Health Home Program
Washington

Health Home Services

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.

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. o Conduct outreach and engagement activities o Develop the HAP including health goals and action steps to achieve the goals o Complete comprehensive needs assessments/screenings and the Patient Activation Measure o Support the client to live in the setting of their choice o 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. o Encourage and support progress towards HAP short and long term goals o Coordinate with service providers, case managers, and health plans o Conduct or participate in interdisciplinary teams o Assist and support the client with scheduling health appointments and accompany if needed o Provide individualized educational materials according to the needs and goals of the client o 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. o Follow-up with hospitals/emergency departments upon notification of admission or discharge o Review post-discharge instructions with the client, family, and caregivers to ensure they are understood o Assist with access to needed services and equipment, and ensure they are received o Provide education to the client and providers located at the setting from which the person is transitioning o Ensure follow-up with Primary Care Provider (PCP) o 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. o Provide education and support of self-advocacy including referral to Peer Support specialists o Access resources to improve self-management, socialization, and adaptive skills o Educate the client, family or caregivers of advance directives, client rights, and health care issues o 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. o Identify, refer and facilitate access to relevant community and social services o Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services o Follow-up with referral resources to ensure appointments and services were established and the client engaged in the services