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Employee Benefit Plan Review

Human Patient Monitoring: Meeting Employers' Great Expectations in Direct Contracting

By Craig Parker

As self-insured employers and at-risk provider organizations, including accountable care organizations (ACOs) and integrated delivery networks (IDNs), sharpen their negotiation skills for direct contracting arrangements, both sides of the table will benefit from the inclusion of personalized care guidance to improve patient satisfaction, ensure better outcomes and lower costs.

The addition of "human patient monitoring," the human touch to care coordination provided by care guides, literally "speaks" to patients and families, uncovers their practical, non-clinical issues, resolves barriers to accessing care and enhances the care journey. When embedded into direct contracting arrangements with provider organizations, care guidance is clearly the pathway to a better patient experience that results in avoidable expenses for hospital admissions, readmissions and expensive interventions.

How It Works

Research from Centers for Medicare & Medicaid Services (CMS)[1] has shown that clinical care accounts for only about 20% of a person's overall health and well-being. This, of course, leaves 80% mostly untouched by the traditional clinical care system. Care guides solve this largely unaddressed problem in a scalable, efficient and data-driven way. Serving as a hands-on point of contact for patients to not only answer questions and explain benefits, non-clinical, specially trained care guides are the optimal, most cost-efficient resource for coordinating the non-clinical aspects of a care journey and helping patient/employee/member to better navigate specialty care and access appropriate services outside of the hospital walls. These personalized interactions help to ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time.

In partnership with hospitals, health systems, payers and other provider organizations that assume risk, care guidance delivers on the need to improve patient access, understanding and compliance. And these are key words: understanding and compliance.

Many institutions have attempted to address these issues with tech-only platforms. But many patients or members who need the most assistance are less likely to solely rely on an over-the-top app or plain text messaging. To reach these patients, and other patient that experience anxiety, confusion or intimidation (nearly everyone at some point), a better approach is to combine the ability of tech to ensure a process is followed with a human to make sure the patient/employee/member understands the importance of the task and has

the resources, capability and motivation to comply.

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It is the combination of highly trained care guides and a patient activation platform that is a proven approach to positively impact patient / employee lives and drive financial and operational improvement. It is a more complete solution for supporting and empowering patients and caregivers with meaningful direction to understand and resolve their barriers to care, resulting in a uniform care experience and optimal outcomes.

Care guidance is also taking on increased importance in the healthcare industry since it is built upon peer-to-patient relationships that identify and resolve non-clinical barriers or escalate clinical issues to the proper clinical and social service teams. These steps help to eliminate the consequences of health disparities which are even more pronounced among lower-income, minority and rural populations. As an intended consequence, a well designed and implemented non-clinical care guidance program will improve health equity.

It is possible to improve health equity because peer-to-patient relationships and interpersonal collaboration can have a vital impact in reducing levels of intimidation, confusion and anxiety that are unfortunately present for many under-resourced patients. Promptly addressing the physical, practical, emotional, informational, cultural, spiritual and familial barriers that impact patients both improves clinical quality and decreases cost. In short, making it simpler for patients/employees/members to understand the importance of their clinical instructions and easier to stay on the correct care journey, results in improved clinical outcomes, patient / employee satisfaction and more economic, efficient care.

Understanding Direct Contracting Objectives

In a direct contracting arrangement, the employer and the provider usually seek to align their respective business interests by aligning their respective economic interests. Rather than pay premiums to a commercial payer/third party traditional health insurer and accept unknown carrier network pricing, employers designate select providers to be their preferred points of service for employees' healthcare needs, with contracts ranging from fee-for-service, risk-based (using capitation or other global payment methods), service level agreements and in some cases, medical tourism programs to access care outside of local or regional delivery system.

In their quest for quality healthcare and cost predictability, employers are increasingly adopting a direct contracting strategy that incorporates robust financial incentives to manage the cost of care for all parties – employers, providers and employees – while delivering enhanced outcomes for patients. This approach establishes a one-to-one relationship between a health system or a provider network and a self-insured employer, with employers assuming the financial risk and responsibility of paying their employees' medical claims.

Typically, the employer contracts with third parties for enrollment, claims processing and provider network construction. According to a recent survey[2] by the Business Group on Health, nearly a quarter (24%) of all employer healthcare purchasers are considering contracting directly with integrated delivery systems.

The Employer Perspective

Benefits decisionmakers are shaking their heads as they reflect upon uneven patient experiences, satisfaction with care and less than optimal outcomes. Amid ballooning expenses related to hospital admissions/readmissions, the impact of social determinants of health (SDoH) and other non-clinical issues posing barriers to accessing care, they are counting on value-based payment and direct contracting models to brighten the outlook and get the results they are seeking.

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Direct contracting offers an increasingly viable way to gain buyer/consumer/seller alignment on priorities, incentives, and engagement; understand and therefore better control healthcare spend; and create a dialogue educating providers on the needs of their largest market, long masked by their carrier relationships.

Further motivating self-insured employers to embrace direct contracting is the harsh reality of unprecedented healthcare costs in 2023, with survey projections[3] indicating that the average costs for U.S. employers that pay for their employees' healthcare will increase 6.5% – from $13,020 per employee in 2022 to more than $13,800 per employee in 2023.

In fact, according to a recent survey by the Business Group on Health, nearly a quarter (24%) of all employer healthcare purchasers[4] are

considering contracting directly with integrated delivery systems. What employers now realize is that they can use their purchasing power to negotiate arrangements that tie provider reimbursements to the quality of care not the quantity of services and get "healthier" results at lower costs – essentially, value-based care.

For example, the employer may pay the provider a bonus for achieving certain agreed-upon quality and/or patient satisfaction metrics, such as hospital admission/readmission rates or immunization rates. The parties may also agree upon a "shared savings" arrangement whereby the provider shares a portion of "savings" generated against a baseline for spending – savings the provider aims to achieve through its care coordination and care management efforts.

The Provider Perspective

When the key driver of financial success is keeping patients healthy – rather than billing for services – provider organizations are seeking more opportunities to improve the patient experience and overcome barriers to accessing care. Beyond expanded office hours, they must deliver self-management support, pro-active care and an environment that optimizes the resources of all medical and non-medical professionals to best serve an employee population.

As they compete for employer contracts, organizations must jointly define what "value" means to them and strive to meet and exceed employer expectations. Once fully aligned on these principles, providers can more quickly turn their collective vision into reality and negotiate a direct partnership as opposed to relying upon conventional models which tend to leverage "one size fits all" approaches for their employer clients. This can translate into the co-development of population-tailored clinical programs, demographically relevant quality measures, and win-win-win economic terms to create financial advantages for patients, employers and providers alike.

Providers that offer a true high-performance network consistently deliver both lower costs and higher quality[5] care that is patient-centered, evidence-based, appropriate and coordinated. The optimal approach to serving employer groups is to expand and enhance opportunities for patient adherence to treatment that leads to quality care at lower costs.

Ideally, the future-state provider model should be designed to secure additional patient volume. This means that organizations take the extra step in offering personalized care that may earn them incentive payments for meeting contractually defined quality indicators.

Understanding The Value of Care Guidance

In direct contracting arrangements, employees are the ultimate consumers and arbiters of healthcare quality. Consumers become frustrated and fear losing their privacy with technology applications like automated voice devices and chatbots, which can lead to mistrust and diminished confidence in their providers.

What is needed and expected is a more human touch to their interactions. Rather than relying exclusively upon digital channels, recorded messages and other impersonal prompts, this approach humanizes interactions and leads to a more meaningful and productive experience that results in better health outcomes at lower costs – the goals of every direct contract.

The term "human patient monitoring" (HPM) captures the essence of the value proposition: people are at the heart of care guidance programs. It's an approach that is indispensable for vulnerable patient populations experiencing certain socioeconomic conditions and characteristics that pose barriers to care access. These factors include SDoH such as race, ethnicity, language proficiency, age, socioeconomic status, place of residence and disability. But even well-resourced patients / employees can encounter confusion and frustration with the health system and given these individuals a relatable peer interaction can immediately reduce the anxiety level, leading to better compliance.

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One study[6] shows that while consumers like voice assistants to perform everyday activities, for more serious situations such as those involving healthcare, they prefer a live human interaction as the most trusted method of communication. This directly contributes to enhancing the consumer experience (CX), with the implementation of optimal care guidance programs that are built specifically for this purpose: a peer-to-patient-powered foundation that is strengthened with evidence-based protocols and the human touch. Together, human and tech elements are effective in identifying and proactively resolving practical issues that can become real barriers to a patient's continuum of care as they navigate the healthcare system.

Proactively enhancing the patient CX in value-based care is in the best interest of everyone in a direct contracting world: happy, informed and activated patients are more motivated, more likely to take the right next step, and are less likely to have avoidable emergency room visits or hospitalizations.

It is not hard to think through the things that should happen in communications with patients about non-clinical barriers and regular symptom assessments, and it is not uncommon for decisionmakers to lean toward the "build it ourselves" mentality

instead of considering an outside partnership.

However, marrying the human interactions with enabling technology, clinical escalation, data collection and impact/outcomes reporting is hard. Providers and payers tend to try to build systems from the clinical view outward, and they frequently start with data gathering systems that are poorly designed for patient relationship and monitoring interactions.

As a result, even large organizations struggle to build effective solutions in this space. What drives success in the identification and resolution of non-clinical barriers while concurrently being able to assess symptoms in ways that minimize frustration and abrasion with patients / employees, is the ability to have the non-clinical personnel at the center of this mode and empowered to operate within a scalable, technology-enabled platform with AI-assisted workflow protocols.

As the imperative to address all of the components of whole person health accelerates, the participants on all sides of the employee/payer/provider landscape should think carefully about the speed to implementation. In many cases, partnering with a vendor who has an existing solution creates speed and can take the guesswork and trial-and-error out of the "build it ourselves" approach.

Regardless of approach, it is vital to keep in mind that the platform must facilitate capturing and communicating relevant (non-clinical) data back to healthcare organizations and on to employers. When properly designed, the platform helps guide a variety of conversations and resolve non-clinical barriers that are completely distinct from clinical issues, a critically important instrument for capturing SDoH data and documenting disparity-related barrier resolution. This also facilitates operational improvement by seamlessly escalating clinically relevant information while delivering SDoH insights for each patient population.

Care guidance provides a service that is complementary to the role of analytics to help identify probable risk, and facilitate communication that leads to real, meaningful patient activation.

These enrichments to care delivery improve health care provider ability to deliver patient-centered care, consider patients' unique needs and deliver personalized care in a way that will generate the best possible patient outcomes and value for all stakeholders. With the addition of HPM, there is a unique opportunity to gain control over both the quality and the escalating cost of health care benefits, enabling companies to design benefit offerings that are custom-tailored to meet the specific needs of its employee population.

Success Metrics for Human Patient Monitoring Care Guidance

Provider organizations that enter into partnerships with employers for direct contracting will find it helpful to assess their performance and benchmark success against reliable metrics. Conversely, these metrics will enable employers to evaluate the operational and financial outcomes of these arrangements.

The right mix of people and technology working together to provide personalized guidance that addresses the needs of all patients, improves individual health outcomes and enhances their satisfaction. Care guidance provides a service that is complementary to the role of analytics to help identify probable risk, and facilitate communication that leads to real, meaningful patient activation.

Measure the delivery of high value healthcare, defined as high quality and efficient care which can be measured through two multiple angles:

- Adherence to quality measurements with a focus on the new HEDIS® Metrics 2023 *for SDoH*[7] as articulated and distributed by the National Committee for Quality Assurance (NCQA) for Social Need Screening and Intervention (SNS-E).
- Implementation of multiple programs for measuring performance and documenting quality, using methodology that includes patient intake assessments, wellness checks and activation of care guides to personally resolve member barriers to care associated with SDoH.
- Make health equity truly actionable, providing opportunities for not only identifying the identification of members who have food, housing and transportation insecurities, but to also document interventions for screening.
- Improve financial measurement for both parties, enabling the tracking of core costs and lowering admissions/readmissions, emergency room visits and high-cost interventions. This 'true north' metric is quite simply the per member per month (PMPM) cost over time, with care guidance shown to bend the overall cost curve of the beneficiaries within the program.

Financial Impact of Care Guidance

Resolving SDoH And Non-Clinical Barriers to Care Results in Documented Cost Savings

Research in the Journal for Healthcare Quality[8] found

socioeconomic factors, such as race, income, and payer status, are correlated with rehospitalization rates, and patients with certain conditions, including heart failure, chronic obstructive pulmonary disease and renal failure, also have higher rates of readmission. Care guidance services have been proven to reduce readmissions, including 31% reductions in Congestive Heart Failure hospital readmissions as well as 41% reductions in chronic obstructive pulmonary disease (COPD) readmissions. The value of care guidance[9] is measurable:

- Improves post-discharge follow-up and patient compliance with treatment by proactively identifying and addressing the non-clinical issues and barriers that could lead to readmissions.
- Reduces resource use and costs to Medicare for navigated patients in the Patient Care Connect Program[10] compared with matched comparison patients, according to a published study by JAMA.[11] This study concluded that lay navigation programs should be expanded as health systems transition to value-based health care.
- Addresses the many elements of patient satisfaction that are determined outside the clinic and proven to increase patient satisfaction ratings to the 90th percentile by addressing non-clinical factors that are beyond the scope of clinical care teams.
- Supports at-risk patients and their providers, taking additional steps to minimize high-risk patients' chances of readmission. This might mean involving the patient's family in post-discharge care instructions or referring the patient to a specialist for further care.

Care guides can help lower readmission rates by ensuring that patients schedule a seven-day follow up with their primary care provider or coordinate transitional care that may include rehabilitative, restorative, or skilled care, physical therapy, nutritional counseling and dietary planning, fall prevention and more. A recent study in *JAMA*[12] found patients who followed this seven-day guideline had a 30-day readmission rate of 12.7%, while patients who waited longer or did not follow up with their physician had a readmission rate of 17.5%.

By moving patients from passive recipients to empowered patients that consistently care for themselves pays dividends.

They also help to ensure patients understand their post-discharge care instructions. This level of personalized support goes beyond the distribution of printed instructions or hastily communicated instructions upon discharge. Care guides recognize that patients misunderstand or forget parts of their post-care directions and help to minimize the risk of patients being readmitted to the hospital in the near future.

An example is the manifestation of SDoH as persistent inequalities in cardiovascular disease (CVD), posing risk factors that often contribute to CVD-related morbidity and mortality. The American College of Cardiology/American Heart Association (AHA) guideline[13] on the primary prevention of CVD recommends that clinicians evaluate SDoH on an individual basis to inform treatment decisions for CVD prevention efforts. Recent evidence shows that low socioeconomic status, adverse childhood experiences, less social support, reduced health literacy, and limited healthcare access are associated with higher CVD risk and poorer health outcomes.

A 2020 AHA statement emphasized the role of structural racism as a fundamental driver of health disparities. The AHA 2030 Impact Goals state a desire to achieve health equity by identifying and removing barriers to healthcare access and quality.

SDoH clearly affects CVD prevention efforts. AHA and others affirm that SDoH that affects CVD risk factors, diseases and outcomes are complex and intersect. Addressing them can be challenging and will require a multilevel and multidisciplinary approach, involving public health measures, changes in health systems, team-based care and dismantling of structural racism.

The Bottom Line: Motivating Employees, Creating Lasting Behavior Change

Given its capabilities and strengths, a recent survey conducted by NEJM Catalyst[14] found that in-person and virtual support is the single most effective method of creating patient behavior change. When specially trained care guides provide persistent, consistent person-to-person outreach, employees are empowered to better manage their condition and appropriately access care.

By moving patients from passive recipients to empowered patients that consistently care for themselves pays dividends. For this and the multiple reasons cited earlier, care guides are experts at encouraging employees to take on bigger challenges, accept accountability, take responsibility for making better choices and adopt a more positive mental attitude – all of which will impact the company's bottom line.

Notes

1. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.

2. https://www.businessgrouphealth.org/who-we-are/newsroom/press-releases/large-employers-double-down-on-efforts-to-stem-rising-us.
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