HRS Health Recovery Solutions

Case Study

Frederick Health

Organization Type:
Health System

Location:
Frederick County, Maryland

HRS Products:
PatientConnect Complete
PatientConnect Mobile

Data Period:
January 2023 - December 2023

Overview

Chronic Care Patients Enrolled in 12-Month RPM Program Yield $2.3M In Savings

Frederick Health is a leading healthcare provider system focused on providing comprehensive medical services to residents of Frederick County, Maryland. The system has over 25 locations throughout Frederick County, including hospital care, home care, hospice, ambulatory care centers, a cancer institute, employer health solutions, women's health services, and urgent care facilities.

The Frederick Health Transitional and Chronic Care (TCCM) team first launched their telehealth program with HRS in 2017 with the goal of reducing readmissions and increasing cost savings to the health system.

Challenge

In the US, six in ten adults have at least one chronic illness, often with multiple co-occurring conditions (CDC). These diseases are also leading causes of death and disability, and also create significant financial burden. Recognizing the strain that chronic conditions place on patients, their families, and health care providers, Frederick Health sought a solution that would improve patient outcomes, reduce readmissions, enhance patient-provider communication, and decrease cost of services.

Frederick Health's CCM telehealth program targeted high-risk patients with an increased risk of hospitalization, including COPD, CHF, diabetes, AFib and hypertension, among others.

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Solution

In 2017, Frederick Health partnered with Health Recovery Solutions (HRS) to provide CCM patients with a comprehensive telehealth solution. The solution allows the CCM clinical team to monitor patient vitals and medication adherence, provide disease-specific education to patients, and improve patient-clinical communication. As the program has grown, Frederick Health has expanded their footprint in the community, accepting patients from ACOs, senior centers, physician practices, paramedic programs, and from the Department of Social Services and Meals on Wheels.

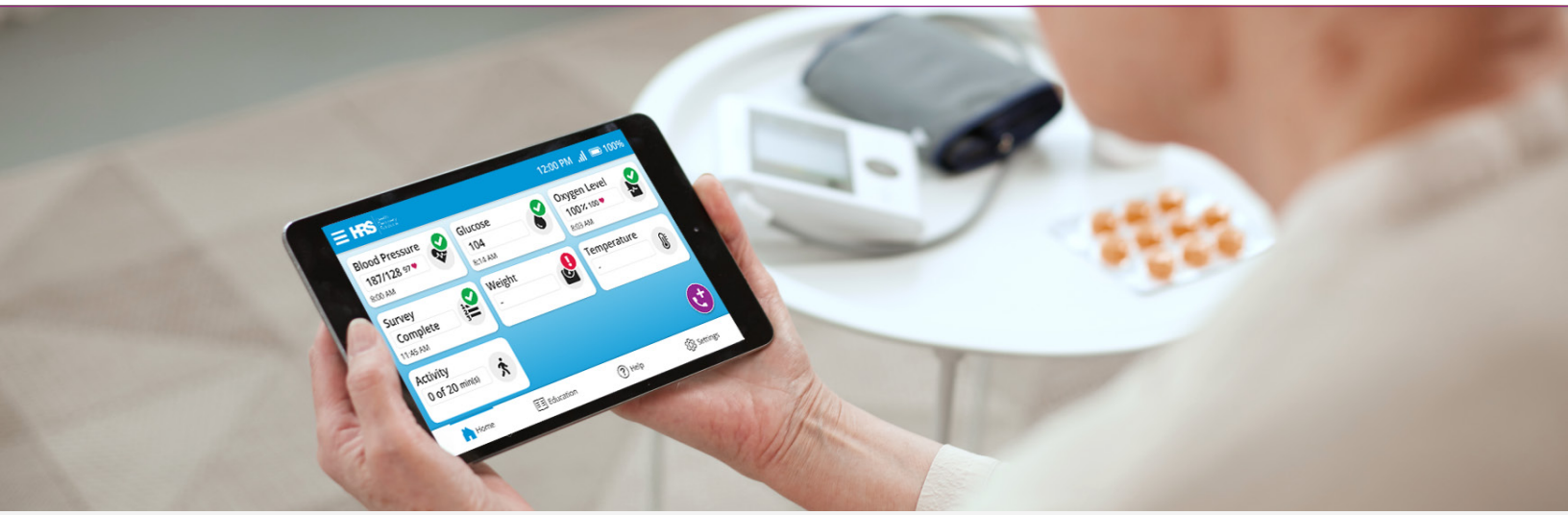
A centralized program structure, with a telehealth team, allows Frederick Health to easily prioritize at risk patients. The telehealth team performs daily and weekly/biweekly check-in calls, home visits for patient/family education, and medication management in the home. Patients use devices to track weight, blood pressure, blood oxygen levels, and other relevant metrics at home.

Program details:

- **Onset:** Program started in 2017 with 3 patients.
- **Patient Census:** Full program census is typically around 450 patients.
- **Program Staffing:** Dedicated team of 5 RN's, 2 LPN's and 1 Social Worker to monitor and intervene on patient needs.
- **Program Components:** RPM used in combination with medication management, home visits and disease education.
- **Referral Sources:** Home Health Care agencies, physician offices, and other county agencies.

"Much of CCMP's success is due to the personal relationships we build with our patients as well as the great technology with the telemonitors. It is wonderful to see the growth and independence [of patients] develop throughout their enrollment in the telehealth program. With our assistance and oversight, patients can stay in their homes and age in place, which is so important for many of them. We celebrate their successes and our collaboration with their providers."

— **Lisa R. Hogan, BSN**
Manager Transitional and Chronic Care
Frederick Health



Results

Starting from January1, 2023 through December 31, 2023, the program has monitored 510 patients. In that timeframe, the average length of stay is 505 days and the program has yielded the following results:

- **30-Day Readmission and ED Rate:** 2% readmission rate and less than 1% ED visit rate.
- **60-Day Readmission and ED Rate:** 3% readmission rate and 1% ED visit rate.
- **90-Day Readmission and ED Rate:** 4% readmission rate and 2% ED visit rate.
- **Patient Satisfaction Rate:** 96%
- **Total Cost Savings in 12 months:** Pre/Post analysis shows a difference of $2.3 Million.

2%

30-Day Hospital Readmission Rate

3%

60-Day Hospital Readmission Rate

4%

90-Day Hospital Readmission Rate

96%

Average Patient Satisfcation Rate

$2.3M

12-Month Savings

Patient Experience

“Mr. B has been with our program for over 3 years. We received a referral for him after he was hospitalized with cardiac issues. He lives alone and has low health literacy.

We connected him with our remote patient monitoring program and have made multiple home visits over the past several years to offer support and education related to diet and overall health education. Since he has been with us, he feels more secure and comfortable monitoring his care and knows when to notify us and his providers. He has had a few ER visits but no admissions to the hospital since joining our program. **He has told us we are like his family and knows we watch him daily. It is a wonderful thing to be a part of watching someone develop confidence and take control of his health.**

Part of the success of our program is meeting people where they are and working with their home situation and finances. We try to tailor the program for the needs of each individual patient since everyone is different with a variety of needs, resources, and knowledge about their health. It is an honor and privilege to care for our community and help make a difference in the lives of others.“