OPTUM™

Modern care management

The care management challenge

Health plans and care providers spend billions of dollars annually on care management with the expectation of better utilization management and cost control. That expectation has intensified.

With the surge in new members coming from exchanges and a greater emphasis on delivering better quality and cost outcomes, traditional care management is at a turning point.

Moving forward, health plans and other health care stakeholders will require a much higher return on investment in care management services. To declare success, health plans have to see real value in the form of improved health outcomes and stable or reduced costs. Specifically, care management services must:

1. Comprehensively address the needs of the complex, high-risk and high-spend members who make up the top 10 to 20 percent of the population
2. Provide the personal 1:1 interaction and engagement to achieve the behavior and decision-making changes desired for this group
3. Meet the member's end-to-end medical, behavioral and social needs across fragmented services

Health plans, in particular, have good reason to expect more from their care management support. They are spending the lion's share of the care management dollars, and they stand to benefit the most from a healthier population — particularly among their Medicare and Medicaid members.

The biggest challenge for health plan leaders is to, first, transform the traditional model into one that meets members where they are, and then, second, scale that model to meet the growing need for care management services. This two-part challenge demands an analytics-driven, locally integrated approach that modernizes care management and its ever-expanding needs.

Care management defined

Interventional care coordination services that address the top 10 to 20 percent of the population drive the vast majority of health care costs. These evidence-based, integrated clinical care activities – tailored for an individual patient – are designed to effectively manage medical, social and mental health conditions.

Care management programs are typically led by primary care professionals and focus on patients 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.

The looming revolution in care management

Care management has a long history of advancing health care delivery. Various forms of this service have emerged and have been successful in improving care, reducing unnecessary utilization and controlling rising costs.

However, traditional care management has a number of widely-acknowledged limitations. For example, the programs are likely to be:

- Dependent on outdated information to fuel analytics as opposed to real time point-of-care data that can dramatically enhance care coordination and overall quality.
- Siloed and nurse intensive, instead of taking a whole-person approach through a team of care coordinators connected to the local patient-physician relationship inclusive of behavioral health advocates integrated in to interdisciplinary care.
- Primarily telephonic and call center based, lacking the personalization required for true behavior change and less able to consider social, behavioral and cultural influencers (such as health literacy) and socioeconomic conditions (such as food security or access to transportation).

A revolution is afoot in care management. Significant aspects are changing in fundamental ways. First, the payment basis is shifting from Per Member Per Month to outcome-based risk sharing. Second, members are changing, from expecting little or no voice in care decisions, to demanding – and having to pay for – many choices. And third, the role of the care management provider is changing from delivering services on a case-by-case approach, to identifying opportunities to improve care at a population level through locally delivered, integrated services. Taken together, these changes will set the framework for a care management model that looks significantly different than what health plans are used to delivering.

Aspect	From	To	Supported by
The **Payment Basis** is changing 	Per Member Per Month paid for activities	Outcome-based risk sharing based on medical expense, health status, STARs ratings and HEDIS score improvements	• Estimates showing that care management can reduce costs by $750B (with guarantees and risk sharing as the entry price)[1]
The **Member** is changing 	Expecting health service experiences to be fragmented, arduous, confusing, rigid and paid for by an employer or the government with little to no member choice	Demanding integrated, convenient, personalized and multi-modal experiences with much of the cost burden and choice on their shoulders	• Consumer driven companies such as Apple, Microsoft, Google, and others are redefining the health space • Shift to exchanges and CDHP
The role of **Care Management companies** is changing 	Identifying individuals with care gaps and intervening on a case basis (leveraging internal staff)	Identifying population health and care delivery system variations and outliers to enable systemic improvement (leveraging community resources, providers and internal staff through a community-based care model)	• Chronic disease affecting nearly 50% of US population and driving 75% of US Healthcare costs[2] • Treatment cost variation driven primarily through chronic conditions

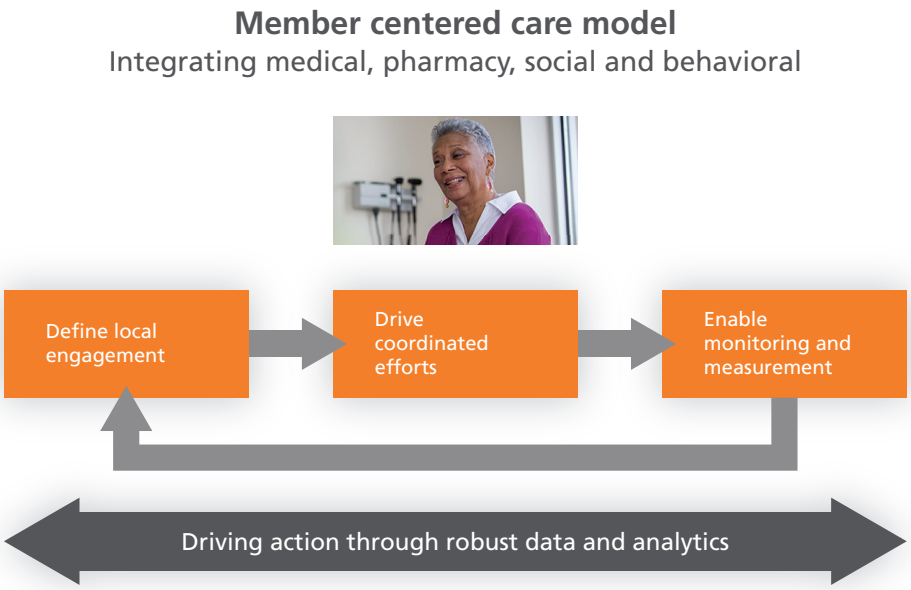
1 The Berwick and Hackbarth study published in JAMA 2012.
2 The Partnership for to Fight Chronic Disease.

Modern care management: A view of the future

The payment-basis change, in particular, is driving the economic models for care providers to a value-based framework. To ensure successful migration to value-based contracts, providers will want to look beyond the patients in their waiting rooms and recognize their accountability for the people in their local communities.

The modern care management model will put the member at the center, taking a whole-person approach to supporting care. Care providers from all angles — primary, specialty and behavioral — will need to move in lockstep with each other. They will want to have visibility to and influence over a member's care plan that includes actions around pharmacy and social determinants of health.

In this context, care management success or failure will be determined by three important activities:



1. **Personalizing engagement.** Traditionally, care management has been telephonic. The modern model goes much further by deploying face-to-face, telemedicine, Internet, remote monitoring and other techniques to reach the patient in the best way possible.
2. **Driving coordinated interventions.** Many of these members have multiple conditions, requiring a comprehensive coordinated care plan as a critical tool to better manage their care. Updates can be processed in real time as new and relevant patient information emerges.
3. **Enabling monitoring and measurement.** Success in improving the health of an individual member and larger population is monitored and measured on an ongoing basis. Different forms of engagement (for example, remote patient monitoring) are used extensively to track improvement over time and provide real-time feedback regarding the effectiveness of different care interventions.

Data and analytics are the foundation for these activities. Successful modern care management programs put data and analysis to use in unprecedented ways with and unprecedented level of precision, rigor and action-orientation.

Case study: Removing barriers for Medicaid Recipients

The value of a community-based care team can be seen in this example of a 28-year old Medicaid recipient with sickle cell and multiple ER visits. PCP engagement was suboptimal due to transportation issues. His medication profile revealed that Hydroxyurea was missing for his sickle cell treatment. Also, the patient needed referrals to specialty providers.

The care team RN engaged the PCP and coordinated a visit for the member. The RN discussed the need for Hydroxyurea with the PCP and coordinated with the PCP to arrange for the member to see hematologist and pain management specialty providers. For all visits, the team coordinated transportation to eliminate that barrier.

As a result, the member's PCP visit included the drug protocol for sickle cell. The member was able to decrease symptoms due to the visit with Hematologist and Pain Management/Physiatrist. In addition, ER use was **reduced from 16 visits to 5** visits during 90 days pre and post intervention with the care team.

Building a foundation on advanced analytics

For modern care management to be effective, health plans and providers have to be able to identify the right 10 to 20 percent of the covered population to address their distinct health needs. Although, models that identify and stratify populations are quickly becoming the industry norm, integrated clinical and claims data alone are no longer enough.

Modern care management takes all of this to the next level. Data and analytics are used to inform decisions around integrated care at the individual level. The underlying approach includes:

- Whole-person data (pharmacy, medical, specialty, behavioral, social)
- Decision-making tools across the continuum of care that update in real time and can be accessed by all caregivers
- Dashboards that allow everyone involved to see the same member-specific information

Taken together, these elements inform an actionable care plan based on informed, integrated care coordination. The key is being able to employ the plan effectively, consistently and locally to reach the top-spend and emerging-risk members.

The power of a locally integrated approach

Modern care management relies on nurse care managers and community workers who collaborate with doctors and other care providers.

In turn, members have access to a single, trusted partner in their health care – not just someone on the phone scheduling a provider appointment. The nurse care managers, in collaboration with providers and point of care data, proactively identify critical health complications and recommend treatment before additional damage to a member's health occurs. This proactive, predictive approach is a key advantage over traditional telephonic/call center models.

The locally integrated approach yields improved quality outcomes by motivating, managing and guiding members to:

- Make more informed decisions
- Seek out appropriate treatments and physicians
- Take actions to slow the progression of their condition

As a result, this modern care management model benefits payers and all the participants. Specifically it:

- Reduces utilization and medical costs
- Increases member satisfaction with the health plan
- Improves member health
- Support STARs, HEDIS and risk-adjustment outcomes

While this idea of a face-to-face approach is not new, the challenge is to build it so it can be scaled cost effectively. Fortunately, the programs can be standardized through integration and coordination of existing resources in the community with only a minimal portion requiring customization. This makes the approach not only effective, but also highly affordable.

Case study: Increase engagement, reduce readmissions

Optum nurse case managers were placed in local hospitals to closely manage patients identified as high risk for readmission following discharge. These onsite nurses became the patients' trusted advisors within 24 hours of admission.

The nurses established rapport with the patients to build trust and facilitate follow up. They then contacted patients within 24 hours of discharge to help prepare for after care appointments and facilitate post-discharge services.

The program increased patient engagement by **29 points (from 45 percent to 74 percent)** and reduced readmission rates by more than **35 percent**.

A health plan's call to action

During this dynamic time of new members entering the market and emphasis on delivering better outcomes, a new approach to care management is required for health plans. Care management must move beyond utilization management to a model that addresses the needs of the whole person and is driven by real time data and analytics.

The modern model provides health plans with the edge that they need by removing traditional barriers to consumer engagement and creating opportunities for better health, in addition to improvements in STARs and HEDIS ratings, and financial performance outcomes.

Optum's vision delivers the modern approach that enables care management to:

- Integrate whole-person health
- Support care provider engagement
- Emphasize the local market
- Deeply ground all actions in data, analytics and new technologies

This framework — particularly the ability to use actionable data and analytics to drive locally integrated care — defines the Optum care management model.

Working together with payers and care providers across the system, Optum is moving care management forward to realize significantly better quality and cost outcomes.

Case study: Integrating field-based care

As of mid-August 2014, Optum nurses have been meeting face-to-face with patients in 21 hospitals in Atlanta, Greensboro, Tampa, St. Louis, Fort Worth and Phoenix, Cincinnati and Denver. These locally based nurse case managers work directly with patients who are out of compliance with their medical treatment plans, have gaps in their care and are high hospital or ED users. The field-team:

- Coordinates medications and other treatments
- Facilitates access to community resources
- Provides patient education
- Addresses psychosocial and mental health needs

The program has reduced health care costs by **65 percent** for those patients, achieved higher compliance with treatment plans (resulting in improved evidence-based medicine results and satisfaction with patient self-management strategies), and improved utilization in admits and emergency department visits.

About Optum

Optum™ is a leading health services and innovation company dedicated to helping make the health system work better for everyone. With more than 85,000 people collaborating worldwide, Optum combines technology, data and expertise to improve the delivery, quality and efficiency of health care.

Learn what modern care management can mean to your plan:

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