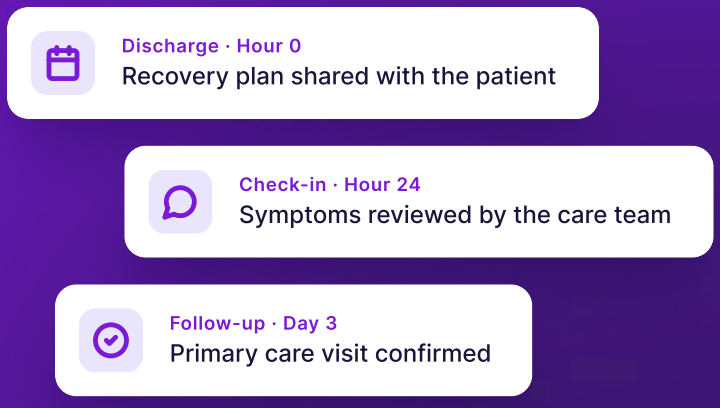
DIMER HEALTH

EXECUTIVE GUIDE

The Post-Discharge Playbook

How Leading Health Systems Reduce Readmissions, ER Utilization, and Patient Anxiety



For hospital executives, care management leaders, and population health executives

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INTRODUCTION

Recovery Begins When the Patient Goes Home

Healthcare in the modern world has never been better at treating patients inside the hospital.

This is because health systems have invested billions of dollars in advanced diagnostics, specialized teams, sophisticated electronic health records, and evidence-based clinical pathways. Many organizations have dramatically improved inpatient outcomes through a relentless focus on quality, efficiency, patient safety, and clinical excellence.

> But one of the greatest risks of patient recovery begins the moment the patient leaves the hospital.

Discharge is typically treated as the finish line, but in reality, it actually signifies the start of one of the most vulnerable phases of the patient's journey. Clinical responsibility begins to fragment as communication passes between multiple providers. Patients and caregivers are expected to manage medications, schedule follow-up appointments, identify warning signs and red flags, and navigate a healthcare system that is becoming more complex with every passing day. There is also often limited support available in real-time to help with this.

For health systems, the consequences are severe. Avoidable readmissions, ED utilization, rising costs, regulatory penalties, and declining patient confidence frequently originate during the days immediately after discharge, instead of during the hospital stay itself.

The challenge here lies in the fact that traditional care models were never designed to provide continuous clinical oversight once patients leave hospital and return home.

This playbook explores why improving post-discharge care has become one of healthcare's greatest strategic opportunities. It examines the hidden factors that drive readmission, explains why the first 72 hours after discharge matter so much, and how AI can strengthen clinical teams, as well as outlining the operational foundations of scalable transition-of-care programs.

For executives responsible for improving quality, reducing avoidable utilization, and delivering better patient outcomes, the post-discharge period represents one of the highest-impact opportunities available today.

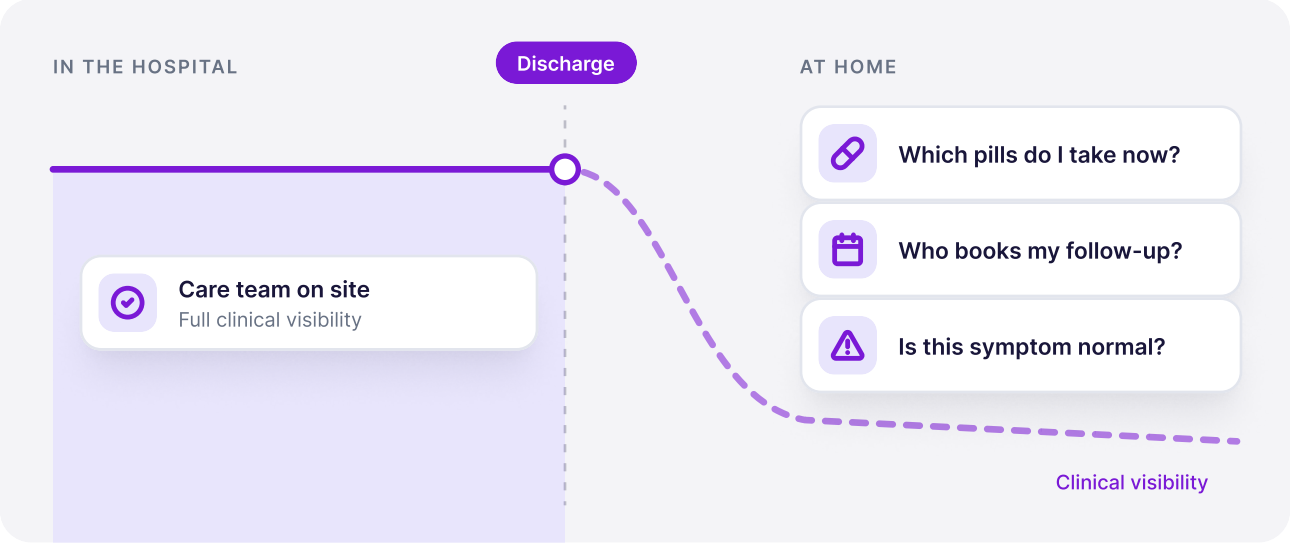
CHAPTER 01

Why Discharge Is Healthcare's Biggest Blind Spot

Most healthcare organizations devote significant attention to everything that happens before the discharge process.

Clinical pathways are carefully designed. Multidisciplinary teams coordinate treatment plans. Specialists collaborate on complex cases. Patient safety protocols are constantly refined and improved. All the stages of inpatient care are overseen by established processes that deliver consistent, high-quality outcomes.

> But then the patient goes home.



At that point, the visibility and coordination established during treatment can rapidly diminish.

Patients leave the hospital with discharge paperwork, medication instructions, appointment schedules, and recovery plans that feel straightforward at the time. However, once patients return home, these factors can become overwhelming and difficult to keep on top of. Family members suddenly find themselves responsible for supporting recovery care with very little clinical training.

Many patients turn to online searches or AI assistants when new questions arise, but generic answers can't replace guidance tailored to their individual discharge plan.

Primary care providers might not yet have complete information about the hospitalization. Many specialists assume follow-up will occur elsewhere, and questions might arise outside of office hours. Small problems can escalate before anybody realizes that there is a need for intervention.

No single failure causes this breakdown. Instead, there are multiple organizations, systems, and individuals responsible. This is why discharge is one of healthcare's biggest blind spots.

For decades, healthcare performance has been measured by what occurs inside the hospital, including infection rates, mortality rates, length of stay, surgical results, and inpatient quality measures.

But recovery truly begins once the patient leaves the hospital. Transition home introduces new risks that don't exist within the controlled hospital environment. Medications can change and symptoms can fluctuate. Patients aren't sure if what they are experiencing is normal, while caregivers struggle to balance support with life responsibilities, while follow-up appointments might be delayed or missed. Factors including transportation, financial barriers, health literacy, and social circumstances all influence the recovery process.

Many avoidable readmissions occur because no structured clinical system exists to identify and address emerging problems before they escalate.

This creates something of a paradox for healthcare leaders, because organizations can deliver outstanding inpatient care while also experiencing disappointing post-discharge outcomes. Investments in clinical excellence inside the hospital can be undermined by issues that arise once patients return home.

Identifying discharge as a critical pain point in the care process has become a strategic priority for health systems seeking to improve quality, reduce avoidable utilization, and improve financial performance.

Instead of viewing discharge as the end of treatment, leading health systems increasingly recognize it as the beginning of a new clinical responsibility. Patients must remain supported, monitored, and connected during the period when they are the most vulnerable.

This shift in thinking forms the foundation of modern transitional care medicine programs and represents one of the most significant opportunities to improve outcomes across the entire continuum of care.

CHAPTER 02

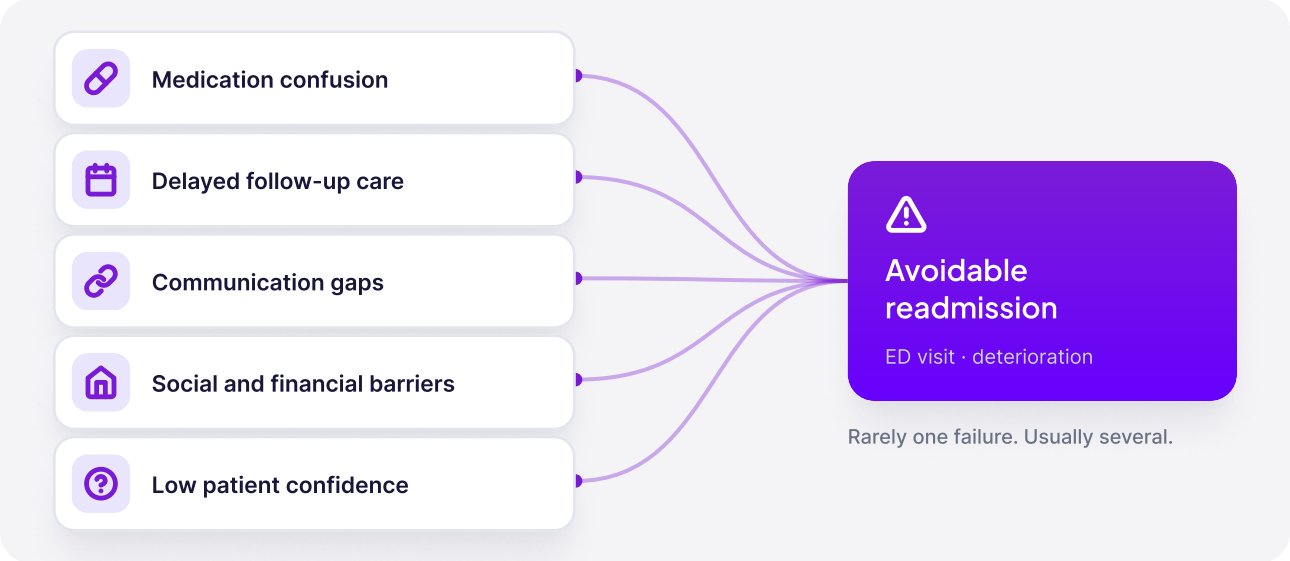
Hidden Drivers of Readmission

Reducing hospital readmissions has remained a strategic priority for health systems for many years. Clinical pathways have strengthened, discharge processes have become more standardized, and quality improvement initiatives are focused on delivering safer and more effective inpatient care.

However, avoidable readmissions continue to place considerable pressure on patients, providers, and healthcare systems alike.

A common misconception is that most readmissions occur because patients are simply too sick to remain at home. Clinical complexity plays a role in this, but the reality is considerably more nuanced.

Many readmissions start well before a patient actually returns to the emergency department. Instead, they develop through a sequence of small breakdowns that occur during the transition from hospital to home. Collectively, these can create conditions that ultimately lead to deterioration, emergency care, or readmission to hospital.



Medication confusion is one of the most common drivers. Patients frequently leave the hospital with new prescriptions, discontinued medications, dosage adjustments, and detailed instructions that can be a challenge to understand. With a lack of clear guidance, misunderstandings can impact recovery and cause complications.

Timely follow-up care presents another significant challenge. Patients might struggle to schedule appointments, face transportation barriers, or assume that someone else is going to support their ongoing care. Delays in seeing a primary care physician or specialist can allow emerging issues to progress unchecked.

Communication gaps between providers also contribute to unnecessary readmissions. Hospitals, primary care practices, specialists, home health providers, and caregivers often operate within separate systems, making it difficult to maintain complete visibility across the patient recovery process. Important clinical information can be delayed, incomplete, or unavailable when decisions have to be made.

For many patients, recovery is also influenced by factors beyond clinical care itself. Limited health literacy, financial pressures, food insecurity, housing instability, caregiver availability, and access to transportation can all affect a patient's ability to follow their care plan successfully. Even patients who are highly motivated might struggle when barriers remain unaddressed.

Patient confidence is equally important. A lot of patients leave the hospital uncertain about what to expect during recovery. They might not know which symptoms are a normal part of healing, and which require immediate medical attention. Faced with uncertainty, some delay seeking help until their condition worsens, and others visit the emergency department out of caution because they have no trusted source of clinical guidance.

These hidden drivers rarely occur in isolation.

A patient experiencing medication confusion might also miss a follow-up appointment. Caregivers managing multiple responsibilities might wind up overlooking early warning signs. A primary care provider might be unaware that the patient has already begun to deteriorate. What began as a series of manageable challenges can evolve into an avoidable readmission.

This is why successfully reducing readmissions depends on maintaining clinical visibility once patients have returned home, and identifying risks before they become emergencies. By addressing the underlying causes of deterioration rather than simply responding to its consequences, health systems can improve outcomes while reducing avoidable utilization across the continuum of care.

Understanding these hidden drivers also explains why the earliest days following discharge are so critical. The majority of these breakdowns begin to emerge almost immediately after patients return home, making the first 72 hours one of the most important opportunities to influence recovery.

CHAPTER 03

The First 72 Hours After Discharge

90%

of patients experience at least one medication discrepancy during their transition from hospital to home. Patients with medication discrepancies are almost twice as likely to be readmitted within 30 days.

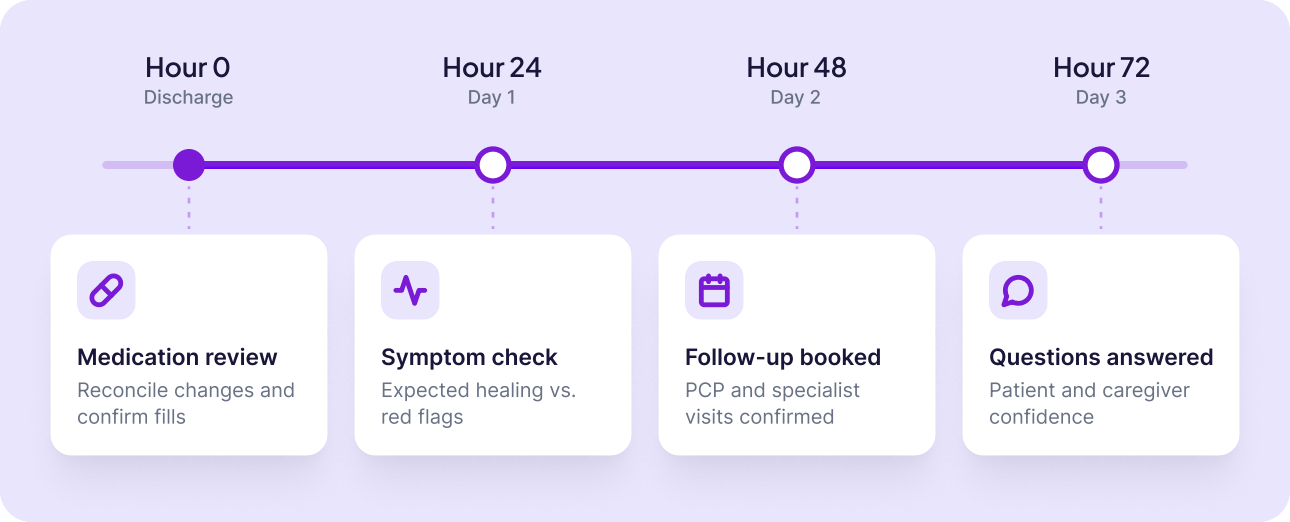
Source: AHRQ [1]

If discharge signifies the beginning of the recovery journey, the first 72 hours represent one of its most critical phases.

A lot of the hidden drivers discussed in the last chapter don't emerge weeks after the patient leaves the hospital, but instead they start within hours. Medication questions can arise within the first hours at home. Symptoms can evolve or get worse. Follow-up appointments might be delayed or unscheduled, and caregivers have to deal with unfamiliar responsibilities.

By the time these challenges become visible to the healthcare system, opportunities for early intervention might already have been missed.

As such, the first 72 hours after discharge have become an area of increased focus for health systems seeking to increase positive outcomes for patient post-discharge care, while also reducing avoidable readmissions. Instead of viewing recovery as a passive process that starts once the patient returns home, leading organizations understand that the earliest days following discharge need active clinical oversight.



Medication management is one of the key initial priorities. Hospitalization frequently results in changes to prescriptions or treatment plans. Patients might continue with expired medications, misunderstand new instructions, or even delay filling prescriptions entirely. Without timely clinical review, these small issues can impact recovery and increase the chances of complications. Research from the Agency for Healthcare Research and Quality (AHRQ) suggests that medication discrepancies can occur in up to 90% of hospital-to-home transitions, which illustrates how vulnerable this period of the process can be [1].

Early symptom assessment is essential, as patients recovering at home often struggle to distinguish between expected discomfort and signs of critical deterioration. Questions that appear minor can actually escalate rapidly if they remain unanswered. Timely clinical assessment helps determine whether urgent intervention is needed.

The first 72 hours also help to establish the foundation for ongoing care coordination.

Follow-up appointments with primary care specialists should already be happening or scheduled. Referrals need to be confirmed. Discharge instructions need to be understood, and patients have to have confidence in the next steps of the recovery process. Delays during this period can create downstream consequences that become much tougher to correct.

The first 72 hours also shape how confident patients feel about the rest of their recovery. A patient who gets a clear answer early is better placed to follow the care plan, while one who hears nothing may wait until symptoms are harder to ignore. Early contact turns uncertainty into a plan before it turns into an ED visit.

44%
less likely to be readmitted

75%
less likely to require an emergency department visit

Patients who attended follow-up appointments within 30 days of discharge, according to an AHRQ evaluation [2].

For health systems, effective proactive intervention during the first 72 hours can improve patient outcomes, strengthen continuity of care, reduce unnecessary utilization, and enhance overall patient care. This helps organizations identify emerging risks while they are still manageable, but the challenge here is scale.

Being able to provide proactive clinical support to discharged patients is difficult via traditional models alone. Care teams already operate under significant workloads, while patient volume keeps growing. Maintaining continuous oversight throughout the earliest stages of recovery requires workflows that are effective and operationally sustainable.

This is where the future of post-discharge care begins to form. Healthcare systems are increasingly exploring models that combine continuous patient engagement with ongoing clinical oversight. By extending visibility beyond the hospital, these approaches allow care teams to identify issues and intervene as early as possible.

Understanding why the first 72 hours matter so much is only a small part of the equation, and the next challenge comes with determining the way health systems can deliver this level of support consistently, at scale.

CHAPTER 04

AI + Clinical Teams Working Together

57%

of physicians believe that AI's greatest opportunity is reducing administrative burden rather than replacing clinical judgment.

Source: American Medical Association [3]

The first three chapters of this playbook have established an important conclusion.

Health systems increasingly recognize that patients need proactive support during the first 72 hours after discharge. Clinical oversight can reduce avoidable deterioration and improve patient outcomes if it happens earlier in the process. The difficulty lies in delivering the level of support that is consistent, efficient, and at scale.

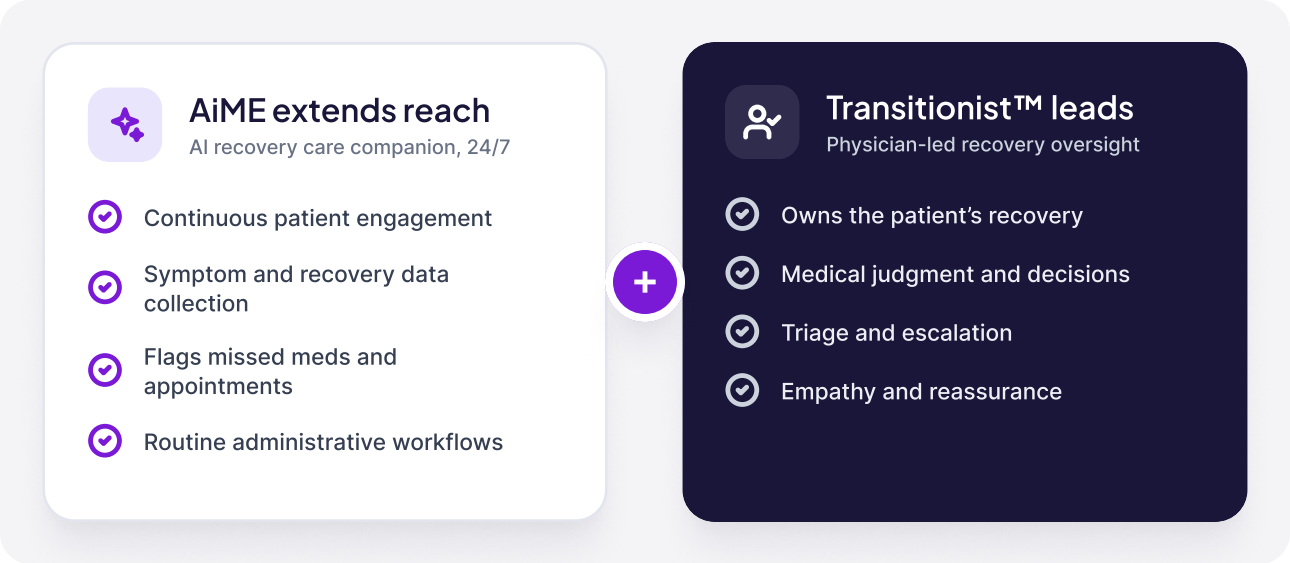
Traditional care models, in particular, find it difficult to achieve this.

Care management teams already operate under significant workload pressures. Patient volumes continue to grow, while physician shortages and clinician burnout place additional strain on the available resources. The Agency for Healthcare Research and Quality (AHRQ) reports that workforce shortages remain one of the most considerable long-term challenges that face primary care delivery throughout the United States, limiting health systems' ability to expand capacity using traditional staffing models alone [4].

This creates a difficult operational reality. Providing oversight for every discharged patient requires enormous clinical resources if performed manually. But failing to maintain visibility during the recovery process increases the chances that emerging issues remain undetected until patients require emergency care or readmission.

AI provides a different approach. Instead of replacing nurses, physicians, and advanced practitioners, AI allows clinical teams to extend their reach. Routine monitoring, patient engagement, symptom collection, and administrative workflows can be supported continuously, which allows clinicians to focus on their expertise where it will create the most clinical value. This distinction is important.

The current physician attitudes toward AI reflect this philosophy. The American Medical Association found that physicians see AI's greatest value in reducing administrative burden, improving documentation, supporting discharge instructions, and streamlining clinical workflows, as opposed to replacing medical decision-making [5].



This is a collaborative model that helps combine the strengths of technology with clinical expertise. AI excels at providing consistency, and it can engage patients continuously, while also collecting recovery information, identifying changing symptom patterns, and highlighting missed medications or appointments. Monitoring doesn't end when office hours stop, or depend upon patients understanding when they need to ask for help.

But clinical teams are able to provide something that technology cannot. Medical judgment, complex decision-making, empathy, reassurance, and treatment planning are integral human responsibilities. AI supplies clinicians with better visibility into patient recovery, while physicians and care teams figure out the right response.

Dimer Health's model is one example of this approach. Dimer Connect and AiME, Dimer's AI recovery care companion, keep patients connected after discharge, deliver personalized guidance, and identify needs earlier. A Transitionist™ is a physician-led clinical role that takes direct responsibility for managing a patient's recovery after discharge, much as a hospitalist oversees care during a hospital stay. The technology extends the clinical team's reach, and the clinician decides what happens next.

This results in a model that allows health systems to scale post-discharge care without the need to compromise on quality. Patients receive timely engagement throughout the recovery process instead of waiting until problems become worse. Clinicians spend more time caring for patients who genuinely require medical intervention, while organizations can gain greater visibility across the recovery journey.

This marks a shift in the way post-discharge care is delivered. Leading health systems increasingly recognize that the greatest value comes from combining both. AI extends clinical capacity, while clinicians provide the expertise and judgment that technology struggles to replace.

The question becomes how health systems are able to build transitional care medicine programs that combine continuous patient engagement with physician-led clinical oversight in a way that's effective and sustainable.

CHAPTER 05

Building a Scalable Transitional Care Program

1 in 5

Medicare patients is readmitted within 30 days of discharge, costing the U.S. healthcare system billions of dollars annually.

Source: PubMed Central [6]

The previous chapters have established why post-discharge care matters so much, and why it demands strategic attention.

Health systems understand that the opening 72 hours represent a critical period for patient recovery, and that continuous clinical oversight is crucial to avoiding deterioration and improving patient outcome.

The remaining question is how these capabilities can be consistently implemented across thousands of patients. Increasingly, leading health systems are implementing the discharge and post-discharge infrastructure needed to extend care beyond the hospital. Successful transitional care programs combine multiple operational capabilities into a single, coordinated model, creating a recovery process that is proactive rather than reactive.

01 **Engage before discharge**

02 **Prioritize the first 72 hours**

03 **Pair technology with clinicians**

04 **One coordinated journey**

05 **Measure what matters**

01

Begin engagement before discharge

Successful transitional care starts before the patient leaves the hospital. Planning and engagement begin prior to discharge, so support is already in place as the patient transitions home and begins recovery.

Follow-up appointments, discharge planning, medication reconciliation, caregiver preparation, and recovery expectations should be established before discharge is confirmed. This early engagement reduces uncertainty, and helps create continuity between inpatient care and at-home recovery.

02

Prioritize the first 72 hours

However, not every patient needs the same level of support. But every patient will benefit from early contact.

The first 72 hours need to include proactive outreach, medication review, symptom assessment, arranging follow-up appointments, and opportunities for patients and caregivers to ask questions before small concerns become bigger clinical issues.

Instead of waiting for patients to initiate contact, leading health systems structure their workflows to identify potential issues early, and ensure the right clinical intervention occurs when required.

03

Combine technology with clinical expertise

Technology alone is not able to improve patient outcomes, but neither can manual outreach alone.

Instead, the most effective form of transitional care programs combine continuous digital engagement with physician-led clinical oversight.

Symptom collection, routine monitoring, patient education, and administrative coordination occur continuously through digital tools, while physicians, nurses and practice providers are focused on clinical assessment and complex patient needs.

04

Create one coordinated recovery journey

Patients find it difficult to distinguish between hospitals, specialists, primary care providers, and community services. Instead, they experience a single recovery journey.

Successful programs therefore focus on coordinating communication across every participant involved in post-discharge care. Timely information sharing reduces duplication, improves continuity, and enables clinicians to make better-informed decisions across the recovery process.

The objective here lies in better coordination and connectivity.

05

Measure outcomes that matter

The effectiveness of transitional care medicine programs cannot be evaluated through merely activity alone. Health systems increasingly measure outcomes that include:

- Thirty-day readmissions rates
- Emergency department utilization
- Medication adherence
- Primary care follow-up completion
- Patient satisfaction and confidence
- Time to first post-discharge contact
- Total cost of care

These steps provide a complete understanding of how effectively patients recover once they leave the hospital. Additionally, they allow organizations to continuously improve clinical workflows while demonstrating value under value-based reimbursement models.

Ultimately, building a scalable transitional care program isn't about introducing another technology platform or expanding another care management team. It's about designing an operating model that delivers consistent support throughout the recovery journey.

The organizations that achieve the strongest outcomes increasingly share the same characteristics — they extend clinical visibility beyond the hospital walls, intervene earlier when risks emerge, and combine human expertise with technology to deliver coordinated care at scale.

As healthcare continues shifting toward value-based models, transitional care medicine programs are becoming more than operational improvements. They are emerging as a core strategic capability for health systems seeking to improve quality and deliver better long-term patient outcomes.

CHAPTER 06

KPIs Every Health System Should Track

The previous chapters have explored why the post-discharge period represents one of healthcare's greatest opportunities to improve quality and strengthen patient outcomes. Building an effective transitional care medicine program is an important first step.

The next challenge comes with determining whether this program is delivering meaningful results.

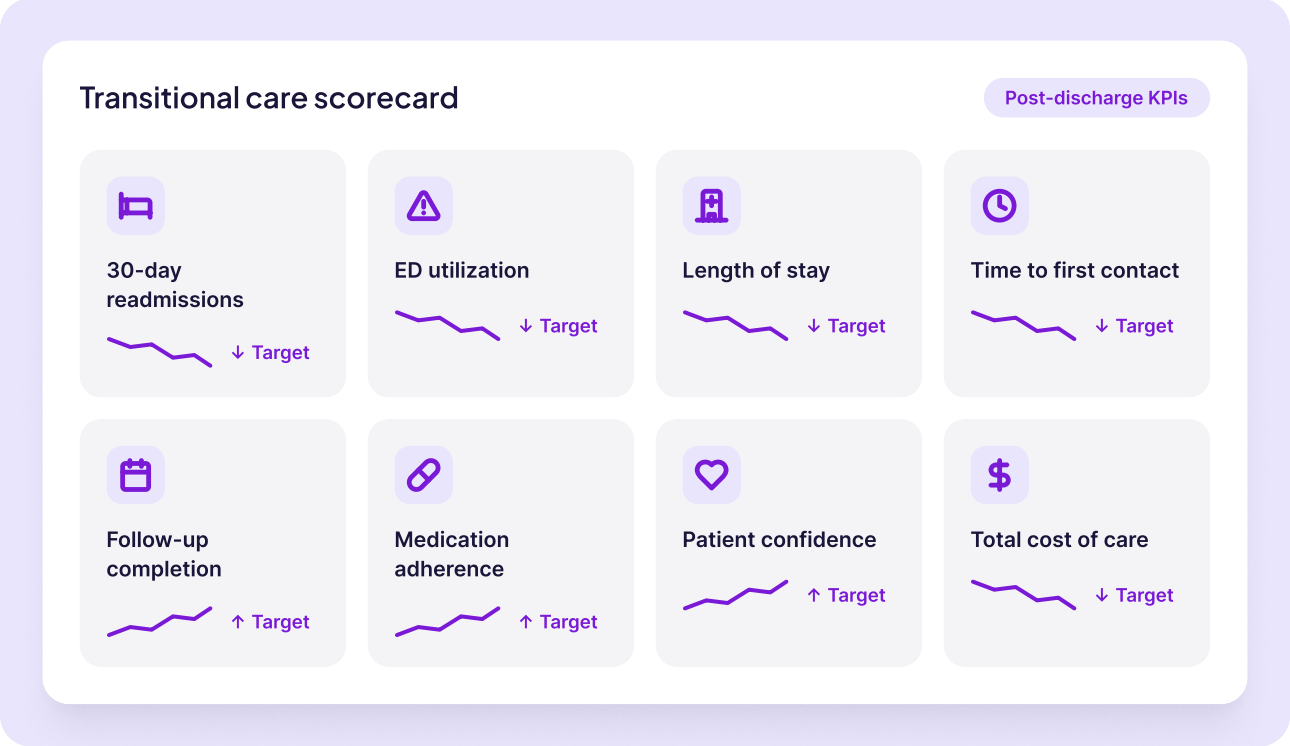
Healthcare leaders cannot measure success solely by the number of patients contacted after discharge or the volume of follow-up activities completed. Operational activity matters, but meaningful performance gets measured through clinical outcomes, financial impact, patient experience, and being able to deliver consistent care at scale.

The most effective transitional care programs therefore focus on a balanced set of key performance indicators that demonstrate both clinical effectiveness and organizational value.

Thirty-day readmission rates

Thirty-day readmissions remain one of the most widely recognized indicators of transitional care performance.

Although not every readmission is preventable, trends in avoidable readmissions provide valuable insight into whether patients are receiving the support they need following the discharge process.



Emergency department utilization

Not every breakdown in recovery results in hospital readmissions. In fact, a lot of patients first return to the emergency department because symptoms get worse and medications become confusing. When this happens, they can become uncertain about where to seek advice.

Tracking post-discharge emergency department utilization can help to give an earlier indication that recovery pathways aren't functioning in an optimal manner.

Reduction in length of stay

Length of stay is often treated as a purely inpatient metric, but it's also a reflection of how confident a hospital feels about what happens after patients leave.

When a coordinated post-discharge plan is already in place, hospitals can discharge patients earlier and without added risk, because they know another clinician is picking up where inpatient care leaves off. Continued monitoring, timely triage, and appropriate escalation don't end at the hospital door, but continue into the next recovery period.

Tracking length of stay alongside post-discharge outcomes gives health systems a clearer picture of whether earlier discharge decisions are safe as well as being faster.

Timeliness of follow-up

The speed with which patients receive follow-up care is a great indicator of transition quality. AHRQ reports that patients completing follow-up visits within 30 days of discharge were found to be 44% less likely to be readmitted and 75% less likely to visit the ED [7].

Additional research across 22 hospitals found that patients successfully reached through nurse-led discharge follow-up calls within seven days had lower 7- and 30-day readmission rates than the patients who were not reached.

Health systems need to monitor key metrics, including:

- Time to first patient contact
- Time to first clinical assessment
- Completion of scheduled follow-up appointments
- Referral completion rates

This helps to illustrate whether or not recovery begins with continuity rather than fragmentation.

Medication reconciliation and adherence

Medication-related issues are among the most commonly preventable complications after discharge. Being able to monitor successful medication reconciliation, prescription completion, and adherence provides valuable insight into whether patients understand treatment plans throughout the recovery process.

Patient confidence and experience

Clinical outcomes tell only a small percentage of the story. Patients who feel supported and understand their recovery plans are more likely to engage well with their ongoing care plans.

Measures such as patient satisfaction, confidence in self-management, and overall experience helps organizations evaluate whether transitional care programs are delivering person-centered care alongside clinical results.

Total cost of care

Ultimately, transitional care programs should create value for both patients and health systems.

Being able to reduce avoidable readmissions, unnecessary emergency department visits, duplicated services, and preventable complications contributes to lower total costs of care while improving quality.

As healthcare keeps evolving toward value-based reimbursement, demonstrating measurable financial outcomes becomes increasingly important along with traditional clinical metrics.

Successful transitional care programs do more than improve individual performance measures. They create greater visibility across the recovery journey, strengthen coordination between providers, improve patient confidence, and enable intervention when risks emerge.

Healthcare leaders can utilize these outcomes because they demonstrate the evolution of post-discharge care, and how it has evolved into a strategic capability that supports better care and improved patient experiences.

Organizations that lead this transformation will be able to recover patients more successfully.

CONCLUSION

Recovery Continues After the Patient Leaves the Hospital

For the longest time, healthcare organizations have invested so much in improving what happens inside the hospital. Clinical pathways have grown more sophisticated, multidisciplinary collaboration has strengthened, and quality improvement initiatives have delivered measurable gains across inpatient care.

> But, one of the greatest opportunities to improve outcomes actually happens once patients leave the hospital.

Transitioning from hospital to home has historically marked the end of the treatment process. The reality is that it represents the beginning of one of the most vulnerable and complicated stages of the patient recovery journey. During this process, clinical responsibility is fragmented, gaps in communication appear, and seemingly minor challenges can quickly escalate into avoidable ED visits.

This playbook explores why the first 72 hours after discharge deserve greater strategic attention, how hidden drivers can contribute to preventable deterioration, why technology needs to extend clinical expertise, and what effective transitional care medicine programs have in common.

Ultimately, the integral lesson here is that improving post-discharge care requires a fundamental shift in the way health systems view and treat recovery.

Leading businesses move beyond a model in which discharge marks the completion of care. They recognize that recovery continues after patients leave the hospital, and maintain clinical visibility throughout the recovery period.

Health systems that invest in proactive recovery management today will find themselves better positioned to reduce avoidable utilization, strengthen patient confidence, improve financial performance, and deliver coordinated care throughout the patient recovery ecosystem.

Ultimately, the future of post-discharge will be defined by health systems that successfully combine continuous patient engagement, physician-led clinical oversight, coordinated care pathways, and measurable outcomes into a single model of recovery.

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DIMER HEALTH

ABOUT DIMER HEALTH

Connected Care That Follows the Patient Home

Dimer Health is building the discharge and post-discharge infrastructure that keeps patients connected to care. Combining an AI-powered platform with 24/7 access to human licensed clinicians, Dimer delivers personalized guidance, identifies needs earlier, and gives care teams greater visibility into recovery at home, helping improve outcomes and reduce avoidable ED visits and readmissions.

Whether partnering with hospitals, health systems, providers, or payers, Dimer's approach extends clinical visibility beyond discharge, while keeping physicians at the center of patient care.

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