Managing Medicaid Health Home Patients

Health Homes is a method of delivering enhanced health care services that promises better patient experience and better results than traditional care. The Health Home has many characteristics of the Patient-Centered Medical Home, but is customized to meet the specific needs of Medicaid recipients with chronic medical conditions or behavioral health conditions.

Use Case: Enable Health Home Notifications and access to Point of Care clinical documentations.

Project Details

6 Federally Mandated Core Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Patient and Family Support
- Referral to Community and Support Services

Impact

- Care transition follow-up within 72 hours of discharge
- Follow-up within 7 to 30 days after hospitalization for mental illness
- Follow-up post Emergency Department visit

DSS

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