East Sussex Healthcare NHS Trust Libraries

Please find below the results of your literature search request. If you would like the full text of any of the abstracts included, or would like a further search completed on this topic, please let us know.

Search details

Search completed for: xxxxxxxxxxxxxx

Date of search: 16/09/2011

Time taken: 4 hours

Search completed by: Jenny Turner and Myriam Nelmes

Email address for follow-up: rosewelllibrary@esht.nhs.uk

Enquiry details

Is there evidence that general practice (GP or nurse) based telephone based care (telecare..? or is it telehealth?) for people at risk of admission / frail elderly / people recently discharged from hospital results in better outcomes in terms of fewer hospital admissions / readmissions / patient measures of better outcomes? *(scope widened to telephone or telemedicine not necessarily based in GP practice following email)*
Other details
part of a large scale frail elderly and urgent care pathways development programme for our Wave 1 pathfinder CCG (Mid-Sussex)

Methods of literature search

We do not currently have the capacity to read, appraise and synthesise all of the articles and documents that may be relevant to your question.

However, we aim to:

- Include as few documents as possible so that you can focus on the most relevant information
- Organise results by publication types, e.g. guidance, synopses, original research, service examples, etc.
- Read the key texts and extract the most relevant passages
- Attach a full search strategy as an appendix

The sources searched and limits used in this search were as follows:
Medline, Embase, Cochrane library, NICE plus a Google search for recent reports

Opening Internet Links

The links to internet sites in this document are 'live' and can be opened by holding down the CTRL key on your keyboard while clicking on the web address with your mouse

Full Text Papers

Links are given to full text resources where available. For some of the papers, you will need a free **NHS Athens Account**. If you do not have an account you can register by following the steps at:
https://register.athensams.net/nhs/nhseng/.
You can then access the papers by simply entering your username and password. If you do not have easy access to the internet to gain access, please let us know and we can download the papers for you.

Guidance on Searching within Online Documents

Links are provided to the full text of each of these documents. Relevant extracts have been copied and pasted into these Search Results. Rather than browse through often lengthy documents, you can search for specific words and phrases as follows:

Portable Document Format / pdf / Adobe
Click on the Search button (illustrated with binoculars). This will open up a search window. Type in the term you need to find and links to all of the references to that term within the document will be displayed in the window. You can jump to each reference by clicking it. You can search for more terms by pressing 'search again'.

Word documents
Select Edit from the menu, the Find and type in your term in the search box which is presented. The search function will locate the first use of the term in the document. By pressing 'next' you will jump to further references.

results found by the library and knowledge service

Overview of findings

This initial search includes 3 reviews and 2 institutional publications which seem generally relevant to telephone care or telemedicine or include sections about telephoning post-discharge.
The research articles look more specifically at the impact of telephoning or telemedicine on admission or readmission rates. Telephoning is often included in a bundle of care, and much of the research is focused on cardiology. The search is not comprehensive; the articles selected should give an overview, and may identify that a more specific search is needed.

Systematic reviews

Telephone consultation and triage: effects on health care use and patient satisfaction, Cochrane Systematic review, 2009
Bunn F, Byrne G, Kendall S
http://www2.cochrane.org/reviews/en/ab004180.html

Telemedicine versus face to face patient care: effects on professional practice and health care outcomes, Cochrane Systematic review, 2000
Currell R, Urquhart C, Wainwright P, Lewis R.
http://www2.cochrane.org/reviews/en/ab002098.html

'Readmission to Hospital' Project – a systematic literature review
University of Kent: Centre for Health Service Studies 2010,
http://www.kent.ac.uk/chss/researchcentre/docs/readmissions_systematic_literature_review_feb_10.pdf

Original research

2006 – current

Title: Home monitoring cuts cardiac readmissions.

Citation: Hospital Case Management, May 2011, vol./is. 19/5(76-7), 1087-0652;1087-0652 (2011 May)

Author(s): anonymous

Abstract: A collaboration between Ocean Medical Center and Meridian At Home care agency in Brick, NJ, to provide remote monitoring for heart failure patients has resulted in a drop in readmissions from 14.93% before the program began to 4.84% in the first eight months of the pilot program. Program aims to get patients accustomed to monitoring weight gain and other symptoms. Hospital case managers screen patients for appropriateness for the program. Eligible patients receive a daily automated phone call, answer questions and record their weight on a remote monitoring device connected to the remote monitoring nurse. Nurses work with patients to reinforce hospital teaching and determine the causes of exacerbation.

Source: MEDLINE

Full Text:
Available in *fulltext* at EBSCO Host
Available in *fulltext* at ProQuest (Legacy Platform)

Title: The impact of postdischarge telephonic follow-up on hospital readmissions.

Citation: Population Health Management, February 2011, vol./is. 14/1(27-32), 1942-7905 (2011 Feb)

Author(s): Harrison PL, Hara PA, Pope JE, Young MC, Rula EY

Abstract: Abstract Recurrent hospitalizations are responsible for considerable health care spending, although prior studies have shown that a substantial proportion of readmissions are preventable through effective discharge planning and patient follow-up after the initial hospital visit. This retrospective cohort study was undertaken to determine whether telephonic outreach to ensure patient understanding of and adherence to discharge orders following a hospitalization is effective at reducing hospital readmissions within 30 days after discharge. Claims data were analyzed from 30,272 members of a commercial health plan who were discharged from a hospital in 2008 to determine the impact of telephonic intervention on the reduction of 30-day readmissions. Members who received a telephone call within 14 days of discharge and were not readmitted prior to that call comprised the intervention group; all other members formed the comparison group. Multiple logistic regression was used to determine the impact of the intervention on 30-day readmissions, after adjusting for covariates. Results demonstrated that older age, male sex, and increased initial hospitalization length of stay were associated with an increased likelihood of readmission ($P < 0.001$). Receipt of a discharge call was associated with reduced rates of readmission; intervention group members were 23.1% less likely than the comparison group to be readmitted within 30 days of hospital discharge ($P = 0.043$). These findings indicate that timely discharge follow-up by telephone to supplement standard care is effective at reducing near-term hospital readmissions and, thus, provides a means of reducing costs for health plans and their members.

Source: MEDLINE

Full Text:
Available in *fulltext* at EBSCO Host

Title: Cost-effectiveness of an intervention to reduce emergency re-admissions to hospital among older patients.

Citation: PLoS ONE [Electronic Resource], 2009, vol./is. 4/10(e7455), 1932-6203;1932-6203 (2009)

Author(s): Graves N, Courtney M, Edwards H, Chang A, Parker A, Finlayson K

Abstract: BACKGROUND: The objective is to estimate the cost-effectiveness of an intervention that reduces hospital re-admission among older people at high risk. A cost-effectiveness model to estimate the costs and health benefits of the intervention was implemented.METHODOLOGY/PRINCIPAL FINDINGS: The model used data from a randomised controlled trial conducted in an Australian tertiary metropolitan hospital. Participants were acute medical admissions aged >65 years with at least one risk factor for re-admission: multiple comorbidities, impaired functionality, aged >75 years, recent multiple admissions, poor social support, history of depression. The intervention was a comprehensive nursing and physiotherapy assessment and an individually tailored program of exercise strategies and nurse home visits with telephone follow-up; commencing in hospital and continuing following discharge for 24 weeks. The change to cost outcomes, including the costs of implementing the intervention and all subsequent use of health care services, and, the change to health benefits, represented by quality adjusted life years, were estimated for the intervention as compared to existing practice. The mean change to total costs and quality adjusted life years for an average individual over 24 weeks participating in the intervention were: cost savings of $333 (95% Bayesian credible interval $ -1,932:1,282) and 0.118 extra quality adjusted life years (95% Bayesian credible interval 0.1:0.136). The mean net-monetary-benefit per individual for the intervention group compared to the usual care condition was $7,907 (95% Bayesian credible interval $5,959:$9,995) for the 24 week period.CONCLUSIONS/SIGNIFICANCE: The estimation model that describes this intervention predicts cost savings and improved health outcomes. A decision to remain with existing practices causes unnecessary costs and reduced health. Decision makers should consider adopting this program for elderly hospitalised patients.

Source: MEDLINE

Full Text:
Available in *fulltext* at National Library of Medicine

Title: Reduction of 30-day postdischarge hospital readmission or emergency department (ED) visit rates in high-risk elderly medical patients through delivery of a targeted care bundle.

Citation: Journal of Hospital Medicine (Online), April 2009, vol./is. 4/4(211-8), 1553-5592;1553-5606 (2009 Apr)

Author(s): Koehler BE, Richter KM, Youngblood L, Cohen BA, Prengler ID, Cheng D, Masica AL

Abstract: RATIONALE: Care coordination has shown inconsistent results as a mechanism to reduce hospital readmission and postdischarge emergency department (ED) visit rates.OBJECTIVE: To assess the impact of a supplemental care bundle targeting high-risk elderly inpatients implemented by hospital-based staff compared to usual care on a composite outcome of hospital readmission and/or ED visitation at 30 and 60 days following discharge.PATIENTS/METHODS: Randomized controlled pilot study in 41 medical inpatients predisposed to unplanned readmission or postdischarge ED visitation, conducted at Baylor University Medical Center. The intervention group care bundle consisted of medication counseling/reconciliation by a clinical pharmacist (CP), condition specific education/enhanced discharge planning by a care coordinator (CC), and phone follow-up.RESULTS: Groups had similar baseline characteristics. Intervention group readmission/ED visit rates were reduced at 30 days compared to the control group (10.0% versus 38.1%, P = 0.04), but not at 60 days (30.0% versus 42.9%, P = 0.52). For those patients who had a readmission/postdischarge ED visit, the time interval to this event was longer in the intervention group compared to usual care (36.2 versus 15.7 days, P = 0.05). Study power was insufficient to reliably compare the effects of the intervention on lengths of index hospital stay between groups.CONCLUSIONS: A targeted care bundle delivered to high-risk elderly inpatients decreased unplanned acute health care utilization up to 30 days following discharge. Dissipation of this effect by 60 days postdischarge defines reasonable expectations for analogous hospital-based educational interventions. Further research is needed regarding the impacts of similar care bundles in larger populations across a variety of inpatient settings. (c) 2009 Society of Hospital Medicine.

Source: MEDLINE

Title: Fewer emergency readmissions and better quality of life for older adults at risk of hospital readmission: a randomized controlled trial to determine the effectiveness of a 24-week exercise and telephone follow-up program.

Citation: Journal of the American Geriatrics Society, March 2009, vol./is. 57/3(395-402), 0002-8614;1532-5415 (2009 Mar)

Author(s): Courtney M, Edwards H, Chang A, Parker A, Finlayson K, Hamilton K

Abstract: OBJECTIVES: To evaluate the effect of an exercise-based model of hospital and in-home follow-up care for older people at risk of hospital readmission on emergency health service utilization and quality of life.DESIGN: Randomized controlled trial.SETTING: Tertiary metropolitan hospital in Australia.PARTICIPANTS: One hundred twenty-eight patients (64 intervention, 64 control) with an acute medical admission, aged 65 and older and with at least one risk factor for readmission (multiple comorbidities, impaired functionality, aged >or=75, recent multiple admissions, poor social support, history of depression).INTERVENTION: Comprehensive nursing and physiotherapy assessment and individualized program of exercise strategies and nurse-conducted home visit and telephone follow-up commencing in the hospital and continuing for 24 weeks after discharge.MEASUREMENTS: Emergency health service utilization (emergency hospital readmissions and visits to emergency department, general practitioner (GP), or allied health professional) and health-related quality of life (Medical Outcomes Study 12-item Short Form Survey (SF-12v2) collected at baseline and 4, 12, and 24 weeks after discharge.RESULTS: The intervention group required significantly fewer emergency hospital readmissions (22% of intervention group, 47% of control group, P=.007) and emergency GP visits (25% of intervention group, 67% of control group, P<.001). The intervention group also reported significantly greater improvements in quality of life than the control group as measured using SF-12v2 Physical Component Summary scores (F (3, 279)=30.43, P<.001) and Mental Component Summary scores (F (3, 279)=7.20, P<.001).CONCLUSION: Early introduction of an individualized exercise program and long-term telephone follow-up may reduce emergency health service utilization and improve quality of life of older adults at risk of hospital readmission.

Source: MEDLINE

Full Text:
Available in *fulltext* at EBSCO Host
Available in *print* at Conquest Hospital Library

Title: Multicenter randomised trial on home-based telemanagement to prevent hospital readmission of patients with chronic heart failure.

Citation: International Journal of Cardiology, January 2009, vol./is. 131/2(192-9), 0167-5273;1874-1754 (2009 Jan 9)

Author(s): Giordano A, Scalvini S, Zanelli E, Corra U, Longobardi GL, Ricci VA, Baiardi P, Glisenti F

Abstract: BACKGROUND: Chronic heart failure (CHF) remains a common cause of disability, death and hospital admission. Several investigations support the usefulness of programs of disease management for improving clinical outcomes. However, the effect of home-based telemanagement programs on the rate of hospital readmission is still unclear and the cost-effectiveness ratio of such programs is unknown. The aim of the study was to determine whether a home-based telemanagement (HBT) programme in CHF patients decreased hospital readmissions and hospital costs in comparison with the usual care (UC) follow-up programme over a one-year period.METHODS AND RESULTS:

Four hundred-sixty CHF patients (pts), aged 57+/-10 years were randomised to two management strategies: 230 pts to HBT programme and 230 pts to UC programme. The HBT pts received a portable device, transferring, by telephone, a one-lead trace to a receiving station where a nurse was available for interactive teleconsultation. The UC pts were referred to their primary care physicians and cardiologists. The primary objective of the study was one-year hospital readmission for cardiovascular reasons. During one-year follow-up 55 pts (24%) in HBT group and 83 pts (36%) in UC group had at least one readmission (RR=0.56; 95% CI: 0.38-0.82; p=0.01). After adjusting for clinical and demographic characteristics, the HBT group had a significantly lower risk of readmission compared with the UC group (HR=0.50, 95% CI: 0.34-0.73; p=0.01). The intervention was associated with a 36% decrease in the total number of hospital readmissions (HBT group: 91 readmissions; UC group: 142 readmissions) and a 31% decrease in the total number of episodes of hemodynamic instability (101 in HBT group vs 147 in UC group). The rate of hearth failure-related readmission was 19% (43 pts) in HBT group and 32% (73 pts) in UC group (RR=0.49, 95% [CI]: 0.31-0.76; p=0.0001). No significant difference was found on cardiovascular mortality between groups. Mean cost for hospital readmission was significantly lower in HBT group (euro 843+/-1733) than in UC group (euro 1298+/-2322), (-35%, p<0.01).CONCLUSIONS: This study suggests that one-year HBT programme reduce hospital readmissions and costs in CHF patients.

Source: MEDLINE

Title: Successful interventions for avoiding readmission in the elderly.

Citation: Medicine & Health, Rhode Island, September 2008, vol./is. 91/9(285-7), 1086-5462;1086-5462 (2008 Sep)

Author(s): Gardner RL

Source: MEDLINE

Full Text:
Available in *fulltext* at ProQuest (Legacy Platform)

Title: Telehome monitoring in patients with cardiac disease who are at high risk of readmission.

Citation: Heart & Lung, January 2008, vol./is. 37/1(36-45), 0147-9563;1527-3288 (2008 Jan-Feb)

Author(s): Woodend AK, Sherrard H, Fraser M, Stuewe L, Cheung T, Struthers C

Abstract: Patients with chronic conditions are heavy users of the health care system. There are opportunities for significant savings and improvements to patient care if patients can be maintained in their homes. A randomized control trial tested the impact of 3 months of telehome monitoring on hospital readmission, quality of life, and functional status in patients with heart failure or angina. The intervention consisted of video conferencing and phone line transmission of weight, blood pressure, and electrocardiograms. Telehome monitoring significantly reduced the number of hospital readmissions and days spent in the hospital for patients with angina and improved quality of life and functional status in patients with heart failure or angina. Patients found the technology easy to use and expressed high levels of satisfaction. Telehealth technologies are a viable means of providing home monitoring to patients with heart disease at high risk of hospital readmission to improve their self-care abilities.

Source: MEDLINE

Title: Telehealth helps hospital cut readmissions by 75%.

Citation: Healthcare Benchmarks & Quality Improvement, August 2007, vol./is. 14/8(92-4), 1541-1052;1541-1052 (2007 Aug)

Author(s): anonymous

Abstract: Most hospitals lose money for every heart failure admission, so issue is critically important. Program teaches patients how to effectively self-manage their condition. Reach expanded from 40 patients to 100 after initial success.

Source: MEDLINE

Full Text:
Available in *fulltext* at EBSCO Host

Title: Reducing heart failure hospital readmissions from skilled nursing facilities.

Citation: Professional Case Management, January 2011, vol./is. 16/1(18-24; quiz 25-6), 1932-8087;1932-8095 (2011 Jan-Feb)

Author(s): Jacobs B

Abstract: PURPOSE/OBJECTIVES: Readmission rates for heart failure patients are a Center for Medicare & Medicaid and Joint Commission core measure. At this urban Midwestern medical center, the 6-month baseline skilled nursing facility (SNF) readmission rate was 30%. Nurse case management implemented a process to decrease the rate for this population. Follow-up phone calls were in place for patients discharged to home, but a gap remained in those discharged to SNFs. Nurse case management developed a follow-up phone call process within 48 hours of discharge to the registered nurse/licensed practical nurse in the SNFs to verify that: 1. Daily morning weights were ordered. 2. Parameters to contact primary care provider if weight gain was greater than 3 pounds per day or 5 pounds per week. 3. 2 gram sodium restricted diet was ordered. 4. Appropriate diuretic was ordered and reconciled. 5. Follow-up provider visits were made, for patient to be seen within 3 to 5 days following discharge.PRIMARY PRACTICE SETTING: Acute inpatient care settings.FINDINGS/CONCLUSIONS: The phone calls resulted in improved continuity of care and clarification of discharge orders. The opportunity for question-and-answer time between the hospital and the SNF nurse provided just-intime education; relationships have also been strengthened. Recent data show that the current readmission rate averages 11.32% (a decrease from 30%). This nurse case management-driven process of follow-up phone calls between the hospital and SNF staff to reduce readmission rates in heart failure patients resulted in improved continuity of care and clarification of discharge orders. IMPLICATIONS FOR CM PRACTICE: This simple, innovative process allowed for improved continuity of care and partnerships between inpatient hospitalization and the SNF, thereby reduced transcription errors and improved patient health outcomes. Enhanced communication between providers allowed for a significant reduction in readmissions from SNFs to the hospital.

Source: MEDLINE

Title: An exercise and telephone follow-up programme reduced emergency readmissions and improved quality of life in older people

Citation: Evidence-Based Medicine, August 2009, vol./is. 14/4(120), 1356-5524;1473-6810 (August 2009)

Author(s): Kinkade S.

Source: EMBASE

Full Text:
Available in *fulltext* at Highwire Press
Available in *print* at Conquest Hospital Library

Title: The influences of postdischarge management by nurse practitioners on hospital readmission for heart failure

Citation: Journal of the American Academy of Nurse Practitioners, April 2006, vol./is. 18/4(154-160), 1041-2972 (Apr 2006)

Author(s): Delgado-Passler P., McCaffrey R.

Abstract: PURPOSE: The primary purpose of this literature review is to examine advanced practice nurse (APN)-directed versus registered nurse (RN)-directed telemanagement programs for heart failure patients. DATA SOURCES: Research articles identified through CINAHL and OVID databases. CONCLUSIONS: Implementing a telemanagement program directed by an APN after hospital discharge decreases the costs and frequent rehospitalizations associated with heart failure and improves the patient's quality of life. While APNs are more costly than RNs, it is important to understand that this level of provider has a more significant impact on the outcomes of patients who use the services provided in the comprehensive discharge programs. IMPLICATIONS FOR PRACTICE: An APN-directed heart failure telemanagement program can reduce the rising healthcare costs that result from frequent readmissions. These programs can improve the quality of care given to heart failure patients while reducing the cost to the institution, the patient, and the healthcare system. When considering the number of older adults hospitalized each year with heart failure, the potential patient benefits and savings to the healthcare system resulting from APN-directed telemanagement are substantial.
Source: EMBASE

Full Text:
Available in *fulltext* at EBSCO Host
Available in *fulltext* at ProQuest (Legacy Platform)

Title: Reducing the cost of frequent hospital admissions for congestive heart failure: a randomized trial of a home telecare intervention

Citation: Medical care, November 2001, vol./is. 39/11(1234-1245), 0025-7079 (Nov 2001)

Author(s): Jerant A.F., Azari R., Nesbitt T.S.

Abstract: BACKGROUND: The high cost of caring for patients with congestive heart failure (CHF) results primarily from frequent hospital readmissions for exacerbations. Home nurse visits after discharge can reduce readmissions, but the intervention costs are high. OBJECTIVES: To compare the effectiveness of three hospital discharge care models for reducing CHF-related readmission charges: 1) home telecare delivered via a 2-way video-conference device with an integrated electronic stethoscope; 2) nurse telephone calls; and 3) usual outpatient care. RESEARCH DESIGN: One-year randomized trial. SUBJECTS: English-speaking patients 40 years of age and older with a primary hospital admission diagnosis of CHF. MEASURES: Our primary outcome was CHF-related readmission charges during a 6-month period after randomization. Secondary outcomes included all-cause readmissions, emergency department (ED) visits, and associated charges. RESULTS: Thirty-seven subjects were randomized: 13 to home telecare, 12 each telephone care and 12 to usual care. Mean CHF-related readmission charges were 86% lower in the telecare group ($5850, SD $21,094) and 84% lower in the telephone group ($7320, SD $24,440) than in the usual care group ($44,479, SD $121,214). However, the between-group difference was not statistically significant. Both intervention

groups had significantly fewer CHF-related ED visits (P = 0.0342) and charges (P = 0.0487) than the usual care group. Trends favoring both interventions were noted for all other utilization outcomes. CONCLUSIONS: Substantial reductions in hospital readmissions, emergency visits, and cost of care for patients with CHF might be achieved by widespread deployment of distance technologies to provide posthospitalization monitoring. Home telecare may not offer incremental benefit beyond telephone follow-up and is more expensive.

Source: EMBASE

HMIC

Title: Development of a program for tele-rehabilitation of COPD patients across sectors : co-innovation in a network.

Citation: International Journal of Integrated Care, 2011, vol./is. 11/, 1568-4156

Author(s): Dinesen, Birthe, Seeman, Janne, Gustafsson, Jeppe

Abstract: INTRODUCTION: The aim of the Telekat project is to prevent re-admissions of patients with chronic obstructive pulmonary disease (COPD) by developing a preventive program of tele-rehabilitation across sectors for COPD patients. The development of the program is based on a co-innovation process between COPD patients, relatives, healthcare professionals and representatives from private firms and universities. This paper discusses the obstacles that arise in the co-innovation process of developing an integrated technique for tele-rehabilitation of COPD patients. THEORY: Network and innovation theory. METHODS: The case study was applied. A triangulation of data collection techniques was used: documents, observations (123 hours), qualitative interviews (n=32) and action research. FINDINGS: Obstacles were identified in the network context; these obstacles included the mindset of the healthcare professionals, inter-professionals relations, views of technology as a tool and competing visions for the goals of tele-rehabilitation. CONCLUSION: We have identified obstacles that emerge in the co-innovation process when developing a programme for tele-rehabilitation of COPD patients in an inter-organizational context. Action research has been carried out and can have helped to facilitate the co-innovation process. [Abstract]

Source: HMIC

Full Text:
Available in *fulltext* at National Library of Medicine

2000 - 2005

Title: A randomized, controlled trial of an intensive community nurse-supported discharge program in preventing hospital readmissions of older patients with chronic lung disease.

Citation: Journal of the American Geriatrics Society, August 2004, vol./is. 52/8(1240-6), 0002-8614;0002-8614 (2004 Aug)

Author(s): Kwok T, Lum CM, Chan HS, Ma HM, Lee D, Woo J

Abstract: OBJECTIVES: To evaluate the effectiveness of an intensive community nurse (CN)-supported discharge program in preventing hospital readmissions of older patients with chronic lung disease (CLD).DESIGN: Randomized, controlled trial.SETTING: Two acute hospitals in the same health region in Hong Kong.PARTICIPANTS: One hundred fifty-seven hospitalized patients aged 60

and older with a primary diagnosis of CLD and at least one hospital admission in the previous 6 months.INTERVENTION: CNs made home visits within 7 days of discharge, then weekly for 4 weeks and monthly until 6 months. CNs coordinated closely with a geriatric or respiratory specialist in hospital. Subjects had telephone access to CNs during normal working hours from Monday to Saturday.MEASUREMENTS: The primary outcome was the rate of unplanned readmission within 6 months. The secondary outcomes were the rate of unplanned readmission within 28 days, number of unplanned readmissions, hospital bed days, accident and emergency room attendance, functional and psychosocial status, and caregiver burden.RESULTS: One hundred forty hospitalized patients completed the trial. Intervention group subjects had a higher rate of unplanned readmission within 6 months than control group subjects (76% vs 62%, P=.080, chi2 test). There was no significant group difference in any of the secondary outcomes except that intervention group subjects did better on social handicap scores.CONCLUSION: There was no evidence that an intensive CN-supported discharge program can prevent hospital readmissions in older patients with CLD.

Source: MEDLINE

Full Text:
Available in *fulltext* at EBSCO Host
Available in *print* at Conquest Hospital Library

Title: Reducing the cost of frequent hospital admissions for congestive heart failure: a randomized trial of a home telecare intervention.

Citation: Medical Care, November 2001, vol./is. 39/11(1234-45), 0025-7079;0025-7079 (2001 Nov)

Author(s): Jerant AF, Azari R, Nesbitt TS

Abstract: BACKGROUND: The high cost of caring for patients with congestive heart failure (CHF) results primarily from frequent hospital readmissions for exacerbations. Home nurse visits after discharge can reduce readmissions, but the intervention costs are high.OBJECTIVES: To compare the effectiveness of three hospital discharge care models for reducing CHF-related readmission charges: 1) home telecare delivered via a 2-way video-conference device with an integrated electronic stethoscope; 2) nurse telephone calls; and 3) usual outpatient care.RESEARCH DESIGN: One-year randomized trial.SUBJECTS: English-speaking patients 40 years of age and older with a primary hospital admission diagnosis of CHF.MEASURES: Our primary outcome was CHF-related readmission charges during a 6-month period after randomization. Secondary outcomes included all-cause readmissions, emergency department (ED) visits, and associated charges.RESULTS: Thirty-seven subjects were randomized: 13 to home telecare, 12 each telephone care and 12 to usual care. Mean CHF-related readmission charges were 86% lower in the telecare group ($5850, SD $21,094) and 84% lower in the telephone group ($7320, SD $24,440) than in the usual care group ($44,479, SD $121,214). However, the between-group difference was not statistically significant. Both intervention groups had significantly fewer CHF-related ED visits (P = 0.0342) and charges (P = 0.0487) than the usual care group. Trends favoring both interventions were noted for all other utilization outcomes.CONCLUSIONS: Substantial reductions in hospital readmissions, emergency visits, and cost of care for patients with CHF might be achieved by widespread deployment of distance technologies to provide posthospitalization monitoring. Home telecare may not offer incremental benefit beyond telephone follow-up and is more expensive.

Source: MEDLINE

Title: Adequacy of home care and hospital readmission for elderly congestive heart failure patients.

Citation: Health & Social Work, May 2000, vol./is. 25/2(87-96), 0360-7283;0360-7283 (2000 May)

Author(s): Proctor EK, Morrow-Howell N, Li H, Dore P

Abstract: Readmission to acute care facilities is a frequent and costly problem among older adults with congestive heart failure (CHF). The study reported in this article tested the hypothesis that adequate home care, operationalized as patient-perceived adequacy of formal and informal assistance, is associated with lower readmission to acute care facilities. The study followed 253 elderly (age 65 and older) Medicare patients discharged to their homes after hospitalization for CHF, through structured telephone interviews at two, six, 10, and 14 weeks postdischarge. Study findings point to the importance of home care in reducing the high risk of readmission among elderly patients. The findings raise implications for practice, policy, and research.

Source: MEDLINE

Full Text:
Available in *fulltext* at EBSCO Host
Available in *fulltext* at EBSCO Host
Available in *fulltext* at ProQuest (Legacy Platform)
Available in *fulltext* at ProQuest (Legacy Platform)

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Source: EMBASE

1990s

Earlier

Service examples / Institutional publications

Telephone consultations in primary **care**: A scoping review
Telephone consultations in primary care: A scoping review June 2003
Anita Kainth, Catriona McDaid, Julie Glanville, Kath Wright, Peter Toon*, Carol Forbes. Centre for Reviews and Dissemination, University of York, YO10 5DD
www.york.ac.uk/inst/crd/pdf/prp**telephone**.pdf

Avoiding hospital admissions : lessons from evidence and experience.
Seminar Highlights
London : The King's Fund, 2010 *HPPP (Kin)*
http://www.kingsfund.org.uk/document.rm?id=8779

Search strategy

Search History:
2. MEDLINE; exp TELEMEDICINE/; 12416 results.
3. MEDLINE; (telephone* OR phone*).ti,ab; 47519 results.
4. MEDLINE; 2 OR 3; 58430 results.
6. MEDLINE; exp HOSPITALIZATION/; 134502 results.
7. MEDLINE; ((admission* OR readmission* OR re-admission*)).ti,ab; 117575 results.
8. MEDLINE; 4 AND 7; 1470 results.
9. MEDLINE; ((admission* OR readmission* OR re-admission*)).ti; 12479 results.
10. MEDLINE; 4 AND 6 AND 9; 111 results.

EMBASE search

exp *TELEHEALTH/ [Limit to: Publication Year 2001-Current]

*HOSPITAL READMISSION/ [Limit to: Publication Year 2001-Current]

8 AND 9 [Limit to: Publication Year 2001-Current]