Health Homes Sharing Meetings 2018 Summary
Rapid City, Sioux Falls, Watertown and Pierre

Welcome and Introductions and Health Homes Basics

Four Health Home Sharing Meetings were during September of 2018. The average attendance at each session was around 25 individuals. This is a combined summary of all 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.
Provider capacity is at an all-time high. There are 129 participating Health Homes serving 133 locations. Two new clinics started July 1, 2018 in Huron and Mitchell. A new clinic, Regional Health in Hill City, became available on October 1, 2018. Centerville, Viborg and Parker clinics disenrolled December 31, 2018.

As of August 28, 2018, there were 5,916 recipients enrolled in the Health Homes Program.

Cumulative eligibility, since July 1, 2013, 50,895 Tier 1 and 25,815 Tier 2 recipients have been determined eligible and 16,611 are opt outs; over 8,000 people are still eligible.

DSS continues enhancements to the online provider portal. Providers can get caseload lists, claims data, and other information online. When you want to know if an individual is eligible, use the Eligibility Inquiry. Additionally, there is an upcoming functionality as a new interface that is a public facing website for people to choose a provider and will contain the recipient selection and change forms.

The portal is 100% provider driven. If a provider needs permissions updated or changed, you need to go to your admin to make changes. The provider admins are responsible for providing the correct access and permissions to each user; anyone who doesn't know who that is, contact Kathi.

Janel Barajas indicated that the first time she processed the quarterly report, the report was alphabetical; but, this time it wasn't and it's beneficial to see it listed alphabetically. Kathi worked with the IT team to identify and correct the issue.

Provider mobility has become an issue for both the Health Home Program and PCP programs. DSS needs to know as soon as possible about provider mobility. If coordinators know a provider is leaving, a months' notice helps DSS clean up prior to the provider's departure. If DSS doesn't know, they end up having to recoup money from the provider and it causes unnecessary issues for the recipient. For example, if a provider leaves on October 29, they need to be ended on September 30. Care coordinators should help transfer recipients to other providers within the clinic, so the recipients remain engaged.

Likewise, if the health home contact is changing for the clinic, notify Kathi as soon as possible so contact lists can be updated and the new contact receives the appropriate information. (e.g. training notices, any changes in coverage, etc.)

During the past summer, quality assurance reviews were done for two periods. 517 recipients were reviewed during this time. Positive outcomes included 96% had care plans and 92% received core services appropriately; except 6% did not actually receive a core service when a core service was claimed. Comparatively, 89% of those in a PCP Health Home and 100% of recipients in a CMHC received a depression screening appropriately in the past year and 97% of recipients in a PCP Health Home and 88% of recipients in a CMHC Health Home received a substance abuse screen. want to see tobacco and alcohol and drug screening. In the area of transitional care, we have seen more cases reviewed; but, there was a drop in cases documented and followed up.

Statistics show we are serving the right people and the Program has helped to avoid costs with $7.7 million in savings. Tiers 3 and 4 are the biggest cost avoidance providers.

The Legislature provided just under $1 million to reward Health Homes for performance. 50% of the money went to everyone by increasing PMP which took effective January – March 2018. The remainder will be dispersed as quality incentive payments.

DSS is partnering the Department of Health (DOH) to provide services to kids in the Children and Youth with Special Health Care Needs (CYSHCN) program who do not meet the criteria for the DSS Health Home Program. This will not impact every provider; DSS will outreach to affected providers. We will look at automatically removing opt outs. Let Kathi know if a case should be marked as not able to return to your clinic. It is hoped that a process will be in place by the end of the year.

DSS has been working with Brown Clinic in Watertown to reintroduce waiver recipients into the program. As that process gets figured out, we will move out to the rest of the state. A waiver is an amendment to the state plan that allows SD to serve people that are not eligible otherwise. There is a case manager who deals with the intellectual disability portion.

Jessica Edwards, Nicky VanDerWerff or Ann Schwartz from Delta Dental attended each meeting and discussed the role of Delta Dental in the administration of the Medicaid dental benefit. There is an emphasis on preventive care. The State implemented the Dental Care Coordination Plan in 2017 to help people understand their Delta Dental benefits. The Coordinators found that in Sioux Falls 72% of recipients didn't even know they had dental benefits while on Medicaid. It was noted in all sessions that it is challenging to find a dentist who will accept Medicaid,

Refer to the one-page handouts from Delta Dental - one for adults and one for kids – *South Dakota Medicaid Dental Care for Kids* and *South Dakota Medicaid Dental Care for Adults*.

People can access the DSS website to obtain forms, provider lists, minutes, outcome measures, provider applications, training, etc. Kathi's contact information was provided as a resource.

Event Notification and Point of Care

Stacie Davis, Clinical Engagement Consultant and Mandi Atkins, Implementation Specialist, both with Dakota State University and SD Health Link, presented information regarding clinical event notifications from SD Health Link and new notification requirements. They work with the SD Health Information Exchange (HIE). They help to access clinical data and make providers aware of where patients are located. See handouts including the *Clinical Event Notifications from SD Health Link*, *Clinical Engagement with SD*, *How does the Point-of-Care Exchange Help?* and *South Dakota Health Link Point of Care Exchange*. SD Health Link recently implemented Community Master Patient Index (CMPI) in Notify which will return better matching rates for Notify end-users. Providers are notified in real time when there is an ambulatory admit, emergency room admit/discharge; inpatient admit; discharge; transfer, etc. (See handouts). 90% of users do batch files. You can have multiple listings for one patient and can follow multiple subscriptions. Timely follow up must occur within 72 hours to meet a core measure.

When a patient registers, checks in, information is sent in real time to Health Link. You can follow the patient through the entire process and can decide when you want to know about admits to different facilities for your patients. Use event notification to allow you to follow up within 72 hours. Patient gets better care; provider gets better reimbursement.

Health Link is working to add more providers and organizations. Staff are constantly traveling and working the state to show providers Health Link's value and benefit to folks in the community. Growth has been strong on the east side of the state; hoping to push for growth on the west side of the state. When providers are added, people utilizing Health Link will be notified.

Point of Care and Health Information Exchange (HIE) event notifications are in concert to each other. The Point of Care Exchange provides electronic access to a patient's clinical information. You can access a patient's medical information from connected facilities when you need it without having to wait. Contributing organizations are those on the *South Dakota Health Link Point of Care Exchange - Data Contributors* list. They contribute data and access data. The system allows 12 months of medication fill history to include date, who prescribed the medication, name of medication, etc. Encounters and problems list shows where and when seen. Continuity of care document includes lab results, EKG results, transcribed documents, problems, allergies, etc. info that is faxed to you from the facility plus demographic information. You are able to find the most up to date information in the Health Link system. If the facility is contributing to Health Links, information gets added real time. Information submitted depends on the provider. Health Link is actively working to streamline information to change it to make it more similar between providers.

Health Link is an electronic health exchange validated to give connectivity to other states; currently connected with North Dakota and currently working with Nebraska and other surrounding states will be next. In the que waiting for the Veterans Administration to add connections as well.

Clinical engagement is provided by Stacie. She meets with groups about workflow, staffing, matrix you need, data, gaps, goals, how can Health Link help fill holes; helps with training developed to meet the needs, targeted to area of greatest impact, customizable to meet needs of the organization. There is continual follow up to ensure user adoption and use, retraining or reminders, troubleshooting problems, or developing new use cases.

A question was asked if there is a charge? If in organization appears on the listed contributor list, they are already participating. Health Link's HIE is fully member funded. Organizations pay to be members. You can be trained to access and use services of Health Link. If anyone wants to learn more about Health Link services, Stacie and Mandi would be happy to come onsite and do a more in-depth settings or demo to walk through the Point of Care in the test environment. Can also discuss the fee structure if an organization is not on the list. Stacie and Mandi have been in touch with IHS, but they decided to go a different route; however, they are continuing to work on it. Rapid City Medical Center is on Health Link's radar. Health Link is in the connectivity phase and working on interphases now. A question was asked if the cost is per patient or lump sum. Point of Care is usually dependent on the number of providers. A fee structure is available online. It's dependent on the facility and facility size. If you want to use Notify like BMS is doing, it's $25 per member per year. Average 200 patients per year, it's paid annually. Paying for recipient.

SUD Coverage and Services

Stacy Krall, Department of Social Services' Division of Behavioral Health provided information about services offered by the Division of Behavioral Health. Behavioral Health provides mental health services, substance use disorder services, prevention services, and behavioral health services for justice involved clients. Refer to the *Division of Behavioral Health* PowerPoint presentation and handouts.

- Substance Use Disorder providers must be accredited by the Division of Behavioral Health to be Medicaid providers. All eligible adults of Medicaid are eligible no for coverage of SUD services. All substance use providers are enrolled in Medicaid. Access the interactive map on the DSS website to find contact information. Based on a needs assessment, a behavioral health provider would recommend outpatient or inpatient services. Funding assistance for treatment services is available to individuals who meet programmatic and financial eligibility. Treatment agencies assist clients in applying for funding. Services include early intervention services, outpatient treatment services, low intensity residential treatment services, inpatient treatment services, and detoxification treatment services. Refer to the *South Dakota Substance Use Disorder Services* handouts for more information.
    - Outpatient SUD takes place at a facility, not at home.
    - Day treatment provides clients with a combination of individual, group, or family counseling services at a minimum of 20 hours per week primarily at the agency. Clients have an individualized care plan.

    - Clinically-Managed Low Intensity Residential Treatment program (previously known as halfway house) allows residents to maintain employment and community supports, spending 5 hours per week with an accredited provider.
    - Medically-Monitored Intensive Inpatient Treatment programs Level of care prior-authorization is necessary for inpatient care.
    - Psychiatric Residential Treatment Facilities (PRTF) program is designed for adolescents with a primary diagnosis of alcohol and other drug use. PRFT requires prior authorization.
    - Specialized Treatment Services
        - Intensive methamphetamine treatment services
        - Detoxification services
        - Criminal Justice Initiative (CJI),
        - Juvenile Justice Reinvestment Initiative (JJRI).
- The primary diagnosis in SD for those seeking SUD services is alcohol, the 2nd is methamphetamine.
- Two years ago, the Legislature declared an emergency and now there are four intensive methamphetamine providers.
    - Keystone in Canton,
    - Dakota Counseling Institute in Mitchell
    - Carroll Institute in Sioux Falls,
    - City County Alcohol and Drug Program in Rapid City.

MH Coverage and Services

- There are 11 accredited community mental health centers located across the state that provide services to youth and adults. Services include screenings and assessments, case management, individual and group therapies and crisis intervention. Outpatient services are provided to individuals who do not meet serious emotional disturbance (SED) or serious mental illness (SMI) criteria. SMI is one of the criteria to be eligible for Health Homes. Intellectual disabilities, epilepsy, other developmental disabilities, alcohol or substance abuse, or brief periods of intoxication, or criminal behavior do not, alone, constitute SMI.
    - Comprehensive Assistance with Recovery and Empowerment (CARE) services are person centered, relationship and recovery focused, have integrated care and medically necessary supports. A patient may start on CARE services, then if CARE is not meeting his/her needs, he/she can move to Individualized Mobile Programs of Assertive Community Treatment (IMPACT). IMPACT is the highest level of outpatient treatment for adults meeting SMI criteria who can't be served in less restrictive services. IMPACT follows a team approach and there is contact with the patient multiple times per week. Each IMPACT group has a mobilized health group. Services require prior-authorization with the Division. There are currently six communities that have IMPACT services. The therapist goes to the persons home to provide services.

- Additional mental health services include emergency services 24/7 for persons experiencing a mental health services or crisis; indigent medication program - covers opioids and alcohol cessation. Heroin and opioids are in the news; medication assisted treatment is a best practice to provide meds to patients to help with their treatment. Services are managed by the provider and treatment entity providing services to the person.
- Projects for Assistance in Transition from Homelessness (PATH) is a federal grant to provide community-based outreach, services for SUD and MI, etc.

- Refer to the last slide of the PowerPoint for help in resource coordination for providing services and getting people connected to community health centers in the community. Be aware of resources and assistance.Stacey.Krall@state.sd.us.

Health Home Resources

Refer to slides 31-36. In addition to the resources listed, the group discussed addition of the following resources at the **Rapid City** Meeting

- Vocational Rehabilitation - Works with clients who have schizophrenia, etc. and helps people maintain employment and keep a job
- LYFT – assistance with transportation
- Community Health Representative (CHR) – 355-2310 – Native American, 24/hour advanced notice required; based on availability
- Tribal Patient Advocate – Eagle Butte area
- Prairie Hills Transit – transportation services may be available from 10:30 to 2:30
- Hill City Taxi – Call Ken 877-2255
- Long Term Services and Supports (LTSS) within Department of Human Services (DHS)
- River City Transit
- Medicine Shoppe – Bubble Packs
- Better Health Better Choices

In addition to the resources discussed in the Power Point provided by Kathi, the following resources were discussed at the **Sioux Falls** Meeting

- **Community Resource Guide**
  - 211
    - Text2know http://www.helplinecenter.org/2-1-1-community-resources/partnerships/
    - Statewide Community Guide - http://www.helplinecenter.org/2-1-1-community-resources/#ResourceGuides.
- **Communication**
  - ENTOUCH - https://freegovernmentcellphoneguide.com/entouch-wireless-lifeline-phone-providers/

- **ESL Recipients**
  - Lutheran Social Services https://www.lsssd.org/
    - Center for New Americans
    - Interpreters
    - Classes
    - Etc
- **Transportation Services**
  - SDUIH
  - LYFT
  - Para-Transit
  - Non-Emergency Medical Transportation
    - https://dss.sd.gov/medicaid/recipients/title19transportation.aspx
  - Project Car – Free transportation for the Elderly – (605) 332-2777
  - Works on Wheels - Free transportation for the Elderly for Medical and Grocery (605) 333-3317.
- **Food**
  - Meals on Wheels and Animeals on Wheels
  - Banquet
  - Feeding South Dakota
- **Prescription Meds**
  - Rx Outreach https://rxoutreach.org/
  - Goodrx https://www.goodrx.com/
  - Low Income Subsidy through SHIINE http://shiine.net/
  - Samples
- **Clothing**
  - Salvation Army
  - Helping Hands

In addition to the resources discussed in the Power Point provided by Kathi, the following resources for Transportation were discussed at the **Watertown** Meeting

- Public Transit, Huron, Likes 24-hour notice. Will travel out of town.
- Ride Line, Aberdeen, 24 hour notice required. Won't do same day.
- Prairie 5, Minnesota, difficult out of town; use VA or Salvation Army.
- Community Transit, Sisseton, Local, will make special trips, price depends on number traveling.
- VA transit is issue.
- Lake Area Kidney Endowment, Watertown, serves Northeast SD, Western Minnesota, 3x a year, $750 max; rent, utilities, wheelchair, hospital bed, etc. Phone number 660-4465. There is an online application. Partners with churches for coats, Christmas gifts, etc. http://www.lakeareakidneyendowment.com/.

In addition to the resources discussed in the Power Point provided by Kathi, the following resources were discussed at the **Pierre** Meeting

DME

- Recycle for life- (605)224-4501

Transportation

- Pierre: River City Transit-(605)945-2360
- Mobridge: Standing Rock Transit (will go to Bismarck)
- CRST: ABD Ride line (605)964-RIDE. I H S transportation will go to Mayo.

Food and Clothing

- PARS: food and clothing
- Birth Right: formula, diapers, blankets etc.
- Right Turn: (605)222-9160 car seats (Mary)
- Feeding South Dakota
- County Funds: application for hardship
- Salvation Army

MEDS:

- 340B program-discount meds FQHC
  - Patient Assistance Program
  - Needy meds .org

Vision:

- Sight for students-18 and under

Dental:

- Community Health Centers
- Donated Dental- (605)224-9133

Patient Engagement Best Practices – Rapid City

Open discussion was held regarding how to best engage patients to assure positive outcomes. Some of the ways Health Home representatives and care coordinators are getting this accomplished are as follows:

- Explain Health Homes at the patient's level; 4th grade level is a good level to follow; work on one thing at a time (dietary; meds; don't overwhelm the patient).
- Meet the patient face to face at his/her appointment – helps to build a relationship with the patient and earn trust.
- Give the patient your business card – give your desk number so they can call direct to your desk so when you answer the phone you can help the patient understand and build trust, so he/she is comfortable reaching out to you.
- Use motivational interviewing techniques.
- Ask the patient what's important to them and listen and act.
- Educate with positive reasons to be in Health Homes.

- Make the patient feel special – 'On my list to case manage…'
- Find a connection- hobbies etc.
- Greet and acknowledge them
- Thank them for coming in.
- Rename the program.

In the **Sioux Falls, Watertown and Pierre** sessions patient engagement discussions were focused around specific groups which are typically challenging to engage.

- **Toughest to engage – Not interested in the program or their health**:
    - Motivational interviewing
    - Education
    - Letter from State
    - Catch them while they are at their appointment to meet them in person.
    - Texting is a great way to communicate with recipients.
    - Offer to assist with transportation.
    - Include trifold with letters (order trifolds from DSS Forms and Publications)
    - Meeting recipient where they are – their goals
    - Peeling the onion – getting down to real issues or barriers
    - Right staff to match individual
    - Coordinate with counselors
    - In-person- build relationship – gain trust. Make sure person knows they "aren't less"
    - Always follow up and do what you say you will do. If can't do it, explain why.
    - Use the "No wrong door approach"
    - Appropriate referrals
    - Small steps
    - Keep asking/talking

- **Financial Burdens - Poor, can't afford cost of treatment, medications; or healthy alternatives. Lack of follow through**
    - Resources
    - Feeding South Dakota
    - Needs of family are put before self (Back Pack program – take care of family)
    - Tribal incentive programs – rewards for preventive health screenings - $20 reward cards

- **Pain Seekers – Mental health/substance use disorders**
    - Control SUD to treat MH
    - Genetic testing
    - Medication management
    - Standard Practices within a community and clinic
    - Create pain contracts
    - Education
    - Encourage use of Alternative services

        - Physical Therapy
        - Chiropractor services
        - Counseling
        - Acupuncture
        - Dry Needling
    - Address acute pain prior to becoming chronic

- **Developmental Disabilities/Intellectual Disabilities/People with Disabilities**
    - Involve clinic with both DD/ID and family
    - Accompany patient to appointment

- **English as a Second Language(ESL) recipients**
    - Use Language line for initial calls and appointment reminders
    - Younger family members can help interpret.
    - Google Translator and Inhouse interpreters.

- **Homeless**
    - Treat them as a person
    - Put away your own judgement
    - Meet them where they are at.
    - Fill drugs week by week.
- **Difficult to contact**
    - Try to monitor appointments and grab them while they are in the clinic for other purposes. (stalk them)
    - Use your Community Health Representative(CHR) to help track them down.

- **Diabetic**
    - Include family in education
    - Refer to the Better Choices Better Health Program
    - Getting patient engaged/ownership
    - Celebrate the wins both big and small
    - Address the outlying problems: homeless, money, etc.
    - Thinking creatively to maximize their resources
    - Help them find a support group

The **Pierre** group also discussed Physician and Facility Engagement and offered the following suggestions

- Meet with the providers on a regular basis
- Document and share successes
- Educate all staff on program
- Educate partners in community

Case Studies

Round table discussions were held at each session where the care coordinators/clinics shared challenges and successes:

The theme throughout is that the challenges often become the biggest successes. The focus is to keep people out of emergency rooms and hospitals and keep them engaged in the Health Homes program.

Identified issues

- It was identified that the screening for Substance Use should allow for each of the substances to be identified separately. DSS will take this issue to the Implementation Workgroup
- It was also raised by several group that recipient have been returned to their list after they were opted out. Kathi encouraged those individuals to send examples so she can review the situations. This remains an open invitation.
- CMHC and PCP Health Homes continue to struggle with the exchange of information. The DSS Division of Behavioral Health suggests using the attached Release of Information.

Success Stories

- Kathi asked for providers to provide success stories as they were sharing their case studies. If your case study was identified, please send those as soon as possible.