TAKE CONTROL
OF YOUR ENTIRE PATIENT COMMUNITY

Primaris' three-step population health solution

ONE : Operational Data Analysis Opportunities
We use a patent pending software program to identity gaps and opportunities to better manage ACO membership. Using our proven outcomes experience in population health, we identify actionable opportunities to enhance members' quality of care, plus improve the ACO benchmark to accurately reflect the illness severity of members. This process does not require data input or research time by physicians or radical changes to the physician's office flow. Our actionable information significantly enhances the ACO's potential for achieving a CMS bonus payment.

TWO : Documentation and Coding Training
Primaris provides training on CMS Hierarchical Condition Category (HCC) model and the patient chart documentation requirements to support compliant ICD diagnosis coding and billing. Training sessions encompass gaps and opportunities identified in reports from step one. The goal of the training is to instruct primary care physicians, clinical staff and office administration on how to accurately code a diagnosis to optimize population health management (quality) and financial performance.

THREE : Auditing and Performance Improvement Consulting
Primaris provides project management as well as auditing and retraining to ensure that the clinical documentation training was retained and being employed by the physicians and practice managers. Primaris can also provide GPRO benchmarking, additional abstraction services and performance improvement consulting around Physician Quality Reporting System (PQRS).

Improve the quality of care for individual patients and populations

As value-based care delivery models — like accountable care organizations (ACOs) — enter the mainstream of healthcare, managing population health and risk stratification becomes more important than ever. Healthcare organizations working to change their cost structure and improve outcomes must understand the health risk of all patient populations while focusing on high-risk patients as well as addressing preventive and chronic care needs of every patient.

Primaris' population health solution helps providers analyze and categorize patient population by risk level to identify gaps in care. We then help you look at documentation, coding and performance improvement opportunities to better manage population health, thus improving both quality and cost.

IT'S ALL ABOUT TIME

TIME, the Primaris Healthcare Improvement Model, comprises four areas of focus proven to improve care coordination:

1. Thresholds for Success
The first step in our healthcare improvement model is to identify the success thresholds – or the minimum acceptable performance standards you must achieve – in order to receive your monetary incentives for improving and coordinating healthcare. We also gather baseline performance data to evaluate how you align with the often pre-determined success thresholds. How much improvement is required to meet and exceed the success thresholds?

2. Improvement Strategies
Once we've determined where you stand, we focus on developing improvement strategies that will enable you to close the gaps in the quality and efficiency of care across your healthcare organization. We use this knowledge to devise a strategy tailored to address your specific challenges, drive quality improvements and cost reductions. Our goal is to help you achieve all of the thresholds for success in today's performance-driven healthcare system.

3. Measures for Goal Attainment
Most healthcare organizations have a lot of work to do, and success doesn't happen overnight. We focus on multi-year goal setting that enables healthcare organizations to drive incremental improvement over time to achieve all success thresholds. Our measures for goal attainment help you increase achievement and close gaps so you can cross the success threshold, avoid penalties and increase monetary incentive revenues.
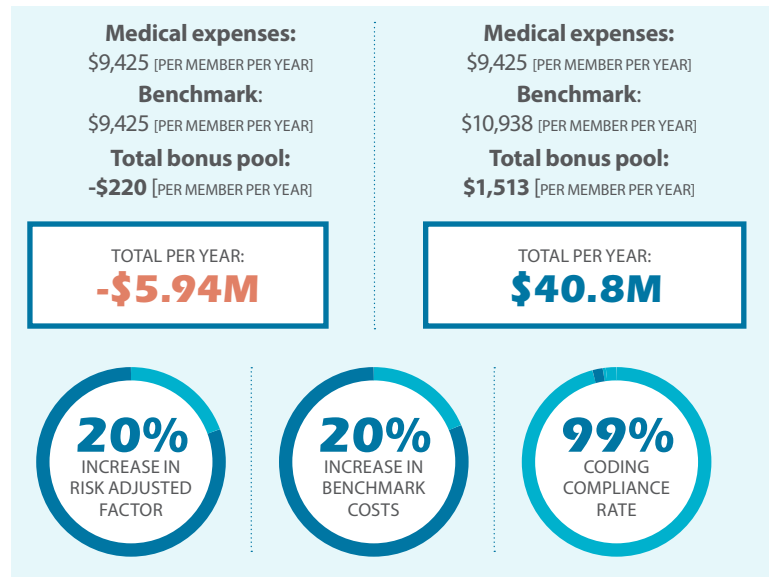
4. Execution and Evaluation
From processes and procedures, to workflows, to training, to documentation, to office design, to technology or any other improvement strategy, we combine implementation with ongoing evaluation to drive measureable healthcare improvements and cost reductions.

THRESHOLDS FOR SUCCESS

PRACTICING POPULATION HEALTH PAYS OFF

DOCTOR TO PATIENT RATIO:
1:675

⚕ EQUALS 50 PATIENTS

Within three years of practicing Population Health, healthcare facilities could see the following improvemnents:
(ASSUMING A 0.16 ENHANCEMENT ON RISK ADJUSTED FACTOR IN YEAR 3 OF AN ACO CONTRACT)

Medical expenses: $9,425 [PER MEMBER PER YEAR]	**Medical expenses:** $9,425 [PER MEMBER PER YEAR]
Benchmark: $9,425 [PER MEMBER PER YEAR]	**Benchmark**: $10,938 [PER MEMBER PER YEAR]
Total bonus pool: -$220 [PER MEMBER PER YEAR]	**Total bonus pool:** $1,513 [PER MEMBER PER YEAR]
TOTAL PER YEAR: **-$5.94M**	TOTAL PER YEAR: **$40.8M**

20% INCREASE IN RISK ADJUSTED FACTOR

20% INCREASE IN BENCHMARK COSTS

99% CODING COMPLIANCE RATE

KNOWING THE BENEFITS

Better Patient Experiences
By addressing all of a patient's conditions, a tighter, trusting relationship is developed with the physician.

Increased Revenue
Train staff on accurately documenting and coding to optimize population health management and financial performance. Analysis of one ACO identified 40% of beneficiaries had potential "dropped" and/or "suspect" diagnoses and could potentially increase their ACO benchmark by $605 per member per year.

Fewer Hospital Admissions and Readmissions
Keep patients out of the E.R. and reduce hospital visits by identifying problems before they require an inpatient stay.

Improved Clinical Outcomes
Identify and track opportunities to impact patient's chronic conditions and intervene prior to the condition manifesting itself into a catastrophic event. Monitor and manage effectiveness of improvement initiatives to ensure quality outcomes.

Reduced Medical Costs
Identify and manage high-risk patients and populations through the use of evidence-based care plans.

Higher Quality of Care
Treat patients holistically and collaboratively for all chronic conditions, rather than episodically by individual physicians for each system at an isolated office visit.