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New Study Quantifies Value of Home Care Programs In Reducing Hospital Readmissions and Costs

As hospitals look to reduce their rates of readmission and avoid consequent Medicare penalties, a new study by Simione Healthcare Consultants profiles five innovative programs developed by home care agencies to substantially lessen the need for patients to return to the hospital for treatment.

The study, prepared by Simione in partnership with the Home Care Association of New York State (HCA), specifically found that innovative care-transitions programs for a defined group of high-risk patients at just five of the state's approximately 230 Medicare-certified home health agencies saved **\$1.2 million** in averted hospital expenses annually by reducing the 30-day readmission rate, a key quality metric in federal health reform efforts.

To download the complete study – *Innovative Home Care Models: Five Profiles in Cost Savings, Care Transitions* – visit <http://www.hca-nys.org/SimioneInnovativeHomeCareReport.pdf>.

Most of the home care programs studied in the study used home telehealth, an innovative technology that allows for remote monitoring of a patient's health to prevent a health care crisis requiring higher levels of care. More complex types of home telehealth devices have video capabilities that allow for visual contact with the patient and/or remote biometric measurements, such as weight, blood pressure, pulse, temperature, pulse oximetry, electrocardiogram and blood glucose. Other devices can also include medication reminders and motion and position detectors. Devices are linked to home care agency clinical case managers via telephone lines (wired and wireless), satellite, and the internet.

The specific home care programs and results featured in the study include:

- **Oneonta-based At Home Care, Inc.**'s telehealth program, which has achieved a 16% hospital readmission rate for patients monitored using telehealth compared to a 23% readmission rate for all patients.
- **Patchogue-based Brookhaven Memorial Hospital Home Health**'s telehealth program for patients with chronic obstructive pulmonary disease (COPD) and pneumonia, which has resulted in a 7% and a 0% readmission rate for COPD and pneumonia patients monitored through telehealth, respectively, compared to a 23% readmission rate for all COPD patients and a 26% readmission rate for all pneumonia patients at Brookhaven.

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- **Buffalo-based Catholic Health Home Care’s** multidisciplinary transitions-in-care program, which has yielded cost savings for managed care payers and the participating hospital while reducing the affiliated hospital’s 30-day readmission rate. Participants in the care-transitions program experienced a 5.2% readmission rate compared to a 9.6% readmission rate for non-participants.
- **New York City-based MJHS’s** Heart Failure Program, which is the first program of its kind in the nation to receive accreditation from the Joint Commission and incorporates a multidisciplinary approach designed with standards of care, medication management and clinical guidelines to define best practices. Upon introducing the program, MJHS has reduced its readmission rate from 25.7% to 21.7%.
- **Albany-based St. Peter’s Hospital Home Care’s** hybrid transitions Heart Failure Program, which utilized a telehealth component that has achieved a reduced readmission rate of 10% for telehealth patients compared with a readmission rate of 16% for patients who did not have telehealth.

Hospital Cost Savings Due to Decreased Readmissions						
Agency Name	Patient Criteria	Number of Patients in Program	Readmit Rate of Patients in Program	Readmit Rate of Non-Program Patients	Difference	Total Annual Savings ¹
At Home Care, Inc.	Heart Failure; onset Diabetes; COPD; onset Atrial Fib.	900	16%	23%	7%	\$466,200
Brookhaven Home Health Agency	COPD; pneumonia	181 92	7% 0%	23% 26%	19% 26%	\$254,486 \$177,008
Catholic Health Home Care	TARGET Assessment	1789	5.2%	9.6%	4.4%	\$256,898
Metro Jewish Health System Home care	Heart Failure	300	21.7%	25.7%	4%	\$88,800
St. Peter’s Home Care	Heart Failure	213	10%	16.5%	6.5%	\$102,453
Total Annual Savings of All Projects						\$1,234,845

NOTE: Data is self-reported and variables are not controlled between agencies.

¹ Savings were calculated based on MedPAC’s estimation of the average Medicare hospital readmission cost of \$7,400; use of NY-actual Medicare readmission cost would show even greater savings.

“As demonstrated in this report, home care agencies are implementing innovative care models with promising outcomes of enormous interest to hospital partners and policymakers,” the report states. “The results – specifically in reduced hospital readmission rates – underscore home care’s value as a contributor to the future of health care.”

“Home care agencies are already drivers of cost savings for preventable hospital admissions; the findings of this study seek only to identify areas of *additional* cost-savings attributable to specific program innovations delivered to discrete patient populations,” state the report authors Betty L. Gordon, Principal; Laura Gramenelles, Director; and Kristy Wright, Director, at Simone.

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Hospital readmissions are a major focus of federal policy changes because readmissions contribute disproportionately to health care costs. A 2004 study published in the New England Journal of Medicine found that one in five Medicare patients was re-admitted to the hospital within 30 days of discharge, costing Medicare approximately \$17.4 billion.

The fact that the vast majority of these readmissions may be preventable – up to 76% of all readmissions, according to Medicare Payment Advisory Commission estimates – has prompted federal policymakers to view hospital readmissions as a significant area for cost savings, especially by aiming care coordination efforts at select diagnoses that are the most likely contributors to a hospital readmission. As a result, several provisions within the Affordable Care Act (ACA) are designed to decrease preventable hospitalizations and save Medicare \$26 billion.

Starting in October 2012, ACA has begun the process of decreasing reimbursement to hospitals with high re-admission rates for three diagnoses: acute myocardial infarction, congestive heart failure, and pneumonia. The law expands penalties to four additional diagnoses in 2014.

In addition to reduced readmission rates, the study also found that the use of home telehealth technology and other features of these programs saved on personnel costs, emergency room diversion, decreased medication costs and in other areas.

“When a patient is discharged from the hospital, a home care agency provides vital services to help the patient recuperate and avoid ending up back in the hospital,” said HCA President Joanne Cunningham. “For patients most at risk, this effort requires novel approaches to care management, enhanced by technologies like home telehealth. By developing these creative, solution-oriented approaches, the agencies examined in this study provide exceptional, innovative care to their patients, and yet they are just a few of the many home care providers doing similar work to keep patients out of institutional settings.”

“Policymakers, hospitals, and other health system partners of home care agencies should pay close attention to these important results which demonstrate the vital role of home care agencies in the care-transitions process,” Ms. Cunningham added. “By emulating these care-transition models on a more widespread scale, providers across the continuum of health care can improve the experience for patients and reduce costs as a whole.”

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