# Texas Medicaid Wellness Program

*Program Overview*

TEXAS
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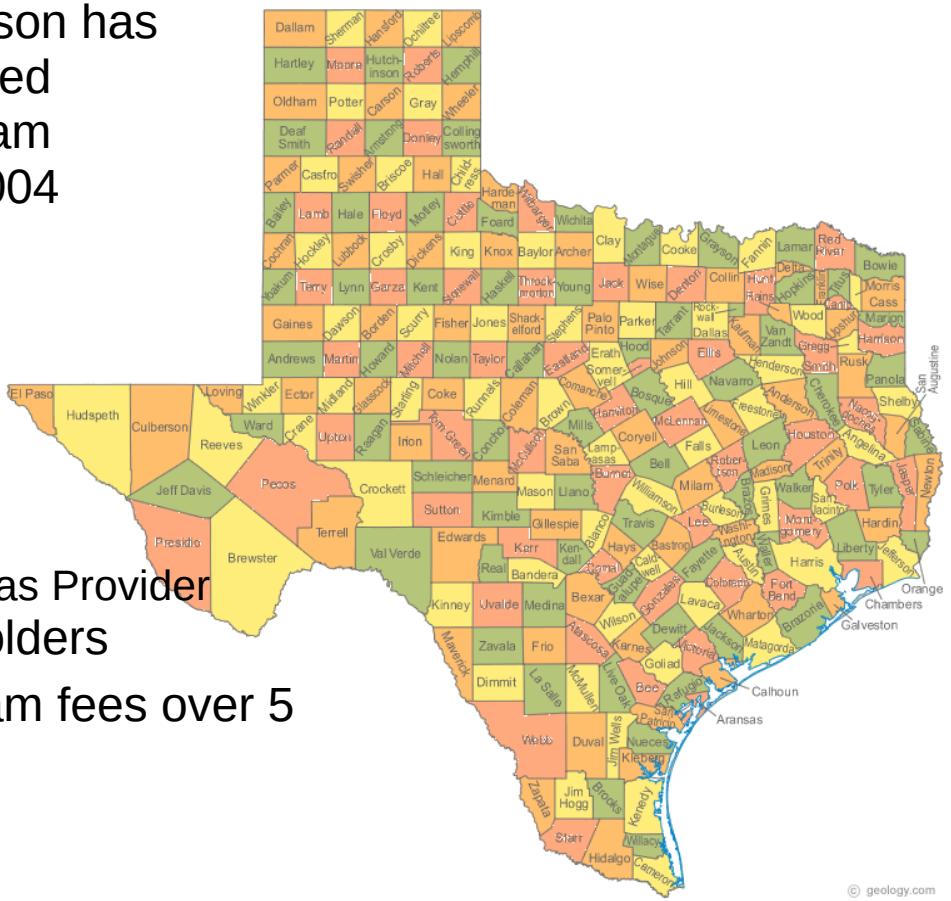
# The State of Texas and McKesson

*A History of Partnership with Positive Outcomes*

- In partnership with HHSC, McKesson has successfully delivered the Enhanced Care Disease Management program to Texas Medicaid clients since 2004
  - 168,000 Medicaid clients in Texas
  - 7,000 visits to providers throughout the state
  - New pilot programs for clients and providers in the Enhanced Care Program
  - Trust and partnership with the Texas Provider community and other key stakeholders
- $40.1 Million Savings after program fees over 5 years



# Texas Partners

*We have the relationships in the state*

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TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

TEXAS DIABETES COUNCIL

tafp.org
TEXAS ACADEMY OF FAMILY PHYSICIANS

TEXAS Department of State Health Services

TEXAS Department of Aging and Disability Services

Texas Psychological Association

THA TEXAS HOSPITAL ASSOCIATION

TACHC
The Heartbeat of Texas Community Health Centers

ASTHMA COALITION OF TEXAS

Texas Association of Rural Health Clinics
Quality Health Care for Rural Texas

# New Care Management Program

- Enhanced Care Disease Management - 2004
- Competitive Request For Proposal Launched – August, 2009
- RFP Awarded to McKesson Health Solutions – October, 2010
- Wellness Program Launch Date – March 1, 2011
- Program refocused on disabled clients ages 2-21 with FFS – March 1, 2012

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# PROGRAM HIGHLIGHTS

## Whole Body Management

- ✓Whole Person Care Management – No Disease Exclusions
- ✓Open to all High Cost / High Risk (HC / HR) children
- ✓Clients Identified via predictive modeling
- ✓Supports MD as Leader of Care Team
- ✓Engages & motivates client with education and support
- ✓24/7 Nurse Advise Line
- ✓Practice initiatives & incentives
- ✓Web portal

# Medicaid Population

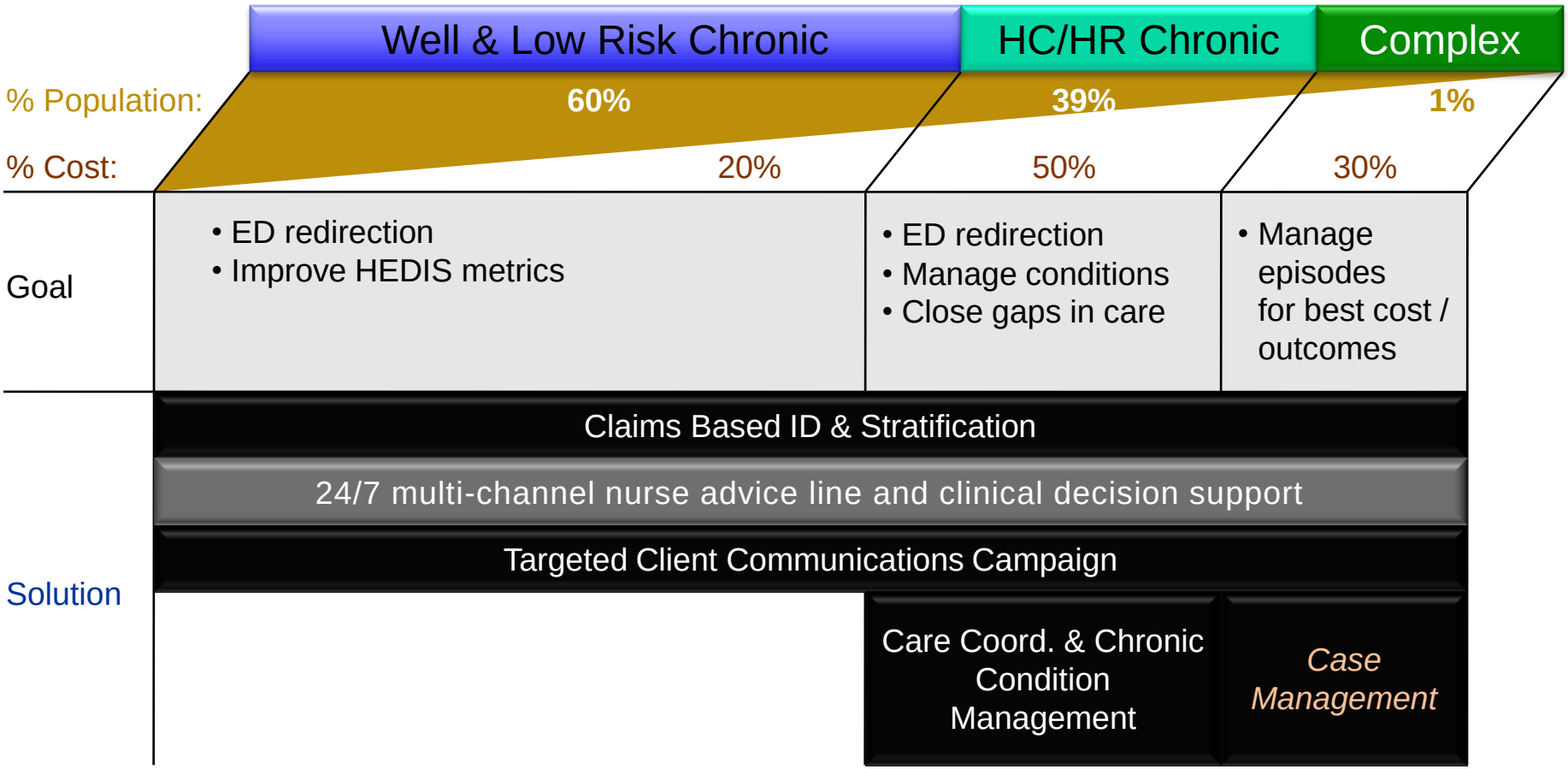
*A very challenging population*

- 45% of Aged, Blind, Disabled beneficiaries have three or more chronic conditions[1]
- 49% have at least one psychiatric illness[1]
- Harder to find, engage, and activate
- Requires a different and more intensive intervention set
- Member engagement is challenging but necessary
- Best served by staff located in their community

[1] Kronick, Bella, & Gilmer, 2009

# Care Management Solution

*Targeted interventions that deliver savings*



# Intervention Details

*Knowing who to act upon and what to do*

- **Identification & Stratification:** Identifying the correct population to focus on
- **Assessment / HRA:** Identifying gaps to be addressed will reduce medical costs
- **Individualized Care Plans:** Outlines educational needs & gives providers more information to support treatment plans
- **Nurse Advice Line:** Redirecting clients to the right level of care
- **Targeted Communication Campaigns:** Getting the right clients to call the Nurse Advice Line
- **Care Coordination & Chronic Condition Management:** Addressing barriers to care & closing gaps in care
  - Holistic approach to addressing client barriers to care, physical and mental health gaps in care
  - Regional care team, blending telephonic and face-to-face interventions

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# Intervention Details

*Engaging the providers and patients*

**Care Coordination & Chronic Condition Management**: Provider engagement

- Working with Medicaid providers
  - Our local staff engage face to face with the provider offices
    - Supporting the Patient Centered Medical Home model
    - Helping clients show up and be prepared for their visits
    - Chart reminder program
- Gaps in care reporting – paper and on the portal

**Provider Portal:** Putting actionable information into the provider's hands

- Bidirectional portal for sharing care plan and gaps in care

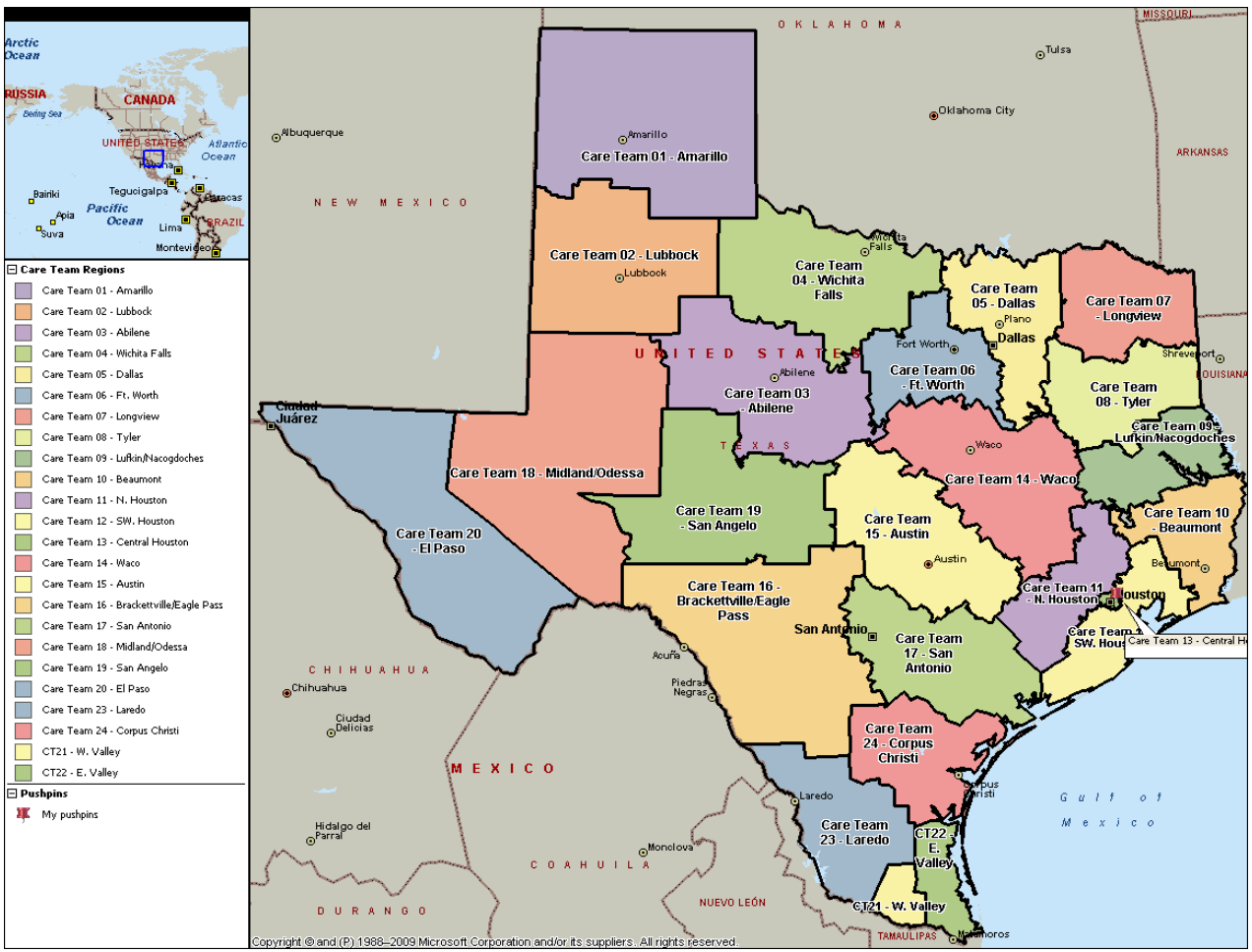
**Client Portal:** Different engagement channel

- Full suite of wellness tools and personalized action plans

# Regional Care Team Overview

*Statewide Distribution*

- 26 Care Teams across the state
- 68 Community Based Primary Nurses coordinating care



# Regional Care Team Overview

*Multiple Specialists to Better Serve the Client*

# Regional Care Team Overview

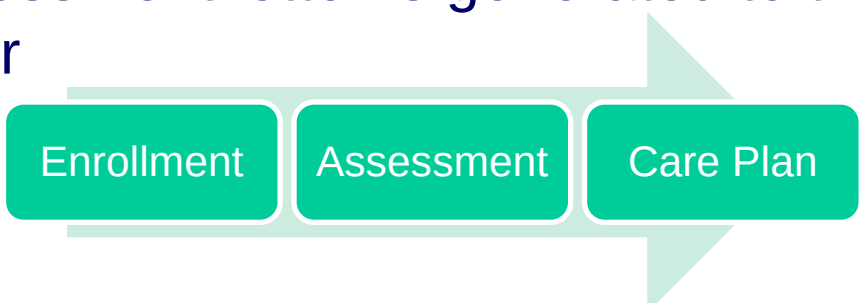
## *Defining Staff Roles*

| Title | Role |
|---|---|
| Community Based Primary Nurse (CBPN) | Lead Regional Care Teams, Primary Care Manager for all clients in their region, work with providers and coordinate a multi-disciplinary care team |
| Certified Promotor(a)/Community Heath Worker (CHW) | Under direction of CBPN, engage clients around care plan and assist with meeting those goals, locate clients, educate about Medical Home, work with local organizations and provider practices |
| Health Resource Coordinator (HRC) | Staff Client and Provider phone lines, provides program information and resources, process real time referrals |
| Behavioral Health Specialist Nurse (BHS) | Assume primary nurse role for clients with dominant Behavioral Health conditions or act as a consult for low risk as needed, build relationships with providers in their regions |
| Licensed Social Worker (SW) | Provide support for frequent ED users, focus on high risk, complex care coordination needs, coordinate social services needs with local organizations |
| Complex Case Management Nurse (CCM) | Assume primary nurse role for clients with complex case management needs or resource referrals as needed, build working relationships with hospitals to help support discharge planning |
| Pharmacist/Pharmacy Technician | Review medical and pharmacy claims for appropriateness, poly pharmacy, or high risk prescriptions, coordinates with providers |
| Practice Support Facilitator (PSF) | Educate providers on care management, conduct learning collaborative programs, engage in provider outreach activities |

# Regional Care Team Overview

*Assessment and Coaching*

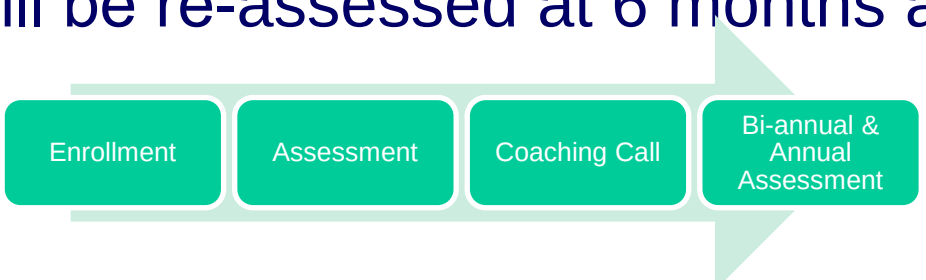
- Once a client completes their enrollment into the program, a health history assessment is completed by a registered nurse
- Based on responses to that assessment, a care plan is generated to begin to build a platform for client education
- Client's own program goals are elicited and are incorporated to help drive movement on care plan items
- A post assessment letter is generated to the client and the provider



# Regional Care Team Overview

*Assessment and Coaching*

- Once an assessment has been completed, the client will be scheduled for future coaching calls
- Client's risk level will determine the frequency of these interventions
- During the coaching call, the client's level of motivation for each care plan item is determined
- Care plan items are prioritized and education is provided
- Client's will be re-assessed at 6 months and 12 months



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# Regional Care Team Overview

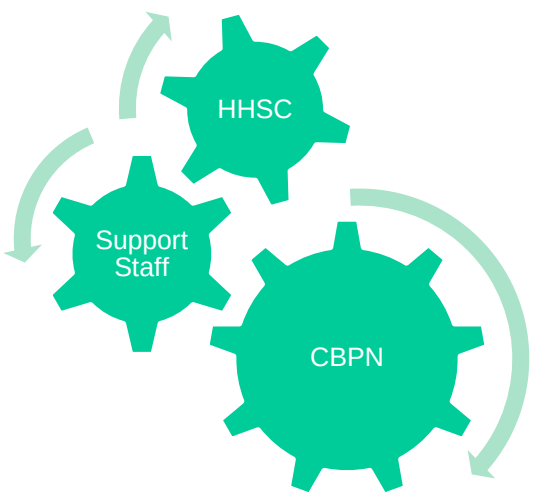
## *Client Education*

| Step | Goal | Examples |
|---|---|---|
| • Step 1 | •Understand clients' **beliefs, behavior and knowledge** | • Conduct **assessment**<br>• Ensure culturally competent staff<br>• Team **understands the community** |
| • Step 2 | •Provide clients with specific **information about health risks & benefits of change** | • **Personalize** the information<br>• **Link exam/test results to behavior**<br>• Use multi-media and repeat messages<br>• **Ask** clients if they want more info on topic of interest and provide it. |
| • Step 3 | •**Collaboratively set goals** based on clients' confidence in their ability to change behavior | • Develop **action plans** with goals to achieve over a 1 to 2 week period<br>• Use **motivational interviewing**<br>• Have provider & influencers **reinforce** |
| • Step 4 | •Assist clients with **problem solving** by identifying personal barriers, strategies and support systems | • Teach **problem solving** approach<br>• Use group visits<br>• Use **family clients/friends** to assist<br>• clients teach back what they learn<br>• Identify **community resources** |
| • Step 5 | •Arrange specific **follow-up** | • Arrange care and community resources<br>• Frequent **follow-up on goal** progress **to celebrate** successes with client<br>• Problem solve/change goals |

# Regional Care Team Overview

*Coordination of Care*

- The Community Based Primary Nurse will send referrals to other members of the Regional Care Team when support is needed
- Care teams will discuss cases and hold internal care coordination meetings
- Care teams will bring more complicated cases forward for discussion with HHSC & TMHP care coordination meetings



# Regional Care Team Overview

*In the Community*

- The Regional Care Team will continue to gather local resources in the community
- The care team will be informed of most up to date program offerings
- The care team will work closely with other vendors
- The care team will work to get program information into the community

# Program Initiatives

- Provider Incentive Program
- Provider Portal
- TransforMED & Delta Exchange
- Patient-Centered Medical Home
- Practice Support

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# SUPPORT OF ACOs

Texas Medicaid Wellness Program enhances the function of ACOs by:

- ✓ Patient care coordination
- ✓ Reduction in duplication of services
- ✓ Quality metrics
- ✓ Cost avoidance
- ✓ Preventive services

✓TRUE COLLABORATION