Prioritizing Outreach for Care Coordination Amid the COVID-19 Pandemic

THE CHALLENGE

OneCare Vermont sought to identify which of its patients were at the highest risk of serious illness or mortality from COVID-19, and desired to determine which of its patients with chronic healthcare problems needed care for medical issues other than COVID-19, or support to navigate the healthcare system and avoid risk. The participants' EMRs did not have a mechanism to systematically identify patients with specific high-risk factors.

THE PROJECT

OneCare Vermont used the Health Catalyst® Data Operating System (DOS™) platform to leverage publicly available risk criteria, medical and pharmacy claims, medical data, and social factors data to identify high-risk patients, and to identify the patients at risk of a poor outcome if they were to get COVID-19. Providers can filter the risk criteria to prioritize patient outreach.

Filters include options for narrowing selections to identify patients who:

- Are over 60 years old with specific chronic conditions.
- Are considered frail.
- Are high users of healthcare resources.
- Have seen at least seven different providers in the last year, indicating a potential care coordination issue.
- Have evidence of mental health or substance abuse comorbidity.
- Have high social complexity and challenges accessing food and/or social isolation.

THE RESULT

Using DOS, OneCare Vermont enabled rapid identification of at-risk patients. Providers and care teams use the risk-stratification care coordination tool to proactively conduct patient outreach, including telephone calls and telemedicine virtual visits, ensuring patients receive needed social support and medical care during the pandemic.

"The care coordination prioritization application is enabling our teams to identify and proactively engage high-risk patients. Teams can provide much needed social support, and can ensure patients receive needed medical care."

Tyler Gauthier, MHA, CPHQ, CSM
Director, Value-Based Care