FUTURE OF NURSING™
Campaign for Action
AT THE CENTER TO CHAMPION NURSING IN AMERICA

Robert Wood Johnson Foundation

AARP

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

Webinar Summary
June 11, 2012

Participants:

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Across the country, there is a movement to advance the field of nursing so that all Americans have access to high quality, patient-centered care in a health care system where nurses contribute as essential partners in achieving success. This national level Future of Nursing: *Campaign for Action* is a result of the Institute of Medicine's landmark 2010 report on the Future of Nursing: *Leading Change, Advancing Health*.

The *Campaign for Action's* field-based teams, the Action Coalitions (ACs), are leading this movement and are equipping themselves with knowledge gained from technical assistance provided by the Center to Champion Nursing in America (CCNA), a joint initiative of AARP, the AARP Foundation, and the Robert Wood Johnson Foundation. Such technical assistance comes in the form of webinars, face to face interactions, and other facilitated engagements with public policy leaders, content experts, consultants, and Action Coalition peers across the country.

Background

The United States has the chance to transform its system and culture of health care, but only if nurses are better prepared and able to practice and lead to the full extent of their education and training. Through efforts nationally and locally, the *Campaign for Action* aims to utilize the skills and potential of nurses and nurse champions to effect sweeping change. All nurses need to join this effort.

Health plans have a major role in the health care system with a focus on wellness, prevention, and chronic care management. Employed at all levels of health plans and in every operating unit, nurses influence the development, direction and implementation of patient and family-centered programs. This webinar features three nurse leaders from Aetna, Humana Cares and Horizon Healthcare Innovations who will describe examples of how nurse-led programs directly impact the health outcomes of consumers.

For Part I in this series, visit www.championnursing.org/events

Webinar Goals

- ❖ Learn about the variety of roles nurses play in health plans and the types of nurse-led programs and services delivered within them
- ❖ Understand the links between nurses, health plans, the future of health care delivery and the IOM's recommendations
- ❖ Understand the impact nursing interventions in health plans have on consumer health outcomes.
- ❖ Relate issues of quality, access and cost to nurse-led programs in health plans

Webinar Overview

Today's webinar on the Role of Nurses in Health Plans aligns with the campaign's vision and the key area of nursing leadership, which is part of the Institute of Medicine report. Health plans play a big role among state Action Coalitions. Many have partnered with health plans to help advance their work and four Action Coalitions have co-leads who represent health plans.

As **Pat Polansky** of AARP noted, nurses fill a variety of roles in health plans, contributing to the campaign's vision of quality, patient and family-centered care. In Part I of this webinar series, nurse leaders spoke about the mission of health plans and the unique role they play in the overall health care system. This webinar features three nurse leaders in health plans who will:

- ✓ Highlight the links between nurses, health plans, the future of health care delivery, and the IOM's Future of Nursing report recommendations;
- ✓ Describe the variety of ways that health plans are driving innovations through programs and services that address access, quality and cost of care;
- ✓ 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; and

Susan Kosman of Aetna said in response to the IOM's Future of Nursing report, a diverse group of nurse leaders across various health plans and members from America's Health Insurance Plans have been meeting for the past year to focus on: Discussing the Future of Nursing report and the implications on health plans; sharing the IOM's report within our respective organizations; brainstorming ideas/actions that health plans can take to support/advance the IOM's recommendations; collaborating where possible on actions that support the IOM's recommendations; developing this webinar that describes the various roles that nurses play in health plans, the linkage to the IOM's recommendations, and the future of health care.

Aetna has a variety of programs that focus on engaging members across the care and life continuum while also addressing access, quality and cost, **Kosman** said**. In Touch Care** is one of Aetna's newest models of care delivery. There were a number of factors that led Aetna to

create this approach, including Aetna nurses who provided feedback and suggestions on how better to engage and work with members in driving better outcomes. The In Touch Care model addresses the needs by:

- ✓ improving identification and stratification of members who in priority fashion could benefit from services at the right time;
- ✓ providing the right level and the right setting, with better and more appropriate consideration for what services we deliver; and
- ✓ improving the members' whole experience.

In this webinar, **Kosman** focuses on the role of the nurse as a single point of contact and highlights the member experience.

In this model, there is one nurse at each stage of an individual's health and life continuum, who has the ability to respond with the appropriate level and method of intervention based on an individual's need and preference. "We believe this would help to better drive and facilitate member engagement and to build long-term relationships between member, nurse, and provider**," Kosman** said.

This model manages members with both acute and chronic care issues through a **single nurse** referred to as the **Primary Care Manager**. They use a holistic approach which includes a member's clinical and cultural needs.

The Primary Care Manager considers both internal and external influences on an individual's health status to customize a care plan around the individual and their cultural values. The Primary Care manager is not only the member's nurse, but assists all dependents to become a **family resource**.

Through this approach, Aetna is able to help the member and their families get an appropriate level of support and meet their clinical needs. There are triggers that nurses use to make contact with members at a point in their care and treatment when it really matters. For example, the program will identify members with a higher likelihood of a hospitalization in the next nine months to attempt to avoid an admission (pre and post hospitalization calls).

At its core, the model takes a member-centric approach that enables the nurse to use a holistic approach to engage members with optimal program resources and intensity, and provides additional means for support, based on member preference and need.

Here is an example of the impact the nurse can have on a consumer as a Primary Care Manager:

Gina* is a 60 year-old female admitted to the ER with shortness of breath, weakness and nausea. She was diagnosed with Atrial Flutter with A-V block. She was given a new diagnosis of diabetes. She was discharged home after medication cardioversion. Co-morbid conditions included obesity, hypertension, hypothyroidism, hyperlipidemia, a torn medial meniscus of the left knee, and the new diabetes diagnosis. Medications at discharge included her pre admission

* Not her real name.

medications for blood pressure, thyroid, and cholesterol medications as well as new insulin medications.

The goals for this consumer:

1. HbA1c less than 8.0 to allow left knee surgery.
2. Diabetes control with diet, exercise and oral medications to allow discontinuation of insulin.
3. Weight loss for diabetes control.
4. Increased activity, endurance and strength using outpatient therapy and pool walking.
5. Return to work post knee surgery with ability to ambulate without device.

At times the member was tearful but denied depression. She indicated she had a long history of poor diet and minimal exercise. The care manager provided emotional support and encouragement to follow through with her diet and exercise. The member expressed comfort in talking with her care manager and agreed to continued bi-weekly contact. The care manager contacted the primary care/diabetes provider. The primary care provider identified the plan of care for the member for which the care manager supported in conversations with the member. The same care management nurse provided continual support beginning with her acute situation in the hospital through the management and control of her newly diagnosed chronic condition until she was ready to transition to virtual care support.

Health Outcomes:

Within a 4 week period the member progressed toward her goals with a change in HbA1c 13.4 to 10.6 by implementing her nutrition and activity plan. At that time the member purchased an exercise glider and began using it daily. She had a 20 pound weight loss and was still attending diabetes classes. She eliminated fruit juices and sweets from diet, and was eating whole grains. As she progressed toward her goals she experienced a more positive attitude and was pleased with her progress.

Long-Term Success:

By working with the primary care nurse, this member was able to reach her goals and was in a better position to plan for her knee surgery. She verbalized a good understanding of managing her diabetes and felt more positive and confident after having achieved her goals. She was transitioned to Aetna In Touch Care Virtual Support programs which provided her with continued support for diabetes management and coordination and planning for other needed resources.

Mary Aikins of Horizon Healthcare Innovations discussed the landmark results around Horizon Blue Cross Blue Shield of New Jersey's (BCBSNJ) Patient-Centered Medical Home (PCMH) Program and the role that nurses have played in achieving those results. She also discussed Horizon's approach to deliver robust transformation and the core elements to achieve sustainable results.
Horizon Healthcare Innovations (HHI) was developed to solely address two fundamental problems: lagging quality of care and cost containment.

The only way to truly address these issues is to fundamentally change how health care is delivered and that is the goal of Horizon Healthcare Innovations – to lead a collaborative effort with health care professionals across New Jersey to find ways to deliver better health and better health care at a lower cost.

HHI focuses on three core priorities, the Triple Aim: to improve the quality and coordination of care; to create a healthier population; to deliver a better overall member experience, and to reduce the total cost of health care to make health insurance more affordable for members.

HHI focused on developing a collaborative Patient-Centered Medical Home program.

What is a medical home?

- ✓ A Patient-Centered Medical Home is a primary care delivery model that puts the patient at the center of the delivery system.
- ✓ It helps ensure patients receive accessible, proactive and coordinated care at the right place and at the right time.

The medical home model was developed and designed in strong collaboration with eight New Jersey primary care physicians and leadership of the New Jersey Academy of Family Physicians. By working together to continually revise, refine and adapt the model, they have made great strides on behalf of patients and members.

This model is focused on chronic and at-risk patients, but is available to all Horizon Members. New Jersey's Patient-Centered Medical Home Program currently includes over 80,000 members supported by over 150 physicians at 22 practices. By the end of this year, approximately 200,000 members will be participating in the medical home program.

Aetna compared 2011 preliminary quality and cost trends between 24,000 Horizon BCBSNJ members participating in the PCMH program and a control group not in the program.
The findings show that patients within the PCMH program are benefiting and the costs are lower:

Some of the results: eight percent higher rate in diabetes control; six percent higher rate in breast cancer screening, 10 percent lower cost of care per member per month; 26 percent lower rate in ER visits; 25 percent lower rate in hospital readmissions and 21 percent lower rate in hospital inpatient admissions.

There are five core elements necessary for a medical home to achieve sustainable results:

- ✓ Payment reform – moving away from fee-for-service to fee-for-value
- ✓ The effective use of population care coordinators
- ✓ A PCMH playbook and collaborative learning network
- ✓ The sharing of actionable data through technology
- ✓ The ability to help practices engage, educate and empower patients

Payment reform is critical to transforming the delivery system. "We need to move away from fee-for-service and toward reimbursing physicians for getting and keeping their patients healthy.

Health care professionals should be paid based on the quality of care they deliver to our members, not on the volume of procedures, visits or tests," **Aikins** said.

Another core component is population care coordinators (PCCs), who are nurses located within the practices. Care coordinators are strong communicators that proactively engage at-risk individuals, those with chronic health conditions and those with behavioral health concerns. These nurses play a pivotal leadership role by working with the primary care physicians and their teams, and helping coordinate care.

A population care coordinator is an RN with a valid nursing license in NJ who must have 3-5 years of clinical experience and ideally have experience in discharge planning, case and or disease management. These nurses participate in the HHI/Duke/Rutgers PCC 12-week training program, which includes:

- ✓ Effective communication strategies with patients and health care providers;
- ✓ Accessing and using databases including disease registries and electronic medical records;
- ✓ Case management of complex patients;
- ✓ Patient coaching and coordinating transitions of care;
- ✓ Implementing and managing change in health care organizations; and
- ✓ Operations of a Patient Centered Medical Home Role of population care coordinators in improving patient outcomes.

An example of how Population Care Coordinator can make a big difference:

Claudia, the PCC, identified a patient in the system as high risk. She was a diagnosed diabetic whose last labs indicated an H1AC 11.5 from 11-10-10. The patient had no mammogram, no pap since 2009 and had no eye exam. Claudia reached out to the patient to schedule a planned visit and begin patient education on the importance of maintaining the structures to ensure her wellness. While in discussion, the patient shared that she had recently been having some shortness of breath and chest pain.

The patient was scheduled for an appointment in the patient centered medical home later that day. Upon exam it was determined that the patient needed to have a cardiac cath and placement of stents. Three weeks after the procedure, the patient came back to the primary care doctor and asked to see both the doctor and Claudia. The patient said she wanted both to know that through their intervention they had saved her life. Claudia describes it as an enormously fulfilling moment as a nurse as she was truly able to impact patient care.

Diane Hogan says that the Humana Cares model of care provides integrated health care solutions, serving as Humana's care management provider for complex care, dual and chronic care special needs plans and chronic and specialty condition management.

These programs are integrated into Humana's health service offerings, and are branded as **Humana Cares**. Humana Cares works with over 200,000 Medicare Advantage, Medicaid and commercial members telephonically in all 50 states, and is on the ground with field staff infrastructure in 34 states. The programs are designed to link health care and social care, allowing members to remain as healthy and independent as possible in their homes.

Complex care members are those people living and coping with one or more chronic, lifelong conditions, with good days and bad days, acute and chronic needs. They are frail, disabled and vulnerable, and need a high degree of self-care management support. They may be facing end-of-life concerns and may be dually eligible for Medicare and Medicaid.

Members in Medicare see on the average 13 providers a year and take on average eight to 10 medications. **Hogan** says that 82 percent of seniors have a chronic condition and 62 percent have two or more.

"We practice a "member for life" philosophy. Studies have demonstrated a strong "dosage effect whereby member cost and utilization decreases and stabilizes the longer members are in care management," **Hogan** noted.

Humana Cares' mission is to provide a highly trained, multidisciplinary care management team – on the telephone and in the field – to address the complex, acute and chronic care needs of chronically ill Humana members. Humana Cares links medical and behavioral care with social care to combat the challenges of aging and chronic illness. Humana Cares managers respond to member needs and adjust levels of intervention to meet changing concerns. All of this plus clinical judgment drives the next steps and care pathways.

Program goals are to optimize health and well-being "member-by-member" by: assessing the member's total health status over time; supporting informed healthcare consumerism and the member's ability to self-manage; providing individualized health education to help the member set and meet health goals; evaluating the member's environment and support network; coordinating care and adhering to treatment plans across providers and sites of care; connecting the member to available community support and resources and advocating for the member through his or her care and life transitions.

The Humana Cares Program:

- ✓ Involves the assignment of complex-chronic members to one primary nurse who will become the members' primary contact to the health care system.
- ✓ Builds long term relationships while actively managing their co-morbidities and coordinating access between internal/external programs and multiple providers.
- ✓ Care center blends on-site and telephone support; marries acute and chronic care management.
- ✓ Supports the most fragile of members with a multidisciplinary team comprised of medical, behavioral, social work, pharmacy, and home visits.
- ✓ Sophisticated predictive models identify individuals before critical events and on an on-going basis; Member for Life.
- ✓ Develops Individualized Self-Care Goals, supports behavior change through proven psychological techniques.
- ✓ Telephonic Coverage in 50 States with Field Presence in 32.

Humana Cares navigates the confusing provider systems for patients; creates one stop care for medical and quality of life needs; encourages and supports clients, family and care givers to take an active part in their own healthcare; connects clients to community resources and

services; and deals with small problems before they escalate to major physical and financial problems.

The model of care is robust and fluid. It allows for real time clinical consultations and member reassignments to a higher level of intervention when needed. The primary care managers engage additional resources and support for the member, caregivers, and legal representatives.

A Humana Care case study:

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

The areas of concern were chronic condition management (diabetes eye exam; depression; difficulty sleeping due to anxiety over possible eviction from the apartment; newly diagnosed prostate cancer; a fall history, pain management; financial issues.

The key interventions for this man were preventive measures and health risk reduction support for diabetes management; care coordination with post discharge support and pain management; developing of member-driven action plans, care plans and care manager-guided coaching and care navigator support and connections to pharmacy assistance and community resources.

The IOM's recommendations address more and advanced education of registered nurses; nurses leading innovations in health care and being appointed to decision making bodies; all nurses practicing to the full extent of their education and training; a more diverse nursing workforce and faculty; nurses and other clinicians inter-professional learning and practicing together; and several others.

Next Steps

- On September 24, CCNA will host be a webinar featuring nurse leaders who are leading change and advancing health following their participation in one of the Sigma Theta Tau Leadership Academies.
- Archived webinars: www.championnursing.org/events
- Request Toolkit: "Nurse Leaders in the Boardroom: The skills you need to be successful on a Board" at http://championnursing.org/nurse-leaders-resource

Resources:

- Visit the Extranet at http://ifnreport.projectspace.com for more information on Action Coalitions. Problems logging into the extranet, contact Barbara Akinwole at bakinwole@aarp.org
- Also visit CCNA at http://championnursing.org and http://thefutureofnursing.org
- Follow CCNA on twitter at http://twitter.com/#!/championnursing and the Future of Nursing at www.twitter.com/futureofnursing
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- For more information from the Center to Champion Nursing in America about this webinar, technical assistance, or other questions about the Future of Nursing: *Campaign for Action*, please contact Michael Pheulpin at MPheulpin@aarp.org or 202.434.3882.

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