A LOOK INSIDE
Closing the Loop in Vermont and Beyond

Dear Valued Partner,

This month, we're pleased to highlight PatientPing, a software platform that utilizes a simple technology – a Ping. Providers can coordinate care through real-time notifications referred to as "pings" when patients are admitted, discharged, or transferred from a health care facility.* For example, a patient is on vacation in North Carolina, has an acute episode, and lands in the emergency room. The patient's medical home in Vermont gets "pinged" of this admission real-time. The patient's provider can then anticipate necessary post-acute care when the patient returns home. Federally qualified health centers and other primary care practices use this tool as part of their work in preventing readmissions.

Initially facilitated in April 2016 by Community Health Accountable Care, LLC (CHAC), PatientPing is currently used by eight CHAC health centers. Notably, three of these organizations have chosen to expand the use of this powerful tool by implementing it for their entire patient panel. With patient data being sourced from Vermont's Health Information Exchange and PatientPing's network, Vermont providers receive timely notifications from 100% of Vermont hospitals and over 2,000 facilities nationwide.

**Using a proprietary algorithm, PatientPing generates Pings by cross-referencing patient lists submitted by FQHCs against patient events at participating admitting facilities.*

A CARE COORDINATION COMMUNITY

"It's setting a precedent to patients that they don't always need to go to the ER. They can call us."

– Kielee Pelland, RN and Quality Specialist
Mountain Health Center

MOUNTAIN HEALTH CENTER

PATIENT POPULATION ON PLATFORM: 3,381
TOTAL PINGS: 2,290+ (9 months on platform)
BENEFIT: Mountain Health Center uses the platform to track how often and how many patients are being admitted into the ER. From this data, they track their high ER utilizers and become more familiar with their patients' behaviors and, in turn, are able to provide better and, at times, preemptive care.

NORTHERN TIER CENTER FOR HEALTH

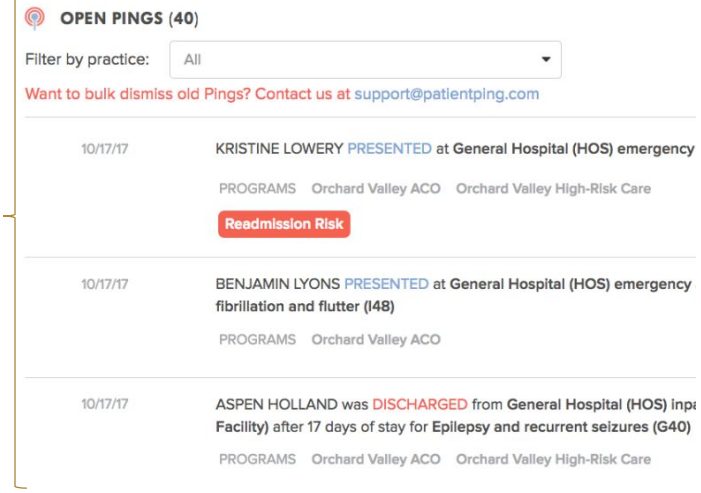
PATIENT POPULATION ON PLATFORM: 8,873
TOTAL PINGS: OVER 10,970+ (8 months on platform)
BENEFIT: NoTCH's Care Coordination Department is able to easily identify patients who are discharged to Skilled Nursing Homes and home health agencies. The platform is an invaluable tool for coordinating care after acute episodes for their aging population.

THE HEALTH CENTER

PATIENT POPULATION ON PLATFORM: 4,422
TOTAL PINGS: 11,730+ (11 months on platform)
BENEFIT: The Health Center staff is able to know immediately when a patient has been admitted to or discharged from a hospital. Providers can connect directly with the hospital to gather pertinent details and summary reports. A follow-up care plan can be created early in the process.

DASHBOARD

Fictitious data for illustration purposes only



Community Health Accountable Care LLC
Transitioning Our Communities for Better Health

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