eHealth@Home: Avoiding Readmissions for Heart Failure Patients

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eHealth@Home: Avoiding Readmissions for Heart Failure Patients

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Results

50.97% readmission decrease for enrolled patients as compared to 12 months prior to enrollment.

Background

1 in 4 HF patients are readmitted within 30 days of discharge
2 in 4 HF patients are readmitted within 6 months
eHealth@Home started as a small grant funded nurse led pilot in 2016 to decrease HF readmission by providing proactive in-home care and telemedicine to qualified patients. To date, the program has served over 700 patients.

Intervention

Patients meeting program criteria voluntarily enrolled in eHealth indefinitely. The patient’s team consists of an RN, NP and Community Health Worker. Needs identify an acuity category determining how often team checks in on them, either by telemedicine or home visit. Patients receive education, med reconciliation, care coordination and symptom management. A 24/7 number to call is provided.

Evaluation

Retrospective analysis compared hospital utilization and readmissions data of eHealth patients (N: 697) pre vs post enrollment.

Pre period defined as 12 months prior to enrollment; post period time patient was active in the program

Readmission defined as hospitalization occurring within 30-day period following discharge.

Conclusion

Interventions performed by the eHealth@Home team led to a marked decrease in readmissions and other acute care utilization. eHealth has become an important part of the RRH’s initiative to decrease HF readmissions. This program highlights the importance of a consistent proactive approach to caring for the needs of a highly complex patient population.

Future Considerations

Conduct a randomized controlled trial with newly identified HF patients
Conduct a study measuring patient’s perceived benefits of the program and perceived quality of life
Adapt program for use in other chronic disease populations

References