Falls Prevention for the Community Residing Elderly: A Collaborative Approach.

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Molina Healthcare of Ohio

MOLINA HEALTHCARE

The Molina Story

Over Three Decades of Delivering Access to Quality Care

Molina Healthcare was founded as a single clinic in 1980, to serve patients who wouldn't otherwise have access to quality health care. The company mission: **We improve the health and lives of our members by delivering high-quality health care.**

Today, Molina is a FORTUNE 500 company, providing managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Molina serves the diverse needs of over **3.6 million members** across the U.S. through government-funded programs. Molina provides NCQA-accredited care and services that focus on promoting health, wellness, and improved patient outcomes. Although Molina has evolved into a national health care company, the mission has remained the same. Molina takes every opportunity to **put members first.**

MOLINA HEALTHCARE
Your Extended Family.

The Molina Mission

Our Vision

We will distinguish ourselves as the low cost, most effective and reliable health plan delivering government-sponsored care.

Our Mission

We improve the health and lives of our members by delivering high-quality health care.

Core Values

- Integrity Always
- Absolute Accountability
- Supportive Teamwork
- Honest and Open Communication
- Member and Community Focused

Care Management – MyCare Ohio

Integrated Care Management Program

IDENTIFYING
AT-RISK
MEMBERS

ASSESSING
NEEDS
& PRIORITIES

ONGOING
CARE
COORDINATION

Roles

CARE MANAGEMENT:
MEMBER-CENTERED
PROBLEM-SOLVERS

INTERDISCIPLINARY CARE TEAM:
COLLABORATIVE
EFFORTS FOR BEST OUTCOMES

TRANSITIONS OF CARE:
HIGH-TOUCH
CARE FOLLOWING DISCHARGE

Levels

1 CARE MANAGEMENT FOR LOW/MONITORING MEMBERS

2 CARE MANAGEMENT FOR MEDIUM-RISK MEMBERS

3 FACE-TO-FACE CARE MANAGEMENT FOR HIGH-RISK MEMBERS

4 FACE-TO-FACE CARE MANAGEMENT FOR COMPLEX/INTENSIVE MEMBERS

MOLINA HEALTHCARE

Falls Risk Assessment within the Managed Care Clinical Framework

Why it matters –

- Falls are the leading cause of death by injury in people 65 and older: Every year, one in three older adults falls.[1] Falls can cause hip fractures and head wounds. Which increases the risk of early death. This incites fear that can reduce mobility, cause depression and social isolation.[2,3]
- Falls are a threat to the health and independence of older adults.[4] The majority of falls could be prevented through **evidence-based interventions, initial discussions with practitioners about future risk of falls and practical lifestyle adjustments**.

Falls Risk Assessment within the Managed Care Clinical Framework

Molina aligns its approaches with Ohio Department of Health, CMS, NCQA, AHRQC, and CDC:

- Ensuring Member Health, Safety, and Welfare is at the core of Molina's clinical and quality programs
- Understanding that unnecessary and preventable falls are serious and costly and can snowball over time
- Reviewing falls and the causes ongoing with proactive fall prevention strategies
- Realizing that Medicare and Medicaid shouldered 75% of these costs
- Realizing that one out of five falls causes a serious injury such as broken bones or a head injury
- Realizing that each year, 3 million older people are treated in emergency departments for fall injuries

Falls Risk Assessment within the Managed Care Clinical Framework

Molina aligns its approaches with Ohio Department of Health, CMS, NCQA, AHRQC, and CDC:

- Integrating best practice approaches within our model of care framework, data and analytics processes, clinical documentation system and overall key performance metric monitoring
- Incorporating NCQA - Fall Risk Management as it is a Measure Collected Through the Medicare Health Outcomes Survey
- Collaborating closely with providers, members, and community-based organizations regarding all aspects of our fall prevention program
- Providing education to key stakeholders regarding early signs of change in condition which can cause preventable falls, emergency room and hospital visits

References

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Enhanced Stepping On with Molina Health

People Working Cooperatively's
WHOLE HOME INNOVATION CENTER
REMODELING • EDUCATION • HEALTH • DESIGN

Nina Creech

Senior Vice President

PWC/Whole Home Innovation Center

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www.wholehome.org

A History of Expert Service and Outreach

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Healthy at Home

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- Aging in Place [video]
- Healthy Home
- Lead Paint

Safe & Healthy at Home

Healthy at Home

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- Partnership with Molina
- Enhanced Stepping on Pilot
- Education plus
- Fall prevention assessments
- Installation of customized home solutions
- Data collection and evaluation

Safe & Healthy at Home

Stepping On

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Falls are preventable.
Don't wait until a fall injures more than your pride!

Here at Whole Home Innovation Center, we are committed to helping people live safer, healthier lives at home. Stepping On does just that—in a positive, fun format.

Stepping On is a falls prevention workshop that meets two hours a week for seven weeks. Trained leaders coach you to recognize your risk of falling and help you build the balance, strength and practical skills you need to avoid a fall. Gain the confidence to stay active in your community and do the things you want to do.

Stepping On

Who this is designed for:
- People 60 or older who live independently
- People who have fallen, are concerned about falling, or worry about someone in the home

Who this is NOT meant for:
- People who use a wheelchair full time
- People living with dementia or cognitive impairment

What to expect:
- 2 hours a week of interaction with facilitators and guest experts (and a snack break!)
- Exercise instructions and practice
- Physical items on display
- Easy weekly homework
- A free home assessment offered by our Whole Home Experts

Stepping On is a falls prevention workshop which, according to research, is proven to reduce falls by 30%.

Topics include:
- Balance and strength exercises and how to advance exercises
- Home hazards and solutions
- Vision and Falls
- Community safety, getting out and about
- Shoe and clothing hazards
- Medication management, bone health, and better sleep
- Follow-up home visit (free home assessment)

Guest experts include:
- Physical therapist, vision expert, pharmacist, housing professional
- Community safety expert (often a firefighter/EMT)

In-person and Zoom-based options available

Healthy at Home

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- Home Assessment

Bathroom
Lighting, night light
Grab bars, handheld
Seat/bench needed
Toilet height(s)

Living Areas
Rugs, transitions, cords
Lighting (especially in stairway)
Handrails
Kitchen

Entry, Deck, Porch, Outside
Walkway clear, in good repair
Handrails
Exterior lighting
Other notes

Safe & Healthy at Home

Healthy at Home

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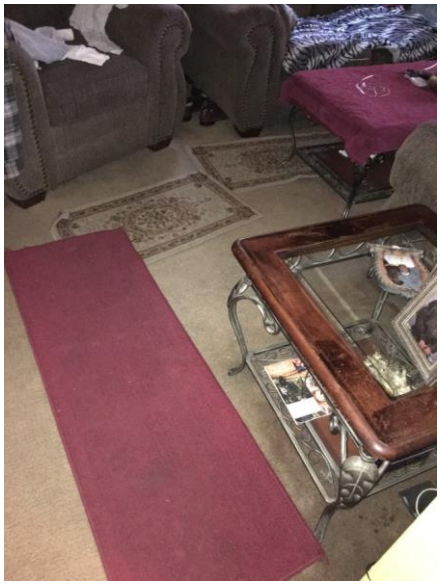
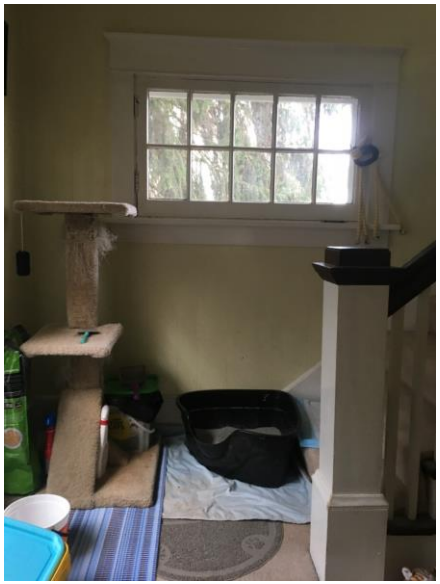
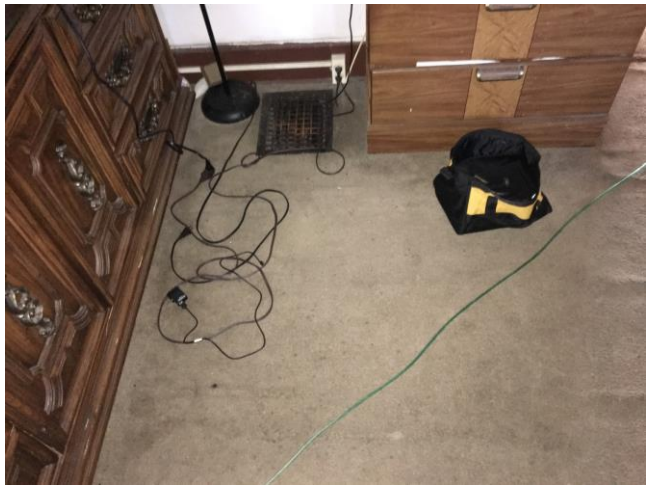
- Trip Hazards







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- Our Work

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https://your.wholehome.org/

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Evaluation of the Enhanced Stepping On Program

Green & Healthy Homes Initiative®

Addressing the social determinants of health and racial equity through healthy housing.

Mission

GHHI is dedicated to addressing the social determinants of health and the advancement of racial and health equity through the creation of healthy, safe and energy efficient homes. By delivering a standard of excellence in its work, GHHI aims to eradicate the negative health impacts of unhealthy housing and unjust policies for children, seniors and families to ensure better health, economic and social outcomes with an emphasis on black and brown low-income communities.

Why evaluate the Enhanced Stepping On Program?

Background: Enhanced Stepping On program is designed to provide home assessment and modifications for older adults who are participating in the Stepping On group education program.

Physical Activity, Home Hazards and Fall Prevention:
Problem: Residents ages 65 and older account for 84 percent of all fall deaths and 75 percent of nonfatal fall hospitalizations in Ohio. (Ohio Department of Health 2016).

Most fall-related injuries (55%) occur inside the home (Pynoos et al 2010) and most unintentional fall deaths among older adults, regardless of sex and age, the injury occurred at home (Ohio Department of Health 2019).

Inactivity linked to Rate of Falls: "Correlation between physical inactivity and the rate of falls among respondents of ODA's 2017 Statewide Needs Assessment Survey. More than 52% of respondents who had experienced a fall within the last 12 months indicated that they engaged in only moderate physical activity two days or less each week." (Ohio Department of Aging 2020).

Health Disparity: Older Ohioans with the lowest incomes have particularly high rates of physical inactivity and greatest exposure to home injury hazards. (Ohio Department of Health 2019).

Evaluation Plan for Enhanced Stepping On

Study Population: Goal of enrolling 100 Molina members who will complete the Enhanced Stepping On program, either virtually or in-person.

Eligibility inclusion/exclusion criteria:

- 60+ years of age
- MyCare Ohio (Medicare Medicaid Plan) members (opt-in and opt-out)
- High or Medium or Low need/risk stratification
- Have a claim or assessment that indicates a fall or screened by Molina case managers for having a self-reported fall in the past 6 months or fear of falling
- Focus on members vaccinated for Covid 19
- Live in Hamilton, Butler, Clermont, Greene, Warren, or Montgomery County

Evaluation Methods:

- Pre- and post-intervention assessment of participant awareness and physical ability; self-report survey of falls in past 3 months; rate of home injury hazards identified and remediation costs.
- Matched case control analysis of health care utilization and total costs of care.

Comparative Effectiveness Research: Stepping On Program

Clemson et al (2004): Results of the RCT showed the intervention group experienced a 31% reduction in falls (relative risk (RR) 5 0.69, 95% confidence interval (CI) 5 0.50–0.96; P 5.025). Results also indicated “participants used more protective behavioral practices than the control subjects (FaB, P 5.024)”.

Tiedeman et al (2020): Increase in FaB Scale, indicating less risk-taking behaviors, at baseline 2.9 out of 4 (SD 0.4), and this increased to 3.1 (SD 0.4); (mean increase 0.15 out of 4; 95% [CI] 0.12, 0.19; $p < 0.0001$).

Increase in total activity, hours per week. Baseline: mean 28.6 (18.3) Follow-up: mean 29.7 (19.4) p=0.3.

Ford II et al (2017): Reduced falls risk behaviors ($P < .001$), 0.429 fewer falls ($P < .01$), and 0.028 fewer medical record–verified emergency department visits for falls-related injuries ($P < .05$) compared with the 6 months before the intervention.

Carande-Kulis et al (2015): Stepping On had a net benefit of $134.37 and an ROI of 64%. This assumes average cost of $211.38 per participant and average expected benefit of $345.75 per participant. ROI remained positive if program effectiveness was 19% or higher.

OBJECTIVE

Evaluation of the Enhanced Stepping On Program

Determine if the Enhanced Stepping On program is effective in improving awareness of home injury risks, improving physical ability and behaviors to address those risks, providing home modifications to remediate home-based hazards, reducing rate of falls, and whether it is cost-effective and economically feasible to implement on a statewide scale.

Aim 1a – Assess the effectiveness of the program at improving the awareness and practice of fall prevention behaviors

Aim 1b - Assess the effectiveness of the program at improving physical ability

Aim 2 - Determine if the program reduces the rate of falls, healthcare utilization, and medical costs

Aim 3 - Determine the economic feasibility implementing the Enhanced Stepping On program, either in-person or virtually, on a statewide scale

Outcome Measures

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Indicator	Metric	Type	When Collected
Primary Outcome: Education for Awareness of Fall Hazards and Fall Prevention Behaviors			
Falls Behavioral (FaB) Scale	Increase awareness of and practice of behaviors that could potentially protect against falling	Validated instrument	Pre - week 1 Post - week 12
Primary Outcome: Assessment of Physical Ability			
Mobility	Timed Up & Go (TUG) Test	Validated instrument	Pre - week 1 Post - week 12
Strength & Endurance	Assessment 30 Second Chair Stand	Validated instrument	Pre - week 1 Post - week 12

Indicator	Metric	Type	When Collected
Secondary Outcome: Education for Awareness of Fall Hazards and Fall Prevention Behaviors			
Quality Improvement	Activities of Daily Living (ADL)	Self-report in PWC survey	Pre - week 1 Post - week 12
Fall Prevention	Reduce number of falls; occurrence of falls, defined as an event that results in a person unintentionally coming to rest on the ground, floor, or other lower level.	Self-report in PWC survey	Pre - week 1 Post - week 12
	Reduce health care utilization emergency department (ED) visits and hospitalizations (IP)	Molina Claims Data	Pre – 12 months Post - 12 months
Health care costs	Reduce total cost of care	Molina Claims Data	Pre – 12 months Post - 12 months
	Reduce unintentional injury cost of care		Pre – 12 months Post - 12 months

Power Analysis Results

Primary Outcome Measure	% Mean Change detectable at 0.80 power	% Mean Change detectable at 0.90 power	% Mean Change detectable at 0.95 power	Mean difference detectable at 0.95 power
Fall Behavior Scale	3.875%	4.475%	**4.975%**	**Increase of 0.14427**
Timed Up & Go (TUG)	11.875%	13.75%	**15.25%**	**Decrease of 2.05875 seconds**
30 Second Chair-Stand Test (30s-CST)	8.375%	9.7%	**10.8%**	**Increase of 1.474 stands**

Secondary Outcome Measure	% Mean Change detectable at 0.80 power	% Mean Change detectable at 0.90 power	% Mean Change detectable at 0.95 power	Mean difference detectable at 0.95 power
Fall Rate (Case-Control)	48%	54%	**59%**	***Relative fall rate decrease in 12 months**
Fall Rate (Pre-Post)	37.75%	43.625%	**48.625%**	**Decrease of 1.0648875 falls**
Hospitalizations	8%	9.2%	**10.25%**	**Decrease of 0.166**
Activities of Daily Living	2.8%	3.25%	**3.625%**	**Increase of 0.1825**

Green & Healthy Homes Initiative®

Solution: Utilize Innovative Funding to Create Sustainable Services for SDOH and Energy Impact at Scale

Hospital Investment:
Lancaster General Hospital (LGH)

- $50M in LGH hospital funds will be invested to de-lead Lancaster County, PA

Health Care Investment:
ProMedica & GHHI

- ProMedica $100 million Impact Fund investment to create 7,000 green and healthy homes over the next three years in low-income communities in seven cities

California Advancing and Innovating Medi-Cal (CalAIM):
In Lieu of Services

- Environmental Accessibility Adaptations (Home Modifications) are physical adaptations necessary to ensure the health, welfare, and safety of the individual or to enable the individual to function with greater independence in the home. Total lifetime maximum of $7,500.

Government:
CHIP Health Services Initiatives (HSI)

- States use administrative dollars and enhanced federal match to fund lead abatement, asthma care management, and other non-covered services
- State examples of lead/healthy homes HSI: IN, MD, MI, OH, WI

Thank You

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