

Social-Centric Care Coordination: Preparing for new health plan standards



New NCQA population health standards for 2018 have been formulated to maintain and improve the physical and psychosocial well-being of your members, particularly those in vulnerable Medicaid and dual eligible populations. Meeting these standards requires a strategy to identify and address the social determinants of an individual's health and well-being.

How prepared are you to meet this new requirement? How confident are you in the data used to comply? Have you considered how your Population Health Management/ Care Coordination model needs to change?

Capturing Medicaid data and turning it into useful insights for an effective care coordination model can be challenging. Optum can help you connect the dots, so you can see the bigger picture. We'll show you how to recognize relevant data, understand it and perform meaningful analysis. The result: You'll have the components in place to develop a new care coordination model aligned with the latest NCQA population health requirements.

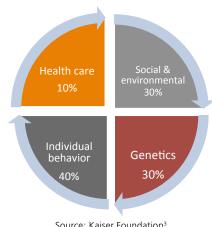
Identify, reach and engage

First step in crafting a new model is to understand more about your populationleveraging analytics to start to understand more about your members. We'll help you design a care coordination model around your population's unique needs. Using our intelligence engine, OptumIQ™, we will help you:

- Identify the right people. By means of Optum proprietary algorithms, our model finds the members most willing to engage, as well as those living with serious medical conditions. Impacting this population segment is essential for improving outcomes.
- Understand the willingness to engage. With a health ownership rating and social isolation index, our time-tested member inclination index considers a member's propensity to engage. These data sets may also pinpoint the members most likely to respond – focusing your efforts and investments where they will make a difference.
- Deploy community-based outreach. Optum community-based health workers, social workers and case managers provide compassionate care coordination and support for the most vulnerable members at home or prior to discharge from a hospital stay. This fundamental approach removes SDOH barriers and can help reduce behaviorrelated medical episodes and associated costs. For example, 40 percent of Californians eligible for Medi-Cal reported a language other than English as their primary language.1

Why SDOH are important to California?

- 90% of estimated health care spending is attributed to social determinants.1
- 70% of all Medi-Cal managed care beneficiaries are enrolled in California's publicly managed not-for-profit health plans.2
- 38M enrollees make California's Medicaid program the largest state Medicaid program in the nation.1



Source: Kaiser Foundation³

Zip code vs. genetic code

Social determinants typically impact your most vulnerable members. Poverty, lack of affordable housing and access to transportation; and lack of access to parks and playgrounds, libraries and full-service grocery stores can pose ongoing challenges to health and wellness.

And managed care plans are engaged in activities to identify and address these social needs.⁴ A recent survey of Medicaid managed care plans found that 91 percent of those responding reported activities to address social determinants of health.⁴ Although winds of change at the federal level portend modifications, 19 states in 2017 required Medicaid managed care plans to screen for and/or provide referrals for social needs.⁴

Optum understands the national trends, is cognizant of the challenges and can help your at-risk members overcome their barriers to care.

Make the investment

Make your health plan's investments count. With Optum, you have partner who can marshal SDOH analytical, operational, and engagement data and expertise on your behalf.

You can benefit from the Optum national-level view of the trends, research and innovation that is changing the health care landscape. Because Optum works with nearly 300 health plans and touches more than 50 percent of Medicaid recipients, you gain from experience and insight that enable smarter decisions using SDOH, consumer and predictive analytics, prescriptive analysis and the most current modeling. In turn, your plan improves care quality, member experience and health care outcomes.

Determinants of health and wellbeing

Optum is here to help. Whether you are looking for SDOH capability assessments, data and analytical solutions or a new social-centric care coordination approach, we have the resources, experience and expertise to support your efforts. Let's connect soon.

Sources:

- Margaret Tatar, Julia Paradise, and Rachel Garfield, "Medi-Cal Managed Care: An Overview and Key Issues." March 2016. Henry J Kaiser Family Foundation. https://www.kff.org/.../medi-cal-managed-care-an-overview-and-key-issues-issue-brief... Accessed July 2018.
- 2. Local Health Plans of California. https://www.lhpc.org/about-lhpc. Accessed July 2018.
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- 4. David Machledt, "Determinants of Health through Medicaid Managed Care," November 29, 2017, The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/ addressing-social-determinants-health-through-medicaid-managed. Accessed July 2018.

It's not just California. Other states are integrating SDOH into their Medicaid contract to improve health outcomes.

- Arizona requires coordination of community resources, housing and utility assistance, under its managed long-term services and supports program
- Washington, D.C. encourages referrals for members with three or more chronic conditions to care coordination and social support services, among others
- Louisiana requires referrals to WIC and Louisiana Permanent Supportive Housing if appropriate
- Nebraska requires MCOs to have staff trained on SDOH and be familiar with community resources

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