

Disease Management

UnitedHealthcare Disease Management (DM) programs are part of our innovative Care Management Program. Our Disease Management (DM) program is guided by the principles of the UnitedHealthcare Personal Care Model™. We developed the Personal Care Model to address the needs of medically underserved, cultural, physical, behavioral and socio-economic factors.

Identifications and Stratification

The Health Risk Assessment (HRA) and our predictive modeling and stratification system are the primary tools for identifying Members for disease management programs.

As a provider, you may refer Members for assessment and triaging for Care/Disease Management program.

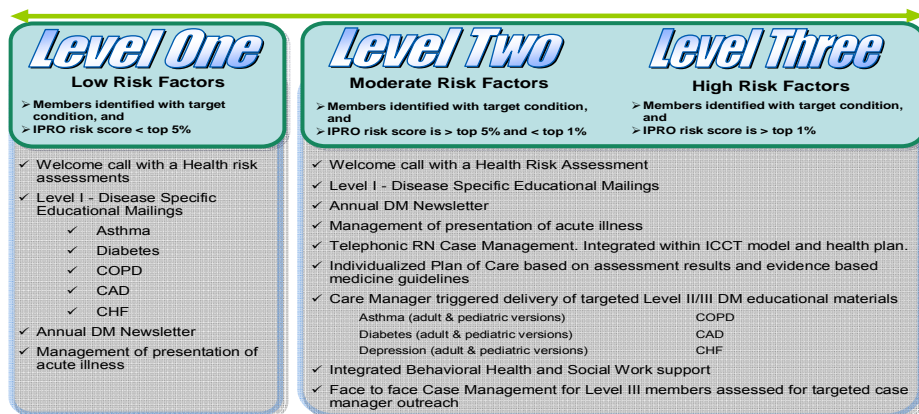
Health Risk Assessment

The HRA is an initial assessment tool used for new and existing Members to identify a Member’s health risks. Based upon the Member’s response to a series of questions, the tool will assign a score that corresponds to a level. These levels are as follows:

- **Level 1:** Low risk Members who are typically healthy, stable, or only have one medical condition that is well managed.
- **Level 2:** Moderate risk Members who may have multiple conditions.
- **Level 3:** High risk Members who are medically fragile who are at high risk for utilization of services.

Stratification

Our multi-dimensional predictive modeling tool compiles information from multiple sources such as claims, laboratory, pharmacy, inpatient and emergency data and predicts future risk. On a monthly basis, the system generates algorithms to identify members for care and disease management.



Outreach and other Identification Processes

While HRAs and retrospective data are the first line of identification of new Members in the UnitedHealthcare Care Management/Disease Management (CM/DM) programs, we have developed an extensive outreach program that supports identification and referral for our CM/DM services. Our CM/DM staff is responsible for collaborating with other community partners such as program care managers, clinic staff, other health care team community partners, and fiduciary entities in order to identify Members. Finally, in addition to claims and pharmacy data, we integrate authorization and pre-certification information into the CM/DM identification stratification methodologies.

DM Interventions

After a Member has been identified via claims with one of the five core conditions (asthma, diabetes, COPD, CAD or CHF), they receive health education materials related to the identified condition. The accompanying letter informs the Member on how the Member can engage in care/disease management services or opt out any of the available programs. Those Members who are viewed to be more complex utilizing various stratification methodologies are eligible for care management services. The Care Manager contacts the Member by telephone and sends additional program and health education materials targeted to the Member's specific care opportunities.

We have developed evidence-based interventions for our DM program. The following general interventions have been structured to improve Members' health status.

- Health risk assessment
- Health review phone calls
- Provide assigned Care Manager's phone number to the Member/family
- Ongoing monitoring of claims and other tools to re-assess risk and needs
- Access to program website
- Episodic educational interventions, as needed
- Post hospitalization and emergency room assessment
- Educational materials are sent to Member
- Letter is sent to the provider identifying the Member's involvement, intervention and point of contact for the Care Management program.
- Additional and/or specific interventions are also conducted in order to individualize the plan of care.

Plan of Care

Our member-centric care management program, encourages member to be active in setting practical goals (plan of care) to improve their overall health. This approach also is levied to establish a medical home and to keep members healthy in their communities. We have found with available resources and member-centric care it improves their overall functional and emotional status.

Care Management Goals are:

- To assure the Member is leveraging personal, family, and community strengths.
- To ensure that we are using evidence-based guidelines and best practices for education and self-management information while integrating interventions to address co-morbidities.
- To modify approach or services based on the feedback from the Member, family, and other health care team members.
- To monitor outcomes
- To communicate effectively to establish a medical home and to coordinate services with provider/specialist.
- To evaluate Member satisfaction.

The Care Manager develops and implements an individualized Plan of Care for Members. The Care Manager will involve the provider caring for the Member in the plan of care development process and assist them in directing the course of treatment in accordance with the evidence-based clinical guidelines that support our care management program.

The Plan of Care addresses the following areas of care:

- Psychosocial adjustment
- Nutrition
- Complications

- Medication
- Prevention
- Self-monitoring, symptoms and vital signs
- Emergency management/co-morbid condition action plan
- Appropriate health care utilization

Prospective Identification—UnitedHealthcare uses numerous data sources to identify Members for care management. These data sources include but are not limited to:

- Emergency room utilization and hospital inpatient combined events
- Physician/Member referrals
- UnitedHealthcare clinical staff referrals
- Health Risk Assessment Score

Risk Stratification—All identified Members complete a health risk assessment that scores them into risk categories. Based on the actionable population and aid categories of each Health Plan and state program, we determine the specific threshold for each care and disease management level. As previously mentioned, Members are stratified **into one of three levels** and are assigned to the appropriately qualified staff.

Clinical Practice Guidelines

UnitedHealthcare uses nationally recognized, evidence-based clinical criteria to guide our medical necessity decisions, including Milliman Healthcare Management Guidelines, McKesson InterQual Guidelines and CMS policy guidelines. Milliman and InterQual are nationally regarded for its scientific approach, using comprehensive medical research to develop recommendations on optimal length of stay goals, best-practice care templates, and key milestones for the best possible treatment and recovery. These guidelines are integrated into our clinical system. For specific state benefits or services not covered under national guidelines, we develop criteria through the review of current medical literature and peer reviewed publications, Medical Technology Assessment Reviews and consultation with specialists. The clinical practice guidelines are reviewed and revised annually. The UnitedHealthcare Executive Medical Policy Committee (EMPC) reviews and approves nationally recognized clinical practice guidelines. The guidelines are then distributed to the National Quality Management Oversight Committee (NQMOC) and the Health Plan Quality Management Committee. Medical guidelines are available and shared with providers upon request and are available on the provider website, www.uhcommunityplan.com. Policies and guideline updates are communicated through provider notices prior to implementation.