PersonalTouch™

Empower the new standard of patient-centered, accountable care

HealthCall®
Transforming Medical Communications

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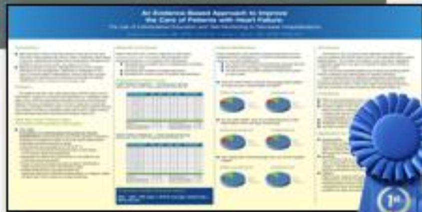
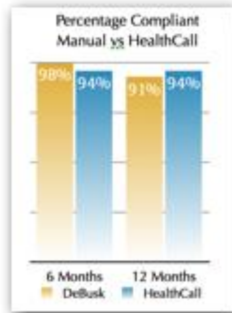
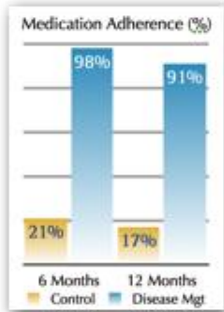
Award-Winning Clinical Innovation

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.

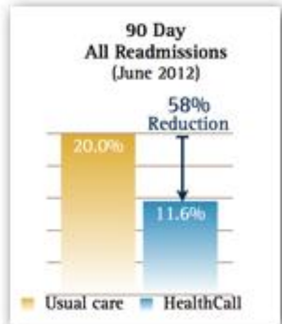


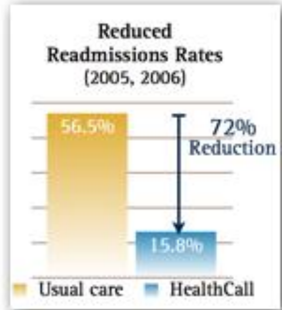




Studies presented at the Heart Failure Society of America

- 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





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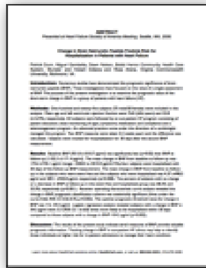
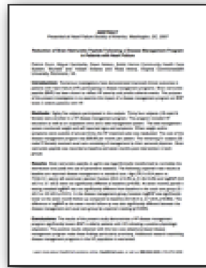
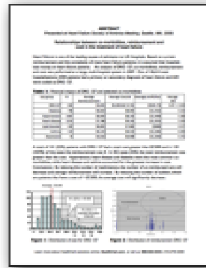
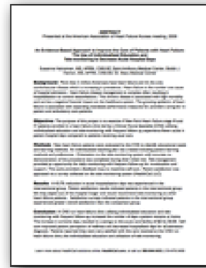
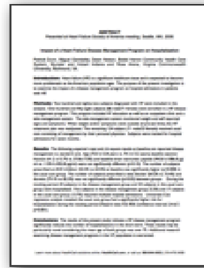
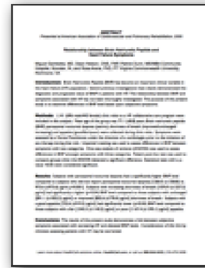
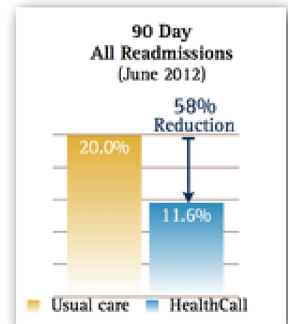
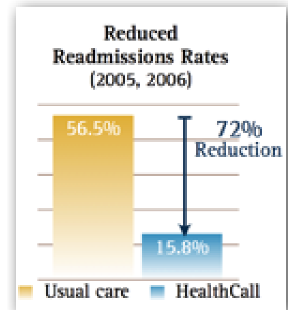







Award-Winning Clinical Innovation

- 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





17%
6 Months
12 Months
Control
Disease Mgt

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Demonstrated & Published

Heart Failure Society of America

- 2005: 72% Reduced Readmission Rates
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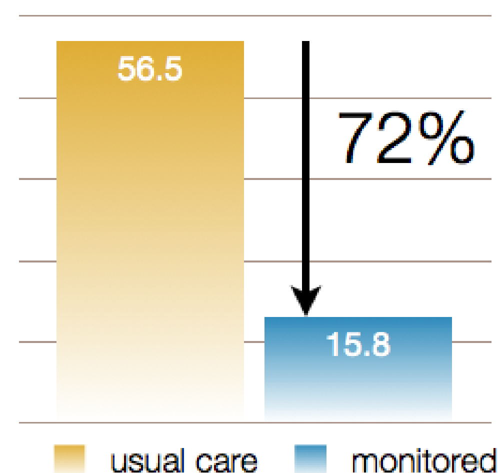

*BNP: b-type natriuretic peptide

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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

Susanne Heinzman, MS, APRN, ACNS-BC • Bobbi J. Herron, MS, APRN, ACNS-BC

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

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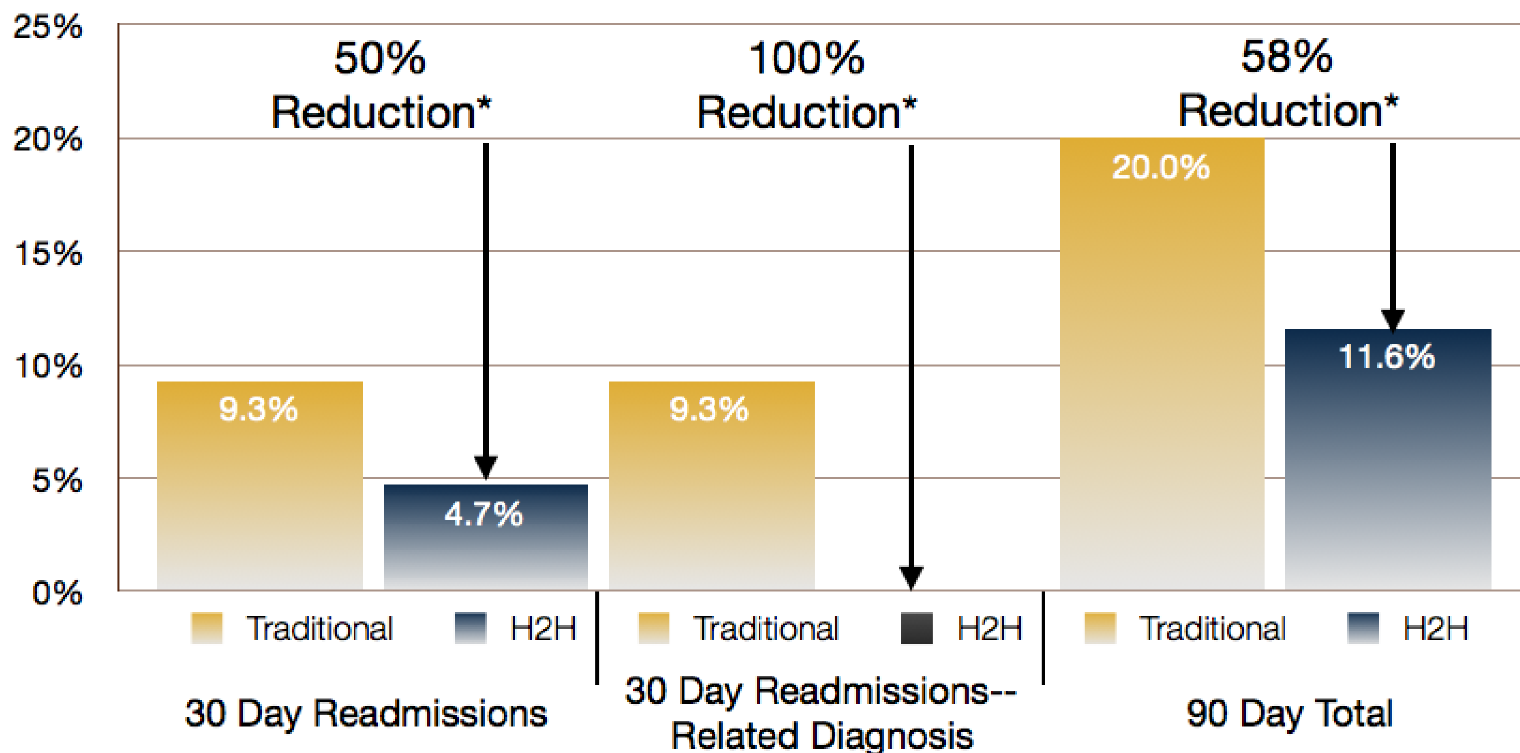
Impact of Program-Type on Readmission Rates

Bart Collins, Ph.D.
Purdue University



* Results are not typical

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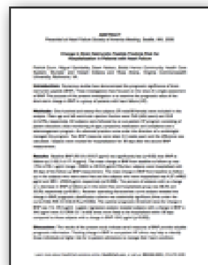
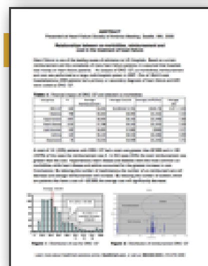
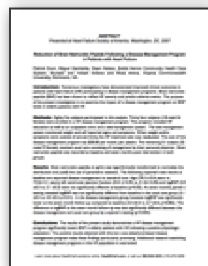
Can readmissions be predicted?







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

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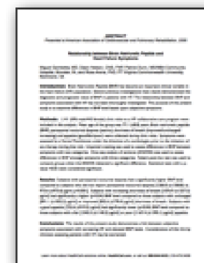
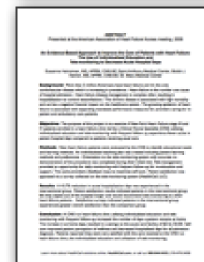
Can readmissions be prevented?

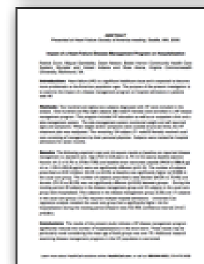
Reduction of B-Type Natriuretic Peptide using Telemanagement in Patients with Heart Failure
Presented at Heart Failure Society of America Meeting, Seattle, WA, 2006.



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

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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

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PersonalTouch™ Example Outreach

COPD- First 30 Days After Set-Up

SUN	MON	TUE	WED	THU	FRI	SAT
	Receive O2 Rx Verify Insurance	In-home Set-up	48 Hours	1st Call	Health Assessment	
		Health Assessment				
		2nd Call			Health Assessment	
		Health Assessment				
		Health Assessment				

Administrator:
- Verify Insurance
- Check Rx

(Does it match physician's order?)

48 Hr, Live Call: RT or Care Specialist

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

14 day, Live Call: RT or Care Specialist

System is configured to avoid weekends. No Live or automated calls are scheduled for Saturday or Sunday

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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)

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Transforming Medical Communications

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Patient-Centered Population Management

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

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

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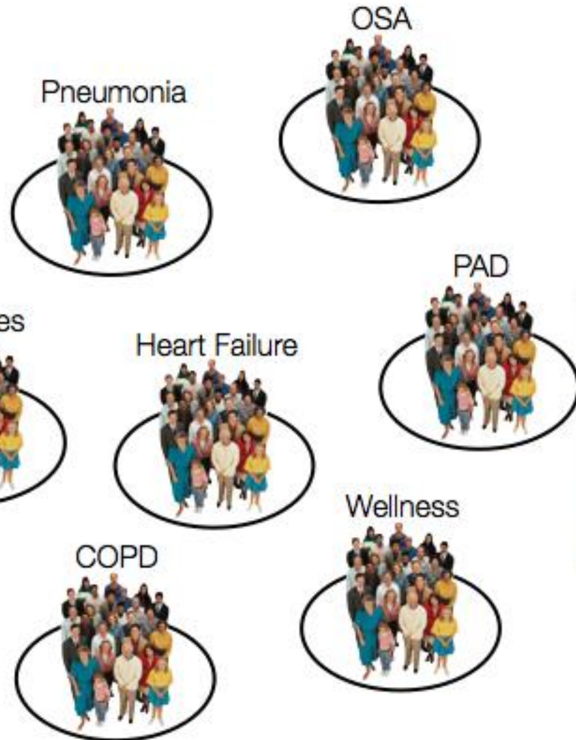
Patient-Centered Population Management



Individualized

Clinical Monitoring, Adherence and Follow-up

Bay Area Medical

Segmented Populations

Individualized Care Plan

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Secure Collaboration In the Outpatient Setting

HealthCall Cloud

Hospitals
(Providers, Discharge planners, etc.)

Segmented Populations

HME
(Care Specialists & RTs)

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Powered by HealthCall®

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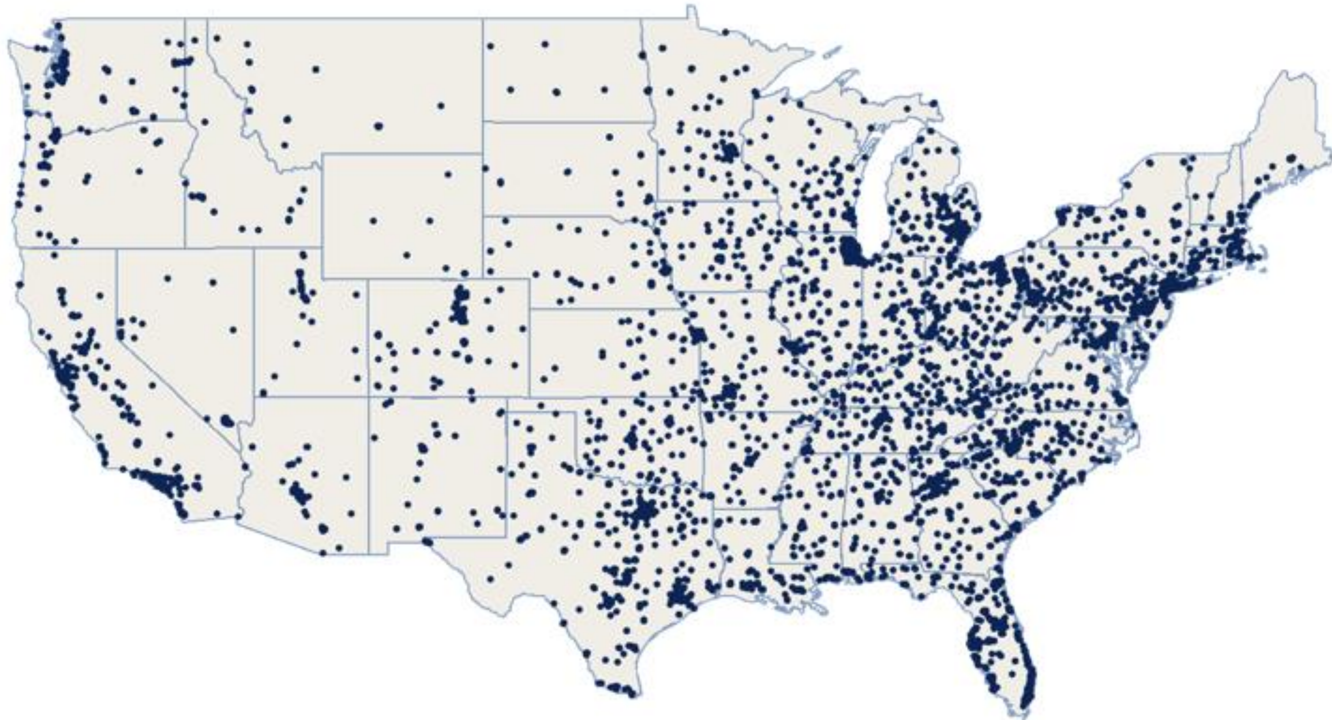
Available Service Locations



The Best, Most Comprehensive Coverage!

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Training for Coaches

- Building relationships & rapport
  - Building report 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

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Encounter Management

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

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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

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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

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Population Management

Bay Area Health

Email Help | Log

Welcome Doctor Wh

Home | Population | Patients | Reports | User Journals | Messaging Center | Media Library | Configure

Population

Add Mon

Date Range From: 10/03/2011 To: 10/03/2011 | 20 Rows per page | Apply Filter

▼ Advanced Options

Filter Assessments:
- ☑ Call Required
  - ☐ Show Only Call Required
- ☑ Missed
- ☐ Evaluated

Filter Source: Show All Clinics / Show All Programs

For missed: ◉ Show Missed Assessments / ○ Show Attempted Calls

Show this level and higher: At Goal

Name	Current	Status	Next	Risk	Program	Actions
CHF – Bay Area Clinic						
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 I	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	

Page 1 of 3 | Ne

Bay Area Respiratory O_2

Self-Management of Heart Failure

Green Zone: All Clear	Green Zone Means
• No shortness of breath • No swelling • No weight gain • No chest pain • No decrease in your ability to maintain your activity level	• 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	**Yellow Zone Means**
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**	• 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	**Red Zone Means**
• 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**	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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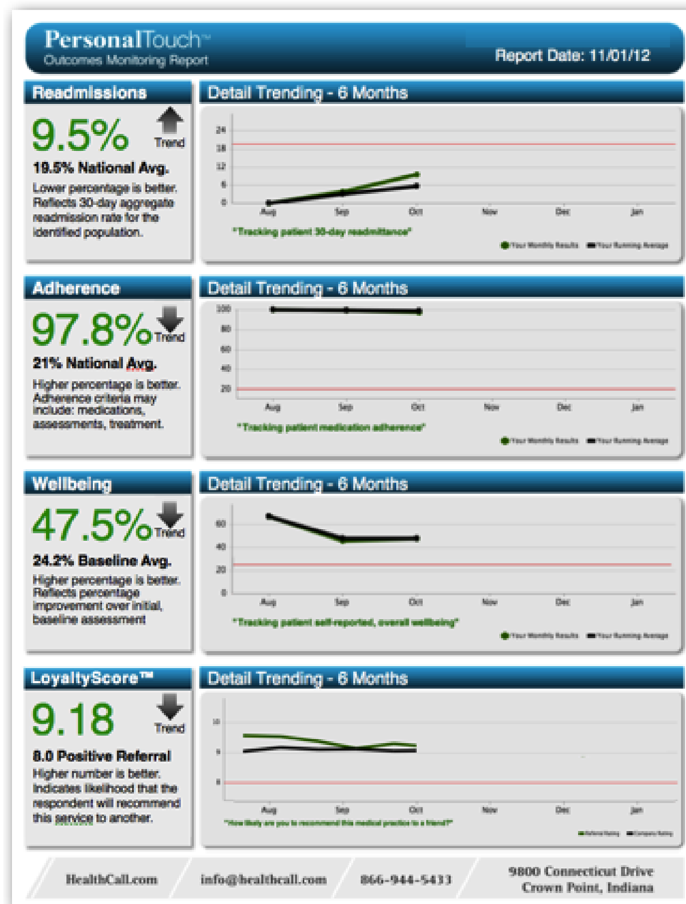
Compelling Referral Source Reports



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

Your Data, Your Value!

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PersonalTouch™
Outcomes Monitoring Report

Report Date: 08/01/13

Readmissions

15.8% Trend

19.5% National Avg. [1,2]

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. [3,4]

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

Detail Trending - 6 Months

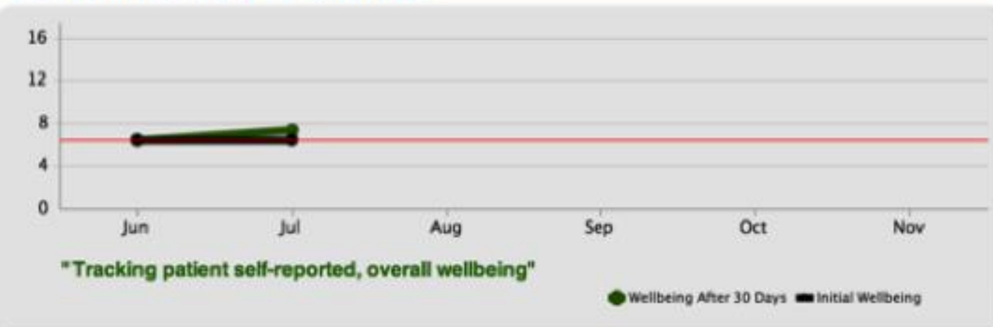
Wellbeing

7.42 Trend

Initial Avg: 6.46

Reflects improvement in overall patient wellbeing over initial baseline assessment.

Detail Trending - 6 Months



ehension

easures

harks

Value!

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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).

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Thank you!

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www.healthcall.com

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