

Read Reducing hospital readmissions

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this second edition of the handbook addresses the evolving interdisciplinary health care context and the broader social work practice environment as well as advances in the knowledge base which guides social work service delivery in health and aging this includes recent enhancements in the theories of gerontology innovations in clinical interventions and major developments in the social policies that structure and finance health care and senior services in addition the policy reforms of the 2010 patient protection and affordable care act set in motion a host of changes in the united states healthcare system with potentially profound implications for the programs and services which provide care to older adults and

their families in this volume the most experienced and prominent gerontological health care scholars address a variety of populations that social workers serve and the arenas in which they practice followed by detailed recommendations of best practices for an array of physical and mental health conditions the volume s unprecedented attention to diversity health care trends and implications for practice research policy make the publication a major event in the field of gerontological social work this is a must read for all social work social work educators practitioners and students interested in older adults and their families

this text provides a clear reproducible step by step guide for each colorectal surgery operation the format follows that of both a how to manual as well as an algorithm based guide to allow the reader to understand the thought process behind the proposed treatment strategy each chapter includes both operative technical details as well as perioperative tips and tricks that the authors utilize in the management of these complex surgical patients in addition it addresses the optimal next step in dealing with more challenging situations such as pregnancy emergent surgery the elderly and the obese patient throughout the text each author provides an ongoing narrative of his her individual surgical techniques along with color illustrations and diagrams to personally take the reader through the crucial steps of the procedure as well as key points of patient care inherent to that topic additionally where appropriate links to online or downloadable videos will give the reader an up front look into technical aspects of traditional straight laparoscopic and hand assisted minimally invasive surgery as well as notes transanal robotic single incision colectomy and combined laparoscopic endoscopic resection minimally invasive approaches to colon and rectal disease technique and best practices will be of great utility to colorectal general and oncologic surgeons who want to learn or improve their minimally invasive skills in colorectal surgery furthermore this text will be of particular interest to the surgeons in training and the general and colorectal surgeon who is often called upon to manage a variety of colorectal surgery conditions through a minimally invasive approach

this book provides a road map for defining the care of acute heart failure hf patients in the short stay or observation unit setting supported by the society of cardiovascular patient care a quality improvement organization that trains and accredits over 1 000 hospitals for heart failure chest pain and atrial fibrillation management it presents a description of the problem defines the measures of success elucidates the implementation of interventions required to be successful and provides the tools to insure quality hf management fully updated and revised the third edition discusses administrative and regulatory issues relating to hf management pathophysiology and demographics of acute hf emergency department assessment and treatment of acute hf admission treatment and disposition of acute heart failure in short stay units and resources such as clinical pathways algorithms and patient education tools that can be directly utilized in various healthcare settings short stay management of acute heart failure third edition is an essential guide for cardiologists emergency physicians and hospital administrators as well as for institutions wishing to be recognized as quality heart failure centers

this work ushers in a change in the approach of books on hospital administration to make the text interesting authors have used the case based learning approach apart from this many new topics have been introduced in this book which had not been addressed so far in the available books for example due importance has been given to the role of engineering department in ensuring provision of good quality of medical care by the hospitals new concepts in hospital administration like information therapy use of information and communication technology health promoting hospital approach impact of globalization on hospital care etc have also introduced through this book usp of the book is giving due importance to the feedback from experienced hospital administrators across public and private hospitals of country this book will surely be of use to medical superintendents and hospital administrators in government and private hospitals in india and other countries students as well as teachers of various courses namely regular and distant learning courses of mba in health care hospital administration diploma of masters in hospital administrator md in hospital administrator md in community medicine diploma masters in laws master s in public health will also find this book of immense value this book will also be helpful for civil surgeons and senior medical officers of state health services the book comprehensively consolidates a lot of practical aspects by incorporating plenty of illustrations photographs case studies real life situations etc which will help the readers to get a realistic practical experience salient features new concepts in hospital administration like use of information and communication technology health promoting hospital approach impact of globalization on hospital care role of engineering department and information therapy etc have been introduced case studies presented in the chapters are useful for case based learning approach comprehensively consolidates a lot of practical aspects by incorporating plenty of flowcharts figures and tables help the readers to get a realistic practical experience

one of the significant sources of waste in the unites states health care systems is preventable hospital readmission about 2 3 million medicare fee for service beneficiaries are re hospitalized within 30 days after discharge which incurs an annual cost of 17 billion however it is reported by the medicare payment advisory commission that about 75 of such readmissions can and should be avoided because they are the results of factors such as poor planning for follow up care transitions inadequate communication of discharge instructions and failure to reconcile and coordinate medications hence reducing unnecessary rehospitalization through care transition and systems engineering principles has attracted policymakers and health organizations as a way to simultaneously improve quality of care and reduce costs in this dissertation we investigated predictive and prescriptive analytics approaches for discharge planning and hospital readmission problem motivated by the gaps in research we first develop a new readmission metric based on administrative data that can identify potentially avoidable readmissions from all other types of readmission the approach is promising and uses a comprehensive risk adjustment diagnostic cost group hierarchical condition category to assess the clinical relevance between a readmission and its initial hospitalizations next we tackle the difficulties around selecting an appropriate readmission time interval by proposing a generic continuous time markov chain ctmc approach

conceptualizing the movements of patients after discharge we found that cutoff point defining readmission time interval must not depend on the instantaneous risk of readmission but rather it has to be based on quality of inpatient or outpatient care received

hospital readmission is one measure of quality of care and is an area that needs to be addressed to cut health care costs as part of the affordable care act aca the center for medicare and medicaid services cms implemented the hospital readmissions reduction program hrrp to encourage hospitals to engage patients in discharge planning and improve care coordination to improve america s health care hospitals are financially penalized if they have excessive rates of hospital readmission using a three year rolling period to help meet hrrp s goal various emergency medical services providers piloted or implemented mobile integrated health mih models there are several challenges for mih but the primary hurdle is health insurance reimbursement particularly cms reimbursement donabedian s quality of care framework was used as the model to conceptualize mih cp and its impact on hrrp a literature search was conducted using key terms and inclusion and exclusion criteria yielded 10 hrrp articles and two reimbursement articles for review source materials from various government agencies and private entities were reviewed for background and additional information california started developing its mih programs in 2014 using pilot projects the state had five pilot projects designed to evaluate mih s safety and efficacy in reducing hospital readmissions an evaluation of the california and three pilot projects in other states showed that they effectively reduced hospital readmissions with significant cost savings to medicare and medicaid analyses of four mih cp programs implemented across the nation showed similar findings a review of reimbursement of mih cp services outside of pilot projects showed that several states allow mih cp providers to bill medicaid and commercial insurance plans policymakers should evaluate the feasibility of implementing an mih model in their jurisdiction and explore reimbursement mechanisms for mih cp services to be sustainable

abstract the hospital readmission of patients within 30 days of discharge is crucial to healthcare quality and has involved with high costs in medicare expenditures reducing hospital readmissions has earned great importance in recent relevant healthcare studies thus it is important to identify the factors which cause readmissions and methods to optimally predict the risk of 30 day readmissions for readmit patient populations this study summarizes the findings of a literature review to answer above mentioned questions literature reviews on social studies identified the following high impact factors on readmissions sociodemographic socioeconomic social environment behavioral sociocognitive neighborhood activities of daily living geography and hospital size and hospital admission and discharge information also the studies emphasized the need of adjusting the readmission rate calculation by adding social determinants that have not taken into account almost all statistical and machine learning models have been proven to provide promising predictive performance when compared to standardize readmission tool lace index used by hospitals neural networks penalized model gbm and svm have outperformed other machine learning models when predicting risk of 30

day readmissions

a national focus for healthcare reform is preventing hospital readmissions thirty day unplanned hospital readmissions impact patient outcomes and are costly to the healthcare system this project explored the impact between the discharge navigator and 30 day unplanned readmissions for heart failure and sepsis populations in a 238 bed community hospital located in central virginia the primary aim of this discharge navigator project was to reduce 30 day readmissions for the heart failure and sepsis populations to meet the goals of the top quartile for like hospitals and the evaluation of cost avoidance for these readmissions heart failure and sepsis populations are high risks for readmissions nationwide because they account for the largest frequency of unplanned readmissions within 30 days identification is an essential piece of reducing 30 day readmissions the discharge navigator identified high risk readmission patients that meet the inclusion criteria developed a comprehensive discharge plan collaborated with pharmacy services and aided in the transition of care from acute care to home there was a reduction in 30 day readmissions while the project was being implemented and the goal of top quartile for like hospital was met at the end point of the project potential cost avoidance sums can support the discharge navigator role the discharge navigator project added to the body of knowledge for comprehensive discharge planning coordination and education that is needed for these types of patient populations that have a great deal of medical complexity

the purpose of the study was to look at the recurrence of hospital readmissions and whether a telephone call follow up after discharge to reinforce patient education and understanding medication compliance transition issues and adherence to medical direction is effective at reducing heart failure patient readmission rates within 30 days of hospital discharge

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