

Grounding frequent fliers



Doctors Roberta Capp and Jennifer Wiler of the University of Colorado School of Medicine. Dr. Wiler said the successful Bridges to Care program is "antithetical to the way health care is currently delivered."

KATHLEEN LAWRE, BUSINESS JOURNAL

U of Colo. Hospital brings together care network for proactive plan

BY ED SEALOVER
esealove@bizjournal.com
303-803-9228, @EdSealoverDenCo

Some 864,000 patients come through the doors of University of Colorado Hospital each year, and – as with most health systems in the state – a number of those patients are better served at less-acute care facilities.

But in determining how to deal with those "frequent fliers" – the term commonly applied to the 1 percent of health-care patients who account for roughly 25 percent of health costs nationally – hospital leaders knew they didn't want to go it alone. And in fact, several community groups came to them with a plan.

Working with the Metro Community Provider Network, Together Colorado and Aurora Mental Health Center, the hospital implemented a "Bridges to Care" program that seeks out the most common visitors to the emergency department.

It then pairs them with health care

workers and social workers in an intensive regime that is high-cost in the short term. But the results it has achieved, including a more than 50 percent reduction in hospital admissions among these patients, are opening a lot of eyes.

"It feels antithetical to the way health care is currently delivered," said Dr. Jennifer Wiler, an associate professor of emergency medicine at the University of Colorado School of Medicine, which also participated in the program. "I think there's really an opportunity for policy makers to think about this."

Problems with delivery system

Health advocates count many problems with the current delivery system in this country, but two of the main interconnecting issues are the payment system and the siloing of care. Because doctors are paid on a per-visit basis rather than for the overall scope of care they deliver to patients, few offer the kind of monitoring to ensure that patients are following their advice and staying healthy. And because of that, patients – especially lower-income residents who do not have a specific primary-care provider – tend to bounce between clinics without doctors in different locations knowing what care they've received.

Officials in the Bridges to Care program made two key observations early on. One was that there was a ton of

"The number of visits to the emergency department by these patients fell by 49.8 percent."

HEATHER LOGAN, director of accountable care for the Metro Community Provider Network, on the "frequent flier" patients in the Bridges to Care program.

waste from lack of coordination among care providers; one patient, they found had five different case workers who did not communicate with each other. The other was that 81 percent of the patients who were the most frequent visitors to the emergency department were dealing with some sort of behavioral-health issue.

So, with a \$4.5 million grant from Rutgers University in hand, the participating organizations began by putting a community worker in the emergency department to identify and communicate with frequent visitors, choosing patients who would be willing to participate in the program. Within 72 hours of discharge from the hospital, a health-care worker is sent to review their home and call in a larger team to administer services.

That worker will do a medication reconciliation to make sure that prescription drugs don't overlap or conflict with each other. A medical assistant visits to evaluate the safety of the home. Aurora Mental Health dispatches a therapist and case manager to determine if help is needed in that

area. And a health coach gets in touch with the patient to schedule ongoing appointments ranging from walks to nutrition classes to pedometers given to participants.

The goal is not just to have the patient recover from the problem that required the most recent hospitalization but to give them the tools, the motivation and the knowledge of the health care system to allow them to care for themselves, said Heather Logan, director of accountable care for the Metro Community Provider Network. And after some 600 patients went through the program between July 2012 and June 2015, the results spoke loudly.

ER visits down

The number of visits to the emergency department by these patients fell by 49.8 percent, Logan said. Even costlier hospital admissions dropped by 54 percent. And avoidable emergency-room visits – those in which urgent care was not appropriate – dropped 42 percent.

This all resulted in savings of about

\$22,000 per patient – about \$7.9 million overall, Wiler said. And it helped patients deal effectively with a number of conditions, particularly chronic pain.

Program leaders have submitted their findings to Health Affairs magazine and are eager to talk to state and federal officials about the results. They are aware that each community will need to come up with their own plan to solve this problem but believe Bridges to Care can serve as a blueprint.

"We definitely, I think, found our secret sauce," Logan said. "Every partner did what we could."

The trick now is continuing the momentum. The three-year grant expired at the end of June. And while participating organizations have dedicated staff and resources to keep the program going, they need financial help and need both government and private insurers to change their method of reimbursement to pay for this holistic care rather than pay only when someone is sick enough that they have to see a doctor, said John Reid, vice president of development for Metro Community Provider Network.

The question now remains who will step up to the plate to continue this success.

"We've done this for 600 people and shown great results," said Rich McLean, director of Aurora Health Access. "But the bottom line is it should be a standard for a lot more people."