PROJECT access NORTHWEST

HEALTH HOME PROGRAM

A Project Access Northwest program

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Fact Sheet

Project Access Northwest's **Health Home Program** provides intensive, home-based, care coordination services for individuals with one or more chronic conditions. Health Home services are covered by Washington's Medicaid program and are designed to address complex health issues through a "whole-person" approach.

WHO is eligible for Health Home services?

Project Access Northwest has partnered with **Coordinated Care, Full Life Care and Northwest Regional Council** in King, Kitsap and Snohomish counties. We are reaching out to Medicaid clients of all ages who are eligible for Health Home services. Typically, clients will have at least one significant chronic medical condition or a serious mental health condition, and be at increased risk for future medical needs.

WHAT are the goals of the program?

- Bridge systems of care to improve the quality and coordination of care across systems
- Reduce expenditures in the rising costs of health care
- Increase client engagement and confidence in self-management of health goals
- Slow the progression of disease and disability

HOW does the program work?

- Clients will receive a care coordinator who will partner with them, their families, providers and other agencies to ensure that everyone is on the same treatment plan.
- Care coordinators will assist in developing a client-centered Health Action Plan to support each individual in achieving personal goals.
- Clients will receive core services, including:
  - ❏ Comprehensive care management;
  - ❏ Care coordination: so all providers are aware of the client goals;
  - ❏ Health promotion: education and coaching;
  - ❏ Comprehensive transitional care and follow up;
  - ❏ Client and family support; and
  - ❏ Referrals to community and social supports: to find and get services to meet needs.
- There is no specific end date for the program. Clients will receive services for as long as they remain engaged and maintain the same insurance coverage.

WHERE will services take place?

The Health Home care coordinators will provide in-person visits at the client's home or another convenient setting. They can meet clients in hospitals and clinics to ensure consistent care. Providing care coordination at the location where clients need it the most can help reduce barriers to services.

WHY is the Health Home Program so valuable?

Clients who have participated in the Health Home Program in other parts of the state report significant improvement in health or quality of life, as well as appreciation for the role of their care coordinator. Initial studies demonstrate significant health care savings. Clients receive the right level of care at the right time.

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