Consumer eHealth Affinity Group

Provider Engagement Strategies from HealthInsight, the New England Healthcare Institute and Atrius Health

Korey Capozza
Consumer Engagement Director, HealthInsight, Utah Beacon Community

Wendy Everett, ScD
President, NEHI

Lisa Payne Simon, MPH
Senior Program Officer, NEHI

Mariah Quinn, MD
Study Principal Investigator, Atrius Health

Teen Perron, RN
Complex Chronic Care Program, Atrius Health

Pat Blazewicz, NP
Complex Chronic Care Program, Atrius Health

February 27, 2012
Home Tele-Health Initiative
Center for Technology and Aging
Consumer eHealth Affinity Group Webinar
February 27, 2012
Home Tele-Health Demonstration Project: A collaboration of three organizations...
Today’s Presenters

• Presenters from Atrius Health
  – Mariah Quinn, MD – Study Principal Investigator
  – Teen Perron, RN – Complex Chronic Care (CCC) Program
  – Pat Blazewicz, RN - Complex Chronic Care (CCC) Program

• Presenters from NEHI
  – Wendy Everett, ScD – President
  – Lisa Payne Simon, MPH – Senior Program Director
• Patients to transmit health data (physiologic and symptomatic) from their home to clinicians via HT System
• Patients receive automated health coaching from the HT system or from their providers based on the clinical data they transmit
Heart failure patients who receive Home Tele-Health (HT) monitoring and management as a component of follow-up care to hospitalizations have, on average:

- Lower rates of re-hospitalization and emergency department visits for heart failure than similar patients whose follow-up care does not include HT.

- Lower total health care charges (including usual charges for the tele-health system) than similar patients whose follow-up care does not include HT.
Study Methods

- A randomized controlled study design
  - 9 month observation period
  - Sample size: 100 participants per study group
  - Intervention arm receives Philips HT device
  - All Harvard Vanguard Medical Associates sites and 1 Atrius site

- Primary outcome measures focus on health care service utilization and total cost of care

- Secondary outcomes focus on patient and provider qualitative measures

- Return-on-investment analysis
Home Tele-Health Demonstration Goals

HT Demonstration Project Goals:

- Identify appropriate target populations
- Test a technology-supported best practice
- Quantify the clinical benefits of HT
- Quantify the financial benefits of HT for Massachusetts
- Assess ROI for all stakeholders
• The clinical effectiveness of HT in monitoring and management of CHF has demonstrated:
  – Reductions in mortality
  – Reductions in rates of hospitalization (CHF and all-cause)

• But: There has been a lack of evidence about:
  – Net impact of HT on total costs of care
  – Return on investment of HT in the treatment of patients with CHF
Proposed contributions of this study include:

– Demonstration of return on investment (ROI) of HT in treatment of patients with CHF;

– Evidence regarding optimal duration of HT use by patients with CHF for the purpose of internalizing self-management techniques, and

– Strategies for successful HT integration
HT Demonstration operates in two different clinical/care management settings at Atrius. Different processes for care management have implications for HT technology integration.

Setting #1 is Granite Medical where data managed by individual clinicians presents barriers to the HT study

- Complex to determine who will monitor patient data and manage abnormal vital signs as part of their daily work
- Presents a barrier to physicians agreeing patients are appropriate to the HT intervention
HT Technology Integration at Atrius

• HT Demonstration operates in two different clinical/care management settings at Atrius. Different processes for care management have implications for HT technology integration.

• Setting #2 is Harvard Vanguard Medical Associates - where a specialized RN group (the CCC program) works with a population of CHF patients, reviews patient data, and is experienced with telephonic management. For the HT Study, clinical plans for patients can be made with RNs in the CCC program.
  – PCPs, Cardiologists do not have added burden of uncompensated work
  – Once this workflow was determined, there was rapid acceptance of the study by the Internal Medicine Department.
• How do Atrius providers feel about using the HT technology?
  – Technology trouble shooting
  – Patients with inaccurate vital signs transmitted
  – Managing patients expectations/anxiety
Provider Engagement Strategies in Use

- Make a strong case to providers by describing how the intervention produces results meaningful to the provider.
- Ensure messaging is appropriate - emphasize how interventions will complement care processes, activate patients.
- Lower the administrative burden on providers/practice sites where possible; use of opt-out strategy.
- Target appropriate members of the workforce for different project roles.
- Identify and select clinician champions to build trust among less engaged clinicians and maintain momentum.
- Elicit feedback and adjust the program through regularly scheduled discussions.
- Leverage existing improvement programs where possible.
Care4Life Provider
Recruitment: Lessons Learned

Korey Capozza
IC3 Consumer Engagement
Director
Utah Beacon Team

- Christie North
- Heidi Smith
- Sarah Woolsey
- Cheryl Simpkiss
- David Smith
- Janet Tennison
- Steve Oostema
- Korey Capozza

- Gary Berg
- Kimberly Mueller
- Jeff Black
- Clare Lence
- Ryan Brown
- Stephanie Barber
- Travis Smith
- Nelly Bello
Beacon Clinic Activities

- 360 providers at 60+ clinics are participating in Beacon efforts.
- All clinics are in process of attesting to Stage 1 MU by end of 2012.
- ~40 clinics participating in process and quality improvement efforts.
- Bi-directional EHR to cHIE interfaces are slowly being created.
In the Clinic ➔ Outside the Clinic

• Experiment with new tools to help patients succeed outside the clinic
• Measure and evaluate
• Spread learning
Coaching

Care4Life coaching is delivered directly to your mobile phone, with tips based on diabetes care guidelines to help reduce the risk of complications. You will receive educational messages to help build your knowledge about diabetes, as well as motivational messages to help you make the right lifestyle choices.

The education content has been developed by a team of renowned diabetes experts and is based on American Diabetes Association clinical guidelines.

Check out these 3 things you can do by text:
Relationships

Cheryl Simpkiss
- Coalville Health Center
- Park City Healthcare, Inc.
- Riverton Family Health Center
- Kathryn Allen MD
- Health Clinics Of Utah – SLC
- Barbara Rizzardi, MD
- Intermountain Medical Clinics
- Alpine Internal

David Smith
- Jordan Family Health
- Valley Family Medicine
- Foothill Family Clinic South
- Health First Family Medicine
- Copperview Medical Center, LLC
- Wasatch Internal Medicine, P.C.
- St. Mark's Family Medicine
- Holladay Family Practice
- Patrick Green MD
- Advanced Practice Medical Clinic

Janet Tennison
- Jordan Meadows Clinic
- Granger Medical Clinics
- West Valley Family and Preventative Medicine
- Jordan Ridge Clinic
- J Randall Young, MD
- Community Health Centers, Inc.
- Evolutionary Healthcare
- Olympus Clinic
- Wasatch Homeless
What you need to know:

• Free
• Optional
• May help patients
• No new work
• Cutting edge/new tech
Rationale

• Diabetes education and care management have been shown to improve patient engagement and self-care activities

• mHealth may be able serve this function at much lower cost, thus increasing access to care management services

• Cluster-Randomized Trial, Mobile Coaching
  – University of MD, 163 patients, 1 year
  – Showed 1.9% HbA1c reduction vs 0.7% in usual control (p>0.001)

Care4Life Overview

• Draws on concepts and experience in 2 Mexico deployed systems (DiabeDiario and DiebeNet)
• Based in science and follows national standards:
  – Behavior change theories
  – ADA guidelines for diabetes management
  – National Diabetes Education Program
  – AADE 7-step program
• Multi-channel approach
  – Two-way interactive SMS (text messaging)
  – Personal web portal (optional for participant; provider can use to review progress)
a) User can set glucose reminders according to their doctor’s recommendations (i.e. before breakfast daily)

b) System sends glucose reminders & provides immediate feedback

c) User can track all glucose recordings on web portal

d) System sends education messages & tips
HealthInsight staff pitch the clinic

Clinic agrees to participate

HealthInsight runs an EMR query to ID patients using screening criteria:
- Clinical diagnosis of Type 2 DM
- Lab test of HbA1c>8 within past yr.
- Age >18
- Not pregnant

HealthInsight or clinic generates invitations on clinic letterhead using mail merge

HealthInsight matches patients with a Subject ID#

HealthInsight associates enrolled patients with clinics.

Patient consents to participate in the study at www.care4life.com using the subject ID

Site randomizes the consented patient to intervention or comparison arm:
- 66% intervention
- 33% comparison

Consented patient sees one of two screens after clicking “consent” button

IN
Congratulations, you have been selected for participation in Care4LIFE! The next screen will help you get started. Upon completion we will mail you your $20 gift card.

OUT
You just earned a $20 gift card! Thank you for your participation in our study. You have no further obligations at this time.

Site stores list of intervention and control subjects with Subject ID# to access database for tracking and evaluation. HealthInsight associates enrolled patients with clinics.

Patient enrolls in program at utah.care4life.com

Patients begin receiving messages. Gift card mailed within 1 week.

HealthInsight sends subjects gift certificates within 1 week.
Independent Clinic Response

- Responsive = 5
  - No, with reason = 3
- Yes = 20
- No = 8
“No” Reasons

1. Patient population issues (Homeless Clinic)
2. Specialty clinic (podiatrist)
3. Too busy with Meaningful Use/other responsibilities
Clinic Touches

IRB-approved HealthInsight staff

<table>
<thead>
<tr>
<th>Clinic Pitch</th>
<th>Data Use Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>HI generate invites from pt list</td>
<td></td>
</tr>
<tr>
<td>Clinic signs letters</td>
<td></td>
</tr>
<tr>
<td>HealthInsight mails letters</td>
<td></td>
</tr>
<tr>
<td>HealthInsight handles patient calls</td>
<td></td>
</tr>
</tbody>
</table>

Clinic
Selling Points

- Trusted partner, est. relationship
- Pitch, not a hard sell
- Patient engagement: the holy grail
- No cost to provider
- No new work
- New technology
- Opportunity to learn something
- Attention to patient privacy
- EMR assistance
Status

• IRB approved September 2011
• 20 clinics on board, 13 more in a separate IRB approval process
• Currently enrolling patients
• Evaluation late 2012-early 2013
Questions?
Thank you

kcapozza@healthinsight.org
Provider Engagement Strategies

1. Make a strong case to providers by describing how the intervention produces results that are meaningful to the provider; provide empirical data and rationale.

2. Ensure messaging is appropriate to reach reluctant providers, i.e. emphasize how interventions will complement care processes and activate patients via coaching and education.

3. Lower the administrative burden on providers/practice sites where possible, i.e. handle identification of eligible patients and enrollment processes for intervention, consider opt-out strategy.

4. Target appropriate members of the workforce for different project roles.

5. Identify and select clinician champions to build trust among less engaged clinicians and maintain momentum.

6. Elicit feedback and adjust the program through regularly scheduled discussions.

7. Build buy-in by including providers (including physicians, nurses, and other stakeholders) in the design of workflows and other program elements such as exclusion criteria.

8. Leverage existing improvement programs where possible to take advantage of previous relationships.

9. Incentivize providers for participation to ensure accountability on key metrics.
Questions?

Korey Capozza
Consumer Engagement Director
HealthInsight
Utah Beacon Community

Wendy Everett, ScD
President, NEHI
Lisa Payne Simon, MPH
Senior Program Officer, NEHI
Mariah Quinn, MD
Study Principal Investigator, Atrius Health
Teen Perron, RN
Complex Chronic Care Program, Atrius Health
Pat Blazewicz, NP
Complex Chronic Care Program, Atrius Health

Consumer eHealth Affinity Group