HealthCall®

CASE STUDY: COMMUNITY HEALTH SYSTEM

COMMUNITY HOME HEALTH MIGRATES COMMUNITY HEALTH NETWORK AND TELE-HEALTH PATIENTS TO THE HEALTHCALL-PRO PLATFORM TO IMPROVE CARE AND REDUCE COSTS

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Community Health Network Migrates Patients to the HealthCall-Pro™ Platform to Improve Care and Reduce Costs

Community Home Health monitors patients of physicians, heart failure clinics, diabetes care clinics and their own home health populations within the Community Health Network.

Additionally, they monitor hospital patients after discharge to help ensure their successful transition back into their home. Reducing 30-day readmissions is especially critical given Affordable Care Act penalties tied to patient readmissions.

THE CHALLENGE: An Old System that Couldn't Meet Expanding Needs

The prior system Community Home Health was using couldn't keep pace with the increasing demands.

"We needed a more robust system that would allow us to take it to a different level—one with more depth—and expand very rapidly," said Lisa Collins, chief clinical and operations officer for Community Home Health.

Changes could be made to the system, but it wasn't easy, it wasn't fast and it often involved recoding, which was time-consuming and frustrating. In short, the old system was incapable of providing the flexibility and expanded capacity Community Home Health needed.

To reduce headaches and ensure it would be prepared for its ever-expanding role, Community Home Health needed to find a better solution.

THE SOLUTION: A Credible Partner in HealthCall, LLC

Many vendors were considered during the search process, then Collins heard about HealthCall, LLC, from different sources, including a nurse who had used it at another hospital and recommended it highly.

Collins was impressed with HealthCall's responsiveness, user-friendly interface and the team's ability to comprehend Community Home Health's needs. The fact that HealthCall's team consists of seasoned healthcare professionals was "a plus."

A HealthCall implementation team met with the managers and nurses to develop customized care plans derived from evidence-based guidelines and tailored to

Community Home Health's needs. HealthCall-Pro™, HealthCall's cloud-based care coordination platform, can be configured for disease management, post-discharge monitoring of patients and virtually any instance where patients need to be tracked over time.

The best-practice care plan assigned to a patient can easily be modified during the initial enrollment process by unselecting irrelevant questions, assigning new ones and indicating the days the automated assessments and live encounters should occur.

"When it comes to healthcare, we believe one size does not fit all," said Daniel Hayes, president and CEO for HealthCall. "With HealthCall, staff can very quickly individualize health assessments to fit the needs of each patient to better care for multiple comorbidities and changing disease states."

The program was completed in record time, with every deadline met. The last step was for HealthCall to train Community Home Health's staff to use the new platform. On April 14, 2014 the first patients were transitioned to HealthCall-Pro.

"It was a very smooth conversion," Collins said. "HealthCall has just been fantastic to work with."

Staff can focus on managing by exception and providing patient-centric care

Whenever a patient's response falls outside the built-in parameters, HealthCall-Pro flags the patient's chart. The nurse needs to run only one report, identify the flagged charts and prioritize her follow-up calls accordingly. A huge patient population can be managed efficiently and effectively by very few staff.

Not only that, but nursing staff can focus on the right patients at the right time, providing patient-centric care where it's needed most as they interact with patients during critical follow-up calls.

"The nurse finds out exactly what's taking place with the patient," Collins said. "At that point she can add personalized patient education or reinforcements specific to that individual patient's needs."

Patients learn to practice long-term self-care for a healthier lifestyle

The system not only gathers critical data on patients, it educates patients on why incorporating certain routines or habits into their lifestyle is so important.

"I think that's the biggest key," Collins said. "Unless patients recognize the need for changing their behavior, it's never going to happen. The biggest change in patients comes from the combination of consistent reinforcement from the automated assessments and nurse encounters. Patients are able to sustain those changes for the long-run, stay out of the hospital and enjoy a better quality of life."

A superior alternative to device-based tele-health systems

Community Home Health was so pleased with how well the HealthCall-Pro system worked for its post acute-care population that after just two months (June, 2014) it migrated 100 device-based tele-health patients to the HealthCall care coordination platform.

"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."

The savings were substantial—no equipment rental or purchase upfront, no delivery and pick-up fees, no cleaning and refurbishment of equipment.

"As a healthcare provider the benefit we see is the efficiency and the cost-effectiveness while ensuring patient outcomes."

Lisa Collins,
Chief Clinical & Operations Officer
Community Home Health.

While some people were skeptical about replacing a device-driven tele-health system with a self-report system, Collins said it hasn't been a problem, adding that if someone's inclined to cheat, they'll find a way to do it, even with a device-based system.

When it comes to patient care, the value-added HealthCall brings is it's ability to bring non-measurable symptoms, such as swelling of the ankles, to the attention of the nursing staff early. They can then intervene and head off potential problems before they occur.

"There are key symptoms that will manifest weeks or months before measurable signs such as blood pressure or weight usually manifest," Hayes said. "We also track symptoms so we are substantially more proactive in reducing readmissions."

Another big plus is that patients are actively engaged in their own care rather than submissively letting the equipment take and report all the data.

RESULTS: Reduced Costs, Increased Efficiencies and Low Readmission Rates

Community Home Health's hospital readmission rate is far below the national average. Currently the average readmission for heart failure patients is about 18.5 percent within

30 days after discharge from the hospital. “We just pulled our data and we’re at a 4.7 percent readmit rate,” Collins said. She also noted that AIC levels in diabetic patients have significantly dropped since implementing the HealthCall system.

Staff can efficiently manage by exception and provide patient-centric care to patients who need it most. The HealthCall automated assessment reinforce healthy habits that patients can follow for their lifetime.

Collins is working with HealthCall to create a hospice care plan for their hospice patients and their caregivers. “It will allow us to have a laser focus on their pain and symptom management,” Collins said. That program is slated for the fourth quarter of 2014.

“HealthCall has just been fantastic to work with,” Collins said.

“As a healthcare provider the benefit we see is the efficiency and the cost-effectiveness while ensuring patient outcomes,” said Lisa Collins, chief clinical and operations officer for Community Home Health.

ABOUT COMMUNITY HOME HEALTH SERVICES

Community Home Health, part of Community Health Network, has been providing home health care to central Indiana residents for more than 55 years. It is one of the largest home health agencies in Indiana and is accredited by the Joint Commission.

ABOUT HEALTHCALL, LLC

HealthCall, LLC, a leading medical communications company, pioneered Automated Patient Response™ solutions. Since 2003 HealthCall has consistently demonstrated a significant reduction in hospital readmissions and improved clinical outcomes in large patient populations. Today, the company provides innovative care coordination platforms, intelligent patient engagement, and proven care plans for use in chronic disease management, post-acute care, and population health management. The HealthCall care coordination network connects patients and providers within health systems, hospitals, clinics, hospice, home health, home medical equipment providers and emergency medical services.

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