Healthy San Diego
Behavioral Health Subcommittee

HEALTH HOMES WORK GROUP

Agenda
Friday, September 28, 2018
11:30 AM to 1:30 PM

Dial In Number: (877) 594-8353 - Passcode: 92819822#

2-1-1 San Diego Connection Center
3860 Calle Fortunada, Suite 101
San Diego, CA. 92123

PLEASE BRING YOUR OWN LUNCH

A.	Call To Order / Introductions	George Scolari/Caryn Sumek
B.	Review of the Health Homes Kick Off Event (July 23, 2018)	George Scolari
C.	Additions to Agenda	All
D.	Healthy San Diego Overview	George Scolari/Greg Knoll
E.	Healthy San BH Subcommittee Charter	George Scolari
F.	HSD Health Homes Contact Card	All
G.	Health Homes Membership (who's missing)	All
H.	Collaboration with Whole Person Wellness	George Scolari/Susan Bower
I.	DHCS Health Homes Crosswalk Template	All
J.	Legal Aid Society/Consumer Center	Greg Knoll
K.	DHCS Health Homes Readiness Review	All
L.	Centers for Supportive Housing (CSH Project)	Simonne Ruff/Susan Lee
M.	Updates and Announcements	All
N.	Next meeting: October 26, 2018	
O.	Adjournment	

Healthy San Diego

Overview

Formed in 1998, Healthy San Diego is the umbrella in which Medi-Cal Managed Care Plans operate. There are 3 Medi-Cal Managed Care Models. County Operated Health Systems (COHS), Two Plan Models and Geographic Managed Care. San Diego and Sacramento are Geographic Managed Care.

- COHS is a system in which a County runs the Medi-Cal Managed Care system. For example, Orange County is a COHS. CalOptima is the one and only Medi-Cal Managed Care Plan.
- Two Plan model is a system in which there are two basic plans to choose. 1 would be a County managed plan and 1 a private plan. For example, LA is a Two Plan Model. In LA County, you choose LA Care or Health Net. Under LA Care and Health Net are other contracted plans like Kaiser, Blue Cross, Care1st etc... But a members card will say LA Care or Health Net.
- Geographic Managed Care is San Diego and Sacramento only. Any plan can apply to be a Medi-Cal Managed Care Plan in these two Counties. It promotes healthy competition among Plans and consumer choice.

HSD STRUCTURE

Healthy San Diego Joint Consumer & Professional Advisory Committee. Monitors Medi-Cal Managed Care issues affecting San Diego County and advises the Director of San Diego Health and Human Services Agency.

Healthy San Diego QI Subcommittee. The QI Subcommittee consists of the health plans, AIS, BHS, Hospitals, Providers, CCHEA and HHSA. All of our Work Groups report up to the QI Subcommittee.

Healthy San Diego BH Subcommittee. The BH Subcommittee consists of the health plans, BHS, BHS Organizational Providers, Hospital Association, Psychiatric Health Facilities, The Patient Advocacy Program, CCHEA and HHSA.

Work Groups. Work Group's report to either the QI or BH Subcommittee.

- Health Plan Work Group
- Regional Center Work Group
- Health Ed/Cultural Linguistics Work Group
- Facility Site Review Work Group
- Health Homes Work Group
- BH Operations Work Group

MOU's. Within HSD we manage MOU's with several agencies, mostly HHSA. Examples are Behavioral Health, AIS, Regional Center, California Children's Services (CCS), CHDP, TB Program, Polinsky Center for Children, Women, Infants & Children (WIC) and several others.

Healthy San Diego (Medi-Cal)

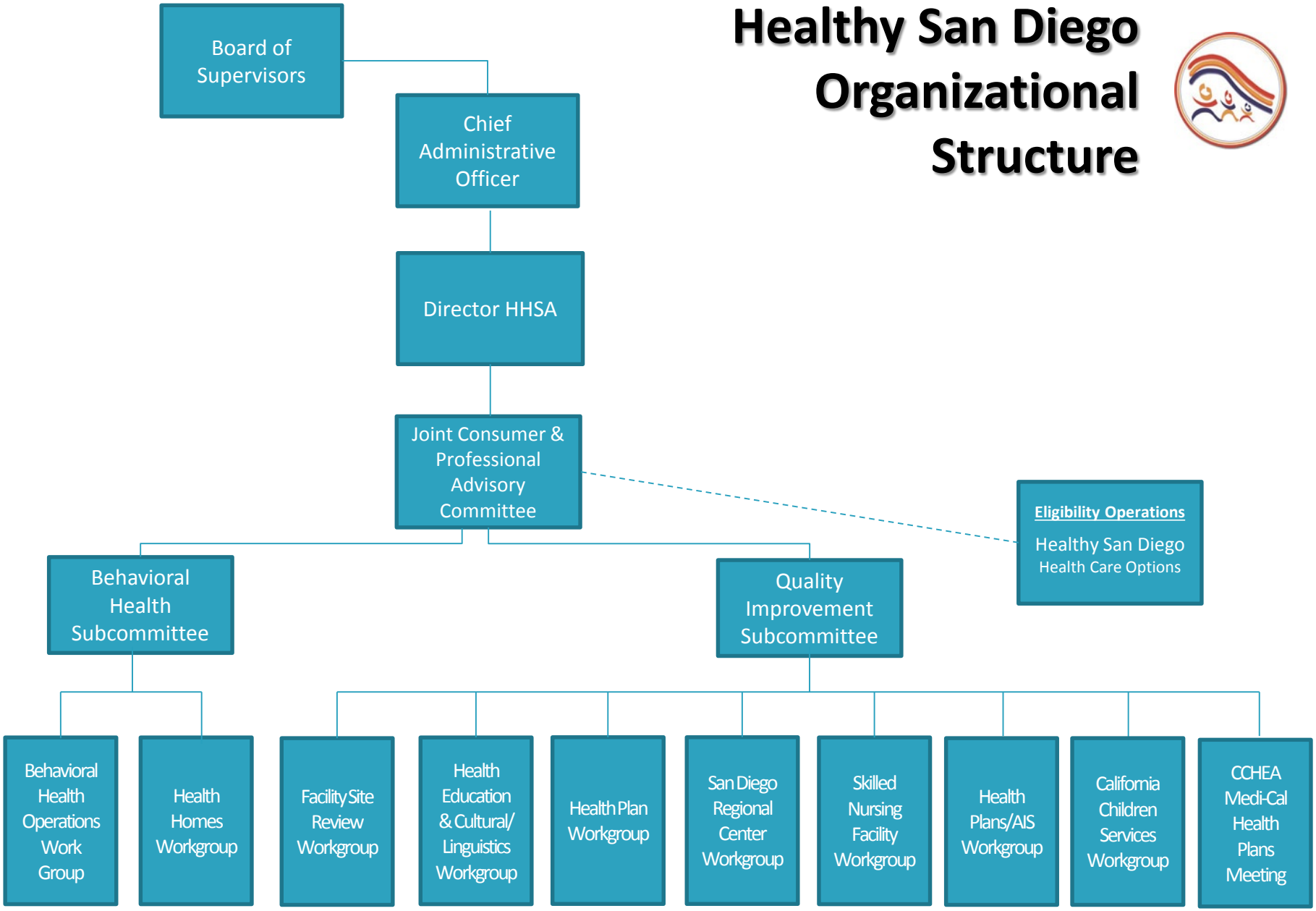
Health Homes Program Contact Information

Health Plan	Member Services	Pharmacy Line	Behavioral Health Liaison	Physical Health Liaison	Health Plan Primary Liaison
Aetna Better Health	1-855-772-9076	1-866-785-5702	Jeff Dziedzic 1-602-799-1631	Jeff Dziedzic (602) 799-1631 DziedzicJ@AETNA.com	**Jeff Dziedzic** **(602) 799-1631** **DziedzicJ@AETNA.com**
Care1st Health Plan	1-855-699-5557	1-800-605-2566	David Bond (323) 889-6638 ext. 5238	Christy Taylor (619) 528-4800 ext. 7648 ctaylor@care1st.com	**Kim Fritz** **(619) 528-4817** **KFritz@care1st.com**
Community Health Group	1-800-224-7766	1-800-224-7766	Juan Vazquez 1-800-404-3332	Yousaf Farook (619) 498-6540 YFaroo@chgsd.com	**George Scolari** **(800) 404-3332** **gscola@chgsd.com**
Health Net	1-800-675-6110	1-800-867-6564	Nadia Pugh (818) 676-6152	Kelly Nokleby (916) 246-3590 Knokleby@cahealthwelllness.com	**Fedra Hassanpour** **(314) 365-7112** **Fedra.Hassanpour@healthnet.com**
Kaiser Permanente	1-800-464-4000	1-800-290-5000	Cheri Mason (760) 599-2272	Anna De Groote (626) 372-9233 Anna.M.Degroote@kp.org	**Sarah Legg** **(619) 372-1861** **Sarah.j.legg@kp.org**
Molina Healthcare	1-888-665-4621	1-800-526-8196	Randy Nater (562) 951-8301 ext. 121122	Lily Wang (858) 974-1737 Lily.Wang@MolinaHealthcare.com	**Vivian Urquizu** **(858) 614-1580 ext. 121589** **Viviana.Urquizu@Molinahealthcare.com**
UnitedHealthcare	1-866-270-5785	1-800-310-6826	Christin Dillon 1-619-641-5345	Reina Hudson (916) 403-0643 Reina.hudson@optum.com	**Reina Hudson** **(916) 403-0643** **reina.hudson@optum.com**
San Diego County Access & Crisis Line (888) 724-7240 / Consumer Center for Health Education & Advocacy (877) 734-3258					

HHSA Behavioral Health Services Caryn Sumek (619) 584-5009 Caryn.Sumek@sdcounty.ca.gov	HHSA Integrated Services/Whole Person Wellness Susan Bower (858) 692-5574 Susan.Bower@sdcounty.ca.gov	Consumer Center for Health Education & Advocacy Carol Neidenberg (619) 471-2612 CarolN@cchea.org

7-25-18

Healthy San Diego Organizational Structure



Healthy San Diego
Behavioral Health Subcommittee, Operations Work Group and Health Homes Work Group Charter

I. PURPOSE OF WORKGROUP

The purpose of the Healthy San Diego Behavioral Health Subcommittee (BHSC]) is for Medi-Cal Managed Care Plans (hereinafter referred to as "Plans") in San Diego County to collaborate in activities that support contractual requirements set forth by plan regulatory agencies. The overall goal of these collaborative activities is to improve physical health, behavioral health and well-being, preventive health care knowledge, and health care utilization of Medi-Cal Managed Care plan members in San Diego County.

II. BACKGROUND

The HSD BHSC was formed in 1998 under the direction of the Joint Consumer and Professional Advisory Committee of Healthy San Diego (HSD).

The HSD BHSC Operations Group was formed in 2014. The HSD BHSC Operations Work Group reports directly to the HSD BHSC. The Operations Work Group was formed to work through contractual agreements between the Medi-Cal Managed Care and County Mental Health Plan and to develop Policy & Procedures. The Operations Work Group is comprised primarily of Medi-Cal Managed Care and County Mental Health Plan staff however others may be invited as needed.

The HSD BHSC Health Homes Work Group was formed in 2018. The HSD BHSC Health Homes Group reports directly to the HSD BHSC. The Health Homes Work Group was formed to develop and implement the Department of Health Care Services Health Homes Program due to be implemented in July 2019. The Health Homes Program will be a Medi-Cal Managed Care benefit and high levels of coordination with Federally Qualified Health Centers (FQHC's), San Diego County Health & Human Services Agency, their contracted programs and other Community Based Organizations will be necessary and required. The Health Homes Program is not specific to behavioral health. Health Homes will coordinate the full range of physical health, behavioral health, community based long term services and supports needed by Medi-Cal Managed Care members.

This Charter was established in 2017 to clarify activities of the Healthy San Diego Behavioral Health Subcommittee and its Work Groups.

III. SCOPE OF WORKGROUP

The BHSC:

- Reports to the Healthy San Diego Joint Consumer & Professional Advisory Committee

- Meets monthly or as needed
- Focuses on coordination between Medi-Cal Managed Care and County Mental Health Plan
- Identify and break down barriers to physical and behavioral health care
- Facilitates trainings to Medi-Cal Managed Care and County Mental Health Plan providers
- Support integration/communication between physical and behavioral health care

The BHSC Operations Work Group:

- Meets monthly or as needed
- Develops and updates contractual agreements
- Develops and updates joint Policy and Procedures
- As needed reviews dispute resolution cases in private between the Medi-Cal Managed Care Plan involved and County Mental Health Plan

The BHSC Health Homes Work Group:

- Meets monthly or as needed
- Develops and updates contractual agreements
- Develops and updates joint Policy and Procedures
- Provides a forum for physical and behavioral health providers to coordinate care

IV. ROLE AND RESPONSIBILITY OF SUBCOMMITTEE AND WORK GROUP MEMBERS

The Subcommittee and Work Group's consists of at least one representative from each Medi-Cal Managed Care Plan in San Diego County as well as representatives from the County Mental Health Plan and their Administrative Service Organization, HHSA Medical Care Services Division, HHSA Integrated Services advocates, providers and hospitals. For the Health Homes Work Group, additional physical health and homeless service providers are included in the membership. Participating members should have knowledge of issues relating to the Behavioral Health Subcommittee and its Work Groups.

V. PROCEDURES

1. Committee Members (BHSC)

- At least 1 representative per Medi-Cal Managed Care Plan operating in San Diego County
- 1 HHSA Medical Care Services Division representative
- 1 County Mental Health Plan Quality Improvement representative
- 1 County Mental Health Plan Adult System of Care representative
- 1 County Mental Health Plan Child Youth and Families System of Care representative
- 1 County Mental Health Plan Administrative Service Organization representative

- 1 Hospital Association representative
- 1 Psychiatric Hospital representative
- 1 Health Care advocate
- 1 Health Plan behavioral health provider
- 1 County Mental Health organizational provider
- 1 Alcohol and Drug Services representative
- 1 Federally Qualified Health Center representative
- 1 Health Center representative
- 1 appointed Healthy San Diego representative to assist with administrative duties

Committee Members (BHSC Operations Work Group)

- No more than 2 representatives from each Medi-Cal Managed Care Plan
- 1 County Mental Health Plan Quality Improvement representative
- 1 County Mental Health Plan Adult System of Care representative
- 1 County Mental Health Plan Child Youth and Families System of Care
- 1 County Mental Health Plan Administrative Service Organization representative
- 1 appointed Healthy San Diego representative to assist with administrative duties

Committee Members (BHSC Health Homes Work Group)

- No more than 4 representatives from each Medi-Cal Managed Care Plan
- 1 County Mental Health Plan Quality Improvement representative
- 1 County Mental Health Plan Adult System of Care representative
- 1 County Mental Health Plan Child Youth and Families System of Care
- 1 County Mental Health Plan Administrative Service Organization representative (Optum)
- 1 representative from Alcohol & Drug Services Contractors Association
- 1 representative from the Hospital Association of San Diego & Imperial Counties
- 1 representative from an acute psychiatric hospital
- 1 representative from an acute medical hospital
- 1 appointed Healthy San Diego representative to assist with administrative duties
- 1 Federally Qualified Health Center representative
- 1 Health Center representative
- 1 representative from HHSA Integrated Services
- 3 representative from Homeless & Community Housing
- 1 representative from the Consumer Center for Health Education & Advocacy
- 1 representative from Legal Aid Society of San Diego
- 1 representative from the Department of Health Care Services and/or Harbage Consulting
- 1 representative from 211 San Diego

2. Budget

The HSD BHSC, Operations Work Group and Health Homes Work Group does not have a Budget.

3. Term of Service

Participation in the HSD BHSC is required for each Medi-Cal Managed Care Plan operating in San Diego County and appropriate San Diego County Health & Human Services Agency staff. Participation in the HSD BHSC Operations Work Group is determined by each Medi-Cal Managed Care Plan and the County Mental Health Plan. The Chair of the HSD BHSC is appointed by the HSD BHSC and must be a representative of a Medi-Cal Managed Care Plan operating in San Diego County. The Chair of the HSD BHSC Operations Work Group is appointed by the Operations Work Group and must be a representative of the County Mental Health Plan. The Chairs of the HSD BHSC and BHWG Operations Work Group serve as each other's Co-Chair. The BHSC Health Homes Work Group Co-Chairs consist of one Medi-Cal Managed Care representative and one County Health & Human Services Agency representative.

4. Attendance and Frequency of Meetings

The HSD BHSC, Operations Work Group and Health Homes Work Group meets at least monthly unless it is determined by the Chair, Co-Chair and/or majority of the membership to cancel a meeting.

5. Other Duties and Responsibilities

The HSD BHSCChair reports to the HSD Joint Consumer and Professional Advisory Committee on a monthly basis. The HSD BHSC Operations Work Group and Health Homes Work Group Chair and or Co-Chair reports to the HSD BHSC during the BHSC monthly meeting.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: June 28, 2018

ALL PLAN LETTER 18-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS PARTICIPATING IN THE HEALTH HOMES PROGRAM

SUBJECT: HEALTH HOMES PROGRAM REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance regarding the provision of Health Homes Program (HHP) services, and the development and operation of the HHP, to Medi-Cal managed care health plans (MCPs) implementing the HHP.

BACKGROUND:
The Medicaid Health Home State Plan Option is authorized under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the HealthCare and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703 of the ACA allows states to create Medicaid health homes to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

In California, Welfare and Institutions Code (WIC) Sections 14127 through 14128 authorize the Department of Health Care Services (DHCS), subject to federal approval, to create the HHP for Medi-Cal members with chronic conditions who meet the eligibility criteria specified by DHCS.

POLICY:
Effective upon the HHP implementation date for each MCP implementing the HHP, the MCP is responsible for providing the following six core HHP services to eligible Medi-Cal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

The Medi-Cal Health Homes Program Guide (Program Guide) is available on the HHP webpage of the DHCS website.[1] The Program Guide outlines HHP policies, including member eligibility criteria, and contains DHCS' operational requirements and guidelines on HHP. DHCS may update the Program Guide to reflect the latest HHP requirements

[1] The HHP Program Guide can be found at: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

and guidelines. DHCS will notify MCPs whenever the Program Guide is updated, so that MCPs can obtain the latest information on HHP.

HHP MCPs must meet all program and reporting requirements specified in the Program Guide, all applicable state and federal laws and regulations, MCP contracts, and other DHCS guidance, including, but not limited to, APLs. Additionally, MCPs must communicate all HHP requirements to, and ensure the compliance of, their contracted HHP providers, including Community Based Care Management Entities, as well as any delegated entities and subcontractors.

MCPs are responsible for ensuring that all delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Health Homes Program: 2018/Early 2019 Learning Collaborative Plan

8/13/18

Harbage Consulting is facilitating the Health Homes Program Learning Collaborative on behalf of the California Department of Health Care Services (DHCS). The Learning Collaborative is designed to provide technical assistance to health plans to support implementation of the program and to serve as a vehicle for health plans to share learnings and best practices. All of the health plans that will be participating in the Health Homes Program are invited to participate, regardless of their implementation phase.

Below is a summary of the Learning Collaborative activities that will take place in 2018 and early 2019. These areas of technical assistance were identified based on DHCS and health plan experience as they have been planning for, and beginning to implement, the Health Homes Program. Plans will be subsequently developed for Learning Collaborative activities in future years.

2018 / Early 2019 Learning Collaborative Activities

Six Sessions. Six Learning Collaborative sessions will be held between August 2018 and January 2019. Harbage Consulting will plan the sessions and will solicit DHCS and health plan input and participation. The sessions will be held by teleconference or webinar. The Learning Collaborative sessions will cover the following topics:

1. Informal Lessons Learned Call (August 2018). This informal call will include Phase 1 and Phase 2 health plans. It will provide an opportunity for Phase 1 plans to provide advice and lessons learned to the Phase 2 plans, and for Phase 2 plans to ask questions.

2. Preparing for Implementation (September 2018). This session will focus on helping the Phase 2 and 3 health plans establish Health Homes Program infrastructure and processes and build and train provider networks.

   This webinar will involve Phase 1 health plans sharing their experience with establishing Health Homes Program infrastructure and processes and developing the materials for the DHCS readiness review process.

   Building provider networks is core to the development of the Health Homes Program. It would be helpful if the Phase 1 health plans would discuss their experience building their provider networks and any advice they have for Phase 2 and 3 health plans. This could include efforts they undertook to train their new providers, work within their county to streamline HHP processes for providers and collaborate on provider training.

3. Health Homes Program/Whole Person Care Intersection (October 2018). This session will focus on providing technical assistance to Phase 2 and Phase 3 health plans on the intersection of the Health Homes Program and the Whole Person Care Pilot Program.

   This would include presenting DHCS guidance on how to handle people who are eligible for both programs, providing technical assistance on how to use and tailor the Health Homes Program/Whole Person Care Pilot services crosswalk template, and discussing how to determine which Medi-Cal beneficiaries are eligible for both programs and how to work collaboratively with Whole Person Care Pilots to serve beneficiaries.

4. Early Implementation Learnings (November 2018). This session will focus on health plan experience implementing the Health Homes Program in Phase 1. The session would be for both Phase 2 and Phase 3 plans. Topics covered for this session would be developed in concert with the Phase 1 plans but may include: targeted engagement list, outreach and enrollment, information sharing, CB-CME reporting, and interactions with the specialty mental health system.

5. Serious Mental Illness Population Model Development (March 2019). This session will focus on how Phase 1 plans developed their model for providing Health Homes Program services to individuals with serious mental illness. This session would be for both Phase 2 and Phase 3 plans. We anticipate that a future session will discuss lessons learned and best practices for providing services to this population.

6. Intersection with Drug Medi-Cal (April 2019). This session will focus on the intersection between the Health Homes Program and the Drug Medi-Cal Organized Delivery System.

Facilitate Information Requests. Harbage Consulting will facilitate health plan requests for information related to best practices and lessons learned from previous implementation phases.

Identify Future Learning Collaborative Topics. Topics will be identified for additional 2019 Learning Collaborative activities based on input and questions from the health plans.

Template for Comparing Health Homes Program and Whole Person Care Pilot Program Services

The California Health Homes Program (HHP) and the Whole Person Care (WPC) pilot program both provide care management and care coordination services to eligible Medi-Cal beneficiaries. In some situations, Medi-Cal beneficiaries may be eligible for both programs.

This document provides a template for WPC Lead Entities (LEs) to use to compare the services that will be provided to Medi-Cal beneficiaries under the HHP with the services provided under the WPC pilot program.

Health Homes Program: The HHP is a comprehensive, longitudinal benefit that is available to eligible managed-care plan members to support identified medical, behavioral health, substance use, and housing support services until such time as care plan goals are accomplished or are no longer relevant. Care coordination services provided through the HHP are based on comprehensive, multi-disciplinary evaluations of members that inform the development of an individualized Health Action Plan (HAP) for each member, which is shared amongst the care team in a collaborative effort to manage each member's care appropriately and efficiently.

Relevant care plan goals (HAP goals) are the responsibility of this multi-disciplinary care team and are addressed and modified over time as members' needs change. Members are not required to interact with a particular type of service in order to be eligible or to receive HHP services. This is a key difference that separates the HHP from WPC: HHP service eligibility is not determined, nor is it affected by, other services a person has accessed or is currently receiving.[1]

Column 1 below lists the services that must be provided to eligible Medi-Cal beneficiaries under the HHP. Health plans may choose to provide additional services within these service types.

Whole Person Care: The participating LEs determine which of their DHCS-approved services are provided to each pilot target population. This program is designed to provide Medi-Cal reimbursement for services that are not otherwise coverable by

[1] Hospice and Nursing Facility Residents are excluded from participation in the Health Homes Program.

Medi-Cal. Some of the care management and care coordination services the pilots provide may be duplicative of the services provided under the HHP and therefore are not eligible for Medi-Cal reimbursement; however, there are other services that may qualify. For example: Medical respite, recuperative care, sobering center services, outreach and engagement, and other mobile services. If you have any questions or would like additional guidance on a specific service, please bring this to the attention of and discuss with DHCS.

For additional information, please see the HHP and WPC Eligibility & Enrollment Policy Guidance released by DHCS in June 2018.

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
1. Comprehensive Case Management			
Engage member in HHP and in their own care			
Assess member's readiness for self-management using screenings & assessments with standardized tools			
Promote member's self-management skills to increase their ability to engage with health and service providers			
Support achievement of member's self-directed, individualized health goals to improve their functional or health status, or prevent or slow functional declines			
Complete a comprehensive health risk assessment to identify the member's physical, mental health, substance, palliative care, and social service needs			
Develop a member's Health Action Plan to be shared with the member's multi-disciplinary care team and revise it, over time and as care plan goals and priorities change, as appropriate			
Reassess a member's health status, needs, and goals			
Coordinate and collaborative with all involved parties to promote continuity and consistency of care			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Clarify roles and responsibilities of the multi-disciplinary team, providers, member, and family/support persons			
2. Care Coordination			
a. Member Support			
Working with members to implement their Health Action Plan			
Assisting members in navigating health, behavioral health, and social service systems, including housing			
Sharing options with members for accessing care and providing information regarding care planning			
Identifying barriers to treatment and medication management adherence			
Monitoring and supporting treatment adherence (including medication management and reconciliation)			
Assisting in attainment of member's goals as described in the Health Action Plan			
Encouraging member decision-making and continued participation in HHP			
Accompanying members to appointments, as needed			
b. Coordination			
Monitoring referrals, coordination, and follow-ups to ensure needed services and supports are offered and accessed			
Sharing information with all involved parties to monitor member conditions, health status, care planning, medication usages and side effects			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Creating and promoting linkages to other services and supports			
Helping facilitate communication and understanding between HHP members and healthcare providers			
3. Health Promotion			
Encouraging and supporting health education for the member and family/support persons			
Assessing the member's and family/support persons' understanding of the member's health condition and motivation to engage in self-management			
Coaching members and family/support persons about chronic conditions and ways to manage health conditions based on the member's preferences			
Linking the member to resources for: smoking cessation; management of member chronic conditions; self-help recovery resources; and other services based on member needs and preferences			
Using evidence-based practices, such as motivational interviewing, to engage and help the member participate in and manage their care			
4. Comprehensive Transitional Care *The Health Homes Program supports and, when necessary, provides comprehensive transitional care services to enrolled members, regardless of service location.*			
Providing medication information and reconciliation			
Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Collaborating, communicating, and coordinating with all involved parties			
Easing the member's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management			
Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services			
Arranging transportation for transitional care, including to medical appointments, as per NMT and NEMT policy and procedures			
Developing and facilitating the member's transition plan			
Preventing and tracking avoidable admissions and readmissions			
Evaluating the need to revise the member's HAP			
Providing transition support to permanent housing			
5. Individual and Family Supports			
Assessing the strengths and needs of the member and family/support persons			
Linking the member and family/support persons to peer supports and/or support groups to educate, motivate and improve self-management			
Connecting the member to self-care programs to help increase their understanding of their conditions and care plan			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Promoting engagement of the member and family/support persons in self-management and decision making			
Determining when member and family/support persons are ready to receive and act upon information provided and assist them with making informed choices			
Advocating for the member and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals			
Accompanying the member to clinical appointments, when necessary			
Identifying barriers to improving the member's adherence to treatment and medication management			
Evaluating family/support persons' needs for services			
6. Referral to Community and Social Supports			
Identifying the member's community and social support needs			
Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, child care, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the member			
Providing member with information on relevant resources, based on the member's needs and interests			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports			
Following up with the member to ensure needed services are obtained			
Coordinating services and follow-up post engagement			
Checking in with the members routinely through in-person or telephonic contacts to ensure they are accessing the social services they require			

Crosswalk Template: Health Homes Program and Whole Person Care Housing Services

The California Health Homes Program (HHP) and the Whole Person Care (WPC) pilot program both provide housing support services to eligible Medi-Cal beneficiaries. In some situations, Medi-Cal beneficiaries may be eligible for both programs.

This document provides a template for counties to use to compare the housing services that will be provided to Medi-Cal beneficiaries under the HHP with the housing services provided under the WPC Pilot program.

Health Homes Program: The HHP provides the following two sets of housing services, which are listed in Column 1 and outlined in the 2015 Centers for Medicare & Medicaid Services informational bulletin, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities:"

- Individual Housing Transition Services, including services that support an individual's ability to prepare for and transition to housing such as individual outreach and assessments; and

- Individual Housing and Tenancy Sustaining Services, including services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy, such as landlord education and tenant coaching.

Whole Person Care: The pilots determine the housing services that are provided to each pilot target population. This program is designed to provide Medi-Cal reimbursement for services that are not otherwise coverable by Medi-Cal. The housing services the pilots provide may be duplicative of the services provided under the HHP. However, there are other housing services that may qualify for Medi-Cal reimbursement. For example: Funding for housing (e.g. first/last months' rent, utilities set-up charges). If you have any questions or would like additional guidance on a specific service, please bring this to the attention of and discuss with DHCS.

For additional information, please see the HHP and WPC Eligibility & Enrollment Policy Guidance released by DHCS in June 2018.

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
1. Individual Housing Transition Services			
Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers			
Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal			
Assisting with the housing application process. Assisting with the housing search process			
Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses			
Ensuring that the living environment is safe and ready for move-in			
Assisting in arranging for and supporting the details of the move			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized			
2. Individual Housing and Tenancy Sustaining Services			
Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations			
Education and training on the roles, rights and responsibilities of the tenant and landlord			
Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy			
Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action			
Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized			
Assistance with the housing recertification process			
Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers			
Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management			

Medi-Cal Health Homes Program

Member Toolkit

The Health Homes Program offers new, free services to help you get the health care you need. These services are part of your Medi-Cal benefits.

What's in this toolkit?

Welcome to the Health Homes Program

Dear Member,

You qualify for new, free services to help you get the health care you need. You can get these services through the "Health Homes Program." These services are part of your Medi-Cal benefits.

What services can I get?

This new program gives you a care team—including a care coordinator. Your care coordinator will work with you and your health providers, such as your doctors, specialists, pharmacists, case managers, and others. They will make sure everyone is informed about your health and the services you need. Your care team can also help you find and apply for services in the community, such as food and housing.

You don't have to change your doctor or any of your other providers. Your care coordinator will help the providers you already have work together.

Your care team can help you:

- Find doctors and get an appointment.
- Better understand your prescription drugs.
- Set up transportation to your doctor visits.
- Get follow-up services after you leave the hospital.
- Find and apply for food benefits and housing.
- Connect you to other community programs and services.

How do I get these services?

If you want to get these services, call your Medi-Cal plan and tell them you want to be in the "Health Homes Program." You can find the phone number for your Medi-Cal plan by going to to **www.dhcs.ca.gov** and searching for "health care directory."

Someone from your care team will contact you to talk about your health goals. They will also help you make a plan to get the care you need.

These services are free as part of your Medi-Cal benefits. Joining the Health Homes Program is your choice. You do not have to be in the program if you don't want to. If you want to try this program, you can join now and stop at any time. If you have questions, contact your local health plan.

What Is the Health Homes Program?

The Health Homes Program offers new, free services to help you get the health care you need. These services are part of your Medi-Cal benefits.

If you join this program, you will have your own care team to support you as you work toward your health goals.

- Joining the Health Homes Program will not change or take away any Medi-Cal benefits you have now.
- You won't have to change your doctor or any of your providers.
- Your providers will get extra help to better coordinate your care, including a care coordinator and a care team.

Care Coordinator

A care coordinator is a trained professional. You can call them when you need help with your health care or getting services. Your care coordinator will help you set up a care team that includes all of your providers and your personal support system.

Your care coordinator can help you:

- Connect with all your doctors so that everyone is fully informed
- Find doctors and get appointments
- Better understand your prescription drugs and order prescription refills
- Get follow-up services after a hospital visit
- Set up transportation to your doctor visits
- Connect with other community programs and services

Care Team

Your care team will keep all of your providers fully informed, help you manage all of your health care services, and help you set goals for getting and staying healthy. Your care team will also help you find out if you need any health care or community services and apply for them.

For example, your care team can help you find and apply for:

- A place to live
- Food and nutrition benefits
- Employment counseling
- Legal services
- Child care
- Community-based long-term services and supports
- Disability services

You can apply for services provided by both county and community agencies. If you already have a case manager at a community agency, that person can be part of your care team.

Who Can Join the Health Homes Program?

2

Health Homes Program services are for Medi-Cal members with certain chronic health conditions. Your Medi-Cal plan will contact you if you qualify for the program. You can also call your Medi-Cal plan to find out if you qualify, or you can ask your doctor or clinic.

Do You Qualify for the Health Homes Program?

To qualify for the Health Homes Program, you have to meet all of these requirements.

1 ☑ You can check at least one of the boxes below:

- ☐ You have at least two of these conditions: chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic kidney disease, dementia, or substance use disorders.
- ☐ You have hypertension (high blood pressure) and one of these conditions: COPD, diabetes, coronary artery disease, or chronic or congestive heart failure.
- ☐ You have one of these conditions: major depression disorders, bipolar disorder, or psychotic disorders (including schizophrenia).
- ☐ You have asthma.

2 ☑ You can check at least one of the boxes below:

- ☐ You have three or more of the conditions listed under #1.
- ☐ You stayed in the hospital in the last year.
- ☐ You visited the emergency department three or more times in the last year.
- ☐ You do not have a place to live.

If you want to know more, call your Medi-Cal plan and ask about the "Health Homes Program." It is your choice to join. If you want to try the services, you can stop at any time.

You can find the phone number for your Medi-Cal plan by going to www.dhcs.ca.gov and searching for "health care directory."

To find out how to join the Health Homes Program, see the other side of this sheet. ▼

How Do I Sign Up for the Health Homes Program?

If you want Health Homes services, you have to join the program. **But you are not required to get these services.** You can also stop the services at any time.

Joining the Health Homes Program Is Simple

All you have to do is call your Medi-Cal plan and tell them you want to join the "Health Homes Program."

You can find the phone number for your Medi-Cal plan by going to www.dhcs.ca.gov and searching for "health care directory."

You can also call Health Care Options at 1-800-430-4263 to get connected to your Medi-Cal plan over the phone.

You can also tell your doctor or clinic staff that you want to get Health Homes services.

What Happens Next?

After you tell your Medi-Cal plan that you want to join the Health Homes Program, a member of your care team will contact you. This discussion will be to talk about your health goals, needs, and current providers. You will be assigned a care coordinator who will work with you and your providers to make a plan for getting you the services you need.

What Are Health Homes Services?

Health Homes Services try to make it easier for you to get the care you need.

Coordinating Your Care

After you contact your Medi-Cal plan, they will assign you a care coordinator. Your care coordinator will talk with you about what care you need, and work with you to put together a care team.

Your care team can include:

- Your doctors and specialists
- Your pharmacist
- The medical equipment company you use
- A housing navigator
- Other people that you choose, such as your family or other support people

Keeping Everyone Up to Date

Your care coordinator can connect you to doctors and treatment, help you talk to doctors about your needs, and even go with you to appointments.

Your care coordinator can keep all of your providers up to date on your health and the services you receive.

Getting Tools to Help You Stay Healthy

You and your family can learn about the best ways to manage your health conditions. Your care coordinator can also connect you to self-help resources and other educational services.

Helping You Move From One Care Setting to Another

If you need to enter or leave a hospital or nursing facility, your care team will help you move safely and easily from one place to the other. Your care coordinator can help you with issues like:

- Learning how to take care of yourself after a hospital stay
- Making follow-up appointments
- Filling prescriptions
- Getting transportation to appointments

Your housing navigator may be able to help you find a temporary or permanent place to stay after you leave the hospital.

What Are Health Homes Services?

Strengthening Your Support System

If you choose to include your family or friends on your care team, your care coordinator can make sure they know about your conditions and ways to help you. They may also be able to go with you to appointments.

Connecting You to Community Services

Many things affect health, not just going to the doctor or hospital. Your care coordinator can help you find and apply for the community resources that you need. These include food, temporary and permanent housing, work, child care, disability services, services to help you stay in your home, and others.

How Does Care Coordination Work?

More About Your Care Team

Your care team is built around you. It includes your care coordinator, as well as your doctors, nurses, pharmacists, and caregivers. Your care team can include a housing navigator, who can help you find and apply for temporary and permanent housing. Your care coordinator can also help you contact other people you trust, such as people from community organizations that provide meals or other services.

More About Your Health Action Plan

Together, you and your care team will write a "Health Action Plan." This plan can cover how you can get help with various needs, including:

- Physical health
- Mental health
- Addiction or substance abuse treatment
- Services that help you stay in your home (such as help with bathing, dressing, and household chores)
- Community programs, including food services and housing

Your plan will also note any other doctors that you see. The plan will be updated as you receive services and as your needs change.

Your Health Action Plan will be available to all of your providers, and anyone else who you choose. This lets your entire care team know how to help you reach your health goals. ■

Frequently Asked Questions

Will I lose any medical coverage or benefits if I join the Health Homes Program?

- No. The Health Homes Program is a new benefit for people who qualify. You will keep all of your existing benefits and rights as a Medi-Cal member. The Health Homes Program will be different from any care coordination or case management services you are getting now. If you join the Health Homes Program, your Medi-Cal plan will give you extra services and support to help improve your care.

Does it cost anything to join?

- No. These services are free. They are included as part of your Medi-Cal coverage.

How do I join?

- Call your Medi-Cal plan today to find out if you qualify. If you join, you can stop getting services at any time.

Will I have to change my doctors?

- No. You do not have to change your doctors to join the Health Homes Program. The program helps all your doctors have the same information about your health care needs and work together to coordinate your services. It also provides more people to support your care team, like a care coordinator and a housing navigator, if you need one.

What is a care coordinator andwhat do they do?

- A care coordinator is a trained professional, like a nurse or social worker. They will make sure that your doctors, pharmacists, and other providers work together to help you take care of your health. You can work with your care coordinator and even involve your family or friends if you want.
- Your care coordinator will:
  - ☐ Ask you what you need and try to help you get it
  - ☐ Be available for you to call and ask questions
  - ☐ Help you make appointments, arrange transportation, get approval for services, and check on prescriptions
  - ☐ Help you find the right providers, including specialists and mental health providers
  - ☐ Help you apply for services you may need to help you live independently (such as meal delivery, housing, and help with personal care)

Will this program help me find aplace to live?

- Your care team can include a housing navigator. They can help you find and apply for temporary or permanent housing. The Health Homes Program can't help you pay for rent, but it could help you find and apply for housing programs that help pay for rent. ■

Still have questions? *Call your health plan for more details.*

Contact Information for Local Resources and Medi-Cal Plans

5

Health Homes resources in your county:

Managed Care Plan:

Local Organizations:

Other Local Resources:

Questions:

Know Your Rights & Responsibilities

As a member of a health plan, you have rights and responsibilities. You have these rights in all Medi-Cal plans and programs, including the Health Homes Program.

You have the right to:

- Be treated with dignity, free from discrimination on the basis of race, national origin, age, or gender.
- Get timely access to medically necessary services.
- Be told where, when, and how to get needed services.
- Take part in decisions about your care, including the right to refuse treatment or to choose someone to make decisions for you.
- Be treated by providers who have experience and expertise in your condition.
- Have your medical records, care plan, and treatment kept private.
- Get a copy of your medical records and care plan.
- Hire, fire, and manage your In-Home Supportive Services (IHSS) provider.
- Have someone help you receive the health care you need.
- Receive accessible care if you have a disability—including braille or large print, if wanted.
- Receive language services, including interpreters and documents in another language, if wanted.
- File an appeal for services that are denied or reduced, and file a grievance (complaint) about your health plan.

You have the responsibility to:

- Use providers in your health plan's network.
- Work with your provider and health plan to get prior authorization (pre-approval) for needed services.
- Tell your health plan about your care needs and concerns.
- Tell your health plan and your county Medi-Cal office about any changes in your contact information (if you move or change your phone number).

For more information about all of your rights, call the Department of Managed Health Care at ***1-888-466-2219****.*

Medi-Cal Health Homes Program

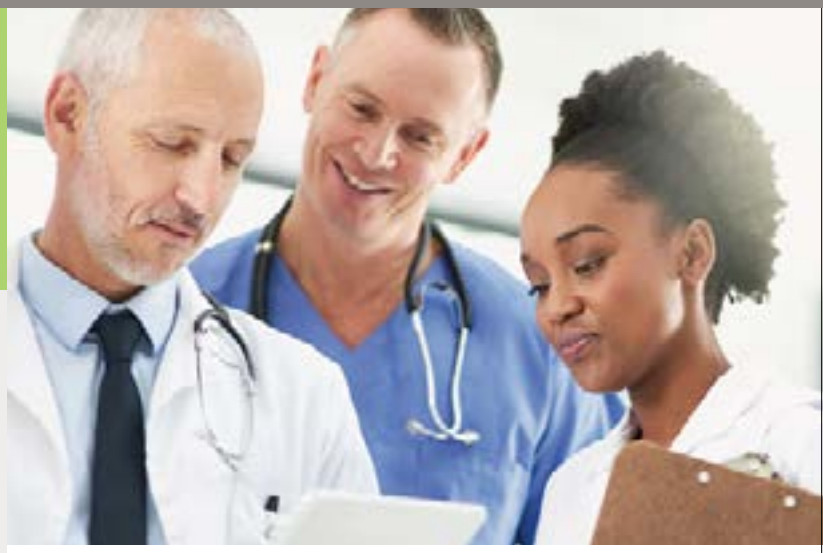
Provider Guide

This provider guide provides information on the California Medi-Cal Health Homes Program (HHP) for Community-Based Care Management Entities (CB-CMEs), providers, community-based organizations, and other stakeholders.

Health Homes Program

An Overview

The Medi-Cal Health Homes Program (HHP) provides new services for certain Medi-Cal members with chronic conditions.



Health Homes Program Basics

- HHP services are new services that are free for eligible individuals as part of their Medi-Cal benefits.
- Patients stay enrolled in their Medi-Cal Managed Care Plan and continue to see the same doctors, but they now have an added layer of support.
- Patients have a care coordinator and a care team to coordinate their health care services and link them to community services and housing as needed.

Who Is Eligible for the HHP?

Medi-Cal members who have certain complex medical needs and chronic conditions are eligible for the HHP. They must be enrolled in a Medi-Cal Managed Care Plan and meet the following two requirements:

1. Have certain chronic conditions
2. Meet at least one acuity/complexity criteria

See "Eligibility and Enrollment" for more information.

How Do Eligible Medi-Cal Members Join the HHP?

1. **Most eligible patients will be contacted about the program.** The Department of Health Care Services (DHCS) gives the Medi-Cal Managed Care Plans a list of most of their members who are eligible for the HHP. This list is based on patient data and claims histories. It is updated every 6 months. Other individuals may be eligible even if they are not on the list. Medi-Cal Managed Care Plans and/or Community-Based Care Management Entities (CB-CMEs) will be responsible for outreach.
2. **A provider submits a referral form for a patient.** If a patient is not on the HHP list but may be eligible, the provider can submit a referral form to the patient's Medi-Cal Managed Care Plan to see if they are eligible. This may be necessary if the individual is newly enrolled in Medi-Cal.
3. **A patient asks to join.** Individuals can contact their Medi-Cal Managed Care Plan and ask if they qualify for the Health Homes Program.

The HHP is for Medi-Cal Managed Care Plan Members

Only Medi-Cal Managed Care Plan members can receive HHP services. Individuals who receive care through the fee-for-service delivery system and qualify for the HHP must enroll in a Managed Care Plan to receive HHP services.

What Are CB-CMEs?

Community-Based Care Management Entities (CB-CMEs) are health care and community providers that contract with Medi-Cal Managed Care Plans to provide HHP care coordination and other services. CB-CMEs can be primary care providers, Federally Qualified Health Centers, community health centers, local health departments, and other service providers. Many patients will be able to receive HHP services where they are already receiving care.

What Services Does the HHP Provide?

The HHP provides six main services to help manage and improve a member's health:

- Developing and updating a Health Action Plan to guide services and care
- Coordinating care across all of their providers
- Facilitating care transitions between the hospital, nursing homes, other treatment facilities, and home
- Supporting the self-management and decisionmaking efforts of patients and their family and/or support team
- Educating patients about and supporting them in healthy behaviors
- Connecting patients to community and social services, including housing, as needed

Can Patients Join the HHP and Other State Programs?

It depends on what the other program is. For details, see "Patients Enrolled in the HHP and Other California Programs."

Who Provides HHP Services?

The HHP gives each member a care team, including a care coordinator. The care coordinator is either from a CB-CME or from the member's Medi-Cal Managed Care Plan. The care coordinator works with all of the patient's providers—such as doctors, specialists, pharmacists, and others—to make sure everyone is on the same page about their health and care needs. The HHP care team also includes a HHP director, clinical consultant, and housing navigator. The team may also include a community health worker and other team members such as a pharmacist or nutritionist, as needed.

Health Homes Program

Eligibility and Enrollment

The Health Homes Program (HHP provides new services for certain Medi-Cal members with chronic conditions. Patients qualify for HHP services based on their health conditions.

Who Is Eligible for the HHP?

To be eligible for the HHP, patients must meet both of the following requirements:

1 **The individual has certain chronic condition(s)** that are determined by certain ICD 10 codes. The patient can check **at least one** box below:

- ☐ At least two of the following: chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic kidney disease, dementia, or substance use disorders
- ☐ Hypertension (high blood pressure) and one of the following: COPD, diabetes, coronary artery disease, or chronic or congestive heart failure
- ☐ One of the following: major depression disorders, bipolar disorder, or psychotic disorders (including schizophrenia)
- ☐ Asthma

2 **The individual meets at least one acuity/complexity criteria.** The patient can check **at least one** box below:

- ☐ Has three or more of the HHP-eligible chronic conditions
- ☐ Had at least one inpatient hospital stay in the last year
- ☐ Had three or more emergency department visits in the last year
- ☐ Has chronic homelessness (see next page for definition)

Who Is NOT Eligible for the HHP?

- Individuals whose health is well-managed through self-management or another program, or the patient is otherwise determined to not fit the high-risk eligibility criteria
- Patients who do not want to cooperate or participate in the HHP
- Patients whose behavior or environment is unsafe for staff
- Patients who would be better served in another care management program

How to Determine Chronic Homelessness

The federal definition of chronic homelessness is used in HHP eligibility determinations. According to the definition, a person is homeless if he or she has been homeless for:

1. 12 consecutive months, or
2. A total of 12 months over the past 3 years with minimal breaks between periods of homelessness.

If a person met this definition of homelessness and then resided in an institution such as a jail, substance abuse facility, mental health facility, or hospital for fewer than 90 days, they are still considered chronically homeless.

A whole family can be counted as homelessif the head of household was homeless under this definition.

For more details, see the Department of Housing and Urban Development's definition at www.ecfr.gov.

How Do Patients Join the HHP?

1. **The Medi-Cal Managed Care Plan or community-based care management entities (CB-CMEs) will contact their eligible members to discuss the program.** The Department of Health Care Services (DHCS) gives each Medi-Cal Managed Care Plans a list with most of their members who are eligible for the HHP. The lists are based upon the Medi-Cal members' health conditions, eligibility, and medical service information. Other individuals may be eligible even if they are not on the list and can join the HHP in the following two ways.
2. **A health care provider submits a referral form for a patient.** If a patient is not on the HHP list but may be eligible, the provider can explore their eligibility by submitting a referral form to the patient's Medi-Cal Managed Care Plan. This may be necessary if the patient is newly enrolled in Medi-Cal and not yet on the HHP list.
3. **A patient asks to join.** Patients can contact their Medi-Cal Managed Care Plan and ask if they qualify for the HHP.

What Can Patients Expect When They Join the HHP?

Someone from the patient's care team will contact them to talk about their health needs, goals, and current providers.

The patient will be assigned a care coordinator who will work with them to make a plan for getting the health care and community services they need.

Tips for Talking to Patients About the HHP

CB-CMEs, providers, and communitybased organizations play key roles in explaining the HHP to patients. When talking to patients, consider sharing the following messages:

- You receive extra support for free as part of your Medi-Cal benefits, including help with:
  - Finding doctors and getting appointments
  - Understanding your prescription drugs
  - Setting up transportation to your doctor visits
  - Getting follow-up services after you leave the hospital
  - Finding and applying for food benefits and housing
  - Connecting to other community programs and services
- You can keep your doctors, and you can get connected to other doctors you might need.
- You will have a care coordinator who supports you and your team. They make sure everyone is on the same page about your health and care needs.
- You must qualify for the HHP, based on needing extra help with your health.

Health Homes Program

Patients Enrolled in the HHP and Other State Programs

California has multiple programs designed to coordinate care. Counties, Medi-Cal Managed Care Plans, and providers work together to coordinate services across these programs and toavoid duplication.

Patients can receive services through both the HHP and the programs listed below:

- Whole Person Care Pilot Program
- California Children's Services Program
- Specialty Mental Health and Drug Medi-Cal

Patients must choose the HHP OR the program listed below:

- Cal MediConnect and Fee-for-Service Delivery Systems

  To receive HHP services, patients have to leave the Cal MediConnect or Fee-for-Service Delivery System and join a Medi-Cal Managed Care Plan.

- Targeted Case Management

  Patients with county-operated Targeted Case Management (TCM) have to choose TCM or the HHP. HHP members can receive TCM as part of the County Mental Health Plan Specialty Mental Health (MHP SMH) as long as their providers coordinate.

- 1915(c) Home and Community-Based Waiver Programs

  These programs include: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), Nursing Facility Acute Hospital (NF/AH), and Pediatric Palliative Care (PPC).

Medi-Cal Managed Care Plans can determine if other programs are duplicative of the HHP.

Patients cannot receive HHP services if they are:

- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month
- Hospice services recipients

Health Homes Program

Six Core Services

The Health Homes Program (HHP) provides extra services for certain Medi-Cal members with chronic conditions. It provides additional care coordination services and connections to community supports.

How Can Patients Access HHP Services?

- These services can be provided in-person where the patient seeks care or lives, or at any location that is accessible to the patient.
- Services can also be provided by phone or other communication methods that work for the patient.

What Extra Services Does the HHP Provide?

1. Care Management
2. Care Coordination
3. Health Promotion
4. Transitional Care
5. Member and Family Supports
6. Referral to Community and Social Supports

HHP services must be culturally appropriate and meet trauma-informed care standards. All communications must meet health literacy standards.

1. **Care Management:** The patient, their care coordinator, and their HHP care team work together to develop a comprehensive, individualized Health Action Plan. This plan is based on the patient's health status, needs, preferences, and goals regarding:
   - Physical health
   - Mental health
   - Substance use disorders
   - Community-based long-term services and supports
   - Palliative care
   - Trauma-informed care needs
   - Community and social supports
   - Housing

Health Action Plan

This is a comprehensive plan developed with the patient that addresses their physical and mental health and community support needs and goals. The plan is used to guide and track their care. It is reviewed and revised over time based on their changing needs.

2 **Care Coordination:** Services are provided to help patients implement their Health Action Plan and navigate and connect to needed health and community services. The care coordinator is a key point of contact for patients and their providers. Care coordination services may include:

- Helping the patient navigate, connect to, and communicate with health, behavioral health, and social service systems, including housing.
- Sharing options for accessing care and providing information regarding care planning.
- Monitoring and supporting treatment adherence, including medication management and reconciliation.
- Monitoring referrals to needed services and supports, as well as coordination and follow-up.
- Facilitating transitions among treatment facilities, including admissions and discharges, and reducing avoidable hospital readmissions.
- Sharing information with all involved parties to monitor the patient's conditions, health status, medications, and any side effects.
- Accompanying patients to appointments.
- Holding case conferences for the care teamto discuss the patient's needs and services.

These services are integrated with current Medi-Cal Managed Care Plan coordination activities, but the HHP provides a more intensive level of support.

3 **Health Promotion:** Patients are coached on how to monitor and manage their health, and identify and access helpful resources. These services may include:

- Supporting health education for patients and their family and/or support team.
- Coaching about chronic conditions and ways to manage them.
- Using evidence-based practices to help patients manage their care.

4 **Transitional Care:** Patients receive services to facilitate their transitions between treatment facilities, including admissions and discharges, and to reduce avoidable hospital admissions and readmissions. This includes transitions between the emergency department, hospital inpatient facility, residential/treatment facility, mental health facility, skilled nursing facility, incarceration facility, or other treatment center, and their own home. These services may include:

- Collaborating, communicating, and coordinating with all involved parties.
- Planning timely follow-up appointments with outpatient and/or community providers and arranging transportation as needed.
- Educating patients on self-management, rehabilitation, and medication management.
- Planning appropriate care and social services post-discharge, including a place to stay.
- Developing and facilitating the transition plan, evaluating the need to revise the Health Action Plan, and preventing and tracking avoidable admissions or readmission.
- Providing transition support to permanent housing.

5 **Member and Family Supports:** Patients and their family and/or support team are educated about their conditions to improve treatment adherence and medication management. These services may include:

- Assessing strengths and needs of patients and the family and/or support team and promoting engagement in self-management and decision-making.
- Linking patients to self-care programs and peer supports to help them understand their condition and care plan.
- Determining when patients are ready to receive and/or act upon information provided and assist them with making informed choices.
- Helping patients identify and obtain needed resources to support their health goals.
- Accompanying patients to appointments when necessary.
- Evaluating the family and/or support team's need for services.

6 **Referral to Community and Social Supports:** Patients receive referrals to community and social support services and follow-up to help ensure they get connected to the services they need. This may include:

- Identifying community and social support needs and community resources.
- Identifying resources and eligibility criteria for programs, including housing, food security and nutrition programs, employment counseling, child care, and disability services.
- Actively engaging with appropriate referral agencies and other community and social supports.
- Providing housing transition services and tenancy sustaining services.
- Routinely following up to ensure needed services 5 are obtained.

What Transportation Services Are Provided?

The HHP arranges for transportation to be provided, but it does not provide actual transportation to services.

However, under Medi-Cal, Managed Care Plans are responsible for providing non-emergency transportation to medical services.

What Housing Services Are Provided?

The HHP provides services to help patients obtain and maintain housing. It does not provide actual housing for patients.

For HHP patients experiencing homelessness, the housing navigator that is part of the care team partners with housing agencies to help patients find and maintain permanent independent housing, including supportive housing.

Health Homes Program

Care Management and the Health Action Plan

The Health Homes Program (HHP) provides extra services for certain Medi-Cal members with chronic conditions. HHP care coordination is centered around the Health Action Plan.

The Health Action Plan

Each patient has a Health Action Plan to guide their services and care. It is developed by the patient and their HHP care team.

The plan is based on the patient's health status, needs, preferences, and goals regarding:

- Physical and mental health
- Substance use disorders
- Community-based long-term services and supports, and palliative care
- Trauma-informed care needs
- Community supports, including housing

Who's Involved

One of the main members of the care team is the care coordinator. Either the Medi-Cal Managed Care Plan or the Community-Based Care Management Entity (CB-CME) assigns a care coordinator for each member. This person works with the patient to create the Health Action Plan, coordinates their care, and makes sure they receive all needed services. Other care team members also participate in developing and implementing the Health Action Plan, as necessary.

If the patient's primary care provider is affiliated with a CB-CME, the patient will be assigned to that CB-CME, unless they choose a different one. If the patient's primary care provider is not part of the CB-CME, the CB-CME must coordinate with the primary care provider.

Implementing the Health Action Plan

Once the Health Action Plan is complete, the HHP offers comprehensive care management activities to help patients achieve their goals. Care management services are supported by the care coordinator and care team, and may be provided in person or by phone, email, text, or other communication methods that work for the patient. The Health Action Plan is reviewed and revised over time, based on the patient's progress and changes in their needs.

Care Management Best Practices

Materials have been developed to assist CB-CMEs and providers engaged in care management activities. These evidence-based practices have been found to be effective for treating complex patients such as those in the HHP. See best practices in care management on the DHCS Health Homes Program website or contact the Medi-Cal Managed Care Plan for resources and training opportunities.

Health Homes Program

Team Roles and Responsibilities

The Health Homes Program (HHP) provides extra services for certain Medi-Cal members with chronic conditions.

Members stay enrolled in their Medi-Cal Managed Care Plan and continue to see the same doctors. However, they now have a care coordinator and an HHP care team that coordinates their health care services and links them to community services and housing, as needed.

HHP Team At a Glance

Three main entities work together to deliver HHP services:

- Medi-Cal Managed Care Plans
- Community-Based Care Management Entities (CB-CMEs)
- Community-Based Organizations

Together, they form a care team around the patient. This care team could include:

- Care coordinator
- HHP director
- Clinical consultant
- Community health worker
- Housing navigator
- Current providers
- Family/friends
- Case manager from a community organization

Medi-Cal Managed Care Plans

Medi-Cal Managed Care Plans oversee the administration of the HHP. They must be certified to participate in the HHP by meeting certain criteria and passing a readiness review. They receive payments from the Department of Health Care Services (DHCS) and disburse payments to the CB-CMEs and other contracted providers of HHP services.

Medi-Cal Managed Care Plan responsibilities include:

- Contracting with qualified CB-CMEs to provide and oversee HHP services
- Assigning eligible patients to CB-CMEs to coordinate their care
- Notifying CB-CMEs of inpatient admission and emergency department visits/discharges
- Tracking and sharing data with CB-CMEs regarding each patient's health history
- Developing training tools and reporting capabilities for CB-CMEs
- Providing HHP customer service and member grievance resources
- Conducting regular auditing and monitoring to ensure that HHP requirements are completed
- Collecting, analyzing, and reporting health status, financial and other measures, and outcome data to DHCS.

Community-Based Care Management Entity

Each patient has a Community-Based Care Management Entity (CB-CME) that serves as their provider of HHP services. The patient's Medi-Cal Managed Care Plan assigns them to a CB-CME, but they may choose another one if they prefer.

In most cases, the CB-CME will be a community primary care provider that serves a high number of HHP-eligible patients. If the CB-CME is not the patient's assigned primary care provider, the CB-CME must maintain a strong connection to the primary care provider to ensure their participation in the development and implementation of the Health Action Plan.

CB-CME responsibilities include:

- Overseeing care team staffing and the delivery of HHP services
- Working with patients and care teams to develop and update the Health Action Plan
- Ensuring that patients have access to their care team and care coordination services, including case conferences to ensure coordination among providers
- Managing referrals, coordination, and follow-up to needed services and supports
- Supporting patients and their families during discharge from the hospital and treatment facilities
- Providing services in person and accompanying patients to appointments when needed

CB-CMEs must meet HHP certification and qualification requirements.

If your organization is interested in becoming a CB-CME, please contact the Medi-Cal Managed Care Plans in your county.

CB-CMEs may be, but are not limited to:

- Primary care or specialist physician or physician group
- Federally Qualified Health Center
- Community health center
- Hospital or hospitalbased physician group or clinic
- Rural health center
- Indian health center or clinic
- Local health department
- Behavioral health entity
- Community mental health center
- Substance use disorder treatment provider
- Providers serving individuals experiencing homelessness

Community-Based Organizations

As part of providing comprehensive care coordination, the HHP care team tries to identify a patient's community and social support needs and link them to social services and housing, as needed. Since many community-based organizations (CBOs) have established trusting relationships with patients, they can be an important source of information and support to help patients meet their health goals. The HHP care coordinator, community health workers, and housing navigators work with CBOs to make connections to needed services.

The Care Team

Certain team members are part of every HHP care team. Additional professionals, such as pharmacists and nutritionists, may be included in the care team if needed. There may also be other providers (such as specialists) who are not part of the care team but who provide services to patients, participate in case conferences, and share information to support the Health Action Plan. Patients can also include family and other people from their support system on their care team.

Team Member	Qualifications	Key Role
Care Coordinator (CB-CME, MCP, or by contract)	Paraprofessional with appropriate training, or licensed care coordinator, social worker, or nurse	• Engage eligible patients • Oversee services and Health Action Plan implementation • Connect patients to medical and social services • Advocate on behalf of patients • Monitor treatment adherence and help with medication management • Accompany patients to office visits as needed and permitted • Arrange transportation
HHP Director (CB-CME)	Ability to manage multidisciplinary care teams	• Oversee management and operations of the team • Oversee reporting for the team, including quality measures • Oversee quality measures and reporting
Clinical Consultant (CB-CME or MCP)	A health care professional such as a primary care physician, specialist, psychiatrist, nurse, nutritionist, social worker, or behavioral health care professional	• Review and advise on Health Action Plan • Act as clinical resource for care coordinator • Facilitate access to primary care and behavioral health providers as needed
Community Health Workers (CB-CME or by contract)* * Recommended but not required	Paraprofessional or peer advocate	• Engage eligible patients • Accompany patients to office visits, as needed and permitted • Support health promotion and self-management training • Arrange transportation • Assist with linkage to social supports
Housing Navigator (CB-CME or by contract)** ** Only required for members experiencing homelessness	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Develop and maintain relationships with housing agencies and permanent housing providers • Connect members to permanent housing options, including supportive housing • Coordinate with members in the most easily accessible setting as permitted (e.g., mobile unit)

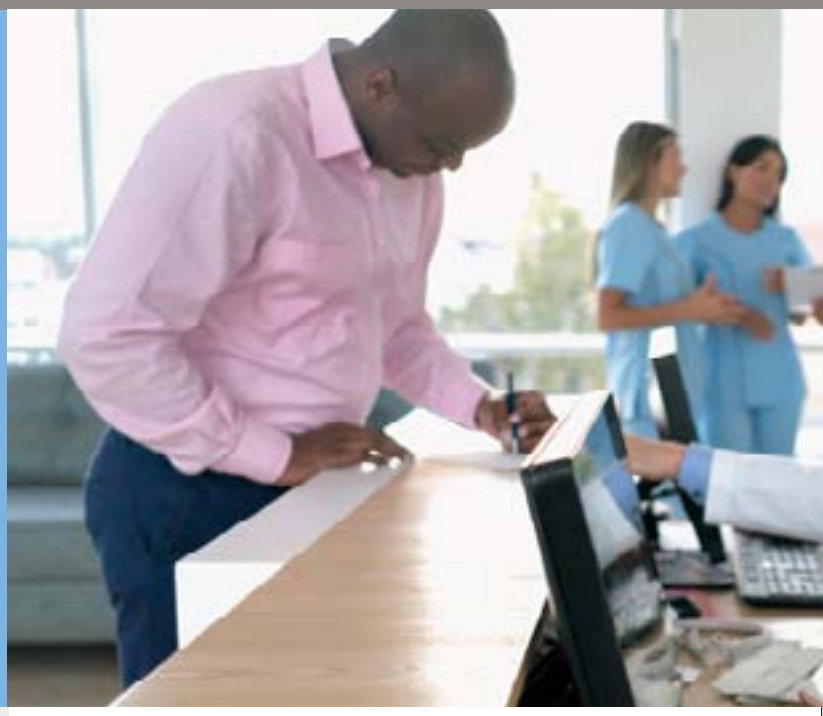
Health Homes Program

Information Sharing, Reporting, and Payment

The Health Homes Program (HHP) provides new services for certain Medi-Cal members with chronic conditions.

The HHP care team must share information about the services they provide to the patient.

Medi-Cal Managed Care Plans must report data to evaluate the enrollment, utilization, costs, and quality of care provided.



Information Sharing Across Entities

For care management activities to be successful, the entire HHP care team must share and access information about a patient's services and care. This helps all of a patient's providers stay on the same page about their care.

For example, Medi-Cal Managed Care Plans can provide electronic patient-level data about hospital and emergency department utilization to providers and care coordinators. Timely information about hospital discharge will support seamless care transitions.

Medi-Cal Managed Care Plans are responsible for developing standardized data-sharing agreements with HHP partners. These agreements will ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all other relevant federal and state regulations.

Program partners are encouraged to use technology to ensure timely, accurate, and secure sharing of information. Ideally, partners should use electronic health record (EHR), health information technology (HIT), and health information exchange (HIE) systems for tracking, charting, and information sharing. In cases where EHR/HIT/HIE technology is not widely used or available, Medi-Cal Managed Care Plans and program partners will work together to develop information sharing processes that are timely, accurate, and secure.

Reporting Requirements

Medi-Cal Managed Care Plans must report program data to the Department of Health Care Services (DHCS). Some of this data may be provided by community-based care management entities (CB-CMEs) and providers to Medi-Cal Managed Care Plans.

Data must be reported in three areas:

1 Program Eligibility and Enrollment

Medi Cal Managed Care Plans track and report the number of patients:

- Eligible for the HHP
- The MCP or the CB-CMEs are actively seeking to engage
- Participating in the HHP Reports must reflect any changes from the prior month and the reason for the changes (e.g., switching from engaging the patient to providing services).

2 Costs and Utilization

Medi-Cal Managed Care Plans report the number of:

- Services, visits, or units for each type of HHP service
- Associated costs

In some cases, these reports may require additional data submission from CB-CMEs and providers.

3 Quality of Care

Program partners must submit reports on HHP program measures:

- Core services measures
- Operational measures
- CMS core set measures
- CMS utilization measures

Payments

- HHP payments are made directly from DHCS to the Medi-Cal Managed Care Plans through capitation rates.
- Medi-Cal Managed Care Plans negotiate individual contracts and payment terms with CB-CMEs and other contracted providers to ensure the delivery of HHP services.
- Services may be provided directly by the MCP or CB-CME, or certain activities may be subcontracted to other entities.

HHP Program Measures

Core Service Measures*

- Number of members excluded from the targeted engagement list, by reason
- Number of members referred to HHP who were enrolled or excluded
- Average number of care coordinators
- Number of members with initial HAP completed within 90 days
- Number of members referred to, and receiving, housing and supportive housing services

CMS Core Set Measures

- Adult Body Mass Index (BMI) Assessment
- Screening for Clinical Depression and Follow-Up Plan*
- Follow-Up After Hospitalization for Mental Illness
- Controlling High Blood Pressure*
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Prevention Quality Indicator 92: Chronic Conditions Composite

Operational Measures*

- Number of members who received services
- Number of each HHP service received, by member
- Number of each HHP service unit provided
- Aggregate care coordinator ratio

CMS Utilization Measures

- Ambulatory Care — Emergency Department Visits
- Inpatient Utilization
- Nursing Facility Utilization

* MCPs must report these measures directly to DHCS. DHCS will calculate all other measures based on MCP-provided encounters. These reporting requirements are subject to change.

HHP Service	HCPCS Code	Modifier	Units of Service (UOS)
In-Person: Provided by Clinical Staff	G0506	U1	15 minutes equals 1 UOS; multiple UOS allowed
Phone/Telehealth: Provided by Clinical Staff	G0506	U2	15 minutes equals 1 UOS; multiple UOS allowed
Other Health Home Services: Provided by Clinical Staff	G0506	U3	15 minutes equals 1 UOS; multiple UOS allowed
In-Person: Provided by Non-Clinical Staff	G0506	U4	15 minutes equals 1 UOS; multiple UOS allowed
Phone/Telehealth: Provided by Non-Clinical Staff	G0506	U5	15 minutes equals 1 UOS; multiple UOSallowed
Other Health Home Services: Provided by Non-Clinical Staff	G0506	U6	15 minutes equals 1 UOS; multiple UOSallowed
HHP Engagement Services	G0506	U7	15 minutes equals 1 UOS; multiple UOSallowed

Use in conjunction with guidance from the Medi-Cal Managed Care Plans.

Health Homes Program Opportunity

Since the CA Health Homes bill passed in 2013, CSH has worked closely with DHCS to design the Health Homes Program (HHP) as it would apply to Medi-Cal beneficiaries experiencing homelessness. The HHP, a new Medi-Cal benefit designed to address the needs of beneficiaries with chronic health conditions, will provide care management services to help beneficiaries manage care and improve health outcomes. The HHP offers an opportunity to fund care coordination services for people experiencing homelessness. People with complex health conditions and experiencing chronic homelessness[1] are particularly expensive to our health system and die an average of 25-30 years earlier than their housed counterparts. They are among the most vulnerable beneficiaries who will be eligible for the Health Home Program (HHP). DHCS anticipates that 10% (estimated at up to 50,000) of eligible HHP beneficiaries will be chronically homeless, and chronic homelessness is one acuity indicator to be eligible for HHP.

DHCS launched HHP in July 2018 as a phased implementation across 29 HHP counties[2]. HHP will be administered by Managed Care Plans (MCPs) through a network of designated HHP providers called Community-Based Care Management Entities[3] (CB-CMEs). CB-CMEs will provide HHP care management and linkages to social services and housing. For health home beneficiaries experiencing homelessness, services that help people access safe, decent, affordable housing, as well as tenancy support services that promote housing stability, will be critical.

Currently, prospective CB-CMEs lack the capacity, expertise, and in many cases, the organizational and systemic partnerships necessary to serve the full spectrum of needs typical of people experiencing chronic homelessness, including access to housing vouchers and supportive housing units. To leverage the HHP in a way that addresses the complex needs of beneficiaries experiencing homelessness and stops the costly cycle of crisis healthcare utilization among homeless patients, CB-CMEs serving members experiencing homelessness will need to include homeless service providers and other social service partners. To that end, CB-CMEs will require technical assistance (TA) designed to build their capacity to function as cross-sector HHP teams.

CSH Capacity-Building Strategy

CSH's capacity-building initiative will position MCPs and HHP providers to build a successful Health Home Program infrastructure and build their capacity to deliver effective services that address the needs of chronically homeless Medi-Cal beneficiaries. Drawing upon national experience and expertise, CSH will partner with MCPs, CB-CMEs, clinics, hospitals, homeless services providers and supportive housing providers to engage and serve homeless individuals with an integrated health and housing HHP model. We have three key goals:

1. Leverage HHP funding to expand access to housing and services for Medi-Cal super-utilizers of healthcare services who are experiencing chronic homelessness.
2. Partner with MCPs and local providers to lay the groundwork for putting HHP into operation to serve homeless and chronically homeless individuals in local California communities, building on the infrastructure developed through the Whole Person Care pilots in each county.
3. Cultivate and prepare CB-CMEs to effectively serve and house HHP members who are experiencing homelessness across the state.

Our aim is to provide 1) individualized consulting support to targeted MCPs in up to 10 counties, supplemented by webinars for all 29 HHP counties, and 2) in-person trainings for CB-CMEs in up to 10 counties, supplemented by webinars for all 29 HHP counties.

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[1] Chronic homelessness (HUD): homeless for at least one year continuously or on at least four occasions in the last three years where those occasions cumulatively total at least 12 months.

[2] Group 1 (San Francisco) launches in July 2018, Group 2 (Riverside, San Bernadino) in January 2019. The remaining 26 HHP in Group 3 launch in July 2019: Del Norte; Humboldt; Lake; Marin; Mendocino; Napa; Shasta; Solano; Sonoma; Yolo; Imperial, Lassen, Merced, Monterey, Orange, San Mateo, Santa Clara, Santa Cruz; Siskiyou; Alameda; Fresno; Kern; Los Angeles; Sacramento; San Diego; Tulare.

[3] CB-CMEs may be a Federally Qualified Health Center (FQHCs), community health clinic, behavioral health entity, hospital, physician group, or local health department.

1 **Capacity-building for MCPs:** CSH will reach out to MCPs and provide one-on-one technical assistance for up to 10 counties that express interest in assistance with linking to homeless services providers, homelessness and housing systems, and contracting with homeless services providers.

a. Capacity building in each county will focus on topics critical to integrating health and housing:
   i. CB-CME network development to ensure comprehensive partnerships to address all health home members' needs including housing and tenancy support, and
   ii. MCP/HHP linkages to county homelessness and housing systems to ensure housing vouchers and units for HHP members experiencing homelessness.

b. CSH will additionally produce webinars for all 29 HHP counties sharing key principles and strategies for addressing both topics.

2 **Capacity-building for CB-CMEs:** CSH will provide in-person training series for CB-CMEs in 10 sites, which will be available to CB-CMEs from all 29 HHP counties. Proposed sites include Riverside, San Bernardino, Napa, San Mateo, Alameda, Santa Clara, Fresno, Los Angeles, Orange, and San Diego counties.

a. Each training series will include 3 modules: 1) CB-CME Structure and Services, including supportive housing and tenancy supports, 2) Integrated Services Plan and Feasibility Analysis, and 3) Collaboration, Data, and Contracting.
b. To ensure our training reaches additional counties across the state that may not be able to travel to the in-person trainings, CSH will also produce a series of webinars and a virtual training curriculum available to HHP teams in other counties via our CSH Training Center e-learning platform.
c. CSH will continue to provide technical assistance to CB-CMEs around certification for CB-CMEs and readiness for data sharing leading up to the HHP launch date.

CSH Capacity-Building for California's Health Homes Serving Complex Members Experiencing Chronic Homelessness

September2018

Susan Lee, Senior Program Manager

Susan.Lee@csh.org

CSH

CA Health Home Program (HHP) Launch

Group 3: July 2019

DHCS' HHPwill utilize California's Medi-Cal Managed Care infrastructureto provide HHP services to members with chronic healthconditions. MCPs will develop networks of providers that will integrate and coordinate primary, acute, & behavioral health services for the top 3-5% highest risk Medi-Cal beneficiaries.

- 90% federal matching funds first 8 quarters of HHP. Then, reduced to 50% federal match for population with Medicaid benefits pre-2014. Medicaidexpansionpopulation receive 100% for HHP, decreasing to 90% in 2021.
- Roll-out: Group 1: Jul 2018 •Group 2: Jan 2019 •Group 3: Jul 2019

Target Population:
Top 3-5% highest risk Medi-Cal beneficiaries meeting A+B

A) eligible chronicconditions
- asthma, hypertension, COPD, diabetes,TBI, CHF,coronary artery disease, chronic liver disease, dementia, SUD
- major depression, bipolar disorder,psychoticdisorders/ schizophrenia
- *see detailed eligibility chronic conditioncombinations*

B) high acuity
- 3+ chronic conditions **OR**
- at least 1inpatientstay in last year **OR**
- 3+ ED visits in last year **OR**
- chronic homelessness

Must showat least 2 claims for eligible condition

Enrollment cannot be capped

Lead Entity/Structure:
Medi-Cal managed care plans (MCPs) organize the payment and delivery of services

MCPs certify & contract with **Community-Based Care Management Entities (CB-CMEs)**, which mayinclude
- communityhealth centers
- FederallyQualifiedHealth Centers
- behavioral health entities
- communitymental health centers
- rural health centers
- Indian health centers
- hospitals
- physiciangroups
- local health departments
- SUD treatment providers
- homeless services providers

Core Services:
1) comprehensive care management
2) care coordination
3) health promotion
4) comprehensive transitional care
5) individual and family support services
6) referral to communityand social supports

HHP only funds care coordination services. HHP does not fund direct medical or social services.

Outcomes:
- Improve care coordination
- Integratepalliative care intoprimary care delivery
- Strengthen community linkages within health homes
- Strengthen team-based care, including use of community health workers/ promotores/frontline workers
- Improve the health outcomes of people with highrisk chronic diseases
- Reportable net cost avoidancewithin two years

Health Homes Capacity Building: Housing Navigation and Tenancy Supports for HHP Beneficiaries Experiencing Homelessness


California State Senate
SENATE COMMITTEE ON BANKING AND FINANCIAL INSTITUTIONS
AGENDA

CA HealthHomes Bill 2013

- Medi-Cal beneficiaries experiencing chronic homelessness and frequent hospital users

DHCS HHP Launch July 2018

- MCPs administer benefit &networks
- CB-CMEs provide HHP services

CSH Capacity-Building for HHP Counties

- **individualized TA to MCPs**
- **in-persontrainingsfor CB-CMEs**
- **webinars** for HHP counties on housing and tenancysupports

MCP Capacity-Building in each county will focus on topics critical to integrating health and housing:

- CB-CME network development to ensure partnerships aroundhousing and tenancy support
- MCP/HHP linkages tocounty systems to ensure housing vouchers and units

CSH webinars for all 29 HHP counties sharing key principles and strategies

CB-CME trainings: 1) CB-CME Structure& Services, including supportive housing and tenancy supports,2) Integrated Services Plan and Feasibility Analysis, and 3) Collaboration and Data.

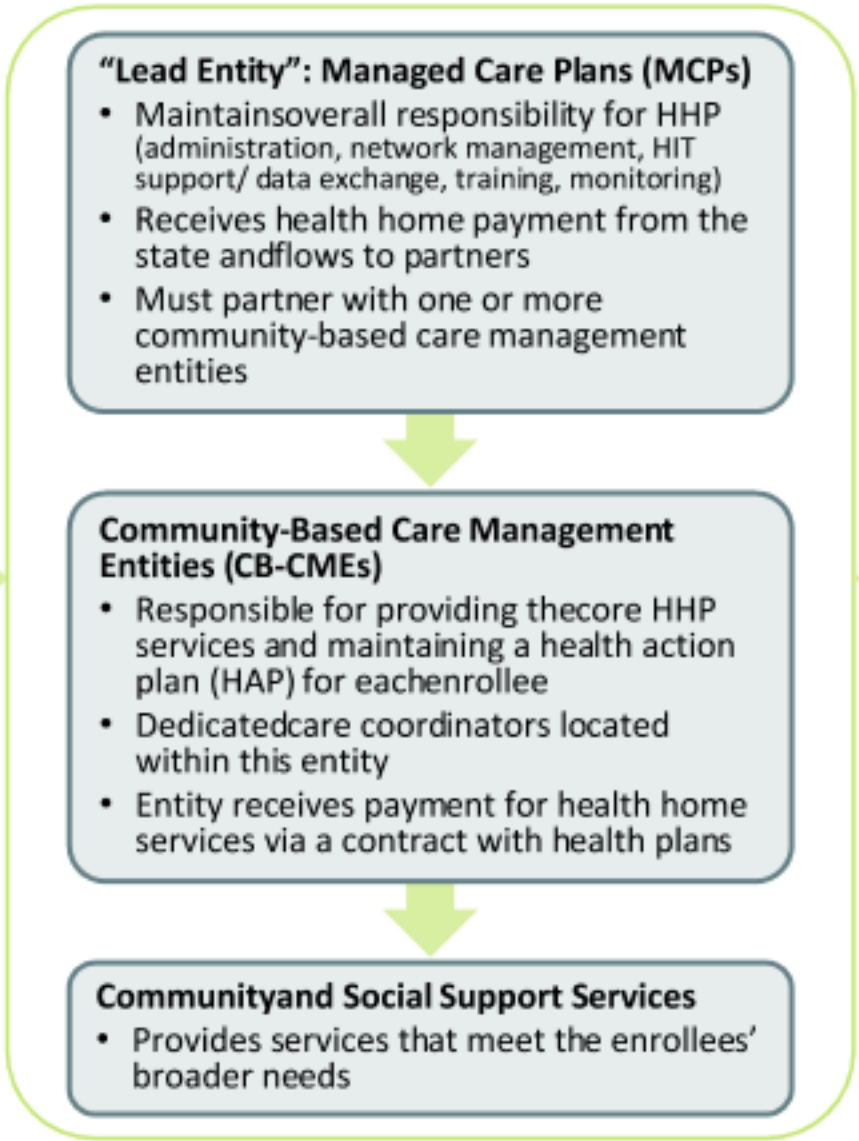
CSH webinars and virtual training curriculum available to HHP teams viaCSH Training Centere-learning platform

Readiness for Health Homes Program (HHP)
Housing Linkages & Tenancy Support Services

MCP Internal Capacity	1) Clearly defined rationale, vision, mission, and strategies for HHP enrollees experiencing homelessness. 2) Recognizes the multiple causes of homelessness and their solutions. Embraces Housing First, provides services in a culturally-competent manner, employing harm reduction, motivational interviewing, and trauma-informed care. 3) Key staffwith experience in housing and homelessservices part of MCP HHP team.
Cross Sector Partnerships	1) Strong MCP relationship with local Continuum of Care (CoC) and clear process toenroll HHP enrolleesinto local coordinated entry system. MOUs in place with HMIS (Homeless Management Information System). 2) Understands the service offerings of anarray of homeless services providers and supportive housing providers. Works withkey homeless services and housing providers and has a contracting mechanism in place. 3) Good relationships with County Whole Person Care program and WPC homeless service providersexpert inengaging and case managing members experiencing homelessness.
Research and CB-CME Training on Best Practices	1) Understands "high-touch," client-centered wrap-around services for homeless members: outreach and engagement, "whole-person"care management, housing navigation, and tenancy supports. 2) Post housing, HHP provider network helps beneficiaries integrate intocommunities and provides tenancy support services promoting housing stability. 3) Training plan for CB-CMEs for integrating housing and homeless services best practices into HHP model.
Data and Analytics	1) Can identify, flag,and risk-stratify HHP-eligible members experiencing homelessness and chronic homelessness. 2) Capability to trackHHP enrollment, housing metrics, and service encounter activity of members experiencing homelessness. 3) Clear, measurable, and meaningful key performanceindicators to trackhousing navigation and housing retention.

HHP INFRASTRUCTURE

HHP will be structured as a health home network functioning as a team to provide care coordination



KEY QUESTIONS

1. What are MCPs' relationships with the Continuumof Care? Is there a processfor enrolling HHP members in **CES**?
2. How will housing navigation and tenancy support services be structured in the HHP **network**? (in-house v. sub-contract)
3. Which **providers** in the communityare positioned to provide housing and tenancy support services?
4. What **training** will CB-CMEs get in housing navigation and tenancy support services?
5. Will housing **metrics** for homeless HHP members be tracked?

Core Health Homes Services at-a-Glan

COMPREHENSIVE CARE MANAGEMENT

- Engaging member in HHP and in care
- Assessingmember Self-management
- Promoting Self-management
- Developing member's HAP
- Supporting goals
- Coordinating and collaborating with providers

CARE COORDINATION

- Implementing HAP and supporting members
- Navigating health, BH, social svcs & housing
- Monitoring treatment adherence
- Accompanying member to appts as needed
- Monitoring referrals
- Sharing information with all parties
- Facilitating communica-tion bet. member and healthcare providers

HEALTH PROMOTION

- Encouraging health education
- Assessingmember understanding of health condition
- Coaching member to manage conditions using EBPs such as motivational interviewing
- Linkages to health resources

COMPREHENSIVE TRANSITIONAL CARE

- Providingmedication info & reconciliation
- Timely scheduling of follow-upappts
- Educatingmember on transition
- Bridge housing and transportation
- Preventing and tracking readmissions
- Evaluating need to revise HAP

INDIVIDUAL and FAMILY SUPPORTS

- Linking member to peer supports, support groups, self-care
- Accompanying member toappts as needed
- Treatment adherence& medication management

COMMUNITYand SOCIAL SERVICES

- Identifying social support needs
- Linking to member to communityresources& actively engaging referrals to housing, food, employment, child care, LTSS
- Housing navigation & transition services(not just referrals) for members experiencing homelessness
- Housing &tenancy sustaining services

HEALTH ITDATA

- HHP Member Portal
- Register HHP Members
- Point of Care Charting
- Summary of Care Records for Care Transitions

For the complete list of services, see ***DHCS Medi-Cal Health Homes Program: Program Guide*** **(June 28,2018)**

The Foundation = Individual Health Action Plan (HAP)

The **HAP** incorporates the member's needs in theareas of physical health, mental health, SUD, community-based LTSS, palliative care, trauma-informed care needs, social supports, and, as appropriate for individuals experiencinghomelessness, housing.

CSH

Housing Navigation and Tenancy Support Services

- Housing Navigator as part of the HHP care team for members experiencing homelessness + Housing Navigators as part of CB-CME teams for members experiencing homelessness
- **Provide housing navigation services, not just referrals to housing**
- **Housing transition services**
  - Tenant screening and housing assessment
  - Develop individualized housing support plans
  - Enroll in Coordinated Entry System for housing vouchers
  - Assist with housingapplication and apartmentsearch
  - Assist with logistical support and moving expenses
  - Ensure that the living environment is safe and ready for move-in
  - Assist in arranging for and supporting the details of the move
  - Develop housing support crisis planthat includes prevention and early intervention services when housing is jeopardized
- **Tenancy support services promoting housing stability**
  - Coaching on roles, rights andresponsibilities oftenant and landlord, and developing and maintaining relationships with landlords
  - Early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations
  - Assist in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action
  - Ongoing support with activities related to household management

Health Homes Capacity Building: Housing Navigation and Tenancy Supports for HHP Beneficiaries Experiencing Homelessness

One-on-one TA for MCPs + Webinars for MCPs

MCPs
HHP Network Development – Integrating Homeless ServicesProviders

MCPs
Linkage to Homelessness and Housing Systems



CB-CME Trainings

1) In-person
2) Train the trainer
3) Webinars

Phase 1 (1.5 hours):
Housing & Homeless Services 101

Phase 2 (1.5 hours):
Services & Staffing

Phase 3 (1.5 hours):
Collaboration Data

1-1 TA to CB-CMEs
Data Readiness

Housing and Homeless Services 101
- services needed by HHP members experiencing homelessness
- supportive housing 101 Ø coordinated entry, CoC
- partnerships w/homeless services providers in San Diego
- coordinating outreach & engagement

Integrating Homeless Case Management
- integrated care models for homeless members
- housing navigation Øhousing 1st
- tenancy supports Øharm reduction/ MI
- staffing & caseloads across CB-CMEs

Collaboration & Data Sharing
- best practices
- communication across sectors
- case conferencing
- data sharing & HMIS
- housing metrics & reporting

CSH