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PRESS RELEASE

TouchPointCare Introduces TPC Transition Home

April 13, 2009

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Libertyville, IL (April 13, 2009) TouchPointCare is pleased to announce the introduction of TPC Transition Home, the first comprehensive, turnkey system solution designed to enable hospitals to reduce the \$17 billion cost associated with unplanned hospital readmissions. Rehospitalization and the attendant cost is “associated with gaps in follow-up care” according to a recently released report in the New England Journal of Medicine. TPC Transition Home enables hospitals to manage the transition of each patient into their home from the hospital with a follow-up program customized for each unique set of discharge instructions.

TPC Transition Home begins with the implementation of the Care Transitions Program (CTMTM -15 or CTMTM -3) developed by Dr. Eric Coleman, MD, MPH. As stated in the Care Transitions InterventionSM web site, www.caretransitions.org, Dr. Coleman and colleagues, “with support from The Commonwealth Fund, The Robert Wood Johnson Foundation, and the Paul Beeson Faculty Scholars in Aging, designed a 15-item uni-dimensional measure, the Care Transitions Measure (CTMTM), to assess the quality of care transitions. The primary objective of this endeavor has been to develop a measure that is both substantively and methodologically consistent with the concept of patient-centeredness, and useful for the purpose of performance measurement and subsequent public reporting.”

“Psychometric testing of the CTMTM has been completed, demonstrating high internal consistency, reliability, and applicability for assessment across multiple sites of care (i.e., hospital to home, hospital to skilled nursing facility, skilled nursing facility to home, etc.). The measure also demonstrated the power to discriminate between: 1) patients discharged from the hospital who did/did not experience a subsequent emergency visit or rehospitalization for their index condition, and 2) health care facilities with differing levels of commitment to care coordination.”

“While the testing of the CTMTM was done using a post-hospitalization model, this measure is applicable to a variety of settings, including skilled nursing facilities, rehabilitation, and other locations patients are likely to utilize during transition.”

TouchPointCare Transition Home then closes the loop in the discharged patient follow up process. Using the CTM™ score hospitals can use TPC Transition Home to incorporate diagnosis, cognitive issues, health literacy, specific discharge instructions, including medication, and family and caregiver resources into a comprehensive customized, follow-up program for each patient. TPC Transition Home combines a variety of technologies ranging from the telephone to internet based IVR systems to meet the unique transition follow-up needs of patients and their family/caregivers.

Through a set of proprietary TPC Transition Home templates a hospital simply indicates patient diagnoses, identifies cognitive issues, rates health literacy, identifies family/caregivers, downloads discharge instructions, including current medications, and selects a follow-up schedule. TPC Transition Home then creates a custom follow-up program to track and monitor patient symptoms and compliance. The system also serves to train and educate patients and family/caregivers in the process. The collected data closes the loop with continuous feed back to the hospital.

This data centric but personalized approach to discharge follow-up, pioneered by TouchPointCare, enables the hospital to extend their care into the patient's home, thus, reducing unplanned rehospitalization and the attendant emotional and financial cost.

For more information visit our web site at www.touchpointcare.com or contact us to schedule a demo.

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