# Health Home Herald

## Special Edition - July 2023

## Thank You from the State Health Home Team

10 years!!! July 2023 marks the 10-year anniversary of the Health Home program!

On behalf of the entire state Health Home team, we would like to express our sincere gratitude to all those who work in the Health Home program as well as all those who previously worked in the Health Home program. You all have made the program what it is today. We could not have done it without you, your dedication, and your passion for the program. To Care Coordinators, allied staff, trainers, program management staff, Leads, and others who support the success of the Health Home program…we admire how you work together to provide top-notch services to our clients.

Your commitment to not just this program, but also those you serve is remarkable. You always keep clients at the forefront in your work. The Health Home program is fortunate to have each and every one of you working in this program and doing what you do every day to improve the lives of our clients in Washington state.

Thank you…for all you do…for who you are...thank you!

Jessica Diaz
Glenda Crump
Christine Del Buono
Brendy Visintainer
Elizabeth Greil
Pierre Katona
Matthew Pavelle
Johnny Shults
Silke Kramer
Kelli Emans
Kerri Hummel
Alice Lind
Tiffany Maples

Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority
www.hca.wa.gov

CMS.gov

Candace Goehring, MN, RN (retired)

*"You are like family, we have been together for so long, I'm so blessed to have you a part of my team!"*


Bridging Care - Bridget Hoggard, Asha Way, Karina Yamin, Mary Munjua, Nicole Pekol, Gabriela Martinez, Mikel Samaniego, Maurielys Ramirez, Asuzena Lara, Tseyon Nurilegn, Bethany Mahlum, Debbie Victor, Keidria Reed, Hilda Parnell

Bridging Care - Gabriela Martinez, Mikel Samaniego, Karina Klein, Mary Munjua, Mohamed Khalif, Karina Yamin, and Maurielys Ramirez

ALTCEW - Nnebueze Njoku, Beverly Robbins, David Donally, Lydell Gorski, Cassandra Ibarra, Meagan Johnson, Milena Pointer, Halina French, Jenna Hernandez

*A client sent a picture of him and his family with the caption: "I never knew my life could be like this. Thank you for being one of the ones that helped these things happen."*

Sunrise Services Whatcom County


Sunrise Services Snohomish County

Molina Spokane: Nicole Gonzalez, Amie Jones, Ashley Nelson, Nicole Smith, Mel Roy, Teresa Mancinelli-Ryan, Maureen Correia, Michelle Lockman, Margie Locher, Allison Burton, Kate Carrow , Misty Queen, Trannell Schmidt


MOLINA HEALTH HOME TEAM 2019
Back Left: Tatyana Agapov, Dodie Lund, Lauren White, Erica Sanabria, Christina Justice, Andrea Vaughn.
Front Left: Melissa Mohiswarnath, Sara Ashley, Kristen Maldonado, Estephani Lopez.

Molina: Pamm Silver

Molina

**Lead - Molina**
**CCO – Molina**
**Care Coordinator – Joanna McLaughlin**

Client is a 56-year-old male with many health concerns including Coronary Artery Disease, Heart Failure, limited mobility, Knee replacement, history of falls, and Depression. His initial PAM score was 3.

He has been homeless for the last year living in a Spokane area shelter with limited mobility and difficulty navigation the health care system and obtaining social supports. He was experiencing an increased in number of falls and needed a knee replacement. The client's Orthopedic Surgeon declined to complete the surgery until he had the proper social supports in place and his cardiac issues were addressed.

The Molina Care Coordinator collaborated and coordinated care between the client, Cardiologist, Orthopedic Surgeon, PCP, Elder Services, Revive Counseling Case Manager, Caregiving Agency, DSHS, Household goods/furniture voucher, and SNAP for housing assistance to help this client obtain the necessary social supports and provider communication needed to receive approval schedule his knee replacement surgery.

Many hours of care coordination were provided by the CC in order align all the pieces together for him to improve his health, increase his mobility, obtain housing, and engage with his providers. The client is now living in his own apartment, and it has been furnished with the help of a household goods voucher. He also has a wheelchair, recliner lift chair, and an alert button in the event he has a fall or is unable to get to a phone during an emergency. His caregiving hours have been increased, he is engaged with his mental health providers, and is obtaining all the necessary tests required to clear him for the knee surgery. The Client is now able to address his chronic health conditions with far less barriers in place, he feels safe in his own home, and now has a social support system in the community.


Molina: Brian Laing, Katterine Nazario, Lupe Gutierrez, Kellie Cooper, Sara Irish

Molina: Austin Goodman &
Tracy Papachristodoulou

Molina: Jackie Southerland

*"Helping one person might not change the world, but it could change the world for one person"*

Molina: Kellie Cooper, Pamm Silver, Nathan Render, Christina Garcia, Ashley Stansberry

*"You are so good! Thank you so much for everything. I wish you were my daughter."*

Molina: Ocean Shores, From left to right:

Top Row:, Deborah Ulrich, Lucy Graves, Myeasha Cubean, Kellie Cooper, Nathan Render, Laurie Berg, Cheryl Bertha, Nicki Carrillo, Jamie Bumstead

Middle Row: Deena Otterstetter, Gail Misner, Pamm Silver, Lesli Scarborough, Pearl Hernandez, Christina Garcia (and Toby), Bottom Row: Yul Gamboa, Mandi Goodman, Tracy Papachristodoulou, Laurie Lembke

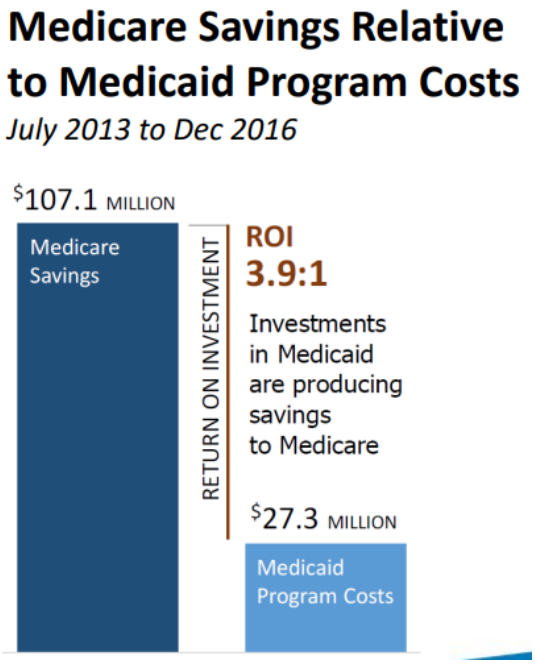
Skagit HH Forum 20223 - Rita Van Horn, Glade Jones, Tiffany Gorski, Collin Elaine, Francis Gough, Christina Garcia, Pearl Flores, Angela Randazzo, Jay Fathi

*"You are highly appreciated always."*

# 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



"Thanks for checking on me and my health and sending me that useful information that you send to me always."

Molina:
back row: Rita, Margie, Rob.
front row: Dawn, Allison Buton, Maureen Correia, Anthony Foster

"I alone cannot change the world, but I can cast a stone across the waters to create many ripples." -Mother Teresa

ICRC | Integrated Care Resource Center

CASE STUDY

February 2019

# Using Health Homes to Integrate Care for Dually Eligible Individuals: Washington State's Experiences

*By Nancy Archibald, Kathy Moses, and Lauren Rava, Center for Health Care Strategies*

**EXECUTIVE SUMMARY**

To provide more integrated, coordinated care for its residents who are dually eligible for Medicare and Medicaid, Washington State is operating a demonstration under the Financial Alignment Initiative offered by the Centers for Medicare & Medicaid Services. This case study describes: (1) the demonstration's structure; (2) results achieved to date; and (3) insights on the demonstration's implementation from the state and other stakeholders.

- **Demonstration Structure:** The demonstration, which was launched in July 2013, uses a managed fee-for-service model based on Medicaid Health Homes. It does not change how enrollees' medical and behavioral health care or long-term services and supports are delivered, but instead uses health homes to better integrate care across these settings. Washington State contracts with Health Home

**Molina Healthcare**


Gratitude is one of the most powerful emotions a human being can have. As we reflect on the last 10 years, could any of us have known what an incredible impact the Health Home Program would have on our members and staff?

For 10 years, Health Home staff internal and external to Molina have served our members tirelessly. We have had the honor of being first-hand witnesses to changed lives. We've watched members in the deepest depths of despair find hope and take measures to rebuild their lives. We've coached members through reframing negative self-talk to learning to speak positively. We've modeled self-care and the critical importance of taking care of our minds, bodies, and souls. We've demonstrated what it means to set boundaries and value ourselves. We've advocated tirelessly, spending thousands of hours with providers and community partners. We've stood up for those too worn down to stand up for themselves, and then watched patiently and applauded when our members took small steps to improve their health, which then led to accomplishment of gigantic goals!

Rapport-building requires patience and time. Trust must be built through consistency and dedication. Once established, amazing transformation takes place! Members who have lost faith in the medical system have had their faith restored. Members who saw no value in themselves, had no hope for their futures, and expressed no reason to go on have participated in this program and sang its praises. Staff have been likened to guardian angels who have demonstrated compassion, empathy, and been a shining light in their darkness.

10 years have passed as staff attended provider appointments side by side with our members, meeting at apartments, homes, coffee shops, grocery stores, provider's offices, parks, … 10 years of building one Health Action Plan after another … 10 years of revising short-term goals … 10 years of performing assessments … 10 years of building confidence and refusing to give up when obstacles surface.

From the bottom of our hearts, in honor of every member served, THANK YOU to every Health Home internal staff as well as our external network - Care Coordinator, Community Connector, Case Management Processor, Trainer, and Leadership Staff alike – you've made more of a difference than you could have ever imagined.

The Molina Health Home Leadership Team

Thurston Forum 2022 – Ashley Stansberry, Grace Campbell, Shanne Montague, Sasha Waring, Rena Cleland, Jay Fathi,

## Over the 10 years of the Health Home program (from July 2013 to July 2023)

- 56,356 unique clients (and counting) have been engaged with at least one month of Health Home care coordination (for a total of nearly 1 million client-months of engagement).
- Each month, on average, nearly 500 clients became newly engaged in the program.
- Each month, on average, nearly 8,000 clients received Health Home care coordination services.
  - In recent years, the monthly number of engaged clients has been steady about 10,000 clients receiving Health Home care coordination services.
- 40% of the clients with some engagement in the program, received one year, or more, of Health Home care coordination services.
- When looking at the clients with the longest amount of engagement (total number of months with a service), we see…
  - 2,678 clients have received over 5 years of Health Home care coordination services.
  - 1,489 clients have received over 6 years of Health Home care coordination services.
  - 735 clients have received over 7 years of Health Home care coordination services.
  - 278 clients have received over 8 years of Health Home care coordination services.
  - 23 clients have received over 9 years of Health Home care coordination services.


Pathways - Top Row from left to right: Sara Dillman, Jared Stone, Shannon Curry, and Aaron Anderberg. Middle Row Left to Right: Lea Cantu-Altom, Vangie Farley, Joe Russo, and Jenette Henderson. Bottom Row Left to Right: Dani Diaz, Katie Sulpizio, Gina Barringer, and Mark McEnderfer

SeaMar Skagit

SeaMar Skagit – Dalila Acevez, Anna-Maria Valentine, and Julie Rasmussen

*"Thank you. ♥ 😊 I am so happy to have all this done and set up for my next one is fantastic. It's such a load off me stress wise. I just think you are the most amazing smart quick-witted caring person. I am so content and reassured having you as my friend and advocate. You are today Awesome!!!! Thanks again for all your help. ♥ 😊"*

SeaMar Skagit - Skagit Care Management Team- Paola (Vanessa) Esparza, Veronica Medrano, Ivy Hendricks, Carla Badillo, Anna-Maria Valentine and Shannon Cross

*"Thank you so much for always thinking of us. You're a reminder that there are people out there that care… I always feel better after we talk."*

WASHINGTON STATE PRISM PROJECT was one of Three Projects Receiving the Inaugural State and Local Innovation Prize from Milbank (2018)

WASHINGTON STATE PRISM PROJECT Drawing from multiple data sets to coordinate care for dual eligibles: Using Medicaid and Medicare claims data to direct and inform its health home program allows Washington State to target high-cost beneficiaries, improve their health status, and save money. Problem it solves: Medicaid agencies rarely use their scarce resources to coordinate care for high-cost, dual-eligible beneficiaries since their medical bills are paid by Medicare. Medicare has not traditionally paid for Medicare savings generated by Medicaid coordination efforts. Agencies involved: Centers for Medicare and Medicaid Services (CMS) Washington State's Department of Social and Health Services Status: Up and running since 2013.

The program was not just a success for CMS and the state, which earned half of the $67 million Medicare estimates it saved through the program, but it confirmed the value of the state's pioneering foray into using data drawn from both agencies to identify the most expensive patients who would benefit most from care coordination.

*"I cannot say it strongly enough. Being a cancer patient is a very lonely thing, and having the support of all of you has been a real blessing."*

Neighborhood House – Nimo Ege, Maria Mungarro, Kaelyn Carlson, Layla Jama, & Isra Adel

Neighborhood House – Giada Szanyi, Muna Mohammed, Hana Al Batati, Danielle Danao, Nimo Ege, Layla Jama, Binto Hussein, below; Saba Yohannes, Peter Chum, and Emilie Laik

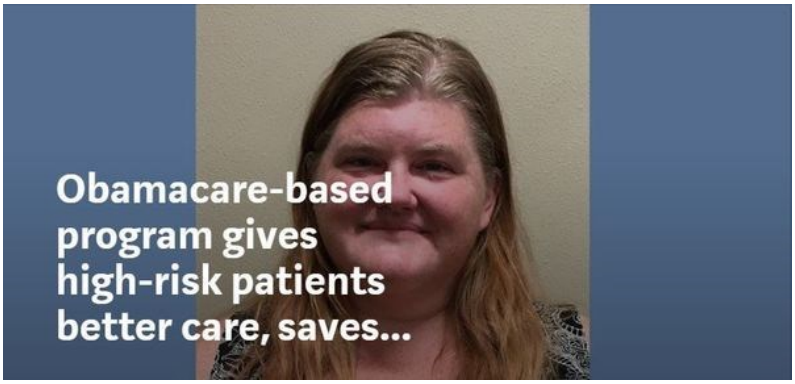
Neighborhood House – Hana Al Batati, Yessica, Nimo Ege, Kaelyn Carlson, Neyla Terletska, Muna Mohammed, Layla Jama, below is Dalal Battati and her niece


Neighborhood House – Saba Yohannes, Heather Malone, Kaelyn Carlson, Emilie Laik, Dalal Battati, Danielle Danao, below; Nimo Ege, Muna Mohammed, Hana Al Batati, Peter Chum

WASHINGTON GOVERNOR
JAY INSLEE

# ACA-based program gives high-risk patients better care, saves money

October 10, 2017




Hilary Edmondson needed an advocate after the amputation of her leg, and thanks to the Health Home program, she had one.

Five days after her surgery — with the wound-closing staples still in her leg — the hospital discharged the Spokane woman to her home because staff could not find a physical rehabilitation center to take her.

Back at her apartment, she managed on her own for one night. She was still experiencing some shock from the loss of her foot, and because her apartment was not wheelchair accessible, she had to crawl to get around. When she had trouble administering her antibiotics intravenously, she called for help and was taken back to the hospital by ambulance.

That is when her advocate, Sharon Miller, a care coordinator through the state's Health Home program, discovered the hospital had discharged Edmondson and stepped in. Miller realized that although the hospital had checked for beds in rehabilitation facilities, it hadn't checked with skilled nursing facilities. She worked with the hospital's discharge team and found Edmondson a bed in a nursing facility, where she was able to receive follow-up care such as physical therapy and to learn the skills to become more independent.

Through the Health Home program, Edmondson gets more than an advocate. The program provides highly coordinated care, including comprehensive care management, health promotion, follow-up, individual and family support, and referral to community and social support services, as needed.

The program began in 2013 as part of the federal Affordable Care Act, sometimes referred to as Obamacare. By focusing comprehensive care on high-risk, high-cost patients, the program actually saves money. Health Home resulted in a preliminary gross Medicare savings of $67 million over two years, according to a new report by the federal Centers for Medicare & Medicaid Services.

Read the rest of the story on the governor's Medium page.

## Media Contacts

Tara Lee
Governor Inslee's Communications Office
360.902.4136


**Lead - AAADSW**
**CCO – AAADSW**
**Care Coordinator – Kathleen Chilson**

Dana is a 45-year-old female with Noninflammatory Disorders, Major Depressive Disorder and her PAM score is 55.6. The CC was able to support Dana with her goal to downsize her home and minimize her collection of things in storage. Dana needed to get rid of the storage to save money and use some of that money for her second goal to go to the YMCA for exercise. It took a while to get this goal done because of Dana having attachments to her items. She made her choice of letting go of enough of her things to get rid of the extra cost of a storage unit. Dana is now able to put some of that money towards a YMCA membership, have some extra money and is feeling much better.

Top (L-R): Keith Seals, Christina Rose, Angelique Harding, Shawna Thom.
Middle (L-R): Kathleen Chilson, Katie Haglund, Gail Gallien. Bottom: Cyndi Doolin.

**Area Agency on Aging & Disabilities of SW Washington**

I began working at AAADSW in 2013 in the case management department. But it wasn't before long before I noticed this neat program called "Health Homes" that our agency was also administering. Once I learned more about that program and the work involved, I immediately focused my sights on becoming a Care Coordinator. I started as a Care Coordinator in 2015 and moved onto becoming a Supervisor a year later – supervising a team of 10 Care Coordinators in our internal CCO. Working as a Care Coordinator and supporting my team in their work as Care Coordinators has been my most rewarding role in my entire career. In 2018 our Agency became a Health Home Lead and I stepped into the role as the Coordinator for the Health Home Program.

Having been involved in nearly every aspect of this program has given me a profound appreciation and love for this work, as well as a deep understanding of the difficult work our Care Coordinators do each day. Every chance I get to speak about this program I completely light up and am honored to boast about all the hard work that is being accomplished. I am so privileged to be able to support my network in Southwest Washington. Thank you for showing up day after day and making a profound difference in the lives of our clients!

Amberly Rose
*Health Home Lead Program Coordinator*

Amberly Rose

Mike Reardon,
Executive Director

*Thank you. Thank you so much for fighting so much for older people. May God bless America and people like you who sacrifice time caring for those in need. Thank you for checking on me and my health. God is great and you are great!*


Top (L-R): Kevin Kuper, Lavonda Spillers, Juli Williams. Middle (L-R): Teresa Vela, Alicia Taylor. Bottom: Dawn Felten


**Vancouver Care Coordination**
Health Homes


"When we are no longer able to change a situation – we are challenged to change ourselves."
Viktor E. Frankl


Rural Resources Grand Coulee Team

**Action Health Partners**

Thank you:

*"Coming together is a beginning, staying together is progress, and working together is success."*

~Henry Ford

The Action Health Partners Health Home Lead team extends deep gratitude to our long-term CCO partners for the tenacious service over the past 10 years. The success of the program in Area 6 would not have been accomplished without the compassionate workforce, quality management and strong voices of our partners. As we begin a new decade in the program, may we collectively continue to build on past successes with care and compassion for those we serve at the forefront.

Deb Miller


*"You're a rock and such a help to me since the first time I met you. You are a very special person and probably not just to me either."*

## Community Choice Action Health Partners

*"Thanks so much for furnishing me with info and little tips to help me with daily living. God bless you so much."*

On September 9, 2020 six Care Coordinators from across CCO partners in Area 6 came together (via Zoom) to talk about the Health Home program. The online event was hosted by the North Central Accountable Communities of Health (now known as Thriving Together NCW) and provided program details from the perspective of the community-based workforce.


Midge Kirkpatrick (CC-AHP), Bill Murray (CC-AHP), Meghan Sullivan (RR), Gladys French (CC_AHP), Cheri Peterson (CC-AHP), Heather Peterson (RR), Teresa Posakony-Emerging Wisdom facilitator.

"Thank you for putting up with me all of these years. I appreciate you so much."


Bill Murray, Emilie Milburn, Alicia Kramar, Darcee Anderson, Irene Sanchez, Cari Magnussen, Brandi Larson, Stephanie McLucas, Vickie Seabrook, Gladys French, Jill Milner, Kaitlin Quirk, Jolyn Hull, Valeria Gonzalez , Deb Miller


Lead Organization Community Choice at their office in Wenatchee in 2018
Back Row: Gladys French, Brandi Larson
Second Row: Bill Murray, Cari Magnussen, Darcee Anderson, Emilie Milburn, Valeria Gonzalez, Jill Milner, Alicia Kramar, Jolyn Hull, Kaitlin Quirk, Irene Sanchez
Front Row: Stephanie McLucas, Deb Miller

**Lead – AHP**
**CCO – Frontier Behavioral Health**
**Care Coordinator – Tia Sijer**

ACTION HEALTH PARTNERS
Building Bridges to Optimal Health

Client is a 40-year-old female living with Borderline Personality Disorder, PTSD, Bipolar 2, Anxiety, Depression, ADHD inattentive, Kidney Disease, Asthma, and many other chronic conditions. She came to our agency from another CCO, and her initial PAM score was 65.5. As of today, her score is 72.5.

CC provided education on the interrelatedness of physical health conditions and mental health conditions and the impact each can have on the other. CC was able to make referrals to client's PCP and other specialists that accept her insurance. CC provided resources for client and her family for them to participate in activities that help and support the family. Through this work together, this client was able to get approved for and complete breast reduction surgery and is already seeing improvements in her back and shoulder pain from a seven down to a three. Due to the reduction in pain, she is also seeing a reduction in depression from 21 to a 17. She has also had a reduced BMI from 46.1 to 44.6.

**Community Choice - Action Health Partners**

Back Row: Jamie Withrow, Kami Yacinich, Kaitlin Quirk, Gladys French, Kayelee Miller-Craig
Middle Row: Kill Milner, Kelsey Gust, Paige Bartholomew, Karen Francis McWhite
Front Row: Viba Sri-Facilitator, Jolene Mendoza, Elaine Bandy, Deb Miller, Maribel Alvarez

Community Choice CCO Care Coordinator Maribel Alvarez helps organize resources in the new Action Health Partners office in the Spring of 2021.

Action Health Partners team participated in The Joy of Gratitude Workshop in May 2019. Elaine Bandy, Gladys French, Jill Milner

*"A good coach can change a game. A great coach can change a life." -John Wooden*

"Not all of us can do great things. But we can do small things with great love" Mother Teresa


from left to right – Zane, Cheri, Njambi, Cindi, Kelsey, Josette and Spencer.
(Cheri and Josette are no longer with CCW, Kelsey and Cindi are with CCW but not with Health Home)


from left to right, Zane, Josette, Cindi. Back row: Cheri, Njambi, Spencer, Dawn
(Cheri and Josette are no longer with CCW, Cindi is with CCW but not with Health Home)

**Coordinated Care of Washington**

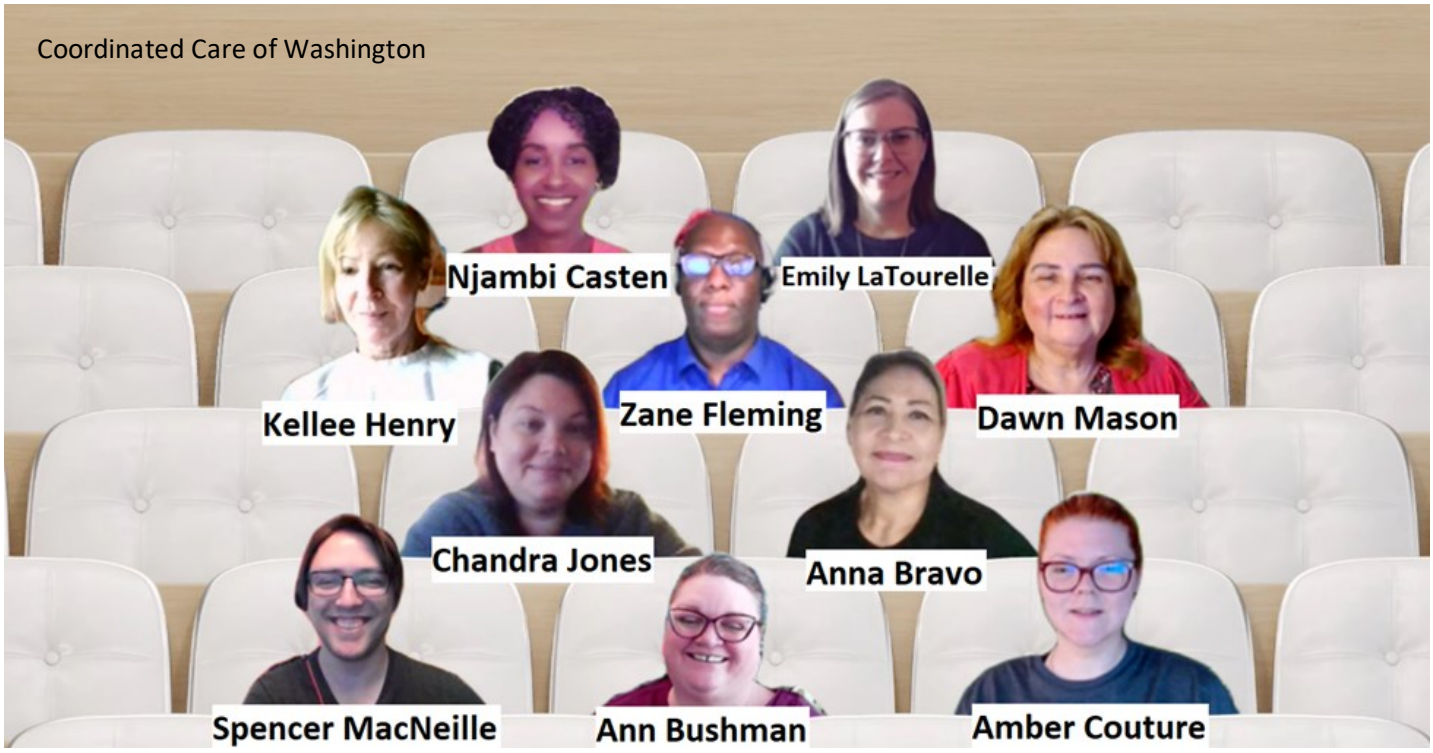
*As we celebrate 10 great years of the Health Home Program, Coordinated Care' s Health Home Program would like to extend our gratitude and appreciation to all Health Home Staff! Thank you for your hard work, dedication and passion that have kept this program going. Thank you for partnering with us as we work to transform the health of the community one person at a time! Whatever part of this Program's journey you have been in these past 10 years, you have been integral to our members' success and ultimately the success of the Health Home Program. You are a Health Home Hero to us! We appreciate you!*

Thank you!
-Njambi Casten
Manager, Medical Home/Health Home
Health Home Trainer

Njambi, Spencer, Chandra, Dawn and Kellee

CCW Part of the Health Home Team (Picnic 2022)

"Thank you for coming to see me. You have made my entire day."





Kellee, Emily, Spencer, Dawn


"Be brave enough to have conversations that matter. Be brave enough to listen".

**Lead – CCW**
**CCO – SeaMar**
**Care Coordinator - Yolanda Reynoso Aguilar**

Amber is a 41-year-old female living with Ehlers Danlos Syndrome and PTSD. It truly is amazing to hear feedback from our clients about the positive impacts Health Home has on their lives. I began working with Amber in September 2022. As we completed the assessments during her initial HAP, she shared more about her life, daily struggles, and concerns with the healthcare system. She had a unique perspective as she has worked in respite care for the elderly, assisted children diagnosed with a developmental disability, and even spent time caring for her own family members during their last days. At the time of the first HAP, my client was unemployed due to her health conditions and relied on savings to make ends meet. As a result, her first long term goal was to "get on disability".

At that time, her husband was her caregiver, though it was difficult due to his work schedule. I referred her to the COPES program to receive the adequate care that she was needing. I also provided her the information needed to begin the process to get on social security disability.

As the months went by, I listened to her struggles and worked alongside her to ensure that she received the help she needed and that she was heard by her care team.

This assistance was initiated by helping her find a new PCP at a clinic closer to her home. After her first appointment, she expressed how happy she was with the provider and that she was looking forward to future care from them. As of January, she has qualified for 69 hours of caregiving each month and her husband has stepped into the position full-time! She has also been approved for the Aged, Blind, or Disabled program now having access to an organization that will provide her assistance in applying for SSI even though she had been hesitant to apply for SSI in the past. With this resource, she is getting closer to her long-term goal.

In my client's own words, "Thank you so much Yolanda! I don't want to get sappy here, but I feel like it's very important to let you know the effect you have had on my family. I have been struggling to get help for at least 10 years, it has taken a huge toll on me. Until you came along and put things in motion, I had no hope for my future, the thought of trying to fight another day gave me so much panic. You were the one who set me up with the social worker from DSHS that finally understood how bad off I was and that I needed more care than I had ever been able to explain! You are one of the people that change lives, give people hope, our community is so lucky to have you, the world needs more people like you. Thank you so much! Have a lovely day,
Yolanda!"

coordinated care™

**CHPW**

We at CHPW would like to thank our network for all the wonderful work you do. We are fortunate to have such dedicated passionate individuals participating in the Health Home program that have made such a meaningful impact to our clients. It has been an amazing 10 years of Health Homes and the program wouldn't be where it is today without all of you!

Thanks,

James Cook

Program Manager II, Clinical Services Operations

From left to right- Rebecca Fansler, Dana Janigian, James Cook, Amy Sharrett, Jessica da Hora.

"Thankyou for all your hard work on my behalf and also for being such an important advocate for me."

*Community Health Plan of Washington from 2018 (L to R): James Cook, Lori Cohen, Karen Mamaril, and Dana Janigian.*

**Lead - CHPW**
**CCO – Columbia River Mental Health Services**
**Care Coordinator – Debbie Johnson**

COMMUNITY HEALTH PLAN of Washington™
The power of community

Client is a 62-year-old female living with Type 2 Diabetes, High Blood Pressure, and Chronic Pain. Health Homes has supported her by assisting with transportation arrangements and cell phone. The client has also been attending recovery café, Luepke Center for social opportunities and has been exercising by walking and losing weight.

The client was successful in planning and going back to her hometown recently. Best practices have been empathy, active listening, education on reducing anxiety, and reviewing long-term and short-term goals and assessments.

The client was homeless and is now housed in an apartment. She is actively interviewing for jobs and working with a supportive employment specialist that the Care Coordinator referred her to. The client is determined to get back on her feet after her husband died and her son deserted her. She is positive and has a bright outlook on the future. The Client is very motivated to help herself and advocate for her own needs.

## News Release

December 2018

### Health Home program saves more than $100 million in Medicare program over three years

*State and federal government shares in care coordination program savings*

OLYMPIA – An innovative program meant to support Apple Health clients with chronic illness has saved Medicare more than $107 million over three years, according to new analysis from the Centers for Medicare & Medicaid Services (CMS).

**Current Health Home design and innovation**

- High-quality trained staff to interact with clients who have complex needs
- At home, in-person care coordination
- Client directed care coordination
- Conflict free care coordination

SSA call was a success.

Client said afterwards that she was smiling so hard that her ribs hurt!

"I 100% trust your judgement and intuition."

"Thank you so much for being here for me."

SeaMar Skagit


*Full Life Care in Seattle 2018.*

*Full Life Care became a Lead Organization in King County beginning April 2017.*

*Pictured left to right: Tim Morley, Jessica Herzer, and Rena Ferretti.*

**Lead - FLC**
**CCO – Neighborhood House**
**Care Coordinator – Dawn McCain**

Client is a 65-year-old female living with Cancer, CHF, Chronic Kidney Disease, and Type 2 Diabetes. She has actively participated in her HAP and utilized referrals to reach her goals. In March 2023 she expressed frustration trying to get a dental appointment at the UW clinic. She had a broken tooth that was causing pain and cuts inside her mouth. She had been waiting several months for an appointment, when she was notified that the appointment would need to be postponed longer. CC referred her to a Dentist closer to home that accepted her Medicaid. She was able to get in right away and have her tooth repaired. She was happy that they were able to save the tooth and she has a follow up appointment

*"Thank you, lovey!"*

FLC: Barbara Lewis and Tara Avila

FLC: Barbara Lewis, Hannah Brendemuhl, Diana Rawls, Tara Avila, Mae Hochstetler, Colleen Brady

**Full Life Care**

Full Life Care wants to thank all the amazing agencies that make up our network: Asian Counseling and Referral Service, Aging and Disability Services, Neighborhood House, our internal Full Life Care CCO, and Kin On. Together, we have been able to provide services to people in our communities with a focus on cultural competency with the diversity in our staff. The dedication, compassion, resourcefulness, and resiliency of our network is incredible, not only throughout the pandemic but in their everyday work over the last 6 years. Thank you for the continued commitment to the Health Home program and allowing us at FLC the space to grow and learn as a Lead entity, none of it goes unnoticed.

Full Life Care would also like to express its gratitude to the Health Care Authority and DSHS for your on-going support and commitment to this program. It has been a pleasure working with, not only the current staff, but also the staff who have since moved on to other opportunities. We sincerely appreciate all of you.

Thank you again,
The Full Life Care Team

Above: Pierce Co. Human Services CCO from 2019. Back row (L to R): Chet Budinger, Amy Allen, Bobby Ocasio, Linda Russell, Kim Peterson, Daphne Gill, Marissa Bass. Front row (L to R): Ginny Codd, Tiffany Conaway, Srey Kray, Penny Rae Bradon

**Pierce County Human Services**

To our amazing Care Coordinators,

Kris Dowling and Kirstin Fahnoe

We are in awe of your talents every day. Coaching is such an incredibly challenging job. The skills to be an effective coach can make you feel like you are on a seesaw somedays. You have to strike the right balance between leading a client and following their lead, actively listening while also guiding, being compassionate while also challenging them, modeling behaviors while also encouraging independence, providing feedback while also allowing natural consequences to happen, stepping forward to demonstrate how to do something while not taking "the bat" out of their hands. You must have the patience and self-discipline to always have your eye on the long term goals, resisting the urge to jump in, "do" for a client, and solve the current issue/crisis for them which comes so naturally. You are helping some of the most complex adults in our State make life-improving changes one small goal and action step at a time, and that is no easy task. You are all super stars, and we thank you!!

Kris and Kirstin

**Lead - PCHS**
**CCO – PCHS**
**Care Coordinator – Jon Reimer**

Client is a 68-year-old female living with COPD, CHF, Fibromyalgia. CC Jon reported a small and simple success story that he feels reflects the core of this program. He states he has been working with a client who used to go the YCMA pool for swim therapy but had not been able to access the pool since last August due to transportation issues. Jon called her over the last few months and encouraged her to discuss with her caregiver about ride options. When he spoke with his client this month, she reported she made it back to the pool this week with the help of her caregiver. She now plans to go every week and eventually work her way up to three times per week. Jon states, "Sometimes it's the little things that lead to success." He also reported that though this is a small step to overall health, it is these smalls steps, that can sometimes take months, that slowly build to huge life changes. He wants to encourage all the CCs out there to not give up when big changes don't seem to be happening. Focusing on the little successes makes the big differences.

HHCC Group (May 2022). People in the attached picture: Front Row: Kasey Faughn, Silva Sarafian, Allison Cole, Ericka Christensen, Jessica Reynolds; Back Row: Mariah Davis, Kelly Hayter, Katie Veening, Helga Wissenbauch, Kim Acuff, Joshua Lecha, Brenda Perkins, Lynn Moore, Tatiana Kondratyuk, Linda Hill.


Team Amerigroup from 2019 Annette, Lenora, Ali, Jordyn, Tami (back), Cassy, Danielle (back), Sarah, Tina (back), and Janice.

**Amerigroup**

*Amerigroup wants to express our sincerest gratitude and appreciation for the exceptional care provided by our CCO Network and Lead Entities over the last 10 years. Your dedicated teams have provided exemplary service and demonstrated an unwavering commitment through many years, including the incredibly challenging pandemic years. Over the last decade, we have been impressed with the level of care coordination you have been able to provide and the tremendous impact it has had in the community and with the individuals served. As we celebrate this significant milestone anniversary, we want to say thank you for your commitment and dedication throughout the years for the program and our mutual clients. We look forward to our continued partnership and collaboration in the years to come.*

Torri Canda

Torri Canda

"God is great, and you are great. Thank you so much for fighting for older people."

**Amerigroup**

Cassy Wold

Danielle Beckham

Mary Brooks

Monica Kelley

Jordyn Martinez

Shannon Weber

**Lead - AMG**
**CCO – MedZed**
**Care Coordinator - Elena Mahoney**

Client is a female living with Depression and Anxiety. Her goal was to locate a Dentist and Optometrist. The Care Coordinator researched a Dentist, Optometrist, and a Mental Health provider who would accept the client's insurance. This included calling each provider to verify they accepted the client's insurance and confirmed next available appointments. The Care Coordinator went with the client to the Optometrist to schedule an appointment and verify they cover both intake appointments, exams, and lenses. The client wanted to schedule an appointment as soon as possible with a Mental Health provider due to going on an extended vacation for the following week. The Care Coordinator was able to get the mental health appointment scheduled for the next day and then followed up the next week to confirm the client went to the appointment. The client is still currently working with her Care Coordinator and is highly involved with the Health Home Program now taking initiative in scheduling her own appointments.

**Olympic AAA**

O3A would like to thank each and everyone that works with our clients and encourages them to meet the goals and have a better life. Your commitment is great! Keep up the great work!

Also, to our amazing CCO partners we work with, your dedication and care about your clients is visible in the way you write your notes. These clients are lucky to have you as part of their life, help in guiding them to get resources they need to help with getting the correct bus schedule or setting them up with Paratransit, or just being a person that is there for your clients. You are making  difference in peoples lives and that is what this program was designed to do.

The last few years have been challenging to say the least, with COVID taking over our State and lives, changing the way outreach was done, phone visits versus face-to-face visits. Luckily the PHE ended 5/11/2023 and hopefully everyone will be able to make visits and see their clients again face to face!

Just a big thank you to anyone that has been a part of this program and helping to build it up, I am eternally grateful.

Lori Lindley RN

Nurse Manager/CCO Manager/Health Home Lead

Lori Lindley, Maureen Woods, Dorothy Akin

Below
Dorothy Akin,
Lori Lindley

"You remind me of how great I really am."

Submit your story, resource, or ideas to the Care Coordinator Corner via our newsletter inbox:

healthhomenewsletter@dshs.wa.gov

"You can explain what I need to do in a way I can comprehend."

OAAA at the Makah Health Fair

Left
O3A CCs in 2020:
RuthAnn Kolodzie,
Yolanda Pearson,
Katrine Colten

Below
O3A CCs in 2020:
Megan Valdepena,
Pam Adams,
Cindy DeFord

Lori Lindley

*"Hi kind lady, Hope someday we can meet for lunch. Happy Valentine's Day. You are my best friend."*

**Lead – O3A**
**CCO – O3A**
**Care Coordinator – Katrine Colten**

Jason has struggled with Diabetes and high blood glucose levels for many years. He has had a portion of both feet amputated due to infection that would not heal. Over the last year he has been working very hard on doing better. I encouraged him to get a fitness tracking device and he did so and has been getting his steps most days. His caregiver supports him by walking with him. He has been forgetting his medications some days, so I worked with his case manager to get him an electronic medication reminder. Jason has recently lost about 40lbs, and his blood sugar levels have been lower. He has been eating healthier meals and smaller portion sizes and is excited to get his A1C results later this month as one of his goals has been to lower it and we believe he will succeed. We are now working on getting him to join a local gym. Jason's mom has agreed to help pay for the membership to a gym that is within walking distance of his home. He is still a work in progress but has had so many successes recently that I wanted to share his story.

Olympic Area Agency on Aging
Clallam, Grays Harbor, Jefferson & Pacific Counties

**SE WA ALTC**

For the last 10 years Health Home at Southeast Washington ALTC has been a strong program, serving clients in 8 counties and trailblazing through changes. The continued success has been a direct result of the strong leadership of SE WA ALTC's past lead Emily Watts, and the perseverance of the Care Coordinators. Our network of Care Coordinators is made up of workers with diverse educational backgrounds and specialties such as nursing, mental health and drug and alcohol treatment has allowed us to be resourceful and make meaningful connections with our clients. The collaboration of our CBO's has allowed us to touch more clients and provide a service in some of our most remote areas. Change is inevitable and constant; our team has been flexible, and course corrected flawlessly to maintain quality service for our clients. The leadership at SE ALTC applauds the work you do and continues to cheer you on, many thanks for the successes and positive changes you make daily. Cheers to 10 years! THANK YOU!

Felicia Sanchez
SE WA ALTC HH Lead

SE WA ALTC from 2019 - Pictured back left to right: Araceli Medina, Dianne McDonald, Anna Knight, Kay Woolstenhulme, Penny Richards, Jose Salcedo, Linda Rodriguez, Griselda Martinez. Front: Miriam Gonzales, Erin Mulka, Andrea Menendz-Cruz

*"I couldn't have done this without you."*

SE WA ALTC, Above: From L to R, Martin Rivero, Raichelle Steiner, Limbani Tambwari, Kay Woolstenhulme, Alejandra Ramirez-Carrera, Sara Rodriguez, Dianne McDonald, Anne Bruce, Ted Hancock, Mari Prieto, Jeniya Slutskaya, Shannon Young, Misty Kabrich,

**Lead – SE WA ALTC**

**CCO – SE WA ALTC**

**Care Coordinator – Jeniya Slutskaya**

Client is a 66-year-old female living with her caring husband and sweet little dog. Client has been diagnosed with rheumatoid arthritis and chronic gastrointestinal causing her to be in constant pain, have fatigue, poor appetite, rapid weight loss, weakness, and much more. Client's case has been passed down to me and the first request she had for me was to get in touch with HCS for in-home services. Client states her husband has many health conditions he is dealing with so he is unable to care for her. I then assisted her in completing an intake and referral with HCS and quickly sent it their way in hopes of setting her up with caregiving services. When I came by to visit her the next month, she reported that she had the CARE assessment with HCS and was assigned a caregiver that started working the week prior. Client thanked me for the assistance in establishing her with services and mentions with all the harsh medical treatments she goes through, making her feel tired and weak, having help around at home has been a blessing.

The most recent analysis from CMS shows the Health Home demonstration has saved the Medicare program more than $293 million, over the first six years, through better care coordination while transforming the lives of thousands of Washingtonians

## United Healthcare

Dear Health Home Care Coordinators,

I am writing this letter to express my heartfelt gratitude and offer my sincerest congratulations to each and every one of you. Your unwavering commitment to clinical care coordination has made a tremendous impact on the lives of our members, and I am profoundly grateful for the empathic and compassionate care you continuously provide our members.

Your dedication to providing evidence-based care is commendable. It is through your expertise and adherence to best practices that our members receive the highest quality of care possible. Your commitment to staying informed and up to date in our fluid care delivery landscape is a testament to your professionalism and the value you place on delivering excellent outcomes.

I want to acknowledge the exceptional flexibility you have demonstrated in your roles. The ever-changing nature of healthcare requires us to adapt swiftly and efficiently to new challenges. Your ability to navigate through these complexities with grace and agility is truly remarkable. Your willingness to go above and beyond to meet the unique needs of our members is greatly appreciated.

In conclusion, I want to express my deepest gratitude for each of you as you provide services that have a profound impact on the lives our members each and every day. Your empathic and evidence-based approach, coupled with your flexibility, is what makes a difference in the lives of those we serve. Congratulations on your achievements, and please know that your hard work and dedication are valued and recognized.

Thank you once again for your exceptional contributions to improving the lives of our members.

Sincerely,

Andrea Ray
West Regional Director, Community Integrated Care
United Clinical Services, Population Health Clinical Services

Left, Dee Brown - UHC would like to thank our national leader Dee Brown

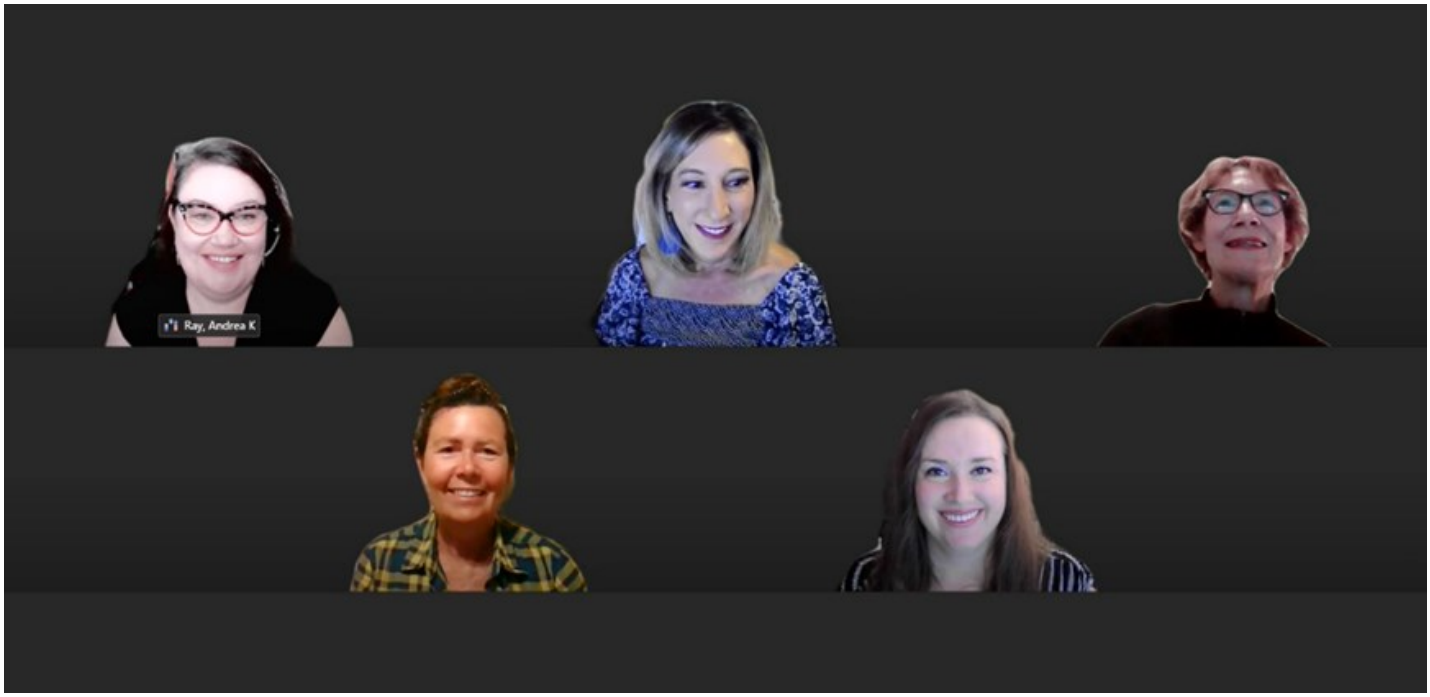
Right, Sharon Williams – UHC has a special note of thanks to Sharon William for her time building the UHC Health Home team and program.

**United Health Care**

*"You don't give up, man, until the job is done!"*

Tiffany Moon, Sharon Williams, & Andrea Ray

Below, Natasha Hoover




Top row left to right: Andrea Ray, Michelle Blankenship, Julie Johnson. Bottom row left to right: Traci Steele, Angela McEachran from UHC. Michelle, Julie and Andrea have worked with HH since the beginning!

*I go home at the end of the day and think about what I did for my UHC members that day. Members need help and support from time to time or constantly, their UHC HH experience gives them the motivation to face challenges and move on with improved health and mood. The HH program assists members with various types of resources and other needs. It's a real pleasure helping the members and doing as much as possible for them and hearing their progress. CC Tatiana Khrestiianovych*

**Lead - UHC**
**CCO – Cowlitz Family Health**
**Care Coordinator – Marlyce Thompson**

Gregori/Sarah is a 31-year-old, living alone in an apartment and is vision impaired with other chronic health conditions. They have a caregiver to assist three days a week and have a small support system. They initially enrolled in the Health Home program in 2020 with a PRISM score of 2.06. Since being in the program, their PRISM score has decreased to 1.58 and they have had less ER visits and decreased cholesterol and improved overall health. The HHCC has helped them accomplish many things including obtaining a new PCP and Endocrinologist, connecting with transportation resources, obtaining a referral (now currently engaged) with OHSU gender clinic, increasing their Braille comprehension, enrolling in college to obtain HS diploma, completing training and obtaining a guide dog, completing referrals to National Federation of the Blind and other blind support services locally and receiving dental care.

Gregori/Sarah has also been struggling with depression and looking for a counselor that has experience with gender identity. Because they live in a very rural area, community resources were sparse. Care Coordinator reached out to the Clinical Practice Consultant to request assistance with BH resources. A referral was submitted to UHC's behavioral health team, and an advocate was assigned to help locate a BH provider in the network. It was a long process, but client reports they are finally successfully engaged with a counselor and very satisfied with services.

Due to client's depression, this year they were struggling with increased diastolic pressures and asked for assistance in finding a home blood pressure cuff which speaks the blood pressure due to vision impairment. HHCC reached out to assigned Clinical Consultant at UHC and was able to obtain information for a local DME provider and ordered equipment. Client now has a blood pressure cuff and has been successfully monitoring their blood pressure on a routine basis.

The Health Homes program has been instrumental in helping the client with navigating the healthcare system and accomplishing goals that had been difficult for them to accomplish on their own.

*"May God bless you and people like you who sacrifice time caring for those in need."*

Successes:

CC was working with Mother of client to find a house, client called two weeks ago to say that she was getting a home by working with the Housing Authority.

CC helped client fill out an application to the Lion's Club to get new eyeglasses. Client called a few weeks after and said that she got her new eyeglasses.

Client was smoking a pack of cigarettes a day and called CC to say that she is now down to one cigarette a day.

A client that is a high falls risk now has a PERS unit.

A client that has suicidal tendencies is now working with Renew and a mental health therapist.

**Lead - NWRC**
**CCO – NWRC**
**Care Coordinator – Tatiana Kondratyuk**

Human services with **you** at the center

Client is a 53-year-old female living with Lupus. She has been on the HH program since 2020 however was recently transferred to my caseload. When I first met her, she was deep into her alcohol addiction. She struggled daily with sobriety and was desperately wanting someone to hear her pain.

As I began working with her and encouraging her to get active, attend medical appointments, participate with caregivers, and focus on positive thoughts, she began to significantly improve. Her drinking binges stopped, she has less ER visits, and her family is seeing improvements in her behaviors.

My client has not had communication with some family or friends on social media in over 6 years and she is now trying to reach out to them. She is optimistic and eager to put the effort into rekindling relationships. Her caregivers are noticing the positive changes.

We have noticed her health becoming more stable and physically she has regained some strength. These improvements would not have been seen if we were not providing services to her. Her father was extremely concerned about her health and was giving up hope of ever seeing her sober. He had mentioned being afraid of walking into her home and seeing her "gone" due to her frail health and deep addiction. He has reached out to me and thanked me for working with her and giving the family hope.

Her son has been visiting her more frequently since she began to take care of herself and maintaining sobriety. Our visits are more positive, and she is a joy to be around!

*Northwest Regional Council (L to R) from 2018: Colleen, Megan, Megin, Brenda, Katie V, Karen F, Sarah, Katie Z, Hannah, Kelly, Lynn, Peter, Silva, Ryan, Ericka, Dave, Allison, Dan, and Joanie.*

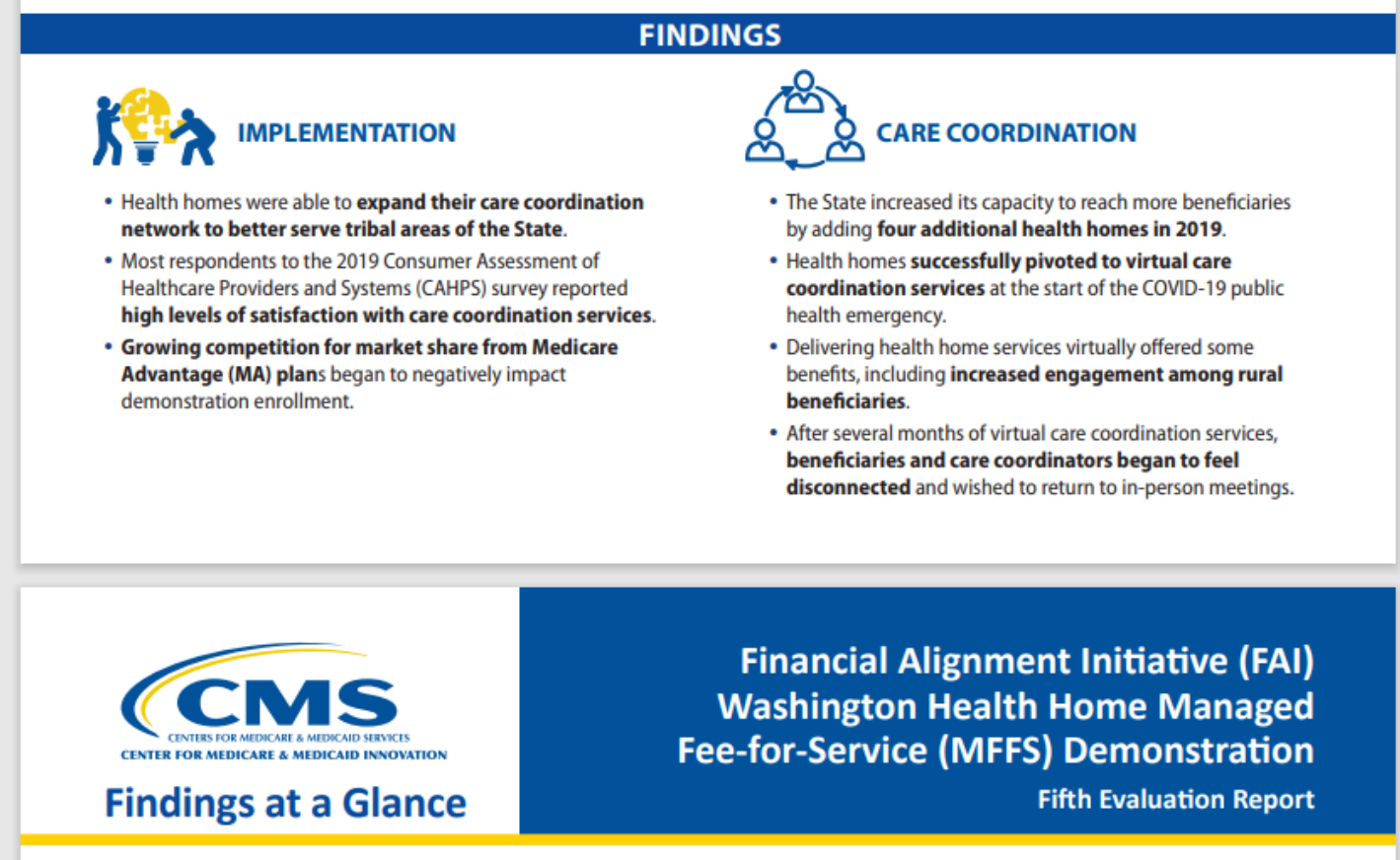
NWRC Human services with you at the center

**NWRC**

It is hard to believe the Health Home program is celebrating this momentous 10-year anniversary. NWRC would like to thank everyone who has contributed to the ongoing success of this program! From care coordinators, supervisors, IT staff, contract specialists, state staff, health plans, legislators, advocates, fiscal staff, directors, and data wranglers, so many have played a part in standing up this valuable service for our community members. We have collectively created something special in Washington State!

Ryan Blackwell

## Shout-out on twitter…

Washington State Health Care Authority

www.hca.wa.gov

Alice Lind

Jessica Bergman

Becky McAninch-Dake

Left:
Agnus Ericson

Right:
Silke Kramer

Agnus Ericson

We

Thank You

Thank You

Thank You

Alice Lind

Paula LarsonSandoz

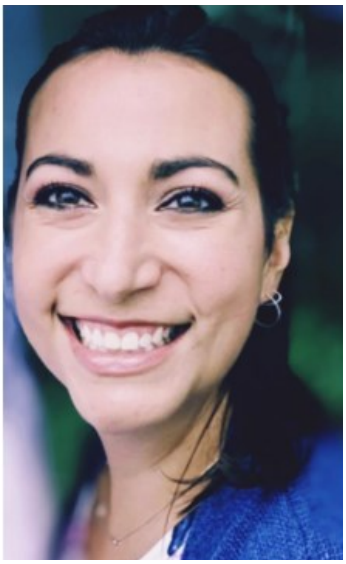
Washington State Health Care Authority

www.hca.wa.gov

Right: Silke Kramer & Glenda Crump

Left:
Johnny Shults

Right:
Jessica Diaz



Glenda Crump

Todd Slettvet

Stacey Bushaw

Christine Del Buono


Bev Court & Matt Pavelle

Cathy McAvoy

Above: DSHS Tribal Affairs team:
Picture was taken on the beach at the Hoh reservation.
Julie Jefferson, Elizabeth Greil, Jillian Morris

Brendy Visintainer and Kerri Hummel at ECCC

Right: Kelli Emans

Washington State Department of Social & Health Services

Transforming lives

Tiffany Maples

Pierre Katona

Mike Garrick

# DSHS — Research and Data Analysis

Below: Bev Court

Paul Genovesi

Matt Pavelle

Health Homes has been the most consistent part of my work since I started my career with the State 10-years ago. I feel like I've grown a lot as a data analyst, with much of the credit due to the plethora of analyses I've been able to work on for you all!

Matt Pavelle (DSHS/FAA/RDA)

Special Mention of some of the state employees who were not pictured in this Herald.

Bishop, Nicole (HCA)
Bobba, Marietta (DSHS)
Burch, Rebecca (HCA)
Dahl, Ann (DSHS)
Dronen, Nicole (DSHS)
Fitzharris, Karen (DSHS)
Garcia, Pedro (DSHS)
Gowen, Jean (HCA)
Hanson, Andi (HCA)
Lantz, Barbara (HCA)
Loza, Rafael (HCA)
Lovato, Yolanda (DSHS)
Martinez, Roseann (DSHS)
Owen, Shauna (HCA)
Pittelkau, Kathryn (HCA)
Vaughn, Christy (HCA)

Sending a heart felt Thank You to all our CCO's & Care Coordinators. We could not succeed without you.

*Thank You*

Child & Adolescent Clinic
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Columbia County HEALTH SYSTEM

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Aging & Long Term Care OF EASTERN WASHINGTON

Community Health of Central Washington

IKRON

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SERVING PEOPLE OF ALL BELIEFS

ICHS International Community HEALTH SERVICES

KWA


LUMMI NATION
TREATY OF 1855


MED ZED


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HEALTHCARE


Rural
Resources
Community Action


Titanium
HEALTHCARE


COMMUNITY
HEALTH
Care
MEDICAL • DENTAL • PHARMACY

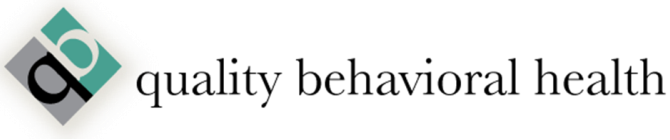

YAKIMA
Neighborhood
Health


Passages
Family Support


HealthPoint
Your Community Health Center


SOUND
The forefront of behavioral healthcare


CFHC
COWLITZ FAMILY HEALTH CENTER


quality behavioral health

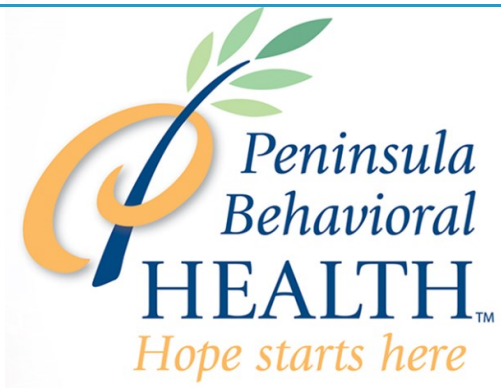

Peninsula Community
Health Services


RAINIER
HEALTH NETWORK


ads
Aging and Disability Services
Area Agency on Aging for Seattle and King County


TRIUMPH


SUMMIT
PACIFIC
• MEDICAL CENTER •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Hope starts here


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RYTHER
WHERE KIDS FIND HEALING AND HOPE