Health Home Program
Washington

Information for Medical Providers

Improving clients' health and independence, reducing their health care costs, and helping them become more engaged in their own health care—these are the goals of the Health Home Program. This program offers opportunities to coordinate all health care services for eligible clients. Clients who participate in the program will receive initial health screenings to identify risk factors that may require early intervention.

Health Home Care Coordinators will help your patients manage their chronic conditions and assist them in meeting their health goals. The Health Home Program reduces gaps in services and increases coordination between all types of service providers (medical, behavioral health, long term services and supports and other social services).

Care coordination services provided through the Health Home Program include:

- Comprehensive care management for the development of individualized health goals and action steps
- Care coordination and health promotion to integrate services
- Transition planning (e.g. from nursing facility/hospital to home)
- Individual and family support services (e.g. identifying and recognizing the role families, informal supports, and caregivers provide in supporting their health goals)
- Referral to community and social support services (e.g. transportation, food, housing)

Health Home Care Coordinators:

- Coordinate services for eligible clients with chronic and complex medical and social needs
- Provide appointment assistance
- Identify gaps in care and remove barriers
- Connect clients to a broad range of benefits and community resources
- Support successful transitions from hospitals to other levels of care
- Help establish primary care relationships

To be eligible for the Health Home Program, Apple Health clients of all ages, including Medicaid/Medicare dual eligible clients, must:

- Have at least one chronic condition and
- Be at risk of poor health outcomes in the future based on age, gender and diagnoses.

Participation in the Health Home Program is voluntary. To get Health Home services:

- The State enrolls eligible fee for service clients with Qualified Health Home Lead Organizations or contacts the health plan for managed care enrollees to inform the plan that the enrollee is eligible.
- The Qualified Health Home Lead or Managed Care Organization either offers health home services directly to the client or refers eligible clients to a Care Coordination Organization.
- A Care Coordinator contacts the client to explain the program and offer services.
- Declining Health Home services does not impact a client's other benefits.

We appreciate anything that you can do to support clients in their choice to enroll and participate in the Health Home Program.

For more information about the Washington Health Home Program visit the Health Home website at http://hca.wa.gov/billers-providers/programs-and-services/health-homes.

Care Coordination for Better Health

The Health Home Program is a partnership between the Health Care Authority and the Department of Social and Health Services