Catalyst
HEALTH NETWORK

CHN Utilization Program

Utilization: Performance Advocacy and Support

The Catalyst Performance Advocate team provides ongoing utilization performance visibility to participants of Catalyst Health Network by providing practice and NPI-level **Utilization Performance Reporting** along with **High Utilizer Care Opportunity Reporting.** This Utilization Reporting is maintained and updated by the Catalyst Health Group Data Management department and is sourced from claims data reported to insurance companies on behalf of the patients assigned to Network Participants. Network Participants are encouraged to review the prepared utilization reporting for opportunity to reduce total cost of care for their assigned patient populations through patient engagement and clinical or administrative workflow implementation.

Utilization Focuses Most Applicable to Network Participants	
Emergency Room (ER) Utilization **Metric:** ER per 1000	Avoidable ER Utilization **Metric:** Avoidable ER/K
Hospital In-patient Admissions **Metric:** Admissions per 1000	Hospital In-patient Re-admissions **Metric:** Re-admit/K
High-Cost Prescription utilization	High-risk patient management
Preferred Specialist Navigation	Ambulatory Surgery Center (ASC) Utilization

Utilization: Care Management Support: The Catalyst Care Team is a tool and resource to reduce the Total Cost of Care. when possible, and support patients who utilize healthcare services at hospitals and free-standing ERs. Network Participants will be notified of patient events when our team is notified. Support may include patient outreach for:

- ER Utilization: For high-risk patients, the Care Team assists with ER follow up outreach. The process of coordinating care for patients who have had an ER visit and then are discharged home. Addressing barriers, follow-up appointments, and medications. For ER visits that were avoidable, the Care Team includes reminding patients of office hours, after hours support and to call their Provider before going to the ER or consider Urgent Care.

- Reducing admissions and re-admissions: For high-risk patients, the Care Team assists with Transitions of Care outreaches. The process of coordinating care for patients who have had an inpatient admission and then are discharged home. Addressing barriers, follow up appointments and medications.

- Comprehensive Care Support: For patients with chronic conditions, they can be referred to the Care Team for ongoing support with care coordination, resource access, education, and comprehensive care planning which aims to prevent unnecessary hospital admissions, ER visits, and maintain an optimal state of health.

- Medication Management: The goal is to work to optimize patients' medication management to optimize health care outcomes. This includes consultation with a pharmacist regarding medication-related questions and the ability to optimize drug therapy and improve therapeutic outcomes for patients in partnership with their physician.

Utilization: Referral Management Support: Through the utilization of LeadingReach platform, Catalyst Health Network Participants are supported with connecting patients to Premium Designated and Preferred Network specialists, who provide quality and cost-effective care. Catalyst Health Network Participants are encouraged to utilize preferred and in-network specialists.

Call Us First Campaign: Catalyst Health Network Participants can access patient educational resources aimed at routing patients back to their Primary Care Provider for care when appropriate instead of of going to an urgent care or an emergency room. Refer to the Call Us First Campaign resources available to Catalyst Health Network Participants.