BlueCross BlueShield Minnesota

MEDICAID POPULATION HEALTH

STRATEGY & ROADMAP

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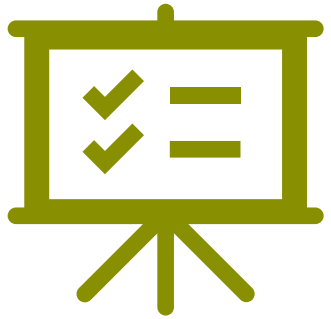
WELCOME!

Learning Objectives for this Training

1. Participants will be able to define and understand Population Health
2. Participants will better understand how Population Health and data guides our programs and interventions to improve member outcomes
3. Participants can leverage this information as a tool to evaluate and share information about their communities to improve member outcomes



Housekeeping

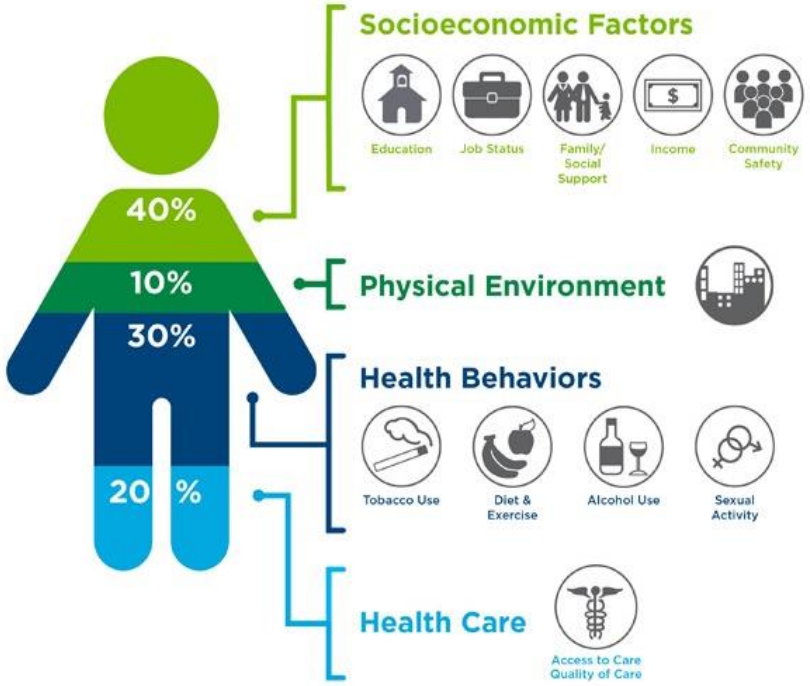
1. All attendees will be muted
2. Please enter questions in the chat to be reviewed at end of presentation as time allows
3. Training is recorded and will be posted to the Care Coordination website

WHAT IS POPULATION HEALTH?

DEFINITION: A strategic framework to improve the **outcomes** of a defined **group of people** and informs a model of care for addressing individuals' comprehensive health needs.

➡**People:** Race & ethnicity, age, gender, gender identity, disease or condition, and genetics.

➡**Factors that contribute to health:** Environmental, geography, income, employment, safety, education, etc.



WHAT IS POPULATION HEALTH?

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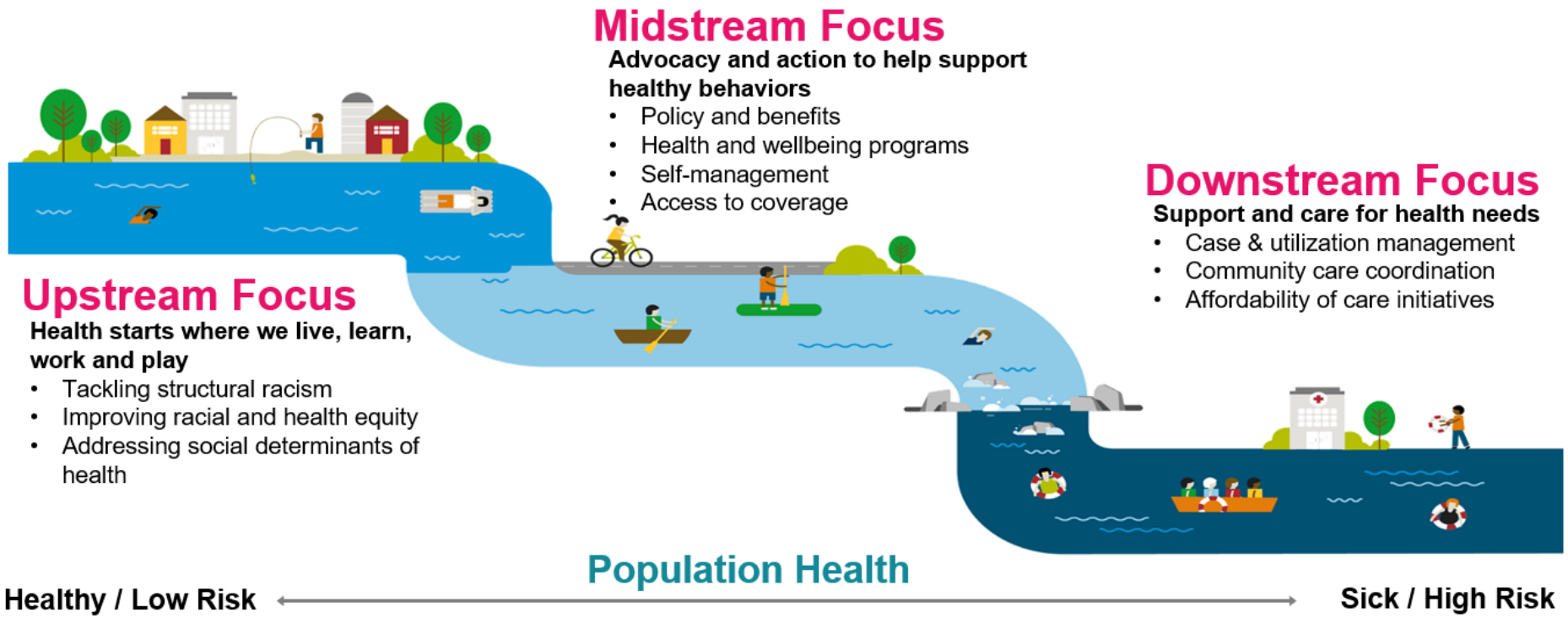
➡**Interventions**: Clinical, behavioral, social, educational, legislative, systematic or environmental.

➡**Outcomes**: health (equity, morbidity, mortality), experience, wellbeing, quality of life

Clinical	Case and utilization management, quality of care (i.e., addressing gaps in care, managing transitions in care) and affordability of care initiatives
Behavioral	Behavior change programs like Omada and consumer incentives to help members adopt healthy behaviors
Social	Addressing social determinants of health like housing, food, employment, education and safety with community partners
Educational	Workforce development and training, education and skill building for members as well as navigation support to find and receive the right care
Legislative	Local and state level policy reform and associated awareness campaigns like access to coverage or tobacco use restrictions
Systematic	Payment reform, value-based partnerships and other payment incentives with providers and benefit design changes to influence over/under utilization
Environmental	Home, work and community improvements like grab bars to prevent falls, healthy food options in the workplace and complete streets for exercise

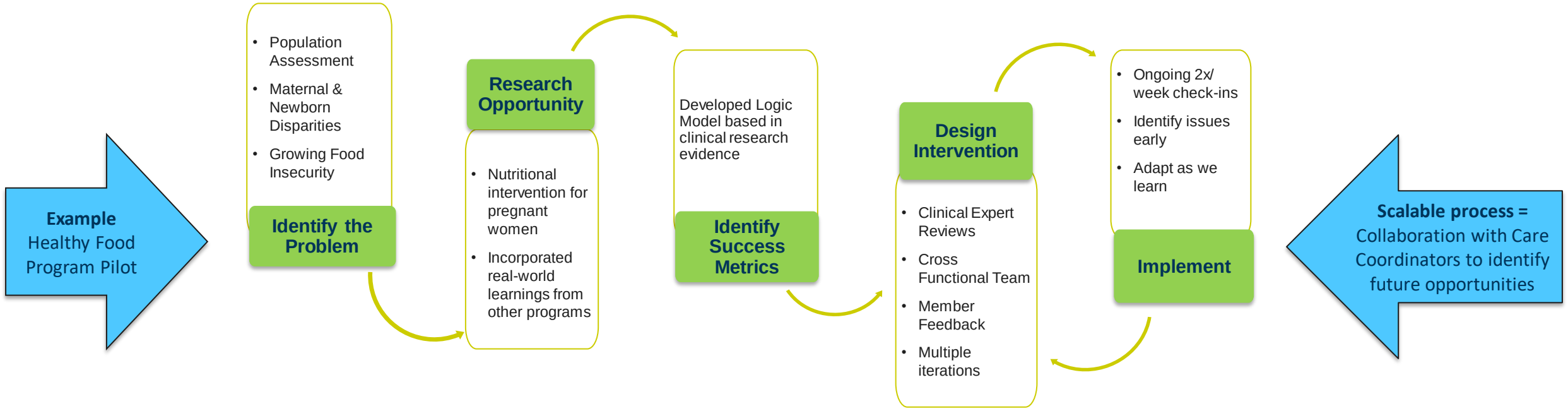
THE CONTINUUM OF HEALTH

To increase our impact in supporting consumer health and cost sustainability, we focus and connect the efforts from upstream to downstream.



PHM STRATEGY: INTEGRATING DATA TO INFORM INTERVENTION

Our Population Health design process follows a continuous improvement cycle to determine root causes and engage stakeholders in the design of interventions and actions. This process best positions our interventions to meet the needs of our members and ultimately be successful in maintaining and improving health, well-being, and quality of life.



EXAMPLES OF POPULATION HEALTH INTERVENTIONS & PROGRAMS IN FLIGHT

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Patient Safety & Outcomes Across Settings

- Papa
- Blue Plus Member-specific Housing Initiatives
- Martin County CHW Pilot

Keep Members Healthy

- Odam Medical Group Mobile Clinic
- BlueRide Grocery Ride Pilot
- North Memorial Health Clinical Care Navigator

Manage Members with Emerging Risk

- CHW Hubs: Winona Hub, Mankato Hub and Minneapolis PUC
- WellShare CHW Diabetes Pilot
- MHealth Community Paramedic

Manage Multiple Chronic Illnesses

- CareSignal Pilot
- Livio Health Palliative Care
- Winona Health Food as Medicine Pilot

POPULATION HEALTH INTERVENTIONS IN FLIGHT

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PATIENT SAFETY & OUTCOMES ACROSS SETTINGS

Program	Description	Population Health Lever(s)	Health Continuum	Targeted Population	Measurable Goal	How Members are Informed
Papa Pilot	Connects locally sourced trained caregivers to seniors at high risk for social isolation to provide companionship. Visits are performed both in-person and virtually.	• Social • Environmental	Midstream	Community-dwelling MSHO and MSC+ members in the top quartile of risk for social isolation in St. Louis, Winona and Olmstead counties	• Reduce member isolation • Assess for SDOH • Complete UCLA Loneliness and CDC Healthy Days measures	• CC referral • Member mailing
Blue Plus Member-specific Housing Initiatives	Funding provided to Catholic Charities of St. Paul & Minneapolis, SW Minnesota Housing Partnership & Brainerd HRA to assist Blue Plus members with housing assistance	• Environmental • Clinical • Behavioral	Downstream	Members in Minneapolis and St. Paul, SW Minnesota and Brainerd experiencing homelessness or housing instability	Show continued housing stability based on number of members served and remaining in housing at 1, 3 and 6 months.	Organization informs Blue Plus members who are already receiving assistance of additional funding to alleviate barriers
Martin County CHW Pilot	Pilot with CHW Solutions to conduct in-home outreach to seniors to help them live at home as long as they safely can	• Social • Environmental • Clinical	Midstream	Members in Martin County at risk for moving to assisted living/nursing homes	Goals in development	Member letters CHW Solutions outreach Care Coordinators

KEEPING MEMBERS HEALTHY

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Program	Description	Population Health Levers	Health Continuum	Targeted Population	Measurable Goal	How Members are Informed
Odam Medical Group Mobile Clinic	Mobile clinic collaboration to bring medical care to members in their homes	• Clinical • Behavioral • Social • Educational • Environmental	Upstream Midstream Downstream	Members in the following counties: Stearns, Wright, Benton, Sherburne, Clay, Crow Wing, Otter Tail, Cass, Wadena, Todd, Morrison, Mille Lacs, Kanabec, Meeker, Kandiyohi, & Becker counties	• Increase access to culturally concordant care • Eliminate barriers to physical access to care • Member satisfaction • Close gaps in care	• Direct outreach from Odam Medical Group • Blue Plus member postcards
BlueRide Grocery Ride Pilot	Pilot using Blue Ride to provide members with up to 2 rides/month to grocery stores	• Social	Midstream	Members in Winona, Kandiyohi, Carlton, Pine, Rice, Blue Earth, Mower, Sherburne, Stearns, Benton & Clay counties	Member satisfaction surveys to inform program improvement and expansion	• Blue Plus member letters
North Memorial Health Clinical Care Navigator	Assists members in navigating health care by providing enhanced support to educate members on the importance of primary care and services and resources of North Memorial	• Clinical • Behavioral • Social – Navigators always screen for SDOH	Midstream Downstream	Members attributed to North Memorial Health Clinic system with SDOH needs and unattributed members residing in their service area	Follow-up on clinician assessment of SDOH and connect to community resources	• Blue Plus member postcards

MANAGING MEMBERS WITH EMERGING RISK

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Program	Description	Population Health Levers	Health Continuum	Targeted Population	Measurable Goal	How Members are Informed
Community Health Worker Hubs	Live Well Winona and Mankato Hub	• Clinical • Behavioral • Social • Educational • Environmental • Legislative	Upstream Midstream	Members experiencing a barrier related to SDOH in Winona, Mankato and Twin Cities	• Increase number of members screened for SDOH.	• Care Coordinator • Provider referral • BCBSMN member letter
WellShare CHW Diabetes Pilot	In-person outreach to MSHO & MSC+ members with pre-diabetes and diabetes to conduct education and referrals to DPP and DSME programs	• Clinical • Social • Educational	Midstream Downstream	Members with pre-diabetes and diabetes in Blue Earth, Nicollet, Brown, Le Sueur, Waseca, and Cottonwood, Ramsey, Hennepin, Dakota, Washington, Anoka, Carver, Scott	• Increased efficacy to manage health (PAM* and DDS* score) • Closed gaps in care (HEDIS A1C measure) • Enroll in DPP & DSME (or working with clinic diabetes educator) ** Patient Activation Measure survey; Diabetes Distress survey*	• Care Coordinator • BCBSMN member letter • BCBSMN Case Management • CHW call
MHealth Community Paramedics	Paramedics partner with primary care clinics and hospitals to bring primary care, BH and LTSS to patients where they live – **This includes medication reconciliation, telehealth education, and culturally specific food boxes for Hmong and Karen members.**	• Clinical • Behavioral • Social • Educational • Environmental	Midstream Downstream	MSHO & MSC+ members in Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, and Washington counties with SUD, depression and high-risk scores for SDOH	• Increase in Healthy days measurement • Increase in Medication Reconciliation year over year • Patient Satisfaction survey completion • Referrals to primary or specialty care	• Outreach and follow-up from MHealth

MANAGE MULTIPLE CHRONIC ILLNESSES

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Program	Description	Population Health Lever(s)	Health Continuum	Targeted Population	Measurable Goal	How Members are Informed
CareSignal Pilot	Remote patient monitoring service in collaboration with Sanford Health. Enables Sanford to regularly check in with patients between visits.	• Clinical • Educational	Downstream	Members attributed to Sanford Health w/ diagnosis of depression, diabetes or heart failure.	• Patient Satisfaction • ER/Inpatient avoidance • Improve equitable health outcomes between BIPOC & non-BIPOC patients	• Sanford Health direct member referral and outreach
Livio Health Palliative Care	Tailored palliative and advanced primary care for people with serious illness through modern house calls.	• Clinical • Social • Environmental	Downstream	Members with complex chronic illness	95% of assessments completed w/in first visit: • Fall risks • Home Safety • Pain/Symptom • Medication Reconciliation	• Provider referral • CC referral • Livio Health outreach
Winona Health Food as Medicine Pilot	Collaboration with Winona Health to provide food boxes to members with diabetes	• Clinical	Downstream	Members with diabetes & hypertension	• Improved A1c • Decreased ED/Urgent Care • Reduced diabetes distress, • Decreased inpatient stays/ days • Weight reduction • Blood Pressure & Lipid Improvement • SDOH Reduction	• Provider referral • Self referral • Community referral

Q&A

1. What trends or opportunities are you seeing in your counties?
2. What do you see as important for your patients that their health plan could help address?
3. Do you have ideas for a county/community-specific pilot or intervention?
4. Are you aware of successful pilots/programs that would improve Population Health outcomes in your communities that we could collaborate on to mirror or improve?