



Geisinger Health Plan's Medically Complex Medical Home Program

A program involving home visits by health care professionals is a challenge for a rural organization such as Geisinger Health Plan. But through judicious use of care providers, each working at the top of his or her training, the health plan has hit on a promising formula that is improving care.

HOW THE PROGRAM WORKS: Team-Based Care in the Patient's Home

Geisinger Health Plan's nine-month pilot identified patients who were appropriate for the Medically Complex Model (see sidebar) through referrals and utilization data, seeking the highest-risk patients based on frequent visits to the emergency department or inpatient admissions and readmissions. The care team Geisinger designed for this special population of complex elderly patients is a nurse case manager and a

community health assistant — a trained, non-licensed health worker.

When a patient is identified, the team members visit him or her in the hospital or nursing facility to introduce themselves and make arrangements to visit at home within 48 hours of discharge.

Geisinger has determined that it is crucial to identify gaps in care and then work to fill them. The team looks for anything that may be an impediment to managing the patient's health conditions, including clinical issues like medication adherence, social issues like the ability to prepare food at home and safety issues like wires or throw rugs that could lead to falls. Medication management is particularly emphasized as medication mishaps are often a cause of readmission.

The care team also reviews with the patient a customized care plan called a Self-Management Action Plan. This plan includes details about symptoms the patient should watch and easily understood actions the patient can take on his or her own depending on the symptoms observed.

The typical length of stay in the program before patients are handed back to the patient-centered medical home team is three to six months, although some patients remain in the program indefinitely if they continue to be high-risk. Hospice is called in as early as possible in cases where it is appropriate, and the team continues to manage the patient's care until his or her death. In some cases, patients have listed care team members in their obituary, recognizing them as a part of the person's family and a key element of the support structure for the last chapter of life.

Medically Complex Medical Home: At a Glance

- High-risk medically complex patients are managed and monitored by a two-person care team of a nurse case manager and community health assistant.
- The team oversees the transition home from the hospital or skilled nursing facility, visits the home and creates a care plan that is easily understood and implemented by the patient.
- The team ensures follow-up care and appointments and arranges for support services.
- The patient's care is handed back to the Medical Home when appropriate.

RESULTS:

More Complete Care, Lower Costs

The program has resulted in an approximately 20 percent, \$1000 per-member-per-month, cost reduction for those in the program, largely from a significant decrease in the number of times a member needed to visit the emergency department or be admitted to the hospital.

During the nine-month pilot, a redesigned care team managed 75 medically complex patients. Program leaders have tracked how well the program has addressed gaps in care and what the effect has been on utilization and costs. Over the nine-month period they closed:

- 433 gaps in care related to plan of care optimization (standards of care gaps).
- 201 gaps in care related to safety.
- 21 gaps in end-of-life planning.
- 416 gaps related to medication management including medication omissions and medication adherence. 🍊

A Medically Complex Patient Story: Before and After

"Mary" is 88, with a history of heart failure, COPD, kidney disease and atrial fibrillation. She lives alone, is hard of hearing, does not drive, eats poorly and struggles to care for herself.

After visiting Mary, the Geisinger Medically Complex Medical Home team arranged for home-delivered meals, transportation services and some in-home care. They also taught her about self-care. The program made an important difference in the quality of Mary's life: In the nine months before she enrolled in the program, Mary had two urgent hospital admissions, one skilled nursing facility (SNF) stay and one emergency room (ER) visit for heart failure. In the first eight months of her enrollment, she had no inpatient admissions or SNF stays and one ER visit.



A member of the Geisinger care team talks with a program enrollee about her medications.