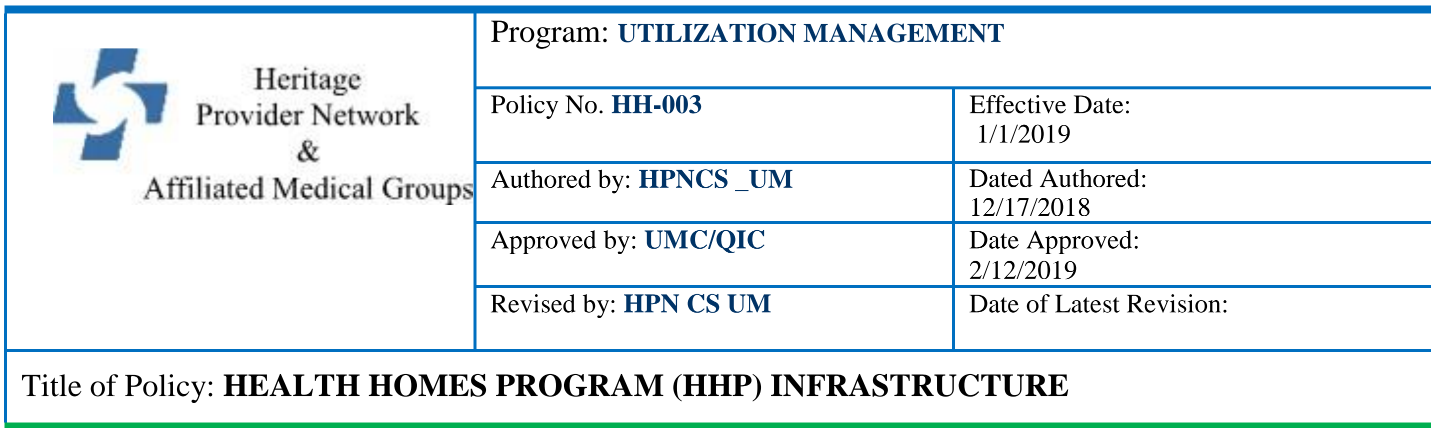

Heritage Provider Network & Affiliated Medical Groups	Program: **UTILIZATION MANAGEMENT**	
	Policy No. **HH-003**	Effective Date: 1/1/2019
	Authored by: **HPNCS _UM**	Dated Authored: 12/17/2018
	Approved by: **UMC/QIC**	Date Approved: 2/12/2019
	Revised by: **HPN CS UM**	Date of Latest Revision:
Title of Policy: **HEALTH HOMES PROGRAM (HHP) INFRASTRUCTURE**		

PURPOSE:

In accordance with DHCS contractual requirements and regulatory guidance, Molina Healthcare of CA (MHC) provides Health Homes Program (HHP) services to eligible members as defined by the DHCS Health Homes Program Guide.

POLICY:

The Health Homes Program is designed to coordinate the full range of physical health, behavioral health, and community- based long-term services and supports (LTSS) needed by members with chronic conditions and severe mental illness diagnoses. HHP is structured as a health home network, working together as a team to provide comprehensive care coordination services. The HHP network consists of MHC, Community-Based Care Management Entities (CB-CMEs – Heritage Provider Network and its affiliated Medical Groups – Regal Medical Groups and Desert Oasis Healthcare) and other community-based organizations that provide linkage to community and social support services -such as, but not limited to, referrals to various housing authorities, food banks, community based services as needed to maintain the member.

The HHP will serve as the central point for coordinating patient- centered care and will be accountable for:

1. Improving member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long-Term Services and Supports (LTSS), palliative care, and social support needs
2. Reducing avoidable health care costs, including hospital admissions/readmissions, visits, and nursing facility stays

PROCEDURE:

1. Organizational Model
    a. HHP Network
        i. MHC will build an HHP network in which a member can choose Heritage Provider Network and its Affiliated Medical Groups (HPN) – Regal Medical Groups and Desert Oasis Healthcare) they want for their care coordination. The network will promote HHP goals including:
            1. Ensuring that care management delivery and sufficient HHP funding are provided at the point of care in the community;

2. Ensuring that providers with experience serving frequent utilizers of health services, and those experiencing homelessness, are available as needed per AB 361 requirements;
3. Leveraging existing county and community provider care management infrastructure and experience, where possible and appropriate;
4. MHC will encourage CB-CMEs to utilize community health workers in appropriate roles.

b. MHC and CB-CME Responsibilities

i. MHC will act as administrator of the HHP and provide oversight. See Health Home Roles, Division of Labor & Delegation of Services Policy and DO-92 Health Homes Oversight Policy

ii. HPN will serve as the frontline provider of HHP services and will be rooted in the community. HPN will provide the six HHP services. See Health Home Roles, Division of Labor & Delegation of Services Policy

2. Staffing

a. HPN will ensure that HHP requirements for staffing are met. This includes:

i. Care Coordinator Ratio

1. Will have staff equivalent to the 60:1 care coordinator ratio by 2 years from inception of the program

ii. Multi-Disciplinary Care Team Qualifications and Roles.

1. The following roles or their equivalent are required:
    a. HHP Coordinator
    b. Outpatient Medical Director
    c. Project Manager
    d. Licensed Social Worker for homeless members
2. Heritage Provider Network and its affiliated Medical Groups – Regal Medical Groups and Desert Oasis Healthcare may include additional roles in the multidisciplinary team as desired, for example, Community Health Workers, pharmacists, nutritionists, or others. See Attachment 1 to this policy and Health Homes Staffing Policy for additional detail.

b. HPN will dedicate staff to the Health Homes program to (1) coordinate with all departments contributing to the smooth functioning of the HHP; (2) provide technical assistance, administrative support, and training.

c. Heritage Provider Network and its affiliated Medical Groups – Regal Medical Groups and Desert Oasis Healthcare may include additional roles in the multidisciplinary team as desired, for example, Community Health Workers, pharmacists, nutritionists, or others. See Attachment 1 to this policy and Health Homes Staffing Policy for additional detail

3. Health Information Technology/Data

a. All care coordination activities and documentation for HHP members will be stored in HPN electronic care management platform.

b. When limitations or risks limit the use of the electronic care management platform, other means of data exchange will be considered.

ATTACHMENTS:

Table 1: Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	- Oversee provision of HHP services and implementation of HAP - Offer services where the HHP member lives, seeks care, or finds most easily accessible and within MCP guidelines - Connect HHP member to other social services and supports he/she may need - Advocate on behalf of members with health care professionals - Use motivational interviewing and trauma-informed care practices - Work with hospital staff on discharge plan - Engage eligible HHP members - Accompany HHP member to office visits, as needed and according to MCP guidelines - Monitor treatment adherence (including medication) - Provide health promotion and self-management training - Arrange transportation - Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	- Have overall responsibility for management and operations of the team - Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or MCP)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	- Review and inform HAP - Act as clinical resource for care coordinator, as needed - Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within MCP guidelines • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing and trauma-informed care practices • Monitor treatment adherence (including medication)
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Additional team members, such as a pharmacist or nutritionist, may be included on the multi-disciplinary care team in order to meet the HHP member's individual care coordination needs. HAP planning and coordination will require participation of other providers who may not be part of the CB-CME multi-disciplinary care team. It is the responsibility of the MCP to ensure their cooperation.

HPN HOME HEALTH PROGRAM CB-CME ROLE				
HHP Job Title	Essential Duties	Education	Experience	License/Cert's
Outpatient Medical Director	1. Oversee and direct medical management activities to attain quality and timeliness of care, utilization management, and related care goals 2. Implement care management programs as they relate to the HHP program 3. Actively enlist network physicians, provider, and facilities to optimize HHP services and attain resource utilization goals 4. Provide clinical management and administrative input to other organizational departments to optimize processes, staffing, policies and procedures and positively impact the delivery of the HHP model.	1. Graduate of an accredited medical school with an MD or DO degree 2. Completion of accredited residency training program	1. Minimum five years medical practice after completing residency-training requirements for board eligibility 2. Minimum three years medical management experience in a managed care environment 3. Prior experience in clinical leadership role desirable, experience managing physician and clinical staff is preferred	1. Board certification in an ABMS recognized specialty 2. Unrestricted active California MD license
Project Manager	1. Identifies opportunities for the development and implementation of approaches that improve efficiencies and produce high-quality care and optimal outcomes for the HHP Program. 2. Works collaboratively with internal departments and staff to produce reports as requested. 3. Supports the implementation of the HHP program and interventions implemented within the region. 4. Monitors and analyzes programs and interventions to ensure fidelity and optimal outcomes within the region. 5. Tracks and manages ongoing performance metrics and reports 6. Coordinates and performs other duties, as assigned.	1. Master's degree preferred, but not required 2. Bachelor's degree from a four year university required	1. At least 2 years prior full-time work experience (healthcare not required, but preferred)	
HHP Coordinator	1. Coordinates daily schedules for Community Health Workers for individual in-home and group community meetings ensuring all relevant parties are informed and kept abreast of schedule awareness. 2. Compiles collateral to support Community Health Worker meetings. 3. Creates profiles of members participating in the HHP program. 4. Assists field staff in troubleshooting member issues and facilitating timely handoffs to other	1. Bachelor's Degree in healthcare and/or business administration, marketing or related field preferred. Exceptional experience considered in lieu of degree.	1. 1-2 years of related experience successfully demonstrating increasingly higher levels of work. 2. Proficiency required in Word and Excel, and Internet use.	

	areas including case management, pharmacy, social work, etc. 5. Effectively navigates through multiple platforms or applications to efficiently locate information and complete required tasks. 6. Other staff and member support duties as assigned.			
Member Advocate	1. Educates members on the role of the HHP program 2. Introduces member to case management and care team. 3. Provides service recovery by facilitating member's needs by working directly with appropriate staff. 4. May assist patients with various appointments and scheduling. 5. Maintains routine communications with members providing timely follow-up to ensure resolution of issues. 6. Provides clear and effective documentation of all visit for internal team; including supervisors, manager, pharmacist and other teams of the care team. Documentation must meet internal and regulatory guidelines.	1. Successful completion of High School with Diploma	1. Minimum 2 years of experience in health care 2. Excellent verbal and written communication skills in English 3. Proficient at Microsoft Office products 4. Ability to work independently in the field, while still meeting team deadlines and requirements	
Licensed Clinical Social Worker	1. Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers 2. Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing 3. Connect and assist the HHP member to get available permanent housing. 4. Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)	1. Master's degree in Social Work	1. Experience working with a diverse member population, primarily consisting of senior members	1. Licensed LCSW or MSW