



CareSignal™



**STRIDE**  
COMMUNITY HEALTH CENTER

# Case Study

**How Federally-Qualified Health Center  
STRIDE Community Health Center  
Prepared for the Shift to Value-Based Care by  
Increasing Engagement & Improving  
Outcomes Among Medicaid Patients**

# Challenge

## Increasing Engagement With Limited Resources

STRIDE Community Health Center, the largest Federally Qualified Health Center (FQHC) in Colorado, sought to prepare for the shift from fee-for-service to value-based care by moving to a proactive care model. Yet it faced challenges common to many FQHCs, including limited financial and staff resources and the difficulties of engaging vulnerable Medicaid and dual eligible populations.

Previously, STRIDE had increased patient engagement by hiring diabetes and hypertension educators. However, STRIDE administrators realized they needed to increase engagement on a larger scale in order to meet quality metrics and receive financial incentives — and do so without putting further strain on limited resources. They saw the opportunity to enhance current services with technology.

# Solution

## Scaling Engagement With Remote Monitoring

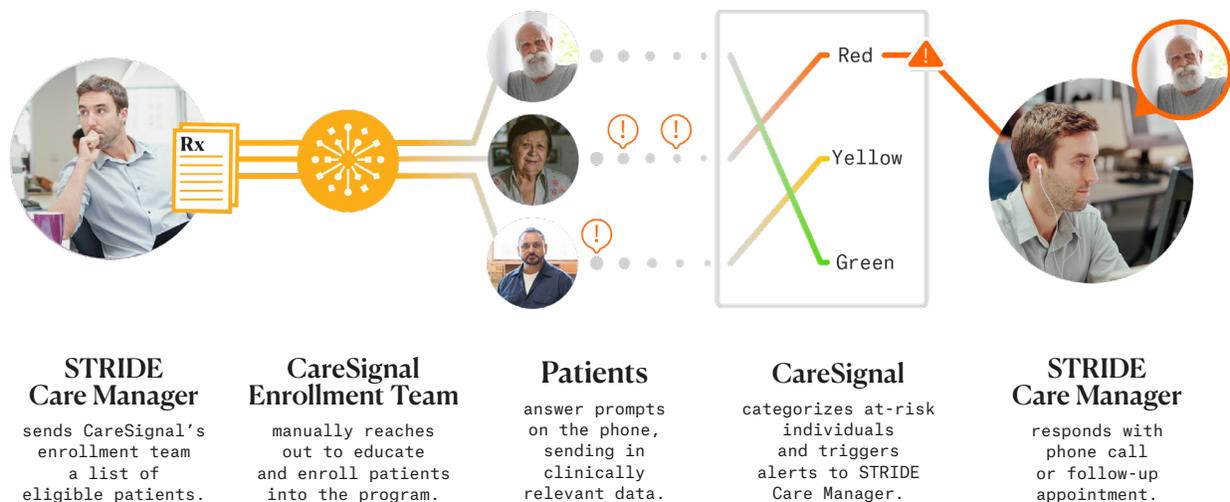
STRIDE implemented CareSignal’s automated text- and call-based remote patient monitoring platform to extend the reach of its care team. It sought to increase patient engagement and condition self-management for those with diabetes and hypertension.

“Texts and phone calls are accessible for our patients because they can use their existing cellphone or landline,” said Stephanie Campbell, RN, director of nursing at STRIDE.

To save STRIDE’s staff time and quickly get patients to adopt the program, STRIDE provided CareSignal’s enrollment team with a list of eligible patients. The enrollment team manually outreached to educate and enroll patients into the program in both English and Spanish, eliminating language barriers and ensuring equitable access to care.

“We’re definitely reaching, with CareSignal, a broader population, and we’re catching more patients in real time than what we were before,” said Campbell.

### CareSignal Workflow



# Creating Strategic Impact

## Aligning Clinical Goals With Value-Based Contract Initiatives

When choosing which patients to enroll in CareSignal, STRIDE strategically aligned its clinical goals with its value-based contract initiatives. STRIDE selected key quality metrics and enrolled patients who met the inclusion criteria. By providing remote monitoring to

these patients, STRIDE extended the reach of its care team to improve specific patient health outcomes and support meeting quality metrics. If benchmarks are met, it can increase federal funding to improve care further.

Condition	Quality Metric	Patient Inclusion Criteria
Diabetes	Reduce patient HbA1C levels to under 8%	HbA1C above 8%
Hypertension	Reduce patient blood pressure scores to under 140/90	BP above 140/90

## Timely Patient Data Increased Collaboration Among Care Teams

As STRIDE’s care teams received real-time patient data from CareSignal, they were able to catch changes as they happened, as opposed to waiting until patients’ next clinic appointments. This resulted in increased collaboration between diabetes and hypertension educators, care managers, and providers.

because he was unable to afford them. The educator notified a nurse, and the care team was able to figure out a solution quickly after the problem arose (rather than waiting three months until his next scheduled appointment).

Consider the case of one patient on the CareSignal program who was triggering alerts daily. A diabetes educator saw on the alerts that the patient’s blood sugar was out of control and reached out to him. The educator discovered that the patient wasn’t taking the proper medications

Real-time data from CareSignal gave care teams a more holistic picture of each patient. Because the tool automated engagement and care managers were alerted only when interventions were necessary, it also freed up more time for care managers to focus on the patients who were most in need.

“CareSignal helps us engage hard-to-reach patients and see which patients are alerting, and sometimes, we find that they haven’t been refilling their meds or haven’t been to the clinic for over a year, and their blood pressure or blood sugar is out of control. CareSignal gives us way more visibility into our patient populations and allows us to reach out to patients and help.”

- Stephanie Campbell, RN, director of nursing at STRIDE Community Health

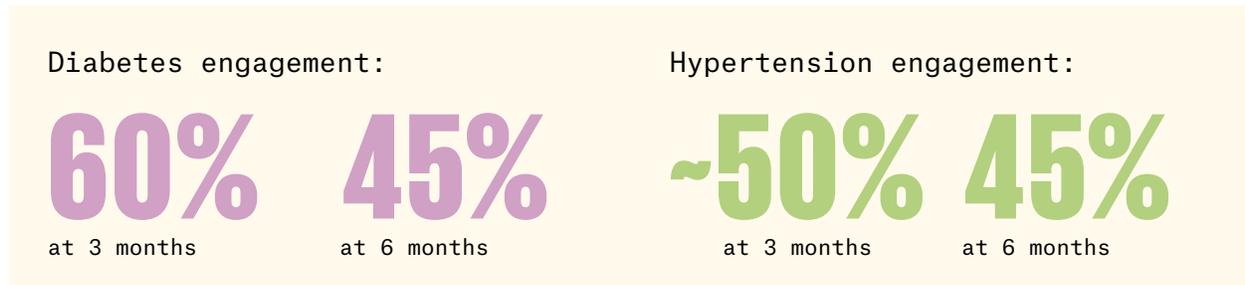
# Patient Focused

## STRIDE Increased Patient Engagement

Over the first nine months of the partnership, 474 patients engaged with the CareSignal platform. STRIDE staff members were alerted to 397 instances where patients needed support because of worsening symptoms.



## Long-Term Patient Engagement



## Patient Survey Feedback

Patients with diabetes reported:

**“This helps me to be more responsible** in case I forget. I know you’re going to send me a message, and it helps me to be prepared to answer.”

**“I have more control with my diabetes,** and it helps me remember to take my blood sugar every day.”

Patients with hypertension reported:

**“It helps me to remember to take my medication. I haven’t forgotten to take it since this service started.”**

**“It brings closeness between STRIDE and its patients.”**

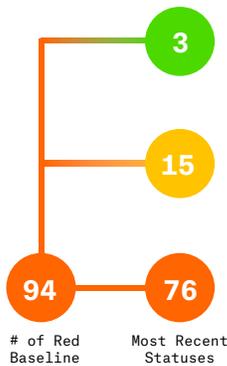
# STRIDE Improved Health Outcomes

Clinical outcomes from the first nine months:

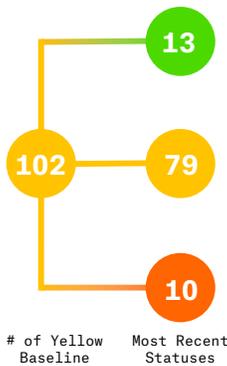
Increased engagement and timely alerts gave STRIDE’s care teams the ability to intervene and move high-risk patients into medium- and lower-risk categories.

## Diabetes Key Insight:

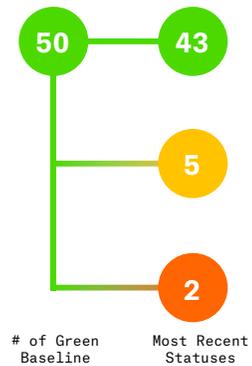
Patients with a baseline A1C > 9% showed a 2.02% decrease on average.



Of 94 high-risk diabetes patients, 19% of them improved.



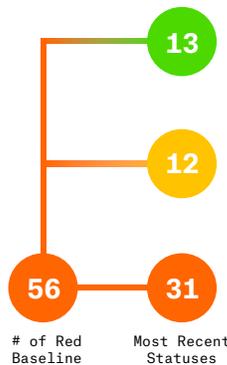
Of 102 rising-risk diabetes patients, 77% of them maintained.



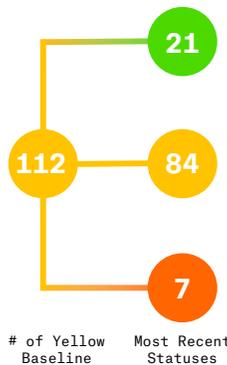
Of 50 low-risk diabetes patients, 86% of them maintained.

## Hypertension Key Insight:

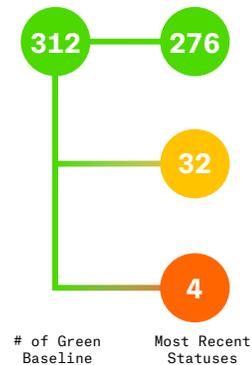
Patients with a baseline > 160 mmHg showed 10 mmHg average SBP drop.



Of 56 high-risk hypertension patients, 45% of them improved.



Of 112 rising-risk hypertension patients, 75% of them maintained.



Of 312 low-risk hypertension patients, 88% of them maintained.

# What's Next for STRIDE?

By implementing CareSignal's remote patient monitoring program, STRIDE was able to extend the reach of its care teams, increase engagement, and improve outcomes among the particularly vulnerable populations it serves. As a result of the initial successful year, STRIDE leadership is reviewing opportunities to incorporate CareSignal into its organization-wide strategic initiatives.

To learn more, try a self-guided demo or schedule a brief consultation with our sales team.



**CareSignal™**

**Our mission is to highlight key moments for life-changing intervention, *accentuating* care our partners provide.**

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