Health Homes Program

CONNECTING MEMBERS TO COMMUNITY AND SOCIAL SERVICES

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

TRAINING PURPOSE

- This training will review the Health Homes Program (HHP) requirements for connecting members to community and social services and recommend strategies for implementing them
- Each Medi-Cal Managed Care Plan (MCP) has some flexibility in how they design their HHP so check with them about their process
- MCPs and CB-CMEs may already have infrastructure in place for these types of activities
- Additional program information can be found in the HHP Program Guide

TOPICS COVERED

- HHP Overview

- Identifying Member Needs and Developing a Service Directory

- Creating Internal Referral Infrastructure

- Developing Connections with Community Agencies

- Making Referrals to Services

- Preparing Members and their Family for Success

- Evaluating the Referral Process

- Additional Information

HEALTH HOMES PROGRAM OVERVIEW

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- 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

THE HEALTH ACTION PLAN GUIDES CARE

- After people join the HHP, they work with their care team to develop a **Health Action Plan** (HAP) to guide their services and care

- The HAP is based on a comprehensive assessment of the member's:
  - Needs, goals, and preferences
  - Physical, mental, and dental health, and Substance use
  - Community and social service needs, including housing

THE HEALTH ACTION PLAN GUIDES CARE

- The HAP is used to determine the services a member **needs** and to track the services they **receive**
  - o Must incorporate community and social services
  - o Must track referrals and whether community services are received
- The HAP is revised over time as the member's needs and goals change

CONNECTING MEMBERS TO COMMUNITY AND SOCIAL SERVICES

Based on the HAP, the care team identifies and connects members to needed community and social services, such as:

- Housing services
- Transportation services
- Long-term services and supports
- Support groups
- Employment counseling
- Child Care

- Educational opportunities
- Legal resources
- Food security and nutrition resources
- Physical activity options
- Other community and social services

HOW HHP CONNECTS MEMBERS TO COMMUNITY AND SOCIAL SERVICES

- Identifies appropriate community and social services

- Provides warm handoff referrals to, and engages with, community-based organizations (CBOs) and social service agencies (agencies)

- Helps members apply for programs they may qualify for, such as housing, legal resources, food assistance, etc.

- Routinely follows up with CBOs/agencies to ensure needed services are obtained

FOCUS ON HOUSING

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

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

FOCUS ON TRANSPORTATION

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

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 helps members arrange for transportation to be provided

- HHP care coordinators can help members get transportation services authorized and arrange their pick-ups and drop-offs

HOW CB-CMES AND CBOS/AGENCIES CAN WORK TOGETHER

There are several ways that CB-CMEs and CBO/agency staff can work together to support HHP members:

1. *Most Common Role:* A member's care team identifies needed services, refers the member to CBO(s)/agencies, seeks to mitigate barriers to accessing services, and supports engagement in services

HOW CB-CMES AND CBOS/AGENCIES CAN WORK TOGETHER

An HHP care team member may contact a CBO/agency to discuss the:

- Types of services it provides

- Contact person and process for referring members to the organization

- Process for following up with the organization to ensure members received services

- Process for the organization to provide information to the HHP care team on additional member needs

- Organization's interest in providing services to members at the CB-CME's office

HOW CB-CMES AND CBOS/AGENCIES CAN WORK TOGETHER

2. The care team may ask the CBO/agency staff to be part of a member's care team - for clients they already serve and clients newly linked to their services through the HHP. This could include:

   – Participating on the HHP care team (at the member's request)

   – Helping determine the member's community and social service needs

   – Providing information on the community and social services the member is receiving

   – Attending HHP care team meetings

3. CBO/agency staff could provide information about the HHP to existing clients who may qualify and tell them where to get more information

   – E.g. Provide HHP educational materials to clients and/or have brochures and toolkits on-site

IDENTIFYING MEMBER NEEDS AND DEVELOPING A SERVICE DIRECTORY

DEFINE AND ASSIGN STAFF RESPONSIBILITIES

Establish who on your team will be responsible for the following tasks and define their scope of work:

- Identify member's community and social service needs

- Identify any existing infrastructure/processes at your organization for communicating with CBOs/agencies

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DEFINE AND ASSIGN STAFF RESPONSIBILITIES

- Develop and maintain a service directory of organizations that provide services to meet member needs

  - Note: Your MCP <u>may</u> choose to develop the service directory – check with them before starting this

- Develop relationships with organizations

IDENTIFY MEMBER NEEDS

Identify your HHP-eligible members' most frequent and urgent community/social service needs (e.g. housing or food):

- Use existing information and member data

- Use existing tools – e.g. care management assessment tool, PRAPARE tool

- Ask members about their social service needs - individually and/or through small focus groups

- Ask members about what community and social services have been helpful to them, and what you should tell members who you refer to that agency

- Include members on health plan/CB-CME committees to provide input on successes and challenges

IDENTIFY RESOURCES IN YOUR COMMUNITY

- Check with your MCP to see if they are developing and maintaining this list or if this is the CB-CME's responsibility

- If it is your responsibility, see if a list already exists at your organization

- Ask around to see if something similar has already been created (e.g. local United Way, 2-1-1, YMCA, county health and human services department)

IDENTIFY RESOURCES IN YOUR COMMUNITY

- Check with umbrella organizations that contract with or have relationships with a group of CBOs

- Through research, identify specific people at CBOs/agencies to contact

- Identify any gaps in services

- Don't stress about it being the most comprehensive and updated list

CREATE DIRECTORY OF COMMUNITY RESOURCES

- Include organization name, website, contact person/information, summary of organization's services, program/service eligibility and application/enrollment information if applicable, organizational capacity, costs for services if applicable, ability to communicate in other languages

  o You may be able to obtain some of this information through research, but it can be supplemented by meetings with organizations

  o Once determined in concert with community organizations, document referral and follow-up processes for each organization

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- Consider the best way to store this information based on your infrastructure

  - Excel? Wikipage? SharePoint?
  - Explore software solutions to maintain a comprehensive list (e.g. Healthify, Purple Binder, or Aunt Bertha)

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CREATE DIRECTORY OF COMMUNITY RESOURCES

- Develop a process for keeping organization information updated – not having updated information can be a barrier to members getting needed services
  - This is where a software solution can be advantageous
  - Who will keep information updated and add organizations? Who has authority to amend the information? How can this task be shared among staff?
  - How often will information be updated?
- Ensure that the appropriate staff have access to review and edit the service directory

SHARE RESOURCES WITH MEMBERS

Create a "Community Resources" section in your organization and on your website, including:

- List of CBOs/agencies and contact information

- Brochures, pamphlets, and other information for local resources

SHARE RESOURCES WITH MEMBERS

- Feedback forms to solicit input from members

- A phone members can use to call agencies

- Public transit schedules and other transportation options

CREATING INTERNAL REFERRAL AND DOCUMENTATION INFRASTRUCTURE

CREATE INTERNAL REFERRAL INFRASTRUCTURE

Develop processes for making referrals, conducting warm hand-offs, and communicating with CBOs/agencies. The process should include a:

- Plan for phone, electronic, in-person, and mail communications

- System for sharing member information with organizations

- Process for getting consent from members to share information

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DEVELOP FOLLOW-UP AND DOCUMENTATION PROTOCOL

Develop a protocol for following up on community/social services and documenting referrals and use in the member's HAP:

- Document referrals made and date

- Develop a protocol for following up with organizations to see whether the member applied for services/programs and utilized the services

- Determine what to do if the member does not apply for or does not utilize services

- Develop protocol for documenting the services members receive in the HAP

- Document all protocols and share with community organizations

IDENTIFY ROLES ON EACH HHP CARE TEAM

Identify who on <u>each</u> member's HHP care team is responsible for assessing community and social service needs, discussing them with the member, and managing and following up on referrals to organizations. This person could be:

- The care coordinator or another designated person (like a "referral specialist")

- Another staff member

- The housing navigator for housing issues

Develop a process for care coordinators and the housing navigator to work together

DEVELOPING RELATIONSHIPS WITH CBOS AND AGENCIES

ESTABLISH AND MAINTAIN RELATIONSHIPS WITH CBOS/AGENCIES

Leveraging the preliminary service directory, reach out to organizations to establish relationships with them. Schedule an in-person meeting (or phone call) to discuss:

- The HHP

- The process for making referrals/warm hand-offs and following up

- How the MCP/CB-CME will share member information and how CBO/agency will share information about members

ESTABLISH AND MAINTAIN RELATIONSHIPS WITH CBOS/AGENCIES

- Whether the services/programs have applications, eligibility criteria, and fees

- How people access services

- Service directory information and a process for keeping it updated

- How your organizations will maintain this connection on an ongoing basis

THINGS TO CONSIDER

- Be mindful of an organization's capacity to provide services – they are not getting extra funding to support members in the HHP

- Create a service directory for members – brochures, referrals, contact info

- Consider assigning staff to attend existing community coalitions or meetings

- Consider whether you want to ask organizations if they would like to have staff provide services at the health care provider office (recognizing they may not have capacity to do this)

  o Offer space to CBO/agency staff that your members most frequently use

  o Consider having care coordinator or other staff person hold member meetings at a CBO/agency on certain days

MAKING REFERRALS AND PREPARING THE MEMBER AND THEIR FAMILY FOR SUCCESS

EVALUATE THE MEMBER'S NEEDS AND WISHES

- Leveraging the HAP, talk to the member about what community and social services they are already receiving and their need for additional services

- Assess the member's and their family's needs and capacity to access additional services – try to mitigate the barriers, whenever possible

- Consider whether the member will need additional support to get to, establish eligibility for, and successfully engage in new services

ANALYZE THE ORGANIZATION'S ABILITY TO MEET THE MEMBER'S NEEDS

- Once you identify an organization that may be able to provide needed services, review the organization's eligibility and application or enrollment requirements to make sure the member is eligible and to provide them with information on how to enroll in services

- Be aware of the capacity of an organization or program to provide services – find out what services are available and when they can begin

- Consider whether an agency and its staff will be able to communicate clearly and meaningfully with the member in a language they are comfortable with and in a culturally sensitive manner

PREPARE THE MEMBER AND THEIR FAMILY FOR SUCCESS

Goal: Ensure services are realistic, fully understood by the member (and family/social support system, if appropriate), accessible for the member, and that the member is comfortable obtaining services

- Talk to the member about the services that are available at the organization

- Gauge their interest and willingness to accept the services

- Talk to the member about the costs of the services (real or perceived) and any financial assistance that is available

PREPARE THE MEMBER AND THEIR FAMILY FOR SUCCESS

- Offer additional encouragement and support to help the member engage in services that will address their critical needs

- Help the member understand potential wait times and what they may need to do to follow up on their eligibility for services or other types of assistance

- Explain what information the member will need to provide to the CBO/agency, including whether an application is required

  - If client must apply for services, provide assistance with applications, etc.

PREPARE THE MEMBER AND THEIR FAMILY FOR SUCCESS

- Offer to accompany and/or to advocate for the member to help them obtain services or other needed resources (e.g. transportation) as needed to support their ability to meet their health goals

- Tell the member that you will follow-up with them within a set number of days to see how the services are going or to find out about the status of their application

  o Tell them you will also check with the CBO/agency to make sure they are getting the services they need

- Tell the member to reach out to you if they have any questions or concerns with starting or maintaining the services

EXAMPLES

ALBERT

Albert has hypertension, diabetes, and coronary artery disease. He has had several conversations with his PCP about his challenges managing his conditions; specifically, he doesn't always have a place to refrigerate his insulin.

Albert's care team looked into various options to help Albert with medication storage. They found a community food bank that also provides home furnishings to those in need. The community food bank found a donated mini-fridge that Albert now uses to store his medications. They are also working with his primary care physician to determine if there are other medication options that do not require refrigeration.

SUSAN

Susan overdosed on opioids six months ago, resulting in a hospital inpatient stay while she was trying to find a stable residence for discharge. She has also been diagnosed with diabetes, which she struggles to keep under control. She has spent the last two years essentially homeless, cycling through shelters and crashing with friends or family.

Susan's care team first addressed her housing situation and found her temporary housing with case managers who will work with her while she works on her sobriety. They also found a local food pantry that serves people with chronic conditions who need specific nutritional meals. They provide Susan with healthy food options also nutritional education to help Susan better understand how to control her diabetes through nutrition.

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EVALUATING THE REFERRAL PROCESS

EVALUATE THE REFERRAL PROCESS

- Develop a comprehensive process for reviewing the referral process to organizations and seeing if members received needed services

- Obtain feedback from members

- Obtain feedback from organizations

- Discuss whether members had needs that could not be met by organizations in the service directory

- Discuss the process with all care coordination/housing navigator staff

EVALUATE THE REFERRAL PROCESS

- Look at the data, such as:
  - Number of referrals made
  - Number of referrals made to each organization in the service directory, including where no referrals were made
  - Percentage of people who received services they were referred to
  - Percentage of people who continued to receive services after X months
  - Percentage of referrals where the services were not appropriate for the member's needs

EVALUATE THE REFERRAL PROCESS

- May be useful to identify trends and evaluate which organizations are best serving your members to improve the referral process and ensure you can strengthen relationships with key partners

- Share this data with all staff working on care coordination and referrals to discuss how you can collectively improve the referral process

- Make process improvements as needed

ADDITIONAL INFORMATION

- AAP Bright Futures Community Resources

- Next Step in Care: Referring Patients and Family Caregivers to Community-Based Services: A Provider's Guide

- Agency for Healthcare Research and Quality: Clinical-Community Linkages

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