Health Home Tiers

Washington State Health Homes have designated three tiers that define the level of care coordination services provided:

1. Initial engagement and action planning = Tier One
2. Intensive level of care coordination = Tier Two
3. Low level of care coordination = Tier Three

The Tier Level of the client is intended to reflect the overall level of:

1. Engagement and activation level of the client and/or their caregivers
2. Activity in the Health Action Plan
3. Provision of at least one of the qualified Health Home services
4. Frequency of contacts (face-to-face visits, phone calls, referrals, or care coordination).

Selecting the appropriate Tier should most closely reflect the above activities. Typically the Tier will not change from month to month, between Tier 2 and Tier 3, but does change when the client and/or their caregivers consistently demonstrate an *intensive* or *low* level Health Home need.

Qualified Health Home services include;

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care
5. Individual and Family Supports
6. Referral to Community and Social Support Services if relevant

The descriptions below of each Tier Level are to be used as a guide when selecting the Health Home Tier.

Tier One – Outreach, Engagement and Health Action Plan (HAP) development

- Lead Organization assigns an eligible client to a Care Coordination Organizations (CCO) using PRISM information or other data systems to match the client to the CCO which will provide most of the Health Homes services and outreach begins.
    a. The CCO assigns the client to a Care Coordinator who completes a preliminary assessment of the client's Health Home needs, based upon known health and other risk factors.
    b. Contact is made with the client to arrange a face-to-face meeting to confirm the client's desire to participate in the Health Home Program.
    c. Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop a HAP.
    d. The client 's Health Action Plan shall provide evidence of:
        1. Chronic conditions, severity factors and gaps in care, the client 's activation level, and opportunities for potentially avoidable emergency department visits, inpatient hospitalizations and institutional placement;
        2. Client self-identified goals, needed interventions or action steps, transitional care planning, supports and interventions;
        3. Use of self-management, recovery and resiliency principles using person-identified supports, including family members, and paid and non-paid caregivers;

- Once the outreach, engagement and HAP have been developed, a Tier One claim will be submitted and paid. Tier One may be paid one time.

Tier Two - <u>Intensive Health Home care coordination</u>

- Intensive Health Home care coordination is the highest level of care coordination. This level of care coordination includes evidence that the Care Coordinator, the client and the client 's caregivers are actively engaged in the HAP, participating in activities that are in support of improved health and well-being, have value for the client and caregivers, and support an active level of care coordination through delivery of the Health Home services. At a minimum, Tier Two includes one face-to-face visit with the client every month. *Recognizing the instability of some Health Home client's physical and mental health, housing or other environmental or psycho-social characteristics exceptions may be made for the minimum face-to-face requirement with the client, as long as there is evidence of the other types of activities described above. A face to face visit with other health and social service providers directly related to the HAP would also be considered as an exception to the face to face visit with the client.*

  At least one qualified Health Home service must be provided prior to submitting a Tier Two claim.

- Services may include:
  a. Administration and follow up on clinical, functional, and resource use screenings, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual;
  b. Continuity and coordination of care services through in-person visits, telephone calls and team meetings, and the ability to accompany beneficiaries to health care provider appointments, as needed;
  c. Client assessments to determine readiness for self-management and promotion of self-management skills so the client is better able to engage with health and service providers and support the achievement of self-directed, individualized health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning;
  d. Fostering communication between the client and providers of care including the treating primary care provider and medical specialists and entities authorizing behavioral health, chemical dependency, developmental disability and long-term services and supports;
  e. Promoting optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the HAP;
  f. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes; and
  g. Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs to increase the client's knowledge about their health care conditions and improve adherence to prescribed treatment.

Tier Three – <u>Low level Health Home care coordination</u>

Tier Three is selected when one of the situations described below matches the care coordination needs of the client. Typically after the Tier One activity of establishing the HAP is completed a client will move to the Tier Two level. In some cases, based on the preference of the client, and their individual needs, they may move directly from Tier One to Tier Three. For example, a client with an Activation Level of Four who is actively self-directing their care and needs infrequent coaching to maintain their health.

Remember, the Health Home Tier system, was not designed to have beneficiaries changing Tiers month to month based solely on the number or types of contacts. The movement to a Tier or between Tiers is based on;

1. Engagement of the client and/or their caregivers;
2. Activity in the HAP;
3. Provision of at least one of the qualified Health Home services
4. Frequency of contacts (face to face visits, phone calls, referrals, or care coordination).

The following situations describe when Tier Three (Low Level Care Coordination) would be selected for a client.

- Low Level Health Home care coordination supports maintenance of the client's self-management skills with periodic home visits and/or telephone calls to reassess health care needs.
- The client expresses their preference to have fewer contacts or a lower level of engagement with the care coordinator.
- The client and the Care Coordinator identify that the client has achieved a sustainable level of self-management for their primary chronic conditions.
- Activity level supports a high level of activation and client demonstrates optimal self-management and health promotion skills.

At Tier Three the review of the HAP must occur minimally at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities.

At least one qualified Health Home service must be provided prior to submitting a Tier Three claim. Qualified Health Home service categories include comprehensive care management, care coordination, health promotion, individual and family support, and comprehensive transitional care.

Movement between Tiers

Based on the needs and preferences of the client they may move between Tiers; higher intensity to lower or lower intensity to higher**.**

- Examples of moving a client from **Tier Two to Tier Three** include:
  - The client's Patient Activation Measure (PAM) score has stabilized over the past four month period with optimal level of activation and HAP goals have been achieved.
  - The client's PRISM risk score is under 1.0 for eight months and the client's PAM Level is at least a three.
  - A client has met their goals and is actively sustaining self-management activities.
  - The client has no new HAP goals to set or current issues to achieve requiring a higher level of coordination, and has achieved and demonstrated self-management skills. Goals

may be modified or new goals added in collaboration by the client with the care coordinator.
- The client requests a lower level of care coordination.

A client may move from Tier Three to Tier Two.

- Examples of moving a client from **Tier Three to Tier Two** include;

  - An adverse health condition or new diagnosis resulting in increased emergency department use, hospital admissions, readmissions, escalation or exacerbation of a behavioral health or social concern.
  - The client expresses a desire to set a new HAP goal.
  - Environmental or psychosocial changes trigger a need for more intensive Health Home services.

Unsuccessful outreach and engagement:
Some beneficiaries may not be successfully reached or engaged in Health Home services despite multiple attempts to contact them in person, by phone, by mail, or through collateral contacts. In these situations a Tier One claim for the engagement attempts cannot be submitted. The Care Coordinator must consult with their organization for direction regarding policy and procedure for engagement attempts and documentation of failed attempts to reach a client.

When a client is not actively participating in the Health Home Program a claim cannot be submitted to reflect the outreach attempts prior to Tier One (establishing a HAP), or after the Tier One.

REMEMBER: A qualified Health Home service must be provided each month in order to submit a claim for Tier Two or Tier Three payment.

HEALTH HOME TIERS GUIDELINES[1]

July 2014

Washington State Health Homes have designated three tiers that define the level of care coordination services provided:

4. Initial engagement and action planning = Tier One
5. Intensive level of care coordination = Tier Two
6. Low level of care coordination = Tier Three

The Tier Level of the client is intended to reflect the overall level of:

5. Engagement and activation level of the client and/or their caregivers
6. Activity in the Health Action Plan
7. Provision of at least one of the qualified Health Home Services
8. Frequency of contacts (face-to- face visits, phone calls, referrals, or care coordination).

Selecting the appropriate Tier should most closely reflect the above activities. Typically the Tier will not change from month to month, between Tier 2 and Tier 3, but does change when the client and/or their caregivers consistently demonstrate an *intensive* or *low* level Health Home need.

Qualified Health Home Services include;

7. Comprehensive Care Management
8. Care Coordination
9. Health Promotion
10. Comprehensive Transitional Care
11. Individual and Family Supports
12. Referral to Community and Social Support Services if relevant

Movement between Tiers

Based on the needs and preferences of the beneficiary they may move between Tiers; higher intensity to lower or lower intensity to higher**.**

[1] This document is intended to be used as a companion to the Health Home Training Manual/ Health Home Tiers document revised July 2014.

Tier Level	Minimum Contact	Activity Examples
Tier One	Contact is made with the enrollee to arrange a face-to-face meeting to confirm the enrollee's desire to participate in the Health Home Program.	Review PRISM and other available client records Administer required screenings. Administer optional screenings as needed. Together, the Care Coordinator and the enrollee identify the enrollee's health goals (long term and short term) and develop a Health Action Plan or HAP. Establish a follow up plan with the client. Submit Tier One Claim for payment once the HAP has been completed.
Tier Two **Intensive Health Home care coordination**	At a minimum, Tier Two includes one face-to-face visit with the beneficiary every month. *Exceptions may be made for the minimum face-to-face requirement as long as there is evidence of the other types of qualifying health home activities being provided* *A face to face visit with other health and social service providers directly related to the HAP would also be considered as an exception to the face to face visit with the client.*	Administration and follow up on clinical, functional, and resource use screenings Continuity and coordination of care services through in-person visits, telephone calls, and team meetings, and the ability to accompany beneficiaries to health care provider appointments, as needed. Beneficiary assessments to determine readiness for self-management and promotion of self-management skills so the beneficiary is better able to engage with health and service providers.

	At least one qualified Health Home service must be provided prior to submitting a Tier Two claim.	Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes. Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs. Medication reconciliation as part of care transitioning. Education and coaching of caregivers, family members, and other supports.
Tier Three **Low level Health Home care coordination**	Contact may not occur every month depending on the HAP and the needs of the client. At Tier Three the review of the HAP must occur minimally at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities. At least one qualified Health Home Service must be provided prior to submitting a Tier Three claim.	Monthly calls to the client to discuss success with maintaining health and/or behavioral changes. Monthly call to check in on HAP progress and to identify new or changing goals.