

Exhibit B – Essential Requirements

The Washington Health Home program provides a bridge to integrate care within existing care systems. A Health Home is the central point for person-centered care and is accountable for the following:

1. Reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits;
2. Providing timely post discharge follow-up; and
3. Improving Beneficiary outcomes by mobilizing and coordinating primary medical, specialist, behavioral health, and long-term care services and supports (LTSS).

Health Home Care Coordinators must be embedded in community-based settings to effectively manage the full breadth of Beneficiary needs.

The Health Home provider network is administered by a Lead Entity. The Lead Entity contracts with care coordination organizations (CCOs) that deliver Health Home services through Health Home Care Coordinators. The CCO network must include local community agencies that provide community based services or have the expertise needed to support Beneficiaries when providing Health Home services. Examples of these agencies are:

- Community Mental Health Agencies (CMHAs),
- Area Agencies on Aging,
- Substance Use Disorder providers,
- Public Health Districts,
- Accountable Care Organizations,
- Medical Homes, such as Federally Qualified Health Centers or Rural Health Centers and
- Charities.

The Health Care Authority (HCA) and the Department of Social and Health Services (DSHS) have identified specific administrative functions for both Lead Entities and CCOs. Our intent is to assure these functions are accounted for in the Health Home qualification process and documented in signed contracts and subcontracts. We are not restricting the accountability of the administrative functions. A Qualified Health Home may delegate some or part of these functions to downstream contracts with proper oversight.

Lead Entity Requirements – The Lead Entity is accountable for administration of the Health Home program. The Health Home Lead Entity:

1. Has experience operating broad-based regional provider networks.
2. Contracts directly with the state as a Qualified Health Home.

3. Has capacity to provide Health Home services to at least 300 Beneficiaries within their Health Home provider network.
4. Subcontracts with community based organizations to directly provide the Health Home care coordination services.
5. Assigns Health Home Beneficiaries to CCOs, using a smart assignment process, whenever possible. A smart assignment process:
 - a. Uses PRISM or other data systems to match the Beneficiary to the type of CCO that provides most of their services, or
 - b. The CCO has the expertise necessary to support the Beneficiary; or
 - c. Optimizes Beneficiary choice.
6. Maintains a list of CCOs and their assigned Health Home population.
7. Accepts and reports encounters to the HCA in a HIPAA compliant standardized transaction format.
8. Disburses payment to CCOs based upon encounters and services provided by the Health Home Care Coordinator and in accordance with the established three tier Health Home payment system.
9. Ensures person-centered and integrated health action planning. This includes having sufficient Health Home Care Coordinators to provide high touch, in-person, care management, and ensuring that the work of allied staff is documented and complements the work of the care coordinator.
10. Ensures the Health Home Lead Entity obtains all necessary licenses to use the Insignia Health Patient Activation tools. <http://www.insigniahealth.com/products/pam-survey>

Care Coordination Organization Requirements – The CCO must:

1. Subcontract with a Qualified Health Home Lead Entity.
2. Assign a trained and qualified Health Home Care Coordinator to provide the needed Health Home services.
3. Ensure Health Home Care Coordinators actively engage the Beneficiary in developing a Health Action Plan (HAP). *See Exhibit I and J.*
4. Ensure documentation is maintained with confidentiality by all staff, including those complementing the work of a Health Home Care Coordinator.
5. Implement a systematic protocol to assure timely access to follow-up care post

discharge and to identify and re-engage Beneficiaries who do not receive post discharge care.

6. Establish methods to share critical events with the Health Home Care Coordinator within established time periods, such as emergency department visits, inpatient hospitalizations, inpatient discharges, institutional placement and/or discharge, and the need for preventive care.
7. Use a system to track and share Beneficiary information and care needs across providers to monitor outcomes, to initiate recommended changes in care, and to address achievement of health action goals.
8. Use interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting health and health care choices.
9. Provide Health Home services that addresses health disparities with cultural humility.
10. Ensure Health Home Care Coordinators will discuss with treating/authorizing entities, on an as-needed basis, changes in Beneficiary circumstances, conditions, or HAP that may necessitate timely, and in some circumstances, immediate changes in treatment or services.
 - a. A HIPAA-compliant data sharing agreement must be in place when sharing either hard copy or electronic health information;
 - b. The Beneficiary must sign the Health Home Participation Authorization and Information Sharing Consent form before the Health Home Care Coordinator can share protected health information.
11. Ensure Health Home Care Coordinators:
 - a. Complete the Health Home Care Coordinator two day “Basic Training” class prior to serving Beneficiaries and completing HAPs.
 - b. Have access to PRISM, a clinical decision support tool, to view cross-system health and social service utilization to identify care opportunities.
 - c. Accompany the Beneficiary to appointments when necessary to assist in achieving health action goals.
 - d. Coordinate and mobilize treating/authorizing entities as necessary to reinforce and support the Beneficiary’s health action goals.
 - e. Provide in-person care coordination activities and interventions, educational, and informational materials with cultural humility.

- f. Include and leverage direct care workers (paid or unpaid) who have a role in supporting the Beneficiaries to achieve health action goals and access health care services.
- g. Address the full array of Beneficiary needs, as reflected in the implementation of a person-centered HAP. This includes administering standardized mandatory and, when medically appropriate, optional health screenings, identifying inappropriate or gaps in health care utilization, making referrals and facilitating communication across systems of care.