

Health Homes

A collaborative approach to improving the health of Washington's Medicaid enrollees

BACKGROUND

Health homes offer a new approach to the medical homes concept by serving the whole person across the primary care, long term care, mental health and substance abuse treatment components of the health care delivery system. Health homes coordinate a variety of services including primary care and specialty care, ensuring referrals to community supports and services are effectively managed. Comprehensive care management seeks to support the person in their self-management goals and provide clinical services that contribute to improved health outcomes for the individual. Health homes emphasize a person-centered approach, offering an array of services and referrals to individuals and their families seeking care. "Health Home Services" as articulated by the Affordable Care Act, Section 2703 and in Senate Bill 5394 include:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care between health care and community settings
- Individual and family support
- Referral to community and social support services

These services make use of available health information technology, providing more complete health information to people and the care providers who serve them.

WHAT IS NEW

Governor Gregoire and Health and Human Services Secretary Kathleen Sebelius are working together to remove some of the obstacles that interfere with continuity of care for individuals and the efficient operation of Medicaid programs at ground level. Health homes offer an excellent opportunity to add flexibility to the system and improve health outcomes at the same time. In July 2011, Washington received approval to match federal dollars to plan and develop the health homes framework in Washington. The planning effort will seek to further Governor Gregoire's goals to:

- Emphasize evidence-based care
- Promote prevention, healthy lifestyles, and healthy choices
- Better manage chronic care
- Create more transparency in the health system
- Make better use of information technology

Under this agreement, Washington State's development of health home strategies will be defined in a series of State Plan Amendments that reflect the diversity of health home activity in our state.

HOW IT WORKS

The planning period, led by the Health Care Authority in partnership with Aging and Adult Services Administration and the Department of Health, allows us to consider two different health home service delivery pathways which respond to the specific needs of the individuals served.

- The primary care health home pathway will include care management and referral to additional types of services, such as mental health, long-term care, and substance abuse treatment available in community settings. Health home services may be provided through primary care physicians, clinics or other medical delivery systems.
- The community based health home services pathway will deliver services in settings which focus on behavioral health or physical, cognitive or developmental needs. Health home services in these settings would include referral, care management and coordination with the primary care delivery system. In community based health homes, services might be provided through care settings such as community mental health centers, aging networks or other community providers.

The foundation of effective health homes remains the same in either case – to improve self-management skills and focus on elements of the Medicaid patient base where intervention will have positive results. The goal is to help patients achieve better health outcomes, use more cost-effective therapies and gain better access to the community-based services that are needed at both entry points in the health homes system.

NOTE: The funding match available to Washington State to support health home planning was authorized by the Centers for Medicare and Medicaid Services under the Affordable Care Act of 2010.

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