

Transforming traditional case management
through local provider partnerships



Introduction

The dramatic changes sweeping the health care industry are driving a strong interest in engaging patients at the local level of care to improve outcomes and optimize cost savings. This transformative approach to care delivery leverages the natural synergies that occur when a local, multi-disciplinary team supports patients throughout the continuum of care.

This paper will highlight how Optum has applied this approach to its traditional case management program by physically and geographically integrating nurses into the local provider community in order to:

- Help employers stem the impact of high-cost claims
- Assist providers in delivering improved care and reducing hospital readmissions
- Enhance consumers' quality of life at home and at work



- The traditional case management model will realize its full potential once it is integrated with the local provider community.

Traditional (phone-based) case management

Case management has long focused on those employees (one to five percent of most employers' populations) with chronic, high-cost conditions, such as heart disease, diabetes and cancer, as well as those with complicated pregnancies, trauma or other acute medical conditions.

Highly trained, nurse case managers typically work over the phone with patients who need long-term support following a hospitalization, a catastrophic health event, or a complex medical condition diagnosis. Nurses educate, empower and support patients' post-hospitalization recovery process. They are charged with improving patients' compliance with their treatment plan and ultimately, lowering employers' medical spend by:

- Reducing hospital readmissions
- Limiting inappropriate specialty care
- Decreasing misuse of the emergency room

Although this traditional model has already produced significant results, Optum believes that the full potential of case management has yet to be realized. And, the limiting factor may be simple logistics.

Realizing the full value of case management

Traditionally, nurse case managers are not in the same physical location as patients, and need to facilitate case management services by telephone from remote call centers. This disconnect from the local care delivery system and the patient's "home base" may inhibit the nurse's ability to build synergies with the local care team and to more fully consider non-clinical aspects of a patient's recovery when designing his or her care plan.

Consider this... imagine you are a nurse case manager, trying to build a relationship with a patient who is recovering from a difficult surgery, but with whom you can only communicate by phone. You haven't met the patient or been to his or her home, and haven't met any members of the care team either. Despite these barriers, you work

hard to develop rapport and help the patient comply with a complex treatment plan, all while following evidence-based medical guidelines.

As you can imagine, the lack of physical proximity with the patient and his or her care team, can pose some very real limitations, even for the most seasoned nurse case manager.

Addressing the challenges

Remarkably, despite all the challenges facing nurse case managers, the traditional phone-based model has produced solid results — reductions in inappropriate specialty care visits, emergency room visits and hospital readmissions. But we can do better, and now is the time to address these limits.

That is why Optum has identified two significant ways to enhance the traditional case management model and deliver even stronger results for employers, providers and patients.

A Challenge: How do we build connectivity between case managers, patients and the local care team?

» **Solution:**

Place nurse case managers within physical proximity of local providers to bridge the gap that occurs with the traditional model — case managers’ unfamiliarity with patients’ doctors, nurses, hospitals and home health service providers.

B Challenge: How do we develop an authentic, “whole person” relationship with patients?

» **Solution:**

Station case managers in patients’ communities to enable face-to-face patient contact, helping them gain insight into non-clinical factors such as social support needs, mental health issues and financial circumstances that often have a profound impact on patients’ recovery.

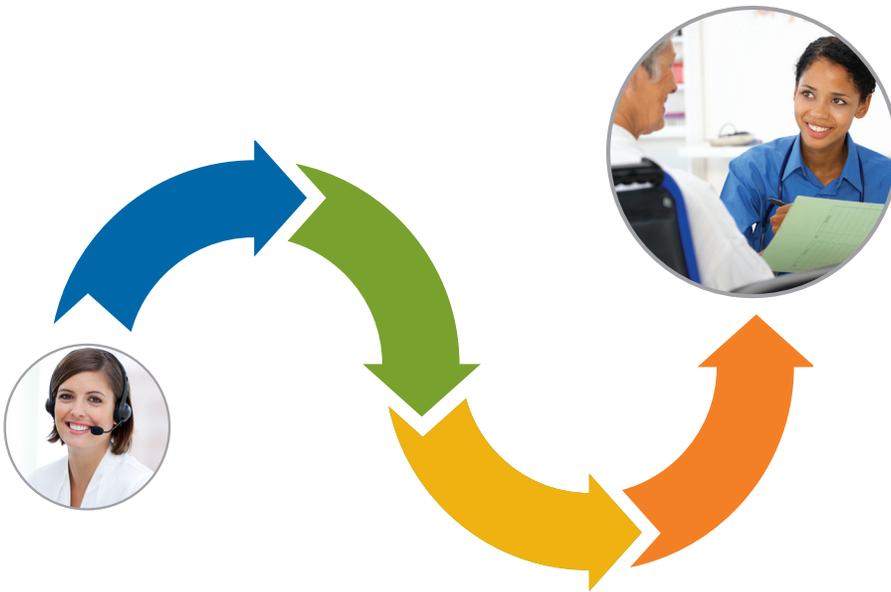


A new local care delivery model will enable:

- Improved care coordination
- Deeper patient relationships
- Care plans that consider clinical, social, mental and financial factors

The next generation model at Optum

Optum is leveraging its 20-plus years of case management experience to broaden its traditional model of care. We are locating nurse case managers in several densely populated areas throughout the United States that contain a significant volume of patients with high-cost, chronic conditions. The goal is to improve case managers' ability to serve as patient advocates by working one-to-one with patients and to more closely integrate case management services with the local care team.



Benefits of the new local care delivery model

Maintaining a local presence enables Optum nurse case managers to:

- » **Work closely with patients' doctors** and other providers to coordinate care and ensure that patients are following their treatment plan.
- » **Build a relationship with the patient** — visiting them at home or in the hospital and accompanying them to doctor appointments.
- » **Design a personal care plan** that considers social, mental and financial factors that may be affecting recovery.

The model places no limits on the number of phone calls or in-person patient visits that Optum nurse case managers make. The goal, simply, is to achieve positive health outcomes, and case managers are evaluated by how well they attain that goal.

Case studies: Local case management models in action

Case study 1

Optum recently completed a pilot program with a large hospital system (32,000 employees and dependent health plan members) using its new case management model. Optum nurse case managers were placed in local hospitals in an effort to closely manage patients identified as high risk for readmission following discharge from a hospital or skilled nursing facility.

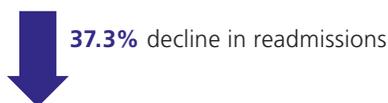
Onsite nurses became patients’ trusted advisors within 24 hours of admission. They met in person at the hospital with patients and their discharge planner to ensure that there was a continuation of care post discharge and that a rapport was established with the patient to facilitate trust and follow up. The case managers then followed up by phone with the patient within 24 hours after discharge, reviewing medications and reconciling them with the Primary Care Physician (PCP) and discharge physician, ensuring durable medical equipment was set up at home, and making a follow-up appointment with the patient’s primary care physician within five days of discharge. The nurse case manager continued following up with the patient for the next thirty days to help prevent a readmission.

Post discharge	Onsite	Home visit	Telephonic
	<p>Onsite RNs at each facility establish communication with patient as a “trusted advisor” within 24 hours of admission.</p>	<p>Available to highly complex, at-risk populations, nurses provide an initial in-home comprehensive assessment and follow-ups.</p>	<p>Case managers establish communication within 24 hours of discharge, prepare for follow-up appointments and facilitate post-discharge services.</p>

The results:



Readmission rate declined **37.3 percent** for system hospitals where we deployed readmission prevention program.



Case study 2

A pilot with an integrated delivery system with 10,000 employees and dependents in south Texas was also recently implemented to manage employees with complex and chronic conditions such as coronary artery disease, diabetes and heart failure. Locally based nurse case managers worked directly with patients who were out of compliance with their medical treatment plans based on Optum claims-based predictive modeling capabilities and the physician's clinical practice notes.

Our specially trained nurse case managers helped fill the gaps between treating physicians' care and patients' ability to care for themselves by coordinating medications and other treatments, facilitating access to community resources, providing patient education and addressing psychosocial needs.

The results included:

- Reduction in health care cost by 65 percent for those high-cost patients who were managed in an Optum program
- Higher compliance with treatment plans resulting in improved evidence based medicine results and satisfaction with patient self-management strategies
- Improved utilization in admits and emergency department visits

Looking ahead

As the health care delivery system evolves, employers will have multiple options for ensuring that their sickest and highest-cost employees receive top-quality case management services. As the cost of chronic care continues to escalate, it is critical that employers collaborate with an experienced partner offering:

- Nurses that are geographically integrated with the local care delivery system
- Services on a national basis
- Sophisticated analytics that can identify high-cost conditions
- A long track record of managing complex conditions and diseases
- Ongoing investments in staffing and infrastructure to integrate with local care providers

The new Optum case management model rests on a foundation of high-touch relationships. Chronic, complex medical conditions demand nothing less. Managing those conditions effectively requires a combination of coordinated clinical care, increased engagement by patients in managing their own care, psychosocial support and lifestyle coaching — all on an ongoing basis. For employers, that combination can yield decreased hospital readmission rates, faster return to work, improved productivity and improved medical costs.

Author

Hilary D. Lyon, MBA, MPH, RN
Vice President Clinical Consulting, Optum | Houston, TX

Hilary D. Lyon, MBA, MPH, RN is the Vice President of the Optum Clinical Consulting Team. In this role she provides clinical expertise and consultation to national and international clients across all markets. Hilary seeks solutions for clients based on their strategic goals, disease trends and opportunities to better manage medical cost. Hilary partners with both internal and external partners to bring the best to our customers.

Hilary has over 35 years' experience in the health care industry, including health plan operations, consulting at a national and international level, developing innovative clinical solutions to meet complex client needs and evaluating clients, existing programs to ensure they meet stated goals. Hilary has previously held roles developing and leading our innovation and entry into the provider market, as well as developing and evolving the case and disease management models used at Optum today. Hilary also spent several years consulting at a senior level for a health care consulting company specializing in health plan turnaround operations.

Hilary obtained her Masters in Public Health from the University of Texas, an MBA from the University of Houston and a registered nursing degree from the University of London.

Contact us:

Call: 1-866-386-3408

Email: resourcecenter@optum.com

www.optum.com



13625 Technology Drive, Eden Prairie, MN 55344

All Optum trademarks and logos are owned by Optum, Inc. All other brand or product names are trademarks or registered marks of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.

© 2013 Optum, Inc. All rights reserved. OPTPRJ2096 09/13 CSCRS03955001CM