cureatr

PAYERS & RISK-BEARING ORGANIZATIONS

Executive Summary

DO YOU KNOW WHERE YOUR MEMBERS ARE? Cureatr's Care Transition Notifications™ (CTN) Network provides real-time registration, admission, and discharge event notifications to its users, anytime a member for whom they are responsible transitions care settings. The CTN Network includes hospitals, IDN's, home care providers, and skilled nursing facilities (SNFs) that provide Admission, Discharge, and Transfer (ADT) feeds to Cureatr. Cureatr "listens" to these live feeds to identify when members are registered, admitted or discharged at surrounding facilities. When a match is identified, Cureatr delivers real-time notifications through the mobile or desktop application, directly to the member's care team.

The CTN Network gives payers real-time visibility when their members are receiving care – anytime, anywhere – across the continuum. This enables payers to impact avoidable hospitalizations through ED diversion, improve post-discharge follow-up, impact length of stay, and gain real-time insight into network leakage.

Manage Members Effortlessly with Subscribe, Notify, Coordinate Platform

A payer sending all or part of their member roster to Cureatr can build custom notification routing and response rules leveraging Cureatr's rules engine. Custom routing ensures the correct providers receive a notification at the right time, and the notifications outline best-practices and standardized follow-up interventions for a particular care transition event. Notifications are delivered to an individual, such as a care manager, or to a care coordination team responsible for patient care transitions, often via Cureatr's mobile or desktop applications, which are optimized for receiving and responding to event notifications. Cureatr is endpoint agnostic and delivers notifications to any endpoint that best fits into a care-team's processes.

When Cureatr's care coordination platform receives a notification, users respond by sending instant secure messages, or launching a pre-designed structured form or checklist.

When it Matters

CTNs are delivered to an individual, such as a care manager, or to a team responsible for patient care transitions. These providers receive the CTN alert on their iPhone, Android, or Windows Mobile Device via the Cureatr app.

The CTN Network improves communication during transitions of care. Notifications fit into a care team's workflow to facilitate reductions in avoidable hospital admissions, readmissions and improved patient experiences.

Quality Metrics in Real-Time

Improve HEDIS, PQRI and other quality metrics through the use of real-time event notifications to reduce complications associated with transitions of care:

- alert specialty care providers when patients register in the ED
- notify primary care providers in real-time when their patients are discharged
- support medical home care coordination programs

CMS sites the Benefits of Coordinated Care Transitions as:*

- Improving the overall quality of care and patient safety
- Reducing hospitalizations
- Reducing Duplication of Services
- Reducing adverse drug events through improved medication reconciliation practices
- Controlling health care costs
- Improving patient/caregiver satisfaction
- Engaging patient/caregiver in the care planning process
- Informing you of post-acute admissions and discharges

**Sources available upon request*

Key Clients

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SUBSCRIBE NOTIFY COORDINATE

Care Transition Notifications™

Subscribe to a Patient Roster

Providers receive real-time notifications when a patient receives care anywhere in the region

ED

Acute

Post-Acute

Providers coordinate & respond or intervene in real-time

SUBSCRIBE | **NOTIFY** | **COORDINATE**

Cureatr Works to Transform Your System...

Track and report on care activities anywhere in your region

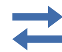
Transform care transitions with automated real-time alerts delivered to mobile devices

Simplify communication with a single HIPAA-secure mobile messaging solution

...And to Achieve Delivery Reform

Reduce preventable admissions and readmissions

Identify and monitor frequent use, high-risk patients



Increase information transfer and follow-up with the PCP, Specialist, and Care Manager at discharge

Improve clinical outcomes and meet quality reporting requirements

Overview of Features

CARE TRANSITION NOTIFICATIONS™

- CTNs via ADT Feeds:
  - Registered at Facility
  - Admitted as Inpatient
  - Transferred
  - Discharged from Service
- Enterprise Portal to Intelligently Route Notifications
- Upload & Manage Multiple Patient Lists

PATIENT-CENTRIC MESSAGING & STRUCTURED CHECKLISTS

- HIPAA-Secure Group Messaging
- Shared Evidence-Based Structured Forms & Checklists
- Secure Photo & File Sharing
- Message Prioritization & Read Receipts
- Set User Status, Availability, Coverage & Service

ENTERPRISE TOOLS & ANALYTICS

- Searchable Directory & CTN Routing by Name, Specialty and Role
- Set User & Patient Groups to Customize CTN Delivery
- Cureatr API for 3rd Party Systems Integration
- EMR Integration
- Custom Reporting & Analytics