The Power of a Consumer-based Healthcare Approach

Session #107, February 21, 2017

Mason Beard, CPO | Harm J. Scherbier, CMO | Stephanie Kovalick, Chief Strategy Officer

DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.
Speaker Introduction

Mason Beard
Chief Product Officer

PHILIPS
wellcentive
Speaker Introduction

Harm J. Scherpbier, MD MS
CMO

PHILIPS
wellcentive
Speaker Introduction

Stephanie Kovalick
Chief Strategy Officer
Conflict of Interest

Mason Beard, Harm J. Scherpbier and Stephanie Kovalick:

Have no real or apparent conflicts of interest to report.
Agenda

• The journey to VBC success
• The impact of effective patient engagement on PHM
• How patient engagement varies based on populations
• Why patient engagement has been historically difficult
• Direct perspectives and potential solutions
Learning Objectives

• Review the benefits of moving from the old population health management view to a model based on true partnerships with patients
• Identify the benefits of engaging patients as consumers
• Discuss ways for overcoming roadblocks such as fragmented networks and information systems and outdated mindsets, workflows and behavior patterns
The Journey to Continuous Health

- You’ve identified your populations, you know what you need to improve, next step is getting your patient to work with you
- Patient engagement should be a key area for planning and strategy—and turning strategy to action
- Building physician alignment and adaptation to create a lasting relationship with the patient
Integration & 1-Way Messaging

Informed
- Educate and Connect
  - Provide way finding services
  - Offer e-tools for education, wellness and prevention

Engaged
- Garner Patient Participation
  - Offer interactive wellness tools
  - Use real-time scheduling and communication
  - Provide access to records

Directed Care & Communication

Empowered
- Encourage Self-Advocacy
  - Deliver reports and ratings for providers
  - Encourage active participation by the healthcare consumer
  - Drive quality and cost transparency to allow patients to make their own decisions

Partnered
- Establish True Clinician / Patient Partnership
  - Create shared decision-making for outcomes and cost
  - Offer passive and active home monitoring
  - Deliver patient-specific analytics intended to drive patient behavior change
The impact of effective patient engagement on PHM

• Chronic patients often see more than a dozen caregivers each year
• Adults with a chronic illness typically receive only 56 percent of the care recommended by clinical guidelines due to ineffective transitions and/or personal barriers
• The impact of activating patients using connected devices significantly shifts the game plan
Reducing readmissions and inpatient days

• Approximately 19% of Medicare patients are readmitted within 30 days.
• Evidence suggests that improved patient satisfaction is associated with decreased 30-day readmission rates.
• Medicare’s Chronic Care Management program (CCM), a telehealth-enabled initiative, relies on patient engagement.
• To address the problem of avoidable readmissions, ACA created the Hospital Readmissions Reduction Program and Partnership for patients, which aims to improve engagement.
The impact of effective patient engagement on PHM

• Reduction in hospital readmission and inpatient days
• Cost savings
• Increase adherence to care including referrals
• Overcome treatment barriers
• Reduces complex billing procedure
How patient engagement varies based on population

• Cannot use the same engagement strategy on different populations—diabetic vs asthma vs cardiac, for example.

• Reimbursement Challenges: Medicaid, Medicare and Commercial Payers
Why patient engagement has been historically difficult

- Lack of providers time
- Lack of effective access to a technology
- Lack of patient compliance
- Lack of investment
- Complex regulation
Case Study: EvergreenHealth Partners

- EHP’s top priority has been to increase proportion of membership assigned to a PCP within EHP

<table>
<thead>
<tr>
<th>Goal</th>
<th>Target</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Increase the percentage of members attributed to an EHP PCP</td>
<td>+ 2.0%</td>
<td>+ 3.3%</td>
</tr>
<tr>
<td>2) Reduce members with no PCP designation</td>
<td>- 4.0%</td>
<td>- 3.9%</td>
</tr>
</tbody>
</table>
Case Study: EvergreenHealth Partners

- 2015 plan year succeeded in reducing PEPM expenses back to 2009 levels.

2009-2012

13.2% Increase
Per Employee Per Month (PEPM) claim expenses increased 13.2% over this time

2013

10.5% Decrease

2014

0.8% Decrease

2015

5.1% Decrease

As a result of 3 years of targeted network and design changes, 2015 paid medical/pharmacy claims were lower than 2009 paid claims PEPM.
Case Study: EvergreenHealth Partners

Strategies for Quality Improvement
- Strengthen relationships with practices and develop shared culture of EHP
- Educate members on clinical integration and EHP’s strategy for improving population health
- Focus on closing care gaps for quality initiatives with large denominators
  - Preventative care screenings
  - Well-care visits
  - Diabetes maintenance
- Leverage Wellcentive in primary care practices to support care gap identification and care management
Case Study: EvergreenHealth Partners

Solutions for Quality Improvement
• Created individual care gap alerts to identify patients out of compliance with preventive or condition-specific quality measures
• Then created master care gap alerts by contract that pulled in the quality measure alerts specific to each

Learnings: Quality measures must be worked at the patient level
Direct Perspective
Questions

PHILIPS wellcentive

Don’t forget to complete the online evaluation for this session.