



# Coordinated Care Health Homes

Member Handbook to Health Home Services for Eligible  
Medicaid Members

## Contacts

### By Phone

If it is hard to read or understand this booklet, please call Member Services at 1-877-644-4613. We can help by providing the information in another format, such as LARGER PRINT, Braille, or have the information read to you in your primary language.

For people who have difficulties with hearing or speech the TDD/TTY 1-866-862-9380. Your phone must be equipped to use this line.

### By Mail

1145 Broadway, Suite 300  
Tacoma, WA 98402

### On the Web

[www.CoordinatedCareHealth.com](http://www.CoordinatedCareHealth.com)

### Other Languages

You can ask for this guide in other languages call: 1-877-644-4613

**SPANISH:** Si la información adjunta no está en su idioma primario, por favor llame al 1-877-644-4613 (Para TDD/TTY, llame al 1-866-862-9380).

**VIETNAMESE:** Nếu tin tức đính kèm không có ngôn ngữ của quý vị xin gọi 1-877-644-4613 (TDD/TTY: 1-866-862-9380)

**CHINESE:** 如果隨附的資料不屬你的母語，請打電話 1-877-644-4613 (TDD/TYY: 1-866-862-9380)。

**CAMBODIAN:** ដល់អ្វីដែលព័ត៌មានដែលបានភ្ជាប់នៅទីនេះមិនមែនជាភាសាដើមរបស់អ្នកទេ សូមទូរស័ព្ទមកលេខ 1-877-644-4613 (សម្រាប់អ្នកមានវិញ្ញាណ TDD/TTY សូមទូរស័ព្ទមកលេខ 1-866 862-9380)

**RUSSIAN:** Если прилагаемая информация не на вашем родном языке, позвоните, пожалуйста, по номеру телефона 1-877-644-4613 (номер телекоммуникационного аппарата (телетайпа) для лиц с нарушениями слуха: 1-866-862-9380).

**KOREAN:** 동봉한 안내자료가 귀하의 모국어로 준비되어 있지 않으면 1-877-644-4613 (청각장애자/시각장애자용: 1-866-862-9380) 으로 연락하십시오.

**LAO:** ຖ້າຫາກວ່າຂ່າວສານອັນນີ້ບໍ່ແມ່ນພາສາທີ່ທ່ານຮູ້ຈັກ, ກະຮຸນາໂທຣະສັບໄປຫາ 1-877-644-4613 (TDD/TTY: 1-866-862-9380).

# Table of Contents

Contacts .....	2
By Phone or Mail.....	2
Other Languages .....	2
On the Web .....	2
What is a Health Home.....	4
Who is eligible for Health Home services? .....	4
When does the Health Home program start? .....	4
Who provides Health Home services? .....	4
What is a Health Home Care Coordinator? .....	4
How do Health Home services work for you? .....	5
How do you get Health Home services?.....	5
Do you get to stay with your health care and other providers?.....	6
How will providers know if you are in the Health Home program and who to contact?.....	6
Do you have to be in the Health Home program?.....	6
Do you have to pay for Health Home services? .....	6
What if you are unhappy with your Care Coordinator? .....	6
What if you move to another area of the state?.....	6
What if you lose Medicaid coverage? .....	6
What are your grievance and appeal rights? .....	6
What if you change your mind and want to participate in Health Home services again?.....	6
For American Indians or Alaskan Natives .....	7
What happens if you need help right away because of a health crisis? .....	7

## What is a “Health Home”?

A Health Home is not a place. It is a set of new care coordination services, provided by a care coordinator who will work with you to increase coordination of all the services and supports the care you currently receive. This is a free benefit provided to you by your Medicaid health plan, Coordinated Care.

Participation in a Health Home will make things go more smoothly for you by working to coordinate your various care needs. The result should be fewer unnecessary hospital admissions and fewer avoidable visits to emergency departments. The system is designed to improve your satisfaction through coordinated care.

Health Home services include:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional planning (example: help when you are discharged from a hospital or a care facility)
- Individual and family support services (example: identifying and recognizing the role families, informal supports, and caregivers provide in supporting you to reach your health goals)
- Referral to community and social support services (examples: transportation, food, housing)
- Use of health information technology to link services, if applicable

Health Home services are designed to support you with your ongoing chronic conditions and assist you in meeting your health goals. Health Home services improve coordination and care for medical and other social service needs such as long term services and supports, mental health services, and chemical dependency services. Health Homes are intended to reduce gaps in service and increase coordination between all of your providers.

## Who is eligible for Health Home services?

The services are only for individuals with Medicaid coverage who have chronic conditions.

## When does the Health Home program start?

This program will begin on July 1, 2013, but you may qualify for these services at any time.

## Who provides Health Home services?

An individual called a “care coordinator” is the primary person who provides Health Home services. These care coordinators work for Coordinated Care, your Medicaid health plan. You will receive a call from a care coordinator who will answer your questions and set up a time to meet with you.

## What is a Health Home Care Coordinator?

A Health Home care coordinator is an individual who, with your written consent, will work with you to develop a Health Action Plan (HAP) and participate in health home services. The care coordinator will work with you to coordinate your care so you receive the right care, at the right time, and in the right place.

A care coordinator will contact you to describe Health Home care coordination services and answer your questions. When this individual contacts you, you may choose whether you want to participate. If you decide not to participate in the Health Home program, it will not impact your eligibility for other services. You can get more information on Health Homes on the internet by going to the Health Home link at [www.CoordinatedCareHealth.com](http://www.CoordinatedCareHealth.com).

## How do Health Home services work for you?

Here are some examples of Health Home services. These provide an idea of how the services can work for you. Although this is not a complete list, it may be helpful.

Health Home Program	Example of Service
Get coaching from a care coordinator to support your participation in your care.	Assistance in developing your list of questions for your specialist so you have them ready when you go to your appointment.
Ongoing communication between your care coordinator and providers.	<p>A message that alerts your providers if you are admitted to or released from the hospital.</p> <p>A person you can talk with when you are worried your provider does not understand how hard it is to travel to appointments.</p>
Coordination of the team of providers working with you.	Your personal care provider, primary care doctor, care coordinator, psychologist and pharmacist meet and make sure your prescriptions work together. They let you know it's ok or if you need to change prescriptions.
24 hour/7 day a week availability to provide information and emergency health home service consultation services.	A person you can talk to if you think your medicine is making you sick and don't know if you should seek help or not.

## How do you get Health Home services?

It's as easy as 1, 2, 3...

1. **Speak to a Care Coordinator to Learn More:** You will be contacted by a care coordinator to discuss the Health Home program. The care coordinator will answer your questions and you can decide whether or not to participate.
2. **Complete a Consent Form for Information Sharing:** The care coordinator will support you in completing a Health Home Services Consent Form. This consent provides your permission to allow sharing of your medical and social service information. The information will only be shared with providers and others you designate.
3. **Complete a Health Action Plan (HAP):** The care coordinator will support you in completing a Health Action Plan (HAP). The Health Action Plan will include health goals that you choose.

Using the Health Action Plan for guidance, the care coordinator will work with you to see if you need more coordinated or additional services and resources for:

- health care
- long term services and supports
- mental health
- chemical dependency

You can request and arrange future visits at any time. You can choose to meet in person or talk on the phone.

## Do you get to stay with your current health care and other providers?

Yes! They continue as they are now and future services will be authorized the same way they are now. As part of Health Home services, your care coordinator may be in contact with providers about coordinated coverage and transitions in care as your needs change.

## How will providers know if you are in the Health Home program and who to contact?

Once you have completed the release of information form, Coordinated Care will be in touch with them and let them know you are enrolled in the program.

## Do you have to be in the Health Home program?

No, this is a voluntary program. You are not required to participate.

## Do you have to pay for Health Home services?

No, there is no cost to you for these services.

## What if you are unhappy with your care coordinator?

You can contact Coordinated Care anytime and let us know. We will get a different care coordinator assigned to you.

## What if you move to another area of the state?

If you move, you will be contacted by a new care coordinator about ongoing services.

## What if you lose Medicaid coverage?

You will lose Health Home services until you regain coverage.

## What are your grievance and appeal rights?

You keep your current Medicaid grievance and appeal rights.

## What if you want to opt out of the Health Home program?

You can call Member Services at 1-877-644-4613 and say you don't want to be in the Health Home program any more. The program is voluntary.

## What if you change your mind and want to participate in Health Home Services again?

You can contact the Coordinated Care at 1-877-644-4613 and let them know you want Health Home services again.

## For American Indians or Alaskan Natives

If you are a member of a federally recognized Tribe or an Alaskan Native, you may choose to participate in a Health Home. If you decide to go back to your Tribal clinic or fee-for-service, let your Tribal clinic know (they can assist you) or call Member Services at 1-877-644-4613. You will not have to wait to switch back.

## What happens if you need help right away because of a health crisis?

- If there is a life threatening emergency call 911
- Mental health crises, call the Crisis Line at 1-800-584-3578
- Statewide Domestic Violence Hotline, call 1-800-562-6025