

DRAFT

Washington State Health Home Essential Requirements

Under Washington State's approach, health homes are the bridge to integrate care within existing care systems. A health home is the central point for directing patient-centered care and is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up; and improving patient outcomes by mobilizing and coordinating primary medical, specialist, behavioral health and long-term care services and supports. Care Coordinators must be embedded in community based settings to effectively manage the full breadth of beneficiary needs.

Health Home Network - The network must include local community agencies that authorize Medicaid, state or federally funded mental health, long-term services and supports, chemical dependency and medical services. If the qualified Health Home supports managed care beneficiaries, the network must include one or more of the five Healthy Options managed care organizations. Other examples of providers are Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, Substance Use Disorder providers, Hospitals, Public Health Districts, Accountable Care Organizations, Medical Homes, Charities, Network Alliances, and community supports that assist with housing.

The Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) have identified specific administrative functions for both lead entities and care coordination organizations. However, our intent is to assure that these functions are accounted for in the Health Home qualification process and documented in signed contracts and subcontracts. We are not restricting the accountability of the administrative functions. A qualified Health Home may base those functions on their organizational structure.

Lead Entity Requirements – The lead entity is accountable for administration of the health home. The lead entity:

1. Experience operating broad-based regional provider networks;
2. Contracts directly with the state as a Qualified Health Home;¹
3. Provides a toll-free line and customer service representatives to answer questions regarding health home enrollment, disenrollment and how to access services or request a change to another care coordination organization;
4. ²Subcontracts with organizations to directly provide the Health Home care coordination services;

¹ Healthy Options MCOs may also serve as Lead Entities as long as the network is qualified by the state. The state's current Healthy Options contract will suffice as the Health Home contract.

² Contractual relationships between the lead entity and their Care Coordination partners must be developed and in place prior to enrollee assignment.

5. Assigns Health Home beneficiaries to care coordination organizations, using a smart assignment process, whenever possible. A Smart assignment process:
 - Uses PRISM or other data systems to match the beneficiary to the care coordination organization that provides most of their services; or
 - Optimizes beneficiary choice;
6. Maintains a list of care coordination organizations and their assigned Health Home population;
7. Maintains Memorandums of Agreement (MOA) with the organizations that are part of the Health Home network. At minimum, MOAs will be executed with organizations that authorize Medicaid services to ensure coordination of care is achieved. MOAs will contain information related to beneficiary privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.
8. Collects and reports encounters;
9. Disburses payment to Care Coordination organizations based upon encounters;
10. Ensures person-centered and integrated health action planning including the provision of high touch care management; such as the beneficiary to care coordinator ratio and documentation of support staff that compliments the work of a care coordinator;
11. Ensures standards are met;
12. Collects, analyzes and reports financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals.

Care Coordination Organization Requirements – The Care Coordination Organization must:

1. Subcontract with the Lead Entity;
2. Hire enough Health Home Care Coordinators to maintain the beneficiary to care coordinator ratio of 50 to one.
3. Assign a Health Home Care Coordinator to provide health home services;
4. Document when staff are complimenting the work of a care coordinator by providing in-direct care coordination support;
5. Implement a systematic 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;
6. Establish methods to share hallmark events with the Health Home Care Coordinator within established time periods, such as emergency room visits, inpatient hospitalizations, inpatient discharges, missed prescription refills, institutional placement and/or discharge, and the need for preventive care;
7. Use a system to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate recommended changes in care, as necessary, to address achievement of health action goals including the beneficiaries preferences and identified needs³;
8. Provide 24/7 availability of information and emergency consultation services to the beneficiary;

³ Preferences means an informed decision, input into a decision and decisions that have value to the beneficiary.

9. Assure that hospitals have procedures in place for referring health home-eligible beneficiaries who seek or need treatment in a hospital emergency department for health home enrollment;
10. Use informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors impacting health and health care choices; and
11. Provide health home services in a culturally competent manner that addresses health disparities. Examples of cultural competency:
 - Interacting directly with the beneficiary and their families by speaking their language,
 - Recognizing and applying cultural norms when creating the Health Action Plan,
 - Understanding the dynamics of substance use disorder without judgement,
12. Ensure that Health Home Care Coordinators (within the care coordination organization) can discuss with the treating/authorizing entities on an as needed basis, changes in patient circumstances, condition or health action plan that may necessitate timely, and in some circumstances, immediate changes in treatment or services;
 - A data sharing agreement that conforms to HIPAA requirements must be in place when sharing either hard copy or electronic health information.
 - The Health Home beneficiary must sign a “Health Home Patient Information Sharing Consent Form” before the Health Home Care Coordinator can share protected health information with other health care professionals and caregivers.
13. Ensure that Health Home Care Coordinators have access to PRISM, a clinical decision support tool, to view cross-system health and social service utilization to identify care opportunities;
14. Ensure that Health Home Care Coordinators provide in-person beneficiary health screening and health action planning, using HCA and ADSA standardized and approved;
15. Ensure that Health Home Care Coordinators accompany the beneficiary to critical appointments when necessary to assist in achieving health action goals;
16. Ensure that Health Home Care Coordinators actively engage the beneficiary in developing a health action plan;
17. Ensure that Health Home Care Coordinators coordinate and mobilize treating/authorizing entities as necessary to reinforce and support the beneficiary’s health action goals;
18. Ensure that Health Home Care Coordinators deliver culturally appropriate interventions, educational and informational materials;
19. Ensure that Health Home Care Coordinators maintain a caseload not to exceed 50:1. The caseload may be adjusted when community health workers, peer counselors or other non-clinical staff is used to facilitate the work of the assigned care coordinator.
20. Ensure that Health Home Care Coordinators provide in-person care coordination activities.
21. Ensure that Health Home Care Coordinators include and leverage direct care workers (paid and unpaid) who have a role in supporting beneficiaries to achieve health action goals and access health care services;
22. Ensure that Health Home Care Coordinators address the full array of beneficiary needs, as reflected in the implementation of a person-centered health action plan. This includes administering standardized health screening, identifying the root causes for inappropriate or gaps in health care utilization and making referrals and coordinating communication across systems of care.