PRIMARY PARTNERS, LLC

Our Journey with the State HIE

About Us

- As a 2012 starter, Primary Partners was one of the 1st Medicare ACO's in the country
- Our 2nd Medicare ACO was formed in 2013
- In late 2014 we signed a partnership with Cigna
- In 2017 we signed agreements with Florida Blue, Orlando Health and Florida Hospital
- Today our group has 42 Physician Offices in Central Florida and we cover approximately 45,000 patients

Status Pre-HIE

- Offices reacted to events in lieu of preventing events
- Offices would send patients to the ER (no open slots)
- Prior to connecting to State HIE a large % of our offices only knew a patient went to the hospital if they called the office and told them.
- Patient outcomes were sometimes compromised
- Patients were paying unnecessary out of pocket expenses
- Hospital systems did offer physician portals but logging into each hospital system to look for patients that were admitted was a lengthy process (average of 4 hospital systems were checked daily)

Use Cases

	Avoidable Hospital Readmission	Patient Discharged from Hospital to SNF
Patient Status	75 year old male ACO patient with poor home support admitted to and discharged from Hospital for COPD. Referred to pulmonologist within 1 week.	85 year old female ACO patient with congestive heart failure and cognitive deficits discharged from Medical Center to Skilled Nursing Facility ("SNF")
Outcome before Notifications	Patient does not have transport, misses appointment, has difficulty breathing 1 month later **Ambulance to ER, emergency surgery, hospital penalized for readmission**	ACO case management does not learn of hospital discharge or admission to SNF **Patient stays at SNF for 30 days, contracts infection, readmitted to hospital**
Intervention opportunity created by notification	ACO care coordinator receives notification upon patient discharge and notifies primary care practice of admission **Practice manager calls transport service to drive patient to PCP office**	ACO care coordinator receives notification upon patient discharge and SNF admission and notifies field nurse **Field nurse visits patient during regular rounds at SNF to monitor status**
Outcome with notifications	Nebulizer treatment, inhaler RX and education on proper use of inhaler, hospitalization avoided **Better outcome and higher patient satisfaction**	Discharged from SNF in 7 days versus 30 days and supported with home health **Improved care transition, better outcome, and higher patient satisfaction**

How we Started

- 1st ACO to connect to the HIE
- Started May 2015 with only 4,000 Medicare patients
- Targeted regional areas where direct ADT feeds were not available
- Within the 1st 6 months we had received 400 event notifications
- January 2016 added Cigna patients
- Performed testing in mid 2016 to help improve the match rate of the MPI (master patient index)
- In March 2017 we added all patients and practices

Early Challenges

- Creating the Patient Roster
- Minimal alerts for patients without an address
- Limited required data; optional information was not being sent
- Discharge status is not standard
- Not all admission messages were sent (Quick Registration was one of them)
- Difficulty in analyzing alerts against claims due to Event Date vs. Date of Service
- 4 Hospital systems were blocking commercial alerts & reprogramming was necessary to receive Cigna alerts

Patient & Office Issues

- Office staff didn't fully comprehend the movement to proactive initiatives
- Practices were reluctant to leave open schedule gaps to fit in urgent visits
- Patients didn't want to call after-hours to bother the physician
- Patients would often ask "How did you know I went?"
- Patient education was the biggest hurdle to overcome

How we use the ENS System

- Daily flat files come in twice a day
- Data is ingested into Access Database with other direct ADT feeds
- Practice reports are delivered every morning with a 5 day lookback of admits
- Each office calls ER and Inpatients for follow-up PCP visit & does Medication Reconciliation within 2 days
- ACO Leadership reviews activity weekly for outliers
- Analytics department uses HIE and ADT Feeds to evaluate PCP Utilization, patients that are candidates for Care Management and more

OUTCOMES

How we measure our success

Statistics that will be used in the following slides

- 2013 National Institute of Health study put the median cost of an ER visit at $1,233
- Mean hospital costs in 2012 were highest for hospital stays billed to Medicare: $12,200 courtesy of H-CUP US
- Agency for Quality Health and Research, they estimate that the average cost of a readmission for a patient who is receiving Medicare is **$13,800** or $14,200 for Private Insurance
- **In 2015, only 59% of U.S. hospitals routinely electronically notified patient's PCPs upon emergency room entry**
  - Only one in three notify PCPs outside of the health system

Patient Outcomes

- Most common success stories center around Medication Reconciliation after hospital discharges. Many patients are confused about new medications vs. the daily medications they took prior to stay. With timely intervention from the PCP adverse reactions have been avoided.
  - 94 year old female who is cared for by multiple family members is admitted to local ER. The ER alert was sent to PCP who picked up the phone and spoke to the ER Doctor. PCP sent recent imaging and labs and the patient was able to be discharged home versus a full work up in the ER and possible observation stay.
- PCP called their patient to follow-up on a out-of-range lab result and could not reach them. The HIE delivered an alert that the patient had been in a car accident in South Florida. PCP was able to fax labs and chart notes to the hospital.

Utilization per 1000 Changes & Savings

Measure	Q1-2015 per 1000	Q2-2016 per 1000	% Change	Savings
Hospital Admits	260	233	11%	$3,864,960
ER Admits	554	495	11%	$ 901,668
Re-Admits	150	132	12%	$2,742,366
Total Savings				**$7,508,964**
HIE Costs 12 Months				$10,000

TARGETED RETURNS

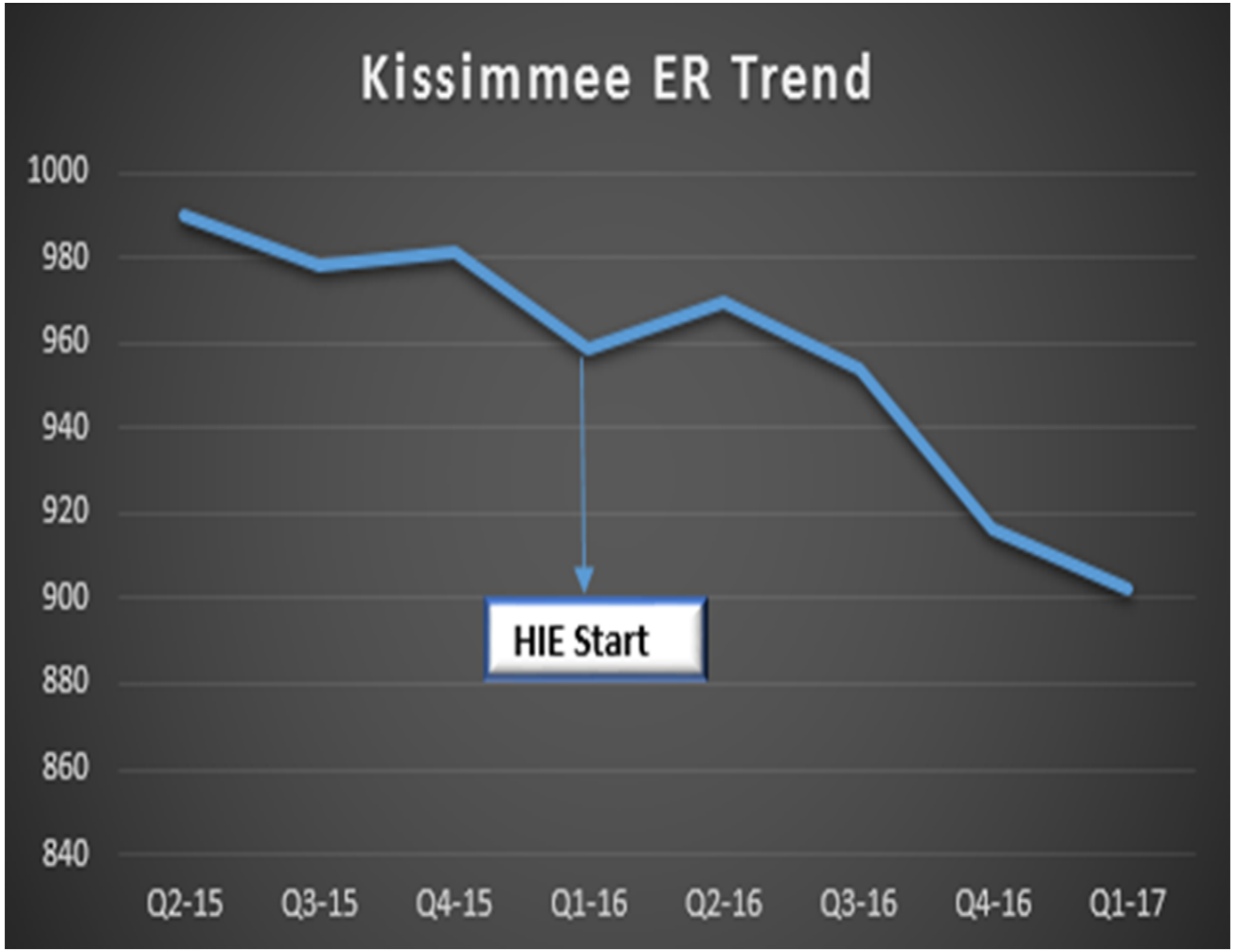
Geographic Area of Kissimmee

Cigna Patients

ER Trends

- Graph shows Quarterly count of ER Visits for Five Physician practices.
- Q1 2016 we added our Cigna patients to the State HIE.

By the following year we had seen an 8.1% Reduction in total ER Visits

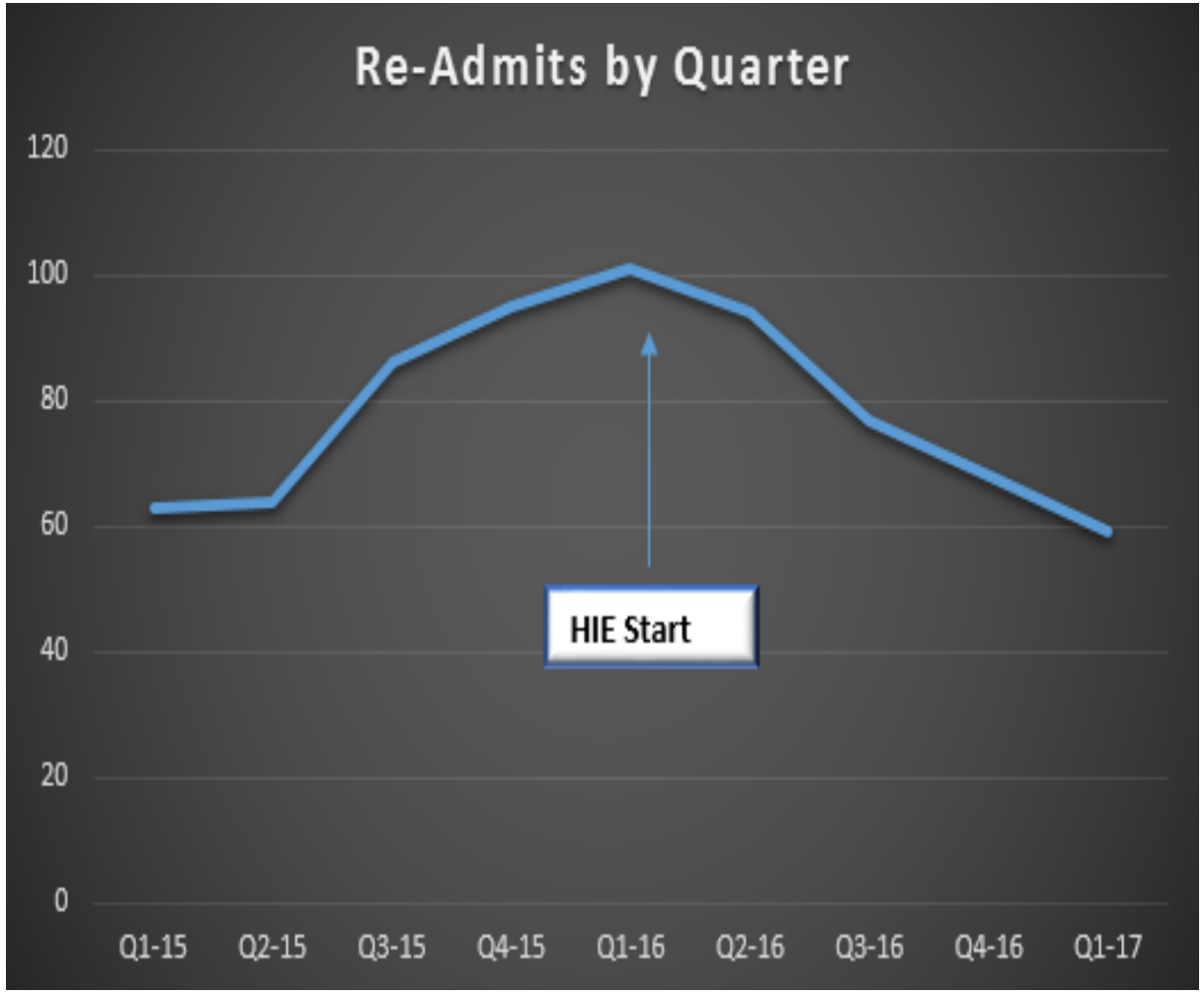


Re-Admissions

The graph shows that after starting the State HIE our re-admissions had a dramatic decrease.

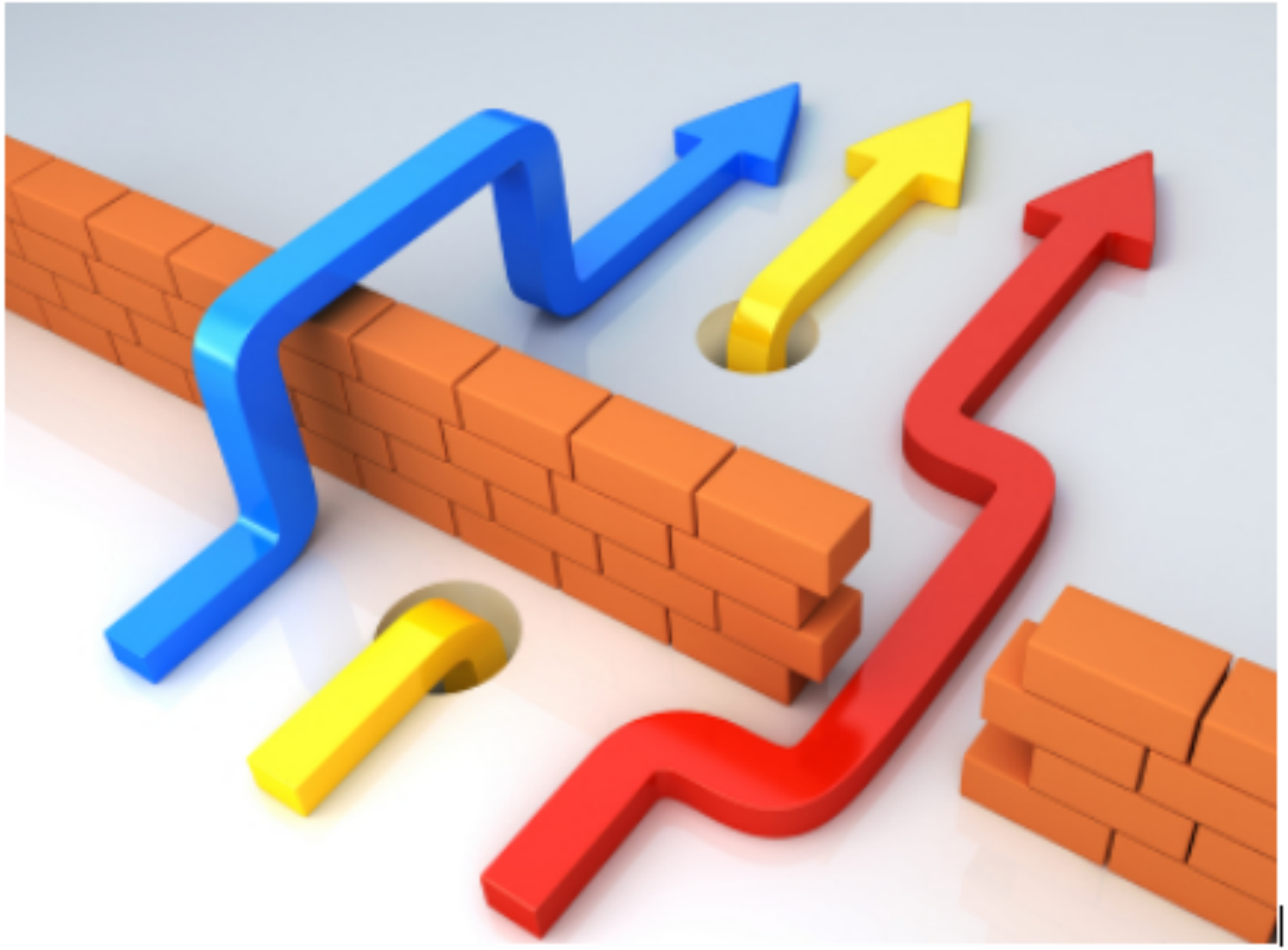
Let's assume 50% of our reduction is tied to knowing the patient was admitted and being able to do the TCM visit

Average Re-Admit Cost $14,200
Total Annual Savings on 20 visits is $284,000



Actual re-admission admit counts per quarter

Success is more than a one-way street



Use Multiple Sources

- Earlier we mentioned that we targeted regional areas where we didn't have a direct ADT Feed.
- In the city of Clermont there is 1 hospital system & we have a direct ADT Feed
- In a prior review when we only had Medicare patients it was determined that almost 90% of the time they used that hospital (close to home)
- In early 2017 one of our Clermont offices was reviewing Cigna ER usage reports via claim line feeds. There was a patient with 10 ER visits in which she had no knowledge of. Patient was using a hospital in Orlando & not notifying her PCP
- After analyzing Commercial claim lines we determined we were **missing 35%** of ER notifications by not getting the State HIE alerts

No data feed is perfect

- I encourage anyone looking to get admission notifications to combine all available notification systems as they are all different.
- Direct ADT feed- built on Physician NPI #. If the patient doesn't name you as the PCP or Registration Clerk doesn't update: **You Don't Get the Alert!**
- State HIE- operates on caution; patients must match several indicators before you get the alert
- Commercial Payers- some only send information if it's out for authorization
- You may end up with duplications but it's better than not enough information
- One feed may offer more details of the patient's visit than another feed

HIE Improvements

In late 2017 the required data fields have been updated

Data now includes key data such as:

- Additional event types are now being sent
- Admit Date
- Discharge Date
- Reason for Visit
- Patient address
- Date of Death, *if applicable*

Post HIE

- Patients understand they can call for non-emergent issues
- Patients are educated to loop back in their PCP after ER or IP
- Costs are down for the patient and the ACO
- Our offices are acting in a Proactive mindset
- Patient safety has increased
- Office staff have more time since real-time delivery is pushed to them

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