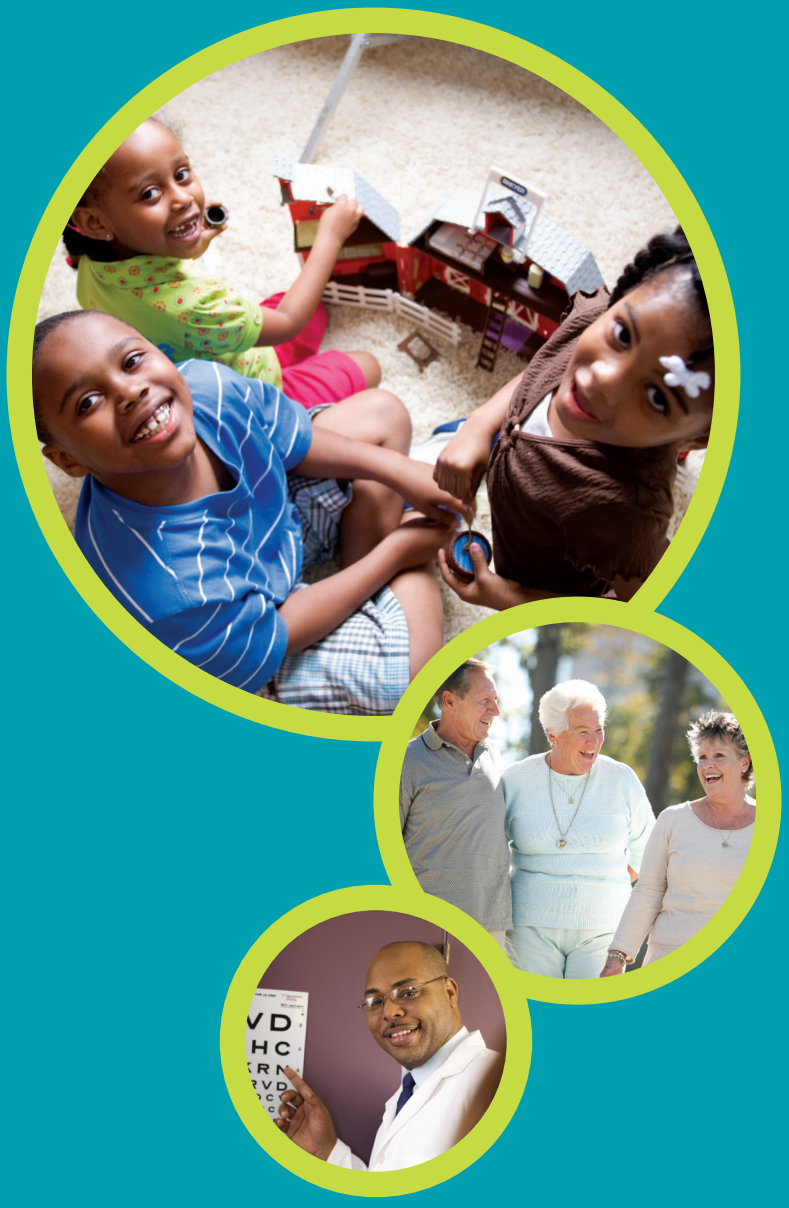
Health Home

Improving your quality of life by coordinating medical and social services



MOLINA® HEALTHCARE

English
If you need this information in a different format or language, call Molina Healthcare at (800) 869-7165.

Armenian
Այս տեղեկատվությունը մեկ այլ ձևաչափով կամ լեզվով ստանալու համար, զանգահարեք Մոլինա Առողջապահություն (800) 869-7165:

Hindi
यदि आपको यह जानकारी भिन्न फॉर्मेट अथवा भाषा में चाहिए तो मोलिना हैल्थकेयर को (800) 869-7165 पर कॉल करें।

Hmong
Yog koj xav tau cov xov xwm no ua lwm tus qauv lossis lwm hom lus, hu rau Molina Healthcare ntawm (800) 869-7165.

Lao
ຖ້າທ່ານຢາກໄດ້ຂໍ້ມູນໃນແບບຕ່າງ ຫຼື ພາສາອື່ນ, ໂທຫາອົງການດູແລສຸຂະພາບໂມລິນ່າທີ່ (800) 869-7165.

Khmer
ប្រសិនបើលោកអ្នកត្រូវការព័ត៌មាននេះ ជាទម្រង់ និងភាសាផ្សេងគ្នា សូមហៅទូរស័ព្ទមក Molina Healthcare គឺលេខ៖ (800) 869-7165។

Korean
다른 포맷이나 언어로 정보를 이용하려면, 몰리나 보건 사업부 (800) 869-7165에 문의하십시오.

Punjabi
ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦੀ ਵੱਖਰੇ ਪ੍ਰਾਰੂਪ ਜਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਲੋੜ ਹੈ, ਤਾਂ ਮੋਲੀਨਾ ਹੈਲਥਕੇਅਰ ਨੂੰ (800) 869-7165 ਤੇ ਕਾੱਲ ਕਰੋ।

Romanian
În cazul în care aveți nevoie de aceste informații într-o formă sau limbă diferite, apelați Molina Healthcare la (800) 869-7165.

Ukranian
Якщо ви бажаєте отримати цю інформацію в іншому форматі чи іншою мовою, зателефонуйте в компанію Molina Healthcare на номер (800) 869-7165.

Russian
Если данная информация нужна вам в другом формате или на другом языке, позвоните в компанию Molina Healthcare по телефону (800) 869-7165.

Somali
Haddii aad warbixintan ku rabto qaab kale ama luuqad kale, ka wac Molina Healthcare (800) 869-7165.

Tigrinya
እንተደኣ ነዚ ሓበሬታ ብካልእ ቅርጺ ወይም ቋንቋ ደሊኹም፣ ናብ Molina Healthcare ብቀጥሪ ስልኪ (800) 869-7165 ደውሉ።

Traditional Chinese
如果您需要不同格式或不同語種的此資訊，請致電Molina醫療保健：(800) 869-7165 。

Vietnamese
Nếu bạn cần thông tin này ở định dạng hoặc bằng ngôn ngữ khác, hãy gọi cho Molina Healthcare theo số (800) 869-7165.

Samoan
Pe a e manaomia lenei faamatalaga ise faatulagaga ese poo se isi gagana, telefoni atu ia Molina Healthcare ile (800) 869-7165.

Amharic
ይህንን መረጃ በሌላ ቅርጽ ወይም ቋንቋ ለማግኘት ከፈለጉ፣ ለሞሊና የጤና ማዕከል በስልክ ቁጥር (800) 869-7165 ይደውሉ።

«Dt»

«LtrMbrNm»
«Address»
«CSZ»

Member ID: **«CardId»**

As part of your Molina Healthcare benefits, beginning **«Date»** you will have the chance to receive new Health Home care coordination services. These services are in addition to your Medicaid coverage.

What is a Health Home? A Health Home is not a place. It is a set of new care coordination services. These services include:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional planning- get help when you are discharged from a hospital or other institution such as a nursing home
- Individual and family support services- educate family, friends, and caregivers in providing support to reach your health goals.
- Referral to community and social support services
- Support your chronic conditions and assist in meeting your health goals

How does this affect your current coverage?

- Your current Medicaid benefits do not change, including appeal rights
- You can keep the providers you have
- Health Home care coordination services are voluntary additional benefits available at no cost to you

If you are currently enrolled in any Molina Healthcare services or are receiving community based care coordination services, they are listed below. You will have the choice to continue with these services and take part in the new Health Home program. If you decide to opt-out of the Health Home program, it will not impact your eligibility.

«CMPrg»

A care representative will be contacting you with more details about the program. If you have questions, please call Molina Healthcare at (800) 869-7165 or 711 (TTY) Monday through Friday from 8:00 a.m. to 5:00 p.m. Management

Table of Contents

How to get more information

By Phone

If it is hard to read or understand this booklet, please call Molina Healthcare Member Services at (800) 869-7165. We can help by providing the information in another format, such as LARGE PRINT or Braille or have the information read to you in your primary language.

For people who have difficulties with hearing or speech, the TTY/TDD line is 711. Your phone must be equipped to use this line.

Online Client Portal

If you wish to verify your Health Home services coverage, select a different Health Home, or to opt-out of the Health Home program go to www.WAProviderOne.org.

Interactive Voice Recognition (IVR)

You may call our automated system anytime at (800) 869-7165.

During business hours, Monday through Friday from 8:00 a.m. to 5:00 p.m., you may always talk to a live person by following voice prompts.

Other Languages

You can ask for this guide in other languages by calling (800) 869-7165.

On the Web

For more information on Medicaid, visit www.hca.wa.gov/medicaid.

For more background on the Health Homes program, visit www.hca.wa.gov/pages/health_homes.aspx.

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 you currently receive.

Participation in Health Home services will make things go more smoothly for you by working to coordinate your various care needs. The results should be fewer unnecessary hospital admissions and avoidable visits to emergency departments. The system is designed to improve your satisfaction through coordinating your 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 increase coordination between all of your providers.

Who is eligible for Health Home services?

The services are for Medicaid members who need services that support them with their chronic conditions. The Health Care Authority determines who is eligible for Health Home services.

When does the Health Home program start?

This program began on July 1, 2013 and was phased in throughout Washington State into November 2013.

Who provides Health Home services?

A "care coordinator" is the primary person who provides Molina Healthcare Health Home services. Care coordinators work for Health Home lead organizations that contract with Medicaid. A care coordinator will call you, 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 someone who, with your written consent, will work with you to develop a Health Action Plan (HAP) and coordinate your care so you receive the right care, at the right time and in the right place. Care coordinators have specialized training to assist members with achieving their health goals.

A care coordinator will contact you to describe Health Home care coordination services and answer your questions. When you are contacted, you may choose 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 at www.hca.wa.gov/health_home.aspx.

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 if you choose to participate. Although this is not a complete list, it may be helpful.

Health Home Program (if you give permission)	Example of Service
Get coaching from a care coordinator to support your participation in your care	Help in making a list of questions for your specialist so you have them ready when you go to your appointment.
Ongoing communication between your care coordination and providers	A message that alerts your providers if you are admitted to or released from the hospital. A person you can talk with when you are worried your provider does not understand how hard it is to travel to appointments.
Care coordination through a team of providers working with you	Your personal caregiver, primary care provider, care coordinator, psychologist and pharmacist meet to make sure your medications work together. They let you know it is okay or if you need to change your medications.
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 do not know if you should seek help or not.

How do you get Health Home services?

It is as easy as 1, 2, 3…

1. **Be assigned to a Health Home:** Once you are eligible, you will be connected to a Health Home care coordinator. 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.

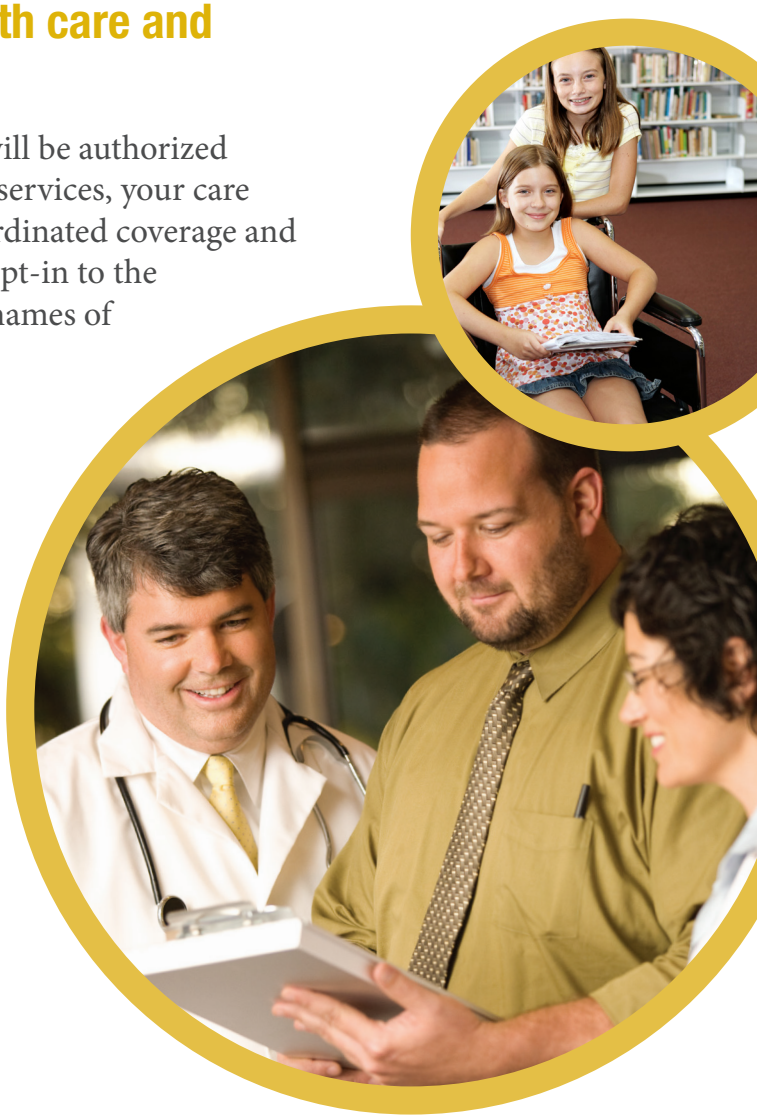
3. **Complete a Health Action Plan (HAP):** The care coordinator will support you in completing a Health Action Plan (HAP). The Health Action Plan will include health goals that you choose. The care coordinator will meet with you face-to-face, in a place you are comfortable, to complete the HAP.

   Using the Health Action Plan for guidance, the care coordinator will work with you to see if you need additional services or resources for:
   - Health care
   - Long term services and supports
   - Mental health
   - Chemical dependency

   You can request and arrange future visits any time. Whether you meet in person or talk on the phone depends on your needs.

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 the Health Home services, your care coordinator may be in contact with providers about coordinated coverage and transitional care as your needs change. If you decide to opt-in to the program, be sure to let your care coordinator know the names of your providers and the services you are receiving.



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

They can tell by accessing your Medicaid information through ProviderOne.

Do you have to be in the Health Home program?

No, this is a voluntary program. You are not required to participate however, the Health Home program provides important care coordination assistance to get all of the medical and social services you need.

Do you have to pay for Health Home services?

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

What if you disenroll from Molina Healthcare or move to another area Z of the state?

If you lose your Medicaid eligibility, you will no longer be eligible for Health Home services. If you move to an area where there is a different Health Home lead organization, you will be contacted by a new care coordinator about ongoing services.

What are your complaint and appeal rights?

You keep your current Medicaid complaint and appeal rights.

What if you want to opt out of or withdraw from the Health Home program?

You can call Molina Healthcare at (800) 869-7165 and say you do not want to be in the Health Home program or talk to your care coordinator. The program is voluntary.

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

You can contact the Molina Healthcare at (800) 869-7165 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 (800) 562-3022. You will not have to wait to switch back.

Who to call in the event of a health crisis

- For a life threatening emergency, call 911
- For mental health crisis, call the Crisis Line at (800) 584-3578
- For the Statewide Domestic Violence Hotline, call (800) 562-6025

34944WA0913
MRC Part #13-1330
Approvals: MHW – 10/8/13 HCA – 11/12/13