

Ohio Medicaid Health Homes – Service Definitions
DRAFT: September 7, 2011

Health Home Service	Definition
Comprehensive Care Management	<ul style="list-style-type: none"> • Identification of consumers who are potentially eligible for health home services: <ul style="list-style-type: none"> ○ Health Home invites qualified patients affiliated with practice ○ MCP/administrator identifies patients without regular source of care using predictive modeling & sends list to Health Home site to recruit patients ○ Complete a standardized health risk assessment to document conditions/severity that may qualify someone for health home participation • Recruit and engage consumers through discussing the benefits and responsibilities of participating and any incentives for active participation and improved health outcomes. • Conduct comprehensive health assessment <ul style="list-style-type: none"> ○ Physical/functional, medical history, psychological, behavioral (developmental, substance abuse and mental health), co-occurring conditions, environmental/residential, family, legal status (guardianship and/or criminal legal status, e.g. incarcerations, probation, parole, NGRI), financial status (payeeship), educational status, occupational & vocational functioning, military service, cultural spiritual/religious needs, assistive technology needs, hobbies/recreational/leisure activities, preferences, access to community resources for food, housing etc., support system, self care capabilities, health literacy, transition/discharge plan, child care, transportation capability/constraints, etc. ○ Use of data from multiple sources – medical records, administrative data, consumer/family, physicians, providers, and other members of team of health care professionals. • Form a team of health care professionals to deliver Health Home services based on the consumer’s needs. Establish and negotiate roles and responsibilities, including the accountable point of contact. • Develop/update care treatment plan <ul style="list-style-type: none"> ○ Identification and prioritization of problems based on information in the comprehensive health assessment that would benefit from interventions. ○ Agreement among team of health care professionals with the active involvement of the consumer and/or their family about the immediate, short term, and long term issues that should be addressed and desired health outcomes. All team members, including the consumer, should have an opportunity to participate in development of care treatment plan. ○ Establish goals and actions with timeframes for completion. ○ Develop a communication plan with the consumer, primary care provider and team of health care professionals.

Health Home Service	Definition
	<ul style="list-style-type: none"> ○ Identification of providers who are responsible for delivering services. ○ Develop a crisis management and contingency plan working with the consumer, family and significant other to coordinate and assist in crisis management and stabilization as needed.
Care Coordination	<ul style="list-style-type: none"> ● Implementation of individualized care treatment plan ● Assist consumer in obtaining health care (preventive, acute and chronic long-term care services), including mental health, substance abuse services and developmental disabilities services, ancillary services and supports, including referrals to providers for services and supports not offered by the health home. This includes assistance with contacting the agency or provider, making an appointment, and validating that the consumer received the service. ● Medication management, including reconciliation. ● Track tests and referrals and follow up as necessary. This includes exchanging information between the lab/provider and the Health Home. ● Coordinate, facilitate, and collaborate with consumer, family, team of health care professionals, providers, institutional facilities, long term care providers, etc. This includes discharge planning or developing a transition plan between care settings. ● Develop a crisis management and contingency plan working with the individual, family and significant other. Coordinate and assist in crisis management and stabilization as needed. ● Assist consumer in obtaining referrals to community, social, and recovery supports, making appointments and validating that consumer received service. ● Monitor care treatment plan <ul style="list-style-type: none"> ○ Monitor utilization and adherence to clinical care guidelines, medication regimes, etc. ○ Monitor services and providers identified in the care plan to ensure that the plan is being implemented as written. ○ Monitor the individual's progress in achieving goals and objectives/anticipated outcomes as documented on the care plan. ● Monitor the individual's status in relation to his or her care plan goals to identify when a change in symptoms/health status, transition across settings, barriers to care, etc. indicates a need for a clinical review and/or update of the individual's health assessment and care plan. ● Reassess the consumer at least once every 90 days to determine if a change is needed in the treatment plan, whether HH services are still needed or if there is a change in health status.

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	<ul style="list-style-type: none"> • Provide clinical summaries, consumer information, etc. along with routine reports of treatment plan compliance to the team of health care professionals, including consumer/family.
Health promotion	<ul style="list-style-type: none"> • Provide education to the consumer and his/her family/guardian/significant other that is specific to his/her needs as identified in the assessment (e.g., chronic disease management, living with SPMI, health and social consequences of substance use/abuse) • Assist the consumer to acquire symptom self-monitoring and management skills so that the consumer learns to identify and minimize the negative effects of the chronic illness that interfere with his/her daily functioning. • Provide or connect the consumer with services that promote healthy life-style and wellness and are evidence-based such as Smoking Cessation, certified Chronic Disease Self-Management Programs, Nutrition, Physical Exercise, Wellness Management and Recovery (WMR), Wellness Recovery Action Plan (WRAP), and Advance Directives (Medical and Psychiatric). • Actively engage the consumer in developing and monitoring the care treatment plan • Connect consumer with peer supports including self help/self management and advocacy groups. • Develop a consumer specific self management plan anticipating possible occurrences or reoccurrences of situations requiring an unscheduled visit to Health Home or emergency assistance in a crisis • Population management – use clinical and consumer data to remind consumers about services needed for preventive/chronic care. • Promote healthy behaviors and good lifestyle choices. • Educate consumer about accessing care in appropriate settings.
Transition of care	<ul style="list-style-type: none"> • Health Home will coordinate with providers, facilities and manage care transitions (inpatient to inpatient, residential, community settings) to prevent unnecessary inpatient admissions, inappropriate emergency department use, and other adverse outcomes, such as homelessness • The development of a comprehensive discharge and/or transition plan with short term and long term follow up. If possible, the items will be arranged and scheduled prior to discharge. • Clinical hand offs: face to face interactions between providers to exchange information and ask questions

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Individual and family supports	<ul style="list-style-type: none"> • Provide expanded access and availability. • Provide continuity in relationships between consumer/family with physician and care manager. • Outreach to the consumer and their family and perform advocacy on their behalf to identify and obtain needed resources such as medical transportation and other benefits to which they may be eligible. • Educate the consumer in self management of their chronic condition. • Educate the family on how they can assist the consumer in self management of their chronic condition. • Provide opportunities for the family to participate in assessment and care treatment plan development. • Ensure that HH services are delivered in a manner that are culturally and linguistically appropriate • Referral to community supports. • Assist with “natural supports”, such as local faith-based and/or community-based organizations • Promote personal independence • Empower the consumer to improve their own environment. • Include the consumer family in the quality improvement process (including surveys used to capture experience with health home services) • Use of a Patient/Family Advisory Council at the Health Home site • Allow consumers/families to access electronic health record information or other clinical information.
Referrals to community and social supports	<ul style="list-style-type: none"> • Provide referrals to community/social/recovery support services. Examples include: maintaining eligibility for Medicaid health care, applying for disability benefits, obtaining legal assistance, seeking safe and affordable housing, faith based organizations, vocational services, etc. • Assist consumer in making appointments. Validate that the consumer attended the appointment and the outcome of the visit and any needed follow up.