Health Home Implementation Workgroup
Meeting Minutes
September 15, 2014
Teleconference 10 am - noon

Members in attendance: Tony Tiefenthaler, Sandy Crisp, Terry Dosch, Dayle Knutson, Dr. Mary Carpenter, Kathi Mueller; Kirby Stone, Brenda Tidball-Zeltinger, Amy Iversen-Pollreisz, Leah Ahartz, Mark Wheeler, Joe Manual, Heather Lawrence, Joan Friedrichsen, Kathy Jedlicka, Debra Thalhuber and Jean Reed.

Others in attendance: Kelly Hasvold, Byron Okutso, Vanessa Sweeney, and Cindy Schuch.

Welcome and Introduction
Kirby Stone opened the meeting and thanked the workgroup members for taking the time to participate in the meeting and for their ongoing commitment and support to the Health Home initiative. Kathi Mueller proceeded to take roll call.

General Update
Provider Capacity
Kathi Mueller provided a general update on provider capacity for October 1, 2014. There are currently 116 Health Homes serving 124 locations. This consists of 23 FQHC's, 11 IHS units, 11 CMHCs, and 71 other clinics. Kathi Mueller explained that going forward designated providers will be presented in two ways to address those times when a designated provider will serve in more than one location. Currently there are 533 unduplicated designated providers and 579 duplicated designated providers. New Health Homes, who started to provide Health Home services effective July 1, 2014 include:

Massa Berry Regional Clinic - Sturgis
Queen City Regional Health Clinic - Spearfish
Southern Plains Behavioral Health - Winner
Three Rivers Mental Health and Chemical Dependency Center – Lemmon

Horizon Clinic in Aberdeen will become a Health Home October 1, 2014.

The group reviewed the Health Home County by County grid and the increased number of recipients. This increase is predominantly related to the addition of the new Health Homes.

As of the August 27, 2014 payment date, there were 6,140 Health Home recipients. The breakdown is as follows.

Type HH	Tier 1	Tier 2	Tier 3	Tier 4	Total
CMHC	6	328	422	106	862
IHS	8	1,043	657	286	1,994

Other Clinics	73	1876	913	422	3,284
Total	82	3,247	1,992	814	6,140

Recipient Participation Levels
Kathi Mueller provided an overview of recipient participation during FY 2014. 8,820 recipients were in a Health Home at least one full month. Thirty percent (2,719) of recipients were in a Health Home for the full 11 months. Forty-eight percent (4,237) of recipients were in a Health Home for 9, 10 or 11 months. Gaps in continuous enrollment in Health Homes are typically accounted for by inconsistent Medicaid eligibility, delayed start date due to the large volume in assignments or change in provider.

Providers should continue to engage existing recipients that are not part of a Health Home through the Manual tiering process.

Breaks in coverage
DSS completed a review on the difference in the number of recipients between May (5,847) and June (5,773) a total of 74. Over 50% of the recipients who left were due to losing Medicaid eligibility or losing Medicaid eligibility and being reinstated later the same month. Members of implementation workgroup brainstormed what the Health Homes could do to help address this situation. One question raised was whether or not DSS would be able to add recipient eligibility review information to the caseload report. DSS will follow-up and let the group know if this is a possibility. Other than this, there were no specific ideas generated. Health Homes were asked to discuss internally and report any possible solutions at a future meeting.

Transitional Care Notification
Kathi Mueller asked the group to provide updates on how their respective processes are progressing within the respective organizations.

Sanford Health indicated that they automated the Health Home transitional care notification process within Sanford. When a recipient presents at any Sanford location, information is transferred to the appropriate Sanford Health Home site. This same information is forwarded to Avera albeit through a different process. It was noted that it was also possible to provide the information to both Falls Community Health and Southeastern Behavioral Health. Mark Wheeler was identified as the contact person at Sanford.

Regional Health and the Community Health Center of the Black Hills are working together to share information through a SharePoint system that notifies the Health Home when a recipient has been in the Emergency Room.

Patient Engagement Strategies
The group discussed the third quarter Core Service performance which showed improvement. Health Homes reported that internal Health Home staff is finding the overall process easier to work with, recipients are more aware of what to expect and, as

a result, more willing to participate in the process. It was also noted that while this last quarter has shown an improvement, it represents the smallest increase in core services provided over prior quarters.

Health Homes were asked to share success stories or their experiences over the past year. The common denominator was that these recipients take substantial time and require a good deal of social work. Group members shared that the first year included a learning curve for both Health Home staff and the recipients. In this first year Health Homes also become more familiar with the preferred method of communication/contact with recipients. When to use phone calls and when face-to-face conversations are most beneficial.

Outcome Measures

Prior to reviewing the Quality Sub-Group recommendations, Kirby provided the background information on how the outcome measures were initially developed and the role of the Quality Sub-Group. She explained the following:

- Outcome measures were developed in conjunction with the State Plan Amendment (SPA) by the Health Home Outcome Sub-Group
- Measures focused on meeting CMS requirements; gathering data to support ongoing improvement and sustainability; and mirroring outcome measures providers were currently using whenever possible.
- The initial Outcome Sub-Group was a subset of the Health Homes Workgroup and others; including clinical and administrative representatives from potential PCP and CMHC Health Homes.
- Primary resources for quality measures include CMS, Commonwealth, NCQA and PQRS.
- Several measures/methodologies are required to be reported to CMS and cannot be changed.

The outcome measures were established to support the three overall Health Home strategic goals, which are as follows:

- Improve the health of Medicaid Health Home recipients with chronic conditions
    - Approach was to measure at least one key clinical for each chronic condition.
- Provide cost effective, high-quality health care services for Medicaid Health Home recipients.
    - Approach was to measure industry standard financial measures and key utilization measures.
- Transform the health care delivery system.
    - Approach was to measure chronic care management, care coordination, transitional care and follow-up.

She also reviewed the role of the Quality Sub-Group, which is as follows:

- To make recommendations to the Implementation Workgroup on the appropriateness of the PCP & CMHC HH Outcome measures.
- To annually review the aggregate outcomes report and recommend opportunities for improvement.

- Over time to establish a process to set minimum levels of performance and recommend performance goals.
- Recommend outcome measure modification/changes to the Implementation Workgroup.

Since the last Implementation Workgroup meeting the Quality Sub-Group has met twice. Kirby Stone provided the Implementation Workgroup a review of the information the Quality Sub-Group had discussed and the recommendations the Quality Sub-Group was bringing forward. In summary, the Quality Sub-Group reviewed seven technical/operational areas and discussed the evolution of outcome measures. The final recommendations fall in three buckets:

- Changes that can be made now through clarification of existing documents.
    - Chronic Pain Measure
    - Active vs. Inactive
    - Hypertension Measure
- Changes that can be made and implemented by January 1, 2015.
    - Common PCP Patient Experience Survey
- Future Changes
    - Cancer Screening Measures
    - Vascular Disease Measures
    - Formula for ER Utilization & Hospital Admits per 1,000
    - Updating Existing Measures
- The Quality Sub-Group will continue to meet to discuss the measures that make sense over the long term for Health Homes. These meetings will take place face to face over the winter months.

Other Updates

Health Home Notices

Health Home notices will be updated in the future. The Workgroup was reminded that these notices are hard coded and require programming changes.

Payment Recoupment

Recoupment letters for Quarters 2, 3 and 4 were mailed on September 2. September 15, 2014 is the deadline for the payment unless an extension was requested. The group was reminded if they are unable to submit payment by September 15 they need to contact Kathi Mueller.

Kathi Mueller presented to the group a retrospective PMPM payment recommendation. Payment would be made for a full quarter for all enrollees who received a core service (based on member months). At the conclusion of the discussion, all in attendance unanimously accepted the recommendation.

Cost Reports

It was noted that several cost reports are still outstanding and that it is important that the reports be completed and submitted. Additionally, DSS finance will be reaching out to several of the Health Homes to discuss how the cost report calculations were completed.

Department of Health Resources
Linda Ahrendt, Department of Health, provided an overview of the Better Choices Better Health; Good and Healthy South Dakota Communities program. The Department of Health and South Dakota State University Extension support this program. Statewide master trainers on such topics as managing pain, fatigue, stress, personal exercise plans and more support the program. It is an evidence-based resource available to Health Homes. Linda also discussed the DOH's Obesity Prevention and Diabetes programs. These topics were recommended as a future Health Home training session.

Health Home Training Needs
Care Plan training is being targeted for October. Health Homes will be notified when a date has been selected for the training. Other topics that have been suggested include quality measures, motivational interviewing, cultural competence, and best practices for populations served, referral training and transitional care coordination. As mentioned above, the Better Choices Better Health Good and Healthy South Dakota Communities program will be added to the list of training needs.

Next Steps
The group was provided an update on the quality assurance review. They were also provided an overview of a recipient survey that DSS will be sending to recipients that have participated in a Health Home for nine, ten or eleven months.

In closing, the group was again thanked for their participation and ongoing commitment to Health Homes. The next group meeting is planned for December 15, 2014. The 2015 meeting dates will be brought to the December meeting.