

How Stratum Med & Deviceless RPM Help Providers Confidently Transition from Fee-for-Service to Value-based Care

Background

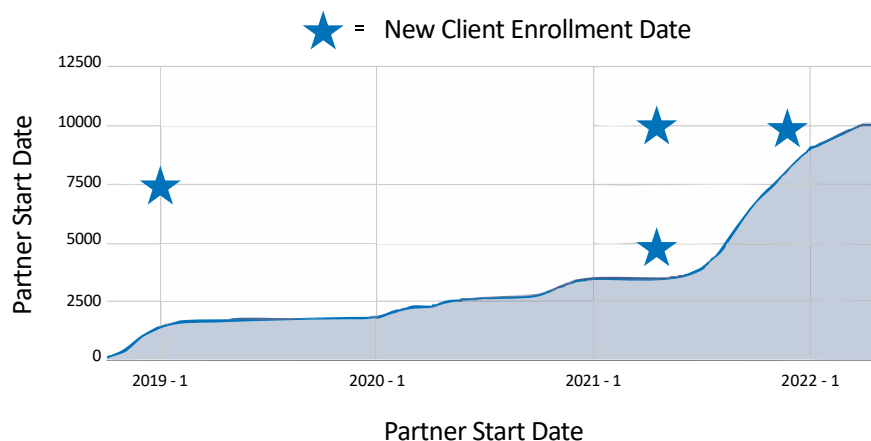
Four organizations representing partial risk to full capitation share their RPM strategies for success in value-based care. Learn from leaders at Christie Clinic, Esse Health, Health Alliance, and Mankato Clinic.



Providers making transformational investments to succeed in value-based care often face the challenge of doing so while still generating revenue in fee-for-service (FFS). To bridge the two worlds, providers must prioritize strategies such as growing chronic care management (CCM) billing and automated tech such as Deviceless Remote Patient Monitoring (RPM).

This case study features the journeys of four such Stratum Med provider groups that implemented Deviceless RPM as the catalyst to overcome staffing shortages while extending care to rising-risk patients, and preventing avoidable utilization to generate shared savings.

Lightbeam Enrolled > 10,000 High and Rising-risk Stratum Med ACO Patients into Deviceless RPM (Oct. 2018- Mar. 2022)



Proactive Alerts Scale Staffing and Drive ROI for Stratum Med Providers

TOTAL PROACTIVE ALERTS RAISED

17,354

AVERAGE ALERT RATE

2% of messages sent result in alerts

TOTAL MEDICAL COST SAVINGS*

\$3.6MM

REDUCTION IN ED VISITS*

46% CHF **31%** COPD

STAFFING EFFICIENCY WITH AUTOMATION

15x Increase

100 patient case load to 1,500*

*Data Source: Esse Health Claims Analysis

Early Stages of Value-based Care

Goal: Leverage FFS & Quality Metric Incentives to Subsidize Programs with Large Shared Savings Upside.

Christie Clinic

Mid-sized provider-owned group based in Central Illinois with 200 providers.

Value-based care Journey:

- First ACO Performance Year 2014
- Joined Stratum Med MSSP ACO & Medicare Advantage 2019

Deviceless RPM Partnership Goals

1. Identify and enroll patients in Chronic Care Management
2. Scale RPM to patients in current and future at-risk contracts
3. Reduce overall cost of care
4. Improve clinical quality metrics particularly for the rising-risk patients



“There is major value in automatically checking in with patients via Deviceless RPM, it is particularly great for patients who are reluctant to reach out to their provider, reaching these patients is most impactful for controlling costs.”



Zachary Sehy, JD, Chief Operating Officer
& General Counsel, Christie Clinic

Hypertension Outcomes:

10.14

Average Drop in sBP

5.35

Average Drop in dBP for
Baseline Patients > 160 sBP



This is working out very well for me. I receive the text and reply as soon as I can to it. I honestly appreciate this procedure and feel like these people really do care. It also shows that Christie works as a team.”

– Patient

Mankato Clinic

One of Minnesota's largest physician-owned practices with 180 providers.

Deviceless RPM Partnership Goals

1. Increase Chronic Care Management enrollment to improve patient outcomes for those who need the most support
2. Reduce unnecessary medical costs
3. Scale care management to high and rising-risk population



“Deviceless RPM helps closely monitor our patients’ health and alert nurse care managers to quickly reach out to patients who need help. Through simple phone calls or text messages, our patients can report any changes in their health. By knowing how their patients are doing from week to week, our nurses will be able to prevent avoidable hospitalization.”



Marti Wolter, MS, RN, Chief Clinical Officer, Mankato Clinic

Growing Chronic Care Management:

1,800

New CCM Patients Enrolled

Doubled

CCM Billings Per Month
from 136 to 276

Clinical Outcomes:

29

ED Visits Averted

2.1%

Avg. Drop in eHbA1c
(>9% Baseline)



It’s a fairly painless way to keep a log of general health without having to go in detail, and serves as a reminder that there is help if I need it.”
–Patient

Later Stages of Value-based Care

Goal: Prioritize Quality Improvement Over Billable Codes with Systems that Scale.

Esse Health

Esse Health is an independent physician group based in St. Louis, Missouri and has provided Deviceless RPM to its Medicare Advantage population since 2018.

Esse Health has sustainably scaled high quality, low-cost Deviceless RPM to previously unmanaged rising-risk patients, enabling it to deliver proactive care, improve quality, reduce ED visits, and generate shared savings.

Expand Care Management Amidst Staffing Challenges by Automating Manual Outreach

Esse's care managers previously made manual outbound calls to check on patients. Deviceless RPM automated that outreach and data collection via texts and calls, turning care management from an outbound manual model to an automated inbound model.



"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"



Carla Beckerle, DNP, APRN, ANP-BC,
VP of Clinical Programs, Esse Health

Clinical Outcomes:

46%

Reduction in CHF ED visits

31%

Reduction in COPD ED visits

2.91%

Avg. Reduction in A1c Among Patients with a Baseline of > 9% A1C

Financial Outcomes:

\$124

PMPM Savings

\$3.6M

Total Medical Cost Savings

Health Alliance

As an integrated delivery network, Health Alliance and Carle Health collaborate closely. Carle Health's population health team, which is housed within Health Alliance, Carle's Health Plan, spearheads programs to reduce member costs and improve quality.

Health Alliance is the most recent Stratum Med member to implement Lightbeam's Automated Patient Engagement solution for its members, and has already expanded the offering to its Carle Health's ACO members.

When searching for RPM, Health Alliance looked for a solution to improve quality with the ability to scale at a low cost. Because it wasn't focused on FFS revenue, it didn't have to think about CPT codes, and billable requirements, because improving quality is the only goal that matters in value-based care.

Deviceless RPM Partnership Goals

1. Reduce readmissions and PMPM spend
2. Improve member's experience, while increasing health literacy and empowering members to better self-manage their chronic conditions
3. Expand access to care management to the high and rising risk populations



“Our team selected Lightbeam's Deviceless RPM as the best fit for Health Alliance's remote patient monitoring strategy due to its clinically-validated pathways, ability to scale, and ease of use for our members. With this technology, we will expand access to care management, reduce disparities in health outcomes, enhance the member experience, and reduce avoidable utilization.”



Margie Zeglen, MBA, FACHE,
Vice President of Population Health at
Health Alliance and Carle Health

Staffing Efficiencies with Virtual Care Navigation:

Health Alliance is bolstering its Care Coordination team with Lightbeam's Automated Patient Engagement solutions virtual care navigators enabling it to manage a larger member pool without needing to commit additional staff.

Virtual care navigators first intervene with rising-risk members before escalating to the Health Alliance team.

By handling routine review and disease management education, the virtual care navigators enable Health Alliance's Care Coordination team to work at the top of their license, freeing up their time to help the sickest members.

Virtual Care Navigators Work the Front Line & Enable Care Coordinators to Work Top of License



Alert Triggered from Deviceless RPM



Virtual Care
Navigator



Health Alliance
Care Coordinator



Example Alerts: Breathing Status • Swelling • Member Needs Care

Key Takeaways

1. The reality is that as providers transition towards value-based care they still have one foot in each canoe: one in FFS and one in VBC. To successfully make the adjustment, take advantage of available incentives such as CCM and quality improvement to propel yourself towards more VBC.
2. Prioritize holistic quality improvement and leave behind the rough waters of billing requirements and reimbursement codes that barely lead to break-even.
3. Build financially sustainable systems that scale before growing VBC participation and risk.
4. Proactively monitor the rising-risk population to make a meaningful dent in ED visits and substantial medical cost savings.
5. Extend care management's impact with automation and virtual care navigation efficiencies that enable sustainable scaling.

About Stratum Med

Stratum Med, incorporated in 1996, is a medical group collaborative alliance originally formed by nine highly successful Midwestern medical groups. Today Stratum continues to be wholly owned and governed by 16 physician led groups and systems and has client relationships with over 100 healthcare organizations across the country, representing over 11,000 physicians.

All of Stratum's services and programs were built around the premise of leveraging volume to drive higher margins, promoting shared learning and pursuing collaborative business strategies that are made feasible by bring high performing, entrepreneurial groups together.