

South Jersey Program Seeks to Reduce Readmissions, Improve Quality

Ben Cole, for *HealthLeaders Media*, December 10, 2009

By having heart failure patients monitor their own conditions after leaving the hospital, a partnership between South Jersey Healthcare and Pharos Innovations has the potential to reduce rehospitalizations and costs.

Through the program, heart failure patients at South Jersey Healthcare's two acute care hospitals have access to Pharos' Tel-Assurance remote patient monitoring system. Using the system, patients use a telephone or Internet connection and basic health measurement tools, such as bathroom scales and glucometers, to gather and report basic symptom information into a database reviewed by staff at South Jersey Healthcare.

"That information is usually collected before noon each day, and then after that time I access the program to look at any kind of clinical variance that the patient might have—signs that they are having some issues as far as heart failure is concerned," says Patricia Heslop, RN, clinical outcomes manager for heart failure at South Jersey Healthcare. "Then I would either contact them or their physician, and work on the appropriate intervention for the clinical variance."

By empowering patients to monitor their own conditions, they are more aware of their diseases, what causes their heart trouble, and when it is beneficial to implement home-based treatment or simple lifestyle changes rather than going to the hospital, Heslop says.

Heslop says that because of the program, she has noticed patients are well-informed on admission days, and are able to participate in their care more.

"It amazes me to find how many patients out there are not fully aware of the importance of taking care of themselves after they leave the hospital, and are not aware of the resources available to assist them in doing that," Heslop says. "We found that sometimes when we have patients discharged from here, we only have them return again within a matter of days, and some of the reasons they gave us for returning are just unbelievable."

The program was implemented in May, and an analysis was completed after the first four months of the program after 127 patients with congestive heart failure had enrolled, says Pharos CEO Randall E. Williams, MD.

At the end of four months, 62 hospital admissions had been averted for the people in the program, Williams says, and that was about an 83% reduction in admission rates compared to what was calculated as the control rate of admissions for this population. In addition, those patients who did have to be hospitalized experienced about a half a day shorter length of stay in the hospital, he says.

Williams says that while these results are only preliminary because it was just for a four-month period, "we were able to accomplish a significant reduction in admissions."

"And even those that did have to be admitted were able to get in and come home sooner," Williams says. "As we add more people to the program and they experience more time in the program, undoubtedly some of these folks will be hospitalized. But we are seeing quite a nice aversion of admissions so far."

Heslop says the program "absolutely" has the potential to keep costs down as well, because patients' length of stay will be reduced and they will be home for longer periods before coming back to the hospital. Williams says the average heart failure patient will spend an average of 1.5-2.5 days per year in the hospital, costing roughly \$10,000 in related expenses.

The program helps by keeping those patients out of the hospital unless it is absolutely necessary, he says.

"We are already seeing in this four-month analysis some significant improvement in the costs of care because of the program," Williams says. "We are quite convinced that on a national scale there is a significant financial improvement for the country for programs like this should they be implemented broadly."

All these benefits provided by the technology improves quality as well, Williams says, by helping care teams provide better treatment.

"The way it does that is by creating this little daily action that patients need to take to hold them accountable to being part of that care team," he says.

That simple daily action allows the patients to feel they have much more instant access to their care team, but secondly acts like an accountability program that provides "instant feedback" about their behavior, Williams says.

Williams uses the example of a heart failure patient who eats dinner at a Chinese restaurant buffet the night before and then reports in the South Jersey database that their ankles are swollen and short of breath. He says a light bulb goes off and they often understand now for the first time in many cases that what they do daily impacts their condition.

When patients have that real-time feedback about their activities and how it ties in to their condition, they are more likely to be hold themselves accountable for less-than-healthy behavior, Williams says.

"Patients then develop more confidence, more comfort with their condition, and they know how to manage it and they feel like this little daily routine can keep them healthy and out of the hospital," Williams says.

Ben Cole is an associate online editor with *HealthLeaders Media*. He can be reached at bcole@healthleadersmedia.com.

[Back](#)