

Utilizing Deviceless Remote Monitoring Within a Medicaid Managed Care Plan to Identify Rising Risk for Early Intervention with Promising Results

Background Community Care Plan (CCP) is a Florida-based Managed Care Plan formed by two safety-net hospitals, Broward Health and Memorial Healthcare System, to support multiple lines of business. CCP covers over 100,000 lives including a fully capitated Medicaid and pediatric population. The group's vision of ensuring access to high-quality and affordable healthcare fuels its innovative pursuits, including its concierge care coordination (C3) program.

C3 is a multidisciplinary approach to case and disease management that incorporates biological, social, and psychological initiatives which have contributed to CCP's consistently high record for quality care (4.59/5 and 3.5/5 Stars in the AHCA and NCQA report cards, respectively). Each member is assigned a dedicated C3 nurse to coordinate care. High-risk members, such as those managing complex chronic conditions receive additional support via disease management programs.

Challenge In order to succeed in its fully-capitated Medicaid contract, CCP needed to achieve HEDIS quality benchmarks by proactively coordinating care and reducing ED visits. Since hiring additional staff was unfeasible, CCP's C3 team needed a low-cost and scalable technology to help it reach a larger portion of its population, the rising-risk.

“Our partnership has worked by first extending our ability to monitor and reach out and support a larger segment of our members.”




Miguel Venereo
MD, FACOG, CPPS
Senior Vice President,
Chief Medical Officer
Community Care Plan

Solution To this end, CCP implemented CareSignal's Deviceless Remote Patient Monitoring (RPM) platform, choosing three of its clinically-validated programs (asthma, diabetes, and hypertension) to align with priority HEDIS measures. The [CCP-CareSignal](#) partnership's goal was to proactively manage the health status of the Medicaid rising-risk members whose escalating disease states would require more intensive and costly care if not addressed earlier.

Unlike legacy remote member monitoring devices that are high-tech and burdensome, the Deviceless RPM platform leveraged the member's existing phone and familiar with text messaging and phone calls to provide connection and complement C3's disease management programs.

Partnership At-a-Glance

ED Visits Averted for Engaged Asthma Members

 **-22%**

Average Decrease in HbA1c for Engaged Diabetes Members

 **1.35**

Engaged Hypertension Members Maintained or Brought to Control < 140 sBP / < 90 dBP

 **82%**

Use Cases Implemented

Asthma, Diabetes, Hypertension

Members Engaged

 **401**

Outreaches Automated

 **37,117**

Actionable Alerts Triggered

 **566**

Community Care Plan's Remote Member Monitoring Workflow from Enrollment to Member Outreach

A team of engagement specialists provided by the RPM company consented and enrolled members on behalf of CCP into the appropriate care program. CCP prioritized three conditions: asthma, hypertension, and diabetes, with all programs for adult populations and asthma for the pediatric population. All programs supported English and Spanish speaking demographics. Members were proactively sent clinically validated, automated SMS texts and calls specific to their medical condition on their own phone (including smartphone, pay-as-

you-go phones, and/or landlines) once enrolled (fig. 1).

The RPM platform risk-stratified members based on this data (fig. 2) and sent actionable alerts to clinicians, enabling timely, triaged outreach (fig. 3) to prevent unnecessary ED visits or exacerbations. The RPM platform's risk stratification classified members into high, rising, or low risk which determined if member outreach occurred weekly, status is actively monitored, or passively monitored respectively. CCP care managers are able to use these alerts to

contact members and provide education to help members better manage their conditions.

“ We worked with CareSignal to integrate alerts, adapting to the Care Managers' existing workflow by sending them directly to their inbox.

Claudia Navarro, FMD, MHA, BSN, RN, MSN, FNP-C, Director, Care Coordination, Community Care Plan

RPM Platform Programs and Dashboard

Figure 1
Proactive Monitoring

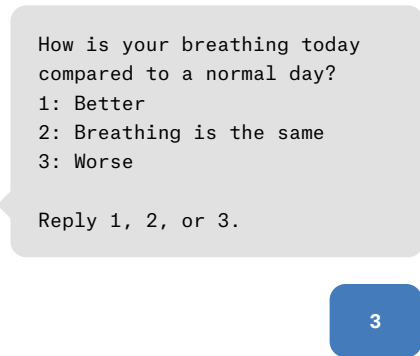
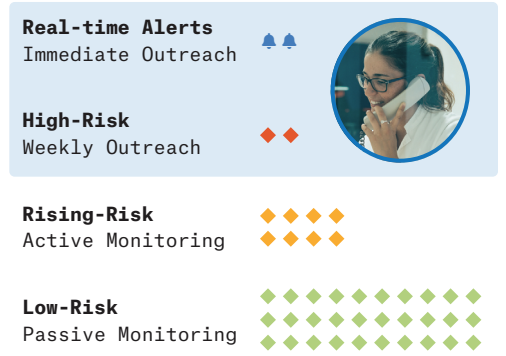


Figure 2
Risk Stratification



CCP Care Team

Figure 3
Triaged Outreach



End-to-End Enrollment Tailored to CCP Members Covered by Medicaid

Increasing member enrollment in technology solutions is at the top of every payer's wish list. To increase CCP's member enrollment, the RPM platform developed comprehensive, multi-channel enrollment campaigns. Each white-labeled, condition-specific touch point was written at a fourth-grade reading level in both English and Spanish to meet Florida's Agency for Health Care Administration (AHCA) literacy standards.

CCP's Enrollment Rates by Campaign

English **32%** Spanish **16%**

Awareness

Provider Materials



Mailer Campaigns

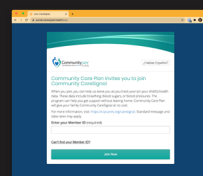


Text Message Blasts



Enrollment

Self-Enrollment Portal



Enrollment Calls



Post-Enrollment

Program Materials



Follow Chloe's member journey on next page.

Concierge Care Coordination (C3) Provides Whole-Member Support with a Collaborative, Multidisciplinary Approach

Chloe's Story: Follow Community Care Plan member, Chloe, as the C3 team uses the RPM platform to monitor her asthma condition and coordinate whole-member care.

Member Assessment

Member is a 12-year old male

History: Member reported being awakened by asthma symptoms. (CareSignal alert received)

- Upon chart review, identified four PCP visits for asthma-related symptoms within last 12 months.

Lack of Knowledge and Awareness About:

- Managing asthma symptoms and preventing exacerbations.
- Staying adherent to ADHD medications.
- Scheduling provider appointments.

Barriers & Challenges Identified:

- Lack of knowledge around asthma self-management.
- Low medication adherence and financial resources.

Interventions

C3 Care Manager (CM) following the C3 Model facilitates coordination of the services by integrating the expertise of the C3 Behavioral Health (BH) case manager, C3 Social Work (SW) team, and C3 clinical pharmacist team member to assist with the identified member/caregiver needs:

Behavioral Health: C3 CM worked with C3 BH team to coordinate the engagement and continuation of the ADHD treatment plan including timely follow up with provider.

Clinical Pharmacy: C3 CM worked with C3 Clinical Pharmacist team member to facilitate and expedite the medication for the ADHD condition.

Social Determinants of Health: C3 CM worked with C3 SW team to assist with the social need by connecting them to financial resources.

Outcomes

Asthma: Due to the asthma adherence education, support, and care coordination provided by C3, the member is more confident in managing his health and he reported he is now able to sleep better without being awakened by asthma symptoms.

- No ER or inpatient visits since enrolled in the program.
- Engaged and compliant with treatment plan, and PCP follow-up appointments.

Behavioral Health: Engaged and compliant with PCP follow-up appointments.

Clinical Pharmacy: Engaged and compliant with BH therapy twice a week.

Social Determinants of Health: Member received financial support for utilities from community organization.



“ Sometimes health literacy—educating the member about their condition—is all you need. CareSignal’s technology plays a huge part in that.”

Miguel Venereo MD, FACOG, CPPS
Senior Vice President
Chief Medical Officer
Community Care Plan

Members Enrolled in CareSignal RPM and C3 Care Management Achieved HEDIS Benchmarks at a Much Higher Rate Than Those in the Control Group

Programs Used



Asthma N=300



Diabetes N=21



Hypertension N=80

ED Visit Reduction Intervention Group

-22%

of ED Visits Averted

-27%

of ED Visits Averted

-4%

of ED Visits Averted

Control Group

+4%

Increase in ED Visits

-20%

of ED Visits Averted

+27%

Increase in ED Visits

Clinical Outcomes Intervention Group

91%

Compliant for Asthma Medication Ratio

1.35

Average Decrease in HbA1c

82%

Maintained or Brought to Control < 140 sBP / < 90 dBP

Control Group

73%

Compliant for Asthma Medication Ratio

0.01

Average Decrease in HbA1c

63%

Maintained or Brought to Control < 140 sBP / < 90 dBP

CCP Benchmark

≥ 75th

Percentile for Medication Ratio

≥ 1.00

Average decrease in HbA1c

≥ 30%

Maintained or Brought to Control < 140 sBP / < 90 dBP



“ [With CareSignal] you are letting the member know you care for them, that you are aware of them, and you are taking care of them.”

Miguel Venereo MD, FACOG, CPPS • SVP, CMO • Community Care Plan



Most CareSignal enrollees agree that they are getting the best possible care from Community Care Plan. N=120 • Average=7.45/9



Most CareSignal enrollees agree that their communication with Community Care Plan has improved. N=108 • Average=7.16/9



This is one of the best I have ever been with. Thank you for having me a customer, thank you so very much the service is awesome.”

– Member, Community Care Plan



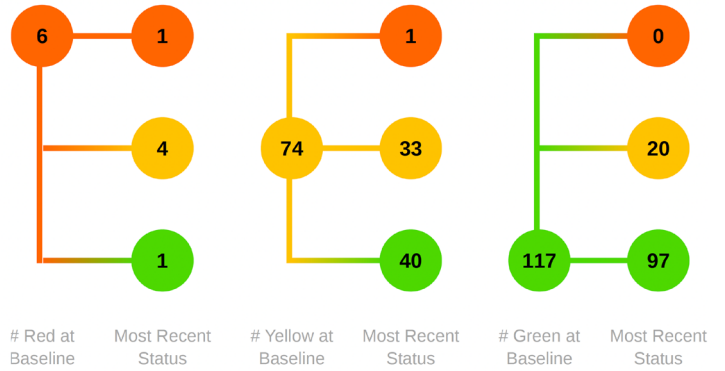
It helps to show that [Community Care Plan] is trying and using different ways to reach out to their clients (members).”

– Member, Community Care Plan

Lowering Member Risk Levels Across the Continuum

In addition to reducing ED visits and improving clinical outcomes, CCP's primary goal is to prevent at-risk members from escalating to medium and high risk levels, and to keep low risk members healthy, but catch them as they escalate. The graph on the right shows that together, the RPM platform and the C3 Care Management team are preventing at-risk members from escalating while getting low-risk members to control and keeping them there.

Asthma Status Changes



Next Steps

With promising results in scaling care management to more members, CCP is further exploring proactive care management in more conditions including COPD and maternal care. CCP's RPM platform contains a flexible portfolio of more than thirty clinically-validated programs including behavioral health, enabling CCP to expand as strategic growth opportunities arise.

▶ Take Away Even More from Our Joint Webinar

Learn from Dr. Miguel Venereo, M.D., FACOG, CPPS, Senior Vice President and Chief Medical Officer of Community Care Plan and Blake Marggraff, CareSignal's CEO as they review how CCP implemented Deviceless Remote Patient Monitoring as an integral part of their virtual care strategy and how executive payer leaders can deliver enterprise-wide virtual care solutions to high and rising-risk members to improve clinical and financial outcomes. [Watch the Webinar](#)



Learn how to leverage Deviceless RPM at your organization. Schedule a free consultation with Value-Based Care experts at CareSignal: bit.ly/meet-with-caresignal.



About CareSignal, a Lightbeam Company:
 Together, Lightbeam and CareSignal align best-in-class population health capabilities with proven remote engagement and monitoring solutions. Learn more about solutions specific to your organization and population by trying our self-guided demo: <https://try.caresignal.health/>

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