



Molina Medicaid Managed Care: Telehealth and Innovations in Coordinated Care

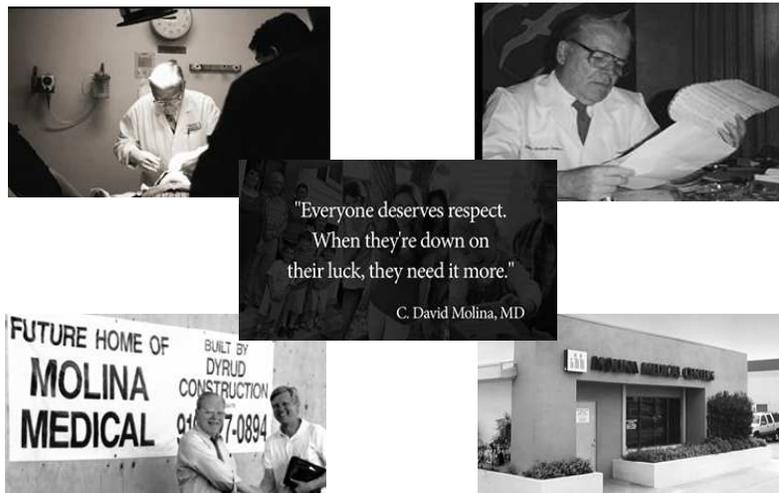
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Irene Krokos, M.D.
Chief Medical Officer
Molina Healthcare of New Mexico



Molina Story



"Everyone deserves respect.
When they're down on
their luck, they need it more."
C. David Molina, MD

FUTURE HOME OF
**MOLINA
MEDICAL**

BUILT BY
DYRUD
CONSTRUCTION
01-7-0894

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Molina Mission and Core Values

Our mission is to provide healthcare services to low-income families and individuals covered by government programs.

- Care about people we serve and advocate on their behalf
- Provide quality service and remove barriers to health services
- Healthcare innovators and embrace change quickly
- Respect each other and value ethical business practices
- Careful in the management of our financial resources and serve as prudent stewards of the public's money

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Molina Healthcare of New Mexico

- Salud! and SCI (State Coverage Insurance)
- Fee for Service (FFS) and Third Party Administrator (TPA) for the State of New Mexico
- Medicare



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 **MOLINA HEALTHCARE**

Chronic Disease

Diabetes

- 23.6 million people in the U.S. have diabetes
- 5.7 million people have undiagnosed diabetes in the U.S.
- 1 in 3: ratio of Americans who will develop diabetes in their lifetime
- \$174 billion is the estimated total annual cost of diabetes in America

Cardiovascular Disease

- 26.6 million (12%) adults have heart disease in the United States
- 16 million annual medical visits have heart disease as primary diagnosis in the U.S.

Asthma

- 7.0 million (9.4%) children; 16.4 million (7.3%) adults
- 1.8 million visits to emergency departments (2004)
- 12.8 million school days missed (2003)

<http://cmcd.sph.umich.edu/statistics.html>

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Behavioral Health

- 25% of all U.S. adults have a mental illness and that nearly 50% of U.S. adults will develop at least one mental illness during their lifetime
- \$300 billion dollars estimated economic burden in the U.S. (2003)
- Mental illnesses account for more disability in developed countries than any other group of illnesses, including cancer and heart disease
- Mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, epilepsy, and cancer
- 2 to 6 times higher rates for both intentional (e.g., homicide, suicide) and unintentional (e.g., motor vehicle) injuries among people with a mental illness than in the population overall
- Bipolar disorder: inpatient hospitalization rate 39.1% vs 4.5% for all other behavioral health diagnoses; for every dollar allocated to outpatient care \$1.80 is spent on inpatient care.

http://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html⁷



Social Determinants of Health

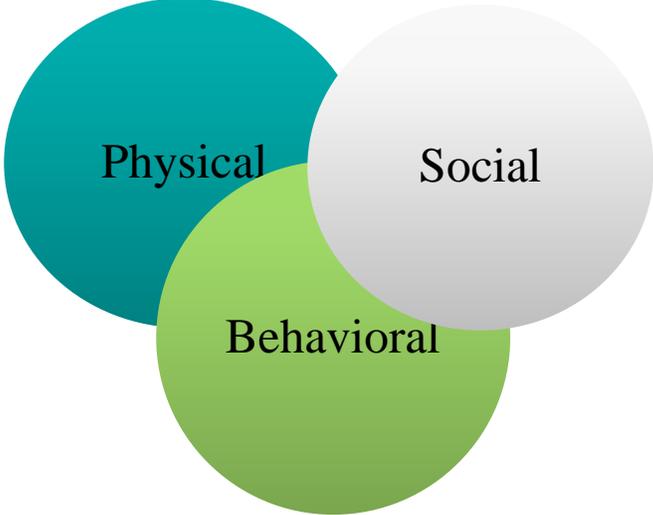
- People's lifestyles and the conditions in which they live and work strongly influence their health.
 - How a person develops during the first few years of life (early childhood development)
 - How much education a persons obtains
 - Being able to get and keep a job
 - What kind of work a person does
 - Having food or being able to get food (food security)
 - Having access to health services and the quality of those services
 - Housing status
 - How much money a person earns
 - Discrimination and social support
- Health literacy: 90 million people have difficulty understanding and acting upon health information

www.cdc.gov; Health Literacy: A Prescription to End Confusion (2004)

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 **MOLINA HEALTHCARE**

Integrated Model of Health Management



Physical

Behavioral

Social

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 **MOLINA HEALTHCARE**

Leveraging Technology in Integrated Health Management



Project ECHO®

Patient-Centered Medical Home

Community Health Worker

Care Transition

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Project ECHO



- Promoting quality, best practice care in rural and underserved areas thru telemedicine
- Supports primary care practitioners (PCPs) in caring for their patients
- Improving access to specialty consultation and disseminating advancements in medicine
- Complex Care Clinic – a new model for primary care
- Sustainability

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Patient Centered Medical Home



- 18 of our network practices have achieved NCQA recognition as Patient Centered Medical Homes.
- Molina is providing incentives for primary care practices to implement up to five modules that are consistent with PCMH principles including Electronic Medical Records, Patient Tracking and Registry, E-prescribing, Access and Communication, and Performance Reporting and Improvement.
- To date, about **80** primary care provider practices from across the State of New Mexico are working with Molina's PCMH Module Program. **Over 25,000** Molina members receive their primary care from these practices (about one-third of our total membership).
- The practices participating in Molina's PCMH Module Program include a **School Based Health Center** which is one of the first in the nation to be working towards NCQA Recognition.

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Community Connector



- Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have an unusually close understanding of the community they serve. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Explore HealthCareers.org

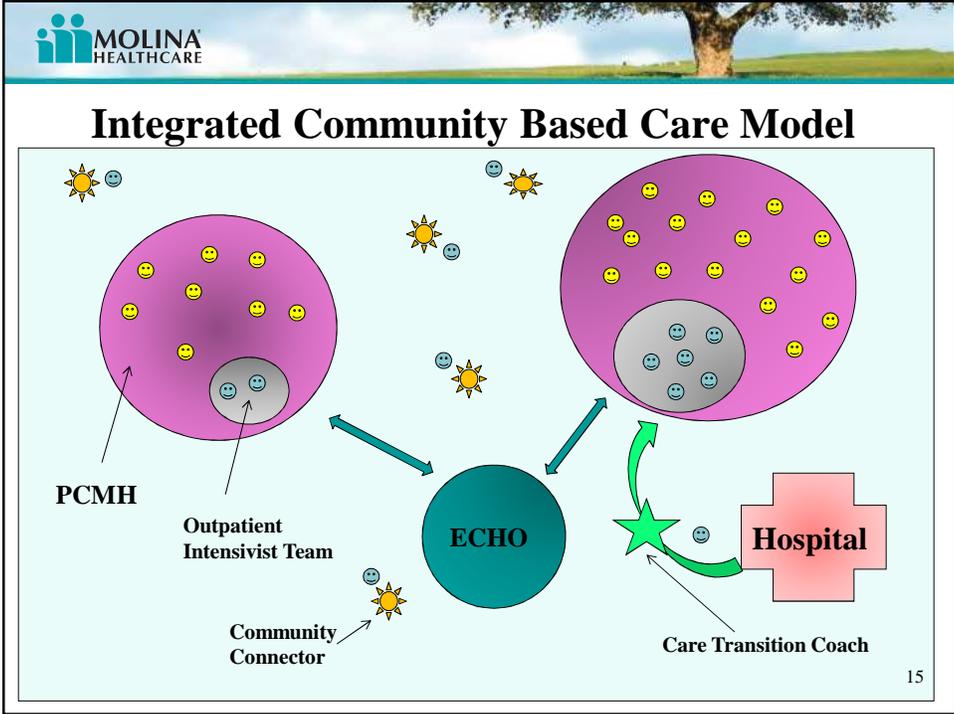
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Care Transitions



- Improve self-management and empower members to navigate a complex system.
- Provide support and assistance during the time of transition from facility to home and back to primary care practitioner.
- Nurse visits member in hospital and then at home. Additional follow-up over 4-6 weeks by phone and home visits as needed.

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Conclusion

Molina Healthcare of New Mexico with our valued partners is working to create innovative, high-quality, evidence-based, sustainable solutions for the members we serve.

A photograph of a woman with dark hair smiling warmly while holding a young child. The child is also smiling and looking towards the camera. The background is a soft-focus outdoor setting.

Questions



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