

HEALTH HOME TIERS GUIDELINES

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 Two and Tier Three but does change when the client and/or their caregivers consistently demonstrate an *intensive* or *low* level Health Home need. At least one of the six qualifying Health Home services must be provided within each Tier Level in order to bill and receive payment for the service.

Qualifying Health Home Services include;

- **Comprehensive Care Management:** The initial and ongoing assessment and care management services aimed at the integration of physical, behavioral health, long-term services and supports, and community services, using a detailed person-centered HAP which addresses all clinical and non-clinical needs.

Examples:

- Conduct outreach and engagement activities
- Develop the HAP setting client centered goals and action steps to achieve the goals
- Complete comprehensive needs assessment such as the Patient Activation Measure (PAM) and other required assessments for the HAP
- Prepare crisis intervention and resiliency plans
- Support the client to live in the setting of their choice
- Identify possible gaps in services and secure needed supports

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HEALTH HOME TIERS GUIDELINES

- **Care Coordination and Health Promotion:** Facilitating access to, and monitoring of progress toward goals identified in the HAP to manage chronic conditions for optimal health and to promote wellness. Accomplished through face-to-face and collateral contacts with the client, family, caregivers, physical care, and other providers.
Examples:
 - Support to implement the HAP
 - Encourage and monitor progress towards individualized short and long term goals
 - Coordinate with service providers, case managers, and health plans
 - Conduct or participate in interdisciplinary teams
 - Assist and support the client with scheduling health appointments and accompany if needed
 - Communicate and consult with all providers and the client
 - Provide individualized educational materials according to the needs and goals of the client
 - Promote participation in community educational and support groups
- **Comprehensive Transitional Care:** The facilitation of services for the client, family, and caregivers when the client is transitioning between levels of care.
Examples:
 - Follow-up with hospitals/ED upon notification of admission or discharge
 - Provide post-discharge contact with client, family, and caregivers to ensure discharge orders are understood and acted upon
 - Assist with access to needed services or equipment and ensure it is received
 - Provide education to the client and providers that are located at the setting from which the person is transitioning
 - Communicate and coordinate with the client, family, caregivers, and providers to ensure smooth transitions to new settings
 - Ensure follow-up with Primary Care Provider (PCP)
 - Review and verify medication reconciliation post discharge is completed
- **Individual and Family Supports:** Coordination of information and services to support the client and their family or caregivers to maintain and promote quality of life, with particular focus on community living options.
Examples:
 - Provide education and support of self-advocacy including referral to Peer Support specialists
 - Identify and access resources to assist client and family supports in finding, retaining and improving self-management, socialization, and adaptive skills
 - Educate client, family or caregivers of advance directives, client rights, and health care issues
 - Communicate and share information with the client, family, and caregivers with appropriate consideration of language, activation

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HEALTH HOME TIERS GUIDELINES

level, literacy and cultural preferences

HEALTH HOME TIERS GUIDELINES

- **Referral to Community and Social Supports:** The provision of information and assistance for the purpose of referring the client and their family or caregivers to community based resources as needed.
Examples:
 - Identify, refer and facilitate access to relevant community and social services that support the client's HAP
 - Assist the client to apply for or maintain eligibility for health care services, disability benefits, housing, and legal services not provided through other case management systems
 - Monitor and follow-up with referral resources to ensure appointments and other activities were established and the client engaged in the services
- Use of Health Information Technology to link services: Determine level of service provided and update client health records and HAP according to the Health Home Qualified Lead required information systems.

Client movement between Tiers

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

Tier Level	Minimum Contact	Activity Examples

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HEALTH HOME TIERS GUIDELINES

Tier One	<p>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.</p> <p>Care Coordinator visits the client to complete required assessments and develop the Health Action Plan (HAP) with client centered goals and action steps to achieve those goals.</p>	<p>Review PRISM and other available client records</p> <p>Administer required screenings.</p> <p>Administer optional screenings as needed.</p> <p>Together, the Care Coordinator and the client identify the client's health goals (long term and short term) and develop a Health Action Plan (HAP).</p> <p>Establish a follow up plan with the client.</p> <p>Submit Tier One Claim for payment with date of service when the HAP has been completed.</p>
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HEALTH HOME TIERS GUIDELINES

Tier Level	Minimum Contact	Activity Examples
<p>Tier Two</p> <p>Intensive Health Home care coordination</p>	<p>At a minimum, Tier Two includes one face-to-face visit between the care coordinator and the client during the month in which qualifying health home services are provided.</p> <p><i>Exceptions</i> can be approved to the monthly care coordinator’s face-to-face visit by the Health Home Lead entity. A face-to-face visit with other service providers or allied staff directly related to the client’s HAP goals and included in the action steps may be considered as an exception.</p> <p><i>Exceptions</i> can be approved to monthly care coordinator’s face-to-face visit by the Health Home Lead entity as long as there is documented evidence of other types of qualifying health home activities being provided.</p> <p>At least one qualifying Health Home service must be provided prior to submitting a Tier Two claim for payment.</p>	<p>Administration and follow up on clinical, functional, and resource use screenings</p> <p>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.</p> <p>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.</p> <p>Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes.</p> <p>Referrals and assessment of the use of peer supports, support groups and self-care/self-management programs.</p> <p>Medication reconciliation as part of care transitioning.</p> <p>Education and coaching of caregivers, family members, and other supports.</p>

HEALTH HOME TIERS GUIDELINES

Tier Level	Minimum Contact	Activity Examples
<p>Tier Three</p> <p>Low level Health Home care coordination</p>	<p>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.</p> <p>The client expresses their preference to have fewer contacts or a lower level of engagement with the care coordinator.</p> <p>Contact may not occur every month depending on the HAP and the needs of the client.</p> <p>At least one qualifying Health Home Service must be provided prior to submitting a Tier Three claim for payment.</p>	<p>Monthly calls to the client to discuss success with maintaining health and/or behavioral changes.</p> <p>Monthly call to check in on HAP progress and to identify new or changing goals.</p> <p>At Tier Three the review of the HAP must occur at least every four months for progress towards goals, level of activation, and new or unidentified care opportunities.</p>