Health Home Implementation Workgroup
Meeting Minutes
March 17, 2014
Teleconference 10 a.m. – 12 p.m.

Members in attendance: Barb Smith, Tony Tiefenthaler; Terry Dosch; Alan Solano, Sandy Crisp, Nancy Haugen, Dayle Knutson, Dr. Mary Carpenter, Kathi Mueller; Ann Schwartz; Kirby Stone, Brenda Tidball-Zeltinger, Amy Iversen-Pollreisz, Leah Ahartz, Jean Reed, Mark Wheeler, Joan Friedrichsen, Sandy Giovannettone, Mary Beth McLellan, Kathy Jedlicka, Shawn Nills, Jamie Risse, Kelsey Raml, Linda Ross, Vanessa Sweeney

Others in attendance: Amy Richardson, Mark East and Rebecca Craddick

Welcome and Introduction
Kirby Stone opened the meeting and provided the group with an overview of the organizational changes that had recently taken place within the Department of Social Services. She explained that Kim Malsam-Rysdon moved to the Governor's Office effective March 1, 2014 and Amy Iversen-Pollreisz would assume primary responsibility for the continued implementation of the Health Home initiative. She thanked workgroup members for their ongoing commitment and support to this important initiative.

General Update
Ann Schwartz provided a general update on provider capacity. There are currently 113 Health Home serving 118 locations. This consists of 23 FQHC's, 11 IHS units, 10 CMHC's, and 69 other clinics. There are 574 designated providers that support these locations. The group reviewed the Health Home County by County grid and discussed ways to improve capacity in areas with little or no coverage. Members were encouraged to consider expanding their Health Home coverage into areas where there is currently no Health Home coverage. The process to add a new designated provider when new providers join an existing Health Home's staff was reviewed. The steps include provision of internal training in the Health Home process, having the new provider sign the attestation to the Health Home application, and submitting the signed attestation to DSS. DSS will continue to conduct outreach to fill the existing shortfalls. Two new Health Homes joined on January 1, 2014 and one new Health Home is expected for April 1, 2014.

As of the February 2014 payment date, there were 5,664 Health Home recipients. The breakdown is as follows.

Type HH	Tier 1	Tier2	Tier 3	Tier 4	Total
CMHC	6	349	427	90	872
IHS	5	826	526	272	1,629
Other Clinics	81	1764	920	398	3,163
Total	92	2,929	1,873	760	5,664

In February, 707 new Tier 1 notices were sent.

The group was provided notification that DSS has implemented an automated process that will provide notification to both recipient and provider when the recipient declines participation. Providers will receive notification when the recipient is active in the Health Home. This improvement was implemented as a result of a workgroup suggestion.

Follow-up Item
As a follow-up to earlier meetings, the Health Home notices were discussed. Limited feedback was received and members were asked to forward additional feedback to Kathi Mueller for consideration. Once all feedback is received, it will be considered. The group was reminded that the letters are hard coded and that any changes will take time. Once changes are finalized, the changes and an expected completing date will be provided to the group.

Transitional Care Notification
The next item addressed was the Transition of Care Notification requirement. The current requirement as approved in the State's SPA is as follows:

> HH must have agreements or a method in place to 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 occur to ensure information is received from other systems when a recipient is transitioning from one care setting to another or home. HH must contact the recipient within 72 hours after the transition occurs.

The group agreed that the goal of the requirement is to assist individuals in successfully transitioning to other care settings without experiencing a set back or readmission.

Discussion regarding transition of care and the notification process continued. Since the last meeting, DSS has implemented methods for providers to validate recipient and provider Health Home participation electronically. Both IVR (Interactive Voice Response) and Emdeon (card swipe) have been updated to indicate a recipient is part of a Health Home. Also, at the request of the Health Home Workgroup, the Transitional Care Contact List has been posted on the web at http://dss.sd.gov/healthhome/transcarecontacts.asp.

Workgroup members shared experiences within their respective Health Homes as to how they are addressing both the notification and follow-up after transition process. These examples included improving flow of internal communication and building notification processes across organizations and communities. Many examples also demonstrated progressive use of electronic health records.

Patient Engagement Strategies
The group discussed the second quarter Core Service experience. It was reported that there was an improvement in the percentage of recipients that received a Core Service. Health Homes discussed their specific experiences in providing Core Services and discussed several questions. Individual Health Homes shared several success stories.

The process to recoup the Per Member Per Month (PMPM) payments for Core Services paid to Health Homes for Core Services not delivered in a quarter was discussed. It was explained that for the State to recover these dollars, additional programming was required and so the dollars would not be paid back to the State for several months. The specific dates and process will be shared with the Health Homes when that information is available.

Next the group discussed their experience with the disenrollment policy for those recipients a Health Home was unable to reach. Overall the experience with the policy has been positive. The policy is as follows:

Disenrollment by Health Home due to Inability to Contact the Recipient
Health Homes may disenroll a recipient from their Health Home due to their inability to contact the recipient or recipient's parents using the following criteria:

1. The recipient has been on the caseload of the Health Home for 45 days.
2. An attempt to contact them has been made every 2 weeks during this period of time.
3. At least two different methods were used to try to contact them.
4. A record of contact has been documented in the notes of the EHR.

If the above criteria have been met, the Health Home should complete the Decline to Participate form found on the website at http://dss.sd.gov/healthhome/forms.asp. Please check the other reason and indicate No Contact per Health Home.

As a follow-up to the last meeting, the subject of a "warm transfer" was discussed. After some discussion, it was determined that utilizing the transition of care contact list could serve as a resource to facilitate communication between the Health Homes when assisting recipients and their family members.

Health Homes were asked to share specific success stories with the implementation workgroup. One of the Health Homes indicated they had been able to go back and review the past 12 months of a recipient's clinical and financial information. There have been noticeable improvements in this recipient's clinical and quality of life. It was noted that this would be a regular agenda item and that we hoped that there would be stories to share and that through the stories case studies that could be benchmarked could be identified.

It was also noted that DSS has been invited to present on a webinar hosted by the Center for Health Care Strategies. DSS worked closely with this group during the State Plan preparation, submission and approval process. DSS was asked to present because of the unique features of stakeholder involvement, IHS participation and the use of CDPS to tier participants.

Outcome Measures
The group was thanked for all of their efforts in getting the outcome data submitted. It was acknowledged that there is a significant volume of measures and it was a challenge to work through the first submission. It is also clear that a few of the measures will need

to be re-evaluated. That re-evaluation process will be taken back to the quality sub-group for review with a timeframe for implementation to be determined by them as well.

The recipient satisfaction or patient experience survey was discussed. Early indications are that this indicator may require changes. Not having everyone using the same scale is posing issues in being able to get a valid measure of satisfaction. There seemed to be general consensus the sub-group should evaluate this. Those Health Homes that used simple satisfaction tools offered to share the tool and were asked to forward them to Jean Reed by March 31, 2014.

The next topic the group discussed was the frequency of data reporting. It was agreed that the reporting frequency should remain at six months.

The quality sub-group will be asked to evaluate the results of the outcome measures and recommend any necessary changes. Those recommendations would then be presented to the Implementation Workgroup at the September meeting. Once this work is complete the quality sub-group would be tasked with developing minimum achievement levels that could potentially support a shared savings model.

Health Home Training Needs
As a result of the feedback from the group, a training conference call has been scheduled for March 26, 2014 from 1:00-3:00pm. The training will focus on the Core Services and will include examples of what other clinics have counted as core services in the electronic health record. Other topics that were suggested include quality measures, motivational interviewing, cultural competence, best practices for populations served, referral training and transitional care coordination.

Next Steps
The process and timeline to collect information for the October – March six month cost report was discussed. A template was provided to the Health Homes. The Health Homes were asked to provide Leah feedback on the template by March 31, 2014.

The group reviewed a proposed quality review plan. Again, they were asked to review and provide feedback to Kathi Mueller by March 31, 2014. It was explained that once the quality review plan was final, it would be included in the orientation plan so Health Homes understand the process and requirements in the early stages of the process.

In closing, the group was again thanked for their participation and ongoing commitment to Health Homes. The next Implementation Workgroup meeting is scheduled for June 16, 2014.