Date:----------

Dear Medical Provider,

Your patient _____ is currently enrolled in Community Healthcare Network's Health Homes Care Coordination Program. Health Homes is a care coordination/care management model that is designed to promote and/or facilitate the communication among all of the professionals (such as yourself) that are involved in a patients care in an effort to ensure that all of his/her medical, behavioral and social services needs are met in a comprehensive manner. Your patient became enrolled in the Health Homes Program, by virtue of his/her Medicaid eligibility and chronic medical and behavioral condition. As such, our goal is to work together to increase the quality and efficiency of care received while reducing some of the high costs that come along with preventable hospitalizations and Emergency Room visits.

We acknowledge the time constraints and demands of your medical practice. However, greatly appreciate your recommendations or those of a team designated by you in order to collaboratively work towards:

- Complete coordination and integration of services such as medical, mental health, specialty and community based services
- Increasing patient adherence to medical appointments and treatment recommendations
- Ensuring the patient's medical, behavioral and psycho-social needs are met
- Our contacts will either occur in the presence of our patient, at a scheduled appointment, or via telephone conferences.

Your patient has been assigned to a Care Management team. The Care Management team lead by _____ will:

- Thoroughly assess and assist with psycho-social needs to include housing, entitlements, legal, education and support services at the community level
- Remind patient of appointments
- Provide escorts to appointments
- Coordinate transportation if necessary
- Assist patient with navigating medical and social service systems
- Serve as a liaison between the patient and the service providers
- Reach out to the designated medical team periodically to discuss medical recommendations, incorporating them into the patient's care plan goals and provide updates on client progress through phone contacts and at scheduled appointments

We look forward to collaborating with your medical team to promote our mutual patient's adherence to care and treatment. If you should have any questions or concerns, please call the Health Homes Care Coordination Program toll-free at: (855) 246-4422.

If you have any additional questions or concerns you may also call the following team members directly:

Patient Navigator: **(Name, Tel#, and Email)**

Care Manager: **(Name, Tel#, and Email)**

Care Coordinator: **(Name, Tel#, and Email)**

Sincerely,
Community Healthcare Network Health Homes Care Coordination Program Team