Medical Home Network achieves significant decrease in hospital readmissions

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Medical Home Network achieves significant decrease in hospital readmissions and increase in follow-up care through innovative care coordination exchange

The Medical Home Network (MHN) collaboration in Chicago is changing the way health care is being delivered to Medicaid patients through the use of innovative technology combined with a highly efficient, patient-centered and team-based model of care, according to information released October 15. This has an impact on hospital readmissions, the length of hospital stay and the cost of providing care. Rush University Medical Center is one six founding hospital partners.

The data from two years of using MHN Connect's secure web-based care coordination tool (2012-2013) versus a baseline year (2011), reveals that there was a significant decrease in hospital readmissions and a substantial increase in timely follow-up visits with primary care doctors among the pioneer early adopters, specifically six Federally Qualified Health Centers and six hospital systems, including Rush, caring for 170,000 Medicaid patients in Chicago.

"This data has proven MHNConnect to be a highly efficient and reliable care coordination tool, giving care teams access to their patients' pertinent information and activity, which helps provide a better understanding of the health care history and patient use of health care services throughout the system," said Anthony Perry, MD, chief medical officer of Rush University Medical Group, which has been using

MHNConnect since its introduction. "Providing that information to the health care team empowers them to understand and meet their patients' needs and make the best health care decisions with those patients."

Comparing performance year one (2012) to the previous year (baseline), Medical Home Network's partner hospitals and clinics recorded a 12.4 percent reduction in hospital readmissions (within 30 days of being discharged) in year one and 24.8 percent reduction in year two (2013). The number of inpatient hospital days decreased 3.7 percent from baseline in year one and 24.4 percent from baseline in year two. The average length of stay decreased 5.1 percent from baseline in year one and 20.2 percent from baseline in year two. Finally, the cost of care per member, per month, decreased 3.3 percent from baseline in year one and 5.0 percent from baseline in year two.

MHNConnect was the first technology of its kind to be implemented across disparate entities like hospitals and primary care practices in Illinois. This enables providers and care teams access to real-time and historical data, plus immediate patient activity alerts, prompting them to log into the system. As a result, care gives can make better, more informed decisions at the point of care, and make faster, more coordinated care transitions for patients across wherever they receive care. The reach of MHNConnect continues to expand and is currently providing integrated connectivity for 20 hospitals and more than 170 primary care practices.

"MHNConnect's connectivity is transforming the way providers collaborate to deliver better care at a lower cost," said Cheryl Lulias, president and executive director of Medical Home Network. "This care model is effectively breaking down the four walls of the doctor's office and extending care delivery to our patients and the entire health care community linked on MHNConnect."

The impact of MHNConnect is exemplified by the story of a 34 year-old man, who up until the introduction of the Affordable Care Act had no medical coverage. After January of 2014, he was assigned to Rush University Medical Center for his primary care. A nurse care coordinator received a real-time alert, logged into the portal, and was able to track his health care usage in the MHNConnect system. The man suffered from COPD, diabetes, and sleep apnea and was in and out of the emergency department at several hospitals in order to receive care. The nurse care coordinator contacted the man and assigned him to a primary care physician for his overall care, a pulmonologist for his COPD and dietician for his diabetes. Two days later, she was surprised to receive a MHNConnect real-time alert saying he was in Stroger Hospital's emergency room to get his blood pressure and glucose levels checked. The man did not realize that he could have contacted, or even walked into, his medical home, his primary care clinic. The nurse explained this to him, and he is now on track to improve his health and has a medical care team he can access at any time. The nurse worked with him to establish a plan and for the first time in his life, he has a health record that his doctor, specialists and care team can review in order to best help him.

"Having access to real-time information and up-to-the-minute details pertaining to each patient's health care utilization is invaluable," said Arthur Jones, MD, chief medical officer of Medical Home Network and longtime practicing physician on Chicago's West side. "Analysis reveals that now, for each Chicago Medicaid patient going to the hospital for a health problem, one out of every three will make a follow-up visit to their primary care physician after hospital discharge. That's a big step in the right direction for health care in Chicago."

The successful incorporation of technology into Medical Home Network's hospitals and clinics is now being applied to the Medical Home Network (MHN) ACO, working with Cook County Health and

Hospitals System's managed care program, CountyCare, garnering similar results and signaling the future use of technology to deliver affordable and efficient quality health care.

Provided by Rush University Medical Center