Health Homes Program

CALIFORNIA'S HEALTH HOMES PROGRAM OVERVIEW

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TOPICS COVERED

- What is the Health Homes Program?
- Team Roles and Responsibilities
- Eligibility and Enrollment
- Six Core Services
- Implementation Schedule
- Training and Technical Assistance
- Resources and Information
- Questions

Health Homes Program

WHAT IS THE HEALTH HOMES PROGRAM?

- The Medi-Cal Health Homes Program is a new program that provides extra care coordination services to certain Medi-Cal patients with complex medical needs and chronic conditions.
- Patients have their own **care coordinator** and **care team** to coordinate their physical and behavioral health care services and link them to community services and housing, as needed.

WHAT IS THE HEALTH HOMES PROGRAM?

- Patients stay enrolled in their Medi-Cal Plan and continue to see the same doctors, but now have an extra layer of support.
- These new services are free as part of their Medi-Cal benefits.
- Community-Based Care Management Entities (CB-CMEs) will be primarily responsible for delivering HHP services.

THE ROLE OF MCPS AND CB-CMES

Community-Based Care Management Entities

(CB-CMEs)

- CB-CMEs are the single community-based entity with responsibility, in coordination with the MCP, for ensuring that HHP members receive HHP services.
- In most cases, the CB-CME will be the member's MCP-assigned primary care provider (PCP) such as a community clinic, primary care provider, or practice that serves a high volume of HHP eligible members.
- If the CB-CME is not the member's MCP-assigned PCP, the MCP and the CB-CME should work together to coordinate and collaborate with the PCP on care management for the member, including sharing relevant information.

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THE ROLE OF MCPS AND CB-CMES

MCPs Choose From One of Three Care Management Models

Each plan has flexibility to choose a care management model, which determines where care management services are provided and by whom. No matter which model is used, the care coordinator and care team's roles and responsibilities remain consistent.

Model 1: The CB-CME is on-site at a community health care provider

- This is the most common model, expected to serve HHP members receiving care from high-volume, usually urban providers. In most cases the CB-CME will be the member's MCP-assigned PCP.
- The community provider, such as a large primary care practice or clinic, will usually employ the CB-CME staff to provide care coordination and housing navigation.
- In limited circumstances, some care coordination staff could be MCP employees but housed at the community provider location.

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THE ROLE OF MCPS AND CB-CMES

These models will serve a smaller number of members who see providers with a small volume of HHP patients, and thus cannot receive CB-CME services through their MCP-assign PCP.

Model 2: Care management services provided by a community-based entity or MCP staff

- This model is designed for members who are served by low-volume providers, in either rural or urban areas, who do not wish to, or cannot, take on the responsibility of hiring and housing care coordinators on site.
- The CB-CME will be a community-based entity or staff within the existing MCP care management department. Community-based entities could include health care providers or social services organizations.

Model 3: Hybrid model

- This model is designed for members who live in rural areas and are served by low-volume providers.
- The CB-CME will be located in regional offices to be geographically close to members, and will use technology and other monitoring and communication methods, such as visiting the member at their location.

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CB-CME TEAM ROLES AND RESPONSIBILITIES

Core Care Team
(can include MCP and/or CB-CME staff)

Care Coordinator

- Oversees HHP services and Health Action Plan (HAP) implementation
- Helps connect members to needed services, including arranging transportation
- Directly supports member self-management, including helping make appointments and monitoring treatment adherence

Health Homes Program Director

- Oversees management and operations of the team
- Oversees reporting for the team, including quality measures

Clinical Consultant

- Reviews and advises on HAP
- Serves as a clinical resource and assists care coordinator, as needed

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CB-CME TEAM ROLES AND RESPONSIBILITIES

Additional Care Team Members (determined by patient's needs)

- Community Health Workers
- Housing Navigator
- Pharmacists, nutritionists, and other specialists
- Family members, friends, and/or caregivers

Community-Based Organizations (CBOs)

- Care team will identify community and social supports already in place for a patients as well as their unmet needs.
- As needed, the team will link them to CBOs providing social services and housing, and work with CBO community supports that are already in place.

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ELIGIBILITY AND ENROLLMENT

1) The member has certain chronic condition(s) which are determined by specified ICD 10 codes. The member can check at least one of the boxes 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: chronic obstructive pulmonary disease, 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 member meets at least one acuity/complexity criteria. Member can check at least one box below:

- ❑ Has three or more of the HHP-eligible chronic conditions.
- ❑ Has stayed in the hospital in the last year.
- ❑ Has visited the emergency department three or more times in the last year.
- ❑ Has chronic homelessness.

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ELIGIBILITY AND ENROLLMENT

Definition of "Chronic Homelessness": The AB 361 definition will be used in eligibility determinations.

A homeless individual:

1. *With a condition limiting his or her activities of daily living; and,*
2. *Who has been continuously homeless for a year or more, or had at least four episodes of homelessness in the past three years.*

For purposes of this article, an individual who is currently residing in transitional housing or who has been residing in permanent supportive housing, for less than two years shall be considered a chronically homeless individual if the individual was chronically homeless prior to his or her residence.

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ELIGIBILITY AND ENROLLMENT

Examples of potential HHP Members:

ALBERT
Albert has hypertension, diabetes, and coronary artery disease. He has had several conversations with his PCP about his challenges managing his conditions; specifically he doesn't always have a place to refrigerate his insulin.

SUSAN
Susan overdosed on opioids six months ago, resulting in a hospital inpatient stay while she was trying to find a stable residence for discharge. She has also been diagnosed with diabetes, which she struggles to keep under control. She has spent the last two years essentially homeless, cycling through shelters and crashing with friends or family.

JOSE
Jose has asthma and has visited the Emergency Department six times in the last year for uncontrolled asthma. Despite referrals to an outpatient clinic to help get his asthma under control, Jose hasn't been able to get that follow-up care.

ELIGIBILITY AND ENROLLMENT

Three ways for members to join:

1. The MCP or CB-CME will attempt to contact their eligible members to discuss the program, including through mail, calls, and/or in-person outreach.
2. Providers can refer members by submitting a referral to the MCP.
3. Members can self-refer by asking their MCP if they can join the program.

Please note:

- Members must consent to be enrolled in the HHP program.
- A patient must be a member of a MCP to join the program.
- Fee-for-Service (FFS) members who meet the eligibility criteria can enroll in a MCP to receive HHP services.

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ELIGIBILITY AND ENROLLMENT

- Eligible members are assigned a CB-CME by their MCP that serves as their frontline provider of HHP services.
- Members may choose another CB-CME if they prefer.
- In most cases, the CB-CME will be a community health care provider that serves a high number of HHP-eligible patients and is the patient's MCP-assigned PCP. (Model 1)
- If the CB-CME is not the patient's assigned PCP, the CB-CME must maintain a strong connection to the PCP to ensure their participation in the development and implementation of care management and coordination activities. (Models 2 & 3)

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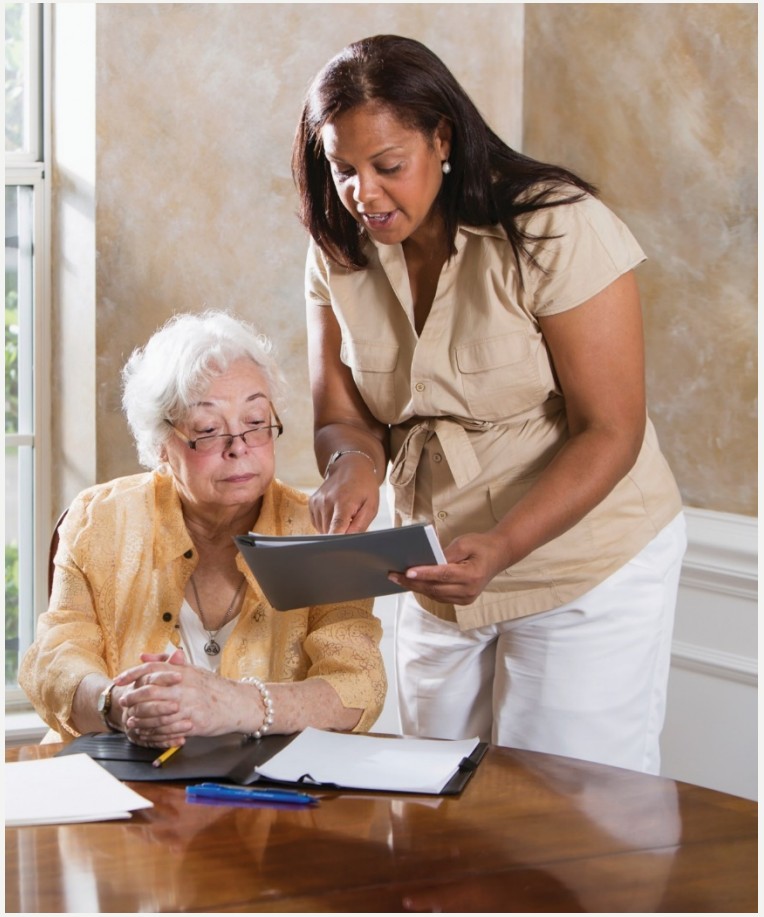
ELIGIBILITY AND ENROLLMENT

When talking to members about the HHP, consider sharing the following messages:

- You receive extra support for free as part of your Medi-Cal benefits.
- 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 care team. They make sure everyone is on the same page about your health care and community support needs.
- To receive HHP services, you must be eligible based on needing extra help with your health.
- Nothing else about your Medi-Cal benefits will change.



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MEMBERS ENROLLED IN HHP AND OTHER CALIFORNIA PROGRAMS

California has multiple programs designed to coordinate care. Counties, MCPs, and providers will work together to coordinate services across these programs and to avoid duplication.

Members can receive services through both HHP **AND**:

- Whole Person Care Pilot
- California Children's Services Program
- Targeted Case Management through Specialty Mental Health and Drug Medi-Cal
- Long-term services and supports benefits such as CBAS and IHSS

Members must choose HHP **OR**:

- Cal MediConnect and Fee-for-Service Delivery Systems
- Targeted Case Management – other than through Specialty Mental Health
- 1915(c) Home and Community-Based Waiver Programs (HIV/AIDS, ALW, DD, IHO, MSSP, NF/AH, PPC)

Members **can't** receive HHP services if they are:

- Skilled Nursing Facility (SNF) residents with a duration longer than the month of admission and the following month (e.g. members are only eligible within the first two months of admission to the SNF)
- Hospice services recipients

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WHOLE PERSON CARE AND HEALTH HOMES

Medi-Cal beneficiaries that are eligible to receive services from both the WPC Pilot program and the HHP can be enrolled in either program or both, based on beneficiary choice.

- WPC pilots provide care coordination services that are similar to the care coordination services provided by the HHP program.
- If a beneficiary is eligible for both, they may choose which program's care coordination services that want to receive.
- If the beneficiary wants to receive care coordination from WPC, they can't receive HHP services. The beneficiary can receive HHP care coordination services, and other services that are not duplicative, or similar to, HHP.
- The member may not receive duplicative care coordination services from both WPC and HHP.
  - If the beneficiary is receiving care coordination services through the HHP, it is the responsibility of the WPC pilot to ensure that a beneficiary does not receive duplicative care coordination services from WPC.
  - The WPC pilot may not claim WPC reimbursement for care coordination services that are duplicative of HHP care coordination services that are provided during the same month.

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HHP SIX CORE SERVICES

Members can receive the following sets of services:

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

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HHP SERVICES: COMPREHENSIVE CARE MANAGEMENT

Development of the Health Action Plan (HAP)

- The HAP is a plan developed by the patient and their care team to address their physical and mental health and social support needs and goals.
- The HAP is based on a comprehensive assessment of the member's health status, needs, preferences, and goals regarding:
  - Physical health
  - Mental health
  - Substance use disorder
  - Dental health
  - Community-based long-term services and supports
  - Palliative care
  - Trauma-informed care needs
  - Social supports
  - Housing
- Care management is centered around implementing the plan, determining needed services, identifying supports, and monitoring referrals and care.

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HHP SERVICES: COMPREHENSIVE CARE MANAGEMENT

Implementation of the Health Action Plan

- Each MCP will provide guidance to their CB-CMEs on how the HAP will be implemented, and how HAP data will be collected and shared.
- Some patients and CB-CMEs may already have a care coordination or case management plan template or software, which may be adapted and used for the HAP.
- The HAP is reviewed and revised over time based on the member's progress and needs.
- Care management services are provided using communication methods suitable to the individual patient – e.g. in-person or by phone. Email and text communications are permitted, but not required.

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HHP SERVICES: CARE COORDINATION

Care coordination services ensure that providers are on the same page as the **Health Action Plan** is implemented. The **Care Coordinator** is the key point of contact for the patient and the care team to ensure these services are provided, including:

- Helping the member 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 coordinating 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 admissions and readmissions.
- Sharing information with all involved parties to monitor the member's conditions, health status, medications and any side effects.
- Accompanying members to critical appointments.

HHP SERVICES: HEALTH PROMOTION

Members are coached on how to monitor and manage their health and to identify and access helpful resources, such as:

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

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HHP SERVICES: COMPREHENSIVE TRANSITIONAL CARE

Facilitate transitions between treatment facilities, including admissions and discharges, to reduce avoidable hospital admissions and readmissions, such as:

- Collaborating, communicating, and coordinating with all involved parties.
- Sending a summary of care record or discharge summary to all involved parties.
- Planning timely follow-up appointments with outpatient and/or community providers and arranging transportation as needed.
- Educating members 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.

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HHP SERVICES: MEMBER AND FAMILY SUPPORTS

Educate members and their family and/or support team about their conditions to improve treatment adherence and medication management, such as:

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

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HHP SERVICES: REFERRALS TO COMMUNITY AND SOCIAL SUPPORTS

Provide referrals to community and social support services and follow-up to help ensure that members are getting connected to the services they need, such as:

- 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, disability services, as needed.
- Actively engaging with appropriate referral agencies and other community and social supports.
- Providing housing navigation services and tenancy sustaining services.
- Routinely following up to ensure needed services are obtained.

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HHP SERVICES: REFERRALS TO COMMUNITY AND SOCIAL SUPPORTS

Through the HAP, the care team can develop strategies to address **housing and transportation** needs, two of the most commonly needed supports.

- Common Barriers
  - Inconsistent, unsafe or inadequate housing
  - Inconsistent or unreliable transportation
  - Financial barriers
- While HHP does not provide actual housing or transportation services, it does provide services to help members obtain and maintain housing or transportation, including:
  - Housing navigation services, not just referrals to housing agencies
  - Arranging for medical transportation, as covered by Medi-Cal, including:
    - Authorization, if needed
    - Arranging for pick-ups and drop-offs

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INFORMATION SHARING AND REPORTING

Information Sharing Across Entities

- For care management activities to be successful, the entire HHP care team must be able to share and access information about a patient's services and care.
- MCPs are responsible for establishing and maintaining data-sharing agreements with HHP partners.
- Providers are encouraged to use technology to ensure timely, accurate, and secure sharing of information.

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PAYMENT INFORMATION

- HHP payments are made directly from DHCS to the MCPs through capitation rates (a set amount per member, per month).
- MCPs negotiate individual contracts and payment terms with CB-CMEs and other providers to ensure the delivery of HHP services such as care coordination or housing navigation.
- The MCP and the CB-CME or other providers will determine payment terms. Payment terms may be a per member, per month rate or a fee-for-service payment, and may vary by provider.

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THE HHP WILL BE PHASED IN BY COUNTY

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	• San Francisco	July 1, 2018	January 1, 2019
Group 2	• Riverside • San Bernardino	January 1, 2019	July 1, 2019
Group 3	• Alameda • Fresno • Imperial • Kern • Los Angeles • Sacramento • San Diego • Santa Clara • Tulare	July 1, 2019	January 1, 2020
Group 4	• Orange	January 1, 2020	July 1, 2020

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TRAINING AND TECHNICAL ASSISTANCE

DHCS Required Training Topics for CB-CME Staff

1. Overview of the Health Homes Program
2. Topics in Care Management (3 part series)
   - Comprehensive Care Managements and the Health Action Plan
   - Introduction to Care Coordination Services
   - Introduction to Care Transitions
3. Community Resources and Referrals

Learning Collaboratives

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HHP RESOURCES AND INFORMATION

DHCS Health Homes Website

- bit.ly/HealthHomes

Outreach and Education Materials

- Member Toolkit
- Provider Guide
- Brochures
- One-Pagers

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QUESTIONS

DHCS HHP email box

hhp@dhcs.ca.gov