Patient Lookup
Value-Based Care Patient Profile

Legacy Solution

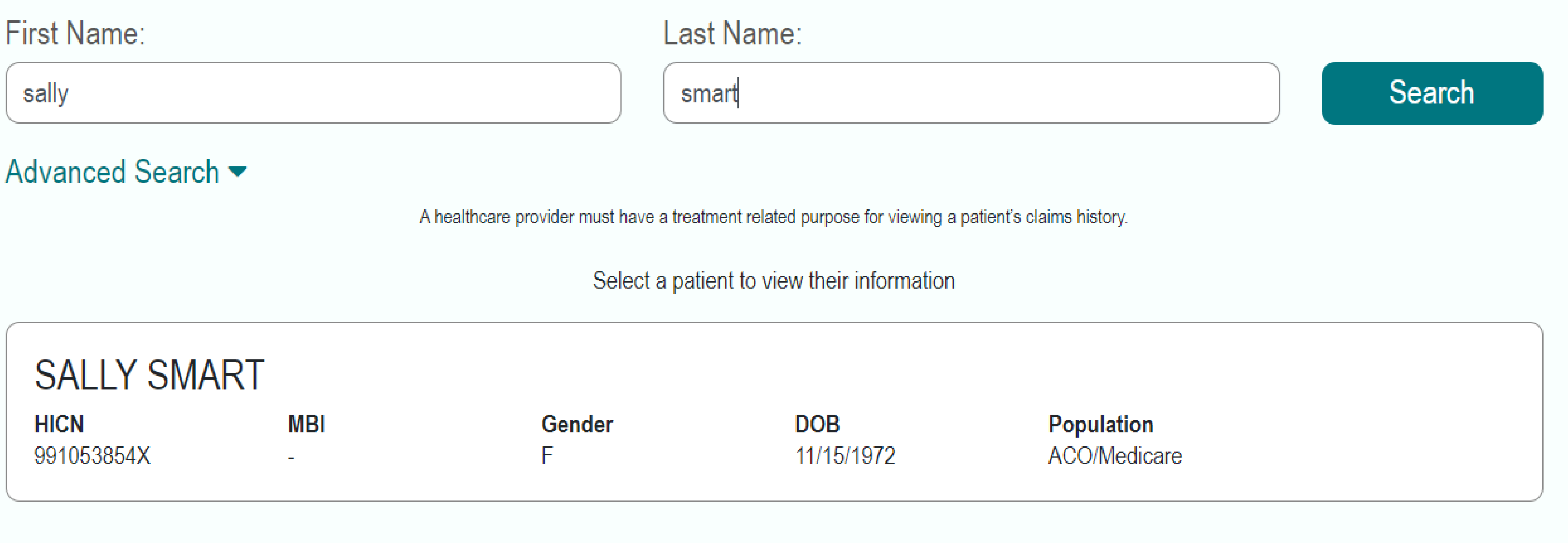
Patient Lookup (Legacy) Solution access points:

- HealthEndeavors.com
  - Login at healthendeavors.com and search for patient in navigation bar.

  - Login at healthendeavors.com and click Care Tab in navigation bar and then select Patient Master Dashboard. Search for a patient in the filters and click on the action item patient lookup to access.

Patient Lookup (Legacy) Solution access points:

PatientLookup.com: Login at patientlookup.com using your Health Endeavors credentials and search for patient in navigation bar.



Patient Lookup Tab Definitions

Quick Profile | Claims Calendar | Patient Contact Details | CCT ▾ | Do you want this in your EHR? Complete our EHR Request Form ×

Quick Profile: Quick summary of status of value-based care goals for the patient such as quality and financial performance.

Claims Calendar: Calendar view of Part A inpatient and Part B outpatient encounters color-coded for in and out-of-network.

Patient Contact Details: Contact details uploaded by client or populated from claims data.

CCT or Care Coordination Tool: Care managers or navigators create or edit patient events to follow-up on in the future. Click here: More Information

Complete EHR Request Form: Complete this form to integrate quick profile or segments of quick profile into your EHR.

EHR Integration Options

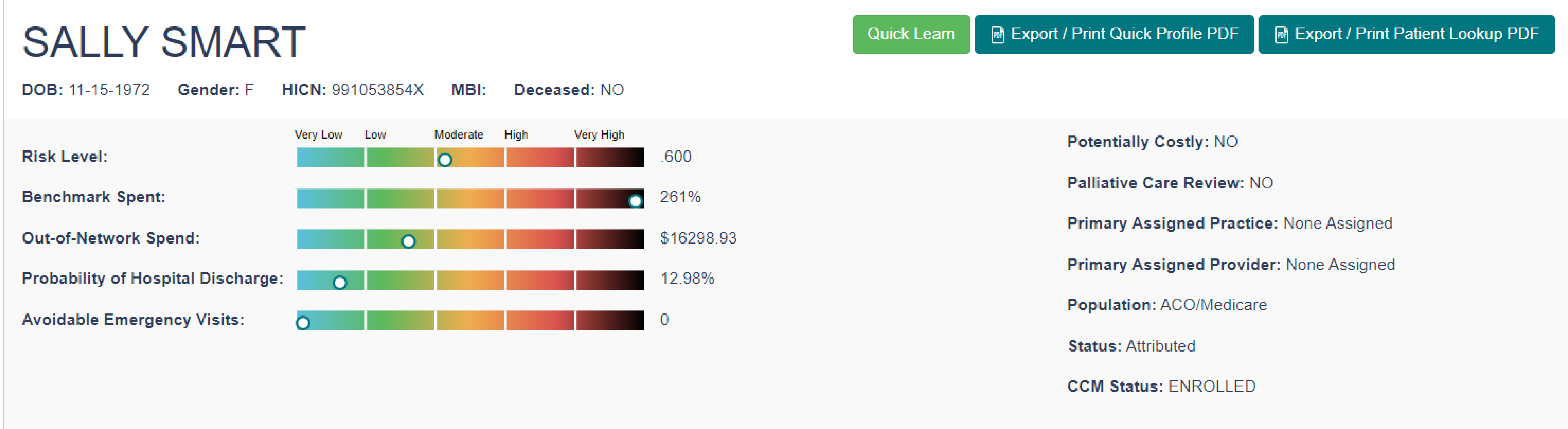
SMART on FHIR

Push/Pull data from EHR and other data repositories

API

Proprietary Application Program Interface (API to populate tab on patient chart

Patient Lookup Header



Patient Demographics: Full Name, Insurance Subscriber Identifier such as MBI for Medicare beneficiary, date of birth (DOB), Gender and deceased status.

Export Quick Profile: Export Quick Profile page only to PDF.

Export Patient Lookup: Export all pages to PDF.

Patient Lookup Visual Definitions

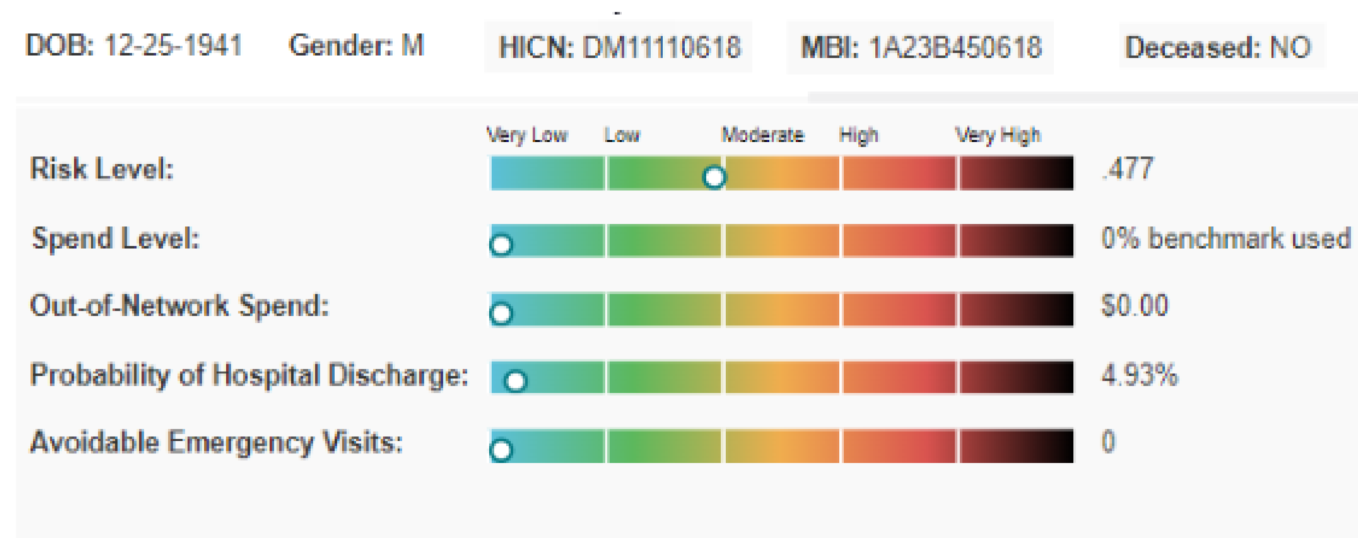
Risk Level: A color coding system to indicate if the patient's HCC risk score is: Very High (2.75 and up) | High (1.1 to 2.74) | Moderate (.51 to 1.0) | Low (.11 to .50) | Very Low (0 to .10)

Spend Level: A color coding system to indicate the patient's percentage of the current year HCC benchmark spend Vs. the current year YTD spend: Very High (81% - 100%+ | High (61% - 80%) | Moderate (41% - 60%) | Low Risk (21% - 40%) | Very Low Risk (20% or less)

Out of Network Spend: A color coding system to indicate the paid claims for out of network services: Very High ($40,001 - $50,000+ | High ($30,001 - $40,000) | Moderate ($20,001 - $30,000) | Low ($10,001 - $20,000) | Very Low ($0 - $10,000)

Probability of Hospital Discharge: A color coding system to indicate the patient's probability of hospital discharge:
Very High (81% - 100%+ | High (61% -80%) | Moderate (41% - 60%) | Low (21% - 40%) |Very Low (20% and below)

Avoidable Emergency Visits: A color coding graph to indicate how many avoidable emergency visits a patient has had:
Very High (8 and up) | High (6-7) | Moderate (4-5) | Low (2-3) |Very Low (0-1)



Patient Lookup Header Definitions

Potentially Costly: Risk score in the top 30% this year or previous year, 1 or more hospitalizations in last 12 months, 3 or more emergency department visits in the last 24 months and 3 or more chronic conditions.

Palliative Care Review: Yes or No indicator to flag the patient as Potentially Eligible for Palliative Care. The criteria to determine Yes or No includes terminal diseases, admissions, and emergency room visits. A Yes indicates the patient may need to be reviewed for palliative care. The intent is to show patients seriously ill who are utilizing the emergency room instead of their primary care provider.

Primary Assigned Practice: Practice the patient is assigned to.

Primary Assigned Provider: Provider that the patient is assigned to.

Population: Payor type population.

Status: Whether the patient is attributed or non-attributed.

CCM Status: Indicator if the patient is eligible, non-eligible, or is enrolled in the CCM enrolled program type within Health Endeavors.

Potentially Costly: NO

Palliative Care Review: NO

Primary Assigned Practice: None Assigned

Primary Assigned Provider: None Assigned

Population: ACO/Medicare

Status: Attributed

CCM Status: ENROLLED

HCC Diagnoses
Not Recaptured, V28 and Suspect

Diagnosis Not Recoded (Not Recaptured): This means the diagnosis has not been recoded in the current year and will be removed from the risk score calculation. You may drill into the HCC category to see the ICD10 diagnosis, rendering provide and date of service.

Diagnosis Recoded (Recaptured): This means the diagnosis has been recoded in the current year. If coded during a lab encounter, we encourage your team to re-code in your clinic setting. You may drill into the HCC category to see the ICD10 diagnosis, rendering provide and date of service.

Diagnosis Added: This means the diagnosis was added in the current year. You may drill into the HCC category to see the ICD10 diagnosis, rendering provide and date of service. A category underneath the HCC category that states "overridden" means the HCC diagnosis has been overridden by another HCC category. You may drill into the HCC category to see the ICD10 diagnosis, rendering provide and date of service.

Suspect: Drilling into the diagnosis will display if the diagnosis was coded in a lab or DME order.

V28 Status: Removed or Changed codes under the new HCC model for 2024 along with the new dollar value.

Total Diagnosis Value: Value of the diagnosis benchmark leakage for chronic HCC's that have not been recoded in the current year.

2023 vs 2022 HCC DX

Not Recoded in 2023	Total Diagnosis Value: $2,995.87
Vascular Disease	Diagnosis Value: $2,995.87 v28 Status: Removed | Value: N/A
Recoded in 2023	
Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	v28 Status: Changed | Value: $6,418.24
Added in 2023	
Complications of Specified Implanted Device or Graft	v28 Status: Removed | Value: N/A
Diabetes with Chronic Complications	v28 Status: Changed | Value: $1,726.79
Acute Renal Failure	v28 Status: Removed | Value: N/A
Chronic Kidney Disease, Moderate (Stage 3) - overridden	v28 Status: Changed | Value: $1,321.10
Protein-Calorie Malnutrition	v28 Status: Removed | Value: N/A
Dementia Without Complication	v28 Status: Changed | Value: $3,547.20

HCC Diagnoses: Not Recaptured, V28 and Suspect Encounter Details

Code – The ICD-9/ICD-10 code of which the patient has been diagnosed

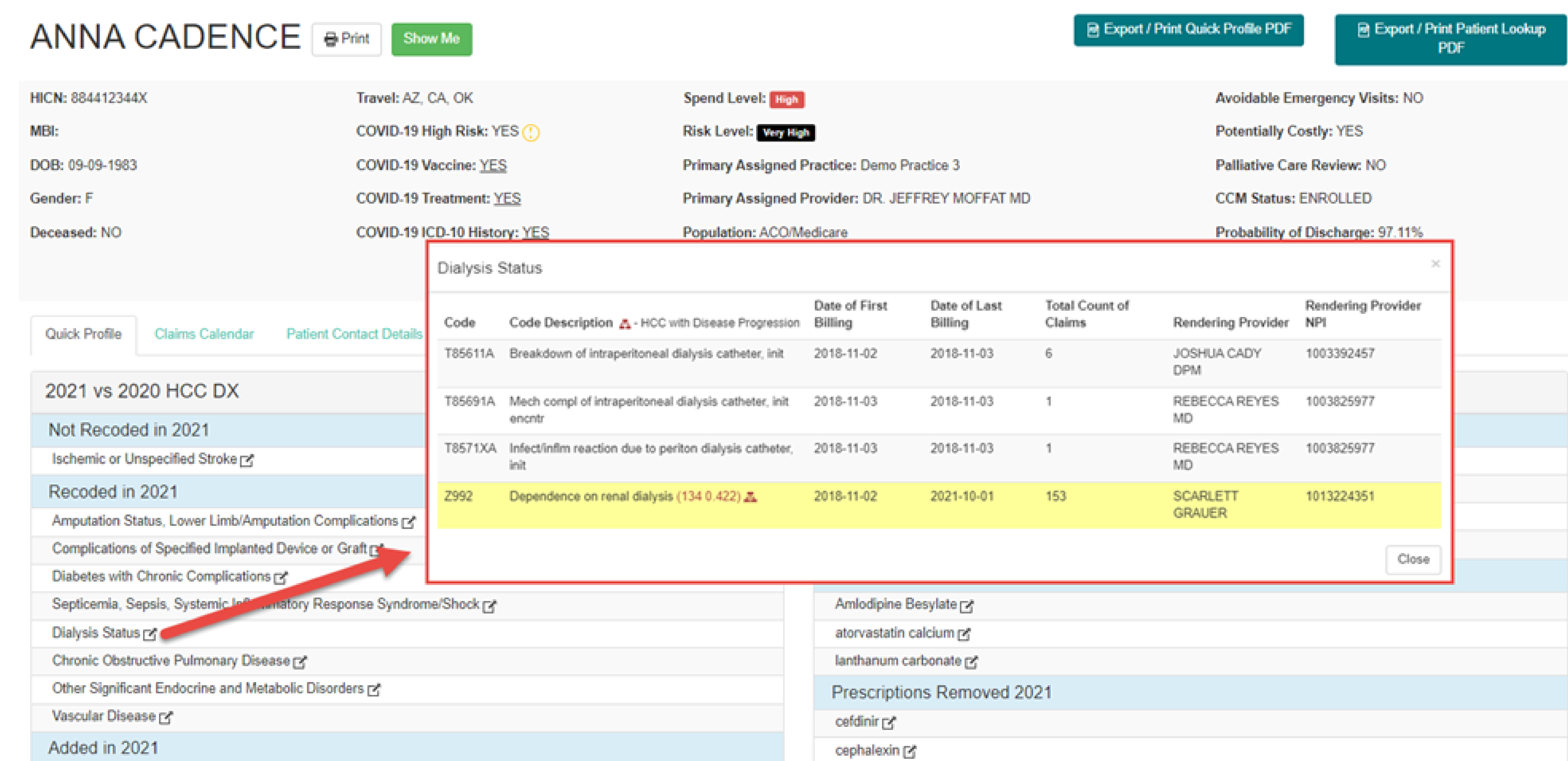
Code Description – The definition of the ICD-9/ICD-10 code the patient has been diagnosed with

Date of First Billing – The date of the first encounter in which the patient was diagnosed with the ICD code

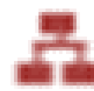
Date of Last Billing – The date of the most recent encounter in which the patient was diagnosed with the ICD code

Total Count of Claims – The total number of times the diagnosis has appeared in the patients claims.

Rendering Provider Name and NPI – The legal name and National Provider Identification number of the provider who most recently diagnosed the patient with the condition.



HCC Diagnoses Hierarchy



Use this icon to drill into the HCC disease progression of an HCC ICD10 diagnosis.

HCC Code – The HCC code within the hierarchy of disease progression for the selected diagnosis.

Description – The definition of the HCC code within the hierarchy of disease progression for the selected diagnosis.

Weight – The HCC coefficient assigned to the listed HCC score for an aged, non-dual beneficiary. This should not be used as an absolute increase for billing the related code but rather to get a sense of weight when comparing similar HCC categories. A higher score indicates a higher level of risk, and therefore a greater benchmark for predicted spend.

ICD Code – The ICD-10 codes that relate to the chosen HCC code.

ICD Description – The definition of the ICD-10 codes that relate to the chosen HCC code.

Dialysis Status

×

Code	Code Description - HCC with Disease Progression	Date of First Billing	Date of Last Billing	Total Count of Claims	Rendering Provider	Rendering Provider NPI
T85611A	Breakdown of intraperitoneal dialysis catheter, init	2018-11-02	2018-11-03	6	JOSHUA CADY DPM	1003392457
T85691A	Mech compl of intraperitoneal dialysis catheter, init encntr	2018-11-03	2018-11-03	1	REBECCA REYES MD	1003825977
T8571XA	Infect/inflm reaction due to periton dialysis catheter, init	2018-11-03	2018-11-03	1	REBECCA REYES MD	1003825977
Z992	Dependence on renal dialysis (134 0.422)	2018-11-02	2021-10-01	153	SCARLETT GRAUER	1013224351

Close

Full ICD10 Diagnosis List

Current Diagnosis List: This will list the ICD-10 along with the description of all diagnoses that have been billed in claims for the current year. If there is an HCC with disease progression symbol next to the diagnosis, you may click on it to open the HCC details.

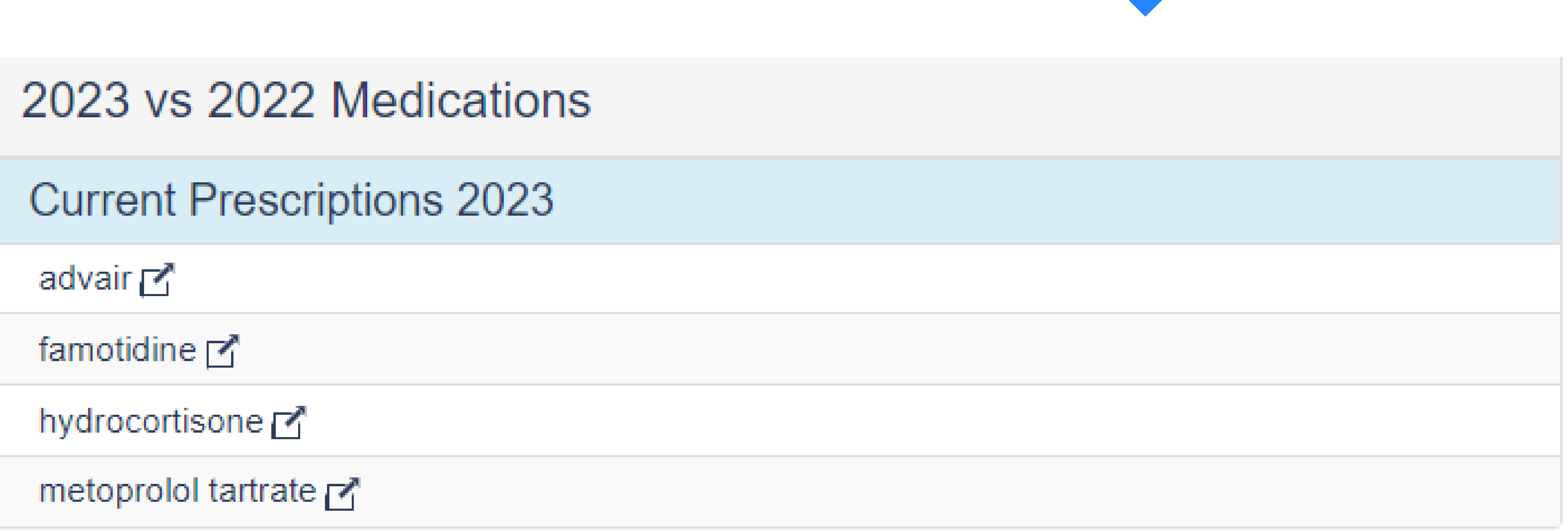
Current Diagnosis List (ICD-10) - HCC with Disease Progression
N179 Acute kidney failure, unspecified (135 0.435)
R4182 Altered mental status, unspecified
D649 Anemia, unspecified

Medications

Current Prescriptions: This is a list of the current prescriptions prescribed during the current year. You may drill into the prescription to see the prescription information, prescribing provider, and servicing pharmacy.

Prescriptions Removed: This is a list of prescriptions no longer being picked up in the current year. You may drill into the prescription to see the prescription information, prescribing provider, and servicing pharmacy.

Prescriptions Added: This is a list of new prescriptions in the current year. You may drill into the prescription to see the prescription information, prescribing provider, and servicing pharmacy.



Social Determinants of Health

Social Determinants of Health (Z-codes): This will list the Z-code along with the description of all the related social determinants of health Z-codes that have been billed in claims for the current year.

Cost & Utilization

Cost and Utilization - identifies high-cost utilization such as emergency department, admission, re-admission, or imaging. The end-user may drill into the encounter to determine the provider and place of service.

2022 YTD Spend – The sum of paid claims in 2021 (2022).

2022 HCC Benchmark – A financial spend benchmark based on the patient's HCC score and demographics.

2022 HCC Benchmark vs 2021 (2022) YTD Spend – Percentage of financial spend benchmark used year to date. What has been spent vs what is left.

Benchmark Prediction – A warning symbol to indicate if the Health Endeavors Algorithm predicts if the patient will exceed their benchmark before the end of the current year.

Out of Network Spend – The sum of paid claims for the current year billed by providers who are considered out of network per the configuration of your account.

Office Visits – A listing of dates in which the patient had an encounter that is considered an office visit.

Most Visited Provider – The NPI and name of the provider the patient has encounters with most frequently

Admits - Number of times in which the patient has been admitted during the current year.

Readmissions - Number of times in which the patient was discharged and within 30 days, readmitted to a hospital during the current year.

ED Visits – The number of times in which the patient has had an encounter considered to be an Emergency Department Visit during the current year.

ED Visits that led to Hospitalizations – The number of times in which the patient had an Emergency Department Visit and was admitted because of the ED Visit during the current year.

CT Scans – The number of CT Scans for the patient during the current year.

MRI Events – The number of MRI Events for the patient during the current year.

Cost and Utilization		
2021 YTD Spend		$95595.08
2021 HCC Benchmark		$53335.70
2021 HCC Benchmark vs 2021 YTD Spend	⊗	**179.00%**
Benchmark Prediction*		Yes
Out of Network Spend*		$94390.47
Office Visits*		0
Most Visited Provider*		0
Admits *	⊗	**1**
Readmissions*		0
ED Visits *	⊗	**2**
ED Visits that led to Hospitalizations *	⊗	**1**
CT Scans *	⊗	**2**
MRI Events*		0

Quality Care Gaps

<u>**Quality Care Gaps**</u> – If the provider is enrolled in a quality program, the list of measures will populate with an indication of action required, not applicable, or done. Action Required means the measure needs to be completed for the patient. If your organization has signed up for SMART on FHIR quality get calls program with Health Endeavors, we are able to pull data from the EHR into the quality measure repository.

Cost and Utilization		
2021 YTD Spend		$95595.08
2021 HCC Benchmark		$53335.70
2021 HCC Benchmark vs 2021 YTD Spend	⊗	**179.00%**
Benchmark Prediction*		Yes
Out of Network Spend*		$94390.47
Office Visits*		0
Most Visited Provider*		0
Admits *	⊗	**1**
Readmissions*		0
ED Visits *	⊗	**2**
ED Visits that led to Hospitalizations *	⊗	**1**
CT Scans *	⊗	**2**
MRI Events*		0

COVID-19

Travel: Indicates if the patient has claims in multiple states in the last 120 days and is populated with a list of states in which the patient has had claims.

COVID-19 High Risk: Yes or No flag to indicate if the patient meets our high-risk algorithm of underlying conditions, medication adherence issues and other high-risk factors for COVID-19.

COVID-19 Vaccine: Indicates if the patient has record of receiving the COVID-19 vaccine. If yes, drill into the details for the date, rendering provider, and type of COVID-19 vaccine administered.

COVID-19 Treatment and Diagnosis History: If yes, drill into the details of treatment and diagnosis.

COVID-19	
Travel	AZ,CA,OK
COVID-19 High Risk	⊗ **Yes**
COVID-19 Vaccine	YES
COVID-19 Treatment	YES
COVID-19 ICD-10 History	YES

Patient Lookup – Claims Calendar

Quick Profile | Claims Calendar | Patient Contact Details | CCT

Do you want this in your EHR? Complete our EHR Request Form ×

Eligibility

Dual Eligible: Non-Medicaid

Medicare Status Code: Aged without ESRD

HCC Trend

2023 Your Risk Score: .600

2022 Your Risk Score: 1.328

2021 Your Risk Score: 3.268

2020 Your Risk Score: 1.784

Claims History *(04/01/2022 - 03/31/2023)*

Part A Claims: **$45,895.22**

Part B Claims: **$4,838.46**

Part BDME Claims: **$0.00**

Part D Claims: **$0.00**

Part A In Network | Part A Out Of Network | Part B In Network | Part B Out Of Network

March

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

April

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

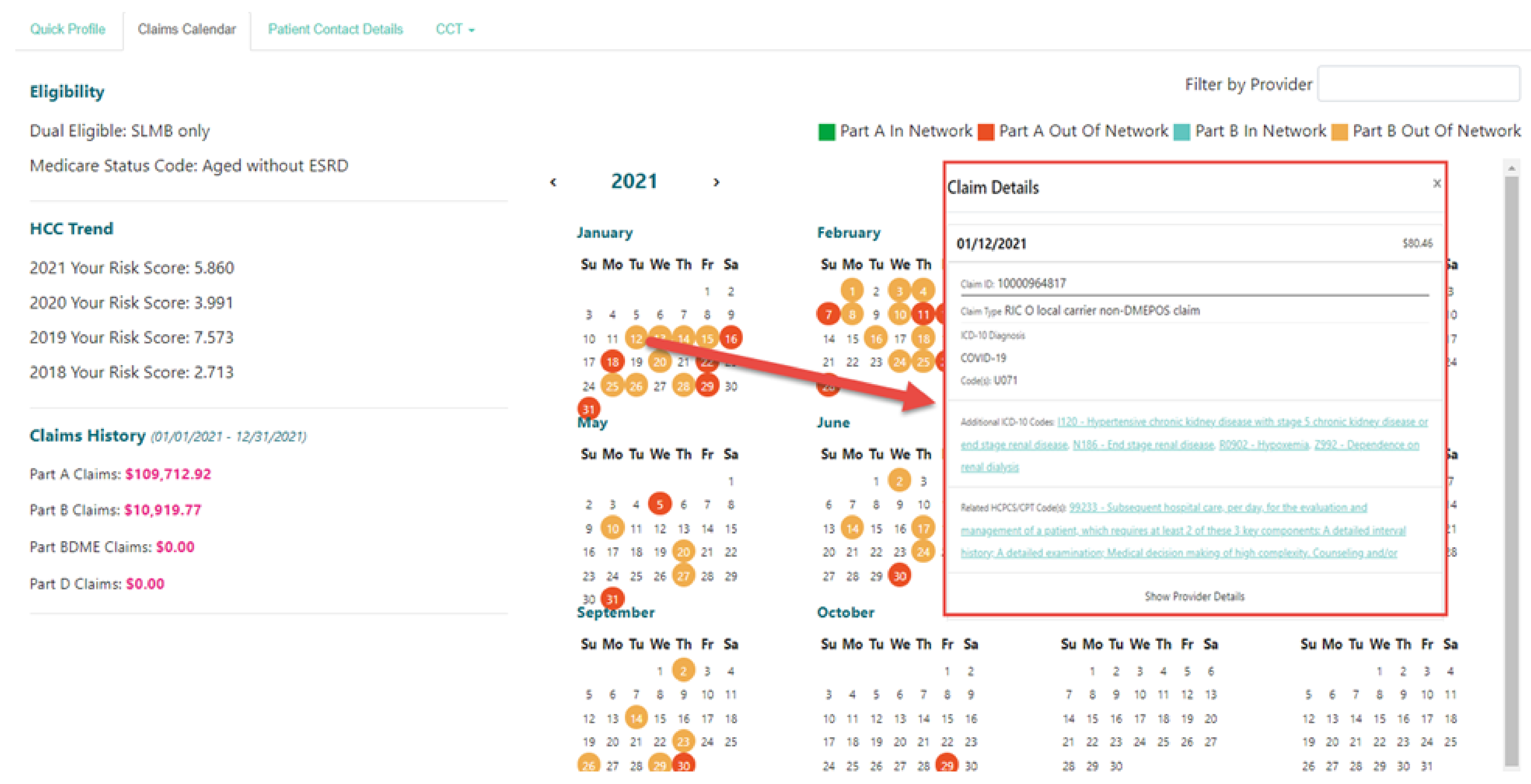
May

Su	Mo	Tu	We	Th	Fr	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

June

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Patient Lookup – Claims Calendar Drill Down



Patient Lookup – Claims Calendar Definitions

Out-of-Network is determined by your network setup.

Dual Eligible – Indicates if the patient is dually eligible for Medicare and Medicaid benefits.

Medicare Status Code – Indicates how the beneficiary became eligible for Medicare benefits.

HCC Trend – The patient's HCC score trended over a four-year period. HCC Scores are calculated from patient demographics and specific diagnoses to calculate a patient risk score. A larger score indicates the patient to be a higher level of risk than that of a patient with a lower risk score.

Claims History – A rolling 12-month period to provide an overview of the patient's financial spend.

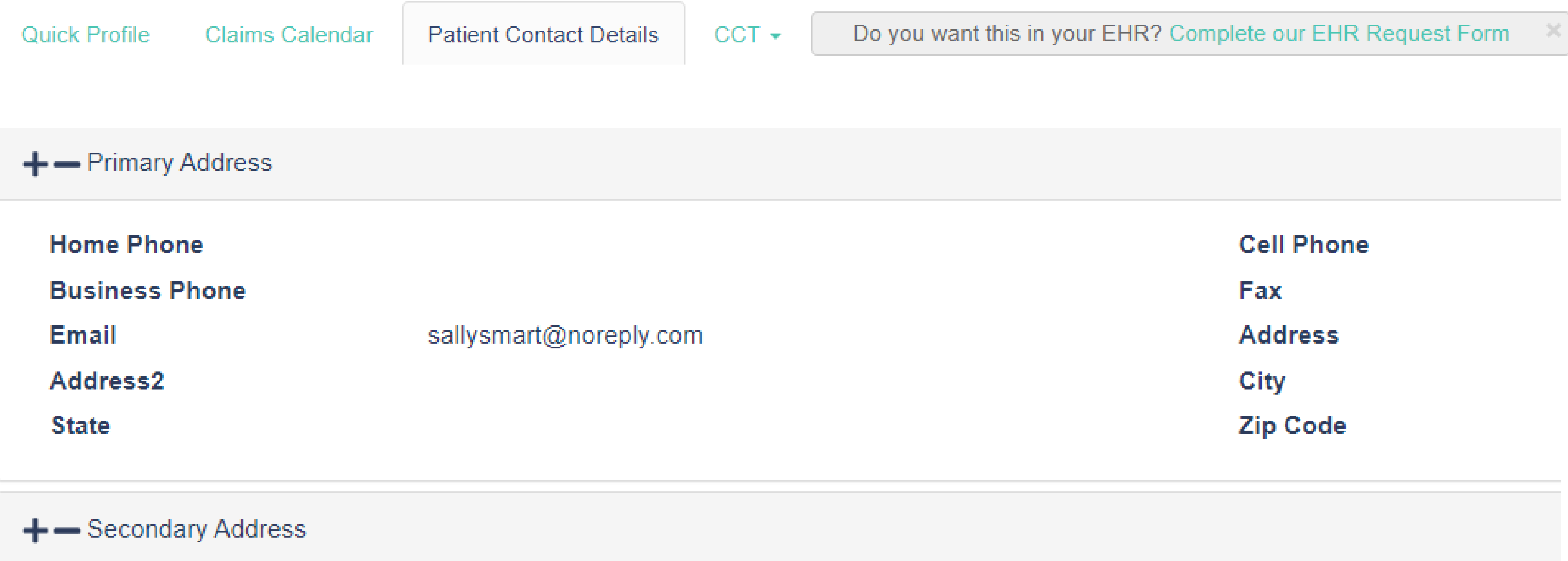
Part A Claims – The beneficiaries' sum of claims in the current calendar year that are billed by a facility or agency covered under Part A benefits.

Part B Claims - The beneficiaries' sum of claims in the current calendar year that are billed by providers for things such as outpatient care, preventative services, ambulance services, and laboratory services under Part B benefits.

Part B DME Claims - The beneficiaries' sum of claims in the current calendar year for durable medical equipment for things such as oxygen, canes, or infusion pumps that are billed under Part B DME benefits.

Part D Claims – The beneficiaries' sum of claims in the current calendar year that are billed and covered under Part D benefits. Blank if the patient is not enrolled in Part D

Patient Lookup – Patient Contact Details



Patient Lookup – Patient Contact Details

Quick Profile | Claims Calendar | Patient Contact Details | CCT | Do you want this in your EHR? Complete our EHR Request Form ×

Data Sharing – Details if the beneficiary has opted out of sharing their data and if claims data was ever received. This section will also detail the reason the beneficiary opted out such as the beneficiary was excluded by CMS or if the beneficiary is to decline.

Data Sharing

Beneficiary is NOT opted out of data sharing and has claims data available.

Beneficiary is NOT opted out of data sharing but has NO claims data available.

BD - Beneficiary Declined: Beneficiary declined to share medical claims information or Beneficiary has opted-out of medical data sharing.

PL - Participant List Change: Beneficiary has been excluded based on participant termination or deletion.

EC - Excluded by CMS: Beneficiary has been excluded by CMS from claims information being shared with an ACO.

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