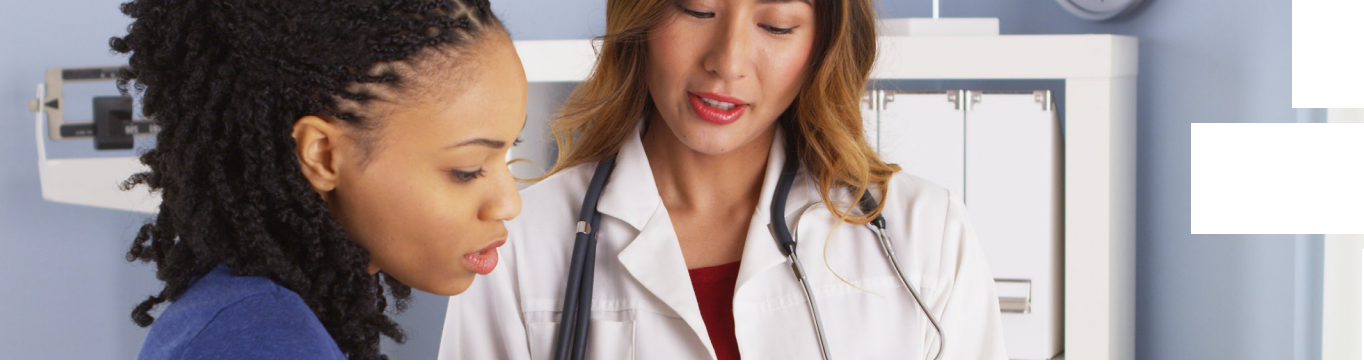

CASE STUDY

Brevard Health Alliance Reduces Readmissions and Gaps in Care Using Encounter Alerts

Brevard Health Alliance is a Federally Qualified Health Center (FQHC) in Florida using the Encounter Notification Service® (ENS®), powered by Audacious Inquiry, to provide timely follow-up and education with the goal of reducing readmissions and improving care for the uninsured and underinsured.

FQHC Providing Care for Underserved Populations in Florida

Brevard Health Alliance is a Federally Qualified Health Center (FQHC) in Brevard County, Florida, that serves over 88,900 patients, regardless of their ability to pay. Brevard Health Alliance provides comprehensive medical services, including primary care, behavioral health, dental care, medication management, and referral services. FQHCs that are certified by the Centers for Medicare and Medicaid (CMS) receive funding and malpractice coverage for treating underserved populations that may be uninsured, underinsured, or otherwise lack access to quality care.

The Challenge: Preventing Readmissions

One of the major challenges facing health systems at present is preventing hospital readmissions. According to National Center for Health Statistics, hospital care makes up roughly 33% of the total annual healthcare expenditure and represented more than $1.2 trillion in spending in 2018 alone. For this reason, reducing preventable hospitalizations and readmissions has become a top priority for hospitals, payers and policymakers.

Knowing when a patient is hospitalized is crucial for allowing care managers to intervene and provide vital follow-up care education. When a patient is discharged, follow-up care and education is integral to ensuring that the patient's healthcare needs continue to be met.

If symptoms continue, this education helps patients identify if they can be treated by their physician or at an urgent care and avoid unnecessary hospital utilization. In the past, providers and care managers have had a difficult time controlling readmissions because they are not alerted when a patient is hospitalized. Claims and authorization data is often delayed by several months

Since implementing ENS, Brevard has seen an overall reduction in readmissions, including a reduction in hospital readmission rates for Medicaid patients from 17.29% in 2017 to 8.59% in 2018, and a reduction in readmission rates for Medicare patients from 19.15% in 2017 to 13.25% in 2018.

so providers are often not notified of an admission and are unable to provide follow-up care. Setting up admission, discharge, and transfer (ADT) notifications can offer automated, real-time insight into what is happening with a patient to allow for timely follow up and care coordination.

Closing Gaps in Care with ADT Alerts

In May of 2018, Brevard Health Alliance took action to reduce readmissions and close gaps in care by implementing the Encounter Notification Service® (ENS®), powered by Audacious Inquiry. This service provides near real-time ADT alerts to ED Navigators when a patient is admitted, discharged, or transferred from a healthcare facility, enabling outreach, timely follow-up care, and education. ADT alerts are more actionable than claims data since alerts are delivered in real-time rather than weeks or months later. Additionally, claims data does not provide information for uninsured patients, which make up a large percentage of FQHC patients.

Outcomes: Real-Time Alerts Improve Patient Tracking, Reduce Readmissions

Real-time alerts allow for timely follow-up and outreach compared to claims data, enabling improved workflow management and resource allocation. Using ENS notifications, Brevard has been able to effectively track patients and help to close gaps in care for the uninsured and underinsured.

4.6% decrease
in uncontrolled diabetic patients

8.7% decrease
in readmission rates for Medicaid patients

5.9% decrease
in readmission rates for Medicare patients

ENS has enabled better patient tracking for Brevard patients by providing real-time alerts for admissions, discharges, and transfers. With increased information on patients' conditions and healthcare journeys, Brevard was able to better manage patients with complex and chronic conditions through chronic care management and enable care managers to divert unnecessary ED utilization and establish regular care. Using ENS, Brevard saw a **reduction in the percentage of uncontrolled diabetic patients** (HbA1c>9%) from 19.05% in 2017 to 14.49% in 2018.

May 2018. Encounter Notification Service® implementation begins for Brevard Health Alliance patients

July 2018. Claims data to track patients within the healthcare system process is retired.

November 2018. Reduction in readmissions begin to take shape across Brevard Health Alliance.

The Community Health Centers Alliance (CHCA) and The Center for the Advancement of Health IT (AHIT), a non-profit group helping FQHCs adopt technology to better serve their patients, help FQHCs utilize ENS by providing education, training, and onboarding assistance. Since implementing ENS with CHCA's support, Brevard has seen an **overall reduction in readmissions, including a reduction in hospital readmission rates for Medicaid patients from 17.29% in 2017 to 8.59% in 2018, and a reduction in readmission rates for Medicare patients from 19.15% in 2017 to 13.25% in 2018.**

> "The ENS platform has been invaluable in helping our organization conduct more effective outreach and tracking for our patients when they are admitted across the various hospital systems."
>
> — **JASON BURGOS BREVARD HEALTH ALLIANCE, DIRECTOR OF HEALTHCARE SUPPORT SERVICES**

Brevard HEALTH Alliance™

AUDACIOUS INQUIRY