Health Plan Innovations in Patient-Centered Care

Transitions of Care
Health Plan Innovations in Patient-Centered Care:

Transitions of Care from Hospital to Home

Practices Used by Community-Based Health Plans to Facilitate Successful Care Transitions

A publication of the Alliance of Community Health Plans, with research, analysis, and compilation of findings by Avalere Health

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Dear Colleagues,

Many of us have experienced—either ourselves or with a loved one—the anxiety of hospitalization and the confusion that often follows after returning home. All the information, different medications, and sets of instructions can seem overwhelming, especially when they come from multiple people and places. Patients who have been recently discharged from the hospital should focus on getting better and not have to worry about whether their primary care physician knows and agrees with what a specialist at a hospital prescribed, or have to sort out complicated medication instructions and possible side effects.

Uncoordinated care and errors that result from poor communication among providers during the hospital-to-home transition can lead to medication errors and rehospitalizations. Every year, millions of Medicare beneficiaries are readmitted to a hospital within 30 days of being discharged. Not only is this stressful and dangerous, as every hospitalization increases the risk of hospital-acquired infections or other adverse effects, it is costly. Medicare readmissions alone cost the United States over $26 billion a year.

The ACHP “Health Plan Innovations in Patient-Centered Care” series focuses on initiatives of Alliance of Community Health Plans members to achieve improved population health, enhanced patient experience, and more affordable costs. Our goal is to add to the increasingly urgent discussion on how to deliver high-value care, with a parallel focus on high quality, the best clinical outcomes, patient satisfaction, and a health care cost curve that bends down. The first publication in the series, released in November 2011, focused on care management of complex, chronically ill populations. This second publication looks specifically at work ACHP members have been doing to improve transitions from hospital to home.

ACHP members—a group of 22 not-for-profit, community-based health plans and provider organizations around the country—have years of experience working to improve patients’ transitions of care. To share the lessons learned from this work, ACHP commissioned Avalere Health to interview our member plans and summarize their findings about health plan practices that can improve transitions from hospital to home.

We hope that this report will serve as a useful resource to a variety of groups—including health plans, providers, and policymakers—looking to increase quality of care and decrease the costs, both personal and financial, associated with readmissions and adverse events after a hospital stay. In this time of increasing urgency around lowering costs and increasing quality, we can all benefit from looking at successful programs our plans have initiated, as well as challenges they faced, and use their experiences to continue searching for innovative ways to improve care transitions.

Patricia Smith

President & CEO
Alliance of Community Health Plans
Executive Summary

Why Focus on Care Transitions?

Nearly one in five Medicare patients discharged from a hospital is readmitted within 30 days, leading to high costs of care, poor quality care, and low patient satisfaction.\(^1\) The U.S. Department of Health and Human Services (HHS) has also found that one in five patients discharged from hospital to home experiences an adverse event—or harm resulting from medical care—within three weeks of discharge.\(^2\) Researchers and policymakers believe that many of these readmissions and adverse events could be prevented if patients’ care were better coordinated and if patients received adequate follow-up care outside the hospital.

Uncoordinated care and fragmentation, as a result of a lack of communication among all of a patient’s providers and sites of care, can result in duplication of care and resources, medication and medical errors, and patient frustration. Transitions in care—or movement between one setting or provider to another, or to home—are a particularly vulnerable time for patients and have been the subject of recent attention among researchers, health plans, providers, and policymakers.

Health Plans’ Unique Role in Care Transitions

Alliance of Community Health Plan (ACHP) member plans have been at the forefront of work to improve care transitions for their members by drawing on existing best practices and developing new models to meet the needs of their own populations. Helped by close ties to their communities and longstanding partnerships with providers, ACHP plans work with community partners to integrate transition planning into routine patient care.

Health plans are in a unique position to orchestrate seamless care transitions, as they are often the only entities that have a complete picture of a patient’s care across settings. Plans have rich data assets that can be used for predictive modeling and to better understand patient outcomes, and they can encourage patients to take responsibility for their health by engaging with their members at various stages throughout a care transition.

About This Publication

This report highlights the role of the health plan in implementing and sustaining improvements to patient transitions from hospital to home. Eleven ACHP plans\(^3\) contributed to the publication by sharing insights on the development, implementation, ongoing operations, and results of their care transitions programs. Avalere Health collected this information through written surveys and structured telephone discussions.

Although ACHP plans’ efforts to improve care transitions are, for the most part, still in the early stages, these plans are making investments and beginning to see early returns, evaluate results,

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3. A twelfth plan, Scott & White Health Plan, provided a white paper - “Care Transitions, Hospital Readmissions, & VitalBridges - Analysis and Recommendations,” written by Benjamin Perry - which was incorporated into a plan profile.
and use these findings to make modifications and improvements moving forward. We expect that the practices highlighted in this paper to facilitate successful care transitions will continue to evolve and will be supported by a growing evidence base, as plans accrue more years of experience to evaluate.

The objectives of this report are two-fold. First, it is a resource for health plans contemplating an investment in care transitions programs by offering examples of approaches that plans are taking, highlighting practices worthy of consideration, and discussing challenges that plans face when designing and implementing care transitions programs. The practices, described in greater detail on pages 18 to 33, include: (1) using data to tailor care transitions programs to patients’ needs, (2) contacting patients early in the transitions process, (3) engaging providers to become program partners, (4) leveraging technology, and (5) incorporating care transitions into the standard of care.

Second, the report offers insights to policymakers and other stakeholders wishing to understand both the efforts being made to improve quality and reduce costs by focusing on care transitions and how health plans can play an integral role in those endeavors.

Promising Results

Health Outcomes: Many plans measure hospital readmission rates and/or process measures to track the success of their care transitions programs. For example, HealthPartners of Minnesota’s readmission rate for patients in its Inpatient Case Management Program declined from 10.1 to 8.6 percent from 2010 to 2011. With evidence showing that a visit with a follow-up physician is an important element of care transitions, some Kaiser Permanente medical centers see up to 70 percent of patients in the clinic within a week following discharge from the hospital.

Cost Savings: A few ACHP plans are able to quantify cost savings from their care transitions programs. For example, Group Health Cooperative reported that its Emergency Department Hospital Inpatient program resulted in an estimated $51 million in savings in 2010, due to a reduction in readmissions, emergency room utilization, and initial inpatient admissions. Presbyterian Health Plan estimated that its care transitions program saved approximately $1.8 million in 2010 as a result of reduced readmissions.

Patient Satisfaction: ACHP plans also use patient satisfaction surveys to monitor the perceived value of their care transitions programs. At Geisinger Health Plan, 99 percent of patients in its care transitions program rated their care managers as “good” or “very good.” According to UPMC Health Plan’s patient survey in 2011, 96 percent of patients in its care transitions program were either “satisfied” or “very satisfied” with the program.

Implications

Policymakers at the local and national level are increasingly focused on improving care transitions as a way to improve quality and reduce costs. Over the next several years, the Centers for Medicare & Medicaid Services (CMS) will implement several new payment and delivery reform pilot programs; better care transitions will be an important element of these models. These changes will offer new incentives for physicians, hospitals, skilled nursing facilities, and other providers and sites of care to work together to improve the quality of care that they deliver to patients.

ACHP health plans have been leading the way in these efforts for the last several years and are well-positioned to continue to shape improvements in care delivery—including around care transitions—and to serve as examples for policymakers, providers, and other health plans.
ACHP member plans are testing and developing innovative models for improving the patient experience and working with providers and community partners during patients’ transitions from hospital to home. The practices described here focus on the role of the health plan in implementing and sustaining a program that promotes coordination of, accountability for, and improvement in the health and health care of its patients. The following five practices, therefore, focus on the role that health plans can play in improving transitions of care.

1. Use Data to Tailor Care Transitions Programs to Patients’ Needs

ACHP plans use available data to identify patients most at risk for readmission and likely to benefit from additional services (such as careful monitoring and follow-up) in support of their transition from hospital to home. The appropriate identification of patients most in need of additional services allows plans to target resources to those members. Some plans have developed complex data-driven models to predict which patients are most likely to be readmitted, while others use data in simpler ways, such as by identifying patients who had a prior admission within 30 days, or identifying the top 10 or 15 readmissions diagnoses from the prior year and targeting patients with those diagnoses.

Fallon Community Health Plan focuses on patients with conditions most likely to lead to readmission, including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), cardiovascular disease (CVD), and pneumonia.

Group Health Cooperative tailors care transitions support according to one of five clinical pathways, depending on the patient’s conditions and transition needs. These pathways range from “blue” patients who need and receive minimal post-discharge care, to “red” patients who are likely to need palliative care post-discharge.

HealthPartners utilizes a predictive modeling system to identify members who are at risk for rehospitalization or worsening of conditions, using a mix of membership, claims, pharmacy, and lab data. Inpatient case managers also screen and stratify every member admission, using a standardized evidence-based assessment, paired with clinical judgment.


Most plans emphasize the importance of connecting with patients prior to discharge from the hospital, ideally by the same nurse who will be making home visits. This can help ensure that patients are discharged to an appropriate setting, with the proper combination of post-discharge instructions, follow-up appointments, medications, and support resources.

When nurse case managers from Security Health Plan visit patients prior to discharge to engage them in the care transitions program, patients are given a “Get Well Card.” This card briefly explains the transitions services and resources, while also letting patients know that the plan is aware of their hospitalization and wishes them a speedy recovery.

Kaiser Permanente equips discharged patients with a special transitions phone number to call if they have questions about their condition prior to the follow-up physician visit. The nurses on the line address these questions and can also connect patients to hospital physicians. KP has observed a drop in readmissions, which it attributes to this popular program.

3. Engage Providers to Become Program Partners

Given the central role of providers in facilitating a smooth transition, provider engagement in the design and ongoing operation of care transitions programs is crucial. ACHP plans use various strategies to include providers in the planning process and maintain...
physician engagement. These include feedback mechanisms, participation incentives, and quality measurement and pay-for-performance incentives, aligned with transitions program goals.

When Kaiser Permanente first began to focus on improving care transitions, it assembled a team comprised of physicians and nurses from their hospitals, clinics, skilled nursing facilities, and elsewhere to garner input on the current state of care transitions and opportunity for improvement. This group jointly agreed to a standard set of care transitions services that now serves as the foundation of the programs in each of KP’s eight regions.

In its pilot program, Capital District Physicians’ Health Plan (CDPHP) offered financial incentives to physicians who saw patients within seven days of hospital discharge. Providers responded positively to these incentives, and CDPHP saw a reduction in readmissions. CDPHP identified these incentives as a key factor in the success of the pilot program.

To maintain ongoing enthusiasm for program goals, Independent Health hosts ad hoc meetings with hospital staff, including physicians and nurses, to offer positive reinforcement and to discuss opportunities to improve care transitions. For example, such groups review cases of patients who would have benefited from the care transitions program but were not enrolled.

4. Leverage Technology to Improve Care Transitions

ACHP plans use technology, including electronic medical records (EMRs), to track patients throughout their transitions and to ensure that all providers have access to the complete picture of the care a patient is receiving. In addition, some ACHP plans are using telehealth programs to improve post-discharge monitoring and to intervene more quickly if a patient’s condition escalates.

UPMC Health Plan uses a patient-centric documentation system called HealthPlaNET to streamline the collection of information across its care management, wellness, disease management and care transitions programs. UPMC also provides mobile care managers with HealthPlaNET-equipped laptops to complete patient assessments and coordinate follow-up with providers and telephonic care managers during home visits.

At Geisinger Health Plan, the EMR shares information across providers, uses embedded risk stratification to alert clinicians of a patient’s risk for readmission upon their admission to the emergency department, notifies primary care physicians when one of their patients is admitted to the hospital, and electronically transmits discharge summaries.

Priority Health’s telehealth program uses glucometers to remotely manage CHF patients with diabetes in rural Michigan. Data are captured daily, and monthly reports are disseminated to providers to help them regularly monitor patients. If the daily data report a red flag, the provider contacts the patient immediately by telephone or conducts a home visit.

5. Incorporate Care Transitions into Standard of Care

ACHP plans consistently incorporate their care transitions programs as part of a broader scope of quality improvement activities. Some plans use the care transitions intervention as a conduit to enroll members into additional programs, such as disease management, while other plans make care transitions intervention a piece of a larger program, such as patient-centered medical home (PCMH), rather than a standalone initiative.

A nurse from Presbyterian Health Plan calls patients within 48 hours post-discharge from the hospital; this touch point is used as an opportunity to enroll patients with diabetes or coronary artery disease (CAD) into one of its disease management programs.

Group Health Cooperative incorporates care transitions into its larger EDHI (Emergency Department Hospital Inpatient) program, which provides transitions coaching and follow-up care for patients with complex needs. This initiative has improved care transitions, increased patient access to alternative care settings, and reduced readmissions, preventable admissions, and emergency room visits.
I. Introduction

Sections

About ACHP
About ACHP’s Innovation Series
Introduction to Care Transitions
The Role of Health Plans in Care Transitions
Overview of ACHP Plans’ Approach to Care Transitions
ACHP (the Alliance of Community Health Plans) is a national leadership organization founded in 1984 that brings together innovative health plans and provider groups that are among America’s best at delivering affordable, high-quality coverage and care in their communities. The 22 community-based and regional health plans and provider organizations that belong to ACHP improve the health of the communities they serve and are on the leading edge of patient care coordination, care transitions, patient-centered medical homes, accountable health care delivery, information technology use, and other innovations that aim to improve affordability and the quality of care that patients receive.

ACHP members are:

- Not-for-profit health plans, subsidiaries of not-for-profit health systems, or provider groups associated with health plans. Member organizations work primarily with mid-sized and smaller employer groups and have deep roots in their communities.
- National leaders in health care quality that annually rank among the top-performing health plans in the nation.
- Innovators in delivering affordable, coordinated, multidisciplinary care, and pioneers in the use of electronic health records.
- Role models for other health plans in innovating to achieve the industry’s aim of better health and better care at a lower cost.

The plans profiled in this report span a variety of delivery models, geographical areas and member populations. At Group Health Cooperative, which serves more than 600,000 members in Washington and Idaho, almost 60 percent of physicians are part of a large multispecialty, affiliated group. Fallon Community Health Plan in central Massachusetts, on the other hand, has 190,000 members and an entirely contracted network relationship with physicians.

In spite of their differences, ACHP plans share a commitment to their patients and their communities that is reflected in the design of their care transitions programs, as described in this report.

Figure 1: States containing at least one ACHP plan
ACHP’s Health Plan Innovations in Patient-Centered Care is a series of publications profiling the roles health plans can play in advancing care.

The first publication in the series, on care management strategies and the role of care management nurses, examines the exceptional work being done by ACHP plans to manage care of high-risk, chronically ill patients with complex needs.

The second publication, “Transitions of Care From Hospital to Home,” explores a variety of approaches these plans are using to effectively transition patients and their care from acute care settings to home. ACHP members are leaders in the health care industry and in developing care transitions programs that improve delivery system quality and overall health of patients. These strategies also have the potential to help address costs for enrollees and health care markets. To highlight these innovative programs, ACHP commissioned Avalere Health to identify practices for plans and providers that facilitate successful transitions.

A forthcoming study will focus on patient-centered medical homes, primary care transformation, and the ACHP Primary Care Innovation Collaborative, formed in 2008. Members of this collaborative have developed four patient-centered medical home standards, clarifying the unique role of health plans in partnering with provider practices to deliver better-integrated, patient-centered care. These standards, which expand upon the standards developed by the National Committee for Quality Assurance, focus on patient-centered care and coordination, integration, outcome measurement, and value-based reimbursement. ACHP has found these additional standards to be central to the success of patient-centered medical homes. ACHP is partnering with Michigan State University for a future publication on the collaborative progress its members have made in capturing the greatest value from the PCMH.

For free electronic copies of publications as they become available, visit www.achp.org or email innovations@achp.org.
What Are Care Transitions?

The term “care transitions” refers to the movement patients make among health care practitioners and settings as their condition and care requirements change over the course of an illness. For example, a patient experiencing an acute exacerbation or significant worsening of an illness might receive care from a primary care physician (PCP) or specialist in an outpatient setting then transition to a hospital physician and nursing team during an inpatient admission before moving on to yet another care team at a skilled nursing facility. Finally, the patient might return home, where he or she may receive care from a visiting nurse. Each of these shifts between care providers and settings is defined as a care transition.

Improving Care Transitions

Due to inadequate communication among various sites and providers, the care patients receive over the course of an illness is often uncoordinated. Inefficiencies in service delivery that increase the costs of care—and potentially lead to greater utilization of health care resources such as inpatient hospital stays, emergency room visits, and post-acute care—are associated with poorly executed care transitions. Additionally, patients who receive fragmented care often suffer from negative consequences such as duplication of services, inappropriate or conflicting care recommendations, medication errors, patient or caregiver distress, and higher costs of care. The U.S. Department of Health and Human Services (HHS), for example, reported in November of 2011 that one in five patients discharged from hospital to home experiences an adverse event within three weeks of discharge, when an adverse event is defined as an injury resulting from medical management rather than the underlying disease.

Health plans, as well as their affiliated providers and health systems, can implement programs to improve care transitions that may reduce preventable readmissions and keep members healthy at home. ACHP plans are actively testing new models of care to ensure that their enrollees experience safe and effective transitions from one health care setting to another. Such care transitions programs not only increase patient satisfaction but also reduce readmissions, improve health outcomes, and produce cost savings.

Care Transitions Models

ACHP member plans have relied on existing research and proven care transitions models as the basis for developing their own care transitions programs. In interviews conducted with ACHP member plans, one of the most prominently cited models was Dr. Eric Coleman’s Care Transitions Program®, which focuses on helping
Health Plan Innovations in Patient-Centered Care

I. Introduction

While transitions among all settings of care warrant attention, this publication focuses specifically on the transition from hospital to home. ACHP member health plans have been at the forefront in developing care transitions programs to ensure that patients receive appropriate support and follow-up care when returning home after a hospital stay. In designing these programs, they have borrowed elements from proven models and applied them to their own programs.

Policy Importance

In recent years, there has been a growing emphasis on the importance of care transitions in improving health care outcomes. A broad range of stakeholders, including Congress, federal agencies, physician associations, business groups, and quality improvement organizations, have designed an array of programs to encourage health plans, hospitals, physicians, and other providers to improve care transitions by creating incentives to provide better care.

In March 2010, President Obama signed the Affordable Care Act (ACA) into law, which calls for considerable changes to the nation’s health care system. The new law will have a profound impact on how Americans obtain health insurance coverage and access the health care system. The ACA also aims to reduce costs and improve quality by realigning financial incentives for providers to supply high-quality care in a cost-effective manner. The law is an important early step toward reforming the health care system, in part because it includes new care delivery and payment models with the overall goal of achieving higher value health care services. Several initiatives, in particular, will draw increased attention to the importance of care transitions as well as, more broadly, an evolving payment and delivery system.

patients maximize their own knowledge and control, using four key concepts, known as The Four Pillars®. These pillars are:

- Medication self-management,
- Use of a dynamic patient-centered record,
- Primary care and specialist follow-up, and
- Knowledge of red flags.4

The goal of Coleman’s care transitions program is to “improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move from hospital to home.”92

Other ACHP plans cited the influence of the Transitional Care Model (TCM), led by Mary D. Naylor, PhD, FAAN, RN, and a multidisciplinary team. This model provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. The model uses a Transitional Care Nurse to follow the patients from the hospital into their homes. While nurses are at the hub of this care transitions program, the TCM also includes physicians, social workers, discharge planners, pharmacists, and other members of the health care team.

ACHP plans also pointed to Project RED (Re-Engineered Discharge), led by a research group at Boston University Medical Center, as a model for piloting their programs. Project RED “develops and tests strategies to improve the hospital discharge process, while promoting patient safety and reducing re-hospitalization rates.” Project RED has 11 interventions—including educating and engaging the patient, making follow-up appointments, and organizing post-discharge services—that have been proven to reduce rehospitalizations and increase patient satisfaction.
Such initiatives include:

- **The Hospital Readmission Reductions Program (HRRP):**
  The ACA mandated implementation of a program to reduce Medicare payments to hospitals that experience excess readmissions. Beginning October 1, 2012, the Centers for Medicare & Medicaid Services (CMS) will lower payment rates for all Medicare discharges at acute care hospitals that experience higher-than-average readmission rates for three conditions: acute myocardial infarction (heart attacks), heart failure, and pneumonia. Beginning in 2015, CMS may add additional conditions or procedures it believes represent high costs and high volume of readmissions.

- **The National Pilot Program on Payment Bundling:**
  Currently, hospitals, physicians and other clinicians who deliver care to Medicare beneficiaries are paid separately for their services. Under the bundled payment pilot program, CMS will pay a single rate for a package of services that patients receive across providers during a single episode of care. In turn, these providers will have a greater incentive to coordinate with each other and ensure continuity of care across settings, resulting in better care for patients. Better-coordinated care can reduce unnecessary duplication of services, preventable medical errors, and readmissions; improve care transitions; and lower costs.

- **The Center for Medicare and Medicaid Innovation:**
  The ACA created the Center for Medicare and Medicaid Innovation to test innovative payment and delivery models in Medicare and Medicaid. The legislation grants broad authority to the Innovation Center to determine which models to test, in which populations, and for how long, with a preference for models that address deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The Innovation Center has introduced a variety of pilots and programs, some of which focus on care transitions. For example, one of the models currently being tested is the Patient-Centered Medical Home (PCMH). Mounting evidence suggests that a strong primary care system can help reduce costs and improve health care quality, including by helping patients navigate through care transitions.

- **The Community-Based Care Transition Program:**
  The ACA provided $500 million to support hospitals and community-based organizations in their efforts to help Medicare beneficiaries at high risk for readmission safely transition from the hospital to other care settings. The goals of the Community-Based Care Transition Program are to reduce hospital readmissions, test sustainable funding streams for care transition services, maintain or improve quality of care, and document measureable savings to the Medicare program.

- **The Partnership for Patients:**
  With support from HHS, the Partnership for Patients will work with a wide variety of public and private partners to achieve its two core goals: keeping patients from getting injured or sicker in the health care system, and helping patients heal without complication by improving transitions from acute-care hospitals to other care settings, such as homes or skilled nursing facilities. Former CMS Administrator Donald Berwick, MD believes that provisions in the ACA such as the Partnership for Patients “will provide hospitals with incentives to improve the quality of health care and provide real assistance to medical professionals and hospitals to support their efforts to reduce harm.”
Health plans are in a unique position to play an instrumental role in orchestrating care transitions, as the patient’s health plan has access to a broad scope of information that spans a variety of settings. Often patients rely on their primary care physicians (PCPs) to be the principal point of contact for all of their health care needs. However, many times PCPs are unaware that their patients have accessed the health care system, for example, through a hospital admission or receipt of services at another setting of care.

Health plans can facilitate the flow of information to ensure a patient’s care is not provided in silos, by designing protocols and tools to help providers communicate with each other. Health plans are a centralized source of information critical to patient safety: primary diagnoses and major health problems, the identity and contact information for physicians and specialists with whom patients have regular contact, and current prescription medications. As a patient moves among providers, health plans can make a “warm hand-off,” equipping each successive provider with the complete picture of that patient’s health care history and current needs.

Health plans also can encourage patients to be proactive about their health and recovery by engaging with them at various stages of the care transition. ACHP member plans use multiple approaches to foster these cross-stage relationships with their members, but have consistently pointed to the importance of ensuring that plan and program staff are held accountable for that relationship.

Eleven ACHP plans contributed to this publication by sharing insight on the development, implementation, ongoing operation, and results of their care transitions programs. This information was collected by Avalere Health, through written surveys and structured telephone discussions. Avalere sought to better understand program design, objectives, and outcomes, and to translate these findings into practices and lessons learned for other health plans and health systems seeking to improve the care transitions of their own members and patients.

Significant attention and research has been focused on the most appropriate clinical elements for inclusion in care transitions programs; this publication aims to fill a gap by concentrating on the role of the health plan in implementing and sustaining improvements to care transitions.

* In addition, a 12th plan, Scott and White Health Plan, provided a white paper, “Care Transitions, Hospital Readmissions, & VitalBridges - Analysis and Recommendations,” written by Benjamin Perry, which was incorporated into a plan profile.
Although there is no one-size-fits-all model for approaching care transitions, ACHP plans’ programs share a similar process for assisting members in their care transitions. Figure 2 below depicts the steps that each plan takes as patients move from hospital to home to follow-up physician care. In addition, a table with additional details on the components of each ACHP plan’s care transitions program may be found in the Appendix, on page 60.

Plans begin their care transitions initiatives by determining how they will identify members who will require care transitions support. These members first receive interventions at the hospital, which may include visits from home care nurses, case managers, or transition coaches in the hospital to help prepare the patient for the transition home.

After a patient’s discharge from the hospital, plans begin intervention at the home. For example, all ACHP plans make contact with the patient within 48 to 72 hours of discharge, some via telephone call and others through home visits. Plans also arrange for the provision of services at the home, including the review of discharge instructions, assessment of the patient’s social and living environment, and medication reconciliation. All ACHP plans’ care transitions programs emphasize a timely follow-up visit with the patient’s primary care physician or specialist shortly after discharge, usually within five to seven days. Plans often enlist case managers to make appointments for their patients and coordinate transportation to ensure patients can get to their appointments. Over the course of the month following discharge, plans’ case managers may continue regular follow-up calls to provide ongoing education and support.

The approaches that plans take to carry out the above activities are supported with strategic use of data as well as careful design of processes and systems to ensure coordination and optimize outcomes. The next section examines the approaches, practices, and strategies that ACHP plans employ during this transitions process to carry out the activities in Figure 2.
II. Practices

Sections

Use Data to Tailor Care Transitions Program to Patients’ Needs

Contact the Patient Early in the Transitions Process

Engage Providers to Become Program Partners

Leverage Technology to Improve Care Transitions

Incorporate Care Transitions into Standard of Care
While ACHP member plans have varied approaches to care transitions, they cite similar practices and factors as key to the successful implementation and ongoing operation of their care transitions programs. This section explores five practices that the plans identified as key to their success. For health plans considering focusing their resources on care transitions, these practices may serve as a guide to implementing their own initiatives.

The practices described here focus on the role of the health plan in implementing and sustaining a program that promotes coordination of, accountability for, and improvement in the health and health care of its patients. Much has been written in the literature about the various clinical models and techniques that are effective in care transitions. In contrast, much less is available on the role of the health plan, even though health plans play a unique role in care transitions programs—as program architects and champions, and also as ongoing coordinators of patient information across providers and facilities.

This section highlights five practices that plans identified as facilitating the success of their care transitions programs and describes the approaches that ACHP plans have taken to implement these practices. They include:

1. Use data to tailor care transitions programs to patients’ needs
2. Anticipate patients’ needs and engage them early in the transition process
3. Engage providers to become program partners
4. Leverage technology to improve care transitions
5. Incorporate care transitions into standard of care

Health plans play a unique role in care transitions programs - as program architects and champions, and as ongoing coordinators of patient information across providers and facilities.
Use Data to Tailor Care Transitions Programs to Patients’ Needs

ACHP plans use available data to identify patients most at risk for readmission and most likely to benefit from additional services—such as careful monitoring and follow-up—in support of their transition from hospital to home. Appropriate identification of patients in greatest need of additional services allows plans to target resources to those members. Some plans have developed complex data-driven models to predict which patients are most likely to be readmitted, while others use data in simpler ways, such as by identifying patients who had a prior admission within 30 days or identifying the top 10 or 15 readmissions diagnoses from the prior year and targeting patients with those diagnoses. A few plans instead target all patients with specific conditions commonly associated with readmissions, including heart failure, chronic obstructive pulmonary disease (COPD), and coronary artery disease (CAD).

Using Diagnosis to Predict Risk for Readmission

Several ACHP plans use “look-back” methods to identify conditions that were most frequently associated with high rates of readmission in the prior year. Priority Health, based in Grand Rapids, Michigan, and Presbyterian Health Plan in Albuquerque look back at the prior year and identify the top 10 and 15 readmission diagnoses, respectively. Priority Health readjusts its list periodically, allowing for changing case-mix dynamics. Some of the conditions are mandatory for outreach and enrollment into the program, while others are left to the clinician’s discretion. As the plans identify patients with those conditions, they are added to condition-specific registries that circulate on a daily basis to all participating hospitals, ensuring that case managers and other clinical staff are aware of which patients need care transitions services.

Fallon Community Health Plan (FCHP) in central Massachusetts screens patients with conditions most likely to lead to readmissions for enrollment in its care transitions pilot program. These conditions include COPD, congestive heart failure (CHF), cardiovasvulat disease (CVD), and pneumonia. By focusing on these conditions, FCHP has been able to appropriately target resources to patients most able to participate in and benefit from the transitions intervention. Capital District Physicians’ Health Plan (CDPHP) in Albany, New York, has targeted these same conditions, which lead to 75 percent of its own readmissions.

Independent Health’s program’s identification criteria differ by business segment. All Medicare patients at the Buffalo, New York, plan are eligible to enroll in the care transitions program, while commercial patients are eligible only if they have primary or secondary diagnoses of COPD, CHF, myocardial infarction, coronary artery bypass graft, cardiac valve, pneumonia, or carotid stenting procedures. Medicaid patients are targeted for enrollment if they are hospitalized for treatment of asthma, CHF, pneumonia, or COPD, or if they appear to have another risk factor for readmission, such as lack of caregiver support or history of readmission, even if they do not otherwise meet the clinical criteria.

Group Health Cooperative in Washington provides some level of care transitions support to all patients as a standard of care. All patients admitted to a partner hospital are placed into one of five clinical pathways depending on the patient’s condition and transition needs (see Figure 3):

- Blue—patients with uncomplicated conditions who will need minimal post-discharge care;
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- Green—patients discharged to a skilled nursing facility;
- Yellow—patients with complex medical needs, at moderate risk, who will need care transitions, including medication reconciliation and post-discharge orders;
- Orange—patients at the highest risk who receive a follow-up call 48 hours post-discharge, a medication reconciliation call from a clinical pharmacist, and follow-up physician visit; or
- Red—patients who will likely need palliative care.

Although Group Health Cooperative addresses the care transitions needs of all patients, like other ACHP plans, they reserve the highest intensity support for the patients with greatest need and ability to benefit.

Group Health has recently adjusted its patient risk stratification approach by adding a new orange pathway for patients at the highest risk level, defined as those patients whose medical condition worsened during their hospital stay or who have three or more specific conditions; recommended follow-up is within seven days of discharge. The yellow pathway has been modified for patients at moderate risk, defined as those patients with one to two specified conditions who could benefit from a face-to-face visit within 14 days of discharge. Both orange and yellow patients receive a 48-hour post-discharge follow-up call from a care manager. The orange pathway patients receive a call from a clinical pharmacist within seven days of discharge for medication reconciliation; the yellow pathway patients no longer receive this call. This change in patient risk assignment was based on literature searches, a best practice scan, internal evidence and analysis, and clinical expertise with the highest readmit populations.

Predictive Modeling for Tailored Interventions

Several ACHP plans are using predictive modeling to identify patients who are most at risk of readmission. For example, Geisinger Health Plan in Pennsylvania has a two-pronged approach to identify patients for enrollment in its care transitions program. The approach uses a risk stratification model that predicts the risk of readmission for all patients upon admission to the emergency department (ED). The plan supplements the results of the predictive model to include patients with specific diagnoses such as heart failure, COPD, and post-surgical conditions who may not have been initially identified with the predictive model.

Each Group Health patient is assessed for level of risk and care transition need:

- Pre-admission assessment for alternative placement/services
- Transition management for high risk of readmission
- Transition management for moderate risk of readmission
- Transition management for low risk of readmission
- Coordinated transitions with facilities
- Engaging patients with their end-of-life choices

Figure 3: Group Health’s Patient Pathways
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Kaiser Permanente: Case Study on Patient Involvement in Care Transitions

One of the main objectives when Kaiser Permanente (KP) began its efforts to improve care transitions was to better understand the care experience, from beginning to end, of patients transitioning from hospital to home. In order to accomplish this, KP staff interviewed hundreds of patients and caregivers and completed a readmission diagnostic evaluation using an Institute for Healthcare Improvement tool to track over 600 readmissions.

KP then took the unique step of using video ethnography to document care as it was being delivered. With the patients’ agreement, camera teams followed and recorded patients at each step—from hospital admission to discharge to their arrival home—in order to better understand common facilitators and barriers to appropriate care. KP then used this video footage to identify areas of consistency across patients’ experiences. While some of this information was assessed qualitatively, the team also coded and scored care interactions and other elements identified in the recordings, to quantify factors associated with readmissions.

From the many hours of footage, common themes emerged that contributed to the design of KP’s care transitions program. For example, it was discovered that while Kaiser Permanente is an integrated delivery system and patients think of it as a single entity/provider, sometimes a patient’s primary care physician (PCP) was unaware of a patient’s admission to the hospital. KP responded to this insight, in part, by creating communication tools to strengthen the relationship between hospitals and PCPs.

KP created a video library as a result of these efforts, which is available throughout the entire organization for use in care improvement work. Additionally, it created short video segments of 4-10 minutes from the video footage, capturing the patient’s voice in describing their care experience and any concerns or important issues. KP continues to use video tools to motivate staff and drive ongoing improvements, having found that using the patient to communicate issues can help gain both executive- and provider-level engagement in a way that a typical presentation does not.

Kaiser Permanente also continues to engage patients in its care transitions work; for example, patients serve on the transitions redesign and improvement teams. Overall, KP believes that capturing and incorporating feedback from patients has helped it design a set of care transitions services that make it easier for patients to get the right care, which results in positive feedback from patients.
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UPMC Health Plan’s health economics department used its own medical, pharmacy, lab, and behavioral health claims data to build a model that employs claims-based algorithms to identify conditions most associated with 30-day readmissions. The model identifies patients and classifies them as being at high, medium, or low risk of readmission. Then plan is then able to direct the appropriate level of services to these patients, reducing avoidable readmissions, improving quality, and coordinating transitions and access to follow-up care.

HealthPartners, a consumer-governed health plan in Minnesota, has implemented a multi-phased approach to identify members who are at risk for re-hospitalization. Inpatient case managers screen and stratify all member admissions for risk using a standardized evidence-based assessment paired with clinical judgment. The health plan uses a proprietary predictive modeling system chosen for its reportedly high level of sensitivity and low level of false positives. Membership, claims, pharmacy, and available lab data are processed through a sequence of algorithms that distinguish patterns suggestive of potentially worsening conditions, probable complications, and hospitalization. The output is a patient registry, which is refreshed monthly. Each registry is overlaid with a score that ranks patients based on risk of future high total medical expenditures. HealthPartners reports that outcome data confirm that the systematic use of a standardized risk assessment tool supported by formalized work flows makes certain that all individuals are assessed for readmission risk as a routine process.

Regardless of how ACHP plans identify and target patients for inclusion in their care transitions programs, some consistent themes emerge from all plans:

- Resources are scarce, so it is essential to develop methods that allow plans and providers to deliver efficient and quality care to patients most likely to benefit;
- Good data are crucial to building any sort of predictive model—preferably data that capture the full prior 12 months of claims; and
- The results of the model or other patient identification strategies must be easily communicable to the plan’s care delivery partners so that they can quickly direct resources to patients.
Most ACHP member plans stressed that it is critical to engage patients prior to discharge from the inpatient hospital. There are multiple reasons why this initial outreach is important. First, it can help ensure that patients are discharged from the hospital to the appropriate setting and with the proper set of post-discharge instructions and medications. Second, initial outreach in a hospital setting can increase patients’ acceptance of post-discharge transition assistance by helping to allay their fears about receiving a home visit from a care manager. Patients also may feel less urgency to accept care transitions assistance after being home for several days, even though they may still be at risk for readmission. Finally, this initial contact is a good opportunity for plans to provide initial education, such as on which symptoms should be addressed immediately, in advance of a home visit or follow-up telephone call.

Conducting Initial Outreach in the Hospital

ACHP plans conduct initial outreach in a variety of ways while the patient is still in the hospital. Health plan nurses or care managers may be deployed to hospitals, while at other times they work directly with hospital staff, to ensure that patients receive adequate discharge planning instructions.

For example, when a member of Priority Health is hospitalized, a nurse from the health plan visits the patient while he or she is in the hospital, to introduce the care transitions program and help the patient understand the importance of the home visit post-discharge. Priority Health views this initial visit as central to engaging the patient in the transition process.

CDPHP deploys the services of visiting nurse associations (VNAs) for its care transitions program. Inpatient care coordinators—nurses employed by CDPHP to monitor hospitalized patients—serve as the patients’ initial introduction to the care transitions program and VNA services. A VNA nurse then visits the patient in the hospital, prior to discharge, to engage the patient in the program. CDPHP and the VNA strive for consistency by having the same nurse who meets with the patient in the hospital perform the post-discharge home visit. CDPHP stressed that this consistency in staff greatly increases the acceptance of the program by its patients, as it raises their comfort level with having a nurse visit them at their homes.

Security Health Plan in Wisconsin collaborates with the discharge planners at each of its major contracted hospitals and, where possible, has nurse care managers from the plan visit patients prior to discharge to be educated about discharge expectations and engage them in the care transitions program. One tool that Security has found to be both effective and positively received by patients is a “Get Well Card” (Figure 4) that is given to every patient prior to discharge. Security has found that this card serves to both provide an explanation of and to engage patients in the care transitions program, as it bolsters the patient’s perception of the care transitions services.

When Independent Health started its care transitions program in 2009, the plan’s hospital partners wanted to take a collaborative approach to care transitions. The goal was for all providers to “own” their role in reducing readmissions in order to standardize this type of process in their respective communities. The program therefore relies on hospital staff to make the initial contact with patients prior to discharge, and to refer patients into the care transitions program.

Independent Health works collaboratively with the hospitals to support these programs and has access to the hospitals’ electronic systems,
which allows them to obtain admission and discharge reports. Hospitals document whether an Independent Health member has been referred to its care transitions program, so that the plan is able to ensure those patients receive adequate care. This allows Independent Health to target any additional care transitions candidates who might benefit from the program.

Initiating Interventions Prior to Discharge

Plans have varying strategies to engage the patient in care transitions prior to and at discharge from the hospital. Some opt to equip their members with telephone numbers to call in case of an emergency, while others find it most effective to schedule home visits and/or PCP appointments before the patients leave the hospital.

Kaiser Permanente gives discharged patients a special transitions telephone number where nurses are available to answer the patients’ questions about their condition prior to the follow-up visit with their PCP. These nurses can address the majority of patients’ issues; for the remainder, the nurse is able to connect the patient on the line to a hospital physician. KP has observed a drop in readmissions, which it attributes to this popular program, as patients now can use an alternate venue for addressing concerns post-discharge.

Geisinger Health Plan makes a follow-up appointment for all patients prior to their discharge from a Geisinger hospital. Likewise, Kaiser Permanente ensures that high-risk patients have already scheduled a follow-up appointment with their physician, for within five days of discharge, before they leave the hospital.
While early engagement with the patient is critical, one of the challenges that many ACHP plans acknowledged was ensuring that all eligible patients are identified and asked to participate in the care transitions program. Hospital staff have many competing demands, and post-discharge care may not be their priority early in a patient’s stay. ACHP plans have discovered that designating staff, whether plan staff or hospital staff such as social workers, to be responsible for introducing the care transitions program improves the rate of outreach to patients.

**Engage Providers to Become Program Partners**

Successful care transitions rely on multiple providers, including physicians, nurses, case managers, and social workers, among others, to deliver coordinated care across an array of settings. Each of these providers must be engaged in care transitions and actively fulfill his or her roles in order for the program to result in improved care. For instance, PCPs must be willing to see patients for a follow-up visit shortly after hospital discharge, while hospital-based physicians must provide timely and accurate discharge notes.

Given their central roles in the care transitions process, ACHP plans repeatedly emphasizes the importance of ensuring that providers at each stage of the transition are engaged in the program. This includes gaining initial interest and participation in the program, as well as maintaining ongoing engagement once the program is well underway.

**Gaining Early Buy-In for Program Objectives**

Several ACHP plans described the importance of initial outreach to providers as a key factor in the ultimate success of their programs. Ideally, engagement of providers begins during the planning and implementation phases of the care transitions program. These early efforts may be critical in gaining endorsement of physician leaders who can help bolster support for the program among their colleagues and staff at the hospital or physician office. For example, Group Health Cooperative noted that without the active engagement of key leadership in its group practice, it would not have gained the engagement of the practice, and consequently, its program would not have been successful.

ACHP plans sought early engagement from provider partners in different ways. Some plans, such as Kaiser Permanente, involved providers in the design of their care transitions programs, while staff at other plans—such as Security Health Plan—personally reached out to providers to introduce them to the care transitions program in the early phases of implementation.

When Kaiser Permanente first began to focus on improving care transitions, it assembled a team comprised of physicians and nurses from its hospitals, clinics, and skilled nursing facilities (among others) to garner input on the current state of care transitions and as opportunities for improvement. This group jointly agreed to a standard set of care transitions services, known as the “care transitions bundle,” that now serves as the foundation of the programs in each of Kaiser Permanente’s eight regions. KP’s efforts to engage clinicians across its system at the start of the program led to the creation of provider-supported tools. For example, its
hospital and clinic physicians jointly constructed a standard discharge summary that functions to ease the administrative burden for both parties, ultimately contributing to better patient transitions.

Security Health Plan developed and piloted its care transitions program with just two hospitals; by 2012, participation had increased to 22 hospitals. To bring the additional facilities on board, the nurse managers who lead Security’s care transitions program personally met with hospital leaders to educate them about the program. These in-person visits helped increase the hospital staff’s understanding of the program’s overall objectives, as well as the logic underlying its specific components. The program also garnered a very positive response, particularly among smaller hospitals which welcomed the additional resources for their patients.

Maintaining Ongoing Commitment to Program Goals

Once the care transitions program is underway, maintaining provider engagement is critical. Many ACHP plans note that once the novelty of their program subsided they needed to devote more attention and resources to keeping providers interested in and committed to the goals of the program. Plans also rely on provider partners to help maintain excitement and interest around the program; Geisinger Health Plan, for example, looks to physician leaders to keep energy high.

Some ACHP plans hold meetings with staff at each care setting to discuss patient success stories. Presbyterian Health Plan found that anecdotal stories about readmission “catches” attributable to the program are great motivators for staff. Other plans share aggregate data on program outcomes; Group Health Cooperative, for example, created a visual system for staff to track progress on outcomes measures. In addition to reminding staff about the program, these feedback mechanisms encourage continual improvement in the delivery of the care transitions program.

Independent Health hosts ad hoc meetings with hospital staff (including discharge planners, case managers, and hospitalists) to offer positive reinforcement and discuss opportunities to improve transitions. These may include case studies, such as discussing patients who were appropriate for, but not enrolled in, the care transitions program.

Kaiser Permanente created a virtual network for education and engagement of providers across its eight regions. Through this network, KP hosts monthly webinars on important care transitions topics, offers skill building, and makes a virtual toolbox available for sharing best practices across the regions.

Geisinger Health Plan has developed a “Medical Neighborhood” as part of its ProvenHealth Navigator® model, whereby care managers direct patients to services in their communities that deliver the highest value. For example, case managers and PCMH practices identify home health agencies that are willing to provide services at a moment’s notice. Geisinger uses this medical neighborhood to continually strengthen its relationship with patients and to improve care transitions and other aspects of patient care. For example, Geisinger hosts monthly meetings with hospitalists and inpatient care managers during which they discuss the cases of patients who have been readmitted. Likewise, at monthly medical home meetings, the health plan equips the team with information on ED visits, hospitalizations, and readmissions, which can help identify opportunities at PCMH practices to improve care transitions.
To date, Group Health Cooperative has focused its transition management work primarily on Group Health providers, including hospitalists, care management nurses, skilled nursing facility clinicians, and home health nurses. Since approximately 40 percent of Group Health members receive care from non-Group Health providers, the plan recognizes the need for coordination and collaboration with contracted providers to maintain continuity of care.

Recently, Group Health began piloting an expansion of its transitions management work through enhanced criteria to identify readmission risk and the development of new post-hospital discharge follow-up standards. One challenge of this work was to ensure that the new standards are reinforced for patients seeing contracted providers.

To address this challenge, Group Health broadly disseminated information on the new standards via electronic provider portals, mail, and in-person visits. The plan also deployed administrative and medical leadership to partner hospital leadership to introduce the expanded work. Additionally, Group Health invited clinicians from partner hospitals and clinics to webinar training sessions that offered high-level and detailed information about the expanded work. This gave an additional opportunity to review the new standards and provided a forum for clinicians to air questions and concerns. Group Health reports that this approach was well-received by partner providers during the pilot period and is part of the planned communication approach for its upcoming full implementation.

Group Health uses a patient pathway assignment scheme to classify patients into five strata of care transitions. The patient pathway assignment is completed for each patient every morning during the care management “huddle” with Group Health hospitalists and care managers. This allows Group Health clinicians to consult on all Group Health patients and to determine the appropriate plan of care during and after hospital discharge. Group Health believes that this approach works well for Group Health providers and has become their standard method of providing hospital care to plan members.

Since contracted providers are rarely able to participate in morning huddles, Group Health developed a patient chart cover sheet that identifies a patient’s pathway assignment and recommends a follow-up physician visit timeframe, according to the new standards. While the work is just beginning, the plan reports that some hospital partners have found the pathway assignment scheme so useful that they have added the color coding to their own admission orders.
Incentives for Participation and Performance

Overall, very few ACHP plans reported using financial incentives specifically to gain provider participation or engagement in their care transitions programs. However, plans are aligning their broader incentive programs—such as quality measurement, pay-for-performance, and gain-sharing arrangements—with the objectives of their care transitions programs. In addition, at least one ACHP plan also uses non-financial incentives—an awards program—to spur innovation and engagement.

CDPHP tested financial incentives to physicians who met the process goals of its care transitions program. In its pilot program, CDPHP increased reimbursement for physicians who saw patients within seven days of hospital discharge. According to CDPHP staff, providers responded positively to the financial incentives, seeing patients quickly. Due to the administrative costs that CDPHP devoted to ensuring the incentives were paid appropriately and that patients attended their scheduled appointments, CDPHP did not incorporate the financial incentives into their current program. However, CDPHP has identified the incentives as key to the success of the pilot program and is reconsidering whether to add them to their current program.

HealthPartners has financial incentives for providers who improve care transitions, though they are not as explicitly tied to compliance with program components as CDPHP’s. HealthPartners uses “total cost of care” arrangements that share savings with those provider partners who reduce costs while meeting quality goals. These arrangements offer clear incentives for providers to improve care transitions in order to reduce readmissions and ultimately reduce the cost of care for those patients. For instance, by coordinating primary and specialty care following a hospital admission, providers can reduce duplicative testing, ensure more efficient use of specialty services, and transition patients back to primary care quickly and effectively.

In addition to financial incentives, HealthPartners recognizes medical groups—those affiliated with the plan as well as those that are contracted—that have demonstrated innovation in improving care transitions through its Health Care Award program. The awards help maintain provider engagement as well as encourage continuous quality improvement that can be leveraged across all of HealthPartners’ providers. For example, in 2010, Lakeview Hospital won the award for developing a post-hospital discharge pharmacist intervention. Pharmacists contact patients at risk for medication-related adverse events 7-10 days after discharge. The discharge medication list is compared with the patient’s current medication regimen; patients receive education about medication use, side-effects, interactions, precautions, administration, and compliance; and medication-related questions and concerns are addressed. Both the patient and the primary care provider receive documentation of the encounter and an updated medication list.

UPMC Health Plan, Priority Health, and Geisinger Health Plan, along with other ACHP plans, use quality measurement and pay-for-performance incentives that are aligned with their care transitions programs. Likewise, Presbyterian Health Plan and Independent Health both noted that there is overlap with the incentives for their PCMHs and the goals of their care transitions programs.
Leverage Technology to Improve Care Transitions

Technology plays a critical role in assisting health plans to facilitate communication between patients and their myriad providers during a transition of care. Health plans can contribute to improved coordination of care during this period by maintaining and promoting access to a centralized and accurate record of a patient’s medical history. ACHP member health plans fulfill these roles by supporting electronic medical records (EMRs) and using telehealth solutions.

Using Technology to Guide Patient Interventions

ACHP health plans are using technology to track patients throughout their transitions between settings of care and to ensure that all providers have access to a complete picture of the care a patient is receiving. Plans also use health information technology to ensure patients receive adequate follow-up care and to identify patients for enrollment in additional programs such as disease management or complex case management.

For example, all of HealthPartners’ onsite case managers are equipped with laptops, which permit secure remote connection to their information systems and platforms, which include patient assessment and decision support tools and evidence-based guidelines. To further augment these capabilities, in 2011, HealthPartners developed and implemented a care transitions “activity” documentation tool. This tool helps clinicians adhere to the protocols of their program and also results in more robust outcomes reporting. HealthPartners continues to make improvements to the tool and plans to continue adding additional capability enhancements to intervention and outcome reporting.

UPMC Health Plan uses a patient-centric care management documentation system called HealthPlaNET to streamline collection of information. Care managers for each program—such as wellness, disease management, and care transitions—all use the same system. As a result, a provider or care manager can pull up a record and view case notes for all of the interventions a patient has received. The care management documentation system can also be used to share workflows in order to systematize referrals to care management for each of the plan’s clinical initiatives. As a result, the plan is able to ensure that patients who need additional care coordination are enrolled in care management programs in a timely manner. UPMC Health Plan also equips mobile care managers with laptops to complete assessments during home visits. Mobile care managers coordinate follow-ups with PCMH and telephonic care managers directly via the care management system, while still in the home, to facilitate enrollment into care management programs. They can also schedule follow-up appointments with home care, and make referrals electronically to Emed Health* through work lists, via the care management documentation system.

Increasingly, ACHP plans are able to ensure that all providers caring for a patient have access to the same set of information through EMRs. The use of EMRs can improve delivery of care, reduce medical errors, and ensure complete documentation of a patient’s medical history. EMRs facilitate care transitions programs by enabling faster flow of information and standardization of information such as discharge

* Emed Health is a division of the nonprofit Center for Emergency Medicine of Western Pennsylvania, Inc.
notes. ACHP member plans such as Geisinger Health Plan, Kaiser Permanente, HealthPartners, and Group Health Cooperative, use EMRs to transmit information across providers and have found them to be a very valuable tool for care transitions.

At Geisinger, a patient's EMR automates his or her care transitions, contributing to improvements at each step of the transition process. The use of EMRs also ensures that all providers who see a patient admitted to a Geisinger facility have easy access to that patient’s information. For example:

- Geisinger’s EMR, which has risk stratification embedded in it, alerts clinicians immediately of the patient’s risk for readmission, upon admission to the ED.
- Inpatient care managers input their assessments into the EMR, allowing all providers who see the patient to access this information.
- The EMR is used to notify PCPs when one of their patients is admitted to the hospital.
- Patients’ discharge summaries are included in their EMRs within 48 hours of their discharge and electronically transmitted to their PCPs.

Using Telehealth to Improve Communication Between Providers and Patients

All ACHP plans recognize the importance of ongoing contact with patients during the post-discharge period and include telephone calls and/or home visits as part of their follow-up approach. ACHP plans have also implemented telehealth programs to include daily, weekly, and/or monthly monitoring of a patient’s condition. Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, health-related education, and health care administration. Overall, telehealth allows providers more opportunities to observe discharged patients and to intervene quickly, before a condition escalates.

Telehealth is particularly well suited to the needs of patients living in rural areas or with conditions that require more constant monitoring. For example, all five ACHP plans that currently use telehealth are using telemonitoring for patients with CHF. In such programs, a heart monitor unit is placed in the patient’s home and connected through the patient’s telephone line, alerting a home care nurse if a patient is in need of follow-up care.

Security Health Plan instructs its home health agency (HHA) partners to use telemonitoring units with heart failure patients. The HHA connects a weight scale and telemonitoring unit to the patient’s phone. The patient’s weight and blood pressure data are transferred electronically to the HHA, where a nurse monitors the data and is able to respond quickly to any changes outside of an allowed range, and, if necessary, contacts the physician to adjust medications.

Geisinger Health Plan’s model is similar to Security Health Plan’s. Patients receive a Bluetooth® scale and reminders to weigh themselves daily. If a patient’s weight increases above pre-defined levels, the scale will automatically signal the patient’s case manager, who will then follow up with the patient. Geisinger is also considering expanding its telehealth offerings to include video monitoring, Bluetooth pill boxing, Bluetooth glucose monitors, and inhalers, to ensure patients are following care plans.
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In addition, Geisinger’s care transitions patients receive weekly interactive voice response messages for the first four weeks post-discharge. Any adverse responses are automatically directed to the case manager for follow-up. In the past year, Geisinger has linked this data to its EMR, making it available to the providers in its network.

In Michigan, where ensuring access to quality health care in rural areas is an important concern, Priority Health’s telehealth program assists in bringing the provider to the patient in remote communities. Earlier this year, Priority Health was one of fifteen Michigan HMO plans to win a “Pinnacle Award” from Michigan’s HMO association for its innovative approach to telemedicine for heart failure patients. The plan uses glucometers to remotely manage CHF patients with diabetes. Data are captured daily, and monthly reports are disseminated to providers to help them monitor their patients. If the data report a red flag, the provider contacts the patient immediately by telephone or, if necessary, conducts a home visit. Priority Health has since expanded telemedicine to patients with COPD and other cardiac conditions.

UPMC Health Plan uses telehealth to treat patients with slow-healing or non-healing wounds. As part of this program, wound care nurses visit patients in their homes to take measurements, adjust wound care treatment via detailed algorithms, and to take digital photos of the wounds to be shared with the patient’s PCP or vascular surgeon. The PCP or surgeon can then determine the best course of action. The plan is currently working on upgrading its telehealth system to use time-series photographs to track wound care.

UPMC Health Plan also has a telehealth program for heart failure and COPD, in collaboration with UPMC Home Health. The primary goals are to reduce frequency of acute inpatient and ED admissions for heart failure, facilitate member self-management skills, and aid physician follow-up. UPMC Home Health collaborates with PCPs to establish member-specific vital sign parameters.

ACHP plans that have implemented telehealth systems have reported improvements in quality measures such as reduced readmissions for CHF patients. In the case of UPMC Health Plan, wound healing has improved by 50 percent. Despite reported benefits, there are certain challenges to implementing and expanding telehealth programs. First, telehealth programs have high upfront implementation costs. Second, more available data can only improve care transitions if the plan has sufficient staff and resources to review the data and respond to resulting increases in patients’ needs.
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Incorporate Care Transitions into Standard of Care

There is no single solution to reduce readmission rates or to more generally ensure that members have positive outcomes after a hospitalization. However, ACHP plans have consistently underscored their care transitions programs as being one piece of a broader scope of quality initiatives.

Some ACHP plans use their care transitions outreach as a conduit to enroll members in programs such as disease management. For example, after a patient is discharged from the hospital, a nurse from Presbyterian Health Plan calls the patient within 48 hours. Presbyterian uses this touch point as an opportunity to enroll patients with diabetes or coronary artery disease into their disease management programs by having a nurse on the disease management team call those patients.

Likewise, Security Health Plan aims to use its care transitions program to ensure that its members are connected with additional support, such as case management programs, once they return to the community. For example, at the conclusion of the four-week care transitions program, the case manager will assess a patient’s continuing needs and makes referrals into more intensive case management or disease management, if appropriate.

Other plans see their care transitions programs as one component of a larger initiative. For instance, that program is just one piece of Group Health’s EDHI (Emergency Department Hospital Inpatient) program. EDHI brings together inpatient hospital, care management, and skilled nursing facility (SNF) staff, along with other providers, to not only improve care transitions and reduce readmissions, but also to reduce preventable admissions and ED visits. The EDHI program seeks to provide intensive, evidence-based transitions coaching for patients with complex needs and consistent, reliable post-hospital follow-up care. In addition, it focuses on increasing patient access to alternative care settings and engaging patients in advanced care planning, including palliative and end-of-life care. As a result of this work, Group Health Cooperative has seen hospital admissions decline and attributes its stable readmission rates to this overall decline in admissions.

Geisinger Health Plan’s focus on enhancing transitions of care is just one of the objectives of its medical home initiative, ProvenHealth Navigator©. As part of this initiative, Geisinger embeds case managers in primary care practices, allowing case managers to be incorporated into the workflow of the practice. Patients in ProvenHealth Navigator© are contacted after discharge from the hospital by the case manager from their medical home. The case manager can also schedule and attend follow-up visits with the primary care provider.

Priority Health has made its care transitions program, in its own words, “its standard level of care.” As such, one of its aims is that every patient see a PCP within five days after a hospital discharge. By instilling this culture among its providers—those who are part of the integrated delivery system as well as those who are contracted—it has been able to achieve this goal of prompt follow-up visits.
III. Profiles of ACHP Plans’ Care Transitions Programs

Sections

- Capital District Physicians’ Health Plan
- Fallon Community Health Plan
- Geisinger Health Plan
- Group Health Cooperative
- HealthPartners
- Independent Health
- Kaiser Permanente
- Presbyterian Health Plan
- Priority Health
- Scott & White Health Plan
- Security Health Plan
- UPMC Health Plan
Capital District Physicians’ Health Plan (CDPHP) developed and launched its care transitions program on July 1, 2011, building upon a successful initial pilot program focused on Medicare Advantage members. CDPHP designed the program as a joint venture among nursing agencies, hospitals, and physicians to target members with diagnoses of CHF, CAD, and COPD. The nursing agencies ensure that a nurse first meets the patient while still in the hospital and then visits the patient at home within 24 to 48 hours of discharge. During the home visit, the nurse reviews discharge instructions, does medication reconciliation, reviews home safety, and assesses caregiver support. The nurse also makes sure that the patient has scheduled a PCP visit within seven days after discharge. Within 10 to 14 days of the home visit, the nurse makes a follow-up phone call to the patient. Hospital staff are responsible for having the appropriate paperwork available to PCPs and are required to cooperate with detailed and timely discharge instructions.

CDPHP employs inpatient care coordinators (ICCs), who are registered nurses, to introduce patients to the care transitions program. The manager coordinates all of the ICCs and visiting nurse agencies; CDPHP believes that having one person responsible for the coordination of the program is a key component of its success. The manager of the program has relationships with provider practices and hospitals, facilitating cooperation across the board. In the Medicare pilot, CDPHP reimbursed physicians more generously if they saw patients within seven days of discharge from the hospital. CDPHP did not incorporate these incentives into its current care transitions program, but it is something the plan may do in the future.

In August 2011, CDPHP began another program to further target the most at-risk patients. This program focuses on patients who have been admitted to a hospital two or more times during a six-month period. Participating patients must have at least two conditions, one of which must be congestive heart failure, coronary artery disease, or chronic obstructive pulmonary disease. Patients get a visit from a nurse or social worker at least once a week for three months. CDPHP plans to pilot this program with 100 patients and then compare the results against a control group. CDPHP contracted with Senior Bridges to conduct the pilot, but intends to bring the program in-house if it is successful. CDPHP has also replicated its care transitions program to create a successful behavioral health program. The plan built on the concept and lessons learned from its care transitions program to design a program in which a social worker visits patients with behavioral health needs in the hospital and at home, and ensures that patients receive follow-up care.

In addition to CDPHP’s hospital-to-home program, the plan focuses some resources on transitions from the hospital to facilities. In January 2009, CDPHP partnered with Matrix Medical Network* to see every patient who is discharged to a facility. The Matrix Medical nurse practitioner sees every patient upon arrival at the admitting institution. If the patient is later discharged home, the Matrix Medical nurse visits the patient in the home to ensure a safe transition.

CDPHP estimates the all-cause 30-day readmission rate for participants in the care transitions program at about 10 percent, which compares favorably to its target rate of 11 percent and plan-wide rate of 12 percent.

* Matrix Medical Network provides medical assessments on the behalf of health plans and medical service providers.
III. Profiles of Plans’ Care Transitions Programs

FALLON COMMUNITY HEALTH PLAN

From November 2009 to April 2010, Fallon Community Health Plan conducted a pilot care transitions program focusing on patients with CAD, COPD, and pneumonia admitted to the hospital and skilled nursing facilities (SNFs). For the pilot, Fallon contracted with a vendor who deployed pharmacists to conduct a home visit within 48 hours of a patient’s discharge from the hospital or SNF. The pharmacist’s primary goal during the home visit was to conduct medication reconciliation. However, pharmacists were also responsible for assessing a patient’s social and living environment to identify non-clinical factors that may impact health. Additionally, the pharmacist ensured the patient had a PCP or specialist follow-up appointment within five days. Over the course of the pilot, 120 of Fallon’s members participated in the program.

Fallon’s greatest challenge has been identifying the right patients for inclusion in the care transitions program, ensuring that patients are sufficiently at-risk to benefit but not so sick they are unable to participate in the interventions. On a daily basis, Fallon receives a list of patients from hospitals and SNFs that helps them identify patients for the program. The plan has a program coordinator who reviews the list and assesses the need for those patients to be included in the care transitions program.

Although the pilot decreased readmission rates by a few percentage points, there weren’t any cost savings associated with this decrease. This was largely due to Fallon’s existing payment policies under which they do not pay a hospital for a readmission if patients are readmitted for the same or like diagnosis, for 11 disease states.

Fallon is using the lessons learned from the pilot to develop a care transitions program deploying in-house resources instead of contracting with a vendor. One of the key differences between the pilot program and the broader program the plan is currently designing will be the designation of a program coordinator. In an effort to realize savings, Fallon also identified opportunities to use less-costly, non-pharmacist providers for certain aspects of the program and is deploying pharmacists only for medication reconciliation. The plan’s other medical professionals or administrative staff will make follow-up appointments, ensure patients have transportation to the appointments, and make certain that patients have adequate resources at home to manage their conditions. The program will also assign a care manager to each patient. Additionally, Fallon is working with physician groups to identify their needs and determine how best to incorporate them into the program.

One of Fallon’s largest physician groups, comprised of over 250 physicians (including specialists) agreed to see members within 48 hours of a discharge. This significantly improved patient follow-up with primary care physicians or specialists.
In May of 2008, Geisinger Health Plan piloted a transitions of care program in conjunction with its Geisinger Health System inpatient facilities. Although the transitions of care program is now fully implemented, Geisinger continues to refine the model based on lessons learned. The program is designed to decrease fragmentation associated with poorly coordinated transitions, facilitate timely communication of discharge summaries, increase the number of patients who get follow-up care within seven days, engage patients by incorporating “teach back” techniques, reduce 30-day readmissions and associated costs, and reduce post-discharge emergency department visits.

Geisinger uses EMRs to automate care transitions and ensure that there is a coordinated transition of care for its members. For instance, Geisinger relies on the EMR for:

- conducting risk stratification for all patients who are admitted into the emergency department (risk stratification is embedded into the EMR and predicts risk for readmission);
- capturing the inpatient care management assessment;
- notifying PCPs of admissions and discharges for their patients (if the providers are outside of Geisinger’s EMR, they receive a faxed notification);
- completing a discharge summary within 48 hours of discharge; and
- automating discharge instructions (faxed to providers without EMR connectivity).

Beyond using EMRs with robust clinical data to coordinate care, Geisinger also has a set of guidelines in place to ensure patients receive adequate support. Prior to leaving a Geisinger hospital, all patients have post-discharge follow-up appointments. For non-Geisinger hospitals, outpatient case managers are responsible for ensuring the patient visits a PCP.

Further, patients that are part of Geisinger’s medical home model are contacted by phone by a case management team within 24 to 48 hours of discharge. Geisinger case managers focus on six key aspects of care transitions:

- conducting medication reconciliation,
- scheduling a PCP visit within 5-7 days,
- identifying gaps in care and ensuring appropriate care coordination,
- assuring patient safety and adequate social support,
- procuring appropriate home health and durable medical equipment, and
- ensuring patients or family members have an action plan for managing exacerbations of their condition.

Geisinger also places weekly interactive voice response (IVR) automated phone calls to members who are discharged from the hospital, for at least four weeks. A January 2012 study found reductions in readmissions of 44% for Medicare Advantage members who received these IVR calls in addition to case management. Adverse patient responses automatically generate an alert to a case manager. Geisinger also has capabilities to conduct telemonitoring with Bluetooth scales for members with heart failure, alerting case managers if a patient’s weight increases above pre-defined limits.

In addition to Geisinger’s hospital-to-home program, the plan has a Nursing Home Initiative that places advanced practitioners in nursing homes who follow patients through short- and long-term stays. This hospital-to-facility model provides clinical assessment and oversight of patients, acting as a liaison between the nursing home and the patient, and directing the patient’s clinical information back to the PCP and other care team members.
Group Health Cooperative began its care transitions work in June of 2009 and rolled out its program by the end of that year. Group Health approached the program by looking at the continuum of a patient’s care, from when the patient arrived at the ED to when they were discharged to their home. Since the plan does not own its own hospitals, its staff worked with seven hospitals to implement the program. The program has undergone minor enhancements since its implementation, with the goal of better addressing the causes of their 30-day readmissions.

Group Health’s work is based on Dr. Eric Coleman’s Four Pillars® transition model. All nurses are trained to provide coaching to high- and moderate-risk patients prior to hospital discharge and to reinforce the messaging during the post-discharge phone call.

All Group Health patients are reviewed for transition needs and are categorized into one of five pathways (see page 23). These pathways allow providers to target transition interventions appropriately. Patients in the blue pathway are those with uncomplicated conditions, such as new mothers with uncomplicated births or patients getting an appendectomy, who will need minimal post-discharge care. Patients in the orange pathway—the fifth and newest pathway Group Health began using in January 2012—are those at highest risk of readmission, due to a decompensated medical stay or with three or more specific conditions. Patients in the yellow pathway are those at moderate risk of readmission, who will need help with their condition, drugs, and doctor’s orders. Patients in the green pathway are those who will be discharged to a SNF. Patients in the red pathway are those patients who are most likely to need end-of-life care.

Patients in the orange and yellow pathways receive the most follow-up care after a discharge. Those patients receive a call from their hospital nurse within 48 hours after discharge. Additionally, patients in the orange pathway receive medication reconciliation from a pharmacist within seven days.

Group Health Cooperative has modified its approach to post-hospital follow-up care, based on the recommendations of a physician team it convened. In January 2012, Group Health implemented a more robust patient risk stratification approach with specific post-discharge follow-up recommendations to ensure patients see a PCP or specialist within seven or 14 days (depending on risk).

In 2010, Group Health Cooperative saw $51 million in savings from their efforts to reduce the number of hospital admissions.

In addition, Group Health’s EDHI (Emergency Department Hospital Inpatient) program coordinates inpatient hospital staff, care management staff, SNF staff, and other providers. The program is centered on the patient experience to ensure the best possible outcomes for patients. Some of the interventions include intensive evidence-based transition coaching for hospitalized patients with complex needs; consistent, reliable post-hospital follow-up care; proactive palliative care planning through engaging patients and their families about end-of-life care preferences; and increased access to alternative care settings, including nonhospital extended observation and urgent care.
Health Plan Innovations in Patient-Centered Care

III. Profiles of Plans’ Care Transitions Programs

The most intensive program is available to those patients receiving care at one of Group Health’s seven contracted hospitals, where the plan has on-site hospitalists and nurse care managers. In these seven hospitals, Group Health’s hospitalists may assess patients in the ED to determine if they need to be admitted, allowing the plan to route patients to more appropriate care settings and decrease total admissions.

Group Health has nurse care managers at an additional two hospitals. These hospitals, together with the seven contracted hospitals with on-site hospitalists, account for 65 percent of Group Health’s total hospital admissions. Patients who receive care outside of these nine hospitals receive transition planning telephonically, upon discharge from the hospital. Additionally, all of Group Health’s SNF and home health physicians and advanced practice registered nurses participate in the care transitions program to ensure safe transitions from hospital to SNF or home.

In 2010, Group Health Cooperative saw $51 million in savings from multiple efforts to reduce the number of hospital admissions, including its EDHI program. From April to June of 2011, Group Health completed a thorough analysis designed to better understand the causes of 30-day readmissions.

HealthPartners first implemented its Inpatient Case Management program in 1999 to focus on safe care transitions. HealthPartners leverages its full enterprise—including its health plan, the HealthPartners Medical Group, and its hospitals—to support safe care transitions.

HealthPartners utilizes a multi-phased approach to identify members who are at risk for re-hospitalization. Inpatient case managers screen and stratify all member admissions for risk using a standardized evidence-based assessment, paired with clinical judgment. The health plan uses a proprietary predictive modeling system, chosen for its reportedly high level of sensitivity and low level of false positives. Membership, claims, pharmacy, and, if available, lab data, are processed through a sequence of algorithms to distinguish patterns suggestive of potentially worsening conditions, likely complications, and hospitalizations. The output is a registry, which is refreshed monthly. Each registry is overlaid with a score that ranks the registry patients based on their risk of future high total medical expenditures. HealthPartners reports that outcome data confirm that the systematic use of a standardized risk assessment tool supported by formalized work flows makes certain that all individuals are assessed for readmission risk as a routine process.

Inpatient case managers collaborate with the hospital-based care team, and connect with patients and their families to support smooth transitions to complex case management services post-discharge. They also make warm referrals to their counterparts within the Complex Case Management program. This allows the inpatient case manager to reference the complex case manager by name, setting the stage for a seamless transition of care. At-risk members already managed through HealthPartners’ Complex Case Management and Disease Management programs automatically receive post-discharge phone calls from their case managers, to ensure that a safe transition of care occurs, as well as to facilitate continued program participation.
HealthPartners’ inpatient case managers work onsite with patients and families in most of the local metropolitan hospitals. HealthPartners believes that its onsite presence plays a significant role in helping case managers build credibility and meaningful professional relationships with physicians, nurses and other hospital staff, allowing them to work as members of the hospital-based team. For out-of-state hospitals, the same services are provided telephonically.

All of HealthPartners’ case managers are equipped with laptops, which provide a wireless connection to all of HealthPartners’ information systems and platforms. This permits access to all relevant member information, including the member’s care plan, as well as a variety of tools (including assessment tools, decision support tools, and evidence-based guidelines) made available through the system.

In 2009, Inpatient Case Management program enhancements were implemented to strengthen HealthPartners’ ability to significantly reduce readmissions associated with preventable complications. As part of this change, the plan broadened the scope of targeted criteria for proactive post-discharge outreach. All admissions that were assessed as “moderate/borderline” risk began to receive an outreach call within two days post-discharge for further assessment and program referral, as appropriate, which might include Case Management (medical or behavioral health), Disease Management, and Hospice or Palliative Care.

HealthPartners promotes and rewards medical groups that demonstrate innovations in care transitions through its Health Care Award program. For example, in 2010 Lakeview Hospital won the award for developing a post-hospital discharge pharmacist intervention. In this intervention, pharmacists contacted patients at risk for medication-related adverse events 7-10 days post discharge. The discharge medication list was compared with the patient’s current medication regimen; patients received education about medication use, side effects, interactions, precautions, administration, and compliance; and medication-related questions and concerns were addressed. Both the patient and the PCP received documentation of the encounter and an updated medication list. HealthPartners believes that the Health Care Award Program recognizes and celebrates the innovative efforts of medical groups and fosters physician engagement.

From 2009 to July 31, 2011, over 3,000 patients referred from inpatient case managers to Complex Care Management have engaged in the program, representing an engagement rate of 94 percent. HealthPartners uses financial and utilization metrics to evaluate its Complex and Inpatient Case Management programs. For its Inpatient Case Management program, HealthPartners primarily focuses on hospital readmission rates and average length-of-stay per admit. For its Complex Case Management program, HealthPartners uses the medical admission rate, emergency department utilization, and total claims costs. HealthPartners has seen a return on its investment of nearly five to one for each of these programs (see page 55).
Independent Health began developing its care transitions program in 2009. Although Independent Health originally conceived of a program based on some of the work that was done nationally, its providers wanted to actively participate, and Independent Health welcomed their engagement. Two major hospital systems in the area and a smaller free-standing hospital are currently actively engaged in the program. Although Independent Health does not drive the program, it has a collaborative relationship with the hospitals and actively contributes to components of the program.

A patient’s care transition begins with coordination of the patient’s discharge status and plan among the hospital, outpatient service providers, and the health plan. As part of the program, the member receives a home visit by a home health agency within 72 hours post discharge. Patients also complete a self-management guide, and a pharmacist conducts medication reconciliation. The patient receives support via phone calls 7, 14, and 28 days following discharge.

Independent Health has been able to engage the physician community, which has been very supportive of its care transitions initiatives. Every year, Independent Health has a large comprehensive quality incentive program, for which it identifies a variety of quality measures and sets a target for each of those measures. Given that reimbursement is linked to the measures, which focus on elements associated with care transitions, physicians and hospitals tend to be very engaged.

The plan has found that the greatest challenge is ensuring that all eligible patients are introduced to the care transitions program. The hospitals are in charge of making patients aware of the program, but that introduction can be easily lost in the day-to-day health care needs that hospitals and physicians must first address for the patient. To improve outreach to patients, some of the hospitals have started using dedicated social workers to introduce the transitions program to patients and their families.

Independent Health has begun to evaluate the impact of its care transitions program on the number and cost of its readmissions. After initially looking at the total number of readmissions, the plan has since modified its methodology to stratify readmissions by severity, ranked on a scale from one to four. It has found that there are fewer readmissions year over year, with the majority of the prevented readmissions in the least severe levels, one and two. However, because there has been far less reduction in level three and four readmissions, which are the most costly, the plan has not yet documented significant cost savings.

Approximately 80 percent of network hospitals are participating and helping identify members for referral to the program.
Kaiser Permanente (KP) began to focus on improving care transitions three years ago. Since its 35 medical centers, located in eight different geographic regions, are in different stages of program development, KP created a Reducing Readmissions Governance Oversight Group that includes representatives from all groups, to ensure coordination of the various initiatives developing across the regions. To further aid its regions in program implementation, KP developed a patient-centered “Transition Bundle” designed for all patients leaving the hospital, with tailored care for those who are high risk. Elements of this bundle are being incorporated in all of its regions. Some of the bundle elements include:

- **Risk stratification with tailored care**: Patients who are at high risk for readmission are identified to ensure they have additional interventions.

- **Standardized discharge summary**: A uniform discharge summary is completed by the doctor on the day the patient leaves the hospital or SNF.

- **Specialized transitions phone number for patients**: The hotline is answered by a nurse at all times, and the nurse is able to follow-up with the doctor from the hospital or SNF who is accountable for the patient, until the patient sees his PCP.

- **Timely follow-up**: Follow-up appointments are made in the hospital; all high-risk patients have a follow-up visit scheduled within five days of being discharged. Nurses also call all patients after discharge—and there is a more comprehensive 30-day case management program for high-risk patients.

- **Medication reconciliation across all settings**: High-risk patients have pharmacists’ involvement and a follow-up call with a pharmacist once returning home.

In developing the “Transitions Bundle,” in order to understand the end-to-end experience of patients leaving the hospital, Kaiser Permanente staff interviewed hundreds of patients and caregivers and completed a readmission diagnostic evaluation on over 600 cases. This included chart review, as well as an interview with both the physician and the patient. KP also used video ethnography to capture the patient’s experience in the hospital and at home following discharge, which was compiled into a video library for its regions to use in their own program development (see case study on page 24). One of their key findings was that for patients, the transition doesn’t really happen until they return home. Currently, patients remain involved in the development of the Transitions Bundle by serving on KP’s transitions redesign and improvement teams.

Another important lesson Kaiser Permanente learned from its patients was that they wanted to be able to easily contact the plan. Taking that feedback into consideration, KP has developed a special transitions telephone number where nurses are available to answer the patients’ questions about their condition, prior to the follow-up visit with their PCP. These nurses can...
address the majority of patients’ issues; for the remainder, the nurse is able to connect the patient on the line to the hospital physician. Kaiser Permanente has received a very positive response from both patients and physicians, and reported a drop in the readmission rate, as patients now have an alternative venue for addressing concern post-discharge.

To further focus on high-risk patients, KP developed a program for patients with conditions such as congestive heart failure (CHF), called the Transitional Care Program (TCP). Patients enrolled in this program get an inpatient assessment, a home visit within 48 hours of discharge, and a timely referral and follow-up in the heart failure clinic. This program includes elements of the Transitions Bundle, plus additional interventions, including educational materials, the use of teach back, standardized screenings, referrals to Palliative Care Services, and follow-up nurse visits within 48 hours of leaving the hospital. This program has resulted in a 30 percent decrease in readmissions, a 40 percent improvement in quality measures related to CHF, and an increase in patient satisfaction.

Kaiser Permanente’s employees across all eight regions actively engage in the improvement of care transitions on a regular basis; openly sharing success stories and communicating about challenges is core to the program. A team of KP employees throughout the eight regions holds weekly phone calls to discuss best practices for follow-up care. KP has also created a network of over 1,000 employees who engage with each other through webinars and a virtual toolbox that allows employees to get online and see what others are doing.
Presbyterian Health Plan began its care transitions program in September of 2009. Presbyterian has identified its top 15 readmission diagnoses and uses those to target members who are at high risk for readmission. Those members who are targeted receive two visits during their inpatient hospital stay. If they are at an out-of-area facility, they receive a telephonic “visit.”

Presbyterian has estimated a decrease in average length of stay related to targeted diagnoses, yielding savings of $1.8 million.

An inpatient case manager helps answer questions about the health plan benefits, evaluates the member’s understanding of the discharge plan and assesses whether that plan is realistic, identifies contact information upon discharge, has discussions with the attending physician and discharge planner as appropriate, and facilitates necessary authorizations to conduct initial and concurrent review. Inpatient case managers visit patients for a second time before a discharge occurs. Case managers review discharge instructions and make sure the member receives a phone call within 48 hours after discharge. During this phone call, the case manager conducts medication reconciliation, ensures that all durable medical equipment has been delivered, and initiates contact with home health care, if necessary. Staff use a variety of scripts and checklists as references during interactions with patients.

In the Albuquerque area, Presbyterian uses navigators in EDs to identify patients who are at the ED to receive non-emergent care. Navigators assist individuals in accessing appropriate levels of care within the next 24 hours, such as by scheduling a PCP appointment.

Presbyterian uses data to drive decision-making, which is one of the key success factors of its program. The plan does this by streamlining communication. The Director of Health Services for Presbyterian, who manages the plan’s care transitions program, as well as the Director of Case Management for Presbyterian Hospital, who is responsible for care transitions from the provider side, both report to the same Vice President within Presbyterian Healthcare Services (the corporate parent). This fosters a strong relationship between the plan and the hospital. The two program directors are able to share data more easily, giving them both the ability to see every patient in the system at any time; they also have a shared incentive to work together to solve problems and improve care for the system overall, and not for just the plan or just the hospital. In addition, the plan shares data on performance with providers and has found that even anecdotal stories about “catches” that resulted from the program are great motivators for staff.
In 2008, Priority Health began a care transitions program modeled after the work lead by Dr. Eric Coleman at the University of Colorado. The program started with PriorityMedicare and focused on patients with a primary diagnosis of heart failure. After initial success in the pilot, Priority Health expanded the pilot to additional diagnoses and all regions and products, including commercial patients.

Priority Health uses the top ten readmissions diagnoses from the previous year to identify high-risk patients. For select diagnoses, clinicians have some discretion to determine whether these patients would benefit from the program.

The care transitions program begins when a registered nurse visits the patient in the hospital. The nurse introduces the program and explains the need for post-discharge home care visits. All patients are automatically authorized two home visits post discharge. In order to do this, Priority Health works closely with its integrated delivery network, Spectrum Health System, to ensure physicians and hospitals are engaged in the care transitions initiative. Although Priority Health has tried to engage all of its providers, it has had less success engaging providers that are not part of the integrated delivery network.

Priority Health learned that visiting patients within two days of hospital discharge was crucial. In particular, Priority Health’s case management team believes the best approach to conducting medication reconciliation is by being in the home with the patient to ensure the patient understands the dosing and interaction effects of his or her pre-hospitalization medications and post-discharge medications. Another important component of the home visits is the review of the patient health record (PHR). Case managers review PHRs with patients, add questions from patients to their physicians, and update the discharge summary. Priority Health aims to get all patients in to see their physicians within five days of discharge. Priority Health has been able to get physicians on board by emphasizing that ensuring patients see their doctor five days after discharge is its standard level of care.

The Priority Health case management team follows up with telephone calls to patients enrolled in the care transition program 7, 14, and 28 days post discharge. After this period of outreach, which also includes referral management and close coordination with the patients’ PCPs, the member, and all of the people involved in coordinating care for the member, determine the appropriate level of care moving forward.

Priority Health has been very successful getting patients back to see their physicians, as patients see physicians within five days of being discharged. Prior to the program patients typically waited over two weeks for a visit.

In 2010, Priority Health decided to begin using a telemonitoring program. Many of its members are located in rural areas of Michigan, and although the plan has been using its telemonitoring program with patients regardless of their location, it has proven vital for patients living in rural areas without immediate access to care. To be eligible for telemonitoring, patients need to be admitted to the hospital for heart failure and have poor adherence to treatment regimens. Priority Health contracts with a vendor to install and de-install the device and
to monitor the feed from the patient’s home, typically for a period of three months. In the case of red flags, the vendor immediately calls the member.

Priority Health has measured its return on investment since the beginning of the program. The plan looks at its overall readmission rate, excluding certain readmissions that are not reimbursed separately. It then compares the readmission rate for the current period against the rate for the same time period for the previous year. The difference in readmissions between periods is the estimated savings for the care transitions program. Priority Health’s readmission rate for the first half of 2011 is between 10.5 and 11 percent, a 1-1.5 percentage point decline relative to 2010.

**Scott & White Health Plan**

In April 2010, Scott & White Health Plan (SWHP) in Texas started the VitalBridges (VB) program as a way to identify the unmet needs of members when they are most vulnerable, directly after hospital discharge. The program is a telephonic service offered to members discharged from a Scott & White hospital to homes. Members are contacted within 48 hours of hospital discharge by a vendor contracted by SWHP to better ensure a smooth hospital-to-home transition.

In the first nine months of 2010, at least 5,924 calls were made, resulting in contact with 2,491 members and almost 500 family members. These phone calls resulted in over 400 referrals.

On a daily basis, SWHP generates a list of members who have been discharged from Scott & White hospitals and transmits the names of those patients to a VB customer advocate who makes at least three attempts to reach the patient. When a patient is reached, the caller uses an approved script to assess how the member is feeling and address any needs related to the member’s post-discharge plan. The VB caller also solicits feedback on the member’s hospital stay. In some cases, with the member’s permission, additional outreach is done to family members or caregivers. VB staff also work to make family members aware of services available to them through the health plan, such as home health care.

The VB customer advocate often refers members to additional services such as Case Management, Pharmacy, Health Plan Benefits, Direct Nurse Assistance, Patient Relations, and Physician Appointment Assistance Services. If the VB advocate wants to refer a patient to a service, he or she sends an email to a member of the VB support staff who forwards the referral request to the appropriate point-of-contact for the respective service within SWHP.

Additionally, the VB customer advocate tracks the number of calls and referrals made from the program; this information is compiled into weekly and monthly reports that are regularly relayed to SWHP. In the first nine months of 2010, for example, at least 5,924 calls were made, resulting in contact with 2,491 members and almost 500 family members. These phone calls resulted in over 400 referrals, with just over 40 percent of those referrals being made

*Scott and White Health Plan provided Avalere Health with a white paper, “Care Transitions, Hospital Readmissions, & VitalBridges · Analysis and Recommendations,” written by Benjamin Perry, which was summarized for this plan profile.*
to Case Management Services for members with chronic conditions, such as diabetes, or those requiring therapeutic monitoring. Almost 15 percent of the referrals were made to the Physician Appointment Service to offer help to members in making appointments with their PCPs or specialists.

SWHP reviewed data generated from the program to learn more about members’ needs during the transition period, and to effect changes at the health plan level to better meet those needs. For example, the health plan found that many members did not have timely follow-up appointments with their physicians after discharge; in response, SWHP started a 24/7 customer services program that makes follow-up appointments with and for members, significantly decreasing the time members have to wait to see providers after discharge.

SWHP conducted a survey of 92 members to receive feedback about the program. Members selected for the survey were those who had been contacted by VB customer advocates within the previous month, to increase the reliability of members’ response. Virtually every survey respondent felt that the VB caller offered clear explanations, and one patient noted how the health plan kept patients connected with providers who were able to answer questions and provide care.

Medication reconciliation is an important component of many plans’ transition programs
III. Profiles of Plans’ Care Transitions Programs

**Security Health Plan**

Security Health Plan launched its Transition to Home (TTH) program on January 1, 2009, initially targeting admissions and readmissions of members with diabetes, heart failure, and COPD. The program started at Security’s two major hospitals, through collaboration with discharge planners and care managers at each hospital to facilitate the discharge to the home. Security has since expanded the program to 22 hospitals through the efforts of two nurse managers who visited each hospital to engage staff in the program. Security’s nurse care managers work with hospital case managers to identify patients eligible for the TTH program. In the two largest hospitals, nurse care managers make attempts to visit identified members in the hospital prior to discharge to meet them, educate them, set discharge expectations for them, and engage them in the TTH program.

Following a patient’s discharge, a nurse visits the home. The focus of the home visit is performing medication reconciliation, assessing the patient’s knowledge of his or her condition and discharge instructions, and ensuring that a PCP follow-up visit has been scheduled. Nurse care managers then make weekly follow-up telephone calls to patients for at least three to four weeks, to assess transitional needs and stability. After four weeks, a patient satisfaction survey is performed. Members with ongoing needs are referred to complex care management or disease management services through the plan.

Security’s home health agency uses telemonitoring units for patients with heart failure. The unit is connected to a phone, which transmits the patient’s weight and blood pressure to a central location. This is an “above and beyond” service tool that allows the home health agency to indentify warning signs more quickly. The agency contacts the physician if there are any issues, and ensures medication is adjusted as needed.

In 2010, the plan determined, from its member satisfaction survey, that promotional materials included with the discharge guidelines provided to members in the hospital were not memorable to patients. In response, Security’s marketing team developed a “Get Well Card” (see page 27) given to members prior to discharge. The card briefly explains the TTH services, and includes key contact numbers for members to use if they have questions about their conditions or discharge.

**Security Health Plan’s program has helped approximately 2,000 members transition from the hospital to home.**

In 2010, the plan determined, from its member satisfaction survey, that promotional materials included with the discharge guidelines provided to members in the hospital were not memorable to patients. In response, Security’s marketing team developed a “Get Well Card” (see page 27) given to members prior to discharge. The card briefly explains the TTH services, and includes key contact numbers for members to use if they have questions about their conditions or discharge.

Security Health Plan also determined, in 2011, that there was not a significant number of members admitted or readmitted with a primary diagnosis of diabetes, given ongoing disease management programs with that population. Because of the lack of diabetes patients, Security decided to expand the program to include other conditions. The TTH program is now offered to members admitted or readmitted for the following conditions: heart failure, COPD, respiratory conditions, pneumonia, multiple trauma, failure to thrive, dizziness, giddiness, and altered mental status.

Security has found success in engaging with smaller hospitals in rural settings despite their limited resources. Specifically, the plan found that nurses at smaller hospitals act as “champions” of the program and encourage eligible members to participate. Security continues to evaluate ways to measure the outcomes of its TTH program; it is considering various approaches, including estimating nurse time and/or conducting a DRG analysis.
UPMC Health Plan’s care transitions program has been phased in over the last three years. Over the past year, the plan piloted Project RED at one of its facilities. The pilot included both medical and surgical admissions and is being used as a platform to expand its care transitions program to other facilities. UPMC Health Plan has also focused resources in post-acute care settings, including SNFs, where it has embedded two project managers and five case managers in its highest-volume facilities. The most notable difference from the pilot has been that the plan decided to focus only on medical admissions.

**UPMC Health Plan’s readmission rate decreased by 10.9 percent in the first year after implementation of its care transitions program.**

UPMC Health Plan members are targeted for enrollment in the care transitions program if they are admitted at an inpatient facility and are identified as having moderate or high risk for readmission, having complex medical diagnoses, or being frequent users of inpatient or other high cost care.

The care transitions program depends on collaboration between UPMC Health Plan, the hospitals, the post-acute settings, and the PCMHs. As part of its care transitions program, the plan currently has hospitalists, onsite case managers at SNFs, practice-based case managers at high volume physician practices, and a palliative case manager onsite at a large inpatient facility. The plan uses a patient-centric EMR that allows all persons interacting with the patient to have access to that patient’s information.

UPMC Health Plan has innovative approaches to staying in touch with patients after they leave the hospital. In some counties, it deploys paramedics to do home visits; this is part of its Emed Health program, which focuses on ensuring that patients who have a primary diagnosis of heart failure or COPD post-discharge have a “safe landing” at home.

UPMC Health Plan also has a wound telehealth program. When a patient has a wound that has not healed for more than four weeks, the plan sends nurses out to continuously monitor the patient at home. Nurses have a tailored approach to analyzing wounds, which includes actively engaging the member’s PCP and surgeon via photos and scans to ensure the patient’s wound is healing correctly or to modify treatment regimens. A nurse visits the patient every two weeks, and a member of his or her skin care team visits weekly to help the patient and family members care for the wound.

The plan’s health economics outcomes team has been very involved with its care transitions program since before the inception of the program. Every outcome measure that UPMC Health Plan currently collects was defined prior to the program, and the health economics outcomes team was actively engaged in the structure and design of the program to ensure the adequate collection of those data points. UPMC Health Plan lowered its readmission rate by 10.9 percent from the previous year. It also reported that complex patients were less likely to have an inpatient admission, which it attributed to its care transitions program. The plan also reported a 13 percent reduction in inpatient admissions through the ED, which it attributed to having case managers in high-volume SNFs.
III. Promising Results

Sections

Health Outcomes
Patient Satisfaction
Cost Savings
ACHP member plans have varied approaches to measuring the outcomes of their care transitions programs. Some plans use clinical metrics to assess whether their programs are improving health outcomes and reducing readmissions. Others use their health economic teams to perform cost benefit analyses. Plans may also use patient surveys to monitor satisfaction from their care transitions programs.

The results of these evaluations should be considered in light of the fact that the care transitions initiative is often just one of many interventions that is happening within a plan, and it is difficult to differentiate the effect of managing transitions from the impact of other programs that occur simultaneously. Likewise, it may not be possible to parse out savings due solely to care transitions interventions, nor can plans allocate program costs uniquely to the care transitions program.

This section highlights common metrics used to evaluate care transitions programs—namely, health outcomes, cost savings, and patient/provider satisfaction—and describes the approaches that ACHP plans have taken. Measures and outcomes referenced in this section were reported by the ACHP plans.

Many of the ACHP plans highlighted in this report have evaluated the effect of their care transitions programs on the health status and clinical outcomes of the participating patients. Of those, most look at reduction in hospital readmissions to track the success of their programs; reducing readmissions was one of the most frequently cited goals of ACHP’s care transitions programs. Other health plans also look at clinical measures, such as HEDIS measures, to compare management of chronic conditions for their care transitions population with their entire membership base. What follows are the results of select outcomes assessments conducted by ACHP plans.

HealthPartners reported that the readmission rate for patients participating in the Inpatient Case Management Program was 8.6 percent as of the third quarter of 2011, compared to 10.1 percent for 2010.

Kaiser Permanente developed a program to focus specifically on high risk patients, such as those diagnosed with CHF, and reported this program to be very successful, resulting in a 30 percent decrease in readmissions, a 40 percent improvement in quality measures related to CHF, and an increase in patient satisfaction over a three-year period. KP also tracks how soon a patient is able to see a physician in the clinic after a hospitalization. In some medical centers, up to 70 percent of patients are seen in the clinic within a week of hospital discharge.

Priority Health has measured readmissions since the beginning of its program. Staff look at the plan’s overall readmission rate, excluding certain readmissions that are not reimbursed separately; they then compare the readmission rate for the current period against the rate for the same time period of the previous year. The difference in readmissions between periods is their estimated reduction due to the care transitions program. Priority Health’s readmission rate for the first half of 2011 was between 10.5 and 11 percent, a 1-1.5 percentage point decline relative to 2010.
III. Promising Results

UPMC Health Plan actively engaged its health economics department during the development of its care transitions program. The plan wanted to ensure that all outcomes measures that would be needed to evaluate the program were accounted for in the program design and built into tools used to collect data. This advance planning has permitted UPMC to monitor the effect of the program over time. UPMC reports that the readmission rate as of March 2011 was 10.9 percent lower than at the same time the previous year, and 7.3 percent lower than at the end of 2010.

In 2009, Geisinger Health Plan gave its case managers access to the Geisinger Monitoring Program (GMP), a telemonitoring support system for case managers in its ProvenHealth Navigator model. The GMP helped case managers track patient compliance to treatment plans post-discharge and prioritize outreach to patients. Patients who were enrolled in the GMP received one automated phone call a week for the first month post discharge; case managers could make additional calls to patients or arrange to see them in-person. A January 2012 study found that use of the GMP reduced readmission rates among Medicare Advantage members in its case management program by 44%.18

PATIENT SATISFACTION

A few ACHP plans use patient satisfaction surveys to monitor the perceived value of their care transitions programs. Patients receiving care transitions interventions have provided valuable feedback that has led plans to make program improvements.

Geisinger Health Plan asked patients to rate the effectiveness of their case managers in working with them and their care team, including tasks such as setting up referrals and facilitating communication between patients and their doctors. In their care transitions program, 422 patients, or 99 percent of survey respondents, thought their case managers were “good” or “very good.”

In 2010, Security Health Plan determined, from its patient satisfaction survey, that promotional materials included with the discharge guidelines provided to patients in the hospital were not memorable to patients. In response, Security’s marketing team developed a “Get Well Card” given to patients prior to discharge. The card briefly explains the transitions services and includes key contact numbers for patients to use if they have questions about their conditions or post-hospital care. Security’s subsequent patient
III. Promising Results

Plans have different approaches to calculating cost savings, although only a few ACHP plans are able to point to concrete cost savings from their care transitions programs. For example, some plans estimated the number of hospital admissions avoided as a result of a care transitions program, while another plan estimated the reduction in bed days for its top five readmissions diagnoses.

Group Health Cooperative reported $51 million in savings from its EDHI program in 2010, due not only to reduced readmissions, but also to a reduction in ED utilization and initial inpatient admissions. The program is designed to ensure that patients receive care in the most appropriate setting and helps avoid unnecessary admissions (or readmissions) to the hospital. To support the program, Group Health hired two new physicians and four new nurses.

HealthPartners uses utilization and financial metrics to evaluate its Complex and Inpatient Case Management programs. For its Inpatient Case Management program, HealthPartners primarily focus on hospital readmission rates and average length of stay per admission. For its Complex Case Management program, HealthPartners uses its medical admission rate, ED utilization, and total claims costs. In 2011, HealthPartners saw a return on investment of over four to one for each of these programs (see Figure 5).

Kaiser Permanente primarily used changes in readmission rates to evaluate cost savings associated with improved transitions. The plan reports that its Transitional Care Program for patients with CHF reduced readmissions by 30 percent, resulting in an estimated cost savings of $1.2 million dollars since the beginning of the program.

Finally, Kaiser Permanente saw an increase in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores for the “Leaving the Hospital” measures. Patients who had a follow-up phone call once they returned home were significantly more satisfied than those who did not receive a call.

Cost Savings

<table>
<thead>
<tr>
<th>Program at HealthPartners</th>
<th>Return on Investment</th>
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<tbody>
<tr>
<td>Inpatient Case Management</td>
<td>4.2:1</td>
</tr>
<tr>
<td>Complex Case Management</td>
<td>4.4:1</td>
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Figure 5: ROI for HealthPartners’ Inpatient and Case Complex Management Programs

Presbyterian Health Plan has looked at a variety of metrics to analyze savings associated with its care transitions program, including average length of stay, number of face-to-face visits, and number of follow-up calls. Presbyterian’s medical economics team calculated the reduction in bed days for the top five readmission diagnoses that were targeted by its care transitions program, and then applied a per diem rate for each bed day avoided to determine cost savings, estimating that the program saved approximately $1.8 million in 2010.

Satisfaction surveys indicated a highly positive response to these services, including appreciation for the Get Well Card.

According to UPMC Health Plan’s patient survey in 2011, 96 percent of patients in its care transitions program were either “satisfied” or “very satisfied.”
IV. Reflections

Sections

Challenges

Conclusion
ACHP member plans have made great strides in implementing care transitions programs. Not surprisingly, however, the plans have experienced challenges when designing and implementing the programs, and they continue to face challenges as they refine their programs and work to ensure the ongoing success of their programs.

Initially, some plans experienced some resistance from members and reluctance from providers. At first, some members were hesitant to have nurses visit their homes or to receive regular follow-up calls. ACHP plans noted that they had to invest time in getting providers’ buy-in on their programs’ goals. In particular, plans continue to struggle with ensuring their members have follow-up physician visits within a short time after hospital discharge. Many times, providers have scheduling limitations that prevent them from making follow-up appointments with patients in the days immediately following discharge. Plans also struggle to ensure that their patients not only make their appointments, but keep them, as patients often also face transportation barriers.

Some plans do not themselves manage referrals of patients and instead depend on hospital staff to refer patients to their care transitions programs. Such plans noted that one challenge is ensuring that all appropriate patients are identified and referred to the programs. The plans recognize that hospital staff may have competing clinical demands, and that dedicated resources are needed for consistent program referral. In addition, a hospital’s patients are covered by many different insurers, which may decrease the likelihood that hospital staff will remember to make program referrals for those patients who are members of the ACHP plan. In some cases, staff may not even be aware of the insurance coverage each patient has. Identification of, and regular communication by plan staff with, a point person at the hospital can help ensure that a plan’s patients are appropriately referred to the care transitions program.

One of the biggest challenges health plans mentioned was communication between the plan and each patient’s providers and sites of care. A patient’s PCP or specialist is not always aware that a patient has been hospitalized. Ensuring that a patient’s care is not provided in silos continues to be a challenge, even as plans try to design protocols and tools that assist providers in communicating with each other. While some plans have been able to make progress through the use of technology, such as through the use of electronic medical records, technological integration is a work in progress, as not all providers use the same technology platform.

Finally, plans are working to improve their programs’ success and to continue to demonstrate value, often while lacking the robust data that are needed for decision-making and evaluation. Without being able to demonstrate a return on investment, many program directors struggle to receive adequate funding to be able to continue these initiatives.
As a result of the ACA, policymakers are increasingly focused on improving care transitions as a way to improve quality of care delivered and reduce costs. Over the next several years, CMS will implement several new payment and delivery reform pilot programs that test various incentives to improve care transitions, including penalties for readmissions, bundled payments, and PCMH models.

These changes will offer new incentives for physicians, hospitals, SNFs, and other providers and sites of care to work together to improve the quality of care that they are delivering to patients. Increasingly, providers will be held accountable for delivering high-value care, not only through quality measurement, but also through changes to the manner in which they are reimbursed. Health plans have been leading the way in these efforts for the last several years and are well-positioned to continue to shape improvements in care delivery, including around care transitions.

In particular, ACHP members have led in the development of care transitions programs that promote the Triple Aim: improving quality of care, improving the overall health of patients, and reducing health care costs. ACHP member plans have deep roots in their communities and serve as role models for other health plans in how to engage with provider partners to achieve these aims.

This publication has highlighted different approaches to improving care transitions and the unique role that health plans can play. While there is no one best model, ACHP members’ experiences offer some practices and lessons learned worthy of consideration. These should serve as a guide for policymakers, other health plans, and providers seeking to support and implement care transitions programs that will improve health outcomes and save health care costs.
V. Appendices

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# Summary of Care Transitions Programs

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<th>Targeted Patients and/or Conditions</th>
<th>Interventions at the Hospital</th>
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<tr>
<td>Capital District Physicians' Health Plan</td>
<td>CHF, CAD, and COPD</td>
<td>Nurse from nursing agency sees the patient while still in the hospital</td>
</tr>
<tr>
<td>Fallon Community Health Plan</td>
<td>CVD, CHF, COPD, and pneumonia</td>
<td>Care coordinator identifies the patient in the hospital and signs them up for the care transition program</td>
</tr>
<tr>
<td>Geisinger Health Plan</td>
<td>All patients, prioritized based on risk-stratification</td>
<td>Inpatient care management assessment is done through EHR</td>
</tr>
<tr>
<td>Group Health Cooperative</td>
<td>All patients into one of five pathways: blue, yellow, green, orange, or red depending on the severity of their condition</td>
<td>Hospitalists see specified patients in the ER before deciding if the patient needs to be admitted; hospitalists assign patients a pathway based on severity of their condition. Facility-based care managers provide transition coaching based on Coleman’s Four Pillars® model</td>
</tr>
<tr>
<td>Health-Partners</td>
<td>All member admissions screened and stratified for risk of readmission using a standardized evidence-based risk assessment</td>
<td>Inpatient Case Managers collaborate with the care team and connect with patients and their families to support transition to complex case management services post-discharge</td>
</tr>
<tr>
<td>Independent Health</td>
<td>All Medicare members; commercial members with COPD, CHF, MI, CABG, cardiac valve, pneumonia, or stent; Medicaid members with asthma, CHF, pneumonia, and COPD</td>
<td>Varies by hospital system, includes facilitation of home health visit</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>All patients discharged from the hospital receive their “transition bundle,” while patients with high risk diseases, like CHF participate in TCP (Transitional Care Program)</td>
<td>Risk stratification; standardized discharge summary; high-risk patients leave the hospital with a PCP appointment within 5 days and case management for 30 days; high-risk patients have pharmacists review medications</td>
</tr>
<tr>
<td>Presbyterian Health Plan</td>
<td>Top 15 readmission diagnoses</td>
<td>Targeted members receive two visits during their inpatient hospital stay</td>
</tr>
<tr>
<td>Priority Health</td>
<td>Top 10 readmission diagnoses from the previous year</td>
<td>Nurse visits patients at hospital prior to discharge</td>
</tr>
<tr>
<td>Security Health Plan</td>
<td>Heart failure, COPD, respiratory conditions, pneumonia, multiple trauma, failure to thrive, dizziness, giddiness, and altered mental status</td>
<td>Nurse visits patients at hospital prior to discharge</td>
</tr>
<tr>
<td>UPMC Health Plan</td>
<td>Members admitted at inpatient level identified as moderate or high risk for readmission and/or complex medical diagnoses and members who are high utilizers.</td>
<td>Case managers visit patients in the hospital and introduce patients to nurses that will assist with follow-up care. The CMs focus on preparing members for discharge.</td>
</tr>
</tbody>
</table>
### Summary of Care Transitions Programs

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Interventions at Home</th>
<th>Services Received at Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital District Physicians' Health Plan</td>
<td>Home visit within 24-48 hours post-discharge by same nurse that met the patient at the hospital</td>
<td>Review of discharge instructions, medication reconciliation, review of home safety, and assessment of care giver support</td>
</tr>
<tr>
<td>Fallon Community Health Plan</td>
<td>Home visit within 48 hours post-discharge by pharmacist</td>
<td>Assessment of patient’s social and living environment</td>
</tr>
<tr>
<td>Geisinger Health Plan</td>
<td>Patients that are part of Geisinger’s medical home model are contacted telephonically in 24 to 48 hours by their case management team</td>
<td>Medication reconciliation, identification of gaps in care, assure patient safety and adequate social support, and facilitate appropriate home health and DME equipment</td>
</tr>
<tr>
<td>Group Health Cooperative</td>
<td>Call within 48 hours post-discharge by care manager based on Coleman’s Four Pillars® model, seven day post-discharge call by pharmacist to highest risk patients for medication reconciliation</td>
<td>Care managers conduct telephonic transition coaching based on Four Pillars® work from Coleman</td>
</tr>
<tr>
<td>Health-Partners</td>
<td>All identified members receive an outreach call within two days post-discharge</td>
<td>Case managers provide telephonic transition coaching to ensure PCP appointment, medication reconciliation, red flag action plan, and facilitate appropriate in-home care and DME</td>
</tr>
<tr>
<td>Independent Health</td>
<td>Home health agency visits patient within 72 hours of discharge</td>
<td>Patient completes self-management tool with nurse completing the home visit, the nurse conducts an initial medication reconciliation, a pharmacist then does a thorough medication review and shares any findings or recommendations with the PCP</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>Patients with heart failure enrolled in TCP receive a home visit from a nurse within 48 hours regardless of homebound status</td>
<td>Follow-up phone call for Medication reconciliation, educational materials with the use of teach back, standardized screening, and referral to palliative care services</td>
</tr>
<tr>
<td>Presbyterian Health Plan</td>
<td>Patients receive phone call within 48 hours of discharge, home visit by case manager in certain cases; ensure follow-up appointment is scheduled with provider; if one is not scheduled, there is a warm transfer to get them an appointment</td>
<td>Medication reconciliation, assurance all DME has been delivered, and evaluation of need for home health care</td>
</tr>
<tr>
<td>Priority Health</td>
<td>Two home visits post-discharge</td>
<td>Medication reconciliation and review of the patient health record</td>
</tr>
<tr>
<td>Security Health Plan</td>
<td>Home visit within 24 hours post-discharge by home health nurse; patients who decline home visit receive assessment via phone</td>
<td>Medication reconciliation, assessing the patient’s knowledge of the condition and discharge instructions</td>
</tr>
<tr>
<td>UPMC Health Plan</td>
<td>Intervention based on risk assessment varies but may include: home visit within two days or case management phone call within 48 to 72 hours of discharge</td>
<td>Medication reconciliation, assessment of home safety and care giver support, ensure follow-up MD appointment, and conduct education regarding condition and discharge instructions</td>
</tr>
<tr>
<td>Health Plan</td>
<td>Follow-Up Visit with Physician</td>
<td>Other Follow-Up Care</td>
</tr>
<tr>
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</tr>
<tr>
<td>Capital District Physicians’ Health Plan</td>
<td>Members see PCP within seven days of discharge</td>
<td>Within 10 to 14 days of the home visit, the nurse makes a follow up call</td>
</tr>
<tr>
<td>Fallon Community Health Plan</td>
<td>Members see PCP or specialist within five days of discharge</td>
<td>Member is enrolled in the program for 30 days, Afterwards transferred to appropriate FCHP care services program</td>
</tr>
<tr>
<td>Geisinger Health Plan</td>
<td>Members see PCP within five-seven days of discharge</td>
<td>Geisinger uses interactive voice response to call patients on a weekly basis for up to four weeks after discharge; alerts are automatically directed to the case manager</td>
</tr>
<tr>
<td>Group Health Cooperative</td>
<td>Patients visit PCP within 7-14 days, depending on patient risk level</td>
<td>Group Health focuses on increasing patient access to alternative care settings and engaging patients in advanced care planning such as for palliative and end-of-life care</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>Members see PCP within seven days of discharge</td>
<td>Members receive ongoing support from case managers until mutually established goals are met; case managers ensure seamless transition to other internal programs, such as disease management and lifestyle behavior change programs</td>
</tr>
<tr>
<td>Independent Health</td>
<td>Members see PCP within seven days of discharge</td>
<td>Case management team calls patient on days seven, 14, and 28 after discharge</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>High risk patients see PCP within five days</td>
<td>All patients receive a follow-up phone call within 48 hours; case management for 30 days for high risk patients</td>
</tr>
<tr>
<td>Presbyterian Health Plan</td>
<td>Upon discharge, a case specialist facilitates getting the members’ discharge summary to their PCP or specialist</td>
<td>Referrals to Care Coordination are made for members with new diagnosis of diabetes, asthma, repeated inpatient admissions, complex medical issues requiring extensive follow-up care, or catastrophic events</td>
</tr>
<tr>
<td>Priority Health</td>
<td>Members see PCP within five days of discharge</td>
<td>Case management team calls patient on days seven, 14, and 28 after discharge</td>
</tr>
<tr>
<td>Security Health Plan</td>
<td>Nurse ensures PCP visit scheduled during home assessment</td>
<td>Nurse care managers call patients at least weekly for three to four weeks</td>
</tr>
<tr>
<td>UPMC Health Plan</td>
<td>Members see PCP within five-seven days of discharge</td>
<td>Members may be followed intensively in complex case management or referred to a specific DM program. Members may also be followed up to 21 days post discharge by the inpatient supportive services case manager, who also shares the plan of care with the PCP</td>
</tr>
</tbody>
</table>
Acknowledgments

For more information about care management efforts at ACHP plans or the Health Plan Innovations in Patient-Centered Care series, email innovations@achp.org.

General questions about ACHP can be directed to info@achp.org. More information can also be found at our website at www.achp.org.

This report was made possible through the hard work and dedication of our member plans and their commitment to patient-centered care. We thank all of our members for the significant time and effort they put into this publication.

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ACHP Member Organizations

**Capital District Physicians’ Health Plan**
Albany, New York | www.cdphp.com

Capital District Physicians’ Health Plan was founded in 1984 as a not-for-profit IPA model HMO in Albany, New York. Since then, Capital District and its affiliates have grown to serve more than 400,000 people in 29 counties throughout New York state and seven counties in Vermont.

**Capital Health Plan**
Tallahassee, Florida | www.chp.org

Created in 1982, Capital Health is a not-for-profit health plan serving more than 118,000 members in the six-county area of Tallahassee, Florida. Capital Health Plan is a mixed model HMO that owns two health center complexes where physicians, nurses and allied health care professionals are directly contracted with Capital Health and provide coordinated care to members.

**CareOregon**
Portland, Oregon | www.careoregon.org

CareOregon is a not-for-profit organization serving low-income and vulnerable residents of Oregon. The organization was created in 1993 by a partnership of the state’s safety-net providers. With 950 primary care providers, CareOregon serves more than 155,000 members in 20 counties throughout the state.

**Fallon Community Health Plan**
Worcester, Massachusetts | www.fchp.org

Founded in 1977, Fallon Community Health Plan is a locally integrated health plan serving more than 160,000 and providing its members with access to physicians and hospitals throughout Massachusetts. Fallon is the only health plan in Massachusetts that is both an insurer and provider of care, providing group and non-group health plan options, including HMO, POS and PPO, as well as Medicaid and Medicare Advantage plans.

**Geisinger Health Plan**
Danville, Pennsylvania | www.thehealthplan.com

Geisinger Health Plan is a not-for-profit health plan serving 250,000 members in 42 counties throughout central and northeastern Pennsylvania. Founded in 1985, Geisinger provides HMO, PPO and TPA plans for businesses, individuals and families, and Medicare beneficiaries and children enrolled in the Children’s Health Insurance Program (CHIP).

**Group Health Cooperative**
Seattle, Washington | www.ghc.org

Founded in 1947, Group Health Cooperative is a consumer-governed, nonprofit health care system that integrates care and coverage. Along with its subsidiaries, Group Health Options, Inc., and KPS Health Plans, Group Health serves more than 670,000 members in Washington and Idaho. It employs more than 9,000 staff and operates medical centers, a charitable foundation and a research center.

**Group Health Cooperative of South Central Wisconsin**
Madison, Wisconsin | www.ghcscw.com

Group Health Cooperative of South Central Wisconsin is a nonprofit, managed health care organization serving more than 64,000 members. Group Health’s five primary care clinics integrate with its insurance arm to provide primary care and health insurance products and, through its partnership with the University of Wisconsin, specialty and tertiary care to its members.

**HealthPartners**
Minneapolis, Minnesota | www.healthpartners.com

Founded in 1957 as a cooperative, HealthPartners is the nation’s largest consumer-governed, nonprofit health care organization. It serves more than 1 million members, including a large population of residents in the Minneapolis/St. Paul area. HealthPartners is a pioneer in developing programs that measure health care quality and reward providers that meet high clinical standards of care.

**Independent Health**
Buffalo, New York | www.independenthealth.com

Independent Health began in 1980 as one of western New York’s first HMOs. Independent Health covers more than 280,000 members in New York and across the country with more than 100 plans, services and products. Among other programs, Independent Health is leading a multifaceted program to redesign physician offices to be more patient-centric.

**Kaiser Permanente**
Oakland, California | www.kaiserpermanente.org

Founded in 1945, Kaiser Permanente is a health care provider and not-for-profit health plan serving more than 8.9 million members in nine states and the District of Columbia. Kaiser Permanente comprises Kaiser Foundation Health Plans, Kaiser Foundation Hospitals and the Permanente Medical Groups.
Martin’s Point Health Care  
Portland, Maine | www.martinspoint.org

Martin’s Point is a not-for-profit health care organization based in Portland, Maine. Through health care centers, health plans and employer wellness services, Martin’s Point serves more than 38,000 members throughout northern New England and New York.

New West Health Services  
Helena, Montana | www.newwesthealth.com

Founded in 1998, New West Health Services is a provider-sponsored health plan serving residents of Montana. With headquarters in Helena, operations center in Kalispell, and regional offices in Billings and Missoula, New West has partnerships with more than 4,600 medical providers and serves more than 40,000 members and 700 employer groups.

Presbyterian Health Plan  
Albuquerque, New Mexico | www.phs.org

Presbyterian Health Plan and Presbyterian Insurance Company, Inc., are owned by Presbyterian Healthcare Services, New Mexico’s largest locally owned health care system, serving more than 400,000 members. Based in Albuquerque, Presbyterian Health Plan offers a statewide health care delivery system and has more than 25 years of experience in managed care.

Priority Health  
Grand Rapids, Michigan | www.priorityhealth.com

Priority Health is a nonprofit health plan serving more than 609,000 members in 65 counties in lower Michigan. More than 12,000 employers offer Priority Health coverage to their employees, and more than 14,000 health care providers participate in its network. Priority Health offers products for employer groups, individuals, and Medicare and Medicaid patients.

Rocky Mountain Health Plans  
Grand Junction, Colorado | www.rmhp.org

Rocky Mountain Health Plans (RMHP), founded in Grand Junction, Colorado in 1974, is a locally-owned, not-for-profit organization that serves more than 173,000 members. RMHP is the only health plan in Colorado serving every market segment including employers, individuals, Medicare and Medicaid beneficiaries.

Scott & White Health Plan  
Temple, Texas | www.swhp.org

Scott & White Health Plan began operations in 1982 as Centoplex Health Plan, a not-for-profit HMO covering two central Texas counties. Scott & White has grown to more than 194,000 members in 50 counties and offers a variety of insurance plans for members and employers, including a child-only plan, statewide self-insured plan and a Medicare prescription plan.

Security Health Plan  
Marshfield, Wisconsin | www.securityhealth.org

Security Health Plan is a physician-sponsored, not-for-profit HMO founded in 1986 as an outgrowth of the Greater Marshfield Community Health Plan. Security Health Plan has a membership of more than 187,000 people in 32 counties in northern, western and central Wisconsin, and a network that includes more than 4,350 affiliated physicians, 40 affiliated hospitals and over 55,000 pharmacies nationwide.

SelectHealth  
Murray, Utah | www.selecthealth.org

SelectHealth is a non-profit health insurance organization serving more than 538,000 members in Utah and southern Idaho. As a subsidiary of Intermountain Healthcare, SelectHealth is committed to health improvement, superior service, and providing access to high-quality care. In addition to medical plans, SelectHealth offers dental, vision, and life and disability coverage to its members. SelectHealth also administers several government health plans including both state and federal high risk pools and the Children’s Health Insurance Program.

Tufts Health Plan  
Watertown, Massachusetts | www.tufts-health.com

Founded in 1979 as a not-for-profit HMO, Tufts Health Plan offers health care coverage to individuals and through employer groups in Massachusetts and Rhode Island. Serving more than 743,000 members through a network of 90 hospitals and over 250,000 providers, Tufts has the highest enrollment in consumer-driven health plans in New England.

UCare  
Minneapolis, Minnesota | www.ucare.org

Founded in 1984, UCare is an independent, nonprofit health plan serving more than 195,000 members in Minnesota and western Wisconsin. UCare provides health care programs sponsored by the state of Minnesota and Medicare through a network of health care providers, including 16,000 physicians at nearly 5,000 locations.

UPMC Health Plan  
Pittsburgh, Pennsylvania | www.upmchealthplan.com

UPMC Health Plan is owned by the University of Pittsburgh Medical Center (UPMC). UPMC serves more than 1.1 million members. As part of an integrated health care delivery system, UPMC Health Plan partners with the medical center and a community network of more than 80 hospitals and 7,600 physicians to serve residents in a 29-county region of western Pennsylvania.
References


10. Affordable Care Act of 2010, Pub. L. No. 111-148, § Sec. 3023


18. Ibid.