



Report to the Legislature

HEALTH HOME DIABETES PROJECT

Engrossed Substitute Senate Bill 6002
Chapter 221, Laws of 2014

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Executive Summary

The legislative report, Health Home Diabetes Project, was created in response to Section 213 (20) of Engrossed Substitute Senate Bill 6002, enacted as Chapter 221, Laws of 2014, which directs the Health Care Authority (HCA) to address strategies to improve adherence of diabetic patients to their treatment plans. The strategies are to be implemented through at least one Health Home program as identified by the HCA. The section directs the HCA to submit a report to the governor and the state legislature in December of 2014. The section further directs the HCA to calculate the cost savings derived from the strategies, to make recommendations for improving these strategies, and to report this information to the governor and the legislature in December of 2015.

Washington Health Home Program

In 2013, the Health Care Authority implemented a Health Home Program in all but two counties of Washington State. Half of the counties began enrolling clients in July, and half in October.

Admission to the Health Home program is offered to eligible Medicaid and dual beneficiaries of Medicaid and Medicare as part of their Medicaid benefit. This benefit has been made available through the Patient Protection and Affordable Care Act. Both fee-for-service and managed care enrollees in Apple Health are eligible for Health Home services if they:

- Have 2 or more chronic conditions, which may include asthma, diabetes, heart disease, and obesity (or other chronic conditions, upon approval from CMS);
- Have one chronic condition and are at risk for a second; or
- Have one serious and persistent mental health condition.

The Health Home model seeks to address complex problems by offering:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care and follow-up;
- Patient and family support; and
- Referral to community and social support services.

Registered nurses and other licensed medical professionals are employed as Care Coordinators to facilitate implementation of the services. They are employed by Care Coordination Organizations that are, themselves, contracted by Qualified Health Home Lead Entities. These Lead Entities include Apple Health managed care organizations and community-based organizations.

Health Home Diabetes Project Request

Enrolling high risk beneficiaries in the Health Home Program is in itself a strategy for improving outcomes for Medicaid enrollees with chronic illness. For example, within Apple Health managed care contracts and the fee-for-service Health Home contract are these required interventions for the Care Coordinator:

- Complete a set of standard screening tools and an assessment;
- Complete a Health Action Plan (HAP) that includes enrollee-selected goals;
- Identify and address enrollee gaps in care (such as missing lab tests or eye exams for diabetes);
- Provide or oversee interventions that address the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting the enrollee's health;
- Collaborate with health care professionals such as primary care providers, mental health professionals, chemical dependency treatment providers, and social workers; and
- Coordinate or collaborate with nutritionist/dieticians, direct care workers, pharmacists, peer specialist, family members and housing representatives or others, to support the enrollee's Health Action Plan.

The Care Coordinator assists the patient to create the Health Action Plan, which includes short and long-term self-selected health or healthy behaviors goals. For patients with diabetes, goals might include improved blood sugar, weight loss, and health eating habits. The HAP identifies prioritized action steps for the client, their personal care worker or caregiver, collaterals, the Care Coordinator, and other health or social services, partners. Examples of person-centered short-term goals in the initial HAPs for beneficiaries with diabetes fall into a several groups.

Focus area	Goal from Health Action Plan
Exercise or activity-related	<ul style="list-style-type: none"> • Use right hand and wrist without pain, resolve carpal tunnel, to regain self-care skills. • Decrease shortness of breath when walking and be able to walk outside again. • Develop or continue to follow a regular exercise routine. • (Client) stated she is open to learning seated exercises and her caregiver supports this. • Be able to walk further.
Specific to diabetes	<ul style="list-style-type: none"> • (Client) would like to better manage her blood sugar numbers. • Bring Diabetes under control. • To maintain good numbers and continue to eat healthy and exercise. • (Client) wants to lose weight in order to feel better, be

	active, and help manage diabetes.
Nutrition and weight	<ul style="list-style-type: none"> • She is wanting to decrease her weight. • Make healthier food choices/improve nutrition. • (Client) will work on eating a healthier diet.
Health care/other systems	<ul style="list-style-type: none"> • Decrease frustration over access to health care. • Obtain Safe and Stable Housing.
General health	<ul style="list-style-type: none"> • Cut down/quit tobacco use. • Organize medications and understand them enough to talk to doctor about need for all medications. • Stay on top of health issues, and delegate more assist. • (Client) would like to function pain free. • Learn what my options for dialysis are. • Control and maintain chronic pain.
Quality of life	<ul style="list-style-type: none"> • Improved mood and outlook. • Client will go out into the community once a week. • I want to get physically stronger.

In keeping with the legislative request to have at least one Health Home implement an improvement strategy on diabetes, the managed care Health Home Leads were asked by HCA to conduct a project for enrollees with diabetes. Three managed care plans volunteered to report on the effect of enrolling clients in a Health Home program on their diabetes.

The Burden of Disease

Diabetes is a serious, chronic, and costly condition. According to a 2012 report by the Washington Department of Health, an estimated 425,000 citizens were diagnosed, 172,000 were undiagnosed, and 1.8 million had pre-diabetes. It is the leading cause of new cases of blindness in adults and a major cause of kidney failure, peripheral nerve disease, and loss of lower extremities. The Legislature will receive the “Diabetes Epidemic and Action Report” at the end of December, 2014. This collaborative report by the Washington State Department of Health, Department of Social and Health Services, and Health Care Authority provides comprehensive information about the impacts of diabetes in our state. It includes a definition of and general treatment for diabetes, the prevalence of disease and the affected populations, the financial costs of the disease to the state, the current programs and services that the state provides to address the diabetes epidemic, and recommendations for future policy.

Diabetes Testing

Glycosylated hemoglobin, or HbA1c, is a blood test that measures a person’s average blood sugar over three months. It is a standard test used for the diagnosis and ongoing monitoring and treatment of diabetes. The American Diabetes Association recommends that the HbA1c test be performed at least twice a year in patients who are meeting their treatment goals and have stable blood sugar levels. As part of its Comprehensive

Diabetes Care measure, the National Commission for Quality Assurance includes HbA1c as one of the core elements to be addressed during the measurement year.

Project Parameters

The Qualified Health Home Leads were asked to report rates of HbA1c testing of engaged Health Home members and of managed care patients not participating in the Health Home program. Patients in both groups had either type 1 or type 2 diabetes. Engaged Health Home members were those who had been personally contacted by a Care Coordinator, who had completed a Health Action Plan, and whose claims data showed submission of a procedure code indicating Health Home engagement. Non-Health Home patients were randomly selected from all other patients with diabetes in the managed care plan.

The test group was comprised of Health Home patients. The control group was comprised of non-Health Home patients. All patients had an indication for HgA1c testing. Other inclusion criteria included:

- Ages 18-75 years as of December 31, 2014;
- A primary diagnosis of diabetes type 1 or type 2, as identified by diagnosis codes ICD-9 code 250.xx;
- Continuous enrollment in Health Homes or traditional managed care plans during the measurement period, which was variable, according to the managed care plan; and
- An allowable gap of no more than 45 days during the measurement period.

Patients with certain diagnoses associated with diabetes or insulin insensitivity at any time during or preceding the measurement year were excluded from the PIP. These included:

- Patients with a diagnosis of polycystic disease;
- Patients with a diagnosis of gestational diabetes;
- Patients with steroid-induced elevated blood sugar.

Health Home Diabetes Project Results

Three Lead Entities responded to the request and submitted information in August of 2014. Molina Healthcare of Washington reported that it served 37 Health Home patients who met the inclusion criteria. Due to the small sample size, they included all patients in the test group. The non-Health Home patient population meeting inclusion criteria numbered 462. They created a 37-member random sample control group. Information was collected from their claims data from July 1, 2013 to March 31, 2014. They reported the following results:

- Twenty-eight of thirty-seven (75.68% of) Health Home patients had HgA1c testing.
- Thirty of thirty-seven (81.08% of) non-Health Home patients had HgA1c testing.

Coordinated Care was another respondent. They reported to have served 44 Health Home patients and likewise included all of these patients in the test group. They compared this group to a 30-member random sample control group. Information was collected from claims data from January 2014 to July 2014. They reported the following results:

- Thirty-nine of forty-four (88.63%) Health Home patients had HgA1c testing.
- Of the thirty patient claims records reviewed, 73.33 % (assumed to be twenty-two of the thirty patients of) non-Health Home patients had HbA1c testing.

Community Health Plan of Washington reported results that were collected from patients cared for at one clinic, Sea Mar Community Health Center, during the period of July 1 to July 31, 2014. They included information from 31 Health Home and 28 non-Health Home patients. This Lead reported the following results:

- Thirty-one of thirty-one (100%) of Health Home patients had HbA1c testing.
- Twenty-nine of twenty-nine (100%) of non-Health Home patients had HbA1c testing.

Discussion

As noted above, among those patients who were members of Molina Healthcare of Washington, non-Health Home members had a higher rate of testing than did Health Home members. Among Coordinated Care patients, the opposite was true for this project. As CHPW's SeaMar clinic reported 100% performance, Health Home enrollment was not able to demonstrate a positive effect. A number of factors might account for these rates, but with such small numbers, the difference among the managed care plans is not likely to be statistically significant. The intent of this project was to establish a baseline and a methodology for looking for improvement next year.

The general health, social situation, and behavioral characteristics of the patients in the test groups and those of the control groups are not assumed to have been similar other than for having met the inclusion criteria. Indeed, patients are enrolled in Health Homes specifically because of the complexity of their health problems. Although it would be encouraging to see the rates of HgA1c testing higher among Health Home patients than among the general diabetic population, this wasn't an expectation so early in the project.

In December, 2015, the Health Care Authority will submit a follow-up report to the Governor and to the Legislature. It will include the same measurement results from these managed care organizations, but they will have been derived from July 1, 2014 to June 30, 2015. It is hoped that ongoing engagement of patients with the Health Home program will result in higher rates of HgA1c testing.