Using mobile technology to support quality improvement, interoperability, and sustainability for community based organizations

Andrey Ostrovsky, MD
CEO | Co-Founder | Care at Hand
andrey@careathand.com
ACA forcing a shift toward less expensive care delivery models
Data consumption and communication depend on context

Who are the costliest patients?

Which neighborhoods have the highest readmission rates due to poor access to transportation?

Is the community-based transition program more cost-effective than our hospital-based program?

What day of the week is the safest to discharge someone to their home?

Does this patient need to be seen by a nurse or a community health worker today?
User experience - Community can’t wait for standards to evolve
Non-clinical workers reduce costs, predict readmissions

Estimated Net Savings

<table>
<thead>
<tr>
<th>Total Cost of Care Coordination</th>
<th>Total Technology + Training Cost</th>
<th>Savings from prevented admissions</th>
<th>Net Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>$700,000</td>
<td>$600,000</td>
<td>$500,000</td>
<td>$400,000</td>
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</tbody>
</table>

Care at Hand Risk points and Readmission Rate

AHRQ. Service Delivery Innovation: Community-Based Health Coaches and Care Coordinators Reduce Readmissions Using Information Technology To Identify and Support At-Risk Medicare Patients After Discharge. Rockville, MD. 2014.
It's not about QI or data standards…

…it’s about the community and aging in place
Thank you!

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