

Research Highlight:

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

America's Health Insurance Plans' (AHIP's) new report *Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use* provides an overview of health insurance plans' creative programs to revitalize primary care, improve care transitions, and help patients across the country achieve better health outcomes and thus avoid preventable hospitalizations and emergency room (ER) visits.

The recently enacted health reform law 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.

The following are highlights from the AHIP report:



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 (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.

To access AHIP's full *Innovations* report online, go to: <http://www.ahipresearch.org/pdfs/innovations2010.pdf>. For a hard copy, please contact: customersolutions@ahip.org.