

Case Studies



■ How a Focus on High-Risk Patients Reduces Avoidable Admissions



One of the largest Federally Qualified Health Centers (FQHC) in the U.S., El Rio Community Health Center serves the communities around Tucson, Arizona and provides

comprehensive medical, dental, behavioral, and preventive health services designed to meet the needs of individuals and families. Currently serving more than 92,000 patients annually across 11 campuses—with over 22,000 members enrolled in UnitedHealthcare Community Plan—El Rio was one of UnitedHealthcare's first Medicaid ACOs. The relationship focuses on enhancing care coordination among high-risk patients and engaging them in care opportunities earlier on to reduce avoidable hospital admissions down the road. As El Rio's CEO Nancy Johnson put it, "90% of what creates health happens in the community, not the exam room." El Rio utilizes integrated and coordinated patient-centered care models and launched a number of process improvements to directly impact its patients' care experience:

- Created a team of dedicated nurses to manage discharge care management;
- Expanded its hours and availability of same day appointments;
- Began placing follow up calls to patients after an ER visit;
- Offered 24/7 Registered Nurse triage capability; and
- Shared data with UnitedHealthcare to identify and treat the patients in need of care.

UnitedHealthcare augmented these services with its own community health workers who visit patients in their homes who have complex medical needs and/or cannot easily make it to doctors' offices for care. The result: Medicaid participant ER visits reduced by 2%, avoidable admissions/readmission went down by 19%, and enrollment in UnitedHealthcare's Community Plan increased by 8%.

■ Using Data Analytics to Improve Diabetes Management



Located in Northeast Tennessee, State of Franklin Healthcare Associates (SOFHA) is a leading

example of how smaller organizations are effectively implementing Value-based Care models. A physician owned and operated group comprised of approximately 78 primary care physicians and 30 advanced practitioners with relatively low overhead and low annual informatics spend, SOFHA relies on UnitedHealthcare's data analytics and back-end IT to support its population health programs.

One way the data is used is to better serve Medicare patients living with diabetes, which comprised nearly one-third of the physician practice's Medicare beneficiaries. UnitedHealthcare provides the practice with daily census data, monthly claims and utilization information as well as quality data. Clinical reporting is developed to include Patient Profiles, High Risk Population data and Patient Care Opportunity Reports (PCOR) for all UnitedHealthcare members being treated by SOFHA doctors, giving the physicians valuable and timely information to identify gaps in care and the ability to see all the other places outside the primary care practice where patients have received care.

Armed with this information, SOFHA physicians are able to better identify the types of care patients need. In addition to the data, the collaboration between UnitedHealthcare's ACO team and SOFHA's leadership and clinical team has formed a true win-win relationship. The result: in just three years SOFHA has become one of the highest performing groups in the Medicare STAR Ratings System, rising from 3.0 in 2012 to 4.5 in 2015. The rate of annual wellness visits among Franklin patients went from 2% to 59% in just three years.

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— Nancy Johnson, CEO of El Rio Community Health Center