What really matters to patients?

Aligning ACO engagement efforts with patient preferences

NAACOS Spring Conference | April 11, 2024

Speakers

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BJC Healthcare ACO and BJC Medical Group

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American Heart Association

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Upperline Health

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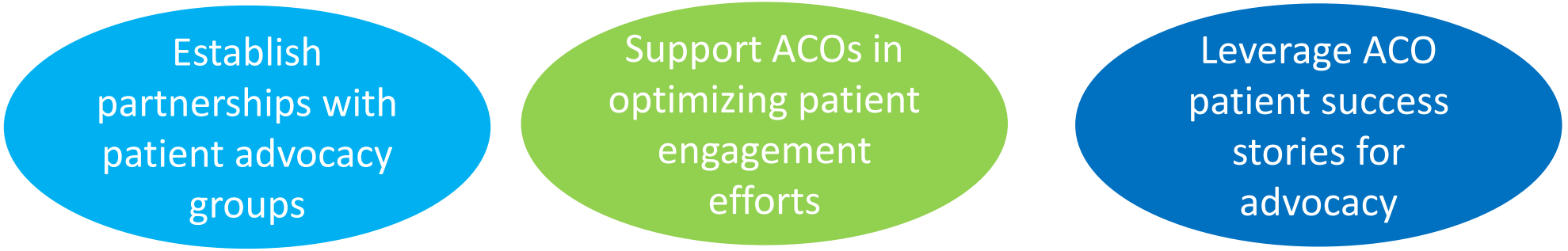
Regional Medical Director

Aledade

Background

- Value-based care and ACOs have historically had bipartisan support as key strategies to improve our health care system.
- Recently seeing misunderstanding about the roles that VBC and ACOs play in the health care system and how they affect patients.
- Need to effectively communicate the importance of ACOs and VBC to patients and engage them in advocacy and messaging.

In 2023, NAACOS launched a patient engagement strategy to:



NAACOS' Patient Engagement Work

- ✓ Formed the Patient Engagement Advocacy & Learning Network for ACO members focused on patient engagement.
- ✓ Met with patient and consumer advocacy organizations to develop relationships and align on shared priorities.
- ✓ Updated ACOs & Patients fact sheet with patient success stories.
- ✓ Conducted a survey of ACOs' patient engagement strategies and current challenges to identify resource needs.
- ✓ Published the resource *Recruiting & Engaging Patient Representatives: Foundations & Best Practices for ACOs*.
- ✓ Convened a group of ACOs, patient and consumer advocacy organizations, and other stakeholders to discuss shared recommendations for aligning ACO program requirements with patient preferences.

Work Continues

- Patient engagement and person-centeredness are vital to the success of ACOs.
- Many patients still don't know what 'value-based care' 'accountable care' or 'ACOs' are, and don't understand what it means to be a patient in an ACO.
- Patient support will be needed to achieve CMS's 2030 goal to have all traditional Medicare beneficiaries in accountable care relationships.
- Policymakers, ACOs and other health care providers, patient and consumer advocacy organizations, and other stakeholders will all need to work together to effectively communicate, educate patients, and design programs with true patient-centeredness.

What Really Matters to Patients? Aligning ACO Engagement Efforts with Patient Preferences

Melanie G. Phelps, DrPH, JD

Senior Advocacy Advisor, Health System Transformation

American Heart Association

- + American Stroke Association
- Celebrating 100s years of fighting heart disease and stroke, striving to save and improve lives
- **Mission:** To be a relentless force for a world of longer, healthier lives
- **Vision:** Advancing health and hope for everyone, everywhere

American Heart Association

- AHA is the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke.
- Next to the federal government, we are the largest funder of research
- Headquartered: Dallas, Texas
- US and global reach
- > 35 million volunteers and supporters

American Heart Association

Why are we here?

- CVD leading cause of mortality & morbidity
- Stroke among top 5 causes of mortality
- Significant disparities
- Worsening trends
- Increasing costs

American Heart Association

Why are we here?

- US spending on health (sick) care
- US population health performance
- US does not provide universal coverage
- Significant lag innovation to adoption
- Underinvest in public health and prevention

American Heart Association

Why are we here?

- Lack of confidence in our FFS-based system
- Misaligned incentives
- Promote more care not better care or outcomes
- Significant fragmentation
- Higher costs

American Heart Association

We can do better!

American Heart Association

Related AHA Activity

- 2017 Call to Action for Payment care Delivery System Reform
- 2018-2020 Value in Health Care Initiative
- 2021-2022 Improving Heart Health Through Value-Based Payment
- 2021 Call to Action on Maternal Health
- 2023 Policy Statement on VBP for Clinicians

Other AHA Value-Adjacent Efforts

- Advocacy efforts
- Policy and Scientific Statements on VBC and related issues
- Community Impact Funds and Activities to Address SDOH
- Employer Resources
- Evidenced-based Guidelines for Heart Disease and Stroke
- Resources to implement the guidelines in practice
- Quality Measure Development & Stewardship,
- Certification and Recognition Programs
- Million Hearts collaborator
- National Hypertension Control Initiative
- Palliative Care / Heart Failure pilot
- Consumer Health Solutions

AHA Heart Failure: Partnering in Your Treatment

American Heart Association.

Heart Failure: Partnering in Your Treatment

Bring this sheet with you to your appointment and discuss the following with your doctor.

Understand Your HF

- How serious is my heart failure?
  - ○ Mild ○ Moderate ○ Severe
- In what ways does having heart failure increase my health risks?
- How likely is it that having HF will worsen the effects of other conditions I may have?
- Would any of the following lifestyle changes help me to better manage the progress of HF?
  - ☐ Managing weight
  - ☐ Quitting smoking
  - ☐ Making other important changes?

Identify Your HF Needs

- Am I a candidate for HF cardiac rehab?
  - ○ Yes ○ No
- Are there any additional tests we need to do to learn more about my heart function? If so, which ones?

Explore HF Treatment

- What are the most important things I can do to manage my HF?
- What should I expect in the coming weeks, months or years?
- Are there any activities that are off limits for me at this time? (List specific concerns you may have, such as exercise, sex, housework.)
- What treatment options should I be thinking about for managing my HF?

What are my treatment goals at this time?

Symptoms of HF



- Should I be tracking and reporting my symptoms to you?
  - ○ Yes (instructions below) ○ No
- What symptoms or problems would you want me to notify you about?

Questions About Medication

- Will I be taking a medication(s) for HF?
  - ○ Yes ○ No
- What should the medication(s) do?
- What will happen if I don't take the prescribed medication(s)?

Learn to recognize and manage symptoms of HF.



heart.org/HF

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American Heart Association

Why am I here?

- Improving Heart Health in VBP Initiative
- AHA's role in VBC
- Personal Background


BIRTHDAY GIRL
Birthday Girl

American Heart Association

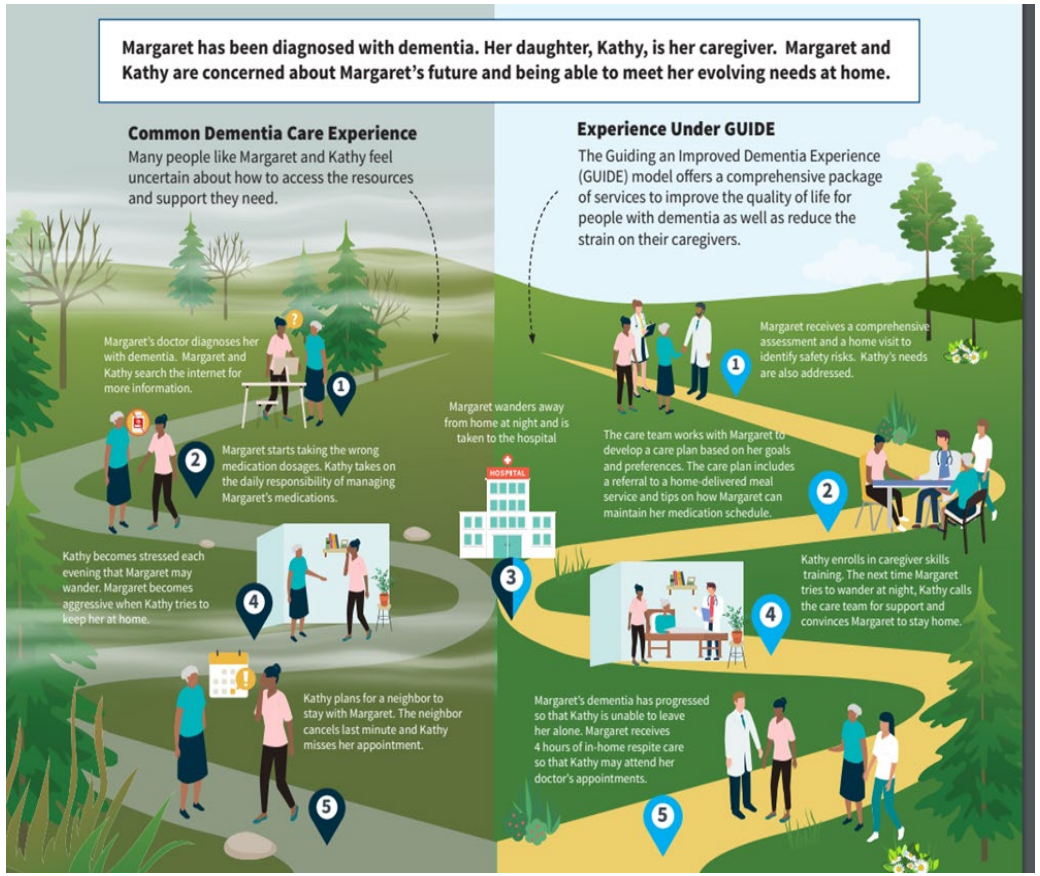
- Most efforts were provider focused
- Lack of participation by consumer/patient advocacy groups
- Lack of knowledge, understanding, and thus engagement by consumer/patient advocacy groups
  - Skepticism and confusion
- **Current focus:** elevating consumer/patient voices in VBC

Barriers to Elevating the Consumer/Patient Perspective

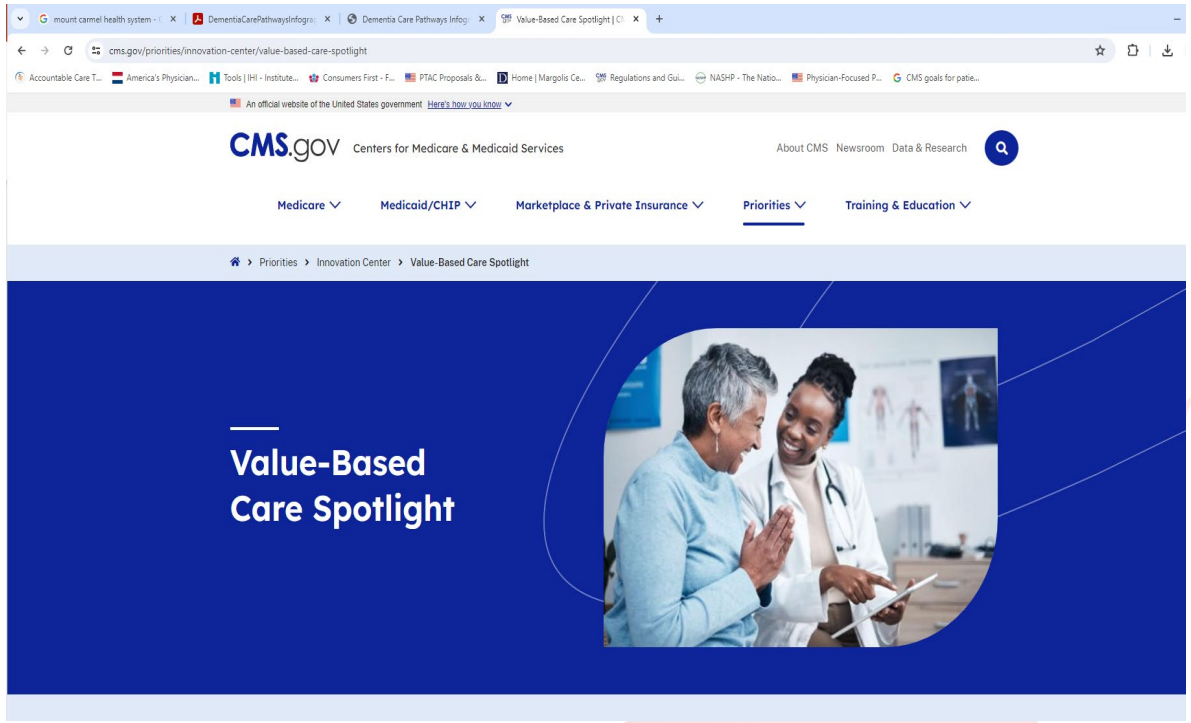


CMMI Efforts

GUIDE Model



CMS VBC Spotlight



https://www.cms.gov/priorities/innovation-center/value-based-care-spotlight

AHA AAPM Experience Research

- Research on experience with Advanced APMs
  - Medically complex patients and/or their family caregivers, and
  - Members of health care teams who support medically complex patients
- Need diverse patient populations & team members
  - Not limited to CVD or stroke patient
- All payers types

AHA AAPM Experience Research

- Research by a patient advocacy organization
- For patient advocacy organizations & policymakers
- To create better messaging re: the benefits of VBC by capturing the benefits from those served or providing care

Related Activities

- US of Care—messaging research
- Families USA—Pro-consumer Policy Agenda to Achieve Meaningful Health System Reform
- National Partnership for Women and Families—Equity-Centered Payment Reform - Learning Collaborative
- Primary Care Collaborative—webinars
- NAACOS/HCTTF—Person-Centered Care in ACOs

NAACOS/HCTTF
Person-Centered Care in ACOs

- **Goals:** improved patient engagement & aligned ACO program patient engagement requirements across programs
  - Macro/policy & micro/organizational and office visit levels
- Barrier & Best Practices identification
- Output: resources that outlines the issues and short- and long- term recommendations.

####

What Really Matters to Patients?

Aligning ACO Engagement Efforts Utilizing Remote Patient Monitoring

Megan Guinn, MBA, BSN, RN
Director Clinical Improvement
BJC HealthCare ACO
BJC Medical Group

BJC Health System

One of Missouri's largest employers, serving two regions — BJC HealthCare in the east and Saint Luke's in the west



#1-3

BEST HOSPITALS U.S.News & WORLD REPORT HONOR ROLL 2023-2024

Top three hospitals in Missouri, according to *U.S. News & World Report*

250+

Clinics and service centers meeting patients where they need us

44,000

Extraordinary caregivers and support staff

BJC Medical Group

14 Hospitals

30,751+ Employees

$6.3 Billion Net Revenue

3,275 Staffed Beds

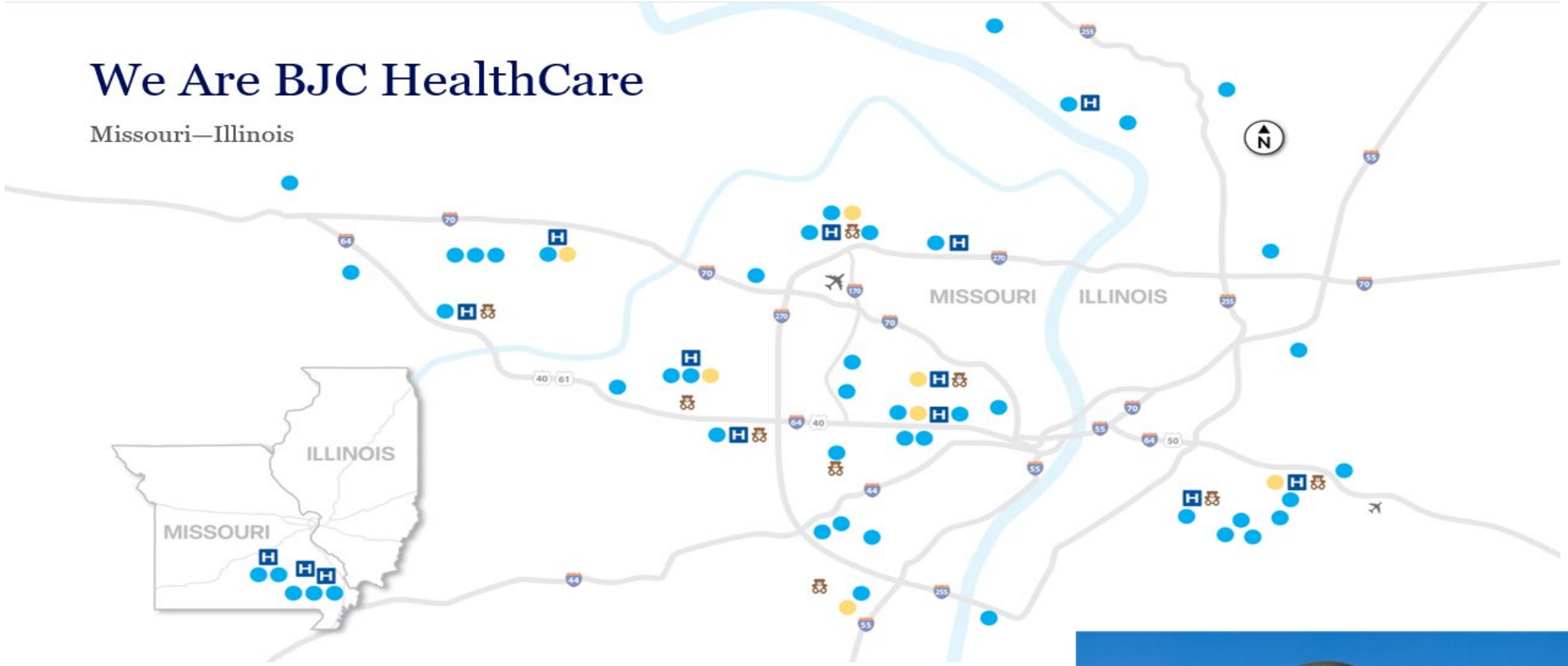
4,636+ Providers
600+ Ambulatory

150+ Clinic Locations

BJC Medical Group

We Are BJC HealthCare

Missouri—Illinois



Our Mission

As one of the largest non-profit health care integrated delivery organizations in the country, we are committed to improving the health and well-being of the people and communities we serve through leadership, education, innovation, and excellence in medicine.



BJC HealthCare ACO



2012: TRACK 1 ACO

2024: ENHANCED TRACK ACO



MSSP

MEDICARE ADVANTAGE

COMMERCIAL

MANAGED MEDICAID

DIRECT TO EMPLOYER



35,000 MSSP LIVES

~100,000 COMBINED TOTAL LIVES



2022 QUALITY SCORE:

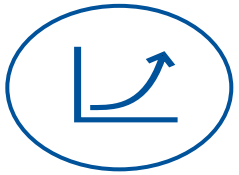
86.3%



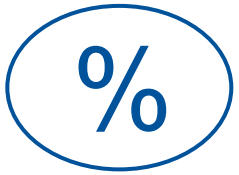
SAVED MEDICARE OVER $72M FROM 2012-2022

GENERATED SHARED SAVINGS OF $53.7M

The Time for Proactive Patient Engagement Is Now



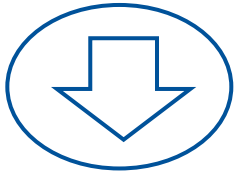
Expanding volume of value-based contracts



Increasing exposure of downside risk



Increase in patient acuity



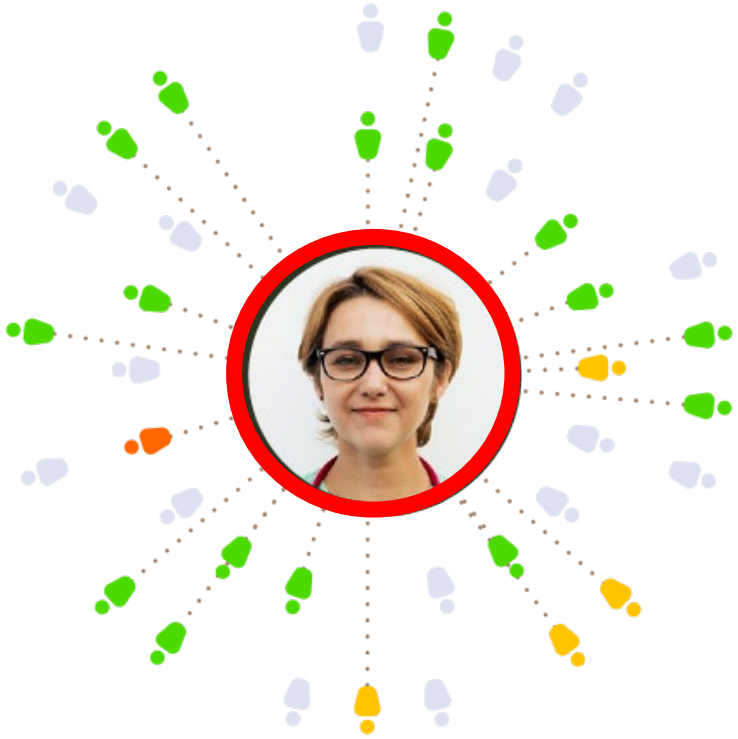
Decreasing quality metric performance



Growing emphasis on health equity

Challenge: Traditional Patient Engagement Methods are Not Scalable

Reactive
Manual outbound outreach



Proactive
Automated inbound insights



BJC Medical Group

Lightbeam Health Solutions

BJC ACO Designs New Patient Engagement Program for Rising-Risk Population

Team	Use Case	Modules
Alpha: Traditional Case Management	Manual, phone-based outreach & in-person visits	CHF, COPD, Diabetes, Hypertension, Post-discharge, General Medical
Beta: Case Management with Deviceless RPM	Outreach based on patient-reported symptoms	CHF, COPD, Diabetes, Hypertension, Post-discharge, General Medical

Driven by the need to manage more patients with existing staff, BJC created a two-tiered patient engagement approach

Post-Discharge Workflow

Before Deviceless RPM

After Deviceless RPM



30 Days

Manual Touches Once a Week, No Enrollment into RPM

60 Days

Follow-Up via RPM No Manual Touches

Enrollment into Condition Specific Program After 60 Days (e.g., CHF, COPD)

Patient & Provider Engagement

- Ensure provider buy-in
- Improve patient communication and engagement with the program
- Understand provider responsibility with alerts
- Create clinical workflow to follow once alerts are triggered

Help Clear the Air About your Flare-ups with our New Service, CareSignal!

BJC Accountable Care Organization

Answering a couple questions each week will help your Care Manager and Doctor's Office stay up-to-date with your breathing trends.

How Does CareSignal Work?

- You will receive computerized phone calls or text messages asking about your breathing. Answering is fast and easy and keeps your primary care physician team informed of your breathing trends. If you call the service back, it will try to connect you to your care manager.
- CareSignal messages will come from **1 (855) 434-3795**. We will not charge you for the service, but message and data rates may apply. If you are worried about possible message charges, sign up for the toll-free phone call option.

What Does it Start?

- You can expect messages two times per week soon after you enroll. You can opt out at any time by texting **STOP** or pressing * during a phone call.

How Often Will I Be Messaged?

- You will get messages twice a week.
- Answering these questions will help keep your Care Manager and Doctor's Office stay up-to-date with your breathing trends.

What if I don't feel well?

- This product is not intended to replace the communication that you have with your provider.
- **If you have an emergency, call 911.**

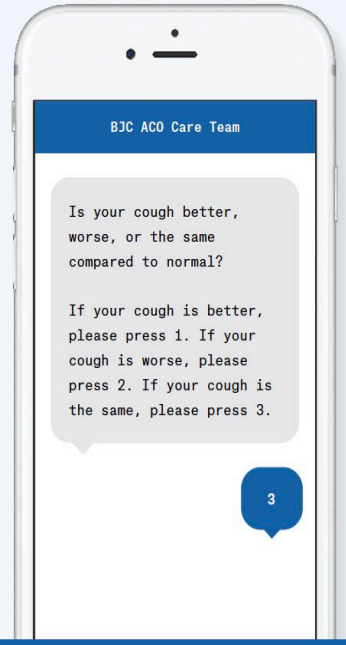
More Information

- For questions or information about the BJC ACO, please contact 844-996-7020 or visit www.bjc.org/ACO
- For more information about Acccountable Care Organizations, please visit: www.medicare.gov/acos.html
- Or call 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048

Messaging Available for Any Type of Phone

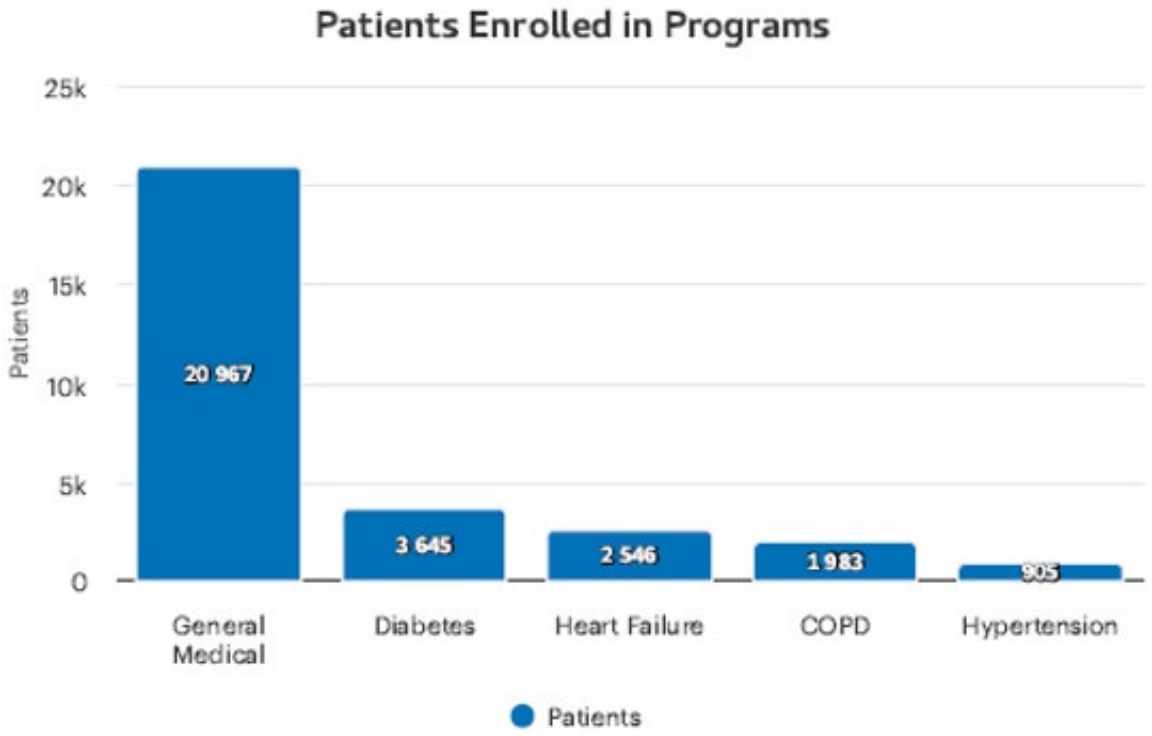


Example COPD Messages



HIPAA · The privacy of your medical record is protected by law. These messages and the responses you provide do not contain information that can be used to identify you. All data will be stored on secure, HIPAA-compliant servers and is only accessible to your clinical care team.

Over 25,000 Patients Engaged With Deviceless RPM



All-time Utilization (2017-Present)

- **1.3 Million** **Automated Patient Touches**

  Texts **899k**

  Calls **443k**

- **29k** **Proactive Alerts Raised**

- **3.3hrs** **Avg. Alert Response Time**

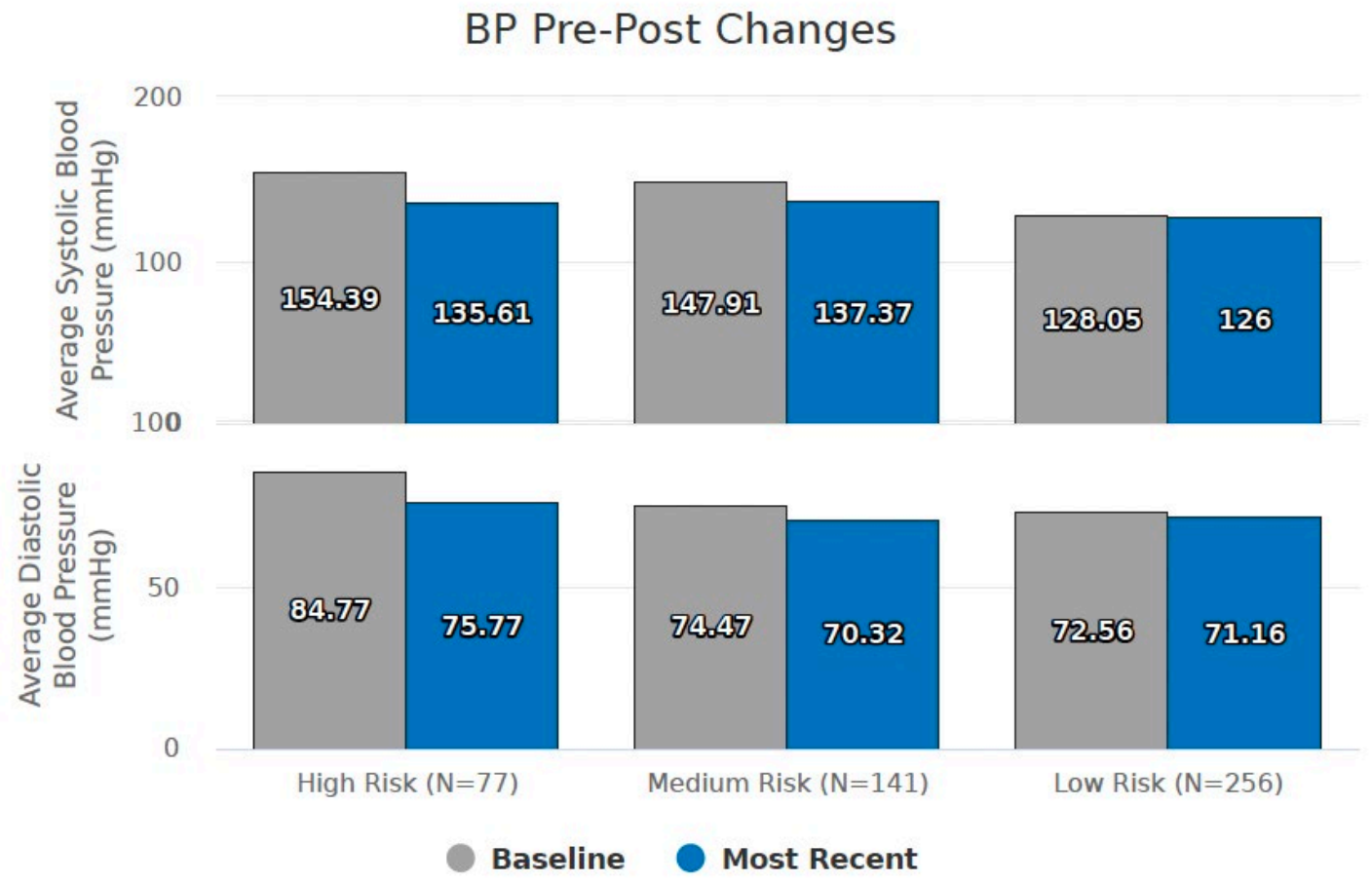
BJC Medical Group

Lightbeam Health Solutions

Hypertension Program Outcomes

Key Insights:

- 10.54 mmHg average drop in sBP and 4.15 mmHg average drop in dBP for baseline patients 140-160 sBP (n=141)
- 18.78 mmHg average drop in sBP and 9.0 mmHg average drop in dBP for baseline patients >160 sBP (n=77)

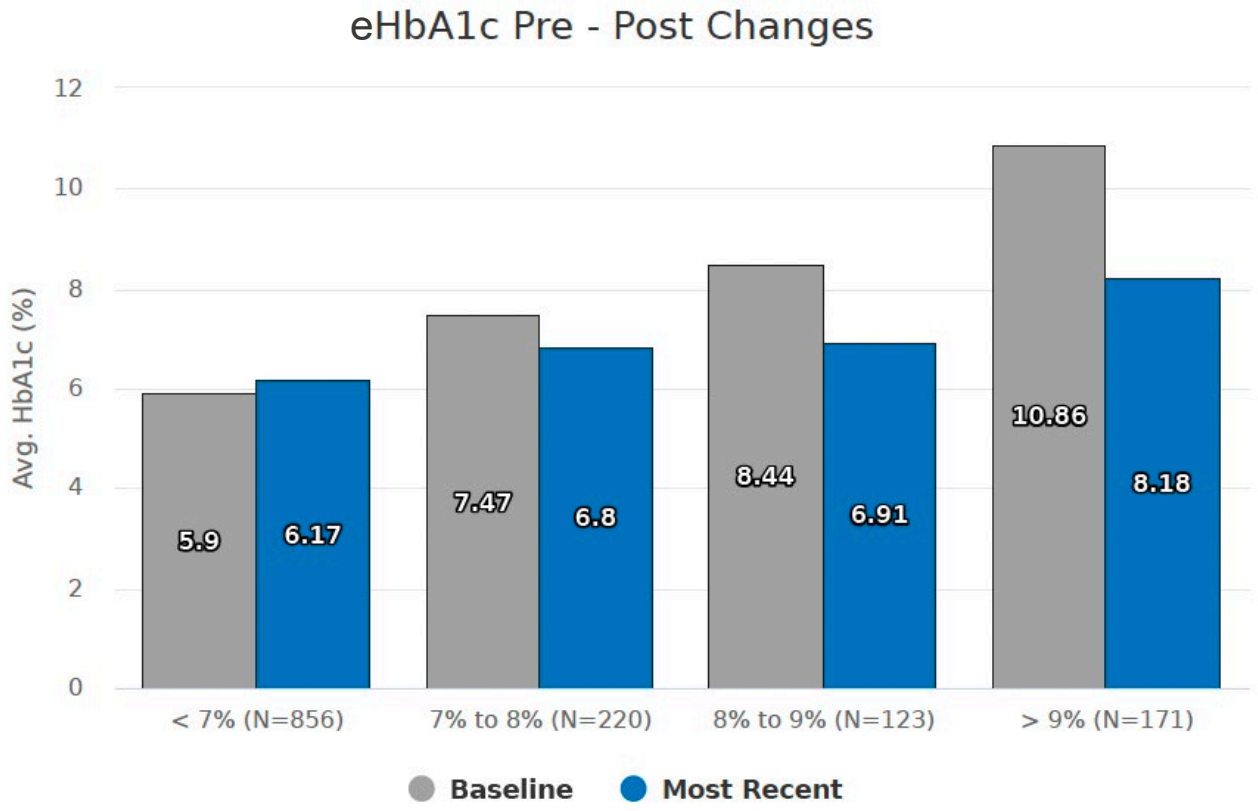


Diabetes Program Outcomes

Key Insights:

- Average drop in eHbA1c of 2.68 points for baseline patients >9% (n=171)
- Average drop in eHbA1c of 1.53 points for baseline patients 8-9% (n=123)
- Weighted Average 2.2 drop in eHbA1c for patients >8% (n=294)

eHbA1c Pre - Post Changes



Impact Analysis for CHF & COPD

	Engaged 1-3 Months (N=82)	Engaged 4+ Months (N=299)
PMPY Savings	($3,965)	($10,475)
ED Visits Per 1K % Change	-60%	-75%
Admits per 1K % Change	-32%	-62%

Staff Can Engage Over 10x More Patients

Team	Use Case	Modules	Caseload
Alpha: Traditional Care Management	Manual, phone-based outreach	CHF, COPD, Diabetes, Hypertension Post-discharge, General Medical	**1:100**
Beta: Care Management with Deviceless RPM	Outreach based on patient-reported symptoms	CHF, COPD, Diabetes, Hypertension Post-discharge, General Medical	**1:1,300**

Patient and Staff Satisfaction

Patient Quotes

“It's actually very reassuring that someone from BJC is checking and providing quality medical care that extends beyond an initial problem”

“This is a wonderful service. I am recently widowed and so appreciate the texts from BJC. It feels like a friend is calling to check in on me. Wouldn't change a thing.”

Health Literacy

Health Literacy: *Messages from BJC ACO have helped me understand my condition better.*

N = 1,156

Average = 6.47



1 - Strongly Disagree Strongly Agree - 9

6.47 – Health Literacy

Health Literacy: *Messages from BJC ACO have helped me understand my condition better.*

N = 1,156

Average = 6.47



1 - Strongly Disagree Strongly Agree - 9

"I love being able to do proactive outreach daily for so many patients and seeing the positive impact that it has on their disease process.”

- **Melanie Staggs, ACO RN, BJC ACO**

Thank You

upperline HEALTH

Making the Most of Every Patient Visit

April 2024

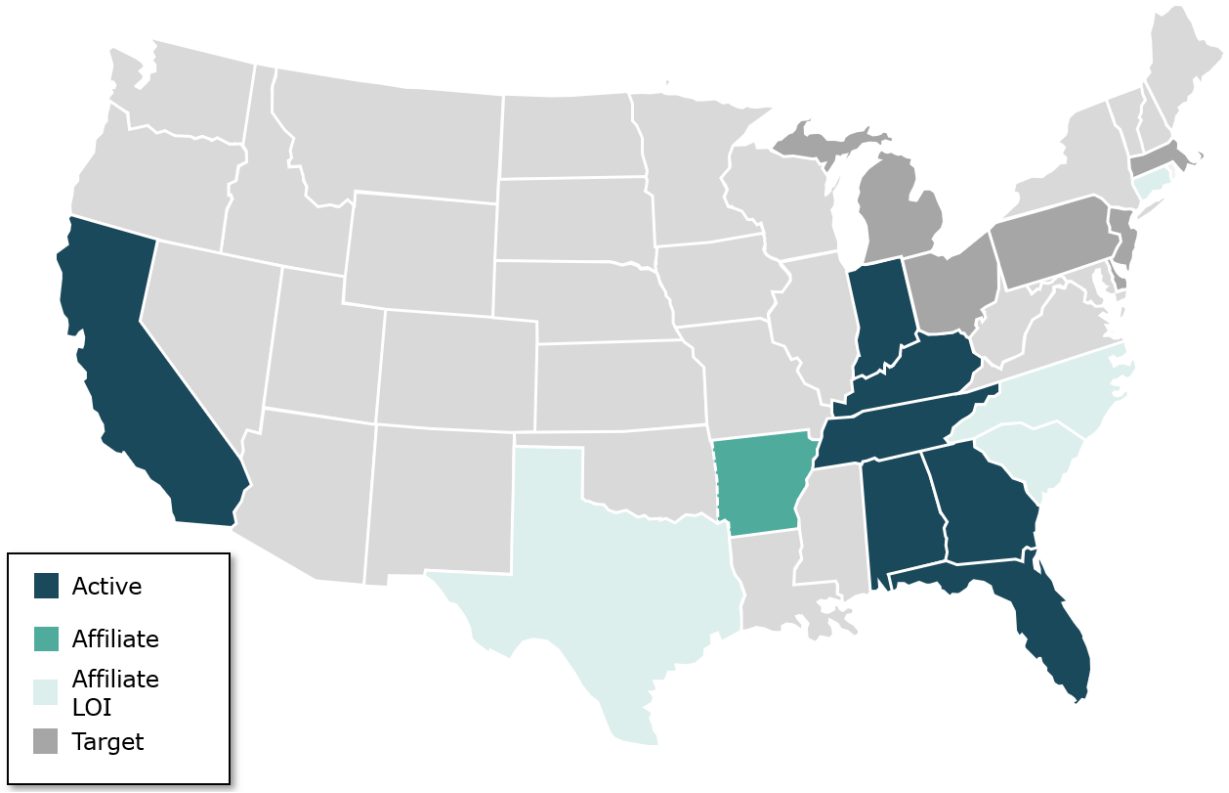
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Upperline Health is one of the nation's largest specialty physician practices providing comprehensive care through frequent specialist visits. Our mission is to transform how specialists engage with patients and partner with PCPs, payers and other providers to improve patient care.

Upperline Health's specialists provide care for patients with multiple chronic conditions who can benefit from better care coordination from an interdisciplinary team.

Upperline Health by the Numbers

200+ Providers	350k+ Patients	130+ Clinics	1M Visits	5 Specialties



Payer Mix

- 80K Medicare FFS
- 27K ACO REACH
- 120K Medicare Advantage
- 150K Commercial

The specialist imperative

9 in 10

Physicians are specialists [1]

60%

Healthcare encounters with specialists [2]

2 in 5

Adults receiving general healthcare from specialists [3]

30%

Medicare patients see >5 physicians annually [4]

- At Upperline, we have built a **comprehensive care model** around the patient population we serve
- Our evidence-based care model includes **frequent touchpoints** with patients annually
- Interventions have a central **focus on treatment & prevention**

Patient engagement with Upperline starts at the clinic and involves a large, integrated team

Medicare patient comes to specialist clinic

Sees Specialist and trusted clinic team

Connected to broader care team

Patient cared for by integrated team

Integrated care team



Upperline Health's interdisciplinary team is purpose-built to support the unique needs of our patient population



Doctors & APPs

Conduct in-depth patient assessments, develop patient care plans, manage medications, conduct routine follow-up & urgent visits with patients as needed, & lead the weekly interdisciplinary team meetings; on call 24/7



Nurse Care Managers

Provide complex care management, education and patient monitoring for patients with chronic or acute care needs



Pharmacists

Available for consults with patients & providers. Our pharmacists also review high-risk patients and will reach out to providers with suggestions when appropriate.



Care Navigators

One point of contact for Upperline Plus patients. Navigators build relationships with patients & coordinate care in between Upperline Plus care team members & other providers involved in patient care



Social Workers

Provide psychosocial assessment, mental health counseling and resource support for social determinant issues impacting patient health



Clinical Dietitians

Provide personalized care plans for each individual patient and utilizes remote technology to engage the patient and track progress over time



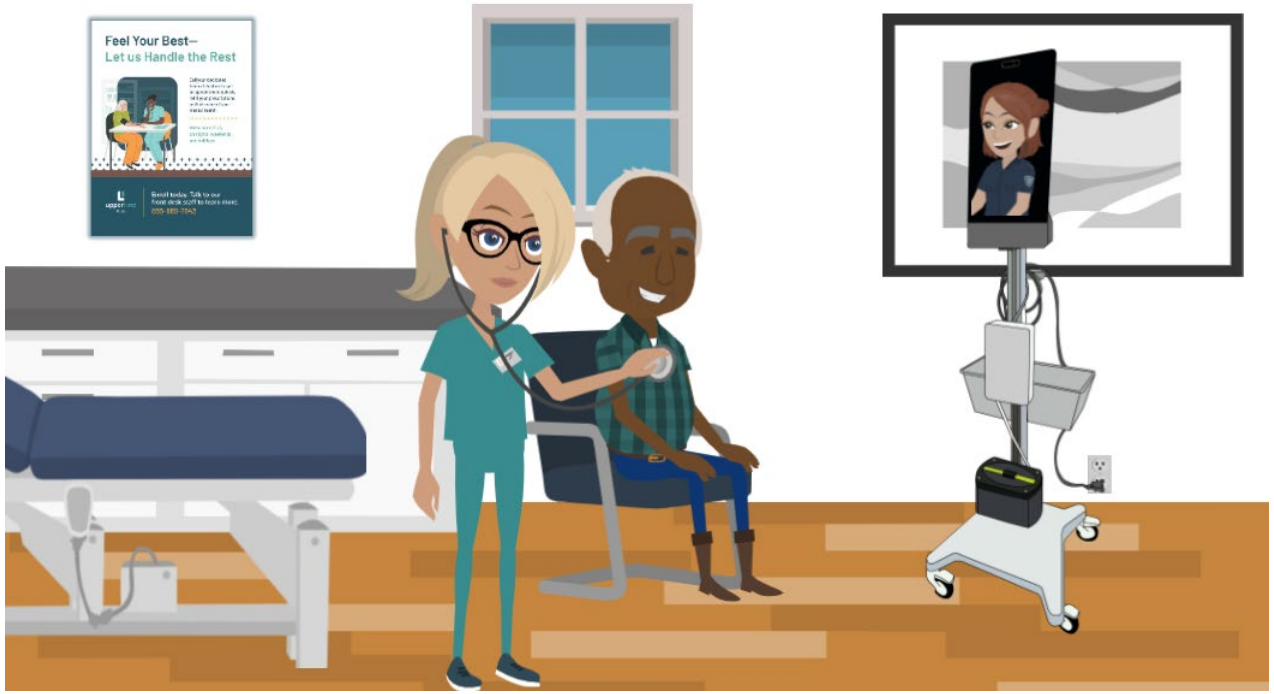
Health & Wellness Coordinators

Work in podiatry clinics as care coordinators for Upperline Plus patients. Educate patients on Upperline Plus resources and connect patients to resources in clinic or at home.

Health & Wellness Coordinators are dedicated clinic team members who provide care coordination in and out of clinic

Health & Wellness Coordinators are specially trained medical assistants who take extra time in clinic to:

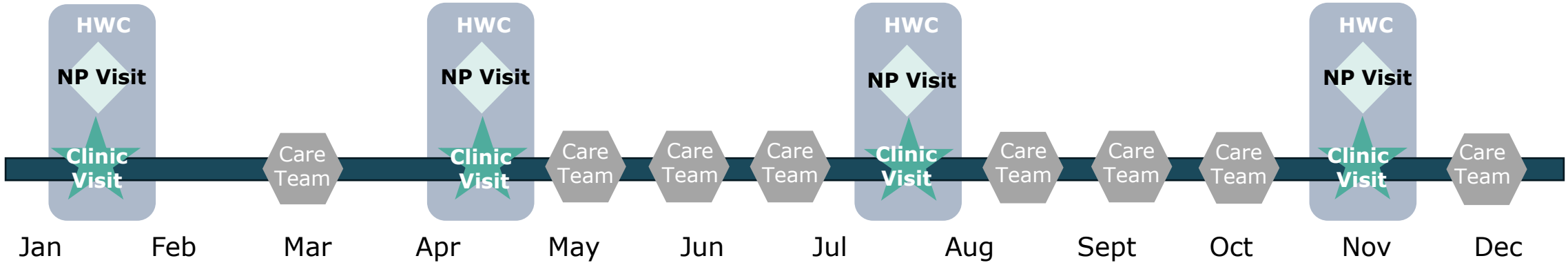
- Really get to know patients
- Complete assessments
- Facilitate a virtual visits
- Coordinate care activities such as,
    - Referrals to other care team members (social work, registered dieticians, pharmacists, RN care managers)
    - DME orders
    - In-home care services



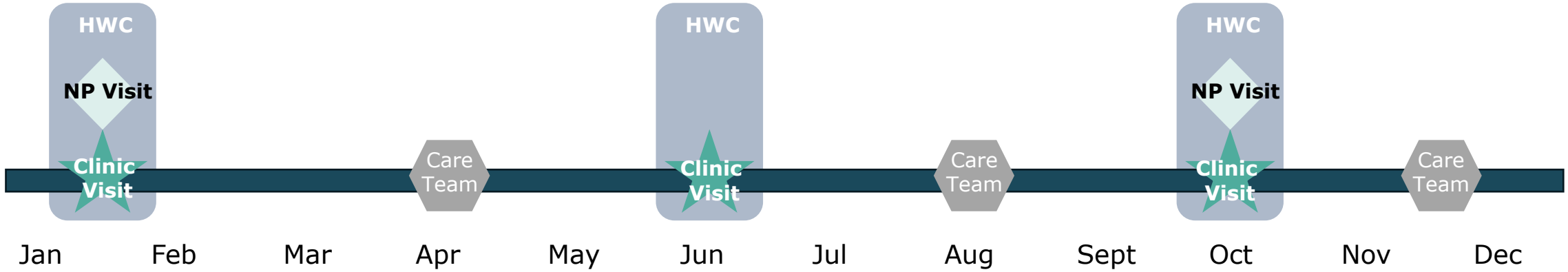
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Many patients are seen with relative frequency which provides opportunity for intervention and care coordination

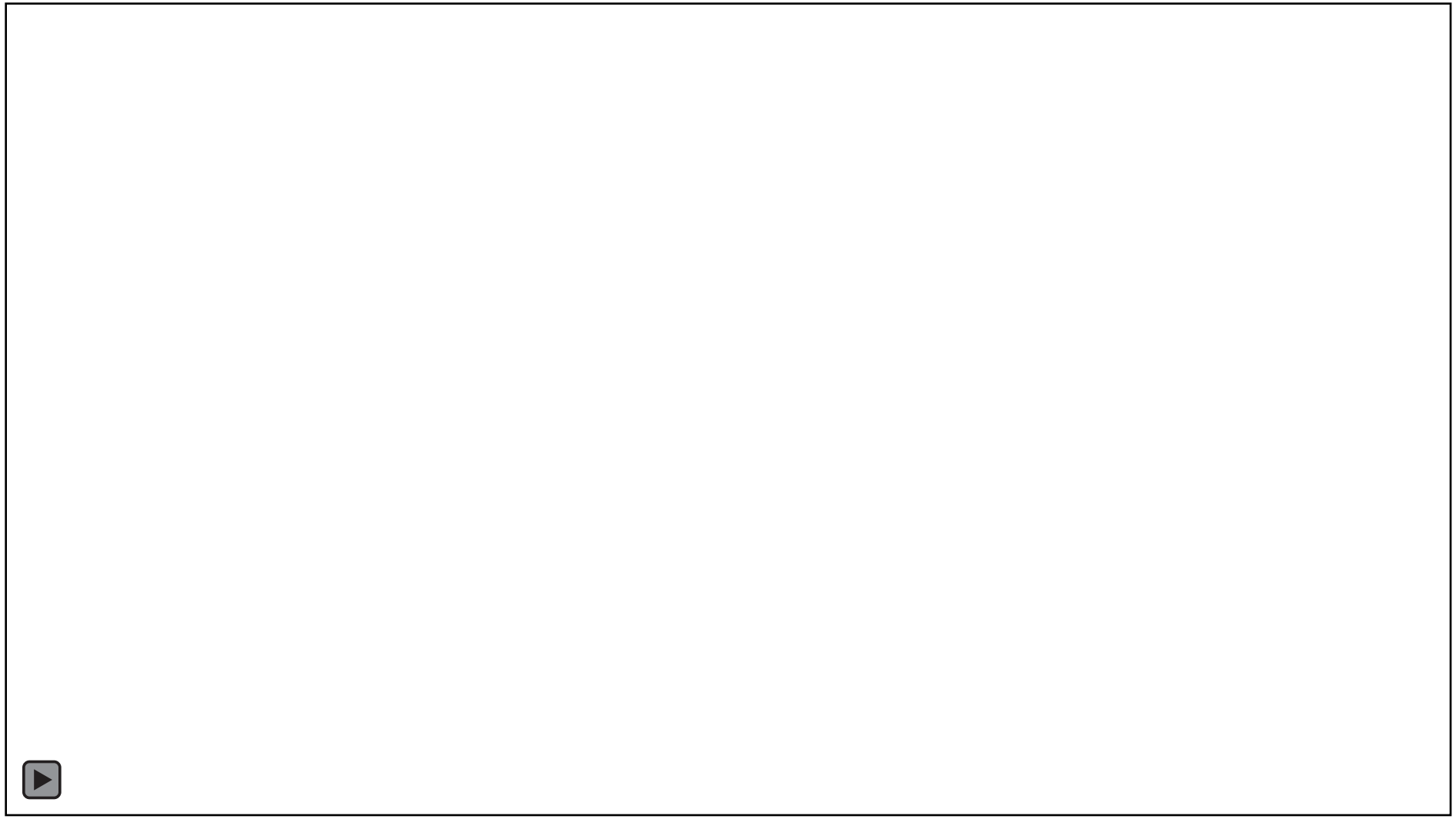
High-Risk Patients



All Patients



Ann’s Story



Patient outcomes improve when patients engage with the comprehensive care team

	PMPM reduction when patient sees NP (% reduction)				
Patient risk	**Total**	**Inpatient**	**Outpatient**	**Professional**	**Other**
Low	**$59 (4%)** ↓	$26 (37%) ↓	$27 (19%) ↓	$12 (3%) ↑	$18 (29%) ↓
Moderate	**$65 (5%)** ↓	$43 (15%) ↓	$6 (2%) ↓	$1 (~1%) ↓	$15 (7%) ↓
High	**$493 (11%)** ↓	$271 (16%) ↓	$128 (20%) ↑	$134 (12%) ↓	$216 (22%) ↓

Highest priority patients for NPs

When patients see **Health & Wellness Coordinator**, similar results; **$64 PMPM expense decrease (4%)**. HWCs have seen ~30% of the population.

Note: Other costs include SNF, DME, HHA, Hospice

Strong patient engagement enables the team to provide consistent comprehensive care

	# of patients | % of total	% engaged with UL	% engaged with UL+ care team	100% protocol compliance	
				Current	Target
Low risk	12,500 | 50%	70%	20%	64%	80%
Medium risk	8,500 | 35%	85%	33%	31%	70%
High risk	3,750 | 15%	85%	58%	21%	60%

Care team priority

67% of high and medium risk pts have seen specialist >2x in 2023

Higher % of high risk patients are engaged with care team, but lower % compliant with protocol due to higher standard

References

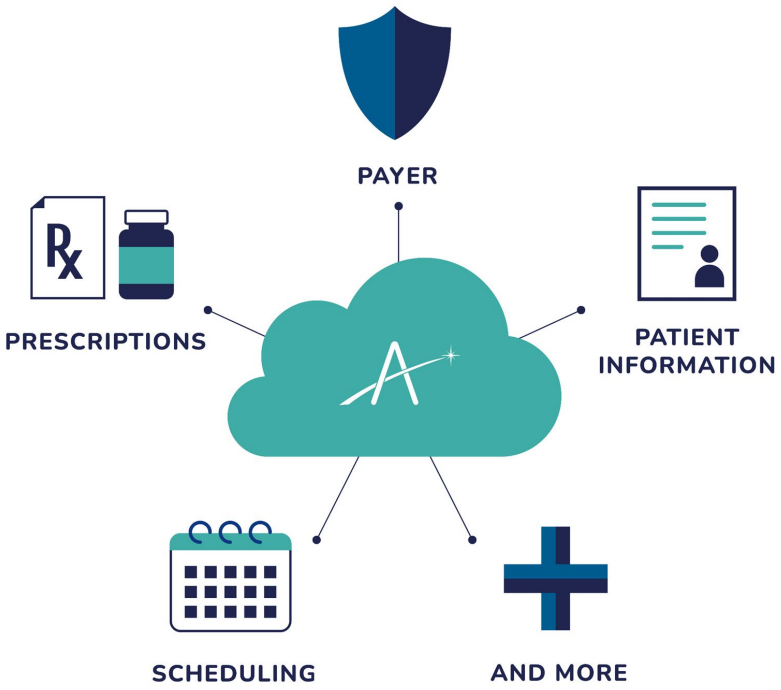
1) Source: 4 Ways to Improve Specialty Health Care in the U.S. (hbr.org)
2) Source: Trends in Outpatient Care for Medicare Beneficiaries and Implications for Primary Care, 2000–19 - PMC (nih.gov)
3) Source: Provision of primary care by specialist physicians: a systematic review - PMC (nih.gov)
4) Source: Use of Primary Care and Specialty Providers: Findings from the Medical Expenditure Panel Survey - PMC (nih.gov)

Making the Connection:
Patient communications yield proven increases in engagement.

Dr. Deb Dittberner
April 11, 2024

Aledade facilitates customized patient communications and outreach to help practices improve care and outcomes for their patients.

INFORMATION

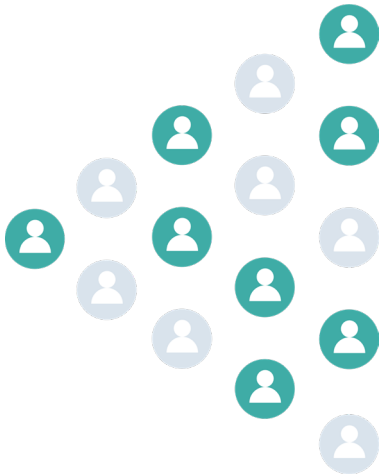


COMMUNICATIONS

In Clinic, conversation with patient

Out of Clinic, patient outreach

ENGAGEMENT



54

For member practices that want more, Aledade serves as physician/practice extenders

We asked: What are direct-to-patient services we can offer to engage patients and take the load off practices?

- Comprehensive Advance Care Program — delivered to over 14,000 patients
- Medication Adherence — over 30,000 patient engagements in the past year
- Appointment Scheduling — 19,000 scheduled this year

- >870,000 pieces of direct mail
- >600,000 text messages
- Almost 500,000 print materials



Keys to Success in Patient Engagement

Rigorous testing of everything we do



Patient engagement teams have 3 goals:

Productivity

Calls per hour

Effectiveness

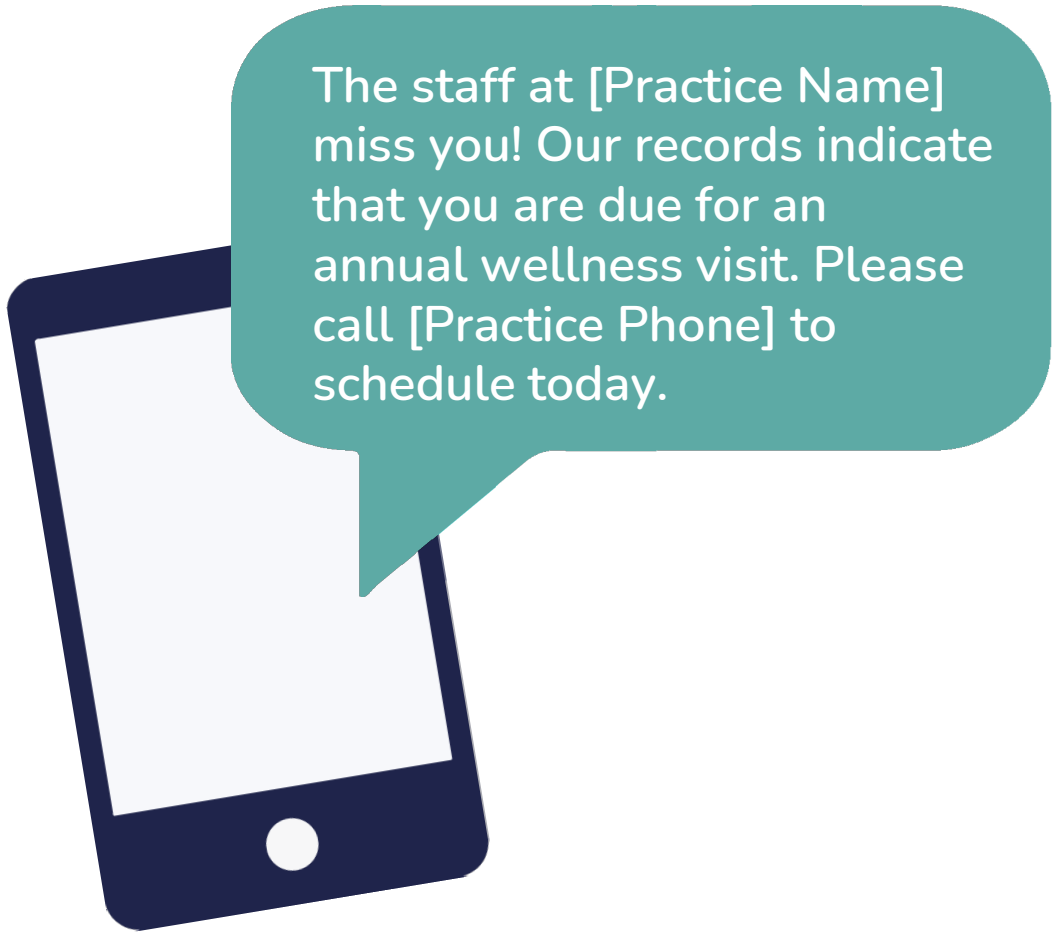
Did I drive behavior change? (*refills, scheduled appointments, did the patient show up for the appointment)*

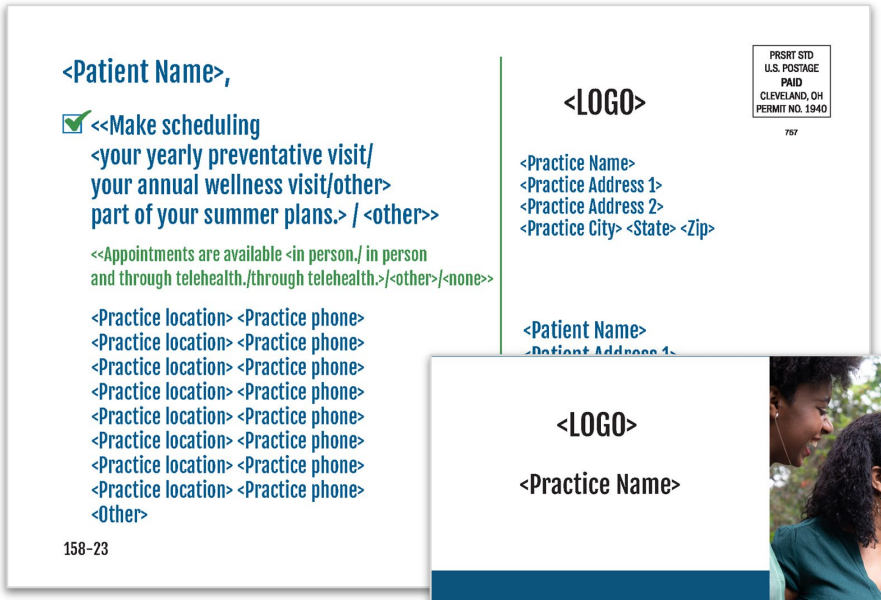
Quality

Recorded calls are scored

Our Summer Wellness campaign contributed to our success in increasing access to primary care services.

70.4% more patients completed an AWV compared to no outreach.**





POSTCARD BACK*



POSTCARD FRONT

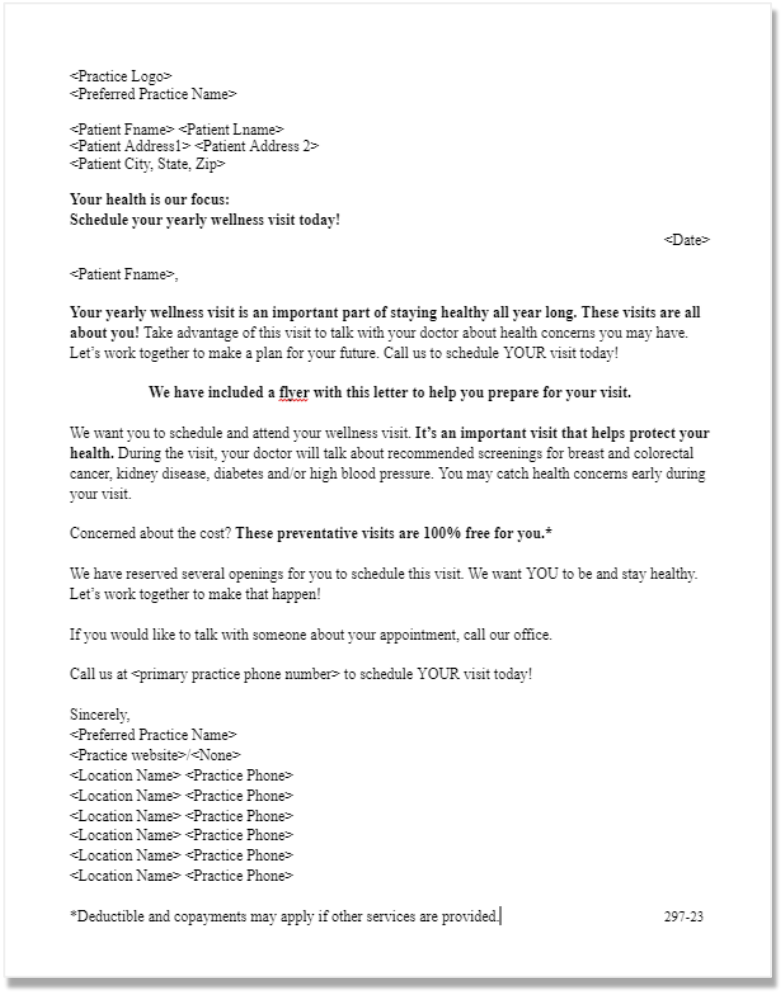
*All assets are product samples.

**Results from PY21 campaign. Postcard compared to no outreach.

663-23

Our AWV letter + flyer combo helps CHCs, PCPs increase AWVs.

This campaign supports CHCs located in Primary Care Health Professional Shortage Areas and in Medically Underserved Areas.



<Practice Logo>
<Preferred Practice Name>

<Patient Fname> <Patient Lname>
<Patient Address1> <Patient Address 2>
<Patient City, State, Zip>

Your health is our focus:
Schedule your yearly wellness visit today!

<Date>

<Patient Fname>,

Your yearly wellness visit is an important part of staying healthy all year long. These visits are all about you! Take advantage of this visit to talk with your doctor about health concerns you may have. Let's work together to make a plan for your future. Call us to schedule YOUR visit today!

We have included a flyer with this letter to help you prepare for your visit.

We want you to schedule and attend your wellness visit. **It's an important visit that helps protect your health.** During the visit, your doctor will talk about recommended screenings for breast and colorectal cancer, kidney disease, diabetes and/or high blood pressure. You may catch health concerns early during your visit.

Concerned about the cost? **These preventative visits are 100% free for you.***

We have reserved several openings for you to schedule this visit. We want YOU to be and stay healthy. Let's work together to make that happen!

If you would like to talk with someone about your appointment, call our office.

Call us at <primary practice phone number> to schedule YOUR visit today!

Sincerely,
<Preferred Practice Name>
<Practice website>/<None>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>

*Deductible and copayments may apply if other services are provided.

297-23

LETTER*



YOUR HEALTH IS OUR FOCUS!

Set up your free Annual Wellness Visit*

4 Reasons Your Yearly Wellness Visit is Important

1. Protect your health — Talk about recommended cancer screenings
2. Keep you well — Review recommended vaccines and take vital measurements
3. Save you money — Talk about concerns, so it is easier to stay healthy
4. Get you the best care — Connect with your doctor and get the big picture on your health

What to bring to your visit:

- Shots, test or screening results
- Current prescriptions, supplements and over-the-counter medications
- Other doctors you may be seeing

What to expect:

- Blood pressure check
- Talk about medical history
- Create personalized plan
- Specialist referrals, if necessary

Questions:

What does the visit cost?

These preventative health visits are **100% free** for you*

YOUR PRACTICE LOGO HERE

<Practice Name>
<Practice website>/<None>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>
<Location Name> <Practice Phone>

Call us to schedule **YOUR** wellness visit today!
Let's work together to keep **YOU** healthy.

*Deductible and copayments may apply if other services are provided.

138-23

LETTER INSERT

*All assets are product samples.

The Invitation to Care campaign achieved a 5% increase in appointments within 7 days of receipt.

Our West Virginia ACO was 1st in MSSP for getting timely care, appointments and information to patients.



Commercial Script

Hi! This is your care team at <Practice Name>. Our records show <Patient Name> doesn't have a preventive visit scheduled yet for 2023. Let us make sure all your health needs are taken care of and all your preventive health screenings are up to date! Call to schedule this important visit at <Practice Phone Number>.

Medicaid Script

Hi! This is your care team at <Practice Name>. Our records show <Child's Name> doesn't have an annual checkup scheduled yet for 2023. Let us help your family stay healthy! Call to schedule this important visit at <Practice Phone Number>.



We saw a 3% increase in patients scheduling their Well Child Visit sooner with our campaign.

We help you overcome barriers so your hardest-to-reach patients
can access the care programs that enable them to accomplish their health goals.



Commercial Script

Hi! This is your care team at <Practice Name>. Our records show <Patient Name> doesn't have a preventive visit scheduled yet for 2023. Let us make sure all your health needs are taken care of and all your preventive health screenings are up to date! Call to schedule this important visit at <Practice Phone Number>.

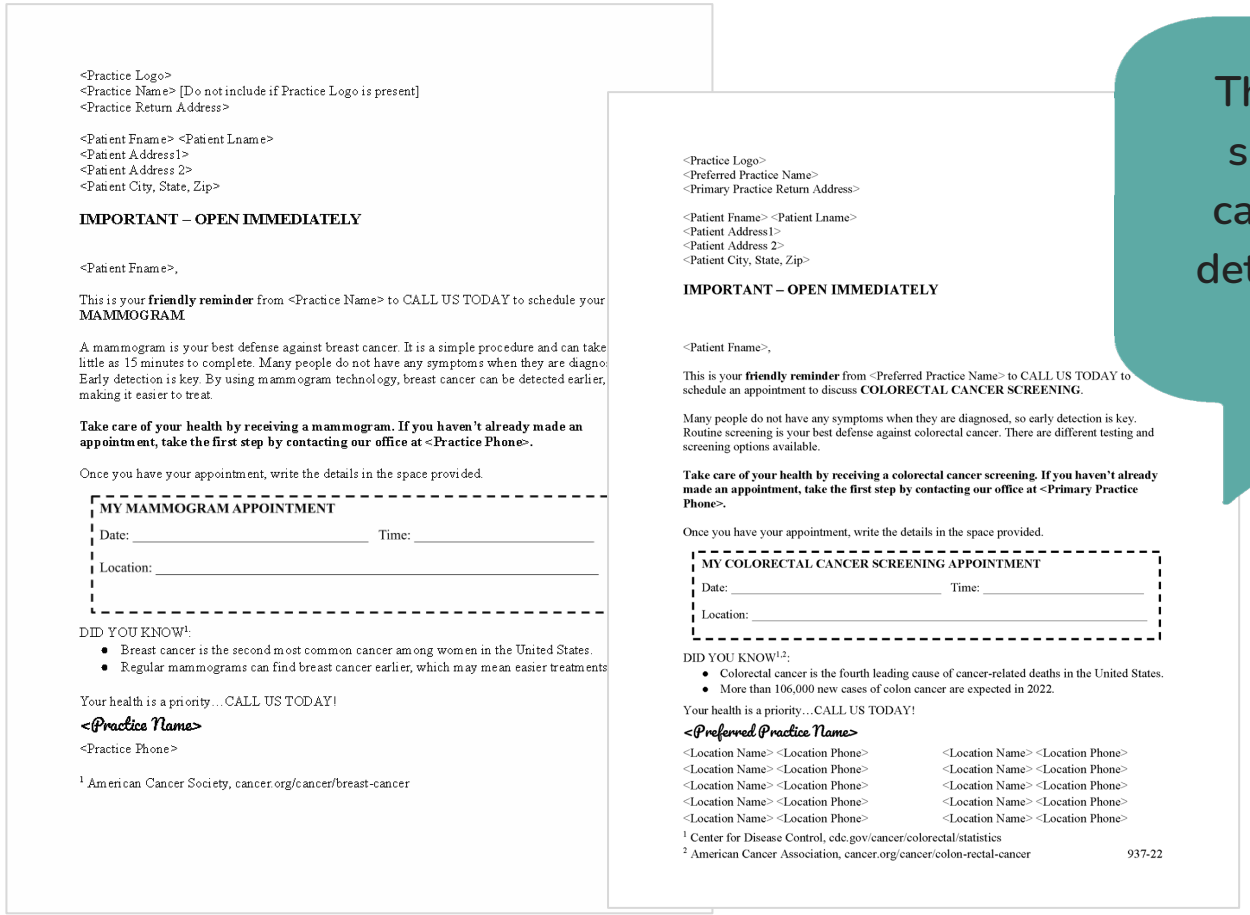
Medicaid Script

Hi! This is your care team at <Practice Name>. Our records show <Child's Name> doesn't have annual checkup scheduled yet for 2023. Let us help your family stay healthy! Call to schedule this important visit at <Practice Phone Number>.



We help connect practices with patients with care gaps, such as hypertension or cancer screenings.

Our care gaps patient letter helped lower the number of patients suffering from uncontrolled hypertension by 4%.



<Practice Logo>
<Practice Name> [Do not include if Practice Logo is present]
<Practice Return Address>

<Patient Fname> <Patient Lname>
<Patient Address1>
<Patient Address 2>
<Patient City, State, Zip>

IMPORTANT – OPEN IMMEDIATELY

<Patient Fname>,

This is your **friendly reminder** from <Practice Name> to CALL US TODAY to schedule your **MAMMOGRAM**.

A mammogram is your best defense against breast cancer. It is a simple procedure and can take little as 15 minutes to complete. Many people do not have any symptoms when they are diagno Early detection is key. By using mammogram technology, breast cancer can be detected earlier, making it easier to treat.

Take care of your health by receiving a mammogram. If you haven't already made an appointment, take the first step by contacting our office at <Practice Phone>.

Once you have your appointment, write the details in the space provided.

MY MAMMOGRAM APPOINTMENT

Date: _____ Time: _____

Location: _____

DID YOU KNOW[1]:

- Breast cancer is the second most common cancer among women in the United States.
- Regular mammograms can find breast cancer earlier, which may mean easier treatments

Your health is a priority…CALL US TODAY!

<Practice Name>

<Practice Phone>

[1] American Cancer Society, cancer.org/cancer/breast-cancer

<Practice Logo>
<Preferred Practice Name>
<Primary Practice Return Address>

<Patient Fname> <Patient Lname>
<Patient Address 1>
<Patient Address 2>
<Patient City, State, Zip>

IMPORTANT – OPEN IMMEDIATELY

<Patient Fname>,

This is your **friendly reminder** from <Preferred Practice Name> to CALL US TODAY to schedule an appointment to discuss **COLORECTAL CANCER SCREENING**.

Many people do not have any symptoms when they are diagnosed, so early detection is key. Routine screening is your best defense against colorectal cancer. There are different testing and screening options available.

Take care of your health by receiving a colorectal cancer screening. If you haven't already made an appointment, take the first step by contacting our office at <Primary Practice Phone>.

Once you have your appointment, write the details in the space provided.

MY COLORECTAL CANCER SCREENING APPOINTMENT

Date: _____ Time: _____

Location: _____

DID YOU KNOW[1,2]:

- Colorectal cancer is the fourth leading cause of cancer-related deaths in the United States.
- More than 106,000 new cases of colon cancer are expected in 2022.

Your health is a priority…CALL US TODAY!

<Preferred Practice Name>

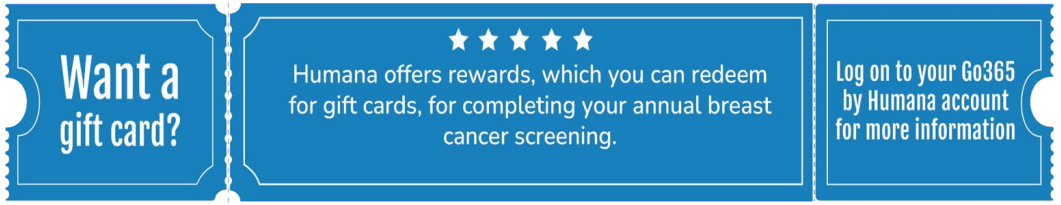
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[1] Center for Disease Control, cdc.gov/cancer/colorectal/statistics
[2] American Cancer Association, cancer.org/cancer/colon-rectal-cancer

937-22

This is <Practice>. <Patient Fname>, our records show that it is time for you to have a colorectal cancer screening. These screenings save lives by detecting problems early. Call us today to arrange this screening at <Practice Phone Number>.

Example: Incentive graphic included in 2023 letter for Aetna/Humana patients.



For illustrative purposes only. Not redeemable for cash or other rewards. Subject to terms and conditions of rewards program by Humana.

*All assets are product samples.

Advance care planning supports patients making future health care plans.

Average savings generated per enrolled patient was between $4.1K to $13.8K over a 14-month period, driven by significantly reduced cost of inpatient and skilled nursing facility care.

YOUR PRACTICE LOGO HERE

The Medical Solutions
123 Main St, Ste 301
Anytown, USA 123456

<Patient FName> <Patient LName>
<Patient Street Address>
<Patient City, State Zip>

Dear <Patient FName>,

Our practice cares deeply for our patients. As your care team, we feel it is important for you to create an advance health care plan. It is never too early to plan for the future.

We are writing to you to offer no-cost health care planning services through our trusted partners at Iris. We have engaged Iris to help our patients plan for their future health care needs.

This service takes less than an hour to complete via phone or video. The goal is to understand your wishes and help you document them. Iris will spend as much time with you as you need and is able to include your family or caregivers in the conversation, if you wish.

In the coming days, Iris will call you to provide more information and schedule your health care planning appointment. When you are finished, Iris will send us a copy of your documents. We will review them to make sure you, your family and our team are all on the same page.

If you have already created some documents, chosen a health care representative or completed an advance directive, we still recommend that you participate. Iris can review your current documents and help you update them as needed.

We believe you will find this service helpful and professional.

If you would like to get started now, want more information or would like to opt out of this program, please **call Iris at 1-800-845-2081.**

Sincerely,
The Medical Solutions

(Over, please)

iris
1051-22

LETTER*



IN-CLINIC BROCHURE

*All assets are product samples.

Our medication adherence texting outreach yielded a 35%+ increase in on-time refills.

Patients refilled their medications within a week of receiving our text message.

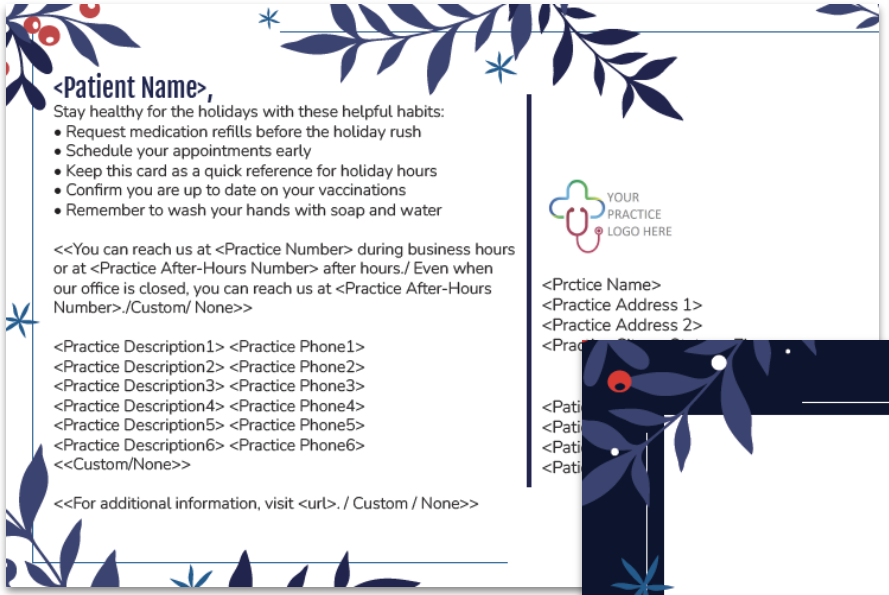


Healthy for the Holidays decreased emergency department visits by 23%*

The campaign led to $1.1 million in Shared Savings



POSTER**



POSTCARD BACK

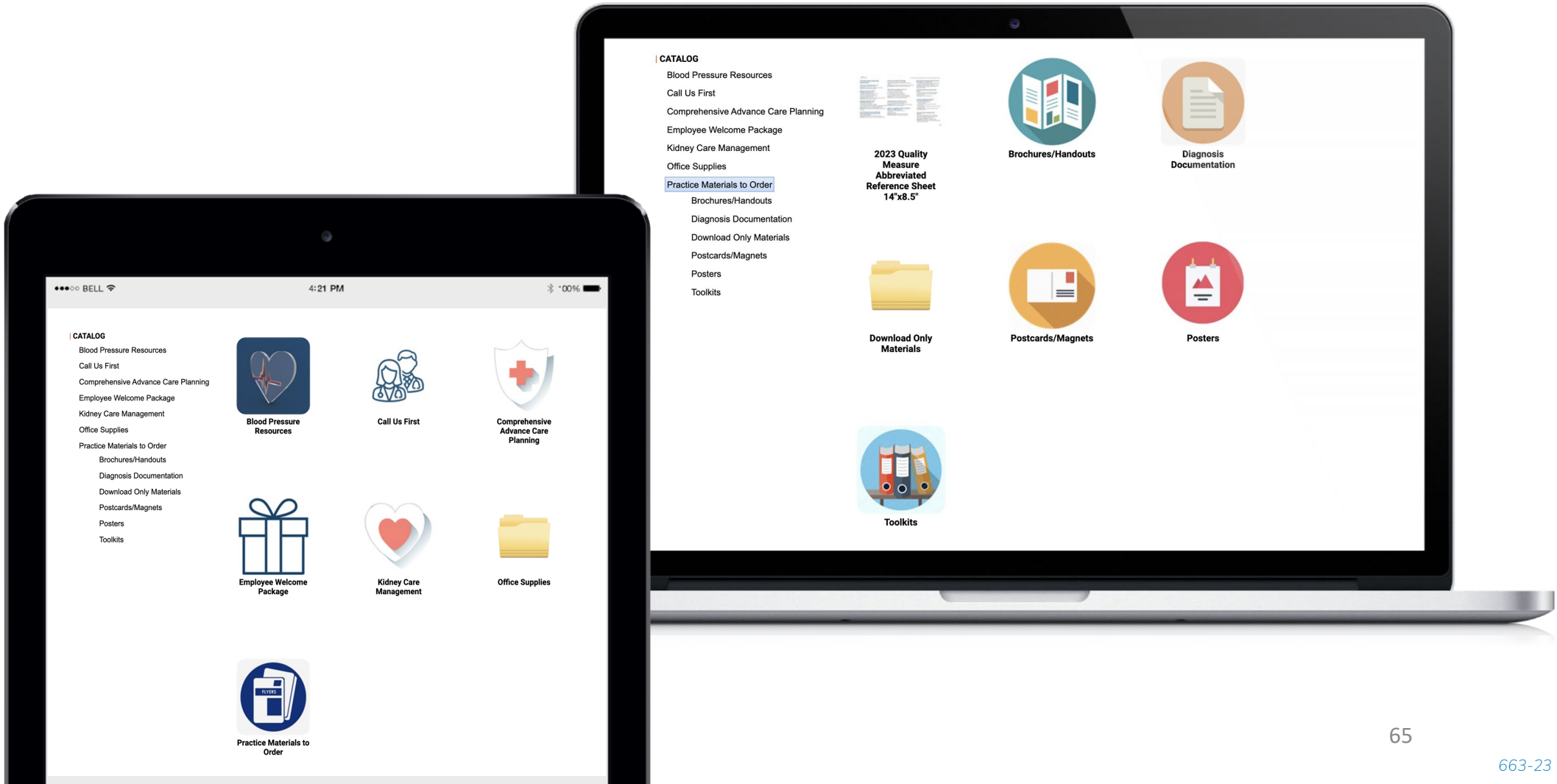


POSTCARD FRONT

*This data reflects the results of the PY20 campaign. **All assets are product samples.

Our Resource Library provides practices with a self-serve shop for their patients' needs.

More than 157,000 resources were ordered from our library at no cost to practices in 2022.



Discussion and Audience Q&A