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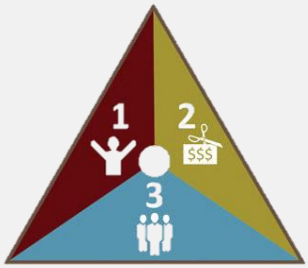
Fact Sheet for Administrators, Providers, and Policy Makers

Housing Outreach and Member Engagement (HOME)

The MaineCare HOME health home model began in August 2022 and serves individuals with chronic conditions and Long-term Homelessness.[1] As of May 2023, there were five (5) HOME provider organizations enrolled and beginning to deliver services to eligible MaineCare members.



Source: Institute for Healthcare Improvement

Improved Patient Experience

The roles of peer supports and community health workers with training and lived experience are part of the HOME provider team. These roles are identified as valuable for successful outreach and health promotion.

Reduced Cost

Health care costs among individuals with homelessness are attributed to preventable hospitalization and emergency room visits.[3] HOME services connects and coordinates members to preventive care services.

Improved Population Health

People with homelessness and unmet HRSNs face obstacles to accessing health care services. HOME services provides care management, coordination, and supports to improve access to preventive care to improve health.

Delivery Model

HOME services are a team-based, innovative, integrated, health home service model that is whole-person-oriented and designed to improve patient experience and health outcomes over those achieved in traditional services. People with a history of homelessness have higher rates of chronic conditions and are at three to eleven times greater risk for death than the general population.[2] Key contributors to poor health include unmet health-related social needs (HRSNs), substance use disorders, tobacco dependence, malnutrition, history of trauma, untreated infections, and difficulty obtaining routine preventive and primary care.[2] HOME provider teams deliver comprehensive care management services to facilitate access to housing, behavioral health care, medical care, and community-based social services.

Components of a HOME Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and support services

Goals of HOME Provider Team Services

- Support and strengthen coordination between primary care and behavioral health
- Coordinate access to housing
- Decrease preventable inpatient hospitalization and emergency room visits.
- Reduce barriers to timely access to services

[1] MaineCare Benefits Manual, Chapter II, Section 91:01-8: Definition of Long-term Homelessness.

[2] Health Conditions Among Individuals with a History of Homelessness. 2021. HHS ASPE.

[3] Cost of Homelessness: Cost Analysis of Permanent Supportive Housing State of Maine-Greater Portland. 2007. University of New England et al

For more information, visit:
https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/health-homes