Care Network of Alabama, Inc.

Health Home Provider Reference Guide

What is the Health Home?

An enhanced Primary Care Case Management program intended to provide Alabama Medicaid recipients with a medical home in order to achieve high-quality, lower costs, improved access, and better utilization in the management of care

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Any pa	tient with one chronic condition	at risk	of developing another
•	Mental Health Condition	•	Cardiovascular Disease

Substance Use Disorder

Who is eligible for the Health Home?

- Asthma
- Diabetes
- Heart Disease
- BMI over 25
- Transplants

- Cardiovascular Disease •
- COPD
 - Cancer •
 - HIV •
 - Sickle Cell Anemia
 - Hepatitis C Virus

Goals of the Health Home

- Improve health outcomes for Alabama Medicaid Patient 1st Population •
- Help Primary Medical Providers effectively manage patients with chronic conditions •
- Improve communication across care settings
- Integrate behavioral health with physical health
- Empower patients to self-manage their conditions
- Reduce the cost of care

How will the Health Home affect my practice?

- PMPs will continue to determine their panel size
- Implementation of the Health Home program will not change a PMP's current panel. Patient 1st patients will • continue to have the ability to choose the doctor or clinic for their PMP and change PMPs as is presently done
- Must be willing to collaborate with Health Home staff for care coordination success
- Must participate in quarterly medical management meetings via one of the following options: •
 - Attend regional meeting
 - Alabama Care Plan Representative one-on-one at provider's office

Reimbursements/Financials:

- \$8.50 for each patient qualifying for Health Home Services
- \$0.50 for all other Patient 1st patients on your panel
- Case Management fees will continue to be made on the first check run of the month to Patient 1st PMPs
- Not applicable for Rural Health Clinics or Federally Qualified Health Centers

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Services:		
 Care Coordination: Nurses and Licensed Social Workers Completion of psychosocial assessments to determine the needs of patients Referral for needed resources including transportation, financial assistance, food, and support services Provide education regarding chronic illnesses and provide support in managing their care 	 <u>Transitional Care:</u> Nurses and Licensed Social Workers Assist patients in transitioning from one level of care to another Partnering with medical facilities to develop discharge plans Medication reconciliation Education and support services in managing chronic conditions 	 <u>Medication Management:</u> Pharmacists Medication reconciliation Educate patients regarding medication management Prior authorization assistance Programs to improve adherence and health literacy
Care Complaints/Grievances:		
 Recipient complaints and grievar Coordinator, Health Home Executoll-free number The Health Home's Quality Care will respond to the recipient with Complaints and grievances are m Executive Director to identify issuffor improvement 	Health Home Toll Free: at and 855-698-2273 Health Home Local: 205-558-7660	
How to refer a patient for Health Home	Services:	
 Submit Health Home Referral Fo Call the Health Home toll free or Contact your Care Coordinator d 	local number: 855-698-2273 or 205-558	3-7660
	Contact Information:	
Michael Battle Executive Director of Alabama Care Plan Health 205-558-7645 <u>mbattle@uabmc.edu</u>	f Home	eral Health Home Inquiries Toll Free: 855-698-2273 Local: 205-558-7660