Addressing Social Needs with Molina Healthcare

1/24/2018 | Presented by: Beverly G. Hamilton

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Molina Healthcare, Inc. was started over 35 years ago by C. David Molina, MD when he noticed that low-income, uninsured or non-English speaking patients were coming to the emergency room in need of general health care services.

Originally, Dr. Molina opened Health Clinics to meet the needs of underserved families with a basic belief that everyone should be treated like family. Later the company expanded to become a health plan with the mission of providing quality care to people receiving government assistance.

- Now a multi-state health care organization providing services in 12 States & Puerto Rico
- Quality Focused to meet individual's needs
- Person-Centered, High-Touch Care

Molina Healthcare, Inc. serves members in the following programs:

- Medicaid

- Medicare

- Medical Long-Term Services and Supports (MLTSS)

- Medicare/Medicaid Programs (MMP), and

- Health Insurance Exchange Programs

- In each of the states in which we do business, Molina strives to actively work with state and local entities to jointly address identified needs. Some basics include:
  - Listening to our Members and Partners
  - Supporting Health Systems and Providers with whom we contract
  - Joining forces with Community Based Organizations & Groups already serving the population
  - Ensuring that Molina employees serve by paying each for 16 hours of Volunteer Time Off (VTO)/year to back up our commitment.

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Social Determinants of Health

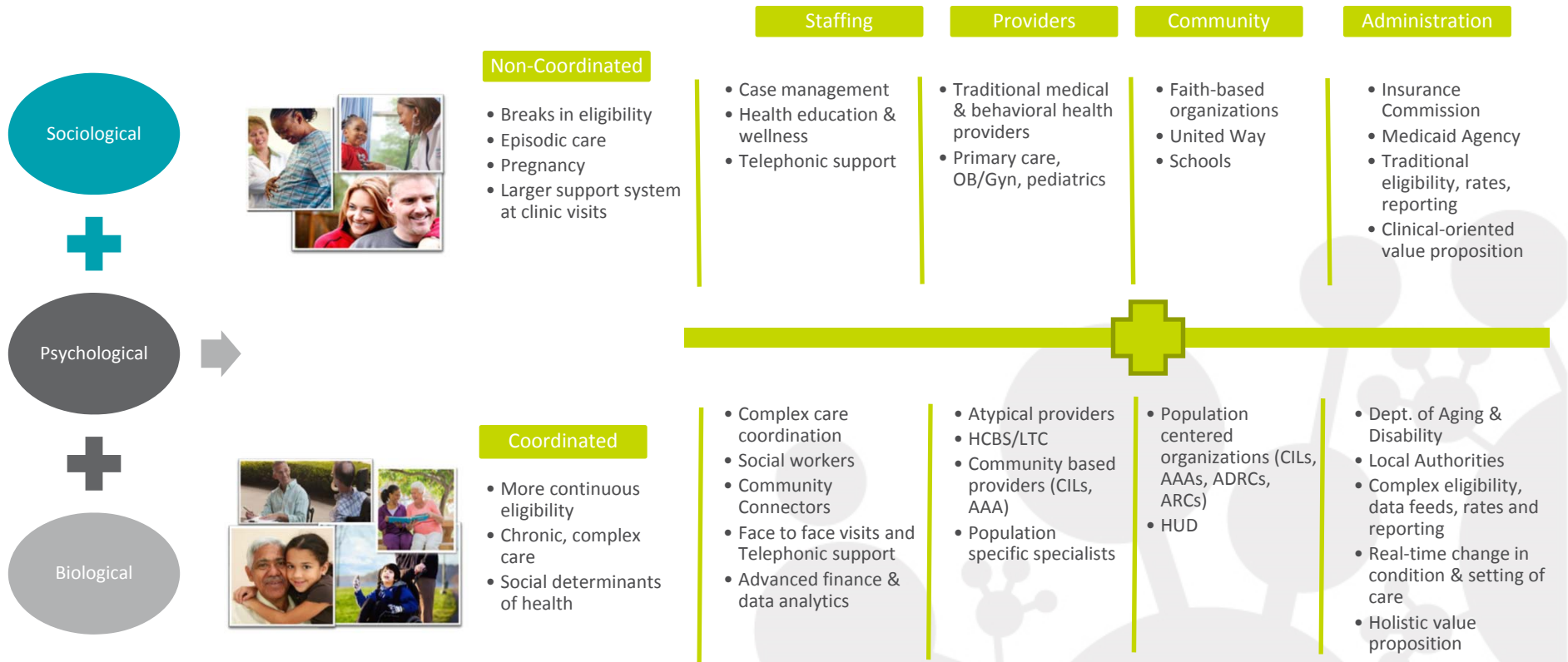| Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education			Quality of care
Support	Walkability				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Heiman, Harry J. & Artiga, Samantha (2015). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. http://www.kff.org

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Medicaid Solutions

Expanding Beyond a Medical Model

Integration and coordination are keys to success

	Staffing	Providers	Community	Administration
Non-Coordinated **Sociological** • Breaks in eligibility • Episodic care • Pregnancy • Larger support system at clinic visits	• Case management • Health education & wellness • Telephonic support	• Traditional medical & behavioral health providers • Primary care, OB/Gyn, pediatrics	• Faith-based organizations • United Way • Schools	• Insurance Commission • Medicaid Agency • Traditional eligibility, rates, reporting • Clinical-oriented value proposition
Coordinated **Psychological** **Biological** • More continuous eligibility • Chronic, complex care • Social determinants of health	• Complex care coordination • Social workers • Community Connectors • Face to face visits and Telephonic support • Advanced finance & data analytics	• Atypical providers • HCBS/LTC • Community based providers (CILs, AAA) • Population specific specialists	• Population centered organizations (CILs, AAAs, ADRCs, ARCs) • HUD	• Dept. of Aging & Disability • Local Authorities • Complex eligibility, data feeds, rates and reporting • Real-time change in condition & setting of care • Holistic value proposition

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For our Members, "Community Connectors"

- Actively work to expand beyond a Medical Model of Care
- Ensure that we are Person-Driven and Inclusive
- Remain Effective & Accountable
- Connect and Coordinate with Local Entities, and
- Are Culturally Competent

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For our Communities

- We engage and listen to learn what the identified needs are.

- Participate and get involved. Serve on boards and committees to address shared goals.

- Invest financially and with in-kind labor. Focusing on Food, Health, Housing and Hope

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Examples of Specialized Programs to address Social Needs

- **Community Development for All People Partnership in Ohio (CD4AP)**
  - Community Connectors answer questions, assist with resource needs such as housing, food clothing and transportation. They also help with scheduling doctor's appointments, arranging transportation, and managing medication.
  - Two focused programs within CD4AP include:
    - **Healthy Moms & Babies** – Subgroup that ensures moms-to-be and new moms are connected to education and services as timely as possible and followed through their first year of life
    - **Workforce Development & Job readiness** – Molina is establishing a member referral program as part of the organization's new workforce development space. We are also offering training, information and referral, and supporting job fairs in the neighborhood.

Furniture Bank of Central Ohio

Molina is partnered with the Furniture Bank of Central Ohio to provide free furniture to individuals and families in need due to poverty or other severe life challenges. While services are provided free of charge to Molina members, Molina pays the Furniture Bank a fee to cover the direct costs the Bank incurs by serving its referred members. Prioritizes families with new babies and individuals recently released from incarcerations.

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Food Share South Carolina

Food Share is a program in the Midlands area of South Carolina that distributes fresh fruits and vegetables to low-income families at a reduced price.

Along with this, healthy recipes and cooking classes are offered.

Molina provides financial support for a staff member at Food Share along with providing a great venue for VTO on a bi-monthly basis.

Prospera Housing & Community Services in Texas

Pilot project started in June, 2017 between Molina and Prospera to provide safe, high quality, affordable housing with support services for Molina members at two selected sites in San Antonio and Laredo.

Tracking overall costs for members:
- ED utilization
- Inpatient hospitalizations
- IP readmissions, selected
- HEDIS scores
- Member growth and retention rates
- Member satisfaction

If pilot determined to be successful, expect broader relationship with Prospera in Texas and similar organizations in other states.

Addressing Social Determinants of Health – It Takes a Village

Top Social Determinants of 2016 for Molina Members

Housing

- ✓ Effective training and resources
- ✓ Collaborations with affordable, accessible housing communities

Food Security

- ✓ Transition meals program
- ✓ Nutritional counseling and programs through CBO partners

Support Systems and Community Engagement

- ✓ Caregiver support training program
- ✓ Caregiver assessment and toolkit
- ✓ Community Champion awards and grants
- ✓ Molina Quality Living Program

Quality of Care

- ✓ Change in condition training and support

"My next goal is to start, try to start, walking without my walker and my biggest goal is to get on the back of a motorcycle."

-Molina Medicare-Medicaid Plan demonstration member

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Impacts of Addressing Social Determinants in Texas

- >8:10 people satisfied with care coordination

- >8:10 people satisfied with heath plan

- Molina Quality Living Program

  - ✓ 67,287 lives enriched through attendance at community integration activities (in just one state pilot program)

  - ✓ 2% lower total claims cost for members residing in a MQL facility

  - ✓ 22% lower admissions to acute for members residing in a MQL facility

- Nursing Facility to Community Transitions

  - ✓ 9.6%
  - ✓ $1.1M savings in overall healthcare costs

- Nursing home diversion rate >96%

- 15% reduction in inpatient admissions and 10% reduction in readmissions following caregiver change in condition training

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