Community VNA Telehealth Program Reduces Hospital Readmissions by 55% with HRS

Community VNA's telehealth program has reduced all-cause hospital readmissions rates by 55% from Q1 of 2018 to Q1 of 2019 utilizing software from Health Recovery Solutions (HRS) and due to the hyper-vigilance of the telehealth nursing staff.

ATTLEBORO, Mass. (PRWEB) May 23, 2019 -- Community VNA's telehealth program has reduced all-cause hospital readmissions rates by 55% between Q1 of 2018 and Q1 of 2019 due to the hyper-vigilance of the telehealth nursing staff and remote patient monitoring software from Health Recovery Solutions (HRS). In addition to this steep reduction in readmissions, Community VNA has achieved remarkable patient adherence rates averaging above 83% and demonstrating the importance of patient engagement and education in chronic care management.

Community VNA's telehealth program works in collaboration with HRS, a remote patient monitoring, and telehealth software provider. HRS and Community VNA partnered in October of 2018; however, Community VNA launched their initial telehealth program in 2005 and is one of the first healthcare providers in Massachusetts to offer telehealth and remote patient monitoring services.

As an early adopter of telehealth, Community VNA has an expansive program working with various patient populations including chronic care patients with COPD, CHF, and diabetes, as well as post-surgery patients, kidney transplant patients, cancer patients, and patients at fall-risk. Community VNA, along with their referral partners, identify patients for the telehealth program on a case-by-case basis using several indicators such as high blood pressure or an OASIS score greater than five. Community VNA's enrollment procedures work to ensure that any patient who would benefit from remote monitoring receives care.

Patients enrolled in the telehealth program are provided a 4G tablet pre-loaded with the HRS platform. Patient's utilize the tablet and accompanying Bluetooth biometric devices to engage in their care; taking their vitals, receiving medication reminders, watching educational videos, and answer daily survey questions about their health status. The software also acts as a communication platform allowing clinicians, patients, and caregivers to connect via text, call, or video conference. Patient metrics are seamlessly uploaded into the clinician's dashboard, enabling clinicians to be continuously updated on a patient's status. Community VNA operates as a centralized telehealth model with a designated clinician monitoring patient vitals and metrics as they are received.

Community VNA's commitment to building a proactive telehealth program has significantly contributed to their decrease in hospital readmissions and their notable patient adherence. All patients on the telehealth program, regardless of status, receive a daily call from the central telehealth coordinator for the first 14 days following their enrollment on the program and receive at least one video call and more if needed. Community VNA utilizes the communications platform to build relationships with patients new to the program and to educate them on the platform ensuring patients engage in their care plan and feel comfortable reaching out to clinicians when the need arises.

Since partnering with HRS six months ago, Community VNA has further developed its telehealth program creating a more robust tracking system to analyze trends behind readmissions and clinician interventions. The new tracking system requires all interventions achieved through telehealth be documented and categorized into
four categories: medication saves, RN visit saves, hospitalization saves, and ER visit saves.

A medication save occurs anytime the central telehealth coordinator identifies and corrects medication discrepancies for a patient, in consultation with their physician. Medication saves are critical to reducing skilled nursing (SN) visits, ER visits, and hospitalizations, which in turn reduce costs.

Similarly, an SN visit save occurs any time that a medication change, a virtual visit, or a phone call replaces or prevents an SN visit to the patient’s home. Reducing unnecessary visits can result in significant cost savings to providers, payors, and patients.

In a mere six months since implementing the new system, Community VNA has corrected an average of 12.5 medication regimens and prevented an average of 5.5 unnecessary SN visits, 1.5 hospitalizations, and 1.3 ER visits per month. Utilizing data from their telehealth program, Community VNA is achieving small goals, such as correcting a patient's medication regimen, in turn achieving their overarching goals - reducing readmissions and improving clinical outcomes.

Sandy Legg-Forgiel, Community VNA's Telehealth Coordinator, discussed the new program stating, "The comprehensive system allows our telehealth nursing team to identify risk factors for patients and intervene most efficiently. Patient-clinician relationships are crucial to the success of the new tracking system, and Community VNA is extremely proud of our nursing team for their dedication to our patients and the telehealth program."

HRS Client Success Manager, Will Ashton, adds, "Community VNA's success stems from their team's dedication to patient engagement and proactive care intervention. Community VNA's detailed intervention tracking is truly unique and will continue to play a significant role in reducing their hospital readmissions and improving the clinical outcomes of their patients."

About Community VNA:
Community VNA has been dedicated to enhancing health, wellness and quality of life for more than 100 years, providing a range of services, including: Home Health Care, Hospice Care, Palliative Care, Private Care, Adult Day Health Care, Alzheimer’s Assistance Program, as well as Lifeline Services and Annual Elder Dental Clinics. Community VNA has been recognized as a 2017 HomeCare Elite Top 500 (ranked among the top 5% of home health care agencies nationwide). This recognition is based on publicly available performance measures in quality outcomes, best practice implementing patient experience, quality improvement and consistency, and financial performance. For more information, visit www.communityvna.com, and connect with Community VNA on Facebook.

About Health Recovery Solutions (HRS):
Health Recovery Solutions (HRS) supplies leading home care agencies with the most advanced remote monitoring platform focused on changing patient behavior to reduce readmissions and improve clinical outcomes. HRS' disease-specific engagement kits are customized with educational video, care plans, medication reminders while integrated with Bluetooth peripherals to engage patients. For clinicians, HRS' software allows for the management of high-risk patients and provides seamless communication with them through video chat, wound imaging and text messaging. For family members and caregivers, HRS' software gives them the ability to be fully involved in their family member's care and well-being. To learn more about Health Recovery Solutions, visit https://www.healthrecoverysolutions.com/ or call (347) 699-6477.
Contact Information
Tess Meehan
Health Recovery Solutions
201-957-0125

Online Web 2.0 Version
You can read the online version of this press release here.