

Exhibit C-2

Health Homes

1 Health Homes Definitions

- 1.1. “Aging and Long-Term Support Administration (ALTSA)” means the administration within the Department of Social and Health Services responsible for providing long-term services and supports to individuals who are functionally and financially eligible 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.
- 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, Behavioral Health Organizations, and Home and Community-based Services Providers.
- 1.4. “Behavioral Health Organization (BHO)” means a county authority, a group of county authorities, or other entity recognized by the secretary of the Department of Social and Health Services in a defined regional service area that provides both mental health and substance use disorder treatment 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. “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.
- 1.7. “Caregiver Activation Measure (CAM)” means an assessment that gauges the knowledge, skills and confidence of the caregiver essential to providing care for a person with chronic conditions.
- 1.8. “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.
- 1.9. “Coverage Area(s)” means pre-determined geographical areas composed of specific counties.
- 1.10. “Department of Social and Health Services (DSHS)” means the Washington State Department of Social and Health Services.
- 1.11. “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.

- 1.12. "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.
- 1.13. "Engagement" means the enrollee's agreement to participate in Health Homes as demonstrated by the completion of the enrollee's Health Action Plan.
- 1.14. "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.
- 1.15. "Full Dual Eligible" means a Beneficiary or Participant who is eligible for the full scope of Medicare and Medicaid covered benefits.
- 1.16. "Hallmark Events" means elevated episodes of care that have potential to seriously affect the enrollee's health or health outcomes.
- 1.17. "Health Action Plan (HAP)" means an enrollee-prioritized plan identifying what the enrollee plans to do to improve his or her health.
- 1.18. "Health Home Care Coordinator" means an individual employed or contracted by the CCO that provides or oversees Health Home Services. Services are delivered or overseen by registered nurses, licensed practical nurses, psychiatric nurses, psychiatrists, physician's assistants, clinical psychologists, licensed mental health counselors, agency affiliated certified mental health counselors, licensed marriage and family therapists, Masters in Social Work, Bachelors in Social Work or related professionally prepared social workers, and certified chemical dependency professionals.
- 1.19. "Health Home 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.
- 1.20. "Health Home Services" means a group of six services defined under Section 2703 of the Affordable Care Act. The six (6) Health Home Services are:
 - 1.20.1. Comprehensive Care Management
 - 1.20.2. Care Coordination and Health Promotion
 - 1.20.3. Comprehensive transitional care from inpatient to other settings including appropriate follow-up
 - 1.20.4. Individual and Family Support

1.20.5. Referral to Community and Social Support Services

1.20.6. The use of Health Information Technology to link services, as appropriate.

- 1.21. “Katz Index of Independence in Activities of Daily Living (Katz ADL)” means a screening instrument used to assess basic activities of daily living in older adults in a variety of care settings.
- 1.22. “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.
- 1.23. “Memorandum of Agreement/Understanding (MOA or MOU)” means a business agreement for partnerships that do not involve a financial arrangement describing the roles and responsibilities of each party to the agreement.
- 1.24. “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 Health Home Care Coordinator. Optional team members may include nutritionists/dieticians, direct care workers, pharmacists, peer specialists, family members or housing representatives.
- 1.25. “Parent Patient Activation Measure (PPAM)” is an assessment that gauges the knowledge, skills and confidence of the parent’s management of their child’s health.
- 1.26. “Participant” means an individual who agrees to participate in Health Home services as demonstrated by the completion of a Health Action Plan.
- 1.27. “Patient Activation Measure (PAM)” means an assessment that gauges the knowledge, skills and confidence essential to managing one’s own health and health care.
- 1.28. “Patient Protection and Affordable Care Act” or “ACA” means Public Laws 111-148 and 111-152 (both enacted in March 2010).
- 1.29. “PRISM User Coordinator” means the employee appointed by the Contractor to be the point of contact for the HCA and DSHS’s PRISM Administration Team.
- 1.30. “Qualified Health Home” means an entity composed of community-based providers, qualified by the state to provide Health Home Services to eligible enrollees.
- 1.31. .

2 Health Home Services for Apple Health (AH) Enrollees

- 2.1 The Contractor shall provide Health Home services in addition to the Care Coordination Services described in Section 14 of the Apple Health Contract, to high cost, high needs enrollees who meet Health Home eligibility criteria. Health Home Services shall be community-based, integrated and coordinated across medical,

mental health, substance use disorder, and long-term services and supports to 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 Submission of completed and updated Health Action Plan (HAP) data through the *OneHealthPort* Health Information Exchange using the OneHealthPort Canonical Guide located at: http://www.hca.wa.gov/medicaid/health_homes/Documents/HAP_Canonical_Guide.pdf. 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 support health action goals, including the enrollee's preferences and identified needs;
- 2.1.3 A system to track Health Home Services through claims paid or services rendered and report the encounter data in accordance with the HCA Encounter Data Reporting Guide;
- 2.1.4 Enrollee access to toll-free line and customer service representatives to answer questions, 8:00 AM to 5:00 PM from Monday through Friday regarding Health Home enrollment, disenrollment and how to access services or request a change to another CCO;
- 2.1.5 A system for emergency consultation and general information available 24/7;
- 2.1.6 Policies, procedures and agreements with hospitals for transitioning care for Health Home enrollees and referring eligible enrollees who seek or need treatment in a hospital emergency department for Health Home enrollment;
- 2.1.7 The Contractor's PRISM Coordinator shall identify all Designated Staff who have a business need to access PRISM.
 - 2.1.7.1 The Contractor shall ensure that Designated Staff complete and submit to the DSHS PRISM Administration Team all necessary forms required by CMS and DSHS for data authorization and PRISM access, including:
 - 2.1.7.1.1 The PRISM registration form; and
 - 2.1.7.1.2 The DSHS provided spreadsheet.
 - 2.1.7.2 The Contractor shall promptly notify the DSHS PRISM Administration Team when established Designated Staff user accounts should be removed due to employment termination, job reassignment, or other changes in circumstances.
- 2.1.8 Policies and Procedures: The Contractor shall abide by all HCA policies and procedures for Health Home services, and maintain regularly updated

Contractor-specific policies and procedures that address the following:

- 2.1.8.1 The requirement to maintain frequent, in-person contact between the Health Home enrollee and the Health Home Care Coordinator when delivering Health Home services;
 - 2.1.8.2 Ongoing availability of support staff to complement the work, collaborate, receive direction and report to the Health Home Care Coordinator;
 - 2.1.8.3 Support screening, referral and co-management of individuals with both behavioral health and physical health conditions;
 - 2.1.8.4 The Contractor's and subcontractor's roles and responsibilities for enrollee engagement;
 - 2.1.8.5 Ensuring an appointment reminder system is in place for beneficiaries;
 - 2.1.8.6 Tracking of enrollee assignment to Care Coordination Organizations;
 - 2.1.8.7 Referrals to HCA for eligibility review of any potential enrollee who seeks or needs Health Home Services;
 - 2.1.8.8 Transitional care services for enrollees transferring to or from hospital or other inpatient setting or emergency departments;
 - 2.1.8.9 A policy and procedure to deal with the compromise or potential compromise of Data that complies with the HITECH Act of ARRA; and
 - 2.1.8.10 Due diligence for contacting the enrollee for affirmation of participation.
- 2.1.9 Methods to identify and address enrollee gaps in care through:
- 2.1.9.1 Assessment of existing data sources (e.g., PRISM, CARE, etc.) for evidence of the standard of care for and preventive care appropriate to the enrollee's age and underlying chronic conditions;
 - 2.1.9.2 Evaluation of enrollee perception of gaps in care;
 - 2.1.9.3 Documentation of gaps in care in the enrollee case file;
 - 2.1.9.4 Documentation of interventions in the HAP and progress notes;
 - 2.1.9.5 Findings from the enrollee's response to interventions; and
 - 2.1.9.6 Documentation of follow-up actions, and the person or organization responsible for follow-up.

- 2.2 The Health Home Care Coordinator shall provide or oversee interventions that address the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting the enrollee's health and health care choices available to Health Home enrollees.
- 2.3 The Health Home Care Coordinator shall provide or oversee Health Home Services in a culturally competent manner that addresses health disparities by:
 - 2.3.1 Interacting directly with the enrollee and his or her family in the enrollee's primary language and recognizing cultural differences when developing the HAP;
 - 2.3.2 Understanding the dynamics of substance use disorder without judgment; and
 - 2.3.3 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 Health Home Care Coordinator shall:
 - 2.4.1 Discuss changes in enrollee circumstances or conditions with the treating/authorizing entities who serve the enrollee;
 - 2.4.2 Document changes in the enrollee's circumstances or conditions in the HAP in a timely manner;
 - 2.4.3 With the enrollee's permission, include paid and unpaid caregivers who have a role in supporting the enrollee to achieve health action goals and access health care services;
 - 2.4.4 Collaborate with health care professionals such as primary care providers, mental health professionals, chemical dependency treatment providers, and social workers;
 - 2.4.5 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), substance use disorder and medical services. This group may include BHOs, DSHS-Home and Community Services (HCS), Community Mental Health Agencies (CMHA's), Area Agencies on Aging (AAAs), substance use disorder providers, and community supports that assist with housing; and
 - 2.4.6 Coordinate or collaborate with nutritionist/dieticians, direct care workers, pharmacists, peer specialists, family members and housing representatives or others, to support the enrollee's HAP.
- 2.5 Lead Entities must have executed a Memorandum of Understanding or Agreement with organizations that authorize Medicaid services such as DSHS Home and Community Services (HCS), BHOs, DDA, and Area Agency on Aging 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 Training Requirements

The Contractor shall ensure that:

- 3.1 Health Home Care Coordinators and affiliated staff complete client confidentiality and data security training upon hire and annually thereafter.
- 3.2 Health Home Care Coordinators complete the State-approved Health Home Care Coordinator training prior to completing the HAP with an enrollee.
- 3.3 Health Home Care Coordinators complete the following special-topic modules through State-sponsored classroom training or using State-developed training materials published on the DSHS website within six (6) months of hire.
 - 3.3.1 Outreach and Engagement Strategies;
 - 3.3.2 Navigating the LTSS System: Part 1;
 - 3.3.3 Navigating the LTSS System: Part 2;
 - 3.3.4 Cultural and Disability Competence Considerations;
 - 3.3.5 Assessment Screening Tools; and
 - 3.3.6 Coaching and Engaging Clients with Mental Health Needs.
- 3.4 Health Home Care Coordinators and affiliated personnel comply with continued training requirements as necessary.
- 3.5 Evidence of satisfactory completion of training requirements is maintained in the appropriate personnel records.
- 3.6 The Contractor has a Health Home Care Coordinator trainer on staff, or shall subcontract for Health Home Care Coordinator training services.
 - 3.6.1 The trainer shall be qualified by DSHS prior to providing Health Home Care Coordinator training.
 - 3.6.2 Trainer Qualification includes:
 - 3.6.2.1.1 Completion of the Health Home Care Coordinator training course;
 - 3.6.2.1.2 Completion of a State-sponsored trainer's preparation course;
 - 3.6.2.1.3 Satisfactory delivery of a Health Home Care Coordinator training observed by DSHS;
 - 3.6.2.1.4 Receipt of a State-issued letter authorizing the individual to

provide training to Health Home Care Coordinators.

3.7 The Contractor shall ensure that the trainer uses and maintains fidelity to the State-developed Training Manual for Health Home Care Coordinators.

3.7.1 The Health Home Care Coordinator training is delivered using all of the DSHS materials including the small group activities using de-identified PRISM data, training agenda, training manual inserts, and handouts.

3.7.2 The trainer does not change, alter, or modify the State-approved Health Home Care Coordinator training, activities, curriculum or materials or include unauthorized topics, curriculum, or material in the Health Home Care Coordinator training.

4 Eligibility and Enrollment

HCA shall determine eligibility and identify enrollees who are eligible for the Contractor's Health Home program.

4.1 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:

- 4.1.1 Mental health conditions;
- 4.1.2 Substance use disorders;
- 4.1.3 Asthma;
- 4.1.4 Diabetes;
- 4.1.5 Heart disease;
- 4.1.6 Cancer;
- 4.1.7 Cerebrovascular disease;
- 4.1.8 Coronary artery disease;
- 4.1.9 Dementia or Alzheimer's disease;
- 4.1.10 Intellectual disability or disease;
- 4.1.11 HIV/AIDS;
- 4.1.12 Renal failure;
- 4.1.13 Chronic respiratory conditions;

- 4.1.14 Neurological disease;
 - 4.1.15 Gastrointestinal disease;
 - 4.1.16 Hematological conditions; and
 - 4.1.17 Musculoskeletal conditions.
- 4.2 HCA shall include a Health Home Clinical Indicator in the monthly enrollment listing of AH enrollees that meet Health Home criteria.
- 4.2.1 The Contractor shall ensure eligible Health Home enrollees are offered Health Home services through a contracted Qualified Health Home or a CCO until they agree to participate or decline to participate in the Health Home program. The Contractor shall follow the HCA documented due diligence process in offering services to eligible enrollees.
 - 4.2.2 The Contractor must document in the client record why an eligible enrollee declines to participate, unless the enrollee does not want to explain his or her decision.
- 4.3 The Contractor shall ensure Health Home eligible enrollees are assigned a Health Home Care Coordinator through a Qualified Health Home.
- 4.4 Enrollees who have agreed to participate may disenroll from the Health Home program at any time. The Contractor shall maintain a record of all enrollees who choose to disenroll from the Health Home program and the reason why.
- 4.5 Enrollees who disenroll from the Health Home program may re-enroll at any time.
- 4.6 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 unless the enrollee declines to participate in the program.
- 4.7 The Contractor shall accept referrals for Health Home services from any health care provider, whether or not the provider is contracted with the Contractor.

5 Assignment, Engagement, and Participation.

- 5.1 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(s). This may be achieved by:
- 5.1.1 Using PRISM or other data systems to match the enrollee to a CCO that provides most of the enrollee's services; or
 - 5.1.2 Allowing enrollee choice of CCOs.
- 5.2 The CCO selected must have a written agreement with a Qualified Health Home or

the MCO.

- 5.3 The Contractor shall ensure each enrollee file includes a contact log that includes the date of assignment to the CCO or internal Health Home Care Coordinator, the date the client agrees to participate, the date and purpose of each contact, and identifies the staff that interacts with the enrollee.
- 5.4 The Contractor shall ensure the Health Home Care Coordinator uses the following resources to develop enrollee HAPs:
 - 5.4.1 The enrollee's medical record, if available, and PRISM data;
 - 5.4.2 Treatment plans, CARE assessments, and results of previous screens and assessments, if available;
 - 5.4.3 Information from the Contractor's authorization and service utilization systems; and
 - 5.4.4 Input from the enrollee and his or her family and/or caregivers.
- 5.5 The Contractor shall ensure the Health Home Care Coordinator completes the initial HAP within ninety (90) calendar days from the date of notification of Health Home eligibility. A complete HAP must include documentation of agreement by the enrollee to participate in the Health Home program.
 - 5.5.1 The Contractor must ensure that:
 - 5.5.1.1 The Health Home Care Coordinator meets in-person with each enrollee at the enrollee's choice of location to explain, develop, and complete the HAP with input from the enrollee and/or the enrollee's caregiver(s);
 - 5.5.1.2 The HAP documents the enrollee's diagnosis, long-term goals, short-term goals, and related action steps to achieve those goals identifying the individual responsible to complete the action steps;
 - 5.5.1.3 The HAP includes the required BMI, Katz ADL, and PSC-17 or PHQ-9 screening scores;
 - 5.5.1.4 The HAP includes the required Patient Activation Measure (PAM), or Patient Parent Activation Measure (PPAM), or Caregiver Activation Measure (CAM) activation level and screening score;
 - 5.5.1.5 The HAP identifies optional screenings administered, if applicable, and
 - 5.5.1.6 The HAP includes the reason the enrollee declined assessment or screening tools.
 - 5.5.2 HAPs must be reviewed and updated by the Health Home Care Coordinator at a minimum:

- 5.5.2.1 After every four (4) month activity period to update the PAM, PPAM, CAM, BMI, Katz ADL, and PSC-17 or PHQ-9 screening scores and reassess the enrollee's progress towards meeting self-identified health action goals, add new goals or change in current goals;
- 5.5.2.2 Whenever there is a change in the enrollee's health status or a change in the enrollee's needs or preferences.
- 5.5.3 Completed and updated HAP content, enrollee's goals and action steps must be shared with enrollees and with consent of the enrollee, the enrollee's caregiver and family
- 5.5.4 Additional information not included in the State-developed HAP form must be included as an addendum. Written information in the HAP must use language that is understandable to the enrollee and/or the enrollee's caregiver(s).
- 5.5.5 Upon request, completed and updated HAPs must be shared with other individuals identified and authorized by the enrollee on the signed Health Home Information Consent form.
- 5.5.6 The Health Home Care Coordinator or affiliated staff shall:
 - 5.5.6.1 Arrange an in-person visit in the enrollee's choice of location.
 - 5.5.6.2 Describe the program to the enrollee, including a description of Health Home Services and care coordination.
 - 5.5.6.3 Arrange an appointment with the Health Home Care Coordinator to complete the HAP.
- 5.5.7 The Health Home Care Coordinator shall meet with the enrollee in person to complete the HAP, including the following:
 - 5.5.7.1 Explain the HAP and the development process to the enrollee;
 - 5.5.7.2 Complete a Health Home Information Sharing Consent form;
 - 5.5.7.3 Evaluate the enrollee's support system; and
 - 5.5.7.4 Administer and score either the Patient Activation Measure (PAM), Parent Patient Activation Measure (PPAM) or Caregiver Activation Measure (CAM).
- 5.5.8 The Health Home Care Coordinator uses the PAM; PPAM; or CAM to:
 - 5.5.8.1 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;

- 5.5.8.2 Target tools and resources commensurate with the enrollee's level of activation;
- 5.5.8.3 Provide insight into how to reduce unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health;
- 5.5.8.4 Document health care problems through the combined review of medical records, PRISM and face-to-face visits with the enrollee; and
- 5.5.8.5 As indicated by clinical judgment, complete HCA-approved screening tools for behavioral health conditions, if not already obtained from other sources.

5.6 Comprehensive Care Management Services

The Contractor shall ensure the Health Home Care Coordinator:

- 5.6.1 Documents interactions with the Health Home enrollee including periodic follow-up, both in-person and telephonically;
- 5.6.2 Assesses enrollee's readiness for self-management and promotion of self-management skills;
- 5.6.3 Reassesses the HAP and Health Home enrollee's progress in meeting goals;
- 5.6.4 Manages barriers to achieving health action goals;
- 5.6.5 Facilitates communication between the Health Home enrollee and service providers to address barriers and achieve health action goals;
- 5.6.6 Supports the achievement of self-directed, health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning;
- 5.6.7 Reassesses patient activation at minimum every four (4) month activity periods, or more frequently if changes warrant reassessment using the PAM; PPAM or CAM and documents the results in the HAP; and
- 5.6.8 Ensures communication, coordination, and care management functions are not duplicated between the Health Home Care Coordinator and Medicaid case managers involved in the enrollee's care, including DSHS and AAA case managers.

5.7 Care coordination and health promotion

The Contractor shall ensure the Health Home Care Coordinator:

- 5.7.1 Develops and executes cross-system care coordination to assist enrollees to access and navigate needed services;

- 5.7.2 Fosters communication between the health care providers, including the treating primary care provider, medical specialists, behavioral health providers and entities authorizing behavioral health and long-term services and supports;
- 5.7.3 Maintains a caseload that ensures timely intervention;
- 5.7.4 Uses community health workers, peer counselors or other non-clinical staff to assist clinical staff in the delivery of Health Home Services;
- 5.7.5 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; and
- 5.7.6 Provides educational materials that promote the following:
 - 5.7.6.1 Improved clinical outcomes;
 - 5.7.6.2 Enrollee participation in his or her care;
 - 5.7.6.3 Continuity of care;
 - 5.7.6.4 Increased self-management skills; and
 - 5.7.6.5 Use of peer supports to increase the enrollee's knowledge about his or her health conditions and improve adherence to prescribed treatment.
- 5.7.7 Shares 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 substance use disorder treatment providers.
 - 5.7.7.1 The HAP shall provide written evidence of:
 - 5.7.7.1.1 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;
 - 5.7.7.1.2 Enrollee self-identified goals;
 - 5.7.7.1.3 Needed interventions and desired outcomes;
 - 5.7.7.1.4 Transitional care planning, including assessment and deployment of needed supports; and
 - 5.7.7.1.5 Use of self-management, recovery and resiliency principles that employ person-identified supports, including family members, and paid or unpaid

caregivers.

5.7.7.2 The Health Home 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:

- 5.7.7.2.1 Introduction of customized educational materials based on the enrollee's readiness for change;
- 5.7.7.2.2 Progression of customized educational materials in combination with the enrollee's level of confidence and self-management abilities;
- 5.7.7.2.3 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;
- 5.7.7.2.4 Documentation of wellness and prevention education specific to the enrollee's chronic conditions, including assessment of need and facilitation of routine preventive care;
- 5.7.7.2.5 Support for improved social connections to community networks, and links the enrollee with resources that support a health promoting lifestyle; and
- 5.7.7.2.6 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.

5.7.8 Ensures 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.

5.7.9 Ensures treating providers and authorizing entities coordinate and mobilize to reinforce and support the enrollee's health action goals.

5.8 Transitional Care

5.8.1 The Contractor shall provide and document the comprehensive transitional care for Health Home enrollees to prevent avoidable readmission after discharge from an inpatient facility and to ensure proper and timely follow-up care.

5.8.2 In addition to services described in Transitional Care provisions of this

Contract, the Contractor's transitional care planning process must include:

- 5.8.2.1 Participation by the Health Home 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;
- 5.8.2.2 A notification system between the Contractor and 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;
- 5.8.2.3 Progress notes or a case file that documents the notification;
- 5.8.2.4 Transition planning details such as medication reconciliation, follow-up with providers and monitoring documented in the HAP;
- 5.8.2.5 The Contractor may employ staff that have been trained specifically to provide transitional services, as long as the Health Home Care Coordinator is an active participant in the transitional planning process; and
- 5.8.2.6 Established frequency of communicating hallmark events to the assigned Health Home Care Coordinator.

5.9 Individual and family support

- 5.9.1 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.
- 5.9.2 The Contractor shall ensure the Health Home Care Coordinator, with the enrollee's participation:
 - 5.9.2.1 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;
 - 5.9.2.2 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;
 - 5.9.2.3 Within the first or second HAP trimester documents discussion of advance directives or representative in the discussion; and
 - 5.9.2.4 Communicates and shares information with the enrollee's family

and other caregivers, with appropriate consideration of language, activation level, literacy, and cultural preferences.

5.10 Referral to community and social support services

5.10.1 The Health Home Care Coordinator shall ensure that:

5.10.1.1 Available community resources are identified and accessible to the Health Home enrollee.

5.10.1.2 Referrals:

5.10.1.2.1 Are overseen by the Health Home Care Coordinator;

5.10.1.2.2 Support the enrollee's health action goals;

5.10.1.2.3 Include long-term services and supports, mental health, substance use disorder and other community and social supports; and

5.10.1.2.4 Are documented in the enrollee's progress notes and HAP.

5.10.1.3 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.

5.10.1.4 Services are coordinated with appropriate departments of local, state, and federal governments and community-based organizations.

5.11 Quarterly Quality Reports

5.11.1 The Contractor shall submit quality reports to HCA in accordance with the following reporting periods:

5.11.1.1 January through March due May 1st;

5.11.1.2 April through June due August 1st;

5.11.1.3 July through September due November 1st; and

5.11.1.4 October through December due February 1st.

5.11.2 Quarterly quality reports must contain the following elements:

5.11.2.1 Summary and overview of Health Home Service:

5.11.2.1.1 Activities;

5.11.2.1.2 Strengths and best practices; and

- 5.11.2.1.3 Barriers encountered during the reporting period.
- 5.11.2.2 Updated Care Coordination network of providers in the format provided by HCA.
- 5.11.2.3 De-identified individual Health Home enrollee success stories for two (2) to five (5) enrollees that may include the following:
 - 5.11.2.3.1 Risk score at initial engagement;
 - 5.11.2.3.2 Gender; age; race; and ethnicity;
 - 5.11.2.3.3 Health concerns;
 - 5.11.2.3.4 Initial PAM Score/Activation Level;
 - 5.11.2.3.5 Current PAM Score/Activation Level; and
 - 5.11.2.3.6 The enrollee story describing how the Health Home program provided support to the enrollee.
- 5.11.2.4 Number of Health Home enrollees identified and enrolled with the Contractor during the quarter;
- 5.11.2.5 Total number of Health Home enrollees referred to a CCO or internal Health Home Care Coordinator regardless of enrollment date;
- 5.11.2.6 Total number of Health Home enrollees not yet referred to a CCO or Health Home Care Coordinator because of lack of capacity or inability to contact after due diligence;
- 5.11.2.7 Total number of newly engaged Health Home enrollees during the reporting period.