Heritage Provider Network & Affiliated Medical Groups	Program: **UTILIZATION MANAGEMENT**	
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	Authored by: **HPNCS _UM**	Dated Authored: 12/17/2018
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Title of Policy: **HEALTH HOMES CARE MANGEMENT PROCESS**		

PURPOSE:

The purpose of this policy is to define the care management process for the Health Plan, where delegated, members that are enrolled in the Heritage Provider Network and Its Affiliated Medical Groups (HPN) managed Health Homes Program including member assessment, development of the Health Action Plan (HAP), multi-disciplinary care team process, referral process and program disenrollment.

POLICY:

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

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.

The Health Plan, in conjunction with the Community Based – Care Management Entity (CB-CME) HPN ensures the provision of comprehensive care management to all members enrolled in the HHP. Through person centered care planning, the HHP care management process engages the member, their family/support system, to develop and implement the Health Action Plan (HAP). The HAP is designed based on the needs and desires of the member, focusing on agreed-upon goals and outcomes. Through screening and use of assessment tools, the HAP incorporates the member's needs in the areas of physical health, mental health, SUD, community ‐ based LTSS, palliative care, trauma ‐ informed care needs, social supports, and, those experiencing homelessness, housing.

The care management process includes a multi-disciplinary care team approach to facilitate the communication and information flow regarding all aspects of the members care. Furthermore, this approach also ensure appropriate program disenrollment for those members who no longer qualify or require HHP services.

The health plan also strives to facilitate care management activities by ensuring that members have access to HHP information. Both potential and enrolled HHP members are flagged in the core data management platform, for visibility to other member facing departments. This enables immediate identification of HHP members, thus streamlining the member call experience. The HPN Member Services department is available to assist HHP members and all members with HHP inquiries or input from Monday through Friday, 8:00 A.M. to 5:00 P.M. toll free at (). Members enrolled in HHP are always encouraged to contact their assigned CB-CME, HPN. However, the Case Management phone queue is also available for members to call and for other business units to triage calls from enrolled HHP members or potential HHP members.

DEFINITIONS:

Person-Centered Planning – means a highly individualized and ongoing process to develop individualized care plans that focus on a person's abilities and preferences. Person-Centered Planning is an integral part of Basic and Comprehensive Care Management and Discharge Planning and is applied t Health Homes program members.

Health Action Plan – defined as the Individualized Care Plan with the inclusion of any elements specific to Health Homes Program When a member begins receiving HHP services, the member will receive a comprehensive assessment and a HAP will be created. The HAP will be reassessed at regular intervals and when changes occur in the member's progress or status and health care needs.

Well-managed –meaning that there was no substantial avoidable utilization or the member is enrolled in another care management program that will meet their care coordination needs

PROCEDURE:

A. **Member Assessment**

1. Upon opting-in to the HHP, member assessment is conducted for the purposes of understanding the member's current needs and goals and developing the Health Action Plan (HAP).
2. As stated in the DHCS Health Homes Program Guide, the plan leverages existing Cal Medi-Connect and Seniors and Persons with Disabilities (SPD) care management tools as part of the assessment process to develop the HAP. Therefore, the requirements specified by DHCS regarding the Health Risk Assessment (HRA) and Health Action Plans (HAP) are applied to HHP members. The care management process for HHP members follows the guidelines and requirements specified in *HH-006 Case Management (Medi-Cal)*. However, the process is customized for HHP members to ensure that specific HHP elements, such as housing and trauma-informed care. Trauma-informed care includes: safety; trustworthiness and transparency; peer support, collaboration and mutuality; empowerment, voice and choice, and cultural, historical and gender issues. These elements are captured in the assessment process and incorporated into the HAP, by utilizing supplemental assessments in addition to the HRA (Reference Attachment 1 – HHP Assessments). The list of assessments is required for all HHP members as appropriate, with the understanding that some assessments may not apply or only be conducted based on responses to other questions.
    a. Initial health assessments and documentation include assessment of health status, clinical history, activities of daily living and instrumental activities of daily living, mental/cognitive health status, life planning, cultural/linguistic needs, visual/hearing, and caregiver resources.
    b. The member is also evaluated for eligibility and current/past participation for health and other service program benefits including but not limited to mental health services carved out to the county, In Home Supportive Services, Community Based Adult Services Multipurpose Senior Services Program, SSI, and disability. Other pertinent financial information may be discussed to identify needs for HUD housing, utility assistance, nutrition programs (WIC, SNAP), etc.
3. Assessments will determine the risk level which members will be assigned. CB-CMEs will follow standardized risk leveling criteria, referred to as Acuity levels: Medium, High and Catastrophic. These acuity levels align with Level II, III and IV criteria as specified per *HH-006 Case Management (Medi-Cal)* – see Attachment 2: HHP Risk Levels.
    a. Heritage Provider Network and its affiliated Medical Groups, where delegated, (HPN) will assign acuity levels upon member assessment, which will determine the level of service

provided to the member. For example, as stated in Attachment 2, members that are Medium acuity may be managed through telephonic or face-to-face, intervention.

b. Alternatively, members with higher acuities are managed through both face-to-face and telephonic intervention, with more frequent follow up as these members tend to have more needs that require consistent monitoring and care coordination. Ultimately, the care management and interventions are based on individual member needs. ii. Members at an Acuity level of High or Catastrophic will be co-managed by the plan and HPN, in accordance with NCQA guidelines.

c. Review of the level of care is done based on identification of changes in member's health status during ongoing follow-up by the assigned care coordinator. The initial level of care may change over time as the member's condition progresses or their needs change. The care coordinator may utilize clinical judgment and/or consult with the HHP clinical consultant, in determining whether to change a member's risk status level.

d. The risk levels are subject to modification as the plan refines the HHP care management process through ongoing monitoring and evaluation. The plan will ensure that HHP members are receiving appropriate services at the appropriate intensity level, including tiering of services based on risk grouping (see attachment 2, HHP Risk Levels).

B. **Health Action Plan (HAP)**

1. The Health Action Plan (HAP) is an individualized, member-centric care plan developed based on member assessment and is housed in the care management platform. The HAP is customized to reflect specific programs, goals and interventions that are populated depending on the member's responses to assessments, which may include but is not limited to behavioral health needs, housing needs, palliative care needs, and trauma informed care.
2. The HAP will include the following:
    a. Information from medical records, prior utilization data, member and/or family input, Primary Care Physician (PCP) input if member has an established PCP. If there is no established PCP, the care coordinator will assist member in arranging an appointment with the Molina PCP (if different from the HPN Provider).
    b. Diagnosis, pertinent clinical, social and environmental factors.
    c. Interdisciplinary/ holistic and preventive focus.
    d. Plans to address barriers to care.
    e. Accommodations specific to the cultural and linguistic needs of the member.
    f. Efforts to work with member and others to determine housing, food, income, health and dental care, transportation, work school or other daily activities, social life and referrals services and assistance obtaining these supportive services.
    g. Provide the member with accompaniment services to appointments. All accompaniment services require the consent of the member and the utilization of the Health Plan's non-medical transportation services. Consent for these services will be documented in the member's case management file. (See Job Aid JA-001 Transportation for Accompaniment Services JA-001 Accompaniment Services and JA-002 Accompaniment Services). The safety of the employees is described in Job Aide 003.
    h. Advance directive planning.
    i. Goals and objectives, including a self-management plan as appropriate to the member's condition/health status.
    j. Expected timeframe to achieve goals/milestones.
    k. Monitoring, evaluation and revisions if necessary, noting progress towards goals and objectives.
    l. Possible alternatives to the care plan. Dependent on the specific member situation these alternatives may include, but are not limited to, coordination of medical services, long-term

services and supports, coordination with appropriate entities, and dental health services, in addition to community resources.

m. Members are encouraged to make lifestyle choices based on health behavior with the goal of motivating members to successfully monitor and manage their health.

3. The HAP will be created within 90 days of enrollment into HHP (member opt-in date). Based on member preference, initial HAPs and revisions are communicated via fax, mail, and/or electronic submission following HIPAA compliant practices to the member/member's representative, multidisciplinary care team, PCP, behavioral health provider, or any other appropriate providers. The member's assessment and HAP are available to any member of the care team and other providers upon member's request.
4. HPN is responsible for the development and implementation of the HAP. The member's care coordinator, in partnership with other members of the HHP care team, will arrange and coordinate the provision of support and health care services identified in the care plan, including early intervention, preventive care, skilled specialty services and community-based services.
5. The HAP is reviewed with the HHP member/member representative. The member's agreement with the initial and revised HAP shall be documented in the HAP. The established communication plan includes anticipated frequency of contacts, with the member, the primary care provider and, as appropriate, other providers.
6. The HAP is monitored and reassessed at a minimum of every six (6) months or sooner based on the member's needs/priorities or changes in the member's condition or status.
7. All assessment, re-assessment and HAP activities will be documented and/or stored with the electronic care management platform, utilized by both HPN and health plan staff. Timely documentation will occur for activities such as, but not limited to:
    a. Referrals
    b. All contacts with member, provider and/or community, etc. If unable to make contact with the member, documentation and a letter will be sent requesting to contact member of the te Health Plan's Care Management and/or Heritage Provider Network and its affiliated Medical Groups, where delegated, staff.
    c. Updates to care plan
    d. Tracking and coordination of member transfers from one level of care to another to ensure continuity of care.

C. **Multi-Disciplinary Care Team**

1. The multi-disciplinary care team (MDT) is an integral part of the care management process. The MDT integrates all participants who provide care to the member including primary care, specialty care, behavioral health, LTSS, and referrals to community-based resources, as appropriate. The MDT provides care management, including assessment, care planning, authorization of services, discharge planning and appropriate and efficient transitions of care to stabilize medical conditions, medication management to increase adherence with care plans and maintaining functional status. Through case conferences, ongoing communication and collaboration, the MDT not only assists in the development of the HAP, but also assists in the implementation and monitoring of the HAP to meet the member's goals and objectives.
2. Composition and leadership: The MDT is comprised of professionally trained and/or credentialed personnel. The HPN determines the composition of the MDT based on assessed needs and member preference. This may include, but is not limited to, members of the HHP care team, such as Licensed Clinical Social Workers, RN case manager, Community Health Worker and clinical consultant, in addition to providers actively involved in the member's care.

3. The member's HPN will provide ongoing communication with the member and any family, friends, and professionals chosen by the member to participate fully in any discussion or decisions regarding treatments and services.
4. MDT communications utilize secure fax, mail, and/or electronic submission following HIPAA compliant practices, based on member communication needs (i.e. cultural, linguistics, cognitive, hearing, or alternate formats as needed).
5. The MDT makes recommendations for the frequency of case follow up in the case conference. The care coordinator can request a case conference and MDT review at any time, and as needed based on the member's condition.
6. The care coordinator documents all MDT information in the electronic management platform, including the following:
    a. MDT contact information ii. Documentation of the MDT invitation sent to the member/caregiver and providers via the most appropriate method (e.g. email, telephone, fax, mail).
    b. Documentation of the MDT invitation sent to the member/caregiver and providers via the
    c. MDT meeting attendance and participants
    d. MDT recommendations
    e. Consult with members of the MDT, especially in preparation for case conferences.

D. **Program Referrals**

1. The primary enrollment source for HHP is the DHCS Targeted Engagement List (TEL) and the Molina TEL, generated using HH Program Guide criteria and health plan data. However, members and providers are also able to make referrals into the program.
2. Members may self-refer into the program by contacting the Health Plan Member Services or through the Case Management department. Self-referrals are received and triaged to a dedicated HHP team to review member eligibility in accordance with Program Guide criteria. Per DHCS guidance, self-reported diagnosis and utilization is allowable to enroll members into the program. However, following program enrollment, initial and ongoing member assessment will occur to determine if member continues to meet HHP criteria.
3. Providers are also able to make referrals into the program, leveraging the existing Case Management referral process and indicating Health Homes Program as the reason for referral. These referrals are triaged to the dedicated HHP team to review and verify if the HHP eligibility criteria is met.
4. In all referral instances, the HHP team will conduct follow up with the member and/or provider for additional information, if needed. As mentioned, initial and ongoing member assessment will determine if the member continues to meet program criteria following enrollment into the program.
5. Members may be referred to health education and disease management programs as appropriate in accordance with the Member's needs and preferences.
6. If the member is referred to Specialists and the care coordinator will ensure that there is follow-up after the referral

E. **Program Discharge**

1. Members who meet HHP eligibility criteria, in accordance with the DHCS Health Homes Program Guide, are opted in to the program upon successful outreach and agreement from the member. As such, as a member is able to opt-out of the HHP at any time if they wish. Program discharge is discussed by the MDT as need, and with the member, as appropriate to ensure communication and agreement.

2. Member choice is considered a voluntary discharge reason from the program, and therefore, does not require a Notice of Action letter. Members who are discharged from the program on a voluntary basis may re-enroll into HHP at a later date if they wish, provided that the member still meets the HHP eligibility criteria as specified by the Health Homes Program Guide. This includes members who cannot be reached/engaged or are otherwise unable to contact. Members who are unable to contact will receive an unable to contact letter after various attempts have been made. The notice requests the member to contact the plan, at which time the member would be re-instated in Health Homes, which differs from a denial.
3. However, should the member be involuntarily discharged from the program for any of the following, the plan will send a Notice of Action, including appeal rights, as required by the Health Homes Program Guide:
    a. The member develops exclusionary criteria (as stated in the Health Homes Program guide, i.e., becomes admitted to a SNF, participates in one of the identified waiver programs, etc.).
    b. The member has a change in condition and/or health status and is now well-managed (*see Definitions*).
    c. The member does not actively participate in HHP planning and coordination.
    d. The member's behavior or environment becomes unsafe.

F. **Reporting**

Standardized metrics, following the DHCS issued HHP reporting template, will be applied to contracted CB-CMEs for monitoring and reporting purposes regarding HHP activities, such as enrollment, HAP completion and referrals to housing. The data will be reported in the manner, frequency and format as specified by DHCS.

ATTACHMENTS:

Attachment 1 - HHP Assessment List
Attachment 2 - HHP Risk Levels

Attachment 1 - HHP Required Assessment List

1. AD 8 Cognitive Screening
2. AMA Caregiver Assessment
3. ASAM Substance Abuse Assessment
4. Asthma
5. Behavioral Health Assessment Adolescent and Child
6. Behavioral Health Assessment Adult
7. CA HRA
8. CDSMP
9. Congestive Heart Failure (CHF) Assessment
10. COPD
11. Depression Initial Assessment
12. Diabetes
13. ESRD
14. Hypertension
15. Pain Management Assessment
16. Pediatric Asthma Assessment
17. Pediatric General Care Management Assessment
18. Pediatric Symptoms Checklist (PSC-17)
19. Peds QL Child 5 to 7
20. Peds QL Child 8 to 12
21. Peds QL Parent 13 to 18
22. Peds QL Parent 2 to 4
23. Peds QL Parent 5 to 7
24. Peds QL Parent 8 to 12
25. Peds QL Teen 13 to 18
26. Peds QL Young Adult 18 to 25
27. PHQ-9

Attachment 2 – HHP Risk Levels

Acuity Level: Medium (Level II – Case Management)
Care Management is provided for members that need more support than low acuity level and need further evaluation. Care Management is helpful for members needing short-term assistance with services coordination such as durable medical equipment approval and set up or home health. Care Management is also helpful for members needing assistance working with multiple providers. Care Management activities may be telephonic or face to face depending on the needs of the member. Provider input and engagement is very important for achieving member clinical stability. Motivational interviewing and/or member activation assessments are used to ensure care planning is based on the member's needs and preferences. The case manager may enlist the help of a Community Health Worker or Community Connector to meet with the member in the community for education, access or information exchange.

Medium Acuity Level Identification Criteria including, but not limited to, the following diagnoses:

1. Cardiovascular Disease (CVD)
2. Atrial Fibrillation (Afib)
3. Cystic Fibrosis (CF)
4. Chronic Kidney Disease CKD)
5. Cardiovascular Accident (CVA)
6. Seizure
7. Dementia
8. Congestive Heart Failure (CHF)
9. Chronic Obstructive Pulmonary Disease (COPD)
10. Diabetes Mellitus (DM)
11. Human Immunodeficiency Virus (HIV)
12. Progressive Neuromuscular Disease
13. Psychiatric Disorders (Bipolar, Borderline Personality Disorder, Substance Use Disorder,
    a. Schizophrenia/Schizoaffective Disorder, Post-Traumatic Stress Disorder)
14. Social Determinants
15. Member is homeless/resides in shelter
16. Caregiver issues/lack of support/functional needs
17. Members leveling up or down based on acuity.

Acuity Level: High (Level III- Complex Case Management)
Complex Case Management is provided for members with multiple complex medical or behavioral conditions withpoor clinical stability. These members are undergoing active treatment and need help navigating the health care system to facilitate the appropriate delivery of care and services. Complex Case Management goals include helping members improve functional capacity and regain optimum health in an efficient and cost-effective manner by educating, assisting, and facilitating access to the most appropriate health care services available. Case managers monitor, follow-up and evaluate the effectiveness of the services provided on an ongoing basis by both telephonic and/or face-to-face interventions for review and revisions to the individualized care plan as identified. HCS staff will communicate findings and care plan updates to the Interdisciplinary Care Team as appropriate based on member's preference. Motivational interviewing and/or member activation assessments are used to ensure care planning is based on the member's needs and preferences. Members and providers are strongly encouraged to participate in the Interdisciplinary Care Team process to develop the most effective care plan for the member.

High Acuity Level Identification Criteria including, but not limited to, the following diagnoses:

1. Sickle Cell Disease

2. Cirrhosis
3. End Stage Renal Disease (ESRD)
4. Acquired Immunodeficiency Syndrome(AIDS)
5. Cancer
6. Persistent Suicidal Ideation
7. Members leveling up or down based on acuity

Acuity Level: Catastrophic (Level IV- Intensive Need)

Catastrophic Acuity Level focuses on members with multiple complex conditions at the end stage of treatment
(hospice) or palliative care (comfort care and active treatment). These members are at imminent risk of an emergency department visit, an inpatient admission, or institutionalization related to environmental and/or social issues, and offers additional high intensity, highly specialized services. These members may be facing deterioration of mental or physical condition, having fragile or insufficient informal/formal caregiver arrangements, and/or a terminal illness which require more intensive services. The clinical goal is providing the needed services in the least restrictive setting. Case managers monitor, follow-up and evaluate the effectiveness of the services provided on an ongoing basis by both telephonic and/or face-to-face interventions for review and revisions to the individualized care plan as identified. HCS staff will communicate findings and care plan updates to the Interdisciplinary Care Team, as appropriate, based on member's preference. Motivational interviewing and/or member activation assessments are used to ensure care planning is based on the member's needs and preferences. Members and providers are strongly encouraged to participate in the Interdisciplinary Care Team process to develop the most effective care plan for the member.

Catastrophic Acuity Level Identification Criteria including, but not limited to, the following diagnoses:

1. End Stage Cancer
2. End Stage COPD
3. Stage 4 CHF
4. Palliative Care Needs
5. Non-transplantable organ failure
6. Member leveling down based on acuity.