Health Home Program
Washington

Information for Long Term Services and Supports

Improving clients' health and independence, reducing their health care costs, and helping them become more engaged in their own health care—these are the goals of the Health Home Program. To be eligible for the Health Home Program, Apple Health clients of all ages, including Medicaid/Medicare dual eligible clients, must:

- Have at least one chronic condition and
- Be at risk of poor health outcomes in the future based on age, gender and diagnoses.

Clients in the health home program are assigned Care Coordinators who help coordinate medical care, behavioral health services, long-term services and supports, and other social services. Health Home services are provided by organizations qualified by the Health Care Authority and the Department of Social and Health Services.

The Health Home Program includes support to clients receiving care either in their own home from a personal care provider or homecare agency, or in a residential or other more intensive care setting such as:

- Assisted Living Communities
- Adult Family Homes
- State Operated Living Alternatives
- Adult Day Centers

Clients who participate in the Health Home Program will continue receiving their other services and supports from their current providers. Participating in the health home program will not change the way a client's other services are currently authorized.

Care Coordinators will contact you, or someone else from your organization to discuss coordinated coverage and transitions in care for your clients who participate in or who are considering enrolling in the program. Care Coordinators do more than just support clients in identifying and achieving personal health goals. They also support providers, like you, in ensuring that care is well-coordinated to meet clients' needs. Care Coordinators also provide:

- **Transition planning** to ensure that appropriate follow-up services are in place for those discharging from a hospital, nursing facility, or other institutional care setting.
- **Coordination of individual and family support services** to increase health knowledge, promote engagement and self-management capabilities.
- **Social service connections** for which your client may be eligible (e.g., housing, transportation, education supported employment, heating assistance, etc.).
- **Appointment assistance** to help clients learn and better understand how to get the most out of their time with physicians and other providers.

We appreciate anything that you can do to support clients in their choice to enroll and participate in the Health Home Program.

For more information about the Washington Health Home Program visit Health Home website at **http://hca.wa.gov/billers-providers/programs-and-services/health-homes**