Mirth Care Enterprise.
Population Health Management.

Manage patient populations; help drive coordinated care

Mirth® Care Enterprise is a cloud-based chronic disease and care management platform that supports patient engagement and drives population health outcomes using data integration created with Mirth® Connect, Mirth® Mail, and Mirth® Results. It supports program administrators, nurse care managers, and other care team members to help them manage patients with prevalent chronic conditions at both population and individual levels.

The system enables greater efficiencies by standardizing population health management processes where timely and effective care increases quality of life, improves outcomes, and reduces healthcare costs.

What makes Mirth Care Enterprise different?

- Supports advanced care teams and medical homes
- Customizable rules, decision support tools, questionnaires, and clinical content for chronic diseases support varying organizational needs
- Robust filtering capabilities for the patient population (positive and negative)
- Performs batch activities on selected sets of patients and other data objects
- Creates tasks, alerts, and reminders at clinically appropriate times using system rules
- Tracks performance measures longitudinally and uses them to help manage care team performance
- Identifies, groups, and manages sub-populations

Mirth Care Enterprise makes it easier to manage complex patients and your entire patient population by delivering true community care integration.
Mirth Care Enterprise in practice

Facilitate patient-centric disease management and care coordination processes:

- Enroll patients in defined clinical programs
- Collect data related to clinical focus areas
- Create a personalized care plan to address patient issues and set treatment and self-management goals
- Document and report on various activities in support of patient populations, such as care planning, contacts, tasks, fulfillment, resource assignment, etc.
- Leverage decision support tools/system logic that use patient attributes and client-defined minimum data sets to inform the user about:
  - Which clinical values should be collected and monitored
  - How and where to focus care management efforts
  - Optimum and “alert” ranges for clinical values
  - Recommended medication classes appropriate for each patient
- Use the care manager interface to enable all of the care team members to facilitate the coordination of care and shared team activities

Workflow:

- Enables care managers to help build deep clinical relationships with patients during the critical time between office visits
- Uses industry standards to receive secure communication and data exchange between users and any other members of the care management team

Integration:

- Bidirectional exchange of patient demographic, group, and clinical data with the Mirth Results clinical data repository
- Synchronization with Mirth Mail, which allows secure communication between users and any other members of the care management team using the Direct protocol messaging architecture and standards
- Retain patient context when switching between Mirth® applications
- EHR and Mirth Results users have direct access to care management data at the point of care (most recent care plan, medication reconciliation, and patient summary) and visual indicators for patients who are actively care managed
- Ability to pull in high-value cohorts of patients in need of care management from community and local data

Mirth Care Enterprise supports chronic care management
Mirth Care Enterprise clinical modules

- Mirth Care Enterprise supports the management of cardiovascular disease (including congestive heart failure, hypertension, and hyperlipidemia); asthma (adult and pediatric); diabetes; and chronic obstructive pulmonary disease
- System flexibility enables users to define and implement additional clinical and/or preventive care modules
- Set individualized clinical goals based on patient enrollment in clinical modules
- Define a minimum data set for each clinical module

Online content integrated with Mirth Care Enterprise

- A variety of health behavior and condition-specific questionnaires enable care managers to conduct consistent patient assessments and patient-reported outcomes, leading to better informed care planning
- Access patient guides that provide condition-specific and behavior-change strategies for educating and empowering patients
- Gain key recommendations that operationalize evidence-based guidelines for clinical management and program evaluation
- Use care manager guides that provide clinical education and process guidance to care managers for assessing patients, building care plans, and identifying interventions
- Leverage care manager priorities that correlate the patient care objectives with the corresponding patient education materials to facilitate the education process between care managers and patients
- Benefit from consumer-tested, low-literacy patient education materials for chronic conditions, prevention, and lifestyle modification
Mirth Care Enterprise, under its previous name of InformaCare, has been used to manage population health by numerous healthcare/plan systems across the US, including:

- Molina
- Florida Medicaid
- The UK National Health System
- Providence Health Plans
- Blue Cross plans in Idaho, Kansas, South Carolina

Proven results

- Improved self-care abilities
- Reduction in acute symptoms
- Demonstrated patient and physician satisfaction
- Adherence improvements
- Care management reporting for process improvement and scale