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Advancing High Performance Health

## AMGA Member Best Practices

# *Embracing Health Equity and Scaling Population Health: Lessons from Esse Health and UnityPoint Health*

# Embracing Health Equity and Scaling Population Health: Lessons from Esse Health and UnityPoint Health

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*Webinar, October 19 , 2022*

## Learning Objectives

- ***Explain*** *the technological and staffing barriers to scaling population health initiatives and strategies to overcome them*
- ***Describe*** *how artificial intelligence (AI) models include nonclinical factors and the impact on predicting utilization and patient outreach precision*
- ***Identify*** *the ways in which real-time alert data enable top-of-license care management*

As the healthcare industry continues its shift toward value-based care, increasing precedence is being given to health equity. But how can you make sure your organization is prepared to fully embrace this initiative?

In the webinar "Embracing Health Equity and Scaling Population Health: Lessons from Esse Health and UnityPoint Health," Blake Marggraff, Co-Founder and CEO of CareSignal, Lightbeam's Deviceless Remote Patient Monitoring™ solution, led an invigorating discussion on this topic with Anna Keller, BSN, RN, Executive Director of Ambulatory Enterprise Intellicenter at UnityPoint Health, and Carla Beckerle, DNP, APRN-BC, Vice President of Clinical Programs at Esse Health.

Marggraff opened the conversation by summarizing the need for a health equity focus, saying "Not only is it a moral imperative—it's soon going to be a financial necessity for organizations to thrive."

He presented common challenges across population health, namely:

- **Overly Broad Patient Risk Data**
  - Poor data sources are leveraged to assess health equity; there is a need for individual patient-level data to assess clinical and social risk factors.
- **Creating a Silo'd, Static Social Determinants Strategy:**
  - The current standard of care assesses SDoH factors manually, infrequently and lacks a robust workflow for connecting dynamic patient needs to community resources.
- **Failing to Engage the Most Vulnerable**
  - Relying on face-to-face visits misses rural and urban patients alike as they both face transportation barriers. Most technology solutions (apps, portals, telehealth) aren't accessible to low resource patients.
- **Building Care Processes that Don't Scale Up**
  - Reliance on labor intensive processes amidst the staffing crisis will result in patients falling through the cracks.

- **Not Adjusting to the Shift To Equity, Utilization, Satisfaction Metrics**
    - Historically, providers have prioritized and succeeded in achieving high quality scores. However, CMS's focus is shifting to address health equity, overall utilization, and patient satisfaction.

## Assess an Individual's Risk with a Holistic and Actionable Lens

In order to overcome these challenges, it is vital to first understand the population—and that means a lot of new data. Organizations will need community-level data, such as access to care and air pollution, as well as individual data, such as current health conditions and food security.

"I don't think it will surprise anybody that most of the predictive power comes from outside the raw, structured healthcare data," Marggraff said. "It comes from the messier, often harder-to-get data." That means understanding what household characteristics look like down to a block level. "Not only the ZIP Code," he said, "but those extra four digits, as well."

It also means looking at how individuals in an area might interact with transportation and what specific environmental hazards they might be exposed to. "I'm talking not just air quality," Marggraff said, "but which specific volatile organic compounds within the air are most impactful, and what's going to be the best way to manage them."

"The goal," he continued, "is to pair that prediction with a specific rationale, and then recommend actions that can be taken to prevent that negative outcome from occurring."

So, what breaking-edge technology is CareSignal using to achieve these goals?

## Take Action to Reduce Risk with Deviceless Remote Patient Monitoring®

"As long as you have a cell phone—even if it's out of minutes—or a landline, you can use Deviceless remote patient monitoring (RPM)," Marggraff explained.

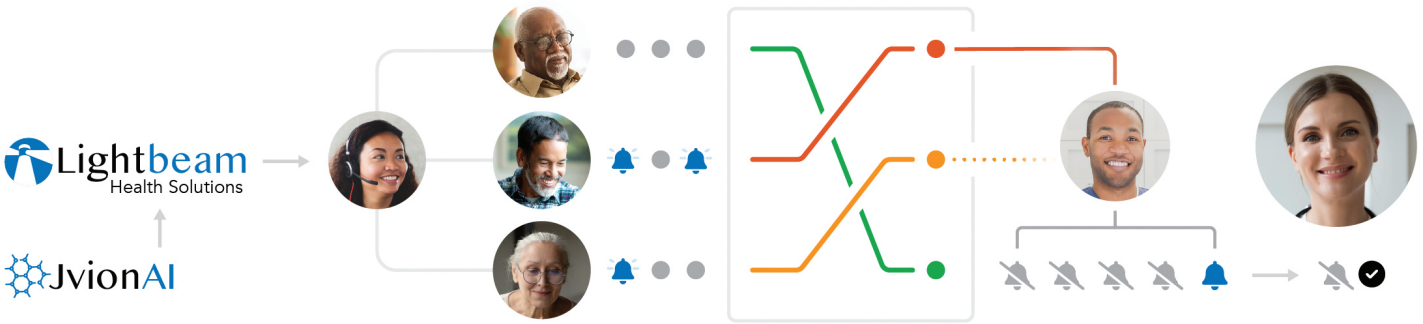
Marggraff described Deviceless RPM as technology that "is just as clinically actionable and impactful as device-based RPM—just as good from a clinical perspective—but at a fraction of the cost." The major benefit is that Deviceless RPM "is scalable to far more patients across far more conditions than device-based RPM ever could be," he said.

"Improving health equity starts with technology that is so accessible and intuitive that it almost doesn't feel like technology at all," Marggraff explained. "We can send and receive messages at no cost to phones that are out of minutes [and] use whatever language needed at a low reading level in order to make sure patients always feel comfortable responding to the questions they're asked."

Marggraff explained the workflow: "Lightbeam's powerful predictive analytics" and "best-in-class, lightning-driven population health… generate cohorts to identify just the right patients that need help at the right time." Those patients are "passed to a white-labeled engagement specialist capability that reaches out on behalf of a health company, such as UnityPoint Health, to enroll patients in CareSignal, a new, free program to keep them healthy." This is done at "a massive scale" with "tens of thousands of calls a week."

As a result, CareSignal can highlight those patients at highest risk for adverse outcomes for the provider, enabling early intervention. Patients appreciate the convenient program, which provides "a better patient experience," while population health leaders appreciate that it "allows for staffing scalability for care teams and technology that are already in place." (See "Workflow: From Insights to Outcomes.")

**Workflow: From Insights to Outcomes**




**Jvion**
Predictive analytics surface top health inequities and readmission risk

**Lightbeam**
Identifies cohort of target patients for CareSignal

**Engagement Specialist**
Enroll patients via text, email, mailers, and direct phone calls

**Patients**
Answer automated SMS & phone call prompts, sending in clinically-relevant data

**Deviceless RPM**
Categorizes at-risk patients and triggers alerts in real-time

**LCS**
Care Managers monitor dashboard and follow standard operating procedures

**Providers**
Receive escalations, only as needed

## Case Study: UnityPoint Health Offers Deviceless RPM to Rising-Risk Cohorts

Keller shared that UnityPoint began its partnership with CareSignal for chronic obstructive pulmonary disease (COPD) and diabetes programs for rising-risk populations. “Patients may be enrolled via a flat file process or referred to the program by a provider or the transition care nursing team,” she said. “We added the post-discharge program in March of 2022 with a slow, progressive rollout to learn about the needs, engagement, and response rate of specific populations. This allowed us to fine-tune how we adjust our workflows and call processes to meet the needs effectively and efficiently.” Keller was proud to announce that UnityPoint has “supported the initial rollout without adding any additional production hours” and exceeded the 70% patient acceptance goal with an 86% acceptance rate.

**4,083** patients

**32,000** automated patient touches

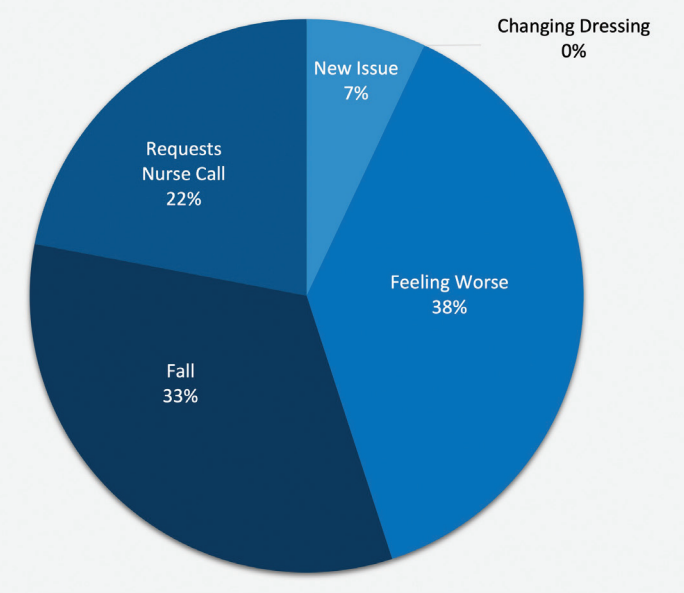
**2,171** alerts

Over 4,000 UnityPoint patients have benefited from the post-discharge program. The program increases communication between the patient and the care team for 30 days following an ED visits or inpatient admission. Patients receive an automated SMS text message or phone call checking in once a week, allowing the patient to report concerns which are escalated to the UnityPoint care team. From over 32,000 automated patient messages, UnityPoint care managers received 2,171 alerts for patients reporting a need for support, the low alert rate resulted in a manageable volume. Alerts ranged from requests for medication help to falls.

## Post-Discharge Alert Breakdown

Keller said, "The IntelliCenter’s Transition of Care RN team report an average handle time savings of 4 to 5 minutes per encounter as a result of knowing why the patient is alerting and being able to go through the assessment in a more efficient manner. Patients are also more prepared when the nurse calls, which helps our nurses get to the heart of the issue quicker. This same team connects with patients 77% of the time following a CareSignal alert, compared to 69% of the time when reaching out to a patient without an alert

**Post-Discharge Alert Breakdown**




(following an ED visit or inpatient stay). We believe when patients are expecting the call, they answer at a higher rate and are more engaged in the assessment process." Not only is the team impacting the right patients, the small efficiency improvements can have a large impact; with approximately 5 minutes saved per patient across 2,171 patients over 10 months results in 22.5 staff days saved.

Patients' gratitude for the convenient program is reflected in satisfaction measures. A patient said, "I appreciate the way that I am receiving these text messages, it indicates my care team is reaching out to me and I have easy access to reply." In satisfaction surveys, patients participating in the Deviceless RPM program agree that they're getting the best possible care from UnityPoint Health (7.8/9) and that the messages have improved communication with UnityPoint Health (7.6/9).

**Care Satisfaction:** *You are getting the best possible care from UnityPoint Health.*

N = 1,647
Average = 7.83

1 - Strongly Disagree — Strongly Agree - 9

**Improved Communication:** *These messages have improved your communication with UnityPoint Health*

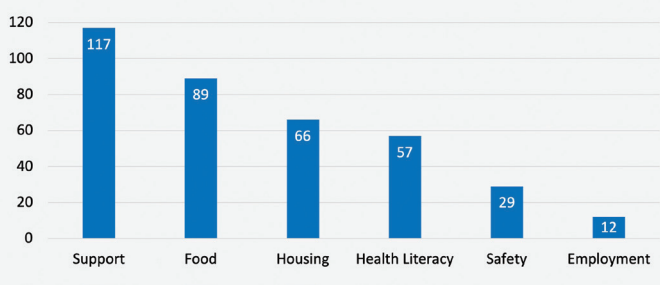
N = 1,608
Average = 7.63

1 - Strongly Disagree — Strongly Agree - 9

## Case Study: Esse Health Expands Deviceless RPM Use Beyond Chronic Conditions to SDoH

Beckerle echoed excitement for Esse Health's use of the Deviceless RPM program that collects patient-reported social determinants of health. "We have dipped our toe into it this year, working with different aspects of the eight-question SDoH survey," she said. Patients completed over 1,300 automated SDoH surveys so far, identifying needs such as food assistance, housing, and health literacy. "We found that we were able to reach out to quite a few individuals, either with our care management team or our social workers and provide them information they needed in regard to food insecurity and other issues."

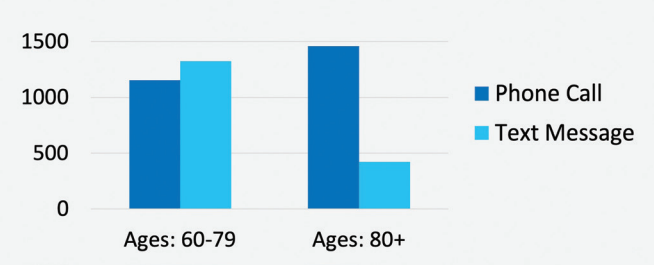
### SDOH Needs Reported




"One of the things we wanted to know was what kind of engagement preferences our patients have," Beckerle said. Esse Health was somewhat surprised to learn that, while patients older than 80 years had an overwhelming preference for phone calls, those aged 60-79 tended to prefer text message interfacing.

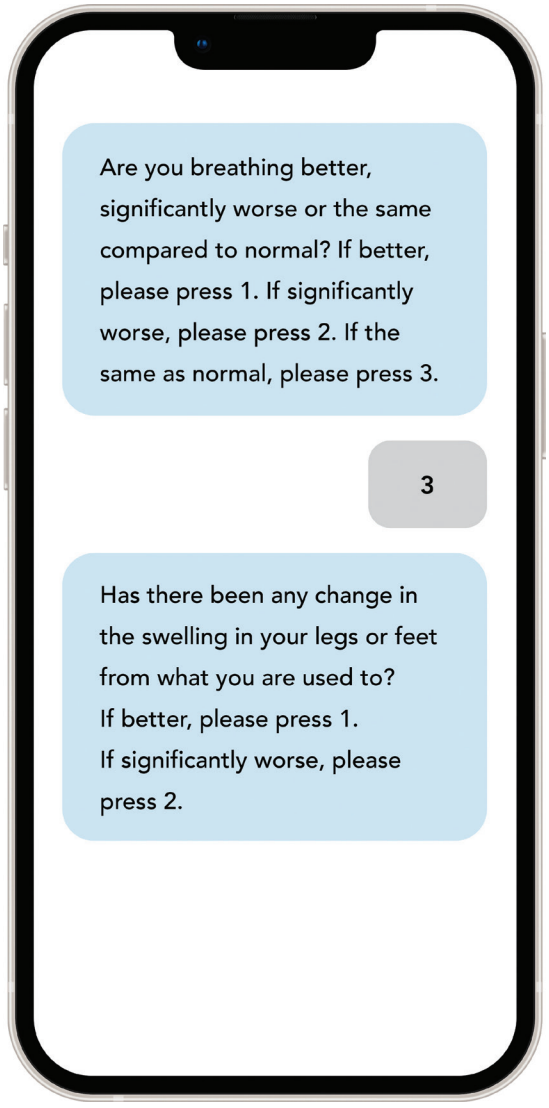
"It was really pleasant to know that when we engaged with these patients, they were able to state their preference and then get their information and their questions in the method they wanted."

### Esse Patient Communication Preference by Age

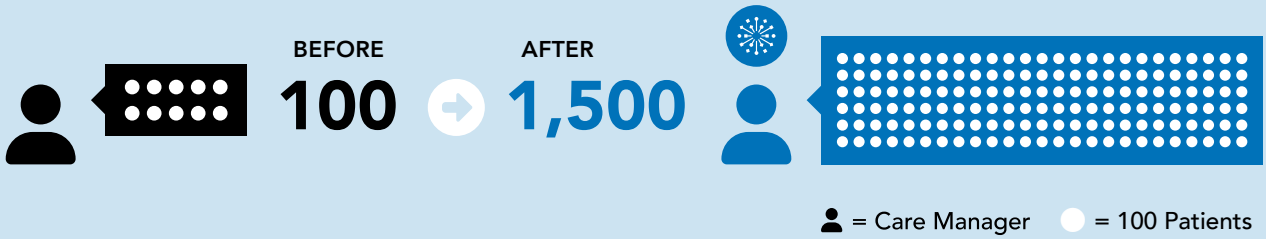



Beckerle shared that the use of Deviceless RPM allowed for Esse Health to see a 46% drop in emergency department visits for CHF (N>1,000) as well as a 31% reduction in ED visits for patients with COPD.

### CHF Sample Message



## ONE CARE MANAGER SUSTAINABLY GREW THEIR CASELOAD 15x WITH *DEVICELESS RPM*




**Esse was able to turn care management from a manual, outbound call model into an inbound alert model.** By automating routine patient check-ins with Deviceless RPM (see CHF Sample Message) the care team could spend time addressing the patients who indicated worsening symptoms, enabling them to reach many more patients than they could have otherwise. "We were able to very quickly determine that the caseload for care managers responding to these alerts and doing timely intervention could grow significantly," Beckerle said.

Marggraff closed by asking Beckerle to share thoughts on her philosophy. "I want our company to focus on the new rising-risk populations across not only Medicaid and Medicare Advantage, but also Medicare fee-for-service patients," she said.

"The other thing I really want to focus on," Beckerle continued, "is working on SDoH stratification and outreach that will enable our patients to function using a higher level of healthcare strategies. A tool like CareSignal," she said, "provides the potential to achieve these goals."

### Learn More:

Looking to start tackling health equity? Discover the power of healthcare AI and receive Lightbeam's Health Equity "Strategy-in-a-Box," which is customized to your ZIP Code at no cost.

**https://lightbeamhealth.com/radian-demo/**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