NAACOS- ACO Boot Camp
Patient Engagement

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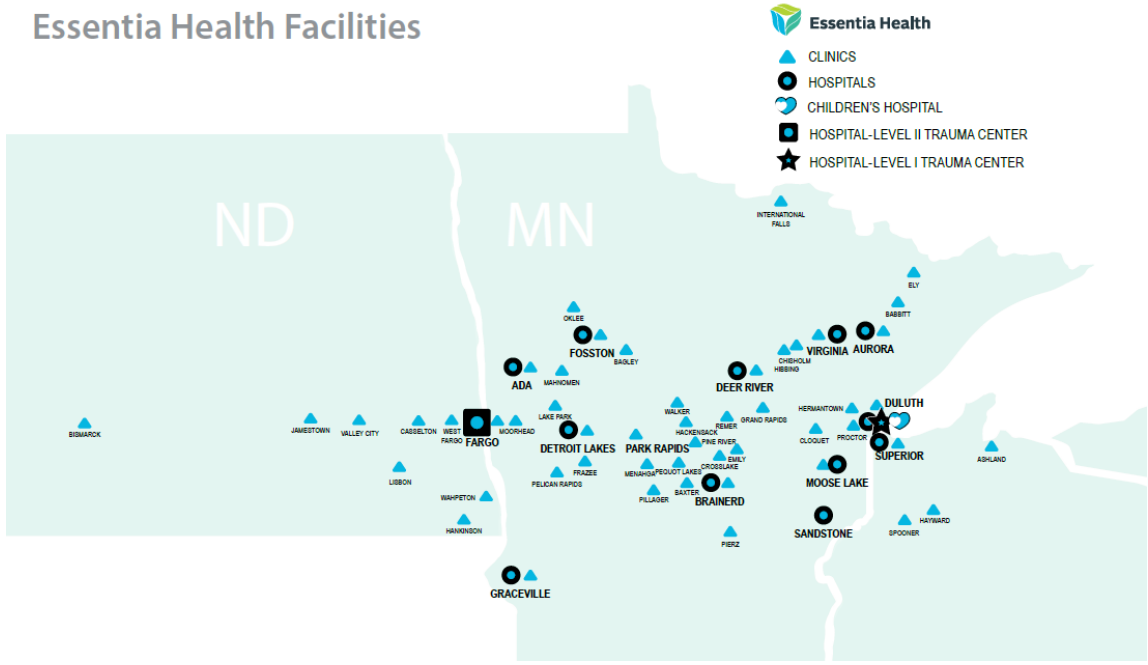
Objectives

- Define patient engagement
- Provide practical techniques to identify patients
- Identify reasons why patients may be difficult to engage.
- Describe tactics that could be put in place to improve patient engagement.

Essentia Health

Our mission: We are called to make a healthy difference in people's lives.

- **15,700** colleagues
- **14** hospitals
- **79** clinics
- **6** long-term care facilities
- **6** assisted living & independent care facilities
- **7** ambulance services
- **1** research institute



Our Value Based Care Journey

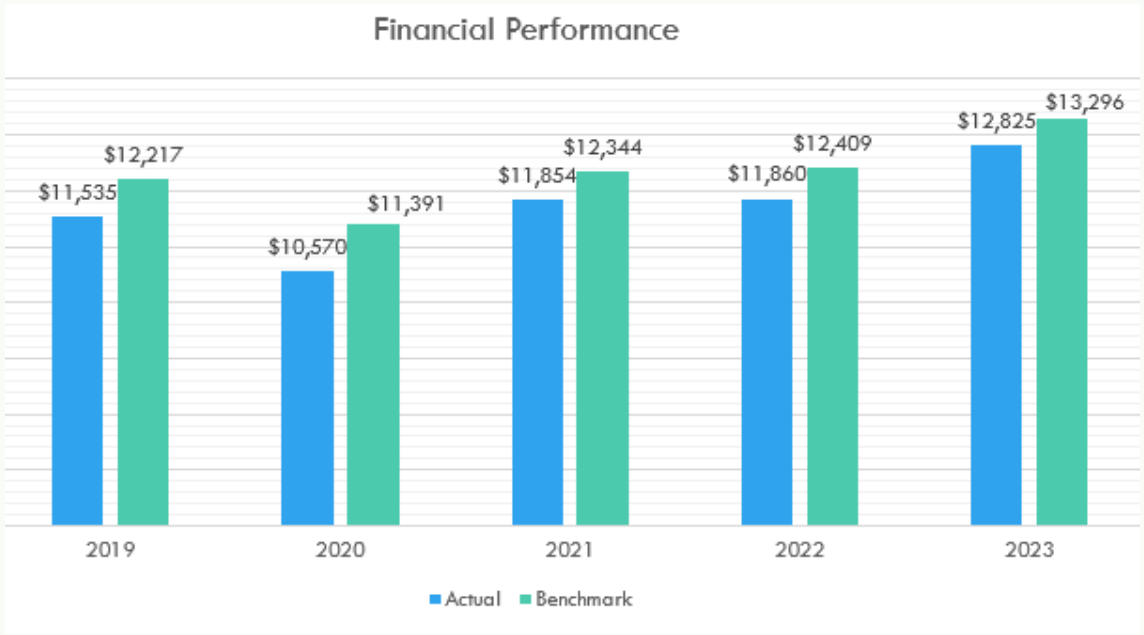
Continued to add VB payer programs

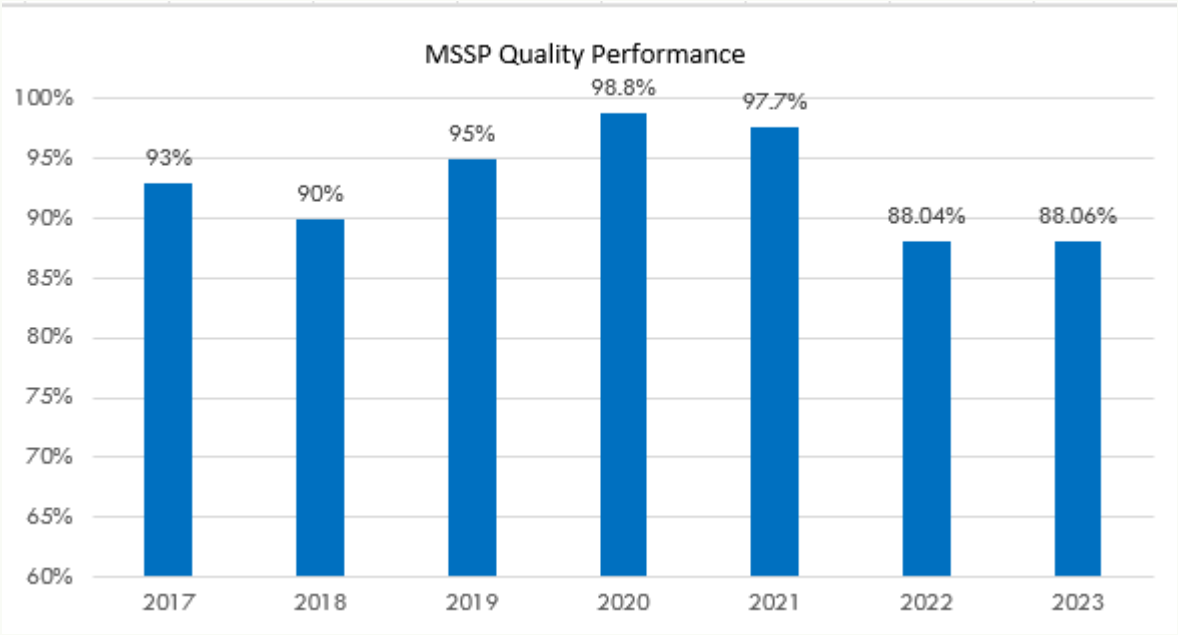
- **2005:** First value-based contract
- **2009**: Co-branded Medicare Advantage Plan
- **2012: Accountable Care Organization Formed**
- **2013**: MN DHS Medicaid (IHP) & Medicare Shared Savings (MSSP)
- **2016:** Medicare Shared Savings Program (risk added)
- **2017**: Co-branded commercial ACO product launched
- **2018**: Transition to MN Medicaid (IHP) Track 2 (risk added)
- **2023**: 24% YOY growth in attributed lives
- **Today:** 23 VB programs with 240,000+ attributed members

Essentia Health ACO

- Single entity rural ACO, headquartered in Duluth, MN
- Formed in 2012 as vehicle to advance population health and value-based programs within the organization.
- MSSP and MN Medicaid (IHP) are directly within the ACO with 28,000 and 48,000 attributed lives, respectively.
- Manage the other 21 value-based programs (over 160K lives) using the ACO population health model.
- Total population split is approx. 55% commercial/45% government
- 40% of the system's total revenue flows through the value-based programs.

Essentia MSSP Performance 2017-2023





Earnings totaled $8.3 million in 2023, $10.9 million in 2022, $10.1 million in 2021, $10.6 million in 2020, and $9.5 million in 2019

Value Based Care Initiatives

Key components reducing the total cost of care (payer spend) and improving outcomes are:

1. **Quality & Outcomes**
   - Annual Wellness Visits (AWV) and Preventive Care
   - Closing gaps in care
   - Accurate documentation of new and chronic conditions

2. **Utilization and Cost**
   - Reduce potentially avoidable ED visits
   - Lower occurrence of preventable inpatient stays
   - Reduce readmissions

We are called to make a healthy difference in people's lives.

Patient Engagement

Essentia Health

Definition of Patient Engagement

Collaboration between patients & health care providers to improve healthcare outcomes.

Key Elements:

- Identifying patients who may need support
- Creating workflows and tools to help make this efficient
- Evaluating success

Identifying patients

- Attribution
- Empanelment
- Care Gaps

Attribution

- Evaluating stayer/leavers/churn
- Identifying members who are at risk of leaving ACO or value-based contract
  - Outreach: MyChart/Letter
- Identifying members who have only seen Advanced Practice Provider
- Voluntary Alignment

Primary Care Empanelment

- Meaning: Does that patient have a primary care provider assigned in their patient medical record?

Who is the Quarterback?

- Reports identifying:
  - Patients with no PCP on file
  - Patients with inaccurate PCP (non-provider)
  - Patients with PCP who are no longer with organization

Why does Primary Care matter?!?

- Regular visits increase preventive service use[1].
- Better management of chronic diseases, leading to fewer complications[2].
- Improved patient outcomes, including lower mortality rates and fewer hospital admissions[3].
- Higher patient satisfaction, leading to better adherence and improved outcomes[4].
- Cost-effective by reducing the need for expensive specialty and emergency care through early and efficient management[5].

Care Gaps

- Medicare Annual Wellness Visits
- Quality – Gaps in Care
  - Examples: Diabetes Control, Hypertension Control, Colorectal Screening
- HCC Recapture Rate

Providers Tools for Engaging Patients

Connection with Primary Care

Goal: Annual visit with Primary Care

- Scheduling Visit with Primary Care prior to leaving appointment
- Standard work around rooming

Quality – Standard work

- Diabetes
- Hypertension
- Depression Remission

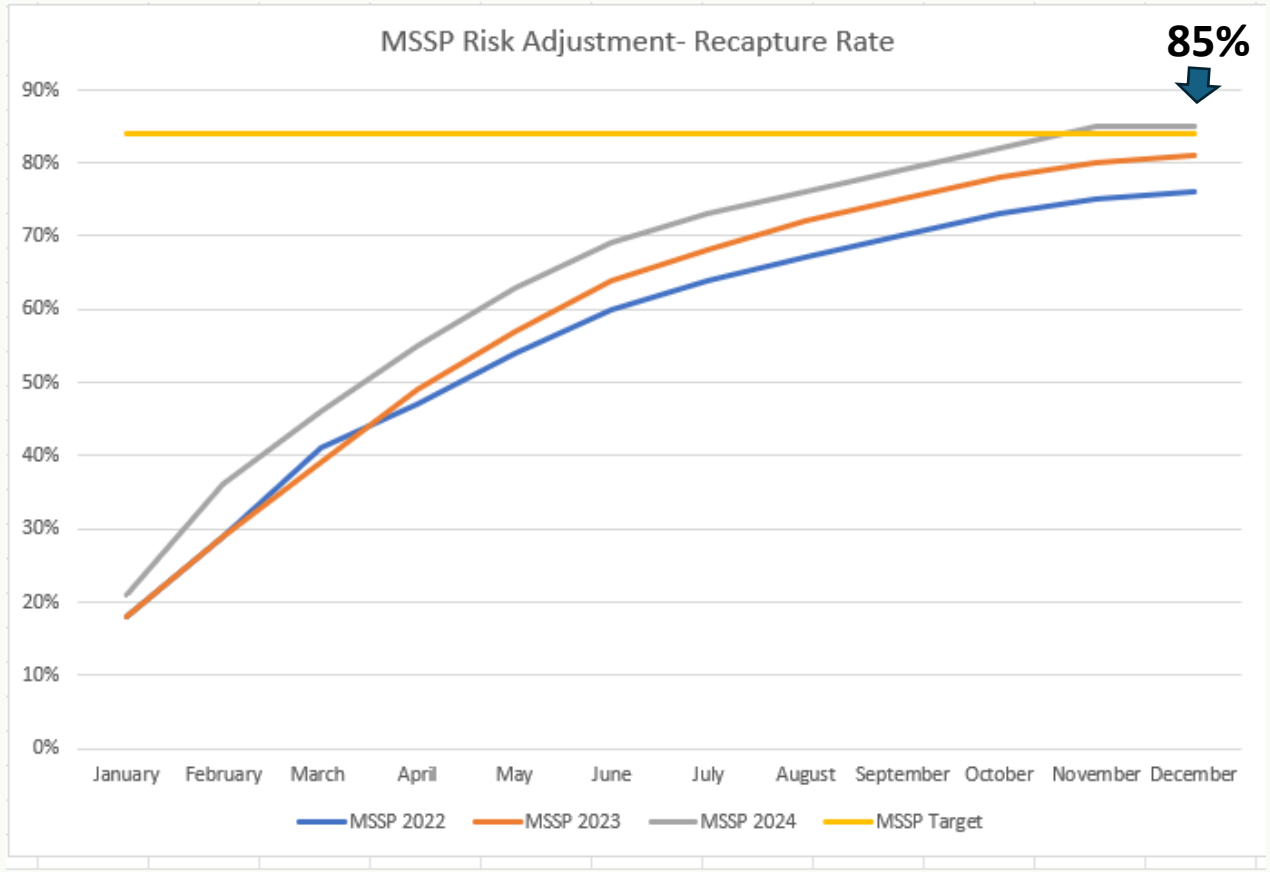
Coordinating Care

- Identified panel of patients
- Transitional Care Management
- Chronic Care Management Program
- Social Determinants of Health

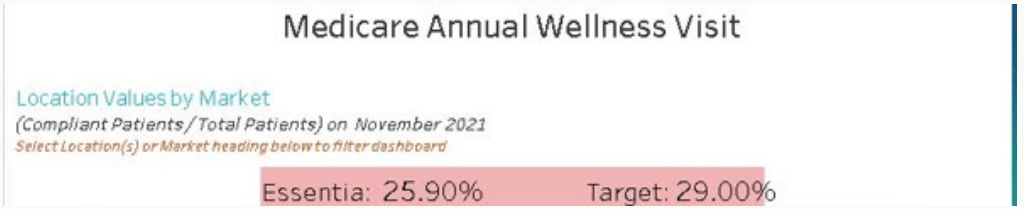
Capturing Patient Risk

- Recapture Rate of HCCs
- Provider Education
- Electronic Tools

Monitoring progress over time



November 2021: 25.9%



November 2024: 61.41%

Appendix - Sources

1. Preventive Care: Source: Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Q. 2005;83(3):457-502.
2. Chronic Disease Management - Source: Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients With Chronic Illness. JAMA. 2002;288(14):1775-1779.
3. Continuity of Care - Source: Pereira Gray DJ, Sidaway-Lee K, White E, Thorne A, Evans PH. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. BMJ Open. 2018;8(6):e021161.
4. Patient Satisfaction - Source: Fan VS, Burman M, McDonell MB, Fihn SD. Continuity of Care and Other Determinants of Patient Satisfaction with Primary Care. J Gen Intern Med. 2005;20(3):226-233.
5. Cost-Effectiveness- Source: Kringos DS, Boerma WG, Hutchinson A, van der Zee J, Groenewegen PP. The breadth of primary care: a systematic literature review of its core dimensions. BMC Health Serv Res. 2010;10:65

Thank you!

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Essentia Health

NAACOS Boot Camp

Engaging Your Patients: Strategies for Success

Geisinger

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What is Patient Engagement?

As described in a Health Affairs article online…..
“Patient engagement” is a concept that combines a patient's knowledge, skills, ability and willingness to manage his own health and care with interventions designed to increase activation and promote positive patient behavior.

Unraveling the meaning of patient engagement: A concept analysis - PubMed (nih.gov)
Patient engagement is defined as the desire and capability to actively choose to participate in care in a way uniquely appropriate to the individual, in cooperation with a healthcare provider or institution, for the purposes of maximizing outcomes or improving experiences of care.

HIMSS states:
Providers and patients working together to improve health.

Is this it?

What is Patient Engagement according to Healthcare Professionals?

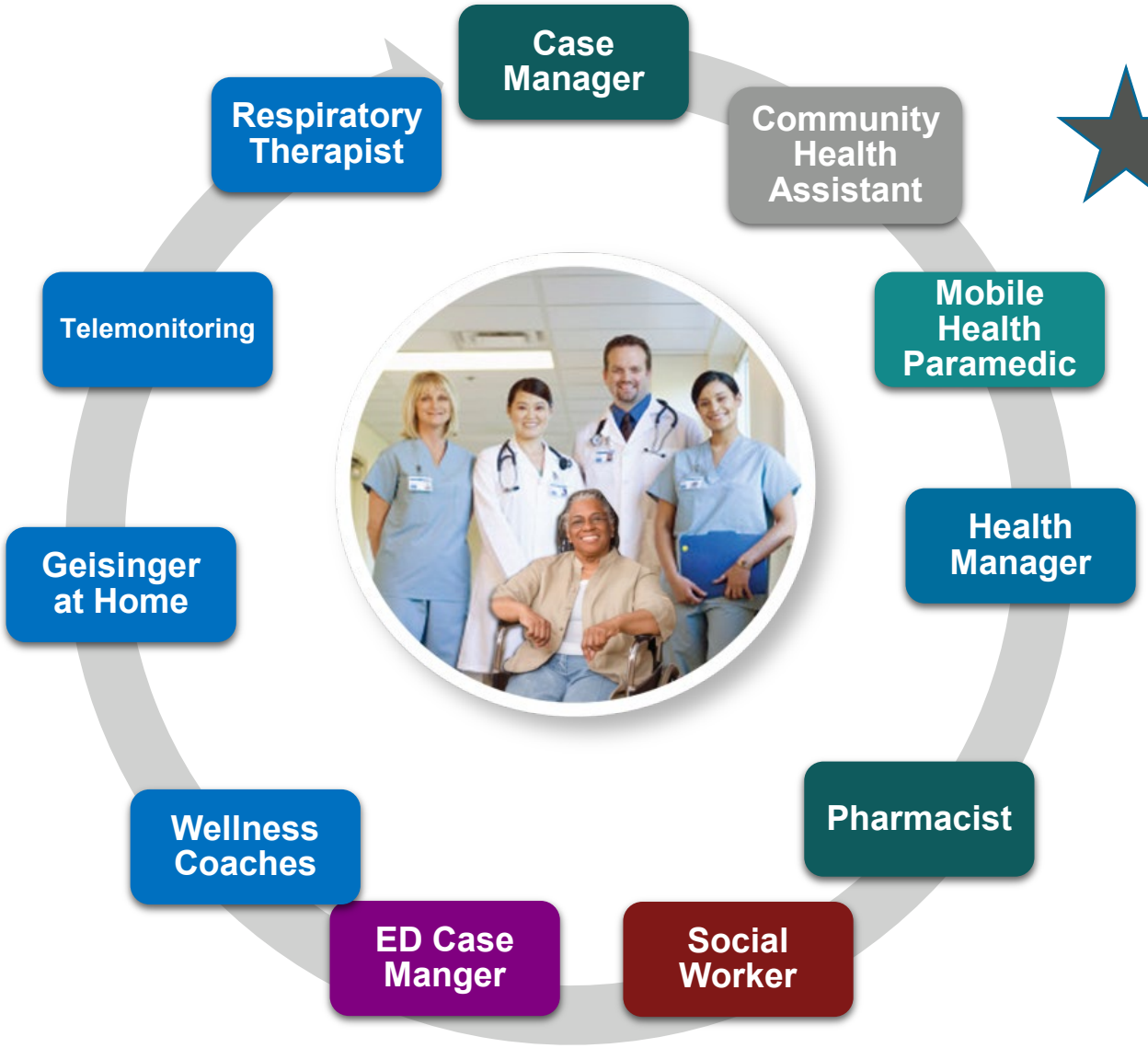
The patient…

- ✓answers the phone
- ✓calls me back
- ✓answers my questions
- ✓works with you
- ✓comes to their appointments

Is this it?

Ambulatory Care Team

- Social Determinants of Health
- Benefit Management
- Chronic Condition Management
- Transitions Of Care



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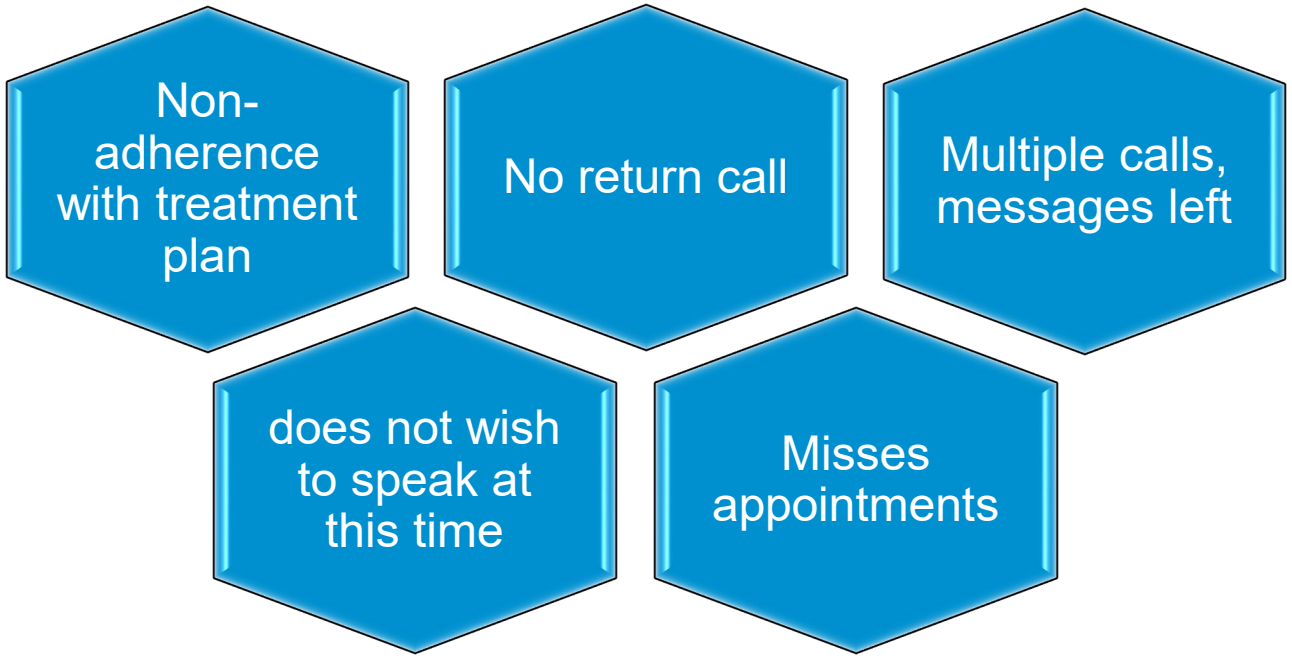
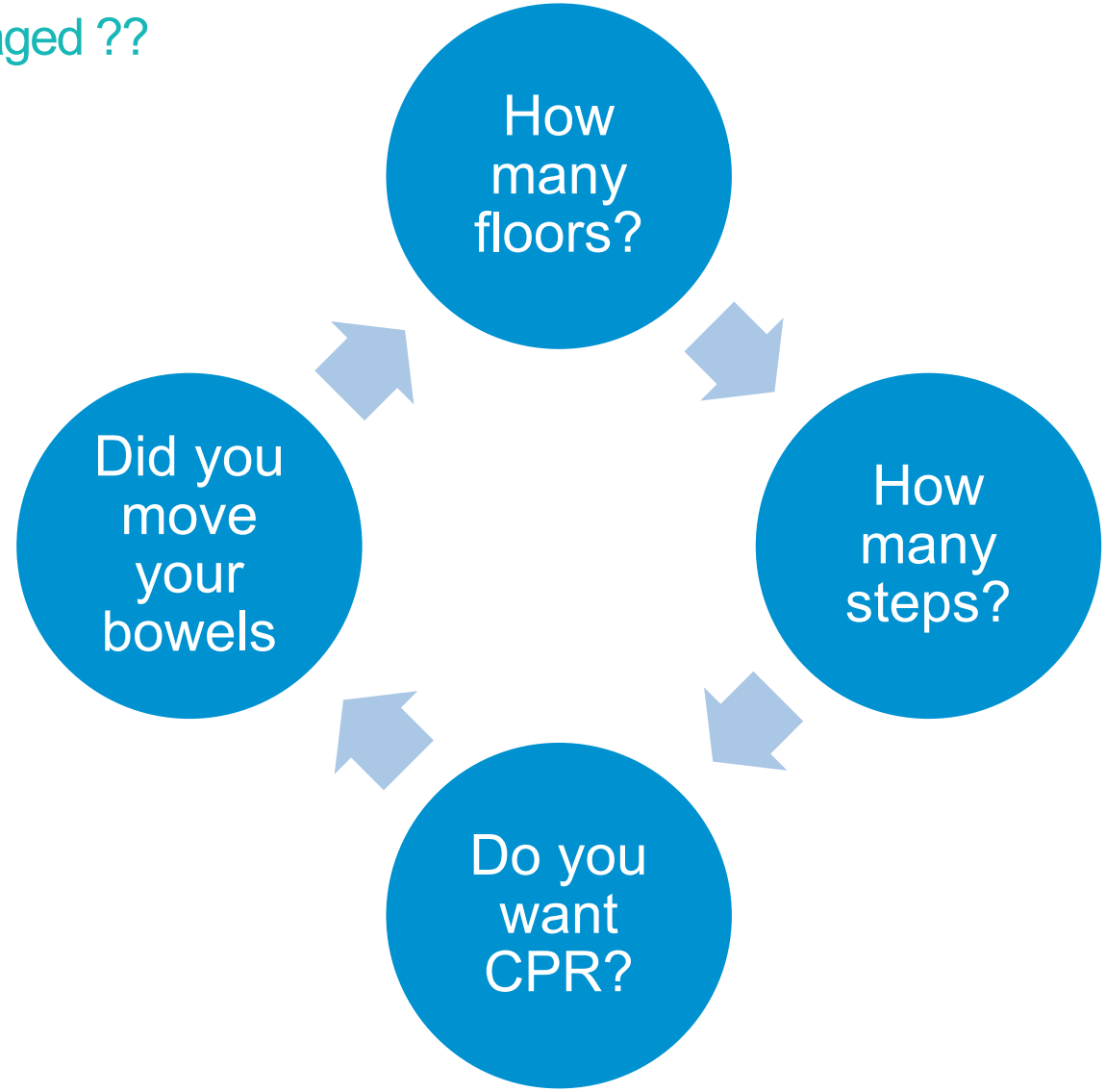


DO WE EVER FIND OUT WHY?

First Call

Would you be engaged ??



Case #1 Medicaid

29yo female 1st generation Latino diabetes, diagnosed at age 5.

History of frequent ER visits and hospitalization

Frequent dizziness, hypotension, autonomic neuropathy

- Referred to Community Health Assistant (CHA)
- CHA went to the ER and met with patient's mother.
- Mother said, "Thank God someone is going to help us I am worried for my daughter's life".
- Autonomic Neuropathy uncontrolled → unable to work
- BP monitoring, home fluid infusions. Managed with medications
- Graduated from LPN Program

What would have happened if we did not think out of the box ????

Case #2 Medicaid

50-year-old male, post removal of malignant neck tumor. History of COPD, hypertension, lives alone. Discharged to home with O2, tracheostomy and feeding tube

- Case Manager calls x3, no answer. Sends letter, no reply. "We are too late"
- Case Manager called the hospital for copy of discharge. Home Health agency never received referral.
- Community Health Assistant (CHA) completed cold home visit. Patient yells to "come in"
  - Sitting in chair and looks "rough"
  - CHA checks pulse ox – 88%
  - Pt complaining of difficulty breathing
- CHA collaborates with Case Manager
- 911 contacted

What would have happened if we did not think out of the box ????

Give the Patient the Chance They Deserve

Engagement	Care Team Lead EHR Care Plan Support team “who is their person” Communication method Information overload
Build Relationships	Home Health Pharmacy Hospitals Nursing Home
Think “Outside the Box”	Meet them where they are i.e. hospital, PCP appt Outreach Collaboration Assessment ‘is it too much” Motivational Interviewing “one size does not fit all” Getting to the root of why a complex patient is not engaging Team performance “are we just checking the box?”


MEET ME
HALF-WAY

Thank you

Geisinger