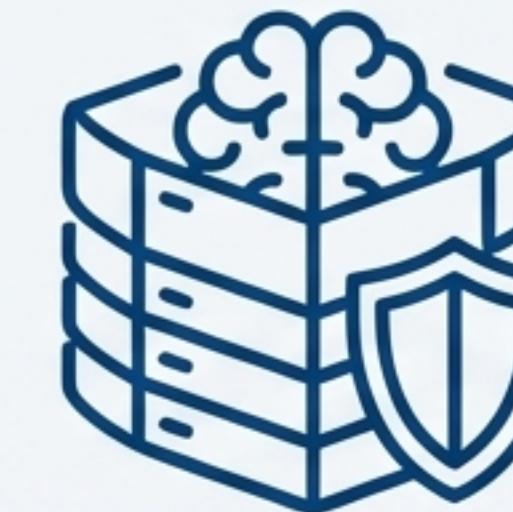
Audit Controls (Audit Trails)

All PHI mutations are logged in a dedicated, immutable `audit_logs` collection.



Transmission Security

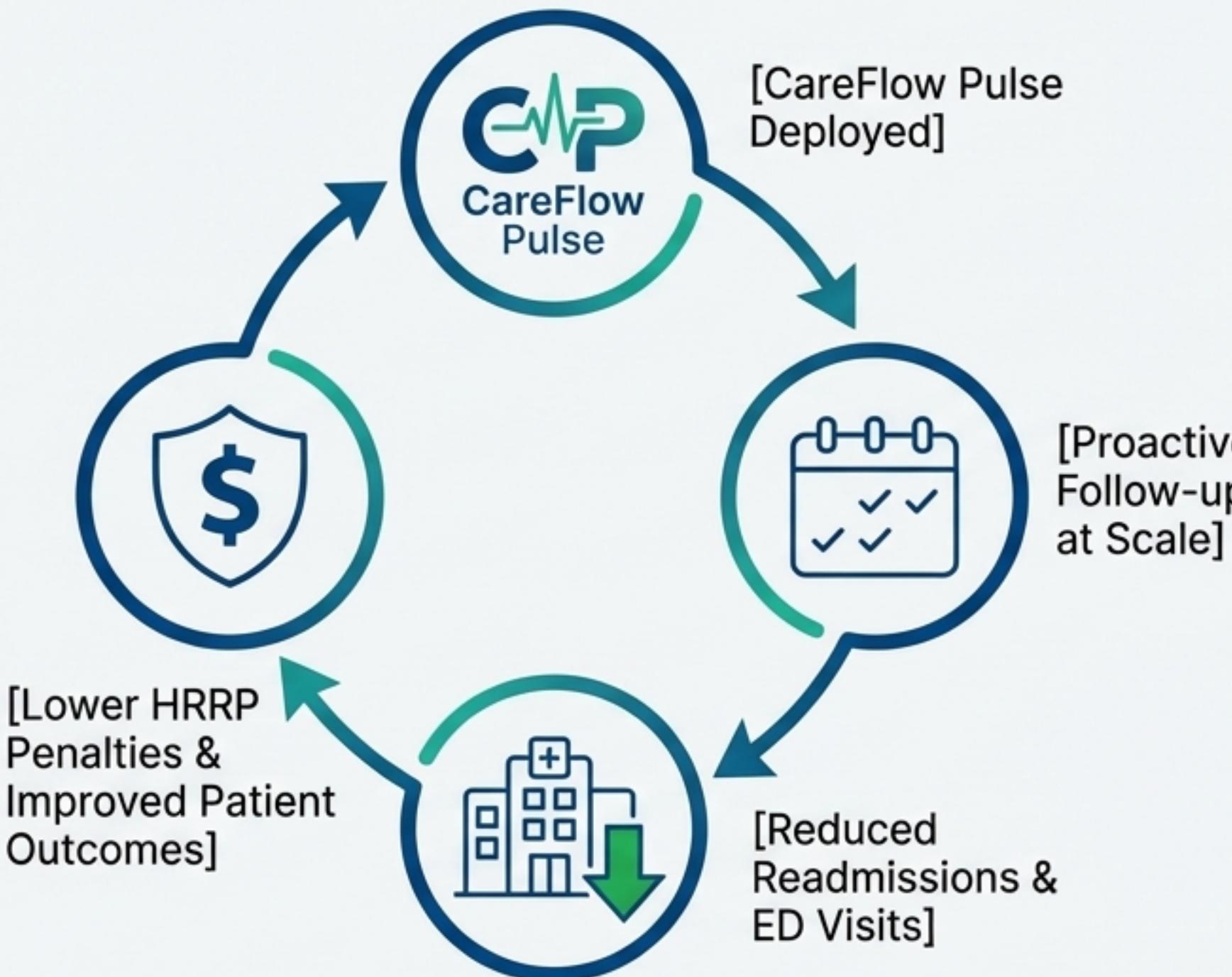
All data is encrypted in transit via TLS 1.2+ with HSTS enabled.



AI Defense in Depth (Model Armor)

Real-time sanitization of inputs and outputs to block prompt injection, prevent PII/PHI leakage (DLP), and filter for safety.

The Business Case for CareFlow Pulse



Reduce Financial Penalties:

Directly address the leading drivers of HRRP penalties.



Increase Staff Efficiency:

Empower your nursing staff to work at the top of their license, improving retention and job satisfaction.



Improve Clinical Outcomes:

Intervene earlier for at-risk patients, preventing complications and saving lives.

**Breaking the cycle of readmissions is no longer
a question of strategy, but of technology.**



**Let's build a safer, more efficient bridge
from hospital to home.**