



Health Homes Care Coordinators Training

Non-Emergency Medicaid Transportation for Health Home Clients and Comprehensive Care Transitions



May 14, 2015



Today's Presenters

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Washington State Health Care Authority
Program Managers

Non-Emergency Medical Transportation Program

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Training and Quality Assurance Program Manager
Health Home Program





Objectives



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Training Objectives

1. To learn about the New Non-Emergency Medical Transportation Program designed especially for your Health Home clients
2. Review Comprehensive Care Transitions - one of the six health home services
 - Expectations of Care Coordinators
 - Strategies for effective Care Transitions

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Non-Emergency Medical Transportation (NEMT)



A new Medicaid benefit designed especially for Health Home clients

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What is NEMT?

Beginning April 1, 2015, Care Coordinators may request non-emergency medical transportation for Health Home clients when:

- the client is homeless, or
- lives in an unhealthy or unsafe environment.

A Care Coordinator may request non-emergency medical transportation to alternate locations to deliver the Health Home services including but not limited to:

- developing the Health Action Plan (HAP),
- obtaining consent to participate, or
- administering health assessments.

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Why Would I Request NEMT?

The development of the HAP, as well as some on-going health home services, require face-to-face visits that usually take place in the client's home.

If a client is homeless or lives in an unsafe or unstable environment, the Care Coordinator may identify an alternate location for the face-to-face visit. In these instances, the client may need transportation to the alternate location.

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Who Can Request NEMT?

Only a client's Care Coordinator can request NEMT services from a transportation broker for providing Health Home services.

Clients may not schedule this service.

The Care Coordinator must contact the NEMT broker available in the client's county of residence and submit a NEMT Health Home Services Request Form to the broker.

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Procedure for Using the Program

1. Only the Care Coordinator can request NEMT for the Health Home client. The client must be behaviorally and medically stable and safe to transport.

2. The Care Coordinator must identify an alternate location where he/she may meet the client in person. Examples of acceptable alternate locations include but are not limited to:

- A medical office or behavioral health setting
- A community-based social or health services location such as senior center, community services office, area agency on aging, or local health department

3. The Care Coordinator must ensure the availability of the alternate location prior to scheduling the transportation.

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Procedure for Using the Program cont.

4. NEMT for clients can only be used when providing a qualifying Health Home service and is limited to the following distance standards:

- Within 10 miles of the beneficiary's residence in urban/suburban areas
- Within 25 miles of the beneficiary's residence in rural areas
- Exceptions may be made to the distances criteria on a case-by-case basis in remote areas of the state and be approved by HCA. To request an exception, the Health Home lead entity with whom the client is enrolled must request the approval by sending an email to: healthhomes@hca.wa.gov. Include the client name and ProviderOne ID, and the reason for the exception. HCA will notify the Health Home lead entity and the transportation broker of approved exceptions to the distance standards.


5. The Care Coordinator must complete the Request Form for Non-Emergency Medical Transportation (NEMT) for Health Home Services; FAX the form to the NEMT broker and maintain a copy in the patient file for audit purposes.

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Request Form

The form does not have a form number and is located on the Health Care Authority's Health Home Website




Non-Emergency Medical Transportation (NEMT) for Health Home Services REQUEST FORM

Date: _____

TO NEMT Broker: _____ FAX #: _____

NEMT Broker Look-up: <http://www.hca.wa.gov/medicaid/transportation/pages/phone.aspx>

FROM (Care Coordination Organization): _____

Name of Care Coordinator: _____ Phone #: _____

Health Home Lead Agency: (Check one)

<input type="checkbox"/> Community Choice Healthcare	<input type="checkbox"/> Northwest Regional Council
<input type="checkbox"/> Community Health Plan of Washington	<input type="checkbox"/> Optum Health
<input type="checkbox"/> Coordinated Care Corporation	<input type="checkbox"/> SE WA Aging and Long Term Care
<input type="checkbox"/> Molina Healthcare	<input type="checkbox"/> United Healthcare

Section I - Client Information

Last Name _____ First Name _____

Provider/One ID Number _____ DOB _____

Transportation Date (mm/dd/yyyy): _____

Pick-up Address (exact address/entrance): _____

Drop-off Address (exact address/entrance): _____

Special Needs (e.g. escort, oxygen, wheelchair/oversize wheelchair, etc.): _____

Section II - Certification:

Client is Medicaid Eligible Client is enrolled with the Health Home Lead selected above

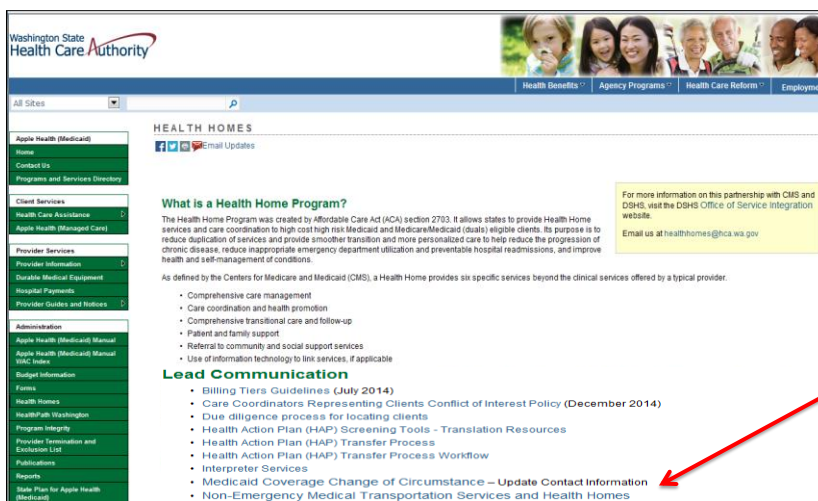
Client needs transportation to an alternate location to receive health home services

Care Coordinator Signature/Date: _____ / _____

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Where Can I Find Information and Forms?



The screenshot shows the Washington State Health Care Authority website. The main content area is titled "HEALTH HOMES" and includes a "What is a Health Home Program?" section. A red arrow points to the "Non-Emergency Medical Transportation Services and Health Homes" link in the "Lead Communication" list.

What is a Health Home Program?

The Health Home Program was created by Affordable Care Act (ACA) section 2703. It allows states to provide Health Home services and care coordination to high cost high risk Medicaid and Medicare/Medicaid dually eligible clients. Its purpose is to reduce duplication of services and provide smoother transition and more personalized care to help reduce the progression of chronic disease, reduce inappropriate emergency department utilization and preventable hospital readmissions, and improve health and self-management of conditions.

As defined by the Centers for Medicare and Medicaid (CMS), a Health Home provides six specific services beyond the clinical services offered by a typical provider:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care and follow-up
- Patient and family support
- Referral to community and social support services
- Use of information technology to link services, if applicable

Lead Communication

- Billing Tips: Guidelines (July 2014)
- Care Coordinators Representing Clients: Conflict of Interest Policy (December 2014)
- Due diligence process for locating clients
- Health Action Plan (HAP) Screening Tools - Translation Resources
- Health Action Plan (HAP) Transfer Process
- Health Action Plan (HAP) Transfer Process Workflow
- Interpreter Services
- Medicaid Coverage Change of Circumstance - Update Contact Information
- Non-Emergency Medical Transportation Services and Health Homes

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Where Can I Find the Contracted Transportation Brokers?

Website:

<http://www.hca.wa.gov/medicaid/transportation/Pages/phone.aspx>

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REGIONAL BROKER PHONE LIST - MEDICAID TRANSPORTATION

Transportation Home | Eligibility Requirements | Request Transportation | Resources
Non-emergency medical transportation is provided through businesses called Regional Brokers.
Below is a table listing the Regional Brokers that serve Medicaid clients by county, business name, and phone and fax number.
Find your county to see what Regional Broker serves that area.
Additional information about each broker can be found by clicking on the link to the Regional Broker's website.
You can also print the list of Regional Brokers.

County	Broker	Phone	FAX
Adams	Special Mobility Services	(509) 534-8760	(509) 534-6880
		1-800-882-4817	1-888-629-3915
		TDD/TTY: (509) 534-8566 or 800-821-7197	
Asotin	Special Mobility Services	(509) 534-8760	(509) 534-6880
		1-800-882-4817	1-888-629-3915
		TDD/TTY: (509) 534-8566 or 800-821-7197	
Benton	People for People	(509) 248-4783	(509) 574-5085
		1-800-233-1624	
		TDD/TTY: 800-895-1302	
Chelan	People for People	(509) 248-4783	(509) 574-5085

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NEMT Brokered Transportation

Overview

Purpose:

- Provide transportation access to necessary non-emergency medical services for all eligible clients who have no other available means of gaining access to these services
- **Pre-authorized** access to covered medical services is provided by the most cost-effective mode which meets the clients' mobility status and personal capabilities
- Lodging may be paid for if the client must go out of their area for specialty care. Payment need to be pre-approved by the broker
 - Brokers have established contracts with hotels and pay the hotel on the client's behalf.

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NEMT Brokered Transportation

Rules and Regulations related to NEMT:

- **NEMT services are authorized under 42 CFR 440.170 for Title XIX Medicaid clients; WACs: 182-546-5000 through 5700**

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6 Transportation Brokers Serving 13 Regions Statewide

Transportation Broker's Responsibility:

- Authorize the type of transportation
- Select transportation service provider
- Select type of transportation mode that is:
 - ✓ appropriate to a client's medical condition and capabilities
 - ✓ lowest cost available
 - ✓ accessible

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Broker Responsibility

The Transportation Broker:

- Arranges for transportation to healthcare services within a client's local medical community;
- May arrange for transportation outside the local medical community if justification or medical necessity is provided
 - ✓ *The client's primary care provider usually provides medical necessity documentation to the broker for client to access services outside the local medical community.*

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Eligibility for Transportation

- **Clients call broker to request ride for:**
 - ✓ **Scheduled trip:** request **2 business days in advance of trip** (up to 14 days in advance)
 - ✓ **Urgent Call & Hospital Discharges:** requests accepted depending on available resources (drivers and vehicles)
- **Clients must be Eligible:**
 - ✓ **Clients must be Medicaid-eligible (or Dual: Medicaid & Medicare)**
 - ✓ **Medical Services must be covered by client's benefit services package**
 - ✓ **Medical Services must be necessary**
 - ✓ **Medical Provider must be a HCA-enrolled provider or contracted with the managed care plan**

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Modes of Transportation

- Brokers ensure client resources & lowest cost transportation are used first, based on each **client's mobility & personal capabilities**.
- Clients are screened for **most appropriate & cost efficient mode**:
 - ✓ **Personal Vehicle** (mileage reimbursement, gas vouchers, gas cards)
 - ✓ **Volunteer Drivers** (base rate, mileage reimbursement)
 - ✓ **Public Transit** (bus fare, tickets, passes, etc.)
 - ✓ **Shared Rides/Multiple Passengers**
 - ✓ **Wheelchair Van**
 - ✓ **Taxi**
 - ✓ **Ferries, Water Taxi**
 - ✓ **Tickets for commercial bus, rail, air**

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NEMT Transportation Program Contact Information

- ✓ Website: (broker list by county)

<http://www.hca.wa.gov/medicaid/transportation/pages/index.aspx>

- ✓ E-mail Address:

HCA DL DHS OCS NEMT TRANSPORTATION
HCANEMTTRANS@hca.wa.gov

- ✓ HCA Customer Service Center:

1-800-562-3022 (ask for Transportation Program)

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Transportation Costs

- **Transportation Program is a \$65-\$75M program**
- **About 3 Million Trips / year; 12,000 Trips/day**
- **Costs keep rising as a result of:**
 - ✓ increasing caseloads (Medicaid Expansion)
 - ✓ fuel costs
 - ✓ out-of-area costs
 - ✓ clients may have less resources

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Who Do I Contact if I Have Questions?

- **RosaMaria Espinoza**
NEMT Program Manager/HCA
(360) 725-1721
- **Stephen Riehl**
NEMT Program Manager/HCA
(360) 725-1441

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Comprehensive Care Transitions



One of the six Health Home Services

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The Six Health Home Services

- 1 Comprehensive care management
- 2 Care coordination
- 3 Health promotion
- 4 Comprehensive transitional care
- 5 Individual and family support
- 6 Referral to community and social support services

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Hospital Readmissions

Research shows that 20% of Medicare patients in the U.S. are re-hospitalized within 30 days of discharge.

While some readmissions are necessary and appropriate, up to 76% of these readmissions are potentially avoidable for a variety of reasons.

Four out of five Medicare clients have no direct communication with the hospital or their PCP after they leave the hospital

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What are the Reasons?

Social or resource issues and not for medical issues

Lack of strategies that incorporate both social and medical factors

Poorly executed transitions:

- Impact family and support systems
- Result in poor outcomes for the client

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Social and Resource Barriers

- Limited or no income
- No financial resources
- Lack of advanced care planning
- Current living situation
- Unstable housing or lack of housing
- Unsafe living environment
- Poor health literacy
- Lack of employment
- Lack of family support
- Mental health symptoms
- Poor nutrition and/or food insecurity
- Lack of an alternate decision maker
- Abuse, neglect, and/or exploitation
- Beliefs and values
- Lack of dependable transportation and/or escort

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Adverse Outcomes

The lack of proper comprehensive care transitions can result in:

- Avoidable Emergency Department visits
- Avoidable hospital re-admission
- Medication errors
- New or increased symptoms
- Adverse events
- Misdiagnosis, delayed diagnosis, or wrong treatment
- Death

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Care Transitions Defined

Comprehensive Care Transitions are a set of Health Home activities and services provided by the Care Coordinator. The intent is to prevent avoidable readmissions to hospitals, nursing facilities, and other inpatient facilities. Properly executed care transitions result in better client outcomes, reduced risk, and reduced costs.

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Six Strategies for Care Transitions

- 1 Consistent plan of care with primary care provider and home health care (if applicable) upon arrival and discharge from the hospital, skilled nursing facility (SNF), or other institution
- 2 Coordinated follow up call or visit at discharge
- 3 Timely visit to primary care provider (PCP) or specialist
- 4 Reconciliation of medications soon after transition
- 5 Patient education coordinated between settings
- 6 Support through increased care management for high- risk patients

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Preplanning

Successful care transitions begin with:

- Advanced planning

- Interdisciplinary Care Teams (ICT)

- Inclusion of family members, caregivers, and other collaterals

- Health promotion and education before admission (and continued as needed after discharge)

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Online Resource

National Transitions of Care Coalition

http://www.ntocc.org/Portals/0/PDF/Resources/Taking_Care_Of_My_Health_Care.pdf

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How Will You Know if a Client has Been Hospitalized?

Review PRISM data: there is a lag in submission of billing claims

PRISM can identify placements in nursing facilities

Emergency Department Information Exchange (EDIE) or PreManage: find out if your Lead or agency subscribe to this service

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PRISM Inpatient Risk Score

PRISM Health Report

Events AD Elig Risk **TP Score** Claims OP IP ER AOD MH LTC Labs Providers CARE PAM HRI

DEMOGRAPHICS (.)

Name: KNUT, SACHA DOB: 1945-03-05
 Gender: F Age: 70
 PID (ACES): 100234567WA (002123456) Phone: (855) 256-7654

RISK PROFILE FOR SERVICE DATE RANGE FROM 2013-06-03 TO 2014-09-12

Risk Score: **4.08** IP Admit Risk Score: **95.0%**

Primary Risk: **Cardiovascular, medium** Secondary Risk: **Renal, very high**

Mental Illness: **Psychiatric, medium, low** Substance Abuse: **No**

Risk Factor	Weight (raw)	Claims	Last Date	Events
Count of IP admits in past 181 to 365 days	4.1%	2	2013-11-14	2
Count of IP admits in past 366 to 730 days	6.5%	2	2013-07-16	2
Count of ER in past 31 to 90 days	3.5%	4	2014-07-30	4
Count of ER in past 91 to 365 days	9.0%	29	2014-03-21	29
Count of ER in past 366 to 730 days	1.3%	6	2013-09-11	6
Cardiovascular, medium	9.0%	8	2013-07-18	
Skin, low	7.6%	14	2013-08-21	
Renal, very high	6.8%	30	2014-08-25	
Gastro, medium	5.8%	50	2014-07-25	
Pulmonary, medium	5.1%	10	2013-07-26	
Diabetes, type 1, medium	4.1%	2	2013-12-25	

Inpatient Admission Risk(s)

- Count of IP admits in past 181 to 365 days
- Count of IP admits in past 366 to 730 days
- Count of ER in past 31 to 90 days
- Count of ER in past 91 to 365 days
- Count of ER in past 366 to 730 days
- Cardiovascular, medium
- Skin, low
- Renal, very high
- Gastro, medium
- Pulmonary, medium

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Interdisciplinary Care Teams (ICT): an approach to planning

- May be initiated by the Care Coordinator
- May be a part of interdisciplinary care teams at the nursing facility
- May be a part of the hospital discharge department
- May be coordinated by other medical and mental health providers

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Who Should Be on the ICT

- **Prior to or during admission determine who should be on the Interdisciplinary Care Team (ICT):**
 - Care Coordinator
 - Allied or affiliated staff (e.g. peer support specialist)
 - Facility discharge staff: RNs, Rehab, Dietary, and Social Services
 - Family, legal representatives, caregiver/s, other collaterals
 - Primary Care Physician (PCP)
 - Other medical professionals (e.g. PT, home health)
 - LTSS case managers and nurses
 - Mental health and other social service providers

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Preparing for Discharge

- **Some things to consider:**
 - Home evaluation
 - Follow-up and after hours care
 - Care needs:
 - Supervision: 24 hour care
 - Activities of daily living (ADLs) and Independent Activities of Daily Living (IADLs)
 - Care needs:
 - personal care for ADLs and IADLs
 - skilled nursing and other therapies

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The logo for the Department of Social & Health Services, featuring a stylized figure and the text "Department of Social & Health Services".

Preparing for Discharge cont.

- **Some things to consider:**
 - Financial assistance
 - Durable medical equipment and supplies
 - Special dietary needs
 - Paid and unpaid caregiving
 - Transportation and escort
 - Housing: rent and utilities paid? Risk for losing housing voucher?

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The logo for the Department of Social & Health Services, featuring a stylized figure and the text "Department of Social & Health Services".

Does the Client or Caregiver Know Which Red Flags or Warning Signs May Require a Call to the Provider?

- Chest pain or palpitations
- Cough
- Infection
- Blurred vision
- Headache
- Fatigue,
- Insomnia or problems sleeping
- Discharge
- Warmth to an affected area.
- Fever
- Pain
- Nausea and/or vomiting
- Poor appetite
- Weight loss or weight gain
- Cough
- Bleeding
- Constipation
- Difficulty urinating or no urination
- Dizziness
- Falls

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Triage Grid for Follow-up Care

Communication and Follow-Up Based on Patient Triage/Clinical Need				
Patient	Criteria	Appointment Needed w/in	Provider Handoff	Plan of Care Transfer
High Risk	<ul style="list-style-type: none"> • Admitted 2 or more times in the past year • Unable to teach back • Low likelihood to follow treatment plan • High likelihood patient readmitted within 30 days 	48 Hours	Doctor to Doctor	Phone <u>and</u> FAX
Moderate Risk	<ul style="list-style-type: none"> • Admitted once in the past year • Moderate likelihood to follow treatment plan • Moderate likelihood patient readmitted within 30 days 	5 – 7 days	Hospital to PCP Team	EHR or FAX
Low Risk	<ul style="list-style-type: none"> • No other admission in the past year • Able to teach back • Low likelihood patient readmitted within 30 days 	As Needed	Hospital to PCP Team	EHR or FAX



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Arrange for Follow-up Care

- **Questions to consider:**
 - What are the discharge orders?
 - Who should the client see after discharge?
 - What special and/or routine care is needed?
 - How soon should the client be seen?
 - What questions does the client need to ask at the appointment/s?
 - Are there test results that should be reviewed?

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Arrange for Follow-up Care cont.

- **Questions to consider:**
 - Was the client or collateral informed of the appointment/s?
 - Who should attend?
 - Is transportation and/or escort arranged?
 - How will the provider be informed about the hospitalization?
 - Do they have access to the Electronic Health Record (EHR)?
 - Discharge orders?
 - Does the client need new prescriptions for medications, durable medical equipment and supplies, and/or additional rehab sessions?

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Medication Reconciliation

The role of the Care Coordinator is to facilitate/coordinate the reconciliation

- This may start during the hospital stay
- Within 5 days following discharge
- Care Coordinator will ensure that it is completed by a qualified professional OR
- Care Coordinator may provide the service if it is within the scope of their practice

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Medication Reconciliation cont.

Who can help reconcile medications?

- Primary care physicians (PCP)
 - The PCP's nurse or physician's assistant (PA)
- Family members
- Pharmacists
- Pharmacies that deliver bubble packed medications to adult family homes
- Home Health nurses
- Contracted nurse delegators for LTSS
- Nurses in nursing facilities, assisted living, adult family homes, and other institutions

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Checklist for Post Hospital Follow-up Visits

- ✓ Medication reconciliation
- ✓ Instruction in self-management; when to call and who to call
- ✓ Red flags or warning signs
- ✓ Follow up appointments made and confirmed
- ✓ Client knows what to do if he/she does not feel well
- ✓ Plan for paying for care or non-covered benefits, equipment, and environmental modifications

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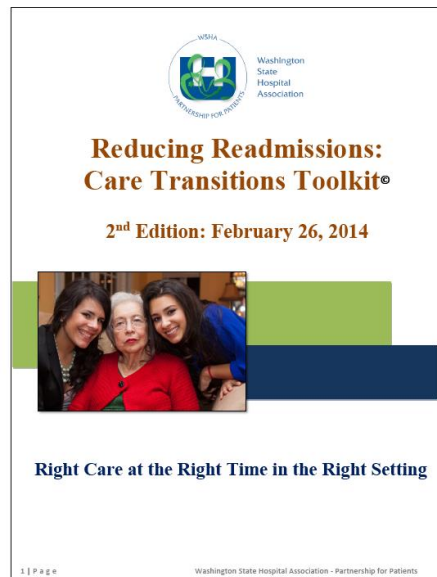


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Valuable Resource

http://www.wsha.org/files/177/CareTransitions_Toolkit_Version2_Final.pdf



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Interventions Following Discharge

Follow up call script by clinical staff

- Please review the script

Follow up call by non-clinical staff

- Please review the script

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Follow-up Script for Clinical Staff from “Reducing Readmissions: Care Transitions Toolkit”

Tool 10.1: Follow-up Call by Clinical Staff

Hello Mr. Ms. _____ I am (caller's name), a (title) from (name of facility). I am calling to see how you are doing after your discharge and if there is anything I can do to help you. We will also review your medications during this call. Can you bring all of your medications including non-prescription medicines and herbal supplements to the telephone, please?

HEALTH STATUS:

- Before you left the hospital, your main medical problem during your hospital stay was explained to you. Can you explain to me your main problem or diagnosis?
 - Yes - Confirm the patient's knowledge of the discharge diagnosis.
 - No - Use this opportunity to provide patient education about the discharge diagnosis.
- Do you have any questions for me about your diagnosis?
 - Yes - Explain again.
 - No - Continue.
- Since you left the hospital, do you feel your main problem has improved, worsened or not changed? What does your family or caregiver think?
 - Worsened - Refer to an appropriate provider.
 - Improved/No change - Continue.
- Have you experienced any new medical problems since you left the hospital?
 - Yes - Ask what has happened?
 - No - Continue.

WARNING SIGNS:

- What did the medical care team tell you to watch out for and things to do for this diagnosis e.g. weigh self, blood sugar, blood pressure, peak flow chart, etc.
- Do you have any questions about what to do if a problem arises?

FOLLOW-UP:

- Can you please tell me what appointments are scheduled? Who is it with? If it is a lab/test, what is it for? When is it? Are you going to be able to make it to your appointment?
 - Yes - Continue.
 - No - Help with the issues or get appointment rescheduled.

Note: If there is no appointment scheduled already, set up an appointment based on the discharging provider's request and according to the usage grid.

- Please remember to bring all your medications, including non-prescription medicines and herbal supplements, with you to your visit.

MEDICATIONS:

- What questions do you, your family, or caregiver have regarding your medications?

EDUCATION PROVIDED:

- Do you have any other questions for me?

ADDITIONAL ACTIONS TAKEN:

Adapted from [Project RED](#)

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Follow-up Script for Non-Clinical Staff from “Reducing Readmissions: Care Transitions Toolkit”

Tool 10.2: Follow-up Call by Non-Clinical Staff

Hello Mr. (Ms. _____) I am (caller's name), a (title) from (name of facility). I am calling to see how you are doing after your discharge and if there is anything I can do to help you.

FOLLOW-UP:

- Can you please tell me what appointments are scheduled? Who is it with? If it is a lab/test, what is it for? When is it? Are you going to be able to make it to your appointment?
 - Yes - Continue.
 - No - Help with the issues or get appointment rescheduled.

Note: If there is no appointment scheduled already, set up an appointment based on the discharging provider's request and according to the triage grid.

- Please remember to bring all your medications, including non-prescription medicines and herbal supplements, with you to your visit.

WARNING SIGNS:

- What did the medical team tell you to watch out for to make sure you are okay?
- Do you have any questions about what to do if a problem arises?
 - Yes - Continue.
 - No/Have questions - Refer to a clinician.

HEALTH CARE STATUS:

- Before you left the hospital, someone spoke to you about your main problem during your hospital stay. Can you explain to me your main problem or diagnosis?
 - Yes - Continue.
 - No - Refer to a clinician.
- Since you left the hospital, do you feel your main problem has improved, worsened or not changed? What does your family or caregiver think?
 - Worsened - Refer to a clinician.
 - Improved/No change - Continue.

Have any new medical problems occurred since you left the hospital?

- Yes - What has happened? Refer to a clinician.
- No - Continue.

MEDICATIONS:

- What questions do you/your family or caregiver have regarding your medications? (Refer to a clinician if there are questions)

EDUCATION PROVIDED:

- Do you have any other questions that I can forward to the clinical team?

ADDITIONAL ACTIONS TAKEN:

Adapted from [Project RED](#)

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Patient, Family, and Caregiver Support

- Care Transitions provide an opportunity to:
 - Assess and educate
 - Provide coaching and health promotion
 - Review and revise the HAP to support the client and others in meeting their client-centered goals
 - Improve health literacy and activation

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“Teach Back”

Literature shows “**Teach Back**” is one of the most effective methods for educating patients. Teach Back involves asking the patient, family, or caregiver to recall and restate in their own words what they thought they heard during education or other instructions.

Be aware of the client or caregiver activation level when teaching or using “teach back” techniques.

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Teach Back Training Resource:

<http://www.teachbacktraining.org/>

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Other Care Coordination Services

- Patient and caregiver education and health promotion
 - Consider the PAM, PPAM, and CAM level
- Family and caregiver support
- Referral to social and other services
- Comprehensive care coordination
 - Administer screening tools
 - Review and revise the HAP

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Summary

Consider the NEMT program when coordinating visits with your client for the purposes of Health Home services

Review the six strategies when working with your client on care transitions

Comprehensive Care Transitions provides the greatest opportunity for reducing costs and improving outcomes for our clients

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- Topic: Medicaid 101

Make your reservation now at:

<https://attendee.gotowebinar.com/rt/2336104130912005121>

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Certificate of Completion

Non-Emergency Medical Transportation for Health Home Clients

presented by RosaMaria Espinoza and Stephen Riehl
Program Managers for the Washington State Health Care Authority

Comprehensive Care Transitions

presented by Cathy McAvoy
Health Homes Program Manager
Integration Services – DSHS

*Webinar aired on: May 14, 2015 in Lacey, Washington
for Health Home Care Coordinators*

Please sign and date this slide to attest that you reviewed this training PowerPoint

Your Signature

Date

Supervisor's Signature

Date

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Post Webinar Discussion

- What experience have you had working with clients as they discharge from hospitals, nursing facilities, or other institutions?
- What approaches have you used to work successfully with discharge planners? LTSS case managers? Behavioral health providers? Other medical and social service providers?
- How have you enlisted the support of others in preparing and executing successful discharges? Do you participate in Interdisciplinary Care Teams?
- Where do you go to research resources for your clients?