Health Homes Program

INTRODUCTION TO CARE COORDINATION SERVICES

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

October 2018

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TRAINING PURPOSE

- This is the 3rd training in the series
- It will review the **care coordination requirements** for the Health Homes Program (HHP) and resources for best practices
- Each Medi-Cal MCP has some flexibility in how they design their HHP
- Your Medi-Cal MCP will have follow-up trainings to explain how its HHP will work operationally and to explain your role
- Additional program information can be found in the HHP Program Guide

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TOPICS COVERED

- HHP Overview
- Care Coordination Services
- Best Practices for Chronic Conditions and Mental Health Conditions
- 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

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ELIGIBILITY AND ENROLLMENT

- 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)

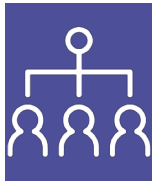
HHP Director

- 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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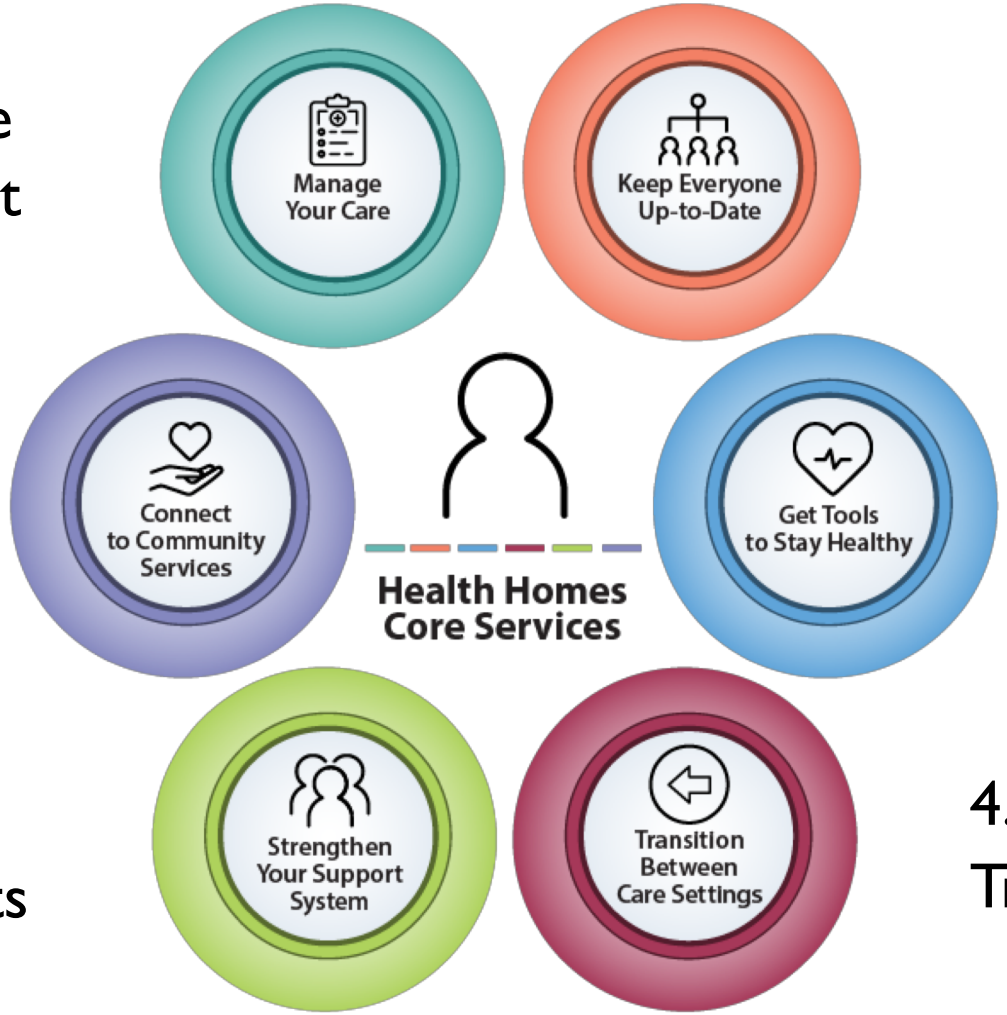
HHP SIX CORE SERVICES

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

CARE COORDINATION SERVICES

- Each member is given a **care coordinator**, who is the key point of contact for the member, their providers, and their **HHP care team**
- The care team helps the member develop and implement their **Health Action Plan (HAP)**
- The care team helps the member **navigate and connect to needed health care and community/social services**

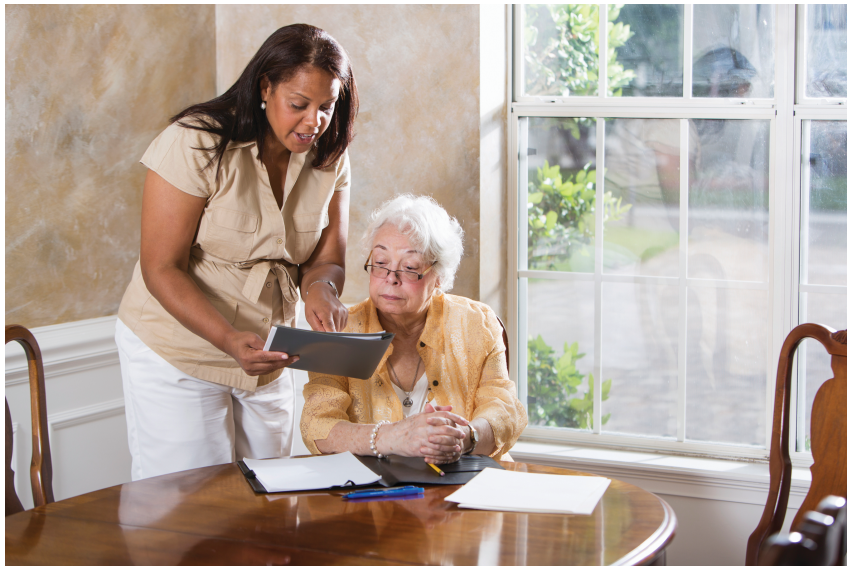
CARE COORDINATION SERVICES

Care coordination services may include:

- Helping members navigate and communicate with health, behavioral health, and social services, including housing and transportation
- Sharing options for accessing care and providing information regarding care planning
- Monitoring and supporting treatment adherence, including medication management and reconciliation
- Monitoring referrals to needed services and supports, as well as coordination and follow-up connected to care

CARE COORDINATION SERVICES

- Facilitating transitions among treatment facilities, including:
  - Admissions and discharges
  - 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
- Preparing for and accompanying members to appointments
- Providing home visits



CARE COORDINATION SERVICES

- Caseloads for care coordinators depend on member acuity, frequency of interactions, travel for member visits, and other factors specific to the clinic and member population
- Care coordination interactions may happen **weekly, biweekly, or monthly**
  - In limited cases, daily interaction may be necessary for high-acuity members and those in crisis
- Care coordination interactions may take place using the **communication methods most suitable for the member**. Email and text communications may be permitted.
- **In-person visits** may take place in the primary care setting, in hospitals or emergency departments, in the community, or in the member's home

MEMBER AND FAMILY SUPPORT SERVICES

A key component of care coordination is **engaging and educating members and their family and/or support team** about the member's conditions to improve treatment adherence and medication management

Services may include:

- Assessing strengths and needs of members, their family and/or support team
- Promote self-management and decision-making
- Linking members to self-care and peer supports to help them understand their condition

MEMBER AND FAMILY SUPPORT SERVICES

- Assessing member motivation and readiness for change
- Assisting members with making informed choices
- Helping members identify and obtain needed resources to support their health goals
- Advocating for member needs and preferences

ENGAGING MEMBERS AND FAMILIES

To increase member engagement, consider:

- Including a trusted primary care provider in the initial meeting between the care team, the member, and their family/support network

ENGAGING MEMBERS AND FAMILIES

- Offering the member additional support at times of high need, such as during a hospitalization
- Offering the member support that addresses language and cultural barriers

ENGAGING PROVIDERS

Care coordination involves engaging with providers

To increase provider engagement, consider:

- Frequent and consistent communication with providers and their staff
- Helping providers and staff understand the role of care team members

ENGAGING PROVIDERS

- Demonstrating how the HHP adds value to provider practices
- Providing information and resources to address gaps in care
- Not duplicating services or creating extra work for providers and staff
- Maximizing technology and electronic health records, when appropriate

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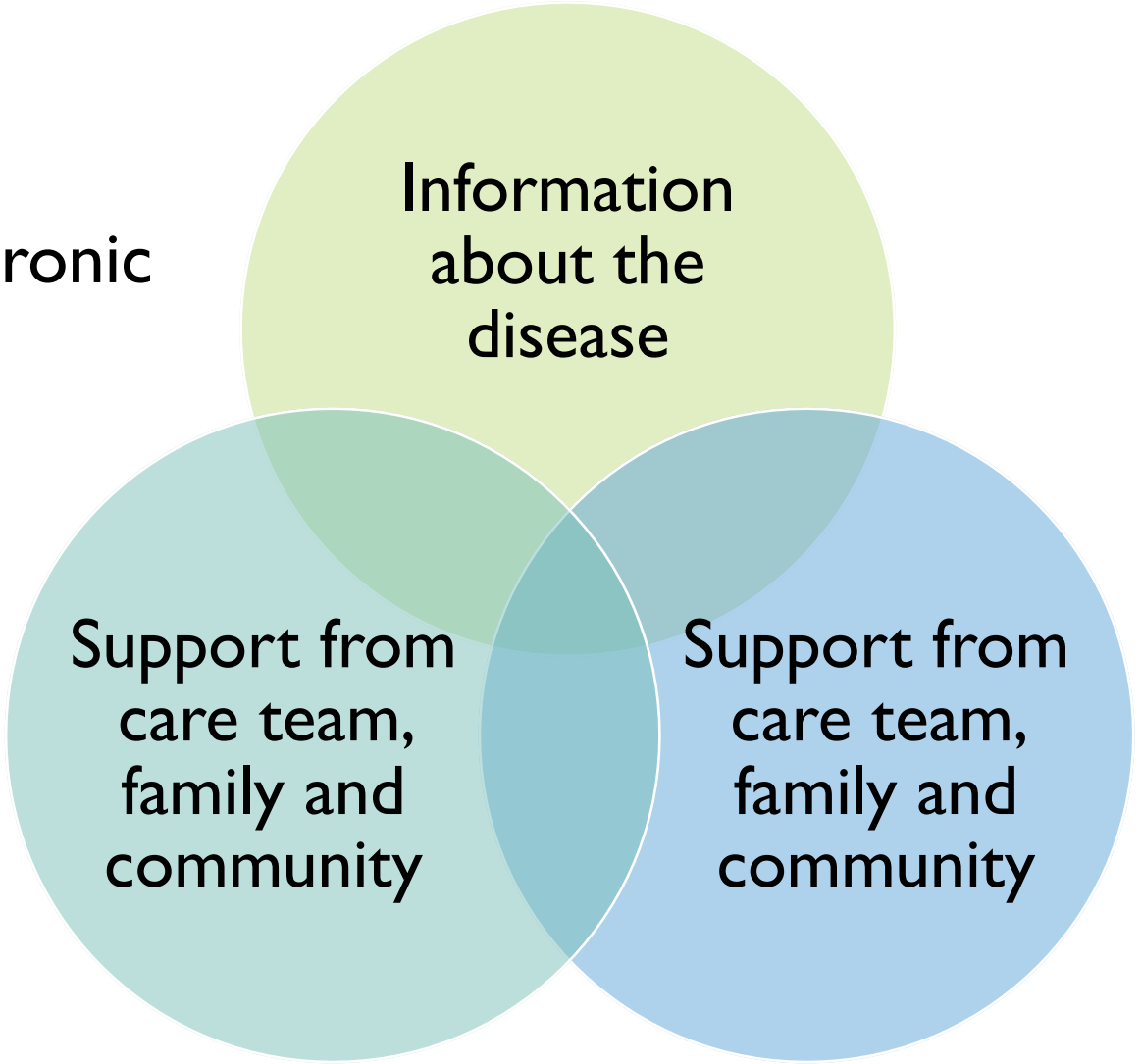
BEST PRACTICES: SUPPORTING MEMBERS WITH CHRONIC DISEASE

To successfully manage chronic disease, members need:



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BEST PRACTICES: SUPPORTING MEMBERS WITH CHRONIC DISEASE

- Ensure all care team members support self-management goals and activities
- Coach members about chronic conditions and management options
- Coach members to develop and monitor personalized self-management goals
- Use evidence-based practices and tools to help members manage their care
- Use group and peer support to engage members in self-management

See *Institute for Health Improvement Self Management Support for People with Chronic Illness*

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BEST PRACTICES: DIABETES SELF-MANAGEMENT

Evidence-Based Core Concepts in Diabetes Self-Management:

- Describe the diabetes disease process and treatment options
- Assess member's level of understanding of chronic condition
- Incorporate physical activity and nutritional management into lifestyle
- Use medication(s) safely and for maximum therapeutic effectiveness

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BEST PRACTICES: DIABETES SELF-MANAGEMENT

Evidence-Based Core Concepts in Diabetes Self-Management:

- Monitor blood glucose and other parameters and interpreting and using the results for self-management decision making
- Prevent, detect, and treat acute and chronic complications
- Develop personal strategies to address psychosocial issues and concerns
- Develop personal strategies to promote health and behavior change

See National Standards for Diabetes Self Management

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TOOLS AND GUIDELINES FOR OTHER CHRONIC CONDITIONS

Chronic Disease Management

- Group Health Research Institute: Improving Chronic Illness Care

Diabetes

- National Standards for Diabetes Self Management

Obesity

- American Academy of Family Physicians Obesity Clinical Guidelines

Asthma

- AARC Asthma Self Management Education

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TOOLS AND GUIDELINES FOR OTHER CHRONIC CONDITIONS

Hypertension and Heart Disease

- Patient Self Management Support: Novel Strategies in Hypertension and Heart Disease
- American College of Cardiology 2017 Guidelines for High Blood Pressure in Adults
- American Academy of Family Physicians Coronary Artery Disease Clinical Guidelines

Chronic Obstructive Pulmonary Disease (COPD)

- American Lung Association COPD Management Tools

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BEST PRACTICES: SUPPORTING MEMBERS WITH MENTAL HEALTH CONDITIONS

- Treat members with respect and hopefulness and without negative attitudes, prejudice, and discrimination
- Empower members to share their preferences and to actively engage in their own care and recovery
- Provide sufficient information so members can make informed decisions about their care and recovery
- Focus on the member's strengths, abilities, and resources in developing and implementing the HAP

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BEST PRACTICES: SUPPORTING MEMBERS WITH MENTAL HEALTH CONDITIONS

- Remember that the acuity of the member's mental health condition may change, and service type and service intensity must be adjusted accordingly
- Help members receive services where they want and in the least intensive and most natural setting possible
- Incorporate physical health treatment needs into mental health care treatment planning
- Connect members to peer supports, as appropriate
- Ensure that members are connected to the social services they need

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BEST PRACTICES: SUPPORTING MEMBERS WITH MENTAL HEALTH CONDITIONS

- Check if the member is receiving services through a county Medi-Cal Specialty Mental Health Services program
  - If so, see best practices on the next slide
- Check if the member has a written plan to help direct their care – e.g. advanced directive, safety plan, wellness recovery action plan, etc.
  - If not, ask them if they want to develop a plan
- Ensure that federal and state privacy laws are followed before exchanging behavioral health information

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BEST PRACTICES: SUPPORTING MEMBERS WITH MENTAL HEALTH CONDITIONS

For members who receive services through a Medi-Cal county specialty mental health plan services (SMHS) program:

- Check your MCP's policies for coordinating with SMHSs
- Find out the SMHS point of contact
- Provide the SMHS with CB-CME contact information
- Develop a communications strategy with the SMHS to:
  - Share information on member's physical and behavioral health status
  - Follow-up on mental health-related referrals
  - Exchange information (e.g. on medication, upcoming appointments, housing status, etc.)

MENTAL HEALTH RESOURCES

- DHCS All-Plan Letter 18-015: Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans
- SAMHSA Evidence-Based Practices Resource Center
- SAMHSA Cultural Competence Guide
- SAMHSA Illness Management and Recovery Evidence-Based Practices Toolkit
- Suicide Prevention Resource Center

ADDITIONAL INFORMATION

- DHCS Health Homes Website
- California Health Care Foundation/California Quality Collaborative Complex Care Management Toolkit
- Commonwealth Fund Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?

ADDITIONAL INFORMATION

- Center for Health Care Strategies, Inc. Introduction to Medicaid Care Management Best Practices
- The Health Care Transformation Task Force Developing Care Management Programs to Serve High Need, High Cost Populations
- Improving Chronic Illness Care-Group Health Research Institute

FUTURE TRAININGS

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

Optional trainings may be provided by DHCS or MCPs