The West Coordinated Communication Pathway

WEST HEALTHCARE PRACTICE

THE WEST COORDINATED COMMUNICATION PATHWAY (CCP)

The **Coordinated Communication Pathway (CCP)** from West is a suite of applications that are part of a cloud-based communication platform that enables organizations to align patient communication and engagement with medical and clinical guidelines or a plan of care.

The applications are comprised of condition-specific and outcome-focused libraries of automated communication interventions that a healthcare provider can "**subscribe**" to. For example:

- An organization may subscribe to the *CCP Library for Hypertension Chronic Care Management* to facilitate its care management program for risk-stratified hypertensive patients;
- An organization may also subscribe to the *CCP Library for Transition Care Management* to facilitate patient engagement post-discharge to reduce hospital readmissions;
- Similar libraries exist for all major chronic conditions and for less complex Routine Care Management scenarios and for reducing gaps in care (e.g. wellness visits, screenings, and immunizations).

A provider "**prescribes**" a CCP from the Library to a patient population. The CCP contains a standard set of communication interventions, which are designed and sequenced to automate tasks common to that particular chronic condition or outcome. This is the **Standard CCP**.

To enable provider flexibility and drive greater patient-centeredness, the CCP is "**customizable**" at the patient level such that communication interventions can be added or omitted, and various parameters of the communication intervention such as sequence, duration and frequency, can be modified. This results in a **Custom CCP**.

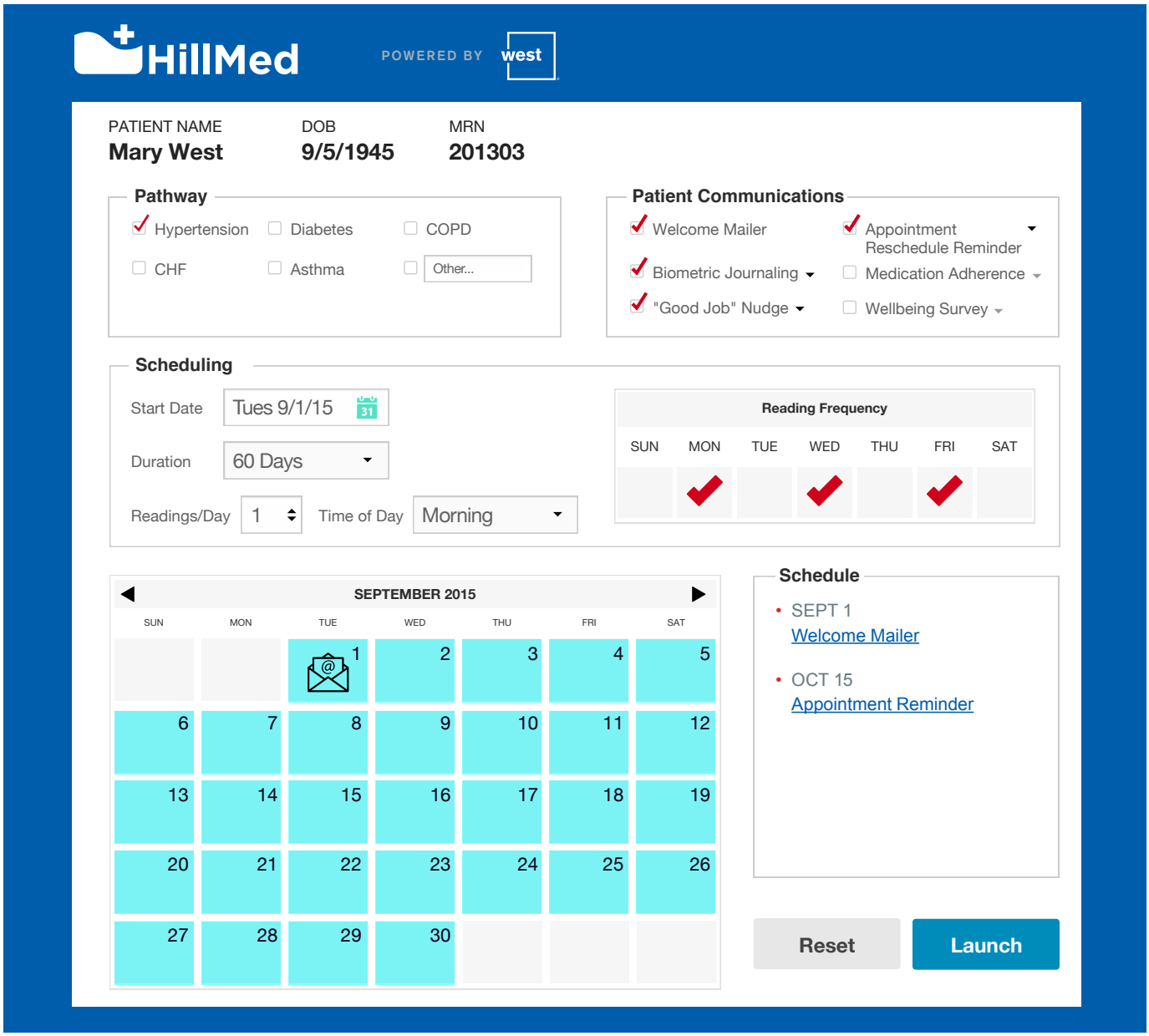
A **CCP** can be used to more effectively manage patient populations across the care continuum. In the case of chronic care management, automating communication around routine tasks such as biometric journaling, helps organizations achieve greater scale and capacity by significantly increasing patient-to-care coordinator ratios and enabling them to spend more quality time with patients, thereby more efficiently managing to better patient outcomes.

Key CCP Benefits

- Affords Care Coordinators the ability to better manage large panels of patients
- Once prescribed, CCP allows a Care Coordinator to better observe which patients are doing well against their Plan of Care, and which require intervention
- Enables Care Coordinators to have complete visibility into all communication activity with their entire patient panel
- Drives Care Coordinator efficiency and better patient experience by gathering information during automated communications and updating the patient record as needed
- Maximizes patient activation since communications within a CCP can be delivered in the patient's channel of choice (i.e. email, SMS text, voice, video)
- Minimizes Care Coordinator effort by ensuring automated patient communications are automatically sent as scheduled

Use Case: CCP for Hypertension

CARE COORDINATOR PRESCRIBES A PATIENT CCP



About the CCP Authoring Tool

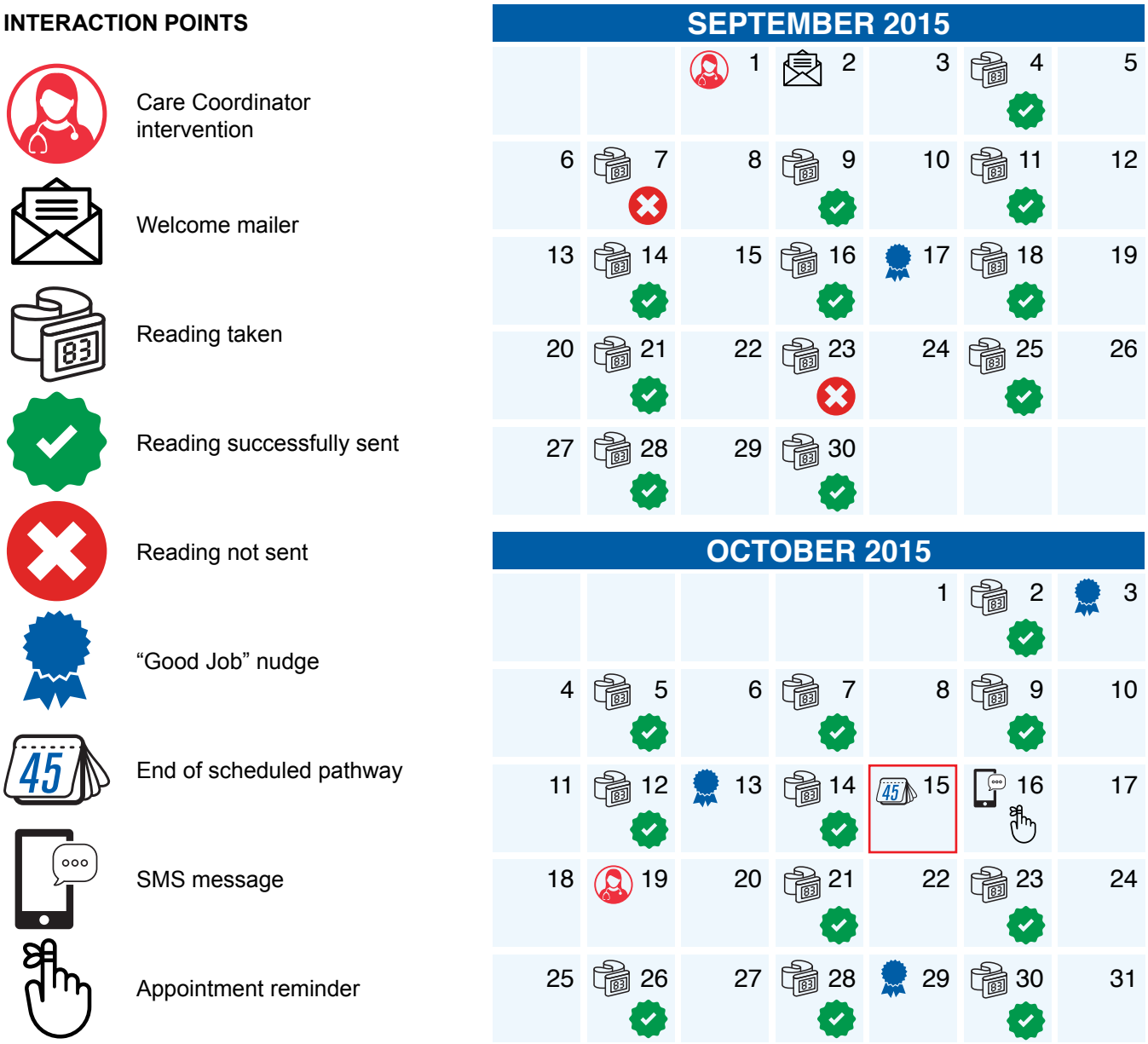
- The Care Coordinator prescribes the Hypertension CCP for the patient.
- This creates a default set of patient communication interventions that are aligned with the provider's standard Hypertension care plan. In the case of this provider, these include: a program welcome mailer, automated biometric journaling, a reminder to reschedule an appointment, and a good job message when the patient's biometrics are in range for a given timeframe.
- The Care Coordinator can de-select communication interventions that may not be relevant to a particular patient.
- The Care Coordinator schedules these communication interventions by indicating a start date, duration, how many biometric readings the patient should provide each day, and the time of day the patient should be prompted to provide their readings.
- By selecting "Launch" these automated communication interventions are scheduled and will occur without additional effort or intervention from the Care Coordinator.

Use Case: CCP for Hypertension

AT-A-GLANCE PATIENT CCP

INTERACTION POINTS

- Care Coordinator intervention
- Welcome mailer
- Reading taken
- Reading successfully sent
- Reading not sent
- "Good Job" nudge
- End of scheduled pathway
- SMS message
- Appointment reminder

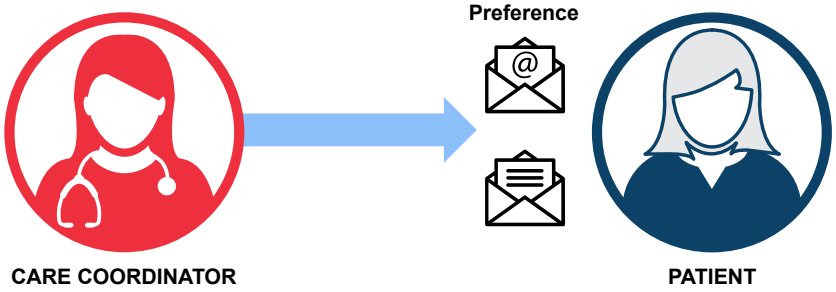


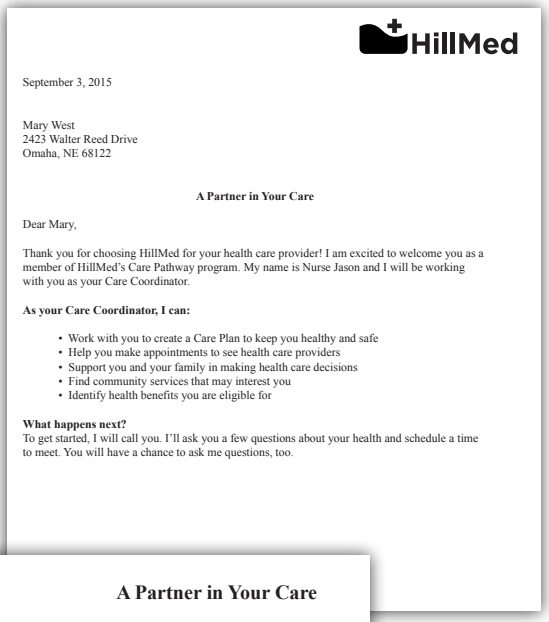
About This Communication Intervention

- A Patient CCP dashboard is at the Care Coordinator's fingertips so they can see all of the scheduled communication interventions for the patient and track progress.
- If needed, the Care Coordinator can modify any future communication intervention by clicking on it.

Use Case: CCP for Hypertension

PATIENT RECEIVES WELCOME MAILER





HillMed

September 3, 2015

Mary West
2423 Walter Reed Drive
Omaha, NE 68122

A Partner in Your Care

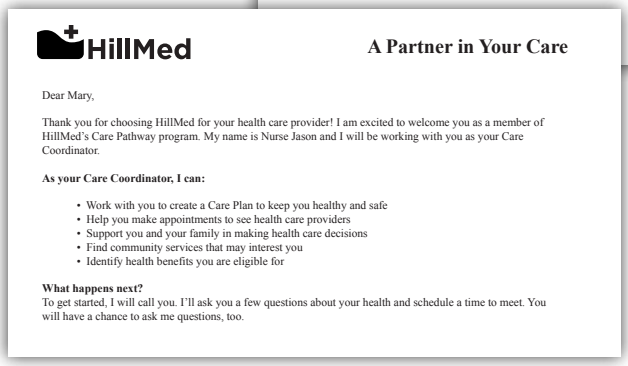
Dear Mary,

Thank you for choosing HillMed for your health care provider! I am excited to welcome you as a member of HillMed's Care Pathway program. My name is Nurse Jason and I will be working with you as your Care Coordinator.

As your Care Coordinator, I can:

- Work with you to create a Care Plan to keep you healthy and safe
- Help you make appointments to see health care providers
- Support you and your family in making health care decisions
- Find community services that may interest you
- Identify health benefits you are eligible for

What happens next?
To get started, I will call you. I'll ask you a few questions about your health and schedule a time to meet. You will have a chance to ask me questions, too.



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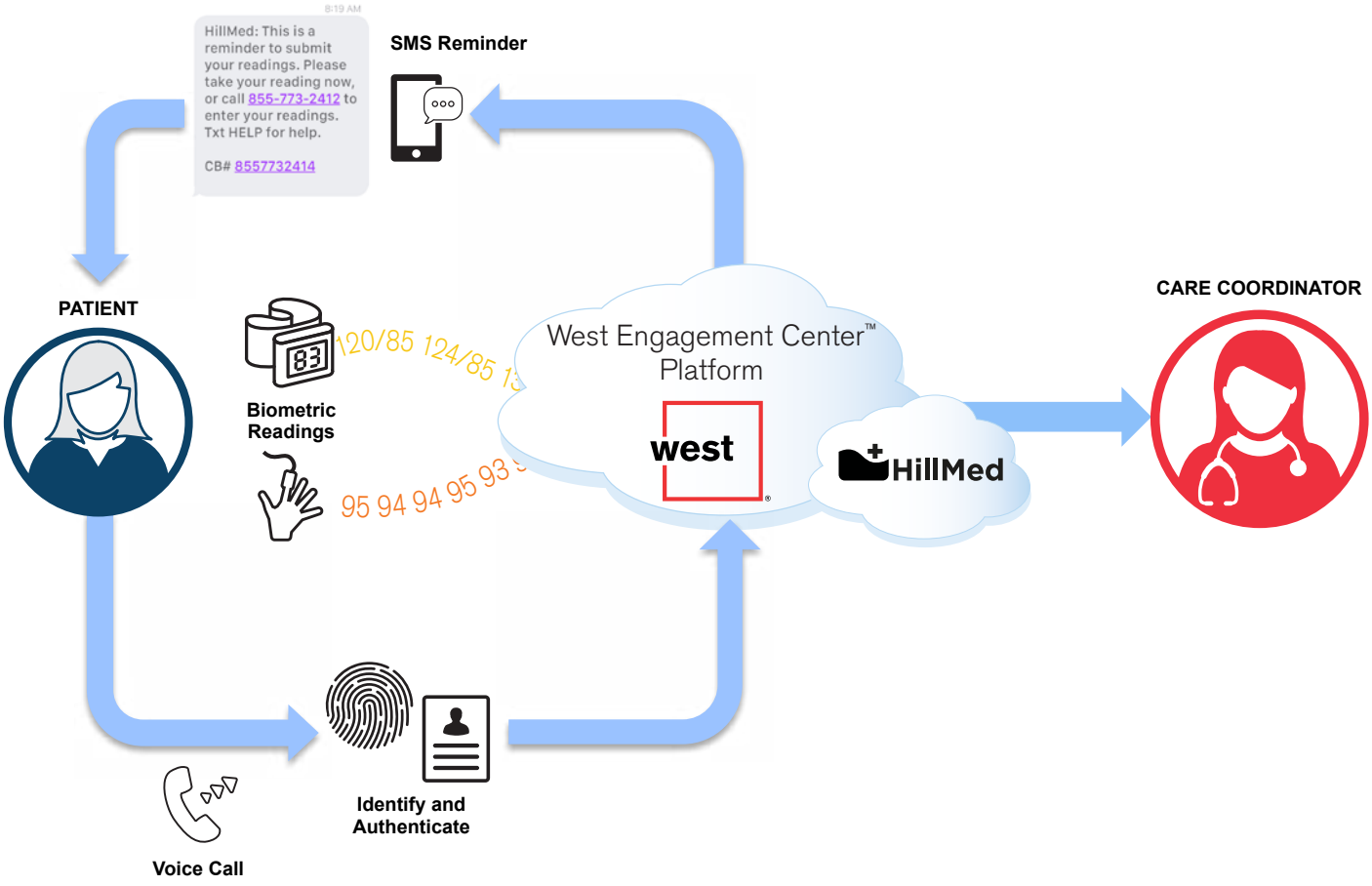
About This Communication Intervention

- Patient education is key in any care coordination program.
- A program welcome mailer – whether delivered via email, direct mail, or automated voice is a great way to educate patients on what to expect from being enrolled in the program.

Use Case: CCP for Hypertension

PATIENT PROVIDES BIOMETRIC READINGS

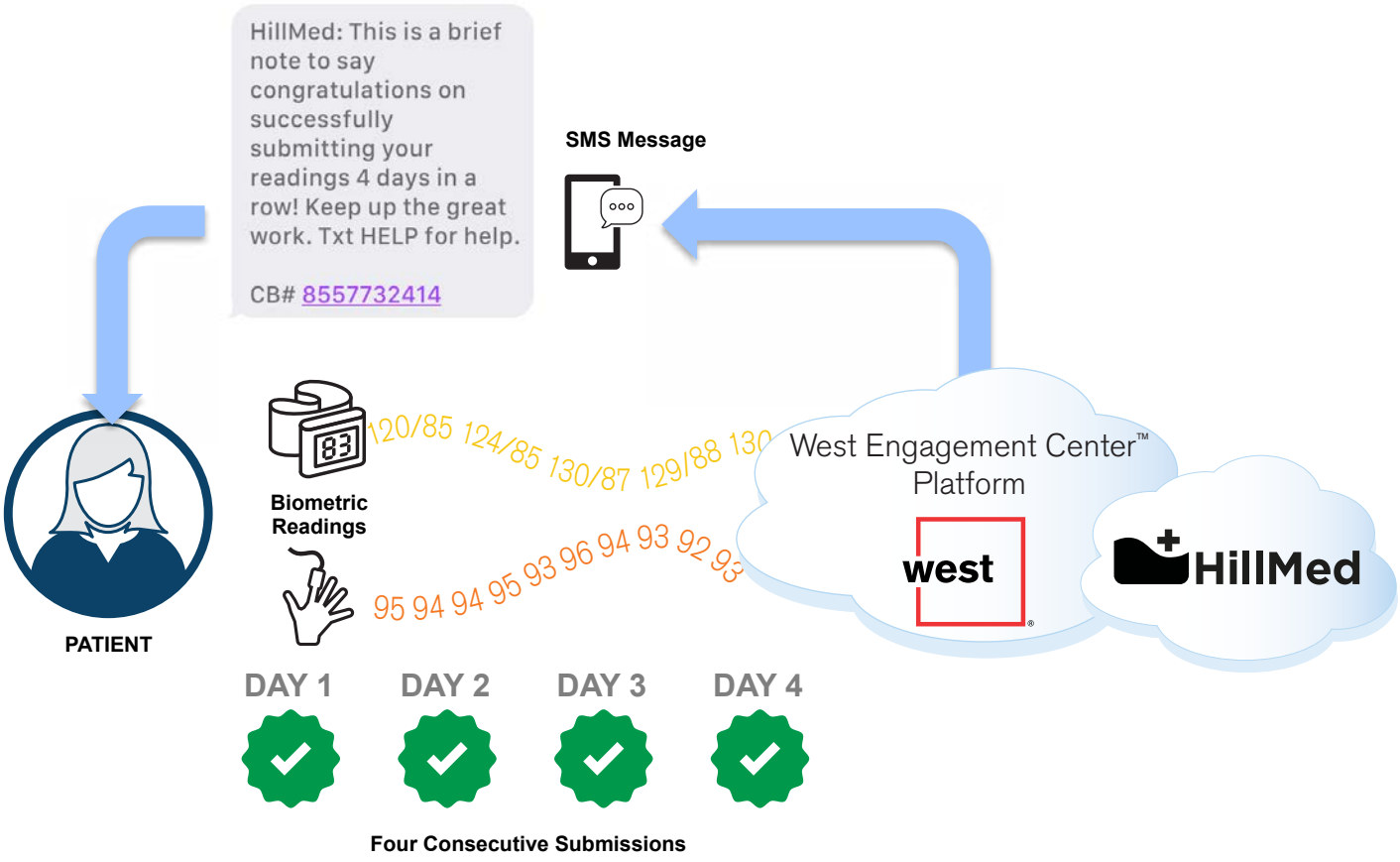


About This Communication Intervention

- Biometric journaling is an important component for many care coordination programs and tends to consume time and effort of Care Coordinators.
- With this communication intervention, patients submit biometric readings by automated voice, portal, or through remote sensor.
- If the patient fails to submit readings during the scheduled time frame, they receive a reminder notification.
- After a number of unsuccessful attempts to remind the patient, the system flags the patient for escalation by the Care Coordinator.

Use Case: CCP for Hypertension

PATIENT RECEIVES A “GOOD JOB” MESSAGE FOR MOTIVATION

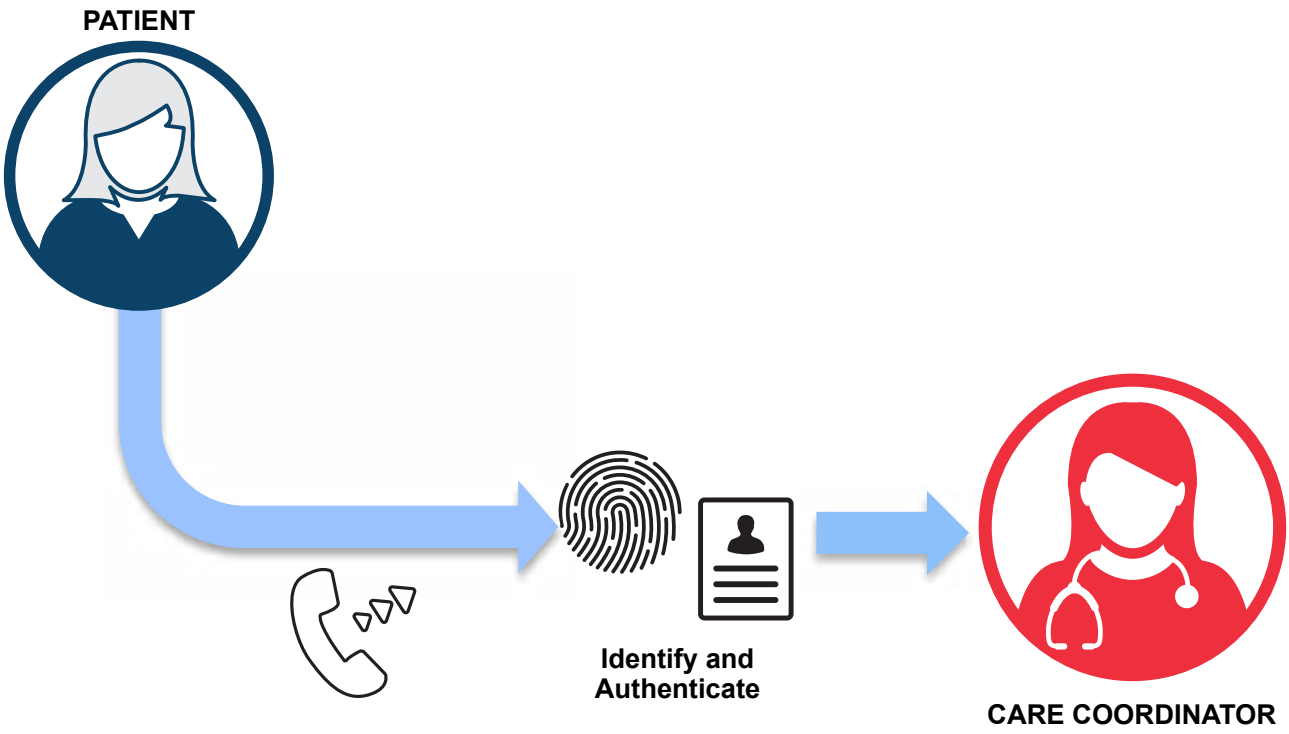


About This Communication Intervention

- Motivating patients to stay on track with journaling is important.
- When the patient submits a specified number of acceptable journal readings, they receive a “good job” message.
- This message can also include a notification of an incentive or award, if used by the provider.

Use Case: CCP for Hypertension

PATIENT CALLS CARE COORDINATOR

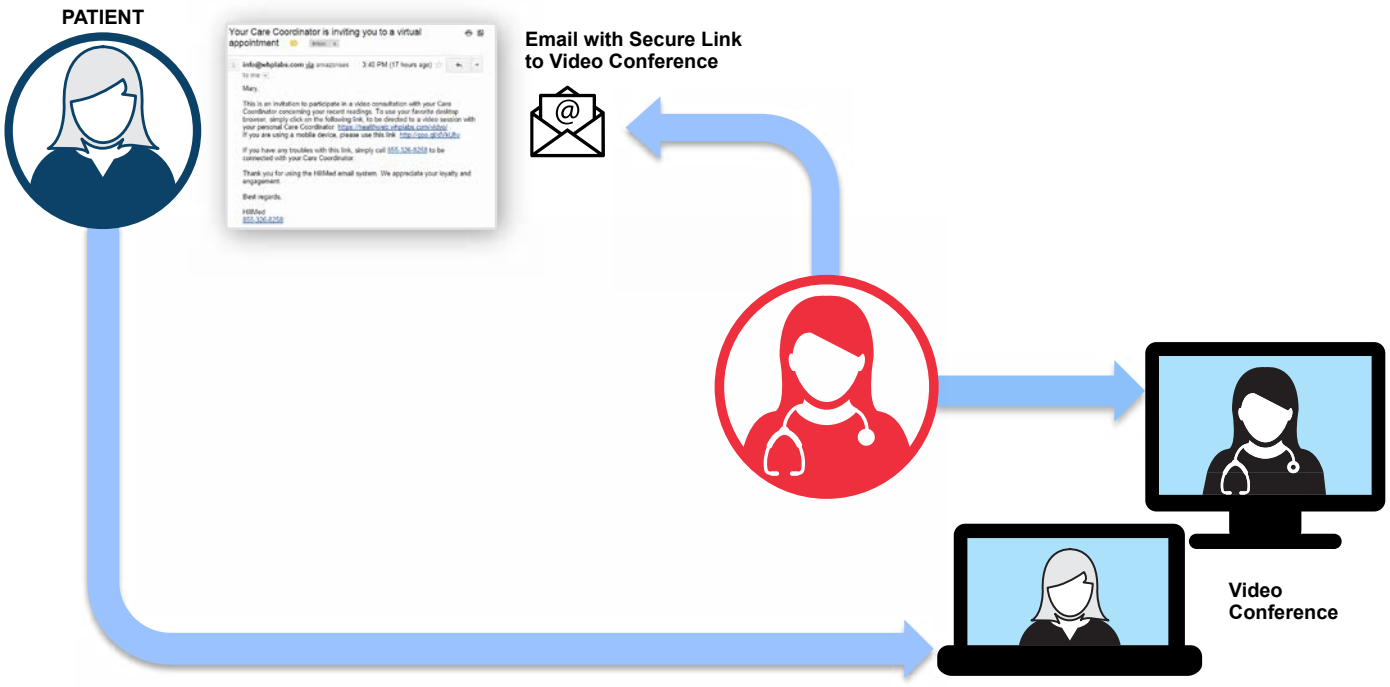


About This Communication Intervention

- A patient needs to know their Care Coordinator is available when needed.
- The patient dials an 800 number, is identified and verified, and is routed to their care coordinator, regardless of where he or she may be located.
- The patient's record, along with the reason for their call, is made available on the Care Coordinator's desktop in order to facilitate a personalized experience and reduce time and effort for the care coordinator.

Use Case: CCP for Hypertension

CARE COORDINATOR CONSULTS WITH PATIENT VIA VIDEO



About This Communication Intervention

- Sometimes a visual intervention is needed to properly assess the patient situation or provide them with instruction.
- The Care Coordinator initiates a video consult by sending the patient a web link via email or SMS text.
- The patient logs in and has a video interaction with their Care Coordinator.
- There is an option to include a third party, such as a family caregiver or physician, in the video consult.