2021 Health Home Sharing Sessions Summary

Due to COVID-19, the 2021 Health Home Sharing Sessions were done via Zoom. As suggested last year, the sessions were done as a large group rather than in breakouts. Most sessions were recorded and are now posted with the associated Power Point. (see the Reference section for a list of materials available for each session.

Welcome and Health Home Update

Reference – Sharing Session 2021.pdf and Health Home Updates.mp4

The meeting began with Kathi reviewing several instructional slides related to Zoom functionality. Kathi used the poll function to test the group's knowledge of the following:

- Goals of the Health Home program which include
  - Reducing the cost of care for high cost, high need recipients.
  - Improving health home outcomes.
- Three main eligibility criteria of the Health Home Program which include Medicaid recipients with:
  - Two or more chronic conditions.
  - One chronic condition and one at risk condition.
  - One severe mental illness or emotional disturbance.
- Four basic criteria of a core service
  - Recipient should be engaged by the action, not simply provider care conference.
  - Actions that are specific to the patient, tied to their care plan.
  - Documented in the electronic health record.
  - Not a service previously billed to Medicaid using a fee-for-service, daily or encounter rate
- Six core services
  - Comprehensive Care Management
  - Care Coordination
  - Health Promotion
  - Comprehensive Transitional Care
  - Recipient and Family Support Services
  - Referrals to Community and Social Support Services

Kathi updated the group on the current Heath Home statistics.

- Currently 135 clinics are enrolled, serving 139 locations. This is an increase of five clinics since last we met.
- Two new providers were added, effective January 2021 - Access Health – Brookings and Madison Regional Health Care System.
- One new provider was added, effective April 2021, - Oahe Valley Health Center.
- Three new providers were added, effective July 1, 2021 - Redfield Clinic, Dakota Family Medicine in Chamberlain, and Rapid City Medical Center – Tower Road.
- Kathi indicated that while we have increased the capacity in the program, the Public Health Emergency (PHE) is keeping participation at an all-time high. Kathi

indicated that all recipients, except for SCHIP (78 and 79), are required to be left on the program unless the recipient:
    - Dies
    - Moves out of state
    - Requests that their case be closed or
    - They are convicted of fraud or abuse
- Examples of recipients who may lose coverage when the PHE expires include:
    - Pregnant women whose post-partum period has expired
    - Non-disabled recipients who turn 19
    - Recipients whose Transitional Medical Benefit (TMB) have expired.
- Kathi indicates that unfortunately there is no way to determine which recipients may fall off the program if the PHE expires on 12.31.2021.
- As of July 27, 2021, there are 6,868 Medicaid recipients in a Health Home.

Health Home Subgroups
Kathi walked through the subgroup work that occurred since we last met. This included two meetings of the quality outcome measure subgroup to establish targets for each measure and to refine the measures. The work of the Subgroup reduced the number of data points to report from 60 to 18.

Kathi also discussed the work of the Health Home Quality Incentive Payment (QIP) subgroup. This group revised the QIP to address some of the concerns raised by clinics regarding the use of standard deviation. The new methodology rewards both improvement and attainment of the target. Measures could be weighted; and provider caseloads were weighted based on severity. Kathi walked the group through an example of how the new methodology was applied. See slides 20-22

2020 Quality Assurance Review
Raegan presented the results of the 2020 Quality Assurance Review. See slides 23-25 to view the results. Kathi indicated that they will be looking for an external vendor to perform this task next year.

South Dakota Medicaid Provider Communication
Kathi walked through how Health Homes can remain up to date on the latest communication from SD Medicaid. See slide 26.

Telemedicine
Kathi also provided an update on the future of telemedicine in SD Medicaid. See slide 27.

Community Health Workers

Reference: CHWSD_CHW.pdf, CHW_HH Presentation.pdf, and CHW.mp4

Ben Tiensvold presented information on the Community Health Worker (CHW) Collaborative of SD and new funding available to help clinics start a CHW program. Following Ben, Samantha Hynes presented on the difference between a CHW service and a core service through the Health Home program. Samantha also touched on the billing and enrollment aspect of the program.

See the materials referenced above for more information.

Online Tools and Core Services

Reference: Online Resources_Core Services.pdf, and Online Tools and Core Services.mp4

Kathi presented on online tools available to the Health Home care coordinators. Kathi indicated that the most important advancements has been the implementation of the Online Selection Tool. She played the recording of the webinar for the group. There is a small portion where Kathi's computer was muted so participants can not hear the voice. As a result, Kathi encourages the reader to listen to the Webinar found at the bottom of this website Department of Social Services (sd.gov).

Kathi also provided a tour of the website and other resources. See Slides 4-5.

Kathi then moved on to the topic of core services and reminded the group of the core services criteria. Then an open forum was held about core services where individuals could ask the group about a specific service and if they felt it was a core service. Kathy Jedlicka and Kelsey Raml queued up the first example and others followed.

Health Link/Notify

Reference SDHL Presentation.pdf, Point_of_Care_Data_Contributers.pdf. Health Link Program Overview.pdf, and Healthlink.mp4.

Lisa Fox and Mandi Stegenga presented an Overview and Demo and South Dakota Health Link and discussed Notify. See the Presentation, Overview, and Data Contributors for more information. Kathi also indicated she could help connect provider groups who were interested in learning more.

See the materials referenced above for more information.

Department of Health Updates

Reference WIC_MCH.pdf, Self-Monitoring Blood Pressure.pdf, and BCBH_Health Homes.pdf – no recording

Jenn Folliard and Rhonda Buntrock from the Department of Health, Office of Child and Family Services provide basic information and updates on the Women, Infant, and Children's (WIC) and Maternal Child Health (MCH) Programs.

Rachel Sehr provided information about the South Dakota Cardiovascular Collaborative's initiative to work with providers to implement self-monitoring blood pressure in locations around the state and the benefits of this initiative.

Lori Oster from the SDSU extension presented information about the latest updates for the Better Choices Better Health (BCBH) program. This is now a statewide program with virtual options.

See the materials referenced above for more information.

Long Term Services and Supports Overview

Reference: LTSS_overview.pdf, no recording

Leslie Lowe from the Department of Human Services (DHS) provided an Overview of the Long-Term Services and Supports (LTSS) available through DHS.

See the materials referenced above for more information.

Success Stories

Reference - None

Kathi asked coordinators to provide examples of success stories from their clinics. Kathi noted that it would be helpful to have examples of how COVID impacted the work of the care coordinators and how success is not always found in the numbers.

Kathi wrapped up the day by answering any questions and asking participants to complete the evaluation.