Health Homes: Success in Washington State

Presented by:
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Lori Brown, Executive Director, Southeast Washington Aging & Long Term Care
• It’s not a place
  • It’s person centered care coordination

• It works!
  • $67.5 million in savings to Medicare.

• It’s unique!
  • Washington gets shared savings from the Feds.

• It needs reinvestment to get to scale
  • Higher enrollments = increased savings
Stories from the Field: Peter Acosta
Client Impact: AAADSW

- https://www.youtube.com/watch?v=ODprC5nFbks
Washington State’s Health Home Program: Engagement Rates and Medicare Savings Outcomes

David Mancuso, PhD
Director, DSHS Research and Data Analysis Division
October 19, 2017
Fee-for-Service Duals are One-Fourth of Those Enrolled for Health Homes but Nearly Half of Those Actively Participating

Health Home Enrollment
JULY 2017 TOTAL = 82,538
- High Risk Medicaid-Medicare Dual Clients: 24% (n = 19,654)
- High Risk Medicaid-Only Clients: 76% (n = 62,884)

Active Participation
JULY 2017 TOTAL = 8,018
- High Risk Medicaid-Medicare Dual Clients: 46% (n = 3,726)
- High Risk Medicaid-Only Clients: 54% (n = 4,292)

NOTES: Includes all Health Home eligible clients.
SOURCE: Washington State Health Care Authority, ProviderOne (Medicaid) database.
Dual Eligible Health Home Enrollment and Engagement

JULY 2013 – MAY 2017

Eligible, Chose Not to Participate
Eligible and Enrolled
Eligible, Not Yet Enrolled
Enrolled and Engaged Ever
Engaged in Month


DSHS | Services and Enterprise Support Administration | Research and Data Analysis Division | OCTOBER 2017
Medicare Shared Savings for Dual Eligibles

• Dual eligible Medicare savings from the first 30 months of Health Home program operations (July 2013 to December 2015):

  – $67.5 million in total Medicare savings
  – $61.3 million in savings available for sharing after “outlier adjustment”
  – Up to 50% of savings are shared with the State, depending on Medicaid cost impacts and performance on quality metrics
  – HCA has received approximately $20 million in payments for Medicare savings achieved though December 2015
  – In 2017 the Legislature approved sharing savings with Health Home Leads who meet engagement goals
Selected Preliminary Findings
Washington State Managed Fee-for-Service Duals Demonstration

Percent of High-Risk Duals Receiving Home and Community-Based Long-Term Services and Supports
TOTAL CLIENTS = 408

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<td>58%</td>
<td>64%</td>
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Average Patient Activation (PAM® Score)
TOTAL CLIENTS = 285

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DSHS Research and Data Analysis Division, Client Outcomes Database.
Selected Preliminary Findings
Washington State Managed Fee-for-Service Duals Demonstration

Number of Emergency Department Visits Deemed Non-Emergent or Primary-Care Treatable

- Pre-Period: 339
- Post-Period: 307
- Down
- p = <.05

Ambulatory Care-Sensitive Hospital Admissions per 100,000 Client Months

- Pre-Period: 1,225
- Post-Period: 817
- Down
- p = <.05

Timeline
1-Year Pre-Period
Initial Health Home Service
1-Year Post-Period

DSHS Research and Data Analysis Division, Client Outcomes Database.
Focus Group Results
Washington State Managed Fee-for-Service Duals Demonstration

1. More than half of participants reported a significant improvement in their health or quality of life:
   - Participants set goals and took responsibility for their own health, working with Health Home Care Coordinators
   - Achieving personal health-related goals had benefits, e.g. decreased use of emergency departments and medications; increased physical activity and weight loss

2. Participants value the relationship with the health home care coordinator:
   - Viewed as particularly helpful in setting goals and developing plans to achieve them

3. Participants indicated that they wanted to be involved in their health care, and emphasized the need to advocate for themselves

4. Half of participants had achieved a goal or improvement in their health or quality of life:
   - Most participants achieved goals by changing their own behavior rather than accessing additional services
• Blue Print For the Fidelity Model Came Out of Chronic Care Management Project that started in 2004 with the AAA

• Expanded to populations beyond Long Term Supports and Services
Community Based Lead Organizations

• Health Home CBO as Leads
  • Imbedded in the communities they are serving
  • Have natural partnerships through the course of their work

• Importance of a diverse Network
  • Behavioral Health
  • Organizations with niche experience, homelessness
  • Smart Assignments to best serve client
  • Client may have an established relationship
Start Up as a Community Based Lead

• No Start Up Funds
• Specialized Database to pull down enrollments and bill HCA, Health Action Plan and Platform to go into One Health Port
• Build a Network
• Perform SMART assignments
• Perform Quality Assurance
• Train to the Fidelity Model
• Commitment to the mission- model and service
Dual Eligible Health Home Enrollment and Engagement

JULY 2013 – MAY 2017

Call for Action

• Share the Success!

• Health Homes in every community – reinvest shared savings and bring it to scale statewide.