



Social Determinants of Health: Update from HCA for Health Benefit Exchange Advisory Committee

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Critical needs

- Leadership
 - Includes health and community leaders from all sectors
- Data
 - Current state of social determinants in Washington
 - Impact on patients (individual and population level)
 - Which gaps in existing resources are most critical
- Connection
 - Increased communication and coordination between clinical systems and community supports, and across agencies



Snapshot of HCA efforts in progress

- Medicaid Behavioral Health Integration with physical care, focusing on whole person care
- Medicaid Transformation Project (part of 1115 waiver)
 - Accountable Communities of Health (ACHs) shift the conversation about health to the community and regional level, engaging all sectors in improving health through addressing both upstream and downstream issues
 - American Indian Health Care Provider projects
 - Foundational Community Supports – Housing and Employment Supports
 - Long Term Care Services and Supports – new benefits
- Home Health Care Program

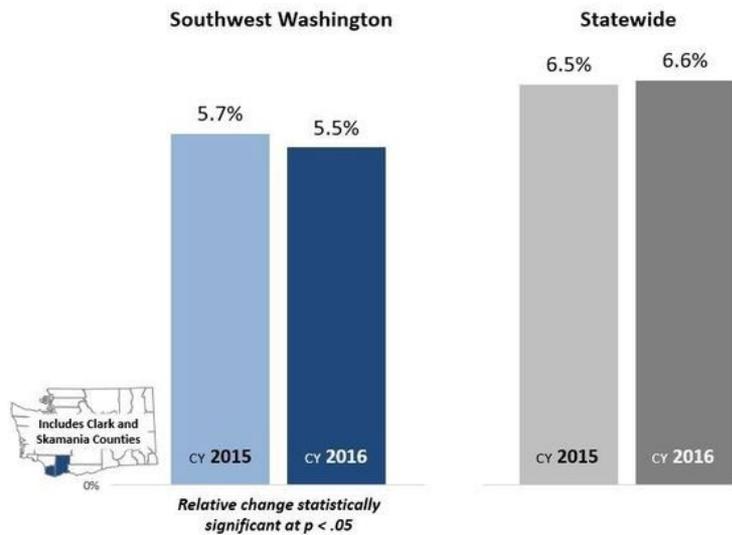
Behavioral Health Integration – early results

- The early integration region, Southwest Washington, is performing better than non-integrated regions in 10 of 19 measures
- Statistically significant improvement for Medicaid beneficiaries for:
 - Adults' Access to Preventive/Ambulatory Health Services
 - Cervical Cancer Screening
 - Chlamydia Screening in Women
 - Comprehensive Diabetes Care - Hemoglobin A1c Testing
 - Antidepressant Medication Management - Continuation Phase Treatment
 - Percent Homeless
 - Percent Arrested

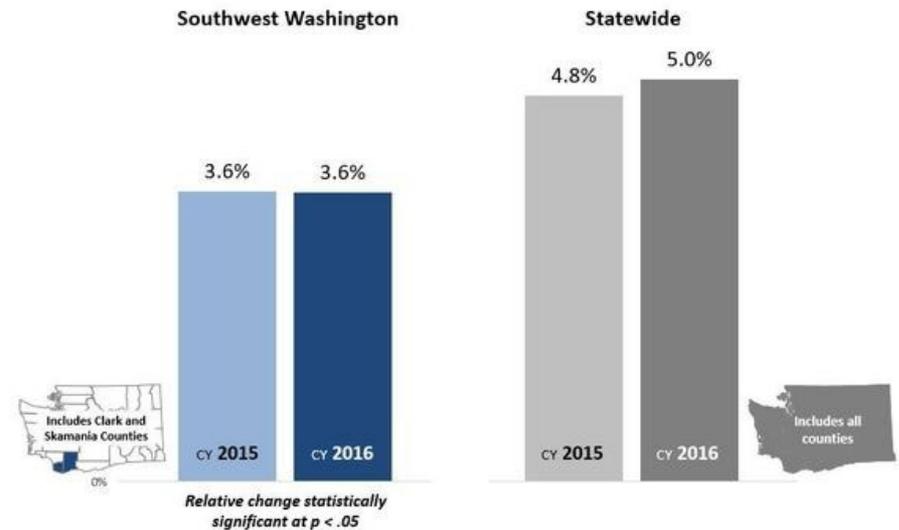


BH Integration Early Findings: Social factors in Southwest Washington

Percent Arrested
(WSP WASIS Match)
AGE 18 to 64



Percent Homeless - Narrow Definition
(ACES Living Arrangement Data)
AGE 18 to 64



Medicaid Transformation Waiver Projects

- Accountable Communities of Health -specific areas of focus include:
 - Care coordination and connection to community services
 - Transitions of care (including hospital to nursing care or home, jail to home, etc)
 - Promotion of role of Community Health Workers, coordination broadly coordination beyond traditional medical (linkage with MCO care coordination)

MTP Waiver projects, con't

- Medicaid Transformation Waiver also includes:
 - Foundational community supports
 - Helping those with complex health needs obtain and maintain housing and employment
 - Long-term services and supports
 - Supporting unpaid family caregivers
 - Supporting people who need long-term services and are at risk of spending down to impoverishment



Waiver and Indian Health Care Provider projects

- Integrate physical and behavioral health purchasing and service delivery to better meet whole person needs
 - Behavioral Health Integration, Traditional Healing, Start/expand a Tribal 638 clinic, Dental Integration
- Support provider capacity to adopt new payment and care models
 - Tribal FQHC, Telemedicine, Community Outreach
- Implement population health strategies that improve health equity
 - Workforce Development/CHAP Board, Public Health, Integrate Behavioral Health and Law Enforcement, Childcare



Health Home program – Dual Eligibles

- A person-centered, holistic approach in which individual Health Action Plans include goals set together with the client
- Services include
 - Comprehensive care management
 - Care coordination
 - Health promotion
 - Transitional care planning
 - Individual and family supports
 - Referrals to community and social support services
- Health Home services are **reducing** health care costs
 - Dual eligible Medicare savings from the first 30 months of Health Home program: Preliminary gross Medicare savings of \$67.5 million over two years*

*Report for Washington Managed Fee-for-Service, Final Demonstration Year 1 and Preliminary Demonstration Year 2 Medicare Savings Estimates, Centers for Medicare & Medicaid Services, July 2017

Emerging Areas

- Areas we are exploring:
 - Development of Medicaid bundles focused on maternal child issues, working with the CMS Medicaid Innovation Accelerator Program, to help identify resources and options to structure value based payment with SDOH
 - Potential grant with CMMI, Integrated Care for Kids (InCK) model – request for applications (focus on children with physical, behavioral, or other health related needs such as food insecurity and unstable housing)
 - Exploring more data opportunities with DOH and DSHS

Opportunities?

- Be aware that SDOH will strongly impact health outcomes and health costs for Exchange members
- Support health plans that recognize need to address social context to improve health
- Possible role for Exchange Navigators in making clients aware of supports for social needs
- Promote patient activation and empowerment
- Support efforts to improve data about social determinants and their impacts; opportunities to capture information upfront with enrollment?
- Support ACHs in developing regional approaches to health improvement



Questions?

More Information:

<https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation-resources>

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