SOUTH DAKOTA
Foundation for Medical Care
2022 Health Home Quality Review
Tina Welbig, BSN, RN, CCM, PMH-BC
Dawn Hahn, RN-BC, CMCN, CARN

Health Home Quality Review

Overview

- 2 recipients randomly chosen from each clinic belonging to
  - Sanford
  - Avera
  - Horizon Health
- For other participating clinics, 2 recipients plus 3% of those enrolled were chosen
- 381 records met criteria for inclusion in the analysis
- Reviewing Quarter 3 clinical
  - July 1st – September 30th, 2022

Goals & Objectives

- Complete review annually to measure the accuracy of Health Home implementation
- Deeper dive into care plan components
  - Questions we added to the 2022 review cannot be compared to the 2021 review

Health Home Quality Review

Challenges

Challenges from 2021 : all improved in 2022 review

- Clinic response time
- Enrollment period
- Claims
  - ER
  - Hospital

Challenges in 2022

- Time frame for substance use and depression screenings

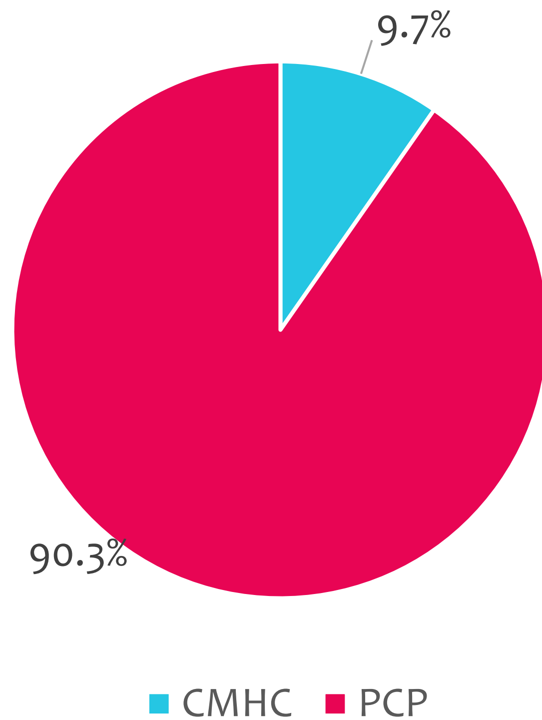
Opportunities

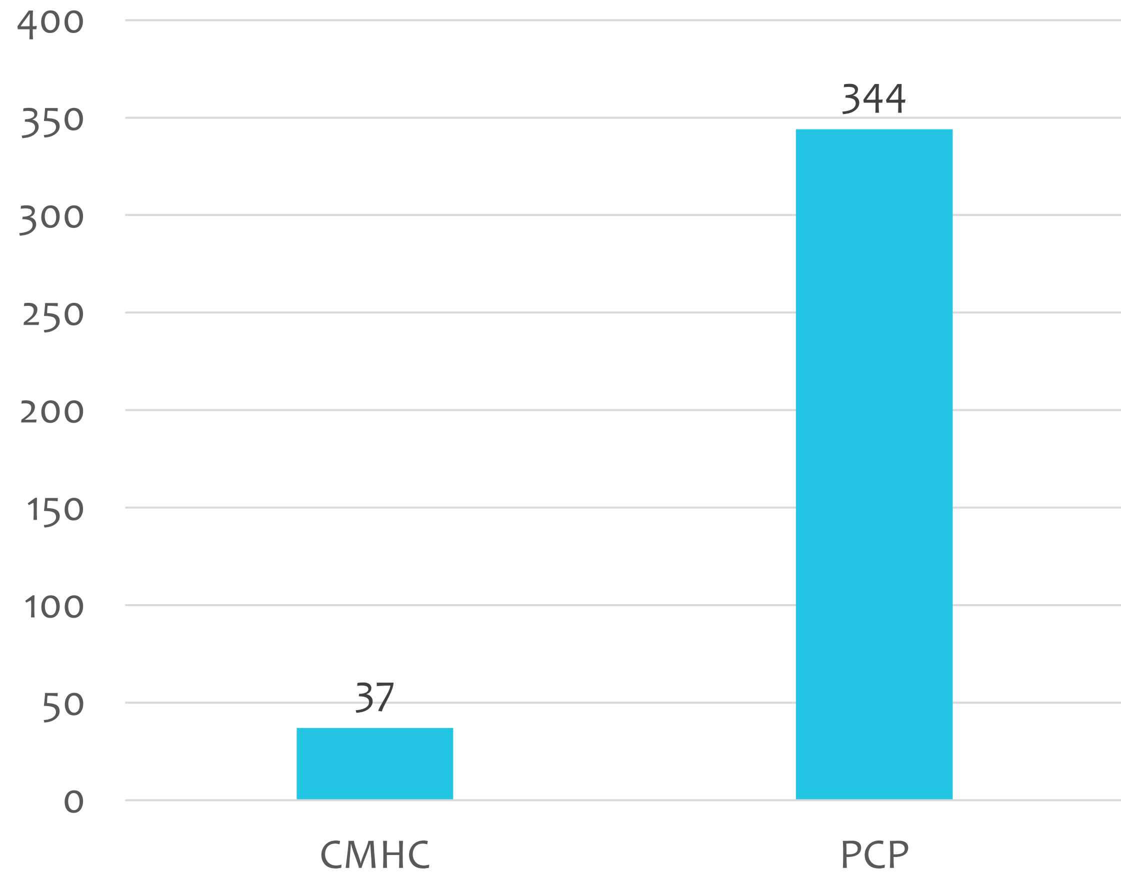
- Standardize information for reviews
- Education on care plans
  - Worked with 3 clinics
- Collaborate with clinics to assist in building protocols
- Engage more experienced mentors to train new Health Home clinics
- Provide training opportunities

Key Measures

- Care Plans
- Core Services
- Depression Screenings
- Substance Use Screenings
- ER/Hospital Follow-ups

Review Volume 2022





Results & Findings

Take Note

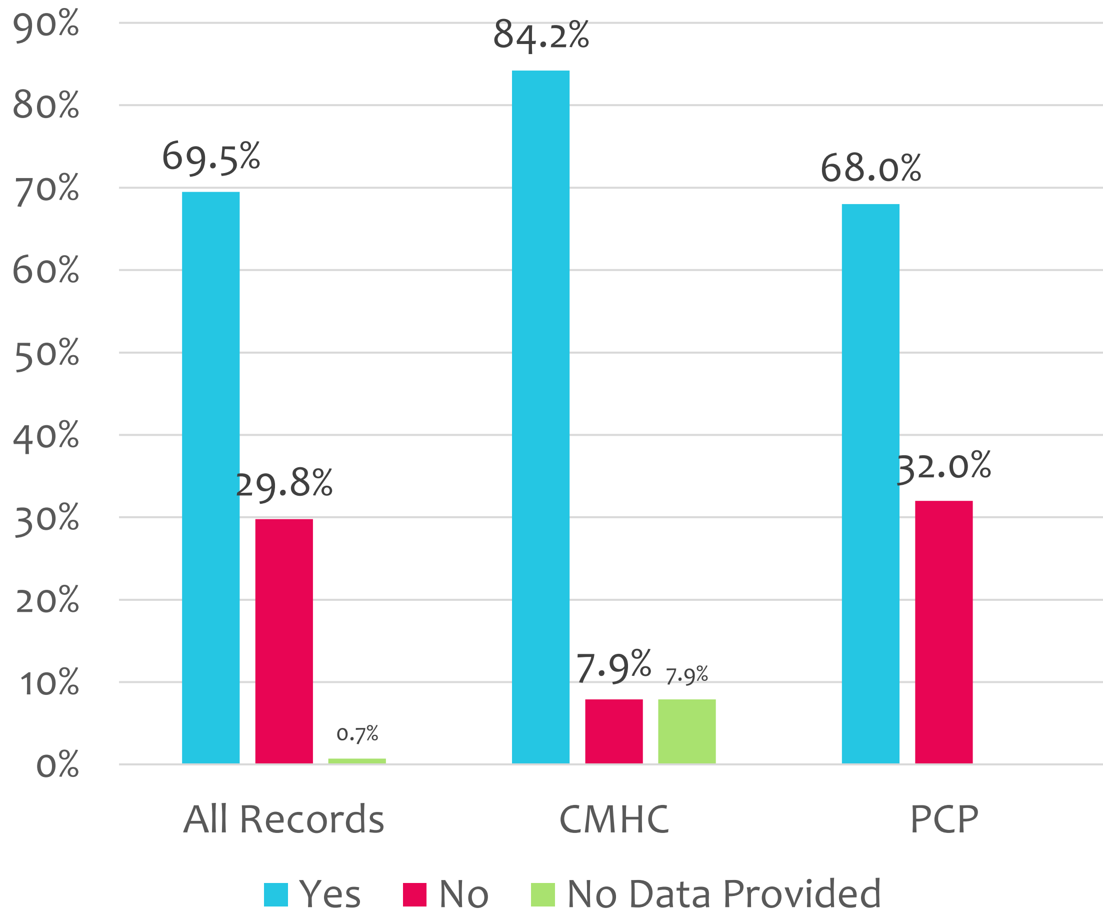
- Care plan
  - Was it updated in Quarter 3
    - Not required but best practice
    - Is it being utilized
  - Took a closer look at key elements in care plans (no comparison for 2021 as they are added questions)
    - Individualized goals
    - Summary of medications
    - Plan for services
      - Physical
      - Mental health

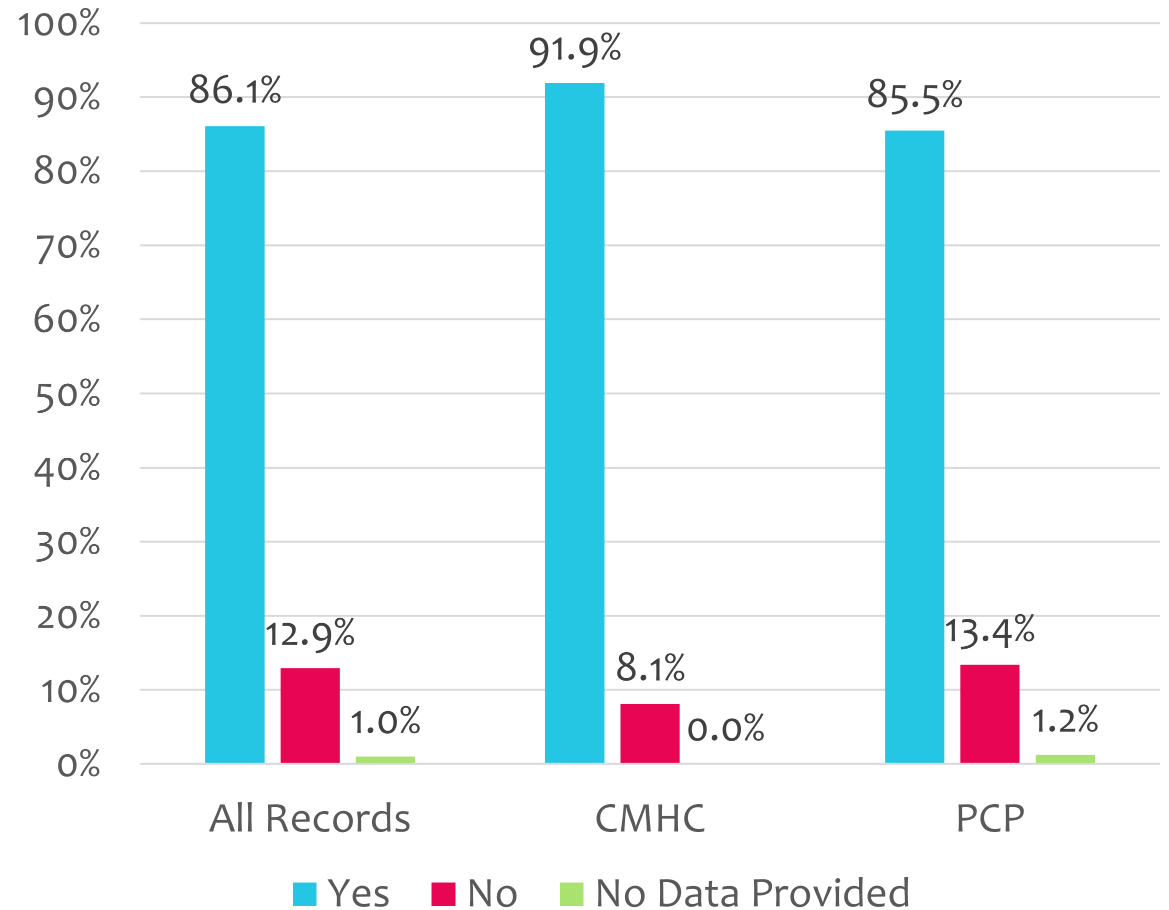
*Care plans-data analysis

- yes- if one was established
- asked other questions
  - -was it updated this quarter
  - -is it being utilized
  - -elements

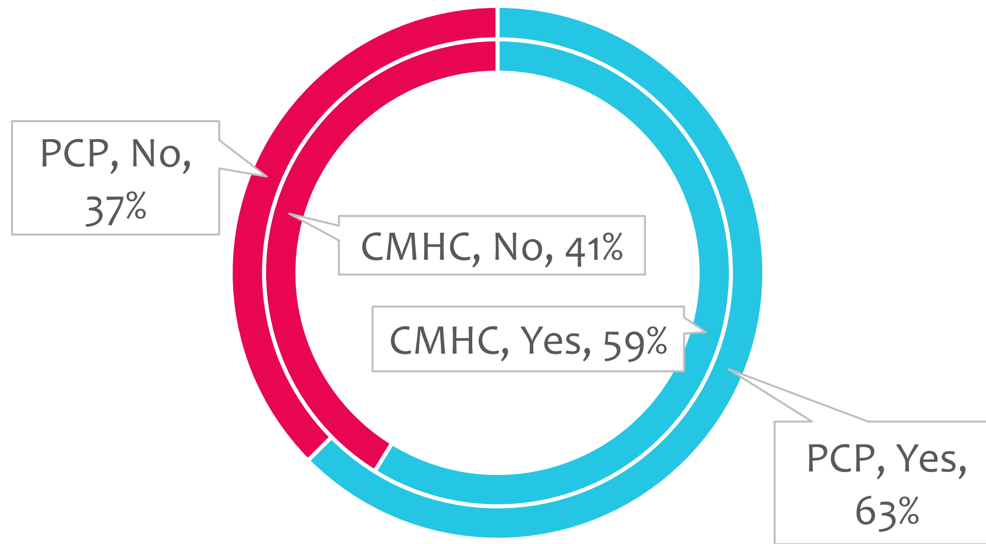
Best practice is to update care plans quarterly but not a requirement.

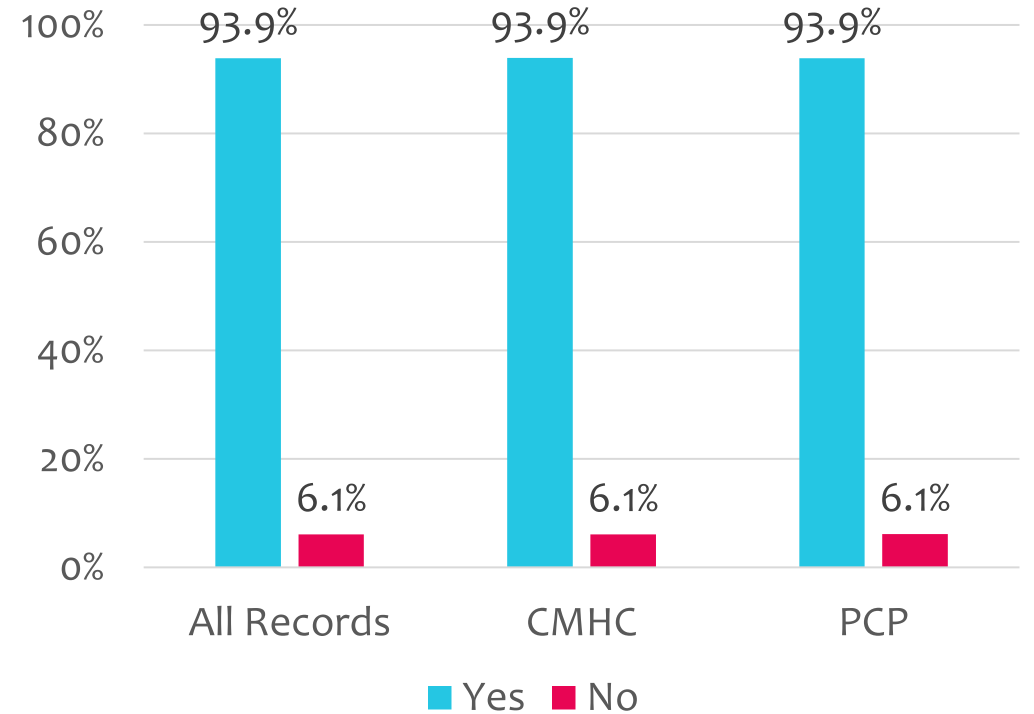
Is there a care plan?





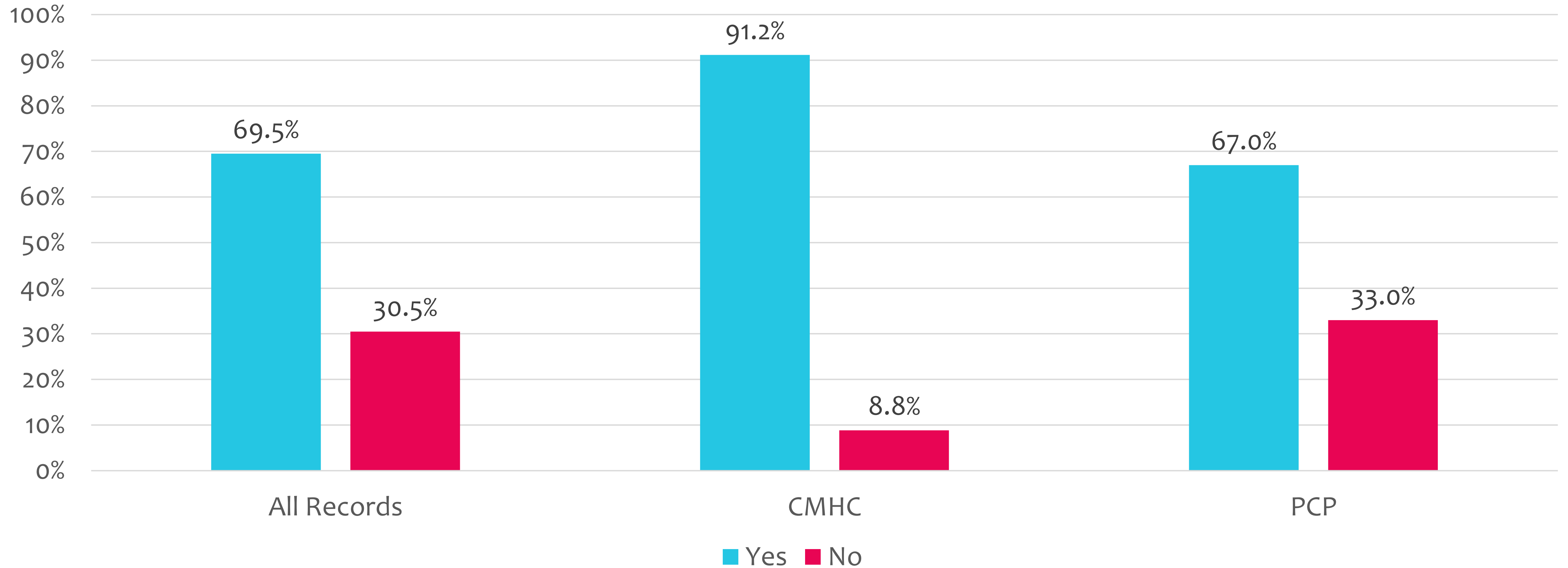
Care Plan





Care Plan

Key Elements



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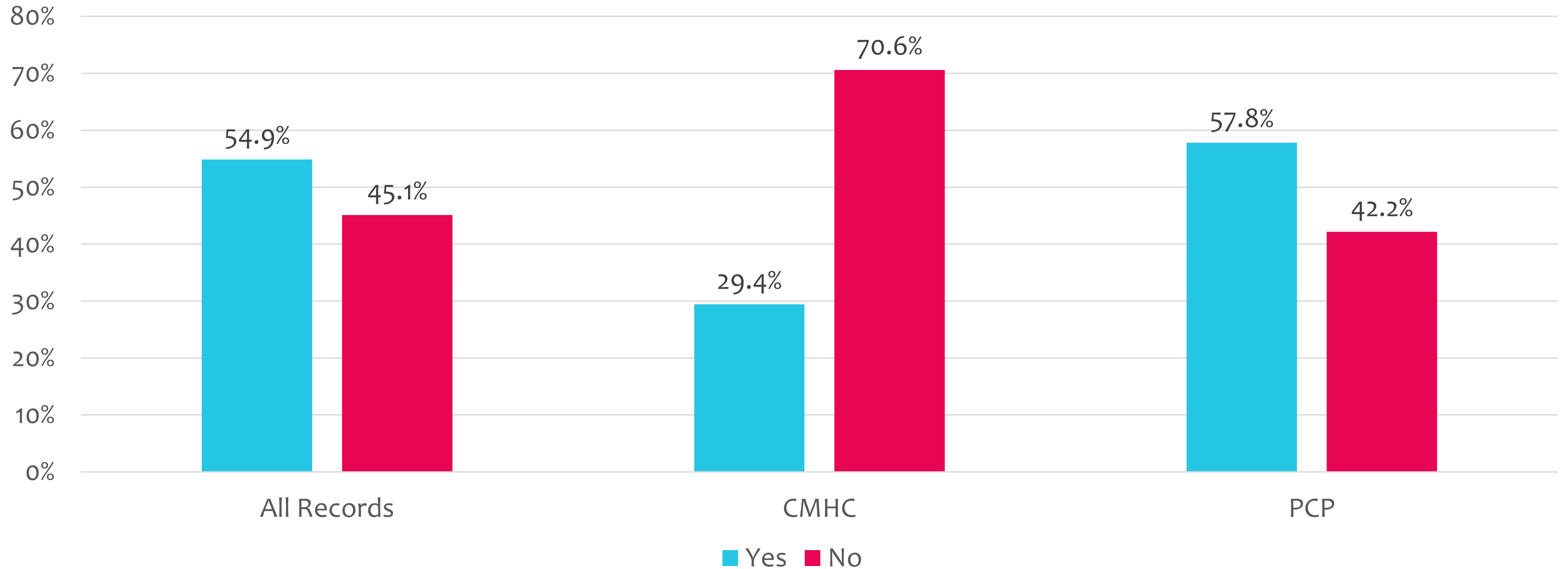

Care Plan

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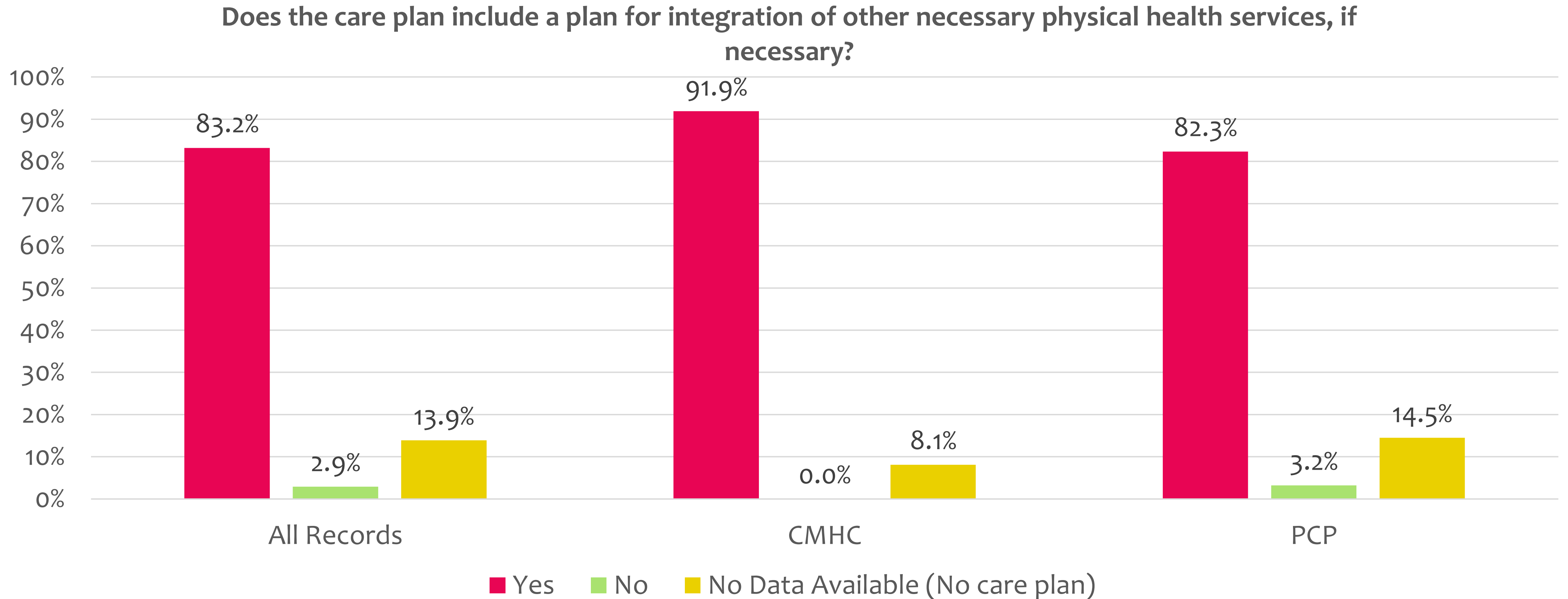
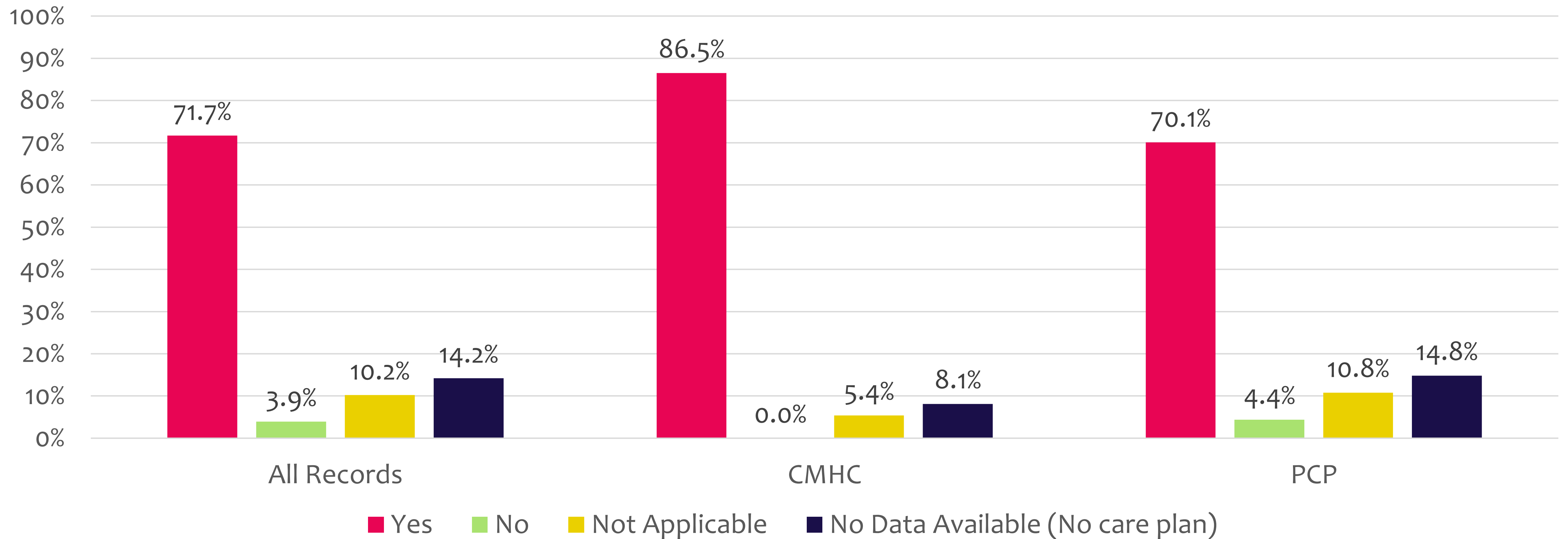


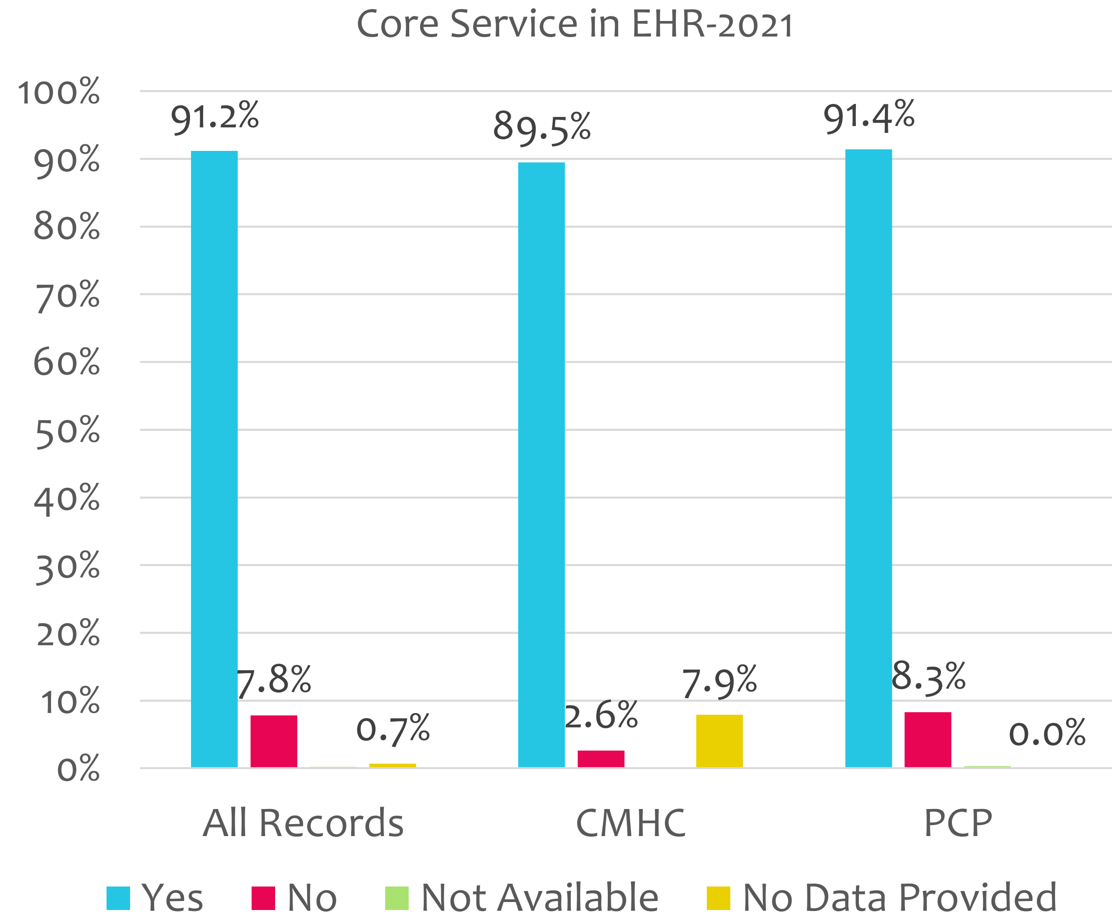
Care Plan

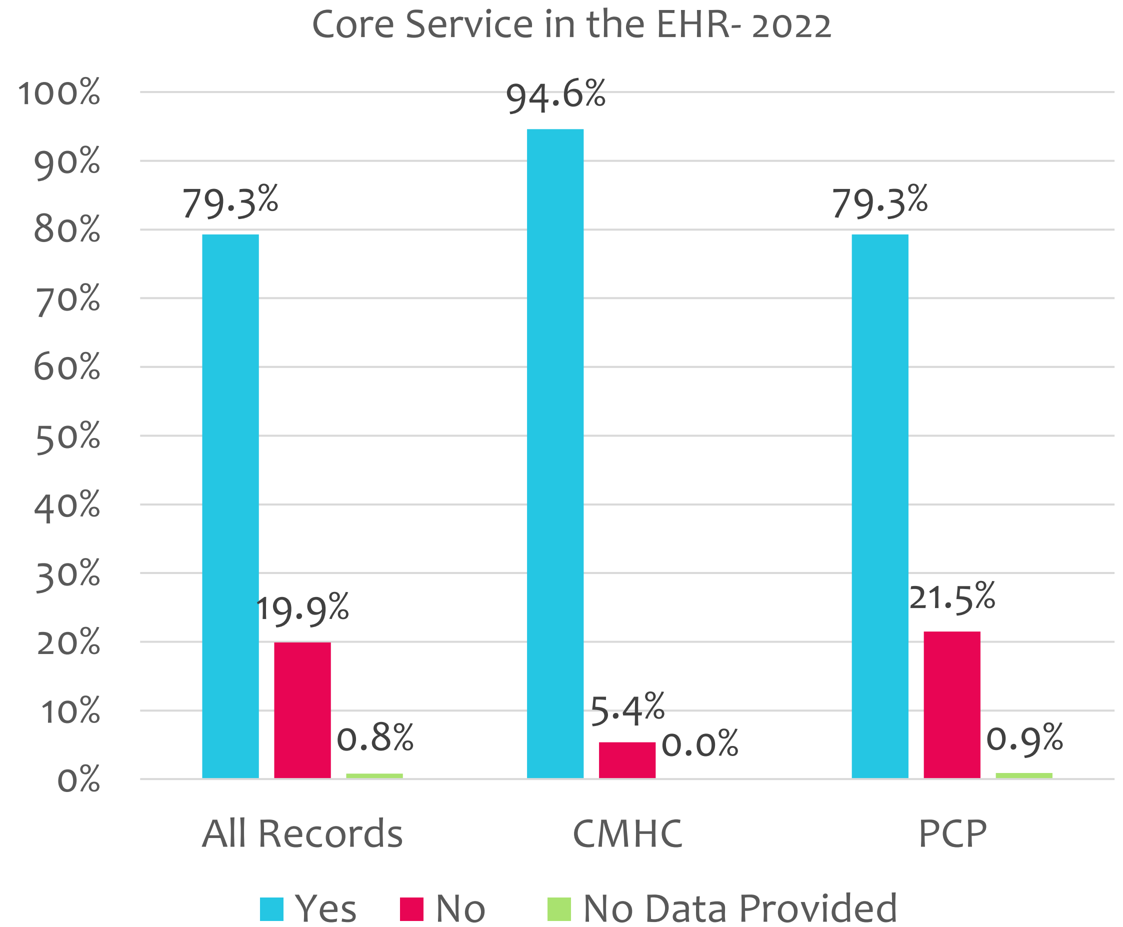
Key Elements



Not applicable refers to those who did not require mental health services.

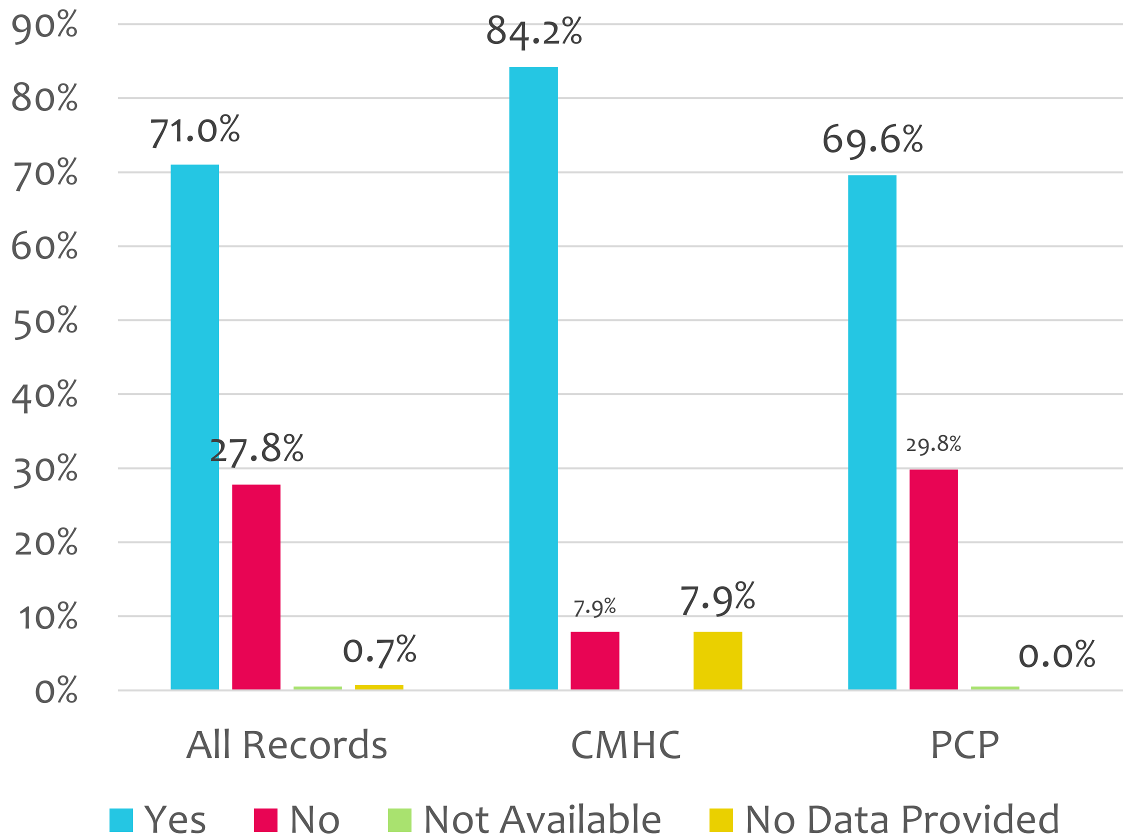
Was there a core service in EHR?

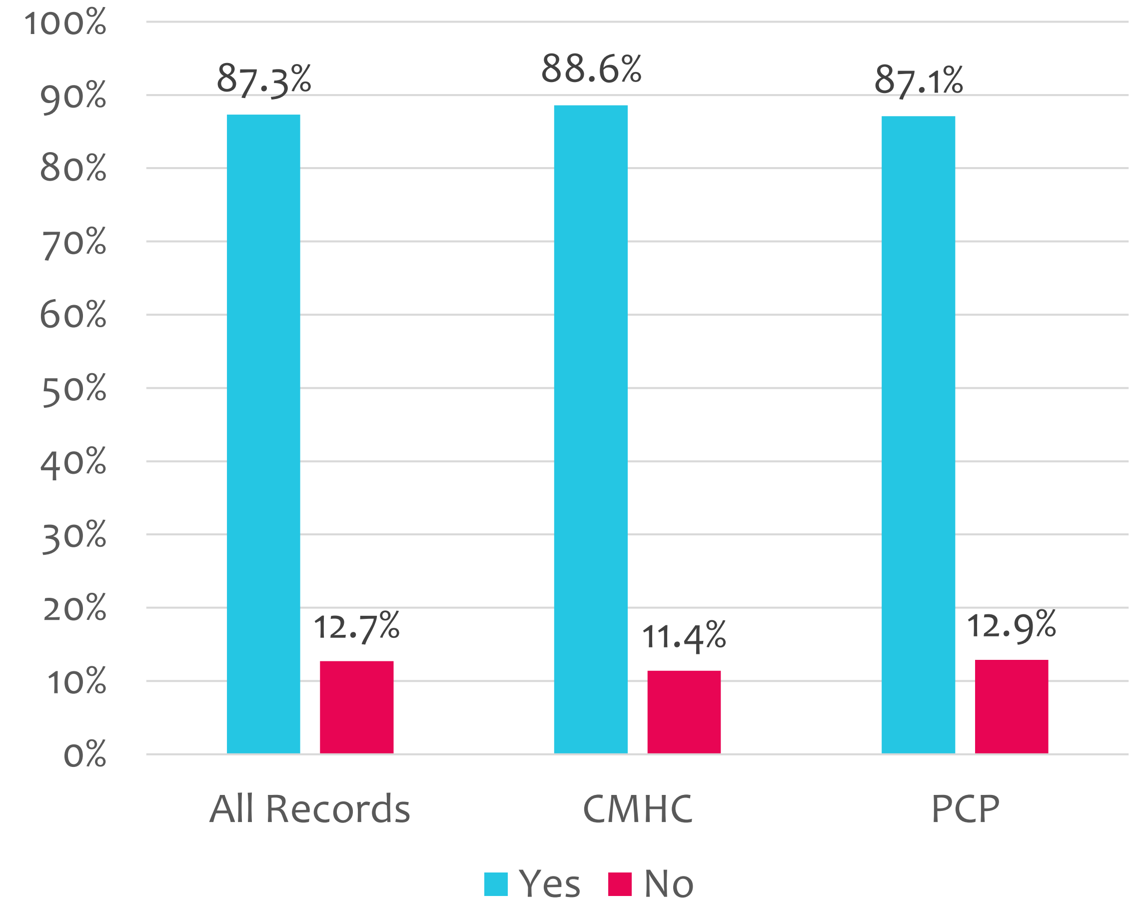




Not Available in 2021: clinics did not send in additional information documentation when requested.

Do core services tie to the care plan?

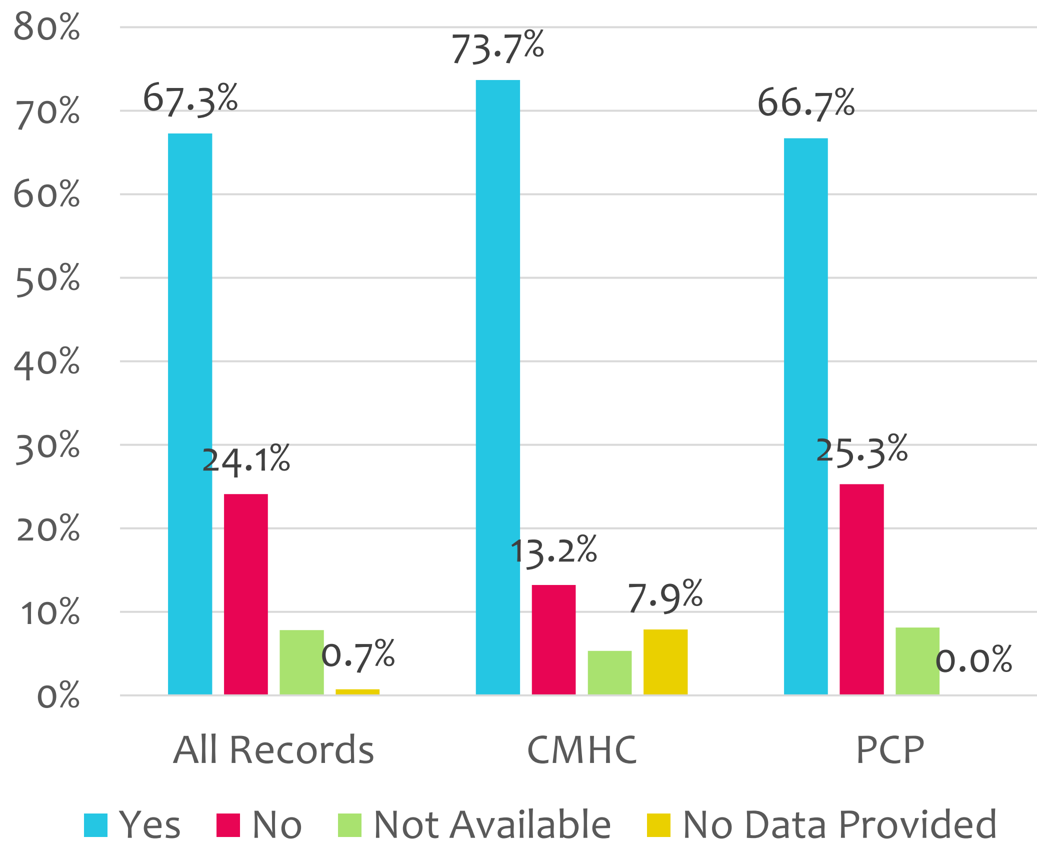


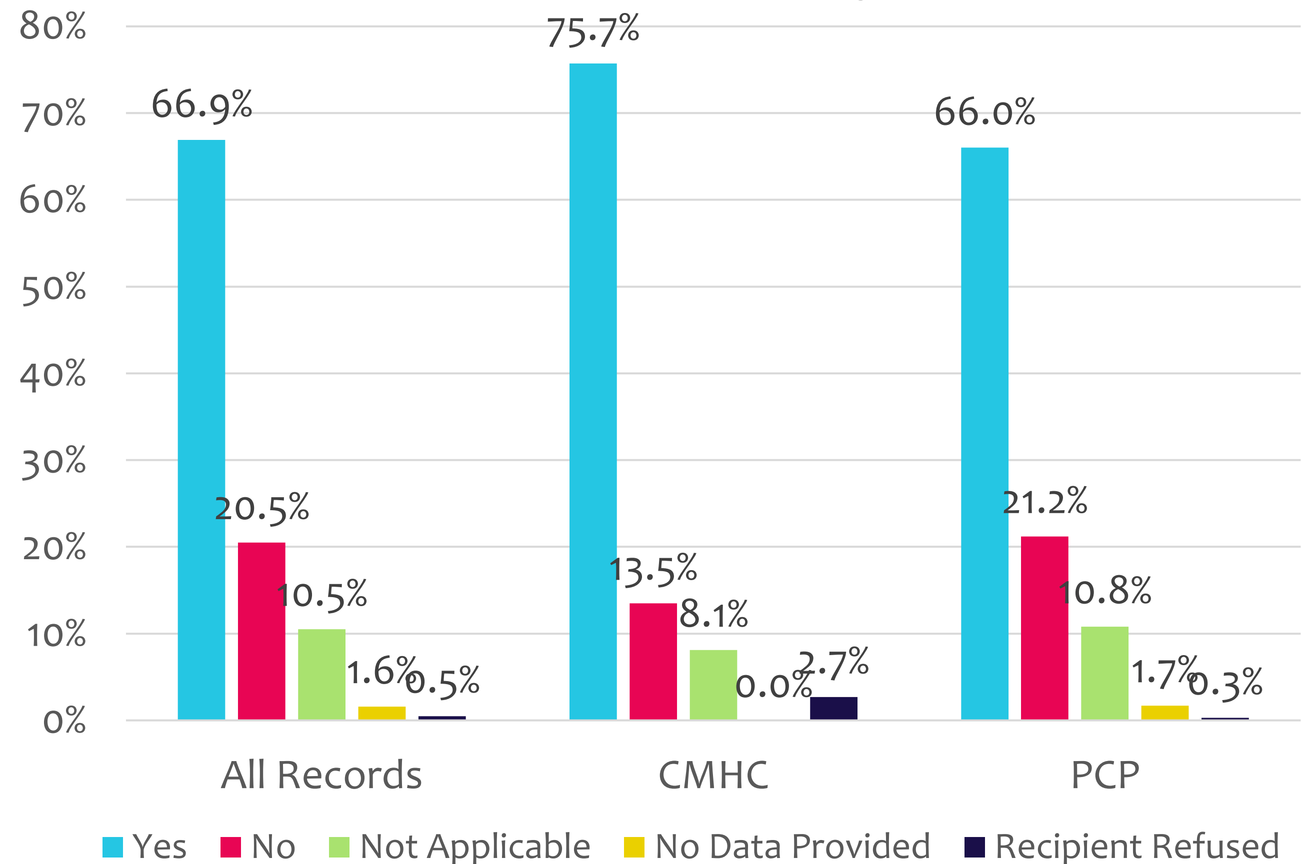


in 2021, not available refers to requested information after first records reviewed but not never received. No data provided refers to records never being received.

Results & Findings

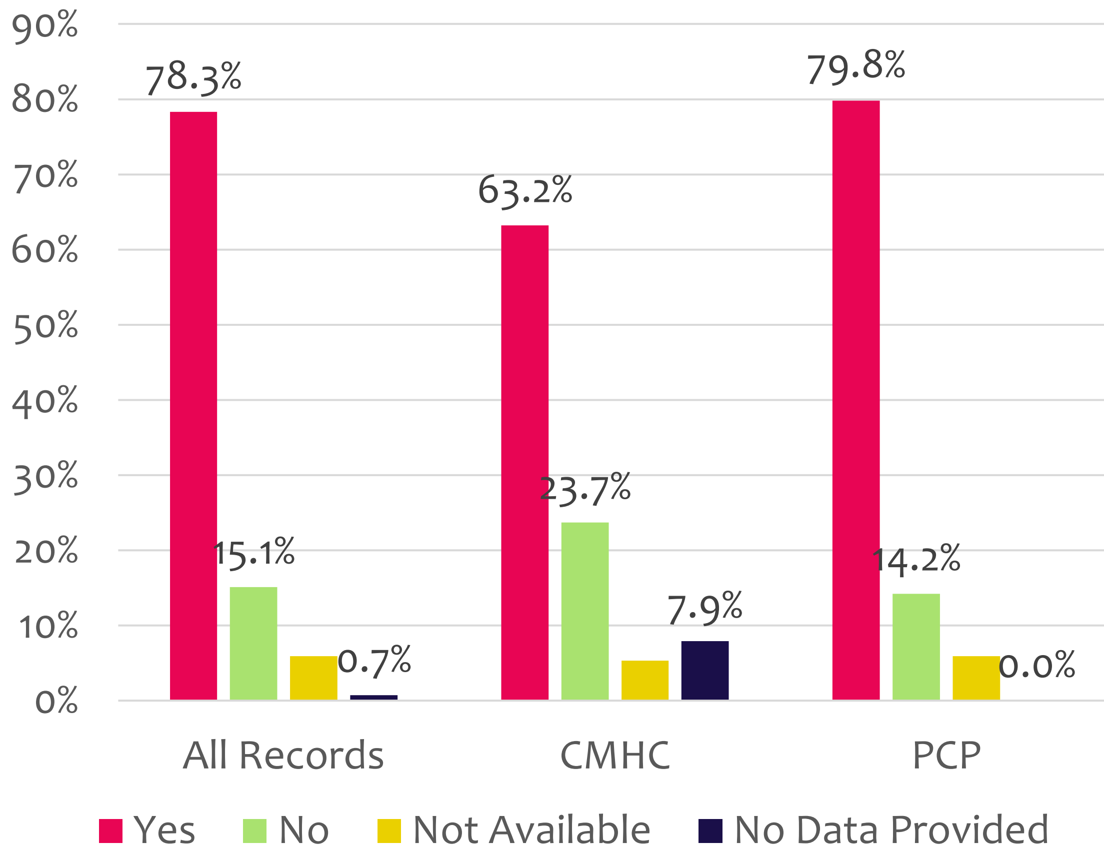
Is there evidence an annual depression screening was completed?

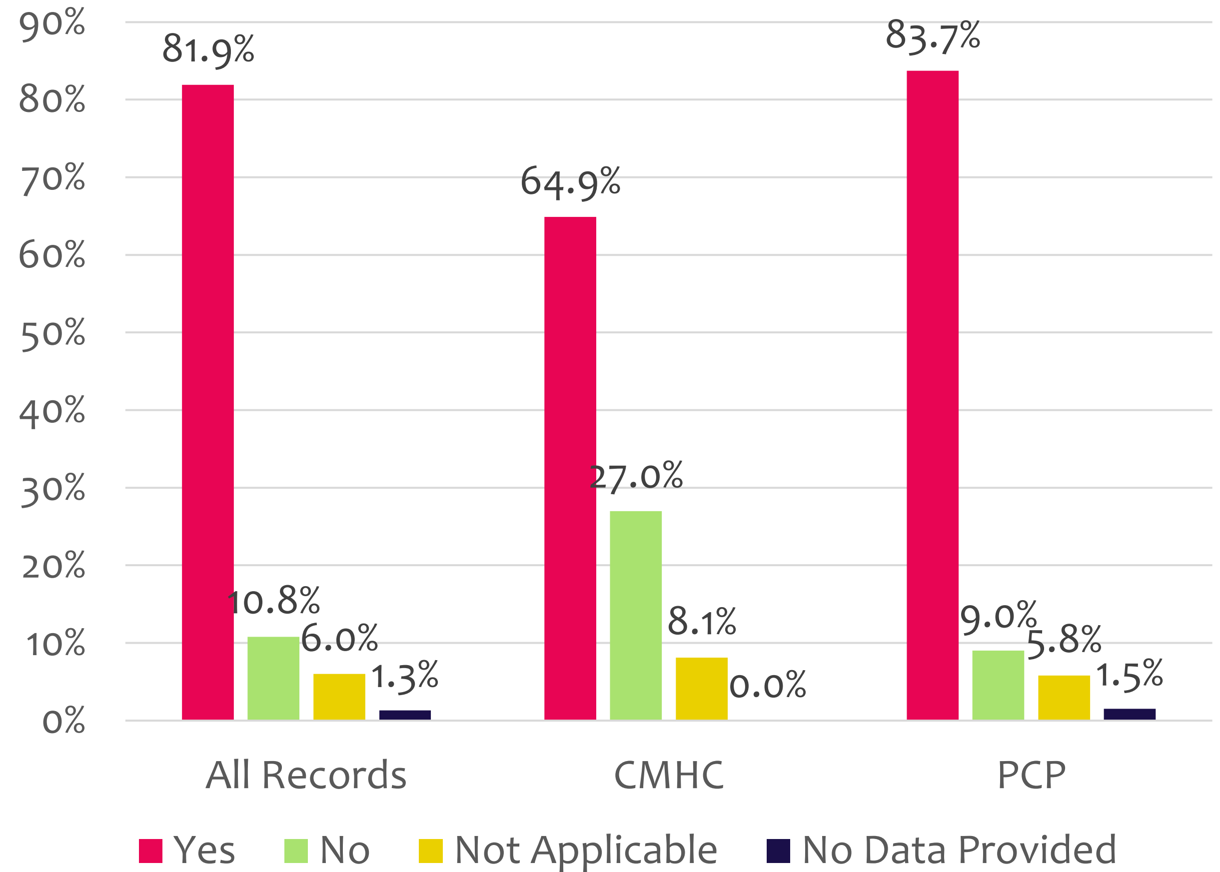




Not Available in 2021: clinics did not send in additional information documentation when requested.

Is there evidence an annual substance use screening was completed?





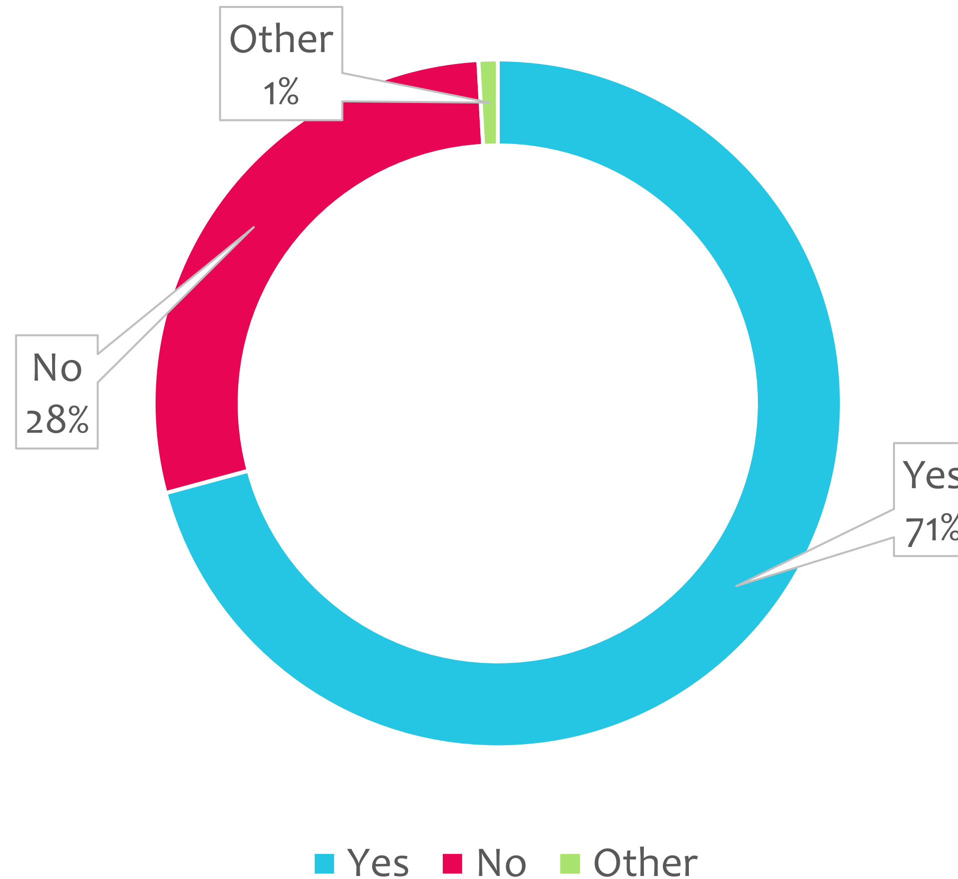
ER Visits & Hospital Admissions

Results & Findings

ER / Hospital Visits Per Patient

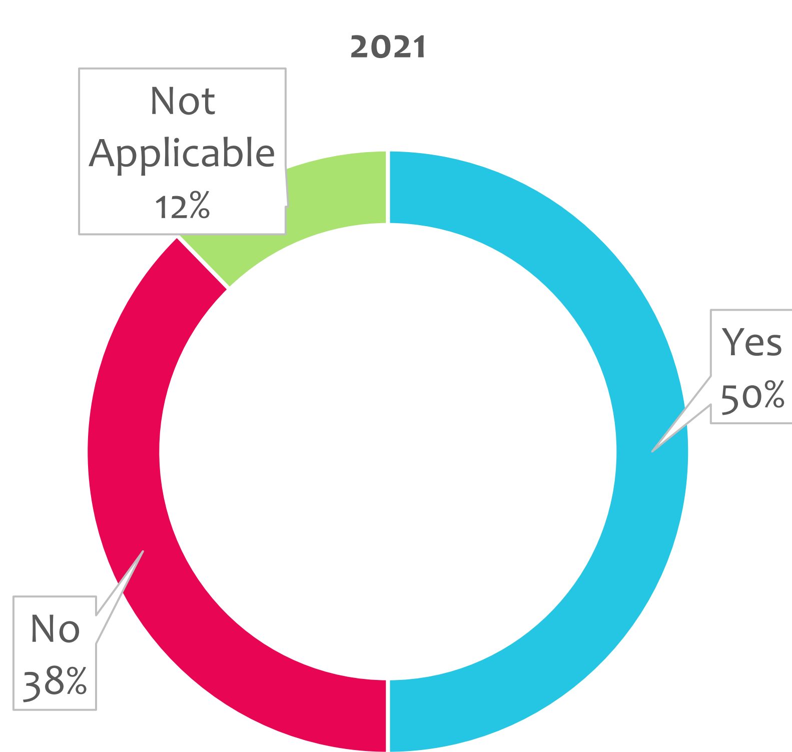
Type of Visit	Number of Recipients	% of all Recipients (of 381)
ER	72	18.9%
Inpatient	27	7.1%

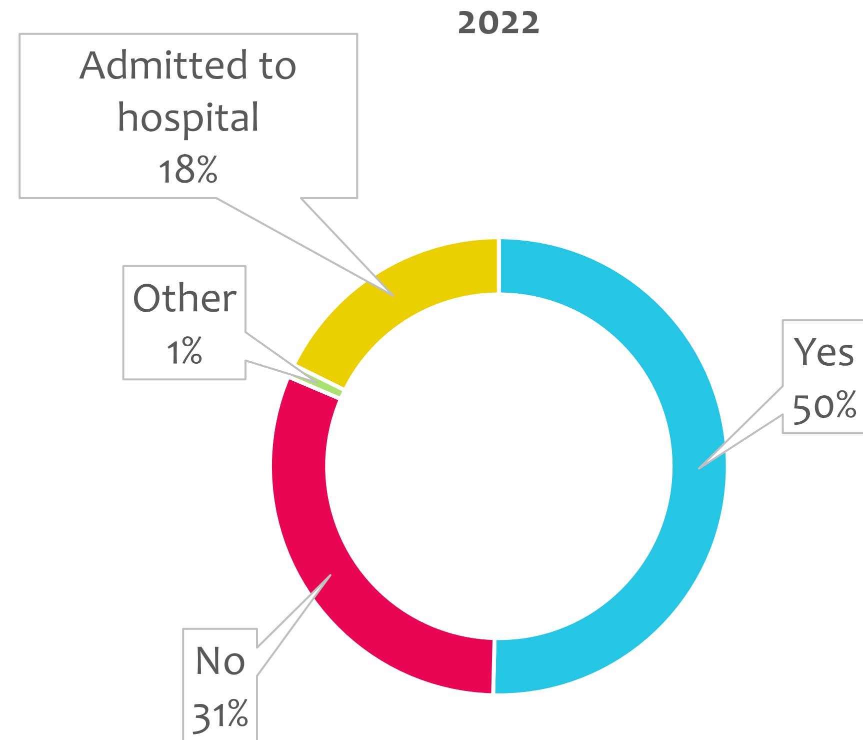
ER – was notification of ER visit documented in the EHR?



Other in 2022 refers to those admitted in Nursing Homes or per clinic they stated recipient had new PCP

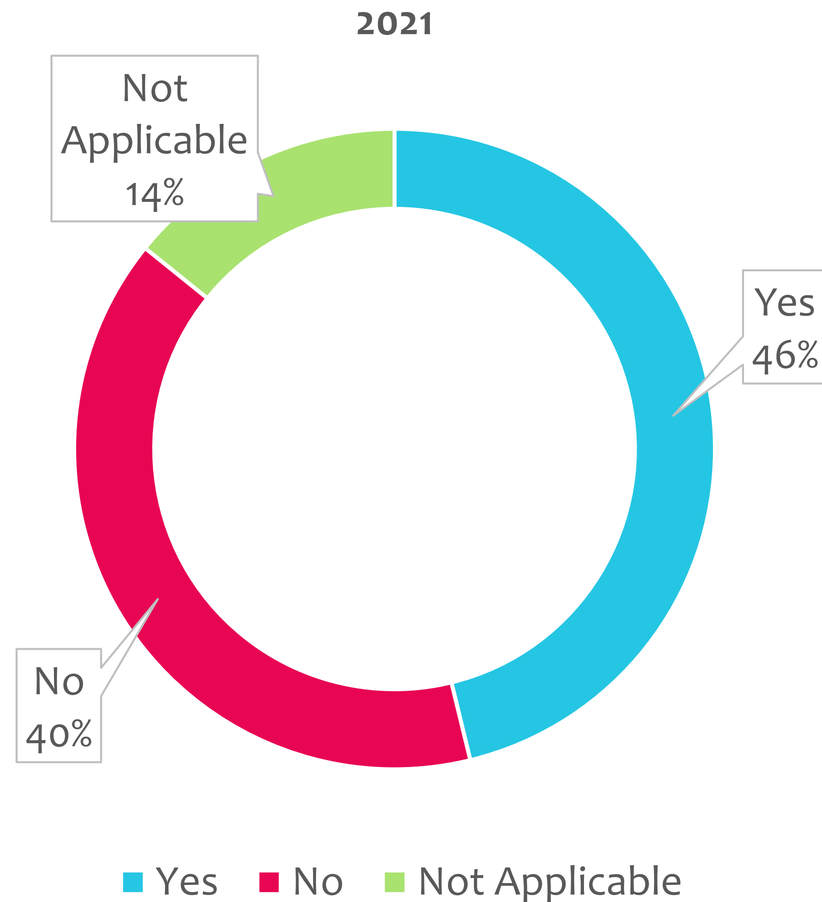
ER – was Health Home notified within 24 hours of ER visit?

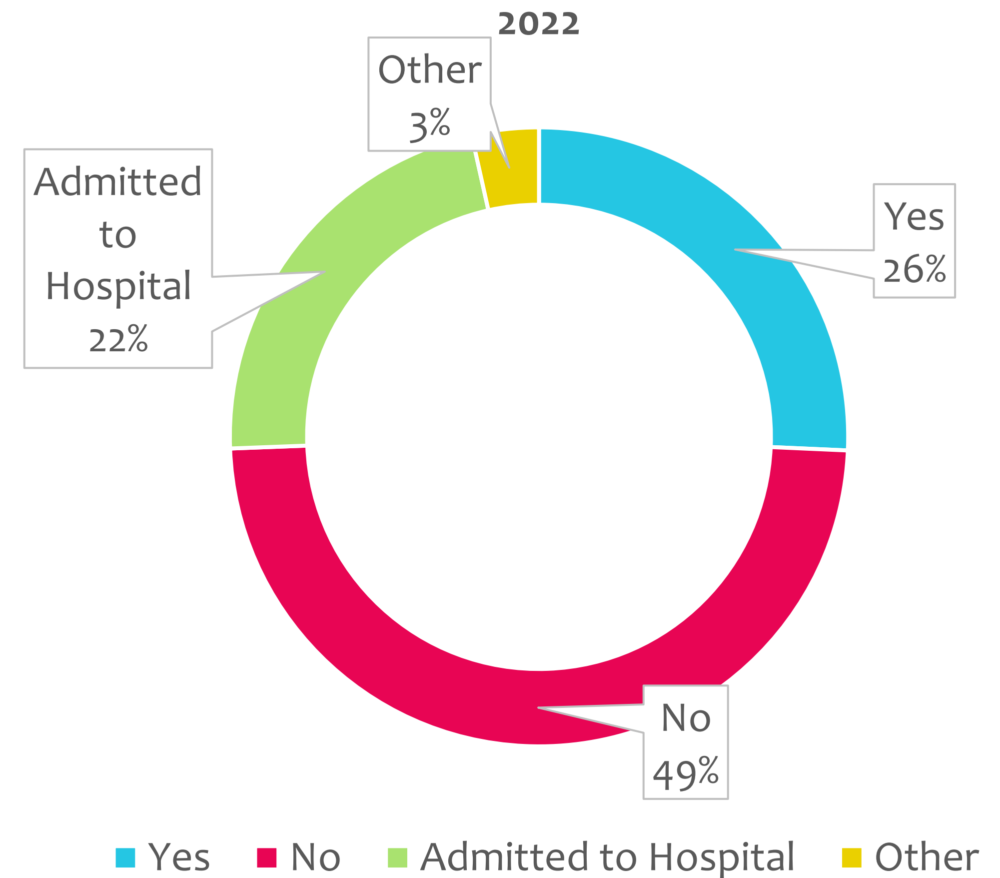




Other in 2022 refers to those admitted in Nursing Homes or per clinic they stated recipient had new PCP. *Not applicable in 2021 had many variables such as not enrolled or transferred to another ED or admitted to hospital.

ER – Did the Health Home contact recipient within 72 hours of discharge?





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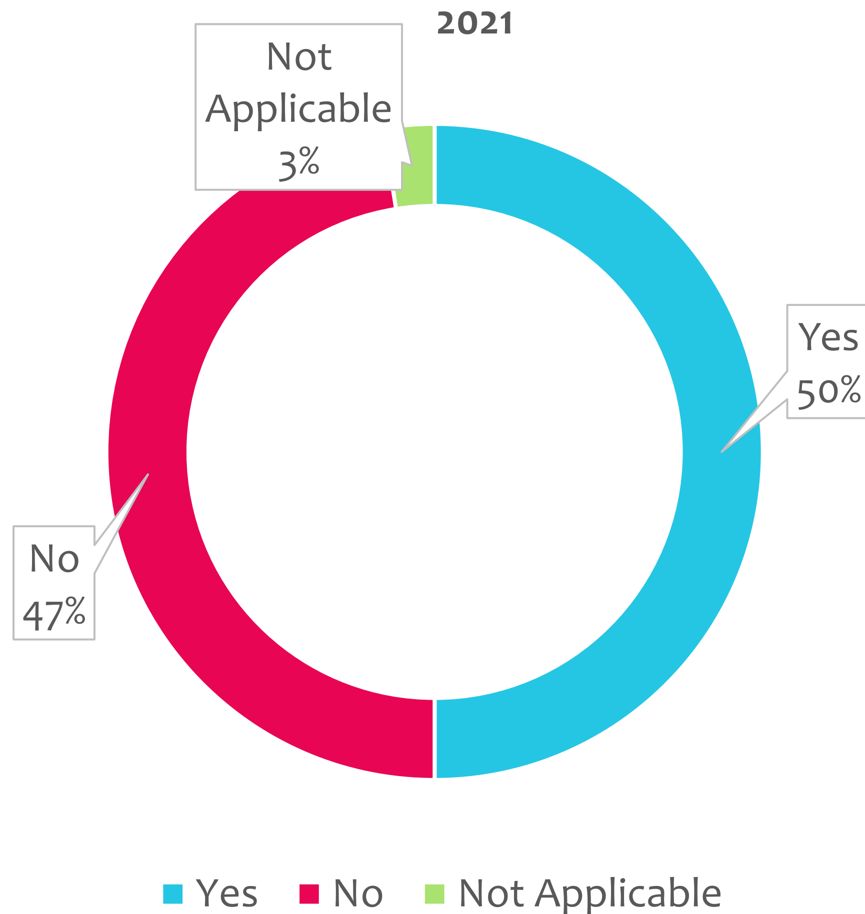
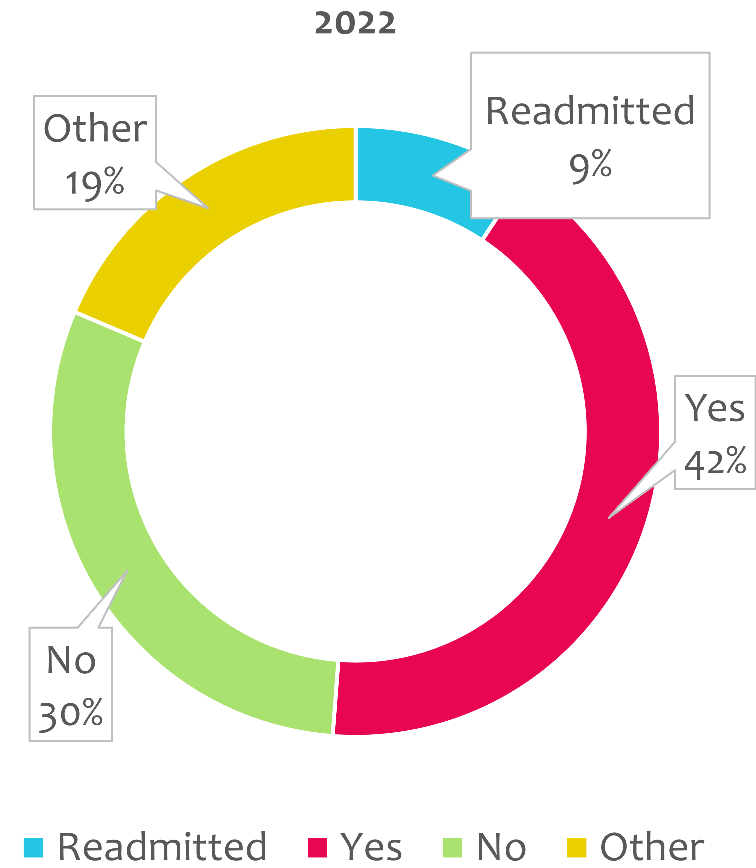
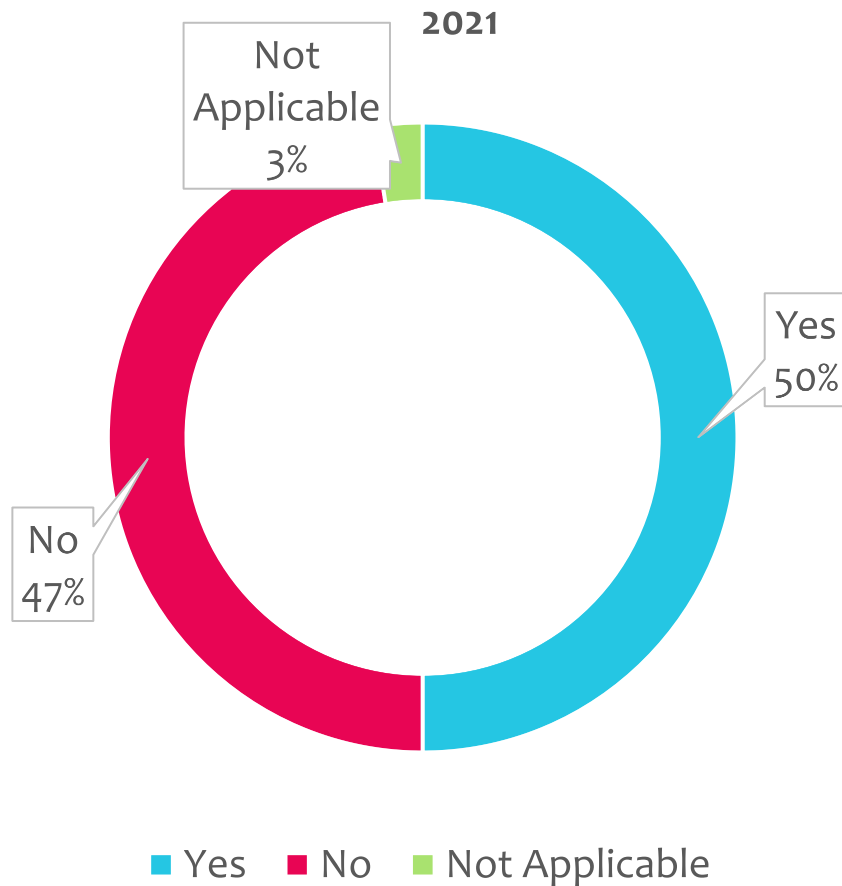
Hospitalization – did Health Home follow-up within 72 hours of discharge?

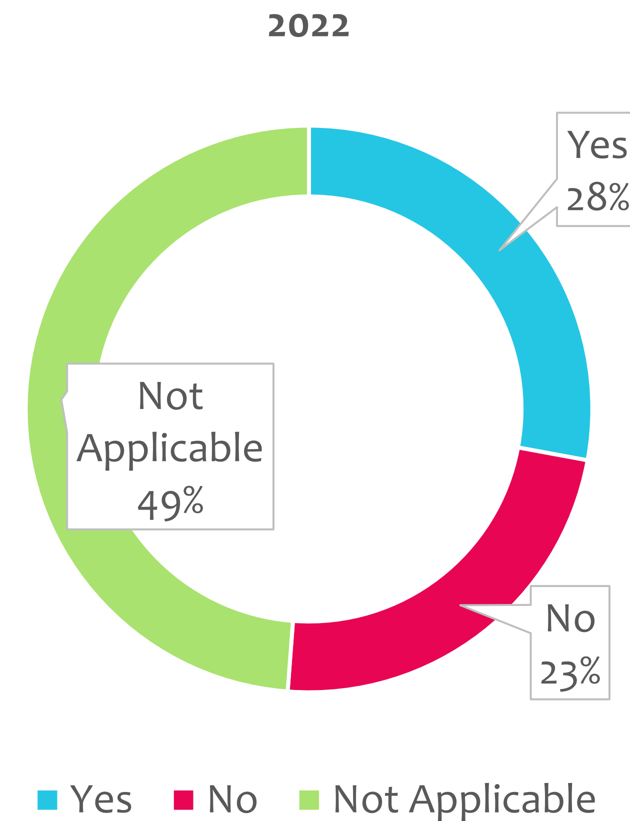




Other in 2022 refers to those admitted in Nursing Homes or per clinic they stated recipient had new PCP. *Not applicable in 2021 had many variables such as not enrolled or transferred to another ED or admitted to hospital.

Hospitalization – was Health Home involved in the transition of care?





*Not applicable in 2021 and 2022 refers to those recipients not needing help with the transition back to home/community.

Overview

Progress

- From 2021-2022 there was a 16.6% increase in the number of care plans completed
- Core Services tied to care plan increased from 71% to 87.3%

Improvement Opportunities

- Core Service in the EHR decreased from 91.2% to 79.3% in 2022
- Depression screening decreased 0.4% overall and was at 66.9% completion rate for 2022
- ER follow-up within 72 hours of discharge decreased from 46% to 26%
- Health Home involvement in transition of care decreased from 50% to 28%
- Hospitalization follow-up within 72 hours of discharge decreased from 50% to 42%

Our Focus

- SDFMC will work with clinics to achieve the goals of the Medicaid Health Home program including:
  - Improve recipient care
  - Help recipient ability to self-manage
  - Help guide clinics with best practices education
  - How can we work with clinics to improve ER/Hospital follow up and transition of care?

Next Steps

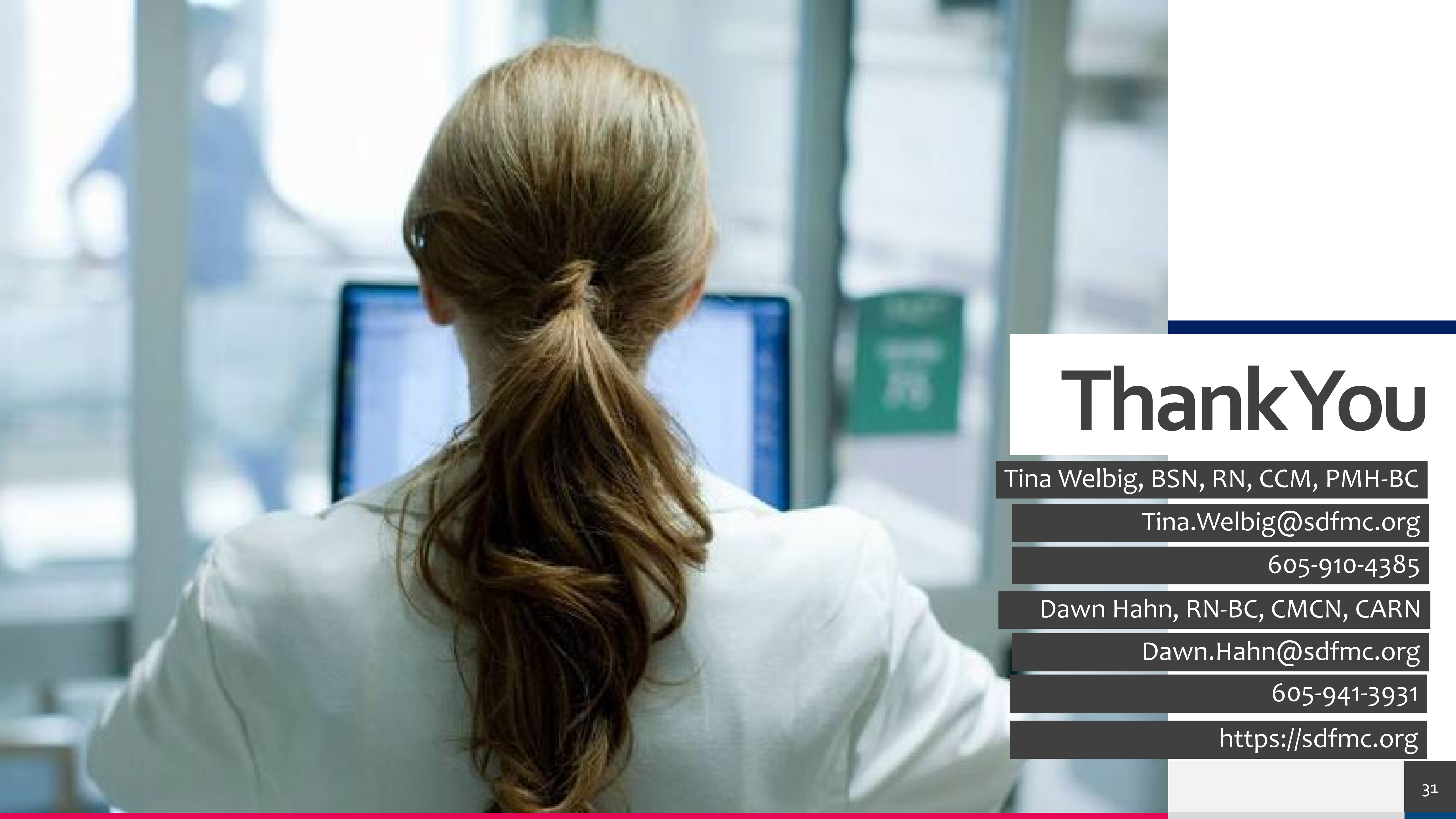
Health Home Quality Review

- Brainstorm with clinics strategies to improve their ER/Hospital follow-up process and notifications
- Hold a follow-up Webinars

References

- https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Care_Management/Health_Home_Program.pdf
- health-homes-section-2703-faq.pdf (medicaid.gov)
- https://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Care-Coordination.pdf
- https://pcmh.amerihealthcaritas.com/pdfs/implementation/care-management-support.pdf
- Integrating Personalized Care Planning into Primary Care: a Multiple-Case Study of Early Adopting Patient-Centered Medical Homes - PMC (nih.gov)
- https://dss.sd.gov/docs/healthhome/teams_based_care/Orientation_Provider.pdf
- https://dss.sd.gov/docs/healthhome/outcomemeasures/2021_Items_for_the_Care_Plan.pdf
- https://dss.sd.gov/docs/healthhome/application_attachment2_core_services_definitions.pdf

Questions



Thank You

Tina Welbig, BSN, RN, CCM, PMH-BC
Tina.Welbig@sdfmc.org
605-910-4385
Dawn Hahn, RN-BC, CMCN, CARN
Dawn.Hahn@sdfmc.org
605-941-3931
https://sdfmc.org