



CareSignal®

Deviceless Remote Patient Monitoring



Virtual Care That Scales: How Esse Health Supports Thousands of Medicare Advantage Patients With Deviceless Remote Patient Monitoring

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Agenda & Learning Objectives

- Review the **State of Virtual Care** in the context of Medicare Advantage Populations: Balancing Revenue & Relationships
- Examine **Real-world Impacts & Quantitative Outcomes**: Operational Improvements, Patient Engagement Rates, Clinical Results, & Financial ROI
- Identify **Specific, Actionable Strategies** to Increase Care Access for High-risk & Rising-risk
- Connect **Key Learnings** to Your Organization's Position
- Q&A

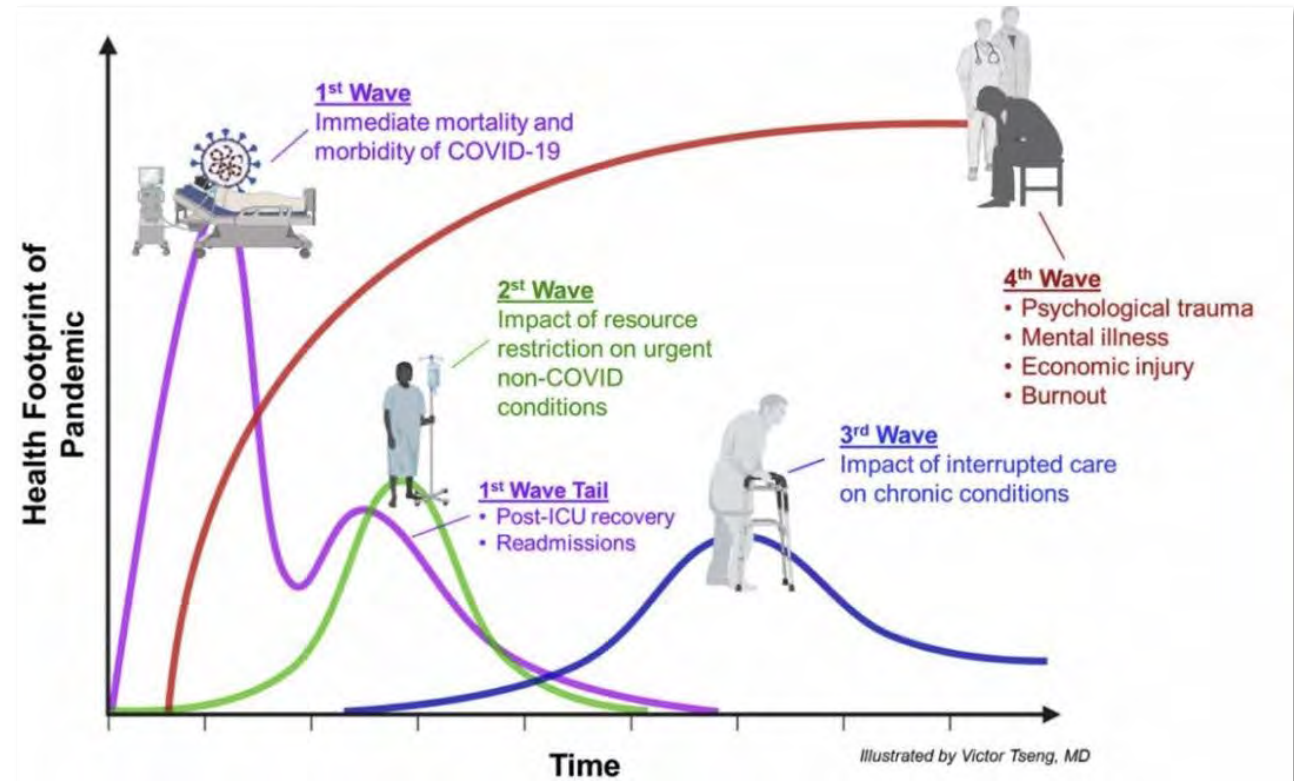
Applying Past Learnings: Sensitive Patients Avoid Care, Resulting in Higher Morbidity & Mortality



“[T]he continuity of regular medications or treatments for chronic diseases were **interrupted** during the SARS epidemics because the **patients were fearful of going to hospitals.**”
(T.-H. Lu et al., 2007)



“[M]ortality caused by **diabetes mellitus and cerebrovascular diseases significantly increased** during the SARS epidemic by 8.4% and 6.2%, respectively.
(S.-Y. Wang et al., 2012)



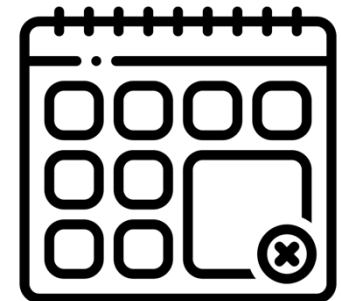
New Challenges Exist for Risk-bearing Providers

Inappropriate utilization, stemming from a combination of fear and poor communication, manifests as ED utilization



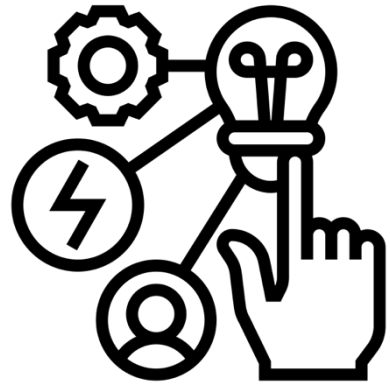
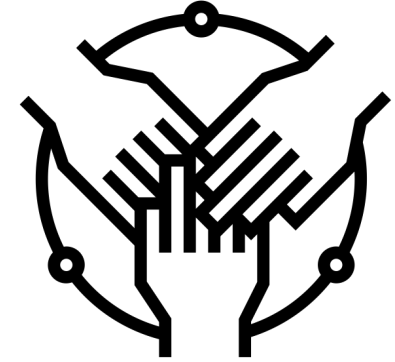
Low health literacy and situation-specific education leads to lower preventative care uptake, from check-ups to flu shots

Delayed care, compounded by poor communication, results in worsened outcomes, costs, and member experiences



Many Opportunities Exist to Recover, and Improve

Providers can leverage relationships with patients, and coordinate or augment care with care management teams



Patients, more open to virtual health than ever before, may be engaged through new communication pathways

Existing care coordination resources in which provider organizations have invested can be leveraged to drive outcomes and value



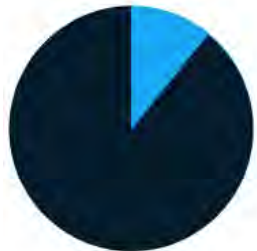
All Patient Demographics Now Expect Virtual Options

\$250B of US healthcare spend will likely be virtualized¹



Consumer

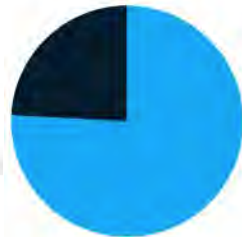
Shift from:



11%

use of telehealth in 2019

To:



76%

now interested in using telehealth going forward

88% of healthcare providers have made or are planning to make investments in RPM²

Core Questions & Measures

Questions

Can we sustainably increase the capacity of existing care management by adding remote patient engagement technology (SMS texts and IVR phone calls)?

Can the collection of patient-reported symptom data and automated alerts improve the timing of care management outreach and result in clinical impact?

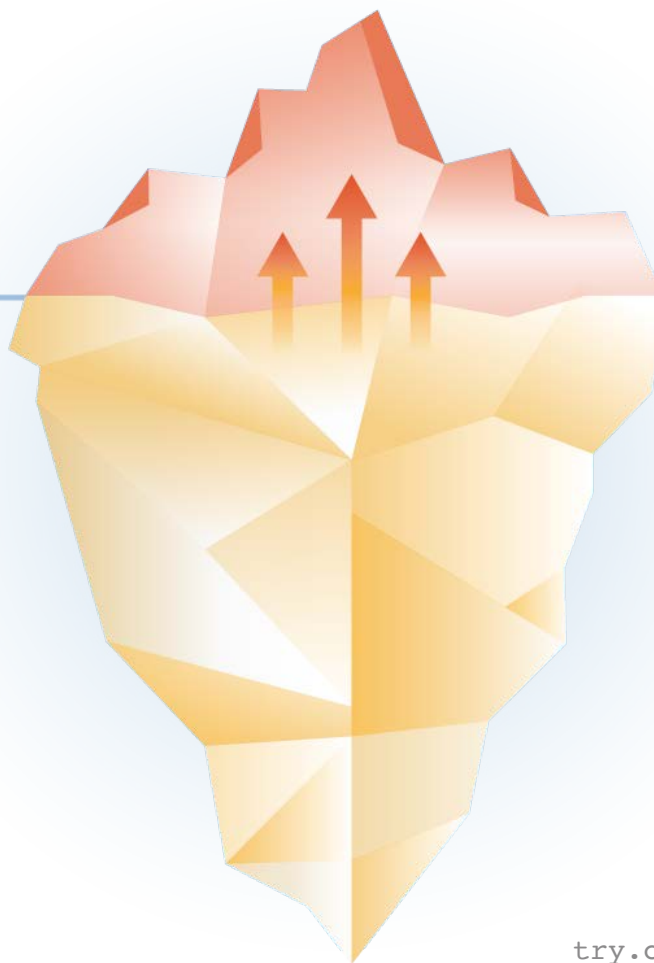
Will reducing avoidable hospitalizations generate medical cost savings?

Measures

- Caseload
 - Care manager satisfaction
 - Patient engagement rate
 - Patient satisfaction
-
- # of alerts
 - Clinical measures (BP, A1c)
 - Hospitalization rate
-
- Per Member Per Day (PMPD) Spend

Specific, Actionable Strategies Begin With the Right Population Focus

Each year, 1 in 5 of **rising-risk** patients become expensive, **high-risk** patients



High-Risk:
5% of
population

Rising-Risk:
20% of
population

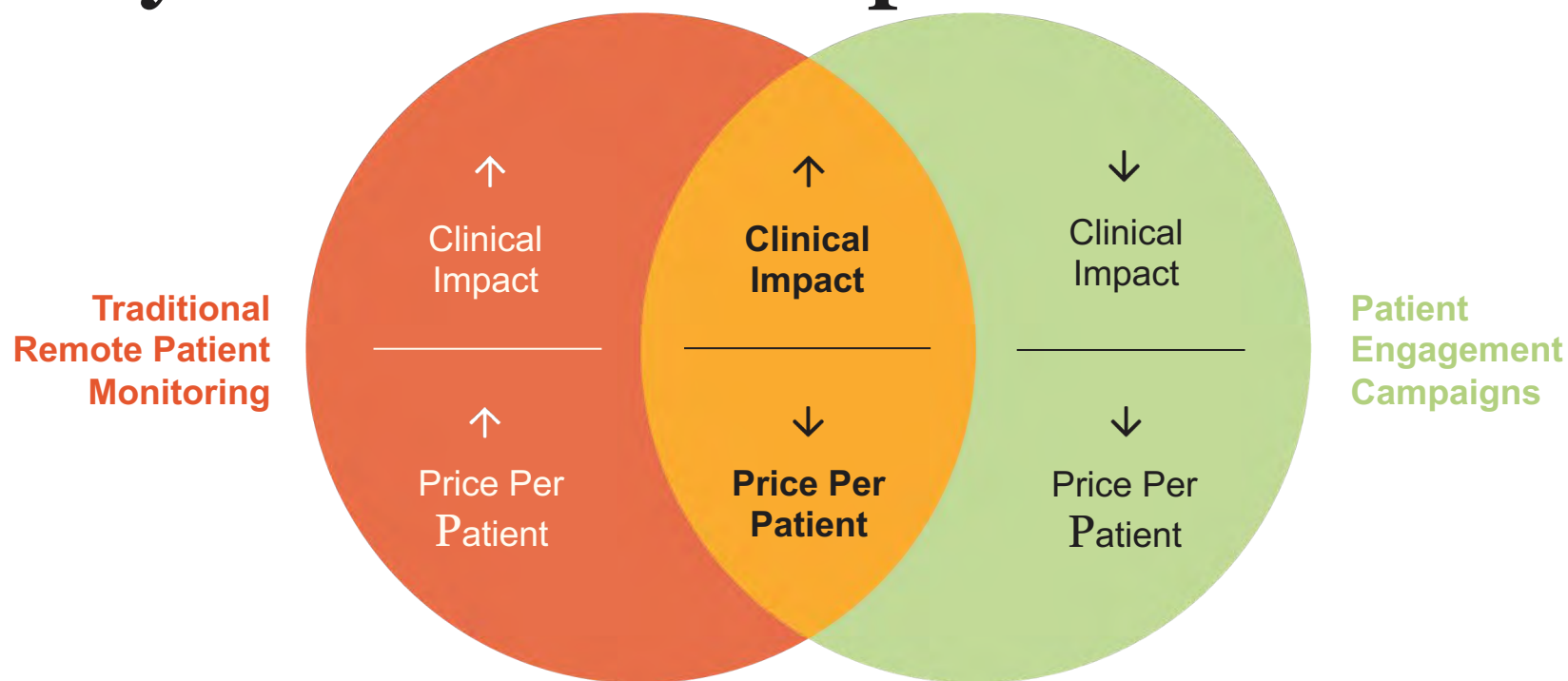


The NEW ENGLAND
JOURNAL of MEDICINE

*“Our findings may also reflect fundamental challenges with the strategy of targeting superutilizers: **many patients whose medical costs are high today will not be as high in the future.**” – Hotspotting Study*

(A. Finkelstein et al., 2020)

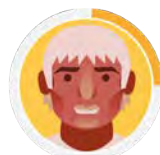
Deviceless Remote Patient Monitoring: a Scalable, Clinically Actionable Component of Virtual Care



High Risk
0.5 – 5 %



Rising Risk
20%



Low Risk
75%



Relevant Patient Population

Financial Opportunity



CareSignal™

try.caresignal.health

Ubiquitously Accessible Technology Meets Patients Where They Are

CareSignal works for **any** patient

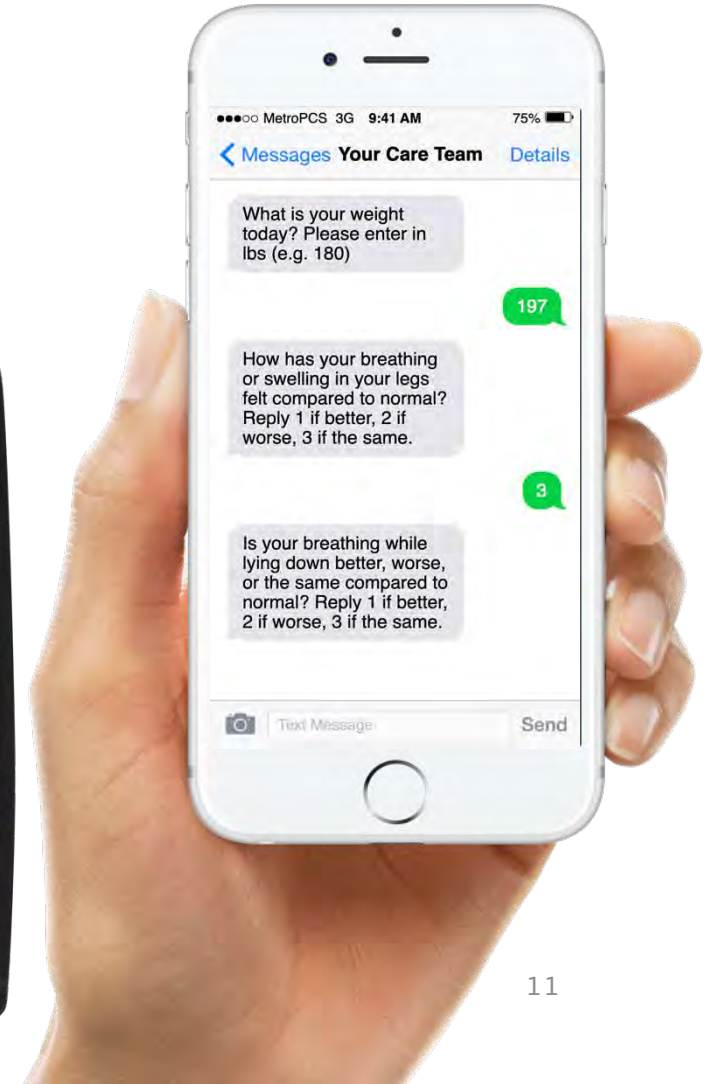
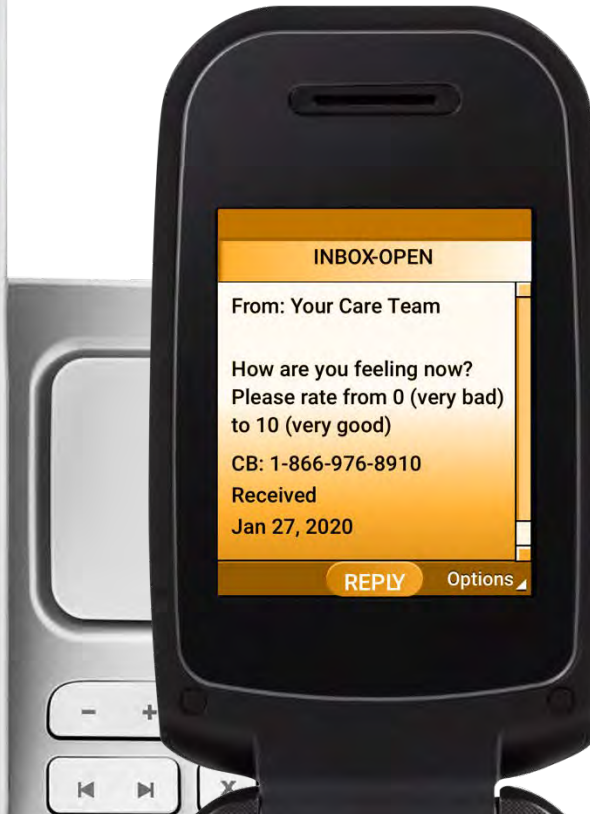
Via **smartphone**, **pay-as-you-go phone**, **landline**, or **concerned caregiver's phone**

10+

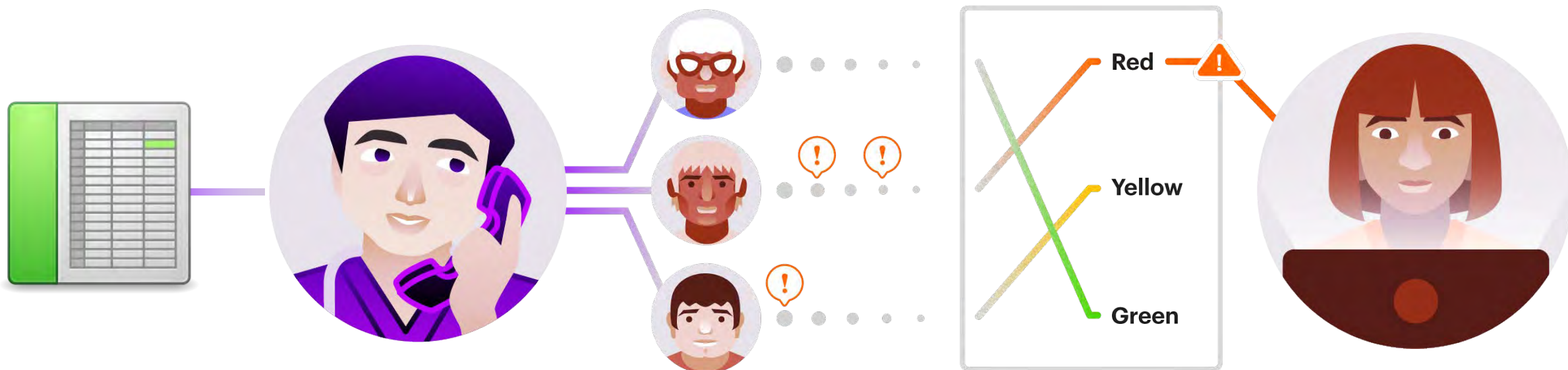
Publications in peer-reviewed journals



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Examining the Esse Health + CareSignal Workflow



Esse Health

Provides list of eligible patients to CareSignal via secure transfer

CareSignal

Engagement Specialists call patients, gather consent, and enroll

Patients

Answer prompts on the phone, sending in clinically-relevant data

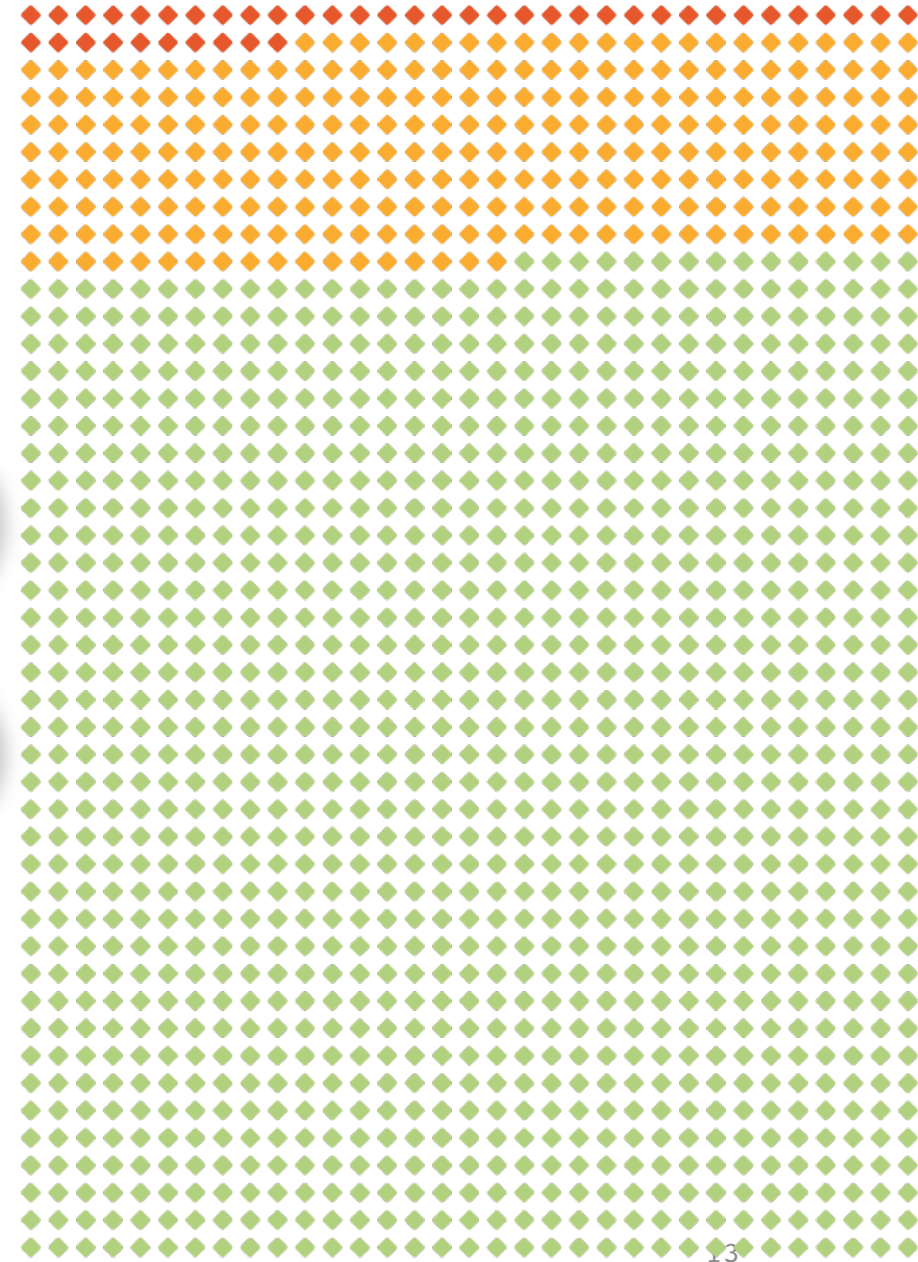
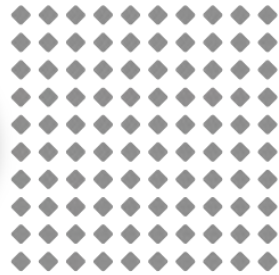
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Categorizes at-risk individuals and triggers alerts in real-time

Esse Health

Care Managers respond with appropriate intervention

Fundamental Shift: Cold/Reactive → Warm/Proactive



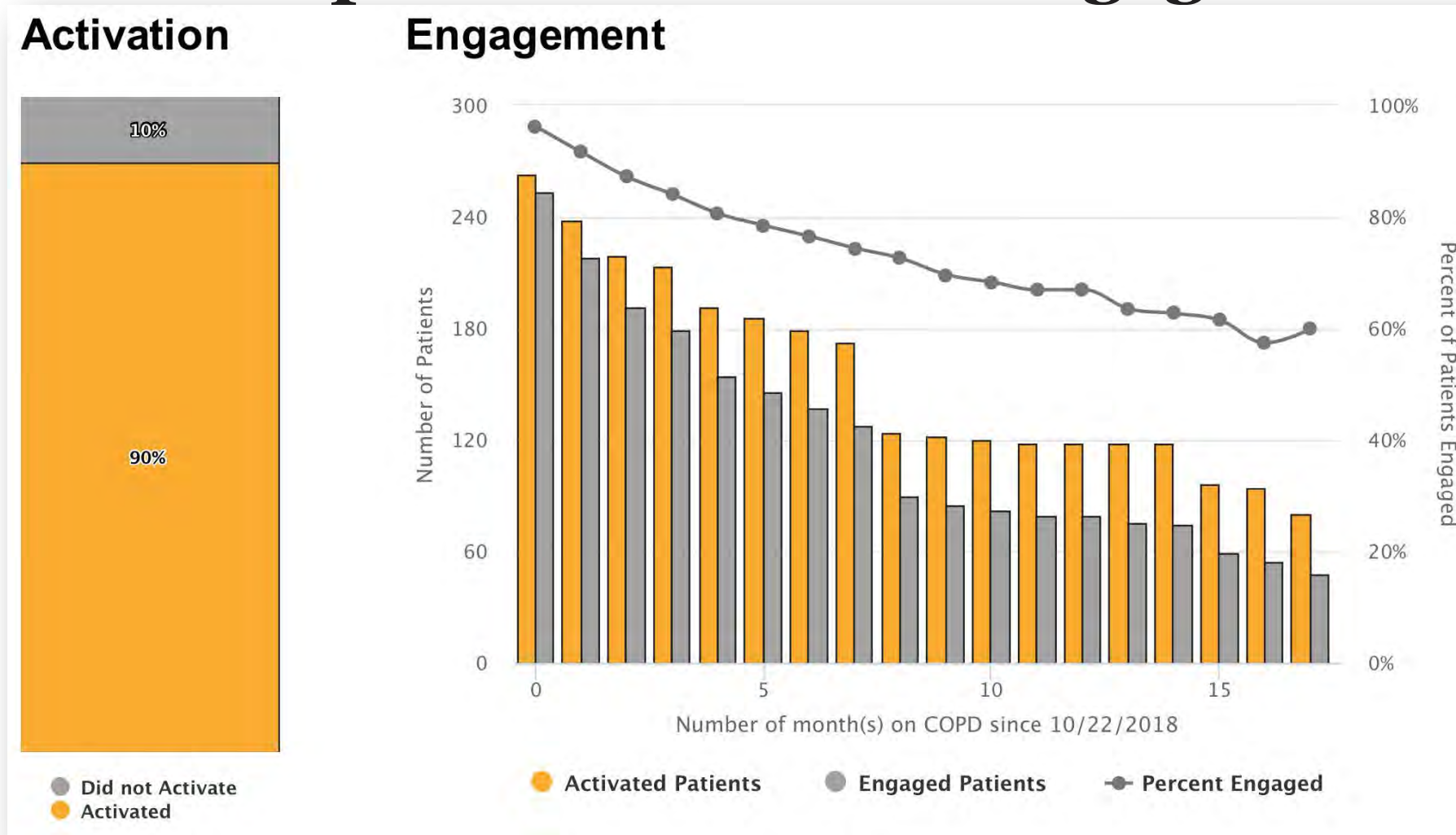
With CareSignal:

- 1,527 patients : 1 RN
- 170,000 automated touches
 - 103,000 calls
 - 67,000 text messages
- 4,100 alerts for patients worsening



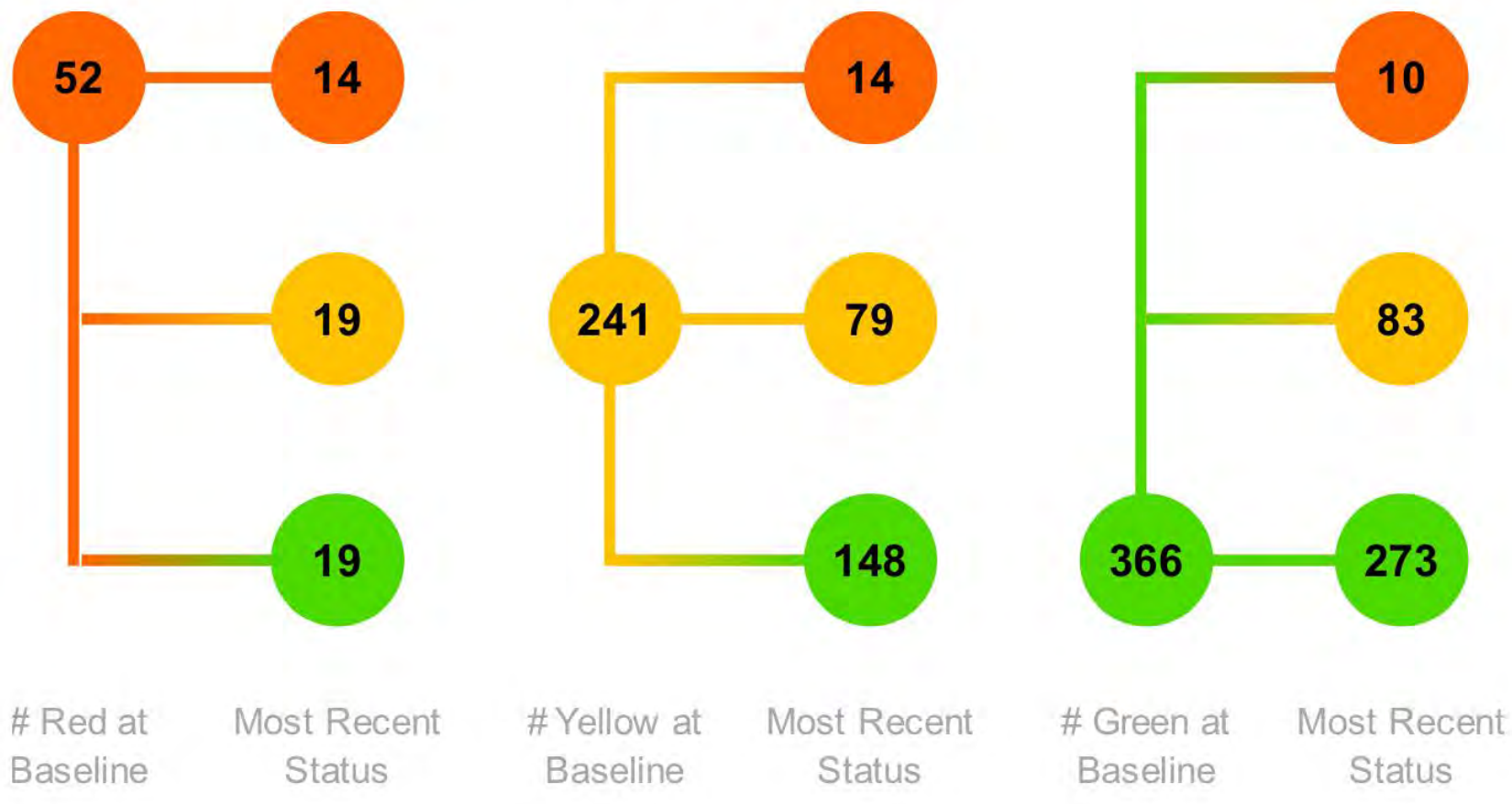
CareSignal™

Real-world Impact: Activation & Engagement (COPD)



Real-world Impact: Clinical Outcomes (Heart Failure)

Heart Failure Status Changes



Real-world Impact: Patient Satisfaction/Experience

I am pleased. Recently, I needed an answer. The team was able to get me the answer. One call and a call back from them. I have no complaints. -Patient #21278

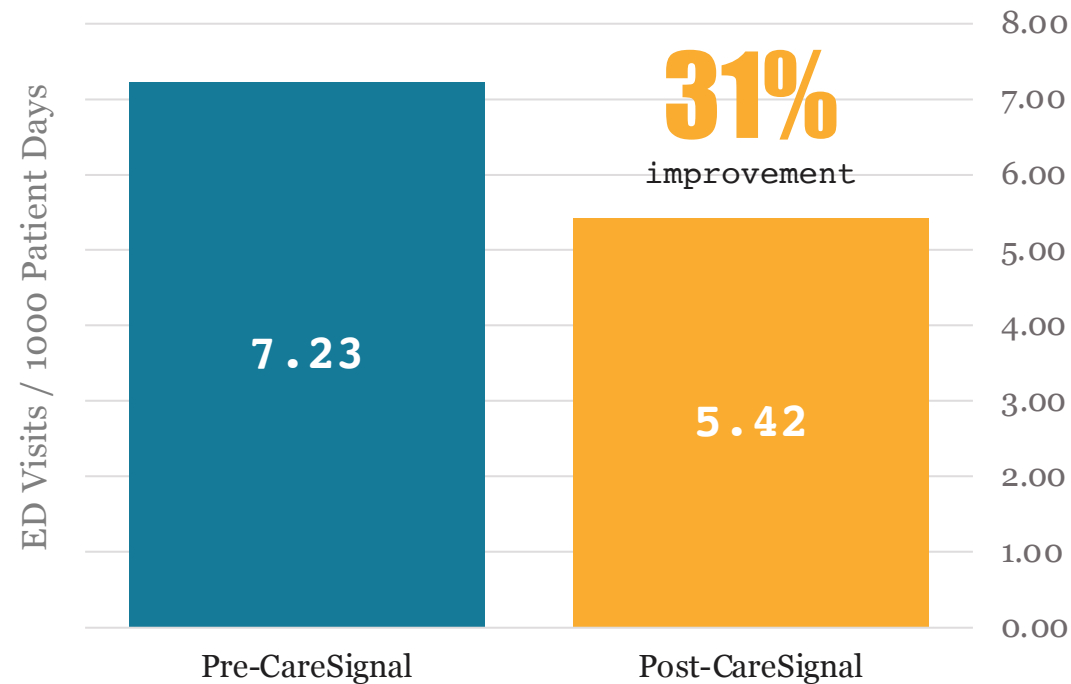
Once I was given the option of communicating through text I felt less confined with participating. I really appreciated that we could do this through texting, so I really have no suggestions. -Patient #21180

feel that it is excellent because I can answer when I feel like it it doesn't interfere with my daily schedule or whatever I'm doing so please do continue and I thank you for your courtesy -Patient #23083

COPD ED Claims Analysis: 214 Patients

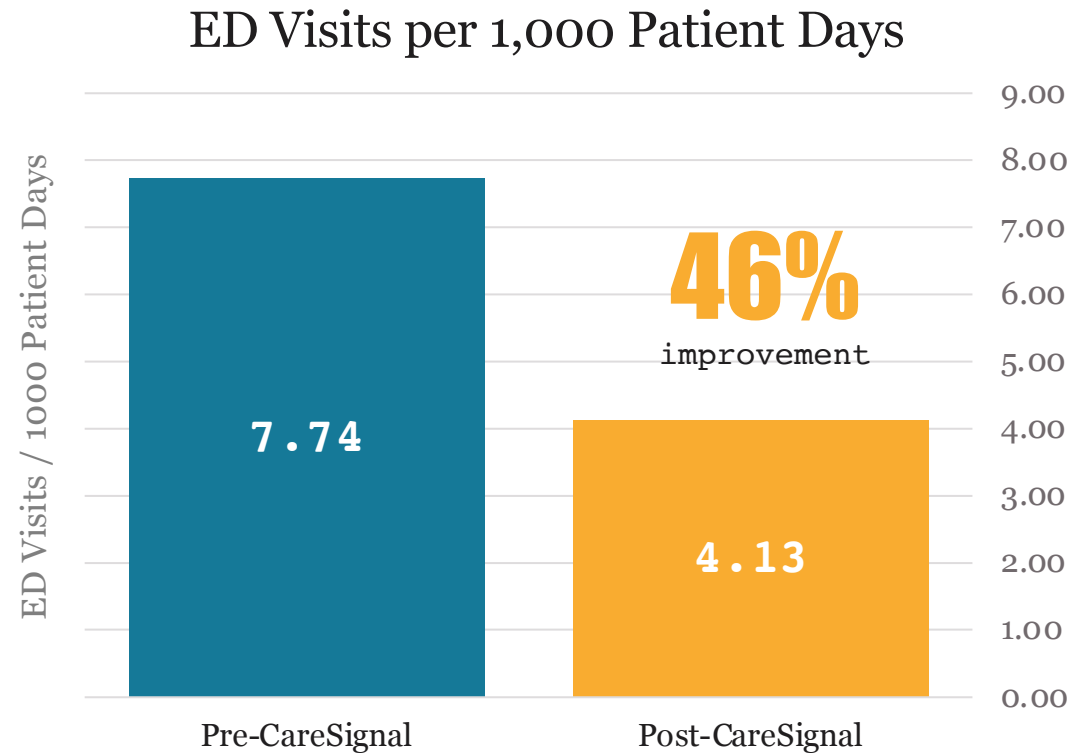
51 Reduced ED Visits

ED Visits per 1,000 Patient Days



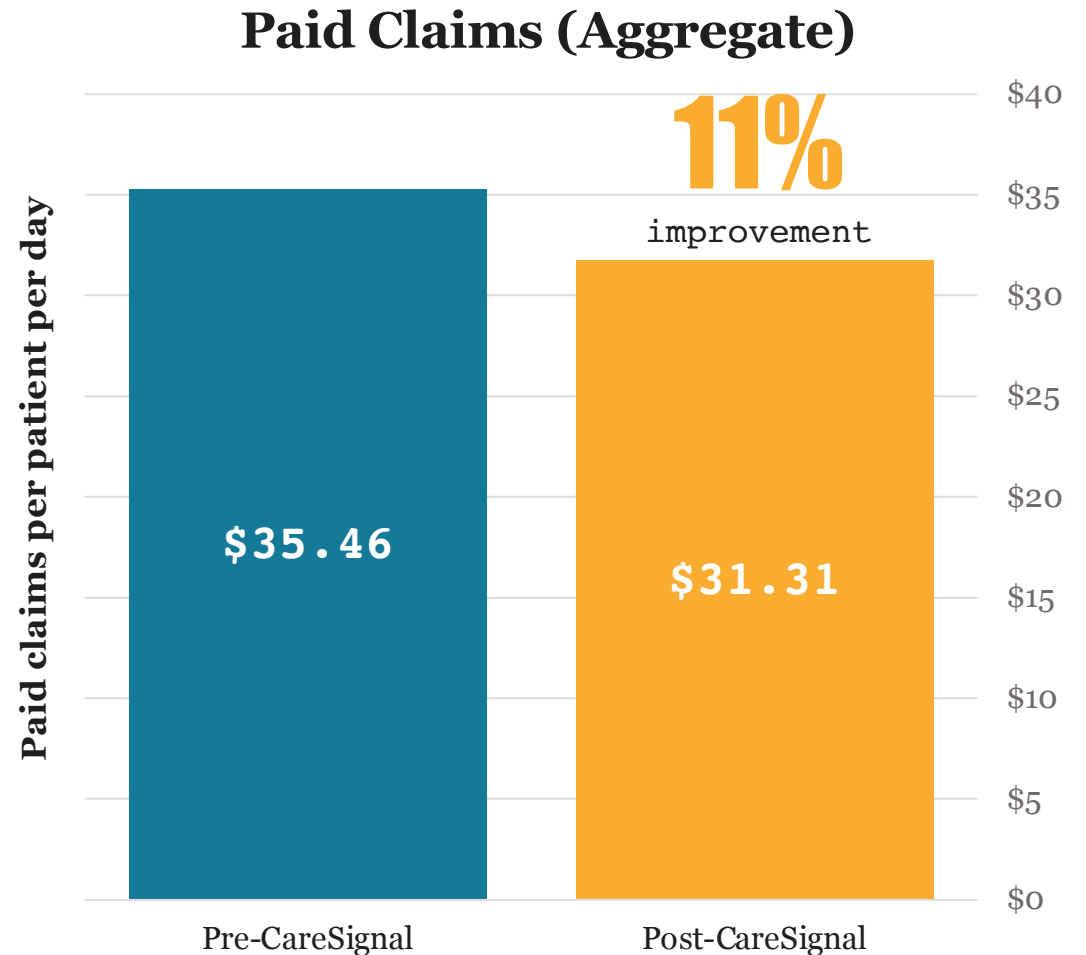
CHF ED Claims Analysis: 1,018 Patients

473 Reduced ED Visits



All Claims Analysis: 1,527 Patients

- \$3.6M Total Savings
- 8.0x ROI
- \$124 Savings PMPM
- $P = 0.017$



Key Learning #1: Sustained Capacity Improvement of Existing Care Management with Deviceless RPM

Question Can we sustainably increase the capacity of existing care management by adding remote patient engagement technology (SMS texts and IVR phone calls)?

Measures

- Caseload
- Care manager and patient satisfaction

Outcomes

- **100:1 → 1,500:1 patient to RN ratio**
- **High care manager and patient satisfaction**

Key Learning #2: Patient-reported Outcome Automation to Improve Outreach Timing & Impact

Question Can the collection of patient-reported symptom data and automated alerts improve the timing of care management outreach and result in clinical impact?

Measures

- # of alerts
- Clinical measures (BP, A1c)
- ED rate

Outcomes

- **4,100 alerts**
- **-14.75mmHg sBP / -7.55mmHg dBP, 0.515% lower A1c**
- **31% reduced COPD ED rate, 46% reduced CHF ED rate**

Key Learning #3: Reduced Avoidable Utilization to Generate Medical Cost Savings & Positive ROI

Question Will reducing avoidable hospitalizations generate medical cost savings?

Measure

PMPD spend

Outcomes

11% decrease in paid claims (aggregate) per patient per day

- Pre: \$35.46
- Post: \$31.31

Learn More: Read the Case Study

https://www.caresignal.health/esse.health_case.study



try.caresignal.health



Succeeding in Medicare Advantage by Managing High- and Rising-Risk Patients:

**How Esse Health Saved \$124 PMPM
and Lowered Heart Failure
ED Visits by Half Among 1,000
Medicare Advantage Patients**





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Key Learning #1: Patient Outcomes & Relationship Quality Benefit from Virtual Care



“Significant reductions in ambulatory care (23.9%) [and] inpatient care (35.2%) were observed. Adverse health outcomes resulting from **accessibility barriers posed by the fear of SARS** should not be overlooked.”
(H.J. Chang, et al., 2004)

“One by-product of the COVID-19 pandemic: 67 percent [decline in utilization] in the week of April 12th [2020], is unparalleled... fear of contagion is driving these effects.”
Telemedicine, however, holds promise.
(P. Chatterji et al., 2020)



Key Learning #2: Investments in Solutions Such as Deviceless Remote Patient Monitoring Yield ROI

Telemedicine and digital engagement have the potential to bolster otherwise risky populations, and increase market share, if leaders act quickly.



“Average monthly service volume for the base year... and the following two years were 55%, 82% and 84%”

“[D]ue to SARS or a similar disease, **the impact is longer than previously reported.**”

(D. Chu et al., 2008)

“[Despite reductions in outpatient utilization during the pandemic], **the admission rates for most ACSCs did not change in the post-SARS period.**”

(Y.T. Huang, et al., 2009)



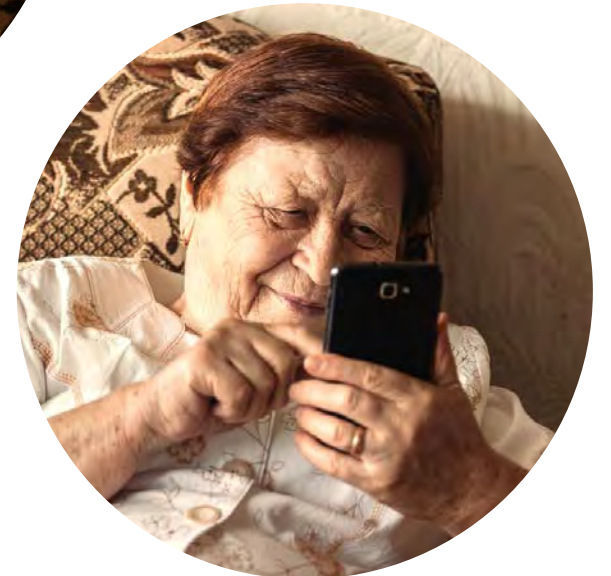
Why automated calls and texts?

- Scale patient engagement with standardized check-ins
- Receive timely and clinically-relevant patient data
- No time spent providing technical assistance



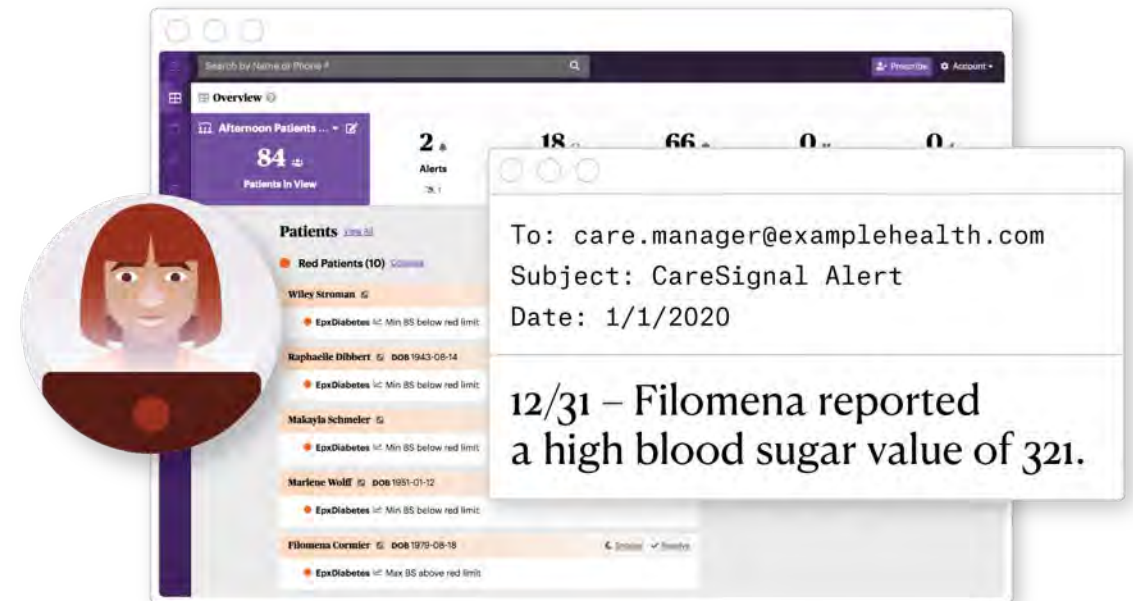
Patients can use a device they already own—their phone.

Most patients already know how to respond to IVR calls or SMS texts.



CareSignal Journey: Esse Care Manager

1. One Esse team member monitors CareSignal dashboard to access patient alerts, see risk-level in real-time, and triage members to the appropriate Esse care manager
 - e.g. Patient has two-week blood sugar average of 170
2. Esse care manager conducts proactive intervention for patient in the red high-risk level
 - e.g. Patient has two-week blood sugar average of 170
3. Esse care manager conducts medical intervention for patient if alert is generated
 - e.g. Patient reports low blood sugar value of 5



Simulated CareSignal dashboard and an example email alert.

Esse Patient Testimonials

“When you respond that you are having issues, they call you and find out the kind of issues and contact your doctor’s office.”

“It keeps office up to date on how I’m doing with my medications”

“Felt it kept me in contact with my Moms doctor in an easy manner”

“Felt it kept me in contact with my doctor”

“Makes me feel like my dr is always in touch with me”

“Good way to communicate with md if they review and provide feedback or suggestions to improve blood sugar”

“Feel you are caring for my health”

“Keeps Dr informed”

“I don’t feel alone I know someone is checking on me”



CareSignal Portfolio

Chronic Condition Management

- Diabetes
- Hypertension
- Heart Failure
- COPD
- Asthma
- Dialysis
- Epilepsy

Behavioral Health & Substance Use

- Depression
- Substance Use
- Opioid Management
- Mood
- Caregiver support
- Basic Needs / SDOH

Maternal Health

- Breastfeeding
- Breastmilk
- Postpartum depression

Discharge Support

- Appointment Reminder
- Post Discharge
- Referral
- Surgery
- Pneumonia

Screening Reminders

- Colorectal cancer
- Breast cancer
- Cervical cancer
- Diabetes ophthalmology
- Chlamydia screening
- Lead screening

Complementary Support

- Fall Risk
- Wellness
- Medication Tracking
- Medication Adherence