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**Evaluation of the  
Medicaid Value Program:  
Health Supports for  
Consumers with Chronic  
Conditions**

*Washington State Case Study*

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## **WASHINGTON MEDICAID INTEGRATION PARTNERSHIP**

The Washington Medicaid Integration Partnership (WMIP) integrates primary care, mental health, substance abuse, and long-term care services that are customarily provided separately in Washington State, for categorically needy aged, blind, and disabled (ABD) Medicaid beneficiaries in Snohomish County (north of Seattle). The Washington State Department of Social and Health Services (DSHS) contracted with Molina Healthcare of Washington (Molina Healthcare), a for-profit health maintenance organization focused on Medicaid and other vulnerable populations, to provide care coordination of these services to ABD beneficiaries. The primary motivating factor underlying the implementation of WMIP is the disproportionate use of health care by ABD beneficiaries who tend to have complex health profiles and are the fastest growing segment of the DSHS client base. While ABD Medicaid clients in Washington constitute 15 percent of the total Medicaid caseload, they account, according to state officials, for 35 to 40 percent of total fee-for-service expenditures.

DSHS reported that, before WMIP, ABD clients received substantial amounts of inappropriate care in emergency rooms and hospitals, due to lack of care management by physicians and nursing facilities and because patients were not aware of or did not know how to access the care available to them. For this Medicaid Value Program (MVP) intervention, DSHS is particularly interested in improving the use of mental health and substance abuse services as the need for these services is high among the target population and accounts for a considerable portion of their total costs. Prior research by DSHS suggests that increased use of substance abuse and chemical dependency treatment offsets its costs, and increased use of mental health care also results in cost savings.<sup>1</sup>

While the intermediate goals of the intervention include increased use of mental health care and substance abuse services, long-term objectives consist of improved patient quality of life and independence, reduced inpatient admissions and emergency room visits, and lower medical costs (Figure 1). WMIP began in January 2005 and had a monthly patient caseload of nearly 2,700 by April 2007. DSHS examined the impact of WMIP on patient outcomes by selecting a comparison group of similar patients from neighboring counties.

### **ORGANIZATIONAL CONTEXT**

WMIP is one of the largest Medicaid pilot programs implemented in Washington State that involves multiple divisions within DSHS. The DSHS Health and Recovery Services Administration is implementing the intervention with cooperation and joint funding from the Aging and Disability Administration. The DSHS Research and Data Analysis Division is the lead for the evaluation process. All participating divisions (Mental Health, Home and

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<sup>1</sup> Mancuso, D.C. and S.L. Estee. *Washington State Mental Health Services, Cost Offsets and Client Outcomes: Technical Report*. Washington State Department of Social and Health Services, Research and Data Analysis Division, Report Number 3.29, December 2003.

Community Services, Alcohol and Substance Abuse) are particularly interested in examining whether the care coordination services provided under WMIP can reduce inappropriate service use, such as avoidable emergency room use or unplanned hospital admissions that result in a large cost burden to all state health divisions.

Other organizations are also directly involved with WMIP. Molina, a subsidiary of Molina Healthcare, Inc. based in California, provides care coordination services to patients. It also operates a program for the Temporary Assistance for Needy Families (TANF) population (called *Healthy Kids Now!*) and a Medicare Special Needs Plan (SNP) in Washington. Molina Healthcare has never participated in such a project before, but believes WMIP is aligned with its core mission to serve the underserved.<sup>2</sup> In terms of incentives for participation, Molina Healthcare sees WMIP as an opportunity to expand its client base in Washington and further its corporate mission. Moreover, as a for-profit health maintenance organization, Molina Healthcare would benefit from demonstrating that its services can increase the quality of patient care while reducing costs.

The state created an advisory committee for WMIP in Snohomish County, consisting of local human services personnel, mental health providers, medical practitioners, long-term care practitioners (including individual providers and adult family homes) and patient advocates. The committee has provided DSHS information on how to best support clients with co-occurring disorders by reviewing WMIP materials and offering suggestions as to which services were most valuable to clients with multiple diagnoses.

**PROGRAM INTERVENTION**

WMIP integrates health care services (primary care, mental health, substance abuse, and long-term care) that are traditionally provided separately to Medicaid clients in Washington State through care coordination provided by Molina Healthcare. Uncertain of its ability to integrate these services effectively all at once, DSHS chose instead to phase in these components. Beginning in January 2005, WMIP enrollees could receive both primary and substance abuse care. Mental health care was integrated in October 2005 and long-term care was added in October 2006. Under WMIP, enrollees are eligible to receive all the same medical services that they would have received under fee-for-service Medicaid except that Molina provides a central point for care coordination and management.

Nondual ABD Medicaid beneficiaries, identified by DSHS, are auto-enrolled into WMIP, but have the option to opt out at any time. Dual eligible clients (eligible for both Medicare and Medicaid), Native Americans, and Alaskan Natives must opt into WMIP. To aid in recruitment, DSHS sent WMIP information booklets to 5,025 Medicaid-only members in November 2004 (and a total of 6,836 members by April 2005), with auto-enrollment set for January 2005.

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<sup>2</sup> Molina Healthcare’s corporate office, however, has implemented interventions and pilot studies with the Robert Wood Johnson Foundation and similar groups. Molina Healthcare also has participated in state-sponsored disease management collaboratives and in demonstration projects to create “medical homes” for children with special health care needs. Since the start of WMIP, Molina Healthcare has also began programs for ABD clients in Texas and Ohio, applying lessons learned from WMIP to the implementation of those programs.

Molina Healthcare also recruited some duals through its Medicare SNP. DSHS staff reported that data systems barriers made auto-enrollment of long-term care patients problematic, so DSHS required them to opt into WMIP and manually adjust the data systems.<sup>3</sup>

Because most participants are auto-enrolled into the program and normally are unaware of the availability of WMIP services until they are contacted by a Molina Healthcare staff member, patient outreach and engagement are critical. Molina Healthcare sends welcome letters and attempts up to three welcome calls to all enrolled patients within 30 days of assignment to the intervention. For those patients Molina Healthcare cannot reach by telephone (about 40 percent), it mails letters to their last known address with a request to call a Molina Healthcare care coordination team (CCT) member (12 to 20 percent called back within 4 to 6 weeks). Molina Healthcare also attempts to locate patients through physicians who previously served patients and hospitals where patients sought care (as identified through claims data). If patients opt out of WMIP, Molina Healthcare will not contact them again; however, the services remain available if patients later decide that they would like to re-enroll.<sup>4</sup>

Molina Healthcare's CCTs consist of a registered nurse or licensed mental health counselor and a care coordination specialist (a non-licensed staff member with a background in insurance or mental health care administration). These teams are supervised by an operations manager who monitors day-to-day activities, while a separate contracts manager is the primary liaison with DSHS for administrative issues. The CCTs provide care coordination services to WMIP clients. The primary mode of care coordination activities is by telephone, but patients in WMIP's long-term care component also receive in-person care coordination from team members. There are eight different CCTs that work with patients and a supervisor team that assists the other teams. Long-term care members were integrated into each team's caseload, but Molina staff reported that they were considering shifting all long-term care patients to two or three teams, possibly with two specialists assisting one nurse on each team. Care coordination teams are located side-by-side in the Molina Healthcare office, facilitating communication between team members and across teams.<sup>5</sup> The average caseload among teams that coordinate care by telephone is 350 to 450 patients per team, while the caseload for long-term care patients in person is expected to be approximately 80 to 100.

Molina Healthcare's care coordination program includes health risk assessment, monitoring of patient symptoms, and education. Molina Healthcare CCTs coordinate home care, inpatient care, skilled nursing facility placement, long-term care, disease management, mental health care, substance abuse care, durable medical equipment, transportation, and day health care for patients in WMIP. Molina Healthcare also offers a 24/7 nurse line to all members and the CCT follows up on all calls made to the line by WMIP members. The degree of contact with patients varies from patient to patient, depending on their conditions. At a minimum, Molina Healthcare staff contact patients whose conditions are most stable once per quarter. However, patients whose

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<sup>3</sup> In April 2007, there were 225 long-term care patients enrolled in WMIP.

<sup>4</sup> Molina Healthcare staff reported that some patients have called them back seeking assistance after experiencing an adverse event, such as a hospitalization or an emergency room visit.

<sup>5</sup> Molina also has its Medicare SNP CCT (of two nurses and two specialists) located in the same space, allowing this team to learn from its WMIP peers and vice versa.

conditions are more fragile or require closer monitoring (approximately 30 percent of WMIP patients) are contacted at least twice per month or more often if needed. In interviews with them, Molina Healthcare staff reports that WMIP patients are largely unaware of many of the services available to them when they are first contacted, and that they often need help scheduling appointments, particularly after hospital discharge.

CCT members use a computerized data system when talking to patients over the telephone to coordinate care. This system allows Molina Healthcare to maintain an electronic contact record and problem list for each patient that includes information about past calls and any relevant clinical information that CCT members have previously collected. It also includes task lists, automatic reminders, and care plans that can be tailored to specific patient needs to assist CCTs in coordinating patient care.

Molina Healthcare also engages and educates providers about the intervention and the services available to patients. Molina Healthcare’s Provider Services department conducts on-site meetings with physicians. Molina Healthcare representatives also answer provider questions on issues such as payment and prior authorization. CCTs also engage providers by telephone when coordinating care for patients; for example, if a patient’s blood sugar level is abnormally high, a nurse will alert the doctor’s office of the high reading and will help schedule an appointment for that patient.

## **PROCESS AND OUTCOME MEASURES**

DSHS measured claims-based outcomes and self-reported outcomes from surveys of enrollees and disenrollees, and compared results with a group made up of similar patients in other counties to determine if WMIP had an impact. Patient surveys identified reasons for WMIP enrollment or disenrollment and assessed patient satisfaction, using questions taken from the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) survey, making results directly comparable across all three groups.<sup>6</sup> Claims-based outcome measures included physician visits, inpatient admissions, emergency room use, and prescriptions filled. In addition, DSHS reported on the proportion of patients with mental health or substance abuse problems who used mental health and chemical dependency treatment and mental health hospital admissions. DSHS staff reported that these last outcome measures were the most challenging to report as they had to collect data from three different reporting systems and experienced some delays in reporting from Molina. (Despite these challenges, the data were available as of the last reporting period under the MVP grant.)

DSHS reported claims-based measures for the intervention period and one-year pre-intervention period. Because all clients in Snohomish County were eligible for the intervention, DSHS selected a comparison group from other counties by matching patient characteristics (such as medical eligibility criteria, demographics, and utilization of medical and mental health

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<sup>6</sup> DSHS has also shared disenrollee survey results with Molina Healthcare to assist it in patient outreach.

services) with a propensity scoring algorithm using data from the year prior to the intervention.<sup>7</sup> This approach is limited by how well propensity scoring identifies a comparison group that matches the intervention group. However, the approach is also much more robust than simply choosing a comparison group without matching patients’ characteristics systematically.

Outcomes measures reported to CHCS in April 2007 suggest that WMIP appears to have slowed the rate of inpatient admissions and mental health hospital days (Table 1). However, other measures were either flat or counter to expectation. DSHS did not produce statistical tests of significance for any of its reported measures as staff felt that these measures were more valuable for monitoring than making early determination of potential impacts.

DSHS reported outcomes for 1,427 Medicaid-only ABD patients and 15,301 comparison group patients.<sup>8</sup> Though it is not possible to tell from its final monitoring report, early DSHS reports indicated that WMIP enrollees had lower monthly medical expenditures, on average, at baseline than disenrollees (about \$600 for enrollees and \$950 for disenrollees as reported in September 2006).<sup>9</sup> This disparity in the type of Medicaid patients who chose to participate in the program might limit program findings somewhat as it would not be entirely clear if the intervention was beneficial for the highest-cost ABD beneficiaries.

Compared to the baseline period, inpatient admissions (per 1,000 member months) rose by 8.7 percent (from 13.8 to 15.0) in the intervention group (over the first 18 months of the program). However, admissions grew by 24.6 percent in the comparison group (from 13.8 to 17.2), nearly three times as fast. Slow growth in overall hospitalizations was also reflected in the rate of mental health hospital days which rose 46 percent in the intervention group (from October 2005 to September 2006) but more than doubled in the comparison group over the same period of time.

At the same time that WMIP enrollees appear to have favorable outcomes for these long-term measures, there was less evidence for some short-term measures. For example, the number

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<sup>7</sup> The comparison counties include King, Pierce, Whatcom, Skagit, Kitsap, Thurston, and Clark. To select a group that matched the intervention population, DSHS (1) identified clients in comparison counties who met intervention eligibility criteria; (2) measured baseline demographic and medical characteristics; (3) estimated a logistic regression, using measurable characteristics, for the pooled WMIP and comparison group samples to estimate the probability (the “propensity score”) of enrolling in WMIP; and (4) stratified propensity scores into quintiles, randomly sampling comparison group members from each quintile to match WMIP enrollees. Reported outcomes data indicate that the intervention and comparison groups had similar baseline outcome measures, suggesting the groups were well-matched. A more detailed description of the comparison group selection process appears in the technical notes of a presentation made to the Snohomish County Community Advisory Committee on September 14, 2006 by DSHS.

<sup>8</sup> DSHS did not impose strict continuous enrollment criteria on the study sample used to examine outcome measures. The vast majority of clients were continuously enrolled through the first 12 months of WMIP, but by September 2006, 22 percent were disenrolled. The 1,427 clients in the study sample represent Medicaid-only clients who were enrolled in WMIP in December 2005. Comparison group patients were chosen based on a propensity score model that first estimated the likelihood of being a program enrollee (based on observable characteristics) and then matched actual enrollees with comparison group members based on each client’s estimated likelihood.

<sup>9</sup> See the WMIP September 2006 Monitoring Report.

TABLE 1

CLAIMS-BASED OUTCOME MEASURES BEFORE AND AFTER IMPLEMENTATION  
FOR INTERVENTION AND COMPARISON GROUP PATIENTS  
(Per 1,000 Member Months, Unless Otherwise Noted)

	WMIP Enrollees						Comparison Group		
	Sample Size	Pre-Intervention	Intervention	Percent Difference	Sample Size	Pre-Intervention	Intervention	Percent Difference	
	Inpatient hospital admissions	1,427	13.8	15.0	8.7%	15,301	13.8	17.2	24.6%
Outpatient emergency room visits	1,427	127.8	127.0	-0.6%	15,301	113.8	114.7	0.8%	
Physician visits	1,427	1,084	1,069	-1.4%	15,301	1,047	1,108	5.8%	
Prescriptions filled	1,427	3,420	3,643	6.5%	15,301	3,346	3,731	11.5%	
Mental health prescriptions filled	1,427	637	680	6.8%	15,301	604	635	5.1%	
Mental health hospital days	1,427	13.8	20.2	46.4%	15,301	20.4	41.9	105.4%	
Percent of patients with AOD needs who received treatment	322	13.0	15.8	21.5%	3,333	14.4	18.9	31.3%	

Source: WMIP MVP Data Briefing, April 15, 2007 and MVP workbook.

Note: The pre-intervention period was calendar year 2004 for all measures except for mental health hospital days for which October 2004 through September 2005 was the pre-intervention period. The intervention period for all members but mental health hospital days was January 2005 through June 2006; for mental health hospital days it was October 2005 to September 2006. Comparison group members were enrolled in fee-for-service Medicaid in King, Pierce, Whatcom, Skagit, Kitsap, Thurston, and Clark counties. WMIP enrollees include all Medicaid-only members enrolled in the intervention in December 2005.

AOD = Alcohol and Other Drug.

of physician visits per 1,000 members fell 1.4 percent in the intervention group compared with an increase of 5.8 percent in the comparison group (this difference might not be statistically significant). One of the primary hypotheses of the WMIP was that care coordination might increase the rate of physician visits, improving clients' access to primary care services. It is possible that clients substituted care coordination services for physician visits, particularly if there was no immediate need to visit a physician or that, because of care coordination, patients required fewer overall office visits.

Results for mental health/substance abuse services utilization outcomes were also mixed. Mental health prescriptions filled rose slightly more in the intervention group than the comparison group (6.8 percent versus 5.1 percent), suggesting that intervention group members were receiving prescriptions required to manage their behavioral issues, but at only a slightly better rate than the comparison group. Less encouraging, the proportion of patients with identified needs for alcohol or other drug treatment services who received these services rose at a slower rate in the intervention group compared with the comparison group (21.5 percent versus 31.3 percent), but the difference may not be significant. However, Molina staff reported that WMIP enrollees likely underreported substance abuse/chemical dependency issues, making it challenging to provide services to patients who did not report a need for them. Staff noted that clients were much more willing to talk about mental health issues than substance abuse issues with clinical staff.

Survey results indicated that WMIP improved client satisfaction with some aspects of care delivery (and reduced it for others) compared with a comparison group, and improved care coordination for many intervention group members. DSHS began fielding the patient survey to intervention and comparison group patients in early 2006 to examine satisfaction with health care under either WMIP or fee-for-service Medicaid.<sup>10</sup> Among intervention group clients, when asked if their care was better coordinated since joining WMIP, 40 percent responded that coordination was better compared with 7 percent who reported it had gotten worse. WMIP enrollees reported improved satisfaction with some aspects of care delivery, including wait times for routine care appointments (WMIP enrollees were less likely than fee-for-service clients to have to wait 15 days or more), delays while waiting for health care approval, and problems with customer service or paperwork. However, WMIP enrollees were also less satisfied with other aspects of care than their fee-for-service counterparts. Those areas included getting (1) help when calling health care providers during regular office hours, (2) help for urgent care right away, (3) needed treatment or counseling for a personal or family problem, and (4) prescription drugs (consistent with reports from Molina nurses about prior authorization issues). WMIP enrollees who responded to the survey also rated their health care and health plan lower than fee-for-service clients, on average.

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<sup>10</sup> Survey samples included clients enrolled in WMIP or traditional fee-for-service Medicaid as of December 2005. More than 80 percent of surveys for both groups were completed by mail with the remainder completed by phone. A total of 362 WMIP enrollees and 469 traditional fee-for-service clients completed surveys from January 2006 to July 2006.



## INTERVENTION CHALLENGES

DSHS and Molina Healthcare experienced a number of challenges in implementing WMIP. There were concerns both internally and externally over continuity of patient care and duplication of services once patients were auto-enrolled in the program. In addition, uncertainty about how the program would be implemented led to resistance by some stakeholders in Snohomish County.<sup>11</sup> DSHS passed a budget provision that allowed it to choose an area of the state to implement WMIP and Snohomish was selected because of the prevalence of high-cost ABD clients. In addition, some DSHS officials were concerned about awarding WMIP to a for-profit health maintenance organization. To address this, DSHS staff discussed the benefits of WMIP and why it was appropriate to pursue the intervention with a managed care model. Quality provisions were included in Molina Healthcare's contract to assure proper monitoring of the intervention. The cost of the evaluation was another area of concern; however, it was necessary to assess whether or not the pilot was successful in permanently reducing patients' use of unnecessary services and medical costs.

Patient engagement also was a challenge since the onset of the intervention, which is not unusual for a program like WMIP, where patients are auto-enrolled. Of the more than 5,000 members enrolled in December 2004, nearly 2,000 chose to disenroll within the first month of the intervention. In addition, enrollment steadily fell to 2,180 active participants by June 2005 and 1,700 by March 2006, as patients lost Medicaid eligibility or moved out of the county. After identifying additional eligible patients in early 2006, enrollment rose to nearly 2,700 in June 2006, and remained steady through April 2007. DSHS staff members reported that the primary reason for stabilization in enrollment was the addition of a staff member who manually searches for new or reconnected clients to be auto-enrolled into WMIP, a task that their data system was unable to accomplish automatically.

To gain insight on the enrollment issue, WMIP conducted a disenrollee survey (in spring 2006). The results show that more than half of disenrollees either lost Medicaid eligibility or moved from Snohomish County, while 37 percent opted out voluntarily. The primary reasons patients opted out of WMIP included problems with access to providers and prescription drugs.<sup>12</sup> Among patients who opted out, 36 percent reported that their regular doctor was not with Molina Healthcare, 24 percent reported they had to travel farther to visit their Molina Healthcare physician, and 18 percent reported issues with the language spoken by their physician.<sup>13</sup> Additionally, 30 percent reported that a family member or a case worker influenced their decision to leave.

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<sup>11</sup> The Snohomish county executive who was in place before WMIP implementation was reportedly interested in the program, but his successor was not interested.

<sup>12</sup> Molina staff have noted that its drug formulary is more restrictive than the state's but that CCTs work with clients and their physicians as much as possible to resolve prior authorization issues that arise to provide clients with all the drugs they need in as timely a manner as possible.

<sup>13</sup> Staff reported that WMIP members might have an issue with language when their providers are of different ethnic backgrounds or have accents.

DSHS and Molina also encountered hurdles in the implementation of the long-term care component. The Home and Community Services division sub-contracts long-term care with Area Agencies on Aging to manage long-term care facilities; these facilities were not familiar with managed care contracting processes, such as credentialing or billing practices. Individual providers who provide many of the in-home services were also not familiar with managed care. Working directly with Home and Community Services, Molina Healthcare and the Area Agencies on Aging resolved many of the concerns of the affected parties. In addition, DSHS has found that the data systems for determining payments for long-term care patients cannot easily account or be automated for patients who enroll in WMIP. Because the data systems are cumbersome and the number of eligible long-term care patients is small, DSHS decided to have these patients opt into the program rather than auto-enroll them.

Molina staff reported that long-term care patients were the most challenging clients for whom to coordinate care due to the uniqueness of each client case. Molina supervisors also noted that the complexity of long-term care patient cases added considerable strain to CCT caseloads and resources; coordination of care for one long-term care patient could take up to a entire day of a nurse's time. Molina also found it difficult to find independent and residential providers who meet its requirements (which Molina staff reported are more stringent than DSHS standards). Staff also noted that long-term care eligibility or number of hours determinations from DSHS takes as much as 30 days, resulting in delays in services available to patients with long-term care needs.

## **CONCLUSIONS**

The WMIP intervention was one of the more developed ones in MVP and its project team was well prepared to provide quantitative measures of the intervention's progress. It was particularly advantageous for this intervention that WMIP began in 2005, and that planning for it began well before then. Outcomes reported in April 2007 suggest that WMIP had some success at slowing the rate of growth in hospital admissions and the number of hospital mental health days; however, DSHS has yet to conduct a cost analysis of WMIP (though one is planned). Moreover, according to the survey conducted by DSHS, among patients enrolled in WMIP, a considerable portion believes that their care is better coordinated under Molina than under the traditional fee-for-service arrangement.

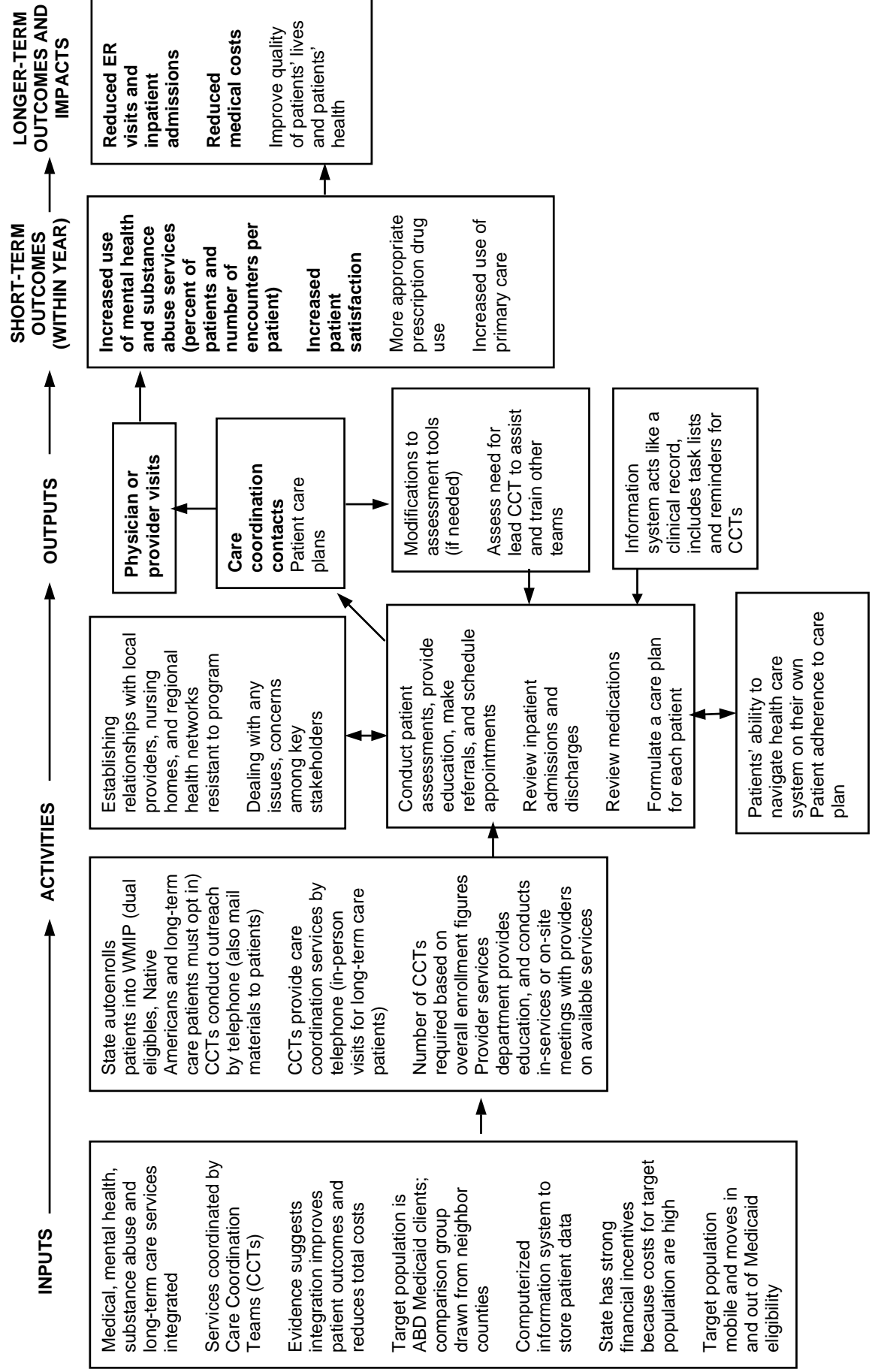
In addition to learning about impacts on patient outcomes, WMIP also provided extensive qualitative information on care coordination program implementation for ABD Medicaid clients. In particular, open-ended responses to the DSHS disenrollee survey and Molina Healthcare's efforts to reach out to auto-enrolled members have helped DSHS and Molina determine the barriers others are likely to face when implementing an intervention like WMIP. The intervention has also provided valuable information on the needs of the target population and lessons on how to best manage those needs. In fact, Molina Healthcare has reported that it has already been able to apply some of these lessons to its Medicare SNP in Washington and similar programs in Texas and Ohio, in terms of proper staffing requirements and patient needs for pharmacy and disease management. An additional lesson learned by staff was that patients with substance abuse issues were not very likely to report those issues to care coordinators, even though they were highly likely to talk freely about their mental health.

WMIP patient enrollment trends have implications for the generalization of program impacts. Though enrollment stabilized near the end of MVP, DSHS reports indicated that enrollees had lower monthly medical expenditures, on average, at baseline than disenrollees. This discrepancy suggests that the WMIP population may not be representative of all ABD patients in the state. Consequently, any observed impacts of the intervention might also not allow generalizing to a higher-cost population.

Despite these challenges, the intervention itself (integrating health care through care coordination) is likely replicable in other Washington counties, now that Molina Healthcare has experience with managing care for this client base. In fact, the Washington State legislature approved an expansion of WMIP into Eastern Washington (likely Spokane) with funding for up to 13,000 total patients, indicating that the intervention is sustainable for at least the near future. Both Molina and DSHS staff have thought about how they would implement a new program from the beginning. In particular, staff from both organizations acknowledge that rolling out all three components of WMIP might have been a better strategy than phasing them in one at a time and, possibly, excluding the long-term component from the program. Staff noted that the physical and mental health/substance abuse components could begin simultaneously. This would be especially advantageous, since many ABD clients have mental health and chemical dependency needs. Staff also noted that it would be important to have strong community buy-in before implementing the intervention elsewhere to avoid the problems WMIP encountered in Snohomish County. Lastly, staff have identified other outcome measures that would be particularly interesting, and appropriate, to examine in the future, including mortality, arrests, HEDIS-like quality of care measures, and falls (of particular importance for long-term care patients).

FIGURE 1

LOGIC MODEL FOR WASHINGTON STATE'S WMIP INTERVENTION



Note: **Bold** indicates reported process and outcome measures.