

# Bring whole-person health into focus

*Four use cases demonstrate how Pack Health addresses the full picture of member health, leading to better outcomes.*

With 80% of health outcomes driven by nonclinical factors, it's increasingly necessary to look at patient health through a more holistic lens. Patient engagement platform Pack Health, now a Quest Diagnostics company, bridges the gap between diagnostic data and member engagement to complete the whole picture of member health. By considering nonclinical factors like social determinants of health, Pack Health engages members 1-on-1 through personalized health programs that address over 30 chronic conditions and comorbidities, along with lifestyle and behavioral health.<sup>1</sup>

Pack Health has a documented history of successful member engagement. Our use cases cover a variety of different challenges: coaching patients post-discharge through adherence to treatment plans and improved care management; identifying and addressing behavioral health needs; enhancing self-efficacy and wellness in patients with cancer; and combatting food insecurity for patients with cardiometabolic conditions.

As diverse as these challenges are, a common thread runs through all of them. Pack Health Advisors work directly with members to create personalized health plans that address the full picture of member health, leading to better health outcomes.



**Post-discharge coaching**



**Behavioral health coaching**



**Oncology coaching and the future of cancer**



**Cardiometabolic coaching with food delivery services**

1. Magnan S. Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives. National Academy of Medicine. doi:10.31478/201710c

# Post-discharge coaching

## The challenge

Hospital readmissions are a major contributor to healthcare expenditure in the US. In addition to individuals having more complex care and poorer outcomes, the cost burden of readmissions affects payers and health systems, as well as those seeking care. The overall average readmission rate is 14% and the average readmission cost is \$15,200.<sup>1</sup> In addition, hospital readmissions can be amplified by social determinants of health that affect a wide range of health, functioning, and quality-of-life outcomes and risks.<sup>2</sup>

## Pack Health's solution

Pack Health's platform offers a 30-day patient engagement program to support patients post-discharge. This program aims to address patient needs, help patients adhere to treatment plans, and improve care management in order to avoid readmissions and prevent subsequent penalties. Pack Health matches each patient with their own personal Health Advisor, who serves as a single source of care to engage and navigate each patient through their condition-specific health journey.

### Program customizations

-  **30-day, 90-day, and year-long** program cadence
-  Can be deployed across **30+ conditions**
-  Ability to segment across **specified diagnostic criteria**



### Add medically tailored meals:

- Condition-specific, ready to eat
- Delivered directly to member at a customizable cadence
- Helps member focus on postdischarge recovery and maintain dietary restrictions of treatment plans and comorbidities

## Measurable outcomes

A Pack Health hospital readmissions pilot program featuring 471 participants showed significant reduction in 30-day readmission rates as well as readmission penalties.

**38%**  
decrease in readmission rate,  
compared to unassisted populations

**\$300,000**  
estimated savings in preventing hospital  
readmission penalties

1. Weiss AJ, Jiang HJ. Overview of clinical conditions with frequent and costly hospital readmissions by payer, 2018. Agency for Healthcare Research and Quality. Healthcare Cost and Utilization Project; Statistical Brief #278. Published July 20, 2021. Accessed XXXX. <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.pdf>

2. Health and Human Services, Office of Disease Prevention and Health Promotion website. Accessed 3/6/23. <https://health.gov/healthypeople/priority-areas/social-determinants-health>

# Behavioral health coaching

## The challenge

According to the National Institute of Mental Health, individuals with a chronic illness are more likely to develop behavioral health conditions.<sup>1</sup> Studies show that up to one-third of individuals with a chronic illness also have symptoms of depression.<sup>2</sup> In addition, behavioral health conditions can be amplified by social determinants of health—where people are born, live, learn, work, play, worship, and age—that affect a wide range of health, functioning, and quality-of-life outcomes and risks.<sup>3</sup>

## Pack Health's solution

Pack Health offers a patient engagement platform to support patients' behavioral health. We combine person-to-person health coaching through weekly phone calls, text messages, and emails containing evidence-based content to support wellness, improve treatment adherence, and enhance self-efficacy. Pack Health's dedicated 12-week behavioral health program focuses on identifying and mitigating behavioral health needs. Additionally, identifying and addressing potential risk of depression and anxiety is included in all of Pack Health's 30 other chronic condition management programs.



### Configurable support across conditions

The behavioral health program can be configured to address depression, anxiety, and medium to high stress, plus cross management across 25+ comorbidities.



### Empathy-driven to build relationship equity

Each member receives support to manage anxiety, stress, and lack of social support, as well as individual circumstances created by social determinants of health.



### Education and action meet individual needs

Each member receives a holistic, intentional cadence of education that is customized to their unique experiences and drives action to improve their health outcomes.



### PROs to identify and manage changes

Over 150+ patient reported outcomes help Health Advisor track and manage changes in behavioral health and deploy care escalation protocols when necessary.

## Measurable outcomes

In a recent project with a major health plan's implementation of this solution, members were referred to enroll in Pack Health's Behavioral Health program based on inclusion data provided by the health plan. By the end of the 3-month program featuring 710 members, participants averaged:

### DEPRESSION OUTCOMES (PHQ-9)

**46%**

improvement in those with minimal to mild depression

**42%**

improvement in those with moderate to severe depression

### ANXIETY OUTCOMES (GAD-7)

**31%**

improvement in those with minimal to mild anxiety

**37%**

improvement in those with moderate to severe anxiety

1. Chronic illness and mental health: recognizing and treating depression, National Institute of Mental Health website. Revised 2021. Accessed March 2, 2022. <https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health>  
2. Chronic illness and depression: causes, symptoms, treatment. Cleveland Clinic website. Reviewed March 9, 2021. 2021). Accessed March 2, 2022. <https://my.clevelandclinic.org/health/articles/9288-chronic-illness-and-depression>  
3. Health and Human Services, Office of Disease Prevention and Health Promotion website. Accessed 3/6/23. <https://health.gov/healthypeople/priority-areas/social-determinants-health>

# Oncology coaching and the future of cancer care

## The challenge

Cancer care is complex and often occurs in the presence of other chronic conditions, requiring comprehensive management. A large volume of patients on cancer therapy can be challenging to manage alongside newly diagnosed individuals. Bandwidth of clinicians makes it challenging to collect and respond to Patient Reported Outcomes (PROs) in real time. Self-management, medication adherence, and symptom management are pivotal to improving outcomes, but also happen primarily outside the clinic.

## Pack Health's solution

Pack Health patient engagement platform augments clinical care across the cancer trajectory. We combine person-to-person health coaching through weekly phone calls with digital nudges containing evidence-based content to support wellness and enhance self-efficacy during cancer treatment and beyond.



Weekly 1:1 patient engagement through phone calls, text messages, and emails



Strategies to reduce treatment delays or interruptions and missed appointments



Navigation through diagnosis, treatment, and survivorship



Support to manage unique barriers, comorbid conditions, and the impacts of social determinants of health

## Measurable outcomes

The **American Cancer Society** collaborated with Pack Health to provide tumor-agnostic symptom support to individuals across the Southern US. This pilot delivered a 3-month digital health coaching intervention to patients that aimed to address social determinants, transportation, financial support, and provide community-based resources. By the end of the 1,052-person pilot, participants averaged:

**79%**  
overall program satisfaction

**67%**  
reporting no pain in the last 7 days

**4.5%**  
reduction in 3-month ER visits

**68%**  
of those who were at risk for anxiety are no longer at risk

## According to a 2021 study from Future Oncology on Opportunities for Patient Engagement<sup>1</sup>:



As a result of significant drug costs, **64% of patients report financial struggles** following a new cancer diagnosis.



One survey found that **78% of patients never discuss barriers related to social determinants** with their cancer care team.<sup>2</sup>



Due to the complexity of cancer care, patients typically engage with several HCPs. Because of this, **clinicians are less likely to address or offer solutions to a patient's unique barriers.**

1. Gunn A, Sorenson C, Greenup R. Navigating the high costs of cancer care: opportunities for patient engagement. *Future Oncol.* 2021;17(28):3729-3742. doi:10.2217/fo-2021-0341  
2. Greeno RA, Rushing C, Fish Let al. Financial costs and burden related to decisions for breast cancer surgery. *J. Oncol. Pract.* 15(8), e666-e676 (2019).

# Cardiometabolic coaching with food delivery services

## The challenge

Research shows that a lack of access to nutritious foods leads to and exacerbates conditions such as obesity, high blood pressure, heart disease, diabetes, and more.<sup>1</sup>

To treat these conditions, doctors often recommend making significant changes to one's diet, which presents a further dilemma for those who are food insecure. Without adequate food access, condition management becomes an even bigger, if not impossible, struggle. In most cases, individuals without food security will have little success managing health conditions, which can have catastrophic consequences.

## Pack Health's solution

Pack Health delivers an innovative, one-of-a-kind program that supports eligible members with cardiometabolic conditions who are also experiencing food insecurity. The program includes:



Weekly 1:1 patient engagement through phone calls, text messages, and emails



Recipes to effectively utilize the provided healthy foods



Bi-weekly, condition-specific food boxes delivered right to members' doors



Support to manage comorbid conditions and the impacts of social determinants of health

## Measurable outcomes

In a recent project with a major east-coast health plan's implementation of this solution, members were referred to enroll in Pack Health's type 2 diabetes program through eligibility files, social work referrals, or provider referrals. By the end of the 6-month program featuring 1,697 members, participants averaged:

**86%**  
overall program satisfaction

**31%**  
of members with uncontrolled diabetes are now controlled

**23%**  
improvement in Diabetes Distress

**3.5pt**  
improvement in PROMIS Physical Health  
*The average member moved from a score of "fair" to "good"*

## According to a 2019 Tufts University Better Food for Better Health study<sup>2</sup>:



"Prescription" for healthy foods could save more than **\$100 billion** in healthcare costs.



Better Food for Better Health programs were proven to be cost effective at 5 years and **highly cost effective at 10 and 20 years, over a lifetime.**



Better Food for Better Health programs have the potential to **prevent 3.28 million cardiovascular events, 620,000 deaths, and 120,000 cases of diabetes.**

1. Thomas, M. K., Lammert, L. J., & Beverly, E. A. (2021). Food insecurity and its impact on body weight, type 2 diabetes, cardiovascular disease, and mental health. *Current Cardiovascular Risk Reports*, 15(9). <https://doi.org/10.1007/s12170-021-00679-3>

2. Lee, Y., Mozaffarian, D., Sy, S., Huang, Y., Liu, J., Wilde, P. E., Abrahams-Gessel, S., Jardim, T. de, Gaziano, T. A., & Micha, R. (2019). Cost-effectiveness of financial incentives for improving diet and health through Medicare and Medicaid: A microsimulation study. *PLOS Medicine*, 16(3). <https://doi.org/10.1371/journal.pmed.1002761>