OPTUM Care® | Network of Connecticut

# Case management

## Identifying the right members, interventions and resources

Chronic conditions, hospital readmissions and non-compliance to medication or treatment plans all contribute to rising health care costs.

- Nearly half of all adults have one or more chronic condition — diabetes alone costs the nation $327B.[1]
- 14.9% of patients are readmitted to the hospital[2], adding another $41.3B in costs.[2]
- Non-adherence to medication annually costs approximately $100B-300B in health care dollars.[3]

Recovering from a critical illness or managing multiple chronic conditions is not only difficult for the member, but can also impose a huge financial burden. At OptumCare®, our case management programs can help reduce health care spend and safeguard our most vulnerable members without sacrificing quality of care.

OptumCare is differentiated by our proprietary analytics and technology. Our enhanced predictive model and technology platform work in concert to deliver the information that higher risk members and their physicians need to avert health problems. Our logic works to:

- Find and stratify members at risk.
- Calculate their potential medical spend.
- Assess the member's propensity to engage.
- Determine the most suitable interventions.

### Our approach

Our fully integrated approach ensures a member's care and resources are coordinated across the clinical programs in their benefit plan. Not all health plans possess the capacity and clinical expertise to efficiently manage care for members with multiple health needs. Our holistic, intensive and high-touch case management is structured to improve the experience for the member with complex clinical needs.

### Partnering with providers to achieve lasting results

- Ensure common understanding of goals and outcomes
- Provide updates on treatment plan adherence as appropriate
- Improve member-provider communication
- Suggest network specialists
- Exchange information using secure, digital technologies

## Complex case management

The complex case management (CCM) program provides intensive, personalized case management services and goal-setting for members who have complex medical needs and require a wide variety of resources to manage health and help improve quality of life. It is designed to meet the needs of our highest risk members with exceptionally high medical claims and significant resource use to close clinical gaps using network providers and appropriate levels of care.

CCM services are provided in a collaborative, interdisciplinary process that assess, plan, implement, monitor and evaluate the individual's plan of care to ensure quality, cost-effective outcomes. CCM staff are responsible for researching available options and services required to meet a member's health needs.

Nurse case managers and social workers are the heart of the program. Helping members manage multiple health needs or recover from a serious illness demands superior interpersonal skills and expertise navigating the health care system. OptumCare nurses and social workers are quick to establish rapport and trust with the member and also serve as the single point of contact. This relationship allows the nurse and social workers to personalize the member's experience and make efficient use of health care resources.

## Referral criteria

Case management referrals are received and screened based on the following criteria:

- Frequent hospitalizations (two or more unplanned within the last six months)

And/or

- Frequent ER visits (two or more within the last six months) and one or more of the following:
  - Presence of four more active chronic diagnoses
  - Four or more medications prescribed on a chronic basis
  - History of non-adherence to plan of care
  - Frequent use of out-of-network providers or facilities
  - Complex medical/social issues
  - Transition of care difficulties (LACE >/= 15-19)
  - Readmissions
  - Behavioral health diagnosis
  - Placement issues
  - Community resource assistance
  - Home assessment needs

## Contact information

Complex case management is designed to assist our highest risk members.

For more information, please call **1-860-409-4904**

You can also fax the Case Management Referral Form to **1-888-999-1604**


**Sources:**

1. http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html. Accessed 10/2016. https://care.diabetesjournals.org/content/suppl/2018/03/20/dci18-0007.DC1
2. America's Health Rankings: Hospital readmissions https://www.americashealthrankings.org/explore/senior/measure/hospital_readmissions_sr/state/ALL
3. Centers for Disease Control and Prevention, Improving Medication Adherence for Chronic Disease Management — Innovations and Opportunities, November 17, 2017 https://www.cdc.gov/mmwr/volumes/66/wr/mm6645a2.htm?scid=mm6645a2_w




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