



Comprehensive Care Management Program



The ValueOptions Comprehensive Care Management Program:

ValueOptions has partnered with McKesson Health Solutions, a leading healthcare services and technology company, to develop and deliver fully integrated physical and behavioral health care management services. Our model achieves better outcomes than those models focused singularly on “disease management” or “chronic care management.” Our comprehensive care management model takes a whole person view, delivering a suite of services that addresses the specific needs of each individual and supports better health for those with complex conditions through robust physical and behavioral healthcare coordination. Our comprehensive care management design is rooted in the strengths of each organization, as well as in an unmatched understanding of and expertise in serving high-risk individuals. This improved care coordination helps reduce long-term care spending, unnecessary emergency room visits, and lower hospitalization rates.

Key Features of Our Approach:

Key features contributing to the success of our comprehensive care management programs include:

- **A seamless healthcare management system** that combines McKesson and ValueOptions functionality and offers an array of benefits to payers that include:
 - An integrated patient record that provides a comprehensive, single-view of the individual, helps identify gaps in care, and provides more thoughtful care coordination
 - A private, secure cloud deployment accessible through single sign-on by health plan staff, providers, McKesson or ValueOptions users, and even the individual, to improve care plan development and team communication
 - Actionable, integrated data analytics—mobile device enabled—to better evaluate care management trends and track outcomes across the whole health spectrum
- **A data-driven and outcomes-based approach** that uses data to drive identification and outreach activities. Data further informs program development efforts and quality improvement initiatives on an ongoing basis. This includes:
 - rich, predictive modeling and risk stratification capability that helps payers to more effectively stratify high-risk comorbid populations and deliver effective health improvement interventions
 - use of predictive modeling
 - use of health risk assessments and provider care plans (through electronic provider portals) claims analysis, Geo mapping, surveys, and call/outreach statistics to continually inform and improve the care management program.

- **A locally based clinical and multi-disciplinary approach** that recognizes that individuals have myriad needs beyond just their “health care.” Care teams include medical, behavioral, and pharmacy professionals in addition to social workers, peer support workers, lay health educators, and community health specialists. Our care teams assist with the transition of individuals from one care setting to another, such as hospitals to facilities for follow-up care, home or end of life services. Specialized Care Managers follow individuals through a network of providers, identifying opportunities for improving care and reducing cost. Registered nurses help to reduce emergency room visits by redirecting individuals to the appropriate level of care. Social workers and peer support specialists engage each individual to ensure their complete psychosocial and emotional needs are met and that local systems of care are accessed. These diverse and specialized teams, comprehensively “wrap services around” the individual.
- **A member engagement strategy** that meets individuals where they are. This approach recognizes the barriers associated with outreaching to individuals, engaging them in their healthcare plan, and the importance of individual-accepted goals. The approach ensures access to appropriate treatment and resources. Our multiple and varied methods for engagement include:
 - regular member outreach and education through mobile technology and direct mail
 - field-based care managers, lay health educators, and community health workers meeting face-to-face with individuals
 - “no wrong door” referral policy and process
 - a member-centric and person-centered delivery that is culturally and linguistically appropriate and keeps the member at the center of care planning and delivery.
- **A provider engagement strategy** that recognizes and values the provider as a critical member of the care plan team. We provide the resources, training, and information about their patients they need to engage to most effectively impact care and improve outcomes. Additionally, we partner with them to successfully address and align the care coordination and care management activities that must occur outside of the clinical setting.
- **A community engagement strategy** that embraces both individual and population change. We partner with community supports such as peer run organizations, churches, schools, universities, and local governments to provide education, training, research and outreach—all further supporting individuals in achieving better health.

Our Unparalleled Experience:

Our programs emphasize self-management support, evidenced-based treatments, and incentives to shift the delivery system design away from a reactive acute care management model and towards preventive strategies. Through our work in other programs operated by ValueOptions and McKesson, our combined experience is unparalleled in the delivery of integrated care management services to high-cost, high-risk co-morbid populations. Some examples include:

Program Description	
Connecticut “Co-Morbid Care Management Program”	Early in 2011, ValueOptions was re-awarded the statewide contract to manage care for 500,000 Medicaid individuals of the Behavioral Health Program of Connecticut. Partnering with McKesson Health Solutions, we implemented a program as of September 2011 with 300 individuals served. In January 2012, the State expanded the pilot by adding an additional 900 individuals. This pilot is being reviewed by the state as a potential model for expansion of the seriously mentally ill health home initiative current underway.
New York “Chronic Illness Demonstration Programs (CIDP)”	Operating since August 1, 2009, these demonstration projects are a unique collaboration of ValueOptions and New York City and Nassau County-based not-for-profit, multi-service organizations, voluntary and public hospital systems and federally qualified health centers (FQHCs). ValueOptions and these community partners have effectively integrated their respective strengths and experiences to create an innovative model for the management of multiple chronic illnesses in a low-income, disenfranchised target population.
Illinois “Your Healthcare Plus™ Program”	Operating between July 2006 and July 2011, under the direction of the Illinois Department of Healthcare and Family Services (HFS), this McKesson Care Management Program improved the health and wellness of more than 280,000 Medicaid beneficiaries by providing personalized telephonic and community-based registered nurse services. HFS and McKesson launched the multi-disciplinary Care Management Program to help disabled adult Illinois Medicaid beneficiaries and children with asthma and their caregivers, who are part of the Family Health Medicaid program.
Texas “Whole Person Health Management Program”	In 2011, McKesson renewed its partnership with the Texas Health and Human Services Commission (HHSC) to continue providing a Care Management Program for Texas Medicaid members through the Texas Wellness Program. Since 2004, McKesson has provided care management services to Texas Medicaid members. This program engages Medicaid members who are at risk or have developed chronic disease and are identified as being high cost and high-risk. Nurse Care Managers teach better ways to manage conditions through personalized care plans and direct contact. Better condition management ensures that Texas Medicaid members have improved clinical outcomes, while HHSC benefits from cost savings derived from fewer hospitalizations and lower healthcare costs as chronic conditions, including BH co-morbidities, are controlled.
Massachusetts “Essential Care” Program	Operating between July 2005 and September 2009, this integrated physical health and BH program operated by ValueOptions and supported by McKesson for predictive modeling and its CCMS application, demonstrated significant reductions in medical costs for the members served.

The Individuals We Engage:

Our combined experience and expertise offers a variety of methods for identifying and engaging individuals in care management. Each individual intervention is considered and treated as an opportunity for engagement in his or her health and care plan. Specific strategies include:

- new member outreach activities that serve as an early opportunity to identify care management needs and appropriate triage
- condition identification analysis on physical health (inpatient, outpatient, and emergency department) claims, pharmacy claims, and behavioral health claims and predictive modeling/risk stratification.
- completion of health risk assessments and other physical health and behavioral health screenings—through Web-based portals, in physician’s offices, or over the phone with care management staff
- regularly scheduled and ongoing telephone calls, mailings, and in-person visits at the individual’s home and provider’s office
- field-based strategies to locate and engage hard-to-find individuals in the community including community health workers, lay health educators, or “Promotoras,” tasked with making home visits to engage and enroll individuals
- “no wrong door” referral policy, whereby an individual can come into our care management program from any avenue—a referral from a provider, family member, or agency, a predictive modeling output, or an emergency department or hospitalization report
- enhanced provider engagement strategies, providing physicians with direct access to a secure, online care management provider portal which enables providers to more actively engage individuals in their own care.

Outreach and Engagement	
<p>New York “Chronic Illness Demonstration Programs (CIDP)”</p>	<p>Targets High-risk, high-cost, fee-for-service Medicaid beneficiaries who have one or more chronic illnesses. These individuals have complex medical and psycho-social service needs and historically have been out of the reach of the conventional health care systems. Many of these enrollees are transient, homeless, medically underserved.</p> <ul style="list-style-type: none"> • The majority suffer from a chronic BH condition - 95 percent had alcohol/drug problems and 71 percent had psychiatric problems • 45 percent needed a medical home • 41 percent needed assistance with daily living (ADL) • 30 percent of those eligible are also HIV positive or have AIDS <p>The historical annual Medicaid spend for this population exceeds \$53,000. Of the 3,700 individuals whom the State identified as eligible for the program, 1,400 were engaged and 450 are currently enrolled. Outreach and engagement have proved</p>

Outreach and Engagement	
	challenging because the State’s eligible list contains inaccurate information which impact individuals’ actual eligibility for the program.
Illinois “Your Healthcare Plus™ Program”	Targets Medicaid Adults with Disabilities (ABD) population and persons in the Family Health population (~TANF). Additional targeted groups included HCBS Waiver for Persons with Disabilities and HCBS Waiver for Persons who are Elderly, and who have Medicaid only (no Medicare) health care coverage. All individuals entering the program were identified as having one or more of 18 chronic conditions, including schizophrenia and depression, persistent asthma or who were frequent users of ED services. Out of a total eligible population of 285,000 individuals, approximately 170,000 individuals were identified with a chronic condition and targeted for enrollment with McKesson achieving a high cost/high-risk engagement rate of 35%.
Texas “Whole Person Health Management Program”	Targets individuals that are part of Disabled PCCM, Disabled FFS, TANF FFS, and TANF PCCM populations. All individuals are at risk or have developed chronic diseases, and are identified as being high-cost/high-risk. A separate Diabetes Self-Management Training Program is provided to those identified with this condition. Of a total eligible population of 195,000 individuals, approximately 60,000 individuals were identified as having a chronic condition and need for care management. All 60,000 individuals were targeted for enrollment.
Massachusetts “Essential Care” Program	A subset of PCC Plan members with a high risk for adverse medical events; specifically targeted individuals with medical and/or co-morbid BH and physical health conditions Through the life of the program, it served approximately 4,000 Individuals, averaging approximately 450-500 individuals on any given day.

To achieve success ValueOptions McKesson understand that we have to overcome Engagement barriers that are typical across the populations we serve. Some of these barriers include:

- lack of stable housing and homelessness
- unreliable access to a telephone or computer
- unreliable or inconsistent access to transportation
- medical expert imposed goals rather than person selected/accepted goals
- treatment plan adherence
- eligibility changes
- low literacy levels
- mistrust in the health care system
- psychosocial barriers (abuse and neglect, alcohol dependency)
- language/cultural barriers

To ensure our members receive the most benefit from our programs, we have developed successful strategies to address the above barriers and increase engagement rates. Some of these include:

- **Member Engagement Center**—We understand that critical components of sustainable engagement make it easy for Individuals to get information, provide valuable and actionable information and resources to individuals, create a valued experience with staff and connect

with the program. Our Member Engagement Center centralizes all calls through one location for all services. This engagement center is uniquely designed to provide a single point of contact for individuals to receive information, support, resources, and understanding of their health and the clinical services, physical and behavioral health, available to them. Our Member Engagement Specialists are trained in motivational coaching to “meet the individuals where they are” based on the needs and readiness to change, as defined by the individual. We are able to create an easy way for individuals and providers to self-refer, and provide one place where we can get individuals to connect with us. All individuals have access to our Member Engagement Center 24/7.

- **Community-based staff**—We partner with providers and community support programs located in the communities in which our members live and who are familiar with a range of community resources to successfully drive greater member engagement. We offer community health workers and lay health educators of specific ethnicities who provide a “cultural bridge” to the diverse communities by helping individuals to navigate the health care delivery system and by serving as a trusted advocate for Individuals when needed;
- **Field-based engagement model**—Our Field Care Managers are continually out in the community (homeless shelters, emergency rooms, parks/bridges), looking for individuals to engage them in face-to-face meetings. Additionally, our programs assist individuals in overcoming transportation barriers (e.g. distributing metro cards), and provides translation services (interpreters and sign language) in order to overcome cultural and/or medical barriers, and engage individuals in their care.

Additional strategies we have deployed to remove and/or minimize barriers to care have included:

- analysis of health risk assessment, predictive modeling, and claims data based on geographic/provider locations
- analyzing provider Geo mapping data to identify access in care gaps by service type, provider type, and geographic area;
- reviewing “call reason data” tracked in our customer service software to identify individual-specific barriers and population trends regarding “unmet needs;” and provider specific barriers impacting individuals’ access to care
- participating in community meetings to obtain information from stakeholders concerning barriers to care
- conducting annual provider and individual surveys to determine barriers identified by primary care providers, specialists, and other providers and issues of most concern to individuals

What We Have Achieved:

Our comprehensive care management services reduce barriers to care, and provide continual outreach to maintain an individual’s engagement in his or her own healthcare. This includes:

- coordination between and among physical health and behavioral health care providers as well as increased access to preventative and primary care and connection to a Medical Home

- coordination between and among social service systems. These individuals often interface frequently with non-profit organizations and various state agencies, and need support as they move through the system
- provision of and referral to social services, self-help groups, recovery oriented consumer-run organizations and community-based supports. Care coordination services provided to these individuals includes assistance developing social and community connectedness. With accessing transportation, food, and shelter; help with financial troubles; and assistance with dealing with the problems associated with low literacy.

Outcomes for all programs have intended to improve the health status of Individuals served, reduce inappropriate higher levels of care through improved access to preventative and outpatient services, and reduce program costs. Below are descriptions of such programs and their results:

Outcomes Achieved	
New York “Chronic Illness Demonstration Programs (CIDP)”	A recent satisfaction survey, distributed to CIDP enrollees who had been enrolled in the program for six months or more, showed that the majority were very satisfied with the services and the staff, and would recommend the program to others. Enrollees have said that the program offered them hope for healthier future and provided a structure and support that they had not previously known. Several also said that they had never been to a doctor’s office prior to CIDP; all of their care had been received in EDs or in hospitals. ValueOptions’ New York City partnership (Pathways to Wellness) received a 2010 Case in Point Platinum Award in recognition of its innovative Medicaid disease management.
Illinois “Your Healthcare Plus™ Program”	With total projected claims costs approaching \$5.1 billion, McKesson’s Your Healthcare Plus™ saved the state of Illinois a total net savings of \$569 million after program fees over a four-year period. McKesson also achieved measurable results for several HEDIS measures including, but not limited to: COPD, diabetes, CAD, and asthma. For example, for participants with diabetes, McKesson demonstrated a: <ul style="list-style-type: none"> • 36% improvement in retinal eye examinations • 11% improvement in testing for kidney damage • 10% improvement in aspirin use • 11% improvement in statin (cholesterol lowering medication) • 9% improvement in cholesterol testing
Texas “Whole Person Health Management Program”	During the first four years of the program, McKesson generated a total of \$40.1 million in net savings after program fees, against projected claims costs for the state of Texas. Additionally accomplishments include: <ul style="list-style-type: none"> • 6% increase in prescription of rescue inhaler among asthma Enrollees; • 73% increase in annual flu vaccination among heart failure Enrollees • 51% increase in annual flu vaccine among COPD Enrollees • 25% increase in use of daily ASA medication among CAD Enrollees • 86% increase in daily use of ASA or ant-platelet medication among diabetes Enrollees

Outcomes Achieved

Massachusetts “Essential Care” program	In a 2005, researchers at the Center for Health Policy Research (CHPR) at the University of Massachusetts Medical School found the following benefits for Individuals enrolled in EC: <ul style="list-style-type: none">• the PMPM was 19 percent lower for post-enrollment than pre-enrollment, equivalent to a reduction of \$150 PMPM• the rate of office visits declined from 12.1 visits/year prior to enrollment to 7.7 visits/year after enrollment• ED visits declined from 1.8 visits/year to 1.1 visit/year• inpatient hospitalization declined from one out of four people before enrollment to one out of ten after enrollment• those enrolled in EC had significantly fewer gaps in medication refills—4 gaps compared to 10 gaps before Essential Care enrollment
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The most vulnerable in any population are the true test of whether or not we can effectively manage scarce financial resources while improving care coordination and delivery at the same time. Time and again, ValueOptions and McKesson have demonstrated our ability to serve the most difficult and intransigent of Medicaid patients—the seriously mentally ill, the homeless, the incarcerated, and those for whom the emergency department provides primary care.

By fully integrating the physical and behavioral health management platforms, we identify high-risk, costly populations within the Medicaid membership and effectively target these populations with a more cohesive whole health management approach to care. Our approach emphasizes both intensive physical health treatment and behavioral health services in addition to community supports. The end result offers a more effective spend of scarce budget dollars for payers and more positive outcomes for individuals.

We are deeply committed to providing members with the most effective care in the least restrictive setting. ValueOptions’ mission is to “...help people live their lives to the fullest potential.” We know that one person’s best possible health is not the same as another’s. That’s why the principles of recovery and resiliency are so deeply embedded in everything we do. And it’s why our clients will always find us willing to try something new or do something more in the service of a better solution.

For more information, questions or to discuss the process for implementing such a program, please contact:

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About ValueOptions

ValueOptions is a health improvement company that serves more than 32 million individuals. On behalf of employers, health plans and government agencies, we manage innovative programs and solutions that directly address the challenges our health care system faces today. A national leader in the fields of mental and emotional wellbeing, recovery and resilience, employee assistance, and wellness, ValueOptions helps people make the difficult life changes needed to be healthier and more productive. With offices nationwide and a network of more than 127,000 provider locations, ValueOptions helps people take important steps in the right direction. We help them live their lives to the fullest potential. Visit www.valueoptions.com for more information.

About McKesson

McKesson Corporation, currently ranked 14th on the FORTUNE 500, is a healthcare services and information technology company dedicated to making the business of healthcare run better. We partner with payers, hospitals, physician offices, pharmacies, pharmaceutical companies and others across the spectrum of care to build healthier organizations that deliver better care to patients in every setting. McKesson helps its customers improve their financial, operational, and clinical performance with solutions that include pharmaceutical and medical-surgical supply management, healthcare information technology, and business and clinical services. For more information, visit <http://www.mckesson.com>.