MCKESSON

Health Care Guidance Program

Coordinating with you for better care!

Nevada Medicaid Partnering with Providers to Improve Patient Health

A Mandatory Health Program for Medicaid Recipients

CMO Quarterly Meeting

January 13, 2015

BUSINESS
CARE
CONNECTIVITY

CMO Quarterly Meeting Agenda

I. Welcome & Introductions
II. Quality Presentation
III. Provider Outreach Results
IV. Key Accomplishments
V. Lessons Learned
VI. New Business

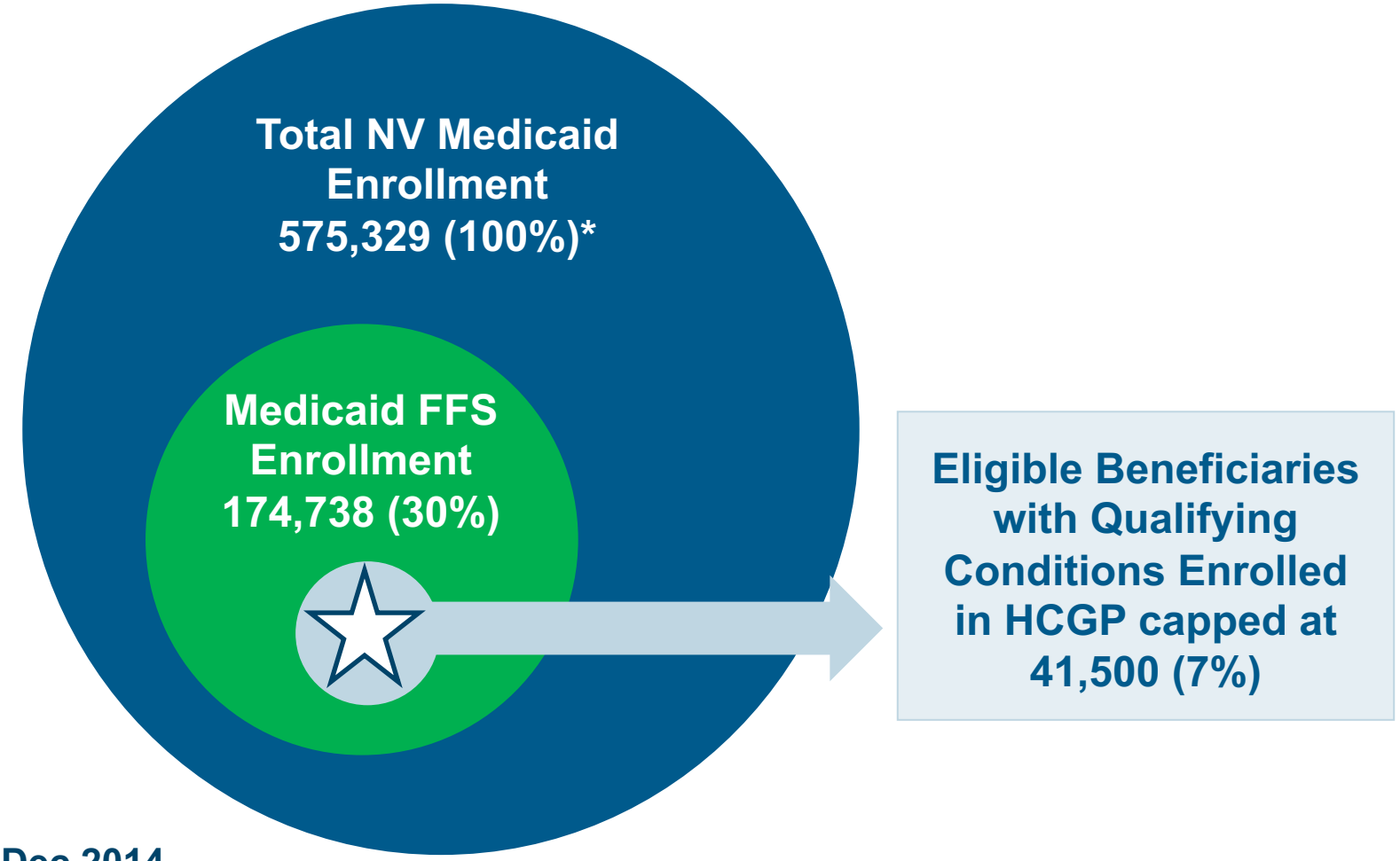
I. Welcome and Introductions

1:00 pm – 1:10 pm John Whaley, DHCFP

- Approval of previous meeting minutes 09/22/14
  - ***Note: Milliman presentation – to be scheduled for a future meeting***

Who is Eligible to Participate

The Health Care Guidance Program Serves…



*As of Dec 2014

II. Quality Presentation

1:10 pm – 2:00 pm

Goal 1: Provide care management to high-cost, high-need Medicaid beneficiaries who receive services on a FFS basis.

II. Quality Goal – Objective 1.1 – 1.4

Objective 1.1: Successfully enroll all Medicaid beneficiaries who qualify for the NCCW program.

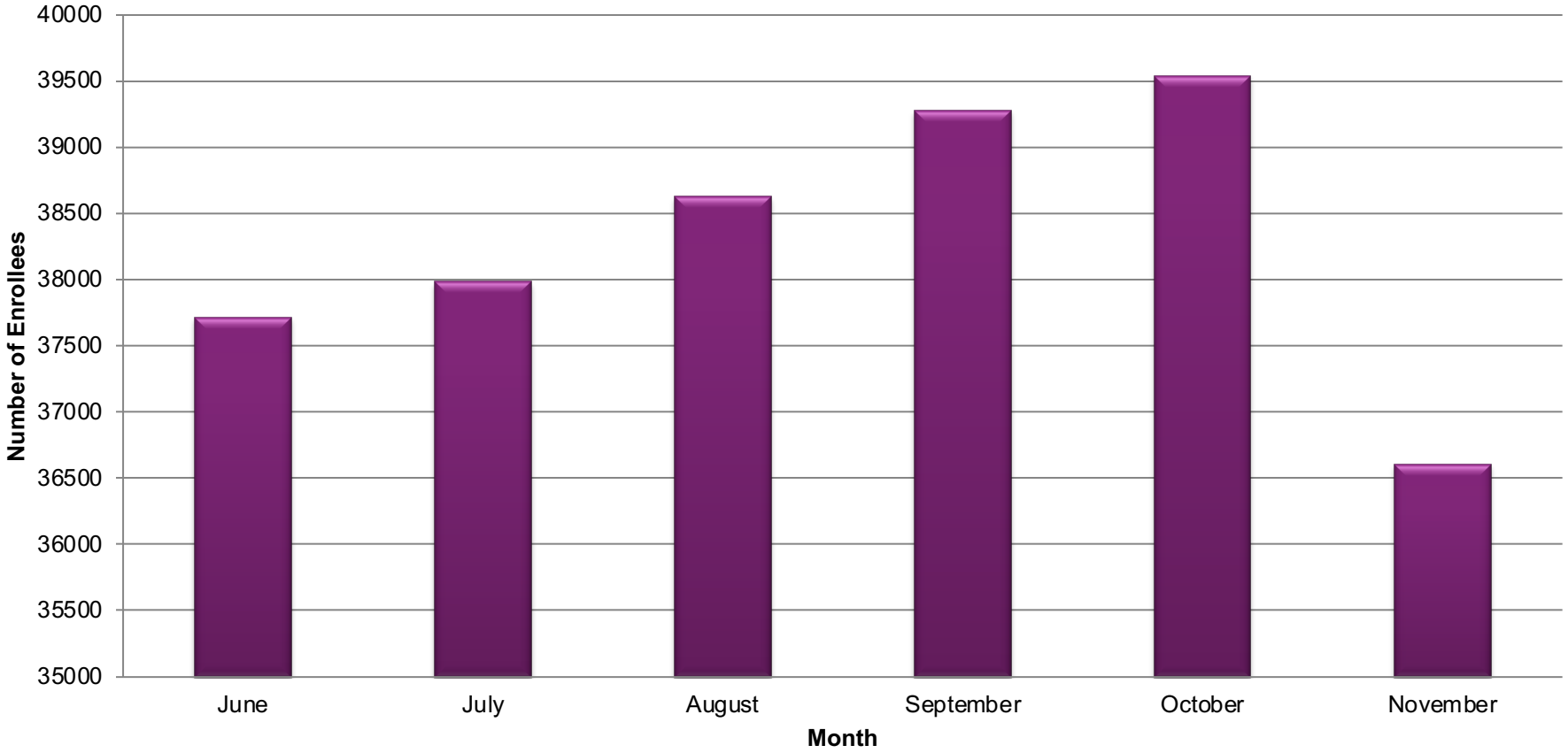
Objective 1.2: Stratify all enrollees into case management tier according to assessed needs.

Objective 1.3: Complete a comprehensive assessment of enrollees with complex or high risk needs.

Objective 1.4: Complete a comprehensive assessment of enrollees with moderate or low risk needs.

HCGP Enrollment, Stratification and Quality Data

Objective 1.1: Successfully enroll all Medicaid beneficiaries who qualify for the HealthCare Guidance Program

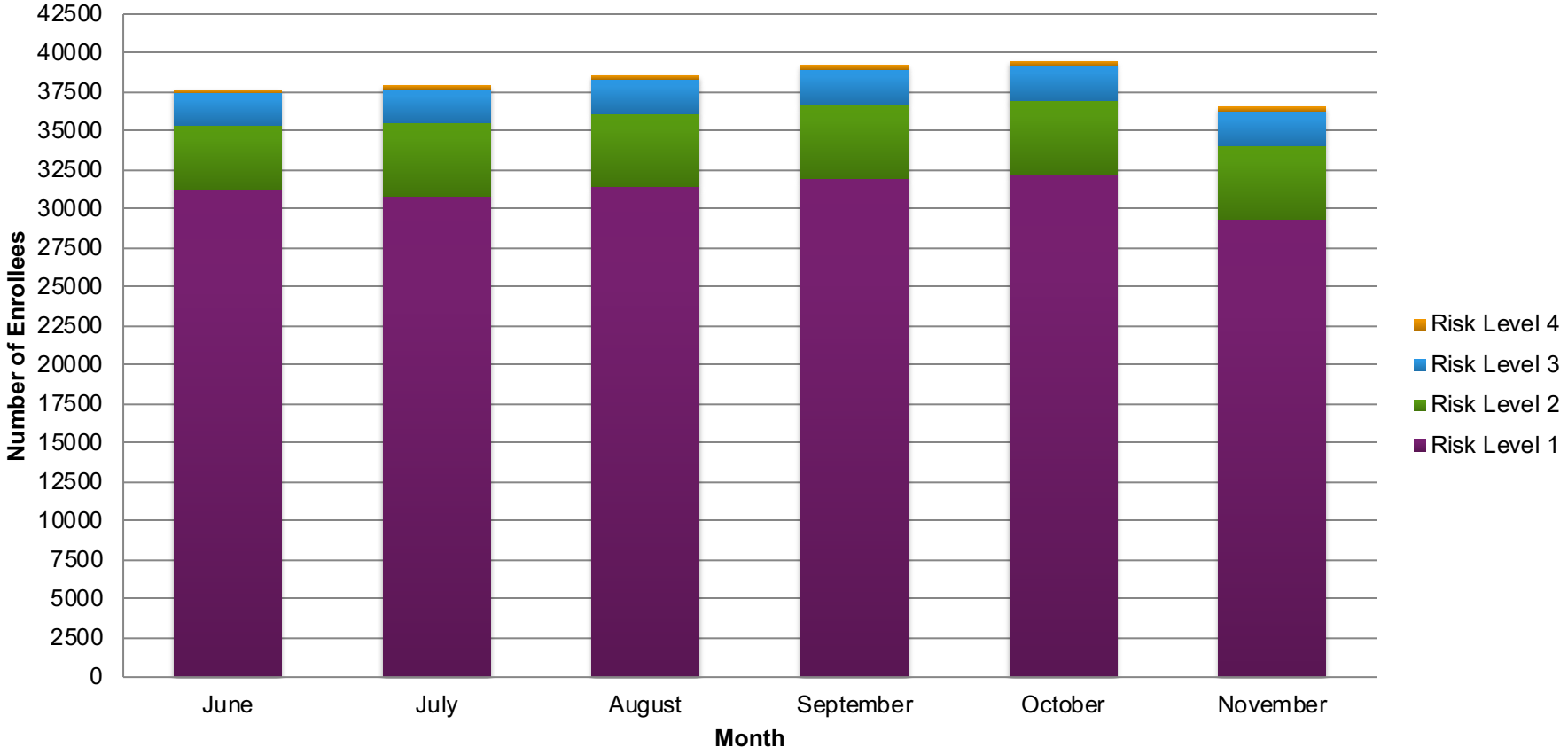


*November enrollment numbers impacted by TCM Population Procedure Memo and technical data loading error.

Source: NEV_Member_Program_Data_Set (June-November 2014)

HCGP Enrollment, Stratification and Quality Data

Objective 1.2: Stratify all enrollees into case management tier according to assessed needs



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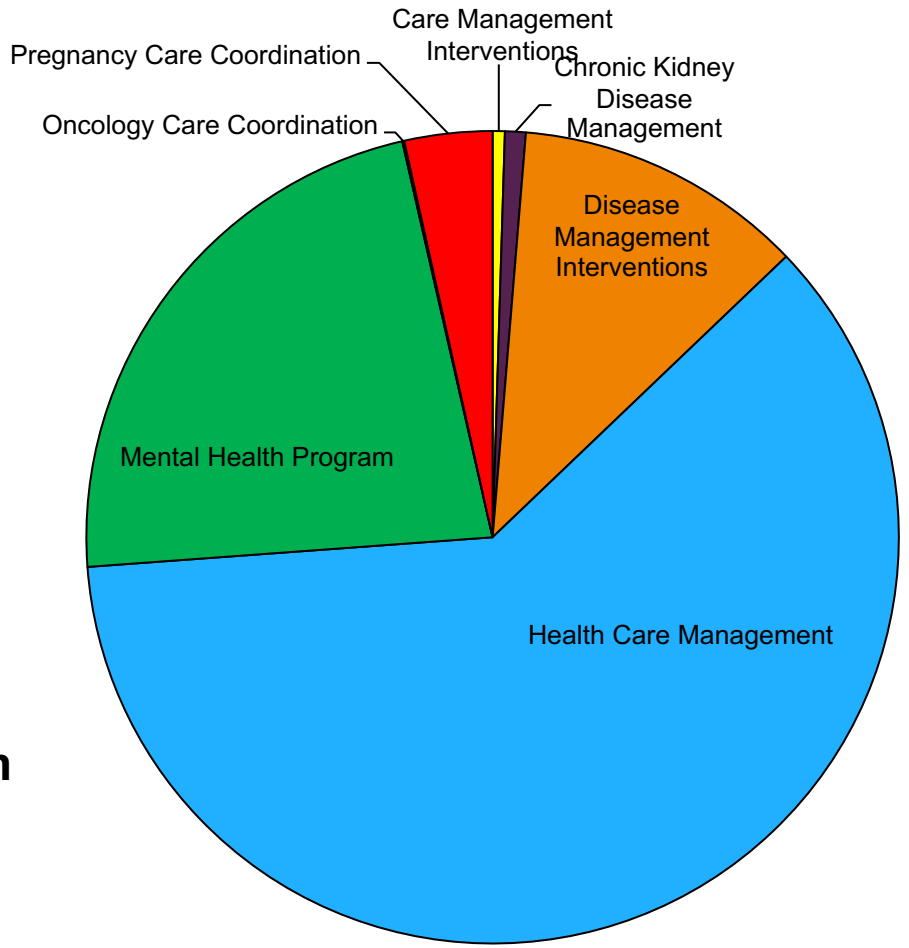
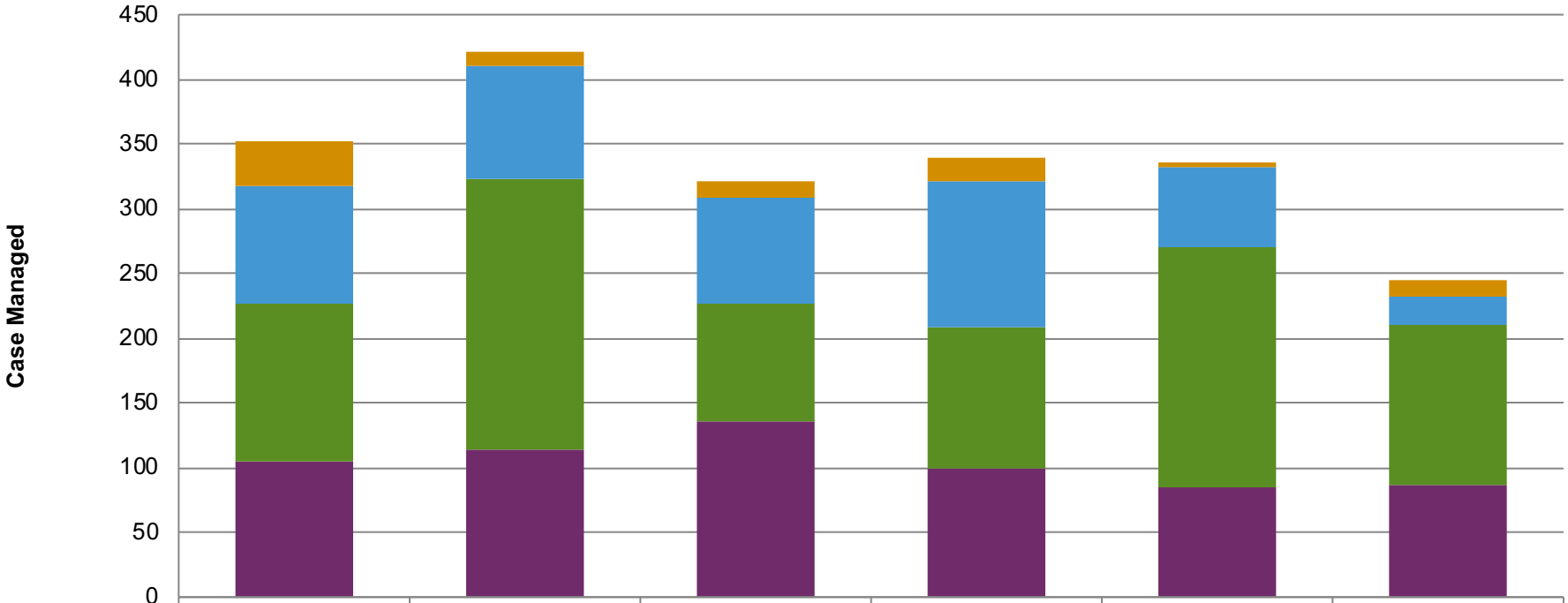


October 2014 Risk by Program
Total Enrolled 39,543

Source: NEV_Member_Program_Data_Set_October2014

HCGP Enrollment, Stratification and Quality Data

Objective 1.3 & 1.4: Complete a comprehensive assessment of enrollees



	June	July	August	September	October	November
Risk Level 4	35	10	13	18	4	13
Risk Level 3	90	88	82	113	61	22
Risk Level 2	122	209	91	109	186	123
Risk Level 1	105	114	135	100	85	87

Average Engagement Rate of 23%-24%

Source: NEV_Member_Program_Data_Set (June-November 2014)

I.5. Utilization of Primary and Outpatient Care

- Linking patients to primary and behavioral health homes
  - At launch, 80% enrollees linked via claims to any PCP or BHP
  - Revised methodology to improve quality of imputation results
  - In Dec 2014, 76% linked to active PCP and 57% to BHP (if BH issue)
- Real time referrals from providers received - June to Dec 2014:

	Jun	July	Aug	Sept	Oct	Nov	Dec	TOTAL
Real-Time Referral	0	9	11	32	114	107	141	412
Program Referral	0	1	0	1	0	2	0	4

- NAL redirection from ED intent to lower level of care (OP, PCP, UC)

  - 63% in June – Aug; 74% in Sept – Nov

- Elements being tracked for annual utilization report include:

  - Inpatient, ED and outpatient visit and readmission rates

  - Total, Rx and PMPM costs

III. Provider Outreach Results

2:00 pm – 2:40 pm

A. Clinical Education and Program Information

B. Behavioral Health Services Update

C. Provider Advisory Board

A. Clinical Education and Program Information

- Directly Interfacing with Hospitals
  - Engaged and educated facility leadership to optimize care and transitions
  - Confirmed process to communicate discharge information and follow up needs
- Actively Reaching Providers
  - Broad face-to-face and Teleconference communication since launch
  - Written program materials and post-assessments provided via mail, email, fax, and portal
  - Provider Outreach Contact (POC) tracking report – engagement level and activity
- Promoting Relevant Education
  - Primary care, behavioral health and community health conferences and public forums
  - ECHO conferences for rural and frontier clinics
  - Interdisciplinary and training rounds in urban Washoe and Clark counties
- Improving Communication and Coordination of Care
  - Of 1344 NV Medicaid PCPs, 497 (37%) have seen at least one HCGP enrollee
  - Collaborating with practice care managers to better integrate services
  - Developing newsletter to inform/educate about top most prevalent conditions

B. Behavioral Health Services Update

- Collaboration with ValueOptions Behavioral Health & Wellness
- Utilize Nevada-based staff to provide care management services
  - 28% of HCGP enrollees identified with leading behavioral health condition
- Multi-disciplinary team composition:
  - Clinical Social Workers and Psychiatric Registered Nurses
  - Psychiatrist Medical Director
  - Specialists
  - Pharmacist
- Engaged with local providers and stakeholders:
  - Community Mental Health Agencies
  - Private and Public Hospitals and Emergency Departments
  - Government & State Agencies (NNAMHS, SNAMHS, Rural Counseling Centers)
  - Others providing non-medical/basic needs support (i.e., food, transportation, housing, financial resources, education, etc.)

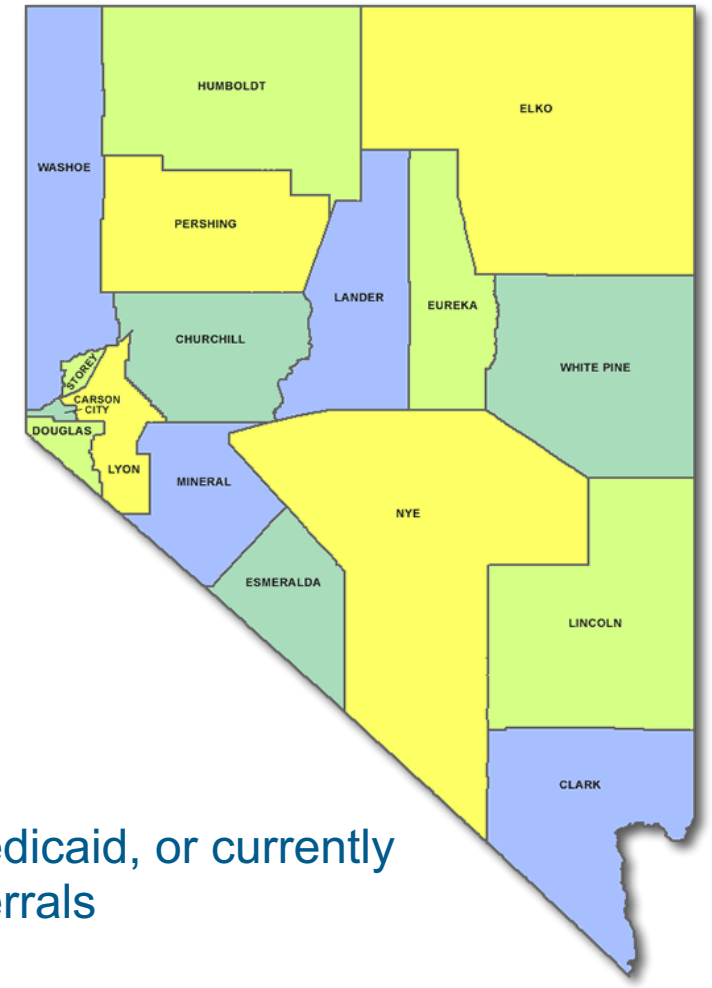
Key Behavioral Health Benefits and Support

- Licensed professionals with knowledge, training & experience
- Monitor and report clinical care gaps to providers
- Weekly case consultation with local board certified psychiatrist
- Behavioral health assessments
- Peer coaching
- Non-discriminatory interventions
- Training in effective listening skills and engagement strategies
- Familiar and engaged with local Nevada providers
- Provide BH resources and health information (i.e., Achieve Solutions)

Behavioral Health Provider Access and Availability

As of Dec 2014, actively participating* FFS Medicaid providers include:

- 21 Psychiatric Physicians
- 17 Inpatient Psychiatric Facilities
- 16 Outpatient PHP/IOP Providers
- 17 Medical Detox/SUD Treatment
- 16 DPBH Rural Counseling Centers



*Includes those currently accepting FFS Medicaid, or currently managing some FFS but closed to new referrals

Case Studies

McKESSON

Health Care Guidance Program

Coordinating with you for better care!

Gender **[F]**
Age **[49]**
Speaks **[English]**
Risk Score **[H]**

Conditions:

[Poly-Substance Abuse, Schizophrenia, Seizure Disorder, Diabetes, Hypertension, Dyslipidemia, GERD, Disc Degeneration/ Cervical Disorder, Spinal Stenosis]

Care Plan Issues

- Pattern of non-compliance with psychotropic meds due to mistrust of providers
- History of aggression when not taking meds
- Refusal to see psychiatrist in her community
- Transportation barriers
- Background multiple traumas and loss
- Stand-offish, reluctant to engage with HCGP staff

Interventions

- In home visit with coaching
- Provided assistance with finding an acceptable provider
- Attended local meeting with member's primary support
- Assisted with transport arrangements
- Provided medication education
- Gave resources for social, MH and bereavement support

Outcomes

- Member confirmed and kept visit with new provider and reported to be happy with new relationship
- Engaging with HCGP staff
- Willing to apply suggested social, emotional and physical interventions
- Adherent to medication and provider treatment plan

Impact: Effective clinical relationship and medication compliance reduce risks and costs

Case Studies

McKESSON

Gender [M]
Age [49]
Speaks [English]
Risk Score [M]

Conditions:
[Substance Abuse, Depression, Paranoia, Schizo-Affective Disorder, Developmental Disability, Diabetes Chronic Fatigue Syndrome, COPD, Asthma, Bronchitis]

Health Care Guidance Program

Coordinating with you for better care!

Care Plan Issues

- Multiple chronic physical and behavioral health conditions
- Avoiding behavioral health and PCP visits
- Signs of major depression and mood instability
- Limited intellectual capacity
- Anorexia with snacking on poor nutrition foods complicating diabetes
- Minimizing symptoms

Interventions

- Provided coaching calls
- Assisted in keeping visits with providers
- Secured nutritional and exercise resources
- Wrapped in family support
- Promoted ways to decrease isolation and paranoia
- Referred to BH Basic Skills Training (BST) services

Outcomes

- Improved nutrition intake
- Stabilized physical and behavioral health issues
- Increased motivation
- Established adherence with medications and keeping provider visits
- Demonstrating willingness to ask for help and weekly task and goal-setting
- Engaged family to provide reliable support

Impact: Improved self-efficacy, care compliance and social support drive health & lower costs

C. Provider Advisory Board

2:00 pm – 2:40 pm

- Recruited provider members from June through September 2014
  - Represent diverse specialties, locations and affiliations
- First meeting held October 28, 2014, via teleconference
  - Introduced members and reviewed charter
  - Presented overview of program goals and clinical guidelines
- Next meeting scheduled January 28, 2015, to be held in Henderson
  - To discuss BH services, care guidelines and resources
  - To inform members on Medicaid updates and legislative issues
  - To share information about Touro Univ clinical training and services

IV. Key Accomplishments

- **Making a Difference**
  - Feedback from beneficiaries
  - Feedback from providers and community partners

- **Serving DHCFP**
  - Strengthening client trust as agent and resource
  - Provided feedback from the field
  - Extended awareness of NV State Medicaid

- **Leveraged Nevada-based staff**
  - Created program awareness across Nevada
  - Promoted local community and beneficiary trust
  - Developed processes to ensure program success

What our Beneficiaries and Providers are saying…

"I have really have enjoyed this program and the support it provided me during this pregnancy. All of my children are now enrolled into WIC. All of my questions have been answered and it was like having a friend to talk to with my questions."
- Beneficiary

"This mother is excited that the "Little Miss Hannah" Grant was arranged for them, they came through with a hospital bed for free, her daughter is now getting occupational therapy for the first time in her life."
- Primary Care Provider

"Thank you so much for helping with this [wheelchair]. I am so glad our patients have the Health Care Guidance Program to help them now."
– Referring Provider

"I really appreciate what you're doing. It keeps me on track when you're calling me and helping me to push myself on the things I need to do for my son."
- Mother of Beneficiary

IV. Key Accomplishments (Continued)

- **Engaged in 6-month audit (in process/pending final results)**
  - •Addressing opportunities for improvement
  - •Aligning regional care teams to hospitals and outpatient sites
- **Collaborated with DHCFP to refine data and processing**
  - •Clarified TCM process
  - •Incorporated EDC file receipt
- **Engaged Providers and Community Stakeholders**
  - •Encouraged real time referrals, including notice of pregnancy
  - •Discussed focus on clinical quality, linking to care and transitions
  - •Positive public comment/feedback at October's Public Workshop
- **Updating community resource list in an ongoing basis**
  - • Better meeting beneficiary clinical and social needs

Top 10 Issues Impacting Access, Quality & Value

1. Assistance for developmental disability
2. Assistance for functional impairment
3. Assistance for visual impairment
4. Assistance for speech impairment

Functional needs

5. Assistance in food security

Basic needs

6. Securing a medical home, PCP or appointment
7. Post-discharge reinforcement of discharge plan
8. No current influenza vaccination
9. Daily ASA not prescribed
10. Counseling on improving physical activity

Clinical/ lifestyle needs

Top 10 Gaps in Care Identified Since Launch

1. Colorectal Cancer Screening
2. Pap Smear (periodic exam)
3. Screening Mammogram

Cancer screening

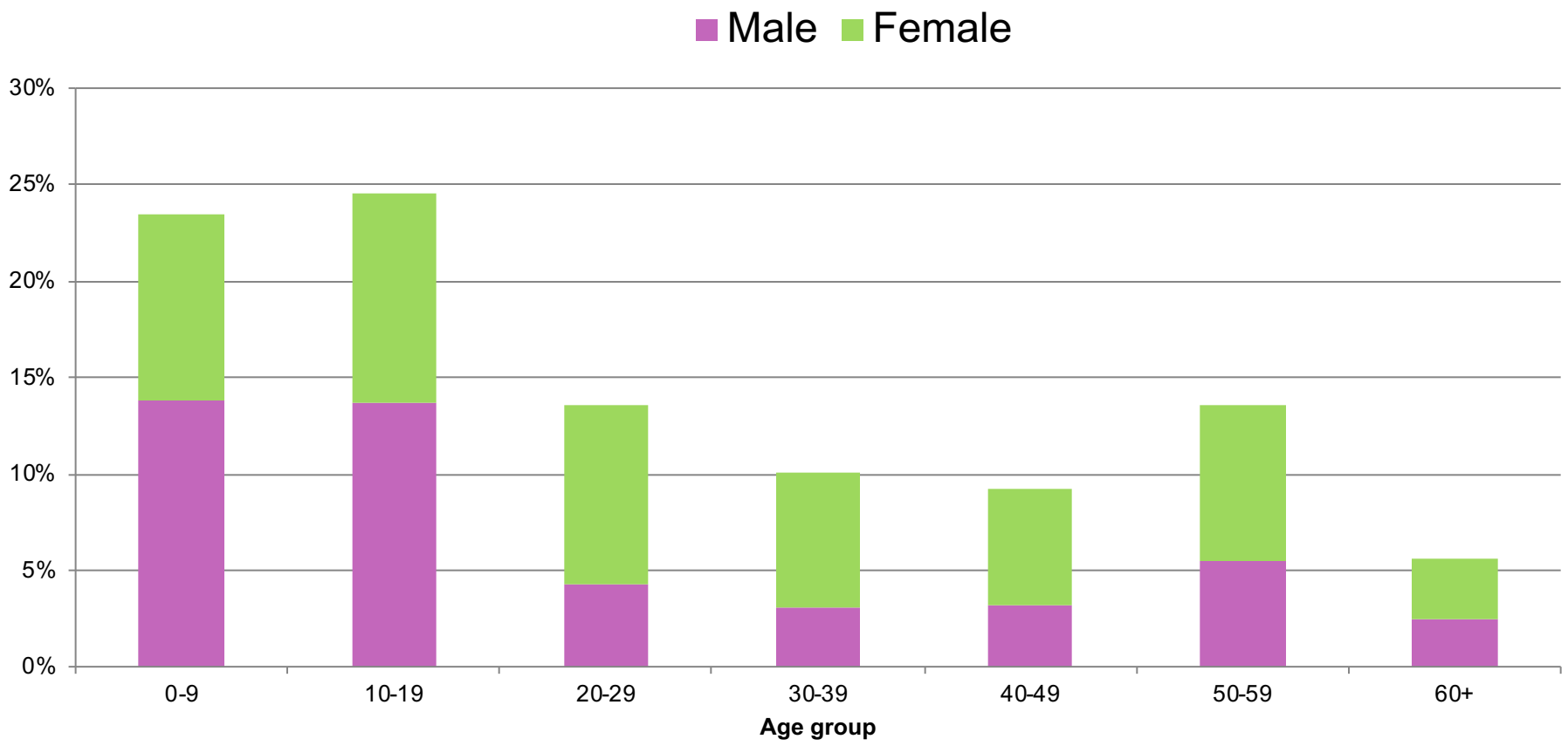
4. Aspirin Anti-platelet (Diabetic med protocol)
5. Aspirin Anti-platelet (CAD med protocol)
6. Eye Exam (annual Diabetic eye exam)

Chronic Disease Management

7. Antidepressant (Medication compliance)
8. Bipolar Medication (Medication compliance)
9. Follow up care (follow up for depression)
10. Follow up care (follow-up for bipolar diagnosis)

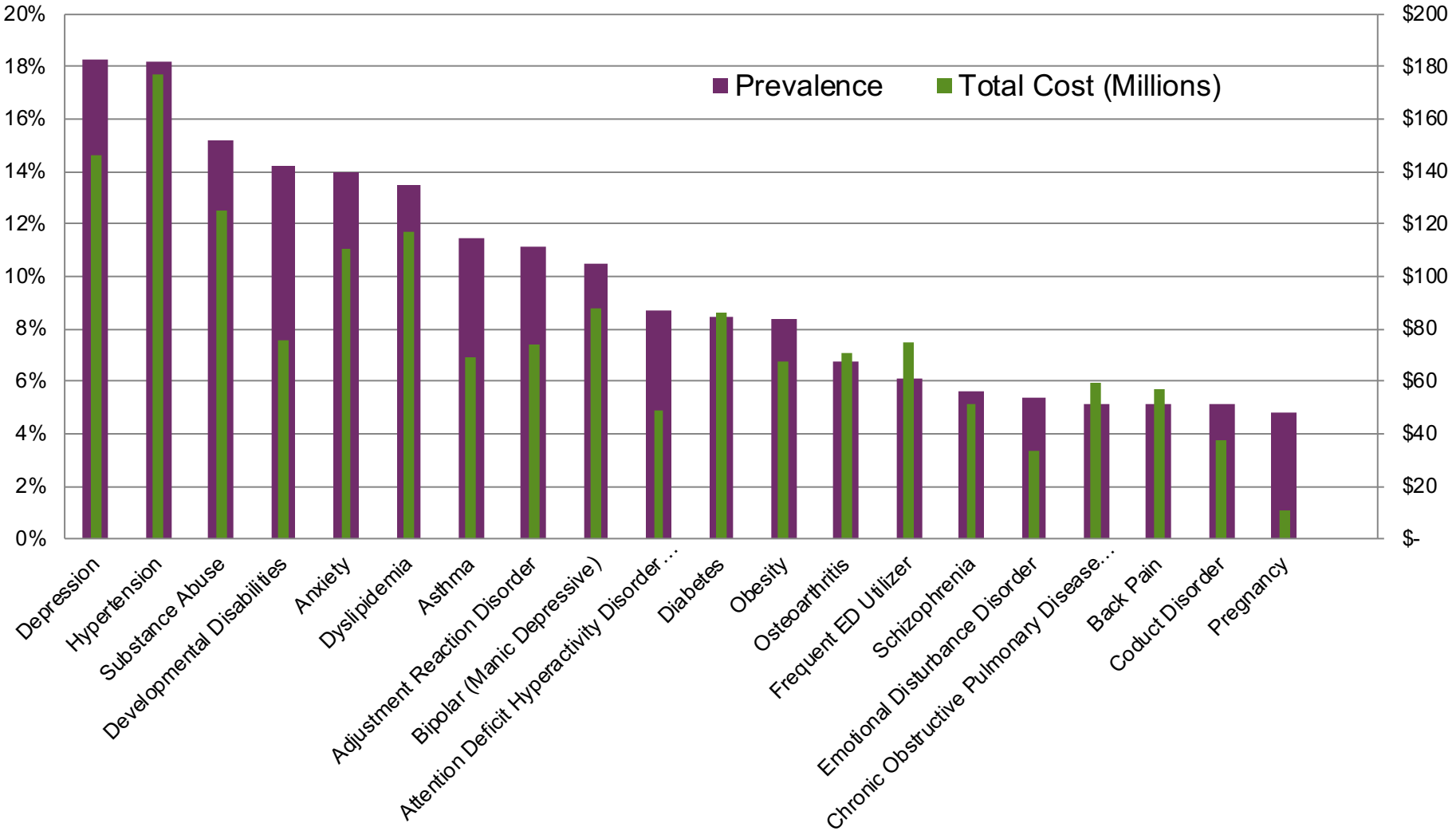
Behavioral Health Management

Gender Distribution by Age Group among HCGP Enrollees



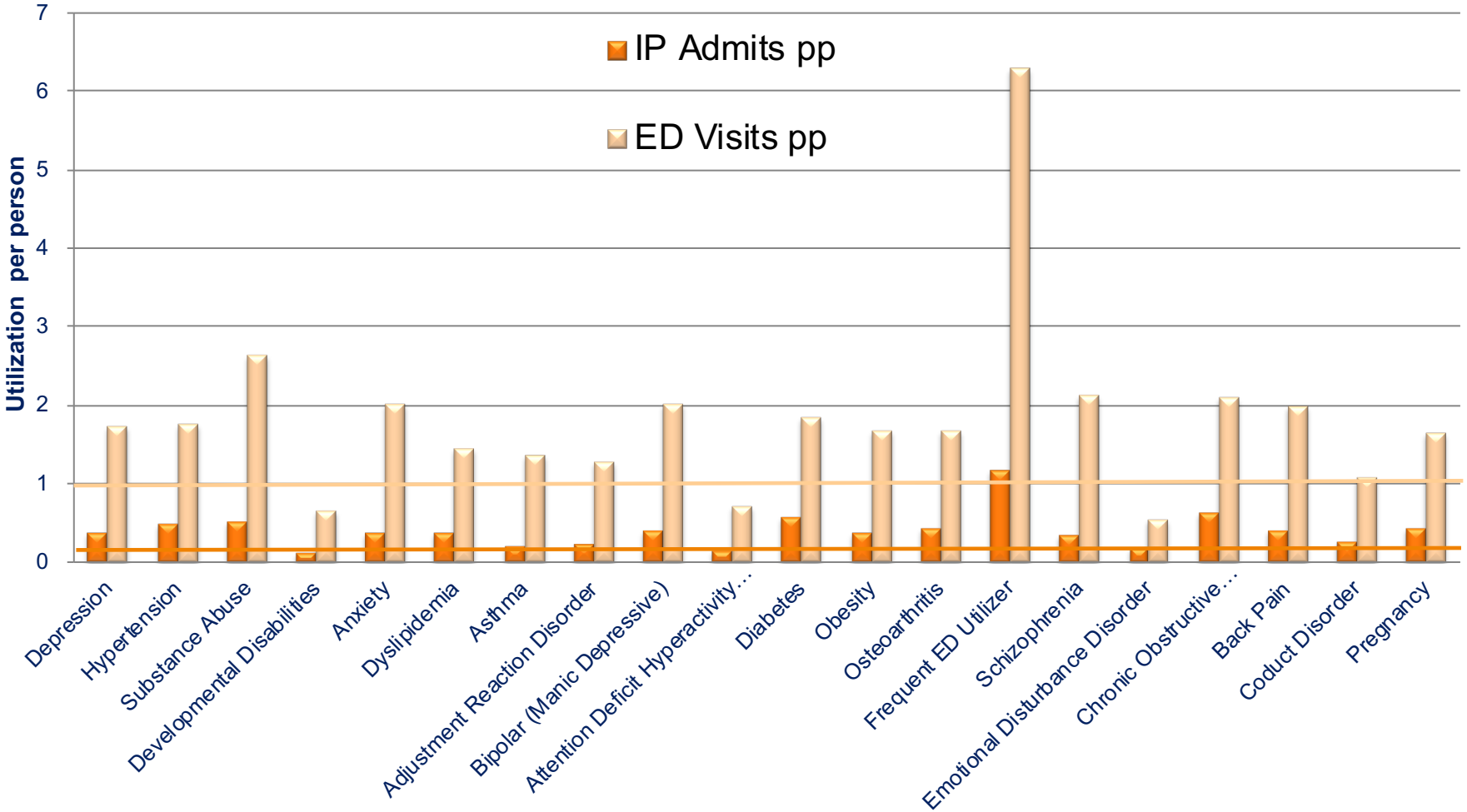
Source: MCK Population Profiler

Prevalence and Total Cost of Top 20 Leading Conditions



Source: MCK Population Profiler

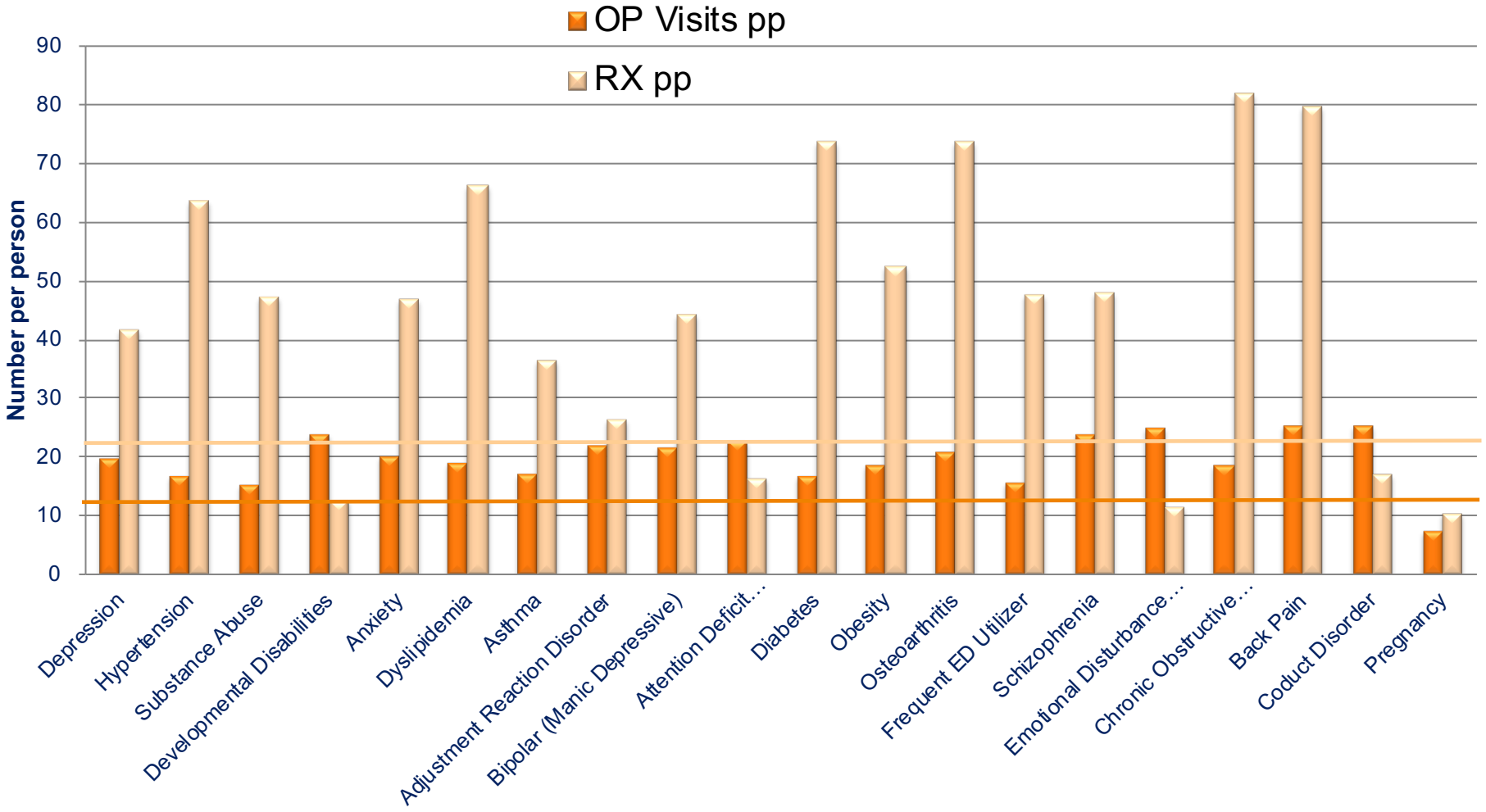
Annual IP and ED Utilization of Top 20 Leading Conditions



HCGP overall annual IP Admits = 0.2 admits per person and ED Visits = 1.0 per person

Source: MCK Population Profiler

Annual Outpatient and Rx Use Among Top 20 Conditions



HCGP overall annual OP visits = 12.3 visits per person and Rx = 22.4 scripts per person

Source: MCK Population Profiler

Pregnancy Enrollment

3:10 pm – 3:55 pm

Monthly Process to Identify:

- Claims diagnoses, EDC file receipt and Real Time Referrals

Newly enrolled to Medicaid:

- Medicaid enrollment averages 45 days
- Presumptive eligibility anticipated through hospitals

Clinical assessment and stratification:

- Maternal age, prior high risk pregnancy, pre-natal visits
- Presence or history of other conditions (poor outcome, diabetes, blood disorders, auto-immune disease, seizures, etc)

Case Update – *Enrolled July 2014*

Gender **[M]**
Age **[25]**
Speaks **[English]**
Risk Score **[H]**

Conditions: **[Diabetes, Gastroparesis, Depression, Recurrent hospital admissions]**

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Care Plan Issues

- Multiple hospital admissions
- Actively engaged with DM and BH case managers
- Ongoing gastroparesis (slow gut emptying) with poorly controlled blood sugars

Interventions

- Face to face meeting with CM while in hospital
- CM accompanied patient to endocrine follow up
- Meeting with providers and patient

Outcomes

- Insulin changed and trial of gastric stimulator requested
- Strengthened patient and provider relationship
- Avoided one re-hospitalization
- Accompany member to appointments

Impact: Supported adherence to care plan and reduced readmission risk

12/19/2014: Initially, no readmission for 16 weeks. Medical issues necessitated admission in Oct and Dec 2014. Gastric stimulator trial denied. DM CM coordinating with member and treating providers, and visited during hospitalization; SW CM supporting member's emotional health. Follow up scheduled in January 2015.

Case Update – *Enrolled August 2014*

Gender **[F, F]**
Age **[8, 42]**
Speaks **[Thai]**
Risk Score **[L, L]**

Conditions: **[Child - ADHD, Anxiety Disorder, Overweight; Mother – MH issues, Diabetes]**

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Care Plan Issues

- CHW visited home to enroll 8 year old beneficiary
- Serious MH concerns with mother identified during visit
- Information on mother and other siblings obtained

Interventions

- Researched family members for criteria to enroll in HCGP
- Facilitated enrollment of mother and child
- Initiated collaboration with mental health providers

Outcomes

- Mother actively engaged with program CM staff
- Mom states "CHW is her angel "
- Linking beneficiaries to primary and BH providers

Impact: Linked beneficiaries to necessary care; prevented higher level of care

1/6/2015: Mother keeping appointments, adhering to treatment plan, establishing with new PCP, utilizing transportation services, and accessing HCGP's nurse advice, disease management and psychosocial services. Child active in BH care and participating in school. Follow up planned in January 2015.

Case Update – *Initial Contact Aug 2014*

Gender **[F]**
Age **[61]**
Speaks **[Spanish]**
Risk Score **[H]**

Conditions: **[Diabetes, Chronic Kidney Disease on Dialysis, Hypertension, Dyslipidemia, wheel-chair dependent]**

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Care Plan Issues

- Member initially declined participation in August
- CHW made face to face visit
- Member enrolled in Dec 2014
- Poorly controlled diet, blood sugar, blood pressure and lipids

Interventions

- Collaborating with PCP, social worker and dietitian
- Promoting team-based care
- Language-appropriate education on diet, Rx and lab values related to conditions

Outcomes

- Secured DME needs such as car lift and shower chair
- Providing personal support for diet/treatment adherence
- Receiving PCA 2 hrs/week
- Engaged with Logisticare for medical visit transport needs

Impact: Successfully engaged high risk beneficiary

1/2/2015: This non-English speaking, non-ambulatory beneficiary resides with her caregiver daughter and two toddler grandchildren. Despite her initial refusal to participate, a home visit effectively engaged this individual with the HCGP where she is learning skills and accessing resources to better manage multiple chronic health conditions.

Focus for January, February and March

- Implement ongoing strategies to increase engagement
- Work with DHCFP to provide context, information and data points to highlight program in the upcoming legislative session
- Ongoing evaluation of “Population Profiler” to target prevalent conditions and increase quality for provider education and staff interventions
- Deploy creative community-outreach strategies to increase face-to-face
- Final approval of Readiness Review items and address Audit opportunities
- Maintain support of Medicaid providers in their continuing care of fee for service participants.

V. New Business

3:55 pm – 4:00 pm

Next meeting topics

Questions?

BUSINESS
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CONNECTIVITY