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			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Coordinate and collaborative with all involved parties to promote continuity and consistency of care			
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			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Sharing information with all involved parties to monitor member conditions, health status, care planning, medication usages and side effects			
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			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Planning timely scheduling of follow-up appointments with recommended outpatient providers and/or community partners			
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			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Connecting the member to self-care programs to help increase their understanding of their conditions and care plan			
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			

Health Home Service	WPC Service Being Provided in Full	WPC Service Being Provided Partially	Notes
Providing member with information on relevant resources, based on the member's needs and interests			
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			