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# **UnitedHealthcare Community Plan**

## **Outreach and Care Management for Behavioral Health**

Behavioral Health Integration Advisory Committee

July 11, 2016

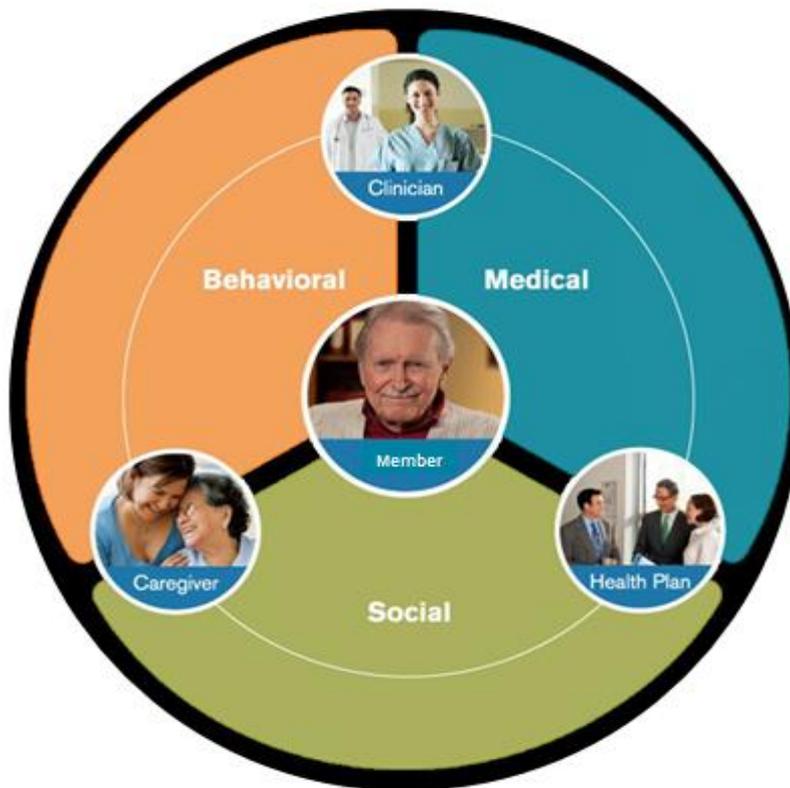
# Whole Person Care Integration

## Goals:

- Achieve physical and behavioral health integration for all members
- Increase integration of treatment for mental health and substance use disorder conditions
  - Our care management program assists members with complex medical, co-occurring and Serious and Persistent Mental Illness (SPMI) needs in the coordination of their care
  - All members are treated from a whole person care, holistic standpoint
- Address the social determinants affecting a member's health and wellness, such as housing, education, food, job assistance

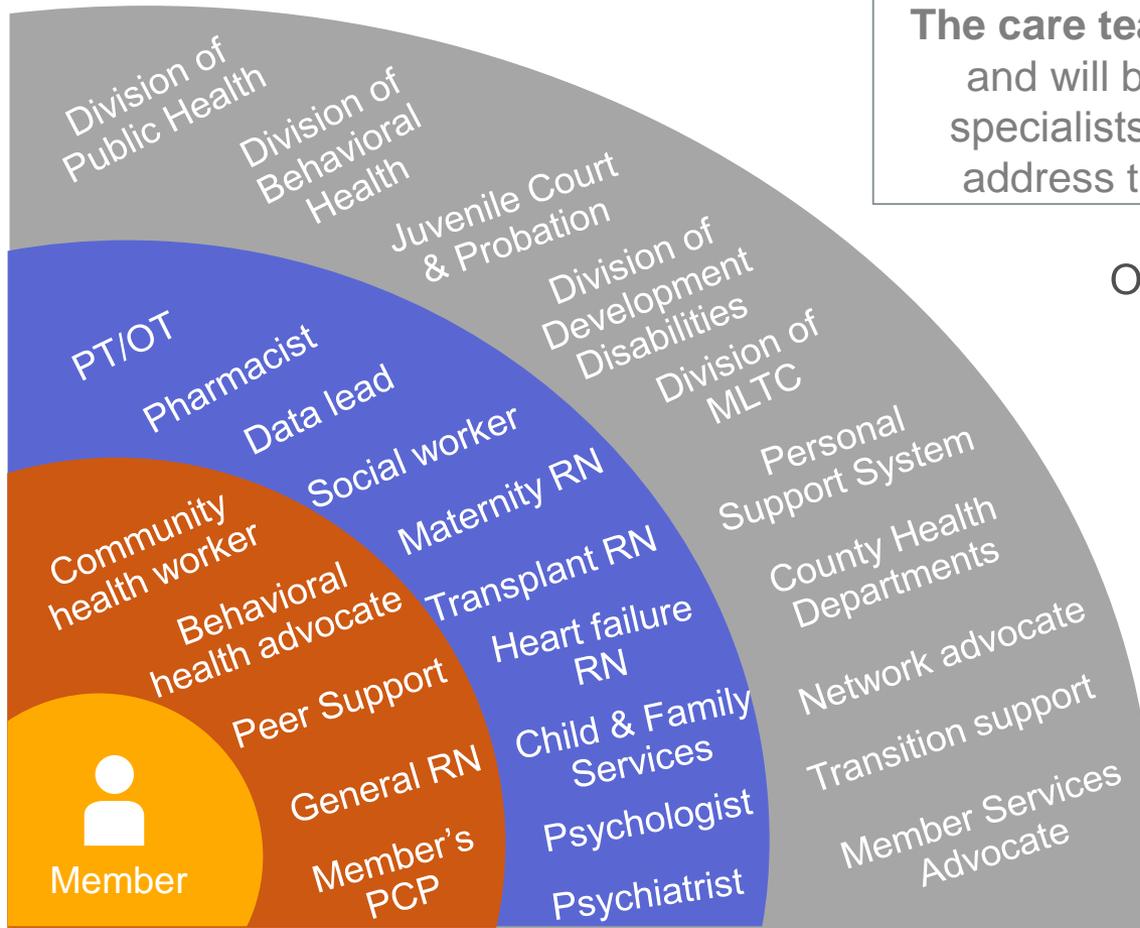
# Our Vision Pivots around Whole Person Care

UnitedHealthcare is committed to members at the community level. The health plan focuses clinical and care delivery through a whole person approach that addresses an individual's physical, behavioral and social needs



- 1** Whole person care, not disease focused  
 Person-Centered is **whole person care** and is not restricted to a facility, specialist physician, or primary chronic disease.
- 2** Integration of medical, behavioral and social care  
 Mix of services will be more **community based** and include **social agencies, housing, transportation, employment** etc.
- 3** Population segmentation and risk stratification allows individuals to be placed into care models best suited for their needs  
 Those with the most **complex needs** often have multiple conditions, represent a smaller portion of those receiving care and **drive most of the costs**
- 4** Leverage the resources and partner with integrated care systems and multi-disciplinary care teams  
 Individuals are served by highly **skilled clinicians** as well as additional **community resources** like **community health workers, peer support specialists**.
- 5** Real time **data sharing** across the care continuum to support better decisions and better outcomes  
**Value-based** pricing with providers supports quality outcomes

# Whole Person Care Team



The care team will report to one leader and will be supported by program specialists who can “flex” to quickly address the needs of the member

## Optimal health and well-being

### Whole person centered care

Whole person care focuses on how the physical, behavioral and social needs of a person are interconnected to maintain good health

### Aligned to the delivery system

Care focused on supporting the physician to member relationship

# Role of the Recovery & Resiliency Team

- Our Recovery & Resiliency (R & R) team will consist of two certified peer support specialists and a recover & resiliency manager
- This team will work with individuals and families to develop wellness, whole person care and recovery action plans of care, including community/social determinants connections
- Family peers/peers will act as conduits to R & R Services (peer support, development of a crisis/recovery plan, life planning activities, community connection, treatment options and more) and to other services as appropriate (legal, shelter, basic needs, etc.)
- Members of the Recovery & Resiliency team will provide a consultancy role to other physical and mental health providers

# Role of the Care Navigators

- The care navigator is there to help members with SPMI, complex behavioral health, and co-morbid medical conditions connect with needed services and resources
- Care navigators collaborate and partner with individuals in the development of a comprehensive plan of care which coordinates the following:
  - Therapeutic services (therapy, medication management)
  - Community and psychosocial supports (education/support regarding illness, coordination with support system, other supportive services)
  - Coordination of care between physical and behavioral health providers and clinicians
  - Recovery and Resiliency Services (peer support, development of a crisis/recovery plan, life planning activities)
  - Other services as appropriate (legal, shelter, basic needs, etc.)
  - For members with SPMI:
    - Tailored engagement to support whole person treatment/medication follow up
    - Development of a communication strategy for coordination between family, service providers and community service organizations
    - Individualized communication about service gaps

# Other Online Tools

- [Liveandworkwell.com](https://www.liveandworkwell.com)
  - Member and family education and support
  - Available in English and Spanish
  
- [Providerexpress.com](https://www.providerexpress.com)
  - National Optum Provider Manual
  - Level of Care, Best Practices and Coverage Determination Guidelines
  - Provider demographic changes/roster management
  - Provider education materials (e.g., webinars, FAQs)

# Contacts-Please call with questions

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