Purpose-Driven Healthcare Innovation

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BOH Ep 03 Int 01 v6
September 2017

Brief Description

Purpose-driven innovation aligns problem, purpose, and business model. Most digital health products lack evidence, very risky for providers and payers. Solera Health enables health plan members to access prevention programs via numerous community-based programs and digital apps. Epharmix achieves very high, long-term patient engagement while improving outcomes and care manager labor productivity. Both purpose-built organizations use and create evidence supporting their innovations. Technology generates better data and efficiency but human intervention is required to generate changed behavior

Highlights

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- Solera Health enables health plan members to access prevention programs via numerous community-based programs and digital apps
- Epharmix achieves very high, long-term patient engagement while improving outcomes and care manager labor productivity
- Both purpose-built organizations use and create evidence supporting their innovations
- Technology generates better data and efficiency but human intervention is required to generate changed behavior

Guest Lower Thirds

Brenda Schmidt Founder/CEO Solera Health ● Healthcare entrepreneur ● Founded Solera in 2015 ● President of the Council for Diabetes Prevention ● Chair-elect of the Population Health Alliance ● Previously CEO of Viridian Health Management Solera Health ● Connects health plan members to prevention, coping and support services ● Preventative Services Benefits Manager (PSBM) ● PSBMs contract on behalf of health plans for a network of community organizations, national partners and digital solutions	Blake Marggraff Founder & Chief Executive Officer Epharmix ● Venture-funded entrepreneur at intersection of medicine and consumer tech ● Co-founded Epharmix in 2015 ● Board Member, Institute for Family Medicine ● Formerly co-founder & advisor, Betabox Epharmix ● Keeps toughest patients in touch with care teams ● Customers are providers with risk-bearing pop health contracts ● Evidence-based patient engagement proven to improve clinical outcomes ● Interventions for 23 complex conditions	Matthew Hanis Host & Executive Producer Business of Healthcare ● 25-year healthcare industry veteran ● Held leadership roles in health systems, payers, and commercial enterprise ● Day job leading Hanisworks LLC, virtual health business consultancy Business of Healthcare ● Serves healthcare executives across all major industry segments ● Audience of over 10,000 stakeholders including 4,700 decision makers ● Editorially independent focused on meeting Mission and Margin goals

Time Stamp	Speaker	Transcript
0:00		VO: the intersection of Mission & Margin is the Business of Healthcare
0:13	Hanis	Blake Marggraff, Brenda Schmidt, thank you so much for joining the Business of Healthcare.
0:17	Hanis	When you think about your journey to creating Solera, you created a purpose-driven organization.
	Schmidt	I think that's really important for startups to identify a problem and then purpose build the business model to solve for that problem. So we recognized that there was tremendous opportunity for community organizations and now all of the digital apps to deliver evidence-based chronic disease prevention programs. Things like diabetes prevention, cardiovascular risk reduction, falls prevention, and we identified all of the barriers, why those programs despite the evidence and impact and return on investment, hadn't scaled and purpose built our business model to solve for those barriers. So we created a market category of a preventative care benefits manager to support the scaling and personalization of these programs.
0:59	Hanis	tell me a little bit about your value proposition, the health plan is your customer right?
1:00	Schmidt	Solera Health contracts with health plans, so that they can offer their members access to evidence-based prevention programs provided by community organizations and digital apps, which the health plan typically just can't contract with themselves. And for those programs, it offers them a sustainable revenue model through medical claims because these typical non-clinical prevention coping and support services just really can't access a health plan contract or those members and patients.
1:29	Schmidt	health plans want to cover preventative services for their members and in some instances, are mandated to cover them. But inherently, it's very difficult for a non-clinical hyper-local community organization to integrate with healthcare and have a health plan contract.
1:45	Schmidt	The non-clinical providers of evidence-based programs are highly fragmented. They just can't meet the compliance regulatory requirements, program integrity, all of that that a health plan requires to actually have a contract with them. So through a single point of contact and contract with Solera, their members access a very wide network of these community and digital program providers.
	Hanis	Yours began as a research project?
	Marggraff	Absolutely. I think this is... This cuts to the purpose of Epharmix, the mission behind it. So my co-founders and I were desperately frustrated that given the plethora of digital health technologies out there and some of them are really, really shiny and look very, very cool, that there was so little evidence and in the same vein that it felt so unsafe from the provider or even payer perspective to adopt new technology. And that is just not fair because here we have an entire nation saying innovate, innovate, innovate and the other

		folks that are holding the bag of dollars, the risk, saying, "I'd love to, but you have to meet me halfway. You have to give me evidence, give me proof on outcomes and finances that this is going to drive value for the folks that I'm trying to help."
	Hanis	So you became purpose-built because you backed into the problem of shiny new technology, must have the same rigorous evidence as aspirin does.
	Marggraff	That's exactly right. And once you have evidence of both engagement and outcomes, then it's finally possible to start building the financial return on investment model.
		Highlight end point
	Hanis	tell me about Epharmix.
	Marggraff	Certainly, so Epharmix helps keep the 20% of toughest patients, generally the high and rising risk patients, that already have generally multiple chronic conditions, in touch with their outpatient care management teams. And similar to Solera, we work with risk-bearing entities. However, generally, that's on the provider's side. Focusing on keeping the outpatient care management teams, the groups of nurses who have been tasked with watching those tough patients, keeping those groups in touch with the patients, by helping them target the right patient at the right time.
3:51	Hanis	So you're... One of the fundamentals of your proposition is about keeping the care manager efficiently connected with their panel?
	Marggraff	successful care management, successful member engagement for that matter, depends on productivity, on the risk-bearing entities' side and then outcomes, I mean productivity as a means to an end.
4:12	Hanis	So tell me about the evidence that you've accumulated and what does that evidence tell us?
4:18	Marggraff	Yep. With now 12 IRBs or Institutional Review Boards that give the Epharmix Research Center permission to do real research with real patients, real people, and over 6000 patients across those IRbs. Epharmix has been able to show that the technology created drives outcomes from dropping A1C for diabetes patients, from helping patients with hypertension move from uncontrolled to controlled states in just a few months and all the while, of course, staying engaged and benefiting their organizations on the financial side.
4:51	Hanis	you bring evidence in your purpose-driven approach but your approach to leveraging evidence is a little different. Can you talk about the evidence strategy that you use?
5:00	Schmidt	Evidence has to be the foundation of any effective healthcare intervention. We are focused on the Diabetes Prevention Program which is a randomized controlled trial of over 3000 people that showed this lifestyle change program delivered by non-clinical community organizations and digital apps, actually resulted in 58% reduction in the transition to type 2 diabetes for adults at high risk.

5:23	Hanis	So, you're using evidence to power what you're doing, but you're generating an enormous amount of data. So that data must become something that will power what you're doing. Talk about how data fits in.
5:35	Schmidt	Yeah, data is extremely important. We use it in a couple of different ways. One, we're aggregating all of the data at the individual level of, what are the demographic psychographic profile health behaviors of individuals, and how can we use that information to better match people to the program where they're going to be successful? So how do we continue getting better and better at matching people with programs that are going to be best for them? And then, we're also accumulating a huge amount of information on actually what is moving the needle on behavior change for individuals in really small subsegments so that we can start understanding what should we be doing more of and what should we doing less of. Not for the whole population, but at an individual level.
	Hanis	How do you fund the community organization? It's hyper-local community organizations that are equipped to do that.
	Schmidt	Well, it's interesting. Originally, they were grant funded so Congress gave CDC the authority to oversee scaling this program and so initially these organizations were grant funded. And then as we started to get health plan contracts to cover these programs as preventative benefits, really once we had a sustainable revenue model for them, there were thousands of organizations that wanted to be able to deliver this program in communities where they had really trusted relationships with those community members.
6:47	Hanis	So fundamentally what you've achieved is you came into your journey aware of this intervention, aware of the evidence, aware of the providers of the intervention and recognizing that there was a market dysfunction. The market dysfunction was these entities were not structured in a way that health plans could contract and so you aggregated them?
7:13	Schmidt	Exactly. There needed to be a marketplace that connected the 86 million Americans at high risk for developing type 2 diabetes. There are now well over a thousand organizations delivering the Diabetes Prevention Program and a payer that wanted to pay for it and a doctor who wanted to refer his patients. But it was very congested and someone needed to organize all of this into something that made it easy.
7:34	Marggraff	It's a perfect alignment, really textbook of defining a problem clearly, creating a solution and proving that it works beyond a shadow of a doubt, really with the gold standard of research and then making sure that as you apply the solution, incentives are aligned for everybody involved.
7:50	Schmidt	I think that's really a key point, that rarely in healthcare are incentives aligned. So from the payer, our commitment is a high performing network. To our network partners, if they don't perform, we don't get paid, so we work very hard to make sure that those... Or community organizations are doing a really, really good job. And for consumers, we just try

		to make it really easy because we believe the consumer choice is driving engagement and outcomes in these programs.
8:17	Hanis	Go down that thread for me within Epharmix, the alignment of the economic incentives.
	Marggraff	Epharmix helps organizations that are more progressive, that have already taken the risk and taking risk in some of their contracts with self-insured employers or payers, but are now struggling with again that balance of productivity and outcomes, helps them monitor the toughest patients. Incentives are fairly clear. It's just, again as Brenda said, it's really, really tough to align them. The dollars start with the risk-bearing entity, the payer or self-insured employer and then some of that risk is passed along to the healthcare provider, in its form, and there are some of the advanced alternative payment models that can make that a little bit more accessible, I think, and easier to understand. But at the end of the day, it's the outcomes for the patient that determine whether or not the process has been successful and then the value ripples back up the chain.
	Hanis	So for your proposition, the economic incentive travels with this transition from volume to value.
9:18	Marggraff	That's exactly right. And as more providers adopt true value-based care, even in bite-sized pieces, then, first, I think the upside for those providers increases, in fact even the leverage over payers can increase and, second, Epharmix can work with more organizations.
	Hanis	Do you think that because one fundamental aspect of your ROI for the provider is the labor productivity of their care manager, is there an ROI in a non-risk-bearing setting? Where simply, "Hey, I I am a health system, I am hiring care managers, they're mighty pricey, how do I make them more productive?"
	Marggraff	Sure. Even in the fee for service world, productivity does play some role because not all actions are alike. Different dollar amounts for different actions, and you can't discount patient satisfaction as a part of the process as well. That said, the value-based care is fortunately the best way to go.
10:19	Hanis	Let's talk about patient engagement. First of all, do you agree with that term, "patient engagement"?
10:25	Schmidt	I think as soon as we call people patients, we lose the fact that they're really consumers and they're making buying decisions as consumers. And we can't bend them to the will of what a physician may want them to do. And we also have to break through the noise of all of the other messages they're getting as a consumer. We have to make it really easy and aligned with their values and their motivators as a person outside of a clinical setting.
10:49	Hanis	One of the things about your work that struck me when I was reading about it was the number of failures that you experienced as you develop a new intervention. Talk about that a little bit.
11:01	Marggraff	[chuckle] Absolutely. The iterative process for consumer technology creation has always been extensive and I think in healthcare that's sometimes overlooked. There's a body of evidence, it must be good to go. You just build on what people have already said works,

		which is fundamentally not acceptable. In fact, for each disease specific tool that the Epharmix team creates, we go through an average of five or six iterations just to get to the point where we're engaging patients and then outcomes and financial alignment take even more refinement.
11:34	Hanis	Give me some statistics in terms of engagement level.
11:37	Marggraff	Epharmix now is posting engagement rates of over 60% for a full year every week and that's for patients. Some of whom are in the lowest socioeconomic quintile. One of our studies had $9600 a year average income and we're over 50% for a full 18-month period which is really the window of risk bearing in today's world. So the fact that we can help those patients maybe return to the consumer life for a year, a year and a half longer is exciting.
12:06	Schmidt	I think that's important, too, from financial incentives. I always talk about on the prevention side of the prevention paradox. How many times can you count the economics of something that you haven't paid for yet? And so it's really important that that return on investment is in 12 to 18 months. And if it's not, you're not gonna be a priority and have the attention because that really is the window that folks are looking at seeing a return for the interventions that we're providing.
	Hanis	Tell me about engagement from Solera's perspective. Give me some statistic.
12:35	Schmidt	Yeah, it's been interesting. Now we have a wide body, tune of tens of thousands of folks who have enrolled in a wide variety of different types of programs and you can't say one program is better than another program. It's the standardized program delivered in 1500 different ways. It's the only variable. So it's been fascinating about looking at the engagement is that people do well and they do equally well when they're allowed to pick the program where they want to participate. So we're seeing the Centers for Disease Control DASH and the Diabetes Prevention Program has standardized milestone benchmarks for engagement and outcomes and we're seeing 77% of the people who start are still engaged at week four. 81% of those at week nine and go on to complete the program. And I've just pulled the data from a few months ago. Half of those people have already lost 5% of their body weight.
	Schmidt	So we're raising all boats by doing a really good job of matching people to the program that meets their specific needs and preferences.
	Hanis	part of your value proposition to health plan is your revenue is based on those milestones.
	Schmidt	Exactly, exactly. We're submitting claims to the health plan only based on those individuals who are meeting those engagement and outcome milestones.
	Hanis	Are you accumulating a liability in your balance sheet because there's all these community-based organizations that you owe money to?
	Schmidt	No. They actually all use our technology. All of the digital apps send us their raw data so we're having this tremendous data lake now of what's actually moving the needle on behavior change and homogeneous subsegments of very diverse populations. But the

		technology automatically determines when those members are hitting those milestones or submitting the claim to the plan under our NPI where the only contractual relationship with the health plan, we get paid and we pay our partner. And since there's no invoice or claims paid to us, we're not accumulating that payable on our balance sheet.
14:33	Hanis	Your financial model is built on a per member per month, but I know you're very aggressive in taking risk. Tell me about it.
	Marggraff	We're aggressive in taking risk and even for small populations where it might not make sense to take substantial risk across the entire population. The pricing is fundamentally consumption based. So only patients that engage will count toward the total which flips the script a little bit. It's not, "Hey, give me this much money and I'll try to help you." It's "Hey, you're only gonna pay when there is that outcome."
	Hanis	you're at this stage of thinking about engagement for consumers versus engagement for patients. How do you think about that differently?
15:10	Schmidt	We have to make it really easy. We need to make the information that we provide to them contextually relevant and align with their values and their motivators and that helps really allow them to take the next step of which we need to present a clear call to action.
15:28	Hanis	Mm-hmm. That makes sense. So, data in your world is building personas, you're building healthcare consumer personas. Does that resonate with you?
15:43	Schmidt	Yeah, I think this whole concept of precision medicine where we're using genomics to drive how we're treating patients. Healthcare typically has been this bell-shaped curve and you're not right in the middle of the expected outcome and evidence, then you're sort of in your own tail, you're not treated the same. And so I think we're both coming at this as how do we take that concept of precision medicine and personalize it for you to have your best outcome based on you as a person, not on a bell-shaped curve.
	Schmidt	So what makes you different?
	Marggraff	I think a large part of it is the fact that Epharmix works for the toughest patient populations. It's not the patients that want to become healthy and a simple tool can help them track something from day to day. These are the individuals who are with multiple chronic conditions, who are very expensive and who are reticent to engage, even with the most talented care managers.
	Marggraff	My approach to thinking about data is as a resource that has a shelf life and especially for patients that are struggling with conditions that are expected to devolve in the near to mid term. Knowing something about a patient on one day is important if and only if you can act within about that same day range. The corollary to that is, knowing that thing three weeks from now is next to worthless.
	Marggraff	it's closing the feedback loop, demonstrating that an action, even something as simple as responding to a text message or a phone call will lead to some benefit. And that could just be a call from a care manager saying, "I noticed that you reported this, I wanted to chat about that." It could be something much more substantial than that.

	Schmidt	I think that's really important. It's the accountability that's driving the results. Technology is just a mechanism to collect data, it doesn't change behavior, it doesn't make patients and consumers accountable. And so, I think that's really important that there typically needs to be a human intervention to actually move the needle and result in outcomes and impact.
	Hanis	Brenda, Blake, thank you so much for joining the Business of Healthcare.
	Schmidt	Thanks so much.
	Marggraff	Good to be here.