Catalyst
HEALTH NETWORK

Care Management

Empowering Patients to Make Better Healthcare Decisions

Our Care Management program is a patient-centered and team-based approach for supporting high-risk patients assigned by the payers to Catalyst Health Network Participants. It includes care coordination, patient care gap assessment, chronic disease support, and healthcare navigation.

Programs

Transition of Care - The goal is for the safe and timely transfer of patients from one level of care to another, or from one type of setting to another. The focus is on educating patients and families to address root causes of poor outcomes and avoid preventable re-hospitalizations.

Emergency Services - The goal is to decrease frequent emergency department use for avoidable conditions. The opportunity is to educate patients on access to care options, appropriate emergency department utilization, and Physician services.

Quality Improvement - The goal is to provide effective, equitable, patient-centered care in a safe, efficient, and timely manner. The care team assists in identifying patients with open gaps and closing them in through a systematic process of strategy and identification.

Care and Disease Management - The goal is to improve the quality of life for individuals by preventing or minimizing the impact of a disease or chronic condition and linking them with appropriate educational services and resources to maximize health outcomes. Focus is to provide health coaching for behavior change by caring for the whole person, rather than for an individual disease. It is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.

Medication Management through StellusRx - The goal is to optimize the medication management of patients 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.

**Eligibility to any of our programs is based on payer assignment.*

Care Management programs are evaluated by different stakeholders and reviewed by CHN Leadership monthly. Additionally, clinical guidelines are reviewed annually by the members of the Quality committee and Medical Directors to determine if any program design changes are needed.

How it works:

- Patients are referred to program(s) by Physicians via LeadingReach, Payers, admission or ER events
- Outreach is performed to enroll in the program(s)
- Informed consent is obtained
- Care Plans and/or assessments are completed, program specific.
- SMART Goals are established and agreed upon with the patient and/or caregiver
- Interventions correlate with the goals and associated health outcomes

- Quality measures are reviewed and updated
- Resources and Education are provided
- Outcomes are tracked
- Followed up on goals or action items is based on agreed upon patient and/or family/caregiver needs and wants
- Continuous assessment is performed while enrolled in the program(s)

Ongoing collaboration with patients and other members of the multidisciplinary team occurs while enrolled in the program(s). The Physician is notified after each interaction with the patient and notes are documented based on the preference of the Physician. Patients are discharged from any of our programs when the patient has reached their patient-specific goals, the patient activates the termination, the patient and/or family have been empowered through the case management relationship, or when a patient can advocate independently for health service needs based on reported outcomes.

Your Care Team

Care Managers - Coordinates continuity of care for patients, often as a liaison between the patient's family and healthcare organization, ensuring that the proper treatment is administered at the appropriate time to maximize health and well-being while also minimizing the need for hospitalization. The Care Manager strives to promote self-managed care and the use of healthcare resources in the most cost-effective way possible. Care Mangers work with patients of all ages and conditions, but primarily focusing on a specific population such as persons at a high-risk level and with multiple chronic conditions. Care Managers hold an active registered nursing license.

Care Coordinators - Assists with the care coordination of patient care under the direction and supervision of the Care Manager. The Care Coordinator assists members by providing support, education, and assistance in the prevention and/or maintenance of their health and wellness state by assisting with treatment plan compliance, collaborative coordination, and assistance with completing quality and/or preventative testing and exams, increasing their quality of life. Care Coordinators have healthcare-related experience or a degree in an allied health related field.

Social Workers - Supports individuals and their families through difficult times and ensures that vulnerable people, including children and adults, are safeguarded from harm. Their role is to help improve outcomes in people's lives by evaluating the psychosocial and emotional needs of members with ongoing and/or situational medical concerns through coaching, education, and support for low acuity emotional needs. They serve as a liaison with the community resources (food stamps, childcare, and health care). Social Workers have a master's degree in social work and hold a current LCSW or LMSW license.

Behavioral Health Care Manager- Supports the mental and physical health care of patients related to admission of psychological and behavioral care. Their role is to track the treatment and monitor patients for changes in clinical symptoms, and support medication management.

CHN Quality – Care Management

Catalyst Health Network participates in Commercial value-based contracts. Quality measures and goals are based on contractual obligations for performance in Commercial value-based contracts. These measures may include quality of care, utilization patterns, and cost-effectiveness measures.

Quality activities supported by Care Management align with the measurable goals outlined in the payer and/or client contracts. Additional goals specific to the individual networks and overall company vision are established for further performance improvement. Goals are patient-centered and are measured through use of evidence-based guidelines.

For all quality goals, strategies are designed and implemented to improve process and outcomes. Polices, workflows, job aids, and other resources support strategies and goals while aiming to focus on the patient as a "whole" by addressing barriers to care.

How it works:

- Patients are referred to program by payer reporting
- Payer reporting is validated by Care Team to determine if quality measure(s) are incomplete
    - If quality measure(s) are closed, the Care Team will gather required information to submit to the payer to close the measure(s)
- If quality measure(s) are incomplete, outreach is performed to engage patient in the program and assist with closing the open measure(s)
- Informed consent is obtained
- Care Plans and/or assessments are completed, program specific.
- Quality measures are reviewed and updated
- SMART Goals are established and agreed upon with the patient and/or caregiver
- Interventions correlate with the goals and associated health outcomes
- Resources and Education are provided
- Outcomes are tracked
- Followed up on goals or action items is based on agreed upon patient and/or family/caregiver needs and wants

Providers can submit a Commercial Quality Supplemental Data Submission Workbook if they have evidence that the payer reporting has not captured closed measure(s) and their performance is not accurately represented. A completed form can be submitted to your Performance Advocate.

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Referral Management

Through the utilization of the LeadingReach platform, Catalyst Health Network members are supported with the referral management process and can expect ongoing monitoring and follow up on focused specialty referrals.

The focused specialty referrals were selected based on their association with high-risk chronic conditions, increased cost, utilization and long-term clinical impact. By focusing on these areas, we expect to see increased ASC utilization, lower ER utilization and decreased acute admissions and readmissions.

Focused Specialty List:

- Orthopedics
- Oncology
- Cardiology
- Pulmonologist
- Gastroenterology
- Endocrinology
- Nephrology
- Neurology
- Urgent Referrals

With this approach we will have a greater impact on both patient experience and total cost of care, for patients with the highest needs.

Your Referral Team

Referral Coordinators - Coordinates follow-up and provides visibility on the referral process to ensure referrals are received, specialists have the necessary information, patients are scheduled, appointments completed, and consult notes are received after appointment. Supports comprehensive patient care and communication between the patient, physician, and specialty office, for focused specialties and urgent referrals.