



IP DISCHARGE CAPACITY PLANNING

Free beds. Improve flow. Protect margin.

A compliant throughput model for difficult-to-discharge patients and post-acute placement bottlenecks.

One-page overview of HealthPact's MSO model, benchmark evidence, legal framework, and ROI structure.

1 PROBLEM STATEMENT

Hospitals are losing capacity and margin when medically stable patients remain in acute beds while waiting for post-acute placement.

10–20%

of acute-care beds can be tied up by alternate-level-of-care patients.

17%

of all acute bed-days can be consumed in some systems.

>\$4K/day

California inpatient cost magnifies every delayed discharge.

- Difficult-to-discharge patients often occupy beds for weeks or months, delaying higher-acuity admissions and elective cases.
- Extended acute stays are not ideal for recovery and are associated with higher risk of complications and readmissions.
- A structured capacity-planning program converts trapped bed-days into throughput, patient-flow, and margin improvement.

Key takeaway: The cost of inaction is recurring bed blockage, slower flow, and avoidable revenue leakage.

2 INDUSTRY EVIDENCE: HEALTHPACT WORKS

Benchmark evidence from industry environmental scan shows HealthPact's IP discharge strategy is both underused and high impact.

~1,200

bed-days eliminated and \$1.92M saved in 2024 by one system.

30–60

days of LOS reduction per patient for roughly 800 patients per year.

14,732

bed-days saved by a third system since January 2023.

2025 Becker's survey: only three health systems reported using HP's IP discharge strategy — and all three produced meaningful throughput gains.

- HealthPact can operationalize the model across selected California facilities with analytics-driven implementation.
- The proposal cites ≈\$58.4M in projected impact from avoided acute-care costs plus higher-value bed backfill.

Underused strategy. Measurable bed-day relief. Strong fit for high-cost California markets.

3 OPERATIONAL MODEL + LEGAL FRAMEWORK

HealthPact acts as the MSO, connecting hospitals with contracted SNF / post-acute partners and coordinating a governed discharge workflow.

1

Reserve beds

Block reserved SNF / post-acute capacity for difficult-to-place patients.

2

Clinical triage

UM nurses review eligibility, level of care, and discharge readiness.

3

Transition logistics

Care coordination plus transportation / NEMT move patients safely and quickly.

4

Govern + optimize

Analytics, quality metrics, and daily operational oversight sustain results.

Legal + compliance guardrails

- Template agreement defines reserved capacity, eligibility, referral protocols, and required documentation.
- FMV compensation is unrelated to referral volume or value.
- Counsel memo addresses Anti-Kickback, Stark, CMS Pub. 15-1, administrative days, and cost-reporting controls.

Outcome: a turnkey, compliant throughput model designed to free beds while protecting against referral-related risk.

4 MODELED ROI + DE-RISKING

Proposal economics combine program fees, modeled value creation, and launch protections that cap downside during ramp-up.

≈\$58.4M

total projected impact (3-facility scenario)

18x

headline ROI (9x at 50% occupancy / ~28M)

\$263K/mo

\$3.159M annualized ~\$75K initiation fee optional

Case Study ≈\$51.4M total projected ROI under the pilot economics presented.

DE-RISKING PROVISIONS

Pressure Test

\$1.2M–\$1.6M bridge funding before Phase 2 covers the first 3–4 months.

Risk-share option

Initiation fee can be waived for a discounted retainer plus shared upside.

Downside cap

Monthly fee acts as the primary risk determinant during phased rollout.

Phased delivery: Pressure Test → Launch → Ramp → Optimize + Scale

**Data-driven. People-focused.
Results-proven.**

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Based on HealthPact Case Study Program.