Collaborative Care- Bridging the Gap in Healthcare

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Unnecessary Hospital Readmissions

- The Accountable Care Act mandated that hospitals with high readmission rates would be penalized with reductions in Medicare discharge payments.
- Almost 18 % of Medicare patients are readmitted within 30 days, “Thirteen percent of the readmissions — $12 billion worth — were “potentially avoidable,” the IPPS rule states” (1)
- 45% of hospitalizations of nursing home patients could have been avoided by preventable treatment or care at a clinic. (314,000 hospitalizations, 2.6 billion in Medicare expenditures in 2005))(2)
- 1 in 5 Medicare patients discharged from a hospital are readmitted within 30 days, at a cost of 26 billion a year (3)

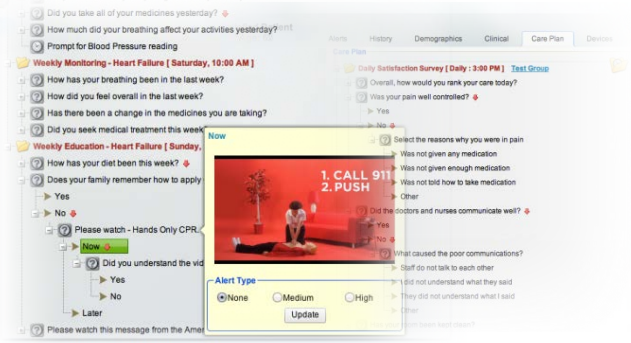
- (1) Report on Medicare Compliance, Volume 17, Number 24 • June 30, 2008
- (2) Healthcare Business News , March 15th, 2012
- (3) CMS website http://www.innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html?itemid=CMS1239313

Unnecessary Hospital Readmissions

- Law went into effect Oct 1, 2012
- “About two-thirds of the hospitals serving Medicare patients, or some 2,200 facilities, will be hit with penalties averaging around $125,000 per facility this coming year, according to government estimates” (1).
- Unnecessary hospital readmissions result for many reasons, notably poor discharge planning, insufficient post acute care support and poor patient compliance.

- (1) RICARDO ALONSO-ZALDIVAR | October 1, 2012 04:27 AM EST | Associated Press

Home Telehealth- Remote Monitoring



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Care Coordination, Case Management and Coaching (Patient Centered Medical Home)

- “Care Transitions Intervention” model designed by Eric Coleman, M.D.:
- Nurse coach helps patient transition back
- Case Managment
- Five contacts: Hospital, Home, 3 calls
- Four pillars:
  - Medication (review)
  - Patient Centered Record
  - Follow up with primary and specialist
  - Knowledge of red flags: signs getting worse and how to respond

(1) Report on Medicare Compliance, Volume 17, Number 24 • June 30, 2008

Coaching

- Results (1)
- 14 days after discharge:
  - 8% of coached patients were readmitted, compared with 17% of uncoached patients.
- 30 days after discharge:
  - 13% of coached patients were readmitted, compared with 20% of uncoached patients.
- 60 days after discharge:
  - 15% of coached patients were readmitted, compared with 29% of uncoached patients.

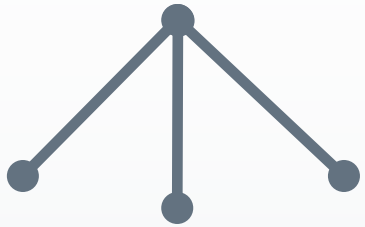
(1) Report on Medicare Compliance, Volume 17, Number 24 • June 30, 2008

Healthcare
Collaboration

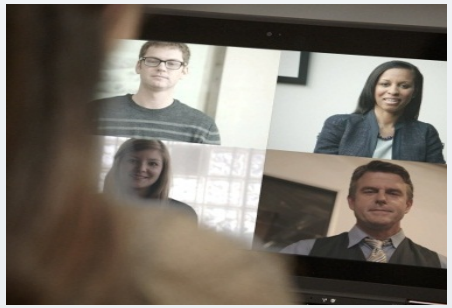
ONE-TO-ONE

- Patient to practitioner
- Peer to peer
- Patient to family member

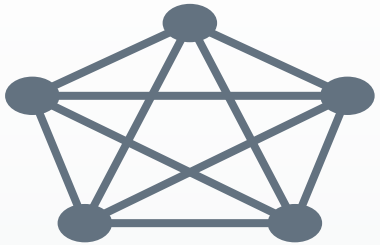
ONE-TO-MANY



- Community health education
- Specialist to many patients

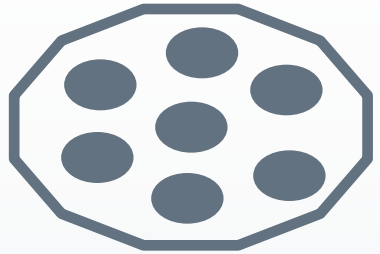


MANY-TO-MANY



- ACO meetings
- Community center to commuinty center
- Hospital to hospital

AD-HOC



- Virtual HC teams
- HC workshops
- Follow up calls
- Transition support

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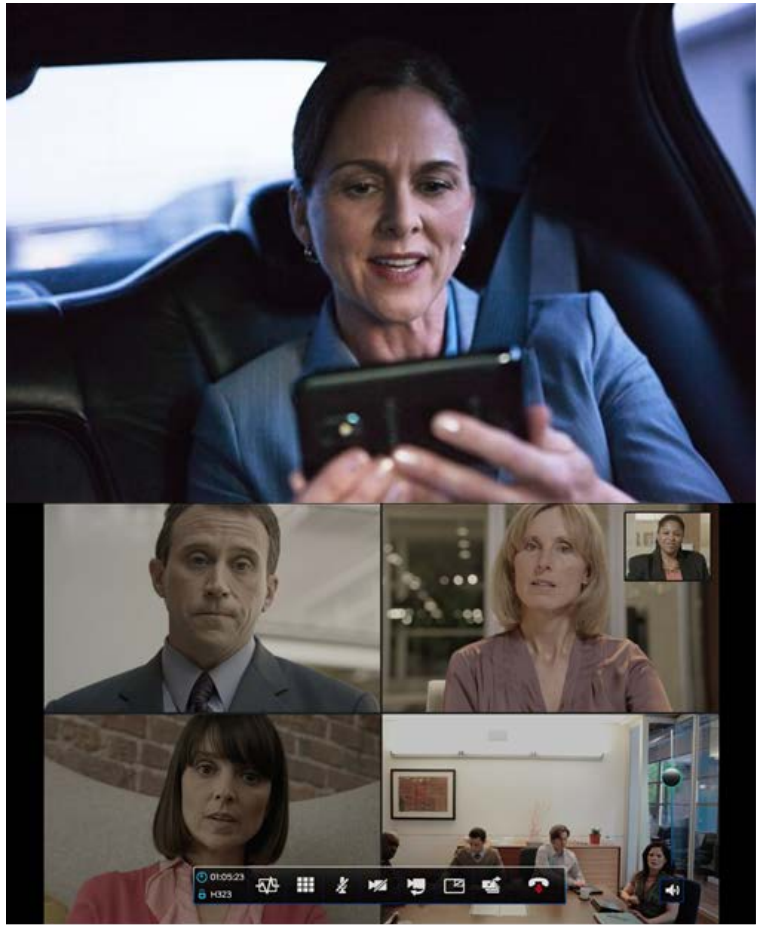
Wellness and Prevention- Predictive Analytics

- Prevention and Wellness Programs
  - Live multipoint, interactive peer to peer educational sessions
  - Stored version available



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Community/Patient Education

- Disease Management
  - Diabetes
  - CHF
  - COPD
  - Mental Health
- Nutritional Education
  - Childhood Obesity
  - BP, HTN
- Public Service Updates
  - Cardiac and Pulmonary Education
- Show PC content!

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Case Management and Discharge Planning

- Collaborate over live multipoint video bringing the patient, family, practitioners, and case managers together for better planning

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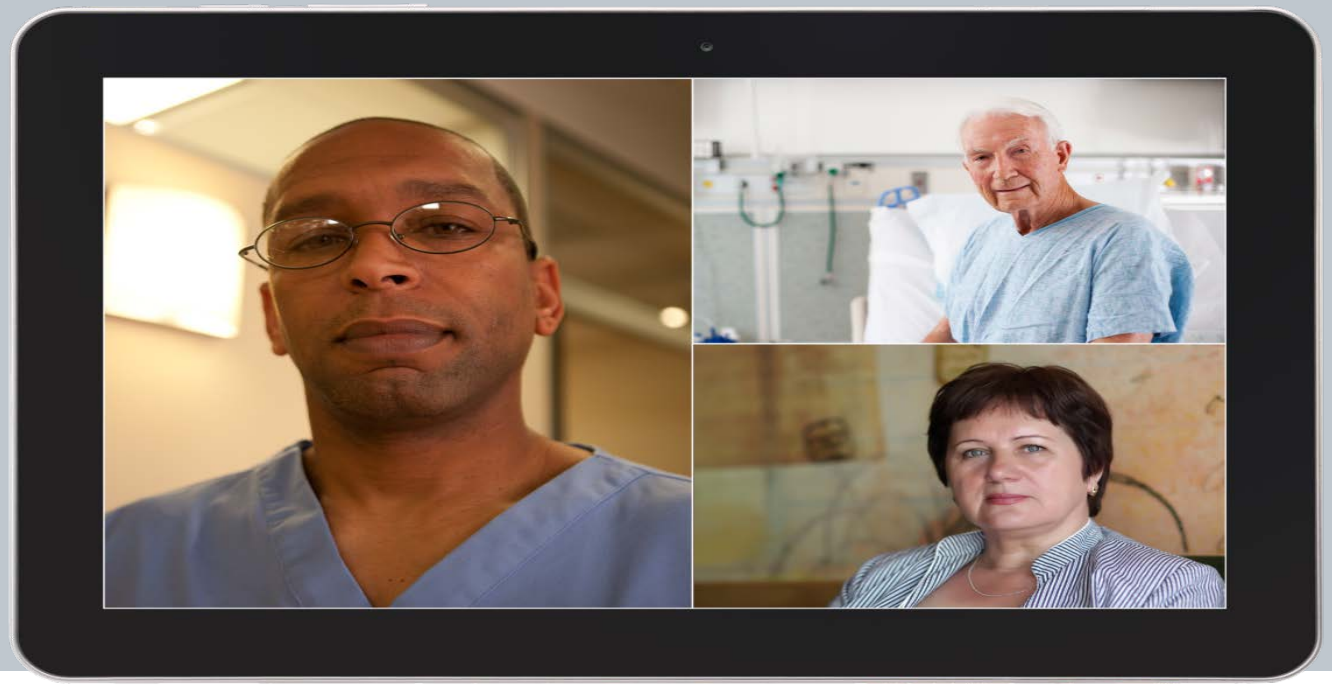
Case Management and Discharge Planning

- Support the patient once home with accessible live educational video sessions, live follow up visits with their case manager and primary care practitioner as well as access to pre-recorded videos to support and guide them toward wellness



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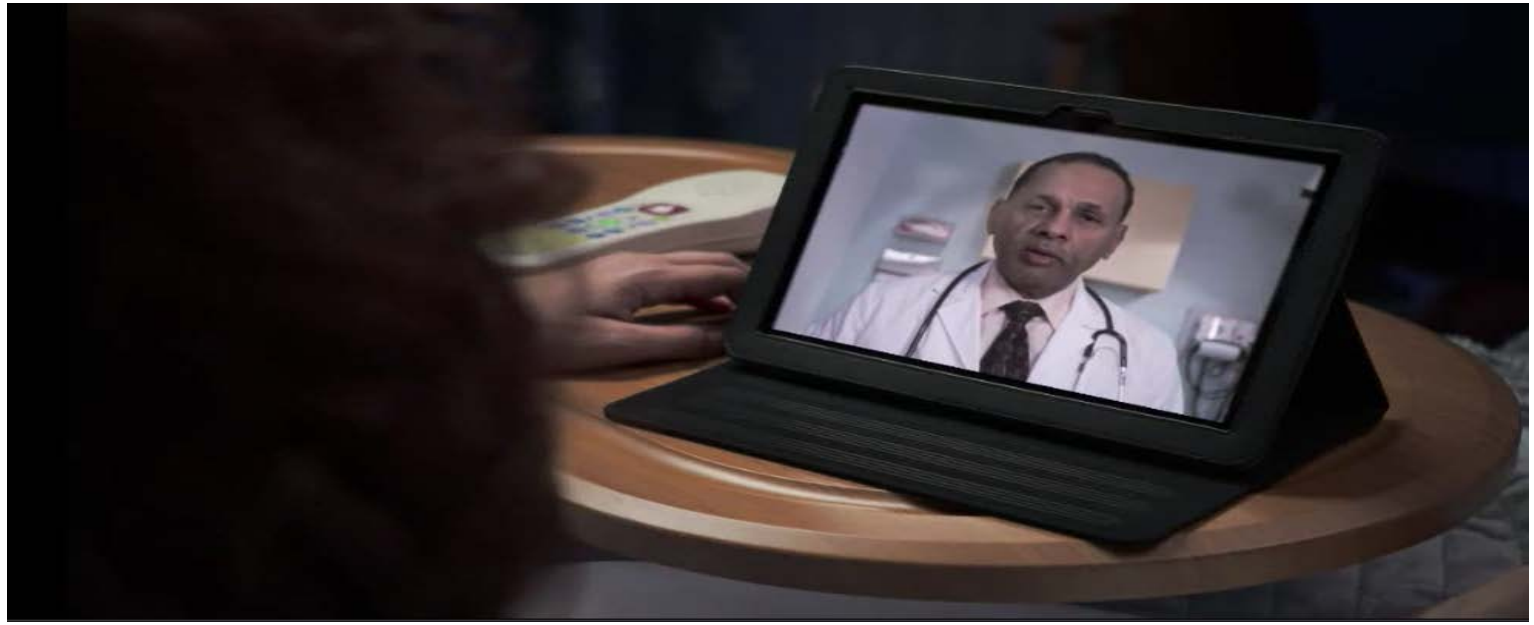
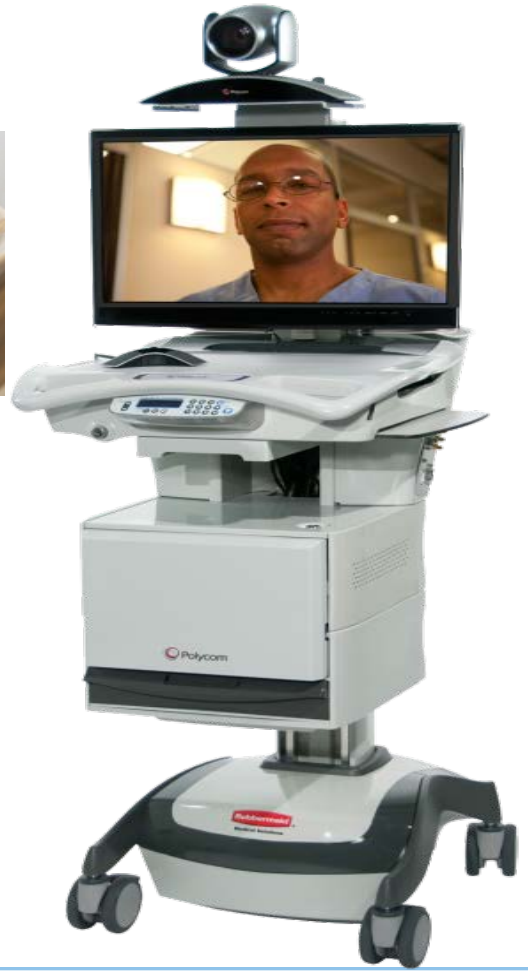
Case Management and Discharge Planning

- Create a discharge plan that is available not only in written form, but which also includes recorded video instructions for post acute care, and information that supports a successful transition to long term care or home



Telemedicine Solutions: How and why?

Patient Side



Physician/Specialist Side

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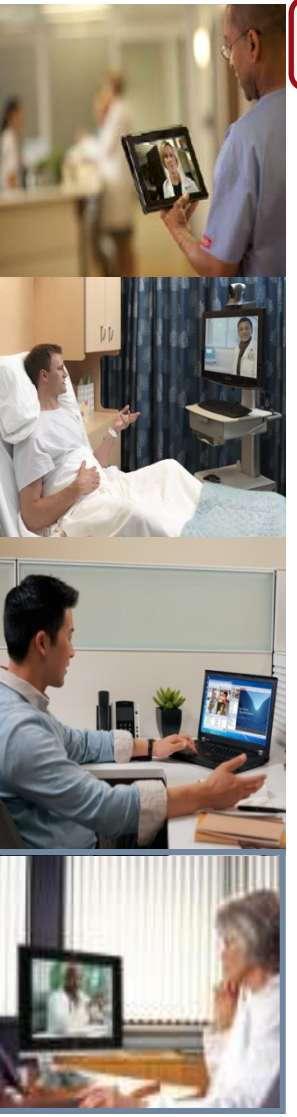
Solution: Collaborative Video for Healthcare



Home | Hospital | Clinic | Long Term Care

Video Care Coordination

Family Video Support

One-to-one Video Practitioner Consultation

Video Health Coaching

Multipoint Video Education

Patient

Recorded Video Education

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Collaborative Video for Healthcare

RealPresence CloudAXIS

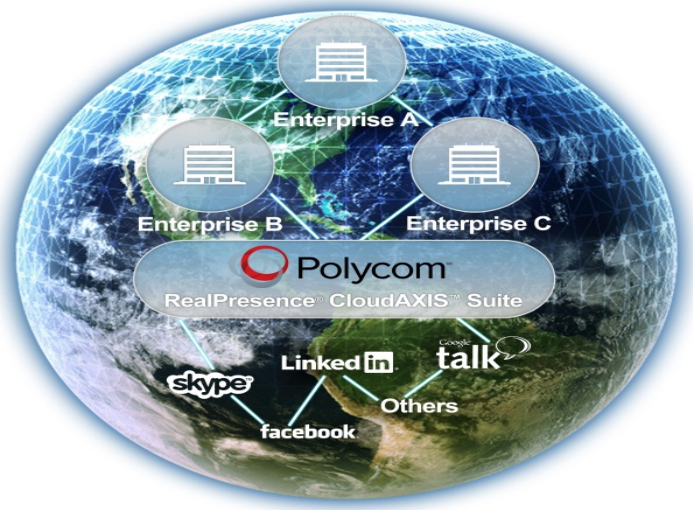
PACS

EHR

IT

Remote Medical Specialists

Mobile



Professional Grade Video Content Management

Telepresence

Physicians Office

Desktop

Community Health Center

Practitioner Cart

Rural Treatment Center

Room based

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Summary:

- Unnecessary re-hospitalizations can be avoided with better care coordination and remote technologies.
- Predictive analytics coupled with prevention and wellness programs can now take advantage of collaborative tools for wide distribution to increase an overall populations health.
- Collaborative video solutions enable continuous patient centered care, and assist in reducing unnecessary re-hospitalizations and increase the on-going quality of care
- Telemedicine provides an efficient way to increase access points

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Thank You