Overview

• Care Coordination
  • Continuity of Care
  • Identification of Special Health Needs Clients
  • Care Coordination
• Special Populations Coordination:
  • Transitional Care
  • Skilled Nursing Facility
  • Children in Foster Care
  • Mental Health Services
Why Care Coordination?

• Greater number of special needs populations

• Research demonstrated efficacy

• Isn’t just about having insurance

• Better coordination and orchestration of services for chronically ill makes sense
Continuity of Care

• Assure continuity for those in active course of treatment

• Elements
  – Preservation of provider-enrollee relationships
  – Prescription continuity during transitions
  – Allow enrollees to continue to receive care from non-participating providers
Identification of Individuals with Special Needs

• Within 90 days of enrollment, identify individuals with special needs
  – Administrative data, e.g., PRISM
  – Chronic conditions
  – Indicator of high risk pregnancy
  – Foster care, SSI designation
  – Social Complexity
  – Enrollees with unmet care needs
  – Responses to surveys/interviews
Initial Health Screen

• Initial health screen required of:
  – New, family connect, and reconnect (greater than 6 month period of disenrollment)
  – Requirement to report performance on screens according to contract schedule
  – Future (July 1 2014) assignments of new individuals based on screening performance
Initial Health Assessment

• Differentiates those eligible; and not eligible for HH, but still have special needs
  – Health Home – PRISM score 1.5 or greater; at least 1 chronic condition
  – Special Needs – Through identification process and required screening – separate activities

• Evaluation of physical and behavioral health status, health and social service history
Care Coordinator Activities

• Care Coordination Plan
  – Enrollee self-management goals
  – Short and long-term treatment goals
  – Identification of gaps/barriers and how these were addressed
  – Timely follow-up of the enrollee
  – Progress on self-management goals
  – Consultation and coordination with providers
SPECIAL POPULATIONS COORDINATION
Transitional Care

• Transitional services must be provided to enrollees
• Operational agreements in place and describe responsibility of each party
• List of activities to reduce re-hospitalization – much from Coleman model
Skilled Nursing Facility

• Plan responsibility for first 29 days – any cause

• Coordinate with:
  – SNF for discharge planning
  – ALTSA Home and Community Based Services for custodial care assessment
  – If client eligible for custodial care, disenrolled
  – If discharged to home or community residential setting, remains enrolled
Children in Foster Care

• Coordination with Fostering Well-Being Program – Medically Fragile Children

• Moving forward with RFP for Foster Children

• Plan release in January
Mental Health Services

• Operating agreements with PIHPs (RSNs)

• Specify exchange of information

• Transitions of care

• Procedures to determine enrollee’s eligibility for RSN services
Other....

- Internal quality assurance
- Screening requirements – added ACES
- Direct access to specialty providers
Health Homes

• Overview
• Health Action Plan (HAP)
• Assignment of a Care Coordinator
• HAP Reassessment
• Wrap Up
Overview

• Reserved for highest risk, highest cost individuals
• Intended to be community-based
• *It is not* primarily a telephonic care coordination program
• Capitalizes on existing community resources to serve as care coordinators
• The enrollee is at the center of the intervention
Health Action Plan

- Centerpiece of the program
- Client is encouraged to identify health action goals
- Coached and supported in self-management of chronic conditions
- Informed by critical assessment of existing data resources, e.g., PRISM
- Use of standardized screening instruments
Assignment of a Care Coordinator

• Use of a smart assignment process
• Assignment to a Care Coordination Organization
• Following HAP:
  – Continued interactions with enrollee
  – Foster communication between providers
  – Problem-solving issues of concern to enrollee
  – Help enrollee navigate care systems
  – Accompany enrollee to critical appointments
HAP Reassessment

• Update screens every 4 months
• Reassess progress towards goals every 6 months
• Provide individual and family support
• Referral to community and social supports
Wrap Up

• Enrollees cannot be discharged from HH
• They can be placed in lower-level intervention category
• They can choose to opt out and opt back in
• They may need a lot of encouragement to participate
• We believe it is a value-added program for Washington Apple Health enrollees
Questions?

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