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|  | Health Home Care Coordinator’s Checklist |
| 🞏 | Receive assigned client from the Lead Organization |
| 🞏 | Review assigned client in PRISM and other records and databases |
| 🞏 | Contact client to engage in Health Home Services and arrange first face-to-face visit   * Fill out referral for Non-Emergency Medical Transportation and submit to local Medicaid broker if client needs transportation to meet outside of residence to participate in the program |
| 🞏 | Provide Tier 1 services with a face-to-face visit to develop the initial Health Action Plan (HAP)   * Administer required screening * Administer optional screenings as indicated * Obtain signature on the Participation Authorization and Information Sharing Consent form and other specialized releases as needed * Discuss advance care planning with client and/or family (must be completed within first year of engagement) * Establish long term goal and short term goal(s) with associated action steps |
| 🞏 | Establish follow up plan with the client, family, caregiver, and other health and social service providers as indicated on the HAP. Complete face-to-face, telephonic, or other contacts as needed. |
| 🞏 | Provide ongoing Tier Two or Tier Three Health Home Services according to the HAP each month as appropriate and document contact(s) and service(s) provided:   * Comprehensive Care Management * Care Coordination * Transitional Care Services with each in patient admission or emergency department visit * Individual and Family Support * Referral to Community and Social Support Services * Health Promotion |
| 🞏 | Update HAP at least every trimester (four-month activity period) and more frequently  as needed and administer required and optional screenings |
| 🞏 | Review documentation by allied staff (e.g. Peer Support Specialists, Wellness Coaches, Community Connectors, Community Health Workers, etc.) to determine if revisions are needed to the HAP. Consult with client as needed to review and revise the HAP. |
| 🞏 | Educate client, family, and other collaterals about eligibility for the Advanced Home Care Aide Specialist Pilot or the Community Integration in Adult Family Home Program and assist with accessing these special benefits. Document collaboration with appropriate case managers. |
| 🞏 | Participate on or organize a multidisciplinary care team and coordinate meetings as needed |
| 🞏 | Complete comprehensive transitional care activities following in-patient admission or emergency department care |