



# **FUTURE OF NURSING™**

## **Campaign for Action**

AT THE CENTER TO CHAMPION NURSING IN AMERICA

### *Transforming Health Care Delivery: The Role of Nurses in Health Plans Part II*

**June 11, 2012**



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Senior Vice President & Director,  
AARP Public Policy Institute;  
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# Campaign for Action Pillars



**Advancing Education  
Transformation**



**Removing Barriers to  
Practice and Care**



**Nursing Leadership**

Interprofessional Collaboration

Diversity

**DATA**

# Today's Webinar Will...



- Highlight the links between nurses, health plans, the future of health care delivery, and the IOM's recommendations.
- Describe the variety of ways that health plans are driving innovations.
- Demonstrate the value and impact nurses have on the quality and outcomes of healthcare delivery by sharing examples of specific programs from various health plans.
- Highlight the impact that nurses have on the overall consumer experience.



**Susan Kosman, RN, BSN, MS**  
Chief Nursing Officer  
Aetna Inc.

# Health Plans Work Team



The Health Plans Work Team works to support the IOM recommendations by:

- Discussing implications regarding health plans
- Sharing the IOM's report within respective organizations
- Brainstorming actions that health plans can take
- Collaborating where possible on actions
- Educating constituents on the various roles that nurses play in health plans, the linkage to the IOM's recommendations and the future of health care delivery

# Health Plans Work Team



- Susan Kosman, RN, BSN, MS, Aetna, Inc.
- Shelley Balfour, RN, BSN, MBA, Aetna, Inc.
- Diane Hogan, DNP, RN, MA, Humana Cares
- Susan M. Pisano, America's Health Insurance Plans (AHIP)
- Cynthia G. Wark, America's Health Insurance Plans (AHIP)
- Mary Aikins, RN, BA, CCM, Horizon Healthcare Innovations - Patient Centered Medical Home
- Tom Michels, RN, HealthPartners Medical Group
- Jared T. Skok, MPA, Blue Cross and Blue Shield of Florida Foundation

# Aetna In Touch Care

*The model is designed to reduce health risk and boost member output:*



**More Engagement**



**Continued relationship across care continuum**



**Member-centric approach addressing Cultural needs**



**Holistic Approach**

Sees the **whole person** and passionately supports them through their mind, body, and cultural values

**Integrated Medical Sources**

**Comprehensive view of member data** about each individual to determine an appropriate level of support

**Clinical Algorithm**

Effectively **identifies and engages members earlier** while capturing preferences around programs and services

**Single Nurse Model**

Designates a **true single-point of contact** offering a 360 degree view of each member's needs

**Multi-Modal Support**

Engages members through our **virtual support channels** who have less urgent care needs and to supplement the one-on-one support



# Aetna In Touch Care – Role of the Nurse

A single **NURSE** point of contact serves as the **PRIMARY CARE MANAGER** for members' health care needs and their families' needs

## Benefits of Single Nurse

- ✚ Nurses are able to customize a personalized health strategy around the individual
- ✚ Fewer hand-offs permitting faster, simpler responses from someone members know and trust
- ✚ More relevant responses to members' needs

## Sample Outcomes

- ✚ Assist members/families with preparing for a hospital stay or planning for recovery
- ✚ Educate members and families on how to make the best use of their benefits plan
- ✚ Provide tips to stay healthy
- ✚ Find resources through benefit plan or in local community

# Highly Personalized Care through Multi-channel Coordination



Members receive individualized care plans based on their health needs and what they need to be successful

- Care plans are individualized based on member preferences
- A variety of modalities are available to meet member needs – online, phone, e-mail, group/social networks, text, or chat
- Member engagement tools put information at members' fingertips so they can stay on top of their health needs



# Aetna Member Experience



## Member Health Background – *Gina*\*

- ▶ A 60 year old female admitted to the emergency room with shortness of breath, weakness and nausea
- ▶ Diagnosed with Atrial Flutter with A-V block
- ▶ Co-morbid conditions included obesity, hypertension, hypothyroidism, hyperlipidemia, a torn medial meniscus of the left knee, and a new diabetes diagnosis



# Aetna Member Experience



## Clinical Support - *How we helped*

- ▶ Primary Care Nurse helping to manage care across care continuum
- ▶ Collaboration and communications with care providers
- ▶ Educational support to manage conditions
- ▶ Goal setting for weight loss and diabetes control
- ▶ Care coordination of resources across care needs
- ▶ Identification and removal of barriers to achieving goals and changing behaviors



# Aetna Member Experience

## Health Outcomes - *Measurable Change*

- ▶ Reduction in HbA1C
- ▶ Weight loss
- ▶ Behavior change
- ▶ Continued participation in diabetes classes
- ▶ Improved knowledge and understanding of managing chronic conditions and associated risks



# Aetna Member Experience

## Long-term Success - *A Better Outcome*

- ▶ Diabetes under control
- ▶ Weight loss
- ▶ Established partnership and relationship with Primary Care Nurse Manager
- ▶ Better informed and aware of managing conditions
- ▶ Actively engaged in prevention and maintenance of conditions
- ▶ Increased confidence in achieving goals



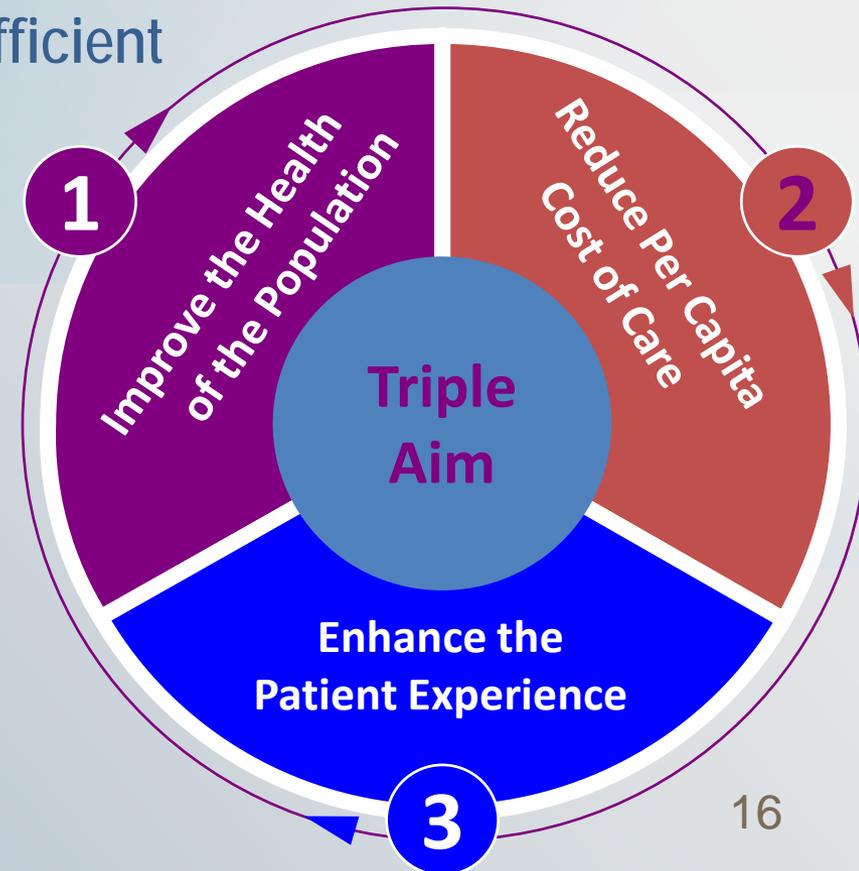


**Mary Aikins, RN, BA, CCM**  
Manager, Care Management Operations  
Horizon Healthcare Innovations - Patient  
Centered Medical Home

## Case Study #2 – Horizon Health Care Innovations Patient Centered Medical Home

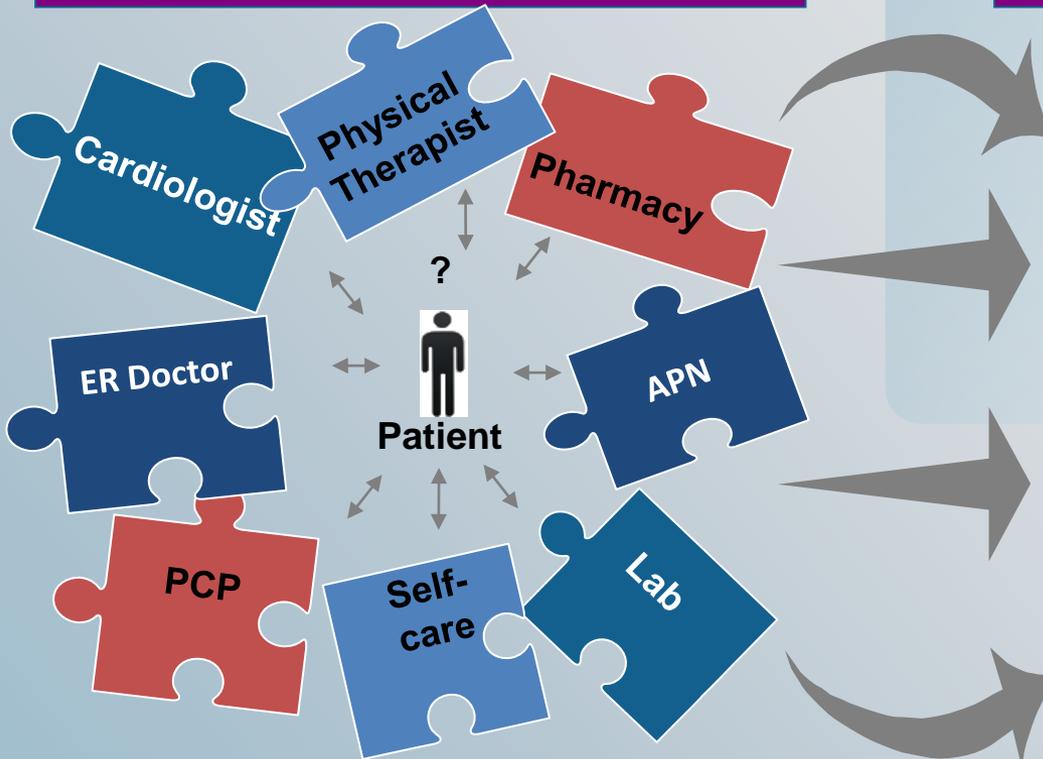


- Horizon Healthcare Innovations - Through collaboration, we are helping to create an **effective, efficient and affordable** health care system
- Achieving better health, better care at lower costs

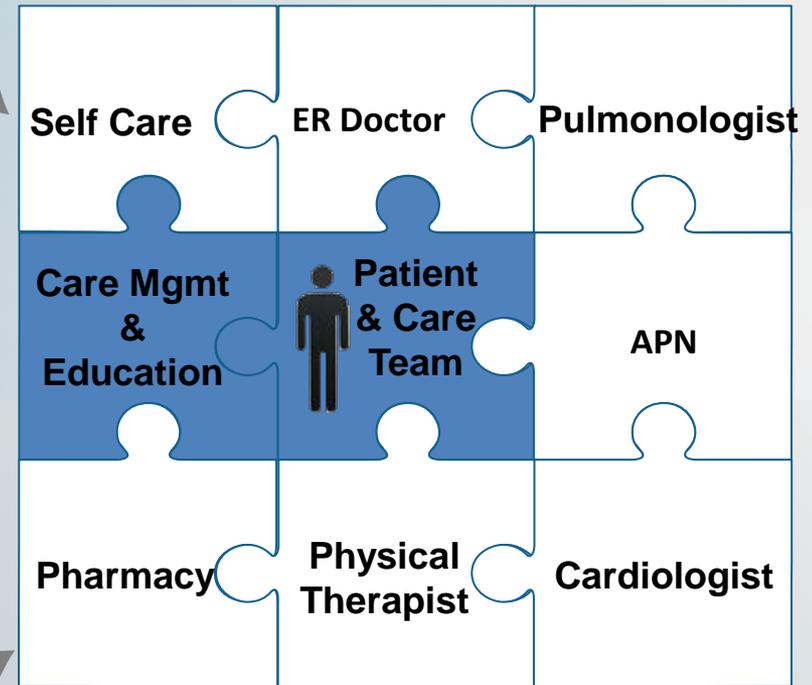


# What is the Patient-Centered Medical Home?

## Today's Care Model



## Patient-Centered Medical Home



**Engaging & empowering patients is critical to providing better care at lower costs**

# Patient-Centered Medical Home



- A Patient-Centered Medical Home...
  - Coordinates the right care, at the right place, at the right time
  - Customizes & personalizes care plans, wellness and preventive care
  - Immediate access for chronic and at-risk patients
- Focus is on **chronic and at-risk patients** but available to all Horizon members
  - Chronic conditions, behavioral health, transitions in care
- Scope of PCMH Initiative:
  - 22 practices covering 80,000 Horizon BCBSNJ members
  - Expand significantly throughout 2012

# Patient-Centered Medical Home – Year One Results



## Quality Measures

- 8% higher rate in improved diabetes control (HbA1c)
- 6% higher rate in breast cancer screening
- 6% higher rate in cervical cancer screening

## Cost and Utilization Indicators

- 10% lower cost of care (per member per month)
- 26% lower rate in emergency room visits
- 25% lower rate in hospital readmissions
- 21% lower rate in hospital inpatient admissions
- 5% higher rate in the use of generic prescriptions

# Five key elements to achieve sustainable results



# Population Care Coordinators (NURSES)

## Population Care Coordinators

- Nurses who work within PCMH practices
- Help improve the coordination of care for patients
- Follow up with patients to address any of their needs
- Continuously update personalized health plans
- Proactively engage, educate and empower patients

## Population Care Coordinator Education Program

- Created a nurse education program with Rutgers and Duke nursing schools
- Partnership will educate a minimum of 200 nurses over the next two years
- Building a transformed nursing role to support new care models
- Nurses will be deployed to PCMH and ACO programs throughout NJ

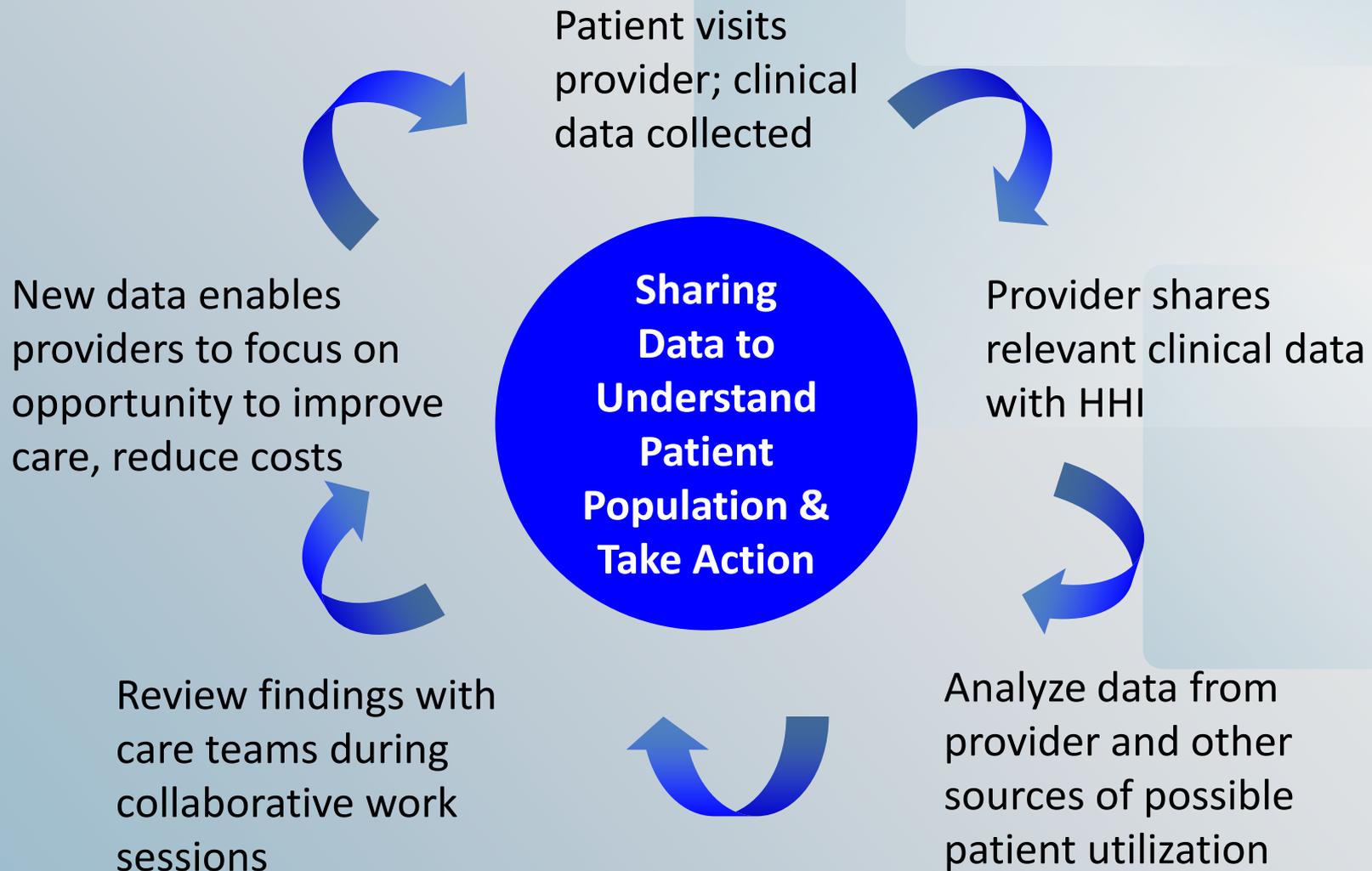
# Who is the population care coordinator?



A full time population care coordinator (PCC) is expected to carry a full-time case load of approximately 150 high risk patients or approximately 2,500 to 3,000 patients

- PCC must be an RN with a valid nursing license in the State of NJ
- Must have at least 3 to 5 years of clinical experience and ideally have experience in discharge planning, case or disease management
- The PCC must be hired, educated through the new program and integrated within 6 months of joining the program
- The PCC leads key care coordination activities conducted by the practice
- Horizon funds the PCC Education Program

# Data & Technology – sharing data to improve care



# Data & Technology – Care Plan Tool



Demographic

**Clinical**

Specialist

Encounter

Medication

Care Plan

All fields in LIGHT GREEN background are Horizon Healthcare Innovation PCMH Program Quality Measures

History	Quality Measures	Result	Eligible	Excluded
	Height	<input type="text"/>		
	Weight	<input type="text"/>		
	BMI Test Result	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	BMI Test Date	<input type="text"/>		
	Pneumonia Vaccination Date	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Smoking/Tobacco Cessation Intervention Date	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Breast Cancer Screen Date	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Colorectal Cancer Screen Date	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Cervical Cancer Screen Date	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Depression Screen Date	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Blood Pressure Date	<input type="text"/>		
	Blood Pressure Result Systolic	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Blood Pressure Result Diastolic	<input type="text"/>		

History	Pertinent Lab Values	Result
	HDL Test Date	<input type="text"/>
	HDL Test Result	<input type="text"/>
	Glucose Test Date	<input type="text"/>
	Glucose Test Result	<input type="text"/>
	Total Cholesterol Test Date	<input type="text"/>
	Total Cholesterol Test Result	<input type="text"/>
	Sodium Test Date	<input type="text"/>
	Sodium Test Result	<input type="text"/>
	Calcium Test Date	<input type="text"/>
	Calcium Test Result	<input type="text"/>
	Protein Test Date - Serum Albumin	<input type="text"/>
	Protein Test Result-Serum Albumin	<input type="text"/>
	Protein Test Date - Urine	<input type="text"/>
	Protein Test Result - Urine	<input type="text"/>

# Key Takeaways – Transforming Health Care System



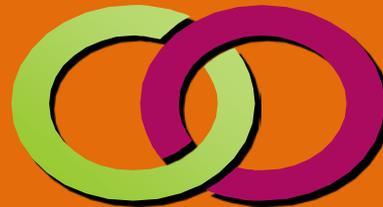
- **Collaboration:** Nurses, physicians, hospitals, health plans, employers and other stakeholders must work together to transform the delivery system
- **Population Care Coordinators:** These nurse leaders are key to driving improvement to deliver better care at a lower cost
- **Patients in PCMH/ACO Programs:** Approximately 200,000 Horizon BCBSNJ members will be participating by Dec. 2012
- **Program goals:**
  - » Better Health Outcomes
  - » Better Patient Experience
  - » Lower Cost of Care



**Diane Hogan DNP, RN, MA**  
Director of Clinical Innovations  
Humana Cares

# Humana Cares Model of Care

Linking **medical and behavioral care** with **social care** to combat the challenges of aging and chronic illness



Creates

- “Scorable Savings” year after year
- Measurable improvements in health
- Satisfaction for member and providers
- Measurable improvements in quality of life
- Transforms healthcare delivery

# Acute Chronicity



- Acute Chronicity: A dynamic chain of good health days and bad health days. Interventions need to be flexible and responsive along the continuum of care

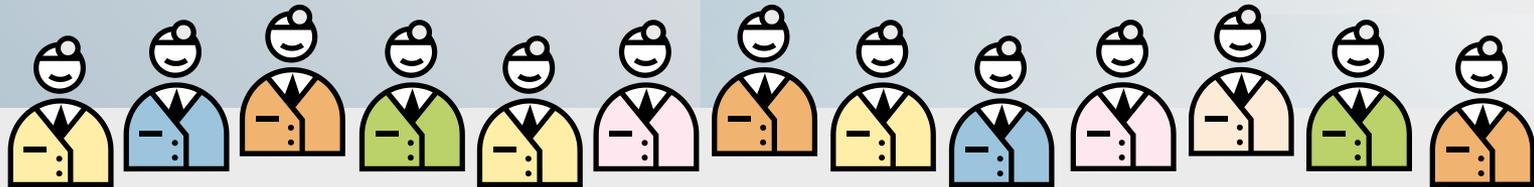


- Humana Cares Managers respond to member needs and adjust levels of intervention to meet changing concerns. This, along with clinical judgment, drives the next steps and care pathways.

# Why Complex Care Management?

*Fragmentation of Care a Serious  
Problem in the Medicare Population*

Members are seeing, on average  
about **13** providers per year...



They take on average **8-10** medications...



# Why Care Management?



82% of seniors have a chronic condition – 62% have two or more

## Medicare member profiles

16.5  
million  
seniors

**\$3,455**  
per  
person

21.5  
million  
seniors

**\$7,478**  
per  
person

4.2  
million  
seniors

**\$14,680**  
per  
person

**39.1%**

**In excellent health**

**51.0%**

**In good health**

**9.9%**

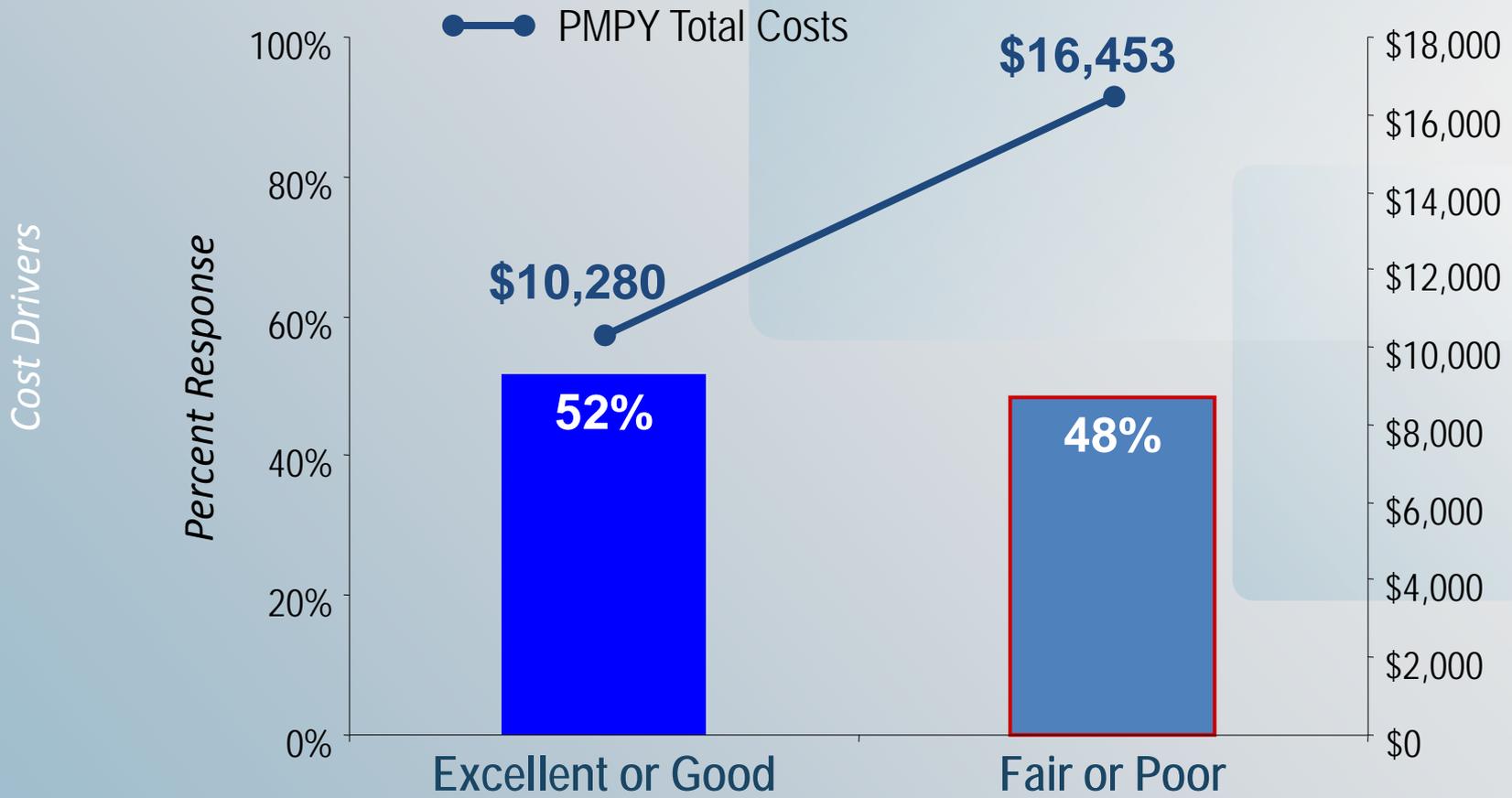
**In poor health**

Costs double at each change in health status

# Poor Health Equals Greater Cost



Compared to Other People Your Age,  
How Would You Describe Your Health?



# Principles of Care Management



## Humana Cares

- Provides “life care” advocate in navigating confusing provider systems
- Supports client to remain independent and safe, for as long as possible, in their home
- Creates “one stop care” for medical and quality of life needs
- Encourages and supports the client, family and care givers to take an active part in their own healthcare
- Connects client to community resources and services
- Anticipatory guidance assists client in identifying and dealing with small problems before they escalate in to major physical and financial problems.

“People do not care how much you know until they know how much you care”



# Humana Cares - Model of Care Map

## Humana Cares for You

Trust Humana Cares<sup>SM</sup> to work with you to improve your health. Here's how we help you set and meet your health goals:



Personal healthcare manager contacts you



Gets to know you and your caregivers



Feel sure about your health goals



Connects you with community services



Supports you after ER and hospital visits



Partners with your doctor



Helps you understand and manage your medicines



Stays in touch

Reach your goals with your Humana Cares personal healthcare manager.

- Find out more about your health and how to take care of yourself
- Stay safe in your home
- Make the most of doctor's visits
- Understand which health screenings are important for you

### Questions?

Call us toll-free at **1-800-662-9508** (TTY: **711**). We're available Monday through Friday, 8 a.m. to 6 p.m. Eastern time. Taking part in Humana Cares is your choice. If you want to stop hearing from us, just call to opt out of the program.

## Member Satisfaction Survey Results



- Majority of participants indicated they benefited from the program and the interaction with their Humana Cares Nurse.
- Evaluations measuring traits of Humana Cares Nurses were outstanding. They said their nurses were knowledgeable and cared for them in an individualized, courteous, and supportive manner.
- The program experience and working with the nurse produced anticipated positive outcomes in the future for most, evidenced by decreased utilization, improvement in health screening and clinical outcomes.
- Two-thirds said they would make a change in how they take care of their health in the future as a result of working with the Humana Cares Nurse.
- Nine out of ten said they would continue to work with their Humana Cares Nurse. A positive outcome, supporting the retention objective.

# Member Centric Model of Care



# Humana Cares Case Study



- **Mr. Simone, 73 year old male, diagnosed with Type 2 diabetes, hypertension, with history of heart attack, early dementia, depression, and prostate cancer, is married and lives with his spouse in a rented apartment**
- **Member enrolled in the HC Complex Care Management program since October 2010**

## Areas of Concern

- **Focus on chronic condition management (i.e. diabetes eye exam, depression)**
- **Difficulty sleeping due to anxiety r/t landlord threat of eviction; assessment uncovered issue of frequent urination**
- **Newly diagnosed prostate cancer**
- **Fall history**
- **Pain Management**
- **Eviction and housing needs**
- **Financial issues related to life transitions**



# Key Interventions



## *Health Education and Support*

Preventive measures and health risk reduction support for diabetes management and tobacco cessation; sleep problems, fall risk reduction

## *Care Coordination*

Post discharge support; Partnering with PCP and oncologist; Pain management

## *Chronic Condition Management*

Member-driven action plans, care plans and care manager-guided coaching, and clinical interventions (i.e. cancer treatment, depression and dementia)

## *Advocacy and Care Navigation*

Care navigator; caregiver support and connections to pharmacy assistance and community resources (i.e. HUD, Michigan Choice chore services)

# Humana Cares



*Complex and chronic care management enhances the care continuum  
and extends reach beyond **case** management and **disease** management  
It's more than the case or the disease ....*



*It is all about the **Member, the Family/Caregiver, and Quality of Life***

# Questions?



## Next Steps



- Upcoming Webinars on Leadership:
  - September 24, 2012 - Sigma Theta Tau International Leadership Institute
- Archived webinars [www.championnursing.org/events](http://www.championnursing.org/events)
- Request Toolkit : Nurse Leaders in the Boardroom: The Skills You Need to be Successful on a Board  
<http://championnursing.org/nurse-leaders-resource>

# Campaign Resources



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