Health Home Herald

Medicare's Annual Open Enrollment

By Vanessa Sherrill Project Manager Advancing Medicare & Medicaid Integration & Kerri Hummel HH QA Specialist

As seasons change and fall arrives, so do pumpkin spice lattes, corn mazes, leaves changing colors, and open enrollment for active Medicare beneficiaries.

Medicare's Open Enrollment (OEP) period occurs annually in the fall from October 15th – December 7th; this is the one time, each year, that current Medicare beneficiaries can make changes to the way they receive their Medicare benefits.

If a beneficiary has had health changes or is unhappy with Original Medicare or their Medicare Advantage plan, they can switch between the two during this open enrollment period. Medicare Advantage plans are becoming more popular as they typically offer benefits that Original Medicare does not such as prescription coverage, dental, vision, hearing aids, and more. Beneficiaries should always research their options before choosing a Medicare Advantage plan as the supplemental benefits will vary by plan.

A month or two prior to open enrollment, the Medicare beneficiary and/or their authorized representative should review their current Medicare coverage to ensure they are on the best Medicare option that meets their health and prescription drug needs *(Original Medicare A & B + Medicare Part D* **or** *Medicare Advantage Part C that includes Part D coverage)*. The *Medicare and You Handbook* I

Continued to Page 4

Spotlight on Resources

Fall and Winter Energy Savings Tips

By Kerri Hummel, HH QA Specialist with DSHS

The following tips will help you save money and energy while staying comfortable during the cool fall and cold winter months. Many of these tips can be used daily to increase your savings and others are simple and inexpensive actions you can take to get you through the winter and help lower that utility bill.

⇒ If you haven't already, conduct an energy assessment with your utility provider to determine where to save the most.

⇒ Take advantage of heat from the sun. Open curtains on the south facing windows during the day to allow sunlight to heat up your home naturally.

⇒ Cover drafty windows. Tape a heavy-duty clear plastic sheet to the inside of your widow frames to keep the cold air out.

⇒ Adjust the temperature. When you are at home and awake, adjust the inside temperature as low as you can still be comfortable.

⇒ Utilize your fireplace. When using the fireplace, reduce heat loss by opening dampers in the bottom of the firebox or open the nearest window slightly (about one inch) and close doors leading into other rooms.

⇒ If you are a fan of holiday lights around your home, use LED lights as they use less energy.

We hope these tips help. As a Care Coordinator you may share them with your clients as they may need assistance with lowering their utility bills or seeking energy assistance.

Participant Portrait

Lead and CCO - Molina
Care Coordinator - Ashley Stansberry

Client is a 57-year-old who took an ambulance to the hospital for foot pain in early October. After being examined in the Emergency Department, he was admitted to Inpatient Care for a low blood platelet count. The client received a bone marrow biopsy which showed that he has Leukemia. He was distraught with this news, but struggled even more when he was discharged without any medications, referrals, follow-up appointments, treatment, or pain management.

The client's inhaler was also stopped without any information on why from his primary care provider (PCP). His mobility has become limited due to the foot pain, and a very basic two wheeled walker seemed insufficient for his needs.

While working with this client at discharge, he presented as hostile and he often yelled and threatened hospital and Molina staff. He would become agitated as he lost his trust in his medical providers, calling them "quacks". The Care Coordinator worked with him daily to assist with having his needs met.

The Care Coordinator found a PCP that he could see for follow-up during the week following his discharge. The client was apprehensive with seeing a new provider, but after the Care Coordinator assured him, that she would attend the appointment with him to offer support and advocacy, he agreed.

The client called his Care Coordinator daily to reiterate his needs and frustration that they are not being met. He stated what was most important to him, which was to have pain management. He also said that he needs an inhaler and treatment for his foot.

The client and Care Coordinator agreed that at the beginning of the upcoming doctor visit, the Care Coordinator would share the client's concerns, barriers, challenges, and discuss his apprehension. The provider was receptive to the client and his concerns and allowed the client to list what he needed. The provider met those needs including a prescription for an inhaler, a referral to a pain management clinic, a referral to an Oncologist, and a referral to a Podiatrist. The provider could not prescribe pain medication, but offered a muscle relaxer and let the client chose which one. The Care Coordinator asked the provider if there was anything to allow the client to be more mobile and comfortable, as his walker does not seem adequate.

Continue on Page 5

Medicare's Annual Open Enrollment

Continued from Page 1

is an excellent resource and includes information on Medicare coverage and Original Medicare A and B cost information; the Medicare & You Handbook, found at https://www.medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf, is sent to all Medicare beneficiaries annually in August/September.

Medicare options, a few things to consider:

- Open Enrollment starts October 15 and ends December 7; changes made go into effect January 1
- If a Beneficiary is currently on a Medicare Advantage plan, they can switch back to Original Medicare or, if on Original Medicare they can switch to a Medicare Advantage plan.
- Part D prescription coverage: a beneficiary on Original Medicare will need to purchase a stand-alone Part D plan through a private insurance carrier; Beneficiaries on a Medicare Advantage (MA) Plan, should make sure the MA plan they select has Part D included, otherwise they have the option to purchase a stand-alone Medicare Part D plan as well.
- Dual Special Needs Plan (DNSP) is a type of Medicare Advantage Plan specifically designed for the dual eligible client (Medicare and Medicaid coverage). When a Health Home client chooses to enroll in a DSNP they will retain their Health Home services allowing for continuity of care not found in a standard MA Plan.

Making changes to one's Medicare coverage can be confusing but, help is available. Whether a beneficiary has questions about Medicare or is considering changing the way they receive their Medicare coverage they can call the Statewide Health Insurance Benefits Advisors (SHIBA) at 1-(800) 562-6900 for free local support throughout WA; they can also call 1-800-MEDICARE. Health Home Care Coordinators can also assist their Medicare clients with researching information and assist with making phone calls.

Motivational Interviewing Skill Building Sessions:

Building on the information from the Motivational Interviewing Overview training, these skill-building sessions will discuss various concepts of MI and attendees will be able to participate in practicing MI. All sessions are 1 hour from 1:00pm-2:00pm. Skill building sessions are presented by Megin Most, Anthony Foster, and Brendy Visintainer

October 3

November 7

December 5

No need to register, just click on the link to join Zoom at the scheduled time. https://dshs-telehealth.zoom.us/j/85734172786?pwd=TVloUUZDY1pKbnRQSEp4bW9YTGt5UT09

Participant Portrait

Continued from Page 3

The provider agreed, and submitted a prescription for a new four-wheel walker with brakes and a seat with storage. At the end of this appointment, the client expressed a deep gratitude for the support and advocacy from his Care Coordinator and stated, "I haven't felt that understood by a doctor." His usual agitated temperament was diminished and instead a very kind, appreciative, and apologetic disposition. Later the client and his wife called the Care Coordinator to reiterate their gratitude for the assistance and ongoing support and shared what it meant to them and how it has positively impacted them personally. The client has gained a new PCP and trust in his provider. He received medications and referrals which should deter him from using the Emergency Department.

Attending PCP appointments for support can help other clients by allowing them to feel heard and have confidence in expressing their apprehension and needs with additional support present.

This member passed away however was able to spend the last hours of his life with his family at his side. He expressed sincere gratitude for the support and services offered to him through the Health Home Program.

Announcement: Changes Coming to Health Home Basic Training!

Effective January 1, 2024, the Health Home Basic Training is changing. The training will no longer be two full days of in-person training. Instead, there will be a series of self-paced learning modules that will be completed prior to registering for a one-day, in-person, instructor-led training. This is an exciting change to the way Health Home training will be presented.

Learning modules include

1. Fundamentals of Health Home
2. Six Health Home Services
3. Tiers and Billing
4. PRISM
5. Outreach
6. Health Action Plan
7. Motivational Interviewing & SMART Goals
8. Initial Engagement
9. Comprehensive Care Transitions
10. Documentation and Quality Assurance
11. Care Coordination
12. Forms and Documents

TEAMonitor Highlights 2023

By Kerri Hummel, Health Home QA Specialist, DSHS

Every year there are two file review periods: TEAMonitor in the spring for Leads who are Managed Care Organizations and in the fall, monitoring of the Fee-for-Service Leads.

We recently finished our TEAMonitor review meetings with Community Health Plan of WA, Coordinated Care of WA, Amerigroup, United HealthCare, and Molina HealthCare.

The file reviews turned out great, and we wanted to share information with all Care Coordinators.

We want to thank all of you for your hard work during this past year. We understand that it has been challenging at times while working during a public health emergency and slowly transitioning to a new "normal". We appreciate the work you have done and continue to do. We wanted to recognize some of the great work you all have done to help support your clients, as seen in the TEAMonitor file review.

Below is a list of your accomplishments:

* Consistent contact with client face to face or phone.
* High PHQ9 and GAD scores addressed and shared with PCP.
* Lots of coaching and encouragement.
* Resources provided (housing, budgeting & finance, food, mental health, groceries, gift cards, OT/PT, apply for LTC services, Diabetes Education).
* Helping clients understand their health journey on their terms.
* Assisting clients with medical equipment, incontinence supplies, and assistive technology devices.
* Maintaining great documentation and follow-up with your contacts.
* Bilingual Care Coordinators worked with clients when English was their second language.
* Celebrating a client's success when meeting their goals, no matter how big or small.

Based on what we read in the files, we can also see areas for improvement. We understand there can be confusion regarding Health Action Plan timeframes, filling out the Consent, and when to complete the additional health screenings for your client.

For further information and assistance, we suggest utilizing the DSHS website at Washington Health Home Program - On-Going Training | DSHS. You will find self-guided trainings for The Health Action Plan, Assessment Screening Tools, and The Health Home Participation Authorization and Information Sharing Consent Form Guidance Training.

If you need any additional support, we suggest you reach out to your CCO or Lead. They are happy to help.

Care Coordinator Corner

Lead – CHPW
CCO - SeaMar
Care Coordinator - Amber Lensch

Cris is a 57-year-old Caucasian male living with Type 2 Diabetes, COPD, Obesity, and history of Colon Cancer, who has been on ABD cash assistance and had no other source of income. He was interested in applying for Social Security Disability Income but lacked the computer skills to even get started with the process.

When Care Coordinator Amber started serving the client in October 2022, she assisted him in creating an email address and an account on the Social Security website. The two dedicated several hours to complete the online application with Cris on the phone. After submitting the application, Cris and Amber checked his Social Security account frequently to check the status.

Five months later, Cris reached out to let Amber know he was approved for SSDI in March 2023. He mentioned that he was finally able to take his significant other to dinner and be able to pay for it himself, something he had not done in a very long time. Cris also mentioned he was able to pay off 17 pending bills he had been struggling to pay.

Submit your story, resource, or ideas to the Care Coordinator Corner via our newsletter in-box at healthhomenewsletter@dshs.wa.gov

Webinar Trainings

Join us for free monthly webinar trainings designed for Health Home Care Coordinators and allied staff. Webinars are typically held from 9:00 a.m. to 10:30 a.m. the second Thursday of each month.

For invitations including registration information please visit the DSHS Health Home website at Washington Health Home Program – Training Invitations | DSHS

Check often for any updates to topics and registration links.

Upcoming topics

NOV 9	*Overview of Medicaid and LTSS*
OCT 12	*DBHR – Illicit Substance Use and Helping Individuals Who Use Drugs*
DEC 14	*NO Webinar this month only*
JAN 2024 9	*Hearing Loss: Impact, Awareness, Education from ODHH*

Guess the Song – Emoji Version

Guess the song and performer based on the emojis.

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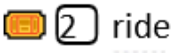
14.  ride _____
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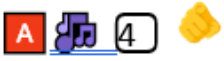
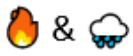
21.  _____
22.  _____
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Answers can be found at Washington Health Home Program - Quarterly Newsletters | DSHS