About ChapCare

MISSION
To provide Excellent, Comprehensive, Innovative healthcare services accessible to the residents of San Gabriel Valley

- Federally Qualified Health Center (FQHC)
- 8 health center locations in the San Gabriel Valley
- Almost 16,000 unduplicated patients annually
- Excellent and Comprehensive Services:
  - Medical
  - Dental Care
  - Retail Pharmacy
  - Telemedicine
  - Optometry
  - Podiatry
  - Behavioral Health and Substance Abuse Counseling
Healthcare Landscape Change

Maximization to Optimization

- Healthcare landscape is shifting from an encounter based episodic care to a value based payment system.

Passive to Active

- ChapCare adopted an Engagement Strategy to change the current passive patient and health center culture into an active patient engagement.
- Health Center that do not develop, implement and execute a Patient Engagement Strategy will be a casualty of the evolving healthcare landscape shift.
- There has been a great deal of discussion about how to engage patients in their care.
- Patient engagement has always been considered a good thing in practices and health care organizations.
- Today it is vital for health centers engaged patient in their care as active participants in order to bend the healthcare cost curve.
Patient engagement is not just patient communication or education; nor is it simply implementing online patient portals.

**True patient engagement refers to:**
1. The knowledge, skills, ability, and willingness of patients to manage their own and family members’ health and care;
2. The culture of the health care organization that prioritizes and supports patient engagement; and
3. The active collaboration between patients and providers to design, manage and achieve positive health outcomes.

**Successfully achievement of Patient Engagement**
Five Key Elements
1. Define organization’s vision for patient engagement.
2. Create a culture of engagement.
3. **Employ the right technology and services.**
4. Empower patients to become collaborators in their care.
5. Chart progress and be ready to change and adapt.
CareMessage Use Cases

- **Health Insurance Appointment Reminders**
  - Utilized by Outreach Department for health insurance enrollment and annual renewals

- **Patient Outreach**
  - Group Outreach supports patient through-put through management of new member IPA list

- **Health Education**
  - Texting education program for chronic disease patients

- **Patient Retention**
  - Group Outreach used for clinical indicator reminders and management of patients lost to care list (1 year w/o a visit)

ChapCare utilizes CareMessage:
- Engage,
- Assist staff manage patients health needs
- and educate at all stages of the healthcare continuum!
Research - Results

UC-Berkeley/CareMessage

- September 2015 – February 2016
- Diabetes text-message education program for low-income, mostly Latino patients at ChapCare’s health Centers
- Produced a clinically-meaningful improvement in glycemic control.
- Patients who were more engaged with the program experienced greater HbA1c improvement.
- Interviews with patients revealed that the program provided both instrumental and emotional support.
- Interviews with staff identified that implementation was facilitated by the ability to reach a large number of patients, making it feasible for a resource-limited community clinic.
“Worrying About Me”: Improved Diabetes Care Management Through a Text-Message Intervention for Low-Income Patients

Jessica L. Watterson, Hector P. Rodriguez, Adrian Aguilera and Stephen M. Shortell

Key Findings

1. A diabetes text-messaging program for low-income, mostly Latino patients produced clinically-meaningful improvements in glycemic control. Patients who were more engaged with the program experienced greater improvements to HbA1c.
2. Interviews with patients revealed that the program provided both instrumental and emotional support.
3. Interviews with staff identified that implementation was facilitated by the ability to reach a large number of patients, making it feasible for a resource-limited community clinic. Staff and patient recommendations to improve the program include integration into in-person clinical care and tailoring the program to baseline patient profile.

Background

- Prevalence among Latinos is almost double that of non-Latino whites.
- Earlier research has found:
  - Some evidence that text messaging programs can reduce HbA1c.
  - But patient engagement and outcomes tend to be worse among low-income Latino populations.

Research Questions

1. Is a text messaging program tailored primarily for low-income Latino diabetic patients associated with improved glycemic control, body mass index (BMI) or blood pressure?
2. What facilitators and barriers influence implementation of the program for patients and clinic staff?

Study Design

- Mixed-methods quasi-experimental design
- Intervention group (n=50) received 12-week, bidirectional diabetes education text-messaging program in Spanish or English (77% enrollment)
- Comparison group (n=50) was constructed from diabetic patients attending the same clinics during the same period.

Qualitative Results

- Patients received emotional support from the messages (5/11): "It felt good... because I knew someone was worrying about my health."
- The messages also provided patients with new information (11/11) and reminders (7/11): "It's just that the messages explains things... better. Because when I go to an appointment and ask, then the doctors speak in English and if the girls that they provide interpret for you, [they] don't fully explain the conversation that you should have with a doctor."
- All patients stated that the program led them to set new goals, to contemplate behavior change or to change their behavior.
- "[The messages] said that you're supposed to take [medication] twice a day at the same time, and so we instituted a little thing where I have the little days of the week [on a]... holder that says, "Noon, Morning, Evening, Night," and we put the pills in there so I take them on the right times... I'm doing it after the messages."
- Interviews with staff identified that implementation was facilitated by the ability to reach a large number of patients, making it feasible for a resource-limited community clinic. Staff and patient recommendations to improve the program include integration into in-person clinical care and tailoring the program to baseline patient profile.

Results

- Quantitative Results
  - 75% Latino/Hispanic
  - 62% primarily Spanish speaking
  - Demographic characteristics of intervention and comparison groups were comparable at baseline
  - Comparison & Intervention Groups
    - Intervention group had an average estimated reduction in HbA1c of 0.62 points at follow-up, relative to the comparison group (p=0.06).
  - No significant results found for BMI or blood pressure

- Key facilitator: staff stated that the text-messaging program allowed them to provide health education to patients using relatively few resources, making implementation more feasible for a resource-limited FQHC.
- Key barrier: staff explained that registration was done by volunteers, and clinical care providers were not involved, limiting the integration of the program into usual practice.
- Recommendations from patients and staff:
  - Include more clinical care staff to increase ‘standing’ of program
  - Tailor the program to patients’ baseline diabetes knowledge

Implications for Future Research

- To strengthen causal inference, future research should assess the effect of the program in this patient population using a randomized trial design.
- Future studies should also examine the integration of patient responses to messages into clinical workflow, as the findings suggest an added benefit.
- The tradeoffs of impact, enrollment and reach for in-person vs. automatic enrollment should be assessed to determine any impact on effectiveness of the program and to identify benefits and drawbacks.
- Given that the findings suggest greater benefits for more engaged patients, future research should test strategies to encourage participation (e.g., positive reinforcement).

References


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Clinical Appointment Reminder Integration

• With OCHIN Epic, clinical appointment reminders will be integrated with CareMessage

• Launch Date: Summer 2018

• Will allow for automated clinical appointment reminders

• Benefits: Decrease no-show rate by facilitating appointment reminders earlier (currently 48 hours before patient visits via phone) and in greater frequency
A web-based application used for health insurance screening and enrollment, creation of an individual health insurance record for each patient/consumer, and robust data reporting.

Utilized via tablets to conduct robust patient satisfaction surveys and mini-surveys.

Coming Soon (in Summer 2018). Will integrate with OCHIN Epic via an automated process to make Lyft rides available to patients to attend their medical appointments.
The healthcare industry is experiencing a major shift towards **value-based care**, which is bringing challenges for both **patients and providers**.
Imagine a world where patients are **empowered** to prioritize their health, and providers use their knowledge of patient behavior to provide **better quality of care**.
What sets CareMessage apart

- Flexible technology & seamless interoperability
- Our commitment to research & outcomes
- Hyper-focused on the high-need patient
A Unique Combination

PEOPLE
Expert staff that acts as advisors and consultants in content development and delivery

PRODUCT
User-friendly interface that allows for easy creation and delivery of messages and campaigns
CareMessage Features

**Appointment Reminders**

Reduce No-Show Rates

**Group Outreach**

Fill Gaps in care through preventive care outreach

**Educational Programs**

Automated disease management for high risk patients

**Direct Messaging**

One-to-one Communication with patients
Thank you