As we shift from a fee-for-service to fee-for-value marketplace, physicians face increased pressure to improve compliance with evidence-based medicine, improve patient outcomes and generate medical cost savings. Yet while physicians can provide excellent care in their office, quality care management must also be available to keep patients with complex and chronic conditions engaged in their care.

Our Complex and Chronic Patient Management program helps you create an efficient and effective care team and works as an extension of your practice to build on your in-office care, targeting patients with high-cost, high-acuity complex and chronic conditions. We help you eliminate fragmentation—so physicians have the time and information they need to work at the highest degree of their licensure.

A Collaborative Approach
Highly customizable to your population, our Complex and Chronic Patient Management program can be driven by you or the analytics process. Once a patient has been identified, the care manager works collaboratively with the physician, the entire health care team and community resources to ensure the best outcomes.

Did You Know?
According to a national survey, approximately 64% of physicians treating patients with chronic conditions believe their training did not adequately prepare them to:

- Coordinate in-home community services
- Educate patients with chronic conditions
- Manage the psychological and social aspects of chronic care
- Provide effective nutritional guidance and manage chronic pain
Complex and Chronic Patient Management

Working on Behalf of Patients
Our nurses function as an extension of the physician practice, working with the patient’s physician to coordinate and ensure compliance with the defined treatment plan. They coordinate all facets of patient needs, including:

• Coordination of multiple physicians
• Care plan coordination
• Access to community resources
• Psychosocial and knowledge needs
• Longer-term condition support

Predictable Outcomes
The Complex and Chronic Patient Management program has predictable, proven outcomes, including:

• Reduction in medical costs
• Reduction in unnecessary medical costs
• Improvement in utilization
• Improvement in functional health status

Improvements in Patient Outcomes Consistent with Evidence-Based Medicine

![Graph showing improvements in patient outcomes]

Sources:
* Available 2012. All measures align with CMS-proposed ACO quality outcomes.

In 2010, we reached more than 1 million patients for care plan non-adherence and realized a 20% improvement in evidence-based medicine compliance.1

High-cost patients managed in an Optum program experienced a 1–2% reduction in health care costs.

Transform Today. Thrive Tomorrow.
Discover how Optum can help your organization meet the demands of an ever-changing health care environment. Call 866.386.3409 or e-mail us at engage@optum.com.

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