Task Analysis: Clinical Provider Performance in Value-Based Care at Optum

Overall Task

Execute high quality and cost efficient patient care in a value based care clinical setting while meeting quality metrics and maximizing performance-based compensation.

Task 1: Manage Quality Metrics & Clinical Performance

1. **Monitor assigned quality measure dashboard regularly**
    - Use Optum Pro Portal for weekly review of analytics
    - Review current performance against benchmarks for all measured targets
    - Identify patients with care gaps
2. **Satisfy clinical interventions to meet STAR measures**
    - Schedule preventive screenings
    - Conduct diabetic eye exams and A1C monitoring
    - Control patient blood pressure to target levels
    - Administer annual flu vaccines
    - Prescribe and optimize for statin therapy for CVD patients
3. **Document care appropriately for quality reporting**
    - Use correct diagnosis codes
    - Complete required quality measure documentation
    - Record clinical rationale for deviations from standard protocols

Knowledge & Skills Required:

- **Clinical Knowledge**: Evidence-based guidelines for diabetes, hypertension, CVD management
- **Technical Skills**: Navigate electronic medical record (EMR) and utilize internal analytics platforms
- **Data Literacy**: Interpret performance reports and understand risk stratification
- **Attitudes**: Commitment to preventive care vs. reactive medicine

Conditions & Environment:

- Access to EMR with integrated quality measure tracking
- Population health dashboard tools
- STAR measure specifications

Learning Objectives:

- Achieve 90%+ compliance on preventive screening measures
- Maintain diabetic A1C control rates above plan benchmark
- Understand how each clinical action impacts STAR rating scores

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Task 2: Optimize Patient Experience (CAHPS Performance Measure)

1. **Improve access to care**
    - Offer same-day/next-day appointments for urgent needs
    - Utilize telehealth for follow-ups and to monitor minor concerns
    - Return patient calls within 24 hours
2. **Enhance communication quality**
    - Confirm patient understanding- use a teach- back method
    - Spend adequate time answering patient questions
    - Explain treatment in plain everyday language
3. **Seamless coordinating of care**
    - Foster smooth transitions between specialists and facilities
    - Follow up within 48 hours of hospital discharge
    - Proactively address medications
4. **Deliver responsive customer service**
    - Address billing or administrative concerns quickly
    - Provide accessible and courteous interactions
    - Resolve complaints before they escalate

Knowledge & Skills Required:

- **Communication Skills**: Active listening, empathy, cultural competence
- **Service Orientation**: Patient-centered mindset
- **Time Management**: Balance thoroughness with efficiency
- **Interpersonal Skills**: Build trust and rapport quickly

Conditions & Environment:

- Flexible scheduling systems
- Telehealth platform
- Care coordinator support for complex patients
- CAHPS survey domains: Getting Needed Care, Appointments, Customer Service, Care Coordination

Learning Objectives:

- Achieve CAHPS scores above 3.5 (national average) across all domains
- Reduce patient complaints to <1%
- Demonstrate patient-centered communication in 100% of encounters

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Task 3: Reduce Hospital Readmissions and Emergency Utilization

Steps:

1. **Identify high-risk patients**
    - Review risk stratification reports bimonthly
    - Flag patients with recent hospitalizations, multiple chronic conditions, or poor adherence to medical intervention
2. **Initiate proactive outreach**
    - Call patients within 48-72 hours post-discharge
    - Schedule follow-up appointments before hospital discharge
    - Connect patients with care coordinators and other social services
3. **Implement medication reconciliation**
    - Review all medications at every transition of care

    - Identify and resolve discrepancies or duplications
    - Educate patients on proper medication use
4. **Provide alternative care pathways**
    - Offer urgent care clinic access instead of ER for non-emergencies
    - Use telehealth for acute issues
    - Establish care plans for chronic disease

Knowledge & Skills Required:

- **Clinical Judgment**: Differentiate urgent against emergent conditions
- **Care Coordination**: Work effectively with multidisciplinary team
- **Pharmacology**: Comprehensive medication management
- **Problem-Solving**: Address social determinants affecting desired health outcomes

Conditions & Environment:

- Care coordinator and nurse navigator support
- Real-time hospital discharge notifications
- Transitional care management protocols
- Plan All-Cause Readmissions measure (weight = 3 in 2025)

Learning Objectives:

- Reduce 30-day all-cause readmission rate to below plan average
- Achieve 95%+ medication reconciliation within 30 days of discharge
- Complete transitional care visits within required timeframes

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Task 4: Improve Medication Adherence

1. **Assess adherence barriers at each visit**
    - Ask about medication-taking habits
    - Identify cost, side effect, or complexity issues
    - Screen for health literacy and any cognitive barriers

2. **Implement adherence interventions**
    - Simplify medication regimens when possible
    - Prescribe 90-day supplies to reduce refill burden
    - Connect patients with medication therapy management programs (Optum RX preferred)
    - Use pill organizers, reminders, or adherence apps
3. **Monitor prescription fill patterns**
    - Review pharmacy data for gaps in refills
    - Advice patients on automatic refills (Optum Rx promotion)
    - Reach out to patients who miss refills
    - Adjust regimens for patients with persistent non-adherence
4. **Collaborate with pharmacists**
    - Engage clinical pharmacists for complex medication reviews

Knowledge & Skills Required:

- **Pharmacotherapy**: Optimize medication regimens
- **Behavioral Counseling**: Motivational interviewing techniques
- **Systems Thinking**: Understand pharmacy benefit and fill patterns
- **Collaboration**: Work with pharmacists and care coordinators

Conditions & Environment:

- Pharmacy claims data access
- Medication therapy management program infrastructure
- Clinical pharmacist support
- Key measures: Adherence for diabetes, hypertension, cholesterol medications (average 3.2-3.3 stars in 2025)

Learning Objectives:

- Achieve 80%+ proportion of days covered (PDC) for chronic medications

- Complete medication therapy management program referrals for 100% of eligible patients
- Reduce medication non-adherence by 20% annually

Task 5: Conduct Preventive Care & Health Maintenance

Steps:

1. **Generate and review preventive care reports**
    - Run monthly reports on patients due for screenings
    - Prioritize patients approaching age milestones
2. **Opportunistically address preventive care**
    - Review preventive care checklist at every visit
    - Order due screenings even when patient presents for acute issues
    - Schedule dedicated wellness visits for comprehensive prevention
3. **Use standing orders and team-based care**
    - Empower nurses and medical assistants to administer flu vaccines
    - Use standing orders for routine screenings when appropriate
    - Have care coordinators schedule preventive procedures
4. **Follow up on abnormal results**
    - Track and close the loop on all ordered tests
    - Ensure timely colonoscopy after testing positive
    - Refer for appropriate specialty care when needed

Knowledge & Skills Required:

- **Preventive Medicine Guidelines**: Follow screening recommendations
- **Population Health Management**: Proactive panel management
- **Delegation**: Effective use of team-based care
- **Follow-Through**: System to track and complete care loops

Conditions & Environment:

- Preventive care tracking system
- Standing order protocols
- Care team (nurses, MAs, care coordinators)
- Key measures: Cancer screenings (average 3.4 stars), flu vaccines (3.2 stars)

Learning Objectives:

- Achieve 75%+ screening rates for all preventive care measures
- Reduce care gaps by 40% within first year
- Utilize team-based delegation for 80%+ of routine preventive tasks

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Task 6: Participate in Shared Savings & Risk Arrangements

Steps:

1. **Understand your risk arrangement**
    - Review contract terms: quality bonus structure, risk-sharing percentages, etc.
    - Know which costs you're responsible for (total cost of care vs. specific services)
2. **Practice cost-conscious care**
    - Choose high-value diagnostic tests and treatments
    - Consider generic medications when appropriate
    - Avoid unnecessary emergency department referrals
    - Use preferred in network specialists and facilities
3. **Monitor panel cost performance**
    - Review quarterly cost reports for your attributed patients
    - Identify costly outliers and opportunities for intervention
    - Understand variance from expected costs
4. **Engage in utilization management**
    - Prior authorization when required

    - Evidence-based order sets
    - Participate in peer review of utilization patterns

Knowledge & Skills Required:

- **Health Economics**: Understand cost drivers and value based purchasing
- **Financial Literacy**: Interpret cost and utilization reports
- **Evidence-Based Practice**: High value care principles
- **Ethical Reasoning**: Balance cost consciousness with patient advocacy

Conditions & Environment:

- Transparent cost and utilization data
- Clearly defined risk contracts
- Decision support tools for cost-effective care
- Quarterly financial performance reports

Learning Objectives:

- Maintain total cost of care within 5% of benchmark
- Achieve quality bonus thresholds (typically >3.5 stars)
- Understand financial impact of clinical decisions on shared savings

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Task 7: Leverage Care Coordination Infrastructure

Steps:

1. **Collaborate with care coordinators**
    - Meet weekly/monthly to review high-risk patients
    - Delegate appropriate
    - Provide clinical direction for care plans
2. **Utilize nurse navigators for complex cases**
    - Refer patients with multiple hospitalizations or chronic conditions
    - Support navigation through specialty care and social services

3. **Access behavioral health integration**
    - Screen for depression, anxiety, substance use
    - Facilitate warm handoffs to behavioral health specialists
4. **Connect patients to community resources**
    - Address social determinants: food insecurity, transportation, housing
    - Refer to community health workers
    - Utilize social service programs

Knowledge & Skills Required:

- **Team Leadership**: Direct and collaborate with support staff
- **Care Planning**: Develop comprehensive, multidisciplinary care plans
- **Social Determinants Awareness**: Understand non-clinical barriers to health
- **Communication**: Clear delegation and information sharing

Conditions & Environment:

- Access to care coordinators, nurse navigators, behavioral health specialists
- Shared care planning tools
- Community resource directories
- Integrated behavioral health services

Learning Objectives:

- Utilize care coordination for 100% of high-risk patients
- Reduce no-show rates by 25% through coordinator outreach
- Improve HOS functional health measures through holistic care

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Task 8: Adapt Practice Patterns for Value-Based Model

1. **Shift from volume to value mindset**
    - Allocate visit time based on patient complexity
    - Focus on prevention and chronic disease management over acute episodic care

    - Measure success by outcomes
2. **Adopt continuous learning practices**
    - Review performance data regularly
    - Participate in quality improvement initiatives
    - Stay updated on measure specification changes
3. **Engage in peer collaboration**
    - Share best practices with other providers
    - Participate in case conferences
    - Learn from high-performing colleagues
    - Use incentives to achieve results
    - Implement soft skills training
    - Foster collaboration between clinical staff and administrative partners
4. **Provide feedback on system improvement**
    - Identify workflow barriers
    - Use Optum Pro Portal to chart and monitor improvements
    - Advocate for resources that support quality care

Knowledge & Skills Required:

- **Growth Mindset**: Openness to change and continuous improvement
- **Quality Improvement Methods**: PDSA cycles, root cause analysis
- **Self-Reflection**: Honest assessment of performance
- **Advocacy**: Voice concerns and suggestions constructively

Conditions & Environment:

- Regular performance feedback and coaching
- Quality improvement training
- Peer learning communities
- Supportive organizational culture

Learning Objectives:

- Transition successfully from fee-for-service to value-based compensation within 12 months
- Achieve top quartile performance on at least 50% of quality measures
- Demonstrate professional satisfaction with value-based care model

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Critical Success Factors Across All Sub-Tasks

Prerequisites:

- Valid medical license and board certification
- EMR and Optum Pro Portal proficiency
- Understanding of Medicare Advantage and STAR rating systems
- Commitment to population health vs. individual episodic care

Tools & Resources:

- Optum Pro Portal analytics and reporting platforms
- Integrated EMR with quality measure tracking
- Care team infrastructure (coordinators, navigators, pharmacists)
- Clinical decision support tools
- Performance dashboards

Performance Metrics:

- STAR rating component scores (target: >3.5 average across measures)
- Quality bonus achievement
- CAHPS survey scores
- HOS functional health improvement measures
- Shared savings realization
- Patient panel retention rates