clearstep

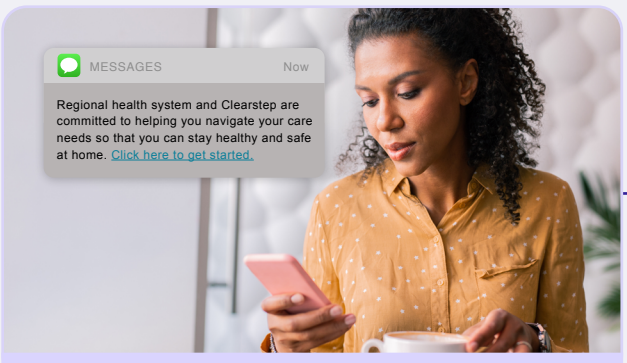
Clinical Journeys™ Overview

Patient is discharged from the hospital.

1

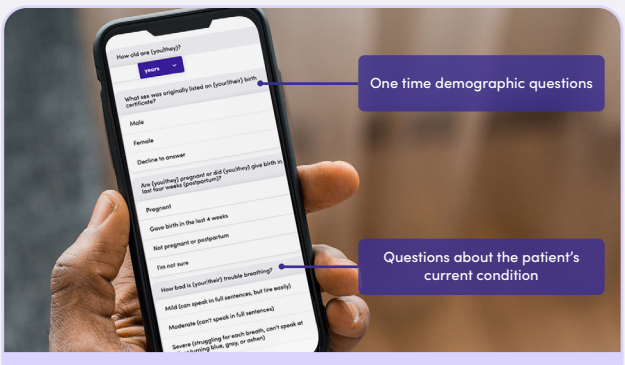
2

Either the Health System or Clearstep determines who is eligible for enrollment into the Clinical Journeys™ program.



Patient receives a text or message inviting them to learn more about Clinical Journeys,™ to complete the consent process, and opt-in to the program.

3



4

The first time a new or existing patient uses their unique Clinical Journeys™ link, the system will confirm their demographic information.

This second set of questions is asked each time the patient checks in to calculate their overall symptom severity score and track how it changes over time.

1. Overall status
2. Signs / symptoms
3. Medication supply and compliance
4. Objective information
5. Social determinants of health
6. Any other needed information not found in the EMR

The responses to these questions are used to determine the patient's immediate triage and when the next outreach should be. Triage and outreach frequency are both calculated based on the patient's baseline level of risk, the severity of their condition at the time of the reachout, and how their condition is changing in severity over time.

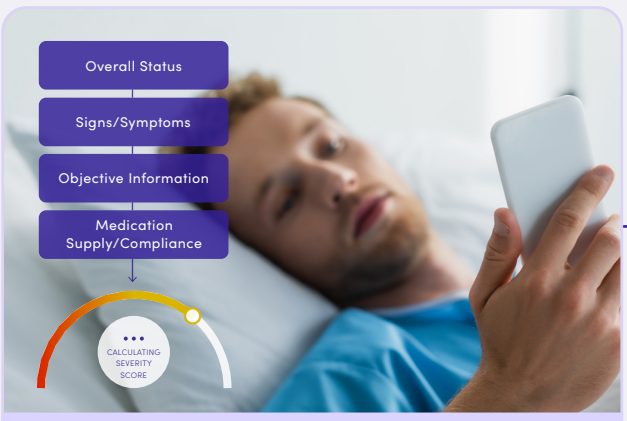
5

TRIAGE AND OUTREACH FREQUENCY

Risk Score + Symptom Severity Score + Change in Severity Over Time

6

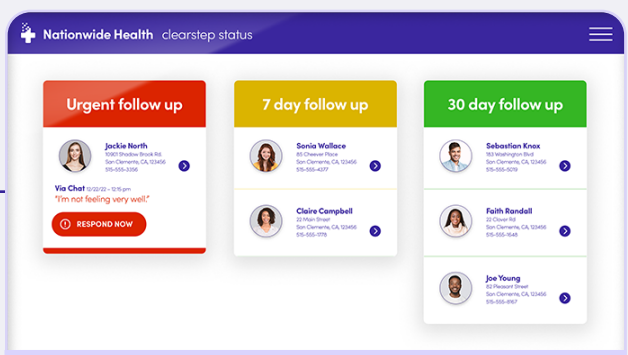
The baseline risk score is calculated based on the patient's demographic factors (including medical, social, behavioral history). Customized scoring systems can be applied.



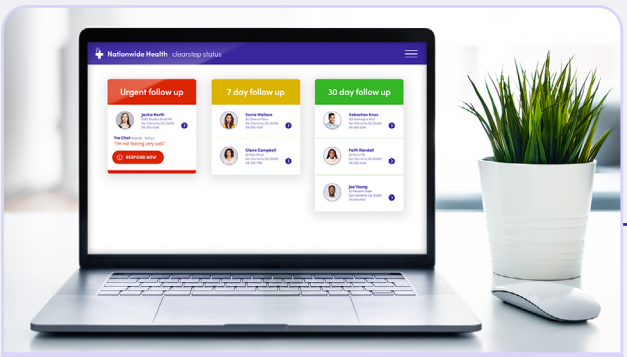
A severity score is calculated using the responses of overall status, signs/symptoms, objective information, and medication supply/compliance.

7

8



Patients are stratified into categories based on a combination of their risk score, severity score, and change in severity over time (i.e. velocity). Patients receive more frequent automated text check-ins if their condition persists and, when clinically recommended, are escalated and queued for proactive reach out from the population health management (PHM) team.



All calculated data is associated with the patient's unique ID and made available to the PHM team.

9

The PHM team can then assess the patient's status and, if needed, dispatch EMS or provide at-home care guidance.

Patients receive less frequent check-ins as their condition resolves, eventually being discharged automatically from Clinical Journeys™ remote monitoring.

After Step 9, the patient will receive another outreach at the determined frequency described in Step 8. Steps 5 through 9 will then continue to repeat.