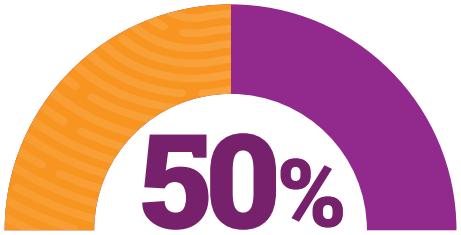
Serious Illness Care at Home

carecentrix®
Empowering Health at Home

Uncovering and addressing unmet social and medical needs to extend palliative care reach and impact.

Palliative care is often thought to be limited to medical management and only appropriate for a small subset of the population at end-of-life. In reality, people with serious illnesses have palliative needs that are social and emotional, as well as medical. By uncovering and addressing these needs long before most programs consider palliative support, CareCentrix is able to improve quality of life for members and reduce medical costs for health plans.



Over-medicalized care for serious illness accounts for nearly half of a health plan's total medical costs.[2]

Up to 5% of an MA-plan's population could benefit from whole-person palliative care.[3]

Our Approach

A population health approach that blends compassionate care with technology to uncover, address, and monitor unmet medical, emotional, and social determinants of health (SDoH) needs for seriously ill people and their caregivers.

1 Predictive Analytics

Proactive, upstream identification of members at risk of over-medicalization near the end of life

2 Palliative Network

Achieve scalability, speed to market, and access to local community expertise and social resources through a network of hospice and palliative care organizations

3 Home-Based Palliative Care

Address whole-person and caregiver needs, enhance engagement through in-home and virtual visits, and coordinate care with the member's healthcare team

4 Serious Illness Care Platform

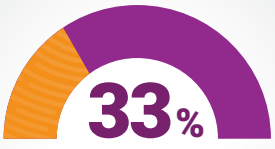
Proprietary platform supports program standardization, workflows, assessment documentation, oversight, and reporting

5 Clinical Management

Drive cost and quality outcomes through coaching, support, and program oversight through CareCentrix's dedicated hospice and palliative care board-certified clinical nurse managers and physicians

Reduction in Total Medical Costs, Including Timely Transition to Hospice[2]

Reduction in ICU[2]



Reduction in Hospital Admissions[2]

Proven Results

Our results, published in the Journal of Palliative Medicine, demonstrate that uncovering and addressing social and medical care gaps pre-decline results in **more compassionate, affordable, sustainable, and high-quality care.** Our upstream, social-first, clinical-second approach supports and coordinates with existing care delivery models, rather than replacing or competing. Through the CareCentrix approach, we expand your reach to close care gaps that, when unmet, exacerbate serious illness. The result is higher quality care, improved member satisfaction, and significantly reduced costs.

The Patient Journey with the **CareCentrix Serious Illness Care at Home Approach**

When partnering with CareCentrix, the key to success is identifying and engaging the highest-risk members pre-decline, when there is still time to uncover and close social and medical care gaps. This not only drives improved quality and satisfaction but also creates up to 35% total cost of care savings.

1 Earlier Identification

Leverage predictive analytics to identify patients earlier and change the course of treatment to reduce potentially inappropriate, unwanted, and expensive treatments and care.

2-5% Could be identified farther upstream, while not currently high-spend, can be on that over-medicalized trajectory.[1]

82% Engagement[2]

2 Outreach & Enrollment

Proactive outreach to members to introduce the supportive care program and invitation to enroll.

3 Comprehensive Assessment at Initial Home Visit

- Goals of care
- Clinical and SDoH needs
- Develop plan of care
- Initiates collaboration with healthcare and case management teams

82% Advance care planning[1]

97% Medication reconciliation complete[1]

4 Ongoing Assessments and Interventions

Implement care plan and continually reassess status, goals and plan of care with patient, caregiver and healthcare team. Assessments are whole-person, including community and social resources for SDoH needs, and care coordination for medical gap intervention.

97% Satisfied with Symptom Management[1]

98% Goals of Care Addressed[1]

Low
Medium
High

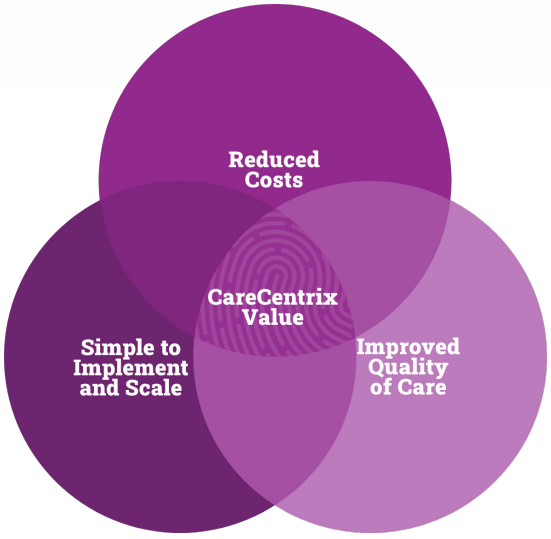
Member's intervention level guides visit frequency based upon care protocols

5 Program Transition or Disenrollment

The CareCentrix Serious Illness Care at Home program monitors patient progress for **timely transition** to the next point of care.

36% Stabilize or improve and can return to health plans' care management[1]

32% Transition to hospice[1]



The CareCentrix Value

Our Serious Illness Care at Home solution is designed to easily implement, scale, and integrate into existing care delivery systems. We proactively identify, engage, and support members and caregivers to remain independent in their homes and make health care decisions aligned with their goals and values.

Our capabilities support quality metrics tied to CMS Star ratings including quality of care, member, and caregiver satisfaction, post-hospital medication reconciliation, and utilization.

1.CareCentrix Data, 2022, **2.**"Effects of a population health community-based palliative care program on cost and utilization." Journal of Palliative Medicine, 2019, **3.**"Managing the Most Expensive Patients",Harvard Business Review, Jan-Feb 2020.https://hbr.org/2020/01/managing-the-most-expensive-patients

Request a Consult Today

to learn how we can help optimize your palliative care strategy for members with serious illness:

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