Name: Barbara Rubino, MD
Professional Title, Organization: Senior Medical Director of Clinical Strategy, Oscar Care/Oscar Health
CHIP Title: A Digital Safety Net Engaging Patients through Automation to Drive Outcomes

Project Description:

"Lost to follow up" is a too-common refrain in the ambulatory healthcare setting and is particularly problematic in primary care, whose focus and value lie in an ongoing, longitudinal relationship with the patient. Academic primary care practices often care for socially or medically complex patients and may lose 25-45% of patients to follow-up. Patients, PCP teams, and the system are all impacted differently by this challenge. Patients can experience a decline in their health status and poor outcomes if they cannot access care in ways and at times that are convenient for them. PCPs can get burnt out and frustrated trying and failing to keep track of their patients. Our systems then see the cost of care increase.

Working for a primary care practice embedded in a healthcare technology company has opened my eyes to data and technology tools. An added focus on engagement can bolster the traditional healthcare focus on outcomes. With these tools, we've created a digital backstop and started to mitigate the "lost to follow up" problem by building a system that continuously engages patients. Notably, we began with a much more specific focus – to improve patent outcomes on key quality metrics (such as rates of cancer screening and diabetes eye exams) but uncovered and are successfully addressing this broader opportunity.

We built a digital safety net – a dynamic data model which keeps track of all empaneled patients and deploys automated patient- and team-facing communication at clinically appropriate intervals. This model is always updating and drives patients back to care. Our goals were: 1) to engage patients with their primary care team at clinically appropriate intervals, 2) to prompt patients to follow through with their care plans, and 3) to promote the healthcare team to reach out to patients when they become overdue for care, to take away the cognitive load of manually tracking patient registries that often burden the care team.

Key Findings and Lessons Learned:

In six months of supporting our panel with this digital backstop, we have shown success and uncovered opportunities:

- We've successfully engaged patients and pushed them to complete care plans using automation.
    - 20% increase in adherence to chronic care testing (ex. A1c monitoring for patients with diabetes) & preventive care screenings (ex. Screening mammogram completion for eligible patients).
    - 40% increase in self-monitoring behavior for patients with hypertension.
    - Over 60% of patients re-engaged with the care team after being lost to follow-up.
- Because not all patients engage with digital modalities, we deployed automation prompt care team members to perform live outreach to patients who did not respond or read our initial outreach.
- These tools and strategies are applicable and not unique to health technology companies – this type of systematic prompting could be adapted to a variety of care settings.

Next Steps:

- Leverage a more nuanced model to support complex and high-cost patients with more frequent touch points – including the connection between the patient and the clinic nurses.
- Quantify long-term benefit and cost savings opportunities directly tied to this type of engagement (i.e., impact on acute care utilization).
    - In the future, leverage this type of approach with a focus on continuous engagement (if not tooling) to support patients in the public sector.