

Health Homes Program

INTRODUCTION TO CARE TRANSITIONS

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

October 2018

TRAINING PURPOSE



- This is the 4th training in the series
- It will review the **care transition services** 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 to explain your role
- Additional program information can be found in the [HHP Program Guide](#)

TOPICS COVERED

- HHP Overview
- What is an HHP Care Transition?
- Services to Support Care Transitions
- Causes of Ineffective Care Transitions
- Best Practices for Care Transitions
- Best Practices for Reducing Readmissions During Care Transitions
- 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

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

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

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 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



WHAT IS A CARE TRANSITION?

- Transitions occur when a member moves from one care setting to another or to their own home
- HHP members receive services to facilitate their transition between different care settings



**The MCP and/or CB-CME must create processes to ensure prompt notification of facility admission or discharge to HHP care team*

WHAT IS A CARE TRANSITION?

- This includes transitions to/from:
 - Emergency department
 - Hospital inpatient facility
 - Residential or treatment facility
 - Mental health facility
 - Skilled nursing facility
 - Incarceration facility
 - Member's own home



**The MCP and/or CB-CME must create processes to ensure prompt notification of facility admission or discharge to HHP care team*

CARE TRANSITION SERVICES

HHP care transitions services may include:

- Collaborating, communicating, and coordinating with all involved parties
- 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



**In some cases, HHP care teams may work with hospital discharge planners on these activities*

CARE TRANSITION SERVICES

HHP services for care transitions may include:

- Planning appropriate care and social services post-discharge, including temporary housing
- Developing and facilitating the transition plan
- Evaluating revising the Health Action Plan to prevent avoidable admissions or readmission
- Providing transition support to permanent housing



**In some cases, HHP care teams may work with hospital discharge planners on these activities*

CAUSES OF INEFFECTIVE CARE TRANSITIONS

Communication Breakdowns

There may not be systems in place to communicate or share information with each other, across care settings, or with members

Member Education Breakdowns

Members may receive conflicting information or may have cognitive, language, or cultural barriers to receiving the information as it is provided

Accountability Breakdowns

There is often no one individual or provider responsible for ensuring coordinated care between care settings and the member's home

Source: The Joint Commission, *Transitions of Care: The Need for a More Effective Approach to Continuing Patient Care.

BEST PRACTICES FOR CARE TRANSITIONS

1. Develop proactive care team communications
2. Increase clinician engagement and shared accountability
3. Conduct a comprehensive planning and risk assessment in the hospital
4. Develop standardized workflows, transition plans, and forms
5. Provide standardized training for care team members
6. Provide timely follow-up
7. Evaluate causes of readmissions, care outcomes, and measures

*Source: The Joint Commission, *Transitions of Care: The Need for a More Effective Approach to Continuing Patient Care*

1. DEVELOP CARE TEAM COMMUNICATIONS



- Make care team communications available to all team members at all phases of the transition and in all care settings
 - Identify hospital discharge staff or other care team members specific to transition
- Plan information transfers across care settings

1. DEVELOP CARE TEAM COMMUNICATIONS



- Conduct daily rounds or huddles, if possible
- Include members and families in information-sharing
- Discuss conflicting information with members and take steps to clarify conflicting orders or instructions

2. INCREASE CLINICIAN ENGAGEMENT AND SHARED ACCOUNTABILITY

- Identify clinicians by name and role at all phases of the transition and clarify roles for members
- Develop relationships and communication strategies between clinicians in different care settings
- Create a culture of shared accountability for transitional care



3. ENSURE COMPREHENSIVE PLANNING AND RISK ASSESSMENT IN HOSPITAL

- Begin discharge planning at hospital admission
- Conduct discharge risk assessment in anticipation of transitional needs
- Assess capacity of the care provider receiving the member regarding member self-care supports, medication availability and management, and home care (such as in-home supportive services), to prevent gaps in care



4. DEVELOP STANDARDIZED WORKFLOWS, TRANSITION PLANS, AND FORMS

- Agree on relevant information to include in transition plan
 - Including warning signs, key contacts, critical medications, and standard care summaries
- Create standardized forms to ensure the relevant information is documented.
- Develop standardized workflows for transition plan information to be shared with relevant team members
- Ensure that transition and discharge information for members is accessible and easy to understand
- Provide standardized training for all care team members on successful transition workflows

5. PROVIDE TIMELY FOLLOW-UP

- Develop standardized workflows for timely transition follow-up including via telephone, in-person, and tele-health contacts
- Ensure that members have 24/7 access to clinical advice and support
- Have a care team member attend the first follow-up outpatient visit with recently discharged members
- Offer post-discharge home visits, if needed

6. EVALUATE PROCESS



- Evaluate causes of relevant readmissions (within 30 days) to determine if additional transition supports are needed
- Monitor compliance with transition workflows
- Consider using surveys, focus groups, and other methods to investigate root causes of transition issues and challenges, and use information to improve processes

ADDITIONAL INFORMATION

- DHCS Health Homes website
- California Health Care Foundation/California Quality Collaborative Complex Care Management Toolkit
- The Joint Commission
- AHRQ Readmissions and Adverse Events After Discharge

FUTURE TRAININGS

- Connecting Members to Community and Social Services.

Optional trainings may be provided by DHCS or MCPs