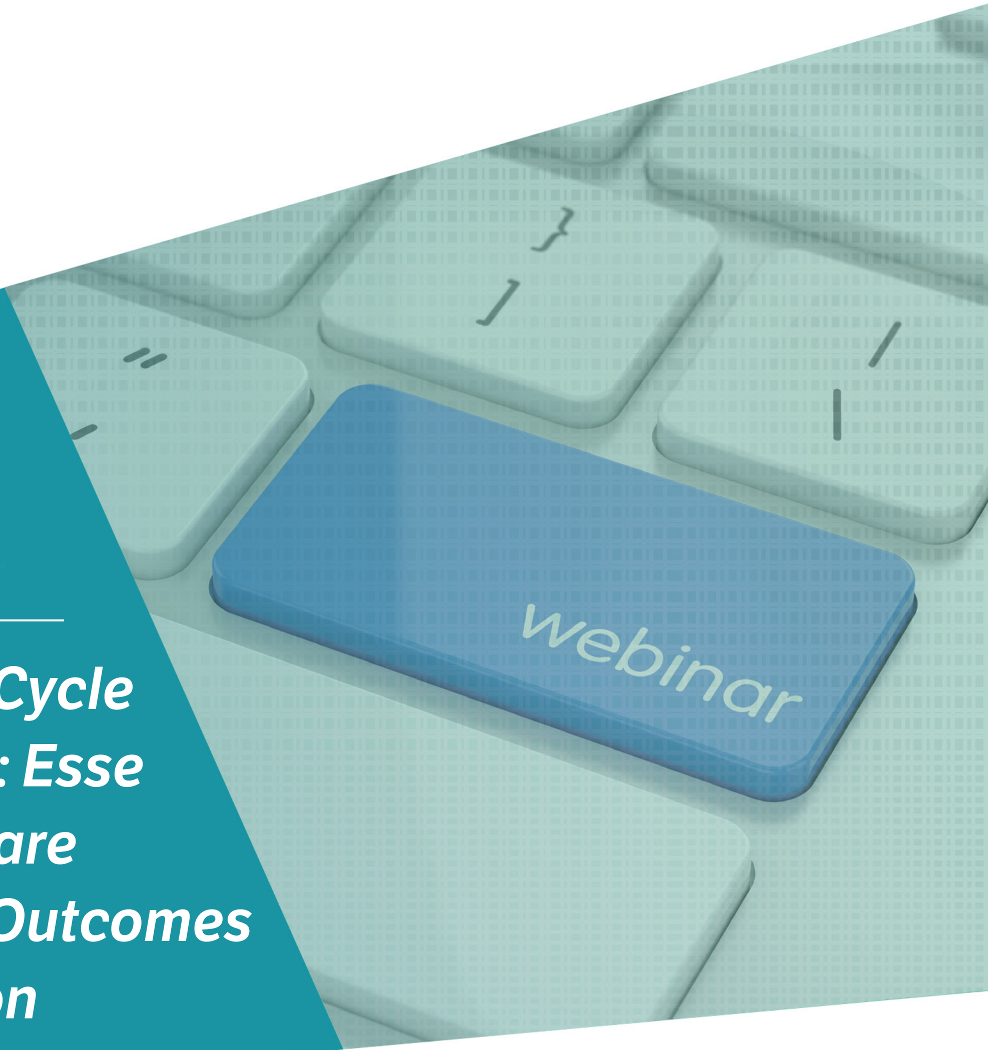
Advancing High Performance Health



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Best Practices

Creating a Virtuous Cycle in Value-based Care: Esse Health's Proactive Care Improves Medicare Outcomes and Staff Satisfaction

Creating a Virtuous Cycle in Value-based Care: Esse Health's Proactive Care Improves Medicare Outcomes and Staff Satisfaction

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"This is a self-management tool, which to me is the biggest win for our patients. They can create their own environment around self-management and around their healthcare."

— **Carla Beckerle, DNP, ARPN-BC**
Esse Health

Supporting growing numbers of high-risk patients in value-based care while reducing burnout and improving staff satisfaction may seem like mutually exclusive and competing goals. But leaders at Esse Health are successfully achieving all of them, using technology and data to deliver what Shelley Davis, MSN, CCM, RNC, vice president of clinical strategy at Lightbeam Health Solutions, describes as "proactive, continuous, holistic care."

Lightbeam's Deviceless Remote Patient Monitoring® product, CareSignal, won Best in KLAS® for Remote Patient Monitoring (RPM) in 2024 based on high clinician satisfaction and product quality. CareSignal has helped healthcare organizations nationwide use data to more effectively engage patients, deliver care, and improve patient outcomes.

By partnering with Lightbeam and deploying CareSignal, Esse, the St. Louis-based, physician-owned practice, has created a virtuous value-based care cycle by achieving a more predictable, manageable workload for staff while reducing ED utilization for CHF and COPD among its Medicare Advantage and Medicare Shared Savings Program Accountable Care Organization (MSSP ACO) populations.

Carla Beckerle, DNP, ARPN-BC, vice president of clinical programs at Esse Health, joined Davis to talk about how they did it with Lightbeam and its Deviceless RPM®, CareSignal.

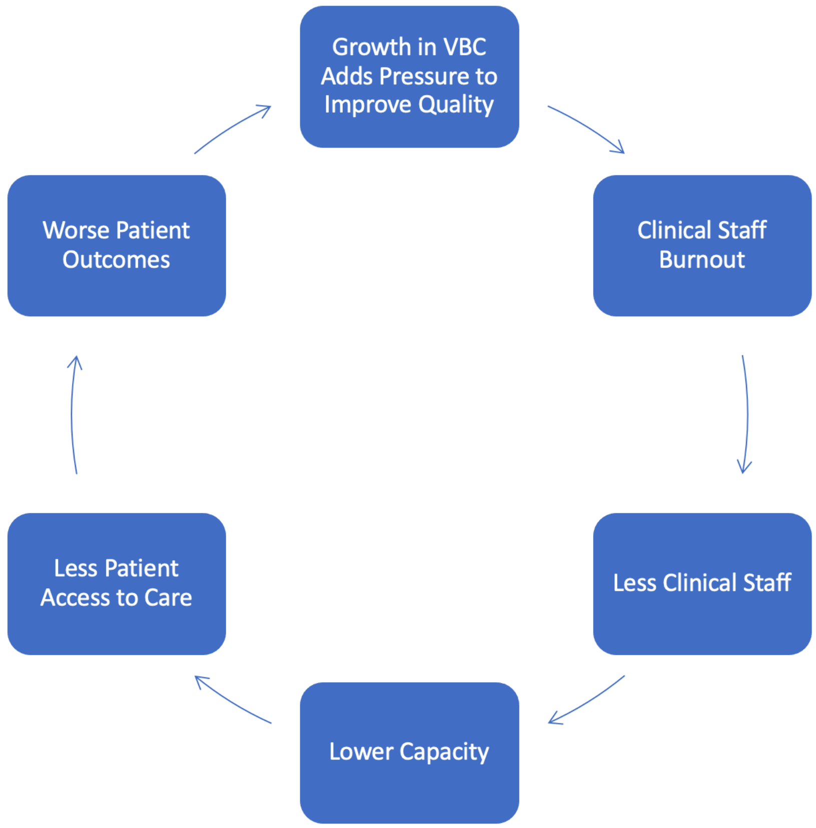
Value-Based Care's Vicious Cycle

Beckerle began by describing a vicious cycle of challenges in an industry moving to value-based care: decreased staffing, patient access, and capacity leading to worse patient outcomes while pressure grows to improve quality, continuing the cycle of burnout while putting the organization's value-based care success at risk.

The nursing shortage combined with burnout across clinical staff caps organizations' capacity to deliver care. So, how can organizations leverage clinical staff most effectively to improve patient outcomes and achieve value-based care goals?

One part of the solution is care managers, which Beckerle calls "the backbone of any successful care coordination or care management program." But traditional care management's reliance on time-intensive, manual patient outreach methods meant that the typical Esse care manager could only handle a caseload of approximately 150 patients. It's

A Vicious Cycle Many Provider Organizations Get Caught In



a struggle that care management teams everywhere face- growing value-based populations, but limited care management capacity. When care managers are unable to manage high and rising-risk patients, they are unable to bend the cost curve. For organizations struggling to cover the 5% of highest-risk patients, how can they possibly support more patients at a time when value-based care necessitates expanding to the 20% of rising-risk patients, a much larger population?

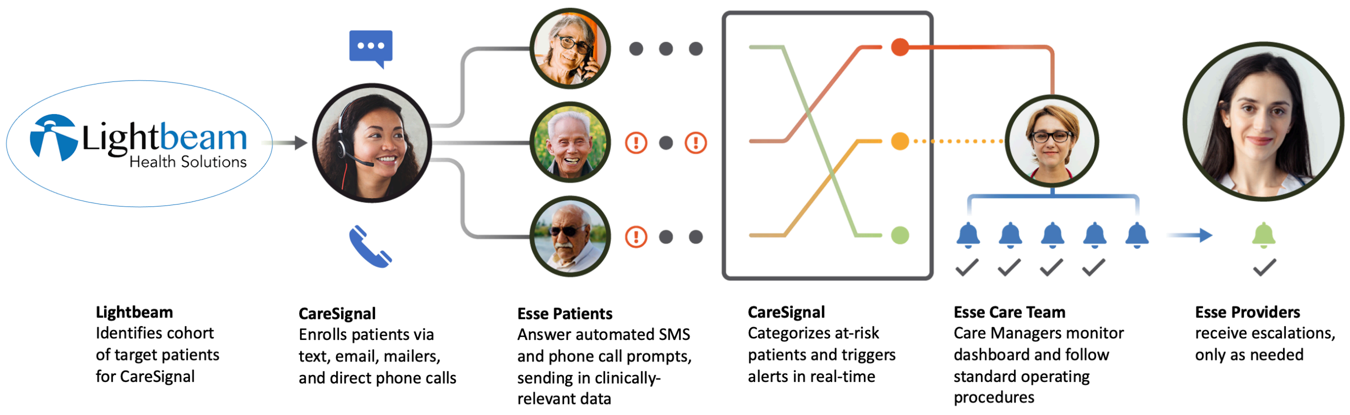
Esse Health considered the role of automation and real-time patient data. Could the automated collection of information such as patient symptom data and trending alerts improve the capacity and effectiveness of care management's outreach? To increase patient engagement at the scale needed to be successful and collect timely patient data, Esse implemented Lightbeam's Deviceless RPM®, CareSignal.

Care at High- and Rising-Risk Patients' Fingertips

CareSignal programs are aligned with many quality measures, including Esse's Medicare Advantage and MSSP ACO population. With goals of reducing avoidable utilization and improving chronic disease outcomes, Esse chose to focus on five use cases: heart failure, COPD, diabetes, hypertension, and post-discharge support.

Given Esse's Medicare population, one of the important considerations was Deviceless RPM's accessibility and ease of use. Patients participate in the program free of charge and use their own phones to communicate via their preference of text message or phone call. "One of the several benefits is that there are no devices required, no apps or downloads. Everyone can use this, so it promotes and elevates health equity," Beckerle said.

Esse & Lightbeam's Chronic Disease Workflow

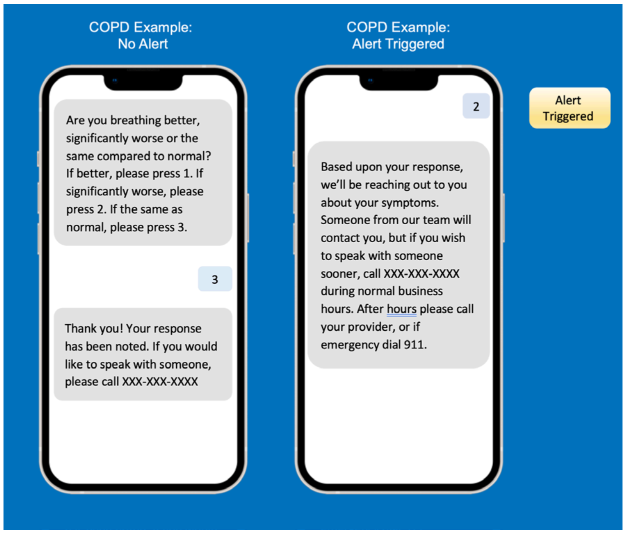


Esse Health & CareSignal's Workflow

How the technology fit into the care manager's workflow was equally important. A smoothly orchestrated workflow among CareSignal and Esse Health enabled eligible patients to be enrolled into the RPM program that matched their condition and alerts to flow to care managers who could escalate to providers as needed. Importantly, CareSignal called, educated, and consented patients into the program eliminating the need for Esse to use its own resources on patient enrollment and enabling Esse to achieve scale with almost 7,000 patients enrolled.

Patients respond to the automated messages, self-reporting clinically-relevant symptoms (e.g., breathing ability, swelling, blood sugar). CareSignal's algorithms categorize patient responses into appropriate risk categories, with high-risk patients triggering an alert to an Esse care manager for clinical review and potential outreach. Automated alerts ensured that Esse's care managers focused their efforts on patients that needed them the most, saving time and allowing them to work top-of-license. Early identification also enabled care managers to shift from a reactive care model to a proactive one, addressing issues before they resulted in avoidable medical costs.

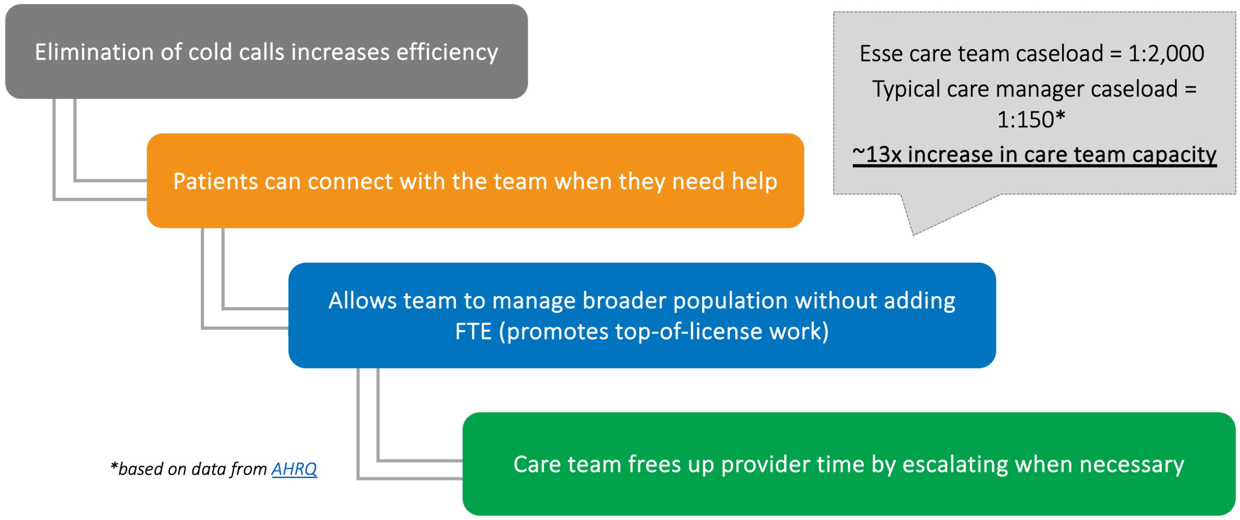
COPD Program:
Sample Message & Alert Response



The post-discharge workflow is a particularly important one. Nationally, one third of 30-day readmissions occur within the first week,[1] Beckerle pointed out. "So, getting patients support as quickly as possible is critical to

1. hcup-us.ahrq.gov/reports/statbriefs/sb230-7-Day-Versus-30-Day-Readmissions.jsp

Scalability/Reach



preventing readmissions." With the streamlined workflow, the median time between patient's discharge date and enrollment in Deviceless RPM was 36 hours.

Patients receive automated messages checking in and offering the opportunity to report how they're feeling and communicate with the Esse care team. At the end of the 30-day post discharge period, patients are eligible to enroll in a chronic-disease program to continue receiving Deviceless RPM monitoring.

A Seamless Increase in Capacity for Esse Health

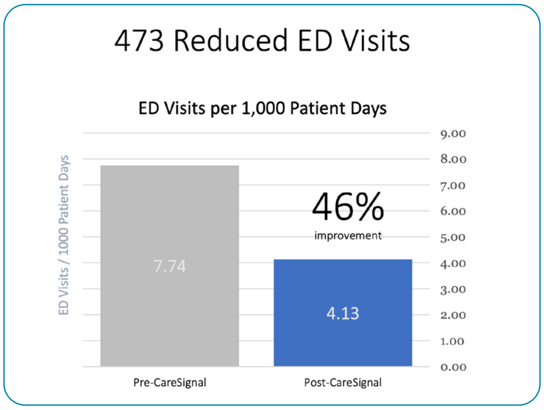
Empowering patients and care teams with CareSignal's technology and data has empowered Esse Health to do more, including extending care to the rising-risk patients, with its existing staffing and resources.

"Right now, one case manager has a workload of 2,000 patients," Beckerle reported. "Now you say, 'Oh, come on now, that can't be true.' But it's because we've been able to implement this in a way that allows patients the ability to do a lot of self-management."

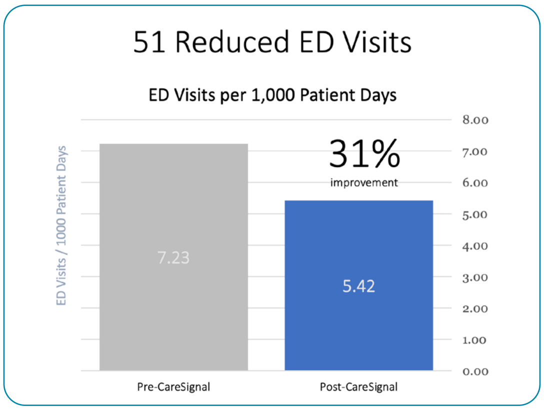
CareSignal frees up care manager time by enabling Esse care managers to focus on patients who have reported worsening symptoms or urgent issues, she explained.

Improving Chronic Disease Outcomes and Patient & Staff Satisfaction

CHF ED Claims Analysis: 1,018 Patients



COPD ED Claims Analysis: 214 Patients



During these times when issues arise, “we respond immediately,” she said. “Then we align them with our providers for escalation, an office visit, or education, whatever their needs might be.”

Claims analyses of Esse Health revealed a 46% reduction in emergency department visits for CHF patients and a 31% reduction for COPD patients and a cumulative savings of over $4.1 million from October 2018 to February 2023.

Further analyses showed improvements in A1c control with an average drop in eHbA1c of 3.21 pts for patients with a baseline >9%, and a 1.65 pt drop for patients with a baseline between 8-9%. Analyses also showed improvements in blood pressure control with a 9.34 mmHg average drop in sBP and 3.0 mmHg average drop in dBP for baseline patients 140-160 sBP. In addition, a 12.57 mmHg average drop in sBP and 5.98 mmHg average drop in dBP for baseline patients >160 sBP.

What’s more, Esse Health achieved these gains in tandem with improved care team and patient satisfaction.

One care team member noted how CareSignal is “another way for patients to gain education about their chronic conditions as well as building a trusting relationship with their medical examiner.”

“It allows for another point of contact for the patients to reach out with any questions or concerns,” another care team member commented, citing “a sense of comfort knowing that they have another attachment to be able to always assist their provider with their care.”

Patient feedback has been encouraging as well, with increases in customer satisfaction and health literacy scores as well as positive comments from individual patients:

- “The best thing about them is (1) the messages remind me to take my BP regularly, and (2) I don’t have to write down my readings to report them to my doctor since she receives the results.”
- “I wouldn’t change a thing. I really appreciate the texts keeping me on point.”
- “I think there is good information that is sent on where to call to ask questions. Very glad someone is monitoring.”

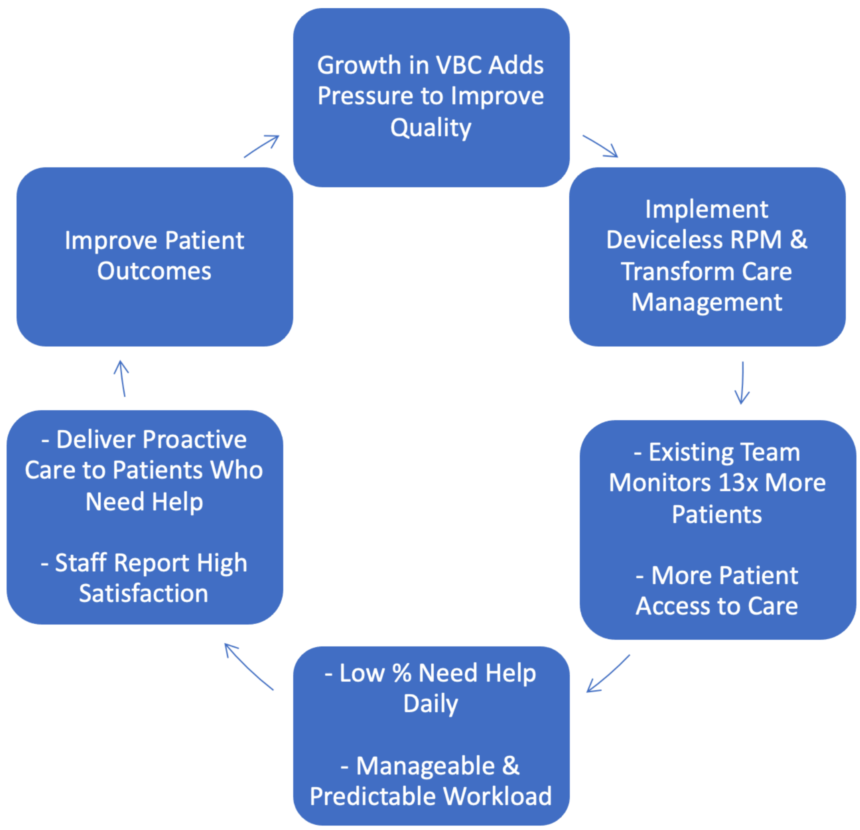
Final Thoughts on Chronic Disease Management, Value-Based Care, and the Human Touch

“When we think about population health and those patients that have needs and need intervention, there are diagnoses that pop up and those are the chronic conditions,” Beckerle said. “We were very fortunate to find CareSignal. Lightbeam had already developed an evidence-based model and tested it, and it was very easy to add that to the chronic condition modules we already had in place.”

Looking forward, she said she sees Esse Health considering expanding to the commercial populations that we’re moving to upside and downside risk.” They tend to be on the younger side because that’s how they want to communicate,” she said.

But in the end, it’s the engagement that matters. “People just want to be communicated with. Period,” Beckerle said.

Creating a Virtuous Cycle Enables Value-Based Care Growth



Q&A

Q: ***How does CareSignal meet the requirement to contact Medicare patients within two days post-discharge?***

A: Lightbeam gets live data feeds in real time and on a daily basis and brings in payer files for pre-authorizations. "We can deploy a workflow very quickly," Davis explained.

Esse Health has an established process in all its offices to call patients 24 hours within discharge. "The work is done, the setting, the appointment for the patient is done," Beckerle said. "The CareSignal tool does not replace any of the processes we already have in place. It augments them by providing sustained follow-up that is so critical for catching patients as they begin to worsen."

Q: ***How do you see CareSignal as supporting population health?***

A: "Opportunities and outcomes," Davis replied. "Lightbeam's population health platform surveils a broad member population to pinpoint impactful opportunities, while CareSignal empowers care teams and providers to intervene earlier in the care journey. Together, they create a powerful synergy in care orchestration: Lightbeam directs resource allocation for maximum clinical and financial impact, while CareSignal drives clinically relevant patient engagement to reduce avoidable utilization."

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