esse HEALTH

Succeeding in Medicare Advantage by Managing High- and Rising-Risk Patients:

How Esse Health Saved $250 PMPM and Lowered Heart Failure ED Visits by Half Among 1,000 Medicare Advantage Patients

CareSignal™

Challenge

A Growing Medicare Advantage Population

Esse Health, one of the largest independent primary care groups in the Midwest, with 45 offices throughout Missouri and Illinois, was expanding its Medicare Advantage population. In the value-based care Medicare Advantage arrangement, Esse is incentivized to improve clinical outcomes and reduce avoidable utilization. As Esse's Medicare Advantage population grew so did the demand on care resources, yet it wasn't financially sustainable to hire more staff.

> "It is not financially sustainable to provide outreach to a new population of patients by doubling the number of employees. It's expedient to look at other ways to do outreach."
>
> **— Carla Beckerle**
> Vice President of Clinical Programs at Esse Health

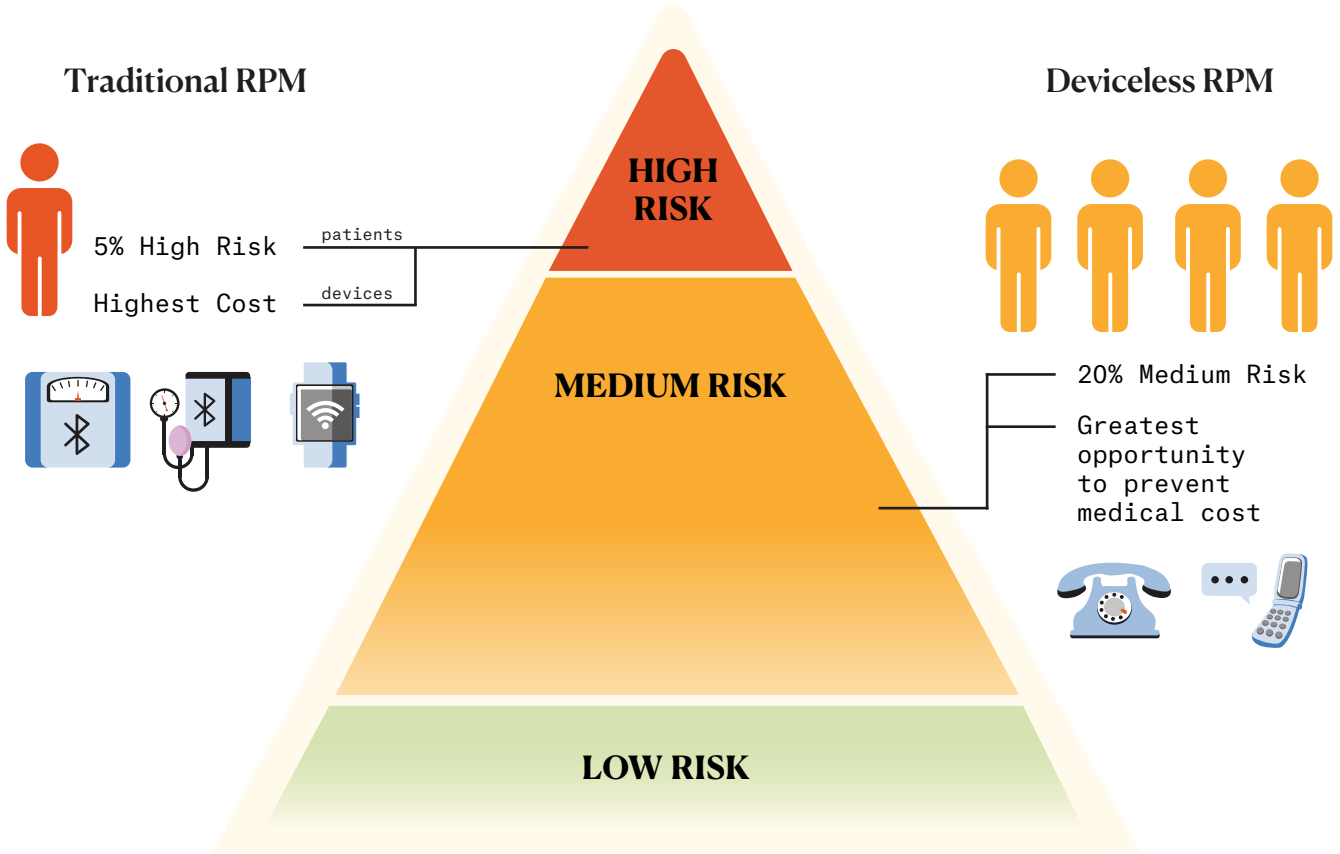
Care Management Was Limited by Staff Capacity and Historic Data

Esse used a high-risk, high-touch care management model, which prioritized a small subset of the sickest patients and resulted in an average care manager caseload of 100 patients. Care managers made manual outbound calls, limiting their ability to engage more than 100 patients each. With a growing Medicare Advantage population, care managers needed a way to engage more patients using technology and identify in real time which patients needed their help. While Esse had a risk-stratification tool and a robust EMR, these tools could not identify patients whose conditions were worsening in real time.

Care Management Needed to Extend its Scope to Rising-Risk Patients

Esse's care management teams focused primarily on the top 5% of high-risk patients because they were at the highest risk of hospitalization. However, Esse's "rising risk" patients not only represent a much larger group of patients (20%), but they also represent a group of medium-risk patients who have a high likelihood of escalating to the high-risk, high-cost category. Because these patients typically did not receive care management, they posed a more significant financial risk. Care management needed to extend its scope to rising risk and leverage automated, cost-effective technology to reach at least 10x more patients to generate the necessary clinical and financial impact in its Medicare Advantage contract.

Deviceless Remote Patient Monitoring Scales to Rising-Risk Patients at a Fraction of the Cost of Device-Based RPM



Solution

Increasing Engagement With Deviceless Remote Patient Monitoring

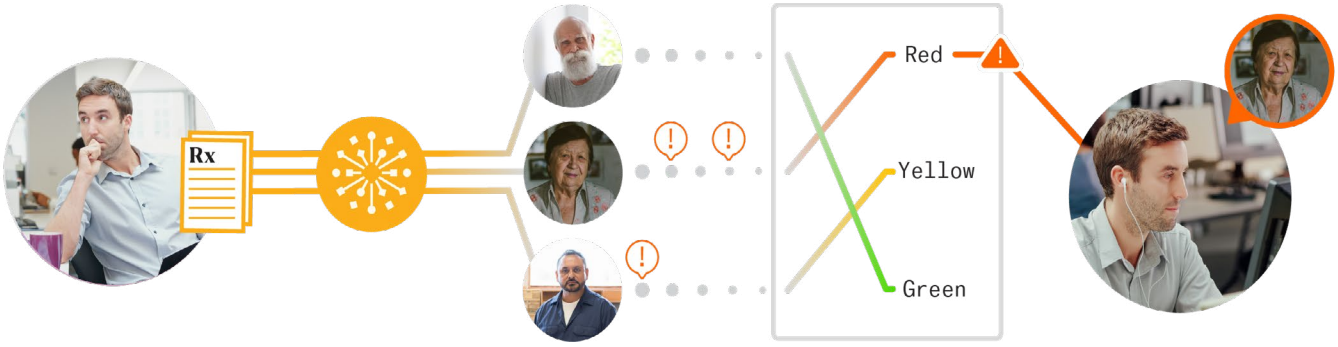
Esse's existing tech ecosystem included a patient portal, telehealth, and device-based remote patient monitoring. Device-based remote patient monitoring, however, was not a feasible method for reaching the growing number of Medicare Advantage patients. "Device-based remote patient monitoring is technologically a little more difficult for patients to negotiate," said Carla Beckerle, Vice President of Clinical Programs, Esse Health.

To increase patient engagement at the scale needed to be successful and collect timely patient data, Esse implemented CareSignal's automated SMS- and call-based deviceless RPM platform.

Esse provided CareSignal with a list of patients with heart failure, COPD, diabetes, or hypertension to enroll in the program. From there, CareSignal called, educated, and consented patients into the program with qualified patient engagement specialists, reducing the need for Esse to use its own resources on implementation.

> "CareSignal complemented what we already had in our technology ecosystem by reaching out to more patients and providing them with a platform that would enable self-management. The technology was also incredibly simple to implement."
>
> **– Erin Stamm**
> Chief Operations Officer at Esse Health

CareSignal Workflow



Esse Care Manager
Sends CareSignal's enrollment team a list of eligible patients

CareSignal Enrollment Team
Manually reaches out to educate and enroll patients into the program

Patients
Answer prompts on the phone, sending in clinically relevant data

CareSignal
Categorizes at-risk individuals and triggers alerts to Esse Care Manager

Esse Care Manager
Responds with phone call or follow-up appointment

Automating Patient Symptom Collection With Deviceless Remote Patient Monitoring

The CareSignal platform texted or called patients on their existing phone asking questions about condition-specific symptoms (e.g., breathing ability, swelling, blood sugar). Patients replied by self-reporting their health data by responding to the text message or IVR phone call. Then, the platform categorized patient responses into high-, medium-, and low-risk categories.

Worsening symptoms were categorized in the high-risk category, which triggered an alert to an Esse Health care manager. The care manager then proactively contacted the patient to address the signs and symptoms noted in the alert.

Automated alerts ensured that care managers focused their efforts on patients that needed them most, saving time and energy while allowing them to reach more patients.

> "Now we've been able to wrap our hands around a whole group of people who otherwise might not have gotten all those touches that they received with the platform. We've been able to scale the outreach dramatically without an increase in staff, and that's really important. High-risk care management is inherently a reactive model. By extending care management into the rising-risk patients, we are becoming more proactive. Now we can say, 'Hey, there might be a problem developing. Let's reach out to the patient instead of waiting until he goes to the ED.' It's helped us manage rising-risk patients who might not have perceived a need for a care management team before."
>
> **— Carla Beckerle**
> Vice President of Clinical Programs at Esse Health

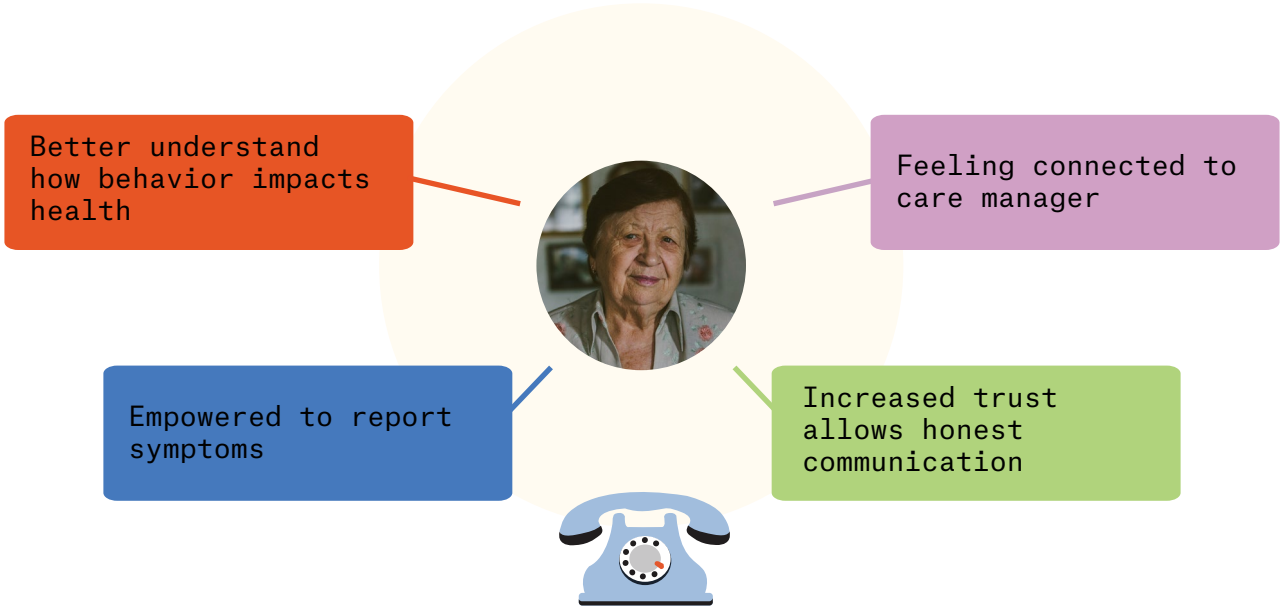
Reaching Rising-Risk Patients: Shifting From a Reactive to a Proactive Care Approach

Because CareSignal alerted care managers when rising-risk patients' symptoms were worsening, care managers were able to provide proactive care addressing issues before they resulted in unnecessary medical costs.

Patient Success Story

A patient enrolled in the heart failure program reported through CareSignal that she was experiencing more swelling, placing her in the high-risk category. CareSignal automatically sent an alert to the care manager, who reviewed the patient's chart and called her. The care manager noted from her chart that any time she had swelling, her primary care physician recommended she call her nephrologist. The care manager asked the patient whether she had called her nephrologist, and the patient said, "I tried, but he was on vacation." The care manager relayed this information to the patient's PCP, who told her to increase a medication to reduce the swelling and scheduled an appointment for her. Because CareSignal alerted the appropriate parties about the patient's worsening symptoms, the care manager was able to intervene in time to prevent an ED visit.

Empowering Patients to Self-Manage Chronic Conditions



Building Patient-Provider Relationships

Along with easy internal implementation, Esse saw a smooth introduction of CareSignal with patients. CareSignal enabled patients to engage in their own care with familiar, easy-to-use technology.

Before implementing CareSignal, Esse observed how chronically ill patients struggled with their diseases — even ignoring symptoms until they developed into crises. Regular texts from CareSignal asking about their symptoms brought patients' health back into focus and enabled them to report valuable information. CareSignal gave patients an easy way to reach out for help and feel more in control of their conditions.

Increased involvement in their own care not only helped patients feel empowered, but the feeling of accountability and connection also strengthened the trust in their care team. The increased trust gave patients the space to have more honest conversations about health issues — which ultimately allowed for care teams to get a fuller picture of rising-risk patients' needs and enabled proactive care and prevention of escalating symptoms. It became a virtuous cycle.

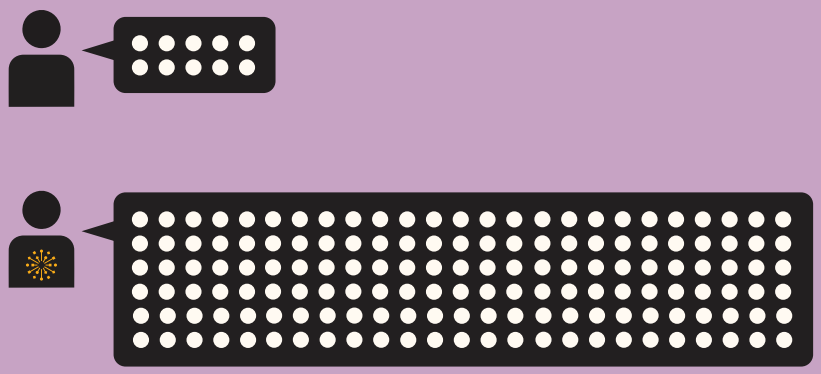
> "The platform gave patients a simple way to ask for help and feel in control of their health. This improved self-management behaviors and strengthened trust between care teams and patients. Additionally, care managers received a broad picture of patients' needs, which facilitated proactive care. It's a cultural change when you're able to engage patients and create trust between the patient and the care manager. If trust exists, people are open to discussing their healthcare challenges."
>
> **— Carla Beckerle**
> Vice President of Clinical Programs at Esse Health

Results

170,000 automated touches, with patient responses triggering **4,100** alerts for worsening symptoms that the care team would not have been aware of otherwise.

Reaching 15x More Medicare Advantage Patients

1 RN care manager sustainably grew caseload **100** → **1,500** high-and rising-risk patients while maintaining high satisfaction.



= 100 patients

Reducing Emergency Room Visits by Nearly Half

Each of the alerts was an opportunity for proactive outreach to the patients who needed it most. This improved patients' clinical outcomes and reduced ED visits for patients with chronic conditions.

Diabetes

0.51%

absolute reduction in A1C
(n=111)

Heart Failure

46%

reduction in congestive heart failure ED visits
(n=1,018)

COPD

31%

reduction in COPD ED visits
(n=214)

Hypertension

-14.75 mmHg
Average change in sBP

-7.55 mmHg
Average change in dBP

Esse Lowered PMPM Costs by More Than $250 in Less Than 8 Months

Improved clinical outcomes led to positive financial results.

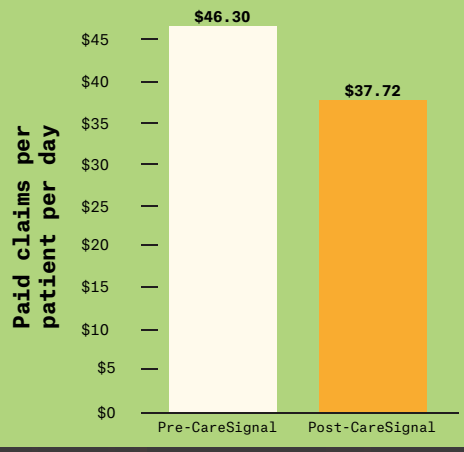
All Claims Analysis: Financial Savings

$2.4M
total savings

14x
ROI

$257
savings PMPM

19%
reduction in total paid medical claim costs



What's Next for Esse?

In the future, Esse plans to further match clinical care with quality measures to support its Star metrics by adding CareSignal's medication adherence and behavioral health programs for its patients.

To learn more about how to manage your rising-risk patients, schedule a self-guided demo or a brief consultation with our sales team.

CareSignal™

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

CareSignal • 4220 Duncan Ave. #201, St. Louis, MO 63110 • 1 (866) 976-8910