CipherHealth

Supporting Patients Through Countless Post-Care Scenarios

Post-care communication plays a critical role in a patient's recovery, ensuring they stay supported and on track after discharge. Yet, many health systems rely on manual processes, making it harder for care teams to balance follow-ups with daily tasks. This can lead to missed connections and higher readmission rates, which average 15% across health systems[1].

CipherHealth empowers care teams to identify patients who need extra support, resolve issues quickly, and reduce readmissions. By staying connected, health systems create a supportive recovery environment, improve outcomes, and boost HCAHPS scores.

High-Risk Readmissions Follow-Up

Middlesex Hospital, a 300-bed community hospital in Middletown, CT, used CipherHealth's Post-Discharge Communications across their inpatient, CHF(Chronic heart failure), and COPD(Chronic obstructive pulmonary disease) programs to provide targeted post-discharge support. By automating outreach, they addressed key challenges like understanding discharge instructions and securing transportation for follow-up care. This focused approach empowered care teams to intervene early, resulting in fewer readmissions, lower costs, and improved patient outcomes.

Key Results

120
readmissions prevented over two years through automated outreach

72.9%
patient engagement rate with follow-up calls

3.4%
lower readmissions occurred in CHF patients who engaged with an Outreach call

9.9%
lower readmissions occurred in COPD patients who engaged with an Outreach call

1. https://www.definitivehc.com/resources/healthcare-insights/average-hospital-readmission-state

Post Discharge Follow-Up

Intermountain Healthcare, serving the Salt Lake City area and beyond with 33 hospitals and over 400 clinics, prioritized preventing readmissions by partnering with CipherHealth and launching a Post-Discharge Follow-Up program. This initiative ensures patients understand their discharge instructions, have access to medications, and can address any questions. Using a centralized callback team, they've achieved impressive 20 minute callback times and streamlined documentation through integration with the EHR. The program has significantly improved patient satisfaction, reduced readmissions, and delivered substantial financial benefits—saving nearly $15 million while costing far less to operate.

Key Results

6,406
patients contacted

43%
of patients required intervention

84%
of patients answered outreach calls

Department Specific Follow-Up

A large academic medical center in Los Angeles, implemented CipherOutreach in their OB unit to enhance communication with new mothers. By deploying a customized OB program, they were able to quickly identify and resolve issues, leading to significant improvements in patient satisfaction and HCAHPS scores.

Key Results

2–17%
improvement in all 7 HCAHPS domains:

17%
increase in Responsiveness of Staff

5%
increase in Hospital Rating

14%
increase in Hospital Environment

4%
increase in Communication with Nurses

5%
increase in Communication About Meds

3%
increase in Discharge Information

2%
increase in Communication with Doctors

Home Care Communications

Penn Medicine Home Health aimed to monitor the well-being of home health patients between in-home visits, ensuring timely support for those in need. They implemented the Wellness Call program using CipherOutreach to track changes in patients' clinical conditions and address questions on non-visit days. By identifying and responding to flagged concerns, the program provided consistent, personalized support and strengthened patient connections to care.

Key Results

233k
patient calls made in 1 year

15%
of calls flagged with issues

67%
of patients reached

99%
of issues resolved within a day