

Success Stories

AAAs Take a Person-Centered Approach to Health Care with Washington State Health Home Model

As health care costs continue to rise across the country, policymakers in Washington state and elsewhere are seeking innovative solutions to reduce costs and improve the quality of care for older adults and people with disabilities. This success story describes how two Area Agencies on Aging (AAAs) in Washington state became involved in the state's Medicaid Health Home program and how their involvement helped reduce costs and improve the health of older adults.

Established in 1973 under the Older Americans Act, AAAs bring decades of experience in case management and person-centered services that enable older adults to continue living in their homes for as long as possible. This experience enabled AAAs participating in two of Washington state's pilot programs to tailor person-centered approaches to quality-of-life and health management services for individuals dually eligible for Medicare and Medicaid who have chronic conditions—while also saving the state's Medicaid programs millions of dollars.

Washington State's Health Home Program

Washington's Health Home program launched in July 2013¹ and was one of just two Managed Fee-for-Service (MFFS) demonstrations operating under the Centers for Medicare & Medicaid Services' (CMS) Medicare-Medicaid Financial Alignment Initiative Program.² Through an agreement with CMS that made the state eligible to receive performance payments based on producing savings and meeting certain quality measures, Washington used the Health Home program model to target its MFFS demonstration to individuals whose medical conditions placed them into high-cost,

high-risk categories, such as those who had an increased likelihood of developing other conditions and those who were dually eligible for Medicare and Medicaid, focusing on intensive care coordination for those with the greatest need. The program enhanced the integration of primary, acute, behavioral and LTSS services for dually eligible individuals and, based on the experience of Washington's AAAs, provided the greatest potential for improved health outcomes and cost savings among participants.

Getting Involved

David Kelly, then Executive Director of the Area Agency on Aging & Disabilities of Southwest Washington (AAADSW), and Roy Walker, then Director of the Olympic Area Agency on Aging (O3A), share the success that their two AAAs have experienced as contracted agencies with the Health Home program. For Kelly and Walker, partnering with the Health Home program made good sense—Washington AAAs were already providing LTSS case management and implementing Older Americans Act programs and services. They saw the Health Home program as an opportunity to reach even more older adults and people with disabilities in their communities.

How Does the Washington State Health Home Model Work?

The Washington State Health Care Authority (HCA), the state's Medicaid agency, provides payments and makes client referrals to Health Home lead agencies that administer the program and assign providers to clients. Lead agencies, which can be community-based organizations like AAAs, or Managed Care

1 The Washington State Health Home Program was a five-year demonstration that ended in 2019.

2 The other state participating in MFFS demonstrations under the CMS Medicare-Medicaid Financial Alignment Initiative Program was Colorado, whose demonstration ended in 2017.

Organizations (MCOs), are paid an administrative fee as well as the HCA Health Home rate for services provided by subcontractors. Coordinated Care Organizations (CCOs) are local Health Home contractors that contract with lead agencies to provide specialized support to clients, such as Care Coordinators who assist clients with their primary care needs.

Lead agencies, together with AAAs, MCOs and CCOs, operate as a systems network. As part of integrating care for participants across multiple delivery systems, Care Coordinators are charged with engaging participants to create Health Action Plans (HAPs), which help participants set goals and increase self-management skills to achieve improved physical and cognitive health outcomes. Some AAAs that served as CCOs contracted with Health Home lead agencies while others took on added responsibility as lead agencies by contracting directly with HCA.

The Health Home model helps individuals understand how their health care choices are affected by the social determinants of health (SDOH), including access to transportation, safe and affordable housing, caregiver supports and more. The key to the Health Home model is its ability to respond to consumers' need for medical care *and* social services in an integrated way that involves patients in the development of their care plans. During monthly visits, Health Home Care Coordinators use the principles of patient activation and engagement to address SDOH barriers and help



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participants adopt behaviors that have a direct impact on the outcomes of medical interventions.

During their ongoing sessions with Care Coordinators, Health Home participants build HAPs that address important issues related to their health and learn new skills that can help them better manage their health conditions. This approach supports participants as they take more control of their own health needs while maintaining a lifestyle of their choosing. Throughout this process, Care Coordinators interview their clients to help gain a better understanding of the client's motivations, develop structured goals and create a deeper knowledge of what makes their clients happy and healthy.

The success of the Health Home Program relies on enhancing participant knowledge—understanding how their specific health needs are affected by access to services that impact the SDOH—and working with participants to create realistic steps they can use to proactively manage their own health care. In this model, care is not driven solely by the medical doctor but in coordination with the HAPs each participant develops with their Care Coordinator, giving participants independence in directing their own care plan. The focus of these care plans usually prioritizes quality-of-life goals rather than medical goals, an example being, “I want to be steady and strong enough to go to my grandkid's birthday party or basketball game,” which helps motivate patients to achieve their goals.

Care Coordinators are key to the success of the Health Home program. As such, AAADSW's and O3A's Care Coordinators receive intensive training on developing HAPs and providing each of the six Health Home services: comprehensive care management; care coordination; health promotion; comprehensive transitional care and follow-up; individual and family support; and referrals for community and social services support. Care Coordinators eliminate gaps in

Participant Success

Before participating in the Health Home program, Earl, age 74, had battled both homelessness and congestive heart failure. Once he gained access to Care Coordination services through the Health Home program, Earl was able to redirect his life. With the help of his Care Coordinator, Earl now has routine doctors' appointments and the right prescriptions for medications to help him manage his health. In addition, Earl's Care Coordinator connected him to a local housing program, and he is now only a few steps away from getting a fully furnished studio apartment that is close to public transit. The Health Home program has brought Earl back from a point where he was just about ready to give up and he continues to make strides in improving his health and quality of life.



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Impact

Washington state’s Health Home program was successful—it engaged target populations and reduced both mortality and the number of emergency room visits made by participants while helping them achieve better health outcomes. Because of the program’s success, more than 20,000 individuals who were dually enrolled in Medicare and Medicaid in Washington state have received better, more coordinated care.ⁱ Over the first few years of the program, the demonstration produced millions of dollars in Medicare and Medicaid cost savings.

Even more important, the Health Home program also achieved improved health outcomes for program participants. AAADSW alone achieved exceptionally high rates of success, with an average engagement rate of 30 percent, exceeding the national average.ⁱⁱ In addition, participants demonstrated improved scores across an array of cost and health management measurements.

As part of the Health Home Program, participants were surveyed at the start and conclusion of their participation to help measure the program’s success. In all measures of patient activation—knowledge, skill and confidence for managing one’s health and health care—survey results showed demonstrable growth in client engagement rates, translating to reductions in poor health outcomes and significant savings for the state’s Medicaid program. Health Home participants reported feeling more in control of their health and that they had a better understanding of how their own actions and daily routines can affect their personal life and goals.

AAA Experiences in Health Homes

Former O3A director Roy Walker shared that the staff involved in this work reported high rates of job satisfaction, indicating that this is their “dream social work job.” Interaction with clients helps cultivate the relationships needed to foster motivation and determination. Time is spent where it matters—in the field providing services to help clients be successful, not engulfed in office paperwork. Participant success reassures staff that their work is making a significant impact in the lives of their clients. Although the road to implementing interventions is never without challenges, improvements in both client satisfaction and health outcomes make the process worth it in the eyes of staff.

O3A, like other AAAs in Washington state, is engaged in health system improvement through local Accountable Communities of Health (ACHs), as well as other efforts, but what’s particularly noteworthy about the Health Homes program model is that it works from the consumer side of the equation. Walker notes that, “by using evidence-based and consumer-informed engagement strategies, we are helping people take more active roles in their own health care, [which is] particularly important for people who have multiple chronic conditions. Empowering consumers to be active members of their own health care teams is very powerful. It inspires hope and clarity of focus.”

More recently, Washington’s Governor, Jay Inslee, has identified equity as one of his main legislative goals, along with climate change and COVID-19 recovery. O3A is targeting the tribes in its region with this program (Washington state has eight federally recognized tribes and another tribe that is seeking federal recognition). O3A has expanded its service area so that it can serve as a lead agency to tribes in neighboring regions and is currently serving as a lead agency for seven counties. The O3A team believes that the Health Home model supports tribal elders particularly well as the mission and values closely align. Many tribes are located in remote coastal regions that are several hours away from services, so having the coaching and support to achieve positive health outcomes with people who tribal elders trust is critical. This is why O3A decided to continue with this model, while seeking additional financial support from the state, in order to be able to implement a supportive staffing strategy that can

lead to success. Effective July 1, 2021, O3A is receiving administrative claiming for providing the lead function for Health Home services.

For AAADSW, the decision to participate in the state's Health Home program was, in part, based on proving that AAAs have the ability and capacity to deliver quality home and community-based services—which they did. Participating in Washington's Health Home program has helped the agency internalize best practices that will inform its future work. While finding a way to make this program sustainable remains a challenge due to the need for high client volume, the positive results achieved for its clients reinforces AAADSW's commitment to this effort. In fact, AAADSW's success as a CCO during the demonstration program led to it becoming a Health Home lead entity, providing oversight and support to all CCOs in its regional network.

Lessons Learned

Advice for Pursuing Contracts

For AAAs in states that have created Health Home programs or other integrated care models that are interested in health care contracting, consider the following:

- **Obtain staff-buy-in:** When it comes to participating in a Health Home program, having skilled and motivated staff can play a critical role in the agency's success. Staff must not only be passionate about social work but should also be proficient in navigating the many platforms that are used to manage client information, document the work performed and ensure proper billing. Kelly emphasizes that, for leadership, it is important to hire not just the right people for the work but also to create and facilitate a work culture that supports staff retention.

AAADSW Case Management Services Manager Samantha Waldbauer reinforces this idea by noting that "staff retention is crucial for this work to be successful—we feel we have done a good job providing an environment, workflow and common mission where staff feel supported and want to remain to help our clients."

- **Develop a cost/pricing structure.** To participate in the Health Home Program, Washington's

Participant Success

Lucy, a Health Home client, has worked with Care Coordinators to obtain glasses, hearing aids, an electric medical bed and a manual wheelchair all of which help her continue living independently at home. Prior to her involvement in the Health Home program, Lucy's lack of access to transportation meant that she frequently missed medical appointments and was therefore not addressing major health concerns. Lucy and her Care Coordinator are now working on getting Lucy dental care, something Lucy has avoided for more than 40 years due to fear and anxiety. Through education, Lucy's Care Coordinator is helping Lucy understand the importance of oral health and its effects on her overall health, and is providing Lucy with information about increasing her physical activity and improving nutrition. Lucy feels that the Health Homes program has helped her achieve important goals and greatly improved her quality of life.

participating AAAs were required to develop a Health Home model with a unit-rate cost structure. To do so, most had to use reserve funding that they had accumulated from other revenue streams. For AAAs seeking to develop a Health Home model in other states, Kelly recommends asking state and other contracting entities whether they have adequate start-up funds that would cover six to 12 months of expenses. Kelly says the key to sustainability is ensuring that the scale of the model fits the pricing structure because this work requires the right client volume to be sustainable.

- **Conduct an external market assessment.** In any state, it is imperative to keep pace with—or stay ahead of—new developments in your market. This is particularly true for AAAs considering adopting new models of care. Kelly suggests that AAAs pursuing contracts in their state's Medicaid LTSS systems should continue to make their service models relevant to the changing landscape of health care financing and consumer choice. Focusing on empowering consumers to actively engage in the day-to-day management of their health is critical. Leadership should regularly analyze the external market and the local ecosystem for opportunities to actively engage health care entities with the services they are currently offering for older adults.

The Aging and Disability Business Institute offers a [suite of assessment tools](#) that AAAs and other community-based organizations preparing for and engaged in contracting work with health care entities. For example, AAAs can use the [External Market Assessment](#) to help them better understand the health care landscape, identify market trends and recognize major players in the market.ⁱⁱⁱ

Through their involvement in Washington's Health Home program, several of the state's AAAs have played a key role in showing how AAAs can successfully participate in new approaches to delivering health care to individuals dually enrolled in Medicare and Medicaid. By providing quality care coordination and delivering a demonstrably positive impact on the lives of participants, Washington state's Health Home program proves that AAAs are powerful partners in delivering home and community-based services and provides a leading example of how AAAs can successfully partner with health care entities to deliver services.

Endnotes

- i Centers for Medicare & Medicaid Services, Report for Washington Health Home Managed Fee-for-Service (MFFS), <https://innovation.cms.gov/files/reports/fai-wa-finalyr2preyr3.pdf>.
- ii Area Agency on Aging of Southwest Washington, *Best Practices for Care Coordination: The AAADSW Model*, <http://www.hel-pingelders.org/download/11422>.
- iii USAgings' Aging and Disability Business Institute, *Assessment Tools*, <https://www.aginganddisabilitybusinessinstitute.org/assessment-tools>.

Learn more about the Washington State Health Home Program:

Health Affairs: Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs (<https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0655>)

Health Management Associates (HMA) Weekly Roundup, Trends in State Health Policy, February 2016 (<https://www.healthmanagement.com/wp-content/uploads/022416-HMA-Roundup.pdf>)

Measurement, Monitoring and Evaluation of the Financial Alignment Initiative for Medicare-Medicaid Enrollees; (<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalResults.pdf>)

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