Health Homes Program

COMPREHENSIVE CARE MANAGEMENT AND THE HEALTH ACTION PLAN

Overview for Managed Care Plan and Community-Based Care Management Entity(CB-CME)Staff

October 2018

TRAINING PURPOSE

- This is the 2nd training in the series
- It will review the **care management requirements** for the Health Homes Program (HHP)
- Each Medi-Cal Managed Care Plan (MCP) has some flexibility in how they design their HHP
- Your MCP will have follow-up trainings to explain how its HHP will work operationally and provide more information about your specific role within the program
- Additional program information can be found in the HHP Program Guide

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TOPICS COVERED

- HHP Overview
- Comprehensive Care Management Services
- The Health Action Plan
- Health Action Plan Best Practices
- Additional Information and Future Trainings

HEALTH HOMES PROGRAM OVERVIEW

- The Medi-Cal HHP is a new program that offers extra services to certain Medi-Cal members with complex medical needs and chronic conditions

- Members are given a **care team** – including a **care coordinator** – that coordinates their physical and behavioral health care services and connects them to community services and housing, as needed

HEALTH HOMES PROGRAM OVERVIEW

- Members stay enrolled in their Medi-Cal Managed Care plan (MCP) and continue to see the same doctors, but now they have an extra layer of support
- Members receive these services at no cost as part of their Medi-Cal benefits
- Community-Based Care Management Entities (CB-CMEs) are primarily responsible for delivering HHP services

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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, 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

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ELIGIBILITY AND ENROLLMENT

2) The member meets at least one acuity/complexity criteria. The 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
- ❑ Is experiencing chronic homelessness

HHP CARE TEAM

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 with treatment adherence

HHP CARE TEAM

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

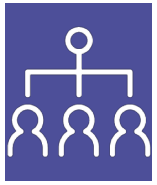
HHP Director

- 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

HHP CARE TEAM



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

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

Community-Based Organizations (CBOs)

- Care team identifies and works with community and social services already in place for members
- Care team identifies unmet needs and connects members to CBOs that provide community and social services

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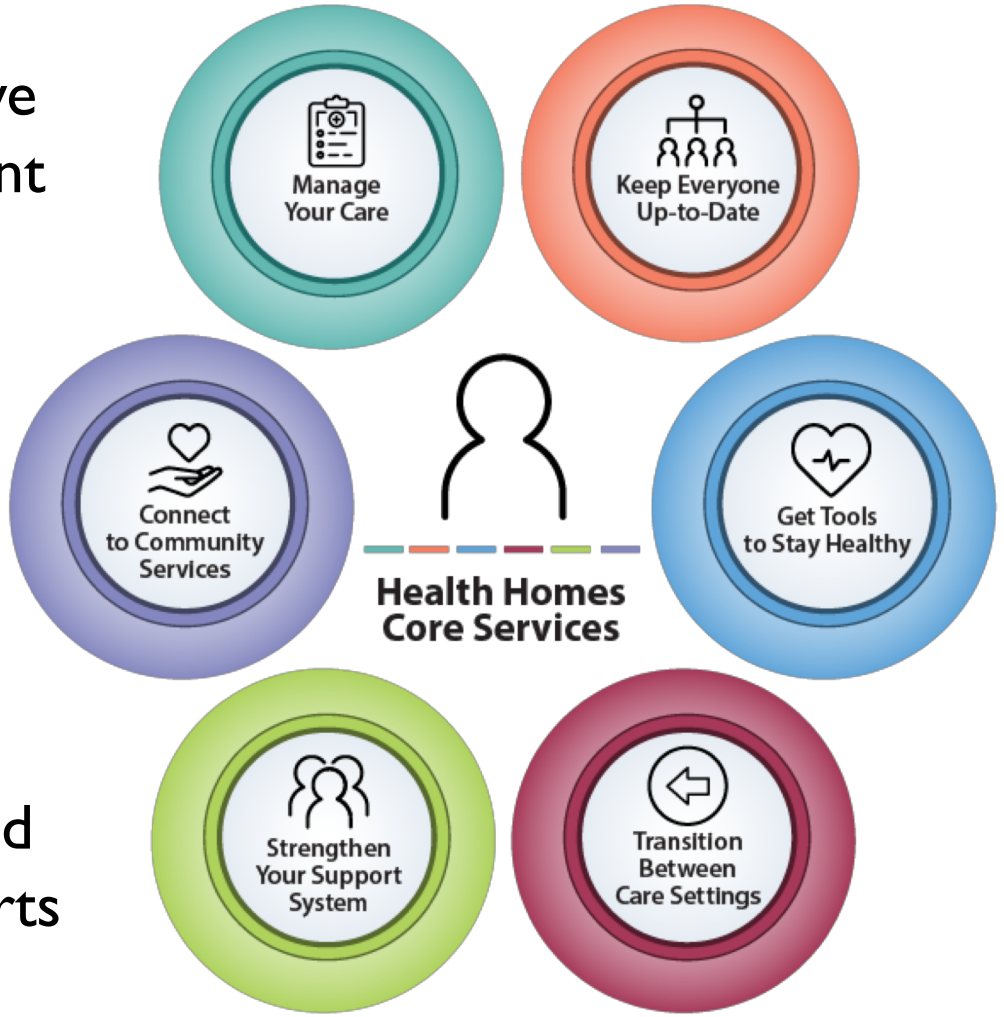
HHP SIX CORE SERVICES

1. Comprehensive Care Management

2. Care Coordination

6. Referrals to Community and Social Services



3. Health Promotion

5. Member and Family Supports

4. Comprehensive Transitional Care

THE HEALTH ACTION PLAN AND COMPREHENSIVE CARE MANGEMENT

- The member and their care team, including a care coordinator, work together to assess the member's needs and develop a **Health Action Plan (HAP)**
- **Comprehensive care management** services are provided based on the HAP, to help members achieve their health goals
- Services are integrated with current MCP coordination activities, but HHP provides an extra layer of support

THE HEALTH ACTION PLAN

Health Action Plan

- A comprehensive individualized plan that addresses the member's physical and mental health and social support needs and goals
  - The **member and care team** work together to develop the HAP
- The HAP is used to determine needed services, identify member and family supports, and monitor referrals and care
- The HAP guides and tracks the member's care and referrals
- The HAP is reviewed and revised over time based on the member's progress and changing needs

The HAP must be developed within 90 days of a member's enrollment in the HHP

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HEALTH ASSESSMENT AND HEALTH ACTION PLAN TOOL

- The MCP provides guidance on tools for conducting the health assessment and developing the HAP
  - In some cases, CB-CMEs will be able to adapt care plan tools and templates they are already using
- Some members may already have an Individualized Care Plan/Care Management Plan. This plan, or a similar one, may be used for the HAP as long as it incorporates required HHP elements
- MCPs will provide guidance on how the HAP is shared with the care team and other providers

KEY COMPONENTS OF THE HEALTH ACTION PLAN

1. Health status assessment
2. Member's needs, preferences, and self-management goals
3. Social supports assessment
4. Identification of community services
5. Identification of housing and transportation needs

1. HEALTH STATUS ASSESSMENT

The HAP is developed based on a health status assessment that may include:

- A review of all conditions – physical health, mental health, dental health, substance use disorder
- Symptoms/disease trajectory
- Mental health assessment
- Assessment of physical/functional status
- Assessment of long-term services and supports needs
- Palliative care needs
- Trauma-informed care needs
- Medication management
- Utilization assessment
- Assessment of care coordination needs

2. MEMBER NEEDS, PREFERENCES, AND GOALS

The HAP is developed based on the member's needs, preferences, and goals for their health, as well as:

- Member engagement and activation in their own care
- Health literacy
- Adherence
- Member preferences
- Cultural factors and preferences
- Member health and lifestyle goals
- Member goals and capacity for self-management

3. SOCIAL SUPPORTS ASSESSMENT

The HAP is developed based on the member's social support assets and needs related to:

- Home environment
- Family and friends
- Employment
- Support network
- Pets, hobbies, and other lifestyle considerations

4. IDENTIFICATION OF COMMUNITY RESOURCES

The HAP identifies and connects members to needed community resources, such as:

- Support groups
- Financial resources
- Employment counseling
- Child care
- Educational opportunities
- Food security and nutrition resources
- Physical activity options
- Other community and social services

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5. IDENTIFICATION OF HOUSING NEEDS

Through the HAP, the care team identifies and addresses barriers and develops strategies to assist members with their housing needs.

Potential Housing Barriers

- Lack of consistent housing
- Unsafe or inadequate housing
- Financial barriers to securing stable housing

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5. IDENTIFICATION OF HOUSING NEEDS

Through the HAP, the care team identifies and addresses barriers and develops strategies to assist members with their housing needs.

HHP Housing Services

- HHP does not provide actual housing, but provides services to help members obtain and maintain housing
- HHP housing navigation services are not just referrals to housing, but ensures member access to community housing resources

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6. IDENTIFICATION OF TRANSPORTATION NEEDS

Through the HAP, the care team identifies and addresses barriers and develops strategies to assist members with their transportation needs.

Potential Transportation Barriers

- Lack of consistent or reliable transportation
- Financial barriers to transportation

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6. IDENTIFICATION OF TRANSPORTATION NEEDS

HHP Transportation Services

- Medi-Cal already covers both non-emergency medical transportation (NEMT) and non-medical transportation (NMT)
- HHP does not provide additional transportation services, but arranges for transportation to be provided
- HHP care coordinators can help members get transportation services authorized and arrange their pick-ups and drop-offs

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IMPLEMENTING THE HEALTH ACTION PLAN

- The care team uses the HAP to guide and track the member's care and referrals
- The HAP is reviewed and revised over time based on the member's progress and changing needs
- Care management services are provided using communication methods suitable to the individual member
  - e.g. in-person or by phone; email and text communications is permitted, but is not required

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HAP BEST PRACTICES

- Motivational Interviewing
- Goal Setting
- Self-Management Support
- Additional Activities

HAP BEST PRACTICES: MOTIVATIONAL INTERVIEWING

- Use active and reflective listening
- Facilitate (vs. direct) member goal-setting
- Illustrate gaps between member's goals/values and current behavior
- Use empathy to address member resistance or ambivalence
- Facilitate member identification of strengths and assets
- Avoid confrontation

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HAP BEST PRACTICES: GOAL SETTING

- Collaborate with member to develop a unique, individualized HAP
- Incorporate member values, preferences, and priorities
- Incorporate cultural, religious, or other individual preferences
- Celebrate successes
- Focus on problem-solving rather than barriers
- Coach member in developing and prioritizing short- and long-term goals
- Encourage development of SMART goals: Specific, Measurable, Attainable, Relevant, Time-dependent

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HAP BEST PRACTICES: SELF-MANAGEMENT SUPPORT

- Encourage member to take an active role in achieving goals
- Offer encouragement and support for self care activities
- Focus on problem solving barriers to self care activities
- Coach member on developing realistic options
- Offer relevant and appropriate self care tools

HAP BEST PRACTICES: ADDITIONAL ACTIVITIES

- Clarify roles and set appropriate boundaries
- Assess need for trauma-informed care
- Assess need for crisis intervention and to develop a crisis response plan
- Include member's family and/or support system on care team, at member's request

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ADDITIONAL INFORMATION

- DHCS Health Homes Website
- California Health Care Foundation/California Quality Collaborative Complex Care Management Toolkit
- Center for Health Care Strategies Inc. Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations

FUTURE TRAININGS

- Introduction to Care Coordination
- Introduction to Care Transitions
- Connecting Members to Community and Social Services

Optional trainings may be provided by DHCS or MCPs