

Molina Healthcare of Utah has adopted a number of programs designed to increase the quality of care and lower cost for our membership under the ACO model. These efforts have focused on two main approaches; direct care management programs and provider engagement through alternative payment models. While we are too early to have adequate data to demonstrate efficacy of these programs, our efforts are based on the latest evidence available. For example, our Transition of Care program is a modification of the Coleman model. Our work with provider groups is designed to progress through the necessary stages to ultimately contract through alternative payment models as envisioned in MACRA.

### **Care Management Programs:**

Our Care Management Team specializes in working with challenging populations. These populations often times have the highest utilization of resources and the highest medical expense ratios. Our team works to support these members and improve both quality of care and cost.

Molina Healthcare regularly monitors high cost reports to identify members with high utilization patterns. Once identified the members are assigned to a Registered Nurse Case Manager or Licensed Clinical Social Worker depending on the driver of the cost - whether that be medical or behavioral health utilization. We then outreach to the member and offer case management services. Once enrolled, the Case Manager uses Motivational Interviewing techniques to empower the member to manage their healthcare needs. A member centric care plan is then developed and goals are put in place. This helps us to provide effective Case Management services and to improve the member's overall health.

Members who would benefit from a Medical Home are provided with information and assisted in coordination efforts to establish consistent, rather than episodic, care. Members can be provided with a myriad of services which could include assistance from a Community Connector to help with needs related to food, shelter, and resources for non-covered benefits. They may also receive face-to-face visits in the inpatient setting, as well as the emergency department, when warranted. All efforts are made to work closely with the PMHP when indicated.

A fully integrated Case Management approach is utilized to ensure that the member receives the support necessary to improve their health and decrease utilization patterns, thus lowering overall costs while improving clinical outcomes.

### **Complex Case Management**

*Complex Case Managers are nurses who Case Manage members who have:*

- Multiple co-morbidities and high utilization patterns
- High risk diagnoses, including BH diagnoses
- Frequent hospitalizations or readmissions

*Complex case managers provide:*

- Education on disease processes, medications and promoting medication compliance
- Individualized care plans and goals with the member
- Care coordination by consulting with providers, pharmacy, and other internal and external sources
- Access to Interdisciplinary care team meetings including the member, their support network and providers

### **Disease Management**

*The Disease Management Health Educators:*

- Identify and provide education to members with asthma, diabetes and CAD
- Coordinate appointments with specialists
- Provide regular telephonic outreach to provide support and resources, to encourage medication compliance and to monitor and evaluate the progress toward goals as defined in the care plan

### **Community Connectors**

*Community Connectors are non-clinical staff with medical backgrounds that connect members to community resources who:*

- Assist members with resources in the community such as food, housing, utility assistance, coordinating and attending physician appointments and transportation
- Advocate for the member and empower them to manage their medical conditions

### **Transition of Care**

*Transition of care nurses:*

- Ensure that our members successfully transition from the inpatient setting to a lower level of care
- Provide resources and education, focusing on medication management, warning signs and symptoms, follow-up care, nutrition management, home and community based services and advanced directives

### **Behavioral Health Team**

*LCSW's, CSW's, SSW's, a Substance Abuse Counselor and Community Connectors specializing in behavioral health who:*

- Provide case management to the SPMI population to ensure compliance with outpatient appointments, medications, and community resources
- Coordinate care with PCP's, BH providers and community agencies

- Perform transition of care activities for Behavioral Health members to ensure their transition from inpatient to a lower level of care

### ED Diversion

*Nurses and community connectors who:*

- Receive CHIE alerts when high ER utilizers register at the ER
- Case Manage and coordinate care between the member, PCP, ER and specialists for appropriate level of service and improved outcomes

### Restriction Program

*Nurse Case Managers who:*

- Identify and refer members who meet state restriction criteria
- Coordinate activities between the member, state and providers to ensure access to care
- Restrict the member to one PCP and one pharmacy

### **Value Based Care and Provider Engagement:**

We believe that our efforts to lower costs and improve clinical outcomes need to be coordinated with our key provider groups. We offer cost savings contracts which incorporate associated quality measures. We anticipate over time that these contracts will include a risk component. These contracts have motivated our key provider groups to engage more actively with us to the benefit of our members. We meet with these groups on a quarterly basis and provide reporting to include the following:

Financial

Quality

High cost members/Care Management

Pharmacy

Network Operations

Risk adjustment

We provide a Community Connector to each of these groups which help to coordinate care between the health plan and clinic, and to act as a liaison between us as partners. These quarterly meetings have allowed us to establish relationships with our clinical partners and coordinate quality and care management activities. These programs have placed us on a track towards improved clinical outcomes, higher patient satisfaction, and lower cost of care.