Health Home Data Dashboard

South Dakota Medicaid’s Health Homes are a person centered system of care focused on transforming care for high cost, high need Medicaid recipients to improve the patient experience, increase preventive and primary care services while improving outcomes for Medicaid recipients and adding value to South Dakota’s Medicaid program.

Increasing Preventive and Primary Care

Health Homes participants have high-cost chronic and/or behavioral health conditions. The goal of Health Homes is to provide care in primary care settings and help participants effectively manage their conditions by increasing preventive care. Overall, primary care has increased by 6%. The measures below show health homes success in increasing preventive screenings.
Transforming Care

South Dakota Medicaid’s Health Homes is changing the way Medicaid recipients receive care by creating a person-centered care team to meet the needs of the patient. The following measures show how the health home is changing the way individuals receive care.

- HH recipients receiving follow-up assistance with care transition within 72 hours of discharge from a hospital, emergency room, or other institution:
  - SFY14: 42%
  - SFY15: 60%
  - July to December 2015: 53%
  - January to June 2016: 60%
  - July to December 2016: 60%

- HH recipients receiving pro-active patient management such as appointment reminders:
  - SFY14: 89%
  - SFY15: 91%
  - July to December 2015: 86%
  - January to June 2016: 91%
  - July to December 2016: 91%

- HH recipients using self-management tools to manage their condition:
  - SFY14: 29%
  - SFY15: 26%
  - July to December 2015: 42%
  - January to June 2016: 42%
  - July to December 2016: 42%

- HH recipients referred for other community services:
  - SFY14: 36%
  - SFY15: 37%
  - July to December 2015: 42%
  - January to June 2016: 42%
  - July to December 2016: 42%

- HH recipients receiving healthy behavior counseling:
  - SFY14: 36%
  - SFY15: 43%
  - July to December 2015: 86%
  - January to June 2016: 87%
  - July to December 2016: 91%

- HH recipients with an active person-centered care plan:
  - SFY14: 55%
  - SFY15: 66%
  - July to December 2015: 64%
  - January to June 2016: 64%
  - July to December 2016: 64%
Improving Patient Experience

Health Homes are tasked with focusing care on the person, including establishing a relationship with health home participants. A positive patient experience helps support the health home model, leading to better continuity of care and better health outcomes. Outcomes in this area are split between primary care clinics and community mental health centers.

Community Mental Health Center Health Homes

- Services were flexible and convenient for me
- I can deal more effectively with daily problems
- I do better in school or work
- I am better able to control my life
- I was able to get all the services I thought I needed
- I would recommend the agency to a friend or family member
- If I had other choices, I would still get services here
- I like the services I received here.

Outcomes in this area are split between primary care clinics and community mental health centers.
My health home provider explained things and a way that was easy to understand.

My health home provider seem to know the important information about my medical history.

My health home provider listened carefully to me.

Primary Care Health Homes

July to December 2015

January to June 2016

July to December 2016

- My health home provider spent enough time with me.
  - July to December 2015: 82%
  - January to June 2016: 84%
  - July to December 2016: 86%

- My health home provider seem to know the important information about my medical history.
  - July to December 2015: 80%
  - January to June 2016: 81%
  - July to December 2016: 84%

- My health home provider listened carefully to me.
  - July to December 2015: 84%
  - January to June 2016: 83%
  - July to December 2016: 82%

- My health home provider explained things and a way that was easy to understand.
  - July to December 2015: 81%
  - January to June 2016: 86%
  - July to December 2016: 87%
Improving Clinical Outcomes

By transforming care, increasing preventive services, and improving the patient experience, Health Homes are able to improve clinical outcomes for patients. The following measures show how clinical outcomes have improved for individuals the longer the individual participates in the program.

A 50-year-old recipient enrolled in the Health Home program since December 2013 has improved health significantly as part of participating in the Health Home program. The recipient’s starting weight was 245 with a BMI of 44.7, and is now down to 129 pounds with a BMI of 23.3. The recipient makes all dental and eye appointments as well as yearly wellness exams. This has reduced the recipient’s cholesterol to the point they were able to stop one medication. The recipient has significantly reduced their smoking and is working towards quitting.

Cost Effectiveness of the Health Home Program

Analysis of Health Home participant utilization, claims and outcomes show significant progress in achieving cost savings and efficiency for the Medicaid program.