CarePlus

Practical, Proven Care for High-Risk, High-Cost Members

Executive Summary

The parallel goals for substantive health care reform are explicit. Achieve higher-quality care that enhances patient health while reducing unsustainable costs. Despite this clarity — and the magnitude of progress still needed — discussions about reform seem more prevalent than actual change.

There is one exception. It takes the form of a **payer-centric** path to care improvement and expense reduction. The solution is an at-home care and care management approach designed to help chronically ill, medically complex members avert acute, high-cost events. Patients receive proactive care and care management where they live. Also important, the member-centric focus emphasizes provider integration and collaboration.

In *this* reform discussion, the critical infrastructure and best practices are established. The qualitative and quantitative outcomes appear in the medical record.

Underperformance Where "High-Risk" Members Intersect Traditional Delivery

Given the traditional health care delivery model, health plans aspiring to better manage care for their chronically ill, highest-cost members may appear to overreach. But the chronic population's disproportionate influence on cost validates looking at a precision-targeted solution that can translate ambitious aspiration into a care-improving, plan-enhancing outcome.

Patients who struggle with multi-faceted, difficult-to-manage needs often represent only 5 percent of a plan's membership, but they drive 50 percent or more of total clinical expenditures.[1] This is due, in significant part, to the fact that current health care delivery often underserves medically complex patients. The result is a high-risk but under-managed segment: members who compile histories of over utilization dominated by high-cost events like emergency room visits, acute hospitalizations and re-admissions.

In the typical cause-effect analysis, a relative few critical inputs account for the problem or underperformance. The same is true in the at-risk, high-cost circumstance. When chronically ill, difficult-to-manage members intersect with traditional health care delivery, payers encounter well-defined obstacles that undermine improved care quality, patient health, cost containment and business performance.

- Medically complex members frequently present with multiple chronic conditions, associated cognitive issues and psychosocial complications that render them high-risk.
- Multiple providers and medications produce disjointed, confusing and sometimes contraindicated care plans.
- Traditional in-office medical care delivery is insufficient — in time and quality — to establish the patient insight and relationship depth that medically complex members uniquely require.
- Under the current care delivery model, primary provider and specialist practices are not structured or equipped to provide the urgent, 24/7 response proven to be critical in preventing chronic illness escalation and exacerbation.
- The accompanying gaps in care — along with a common lack of patient adherence — leave members vulnerable to frequent escalations and exacerbations. These, in turn, devolve into excessive medical crises requiring ER visits, acute hospitalizations, readmissions and unnecessary medications.

This white paper explores a member-centric, provider-driven **direct care** and **care management** model responsive to critical challenges within the medically complex population. The targeted solution — validated by medical outcome and ROI data — enables a health plan to directly impact quality-of-care standards, improve member health, reduce medical expenditures and protect profitability.

Payer Focus on Root Causes Drives Cost, Quality Change for Medically Complex

The chronically ill, medically complex patient profile includes nine or more conditions, 15 or more medications, and multiple acute hospitalizations or emergency room trips.

Under the in-home, direct care and care management model, a health plan provides contracted physicians and nurse practitioners who go to the patient. These "on-the-ground" providers — who also collaborate closely with primary and specialist providers — support the multi-dimensional needs of medically complex members in private residences, group homes, assisted living facilities or nursing homes.

Alone and struggling with COPD, "Arthur" presented an oxygen saturation level that did not qualify for Medicare-provided portable oxygen. He was hospitalized 11 times in 12 months. Frequently panicked by his shortages of breath, Arthur also made 270 emergency room visits during the year.

According to the Optum physician who regularly visited Arthur in his home, a small amount of oxygen calmed him and averted escalations. The care team intervened with Medicare to validate the oxygen need and efficacy. With relief close at-hand, Arthur required only two hospitalizations, avoided the ER completely, and experienced a higher-quality final year of life.

Using in-home observation to provide early intervention and treatment, this form of care management monitors a member's medical, behavioral, environmental and social conditions. In some instances, even the most elemental measures can drive profound outcomes. Simply by identifying trigger events, managing risk factors and implementing self-management techniques.

Repeated, acute hospitalizations for CHF identified "James" as a complex plan member likely to benefit from chronic disease management utilizing a higher degree of hands-on, in-home engagement.

According to James' Optum nurse practitioner, the admittedly non-traditional intervention that reduced CHF exacerbations came to light only when she observed his dietary habits. In particular, binge-eating a high-sodium snack chip that consistently spiked fluid retention. The resulting "prescription" — fortified by telephonic care team check-ins to enhance compliance — established a daily snack chip limit. The measured, allowable portion size curtailed binging and helped James drastically reduce hospitalizations due to acute CHF events.

To interrupt the overutilization cycle within these types of scenarios, payer-administered direct care and care management requires comprehensive strategies and tactics tailored to medically complex member diagnosis, treatment and monitoring. Essential program components range from data-driven member identification and proficient enrollment...to specialized medical resources, systems and processes critical in high-risk patient care.

The following overview of the Optum CarePlus model exemplifies the key constructs in a payer-implemented collaboration with principal medical providers to improve care, enhance patient health and reduce high costs in the chronically ill, medically complex segment.

Identify, Assess and Plan

- Analytics-powered "at-risk" identification is highly predictive (accurate).
- Robust enrollment processes successfully bring high-risk members into the program.
- A comprehensive, provider-conducted in-home assessment of the member's complete health status considers all needs (physiologic, psychosocial, behavioral, functional, and environmental) and co-morbid conditions. The assessment also addresses medication management.
- An all-inclusive care and treatment plan followed by the in-home direct care team is part of an integrated, collaborative effort carried out in constant coordination with the member's PCP and specialists.
- Advance directive/advanced illness orientation and education enable the member, family and care givers to collaborate on the plan for optimal end-of-life care.

High-Risk Specialists, Frequency and Responsiveness

- Regular in-home provider visits each month enable first-hand, real-time observation fundamental to early-stage intervention that helps avert acute care events.
- In-home, direct-care medical providers interacting face-to-face with members are physicians, NPs and PAs trained specifically for chronically ill, high-risk patient care. In addition, each at-risk member works with an assigned nurse care manager and care management assistant to facilitate frequent, tailored care management interactions.
- Enrolled members have 24/7/365 access to request an urgent home visit. The urgent-response commitment is a visit from the member's direct care team within the same day or by that evening.

Leveraged Technology

- Telephonic interaction complements in-home visits. Nurse care managers and care management assistants reach out to members (on a scheduled basis) to educate, support and oversee care plan compliance.
- An electronic medical record gives all providers access to the care plan. The auto-fax feature automatically distributes care plan changes, updates, interventions and home visit notes to the PCP.

The initiative to reform health care benefits from examples of theory translated to actual practice. The in-home direct care and care management model affirms the practicality of key aspirations in health care improvement. There is an executable care delivery option — or at least a strategic complement — to the fee-for-service model. Similarly, it is possible to achieve the higher degree of patient engagement and "care provider relationship" known to be critical in higher quality care, better health and an improved quality of life.

Evidence of Quality-Minded *Theory* Translated to Cost-Reduction *Practice*

Equally important to validating this payer-centric approach as genuine reform, the in-home model includes a track record in expenditure management and financial performance improvement.

A set of foundational metrics underpin the health expenditure management and payer return-on-investment discussion. The metrics reflect insurance plan expenditure performance for CarePlus implementations conducted since 1998 across Medicare and Medicaid populations in 42 markets.

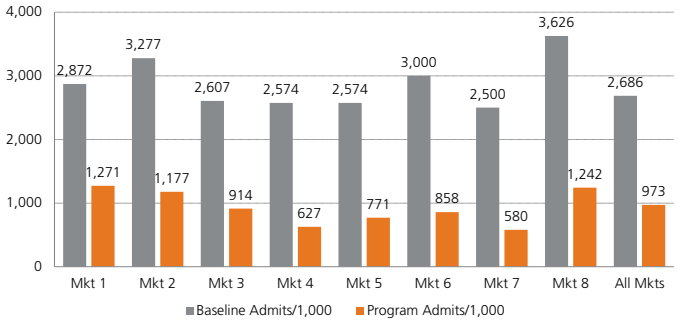
Implementing in-home direct care and care management is calculated to:[2]

- Reduce overall health care costs for medically complex members by 42% to 52% compared to non-managed at-risk members.
- Reduce hospital inpatient admissions by 64%.
- Reduce hospital readmissions by 33%.
- Reduce health care costs in the last six months of life by 61%.

A view of **acute admissions** across multiple plans in varying markets contrasts year-over-year performance in reducing admissions among enrolled medically complex members.

In this study, a 64% cross-market reduction in acute admissions corresponds to an **average PMPM improvement of $1,468.**

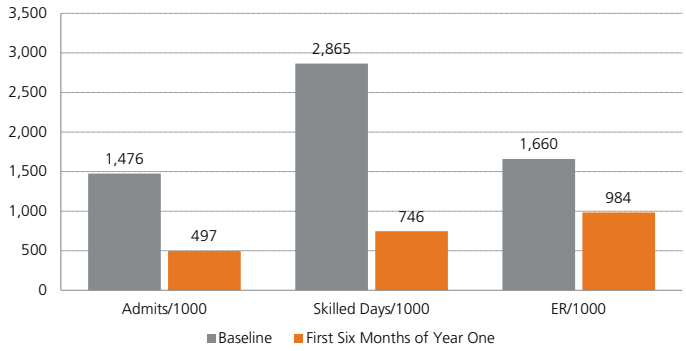
64% Reduction in Acute Care Admissions
Average $2,010 PMPM Improvements



With the capability to achieve cost savings as early as a chronically ill member's first in-home interaction, tailored and preventative care averting high-cost utilizations can generate immediate expenditure reduction. The following performance reports track one health plan's six-month and one-year experience.

Six-Month Impact. During the first six months of performance against the prior year baseline, in-home care and care management for high-utilization members showed significant reductions across acute hospitalizations, skilled days and ER admissions (per thousand).[3]

Six-Month Plan Performance
Reduction in Acute and ER Utilization

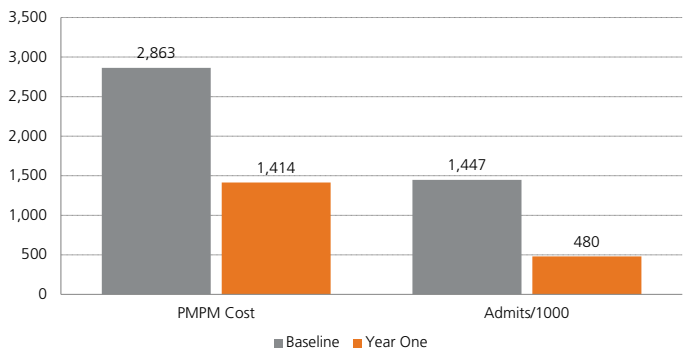


One-Year Impact. After one year, in-home direct care maintained the early, strong results in the acute admissions metric.

A 67% reduction in admissions helped drive a full-year average PMPM cost reduction of 51%.[4]

The following three data capture examples report actual in-home direct care outcomes for a Medicare Advantage payer implementation.

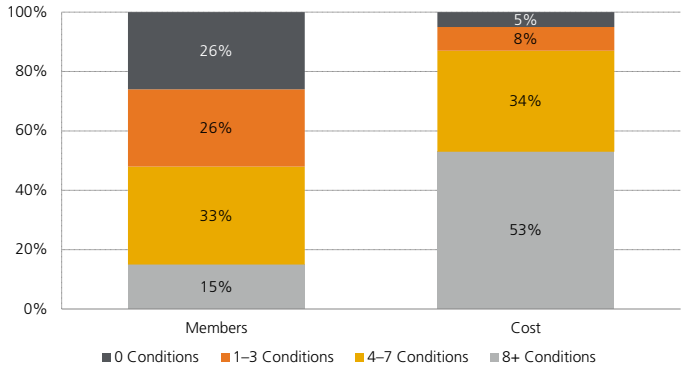
One-Year Plan Performance
Reduction from Baseline



Member/Cost Proportion. This allocation, reflecting plan experience prior to in-home direct care implementation, indicates the relationship between chronic member status and total plan expenditures.

Members with 8+ chronic conditions represented 15% of the plan population, but accounted for 53% of plan costs.[5]

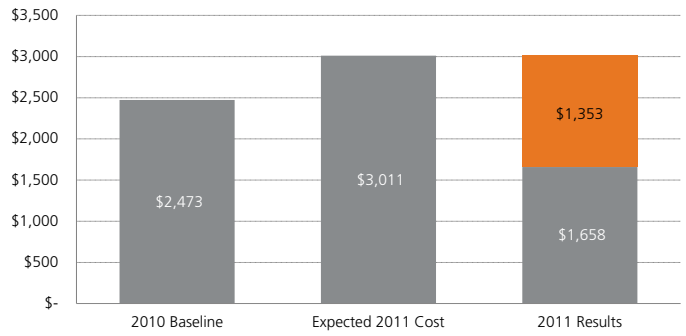
[Example Medicare Plan]
Cost by Chronic Conditions



PMPM Expense Reduction. The impact study established the Medicare Advantage plan pre-program baseline among members with 8+ chronic conditions.

Within the high-risk population, in-home direct care **reduced the average PMPM expenditure** by $1,353 compared to the baseline.[6]

[Example Medicare Plan]
PMPM Reduction Against Baseline
Based on Members with 8+ Chronic Conditions

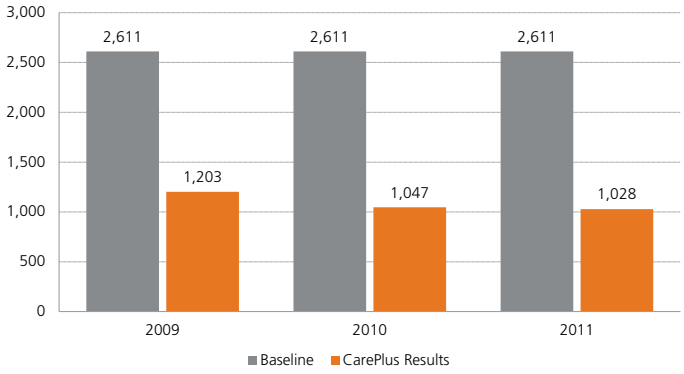


Impact studies across three payers demonstrate consistent high-risk, high-cost performance change using in-home direct care strategies, best practices and provider resources.

Plan 1: Medicare Advantage. The outcome study on in-home direct care and care management for a 20,000-member plan tracked program impact on **inpatient admissions** (per thousand) compare with a pre-program baseline.

Non-enrolled members selected in 2008 presented 2+ chronic conditions and 2+ inpatient admissions. In each subsequent year, admissions experience among enrolled members was measured against the baseline of 2,611 admissions.[7]

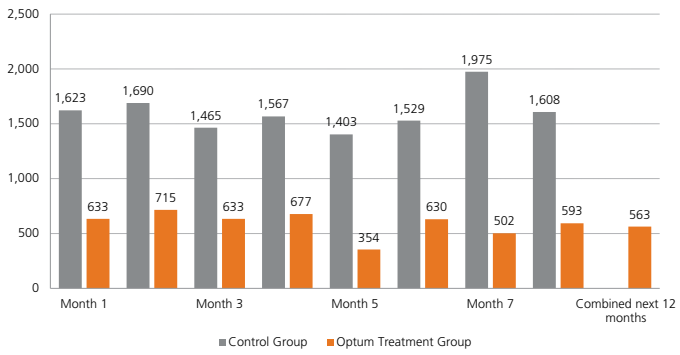
Reduction of Admissions per Thousand



Plan 2: Medicaid Dual SNP. The SNP member study measuring in-home program impact compared **inpatient admissions** to an actuarial equivalent matched cohort. The time frame was 12 months.

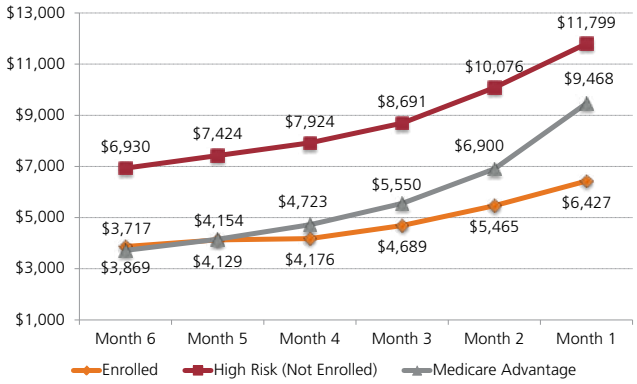
The program identified 800 high-risk members divided equally into a control group and a group receiving in-home direct care. After seven months of acute admissions impact, the plan placed all 800 members into the in-home direct care program.[8]

Acute Care Admissions/1000 Comparison



Plan 3: Palliative Care. A 19-month study measured Medicare Advantage members during the last six months of life. Member experience was measured against an actuarial equivalent cohort and the average Medicare Advantage cost in both markets.[9]

End of Life — Palliative Care



Members with 2+ chronic conditions and 2+ admissions (or 8+ conditions) were identified as appropriate for in-home direct care (enrolled and non-enrolled). The remainder was assigned to the Medicare group. Using the MMR to identify the month a member was deceased, the cost was pulled for the six-month period prior to the death month.

"He keeps me out of the hospital. I'm thankful I can call and someone will be here."

Living independently at age 78, "Eleanor's" support system includes a social worker in the senior apartment building and a daughter who prepares meals. She also relies on a strong relationship with Dr. Jeff Saluck. Through her HMO's contract for in-home direct care and care management, Dr. Saluck comes to Vivian for monthly check-ups and is available on-call if an urgent need arises.

Vivian suffers from advanced COPD. She also has chronic and acute bronchitis and macular degeneration. In the previous year, access to quick, in-home care has helped deter what could have been five emergency room visits or hospital admissions. Vivian has had only one admission during two years of in-home direct care and care management.

We know intuitively that an unwieldy health care system seeking genuine reform of care quality and care cost eventually must focus on chronically ill, medically complex patients like Vivian, Arthur and James. Clearly, a solution that addresses critical factors at the core of high-utilization, high-cost medical care pressure has the potential to create meaningful improvement.

This type of powerful vulnerability and urgency leads fairly easily to the proper ambitions. And compelling theories and strategies always follow closely. But in virtually every important initiative — with health care a prime example — the true challenge is execution. How do we progress beyond theory to repeatable practice?

In that respect, in-home direct care and care management — rightly administered from within the payer-member dynamic — shows genuine problem-solving traction. Particularly if the model emphasizes care delivery and care management as a collaborative, integrated provider effort focused on at-risk member health and quality of life.

About the Author

Ronald J. Shumacher, MD, FACP, CMD currently serves as Chief Medical Officer for Optum Complex Population Management one of the nation's largest care delivery and care coordination companies for chronically ill and medically complex seniors. Dr. Shumacher previously served as Executive Director and Senior Medical Director for Evercare of the Mid-Atlantic, and Medical Director and Vice President of Clinical Delivery for UnitedHealthcare Medicare & Retirement. Prior to his position within UnitedHealth Group, Dr. Shumacher practiced Internal Medicine and Geriatrics in Montgomery County, Maryland and served as the Medical Director of the Trinity Senior Living Community in Burtonsville, Maryland.

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Sources

[1]Stanton MW. The High Concentration of U.S. Health Care Expenditures. Research in Action, Issue 19. AHRQ Publication No. 06-0060, June 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/ria19/expendria.html.

[2]CarePlus Outcomes Study on Acute Admissions, based on claims savings for the large-patient pool programs in Five Markets. 2011. Data compiled by Optum Data Analytics.

[3]Medicare Advantage Outcome study on the immediate and robust impact of CarePlus program within the first six months of program inception. The CarePlus program in the AL market had an average monthly enrollment of roughly 1500 members. An Alabama MA Health Plan with 35,000 lives. Data compiled by Optum Data Analytics.

[4]Medicare Advantage Outcome study on the immediate and robust impact of CarePlus program on the number of acute admits per thousand. An Alabama MA Health Plan with 35,000 lives. Data compiled by Optum Data Analytics.

[5]Data provided by the Alabama MA Health Plan prior to implementing the CarePlus model of care.

[6]Baseline data was provided by the AL Medicare Advantage Health Plan based on members with 8+/2+2+ year over year Trends. Results were compiled by Optum Data Analytics.

[7]CarePlus Outcomes Study for High-Risk Medicare Advantage Health Plan Members (n=20,000 members), Jan. 2007–Dec. 2008. Florida Medicare Advantage Health Plan. Data compiled by Optum Data Analytics.

[8]CarePlus Outcomes Study on Dual Skilled Nursing Population's Inpatient Admissions Compared to Actuarial Equivalent Matched Cohort (n=15,000 members), Jan. 2008–Jul. 2008. Arizona Health Plan. Data compiled by Optum Data Analytics.

[9]CarePlus Outcomes Study on High-Risk End-of-Life Palliative Care Cost Compared to High-Risk Non-enrolled and Medicare Advantage (n=4,575 members), Jan. 2010–Aug. 2011. BCBS Michigan and BCBS Alabama health plans. Data compiled by Optum Data Analytics.

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