WYhealth
Clinical Health Management (HM) Program

What is the WYhealth HM Program? The goal of Health Management is to work with individuals to help them take steps needed to manage their condition(s), remove barriers to care, and get them actively involved in their health. There are multiple components:

General Population Health Management aims to address health concerns within the general Medicaid population through educational materials, education, preventive services, and general wellness initiatives in coordination with Agency and State health priorities.

Catastrophic Care provides shorter-term care for unexpected health conditions requiring longer stretches of hospitalization or recovery periods resulting from situations such as: a car wreck, heart attack, and cancer. WYhealth Staff shall support clients identified for Catastrophic Care Management through referrals (Agency, self, and provider referrals) and approach their wellness appropriately and administer the level of care necessary to support the client's improved wellness depending on each client's unique situation.

Disease Management includes clients with chronic disease states or other targeted conditions, such as diabetes or asthma, for outreach and prevention initiatives. Specific clients will be identified through WYhealth's Persistent Super Utilizer (PSU) Model, claims analysis, in-patient events, and other appropriate criteria and referral sources. While the Agency has identified certain conditions of significant interest (including diabetes, asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), high-risk pregnancy), outreach will be prioritized by the acuity of individuals, inpatient utilization, and not limited by a specific condition list.

Care Transitions is coordination and communication with facility discharge planners, provides training, and refers clients to Care Management (WYhealth) or the Care Management Entity (Magellan Wrap-around care), as appropriate. The process shall focus on a plan of care for post-discharge, including medications, follow-up appointments, and discharge instructions; and contact with facilities to track status. WYhealth Staff will evaluate the client's Social Determinants of Health, ongoing physical health, and behavioral health needs in order to facilitate that the discharge plan meets the client's needs, there is timely follow-up services in place, and that the transition to the community or lower level of care is safe and effective.

Complex Care Management is the most extensive health management method available to Wyoming Medicaid clients. It includes the coordination of services, appointments, follow up with community resources, and coordination of other unmet needs/barriers faced by the client. WYhealth Staff assembles the team required to identify the gaps and provide the services needed to facilitate optimum care for the client. This level of management is for clients determined to be at "high risk" for greater medical costs, and/or have the highest cost of service utilization. This not only includes physical conditions, but also behavioral and mental conditions. These are individuals who are at risk of demonstrating poor health outcomes; experiencing fragmented health care delivery; have high cost utilization of services; or, whose pattern of health services access may indicate an inappropriate utilization of health care resources; and would benefit from Care Management services.

What does WYhealth Care Management look like? WYhealth HM uses an interdisciplinary care team approach to create regionally based Community Health Teams (CHTs). CHTs include Medical Directors, Registered Nurses, Behavioral Health Advocates (BHAs), Community Health Workers (CHWs), and non-clinical support staff. All clinical staff members are licensed and knowledgeable in best practices in the care management of chronic illness.

Each enrolled client is assigned a primary Care Manager. The RN will assess the client using a clinical health assessment, which also asks social determinants of health questions (if positive, will result in referrals for community support or hotlines being provided to the client). Since the assessment takes about an hour to complete, the Care Manager will schedule a separate call with the client to discuss their chronic condition(s), medication(s), and establish goals and a plan of care. Each subsequent call will address aspects of their goals in the POC, as well as "meeting the client where they are at." So, if the client suddenly finds themselves couch surfing, the Care Manager will work with them to find housing rather than work on their health condition during that specific call. Once the SDOH has been addressed, the Care Manager and client can continue working on the health goals in the POC during the next engagement.

A plan of care usually lasts from 3-6 months but could be longer depending on the condition and how quickly the client learns to appropriately manage it. Some clients have been managed for years. At intervals (usually 3-6 months) the clinical health assessment is done again with the client to monitor their needs and SDOH.

How do you refer someone to Care Management? If you have a Medicaid client who you believe would benefit from being enrolled in CM, you can complete the referral form and submit it by fax: 1-888-245-1928 or via email: optumhmwy@optum.com. (Referral form is the last page.)

Applicable Health Incentives, Tools, and Resources:

Choice Rewards: This is an incentive program for Wyoming Medicaid clients who are enrolled in Care Management. The purpose of Choice Rewards is to call attention to a client's diabetes condition, support them to actively manage their diabetes, and engage clients in their health. Clients participating in the program can earn a $25 gift card each quarter for up to four (4) quarters - $100! The client participates by tracking and sharing their A1C Test Results and weight each month and reports these elements to their RN Care Manager. For the client to be eligible, the client must have an A1C at or above seven (7). If the client is unsure or does not know their current A1C, the RN Care Manager encourages the client to contact their PCP.

24/7 Nurseline: 1-888-545-1710. Medicaid clients can have access to registered nurses 24/7/365.

Wiser Together: Everyone has access to the Wiser Together tool. Is a decision support tool, which has 300 conditions to search on, and will give you treatment options based on condition. There is no need to create a profile either, which is nice. It can be found through the WYhealth website: https://www2.mywiserhealth.com/

My 307 Wellness: Is an interactive app with reliable, credible health information for individuals and Wyoming families. You can track health milestones and immunizations, and find information about important screenings and resources available in Wyoming communities. You can find it on Google Play, the App Store, or by texting 'FAMILY' to 307-317-0819.