

Exhibit D

Health Homes

1 Health Homes Definitions

- 1.1. “Aging and Long-Term Support Administration (AL TSA)” means the administration within the Department of Social and Health Services, which is responsible for providing long-term services and supports to individuals who are functionally and financially able to receive such services.
- 1.2. “Area Agency on Aging (AAA)” means a network of State and local programs that help older people to plan and care for their life long needs. AAA’s were created under the Older Americans Act of 1965.
- 1.3. “Authorizing Entity” means an organization contracted by the State to approve or disapprove covered benefits for Medicaid beneficiaries following utilization guidelines. Examples include Managed Care Organizations, Regional Support Networks, Home and Community-based Services Providers.
- 1.4. “Behavioral Health and Service Integration Administration (BHSIA)” means the administration within the Department of Social and Health Services responsible for service integration delivery and is responsible for providing mental health and chemical dependency services to individuals who are functionally and financially able to receive such services.
- 1.5. “Behavioral Health Services” means services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.
- 1.6. “Participant” means an individual who is eligible for Health Home Services based upon at least one chronic condition and being at risk of a second, determined by a predictive risk score of 1.5 or higher.
- 1.7. “Participant Assignment” means the process used to determine which Health Home Care Coordination Organization is responsible for delivering the six Health Home care coordination services to the enrollee.
- 1.8. “Broad-based Regional Provider Networks” mean community entities composed of a broad array of service providers that are responsible to serve all beneficiaries in a defined geographical area.
- 1.9. “Care Coordination Organization (CCO)” means an organization within the Qualified

Health Home network that is responsible for delivering the six Health Home services to the participating enrollee.

- 1.10. “Caregiver Activation Measure (CAM)” is an assessment that gauges the knowledge, skills and confidence essential to providing care for a person with chronic conditions. The CAM assessment segments caregivers into one of four progressively higher activation levels. Each level addresses a broad array of behaviors and offers deep insight into the characteristics that drive caregiver performance.
- 1.11. “Chronic Condition” means a physical or behavioral health condition that is persistent or otherwise long lasting in its effects.
- 1.12. “Comprehensive Assessment Report and Evaluation (CARE)” means a person centered, automated assessment tool used for determining Medicaid functional eligibility, level of care for budget and comprehensive care planning, as defined in chapter 388-106 WAC or any successor provisions thereto.
- 1.13. “Coverage Area(s)” means pre-determined geographical areas composed of specific counties developed to manage a phased-in implementation of Health Homes.
- 1.14. “Contract” or “Agreement” means the entire written agreement between HCA and the Contractor, including any Exhibits, attachments, documents, or materials incorporated by reference. The parties may execute this Contract in multiple counterparts, each of which is deemed an original and all of which constitutes as one agreement. E-mail (electronic mail) or fax (facsimile) transmission of a signed copy of this Contract shall be the same as delivery of an original.
- 1.15. “Department of Social and Health Services (DSHS)” means the Washington State Department of Social and Health Services, the state agency responsible for providing a broad array of healthcare and social services.
- 1.16. “Designated Staff” means either the Contractor’s employee(s) or employee of any Subcontractor or employees of any Health Home Provider with whom the Contractor has a MOA to provide Health Home Services to the Contractor’s enrollees and whom have been authorized by their employer to access Data.
- 1.17. “Dual Eligible” means individual who is enrolled in Medicare Part A and B and who is also eligible for and receiving Medicaid. Such individuals have no other comprehensive private or public health coverage.
- 1.18. “Dual Eligible Beneficiary or Participant” means a Medicare managed care recipient who is also eligible for Medicaid, and for whom the State has a responsibility for payment of cost sharing obligations under the Washington State Plan.

- 1.19. “Developmental Disabilities Administration (DDA)” means the administration within the Department of Social and Health Services that provides services to individuals with disabilities who are functionally and financially determined to receive such services.
- 1.20. “Federally Qualified Health Center” means a community-based organization that provides comprehensive primary care and preventive care, including health, dental and mental health/substance abuse services to people of all ages, regardless of their ability to pay or health insurance status.
- 1.21. “Fee-For-Service (FFS)” means the Medicaid delivery system that provides covered Medicaid benefits to eligible beneficiaries through any willing and contracted provider. Providers are paid on a per service basis.
- 1.22. “Full Dual Eligible” means a Beneficiary or Participant who is eligible for the full scope of Medicare and Medicaid covered benefits.
- 1.23. “Hallmark Events” means elevated episodes of care that have potential to seriously affect the enrollee’s health or health outcomes.
- 1.24. “Health Action Plan” means an enrollee-prioritized plan identifying what the enrollee plans to do to improve his or her health. The health action plan should contain at least one enrollee-prioritized goal; identify what actions the enrollee is taking to achieve the goal(s); and includes the actions of the care manager, including use of health care or community resources and services that support the enrollee’s action plan.
- 1.25. “Health Home” means an entity composed of community-based providers, qualified by the state to provide Health Home Services to Medicaid enrollees. The entity is responsible for coordinating and integrating care across the continuum of services needed and used by eligible enrollees. Each Health Home acts as the lead entity responsible for administrative and oversight functions and includes broad representation of community-based organizations representing primary, acute, mental health, substance use disorder and long term services and supports that provide intensive care coordination to eligible enrollees. A Qualified Health Home includes providers from the local community that authorize Medicaid, state or federally funded behavioral health, long term services and supports, and primary and acute services.
- 1.26. “Health Home Care Coordinator” or “Care Coordinator” means an individual employed or contracted by the Health Home Care Coordination Organizations that provides or oversees Health Home services. Services are delivered or overseen by registered nurses, licensed practical nurses, Physician's Assistants, BSW or MSW prepared social workers, and Chemical Dependency Professionals.
- 1.27. “Health Home Enrollee Information Sharing Consent Form” means a release form

signed by the enrollee to authorize the release of information to facilitate the sharing of the enrollee's health information with the enrollee's health and social services team.

- 1.28. "Health Home Provider Business Associate (HHPBA)" means a Health Home Provider with whom HCA has a Business Associate Agreement.
- 1.29. "Health Home Services" means a group of six services defined under Section 2703 of the Affordable Care Act. Health Home Services are:
 - 1.29.1. Care Coordination and Health Promotion
 - 1.29.2. Comprehensive Care Coordination
 - 1.29.3. Individual and Family Support
 - 1.29.4. Transitional Care
 - 1.29.5. Referral to Community and Social Support Services
 - 1.29.6. Health Information Technology
- 1.30. "Intensivist" means a physician or osteopathic physician who specializes in the care of critically ill patients.
- 1.31. "Long Term Services and Supports (LTSS)" means the variety of services and supports that help people with functional impairments meet their daily needs for assistance in community-based settings and improve the quality of their lives. Examples include: Personal care assistance with daily activities such as bathing, dressing and personal hygiene in in-home and licensed community residential settings; home delivered meals; personal emergency response systems; adult day services; environmental modifications; and other services designed to divert individuals from nursing facility care. LTSS also includes services provided in licensed nursing facilities. LTSS are provided either in short periods of time when recovering from an injury or acute health episode or over an extended period.
- 1.32. "Memorandum of Agreement (MOA)" means a business agreement for partnerships that do not involve a financial arrangement that describe the roles and responsibilities of each party to the agreement.
- 1.33. "Multidisciplinary Team" means a group of clinical and non-clinical staff, such as primary care providers, mental health professionals, chemical dependency treatment providers, and social workers, community health workers, peer counselors or other non-clinical staff that facilitates the work of the Care Coordinator. Optional team members may include nutritionists/dieticians, direct care workers, pharmacists, peer specialists, family members or housing representatives.

- 1.34. “Outpatient Intensivist Team (OIT)” means a community-based clinical team with specialized training to provide intensive primary care to cohorts of complex patients at risk for unnecessary hospitalizations and emergency department visits. The OIT is comprised of a nurse practitioner (lead), nurse, social worker/behavioral health counselor, and community health worker and is supported by clinical specialists via Project ECHO.
- 1.35. “Participation” means agreement by the enrollee to take part in Health Home Services as demonstrated by the Health Action Plan.
- 1.36. “Patient Activation Measure (PAM)” means an assessment that gauges the knowledge, skills and confidence essential to managing one’s own health and health care. The PAM assessment categorized consumers into one of four progressively higher activation levels. A PAM score can also predict healthcare outcomes including medication adherence, ER and hospital utilization.
- 1.37. “Patient Protection and Affordable Care Act” means Public Laws 111-148 and 111-152 (both enacted in March 2010).
- 1.38. “Project ECHO™ (ECHO)” means the Extension for Community Health Outcomes model of clinical mentorship, specialty training, and outcomes measurement. ECHO provides on demand training and specialty consultation (via voice, video, and in-person) to OITs managing cohorts of complex patients.
- 1.39. “PRISM User Coordinator” means the employee appointed by the Contractor to be the point of contact for HCA and DSHS's PRISM Administration Team.
- 1.40. “Regional Support Network (RSN)” means a county authority or group of county authorities or other entity recognized by the secretary of the Department of Social and Health Services to administer mental health services in a defined region.
- 1.41. “Research and Data Analysis (RDA)” means the division of DSHS that supports analyses of client counts, caseloads, expenditures and use rates within and between DSHS services and programs
- 1.42. “Successor” means any entity which, through amalgamation, consolidation, or other legal succession becomes invested with rights and assumes burdens of the original Contractor.
- 1.43. “Vendor” means a dealer, distributor, merchant, or other seller providing goods or services that are required for the conduct of a federal program. These goods or services may be for an organization's own use or for the use of beneficiaries of the federal program. See OMB Circular A-133 for additional details.

2 Health Home Services for Healthy Options Enrollees

- 2.1 The Contractor shall provide Health Home services in addition to those described in Section 13 of this Contract, Care Coordination, to high cost, high needs enrollees. Health Home services shall be community-based, integrated and coordinated across medical, mental health, chemical dependency and long-term services and supports to eligible enrollees based on the services described in Section 1945(h)(4) of the Social Security Act. The Contractor shall ensure that the following are operational:
 - 2.1.1 The ability to submit completed and updated Health Action Plan (HAP) data through the *OneHealthPort* Health Information Exchange. The HAP data will be stored in a Medicaid data base for evaluation purposes;
 - 2.1.2 A system to track and share enrollee information and care needs among 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 enrollee's preferences and identified needs;
 - 2.1.3 Enrollee access to toll-free line and customer service representatives to answer questions, with minimum coverage 8:00 to 5:00 from Monday through Friday regarding Health Home enrollment, disenrollment and how to access services or request a change to another Care Coordination Organization;
 - 2.1.4 A system for emergency consultation and general information available 24/7;
 - 2.1.5 Policies, procedures and agreements with hospitals for transitioning care and referring eligible enrollees who seek or need treatment in a hospital emergency department for Health Home enrollment;
 - 2.1.6 A list of subcontracted CCOs and their assigned Health Home enrollees, regularly updated;
 - 2.1.6.1 PRISM Registration: Each Designated Staff person shall complete the PRISM Registration form available at: PRISM.admin@dshs.wa.gov and submit it to the Contractor's PRISM User Coordinator along with a Nondisclosure of HCA Confidential Information form.
 - 2.1.7 Policies and procedures that support care coordination interventions to:
 - 2.1.7.1 Maintain frequent, in-person contact between the enrollee and the Care Coordinator when delivering intensive care coordination services;

- 2.1.7.2 Ensure availability of support staff to complement the work of the Care Coordinator;
 - 2.1.7.3 Support screening, referral and co-management of individuals with both behavioral health and physical health conditions; and
 - 2.1.7.4 Ensure an appointment reminder system is in place for enrollees.
- 2.1.8 Identification and actions to address enrollee gaps in care through:
- 2.1.8.1 Assessment of existing data sources (e.g., PRISM, CARE, etc.) for evidence of the standard of care for and preventive care appropriate to the age and the enrollee's underlying chronic conditions;
 - 2.1.8.2 Evaluation of client perception of gaps in care;
 - 2.1.8.3 Documentation of gaps in care in the enrollee case file;
 - 2.1.8.4 Documentation of interventions in HAP and progress notes;
 - 2.1.8.5 Findings from the enrollee's response to interventions;
 - 2.1.8.6 Documentation of follow-up actions, and person or organization responsible for follow-up.
- 2.2 The Care Coordinator shall provide or oversee interventions that address the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices are available to Health Home enrollees;
- 2.3 The Care Coordinator shall provide or oversee Health Home services in a culturally competent manner that address health disparities by:
- 2.3.1 Interacting directly with the enrollee and his or her family in the enrollee's primary language;
 - 2.3.2 Recognizing cultural differences when developing the HAP;
 - 2.3.3 Understanding the dynamics of substance use disorder without judgment; and
 - 2.3.4 Recognizing obstacles faced by persons with developmental disabilities and providing assistance to the enrollee and his or her caregivers in addressing the obstacles.

- 2.4 The Care Coordinator shall:
 - 2.4.1 Discuss changes in patient circumstances or condition with the treating/authorizing entities who serve the enrollee and make changes to the HAP in a timely manner;
 - 2.4.2 With the enrollee's permission, include care providers (paid and unpaid) who have a role in supporting the enrollee, to achieve health action goals and access health care services;
 - 2.4.3 Collaborate with health care professionals such as primary care providers, mental health professionals, chemical dependency treatment providers, and social workers.
 - 2.4.4 Have access to providers from the local community who authorize Medicaid, state or federally funded mental health, long-term services and supports (including the direct care workforce), chemical dependency and medical services. This group may include RSNs, HCS, Community Mental Health Agencies (CMHA's), AAAs, substance use disorder providers, and community supports that assist with housing;
 - 2.4.5 Coordinate or collaborate with nutritionist/dieticians, direct care workers, pharmacists, peer specialist, family members and housing representatives or others, to support the enrollee's HAP; and
- 2.5 Lead Entities must have executed a Memorandum of Understanding or Agreement with organizations that authorize Medicaid services to ensure continuity of care. MOU/MOAs must contain information related to enrollee privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.

3 Eligibility and Enrollment

HCA shall determine eligibility for the Health Home program and passively enroll eligible clients in the Contractor's Health Home program.

- 3.1 Those determined eligible for health home services must have at least one chronic condition and be at risk of a second as determined by a minimum PRISM score of 1.5. The chronic conditions are:
 - 3.1.1 Mental health conditions;
 - 3.1.2 Substance use disorders;
 - 3.1.3 Asthma;

- 3.1.4 Diabetes;
 - 3.1.5 Heart disease;
 - 3.1.6 Cancer;
 - 3.1.7 Cerebrovascular disease;
 - 3.1.8 Coronary artery disease;
 - 3.1.9 Dementia or Alzheimer's disease;
 - 3.1.10 Intellectual disability or disease;
 - 3.1.11 HIV/AIDS;
 - 3.1.12 Renal failure;
 - 3.1.13 Chronic respiratory conditions;
 - 3.1.14 Neurological disease;
 - 3.1.15 Gastrointestinal disease;
 - 3.1.16 Hematological conditions; and
 - 3.1.17 Musculoskeletal conditions.
- 3.2 HCA shall provide the Contractor a list of clients that meet Health Home criteria, as determined by HCA. The Contractor shall ensure eligible Health Home enrollees receive services through a Qualified Health home.
- 3.3 The Contractor shall ensure Health Home eligible clients are assigned a Care Coordinator through a Qualified Health Home.
- 3.4 Enrollees may opt out of the Health Home program at any time. The Health Home shall maintain a record of all enrollees who choose to opt out of the Health Home program.
- 3.5 Enrollees who opt out of the Health Home program may re-enroll at any time in accordance with HCA's enrollment guidelines.
- 3.6 The Contractor shall use a standardized tool provided by the State to determine initial eligibility for Health Home services if the enrollee has less than fifteen (15) months of claims history or is referred by a provider. The Contractor shall notify HCA when the enrollee has been screened. When HCA determines the enrollee qualifies,

the Contractor shall ensure the enrollee receives Health Home services.

3.7 The Contractor shall accept referral for Health Home services from any health care provider, whether or not the provider is contracted with the Contractor.

3.8 Assignment, Engagement and Participation:

3.8.1 Whenever possible, the Contractor shall assign Health Home enrollees to CCOs using a smart assignment process that takes into account the enrollee's current health care provider. This may be achieved by:

3.8.1.1 Using PRISM or other data systems to match the enrollee to a CCO that provides most of the enrollee's services; or

3.8.1.2 Allowing enrollee choice of CCOs.

3.8.2 The CCO selected must have a written agreement with a Qualified Health Home.

3.8.3 The Contractor shall have policies and procedures in place to track enrollee assignment to a CCO.

3.8.4 The Contractor shall have in place policies, procedures and protocols that describe the roles and responsibilities for engagement and agreement of the enrollee to participate in the Health Home program;

3.8.5 The Contractor shall ensure that:

3.8.5.1 The enrollee is contacted by his or her assigned Care Coordinator or affiliated staff and offered care coordination and Health Home Services within 45 calendar days of Healthy Options enrollment;

3.8.5.2 Each enrollee file has a contact log that includes the purpose of each contact and identifies staff who interact with the enrollee;

3.8.6 The Contractor shall develop a HAP using the following resources:

3.8.6.1 The enrollee's medical record and PRISM data;

3.8.6.2 Treatment plans, CARE assessments, results of previous screens and assessments, if available;

3.8.6.3 Information from the MCO's authorization and service utilization systems; and

- 3.8.6.4 Input from the enrollee and his or her family and/or caregivers.
- 3.8.7 The Contractor shall ensure the Care Coordinator completes the HAP within 90 calendar days from the date of Health Home enrollment. A complete HAP contains: at least one health action goal, the enrollee's signature and the date of completion.
- 3.8.8 The Care Coordinator or affiliated staff shall:
 - 3.8.8.1 Arrange an in-person visit in the enrollee's choice of location.
 - 3.8.8.2 Introduce the program to the enrollee, including a description Health Home services, including care coordination.
 - 3.8.8.3 Arrange an appointment with the Care Coordinator to complete the HAP.
- 3.8.9 The Care Coordinator shall meet with the enrollee to develop and finalize the HAP, including the following:
 - 3.8.9.1 Explain the HAP and the development process to the enrollee;
 - 3.8.9.2 Complete a Health Home Information-sharing consent form;
 - 3.8.9.3 Evaluate the enrollee's support system;
 - 3.8.9.4 Administer and score either the 13-question Patient Activation (PAM) or Caregiver Activation Measure (CAM).
 - 3.8.9.5 The Care Coordinator uses the PAM to:
 - 3.8.9.5.1 Measure activation and behaviors that underlie activation including ability to self-manage, collaborate with providers, maintain function, prevent declines and access appropriate and high quality health care;
 - 3.8.9.5.2 Target tools and resources commensurate with the enrollee's level of activation;
 - 3.8.9.5.3 Provide insight into how to improve unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health;
 - 3.8.9.5.4 Complete a Goal and Action Planning Worksheet;
 - 3.8.9.5.5 Document health care problems through the combined

review of medical records, PRISM and the initial face to face visit with the enrollee; and

- 3.8.9.6 As indicated by clinical judgment, complete HCA-approved screening tools for behavioral health conditions, if not already obtained from other sources.

3.9 Comprehensive Care Coordination Services

The Contractor shall ensure the Care Coordinator:

- 3.9.1 Documents interactions with the Health Home enrollee including periodic follow-up, both in-person and telephonically;
- 3.9.2 Assesses enrollee's readiness for self-management and promotion of self-management skills;
- 3.9.3 Reassesses the HAP and Health Home enrollee's progress in meeting goals;
- 3.9.4 Manages barriers to achieving health action goals;
- 3.9.5 Facilitates communication between the Health Home enrollee and service providers to address barriers and achieve health action goals;
- 3.9.6 Supports the achievement of self-directed, health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning;
- 3.9.7 Reassesses patient activation at minimum every four (4) months, or more frequently if changes warrant reassessment using the Patient Activation Measure (PAM) or Caregiver Activation Measure (CAM) and documents the results in the HAP; and
- 3.9.8 Ensures communication, coordination, and care management functions are not duplicated between the Care Coordinator and Medicaid case managers involved in the enrollee's care, including DSHS case managers.

3.10 Care coordination and health promotion

The Contractor shall ensure the Health Home Care Coordinator:

- 3.10.1 Develops and executes cross-system care coordination to assist enrollees to access and navigate needed services;
- 3.10.2 Fosters communication between the care providers, including the treating primary care provider, medical specialists and entities authorizing behavioral

- health and long-term services and supports;
- 3.10.3 Maintains a caseload that ensures timely intervention;
- 3.10.4 Uses community health workers, peer counselors or other non-clinical staff to assist clinical staff in the delivery of Health Home services;
- 3.10.5 Provides interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors that affect an enrollee's health and health care choices;
- 3.10.6 Promotes the following:
 - 3.10.6.1 Improved clinical outcomes;
 - 3.10.6.2 Enrollee participation in his or her care;
 - 3.10.6.3 Continuity of care;
 - 3.10.6.4 Increased self-management skills; and
 - 3.10.6.5 Use of peer supports to increase the enrollee's knowledge about his or her health conditions and improve adherence to prescribed treatment.
- 3.10.7 Share the HAP with individuals identified by the enrollee, with the enrollee's written consent. These individuals may include, but are not limited to: family, caregivers, primary care providers, mental health treatment providers, and authorizers of long term services and supports and/or chemical dependency treatment providers.
 - 3.10.7.1 The HAP shall provide written evidence of:
 - 3.10.7.2 The enrollee's chronic conditions, severity factors and gaps in care, activation level, and opportunities to prevent avoidable emergency room, inpatient hospital and institutional use;
 - 3.10.7.3 Enrollee self-identified goals;
 - 3.10.7.4 Needed interventions and desired outcomes,
 - 3.10.7.5 Transitional care planning, including assessment and deployment of needed supports; and
 - 3.10.7.6 Use of self-management, recovery and resiliency principles that employ person-identified supports, including family members, and

paid and non-paid caregivers;

3.10.7.7 The Care Coordinator shall assess the enrollee's patient activation scores and level to determine the appropriate coaching methods and a teaching and support plan that includes:

3.10.7.7.1 Introduction of customized educational materials based on the enrollee's readiness for change;

3.10.7.7.2 Progression of customized educational materials in combination with the enrollee's level of confidence and self-management abilities;

3.10.7.7.3 Documentation of opportunities for mentoring and modeling communication with health care providers provided through joint office visits and communications with health care providers by the enrollee and the Health Home Care Coordinator;

3.10.7.7.4 Documentation of wellness and prevention education specific to the enrollee's chronic conditions, including assessment of need and facilitation of routine preventive care;

3.10.7.7.5 Support for improved social connections to community networks, and links the enrollee with resources that support a health promoting lifestyle;

3.10.7.7.6 Links to resources for, but not limited to: smoking cessation, substance use disorder prevention, nutritional counseling, obesity reduction, increasing physical activity, disease-specific or chronic care management self-help resources, and other services, such as housing, based on individual needs and preferences;

3.10.8 The Care Coordinator shall ensure the HAP is reviewed and updated:

3.10.8.1 Every four (4) months to update the PAM or CAM, PHQ-9, KATZ ADL inventory for appropriate older enrollees in need of appropriate long-term care supports, and BMI scores;

3.10.8.2 Every six (6) months to reassess the enrollee's progress towards meeting clinical and patient-centered health action goals; and

3.10.8.3 When revisions are necessary due to a change in the enrollee's

health status, or a change in the enrollee's needs or preferences;

- 3.10.9 The Care Coordinator shall ensure the enrollee is accompanied to critical health care and social service appointments, when necessary to assist the enrollee in achieving his or her health action goals; and
- 3.10.10 The Care Coordinator shall ensure treating providers and authorizing entities coordinate and mobilize to reinforce and support the enrollee's health action goals.

3.11 Transitional Care

- 3.11.1 The Contractor shall provide comprehensive transitional care for Health Home enrollees to prevent 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.
- 3.11.2 In addition to Transitional care services described in Section 13.2 of this Contract, Transitional Care, the Contractor's transitional care planning process must include:
 - 3.11.2.1 Participation by the Care Coordinator in all phases of care transition; including discharge planning visits during hospitalizations or nursing home stays, post hospital/institutional stay, home visits, and follow-up telephone calls.
 - 3.11.2.2 A notification system between MCOs, hospitals, nursing facilities and residential/rehabilitation facilities that provides prompt notification of an enrollee's admission or discharge from an emergency department, inpatient setting, nursing facility or residential/rehabilitation facility, and if proper permissions are in place, a substance use disorder treatment setting.
 - 3.11.2.3 Progress notes or a case file that documents the notification.
 - 3.11.2.4 Transition planning details such as medication management and monitoring documented in the HAP.
 - 3.11.2.5 The Contractor may employ staff that have been trained specifically to provide transitional services, as long as the Care Coordinator is an active participant in the transitional planning process.
 - 3.11.2.6 The Contractor shall establish the frequency of communicating hallmark events to the assigned Care Coordinator.

3.12 Individual and family support

- 3.12.1 The Contractor shall use peer supports, support groups and self-management programs as needed, to increase the enrollee's and caregiver's knowledge of the enrollee's chronic conditions, promote the enrollee's capabilities and engagement in self-management, and help the enrollee improve adherence to prescribed treatment.
- 3.12.2 The Contractor shall ensure the Care Coordinator, with the enrollee's participation:
 - 3.12.2.1 Identifies the role that the enrollee's family, informal supports and paid caregivers provide to help the enrollee achieve self-management and optimal levels of physical and cognitive function;
 - 3.12.2.2 Educates and supports self-management; self-help recovery and other resources necessary for the enrollee, his or her family and caregivers to support the enrollee's individual health action goals;
 - 3.12.2.3 Documents discussion of advance directives and includes the enrollee's family in the discussion;
 - 3.12.2.4 Communicates and shares information with the enrollee's family and other caregivers, with appropriate consideration of language, activation level, literacy, and cultural preferences.

3.13 Referral to community and social support services.

- 3.13.1 The Care Coordinator shall ensure that:
 - 3.13.1.1 Available community resources are identified and accessible to the Health Home enrollee.
 - 3.13.1.2 Referrals:
 - 3.13.1.2.1 Are overseen by the Care Coordinator;
 - 3.13.1.2.2 Support the enrollee's health action goals;
 - 3.13.1.2.3 Include long-term services and supports, mental health, substance use disorder and other community and social supports; and
 - 3.13.1.2.4 Are documented in the enrollee's progress notes and HAP.

- 3.13.1.3 Assistance is provided to the enrollee to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services, when needed and not provided through other case management systems.
- 3.13.1.4 Services are coordinated with appropriate departments of local, state and federal governments and community-based organizations;

3.14 **Monthly Reports**

- 3.14.1 The Contractor shall submit a monthly report 15 calendar days after the end of the month to HCA with the following information to support the Contractor's submission of Health Home encounters for the previous month:
 - 3.14.1.1 Enrollee's ProviderOne ID;
 - 3.14.1.2 Primary care provider's NPI ID;
 - 3.14.1.3 Date of service;
 - 3.14.1.4 Who provided the service – Care Coordinator or affiliated staff;
 - 3.14.1.5 Number and type of contacts (telephone; in-person and mail);
 - 3.14.1.6 Date encounter was submitted;
 - 3.14.1.7 Date enrollee either terminated his/her enrollment in the program or decided to no longer participate in the program.