Optum CarePlus
Improving performance with chronically ill, medically complex patients

In the late 1980’s, two Minnesota nurse practitioners (NP) – Jeannine Bayard, MPH APRN, and RuthAnn Jacobson, MPH APRN – recognized and were moved to action by the massive physical, emotional and financial costs incurred by patients entering nursing homes, their families, and the broader health system. In response, they devised a program to ease the burden by dedicating an NP for each of the patients in the nursing home to ensure that they experienced better, more coordinated care. It took off and became Evercare, a deeply personalized, compassionate and patient-centric model.

Evercare is now the institutional component of Optum CarePlus, which also includes CarePlus at Home, a patient-centric, community-based care delivery and care management program. AAHPM spoke with Ronald J. Shumacher, MD – Optum’s Chief Medical Officer, Complex Population Management – about how CarePlus is introducing order into the care of the seriously ill.

What’s innovative about Optum CarePlus?

RS: We’re able to reach patients who have a difficult time accessing or aren’t served well by the traditional care delivery system. That’s what makes us unique. The program combines a direct clinical delivery system with the principles of care management. And while we’re out there doing what looks like good old-fashioned house calls, we’re doing them with the benefit of having technology in place to help us. We have people doing telephonic outreach to our patients before and after we see them face-to-face, and we document everything in an electronic health record.

How does CarePlus fit into the suite of services that Optum offers?

RS: CarePlus is part of a diverse health and wellbeing company, and the program’s customers are health plans, ACOs, delegated provider health groups, government agencies – essentially any organization that pays health care claims. We can help them by selecting out a subset of their patient population that is most vulnerable and most high-risk – those people with multiple complex chronic illnesses who don’t have anyone serving as the captain of the ship and directing and coordinating their care. Often times, they fall through the cracks and don’t get the good, pro-active care that they need. Those are the people we can most impact.

We use a high-risk assessment tool that’s powered by analytics, and we look very carefully at claims data over one-to-two years once we begin working with a client. We are most successful interrupting the cycle of high utilization, high cost, fragmented, and inefficient care in patients with chronic conditions, where we can prevent exacerbations. There are certain conditions that we can identify up front as not the best fit for the program. Patients who have, say, active chemotherapy for cancer or are on a transplant list – that’s not someone that we’re necessarily going to impact.

To what degree do you reconfigure the program based on the particular needs of individual clients?

RS: Some elements look the same every time. We have a basic structure for patient selection criteria and how we use our algorithm to determine a client’s high-risk patients. Our patient outreach, which is the second phase, is
also standard. It involves outbound calls in which we tell patients about the program, after which they still have to allow us to come in and take care of them. And the last common component involves a care management team that schedules a comprehensive initial visit by an NP.

How have patients’ other providers responded to the on-the-ground work of your NPs?

RS: The response of providers out in the community is largely positive. Often, the problems these patients have are not just medical, strictly speaking. Many of them have mental health problems, many have difficult family dynamics, many have transportation issues, and it’s difficult for providers to figure out what the next step should be to coordinate all that. That’s where most of them appreciate having our NP’s acting as a central point of contact and our telephonic outreach component coordinating a lot of these things.

We establish up front how a patient’s primary care provider wants us to communicate with them, and we diligently reach out by making sure that we contact them after every visit. They know that we’re out there, and they talk to their patients about us.

That time-intensive outreach is one of several practices that CarePlus deploys in spite of their not being highly-valued components of care. But there seems to be a culture shift wherein the value of such services – for this patient population in particular – is gaining recognition.

RS: From the payer perspective, (care delivery and care management) is a significant cost. Once they look deeply at the program, though, they see a financial return on investment and tremendous quality in the results for the patient. But it takes a very astute payer to understand that.

In addition to the improved outcomes, Medicare Advantage (MA) plans in the program also typically see enhanced revenue due to our thorough and accurate documentation of patients’ conditions. The number, complexity and severity of their patients’ conditions influence Medicare reimbursements, and thorough and reliably accurate documentation is a byproduct of what we do. Because health plans cannot cherry pick the population they are at risk for, payers must find ways to provide excellent, high-quality care to high-risk patients while managing the costs they impose on the system.

What metrics does CarePlus deploy, and what has the data shown?

RS: We have foundational measures, but we also try to capture additional quality and performance metrics that are important to payers because they align with a particular initiative. There are standardized data sets that health plans are held to, and we want to make sure that we are paying attention to those and speaking the same language as payers. With all of our clients, for example, we’re working on decreasing avoidable hospitalizations and ER visits – that’s a primary metric. Typical additional metrics might include advanced care planning discussions; diabetes measures, such as hemoglobin A1c testing and LDL screening in diabetics; annual medication reviews and medication reconciliation; BMI screenings; cardiovascular disease prevention; and use of high risk drugs. It goes on and on, and we look at these not just to show payers the value we’re bringing, but also to help them with the metrics they’re held accountable for by government agencies.

The program’s results in terms of patient experience and payer expenditure management, meeting quality benchmarks and financial performance improvement have been excellent.

How has the maturation and evolution of the program compared to your initial expectations?

RS: When I started with Evercare, it was actually a Medicare demonstration program. I thought it was an amazing concept because it created a win-win for Medicare, it was a great win for nursing home patients, and it was a win for skilled nursing facilities because it created a new revenue stream. That demonstration program was actually
made a permanent part of Medicare in the Medicare Modernization Act of 2001. Beyond that, I never envisioned that we’d be able to integrate that program with a robust community care delivery and care management program. It greatly expanded our ability to bring this model to a huge number of vulnerable, frail and needy populations that we couldn’t reach before.

_Do you have advice for colleagues who may wish to construct a similar program?_

**RS:** Broadly, acknowledge and embrace the changing healthcare environment. Anyone in healthcare faces that, and we should strive to keep programs flexible so we can respond to the changing needs as the system evolves. Also, be mindful of the ongoing challenge of demonstrating value to potential and existing customers. It’s not always easy to attribute results directly to a program, but the ability to make that correlation is central to the program delivering on its promise.

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