KPN

Knowledge Performance Now

KPN Health, Inc.
TMSI Endorsed Partner
TORCH Spring Conference
Hyatt Regency Dallas

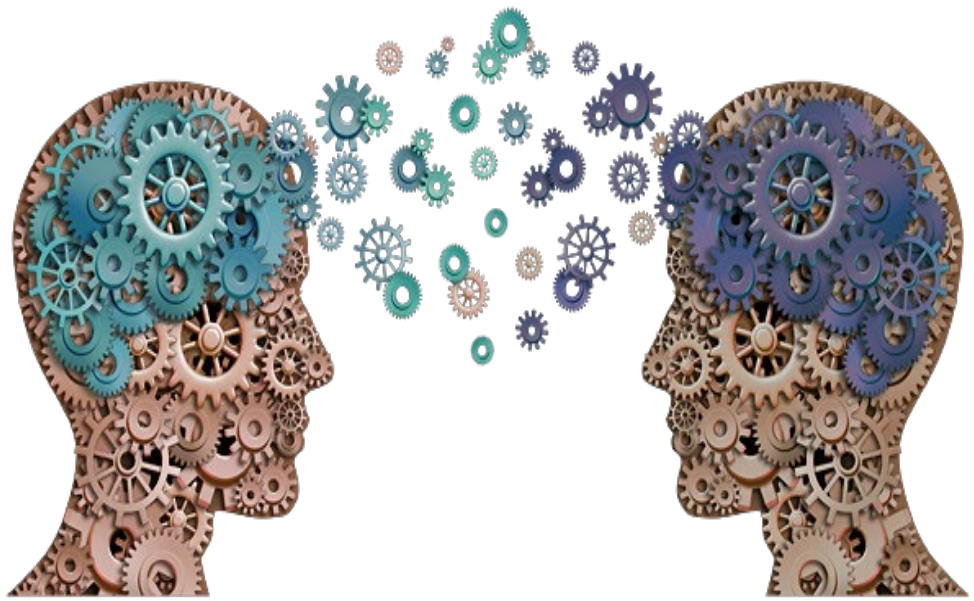
March 30 - April 1, 2021

About KPN Health Inc.

- KPN Health provides IT-based software solutions and a wide range of cross-industry strategic business and operational services, leveraging existing infrastructure and existing technology landscapes based on community health needs. These methodologies offer a faster roadmap to deployment for communities and health care providers.

- KPN Health's *solution sets* and *dashboards* provide physicians with actionable insights into cost, quality, and utilization that influence patient behavior for improved health and financial performance outcomes and improve clinical and operational performance and financial reimbursements.

For more information, visit www.kpnhealth.com



About This Session...

- Accessibility to vital patient information as patients move throughout the continuum of care.
- COVID-19 and healthcare costs have exposed the need for greater care collaboration and informed decision-making at the **“point of care”** and the population level.

Key “Take-Aways”

- Visualize data empowerment.
- Recall how the use of KPN Optimize® Point of Care generates savings, summarizes solid clinical decision support and increases financial reimbursement.
- Utilize care transition to reduce readmissions and overall cost to the system.

KPN Health | Panel of Experts

Kim Pichanick, CEO
kim.Pichanick@kpnadvisors.com

Kim has concentrated her focus in the healthcare industry with a hyper focus on the development of technologies for clinical, operational and financial aspects of healthcare to reduce healthcare costs and the delivery of improved patient care.

Kim holds a BS in Political Science from Troy University; and has completed an Executive Healthcare Leadership Program from Harvard T.H. Chan School of Public Health.

David Hultsman, SVP CITO
David.hultsman@kpnadvisors.com

David is a senior executive with more than 25 years of Fortune 250 experience, having served as Vice President and CIO/CTO for major airlines, banking software development, telecommunications services, oil/gas energy corporations, and health services.

David Mr. has led significant M&A projects, long-range strategy development, global infrastructure optimization and technology innovation initiatives.

David holds an MBA from The University of Dallas, an MA, Psychology and a BA, Social Sciences, from Southern Methodist University.

Gene Hicks, SVP, Chief Strategy Officer
gene.hicks@kpnadvisors.com

Gene has over 25 years in senior executive positions both inside and outside of the healthcare industry focused on commercial strategies and financial success. Gene is an experienced strategist delivering deep knowledge and expertise in establishing value and improving financial performance through increasing revenue and measuring and managing cost.

Gene holds a BA in Economics from Davidson College and completed the Accounting Sequence at UNC Charlotte.

Don Navarro, Executive Chairman
Don.navarri@kpnadvisors.com

A seasoned business executive who is recognized for his leadership and innovative abilities in complex business situations in many industries.

Most recently, Don has concentrated on technology-based companies serving the healthcare industry.

Brandy Killion, Sr. Advisor, RN, BSN, MS
Brandy.Killion@kpnadvisors.com

Brandy is an experienced Vice President Of Clinical Informatics and Quality with a demonstrated history of working in the healthcare industry. Skilled in Clinical Informatics, Quality Metrics and Reporting SME, At Risk clinical and financial bundle management, EMR data interoperability and integration and population health management.

She holds a Master of Science, Health Policy /Health Care Administration/Management, George Mason University – College of Health and Human Services, Bachelor of Science, Registered Nursing, Millikin University. She is currently enrolled in the FNP/DNP program at George Mason University

Edward Bujold, MD, FAAFP
www.bujoldmd.com

Dr. Bujold serves as Sr. Physician Advisor where he brings his extensive knowledge and experience as a practicing family physician to help guide development of KPN Health's Solution Sets and services designed to aid healthcare professionals in achieving the Triple Aim – improved quality metrics, reduced healthcare costs and more satisfied patients.

Dr. Bujold received his Doctor of Medicine Degree (MD), from Wayne State University and his BS, Zoology/Animal Biology ,from University of Michigan.

State of Rural Hospitals Today

Technology Innovation

DATA TYPES

DATA QUALITY

DATA SOURCES

DATA AGGREGATION

DATA EXTRACTION

UNDERSTANDING OF COST AND UTILIZATION

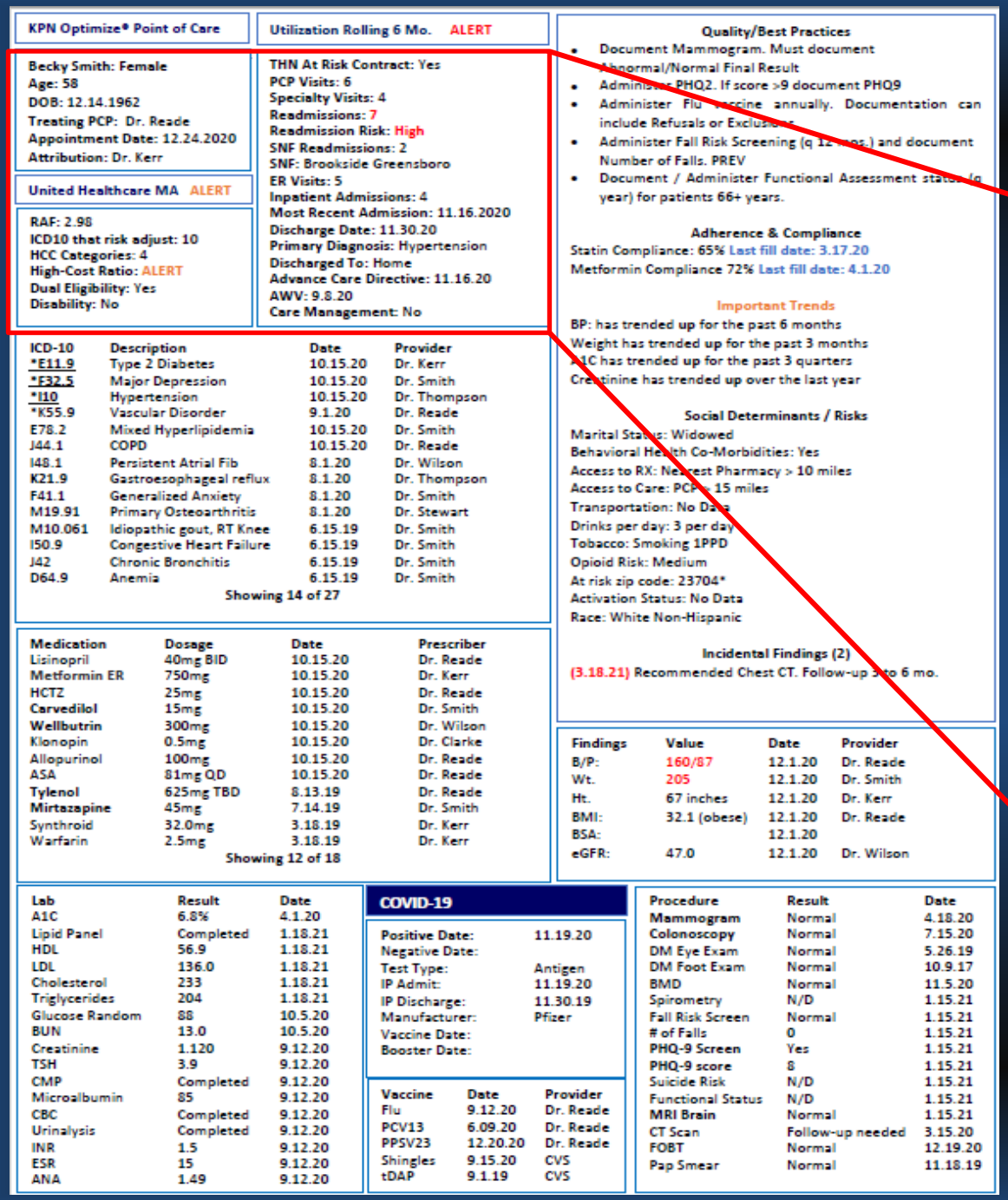
COMPLETE VIEW OF THE PATIENT'S HEALTH

IMPROVED INSIGHTS THROUGH MORE EXTENSIVE DATA

REVENUE OPTIMIZATION AND IMPROVED CARE

KPN POC: Power

- Bring patient behaviors to the forefront
- Manage adherence
- Highlight cost, utilization and significant findings
- Enables providers to view patient outcomes through a different lens
- Streamlines patient engagement
- Helps drive outcomes beneficial to patients, providers and healthcare organizations
- Displays risk elements and drivers



KPN Optimize® Point of Care

Becky Smith: Female
Age: 58
DOB: 12.14.1962
Treating PCP: Dr. Reade
Appointment Date: 12.24.2020
Attribution: Dr. Kerr

United Healthcare MA ALERT

RAF: 2.98
ICD10 that risk adjust: 10
HCC Categories: 4
High-Cost Ratio: ALERT
Dual Eligibility: Yes
Disability: No

Utilization Rolling 6 Mo. ALERT

THN At Risk Contract: Yes
PCP Visits: 6
Specialty Visits: 4
Readmissions: 7
Readmission Risk: High
SNF Readmissions: 2
SNF: Brookside Greensboro
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Most Recent Admission: 11.16.2020
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Primary Diagnosis: Hypertension
Discharged To: Home
Advance Care Directive: 11.16.20
AWV: 9.8.20
Care Management: No

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TSH	3.9	9.12.20
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- Administer Fall Risk Screening (q 12 mos.) and document Number of Falls. PREV
- Document / Administer Functional Assessment status (q year) for patients 66+ years.

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Metformin Compliance 72% Last fill date: 4.1.20

Important Trends

BP: has trended up for the past 6 months
Weight has trended up for the past 3 months
A1C has trended up for the past 3 quarters
Creatinine has trended up over the last year

Social Determinants / Risks

Marital Status: Widowed
Behavioral Health Co-Morbidities: Yes
Access to RX: Nearest Pharmacy > 10 miles
Access to Care: PCP > 15 miles
Transportation: No Data
Drinks per day: 3 per day
Tobacco: Smoking 1PPD
Opioid Risk: Medium
At risk zip code: 23704*
Activation Status: No Data
Race: White Non-Hispanic

Incidental Findings (2)

(3.18.21) Recommended Chest CT. Follow-up 3 to 6 mo.

Findings	Value	Date	Provider
B/P:	160/87	12.1.20	Dr. Reade
Wt.	205	12.1.20	Dr. Smith
Ht.	67 inches	12.1.20	Dr. Kerr
BMI:	32.1 (obese)	12.1.20	Dr. Reade
BSA:		12.1.20	
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Positive Date:	11.19.20
Negative Date:	
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DM Foot Exam	Normal	10.9.17
BMD	Normal	11.5.20
Spirometry	N/D	1.15.21
Fall Risk Screen	Normal	1.15.21
# of Falls	0	1.15.21
PHQ-9 Screen	Yes	1.15.21
PHQ-9 score	8	1.15.21
Suicide Risk	N/D	1.15.21
Functional Status	N/D	1.15.21
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Statin Compliance: 65% Last fill date: 3.17.20
Metformin Compliance 72% Last fill date: 4.1.20

Important Trends

BP: has trended **up** for the past 6 months
Weight has trended **up** for the past 3 months
A1C has trended **up** for the past 3 quarters
Creatinine has trended **up** over the last year

Social Determinants / Risks

Marital Status: Widowed
Behavioral Health Co-Morbidities: Yes
Access to RX: Nearest Pharmacy > 10 miles
Access to Care: PCP > 15 miles
Transportation: No Data
Drinks per day: 3 per day
Tobacco: Smoking 1PPD
Opioid Risk: Medium
At risk zip code: 23704*
Activation Status: No Data
Race: White Non-Hispanic

Incidental Findings (2)

(3.18.21) Recommended Chest CT. Follow-up 3 to 6 mo.

Manage Care, Generate New Revenue & Reduce Cost

Data | Reduce Hospital Readmissions

- Readmission within 30 days = hospital absorbs the cost
- National average cost of in-patient stay = $12k

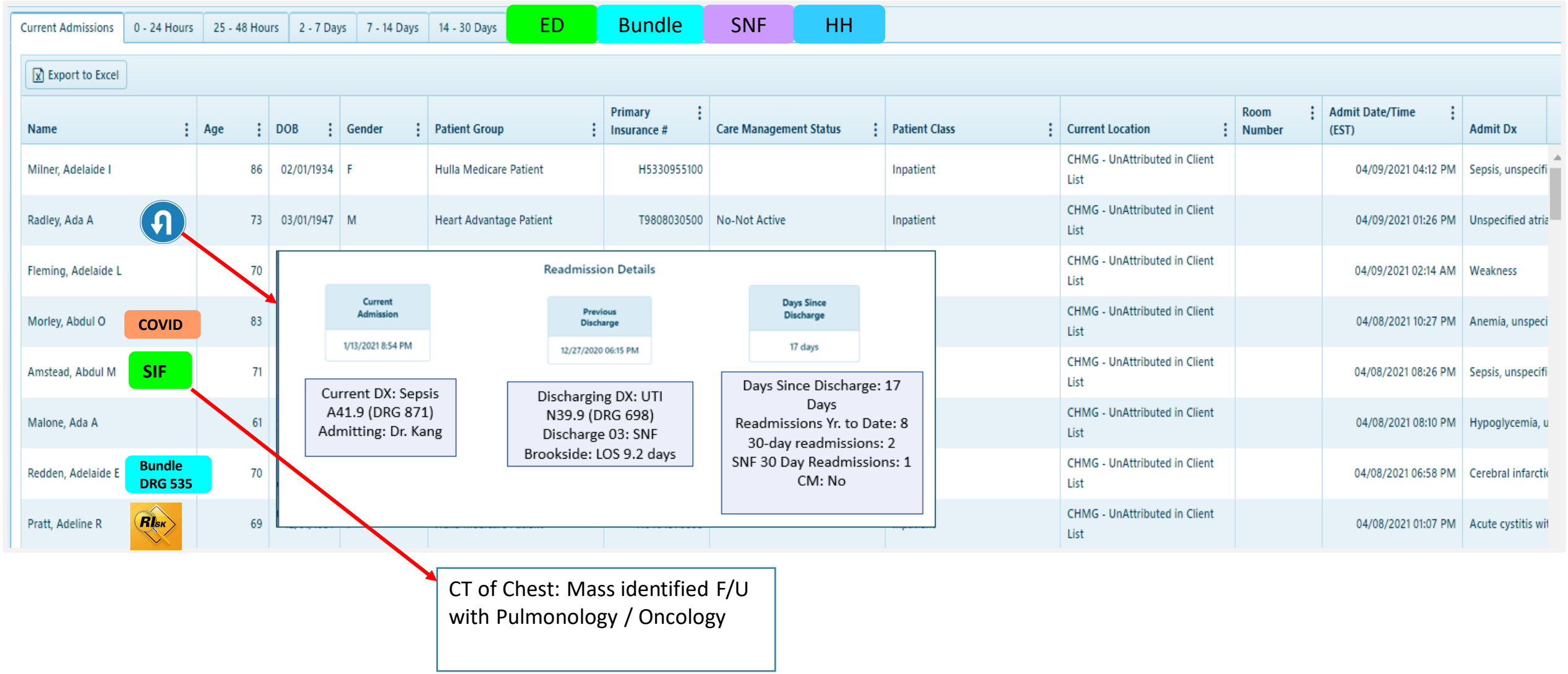
Data | Generate New Revenue

- $7-$10 per Encounter at the *"Point of Care"*
- Remote Patient Monitoring

Data | Improve Margin

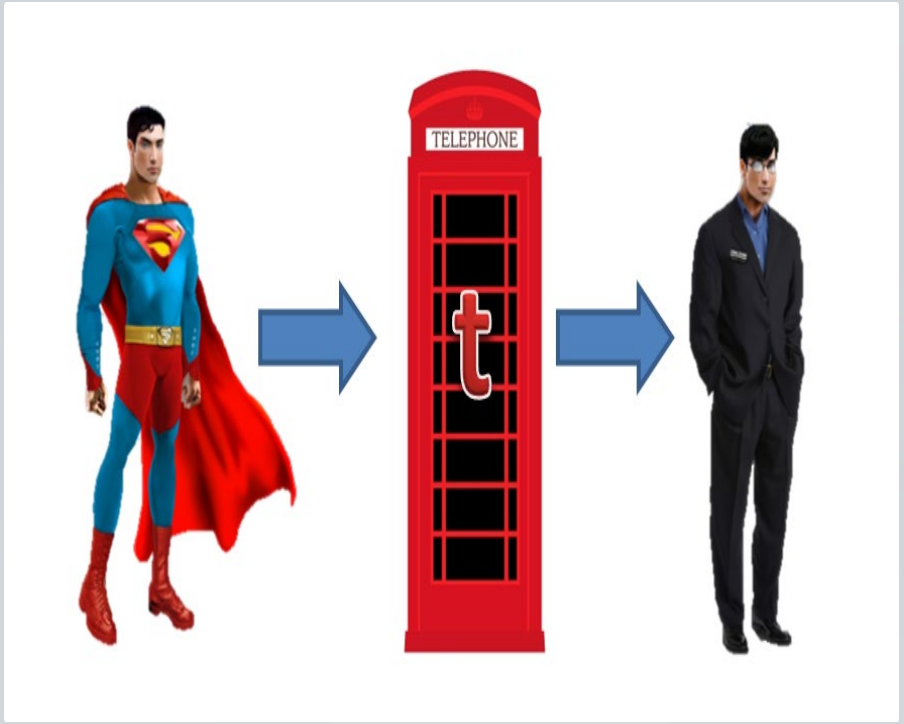
- Expanded Services
  - Critical Access Hospitals - Increase from 2.5% to 3.2%
  - Behavioral Health (Underserved in the Rural Setting)
  - Telehealth (In Partnership with Area Providers)
- Expanded Reach
- Improved Provider Retention

TOC with Post Acute Support



CT of Chest: Mass identified F/U with Pulmonology / Oncology

Ed Bujold, MD, FAAFP



- Independent, Solo Practice in Western North Carolina for 36 years
- Practice includes all aspects of medical care except obstetrics
- Practice continues to see inpatients
- Practice is a member of a Clinical Integrated Network (CIN) and an Accountable Care Organization (ACO)
- Practice also works in the Addiction Medicine Space
- Many Years of Experience on the Hospital Board of my Hospital System (Blueridge Healthcare which is part of Atrium Health in Charlotte, NC)

Patient Centered Medical Home and Team Based Approach to Healthcare

Changing the Culture/Team Members

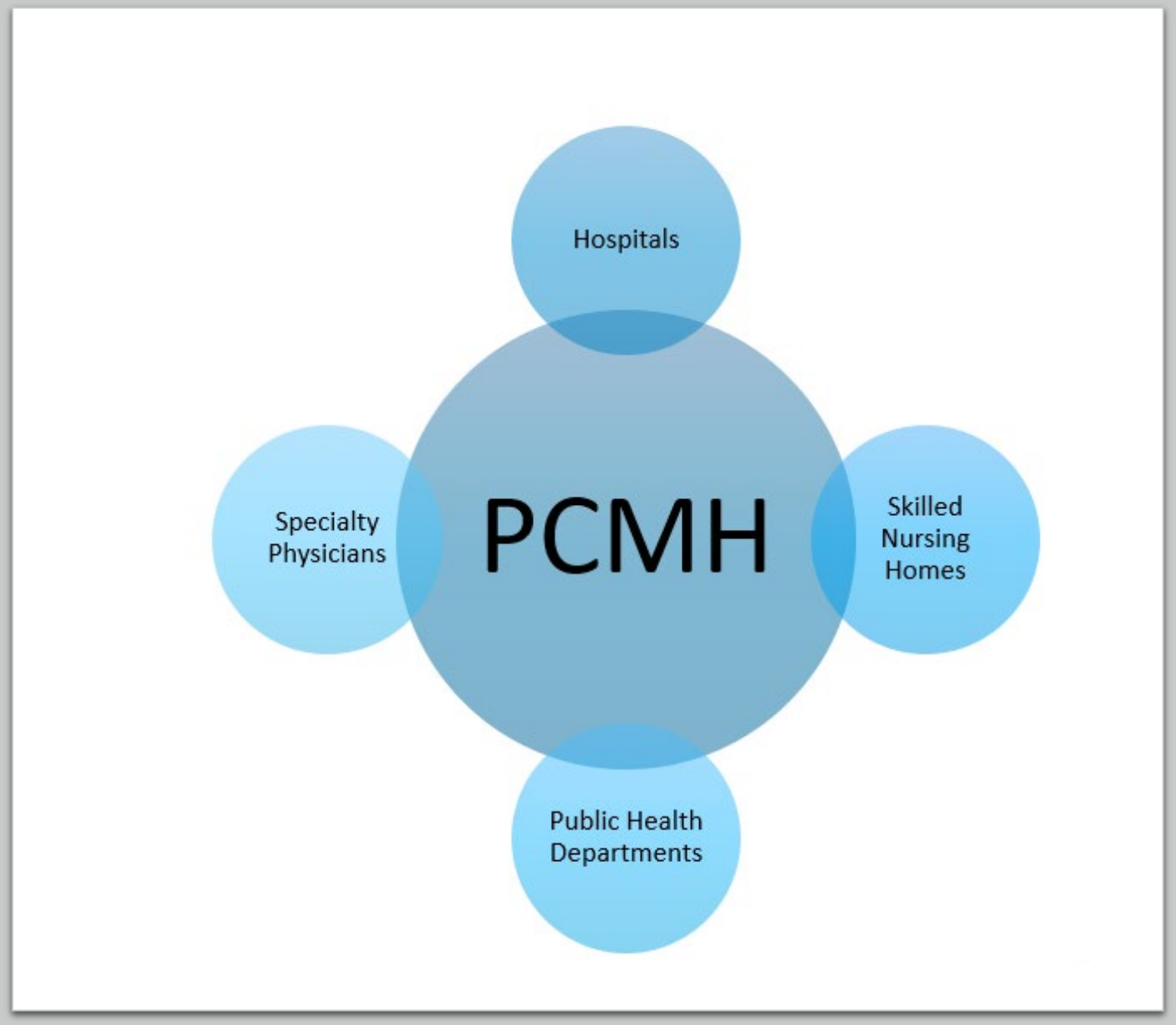
- Embedded Mental Health, PharmD, Physical Therapist, Dietician, Social Worker

Moving towards Value Based Healthcare

- Chronic Disease Management, Preventative Care, Filling in Gaps in Care, Transitions to Care from Hospitals and Nursing Homes, MIPS/MACRA. AWV

KPN Optimize® Point of Care Report

- Extraction of Data Every Night from Electronic Health Record



Our Team Success

80% Decrease in Hospital Admissions

- **Use of the hospital infusion center**
- **IV fluids, IV antibiotics, IV steroids, IV diuretics**

Appropriate Use of Hospice

- **75% of all health care costs occur in the last 6 months of a patient's life**

Home health

- **Use of our Virtual Hospital during the COVID Pandemic**

Decreased Utilization of Emergency Room with Same Day Appts

Information Systems with a Team Approach

- **Accurate, Useful and Up to Date Providing Information at the Point of Care**
- **Cost analysis at the Point of Care**
  - **Who are your High-Cost Patients?**
  - **What are the Drivers of High Cost?**
- **Prescription Pharmacy Fill Rates**
- **Over $100,000 of additional income generated from filling gaps in care and shared savings.**

- 64-year-old Homeless White Female
- COPD, Diabetes, Oxygen Dependent
- No Health Insurance
- Averages Two ER Admissions per Week and Twenty Hospital Admissions over a two-year period
- Cost to the Hospital: $760,000 per year

Hospital Found and Paid for Low Income Housing

Social Worker Enrolled Patient in Medicaid

Hospital Introduced Patient to a Primary Care Physician in Patient Centered Medical Home

Within 6 Months, Utilizing Clinical Guidelines, Chronic Diseases were well controlled

Over the next 2 years, patient had one hospitalization per year and no ER visits

Total Cost to the Hospital System over the next two years: $32,000 per year

KPN

Knowledge Performance Now

Thank You for Attending

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