Challenges and opportunities facing digital health innovation for vulnerable populations

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Major challenges and opportunities

1. Too much focus on doctors and hospitals
2. Moving target of reimbursement
3. Evidence gap for emerging innovations
What We Do

Smart surveys that accurately predict hospitalizations using observations of non-clinical workers

Survey library
- Expert-informed,
- Psychometrically validated,
- Field tested

Risk prediction algorithms
- Evidence-based,
- Statistically significant,
- Inputs: non-clinical observations

Analytics
- Must-have data with most granular leading indicators in the market

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1. Savings are in the community not in the hospitals

Clinician-staffed approaches to reduce admissions are not sustainable

Trends contributing to lack of sustainability

- Current risk prediction tools leave blind spot between doctor visits
- Inability to target interventions to a specific patient
- Quality measurement only limited to quarterly reporting
- Physician and nursing workforce shortage

Example: Reimbursement & salaries for 30 min of chronic care management (CCM)
Customers pay for and underutilize 5 million non-clinical workers in attempting to reduce $250 BILLION in avoidable costs.
Our Solution

Digitizing the “hunch” of non-clinical workers to detect early decline

Care at Hand communication process:

Non-clinical worker completes survey

Nurse Care Manager receives alerts

- Emergency Dept/Admission ($ $ $ $) (Cost to Payer)
- Primary Care Provider Visit ($ $ $) (Cost to Payer)
- Home Visit by Nurse ($ $) (Cost to Payer)
- Call into Home by Care Coordinator ($) (Cost to Payer)
2. Using QI to hit the moving target of reimbursement

Analytics beyond the smart surveys to support QI

Continuous Risk Prediction sheds light on admissions in blind spot between doctor visits

Quality measurement data offers must-have, most granular leading indicators in the market

Hotspotting enables precisely targeted, more cost-effective, patient-centered interventions

Workforce measurement and motivation eliminates high turnover rates
3. Closing evidence-gap for emerging innovations

Once rapid-cycle testing show traction, explore generalizability through research.

Demonstrating new models

<table>
<thead>
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<th>Readmission Timeframe</th>
<th>Mild</th>
<th>Moderate</th>
<th>High</th>
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</tbody>
</table>

Showing results

- 39.6% 30 day readmissions among at-risk patients eligible for health coach

- $109 savings per member per month


Ostrovsky A. Improving Community-Based Care Transitions with Technology – Decreasing cost and improving outcomes. HIMSS. Orlando, Fl. 2014.


Care at Hand

Analytics to make aging more human and less health care

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