

Draft Health Home Proposal  
WA State Department of DSHS and HCA  
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Asian Counseling and Referral Service has been a leader in integrative care and care coordination in culturally and linguistically responsive, community-based settings. Currently, we offer an on-site integrative care clinic for seriously mentally ill Asian Pacific Americans funded as a pilot by SAMHSA. This project uses the Person-Centered Health Home model. **Health Homes represent a significant resource to effectively improve population health, reduce healthcare disparities and enhance patient experience of care, especially for high risk consumers.** The Health Home Proposal developed by the Health Care Authority and The Department of Social and Health Services is an important step in developing this important component of an effective system of care. ACRS is appreciative of the effort by Washington State to develop an intensive coordinated care model and the recognition of the importance of community-based organizations in the development and delivery of services in this model. The emphasis on the whole person, the importance of a network of care and the inclusion of local knowledge and resources are all strengths in this proposal.

We also appreciate the opportunity to provide feedback to strengthen the model. We have organized our feedback into the following categories:

- Entry and eligibility
- Screening and interventions

**Entry and Eligibility:**

1. The Qualified Health Home proposal was released concurrently with the draft proposal for serving the Dual Eligibles population (Pathways to Health: Medicare & Medicaid Integration in WA State/March 12, 2012). Because of this, the Health Homes model appears to give **more emphasis on the behavioral health concerns of the elderly and people with disabilities.** Despite the evidence of the importance of serious mental illness as a significant risk factor across all populations, the chronic care conditions listed do not clearly represent the importance of mental health conditions across all ages as criteria for eligibility. It also is a more limited definition than that proposed in federal guidelines for health homes, not necessarily

representative of the spectrum of significant mental health conditions that may occur in different ages.

**Recommendation: Include mental health conditions** diagnosed at various stages of development

2. The Chronic health conditions listed in the proposal to create eligibility for health homes omits substance abuse disorders, despite the strong correlation of drug and alcohol dependency as a predictor of high risk/high utilization. Furthermore, this list does not include HIV/Aids, a significant health risk across all populations.

**Recommendations:**

- I. **Add Substance Abuse/Chemical Dependency** as one of the criteria for eligibility. Providing effective CD treatment will reduce health costs and improve health outcomes. If this is added, it needs to be stand-alone criteria and should not be limited to only patients with co-occurring disorders.
  - II. **Add HIV/Aids to the list of eligible chronic care conditions.**
3. Washington state's model has a portal that is linked to two factors:
    - I. PRISM Score (which is based upon "claims" utilization in other systems throughout WA such as residential treatment, jail, shelters, hospital/ER, etc) of 1.5 or higher and
    - II. one established chronic care condition as noted above.

While PRISM is an excellent tool for data analysis, too much reliance on PRISM for eligibility may heavily weight cost over care in creating entry criteria. The **PRISM system may not accurately capture API populations** who may not be high utilizers in these systems because of language and cultural barriers but still may be high risk with significant health and mental health conditions, isolated, and at risk for very high cost entry into the system more downstream.

**Recommendation: Do not limit eligibility to those with PRISM score of >1.5** as this may exclude consumers who are high risk and may further exacerbate healthcare disparities. It also structures a system of care that "incentivizes" decompensation and higher cost service utilization before consumers qualify for this effective model of care. This also creates more challenging health trajectories that are more difficult to treat.

4. This **proposal does not include children and youth**. While children and youth represent a small percentage of the high cost/high utilizer population, those that are in this population are uniquely vulnerable and have significant needs. Furthermore, those who are at medium-high risk have issues that are highly correlated and predictive of future chronic care conditions that will move them rapidly into the high cost/high utilizer population. PRISM scores alone may capture only a fraction of the high risk youth who are multi-system engaged and many API families do not show up in those systems-again due to language and cultural barriers-or are prematurely discharged due to lack of culturally competent services. Also, the chronic care conditions listed would not necessarily reflect those health concerns for children and youth.

**Recommendation:**

- I. **Include chronic care conditions more common in children and youth** such as asthma, substance abuse and mental health disorders commonly diagnosed in childhood that may be predictors of serious mental illness in adulthood.
- II. **Use data from screening tools such as Adverse Childhood Experiences (ACES)** rather than PRISM data as it is more relevant to children and youth. Research has shown high correlations between childhood adversity and future chronic care conditions such as those listed in the draft proposal.

### **Screening and Intervention:**

According to the 2010 Census, the Asian population grew faster than any other race group in the United States between 2000 and 2010. According to the Washington State Office of Financial Management minority populations in Washington will double by 2030. Yet, there are few if any mentions throughout the proposal of the necessity to require culturally competent and linguistically responsive services. There are no recommendations regarding effective language access in the different components and service definitions. Interpreter services are not listed as a required element in the different standards and should be explicitly required. The Health Home proposal reflects the medical model common in Western medicine. This model emphasizes a “mind/body” split that often fails to effectively engage and treat minority populations.

#### **Recommendations:**

- I. **Qualified Health Homes should be required to provide culturally competent services with effective language access.** Recognize and create structures to **support integrative health care that incorporates traditional healing practices common in minority populations.**
- II. Matching refugees and immigrants to services often requires high levels of cultural competency to overcome stigma and disparate world views regarding healthcare and particularly mental health treatment. Requirements for culturally competent care will enhance patient experience, improve compliance with treatment and ultimately improve patient health outcomes for diverse populations. **Reduction of health disparities should be one of the fundamental health home guiding principles**, emphasizing cultural competency.
- III. Mandated **screening should include tools that have been normed on the populations to be served** and translated effectively into both primary language and dialects through “back and forth” translation processes that assure mutual understanding of content.
- IV. Evidence-based treatment protocols also must be normed on the populations to be served or the State should **include language that allows EBP’s to culturally adapted to serve marginalized populations** for which there are no EBP’s. We encourage the state to **include Promising Practices as well as practice-based evidence** in its language and requirements. Consult the National Registry of Evidence-Based Practices for projects that have provided research based interventions using Asian American, Native Hawaiian, and Pacific Islander (AANHPI) populations.

#### **Additional Recommendations:**

**Ensure that Human Service professionals have equal standing** in home health networks and in the care teams that coordinate and direct healthcare services. Care coordinators should not be limited to medical professionals (RN’s, etc) or Master’s level Social Workers but should also include professionals with strong cultural and linguistic skills, life experience relevant to the populations to be served and professional development and training relevant to care coordination. Create standards that are flexible and inclusive of those from diverse backgrounds who bring language and cultural expertise vital to the success of patient engagement, patient experience and navigation to better health outcomes. Include peer support specialists, peer education and support, and a workforce development plan that includes outreach and development of professionals in these areas.