Department of Social Services

Health Home Initiative

DSS
Strong Families - South Dakota's Foundation and Our Future

Health Homes

Health Homes provide enhanced health care services to individuals with high-cost chronic conditions or serious mental illness to improve health outcomes and reduce costs related to uncoordinated care.

Health Homes

Medicaid Solutions Work Group

- Established during 2011 Legislative Session
- Goal to develop recommendations to contain and control Medicaid costs
- Maintain quality services
- Health Homes were established by the Affordable Care Act
  - 2 year demonstration opportunity with enhanced funding
- First recommendation of Medicaid Solutions Work Group
- DSS developed Health Home stakeholder planning workgroup to assess feasibility and support implementation of Health Homes in South Dakota

Health Homes

A Health Home is NOT

- Home health
- In-home care
- A place where people live and receive care
- Patient Centered Medical Home

Who do Health Homes serve?

- Medicaid recipients who have…
  - Two or more chronic conditions OR one chronic and at risk for another (Defined separately):
    - **Chronic conditions include:** Mental illness, substance abuse, asthma, COPD, diabetes, heart disease, hypertension, obesity, musculoskeletal, and neck and back disorders.
    - **At risk conditions include:** Pre-diabetes, tobacco use, cancer, hypercholesterolemia, depression, and use of multiple medications (6 or more classes of drugs).
  - One severe mental illness or emotional disturbance.

- Eligibility based on 15 months of claims data based on diagnosis.

- Medicaid recipients that meet criteria are stratified into four tiers based on the recipient's illness severity using CDPS (Chronic Illness and Disability Payment System).

Provider Infrastructure

Primary Care

- Primary Care Physicians
- PAs
- Advanced Practice Nurses

Working in:

- Federally Qualified Health Center
- Rural Health Clinic
- Clinic Group Practice
- IHS

Behavioral Health

- Mental Health Providers

Working in:

- Community Mental Health Centers

Health Care Team

- Care coordinator
- Chiropractor
- Pharmacists
- Support staff
- Health Coach
- Other appropriate services

Provider Capacity

- Current number of Health Homes – 116 serving 122 locations
  - FQHCs = 23
  - Indian Health Service Units = 11
  - Community Mental Health Centers = 11
  - Other Clinics = 71

- Current Number of Designated Providers = 608

Recipient Participation

- There were 5,773 recipients in Health Homes as of June 27, 2014.

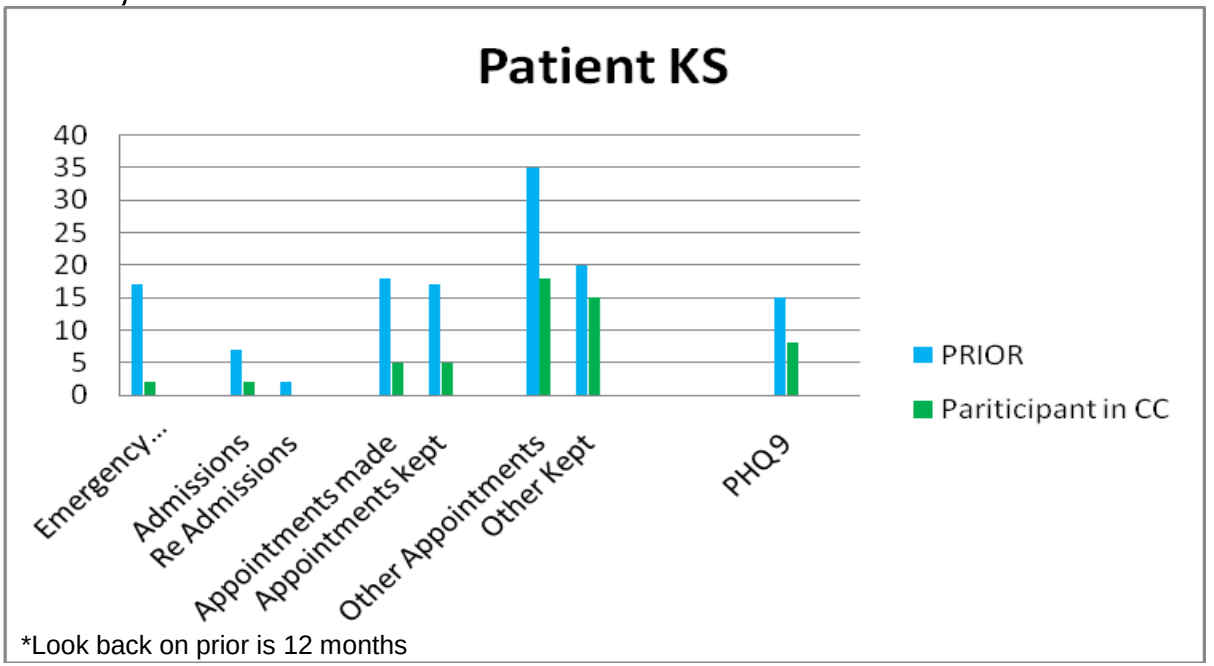
Type HH	Tier 1	Tier2	Tier 3	Tier 4	Total
CMHC	7	308	424	101	840
IHS	8	956	579	280	1,823
Other Clinics	73	1,786	868	383	3,110
Total	88	3,050	1,871	764	5,773

Assessing Quality and Effectiveness

- Quality Assurance Review
  - 1 recipient from each Health Home
- Outcomes data
  - First 6 months submitted and processed. I.H.S. Individual reports sent to Nancy Haugen and Dayle Knutson
  - Data for January – June 2014 due August 31, 2014
- Cost Reports
  - Training on July 15, 2014
  - Will provide guidelines about when the report is due
- Quarterly Core Service Reports
  - April – June 2014 due on July 31, 2014
- FY 2016 Budget Request

Success Stories

- 60 year old female with a history of Depression, Anxiety, Cerebrovascular accident, Short term memory loss, Hypertension, Sleep apnea, Gastric by-pass, Arthritis, Chronic pain, Diabetes, and Anemia.



*Look back on prior is 12 months

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Success Stories

- **Demographics:** Female,41 years old
- **Medical Issues:** Obesity, Pre-diabetes, Thyroid Problems, Past Gastric Bypass Surgery Broken foot bones, not healing
- **Mental Health DX**: Schizoaffective Disorder, Borderline Personality Disorder
- Transitioned out of nursing home care.
- Health home has assumed the role of point of contact between all service providers.
- Participates in NEMHC's Healthy Eating Group as a part of her Health Home Services.
- Developed a diet and exercise program. Lost 70 pounds and, as a result, the bones in her feet are beginning to heal properly.

Success Stories

- 54 year old female
  - Diagnosis is Diabetes and Hypertension
  - She was a very heavy smoker, and didn't check her blood sugars or monitor her diet
  - RN HC started working with patient
  - Gave her a new glucometer that would be easier for her to use
  - She has been working on diet, and portion sizes. She is watching her calories, counting carbs and is reading labels now
  - She is down about 10-15 pounds in the past few months.
  - A1C went from 8 to 6.7
  - She is regularly checking blood sugars and is working on smoking cessation.

Success Stories

60 year old female

- Dx obesity
- Started working with patient on 9/13 on diet and exercise for weight loss.
- Initial weight was 350#. Weight last week (June) 295# by going to gym regularly and keeping food journal and sees RN HC weekly for goal setting/action planning and support.

49 year old female

- Diagnosis: Diabetes
- Started working with patient 6/13 with HgbA1c 10.2 consistently. Last HgbA1c 5/28/14 at 8.1. RN HC either sees the patient in person or communicates via phone every 2 weeks.

Questions?

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