Health Home Program
Washington

The Washington State Health Homes Program

Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority

Health Home Team

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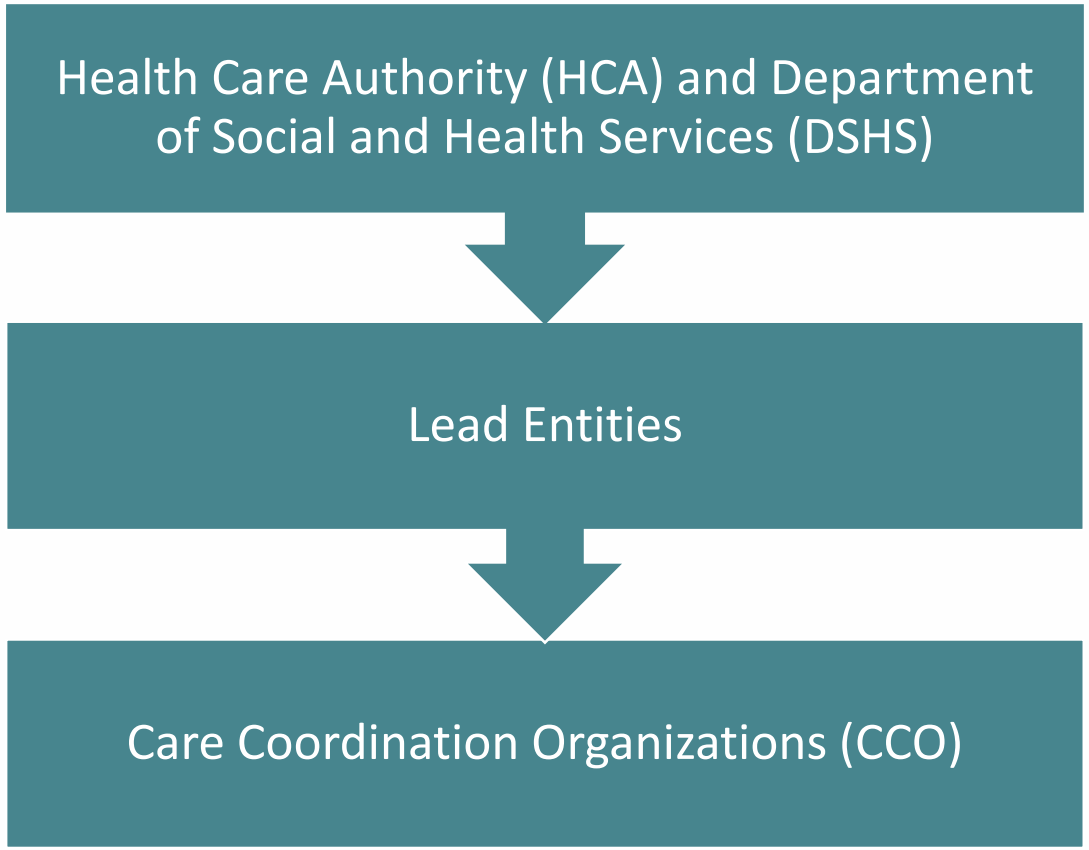
Background

On October 25, 2012, the Department of Health and Human Services(CMS) and Washington State would become the first state to partner with CMS in the Financial Alignment Initiative (FAI) to test a managed fee-for-service (MFFS) model for providing Medicare-Medicaid enrollees with a more coordinated, person-centered care experience. The demonstration program effective date was July 1, 2013.

After each year of the Demonstration, CMS performs a calculation to determine whether the Demonstration achieved savings. These savings are shared with the State of Washington. Our shared savings amount for the Demonstration last year was $17.9 million. To date the State of Washington has received $87.3 million dollars in shared savings from Medicare.

Washington's Health Homes Model

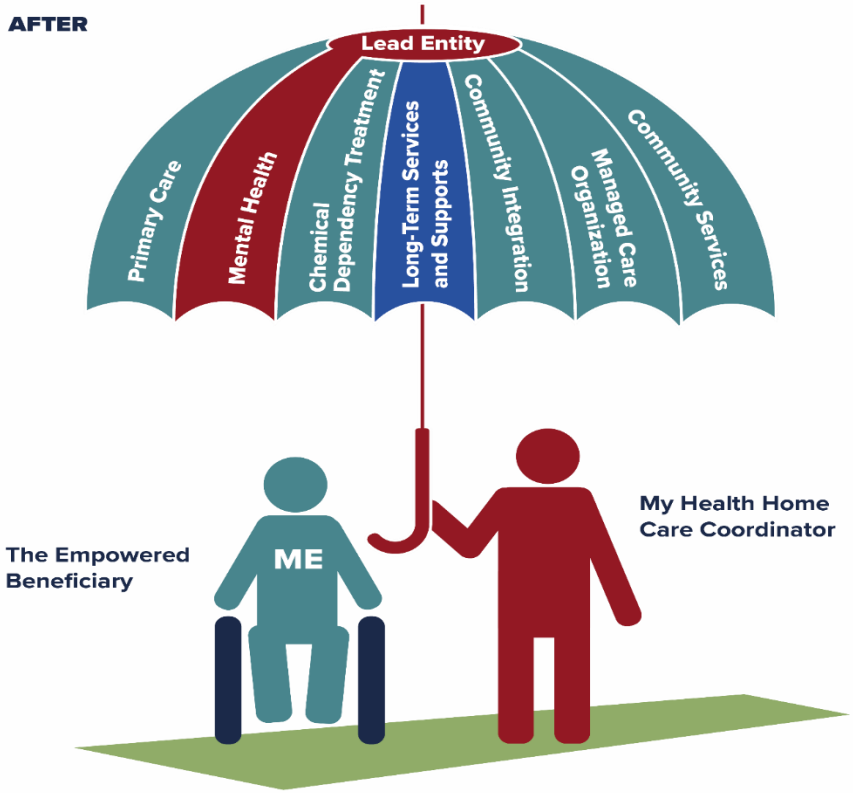


- The Health Homes program is managed by Washington State HCA and DSHS
- Lead entities provide oversight of service delivery and administrative support
- Care coordination is delivered at the local level

The Integration Path

BEFORE

AFTER



What is Health Homes?

Health Homes is a set of services supporting eligible clients. The Health Homes program helps clients:

- Develop a person-centered health action plan
- Improve self-management of chronic conditions
- Ensure care coordination and care transitions

The Basics

- No cost to the client
- Participation is voluntary
- Does not duplicate or change any current providers or benefits
- Community-based intensive care coordination across the existing delivery system
- Not to be confused with “Home Health”

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

The Six Health Home Services

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and social support services

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

Community Collaboration

- Hospitals, adult family homes, skilled nursing facilities, assisted living facilities, PreManage/EDIE
- Area Agencies on Aging, ALTSA, Adult Protective Services, Child Protective Services
- Public housing, senior centers
- Jail, treatment centers, outpatient behavioral health
- Homeless service centers , Salvation Army, Good Will, Lions Club
- Special transportation, translator services, HIV/AIDS foundations

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

Stories

52-year-old woman with Diabetes, Developmental Delay, and primary language is Persian/Farsi with limited English

- Client wanted to be independent and move to an AFH
- Facilitated transitioning client to an Adult Family Home
- Coordination between DD Ombuds, DDA CM, DDA Supervisor, and DDA
- Client enjoys new home, and roommates
- Client is learning to garden

Resources, Contacts & Questions

Health Home email box HealthHomes@hca.wa.gov

DSHS website: https://www.dshs.wa.gov/altsa/washington-health-home-program

HCA website: https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes

Questions?