A cycle of success for value-based care

Aggregating and curating data

Types of data

- Social: environmental, demographic
- Patient-reported: outcomes, screenings
- Clinical: diagnoses, labs, medications, observations, notes
- Claims: cost, utilization, episodes, leakage

Putting analytics into action for care improvement

- Evaluate clinical and financial outcomes
- Predict risk, improve clinical and financial performance, increase efficiency and strengthen relationships with patients and health plans
- Target at-risk members for care coordination
- Evaluate quality of care and interventions
- Quantify program costs and savings
- Determine the effectiveness of care coordination programs

Yielding better outcomes

Using Optum Performance Analytics and Optum Care Coordination Platform in tandem creates improved efficiency and better outcomes.

Leaving 11000 Optum Circle, Eden Prairie, MN 55344

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Learn more about the Optum Care Coordination Platform can support your organization’s efforts:

optum.com/care

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Assess at-risk populations
Diagnose opportunities
Evaluate clinical and financial outcomes
Implement care plans
Set goals and track success

PUTTING ANALYTICS INTO ACTION FOR CARE IMPROVEMENT

OPTUM CARE COORDINATION PLATFORM

OPTUM PERFORMANCE ANALYTICS

See the whole patient, empower patients and care teams, and drive care management program scalability and performance to improve outcomes.

• Coordinate care in the ambulatory environment.
• Create effective care plans and patient engagement.
• Integrates with most EMRs.
• Measure care coordination staff productivity.
• Target at-risk members for care coordination.
• Evaluate quality of care and interventions.
• Quantify program costs and savings.
• Determine the effectiveness of care coordination programs.

LEVERAGING THE POWER OF ANALYTICS TO IMPROVE CARE FOR HIGH-RISK PATIENTS

Temple Health, a multi-hospital academic institution in Pennsylvania, wanted to better target high-risk patients for proactive care outreach. They used Optum Performance Analytics to target high-cost, high-risk patients and create targeted outreach lists through Optum Registry. Patients were then managed and monitored by care managers through the Optum Care Coordination Platform.

Driving collaborative care and better patient outcomes with targeted data

Benevera Health, a population health organization in New Hampshire, was striving to proactively manage patient care, reduce avoidable health costs and improve patient quality of health and life. Partnering with Optum to combine information from a number of disparate sources, Benevera built a single integrated data set that provided a richer view of patients, to help care managers proactively intervene with patients and meet these goals.

In 12 months Temple Health saw:

- A 29% reduction in hospitalization rates among individuals who received this intervention
- A 16% reduction in ED admission rates among individuals who received this intervention

In 12 months Benevera saw:

- A 65% decrease in patients with ED visits
- A 58% decrease in patients with hospital readmissions

Learn how the Optum Care Coordination Platform can support your organization’s efforts: