Washington State Department of Social and Health Services

Transforming Lives

Aging and Long-Term Support Administration

Tribal Health Home Fact Sheet

Overview
The Health Home program is a set of services offered to individuals living with chronic medical conditions that can have a lasting negative impact on their quality of life. It consists of a set of six services that are tailored to promote person-centered health action planning and empower participants to take charge of their own health care. This is accomplished through better coordination between the participant and all their health care providers. Health Homes encourages participants to take an active role in their health care and is designed to ensure participants receive culturally competent care, when it is needed, and with the best providers for each individual's needs.

Goals
○ Increase the health and quality of life for each participant and reduce the stress and strain for their family and supports. ○ Increase confidence and skills for self-management of health goals ○ Establish person-centered health action goals designed to improve quality of life and health-related outcomes ○ Prevent or slow the decline in functioning that comes from living with a chronic condition ○ Bridge gaps in services and ensure there is a cross-system care coordination across the full continuum of services including medical, behavioral, substance use, and long-term services and supports

Eligibility
○ Meet Apple Health (Medicaid) eligibility criteria ○ Participants must be diagnosed with at least one chronic condition ○ Participants must have a PRISM risk score of 1.5 or greater predicting higher than average healthcare costs in the next 12 months ○ Eligibility can begin at birth or during any stage of life

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 screenings are updated on a 4-month cycle or as needed. The centerpiece of the HAP is the participant's self-identified short and long-term health related goals, including what action steps the participant and others will do to help improve his or her health. With participant consent the HAP can be shared with care providers in order to foster open communication, support, and encouragement to reach their health goals.

Tribal Health Home Fact Sheet

Role of the Care Coordinator
A Care Coordinator is an individual who works with eligible participants, their families, and providers to: ○ Coordinate services for participants with chronic and complex medical and social needs ○ Identify gaps in care and help remove barriers ○ Connect participants to a broad range of benefits and culturally competent 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 participant's providers ○ Support and assist participants 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.

Comprehensive Care Management
Initial and ongoing assessment and culturally competent management aimed at integration of physical, behavioral health, substance use, 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 participant 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 participant with scheduling health appointments and accompany if needed ○ Provide individualized educational materials according to the needs and goals of the participant ○ Promote participation in community educational and support groups
Comprehensive Transitional Care
The facilitation of services for the participant, family, and caregivers when the participant is transitioning between levels of care. ○ Follow-up with hospitals/emergency departments upon notification of admission or discharge ○ Review post-discharge instructions with the participant, 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 participant 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 participant 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 participant, family or caregivers of advance directives, participant rights, and health care issues ○ Share information with consideration of language, activation level, literacy, and cultural preferences

Tribal Health Home Fact Sheet

Referral to Community and Social Supports
Providing information and assistance for the purpose of referring the participant and their family or caregivers to community-based resources when needed. ○ Identify, refer, and facilitate access to relevant community and social services ○ Assist the participant 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 participant engaged in Health Home services