ST. JOSEPH'S HEALTH
A Member of Trinity Health

ST PETER'S HEALTH PARTNERS
A Member of Trinity Health

Community Health Connections Health Home

Health Home Core Services

Comprehensive Care Management

- Completion of comprehensive assessment of preliminary service needs
- Development of individualized Plan of Care, including Member goal, objectives and interventions and include family and other social supports as appropriate.
- Consult with multi-disciplinary team on Member's Plan of Care, needs or goals.
- Consult with Primary Care or any specialists involved in the Member's care.
- Monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines.
- Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care & improved health outcomes.
- Prepare client crisis intervention plan.

Care Coordination and Health Promotion Services

- Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info.
- Implementation of the individualized Plan of Care (with active Member involvement) through appropriate linkages, referrals, coordination and follow-up to needed services and supports such as patient education, self-help/recovery and self-management.
- Appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and members or their family members.
- Health education specific to an individual's chronic conditions, development of self-management plans, education regarding the importance of immunizations and screening, providing support for improving social networks and providing health-promoting lifestyle.
- Assist members to participate in the implementation of the Plan of Care and place a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions.
- Conduct case reviews with interdisciplinary team to monitor/evaluate client status/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.
- Monitor/support/accompany the client to scheduled medical appointments.
- Crisis intervention, revise care plan/goals as required.

Comprehensive Transitional Care

- Follow up with hospitals/ER upon notification of a Member's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.
- Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to 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.
- Link Member with community supports to ensure that needed services are provided.
- Follow-up post discharge with Member/family to ensure Member Plan of Care needs/goals are met.

Member and Family Support Services

- Develop/review/revise the individual's Plan of Care with the Member/family to ensure that the Plan reflects individual's preferences, education and support for self-management.
- Consult with Member/family/caretaker on advanced directives and educate Member on rights and health care issues, as needed.
- Meet with Member and family, inviting any other providers to facilitate needed interpretation services.
- Refer Member/family to peer supports, support groups, social services, entitlement programs as needed to help promote health literacy and ability to self-manage care.

Referral to Community and Social Support

- Provide assistance for members to identify, obtain, and maintain eligibility for community based resources, health care, benefits, housing, personal need and legal services.
- Care Coordinator actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- Care Coordinator identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- Care Coordinator promotes evidence based wellness and prevention by linking health home enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.
- Collaborate/coordinate with community base providers to support effective utilization of services based on client/family need.