Health Home Program
Washington

Guidelines for
HH Staff Roles and Responsibilities

February 29, 2016

Health Home Care Coordinators have ultimate responsibility for ensuring the delivery of Health Home services. It is within the scope of their work to delegate some activities to Allied Staff* and non-clinical administrative support staff. The following graph provides a **guide** for potential delegation of Health Home services to Allied and Administrative staff.

CORE HEALTH HOME SERVICES	EXAMPLES OF CORE HEALTH HOME SERVICES, INTERVENTIONS and ACTIVITIES	CARE COORDINATOR functions	ALLIED STAFF potential roles under direction of the Care Coordinator	SUPPORT STAFF under the direction of the Care Coordinator
Outreach and Engagement	Contact the client to introduce Health Home benefits and schedule initial Care Coordinator face-to-face visit.	✓	✓	✓
Comprehensive Care Services	Conduct comprehensive health assessment/reassessment inclusive of medical/behavioral /rehabilitative and long term care and social service need.	✓		
	Complete or revise Health Action Plan (HAP), with a face to face visit with the client to identify client's goals and action steps. Development of the HAP may include family members, caregivers, and other social supports as appropriate.	✓		
	Consult with interdisciplinary care team on client's care plan/needs/goals.	✓		
	Consult with primary care physician and/or any specialists involved in the treatment plan.	✓		
	Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improved health outcomes.	✓	✓	
	Prepare client crisis intervention or resiliency plan.	✓		
Care Coordination	Coordinate with service providers and health plans as appropriate to secure necessary care and share crisis intervention (provider) and emergency information.	✓		
	Communicate with service providers and health plans as appropriate to secure necessary care and supports.	✓	✓	
	Link/refer client to needed services to support care plan/treatment goals, including medical/ behavioral health care; patient education, and self-help/recovery, medication adherence, health literacy, and self-management.	✓	✓	

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	Conduct case reviews with interdisciplinary care team to monitor/evaluate client status and service needs.	✓		
	Advocate for services and assist with scheduling of needed services.	✓	✓	
	Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.	✓		
	Assist and support client with scheduling medical and applicable appointments.	✓	✓	
	Accompany the client to medical and other applicable appointments.	✓		
	Develop a crisis intervention or resiliency plan and revise care plan/goals as required.	✓		
Health Promotion	Provide customized educational materials according to the needs and goals of the client, caregiver, or other social supports as appropriate.	✓	✓	
	Promote participation in community educational and support groups.	✓	✓	
	Provide links to health care resources that support the client's goals.	✓	✓	
	Develop and execute cross-system care coordination activities to assist the client in accessing and navigating needed services.	✓		
	Support the execution of cross-system care coordination activities that assist clients in accessing and navigating needed services.	✓	✓	
	Distribute health education and other materials.	✓	✓	✓
	Assist with follow up calls and provide appointment reminders.	✓	✓	✓
Comprehensive Transitional Care	Follow up with hospitals/ER upon notification of a client's admission and/or discharge to/from an ER, hospital or rehabilitative setting.	✓		
	Facilitate discharge planning from an ER, hospital, or rehabilitative setting to	✓		

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	ensure a safe transition/discharge that ensures care needs are in place.			
	Notify/consult with treating clinicians, schedule follow up appointments, and assist with medication reconciliation.	✓		
	Follow-up post discharge with client/family to ensure client understands discharge orders and medication reconciliation has been completed.	✓		
	Support client with connecting to community supports to ensure that needed services or equipment are received.	✓	✓	✓
Individual & Family Support	Develop, review, or revise the client's Health Action Plan with the client, family, or caregiver to ensure that the plan reflects client's preferences, goals, education, and health literacy to support health self-management.	✓		
	Educate client, family, or caregiver on advance directives, client rights, and health care issues, as needed.	✓	✓	
	Meet with client and family, inviting any other providers to facilitate needed interpretation services.	✓	✓	
	Refer client/family to peer supports, support groups, social services, entitlement programs as needed.	✓	✓	
Referral to Community & Social Support Services	Identify, refer and facilitate access to relevant community and social support services that support the client's health action goals.	✓	✓	
	Assist client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems.	✓	✓	
	Provide general information about upcoming community events.	✓	✓	✓

* Allied health care staff, as identified in the Washington State Plan Amendment, means community health workers, peer counselors or other non-clinical personnel who provide supportive services to the client under the direction and supervision of the Health Home Care Coordinator.