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Disease Management Programs Grid

Program	Diabetes		
	At-Risk **Interactive Voice Response (IVR)**	**At-Risk** **Interactive Text Response**	**High-Risk** **Health Journey – Health Coaching**
Description of Program Services	**Member receives:** • Scheduled IVR telephonic educational calls **OR** text message providing diabetes education • Two diabetes care related questions per call/text, with the option to respond "Yes / No" • Health coaching team reaches out via outbound call/text message if more support is needed • May be eligible for Health Journey - Health Coaching		**Member receives:** • Health Journey Booklet • Telephonic Health Coaching • Tools to monitor condition, if needed **Primary Care Provider receives:** • Enrollment letter • Updates on member's condition, as indicated
Eligible Members	• Ages 18 - 75 years old • Dispensed insulin or oral hypoglycemic/anti-hyperglycemic medication in the last 24 months and/or • Two office visits for diabetes within the last 24 months and/or • One ED/IP event for diabetes within the last 24 months		• Ages 18 - 75 years • ≥2 ED/IP event for diabetes within the last 24 months and/or • Members who trigger an "alert" from the At-Risk IVR calls/texts and/or • Members self-referred or referred from internal/external sources, which would benefit from health coaching support
Exclusions	Members in Long Term Care/Skilled Nursing facilities, on hospice or dialysis, or have a diagnosis of End Stage Renal Disease (ESRD)		
Eligible Products	All Products (except Select)		
Referral Process	Members referred via a monthly Disease Management Report or by referral. Please use referral form on the UCare website UCare® - Disease Management or call the Disease Management Line listed below: 612-676-6539 or 1-866-863-8303		

Connect+: Connect + Medicare ED: Emergency Department IFP: Individual & Family Plans IP: Inpatient Hospitalization MNCare: Minnesota Care MSC+: Minnesota Senior Care Plus

MSHO: Minnesota Senior Health Options PMAP: Prepaid Medical Assistance Program

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Disease Management Programs Grid

Program	Heart Failure (HF)	
	At-Risk Heart Failure Program (Health Journey - Health Coaching)	**High-Risk Heart Failure Program (Medtronic Telemonitoring)**
Description of Program Services	**Member receives:** • A Health Journey Booklet • Telephonic Health Coaching • Tools to monitor condition, if needed **Primary Care Provider receives:** • Enrollment letter • Updates on member's condition, as indicated	**Member receives:** • Monitoring tablet device to assess daily weight & HF symptoms (available in English, Hmong and Spanish) • Data transmitted to Medtronic RN for triage, assessment, and follow up for any flare up of symptoms • RN provides telephonic monthly education on HF, co morbid conditions, and lifestyle management **Primary Care Provider receives:** • Enrollment letter • Notification of any HF symptoms and/or weight outside parameters
Eligible Members	• Ages 18 – 88 years old • < 2 heart failure ED/IP events within the last 15 months • Must be weight bearing Clinical considerations: • Current HF symptoms cause: ✓ No limitation of physical activity ✓ Slight limitation of physical activity	• Ages 18 and older • ≥ 2 heart failure ED/IP events within the last 15 months • MSC+ and MSHO members – Regardless of Utilization • Members regardless of weight bearing status Clinical Considerations: • Current HF symptoms cause: ✓ Marked limitation of physical activity ✓ Severe limitation of physical activity
Exclusions	Members in Long Term Care/Skilled Nursing facilities, on hospice or dialysis, or have a diagnosis of End Stage Renal Disease (ESRD)	
Eligible Products	All products except MSHO & MSC+ (refer to Medtronic) & Select	All products (except Select)
Referral Process	Members referred via claims identification, lab reports, and referral. Please use the referral form on UCare website UCare® - Disease Management or call the Disease Management Line listed below: 612-676-6539 or 1-866-863-8303	

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Disease Management Programs Grid

Program	Migraine Management Program
Description of Program Services	**Member receives:** • Telephonic health coaching education on migraines, stress management, nutrition, and relaxation techniques • Lifestyle medication: identify personal migraine triggers and create plan for eliminating triggers • Education materials/tools to monitor condition, including Migraine Diary and Migraine Action Plan **Primary Care Provider receives:** • Enrollment letter • Updates on member's condition, as indicated
Eligible Members	• Ages 18 - 75 years old • ≥ 1 migraine related encounter in the last 12 months • Pharmacy fill for ≥ 1 prescription for migraine condition in the last 12 months • Members self-referred or referred from internal/external sources, which would benefit from health coaching support
Exclusions	Members in Long Term Care/Skilled Nursing facilities, on hospice or dialysis, or have a diagnosis of End Stage Renal Disease (ESRD)
Eligible Products	Connect, Connect+, MNCare, MSC+, and PMAP
Referral Process	Members referred via a monthly Disease Management Report or by referral. Please use referral form on the UCare website UCare® - Disease Management or call the Disease Management Line listed below: 612-676-6539 or 1-866-863-8303

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MSHO: Minnesota Senior Health Options PMAP: Prepaid Medical Assistance Program

Disease Management Programs Grid

Program	Asthma		
	At-Risk Interactive Voice Response (IVR)	**At-Risk Interactive Text Response**	**High-Risk Asthma Education Program**
Description of Program Services	**Member receives:** • Scheduled IVR telephonic educational calls **OR** text message providing asthma education • Two asthma care related questions per call/text, with the option to respond "Yes / No" • Asthma education team reaches out via outbound call/text message if more support is needed • May be eligible for the High-Risk Asthma Program • An annual Asthma Action Plan (AAP) mailing		**Member receives:** • Telephone calls from a Registered Nurse or Respiratory Therapist to provide education to better understand and manage their asthma. • Annual Asthma Action Plan (AAP) reminder mailing • Incentive opportunity **Primary Care Provider receives:** • Enrollment letter • Updates on member's condition, as indicated

Eligible Members	• Ages 5-64 years old and enrolled in UCare for at least 11 months
	• ≤ 1 ED/IP event for asthma in 24 months and/or
	• ≥ 4 outpatient visits for asthma in 24 months and/or
	• ≥ 4 asthma medications prescribed in 24 months
			• Ages 5-64 years old who have any of the following:
			  ○ ≥ 1 ED/IP for asthma in 24 months
			  ○ ≥ 4 asthma medication prescriptions in 24 months
			  ○ Increased or uncontrolled asthma symptoms
			  ○ Suspected asthma medication non-compliance
			• Members who trigger an "alert" from the At-Risk IVR calls/texts

Eligible Products	Connect, Connect+, IFP, MNCare, and PMAP		
Referral Process	Members identified by claims/pharmacy data or by referral. Please use the referral form on UCare's website UCare® - Disease Management or call the Disease Management Line listed below: 612-676-6539 or 1-866-863-8303.		

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Disease Management Programs Grid

Program	At-Home Monitoring Program for Chronic Conditions
Description of Program Services	UCare has partnered with Medtronic Care Management Services (MCMS) to offer an at-home monitoring program designed to help manage complex, chronic comorbid conditions including Heart Failure (HF), Coronary Artery Disease (CAD), Chronic Pulmonary Disease (COPD), Hypertension (HTN), and Diabetes (DM). **Member receives:** • Monitoring tablet device to provide daily health checks (weight, BP, blood sugars, symptoms) • Tablet provides education about the chronic condition and gathers data via telemonitoring peripherals (i.e. BP cuff, weight scale) • The daily health check responses are analyzed by Medtronic's nursing team • Monthly communication from Medtronic's nursing team. If the daily monitoring data indicates a potential exacerbation, the nurse will reach out to provide further support more frequently **Primary Care Provider receives:** • Enrollment letter • Ongoing updates on the member's biometric and symptom data
Eligible Members	• Ages 18+ years old • Diagnosis of HF, CAD, COPD, HTN, or DM • Medtronic applies a stratification algorithm to identify eligible members. PLEASE NOTE: not all members referred will be eligible based on the stratification
Exclusions	Members in Long Term Care/Skilled Nursing facilities, on hospice or dialysis, or have a diagnosis of End Stage Renal Disease (ESRD)
Eligible Products	PMAP and MNCare
Referral Process	Members referred via a monthly Disease Management Report or by referral. Please use referral form on the UCare website UCare® - Disease Management or call the Disease Management Line listed below: 612-676-6539 or 1-866-863-8303 ****PLEASE NOTE: Not all members referred will be eligible based on Medtronic's stratification algorithm****

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Disease Management Eligible Products

UCare Programs										
	Connect	**Connect + Medicare**	**Medicare – Fairview North Memorial**	**Medicare Advantage-MN**	**MNCare**	**MSC+**	**MSHO**	**PMAP**	**UCare Fairview IFP**	**UCare IFP**
Diabetes High-Risk Health Journey	X	X	X	X	X	X	X	X	X	X
Heart Failure At-Risk Health Journey	X	X	X	X	X			X	X	X
Asthma High-Risk Asthma Education Program	X	X			X			X	X	X
Migraine Management	X	X			X	X		X		
***Behavior Health**					X	X	X	X		

*Behavior Health members diagnosed with:

- Back pain
- Chronic pain
- COPD
- Fibromyalgia
- Heart Disease
- Obesity
- Sleep apnea
- Uncontrolled hypertension

Language Assistance Services UCare provides translated documents and spoken language interpreting free of charge.

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Disease Management Eligible Products

Vendor Programs										
	Connect	**Connect + Medicare**	**Medicare – Fairview North Memorial**	**Medicare Advantage-MN**	**MNCare**	**MSC+**	**MSHO**	**PMAP**	**UCare Fairview IFP**	**UCare IFP**
Diabetes At-Risk WarmHealth IVR	X	X	X	X	X	X	X	X	X	X
Asthma At-Risk WarmHealth IVR	X	X			X			X	X	X
WarmHealth IVR Members receive scheduled IVR or text message providing asthma or diabetes education and two care related questions (Y/N response) to identify asthma/diabetes knowledge and management. If member responses indicate more support is needed, the asthma/diabetes team reaches out via text message/outbound call to provide support.										
Heart Failure High-Risk Medtronic Tele-monitoring	X	X	X	X	X	X	X	X	X	X
Medtronic's Tele-monitoring program provides enrolled HF members with a talking scale to assess daily weight and HF symptoms via Q & A. The telescale is available in English, Hmong and Spanish. Member data is transmitted to Medtronic's RN team for triage, assessment and follow up. If member data suggests a flare up of HF the PCP is contacted and the nurse provides member follow up. The nurse provides monthly member education on HF, co morbid conditions and lifestyle management over the phone. The member's PCP is notified when the member enrolls in the program.										

INQUIRIES AND REFERRALS FOR ALL DISEASE MANAGEMENT PROGRAMS

DM Referral Form on the UCare website

Call the DM Management Line at 612-676-6539 or 1-866-863-8303

Language Assistance Services UCare provides translated documents and spoken language interpreting free of charge.

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Disease Management Eligible Products

Vendor Programs										
	Connect	**Connect + Medicare**	**Medicare – Fairview North Memorial**	**Medicare Advantage-MN**	**MNCare**	**MSC+**	**MSHO**	**PMAP**	**UCare Fairview IFP**	**UCare IFP**
Medtronic Chronic Condition Program					X			X		
Medtronic's Chronic Condition Program offers an at-home monitoring program designed to help manage complex, chronic comorbid conditions. Medtronic will provide the following components: Daily health check monitoring, Outreach to members to encourage engagement and care plan compliance as well as health coaching, Alert based intervention as needed, and Outreach to health plan care managers or physicians as necessary to assist members when struggling or at risk for hospitalizations.										
Mom's Meals			X	X						
Mom's Meals provides meal programs for heart failure members who had a recent hospital stay due to any reason. Members will receive two meals a day for fourteen days post discharge.										
FoodRX					X			X		
FoodRX is in partnership with Second Harvest Heartland to offer a healthy nutrition box program that is designed to help members manage their diabetes, hypertension, and/or heart conditions. It's a 6-month program, at no cost to the member. Provides 25 meals with 3 recipes per box. Education material is also provided within each box. Members receive 1 box per month delivered to their home.										

INQUIRIES AND REFERRALS FOR ALL DISEASE MANAGEMENT PROGRAMS
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