

Health Home Fact Sheet – Residential Settings

Overview

Health Homes promote person-centered health action planning to empower clients to take charge of their own health care to achieve optimal physical and cognitive health. This is accomplished through better coordination between the client and all of their health care providers and encourages involvement and independence. The Health Home program compliments the roles of case managers and residential/AFH staff and is not responsible for work already being done by other health providers.

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 health 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

- Identified chronic condition
- All ages, across all settings
- A risk score of 1.5 or greater predicting 50% higher healthcare costs than the average Medicaid disabled client in the next 12 months

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 his or her health. With client consent the HAP can be shared with care providers in order to foster open communication, support, and encouragement to reach their health goals.

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Role of the Care Coordinator

Care Coordinators are charged with conducting assessments, engaging clients to develop Health Action Plans, and to increase self-management skills to achieve optimal physical and cognitive health. 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

Role of the Residential Provider

- Abide by all licensing and contracting requirements
- Communicate with the Care Coordinator
- Encourage the client in achieving their identified health goals
- Respect the role of the Care Coordinator
- Be a member of the client health care team
- When applicable participate in interdisciplinary teams

Working with the Health Home Care Coordinator

Care Coordinators (CCs) do not duplicate, replace, or contradict services provided by nursing facility staff. The HAP and the nursing facility plan of care should **not** be in conflict. The CC's role is to work with the client to assume greater levels of responsibility and confidence in the management of their own health care. Clients who participate in the program will continue to receive their primary medical, therapy, behavioral health, dietary, and personal care by facility staff. Health Homes will not change the way a client's services are currently authorized, managed, or paid.

The work of the CC should complement that of residential facility/AFH staff. Care Coordinator's will coordinate with all providers, including staff to assist the client in reaching their health goals. This may include partnering with staff to encourage clients to improve their health, increase socialization, offer information and resources to families, work on an issue that needs resolution, or provide advocacy and support in the work you do.

When applicable the clients HAP will include actions steps to be taken by facility/AFH staff in addition to those the CC or client will do related to a specific goal that they are working on together. In this case the staff should receive a copy of the HAP so everyone understands and agrees to the contents and their outlined role.