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# ■ PersonalTouch™

Empower the new standard of  
patient-centered, accountable care

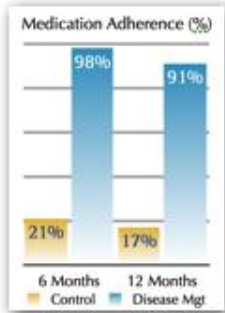
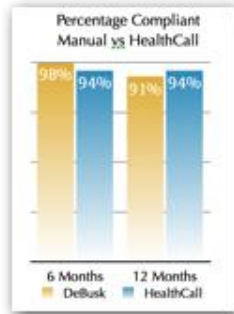
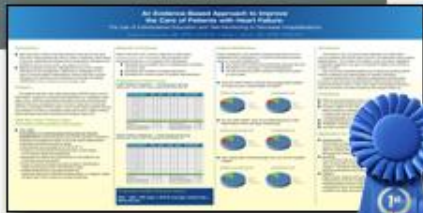




# Award-Winning Clinical Innovation

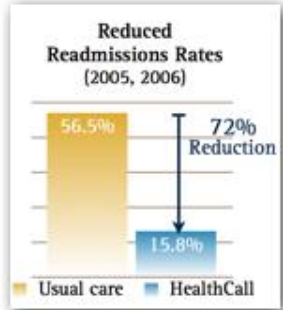
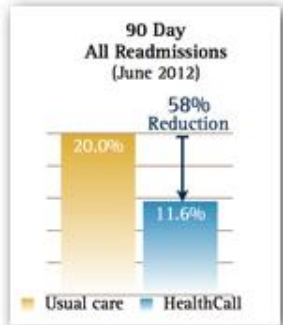
A HealthCall study takes First Place and receives the Evidence-Based Clinical Innovation Award at the 2008 American Association of Heart Failure Nurses (AAHFN) conference.

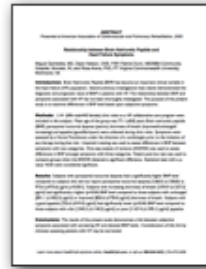
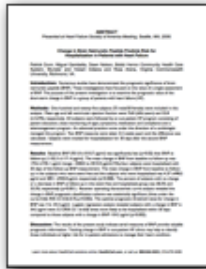
Independent study demonstrates a 56% cost reduction documenting a 10 to 1 ROI, with 10 dollars returned for every dollar invested.



Studies presented at the Heart Failure Society of America

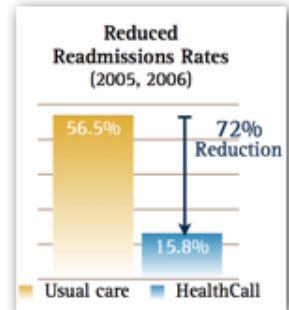
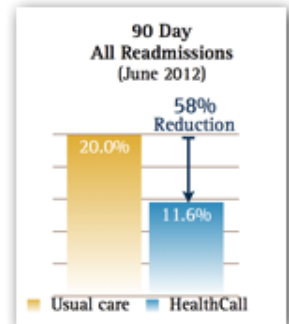
- 2005: 72% Reduced Readmission Rates Collaborative care HF treatment program
- 2006: 72% Reduced Readmission Rates Collaborative care HF treatment program
- 2007: Significant Reduction in BNP\* Positive Physiological Adaptations





# Award-Winning Clinical Innovation

- Proven in production, every day
- Demonstrated and published studies
- HIPAA Compliant procedures and offering
- Over 10 Years in Medical Communications
- 2,000,000+ patients have used the HealthCall network

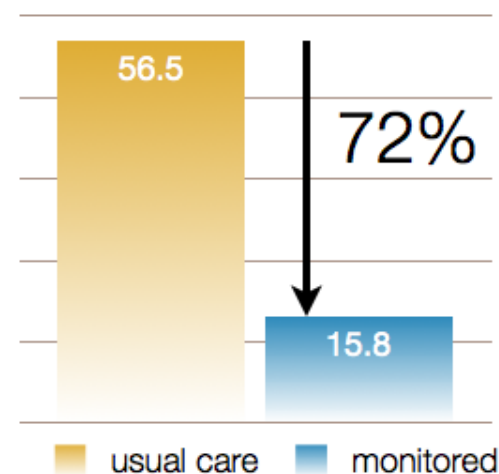


# Demonstrated & Published

## Heart Failure Society of America

- 2005: 72% Reduced Readmission Rates Collaborative care HF treatment program
- 2006: 72% Reduced Readmission Rates Collaborative care HF treatment program
- 2007: Significant Reduction in BNP\* Positive Physiological Adaptations

## Reduced Readmissions Rates



\*BNP: b-type natriuretic peptide

# Evidence-Based Clinical Innovation

A HealthCall study takes **First Place** and receives the **Evidence-Based Clinical Innovation Award** at the 2008 American Association of Heart Failure Nurses (**AAHFN**) conference.

**An Evidence-Based Approach to Improve the Care of Patients with Heart Failure:**  
The Use of Individualized Education and Tele-Monitoring to Decrease Hospitalizations

Suzanne Heikman, MS, APRN, ACNS-BC • Bobbi J. Hewitt, MS, APRN, ACNS-BC

**Introduction**

- More than half a million Americans develop heart failure each year. One half of those patients die within 5 years of diagnosis. Heart failure is the only cardiovascular disease that is increasing in prevalence and incidence among men younger than 65 years of age.
- Patients experience frequent hospitalizations due to the complex difficulties of self-management. Healthcare is challenged to find ways to improve patient independence, improve self-care, provide education and decrease acute admissions and length of hospital confinement. *Journal of Heart Improvement Strategies, 2006*

**Problem**

On patients with New York Heart Association (NYHA) class II and IV heart failure enrolled in a Clinical Nurse Specialist run, ambulatory heart failure clinic, utilizing individualized education and tele-monitoring with frequent follow-up, experience more "in-home" days due to improved self-care, compared to NYHA class II and IV heart failure patients that are not enrolled in a CNS run ambulatory heart failure clinic utilizing individualized education and tele-monitoring with frequent follow-up?

**CNS Run-Heart Failure Clinic: Providing Individualized Education**

- The CNS Completed an Individualized Educational Needs Assessment utilizing education and clinical expertise to influence, evaluate and manage the needs of the heart failure patient/family.
  - Identified individual educational needs.
  - Assessed and evaluated an SF 36 or SF 12.
  - Created an Individualized Educational Plan of Care based on the patient needs and preferences.
  - Educated and trained the patient/family on the effective use of the tele-monitoring system.
  - Goals for learning included accurate symptom identification, weight reporting and other individualized needs.
  - Created patient/family educational goals and objectives following for health/changing patient or caregiver needs for each clinic visit or follow-up via tele-monitoring.

**Methods to Evaluate**

Patient admission with a primary diagnosis of heart failure  $n=20$  (see below) were assessed and compared to the Interventional Group  $n=10$  to assess if the interventions:

- Decreased acute inpatient days of hospitalization including "at home" days.
- Decreased the numbers of hospital admissions.
- Decreased the overall number of inpatient days/admission.

**Hospitalized Patient Days**  
Heart Failure Patients — Comparison Group  
January 2008 - June 20, 2007 (Pre-Intervention) (N=20)

Category	Value
Total Hospitalized Patient Days	1,000
Acute Inpatient Days	800
Home Days	200

Heart Failure Patients — Interventional Group  
January 2008 - June 20, 2007 (Pre-Intervention) (N=10)

Category	Value
Total Hospitalized Patient Days	440
Acute Inpatient Days	340
Home Days	100

**Projected Facility Financial Impact**  
200 - 220 = 180 days x \$1310 average cost/pt day = \$235,800.00

**Patient Satisfaction**

Patient satisfaction was assessed comparing responses from the established clinic participants and the Interventional patient group  $n=10$  to see if patients felt:

- The Heart Failure Clinical Nurse Specialist improved self care.
- Perceptions of a decrease in acute hospitalizations.
- The tele-monitoring system assisted in keeping the patient at home longer.

■ Has the Heart Failure Clinical Nurse Specialist helped to improve your overall state of health?

■ Do you take better care of yourself because of the heart failure clinic and tele-monitoring?

■ Has using Tele-monitoring kept you out of the hospital longer?

**Conclusion**

The effective use of a Clinical Nurse Specialist run Heart Failure clinic for patients with NYHA class II and IV can effectively lower hospital readmissions. The number of in-patient, acute care days, regardless of admitting diagnosis, can also be impacted if patients are enrolled in a CNS run clinic. Tele-monitoring impacted patients and nursing by providing patient data for evaluation and opportunities for frequent interaction. Financial implications for healthcare organizations seeking ways to reduce costs and meet reimbursement criteria should include an advanced practice CNS run clinic that offers individualized education, self-care promotion and tele-monitoring with frequent follow-up.

**Limitations**

- Difficulty proving financial value of the CNS and clinic expense.
- Lack of inter/collaboration from physicians.
- Physician referral to the clinic arrives during the late stages of heart failure providing a challenge for the CNS to:
  - Impact early chronic symptoms or behaviors.
  - Impact length of survival experienced by the patient.
  - Language/Reading/Comprehension barriers.
  - Availability of teaching materials at a 4th grade level.
  - Accurate symptom reporting via tele-management.

**Application for Advanced Practice**

- Organization**  
The Centers for Medicare and Medicaid requires healthcare to provide quality, evidenced health care for patients with heart failure. It's effect on patient health behaviors increases "at-home days" and decreases the financial impact of hospitalization.
- Nursing**  
The role of the CNS for patients with heart failure includes acting as other nursing staff on the care of this patient population and a caregiver. Consistent delivery of quality education for the public requires reinforcement and support for all stages of heart failure.
- Patient**  
Patient social, religious and personal preferences, to support their independence must be considered. A CNS can influence all steps impacting patient care by collaborating, consulting and being a contributor of care. This results in the patient receiving the best possible care that meets their personal needs.



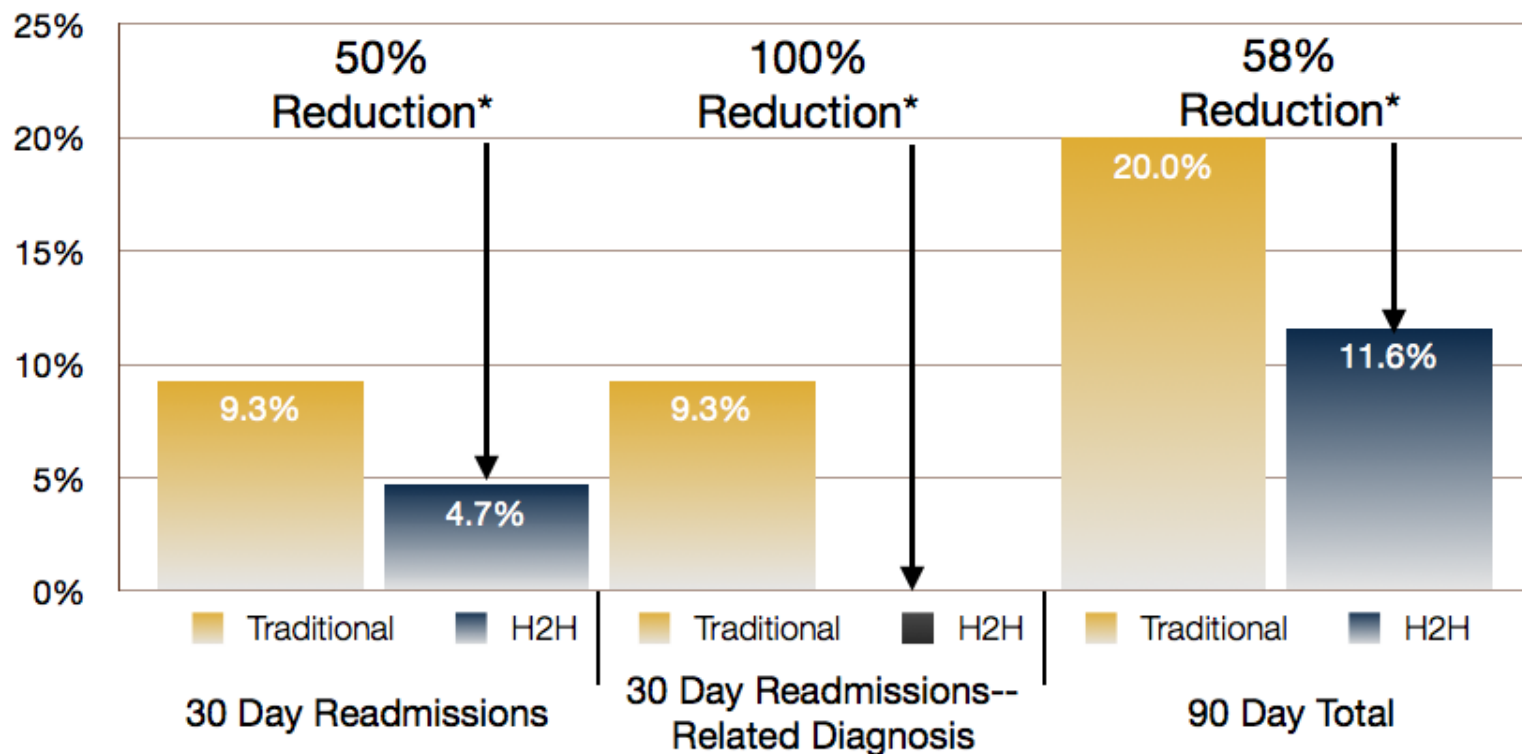
Independent study demonstrates a 56% cost reduction documenting a 10 to 1 ROI, with 10 dollars returned for every dollar invested.



# Impact of Program-Type on Readmission Rates

Bart Collins, Ph.D.  
Purdue University

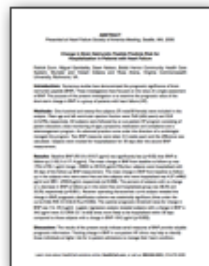
## Reduced Readmissions Rates 2012



\* Results are not typical

**HealthCall**  
Transforming Medical Communications

# Can readmissions be predicted?



## **Brain Natriuretic Peptide is a Predictor of Thirty Day Hospital Admission in Patients Enrolled in a Collaborative Care Heart Failure Treatment Program**

Presented at Heart Failure Society of America Meeting, Boca Raton, FL, 2005.



## **Change in Brain Natriuretic Peptide Predicts Risk for Hospitalization in Patients with Heart Failure**

Presented at Heart Failure Society of America Meeting, Seattle, WA, 2006.



## **Relationship between Brain Natriuretic Peptide and Heart Failure Symptoms**

Presented at AACVPR, 2006

## **Relationship between pulmonary auscultation and brain natriuretic peptide in patients with heart failure**

Presented at the American College of Sports Medicine, 2006



# Can readmissions be prevented?

## **Reduction of B-Type Natriuretic Peptide using Telemanagement in Patients with Heart Failure**

Presented at Heart Failure Society of America Meeting, Seattle, WA, 2006.

## **Reduction in hospital readmissions with a collaborative care heart failure treatment program.**

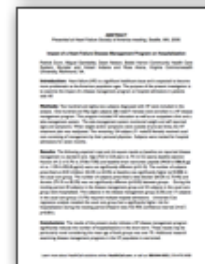
5th Scientific Forum on Quality of Care and Outcomes Research in Cardiovascular Disease and Stroke. 2004. Circulation Online.

## **An Evidence-Based Approach to Improve the Care of Patients with Heart Failure**

AAHF annual meeting, 2008

## **Impact of the Implementation of Telemanagement on a Disease Management Program in an Elderly Heart Failure Cohort**

Progress in Cardiovascular Nursing; 22:196–200, 2007





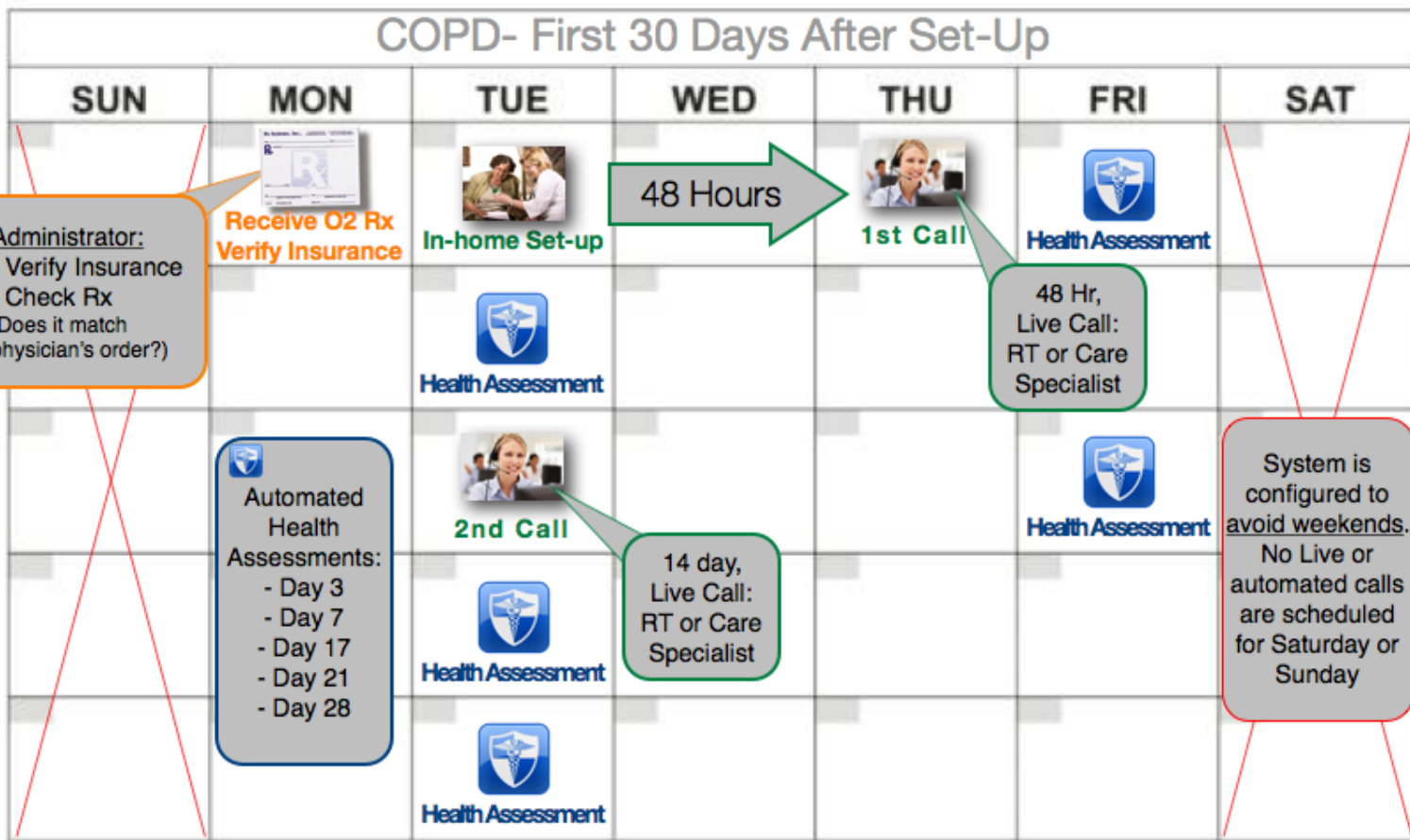
# Introducing **PersonalTouch™**

*Empowering Continuum of Care Partnerships*

- **Proven clinical management platform**
  - Built on nearly 10 years of proven out-patient monitoring
  - Process improvement controls and analytics
  - Robust process management and communication tools
- **Turnkey operation**
  - Eliminates long learning curve and ambiguity
  - Financial and clinical efficacy, on time and on budget
- **Flexible care plans**
  - Patient-centered, evidence based protocols
  - Complements existing H2H programs
  - Coordinated care & collaboration among providers
- **Individualized patient care**
- **Impacts mission critical areas**



# PersonalTouch™ Example Outreach



**Administrator:**  
 - Verify Insurance  
 - Check Rx  
 (Does it match physician's order?)

**Automated Health Assessments:**  
 - Day 3  
 - Day 7  
 - Day 17  
 - Day 21  
 - Day 28

 Automated Health Assessments

**HealthCall.**  
 Transforming Medical Communications

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## Flexible Care Plans

- Aligns with your H2H program
  - Eric Coleman Model
  - Project BOOST  
(Better Outcomes for Older adults through Safe Transitions)
  - Project RED (Re-Engineered Discharge)



# Patient-Centered Population Management

- Driven by the patient's experience
- Segmented by
  - Primary diagnosis,
  - Chief complaint,
  - Wellness program,
  - Fitness goal
- Enables manage by exception
- Individualized care plans
- Enables coordinated care & collaboration among providers
- Reinforces organizations brand and provider loyalty
- HIPAA compliant

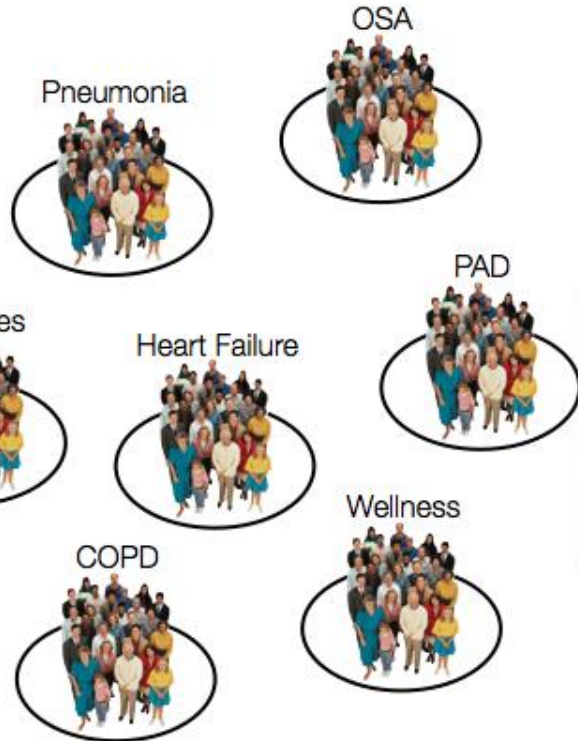


VirtualClinic™ technology enables the management of similar patient populations across multiple geographic locations



# Patient-Centered Population Management

# Clinical Monitoring, Adherence and Follow-up



Individualized



Segmented  
Populations

Individualized Care Plan

**Bay Area Medical**

Patient Name: Elan George  
Patient Number: 10000000000000000000  
Physician: Miguel Salazar  
Date: 10/1/2011 11:44:10AM

**Weight**

Date	Weight (kg)
10/1/2011	70.0
10/2/2011	70.0
10/3/2011	70.0
10/4/2011	70.0
10/5/2011	70.0
10/6/2011	70.0
10/7/2011	70.0
10/8/2011	70.0
10/9/2011	70.0
10/10/2011	70.0
10/11/2011	70.0
10/12/2011	70.0
10/13/2011	70.0
10/14/2011	70.0
10/15/2011	70.0
10/16/2011	70.0
10/17/2011	70.0
10/18/2011	70.0
10/19/2011	70.0
10/20/2011	70.0
10/21/2011	70.0
10/22/2011	70.0
10/23/2011	70.0
10/24/2011	70.0
10/25/2011	70.0
10/26/2011	70.0
10/27/2011	70.0
10/28/2011	70.0
10/29/2011	70.0
10/30/2011	70.0
10/31/2011	70.0

**Medications**

Name	Dose	Frequency	Last Dose Date
Aspirin	81mg PO	QD once a day	
Acetaminophen	325mg PO	QD once a day	
Clonidine	0.1mg PO	QD once a day	
Losartan	50mg PO	QD once a day	
Metoprolol	50mg PO	QD once a day	
Warfarin	2mg PO	QD once a day	
Hydrochlorothiazide	12.5mg PO	QD once a day	
Insulin	100 units	QD once a day	

**Questions**

- Please enter your weight (1144)
- Since your last assessment have you experienced faint you experienced any dizziness? (1307)
- Does your abdomen feel bloated, press 1 for yes, and 2 for no. (2001)
- Since your last assessment have you experienced more shortness of breath? (1312)
- Have you noticed any swelling in your feet, legs, hands, face, belly, or around your eyes? (1311)
- Are you more tired than usual? (1306)
- How many pillows did you sleep with last night? (1315)
- Have you taken your medications as prescribed by your physicians? (1306)
- Within the last week have you done any of the following: have you been admitted to the hospital, gone to the emergency room, visited any healthcare provider, or have you had any blood work or tests conducted? (Monday's only)

**Intervention Log and Notes**

Date	Intervention	Notes
10/1/2011	Check weight	70.0 kg
10/1/2011	Check vitals	BP 110/70, HR 68, RR 16, SpO2 98%
10/1/2011	Check meds	All meds taken as prescribed
10/1/2011	Check symptoms	No symptoms reported
10/1/2011	Check adherence	Medications taken as prescribed
10/1/2011	Check education	Reviewed medication list
10/1/2011	Check follow-up	Next appointment in 30 days



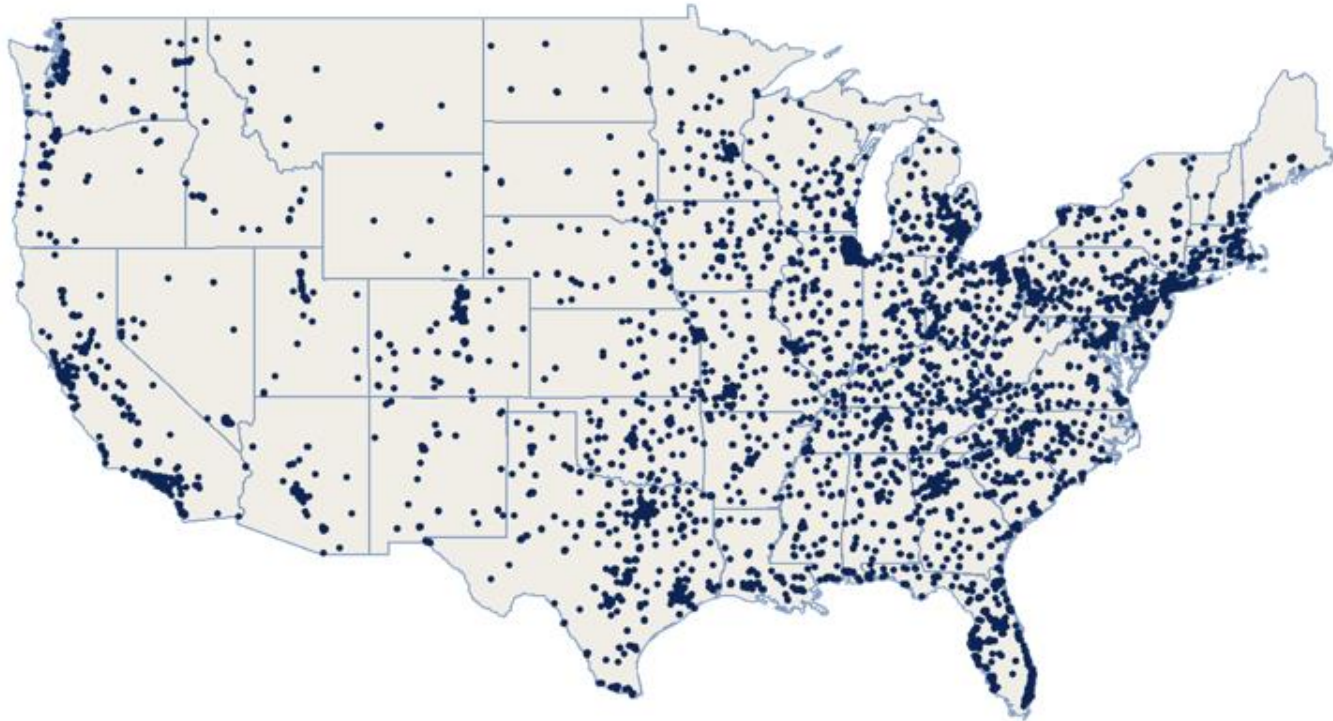
# Secure Collaboration In the Outpatient Setting



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Powered by HealthCall®

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# Available Service Locations



The Best, Most Comprehensive Coverage!



**HealthCall**<sup>®</sup>  
Transforming Medical Communications

# Training for Coaches

- **Building relationships & rapport**
  - Building rapport for accountability
- **Empowering patient self-care**
  - Coaching versus nursing
  - Guiding & correcting behavior
  - Reflective listening
- **Successfully conducting encounters**
  - Face-to-face encounters
  - Phone encounters
  - At-risk encounters
- **Promoting health literacy**



Clinical Educators are RNs and  
Board Certified Nursing Professional  
Development Specialist



# Encounter Management

- Easy task management
- Manage call center operation
- Quickly ramp-up new staff
- Track and manage “work-from-home”
- Completely customizable
  - Format & layout

The image displays four overlapping screenshots of the HealthCall software interface, illustrating its features for encounter management:

- Task Manager:** A central window showing a list of tasks with columns for Task, Assigned, Priority, Date, Clinic, and Program. Tasks include "Check lab report for Raymond Greenblatt", "Flacher, Cynthia - 1st Phone Call", "Gregg, Paul - 2nd Phone Call", "Jackson, David - Hospital Visit", "Markow, Brian - 1st Phone Call", "Mina, Russell - Hospital Visit", and "Transfer Jennifer Landford to heart failure clinic".
- Call Patient (Assessment):** A window for patient assessment for George Smith. It includes fields for Patient Name, Primary Phone, Care Program, Program Duration, and Alternate Contact. The assessment questions include: "On average how many days per week do you use your CPAP machine?", "According to your insurance provider you are eligible to receive new supplies every 90 days including a new mask, cushions, tubing, and filters. Both your doctor and insurance provider promote your health by encouraging you to replace your supplies regularly to prevent complications caused by bacteria and mold. Would you like someone to call you about ordering CPAP Supplies?", "Have you had any changes in your insurance, doctor, or address in the last 90 days?", and "On average how many hours per night do you use your CPAP machine?".
- Call Patient (Checklist):** A window showing a checklist for "Building Stronger Relationships" with items like "Do not criticize, condemn, or complain.", "Give honest, sincere appreciation.", "Show respect for the clients opinion. Never say, you are wrong.", "Smile. Even over the phone, it shows when you smile.", "Learn how to correct.", "Talk in terms of the client.", "Become genuinely interested.", "Be a good listener. Ask questions.", and "Express authentic concern." It also includes a "7-Step Outline for a 30-Day Epworth Sleepiness Assessment Call" and an "Example Script" for a call.
- Call Patient (Notes):** A window for taking notes during the call. It includes a "Type your note here" field, a "Note" table with columns for Note and User, and a "Finish Call" button.

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# Live Call Tracking

- Track outcomes by coach
- Know who needs training
- Objective individual & team measures
- Invaluable training tools
- Complete audit trail
- Enables virtual call centers
- Work from home with full insight



- Complete Call Metrics
- Call time, duration, number
- Full audio of every call
- Works with existing systems
- Fully integrated



## Automated Patient Response™ Health Assessments

- **Comfort:** Natural sounding voice, easy-to-understand questions
- Convenience:** In less than 3 minutes, from home or away
- Care:** Personally tailored, patient-specific follow-up ensures optimal management
- Confidence:** Facilitates education, adherence, and accountability, promotes better self-care habits



CustomCall™ enables tailored calls to the unique needs of individual patients.

*CustomCall™ Personalized Touch*

**HealthCall.**  
Transforming Medical Communications

# Population Management

Name	Current	Status	Next	Risk	Program	Actions
<b>CHF - Bay Area Clinic</b>						
Roberts, Sebastian H	16:10		2011-10-04	High	CHF	
Andrews, Henry M	14:23		2011-10-04	High	CHF	
Boyd, Aidan M	10:26		2011-10-04	High	CHF	
Goodman, Brayden D	10:01		2011-10-04	High	CHF	
Howell, Brady L	09:46		2011-10-04	High	CHF	
Parsons, Hayden A	09:30		2011-10-04	High	CHF	
Adams, Tristan B	08:20		2011-10-04	High	CHF	
Terry, Christopher C	08:00		2011-10-04	High	CHF	
May, Logan B	07:43		2011-10-04	High	CHF	
Townsend, Michael J	06:38		2011-10-04	High	CHF	
Berry, Cameron T	06:19		2011-10-04	High	CHF	
Harmon, Jordan J	09:51		2011-10-04	Low	CHF	
Paul, Joshua G	08:31		2011-10-04	Low	CHF	
Alvarez, Robert A	06:12		2011-10-04	Low	CHF	
Lyons, Ryan J	06:08		2011-10-04	Low	CHF	
Frank, Kaitlyn R	14:45		2011-10-04	At Goal	CHF	
Schneider, Abigail G	14:23		2011-10-04	At Goal	CHF	
Allison, Kevin R	12:01		2011-10-04	At Goal	CHF	
Matthews, Morgan N	12:01		2011-10-04	At Goal	CHF	
Norton, Ella R	11:10		2011-10-04	At Goal	CHF	

## Bay Area Respiratory<sup>2</sup>

### Self-Management of Heart Failure

#### Green Zone: All Clear

- No shortness of breath
- No swelling
- No weight gain
- No chest pain
- No decrease in your ability to maintain your activity level

#### Green Zone Means

- Your symptoms are under control
- Continue taking your medications as ordered
- Continue daily weights
- Follow low salt diet
- Continue answering your automated HealthCall assessments
- Keep all physician appointments

#### Yellow Zone - Caution

If you have any of the following signs and symptoms:

- Weight gain of 2 pounds in 1 day or 5 or more pounds in a week
- Increased cough
- Increased swelling
- Increase in shortness of breath with activity
- Increase in the number of pillows needed
- Anything else unusual that is bothering you
- Call your physician if you are going into the YELLOW zone

#### Yellow Zone Means

- Be sure to elevate feet above hips
- Be sure to take water pill (if prescribed)
- Be sure to keep sodium intake at or below 2,000 mg for the day
- Your symptoms may indicate that you need to see your physician within 48 hours
- Call your physician

Physician \_\_\_\_\_

Number \_\_\_\_\_  
(Please notify your Nurse at the Heart Failure Center if you contact or go to see your MD)

#### Red Zone: Medical Alert

- Unrelieved shortness of breath: shortness of breath at rest
  - Unrelieved chest pain
  - Wheezing or chest tightness at rest
  - Need to sit up in chair to sleep
  - Weight gain or loss of more than 5 pounds in 2 days
  - Confusion
- Call your physician immediately if you are going into the RED zone

#### Red Zone Means

This indicates that you need to be evaluated by a physician right away

- Call your physician right away or call 911

Physician \_\_\_\_\_

Number \_\_\_\_\_

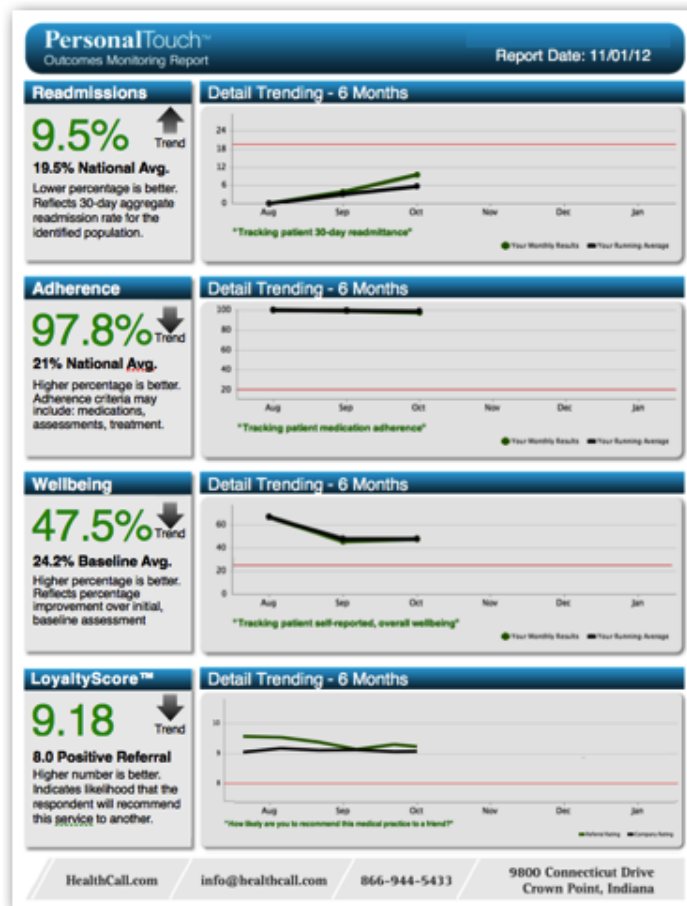
A Personal Approach  
to Optimal Health

HealthCall®

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# Compelling Referral Source Reports



- Intuitive, rapid comprehension
- Objective outcome measures
- Trending and benchmarks
- Mission critical areas
  - Readmissions
  - Adherence
  - Wellbeing
  - Loyalty

***Your Data, Your Value!***

Readmissions

15.8%  Trend

19.5% National Avg.<sup>1,2</sup>

Lower percentage is better. Reflects 30-day aggregate readmission rate for the identified population.

Detail Trending - 6 Months



Adherence

95.9%  Trend

21% National Avg.<sup>3,4</sup>

Higher percentage is better. Adherence criteria may include: medications, assessments, treatment.

Detail Trending - 6 Months



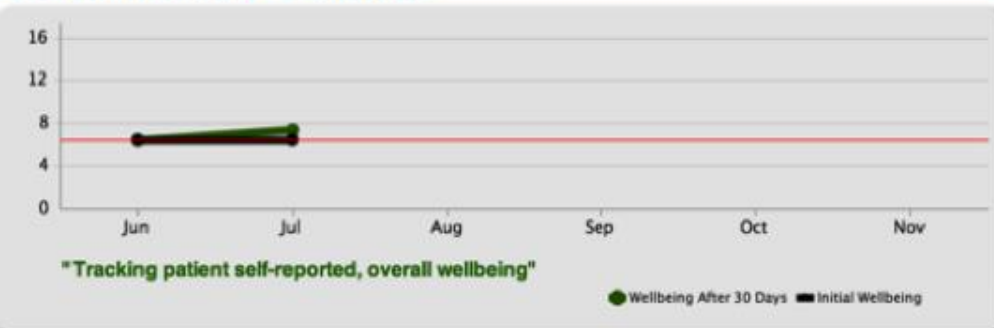
Wellbeing

7.42  Trend

Initial Avg: 6.46

Reflects improvement in overall patient wellbeing over initial baseline assessment.

Detail Trending - 6 Months



enhancement  
measures  
marks

Value!

HealthCall®

Transforming Medical Communications

# PersonalTouch™

*Empowering Continuum of Care Partnerships*

- **Creates a Formal Process**

The formalized process helps ensure a trackable, repeatable process, and predictable outcomes. Patient centered “Care Plans” adhere to “best practices” and help manage the entire clinical process. Standard and custom programs are available for different diseases and disease states.



- **Reinforces Key Disciplines**

Encounter management tools guide HME staff through the process of successfully coaching patients. Checklists reinforce call objectives; tele-prompters support best-practices; assessment forms collect data; and notes aid in relationship building.



- **Ensures Objective Measures**

Personal touch™ tracks key metrics providing insight into chronic populations. Objective tracking and management of the appropriate leading measures helps ensure predictable outcomes (reductions in readmissions and total cost of care).



- **Provides Quality Benchmarks**

This program benchmarks quality of service based upon three key patient engagement criteria: outcomes (readmissions), overall wellbeing, and adherence (medications and plan of care).



**PersonalTouch™**  
Powered by HealthCall®

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Thank you!

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