Massachusetts
Statewide ENS Framework

An Interoperable ENS Network for the Commonwealth

April 2021
Today's Presenters

**Mass Hiway:** Keely Benson  
*Account Management and Consulting Project Director, Mass Hiway Massachusetts eHealth Institute (MeHI)*  
*benson@masstech.org*

**CollectiveMedical:** David Kimball  
*Client Success Executive, East Acute and Payer*  
*David.Kimball@collectivemedical.com*

**PatientPing:** Elizabeth Weber  
*Manager, Strategic Accounts – New England*  
*New England PatientPing Customer Main Point of Contact*  
*eweber@patientping.com*

This presentation has been reviewed and approved by the Mass Hiway, and the presenters are acting as authorized representatives of the Mass Hiway.

The information provided in this presentation is for general information purposes only and in no way modifies or amends the statutes, regulations, and other official statements of policy and procedure that govern access to and use of the Mass Hiway.
Introduction to ENS

Massachusetts Statewide ENS Framework

Framework Advantages

CMS Interoperability and Patient Access Rule (CMS-9115-F)

CollectiveMedical Presentation

PatientPing Presentation

Q & A
The purpose of an Event Notification Service (ENS) is to alert subscribing care providers about their patients’ Admissions, Discharges, and Transfers (ADT) to and from emergency departments, hospitals, and post-acute care facilities.

All admissions, discharges, and transfers trigger an alert notification:
- sent to any subscribed care provider with an existing relationship with the patient
- can include clinical data, such as reason for visit and diagnosis

ADT alert notifications are delivered as:
- Real-time per patient messages, or
- Scheduled multi-patient summary lists

Subscribing care providers can choose:
- What they want to be notified about (e.g., admissions only, discharges only)
- How often they receive the notifications (e.g., real time, daily, twice a day)
- How to receive notification (e.g., direct secure message, SFTP)

Event Notification Services (ENS) are also called Encounter Notification Services.
How ENS Works?

ENS distributes Admit, Discharge, and Transfer (ADT) messages created by hospitals when a patient is treated, transferred inside the hospital, or discharged, to alert patient’s care teams.

When an ENS system receives an ADT message

- It matches the patient through a patient-provider matching algorithm
- Once a match is found, an alert notification is generated
- Alert notification is sent to subscribed providers with a relationship with the patient

ADT alert notifications can include clinical data such as

- Reason for visit
- Diagnosis
Ann has a stomachache and feels dizzy. She goes to the ER, is admitted, given a CT scan, and has a neurology consult.

Ann has diabetes and regular abdominal pains. She is a patient of a PCP.

Ann is also a patient at a pain clinic for chronic issue after an accident.
What an ENS Notification looks like

Example of an Event Notification

<table>
<thead>
<tr>
<th>Facility</th>
<th>Practice</th>
<th>Provider</th>
<th>MRN</th>
<th>Source Facility</th>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Gender</th>
<th>Date of Birth</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Medical Group</td>
<td>Practice 1</td>
<td>Dr. Jones</td>
<td>12345</td>
<td>Hospital 1</td>
<td>ABC 2345</td>
<td>Joe</td>
<td>A</td>
<td>Male</td>
<td>xx/xx/xxxx</td>
<td>123 Main Street</td>
<td>Philadelphia</td>
<td>PA</td>
<td>12345</td>
<td>xxx-xxx-xxxx</td>
</tr>
<tr>
<td>ABC Medical Group</td>
<td>Practice 2</td>
<td>Dr. Smith</td>
<td>8765</td>
<td>Hospital 1</td>
<td>XYZ12345</td>
<td>Mary</td>
<td></td>
<td>Female</td>
<td>xx/xx/xxxx</td>
<td>456 Cherry St.</td>
<td>Cherry Hill</td>
<td>NJ</td>
<td>12345</td>
<td>xxx-xxx-xxxx</td>
</tr>
<tr>
<td>ABC Medical Group</td>
<td>Practice 1</td>
<td>Dr. Jones</td>
<td>91289</td>
<td>Skilled Nursing Facility 8</td>
<td>PQR98744</td>
<td>Pam</td>
<td>C</td>
<td>Female</td>
<td>xx/xx/xxxx</td>
<td>934 Lion Circe</td>
<td>Havertown</td>
<td>PA</td>
<td>45678</td>
<td>xxx-xxx-xxxx</td>
</tr>
<tr>
<td>ABC Medical Group</td>
<td>Practice 4</td>
<td>Dr. Miller</td>
<td>83745</td>
<td>Hospital 3</td>
<td>KDG1384</td>
<td>William</td>
<td></td>
<td>Male</td>
<td>xx/xx/xxxx</td>
<td>874 Ryan's Way</td>
<td>Cape May</td>
<td>NJ</td>
<td>45678</td>
<td>xxx-xxx-xxxx</td>
</tr>
<tr>
<td>ABC Medical Group</td>
<td>Practice 5</td>
<td>Dr. Gonzalez</td>
<td>137894</td>
<td>Hospital 2</td>
<td>UID12374</td>
<td>Amy</td>
<td>K</td>
<td>Female</td>
<td>xx/xx/xxxx</td>
<td>109 Main Street</td>
<td>Langhorne</td>
<td>PA</td>
<td>98345</td>
<td>xxx-xxx-xxxx</td>
</tr>
<tr>
<td>ABC Medical Group</td>
<td>Practice 6</td>
<td>Dr. Orion</td>
<td>76345</td>
<td>Hospital 10</td>
<td>YHT7645</td>
<td>Karen</td>
<td>S</td>
<td>Female</td>
<td>xx/xx/xxxx</td>
<td>101 Hwy 1</td>
<td>Christiana</td>
<td>DE</td>
<td>12367</td>
<td>xxx-xxx-xxxx</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Source Setting</th>
<th>Event Type</th>
<th>Admit Date</th>
<th>Admit Time</th>
<th>Admit Reason</th>
<th>Admit Type</th>
<th>Referral Information</th>
<th>Discharge Date</th>
<th>Discharge Time</th>
<th>Death Indicator</th>
<th>Diagnosis Code</th>
<th>Diagnosis Description</th>
<th>Discharge Disposition</th>
<th>Attending Doctor</th>
<th>Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Admission</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>Chest Pain</td>
<td>Emergency</td>
<td>Physician</td>
<td></td>
<td></td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td>Dr. Alley</td>
<td>IBC</td>
</tr>
<tr>
<td>Patient</td>
<td>Registration</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>Fatigue</td>
<td>Emergency</td>
<td>Physician</td>
<td></td>
<td></td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td>Dr. Callahan</td>
<td>AmeriHealth</td>
</tr>
<tr>
<td>Emergency</td>
<td>Discharge</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>Pneumonia</td>
<td>Routine</td>
<td>Transfer from</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>Y</td>
<td>x.xxx</td>
<td>Pneumonia</td>
<td>Discharged to Home</td>
<td>Dr. R. Smith</td>
<td>Aetna</td>
</tr>
<tr>
<td>Emergency</td>
<td>Discharge</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>Laceration</td>
<td>Emergency</td>
<td>Physician</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>N</td>
<td></td>
<td>Heart Disease</td>
<td>Discharged to Home</td>
<td>Dr. Hall</td>
<td>United</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Transfer</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>Chest Pain</td>
<td>Routine</td>
<td>Physician</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td>Dr. Pope</td>
<td>HPP</td>
</tr>
<tr>
<td>Emergency</td>
<td>Discharge</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>CHF</td>
<td>Emergency</td>
<td>Physician</td>
<td>xx/xx/xxxx</td>
<td>xx/xx/xxxx</td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Subscription to Single ENS System

- ENS is offered by an ENS vendor that has developed its own ENS system
- Care providers can subscribe to the ENS vendor
  ➔ They can exchange ADT alerts with all providers subscribed to the same vendor

Subscription to Interoperable ENS Network

- ENS vendors partner to interconnect their ENS systems to share ADT alerts
- Each ENS system forwards the incoming ADT alerts to the interconnected systems
- Each system sends alert notifications to their subscribers that serve the same patients
- Care providers only have to subscribe to one of these ENS vendors
  ➔ They can exchange ADT alerts with all providers subscribed to any of the ENS vendors

Interoperable ENS Networks consist of interconnected ENS systems that share ADT alerts to expand the number of subscribed care providers that can send and receive the alerts
Introduction to ENS

Massachusetts Statewide ENS Framework

Framework Advantages

CMS Interoperability and Patient Access Rule (CMS-9115-F)

CollectiveMedical Presentation

PatientPing Presentation

Q & A
ENS Initiative Goal: Create a Statewide ENS Framework to improve care delivery, quality, and coordination across care providers in the Commonwealth

EOHHS Guiding Principles

- Create an interoperable ENS network comprised of Certified ENS Vendors
- Leverage the existing ENS vendor marketplace in Massachusetts
- Promote data sharing within the Statewide ENS Framework
- Provide universal access to ENS for Massachusetts care providers of all sizes
- Require/encourage providers to sign up for ENS to send/receive notifications
- Allow providers a single point of submission and reception of ENS data
- Improve ENS notification timing and data flow (real/near-real time)

EOHHS Process

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2018</td>
<td>RFI issued</td>
<td>Collect knowledge from existing ENS marketplace</td>
</tr>
<tr>
<td>Oct 2019</td>
<td>Regulation finalized</td>
<td>Formalize certification process for ENS vendors</td>
</tr>
<tr>
<td>Nov 2019</td>
<td>RFA issued</td>
<td>Accept applications for certification of ENS vendors</td>
</tr>
<tr>
<td>Jan 2020</td>
<td>Application deadline</td>
<td>Process applications to select vendors for certification</td>
</tr>
<tr>
<td>Feb 2021</td>
<td>Applicants certified</td>
<td>Certify ENS vendors to participate in ENS Framework</td>
</tr>
</tbody>
</table>
## ENS Regulatory and Certification Process

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Implement a regulatory Statewide ENS Framework that:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Creates an interoperable ENS network that serves all Massachusetts providers</td>
</tr>
<tr>
<td></td>
<td>• Certifies, interconnects, and leverages the capabilities of existing ENS vendors</td>
</tr>
<tr>
<td></td>
<td>• Supports HIway initiatives that improve care delivery, coordination, and quality</td>
</tr>
<tr>
<td></td>
<td>• Promotes robust privacy and security standards to protect patient data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulation</th>
<th>The Commonwealth issued and promulgated regulations that:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Establish a HIway-facilitated ENS Framework and ENS certification process</td>
</tr>
<tr>
<td></td>
<td>• Require acute care hospitals to submit ADT feeds to certified ENS vendor(s)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Certification</th>
<th>EOHHS developed and defined:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Detailed objective criteria to determine ENS vendor certification eligibility</td>
</tr>
<tr>
<td></td>
<td>• ENS “rules of the road” through ENS vendor certification (e.g., limit use cases, require vendor reflection, security requirements, etc.)</td>
</tr>
</tbody>
</table>
The Statewide ENS Framework

Data Submitters – Acute Care Hospitals

Boston Hospital
Pittsfield Hospital
Cape Hospital

Massachusetts ENS Framework*

Certified ENS 1
Subscriptions
Boston Hospital
Boston PCP
Boston BH

Certified ENS 2
Subscriptions
Pittsfield Hospital
Boston CP

Certified ENS 3
Subscriptions
Cape Hospital
Cape PCP

ENS Recipients

Boston PCP
Boston BH
Boston CP
Cape PCP

*Statewide ENS Framework includes regulations and a vendor certification process that govern an Interoperable ENS Network. 3 Certified ENS Vendors shown in illustration. Actual number will be based on ENS vendors that meet ENS certification criteria.
1. Boston Hospital sends ADT to ENS 1
2. ENS 1 runs own matching algorithm, positive match for client, notification sent to Boston PCP (Boston CP does not yet know that their patient was seen at Boston Hospital)

3. ENS 1 also sends ADT copy to ENS 2 and ENS 3
4. ENS 2 runs own matching algorithm, there is a positive patient match ✓, notification sent to Boston CP
5. ENS 3 runs own matching algorithm, there is no positive patient match ✗, ADT data deleted, retaining only audit data

Federal obligations: HIPAA and 42 CFR Part 2 | State obligations: HIV and genetic testing
Massachusetts Acute Care Hospitals

- Required to subscribe to one Certified ENS Vendor to submit ADT alerts by **April 1, 2021**.
- Certified ENS Vendors can assist hospitals in using ENS to comply with the new [CMS-9115-F](https://www.cms.gov) ADT regulations to receive Medicare and Medicaid reimbursements.

MassHealth ACOs

- MassHealth ACO requirements call for increased use of real-time notification systems in accordance with DSRIP plans.

MassHealth CPs

- Required to subscribe to one Certified ENS Vendor when the Statewide ENS Framework becomes available, per contract with MassHealth.

All Massachusetts Care Providers

- Eligible and encouraged to subscribe to a Certified ENS Vendor to receive ADT alerts. This includes ACOs, clinically integrated networks, PCPs, and all specialty care providers.
CollectiveMedical offers a cost-effective solution that ensures hospitals, psychiatric hospitals, and critical access hospitals are completely compliant, without the need for any additional intermediary service providers.

CollectiveMedical combines data from sources spanning the care continuum, including ADT, continuity of care documents (CCD), claims data, prescription drug histories (PDMP/PMP), imaging, and more, to give insights into patients’ activities.

CollectiveMedical also supports the CMS-9115-F ADT alert requirements.

To visit website, click here.
Advanced E-Notifications System

PatientPing delivers real-time notifications whenever your patients experience care events, whether they are at a hospital, ED or post-acute (SNF, LTACH, HHA, IRF, hospice)

Pings (alerts) allow you to scale how you manage your patient populations. Pings can be embedded within your existing workflow systems or used natively through our web and mobile user experience

PatientPing also supports the CMS-9115-F ADT alert requirements

To visit website, click [here](#)
Introduction to ENS

Massachusetts Statewide ENS Framework

Framework Advantages

CMS Interoperability and Patient Access Rule (CMS-9115-F)

CollectiveMedical Presentation

PatientPing Presentation

Q & A
Utilization of ENS and the Statewide ENS Framework will resolve instances when providers are not contacted, or not contacted in a timely manner, when their patients are admitted or discharged from hospitals, EDs, or other care facilities. Utilization will improve care coordination.

Interoperable Statewide ENS Solution

- The Statewide ENS Framework enables all care providers in the Commonwealth to subscribe to a single interoperable ENS vendor to receive ADT alerts from all Massachusetts’ Acute Care Hospitals, and other subscribing care facilities, to coordinate care after ADT events.

Improves Continuity of Care

- ADT notifications will help patients transition between care providers, especially in emergencies. Patients don’t need to remember to contact their PCPs concerning treatment received at other facilities, as the information is sent automatically, enabling the PCPs to follow up directly.

Enhances Care Coordination

- Clinicians, care managers, and others in the healthcare community receive real-time ADT notifications so they can quickly assess their patients’ medical and social needs, implement support where necessary, and direct patients to the most appropriate care settings.

Enhances Patient Engagement

- Timely ADT alerts and notifications allow care providers to connect more meaningfully with patients, provide better patient education, and guide them to the right care at the right time.
Supports Medication Education and Reconciliation
- Information about patients taking many different medications can be lost in transitions of care, and introducing new medications increases patient risk. **ENS can identify and alert for drug-drug interactions and ensure the patient gets the education they need to safely manage their meds.**

Decreases Repeat Hospitalizations
- Clinicians have the information they need to **create a discharge plan that is well-informed and purpose-built**, to direct patients to a care system that better meets their long-term needs than repeat hospital visits.

Reduces Long-Term Medical Costs
- As disease states progress and a patient is left untreated, the odds of them visiting the emergency room and requiring hospitalization and other expensive interventions increases. **Improving care coordination with their care providers reduces avoidable utilization, lowering overall costs of care.**

Provides Library of Submitted ADTs
- ADT alerts submitted by Acute Care Hospitals will be **archived and available for viewing by any authorized party that may need the information in the future to provide care to the same patients.**
Introduction to ENS

Massachusetts Statewide ENS Framework

Framework Advantages

CMS Interoperability and Patient Access Rule (CMS-9115-F)

CollectiveMedical Presentation

PatientPing Presentation

Q & A
The Statewide ENS Framework supports hospitals in meeting CMS-9115-F

CMS-9115-F requires hospitals, including psychiatric hospitals and Critical Access Hospitals (CAH), to send electronic patient event notifications of a patient’s Admission, Discharge, and/or Transfer (ADT) to another healthcare facility or to another community provider or practitioner.

- The requirement adds to the list of Conditions of Participation (CoP) that hospitals must fulfill to maintain their CMS provider agreement, so they can get CMS reimbursements.
- CMS published the Final Rule to the Federal Registry, and it became effective June 30, 2020.
- The ADT obligation becomes applicable 12 months after publication (*applicable spring 2021*).
- The purpose is to improve care coordination by allowing a receiving provider, practitioner, or facility to reach out to the patient and deliver appropriate follow-up care in a timely manner.
- To review the CMS Interoperability and Patient Access final rule, click [here](#).

The HIway recommends Massachusetts hospitals to participate in the Statewide ENS Framework in their effort to meet the ADT obligation, as it provides the mechanism needed to send and receive ADT alerts. The Certified ENS Vendors can assist hospitals in using ENS to comply with CMS-9015-F.
Introduction to ENS

Massachusetts Statewide ENS Framework

Framework Advantages

CMS Interoperability and Patient Access Rule (CMS-9115-F)

CollectiveMedical Presentation

PatientPing Presentation

Q & A
Collective Medical
Certified ENS Vendor

March 9th, 2021
Introductions and Priorities

Chris Klomp
Executive Vice President
Acute and Payer

Adam Green
VP of Engineering
Acute and Payer

David Kimball
Client Success Executive, East
Acute and Payer
PointClickCare + Collective Medical

Senior Healthcare Information Platform + Integrated Care Coordination Network

Network Coverage + Deep & Broad Data Sets

- 2.3+ million LTPAC admissions processed in 2018
- 750 million medications administered monthly
- 1.7 million patient records managed daily
- 15,000+ skilled nursing facilities

- 3,000+ hospitals & >6,200 total nodes
- Data ingestion & normalization, insights and notifications
- Last-mile workflow integration
- 8 real-time care coordination programs

<table>
<thead>
<tr>
<th>Health systems &amp; Hospitals</th>
<th>ACOs</th>
<th>Health Plans</th>
<th>Public Health</th>
<th>Post Acute Care</th>
<th>Ambulatory</th>
</tr>
</thead>
</table>

Sources:

Integrated Care Coordination Senior Healthcare Information Platform

Real-time Care Coordination Network
<table>
<thead>
<tr>
<th>22,000+</th>
<th>Post-Acute &amp; Senior Living Provider Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,300+</td>
<td>Hospitals</td>
</tr>
<tr>
<td>1,000s</td>
<td>Ambulatory Practices and ACOs</td>
</tr>
<tr>
<td>100%</td>
<td>National Health Plans</td>
</tr>
<tr>
<td>97%</td>
<td>US hospitals discharge to PointClickCare users</td>
</tr>
<tr>
<td>99%+</td>
<td>Customer retention rate</td>
</tr>
<tr>
<td>SaaS</td>
<td>Software as a Service</td>
</tr>
</tbody>
</table>

Largest Combined Acute and Post-Acute Care Network in North America
SNFs available with Collective Medical and PointClickCare network

Hospitals available with network

Broad and Activate Massachusetts Network

- **SNFs Using PCC/Collective**: 76%
- **Short-term Acute Care Hospitals Connected**: 95%
- **Health Plan Covered Lives**: 80%

Collective Medical
A PointClickCare Company
Knowing where your patient is isn’t enough.

The relationship between acute and post-acute must evolve.

Information
Where is my patient?

Action
How are they doing? When should I act?
Risk / Trigger Scenario: Chief Complaint or Diagnosis of Asthma

Member Sally Presents at Any Hospital on EDIE Network With Asthma

Risk based notifications triggered

Notification sent to PCP for follow-up visit

Valley Health Center

Health Plan / ACO Risk Criteria triggered:
- ED HU with ED encounter

Health Plan Risk Criteria triggered:
- Health Homes Eligible Identified
- Health Home Alerted

Health Plan Case Manager notified that member of high utilizer group is in the ED

Health Home notified and engages
- Follow-up appointment scheduled
- Plan of care created

Mount Rogers Mental Health care team is notified via preferred method of ED visit, and is able to follow-up and/or contribute to plan of care
Success Story: Sturdy Memorial Hospital in Attleboro, MA—*The value of coordinating care through real-time alerts and collaborating with BH Community Partners.*

Behavioral health patient with numerous ED encounters (48 times in year prior to Collective implementation)

- ED care team spoke with the BHCP care coordinator and put a plan in place: Whenever this patient presents to the ED, contact the BHCP immediately instead of contacting the ED’s behavioral health team.
- Details about this plan were added to the patient’s Insights on the Collective Platform, ensuring delivery to any ED on the Collective Network, immediately upon presentation.
- Over the following nine months after adding this Insight, the patient had only 12 ED encounters—a reduction of 75%.

*The team at Sturdy Memorial significantly reduced the patient’s ED visits—and when he did present, lengths of stay were reduced from more-than-six hours to less-than-one hour in most cases, as his care manager intervened shortly after his arrivals in the ED.*
ADT-BASED CARE COLLABORATION NETWORK

CollectiveMedical offers a cost-effective solution that ensures hospitals, psychiatric hospitals, and critical access hospitals are completely compliant, without the need for any additional intermediary service providers.

CollectiveMedical combines data from sources spanning the care continuum, including ADT, continuity of care documents (CCD), claims data, prescription drug histories (PDMP/PMP), imaging, and more, to give deep insights into patients’ activities.

CollectiveMedical also supports the CMS-9115-F ADT alert requirements.

Contact CollectiveMedical for questions and/or to subscribe to submitting ADTs or receiving ENS alerts via CollectiveMedical's ENS solution:

Website: collectivemedical.com

Solution: collectivemedical.com/impact/adt-based-care-collaboration/


Contact: David Kimball
Tel: 801-473-8848
Email: David.Kimball@collectivemedical.com
THANK YOU
Introduction to ENS

Massachusetts Statewide ENS Framework

Framework Advantages

CMS Interoperability and Patient Access Rule (CMS-9115-F)

CollectiveMedical Presentation

PatientPing Presentation

Q & A
PatientPing Team

Elizabeth Weber
Manager, Strategic Accounts – New England
New England PatientPing Customer Main Point of Contact

Kevin Field
VP, Hospital & Health System Growth – National
Oversees Account Management and Customer Growth

Sarah Ludlow, MBA, MPH
Manager, Partnerships - Regional Strategy
Project Manager for EOHHS Certified ENS Vendor Program

Jitin Asnaani
VP, Partnerships & Government Affairs
Oversees Partnership Activity with States, HIEs and HIT Vendors
What is PatientPing?

PatientPing is an Enterprise Care Collaboration Platform for your health system powered by the largest, most engaged care-coordination network in healthcare.

National Network

- 5,000+ Post-Acutes
- 1,000+ Hospitals
- 43.2M+ Patients Supported
Patient Profile View

PatientPing

Patricia Sanchez-Liu 48yrs, Female

DOB: 09/24/1968
Current Location: DB 1468 Westside
Current Billing: Blue Cross Blue Shield Anytown State

Patient ID: 125322
Last Encounter Insurance(s): Blue Cross Blue Shield Anytown State, Medicaid, Insurance Company XYZ

Patient Address: 32 Anytown Street, #5
Anytown, ST 01234

Recent Inpatient Stay: Last discharged from the inpatient setting 10/10/18 (14 days ago) at Downtown Medical Hospital. See Encounter Summary

Recent SNF Stay: Last SNF event on 10/23/19 (DISCHARGE from Good Hope Center, Diagnosis: Unavailable). See Encounter Summary

Care Team

**PROGRAM**
Orchard Valley High-Risk Care
Orchard Valley ACO

Lisa Miller
Care Coordinator

Phone: (787) 555-1222
Email: lisamiller@email.com
Fax: (787) 555-1225

**PROGRAM**
Orchard Valley High-Risk Care
Orchard Valley ACO

Thomas Simpson
Admission and Discharge Care Coordinator

Phone: (787) 555-1222
Email: thomas.simpson@email.com
Fax: (787) 555-1225

Care Instructions

**Orchard Valley ACO**

Admit Instructions
1) Please call ACO care coordinator 2 days prior to patient’s expected discharge.

2) Please direct all questions regarding this patient to the ACO care coordinator.

Discharge Instructions
1) Upon discharge, please send a fax to the PCP’s office with the following discharge summary, discharge instruction sheet and
PATIENTPING – THE LOCAL VENDOR

Direct to Provider Connectivity

New England Statistics:

- 10 of 16 MASS HEALTH ACOS
- 12 of 15 MEDICARE ACOS
- ~1,000+ AVG DAILY USERS & ~3000 AVG MONTHLY USERS

- 88.7% acute beds in New England
- 972 post-acute partners
  - 610+ SNFs
  - 340+ home health & hospices
  - 40+ community providers
- Integrations with all major post-acute EHRs

Post-Acute
Hospital

Massachusetts League of Community Health Centers
BAYADA Home Health Care
Kindred Healthcare
WHITTIER Health Network
REAL-TIME ADT NOTIFICATIONS: PINGS

A History of Success

Deliver Shared Savings
$500M
Savings from ACOs using PatientPing in 2019
Based on 2019 MSSP ACO performance results

Reduce Readmissions
24%
Reduced readmissions

Identify High ED Utilization
14x
Increase in ED high-utilizers identified

Improve Home Care Efficiency
$3,500
Weekly savings from improved resource management

Succeed in Medicaid VBC
Holistic treatment and care coordination for all populations
Federally Qualified Health Centers, Nationwide

Payer-Agnostic
+ Program-Agnostic

Driving outcomes for all patient populations
Success in Community Care Transitions

“**Timeliness** is an essential component of successful care. With PatientPing, we no longer have to seek out our patients as they go through the continuum…the automated, immediate notifications let Residential be proactive in our outreach and ready as soon as we are needed for a smoother transition home.”

David Curtis, CEO
Home Health, Residential Healthcare Group

“We care for elderly, frail, and homebound patients…these patients can experience an exacerbation, panic, and call 911 which lands them back in the hospital. Locating these patients through PatientPing, having the opportunity to coordinate care, is critically important. PatientPing has increased the amount of information he have on our patients tenfold.”

Alex Binder, VP
Visiting Nurse Association Health Group

“Prior to PatientPing, we did not have a centralized system to alert us about when and where patients were receiving care across the state. PatientPing is a piece of the puzzle that we were sorely missing, and I’m excited for its impact in helping our community health centers provide improved patient-centered care.”

Diana Erani, COO and SVP
Massachusetts League of Community Health Centers

PatientPing played a pivotal role in the early development of our care coordination model. We saw early on the value that the platform provided; and [we] were able to establish care team workflows that best addressed the needs of our patients.

Olivia Masini, Associate Director of Clinical Services
Heartland Alliance Health

PATIENTPING.COM
Compass Medical, PC

Compass Medical, PC is a multi-specialty medical organization providing care to patients of all ages at 6 different locations across southeastern MA. Compass Medical has grown over the past 23 years to become one of the top healthcare providers South of Boston.

90+ Healthcare Providers

550+ Team members

6 Clinical Practice Sites

80K Patient Population
COVID-19 caused a 52% decrease in appointment volumes in March; Telehealth (audio & video) enabled appointment volumes to quickly rebound in April and have remained steady through June.
Real-Time Discharge Visibility Drives 500% Increase in TCM Follow-Ups

Compass Medical: TCM Work RVUs Billed (Jan – June 2020)
The PatientPing Team – What comes next

Team of Ping guides to support your organization’s early success and lasting impact

Account Management Team – Elizabeth Weber
• Main point of contact
• Email address: ewebber@patientping.com
• Partners with hospitals & health systems to co-develop solutions tailored toward organizational priorities

Support Team
“Your support team is incredible - I’ve always had a wonderful experience with them and how they treat us. Trust me, I work with a lot of support resources (including our own internal help desk) and no one is as easy and effective to work with as you all.”

• KLAS acknowledges PatientPing’s top strengths to be customer-focused services, responsive support functionalities, and a key facilitator of care coordination to reduce readmissions. Also, PatientPing users strongly endorse the platform for their peers as the company received an 8.88 rating on a scale of 1-9.
Thank you!
Introduction to ENS

Massachusetts Statewide ENS Framework

Framework Advantages

CMS Interoperability and Patient Access Rule (CMS-9115-F)

CollectiveMedical Presentation

PatientPing Presentation

Q & A
Thank you!

The Massachusetts Health Information Highway (Mass HIway)

Phone: 1.855.MA-HIWAY (1.855.624.4929)
Email for General Inquires: MassHIway@state.ma.us
Email for Technical Support: MassHIwaySupport@state.ma.us
Website: www.MassHIway.net
ENS

- Is a specialized form of Health Information Exchange (HIE) that occurs after ADT events
- Relies on an ENS system to automate the ADT alert distribution
- Enables efficient transfers of care to reduce readmissions and total cost of care
- Provides secure communication solution between care teams at different organizations
- Used by PCPs, hospitals, payers, and others accountable for coordinating patient care
- Used by 3,000 organizations across the country that send and/or receive notifications
- First pioneered in 2013 to leverage available patient data from HL7 ADT messages
  - (HL7 ADT = Health Level Seven, Admission, Discharge, Transfer)
A patient visits an Acute Care Hospital for an emergency medical issue.

After the patient is treated and discharged, the hospital sends an ADT alert to the Statewide ENS Framework, which results in a notification to a home health agency that serves the same patient.

The agency acts to provide follow-up care and schedules a home care visits as needed.
Resources

https://www.healthshareexchange.org/sites/default/files/11.20.17_ens_overview_final.pdf

https://crisphealth.org/services/encounter-notification-services-ens/

https://lanesla.org/encounter-notification-services/

https://ainq.com/capabilities/software/ens-encounter-notification-service/

https://www.commonwellalliance.org/news-center/commonwell-blog/event-notifications-how-commonwell-is-broadening-its-services/