HEDIS and Quality

For Medicaid SSI and BadgerCare Plus members

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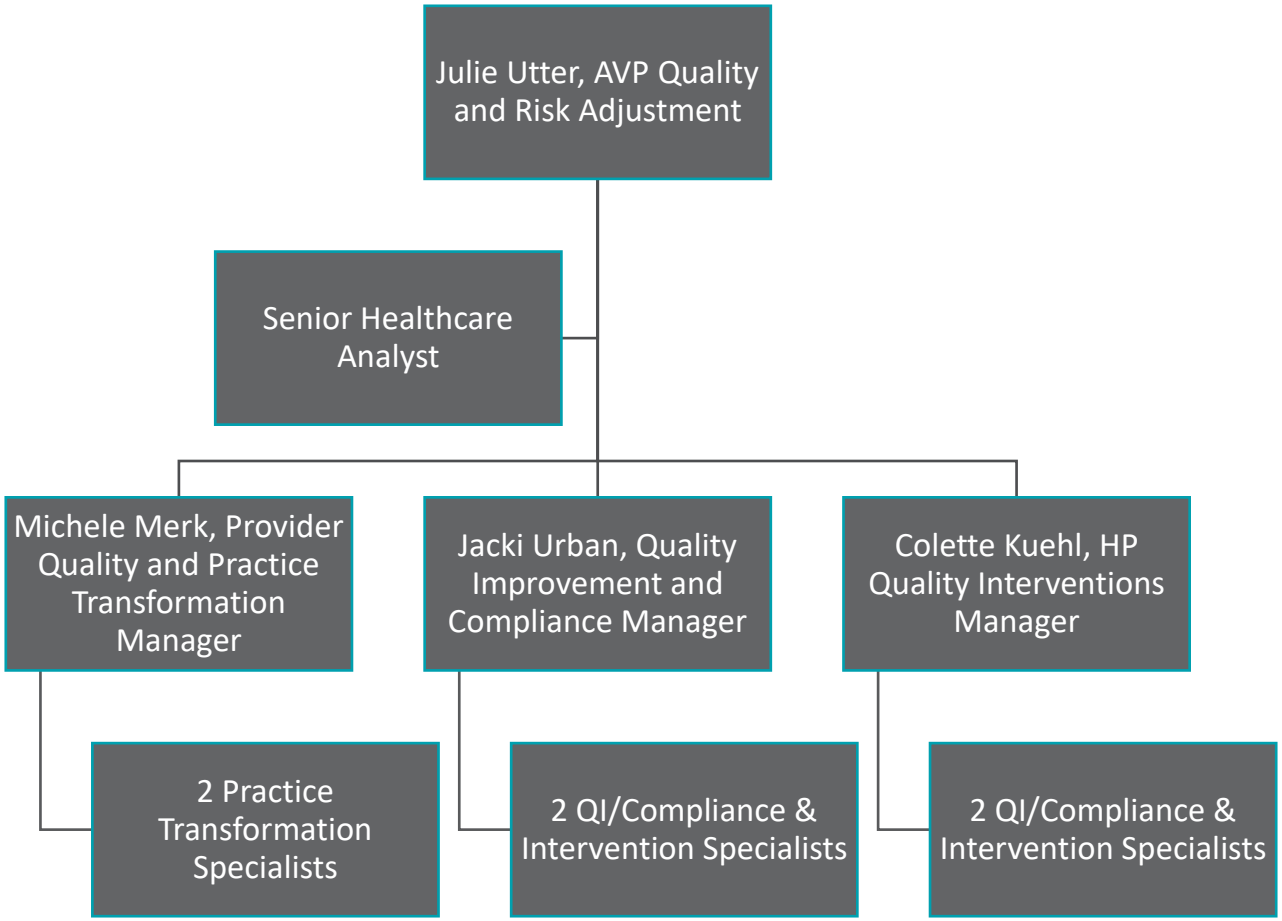
Molina Medicaid Quality Department



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Agenda

- Overview of HEDIS and Quality
- Priority Medicaid Measures in 2024
- Interventions and Resources within our Organization
- CEU Opportunities for Providers

What is HEDIS®?

Healthcare Effectiveness Data and Information Set

- HEDIS® is a standardized set of performance measures utilized by health plans that compares how well a plan performs in these areas:
  - Quality of Care
  - Access to Care
  - Experience of Care
- Developed and maintained by the **N**ational **C**ommittee for **Q**uality **A**ssurance (NCQA)
- How is it measured?
  - The denominator is the number of patients who meet the criteria for a measure.
  - The numerator is those who meet the criteria for completing the measure (i.e., complete a service or have control of a chronic disease.)

$$\frac{\text{15 patients with controlled A1c}}{\text{50 patients who have diabetes}} = \text{30\% performance for diabetes control}$$

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Examples of HEDIS Measures

- Effectiveness of Care
  - Controlling High Blood Pressure (CBP)
  - Diabetic Care: A1c control, Eye exam service completed (GSD, EED)
  - Breast Cancer Screening (BCS)
- Access to Care
  - Adult Access to Preventative Ambulatory Health Services (AAP)
  - Well Child Visits (W30, WCV)
  - Timeliness of Prenatal/Postpartum Care (PPC)
- Member Satisfaction with Health Plans and Doctors (Experience of Care)
  - Getting care quickly
  - How well doctors communicate
  - Rating of personal doctor

We utilize HEDIS results to drive improvements, aligning with the Quintuple Aim to deliver high-quality, equitable, and efficient care

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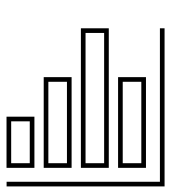
HEDIS Data Collection for Patient Care

How to share data:

- Data comes to us through claims, and CPTII codes added
- Initiate EMR data feed
- Medical record review

With accurate information, we're able to improve metrics, but ultimately improve the patients' health, experience and reduce cost:

$$\frac{\text{30 patients with controlled A1c}}{\text{50 patients who have diabetes}} = \uparrow 60\% \text{ performance for diabetes control}$$



Clinic data → HEDIS database → Care Opportunities Identified

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Priority Measures in 2024

- Child and Adolescent Well-Care Visits (WCV)
- Childhood Immunization Status - combo 3 (CIS)
- Immunizations for Adolescents - combo 2 (IMA)
- Lead Screening in Children (LSC)

- Follow-Up After Hospitalization for Mental Illness - 30 days (FUH)
- Follow-Up After Emergency Department Visit for Mental Illness - 30 days (FUM)
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)

- Timeliness of Prenatal Care (PPC)
- Postpartum Care (PPC)
- Cervical Cancer Screening (CCS)
- Breast Cancer Screening (BCS)

- Glycemic Status Assessment for Patients with Diabetes (GSD)
- Controlling High Blood Pressure (CBP)
- Asthma Medication Ratio - Total (AMR)

Tip Sheets available in Availity or email by request to MHWIQuality@Molinahealthcare.com

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Partnering for Better Outcomes

- At Molina, we recognize the significant impact of social determinants of health (SDOH) on our Medicaid population's outcomes.
- We have implemented targeted interventions to address key challenges, such as:
  - Healthcare access and coordination
  - Housing instability
  - Limited access to healthy food
  - Lack of transportation
  - Mental health and social support

Let’s collaborate!

We invite you to partner with us to further address these needs and work together to improve health outcomes, ensuring equitable care for our Medicaid members.

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Collaborative Programs for Providers and Patients

Care Coordination and Support Services:

- **Care Management Program:**
  - What We Do: Assess and coordinate care for members with complex health needs (including SDOH).
  - How It Helps: Streamlines care coordination, improves outcomes, and enhances communication, reducing provider workload.
- **Transitions of Care Program:**
  - What We Do: Support members transitioning from hospital to home or lower-care settings.
  - How It Helps: Reduces readmissions and ensures continuity of care, allowing providers to focus on clinical care.
- **Community Connectors Program:**
  - What We Do: Schedule and remind members of provider appointments, offering personalized support.
  - How It Helps: Improves appointment adherence, reduces missed or delayed visits, and ensures timely access to care.

Population Health and Patient Education:

- **1:1 Health Coaching with Pop Health Team:**
  - What We Do: Provide personalized coaching for diabetes, hypertension, asthma, and more, in partnership with providers.
  - How It Helps: Promotes disease management, improves compliance, and enhances outcomes.
- **Champions Program:**
  - What We Do: Educate members on chronic conditions like diabetes and hypertension through multimedia resources. Great for maintaining health outcomes achieved in 1:1 coaching.
  - How It Helps: Encourages participation through incentives like tailored meal boxes.

Social Determinants of Health (SDOH) Support:

Language and Cultural Resources:

- **Interpreter Services:** Improve communication via Globo services.
- **Multilingual Resources:** Provide educational tools in multiple languages to diverse populations.

Housing and Transportation Assistance:

- **Milwaukee County Housing Division Partnership:**
  - **What We Do:** Collaborate to help homeless members secure affordable housing.
  - **How It Helps:** Provides stable housing as a key factor in overall health improvement.
- **Member Transportation (MTM):**
  - **What We Offer:** State-provided transportation services to ensure access to medical appointments.

Food and Meal Support:

- **Food For Health Partnership:**
  - **What We Do:** Offer educational events on dietary needs, particularly for maternal health.
  - **How It Helps:** Ensures food security, supporting overall health for members.
- **Molina Help Finder:**
  - **What We Offer:** Web-based tool connecting members to free or low-cost resources (food, housing, etc.).

Maternal and Child Health

OB Medical Home Program:

- **What It Is**: A care model for pregnant Medicaid members in Wisconsin, focused on improving maternal and infant health outcomes through coordinated, comprehensive care.
- **How It Helps**: It provides continuous support from pregnancy to postpartum, emphasizing prenatal care, early risk detection, and care coordination with OB/GYNs and pediatricians.

Healthy Starts Program:

- **What We Offer**: Pregnant members who complete six prenatal visits and select an in-network pediatrician receive a car seat or pack-n-play.
- **How It Helps**: Encourages regular prenatal care and safe practices for new mothers.

BOMB Doula Program:

- **What It Is**: Birth Outcomes Made Better (BOMB), in partnership with Molina, offers Doula services to eligible members living in Milwaukee.
- **How It Helps**: Supports mothers during pregnancy, labor, and postpartum, improving birth outcomes through personalized care.

Engagement and Preventative Care Incentives

Member Call Campaigns:

- **What We Do**: Assist with appointment scheduling, transportation, and medication refill reminders to support HEDIS measures.
- **How It Helps**: Increases engagement in preventive care, ensuring members attend necessary appointments and stay compliant with medications.

Member Mailings & Text Messages:

- **What We Do**: Send educational content and reminders for missing services.
- **How It Helps**: Improves health education and raises awareness about preventive care, helping members stay on top of their health needs.

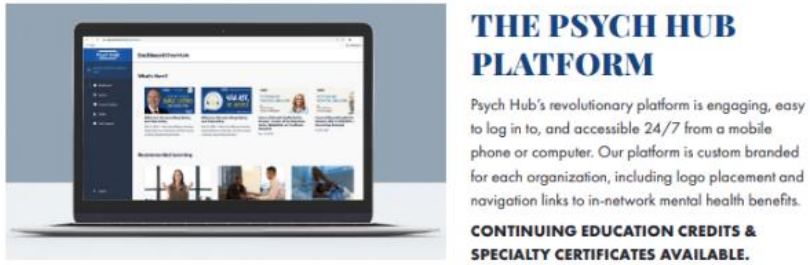
Member Incentive Program:

- **What We Do**: Offer incentives to encourage members to complete recommended services.
- **How It Helps**: Boosts preventive care engagement by motivating members to follow through with essential health services.

Earn CEUs with Psych Hubs Learning Portal

Wide Range of Courses Available

- Mental Health and Psych topics
- Motivational Interviewing techniques
- Trauma-Informed Care



Spotlight: Trauma-Informed Care Training

- Crucial for improving patient outcomes, especially for those with trauma histories
- Helps us create a safe, supportive environment for all patients
- Aligns with our mission to enhance trauma-sensitive services and improve overall care quality

https://psychhub.com/

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Together, We Can Make a Difference

- At Molina Healthcare, we believe that collaboration is key to improving the health outcomes of our Medicaid members. By partnering with you, our dedicated providers, we can address the social determinants of health and ensure our community receives the care and resources it deserves.
- Let's work together to:
  - Improve access to care
  - Enhance chronic disease management
  - Increase preventive services
  - Reduce healthcare disparities
- **We value your partnership and are excited to collaborate with you!**
- Contact us: MHWIquality@molinahealthcare.com

Questions?

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