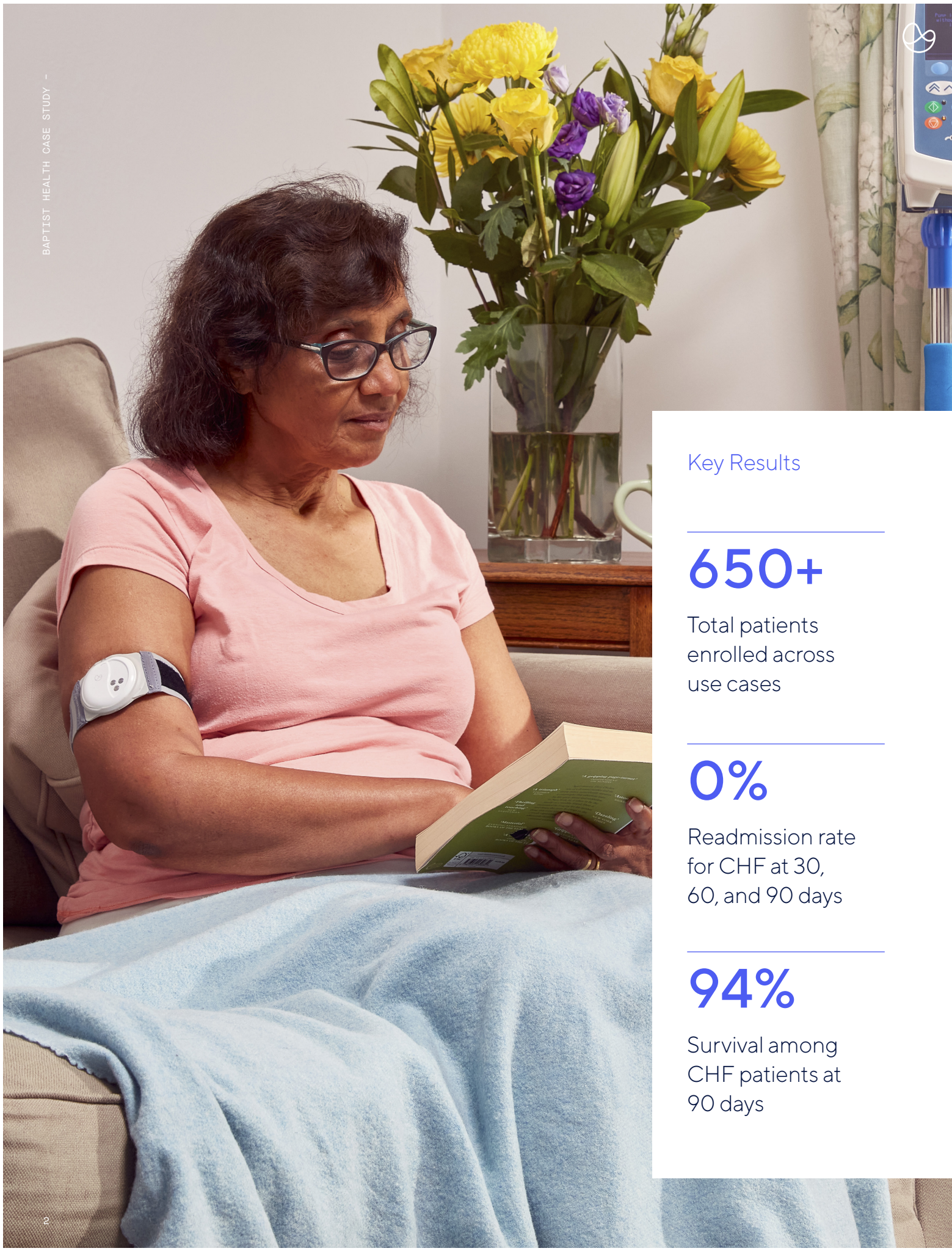


Care-at-home program keeps high-risk heart failure patients out of the hospital

How Baptist Health improved clinical outcomes and delivered an excellent patient experience.



Key Results

650+

Total patients
enrolled across
use cases

0%

Readmission rate
for CHF at 30,
60, and 90 days

94%

Survival among
CHF patients at
90 days



At a glance: Baptist Health

Baptist Health, headquartered in Louisville, KY, is the largest non-for-profit health system in the state.

Baptist Health operates nine hospitals and a broad network of physician practices, urgent care clinics, and outpatient facilities across Kentucky, Illinois, Indiana and Tennessee.

Baptist Health's Home Care team works with chronically-ill or post-acute patients to deliver care at home.



Challenges



High rates of heart failure in the area

11.4% of Medicare population in KY has CHF.



Deliver personalized CHF care

New heart failure clinics needed to lower costs and improve outcomes for CHF patients.



Low connectivity and tech literacy

Many patients are in rural and semi-rural settings, and face some challenges with digital technology.



Support home care team

Home care needed to manage high-risk patients during Covid-19 surges.



Solution

Baptist Health needed a care-at-home solution that could provide significant support as they established their program, easily adapt to different clinical use cases, and scale across the enterprise as they matured.

- Daytime vitals monitoring with night time alarms for high-risk patients
- Lower-risk patients submit daily blood pressure and weight readings
- Telehealth visits as needed through the app
- Clinical Command Center helped establish program with patient engagement and triage support for the home care team
- Data and workflows integrated with Epic EHR

Clinical Command Center

Tablet

Home hub

Current Health Wearable

BP Cuff

Weight Scale

Clinical Dashboard

Study Alpha

Admit

Home

Activity

Calendar

Management

Account

Search for patient

All **Watched** **hospital at home** **not Hypertension** **Sorted by priority**

| | | | | | | |
|---|-----|------|-------------|---------------|-------|-----|
| Richard Gallagher | 15% | High | Dr. Moodley | St. Mary's | COPD | CHF |
| Sepsis Risk started 10:01 Low battery started 09:27 | | | | | | |
| Judy Plaidstow | 15% | High | Dr. Moodley | St. Mary's | COPD | |
| Low SpO2 started 9:30 | | | | | | |
| Alain Boghossian | -- | Low | Dr. Carter | Eugenio Litta | Empty | |
| Ava Long | -- | Low | Dr. Zhang | St. Mary's | Empty | |
| Benjamin Scott | 82% | Low | Dr. Carter | Eugenio Litta | Empty | |
| Bukayo Sako | 79% | Low | Dr. Zhang | Eugenio Litta | CHF | |
| Caitlyn Li | 84% | Low | Dr. Zhang | St. Mary's | COPD | |
| Chirag Shah | 82% | Low | Dr. Zhang | Eugenio Litta | Empty | |
| Christine West | 79% | Low | Dr. Carter | Eugenio Litta | Empty | |



“Like a lot of systems, we’re limited in our resources in IT. So, when we were finding a solution, I wanted something that we could use in a lot of different clinical scenarios, across urban and rural areas, and with many different patient populations.”

Brett Oliver
CMIO, Baptist Health



Results

650+

Total patients enrolled across use cases

Launching their care-at-home program just weeks before the first Covid-19 surge, Baptist Health was able to accommodate the sudden demand for care. Then refocused to innovate experiences for CHF and COPD patients.

0%

Readmission rate for CHF at 30, 60, and 90 days

An adaptable approach to patient monitoring and patient engagement tools allows care teams to identify exacerbations earlier, and prevent hospitalization—a significant accomplishment compared to the expected 18% readmission rate. After 180 days, the readmission rate was still only 2.4%.

94%

Survival among CHF patients at 90 days

Compared to 82% national average, the heart failure patients who participated in the care-at-home program were more likely to survive 90 days after an admission or outpatient IV diuretics for ADHF.

Sample Patient Journey:
Heart Failure Pathway

ED & Hospitalisation,
or clinic

Referred to heart
failure clinic

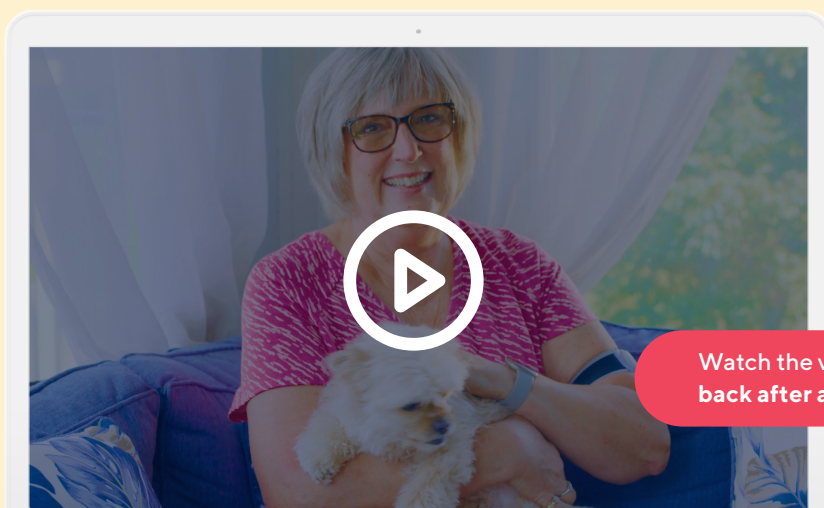
Enrolled in
Current Health

Patient discharged to
self manage

After 3–6 months of
positive trends and
hospital avoidance

Regular engagement
and education by clinic

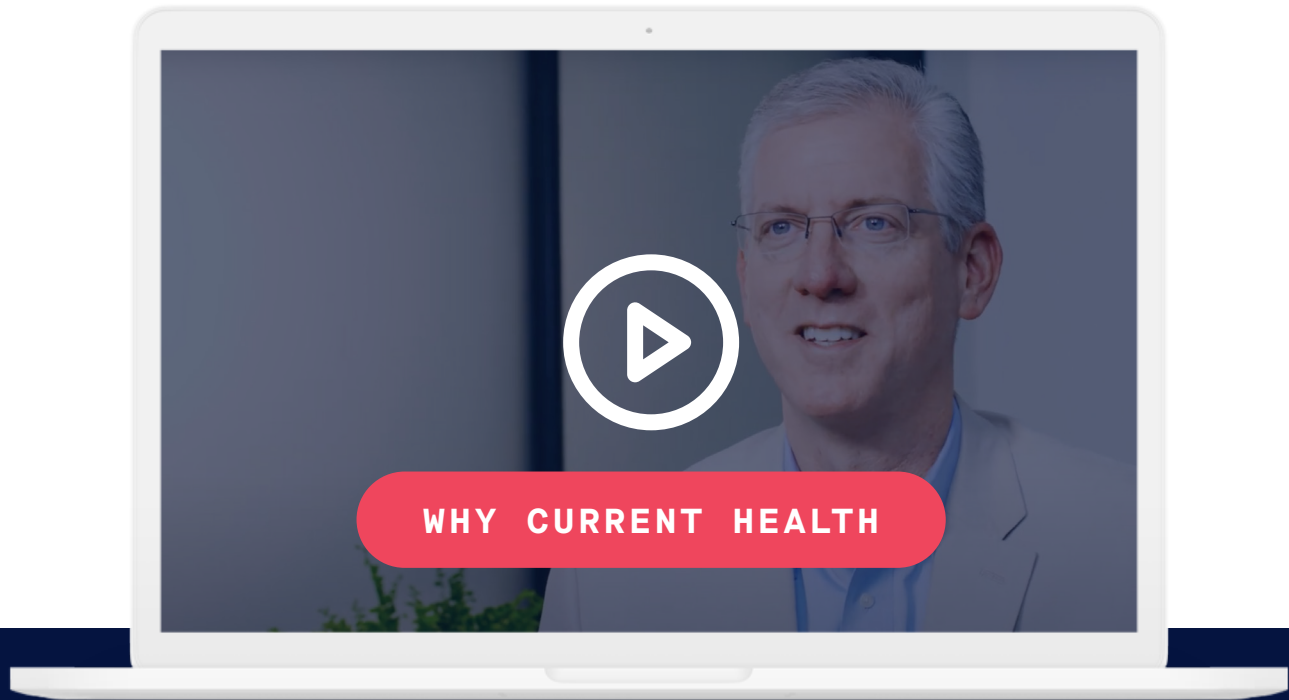
Daily monitoring of
vitals



Watch the video: **How Jenny got her life back after a heart failure diagnosis**



Why Current Health?



“We know you do better at home. Changing care models, lower costs, and patient satisfaction—that's going to allow us to do more things from home in a safe, high quality, effective way. Why would we not be excited about that?”

Brett Oliver, CMIO, Baptist Health



About Current Health

Current Health enables healthcare organizations to deliver end-to-end services in the home, expanding access to high-quality, patient-centric care at a lower cost.

Our enterprise care-at-home platform can be tailored to the needs of the individual patient, supporting the full range of clinical use cases and patient acuity levels. We provide an interoperable platform that combines state of the art technology - including continuous and non-continuous monitoring, telehealth, patient engagement tools - to provide a clear window into the patient's home and enable care teams to intervene with the right patient at the right time. To help our partners scale, we provide full inventory & logistics management, our Clinical Command Center, and third-party in-home services that support the full spectrum of care delivery at home.

For more information, visit currenthealth.com.



For more information
please visit our website:
currenthealth.com

