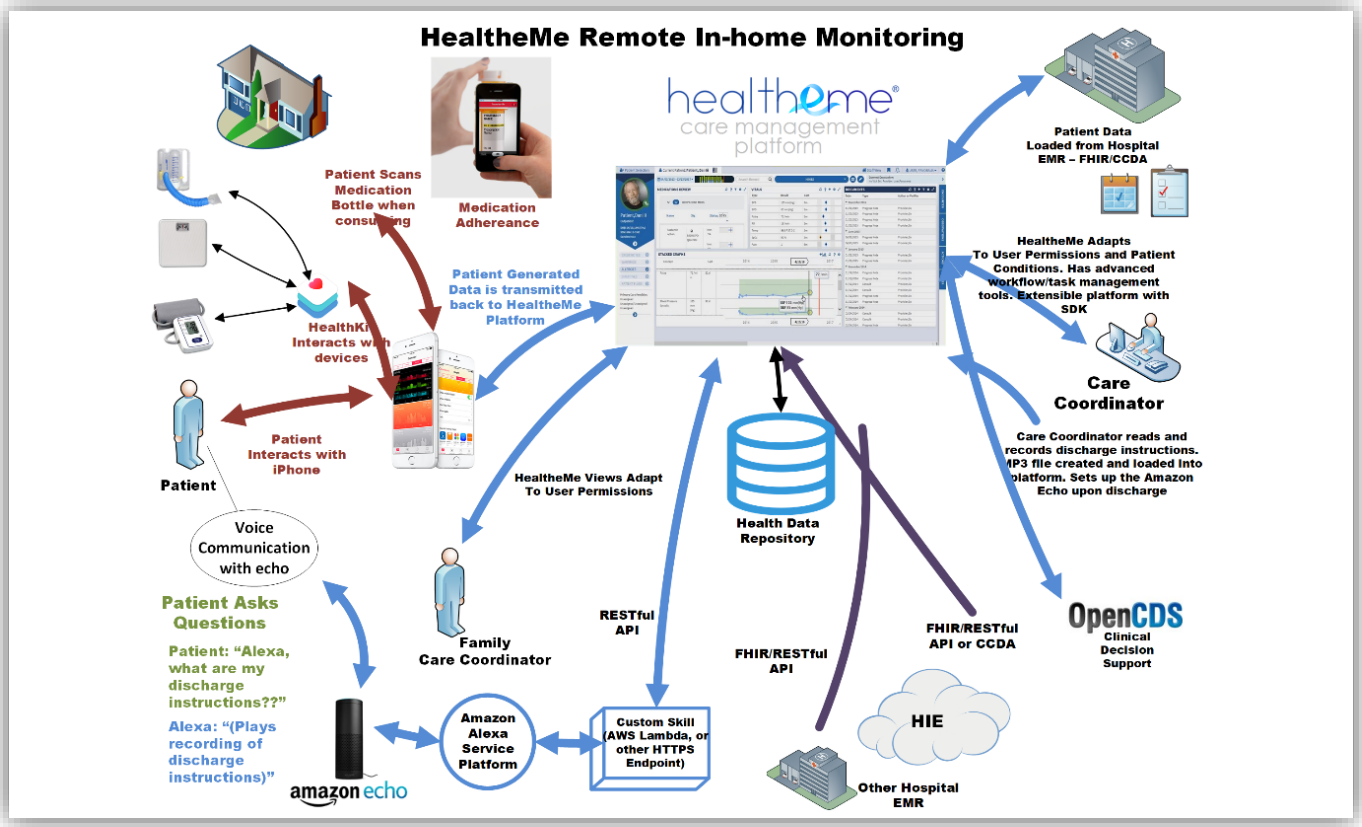
HEALTHEME® CARE MANAGEMENT PLATFORM

The goal of improving the qualtity of patient care while simultaneously lowering costs represents a significant challenge for most health delivery organizations. This is especially true now that the final payment and policy changes for hospital readmissions from the Centers for Medicare & Medicaid Services (CMS) are now in effect. Kaiser Health News reported that 2,610 hospitals face penalties from Medicare due to high readmission rates with a projected overall cost of $428 million. In another study by Modern Healthcare, it was determined that roughly 1% of patients make up 22.7% of hospital costs. The data clearly indicates that better post-discharge and care coordination are necessary.

KRM Associates has long been in demand as an organization that can devise custom software solutions that are both functional and easy to use. And as a small company, we are able to create flexible, custom-tailored, and innovative solutions in order to help our customers overcome the challenges they are facing. From using new technology to extract health data from legacy systems, to integrating an open source medical record framework to manage patient records, the KRM team actively learns and implements new technologies and applies these skill-sets to federal and private applications, especially in the realm of Open Source software. Building on our expertise acquired working in health IT, we have created the Healthe*M*e® Care Management Platform to assist health delivery organizations, as well as patients and caregivers alike, in managing care recovery and chronic disease.



To learn more, contact us today:
304-876-6600 or info@krminc.com

HEALTHEME® CONCEPT AND ARCHITECTURE

Our Healthe*M*e® Care Management Platform is a prime example of our ability to create functional solutions that exceed client expectations. Stemming from a pilot project to explore improving population health by using personal health records systems, Healthe*M*e® continues to evolve and improve. It is a Care Coordination platform for use either by care coordinators from the healthcare organization or by family members and designated caretakers.

The Healthe*M*e® Care Management Platform is a customizable portal built upon KRM's Light Enterprise Application Framework (LEAF) and utilizes the very best "applets" and features from the U.S. Department of Veterans Affairs' Enterprise Health Management Platform (eHMP), such as workflow management, enhanced graphing support, and workspace customization.

Leveraging eHMP's ability to harmonize and display health information from many disparate data sources, patient data can be imported into the Healthe*M*e® platform via FHIR, CCDA or other standards from multiple EHRs.

Workflows can be defined within the Healthe*M*e® care management platform depending upon roles and relevant patient data, such as diagnosis codes or lab results.

Views can also be customized using a robust workspace manager, which allows the system to conform itself to display the pertinent patient data depending upon the role of the user or diagnosis of the patient.

BUILT TO EXTEND

Because it uses LEAF as it's application framework, the Healthe*M*e® care management platform is designed to be extensible. Using the robust Software Development Kit (SDK) provided with LEAF, allows Healthe*M*e® to be customized to meet the needs of any health delivery organization and connect to a wide variety of data sources and devices. New "applets" can be reapidly created using the SDK and quickly snapped into the platform. Because of the extensibility of the Healthe*M*e® Care Management Platform it has the ability to connect with a wide-variety of remote in-home monitoring systems and provide the data to care managers in a meaningful way. As a proof-of-concept, KRM has integrated the Amazon Echo Platform with Healthe*M*e®, which allows patients to use voice activated interactions with to:

- Replay parts of their discharge instructions,
- Hear their medication schedules and instructions, or
- Listen to their medication side-effects and related information.

It is this customizability that gives Healthe*M*e® with the power to adapt to any health delivery organization's needs.

IN HOME MONITORING CONCEPT

Because hospital readmission of patients with chronic conditions, such as diabetes or congestive heart failure (CHF) is expensive (In 2013, CHF readmits averaged $13,000 per occurence) and results in Medicare penalties, better support at home after discharge is needed to avoid readmissions. The goal is to improve outcomes through better compliance with therapeutic instructions and early recognition of negative indications. And since patient compliance is a critical part in reducing readmissions it is imperative to have good communications and quantitative data from the patient once they are discharged. As an example, the system could allow 24/7 in-home patient support and integrate the data from wearables, home health devices, and EHRs to manage patient care and status. The patient's diagnosis could determine which home assistance device(s) and data gathering device(s) would be provided.

Use of the platform and associated device(s) could reduce care management costs by:

- Providing care managers with a robust dashboard of patients along with their risk status;
- Integrating data from wearables, home health devices, and EHRs in a central repository;
- Monitoring real-time data for abnormal conditions or negative trends;
- Orchestrating rules and workflows to meet each patient's needs based upon condition;
- Automating and curating care plans, medications, and care activities;
- Leveraging rich communication and collaboration features to engage and empower family and friend caregivers as well as home care agents; and
- Delivering a tailored user experience and data collection methodology to meet the specific needs and abilities of the patient.

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