HealthCall®

Case Study
Dramatically Improving Outcomes and Reduced Costs

PROVIDER:
Community Health Network

Nonprofit health system with more than 200 sites of care throughout Central Indiana—including one of the state's largest home health agencies

CHALLENGE:
Home Health Monitoring System Couldn't Meet Expanding Needs

Within the Community Health Network, Community Home Health monitors patients of physicians, heart failure clinics, diabetes care clinics, and their own home health populations. They also monitor hospital patients after discharge to help ensure their successful transition back into their homes—and to reduce 30-day readmissions rates.

But the system Community was using to monitor patients couldn't keep pace with increasing demands, and changes often had to be recoded, making the entire process lengthy and frustrating. "We needed a more robust system that would allow us to take it to a different level," said Lisa Collins, Community Home Health's chief clinical and operations officer. "One with more depth, that could expand very rapidly."

SOLUTION:
HealthCall for Home Health and Telehealth Care

Collins considered many vendors for a new software solution. But she was won over by HealthCall's responsiveness, user-friendly interface, and the service provided by a team of seasoned healthcare professionals.

HealthCall's implementation team met with managers and nurses to develop customized, evidence-based care plans tailored to Community's needs. HealthCall can easily be configured to track patients for disease management, post-discharge monitoring, or any other application requiring the tracking of patients over time. The best-practice care plan for each patient can be easily modified by Community's staff during the enrollment process.

Once enrolled, managing patients is just as easy. HealthCall's automated system handles many patient encounters, allowing staff to provide patient-centric care precisely where and when it's needed. The HealthCall system flags the patient's chart and alerts staff whenever a patient's response falls outside the built-in parameters. Staff can add personalized patient education or reinforcements specific to the individual patient's needs.

HealthCall trained Community's staff on the new platform. Its ease of use meant that implementation and training were completed without a hitch, and in record time. "It was a very smooth conversion," Collins said.

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Community was so pleased with how well the system worked for post-acute-care patients, they soon migrated 100 device-based telehealth patients to the system as well. “We knew we weren’t going to compromise patient outcomes by making the transition,” Collins said. “It was just going to be a more cost-effective way for us to manage care internally.”

RESULTS:
Reduced Costs, Increased Efficiencies, and Much Lower Readmission Rates

Since implementing HealthCall, readmission rates for Community Home Health have fallen dramatically. For heart failure patients, Community Home Health’s readmission rate is just 4.7 percent, versus the national average of 18.5 percent. Collins notes that the A1C levels for Community Home Health’s diabetic patients have also dropped significantly since using HealthCall.

“As a healthcare provider, the benefit we see is the efficiency and the cost-effectiveness, while ensuring patient outcomes,” said Collins. “HealthCall has just been fantastic to work with.”

For more information please contact HealthCall at 219-476-3459 or visit our website, www.HealthCall.com.

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