Real-time Insights from Persivia CareSpace® leads to a Dramatic Decrease in Readmissions

Persivia

I. Introduction

Hospital Readmissions Reduction Program" since 2012 yields more than 1200 citations—that either fail to demonstrate consistent measurable improvements in hospital ability to meaningfully impact readmissions or show a modest decrease.[1]

We share a Case Study where significant progress was made and All-Cause 30-day readmission rate decreased for one hospital by 65 %. Hospitals need to develop strategies and implement Health IT systems that equip multidisciplinary teams with the right data at the right time to prevent readmissions.

HIGHLIGHTS

$19 Million

Total Readmission cost avoided.

65%

Reduction in All-Cause 30-day readmission rate.

1282

No. of Readmissions avoided out of 1353 discharges.

Persivia CareSpace®

The health IT system that delivered results by equipping Multidisciplinary Care Team with right insights at the right time.

II. The Challenge: Rising Costs; Unsatisfied Patients

> *Reducing readmissions is critical for improving patient outcomes and reducing healthcare costs. It's a challenge that requires a data-driven approach and effective communication between care teams and patients,*
>
> Dr. Mudassir, Program Director at HCA Florida Oak Hill Hospital.

HCA Florida Oak Hill Hospital in Brooksville recognized this problem and collaborated with their technology partner, Persivia, to implement a Hospital Readmission Reduction program called **"Healthy Transitions"**. The program aimed at reducing readmissions through the power of data and effective communication between healthcare providers and patients to proactively support care coordination.

III. Persivia CareSpace® Empowers Multidisciplinary Teams to Improve Care

Persivia's AI-driven integrated platform, CareSpace®, allows Multidisciplinary team of providers, care managers, social workers, pharmacists to come together with a patient in the center. CareSpace® builds a dynamic longitudinal patient record by curating data from all sources and in addition identifies high-risk cohorts through predictive modelling to generate AI-driven insights and alerts. This helps care managers take the right action at the right time and provides them the true clinical picture of the patient to reduce the risk of readmission after a patient is discharged.

IV. Overview of the Healthy Transitions Program: A Right Intervention goes a long way:

The Healthy Transitions Program focused on taking a patient-centered care approach with the power of CareSpace® to ensure that patients adhere to care instructions after being discharged.

a. Real-Time Insights & Identification of High-Risk Patients

The CareSpace® platform empowered skilled care managers to look at population health data and draw real-time patient information like Admission, discharge, and transfer (ADT) data, medical conditions, risk scores, and medications details to gain insight into the patients' health status and provide effective interventions and outreach.

b. Post-Discharge Outreach

The care managers reached out to patients within two days of discharge to ensure they are following their care plan, taking their medications, attending follow-up appointments, and connected them with their primary care provider if necessary. Care managers added notes to patient records in the CareSpace® platform to document their interactions with the patients and keep the record updated.

PROGRAM AT-A-GLANCE

GOAL: Reduce hospital readmissions and improve care.

PARTNERSHIP MODEL: HCA Florida Oak Hill Hospital engaged Persivia to leverage the power of CareSpace® platform and enable a multidisciplinary team with a dedicated Care Manager to support in-home assessments, linkages to social services, and on-call PCP for post-discharged hospital patients.

IMPACT: **Reduced 30-day readmission by 65 percent**, from Nov 2021 to April 2022, resulting in estimated savings of more than **$19 Million** through 1282 avoided readmissions.

Moreover, the care managers addressed any non-clinical concerns like access to transportation and food-related services the patient had. Two weeks after the initial call, the care manager checked in again to ensure the patient's vitals are stable and assist with any medication barriers. The patient record was updated accordingly on the CareSpace® platform.

Mary Fontana (pseudonym), a patient who has directly benefited from our program, expressed her immense gratitude, highlighting the critical role our care manager played in her healthcare journey. With heartfelt appreciation, Mary shared her experience, stating,

> *I cannot express enough how grateful I am. Thanks to the unwavering support of my care manager, I received my medication on time. Without their assistance, I would have found myself without insulin over the weekend.*

The Results

The Healthy Transitions program was highly successful and achieved remarkable results. HCA Florida Oak Hill Hospital reported a **65% reduction in All-Cause 30-day readmission rate.** Patients received timely interventions and support, which led to improved patient outcomes and experiences. Additionally, the program's financial benefits for the hospital were significant, resulting in decreased healthcare costs and increased revenue.

> *"Our Hospital Readmission Reduction program - Healthy Transitions was a resounding success, achieving a 65% reduction in readmissions. This demonstrates the power of data, the right use of technology and our commitment to providing the best possible care for our patients. CareSpace® allowed us to gain valuable insights into our patients' health status and take timely interventions. It was a game-changer for us in terms of providing effective care coordination."*
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> Dr. Salman Mudassir, Program Director, HCA Florida Oak Hill Hospital.

This is a prime example of how hospitals can partner with Health IT companies to reduce readmissions and improve patient outcomes.

References

1.Sheehy, AM, Locke, CFS, Bonk, N, Hirsch, RL, Powell, WR. Health care policy that relies on poor measurement is ineffective: Lessons from the hospital readmissions reduction program. Health Serv Res. 2023; 58(3): 549- 553. doi:10.1111/1475-6773.14161