Health Homes: It all comes down to **H-E-A-L-T-H**

H—High-risk population: Members identified as high risk for adverse health-related events are assigned to Health Homes. Therefore, Health Homes are entrusted with coordinating the integration of all necessary health services for these Members.

E—Engage early: An intense initial outreach must be made to establish early engagement and reduce the risk of adverse outcomes. Outreach efforts include, but are not limited to:

- Three phone calls to the Member within the first week of assignment, make calls
  - On different days of the week
  - At different times of the day
- Weekly follow-up phone calls to the Member
- Mail Health Home materials to the Member and request a return phone call
- Visits by the Health Home Coordinator to
  - Member's residence
  - PCP/community service appointments
  - Pharmacy
  - Other locations known to be frequented by the member

Use of member health information as a resource is strongly advised.

A—Aggressively manage care: The goal of this phase is to disrupt the patterns which have led to past adverse outcomes and to support sustained wellness. Minimum requirements are outlined in the Program Manual. Some Members will require more frequent contact to ensure engagement and treatment adherence. A collaborative approach among the behavioral and medical care providers and the Health Home strengthens relationships with Members and facilitates to better outcomes.

L—Lead actively: Strong and committed leadership within the Health Home fosters an optimal Member experience across all six core Health Home functions. Leadership should routinely review the Health Action Plans (HAPs), which are an important measure of the Health Home's ability to work collaboratively with providers to positively impact the Member's overall health.

T—Team effort: Intra-agency team meetings, trainings and case conferences held at regular intervals facilitate effective management of each Member's care. Such collaboration helps the team leverage the strengths of individual Health Home team members and provider staff in order to meet the Member's health related needs.

H—Holistic care model: The Health Home model of care considers the whole person, addressing physical, behavioral, social and other needs which have implications for care planning and outcomes. Categorizing and prioritizing Member needs which have the potential to impact health are important parts of the Health Home's initial member evaluation, and should serve as the basis for the initial HAP formulation. For example, a Member who is homeless will likely need assistance in finding housing before other needs can be adequately addressed.