Volume 6, Number 6 June 2017

Readmissions NEWS

CHF Hospital Readmissions Reduced Significantly Among Nursing Home Patients Using Remote Monitoring Protocol

Doctors at NYC's The Allure Group developed remote monitoring procedures that improve patient outcomes and keep costs down

by Jeffrey Bander, M.D.

Complications from congestive heart failure is one of the leading causes of hospital admissions in the United States. It is also one of the most expensive – both for patients and critical care providers. In 2013, congestive heart failure was the sixth-most expensive condition treated in U.S. hospitals and the third-most expensive condition billed to Medicare. Additionally, the risk-standardized readmission rate (RSRR) after an index hospitalization for heart failure is 24.5 percent, according to a 2010 CMS study. In response to the high risk of readmissions and to increase provider accountability, CMS has begun to reduce reimbursements to hospitals with high RSRR.

Many strategies have been employed to reduce readmission rates including a variety of transitional care interventions such as clinic based, home visit, structured telephone support and remote telemonitoring programs. A 2009 Cochrane review found that "case-management" interventions (essentially, home-visiting programs and telephone support) reduced all-cause mortality at 12 months (but not at six months) and reduced heart failure-specific readmissions at six months and one year.

(continued on page 2)

Readmissions Decreased For Some Conditions After Vertical Integration

by Sílvia Lopes, PhD

Why link readmissions with vertical integration?

The integration of providers of different levels of care, e.g. acute and primary care, to promote comprehensive care across the life-course is usually named "vertical integration".[1] Vertical integration has been adopted by health systems worldwide as a response to the negative consequences of fragmentation of care provision.[1] Discontinuities affect mainly chronic patients receiving care from multiple providers not only at the same level of care but also at different levels during their course of illness.[2] With population ageing, the importance of chronic conditions has grown, making vertical integration even more necessary.

Vertical integration is expected to promote better transitions of care. Usual interventions to reduce readmissions include monitoring and managing symptoms after discharge, educating patients to promote self-management, and coordinating care among team members.[3]

(continued on page 3)

In This Issue