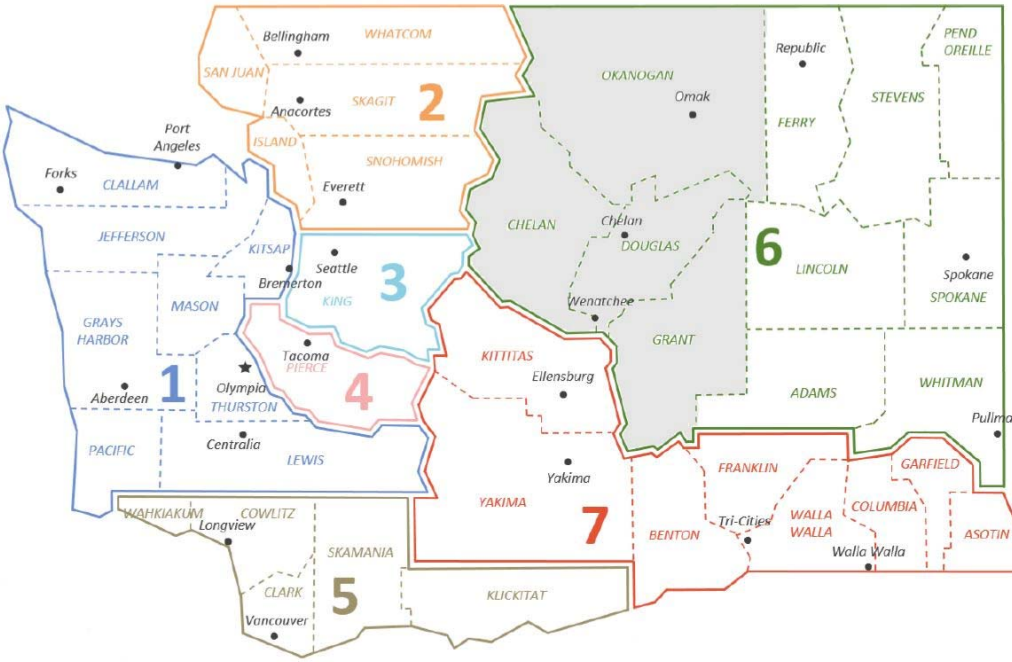
North Central Accountable Community of Health

Health Home Program *in a nutshell*

WHAT IS IT?

The Health Home program was implemented in 2013 and is now active across all Washington State counties. It is the Health Care Authority's (HCA) chosen ***community-based care coordination*** program for high-risk Medicaid beneficiaries.

Health Home services are designed to complement case management by bridging services across multiple settings, in order to support people with chronic and complex medical and social needs.



The NCACH region is part of Health Home Region 6

WHO DOES THE PROGRAM SERVE?

The Health Home program is designed for ***high-risk individuals with Medicaid insurance***. People of all ages are eligible for Health Home services if they have an identified chronic condition and a risk score of 1.5 or greater (as determined by the state's predictive risk score or PRISM.) Based on an April-June 2020 snapshot, ***545 NCACH residents*** were engaged in Health Home services.

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WHO RUNS THE PROGRAM?

Washington State DSHS and HCA contract with *lead entities* to provide oversight of service delivery and administrative support for the Health Home program across the state.

The lead organizations manage a network of *care coordination organizations* (CCO) who employ Health Home care coordinators offering services at the local level.

Leads in NCACH region

- Action Health Partners (CBO)
- Amerigroup (MCO) *lead role is delegated to Action Health Partners*
- Community Health Plan of WA (MCO)
- Coordinated Care (MCO)
- Molina Healthcare of WA (MCO)

CCOs in NCACH region

- Community Choice
- Aging and Adult Care of Central WA
- Family Health Centers
- Comprehensive Healthcare
- Molina Healthcare
- Rural Resources
- Pathways of Washington Inc.

ROLE OF HEALTH HOME CARE COORDINATORS

The Health Home Care Coordinator plays a central and active role in helping their clients access and navigate needed services, including medical, behavioral, long-term services, and other social services and supports. Comprehensive care management and care coordination is ***primarily done in-person with periodic follow-up***.

Care Coordinator Services Depending on Client Need

- Completes *standardized screenings and assessments* to determine needs (e.g. health risk assessments, depression, falls risk, pain, functional impairments, etc.)
- Develops and updates Health Action Plans (HAP) around *client-centered goals*
- Provides health education and coaching -- or links clients to peer supports, support groups, or programs -- to increase self-management skills
- Supports transitions from inpatient facilities (e.g. post-discharge face-to-face visits, health education to support medication management)
- Promotes involvement and support from family and non-family members
- Actively manages referrals to community and social support services