How an Electronic Health Record (EHR) Assists in Improving Mobile Integrated Health and Community Paramedicine

Article by Acadian Health's Electronic Health Record (EHR), HealthCall

Foreword: Tech-Enabled Community Care in Action

By Jeremy Coombs, Senior Director of Acadian Health

At Acadian Health, our mission centers on delivering high-touch, clinical-grade care directly to where patients live and work—whether that is a suburban residence or a rural home. Operating effectively at the edge of the healthcare delivery system requires technology that is as mobile, flexible, and responsive as our field teams.

That is why HealthCall's Care Delivery Platform is an essential component of our operational ecosystem. Standard electronic health records (EHRs) are designed primarily for brick-and-mortar facilities and often fall short in the field. HealthCall serves as a specialized EHR and care coordination platform tailored to the unique realities of Mobile Integrated Health (MIH), community paramedicine, and mobile crisis response. It equips our clinicians with longitudinal patient records, SMART Charts, decision-support tools, real-time telehealth capabilities, and optional patient feedback avenues—ensuring complete visibility and seamless data sharing across the entire continuum of care.

Integrating this platform into our infrastructure allows Acadian Health to continuously elevate and scale our core service lines:

- **Hospital-at-Home:** HealthCall provides the continuous patient monitoring, real-time alerting, and multidisciplinary workflows required to deliver hospital-level oversight in the domestic environment—safely managing complex recovery protocols and driving down 30-day readmission rates.
- **Clinic-at-Home:** Field clinicians utilize SMART Charts, evidence-based care plans, and mobile documentation tools to deliver comprehensive outpatient services directly to the patient's doorstep, including preventive health check-ins, routine chronic condition management, and social determinants of health (SDOH) assessments.
- **Acute-Care-at-Home:** When patient conditions deteriorate unexpectedly, our teams leverage one-click telehealth and decision-support features to conduct high-acuity evaluations, enabling rapid provider intervention and diverting unnecessary emergency department visits.

Technology alone cannot close healthcare gaps—trusted local responders do. However, when skilled clinicians are backed by purpose-built digital tools, we can effectively eliminate the transitions that so often lead to preventable hospital visits.

Below, the team at HealthCall outlines how coordinated, community-based care models and field-ready technology are reshaping post-acute outcomes across the industry.

Closing the Gaps That Drive Readmissions: How Coordinated, Community-Based Care Improves Outcomes

A recent *Modern Healthcare* article, "How closing post-acute care gaps is

reducing hospital readmissions" highlights a persistent challenge: poorly executed handoffs between post-acute facilities and home care. According to CMS data cited in the piece, roughly one in five patients discharged to post-acute care returns to the hospital within 30 days. Badly coordinated transitions, especially from skilled nursing facilities back into the home, remain a leading driver of these costly and avoidable events.

Organizations such as Optum, CenterWell, and Banner Health are responding with technology, staffing, and tighter operational control over the post-acute continuum. Their efforts underscore a clear principle: when care teams have the right information, the right workflows, and the ability to stay connected with patients after discharge, outcomes improve and readmissions fall.

That same principle drives how HealthCall partners with Mobile Integrated Health (MIH), community paramedicine, home health, and crisis response teams every day.

Bridging the Transition Gap Where Patients Actually Live

Hospital and skilled nursing discharge is only the beginning of recovery. The critical period that follows often unfolds in the patient's home, or on the street, where traditional systems have limited reach. HealthCall's Care Delivery Platform was built for these environments. It gives multidisciplinary teams a single longitudinal record and practical tools to close the gaps that otherwise send patients back to the emergency department or hospital.

Key capabilities that support seamless transitions include:

- **Longitudinal patient records and SMART Charts** that travel with the patient across settings, so community responders, home health clinicians, and care coordinators see the same history, medications,

assessments, and care plans.
- **Community Care Network** functionality that enables secure referrals, task assignment, and real-time collaboration among hospitals, EMS agencies, primary care, behavioral health, and community partners.
- **Post-discharge and post-crisis follow-up workflows** that prompt timely in-home or virtual check-ins, medication reviews, and safety assessments before small problems escalate.
- **One-click telehealth and remote patient monitoring** that extend clinical reach into the home, allowing rapid provider input when a community paramedic or home health clinician identifies a concern.
- **Automated alerts, evidence-based care plans, and decision support** that help teams manage by exception and intervene early rather than reacting after a 911 call or readmission.

Together, these features turn fragmented handoffs into continuous, accountable care.

Proven Results Across Diverse Programs

HealthCall clients consistently demonstrate that closing these gaps produces measurable improvements:

- A large home health network using HealthCall achieved a **4.7% 30-day readmission rate** for heart failure patients, compared with the national average of 18.5%.
- In a post-discharge care initiative, readmissions fell **57% at 30 days** and **45% at 90 days**, while average length of stay dropped by nearly five days per patient.
- The Crisis Center of Tampa Bay, after adopting the platform, recorded **86% fewer hospital visits**, **87.6% fewer ED visits**, and **85.8% fewer inpatient admissions** within the first six months.

- Other programs have shown COPD-related readmissions more than 50% below national benchmarks, sharp declines in avoidable 911 utilization, and stronger patient adherence to treatment plans.

These outcomes are not isolated. Across hundreds of implementations, teams using HealthCall report fewer preventable hospital days, lower total cost of care, and higher patient and clinician satisfaction, the classic Triple Aim results that value-based models demand.

Technology + Local Teams: How We Do This Together

Technology alone does not close care gaps. The most successful programs combine a flexible, field-ready platform with trusted local responders who already know the community. HealthCall supplies the documentation, coordination, monitoring, and reporting infrastructure; agencies and health systems supply the clinical judgment, relationships, and presence at the bedside or in the living room.

One partner that exemplifies this model is **Acadian**. Through its Mobile Integrated Health programs, Acadian has leveraged HealthCall to deliver coordinated care across diverse settings, from urban and home-based patient populations to remote industrial and offshore environments. HealthCall has previously highlighted Acadian's innovative approach in two articles on our website: Providing Mobile Integrated Healthcare 300 Miles Offshore and Providing Mobile Integrated Healthcare With Payers. These stories illustrate how Acadian uses the platform to support virtual primary and urgent care visits, preventive screenings, social determinants of health assessments, and seamless coordination with payers and clinical partners, exactly the kind of gap-closing work that reduces avoidable utilization and improves outcomes.

The result is a practical continuum that begins at hospital discharge (or even earlier, at the 911 call) and continues through recovery at home. Patients receive timely follow-up. Care teams share a common record and clear accountability. And health systems, payers, and communities see fewer readmissions and stronger outcomes.

As the *Modern Healthcare* article makes clear, the industry is intensifying its focus on the post-acute transition. For organizations ready to extend that focus into the home and the community, with tools purpose-built for the realities of mobile and community-based care, HealthCall offers a proven path forward.

Connect seamlessly. Document freely. Advance outcomes.

Sources: Modern Healthcare, "How closing post-acute care gaps is reducing hospital readmissions" (July 2026); HealthCall case studies and client results published at healthcall.com, including prior features on Acadian.