

POST-DISCHARGE FAILURE

Is No Longer A Quality Issue. It Is A Board-Level Financial Risk.

\$2M-\$4M PER YEAR
LOST BY THE AVERAGE U.S. HOSPITAL

NOT BECAUSE OF CARE,
BUT BECAUSE CARE IS NOT
EXECUTED AFTER DISCHARGE

Hospitals Deliver Care, But CMS Penalizes What Happens After.

Under CMS Value-Based Programs, Hospitals Are Financially Judged Not On **Intent**, Not On **Effort**, But On **Outcomes** That Occur Weeks After The Patient Leaves.

Those Outcomes Are Driven By:

Patient Behavior
Medication Adherence
Follow-Up Compliance
Understanding Of Discharge Instructions
Continuity Of Care

None Of Which Hospitals Currently Control At Scale.

This Is The Structural Reality

- Up to 3% of Medicare inpatient revenue automatically at risk
- 75–83% of U.S. hospitals penalized annually
- Penalties applied across all Medicare discharges
- Results publicly reported and reputationally visible

(CMS HRRP, Kaiser Health News, Becker's Hospital Review)



Briea®

The Post-Discharge Care Execution Platform

Built To Protect Hospital Revenue, Outcomes, And Reputation

Not Another System Of Record. The System Of Execution Hospitals Are Missing.



Problem #1:

CMS Penalties Are Structural, Not Episodic

CMS penalties are:

- Not exceptions
- Not temporary
- Not appeal-based
- Not tied to staffing levels

They are **annual, cumulative, and automatic**.

For a hospital with:

- \$80–\$120M Medicare inpatient revenue
→ **\$2.4M - \$3.6M exposed every year**

(CMS, MedPAC)

Problem #2:

Readmissions Are Cost Centers, Not Revenue Events

Each readmission typically costs

- \$15,000 - \$18,000 per case

Most are:

- Partially reimbursed
- Resource intensive
- Clinically avoidable

Even a **10% reduction** in avoidable readmissions yields:

\$450,000 - \$900,000 per year saved

(AHRQ HCUP, MedPAC)

Problem #3:

Hospitals Lose Control the Moment the Patient Leaves

Post-discharge, hospitals face

- Patients forgetting medications
- Misunderstanding instructions
- Missing labs and follow-ups
- Delayed complication recognition

Peer-reviewed evidence shows:

- **~60% of readmissions are driven by post-discharge non-adherence**
- **\$100–\$300B/year** lost nationally due to non-compliance

(NEJM, NCBI)

This is not a clinical failure, it is an execution failure.

Problem #4:

Staff Cannot Scale Follow-Up

Hospitals attempt to compensate through:

- Nurses
- Care coordinators
- Case managers

But:

- Staffing shortages are structural
- Follow-up is time-intensive
- Burnout increases turnover

Even **2–3 FTEs consumed by post-discharge chaos** equals:

\$200K–\$300K annually

(BLS, Health Affairs)

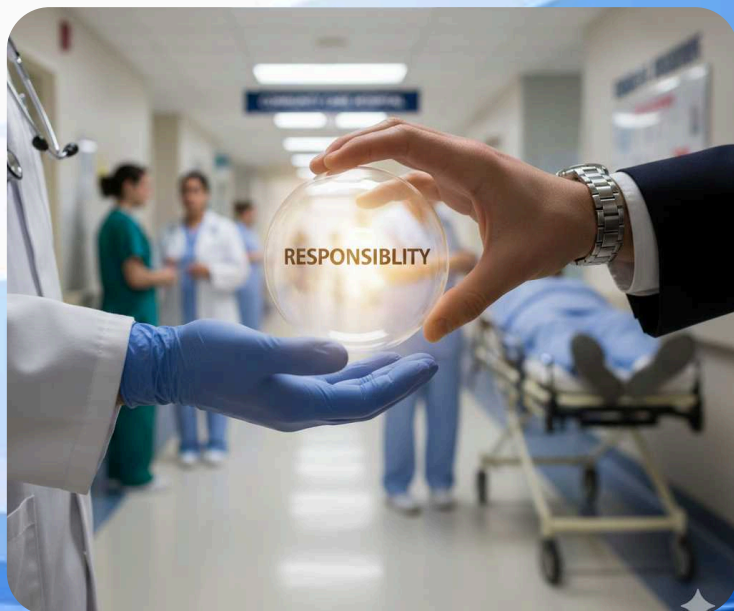
Problem #5:

Static Discharge Instructions Do Not Work

Discharge summaries are:

- Static
- Paper-based or portal-based
- Issued once
- Rarely revisited

Hospitals hand over responsibility but penalties remain.



Bria Is Built for One Purpose, To Execute Post-Discharge Care Over Time, At Scale

Bria does what hospital systems and staff cannot:

1. One-Year Dynamic Care Plans

Bria converts discharge instructions into:

- A **one-year care plan**
- Covering surgery recovery, chronic disease, and post-hospitalization care
- Continuously adjusted based on patient behavior and risk

Impact: Fewer late readmissions, fewer silent failures

2. Proactive, Scheduled Patient Engagement

Bria does not wait. - It:

- Initiates contact on specific dates and times
- Reminds, educates, checks, and follows up automatically
- Continues for weeks and months - not just 7 or 30 days

Impact: Adherence becomes systematic, not accidental.

3. Voice, Text, and WhatsApp - Fully Functional

- No app dependency
- Full functionality available on WhatsApp
- Proven reach among elderly and low-bandwidth populations
- Supported by voice, text, and email

(Pew Research, Statista)

Impact: Engagement without additional staff or training

4. Multilingual by Design

- Removes language-driven readmission risk
- Improves equity-related outcomes tracked by CMS

5. Agentic AI + Generative AI

Bria's AI:

- Understands patient context
- Interprets behavior over time
- Adjusts follow-up intensity
- Escalates only when risk rises

This replaces manual chasing with automated intelligence.



The Financial Result (Conservative, Source-Backed)

Value Area	Annual Impact
CMS Penalty Reduction	\$120K-\$360K
Avoided Readmission Cost	\$450K-\$900K
Staff Cost Offset	\$180K-\$300K
Length-of-Stay Optimization	\$1.2M-\$1.5M
Risk & Liability Reduction	~\$100K
Total Annual Impact	\$2M-\$4M+

(CMS, MedPAC, AHRQ, NEJM, AHA, Johns Hopkins Medicine)



Hospitals Are Already Paying for Post-Discharge Failure.

The Only Decision Is Whether They Continue.

Every year:

- CMS extracts revenue
- Readmissions inflate costs
- Staff absorbs preventable workload
- Reputation erodes quietly

None of this is invisible. None of this is new.

Bria makes Post-Discharge Care Measurable, Controllable, and Scalable

- No new staff
- No patient dependency on apps
- No disruption to existing systems

Just execution - over time, automatically.



This Is Not a Technology Choice. It Is a Financial Governance Decision

Hospitals that control post-discharge execution

- Protect Medicare revenue
- Reduce avoidable costs
- Stabilize operations
- Improve outcomes without expanding payroll



Call to Action

If your hospital is exposed to CMS penalties, inaction is already costing millions.

Deploy Bria. Execute care after discharge. Protect revenue.

1 (415) 236-1558 | partnerships@thebria.com | www.thebria.com

