Care Management & Patient Relationships

Introduction

What would it be like if you or a loved one were struggling to manage multiple medical conditions and this happened?

You received an invitation from your doctor explaining how a team of healthcare professionals would reach out to you to craft and coordinate a personal plan of care that included help addressing the struggles you face with self-care at home, gave you access to this plan so you could access key medical information and communicate with your team, and asked you to participate to make this a successful experience. You were given an app so you could use your phone to communicate and share information with your care team.

At Health Catalyst, we believe this is how healthcare should be delivered. We believe that this care management model is where we need to be in order to improve our healthcare system and truly help people have better outcomes at a lower cost and a better experience.

Vision

Our vision of care management is to support the physician's need to identify and group individuals by their current and anticipated level of need and chronic conditions and then reach out to support them at the right level of care for their situation.

We believe this vision can only be achieved if the following pieces are in place:

- Data Integration
- Patient Stratification & Intake
- Care Coordination
- Patient Engagement
- Performance Measurement

Delivering the right care at the right time to the right patients in the most efficient manner is the goal and responsibility of every healthcare organization and healthcare professional. Unfortunately, evaluating the effectiveness of the population health and care management programs is a huge challenge. And without the ability to assess and adjust these programs, being accountable for the care of these patients is impossible.

We believe healthcare organizations and professionals must be able to answer the following questions:

- Are we managing the right group of patients?
- Are we having an impact for those patients?
- Is there variation between care teams that may help us identify and communicate best practice?

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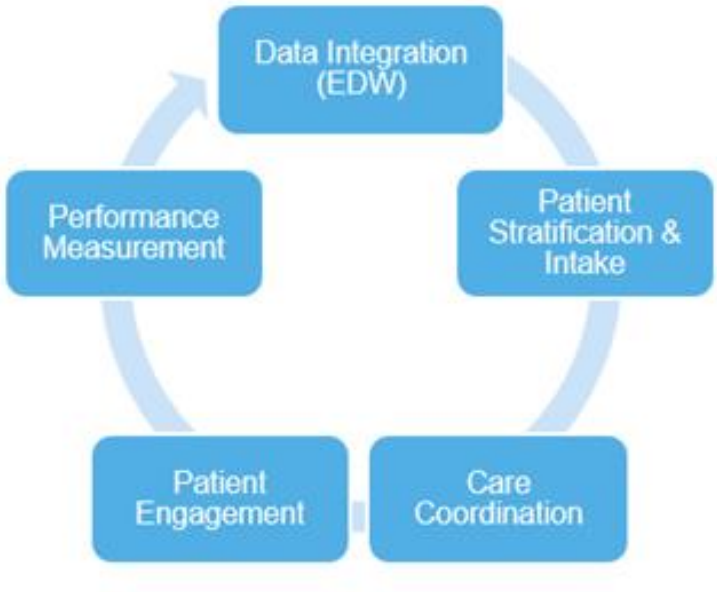
- Is there an opportunity to change how we identify patients or direct them to a different level of support that can positively impact health and program costs?

The Health Catalyst Solution

We have software and services targeted for each of these key needs, enabling clinicians to manage the accountability they are given.



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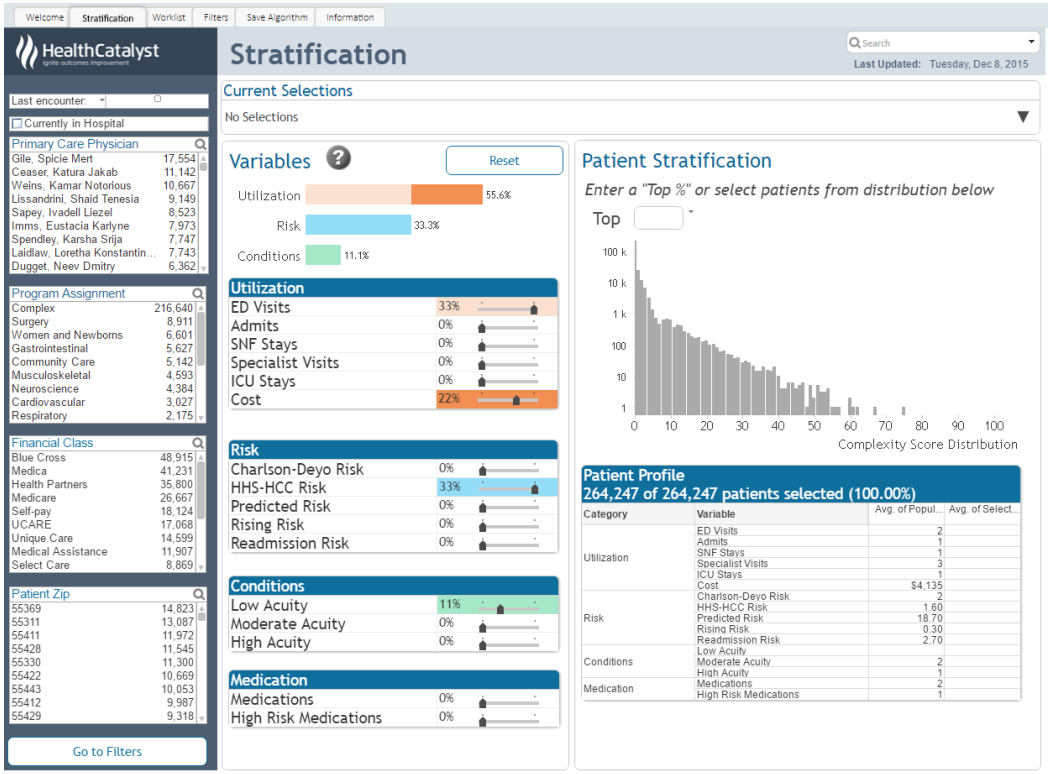
Patient Stratification

Patient Stratification integrates current and cost trends, chronic conditions, and social determinants risk models and disparate sources to identify the individuals most likely to benefit from proactive care management programs. Users can build and analyze different stratification algorithms based on proven risk models and patient utilization to identify the most important candidates for intervention through complex care management, chronic condition management, readmission prevention or other programs.



Features

- Dynamic stratification algorithm creation to enable targeting individuals for a variety of care programs
- Analyze cohort or patient-specific attributes
- Supports complex attribution to the individual's PCP via integration with Attribution Modeler or inclusion of client-provided logic.
- Complex patient filtering capabilities to create precise cohort registries
- Automates patient list management with the care management staff for improved intake processing

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Benefits / Improvements

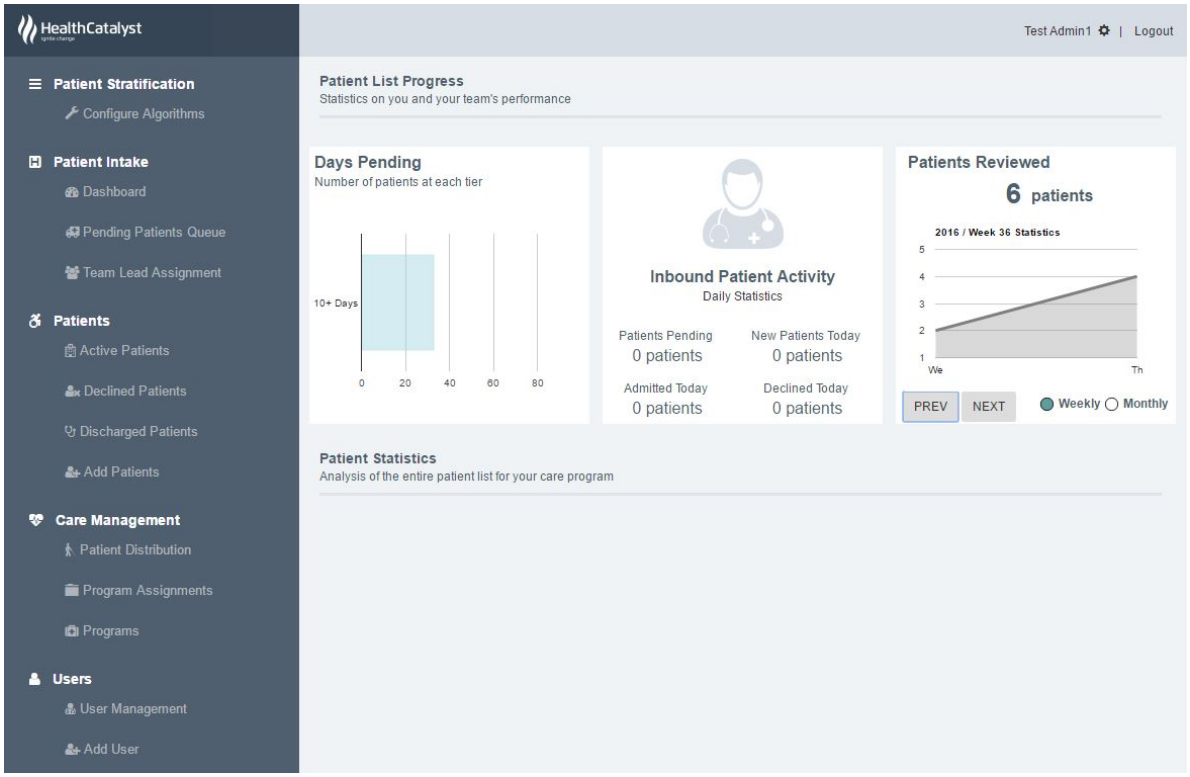
- Expand ability to identify the most critical candidates for Care Management programs
- Ability to tailor criteria to meet unique program requests
- Reduce resource demands to identify individuals for Care Management programs
- Increased timeliness of identifying individuals for Care Management programs
- Closed-loop capabilities to determine the most impactful algorithms for outcomes improvement

Background

Health organizations too often lack visibility into complete, longitudinal patient data that will help them manage their populations. Those that do attempt to identify high risk individuals spend enormous time and valuable resources, often looking at fragmented source data that doesn't provide a holistic view of individual risk. Some of the key data elements which are often missing include: identification of patients with the highest risk for care using multiple models, comparing in-network and out-of-network claims, grouping or analyzing care programs, encounter details, diagnosis codes, providers, age cohorts, and zip codes.

Patient Intake

Patient Intake is a workflow application that enables lists of patients created by other applications to be routed to a series of users based on roles. Users can add or remove patients from the list before routing the patient record to the next person in the workflow. This application is required when deploying Patient Stratification as a patient list source for Care Coordination.



Features

- Multiple workflows
- Multiple user roles and privileges
- Fully integrated with other Health Catalyst applications to import lists of patients from Patient Stratification and output patient lists to the care team using Care Coordination
- Flexible import and export to support EMR based care coordination.
- Fast and easy to setup and maintain via web-based administration.

Benefits / Improvements

- Decrease complexity and costs associated with the use of spreadsheets to facilitate patient intake.
- A single application can support multiple care management, specialty or research programs.

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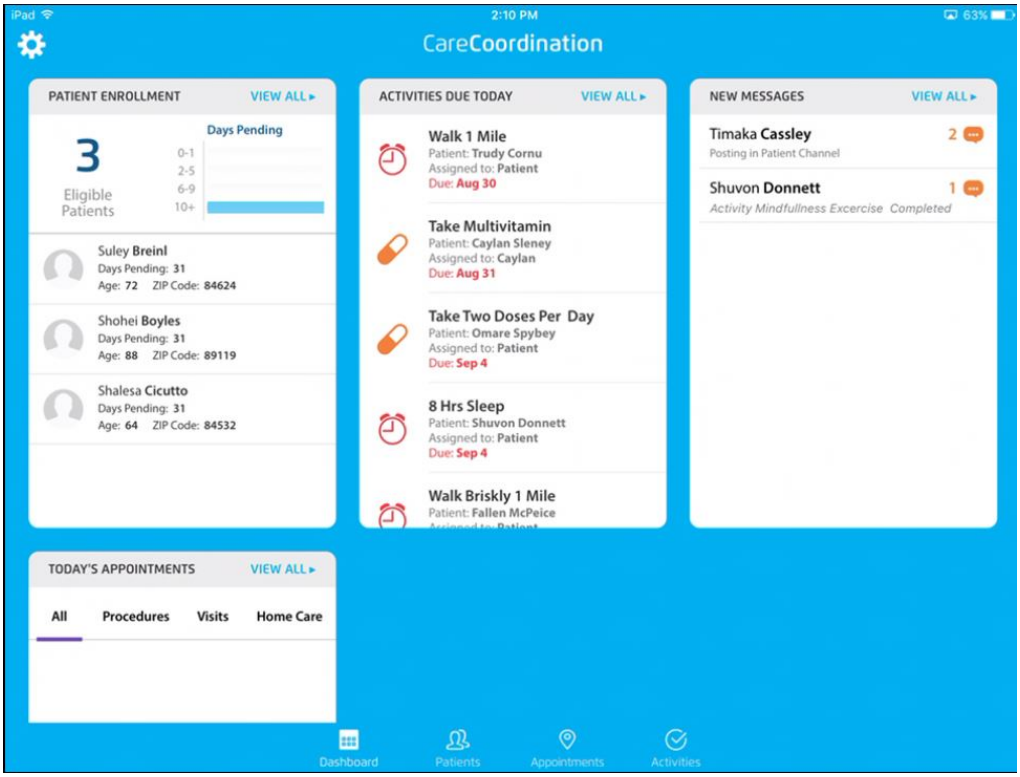
Care Coordination

Care Coordination is a mobile, tablet based application, used at the point of care by care coordinators and team members to organize patient interventions including shared decision making for patient goals and activities, patient and team communications, alerts and notifications for new admissions or decreasing patient engagement activity.

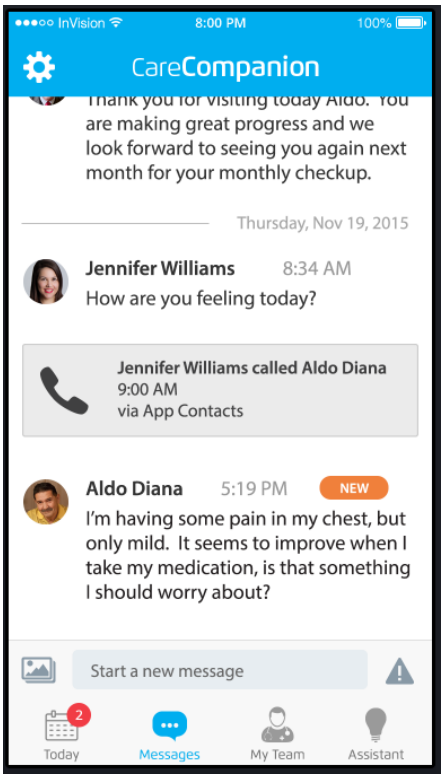


Features

- Tablet application for mobile care team members (web application also available)
- Easily communicate with other care team members associated with a specific patient
- Receive notifications of important or critical patient events, such as readmissions
- Manage new patient assessments and program enrollment
- Organize daily patient care activities and interventions

Care Companion

Care Companion is a mobile phone application for patients supporting direct engagement with the Care Management team of nurses, pharmacists, social workers and others in the process of improving individual patient outcomes.



Features

- Communications with the patient's personal care team
- Patient goals based on shared decision making with the care team
- Tasks and interventions based on the goals
- Progress to the goals

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Care Team Insights

A dashboard application for leaders in the care management organization to enable daily views of enrollment, utilization, risk and cost by care team, facility, care program/family. Comparison between enrolled and non-enrolled patients enables basic indication of Return on Investment for the care management program.