Post-Acute Transitions

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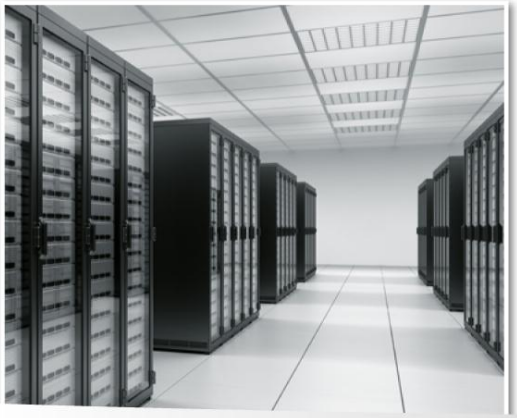
Optum: the health services partner

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

Complex Population Management, an Optum business

Creators of SNF “treat in place” care model

We are the founders of the Evercare model, now called CarePlus, which was designed to treat people in an institutional setting and focus on prevention. Our clinical teams have been providing this care since 1987.

Institutional expertise

Optum Nurse Practitioners and Physician Assistants currently provide bed side care and care management in more than 1,100 facilities to more than 36,000 residents in 27 states.

Collaboration

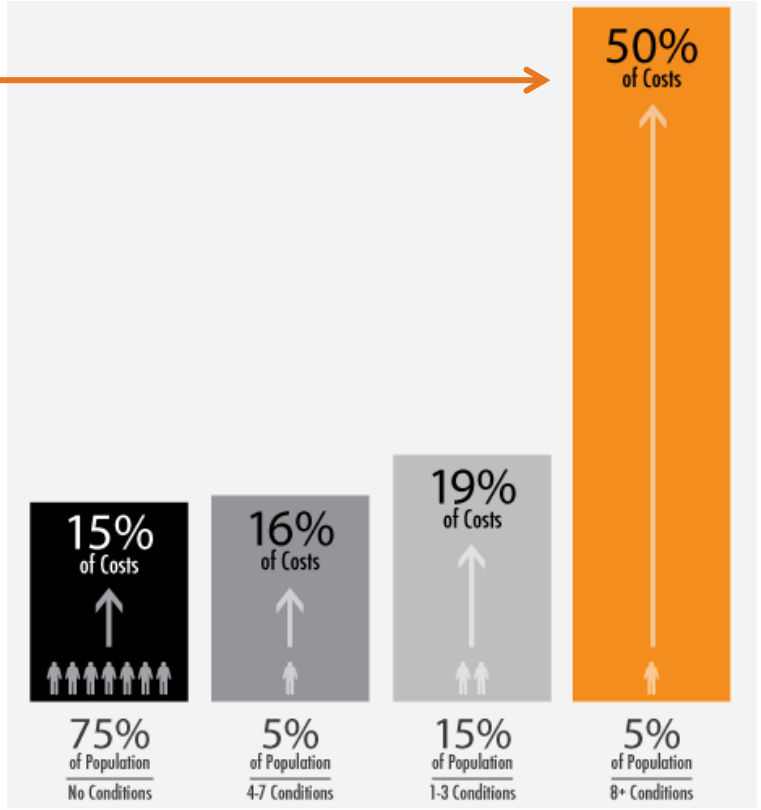
All of our clinicians know that a key priority is collaboration with the facility staff and the primary care physician.

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 → HIGH RISK

- Optum Clinic Urgent Care
- Post-Acute Transitions
  - Home
  - Institutional
- In-Person Assessments
- CarePlus
  - Community
  - Institutional
- Palliative Care
- Hospice Care

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

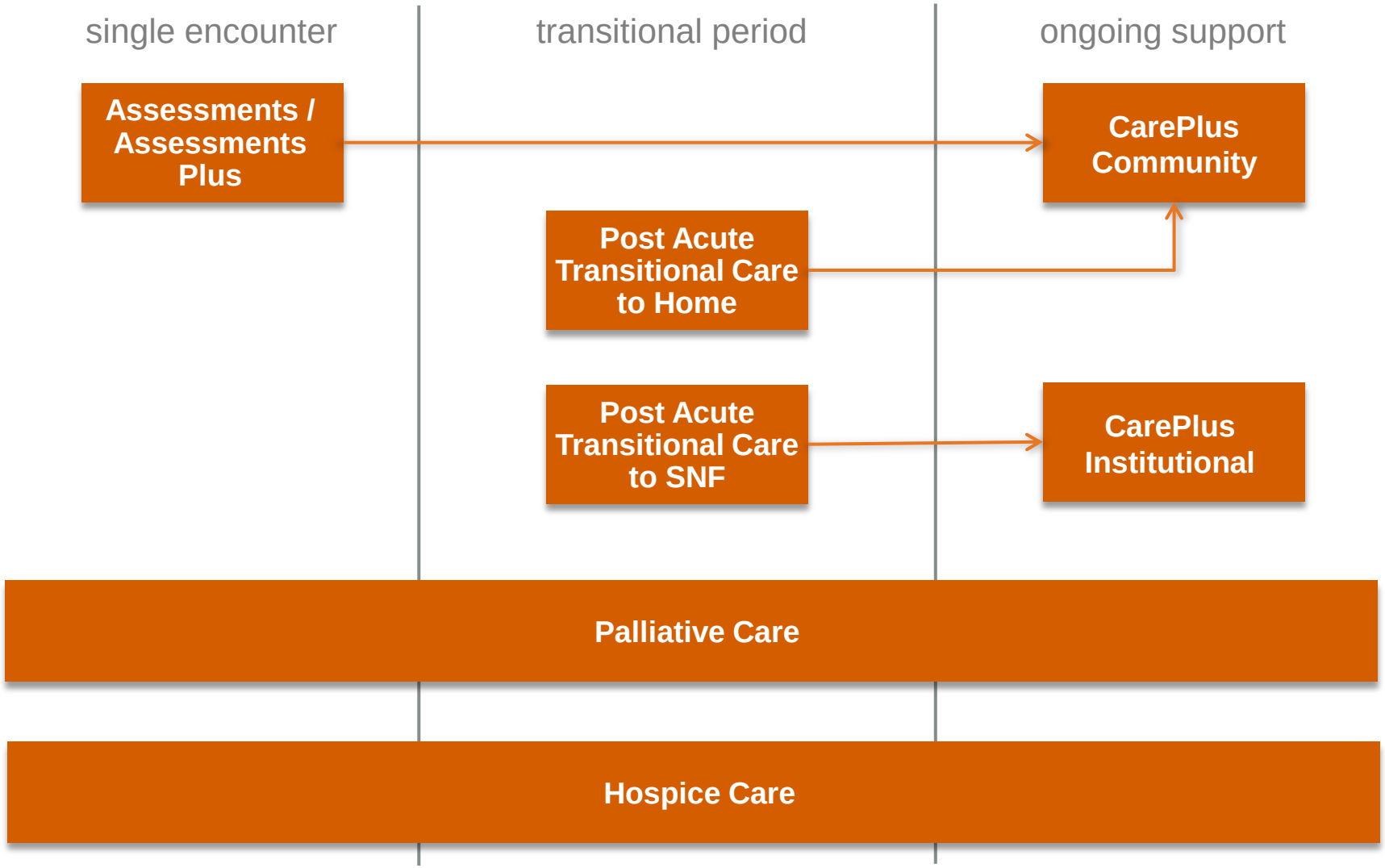
Timely clinical interventions to drive improvements in member stability, payer affordability and quality healthcare and referrals when appropriate.

In-Person Assessments and Risk Stratification

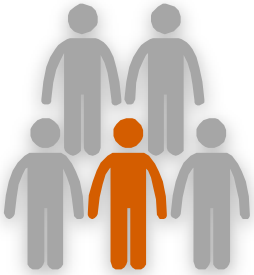
	Place of service: private home or assisted living facility	Place of service: skilled nursing facility
Health status needing longitudinal care	CarePlus Community • Prevent avoidable hospitalizations • Improve quality of care • Patient education and home safety evaluation	CarePlus Institutional • Prevent avoidable hospitalizations • Improve quality of care
Health status requires transitional care	Post-Acute Transition to Home • Safe transition to home • Prevent readmission	Post-Acute Transition to SNF • Safe, appropriate transition to the nursing facility • Prevent readmission

100% of population → **highest risk 5-10% of total population**

Integrated clinical model for medically complex populations



Post-acute industry snapshot



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.

Lavizzo-Mourey R. The revolving door: a report on US hospital readmissions. An analysis of Medicare data by the Dartmouth Atlas Projects. Robert Wood Johnson Foundation. February 2013. Accessed online: http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404178.
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

Right level of care	• Home vs SNF • Reduce acute readmissions • Reduce length of stay in SNF
Patient education and self-care	• 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.)
Quality	• Identify and build relationships with high-quality SNFs • Achieve/exceed quality benchmarks and close gaps in care
Collaboration	• Collaboration with PCPs/specialists and build network relationships

Transitions: reduces hospital readmissions

Post-acute care breaks the readmission cycle, providing an average savings of $11,850 per member[1]

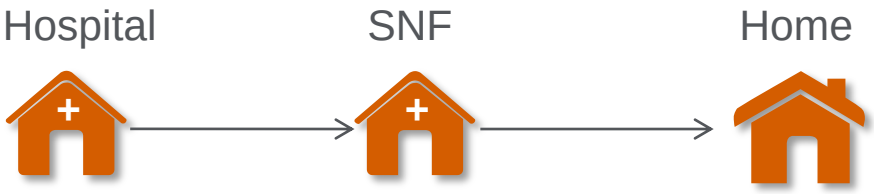
Post-Acute Care manages care during the critical days post discharge from an acute setting.

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[2]

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

1 Kashihara, D. and Carper, K. *National Health Care Expenses in the U.S. Civilian Non-institutionalized Population, 2009.* MEPS Statistical Brief #355. January 2012. Agency for Healthcare Research and Quality, Rockville, MD. www.meps.ahrq.gov

2 Benbassat, Jochanan and Taragin, Mark. (2000) Hospital readmissions as a measure of quality of health care, advantages and limitations. *Arch Intern Med 160(8):1074-1081.*

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Identification of patients for post-acute transition care

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

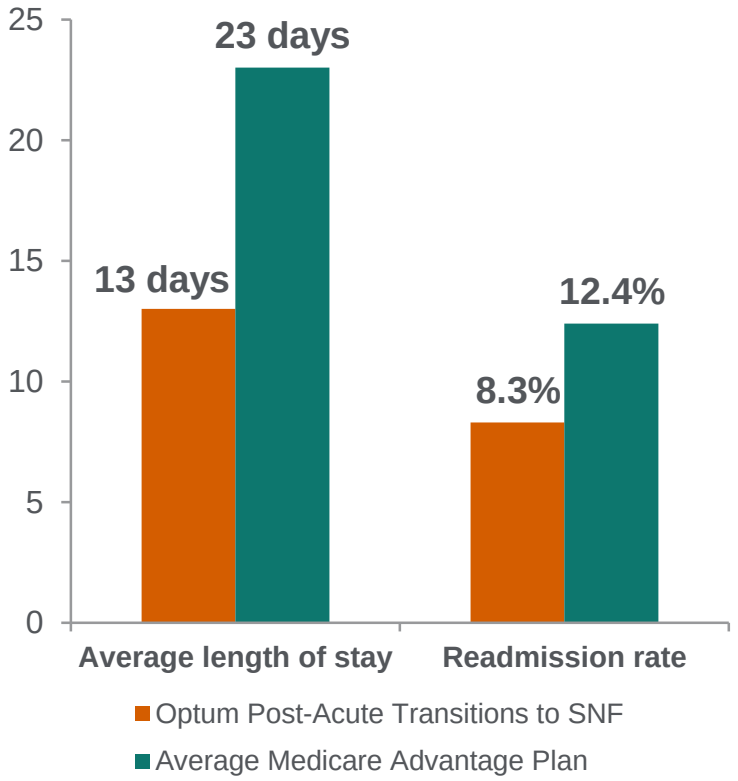
- Health plan inpatient care management team may play a role in evaluating patients for our care program
- Referrals received from health plan care management, hospital UM or inter-disciplinary care team
- Optum Care Management Team assists with disposition and placement issues
- Optum provides care 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

Optum Post-Acute Transitions: care model

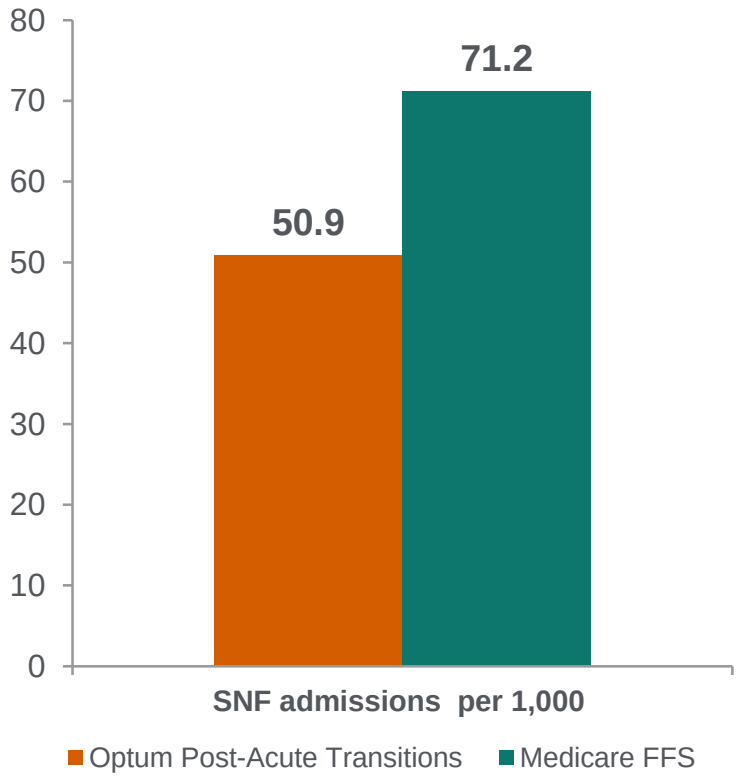
- Provider-driven, patient-centered coordinated care and care management to help avoid acute re-admissions, reduce the length of stay and improve the quality of the clinical care
- Development of an initial plan of care upon admission addressing medical, behavioral and social needs, as well as conversations 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

Optum Post-Acute Transitions reduce readmissions in hospital to SNF program[1]



Optum Post-Acute Transitions reduce overall admissions to SNFs[2]



1 2013 Achieved results with an Optum Hospital to SNF program in Massachusetts as compared to UDSMR National Data.
2 2013Average admission rate to SNF for Optum Post-Acute Transitions in Arizona as compared to national average for Medicare FFS beneficiaries (Skilled nursing facility services: Assessing payment adequacy and updating payments. Report to the congress: Medicare Payment Policy. MedPac, March 2013(166-167). Accessed online: http://www.medpac.gov/chapters/Mar13_Ch08.pdf).

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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

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Thank you

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