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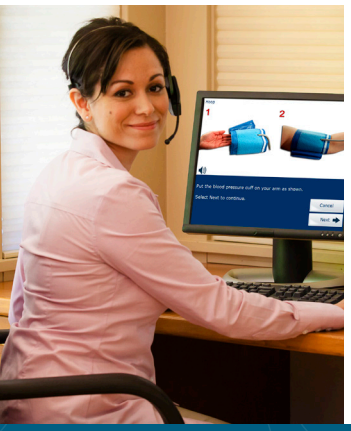
St. Vincent's Hospital Reduces Readmissions by 75 percent with a Remote Patient Monitoring-Enabled Program

Profile:

St. Vincent Health* is a member of Ascension Health, the nation's largest not-for-profit healthcare system. The St. Vincent hospital system is Indiana's largest healthcare employer, with nearly 65,000 admissions per year in 22 hospitals across 47 counties.



Challenge:

Nationally, hospitals readmit an average of 20 percent of patients within 30 days of discharge from the hospital; costing Medicare $17.4 billion per year.[1] Recently enacted national healthcare reform may deny hospitals full reimbursement for these costs. St. Vincent had a goal of reducing hospital readmissions for patients with congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) in an effort to help them stay out of the hospital, away from the emergency room, and reduce the frequency of readmission.

Solution:

As part of an innovative research study, St. Vincent implemented a remote care management program and selected the Intel-GE Care Innovations™ Guide platform to facilitate care delivered in the home. St. Vincent worked with Intel-GE Care Innovations™ to develop clinical protocols and educational materials to help better manage their population. Upon discharge, patients with a primary diagnosis of CHF or COPD were supported at home by a nurse via the Care Innovations™ Guide solution.

Impact:

In less than two years, preliminary results show that the care management program implemented by St. Vincent Health and facilitated by the Guide platform reduced hospital readmissions to 5 percent for patients participating in the program—a 75 percent reduction compared to the control group (20 percent), and to the national average (20 percent).

The Future:

The study runs through December 2012, and St. Vincent is continuing to evaluate its success by measuring ROI, hospital admissions, and patient feedback. Already the hospital is enrolling patients who were not part of the original research study, including those referred from home health agencies, other hospitals, care management organizations, payors, and physician clinics.

Improved Self-Management Behaviors Improve Quality of Life

Patients participating in the care management program that included the Guide solution expressed confidence in their self-management skills, as indicated by their positive responses to survey questions including:

- Taking an active role in my own health care is the most important thing that affects my health.
- I am confident that I can tell a doctor concerns I have even when he or she does not ask.
- I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising.

"A lot of hospitals don't know how to address readmissions because so much happens outside our four walls. With the Guide in the home, we have much more influence and we've seen that it really does make a significant difference in keeping diseases from escalating."

— Alan Snell, M.D.
Chief Medical Informatics Officer
St. Vincent Health

During the 30-day monitoring period, nurses used the Guide to monitor patients using a multidisciplinary approach, including:

- Daily biometric monitoring, including blood pressure, weight, and oxygen saturation.
- Daily interactive health questionnaires.
- Educational videos to help guide patients' daily decision making and health habits.
- At least six video conferences between patients and their nurse.

Behavioral factors, such as noncompliance with medications, lack of adherence to care plans, and not following recommended diets, frequently contribute to readmissions.[2] Using technology as part of an overall clinical care plan to address these issues has been shown to reduce readmissions.

The Guide platform is a comprehensive, remote health monitoring and care management solution that supports early intervention and helps healthcare providers more efficiently extend their services into homes, while engaging patients in creating lasting lifestyle changes.

To find out if the Guide is right for your organization, visit **www.careinnovations.com/guide.**

[1] CMS National Medicare Readmission Findings. Available at: **http://www.academyhealth.org/files/2012/sunday/brennan.pdf**.

[2] Medicare Hospital Readmissions: Issues, Policy Options and PPACA. Available at: **http://www.ncsl.org/documents/health/Medicare_Hospital_Readmissions_and_PPACA.pdf**.

From "Non-Compliant" to "Thriving at Home"

Ann*, 53, has nine chronic conditions. She was admitted to the hospital 13 times last year—12 times within 30 days of being discharged—at a cost of more than $150,000. Ann had been labeled "non-compliant" when her physician suggested using the Guide. For five months, Ann has completed all activities, complied with physician visits, and adhered to her medications. She has also avoided the hospital and the ER, and is doing well at home.

* Name has been changed.

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The Care Innovations™ Guide requires an Internet connection to enable communications with the patient's care team and back-end data hosting. The Guide is intended for use by patients who are able to operate the Guide in accordance with its instructions for use and are under the guidance of a healthcare professional. The Guide is not intended for emergency medical communications or real-time patient monitoring. Available for over the counter use.

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