Population Health

Molina Healthcare of Nevada

March 9, 2023

Agenda

- Population Assessment
- Data Integration
- Population Stratification
- Targeted Interventions
- Measuring Quality Improvement

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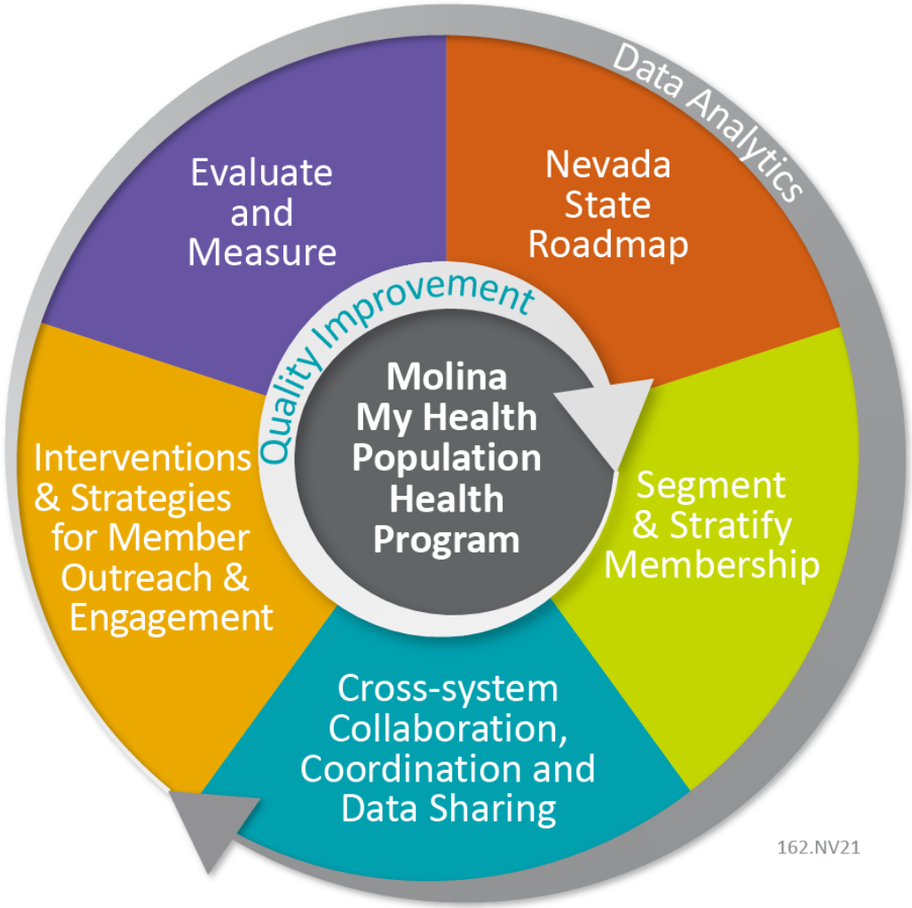
Population Assessment

Population Health Strategy

Identifying Our Population



- Develop a state-specific roadmap
  - Initial Nevada population health summary based on comprehensive assessment and analysis of data
- Segment and stratify members.
  - Apply data analytics to segment Nevada members into population health streams
- Collaborate with cross-system partners.
  - Re-evaluate and refine Provider network and partnerships with community agencies based on the makeup of population health streams
- Develop targeted interventions and strategies for member engagement.
  - Overlay and align cross-system partnerships to tailor specific quality and care management programs and interventions for member engagement strategies
- Measure and evaluate impact.

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Data Integration

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Data Integration

Sources and types of data and information collected and used to inform the population health strategies and initiatives

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- CAHPS
- HEDIS
- Enrollment
- Financial
- Utilization
- Nurse Advice Line
- Quality improvement
- Pharmacy data
- Laboratory results
- Referral information
- Electronic visit verification
- Care coordination programs
- HNAS
- CNAs
- Predictive modeling
- Population Health insights
- Complaints, grievances, appeals
- SDOH (e.g., housing, social isolation)
- Wearables and remote monitoring tools
- Historical claims and consumer analytics
- Claims and encounters, including Z codes
- Service authorizations and discharge planning
- Member and Provider call center and portals
- Comprehensive and condition-specific assessments

DHCFP, State Agencies, Counties, Local Health Departments, and Federal Agencies

- Quality Strategy
- Priority populations
- Health disparities
- Episode and population health reports
- Healthy People 2030
- Nevada DHHS Office of Analytics
- American Community Survey
- Public Health Registries
- Public Safety Reports
- School Performance Reports
- USDA Food Atlas
- CDC Behavioral Risk Factor Surveillance System (BRFSS)
- CDC Chronic Disease Indicators
- CDC National Environment Public Health Tracking

Healthcare Delivery System – Primary Care Providers and Specialists, Hospitals, FQHCs/RHCs/IHCs, Nursing Facilities, First Responders, CCBHCs, and Community Based Organizations

- HealtHIE Nevada
- NCQA Quality Compass Benchmarks
- Community and population needs
- Consumer data
- Vital statistics
- Feeding America reports – Food Insecurity By County, Map the Meal Gaps
- Economic Innovation Group reports – Distressed Communities Index
- Community Needs Assessments
- Behavioral Risk Factor Surveillance System Survey
- American Community Survey
- Robert Wood Johnson Foundation – Housing reports, health assessments, and more

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Population Stratification

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Risk Stratification vs. Programmatic Risk Level

Tools to assist at different points of the care continuum.

Pre-Enrollment

- Risk Stratification

Care Continuum

- Continuous Risk Monitoring

Member Engagement

- Programmatic Risk Levels

Risk Stratification and Programmatic Risk Level are tools that use different strategies to identify members with the highest needs to assist Molina Healthcare of Nevada in managing the member's needs at the appropriate level of care.

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Risk Stratification Overview

Continuous and on-going to assist in prioritizing members with the highest needs.

- Risk Stratification is the process of classifying populations into categories of risk by utilizing the claims data, lab results, medications, and other risk stratification models/algorithms.
- Designate a risk to each member based on risk stratification formula. Categories of risk are based on:
  - Data source may include outpatient/inpatient, ED visits, polypharmacy, LTSS, presence of chronic conditions, and gaps in care.
  - Outreach timeline requirements may vary based on categories of risk.

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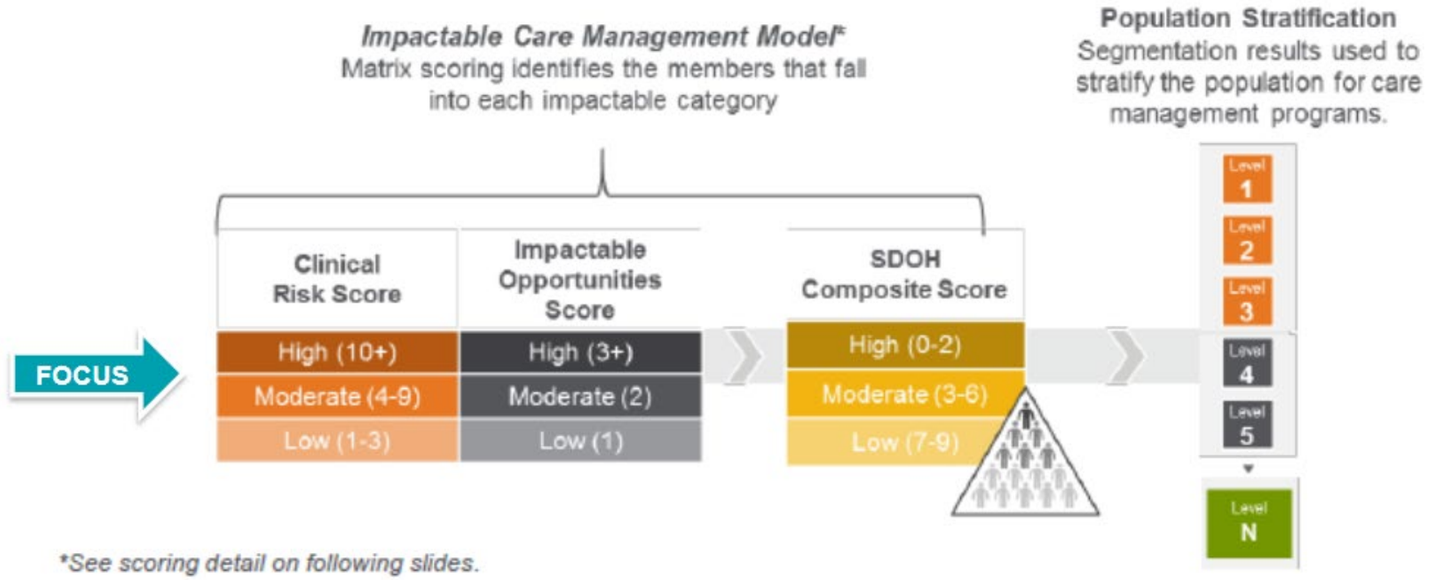
Risk Stratification Model

- Three Dimensions:
    1. ***Clinical Risk Score:*** Determined by a member's clinical, behavioral, and utilization characteristics.
    2. ***Impactable Opportunities Score:*** Determined by the number of opportunities a member has to improve their health based on medical, pharmacy, behavioral health, and social characteristics.
    3. ***SDOH Composite Score:*** Determined by a member's likelihood to engage in their health and participate in care programs.



Applying the Risk Stratification Model

- **Stratification Model**
  - Provides insights into total member population
  - Sets goals for case management
  - Allows for compare and contrast against other referral channels, contractual expectations, etc.
- **Social Determinants of Health**
  - Provides insights into member wants and non-clinical needs.
  - Helps care teams determine outreach prioritization and CM assignment
- **Member-Level Characteristics**
  - Supports and simplifies pre-call reviews
  - Cuts down on research time

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Classifying Members into Programmatic Risk Levels

- Some Clinical Care Advance (CCA) assessments, like the Health Risk Assessments (HRAs), have incorporated logic to classify members into programmatic risk levels based on the member's response.
- After the CCA system identifies a programmatic risk level based on assessment results, CMs are expected to review and adjust the programmatic risk level based on clinical judgement as needed.

Programmatic Levels

Level 0: Health Management (every 90 days; 6-month program)

- Member are not at risk for impending utilization but can benefit from health promotion and education.
- Level focuses on health promotion, disease prevention and member self-management.
- Disease specific member identification

Level I: Care Coordination (every 30-45 days)

- Reduce fragmentation, improve Member's access to necessary services
- Address social determinant of health needs
- Level focuses on returning members to their optimal wellbeing at the lowest level of care.
- **This population is highly manageable with great chance to self-manage their care!**

Level II: Case Management (every 2-3 weeks)

- Member has self-reported "poor" health status
- Member has high-risk chronic illness with clinical instability
- Level focuses on member's main health concern, developing realistic goals, and seeking guidance with other members of ICT to develop interventions that are suitable for the member.
- High-risk chronic illness with clinical instability
- Level focuses on identifying ways to prevent readmission, pain management, end stage treatment, stabilize conditions, develop interventions to bring member to a lower level if possible.

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Targeted Interventions

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Targeted Interventions

- Flu Shot Education
- Annual Health Exam Reminders & Education
- Medical Assistance with Smoking & Tobacco Use Cessation
- Obesity Management for Children
- Prenatal and Postpartum Care
- Women's Health
- SED/SMI Care Management
- Asthma Management
- High Blood Pressure Management
- High Risk OB Case Management Program
- Health Promotion and Disease Prevention

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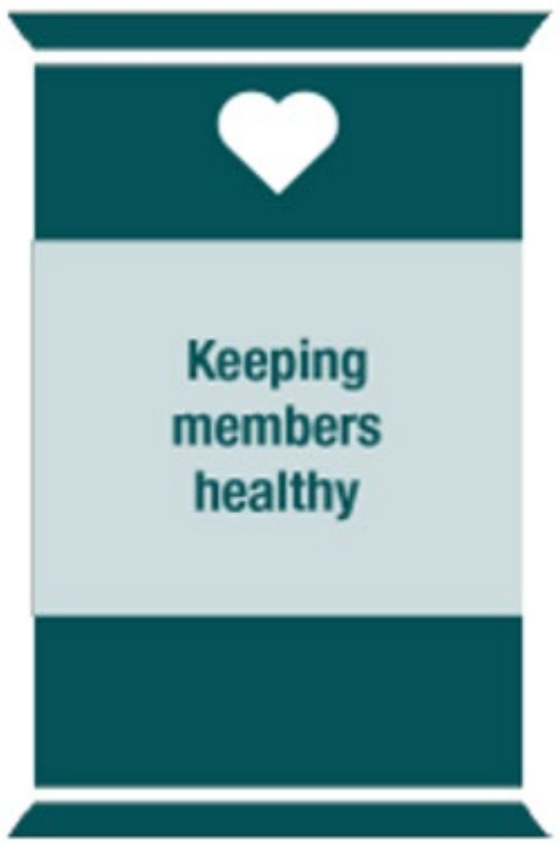
Targeted Interventions

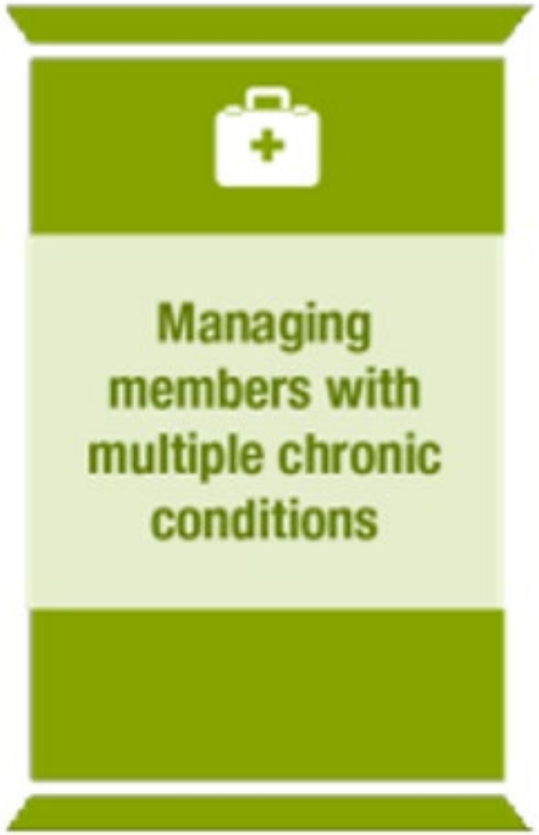
- Diabetes Management
  - Hemoglobin A1C Control for Patients with Diabetes
  - Eye Exams for Patients with Diabetes
- Care Coordination

Targeted Interventions



- Well-Child Visits in the First 30 Months of Life
- Child and Adolescent Well Care Visits

Targeted Interventions



- Case Management
- Transition of Care Program

Targeted Interventions

- Behavioral Health Transition of Care and Follow-up after Hospitalization Program

Measuring Quality Improvement

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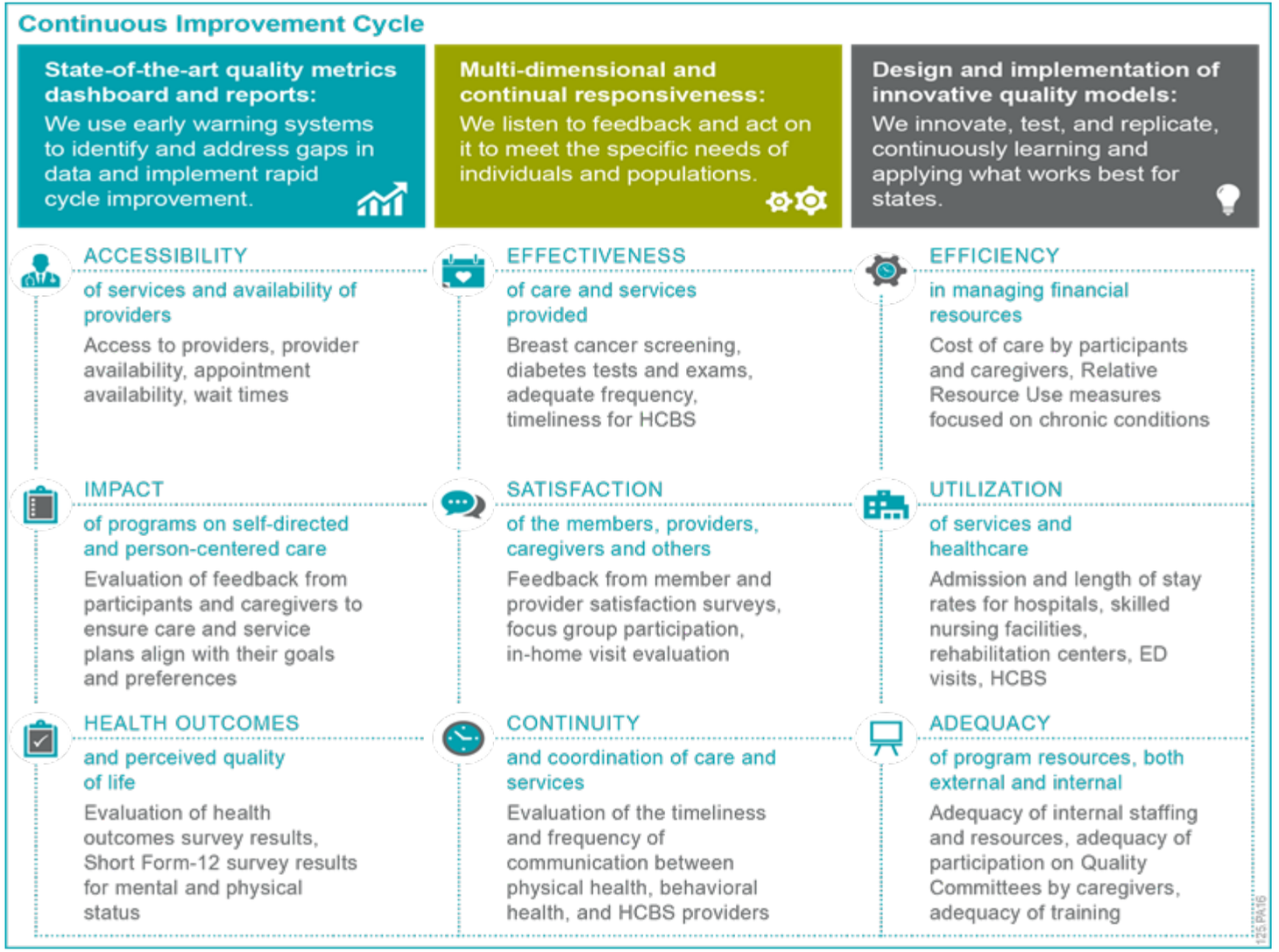
Measuring Quality Improvement



Measuring Quality Improvement

- HEDIS and the Adult Core Set and Child Core Set performance measures are used to assess performance with specific indices of quality, timeliness, and access to care.
- Molina has Interim NCQA status
- Implementation of PIPs, which measure and assess targeted performance improvement interventions on specific topics helps us measure quality improvement through designated initiatives.
- Mechanisms to detect over- and underutilization of services to measure quality of services delivered.
- Use of clinical care standards/practice guidelines.
- Analysis of clinical care, including interventions specifically designed to reduce or eliminate disparities in healthcare.
- Assessment of member satisfaction to determine how satisfied Nevada Medicaid managed care members are with care and services they receive.
- Evaluation of the continuity and effectiveness of the QAPI program.

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