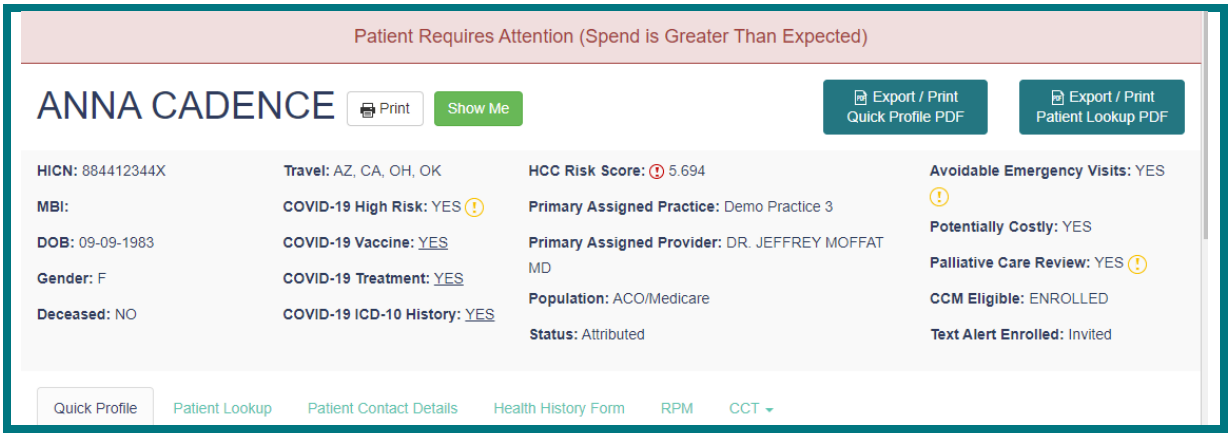
Patient Lookup – Health History

Quick Profile | Patient Lookup | Patient Contact Details | Health History Form | RPM | CCT

Patient Header



Red Bar: indicates patient actual spend has exceeded their allocated financial benchmark.

Patient Demographics: Name, insurance identifier such as Medicare Beneficiary Identifier (MBI), data of birth (DOB), Gender and Deceased status.

Travel: Indicates if the patient has claims in multiple states in the last 120 days and is populated with a list of states in which the patient has had claims.

Covid-19 High Risk: Yes or No flag to indicate the patient meets the Covid-19 our high-risk algorithm of underlying conditions, medication adherence issues and other high-risk factors.

COVID-19 Vaccine: If Yes, drill into the details of the date, rendering provider and type of vaccine administered.

COVID-19 Treatment and Diagnosis History: If Yes, drill into the details of treatment and diagnosis.

Avoidable Emergency Visits: Yes or No flag to indicate if the patient has had an emergency room visit that would be considered avoidable. For example, use of the emergency department to treat a bladder infection would be considered an avoidable emergency room visit.

Palliative Care Review: Yes or No indicator to flag the patient as Potentially Eligible for Palliative Care. The criteria to determine Yes or No includes terminal diseases, admissions, and emergency room visits. A Yes indicates the patient may need to be reviewed for palliative care. The intent is to show patients seriously ill who are utilizing the emergency room instead of their primary care provider.

PPD - Predicted probability of discharge. The predicted probability of the patient having any discharge in the measurement year.

PUCD - Predicted unconditional count of discharge. The predicted unconditional count of discharges for the patient during the measurement year.

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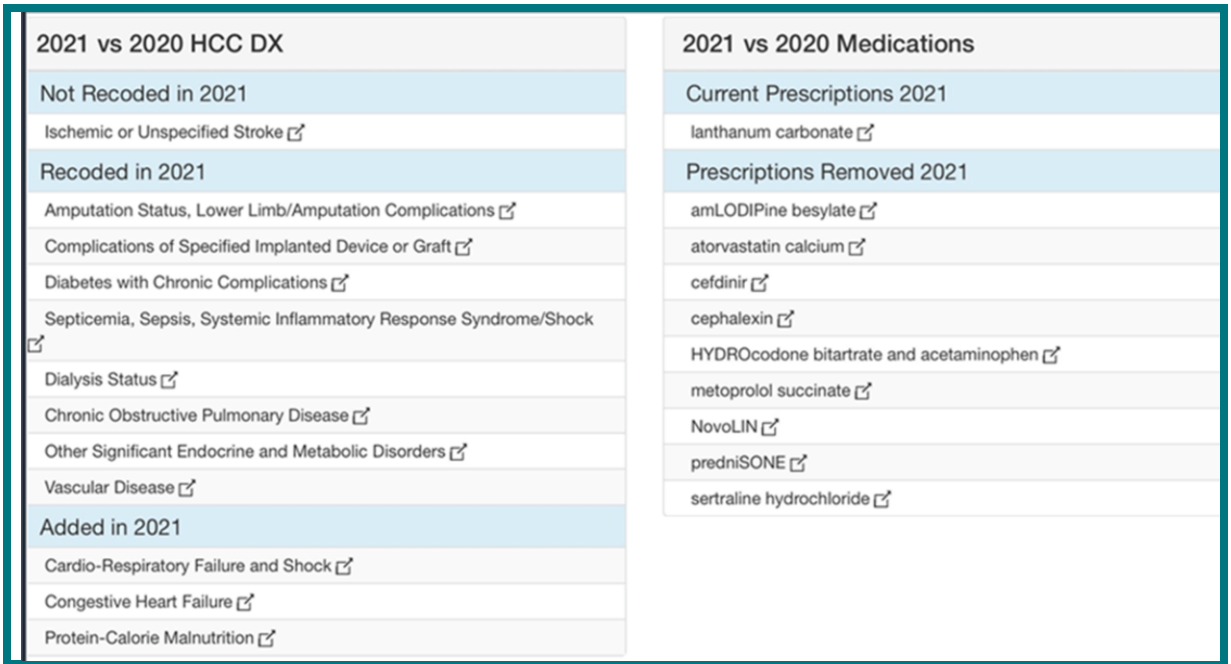
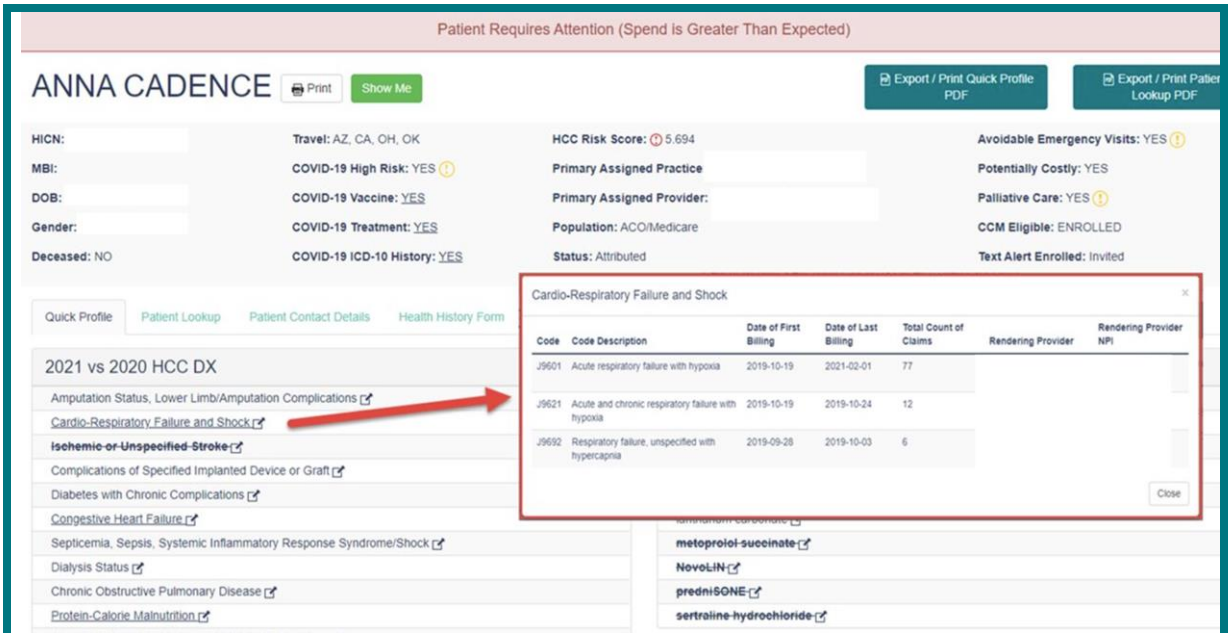


Diagnosis Not Recoded: This means the diagnosis has not been recoded in the current year and will be removed from the risk score calculation. You may drill into the HCC category to see the ICD10 diagnosis, rendering provide and date of service.

Diagnosis Recoded: This means the diagnosis has been recoded in the current year. If coded during a lab encounter, we encourage your team to re-code in your clinic setting. You may drill into the HCC category to see the ICD10 diagnosis, rendering provide and date of service.

Diagnosis Added: This means the diagnosis was added in the current year. You may drill into the HCC category to see the ICD10 diagnosis, rendering provide and date of service. A category underneath the HCC category that states "overridden" means the HCC diagnosis has been overridden by another HCC category. You may drill into the HCC category to see the ICD10 diagnosis, rendering provide and date of service.



Code – The ICD-9/ICD-10 code of which the patient has been diagnosed

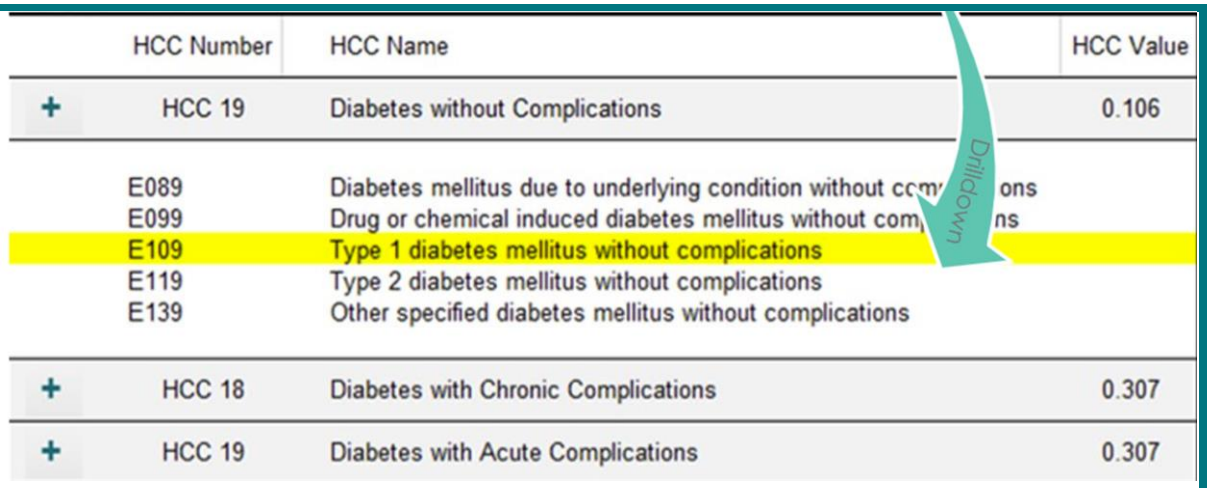
Code Description – The definition of the ICD-9/ICD-10 code the patient has been diagnosed with

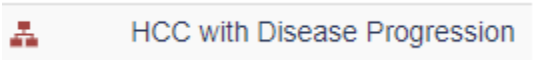
Date of First Billing – The date of the first encounter in which the patient was diagnosed with the ICD code

Date of Last Billing – The date of the most recent encounter in which the patient was diagnosed with the ICD code

Total Count of Claims – The total number of times the diagnosis has appeared in the patients claims.

Rendering Provider Name and NPI – The legal name and National Provider Identification number of the provider who most recently diagnosed the patient with the condition





Use this icon to drill into the HCC disease progression of an HCC ICD10 diagnosis.

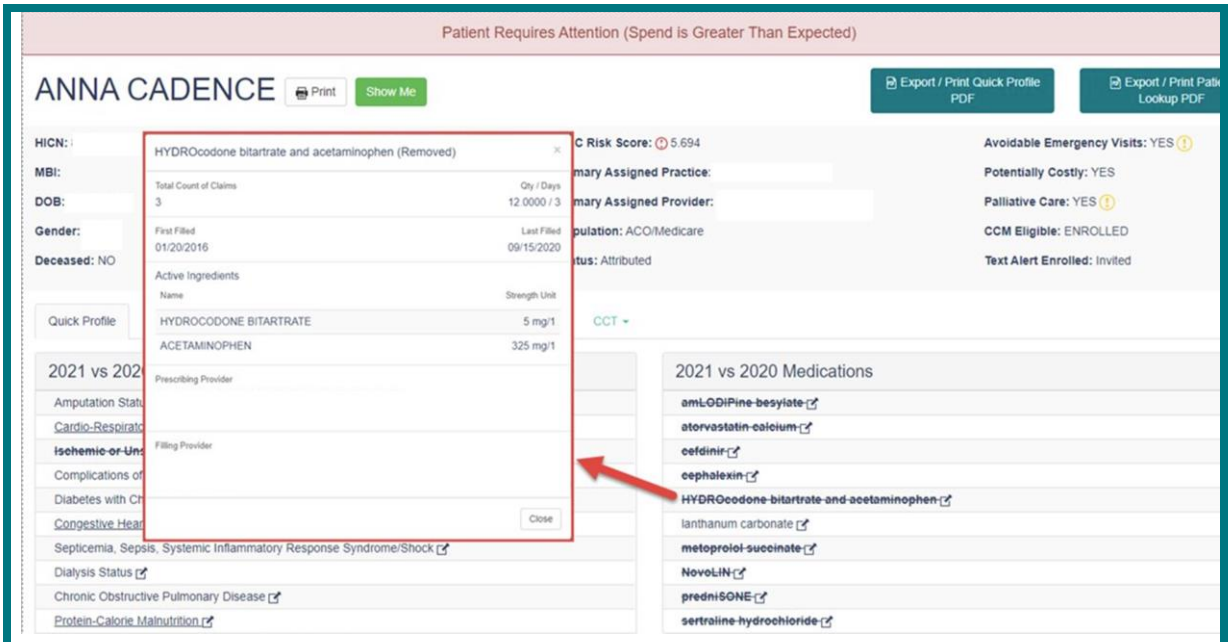
HCC Code – The HCC code within the hierarchy of disease progression for the selected diagnosis.

Description – The definition of the HCC code within the hierarchy of disease progression for the selected diagnosis.

Weight – The HCC coefficient assigned to the listed HCC score for an aged, non-dual beneficiary. This should not be used as an absolute increase for billing the related code but rather to get a sense of weight when comparing similar HCC categories. A higher score indicates a higher level of risk, and therefore a greater benchmark for predicted spend.

ICD Code – The ICD-10 codes that relate to the chosen HCC code.

ICD Description – The definition of the ICD-10 codes that relate to the chosen HCC code.



Current Prescriptions: This is a list of the current prescriptions prescribed during the current year. You may drill into the prescription to see the prescription information, prescribing provider, and servicing pharmacy.

Prescriptions Removed: This is a list of prescriptions no longer being picked up in the current year. You may drill into the prescription to see the prescription information, prescribing provider, and servicing pharmacy.

Prescriptions Added: This is a list of new prescriptions in the current year. You may drill into the prescription to see the prescription information, prescribing provider, and servicing pharmacy.

Cost and Utilization

2021 YTD Spend		$95595.08
2021 HCC Benchmark		$53335.70
2021 HCC Benchmark vs 2021 YTD Spend	⊗	**179.00%**
Benchmark Prediction*		Yes
Out of Network Spend*		$94390.47
Office Visits*		0
Most Visited Provider*		0
Admits *	⊗	**1**
Readmissions*		0
ED Visits *	⊗	**2**
ED Visits that led to Hospitalizations *	⊗	**1**
CT Scans *	⊗	**2**
MRI Events*		0

Cost and Utilization - identifies high-cost utilization such as emergency department, admission, re-admission, or imaging. The end-user may drill into the encounter to determine the provider and place of service.
2019 (2020) YTD Spend – The sum of paid claims in 2019 (2020).

2019 (2020) HCC Benchmark – A financial spend benchmark based on the patient's HCC score and demographics.

2019 (2020) HCC Benchmark vs 2019 (2020) YTD Spend – Percentage of financial spend benchmark used year to date. What has been spent vs what is left.

Benchmark Prediction – A warning symbol to indicate if the Health Endeavors Algorithm predicts if the patient will exceed their benchmark before the end of the current year.

Out of Network Spend – The sum of paid claims for the current year billed by providers who are considered out of network per the configuration of your account.

Office Visits – A listing of dates in which the patient had an encounter that is considered an office visit.

Most Visited Provider – The NPI and name of the provider the patient has encounters with most frequently

Admits - Number of times in which the patient has been admitted during the current year.

Readmissions - Number of times in which the patient was discharged and within 30 days, readmitted to a hospital during the current year.

ED Visits – The number of times in which the patient has had an encounter considered to be an Emergency Department Visit during the current year.

ED Visits that led to Hospitalizations – The number of times in which the patient had an Emergency Department Visit and was admitted because of the ED Visit during the current year.

CT Scans – The number of CT Scans for the patient during the current year.

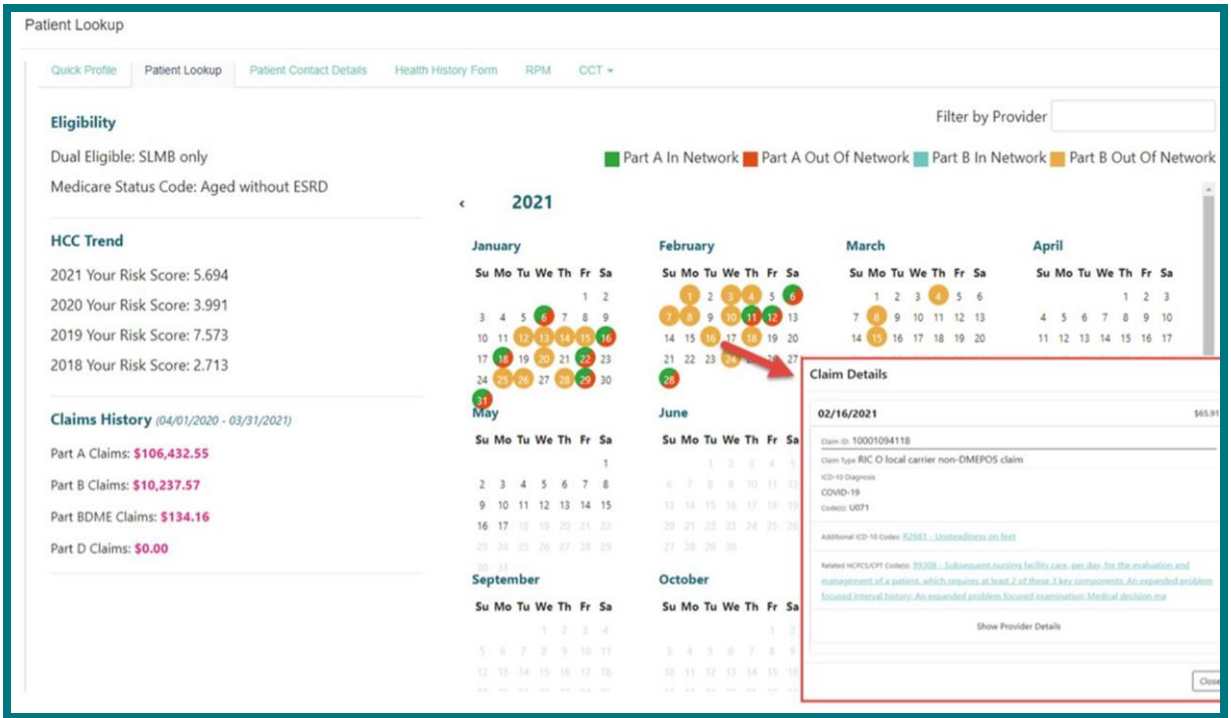
MRI Events – The number of MRI Events for the patient during the current year.

Quality Care Gaps

DM-2 DM with HbA1c > 9 percent (poor control)	Not Applicable
HTN-2 Controlling High BP	Done
MH-1 Depression Remission	Not Applicable
PREV-5 Breast Cancer Screening	Not Applicable
PREV-6 Colorectal Cancer Screening	Not Applicable
PREV-7 Influenza Immunization	Done
PREV-10 Tobacco Use: Screening and Cessation Intervention	Done
PREV-12 Screening for Depression and Follow-up Plan	Done
PREV-13 Statin Therapy	Done
Care-2 Falls: Screening for Future Fall Risk	Not Applicable
Wellness Exam	**Action Required**

Quality Care Gaps – If the provider is enrolled in a quality program, the list of measures will populate with an indication of action required, not applicable, or done. Action Required means the measure needs to be completed for the patient. If your organization has signed up for SMART on FHIR quality get calls program with Health Endeavors, we are able to pull data from the EHR into the quality measure repository.

Patient Lookup – Calendar



Out-of-Network is determined by your network setup.

Dual Eligible – Indicates if the patient is dually eligible for Medicare and Medicaid benefits.

Medicare Status Code – Indicates how the beneficiary became eligible for Medicare benefits.

HCC Trend – The patient's HCC score trended over a four-year period. HCC Scores are calculated from patient demographics and specific diagnoses to calculate a patient risk score. A larger score indicates the patient to be a higher level of risk than that of a patient with a lower risk score.

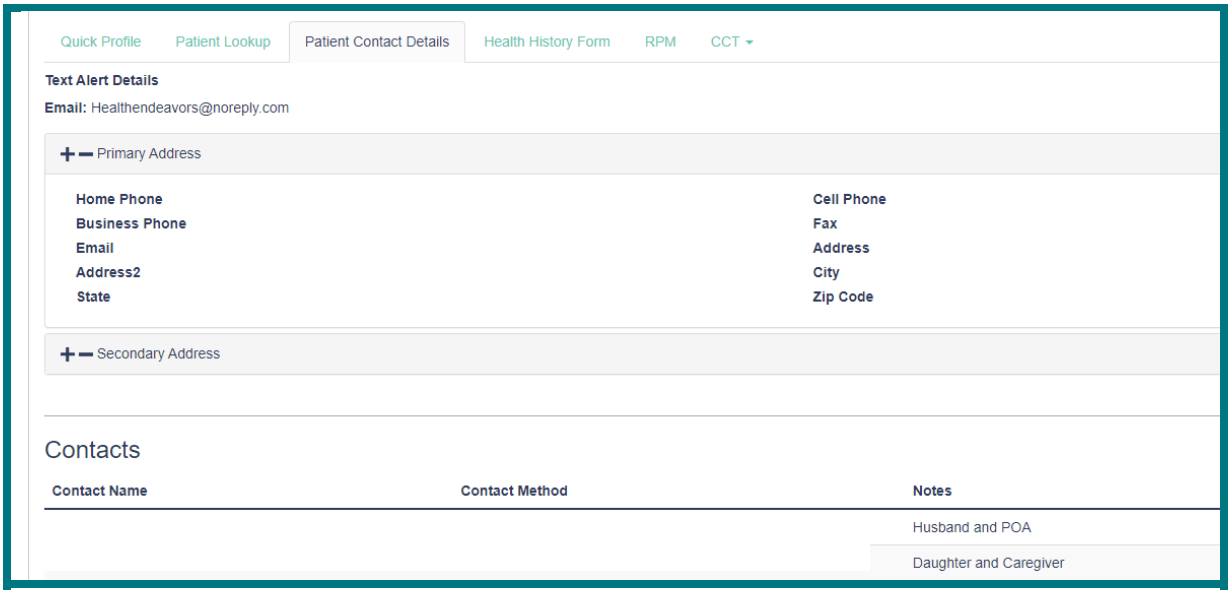
Claims History – A rolling 12-month period to provide an overview of the patient's financial spend.

Part A Claims – The beneficiaries' sum of claims in the current calendar year that are billed by a facility or agency covered under Part A benefits.

Part B Claims - The beneficiaries' sum of claims in the current calendar year that are billed by providers for things such as outpatient care, preventative services, ambulance services, and laboratory services under Part B benefits.

Part B DME Claims - The beneficiaries' sum of claims in the current calendar year for durable medical equipment for things such as oxygen, canes, or infusion pumps that are billed under Part B DME benefits.

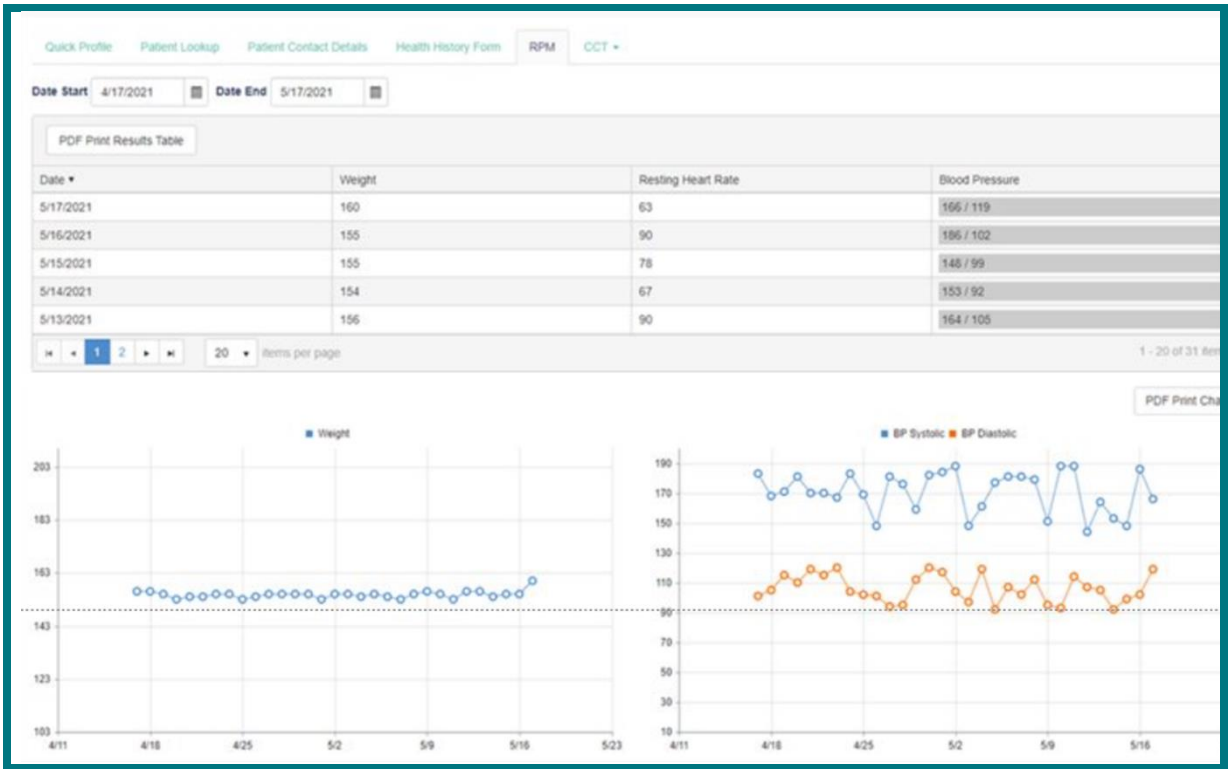
Part D Claims – The beneficiaries' sum of claims in the current calendar year that are billed and covered under Part D benefits. Blank if the patient is not enrolled in Part D



Patient Contact Details

Text Alert Enrollment - allows the healthcare provider to send an enrollment request to the patient to enroll in wellness and quality text or email notifications.

Data Sharing – Details if the beneficiary has opted out of sharing their data and if claims data was ever received. This section will also detail the reason the beneficiary opted out such as the beneficiary was excluded by CMS or if the beneficiary is to decline.



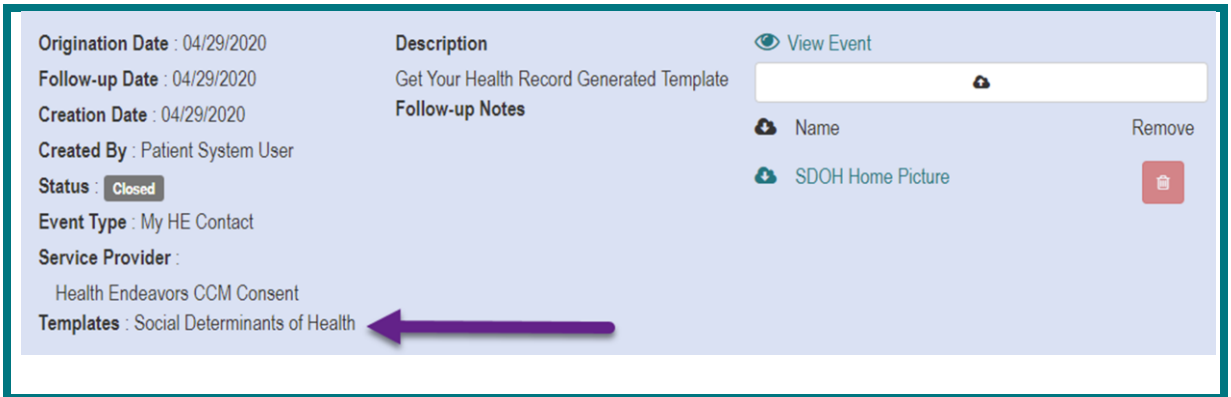
Remote Patient Monitoring (RPM)
Results Table – For patients who are enrolled in RPM, the results from their associated devices will populate in the Results table. This table can be exported to a PDF and sorted based on the available headers.

Weight – Depending on the device used to monitor weight, the values may be normalized from metric to imperial. Once the data has been normalized from kilograms to pounds, the weight is then rounded to the nearest pound.

Resting Heart Rate – The value displayed is the raw data from the device used to monitor the patient's heart rate when at rest.

Blood Pressure - The value displayed is the raw data from the device used to monitor the patient's blood pressure. The values are listed as Systolic/Diastolic.

Trending Charts – Either the normalized values or raw values are plotted in a graph with the associated date of the reading to show the trend over time. The Y Axis is represented by the value associated to the device reading, while the X Axis represents the date of the reading.



Care Coordination Events (CCT) events created by patients such as social determinants of health (SDOH) online screenings or events created by care managers.

Admit, Discharge, Transfer (ADT)
View Events tab includes admit, discharge or transfer (ADT) events.

Social Determinants of Health (SDOH)
Under View Events tab you may view patient's responses to SDOH questionnaires.

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