Collaborative For Children & Families

INTRODUCING HEALTH HOMES

Improving Care for Medicaid Recipients with Chronic Conditions

CORE HEALTH HOME SERVICES	EXAMPLES OF CORE HEALTH HOME SERVICES INTERVENTIONS/ACTIVITIES
Comprehensive Care Management	Complete a comprehensive health assessment/reassessment inclusive of medical/behavioral/rehabilitative and long-term care and social service needs
	Complete/revise an individualized patient centered plan of care with the patient to identify patients' needs/goals and include family members and other social supports as appropriate.
	Consult with multidisciplinary 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 plan.
Care Coordination & Health Promotion	Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info.
	Link/refer client to needed services to support care plan/treatment goals, including medical/behavioral health care; patient education, and self-help/recovery and self-management.
	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 client'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 client with community supports to ensure that needed services are provided.
	Follow-up post discharge with client/family to ensure client care plan needs/goals are met.
Patient & Family Support	Develop/review/revise the individuals plan of care with the client/family to ensure that the plan reflects individuals' preferences, education, and support for self-management.
	Consult with client/family/caretaker on advanced directives and educate on 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 resources and link client with community supports as needed.
	Collaborate/coordinate with community base providers to support effective utilization of services based on client/family need.

All services are for youth 0-21, unless noted

Must have active Medicaid

CLICK HERE to make a referral. Or call 212-444-5437 for more information