



Health Home Core Service Training

March 26, 2014

Dial in 1-866-410-8397

Conference code 605-773-3165

Agenda

- Health Home Core Services Overview
- Review each Core Service and provide examples
- Discuss qualifying services
- Questions

Six Core Services

- CMS requires the six Core Services be provided as appropriate to all enrolled recipients.
- Health Homes are paid a monthly PMPM for the delivery of the Core Services. All medical services continue to be reimbursed according to the current reimbursement structure.
- Health Home minimum requirement is to provide one of the Core Services to each recipient every quarter and to have this action recorded in the Electronic Health Record. Recipient should be engaged by the action – not simply provider care conference.
- Example: Administration of a flu shot is not a core service. Educating the recipient about the benefits of the flu shot is a core service.

Six Core Services

- A minimum of one of the Six Core Services must be provided every quarter:
 1. Comprehensive care management
 2. Care coordination
 3. Health promotion
 4. Comprehensive transitional care/follow-up
 5. Patient and family support
 6. Referral to community and social support services
- Full Core Services definitions are posted on the SD Department of Social Services webpage at dss.sd.gov/healthhome/index.asp

1. Comprehensive Care Management

- Comprehensive Care Management is the **development** of an individualized care plan with active participation from the recipient and health home team members.
- Each recipient's individual care plan is based on a comprehensive assessment with all identified issues incorporated into the care plan and documented in the EHR.
- The designated provider is responsible for providing for all of the recipient's health care needs. Takes responsibility for:
 - Arranging care as needed
 - Coordination with other qualified professionals
 - Discussing appropriate access to care (ER utilization)
 - Preventive education
 - Conducting a standard behavioral health assessment of your choosing.
- Provides same day appointments, timely clinical advice by telephone during and after office hours (24/7), and documents clinical advice in the medical record.

1. Comprehensive Care Management Examples

- First client meeting
 - Complete medical history
 - Obtain information relative to care providers they are seeing now and may have seen in the past (include optometry, dental, support groups).
 - Obtain a medication list and pharmacy information.
 - Complete social history to include depression, alcohol, drug, and nicotine habits, diet and exercise habits.
 - Discuss where and how care is to be accessed.
 - Identify educational needs for the recipient or extended family.
 - Discuss health goal or goals they want to achieve. Try and agree upon one or two. Don't make it too big.
 - Discuss barriers to achieving the goals and potential solutions.
 - Determine how frequently recipient and care coordinator would have contact and best method of contact.
- Document in the recipient's individual care plan in the EHR.
- If integration between behavioral and medical care is needed, discuss a plan as to how that will happen.

Role of an Individual Care Plan

- Care Plans are an integral part of serving recipients in Health Homes.
- Tells the story of where each recipient starts, outlines goals, tracks progress and identified opportunities/needs.
- Remember the Care Plans should be developed with active participation from the recipient and natural supports of their choosing.
- DSS nurses will complete care plan reviews during their random chart reviews.
- When developing the care plan, take into consideration the level of service required for each recipient.

Comprehensive Care Management

- Other examples of how this Core Service is being provided?
- Questions Health Homes may have as to what would qualify?

2. Care Coordination

- Care coordination is the **implementation** of the individualized care plan that coordinates appropriate linkages, referrals, and follow-up to needed services and supports.
- The Health Home care coordinator or Health Home team is responsible for the management of the recipient's overall care plan.
- Shares key clinic information (problem list, medication list, allergies, diagnostic test results) with other providers involved in the care of recipients.
- Integration of medical or behavioral health expertise is crucial to serve the whole person. For example, the Health Home team of a recipient with a severe mental illness who has co morbid physical conditions should include a physician or advanced practice professional as part of the team and vice versa.
- DSS nurses will conduct a random sample of case reviews to ensure care coordination is being provided.

2. Care Coordination Examples

- Placed follow-up call to recipient to remind them of their upcoming appointment(s)
- Recipient needed to travel out of town for an appointment, provide information about location of the appointment, ensure they have transportation, arrange transportation if necessary.
- Recipient was given a prescription, follow-up to be sure script was filled, address any questions, scheduled a follow-up visit with provider.
- Recipient is seeing a behavioral health professional and primary care provider for diabetes; clinical information was provided to behavioral health professional.
- Health Home notified of an ER visit, HH reviewed discharge notes, contacted recipient to ensure they were recovering, understood discharge summary, discussed follow-up care that needed, educated on ER use.

Care Coordination

- Other examples of how this Core Service is being provided?
- Questions Health Homes may have as to what would qualify?

3. Health Promotion

- Health promotion services **encourage and support** healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self manage their health.
- The Health Home care coordinator will provide health promotion activities. Specific activities may include, but are not limited to the following:
 - Provide health education to recipients and their family members specific to the recipient's chronic conditions and/or behavioral health conditions;
 - Develop disease specific self-management plans;
 - Provide education regarding the importance of immunizations and screenings, child physical and emotional development; and
 - Promote healthy lifestyle interventions for substance use and prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activity.

3. Health Promotion Examples

- Discussed the importance of flu shot and arranged for recipient to receive at their next appointment.
- Connected recipient with SD Quit line as they were interested in quitting smoking.
- Recipient established a goal to reduce weight, helped recipient make a food log that will be reviewed at their next visit.
- Educated recipient on meal planning and portion control.
- Discussed an exercise plan, recipient will start out slow and increase amount and intensity over time.
- Shared a copy of exercises that can be completed at home.
- Recipient has young children at home, educated about hand washing to reduce illness.

Health Promotion

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- Questions Health Homes may have as to what would qualify?

4. Comprehensive Transitional Care

- Comprehensive transitional care services are a **process** to connect the designated provider team and the recipient to needed services available in the community.
- Health Home has the overall responsibility and accountability for coordinating all aspects of transitional care including transitions to home, long term care, rehab and other settings.
- Health Home must receive notification when a recipient is admitted to the hospital or seen in an ER within 24 hours as well as any transitions that may be occurring to ensure that they receive information from other providers when a person is transitioning from one care setting to another or to home. The Health Home must also contact the recipient within the first 72 hours after the transition occurs.
- Health Home can also determine status using the DSS Phone system (IVR) or the Card Swipe (emdeon).

4. Comprehensive Transitional Care Examples

- Recipient was hospitalized, HH care coordinator participated in discharge planning care conference, helped coordinate transportation to home. Completed follow-up call to recipient to ensure scripts were filled and confirmed follow-up appointment. Care plan was updated with information regarding hospitalization.
- Client was hospitalized with pneumonia. Upon returning to group home, was assessed to identify any new needs. Medication list was updated.
- Recipient was discharged from hospital after a knee surgery. Talked with client to assess physical environment and mobility levels. Educated on the importance of physical therapy and helped schedule physical therapy treatments.

Comprehensive Transitional Care

- Other examples of how this Core Service is being provided?
- Questions Health Homes may have as to what would qualify?

5. Recipient and family support services

- Recipient and family **support services** reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes.
- A defined member of the designated provider care team is responsible for engaging and educating the recipient/family about implementing the care plan using methods that are educationally and culturally appropriate.
- Assess barriers to care and working with the recipient/family to overcome barriers such as medication adherence, transportation and keeping appointments.
- Identify resources for recipients to support them in attaining their highest level of health and functionality in their families and in the community.
- Provide information on advance directives in order to allow recipients/families to make informed decisions.

5. Recipient and family support services examples

- Working with a recipient that was not taking medication. Met with recipient, family members and medical provider. Family member is now assisting to ensure medications are taken.
- Recipient was not able to drive and missed several appointments. Contacted family member to determine when someone could bring the recipient to their appointments, rearranged appointment timing to match the transportation schedule.
- Recipient was newly diagnosed with diabetes. Educated recipient and family on dietary restrictions and needs.

5. Recipient and family support services

- Other examples of how this Core Service is being provided?
- Questions Health Homes may have as to what would qualify?

6. Referrals to community & social support services

- Referrals to community and social **support services** provide recipients with referrals to support services to help overcome access or service barriers, increase self management skills and improve overall health.
- Responsible for identifying available community-based resources and manage appropriate referrals.
- Coordinates or provide access to recovery services and social health services available in the community (may include housing, personal need and legal services).
- Provide assistance to obtain and maintain eligibility for health care, disability benefits, etc.
- Support effective collaboration with community based resources.

6. Referrals to community & social support services examples

- Worked with recipient who lost her housing. Worked with a local shelter to obtain temporary housing until permanent housing could be secured.
- Recipient was recently divorced and struggling with loneliness. Provided recipient information on a divorced or widowed support group. Contact program coordinator who reached out to recipient and asked them to attend. Followed up with recipient and they had attended the meeting.
- During recent contact, recipient expressed concerns about being able to eat during a time family was traveling as she was not able to cook for herself. Contacted Meals on Wheels and arranged to have meals delivered.

6. Referrals to community & social support services

- Other examples of how this Core Service is being provided?
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Questions?

