Health Home Fact Sheet

Overview
Health Homes promote person-centered health action planning to empower clients to take charge of their own health care. This is accomplished through better coordination between the client and all their health care providers and encourages involvement and independence. The Health Home program is designed to ensure clients receive the right care, at the right time with the right provider.

Goals
• Establish person-centered health action goals designed to improve health and health-related outcomes Coordinate across the full continuum of services including medical, behavioral, and long-term services and supports. • Facilitate the delivery of evidence-based health care services. • Ensure coordination and care transitions among care settings. • Increase confidence and skills for self-management of health goals. • Improve quality of care.

Eligibility
Medicaid beneficiaries of all ages are eligible for Health Home services if they: • Are on active Medicaid, includes dually eligible (Medicaid and Medicare); and • Have one identified chronic condition; and At risk for a second chronic condition (**P**redictive **R**isk **I**ntelligence Syste**M** (PRISM) score of 1.5 or higher)

Structure
The Health Care Authority contracts with designated "Health Home Lead Entities" to provide Health Home services directly, or through contracted Care Coordination Organizations. The Health Home program emphasizes person-centered care with the development of the Health Action Plan (HAP). The HAP includes routine screenings such as the Patient Activation Measure (PAM). The PAM is an assessment that gauges the knowledge, skills, and confidence essential to managing one's own health and healthcare. The HAP also includes screenings for body mass index, depression, level of independence in accomplishing activities of daily living, risk of falls, anxiety, chemical dependency, and pain. The HAP and assessment screens are updated on a 4-month cycle. The centerpiece of the HAP is the client's self-identified short and long-term health related goals, including what action steps the client and others will do to help improve their health. With client consent the HAP can be shared with care providers to foster open communication, support, and encouragement to reach their health goals.

Role of the Care Coordinator
A Care Coordinator is an individual who works with eligible clients, their families, and providers to: • Coordinate services for clients with chronic and complex medical and social needs. • Identify gaps in care and help remove barriers. • Connect clients to a broad range of benefits and community resources. • Support successful transitions from inpatient facilities to other levels of care. • Help establish primary and specialty care relationships. • Communicate and coordinate with the client's providers. • Support and assist clients to reach their identified health goals.

As defined by the Centers for Medicare and Medicaid, and authorized by the Affordable Care Act, Health Home Care Coordination provides the following services beyond the traditional Medicaid or Medicare benefit package.

Information Contact
Brendy Visintainer, Duals Integration Unit Manager, Home and Community Services Division
360-725-2647; Brendy.Visintainer@dshs.wa.gov
www.altsa.dshs.wa.gov/CFCO/
7/2024

Washington State Department of Social & Health Services
Transforming lives

Health Home Fact Sheet

Comprehensive Care Management
Initial and ongoing assessment and management aimed at integration of physical, behavioral health, long-term services and supports and community services using a person-centered Health Action Plan (HAP) which addresses clinical and non-clinical needs. • Conduct outreach and engagement activities. • Develop the HAP including health goals and action steps to achieve the goals. • Complete comprehensive needs assessments/screenings and the Patient Activation Measure. • Support the client to live in the setting of their choice. • Identify possible gaps in services and secure needed supports.
Care Coordination and Health Promotion
Facilitating access to and monitoring of progress toward goals identified in the HAP to manage chronic conditions for optimal health and to promote wellness. • Encourage and support progress towards HAP short- and long-term goals. • Coordinate with service providers, case managers, and health plans. • Conduct or participate in interdisciplinary teams. • Assist and support the client with scheduling health appointments and accompany if needed. • Provide individualized educational materials according to the needs and goals of the client. • Promote participation in community educational and support groups.
Comprehensive Transitional Care
The facilitation of services for the client, family, and caregivers when the client is transitioning between levels of care. • Follow-up with hospitals/emergency departments upon notification of admission or discharge • Review post-discharge instructions with the client, family, and caregivers to ensure they are understood. • Assist with access to needed services and equipment, and ensure they are received. • Provide education to the client and providers located at the setting from which the person is transitioning. • Ensure follow-up with Primary Care Provider (PCP). • Review and verify medication reconciliation post discharge is completed.
Individual and Family Supports
Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life, with particular focus on community living options. • Provide education and support of self-advocacy including referral to Peer Support specialists. • Access resources to improve self-management, socialization, and adaptive skills. • Educate the client, family or caregivers of advance directives, client rights, and health care issues. • Share information with consideration of language, activation level, literacy, and cultural preferences.
Referral to Community and Social Supports
Providing information and assistance for the purpose of referring the client and their family or caregivers to community-based resources when needed. • Identify, refer, and facilitate access to relevant community and social services. • Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services. • Follow-up with referral resources to ensure appointments and services were established and the client engaged in the services.

Washington State Department of Social & Health Services
Transforming lives

Information Contact
Brendy Visintainer, Duals Integration Unit Manager, Home and Community Services Division
360-725-2647; Brendy.Visintainer@dshs.wa.gov
www.altsa.dshs.wa.gov/CFCO/
7/2024