

Transforming
Lives

The Value of Engagement

Achieving Shared Savings in a FFS Environment

Speakers

- **Bea Rector, Director**, Home and Community Services, Aging and Long Term Support Administration, WA
- **Kelli Emans, Integration Manager**, Home and Community Services, Aging and Long Term Support Administration, WA
- **Samantha Waldbauer, Case Management Manager**, Area Agency on Aging and Disability of SW WA - Community lead
- **Sharon Williams, WA Regional Director**, Community Integrated Care, United Healthcare - Managed Care lead

Agenda

- **How we started**
- **What we developed**
- **Where we are**
- **Where we are going**



Sources that Inform WA's Health Home Model

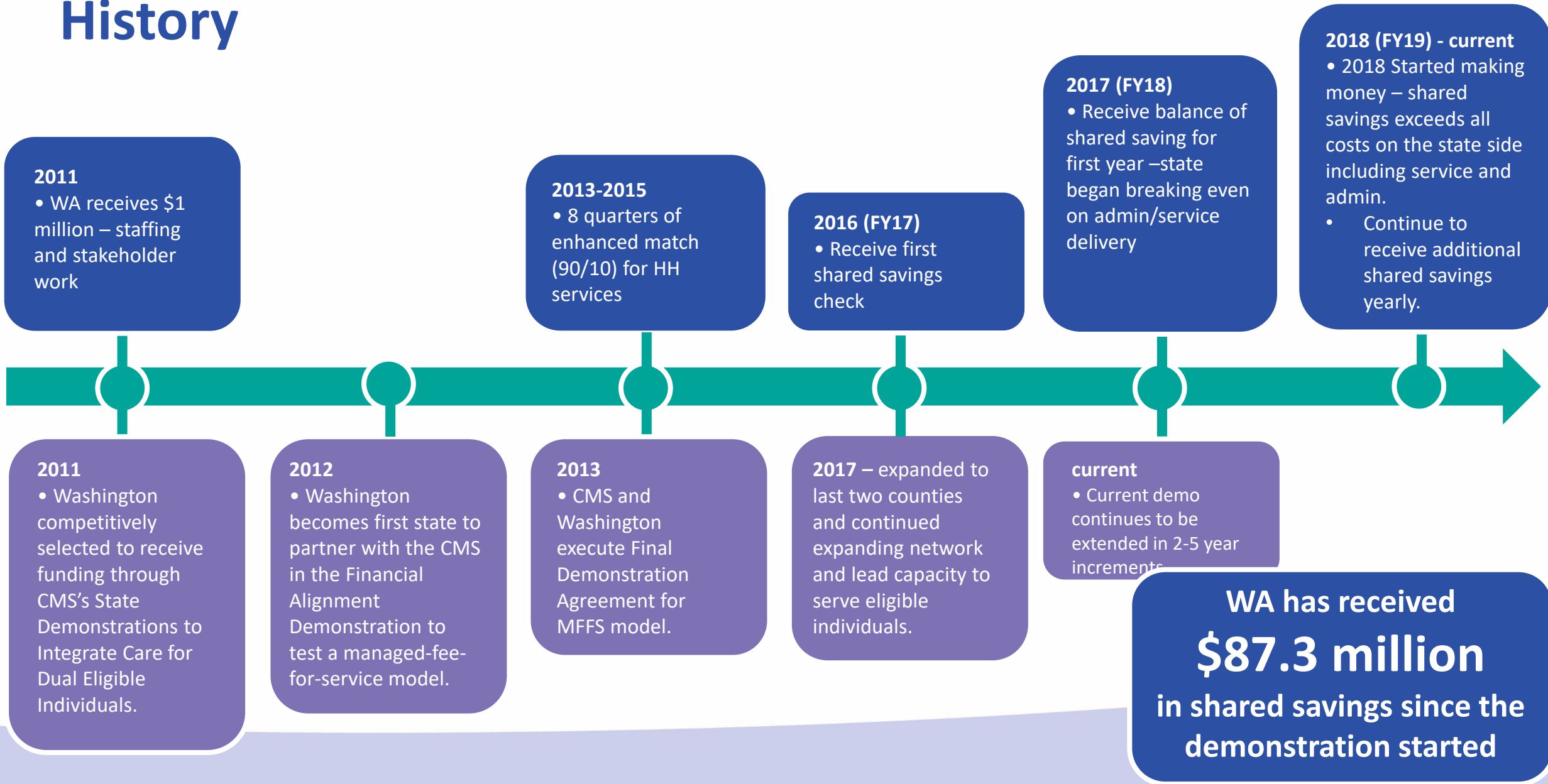
- Federal law – Section 2703, Affordable Care Act
- State law – SSB 5394 (passed in 2011)
- Chronic Care Management State pilots
- Stakeholder feedback during “Duals” planning

- Worked extensively with stakeholders including key informants, beneficiaries, providers, and advocates
- Held forums, meetings, focus groups and informational sessions throughout the state
- Solicited feedback to inform proposal development and through implementation
- Reviewed draft financial models
- Developed Integrated Care Vision that informed development of models

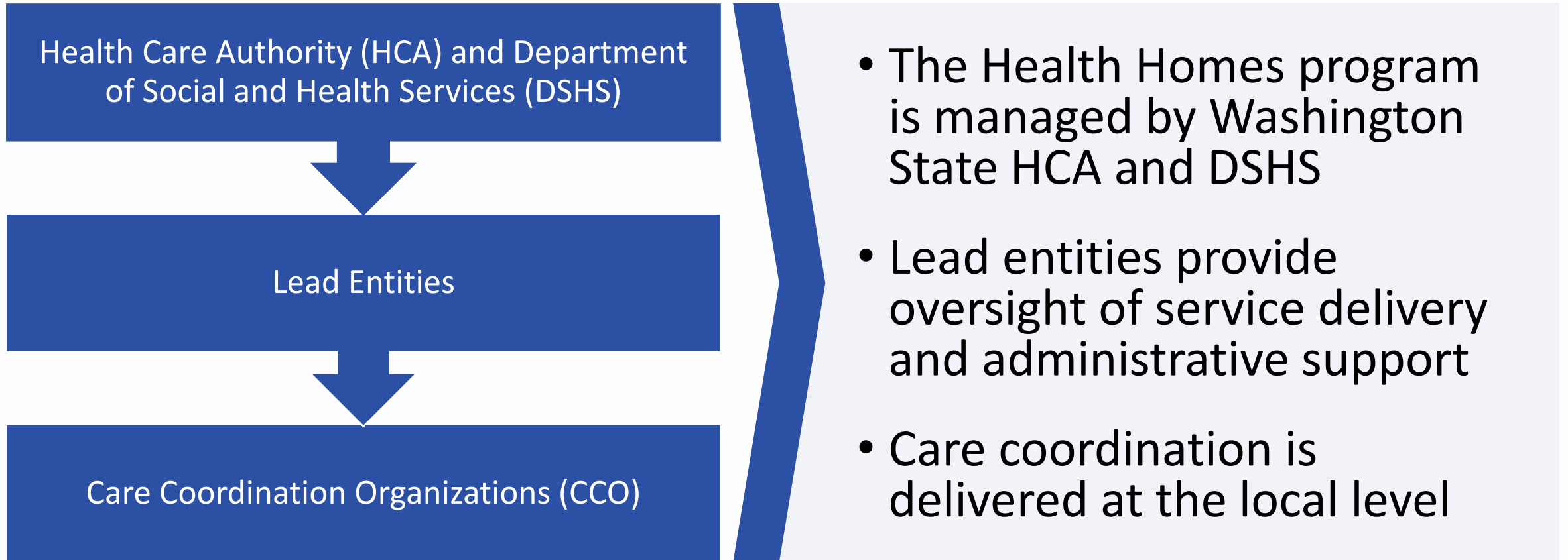
Stakeholder Feedback

- 
- Integrate services across medical and social services to improve coordination and align incentives
 - Create a single point of contact and intentional care coordination for beneficiaries
 - Create flexibility to allow for local variances based on population need and provider networks
 - Capitalize on what is working while improving overall service delivery
 - Build on system strengths and apply lessons learned to bring successful elements to scale

History



Washington's Health Homes Model



Health Homes Payment -Three Tiers

\$

Outreach,
engagement &
Health Action
Plan execution*

\$870.38

\$

High Intensity

\$244.60

\$

Low Intensity

\$200.94

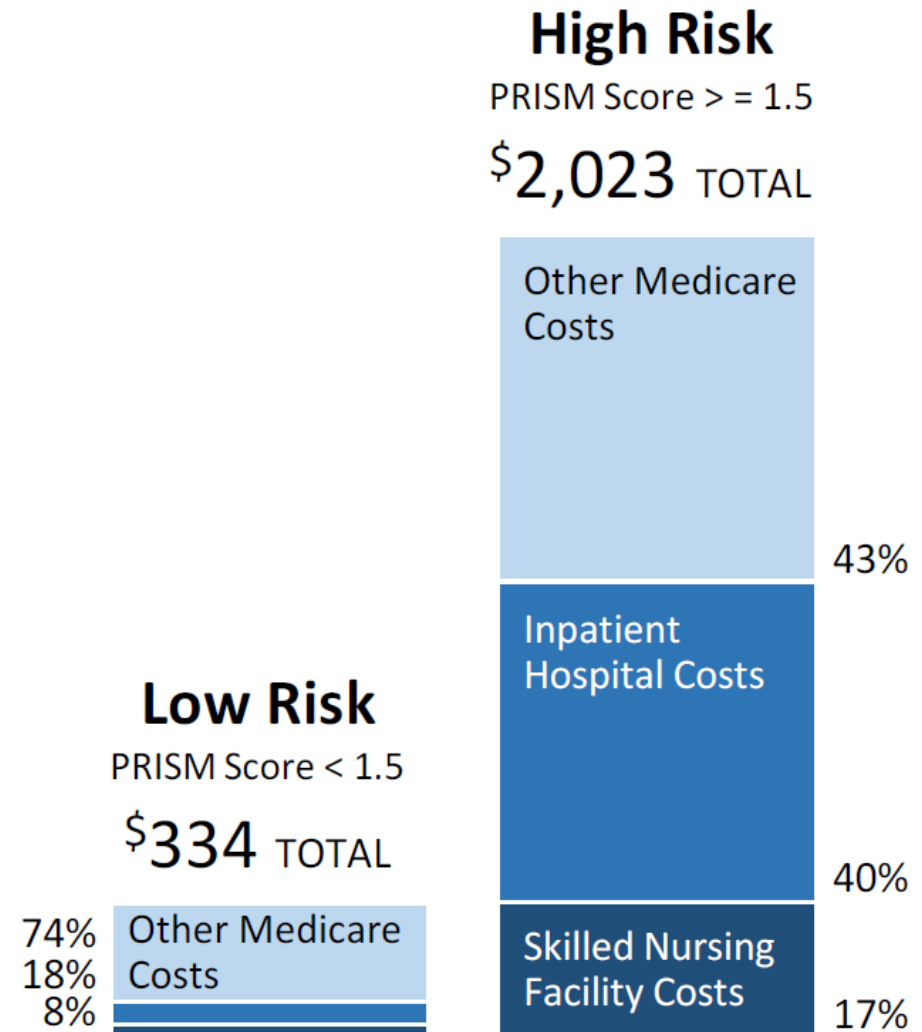
Who is Eligible



- Must be on active Medicaid, includes dually eligible (Medicaid and Medicare)
- Have a PRISM risk score of 1.5 or greater
- Has one chronic condition and is at risk for a second
- All ages are eligible

Targeting High-Risk Clients

- Health Homes services target high-cost, high-risk clients who could benefit from intensive care coordination
- Clients with high PRISM risk scores have disproportionately high medical costs



Ensuring a Person-Centered Model



The Health Homes program:

- Promotes person-centered health action planning to empower clients to take charge of their own health care
- Ensures clients receive the right care, at the right time, with the right provider
- Is person-centered by providing the tools and supports to empower clients to improve their health

Care Coordination – Fidelity is Key

- Standardization
 - Screenings
 - Patient Activation Measure
 - Person-centered health goals
 - PRISM
- Required Care Coordinator training
- Lead meetings
- Quality assurance activities



The Health Action Plan

The Health Action Plan is a plan that the client writes with assistance from the care coordinator. The Health Action Plan:

- Is person-centered
- Is reviewed and updated regularly
- Identifies what the client wishes to do to improve their wellness and quality of life
- Includes health-related goals and non-health-related goals
- May include social determinates of health

Screenings

Primary Screenings

Patient, Parent or Caregiver Activation Measure – PAM® from Insignia

PHQ-9: Patient Health Questionnaire with nine questions to screen for depression and suicide (age 18 & older)

PSC-17: Pediatric Symptoms Checklist for children (age 4 – 17)

Katz ADL: activities of daily living to take care of themselves

BMI: Body Mass Index to determine if they are a healthy weight

Additional Screenings

AUDIT: Alcohol Use Disorders Identification Test

DAST: Drug Abuse Screening Test

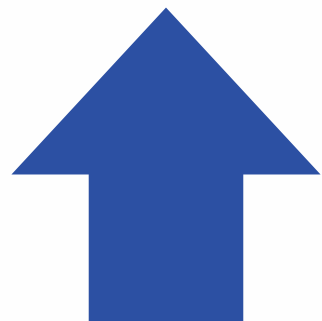
Falls Risk: My Falls Free Plan

GAD-7: General Anxieties Disorder test for stress

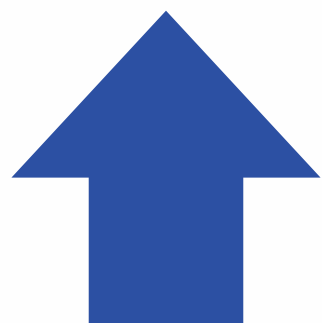
Pain scales: FLACC, Wong-Baker or Numeric

Note: the client, parent and caregiver reserve the right to decline to complete any of these assessments

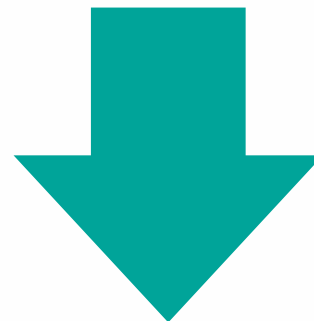
Client Health Outcomes



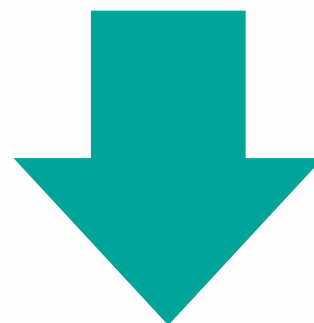
Increased engagement in self-management of chronic health conditions



Increased use of home- and community-based long-term services and supports



Decreased inpatient admissions



Decreased nursing facility admissions

Your Impact: Community Partnership

Health Home Member Success Story – 09/24/2021

Client: 7-year-old male

General Health Concerns & Diagnosis: Cerebral palsy, intellectual disability, end-stage renal disease, trach, quadriplegia

Treatments & Services Coordinated by HH team:

- DME
- Mail-order pharmacy
- Referrals to physical, occupational and speech therapy
- Incontinence supplies
- Medicaid Transport

Activation level: P-PAM Level 2

KATZ ADL: 0



Member was enrolled in the Health Home program in July 2021. Language and literacy communication barriers as well as severe physical limitations identified. Member is living at home with his mother as his primary caregiver and his father as part-time caregiver in another home after recent discharge from facility placement.



Member was referred to Health Homes from DDA case manager who identified that the member could greatly benefit from care coordination. Member's mother was struggling to obtain necessary durable medical equipment for safe placement/return home. DDA case manager and HH Care Coordinator worked together to communicate and facilitate enrollment.



During enrollment it was identified that the mother was overwhelmed with navigating the medical and social service needs of the member. Primary concern was obtaining equipment which they needed in duplicate for both parents' homes and finding financial utility assistance for the mother.



Since enrolling, the Care Coordinator has participated in care team meetings to identify and address member's needs. Her diligent work has resulted in assisting the parents with obtaining the needed equipment which included two Hoyer lifts and two car seats. CC also assisted the mother to receive financial assistance to avoid having her power shut off.



After resolving the initial concerns of the DDA CM and the needs of the Member's parents the CC has continued to assist the Member's parents to obtain necessary mail order medications, referrals to physical, occupational and speech therapy, obtain incontinence supplies and helped to navigate Medicaid transportation.

Your Impact: Community Partnership

Health Home Member Success Story – 4/5/21

Client: 49-year-old male

General Health Concerns &

Diagnosis: Type 2 diabetes, high blood pressure, anxiety, depression

Treatments & Services

Coordinated by HH team:

- Medication for Type 2 diabetes, high blood pressure, anxiety and depression
- Goals set for healthy eating and exercise
- Resources for vaccination and medical coverage

Activation level: PAM Level 1

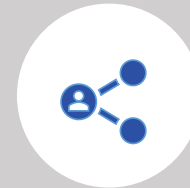
PHQ-9: 4



Member was enrolled in the Health Home program in February of 2021. Member lives on his own and looks after his parents. Member identified a need to focus on weight loss and scheduling of COVID-19 Vaccinations for his parents and self. He also requested information to assist him in follow up on medical coverage for his parents.



The Health Home assigned Care Coordinator gave the member the link to [FindYourPhaseWA.org](https://www.findyourphase.org). SHIBA 1-800-562-6900 number provided for parent's medical coverage needs. COVID-19 Vaccination Education Talking Points were reviewed with member.



The Care Coordinator partners with the Member to schedule appointments, advocate for needed care for self and parents Care Coordinator utilizes internal COVID-19 Resources to provide Health Promotion Materials to member specific to COVID-19 Vaccines.



The Care Coordinator identified that member had difficulty knowing which system to access for COVID-19 vaccine material and medical coverage needs for parents. The Care Coordinator is assisting to resolve both barriers by providing resource and contact correct contact information to access services.



This Member was able to schedule vaccination appointments for parents and self.

Role of the Care Coordinator



- Assists the client, parents, family members, legal representatives, providers and caregivers to navigate the systems of medical and behavioral health, long term services and supports and other services
- Completes required and optional screenings
- Develops the initial Health Action Plan and updates throughout the year (approximately every four months)

The Six Health Home Services



Success story



Success Story



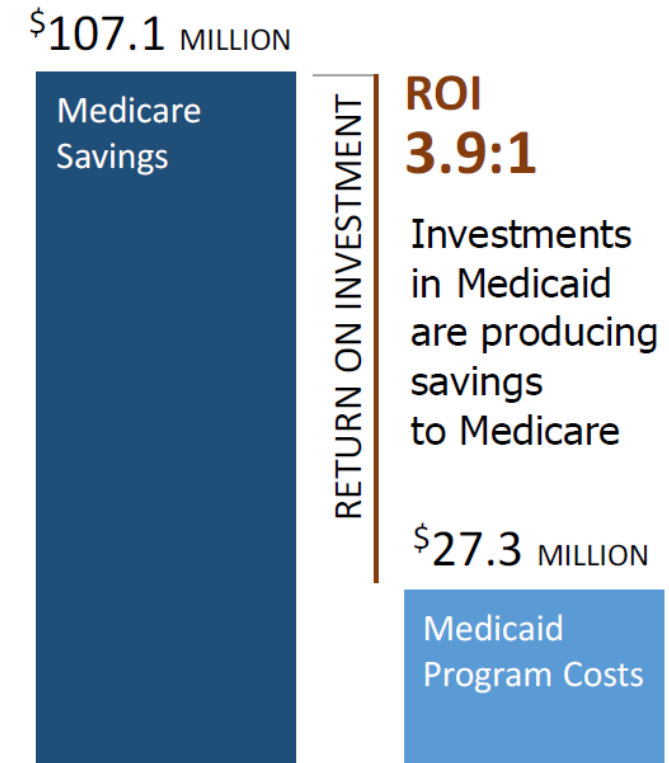
Return on Investment

“While the independent evaluation is still underway, we have seen promising results under the Washington demonstration, which leverages its Medicaid health homes to provide a high-intensity care coordination intervention to high-risk beneficiaries.”

– Seema Verma, Administrator, Centers for Medicare and Medicaid Services, in a letter to state Medicaid directors dated April 24, 2019

Medicare Savings Relative to Medicaid Program Costs

July 2013 to Dec 2016



Certification and Expansion to DSNP contracts

- **Seeking approval from CMS for certification of duals demo**
 - Would alleviate administrative burden and network instability caused by short-term extensions
 - CMS indicated they would be willing to discuss certification, but barriers exist
- **Including HH benefit in our contract with dual eligible special needs plans (DSNPs)**
 - CMS provided guidance around leveraging the model of care.



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