

# Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use



June 2010

*An Update on Health Plan  
Initiatives to Address National  
Health Care Priorities*

# Acknowledgements

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**Alan Adler**

Independence Blue Cross  
Pennsylvania

**Carol Barnes**

Kaiser Permanente  
California

**Brenda Bruns**

Group Health Cooperative  
Washington

**Matthew Burns**

UnitedHealthcare  
Minnesota

**Paula Casey**

Presbyterian Health Plan  
New Mexico

**Christine Cassidy**

Fallon Community Health Plan  
Massachusetts

**Jodi Cohn**

SCAN Health Plan®  
California

**Louis DeMaria**

WellPoint, Inc.

**Mohamed Diab**

EmblemHealth  
New York

**Keith Eckert**

Keystone Mercy Health Plan  
Pennsylvania

**Judith Feld**

Independent Health Association  
New York

**Nelson Fernandez**

Universal American Corporation  
New York

**Leslie Fish**

Fallon Community Health Plan  
Massachusetts

**Robert Flores**

Cigna Medical Group  
Arizona

**Jonathan Gavras**

Blue Cross and Blue Shield of Florida  
Florida

**William Gillespie**

EmblemHealth  
New York

**James Glauber**

Neighborhood Health Plan  
Massachusetts

**Jonathan Harding**

Tufts Health Plan  
Massachusetts

**Brian Harris**

Group Health Cooperative  
Washington

**Lynne Harsha**

Keystone Mercy Health Plan  
Pennsylvania

**Lisa Hartman**

Geisinger Health Plan  
Pennsylvania

**Saira Jan**

Horizon Blue Cross Blue Shield of  
New Jersey  
New Jersey

**Randall Krakauer**

Aetna  
Connecticut

**Premila Mary Kumar**

Horizon Blue Cross Blue Shield of  
New Jersey  
New Jersey

**Janice Kyser**

WellPoint, Inc.  
Indiana

**Mark Leenay**

UnitedHealthcare  
Minnesota

**Susan Legacy**

Fallon Community Health Plan  
Massachusetts

**Diana Lehman**

Independence Blue Cross  
Pennsylvania

**Dennis Liotta**

EmblemHealth  
New York

**Elizabeth Malko**

Fallon Community Health Plan  
Massachusetts

**Helene Martel**

Kaiser Permanente  
California

**Darrin Michalak**

Geisinger Medical Center  
Pennsylvania

**Kathleen Mylotte**

Independent Health Association  
New York

**Sara Nechasek**

Neighborhood Health Plan  
Massachusetts

**Philip Painter**

Humana Inc.  
Kentucky

**Valerie Pillo**

Independent Health Association

**Robert Reid**

Group Health Cooperative  
Washington

**Scott Sarran**

Blue Cross Blue Shield of Illinois  
Illinois

**Pat Slone**

Health Alliance Plan  
Michigan

**Jerry Slowey**

WellPoint, Inc.  
Indiana

**Diane Smeltzer**

AMERIGROUP Florida, Inc.  
Florida

**Karen Smith-Hagman**

EmblemHealth  
New York

**Janet Tomcavage**

Geisinger Health Plan  
Pennsylvania

**Claire Trescott**

Group Health Permanente  
Washington

**Leigh Woodward**

Cigna Medical Group  
Arizona

**Scott Young**

Kaiser Permanente  
California

**Joseph Zeitlin**

EmblemHealth  
New York

**Patricia Zinkus**

Fallon Community Health Plan  
Massachusetts

Design: Ted Lamoreaux

## Highlights:

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Aetna's Medicare Advantage members participating in the Transitional Care Model program receive home visits from advanced-practice nurses within seven days of hospital discharge. Nurses ensure that patients have all of the items and services needed to follow their physicians' care plans and that their home environments are safe.

Following the initial home visit, nurses call patients at least twice a week and conduct additional home visits and phone calls as needed. Nurses can accompany patients on doctor visits and remain in contact with patients for up to several months following hospitalization. They coordinate care to make all treating physicians aware of what the others are doing and to avoid adverse medication interactions.

Results: Among patients receiving services through the Transitional Care Model pilot from 2006-2007, significant improvements were achieved in functional status, depression symptom status, self-reported health, and quality of life. The pilot program achieved a cost savings of \$175,000, or \$439 per member per month. Aetna is now implementing the program for larger populations of Medicare Advantage members across the country.



As part of the Healthy Transitions Program, Fallon Community Health Plan's Medicare Advantage members receive home visits from clinical pharmacists within 72 hours of returning home from the hospital. Pharmacists check for duplicative or conflicting prescriptions and contact patients' doctors to have dangerous combinations removed. They help patients and their caregivers understand what each medication is for, as well as when and how to take it.

Moreover, pharmacists are playing a new, expanded role – serving as patients' care coordinators for 30 days following hospital discharge. Pharmacists help patients make doctor appointments and obtain any lab tests, home treatments, supplies, and home health services they need. Patients who need assistance beyond the 30-day transition period can enroll in Fallon's long-term case management program.

Results: Preliminary findings suggest that the Healthy Transitions program is having a positive impact on patient satisfaction and preventable hospital readmissions.



Presbyterian Health Plan's Medicare Advantage and Medicaid members with specified health conditions have the option of participating in the Hospital at Home program. When clinical evaluations by physicians and nurses suggest that patients can receive care safely and successfully at home rather than being admitted to the hospital, Presbyterian staff arranges for the delivery and set-up of home medical equipment, along with transportation, medications, and home diagnostic testing.

The health plan provides patients with in-home services to help with bathing, dressing, eating, and walking, and a physician conducts daily home visits to evaluate patients' health conditions and needs. Patients use home monitoring equipment to weigh themselves and have their vital signs and other diagnostics transmitted to their doctors.

Results: Nearly 96 percent of patients participating in the Hospital at Home program in 2010 rate it as “very good” or “good.” Services received through the program in 2009 cost approximately \$1,500 less than a comparable inpatient stay.



Members of Group Health Cooperative receive primary care through the Medical Home initiative. As part of the program, primary care physicians work with patients to develop collaborative care plans that address all of their preventive, acute, and chronic care needs. Patients keep in touch by e-mail and phone with the physicians, nurses, clinical pharmacists, case managers, medical assistants, and physician assistants on their care teams. Care teams meet prior to patients’ doctor visits to identify any unmet needs for lab tests, preventive care screening, and other services. They help patients access these services prior to doctor visits whenever possible so that physicians can review the results in advance and make the most of their time with patients.

New Group Health members meet with clinical pharmacists to review medications before visiting their primary care physicians. Clinical pharmacists review patients’ medications regularly to check for dangerous combinations, and they coordinate with doctors and patients to ensure that medication regimens are safe.

Results: After two years, patients at the Medical Home pilot site showed 20-30 percent greater improvements in three of four composite measures of quality compared with those at nonparticipating sites. After accounting for case mix, all-cause inpatient admissions were 6 percent less at the pilot site than in nonparticipating site over a 21-month period. Estimated return-on-investment (ROI) for the pilot 21 months following implementation was 1.5:1.



As part of UnitedHealthcare’s High-Risk Case Management Program, Medicare Advantage members with serious illnesses who are at high risk of hospitalization receive regular phone calls from nurses. During these calls, nurses check on patients’ health status and needs and determine whether they are taking medications correctly, following care plans, and keeping doctor’s appointments.

To help patients overcome barriers to care, nurses provide help with a wide range of issues. For example, they help members obtain needed medications and other treatments. They can obtain affordable home heating and air conditioning on patients’ behalf. They can arrange for transportation to doctor visits; coordinate care provided by multiple clinicians; help patients apply for financial assistance; arrange for Meals on Wheels; and access home health care and durable medical equipment for patients. Patients can contact program nurses at any time, and they can remain in the program indefinitely.

Results: Preliminary research suggests that from 2008-2009, the number of inpatient hospital admissions among members participating in the Medicare Advantage High-Risk Case Management program was 25 percent lower than among a similar population of members receiving traditional case management services.



Horizon Blue Cross Blue Shield of New Jersey

*Making Healthcare Work.*



Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) is helping Medicare Advantage members understand when they should use emergency rooms (ERs) and how to avoid preventable ER use. Each month, a multidisciplinary care team meets to review records of Medicare Advantage members with the greatest number of ER visits. Team members determine the types of services most likely to help each beneficiary address his or her health conditions effectively and minimize preventable ER visits.

Horizon BCBSNJ staff members with expertise in the issues identified contact members to discuss their needs and provide assistance. Clinical pharmacists contact patients whose reactions to medications led to emergencies to review and explain their prescriptions, and they speak with prescribing physicians to find safe alternatives to medications that have caused adverse reactions.

Results: In 2009, ER use declined by 35.9 percent among Horizon BCBSNJ Medicare Advantage members who had eight or more ER visits during the previous year.

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*The publication is the latest in AHIP's series of Innovations reports highlighting the latest trends in health care. Previous volumes include:*

- *Trends and Innovations in Disability Income Insurance*
- *Innovations in Recognizing and Rewarding Quality*
- *Innovations in Prevention, Wellness, and Risk Reduction*
- *Trends and Innovations in Health Information Technology*
- *Trends and Innovations in Chronic Disease Prevention & Treatment*
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# Overview

Perhaps no two aspects of the health care system have greater impact on patients' well-being than the everyday practice of primary care and the care that patients receive in major transitions—from hospital to home, hospital to rehab, or hospital to nursing home. Yet many factors—including the shortage in our primary care physician workforce and the lack of an infrastructure to ensure coordinated primary and transitional care—have contributed to high rates of preventable hospital admissions, readmissions, and the use of emergency rooms for non-emergency conditions, thus raising concerns about patient safety and quality.

Notably, nearly one-fifth (19.6 percent) of Medicare beneficiaries in the traditional fee-for-service program who are discharged from hospitals are rehospitalized within 30 days.<sup>1</sup> About one-third of emergency room visits are classified as non-urgent or semi-urgent and thus represent care that could have been provided more safely and efficiently in other settings.<sup>2</sup>

The recently enacted health reform legislation identified the goal of reducing preventable hospital admissions, readmissions, and emergency room use as a critical national priority. Through a wide range of patient-centered initiatives developed and refined over the last several decades, health plans have been laying the groundwork necessary to achieve this goal.

To revitalize the practice of primary care, health plans are providing for additional staff in physician offices to help ensure that patients receive all of the preventive, acute, chronic, and behavioral health services they need. Health plans are re-engineering work flows to ensure that the members of patients' care teams coordinate their efforts and provide care in a consistent way, according to the medical evidence on what works. They are revamping physician payments to build in incentives for care coordination and improved health outcomes. To help prevent needless trips to the emergency room, health plans are expanding patient access to urgent care centers, after-hours care, and on-call nurses so that patients can access safe alternatives to emergency rooms for non-emergency care.

For patients discharged from hospitals following acute episodes complicated by serious conditions such as heart failure and diabetes, health plans are arranging for phone calls and, in some cases, in-home visits by nurses and other professionals to make sure that follow-up appointments are kept, medications are being taken safely, care plans are being followed, medical equipment is delivered, and home health care is being received. They are offering intensive case management to help patients at high risk of hospitalization access the medical, behavioral health, and social services they need. For frail, vulnerable patients, health plans are arranging for home visits by multidisciplinary teams of clinicians, who provide comprehensive care, teach patients and their caregivers how to take medications correctly, and link families with needed community resources such as transportation and Meals on Wheels.

<sup>1</sup> Jencks, S. et al. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *The New England Journal of Medicine*. 360(14): 1418-1428. Available at: <http://content.nejm.org/cgi/reprint/360/14/1418.pdf>.

<sup>2</sup> Cunningham, P. (2006). What accounts for differences in the use of hospital emergency departments across U.S. communities? *Health Affairs*. 25. w324-w336. Available at: <http://content.healthaffairs.org/cgi/reprint/25/5/w324?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&fulltext=emergency+room&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT>.

These programs, while varied in approach, highlight three important trends:

### **1. Rebuilding primary care requires a team effort.**

Comprehensive, high-quality primary care is essential for good health in this country. But primary care physicians (PCPs) alone cannot transform health care. Health plans therefore are helping create new care models with teams of clinicians and support staff—physician assistants, advanced-practice nurses, social workers, case managers, nutritionists, pharmacists, and behavioral health care practitioners—to give doctors more information about patient health status and preferences before they meet with patients and help arrange for needed care.

Health plans likewise are placing nurses, social workers, and case managers in care settings where it is often difficult for primary care physicians to reach—such as hospitals, skilled nursing facilities, and patient homes—to serve as doctors’ eyes and ears and convey important messages about patient symptoms, medications, and health status to PCPs to allow for timely follow-up.

### **2. Effective care is about building patient relationships.**

Patients returning home from the hospital are often confused about their doctor’s orders. They may have difficulty keeping doctor’s appointments due to lack of transportation or constraints in mobility. Reaching out to make personal connections and build lasting relationships with these patients, by phone or in person, can make all the difference—by letting them know that someone cares, helping them understand and follow their care plans, checking on their symptoms, installing grab bars near their bath tubs, arranging for home health and durable medical equipment delivery, and enabling them to have the follow-up doctor visits needed to put them on the road to recovery.

### **3. The role of pharmacists is more important now than ever before.**

Thanks to advances in pharmaceutical science, it is not unusual for patients to leave the hospital with prescriptions for 10 or more medications. Patients and their caregivers often have trouble making sense of their drug regimens and setting up reminder systems to avoid errors. They often have unanswered questions about their medications and may not know whom to call.

Health plans therefore are connecting patients with pharmacists directly, by phone and in person, to carefully review the purpose, dosage, and frequency of each medication; check for duplication and the potential for dangerous interactions; ask about symptoms and side effects; confer with physicians; and have doses adjusted as needed.





## Breaking New Ground with Innovative Care and Payment Models

Health plans' innovative new models of health care delivery and payment are providing the building blocks necessary for lasting improvements in health care quality and measurable reductions in cost growth. Health plans' medical home initiatives use multidisciplinary teams of professionals—including physician assistants, advanced-practice nurses, social workers, and pharmacists—to assess the full range of patients' preventive, acute, and chronic care needs and support primary care physicians in developing and implementing comprehensive care plans to address all of these needs. With the resources health plans are providing to physician groups through medical home initiatives, physician practices have been able to expand office hours, hire additional staff, allow more time for office visits, and develop electronic communication systems that allow for timely communication between patients and care teams. New payment models reward physicians for achieving specified targets for health care quality and health outcomes.

Besides implementing medical home programs, health plans are bringing together medical leadership and front-line staff to review the literature and identify best practices for effective care. Through standardized work protocols and bundled payment systems, health plans are working to ensure that all patients receive comprehensive care according to the best available medical evidence.

As demonstrated in this chapter, these programs have been successful in reducing preventable hospital readmissions and reducing complications from surgery.

# ProvenHealth Navigator<sup>SM</sup> Medical Home Initiative

## PROGRAM AT A GLANCE

### Goals:

- ▶ Improve the quality of patient care.
- ▶ Increase patient and physician satisfaction.
- ▶ Enhance the role of the primary care physicians (PCPs).
- ▶ Make health care delivery more efficient and slow medical cost trends.

### Key Strategies:

- ▶ Build information technology infrastructure so that patients can go online to: communicate with primary care doctors and nurses; make and change appointments; and send health monitoring information such as blood glucose and blood pressure levels to health care practitioners.
- ▶ Expand the role of non-physician practitioners on health care teams:
  - Give nurse case managers responsibility for helping patients at highest risk of hospitalization manage their conditions.
  - Have office-based nurses and medical assistants take the lead in ordering routine screenings for preventive and chronic care.
- ▶ Change office workflow to: expand office hours; arrange for follow-up visits with primary care physicians within seven days of hospital discharge; and allot more time for post-discharge appointments with PCPs.
- ▶ Provide enhanced outreach and follow-up care for all patients after hospitalization.
- ▶ Realign physician incentives to promote quality and provide payment based on health outcomes.

### Results in Brief:

- ▶ Among patients at ProvenHealth Navigator medical home sites from 2006-2008:
  - The number of hospital readmissions fell by 20 percent.
  - The number of hospital admissions fell by 18 percent.

## BACKGROUND

In an effort to improve primary care for patients and physicians, Geisinger Health Plan established the ProvenHealth Navigator medical home initiative in 2007. The program serves patients with Medicare Advantage and commercial coverage, as well as beneficiaries in the Medicare fee-for-service program. As of November 2009, Geisinger had 37 medical home sites serving approximately 65,000 patients. Of these, 40,000 were Medicare beneficiaries and 25,000 were commercial members.

## APPROACH

### *Enhancing IT Infrastructure*

To increase patients' access to health care, Geisinger built new information systems that enable electronic health records (EHRs); registries to track care for patients with chronic conditions; and streamlined phone systems to simplify the process of contacting clinicians and office-based

case managers. Doctors and nurses can communicate with patients through secure e-mail via Geisinger's patient portal. Patients can use the portal to schedule appointments, request medications, and send blood pressure and blood glucose readings to health care practitioners for review. EHRs alert physicians when patients are due for recommended chronic and preventive care.

### *Moving Practice Staff to the Top of Their Licenses*

A key component of ProvenHealth Navigator is increasing the range of services that primary care practices provide. To achieve this change, Geisinger has retrained staff and created new roles for members of health care teams. For example, the health plan provides training to physicians, advanced-practice nurses, and other nurses on managing severe complications of conditions such as heart failure, chronic obstructive pulmonary disease, pneumonia, and atrial fibrillation. The role of office-based nurses has expanded to include taking the lead in ordering routine screenings for

preventive and chronic care. They coordinate with physician assistants on plans for scheduling all age-appropriate immunizations and screenings, and they help people enroll in exercise and weight management programs.

Nurse case managers play a critical role in identifying and helping patients who are at highest risk of hospitalization to manage their conditions. Case managers coordinate with primary care physicians, advanced-practice nurses, specialists, and other staff to develop patient-specific care plans that ensure that patients—along with their families—are active partners in managing their conditions.

As part of its practice redesign, Geisinger expanded physician office hours and modified workflows to provide same-day appointments and reserved times for post-hospitalization follow-up visits.

### *Offering Additional Support for Patients with Chronic Conditions*

Nurse health managers review electronic health records of patients with chronic conditions to identify those who could benefit from additional support. Health managers contact these patients by phone or in person to teach them how to manage their conditions and answer questions about issues such as measuring blood glucose, counting carbohydrates, monitoring blood pressure levels, exercise, and dietary changes. Health managers work closely with physicians to make medication changes for patients who have not reached their goals for blood pressure, cholesterol or blood glucose levels.

Geisinger uses predictive modeling software to identify patients with chronic conditions who are at increased risk of hospitalization, and nurse case managers help these patients address their medical and behavioral health needs. Case managers coordinate care transitions for patients following hospital discharge; they work with patients' primary care physicians to develop patient-specific action plans; and they help coordinate care among multiple specialists. They also check on home safety; help patients participate in disease management programs; perform comprehensive medication reconciliation; and develop "rescue kits" with medications for patients to take if their conditions are worsening. Case managers are available on a 24/7 basis, and they ensure that patients see their doctors promptly if their health status changes.

### *Promoting Smooth Post-Discharge Transitions*

Patients at medical home sites who have been hospitalized have appointments with primary care physicians within five to seven days of discharge. As part of the initiative, Geisinger increased the time allotted for these appointments to 40 minutes. In addition, all patients discharged from hospitals

receive case management services for at least 30 days. Case managers contact patients by phone within 48 hours following discharge to promote safe transitions. During these calls, they review prescriptions to avoid dangerous combinations; help patients understand their medications and take them correctly; and ensure that patients have the help and social support they need for a smooth recovery. After the initial call, case managers generally contact patients by phone once a week. Case managers typically contact patients with complex medical needs on a daily basis and provide case management services for extended periods to help them achieve positive health outcomes.

### *Providing On-Site Support for Nursing Home Patients*

In 2009, Geisinger added a nursing home component to the program. Physician assistants and nurse practitioners work full-time in nursing homes with high volumes of Geisinger members to help residents manage their health conditions on an ongoing basis. When patients need acute health care services (e.g., treatment for pneumonia), Geisinger staff ensure that they obtain care promptly to avoid medical emergencies. Nursing home clinical staff can check patients' surgical wounds to ensure that they are healing and to provide treatment as needed. They also coordinate with Geisinger's case managers to provide post-discharge follow-up care to nursing home residents.

### *Realigning Payment Incentives to Promote Quality*

Geisinger provides up-front stipends for physicians and practices participating in the medical home initiative. In addition, medical home practices receive bonus payments for meeting quality and efficiency goals. These may include targets for the number of PCP visits within seven days of hospital discharge, improvement in HbA1c levels for patients with diabetes, and development of care plans for patients with heart failure.

## RESULTS

- ▶ Among patients at medical home sites from 2006-2008:
  - The number of hospital readmissions fell by 20 percent.
  - The number of hospital admissions fell by 18 percent.

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### *For more information, contact:*

Janet Tomcavage  
Vice President of Health Services  
Geisinger Health Plan  
(570) 271-6471  
jtomcavage@geisinger.edu

# ProvenCare Acute

## PROGRAM AT A GLANCE

### Goal:

- ▶ Ensure that surgery patients consistently receive all of the treatments and procedures proven to promote successful health outcomes.

### Key Strategies:

- ▶ Develop evidence-based protocols for surgeons and other health care providers to follow for coronary artery bypass graft (CABG); cataract surgery; angioplasty; total hip replacement; bariatric surgery; pregnancy; and low-back pain.
- ▶ Provide a 90-day bundled payment for each episode of care. If patients have complications or are readmitted to hospitals for the original diagnosis during that period, hospitals and physicians do not receive additional payments.

### Results in Brief:

- ▶ From 2006-2007, the proportion of CABG patients:
  - Who were readmitted to hospitals dropped by 44 percent.
  - Who experienced any complication fell by 21 percent.

## BACKGROUND

As part of its overall effort to reduce preventable hospital readmissions, Geisinger Health Plan implemented ProvenCare Acute in 2006.

## APPROACH

### *Promoting Evidence-Based Care*

The program is designed to ensure that patients receive all of the treatments and procedures demonstrated to be effective for their health conditions. Based on their review of the medical evidence, Geisinger clinicians developed evidence-based treatment protocols for: coronary artery bypass graft; cataract surgery; angioplasty; total hip replacement; bariatric surgery; pregnancy; and low-back pain.

The pre-surgical protocol for CABG includes procedures such as: identifying the patient; documenting the reason for the procedure in patients' records; delivering intravenous (IV) antibiotics within one hour of surgery; confirming that the patient has not received medications (aspirin or Coumadin) prior to surgery that could cause excessive bleeding; beginning patients on beta-blocker treatment; providing IV fluids; and doing electrocardiograms, as well as urine and blood work.

Also as part of the program, patients sign a compact agreeing to be active participants in their care. The compact covers areas such as taking prescribed medications and engaging in cardiac rehabilitation following surgery.

### *Bundling Payments for Episodes of Care*

For each of the treatments covered by the program, Geisinger provides a 90-day bundled payment to hospitals and surgeons for an episode of care. If patients have complications or are readmitted after surgery for the same condition, providers do not receive additional payments.

## RESULTS

- ▶ From 2006 (prior to ProvenCare) to 2007 (with ProvenCare), the proportion of CABG patients with:
  - Any complication declined by 21 percent.
  - More than one complication fell by 28 percent.
  - Atrial fibrillation decreased by 17 percent.
  - Neurologic complications fell by 60 percent.
  - Any pulmonary complication declined by 43 percent.
  - Blood products used decreased by 22 percent.

- Re-operation for bleeding fell by 55 percent.
- Deep sternal wound infections dropped by 25 percent.
- Hospital readmissions within 30 days fell by 44 percent.

(n = 132 before ProvenCare; n=181 with ProvenCare)

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*For more information, contact:*

Darrin Michalak  
Senior Performance Innovation Consultant  
Geisinger Medical Center  
(570) 271-5430  
dmichalak@geisinger.edu

# The Emergency Department and Hospital Inpatient Improvement Program

## PROGRAM AT A GLANCE

### Goals:

- ▶ To improve health care quality and reduce avoidable costs during care transitions.
- ▶ To reduce preventable hospital admissions, readmissions, and emergency room (ER) visits.

### Key Strategies:

- ▶ Hold four five-day working sessions with front-line staff and physicians to develop ideas, approaches, and new standard work processes for improving each component of a hospital stay.
- ▶ Develop standard processes, based on best practices, to improve: hospital admissions and discharges; emergency room procedures; admissions to skilled nursing facilities (SNFs); and arrangements for palliative care.
- ▶ Triage all new patients at the time of hospital admission to determine the level of care coordination they will need.
- ▶ Inform patients in the hospital about the care they will need following discharge.
- ▶ Contact patients within 48 hours of hospital discharge to answer questions and address continuing care needs.
- ▶ Ensure that patients at risk of readmission visit their physicians within 14 days of discharge.
- ▶ Conduct in-person interviews with patients readmitted to hospitals to evaluate reasons for readmission.

### Results in Brief:

- ▶ Preliminary results show improvement in hospital readmission rates. The number of readmissions per 1,000 Medicare Advantage members was 8.5 percent lower in the nine months following the program's implementation than it was in the previous nine months.

## BACKGROUND

To improve patients' experiences with care transitions and reduce preventable hospital admissions, readmissions, and emergency room visits, Group Health Cooperative established the Emergency Department and Hospital Inpatient Improvement Program in June 2009. The program is in place for all Group Health members, including those with Medicare, Medicaid, and commercial coverage. The program initially was operational only for patients hospitalized for treatments other than surgery and procedures. Group Health will complete its implementation among patients admitted for surgery and procedures by the end of 2010.

## APPROACH

### *Brainstorming on Best Practices*

Prior to implementing the new program, Group Health staff researched the medical literature to identify best practices for achieving successful care transitions. Group Health staff discussed these findings and identified additional effective strategies during brainstorming sessions at four five-day Rapid Process Improvement Workshops in 2009. Front-line staff—including hospitalists, nurses, hospice professionals,

and skilled nursing facility staff—as well as medical directors participated in the sessions. Based on their conclusions and recommendations, Group Health developed new standardized work processes to ensure the use of evidence-based strategies in emergency rooms, hospitals, post-hospital transitions, nursing homes, and palliative care settings. Group Health refers to these evidence-based practices as Standard Work.

### *Implementing Standard Work*

Group Health launched a Standard Work pilot project in the community hospital that admits the greatest number of its members. In 2010, Group Health is expanding the initiative to all of the other inpatient facilities in its network. As part of Standard Work, Group Health clinicians assess the full range of patients' needs as soon as they enter the hospital or emergency room. ER staff consult with Group Health's on-site hospitalists to evaluate patients' symptoms, review their electronic health records, and determine whether they need to be admitted to the hospital or whether their conditions can be treated safely and more effectively in other settings (e.g., in rehabilitation or long-term care facilities, or at home with home health care services). If hospitalists and ER clinicians believe patients can be treated more effectively outside the



hospital, they contact a Group Health physician and a health plan staff member designated as the patient resource—both of whom are on call 24/7. The patient resource staffer confers with patients and their families to discuss the options, checks patients' benefits, and helps arrange safe placements in care facilities.

To ensure that patients admitted to hospitals receive the level of support that best meets their immediate and post-discharge needs, Group Health's hospitalists and care management nurses meet each day and classify patients into four categories:

- (1) Patients with multiple complex needs who will need help with their conditions, medications, and orders.
- (2) Patients who will be discharged to skilled nursing facilities.
- (3) Patients who may be candidates for palliative care.
- (4) Patients with uncomplicated conditions who will have minimal post-discharge needs.

Each day, hospitalists and nurses determine how many patients they have in each of the four categories and set up individual care plans according to patients' needs.

### ***Providing Extra Assistance to Patients with Complex Care Needs***

Patients with complex needs meet with Group Health nurses three times in the hospital. During these meetings, nurses explain their medical conditions and medications. They teach patients how to recognize symptoms that represent "red-flag" warnings of medical problems should they arise post-discharge, and they instruct patients to contact their doctors immediately upon experiencing these symptoms. In addition, they set up follow-up appointments with patients' primary care physicians within 14 days of hospital discharge.

Within 48 hours of discharge, Group Health nurses contact these patients by phone to check on their health status and to reiterate key information about their conditions, prescriptions, and red-flag symptoms. Nurses also can help patients access any additional items or services they need (e.g., home health, durable medical equipment, transportation), and they are available to patients by phone on a 24/7 basis. Within seven days of discharge, each patient also receives a telephone call from a Group Health pharmacist, who reviews and explains medications, checks for duplication and dangerous combinations, and follows up with patients' physicians to ensure that medication regimens are safe and effective.

If patients are readmitted to the hospital for any reason within seven days of discharge, nurses meet with them to determine what they experienced in the post-discharge period. Group Health uses this information to further improve the care transition process.

### ***Preparing Patients for Discharge to Nursing Homes***

When care plans indicate that patients will be discharged

from hospitals to skilled nursing facilities, Group Health's hospitalists arrange for a care team of Group Health physicians and/or advanced registered nurse practitioners to meet with patients within 48 hours of SNF admission. Once patients are transferred to SNFs, discharge planning follows the same procedures as those used in hospitals. Nursing home teams educate patients with complex care needs about their conditions and medications, discuss red-flag symptoms, and arrange for follow-up care with primary care physicians. Patients discharged from SNFs likewise receive post-discharge support and assistance from nurses and clinical pharmacists. In addition, the care team ensures that patients have set up durable powers of attorney and physician orders for life-sustaining treatment.

### ***Discussing Options for End-of-Life Care***

When a physician indicates that life expectancy for one of his or her patients is most likely a year or less, Group Health's hospitalists meet with the patient to discuss end-of-life treatment options. During these consultations, hospitalists discuss patients' prognoses and ask what types of care they would like to receive in the final months of their lives. Group Health clinicians then align care with patients' preferences.

### ***Consultations with Pharmacists and Primary Care Physicians for All Patients Following Discharge***

Patients who are hospitalized for uncomplicated medical or surgical procedures receive phone calls from clinical pharmacists within seven days of discharge to review prescriptions and ensure that medication regimens are safe. In addition, Group Health schedules them for PCP follow-up visits within 14 days.

## **RESULTS**

- ▶ In the hospital where the program was implemented, the 30-day readmission rate (readmissions per admission) fell from 15.7 percent in 2008 to 14 percent in December 2009.
- ▶ Throughout the Group Health system, in the nine months after the program was launched, the number of readmissions per 1,000 Medicare Advantage members was 8.5 percent lower than in the previous nine-month period.

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### ***For more information, contact:***

Brian Harris  
Vice President, Network Services and Care Management  
Group Health Cooperative  
(206) 448-2540  
harris.bl@ghc.org

Brenda Bruns, M.D.  
Executive Medical Director  
Group Health Cooperative  
(206) 448-2490  
Bruns.b@ghc.org

# The Medical Home Initiative

## PROGRAM AT A GLANCE

### Goals:

- ▶ To improve the quality of primary care and the work life of primary care physicians (PCPs).
- ▶ To improve patient experiences with primary care.
- ▶ To make health care delivery more efficient.
- ▶ To control health care costs.

### Key Strategies:

- ▶ Place a multidisciplinary team of physicians, nurses, clinical pharmacists, and medical assistants in physician offices to review patients' records in advance of visits and highlight unmet needs for acute, chronic, and preventive care for physicians to address.
- ▶ Promote electronic and telephone communication between patients and their primary care teams to address health care issues and concerns.
- ▶ Have physicians and patients collaborate on care plans that address their diagnoses, medications and other treatments, targets for key health indicators, and schedules for doctor visits.
- ▶ Arrange for nurses to contact patients by phone within 48 hours of hospital discharge to review medications and address care needs.
- ▶ Create an expanded role for clinical pharmacists on patient care teams.

### Results in Brief:

#### ▶ Quality of Care

- Patients at the pilot site scored better than those in nonparticipating clinics on four composite measures of quality at baseline, and they showed greater improvements after 12 months of program operation than patients at the control sites. After 24 months, quality measures at both the pilot site and nonparticipating sites showed improvement, and improvements at the pilot clinic continued to be 20-30 percent greater for three of the four composites.

#### ▶ Hospital Admissions

- After accounting for case mix, all-cause inpatient admissions were 6 percent less over 21 months at the pilot site than for patients in the other clinics serving as controls.

#### ▶ Cost Savings

- The estimated return on investment for the Medical Home pilot 21 months following implementation was 1.5:1.

## BACKGROUND

In response to increasing burnout among primary care physicians, rising costs, and concerns about quality of care, Group Health launched a Medical Home pilot program in 2006. Based on success of the pilot, the health plan began expanding the program to all of its clinics in 2008, and implementation will be completed in 2010. The program will continue to be enhanced and refined over time. Eleven thousand patients received services at the pilot site, and once the program is fully implemented, it will be available to all 400,000 Group Health members, including those with Medicaid, Medicare, and commercial coverage.

## APPROACH

### *Increasing Clinical Staff to Increase Patients' Access to Care*

At the time of program launch, Group Health increased its clinical staff by about 30 percent. The health plan added more physicians, medical assistants, nurse practitioners, and clinical pharmacists to its primary care teams. The size of PCPs' patient panels was reduced from 2,300 to 1,800, and standard appointment times were increased from 20 to 30 minutes. As a result, participating physicians now see 12-18 patients per day rather than 20-25. Patients can obtain same-day doctor appointments, and doctors have time to communicate with patients electronically and by phone.

### ***Providing Care with Multidisciplinary Teams***

Medical Home patients receive care from multidisciplinary teams of physicians, registered nurses, case managers, clinical pharmacists, medical assistants, licensed practical nurses (LPNs), nurse practitioners, and physician assistants. Team members review patients' records prior to doctor appointments to highlight unmet acute, chronic, or preventive care needs (e.g., lab tests, mammography, HbA1c tests) for doctors to address. Team members "huddle" prior to patient visits to arrange many of these services in advance. As a result, physicians can make the most of their time during visits and ensure that the full range of patients' health care needs are met. Group Health calls this practice "360-degree care."

### ***First-Call Resolution and Electronic Communication***

To ensure that patients calling Group Health clinics have clinical questions answered promptly and accurately with minimal call transfers, clinic phones are now answered by doctors, registered nurses, and licensed practical nurses rather than administrative staff. Medical Home patients frequently communicate with their care teams by phone and e-mail in addition to or as a substitute for in-person visits.

### ***Collaborative Care Plans***

As part of the Medical Home initiative, physicians and patients collaborate to develop care plans that list patients' diagnoses; medications and other treatments; needed lab tests; targeted health outcomes (e.g., for LDL-cholesterol levels, HbA1c levels); and schedules for follow-up visits. Group Health initially developed care plan templates for five chronic conditions (diabetes, hypertension, chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease), and the health plan is now developing templates that can be used for all patients.

After each doctor visit, patients receive "after-visit summaries" that include paper and electronic copies of their care plans, written in non-clinical language to promote easy understanding. Whereas previously many patients were not aware of their key health indicators such as blood pressure and HbA1c levels, they now can access this information online from anywhere.

Patients whose chronic conditions are unstable receive nursing care plans in addition to their treatment plans. Nursing care plans include "sick-day" instructions, for example, describing what patients with diabetes should do on days that they are vomiting.

Patients with multiple chronic conditions are paired with nurse case managers, who help them access all of the medical, social service, and behavioral health care they need.

### ***Outreach to Infrequent Users of Care***

Patients who have not had doctor visits in the past year receive calls from nurses and/or reminders in their electronic health records suggesting that they receive the recommended preventive care. Group Health makes extra efforts to ensure that Medicare Advantage members visit their doctors at least once a year. LPNs call Medicare Advantage members to remind them to make doctor's appointments, refill their prescriptions, have their blood pressure checked, and have preventive care recommended for their conditions.

Besides sending reminders by phone and e-mail, Group Health mails letters to patients during the month of their birthday each year to remind them to have the preventive care services recommended for their age and health conditions.

### ***Follow-Up with Patients Following Major Health Events***

When patients are hospitalized, admitted to skilled nursing facilities, or have visits to emergency rooms or urgent care centers, they receive calls within 48 hours from care team nurses. Nurses check on patients' health status, review medications, and arrange for home health or other support services.

### ***Expanded Roles for Clinical Pharmacists***

Because medications play an increasingly important role in patients' treatment plans and because adverse medication events often lead to hospital admissions, readmissions, and emergency room use, Group Health has created a major role for clinical pharmacists on patient care teams. Each new Group Health member meets with a pharmacist to review medications before visiting his or her primary care physician. Clinical pharmacists review patients' medications regularly, check for dangerous combinations, and coordinate with doctors to ensure safe medication regimens. They contact patients to check how their medications are working, discuss problems with taking medications as prescribed, and can have doses adjusted to improve health outcomes. Pharmacists also contact all patients following emergency room visits to explain medications and answer questions before patients have follow-up PCP visits.

### ***Payment Reforms***

Physicians participating in the Medical Home initiative receive bonuses in addition to their regular salaries for achieving specified quality benchmarks (e.g., improved patient LDL-cholesterol and HbA1c levels). They also receive reimbursement for phone and e-mail consultations with patients.

## RESULTS

### ► Use of Primary Care

- Within a year of the program's implementation, patients in the pilot sites had 6 percent fewer in-person visits to primary care physicians compared to patients in other clinics. The difference persisted at 21 months. Despite fewer in-person visits, patients at the pilot site used 80 percent more secure e-mail messages and had 5 percent more telephone encounters with clinicians than did those in nonparticipating sites after 21 months of the program's operation.

### ► Quality of Care

- Patients at the pilot site scored better than those in nonparticipating clinics on four composite measures of quality at baseline, and they showed greater improvements after 12 months of program operation than patients at the control sites. After 24 months, quality measures at both the pilot site and nonparticipating sites showed improvement, and improvements at the pilot clinic continued to be 20-30 percent greater for three of the four measures.

### ► Hospital Admissions

- After accounting for case mix, all-cause inpatient admissions were 6 percent less over 21 months at the pilot site than in the other clinics serving as controls.

### ► Cost Savings

- After 21 months of program operation, compared to costs for patients in nonparticipating clinics:
  - Costs for primary care were \$1.60 per member per month higher in the pilot clinic.
  - Specialty care costs were \$5.80 per member per month higher in the pilot site.
  - Costs for urgent and emergency care were \$4 per member per month lower among patients of the participating clinic.
  - Costs for inpatient care were \$14.18 per member per month lower among pilot clinic patients.
- The estimated total per-member per-month savings for the program (totaled across all types of care and adjusted for case mix and baseline costs), was \$10.30, a result that approaches statistical significance ( $p=.08$ ).
- The estimated return on investment for the Medical Home pilot 21 months following implementation was 1.5:1.

### ► Patient Experiences

- After 24 months of program operation, patients at the pilot site reported better experiences with care coordination, access to care, and goal-setting, and modestly better ratings for the quality of doctor-patient interactions and patient activation and involvement than did patients at nonparticipating clinics.

### ► Burnout Among Clinicians

- A year after the program's launch, emotional exhaustion, or burnout, was lower in Medical Home sites—with 10 percent of staff reporting high burnout—compared to 30 percent in nonparticipating clinics. After 24 months of the program's operation, the mean emotional exhaustion score among clinicians at the pilot site was 12.8, compared to 25 at other clinics.

Group Health has found that patients who benefited most from the Medical Home initiative were patients who previously had never accessed care and were motivated through the health plan's outreach efforts to begin receiving health services.

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#### *For more information, contact:*

Claire Trescott, M.D.  
Medical Director, Primary Care  
Group Health Permanente  
(206) 448-6517  
trescott.c@ghc.org

Robert Reid, M.D., Ph.D.  
Associate Medical Director, Preventive Care  
Group Health Cooperative  
(206) 287-2071  
Reid.rj@ghc.org

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#### *Also see:*

Reid R.J. et al. (2010). The Group Health medical home at year two: Cost savings, higher patient satisfaction, and less burnout for providers. *Health Affairs*. 29(5). 835-843. Available at: <http://content.healthaffairs.org/cgi/reprint/29/5/835>.

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# The Patient-Centered Medical Home Pilot

## PROGRAM AT A GLANCE

### Goals:

- ▶ Create a new model of primary care with expanded access to services; ongoing monitoring of health conditions; and coordination of primary, preventive, specialty, and behavioral health care.
- ▶ Improve the work environment for primary care physicians.

### Key Strategies:

- ▶ Redesign primary care practices to provide team-based care.
- ▶ Realign physician payment to support care coordination, evidence-based treatment, and process changes to improve health outcomes.
- ▶ Provide resources to physician offices for: electronic tools and data analytics to improve quality; pharmacy education; case managers and care coordinators; and professional consultation on practice management.
- ▶ Provide educational opportunities for staff to support quality improvement and sharing of best practices.

## BACKGROUND

In 2008, Independent Health convened an advisory committee of primary care physicians and patients to critically examine the state of primary care in Western New York. The committee studied the Patient-Centered Medical Home model, and it reviewed the National Committee for Quality Assurance's (NCQA's) Medical Home certification standards. In 2009, Independent Health implemented the Patient-Centered Medical Home pilot program based on the advisory committee's input.

## APPROACH

### *A Team-Based Model of Care*

Eighteen primary care practices—representing nearly 140 physicians and 40,000 patients in Western New York—participate in the pilot. Participating specialties include family practice, internal medicine, and pediatrics, and sites include solo and group practices in urban, suburban, and rural locations. Patients with Medicare, Medicaid, and commercial health coverage receive care through the pilot.

The Patient-Centered Medical Home pilot is designed to transform the culture of medical practice. Whereas the traditional model of primary care is based on one physician treating one patient, Medical Home is based on a team approach. Each patient has a personal physician, who leads a multidisciplinary care team comprised of physician assistants, nurse practitioners, nurses, pharmacists, health coaches, care coordinators, and case managers. Care team members

work together to meet the full range of patients' primary, preventive, acute, chronic, behavioral health care, and social service needs. Physician assistants, nurse practitioners, and nurses review patients' medical histories in advance of doctor visits to identify patients' unmet needs, and they point out key issues for doctors to address during office visits.

Also as part of the team-based approach to care, registered nurses, nurse practitioners, and physician assistants help develop care plans based on physicians' treatment recommendations. Pharmacists and medical directors are available for consultation on complex cases.

Care plans may cover areas such as changes in diet and exercise, nutritional counseling, behavioral health care, patient self-monitoring, and use of community agencies to help with transportation needs. Care team members communicate with patients by phone and online to help them follow care plans and to answer questions.

### *Payment for Quality*

Independent Health has realigned physician payment to promote quality care and ensure the long-term sustainability of Patient-Centered Medical Home. In addition to traditional fee-for-service-based payments, participating physicians receive monthly prospective grants to facilitate care coordination and office redesign. Prospective payments are based on the size and risk profiles of their patient panels. Independent Health also provides bi-annual retrospective payments to physician practices for reaching specified



## The Patient-Centered Medical Home Pilot

quality benchmarks, such as improving preventive and chronic care and enhancing patients' care experiences.

### *Increased Office Capacity and Improved Coordination*

As part of the effort to transform medical practice, Medical Home sites offer after-hours care and same-day appointments. Participating physician practices also are establishing electronic health records and systems for e-mail communication between doctors and patients. Independent Health's Practice Management Consultants are available to help physician groups with the practice transformation by exploring how to approach staffing and process changes needed to achieve these improvements.

When patients face challenges related to chronic conditions, medications, financial and transportation barriers to care, repeated hospital admissions, and/or extensive medical needs, Medical Home staff link them with Practice Care Coordinators. Practice Care Coordinators' role is to provide ongoing assistance, facilitate continuity of care, and provide links to professionals (e.g., nutritionists and social workers) and community resources (e.g., services for transportation and home-delivered meals).

### *Monthly Collaborative Education Sessions*

Each participating physician group includes a three-person quality improvement team comprised of a physician, a practice administrator, and clinical support staff. Team

members attend monthly collaborative education sessions, which often are conducted by national thought leaders in the specialty of practice transformation. These sessions have covered topics such as disease management, evidence-based care, and NCQA certification standards for Medical Home sites. The meetings offer opportunities to engage in professional networking, share best practices, and highlight lessons learned. Quality teams discuss information gathered at these sessions with colleagues in their Medical Home sites to support the process of practice improvement.

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## RESULTS

- ▶ Independent Health has developed goals and outcome measures for 2010 in the areas of patient and physician satisfaction, as well as health care quality. Physician groups participating in the Medical Home pilot receive data on their performance each quarter. A comprehensive evaluation of the program's impact will be released in late 2010.

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### *For more information, contact:*

Judith Feld, M.D., M.P.H.  
Associate Medical Director  
Independent Health Association  
(716) 635-3781  
jfeld@independenthealth.com



# The Medical Home Initiative

## PROGRAM AT A GLANCE

### Goal:

- ▶ To reduce preventable hospital admissions and readmissions among Medicare Advantage members.

### Key Strategies:

- ▶ Provide medical groups with practice-level data on rates of prescription drug use, hospital admissions, and readmissions.
- ▶ Make physicians aware of patients at high risk of hospitalization (based on their diagnoses, physician visits, and prescription drug use) who could benefit from case management.
- ▶ Offer physician groups the option of having nurse case managers on staff in their practices.
- ▶ Have nurse case managers contact members at high risk to identify needs and help them access services.
- ▶ Encourage physicians to develop innovative approaches to improving care and reducing costs.

### Results in Brief:

- ▶ In the Medicare Advantage HMO plan where the Medical Home initiative was implemented, the hospital readmission rate for the first three quarters of 2009 was 15.1 percent, compared with 16.6 percent for Universal's private fee-for-service plan and 19.6 percent for the Medicare fee-for-service program.

## BACKGROUND

To help reduce preventable hospital admissions and readmissions, Universal American implemented a Medical Home initiative in its Southeast Texas health plan in 1999.

## APPROACH

### *Giving Physicians Data and Resources*

The program aims to provide physicians with the data they need to transform their practices. On a regular basis, the health plan provides physician groups reports with practice-level data on prescription drug use; the rate of brand-to-generic conversion; and the rate of hospital admissions and readmissions. Reports also include member-specific data intended to make doctors aware of patients at high risk of hospitalization who could benefit from case management. These reports indicate which patients: are receiving prescriptions from multiple physicians; have not filled prescriptions; have not had doctor visits in the past year; and/or have two or more chronic conditions and describe their health status as poor. Universal recommends that physicians offer these patients the option of working with nurse case managers. In addition, the health plan provides funding for physician groups to have nurse case managers on staff in their offices.

Nurse case managers working in physician practices regularly review the health plan's list of patients at high risk of hospitalization. They contact these members at frequencies depending on members' needs, to ask how they are feeling, whether they understand how to take their medications, and how they can help. Nurses can help members obtain a wide range of services, such as community-based behavioral health care, low-cost transportation, Meals on Wheels, and financial assistance with medications. In addition, if patients are having difficulty affording their prescriptions, nurses can coordinate with physicians to identify generic alternatives. Patients can continue receiving case management services for as long as needed, and some remain in case management for a lifetime. On average, patients receive case management services for about six months.

Physicians participating in the Medical Home initiative receive financial incentives based on quality measures (e.g., rate of preventive care testing for patients with diabetes, use of ACE inhibitors for patients with heart failure, mammography rates), health outcomes (e.g., lower LDL-cholesterol and blood pressure levels), and coordination of care (as measured by use of e-prescribing, electronic health records, and work with in-house case managers).

### *Providing Physicians Incentives to Innovate*

Universal American encourages physicians to develop innovative approaches to improving care and reducing costs. For example, one medical group found that many of its patients were being admitted to hospitals solely for the purpose of receiving intravenous (IV) medications. Therefore, physicians decided to open an infusion clinic in their offices so that patients could receive IVs safely and efficiently on an outpatient basis. Medical groups whose patients have high rates of preventable emergency room visits may decide to open additional urgent care centers or to expand their office hours. Universal shares the savings from any such innovations with physician groups.

### RESULTS

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► In the Medicare Advantage HMO plan where the Medical Home Initiative was implemented, the hospital readmission rate for the first three quarters of 2009 was 15.1 percent, compared with 16.6 percent for Universal's private fee-for-service plan and 19.6 percent for the Medicare fee-for-service program.

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### *For more information, contact:*

Nelson Fernandez, M.D.  
Senior Medical Director  
Universal American Corporation  
(713) 843-6732  
nfernandez@hhsi.com



## Helping Patients Transition from Hospital to Home

Major transitions in care—whether from hospital to home, rehabilitation facility to nursing home, or nursing home to hospice—typically are confusing for patients and their caregivers. Doctors and nurses are trying to convey a lot of critical information in just a few minutes: how and when to take medications; whom to call if symptoms worsen; when to see the doctor; when home health care will arrive; and more. Often these important messages are delivered when patients are tired and not feeling their best. Clinicians may not know when caregivers will be available to write down important care instructions. As a result, information may be lost; patients may not take medications correctly when they get home; chronic conditions can deteriorate rapidly; and patients often end up back in the hospital for preventable causes.

In an effort to prevent these problems, health plans have implemented robust hospital-to-home transition programs. Through these programs, nurses meet with patients and their caregivers in the hospital to go over care plans. They ensure that patients have follow-up visits scheduled with their primary care physicians and specialists, and they help them make these appointments if necessary. When patients return home, nurses call to see how they are doing, whether they understand their medications, and whether home health, durable medical equipment, and any other assistance ordered has been received. In some cases, they conduct in-person visits in patients' homes to assess safety, arrange for modifications to prevent falls and other mishaps, and review medications in person. In other cases, they may link patients with case managers who can help them find financial assistance to pay for medications, access home-delivered meals, and find social workers who can help with difficult family situations.

In short, hospital-to-home transition programs help patients overcome any barriers they face in following physicians' care plans so that they can live safely and comfortably in their homes. In this chapter, we review numerous examples of health plans' hospital-to-home initiatives.

# The Transitional Care Model

## PROGRAM AT A GLANCE

### Goal:

- ▶ Reduce preventable hospital readmissions among Medicare beneficiaries.

### Key Strategies:

- ▶ Arrange for a home visit by an advanced-practice nurse within seven days of hospital discharge, so that the nurse can evaluate: patients' clinical and psychosocial needs; the safety of the home environment; and the ability of the patient and caregiver to follow the care plan recommended at hospital discharge.
- ▶ Following the initial home visit, provide for additional in-person visits and phone calls by the nurse to coordinate patient care, communicate with physicians as needed, and help patients access all of the resources necessary to follow the care plan successfully (e.g., physical therapy, social workers, financial assistance, Meals on Wheels).

### Results in Brief:

- ▶ Among patients receiving services in a 2006-2007 pilot program for 155 Medicare beneficiaries, significant improvements were achieved in:
  - Functional status;
  - Depression symptom status;
  - Self-reported health; and
  - Quality of life.

## BACKGROUND

In response to a growing number of hospital readmissions among Medicare beneficiaries for the same diagnoses, Aetna partnered with the University of Pennsylvania to implement the Transitional Care Model (TCM) on a pilot basis with 155 patients from 2006-2007.

The TCM was created by a research team at the university and has been developed and refined for the past 18 years. The goal of the TCM is to improve the health care and outcomes of Medicare beneficiaries with chronic illnesses who are making the transition from hospital to home. The TCM emphasizes care coordination, continuity of care and prevention, as well as avoidance of complications. To achieve these goals, program staff work to educate patients and their caregivers about patients' conditions, symptoms, and care plans, and they keep them actively engaged in the care process.

## APPROACH

### *Identifying Members Most at Risk*

In 2006, patients who had histories of avoidable hospital admissions or readmissions were offered the opportunity to

enroll in the program. Avoidable admissions and readmissions were defined as those which most likely would not have occurred if care plans had been followed correctly (i.e., with medications taken as directed, follow-up appointments with physicians made and kept, and dietary recommendations followed).

### *Home Visits and Follow-Up Calls*

An advanced-practice nurse under contract with Aetna visited each participating beneficiary at home within seven days of hospital discharge. During these visits, nurses determined whether patients had everything needed to follow their doctors' care recommendations and whether home environments were safe (e.g., whether there were items that presented risks for falls, burns, or other accidents). Based on this assessment, the nurse arranged for whatever items or services the patient needed to follow physicians' recommendations and live safely at home. These could include, for example, grab bars for the shower, home health services, physical therapy, Meals on Wheels, or consultations with nutritionists. Nurses worked to educate caregivers about patients' care plans, the risks of relapse, danger signs

to watch for (e.g., short-term weight gain among people with heart failure), as well as what to do and whom to call if patients' symptoms worsened.

After the initial home visit, nurses called patients at least twice a week and conducted additional home visits and phone calls as needed. Nurses remained in contact with patients for up to several months in some cases. Nurses accompanied patients on doctor visits as needed, and they coordinated patient care to make all treating physicians aware of what the others were doing and to avoid adverse medication interactions. For example, three different doctors potentially could prescribe Motrin, Naproxin, and Celebrex to the same patient, and the patient could experience severe stomach pains as a result.

If patients were not taking medications as recommended, nurses sought the most workable solutions. They provided additional education about each medication and how to take it, and they coordinated with physicians to have medication regimens modified so that patients could follow them more easily (e.g., changing to a once-a-day pill if the patient had trouble remembering to take a pill twice a day).

### *Expansion of the Transitional Care Model*

Aetna is now implementing Transitional Care Model in Philadelphia, New York, Northern New Jersey, Florida, and Arizona. Later in 2010, the program will expand to additional parts of the country where there are large populations of Medicare members who can benefit from the program.

## RESULTS

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► Among patients receiving services through the pilot:

- Significant improvements were achieved in:
  - Functional status;
  - Depression symptom status;
  - Self-reported health; and
  - Quality of life.
- Forty-five patients in the intervention group were rehospitalized within three months of hospital discharge, compared to 60 in the control group.
- A cost savings of \$175,000, or \$439 per member per month, was achieved.

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### *For more information, contact:*

Randall Krakauer, M.D.  
National Medical Director  
Aetna  
(609) 708-2286  
krakauermdr@aetna.com

# Addressing Readmissions to Psychiatric Hospitals

## PROGRAM AT A GLANCE

### Goal:

- ▶ Reduce preventable readmissions to psychiatric hospitals.

### Key Strategies:

- ▶ Share data with staff of psychiatric hospitals on their rates of admissions, readmissions, length of stay, as well as lists of patients readmitted within 30 days of hospitalization. Hold quarterly meetings with hospital staff to identify factors leading to readmission.
- ▶ Address issues leading to preventable readmissions, for example by: helping members make follow-up appointments for outpatient care; linking members with support groups, group therapy, and case management; and communicating with physicians to find easier ways for patients to take their medications (e.g., every four to six weeks by injection rather than by mouth each day).
- ▶ Arrange for staff of outpatient behavioral health clinics to visit members while in psychiatric hospitals to set up follow-up appointments.

### Results in Brief:

- ▶ From 2008-2009, the readmission rate among psychiatric hospitals participating in the initiative fell by 2.8 percentage points, from 17.7 percent to 14.9 percent.

## BACKGROUND

AMERIGROUP Florida's member population includes individuals covered by Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and Florida's Healthy Kids program. In response to high rates of readmission among patients at some of the psychiatric hospitals in its Florida network, in January 2009 AMERIGROUP began sharing admission and readmission data and holding regular meetings with staff of seven psychiatric hospitals.

## APPROACH

### *Quarterly Meetings with Staff of Psychiatric Hospitals*

Each quarter, AMERIGROUP shares data with psychiatric hospitals on their rates of admissions, readmissions, average lengths of stay, as well as lists of patients readmitted within 30 days of hospitalization. Subsequently, the health plan's behavioral health manager meets with each hospital's medical director, clinical team leader, and medical management staff, to review cases in which patients were readmitted within 30 days. The team seeks to identify factors that could have led to readmission, such as: a length of stay that was too short; lack of a timely follow-up visit with a behavioral health practitioner; difficulties with taking medications as recommended; and substance abuse.

Based on conclusions reached during these meetings, AMERIGROUP helps hospital staff address problems leading to preventable readmissions. For example, AMERIGROUP's behavioral health staff can help arrange patients' follow-up visits to outpatient facilities. If patients are having difficulty taking medications as recommended, AMERIGROUP staff may communicate with health care practitioners to discuss potential alternatives (e.g., long-acting treatments that can be injected every four to six weeks rather than taken orally each day). AMERIGROUP staff also may reach out to family members who can help. The health plan may coordinate with hospital staff to link members with case management, psychosocial rehabilitation groups, support groups, or group therapy. If patients are homeless, AMERIGROUP staff can link them with resources to help with finding affordable housing.

AMERIGROUP expanded the program to two additional psychiatric hospitals in late 2009.

### *Inpatient Visits to Arrange Follow-Up Care*

To help ensure that patients receive timely outpatient care after a psychiatric hospitalization, AMERIGROUP coordinates with two Florida hospitals and outpatient behavioral health facilities so that center staff can meet with patients in the hospital to make appointments for outpatient follow-up.



### *Meetings with Staff of Outpatient Community Health Centers*

Based on the success of the hospital component of the program, AMERIGROUP plans to begin a similar initiative in June 2010 with community mental health centers. AMERIGROUP will provide each center with data on AMERIGROUP members' diagnoses and the services they are receiving, as well as members' overall rate of 30-day readmission to psychiatric hospitals and the rate of seven- and 30-day outpatient follow-up. In addition, the health plan's behavioral health manager will hold quarterly meetings with community mental health center staff to discuss cases involving readmissions and examine underlying factors.

### RESULTS

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- ▶ From 2008-2009, the readmission rate among psychiatric hospitals participating in the initiative fell by 2.8 percentage points, from 17.7 percent to 14.9 percent.
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#### *For more information, contact:*

Diane Smeltzer  
Vice President, Health Care Management Services  
AMERIGROUP Florida, Inc.  
(813) 830-6944  
dsmeltz@amerigroupcorp.com



# The Transition of Care Nurse Program

## PROGRAM AT A GLANCE

### Goals:

- ▶ Help patients make successful care transitions following discharge from hospitals.
- ▶ Promote timely recovery and help prevent recurrence or worsening of health problems associated with hospitalization.

### Key Strategies:

- ▶ Seven Transition of Care nurses:
  - Meet with patients in hospitals, answer their questions, review medications, and prepare for discharge.
  - Relay critical clinical information from outpatient settings to emergency room (ER) physicians and hospitalists.
  - Share up-to-date information about the health status of hospitalized patients with their primary care physicians.
  - Coordinate with hospitalists to develop discharge plans.
  - Contact patients by phone within 24 hours of discharge to check on their health status, review medications, and help with unmet needs.

## BACKGROUND

In the early part of this decade, Cigna Medical Group found that primary care physicians often did not know which of their patients had been admitted to hospitals, what had occurred in the hospital, and what patients' needs were following discharge. As a result, patients often did not receive timely follow-up care and ended up in the hospital again. Likewise, ER physicians and hospitalists often were unaware of the outpatient care patients had received prior to their admissions.

To help ensure continuity of care for patients during and after hospitalization, Cigna Medical Group implemented the Transition of Care Nurse Program in 2004. The program initially was created for CIGNA HealthCare of Arizona's Medicare Advantage individual customers, and it has been expanded to include all Cigna Medical Group patients hospitalized in the facilities where the program exists.

## APPROACH

### *Extra Help in the Hospital*

In the six Arizona hospitals with the highest volume of Medicare Advantage individual customers, the program's nurses help patients from the time they are admitted to the hospital through the post-discharge transition. Nurses spend most of their time with patients needing the most help—who generally are Medicare Advantage individual customers—though they are available to help all Cigna Medical Group patients in the hospital.

Program nurses meet with Cigna Medical Group patients in hospitals to discuss their hospital stays and answer any questions they may have. Nurses work with hospitalists to help develop discharge plans. In addition, they meet with patients prior to discharge to explain their medications and how to take them; determine whether they have follow-up appointments set up with primary care physicians and specialists; and help make these appointments as needed.

### *Decision Support in the Emergency Room*

Program nurses often consult with hospitalists in the emergency room. Nurses can provide hospitalists with important data such as lab and other test results, to determine whether patients need inpatient services or whether they can be safely discharged from the hospital or ER.

### *A Resource for Patients at Home*

Transition of Care nurses contact patients by phone within 24 hours of hospital discharge to ask how they are feeling; answer questions about their medications, symptoms, and care plans; check whether they have received home health services or durable medical equipment; and review follow-up appointments that have been made. Nurses can help patients make appointments with primary care physicians or other health care practitioners as needed. In addition, if home health services or durable medical equipment has not been received as requested, nurses can make sure that patients receive what they need without further delay. If patients report that they are not feeling well during these calls, nurses can ensure

that they see their doctors sooner than originally scheduled, and they can arrange for Cigna Medical Group's Home-Based Care team to visit patients at home to provide care.

Program nurses may continue to work with patients for several days following hospital discharge. If patients need assistance beyond the immediate post-discharge period, nurses can link them with outpatient care coordinators who can help them access services such as financial assistance, behavioral health, and transportation.

#### ***Roles for Clinical Pharmacists and Social Workers***

Because confusion over medications is so common and mistakes in taking prescriptions often lead to medical emergencies, Cigna Medical Group is in the process of adding clinical pharmacists to the program. Clinical pharmacists will check new and previously prescribed medications for potential duplication, medication interactions, and gaps in medication that may have led to the hospitalization in the first place. Cigna Medical Group will provide these consultations in the hospital to all patients in the Transition of Care Nurse Program beginning in mid-2010, and it subsequently will extend the initiative to all patients following hospital discharge.

As Transition of Care Program nurses develop patients' hospital discharge plans, they often include roles for social workers. Social workers help patients access needed care and community services such as transportation and pharmacy

assistance programs. Social workers coordinate with other behavioral health specialists to provide support to patients with depression, particularly those with multiple chronic medical conditions.

#### ***Updated Information for Primary Care Physicians***

To help ensure continuity of care, Transition of Care nurses give all primary care physicians regular updates on their patients who have been admitted to hospitals—including who was admitted; why they were admitted; and how their health status has changed in the hospital and immediately following discharge. In this way, Cigna Medical Group bridges the care gaps that previously occurred between hospitals and primary care physicians' offices.

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## RESULTS

- ▶ By mid-2010, Cigna Medical Group plans to complete an evaluation of the program's impact on patient satisfaction and preventable hospital readmissions.

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#### ***For more information, contact:***

Robert Flores, M.D.  
Medical Director, Population Health  
Cigna Medical Group  
(602) 271-3725  
Robert.flores@cigna.com

# The Healthy Transitions Program

## PROGRAM AT A GLANCE

### Goals:

- ▶ Help Medicare Advantage members meet all of their health care and social service needs following hospital discharge to avoid preventable readmissions.

### Key Strategies:

- ▶ Arrange for clinical pharmacists to visit patients' homes after release from hospitals to:
  - Help patients and caregivers understand medications and take them correctly.
  - Check all of patients' prescription and non-prescription drugs and coordinate with physicians to remove conflicting medications.
- Coordinate patients' health care and social service needs for 30 days.
- ▶ Enroll patients in case management following the initial 30-day transition period as needed.

## BACKGROUND

In an effort to reduce preventable hospital readmissions, Fallon Community Health Plan (FCHP) launched the Healthy Transitions pilot program for 100 Medicare Advantage members in 2009.

## APPROACH

### *A New Role for Clinical Pharmacists*

Within 72 hours of patients' discharge from hospitals, FCHP sends clinical pharmacists into their homes to review medications. Pharmacists check for duplicative or conflicting prescriptions and contact patients' doctors to have dangerous combinations removed. In addition, they help patients and their caregivers understand what each medication is for, as well as when and how to take it.

Notably, pharmacists are playing a new, expanded role—serving as patients' care coordinators for a 30-day transition period following release from hospitals. Pharmacists help patients make appointments with their primary care physicians and/or specialists within a week of hospital discharge. Pharmacists ensure that patients have any lab tests, home treatments (e.g., IV medications), supplies (e.g., nebulizers, durable medical equipment, scales), and home health services they need. In some cases, pharmacists may work with nurse case managers to help patients access services.

After the initial 30-day transition period, patients may enroll in longer-term case management programs. Clinical pharmacists may return to patients' homes at any time as necessary to address health care or psychosocial needs.

### *Coordination with Hospitals and Physicians*

FCHP staff are coordinating with hospitals and physicians to make the post-discharge transition period smooth and avoid unnecessary readmissions. For example, FCHP nurse case managers work with hospital staff to ensure that patients have viable support systems at home. Case managers also can explain patients' care plans and help patients follow them.

FCHP is working with physician groups to ensure that hospital discharge instructions are sent directly into patients' electronic health records. As part of the initiative, primary care physicians will see patients within five days of hospital discharge.

## RESULTS

- ▶ The program has been well-received by doctors and patients, and FCHP is evaluating the program for potential expansion. Preliminary findings suggest that it is having a positive impact on patient satisfaction and preventable hospital readmissions.

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*For more information, contact:*

Leslie Fish, M.D.  
Senior Director of Pharmacy Services  
Fallon Community Health Plan  
(508) 368-9660  
Leslie.fish@fchp.org

Elizabeth Malko, M.D.  
Chief Medical Officer  
Fallon Community Health Plan  
(508) 368-9813  
Elizabeth.malko@fchp.org



MICHIGAN

# The Heart Failure Readmission Program

## PROGRAM AT A GLANCE

### Goals:

- ▶ Reduce preventable hospital readmissions among members with chronic conditions.

### Key Strategies:

- ▶ Use clinical information systems to track members with chronic conditions who are discharged from hospitals.
- ▶ Have nurse health coaches contact members at high risk of readmission within 48 hours of hospital discharge to review medications; ensure that they receive home care as ordered; make doctor's appointments and arrange for transportation as needed.
- ▶ Set up a post-discharge home care visit to help patients identify symptoms requiring immediate action; teach patients how to take their medications correctly; and consult with doctors by phone to ensure that drug regimens are safe and effective.
- ▶ Link patients with Health Alliance Plan's (HAP's) HealthTrack disease management program.

### Results in Brief:

- ▶ From 2007-2008, hospital admissions related to heart failure fell by 37 percent among members with commercial HMO coverage and by 45 percent for Medicare Advantage members.

## BACKGROUND

In response to high costs related to avoidable hospital readmissions among members with heart failure, Health Alliance Plan enhanced its disease management program in 2007 by doing additional outreach to members discharged from hospitals with heart failure, chronic obstructive pulmonary disease, coronary artery disease, and asthma. In 2009, HAP added nursing staff to its disease management team and began collaborating with Henry Ford Home Health Care.

## APPROACH

### *Post-Discharge Follow-Up Calls*

HAP's clinical information system notifies nurse health coaches automatically when members with heart failure are discharged from hospitals, and the system flags members whose diagnoses suggest that they are at high risk of readmission. Health coaches contact members at high risk within 48 hours of hospital discharge to: ensure that they have received home health services as ordered; review medications; check whether they have follow-up appointments with primary care physicians; make appointments; and arrange for transportation as needed.

### *In-Person Visits to Review Medications*

To help avoid the hospital readmissions that often result from errors in taking medications, HAP arranges for in-person medication consultations by Henry Ford Home Health Care nurses. During visits to patients' homes, nurses explain their prescriptions, check for duplication, and consult by phone with doctors to ensure that drug regimens are safe and effective. HAP has found that it can take five to ten sessions—through a combination of phone and in-person meetings with members—to ensure that medication regimens are safe and that members are taking medications correctly.

### *Link with HAP's HealthTrack Program*

When home care nurses complete their medication reviews, they encourage patients to enroll in HAP's HealthTrack disease management program and can facilitate the enrollment process. Through this program, patients have the chance to work with a multidisciplinary team of professionals, including nurse health coaches, behavioral health case managers, and pharmacists.

The program has two levels of health coaching support. Members with complex conditions receive weekly phone calls from nurse health coaches, who help them set health improvement goals, develop action plans, make appointments to consult with other professionals (e.g., nutritionists, behavioral health professionals, and pharmacists), and access



community resources (e.g., transportation services, Meals on Wheels). Based on their progress, members can enroll in the more self-directed component of the program. Members in the self-directed program receive bimonthly calls from nurses, who check on their health status and help them address needs. Members in either level of HealthTrack can contact the nurse at any time to ask questions or request help.

Each HealthTrack participant is offered a call from a behavioral health case manager, who conducts an assessment for depression and anxiety. Depending on results of the assessment, members may be referred to behavioral health specialists and can enroll in a depression disease management program. In addition, they can consult regularly by phone with the behavioral health case manager.

Nurses often arrange for patients taking multiple prescriptions to consult with clinical pharmacists, who can provide additional explanation, answer questions, and address issues related to duplication and safety.

Social workers from Henry Ford Home Health Care are available by phone or in person to help members with issues such as financial assistance and housing. The program's nurses communicate with physicians regularly to update them on members' health conditions and make appointments and adjustments to care plans as necessary.

### *In-Home Telemonitoring*

Each HealthTrack participant with heart failure, diabetes, or chronic obstructive pulmonary disease has the option of receiving an in-home telemonitoring device called the

Health Buddy. The Health Buddy connects with members' phone lines to relay daily weight, blood sugar, and other key indicators to HAP's nurse health coaches. These readings provide early warnings of worsening health conditions so that patients can receive prompt medical attention and avoid emergencies. In addition, nurses teach program participants to recognize early warning signs so that they know when to contact their doctors.

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## RESULTS

- ▶ From 2007-2008, hospital admissions related to heart failure dropped by:
  - 37 percent for members with commercial HMO coverage.
  - 45 percent for Medicare Advantage members.

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### *For more information, contact:*

Pat Slone  
Manager, Clinical Care Management  
Health Alliance Plan  
(313) 664-8235  
pslone@hap.org

# The Post-Hospital Transition Program

## PROGRAM AT A GLANCE

### Goals:

- ▶ To reduce preventable hospital readmissions among patients with complex health conditions.

### Key Strategies:

- ▶ Have Humana nurses contact patients within 72 hours of discharge from hospitals or skilled nursing facilities (SNFs) to ask whether they: understand their health conditions and medications; have follow-up visits scheduled with their primary care physicians (PCPs); need durable medical equipment (DME) and/or home care; and know whom to call for help and when.
- ▶ Arrange for patients to receive any of the items or services they need following hospital or SNF discharge.
- ▶ Connect patients who have ongoing, complex needs with Humana's case management nurses, who help them access medical, social, and/or behavioral health services.

## BACKGROUND

Humana launched the Post-Hospital Transition Program in 2009 for members with Medicare and commercial coverage. The health plan is expanding the program throughout 2010. Currently, the program focuses on patients at the highest risk of hospital readmission, who include: those with congestive heart failure, chronic obstructive pulmonary disease, end-stage renal disease, or pneumonia; patients who were admitted due to heart attack; patients hospitalized solely for observation or testing; and those being discharged from skilled nursing facilities to home. Ultimately the initiative will include all Medicare members discharged from hospitals to home.

## APPROACH

Humana nurses contact patients within 72 hours of hospital or SNF discharge. Most of these contacts are by phone, but when the health plan's predictive modeling determines that patients are at high risk of readmission, nurses conduct home visits. During their conversations with patients, nurses ask whether they: understand their medications and can obtain and take them; understand their health conditions; have follow-up visits scheduled with their primary care physicians; need durable medical equipment, home care, or other assistance; and know whom to call for help and when. Nurses give patients a toll-free phone number that they can call on a 24/7 basis to reach a nurse.

Nurses address any needs identified during these discussions. For example, they may provide patients with more information

about their health conditions and medications; they may set up PCP appointments; and they may help patients obtain wheelchairs, walkers, and other equipment.

If patients have long-term, ongoing needs (e.g., for financial assistance or behavioral health) nurses help them enroll in Humana's case management program. As part of this program, nurse case managers contact members by phone on a weekly basis—and more often as needed—for at least 90 days to help them access the full range of medical, behavioral, and social services necessary to help them make smooth transitions from hospitals or SNFs to home.

## RESULTS

- ▶ Preliminary research on a limited population suggests that 30-day readmission rates were lower among patients receiving post-discharge assessments than among those that did not. Humana is now in the process of comparing readmission rates among larger groups of patients over varying lengths of time. Results will be available in 2011.

### *For more information, contact:*

Philip Painter, M.D.  
Chief Medical Officer  
Humana Health Guidance Organization  
Humana Inc.  
(312) 307-0759  
ppainter@humana.com

# The Transitional Case Management Program

## PROGRAM AT A GLANCE

### Goals:

- ▶ To increase outpatient follow-up visits among patients with specified health conditions who are discharged from hospitals.
- ▶ To reduce preventable hospital readmissions and emergency room visits.
- ▶ To increase members' engagement and enrollment in case management.

### Key Strategies:

- ▶ Have nurses or social workers visit members in hospitals to:
  - Describe the case management services they can receive upon discharge.
  - Ensure that they schedule follow-up visits with primary care physicians and take prescribed medications.
  - Develop personal rapport with patients so that they feel comfortable with subsequent interactions.
- ▶ Following hospital discharge:
  - Have nurse case managers contact members by phone to assess their functional capacity and needs.
  - Provide the full range of case management services to arrange for medical care and help members access community resources (e.g., support groups, transportation), disease management programs, home health services, and durable medical equipment.

### Results in Brief:

- ▶ Based on their average health risk scores, patients who were visited by social workers in hospitals during the program's pilot phase were predicted to be 5.7 percent more likely to be readmitted during the study period in 2007-2008 than those not visited. However, in fact, the readmission rate during the study period among patients receiving the visits was 5 percent lower than among those who did not. Thus the pilot program was associated with a 10.7 percent effective reduction in readmissions.
- ▶ The pilot program achieved a return on investment of 2.6:1 from September 2007 to May 2008.

## BACKGROUND

From September 2007 to May 2008, Independence Blue Cross conducted the Transitional Case Management Pilot Program to help members dually eligible for Medicare and Medicaid transition safely from hospital to home. Based on the success of the pilot, Independence Blue Cross expanded and re-launched the program in 2009 and 2010 to include all members with Medicare Advantage and some with commercial coverage who had congestive heart failure; diabetes; pneumonia; chronic obstructive pulmonary disease; atrial fibrillation; syncope and collapse; dehydration; cellulitis of extremities; and/or gastrointestinal bleeding. Approximately 400 patients in a total of three hospitals will receive services through the program in 2010.

## APPROACH

### *Inpatient Visits*

During the pilot phase of the initiative, social workers visited

dually eligible Medicare/Medicaid members in hospitals to help them schedule post-discharge follow-up visits with physicians; ensure that they took medications as recommended; and describe the case management and subsidized transportation services available to them. Prior to discharge, social workers gave patients information sheets with their contact information, along with reminders to schedule physician visits and take medications as prescribed.

Under the expanded version of the program, registered nurses visit hospitalized patients with the targeted conditions. Nurses work with members to provide support and education and help them access the items and services needed to follow their care plans.

### *Post-Discharge Follow-Up Calls and Assistance*

Independence Blue Cross's nurse case managers and social workers contact patients by phone following hospital discharge to review hospital discharge instructions and identify barriers to following care plans. They help members

## PENNSYLVANIA

schedule doctor visits and determine if they need help obtaining medications. In addition, program staff conduct surveys to assess members' cognitive and language abilities; functional limitations; the extent to which they are taking medications as prescribed; transportation needs; and end-of-life planning.

Based on results of these assessments, case managers and social workers help members develop care plans to achieve optimal health and well-being. Case managers explain patients' diagnoses and discuss the importance of taking medication as prescribed. They also help patients address symptoms and side effects of treatment; link members with support groups and other community resources; and arrange for the medical, behavioral health, and social services they need. For example, case managers may help members apply for financial assistance with medications, access home health services, obtain durable medical equipment, and develop advance directives.

On average, members receive case management services by phone for 90-120 days following discharge. The frequency of contacts depends on patients' needs and the severity of their conditions. Generally, case managers contact members on a weekly basis in the immediate post-discharge period.

## RESULTS

- ▶ An evaluation of the pilot phase of the program found that:
  - Whereas 11.5 percent of patients who did not receive hospital visits from social workers were enrolled in post-discharge case management, 41.5 percent of patients who received social worker visits in hospitals were enrolled in case management following discharge.

- Based on their average health risk scores, patients who were visited by social workers in hospitals during the program's pilot phase were predicted to be 5.7 percent more likely to be readmitted during the study period in 2007-2008 than those not visited. However, in fact, the readmission rate during the study period among patients receiving the visits was 5 percent lower than among those who did not. Thus the pilot program was associated with a 10.7 percent effective reduction in readmissions.
- The pilot program achieved a return on investment of 2.6:1 from September 2007 to May 2008.

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### *For more information, contact:*

Diana Lehman  
Director of Case Management  
Independence Blue Cross  
(215) 241-4623  
Diana.lehman@ibx.com

Alan Adler, M.D.  
Senior Medical Director  
Independence Blue Cross  
(215) 241-4623  
Alan.Adler@ibx.com



# The Transitions-in-Care Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ To help patients transition safely from hospitals to home and reduce preventable readmissions.

### Key Strategies:

- ▶ Interview patients, family members, doctors, nurses, and other hospital and nursing home staff about their experiences with hospital-to-home transitions.
- ▶ Convene meetings of front-line clinical and administrative staff to analyze important aspects of successful hospital-to-home transitions and discuss strategies for improvement.
- ▶ Test alternative improvement strategies.
- ▶ Implement process changes to improve health care quality and increase patient satisfaction.
- ▶ Develop standardized measures to evaluate different versions of the program in each Kaiser service region.

### Results in Brief:

- ▶ Results vary by region. In some medical centers, patient satisfaction has increased; preventable hospital admissions have declined; and the percent of patients with doctors' appointments within five days of hospital discharge has improved.
- ▶ Kaiser Permanente is in the process of measuring and comparing 30-day readmission rates across all of its hospitals.

## BACKGROUND

To gain a deeper understanding of members' experiences with care, Kaiser Permanente conducted extensive ethnographic assessments from 2008-2009. As part of the research process, Kaiser staff interviewed hundreds of patients, family members, doctors, nurses, and other staff in hospitals and skilled nursing facilities. In addition, Kaiser staff observed how patients were obtaining care and how health care professionals performed their work.

During the interviews, Kaiser asked patients about their experiences with hospital-to-home transitions, what worked for them, what was not working well, what they needed at home, and how they were managing their conditions. They asked patients to identify areas in which Kaiser could improve the transition process. Kaiser has captured the information gathered through its research in a series of videos called "Voices of Our Members."

The research identified many opportunities to improve members' experiences in the transition process. Sometimes there were large gaps between patients' hospital discharges and their first follow-up visits with primary care physicians. For example, patients did not always understand their discharge instructions and therefore did not follow them. Medications on

the lists received at hospital discharge did not always match the medications patients had been taking at home. Patients sometimes did not know what to do in these situations or whom to contact at Kaiser for help.

To promote patient safety and health during the transition from hospital to home, Kaiser began the Transitions in Care program in 2008.

## APPROACH

### *Redesigning the Transition Process*

As a first step in redesigning the transition process, Kaiser Permanente convened a series of meetings for 70 front-line clinical and administrative staff, physicians and health plan leaders, patients, and caregivers. During these meetings, staff discussed problems with transition procedures, and they brainstormed about potential changes. For example, Kaiser Permanente staff noted that patients leaving hospitals asked a lot of questions about their medication instructions and added extensive handwritten notes in the margins to describe instructions in layperson's terms. Therefore, staff suggested rewriting instructions in non-clinical language, such as, "I take this medication for my heart, and I take it in the morning."

Also as part of this discussion, a home health nurse noted that the medication lists that Kaiser sent home often did not match

## CALIFORNIA

the medications that patients were actually taking. A Kaiser pharmacist therefore suggested that the nurse call him from patient homes to review medications so he could check them against patients' electronic health records and prevent errors.

Kaiser Permanente provided grants to physician groups in three of its regions for demonstration projects to test these and other techniques for improvement.

### *Highlighting Critical Elements of Care Transitions*

Based on outcomes of the demonstrations, Kaiser identified five critical elements of successful care transitions. These include: assessments of patient and caregiver needs; care plans; medication management; timely exchange of health information; and proactive follow-up care. Kaiser Permanente medical groups subsequently have created hospital-to-home transition programs that incorporate these elements in a variety of ways. All of these programs seek to address unmet patient needs; information needs of health care practitioners; and medication-related errors.

### *Enhancing the Transition Process*

Changes implemented at Kaiser hospitals and medical groups have included:

- ▶ Standard discharge summaries sent to primary care physicians when patients leave the hospital;
- ▶ Follow-up appointments with primary care physicians within five days of hospital discharge;
- ▶ Nurse follow-up by phone within 48 hours of hospital discharge;
- ▶ Post-discharge home visits for patients at high-risk of readmission, regardless of whether they are homebound;
- ▶ Review of all patient medications by clinical pharmacists;
- ▶ Care plans incorporated in patients' electronic medical records;
- ▶ Medication lists written in layperson's language;
- ▶ "Discharge advocates" to help identify patient needs prior to hospital discharge and coordinate post-hospital care; and
- ▶ Readmission diagnostic tools, administered through patient and physician interviews, to explore reasons behind readmissions and identify additional areas for improvement.

## RESULTS

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- ▶ Since the program's implementation, patient satisfaction has increased; preventable hospital admissions have declined; and the percent of patients with doctors' appointments within five days of hospital discharge has improved. Specific results vary by region.

For example:

- The proportion of patients who rated their overall experience in one Kaiser hospital as a "9" or "10" rose from 56 percent to 72 percent over a six-month period.
- One Kaiser medical center reduced 30-day readmission rates for heart failure patients from 14 percent to 9 percent in six months.
- Two Kaiser medical centers increased the proportion of patients with doctor appointments within five days of hospital discharge from 42 percent to 57 percent of all discharges within six months.
- Kaiser is in the process of measuring and comparing 30-day readmission rates across all of its hospitals.

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### *For more information, contact:*

Carol Barnes  
Principal Program Consultant  
Care Management Institute  
Kaiser Permanente  
(720) 384-6737  
carol.ann.barnes@kp.org



# The Acute Care Transitions Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ To help Medicaid members effectively navigate the health care system following hospitalization or emergency room visits.

### Key Strategies:

- ▶ Arrange for:
  - Keystone Mercy Health Plan Acute Care Transition (ACT) case managers to meet with members who have serious health conditions in the hospital or emergency room to assess their needs and identify potential barriers to care.
  - Keystone Mercy Health Plan care coordinators to contact members with serious health conditions by phone following hospital discharge to: provide information about their conditions; explain their medications; discuss the importance of regular visits to primary care physicians; and help patients overcome barriers to following care plans.
  - A Rapid Response and Outreach Team (RROT) to remind patients of upcoming appointments and help them quickly access durable medical equipment; transportation; medications; financial assistance; behavioral health; Meals on Wheels; and other community resources.

## BACKGROUND

In an effort to improve care coordination following hospital discharge, Keystone Mercy Health Plan created the Acute Care Transition Program in 2009. The program is offered to Keystone Mercy members—all of whom are Medicaid recipients—in two network hospitals. Keystone Mercy plans to expand the program to additional hospitals and health systems by the end of 2010.

## APPROACH

### *Post-Emergency Room Follow-Up with Primary Care Physicians*

Every day, Keystone Mercy's ACT case manager receives a list of members who have been admitted to hospitals or visited the emergency room in the past 24 hours. Case managers notify primary care physicians when their patients have visited emergency rooms, and they help members set up follow-up appointments with PCPs.

### *Care Coordination for Members with Serious Illnesses*

ACT case managers conduct in-person interviews with members who have the most serious health conditions (e.g., heart failure, diabetes, asthma, and chronic obstructive pulmonary disease) while they are in the hospital. During these meetings, case managers assess members' needs and the extent to which they understand their health conditions.

Case managers also identify potential barriers to care (e.g., lack of transportation).

Within 48 hours of hospital discharge, ACT case managers send patients' discharge instructions to their primary care physicians. If a member had been receiving case management services from Keystone Mercy prior to hospitalization, the ACT case manager notifies his or her assigned case manager of the inpatient admission to ensure timely follow-up.

### *The Rapid Response and Outreach Team*

Members with serious health conditions who had not previously been receiving case management services are paired with care coordinators from Keystone Mercy's Rapid Response and Outreach Team. The ACT case manager shares information with care coordinators about members' anticipated needs following discharge. Within two days, care coordinators contact members by phone to: provide information about their conditions; explain their medications; discuss the importance of regular visits to primary care physicians; and help patients overcome barriers to following care plans (e.g., by making doctors' appointments and arranging for transportation).

Care coordinators contact members regularly, at frequencies according to their needs. Members can continue to receive assistance for as long as necessary, and some have remained in the program for more than a year.

Depending on their needs, members may receive additional help from clinical social workers, nurses and non-clinical technicians in the RROT. RROT staff can help patients quickly access durable medical equipment; transportation; medications; financial assistance; behavioral health; Meals on Wheels; and other community resources. RROT professionals contact members to remind them of upcoming appointments, and they ensure that members have all preventive care tests and procedures recommended for their age and health conditions. RROT staff can accompany members to appointments as necessary.

Members can reach the RROT during extended business hours, and they can contact the 24/7 Nurse Line for support or assistance at any time. RROT staff work with members for up to four weeks following their initial contacts to ensure that all needs have been met and that they have visited doctors as scheduled.

### RESULTS

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- ▶ Keystone Mercy is evaluating the program and expects to release results by the end of 2010.

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*For more information, contact:*

Keith Eckert  
Associate Vice President, Corporate Communications  
Keystone Mercy Health Plan  
(215) 863-6762  
keith.eckert@kmhp.com

# The Nurse Care Coordinator Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ To ensure smooth transitions from hospital to home and reduce preventable readmissions.

### Key Strategies:

- ▶ Place nurse case managers in hospitals, as well as skilled nursing and rehabilitation facilities, to address gaps in care, discuss discharge plans, identify post-discharge needs, and coordinate with health plan staff to obtain needed items and services.
- ▶ Have nurses contact patients within 48 hours of hospital discharge to review medications, ensure that discharge plans are being followed, and address any outstanding post-discharge needs.
- ▶ Provide case management services for patients with chronic conditions and complex, long-term needs.

### Results in Brief:

- ▶ As of January 2010, the 30-day readmission rate for Medicare Advantage members was 13 percent, and the overall 30-day readmission rate was 6.8 percent.

## BACKGROUND

To reduce the disruptions to patients' lives and the high costs associated with hospital readmissions, Presbyterian Health Plan launched the Nurse Care Coordinator Program in 2008. The health plan initially placed nurses on site at two large metropolitan hospitals, as well as 11 skilled nursing and one rehabilitation facility, and it subsequently expanded the program to include an additional hospital facility in Santa Fe, New Mexico. The program is available to patients with Medicare, Medicaid, and commercial coverage.

## APPROACH

### *In-Person Meetings and Phone Calls Prior to Discharge*

Program nurses meet with patients admitted to participating hospitals, skilled nursing facilities (SNFs), and rehabilitation facilities to determine whether their needs are being met and address any gaps in care. Prior to discharge, nurses meet again with patients to discuss their discharge plans and identify needs for home health or home medical equipment. Nurses work with Presbyterian staff to obtain needed items and services for patients. In Presbyterian network hospitals with high patient volumes that do not have on-site nurse care coordinators, patients receive phone calls from nurses to review discharge plans and address needs.

### *Post-Discharge Follow-Up Calls*

Within 48 hours of discharge from participating hospitals, SNFs, and rehabilitation facilities, nurses contact patients by phone to review their medications, ask whether they have filled prescriptions, and check for duplicative combinations. Nurses help patients access their medications as needed, and they contact physicians to address issues such as prescription drug duplication and the potential for adverse interactions. Nurses check to ensure that discharge plans are being followed, doctor appointments are scheduled within 30 days, and all recommended post-discharge services (e.g., home safety evaluations) are being provided. They address any

outstanding post-discharge needs and give patients their phone numbers to call at any time with questions or concerns.

### *Long-Term Assistance from Nurse Case Managers*

Patients with chronic conditions and complex, long-term needs are paired with outpatient nurse case managers. Case managers coordinate care provided by multiple clinicians, and they can help patients access transportation, financial assistance, and home medical equipment.

### *Contact with Skilled Nursing and Rehabilitation Facilities*

When a patient is scheduled to be discharged from a hospital to a skilled nursing or rehabilitation facility, Presbyterian nurses contact facility staff to ensure that they are aware of the upcoming admission and to review the discharge plan.

## RESULTS

- ▶ From 2008 to 2009, the number of inpatient bed days per thousand for all Presbyterian members (including those in Medicare Advantage plans) fell from 330 to 315.
- ▶ In 2009, the 30-day readmission rate among Medicare Advantage members was 13 percent, and the overall 30-day readmission rate (for members with all coverage types) was 8.6 percent.
- ▶ As of January 2010, the 30-day readmission rate for Medicare Advantage members remained at 13 percent, and the overall 30-day readmission rate was 6.8 percent.

### *For more information, contact:*

Paula Casey  
Clinical Director, Inpatient and Recovery Services  
Presbyterian Health Plan  
(505) 923-5851  
pcasey@phs.org

# The Care Transitions Program

## PROGRAM AT A GLANCE

### Goals:

- ▶ To help patients transition successfully from hospital to home and reduce preventable hospital readmissions.

### Key Strategies:

- ▶ Have nurses and social workers contact members in the hospital and at specified intervals following discharge to answer questions and help with medications, explain what to do if symptoms worsen, help patients reach personal health goals, and offer tools for drafting advance directives.
- ▶ Ensure that patients have doctor visits within seven days of hospital discharge and that doctors are aware of all medications that their patients are taking.
- ▶ Provide general information about the program to all members, staff, and physician groups.

## BACKGROUND

SCAN Health Plan was an early adopter of the Care Transitions model of care in 2005, and it subsequently added the initiative to its suite of case management programs for members at high risk of hospitalization. The program serves approximately 7,500 patients, including those with Medicare, and dual Medicare/Medicaid eligibility.

## APPROACH

### *Early Contact with Hospitalized Patients*

Nurses and social workers on SCAN's Care Transitions team contact hospitalized patients by phone within 48 hours of admission. During this call, they explain the program and ask members if they would like to participate. Team members also explain members' hospital discharge instructions and answer any questions they have.

Members who decide to participate in the program receive welcome packets when they arrive home that include: brochures with information about medications; medication logs; refrigerator magnets with phone numbers for SCAN and a 24-hour nurse line; and a brightly colored form that allows members to record personal health information, such as their diagnoses, upcoming doctor visits, and questions for their doctors.

### *Transition Coaching*

Within two, seven, and 14 days of hospital discharge, SCAN arranges for nurses and social workers trained as transition coaches to contact members by phone to help with their post-discharge needs. In the initial call, coaches ask about patients' personal health goals for the upcoming 30 days. Subsequently

they help patients take the steps necessary to manage their health conditions and achieve these goals.

### *Medication Review and Follow-Up with Primary Care Physicians*

As part of the process, transition coaches explain patients' medications and check for duplication, side effects, and dangerous combinations. SCAN's pharmacy staff and transition coaches help patients overcome barriers to taking medications as recommended. Pharmacy staff may consult with patients directly or work with physicians to modify medication regimens so that patients can follow them more easily.

Health coaches ensure that patients have primary care physicians (PCP) visits within seven days of discharge and can make appointments on patients' behalf. Coaches provide patients with their prescription records, and they direct patients to take these records—along with all of their medications—to their doctor visits for review.

### *Identification of Red Flags and Primary Care Follow-Up*

Health coaches teach patients about warning signs and symptoms of worsening health conditions and make sure they know when to contact their PCPs, when to seek urgent care, when to go to emergency rooms, and when to call SCAN's 24-hour nurse line.

### *Support for Drafting Advance Directives*

During their conversations with patients, health coaches ask if they have drafted advance directives and designated health care proxies. If not, coaches offer them information and tools to document their preferences.

### *Case Management for Long-Term Needs*

Patients with complex conditions who need assistance on an ongoing basis are paired with nurse case managers, who help them access a variety of medical, behavioral health, and social services.

### *Education for Patients, Staff, and Physicians*

SCAN publicizes the Care Transitions program in its member newsletter, in its on-hold phone message, and in informational materials sent to members and families. All SCAN staff who have contact with members take responsibility for providing education about care transitions procedures so that members are prepared for the possibility of hospitalization in the future.

Care Transitions staff have been meeting with medical groups to explain the model and describe the steps involved in implementation. SCAN offers continuing medical education credits for physicians who participate in the information

sessions. The health plan's physician Web site includes tools and information about the program, and some medical groups have taken over responsibility for implementing it.

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## RESULTS

- ▶ SCAN is in the process of conducting member and caregiver satisfaction surveys, and results will be available in Fall 2010.

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### *For more information, contact:*

Jodi Cohn, Dr.P.H.  
Research Director, Geriatric Practice Innovation  
SCAN Health Plan®  
(562) 989-4442  
jcohn@scanhealthplan.com

# The Welcome Home Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ To improve patients' experiences during care transitions and reduce preventable hospital readmissions.

### Key Strategies:

- ▶ Arrange for follow-up phone calls to members at high risk of readmission within two weeks of hospital discharge.
- ▶ Have WellPoint nurses address any needs identified in post-discharge calls and provide ongoing care management for members with complex needs.

### Results in Brief:

- ▶ From October 2008-January 2010, the 30-day readmission rate for Medicare Advantage PPO and HMO members in California and Georgia contacted through the program was 12 percent, compared with 16 percent for Medicare Advantage members whom WellPoint was not able to reach through post-discharge follow-up calls.

## BACKGROUND

To improve patients' experiences during care transitions and reduce preventable hospital readmissions, WellPoint launched the Welcome Home Program within its Custom Care Connections care management initiative in 2008. The program initially was limited to Medicare Advantage members, and subsequently it was expanded to include individuals with Medicaid and commercial coverage.

## APPROACH

Within two weeks of hospital discharge, members receive phone calls from customer service staff, who ask a series of questions to identify their medical and psychosocial needs. For example, patients are asked whether they: have enough help at home; have follow-up appointments with their physicians; understand their medications; are able to follow their discharge instructions; have received home care and medical equipment as prescribed; are having nausea, vomiting, difficulty breathing or completing daily activities; are feeling down or depressed; and/or have certain chronic conditions (e.g., diabetes, congestive heart failure, lung disease, asthma, or multiple sclerosis).

Members who answer "yes" to any of the questions are transferred directly to nurses or are scheduled for follow-up calls. During these conversations, nurses address patients' short-term and long-term needs. For example, they can explain patients' medications and discuss potential side

effects; work with physicians to coordinate lab tests; make patients aware of symptoms to watch for and let them know when they should get help; help members access transportation; and have medical equipment repaired or replaced. Patients with complex conditions and needs are paired with nurse case managers for ongoing assistance.

## RESULTS

- ▶ From October 2008-January 2010, the 30-day readmission rate for Medicare Advantage PPO and HMO members in California and Georgia contacted through the program was 12 percent, compared with 16 percent for Medicare Advantage members whom WellPoint was not able to reach through post-discharge follow-up calls.

### *For more information, contact:*

Jerry Slowey  
Staff Vice President, Public Relations  
WellPoint, Inc.  
(805) 557-6754  
Jerry.slowey@wellpoint.com





## Improving the Quality of Life for Patients at High Risk

Patients with chronic conditions often face a multitude of challenges, such as how to follow drug regimens that may include 10 or more prescriptions, how to travel to appointments with multiple specialists, and how to afford their rent and home heating for the winter. Without help, these patients are at high risk of complications and medical emergencies leading to repeated hospitalizations.

To help patients overcome these challenges and embark on a path toward better health, health plans provide a life line. Case managers—who typically are nurses—contact patients to assess their needs, help them set health goals, and provide extensive, ongoing support to allow them to reach these goals. Case managers teach patients about their health conditions, help them make sense of their medications, and help them follow diet and exercise programs. In addition, they can arrange for installation of home medical equipment, help patients apply for financial assistance, set up Meals on Wheels programs, make doctor’s appointments, and ensure that patients have access to affordable transportation.

Nurse case managers check in regularly with patients, who can contact them at any time for help. As they work together to achieve goals, nurses and patients often form lasting bonds. These friendships take on added meaning for patients who otherwise would be isolated and alone.

This chapter highlights several examples of health plans’ initiatives to improve the quality of life for patients at high risk of hospitalization.



# The Chronic Health Improvement Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ To help patients with chronic conditions receive timely outpatient care.

### Key Strategies:

- ▶ Conduct health risk assessments to identify patients' medical, behavioral health, and financial needs.
- ▶ Develop comprehensive care plans and link patients with case management and community-based services.
- ▶ Call patients regularly so that nurses can monitor their health conditions and help them access needed care.

## BACKGROUND

In response to finding that patients with chronic conditions accounted for a disproportionate share of preventable hospital admissions, Cigna Medical Group established the Chronic Health Improvement Program in 2006. The program is for patients who have congestive heart failure with diabetes and/or chronic obstructive pulmonary disease (COPD). More than 80 percent of program participants are Medicare Advantage beneficiaries.

## APPROACH

### *Outreach to Primary Care Physicians*

Cigna Medical Group staff contact primary care physicians whose patients have the targeted conditions, and they discuss the positive impact the program can have on patients' health. The program receives referrals from physicians, nurse care coordinators, and other Cigna Medical Group staff.

The program's clinical team includes a hospitalist who also provides outpatient care, a board-certified cardiologist who practices internal medicine, nurses, a diabetes educator, and social workers.

### *Health Risk Assessments and Care Plans*

Once patients are enrolled in the program, they receive detailed health risk assessments to identify medical and behavioral health care needs, psychosocial challenges (e.g., depression, inability to travel to medical appointments), lack of effective medications, and financial issues that may make it difficult for them to access care and follow physicians' recommendations.

Based on information gathered through risk assessments, the clinical team develops care plans for patients to link them with the medical, behavioral health, community, and case management services they need. The care plan includes "sick day" contingencies so that patients know what to do and whom to call if they are not feeling well. Patients are urged to call their sick day contacts right away and not wait until symptoms worsen.

### *Regular Contact with Nurses*

Nurses call program participants once a week on average, and more often as needed, to monitor patients' health status and help them access the care they need. For example, if a COPD patient is experiencing increased shortness of breath, the nurse helps the patient make an appointment promptly with a pulmonary specialist. If a patient is having difficulty keeping diabetes under control, the nurse links him or her with a diabetes educator.

Nurses ensure that patients receive the treatments they need. They can order tests, coordinate with doctors to adjust medications, address psychosocial challenges, and teach patients about their conditions. Staff of the Chronic Health Improvement Program work closely with Cigna Medical Group's Home-Based Care and care coordination teams so that patients can access services from more than one of these programs in a seamless manner according to their needs.

## RESULTS

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- ▶ Cigna Medical Group is evaluating the program's impact on preventable admissions to hospitals and skilled nursing facilities. Results are expected in mid-2010.

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*For more information, contact:*

Robert Flores, M.D.  
Medical Director, Population Health  
Cigna Medical Group  
(602) 271-3725  
Robert.flores@cigna.com

# The High-Risk Care Management Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ Reduce preventable hospital admissions and readmissions among Medicare Advantage members with extensive health care needs.

### Key Strategies:

- ▶ Arrange for nurse care managers to:
  - Contact members by phone to assess their needs and discuss health care goals and priorities.
  - Provide ongoing support and assistance to help members make health and lifestyle changes to reach their goals.
- Help members access transportation, financial assistance, home health, medical equipment, and/or other items needed to follow care plans and medication regimens.

### Results in Brief:

- ▶ From 2006-2009, the program's return on investment was 3:1.

## BACKGROUND

To reduce preventable hospital admissions and readmissions among Medicare Advantage members with extensive health care needs, Tufts Health Plan partnered with Healthways to launch the High-Risk Care Management program in 2003. Approximately 2,500 members participate in the program.

## APPROACH

### *Member Outreach to Assess Needs and Goals*

Based on monthly claims analysis and predictive modeling, Healthways identifies members with extensive health care needs who are at the highest risk of hospital admissions and readmissions. Nurse care managers contact these members and offer the opportunity to enroll in the program.

Nurses conduct initial outreach calls to new program participants to gather demographic information; assess patients' health status; identify any cognitive and functional limitations; determine needs for transportation and financial assistance; and screen for depression. Nurses ask members to describe all of their medications, including dosages and frequencies, and they check for discrepancies between how patients are taking medications and how they were prescribed.

Following the clinical evaluation, members are asked to discuss their health goals and priorities. Often members are

motivated to improve their health so they can attend family gatherings such as weddings and graduations.

In subsequent conversations, nurses help members make the health and lifestyle changes (e.g., improving diet, increasing exercise, keeping doctor's appointments, and taking medications as prescribed) necessary to achieve these goals. The frequency of nurses' phone calls depends on members' health status and needs.

### *Ongoing Support and Assistance*

As they help members work toward their goals, nurse care managers can access a variety of products and services on members' behalf, including low-cost transportation; financial assistance for medications and other monthly expenses; home health care; and medical equipment—such as glucometers and pre-filled syringes—that may make it easier to follow care plans and medication regimens.

Program nurses form ongoing relationships with members and help them with psychosocial as well as medical needs. Members often discuss issues with nurses that they do not discuss with family members, often because they do not want to burden family members or because they are afraid that family members will move them into nursing homes. It is not uncommon for patients and nurse care managers to exchange holiday cards and photos of family members and pets.

On average, Medicare Advantage members remain in the High-Risk Care Management Program for 18 months. Individuals transition out of the program if they become independent to the point that they no longer need services or if they move into long-term care facilities or hospice.

## RESULTS

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- ▶ From 2006-2009, the program's return on investment was 3:1.
- ▶ From 2006-2007 (the last year in which members who had declined to participate in the program were used as a control group):
  - The number of hospital admissions per thousand among members participating in the program declined by 44 percent, compared to a one percent drop in admissions per thousand among members who declined to participate in the program.

- The number of emergency room visits among program participants fell by 6.2 percent, compared to a 1.6 percent drop among non-participants.
- The number of inpatient days per thousand among program participants dropped by 40 percent, whereas the number fell by 1 percent for non-participants.
- Total per-member per-month medical costs for program participants declined by 25 percent, whereas total costs rose by 7 percent among nonparticipating members.

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*For more information, contact:*

Jonathan Harding, M.D.  
Medical Director, Senior Products  
Tufts Health Plan  
(617) 923-5432  
Jonathan\_harding@tufts-health.com

# The Medicare Advantage High-Risk Case Management Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ Reduce preventable hospital admissions and readmissions among Medicare Advantage members with serious illnesses.

### Key Strategies:

- ▶ Nurses review members' health conditions and work with members and physicians to ensure that all of their health care needs are addressed.
- ▶ Nurses contact members by phone on a regular basis to:
  - Offer support.
  - Help members obtain needed medications and other treatments
  - Help with accessing products and services such as home health care, durable medical equipment, Meals on Wheels, and affordable sources of heating and air conditioning.

## BACKGROUND

To help Medicare Advantage members in Special Needs Plans who have serious illnesses avoid preventable hospital admissions and readmissions, UnitedHealthcare established the High-Risk Case Management program in 2007. Currently, about 8,000 members participate, and the health plan is expanding the program to all Medicare Advantage members who meet specified health criteria.

## APPROACH

### *Assessing Patients' Needs*

UnitedHealthcare identifies members for the program based on their risk of hospitalization, as determined through a Center for Medicare & Medicaid Services risk adjustment factor and ongoing health risk assessments. Health plan nurses review members' health conditions, including problems associated with aging. They coordinate with members and physicians to ensure that all of members' health care needs are addressed.

Nurses contact new program participants to check on their health status and needs, and to determine whether they are taking medications correctly, following care plans, and keeping doctor's appointments.

### *Providing Ongoing Assistance*

To help patients overcome barriers to care, nurses provide help with a wide range of issues. For example, they help members obtain needed medications and other treatments. They can obtain affordable home heating and air conditioning on patients' behalf. They can arrange for transportation to

doctor visits; coordinate care provided by multiple clinicians; help patients apply for financial assistance; arrange for Meals on Wheels; and access home health and durable medical equipment. Nurses work with family caregivers to help patients follow their care plans.

Nurses contact patients at least monthly, and more often as necessary. Patients can contact the program's nurses at any time to ask questions or request help. Members can remain in the program indefinitely.

## RESULTS

- ▶ More than half (51 percent) of people who are offered the opportunity to enroll participate in the program.
- ▶ Preliminary research suggests that from 2008-2009, the number of inpatient admissions among members participating in the program was 25 percent lower than among a similar population of members receiving traditional case management services.

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### *For more information, contact:*

Mark Leenay, M.D., M.S.  
Senior Vice President, Medicare Medical Management  
UnitedHealthcare  
(952) 931-5493  
Mark\_Leenay@uhc.com





## Caring for Frail Patients at Home

House calls are making a comeback—though in a different form than your grandparents remember. In today’s health care system, there is increasing realization that patients with multiple chronic conditions, who often are frail, have limited mobility, and have difficulty getting to the doctor on a regular basis, can benefit tremendously from home medical visits. During these visits, clinicians—who may be family doctors, internists, geriatricians, advanced-practice nurses—assess patients’ health conditions and evaluate the safety of their home environments; make sure patients can take medications correctly; and coordinate with primary care physicians to make sure that patients receive needed care in a timely manner.

These personal visits are comforting to patients and caregivers who may be socially isolated. Moreover, they help avoid medical emergencies, and they make it possible for patients with multiple chronic conditions to live safely in their homes for as long as they wish.



# The Physician Home Visiting Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ To help patients with extensive health care needs live safely at home.

### Key Strategies:

- ▶ Send physicians to the homes of patients most at risk of hospital readmission to assess needs and fill gaps in patient care.
- ▶ Coordinate with patients' primary care physicians on implementing patients' care plans.

## BACKGROUND

Due to concern about multiple hospital readmissions among patients in advanced stages of chronic illness, Blue Cross and Blue Shield of Florida implemented the Physician Home Visiting Program in 2009.

## APPROACH

The health plan uses predictive modeling software and claims analysis to determine which patients are most at risk of being readmitted to hospitals in the upcoming year. Nurse case managers contact these patients by phone to offer them the opportunity to enroll in the program. Physicians and case managers also can refer people. Blue Cross and Blue Shield of Florida obtains consent from patients' primary care physicians before enrolling their patients.

The program's physicians—who include family practitioners, internists, and geriatricians—conduct home visits with program participants at least monthly and more often as needed. During these visits, physicians evaluate patients' medications to identify duplicative or conflicting prescriptions; they assess the safety of patients' homes (e.g., to identify and eliminate items that represent fall risks); ask patients about their diets; and examine the adequacy of patients' social support systems.

Based on their assessments, physicians treat patients' overall medical needs and help fill gaps in care. For example, they may adjust medications to improve pain management, and they may provide wound care. Physicians also may order home medical equipment or home health services, and they may arrange for social workers to visit patients to address depression or other issues. They can consult with patients

about palliative care and provide referrals to hospice as needed.

## RESULTS

- ▶ The health plan is evaluating the program's impact on hospital admissions and readmissions and will release results by the end of 2010.

### *For more information, contact:*

Jonathan Gavras, M.D.  
Vice President, Delivery System, and Chief Medical Officer  
Blue Cross and Blue Shield of Florida  
(561) 242-1365  
Jonathan.gavras@bcbsfl.com



# The Home-Based Care Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ Improve health care for CIGNA HealthCare of Arizona Medicare Advantage individual customers who have complex needs and have difficulty reaching doctor's offices.

### Key Strategies:

- ▶ Send clinicians and social workers into patients' homes to develop care plans; monitor safety of home environments; check vital signs; help patients take medications correctly; and arrange for patients to access community services such as transportation and Meals on Wheels.
- ▶ Update primary care physicians (PCPs) on the health status of their homebound patients and on the care they are receiving through the program.

## BACKGROUND

In 2004, Cigna Medical Group conducted research to determine why some CIGNA HealthCare of Arizona Medicare Advantage individual customers had not visited their primary care physicians in the past year. Cigna Medical Group found that many of these patients were homebound, had complex medical needs, and were unable to access outpatient services. In response, Cigna Medical Group developed a team of physicians, nurse practitioners, physician assistants, registered nurses, licensed practical nurses, and social workers to visit patients' homes and serve as extensions of primary care physician offices when patients were not able to visit their doctors easily. The team also is available to visit the homes of patients with complex needs following hospital discharge.

## APPROACH

### *Outreach to Patients with Unmet Health Care Needs*

To identify patients for the program, Cigna Medical Group analyzes claims to identify Medicare Advantage individual customers with extensive health care needs who have not been to the doctor in the past year. Cigna Medical Group nurses contact these individuals to offer them the chance to enroll in the program. The program often receives referrals from physicians, Transition of Care Nurses, and hospital case managers.

During their first visit to a patient's home, the program's doctor and nurses assess his or her needs, develop care plans, and determine which professionals should make subsequent home visits. Often nurse practitioners and physician assistants provide the follow-up care.

### *A Variety of Home-Based Services*

The program's clinical team often conducts multiple home

visits over the course of several months. The duration of the program is flexible, depending on patients' needs. During their visits, clinicians check on whether patients are safe in their home environments; arrange for modifications necessary to protect safety; monitor vital signs; provide treatment (e.g., intramuscular antibiotics); review patients' prescriptions and help them take medications correctly; evaluate patients' nutritional needs; and coordinate with case managers and care coordinators to arrange for community services such as transportation and Meals on Wheels.

Team members coordinate with patients' primary care physicians, help patients arrange visits with PCPs, and keep PCPs informed of the care their patients are receiving through the program.

Individuals are discharged from the program if they no longer need home-based services and can transition back to their primary care physicians' offices. PCPs have the option of sending Home-Based Care teams back to their patients' homes as needed to provide additional care at any time.

## RESULTS

- ▶ Cigna Medical Group plans to complete an evaluation of the program's impact on preventable admissions to hospitals and skilled nursing facilities by mid-2010.

### *For more information, contact:*

Robert Flores, M.D.  
Medical Director, Population Health  
Cigna Medical Group  
(602) 271-3725  
Robert.flores@cigna.com

# The Home Run Program

## PROGRAM AT A GLANCE

### Goals:

- ▶ Improve the functional status and quality of life for frail, homebound Medicare Advantage members.
- ▶ Reduce preventable hospital admissions, readmissions, and emergency room visits.

### Key Strategies:

- ▶ Send geriatricians and nurses to patients' homes each month to assess their needs; help them follow care plans; and arrange for needed health care, equipment, and services.
- ▶ Hold monthly social gatherings for program participants.

## BACKGROUND

In an effort to expand services to patients at high risk of hospitalization, Fallon Community Health Plan (FCHP) launched the Home Run Program in 2009.

## APPROACH

### *Home Visits for Frail Medicare Advantage Members*

FCHP analyzes claims and uses predictive modeling software to identify Medicare Advantage members with chronic conditions who are at highest risk of complications and hospitalization. Nurses contact these members and offer them the opportunity to enroll in the program. Members also may be referred by nurse case managers and physicians. Currently, 150 Medicare Advantage members participate in the program.

Multidisciplinary teams that include a geriatrician and geriatric nurse practitioners visit patients' homes each month to assess their needs, check safety issues, and determine whether patients are following care plans. For example, they determine whether patients with heart failure have scales to check their weight each day and whether they are using salt with their meals. They check on whether patients with chronic obstructive pulmonary disease know how to use their oxygen equipment and are avoiding smoking.

Nurses also can make doctor's appointments, arrange for home care services, check whether patients are taking medications correctly, and set up medication reminder systems as needed.

Program participants can call the Home Run Program at any time for assistance. For example, if a health problem unexpectedly arises, patients can call to request help from

a nurse. Nurses can visit patient homes visit to ensure that patients are safe, and they coordinate with the Home Run Care team to address ongoing needs.

Patients can remain in the program until a major life change, for example, if they move into a skilled nursing facility, hospice, or Program of All Inclusive Care for the Elderly (PACE).

### *The Home Run Club*

Each month, program participants have the opportunity to attend gatherings of FCHP's Home Run Club. These events feature light meals, education, and social activities.

## RESULTS

- ▶ FCHP will be evaluating the program's impact on:
  - Patient satisfaction;
  - Emergency room use; and
  - Admissions and readmissions to hospitals and skilled nursing facilities.
- ▶ Findings will be available by the end of 2010.

### *For more information, contact:*

Patricia Zinkus  
Director, Case Management  
Fallon Community Health Plan  
(508) 368-9964  
patricia.zinkus@fchp.org

Susan Legacy  
Senior Manager, Care Management  
Fallon Community Health Plan  
(508) 368-9490  
susan.legacy@fchp.org

# Care Partners for Frail Elders

## PROGRAM AT A GLANCE

### Goal:

- ▶ To help frail Medicare Advantage members with chronic conditions avoid preventable complications and medical emergencies.

### Key Strategies:

- ▶ Arrange for nurses and social workers to visit frail patients at home to educate them about their health conditions, discuss treatment options, explain medications, and arrange for needed services.
- ▶ Update physicians about their patients' health status and needs.

### Results in Brief:

- ▶ Ninety-five percent of members are satisfied with the program.
- ▶ About 80 percent of members believe that the best part of the program is the information they receive about treatment options.

## BACKGROUND

To help frail Medicare Advantage members who were having difficulty living independently at home, Independent Health launched the Care Partners for Frail Elders initiative in 2008.

## APPROACH

### *Providing a Broad Range of In-Home Services*

Physicians, case managers, and health coaches refer members to the program. Once patients are enrolled, they receive initial in-home assessments from nurses and social workers to determine the full range of their needs. Subsequently, nurses and social workers visit patients' homes on a regular basis to check their health status, provide information about their health conditions and medications, and support them in following care plans. Nurses and social workers can arrange for home health care and in-home treatments (e.g., IV administration of Lasix), and they link patients with community resources such as transportation services, support groups, and financial assistance. They also help patients develop advance directives.

Nurses report to physicians regularly on their patients' health status. When patients have urgent health needs, nurses ensure that they obtain care quickly. Nurses and social workers can help arrange relocations to assisted living communities, as well as admissions to rehabilitation and skilled nursing facilities.

### *Keeping in Touch with Regular Visits and 24/7 Access*

Patients can remain in the program indefinitely and have as many home visits as necessary. Initially, nurses may visit patient homes once or twice a week, and subsequently, visits may be once a month. Nurses are available by phone on a 24/7 basis, and they can visit patients' homes on short notice.

## RESULTS

- ▶ Currently the program serves 240 Medicare Advantage members. Independent Health's surveys show that:
  - Ninety-five percent of members are satisfied with the program.
  - About 80 percent of members believe that the best part of the program is the information they receive about treatment options.
- ▶ In light of the program's success, Independent has expanded Care Partners to an adjacent county.

### *For more information, contact:*

Kathleen Mylotte, M.D.  
Associate Medical Director for Quality and Disease  
Management  
Independent Health Association  
(716) 635-3715  
kmylotte@independenthealth.com

# The Hospital at Home Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ To provide an alternative to traditional hospital care for Medicare Advantage members who meet specified health criteria.

### Key Strategies:

- ▶ Have emergency room doctors, primary care physicians, and home care staff identify patients who they believe would benefit from receiving hospital-level care at home.
- ▶ Provide home visits from doctors, nurses, home care aides and other professionals to meet patients' needs.
- ▶ Arrange for remote monitoring of key health indicators.

### Results in Brief:

- ▶ In 2010, nearly 96 percent of patients participating in program rate it as "very good" or "good."
- ▶ Services received through the program in 2009 cost approximately \$1,500 less than a comparable inpatient stay.

## BACKGROUND

To help prevent hospital-related complications and reduce hospital overcrowding, Presbyterian Home Healthcare created the Hospital at Home Program in 2008 in conjunction with Presbyterian Health Plan and Johns Hopkins University. The program is available to Medicare Advantage and Medicaid members with chronic obstructive pulmonary disease; congestive heart failure; pneumonia; cellulitis; deep-vein thrombosis; pulmonary embolism; complicated urinary tract infections; dehydration; nausea; and/or vomiting.

## APPROACH

### *Identifying Patients for the Program*

Emergency room doctors identify patients in emergency rooms who they believe are appropriate candidates for the program. Primary care physicians and home care staff also can refer patients. Physicians notify the program's nurse intake coordinator and physician, who conduct clinical evaluations to determine patients' potential to receive care safely and successfully at home. Depending on results of these evaluations, nurses meet with patients and their families to offer the option of receiving care at home rather than being admitted to the hospital.

### *Providing Equipment, Diagnostics, and Services*

If patients and families choose to participate, Presbyterian staff arranges for the delivery and set-up of home medical equipment (e.g., blood pressure cuffs, telemonitoring

equipment, intravenous machines), along with transportation, medications, and diagnostic testing at home. Presbyterian provides patients with services to help with bathing, dressing, eating, and walking, and a physician conducts daily home visits to evaluate their health conditions and needs. Program nurses complete detailed health assessments. Nurses and program physicians coordinate with patients' primary care physicians on their care and discharge. Patients use home monitoring equipment to weigh themselves and have their vital signs and other diagnostics (e.g., blood pressure, pulse, glucose levels) transmitted to their doctors.

In 2009, approximately 138 members participated in Hospital at Home. Patients remain in the program for an average of three days. By the end of 2010, the health plan will begin using a bundled payment system for the program's services.

## RESULTS

- ▶ Nearly 96 percent of patients participating in program in 2010 rate it as "very good" or "good."
- ▶ Services received through the program in 2009 cost approximately \$1,500 less than a comparable inpatient stay.

### *For more information, contact:*

Paula Casey  
Clinical Director, Inpatient and Recovery Services  
Presbyterian Health Plan  
(505) 923-5851  
pcasey@phs.org





## Helping Reduce Preventable Use of Emergency Rooms

People go to the emergency room for reasons as varied as patients themselves: Many are experiencing life-threatening chest pains. Others have trauma wounds from tragic accidents. Others feel they are too sick to go to the doctor and their health conditions worsen to the point of a medical emergency. Some have no regular source of primary care at all. And there are other reasons: adverse reactions to prescription drugs taken incorrectly due to confusion about doctor's orders; dangerous symptoms that were not addressed because the patient did not see a doctor soon enough after leaving the hospital; and lack of knowledge about safe and convenient ways to access urgent and after-hours care.

Emergency rooms are an essential part of the health care safety net for people experiencing life-threatening conditions. Yet in many cases, patients end up in ERs because they lacked timely access to or knowledge about primary and preventive care. Moreover, emergency rooms typically are not the safest place for many people to access care. Waits are long; patients are exposed to others with contagious illnesses; emergency room doctors are overburdened, and they often lack access to important information from patients' medical histories.

Health plans are using a number of strategies to address these issues: They are educating patients about when they should use emergency rooms. They are beefing up urgent care networks and providing information in doctors' offices about the locations, hours, and services offered by urgent care facilities. They are replacing central nurse triage call centers with local nurse advice lines that can guide patients to safe and convenient sources of urgent care in their communities, along with other local resources that can help them with issues such as transportation and financial assistance. And health plans' nurse case managers work closely with patients who have chronic conditions to access the care they need on an ongoing basis and in a timely manner to prevent medical emergencies.

This chapter reviews health plans' creative approaches to ensure that patients receive the urgent and emergency care they need in the setting best suited to provide timely, safe, and high-quality care.

# The Emergency Room Readmission Program

## PROGRAM AT A GLANCE

### Goal:

- ▶ Reduce the use of emergency rooms for non-emergency treatment.

### Key Strategies:

- ▶ Expand the health plan's network of urgent care facilities.
- ▶ Analyze claims on a monthly basis to determine which members have used emergency rooms three or more times in the past month for diagnoses that do not represent emergencies.
- ▶ Call patients who have used emergency rooms frequently for non-emergency diagnoses to let them know about urgent care facilities and link them with health care practitioners, case management, and disease management programs as needed.
- ▶ Provide members with information about safe and effective alternatives to emergency room care.

### Results in Brief:

- ▶ From 2007 to 2008, use of emergency rooms among the health plan's members declined by 3 percent.
- ▶ From 2008 to 2009, use of the emergency room among health plan members fell by an additional 5.5 percent.

## BACKGROUND

In response to increased use of emergency rooms for non-emergency diagnoses (e.g., upper respiratory infections, abdominal pain), Blue Cross and Blue Shield of Florida implemented the Emergency Room Readmission Program on a pilot basis in 2008. The program was implemented for all members in four Florida counties (with the exception of those covered by Medigap and the Federal Employee Health Benefits program).

## APPROACH

### *Expanding Access to Urgent Care*

To ensure that members could access care outside of regular business hours, Blue Cross and Blue Shield of Florida nearly doubled the size of its network of urgent care centers.

Whereas in 2007, the health plan contracted with 125 urgent care centers in 10 Florida counties, currently it contracts with 233 urgent care centers in 34 counties.

In conjunction with this change, Blue Cross and Blue Shield of Florida sent members brochures with information about urgent care facilities in their communities, including locations, hours of operation, and examples of situations in which urgent care would be a safe alternative to emergency rooms.

### *Linking Members with Health Care Practitioners*

Besides sending written materials, the health plan arranged for customer service staff to call members who had used the

emergency room three or more times in the past month for non-emergency diagnoses. During these calls, health plan staff told patients about the availability and hours for urgent care centers in their communities, asked if they needed to see a primary care physician or specialist, and provided phone numbers for health care practitioners as needed.

In addition, health plan nurses called people with chronic conditions who had used emergency rooms frequently to offer them the opportunity to enroll in case management and/or disease management programs. These programs help members overcome barriers to following physicians' care plans (e.g., lack of transportation or funds for prescriptions) so that medical emergencies can be avoided.

## RESULTS

- ▶ From 2007 to 2008, use of emergency rooms among the health plan's members declined by 3 percent.
- ▶ From 2008 to 2009, use of the emergency room among health plan members fell by an additional 5.5 percent.

### *For more information, contact:*

Jonathan Gavras, M.D.  
Vice President, Delivery System, and Chief Medical Officer  
Blue Cross and Blue Shield of Florida  
(561) 242-1365  
Jonathan.gavras@bcbsfl.com



# The Emergency Room Outreach Program

## PROGRAM AT A GLANCE

### Goals:

- ▶ Ensure that patients know when they should use emergency rooms.
- ▶ Reduce preventable use of emergency rooms for non-emergency care.
- ▶ Identify and address potential gaps in care following emergency room visits.

### Key Strategies:

- ▶ Increase the capacity of urgent care centers to address complex medical needs.
- ▶ Supplement a national nurse triage line with a locally-connected Cigna Medical Group nurse triage center to let patients know when they should go to the emergency room and inform them about local urgent care centers, same-day doctor's appointments, Cigna Medical Group's care coordinators, home-based care, and other assistance.
- ▶ Provide posters and brochures in primary care physicians' offices describing help available for urgent and emergency health care needs.
- ▶ Provide information about the program to emergency room doctors so they can link patients with needed services.

## BACKGROUND

From 2007-2008, emergency room use among CIGNA HealthCare of Arizona's Medicare Advantage individual customers was rising by seven percent annually, and Medicare Advantage individual customers who visited emergency rooms more than once in the past year were likely to be admitted to hospitals. In response to these trends, Cigna Medical Group began planning the Emergency Room Outreach Program.

## APPROACH

### *Research to Inform Program Design*

As a first step, Cigna Medical Group conducted research to determine why patients were using emergency rooms, what they experienced there, and whether they filled medications prescribed by emergency room physicians.

Cigna Medical Group found that most of its Medicare Advantage patients with urgent medical needs after regular business hours believed that emergency rooms were their only viable option and that they were too sick to obtain care elsewhere. Most of these individuals had not contacted CIGNA's national nurse triage line. Cigna Medical Group also found that patients often did not make follow-up appointments or obtain recommended prescriptions after being released from emergency rooms.

Based on these findings, Cigna Medical Group implemented the Emergency Room Outreach Program, which has five components: (1) outreach calls from nurses; (2) a locally-connected nurse triage center to supplement CIGNA's national triage line; (3) increased capacity for urgent care centers; (4) educational materials for doctor's offices; and (5) information for emergency room physicians.

### *Outreach Calls from Nurses*

Cigna Medical Group nurses contact patients within a day of their emergency room visits to talk about the health condition leading to the visit and to describe the availability of same-day doctors' appointments, the 24/7 nurse triage line, and Cigna Medical Group's three urgent care centers. Depending on patients' needs, nurses can schedule primary care physician (PCP) and specialty appointments and help them enroll in Cigna Medical Group's disease management, care coordination, case management, and/or Home-Based Care programs.

### *Enhanced Nurse Triage Services*

Prior to implementing the Emergency Room Outreach Program, Cigna Medical Group found that Medicare Advantage patients had needs for information and post-ER follow-up care that were not being met by the national nurse triage line.



To improve the quality of information available through the nurse triage line, Cigna Medical Group provided education to triage nurses on Cigna Medical Group programs and enabled them to connect directly to its care coordinators, available 24/7. Through the new triage service, Cigna Medical Group can help patients navigate the health care system; obtain emergency care quickly when needed; make doctor's appointments promptly; and access medications, home health services, medical equipment, and home-based care as needed.

### *Improved Urgent Care Capacity*

Also as part of the program, Cigna Medical Group publicized its urgent care centers' ability to address complex medical needs. Cigna Medical Group's urgent care centers, which are open during highest use hours, function at a high level and can offer patients rehydration, intravenous antibiotics, lab tests, X-rays, and other radiology services. Staff in Cigna Medical Group urgent care centers can access patients' electronic medical records to ensure that they incorporate information about allergies, adverse reactions, and other important medical history when providing or arranging care.

### *Brochures and Posters in Doctor's Offices*

Cigna Medical Group's research found that if patients knew they had someone to call for help and advice before going to the emergency room, they would have done so. Therefore, the organization is working to publicize the program among patients and physicians.

As a first step, Cigna Medical Group distributed posters and brochures to doctor's offices. These materials describe how to access help for urgent needs quickly, through sources such as the nurse triage line, urgent care centers, care coordinators, case managers, and the Home-Based Care program. In addition, the narrative directs patients to the emergency room if they are experiencing life-threatening symptoms (e.g., chest pains, difficulty breathing). The brochures, titled "What Do I Do When I'm Sick?" are distributed to all Medicare Advantage individual customers visiting PCPs' offices.

### *Information for Emergency Room Physicians*

Cigna Medical Group is providing emergency room physicians with information about the program so that they can link patients with Cigna Medical Group nurses or other staff who can help meet their needs.

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## RESULTS

- ▶ Cigna Medical Group is currently evaluating the program's effect on the number of urgent care and emergency room visits, and results are expected by mid-2010.

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### *For more information, contact:*

Robert Flores, M.D.  
Medical Director, Population Health  
Cigna Medical Group  
(602) 271-3725  
Robert.flores@cigna.com

# The Emergency Room Outreach Initiative

## PROGRAM AT A GLANCE

### Goal:

- ▶ Help find regular sources of care for people using emergency rooms frequently for non-emergency treatment.

### Key Strategies:

- ▶ Create a multidisciplinary care team to analyze reasons behind frequent emergency room use among some members.
- ▶ Contact members who use emergency rooms frequently for non-emergency diagnoses to address factors preventing them from obtaining ongoing care.
- ▶ Help members access medical care, case management, disease management, and other services as needed.

### Results in Brief:

- ▶ Within six months of the program's launch, emergency room use among participating members was 8 percent lower than among a control group.

## BACKGROUND

After finding that a significant proportion of members were receiving most or all of their health care in emergency rooms, EmblemHealth implemented an emergency room outreach initiative in 2009. The program focuses on the 400 health plan members who visit emergency rooms an average of 10 times per year. In 2009, these members—who had a combination of Medicare, Medicaid, and commercial HMO coverage—accounted for nearly 6,000 emergency room visits.

## APPROACH

### *Finding the Reasons Behind Frequent Emergency Room Use*

Each week, EmblemHealth's case management and medical management nurses, pharmacists, and behavioral health professionals meet to review a list of the health plan members who have visited emergency rooms the most frequently and determine the reasons behind these visits. The team divides up the member list and researches individual cases to identify factors associated with frequent emergency room use. Generally the team includes five to six EmblemHealth staff members, but sometimes the health plan may include up to six additional professionals with appropriate expertise.

Through this process, EmblemHealth has found that many frequent emergency room users have never visited their primary care physicians (PCPs), and PCPs do not know that these members are their patients. In 40 to 50 percent of

cases, members have unmet behavioral health needs. In other cases, members are not following their treatment plans, or treatment plans are not sufficient to meet their needs.

### *Helping Members Access Care*

Depending on individual needs and patterns of emergency room use, an EmblemHealth case management nurse, pharmacist, or behavioral health professional contacts members to offer assistance. Many of these contacts are by phone, but if members cannot be reached easily by phone, EmblemHealth sends professionals to their homes. EmblemHealth staff work with members to identify their medical, social service, behavioral health, and financial needs, and they link them with professionals and resources to help. For example, EmblemHealth staff may help members make appointments with PCPs and specialists. They may help people access home health or transportation services. Or they may help individuals enroll in disease management and access behavioral health services. In all cases, they ensure that members know when they *should* go to emergency rooms.

EmblemHealth staff also reach out to members' physicians, behavioral health care providers, and case managers to help ensure that members receive the services they need in a timely manner.

## NEW YORK

### RESULTS

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- ▶ Within six months of the program's launch, emergency room use among participating members was 8 percent lower than among a control group.
- ▶ Within the first quarter of the program's implementation, emergency room use declined by 20 percent among members who had used emergency rooms 21 or more times during the year.

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*For more information, contact:*

Karen Smith-Hagman  
Vice President, Medical Management  
EmblemHealth  
(646) 447-4594  
[ksmithhagman@emblemhealth.com](mailto:ksmithhagman@emblemhealth.com)



# The Medicare Advantage Emergency Room Initiative

## PROGRAM AT A GLANCE

### Goal:

- ▶ Reduce preventable use of the emergency room (ER) among Medicare Advantage members.

### Key Strategies:

- ▶ Convene monthly meetings of a multidisciplinary team to review records of Medicare Advantage members who account for the greatest portion of ER visits.
- ▶ Contact members by phone to identify issues leading to frequent emergency room use in non-emergency situations and help them access the care they need.

### Results in Brief:

- ▶ In 2009, ER use declined by 35.9 percent among Medicare Advantage members who had eight or more emergency room visits during the previous year.

## BACKGROUND

Upon finding that 53 Medicare Advantage members accounted for more than 660 emergency room visits, Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) launched the Medicare Advantage Emergency Room Initiative in 2008. The program focuses on beneficiaries who have two or more ER visits in one month, as well as those who have six, eight, 11, or 30 visits in a year.

## APPROACH

### *Outreach to Beneficiaries and Primary Care Physicians*

Each month, a multidisciplinary team including the medical director, clinical pharmacists, nurse case managers, disease management care specialists, a social worker, and other behavioral health specialists meet to review records of Medicare Advantage members with the greatest number of emergency room visits.

Based on its review, the team determines the types of services most likely to help each beneficiary address his or her health conditions effectively and minimize preventable ER visits. Staff members with expertise in the issues identified contact members to discuss their needs and provide assistance. For example, Horizon BCBSNJ found that one member with multiple ER visits had anxiety, depression, and a history of alcohol abuse. The member was receiving prescriptions for opioids from multiple doctors and was using emergency rooms to access medication. A case management nurse spoke with the member by phone, and after several

conversations, the person said she felt overwhelmed and suicidal. The case manager linked the member with a Horizon BCBSNJ social worker, who helped her apply for financial assistance and subsidized transportation. The beneficiary's drug-seeking behavior stopped; her condition stabilized; and she began seeking regular care from a primary care physician and social worker rather than the emergency room.

In other cases, clinical pharmacists contact patients whose reactions to medications have led to emergencies. Pharmacists review and explain patients' prescriptions, and they speak with prescribing physicians to find safe alternatives to medications that have caused adverse reactions. Disease management nurses reach out to patients who have experienced emergencies due to chronic conditions that are not being treated, and they offer the opportunity to enroll in disease management and/or case management programs.

Besides helping reduce preventable ER use, Horizon BCBSNJ team members make sure that beneficiaries understand when they should go to emergency rooms. Horizon BCBSNJ staff work with beneficiaries in the program until their conditions are stabilized, often for a period of four to six weeks.

Whenever Horizon BCBSNJ staff contact members for the program, they also speak with members' primary care physicians to make them aware of the recommendations and assistance they have provided.

## NEW JERSEY

### *A Proactive Approach*

Beginning in 2010, Horizon BCBSNJ is evaluating the health conditions that account for the greatest proportion of ER use and will offer these members help—through disease management and case management—in addressing them on an ongoing basis to reduce preventable emergencies.

### RESULTS

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- ▶ In 2009, ER use declined by 35.9 percent among Medicare Advantage members who had eight or more emergency room visits during the previous year.

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### *For more information, contact:*

Premila Mary Kumar  
Manager, Care Management Programs  
Horizon Blue Cross Blue Shield of New Jersey  
(973) 466-5390  
[Premila\\_kumar@horizonblue.com](mailto:Premila_kumar@horizonblue.com)

Saira Jan, M.S., Pharm.D.  
Director of Clinical Pharmacy Management  
Horizon Blue Cross Blue Shield of New Jersey  
(973) 466-4575  
[Saira\\_Jan@horizon-bcbsnj.com](mailto:Saira_Jan@horizon-bcbsnj.com)

# A Multi-Dimensional Approach to Reducing Preventable Emergency Room Use

## PROGRAM AT A GLANCE

### Goal:

- ▶ Reduce avoidable use of the emergency room (ER).

### Key Strategies:

- ▶ Produce quarterly reports for physicians on their patients' use of emergency rooms and post-ER health outcomes.
- ▶ Provide members with information on health conditions and effective treatment strategies through free publications, Web-based resources, and access to a 24/7 nurse triage line.
- ▶ Provide grants to community health centers to:
  - Increase capacity;
  - Expand hours;
  - Leave appointment slots open for post-ER follow-up visits; and
  - Hire triage nurses to meet on-site with patients to discuss their symptoms and help them access same-day doctor appointments.

### Results in Brief:

- ▶ During an 18-month period from 2003 to 2004—when the health plan provided grants to community health centers for programs aimed at reducing preventable ER visits—the rate of emergency room use dropped by 8 percent.
- ▶ From 2006-2007, when similar initiatives were in place, the use of emergency rooms declined in 60 percent of clinics receiving grants. The average decline was 2 percent.

## BACKGROUND

Since 2003, Neighborhood Health Plan (NHP) has implemented a variety of strategies to reduce preventable ER use among its members, who include individuals with Medicaid, commercial, and Commonwealth Care<sup>1</sup> coverage.

## APPROACH

### Reports for Physicians

To increase physicians' awareness of emergency room use, NHP sends quarterly reports to all physician groups in its network to indicate: (1) which of their patients have used emergency rooms; (2) which patients have used ERs frequently (i.e., more than five times in the past year); (3) the diagnoses of patients using emergency rooms and whether they used ERs for ambulatory-sensitive conditions;<sup>2</sup> (4) times of day during which patients have used emergency rooms; and (5) health outcomes following ER visits.

The reports list emergency room visit rates for individual physician groups, as well as a comparison to the NHP network as a whole. In addition, for each physician group, the report shows trends in patients' emergency room use over the past three years; the number of frequent emergency room

users and occasional users (defined as those with three to five ER visits in the past year); and the proportion of patients who have used emergency rooms for ambulatory-sensitive conditions in the past quarter.

NHP sends reports to individual physicians and posts them on its secure Web portal so that physicians can sort and analyze the data.

### Resources for Patients

To help patients understand their symptoms and the most effective ways to address them, NHP sends a publication called the *Healthwise Handbook*—which is available in English and Spanish—to all members who have visited emergency rooms for ambulatory-sensitive conditions in the past quarter. All members also have access to the online version of the handbook, which includes an interactive symptom checker. The system allows patients to click on a body part, e.g., the throat, and view a menu of symptoms. If members click on "sore throat," the system asks a series of questions and, based on an evidence-based tool, it provides care recommendations, such as seeking urgent care, calling a primary care physician, or going to the emergency room.

## A Multi-Dimensional Approach to Reducing Preventable Emergency Room Use

NHP sends families of health plan members under age 12 a book called *What to Do When Your Child is Sick*, published by the Institute for Healthcare Advancement, rather than the *Healthwise Handbook*. In addition to written materials, NHP provides a 24-hour triage line so that nurses are always available to answer questions and guide patients to the type of care best suited to their needs.

### *Expanded Capacity and Nurse Triage*

From 2003 to 2004, 2006-2007, and 2009-2010, NHP received grants from the State of Massachusetts for initiatives aimed at reducing preventable emergency room use. As part of its 2006-2007 grant project, the health plan implemented a total of 15 projects in 21 community health centers. Some clinics increased office hours to include evening and weekend appointments. Other clinics hired triage nurses, who were available at all times to meet with patients, discuss their symptoms, help them obtain same-day appointments, or guide them to emergency rooms as needed. Also as part of the initiative, clinics expanded the capacity of their urgent care centers. At all clinics receiving the grants, NHP provided copies of the *Healthwise Handbook* in waiting rooms for patients to take home at no charge.

In 2009, NHP provided grants to 15 community health centers to implement a total of 10 projects using similar strategies to reduce preventable ER use. Under a federally funded grant program operated by the Centers for Medicare & Medicaid Services, the health plan continues to fund 17 community health centers in 2010 to address these issues.

## RESULTS

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- ▶ During an 18-month period from 2003 to 2004—when the health plan provided grants to community health centers for programs aimed at reducing preventable ER visits—the rate of emergency room use (ER visits per thousand member months) dropped by 8 percent.
- ▶ From 2006-2007, when similar initiatives were in place, the use of emergency rooms declined in 60 percent of clinics receiving grants. The average decline was 2 percent.
- ▶ The rate of emergency room use among NHP members remained flat from 2008 to 2009, at 570 visits per thousand member years.<sup>3</sup>

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<sup>1</sup> Commonwealth Care is a subsidized health insurance program for low-income adults created through Massachusetts' health reform initiative.

<sup>2</sup> The Agency for Health Care Research and Quality defines "ambulatory-sensitive conditions" as those for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. (Agency for Healthcare Research and Quality (2004). *Prevention Quality Indicators Overview*. AHRQ Quality Indicators. Rockville, MD: Author. Available at: [http://www.qualityindicators.ahrq.gov/pqi\\_overview.htm](http://www.qualityindicators.ahrq.gov/pqi_overview.htm).)

<sup>3</sup> A member year is a measure that corrects for the phenomenon of discontinuous enrollment during a calendar year. For example, two members with six months of enrollment in 2009 would constitute one member year.

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### *For more information, contact:*

James Glauber, M.D.  
Medical Director  
Neighborhood Health Plan  
(617) 428-7434  
[Jim\\_glauber@nhp.org](mailto:Jim_glauber@nhp.org)