

South Dakota Health Homes Care Coordination Innovation



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NCSL Health Innovation Task Force – December 6, 2016

South Dakota Health Homes

Health Homes (HH)- provide enhanced health care services to individuals with high-cost chronic conditions or serious mental illnesses to increase health outcomes and reduce costs related to uncoordinated care. Implemented July 2013.

- Medicaid recipients with chronic conditions and/or at risk conditions or with Serious Mental Illness or Emotional Disturbance.
- Health Home reimbursement for providing the Core Services is at per member, per month based on recipient tier.

South Dakota Health Homes

- Health Homes provide enhanced health care services to individuals with high-cost chronic conditions or serious mental illnesses to improve health outcomes and reduce costs related to uncoordinated care.
- By providing the Six Core Services, cost of providing care decreases and health outcomes improve.
- Program design and implementation developed using Health Home Implementation Workgroup - a broad stakeholder group of health home providers.



Six Health Home Core Services

- Comprehensive Care Management
 - Comprehensive Care Management is the **development** of an individualized care plan with active participation from the recipient and health home team members.
- Care Coordination
 - Care coordination is the **implementation** of the individualized care plan that coordinates appropriate linkages, referrals, and follow-up to needed services and supports.
- Health Promotion
 - Health promotion services **support** healthy ideas and concepts to motivate recipients to adopt healthy behaviors and enable recipients to self manage their health.



Six Health Home Core Services

- Comprehensive Transitional Care
 - Comprehensive transitional care services are a **process** to connect the designated provider team and the recipient to needed services available in the community. Especially after an ER Visit or Hospital Stay (72 hour follow-up).
- Recipient and Family Support Services
 - Recipient and family **support services** reduce barriers to recipient's care coordination, increase skills and engagement and improve health outcomes.
- Referrals to Community and Social Support Services
 - Referrals to community and social **support services** provide recipients with referrals to support services to help overcome access or service barriers, increase self management skills and improve overall health.



South Dakota Health Home Participation

Enhanced health care services to individuals with high-cost chronic conditions or serious mental illnesses to increase health outcomes and reduce costs related to uncoordinated care

- Medicaid recipients with chronic conditions and/or at risk conditions or with Serious Mental Illness or Emotional Disturbance.
- Reimbursement of Core Services is at per member, per month based on recipient tier.

119 Health Homes serving 122 Locations (July 1, 2016)

FQHC = 25
Indian Health Service Units = 11
CMHCs = 9
Other Clinics = 74

Current number of designated providers = 584



South Dakota Health Home Tiers

Recipient Participation – December 2015 (5,841 enrolled participants)

- Tier 1: 98 enrolled
Not automatically enrolled in the program but per federal requirements must have ability to opt-in.
Eligible for health home services due to chronic condition/diagnosis – this group is not part of the 5% highest cost/high need population

- Tier 2-4: 5,743 enrolled
Automatically enrolled in the program.
Includes the high cost/high need population that will benefit most from the Health Home program.
 - 75-80% of the highest cost/highest need recipients who have a Health Home in their area are participating in the program.
 - Remaining 20-25% have no health home in their area or are currently working with a non-participating PCP.



Recipient Participation as of Payment Dates

- Recipients are placed into 1 of 4 tiers
 - Tier 2-4 are automatically assigned if health home is available.
 - 75-80% of the highest cost/need recipients who have a health home in their area are participating.
- As of July 26, 2016, there were 5,681 recipients in Health Homes.

Type HH	Tier 1	Tier2	Tier 3	Tier 4	Total
CMHC	21	195	405	121	742
IHS	10	1,064	606	240	1,920
Other Clinics	66	1,741	837	375	3,019
Total	97	3,000	1,848	736	5,681

PMPM Reimbursement

- Providers are reimbursed for core services on a per member per month basis.
 - FY16 total expenditures: \$3.6 million (\$1.0 M general)
- Non-core services are reimbursed separately based on DSS fee schedules.
- Core Services were new and no historical cost information available when the program began in August of 2013.

South Dakota Health Home PMPM rates

- Cost Report Subgroup met several times, developed hybrid cost report that targeted personnel costs and common method of developing operating costs.
- Analysis indicated that PMPM payments in the aggregate were commensurate with actual costs. However, adjustments of PMPM rates within tiers was necessary.
- 2016 PMPM payment schedule

CMHC	Payment	PCP	Payment
Tier 1	\$9.00	Tier 1	\$9.00
Tier 2	\$33.00	Tier 2	\$29.00
Tier 3	\$48.00	Tier 3	\$49.00
Tier 4	\$160.00	Tier 4	\$250.00

Preliminary Outcomes

- Health Homes reports 43 data elements which make up 31 outcome measures. Each of the types of Health Homes also report a set of patient experience questions. Outcome for the program years FY14-FY15 showed improvement on 11 outcome measures.
 - Remaining measures require 2-3 years to establish a baseline.
- As the program matures, anticipate improvements in consistency in reporting outcome measures. Revisions to certain measures were implemented for SFY2016.
- Clinical outcome data for FY2016 will be submitted in the fall of 2016.

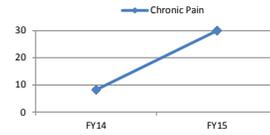
Preliminary Outcomes

- First two years of the program shows an average decrease of 1.2 claims per recipient.
 - Decreased inpatient and outpatient (ED)
- Annual cost avoidance of \$2.5 - \$2.7 million.
- Results are promising – need more program experience to fully assess savings.
- FY16 claims data will yield another year of historical expenditure data. Analysis will be conducted over the course of the next several months. Continuing to isolate individuals that have been enrolled in a health home at least 6-12 months and further refining utilization data.

South Dakota Health Home Clinical Outcomes

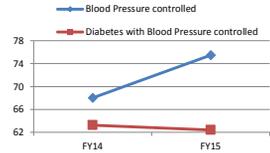
Musculoskeletal

- 21.85% increase in adults with pain assessment using a standardized tool and documentation of a follow-up plan when pain is present.
- Slight reduction in un-necessary imaging studies for low back pain. Measure shows a reduction in imaging studies done within 28 days of diagnosis.



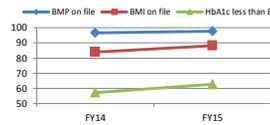
Hypertension

- 7.48% increase in adult recipients BP was adequately controlled
 - Slight decrease among adult recipients with diabetes (-.85%)



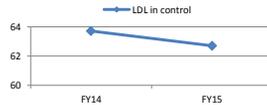
Diabetes

- .9% increase in percentage of children age 6 to 17 with a calculated BMP (Body Mass Percentile) at their most recent visit.
- 4.3% increase in adults who had their BMI documented during the reporting period or the year
- 5.5% increase in adults with diabetes mellitus who had most recent hemoglobin A1c less than 8.0%



High Cholesterol/ Heart Disease

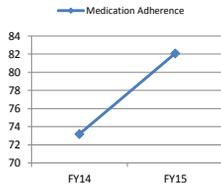
- Slight decrease – 1% in recipients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and who's most recent LDL-C level was in control (less than 100 mg/dL)



South Dakota Health Home Clinical Outcomes:

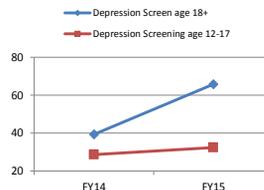
Severe Mental Illness (SMI)

- 8.9% increase in filled prescriptions at least 85% of the time (12 and older)
- Only a Community Mental Health Center (CMHC) measure.



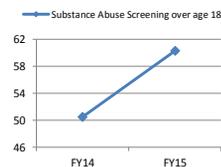
Depression

- 26.4% increase in adults screened for clinical depression
- 3.7% increase in children screened for clinical depression using an age appropriate standardized tool and follow-up documented.



Substance Abuse Screening

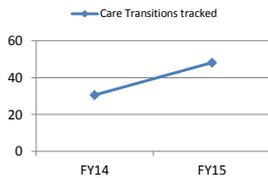
- 9.8% increase in recipients (12 years and older) screened for tobacco, alcohol and other drug dependencies.



South Dakota Health Home Clinical Outcomes:

- **Care Transitions tracked**

- 17.5% increase in discharge notification and records transmission within 24 hours of discharge.



- **Transforming Care**

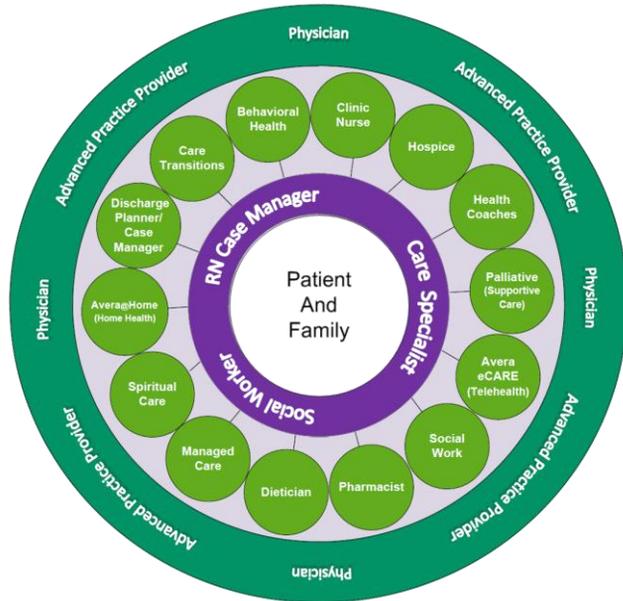
- 7% increase in counseling sessions with recipients /families to adopt healthy behaviors associated with disease risk factors (tobacco use, nutrition, exercise & activity)



Health Home Success Story

When this program started the patient had a BMI of 44.7. With support and coordination of all of her doctors, therapists, case manager and the patient's hard work and dedication the patient's BMI is now 23.3 which is normal for her height and weight. The patient goes in regularly for dental and eye appointments and yearly wellness exams. The patient reduced cholesterol and has been able to get rid of one cholesterol medication. The patient has gone from a pack a day smoking to less than 5 and is working towards quitting.

Avera Coordinated Care Model



Avera Coordinated Care Staffing and Enrollment

- 15 RN Case Managers
- 7 Masters Social Work
- 9 Coordinated Care Specialists
- 1,626 Patients Actively Enrolled – Oct. 2016
 - South Dakota
 - Nebraska
 - Iowa
 - Minnesota



Avera Coordinated Care Outcomes

Coordinated Care Patient Outcomes over 12 month period ending October 2016:

- 9% - 18% reduction in ED utilization
- 6% - 32% reduction in hospital admissions
- 9-17% increase in PCP visits
- 9% - 13% reduction in Diabetic HgbA1c levels
- 12% - 24% improvement in Hypertension control
- 8% - 13% weight loss for obese patients
- 100% of patients enrolled in Coordinated Care are screened for underlying Depression using PHQ9 Depression Screen, monitored to ensure all preventive services are up to date, and have a current Advance Directive housed in the electronic medical record

