JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Health Homes Program: The Basics

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Justice in Aging is a national non-profit organization that fights senior poverty through law. We secure health and economic security for older adults of limited income and resources by preserving their access to the courts, advocating for laws that protect their rights, and training advocates around the country to serve the growing number of older Americans living in poverty.

Visit us at - justiceinaging.org

Commonly Used Acronyms

- Health Homes Program (HHP) – also called Health Homes for Patients with Complex Needs
- Medi-Cal Managed Care Plan (MCP)
- Community Based Care Management Entity (CB-CME)
- Health Action Plan (HAP)
- Medi-Cal Specialty Mental Health Plan (MHP)

Health Homes Program

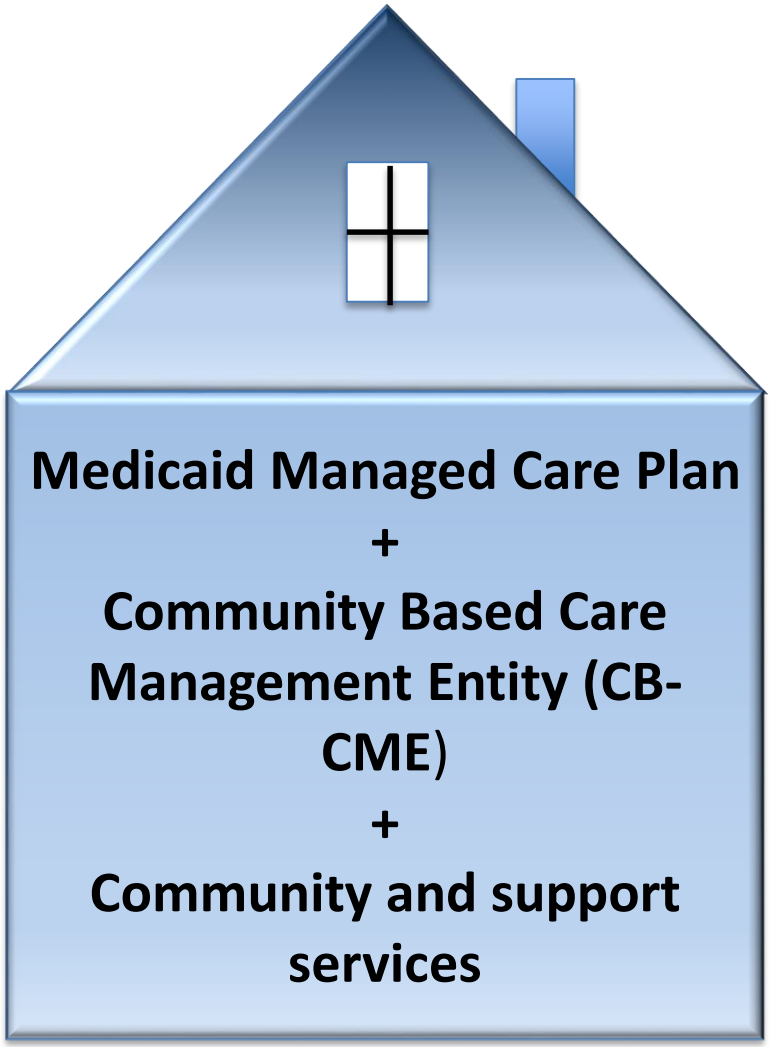
What

Six Goals

- Improve Care Coordination
- Integrate palliative care into primary care delivery
- Strengthen community linkages
- Strengthen team based care
- Improve health outcomes for the highest risk Medi-Cal population
- Savings

Health Homes Program
Structure

What



Health Homes Program

What

HHP Services

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports (including housing needs)

Health Homes Program

What

Medi-Cal Plan Responsibilities

- Assign HHP members to CB-CMEs
- Oversight
- Data Sharing (e.g. ED visits, admissions)
- Collect outcome data
- Provide resources to HHP

Health Homes Program

What

CB-CME Responsibilities

Serve as the frontline provider of HHP Services

Three Models

1. Care managers on site in community provider offices (preferred model).
2. Care management contracted by another community-based entity or a staff member.
3. Care managers off-site entirely (likely to serve individuals in rural areas).

Health Homes Program

What

CB-CME Qualifications

- Community mental health center
- Community health center
- Hospital or hospital-based physician group or clinic
- Local health department
- Primary care or specialist physician or physician group
- Substance use disorder treatment provider
- Providers serving individuals experiencing homelessness
- Other

Health Homes Program

What

CB-CME Duties

- Care team staffing
- Person-centered health planning
- Develop a HAP
- Facilitate the provision of evidence-based care
- Manage referrals, coordination, etc.
- Support HHP members in discharge planning
- Accompany HHP member to appointments
- Provide services in the community
- Coordinate with the plan's nurse line

Health Homes Program

What

Care Team

- Team members include the HHP Director, Dedicated Care Manager, Clinical Consultant
- For HHP member experiencing homelessness: housing navigator
- Additional team members, such as a pharmacist or nutiritionist may be included based on care coordination needs.

Health Homes Program

Who

- Two Target Populations
- Highest Risk
- 3-5% of Medi-Cal population
- ICD 9/10 Code Diagnosis AND High Utilizer
  - Risk Score
  - One inpatient stay in last year
  - Three or more ED visits in last year

Health Homes Program
Two Target Populations

Who

Chronic Conditions

- Two of the following: asthma, COPD, diabetes, TBI, CHF, CAD, chronic liver disease, dementia, substance use disorder OR
- HTN AND one of the following: COPD, diabetes, CAD, CHF

Health Homes Program
Two Target Populations

Who

Mental Health

- Major Depression
- Bipolar Disorder
- Psychotic Disorder (including schizophrenia)

Health Homes Program Assignment

Who

Voluntary

- MCP will engage eligible members through letter (maybe more)
- Member assigned to PCP CB-CME if affiliation – member can always choose

Health Homes Program Group 1

When & Where

Counties	Implementation for SMI Population	Implementation for Other Chronic Conditions
Del Norte Humboldt Lake Marin Mendocino Napa San Francisco Shasta Solano Sonoma Yolo	January 1, 2017	July 1, 2017

Health Homes Program Group 2

When & Where

Counties	Implementation for Chronic Conditions	Implementation for SMI Population
Imperial Lassen Merced Monterey Orange Riverside San Bernardino San Mateo Santa Clara Santa Cruz Siskiyou ~~Ventura~~	July 1, 2017	January 1, 2018

Health Homes Program Group 3

When & Where

Counties	Implementation for Chronic Conditions	Implementation for SMI Population
Alameda Los Angeles Sacramento San Diego Fresno Tulare Kern	January 1, 2018	July 1, 2018

Health Homes Program

Status

- SPA submitted to CMS this week
- DHCS released Request for Applications (RFA) to MCPs in the first group
- DHCS will work with initial groups of MCPs to provide technical assistance

Health Homes Program

Next Steps

- Start conversations with the health plans
- Six months DHCS will release provider self-assessment for participation
- Stay informed

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Want to know more?

- DHCS Health Homes Program Website: http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx
- Concept Paper (Final Version – Mar. 28, 2016): http://www.dhcs.ca.gov/provgovpart/Documents/HealthHomes/HHPCNCaConceptPaper.pdf
- DHCS Health Home Mailbox: HHP@dhcs.ca.gov
- Justice in Aging: acutler@justiceinaging.org