Health Homes Program and Project Roomkey Collaboration

Agenda

1. Welcome and Health Plan Introductions
2. Health Homes Program
3. Questions and Answers

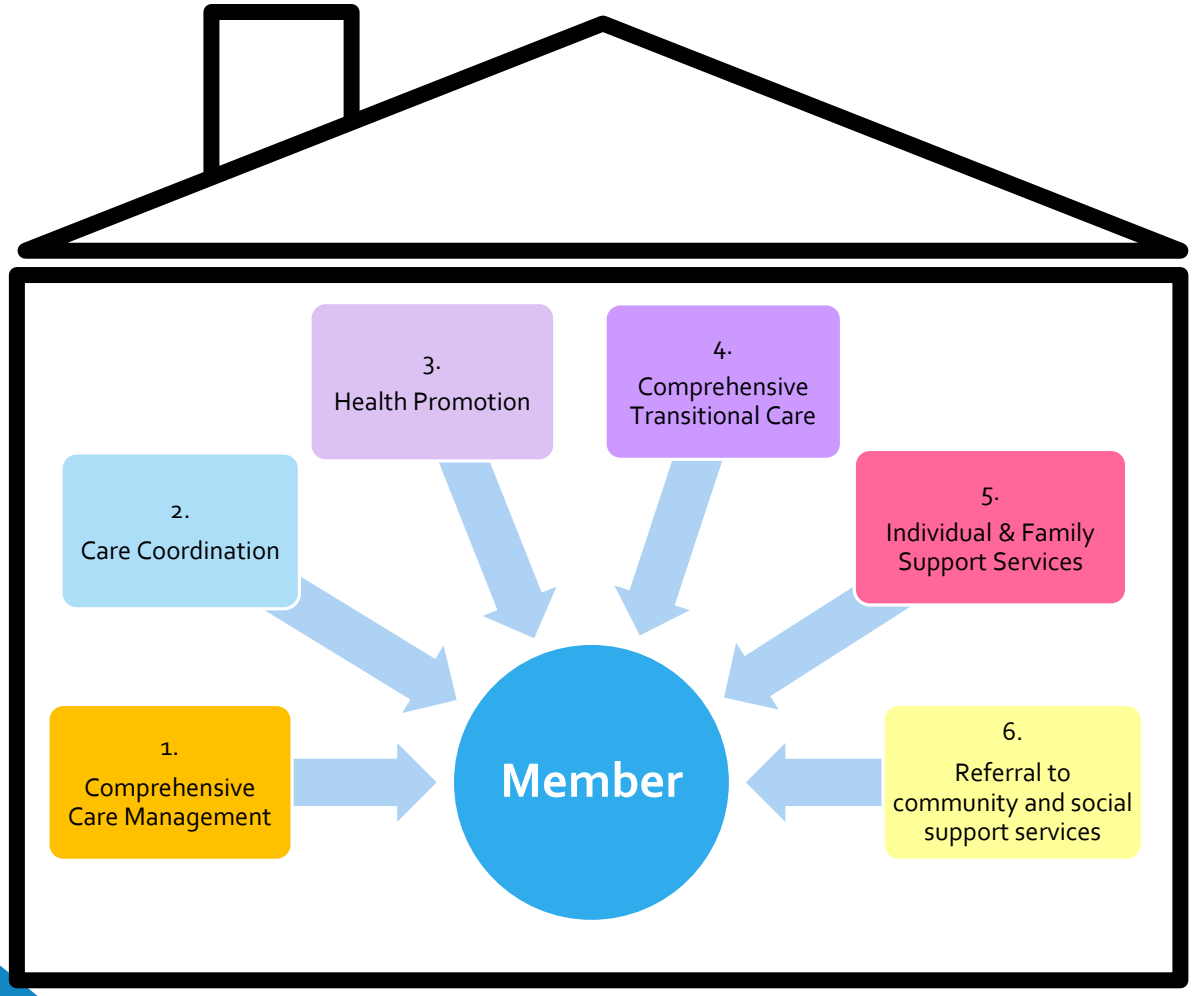
Welcome

- Speakers
  - L.A. Care: Kristin Mendoza, Melissa Wanyo
  - Anthem: Liz Gutierrez
- Health Plans

Health Homes is…

A Medi-Cal program designed to provide in-person, community-based care management and wraparound services to eligible Medi-Cal members with multiple chronic conditions.

The six core services provided include:



Why Health Homes Program (HHP)?

- To *improve member outcomes* by coordinating:
  - physical health services
  - mental health services
  - substance use disorder services
  - community-based long term services and supports
  - oral health services
  - palliative care
  - social support needs

- *Reducing avoidable health care costs*, including:
  - hospital admissions/readmissions
  - Emergency department visits
  - nursing facility stays

- “Improving member outcomes will be accomplished through the partnership between the managed care plan (MCP) and the CB-CME.”*

*source: DHCS HHP Program Guide

Why should PRK providers refer PRK residents to Health Homes Program?

- PRK residents may need case management and care coordination services while they are staying in PRK or if they are transitioning to another housing setting.
- HHP can help PRK residents with coordinating their health care amongst different providers, get them connected to a medical home, review their prescriptions, and connect them to community and social services, such as food and housing.
- HHP CB-CMEs want to collaborate with other case managers who are also supporting the PRK resident.

Health Homes Basic Eligibility Criteria

- HHP is for Medi-Cal members only
- Cal Mediconnect members do not qualify
- In addition to being a Medi-Cal member, a member would have to meet at least one condition from each of the two eligibility criteria to be eligible: Chronic Conditions and High Acuity.

Health Homes Eligibility Criteria: Multiple Chronic Conditions

Members must meet one of the following criteria:

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

*Aligns with PRK eligibility criteria

Health Homes Eligibility Criteria: Acuity

Members must meet one of the following criteria:

1. Has three or more of the HHP-eligible chronic conditions
2. Has stayed in the hospital in the last year
3. Has visited the emergency department three or more times in the last year
4. Has chronic homelessness
   - Chronic Homelessness for HHP is defined by AB 361 or HUD definition (U.S. Department of Housing and Urban Development)

Exclusionary Criteria:

Criteria that makes a member not eligible for HHP

1. Receiving Hospice services
2. Residing in a Skilled Nursing Facility (SNF) with a duration longer than the month of admission and the following month
3. Cal MediConnect (CMC)
4. County Targeted Case Management (TCM) excluding Specialty Mental Health TCM
5. Participates in 1915(c) Home and Community Based (HCPS) waiver programs
   - HIV/AIDS
   - Assisted Living Waiver (ALW)
   - Developmentally Disabled (DD)
   - In-Home Operations (IHO)
   - Multipurpose Senior Services Program (MSSP)
   - Nursing Facility Acute Hospital (NF/AH)
6. Participates in Whole Person Care Programs (some)

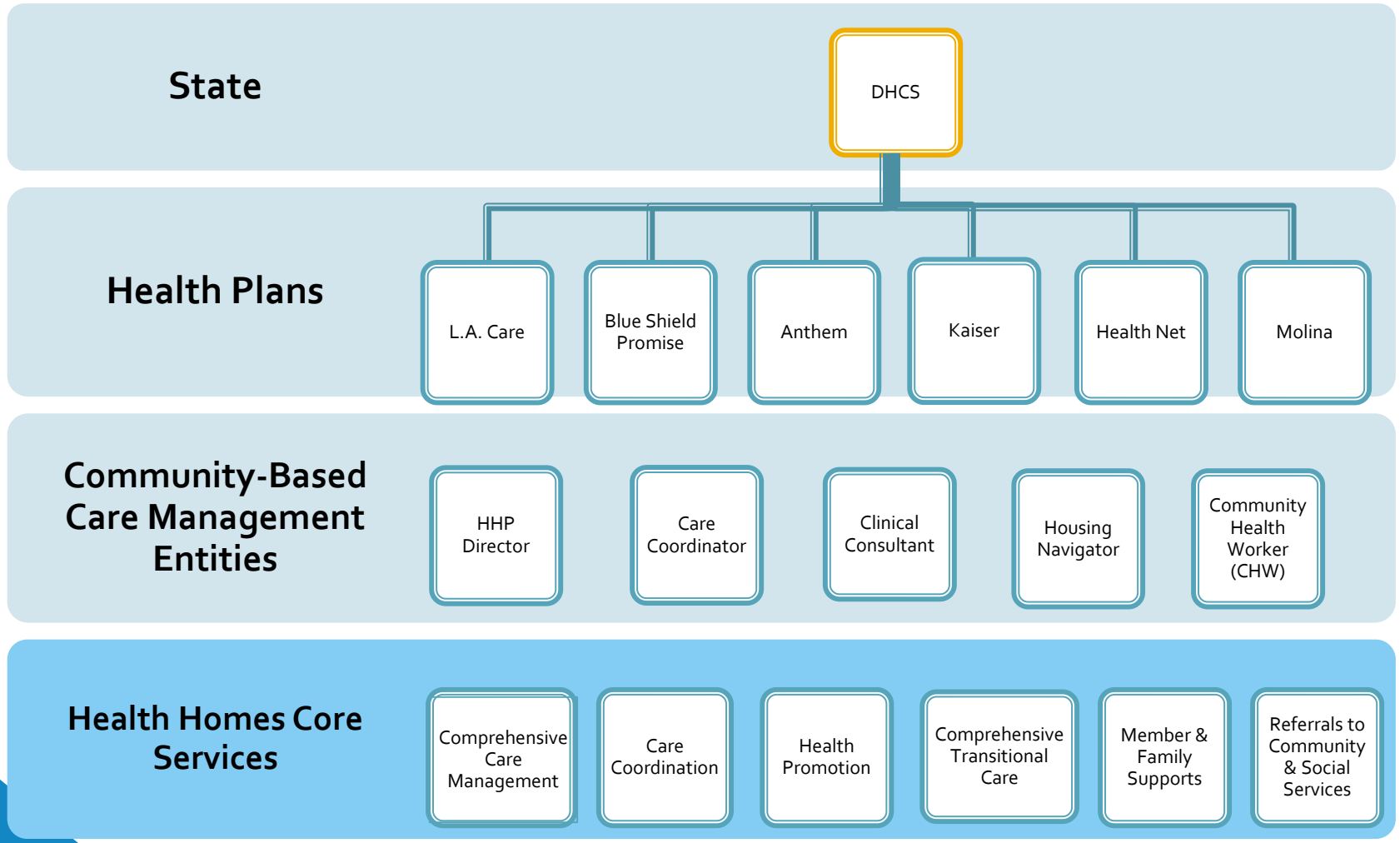
Exclusionary Criteria:
Housing for Health
Intensive Case Management (ICMS)

- ICMS Program operated by DHS Housing for Health which contracts with community based providers and homeless service agencies
- WPC-LA pays for housing transition service and tenancy support services for participants with complex medical/behavioral health conditions
- Utilizes the Coordinated Entry System (CES) operated by Los Angeles Homeless Services Authority (LAHSA) to assess individuals and connect them to appropriate housing. Individuals must be referred to a CES agency for assessment, prioritization and matching
- **Duplicative Program - Member cannot be concurrently enrolled in HHP; Providers should not refer individuals in HFH ICMS into HHP**

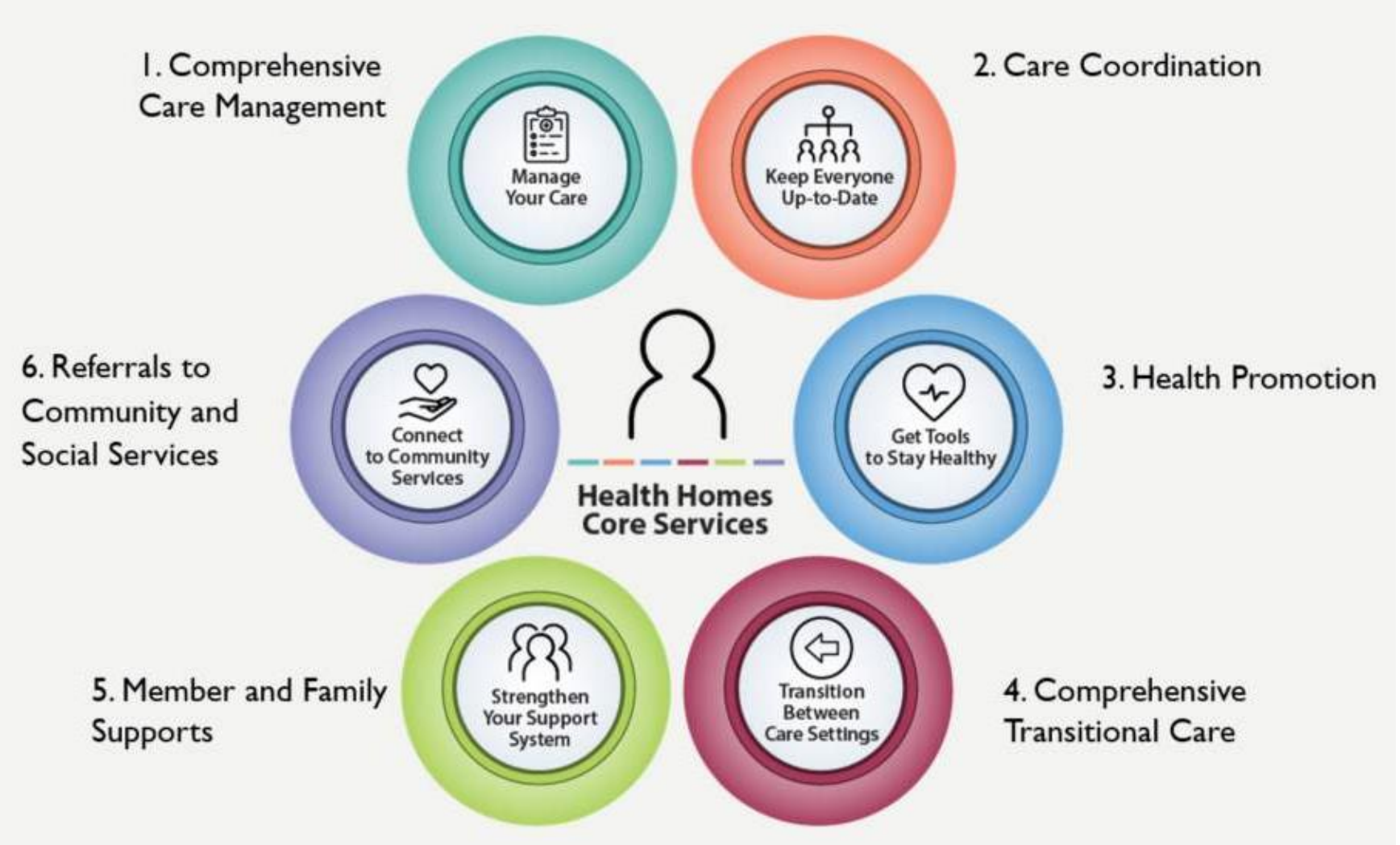
What are Community-Based Care Management Entities (CB-CMEs)?

- Frontline provider of HHP required services
- Conducts outreach and engagement to Medi-Cal members who are HHP eligible
- Delivers HHP services
- May subcontract with other entities or individuals as needed
- 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.

Health Homes Program Structure



HHP Six Core Services



Comprehensive Care Management

Development of the Health Action Plan (HAP)

- The HAP is developed by the member and their care team to address their physical and mental health and social service 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

Care Coordination

Implementation of the Health Action Plan (HAP)

- Care coordination services ensure that providers are on the same page as the HAP is implemented. The Care Coordinator is the key point of contact for the member 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
  - Supporting treatment adherence, including coordinating medication management and reconciliation

Care Coordination: Continued

- 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, as needed
- Health Promotion

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 the 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

Comprehensive Transitional Care

- Help members move safely and easily between different care settings, to reduce avoidable hospital admissions and readmissions, by:
  - Collaborating, communicating, and coordinating with all providers and care settings
  - Sending a summary of care record or discharge summary to providers and care settings
  - 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

Member and Family Supports

- Educate members and their family/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

Referrals to Community and Social Services

- Provide referrals to community and social services and follow-up to help ensure that members are 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 (as needed):
    - Housing
    - food security and nutrition programs
    - employment counseling
    - child care
    - disability services
  - Helping members obtain and maintain housing
  - Actively engaging with appropriate referral agencies and other community and social supports
  - Routinely following up to ensure needed services are obtained

How do I make a referral for a PRK resident to Health Homes Program?

You will have to confirm the PRK resident's health plan, complete the L.A. County Health Homes Program Member Referral Form, and submit the form via secure email or secure fax to the appropriate health plan.

Health Plan	Secure Email Address	Secure Fax Number
Anthem Blue Cross	CAHealthHomes@anthem.com	N/A; Submit secure email only
Blue Shield of California Promise Health Plan	HealthHomesProgram@blueshieldca.com	
Health Net	Health_Homes_Program@healthnet.com Please note underscores in email address	
L.A. Care Health Plan	HealthHomesReferrals@lacare.org	(213) 438-5694 Submit either secure email or fax
Molina Healthcare of California	Health_Homes_Program@Molinahealthcare.com Please note underscores in email address	N/A; Submit secure email only

What happens after I make a referral?

- The health plan will assess the referral form, check member's eligibility, and respond with next steps or request more information within one week.

How quickly do members get connected to services?

- Depends on eligibility
- Health plans will then assign member to a CB-CME
- CB-CME will then reach out/try to contact member
- This process takes time and services may not be immediate
- Please note on referral form if referral is urgent

HHP Referral Information for PRK Providers

- We will share the following documents with PRK Providers:
  - HHP Flyer
  - HHP FAQ for PRK Providers
  - HHP referral form
  - HHP screening check list

- Additional information
  - L.A. Care's Health Home Program: https://www.lacare.org/providers/provider-resources/health-homes-program

HHP Referral Form (1/2)

L.A. County Health Homes Program (HHP) Member Referral Form

Use this form to refer a member whom you assess as HHP eligible. **Please confirm the patient's health plan and submit this completed HHP referral form to the appropriate health plan via secure email or secure fax.** Health plan will assess the submitted member's eligibility and respond with next steps or request more information within one week.

Health Plan	Secure Email Address	Secure Fax Number
☐ Anthem Blue Cross	CAHealthHomes@anthem.com	N/A; Submit secure email only
☐ Blue Shield of California Promise Health Plan	HealthHomesProgram@blueshieldca.com	
☐ Health Net	Health_Homes_Program@healthnet.com *Please note underscores in email address*	
☐ L.A. Care Health Plan	HealthHomesReferrals@lacare.org	(213) 438-5694 *Submit either secure email or fax*
☐ Molina Healthcare of California	Health_Homes_Program@Molinahealthcare.com *Please note underscores in email address*	N/A; Submit secure email only

Asterisk (*) identifies required information field on this HHP referral form

REFERRAL SOURCE INFORMATION	
Internal referring department* (select one): ☐ CM ☐ UM ☐ BH ☐ MLTSS ☐ Other	
External referral by* (select one): ☐ Hospital ☐ PPG ☐ PCP ☐ Clinic ☐ Other	
Referring Individual Name:*	
Referring Organization Name:*	
Referrer Phone Number:*	( )
Referrer Email Address:*	
Has the member expressed interest in enrolling in HHP?* ☐ Yes, and I have completed the HHP screening checklist for the member. ☐ No, I would like to validate HHP eligibility prior to discussing HHP with the member.	
Is the member currently being followed by a health plan case manager or part of an external case management program? ☐ Yes ☐ No ☐ Unknown If yes, please provide contact information as available:	

HHP Referral Form (2/2)

MEMBER INFORMATION					
Member Name:*					
Member's Medi-Cal Client ID #*			Member Date of Birth:*		
Member Address:					
Member Primary Phone Number:*	( )		Best Time to Contact:		
Member's Preferred Language:*					
Caregiver's Name:		Caregiver's Alternate Phone Number *(if available)*:	( )		

MEDI-CAL ELIGIBILITY:*	
	Member in Medi-Cal managed care? *Please check Automated Eligibility Verification System (AEVS)*: ☐ Yes ☐ No
	Member in Cal MediConnect? ☐ Yes ☐ No If yes, member is **NOT** eligible for HHP

DIAGNOSIS*: Please check **all** that apply. For a patient to be eligible for the HHP, they must meet at least one chronic condition **AND** one acuity criteria. Please indicate which chronic condition criteria **AND** which acuity criteria this patient meets.

Chronic Condition Criteria

Member has **at least one** chronic condition in the following categories *(check all that apply)*:

1. ☐ Has at least two of the following: ***OR***
   - ☐ chronic obstructive pulmonary disease
   - ☐ chronic renal (kidney) disease
   - ☐ diabetes
   - ☐ traumatic brain injury
   - ☐ chronic or congestive heart failure
   - ☐ coronary artery disease
   - ☐ chronic liver disease
   - ☐ dementia
   - ☐ substance use disorders
2. ☐ Hypertension and one of the following: ***OR***
   - ☐ chronic obstructive pulmonary disease
   - ☐ diabetes
   - ☐ coronary artery disease
   - ☐ chronic or congestive heart failure
3. ☐ Has one of the following: ***OR***
   (Eligible for the HHP starting 1/1/2020)
   - ☐ major depression disorders
   - ☐ bipolar disorder
   - ☐ psychotic disorders, including schizophrenia
4. ☐ Asthma

AND

Acuity Criteria

Member has **at least one** acuity/complexity criteria:

☐ Has at least three or more of the Health Homes Program-eligible chronic conditions; ***OR***

☐ Has had at least one inpatient stay in the last 12 months
If checked, provide date of last inpatient stay:
_____ (MM/DD/YYYY); ***OR***

☐ Has had three or more emergency department (ED) visits in the last 12 months
If checked, provide date of last ED visit:
_____ (MM/DD/YYYY); ***OR***

☐ Chronic homelessness**

***For Health Homes, a chronically homeless individual means a person with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more, or who has had at least four episodes of homelessness in the past three years. Any of the Health Homes chronic conditions qualify as a condition limiting activities of daily living.*

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. For Health Homes eligibility, individuals can meet either the HUD chronically homeless definition or the AB 361 definition.

Tips for Completing HHP Referral Form

- Completion of the HHP eligibility screening form is required to ensure patients meet HHP eligibility criteria and are not participating in any exclusionary programs.
  - Note: The submission of the completed HHP eligibility screening form is not required but would be good to keep on file if health plans have any questions or need additional information
- Please review referral form and ensure all required sections are completed
- Make sure information on referral form is legible
- Identify one chronic condition criteria + one acuity criteria – member must have one of each
- Give your name and contact info so we can reach out with any questions
- Note any special circumstances or applicable additional information about the patient
- Ensure referral form is submitted to the correct health plan
- Please indicate in the comments section on the referral form this is a PRK referral

Questions?

Thank you!