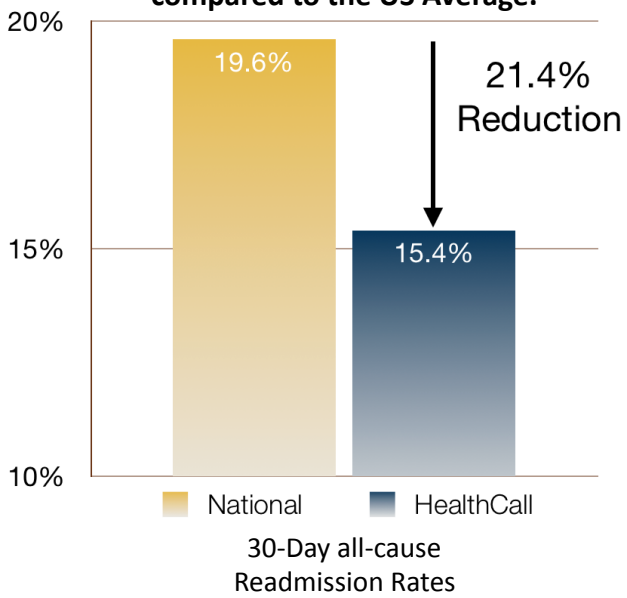
Sustainable Solution Demonstrates Significant Readmission Reductions Across Multiple Entities Nationwide

A key strategy in the Patient Protection and Affordable Care Act of 2010 is prevention of avoidable readmissions to the hospital in the Medicare population. In this vulnerable population, consisting of the elderly and disabled, 20% are readmitted to the hospital within 30 days of discharge, at a cost of $17.4 billion[1]. With the increasing pressure to simultaneously improve care and reduce the overall cost of care, there is increasing need for better care coordination. Specifically, patients who are high risk for readmissions and poor health outcomes need to improve their transition from the inpatient hospital setting to the home. The majority of healthcare providers continue to be unprepared for the increasing emphasis on transitional care[2]. The national goal of a 20% reduction in readmissions is aspirational because there has been no sustainable model for achieving this in all but the very highest risk groups[3] -- until now. HealthCall is the first to provide a sustainable solution proven across multiple providers in multiple organizations nationwide to consistently demonstrate a significant reduction in readmissions in a large cross section of patients.

Readmission rates:

In an analysis of 1,920 patients within a readmission reduction program based upon HealthCall's PersonalTouch™ solution, 296 were readmitted within 30 days, resulting in a readmission rate of 15.42% and a 21.4% reduction compared to the national average of 19.6% (Figure 1). These are real world patients with multiple conditions and comorbidities. Unlike control studies, there were no exclusion criteria.

Figure 1: Readmission rates for HealthCall compared to the US Average.



PersonalTouch™ is an administrative and clinical care coordination system designed for use directly by hospitals, home health agencies, post-acute care providers, and specially trained paramedics (EMS).

Patients are assigned to a care plan within the system based upon their primary diagnosis, such as a respiratory or heart health program. Once assigned, a care specialist can individualize the care plan based upon the patient's specific needs.

HealthCall, LLC
Main: 219-476-3459 • Email: info@healthcall.com • www.healthcall.com

Through a system of education, coaching, and signs and symptoms monitoring, PersonalTouch™ engages patients in the adoption of self-management skills, improves health literacy, and facilitates increased collaboration on behalf of their provider.

Impact

By understanding the root causes of readmissions and working within the system, which enables continuum of care partnerships to ensure that objective measures are attained, HealthCall PersonalTouch™ is a vital tool in improving health outcomes and reducing the overall cost of care. HealthCall's experience and published evidence has resulted in improved health outcomes, better care coordination, improved care effectiveness and population health, better quality, and improved operational efficiency.

Contact

HealthCall, LLC
9800 Connecticut Drive
Crown Point, IN 46307
Phone: 219-476-3459
Email: info@healthcall.com
Web: www.healthcall.com

1. Bradley, E.H., Curry, L, Horwitz, L.I., Sipsma, H., Thompson, J.W., Elma, M.A., Walsh, M.N., & Krumholz, H.M. (2012). Contemporary evidence about hospital strategies for reducing 30-day readmissions. *Journal of the American College of Cardiology*. 60, 607-614.
2. Jencks, S.F., Williams, M.V., Coleman, E.A. (2009). Rehospitalizations among patients in the Medicare Fee-for-service program. *New England Journal of Medicine*, 360, 1418-1428.
3. McClellan, M., McKethan, A.N., Lewis, J.L., Roski, J., & Fisher, E.S. (2010). A national strategy to put accountable care into practice. Health Affairs, 29, 982-990.