Enhancing Patient Engagement Through Digital Checkups
An Update on a Pilot Study

PRESENTED BY
Martin Kleinbart, DPM
Linda Nolton
Citrus Valley Health Partners
CVHP overview
Citrus Valley Health Partners

**Mission:** To help people keep well in body, mind, and spirit by providing quality healthcare services in a safe, compassionate environment

**Vision:** We are an integral partner in elevating our communities’ health

**Values:** Respect, excellence, compassion, integrity, stewardship
CVHP overview

• Three full-service acute-care facilities, a hospice, a surgery center, 12,000 lives IPA, employed physician model, outpatient imaging center, and an affiliated Federally Qualified Health Center

• 623 total beds plus 10 inpatient hospice

• Over 3,200 employees and 1,000 physicians representing two medical staffs

• One primary care practice and one orthopedic group practice

• Market leader in the East San Gabriel Valley service area of almost 1M diverse residents, caring for nearly 1/3 of discharges in the PSA

Queen of the Valley Hospital

Inter-community Hospital

Foothill Presbyterian Hospital
CVHP primary service area/zones
Population expected to grow by 3% by 2020, seniors growing by 18%

Zone 1: Core
Population 192,964
5-year Change 3.0%
Patient Origin 26.3%
Market Share 45.7%
MS Δ: ’14-15 -0.3
65+(%) 13.0%

Zone 2: Northeast
Population 119,797
5-year Change 2.6%
Patient Origin 12.4%
Market Share 30.3%
MS Δ: ’14-15 1.4
65+(%) 17.4%

Zone 3: Central
Population 254,737
5-year Change 2.6%
Patient Origin 34.5%
Market Share 45.7%
MS Δ: ’14-15 0.6
65+(%) 9.6%

Zone 4: West
Population 137,492
5-year Change 2.7%
Patient Origin 5.6%
Market Share 12.2%
MS Δ: ’14-15 0.5
65+ 10.2%

Zone 5: South
Population 193,088
5-year Change 2.4%
Patient Origin 5.6%
Market Share 10.9%
MS Δ: ’14-15 1.5
65+(%) 15.8%
The reasons

Why communicate between visits
Today’s reality

1. Our healthcare system is at capacity
2. Patients and care teams rarely communicate between visits
3. With value-driven care, we need to also keep patient populations healthy, not just help the sick
Life — and health — happens between office visits

Life’s moments generate a ton of consumer data. Also called the “social determinants of health,” these data tell us who people are, where they live, and how they live.
We need... Continuous and Personalized Digital Care based on real-time patient data
Massive change is driving the need for new models of engagement

**Expectation Change**
- Infinite Access
- (Use of 3 different screens per day)
- Personalization
- Instant Gratification

**Consumer Change**
- Volume Value
  - ‘Pay for performance
  - Data-driven
  - Patient outcomes
  - Population health

**Payment Change**
The method
How Healthgrades Care Chats work
Healthgrades Care Chats
Designed to meet patients “where they are”

• API-driven for UX flexibility
• No additional login required
• Import from >200 biometric devices
• Works on any device
• Notification options: Text, email, secure inbox, and (soon) Facebook Messenger Chatbot
Master Consumer Profile

Continuous Engagement

Administrative Communications
- Scheduling
- Billing
- Record Mgmt
- Benefit Mgmt

Lifestyle and Wellness Communications
- Diet
- Exercise
- Lifestyle
- Habits

Marketing Communications
- Acquisition
- Retention
- Loyalty
- Satisfaction

Care Management Communications
- P4P
- CJR
- Bundled
- Capitated

Well & Low Risk Chronic

Chronic Care Management

Complex
Start a conversation...

...Text Hello to 720-410-6448
Manage all patient engagement and results using the clinician dashboard

- Review patients, their enrollments, and their most recent status per conversation module
- New patients are added manually
- Existing patient details can be edited
Ability to add patients and their profiles manually

- New patient details are added
- Patients are enrolled in one or more conversations
- Based on the conversations enrolled, additional detailed questions
View, manage and filter patient results

- Red/Yellow/Green for severity of response to each clinical question
- Last 3 response trend
- Filterable by name, color, or conversation module
- Exportable to CSV
We’ve noticed that your blood pressure has been running higher than we’d like. Let’s see how you’ve been doing lately.

How would you like to share your blood pressure with us today?

- Enter by hand
- Upload automatically
- I haven’t been measuring my blood pressure

Inter-visit Communication
What is CCJR
Comprehensive Care for Joint Replacement
Volume to value
CMS announces goals

<table>
<thead>
<tr>
<th>Medicare move towards Alternate Payment Models (ACO and Bundles)</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>2016</td>
</tr>
<tr>
<td>50%</td>
<td>2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare payments tied to quality or value</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td>2016</td>
</tr>
<tr>
<td>90%</td>
<td>2018</td>
</tr>
</tbody>
</table>
Key elements of CCJR

• All providers paid in traditional FFS model — this is not prospective bundling

• MS-DRGs 469 & 470 (Inpatient only)

• Target Spend set for acute care + 90 days post discharge

• Retrospective review of actual spend vs target price each quarter

• Reconciliation at end of the year, IF
  • Actual spend is above target spend = Hospital will pay Medicare difference
  • Actual price is below target spend = Hospital will receive payment, as long as following quality metrics are achieved: Complication rates, HCAHPS and 30 day Readmission rates

• Waivers for Gainsharing program with Physicians and Others
**Gainsharing Model**

1. **NPRA from CJR Episodes $**
   - NPRA = Net Payment Reconciliation Amount and Quality Incentive Payments from CMS – Must meet specific quality targets to be eligible

2. **ICS from CJR Episodes $**
   - ICS = Internal Cost Savings from Hospital Total Supply Costs reductions – Measured and funded by CVHP

3. **CJR Gainshare Pool = NPRA + ICS**
   - Calculate individual physician results and submit to committee for approval

4. **50% of Gainshare Pool to Orthopedic Surgeons until Phys Cap (@ 50% Part B Allowable)**
   - Electronic transfer of funds to Physicians

5. **Measure Quality Metrics Achieved at Individual Physician Level – Adjust Cap, if necessary**

6. **Quality Metrics achieved:**
   - 1 of 3 = 33%
   - 2 of 3 = 66%
   - 3 of 3 = 100%

7. **Documentation and Audit Trail Necessary – Must Clear out Funds for Each Performance Period**
What we’ve learned
Pilot results
Total knee/total hip

• 60 enrollees all CJR eligible
• Digital sessions offered: 186
• 0 Opt outs and 0 readmissions

“IVC makes my life a helluva lot easier”
— Lisa Ryan,
Nurse Navigator CJR Program
Pilot cost results
Those utilizing digital checkups had improved cost and post-acute-care utilization compared to those who did not use the tool

- The 90-day spend for those receiving a digital checkup was 14% less than those who did not utilize it
- The use of post-acute care was nearly 20% lower in the digital checkup population
  - For those who used SNFs, the digital checkup population’s SNF ALOS was 55% lower than the other patients
- The usage of home health was similar between the two populations,
  - Those receiving digital checkups were slightly less likely to utilize HH after a SNF visit

The patients are those with DRG 470 w/o hip fracture. All data should be considered preliminary until final CMS reconciliation.
CJR responses

• 34% of respondents completed the Patient Reported Outcomes via the tool

• There were a total of 518 responses using the tool
  • 2.7% were “Red”

• The most common questions with red responses were:
  • Fever over 100 degrees
  • Excessive pain
  • Swelling of one leg upon awakening
Lessons learned

CJR

• Change the frequency of the digital checkup to 1x a week rather than every few days post-op

• Patients are more comfortable with the email rather than texting. Seems to be age related over the technology

• If we had the option, we would have the MD help sell the concept when the patient is scheduled for surgery

• Dedicated person to review patient dashboard daily would have helped with catching red flags earlier
Lessons learned
Diabetes and hypertension pilot

• Mass mailing did not engage the patient and therefore resulted in very small pilot

• Physician buy-in was not as robust as is needed to “sell” the product and process

• Calling patients from call center to encourage enrollment caused concern from the patient and office staff

• Integration with Physician EMR would have promoted buy-in and perhaps encouraged the physician to enroll patients he would like to follow
Lessons learned
Diabetes Education Clinic

• Participating Educators and Pharmacist needed more hand holding than we expected

• Assess the technical skill and capabilities of the users earlier in the process

• Start with smaller patient groups rather than trying to tackle all at once (Type II diabetes and Gestational Diabetes)

• Minimize the number of users that will be given access to the dashboard, enroll patients and run reports

• Maximize the possibility that one patient may be enrolled in different programs
Next steps

Roll out diabetes and hypertension program to system-owned primary care practice
Questions?