North Central Accountable Community of Health

Health Home Demystified Highlights

9/9/2020

Background

Six experienced Health Home care coordinators from our rural Eastern Washington regions joined North Central Washington partners via zoom to share stories about their work. Using a "fishbowl" format, care coordinators deepened our understanding of the Health Home program by answering these questions:

- Describe an experience of Health Home at its best. *Listen at 0:20:40*
- What is the range of clients you serve? How is it different rural to urban? *Listen at 0:28:35*
- What are best practices for successful long-term engagement with high-risk populations? *Listen at 0:35:49*
- What's unique about the Health Home program and how does that complement healthcare case management? *Listen at 0:40:50*
- What advice do you have for working well with Health Home care coordinators like you? *Listen at 0:45:50*
- What's the return on investment (ROI) of this program? *Listen at 0:51:10*

Health Home Takeaways

- Care coordinators play a critical role problem solving, advocating and communicating on behalf of and with their clients, across many systems and organizations. The norm for Health Home care coordinators is to be physically there with the client and to let the client's goals drive all of the care coordination. This work is truly patient-centered.
- Client caseloads - clients range from 3 years old to 90+. All clients struggle with chronic health conditions, and many caseloads include clients struggling with homelessness and behavioral health needs. Lack of access to internet and phones, challenging transportation logistics, and language barriers are typical in our rural region.
- Language and cultural needs - All Health Home care coordinators have access to interpretive services if they do not speak their client's native language (e.g. Spanish, Russian). For Washington Tribes, there are nuances around Medicaid eligibility. Tribes are given first right of refusal to be a Health Home lead organization, or they may choose to have one of their departments contract as a care coordination organization. At this time, the Makah Tribe is the only tribe delivering Health Home services to their members. *Listen at 1:02:32*

Reflections from Participants

As a participatory leadership event, everyone had an opportunity to ask questions and discuss opportunities to improve care coordination. Here are some of their reflections:

- Care coordinators who have been cross-trained (e.g. recovery coach) have more community resources, referrals and contacts to draw on to meet the client needs. It is beneficial to have someone available to visit clients in their home to see how treatment plans align and to identify barriers to care.

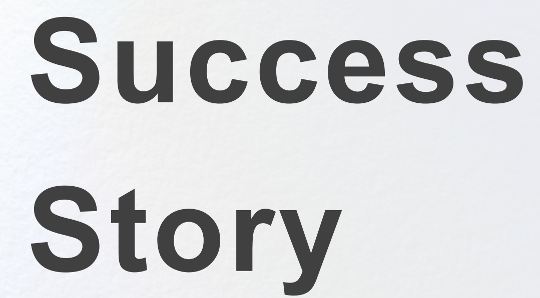
- Relationships build the trust, and that trust enables the care coordinator to help clients with their social determinants and uncover and resolve barriers to their goals. Health education and advocacy is critical because many clients do not know how to navigate the complex systems.
- During a Health Home visit, there is usually 1, or more, members of the household who need significant additional help. They may be rising risk and not qualify for services. If you could work with all of them in the home, then you could move things forward in their care goals. For example, diet, exercise, medication management, and schedules often hinge on what is happening in the home.
- The EMS system can be involved in the partnership of care and coordination. Many times, EMS is seeing high-risk people in the home without transporting and admitting to the Emergency Room.
- Education (for providers and consumers) to raise awareness about Health Home and other programs is key. Can use our community to help advocate for clients and these programs; and process improvements to help make sure that all of the service providers can be connected, especially with shared clients.
- It is not easy for a provider to know if a client is involved in Health Home, or to be alerted when enrolled. Eligibility checks are often done manually by Health Home Care Coordinators.

Opportunities for evolving Health Home program

- Work with Action Health Partners and our community partners (clinical and non-clinical) on co-designing a realistic and helpful process for community partners to check whether their clients are Health Home eligible. This will help with warm hand-offs.
    - Barrier > Community partners (both health care and social service partners) don't know if their client is involved with or eligible for Health Home. While eligibility can be looked up in Provider One, this platform is not available to many social service partners.
- Work on messaging that clarifies basic program qualifiers included in the details about the HH program. If referrals come from many sources, managing caseload may be a consideration, so balancing expectations with reality is important.
- Improve outreach and communications to health care and social service partners to improve collaboration. There are opportunities to build connections with more agencies and providers (including schools) so they know what Health Homes does and who the care coordinators are.
    - Barrier > Many partners do not understand the role of Health Home care coordinators, and how they can help meet shared client goals.
- Work with Medical Assistants and front desk staff to help recognize patient needing more care coordination and potential Health Home eligibility.
- Build relationships with bigger systems doing care conferencing for higher users of the Emergency Department, and look up Health Home eligibility in real time.
- Health Home care coordinators could complete Recovery Coach training, or learn to coordinate with recovery coaches. This would broaden the toolbox and resources to support the needs of clients managing substance use disorders. *Listen at 0:57:58*
- Proactively communicate and coordinate with primary care, so they see Health Home care coordinators as part of the care team. Care coordinators taking the extra step to send a letter to the PCP or medical clinic is very helpful.
    - Barrier > *Listen at 1:27:32*

Opportunities for evolving care coordination network in our region

- 211 is willing to assist NCACH partners with elements of community information exchange (CIE). They have new tools that could assist with information sharing across partners, including resources to address social determinants of health. Resource inventory / database by county would be very helpful to all care coordinators (not just Health Home.) Care coordinators can help find and share quality resources with other care coordinators.
- Expanding this kind of care coordination beyond high-risk target population to “rising risk” (more of a prevention focus). Care coordinators noted that many of their clients have at least one friend or family member who could use care coordination, despite not meeting the Health Home eligibility criteria. One of the main challenges from the clinic setting is referring patients for Health Home only to find that they do not have the "right payer" to receive those services.
- Expanding care coordination in a way that avoids the silos created by payment / reimbursement mechanisms. Work with Health Care Authority and other Health Home leads to ensure that payment mechanisms do not negatively impact clients.
- Still need to work on coordinating care across various models of care coordination. There are organizations that provide similar services. Could we create a process flow to recognize where programs intersect? The goal would be to create a stronger care coordinator network in the community and region.



Success Story

Makah Health Home

August 2020

We are pleased to share the success story of a client.

This is an account of the challenges clients face, living in the rural areas where healthcare resources are limited.

Jane Doe, is a 63 years old, female, with BMI of 32.6

At SOC, in August of 2018, her risk score was at 4.18.

In August 2020, her risk score is at 2.55

List of diagnosis:

- Adenocarcinoma Stg IV
- NIDDM
- Obesity
- Neuropathy
- Hypertension

. Depression

. Neuropathy (s/p Chemotherapy)

. Hyperlipidemia

. Tremors

. Fatigue and weakness

- Her medication list indicates treatment for the above diagnosis.

PRISM HEALTH REPORT

PRISM Health Report	2018	2019	2020
PRISM Score:	4.00	4.18	2.55
• Primary risk of	Cancer	Infection	Cancer
• Secondary risk	Gastro	Cancer	Gastro
• Mental Illness :	Depression	Depression	Depression
• Substance Abuse:	no	no	no
• PAM Score:	42.2	42.2	51.0

The unexpected happens. There wasn’t much time, decisions had to be made, and a lot of information to learn in such as short time. There really wasn’t much time for her to go through the stages of dealing with a cancer diagnosis. She had to meet the challenges head on.

She was diagnosed with an adenocarcinoma of the colon and a tubular adenoma with hyperplastic polyps and sigmoid colon polyps in August 2018, had R. Hemicolectomy, to remove the tumor mass, and remove all the polyps present. Surgery was successful without any complications.

Post surgery infection became a problem. She went through a prolonged battle with her wound care and wound healing process before she was started on her Chemotherapy treatments.

Decisions made: Adjuvant therapy of Surgery and Chemotherapy

We provided moral and emotional report as she confided with us regarding this new diagnosis. Her world came tumbling down. Fears of leaving this life at this age, having to quit her job for the demands of this disease.

We cried with her, gave her lots of encouragement and ensured her that we will be here for her through this ordeal.

We provided encouragement, showed her statistics of positive outcome and survival stories of women and men that have had the same diagnosis and similar experiences that she will be facing.

Health Home Services at work

Initial Care Plan:

1. To assist client as she goes through the stages of dealing with a cancer diagnosis. She was overwhelmed, full of emotions, thoughts of the inevitable possibility of end of her life. Fear, worry, stress, anxiety, sadness and depression
2. To provide support and information with knowledge deficit on the diagnosis of Colorectal Cancer Stage IV (Adenocarcinoma of the Colon). To provide information of adjuvant therapy that includes surgery, chemotherapy, radiation, and biotherapy, depending on what the Oncologist orders.
3. To provide education on the duration of treatment, efficacy, side effects and toxicity of each type of treatment. Ie, surgery, chemotherapy recommended by her Oncologist (i.e. Oxliplatin and 5-FU Fluorouracil).
4. To provide education on how to care for herself with good nutrition, hydration, safety precautions.
5. To provide encouragement, emotional and moral support, dealing with self image after surgery and when alopecia sets in during and after chemotherapy, that could be detrimental to most women.
6. To assist applying, finding and training a suitable health care aid, who can assist her with simple housework chores, shopping, cooking or just simply having someone at home with her for whatever she may need.

Health Action Plans were initiated for her various needs. The STG for her Health Action Plans involved decision making, following through with doctor appointments and looking towards a bright outcome. She was able to be strong, set aside her fears and just trust God that things will work out for her.

Life would be too boring without Bumps along the way

Her surgery in October 2018, was uneventful, successful without complications. Wound care was ordered to be done at the local clinic in our small town.

Every month since surgery, reports of wound is healing from client as well as the local clinic, but chemotherapy is still pending upon wound healing.

Delayed wound healing for total of 4 months, is causing a delay of initiating her chemotherapy treatments. The delay in wound healing process is depriving tis client to get chemotherapy started, affecting her qualify of life and may deprive her of a successful outcome if treatment would be further delayed.

Additional CARE PLANs:

1. Impaired Tissue Integrity
2. Risk of Infection
3. Delayed plan of treatment for Chemotherapy.
4. Increased Depression/ Anxiety/ Frustration.
5. Pain management

Advocacy as part of care coordination

Advocacy to improve the outcome of this dilemma of slowing healing wound of more than 4 months.

Wound assessment had to be done. With the clients' permission. An evidence-based evaluation of the wound. Knowing the etiology of the wound, this assessment included: classification, measurement, assessing the wound bed, determined if there was tunneling and undermining; how much drainage and exudate, if there was any odorous exudate, look at wound edges and if there were any granulating tissues. These assessments provide the way to a successful wound care planning.

Actions taken that paved way to a positive outcome of wound healing

---

After assessing the wound.

Calls were made on her behalf to her PCP, where she was getting wound care, and the local clinic's health director- suggestions and recommendations as we advocate for getting a referral to a wound care specialist without success.

Next step, was to reach out to the surgeon.

Appointment made and escorted client to see the surgeon, who was willing to listen and agreed to our recommendation of having a wound vac to speed up the wound healing process, and requested for wound care orders to Wound care clinic in Forks and follow up by Olympic Medical Home Health Nurses at home.

Road to Wound healing and go forward.

Wound finally healed after 2 months of wound vac therapy. Chemotherapy was initiated when the Oncologist saw that the wound was going in the right direction.

Challenges of Wound Care and Chemotherapy

Care Plan:

1. Care Coordination for transport (2 hour drive to and from cancer center or wound care clinic) and scheduling assistance.
2. Arranging availability of accommodation in hotel near the infusion center in Sequim, and wound care in Port Angeles, if she feels too weak to travel and may desires to stay the night.
3. Providing education regarding signs and symptoms of infection and pain management.
4. Providing information regarding the drugs used in her chemotherapy.
5. Care coordination in requesting for Home Health services
6. Provide education on neuropathy, precautions regarding contraindications with her chemotherapy treatments.
7. Continued moral and emotional support.

Success is on the horizon

The Wound Vac did an amazing work on the wound healing process. Her wound healed at an exponential rate, making the chemotherapy scheduling available sooner.

The Oncologist was on board immediately, he had been waiting impatiently for the a successful wound care treatment and was displeased about the delay to initiate chemotherapy.

It is still better to be late than never (as the saying goes)

She was able to tolerate the challenges of chemotherapy. There were a few holds on treatments due to low blood counts. She was able to maintain good nutrition, hydration and practice safety awareness. She does not hesitate to call whenever she has any questions regarding any problems that may arise.

Four magical words

She tolerated and met the challenges of months of wound care treatments and months of chemotherapy. Endless doctor appointments to see her doctors and nurses at the Cancer Center, Wound Care Clinic, and PCP. All the pain and suffering that she tolerated and endured.

Last week, on August 14, 2020. Exactly 2 years from her encounter with the diagnosis of cancer. She met with her oncologist, after a CT scan and Blood test. The Oncologist informed her that " **YOU ARE CANCER FREE**" and will need to make an appointment in 6 months. The Surgeon tells her than she won't need to see her till another 5 years.

Celebration Time

We celebrate with her on this joyous time. We commend her for her tenacity, fighting spirit and of how well she did.

We asked her: What do you want to do to celebrate !

She replies: She wants to go to Hawaii.

Well, with the CoVid Pandemic, we may have time to plan for this most deserving trip.

So…… Hawaii, Be ready for our visit in 2021 or 2022?