Patient-Centered Care Model for Medicaid

UnitedHealthcare®

The Next Generation of Clinical Care

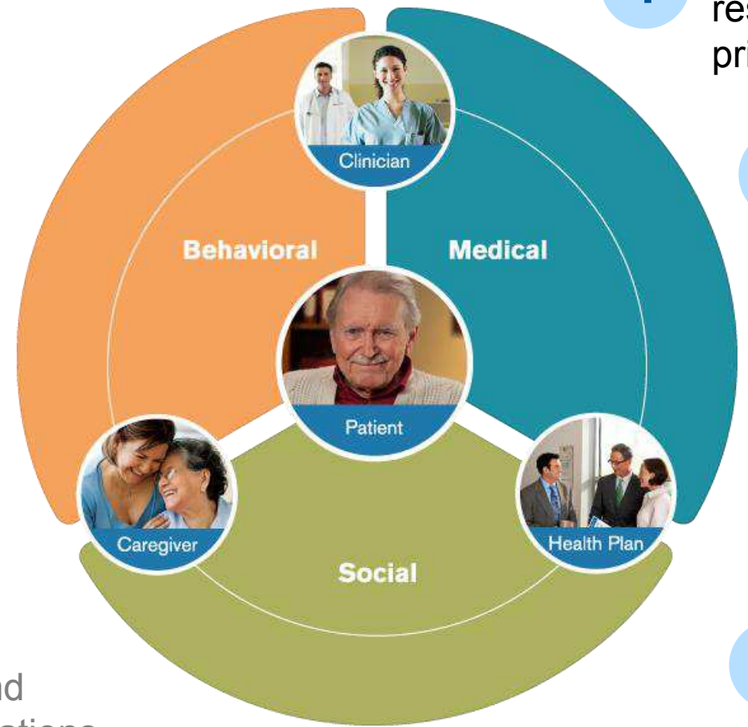
Core Concepts

1. **Patient-centered** solutions, not disease focused.

2. Integration of **medical, behavioral** and **social** care.

3. Population segmentation and risk **stratification for** multiple conditions allows members to be placed into care models best suited for their needs.

4. Leverages the resources of Complex Case Management, Health Homes and other types of integrated care organizations and **multi-disciplinary teams** to reduce costs and improve outcomes.



When Applied to Medicaid

1. Patient-centered is **whole-person care** and is not restricted to a facility, specialist physician or primary chronic disease.

2. Mix of services will be **more community-based** and include **social agencies, housing**, **transportation** and more.

3. The **Super Utilizers,** and often their **care-givers,** have multiple conditions and represent **1.4% of the base, but drive 36% of the costs.**

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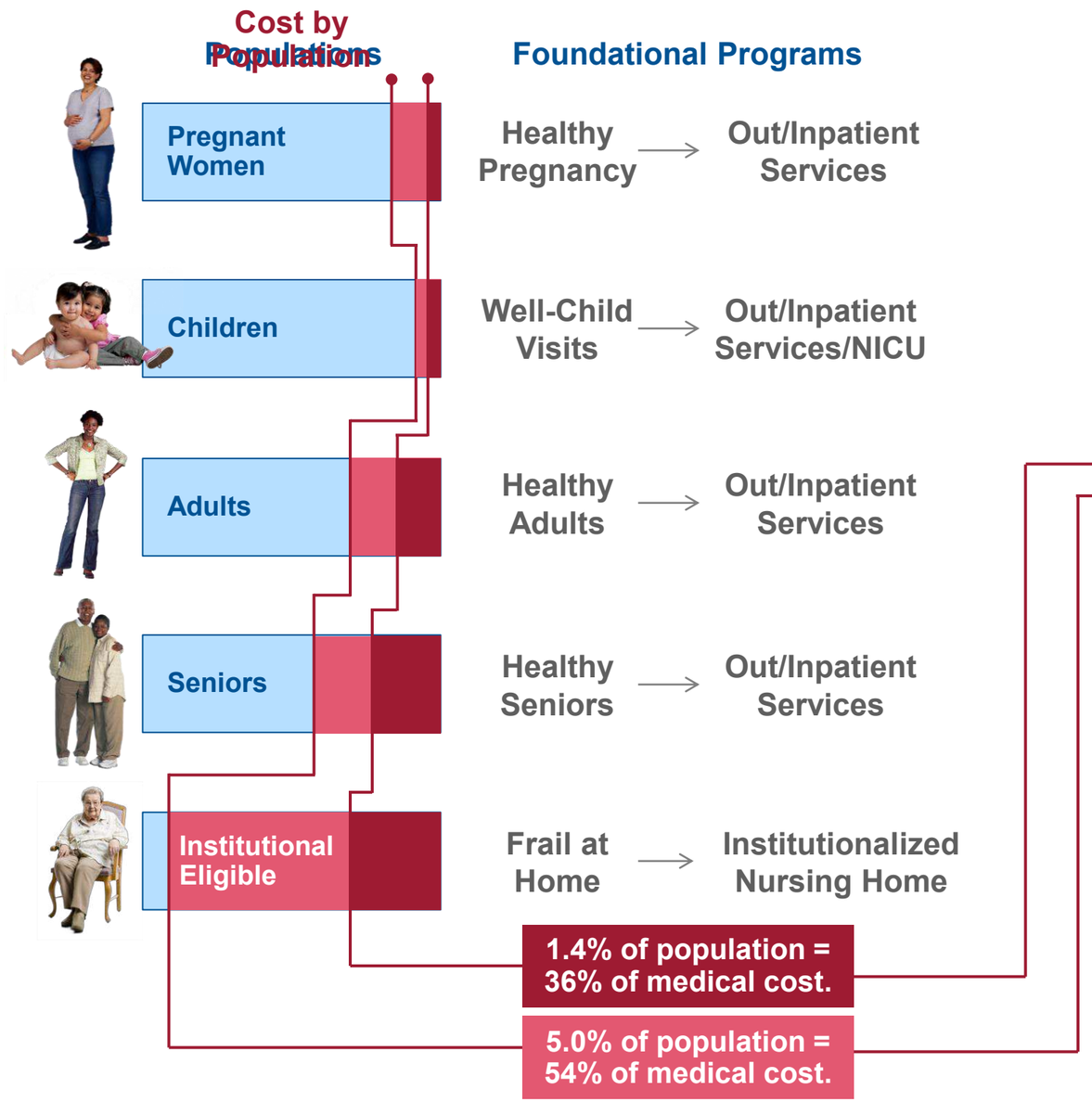
4. Additional **community resources** like **Lay Coaches**, **Food Stamp Workers**, **Promotoras**…

And **networks** like **CMHC** & **FQHCs**.

5 5

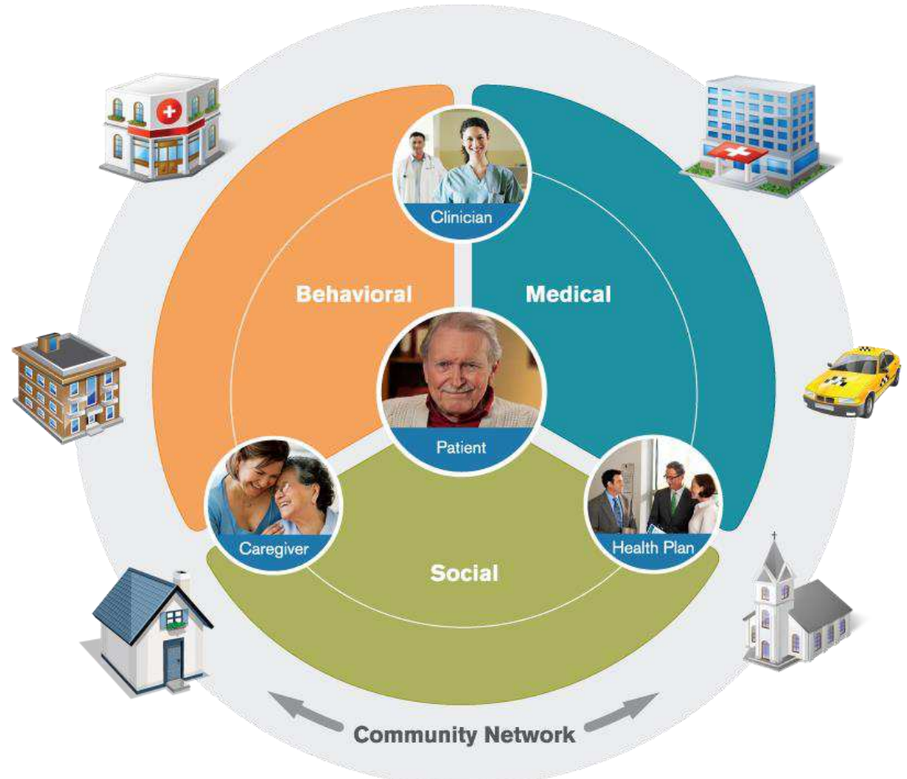
Real-time data sharing across the care continuum to support **better decisions** and **better outcomes**. And, **shared incentives** between providers and members.

Serving the Medicaid Community



Improving Health for Medicaid Populations

Using the Patient-Centered Care Model



Harnessing the community to improve the care of the individual.

Creating and Delivering Care Models that Reflect a Broad Spectrum of Need

Identifying Opportunity and Operationalizing the Model at Scale

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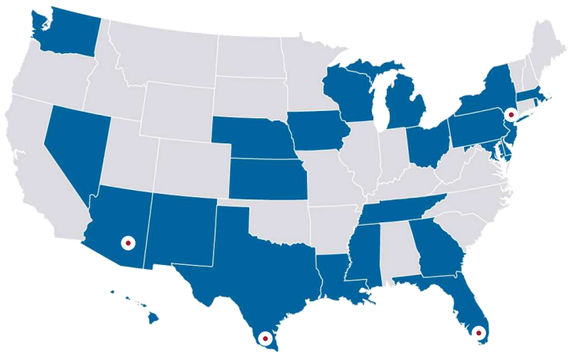
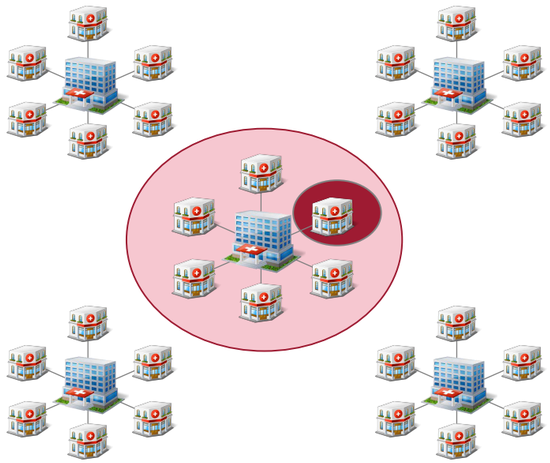
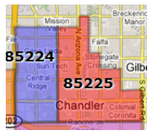
Look Nationally to Locate Community Hotspots



Look Locally Prioritize Network Hotspots



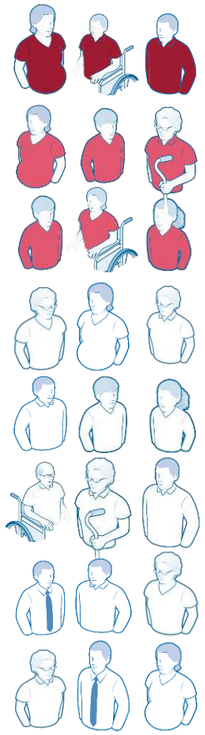
Identify Consumer Hotspots



By Zip

By Clinic

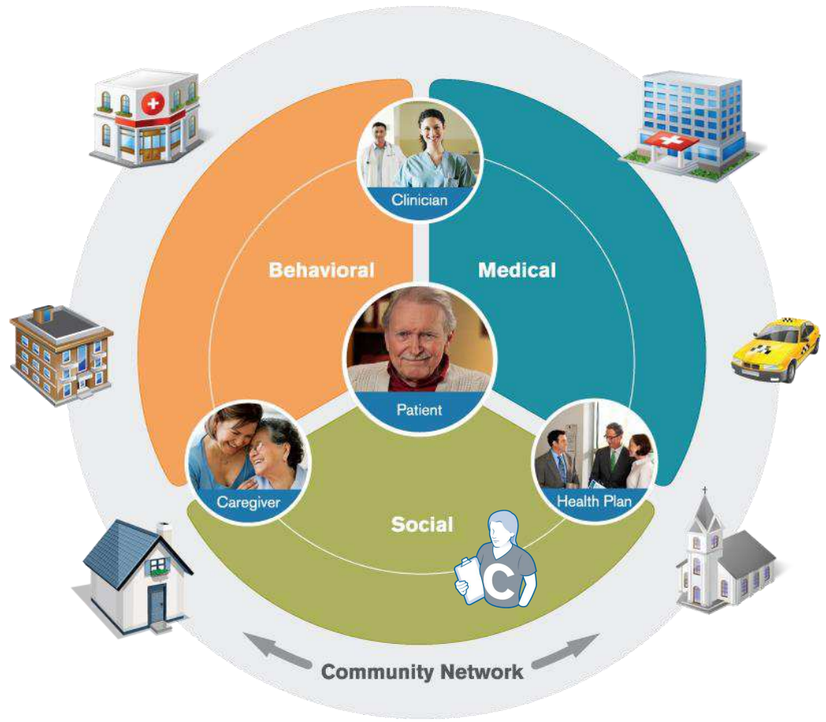
By Sub-Population



1.4% of population = 36% of cost.

5.0% of population = 54% of cost.

Use the Patient-Centered Care Model to Improve Outcomes and Reduce Costs



One Consumer at a time – focused by the data.

= (Red Shirt) Patients. = (White Shirt) Patients. = (Gray Shirt) Service performed by Care Coordinator, Care Provider or a Qualified Community Representative.

Current State

The Next Generation of Clinical Care for Medicaid

Demonstrating the Differences

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Lee

- Chronic back pain.
- Drug-seeking behavior.
- Identified through on-going analysis.

Quality of Outcome

- Episodic care.
- Pharmacy adherence.
- ER use.
- Admissions.
- No behavioral health care.

30 Days | **60 Days** | **90 Days**

- ER visits for back pain.

- Hospital admission after acute diabetic episode.

- ER visits for back pain.

- Hospital admission after pain killer overdose.

M
Medical Care

= (Red Shirt) Patients.

= (White Shirt) Patients.

= (Gray Shirt) Service performed by Care Coordinator, Care Provider or a Qualified Community Representative.

Patient-Centered Care Model

The Next Generation of Clinical Care for Medicaid

Demonstrating the Differences

UnitedHealthcare®

Lee

- Chronic back pain.
- Drug-seeking behavior.
- Identified through on-going analysis.

Quality of Outcome

- Consistent care.
- Better patterns established for long term health.

Cost of Care

- 200bp-500bp reduction in total care.

30 Days | 60 Days | 90 Days

Coordinated Networks of

M Medical Care

- Care Coordinator assigned.
- PCP starts treatment program.
- Patient sees nutritionist.

B Behavioral Care

- Patient assisted to Lock-Down.
- Patient sees Behavioral Health Counselor.
- Behavioral Addiction Specialist supervises patient.

S Social Support

- Lock-Down provides care.
- Peer coach serves as sponsor.
- Patient enters Halfway house.

Connected, Real-Time Data

- D • Narcotic usage. • ER Frequency
- D • Behavioral leads to Care Plan
- D • PCP automates referral to addiction specialist
- D • Addiction Specialist and Peer Coach update Care Plan
- D • PCP documents progress.

= (Red Shirt) Patients. = (White Shirt) Patients. = (Gray Shirt) Service performed by Care Coordinator, Care Provider or a Qualified Community Representative. D Data from Optum.