2017 Sharing Sessions Summary

Tuesday, August 29, 2017 - Watertown – Ramkota
Wednesday, September 12, 2017 – Rapid City – Hilton Garden Inn
Monday, September 18, 2017 - Sioux Falls – Downtown Holiday Inn
Monday, September 25, 2017 – Ft Pierre – Drifters

Four Health Home Sharing Meetings were during August and September of 2017 at the dates and locations listed above. The average attendance at each session was around 25 individuals. This is a combined summary of all of the sessions.

Kathi Mueller did a short presentation on Health Home basics. The entire presentation is available as an artifact of these sessions; here are some of the highlights of new information.

Online Provider Portal

- DSS released the Online Provider Portal earlier this year. This portal allows clinics to access information securely online rather than receive it through the mail. Products currently available through the Portal include:
  - Caseload lists in an Excel and printable format
  - Claims data in an Excel format
  - Remits in a PDF format
  - Eligibility Inquiry - The new eligibility inquiry allows searches for recipients without having the Medicaid number
- Future planned functionality
  - Quarterly Core Service Reports

As a result of this discussion, attendees requested that DSS provide training on the Online Provider Portal and how it pertains to HH care coordinators. This training was held on October 24, 2017 in the form of a Webinar. The presentation is listed under the Training section of the HH webpage at http://dss.sd.gov/healthhome/training.aspx.

Kathi shared information about South Dakota Health Link's (SDHL) Notify product. She emphasized that there were 46 users, representing 5 systems using the product and they receive approximately 120 notifications per month. Kathi also indicated that SDHL has a dedicated employee to help clinics effectively integrate the HIE and notify into their work flows. Any clinic interested in using this service should contact Stacy Davis at 605.256.5867.

Kathi shared the results of the Health Home Program with the group. She indicated that the program helped to avoid $4.2-5.6 million within the Medicaid program. DSS will continue to include Health Homes as part of its annual budget request and include the Health Home PMPM in provider inflation.

DSS implemented a Data Dashboard for the HH program that summarizes the benefits of the program. It can be found at http://dss.sd.gov/healthhome/dashboard.aspx.

Children and Youth with Special Health Care Needs

Barb Hemmelman, SD Dept. of Health (DOH), Office of Child and Family Services, presented to the group on the Title V Maternal and Child Health Block (MCH) grant – specifically the activities covered under services for children and youth with special health care needs (CYSHCN). Barb highlighted some of the activities covered under this grant: coordinate newborn metabolic and hearing screening and the consultants who review the results and offer guidance when there are abnormal screening results; assist with funding for respite care services to eligible families; parent and provider training and resources and referral through the State's Parent Training Center – SD Parent Connections; and direct service financial assistance and care coordination upon request under Health KiCC – cost of doctor visits, labs, hospitalizations, pharmacy, and mileage reimbursement.

The Title V MCH grant was recently revised and states are being asked to implement measures that would assist in ensuring that all children with and without special health care needs receive services in a medical home. Prior to moving forward with any significant changes the Dept. of Health/Office of Child and Family Services is working with an evaluation team to collect data on how to best use the funds we receive from the federal MCH block grant to serve CYSHCN. Each participant was asked to provide informal data to help the DOH identify what are the needs of families, communities, and providers in assisting with accessing medical care; accessing coordinated care; and resource/referral. This data will help the DOH determine how best to facilitate/address those services and supports that families of children with special health care needs and the providers that serve them see as areas of need.

Session Summaries

Participants were asked to provide one take away item for the day. These take a ways are listed below.

- New perspective
- Ideas for patient engagement
- Fresh ideas and energy
- Legislative Update
- Best practices for tracking patients/sharing information
- New ideas
- Networking
- Learn more about the program
- Ideas for patient compliance.

Core Services

Each session had a discussion about Core Services. Kathi started each conversation discussing the three basic requirements to identifying a core service.

- Engage with the patient/family/caregiver. Engagement can be face to face or via phone if documented.
- Document in the EHR

- Tie to care plan

Examples

- Ideas from group to meet the ***health promotion*** core service
    - Locate your local NAMI chapter. Chapter affiliates can be identified at https://namisouthdakota.org/.
    - Refer to the Better Choices/ Better Health Program http://goodandhealthysd.org/communities/betterchoicesbetterhealth/
    - Preventive visits with documentation and education
    - Tests with follow-up results and education
    - Discuss immunization schedule and schedule an appointment to update needed immunizations.
    - Research organ donor options for patients
    - Discuss and schedule a colonoscopy
    - Procedures such as MRI and X-ray with a follow-up on the results and education or assistance making referrals and appointments with specialists.
- Ideas from the groups to meet ***transitional care*** core service
    - Keep contact with discharge planners alive
    - Have intake staff person flag individuals when follow-up appointments are made for ER visits.
- Ideas from the group for ***referrals to community and social support services***
    - Dentist (Delta Dental Smile Mobile)
    - Referral to local transportation services or any services within the community
    - Referrals to State programs such as NEMT, All women count! SD Quitline, Aging and Disability Resource Center.

The following Patient Engagement Best Practices were provide either at the meetings or through the survey done in preparation for the meetings.

- Discuss with the recipient their health and ways to increase their well-being, day to day. Interact with their care teams and provide care coordination with primary care physicians and offices.
- Take advantage of recipients previously scheduled appointment. If the recipient is in the office catch them and discuss or update care plan or educate them on the need for a flu shot and the importance of the immunization to keeping them healthy. Schedule any routine maintenance visits
- Place a flag in the chart so staff is aware of the HH status and which Nurse Case Manager to contact.
- Provide a direct line into the clinic for HH recipients.
- Implement a Health Home monthly huddle with the physicians to discuss the recipients who need to come in and what quality measures need to be done. When the patient comes in they feel like we are on target with what needs to be done when they come to the clinic.
- Follow up as promised. If our patients feel someone else cares about their health and well-being, they tend to care more and try harder to be engaged.

- Use a team approach to provide services, including sending reminder letters for appointments and asking the case managers to remind clients/recipients and assist with transportation if needed. We have structured Health Home Clinic times when our tier 3 & 4 clients/recipients are scheduled to see the psychiatrist.
- Hold an initial meeting prior to appointments to open up communication with the doctor and other team members. Case managers and/or therapists will sit in on the appointment with their client (if client is open to this) to promote the team approach.
- Include a pharmacist and nurse if present.
- Use Motivational Interviewing techniques.
- Identify transportation assistance to and from appointments
- Provide education on how physical and mental health is connected and what effect both combined can have.
- Make personal contact on a regular basis. Initial phone call followed monthly by letters or phone calls.
- Use a team approach, starting with reception that includes nurses and providers.
- Use face to face discussions to explain the program and how benefits can be rendered at the patient level.
- Make initial phone contact to introduce and provide education about the program. Then meet face to face to establish rapport and help them associate a face with the name and how we can help them. Work with the patients and their providers to meet their individual needs.
- Obtain feedback from recipients already in Health Homes and what was most meaningful to them during their introduction to Health Homes.
- Keep the plan patient-centered.
- Give recipients permission to call when needed rather than seek care at the ER.
- Participate in the appointment if the recipient is open to this model. If a patient hasn't been to the clinic and are difficult to contact, Case Managers call frequently in an attempt to contact them.
- Make hospital discharge planners your new best buddy. When the hospital calls to schedule a follow-up appointment make sure you get access to the patient if possible. Should also be a key to look for discharge information on the recipient.
- Keep your own sanity “Damn it” doll
- Use strongly worded letters to help recipient make a decision.
- Use email if available to allow recipient to make contact when it works for them.
- Meet the recipient where they are in the management of their condition. Let the goals be patient - driven and make baby steps
- “Love them up” letting them truly know that you care about them as a person and a patient.
- Provide a transportation voucher
- DSS Public Transit reimbursement (See summary below for details)
- Use something that doesn’t look like a bill a post card saying please call. Use an appropriate reading level.
- Set expectations up front for challenging recipients. We will call you xx amount of times. Need you to do the following to remain on the program. Set up a regular contact schedule until recipient has stabilized.

- Enter your contact into their phone so they know it is you rather than a bill collector calling.
- Use family member to help with conversations for ESL recipients.
- Perseverance.

Community Transportation and Nonemergency Medical Transportation (NEMT)
There was a request to know more about our community transportation program and the NEMT program. The Recipient Handbook discusses both programs. See page 22 in the Recipient Handbook for Community Transportation and Page 26 for NEMT. An online version of the Handbook can be found at the link below. http://dss.sd.gov/formsandpubs/docs/MEDSRVCS/MedicalAssistanceRecipientHdbk.pdf

If after you review this information you would like to know more, please do not hesitate to contact me.

Recipient Handbooks can be ordered through our website if you would like to have paper copy/ies on hand at http://dss.sd.gov/formsandpubs/default.aspx. See the directions for ordering provided in the New Brochure section below.

New Brochure
A new brochure about the Health Home program was released earlier this year. If you would like to use this brochure, it can be ordered through our website at http://dss.sd.gov/formsandpubs/default.aspx. Scroll down to the section titled Medical Services and add the Health Home Brochure to your cart and DSS will mail it to you. You can find and order the recipient handbook discussed above at this site as well.

Medical Services

Doc #	Document Name	Instructions	Online Version	Spanish Version	English Version	Add to Cart
	Recipient Forms: HIPAA Privacy Consent Form	n/a		n/a		
	Primary Care Provider Program Reminders - Emergency Room	n/a		n/a	n/a	n/a
BRO/MS1	Medical Assistance Program Recipient Handbook	n/a	n/a			
BRO/MS3	Well-Child Care Brochure	n/a	n/a			
BRO/MS4	Title XIX Medical Transportation Brochure	n/a	n/a	n/a		
BRO/MS6	Health Home Brochure	n/a	n/a	n/a		

Health Home Challenges and Successes

Each Health Home was asked to provide their greatest success and their biggest challenge. This is an excellent time for new Health Home coordinators to ask questions and exchange ideas.