Post-Acute Transitions
Ronald J Shumacher MD FACP CMD
Chief Medical Officer, Optum Complex Population Management
Optum: the health services partner

Optum is the leading partner for stakeholders across the complex and dynamic health system.

One of the largest **health information, technology and consulting** companies in the world

The leader in **population health management** serving the physical, mental and financial needs of both individuals and organizations

The **pharmacy management** leader in service, affordability and clinical quality

Market leaders within a dynamic health services market
Optum Nurse Practitioners and Physician Assistants currently provide bedside care and care management in more than 1,100 facilities to more than 36,000 residents in 27 states.

**Institutional expertise**

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**Collaboration**

All of our clinicians know that a key priority is collaboration with the facility staff and the primary care physician.

**Avoid unnecessary hospitalizations**

Hospitalizations are often traumatic to this population. Optum clinicians are experienced in understanding the geriatric population and their unique needs.
Distribution of medical spend

5% of the population drives
50% of the medical spend

Key cost drivers
- Emergency room utilization
- Hospitalizations
- Uncoordinated care of chronic conditions
- End-of-life

Right care. Right time. Right place.

Generally Healthy
- Optum Clinic
- Urgent Care
- Post-Acute Transitions
- Home
- Institutional
- In-Person Assessments
- Community
- Institutional

High Risk
- CarePlus
- Palliative Care
- Hospice Care

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How our solutions are delivered from a patient cohort view

**Patient identification tools and referrals**
*Identifying high risk patients needing intervention.*

**High-risk population cohorts**
*Timely clinical interventions to drive improvements in member stability, payer affordability and quality healthcare and referrals when appropriate.*

<table>
<thead>
<tr>
<th>Health status needing longitudinal care</th>
<th>Place of service: private home or assisted living facility</th>
<th>Place of service: skilled nursing facility</th>
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</thead>
<tbody>
<tr>
<td>CarePlus Community</td>
<td>• Prevent avoidable hospitalizations</td>
<td></td>
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<tr>
<td></td>
<td>• Improve quality of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient education and home safety evaluation</td>
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<tr>
<td></td>
<td></td>
<td>CarePlus Institutional</td>
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</tbody>
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<tr>
<th>Health status requires transitional care</th>
<th>Place of service: Post-Acute Transition to Home</th>
<th>Place of service: Post-Acute Transition to SNF</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Safe transition to home</td>
<td>• Safe, appropriate transition to the nursing facility</td>
</tr>
<tr>
<td></td>
<td>• Prevent readmission</td>
<td>• Prevent readmission</td>
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100% of population

highest risk 5-10% of total population
Integrated clinical model for medically complex populations

<table>
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<tr>
<th>Single Encounter</th>
<th>Transitional Period</th>
<th>Ongoing Support</th>
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</thead>
<tbody>
<tr>
<td>Assessments / Assessments Plus</td>
<td>Post Acute Transitional Care to Home</td>
<td>CarePlus Community</td>
</tr>
<tr>
<td>Post Acute Transitional Care to Home</td>
<td>CarePlus Institutional</td>
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Palliative Care

Hospice Care
1 in 5 elderly patients is readmitted to the hospital within 30 days of discharge.

Almost 34% of all Medicare FFS patients are re-hospitalized within 90 days of discharge.

40% of Medicare beneficiaries discharged to a post acute setting. Half of these enter a nursing home.

Cost to Medicare more than $17 billion per year in potentially avoidable readmission costs.


Mor, et. al. The revolving door of re-hospitalization from skilled nursing facilities”. Health Affairs. 29, No 1, 2010: 57-64.
### Health plan goals related to post-acute care

<table>
<thead>
<tr>
<th><strong>Right level of care</strong></th>
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| • Home vs SNF  
| • Reduce acute readmissions  
| • Reduce length of stay in SNF  

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<thead>
<tr>
<th><strong>Patient education and self-care</strong></th>
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</table>
| • Identification of health issues and development of care plan  
| • Successfully transition patients to independence (education re: conditions, accessibility to care, caregiver support, advance directives, etc.)  

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<th><strong>Quality</strong></th>
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| • Identify and build relationships with high-quality SNFs  
| • Achieve/exceed quality benchmarks and close gaps in care  

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<tr>
<th><strong>Collaboration</strong></th>
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| • Collaboration with PCPs/specialists and build network relationships  

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Transitions: reduces hospital readmissions

*Post-acute care breaks the readmission cycle, providing an average savings of $11,850 per member*

**Post-Acute Care** manages care during the critical days post discharge from an acute setting.

Readmissions and SNF days are reduced by:
- Timely, comprehensive evaluation and development of care plan
- In-home visits and 24/7 access to care team in the weeks following discharge
- Patient or caregiver self-management education

75% of all 30-day readmissions are potentially preventable

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**CMMI Bundled Payment Demo Program**

Reduce readmissions by 45% and generate savings for CMS
- Award period begins Jan 1, 2014 – 3 years: Optum assumes full risk
- 20,000 Medicare FFS beneficiaries
- 38 SNF’s run by HCR ManorCare in Detroit, Chicago, Philadelphia

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Optum partners with health plans to provide care to patients transitioning to skilled nursing care

- Health plan inpatient care management team may play a role in evaluating patients for our care program

- Referrals received from health plan care management, hospital UM or inter-disciplinary care team

- Optum Care Management Team assists with disposition and placement issues

- Optum provides care to all patients transitioning from an acute setting to a skilled nursing facility (SNF) subject to provider availability

- Patients can be admitted directly to SNF via waiver of 3 day qualifying hospital stay

Identification of patients for post-acute transition care
Optum Post-Acute Transitions: care model

► Provider-driven, patient-centered coordinated care and care management to help avoid acute re-admissions, reduce the length of stay and improve the quality of the clinical care

► Development of an initial plan of care upon admission addressing medical, behavioral and social needs, as well as conversations regarding advance care directives and health care proxy

► Patient and caregiver education on condition(s), trigger recognition, treatment goals alignment, home safety and treatment plan compliance, as well as who to call when problems arise

► Medication management and reconciliation

► Continued monitoring and check-ins for 30 days following discharge to manage needs, including daily or weekly outbound telephonic follow up

► Coordination with rehabilitation services to set goals, track progress, determine appropriate discharge timing and develop post-discharge plan, which is provided to the PCP upon discharge

► Coordination with the patient’s PCP, facility staff, patient’s caregivers and health plan case management/clinical programs
**Optum Post-Acute Transitions: demonstrated outcomes**

1. **Optum Post-Acute Transitions reduce readmissions in hospital to SNF program**
   - Average length of stay: 13 days vs. 23 days
   - Readmission rate: 8.3% vs. 12.4%

2. **Optum Post-Acute Transitions reduce overall admissions to SNFs**
   - SNF admissions per 1,000
     - Optum Post-Acute Transitions: 50.9
     - Medicare FFS: 71.2

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1. 2013 Achieved results with an Optum Hospital to SNF program in Massachusetts as compared to UDSMR National Data.
Post-acute provider perspective

• Driver of market share vs. “any willing provider”
• Partner with MA, ACO and health systems
• Skilled vs. custodial care: SNFs need to demonstrate proficiency at post-acute care to maintain this population; it is unlikely there will be an increase of beds
• Do not foresee an increase in post-acute discharges; however, it is likely the distribution will be to fewer SNFs
• Overall number of SNF days will decrease, as there will be more post-acute services provided at home (less costly)
• Need to have the option to get patients directly back into SNF if fail at home
• Opportunity to participate in shared savings
Thank you

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