Health Home Program

It does not matter how slowly you go so long as you do not stop – Confucius

Health Homes is a Center for Medicare & Medicaid Services (CMS) demonstration project operating in 37 counties, excluding King and Snohomish throughout Washington State since July 1, 2013. The progress of the program has been slow due to a number of stumbling and road blocks, but as so plainly stated by Confucius, "It does not matter how slowly you go as long as you do not stop". This sentiment holds true for the program and additionally holds true for the clients as they embark on lifestyle changes during their participation.

The Washington Health Home demonstration project works to integrate care for high-cost, high-risk, full benefit Medicare-Medicaid beneficiaries (Duals) based on the principle that focusing intensive care coordination on those with the greatest need provides the greatest potential for improved health outcomes and cost savings. Individuals who are eligible for Health Home benefits have at least one chronic conditions, including mental illness or substance use disorder, and are at risk for another chronic condition as measured by risk scoring. CMS recently released a report Preliminary Findings from the Washington MFFS Demonstration, submitted by Edith G. Walsh, RTI International that highlights the programs potential promising financial success. ***According to the report early indicators of shared savings, based on a reduction of Medicare costs and achieved performance measure, indicates $21.6 million savings in Medicare costs, of which the state could receive approximately $10.8 million.***

These cost savings are being realized in a number of different ways as care coordinators and clients work on lifestyle changes and to bring all of a client's service providers onto the same page. An example of this coordination between multiple services providers is deeply demonstrated by Diane's story.

Diane is an 82 year old with diabetes and a non-healing wound for the last four months when she is enrolled with the Health Home program. Through the conversation with Diane the care coordinator also suspected she has short term memory issues. Diane's wounds were on her right foot and her second toe had turned black. It was determined that the nurse attending to Diane's wounds was doing so without orders from a physician, but Diane was not aware of this information. Trusting in the nurse Diane had canceled her appointment with the wound clinic as she believed the nurse has all her medical needs under control. She did not. The care coordinator quickly alert Diane's physician of the situation and he instructed Diane to attend the wound clinic immediately. At the wound clinic Diane was diagnosed with a blockage of the blood vessels supplying her right foot. She was set up for surgery that saved her right foot from amputation. Through her work with the care coordinator Diane and her care provider learned the importance of being involved in her health care and understanding her needs and not depending on others. Diane's story is just one example of how the Health Home model helps to increase client engagement, improve health outcomes and integrate care.