

Health Homes Stakeholder Meeting  
June 3, 2014

## Small Group Activity

1. Choose a member profile from those listed on the back of this handout.
2. Using the YELLOW Post-its, identify activities the member might experience in a Health Home in the first 4-6 months and place them in the approximate order they might occur.
3. Using the brightly COLORED Post-its, identify internal operational activities that might occur during the same timeframe and create a parallel timeline.

Things to consider:

Six Core Services: *(see Program Manual for complete definitions)*

- **Comprehensive care management** - involves identifying members with high risk environmental and/or medical factors, and complex health care needs who may benefit from a HH, and coordinating and collaborating with all team members to promote continuity and consistency of care and minimize duplication.
- **Care coordination** - the implementation of a single, integrated HAP through appropriate linkages, referrals, coordination, collaboration, and follow-up for needed services and support.
- **Health promotion** - involves engaging members in HH care by phone, letter, HIT and community “in reach” and outreach, assessing members’ understanding of health condition/health literacy and motivation to engage in self-management, assisting in the development of recovery plans, linking members to resources based on member needs and preferences, and assisting in the development of skills and confidence that will enable the member to manage their needs independently.
- **Comprehensive transitional care** - is specialized care coordination designed to facilitate transition of treatment plans from hospitals, Emergency Departments, and in-member units, to home, LTSS providers, rehab facilities, and other health services systems, thereby streamlining POCs, interrupting patterns of frequent ED use, and reducing avoidable hospital stays. . It may also involve identifying members not participating who could benefit from a HH.
- **Member and family support** - involves identifying supports needed for members, family/support persons/guardians need to manage member’s conditions and assisting them to access these supports.
- **Referral to community supports and services** - includes determining the services needed for the member to achieve the most successful outcome(s), identifying available resources in the community, assisting the member in advocating for access to care, assisting in the completion of paperwork, identifying natural supports if service providers are unavailable in the member’s community, following through until the member has access to needed services, and considering the family/support persons/guardian preferences when possible.

### Health Home Partner Team Members

- Chronic Conditions – Physician, Nurse Care Coordinator, Social Worker
- Serious Mental Illness – Physician, Nurse Care Coordinator, Social Worker, Peer Support Specialist/Peer Mentor/Recovery Advocate, Psychiatrist

### Internal Processes *(not an inclusive list!)*

- Use of Health Information Technology
- Maintenance of communication among internal HHP team members
- Maintenance of communication among identified external team members
- Billing submissions
- What else?

## Health Home Member Profiles – Practice Scenarios

Name: Ethel

Age: 81 years old

Diagnosis: Shows symptoms of dementia and depression, Arthritis, Congestive Heart Failure

Other info:

- Ethel receives her primary care services through a Federally Qualified Health Clinic (FQHC).
- Ethel lives on her own with no family members nearby.
- Her primary care provider is concerned that Ethel is not eating properly.
- Ethel reports that she has had two recent falls due to joint degeneration in her knees.

Health Home Assignment: Initial data mining by the MCO has not resulted in an automatic assignment to a Health Home Partner. The FQHC is a contracted Health Home Partner.

Name: Sean

Age: 8 years old

Diagnosis: Asthma

Other info:

- Sean lives in a rural area with his grandparents, who both smoke and do not have reliable transportation.
- Sean does not have a primary care physician, goes to the ER when he has trouble breathing, and relies heavily on a rescue inhaler.
- He has been hospitalized twice in the past year.

Health Home Assignment: Sean is automatically assigned to the Rural Health Clinic near their home. The family does not choose to opt-out and does not request a change in Health Home Partner.

Name: Brien

Age: 34 years old

Diagnosis: Diabetes

Other info:

- Brien lives with an Intellectual Disability, resides in a group home, and participates in Supported Employment services.
- He smokes and is considered obese.
- Brien frequently refuses to take his insulin as prescribed, but does see a primary care physician.
- Brien's weight and illness have made it difficult to walk and, therefore, he uses a motorized scooter for mobility.
- Brien's older brother is his appointed guardian and lives 30 miles away.

Health Home Assignment: The primary care clinic where Brien receives his care is not a contracted Health Home Provider. He is automatically assigned to the local health department, which is based in the same town as his guardian. He and his guardian do not choose to opt-out, however, would like to be assigned to a Health Home partner closer to Brien's group home.