Case study

Scaling Trusted, High-Impact **AI Care Navigation**

Strengthening post-discharge care through AI-enabled navigation

TOPICS: AI-Enabled Care Navigation | Care Transitions | Post-Discharge Coordination | Care Gap Identification | Health Equity

About the organizations

Bergen New Bridge Medical Center (BNBMC) is a not-for-profit safety net hospital serving a predominantly underserved, multilingual patient population.

Dimer Health is a healthcare technology company providing technology-enabled discharge and post-discharge support to help patients stay connected to care and give care teams greater visibility into recovery at home.

The opportunity

- Extend care coordination beyond hospital discharge to help patients successfully transition home and reconnect with ongoing care.
- Leverage AI-enabled technology and targeted human intervention to proactively identify patients with unmet needs, address barriers to care, and connect them with appropriate clinical and community resources.
- Focus care coordination resources on patients with the greatest post-discharge needs.

The challenge

- Discharge instructions alone were insufficient to ensure patients successfully reconnected with care after leaving the hospital.
- Limited visibility into post-discharge needs made it difficult to identify missed follow-up appointments, medication access issues, and barriers related to transportation, insurance, finances, or language.
- BNBMC needed a scalable way to identify and support patients at risk of becoming disconnected from care without adding staff or increasing the workload of frontline clinical teams.

The approach

- **AI-enabled identification:** A real-time admission, discharge, and transfer (ADT) feed identifies discharged patients for follow-up, while AI uses patient-specific clinical information to support engagement, surface potential care gaps, and flag patients who may need additional intervention.
- **Targeted human support:** Dimer's clinicians, referred to as Transitionists™, work directly with patients to resolve identified gaps, coordinating primary and specialty care, diagnostic testing, insurance, transportation, and other clinical and social needs.
- **Continued care coordination:** Patients typically receive support for two weeks to 30 days, with extended engagement when unresolved needs require additional assistance. Once patients reach their recovery baseline, Dimer reconnects them with their long-term care teams for ongoing care.

The impact

- ✔ **360 discharged patients** enrolled in the program within the first four months of implementation.
- ✔ **17% of patients** were identified as having unresolved care gaps requiring human intervention, with nearly one-third of those patients needing support across multiple areas.
- ✔ **62% of patients** requiring active intervention were successfully referred or connected to ongoing care coordination.
- ✔ **4.85/5 average patient satisfaction rating** and a Net Promoter Score of 90.91, reflecting strong patient-reported experiences.
- ✔ **Demonstrated a scalable model** for combining AI-enabled care gap identification with targeted human intervention to support patients beyond hospital discharge and connect them with ongoing care.

> "The Dimer model has allowed us to make that connection after patients leave our hospital through their Transitionists. It's been working so well that we're now looking to expand the model across additional units."

— Deborah Visconi
President & CEO, Bergen New Bridge Medical Center