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CA Health Homes Program

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Health Homes Program

An i**ntegrated** service delivery system for populations with **complex**, chronic conditions intended to **improve outcomes** by **reducing fragmented care** and promoting **patient-centered care**.

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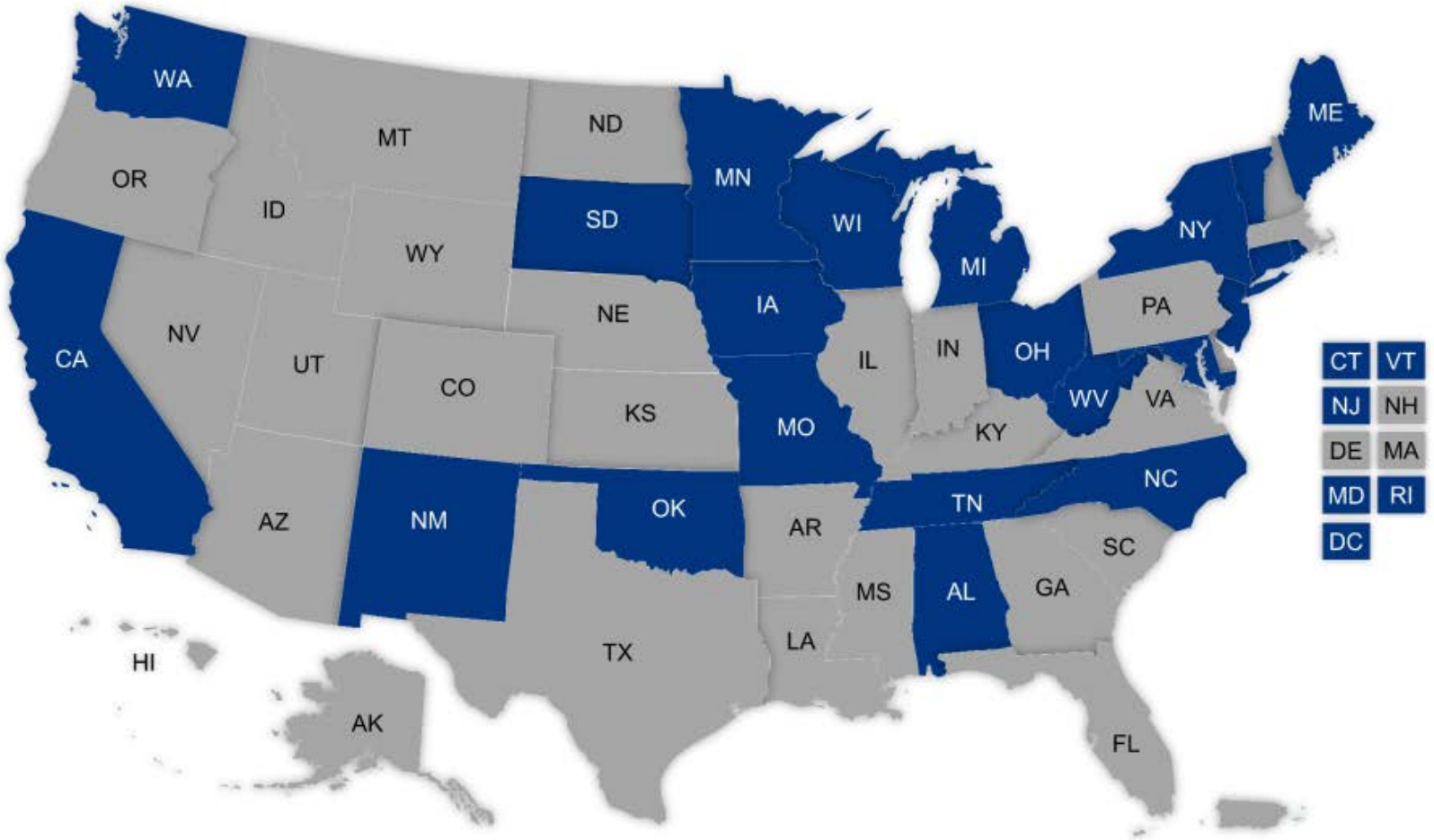
- Local Goals
  - Increase coordination between medical and behavioral health and community support systems and services
  - Create infrastructure to support multi-system coordination and care delivery
  - Address and support access to housing for eligible homeless members and members with unstable housing
- Statewide goals
  - Increased health status and quality of life
  - Enhanced service quality
  - Reduced hospital inpatient admits/length of stays
  - Reduced emergency department utilization
  - Reduced redundancy in tests and procedures

Program Background

- Affordable Care Act, Section 2703
- States will receive enhanced federal funding during the first eight quarters of implementation
- CA State Plan Amendment (SPA) for 11 counties (7 Anthem) for following target populations:
    - Chronic Physical Health Conditions
    - SMI

Participating States



As of April 2018, 22 states and the District of Columbia have a total of 34 approved Medicaid health home models.

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Anthem Counties

- Anthem Participating Counties:
  - Group 1: San Francisco
  - Group 2: N/A
  - Group 3: Los Angeles, Alameda, Fresno, Tulare, Sacramento, Santa Clara

Implementation

Counties	Implementation date for members with eligible chronic conditions and SUD	Implementation date for members with serious mental illness
San Francisco	July 1, 2018	January 1, 2019
Alameda	July 1, 2019 (WPC 7/1/18)	January 1, 2020 (WPC 7/1/18)
Santa Clara	July 1, 2019	January 1, 2020
Fresno	July 1, 2019	January 1, 2020
Los Angeles	July 1, 2019	January 1, 2020
Sacramento	July 1, 2019	January 1, 2020
Tulare	July 1, 2019	January 1, 2020

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Health Homes Core Services

1. **Comprehensive Care Coordination**
2. Comprehensive Care Management
3. Health Promotion
4. Transitions in Care
5. Support for the member and family members
6. Referrals to community services and supports
7. Housing Navigation and Tenancy Support

The Health Home Model

MCO

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Community-Based Care Management Entity (CB-CME)

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Health Home

Who are the CB-CMEs?

- Existing clinic or community organization
- Contracted with the health plan
- Provides all core services
- Established care team, including:
  - Physicians
  - Nurse Care Coordinators
  - Social Workers
  - Behavioral Health Professional
  - Housing Navigator
  - Community Health Worker
- In many cases, this is where the member is already receiving services

St. Anthony's
San Francisco, CA

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Who are the CB-CMEs?

San Francisco	• Marin City • Health Right 360 (multiple sites) • NEMS (multiple sites) • St. Anthony's • Mission Neighborhood • Anthem ESRD Program • SF Health Network (future) • Stepping Stone (future)
Alameda	• Alameda Health System • Lifelong • Family Bridges • Tri-City

CB-CME Responsibilities

- Outreach and Engagement
- Care Management
- Development of Individual HAPs
- Care Coordination
- Health Promotion
- Transitions of Care including Discharge Planning
- Support for Member and Family
- Referrals to Community Services and Supports
- Housing Navigation
- **Reporting** to Health Plan

Member Eligibility

Eligibility Requirement	Criteria Details
1. Chronic condition criteria	Has a chronic condition in at least one of the following categories: • **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 renal (kidney) disease, dementia, substance use disorders; OR • **Hypertension and one of the following:** chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure; OR • **One of the following:** major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia); OR • **Asthma**
2. Meets at least 1 acuity/complexity criteria	• Has at least 3 or more of the HHP eligible chronic conditions; OR • At least one inpatient hospital stay in the last year; OR • Three or more emergency department visits in the last year; OR • Chronic homelessness.

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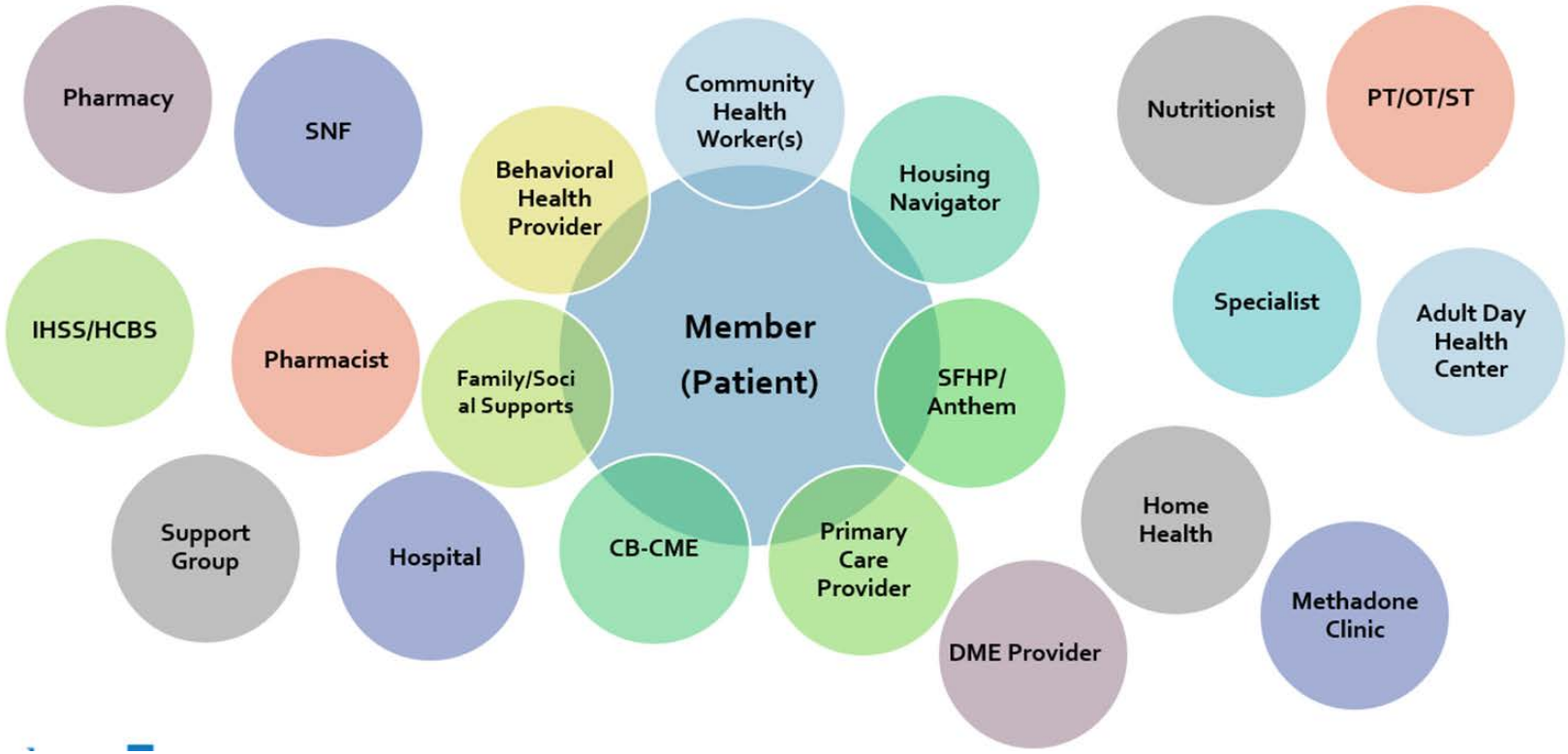
Why would a member opt in?



Members enrolled in the Health Homes program get a **single point of contact** who will help coordinate all of their medical, behavioral health, and social services.

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Member Example

- Jamie, age 52
- Has asthma and diabetes
- Housing unstable, lives with family for now
- Frequent ED visits in the past year
- Difficulty managing medications

Before Health Homes…

Jamie must manage his own care with:

- PCP
- Endocrinologist
- Pulmonologist
- Housing navigator
- Anthem Case Manager
- Hospital Social Worker

After Health Homes…

Jamie's single point of contact is a Health Home Coordinator who:

- Collaborates on a health action plan **(HAP)** based on member's goals
- uses the HAP to guide coordination of care and sharing of information among all those who provide service to the member
  - sets up visits to providers
  - arranges transportation
- tracks goals and progress.

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Anthem Bay Area Implementation Gaps/Challenges

Clinical

- **Difficult to reach population**
- **Large homeless population coupled with housing shortage**
- **Overlapping programs**
- Housing and Palliative Care are new
- **Lack of HAP and assessment process**
- Difficulty integrating behavioral health

Operational

- **Manual processes surrounding care plans and data exchange**
- **Implementation cost v. anticipated revenue**
- Overall system limitations
- **Staffing infrastructures and policy development**
- **Lack of coordination among multiple programs**

Provider

- **Varying degrees of readiness among providers**
- Many new to managed care/FFS environment in SF
- **Lag in rates information delaying readiness activities**
- **Lack of state process for identification and transformation**

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Lessons Learned

- SURVEY TO GAUGE INTEREST AND AWARENESS
- ENGAGE CB-CMEs EARLY – Town Hall Collaborations
- COLLABORATE WITH THE OTHER HEALTH PLANS – Minimize differences
- DISCUSS RATES AND RESOURCES EARLY
- FOCUS ON THE DETAILS
- TREAT CB-CMEs AS PARTNERS – Add resources to supplement efforts
- ADMIT THAT THIS WON”T BE EASY

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Health Homes Questions

Direct all questions and inquires to:
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Or

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