Competing on Patient Engagement
Forging a New Competitive Identity for a Value-Driven Marketplace
Health Care Advisory Board

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Competing on Patient Engagement

Forging a New Competitive Identity
for a Value-Driven Marketplace
Competing on Patient Engagement

Phases of Health System Value Creation

**Elevating Engagement in the Episode of Care**
- Focus on individual patients and individual episodes
- Fixing problems in today’s system around care delivery and coordination to ensure a complete, high-quality episode of care

**Driving Engagement in Ongoing Management**
- Focus on targeted groups such as high-risk patients or chronic condition management
- Building system for proactive management, low-acuity access and ongoing patient self-management

**Transforming Community Health through Engagement**
- Focus on opportunities to impact population and community health
- Identifying opportunities to spur community groups in health activities and drive broader population health

Source: Health Care Advisory Board interviews and analysis.
Three Key Components to Creating a Robust Management System

Active System Management

1. Intensive Case Management
   - Identify and prioritize support for high-risk patients

2. Targeted Care Management
   - Leverage data to identify changes in health status early

Passive System Management

   - Open "smart" access points to promote low-acuity utilization

4. Support ongoing self-management

High Intensity of System Management

Low Intensity of System Management

Source: Health Care Advisory Board interviews and analysis.
The Central Point of Accountability

Care Manager Collaborates with Clinicians to Set Care Plan, Engage Patient

Nurse Care Manager

- RN with 20+ years experience
- Central point of contact for care coordination, patient activation
- RNs may float between clinics lacking sufficient high-risk patient volumes
- RN works with maximum of three clinics

Primary Responsibilities Navigating and Activating Patients Across the Continuum

- Coordinates across sites
- Provides education
- Manages referrals
- Supports patient self-management
- Tracks patient activity
- Encourages frequent communication

Case in Brief: Massachusetts General Hospital, Partners HealthCare

- 900-bed academic medical center based in Boston, Massachusetts
- Part of the six-year CMS Medicare Care Management for High-cost Beneficiaries Demonstration
- Multidisciplinary team provides comprehensive care to top 5% high-risk patients
- Currently expanding program to serve Pioneer ACO patients, other populations under risk


1) Part of management team that includes Project Manager and Team Leader for Case Management.
2) CMS Demonstration covered top 10% high-risk, high-cost Medicare patients; current top 5% population includes medically complex who would benefit from care management (multimorbid chronic, one severe chronic, mental health/behavioral health/substance abuse, lack of socioeconomic resources to manage illness); excludes medically complex, e.g., complicated obstetrics, trauma.
Train Patients to Communicate Proactively

And Increase System Responsiveness to Patient Red Flags

Every Symptom Counts

“We tell patients to accept nothing. If you have issues, you call.”

John Sprandio, MD
Lead Physician

Case in Brief: Consultants in Medical Oncology and Hematology

- Eight-physician medical group located in Drexel Hill, Pennsylvania; created phone triage for oncology patients as part of medical home designation
- Nurses manage triage line during normal hours, on-call physicians field questions during off-hours
- Algorithms ensure standardized, timely recovery support used in clinic and for phone triage

Helping Patients Stay Home

n=13,881

Triage line receives 15-20 calls/day; only 0.1 percent results in direct hospital admission

76%

Manage at Home

Preventing Unnecessary ED Utilization, Hospital Admissions 2007-2011

ED Referrals
(65%)

Hospital Admissions
(43%)

Total Patient Volume
30%

Source: “Good Call: Oncology Practice’s Phone Triage Curbs ED Visits,” The Advisory Board Company Daily Briefing, March 2012; Health Care Advisory Board interviews and analysis.
Targeted Care Management

Setting Up System Cues to Identify Patients in Need of Management

Active System Management

2. Leverage data to identify changes in health status early

3. Open “smart” access points to promote low-acuity utilization

Passive System Management

“Automated” Self-Management

Intensity of System Management

High

Low

Source: Health Care Advisory Board interviews and analysis.
Collecting Accurate Information on Asthma Complications

Real-Time Patient Data Reveals Poor Outcomes, Enables Preemptive Management

Real-Time Management
“There isn’t a great way right now for physicians to understand how patients are doing between visits. Physicians tend to overestimate how well their patients are doing, often because patients accept their symptoms as normal and don’t report them to their physician.”

David Van Sickle
Co-founder and CEO, Asthmapolis

Innovation in Brief: Asthmapolis
- Attachable GPS device for asthma inhalers sends real-time breathing, medication adherence data to provider
- Charts frequency, location of inhaler use
- Enables providers to offer personalized management guidance and advice on medication use
- Currently in pilot with Dignity Health in Sacramento, California and employers, providers in Louisville, Kentucky

Source: Health Care Advisory Board interviews and analysis.
Health Care’s “Check Engine Light”

Translating Comprehensive Patient Information to Reveal Health Risks

Initiating Management in Response to Sudden Health Status Change

- Provider notified when behavior patterns change
- At-risk patients identified to receive immediate care
- Patient data can be connected to HIE

Innovation in Brief: Ginger.io

- Behavioral analytics platform for existing patients that evaluates passive data gathered from mobile phone sensors
- Generates risk-stratified “Check Engine Light” for health that alerts care team of patients who need immediate attention by monitoring, analyzing changes in behavior pattern
- Current pilot with Cincinnati Children’s Hospital Medical Center for IBD and Crohn’s Disease; care team members often install the mobile application for patients directly during office visits

Source: Health Care Advisory Board interviews and analysis.
A Complete Picture of Patient Health

Ginger.io Aggregates Cell Phone Data to Identify New Health Risks

Analyzing Behavioral Indicators of Social, Physical, Mental Health

- Passive Data Collection
  - GPS Location
  - Call/Text Patterns
  - Accelerometer

- Behavioral Index Metrics
  - Socialization
  - Activity Levels
  - Balance

- Protecting Privacy: Tracks activity anonymously; does not report specific contacts or locations

- Detecting Distress: Identifies at-risk patients; translates into flu, depression, stress, or anxiety diagnoses

Source: Health Care Advisory Board interviews and analysis.
3. Open “smart” access points to promote low-acyuity utilization

Making Access Easy for Patients

Worksite Clinics Facilitate Convenient, Low-Acuity Care

60%
Worksite clinic patients without a primary care physician

Prevea Worksite Clinics Manage Chronic Care Patients

Clinic NP\(^1\) coordinates chronic care, PCP follow-up

Clinics serve as medical home extension for successful PCP patient referrals

Case in Brief: Prevea Health

- 200-plus provider multi-specialty group located in Green Bay, Wisconsin
- Established five worksite clinics each staffed by one nurse practitioner, serve an average of 100 patients per month
- Worksite clinics will roll out EMR integration with PCP practices
- Chronic care processes based on medical home pilots at Prevea PCP practices

\(^1\) Nurse practitioner.
“Automated” Self-Management

Engaging the Entire Population in Self-Management

Active System Management

Passive System Management

Intensive Case Management

Targeted Care Management

“Automated” Self-Management

4 Support ongoing self-management

High Intensity of System Management Low

Source: Health Care Advisory Board interviews and analysis.
Health Information at User’s Fingertips

Automated Text Message Program Assists At-Risk Diabetes Population

4. Support ongoing self-management

txt4health Services and User Interaction

Assessment: “Let’s start building your health profile. How much do you weigh? Don’t worry, you can tell me.”

Tips: “Eating slowly helps keep you from going for second servings. If you’re still hungry after a meal, fill up on vegetables or a piece of fruit.”

Goal setting and monitoring: “Time to check in on your goal of ---> pounds. Get on the scale and then reply with your current weight.”

Innovation in Brief: txt4health and Crescent City Beacon Community

- New Orleans program managed by the Crescent City Beacon Community and the Louisiana Public Health Institute
- User self-registers for 14-week program by texting HEALTH to 300400
- Since January 2012 launch, more than 1,000 users have signed up
- Advisory group includes partners such as Blue Cross and Blue Shield of Louisiana, Ochsner Health System, Wal-Mart, Novo Nordisk, Neighborhood Partnership Network
- Additional pilot programs rolled out to Detroit and Cincinnati
- Future goal is to integrate patient data received through platform to HIE

Consistent Management Reminders

4-7 Free, customized text messages user receives each week

Mobile Platform to Set Goals, Track Progress

Macaw App Assigns Weekly Tasks, Rewards Ongoing Engagement

**Activity**
- Bike 30 minutes two days/week

**Nutrition**
- Pack a healthy lunch two days/week

**Knowledge**
- Pneumonia
- Quiz me

User completes weekly challenges, entered into raffle for prizes, rewards

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<thead>
<tr>
<th>Activity</th>
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<tbody>
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Two-Year Decline in Incidence of Key Risk Factors Using The Prevention Plan

*In High-Risk Cohort*¹

n=1,298

<table>
<thead>
<tr>
<th>HDL²</th>
<th>FBS³</th>
<th>Cholesterol</th>
<th>Blood Pressure</th>
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<tr>
<td>(56%)</td>
<td>(68%)</td>
<td>(78%)</td>
<td>(88%)</td>
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Case in Brief: The Prevention Plan

- Web-based suite of prevention tools that establishes personal action plan through health assessment, manages wellness goals, provides health coaching
- Users receive a “Prevention Score”—a credit score for health engagement—that motivates users to continue adherence to personal management plan
- Currently marketed to employers and consumers directly, but now offering “white label” version that health systems co-brand, customize

¹) Includes individuals with 5+ health risks e.g. blood pressure (systolic >139 mm Hg or diastolic >89 mm Hg), cholesterol (>239 mg/dl), HDL cholesterol (<35 mg/dl), fasting blood sugar (≥126), illness days (≥4 days last year), alcohol (>14 drinks/week).
²) High-density lipoprotein cholesterol.
³) Fasting blood sugar.

Multiple Partners for Community Engagement

Encouraging Social Networks to Reinforce Health Activities

Creative Ways to Engage People in Ongoing Wellness

Mount Carmel Health System and School District

Opened community health center on high school campus to provide preventive care, health classes

Sanford Health and YMCA

Offers group visits at YMCA in which physicians walk, bike with patients while discussing healthy lifestyle

St. Luke’s Hospital and Employers

Implementing wellness program with access to group fitness classes, lifestyle programs at 170 local worksites

1. **Identify and prioritize support for high-risk patients**
   Build robust care management systems to target high-risk groups such as comorbid or frail elderly patients. Leverage comprehensive teams—including peers—to encourage low-acuity utilization. Ensure frequent contact to manage care needs before patient symptoms escalate to the point of an ED visit or hospitalization.

2. **Leverage data to identify changes in health status early**
   For medium- and low-risk groups, such as patients with well-managed chronic conditions, create looser management infrastructure to identify when patient health status trends downward or when patient experiences sudden worsening of symptoms.

3. **Open “smart” access points to encourage low-acuity utilization**
   Expand low-acuity access points to ensure the system is available as soon as patients begin experiencing low-level symptoms. Select convenient locations including workplaces and other locations that are part of the day-to-day patient routine. Leverage virtual access points to bring care home to the patient.

4. **Support ongoing independent self-management**
   Help patients integrate health management into daily routine, and empower patients to manage their own health with minimal health system intervention. Ensure that patients are well-equipped with external tools and resources that both challenge and motivate them to achieve their personalized, actionable health goals. Link activities back to system to create seamless care management infrastructure.