Improved Patient Engagement, Lower Readmissions with mHealth

April 14, 2015

Mr. Richard Imbimbo, CFO
Thompson Boyd, MD, FACHE, CHCQM, CPHIMS, CPHM

DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.
Conflict of Interest

Richard Imbimbo, MBA, MSW
Richard is an unpaid member of the Advisory Board of Digital Collaboration Solutions.

Thompson Boyd, MD, FACHE, CHCQM, CPHIMS, CPHM
Has no real or apparent conflicts of interest to report.
Learning Objectives

Reducing Readmissions to Improve Revenue, Care and Collaboration

Demonstrate the positive impact reducing 30-day readmissions from enhanced patient engagement through mobile/email appointment reminders to a patient and their care team such as a family member.

Describe lessons learned introducing a new technology on existing processes, existing roles and existing technologies

Illustrate other uses and opportunities for this new channel of multi-way communications as a means to engage patients and other important members of their care team.

State how a new technology can be integrated into clinical workflows to achieve significant improvement in an important quality and financial metric related to a CMS initiative.
Value Steps

**Satisfaction** – Connects patients, families and caregivers.

**Treatment** – Reduces 30-Day readmissions by 25%.

**Electronic Information/Data** – Enables immediate effect on patient outcomes.

**Prevention and Patient Education** – Improves patient engagement, prevention of readmissions.

**Savings** – Returns 3x on Investment (projected)

http://www.himss.org/ValueSuite
Hahnemann University Hospital is a 496-bed academic medical center at Broad and Vine Streets in Philadelphia, Pennsylvania.

The hospital is a tertiary care institution that specializes in cardiac services, heart failure, OB/GYN, orthopedics, medical, surgical and radiation oncology, bone marrow transplantation, renal dialysis and kidney/pancreas/liver transplantation.

- Magnet® designation by the American Nurses Credentialing Center (ANCC) Magnet Recognition Program®.
- Recognized by the American Heart Association as a leader in stroke and heart failure treatments.
- Named top 50 Best Hospital 2014-2015 U.S. News and World Reports
- Affiliate of Drexel University College of Medicine
- Hahnemann University Hospital is part of Tenet Pennsylvania, which also includes St. Christopher’s Hospital for Children.
- To learn more about Hahnemann, visit www.hahnemannhospital.com
The Design

Issues that can be addressed during a follow-up appointment:

- Medication Duplication
- Missing Medications (Co Pays/Deductibles • Needs Samples)
- Medication Titration
- Dietary Compliance
- New Social/Economic Issues
- Specialty Appointments/Referrals
Program proactively messages patient and caregivers

*Remember to bring your:*
- Medications (bottles) and supplements
- Discharge Papers
- Referral

The Design

- **Appointment Made** → **Discharge Day** → **Discharge to Appointment Day** → **Appointment Day**
- **Patients & Family Enrolled** → **Follow-up Appointment** → **Patients & Family Messaged** → **Appointment Day**

Patients & Families reminded about follow-up appointment

- Text/Phone/email • Language of Choice • Device of Choice • Patient/Family/Friends/PCP/Visiting Nurse, etc.
- Mobile • Tablets • PC • Home Phone • Fax
Pilot at a Glance

• 368 Heart Failure (HF) patients across 784 discharges
• Enrolled Center for Advanced Heart Failure Care inpatients, sending text/phone/email appointment reminders for post discharge appointments
• Tracked appointment adherence and readmissions for patients who were messaged and for those who were not.
• Initial Study Period – 10 Months*
• Baseline readmission rate – 26.7%
  – 10 month rate preceding the study
• Deployed Cloud based HIPAA compliant platform to manage messaging across devices and roles.

* Pilot was extended from an initial 6 month pilot
Participants by Zip Code

Philadelphia, PA
Participants by Income and Zip Code
Program Enrollment by Median Income

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Number Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $32,984</td>
<td>120</td>
</tr>
<tr>
<td>$32,985 to $47,727</td>
<td>40</td>
</tr>
<tr>
<td>$47,728 to $67,106</td>
<td>30</td>
</tr>
<tr>
<td>$67,108 to $99,321</td>
<td>20</td>
</tr>
<tr>
<td>$99,322 to $200,001</td>
<td>10</td>
</tr>
</tbody>
</table>
The Design

- Patient
- Care Team
- Family & Friends
- Devices & Language of Choice
- Dashboard & Patient Appointment Tracking
- Hospital Discharge Team

Manage Appointment Adherence & Reduce Readmissions
The Design

**Automated Appointment Reminder**
- Patient, family members & care team
- Text Message, Voicemail & Email
- Mobile enabled
- Bi-directional - confirm or contact to reschedule

**Manage Patient Appointment Adherence**
- Integrated into discharge process
- Real-time reporting & management dashboard
- Individual patient level tracking
- Identify highest readmission risks

**Easy to Deploy Technology**
- HIPAA Compliant
- Cloud-Based – cost effective, simple to deploy and maintain
- Scalable - # of patients, conditions and clinical sites
- Stand-alone or integrated with other healthcare information systems
"Hello,
This is an appointment reminder from Hahnemann Hospital.
If you have already confirmed this appointment, please consider this a courtesy reminder only.
The Center for Advanced Heart Failure Care at Hahnemann Hospital says you have an appointment on 10/9/2013 3:38 PM.
We are on the 7th floor of the Hospital at Broad and Vine in Center City.
Remember to bring your:
• Medications (bottles) and supplements
• Discharge papers
• Referral
Also make sure your transportation is arranged.
If you need to reschedule or have any questions with this appointment, please call us at 215-762-4200.
Press 1 to confirm the appointment.
Thank you!"
Patient Text Message

Reminder for your appointment with Dr. Eisen on 10/25/2013 4:15 PM
Please reply “C” to confirm, or call 215-762-4200 to reschedule.

Thank you for Confirming
Results to Date through January 30, 2015

TARGET - 2.8% Decrease

ACTUAL
- 10.7% Decrease
- 40.0%* Improvement over Baseline
- 24.9% Improvement over Not Messaged

30-Day Readmissions
Subject to CMS Readmission Penalty

- Baseline: 26.7%
- Pilot - Mobile Messaged Group: 16.0%
- Pilot - Not Messaged Group: 21.3%

* 10.7% ÷ 26.7% = 40.0%

N=541 Discharges
95% Confidence +- 4.21%
Data through January 30, 2015
POLL# 1 – Follow-up appointments

Typically the patients at your hospital are discharged with follow-up appointments within:

A. 3 days  
B. 7 days  
C. 10 days  
D. 14 days  
E. I have no idea
The Care Transitions Intervention
(The Coleman Study)

Care Interventions Lower Readmissions

- Intervention patients had lower rehospitalization rates at 30 days and at 90 days than control subjects.

- Intervention patients had lower rehospitalization rates for the same conditions that precipitated the index hospitalization at 90 days and at 180 days than control subjects.

- Mean hospital costs were lower for intervention patients vs. control subjects at 180 days.

- Coaching chronically ill older patients and their caregivers to ensure that their needs are met during care transitions may reduce the rates of subsequent rehospitalization.

The Care Transitions Intervention, Archives of Internal Medicine/Volume 166, September 25, 2006 pages 1822-1828
The Care Transitions Intervention (The Coleman Study)

Table 3. Utilization Outcomes*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Intervention Group (n = 379)</th>
<th>Control Group (n = 371)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 30 d</td>
<td>8.3</td>
<td>11.9</td>
</tr>
<tr>
<td>Within 90 d</td>
<td>16.7</td>
<td>22.5</td>
</tr>
<tr>
<td>Within 180 d</td>
<td>25.6</td>
<td>30.7</td>
</tr>
<tr>
<td>Rehospitalization for same diagnosis as index hospitalization</td>
<td>2.8</td>
<td>4.6</td>
</tr>
<tr>
<td>Within 30 d</td>
<td>5.3</td>
<td>9.8</td>
</tr>
<tr>
<td>Within 90 d</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 180 d</td>
<td>8.6</td>
<td>13.9</td>
</tr>
</tbody>
</table>

Table 4. Nonelective Hospital Cost Outcomes*

<table>
<thead>
<tr>
<th>Nonelective Hospital Costs</th>
<th>Intervention Group (n = 379)</th>
<th>Control Group (n = 371)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At 30 d</td>
<td>784 (3916)</td>
<td>918 (2971)</td>
</tr>
<tr>
<td>At 90 d</td>
<td>$1519 (4914)</td>
<td>$2016 (4872)</td>
</tr>
<tr>
<td>At 180 d</td>
<td>2058 (5452)</td>
<td>2546 (5466)</td>
</tr>
</tbody>
</table>
Why should hospitals use the RED?

- Patients who received the RED experienced a 30 percent lower rate of hospital utilization within 30 days of discharge compared to patients receiving usual care.

- One readmission or ED visit was prevented for every seven patients receiving the RED.

- RED patients cost an average of $412 less in the 30 days following hospital discharge than patients who did not receive the RED. This represents a 33.9 percent lower observed cost for this group.
## Components of Project RED

1. Ascertain need for and obtain language assistance.
2. Make appointments for follow up care (e.g., medical appointments, post discharge tests/labs).
3. Plan for the follow up of results from tests or labs that are pending at discharge.
4. Organize post discharge outpatient services and medical equipment.
5. Identify the correct medicines and a plan for the patient to obtain them.
6. Reconcile the discharge plan with national guidelines.
7. Teach a written discharge plan the patient can understand.
8. Educate the patient about his or her diagnosis and medicines.
9. Review with the patient what to do if a problem arises.
10. Assess the degree of the patient’s understanding of the discharge plan.
11. Expedite transmission of the discharge summary to clinicians accepting care of the patient.
12. Provide telephone reinforcement of the discharge plan.
American Heart Association Study

Faster follow-up decreases readmissions

- Examined association between outpatient follow-up within 7 days post discharge from Heart Failure hospitalizations and readmission within 30 days.

- Study population of 225 hospitals and 30,136 patients.

- Compared % of early follow-ups per hospital and then correlated with 30-day readmission rate for heart failure.

- Hospitals who achieved an early Physician follow-up experienced a **2.8% decrease** in 30 Day Readmissions.
Impact of 2.8% Decrease in Readmission on Revenues

SAVE OVER $3,000,000

Readmissions Penalties for Hospitals with $100,000,000 in Medicare Payments.

Penalties impact ALL Medicare Reimbursement.

Sample Readmissions Risk Assessment ROI Figures

Medicare revenue recapture @ 50% achievement
Medicare revenue recapture @ 100% achievement

Life to date investment

FY13 (June thru Sept) FY14 FY15 FY16 FY17

$0 $500,000 $1,000,000 $1,500,000 $2,000,000 $2,500,000 $3,000,000

$782,667 $1,550,629 $3,101,257

FY13: $0
FY14: $782,667
FY15: $1,550,629
FY16: $3,101,257
FY17: $5,253,986

Life to date investment

Medicare revenue recapture @ 50% achievement
Medicare revenue recapture @ 100% achievement

Sample Readmissions Risk Assessment ROI Figures
From 2007 to 2009, out of 1,330,157 patients admitted for CHF, 329,308 were readmitted within 30 days. (24.8% rate)

The proportion of patient readmitted for the same condition was 35.2% after the index HF hospitalization.

The majority of the patients (61%) were readmitted within 15 days of hospitalization.

Age, sex, race was not a factor.
Thirty-Day Readmissions by Day
HEART FAILURE, ACUTE MI, AND PNEUMONIA READMISSIONS
JAMA, January 23/30 2013

Heart Failure Hospitalization

- Days 0-3: Percentage of all readmissions, 13.4%
- Days 0-7: Percentage of all readmissions, 31.7%
- Days 0-15: Percentage of all readmissions, 61.0%

61% Readmissions for Heart Failure Patients 0-15 Days

Figure 1. Thirty-Day Readmissions by Day (0-30) Following Hospitalization for Heart Failure, Acute Myocardial Infarction, or Pneumonia.
Data 2006 - 2009
Thirty-Day Readmissions by Day
Hahnemann Pilot Experience

Days 0-3
Percentage of all readmissions, 6%

Days 0-7
Percentage of all readmissions, 20%

Days 0-15
Percentage of all readmissions, 60%

60% Readmissions for Heart Failure Patients 0-15 Days
Messaged – 19%
Not Messaged – 41%

Not Messaged
Messaged

Days Following Hospital Discharge
Data through September 30, 2014
Days between Discharge, Readmissions and Follow-up appointments

For over 550 encounters:

- Average length of stay at home between discharge and **ATTENDED** (showed up) their 1st follow-up appointment – 15 Days
  - Messaged patients – 9 Days
  - Not Messaged patients – 19 Days

- Average Days between Discharge and subsequent Readmissions – 15 Days
  - Messaged encounters – 16 Days
  - Not Messaged encounters – 14 Days

Staff making the appointments are blind as to whether patient was to be messaged or not
POLL# 2 – Average days between discharge & readmissions

The average days between discharge and subsequent readmissions at your hospital for heart failure patients is:

A. 0-5 days
B. 6-10 days
C. 11-14 days
D. >14 days
E. I have no idea
Preferred Method of Communication

- Text: 57%
- Phone: 42%
- Email: 1%

As of September 30, 2014
Impact of 7 Day Follow-up
Messaged patients/Days between discharge and appointment (patient showed up)

Readmission Rates

- **1-7 Days**: 11% of patients, 35% of readmissions
- **8-14 Days**: 31% of patients, 45% of readmissions
- **15-21 Days**: 40% of patients
- **22-30 Days**: 33% of patients

Average days between readmissions: 15 days

Average readmission rate: 31%
Impact of Messaging
Difference in Readmissions based on level of engagement

- Messaged Confirmed: 8.8%
- Messaged Not Confirmed: 15.4%
- Not Messaged Not Confirmed: 22.8%

Readmissions
Impact of Messaging

Difference in Appointment adherence based on level of engagement

- Not Messaged: 46.7%
  - Not Confirmed: 46.7%
- Messaged: 67.8%
  - Not Confirmed: 67.8%
  - Confirmed: 68.4%

Attended
(Patient showed up)
Impact of Messaging
Difference in Cancellations based on level of engagement

- Messaged Confirmed: 5.3%
- Messaged Not Confirmed: 4.0%
- Not Messaged Not Confirmed: 11.8%
POLL# 3 Top Ten Re-admitters

The top ten re-admitters at your hospital for heart failure are responsible for what percentage of total readmissions for Heart failure?

A. 0-15%
B. 16-30%
C. 31-50%
D. >50%
E. I have no idea
Pilot Readmissions Tightly Concentrated Among Few Patients

<table>
<thead>
<tr>
<th># of Readmissions Patients</th>
<th># of Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Readmission</td>
<td>33</td>
</tr>
<tr>
<td>2 Readmissions</td>
<td>15</td>
</tr>
<tr>
<td>3 Readmissions</td>
<td>6</td>
</tr>
<tr>
<td>4 Readmissions</td>
<td>1</td>
</tr>
<tr>
<td>5 Readmissions</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>56</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th># of Readmissions</th>
<th>33</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Readmissions</td>
<td>30</td>
</tr>
<tr>
<td>3 Readmissions</td>
<td>18</td>
</tr>
<tr>
<td>4 Readmissions</td>
<td>4</td>
</tr>
<tr>
<td>5 Readmissions</td>
<td>5</td>
</tr>
<tr>
<td>Totals</td>
<td>90</td>
</tr>
</tbody>
</table>
Pilot Readmissions Tightly Concentrated Among Few Patients

<table>
<thead>
<tr>
<th># of Readmissions Patients</th>
<th># of Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Readmission</td>
<td>33</td>
</tr>
<tr>
<td>2 Readmissions</td>
<td>15</td>
</tr>
<tr>
<td>3 Readmissions</td>
<td>6</td>
</tr>
<tr>
<td>4 Readmissions</td>
<td>1</td>
</tr>
<tr>
<td>5 Readmissions</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>90</td>
</tr>
</tbody>
</table>
63% of Total Readmissions from 8.8% of Patients

<table>
<thead>
<tr>
<th></th>
<th>% of Patients</th>
<th>% of total Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Readmission</td>
<td>12.6%</td>
<td>36.6%</td>
</tr>
<tr>
<td>2 Readmissions</td>
<td>5.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>3 Readmissions</td>
<td>2.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>4 Readmissions</td>
<td>.4%</td>
<td>4.4%</td>
</tr>
<tr>
<td>5 Readmissions</td>
<td>.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>21.4%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
### 63% of Total Readmissions from 8.8% of Patients

<table>
<thead>
<tr>
<th>Readmissions</th>
<th>% of Patients</th>
<th>% of total Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12.6%</td>
<td>36.6%</td>
</tr>
<tr>
<td>2</td>
<td>5.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>3</td>
<td>2.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>4</td>
<td>.4%</td>
<td>4.4%</td>
</tr>
<tr>
<td>5</td>
<td>.4%</td>
<td>5.5%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>21.4%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

These are the people that are adversely bending the cost curve.
**63% of Total Readmissions from 8.8% of Patients**

<table>
<thead>
<tr>
<th># of Readmissions</th>
<th># of Patients</th>
<th>% of Patients</th>
<th># of Readmissions</th>
<th>% of total Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Readmission</td>
<td>33</td>
<td>12.6%</td>
<td>33</td>
<td>36.6%</td>
</tr>
<tr>
<td>2 Readmissions</td>
<td>15</td>
<td>5.7%</td>
<td>30</td>
<td>33.3%</td>
</tr>
<tr>
<td>3 Readmissions</td>
<td>6</td>
<td>2.3%</td>
<td>18</td>
<td>20.0%</td>
</tr>
<tr>
<td>4 Readmissions</td>
<td>1</td>
<td>.4%</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>5 Readmissions</td>
<td>1</td>
<td>.4%</td>
<td>5</td>
<td>5.5%</td>
</tr>
<tr>
<td>Totals</td>
<td>56</td>
<td>21.4%</td>
<td>90</td>
<td>100%</td>
</tr>
</tbody>
</table>

These are the people that are adversely bending the cost curve
### 30% of Total Readmissions from 3.1% of Patients

<table>
<thead>
<tr>
<th># of Readmissions Patients</th>
<th>% of Patients</th>
<th># of Readmissions</th>
<th>% of total Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Readmission</td>
<td>33</td>
<td>12.6%</td>
<td>33</td>
</tr>
<tr>
<td>2 Readmissions</td>
<td>15</td>
<td>5.7%</td>
<td>30</td>
</tr>
<tr>
<td>3 Readmissions</td>
<td>6</td>
<td>2.3%</td>
<td>18</td>
</tr>
<tr>
<td>4 Readmissions</td>
<td>1</td>
<td>.4%</td>
<td>4</td>
</tr>
<tr>
<td>5 Readmissions</td>
<td>1</td>
<td>.4%</td>
<td>5</td>
</tr>
<tr>
<td>Totals</td>
<td>56</td>
<td>21.4%</td>
<td>90</td>
</tr>
</tbody>
</table>

8 of these patients (3.1%) are responsible for 30% of all readmissions. These are the people that are adversely bending the cost curve.
Discharges *Subject to Penalty* by Median Income

- **Less than $32,984**: 9, 2%
- **$32,985 to $47,727**: 47, 12%
- **$47,728 to $67,106**: 60, 16%
- **$67,108 to $99,321**: 63, 16%
- **$99,322 to $200,001**: 212, 54%
30-Day Readmissions by Median Income

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Messaged Readmissions</th>
<th>Not Messaged Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $32,984</td>
<td>20</td>
<td>34</td>
</tr>
<tr>
<td>$32,985 to $47,727</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>$47,728 to $67,106</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>$67,108 to $99,321</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>$99,322 to $200,001</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Readmission Roadmap

Where could one go from here?

1. Implement mobile appointment reminder to improve appointment adherence
   – Immediate impact and return on investment

Readmission Roadmap

Where could one go from here?

1. Implement mobile appointment reminder to improve appointment adherence
   – Immediate impact and return on investment

2. Consider piloting Medication Adherence program
   – CMS estimates that 11% of hospital readmissions occur due to medication non-adherence, estimated to cost nearly $100 billion annually*

Readmission Roadmap

Where could one go from here?

1. Implement mobile appointment reminder to improve appointment adherence
   - Immediate impact and return on investment

2. Consider piloting Medication Adherence program
   - CMS estimates that 11% of hospital readmissions occur due to medication non-adherence, estimated to cost nearly $100 billion annually*

3. Enable care team collaboration
   - Connect care teams and share relevant information between all stakeholders
   - PCP underutilized resource!

Readmission Roadmap

Where could one go from here?

1. Implement mobile appointment reminder to improve appointment adherence
   – Immediate impact and return on investment

2. Consider piloting Medication Adherence program
   – CMS estimates that 11% of hospital readmissions occur due to medication non-adherence, estimated to cost nearly $100 billion annually*

3. Enable care team collaboration
   – Connect care teams and share relevant information between all stakeholders
   – PCP underutilized resource!

4. Enhance the patient and caregiver experience
   – Leverage traditional care with technology

<table>
<thead>
<tr>
<th>Acute Care Clinicians</th>
<th>Pharmacy</th>
<th>Respiratory therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community based Clinicians</td>
<td>Physical therapy</td>
<td>Social worker</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Primary Care access</td>
<td>Speech therapy</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>Primary Care Physician</td>
<td>Visiting Nurse</td>
</tr>
</tbody>
</table>

Improve Patient Care Team Coordination in the Community

Every step in the patient experience journey is critical. By enhancing the post-discharge process, hospitals can improve overall satisfaction scores while reducing penalties.
Conclusions – Mobile Technology Works

• Mobile technology has a role in readmissions reduction
  – Messaged Patients:
    • Are MORE ENGAGED and Readmitted Less Often
    • Show up for their Outpatient Appointments at a Higher Rate, Cancel Less

• Mobile technology helps to facilitate early and timely follow-up
  – Early Follow-up within 7 days Reduces 30-day Readmissions

• Mobile technology enables patient engagement to support:
  – Appointment and Medication Adherence & Transition of Care Coordination
  – Community Care Coordination across the Patient Care Team

• Smallest number of patients responsible for highest percentage of readmissions
  – Require Multi-disciplinary Care with High Touch, along with Technology
  – Intense Management and Stakeholder Accountability
Conclusions

- **Satisfaction** – Connects patients, families and caregivers.
- **Treatment** – Reduces 30-Day readmissions by 25%.
- **Electronic Information/Data** – Enables immediate effect on patient outcomes.
- **Prevention and Patient Education** – Improves patient engagement, prevention of readmissions.
- **Savings** – Returns 3x on Investment (projected)

http://www.himss.org/ValueSuite
CREDITS

Thompson Boyd, MD
Rosemary Dunn, DrNP, CNO
Howard Eisen, MD
Michael Halter, CEO
Shelley Hankins, MD
Rosalyn Huf, RN, BSN
Joan Kavuru, JD
Michael Levinger, CEO DCS
Cindy Marino, Associate CNO
Desiree Morasco, MHA
Timothy Perkins, VP DCS
Stephanie Puccia, MSW, DCM
Alex Rybkin, MD
Brian Talley
Questions?

Thompson Boyd III, MD
Physician Liaison
Hahnemann University Hospital
Phone: 1.215.762.7646
Email: Thompson.boyd@tenethealth.com

Richard Imbimbo, MBA, MSW
Chief Financial Officer
Hahnemann University Hospital
Phone: 1.215.762.7000
Email: Richard.Imbimbo@tenethealth.com