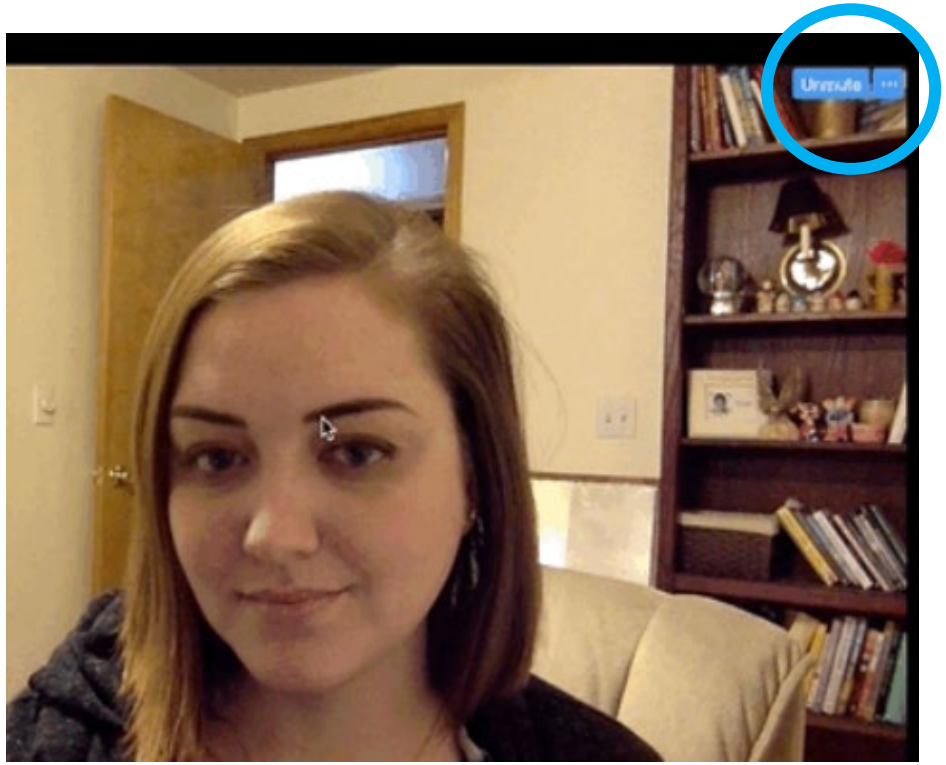
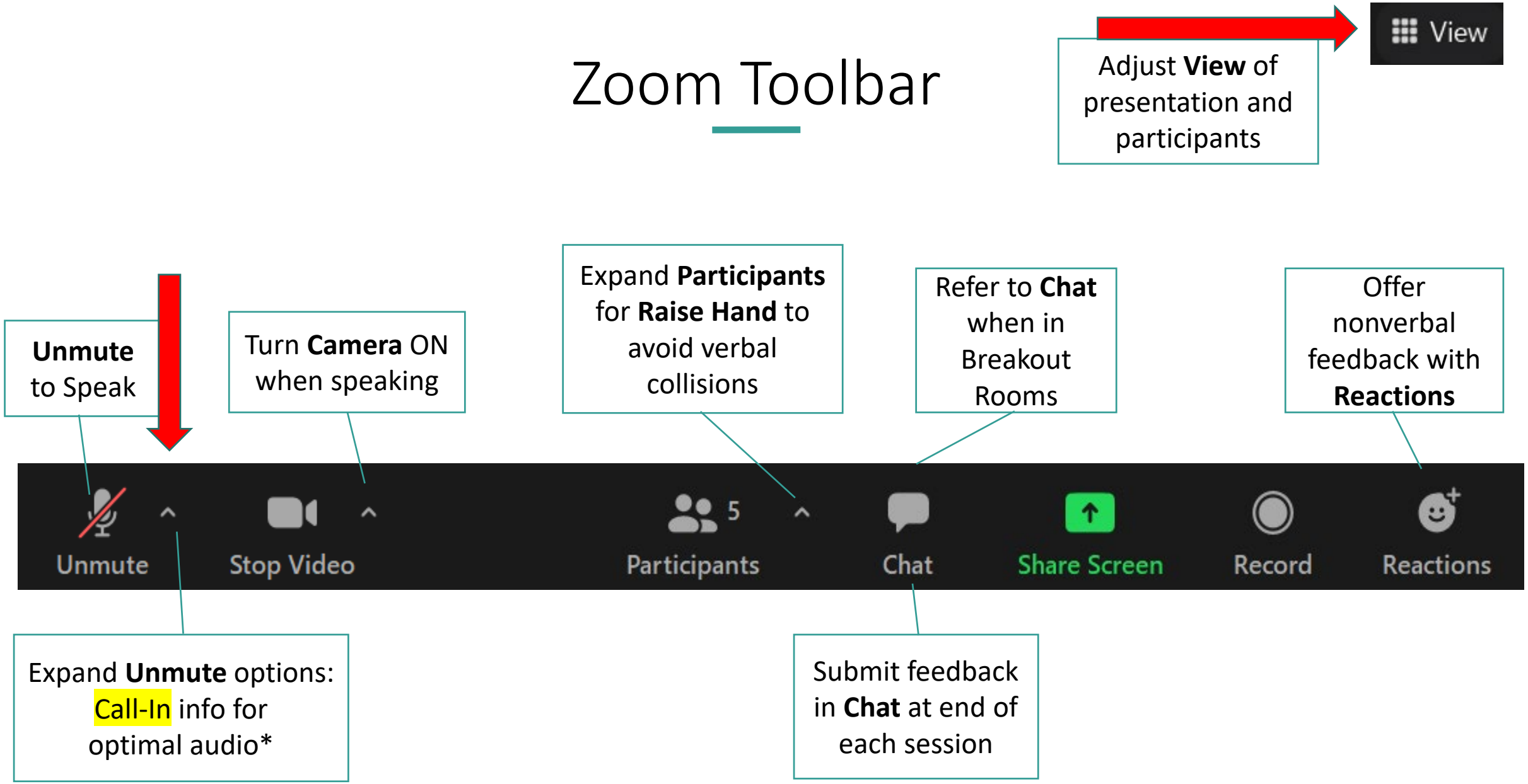
Welcome!

- **To the COMM NET Meeting**
- **We are glad you are here!**
- **Once you get settled…**



- ✓ **Click the 3 dots in the top right of your image**
- ✓ **Select RENAME**
- ✓ **Enter…**
  - ✓ **First name,**
  - ✓ **Pronouns,**
  - ✓ **Your organization/agency name**
- ✓ If you don't see your image, check your view settings at the top of the bar and set to see all webcams or Side-by-Side Gallery View

Zoom Toolbar



*Call-in feature works best with cell phones (not compatible with soft phones)

Housekeeping Items

- Please list your name and affiliation in the chat
- Share one “win” for you, your team, or community in the chat
- If you are new, please add your email address in the chat so we can make sure you are added to our list
- This meeting will be recorded

Washington State Department of Health

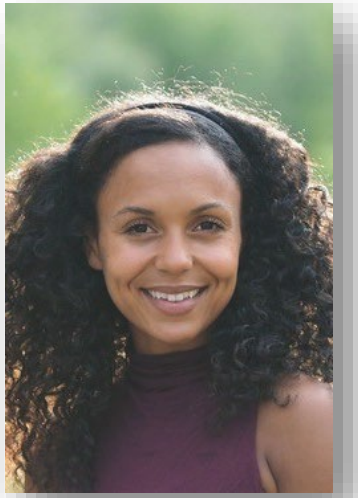
CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Communication Network Meeting – April 14, 2022

CYSHCN Team

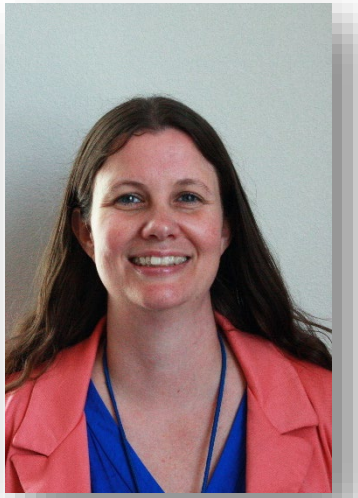
Monica Burke, PhD

CYSHCN Program Director



Sarah Burdette

CYSHCN Process Improvement Specialist

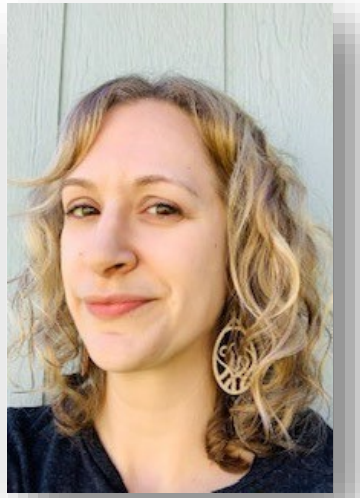


Bonnie Burlingham, MPH

CYSHCN Epidemiologist

Nikki Dyer

CYSHCN Family Engagement Specialist



Khimberly Schoenacker, RDN, CSP, CD

CYSHCN Nutrition Consultant

We honor native land, people, and experience

I acknowledge that I am speaking to you from the traditional lands of the Nuxwsa'7aq (Nooksack), Stillaguamish, Lummi, and Coast Salish people. I honor and thank their ancestors and leaders who have been stewards of these land and waters since time immemorial.

Please share the people you honor of the land you are occupying in the chatbox
Native-Land.ca | Our home on native land (native-land.ca)

Agenda

9:00-9:20	Introductions, welcome, and land acknowledgment
9:20-10:15	**Care Coordination Standards for CYSHCN**
10:15-10:30	Break
10:30-11:00	**Health Homes**
11:00-11:45	**DDA Case Management**
11:45-12:00	**Wrap up and break to get lunch**
12:00-1:00	Networking Lunch

CYSHCN Care Coordination

Our goal:

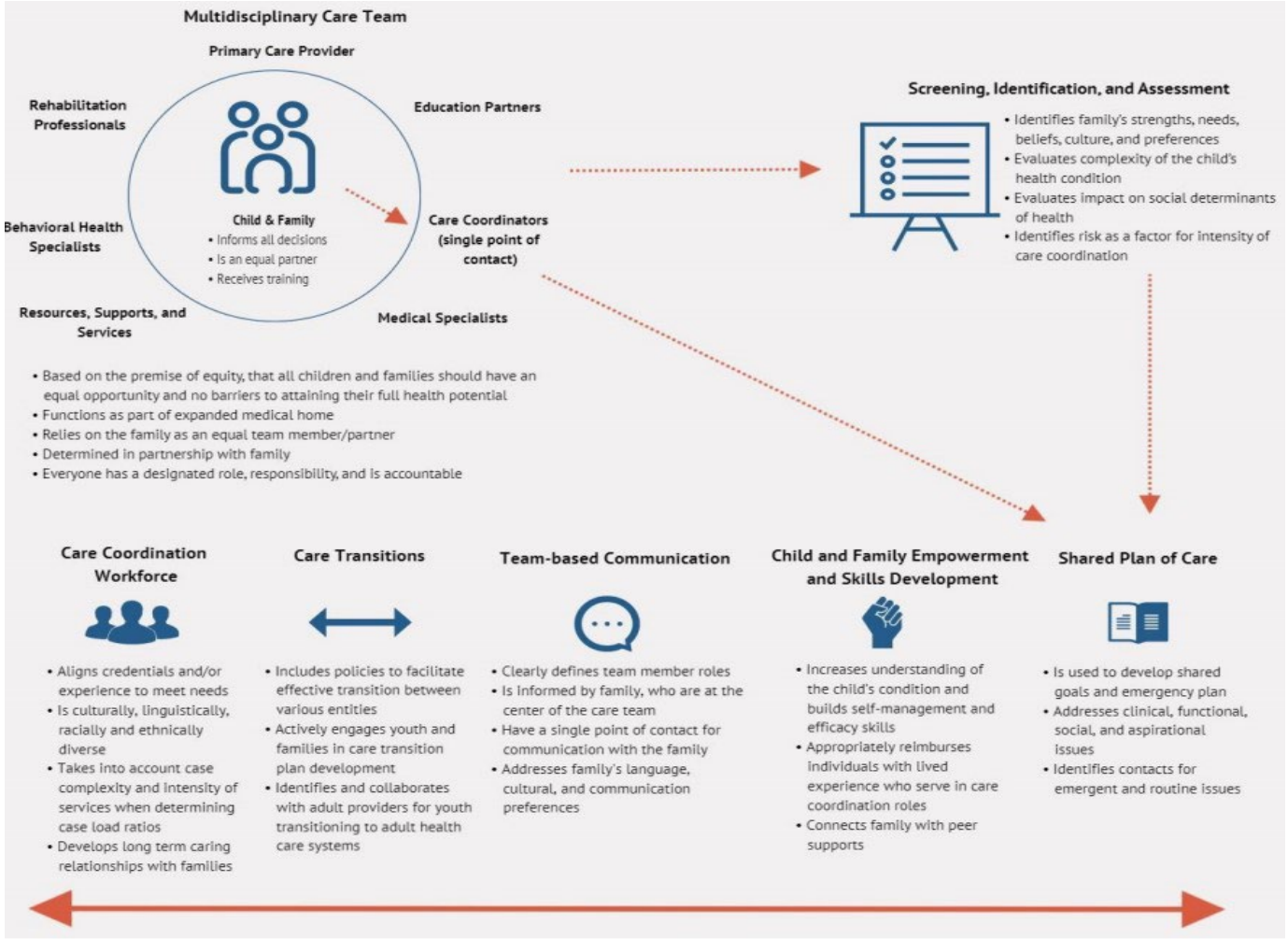
- Promote **family navigation**, and other family-centered **care coordination** models, to meet the complex needs of CYSHCN and their families, including health, socioeconomic, and psychosocial needs.

CYSHCN Care Coordination

Care Coordination Definition:

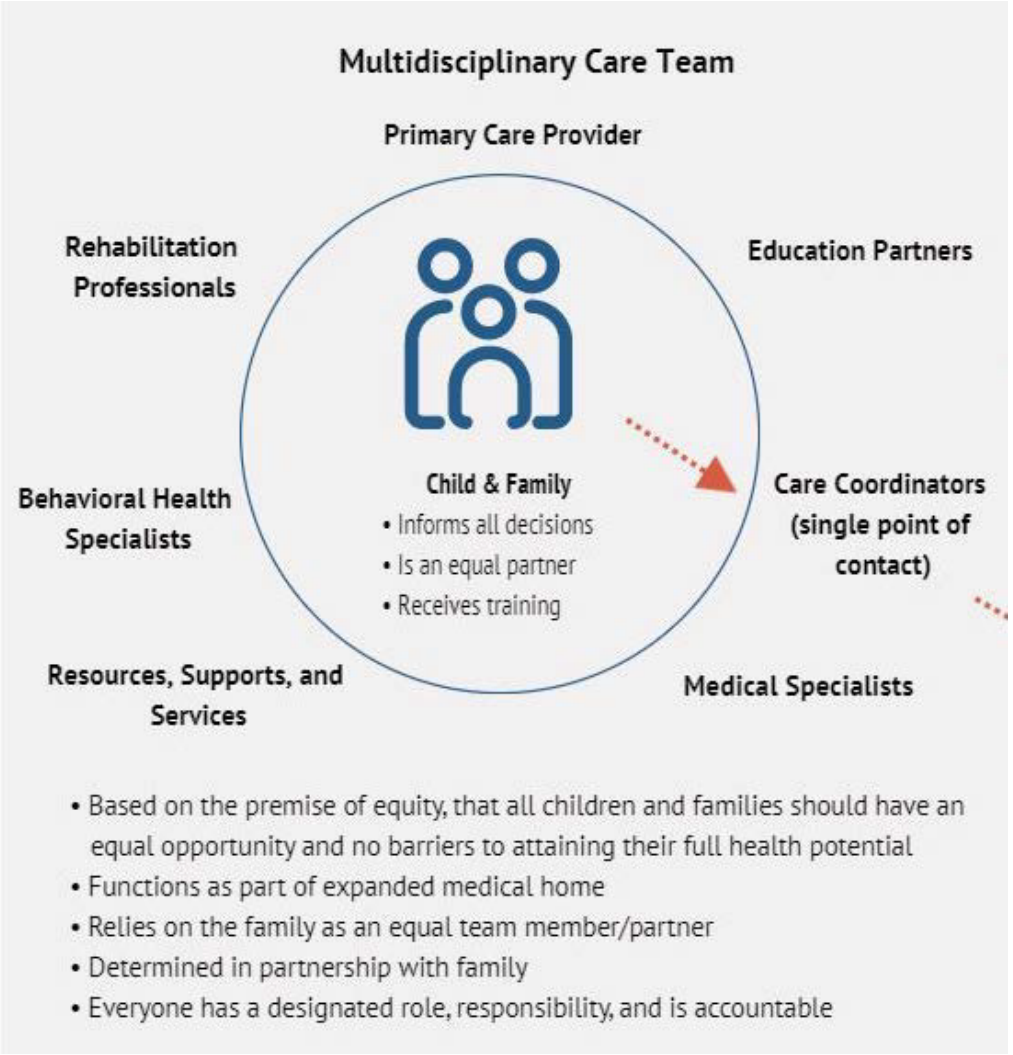
- patient- and family-centered, assessment-driven, team-based activities designed to meet the needs of children and youth.
- Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes, and efficient delivery of health-related services and resources within and across systems

National Care Coordination Standards



National Care Coordination Standards for Children and Youth with Special Health Care Needs (Oct. 2020)

National Care Coordination Standards



National Care Coordination Standards for Children and Youth with Special Health Care Needs (Oct. 2020)

National Care Coordination Standards

Screening, Identification, and Assessment

- Identifies family's strengths, needs, beliefs, culture, and preferences
- Evaluates complexity of the child's health condition
- Evaluates impact on social determinants of health
- Identifies risk as a factor for intensity of care coordination

National Care Coordination Standards for Children and Youth with Special Health Care Needs (Oct. 2020)

National Care Coordination Standards

National Care Coordination Standards for Children and Youth with Special Health Care Needs (Oct. 2020)

Foundational Standards

These seven standards are the foundation for all standards in each domain, and are critical to ensure comprehensive, high-quality care coordination for CYSHCN

1. Care coordination for CYSHCN is based on the premise of **health equity**, that all children and families should have an equal opportunity to attain their full health potential, and no barriers should exist to prevent children and their families from achieving this potential.
2. Care coordination addresses the **full range of social, behavioral, environmental, and health care needs** of CYSHCN.
3. **Families are co-creators** of care coordination processes and are active, core partners in decision making as members of the care team. CYSHCN, families, and care coordinators work together to build trusting relationships.
4. Care coordination is **evidence based** where possible, and evidence informed and/or based on promising practices where evidence-based approaches do not exist.

Foundational Standards

5. Care coordination is implemented and delivered in a **culturally competent, linguistically appropriate, and accessible** manner to best serve CYSHCN and their families.
6. **Insurance coverage** of care coordination for CYSHCN allows for it to be accessible, affordable, and comprehensive.
7. Performance of care coordination activities is assessed with **outcome measures** that evaluate areas including:
   a. the **process** of care coordination (e.g., number of families with a shared plan of care);
   b. Family experience with integration of care across medical, behavioral, social and other sectors and systems;
   c. Quality of life for CYSHCN and families; and
   d. Reduction in duplicative and/or **preventable** health care utilization.

Types/Models of Care Coordination

- Family Navigation
- Care Management
- Case management
- Medical Homes
- Health Homes
- Family Resource Coordination

Family Navigation

- guide families through and around barriers in the health care system
- provide psychosocial support, help coordinate services, provide education related to a child's health care needs, and alleviate challenges.
- give informed recommendations to the family.
- decrease fragmentation of services by
  - coordinating appointments for children and families;
  - facilitating communication among families and providers;
  - providing resources that can alleviate barriers related to transportation, finances, insurance, language, and other issues.
- Help reduce health disparities
- Often provided by family members of CYSHCN with lived experience
- Examples: Within Reach/HMG, PAVE, Patient Navigators at Medical Home

Care Management

- More involved and ongoing
- Focused more on medical needs and coordinating medical care
- Typically a licensed social worker or nurse
- Formal health assessment
- Develop a care plan
- Examples: MCO Care Managers, Nurse or social worker from medical home or specialist's office

Case Management

- Longer-term following a case over time
- Usually associated with a system that provides more intensive support for CYSHCN and families with more significant needs
- Often focused on connecting to a specific service system and related supports
- Examples: DDA Case Management, Infant Case Management

Medical Homes

- Model of primary care
- Team based
- Patient/family centered
- Integrates care coordination within primary care
- Primary care practice serves as the “home”
- Centralized base for medical care
- Connection to other medical and non-medical community resources
- Examples: Patient navigators, care managers at primary care practice

Health Homes

- A set of services supporting clients with more intensive needs

Helps clients:

- Develop a person-centered health action plan
- Improve self-management of chronic conditions
- Ensure care coordination and care transitions

- Current eligibility criteria in WA includes Medicaid (Apple Health) eligibility and evidence of need based on scoring criteria
- New federal program, ACE Kids Act, focuses on children with medical complexity – has not been implemented yet, unsure if WA will participate

Health Home Program
Washington

The Washington State Health Homes Program

Washington State Department of Social & Health Services
Transforming lives

Washington State Health Care Authority

Health Home Team

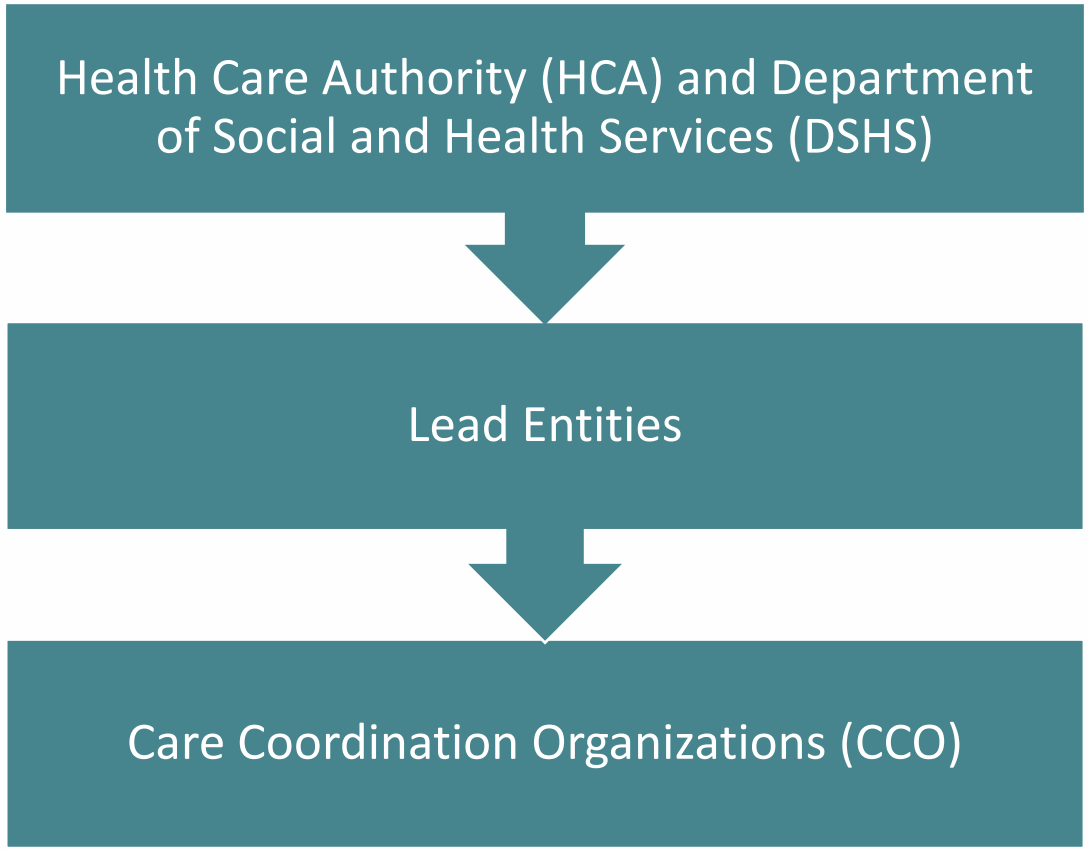
DSHS	HCA
Kelli Emans	Jessica Diaz
Brendy Visintainer	Silke Kramer
Kerri Hummel	Glenda Crump
	Nicole Bishop

Background

On October 25, 2012, the Department of Health and Human Services(CMS) and Washington State would become the first state to partner with CMS in the Financial Alignment Initiative (FAI) to test a managed fee-for-service (MFFS) model for providing Medicare-Medicaid enrollees with a more coordinated, person-centered care experience. The demonstration program effective date was July 1, 2013.

After each year of the Demonstration, CMS performs a calculation to determine whether the Demonstration achieved savings. These savings are shared with the State of Washington. Our shared savings amount for the Demonstration last year was $17.9 million. To date the State of Washington has received $87.3 million dollars in shared savings from Medicare.

Washington's Health Homes Model



- The Health Homes program is managed by Washington State HCA and DSHS
- Lead entities provide oversight of service delivery and administrative support
- Care coordination is delivered at the local level

HEALTH HOME COVERAGE AREA MAP

NOTES

All areas: check Apple Health managed care webpage for MCO availability in each county.

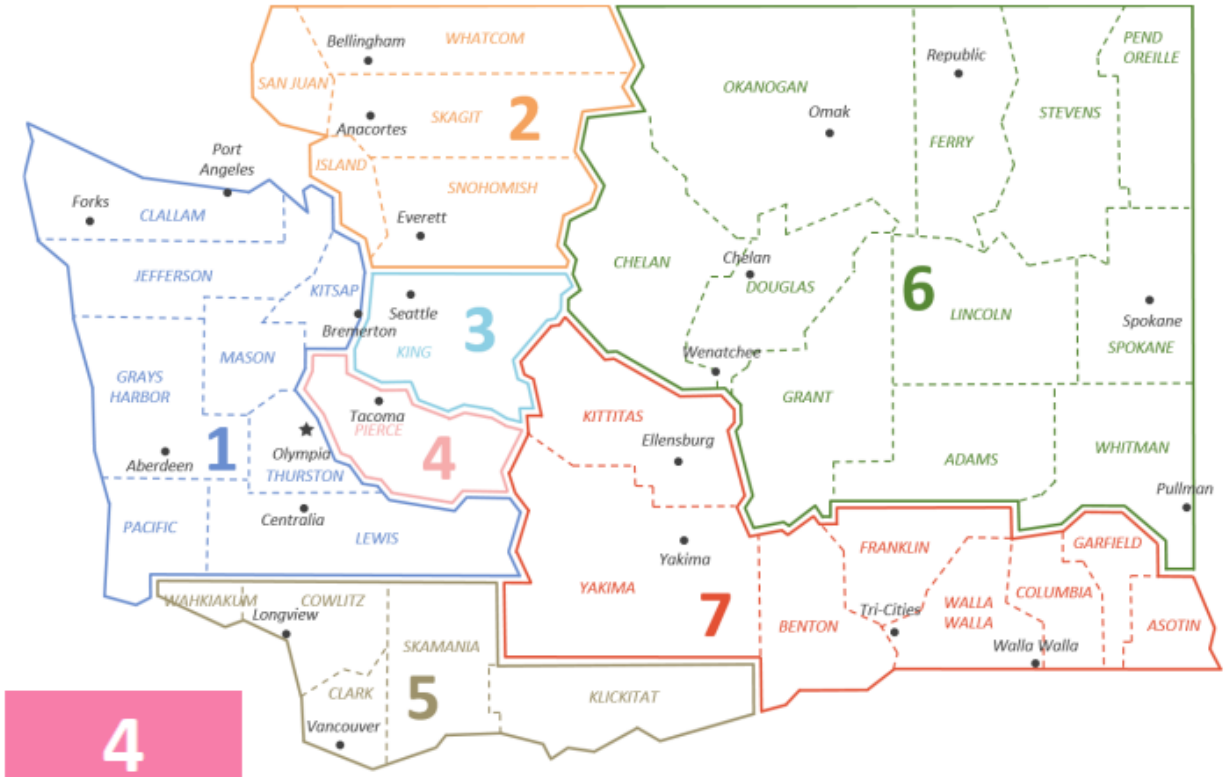
** Not an available MCO in all counties in the Coverage Area.

1		
LEAD	FFS	MC
AMG		✓
CHPW	✓	✓
CCW		✓
MHC	✓	✓
O3A	✓	
UHC	✓	✓

2		
LEAD	FFS	MC
AMG		✓
CHPW	✓	✓
CCW		✓
MHC	✓	✓
NWRC	✓	
UHC	✓	✓

3		
LEAD	FFS	MC
AMG		✓
CHPW	✓	✓
CCW		✓
FLC	✓	
MHC	✓	✓
UHC	✓	✓

4		
LEAD	FFS	MC
AMG		✓
CHPW	✓	✓
CCW		✓
MHC	✓	✓
PCHS	✓	
UHC	✓	✓



LEAD ACRONYMS

AAADSW	Area Agency on Aging & Disabilities of SW WA*
AMG	Amerigroup
CC-AHP	Community Choice Action Health Partners (CCHN)*
CHPW	Community Health Plan of WA
CCW	Coordinated Care of WA
FLC	Full Life Care*
MHC	Molina Health Care
NWRC	NW Regional Council*
O3A	Olympic AAA (OAAA)*
PCHS	Pierce County Health Services (PCAAA)*
SE WA ALTC	SE WA Aging & Long Term Care*
UHC	United HealthCare

*Not a managed care plan

5		
LEAD	FFS	MC
AAADSW	✓	
AMG		✓
CHPW	✓	✓
CCW		✓
MHC	✓	✓
UHC**	✓	✓

6		
LEAD	FFS	MC
AMG		✓
CHPW	✓	✓
CC-AHP	✓	
CCW		✓
MHC	✓	✓

7		
LEAD	FFS	MC
AMG		✓
CHPW	✓	✓
CCW		✓
MHC	✓	✓
MHC	✓	✓
SE WA	✓	

3/2022

What is Health Homes?

Health Homes is a set of services supporting eligible clients. The Health Homes program helps clients:

- Develop a person-centered health action plan
- Improve self-management of chronic conditions
- Ensure care coordination and care transitions

The Basics

- No cost to the client
- Participation is voluntary
- Does not duplicate or change any current providers or benefits
- Community-based intensive care coordination across the existing delivery system
- Not to be confused with “Home Health”

Who is Eligible

- Must be on active Medicaid, includes dually eligible (Medicaid and Medicare)
- Have a PRISM risk score of 1.5 or greater
- Has one chronic condition and is at risk for a second
- All ages are eligible

The Six Health Home Services

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and social support services

The Health Action Plan

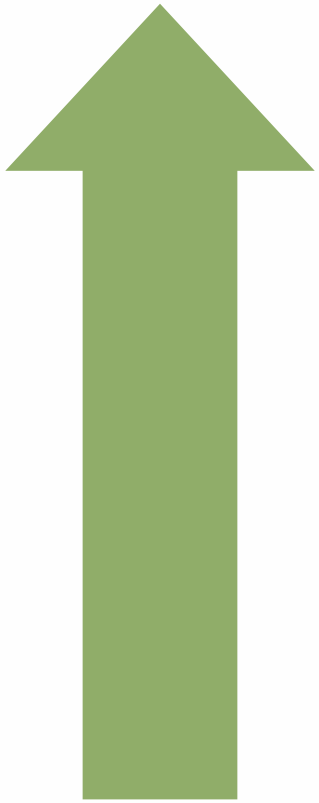
The Health Action Plan is a plan that the client writes with assistance from the care coordinator. The Health Action Plan:

- Is person-centered
- Is reviewed and updated regularly
- Identifies what the client wishes to do to improve their wellness and quality of life
- Includes health-related goals and non-health-related goals
- May include social determinates of health

Community Collaboration

- Hospitals, adult family homes, skilled nursing facilities, assisted living facilities, PreManage/EDIE
- Area Agencies on Aging, ALTSA, Adult Protective Services, Child Protective Services
- Public housing, senior centers
- Jail, treatment centers, outpatient behavioral health
- Homeless service centers , Salvation Army, Good Will, Lions Club
- Special transportation, translator services, HIV/AIDS foundations

Client Health Outcomes



Increased engagement in self-management of chronic health conditions

Increased use of home- and community-based long-term services and supports

Decreased inpatient admissions

Decreased nursing facility admissions

Stories

Seven year old child w/ a rare genetic disease

Single mother with three children with special needs

- Transition planning with and from the wraparound team
- Coordination between providers/resources and mother
- Facilitated childcare resources for outpatient visits for all children
- Worked with DDA for a caregiver
- Worked with the social worker at the Mayo Clinic to better prepare mother for two month visit with sibling
- Created a list of providers and supports used by each child for the mother & grandmother
- Grocery store gift cards, holiday gift resources

Resources, Contacts & Questions

Health Home email box HealthHomes@hca.wa.gov

DSHS website: https://www.dshs.wa.gov/altsa/washington-health-home-program

HCA website: https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes

Questions?

Transforming Lives

Overview of DDA Case Management, Programs, & Services

April 2022

Washington State Department of Social and Health Services

Washington State Department of Social and Health Services

Transforming lives

DDA Guiding Values

Inclusion • Status and Contribution • Relationships • Power and Choice • Health and Safety • Competence

Our Mission

Transforming lives by providing support and fostering partnerships that empower people to live the lives they want.

Our Vision

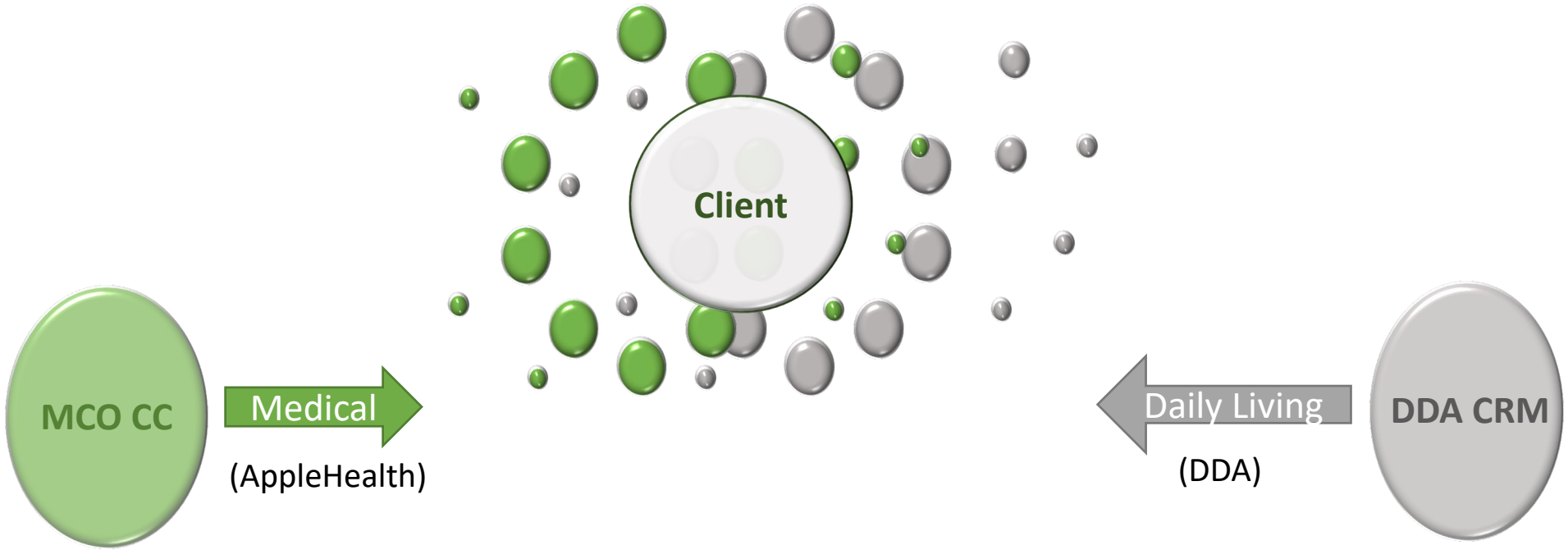
- **Supporting individuals** to live in, contribute to, and participate in their communities;
- **Continually improving supports** to families of both children and adults;
- **Individualizing supports** that will empower individuals with developmental disabilities to realize their greatest potential;
- **Building support plans based on the needs** and the strengths of the individual and the family; and
- **Engaging individuals, families,** local service providers, communities, governmental partners and other stakeholders to continually improve our system of supports.

DDA Case Management Role

- Annual Assessment (Person Centered Service Plan)
  - ICF/IID or NF LOC
  - Formal & Informal Supports
  - Service Hours
    - Personal Care
    - Respite
    - Employment
- Financial Eligibility Verification
- Payment Authorizations
- Resource Planning
- Referrals to Community Resources
- Provider Connection
- Service Quality Monitoring

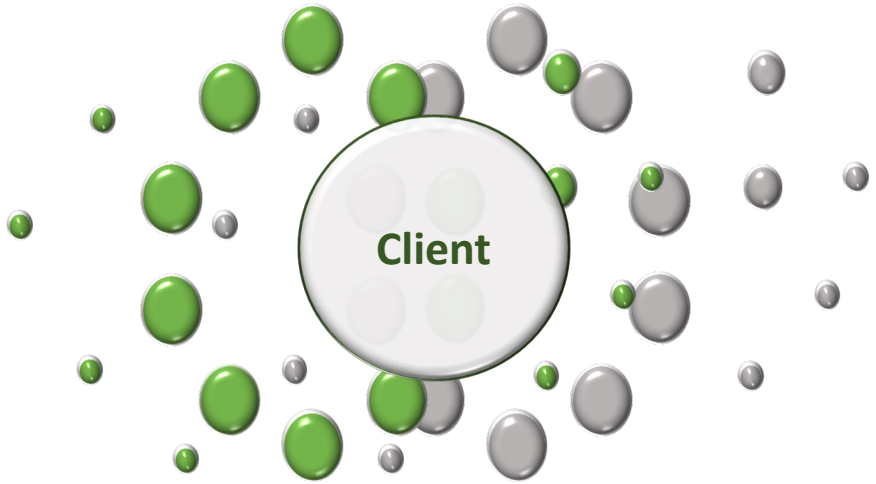
MCO Care Coordination & DDA Case Management

- **The MCO Care Coordinator has a key role in assisting the client to access needed medically necessary health services while the DDA Case Manager assists with habilitative and daily living services and informal support coordination for in home supports.**



Coordination Between Systems

- Behavioral Healthcare
- Physical Healthcare
- Autism Treatment
- EPSDT
- Medical Supplies



- Personal Care
- Respite Care
- Employment Supports
- Non-Medical Goods and Services
- Habilitative Care

DDA's AppleHealth Care Coordination Procedure

DDA Programs and Services

- **Community First Choice (State Plan Entitlement Program)**
  - Personal Care
  - Skills Acquisition Training
  - Nurse Delegation
  - Personal Emergency Response Systems
  - Assistive Technology
  - Caregiver Management
  - Residential Personal Care Services
- **HCBS Waivers**
  - Respite Care
  - Habilitation Services
  - Extended State Plan Benefits for Adults
  - Employment Supports
  - Non- Medical Goods (AT, sensory goods, etc.)
  - Residential Habilitative Services
- **Roads to Community Living Grant**
  - Transition Services
  - Peer Support
- **PASRR**
  - Supports not covered by Nursing Facility

Resources

Videos

Individual and Family Services Waiver
Basic Plus Waiver
Children's Intensive In home Behavior Support Waiver
Core Waiver
Community Protection Waiver
DDA- How to Apply and Why

Brochures

https://www.dshs.wa.gov/dda/publications/dda-brochures

Service and Information Requests

https://www.dshs.wa.gov/dda/service-and-information-request

Thank you

Shayla's Resource List

- Shayla's Resource List (new 4/1/2022) – a brief menu of key financial, transportation and recreation resources to support people with intellectual and developmental disabilities and their families. By a parent, for parents and families. This list will continue to be updated and we welcome your suggestions. Feel free to adapt this handout to your own community.

Final Reminders

- Please fill out our meeting evaluation on Survey Monkey
  - https://www.surveymonkey.com/r/NB2H6TN
- CYSHCN Communication Network 2022 Meeting Schedule
  - Jul 14, 2022
  - Oct 13, 2022
  - 9am-12pm, 12-1 networking lunch hour

- Please remain on zoom if you would like to network during lunch hour from 12-1:00

- Thank you for your participation today!

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.