ElevateHealth

The Care Continuum Network

Care Across Every Stage of Life

At Elevate Health, our goal is to bring whole-person health to the most vulnerable populations in Pierce County. Key to our work is the recognition that the social determinants of health — economic and social conditions in the places people live, learn, work and play — have a major impact on a person's health and their ability to access health care.

Achieving whole-person health means taking into account medical conditions and the social determinants of health. This framework is the foundation of our Care Continuum Network (CCN). The CCN is an ever-expanding network of services designed to bring disparate programs together to support health from preconception to end of life while reducing silos and barriers. The core of the CCN is our network of services — Health Homes, Community Health Action Teams (CHAT) and Pathways Community HUB — all of which coordinate an individual's care and help them navigate the larger care ecosystem. These programs also refer clients to social service organizations and coach them on path to improved health outcomes. In serving people across a spectrum of risks, the network provides a continuum of care for the people who need it most. It also acts as care traffic control in coordinating referrals for the resources and services available in the community.

About Elevate Health and the Care Continuum Network

At Elevate Health, we innovate and collaborate to create purposeful health care reform in Washington state. Our mission is to build and drive community coalitions that transform health systems and advance whole-person health for all. As an Accountable Communities of Health (ACH) organization, we accomplish this work by addressing the core challenges of inequitable health systems and practices in our community, region and state.

The Care Continuum Network (CCN) is one of Elevate Health's core services, and it supports not only the community members in our region – often with multiple health challenges and other needs — but also the region's comprehensive ecosystem of care. This ecosystem includes clinics, hospitals, shelters, social services, community programs, food banks and other resources. Unfortunately, vulnerable populations are often not made aware of or unable to access these vital programs, and they come to rely on their local

hospital and emergency room, instead. The result is that important personal needs go unmet, and essential hospital resources feel the strain of excess use.

Our network, comprising of but not limited to three distinctive, care coordination programs — Health Homes, Community Health Action Teams and Pathways Community HUB — provides tailored solutions for people to access the right services at the right time so they may become healthy while promoting the best possible use of community resources.

Meet the Team

Each program in the CCN is a distinctive care coordination service, one that acts as a bridge between the worlds of health and social services for eligible individuals. Although the programs address different risk criteria, thus providing a continuum of services, they share similarities. Each program provides collaborative, person-centered, community-based and culturally appropriate care coordination with a focus on the social determinants of health. In addition, the programs feed data, using HIPAA-compliant and HITRUST processes into the Community Data Trust so that Elevate Health is able to monitor and guide an individual's enrollment, needs and engagement. The CCN includes:

COMMUNITY HEALTH ACTION TEAMS (CHAT)

Rapid Response and Intensive, Short-Term Care Management for High-Risk Individuals. CHAT expert multidisciplinary cohort assists clients living with complex medical and/or behavioral health diagnoses. CHAT works with clients to help them access, navigate and utilize the larger ecosystem of community services, thus mitigating expensive and ineffective hospital utilization.

HEALTH HOMES

Long-Term Wraparound Care for High-Risk Individuals. Health Homes is a partnership with the Washington State Health Care Authority, which determines client eligibility with a predictive risk score (PRISM). The program's care coordinators work with clients of all ages who have at least one chronic condition. Together, they identify and address health goals and help the client improve their self-management skills. The program also promotes whole-person health by providing care coordination, individual and family support, referrals to community and social support services, and care transitions.

PATHWAYS COMMUNITY HUB

Focused, Learning-Based Care Coordination Services for Low- and Medium-Risk Individuals. Serving vulnerable and traditionally underserved populations, the Pathways program connects clients with community health workers who serve as a centralized source of assistance in navigating ecosystems of care. The evidence-based program allows the community health worker and the client to identify and pursue pathways — activities that help the client remove barriers to health care. Elevate Health's Pathways program is the first and only program certified by the Pathways Community HUB Institute in Washington.

CCN programs coordinate to maximize their effectiveness. For example, CHAT refers potential clients to Pathways if the client is in a lower risk category than the one CHAT manages. Pathways, in turn, refers clients to CHAT or Health Homes if the client is in a higher risk category and needs more care. The CCN team is also available to assist potential clients and community partners with an interest in the network or a potential referral to one of the programs.

OUR LARGER COMMUNITY.

The Care Continuum Network is fortunate to work with a number of partners, including, primary care providers, clinics, behavioral health providers, social services organizations, government entities and community-based organizations, among others.

Today and Tomorrow

The CCN's programs have garnered praise from managed care organizations, which appreciate the network's ability to provide thorough, longer-term care and guidance. Program efficacy and progress is measured by program-specific performance indicators, such as the number of pathways opened and completed, hospital utilization rates, and standardized wellness instruments and measures, among others. Our goal is to expand the reach of the CCN and its services in order to serve a greater number of individuals and increase the volume of coordinated services available so that any need may be addressed in pursuit of community health.

For More Information

If you would like to learn more about the Care Continuum Network and our programs, we invite you to contact us. Our staff will be pleased to help you determine the most appropriate programmatic fit for you or your client.

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Wraparound Care in a Pandemic

Collecting and evaluating HIPAA-compliant data is central to helping clients in the Care Continuum Network. With data, we can track our clients' needs and goals, determine what services they find most useful, and monitor their use of hospital care. Secure data collection allows us to understand if the network is resulting in positive health outcomes — and to address service gaps where needed.

In 2020, our data did something more: It helped us protect battered women's lives.

As you know, the spread of COVID-19 spurred a "stay at home" mandate from public health officials. But this measure, intended to keep people safe, had the opposite effect on some of our neighbors. Our data analysts began seeing an increase in the number of clients mentioning domestic violence on their sign-up forms. The analysts promptly reached out to our providers, who verified the analysts' suspicion: The incidence of domestic violence was, in fact, on the rise.

The Care Continuum Network team sprang into action, addressing the issue by training members of the Pathways and Community Health Action Teams on recognizing signs of domestic violence, implementing screenings that wouldn't endanger people and helping individuals develop a safety plan to use when they have the opportunity to leave their abuser. During social distancing, Elevate Health's data acted as a warning system for a serious health-related problem. And, every day, our systems serve as a community resource that promotes responsive, whole-person care for residents of Pierce County.