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Lower Costs, Higher Quality of Life: Addressing Social Determinants of Health

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In the 35 years that Molina Healthcare has been serving the low-income population, we've learned that physical health issues represent just a fraction of the challenges our members face. In our experience, the issues of members living with chronic medical conditions, mental health disorders, substance abuse, financial insecurity, limitations to performing activities of daily living, and virtually all problems related to well-being are often exacerbated by a challenging socio-economic environment.

It's also true that, the more complex the case, the lower the likelihood of healthy long-term outcomes—and the greater use of higher levels of care, at least some of which are avoidable. Many of these patients get much of their care at the onset of acute symptoms, relying on Emergency Rooms for care that could be much better delivered in a primary care office setting. The presence of behavioral health conditions, commonly under-diagnosed or inadequately treated, pose additional barriers to managing physical health.

The health, behavioral health and human services systems, most of which are fragmented and poorly coordinated, are challenging for any person to navigate. But for members with multiple chronic conditions, daily stressors related to psychosocial needs, behavioral health conditions, and limited health literacy, navigating multiple systems and coordinating care between these systems becomes an insurmountable task for most.

Washington's Health Home program is designed to serve our most vulnerable members with intensive community-based care coordination services delivered in the communities where the members live. The goal of the Health Home program is to assess gaps in care and Social Determinants of Health –the circumstances in which people are born, grow up, live, work and age – to mitigate the negative impact of these social determinants on the overall health and well-being of Medicaid beneficiaries. Health Home Care Coordination involves a holistic approach, evaluating a member's needs on all domains of health to better coordinate care and resources, fully integrated with their traditional care, which we believe will lead to better health outcomes and lower costs to taxpayers who fund the Medicaid program. It's good health. It's good business.

A team approach to cover a range of health issues: It's Personal

Molina's approach to the Health Home program involves a team of professionals working with each member, one-on-one, on their turf to strive to assist not just with traditional health care

access issues, but also health and wellness challenges related to areas of need such as safe and stable housing, adequate and healthy food, affordable transportation, and sustainable employment. Two critical members of the Molina Health Home team are the Care Coordinator and the Community Connector.

The Care Coordinator helps manage a member's services across their many providers. They take time to learn a member's medical history and clinical needs, often identifying concerns and needs that may have never been identified or disclosed in the traditional office visit or ER setting. The Care Coordinator works collaboratively with the member to complete a Health Action Plan, identifying care and social gaps, developing health and wellness goals, and agreeing to a set of planned interventions to solve problems and close gaps. In addition to coordinating care and services, the Care Coordinator works with the member's doctors and nurses to insure that each Health Home member's needs are incorporated into their care plan. The Care Coordinator provides health education and self-management skills, often serving as a member's advocate while activating the member to be their own advocate.

The Community Connector plays several roles, including one-on-one coach for the member, often where the member lives, as well as liaison between the member and his/her multiple clinicians. As community connectors evaluate members in the context of the home environment, they serve as the eyes and ears of the medical providers, often discovering physical or mental health concerns not previously disclosed or treated. By further identifying and addressing issues of safety, security, and assistance required in the home, community connectors help members receive the kind of tailored services that keep them independent and connected to their communities.

With deep knowledge about the neighborhood and community programs that provide housing, food, transportation, childcare, eldercare, and companion care, the Community Connector's focus is primarily on the member's Social Determinants of Health, while the care coordinator addresses clinical needs. In that process and relationship with members, the Community Connector refers and links them to local resources that might help them maintain or improve their health.

So far, results for the Health Home program have been promising. We're beginning to see lower utilization of avoidable ER and hospitalization. Members feel well cared for and supported, and are empowered to take greater responsibility for the management of their care and health. Here are a few actual Health Home success stories from a sample of Molina members. (Names and some details have been modified to insure members' privacy.)

Managing Multiple Chronic Conditions

Ann lived with many chronic conditions including: COPD, asthma, diabetes, sleep apnea, anxiety, depression, and PTSD. She was hospitalized twice in 3 months for exacerbation of COPD symptoms. Ann reported that she "waits until I can't breathe well then I go to the ED." She had not been attending mental health counseling appointments to treat her depression due to transportation barriers.

During their meetings, the Community Connector educated Ann about using a local Urgent Care clinic instead of the ED and seeking treatment early in the progression of symptoms. The Community Connector provided resources for local food banks, nutrition classes, transportation and housing options. The Community Connector learned that Ann had never replaced her broken CPAP machine despite the fact that regular use was a core part of managing her condition. With the prompting of the Community Connector, Ann obtained a new CPAP machine and worked with the Molina Case Manager to learn more about her diseases, how to manage them, and early warning signs and triggers that require follow up with her doctor.

New baby, new challenges

24-year-old Maria suffered a stroke just months after her son was born, leaving her wheelchair-bound. As a mother with an infant, Maria already felt overwhelmed. The added challenges to her mobility and other health problems made it difficult to get to routine doctor appointments. Instead, Maria went to the ER whenever her baby had a cold or she experienced pain. Without the regular care she needed to address her medical conditions, her health continued to deteriorate leaving her further challenged to care for her child.

After joining the Health Home program as a Molina member,

Maria's Care Coordinator, Justin, familiarized himself with her medical history and worked with Maria to effectively communicate her care needs to her providers. As her health improved, Maria was better able to manage her child's routine needs and attend appointments with her child's pediatrician resulting in an end to avoidable visits to the ER. Yul, Maria's Community Connector, visited her at home and observed that Maria's home was not well designed to accommodate a wheelchair. Yul found local resources that were able to make modifications in her living space that made everyday life with a wheelchair easier.

Maria has expressed gratitude for Molina's Health Home program, and especially for the care Yul took with her. She recently commented, "The fact that Yul took the time to visit me in my home and understood that my quality of life was important to my physical health really meant something to me. It gave me hope."

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