HealthCatalyst

EBOOK

5 Steps to Improve Population Health Management with Personalized Patient Engagement

Navigating the Transition to Value-Based Care

Healthcare organizations continue to navigate the complicated shift from fee-for-service reimbursement models to value-based care.

To successfully make that transition, population health management (PHM) is an essential tool to bridge gaps in care, reach underserved communities, and improve the health of at-risk populations.

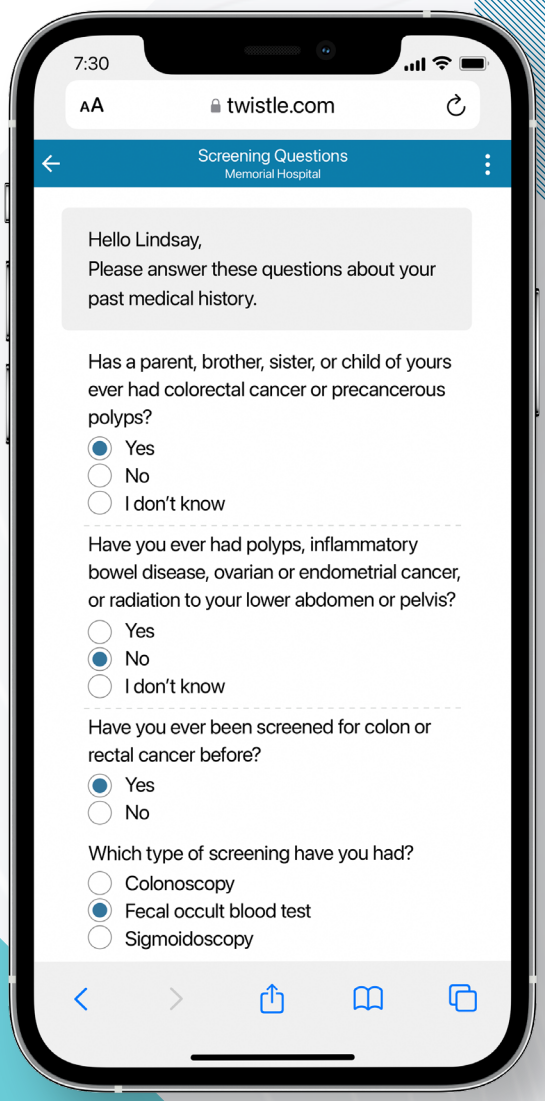
BRIDGE GAPS IN CARE

REACH COMMUNITIES

IMPROVE HEALTH

LEVERAGING PATIENT ENGAGEMENT TECHNOLOGY

There are challenges, though, to deploy comprehensive PHM initiatives. With overburdened care teams and limited resources, patient engagement technology must be at the center of every PHM strategy.



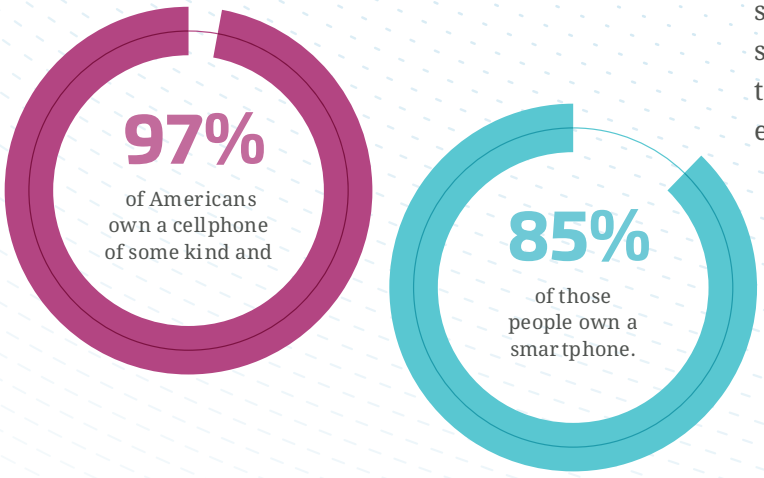
ACHIEVE HIGH PATIENT ENGAGEMENT RATES WITH TEXT-BASED COMMUNICATION

With automated, SMS text-based communication, healthcare organizations can efficiently engage with patients, address barriers, provide education, and reduce inequities. According to the Pew Research Center, 97% of Americans own a cellphone of some kind and 85% of those people own a smartphone. In addition, Gartner reports that SMS open rates are as high as 98% compared to 20% for email.

REACH THE RIGHT PATIENTS AT THE RIGHT TIME

Using a text-based communication tool to deliver easy to understand messages, information, and resources ensures that valuable information is getting to the right patient at the right time. This proactive outreach also encourages patient engagement and optimizes the patient experience.

To get started, there are 5 steps organizations should take to ensure their PHM communication strategy is successful in a value-based landscape.



Step 1: Identify Patient Cohorts

There are many data sources that are needed to accurately identify patients who will benefit from added support via patient engagement technology.

THE IMPORTANCE OF AGGREGATING MULTI-DOMAIN DATA

To accurately identify patient cohorts, a data platform needs to support multi-domain data from any source. For example, HL7 Scheduling Information Unsolicited (SIU) messages contain scheduling data from multiple EHRs which enable an organization to identify patients with an upcoming scheduled Annual Wellness Visit (AWV), whereas claims data is needed to know that a patient is due for an AWV. Another important data source is Admission-Discharge-Transfer (ADT) feeds that alert providers that a patient needs a transitional care management program (TCM). Organizations need a data strategy that will inform an effective patient engagement strategy in population health.

Without access to a robust collection of data sources including claims, clinical, demographic, social determinants ***(Figure 1)***, it will be difficult to capture all the patients in a population – especially those who are at-risk patients.

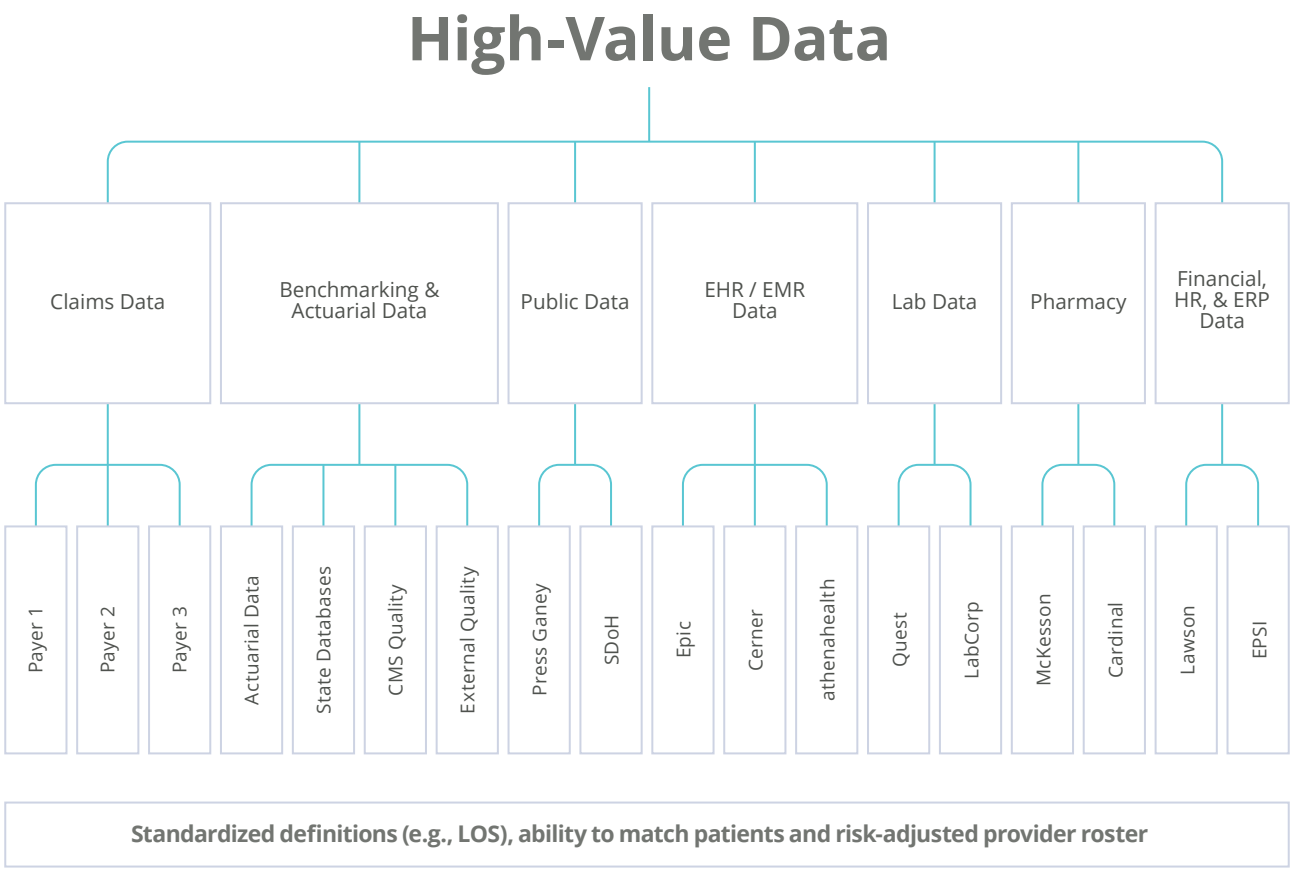


Figure 1: Use Multi-Source Data Integration to Strengthen Data Accuracy and Trust

If this work has to be done manually, it is resource intensive and time consuming. A more feasible and effective approach is to leverage a PHM platform that can aggregate data and help you accurately complete patient cohorting. With this approach you can also incorporate patient-reported data that may not be available in an organization's data source.

Use patient engagement technology including SMS-based survey tools to prompt the patient to report health-related data and risk factors, like social determinants of heatlh (SDOH) or Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) assessments.

> Healthcare organizations are drowning in data from proliferating sources that demand regular review, technical support—and too often, manual reconciliation. They must be able to consolidate data, cut through complexity, and gain meaningful insights.

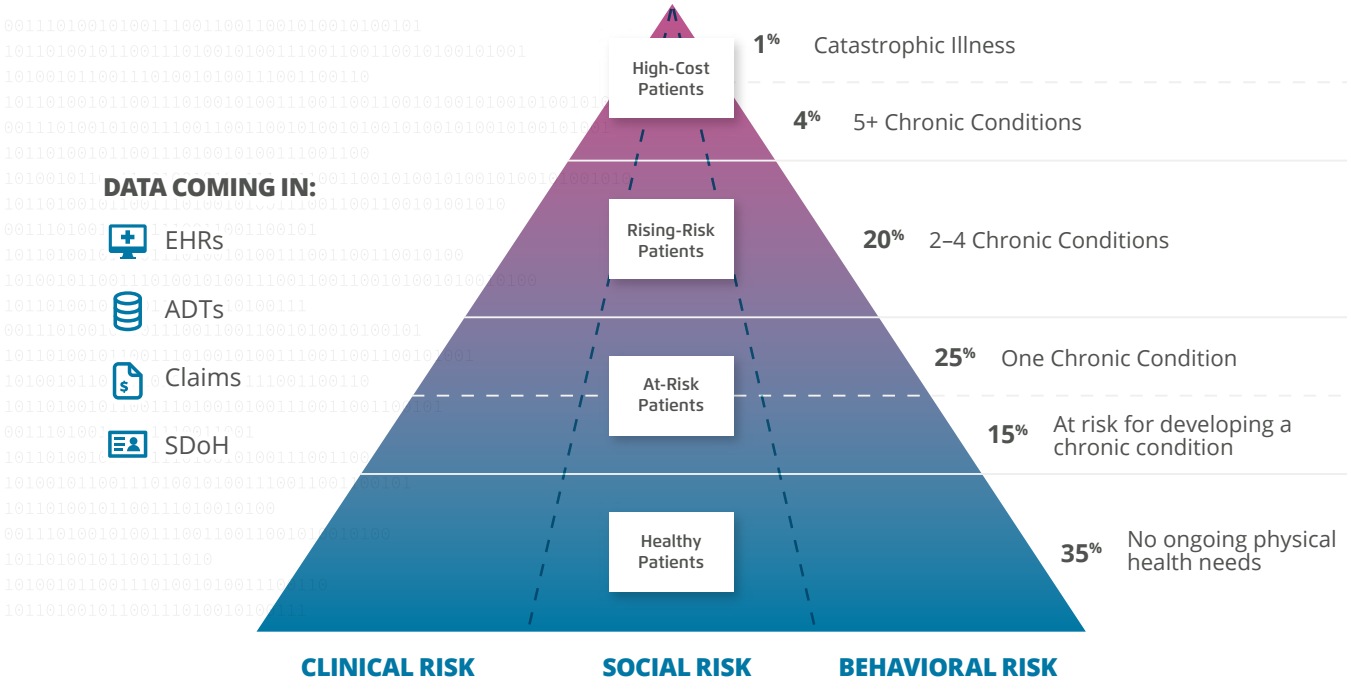
Step 2: Risk Stratification

Identifying patients who will benefit most from a population health intervention will ensure that your efforts are most impactful. All risk stratification tools are not created equally. Making sure patients are stratified to include predictive risk stratification tools enable more granular stratification including those with rising risk.

Consider your unique patient demographics and focus on the largest patient cohorts where the greatest gains can be realized. Risk stratification should consider an array of factors including physical, logistical, and behavioral factors. The analysis should also include SDOH and chronic conditions.

In addition to factors related to a patient's risk, organizations need to understand how current services, processes, and protocols may be hindering optimal care delivery. How are the following influencing outcomes for your patient populations?

- Location of offices, clinics, and care centers
- Wait times for appointments and services
- Use of best practices and standardized protocols
- Use of screening and prevention services



An operational vehicle aligns information to identify populations for interventions

Step 3: Automated Deployment of Personalized Communication Pathways

Once you have created data-informed patient cohorts that are risk stratified, organizations must be able to automate the workflow to drive down burdensome administrative tasks on staff so they can work to the top of their license.

They also need to be able to easily consume and analyze patient data quickly and efficiently. For patient communication to have maximum effect, care pathway content, timing, tone, and other factors matter. Technology that automatically adjusts content and cadence in response to each patient will result in a more sustainable engagement strategy. The journey becomes hyper-personalized and meaningful for patients.

Communication pathways that leverage machine learning will analyze nuanced patient behaviors to deliver the right message at the right time – and with the right subject line!

Patient Engagement Best Practices

TIMING

CONTENT

CADENCE

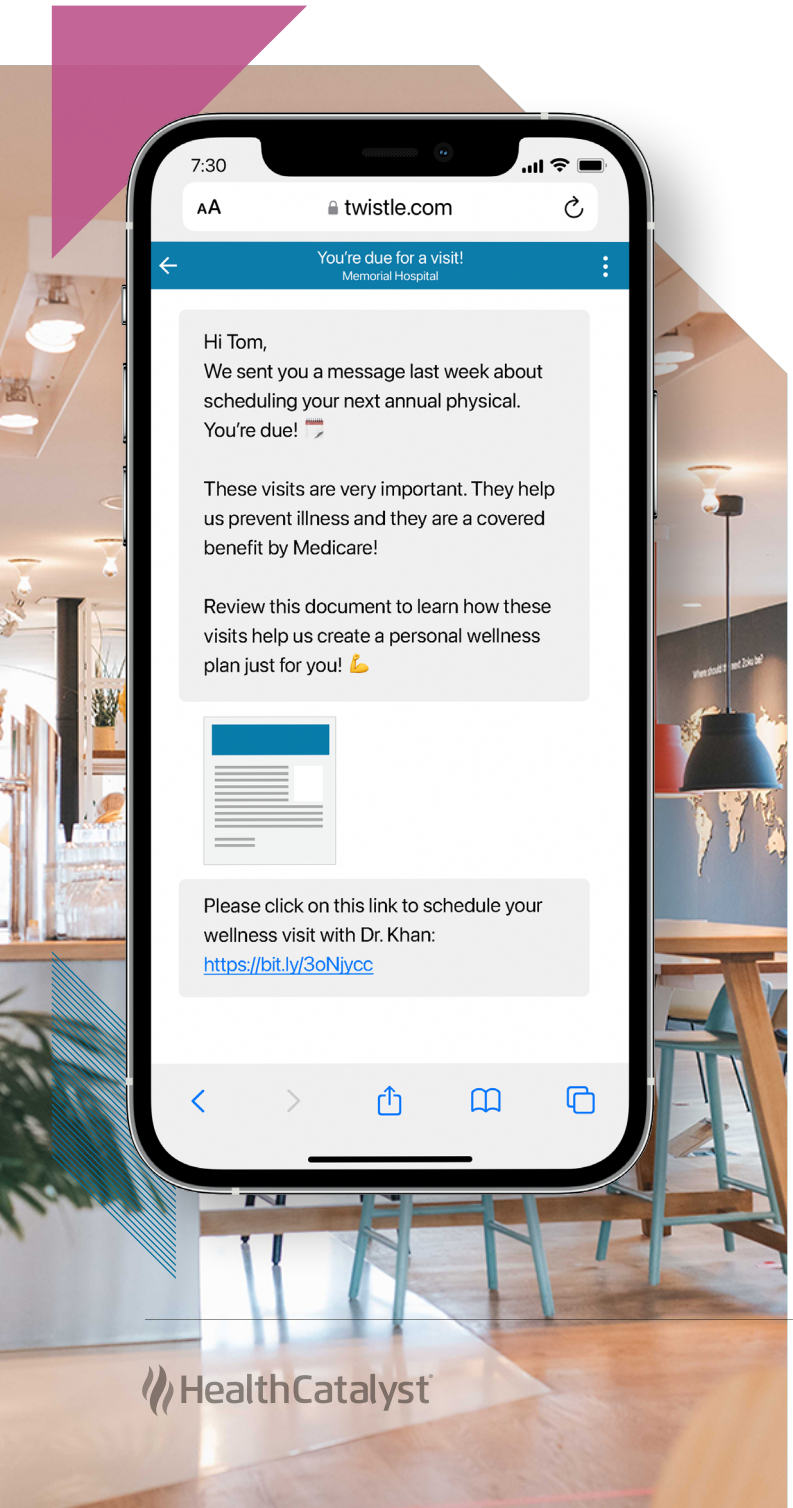
TONE

PERSONALIZATION

MOTIVATION

ACCESSIBILITY

ITERATION



Step 4: Close Gaps in Care and Keep Patients Healthy

Patient engagement technology enables organizations to automate digital outreach to patients who meet certain criteria. When there is a gap in care like a missed cancer screening or vaccination, an integrated technology platform can automatically prompt the patient via text message and provide them information about how to access the care they need.

When care gaps are integrated within the EHR, they become a very powerful tool to improve care. For the clinician, it surfaces the right insight, for the right patient, at the right time – streamlined directly within their workflow. Actionable care gap information is embedded directly into the EHR, resulting in better patient care and use of clinician time.

Proactive outreach to patients and easy access to timely, accurate insights allow organizations to deliver high quality care while also increasing revenue by performing appropriate procedures, decreasing costs by streamlining visits, and improving each patient's quality of life.

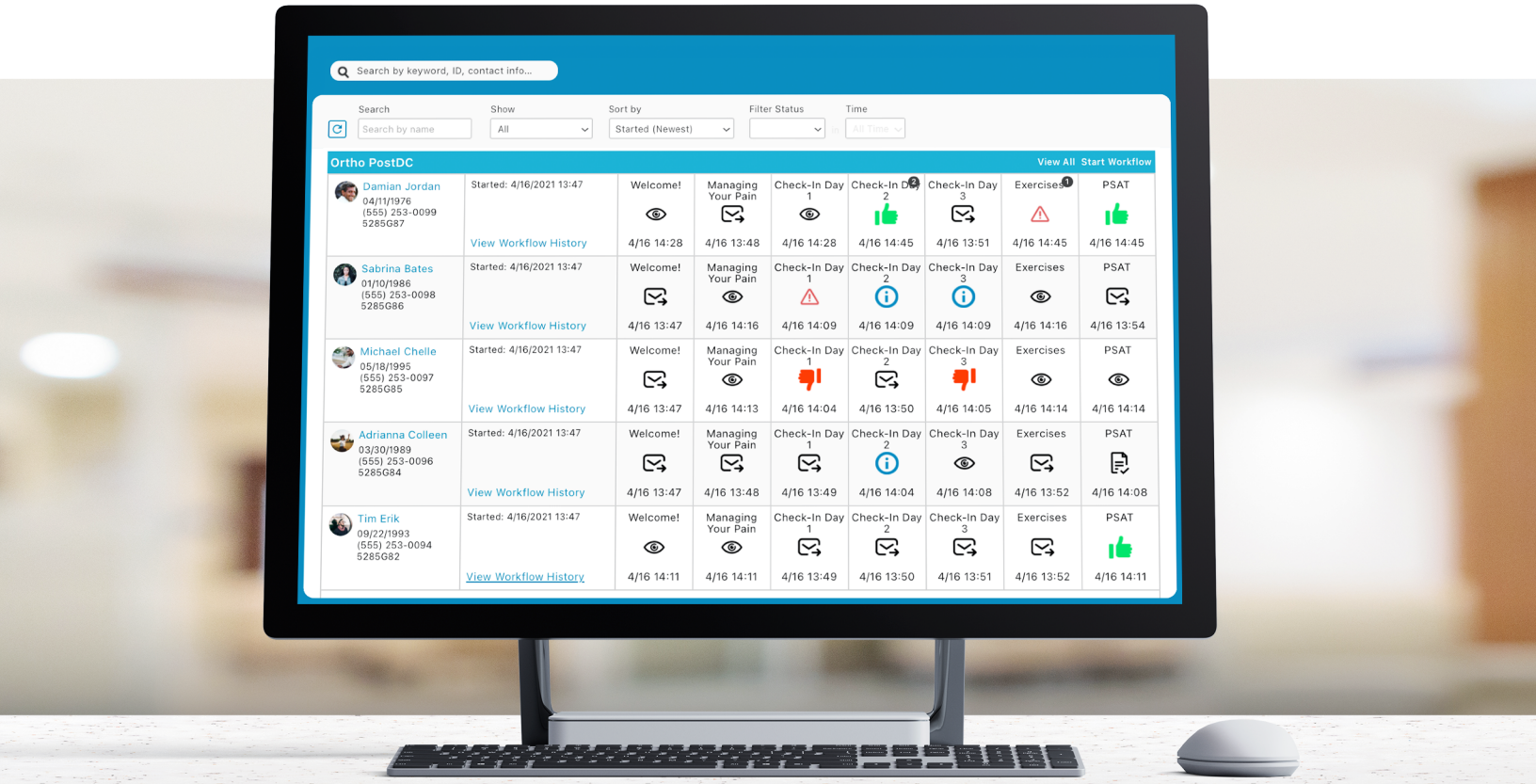
Step 5: Alerts When Patient Requires Intervention

Aggregated data integrated with patient engagement helps you deliver the right information to the right patient at the right time, but it also reduces the burden on the care team. Comprehensive dashboards can help organizations access a snapshot of cohorts and quickly understand what's happening. Create alerts that support the care team's workflow and set thresholds for intervention if patients deviate from their expected course. This enables the care team to focus their care where it's needed most and will be most valuable to the patient and the organization.

COMBINE ACTIONABLE DATA WITH PROACTIVE PATIENT ENGAGEMENT

The shift from volume to value is complex, but a data-based PHM solution to identify patient cohorts and stratify them according to risk combined with a configurable and sophisticated patient engagement platform will be key to success. Knowing which patients are at-risk is not enough.

Care teams need low-touch strategies to stay connected to patients, guide them in health and wellness, and detect patient deterioration. Aggregated data, automated and personalized communication pathways, and embedded care gap information ensure that care teams can reach the right patients with the right guidance and improve health.



About Health Catalyst

Unlike other solutions, Health Catalyst is exclusively focused on healthcare that provides people, process, and technology solutions proven to transform raw data into measurable value.

We offer a data-informed solution that empowers healthcare organizations to instantly identify the most valuable opportunities for improvement across the care continuum, offering actionable guidance for success in risk-based contracts. We partner with our clients to explore opportunities within the complete clinical, operational, and financial context for a given population.

Learn more

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