Health Home Program
Washington

Health Home Services

1. Comprehensive Care Management

Health Home Care Coordinators deliver comprehensive care management, primarily in person with periodic follow-up. Care management services include state approved screens and development of a person-centered Health Action Plan (HAP). Care Coordinators provide continuity and coordination of care through face-to-face visits and telephonic support. Care Coordinators assess beneficiary readiness for self-management and promote self-management skills so the beneficiary is better able to engage with health and service providers. By working with beneficiaries, Care Coordinators support the achievement of self-directed, person-centered health goals designed to attain recovery, improve functional or health status, or prevent or slow declines in functioning.

The initial HAP is developed in collaboration with the client and may include parents, family members, caregivers, legal representatives, and other collaterals. The HAP establishes a long-term goal, a short-term goal or goals, and action steps to achieve these goals.

Screens include clinical and functional screens, including depression, alcohol or substance use disorder, functional impairment, falls risk, and pain, appropriate to the age and risk profile of the beneficiary. Screens support referrals to services when needed such as specialty care and and/or long-term services and supports. The beneficiary's activation level is reassessed at least once during each four-month activity period while receiving health home services.

Other screens and assessments that may supplement comprehensive care management are Medicaid managed care organizations' contractually required health risk assessments for beneficiaries with special health care needs, mental health treatment plans, substance use disorder treatment plans, and/or other pre-existing care plans.

Care Coordinators offer beneficiaries the opportunity to consider and discuss advance care planning. The Care Coordinator may assist the beneficiary to access legal assistance to develop advance directives.

Health Home services do not duplicate other services, such as case management. Care Coordinators bridge the beneficiary's services across multiple settings to ensure access and coordination of needed medical, behavioral, and social support services.

2. Care Coordination

The Care Coordinator plays a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. Care

Coordinators have the ability to accompany beneficiaries to health care appointments as needed. The Care Coordinator fosters communication between care providers including primary care providers, medical specialists, and entities authorizing behavioral health and Long Term Services and Supports (LTSS). Care coordination bridges all of the beneficiary's systems of care, including non-clinical support such as food, housing, legal services, and transportation.

When providing intensive care coordination to the beneficiary, the Care Coordinator caseload is maintained at a level that ensures fidelity in providing required health home services. Community Health Workers, peer counselors, wellness or health coaches, and other non-clinical staff are used to provide outreach, engagement, and support under the direction and supervision of the Care Coordinator.

Care coordination shall provide informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors that impact a beneficiary's health and health care choices. Joint office visits by the beneficiary and the Care Coordinator with health care providers offer opportunities for mentoring and modeling communication with providers. Care Coordinators may establish multidisciplinary care teams or participate on an existing team. Their participation aids to better coordinate services, identify and address gaps in care, and ensure cross-systems coordination to ensure continuity of care.

Care Coordinators will promote:

1) optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the HAP;
2) outreach and engagement activities that support the beneficiary's participation in their care and promote continuity of care; and
3) use of peer supports, support groups, and self-care and self-management programs to increase the beneficiary's knowledge about their health conditions and improve adherence to prescribed treatments and medications.

The HAP is reviewed and revised during each four-month activity period or as needed to address the achievement of goals and action steps and changes in the client's self-management of their chronic conditions. Screening assessments are offered and administered during each activity period.

3. Health Promotion

Health promotion begins for health home beneficiaries with the commencement of the HAP. Health education and coaching is designed to assist beneficiaries to increase self-management skills and improve health outcomes. Each Washington health home must demonstrate use of self-management, recovery, and resiliency principles using person-centered supports including family members and paid and unpaid caregivers. The Care Coordinator uses the beneficiary's activation score and level to determine the coaching methodology for each beneficiary to

develop a teaching and support plan. Educational materials are customized and introduced according to the beneficiary's readiness for change and progress with a beneficiary's level of confidence and self-management abilities. The health home will provide wellness and prevention education specific to the beneficiary's chronic conditions and HAP. Health promotion and education includes assessment of need, facilitation of routine and preventive care, support for improving social connections to community networks, and linking beneficiaries with resources that support a health promoting lifestyle. Linkages include but are not limited to resources for smoking prevention and cessation, substance use disorder prevention, nutritional counseling, obesity prevention and reduction, physical activity, disease specific or chronic care management, self-help resources, and other services. Health promotion and education may also occur with parents, family members, caregivers, legal representatives, and other collaterals to support the beneficiary in achieving improved health outcomes.

4. Comprehensive Transitional Care

Comprehensive transitional care is provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment, or residential habilitation setting) and to ensure proper and timely follow-up care.

The beneficiary's HAP includes transitional care planning. Transitional care planning includes:

1) A notification system with managed care plans, hospitals, nursing facilities, and residential/rehabilitation facilities to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient facility, skilled nursing or residential/rehabilitation facility, and with proper, permissions, a substance use disorder treatment setting. Progress notes or a case file will document the notification. The HAP is updated as a part of transition planning.

2) Active participation of the Care Coordinator in all phases of care transition including: discharge planning visits during hospitalizations or nursing facility stays, post discharge face-to-face visits, and telephone calls.

3) Beneficiary education to support discharge care needs including: medication management, follow-up care, and self-management of chronic or acute conditions. Information on when to seek medical care and emergency care is also provided. Involvement of formal or informal caregivers is facilitated when requested by the beneficiary.

4) A systematic follow-up protocol to assure timely access to follow-up care post discharge and to identify and re-engage beneficiaries that do not receive post discharge care.

5) Medication reconciliation prior to or soon following discharge to the community or other setting.

5. Individual and Family Support

The Care Coordinator recognizes the unique role the beneficiary may give family members, identified decision makers, and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

Peer supports, support groups, and self-management programs are used by the Care Coordinator to increase beneficiary and caregiver knowledge of the beneficiary's chronic conditions, promote the beneficiary's engagement and self-management capabilities, and help the beneficiary improve adherence to their prescribed treatment.

The Care Coordinator will:

1) identify the role that parents, family members, informal supports, and paid caregivers provide to the beneficiary to achieve self-management and optimal levels of physical and cognitive function;
2) educate and support self-management, self-help, and recovery by accessing other resources necessary for the beneficiary, their family, and their caregivers;
3) discuss advance care planning with beneficiaries and their families;
4) communicate and share information with beneficiaries, their families, and their caregivers with appropriate consideration of language, activation level, literacy, and cultural preferences.

6. Referral to community and social support services

The Care Coordinator identifies available community based resources and actively manages referrals. They assist the beneficiary in advocating for access to care and promote engagement with community and social supports related to goal achievement documented in the HAP. When needed and not provided through other case management systems, the Care Coordinator provides assistance to obtain and maintain eligibility for health care services, Medicaid, disability benefits, housing, personal needs, and legal services. These services are coordinated with appropriate departments of local, state, and federal governments, and community based organizations. Referral to community and social support services includes LTSS, mental health, substance use disorder, and other community and social service support providers needed to support the beneficiary in achieving health action goals.

The Care Coordinator documents referrals to and access by the beneficiary of community and other social support services.