ElevateHealth

Health Homes

Long-Term Wraparound Care for High-Risk Individuals

Becoming healthy takes an understanding of the health care system, time, stability and resources. People often contend with multiple obstacles to staying well, such as poverty, a lack of shelter or transportation, underlying health needs, or long-term behavioral health challenges. As a result, people need a full complement of coordinated services — including primary and specialty health care, aid from social services programs and access to behavioral and substance-use programs — to stay healthy. Unfortunately, people 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 that essential hospital resources feel the strain of excess use.

Achieving whole-person health is about more than visiting the doctor. Health begins in our homes, neighborhoods, schools, workplaces and communities. Our health is influenced by:

- access to economic and social opportunities;
- resources and supports available to meet basic housing and food needs;
- the safety of our neighborhoods;
- quality of our schooling, etc.

Individuals experiencing challenges in these areas, in addition to complex medical and behavioral health needs, are especially vulnerable to compromised health and wellness. These individuals require supportive care navigation for their complex circumstances so they may have their needs met.

Health Homes at Elevate Health helps vulnerable adults and children navigate the larger ecosystem of care. A federally funded program, administered by the state, Health Homes seeks to assist people through the coordination of primary care, acute care, behavioral health and social services. In Health Homes, an individual's needs are considered from a 360-degree perspective. This lens takes into consideration every medical condition, as well as the environmental, social and economic conditions that affect quality of life and health. Once enrolled in the program, people may receive services for as long as needed. While helping people secure services essential to their well-being, Health Homes also helps ease unnecessary strain on hospitals, allowing these organizations to focus their resources on providing sophisticated, acute care.

elevatehealth.org
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About Elevate Health and Health Homes

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.

Health Homes is one of our central care coordination services. It currently shares that distinction with two other programs, the Community Health Action Teams and Pathways Community HUB. Together, the three services form the basis of our Care Continuum Network. 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. We actively seek new contracting partners for the provision of care services, including payors, self-funded payors, state agencies and health authorities.

Although the phrase "Health Homes" may conjure up the image of a literal home, it does not refer to a space or a physical location. Rather, Health Homes is a program initially designed to help qualified Medicaid and Medicare recipients access the spectrum of community services they need to achieve and maintain whole-person health.

In providing comprehensive care management, Health Homes care coordinators assess and help address a client's medical and behavioral health needs, such as diabetes check-ups or substance-use counseling. They also address social determinants of health: social, economic, and environmental factors that include language barriers, food access and employment status. Left unaddressed, these determinants make it difficult to access appropriate health care and stay healthy.

Who Needs Health Homes?

The Health Homes Manager was worried.

"We had a pregnant client with several medical conditions, and we were concerned about her and the baby. But she had another concern — that she couldn't afford to buy work clothes that fit."

Worrying about clothes to wear to work might seem completely unrelated to health or health care. Insufficient money for basic needs, however, is a clue that someone might benefit from participating in Health Homes program — a compassionate, effective program that helps clients navigate local medical and social services systems.

Who Can Participate?

Medicaid or Medicare/Medicaid beneficiaries with a high-risk score on a risk prediction tool used by the Washington State Health Care Authority. Beneficiaries must also meet ONE of the following criteria:

- Two or more chronic conditions
- One chronic condition with risk of another
- A serious and persistent mental health condition

To learn more about Health Homes, contact care@elevatehealth.org

Meet the Team

At Elevate Health, we work with our partners to connect Medicaid or Medicare/Medicaid beneficiaries in Pierce County with the Health Homes program. Once in the program, clients receive care coordination from a team that addresses their physical, behavioral and social services-related needs. This team includes:

The Washington State Health Care Authority (HCA)
The HCA gathers data on potential clients, assesses their need for the Health Homes program, and forwards their contact information to Elevate Health. The HCA also reimburses care coordination organizations (CCOs) for services provided to clients.

Elevate Health
As a lead organization, we receive client eligibility lists from the HCA, distribute these lists to our CCOs for client outreach and service engagement, help process billing and reimbursement for our CCOs, provide quality control and assurance to compliance, and manage state reporting requirements. We also input Health Homes' data into the Community Data Trust, using secure, HIPAA-compliant and HITRUST processes to monitor and guide member enrollment, needs, and engagement. The community-governed data trust ingests and encrypts data from multiple sources – such as criminal justice, tribal, education and human services agencies – thus serving as a central resource to assess whole-person health and address community health challenges.

Our Community-Based Partners: Care Coordination Organizations
CCOs contract with Elevate Health to administer Health Homes care coordination services. In collaboration with Elevate Health, our partners, hire, train and supervise care coordinators within their respective organizations. CCOs are also responsible for managing client engagement and care delivery. Our contracted CCOs include health systems, clinics, providers and community-based organizations, among others.

The Care Coordinators
The coordinators – possessing either strong cultural competencies or a degree in social work, healthcare or public health – provide clients with comprehensive care management, coordination and social-emotional support. They help clients navigate the health care ecosystem, serve as a bridge between the worlds of medical and social services, and help clients develop and follow a health action plan (HAP) to achieve measurable goals.

Today and Tomorrow

Clients connect with Health Homes through the HCA-initiated process described in the previous section.
We are actively seeking new contracting partners for the provision of care services, including payors, self-funded payors, state agencies and health authorities. In the future, we would like to make referral a two-way process, one that encourages the CCOs to refer potential clients to us so they may be vetted for Health Homes eligibility. We anticipate that this expansion will allow us to serve a greater number of people, an outcome that will have lifelong beneficial effects for program participants, and decrease the overall cost-burden of healthcare with appropriate utilization.

For More Information

If you would like to learn more about Health Homes, or to become a referral partner, we welcome the opportunity to speak with you.

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