UHC Care Advantage + Optum Care Model

Best-in-class **Quality Care**

Outstanding **Member Experience**

An integrated care delivery program managed by an **interdisciplinary care team** who provides community-based support in the home for the **most fragile and medically-complex populations**.

The journey

- Identify enrollees eligible for the UHC Care Advantage Plan
- Care navigators engage and inform member and family about care team services
- Clinicians perform assessment and create unique care plan (Identifying all diagnoses, SDOH and other member needs and concerns)
- Member stays in the comfort of their home

Member benefits

- Dedicated care team (in-home and virtual visits)
- Identify potential health issues between PCP visits
- Improved health and well-being through care coordination and planning
- Care in home through referrals to supportive service offerings
- Sense of empowerment from understanding and managing health conditions
- Improved satisfaction with their health care
- Robust health plan benefits

Senior housing community benefits

- Gain a broader understanding of the resident's health care needs
- Decrease the risk of serious health events by detecting undiagnosed health conditions and care gaps
- Prevent unnecessary utilization
  - Emergency department
  - Hospital admissions
- Create aging in place care plans for members
- Augmenting staff time spent on resident management through our care navigation team

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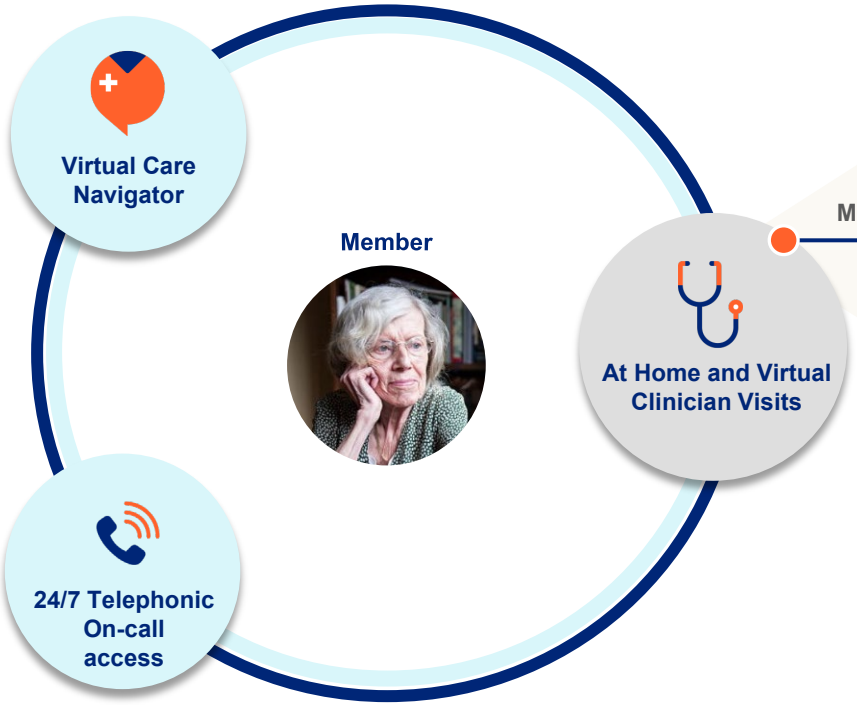
Optum Care Team

Besides excellent low-cost benefits to members, all will receive the longitudinal Optum Clinical Model.



Visits Based on Members Identified Needs

Advanced Practice Clinician (APC)

Nurse Practitioner or Physician Assistant

- Chronic and acute medical management
- Advanced care planning
- Clinical and behavioral assessment
- Establish personalized goals of care
- Advanced care planning and disease trajectory conversations

Registered Nurse (RN)

- Functional assessment
- Follow up visits
- Medication reconciliation
- Case management

Care Navigation

100% of members are assigned a dedicated **Care Navigator**

Proactive Outreach

To help members arrange access to care, coordinate services, and address social needs

Ongoing Support

Should a need arise, members can call the care navigator for help

Transportation	Appointments	Referrals	Community Resources	Individualized Needs
Arrange transport services to doctor, dentist or pharmacy	Arrange appointments with physicians and other healthcare providers	Refer member needs to specialized care teams and programs	Refer to community resources to address SDOH gaps, follow-up with the member post-referral	Escalates care concerns to RN or APC
Deploy urgent care services for emergent needs	If member doesn't have a PCP, schedules appointment with new PCP	Arrange for Behavioral Health services	Help members to utilize health plan benefits	Supports direct skilling to SNF, as needed
Set members up with mail order prescriptions	Scheduling for other care visits, e.g., colonoscopy, breast cancer screenings, etc.	Arrange for DME, as needed	Identify vaccine locations, schedule vaccination appointments and transportation	Help members access their OTC benefits and resolve delivery issues

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