Cracking the care management code:

The right combination of people and technology

SIGNALLAMP HEALTH

The U.S. healthcare financing, payment and delivery models need massive transformation. Over the last 10 years, we've been driving toward new approaches, and for good reason. Costs continue to rise faster than inflation, putting the health of millions of Americans and the U.S. economy as a whole at risk.

To date, most efforts have been focused on insurance and payment reform—key pillars of the required reformation. Lagging far behind, in our view, has been the transformation of our delivery system. We have to fundamentally alter the medical model—a model that today is purpose built for acute and ambulatory sick care—where providers open their doors and wait for patients to come to them.

But, even among the sickest of patients who do find their way to care, we get only brief glimpses into their world. Patients spend most of their time outside the reach of the facility-based healthcare system (i.e., at home, at work and everywhere in between). It's not good enough to see patients periodically. To truly impact care, we have to connect with patients between traditional office visits and facility-based interactions. We need more touches, not fewer.

WHAT IS CCM?

CMS defines CCM services as those provided by a physician, PA, NP, clinical nurse specialist, or certified nurse midwife and their clinical staff, per month, for patients with two or more chronic conditions expected to last at least 12 months or until death, and that place the patient at significant risk of death, acute exacerbation or functional decline.

What is the prescription? In an ideal world, it may look like this:

- See patients more often—engage them proactively outside regular office visits
- Engage patients in preventative care in an ambulatory setting before they're already too sick
- Provide nurse care management for the many, not just for the few
- Be profitable providing care in these new settings
- Digest acquisitions of physician practices and other facilities by more closely integrating care among acute, ambulatory and post-acute settings

If we're honest, the reality of today's healthcare system is far from this ideal. For example, average 30-day readmission rates in 2017 were still high—15.3% hospital-wide and 22.1% for heart failure patients.[1] Consider one other data point: The U.S. spent over $1 trillion in 2016 on chronic

care, or nearly 6% of GDP.[2] And health systems have largely failed to engage with patients outside of the traditional delivery system. For example, CMS's Chronic Care Management (CCM) program, which reimburses providers for caring for patients remotely,[3] has touched fewer than 2% of Medicare beneficiaries. This is true despite the best efforts of mHealth start-ups, EHR and healthcare IT vendors, which have raised hundreds of millions of dollars but produced a litany of failures. Among such failures is CareSync, a Florida-based CCM vendor, which folded just three years after relaunching its own patient engagement software and building a call center with over 300 staff.[4]

EXHIBIT 1

CCM: A WIN-WIN-WIN FOR PAYERS, PROVIDERS AND PATIENTS

Early results from the CCM program show, despite poor uptake among providers, that it can positively impact health and costs:[6]

- CMS netted $36M in the year after the first CCM service delivery period.
- CCM beneficiaries had slower growth in healthcare expenditures. They also were less likely to be admitted for diabetes, congestive heart failure, urinary tract infection and pneumonia.
- CCM improved patients' ability to communicate with their physician, more quickly schedule appointments when appropriate and manage their health and medications.
- Providers' staff could spend more time on care coordination and follow-up.

So why aren't we further along?

We haven't made greater progress because delivering care in new models, with new payments, with sick and complicated patients, is hard to operationalize and to finance. Essentially, it turns the traditional care model of treating sick people in facilities on its head. It requires provider organizations to connect with patients in their homes rather than in their facilities.

That takes more than technology—it also requires new operational expertise and a nursing team that can build ongoing relationships with patients in their homes. And many providers haven't figured out how to offer robust capabilities on the modest care coordination reimbursements available.

"Starting chronic care management is more of a must-do than many other newer programs. It's harder to implement than people think. You have to consider if you can meet the deadlines and put the right processes in place. And if you don't enroll enough patients, you will lose money."

–Kelley Brault
Practice Administrator,
Lake City Primary Care NCQI Level III PCMH practice

Making chronic care management work:

A pragmatic model that funds itself

Many health systems recognize the need to engage with patients outside the office setting to head off preventable ED visits and keep patients healthier in their homes. While some providers will succeed with an in-house remote care management solution, many have found that the time, staffing resources and impact on workflows are far more than anticipated. Other initiatives start with momentum but fade under the pressure to enroll patients and replicate performance month to month. In a healthcare world still driven largely by volume, providers are overwhelmed by the demands of increased patient loads, sicker patients and a complex payment

landscape. Adding a helping of drudgery to their plates often puts them past the tipping point.

Fortunately, with the right partner, healthcare systems can quickly add care management capabilities and broaden their reach beyond the most acute patients. With reimbursement available under the CCM codes, that initiative can pay for itself and bring new resources to the organization.

"The Signallamp CCM program allows us the opportunity to expand chronic care management services for our patients. We are able to outreach to a much larger group of patients with this service."

–Senior Director, Patient Centered Medical Home and Care Coordination, The Guthrie Clinic

A remote care management partner should:

- Become an integral part of the care team, not an arms-length relationship
- Reduce the burden for administrative and clinical staff
- Work seamlessly with any number of EHRs and population health tools
- Minimize integration costs and delays
- Customize a program to suit your specific needs, goals and workflows
- Proactively address social determinants of health and barriers to care
- Offer end-to-end services, including enrollment, service delivery, compliance and billing

Starting with a basic building block like CCM lets you take the first step to better care management. It enables you to better serve patients *and* provides new top-line revenue for your practice or health system. When done well, it funds your transformation to this new delivery model—engaging patients to *directly* increase revenue through CCM billing codes and *indirectly* increase it through more office visits, higher long-term revenue potential from loyal patients, improved quality scores and lower utilization.

The many benefits of chronic care management

When properly executed, a remote care management program can be a win-win; providers make money while patients get better care. It delivers numerous benefits to practices and health systems, including:

1. Net new revenues

Each patient actively engaged in CCM can generate over $500 of additional revenue per year when combining direct CCM reimbursement with ancillary revenues from new office visits and other services throughout the year.[7]

"We saw the CCM programs as an opportunity to strengthen relationships with patients and deliver an added level of care, but we estimated that we would need three to four full-time nurses to fully develop it."

–Kathy Stanton
Practice Administrator, Jamestown Primary Care Partners

2. Loyal patients

Even more significant is the potential long-term value of a loyal patient, which can exceed a million dollars.[8] An effective chronic care management program helps you develop a cadre of loyal patients. But that requires more than getting high marks on a patient satisfaction survey. Loyalty is built on trust that comes from consistently meeting a patient's care needs, meeting or exceeding their expectations and delivering a positive overall experience. That requires two things:

- Easily identified entry and delivery points to provide care after an inpatient stay
- Longitudinal care between office visits to keep patients healthy, longer

3. Better quality, lower-cost care that meets value-based care reimbursement
The results from the CCM study show that this approach can reduce utilization and costs. Signallamp Health's customers have also demonstrated that more patient interactions directly translate into higher MIPS scores and Medicare Advantage HEDIS scores.

"With Signallamp, there has been no distracting impact on our workflow, but actually a clear, positive impact on our team-based care delivery."

–Tiffany Jaskulski
EHR Manager, The Wright Center for Primary Care

4. Happier providers and staff
Providers and in-office staff benefit by being able to focus care management efforts on their highest-risk patients. They also appreciate that remote nurses are able to improve medication adherence, keep patients on their plan of care, reduce facility-based utilization and address questions before they become inbound calls to the practice.

Whether due to the banality of tracking minutes, the need for onerous documentation or the challenge of connecting with patients outside the office, most providers have found they can't operationalize a remote care management initiative that requires a new staffing model, builds in flexibility for the patient and is both efficient and sustainable. But having a partner whose skilled team of nurses can deliver care remotely and has proven its ability to work with a variety of workflows enables you to foster highly-engaged patients and long-term patient satisfaction.

The technology-driven care management fallacy

Delivering high-quality healthcare is incredibly challenging and equally inefficient. Introducing technology is a sensible approach to address the scale and scope of healthcare challenges. However, after pouring tens of billions of dollars into digitizing health records, which many expected would produce enormous benefits, the industry is experiencing a significant technology hangover as it searches for an elusive ROI on its IT investments.

One clear benefit of technology is to help identify at-risk patients among many thousands of patients and millions of data points. But many health systems are ill-equipped for the staffing needs and new workflows required to react to the data and to conduct care management at scale—and beyond today's frequent fliers.

Lost in the rush to use technology to modernize healthcare is the need to leverage the most trusted relationship in healthcare—that between providers and patients. Technology is necessary but should support —not distract from—that personal relationship. That's especially critical with an aging and sicker population. Providers and health systems need solutions and partners that understand the need to leverage the trusted relationship that providers and patients have forged, often over many years. These solutions must include three key facets:

1. Credibility
The nurses must have an intimate knowledge of the patient, their history, and their unique needs. This only works when the additional outreach comes from the same nurse working hand-in-glove with the primary provider and the provider's technology system—truly becoming an extension of the practice. Models that rely heavily on a typical call center approach, where outreach is irregular and without a consistent relationship, fail the credibility test. Patients don't feel valued when provided only token outreach, nor will this kind of approach move the needle on cost or quality.

2. Compassion
Healthcare at its core is extremely personal, especially for chronic care patients. Effective chronic care management models don't lend themselves to sterile, cookie cutter approaches. Patients in need, need someone to care. We firmly believe that care cannot be automated by an app, or a module, or any other technology substitute. Humans will remain at the center of the care equation.

3. Technology

While care is and will remain personal, technology plays an incredibly important role in driving new levels of efficiency—making it easy to integrate chronic care management solutions into the workflow and automating every aspect of the process around the interaction—including what information providers have at their fingertips before and during the call, and afterwards for tracking and reporting.

Providers and health systems need CCM partners that understand the need to combine the power of technology and people—that can support your existing care team and integrate with your existing technology to build long-term relationships that travel with patients on their unique journey. Working on the patient's own timetable and connecting regularly throughout the year, remote nurses leverage the trusting relationship patients have with their providers to increase medication adherence, follow through on care plan goals, reduce missed appointments and close gaps in care.

While provider and patient alignment is a natural dynamic in the face-to-face visit, taking this alignment beyond the four walls of the clinic requires establishing initial credibility as well as maintaining an ongoing compassionate relationship between the remote nurse and patient. That places a significant burden on successful and sustainable execution. The crucial component is a ruthlessly efficient design that enables the practice to remotely manage care without any sacrifices and with much to gain.

EXHIBIT 2

THE ROLE OF TECHNOLOGY	THE ROLE OF HUMAN-DRIVEN OUTREACH
+ Identify patients with multiple chronic conditions	+ Connect chronically ill patients to their own dedicated care management nurse
+ Build care plans for a panel of diabetics	+ Personalize a care plan for the diabetic who lives alone and can't afford test strips
+ Create an online portal	+ Help a patient get an email address and enroll in/use the portal
+ Send text alerts to patients	+ Understand patient preferences to engage via phone, email or text
+ Enable patients to leave messages for providers	+ Hire dedicated nurses to triage messages to facilitate proactive care
+ Enable remote monitoring of blood glucose	+ Hire dedicated nurses to provide ongoing education and support services for the device
+ Expand the use of apps and RPM	+ Engage both tech-averse and tech-savvy patients
+ Create a call center	+ Hire dedicated nurse care manager to create consistent, personal relationship with patient
+ Identify frequent fliers	+ Deploy care management resources to engage next year's frequent fliers today

Technology alone won't engage your high utilizers of today or tomorrow. Instead, health systems that combine integrated technology solutions with human interactions are the ones that will be the winners going forward. Exhibit 2 provides examples of how using human-driven outreach can turn technology into cost-effective, meaningful patient engagement.

The proof: Picking the right partner gets results

An experienced partner that understands how to use technology to operationalize and sustain a remote care management initiative can save organizations significant time, pain and expense. Led by its expert clinical and administrative team, Signallamp Health has partnered with more than 2,000 providers and multiple health systems to enroll and provide remote care for more than 20,000 patients.

To earn the trust of its partners, Signallamp:

- Collaborates with each provider and location to customize workflows and business rules
- Ensures that each patient works with the same nurse care manager to amplify the impact of the nurse-patient relationship
- Works within a client's existing technology infrastructure to launch a proven program in a matter of weeks
- Collects and shares patient feedback about the impact of Signallamp's services on their own health and willingness to recommend their provider

Satisfaction and revenue results speak for themselves: In a recent survey of Signallamp's enrolled CCM patients, 93% stated the program enabled them to recognize and report health issues sooner (Exhibit 3) and 86% said their nurse helps them take their medications properly (Exhibit 4). More than three quarters of respondents also gave the program the highest rating.

Importantly, Signallamp's approach is also generating net new revenue for clients of approximately $500 per patient per year, through a combination of direct CCM revenue and increased annual wellness visits, reduced patient no-shows and improved referral management.

+ REAL DATA

Signallamp Health has partnered with numerous provider and health systems to make chronic care management work.

Over 2,000 participating providers

Over 20,000 enrolled patients

8+ remote interactions/ patient/year

73% patient retention rate

Over $500 net new revenue/enrolled patient/year

Higher MIPS and HEDIS scores

EXHIBIT 3

Having a care management nurse helps me recognize and report health issues sooner.

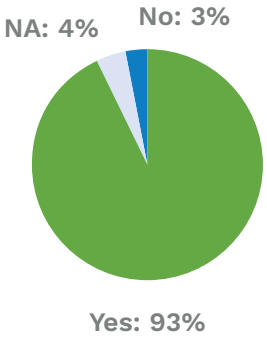
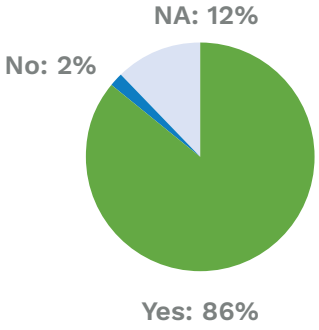


EXHIBIT 4

My nurse helps me understand my medications and take them properly



Source: Signallamp survey of 134 enrolled CCM patients

The bottom line about care management: To survive—and thrive—health systems must become proficient at managing chronic care outside the facility setting and across the care continuum.

Launching a remote care management program with an experienced vendor is an effective way to begin transforming care delivery while growing revenue streams and meeting quality and utilization goals. Care management is surprisingly challenging to implement and operate efficiently. It requires moving from old delivery models to ones that can engage patients remotely and over time. More importantly, it requires a proven team of great people enhanced by effective technology.

Contracting with the right care management partner serves as that critical bridge between acute, post-acute and outpatient care. It enables you to launch a program without disrupting provider workflows or adding staff. In the short term, it delivers untapped revenues along with higher-quality, more coordinated care. In the longer term, you will build a loyal following of patients that drives long-term revenue streams. As you gain experience in delivering coordinated, longitudinal care that keeps patients healthier and happier, you'll also build skills that help you manage risk-based contracts.

Forward-thinking health systems can leverage Signallamp's rich experience to keep both their patients and bottom lines healthier under any type of reimbursement approach. With a small investment of time and no incremental costs, your practice or health system can be one of them.

SIGNALLAMP HEALTH

About Signallamp Health, Inc.

Signallamp Health is a technology-enabled care management provider that works as an extension of health systems and providers and dedicates nurse resources to chronically ill patients. For patients, Signallamp Health builds on trusted physician relationships to enhance patient care, engage patients in their own good health and deliver better health outcomes. For providers and health systems, Signallamp is targeting untapped sources of revenue, driving ancillary services and helping practices succeed in MIPS and value-based reimbursement programs. Learn more at signallamphealth.com.

REFERENCES

1. https://www.statista.com/statistics/325047/readmission-rates-at-hospitals-in-30-days-in-the-us-by-disease/

2 https://www.milkeninstitute.org/publications/view/910

3 https://www.modernhealthcare.com/article/20180220/NEWS/180229988

4 https://medcitynews.com/2018/06/caresync-is-shutting-down/

5 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf

6 https://innovation.cms.gov/Files/reports/chronic-care-mngmt-finalevalrpt.pdf

7 Signallamp program data

8 https://www.beckershospitalreview.com/hospital-management-administration/what-do-you-really-know-about-patient-loyalty.html

9 Signallamp survey of 134 enrolled CCM patients