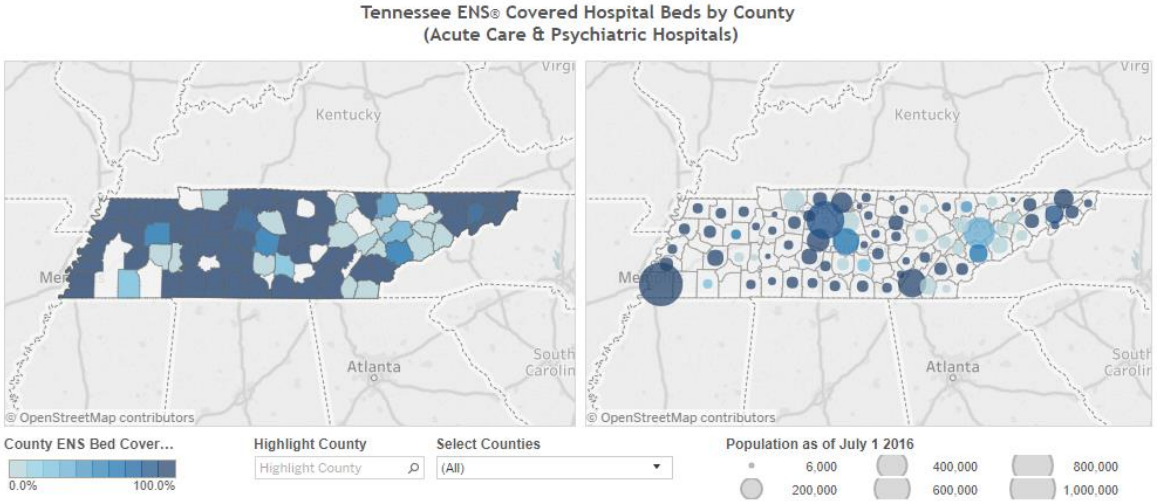
Background

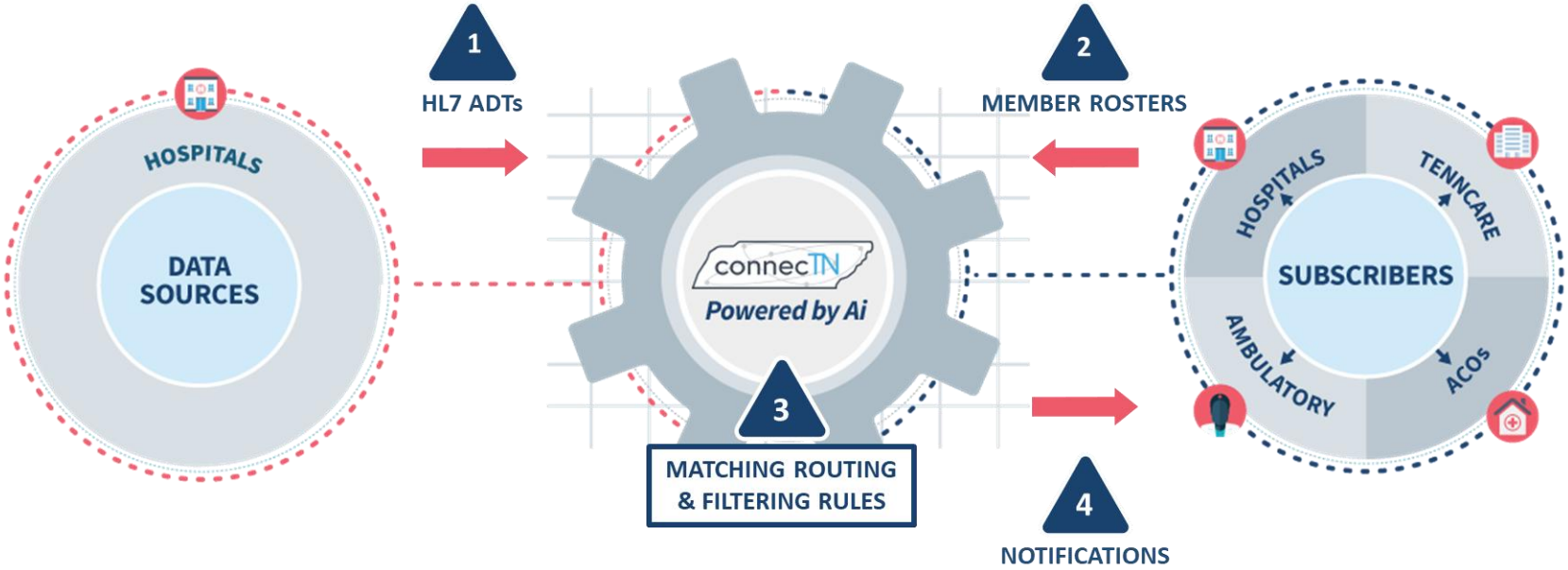
- ConnecTN collects and aggregates real-time, all-payer inpatient and emergency department ADT data from participating hospitals
- Supports TennCare's Patient Centered Medical Home (PCMH) and Tennessee Health Link (THL) programs
- THA Board has approved hospitals, physician practices, and ACOs to subscribe to real-time notifications for their attributed patients for the purpose of care coordination

State Connectivity

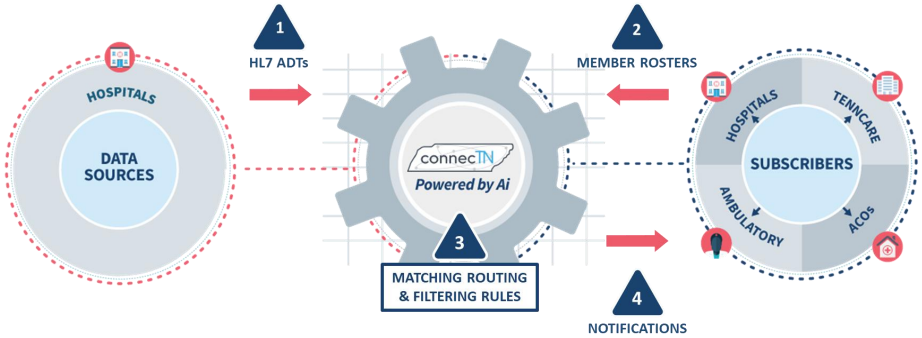


	All Acute Care & Psych Hospitals	All Hospitals, including Rehab
Connected Hospitals	**76%** (121/150)	**72%** (121/168)
Connected Licensed Beds	**74%** (19,129/25,795)	**72%** (19,129/26,688)

ConnecTN – How It Works



Flexible Notification Delivery



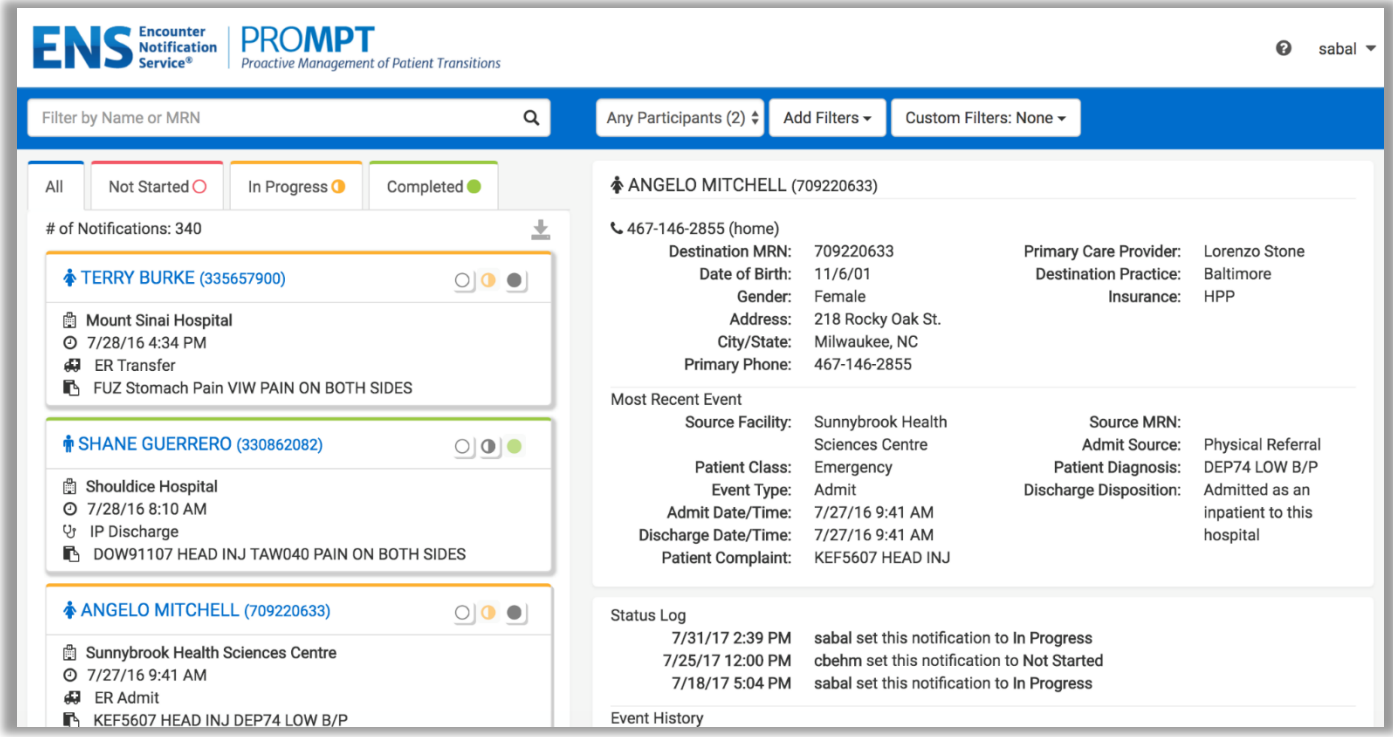
- Web Portal (PROMPT)
- Non-PHI Email
- CSV files
- Workflow Integration – Direct Secure Message
- Workflow Integration – HL7 ADT
- Workflow Integration – HTML/PDF Report

TENNESSEE HOSPITAL ASSOCIATION

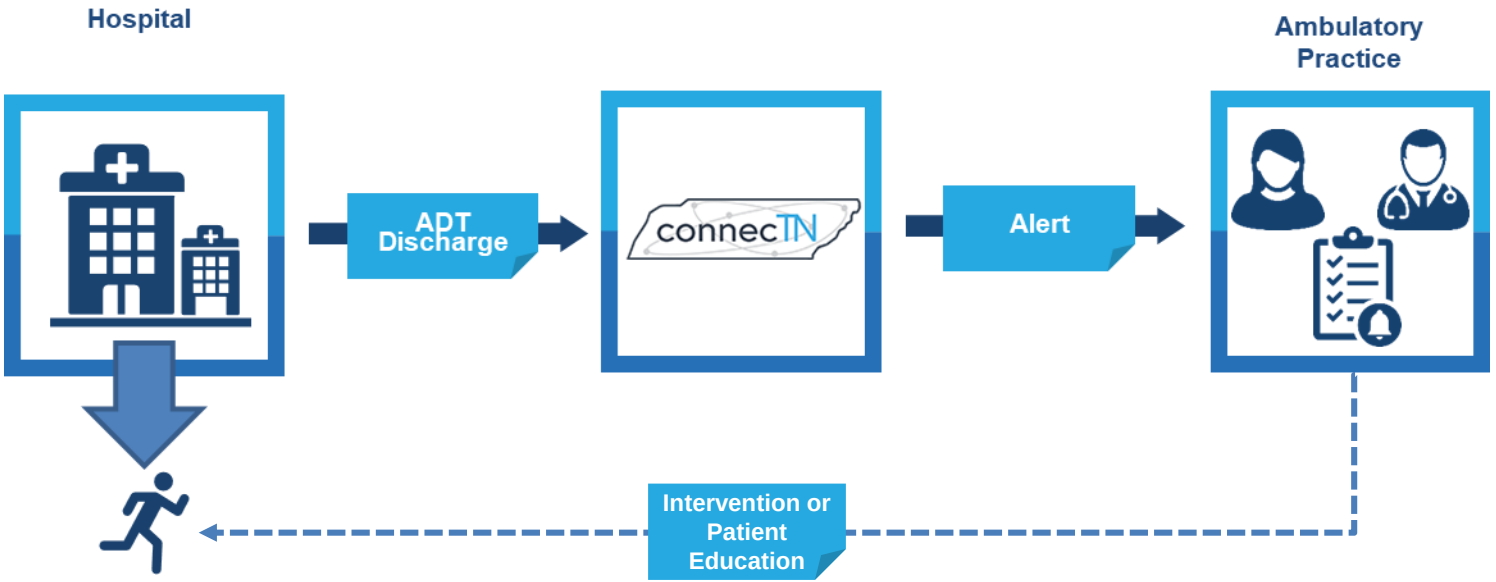
PROMPT Web Portal

Enables users to:

- Easily track work queues
- Mark progress of notifications
- Coordinate patient follow-up activities



Transitional Care Management Use Case



Use Case

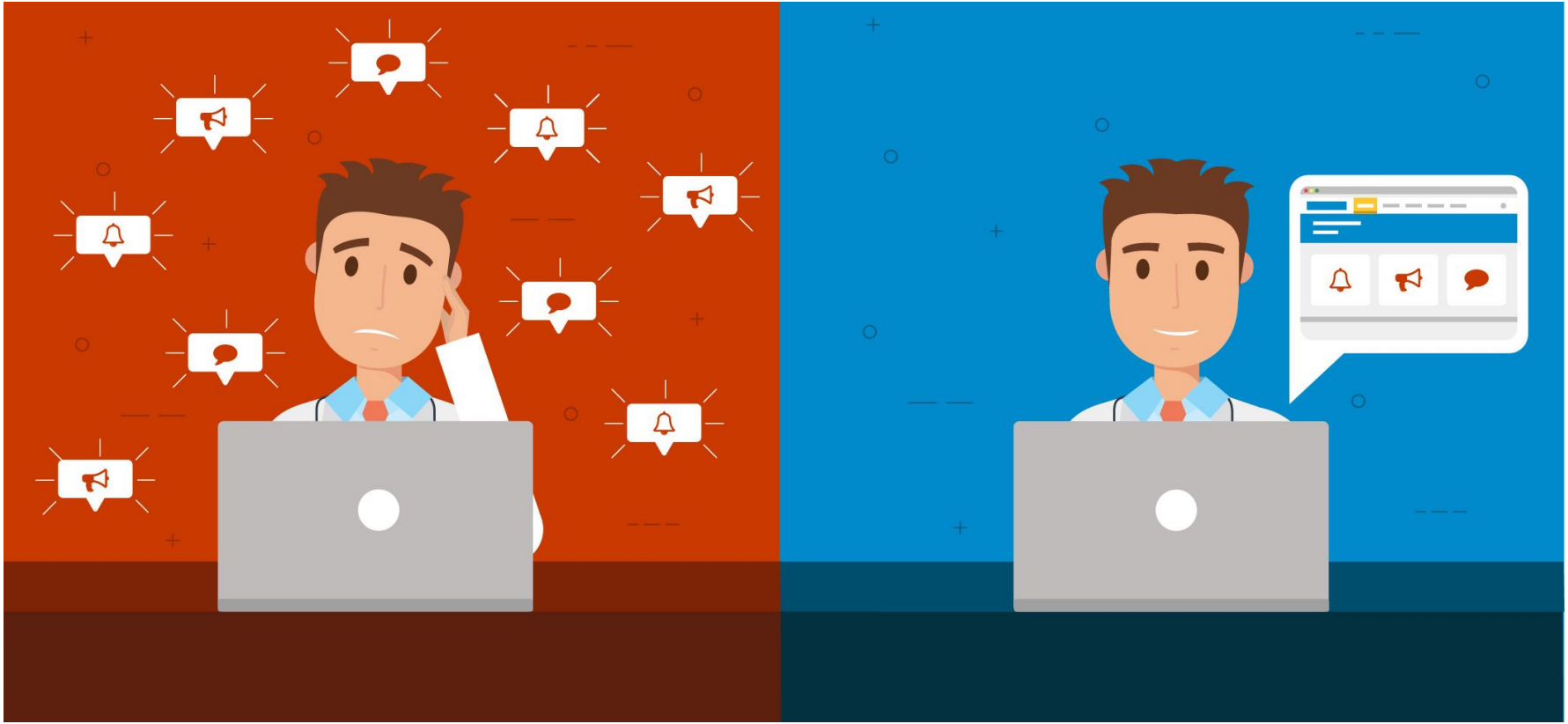
- Alert upon discharge
- PCP follows-up within 2 days and sees the patient within 7 or 14 days
- PCP bills for TCM

Appendix: SmartAlerts

What are SmartAlerts?

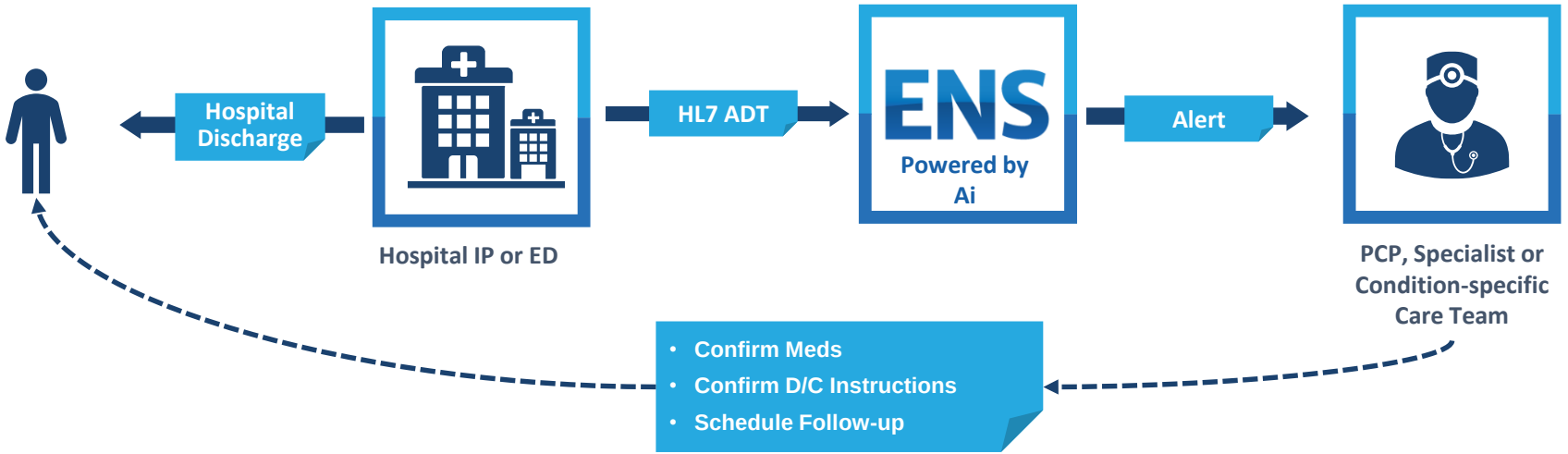
- Targeted real-time alerts to enable rapid and sophisticated care coordination
- Reduce prevalence of “alert fatigue” by delivering customizable, richer, and more actionable data at the point of care
- Advanced logic-based rules determine when alerts are triggered and what information they contain
- SmartAlerts can evaluate many attributes or rules simultaneously

Improve Usability / Reduce Alert Fatigue



TECHNICAL DIAGRAM

Use Case: Condition-Specific Alerts

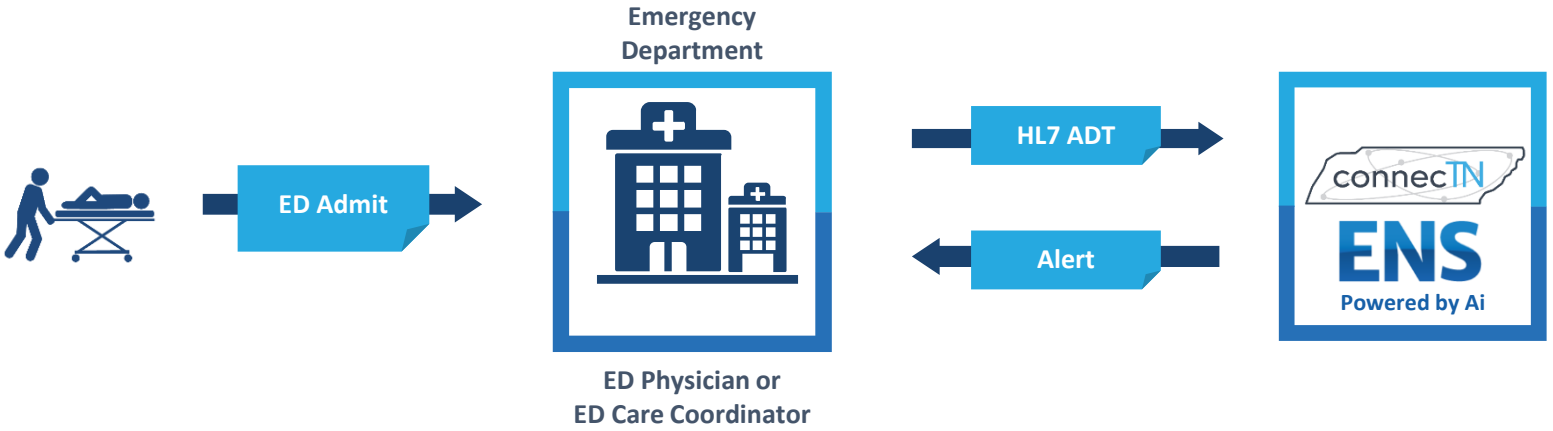


Use Case

1. A patient is discharged from the hospital with a diagnosis of particular interest
2. An alert is sent to the specialist ONLY for certain conditions (e.g., CHF)
3. Specialist's (e.g., Cardiologist) staff receive alert to schedule follow-up care

TECHNICAL DIAGRAM

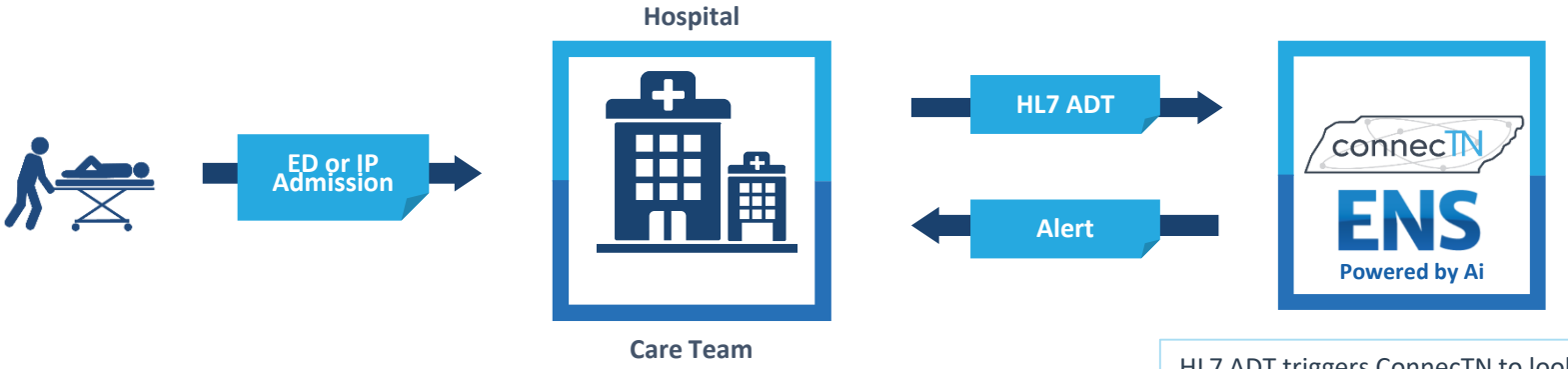
Use Case: ED Re-Utilizer



Use Case

1. A patient arrives at the ED and a registration event triggers ENS
2. ENS responds with visit history, care team, and other information if that patient has had X number of ED encounters in X number of months
3. ENS content integrated into hospital ED track board for easy viewing

TECHNICAL DIAGRAM
Use Case: Opioid Overdose



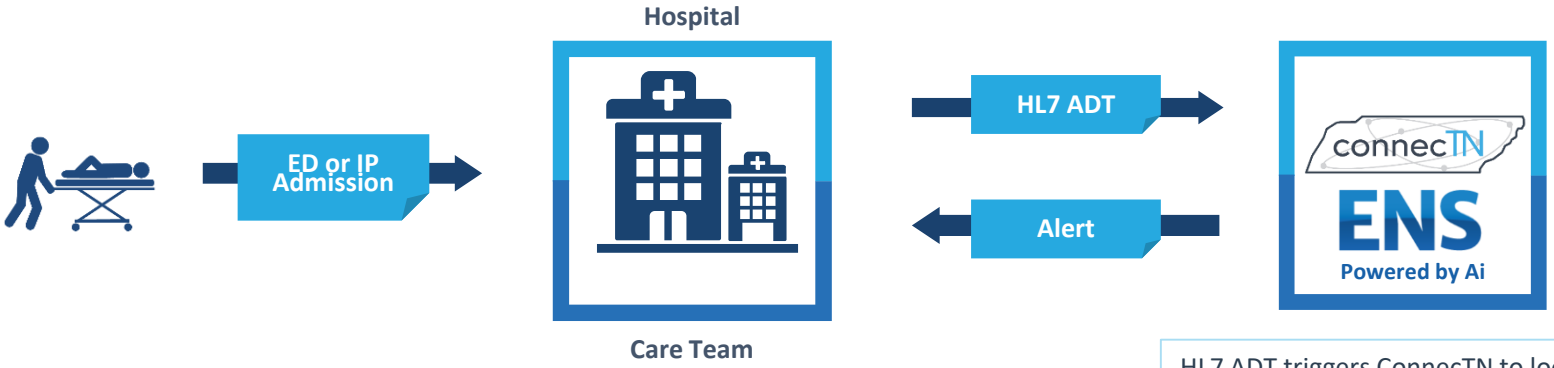
HL7 ADT triggers ConnecTN to look for historical opioid use disorder and/or opioid overdose diagnosis codes and trigger an alert when that criteria is met

Use Case

1. A patient arrives in the hospital to be treated
2. ENS responds with visit history, care team, and other information if the patient has a prior history of opioid use disorder or overdose related events

TECHNICAL DIAGRAM

Use Case: MRSA



HL7 ADT triggers ConnecTN to look for historical MRSA diagnosis codes and trigger an alert when that criteria is met

Use Case

1. A patient arrives in the hospital to be treated
2. ENS responds with visit history, care team, and other information if the patient has a prior history of MRSA related events

Appendix

Transitional Care Management (TCM)

Supporting Case Studies

Organization	Case Studies	Value Props
	• Implementation of ENS Platform Demonstrates Reduction in Readmissions • Johns Hopkins Community Physicians (JHCP) Leverages Encounter Data to Power Effective Callback Program	☑ Readmissions Reduction ☑ Care Coordination ☑ Treatment
	• Primary Partners saw a 40% per quarter drop in readmissions by improving care transitions from hospitals	☑ Readmissions Reduction ☑ TCM ☑ Treatment
	• Palm Beach Accountable Care Organization (PBACO) leverages TCM to add revenue & save costs	☑ Readmissions Reduction ☑ TCM ☑ Treatment
	• Aledade Delaware ACO reduces readmissions by 9% by strengthening their TCM process	☑ Readmissions Reduction ☑ TCM ☑ Treatment

Case Study Takeaways

- ACOs and Plans know that the best way to control costs is by putting the PCP at the forefront of care (“PCPs are the quarterback”)
  - Have robust patient history
  - Cross-specialist view of medications and care plans
  - Able to act on results post-discharge and provide follow-up office visits or care management
  - Medicare Transitional Care Management (TCM) compensates PCPs for managing patients closely during transitional care periods
- Conclusions: PCP Transitions of Care interventions lead to:
  - Reduced 7-day, 30-day, and 90-day hospital readmissions
  - Reduced inappropriate ED use
  - Increased revenue by TCM capture

Transitional Care Management ROI

Palm Beach ACO
(Florida HIE Services participant)

10% increase in TCM revenue captured, generating $30 million in savings

As an ACO, ENS is our single most valuable service and allows us to provide point of care interventions that we would not have otherwise known existed. After having ENS, we can't imagine operating an ACO without it."

- David Klebonis, CEO

Aledade Delaware ACO
(DHIN participant)

Increased their billable TCM opportunities by 26%, resulting in ~41% of TCM captured

Our TCM numbers have improved drastically because this tool puts all the right information in front of the right people, so they can get patients the proper care they need in a timely fashion."

- Tyler Blanchard, Executive Director

Primary Partners ACO
(Florida HIE Services participant)

Saw a 40% per quarter drop in readmissions by improving care transitions from hospitals

In our first year of subscribing to ENS through Florida HIE Services, we recognized a dramatic reduction in re-admissions—40% per quarter. This has saved our network close to $284,000 in readmission costs."

- Dina Lewis, Analytics Program Manager