prevent scripts

CASE STUDY

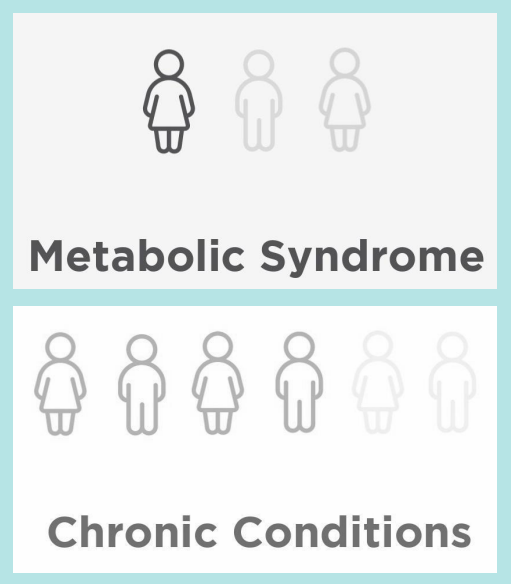
A Tennessee Primary Care Clinic Offers Proactive Services to Patients

Covenant Care is a privately owned practice in Clarksville, TN. The clinic has 4 locations, 12 providers, and 43 total employees serving 17,000 patients and 54,415 outpatient visits in 2021. Covenant is recognized as a “Patient Centered Medical Home" by the National Council on Quality Association (NCQA). Covenant Care is also one of only 3,000 practices participating in the CMS “Primary Care First” initiative, a voluntary five-year payment model that rewards value and quality with an innovative payment structure to support the delivery of advanced primary care. Covenant Care also participates in Medicare Shared Savings.

“If we’re going to tackle the growing disease states of diabetes and metabolic syndrome, we must become proactive. We can do better than the “wait until people get sick” type of care.” - Dr. Wilson, Owner, Covenant Care

THE CHALLENGES

Covenant Care is at the epicenter of the chronic disease epidemic. Approximately 730,416 people in Tennessee, or 13.6% of the adult population, have diagnosed diabetes. An additional 158,000 people in Tennessee have diabetes, but don't know it. More than 34.3% of the adult population have prediabetes with dangerously high blood glucose but not yet high enough for a diabetes diagnosis. Diagnosed diabetes costs an estimated $7.3 billion in Tennessee each year, according to the American Diabetes Association.



This is not just a problem of diabetes or unique to Tennessee. Four in six Americans have a chronic condition. One in three Americans have metabolic syndrome, which is often the precursor to developing a longer-term chronic condition. Most alarming is how often these pre-disease states go undiagnosed. For example, of the 96 million American adults who are pre-diabetic, less than 14% are aware of their condition and fewer than 20% received treatment with interventions.

"Our healthcare system was designed to treat sick patients, so in order for a robust prevention effort to be successful in that same system, we need to try something that can display information quickly and impart that information to the provider in a way that they can then act on immediately." - Dr. Wilson, Owner, Covenant Care

Covenant Care is also experiencing staff shortages and burnout while also working hard to bring in more revenue and provide high quality care to their patients. Between alternative payment models, risk contracts and quality bonus programs, there is tremendous opportunity for capturing additional revenue. However, navigating the relationship with Medicare and commercial payers is complex.

86%

of US total healthcare costs come from chronic diseases

THE SOLUTION

Combining digital health tools and clinical best practices to create a streamlined approach to identify patients early and drive best practices for disease prevention.

"The ability to ***access the data in real time and use it at the time you are seeing the patient, is the most helpful data you will ever get.*** Having something that can be **administered in concert with the normal workflow** of a traditional office visit ***is a game-changer.***" - Dr. Wilson, Owner, Covenant Care

Click to watch how it works

Patients aged 18-65 years old were screened during their normal visits. A patient-facing web page was sent with pre-registration software the morning of the visit. PreventScripts collected responses of the validated surveys, scored them, and sent a risk report to the patient and to the patient chart using direct message.

This clinical decision support tool specifically triages the patient into an intervention, helping providers utilize best practices for obesity and metabolic syndrome. Patient surveys include: PROMIS Global 10 Physical and Mental Health Survey, PROMIS Self-Efficacy Survey, ADA Pre-Diabetes Survey, and Motivation/Readiness.

Eligible patients for the prevention remote patient monitoring intervention were onboarded in-clinic by downloading the PreventScripts app. They then received the starter kit in the mail which included a bluetooth connected scale, water bottle, healthy plate magnet and instructions on how to use the program. Patients were encouraged to self track lifestyle habits daily, complete one of the "My Plans" goal exercises, complete weekly goal check-in surveys, and participate in a monthly call from their clinic care team.

THE RESULTS

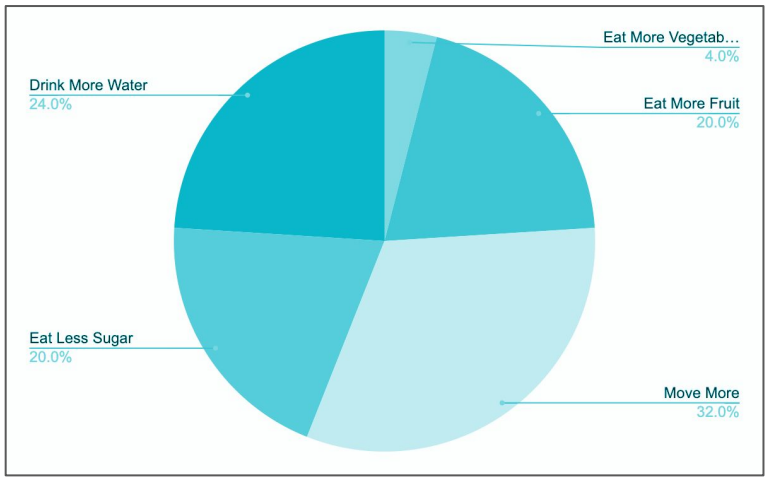
By embedding the PreventScripts platform into clinical workflow, Covenant Care was able to systematically identify at-risk and motivated patients and offer interventions at the point of care.

After several months of utilizing the surveys, the practice began enrolling patients into the remote patient monitoring program in late Summer 2022.

6,593
Patients Assessed

"I love my scale and I love the outcomes so far, I just wish I had more time to exercise."
- Patient with 5% weight loss

PreventScripts engages patients weekly to check in on goals, barriers to improvement and to reset commitment through identifying next steps to accomplish the goal. A monthly actionable report for each patient is sent to the clinic team, and an assigned Covenant Care nurse practitioner reviews the data and calls the patient.



My Plan™ Goals Patients Are Choosing

Percent body weight reduction is a clinical accepted indicator for reducing risk of disease. Forty-seven percent of patients have lost between 1-4% in a 3 month time frame, a strong process indicator towards the goal of 5% body weight reduction. Thirty-two percent of patients have lost 5% or more bodyweight and 21% have remained stable, not gaining or losing.

Average Systolic BP Reduction
↓ 12%

Average Diastolic BP Reduction
↓ 13%

Dr. Wilson has now decided to offer PreventScripts to his diagnosed patients with Diabetes and Hypertension and now deploys PreventScripts alongside his chronic care management program to support deeper, more meaningful behavior change for his patients.

INSIGHTS / WRAP UP

Covenant Care has long been committed to providing high quality care to rural Tennessee residents. The partnership with PreventScripts has allowed them to offer deeper care for a large group of patients. These patients have not historically received this care for pre-disease prevention due to lack of time and staff.

PreventScripts helps Covenant Care implement best practices and clinical algorithms around disease prevention from American Academy of Family Practice, American Heart Association, and Centers for Disease Control. The core of the program, My Plans™, helps the clinic implement the 5A behavior change methodology, endorsed as best practice by Medicare and the US Preventive Services Task Force.

"The idea of being able to capture those people ***before they become sick***, that's kind of like the ***Holy Grail of medicine,*** right? How do we keep people healthy? How do we keep people from becoming ill and, and that's going to translate in the long run to reduce healthcare expenditures as well." - Dr. Wilson, Owner, Covenant Care

What made this so successful? "PreventScripts gave us an opportunity to integrate data directly into our EMR, straight to the patient's chart, and obtain reimbursement. The ability to access the data in real time and use it at the time you are seeing the patient, is the most helpful data you will ever get. Having something that can be administered in concert with the normal workflow of a traditional office visit is a game-changer." - Dr. Wilson, Owner, Covenant Care

Covenant Care has seen reimbursement from major insurance carriers, both commercial and Medicare utilizing the PreventScripts products. The additional revenue played an important role in incentivizing care team participation. This led to the development of a performance dashboard to help care teams see how they are performing with the program against their peers.

Patient box that is mailed to their home upon registration.

PATIENT ASSESSMENT RESULTS

ADA/CDC Prediabetes Risk Test*	3 6
PROMIS Short Form v1.0 – General Self-Efficacy 4a*	52.2
PROMIS ADULT short form - global - version 1.2*	43.5 42.3
Motivation Level	Medium motivation
BMI	34.31
Patient-reported Chronic Condition Status	No

Sample Report.

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More revenue, healthier patients in primary care.

Triaging metabolic conditions in primary care through digital health services. Reimbursable, workflow friendly, and providing earlier care for your patients. We help primary care providers identify and treat metabolic conditions by making proven behavior change practices easily accessible and actionable to care teams and their patients, making it easy to roll out reimbursable digital health services.

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