

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 of 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

- 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.

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