Home Health Success Strategies
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Creating Value in the Market Place by Solving Problems

The emphasis in healthcare today is on proactive, preventive and personalized care. As pressure to prevent readmissions grows, hospitals must partner with other health care providers (skilled nursing facilities, rehabilitation centers, & home health agencies) in a committed and collaborative effort to reduce and/or prevent re-hospitalizations.

Effective October 1, 2013, hospital readmissions above certain thresholds will be subject to payment penalties. Readmission is defined as admission to an acute care facility that occurs within 30 days of discharge. The initial focus will be on readmissions for congestive heart failure (CHF), acute myocardial infarction (AMI) and pneumonia.

Reliant Home Health, a San Antonio based home health agency, has been successful in reducing re-hospitalization with specific CHF and chronic obstructive pulmonary disorder (COPD) disease management programs. According to an Outcome Concepts (Seattle 2006) study, approximately 41% of patient re-hospitalizations occur during the first three weeks following hospital discharge. Additionally, a study by the Schneider Institutes for Health Policy at Brandeis University (2009) found the U.S. national 30-day re-admission rate for CHF is 24.5%.

[Side Bar:]
Reliant Home Health's re-hospitalization rate for the period of January through August 2011 has been less than 10%. These results provide a significant impact for both the patients and the hospitals we serve.

Reliant Home Health's Successful Re-admission Reduction Program

- Vigorous assessment: comprehensive initial assessment by Reliant clinician & identification of high-risk patients
- Coordination: coordinated clinical hand off from hospital case manager to Reliant clinician
- Timely notice: to Primary Care Physician (PCP) of patient's condition
- Patient follow-up: with PCP within two weeks or less
- Front loading: nursing and therapy visits is critical as the initial days and weeks after release from a hospital have the biggest impact on minimizing re-hospitalizations

- Point of care technology: allows all staff real-time, constantly updated patient information
- Patient education: with pre-programmed disease management teaching templates that are used by field clinicians for patient education. These also mirror patient education disease booklets that are left with the patient in the home.
- Accurate patient weights: confirmation that a scale is available and the patient is educated to assure accurate patient weights
- Medication review: including a detailed review with the patient of their medications along with providing an easy-to-use medication pill box with large print for easy recognition to increase medication compliance
- Zone instruction: red, yellow, green zone instruction for patient symptom management and appropriate first response to symptom exacerbations
- Results tracking: bi-monthly re-hospitalization meetings tracking patient's re-hospitalization data

Building an alliance with the physician, hospital and other health care providers is an important component of providing proactive, preventive and personalized care for patients. The Avalere Health report (May 2009) supports the conclusion that ***home healthcare saves more than it costs***. Home health interventions for patients with chronic illnesses are associated with lower Medicare spending and reduced patient re-hospitalization. These collaborative efforts can help solve the re-hospitalization problem which translates to a win-win strategy for everyone.

For more information on how Reliant Home Health can help tackle your healthcare related problems call Judy Wilson, RN, BSN, EVP of Business Development 210-558-9606 or email at judy@relianthomehealth.com