Washington Health Home

Transforming Lives – Improving Outcomes

UnitedHealthcare®
Community Plan

Washington Health Home

UnitedHealthcare Community Plan

What Is Health Home?

Health Home is for people enrolled in Medicaid who:

- Have two or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

UnitedHealthcare Community Plan classifies the Health Home populations into high risk, emerging risk and low risk categories.

Chronic conditions may include issues with mental health, substance abuse, asthma, diabetes, heart disease, HIV/AIDS and being overweight.

- Health Home services may focus on population health data, prevailing health challenges or social determinants of health.
- Health Home services include Medicaid and Medicare dual-eligible.

Population Health Risk Pyramid

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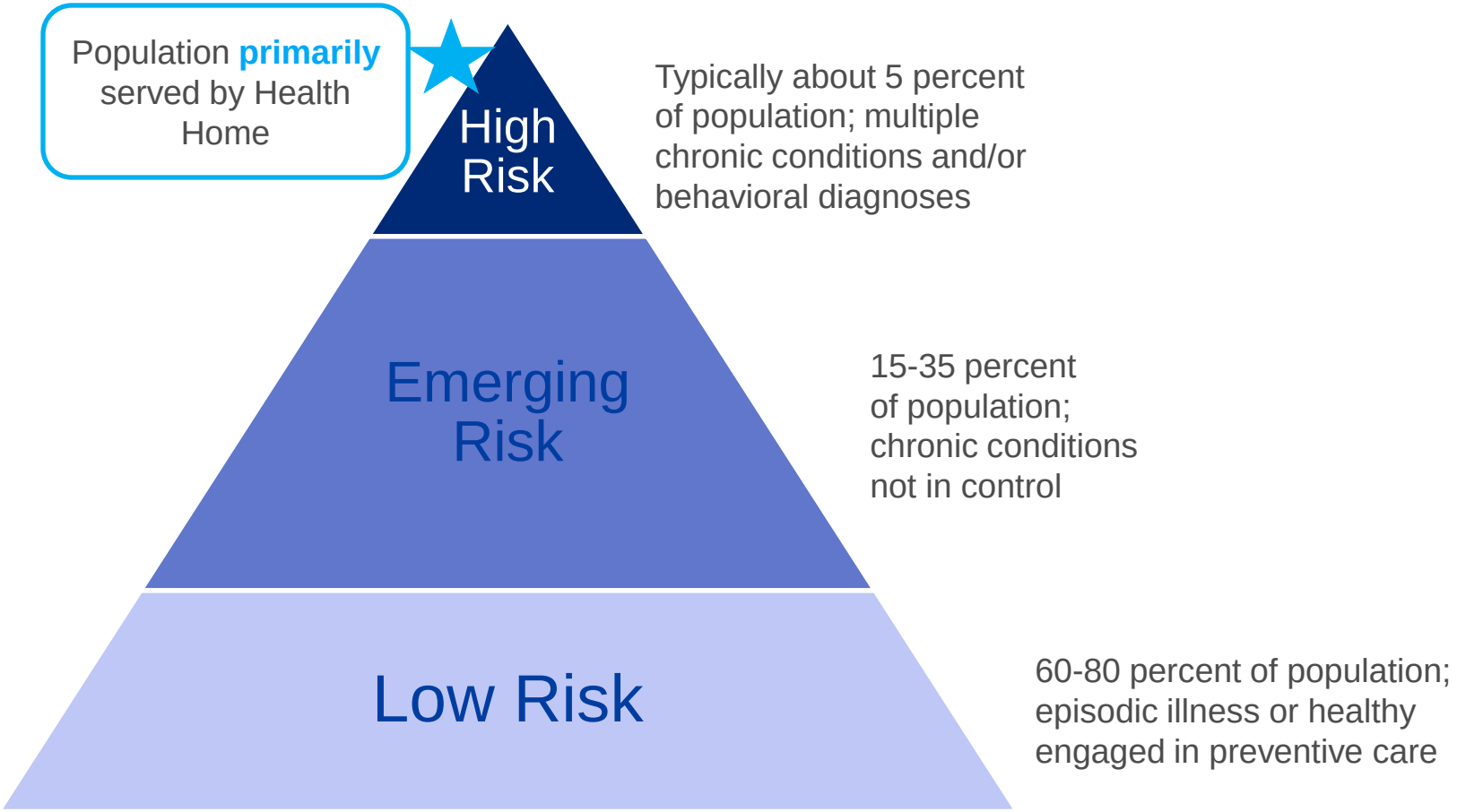
Stratifying the population to identify high-value opportunities for managing total cost of care



Core Services

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Integrating Medical, Behavioral, and Social Services

Accountable for Care Coordination Services and Care Team Integration

High Cost High Need Population

Care Coordination Organization

1. Care Coordination

Cross system care coordination activities to assist participants in accessing and navigating needed services.

2. Care Transitions

Proper and timely follow-up care to prevent avoidable readmission after discharge from an ER and inpatient facilities.

3. Referral Management

Identification of available community based resources and actively managing referrals, assistance to the beneficiary in advocating for access to care and engagement with community and social supports related to goal achievement documented in the Health Action Plan (HAP).

4. Health Promotion

Begins with the commencement of the Health Action Plan (HAP), demonstrating use of self-management, recovery and resiliency principles using person-identified supports. Addressing gaps in care.

5. Individual Support

Support to the beneficiary to access and navigate the healthcare and social service delivery system as well as support health action planning.

6. Family/Caregiver Support

Support to the beneficiary's family and/or caregiver to access and navigate the healthcare and social service delivery system as well as support health action planning.

Comprehensive Approach

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Approach

- Manage our highest risk, highest cost members who have a history of frequent adverse events (sometimes called persistent super-utilizers). These members **need active care coordination**, support and help to more effectively re-engage with their care team.
- Manage care coordination for members who have multiple chronic conditions and co-occurring behavioral health issues, who need extra support to coordinate care among **multiple clinicians involved in their care** – such as primary care providers (PCPs), specialists and hospital teams – to help see that care transitions and referrals are actively managed to reduce the risk of adverse events.

Comprehensive Approach

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Approach

- Health Homes are **community-based organizations** contracted to deliver six key services, defined by the Centers for Medicare & Medicaid Services (CMS), to the identified population through face-to-face and telephonic interactions conducted by community health workers and care coordinators in the communities they serve.
- Our clinical transformation team works directly with each care coordination organization/health home.
- Clinical team consists of health home transformation consultants who empower, monitor and guide daily, weekly, monthly and quarterly tasks.

Integrated Care

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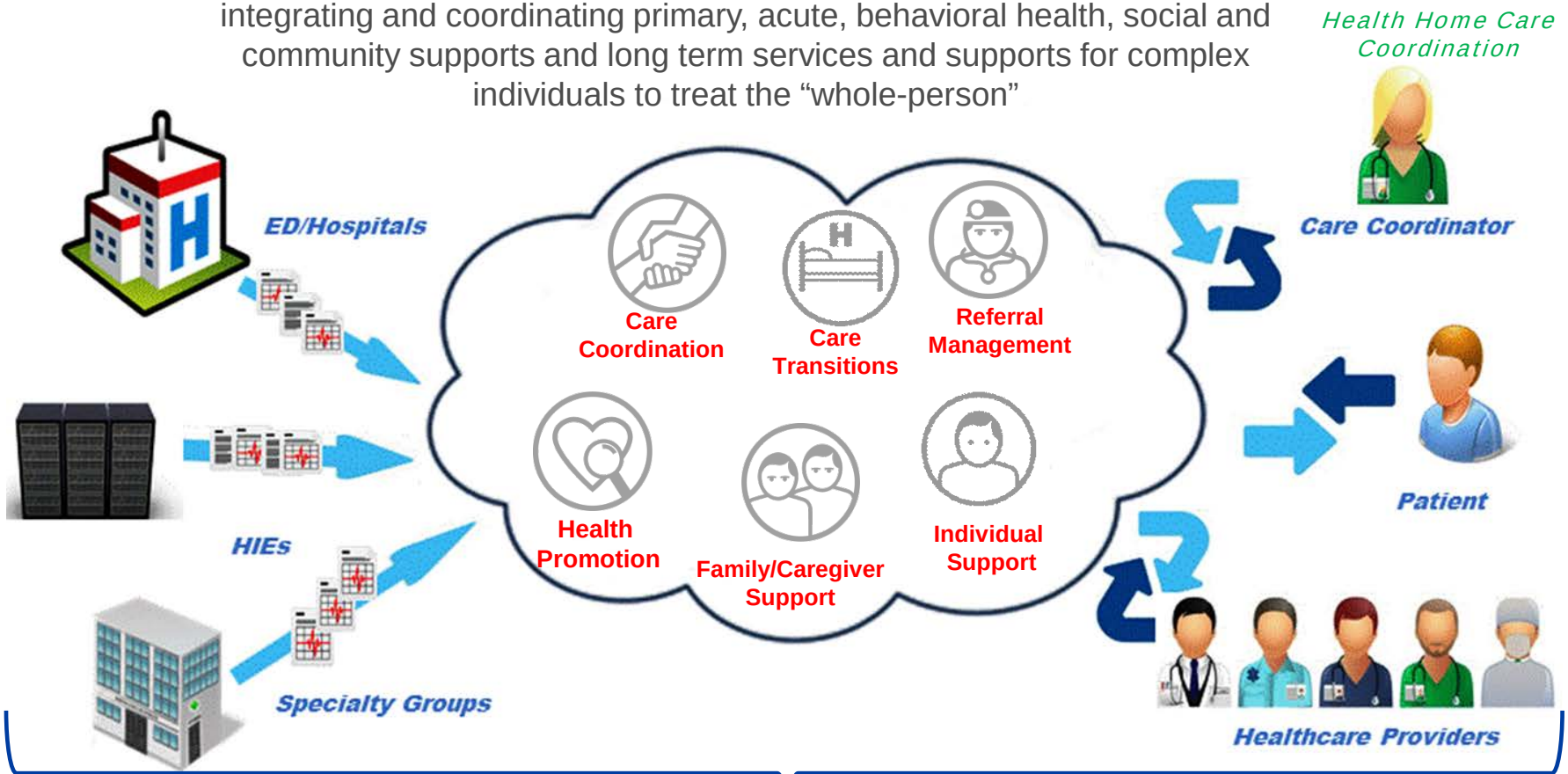
Health home care coordination provides a **comprehensive system of care** by integrating and coordinating primary, acute, behavioral health, social and community supports and long term services and supports for complex individuals to treat the “whole-person”



Goal: Improve health outcomes; reduce emergency department (ED) use, hospital admissions and readmissions, and health care costs; and improve experience of care for population served

Performing Care Coordination

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- Conduct screenings to identify health risks and referral needs.
- Set person-centered goals that aim to help improve member health and access to health care services.
- Improve management of health conditions through education and coaching.
- Support changes to improve member's ability to function in their home and community.
- Empower members' ability to perform self-care.
- Slow progression of disease and disability.
- Reduce avoidable health care costs.

Care Coordination Best Practices

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- Meet members where they are.
- Engage member's parent and/or caregiver, when applicable.
- Collaborate and build trust through regular monthly engagement appointments.
- Perform timely and quality transitional care interventions.
- Empower member by helping to promote their health awareness, ability and confidence

Care Coordination On-Boarding

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- ✓Contract Review and Execution
- ✓Readiness Check List
- ✓Staff/Team Credentialing
- ✓Security Quality Assurance
- ✓Vendor Establishment/Billing
- ✓Systems Access
- ✓Health Home 2-Day Certification Training
- ✓Care Platform Training
- ✓On-Going Training, Support and Team Empowerment
- ✓Monthly Joint Operating Committee Meetings

Success Story

Middle aged female residing in suburban Washington. Diagnosed with a major chronic disease, depression, substance abuse and diabetes. Enrolled in Health Home mid-year 2015.

Barriers to Care:

- Struggled balancing self-care with care of teenage son
- Limited ability and knowledge of regulating sugar levels
- Non-adherence to medication

Health Home Engagement Activities:

- Timely and comprehensive transition care interventions
- Monthly face-to-face encounters
- Connection to behavioral health counseling
- Health promotion and education
- Referrals for compression socks and caregiver.

Success Story (cont'd)

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Health Home Engagement Results:

- Maintains primary care provider (PCP) and specialist appointments
- Adheres to insulin and medication therapy
- Avoided potential need for leg amputation after obtaining and using compression socks regularly
- Patient Activation Measure (PAM) improved from level 1 (passive and overwhelmed) to level 4 (empowered and supporting health)
- PHQ-9 (depression assessment) reduced from high- (major depression, moderately severe) to low-risk score (minimal symptoms)

Thank You