DRAFT
Washington State Health Home
Essential Requirements

7/10/2012

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

1. Identify a lead entity, accountable for administration of the health home;
    a. Administration includes:
        i. Payment disbursement, quality monitoring, contracting, reporting and ensuring standards are met;
        ii. Collecting, analyzing and reporting financial, health status and performance and outcome measures to objectively determine progress towards meeting Health Home goals;
2. Target interventions to high risk/high cost beneficiaries and support the beneficiary through assignment of a care coordinator;
3. Include local community agencies that authorize Medicaid, state or federally funded mental health, long-term services and supports, chemical dependency and medical services. For example, Regional Support Networks (RSNs), Community Mental Health Agencies (CMHAs), Area Agencies on Aging, Substance Use Disorder providers, and community supports that assist with housing;
4. 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;
5. Accountable for addressing the full array of beneficiary needs, as reflected in the implementation of a person-centered health action plan.
6. Assure that the care coordinator 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;
7. 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;
8. Establish methods to share real time data on emergency room visits, inpatient hospitalizations, missed prescription refills and the need for evidence-based preventive care with the care coordinator;

9. Use a system to track and share beneficiary information and care needs across providers, to monitor processes of care and outcomes, and to initiate changes in care, as necessary, to address beneficiary need and preferences;
10. Provide 24/7 availability of information and emergency consultation services to the beneficiary;
11. 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; and
12. Use evidence-based/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.

Care Coordinator Functions:

1. Use a clinical decision support tool (PRISM) to view cross-system health and social service utilization to identify care opportunities;
2. Provide in-person beneficiary health assessments;
3. Accompany the beneficiary to critical appointments;
4. Actively engage the beneficiary in developing a health action plan;
5. Coordinate and mobilize treating/authorizing entities as necessary to reinforce and support the beneficiary's health action goals;
6. Deliver culturally appropriate interventions, educational and informational materials; and
7. 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.