THE HEALTH HOMES PROGRAM

KEY CONSIDERATIONS FOR STAFFING

2020

PRODUCED WITH SUPPORT FROM THE CALIFORNIA ENDOWMENT

INTRODUCTION

California's Health Homes Program, based on Section 2703 of the Affordable Care Act, is geared toward high-risk Medi-Cal enrollees whose care could be improved by additional coordination services. To this end, the program delivers six core services, including comprehensive care management and a Health Action Plan, care coordination, health promotion, comprehensive transitional care, member and family supports, and community and social service referrals.[1] To be eligible for HHP, an individual must be a full-scope Medi-Cal enrollee, have at least one eligible chronic condition,[I] and meet at least one acuity and complexity criteria.[II] There are three ways for eligible Medi-Cal members to be identified: 1) an eligible member's health plan or provider may reach out to the member; 2) a provider may submit a HHP referral form; and 3) a member may reach out to their health plan to see if they qualify.[2]

Designed to enhance care management and coordination, improve outcomes and reduce costly avoidable hospitalizations, delivering the comprehensive set of HHP services requires a team of trained staff. To understand the staffing needs required to implement HHP services in California, JSI Research & Training Institute, Inc. (JSI) conducted interviews from November 2018 to February 2019 with representatives from providers and Medi-Cal managed care plans in HHP Group 1 (San Francisco) and Group 2 (Riverside, San Bernardino) counties and organizations that have implemented "HHP-like" care management programs. The remaining counties implementing HHP are in Group 3 or Group 4 are beginning in July 2019 and January 2020 respectively.[3,III] However, for the purposes of this brief, we considered "HHP-like" programs to be programs that encompass care management services for complex patients similar to those delivered through HHP. However, "HHP-like" programs can have distinct eligibility and different reporting requirements than the state program.

Based on statewide interviews, this brief provides an overview of key considerations for developing a staff team under HHP or "HHP-like" programs and provides specific recommendations for how plans, providers, and provider associations can set the HHP up for success.

PROGRAM BACKGROUND

The key entities in HHP include the State of California's Department of Health Care Services (DHCS), which provides guidance, the Medi-Cal managed are plans (MCPs) that are responsible for program administration, and the Community-Based Care Management Entities (CB-CMEs) that provide HHP services. While CB-CMEs can technically be any provider that a plan contracts to deliver the full set of HHP services, many CB-CMEs are community health centers and county-based health centers. The program allows for flexibility in the care team composition; thus the HHP care teams can vary across CB-CME sites as long as the HHP team can provide the State-designated core functions.

Per the state's guidance, a HHP team must include:[4]

- A care coordinator (the professional in this role can be unlicensed with training or a licensed care coordinator, social worker or nurse).
- The HHP director (this role can be fulfilled by a variety or professionals, but the director must be able to manage multidisciplinary teams).
- The clinical consultant (this role can be fulfilled by a number of professionals, including a primary care physician, registered nurse, advanced practice nurse, licensed clinical social worker, psychologist, psychiatrist, etc.).

Additionally, DHCS highlights two other staffing roles in its guidance to HHP participants: community health workers (a recommended but not required role) and a housing navigator (for members who are experiencing homelessness). Beyond these team members, a HHP team may also use additional staff to meet the care needs of their patient population or could contract with other providers or community-based organizations with HHP funds depending on individual enrollee needs. For example, a CB-CME may choose to contract with other CBOs with experience connecting individuals to social support and community services such as food security and nutrition services.[5]

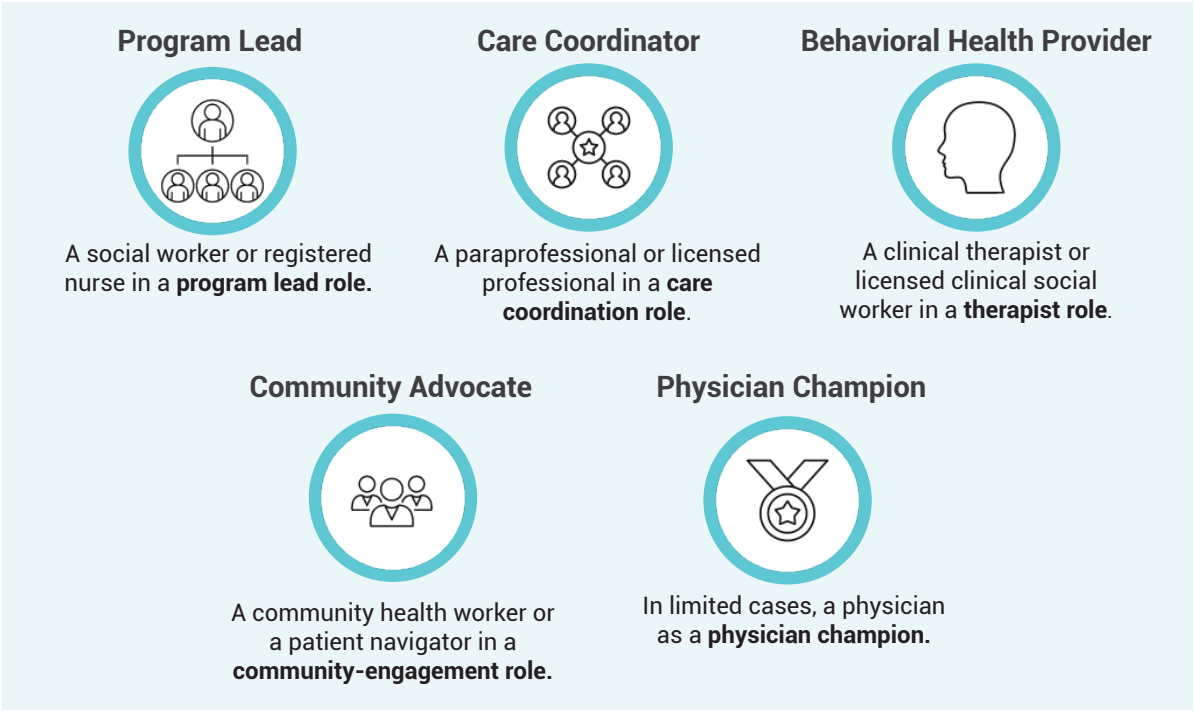
In developing a network for HHP services, the Medi-Cal MCPs may elect to use one of three care management models proposed by the state. Model I includes on-site care coordinators in provider clinics (i.e., CB-CMEs). In instances where Model I is not viable, Models II and III are geared toward lower patient volume settings, in both rural and urban areas, and involve different approaches to the care coordinator role (e.g., care coordinators as MCP staff, care coordinators at the regional rather than clinic level, etc.).

Model II is intended for low-volume providers (in either urban or rural areas) who are unable to hire care coordinators on site. In this case, a MCP care management staff member or someone in another community-based organization would serve as the care coordinator. Model III is geared toward members in rural areas and low-volume providers who may not serve enough HHP-eligible members to participate in the other models. Care coordinators sit in regional offices and can use technology and monitoring to engage members along with occasional in-person visits.[6]

STAFF TEAM PLANNING

Advance planning that considers roles, HHP rates, patient population and caseload is key to deploying an appropriate HHP care team. Among interviewees, Model I appeared to be the most commonly used. Interviewees noted that provider teams tended to include about 4 to 6 key members: a program lead, a care coordinator, a behavioral health provider, a community engagement specialist, and in limited cases, a physician champion (Figure 1).

FIGURE 1. COMMONLY DEPLOYED HHP TEAM MEMBERS



Generally, key informants did not indicate that they utilized a housing navigator in a standalone role; one interviewee shared that "only a small proportion of CB-CMEs have the capacity for housing navigation" within existing primary care models. For example, CB-CME staff may not feel comfortable or have the training to serve individuals experiencing homelessness. In at least one case, a health plan has hired a floating housing navigator who provides housing navigation services on behalf of multiple CB-CMEs. In other cases, some interviewees indicated that other core team members of the HHP took on the responsibilities of a housing navigator for enrollees requiring such services. Other potential solutions that key informants shared include technical assistance for housing navigation services for CB-CMEs or subcontracting for housing navigation services. Additionally, interviewees did not report the use of additional optional team members, such as a nutritionist, to meet the needs of their particular patient populations.

Organizations that had previously participated in HHP-like programs had an advantage in assembling their care teams for HHP. Such prior experience gave CB-CMEs time to determine what type of care team worked for their patient population, which roles they could recruit for and have on-site, and which services they could connect patients to elsewhere. One key informant noted that participation in a preceding HHP-like program allowed them to move quickly to create positions, and hire and train new staff, including care coordinators and clinical therapists.

RATES

The HHP rates determined by the state are fundamental for MCPs and CB-CMEs as they create HHP care teams. San Francisco, the first county to implement HHP, had a unique challenge in their planning because the state had not yet released final rate information. Subsequent counties implementing HHP have the benefit of knowing a priori what the state HHP rates are.

Even in later implementing counties, however, there are challenges to operating within the state rate parameters. Particularly in limited resource settings (e.g., safety-net clinics that may serve as CB-CMEs), leadership are under pressure to demonstrate that staff roles are financially viable for the organization. County-led clinics have another distinct challenge; county hiring processes can be time consuming, and yet a position cannot be posted until funds are available. As a result, county entities are challenged to make the most of available funding to pull together an appropriate team for HHP. Additionally, the decreasing rates as the HHP pilot progresses create a challenge for CB-CMEs to plan and to sustain the program.

ELIGIBILITY AND CASELOAD

Using administrative data, DHCS creates a Targeted Engagement List (TEL) that indicates which plan members are eligible for HHP. Members are HHP-eligible if they meet certain chronic-condition and acuity/complexity criteria. DHCS shares a new TEL every six months using recent administrative claims data.[7] Managed care plans then send information to the CB-CME about the projected number of HHP-eligible patients. Based on the TEL, MCPs and CB-CMEs may further refine the list. Regarding caseload, DHCS guidance states that the minimum care coordinator ratio requirement is 60 patients to 1 care coordinator (60:1).[8]

Some interviewees reported a discrepancy between MCP requirements for CB-CMEs and prospective CB-CME clinic capacity. One interviewee shared that managed care plans requested care coordinator ratios that some clinics could not realistically meet; in some cases, this resulted in health centers electing not to participate in HHP as a CB-CME. Additionally, interviewees noted that there was a need to strike a fine balance between the eligible patient population for which MCPs were seeking CB-CMEs and the capacity of the CB-CMEs. If the eligible populations were too large for the CB-CME's capacity, CB-CMEs could not realistically participate and meet standards of care. If the eligible population was too small, it would not make financial sense for the clinics to participate as CB-CMEs and invest in HHP infrastructure without a critical mass of eligible patients. Interviewees suggested that an imbalance in either direction could cause some organizations to choose not to participate as a CB-CME.

RECRUITING AND HIRING

Clinics selected as CB-CMEs may decide to recruit new staff or assign existing staff to help provide HHP services to eligible patients. Interviewees noted that lengthy hiring processes were a common challenge to assembling HHP teams, and a particular challenge for county entities that include a testing requirement for available positions. Additionally, lag time was a recurring problem for creating new positions that required new classifications and descriptions.

Recruitment challenges will vary by county given the regional nature of health care provider supply. For instance, some interviewees shared that filling therapist and social worker positions was already a challenge before the advent of HHP. A 2018 report by the UCSF Healthforce Center found that the Inland Empire and the San Joaquin Valley had the lowest per capita ratios for almost all behavioral health providers while the Greater Bay Area had the highest.[9] The same report estimated that by 2028, based on current service use plus the unmet need for services, California will have 28% fewer licensed clinical social workers (LCSWs), psychologists, licensed marriage and family therapists (LMFTs) and licensed professional clinical counselors (LPCCs) than needed, and 50% fewer psychiatrists than needed.[10] As such, interviewees predicted that as more organizations become involved in more intensive care management through HHP and other programs, hiring for these roles may become even more difficult and competitive.

Many interviewees mentioned community health workers (CHWs) as potentially valuable members of HHP care teams. However, there are broad, statewide challenges with effectively supporting and deploying the CHW role. For example, the state has been slow to provide clarity around the role, including training (e.g., preparation to work safely and effectively in the community), credentialing or certification, and reimbursement. Interviewees also expressed that hiring for CHWs will likely become more competitive as additional entities gravitate toward this type community-engaged patient care.

TRAINING

Training provided by the MCP to the CB-CME can take various forms with different levels of involvement from each entity. Examples that interviewees shared included:

- Didactic training and monthly meetings.
- Mentorship and a formal oversight plan, including monthly calls and meetings between the MCP and CB-CME clinic staff and leadership.
- Individual practice coaches (hired by the MCP) to provide ongoing coaching for CB-CMEs.
- Coaching CB-CMEs on core competencies for more community-based and community-facing roles, such as community health workers.
- MCP-provided self-assessment tools for CB-CMEs.
- "Learning audits" of selected HHP enrollee records where the MCP reviews a patient assessment and health action plan to provide feedback to the CB-CME.

FIGURE 2. TRAINING OPTIONS FOR CB-CMES

Interviewees noted that "one size does not fit all" in terms of training as evidenced by varying approaches by plans and level of engagement from CB-CMEs. Larger plans and those with more resources may have more structured or prescriptive training requirements. Interviewees noted that a key differentiator among plans is prior participation in "HHP-like" programs. These plans have had time to closely consider contract negotiations, staffing planning, and training capacity for comprehensive care management and community-engaged roles. They also may have the advantage of already building rapport and gaining buy-in from staff for the program rollout.

Interviewees noted that there is a particular need for plans to provide support and technical assistance regarding non-licensed and non-clinical members on the HHP care team. Especially for these roles, the interviewee shared that systems have to be in place to monitor and support effective, high quality case management. As one interviewee expressed, "Each managed care plan is going to have to figure out coaching, support and auditing," as it relates to staff roles such as CHWs to ensure that case management services are meeting patients' and program needs.

There is an overarching need to coordinate and streamline training for CB-CMEs. DHCS has contracted with Harbage Consulting to provide standard training for plans implementing HHP. Additionally, HHP provider teams may look to their CB-CME leadership and the MCP for guidance. In one case, an interviewee shared that this can lead to staff receiving divergent messages. "What we saw evolve was that we ended up with two different lines of supervision," with CB-CME leadership and the MCP coaching team providing guidance that may have conflicted at times.

RECOMMENDATIONS

Based on the insights shared by early adopters of HHP, the following encompass recommendations for planning, hiring and recruiting and training an HHP team.

STAFF TEAM PLANNING

1

BEGIN NEGOTIATIONS EARLY BETWEEN THE MANAGED CARE PLAN AND POTENTIAL CB-CMES.

Managed care plans and potential CB-CME clinics should begin discussions early regarding participation in HHP. Clear expectations around caseload, desired care coordinator to patient ratios, and training should be key topics in such discussions. Given the lag time associated with internal HR processes for hiring new HHP team members, starting discussions as early as possible will give CB-CMEs the best possibility of assembling their HHP team in time for program launch.

2

GAUGE WHETHER THE STAFFING TEAM IS REASONABLE GIVEN THE PROGRAM RATES AND WHAT CHANGES MAY NEED TO BE MADE TO PARTICIPATE IN HHP.

JSI previously developed a Planning Tool: Designing a Care Management Staff Team for health centers considering participation in HHP or other care management programs. The tool allows health centers to combine assumptions about caseload and risk profile of patient population with their organization-specific costs for staff and infrastructure to predict what various care team scenarios would cost. The tool also allows a provider to use a set of evidence-based assumptions for intensity of services needed by various patient populations based on Partnership Health Care of California's experience with an early HHP-like program. The tool can serve as a starting point for providers wanting to understand the resources and staffing levels needed to participate in HHP or care management programs.

3

INTEGRATE HHP TEAM INTO CLINIC STAFF.

One interviewees noted the benefit of having HHP and other clinic staff seamlessly integrated rather than having separate staff for the general health center population and a separate set of staff for HHP enrollees. CB-CMEs that were taking an integrated approach reported a positive work environment and synergies among staff rather than an "us" versus "them" mentality among HHP and other clinic staff.

RECRUITING AND HIRING

1

ACCOUNT FOR LEAD TIME REQUIRED TO HIRE.

Particularly in entities with a lengthy hiring process independent of HHP, organizations should consider the amount of time needed to hire or reassign staff members to assemble an HHP team.

2

CONSIDER ASSIGNING HHP ROLES TO EXISTING STAFF.

If capacity to fulfill HHP roles exists among current staff, consider assigning these staff to limit recruitment and training burden. DHCS allows for staff with various qualifications to serve in the required care coordinator, program director and clinical consultant roles. For example, the clinical consultant role can be fulfilled by a physician, psychologist, registered nurse or a number of other qualified professionals. CB-CMEs can use this flexibility to their advantage to maximize existing staff's participation in HHP teams.

3

CONSIDER CONTRACTING FOR NEEDED ROLES OR HIRING UNLICENSED PROVIDERS WITH CONTINGENCY OF BECOMING LICENSED WITHIN A SPECIFIED TIMEFRAME.

In some cases, interviewees shared that they hired providers in contracted positions as they created their HHP care team. Hiring for contract positions allows CB-CMEs more flexibility if they make changes to their care team composition as the program continues. Additionally, one interviewee noted that for roles that are particularly difficult to hire, the CB-CME decided to hire unlicensed providers with the contingency that these providers would be licensed within a year. However, this approach also poses administrative challenges related to credentialing and billing.

4

ENGAGE OTHER SERVICE PROVIDERS IN THE COMMUNITY.

If clinics do not have the staff needed currently to fulfill HHP requirements, it is possible to extend capacity by contracting with other organizations and providers. CB-CMEs can contract with other community-based organizations to connect HHP enrollees to social support and community services such as housing navigation, food security and nutrition services, disability services, and employment counseling.[11] Additionally, MCPs can consider hiring for certain roles (e.g., housing navigator) and splitting the individual's time between multiple CB-CMEs.

TRAINING

1

TRAINING FOR COMMUNITY-FACING ROLES.

Interviewees consistently noted the additional training and educational investment required for the community health worker role, including training for engaging in the community, documenting while in the community and providing services in a way that maintains CHW safety. MCPs and CB-CMEs should work closely together to ensure a robust training curriculum for community-facing roles.

2

ENGAGE WITH CLINICS THAT PARTICIPATED IN PREVIOUS HHP-LIKE INITIATIVES.

Some clinics and CBOs have extensive experience in intensive care management work, often in partnership with MCPs. There is an opportunity for existing consortia or statewide associations to facilitate regional trainings where experienced health centers share best practices with centers beginning to implement HHP.

3

ENSURE ALIGNMENT BETWEEN DIFFERENT SOURCES OF TRAINING.

MCPs and CB-CMEs should ensure trainings that staff are receiving from the clinic leadership, MCPs or MCP-hired practice coaches are aligned in terms of content and expectations for accountability.

4

TAILOR TRAINING TO CB-CME NEEDS.

CB-CMEs will each have different levels of capacity and expertise. For example, some CB-CMEs may not have existing capacity needed to meet compliance and quality assurance standards required by MCPs administering the HHP. Training CB-CMEs in documentation requirements, claims submission and other data reporting requirements can help ensure HHP program success.

CONCLUSION

California's Health Homes Program is a long-awaited opportunity to improve the care experience and cost and quality outcomes of Medi-Cal enrollees with complex care needs. By collaborating and planning for CB-CME staffing needs, recruiting and hiring strategy, and tailored training, MCPs and CB-CMEs can maximize the possibility of fulfilling the HHP promise and make a strong case for its sustainability.

NOTES

I. There are several eligible chronic conditions. Eligible chronic conditions include **at least two of the following**: chronic obstructive pulmonary disease (COPD), diabetes, traumatic brain injury, chronic or congestive heart failure (CHF), coronary artery disease (CAD), chronic liver disease, chronic kidney disease, dementia or substance use disorders; **OR hypertension and one of the following**: COPD, diabetes, CAD, CHF; **OR one of the following**: major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia), **OR asthma.**

II. To meet acuity or complexity criteria, the member must meet one of the following: have three or more of the HHP-eligible chronic conditions; OR have at least one inpatient hospital stay in the last year; OR have three or more emergency visits in the last year; OR experience chronic homelessness.

III. For each group implementing HHP, there is a Phase I and Phase II of implementation where Phase I indicates implementation for members with eligible chronic physical conditions and substance use disorders. Phase II (beginning six months later) indicates implementation for members with eligible serious mental illnesses.

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