Welcome to Kidney Health Management







Welcome to Healthmap Solutions (Healthmap)

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Solutions (Healthmap)
and our Kidney
Health Management
(KHM) program,
where our focus is
on a collaborative
partnership
leveraging advanced

analytics and clinical expertise for providers

and their members. We capitalize on our predictive models to assist in earlier detection of kidney disease and provide recommendations supporting this population. As part of the program's goal, we identify and recommend members who may benefit from engaging in Care Navigation, a key component of the KHM program.

How is our KHM program delivered?

The program is purposefully integrated into the existing practice workflow to complement a member's current plan of care. Healthmap supplies you, as the provider, with actionable information to more effectively anticipate and deliver the right care, at the right time, in the right setting.

What members are included in the KHM program?

All members identified as CKD stage 3 and higher are included in the program. A predictive algorithm is used to identify members, detect opportunities for interventions, and surface disease-specific coding opportunities, offering the practice greater insight into individually tailored care.

What are member opportunities, and how are they identified?

Opportunities are interventions or care gaps that are identified through specific, unique member data. They are addressed in two ways to achieve the best outcomes: patient opportunities and Care Navigation. All members are monitored to address gaps in care related to medications, lab testing, specialty referrals, and selective quality metrics. Each of these interventions or gaps will then be closed by the provider or the Healthmap Care Navigation team.

What is Care Navigation?

For those patients who may benefit from more intensive support as recommended by their provider, Healthmap offers Care Navigation, a complex care management service to support health care needs between office visits. Care Navigation focuses on identifying and removing barriers that prevent a patient from achieving their optimal health and supports the patient's overall care. All members are eligible for the program.

What does the Care Navigation team do?

- Identify risks and potential care gaps
- Work with you to customize a care management plan based on individual patient needs
- Review medication regimens to identify duplications or medicine interactions
- Coordinate and advocate for the patient across multiple specialty providers
- Educate patients on treatments and in-center dialysis alternatives
- Provide resources for patients to overcome social determinant barriers to care
- Immediately alert providers to any potential risks, changes, or concerns

How is the KHM program different from other programs in the marketplace?

Healthmap partners with practices to guide patients to smarter care based on individual needs and timely data. We help make your time with patients efficient and meaningful with the goal of a more adherent, healthier, and better-maintained chronic kidney disease (CKD) and end-stage renal disease (ESRD) patient.

BENEFITS FOR PROVIDERS

- Facilitates timely and appropriate information sharing among the care team
- Promotes communication of patient adherence to the plan of care
- Maps individual health status to CKD and ESRD guidelines
- Reduces provider fatigue by streamlining patient information
- Addresses care gaps to decrease costs by reducing unplanned Emergency Department visits and hospital admissions
- Improves quality outcomes as measured by performance and quality metrics
- Increases population risk scores through updated coding
- Prevents disruption to routine office activities by integrating into your existing workflows

To learn more, visit www.healthmapsolutions.com or call 1-800-819-5175.

If you suspect Healthmap Solutions of compliance violations of federal or state laws, or violations of Healthmap Solutions policies and procedures, please report your concerns to the

Healthmap Compliance Hotline at 1-800-441-4259.







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