Staying Connected AFTER You Leave the Hospital
OSF HealthCare Newsroom
Shelli Dankoff – Media Relations Program Manager

It's a pretty good bet that nobody *wants* to be admitted to the hospital unless absolutely necessary, and once discharged they don't want to be readmitted.

The reality across the U.S. is one in five Medicare enrollees is readmitted to the hospital within 30 days, and up to 75% of these readmissions are preventable according to information from the American Nurses Association. Such readmissions cost the U.S. health care system billions of dollars each year.

When clinicians discharge patients from the emergency room or a stay in the hospital, each patient is given a care plan to ensure they won't have to be readmitted. While some can follow paper instructions at home, others may need a reminder or other follow-up to keep them on track.

In an effort to reduce readmissions and to improve the health of patients, OSF HealthCare has implemented a variety of digital tools to help, the latest of which allows patients to stay engaged in their care through phone calls and text messages. It's called Epharmix.

SOT Rob Jennetten, Director, Innovation Partnerships for OSF Innovation
(Epharmix uses text messages and phone calls to help us monitor patients in a variety of ways so we're able to keep track of them in between their traditional primary care visit so we can keep track of blood sugars and weight and different activities of daily living with just simply phone calls and text messages. :23)

Epharmix currently tracks diabetes and patients with heart failure from a pilot area in the I-80 region of Illinois.

When called, the person enters data they should already be collecting like weight or blood sugars. Based on the entry, there may be a simple follow up asking such things as if they have eaten to give context to their answer. Regardless, the whole process should take mere minutes or less.

OSF HealthCare virtual coaches monitor the information and notify the patient's primary care office if their numbers are abnormal so the patient can be followed-up with, *before* they land back in the hospital or emergency room.

SOT Rob Jennetten, Director, Innovation Partnerships for OSF Innovation
(The clinicians really like it because it's a fairly light touch and they're not getting pinged on a lot of this data unless it's falling outside of some established parameters - so if the patient's blood sugars continue to get too high or too low then the clinician can be notified through our telehealth department.

The clinician can make a decision as to how they want to intervene with the patient or exactly what they want to do whether that be a phone call or a follow up visit, their clinical decision still remains. :34)

OSF HealthCare successfully piloted the use of Epharmix on about 300 patients in Ottawa, Illinois with 70 percent enrollment and 78 percent of patients staying engaged with the tool. The next step is to implement the digital platform for every home care patient within the organization, impacting about 3,000 people, with an ultimate goal of having a broader, positive impact, in an effort to keep patients – and their communities – healthier.

Learn more about how Epharmix works here.