CASE STUDY

The Information Advantage

How to reduce high-risk ED visits and drive savings

By Carla Moore Beckerle, D.N.P., APRN-BC, and Erin Stamm, M.B.A., RHIA

Medicare Advantage (MA) is one of the fastest growing value-based care arrangements. In fact, MA members now represent 36% of Medicare beneficiaries, a number expected to grow to 50% by 2030.[1] Under MA's capitated payment model, health plans have increased incentive to reduce unnecessary utilization. With bonus payments for meeting and exceeding quality benchmarks and Star ratings, plans are further incentivized to work with providers in their network to improve clinical outcomes.

From the provider perspective, plans are increasingly passing through risk in their provider contracts, thus creating incentive for systems and physician groups to reduce unnecessary utilization. One $5,000 hospitalization could ruin the equation, making it imperative to focus on conditions that contribute to the greatest number of hospitalizations. This presents a challenge, given that MA patients have a high prevalence of chronic conditions, such as heart failure and COPD, and are among the most vulnerable populations.[2]

Incentivizing a Proactive Care Model

We carefully analyzed the environment at Esse Health, one of the largest independent primary care groups in the Midwest, with 45 offices throughout the St. Louis Metropolitan area and Illinois.

In MA, we receive a capitated payment per month to cover the cost of care for our patients. We want our patients well and want to utilize those premium dollars to keep our patients healthy. The more information that we have from our analytics platforms that look at multiple sources of data, the greater the ability of our care managers to reach at-risk patients and avoid an adverse event.

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CareSignal Deviceless RPM™ uses familiar SMS text messages and IVR calls.

Value-based care places an emphasis on proactive, preventative care management. One of the most effective ways to reduce avoidable hospitalizations is by care management proactively helping patients increase self-management of chronic conditions. Our goal in the care management team is to provide a high-touch model, thus enabling us to reach out to our patients multiple times by many team members.

A Scalable Methodology

Yet, as Esse Health's MA population grew by the thousands, we knew the two barriers preventing care management from providing high-touch care to everyone: staff and data. Care managers employing the high-risk, high-touch model had an average caseload of 100 patients, and the manual, outbound call process limited outreach. It is not financially sustainable to provide outreach to a new population of patients by doubling the number of employees. It was expedient to look at other ways to do outreach.

Second, while risk-stratification tools and a robust electronic medical record (EMR) were present, outreach efficiency was hampered by not having a definitive way to identify patients whose conditions were worsening in real-time. The care management team needed methodology to scale the collection of timely data to alert them to patients whose conditions were worsening.

Care at Your Fingertips

Leadership looked first at its existing ecosystem of patient engagement technology, which included a patient portal, telehealth visits, and device-based remote patient monitoring (RPM). RPM was not feasible to successfully reach patient volume and was technologically a little more difficult for patients to negotiate.

To increase patient engagement at the scale needed to be successful and collect timely patient data, an automated text-message and call-based remote patient engagement platform from CareSignal was implemented.

CareSignal seemed to complement what we already had in our technology ecosystem to reach out to our patients and provide them with a tool that would enable self-management. The technology was also incredibly simple to implement.

Care managers identified heart failure, COPD, diabetes, and hypertension patients to be monitored, and CareSignal's enrollment team called, educated, and enrolled patients on the platform. The platform then texted or called patients to inquire about condition-specific symptoms (e.g., breathing status, swelling, blood sugar). Patients self-reported their health data, and the platform categorized patient responses into high-, medium-, and low-risk categories.

Worsening symptoms were placed 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.

Keeping a Heart Failure Patient Healthy at Home

This workflow can prevent ED visits, as illustrated in this example.

When a patient enrolled in the heart failure messaging replied to the automated message that she was experiencing more swelling, the platform alerted our care manager. Upon examination of the patient's chart, the care manager reviewed documentation in the EMR, which indicated any time the patient had swelling, her primary care physician (PCP) recommended she call her nephrologist. When the care manager reached out to the patient via phone, however, the care manager found out her nephrologist was on vacation. The care manager then reached out to the patient's PCP, who increased the patient's medication dosage to reduce the swelling and scheduled an appointment, thus saving the patient an ED visit.

Increasing Patient Self-Management

In addition to giving care managers real-time insights into patients' symptoms and enabling them to promptly intervene when most needed, the platform also opened a new line of communication between patients and care teams.

Esse Health care teams have identified the simplicity and use of the tool as its most exciting aspects. The user-friendly technology gave patients a new level of control over their own

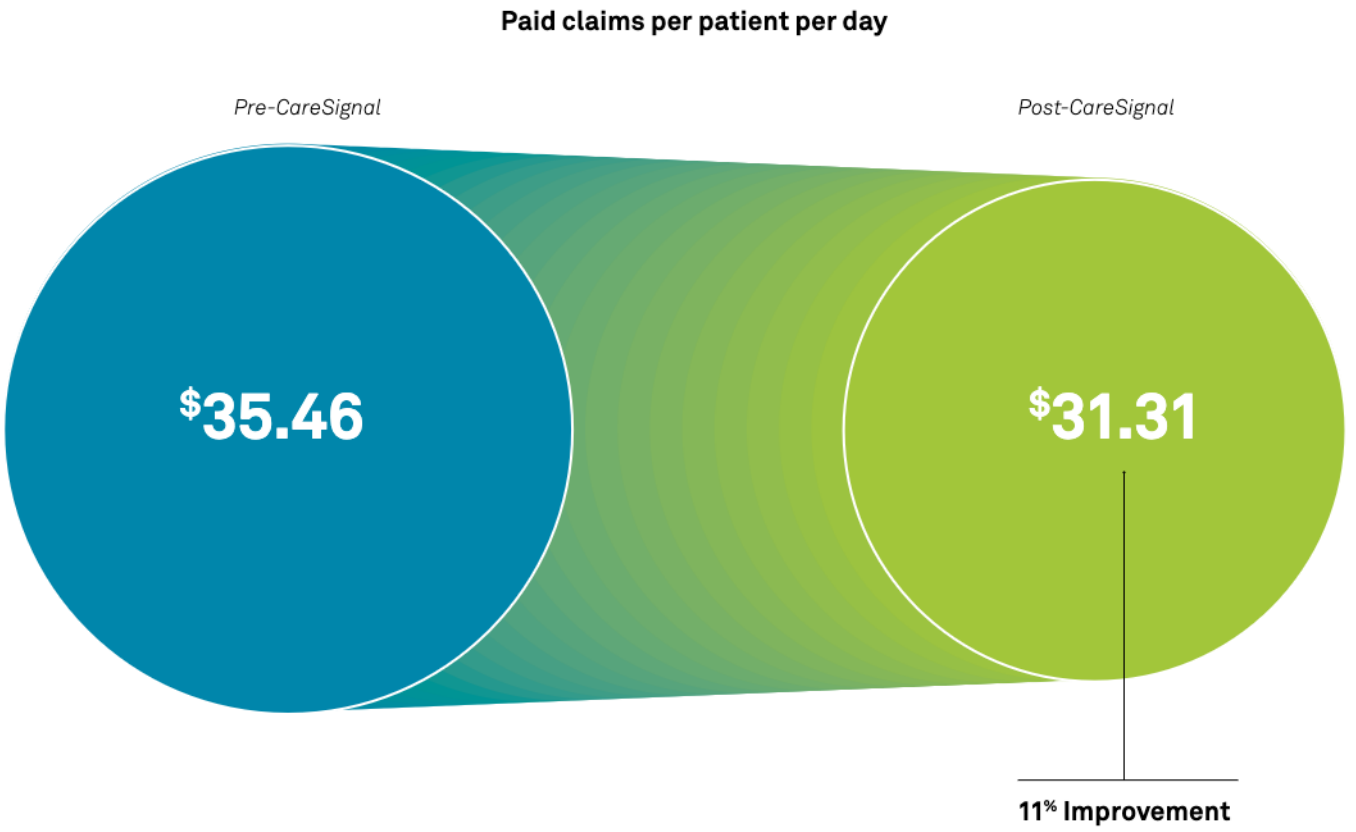
What's Next?

Data on our positive clinical trends show that Esse Health targeted and improved relevant clinical outcomes with the help of a simple yet efficient platform. It gives us additional useful information, and our patients use it and find it helpful.

Esse Health plans to expand the platform beyond the Medicare Advantage population and add medication adherence and behavioral health messaging for other patients.

Figure 1

Aggregate Paid Claims Pre- and Post-CareSignal



health. Chronically ill patients often struggle with their diseases—in fact, many ignore their symptoms altogether until a crisis develops. Receiving daily text messages or phone calls helped patients to prioritize their health and enabled them to report valuable information.

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.

Reaching High- and Rising-Risk Patients

Not only was implementation easy and effective among patients, it enabled care managers to reach a new subset of patients—those with rising risk.

We always tend to focus on the high-risk patients because they need us the most. However, rising-risk patients are those who may become high-risk in the future. They offer a unique opportunity. If we help them manage their disease processes, the trajectory will slow. The end goal is to identify how truly urgent the complaints or symptoms may be and then connect the patient to the office for treatment. The most important factor is a timely intervention.

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Often, the care management team was reaching out to high-risk patients when they had major issues. 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 they go to the ED." It's helped us manage rising-risk patients who might not have perceived a need for a care management team before.

In eight months, Esse Health scaled outreach to higher numbers of Medicare Advantage patients. One full-time RN care manager increased her caseload from 100 patients to 1,500 high- and rising-risk patients while maintaining high satisfaction. During this time, the platform sent 170,000 automated text or call patient touches with patient responses triggering 4,100 alerts.

Clinical and Financial Results

Pre- and post-claims analyses during this period show a 31% reduction in COPD ED visits (N=214), a 46% reduction in congestive heart failure ED visits (N=1,018), an 0.51% absolute reduction in A1c (N=111), and improvements in blood pressure control (average decreases of sBP -14.75mmHg and dBP -7.55, N=74).

All claims analyses show an 11% improvement in total paid medical claim costs, resulting in $3.6 million in savings. This translated to a $124 savings per patient per month. Paid claims per patient per day improved from $35.46 to $31.31 (see Figure 1).

Lessons Learned

As Esse Health care management leaders navigated implementation of remote patient engagement technology, we learned valuable lessons along the way that can serve as guiding principles for others seeking to improve outcomes among MA populations (see "What's Next?"):

- **Align clinical and business goals.** By concentrating on prevalent conditions that contribute to costly utilization and are aligned with Star quality measures, clinical care teams were instrumental in achieving Esse Health's expanded business goals. Engaging clinical and business stakeholders throughout planning, implementation, and outcomes stages made it possible to target and evaluate relevant clinical outcomes and lay the groundwork to sustain and scale the initiative.
- **Measure the impact of care management.** Evaluate the clinical outcomes you are trying to reach, and align implementation of any new technology to meet those benchmarks and produce positive financial results. Reporting on both clinical and financial outcomes shows the full impact of care management.
- **Engage technology to sustainably scale care management.** One of the biggest surprises was the increased capacity of a single care manager after outbound outreach was automated—and its impact on focused care delivery. By scaling care management to both high- and rising-risk patients, providers can confidently take on additional financial risk.
- **Employ user-friendly technology and invest in education.** Patients have been highly receptive. We were surprised there weren't a lot of patient concerns with too much information being shared. There is proactive education that has to happen so that the patients know what the program is and that their physicians are involved. It was exciting for patients to use technology they already have. Many already receive text messages, so use of this technology was not unique. GPJ

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