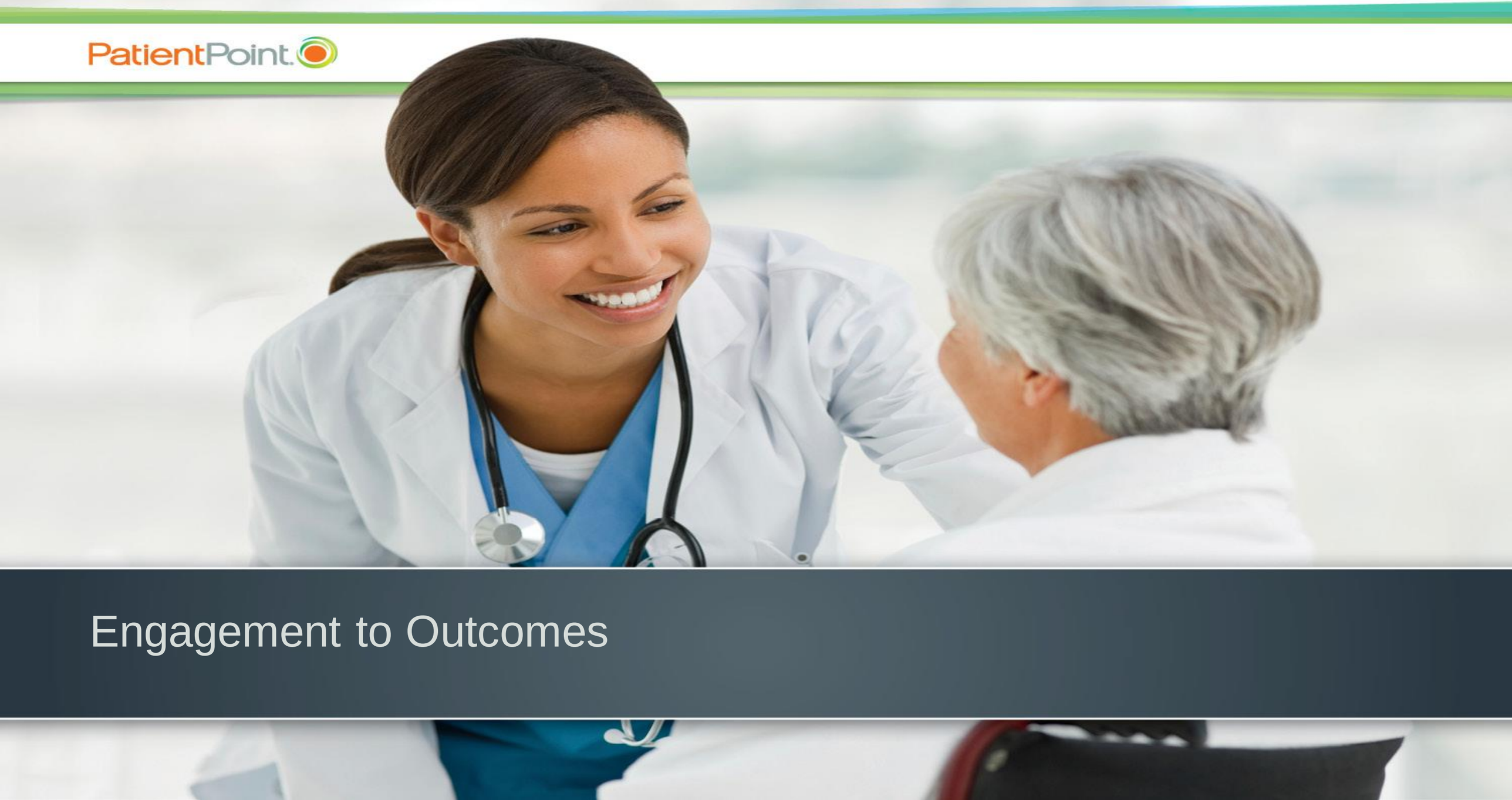


Engagement to Outcomes

The PatientPoint® mission is to turn engagement into outcomes.

PatientPoint® provides integrated patient engagement solutions surrounding key points of care to help healthcare professionals improve health outcomes, efficiency and patient satisfaction.

Comprehensive Patient Engagement Platform

Network Solutions	Coordinated Care Solutions	Hospital Solutions	NEW Outcomes Research
• Formerly Healthy Advice Networks (15+ years) • Key offerings include Waiting Room and Exam Room Networks, and PracticeWire	• Recent acquisition (February, 2012) • Key offerings include HealthSync integrated patient adherence platform featuring care coordination and electronic check-in/check-out, and revenue cycle management	• Formerly Healthy Advice Communications • Key offerings include Patient Guide, CareSearch, and Hospital Digital Network	• Screenings, recruitment, enrollment, and education of eligible patients • Informed consent Process • Study visit reminders and adherence pre and post-care

The PatientPoint Network is in physician practices and hospitals throughout the U.S.

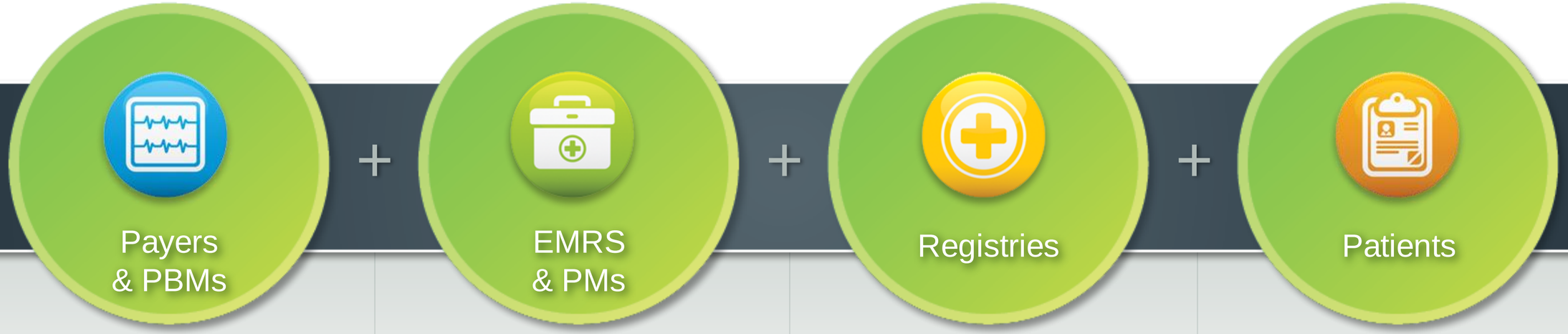
PATIENTPOINT NETWORK	Practices	Hospitals
Locations	24,000	570
Physicians	61,000	165,000
Patients	456 million exposures (annually)	6.5 million exposures (annually)

Industry Transformation & Challenges

Actionable data based Care Coordination and Transitions in Care

PatientPoint Coordinated Care Platform gives a complete view of the patient.

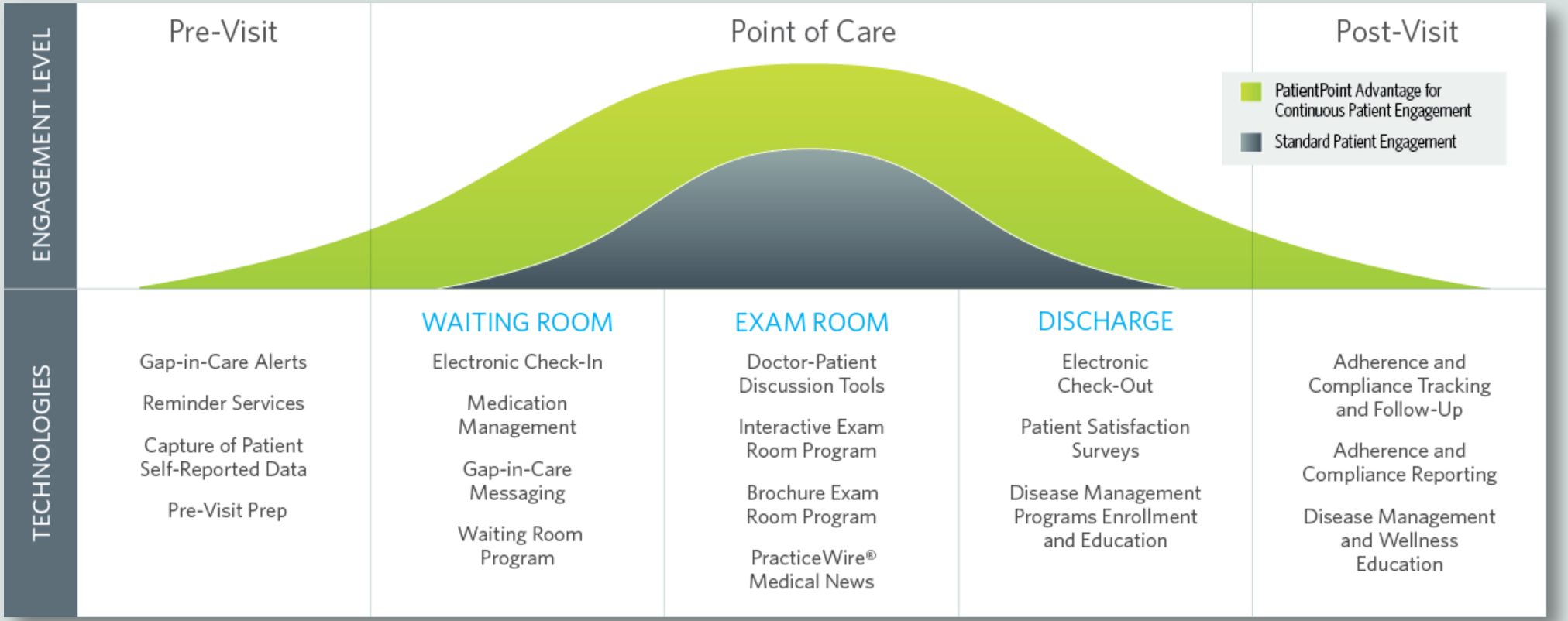
PatientPoint Care Coordination Platform aggregates data from:



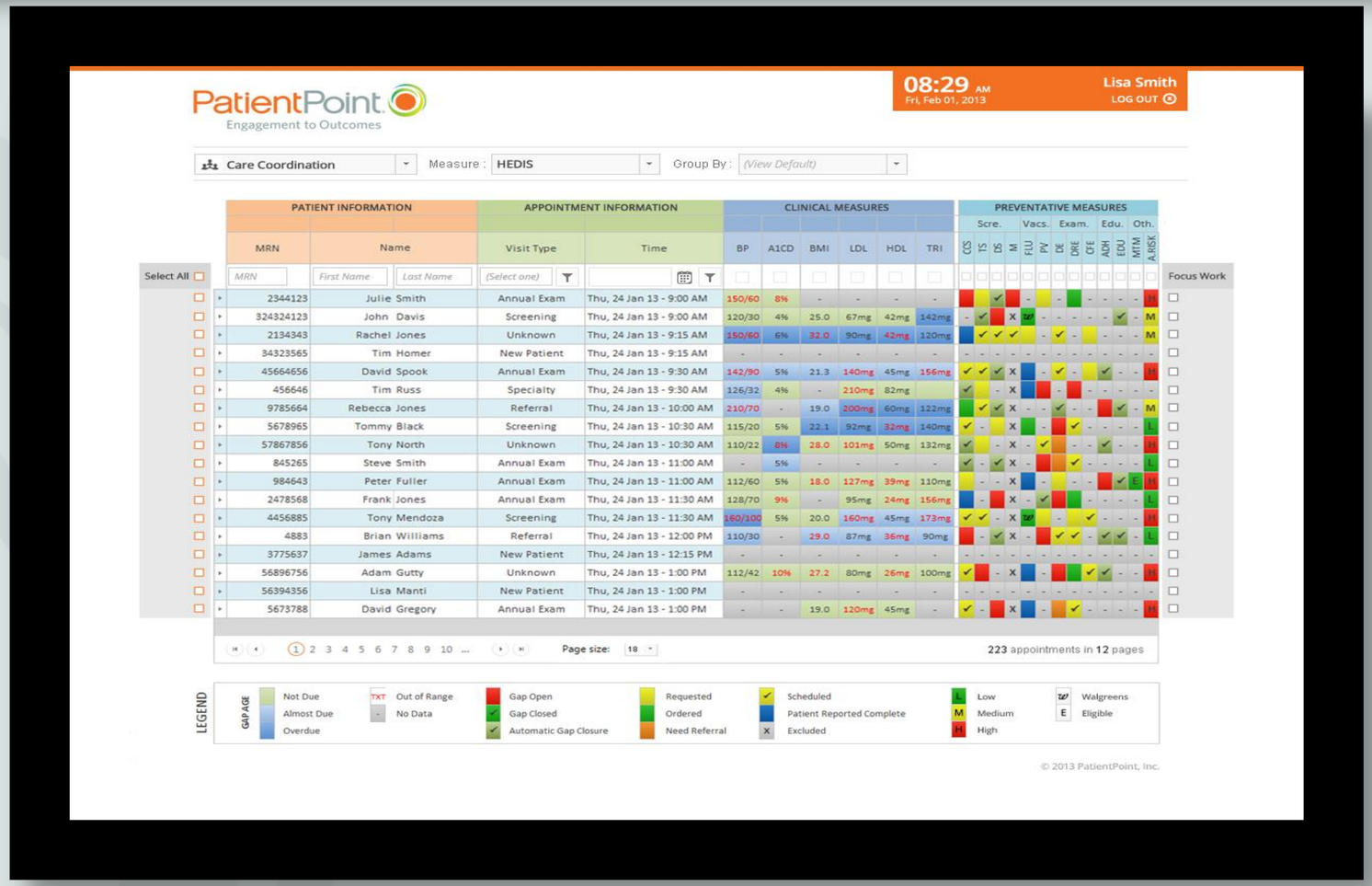
Payers & PBMs	EMRS & PMs	Registries	Patients
Clinical gaps in care	Clinical history	Patient health	Self-reported data
Adherence alerts	Patient demographics	History profile	
Claims data			
Medication reconciliation			

PatientPoint programs facilitate continuous patient engagement.

Interactive technology aligns the patient with the provider and care team



PatientPoint Dashboard displays gap-in-care alerts at a glance.



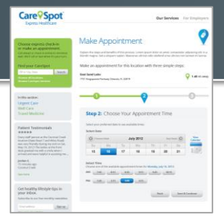
Color coding helps practices quickly identify care gaps and schedule outreach.

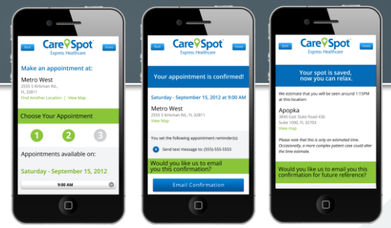
Gap identified by PatientPoint Care Coordination Engine.

MRN	Patient Name	M	BP	BMI	CFE	DRE	DE	A1C	FLP	FLU	PV	TCS	DS	Appt. Date	Appt. Time	Provider Name	Insurance
[redacted]	[redacted]													[redacted]	[redacted]	[redacted]	[redacted]
603800	Lisa Smith													8/22/2012	10:00 AM	Casas Claudia	BCBS
[redacted]	[redacted]													[redacted]	[redacted]	[redacted]	[redacted]

"Hi, this is Dr. Smith. Please listen to the following message. You are due for your annual blood pressure check. Press 1 to schedule an appointment…"

Alert sent to Lisa Smith via IVR…

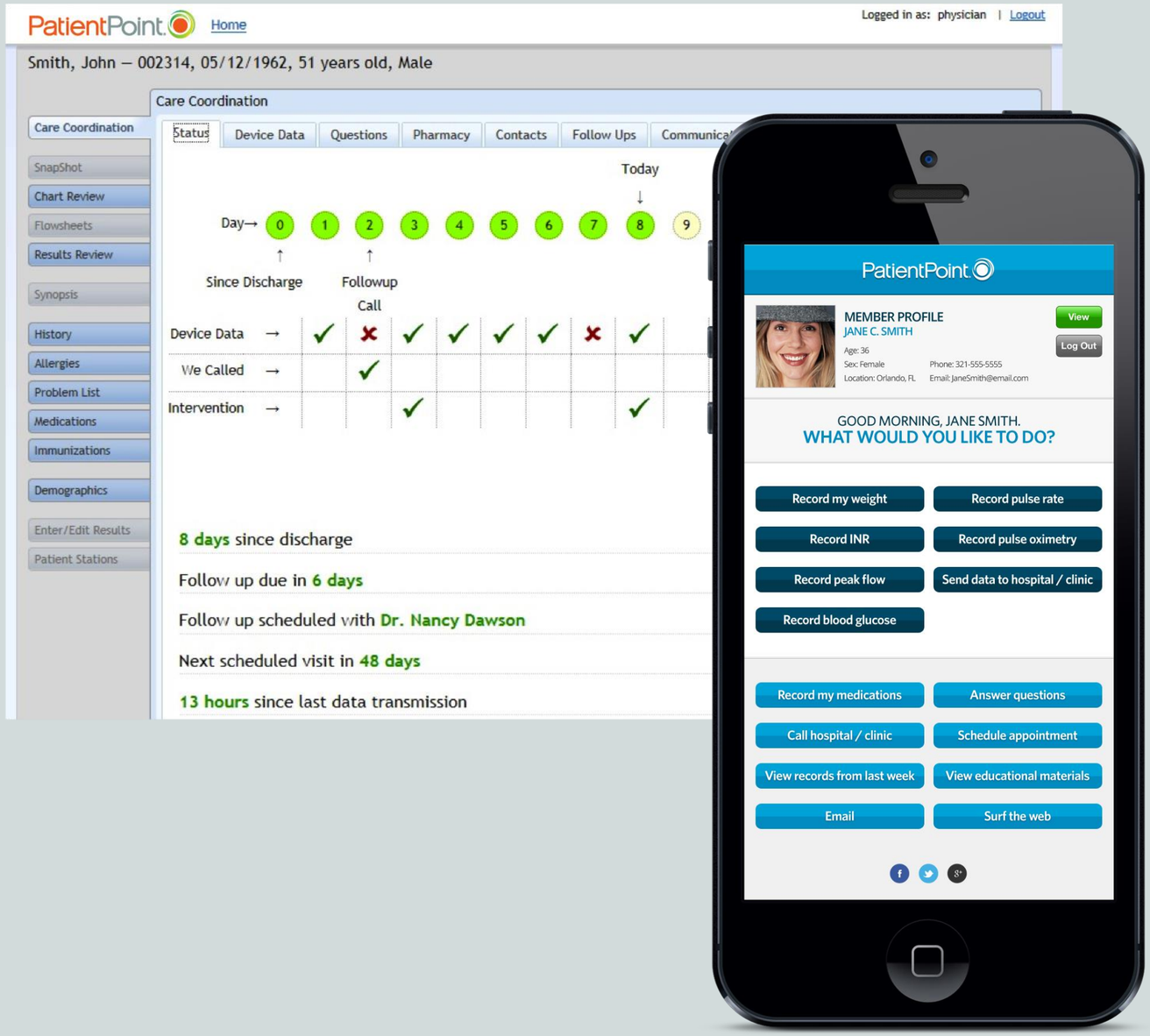




LEGEND

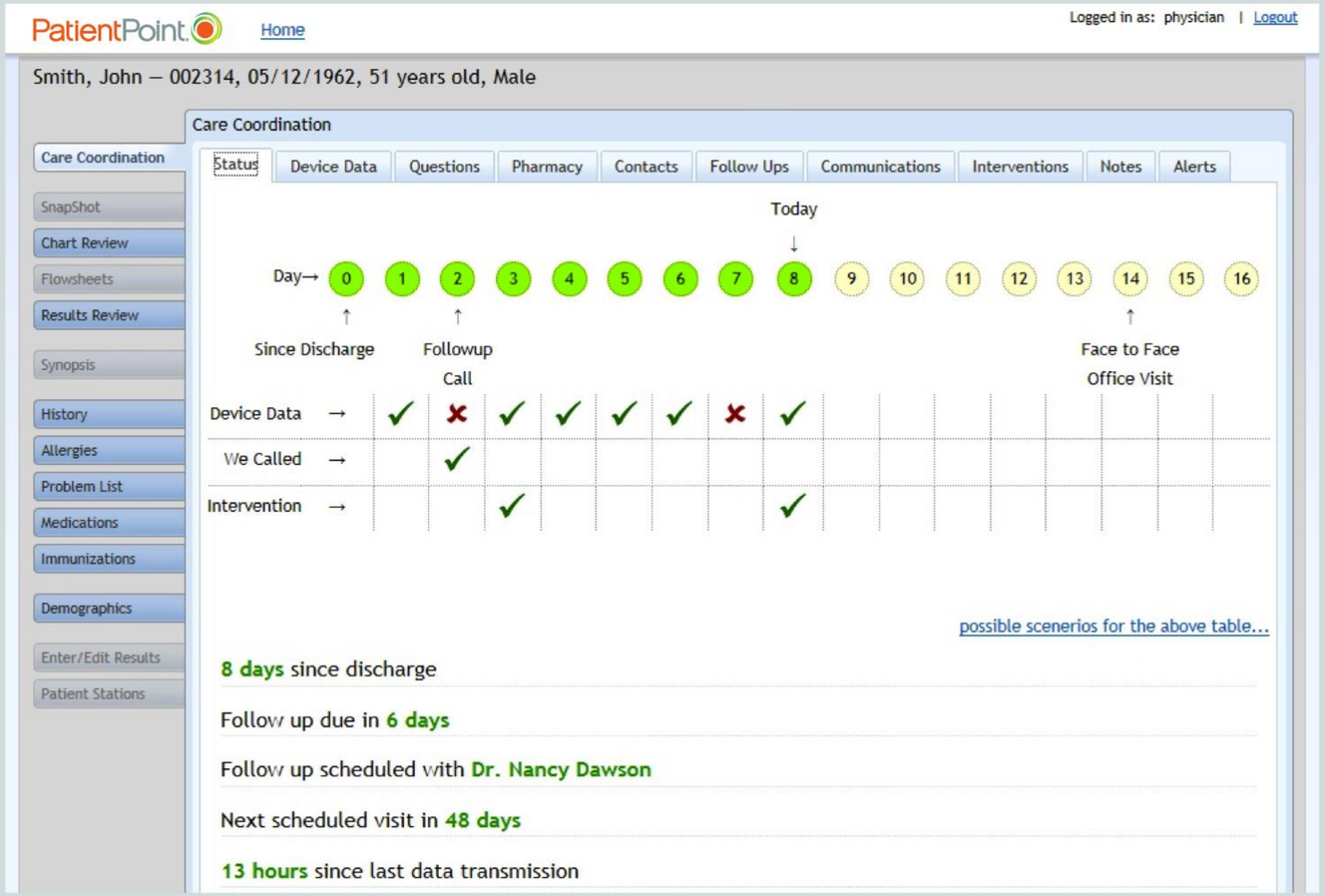
Open | Requested | Scheduled | Patient Completed | Ordered | Closed

PatientPoint



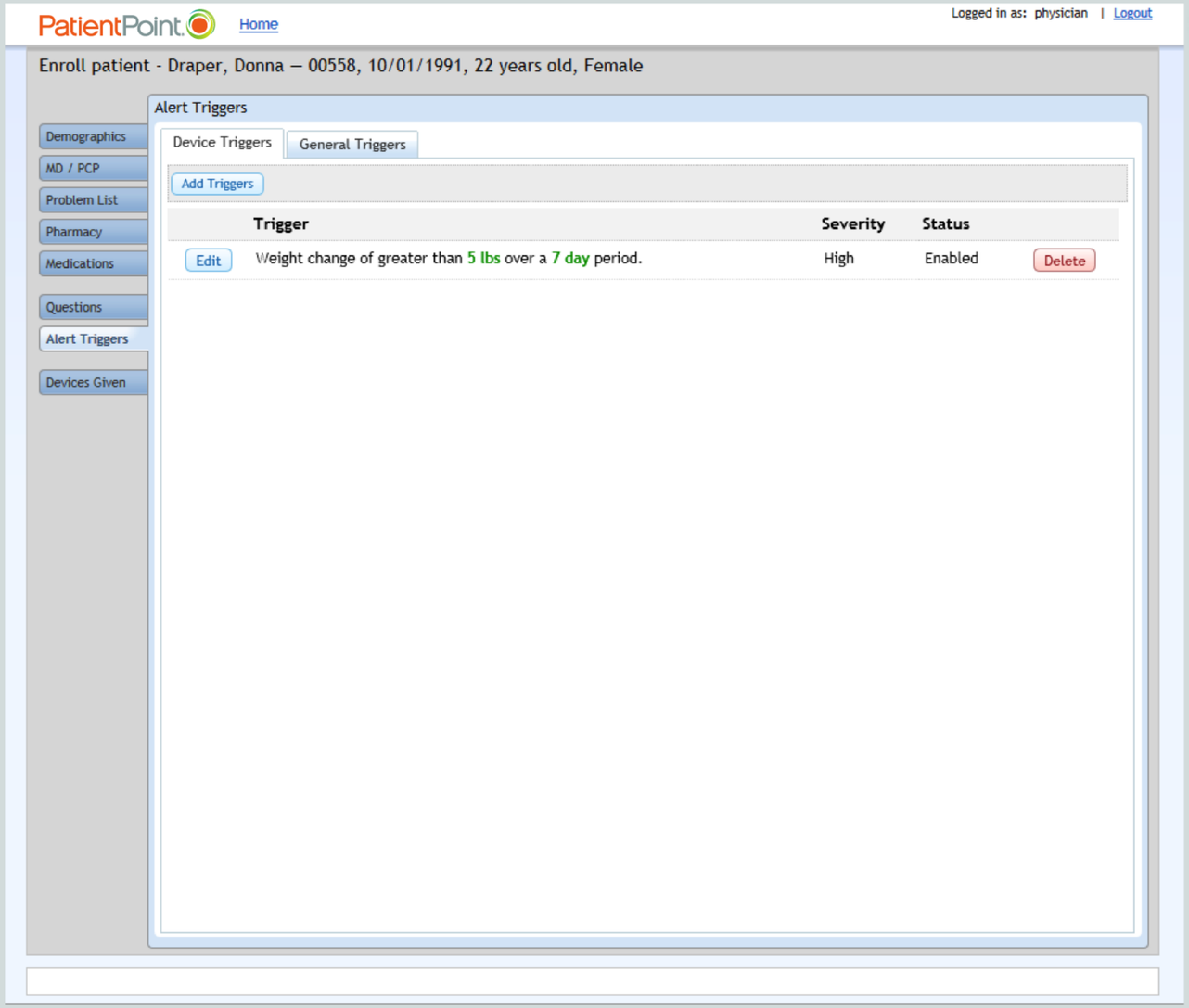
4 stage engagement model

- Stage 1: Predictive modeling using JHU ACG grouper to identify high risk patients and engage in the acute care or ED setting
- Stage 2: Enrollment in the post-acute/Transitional care system, and initial “touch”
- Stage 3: Device education and installation
- Stage 4: Ongoing tele-monitoring and follow up with primary care



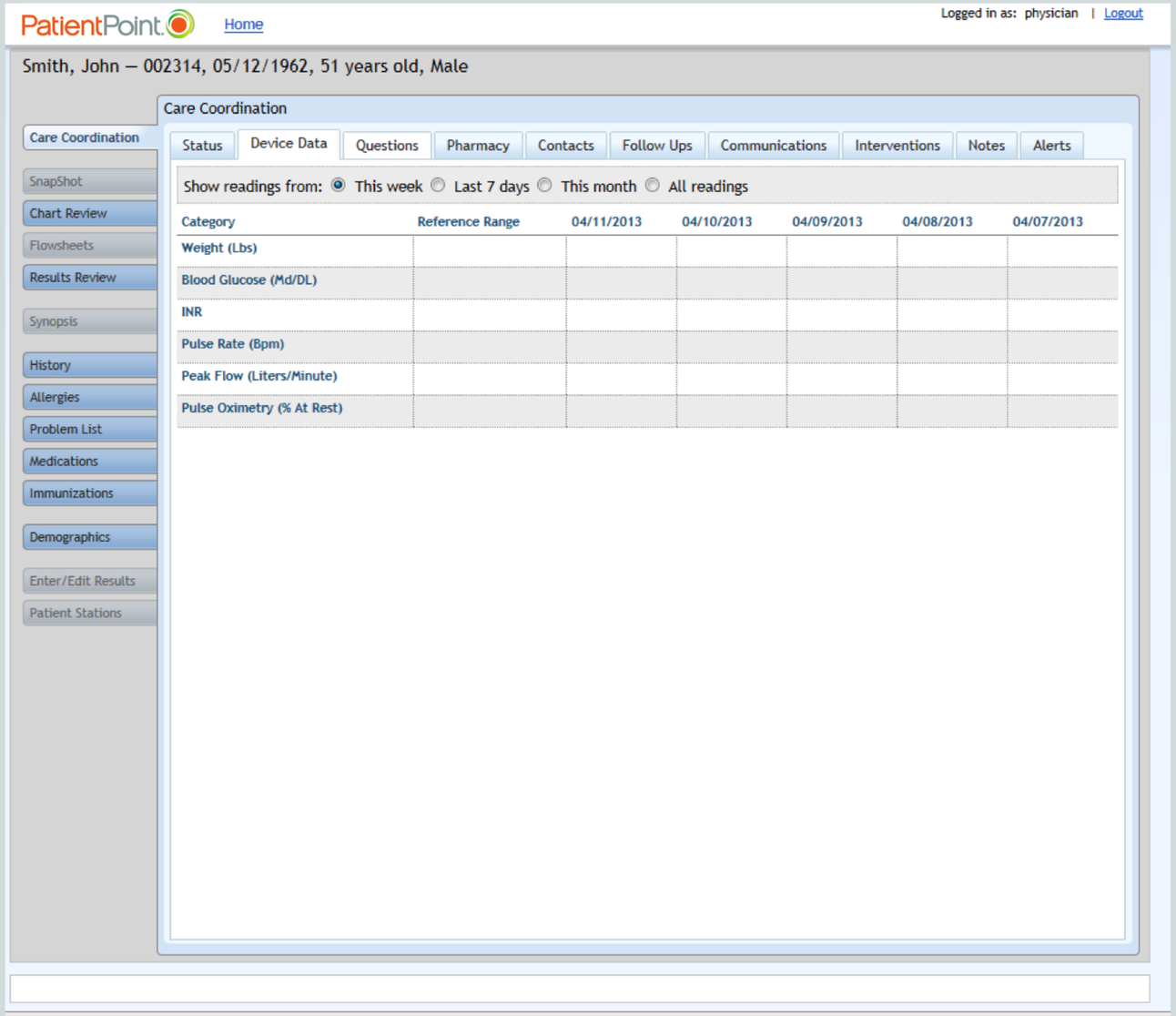
Stage 1

With EMR integration, alerts regarding readmission risk are highlighted when admission orders are being written, and on a daily basis



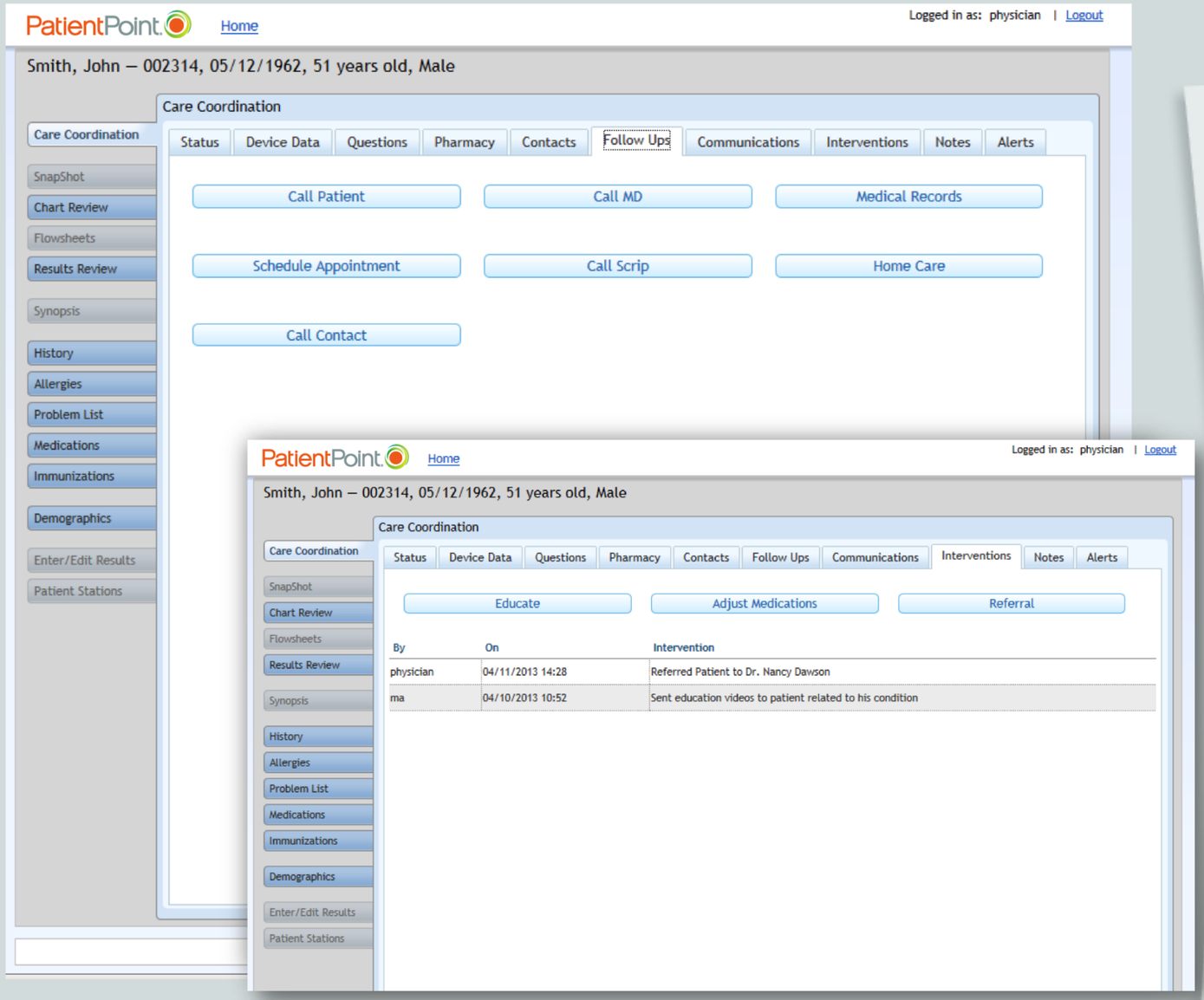
Stage 2

- Just before discharge, EVERY discharge is enrolled in the care coordination system for follow up purposes
- Enrollment loads medications, problem lists, recent studies, sets default triggers



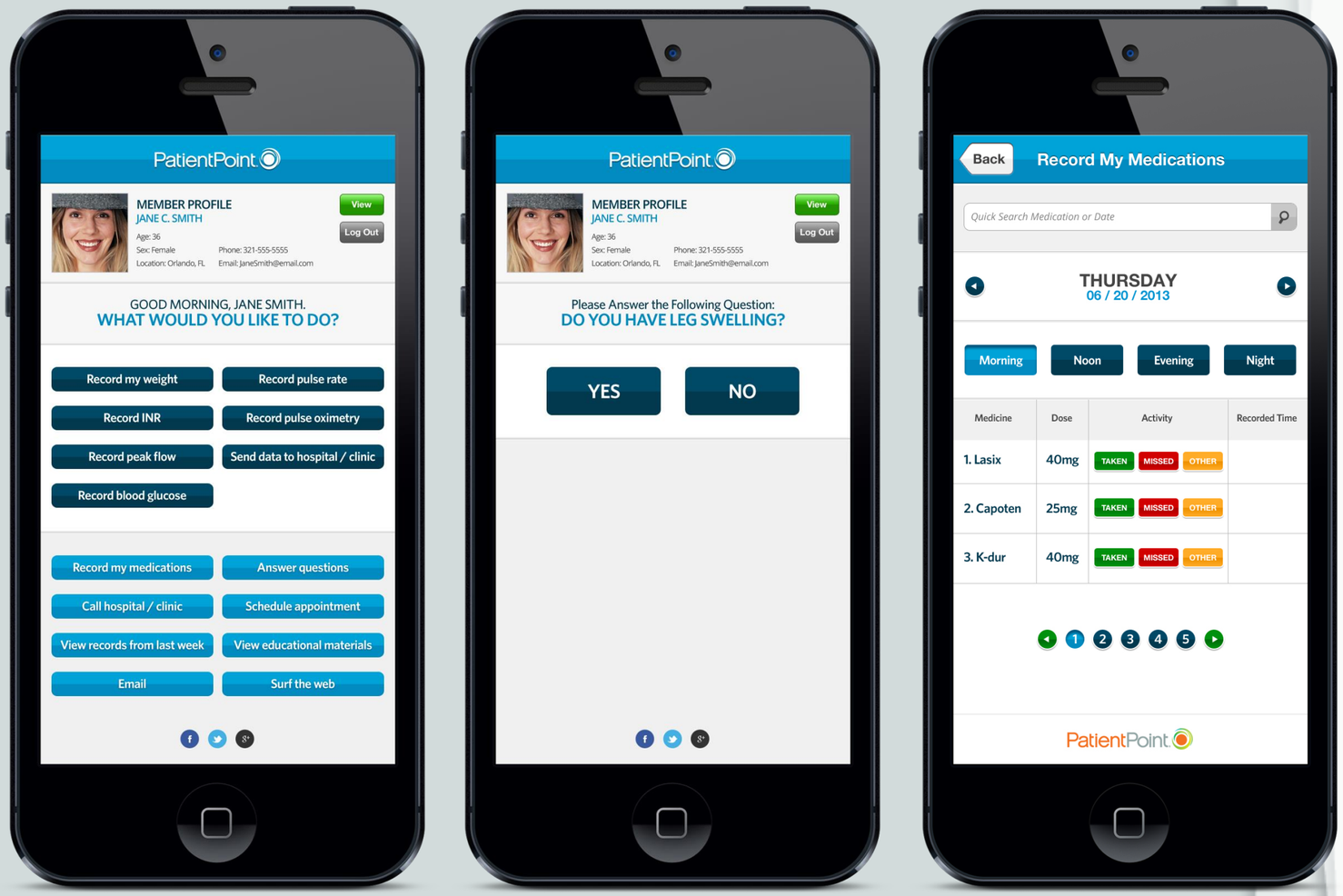
Stage 3

- Patient assessment of whether he/she is a candidate for engagement with devices
- Patient is given education on relevant devices for home use (android based) for coordination and reminders



Stage 4

- Deployment of devices in the patient home or assisted living facility
- Initial “touch” by Call center staff for CPT 99495/99496 within two business days of discharge
- For chronic disease, ongoing monitoring (CHF, DM, CKD, COPD)



Patient Screens

- Mobile based easy to use screens

Dashboard tracks the entire process from identification to closing gaps in care.

4 System detects an order for the gap

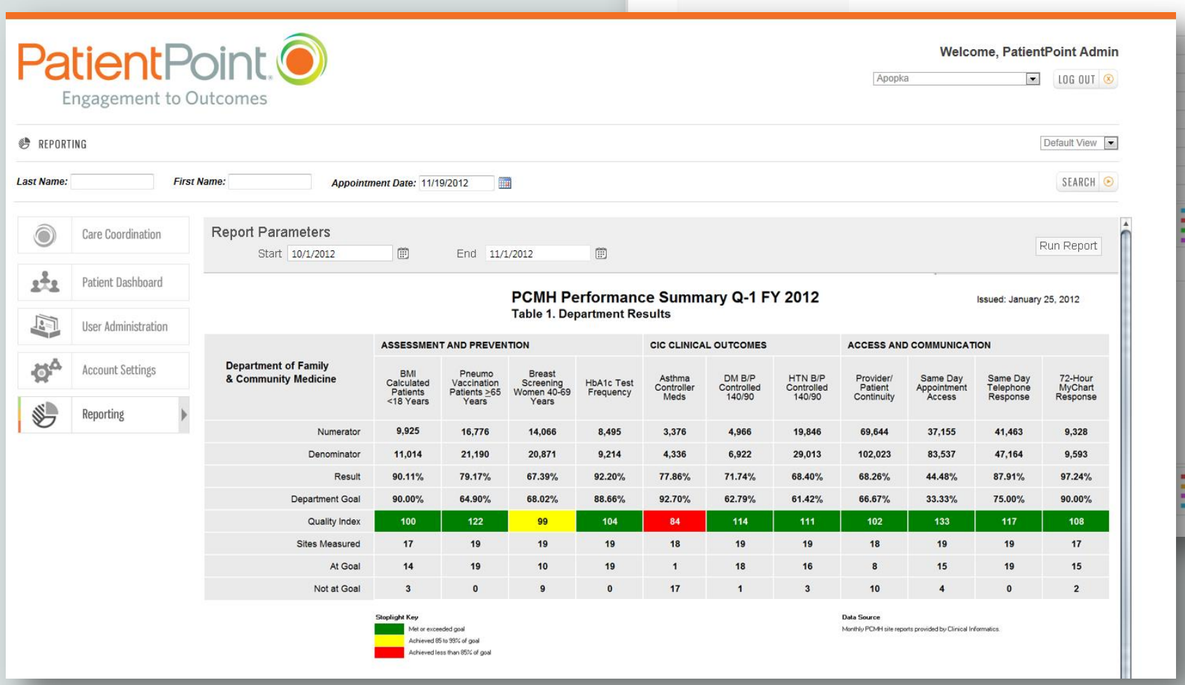
MRN	Patient Name	M	BP	BMI	CFE	DRE	DE	A1C	FLP	FLU	PV	TCS	DS	Appt. Date	Appt. Time	Provider Name	Insurance
[redacted]																	
603800	Lisa Smith													8/22/2012	10:00 AM	Casas Claudia	BCBS
[redacted]																	

5 Gap is closed

MRN	Patient Name	M	BP	BMI	CFE	DRE	DE	A1C	FLP	FLU	PV	TCS	DS	Appt. Date	Appt. Time	Provider Name	Insurance
[redacted]																	
603800	Lisa Smith		✓						✓					8/22/2012	10:00 AM	Casas Claudia	BCBS
[redacted]																	

LEGEND: Open | Requested | ✓ Scheduled | Patient Completed | Ordered | ✓ Closed

Detailed, easy-to-read care coordination reports help track PCMH performance.



Physician Office Visit Engagement

What the Patient Sees on the tablet device

Staff's View is below

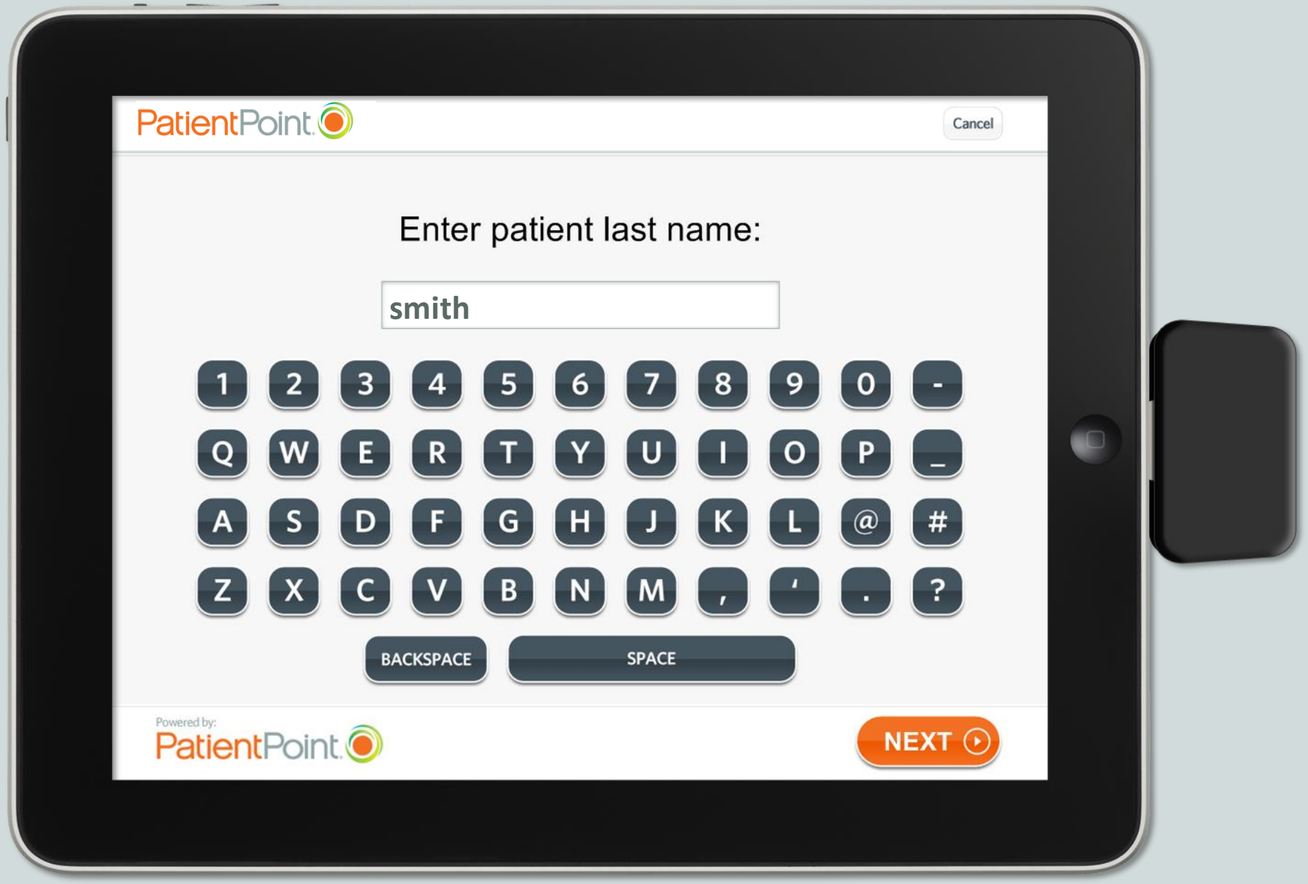
Select All		Patient Information			Appointment Information		Kiosk								Results	
		MRN	Name		Visit Type	Time	D	I	F	P	C	B	O	Usage time	Registrar	Status
	>	2344123	John	Davis	New Patient	Today 9:00:00 AM							✓	8:00	Sandra Jones	In-Service
	>	324324123	Judy	Smith	Annual Exam	Today 9:10:00 AM								-	-	-
	>	2134343	Rachel	Jones	Unknown	Today 9:15:00 AM							◈	7:21	Jim James	In-Waiting

LEGEND
OK
Review
Critical
P In Progress
◈ Complete
✓ Posted

At check-in and check-out, tablet is handed to the patient.

Patients with appointments who have not begun to check-in still appear on the Staff Dashboard view.

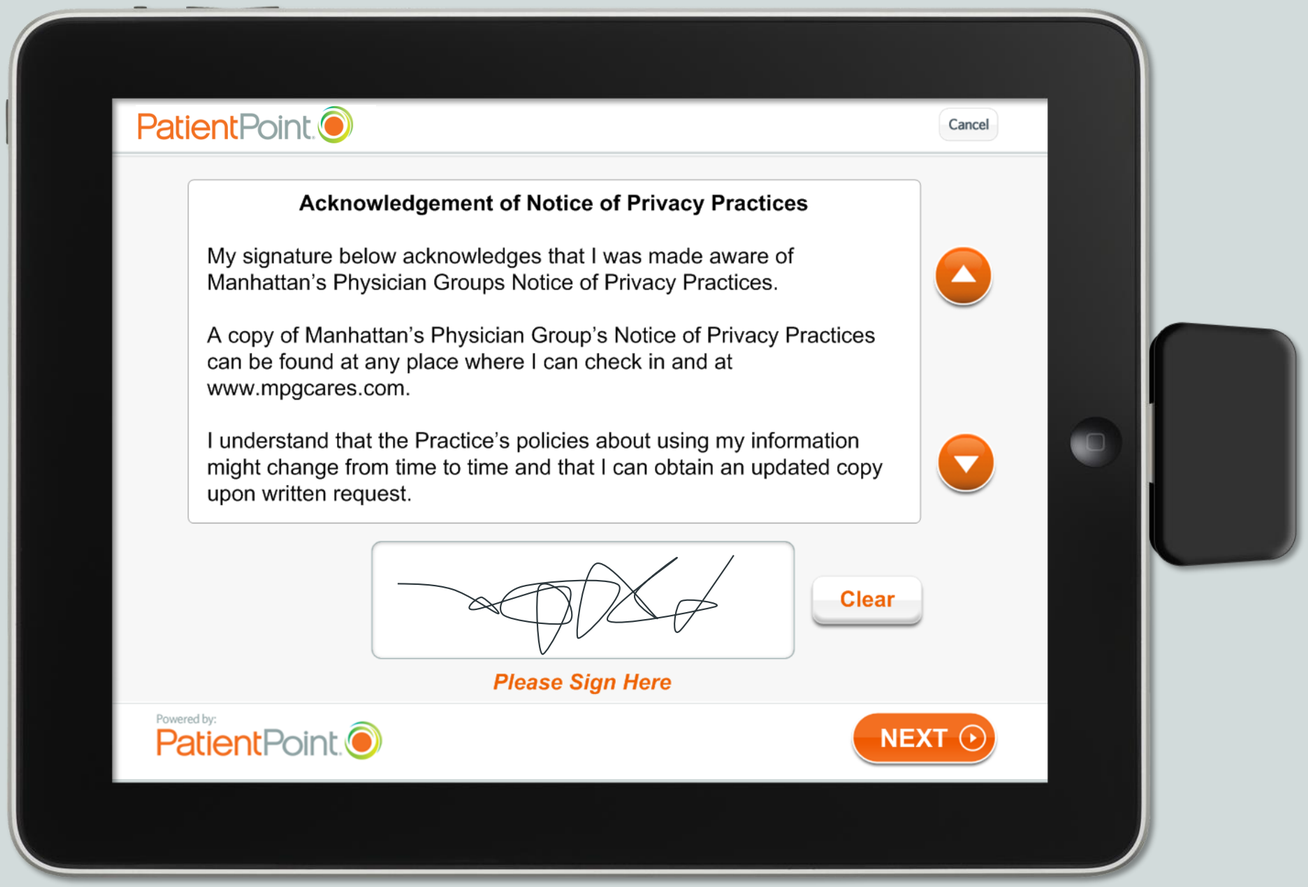
Touch next to continue

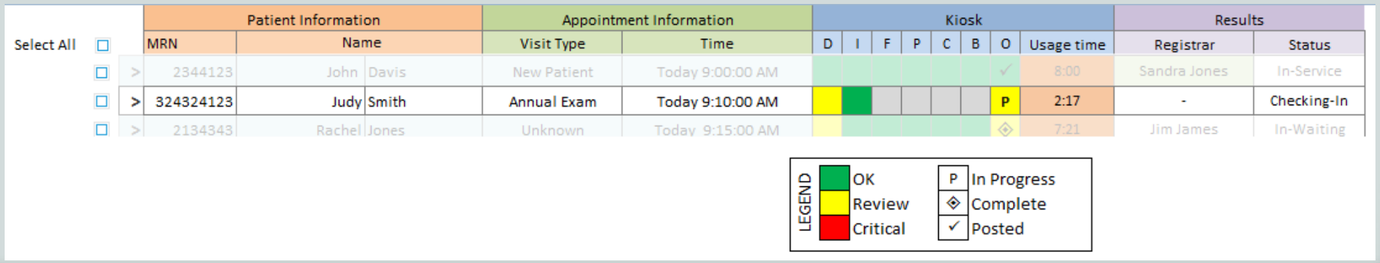


Select All		Patient Information		Appointment Information		Kiosk								Results	
		MRN	Name	Visit Type	Time	D	I	F	P	C	B	O	Usage time	Registrar	Status
	>	2344123	John Davis	New Patient	Today 9:00:00 AM							✓	8:00	Sandra Jones	In-Service
	>	324324123	Judy Smith	Annual Exam	Today 9:10:00 AM								-	-	-
	>	2134343	Rachel Jones	Unknown	Today 9:15:00 AM							◈	7:21	Jim James	In-Waiting

LEGEND: OK, Review, Critical; P In Progress, ◈ Complete, ✓ Posted

Patient enters last name to begin check-in process.





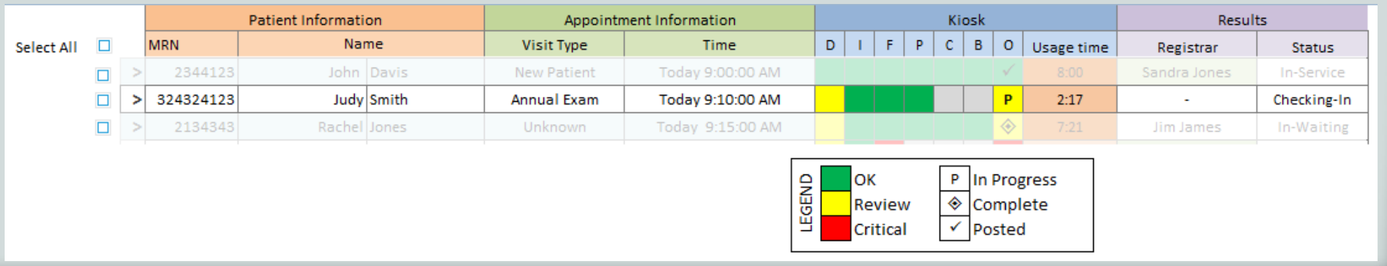
Patient signs any forms that need a signature.

Technical details:

1. Option to decline to sign can be added to any form.
2. Forms, once signed, are converted to a secure PDF or TIF document and automatically attached into the EMR.
3. System automatically remembers form frequency's across the network and will not present unless needed.
4. The signed PDF form can be designed to be identical to the practices current forms.

If Judy chooses to decline a form the dashboard will reflect as a red problem flag as not signing a form may mean denial of service.

Touch next to continue



Screenings are presented to patient when the rules for showing the screenings are met.

Technical details:

1. Results for the screenings are compiled and stored on the check-in summary document (also called the boarding card).
2. The boarding card is stored in the EMR visit record and also printed for the physician to review.

Touch next to continue

Select All		Patient Information		Appointment Information		Kiosk								Results	
		MRN	Name	Visit Type	Time	D	I	F	P	C	B	O	Usage time	Registrar	Status
	>	2344123	John Davis	New Patient	Today 9:00:00 AM							✓	8:00	Sandra Jones	In-Service
	>	324324123	Judy Smith	Annual Exam	Today 9:10:00 AM							P	2:17	-	Checking-In
	>	2134343	Rachel Jones	Unknown	Today 9:15:00 AM							◈	7:21	Jim James	In-Waiting

LEGEND: OK, Review, Critical; P In Progress, ◈ Complete, ✓ Posted

Adherence Support:

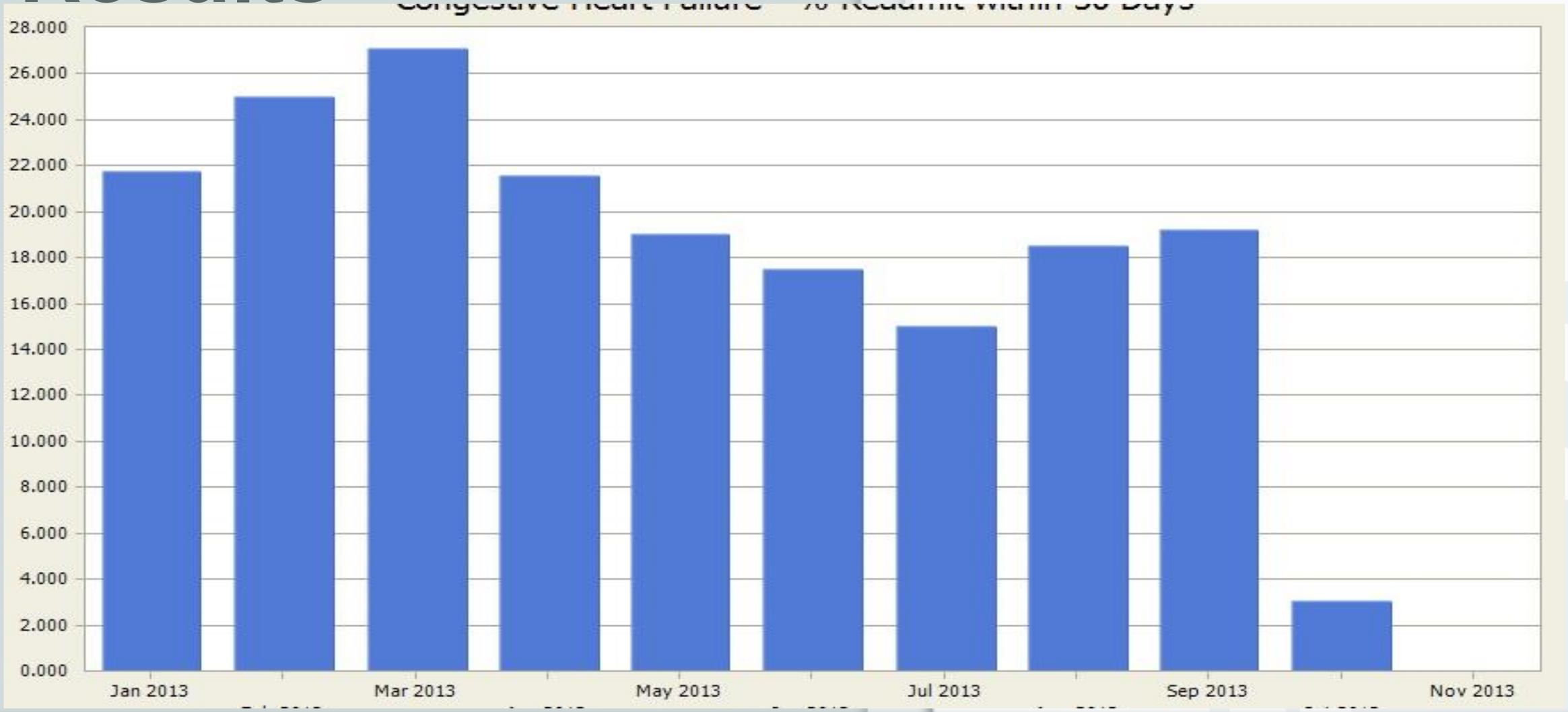
If the patient indicates that they are no longer taking the medication, a reason fro stopping the medication is asked.

Transitions in Care (Case Study)

Avoidable Readmission Pilot
Early results

- Pilot program at a medium sized community hospital in the Midwest
- Patient population and payor mix similar to 1800 of the 5400 CMS registered hospitals
- Feasibility study to assess costs, reimbursement, challenges, and scalability of an end-to-end chronic disease management solution

Results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0.000
Jan 2013
Mar 2013
May 2013
Jul 2013
Sep 2013
Nov 2013

Avoidable Readmission Pilot

- First 90 days focuses on Acute MI (Heart attacks) and Congestive Heart Failure (CHF) patients
- Q1 of 2014 will expand the program to include COPD, Total knee, Total Hip, and Stroke patients
- Includes employed physicians as well as community affiliates

Avoidable Readmission Pilot

- Logistic Regression and Neural network model created based upon admission history over the prior two years for that facility
- Data queries out of Epic, included demographics, medications, comorbidities, discrete lab data, socioeconomic characteristics, other clinical characteristics

Costs of program

- Monitoring service - $120/per patient per month
- Discharge coordinator time, care coordinator time, support overhead, $400 per patient
- Development/update of predictive model, integration, software platform, $150k

ROI

- Based upon penalty elimination, and transition in care reimbursement, there is a 12 to one ROI
- In scenarios without penalties, the ROI is approximately 2.5 to 1

Thank you