CHEST 2011 October 22 - 26 Honolulu, Hawaii

The Texas Medicaid Wellness Program

Ensuring Quality Care for Respiratory Disease

TEXAS Health and Human Services Commission

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Chest 2011 Asthma and COPD Coalitions Annual Meeting
Honolulu, Hawaii
October 25, 2011

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CHEST 2011 October 22 - 26 Honolulu, Hawaii

I have no conflicts of interest and will not promote any commercial product or interests in this presentation.

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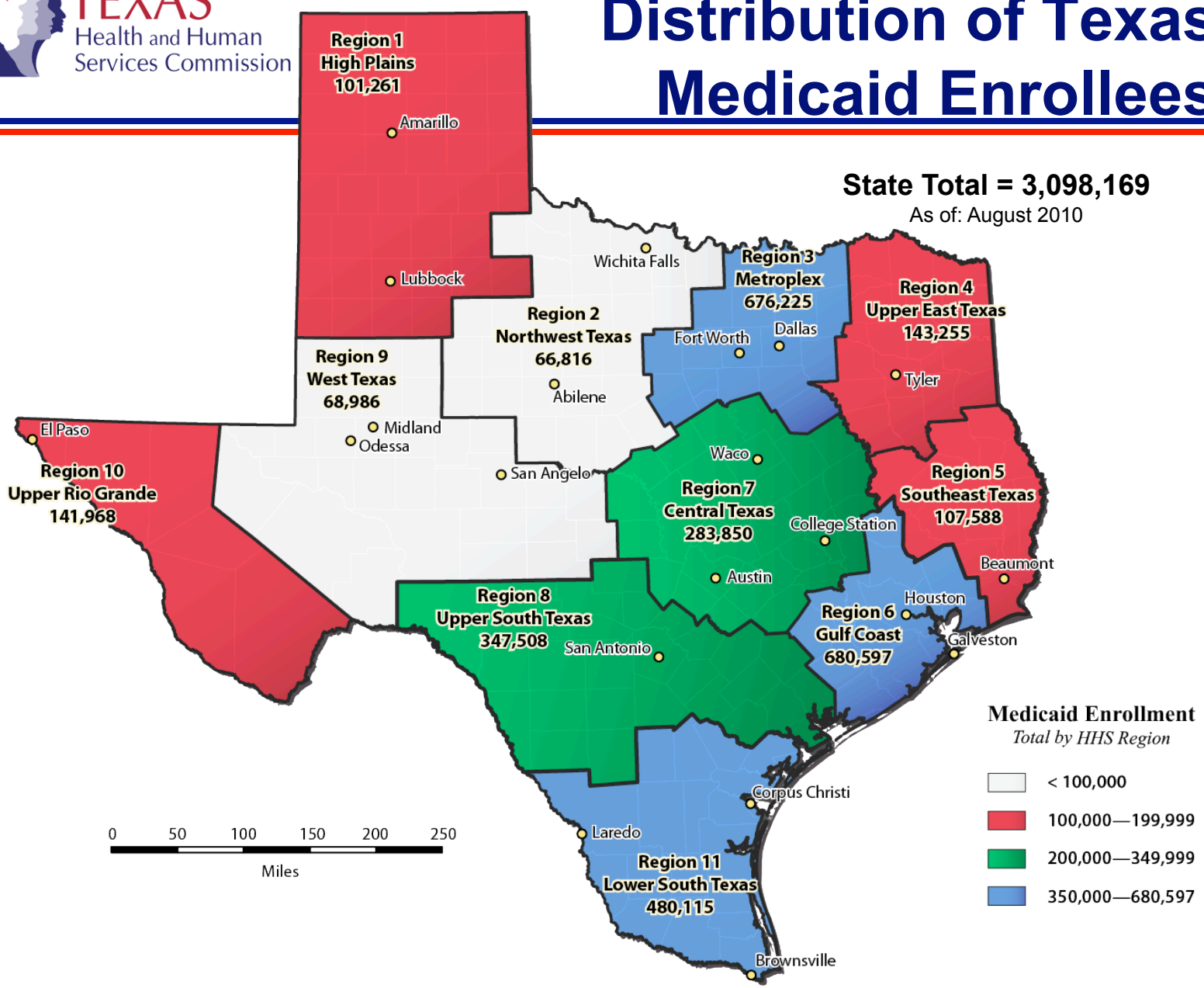
Distribution of Texas Medicaid Enrollees

State Total = 3,098,169
As of: August 2010



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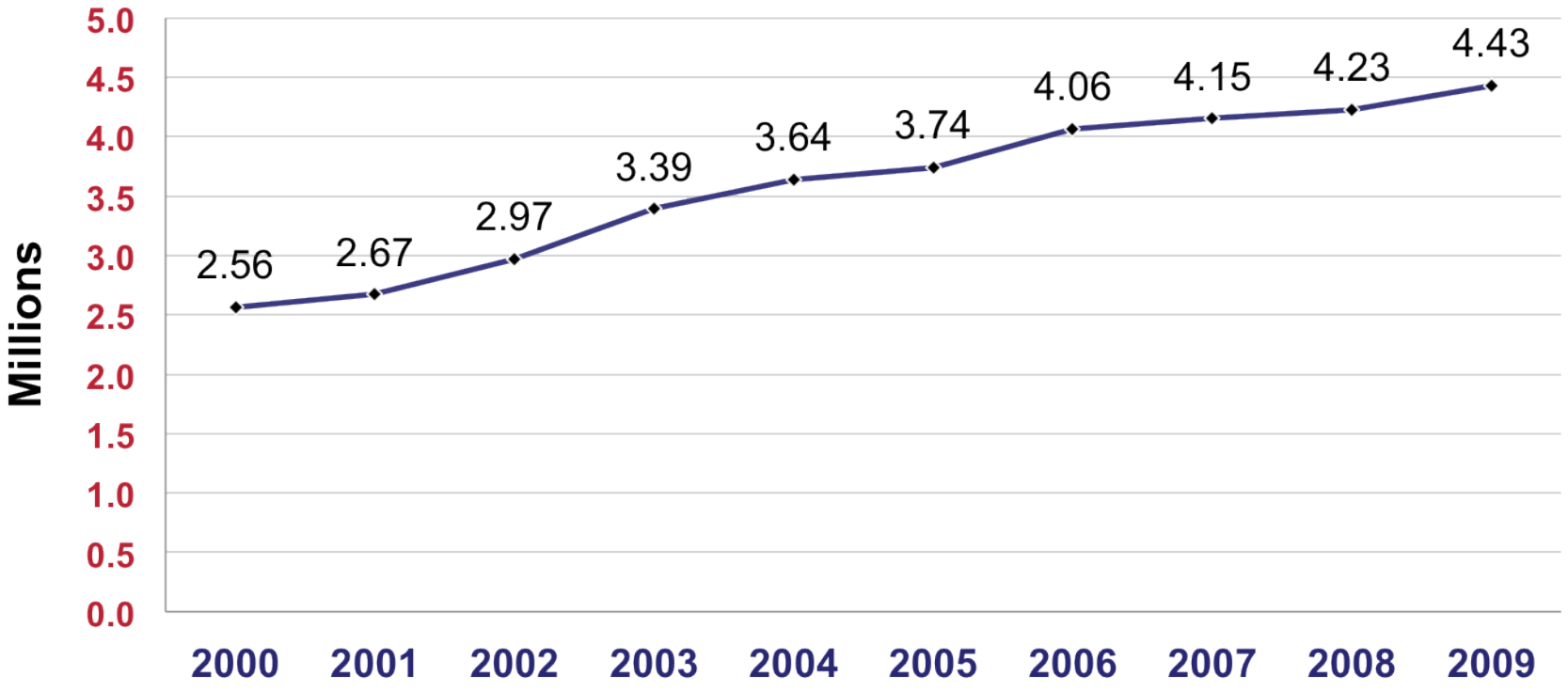
How Many People Does Texas Medicaid Serve?

Texas Annual Unduplicated Medicaid Enrollment SFYs 2000-2009



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New Care Management Program

Holistic Approach

- Competitive Request for Proposal put out (RFP) – August, 2009 - and awarded to McKesson Health Solutions – October, 2010
- Wellness Program launched – March 1, 2011
- Highlights of program:
  - Whole-Person Care Management – No Disease Exclusions
  - Open to all High-Cost/High-Risk (HC/HR) Individuals
  - Patients are identified via predictive modeling

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Medicaid Population

A very challenging population

- 45% of Aged, Blind, and Disabled (a Medicaid-funded program for the elderly and people with disabilities) beneficiaries have three or more chronic conditions[1]
- 49% have at least one psychiatric illness[1]
- Harder to find & engage MCD patients, and activate services
- Requires a different and more intensive intervention set
- Provider engagement is also challenging - but vital
- Best served by staff located in their own community

[1] Kronick, Bella, & Gilmer, 2009

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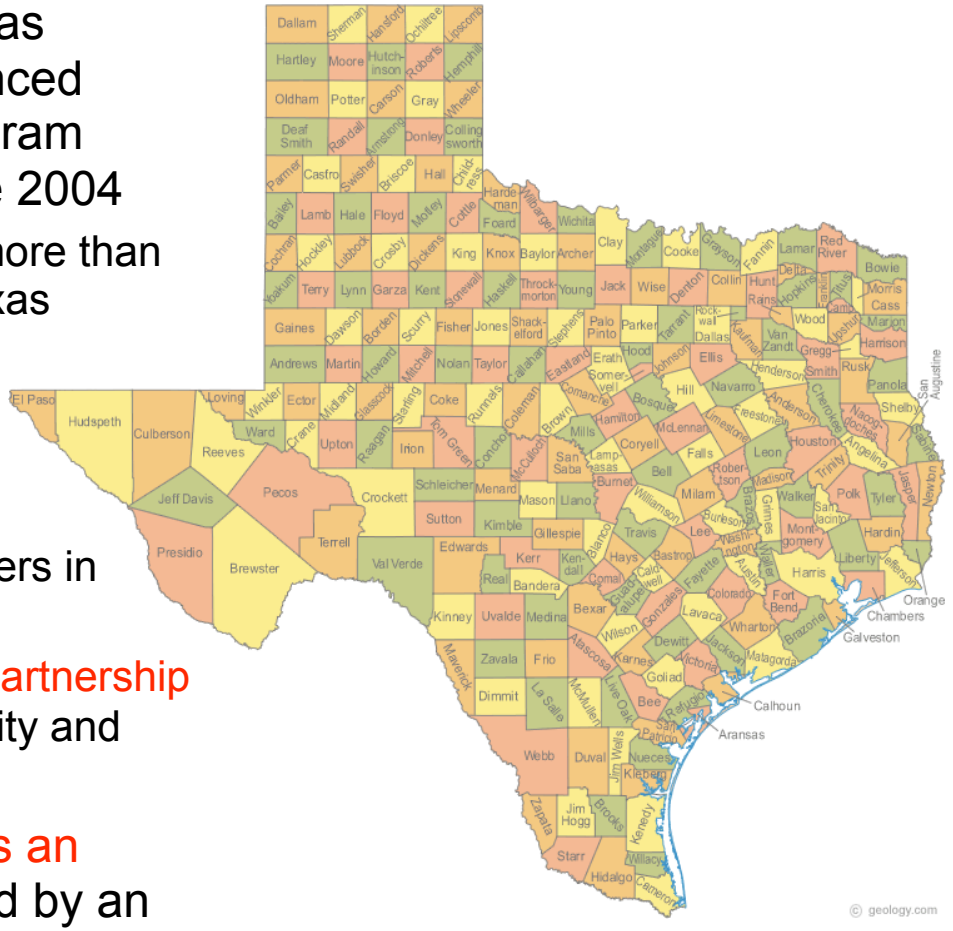
The State of Texas and McKesson

A History of Partnership with Positive Outcomes

- Working for HHSC, McKesson has successfully delivered the Enhanced Care Disease Management program to Texas Medicaid patients since 2004
  - They have touched the lives of more than 168,000 Medicaid patients in Texas
  - McKesson staff conducted over 7,000 visits to providers throughout the state
  - McK launched several pilot programs for patients and providers in the Enhanced Care Program
  - They have developed trust and partnership with the Texas provider community and other key stakeholders
- They have saved state taxpayers an estimated $40.1 Million (validated by an independent accounting firm), after program fees, over 5 years



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Texas Partners

Working relationships in Texas

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

TEXAS DIABETES COUNCIL

tafp.org
TEXAS ACADEMY OF FAMILY PHYSICIANS

THA TEXAS HOSPITAL ASSOCIATION

TEXAS Department of State Health Services

TEXAS Department of Aging and Disability Services

ASTHMA COALITION OF TEXAS

TACHC
The Heartbeat of Texas Community Health Centers

Texas Psychological Association

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

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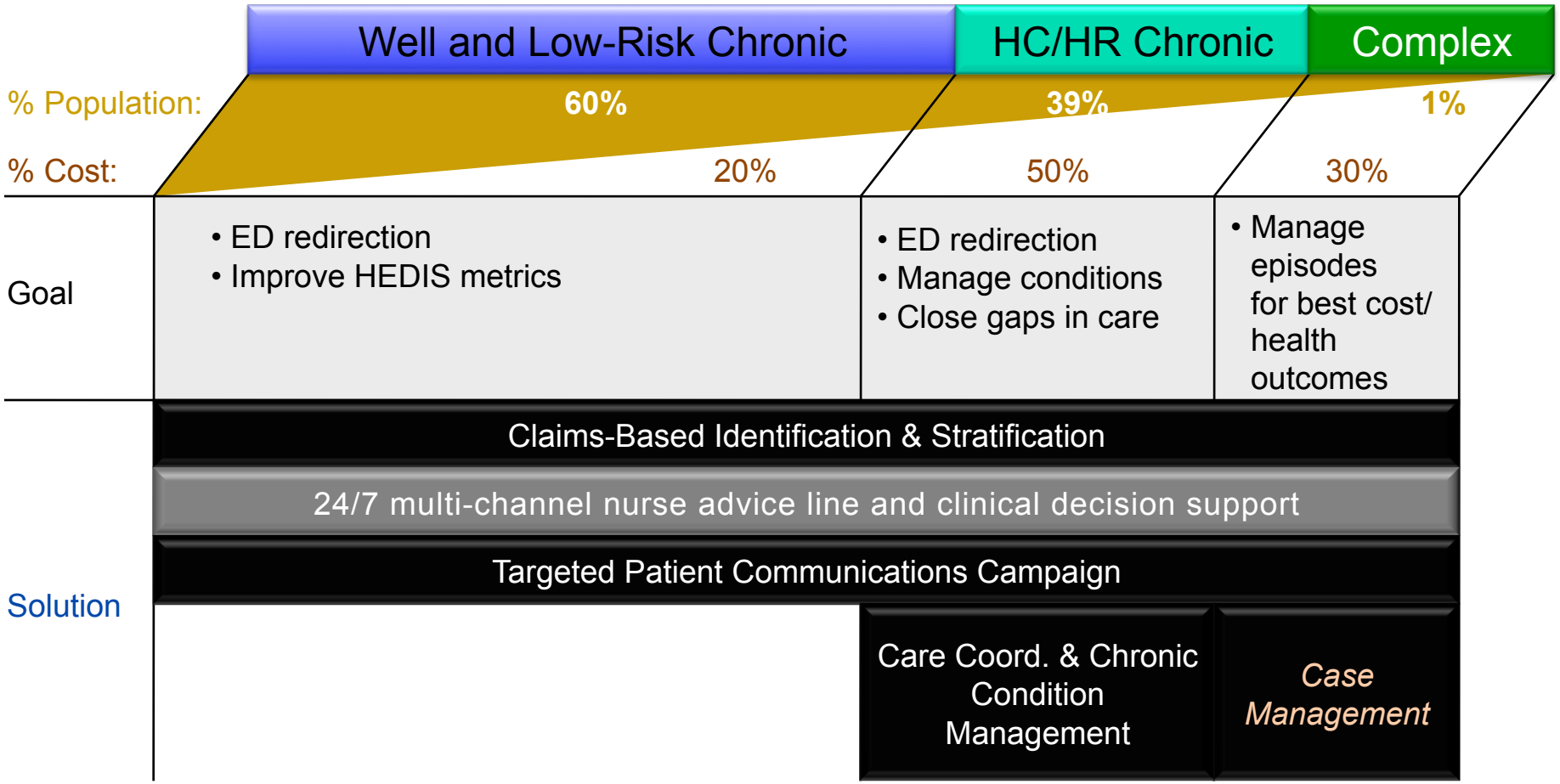
Care Management Solution

Targeted interventions that deliver savings



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Intervention Details

Knowing who to act upon and what to do

- **Identification & Stratification:** Identifying the correct population on which to focus
  - They target the correct patients for management, balancing the appropriate level of intervention and program costs to achieve improved clinical outcomes (for a positive ROI)
- **Assessment/Health Risk Assessment (HRA):** Identifying gaps to be addressed that will reduce medical costs
  - Beyond identifying who is at high-risk, we need to understand the medical, behavioral, and psycho-social gaps to be addressed
  - Develop a single, comprehensive care plan that addresses psychosocial issues, physical health issues, & behavioral health issues

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Wellness Program

Predictive Modeling Results

- 1.2 Million Texas Medicaid recipients identified with chronic disease (out of just >4M)
- 175,587 patients crossed the threshold for management
- 149,339 loaded into the scoring program
- 42 conditions identified
- 37,692 unique patients make up the top 10 highest cost conditions
  - 47,450 conditions make up the top 10 for total costs
  - 9,758 patients with co-morbid conditions (including mental health and substance abuse)

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Wellness Program

Top 10 Conditions by Total Cost

Highest Cost	Condition	N
1	Depression	8899
2	Diabetes	9475
3	Seizure Disorder	4107
4	ESRD	903
5	Sickle Cell Disease	510
6	**Asthma***	8078
7	HTN	11,642
8	CF	172
9	Bipolar Disorder	1788
10	Back Pain (Chronic)	1876

***6,715 under 21**

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Intervention Details

Impacting Emergency Room (ED) Utilization

- **Nurse Advice Line:** Redirecting patients to the correct level of care
  - The most effective intervention at reducing inappropriate ED usage
  - Majority of callers with intent to go to the ED get a recommendation for a lower level of care
- **Targeted Communication Campaigns:** Getting the correct patients to call the Nurse Advice Line
  - Cost-effectively promoting use of Nurse Advice Line for a targeted subset of the population
  - Culturally sensitive
  - At low-literacy level
  - Multiple languages

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Intervention Details

Coordinating care and changing patient behavior

Care Coordination & Chronic Condition Management: Addressing barriers to care & closing gaps in care

- Holistic approach to addressing patient barriers to healthcare, physical and mental health gaps in care
- Regional care team, blending telephonic and face-to-face interventions
  - Work-at-home model
  - RNs, SWs, Behavioral Health Specialists; Promotores/ Community Health Workers (aka Patient Navigators)
  - Cultural sensitivity training and matching
  - Extensive use of community resources
  - Use motivational interviewing techniques

Intervention Details

Engaging the providers

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 patients show up and be prepared for their visits
    - Chart “reminder” program
- Gaps in care reporting – paper and on the portal
- Experience delivering Pay-for-Performance programs

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Intervention Details

Multichannel engagement & transparency

Business Intelligence Tool: Program transparency for HHSC staff

- Access down to the individual patient level

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

- Bi-directional portal for sharing care plan and gaps in care

Patient Portal: Different engagement channel

- Suite of wellness tools and personalized action plans

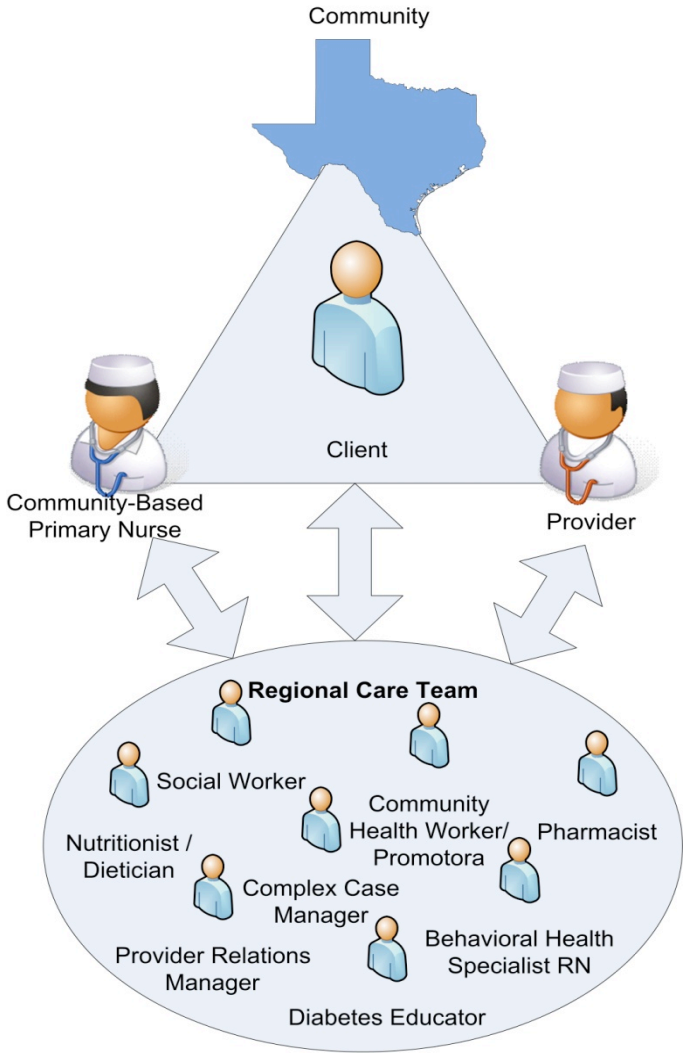
Regional Care Team Overview

Team Care Coordination

- At the core of the Wellness Program are the patients of the Regional Care Team
- There is a whole-person approach to care coordination among the patients of the Care Team
- The Community Based Primary Nurse (CBPN) directs the care of the patient among the various disciplines
- There is continuity of care both telephonically and in the home setting

Regional Care Teams

Multi-disciplinary Care Team Approach



- **Multi-disciplinary regional care team approach** – teams assigned to high volume practices in each region
- **Twenty-four teams** located across eleven high-impact geographic zones
- Three key relationships for each team
  - **Patients**
  - **Providers**
  - **Community Agencies**
- Regional teams **are led by the Community-Based Primary R.N.** and include the following team members to whom tasks are delegated:
  - Licensed Social Worker
  - Certified Community Health Worker/Promatora
  - Complex Case Manager, RN
  - Behavioral Health RN Specialist
- All provider interfacing staff are aligned by geography and assigned to large practices
  - Assist with patient care plans, real time referrals into the program
  - Assist with post-visit education
- **Hired locally** and trained to evidence-based best practices

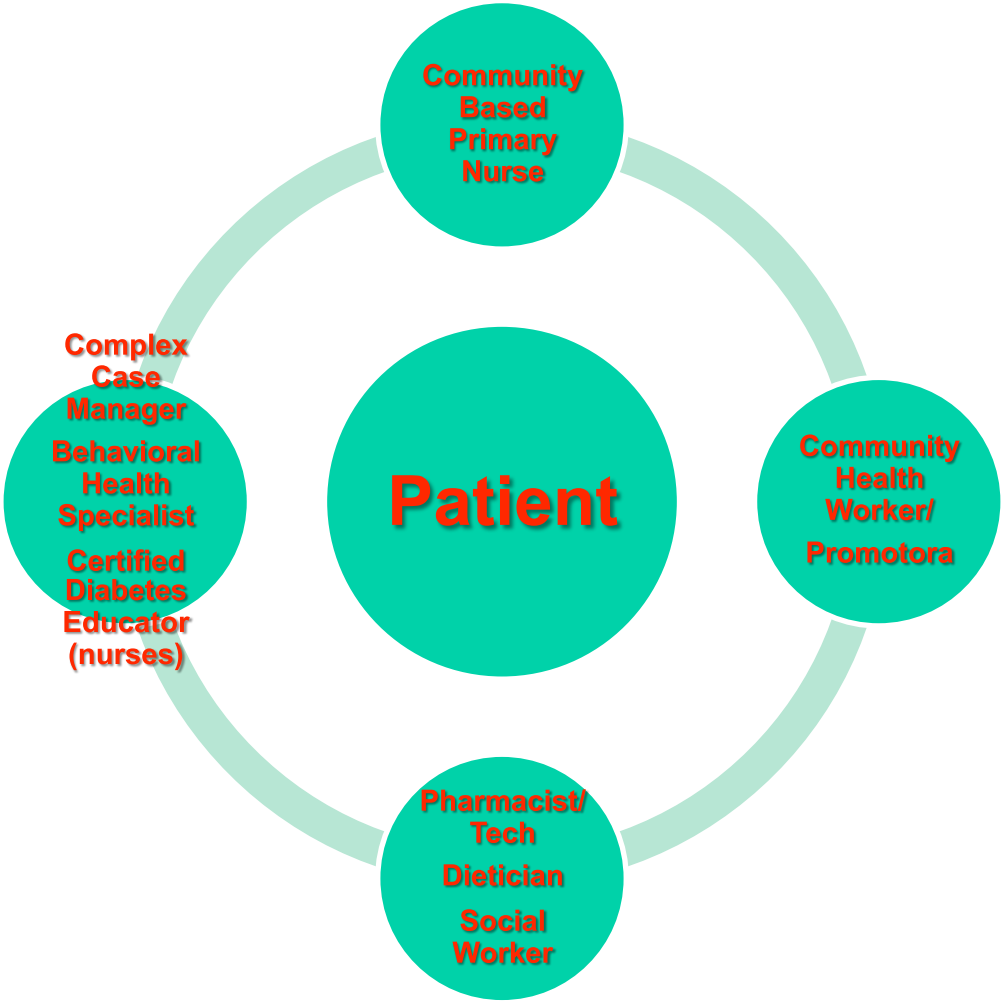
Regional Care Team Overview

Statewide Distribution

- 24 Care Teams across the state
- 24 Community-Based Primary Nurses (CBPN) coordinating care

Regional Care Team Overview

Multiple Specialists to Better Serve the patient



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Regional Care Team Overview

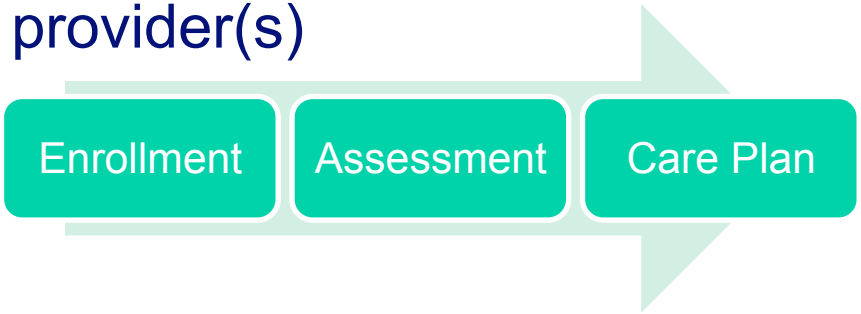
Defining Staff Roles

Title	Role
Community Based Primary Nurse (CBPN)	Lead Regional Care Teams, Primary Care Manager for all patients 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 patients around care plan and assist with meeting those goals, locate patients, educate about Medical Home, work with local organizations and provider practices
Health Resource Coordinator (HRC)	Staff patient and Provider phone lines, provides program information and resources, process real time referrals
Behavioral Health Specialist Nurse (BHS)	Assume primary nurse role for patients 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 patients with complex case management needs or resource referrals as needed, build working relationships with hospitals to help support discharge planning
Registered Dietician	Engage patients in nutritional education and healthy eating plans, referrals to Weight Watchers, coordinate with providers
Certified Diabetes Educator (CDE)	Assume primary nurse role for patients with dominant Diabetes conditions or act as consult for low risk as needed, coordinates care with Dietician support
Diabetes Supporting Instructors (DSI)	Support Diabetes Program, training of program sites, process referrals
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 patient completes his\her 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 patient education
- Patient'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 patient and the various provider(s)



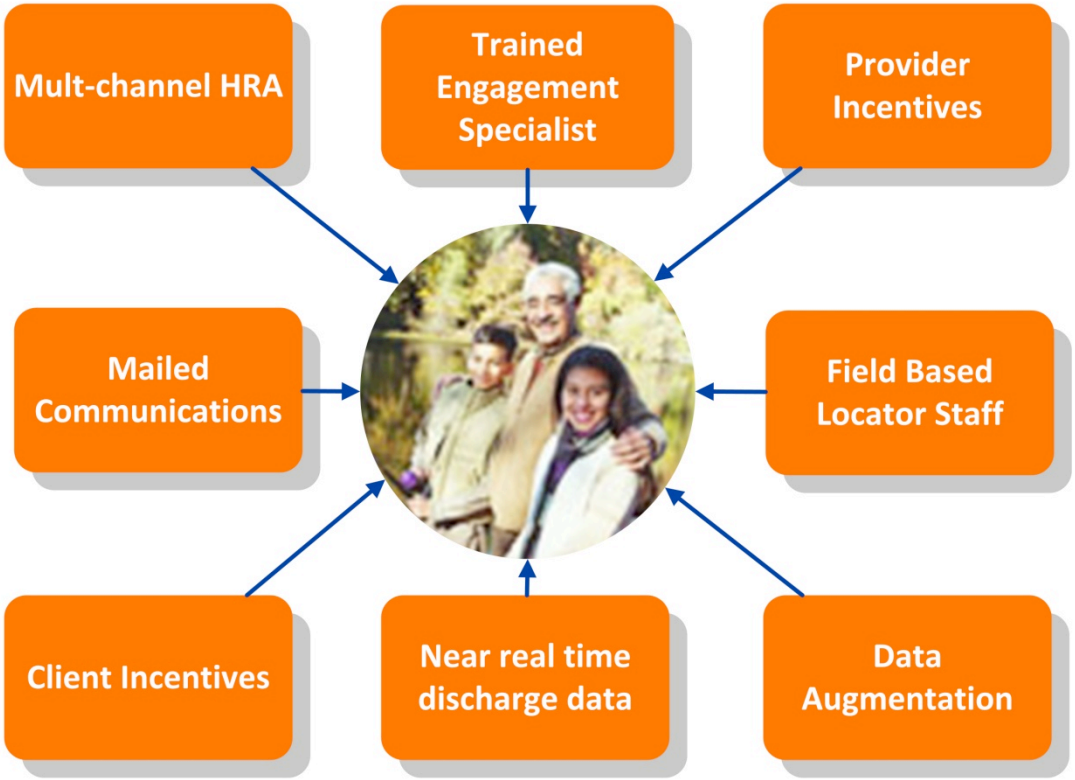
Regional Care Team Overview

Assessment and Coaching

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

Regional Care Team Overview

Patient Engagement



McKesson will maintain current client – RN relationships to maximize engagement

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Regional Care Team Overview

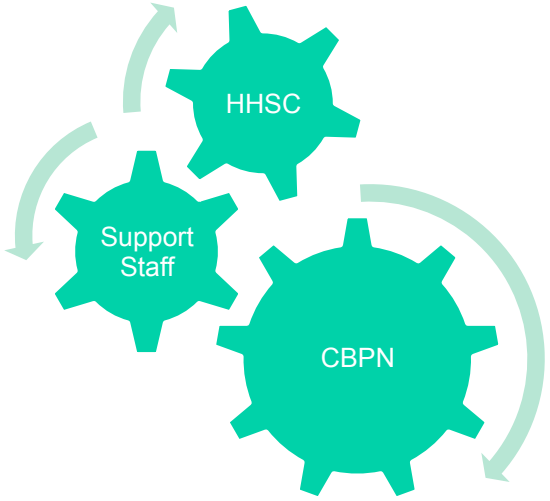
Patient Education

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

Regional Care Team Overview

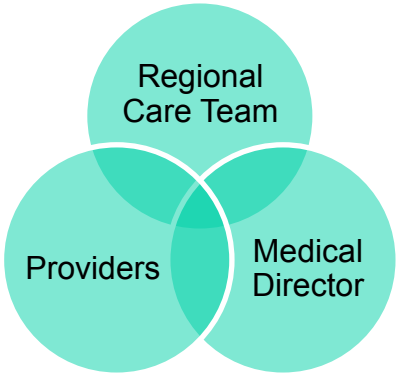
Coordination of Care

- The CBPN sends referrals to other partners of the Regional Care Team, when support is needed, such as to a Certified Asthma Educator
- Care Team discusses cases and holds internal care coordination meetings
- Care Team brings more complicated cases forward for discussion with HHSC in patient care coordination meetings



Regional Care Team Overview

Provider Engagement



- The Regional Care Team establishes relationships with local providers and practices
- The care team receives real-time-referrals into program
- The care team makes recommendations (e.g., from the pharmacist or dietician) and work closely with providers
- The care team discusses complex cases with program's Medical Director, first

Regional Care Team Overview

In the Community

- The Regional Care Team continues to gather local resources in the community
- The care team is informed of the most up-to-date program offerings
- The care team works closely with other vendors
- The care team works to get program information into the larger community

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Pay for Performance

Program Design

- The targeted providers
  - Statewide program
  - 10 or more eligible patients meeting high cost/high risk thresholds
  - 350 providers serving as primary care physicians/medical homes
  - Provider opportunity for additional reimbursement
  - Interactions based out of the Provider Portal

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Pay for Performance

Program Measures

Measure Name	Intent	Payment	Frequency
Enrollment & Endorsement	• Enroll in P4P • Endorse Texas Wellness Program • Encourage referrals • Complete survey	$150	Once
Patient demographics	• Contact information	$20	Per request
Care plan approval	• Review patient care plans • Sign-off on care plans • Encourage care plan comments	$20	Per request
E.G., Asthma controller medication	• Encourage best practice prescribing • Close clinical gap in care • Clinical measure with broad applicability	$20	Once per year

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Pay for Performance

Provider Experience

Awareness

- Direct mail awareness campaign to targeted providers

Enrollment Support

- Telephonic and face-to-face with Practice Support Facilitators
- Assistance with W-9, financial, and survey forms

Participation

- Provider portal for all P4P activities
- Direct deposit to provider's account

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Wellness Program

Asthma population rates as of 8/31/2011

Currently Identified for the Wellness Program

	Low Risk	Mod Risk	High Risk	Total
Under 18	1,455	5,934	26,296	33,685
Over 18	327	1,366	5,612	7,305
Total	1,782	7,300	31,908	40,990 *Asthma*

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Wellness Program

Asthma *population rates as of 8/31/2011**

Currently Active in the Wellness Program

	Low Risk	Mod Risk	High Risk	Total
Under 18	426	1,389	1,374	3,189
Over 18	84	259	315	658
Total	510	1,648	1,689	3,847* ***Asthma***

***Update: as of 10/1/11, 7,353 actively managed patients, so "asthma" more than half of all.**

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Population Based Utilization

Asthma-specific measures

Historical Claims-Based Outcomes from the Enhanced Care Program per 1000 patients

Utilization by Service Type	Baseline	Program to Date	% Difference
Asthma-related hospitalizations	**78.5**	**40.0**	**(49.1)**
Inpatient length of stay (days)	**4.9**	**4.8**	**(3.3%)**
Asthma-related re-hospitalizations 14 days or less	**1.2**	**0.2**	**(81.7%)**
Asthma-related re-hospitalizations 15-30 days	**1.5**	**0.6**	**(56.1%)**

* Claims-based measures calculated from all identified Enhance Care Program patients using reconciliation data, Program Period 6, Quarter 3

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Asthma Clinical Outcomes

*Self reported as of January 31, 2011**

Historical Self Reported Outcomes from the Enhanced Care Program

Indicator	Target goal or relative improvement	Initial Assessment	12 month Assessment	% Change
Action Plan	More than 60% reported having an action plan or 10% relative improvement at 1 year	13%	31%	138%
Annual Flu Vaccine	More than 55% reported receiving flu vaccine or 10% relative improvement at 1 year	46%	57%	24%

*Self-reported data, calculated from 5,955 actively managed patients

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Asthma Clinical Outcomes

*Self reported as of January 31, 2011**

Historical Self Reported Outcomes from the Enhanced Care Program

Indicator	Target goal or relative improvement	Initial Assessment	12 month Assessment	% Change
Limited Passive Smoke Exposure	More than 70% reported "no" routine exposure to passive smoke or 10% relative improvement at 1 year	65%	72%	11%
Rescue Inhaler	More than 65% reported having a rescue inhaler or 10% relative improvement at 1 year	89%	93%	4%

*Self-reported data, calculated from 5,955 actively managed patients

Example of Collaborative Efforts

School of Rural Public Health

- Dr. Genny Carrillo, Assistant Professor at Texas A&M Health Science Center School of Rural Public Health in McAllen, provides real time referrals for children with **Asthma** who are eligible for the Wellness Program.
- Referrals from 6 separate schools
- Known as the “Open Airways” program
- Since February 2011,
  - Total referrals: 88

Wellness Program

Success Stories: Community Based Primary Registered Nurse (CBPN)

- 13 y.o. girl was refusing to use her **Asthma** Controller ("Advair tasted bad"). She experienced frequent asthma exacerbations, emergency department utilization, and required daily treatments with a SABA via nebulizer.
- After frequent telephone contacts and an initial face-to-face visit in May by RN, she began to show improvement.
- By August, she was actively trying to avoid triggers and began taking her Asthma Controller more regularly, with obvious improvement.
- By October, she is regularly using her Asthma Controller and rarely needs her SABA treatments, though she keeps her SABA MDI with her in case she needs it for PE class. She walks to and from school and church. Allergy testing is planned for over Christmas break to identify any other triggers she should avoid.
- Education, disease management, and medication compliance has made a remarkable outcome in this teen.

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Population Based Utilization

COPD specific measures

Historical Claims Based Outcomes from the Enhanced Care Program per 1000

Utilization by Service Type	Baseline	Program to Date	% Difference
COPD-related hospitalizations	118.0	106.6	(9.7)
Inpatient length of stay (days)	5.3	4.9	(8.1)
COPD-related re-hospitalizations 14 days or less	2.6	3.3	28.0%
COPD-related re-hospitalizations 15-30 days	6.1	3.1	(49.4%)

*Claims-based measures calculated from all identified Enhance Care Program patients using reconciliation data, Program Period 6, Quarter 3

COPD Clinical Outcomes

*Self reported as of January 31, 2011**

Historical Self Reported Outcomes from the
Enhanced Care Program

Indicator	Target goal or relative improvement	Initial Assessment	12 month Assessment	% Change
Action Plan	**More than 60% reported having an action plan or 10% relative improvement at 1 year**	**9%**	**23%**	**156%**
Annual Flu Vaccine	**More than 55% reported receiving flu vaccine or 10% relative improvement at 1 year**	**43%**	**58%**	**35%**

*Self-reported data, calculated from 2,030 actively managed patients

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COPD Clinical Outcomes

*Self reported as of January 31, 2011**

Historical Self Reported Outcomes from the
Enhanced Care Program

Indicator	Target goal or relative improvement	Initial Assessment	12 month Assessment	% Change
Ever had Pneumonia Vaccine	More than 80% reported "yes" or 10% relative improvement at 1 year	45%	66%	47%
Early Recognition of COPD Exacerbation	More than 60% reported recognizing symptoms and taking appropriate action as Rx by their doctor or 10% relative improvement at 1 year	39%	60%	54%

*Self-reported data, calculated from 2,030 actively managed patients

Wellness Program

Success Stories:
Community Health Worker

- 55 y.o. female with HTN, bipolar disorder, and **COPD**. CBPN sent Community Health Worker (CHW) to locate patient; no telephone. CHW located and enrolled patient, then used her McK cellphone to do a 3-way call to CBPN for initial assessment.
- Once the initial assessment was completed the patient was transferred to Triage RN to discuss active complaints of dizziness and high blood pressure. The Triage RN determined that the patient was taking double doses of blood pressure medications. Triage recommended contacting PCP.
- The patient reported that she could not get an appointment with her provider until December. The CHW did a three-way call to PCP and was able to get acute instructions for the patient and an appointment within 2 days.
- The CHW also helped set up transportation and got her resources for a personal cellphone.

Wellness Program

Success Stories:
Complex Case Manager

- 63 y.o. Spanish-speaking male with **asthma**, **COPD**, diabetes, CAD, and HTN. He was unable to get in to see his PCP acutely at any time.

- CBPN sent a referral to CCM to assist with locating a new PCP and to acquire assistance in the home.

- CCM did a three-way call and helped locate and schedule an appointment for a new PCP and then worked with DADS to get provider services in the home. CCM also assisted with refilling patients medications which were running low.

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Wellness Program

Success Stories: Social Worker

- 62 y.o. male with diabetes, **COPD**, dyslipidemia, HTN, and CAD. He was called by CBPN and was upset, confused, and quietly frantic about his Medicaid and Social Security disability pension. He reported that he was told mid-month that he was going to lose all benefits and believed it was because of his wife's income. He and his wife had separated 6 months prior but cannot afford a divorce. He was worried about getting medications he needs. CBPN used office communicator software to instantly message Social Worker (SW) for an immediate consultation regarding the patient's situation and subsequently transferred the call to SW.
- SW made a 3-way call contacting the Social Security Administration and the Medicaid PCCM patient services line. Additional calls were made to the local SSI & HHSC offices. Continuation of the SSI disability pension was confirmed; the HHSC Case Worker reactivated the Medicaid.
- The patient was grateful for helping him find the answers, getting live people on the phone instead of recordings, getting his case worker to call him, etc. His anxiety about the situation was relieved and he went into the next month knowing that his social services issues were taken care of and he could re-focus on his health.

Wellness Program

Success Stories: Behavioral Health Specialist Nurse

- 50 y.o. female with CAD, **COPD**, **asthma**, depression and generalized anxiety disorder. The patient's behavioral health issues were negative influences on her physical health conditions. During the initial assessment in April 2011, the patient was very anxious and disorganized in her thought processes. During the interview, she was crying and laughing with shortness of breath and flights of ideas. The patient verbalized feelings of frustration and depression regarding a gastric bypass surgery in 2004 stating, "I had bleeding, pain, and got down to 97 lbs."
- The patient was not showing up for appointments with her PCP. Additionally, she was not taking her medications, as prescribed. Due to low energy, emotional issues, and pain, the patient was isolative. She only had contact with her mother who lived in Austin — 300+ miles away. The initial reminder and monitoring calls were focused on: the need to establish a behavioral health home; taking meds as prescribed; making and keeping appointments with her PCP; and self-management of anxiety.
- During a monitoring call in June, 2011, the patient stated: "I'm doing much better." The patient saw her PCP on scheduled visits. She attends weekly therapy sessions at the MHMR. The patient is taking medications as prescribed, including her antidepressant. The patient implemented the suggestions of asking her PCP for free samples and 90-day DME supplies. Her asthma and COPD are successfully managed with medications and self-management. She practices relaxed breathing and positive self-talk. The patient has gained 8 lbs since April. At the end of the call, the patient happily reported that she was going fishing with a new boyfriend.

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Wellness Program

Summary

- Contractor hired by the state to manage and coordinate care for chronically ill, complex Medicaid patients, including both children and adults
- Level of complexity triggers degree of intervention and menu of services offered
- Although not “disease-specific” anymore, both asthma and COPD are well-represented in the patient mix
- Developing program ideas:
  - Subcontracting for local Certified Asthma Educators
  - Working with local, regional, and statewide coalitions in order to educate both patients and providers (co-sponsoring, funding pilots, etc.)

Questions

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